SELF-GUIDED PRACTICE WORKBOOK

CST TransformationalLearning

CURRICULUM TRACK:

PROVIDER: CRITICAL CARE



Last update: January 25, 2018



F SELF-GUIDED PRACTICE WORKBOOK

Duration	4 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 learning 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. You and your instructor will discuss the Review You will sign the Review and hand it to the instructor



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- ACTIVITY 5.2- Cosign a Note and Add an Addendum to a Completed Note..... Error! Bookmark not defined.
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E Learning Domain

You will be using the learning domain to complete activities in this workbook. The learning domain has been designed to match the actual Clinical Information System (CIS) as close 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 steps to be able to complete all activities
- I If you have trouble following the steps, immediately raise your hand for assistance to use classroom time efficiently
 - Ask for assistance whenever needed



PATIENT SCENARIO 1 - Admitting a Patient

Learning Objectives

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

- Access a patient's chart and review patient care information
- Place and manage admission orders
- Review and manage medications on admission
- Complete patient's admission and document patient care

SCENARIO

As the provider covering the Critical Care Unit, you receive a phone call from a provider on the Medicine Unit. A 47 year old male patient who initially presented to the ED with fever, shortness of breath, and a productive cough was admitted to the Medicine Unit for a course of antibiotics for presumed pneumonia. While on the Medicine Unit, the patient fell and now needs to be admitted to the Intensive Care Unit (ICU) for further evaluation due to decreased level of consciousness and need for airway protection.

You will complete the following 5 activities:

- Access and review the patient chart
- Review home medications and complete admission medication reconciliation
- Place orders through PowerPlans (order sets) for patient admission
- Update problems and diagnoses and document your assessment findings
- Complete and sign an admission note



b Activity 1.0 – Setting the Stage before You Start

Your received a consult request from the Medicine provider and want to open and review the patient's chart.

The recommended way to do this is to use an existing **Medicine Unit** patient list from **Patient Overview** window. Below, you see the example how this might look in real life.





The list helps to locate the patient. If you have never accessed this patient's chart, the patient is marked by **No Relationship Exists.** Clicking patient's name will open the chart.

Patient Overview			
👫 🐚 🖷 🐚 🔍 🔍 100	% 🛛 - 🖱 🖨 🚮		
Patient Overview	*		
List: LGH Emergency Departm	nent (89) 🔻		
Patient Information		Location	Illness Severity
IPPHYSONE. JAN	E	LGH ED	No Relationship Exists
20 yrs F		ACWR	
*ABASSI, FATIMA	Н	LGH ED	No Relationship Exists

If there is no relationship, a prompt **Assign a Relationship** will display. As a consulting provider, you would select **Consulting Provider**.

P Assign a Relationship	×
For Patient: IPPHYONE, JANE	
Relationships:	
Consulting Provider Covering Provider Education Quality / Utilization Review Referring Provider Research Triage Provider	
OK	:

You will be learning more about Patient Overview and patient lists later and will have the opportunity to walk through the steps of accessing the patient's.

Review key steps to admitting patients first.

After reviewing the patient chart and assessing the patient, you can decide whether to admit them.

If you do not admit them, you will create a consult note and close the chart. If you admit them, the first step you need to take is to place the **Admit to Inpatient** order.



It is important that the Admit to Inpatient Order is placed before any other orders. Pharmacy dispensing may be delayed if this order is not placed first. Also, placing this order allows the following important steps to happen automatically:

- The status of the patient becomes inpatient and the **clock starts for the admission**
- There is a notification to Access Services to locate a bed for the patient
- If the patient was from ED, the encounter type changes from Emergency to Inpatient
 - Admission tasks are sent to the inpatient nurse assigned to this patient



ACTIVITY 1.1- Access and Navigate the Patient Chart

The Clinical Information System (CIS) allows for immediate access to the patient chart. Let's go ahead and access the patient's chart.

- 1 Ensure you are logged into PowerChart using provided username and password. Your landing page will be the Message Center.
- 2 To access and review the patient chart click **Patient Overview**



3 Select the **My Assigned Patients** list which groups together all patients for whom you are the attending provider.



Note: There are other ways of accessing a patient's chart that can be learned from other resources.



4 You are prompted to Assign a Relationship to the patient. Select Consulting Provider then click OK.



5 The patient's chart opens to the **Provider View** which is your current default screen when accessing a patient's chart. It is organized into several tabs. Each tab is designed to support a specific workflow. Click each tab to review what is contained in each view.

