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



USING TRAIN DOMAIN

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

Please note:

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

PATIENT SCENARIO 1 - Patient List

Learning Objectives

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

Create a Location Patient List

Create a Custom Patient List

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

SCENARIO

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

As a specialist nurse you will complete the following activities:

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



Activity 1.1 – Set up a Location Patient List

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

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

- 1. Select the **Patient List** icon Article From the **Toolbar** at the top of the screen.
- 2. To create a location list, click the **List Maintenance** icon ². 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.

PowerChart Organizer for TestCD, ICO-Nuise							
Task Edit View Patient Chart Links PatientList Help							
👫 Care-Compass 🎼 Clinical Leader Organized 🛓 Patient List 🥇 🕇 ti-Patient Task List 👫 Discharge Dashboard 📾 Staff Assignment 🎆 LearningLIVE 😓 🗒 Care-Connect: 🕲 PHSA PACS 🕲 VCH and PHC PACS 🕲 MUSE 🔍 FormFast WFI 😓							
🗄 🎢 Exit 🌃 AdHoc 🎟 Medication Administration 🚡 PM Conversation 👻	🔟 Exit 🎽 AdHoc 💷 McGation Administration 👍 / M Conversation 👻 🗟 Medical Record Request 🛧 Add 🖉 🗒 Documents 🚔 Scheduling Appointment Book 🛜 iAware 🚇 Discem Reporting Portal						
🔯 Patient Health Education Materials 🕄 Policies and Guidelines 🔇 UpTo	Date 🖕						
Patient List							
2 * * * * * * * * * *							
	P Modify Patient Lists						
	Available lists:	Active lists:					
			1				
		4					
		New	OK Cancel				

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

Patient List Type			
Select a patient list type:			
Assignment Assignment (Ancillary) CareTeam Custom Rocation Provider Group Query Relationship Scheduled			
Back	Next	Finish	Cancel
	5		

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.

Location Patient List	×					
Image: Services Image: Services Image: Services Image: Services	* III					
Enter a name for the list: (Limited to 50 characters)						
Back Next Finish Cancel						



- 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

Location Patient List		×
✓*Locations [LGH 2 East]	B- C	*
☐ Medical Services ☐ Encounter Types ☐ Care Teams ☐ Relationships ☐ Time Criteria ☐ Discharged Criteria ☐ Admission Criteria	CONTROL CHARACTER CONTROL CHARACTER CONTROL CHARACTE	W
	⊕ □	÷
Enter a name for the list: (Limited t LGH 2 East	to 50 characters)	incel
	9	

- 10. In the Modify Patient Lists window select your Location list.
- 11. Click the **Blue Arrow** icon icon to move the **Location** to the right **Active List**.
- 12. Click **OK** to return to **Patient Lists**. Your Location list should now appear.

Modify Patient Lists	
Available lists: Active lists: Active lists:	
 ● 11 ● 	(1) (3)
	New OK Cancel



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

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 ² in the **Patient List**.
- 2. Click New in the bottom right corner of the Modify Patient Lists window.
- 3. From the Patient List Type window select Custom.
- 4. Click Next



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

Custom Patient List	Care Team #1	
Medical Services Encounter Types Relationships Admission Criteria Discharged Criteria Use Best Encounter		
Enter a name for the list: (Limite JohnDoe_Custom List	d to 50 characters)	

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

Modify Patient Lists			
P Modily Patient Lists			
Available lists:	Active lists:		
JohnDoe_Custom List 7	LGH 2 East		
	8		
]	New OK	_ [9 e



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

- 1 At the beginning of each shift or assignment change, you will add your patients to your custom list from your location list.
 - 1. First, find your patient. Your patient is located on your **Location List**. Right-click on the **patient name**. Using today's handout sheet, select your patient's correct name. Use this custom list for the train session today.
 - 2. Select Add to a Patient List.
 - 3. Select YourName_Custom List.



- 4. Select YourName_Custom tab. The tab may be empty.
- 5. Click the **Refresh** icon is 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.

P PowerChart Organizer for TestUser, RespiratoryTherapist	- 9 -
Task Edit View Patient Chart Links PatientList Help	
📾 Multi-Patient Task List 🖃 Message Centre 🎬 CareCompass 🎬 Clinical Leader Organizer 🐩 Ambulatory Organizer 🛓 Patient List 🔤 Schedule 🛲 Staff Assignment 👫 LearningLIVE 📗 📃 🕄 CareConnect 🔞 PHSA PACS 🕲 VCH and PHC PACS 🕲 MUSE 🕲 FormFast WFI 👦	
🗐 Exit 🗃 AdHoc 💷 Medication Administration 🔒 PM Conversation - 🔩 Communicate + 💠 Add + 🎒 Scheduling Appointment Book 🗃 Documents 📾 Discem Reporting Portal 📴 Javare -	
🔯 Patient Health Education Materials 🙀 Policies and Guidelines 🕲 UpToDate 🚊	
CSTLEARNING, DEMOTHETA DONOTUSELEARN, MONTY	- Q
Patient List	rint 🛛 🍣 0 minutes ago
Ø B > щ 4 4 10 0 € E [m 2] []	5
IGHEmergency Department LGH4 East IGH4 E	
Cacation Name MRN Encounter# Age DOB Admitted Admitting Physician/Reason for Visit/Primary Care Physician Visitor Status	
CIGH EE 622 04 CSTPRODDSSYSTEM, DAVID 7000003100 7000000015807 72 years 21-Mar-1945 30-Nov-2017 10:31 PST Plisvca, Rocco, MD System TestIng TestDS, GeneralMedicine-Physician8, MD	

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

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 📱	CareCo	mpass 📲 Clinical Leader Or	rganizer 📲 Ambula	tory Organizer 🛔 Pa	atient List	Staff Assignment 📲 Lear		
🗄 🎢 Exit 🎬 AdHoc 🎟 Medication Administration	n 🚨 PM	Conversation 👻 📴 Commu	nicate 👻 🗎 Medica	I Record Request 🕂	Add 👻 📻 🛙	ocuments 🖀 Scheduling		
🕴 🔍 Patient Health Education Materials 🔇 Policie	s and Gui	idelines 🕄 UpToDate 🖕						
					_			
Multi-Patient Task List								
🖌 🛇 🐵 🇃 🔍 🕮 🎋								
Departmental View, Assigned Tasks								
Scheduled Patient Care Nurse Collect								
Task retrieval completed								
All Patients		Name	Medical Record Nu	Location/Room/Bed	Task Status	Scheduled Date and Time		
CSTPRODORD PATIENT A		CSTPRODORD, PATIENT A	700001815	LGH 7E / 7EL / 03	Pending	Continuous		
	CSTPRODORD, PATIENT A 70001815 LGH 7E / 7EL / 03 Pending Continuous							
CSTPRODORD, PATIENT B	CSTPRODORD, PATIENT B CSTPRODORD, PATIENT A 70001815 LGH 7E / 7EL / 03 Pending Continuous							
CSTPRODORD, STTESTAAB	CSTPRODORD, STTESTAAB CSTPRODORD, PATIENT B 70001818 LGH 4E / 422 / 03 Pending Continuous							
		CSTPRODORD, STTESTAAB	70000028	LGH 7W / 707 / 02	Pending	Continuous		
CSTTEST, JPADULT		CSTTEST, JPADULT	700001735	LGH 5E / 516 / 01	Pending	Continuous		
WONG-LEARN, JIAN		WONG-LEARN, JIAN	700005463	LGH OR	Pending	Continuous		



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

Task Edit View Patient Chart Links Task	List Options Help									
🔋 🔐 Multi-Patient Task List 🖃 Message Centre 🎬 CareCompass 🎬 Clinical Leader Organizer 🎬 Ambulatory Organ										
🗄 🌌 Exit 📲 AdHoc 💵 Medication Administration 🔒 PM Conversation 👻 🔤 Communicate 👻 🖹 Medical Record R										
👯 🔍 Patient Health Education Materials 🔍 Policies and Guidelines 🔍 UpToDate 🖕										
Multi-Patient Task List										
🖌 😣 🐵 🧃 🔍 🔛 🦗										
Departmental View, Ass 1 1	tient View 2									
Scheduled Patient Care Nurse Collect										
Task retrieval completed										
All Patients Name Medical Record Number										
CSTPRODAC, TRANSFER										
CSTPRODORD, PATIENT A 700001815										
CSTPRODORD, PATIENT A	CSTPRODORD, PATIENT A 700001815									
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

P Task List Properties	×
Time Frames Patient List	
Choose a Patient List Departmental View Nurse Specialist LGH 5 East 405 WoundCare_Custom	Location Filters
View Assigned Tasks 5	Save
	6 OK Cancel

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



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

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

To select the appropriate Time Frame for your MPTL:

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

	Task Edit View Patient Chart	Links Task	List Options	Help							
÷	🔋 Multi-Patient Task List 🖃 Message Centre 🎬 CareCompass 🎬 Clinical Leader Organizer 👫 Ambulatory Organizer 🛓 Patient List 🙄 🙄 😋 CareConnec										
1	📲 Exit 🎬 AdHoc 💵 Medication Administration 🔒 PM Conversation 👻 🔄 Communicate 👻 🗟 Medical Record Request 🕂 Add 👻 💽 Documents										
:	🖸 Patient Health Education Materials 🔞 Policies and Guidelines 🔇 UpToDate										
						n Recent 👻	Name	<u>-</u> ५			
	Multi-Patient Task List							🗇 Full screen 🖷	Print 🛛 🍣 25 minutes a		
	/ 🛛 🖻 🖻 🔍 🕮 🍂										
	Departmental View, Assigned Tasks	- 4				04-December-201	7 06:30 Mon	d in DET 04 December Change Time Fr	ame Criteria 2		
	Scheduled Fatient Care Nurse Colle	ect									
	Task retrieval completed										
	All Patients	Name			Medical Record Nu	Location/Room/Bed	Task Status	Scheduled Date and Tim	e Task Description		
	CSTPRODORD, PATIENT A	CSTP	RODORD, PATIE	NTA	700001815	LGH 7E / 7EL / 03	Pending	Continuous	Wound Care Clinicia		
		CSTP	RODORD, PATIEN	NTA	700001815	LGH 7E / 7EL / 03	Pending	Continuous	Wound Care Clinicia		
	CSTPRODORD, STTESTAAB	CSTP	RODORD, PATIEN	NTA	700001815	LGH 7E / 7EL / 03	Pending	Continuous	Wound Care Clinicia		
	🗹 WONG-LEARN, JIAN	CSTP	RODORD, STTES	TAAB	70000028	LGH 7W / 707 / 02	Pending	Continuous	Wound Care Routine		
		WON	G-LEARN, JIAN		700005463	LGH OR	Pending	Continuous	Ostomy Clinician Fol		

Within the Task List Properties window:

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

P Task List Properties	x
Time Frames 3 tient List	_
Choose one of the following:	
Defined Time Frame O Hour Interval O Generic Time Frame	
Range <u>12 Hour Day Shift</u> O Previous 12 Hour Night Shift	
Gurrent B Hour Day Shift B Hour Evening Shift	
Next 4 B Hour Night Shift 5	
Show me my: 14:00 👻 PST	
From: 04-Dec-2017	
To: 04-Dec-2017	
6 OK Cancel	

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

_											
	Task Edit View Patient Chart	Links	Task List Option	ns Help	1						
1	🗄 👪 Multi-Patient Task List 🖃 Message Centre 🎬 CareCompass 🎬 Clinical Leader Organizer 🎬 Ambulatory Organizer 🗼 Patient List 🙄 🙄 CareConnec										
	🗄 🏨 Exit 🎬 AdHoc 💵 Medication Administration 🔒 PM Conversation 👻 🍱 Communicate 👻 🔝 Medical Record Request 💠 Add 👻 📻 Documents										
	🔅 😋 Patient Health Education Materials 😋 Policies and Guidelines 😋 UpToDate 🖕										
Г											
	Multi-Patient Task List							[🗆] Full screen 🛛 🛑 Pi	int 🛛 🍣 25 minutes a		
	✓ ⊗ ⊠ á ≧ ₩ %						E				
	Departmental View, Assigned Tasks Scheduled Patient Care Nurse Colle	ect				04-December-201	7 06:30 Mon	d y DST 04 December 2 Change Time Fran	ne Criteria 2		
	Task retrieval completed										
	All Patients		Name		Medical Record Nu	Location/Room/Bec	Task Status	Scheduled Date and Time	Task Description		
	CSTPRODORD, PATIENT A		CSTPRODORD, PA	TIENT A	700001815	LGH 7E / 7EL / 03	Pending	Continuous	Wound Care Clinicia		
			CSTPRODORD, PA	TIENT A	700001815	LGH 7E / 7EL / 03	Pending	Continuous	Wound Care Clinicia		
			CSTPRODORD, PA		70000028	LGH /E / /EL / 03	Pending	Continuous	Wound Care Clinicia		
	WONG-LEARN, JIAN		WONG-LEARN, JIA	N	700005463	LGH OR	Pending	Continuous	Ostomy Clinician Fol		

Within the **Task List Properties** window:

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

P Task List Properties					×
Choose one of the follo	wing:	Generic Tim	e Frame		
Range 12 Ho Previous 8 Hot © Current 8 Hot Next 8 Hot	ur Day Shift ur Night Shift ır Day Shift ır Day Shift ır Night Shift				
Show me my: 14:00	▼ PST				
From: 01-Dec-2017 To: 04-Dec-2017	▲ ▼ 1412 ▲ ▼ 1413	PST PST S			
			6	ОК	Cancel

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.