E LEARNINGDEMO,	JOHN - 70000668	4 Opened by TestUser, CriticalCare-P	hysician, MD				
Task Edit View	Patient Chart	Links Notifications Navigation	n Help				
Message Centre	Patient Overs	new 🛒 Ambulatory Organizer 📷 M	yExperience 🍦 Patient List 👫 Dynamic Worklist 🎬	LearningLME ; Q CareConnect	PHEA PACS Q VCH and PHC PACS	QMUSE Q FormFast WFT 1 5 Circle	(Ahsar) @ Propri.0]
Teat Off SEat	Communicat	te + 🗑 Discern Reporting Portal 🕎	GAugen .				
Patient Health Edi	lucation Material	a Q Policies and Guidelines Q Up7	oDate :				
LEARNINGDEM	D, JOHN	1					List Street + Harris - 9
LEARNINGDEM	O. JOHN	De	601-Jan-1970 MRN270000664	Code StatusSillemp	it CFR, Full Code	Process:	Location:LGH 4W; 405; 04
Allergies: morphine		Ag Ge	nder:Male PH029876415442	Dosing Wt:		bolation	Attending/Pisyca, Rocco, MD
Menu		Provider Vie					🗇 Full screen - 🍏 Print - 📀 0 minutes ago
Provider View							
Results Review		Administra	11 Brandon	11 Drander/Dischame	11 Duick Orden	21 4	
Orders	+ Add	- Annual Contraction	14 Cristened	199 Contraction Statement Sec.	11 January 1997	10.1 4	
Medication List	+ Add	Chief Compliant	Chief Complaint				Selected vice 2 =-
Documentation	+ Add	History of Present Illness	Chief complaint				
Allergies	+ AM	Advance Care Planning and Goals of Care	Enter Chief Complaint				
Diagnoses and Problem		Histories					
Histories		Current Medications	History of Present Illness				Selected wat D 2
MAR Summary		Home Medications (5)					
MAR		Documents	Fort + Size + 4 10 28	8 / U 🌆 🗄 🗉 🖬	E 64		
Form Browser		Allergies					
Patient Information		Links					
Interactive View and R		Review of Systems					1 and
Lines/Tubes/Drains Su		Vital Signs & Measurements					Save
Growth Chart		Physical Exam					
Immunizations		Libi	Advance Care Planning and Go	als of Care -			6
Clinical Research		Insiging	Advances Cares Plan (1) Most Record				
CareConnect		Lines/Tubes/Drains	Advances Trianchine Net Found				
		Active Issues	Code Status: Attempt CPR, Full Code				
		Assessment and year _					
		Urber Prome					
		New Order Excly	Histories				Al vars 🤤 = -
		Create Note	Medical History (1) Service	d Heday (11) Famil	Ar Henry (D) Social I	interv RDS	Q Add problem
		ICU Admission Note	Contraction of Change	and the state	in the second		
		100 Consult Note	Rame	(t)		ClassReation	
		Select Other Note	a Chronic Problems (1)				
			Dysipidemia			Medical	



6 The Banner Bar located at the top of the screen displays demographic data, alerts, information about patient's location, and current encounter information.

Click the **refresh** icon **refresh** to ensure that your display is up-to-date. A timer shows how long ago the information on your screen was last updated. **Refresh** frequently.



7 For increase viewing, click on the **Auto hide** 👎 icon to the right of the **Menu** view.

LEARNINGDEMO, JOHN	
LEARNINGDEMO, JOHN	DOB:01-Jan-19
Allergies: morphine	Age:47 years Gender:Male
Allergies, morphile	Genderiviare
Menu 4	🔨 🕘 👻 者 Provider View
Provider View	👫 📄 🔍 🔍 🔍 100% 🗸 🜑
Results Review	Admission 82
Orders 📥 Add	

Note: The table of contents Menu will be in hide view throughout this workbook. By clicking on the Menu button, the table of contents will re-appear again. This can be discussed further during your personalization sessions.

Mer	< 🔹 🚽 者 Provider View					
Ĕ	👫 🐚 📥 🔍 🔍 100%	- • • 🗳				
	Admission	X Rounding	53	Transfer/Discharge	53	Quick Orders
	Chief Complaint					
	Chief Complaint	Chief Complaint				
	History of Present Illness					
	Advance Care Planning and	Enter Chief Complaint				





Now, let's open the **Admission** tab.

LEARNINGDEMO, JOHN 🛛 🛛						
LEARNINGDEMO, JOHN	DOB:01-Jan-1970 Age:47 years	MRN:700008684 Enc:7000000016209	Code Sta	tus:Attempt CPR, Full Code		Process Disease
Allergies: morphine	Gender:Male	PHN:9876415442	Dosing V	Vt:		Isolatio
🅈 🔷 🔹 👘 Provider View						
🖴 🗎 🦣 🕒 🔍 🔧 100% 🗸	•• 4					
Admission	Rounding	23 Transfer/Discharge	23	Quick Orders	23	+
Chief Complaint	Chief Complaint					
History of Present Illness						
Advance Care Planning and Goals of Care	Enter Chief Complaint					
Histories						

9 On the left side of the screen there is a list of components representing workflow steps specific for your specialty. Click the component or use the scroll bar to display the content of the patient's chart.

Admission	22 Rounding	22 Transfer/Discharge	22 Quick Orders	31 +	
Chief Complaint History of Present Illness Advance Care Planning and	Chief Complaint				Selected visit $ \mathfrak{d} =$
Goals of Care Histories Current Medications Home Medications	History of Present Illnes	55			Selected Yor DI $ \mathcal{R} $ =
Documents Allergies Links	[Post +][Sce +][-g	16 86 8 7 ¥ Ar II # # # #	6		
Review of Systems Vital Signs & Measurements					Save
Labs	Advance Care Planning	and Goals of Care -			0 =-
Imaging	Advance Care Plan (1) Moit Re	iciră			
Lines/Tubes/Drains	Advance Directive Not Found.				
Active Issues Assessment and Plan	Code Status: Attempt CPR, Full	l Code			L



10 Each component has a heading. Place the cursor over the heading. This icon h means it is a link. Click this heading to open a comprehensive window with more options.

	22 Transfer/Discharge	22 Quick Orders	22 +	
Chief Complaint				Selected visit 🍣 = -
Enter Chief Complaint				
History of Present Illn	ess			Selected visit $ $ DI $ $ \gtrsim $ $ \equiv -
Font • Size •	- 11 10 B 7 <u>U</u> Ar 10 ± ± ± ≡			
				Save.
Advance Care Plannin	ig and Goals of Care 🗸			Seve.
Advance Care Plannin Advance Care Plan (1) Nost	ig and Goals of Care ↓	_		
Advance Care Plannin Advance Care Plan (1) Most Advance Directive Not Found	ig and Goals of Care ↓	_		
Advance Care Plannin Advance Care Plan (1) Most Advance Directive Not Foun Code Status: Attempt CPR, F	ig and Goals of Care – Recent util Code			Seve.
Advance Care Plannin Advance Care Plan (1) Most Advance Directive Not Foun Code Studio: Attempt CHK, P	ig and Goals of Care ↓ Recent 1 full Code			

Key Learning Points

- When admitting a patient it is critical to place the **Admit to Inpatient** order prior to entering additional orders
- Use the **Patient Overview** and specific patient lists to access patient charts
- Review **Banner Bar** information to ensure you have selected the right patient and the right encounter
- Remember to **refresh** your screen frequently to view the most up-to-date information
- The **Provider View** provides access to various workflow tabs

ACTIVITY 1.2- Review Histories

Your patient's family member told you about the patient's hip replacement surgery that was done last year. In this activity, you will add this information to the patient's history.



Click **Histories** component to display Medical History, Surgical History, Family History, and Social History. Ensure you are in the **Admission** tab.

		1		-		30	
Medical History	(4)	Surgical History	(2)	Family History	(2)	Social History	(3)
Name			*				Classificatio
Chronic Problems	(4)						
Acid reflux							Medical
Asthma							Medical
Back injury							Medical
Tobacco use							Medical

Note: There is a separate tab for each history type. The number in brackets indicates how many entries are in each tab.

2 Select Surgical History to add a new entry

3 Click into the **Search** box and type *hip replacement*. A list of options will appear. Select an appropriate option.

Histories											All Visits $\left oldsymbol{\mathcal{R}} \right \equiv$ -
Medical History	(4)	Surgical History	(1)	Family History	(0)	Social History	(0)	Obs/Gy	nocology	(0)	
		1								CPT4	🤉 hip replacement 🛛 🛞
Procedure d Surgical Records (0)				Surgeon				Implant		Date	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft
No results found △ Procedures (1) Splenectomy				Plisvca, Rocco, MD						1992	Open treatment of spontaneous hip dislocation (developmental, including congenital or pathological), replacement
Documents (12)	•								Last 50 Not	tes All V	of femoral head in acetabulum (including tenotomy, etc); Open treatment of spontaneous hip dislocation (developmental including
()							My n	otes only	Group by e	encounter	congenital or pathological), replacement of femoral head in acetabulum (including
Time of Service	Subject		Not	te Type	A	Author	L	ast Updated		Last Upda	tenotomy, etc); with femoral shaft shortening
05/09/17 14:24	Patient	Discharge Summary	Pat	tient Discharge Summary	1	TestPET, GeneralMedicine-	0	5/09/17 14	:24	TestPET	Add "hip replacement" as free text



4 Enter procedure date information of *Age 47* years and click **Save.**

Save Cancel			×
Arthroplasty, acet replacement (tota or allograft	abular and pro I hip arthropla	oximal femoral prost sty), with or withou	hetic t autograft
Procedure Date At/On 🔽 Age	v	Years	
Provider	Status	Location	
Comments			
	4	<u>.</u>	

Note: To add **Family or Social History**, click on the *Histories* heading in order to add information. For additional information regarding patient history documentation, refer to the reference guide.