1

Activity 2.2 – Review Multi-Patient Task List Functionality

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

Multi-Patient Task List						[□] Full screen	Print	€ 1 minutes ago
🖌 🛛 🖻 🛋 💷 🍂 🔢 1								
Departmental View, Assigned Tasks	2		04	I-December	-2017 06:30 Monda	y PST - 04-Deceml	ber-2017 19	45 Monday PST
Scheduled Patient Care Nurse Collect	3							
Task retrieval completed	_							
All Patients	Name	Medical Record	Location/Room/Bed	Task Status	Scheduled Date an	Task Description		Order Details
	CSTPRODORD, PATIENT A	700001815	LGH 7E / 7EL / 03	Pending	Continuous	Wound Care Clinici	ian Following	2017-Aug-02 1
	CSTPRODORD, PATIENT A	700001815	LGH 7E / 7EL / 03	Pending	Continuous	Wound Care Clinici	ian Following	10-Nov-2017 11
CSTPRODORD, STTESTAAB	CSTPRODORD, PATIENT A	700001815	LGH 7E / 7EL / 03	Pending	Continuous	Wound Care Clinici	ian Following	10-Nov-2017 11
WONG-LEARN, JIAN	CSTPRODORD, STTESTAAB	70000028	LGH 7W / 707 / 02	Pending	Continuous	Wound Care Routir	ne	2016-Sep-01 10
4	WONG-LEARN, JIAN	700005463	LGH OR	Pending	Continuous	Ostomy Clinician F	ollowing 5	2017-Aug-18 10
								•

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....

Multi-Patient Task List						
🗸 🚫 🐵 🍵 🔍 🛄 %						
Departmental View, Assigned Tasks						
Scheduled Patient Care Nurse Colle	ct					
Task retrieval completed						
All Patients	Name	Medical Record	Location/Room/Bed	Task St	Chart Done	
CSTPRODORD, PATIENT A	CSTPRODORD, PA	TIENT A 700001815 1	LGH 7E / 7EL / 03	Pendir	Chart Done (Date/Time)	ician F
CSTPRODORD, STTESTAAB	CSTPRODORD, PA	TIENT A 700001815	LGH 7E / 7EL / 03	Pendir	Chart Not Done	ician F
WONG-LEARN, JIAN	CSTPRODORD, ST WONG-LEARN, JIA	TESTAAB 70000028 AN 700005463	LGH 7W / 707 / 02 LGH OR	Pendir Pendir	Quick Chart	tine Follov
					Unchart	
					Ad Hoc Charting	
					Reschedule This Task	
					Print	•
					Order Info	
					Order Comment	
					Create Admin Note	
						_
					Task Info 2	
					Patient Snapshot	

2



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

P Task Information for: Wound Care C	linician 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	E
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:

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

3

	Name	Medical Record	Location/Room/Bed	Task Status	Scheduled Date an	Task Descr	iption	Order Details		
	CSTPRODORD, PATIENT A	700001815	LGH 7E / 7EL / 03	Pending	Continuous	Wound Care Clinician Following 2017-Aug-			15 PDT	
	CSTPRODORD, PATIENT A	700001815	LGH 7E / 7EL / 03	Pending	Continuous 1	Woun <u>d Ca</u>	re Clinician Following	10-Nov-2017 11:	41 PST	
	CSTPRODORD, PATIENT A	700001815	LGH 7E / 7EL / 03	Pending	Continuous	Woun	Chart Done 🧑		41 PST	
	CSTPRODORD, STTESTAAB	70000028	LGH 7W / 707 / 02	Pending	Continuous	Woun	Chart Done (Dater u	me)	16 PDT, Consta	ant ord
	WONG-LEARN, JIAN	700005463	LGH OR	Pending	Continuous	Ostom	chart bone (bate) h		11 PDT, Reaso	on for fo
							Chart Not Done			
							Quick Chart			
							Chart Details / Modi	fy		
							Unchart			

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

P Assign a Relationship	
For Patient: CSTZEROON	EPYLON, SITTWOMONTY
Relationships:	
Nurse	
Quality / Utilization Review	
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 Col	ect											
Task retrieval completed												
All Patients		Name	Medical Record I	Location/Room/Bed	Task Status	Scheduled Date an	Task Description					
CSTPRODORD PATIENT A		CSTPRODORD, PATIENT A	700001815	LGH 7E / 7EL / 03	Pending	Continuous	Wound Care Clinician Following 2					
		CSTPRODORD, PATIENT A	700001815	LGH 7E / 7EL / 03	Pending	Continuous	Wound Care Clinician Following 1					
CSTPRODORD, STTESTAAB	1	CSTPRODORD, PATIENT A	700001815	LGH 7E / 7EL / 03	Complete	04-Dec-2017 15:4	Vound Care Clinician Following 1					
WONG-LEARN JIAN		CSTPRODORD, PATIENT A	700001815	LGH 7E / 7EL / 03	Pending	Continuous	Wound Care Clinician Following 1					
		CSTPRODORD, STTESTAAB	70000028	LGH 7W / 707 / 02	Pending	Continuous	Wound Care Routine 2					
		WONG-LEARN, JIAN	700005463	LGH OR	Pending	Continuous	Ostomy Clinician Following 2					

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

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

	Multi-Patient Task List										
	🖌 🛛 🖄 🏚 🗒	<i>i</i> h									
	Departmental View, Assigned Tasks										
	Scheduled Patient Care N	Nurse Collect									
	Task retrieval completed										
All Patients				me	Medical Record	Number	Location/Room/Bed	Task St			
			wo	NG-LEARN, JIAN	700005463		LGH OR	Pendin			
		Hide	CST	TEST, JPADULT	700001735		LGH 5E / 516 / 01	Pendin			
	CSTPRODORD, PA	Go To	CST	PRODORD, STTESTAAB	70000028		LGH 7W / 707 / 02	Pendin			
	CSTPRODORD, ST		CST	PRODORD, PATIENT B	700001818		LGH 4E / 422 / 03	Pendin			
		Ad Hoc Charting	CSI	PRODORD, PATIENT A	700001815	1	LGH /E / /EL / 03	Pendin			
		Open Patient Chart 2 🕨		Patient Summary 3				Pendin			
	WONG-LEARN, JLAN			Orders				Fenuin			
				Single Patient Task List							
				MAR							
				Interactive View and IO							
				Results Review							
				Desure station							
				Documentation							
				Medication Request							
				Histories							
				Allergies							
				Diagnoses and Problem	ns						
				CareConnect							
				Clinical Research							
				Form Browser							
				Growth Chart							
				Immunizations							
				Lines/Tubes/Drains Sur	mmary						
				MAR Summary							
				Medication List							
				Patient Information							
				Reference							



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

P Assign a Relationshi	ip 🛛		×
For Patient: CSTZER	DONEPYLON, SITT	WOMONTY	
Relationships:			
Nurse			
Quality / Utilization Re Research Unit Coordination	view		
		ОК	Cancel

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

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

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

CSTLEARNING DEMORETA - 7000082	15 Opened by Testliser IVTherany-Nurse								
Task Edit View Patient Chart	Links Navigation Help								
😂 Multi-Patient Task List 🖃 Message Centre 🎬 CareCompass 🎬 Clinical Leader Organizer 🐩 Ambulatory Organizer 🧽 Patient List 📾 Staff Assignment 🎬 LearningLIVE 📄 😨 CareConnect 😨 PHSA PACS									
🖫 Tear Off 📲 Enit 🎁 AdHoc 🎟 Medication Administration 🔒 PM Conversation - 🔩 Communicate - 📓 Medical Record Request 💠 Add - 📻 Documents 🚔 Scheduling Appointment Book									
🗞 Patient Health Education Materials 🛱 Policies and Guidelines 🎕 UpToDate 💡									
CSTLEARNING, DEMOBETA		← List → @ Recent - Name - Q							
CSTLEARNING, DEMOBETA	DOB:01-Jan-1937 MRN:700008215 Code Status:	Process: Location:LGH 6E; 624; 03							
Allergies: Tape, penicillin	Age:80 years Enc:/000000015056 Gender:Male PHN:9876469831 Dosing Wt:70 kg	Isolation: Enc Type:Inpatient 2							
Menu P	A Patient Summary	[므] Full screen							
Patient Summary		4							
Orders 🕂 Add	Handoff Tool 12 Quick Orders 12 Summary 12	Accessment 17 1							
Single Patient Task List									
MAR	Informal Team Communication								
MAR Summary	Informal ream communication								
Interactive View and I&O	Add new action	Add new comment							
Results Review									
Documentation 🕈 Add 😑	Dressing changed. Will require new pain medication tomorrow.	No comments documented							
Medication Request	Please re-order morphine. TestUser, IVTherapy-Nurse 05/12/17 12:44	All Teams							
Histories		-							
Allergies 🕂 Add	> teette								
Diagnoses and Problems	TestUser, Nurse 26/11/17 17:37								
	All Teams	-							
CareConnect									
Clinical Research									
Growth Chart	Active Issues	Classification: Medical and Patient Stated 👻 All Visits 💐 🗮							
		Add ann an This Mait -							
		Add new as: Inis visit + Y							
۰ III ۲	L								

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.



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

Key Learning Points

٩

- 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.



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:

- 66 Order for nurse to review
- Additional reference text available
- Order part of a PowerPlan
- Grder waiting for Pharmacy verification
- 4. Locate the **IP (inpatient) Consult** orders (e.g. IP Consult to Asthma Educator) and review the details.

Menu 7	< 🔹 🔹 🏦 Orders				
Patient Summary	🛨 Add 🗌 🖓 Document Medication by	Hy Reconciliation	Check Interactions		
Orders 1 🕂 Add		The proceeding and the	- We check interactions		
Single Patient Task List	Orders Medication List Document I	n Plan			
MAR	14				
	View 2	Displayed: All Active	Orders All Inactive Orders All Active Order	rs	3
Interactive View and I&O	··· Orders for Signature		1		
Results Review	+ Plans	N 7	Order Name	Status Dose	Details
Documentation Add	Suggested Plans (0)	⊿ Medications			
	Orders	🗹 词 🛽	vancomycin	Ordered	1,000 mg, IV, q12h, start: 23-Nov-2017 10:00 PS1
Medication Request	Admit/Transfer/Discharge	M 🕫 🛙	HYDROmorphone	Ordered	1 mg, NG-tube, q1h, PRN pain, drug form: inj, s DILAUDID EQUIV
Histories	Status	M 🗵	HYDROmorphone (HYDROmorphone	Ordered	dose range: 1 to 2 mg, PO, q4h, PRN pain, drug
Allergies 🕂 Add	Patient Care		PRN range dose)		DILAUDID EQUIV
Disgnoses and Droblems	Activity	⊻ ‰	salbutamol (VENTOLIN 100 mcg/puf	Ordered	200 mcg = 2 puff, inhalation, as directed, order
Diagnoses and Problems	Diet/Nutrition	<u> </u>	oxyCODONE	Ordered	5 mg, PO, QID, PRN pain-breakthrough, drug fo
	Continuous Infusions	⊻ ‰	ibuprofen (ibuprofen PRN range dose)	Ordered	dose range: 200 to 400 mg, PO, q4h, PRN pain, q
CareConnect	Medications	🗹 🐚 🗷	cefTRIAXone	Ordered	2,000 mg, IM, q12h, drug form: inj, start: 17-Nov
	Blood Products	🗹 🐚	acetaminophen	Ordered	650 mg, PO, q4h, drug form: oral liq, start: 17-N
Clinical Research	- Zaboratory				Maximum acetaminophen 4 g/24 h from all sou
Form Browser	Diagnostic Tests	⊿ Laboratory			
	Procedures	66 📃 🎽	' CBC	Pending Co	Blood, AM Draw, Collection: 19-Nov-2017 03:30
Growth Chart	Respiratory	Image:	Differential (CBC and Differential)	Pending Co	Blood, AM Draw, Collection: 19-Nov-2017 03:30
Immunizations	Allied Health	⊿ Consults/Refe	errals		
	Consults/Referrals		IP Consult to Asthma Educator	Ordered	29-Nov-2017 13:56 PST, Routine, Reason 4 Io
Lines/Tubes/Drains Summary	Communication Orders		IP Consult to Diabetic Educator	Ordered	29-Nov-2017 13:56 PST, Routine, Reason for Co
MAR Summary	Supplies		IP Consult to IV Therapy Team	Ordered	29-Nov-2017 13:56 PST, Routine, Reason for Co
	Non Categorized		IP Consult to Ostomy Clinician	Ordered	29-Nov-2017 13:56 PST, Routine, Reason for Co
Add	Medication History		IP Consult to Wound Care Clinician	Ordered	29-Nov-2017 13:56 PST, Routine, Reason for Co
Patient Information	Medication History		IP Consult to Wound Care Clinician	Ordered	29-Nov-2017 13:46 PST, Routine, Reason for Co
	Personalization History Shapshot		IP Consult to Pharmacy	Ordered	17-Nov-2017 15:03 PST, Reason for Consult: Otl
Kererence	+ Reconclitation History	∠ Communication	on Orders		
			Communication Order	Ordered	23-Nov-2017 15:09 PST, ICU Insulin Infusion pro