Key Learning Points

Histories information including surgical procedures can be added when taking a patient's history



ACTIVITY 1.3- Discontinue Existing Orders and Powerplans Through Order Profile

1 While you are in the Admission tab, locate the **Order Profile** component.

🗚 🐚 🖣 🐘 🔍 🔩 100	% 🔹 🛑 🌑 🚰			
Admission 🛛	Rounding 🛛 Transfer/Disch	arge 🛛	Quick Orders	6
Imaging Lines/Tubes/Drains Active Issues	Pending Orders (51) Group by: Clin	ical Category	Show:	All
Order Profile (51)	(3)	Start	Status	Stat
New Order Entry Create Note	to Inpatient 29-Nov-2017 10:10 PST, to General Internal Medicine, Admitting pvider: TestUser, GeneralMedicine- ysician, MD	29/11/17 10:10	Ordered	29/: 10::
ICU Admission Note	d Transfer Request 17-Oct-2017 11:09	17/10/17 11:09	Ordered	17/
ICU Consult Note	Sebarga Datiant 27 Nov 2017 07:22 DCT	77/11/17	Ordered	171

2 Select the **Order Profile** link





3 Locate and click on the General Medicine Admission PowerPlan in the View navigator

< > - 者 Orders					(D) Full screen 👘 👘 🔥 14 mit	nutes a
+ Add @ Document Medication by Hx Orders Medication List Document In Pla	Reconciliation	n 🕶 🔗 Check Interactio	ons		Reconciliation Status Meds History Admission AD	scharg
	н	4 🛛 😵 🚫 🕂 Add t	to Phase • 🛄 Comments Start: 💈	20-Nov-2017 10:06 PST Stop: None		
View		4 6	Component	Status Dose .	Details	
Plans Document In Plan Medical MED General Medicine Admission (Validated)	A Patient Care	Nov-2017 10:09 PST by: TestPET, (n 20-Nov-2017 10:03 PST by: TestPET, (n 20-Nov-2017 10:03 PST by: TestP ischarge Verify that an 'Admit to' Order has I	GeneralMedicine-Physician, MD ET, GeneralMedicine-Physician, MD been entered prior to completing the power	lan	, m
© Orders		8	Consider Allergy Form Consider Medication Reconciliation	n		
Admit/Transfer/Discharge		60 2	Weight	Ordered	20-Nov-2017 10:06 PST, Stop: 20-Nov-2017 10:06 PS	
🖸 Status		₩ 66° [2	Vital Signs	Ordered	20-Nov-2017 10:06 PST, Stop: 20-Nov-2017 10:06 PS	
C Patient Care		66 68 🔽	Pulse Oximetry	Ordered	20-Nov-2017 10:06 PST, q8h, with vital signs	
Activity		Lines/Tubes/Drain	15			
Diet/Nutrition		3	Urinary Catheter: Document indicat	tion. Refer to organization's CAUTI quideline	S .	
Continuous Infusions		A Activity	Activity as Tolerated	Ordered	20-Nov-2017 10:06 PST	
Blood Products	+	△ Diet/Nutrition	General Dist	Ordered	20 Nev 2017 10:05 DCT	



Click the **Discontinue** icon



5

The discontinued dialog box is displayed. Click **OK** to discontinue all active orders in the PowerPlan

eep	Component	Status	Order Details
atie	nt Care		
	Weight	Ordered	20-Nov-2017 10:06 PST, Stop: 20-Nov-2017 10:06 PST, On admission, standing weight is preferred
	🔁 Vital Signs	Ordered	20-Nov-2017 10:06 PST, Stop: 20-Nov-2017 10:06 PST, Once baseline
	Pulse Oximetry	Ordered	20-Nov-2017 10:06 PST, q8h, with vital signs
ctiv	rity		
	Activity as Tolerated	Ordered	20-Nov-2017 10:06 PST
et/	Nutrition		
	🗭 General Diet	Ordered	20-Nov-2017 10:06 PST
esp	iratory		
	Covgen Therany	Ordered	20 No. 2017 10 00 DCT D. No. These 024- Los 020200
	e oxygen metapy	ondered	20-Nov-2017 10:00 PS1, Koutine, Titrate O2 to keep SpO2 92% or greater
	O oyyun muqy	olded	20-Nov-2017 10:00 PST, Routine, Titrate 02 to keep Sp02 92% or greater

Note: Here, you have the option to keep an order(s) by checking on the box next to the order.



6 Select Orders for Signature

0				a second second	
09 Y	Component	Status	Dose	Details	
O General Medi	cine Admission (Validated) (Discontinued Per	nding)			
updated on: 29	-Nov-2017 15:22 PST by: TestUser, Gener	alMedicine-Physician, MD			
Admit/Transfer,	Discharge				
	🏈 Verify that an 'Admit to' Order has been er	ntered prior to completing t	he powerplan	0	
Patient Care					
	S Consider Allergy Form				
	S Consider Medication Reconciliation				
66 🖬	Code Status	Discontinue		29-Nov-2017 15:22 PST	
66	Weight	Discontinue		29-Nov-2017 15:22 PST	
66	Yital Signs	Discontinue		29-Nov-2017 15:22 PST	
66 63	Pulse Oximetry	Discontinue		29-Nov-2017 15:22 PST	
Lines/Tubes/Dr	sins				
	A Urinary Catheter: Document indication. Re	fer to organization's CAUTI	auidelines		
Activity			and provide the state of the		
	🗠	D:		00.11 004345 03.007	

7 Select Sign

	23	9 🖻	8	Order Name	Status	Start	Details	
⊿	LGH 4	4W; 40	5; 04 End	:7000000013059 Adm	nit: 03-Nov-2	017 10:07 PDT		
⊿	Statu	IS						
		B	💽 66^ 🖳	Code Status	Discontin	29-Nov-2017 15:21	29-Nov-2017 15:22 PST	
⊿	Patier	nt Care	e					
		•	💽 66°	Pulse Oximetry	Discontin	29-Nov-2017 15:21	29-Nov-2017 15:22 PST	
		(💽 66°	Weight	Discontin	29-Nov-2017 15:21	29-Nov-2017 15:22 PST	
		Ð	💽 66^	Vital Signs	Discontin	29-Nov-2017 15:21	29-Nov-2017 15:22 PST	
⊿	Activi	ity _						
		•	₽ 66^	Activity as Tolerated	Discontin	29-Nov-2017 15:21	29-Nov-2017 15:22 PST	
⊿	Diet/I	Nutriti	ion					
		Ð	E 66 [∧]	General Diet	Discontin	29-Nov-2017 15:21	29-Nov-2017 15:22 PST	
⊿	Respi	iratory						
		(†)	E 66 [∩]	Oxygen Therapy	Discontin	29-Nov-2017 15:21	29-Nov-2017 15:22 PST	
	Detail	\$						
01	Missing	Require	ed Details	Orders For Cosignature				Sign



ACTIVITY 1.4 a- Review Patient's Best Possible Medication History and Complete Medication Reconciliation

Note that your patient's best possible medication history (BPMH) was already completed on admission to the Medicine Unit. If your patient was coming directly from the ED, a pharmacy technician will have already documented the patient's home medications. You will have the opportunity to complete a BPMH on a direct admission to ICU later on in this activity. To continue, your patient's spouse informs you that your patient takes Lisinopril 5mg PO daily which was missed during the original BPMH. You will now update the information.

As part of receiving the patient, you review his BPMH and complete his transfer medication reconciliation.

Within your workflow tabs, there are a few tools to help with this:

- **Home Medications** this component lists home medications documented for this visit and carried over from previous encounters
- **Current Medications** this component lists medications administered during the current encounter
 - **Medication Reconciliation Tool** for admission, transfer, and discharge allows you to manage all home and ordered hospital medications through one convenient screen.