- 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

< 🖂 🕂 者 Orders								
Add Check Interactions Add Check Interactions Medication List Document In Plan								
View	Di	splayed: A	ll Acti	ive Orders	All Active Orders			
Orders for Signature		<i>≫</i> ≊		8	Order Name 🔺	Status		
Decument In Plan	⊿	Patient	Care	5				
		=	\checkmark	260	Admission History Adult	Ordered		
TM Red Blood Cell (RBC)		a .		* 41	Pasia Administra Information	Ordered		
- Suggested Plans (0)		1		. <u>×</u> , 00	Adult	Ordered		
Corders		e	\checkmark	<u>X</u> 60^	Braden Assessment	Ordered		
- Admit/Transfer/Discharg			-	46				
Status		(†	\checkmark	X 66'	Infectious Disease Screening	Ordered		
- Patient Care								
A stinites	•	_						

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

P Ordering Physician	×
Order	
Proposal	
[^] Physician name	- 1
Plisvca, Rocco, MD	
er Date/Time	- 1
4 1/2017	ST
*Communication type	
Phone	
Verbal	
Proposed	
No Cosignature Required	
5 ignature Required	
er/Fax	
Electronic	
	_
5 OK Cancel	
	_

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									
*Requested Start Date/Time: 29-Nov-2017 💽 🔽 1441 💿 PST									
Reason for Follow-Up: Continuity of care									
0 Missing Required Details Orders For Cosignature Orders For Nurse Review									

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

1

Activity 4.3 – Review Order Statuses and Details

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 Order entered se	05 PST, Stop: 17-Nov-2017 14:05 PST econdary to inpatient admission.	=
👘 🛄 🛛 Vital Signs			20-Nov-2017 11:	25 PST, q4h while awake	
⊿ Medications					
👘 🗹 🍗 🖻 furosemide	Ordered		20 mg, IV, as dir Administer pre r	ected, order duration: 5 day, drug form: inj, start: 17-Nov ed blood cell transfusion	-
< III				•	

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

	N	7	Order Name	Status	Dose	Details
△ Allied Health						
	⊻		Asthma Educator Following	Ordered		9-Nov-2017 14:41 PST, Reason for follow-up: Continuity of care
⊿	∠ Consults/Referrals					
	\checkmark		IP Consult to Asthma Educator	Ordered		29-Nov-2017 13:56 PST, Routine, Reason for Consult: Education
	\checkmark		IP Consult to Diabetic Educator	Ordered		29-Nov-2017 13:56 PST, Routine, Reason for Consult: Insulin Management
	\checkmark		IP Consult to IV Therapy Team	Ordered		29-Nov-2017 13:56 PST, Routine, Reason for Consult: Need a PICC
	\checkmark		IP Consult to Ostomy Clinician	Ordered		29-Nov-2017 13:56 PST, Routine, Reason for Consult: New Colostomy
	\checkmark		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 *deternotes* appears to the left of the order. This identifies the order as one that needs to be reviewed by a nurse.
- 2. The nurse should click the Orders for Nurse Review button to open the review window.

🔗 🕅 Order Name	Status 🔻	Dose Details
⊿ Patient Care		
▶ 🗹 😚 Vital Signs	Ordered	28-Nov-2017 10:42 PST, q4h
1		
-		
•		4
Details		
Orders For Cosignature Orders For Nurse Review 2		Orders For Signature

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

P	CSTLEARNIN	IG, DEMOALPHA - Actions	Requiring Review					
A	STLEARN	IING, DEMOALPHA	DOB:01-Jan-1937 Age:80 years . Gender:Male	MRN:700008214 Enc:700000001505 PHN:9876469856	Code Status: 5 Dosing Wt:	Process: Disease: Isolation:	Location: Enc Type:I Attending:	L GH 6E; 624; 02 npatient Plisvca, Rocco, MD
	Actio	n Action Da Entered	By Order Det	ails			Ordering	
	Order	28-Nov-201 Plisvcf, 7 10:42:56 Dillon, N	ND Vital Signs 28-	Nov-2017 10:42 PST, q4	h		Plisvcf, Dillon, MD	3
	C 1 . All							
V	Select All	Snow All Details					CSTLEARNING, DEMOA	LPHA Review 4 Cancel

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



Always review and verify the status of orders

Hover to Discover to view additional order information



Activity 4.4 – Place a Verbal Order

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

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

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

To place a verbal order:

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

Menu P	< > - 🛉 Orders
Patient Summary	+ Add 2 Docume CSTPRODORD, PATIENT A - Add Order
Orders 1 + Add Single Patient Task List	Orders Medication L CSTPRODORD, DOB:01-J MRN:700 Code Status: Process:Violence Ris Location:LGH 7E; 7.
MAR	Allergies: codeine,Gender:F PHN:987 Dosing Wt:55 kg Isolation: Attending:
MAR Summary	Vie Plans Search: Ioraze 4 Advanced Options View Type: 👘 Inpatient View View View View View View View View
Interactive View and I&O	Document In Pla
Results Review	Medical LORazepam (mg, PO, PRN anxiety, drug form: tab)
Documentation 🕂 Add	GENSURG Nega
Medication Request	Suggested Plans (0) Sugges
Histories	Orders Drders (0.5 mg, IM, q4h, PRN anxiety, drug form: inj)
Alleraies 🕂 Add	Admit/Transfe
Diagnorer and Problems	Orgentus
	Activity LORazepam (0.5 mg, PO, on call to OR, drug form: tab)
	Diet/Nutrition LORazepam (0.5 mg, PO, qHS, drug form: tab Met OParset (0.5 mg, PO, qHS, drug form: tab Distribution (1.5 PD)
CareConnect	Continuous Int
Clinical Research	Medications Net LOnazeparti (35 mig, subcutaneous, 444, PN analety, ang form; in) Net LOnazeparti (35 mig, subcutaneous, 444, PN analety, ang form; in)
Form Browser	Blood product
Growth Chart	Ladouadoy Oral LORazepam (1 mg, PO, on call to OR, drug form: tab)
	Procedures "Enter" to Search
	Respiratory
Lines/Tubes/Drains Summary	C Allied Health
Medication List 🛛 🕂 Add	Consults/Refe CSTPRODORD, PATIENT A - 7000018 6 Done
	Communicatid

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

P Ordering Physician	P Ordering Physician
 Order Proposal 	 Order Proposal
*Physician name	*Physician name
*Order Date/Time 20-Nov-2017 v 1332 v PST *Communication type	Conder Date/Time 20-Nov-2017 Communication type
Phone 7 Verbal 7 Proposed 7 No Cosignature Required Cosignature Required Paper/Fax Electronic	Phone Verbal Proposed No Cosignature Required Cosignature Required Paper/Fax Electronic
OK Cancel	OK 7 Cancel

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.

< > 🔻 🖬 Orders					니, Full screen	Print	💐 4 minutes age
+ Add J Document Medication by Hx	Reconciliation 🛛 🕭 Check Inte	ractions		Rec	onciliation State Meds History	us D Admissio	on 🔒 Discharge
Orders Medication List Document In Plan							
	Orders for Signature						
View							
Orders for Signature		Jam					
- Plans Document In Plan	🚰 Details 间 Order Comm	ents					
Medical							
GENSURG Negative Pressure Woun	🛨 🖀 In. 🛛 본 🎽			Remaining /	dministrations [.]	(PRN) Sto	op: (Unknown)
GENSURG Negative Pressure Woun							·
- Suggested Plans (0)	*Dose:	1 9					
Orders	*Dose Unit:	ma					
- Admit/Transfer/Discharge	buse unit.	ing .					
- Status	*Route of Administration:	PO 🗸					
Patient Care							
Activity	"Frequency:	once V					
Continuous Infusions	PRN:	🖲 Yes 🔿 No					
Medications	*DDM D						
Blood Products	""KN Keason:	anxiety 🗸					
- Laboratory	Administer over:						=
Diagnostic Tests							
- Procedures	Administer over Unit:	×					
Respiratory	Duration:						
Allied Health							
Consults/Referrals	Duration Unit:	· ·					
Supplies	Drug Form:	tah					
Non Categorized		•					
+ Medication History	First Dose Priority:	~					
Medication History Snapshot	*East Date (The se	01 D== 2017 12:22 DST					
Reconciliation History	Start Date/Time:	01-Dec-2017 12:22 PS1					
	Stop Date/Time:		PST				-
Kelated Kesults (1)							V
Variance Viewer	O Missing Beguired Details	Inders For Cosignature	Beview			10	Sign
Valiance viewei							



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	Displayed: All Active Orders All Inactive Orders All Active Order	ers							
Orders for Signature	Solution of the second	Status	Dose	Details					
Suggested Plans (0)	1 Medications	Ordered		1 mg, PO, once, PRN anxiety, (
Admit/Transfer/Discharge	Vancomycin	Ordered Ordered		1,000 mg, IV, q12h, start: 29-N dose range: 0.1 to 0.5 mg, IV, c					
Status	PRN range dose)	oracica		DILAUDID EQUIV					



Verbal orders are only encouraged to be entered when a physician cannot enter the order directly into the CIS themselves, for example, in an emergency situation or when the physician is sterile in mid-procedure

Required fields are always highlighted yellow

Verbal and phone orders that are entered into the CIS automatically get routed to the ordering provider for co-signature

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

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

To complete an order:

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



4. Click the Orders For Signature button

• 🖬 Orders				لے Full screen 📵 Print 🗞 0 minute
Add 📲 Document Medica	tion by Hx Reco		Reconciliation Status Meds History Admission Discha 	
ders Medication List Docu	ument In Plan			
M				
View	Displayed: All Activ	e Urders (All Inactive Urders) All Active Urders	\$	Show More Urders
Orders for Signature	<i>S P</i>	Order Name	Status	Dose Details
Plans	⊿ Consults/Ref	errals		
Suggested Plans (0)	\checkmark	IP Consult to Spiritual Health Services	Ordered	06-Dec-2017 13:44 PST, F
Urders	M 🕺	IP Consult to Spiritual Health Services	Ordered	06-Dec-2017 09:44 PST, F
Admit/Transfer/Disc		IP Consult to Ostomy Clinician	Ordered	05-Dec-2017 14:28 PST, F
Status	\checkmark	IP Consult to Wound Care Clinician	Ordered	05-Dec-2017 14:28 PST, F
Patient Care		IP Consult to Asthma Educator	Complete	
- Activity		IP Consult to Diabetic Educator	Ordered	29-Nov-2017 13:56 PST, I
Diet/Nutrition	\checkmark	IP Consult to Ostomy Clinician	Ordered	29-Nov-2017 13:56 PST, I
Continuous Infusio	\checkmark	IP Consult to Wound Care Clinician	Ordered	29-Nov-2017 13:56 PST, I
Medications	\checkmark	IP Consult to Wound Care Clinician	Ordered	29-Nov-2017 13:46 PST, I
Blood Products	🗹 🗈	IP Consult to Pharmacy	Ordered	17-Nov-2017 15:03 PST, I
Laboratory	⊿ Communicat	ion Orders		
Diagnostic Tests	🗹 🗈	Communication Order	Ordered	23-Nov-2017 15:09 PST, I
- Procedures 🚽		Communication Order	Ordered	17 Nov 2017 15:02 DCT /
4 III				
Related Results	▲ Details for IP	Consult to Asthma Educator		_
Formulary Details	L			
		aluna Deulana Das Nunas Das Jawa		Didors For Signature



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

Orders for Signature							
2 P P	Order Name	Status	Start	Details			
△ LGH LD Enc:7	00000016552						
⊿ Consults/Refe	rrals						
🗆 🗆 🔂	IP Consult to Asthma	Complete	18-Jan-2018 14:21				
▲ Details							
0 Missing Required	Details Orders For Cosig	nature 0	ders For Nurse Review]	5 Sign		
L							

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

To Cancel/Discontinue an order:

2

1. Review the Order Profile

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

3. Select Cancel/Discontinue



4. Ordering Physician pop-up window will appear. Fill out required fields highlighted yellow below and then click ${\bf OK}$

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

P Ordering Physician
Order
Proposal *Physician name
Plisvca, Rocco, MD
*Order Date/Time 28-Nov-2017 Illa PST *Communication type
Phone Verbal Proposed
No Cosignature Required Cosignature Required Paper/Fa× Electronic
4 OK Cancel

5. Review order to discontinue and click Orders For Signature

■ Details for Asthma Educator Following	
Petails 🕞 Order Comments	
+ 1 a lh. ♥≥	
Discontinue Date/Time: 07-Dec-2017	
Discontinue Reason:	
Orders For Cosignature Orders For Nurse Review	0rders For Signature

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

View	1	≫ @ ➡ ♡ Order Name Status Start Details
Orders for Signature		△ LGH ED Hold; TRIWR Enc:700000000632 Admit: 28-Sep-2016 15:27 PDT
Plans		△ Allied Health
Document In Plan		Asthma Educator Follm Discontin 18-Jan-2018 14:35 18-Jan-2018 14:36 PST
-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	1	🛣 Details
Formulary Details	Ē	
Variance Viewer	ł	0 Missing Required Details Orders For Cosignature Orders For Nurse Review.