LEARNINGDEMO, JOHN					List - Die Recent - Prime
LEARNINGDEMO, JOHN	DOB:01-Jan-1970 Age:47 years	MRN:700008684 Enc:7000000016209	Code-Status:Attempt CPR; Full Code	Process: Dicease:	Location:LGH 4W: 405: 04 Enc Type:Inpatient
Allergies: morphine	Gender:Male	PHN:9876415442	Dosing Wt	Exolation:	Attending:TestUser, CriticalCare-Physician, MD
🖌 🔹 🔒 Provider View					(0, Full screen 🛛 👼 Print 😪 1 hours 40 minu
A 1 1 1 1 1 1 1 1 1 101%	• • • • •				
Admission	St Rounding	33 Transfer/Discharge	22 Quick Orders	¹² +	
Chief Complaint					псоятликит зация, алектросск.
History of Present Illness					
Advance Care Planning and Goals of Care	Current Medications 🕂				
Histories	L				Status: 🛩 Meds History 🖌 Admission 🛛 Transfer 🛛 🔕 Discharge
Current Medications	Order			Order Start	Status
Home Medications (5)	d Scheduled (4) Next 12 hours				
Documents (0)	acetaminophen 650 mg, PO, g4h			Today 10:00	Ordered
Allergies (1)	acetaminophen (TYLENOL) 975 mg, Pl	D, QID		Yesterday 12:00	Ordered
Links	heparin 5,000 unit, subcutaneous, q12	h		Yesterday 10:33	Ordered
Review of Systems	rantidine S0 mg, IV, g8h interval			Yesterday 14:00	Ordered



Select the Home Medications component from the list to view what has been documented.





Click the Home Medications heading.

Admission	🛛 Rounding	X	Transfer/Discharge	X	Qui
Chief Complaint History of Present Illness	Home Med	ications (5)			
Advance Care Planning and	Medicatio	n	*		
Goals of Care	atenolo	50 mg, PO, qdaily, for 30 day, 30 t	ab, 0 Refill(s)		

3 In the Medication List window, click **Document Medication by Hx**.



Click the + Add button on the Medication History toolbar.





5 Type *lisino* and pause. A list of frequently used lisinopril order sentences displays. To truncate the list further, add more details. For this example, type *Lisinopril 5*



lisinopril 5	🔍 Type: 🖨	Document Medication by Hx 🗣
lisinopril 5 mg oral	tablet	Medications
lisinopril 5 mg oral	tablet (1 tab, PO, qdaily	y, # 30 tab)
lisinopril 5 mg oral	tablet (1 tab, PO, qdaily	y, # 90 tab)
ACT Lisinopril 5 m	g oral tablet	
Auro-Lisinopril 5 m	g oral tablet	
Jamp-Lisinopril 5 n	ng oral tablet	
Mylan-Lisinopril 5	ng oral tablet	
PMS-Lisinopril 5 m	g oral tablet	
Pro-Lisinopril-5		
Pro-Lisinopril-5 ora	tablet	
Ran-Lisinopril 5 mg	oral tablet	
Riva-Lisinopril 5 m	g oral tablet	
Sandoz Lisinopril 5	mg oral tablet	
Ratio-Lisinopril P 5	mg oral tablet	
Ratio-Lisinopril Z 5	mg oral tablet	
"Enter" to Search		

- 6 Select the appropriate medication and associated details. Your selection has been placed.
- 7 You can continue searching and adding more medications if needed. In our example, you add just one. Click **Done**.





8 Details for the lisinopril display for your review. It is very important to know if the patient is compliant with their home medications. To add this information, click on the **Compliance** tab.

dd 📃 No Known Home M	Vedications	Unable To Obtain Infr	ormation 📋 Use Last Compliance				 Meds History Admission Discovery
ocument Medication by Hx							
Crder Name	Status	Details		Last Dose Date/Time	Information Source	Complian	Compliance Comments
		✓I	ast Documented On 05-Dec-2017	09:47 PST (TestUser, C	riticalCare-Physician,	MD)	
4 Home Medications							
anitidine (ranitidine 1)	Documen	1 tab, PO, gHS, drug for	m: tab, dispense qty: 30 tab, refill(s):.				
🖨 simvastatin (simvasta.	Documen	1 tab, PO, gHS, drug for	m: tab, dispense qty: 30 tab, refill(s):.				
atenolol	Documen	50 mg, PO, gdaily, drug	form: tab, dispense qty: 30 tab, refill.				
Pending Home Medicatio	ins i						
🚽 lisinopril (lisinopril 5	Document	1 tab, PO, gdaily, drug fe	orm: tab, dispense gty: 30 tab, refill(Patient	Taking as	
: Details for lisinopril PDetails] Order Comm	(lisinopi ents 🕺 Comp	ril 5 mg oral tal ^{iliance}	blet)				
도 Details for lisinopril 말Details) Order Comme Status	(lisinopi Ints 🕺 Comp	ril 5 mg oral tal _{lliance}	blet)		Lasi	t dose date/time	
E Details for lisinopril Details) Order Commo Status Taking as prescribed	(lisinopi ents 🕺 Comp	ril 5 mg oral tal ^{viance}	Information source		Last	t dose date/time	
E Details for lisinopril Details) I Order Commo Status Taking as prescribed Comment	(lisinop) Ents 🕺 Comp	ril 5 mg oral tal Niance	Information source Patient		↓ Last	t dose date/time	A V
E Details for lisinopril 雷Details) 頭 Order Comme Status Taking as presenbed Comment	(lisinop) Ents 🕺 Comp	ril 5 mg oral tai Mance	Information source Patient		Last • /	t dose date/time	
E Details for lisinopril Details) III Order Commo Status Taking as prescribed Comment	(lisinop) Ents 📌 Comp	ril 5 mg oral tai	Information source		Lasi v 77	t dose date/time	
E Details for lisinopril Details) [19] Order Commi Status Taking as prescribed Comment	(lisinop) Ints 🕺 Comp	ril 5 mg oral ta _{Mance}	Information source		Last • 7/	t dose date/time	
Details for lisinopril Details) Dim Order Comme Status Jaking as prescribed Comment	(lisinop) Ints 🕺 Comp	ril 5 mg oral ta ^{stance}	Information source Patient		Las	t dose date/time	
E Details for lisinopril Details) III Order Comme Status Taking as prescribed Comment	(lisinop) Ents 📌 Comp	ril 5 mg oral ta	Information source		↓ Lest	t dose date/time	
E Details for lisinopril Details) [19] Order Commi Raking as prescribed Comment	(lisinop) ents 🕺 Comp	ril 5 mg oral ta _{Mance}	Information source		Las • 77	t dose date/time	

9 Document the following compliance information:

- Status = Taking as prescribed
- Information source = Patient,
- Last dose date/time= Yesterday at 0900

Note: Click **Details** to collapse or expand details for any order.

To practice, repeat steps to add Clonazepam 1mg PO BID.

10 Click **Document History** to complete the process.

Add	Medication History	ledications	Unable To Obtain Information 🛛 Use Last Co	mpliance		Reconciliation Status Meds History Adv	dmission 🖌 Dischar
Docum	ent Medication by Hx						
5	Order Name	Status	Details	Last Dose Date/Time	Information Source	Complian Compliance Comments	
			✓ Last Documented On 05-1	Dec-2017 09:47 PST (TestUser, C	riticalCare-Physician, M	AD)	
⊿ He	me Medications						
4	ranitidine (ranitidine 1	. Documen	1 tab, PO, qHS, drug form: tab, dispense qty: 30 tab	b, refill(s):			
3	simvastatin (simvasta	Documen	1 tab, PO, qHS, drug form: tab, dispense qty: 30 tab	b, refill(s):			
3	atenolol	Documen	50 mg, PO, gdaily, drug form: tab, dispense gty: 30	tab, refill			
⊿ Pe	nding Home Medication	15					
- 4	lisinopril (lisinopril 5	Document	1 tab, PO, gdaily, drug form: tab, dispense gty: 30 t	ab, refill(Patient	Taking as	
	clonazePAM (clonaze	Document	1 tab. PO. BID. drug form: tab. refill(s): 0. start: 05-0	Dec-2017			
E De	tails for clonazeP	AM (clo	nazePAM 1 mg oral tablet)				



11 The updated list of current home medications for your patient is displayed. You will notice under **Status** column that the medications listed are now "Documented".

🗧 < 🔹 🕈 Medication List							[D] Full screen	Print	2 0 minutes ag
Add Pocument Medication by Hx Reco	enciliation	• 🚴 Chee	k Intera	ctions			Reconciliation S Meds History	Admissi	on 🟮 Discharge
View	M	Displayed	Al Active	Orders All Active Medica	tions			58	ion More Orders.
Orders for Signature	*	S	8	Order Name	Status	Dose	Details		
Admit/Transfer/Discharge		⊿ Medic	tions	acetaminophen (TYLENOL)	Ordered		975 mg, PO, QID, drug form: tab, start: 07-Dec-2017 12:00 PST Maximum acetaminophen 4 g/24 h from all sources		
Activity				clonazePAM lisinopril (lisinopril 5	Documen Documen		1 mq, PO, BID, drug form: tab, dispense qty: 30 tab, refill(s): 0, start: 07-Dec 1 tab, PO, gdaily, drug form: tab, dispense qty: 30 tab, refill(s): 0, start: 07-D	2017 10:14 PS	PST
Continuous Infusions		2	7000	HYDROmorphone (DL. atorvastatin (atorvast	Ordered Documen		dose range: 0.5 to 1 mg, IV, g2h, PRN pain, drug form: inj, start: 07-Dec-201 1 tab, PO, gdaily, drug form: tab, dispense gty: 30 tab, refill(s): 0, start: 07-D	7 10:10 PST ec-2017 09:31	PST
Medications Blood Products Laboratory				atenolol ranitidine	Documen Documen		50 mg, PO, gdaily, drug form: tab, dispense qty: 30 tab, refill(s): 0, start: 07- 150 mg, PO, gHS, drug form: tab, dispense qty: 30 tab, refill(s): 0, start: 07-D	Dec-2017 09:0 lec-2017 09:00	0 PST) PST
Diagnostic Tests		🛣 Details							
Related Results Formulary Details		Orders For	Cosigna	ture				Ord	ers For Signature

Note: Home medications can be updated at any time, even if the Meds History status states **complete**. In some cases, you may document that the patient has no home medications or you are unable to obtain information. Click the Home Medications heading and select **No Known Home Medications** or **Unable to Obtain Information** respectively.