Refresh age. 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

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

Add 2 ⁿ Document Medication by Hx Reconciliation • 3 ⁿ Check Interactions Order: Medication Life Document In Plan		Reconciliation Statu Meds History	Admission 4 Discharge
	🐠 😪 🚫 🕂 Add to Phase 🗸 Acheck Alerts 🔐 Comments Start: Now	Duration: None	
View	A V Component Status	Dese Details	
Orders for Signature	D 1 Component Status	Dose Details	
Plans	Peripherally Inserted Central Catheter Insertion (PICC) (Module) (Prototype) (Plan	ied)	
-Document In Plan	Alerte last chacked on 30-Nov-2017 09:32 PST by: Testoser, woundOctomy-Nurse		
Medical	A Datient Care		
Peripherally Inserted Central Catheter Insertion (PICC) (Module) (Prototype) (Planned)	A Indications for PICC insertion:		
Negative Pressure Wound Therapy (VAC) (Module) (Prototype) (Initiated)	-IV antibiotic greater than 5 days		
Heparin Infusion Standard (Module) (Validated) (Discontinued)	-Limited vascular access (unable to obtain/maintain adequate periphe	eral IV access)	
Suggested Plans (0)	-Total Parenteral Nutrition		
Orders	-Chemotherapy		
Admit/Transfer/Discharge	-Home/ Community IV program		
1 Status	A Control disations		
Patient Care	Diagnored bacteremia not treated with effective antihintic therapy for	r minimum 24 hours	
Activity	-Presence of A-V fistula or potential use of arm for A-V fistula formati	en.	
Diet/Nutrition	-Caution is required in patients with stage 4 or 5 chronic Kidney disea	e (eGFR less than 30 mL/min)	
Continuous Infusions	 Bilateral mastectomy and/or lymph node dissection 		
Medications	-Ipsilateral pacemaker	a a ser anna anna anna anna	
Blood Products	-Not suitable for phenytoin, high volume infusions, rapid bolus inject	ions, apheresis, hemodialysis, or CVP monitoring	
	 Dermatitis hums or cellulitis at or around the site of line insertion 	e at the prospective placement site	
Diagnostic Tests	Insert Peripherally Inserted Central Catheter	Routine, using ultrasound guidance	
Procedures	4 Medications	nonnel and annound deserve	
Respiratory	LORazepam (LORazepam sublingual PRN range dose)	dose range: 0.5 to 1 mg, sublingual, as directed, PRN anxiety, drug form; tab	
Allied Health	LORazepam (LORazepam sublingual PRN range dose)	dose range: 0.5 to 1 mg, sublingual, g30min, PRN anxiety, order duration: 2 doses/times, drug	g form: tab
Consulte/Referrale	Iidocaine (lidocaine 1% inj)	_ 1 mL, intradermal, as directed, drug form: inj	
Communication Orders		Prior to vein cannulation	
Supplies	Iidocaine (lidocaine 2% inj)	 0.5 mL, intradermal, as directed, drug form: inj Prior to vein cannulation 	
Medication History	alteplase (alteplase 2 mg inj)	2 mg, catheter, once, PRN other (see comment), drug form: inj PRN reasons: for blocked CVC or VAD lumen. Installed into PICC (Lumens) PRN to clear occu	ulsion. Instillaltion
- Medication History Snapshot	⊿ Laboratory		
Reconciliation History	🗆 😰 свс	Blood, Routine, Collection: T;N, once Prior to PICC insertion	
		Blood, Routine, Collection: T;N, once	
Deleted Devulse			
Featured Results	L Decalis		
Pormulary Details	Orders For Costing three Burley For Name Barrison States as Ma Enumits	100 Leader	ata Ordere For Simothure
vonance viewer			

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 Newigster (View) displays the lists of Dewerplane and elimical estagation of
 - 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.

CSTLEARNING, DI	MOTHET	A 🖪			🔶 List 🔿 🍘 Recent 🕯
CSTLEARNING, D	емотнет	A DOB:01-Jan-1937 Mf	RN:700008216 Code Status:	Process:	Location:LGH 6E; 624; 04
		Age:80 years En	nc:7000000015058	Disease:	Enc Type:Inpatient
Allergies: peniciliin,	ape	Gender:Male PH	114.9876469824 Dosing Wt:	Isolation:	Attending:Pilsvca, Rocco, M
Menu	*	< > The Interactive View and I&O			لنا, Full screen ال
Patient Summary		<u>™ = 3 ↔ / 10 % </u>			
Orders	+ Add		_ 1		
Single Patient Task List		🗙 Adult Quick View			
MAR		VITAL SIGNS Medified Early Marriag Custom			
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Interactive View and I	\$0	Pain Modalities	Result	Comments Rag Date Performed	By
Results Review		IV Drips			
Documentation	+ Add	Insulin Infusion	111 W	20-Nov-2017	
Medication Request		Apnea/Bradycardia Episodes		35 15:38 PST	
		Mental Status/Cognition	Z VITAL SIGNS	Deng	
Histories		Sedation Scales	Temperature Temporal Artery	DegC	
Allergies	🕈 Add	Provider Notification Environmental Safety Management	Temperature Oral	DegC	
Diagnoses and Problems		Activities of Daily Living	Apical Heart Rate	bpm	
-		Measurements	Heart Pate Monitored	bpm	
		Glucose Blood Point of Care	SBP/DBP Cuff	mmHa	
CareConnect		Individual Observation Record	Cuff Location		
Clinical Research		Comfort Measures	Mean Arterial Pressure, Cuff	mmHg	
En um Denue en		Shift Report /Handoff	3 Blood Pressure Method		
Form Browser		Shirt neport/ handon	Cerebral Perfusion Pressure, Cuff	mmHg	
Growth Chart			∠ Oxygenation Respirators Pate	hr/min	
Immunizations			Measured O2% (FIO2)	0,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Liner/Tuber/Drains Sum	many		Oxygen Activity		
cincle rubely brains sum		Q Adult Systems Assessment	Oxygen Therapy		
MAR Summary		Adult Lines - Devices	Oxygen Flow Rate	L/min	
Medication List	🕈 Add	Adult Education	Skin/Nare Check		
Patient Information		Second Product Administration	SpO2 Site	~	
0-(Intake And Output	SpO2 Site Change		
Reference		Advanced Graphing	⊿ Modified Early Warning System		
		Restraint and Seclusion	⊿ Temperature	Deed	
		Procedural Sedation	Temperature Aollary	DegC	
		a dult Critical Care Lines - Devices	Temperature Oral	DegC	
		Additionation Care Cifles - Devices	MEWS Temperature Score	-	
		Additionation Care oddick View	⊿ Heart Rate		
		Aduit Critical Care Systems Assessment	2 Apical Heart Rate	bpm	
21		Clialysis Treatment Management	Peripheral Pulse Rate	opm 2	



- 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.

Changes to Navigator Bands
Changes to navigator bands will not be displayed until you close and restart the application.

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 is 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.

Available Document Types:	Current Document Types:	
acute pain service add to ice worklist adult critical care lines adult critical care quick adult critical care syste adult lines - devices adult lines - devices Itc adult poceduros adult quick view Itc adult quick view Itc	adult education	¢.
	ок 3	Cancel

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.

- Select the Vital Signs component under Adult Quick View
 Double-click the blue box real 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 a 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 🖌

CSTLEARNING, DEMO	otheta 🔳				
CSTLEARNING, DEM	ОТНЕТА	DOB:01-Jan-1937	MRN:700008216	Code Status:	Process:Falls Risk
Allergies: penicillin Tape	•	Age:80 years Gender:Male	Enc:7000000015058 PHN:9876469824	Dosing Wt	Disease: Isolation:
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Patient Summary		nu 🔜 📾 🖓 🖌 🥵 🖿	■ 🏔 ×		
Orders 🕂					
Single Patient Task List		Adult Quick View	1		Last 24 Hours
MAR		Modified Early Warning Syste	em	Find Item - Critical	High Low Abnormal Unauth Flag
Interactive View and I&O		PAIN ASSESSMENT Pain Modalties		Result	Comments Rag Date Performed By
Results Review		IV Drips			
Documentation 🕂	Add	Insulin Infusion Heparin Infusion		<u>س</u> بر _	21-10-2017
Medication Request		Apnea/Bradycardia Episodes			13° 09:37 PST 2
1 Batandara		Mental Status/Cognition		Temperature Axillary	Deg
Histories		Sedation Scales		Temperature Temporal Artery	Deg
Allergies 🕂	Add	Provider Notification		Temperature Oral	Deg 36.9
Diagnoses and Decklopes		Environmental Safety Manag	ement	Apical Heart Rate	bpn
biagnoses and Problems		Activities of Daily Living		Peripheral Pulse Rate	bpn <mark>91</mark>
		Glusses Plead Paint of Com		Heart Rate Monitored	bpn
CareConnect		Induidual Observation Report	-	SBP/DBP Cuff	mmH 140/90
Careconnect		Confort Monouroe	•	Cuff Location	
Clinical Research		Transfer/Transport		Mean Arterial Pressure, Cuff	mmH 107
Form Provisor		Shift Report /Handoff		Blood Pressure Method	
				Cerebral Perfusion Pressure, Cuff	mmH
Growth Chart				2 Oxygenation Recoiratory Rate	br/mints
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Lines/Tubes/Drains Summar				Oxygen Activity	
Lines/Tubes/Drains Summar				Oxygen Therapy	Nasal cann
MAR Summary		av Adult Sustama Assessment		Oxygen Flow Rate	L/min
Medication List	Add	Audit Systems Assessment		Skin/Nare Check	
		Adult Lines - Devices		SpO2	99
Patient Information		Adult Education		SpO2 Site	Hand
Reference		Slood Product Administration		SpO2 Site Change	
Reference				Modified Early Warning System	

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

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 **b**.
- 3. A new column and Change Column Date/Time window appear. Choose the appropriate date and time you wish to document under. In this example, use today's date and time of 0700.
- 4. Click the Enter key



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

CSTLEARNING, DEMOTHETA	700008236 Opened by TestUser, Nurse					
Task Edit. View Patient	Chart Links Options Documentation Order	1 Help				
S CareCompany IS Clescal La	ider Organizer 🍦 Patient List 📪 Multi-Patient Tai	k List 👔 Discharge Dashboard 📷 Staff Assignment 👫 Les	eningLNE .			
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CSTLEARNING, DEMOTI Allergies: penicillin, Tape	IETA DOBO1-Jan-1937 Age 80 years GenderMale	MRV4200008216 Code Status: Enc:2000000015058 PHeXSII26462824 Dosing Wt:	Pro Dis bo	cessFalls F ease: lation:	üsk:	Location:LGH 4E Enc Type:Inpatient AttendingPlaysca
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Matanias	Mental Status Cognition	Temperature Axillary	DegC			
And and a second se	Provider Notification	Temperature Temporal Arten	DepC			
Allerges T Ao	Environmental Safety Management	Temperature Oral	Degc	36.9	37.5	
Diagnoses and Problems	Activities of Daly Living	Peripheral Pulse Rate	bpm	91		
	Measurements Channel Band Doubled Com-	Heart Rate Monitored	lapro			
CareConnect	Individual Observation Record	S8P/D6P Cutt	warding	140,90		
	Confot Measures	Cuff Location				
Christal Research	Transfer/Transpot	Eland Pressure Method	merty	207		
Form Browser	Shit Repot/Handoff	Cerebral Perfusion Pressure, Cuff	manifest			5
		4 Oppression				Charles P

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 **I** to the right Incision/Wound/Skin/Pin Site section heading in the flowsheet.



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

Select the following to create a label:

- Incision, Wound Locations = Abdomen
- Incision, Wound Laterality = *Right*
- 5. Click OK

< 🔹 🔹 者 Interactive View and I&O)		
🎫 🔜 📾 🎶 🖌 🚫 🦉 📰 📰 🍋 🗶 .			
Image:	Find Item Critical F Result C Incision/Wound/Skin/Pin Site R PSYCHOSOCIAL	Dynamic Group - CSTPRODORD, PATIENT A - 700001815 Label: Addomen Right <incision, description:="" location="" wound=""><incision, finger="" location:="" toe="" wound=""> Incision, Wound Location: Additiles Additional Back Breast Breast Batch Breast Batch Back Breast Bittock Catif Chest Chin Coccyx Bar Elbow Epigastric Exye Face Femoral Eincaer Incision, Wound Laterality: Itf Itf Itf Itf Itf Itf Itf Itf Itf Itf</incision,></incision,>	



- 6. The label created will display at the top, under the **Incision/Wound/Skin/Pin Site** section heading.
- 7. Double-click the **blue box** next to the name of the section to document in several cells. You can move through the cells by pressing the **Enter** key.

Now document the activities related to this wound:

- Activity = Assess
- Goal Of Care = Heal
- Type/Etology = Laceration
- Dressing Type = ADB dressing
- Dressing Assessment = Dry, Intact
- 8. Click **green checkmark** icon \checkmark to sign your documentation. Once signed the label will be accessible for other clinicians to complete further documentation within the same dynamic group.

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av Adult Sustama Assessment							
Adult Systems Assessment							
NEUROLOGICAL							
Morse Fall Scale	Find Item Critical		High 📃 Lov	v 📃 Abno	ormal 📃 🛛		
Fall Prevention Interventions	Derek		S	Dec Det			
Post Fall Evaluation	Result		omments	Hag Dat	e		
Pupils Assessment							
Glasgow Coma Assessment	×						
CIWA-Ar			30-Nov-2017	29-No	V-2017		
Neurovascular Check			10:41 PSI	15:34 PST	11:57 PSI		
Neuromuscular/Extremities Assess CARDION/ACCHINAR							
CARDIOVASCULAR			1				
Cardiac Rhythm Analysis	Activity	-	Assess				
Fulses		-	Heal				
Edema Assessment	Skin Abnormality Battern	-	Laceration				
	Skin Abnormality Fattern	-					
RESPIRATORY	A Drassing Type	-					
Breath Sounds Assessment		-	ABD dressi				
Mobilization of Secretions	Dressing Assessment		Dry, Intact	7			
VAP Puedle	Cleansing	_		_			
VAr buildle	Odour Present After Cleansing						
CASTROINTESTINAL	Solution Used						
GENITOURINARY	Topical Agent Application						
INTEGUMENTARY	Length	cm					
Braden Assessment	Width	cm					
Incision /Wound/Skin/Pin Site	Depth	cm					
MUSCULOSKELETAL	Number of Sinus Tract Locatio	ns					

Note: A trigger icon \bigotimes 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 **R** to the right of the Central Line heading in the flowsheet

🔹 🔹 者 Interactive View and I&O	
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💊 Adult Systems Assessment	4
X Adult Quick View	
🗙 Adult Lines - Devices 🛛 🚹	Find Item Critical Hig
Peripheral IV	Danik
Subcutaneous Catheter	W 5.02
Central Line 2	30-Nov-2017
Pain Modalities	📆 🚮 🔁 📆 11:03 PST
Urinary Catheter	⊿ Peripheral IV
Gastrointestinal Tubes	⊿ Subcutaneous Catheter
Arteriovenous Fistula/Graft	⊿ Central Line
Warming/Cooling	

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

Select the following to create a label:

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

5. Click OK





- 6. The label created will display at the top, under the Central Line section heading.
- 7. Double-click the **blue box** next to the name of the section to document in several cells. You can move through the cells by pressing the **Enter** key.

Now document the activities related to this PIV:

- Activity = Inserted central line
- Total Insertion Attempts = 1
- Total Catheter Length = 46
- Tip Confirmation and Location = Radiologist
- 8. Click **green checkmark** icon ✓ to sign your documentation. Once signed the label will be accessible for other clinicians to complete further documentation within the same dynamic group.

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	△ Central Line	
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	♦ Lot Number	
	♦ Catheter Brand/Type	
	♦ Performing Procedure	
	♦ Assisting Procedure	
	Department Placing Line	
	Patient Identified Pid You Assist With (Observa Line Insert	
	Total Insertion Attempts	
	♦ Total Catheter Length Cm46	
	♦ Unsuccessful Veins and Reasons	
	Tip Confirmation and Location 7 Rad	iographic

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)

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

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

Menu P	< 🕞 🕆 Interactive View and I&O
Patient Summary	** = = = # # / 💉 🔕 🐘 📰 🕼 🗶
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MAR	General Education Find Item Critical High Low A
MAR Summary	Activities of Daily Living Education
Internetive View and IRO	Demonstrive Sx Suicide Prevent Education
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Results Review	Dysobania Education 08-Dec-2017 06-Dec-2017
Documentation 📥 Add	End of Life Education
	Falls Education A Respiratory Education
Medication Request	Fluid Volume Education Asthma Treatment Plan/Follow-Up
Histories	Medication Education Understanding Lung Anatomy & Phys
	Nutrition Education Asthma Medications
Allergies 🖬 Add	Nutrition Counseling Comprehensive Breathing Techniques
Diagnoses and Problems	Orthopedics Education Mobilization of Secretions
	Pain Education Cougn/Deep breatning
	Respiratory Education 2 COPD Organization COPD Oxygen Therapy
CareConnect	Skin and Wounds Education COP Breathing Technique
Clinical Research	Social Habits Education Incentive Spirometry
	Stroke Education Mechanical Ventilation
Form Browser	Mechanical Ventilation Weaning
Growth Chart	Peak Flow Meter Use
	CPR Video/DVD Viewed
Immunizations	CPR Class Completed
Lines/Tubes/Drains Summary	Tracheostomy Care
Medication List	Disease Process Suctioning
Add	Succioning

Key Learning Points

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



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

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....

1



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

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Task Edit View Patient Chart Links Options Documentation Orders Help							
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	Age:80 years	Enc:700000015058		()isease:		Enc Type:Inpatient
Allergies: penicillin, Tape	Gender:Male	PHN:9876469824	Dosing Wt:	1	solation:		Attending:PilsVca, Ro
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Diagnoses and Problems	Activities of Daily Living	Apical	Heart Rate	bpm		1	
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	Glucose Blood Point of Care	SBP/D	Rate Monitored	mmHa	140.00	•	
CareConnect	Individual Observation Record	Cuff Lo	ocation		140/50		
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	Iranster/ Iransport	Blood	Pressure Method				
Form Browser	Shiri neput/hdhdoff	Cerebr	al Perfusion Pressure, Cuff	mmHg			
Growth Chart			genation				

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

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Task Edit View Patient Cha	Task Edit View Patient Chart Links Options Documentation Orders Help								
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	Measurements	Heart Rate Monitored	bpm	View History					
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	Comfort Measures	Cuff Location		Unchart 2					
Clinical Research	Transfer/Transport	Right Rescure Method	mmHg 107						
Form Browser	Shift Report/Handoff	Cerebral Perfusion Pressure Cuff	mmHa	change bace/ nine					
Growth Chart		⊿ Oxygenation		Add Comment					
		Respiratory Rate	br/min 16	Duplicate Results					
Immunizations		Measured O2% (FIO2)		Clear					
1: /T. L /D: C		Oxygen Activity							



- 3. The Unchart window opens, select **Charted on Incorrect Patient** from the Reason dropdown.
- 4. Click Sign

CSTLEARNING, DEMOTHETA - 700008216	Opened by TestUser, Nurse						
Task Edit View Patient Chart Links Options Documentation Orders Help							
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Lines/Tubes/Drains Summary	· · · · · · · · · · · · · · · · · · ·						
MAR Summary					L.	Sign Cancel	
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Reference	Second Product Administration	MEWS Systolic	Blood Pressure	Score			
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	Verocedural Sedation	MEWS Total Sco	ore				
	Ambulaton Infusion Contor Monitoring	⊿ Situational Awa	areness Factors	5			

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

CSTLEARNING, DEMOTHETA - 7000	08216 Opened by TestUser, Nurse			
Task Edit View Patient Chart	Links Options Documentation Orders Help			
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Histories	Mental Status/Cognition	Temperature Axillary	DegC	
	Provider Notification	Temperature Temporal Artery	DegC	
Allergies 🕇 Add	Environmental Safety Management	Temperature Oral	DegC 36.9	In Error
Diagnoses and Problems	Activities of Daily Living	Apical Heart Rate	bpm 90	
	Measurements	Heart Rate Monitored	bpm	A
	Glucose Blood Point of Care	SBP/DBP Cuff	mmHg 140/9	0
CareConnect	Individual Observation Record	Cuff Location	-	
Clinical Research	Transfer/Transport	Mean Arterial Pressure, Cuff	mmHg 107	
Form Browser	Shift Report/Handoff	Blood Pressure Method		
		4 Organization	mmny	
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3

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

- 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.

Comment - CSTLEARNING, DEMOBETA - 700008215	×
SpO2 Site: Hand	
Comment	
Right hand	
OK Can	3



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



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

PATIENT SCENARIO 6 – Documentation

Learning Objectives

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

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

SCENARIO

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

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



Activity 6.1 – Review Documentation

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

To navigate to the **Documentation**:

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

Menu 🖓	く → - A Documentation	
Patient Summary	🕂 Add 🛛 🝸 Sign 🚚 🉈 Forward 📪 Provider Letter 😭 Modify 🍡 🖀 🖤 📰 💱 In Error 💷 Preview 🏷	
Orders 🕂 Add		
Single Patient Task List		
MAR	Display : All 🔹 🛄	
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Results Review	Arranged By: Date Newest At Top 7 Arranged By: Date * Final F	<pre> leport * leport</pre>
Documentation 1 + Add	Wound Care Treatment 3 - Nov-2017 13:15:00 2 Wound Care - Initial Asses TistUser, WoundOstomy	
Medication Request	Wound Care Treatment 30-Nov-2017 11:57:00 PST Impaired circulation and pain associated with surgery. Poor management of diabetes and delay seeking treatment.	
	Wound Care - Initial Asses TestUser, WoundOstomy Smokes 1 pack/day of cigarett	
Histories	Nursing Shift Summary 21-Nov-2017 15:42:00 PST	
Allergies 🕂 Add	Free Text Note TestCD, Nurse Result type: Wound Care Treatment Plan	
Diagnoses and Problems	Transport Ticket - Text 16-Nov-2017 10:46:00 PST Result date: Thursday, 30-November-2017 13:15 PST	
	Transport Ticket TestUser, WoundOstomy Result status: Auth (Verified)	
	Recreation Therapy Note 14-Nov-2017 12:40:00 PST Result ttile: Wound Care - Initial Assessment	20 November D
CareConnect	Free Text Note TestCD, RespiratoryTherap Variand by: TestCoser, WoundOctomy-Nurse on Thursday,	20-November-2
Clinical Paratrah	Holter Monitor 14-Nov-2017 12:14:00 PST Encounter info: 7000000006143 LGH Lions Gate Innation	19-1un-2017 - 21
	Holter Monitor TestCST, CardiologyTechn =	19 541 2017
Form Browser	NM Myocardial Perfusion 14-Nov-2017 11:56:30 PST	
Growth Chart	NM Myocardial Perfusion TestCST, MedicalImaging	
· · · ·	NM Myocardial Perfusion 14-Nov-2017 10:25:43 PST	
Immunizations	NM Myocardial Perfusion TestCST, MedicalImaging	
Lines/Tubes/Drains Summary	Wound Care Progress Note10-Nov-2017 11:31:00 PST	
MAR Summary	Free Text Note TestUser, WoundOstomy Discharge Planning Accor 10. Oct 2017 10:20:00 PDT	

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.

splay : 🗐	•						
ervice Date/Time -Dec-2017 08:27:00 PST D-Nov-2017 13:15:00 P D-Nov-2017 11:57:00 P 1-Nov-2017 15:42:00 P 5-Nov-2017 10:46:00 P 4-Nov-2017 12:14:00 P 4-Nov-2017 12:14:00 P	Subject Astma Teaching Plan Note Wound Care - Initial Assessment Wound Care - Initial Assessment Free Text Note Transport Ticket Free Text Note Holter Monitor	Type Interdisciplinary Care Plan Wound Care Treatment Plan Wound Care Treatment Plan Nursing Shift Summary Transport Ticket - Text Recreation Therapy Note Holter Monitor	Facility LGH Lions Gate LGH Lions Gate LGH Lions Gate SGH Squamish LGH Lions Gate LGH Med Imaging LGH Cardiac Lab	Author, Contributor(s) TestUser, WUNdOstomy TestUser, WoundOstomy TestCD, Nurse TestUser, WoundOstomy TestCD, RespiratoryTherap TestCD, CardiologyTechni	Status Modified Auth (Verified) In Error Auth (Verified) Auth (Verified) Auth (Verified)	I∢ Teachi (Please speciali	* Final Re Document Conta ing Plan e enter two sentences you could inclu Ity)
4-Nov-2017 11:56:30 P 4-Nov-2017 10:52:43 P 9-Nov-2017 11:3:00 P 9-Nov-2017 11:3:00 P	NM Myocardial Perfusion Trea NM Myocardial Perfusion Rest Free Text Note Discharge Planning Assessment	NM Myocardial Perfusion Treadmill NM Myocardial Perfusion Rest Wound Care Progress Note Discharge Planning Assessment - Text	LGH Med Imaging LGH Med Imaging LGH Lions Gate LGH Lions Gate	TestCST, MedicalImagingT TestCST, MedicalImagingT TestUser, WoundOstomy TestORD, Nurse	In Progress In Progress Auth (Verified) Auth (Verified)	Adden 09:31 Next se: Result Result status: Result Perforn by: Verifiec Encoun	hdum by TestUser, IVTherapy- PST (Verified) sision on Tuesday type: Interdisciplinary Care f date: Friday, 01-December-2 Modified title: Asthma Teaching Plan med TestUser, IVTherapy-h December-2017 09:06 TestUser, IVTherapy-h December-2017 09:06 TestUser, IVTherapy-h December-2017 09:06

- 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 .

< 🖂 🕘 者 Documentat	ion					
🕂 Add 🛛 📄 Sign 🚚 😂 Forward 📑 Provider Letter 📑 Modify 🍡 🗮						
List						
Arranged By: Date	Newest At Top 🔻 📕					
Interdisciplinary Care Plan	01-Dec-2017 08:27:00 PST					
Asthma Teaching Plan Note	TestUser, IVTherapy-Nurse	Impaired cire				
Wound Care Treatment Plan	30-Nov-2017 13:15:00 PST	Poor manage				
Wound Care - Initial Assessment	TestUser, WoundOstomy-Nurse	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.

Menu 1 7	< 🔹 🕇 Documentation			
Patient Summary	🕂 Add 🥘 🔲 🖌			
Orders 🕂 Add	New Note X List			
Single Patient Task List				
MAR	Note Type List Filter:		All (63) Favorites (1)	Q Sei
MAR Summary	Position 3			
Interactive View and I&O	*Type:	*Note T	emplates	
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Documentation 🕂 Add 2	Wound Care Progress Note	*	ED Supervision/Handoff Note	ED Supervision/Handoff Note
Medication Request	Wound Care Treatment Plan 4		Family Conference Note	Family Conference Note Templ
Histories	Wound Clinic Note Wound Procedure Note	-	Free Text Note	Free Text Note Template
Allergies 🕂 Add	Nursing Narrative Note			
Diagnoses and Problems	*Date:		General Surgery Progress/SOAP No	ot General Surgery Progress/SOAP
	01-Dec-2017 1116 PST	*	ICU Admission/Consultation Note	ICU Admission/Consultation No
CareConnect	*Author		ICU Daily Progress Note	ICU Daily Progress Note Templa
Clinical Research	TestUser, WoundOstomy-Nurse	*	ICU Multidisciplinary Conferencing	g ICU Multidisciplinary Conference
Form Browser		-	ICU Transfer Note	ICU Transfer Note Template
Growth Chart		~		


7. Hover the first line to open the text box

Menu P	< 🔪 🝷 者 Documentation 🗇 Fu	ll screen		€ 29 minutes ago
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Results Review				
Documentation 🕂 Ad				
Medication Request				
Histories				
Allergies 🕂 Ad				
Diagnoses and Problems				
CareConnect				
Clinical Research				
Form Browser				
Growth Chart				
Immunizations	Note Details: Wound Care Treatment Plan, TestUser, WoundOsto Sign/Submit Sa	ve	Save & Clos	e Cancel
Lines/Tubes/Drains Summary				

 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

< 🔹 者 Documentation	[🗆] Full screen	P rint	€ 49 minutes ago
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Impaired circulation and pain associated with surgery. Poor management of diabetes and delay seeking treatment. Smokes 1 pack/day of <u>cigarett</u>			
Note Details: Wound Care Treatment Plan, TestUser, WoundOsto Sign/Su	ıbmit Save	Save & Clos	e Cancel

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

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

Sign/Submit Note			
*Type: Wound Care Treatment Plan	Note Type List Filter: Position	~	
*Author: TestUser, WoundOstomy-Nurse Forward Options	Title: Wound Care - Initial Assessme	*Date: ant 30-Nov-20	1 🛄 1157 PST
Favorites Recent Relations	hips Q Provider Name		
Contacts	Recipients	Comment	Sign Review/C
			Sign Cancel

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

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

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Arranged By: Date	Newest At Top 🔻 🔺	I∎		* Final Report *
Wound Care Treatment Plan	30-Nov-2017 11:57:00 PST			That Report
Wound Care - Initial Assessment	TestUser, WoundOstomy-Nurse;		Impaired circula	tion and pain accordated with surgery
Nursing Shift Summary	21-Nov-2017 15:42:00 PST		Poor manageme	nt of diabetes and delay seeking treatment.
Free Text Note	TestCD, Nurse		Smokes 1 pack/	day of cigarett
Transport Ticket - Text	16-Nov-2017 10:46:00 PST			
Transport Ticket	TestUser, WoundOstomy-Nurse		Result type:	Wound Care Treatment Plan
Recreation Therapy Note	14-Nov-2017 12:40:00 PST		Result date:	Thursday, 30-November-2017 11:57 PST
Free Text Note	TestCD, RespiratoryTherapyStud		Result status:	Auth (Verified)
Holter Monitor	14-Nov-2017 12:14:00 PST		Result title:	Wound Care - Initial Assessment
Holter Monitor	TestCST, CardiologyTechnician6		Performed by:	TestUser, WoundOstomy-Nurse on Thursday, 30-November-2017 12:55 PS
NM Myocardial Perfusion Tread.	14-Nov-2017 11:56:30 PST		Verified by:	TestUser, WoundOstomy-Nurse on Thursday, 30-November-2017 12:55 PS
NM Myocardial Perfusion Tread	TestCST, MedicalImagingTechno		Encounter info:	7000000000143, LGH LIONS Gate, Inpatient, 19-Jun-2017 - 21-Jun-2017
NM Myocardial Perfusion Rest	14-Nov-2017 10:25:43 PST =			

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
- In the Title: box enter = "Your specialty" Assessment.
 Note: It is important to label your note with an appropriate name. Otherwise, it will be displayed as a generic free text note.
- 6. On the right of your screen, under Note Templates select Free Text Note
- 7. Then click OK. A new note opens.





8. Hover the first line to open the text box

Menu 🖡	S > f Documentation	[□] Full scre
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Single Patient Task List		
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Results Review		
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CareConnect		
Clinical Research		
Form Browser		
Growth Chart		
Immunizations		
Lines/Tubes/Drains Summary		
Medication List 🕂 Add		
Patient Information		
Reference		
	Note Details: Nursing Narrative Note, TestUser, IVTherapy-Nurse, 11-Dec-2017 15:54 PST, "Your speciality" Assessment	Sign/Submit Save

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

Menu 🗘	K > → A Documentation	scree
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	Note Details: Nursing Narrative Note, TestUser, IVTherapy-Nurse, 11-Dec-2017 15:54 PST, 'Your speciality' Assessment Sign/Submit 10 Saa	/e

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

\checkmark	
*Date:	
15-Dec-2017	1410 PST
Comment	Sign Review/C

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

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Arranged By: DateNewest At Top Interdisciplinary Care Plan01-Dec-2017 08:27:00 PtAsthma Teaching Plan NoteTestUser, IVTherapy-Nurse; PWound Care Treatment Plan30-Nov-2017 13:15:00 PSTWound Care Treatment Plan30-Nov-2017 11:57:00 PSTWound Care Treatment Plan30-Nov-2017 11:57:00 PSTWound Care Treatment Plan30-Nov-2017 11:57:00 PSTWound Care Initial AssessmTestUser, WoundOstomy-NuNursing Shift Summary21-Nov-2017 11:57:00 PSTFree Text NoteTestUser, WoundOstomy-NuIransport Ticket - Text16-Nov-2017 10:46:00 PSTTransport TicketTestUser, WoundOstomy-NuRecreation Therapy Note14-Nov-2017 12:40:00 PSTFree Text NoteTestCD, RespiratoryTherapySHolter Monitor14-Nov-2017 12:14:00 PSTHolter MonitorTestCST, CardiologyTechniciNM Myocardial Perfusion Tr14-Nov-2017 11:56:30 PSTNM Myocardial Perfusion Rest TestCST, MedicalImagingTecNM Myocardial Perfusion Rest TestCST, MedicalImagingTecNM Myocardial Perfusion Rest TestCST, MedicalImagingTecWound Care Progress Note10-Nov-2017 11:31:00 PST		* 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 TestUser, IVTherapy-Nurse on Friday, 01-December-by: 2017 09:06 PST Yerified by: Verified by: 2017 09:06 PST Encounter 700000006143, LGH Lions Gate, Inpatient, 19-Juninfo: 2017 - 21-Jun-2017	
<< Previous Next >>			

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 Modify Menu д Documentation Patient Summary 2 🕂 Add 🛛 📄 Sign 🚚 🙈 Forward 📑 Provider Letter Modify 81 🖤 🛛 🖬 🖬 In Error Orders Add List Single Patient Task List Display : All MAR • ... MAR Summary Service Date/Time Subject Type Interactive View and I&O 01-Dec-2017 08:27:00 PST Asthma Teaching Plan Note Interdisciplinary Care Plan **Results Review** Wound Care Treatment P 30-Nov-2017 11:57:00 P... Wound Care - Initial Assessment Wound Care Treatment Pla Documentation Add 21-Nov-2017 15:42:00 P... Free Text Note Nursing Shift Summary Medication Request 16-Nov-2017 10:46:00 P... Transport Ticket Transport Ticket - Text Histories 14-Nov-2017 12:40:00 P... Free Text Note Recreation Therapy Note 14-Nov-2017 12:14:00 P... Holter Monitor Holter Monitor Allergies Add
- Alletgies T Aug
- 3. Under *Insert Addendum Here:, type = Next session on Tuesday
- 4. Click Sign.





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

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	rvice .	. V	Subject	Туре	Facility	Author; Contributor(s)	Status ^	'	* Final Rep	ort *		
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	-Nov-	-2017	Wound Care - Initial	Wound Care Treat	LGH Lions Gate	TestUser, WoundOsto	In Error	Teaching Pla	n			
	-Nov-	-2017	Free Text Note	Nursing Shift Sum	SGH Squamish	TestCD, Nurse	Auth (Verifie	reaching rid				
	-Nov-	-2017	Transport Ticket	Transport Ticket	LGH Lions Gate	TestUser, WoundOsto	Auth (Verifie	(Please enter	wo sentences you o	ould include	in a	
	-Nov-	-2017	Free Text Note	Recreation Therapy	LGH Med Imaging	TestCD, RespiratoryT	Auth (Verifie	teaching plan	from your specialty)			
	-Nov-	-2017	Holter Monitor	Holter Monitor	LGH Cardiac Lab	TestCST, CardiologyT	Auth (Verifie					
	-Nov-	-2017	NM Myocardial Perf	NM Myocardial Per	LGH Med Imaging	TestCST, MedicalIma	In Progress					
	-Nov-	-2017	NM Myocardial Perf	NM Myocardial Per	LGH Med Imaging	TestCST, MedicalIma	In Progress 🗉	Addendum I	ov TestUser, IVT	herapy-N	urse on	
	-Nov-	-2017	Free Text Note	Wound Care Progr	LGH Lions Gate	TestUser, WoundOsto	Auth (Verifie	01-Decemb	er-2017 09:31 P	ST (Verifi	ed)	-
	-Oct-	2017	Discharge Planning	Discharge Planning	LGH Lions Gate	TestORD, Nurse	Auth (Verifie	Next session or	n Tuesday			=
	-Oct-	2017	Care Plan for Increa	Interdisciplinary Ca	LGH Lions Gate	TestUser, Nurse	Auth (Verifie					
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	-Sep-	2017	Interventional Radio	IR Procedure Check	LGH Lions Gate	TestMI, Clerk-RadNet1	Auth (Verific	date:	PST		00127	
	-Sep-	2017	Absence Note	Nursing Shift Sum	LGH Lions Gate	TestCD, Nurse	Auth (Verifie	Result	Madified			
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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

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Wound Care Progress Note 10-Nov-2017 11:31:00 PST	ray selected						
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3. In the Result Uncharting window, type = *Charted on the wrong patient* in the Comments box. Then click **OK**.

P Result Uncharting - CSTPRODORD, F	PATIENT A - 700001815	×
In Error Comment - Optional		
Comments:		
Charted on the wrong patient		
	OK Ca	ancel

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

PVNOTES		23
<u>^</u>	The document you are about to view has been marked as IN ERROR. Do you want to continue viewing the result?	
	Yes No	

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





Key Learning Points

A note can be modified by inserting an addendum. A modified note will show up as (Modified)

You can only unchart a note that was initially created by you

PATIENT SCENARIO 7 - Document an Allergy

Learning Objectives

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

Document Allergies

SCENARIO

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

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

Add and save an allergy



Activity 7.1 – Add an Allergy

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

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

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Task Edit View Patient Chart Links Allergy	Help								
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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	v opens.	Select	Tape and	click OK.
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- 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

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Patient Summary														
Orders	🕂 Add	D/A	Substance	Category	Severity	Reactions	Interaction	Comments	Source	Reaction Status	Reviewed	Reviewed By	Est. Onset	Updated By
Single Patient Task List		~	penicillin	Drug	Mild	Rash			Patient	Active	20-Nov-2017 13:43 PST	TestUser, Nurse		20-Nov-2017 T
MAR														
Interactive View and I&O)													
Results Review														
Documentation	🕂 Add													
Medication Request														
Histories		Type Alleri	۵۷ 🔻 An adve	rse reaction to a drug or substa	nce which is	due to an immuni	ological respons	θ.						
Allergies	🕂 Add	*Substance												
Diagnoses and Problem	s	Таре	Free text	No allergy checking is ava	ilable for non-	Multum allergies.	_							Add Comment
CareConnect		Reaction(s):		*Severity	Info source	9	Commante							
Clinical Research			Add Free Text	Mid 👻	Patient	•	Commerks							
Form Browser				At: Knot enter	Onset <	not entered								<u>^</u>
Growth Chart				Year 4	80,000,000									-
Immunizations				Recorded on behalf of	*Categor	y	Status	Reaso	n:					
Lines/Tubes/Drains Sum	nmary				Other	•	Active	•	Ŧ					
MAR Summary						6								
Medication List	🕂 Add					0							K & Add New	Cancel
Patient Information		💿 Up 🕼	Home 🔅 Favorites -	Diders Folder Fav	orites							(
Reference		Sustem Track	had										-	
< [- P													



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

CSTLEAPNING DEMOTHETA - 700	108216 Opened by 1	Forthern Nurro											
COTEEARNING, DEMOTHETA - 700	Juszio Openeo by	restoser, nurse											
Task Edit View Patient Chart	Links Allergy	нер											
: 🎬 CareCompass 🎬 Clinical Leader	Organizer 🤌 Patie	nt List 🔐 Multi-Patient Task	List 🎬 Discharge Dashboar	d 🤮 Staff A	signment 🚦	ELEARNINGLIVE	Ŧ						
🕻 😋 PACS 🜊 FormFast WFI 💡 📰 T	ear Off 📲 Exit 隆	AdHoc IIIIIMedication Adm	iinistration 🔒 PM Conversa	tion 👻 🕞 Ci	mmunicate	 Medical R 	lecord Reque	st 🕂 Add 👻	🖻 Documents 🔮	Scheduling Appointment Bool	k 📾 Discern Reporting Portal		
CSTLEARNING, DEMOTHET	Α 🔀										🗲 List 🔿 🖀 Rec	ent - Nam	ie • ٩
CSTLEARNING, DEMOTHET,	A	DOB:01-Jan-1937	MRN:700008216	Code St	tus:			Proc	ess:		Location:LGH 6E; 624;	04	
		Age:80 years	Enc:700000015058					Dise	ase:		Enc Type:Inpatient		
Allergies: penicillin, Tape		Gender:Male	PHN:9876469824	Dosing	и:			ISOIa	tion:		Attending:Plisvca, Rocci	0, MD	
Menu 🖓	< > • 🖻	Allergies									[D] Full screen	n 🗐 Print	2 0 minutes ago
Patient Summary													Refrech the Allergier
Orders 🕂 Add	Mark All as Re	rviewed											Refresh the Anergies
Single Patient Task List	🕂 Add 🛛 🛒 N	Aodify 🛛 💭 No Known Alle	ergies 🛛 🖓 No Known Mee	lication Aller	ies 🛛 🔗 R	everse Allergy C	heck	Display All					
MAR	· · ·												
Interactive View and I&O	D/A	Substance	Category	Severity	Reactions	Interaction	Comments	Source	Reaction Status	Reviewed	Reviewed By	Est. Onset	Updated By
Poculte Paviau	~	penicillin	Drug	Mild	Rash			Patient	Active	20-Nov-2017 13:43 PST	TestUser, Nurse		20-Nov-2017 T
		Tape	Other	Mild				Patient	Active	20-Nov-2017 14:43 PST	TestUser, Nurse		20-Nov-2017 T
Documentation Add													
Medication Request													
Histories													
Allergies 🕂 Add													

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.

Menu	4	< > - 🕈 MAR	
Patient Summary		*** 66* 📄	
Orders •	Add		
Single Patient Task List		All Active Medications (System)	•
MAR	1	Show All Rate Change Docu	Medications
Interactive View and I&O		Time View	Scheduled
Results Review		Scheduled 2	acetaminophen
Documentation	Add	Unscheduled	650 mg, PO, q4h, drug form: oral liq, start: 17.Nov.2017 14:51 PST
Medication Request		PRN	Maximum acetaminophen 4 g/24 h from
Histories		Continuous Infusions	acetaminophen Temperature Axillary
Allergies	Add	👿 Future	Temperature Oral
Diagnoses and Problems		Discontinued Scheduled	Numeric Pain Score (0-10)
bighoses and Problems		👿 Discontinued Unscheduled	cefTRIAXone
		Discontinued PRN	17-Nov-2017 14:55 PST
CareConnect		Discontinued Continuous Infus	cefTRIAXone
Clinical Research			ramioril
Form Browser			2.5 mg, PO, q12h, drug form: cap, start: 17-Nov-2017 15:22 PST
Growth Chart			ramipril
Immunizations			Systolic Blood Pressure
Lines/Tubes/Drains Summa			and a
Lines Tubes Drains Summa			ranitidine
MAR Summary			50 mg, IV, q8h, start: 17-Nov-2017 15:35 PST
Medication List	Add		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.

All Active Medications	(Syster	m) 🕶 🔜 🔹 🕨			1
Show All Rate Change D	ocu	Medications	23-Nov-2017 14:00 PST	23-Nov-2017 10:00 PST	23-Nov-2017 06:00 PST
Time View		Scheduled		A management	A commence and the
Scheduled		· · · · · · · · · · · · · · · · · · ·	650 mg	650 mg	650 mg
Unscheduled		650 mg, PO, q4h, drug form: tab, stan 20-Nov-2017 14:04 PST	0-Nov-2017	20-Nov-2017 14-08-0CT	20-Nov-2017 14-08 PST
PRN		Maximum acetaminophen 4 g/24 t	rder Info		
Continuous Infusions	3	acetaminophen Temperature Axillary	Event/Task Sum	mary	_
Future		Temperature Oral	Link Info		10
Discontinued Scheduled		Numeric Pain Score (0-10)	Reference Manu	5	
Discontinued Unschedul	led	cefTRIAXone	Med Request	-	
Discontinued DDM	11	1,000 mg, IV, q12h, start: 20-Nov-2	Reschedule Adm	in Times	
Discontinued PKIN		cefTRIAXone	Additional Dose.	-	
Discontinued Continuou	is Infus	а ^с	View MAR Note.		3 mg
		HYDROmorphone 3 mg, NG-tube, q4h, start: 20-Nov- 15:54 PST	Create Admin N	ote	Vov-2017 7 PST
		HYDROmorphone	Alert History		
		Respiratory Rate	Infusion Billing		

- 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

All Orders with Active Tasks in	Tir 🔹 📖 🔹			Tuesday, 28-N	ovember-2017	12:21 PST - Thu	ırsday, 30-Noveı	mber-2017 12:2	1 PST (Clinical R	ange)			7	
Show All Rate Change Docu	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	8		_
Time View	Scheduled											_		
👿 Scheduled	acetaminophen (TYLENOL)	640 mg Last given:												
Unscheduled	640 mg, PO, q4h, drug form: oral liq, start: 29-Nov-2017 14:00	22-Nov-2017 12:41 PST	22-Nov-2017 12:41 PST	22-Nov-2017	22-Nov-2017 12:41 PST	22-Nov-2017	22-Nov-2017							
PRN	Maximum acetaminophen 4 g/24 h from all sources													
Continuous Infusions	acetaminophen													
Commodas infasions	Temperature Axillary													
🗹 Future	Temperature Oral													
Discontinued Scheduled	Numeric Pain Score (0-10)	1.000 mg			1.000 mg				1.000 mg					
Discontinued Upscheduled	vancomycin	Last given:			Last given:				Last given:					
V Discontinued onscheduled	1,000 mg, IV, q12h, start: 29-Nov-2017 12:22 PST	22-Nov-2017			22-Nov-2017				22-Nov-2017					
Discontinued PRN	vancomycin	10:00 P31			10.00 PS1				10.00 P31					
Discontinued Continuous Infus	PRN													
	PRM							1 mg						
	HYDROmorphone (DILAUDID PRN range dose)							Not previously						
	dose range: 0.5 to 1 mg, PO, q1h, PRN pain, drug form: oral liq start: 20 Nov. 2017 12:24 PST							given						
	HYDROmorphone													
	Respiratory Rate													
	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							Pending Not previously given						
	Administration Information							Q						
	sodium chloride 0.9%							3						

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**.

- 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)



- Medication Administration

 CSTLEARNING, DEMOBETA
 MRN: 700008215
 DOB: 01-Jan-1937
 Loc: 624; 03

 Male
 *INF: 700000015056
 Age: 80 years
 *Allergies

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

 Ready to Scan
 1 of 2
 Net
- 2. The Medication Administration pop-up window will appear.

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

			25-Jan-2018 09:43 PST - 25-Jan-2018
I.		Scheduled	Mnemonic
	`জ	PRN	lorazepam
	_		LORazepam (ATIVAN)
ľ	•	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

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



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

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



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

< > - ♠ MAR			
*** 🖬 👘			
All Medications (System)	· ·		Wednesd
Show All Rate Change Docu	Medications	2018-Jan-25 11:48 PST	2018-Jan-25 10:48 PST
Time View	Scheduled		
☑ Scheduled	්ෂණ කී bacitracin-polymyxin B topical (POLYSPORI		
Unscheduled	1 application, topical, BID, drug form: cream, start: 2017-Dec-27 14:20 PST		
PRN 🛛	bacitracin-polymyxin B topical		
🔽 Continuous Infusions	PRN	Med Response	
Future Discontinued Scheduled	LORazepam (ATIVAN) 1 mg, PO, once, PRN anxiety, drug form: tab, start: 2017-Dec-27 14:20 PST	incu kesponse	Complete
Time View Scheduled Unscheduled PRN Continuous Infusions Future Discontinued Scheduled	Scheduled → & bacitracin-polymyxin B topical (POLYSPORI 1 application, topical, BID, drug form: cream, start: 2017-Dec-27 14:20 PST bacitracin-polymyxin B topical PRN → & CORazepam (ATIVAN) 1 mg, PO, once, PRN anxiety, drug form: tab, start: 2017-Dec-27 14:20 PST	11:48 PST	10:48 PS

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

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

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

Show All Rate Change	Medications
	Discontinued Scheduled
Time View	<u></u>
Scheduled	LORazepam (ATIVAN sublingual) 1 mg, sublingual, once, drug form: tab, start: 25-Jan-2018 10:00 PST,
Unscheduled	stop: 25-Jan-2018 10:00 PST
PRN	Discontinued PRN
Continuous Infusions	
🗹 Future	t.
Discontinued Scheduled	LORazepam
Discontinued Unschedule	
Discontinued PRN	
Discontinued Continuous	

Key Learning Points

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

PATIENT SCENARIO 10 - Results Review

Learning Objectives

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

- Review Patient Results
- Identify any Abnormal Results

SCENARIO

In this scenario, you will review your patient's results. One way to do this is in Result Review.

You will complete the following activity:

Review results using Results Review



Activity 10.1 – Using Results Review

1 Throughout your shift, you will need to review your patient's results. One way to do this is to navigate to **Results Review** on the **Menu**.

Results are presented using **flowsheets**. Flowsheets display clinical information recorded for a person such as labs, iView entries such as vital signs, cultures, transfusions and diagnostic imaging.

Flowsheets are divided into two major sections:

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



Review the most recent results for your patient:

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

Menu P	< > 🔸 🛉 Results Review
Patient Summary	
Orders 🕂 Add	
Single Patient Task List	Recent Results Advance Care Planning Lab - Recent Lab - Extended Pathology Micro Cultures Transfusion Diagnostics Vitals - Recent Vitals - Extended 3
MAR	2 uick View - 4 Laugh Ouick View - Charles Group O List
Interactive View and I&O	Towareeu guick new . In teret, guick new . I table O droup O tak
Results Review 1	() Monday, 27-November-2017 15:43 PST - Friday, 01-December-2017 15:43 P
Documentation 🕂 Add	Navigator E
Medication Request	VITAL SIGNS Show more results
Histories	SBP/DBP Cuff Quick View 28-Nov-2017 18:17 PST 28-Nov-2017 18:13 PST
Allergies 🕂 Add	Oxygenation The Story S
Diagnoses and Problems	PAIN ASSESSMENT PAIN ASSESSMENT PAIN PAIN PAIN PAIN PAIN PAIN PAIN PAIN
	Sbr/Job Culli Sprije Stolic Blood Pressure 100 mmHg 100 mmHg
CareConnect	Diastolic Blood Pressure 60 mmHg 60 mmHg
Clinical Research	Kygenadon Registratory Rate 22 br/min (H) 22 br/min (H)
Form Browser	
Growth Chart	
Immunizations	
Lines/Tubes/Drains Summary	
MAR Summary	
Medication List 🕂 Add	
Patient Information	
Reference	

5. Review your patient's recent lab result.

CBC and Peripheral Smear	
WBC Count	1.5 x10 9/L (L)
RBC Count	2.00 ×10 12/L (L)
Hemoglobin	70 g/L (L)
Hematocrit	0.15 (L)
MCV	98 fL
МСН	28 pg
RDW-CV	15,3 % (H)
Platelet Count	10 x10 9/L (!)
NRBC Absolute	5.0 ×10 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 - Decre

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

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

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



Key Learning Points

Flowsheets display clinical information recorded for a patient such as labs, cultures, transfusions, medical imaging, and vital signs

- The Navigator allows you to filter certain results in the Results Display
- Bloodwork is coloured to represent low, normal, high and critical values
- View additional details of a result by double-clicking the value

PATIENT SCENARIO 11 - Document Intake and Output

Learning Objectives

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

Review and Document Intake and Output

SCENARIO

As a nurse, you will complete the following activities:

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



Activity 11.1 – Navigate to Intake and Output Flowsheets Within iView

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

The I&O window is structured like other flowsheets in iView. Values representing a patient's I&O are displayed in a spreadsheet layout with subtotals and totals for specific time ranges. The left portion of the I&O screen lists different intake and output categories. Notice that the time columns in I&O are set to hourly ranges (e.g. 0600-06:59). You will need to document under the correct hourly range column.

1 To navigate to the Intake and Output flowsheets:

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



2 The **Intake and Output** band expands displaying the sections within it, and the I&O window on the right. Let's review the layout of the page.

The intake and output screen can be described as per below:

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

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

- 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

CSTLEARNING, DEMODELTA	DO8:01-Jan-1937	MRN:700008217	Code Status:		Process:	alls Risk	Location:LGH ED; AC; 204	
	Age:80 years	Enc:700000015060			Disease:		Enc Type:Inpatient	
Allergies: Pollen	Gender:Male	PHN:9876469817	Dosing Wt:75 kg		Isolation		Attending:Plisvca, Rocco, MD	
Menu #	✓ ✓ ★ Interactive View and I&O							en 💼 Print 🚓 3 minute
	•• ⊟ ✓ ∅ × ₪							
Orders 🕂 Add								
Single Datient Tark List	X Adult Quick View	4 10		Friday, 01-	December-2017 06:00 PST	- Saturday, 02-December-2017 05:59 PST		14.1
	X Adult Systems Assessment	Today's Intake	0 mi Outnut: 0 mi Bala	ncer 0 mi			Admission to Current	
мак	X Adult Lines - Devices		e inc. ooquus e inc. our	at D 201			Today's Results	
MAR Summary	X Adult Education	1	10:00 -	09:00 . 08:00 .	07:00 . 06:00 .		Other 4	
Interactive View and I&O	Slood Product Administration	2	10:59 PST	09:59 PST 08:59 PST	07:59 PST 06:59 PST			
	Vintake And Output	Intake Total						
	Intake	▲ Oral						
Documentation 🕂 Add	Continuous Infusions	4 Other Intake	Sources					
Medication Request	Medications Cleart Tubes	∠ Negative Pre	ssure Wound Th					
Histories	Enteral	⊿ Surgical Dra	n, Tube Inputs 🙀					
	GI Tube	⊿ Output Total						
Allergies 🕈 Add	GI Ostomy Intake	⊿ Emesis Outp	ut					
Diagnoses and Problems	Urinary Diversion Intake	2 Gi Tube	L.O					
	Oral Others Intelling Comments	A Negative Pro	ssure Wound Th					
	Negative Pressure Wound Therany	⊿ Stool Outpu	1					
CareConnect	Surgical Drain. Tube Inputs	Stool Count	(Number of Stools)					
	Transfusions	E ⊿ Urine Outpu	t					
Form Browser	Unnary Catheter, Intake	Urine Voide	ml.					
	Pre-Arrival Fluid	⊿ Urine Outpu	t mL/kg/hr					
Growth Chart	Blood Outrat		verence					
Immunizations	Chest Tube Output							
Lines/Tubes/Drains Summary	Continuous Renal Replacement Therapy							
Restantion for all Add	Emesis Output							
medication List	GI Tube							
Patient Information	Gi Ostoniy Output							
Reference	Paracentesis Output							
	Pericardiocentesis Output							
	Negative Pressure Wound Therapy							
	Stool Output							
	Surgical Drain, Tube Outputs	1						
	Thoracentesis Output							

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

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

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

Within the Intake And Output band:

- 1. Locate the Oral section in the I&O navigator
- 2. In the flowsheet on the right, document the following by clicking on the appropriate cell.
 - Oral Intake = 50 mL
 - Urine Voided = 375 mL

3. Click green checkmark icon 🗸 to sign



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

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



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

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







- 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

Menu 7	< 🖂 🔸 🛉 Patient Summary									
Patient Summary 1 📤	🗚 🕽 🚭 🕒 🔍 🔩 100% 🗸 🌑 🜑 🚮									
Orders 🛨 Ada	Handoff Tool	🛛 Summary 🖾 Assessment 🖾 Discharge								
Single Patient Task List										
MAR	Informal Team	Informal Team Communication								
MAR Summary										
Interactive View and I&O	Active Issues	2 Dressing changed. Will require new pain medication order tomorrow. Please re-order Morphine								
Results Review	Allergies (3)									
Documentation 🕂 Add	Vital Signs and Measurements	164 characters left								
Medication Request	Documents	Available to All Save Cancel								
Histories	Transfer/Transport/Accompan	No actions documented								
Allergies 🕂 Add	iment									
Diagnoses and Problems	Assessments	All Teams								
	Lines/Tubes/Drains									
	Intako and Output									

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.

Informal Team Communication		
Add new action		
Dressing changed. Will require new pain medication order tomorrow. Please re-order Morphine.	A 🛞	
Testuser, Nurse 04/12/17 16:53		5

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



An Informal Team Communication message is NOT part of the patient's legal chart.

1

Activity 12.2 – Documenting a Nursing shift Summary Note

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

Handoff Tool	Summary	23	Assessment	23 Discharge	Σ	+				- 🖻	s 🔹	
Informal Team Communication	Informal Team Co	mmunication									2	-
Active Issues												
Allergies (3)	Add new action				Add ne	w comment						
Vital Signs and Measurements												
Documents (1)	No actions documented				No com	ments documented						
Transfer/Transport/Accompanim ent (0)	All Teams				All Tea	ns						
Assessments												
Lines/Tubes/Drains	Active Issues							Classificatio	n: All	👻 Al	l Visits 🛛 🤁	=-
Intake and Output												
Labs					Add new a	s: This Visit and Chronic 🔻	Q					
Imaging												-
Medications	Pneumonia				😔 Medi	cation	Actions This Visit	Chronic				
Home Medications	Diabetes				Medi	ral	Thic Vicit	Chronic				
Orders	Perinheral vascul	ar disease			Medi	ral	This Visit	Chronic				-1
Oxygenation and Ventilation	r enpiterar tusea				-icu		THIS VISIC	chronic				-1
Pathology												
Histories	Allergies (3) 💠									All	Visits 2	= -
Create Note												
Interdisciplinary Care Plan	Substance	Reactions	Category	Status	Severity	* Reaction Type	Source		Comments			
Interdisciplinary Rounding Summ	Bees/Stinging Insects		Environme	nt Active		Allergy						ъ
ary Note	ciprofloxacin	-	Drug	Active		Allergy						
Nursing Shift Summary 2	diphenhydrAMINE	-	Drug	Active		Allergy						
Select Other Note	1							Reconciliation	n Status: Incomplete	Complete R	econciliation	
	Vital Sinns and Measurements +										-	

• Click Sign in the Sign/Submit note window



Click the Refresh icon


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

Handoff Tool	Summary	83 Assessment	23 Discharge	23 Quick Orders	8 +		- • • =·				
Informal Team Communication					My notes of	only 🔲 Group by encounter 🛛 D	isplay: Multiple note types 🔻				
Active Issues	Time of Service	Subject	Note Type	Author	Last Updated	Last Updated By					
Allergies (4)	01/12/17 11:49	Free Text Note	Nursing Shift Summary	TestUser, ICU-Nurse	01/12/17 11:52	TestUser, ICU-Nurse					
Vital Signs and Measurements	27/11/17 15:52	Nursing Discharge Checklist	Nursing Discharge Checklist - Text	TestUser, Nurse	27/11/17 16:15	TestUser, Nurse					
Documents (2)	* Displaying up to the last	50 recent notes for the selected visit									
Transfer/Transport/Accompanim ent (0)											
Assessments (0)	Transfer/Transport	t/Accompaniment (0) 🕂 🚽			Sele	cted visit: Selected visit Last 2 hou	rs 🛛 Last 12 hours 🛛 🤁 💷 -				
Lines/Tubes/Drains	Na multi fami										
Intake and Output	No results round										
Labs											
Micro Cultures (0)	Assessments						Selected visit 🛛 🏵 📃 =-				
Home Medications (7)	No results found										
Diagnostics (0)											
Medications							1 - 1				
Orders (3)	Lines/Tubes/Drain:	S (0) ▼					Selected Visit 🛛 🕄 🖃				
Oxygenation and Ventilation (0)	Туре	Loca	bion		h	nserted					
Pathology (0)	⊿ Lines (0)										
Histories	No results found										
Create Note	△ Tubes/Drains (0)										
Interdisciplinary Care Plan	 Discontinued (0) 										
Interdisciplinary Rounding Summ ary Note											
Nursing Shift Summary	Intake and Output					Selected visit (24 hour perio	ods starting at 06:00) $ \mathfrak{S} \equiv$				
Select Other Note			01/12/17* 30/11/17 29/11/	17 28/11/17 27/11/17	26/11/17 25	/11/17 24/11/17	23/11/17 22/11/17				
	Total Summary						1				

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

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



Key Learning Points

A Nursing Shift Summary note is used to write a narrative note about what happened in a given shift for oncoming nurses.

The note must be signed in order for it to be on the chart.

Nurses can view notes like this from the Documentation tab in the Menu.



Activity 12.3 – Handoff Tool

1

Use Handoff Tool to Review Patient information with the oncoming nurse.

From the Menu select Patient Summary. From the Handoff Tool tab:

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

Handoff Tool	22 Summary	23 Assessment	23 Disc	harge	× +				💌 - 🔍 🔍 🔳
Informal Team Communication	Active Issues						Class	sification: Medical and Patier	t Stated ▼ All Visits 💐 🖃
Active Issues					Add new set This Misit -	0			
Allergies (2)					Add new as. This visit •				
Vital Signs and Measurements	Name				Classification	Actions			
Documents (1)	Pneumonia				Medical	This	Asit Chronic		
Transfer/Transport/Accompanim	Diabetes				Medical	This	/isit Chronic		
ent (0)	Peripheral vascular disease				Medical	This	/isit Chronic		1
Assessments (0)									
Lines/Tubes/Drains									a -
Intake and Output	Allergies (2)								All Visits 😍 = *
Labs									Scroll to view
Imaging (0)	Substance Reactions		Category	Status	Severity	Reaction Type	Source	Comments	more
Medications	Bees/Stinging Insects		Environment	Active		Allergy		-	
Home Medications (0)	diphenhydrAMINE		Drug	Active	-	Allergy	-	-	
Orders (19)							Recon	ciliation Status: Incomplete	Complete Reconciliation
Oxygenation and Ventration (0)									
Pathology (0)	Vital Signs and Measurem	ents 🕂					Selected visit: L	atest* Selected visit Las	12 hours 📰 🔟 🥺 =-
notories		NOV 20, 2017							
Create Note	Respiratory Rate br/min	15:57							
Interdisciplinary Care Plan	* Displaying recent results up to 16 of	columns of information for the selected vi	sit						
Interdisciplinary Rounding Summ ary Note									
Nursing Shift Summary	Documents (1)						Selected visit: Last	50 Notes Selected visit	ast 12 hours More 💌 🥸 💷
Select Other Note							My notes only	Group by encounter	Display: Multiple note types *
	Time of Service Sub	bject	Note Type		Author	Last Updab	d	Last Updated By	
	20/11/17 16:37 Fre	ee Text Note	Nursing Shift Sum	nary	TestORD, Nurse	20/11/17	16:38	TestORD, Nurse	

Key Learning Points

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

Activity 12.4 – Documenting Handoff in iView

Document that you have given Report or Handoff in iView by completing the following steps:

- 1. Select Interactive View and I&O from the Menu
- 2. Select Shift Report/Handoff section from Adult Quick View
- 3. Document using the following data:
 - Clinician Receiving Report = Nurse 1
 - Clinician Giving Report = Nurse 2
 - Lines Traced Site to Source = Yes
 - Orders Reviewed = Yes

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

Click green checkmark icon 🗸 to sign your documentation



Key Learning Points

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



b End of Workbook

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