LEAR	RNII gies:	NGDEMO, JOHN		DOB:01-Jan-1970 Age:47 years Gender:Male	MRN:700008684 Enc:700000016209 PHN:9876415442	Code Status: Dosing Wt:		Process: Disease: Isolation:			Location:LGH 4W; 405: 04 Enc Type:Inpatient Attending:Plisvcs, Jame, MD	
+ Ad	d	Medication History	edications	🗌 Unable To Obtain	Information 🛛 🖾 Use L	ast Compliance	1			16	Reconciliation Status Meds History Admission	Discharge
N Do	cun	and Medication by His										
	13	Order Name	Status	Details			Last Dose Date/Time	Information Source	Complian.	Compliance Comm	ents	
					✓ Last Docume	nted On 07-Dec	-2017 10:14 PST (Test	User, CriticalCare-Phy	sician, MD)			
4	Ho	me Medications										
	3	ranitidine	Documen	150 mg, PO, gHS, di	rug form: tab, dispense g	ty: 30 tab, refill((*)	Patient	Taking as .			
	3	atenolol	Documen	50 mg, PO, gdaily, d	drug form: tab, dispense o	gty: 30 tab, refill		Patient	Taking as .			
	4	atorvastatin (atorvast	Documen	1 tab, PO, qdaily, dr	ug form: tab, dispense gt	y: 30 tab, refill(
	3	lisinopril (lisinopril 5	Documen	1 tab, PO, gdaily, dr	ug form: tab, dispense gt	y: 30 tab, refill(Patient	Unable to			
1	3	clonazePAM	Documen	1 mg, PO, BID, drug	form: tab, dispense qty:	30 tab, refill(s):						

12 Use navigation buttons to return to the previous view :

- takes you back one screen
- **n**

takes you to your default view - the Provider View

displays a list of recently visited screens for an easy jump back



LEARNINGDEMO, JOH	N ×	CS	TDE	MC), ZEI	JS	×	
LEARNINGDEMO, JOH	IN		D	OB:0)1-Jai	n-1970	MR	N:7000
Allergies: morphine			G	ge:4 end	r yea er:Ma	irs ale	PHI	N:9876
Menu	ņ	<	>		A	Medi	cation	List
Provider View	*	+	Add	~	Me	dication	List	by H
Results Review			Auu		Pro	vider Vi	ew	<i>oy</i> .

13

Back in the **Admission** tab, check your new entries. Click the **Refresh** icon to display the most recent information for this component.

K 🔹 🔹 📅 Provider View							(D)	Full screen 👘 Print	2 11 minutes
A B B 8 4 100%	- 6								
Admission	23	Rounding	13	Transfer/Discharge	53	Quick Orders	12 +		•
Chief Complaint History of Present Illness	Ho	me Medications	5 (5)					All Ve	st ∂≡-
Advance Care Planning and		Medication		*		Responsible Provider	Compliance	Estimated Supply Remai	ning
Goals of Care	4	atenolol 50 mg, PG), qdaily, for 30 day, 3	0 tab, 0 Refill(s)		141). 141)	Taking as prescribed	30 days remaining	
Histories	4	atorvastatin (atorv	astatin 10 mg oral tabl	et) 1 tab, PO, qdaily, 30 tab, 0) Refill(s)	H (-	
Current Medications	4	clonazePAM 1 mg,	PO, BID, for 15 day, 3	0 tab, 0 Refili(s)			-	15 days remaining	
Home Medications (5) Documents (0)	4	lisinopril (lisinopril	5 mg oral tablet) 1 tab	, PO, qdaily, 30 tab, 0 Refill(s)		7.0	Unable to obtain information	-	
Allergies (1)	4	ranitidine 150 mg,	PO, qHS, for 30 day, 3	0 tab, 0 Refill(s)		-	Taking as prescribed	30 days remaining	
Links Review of Systems				Do	cument History	Completed by TestUs	er, CriticalCare-Physiciar	n, MD on 07/12/2017	At 10:14

14 With the BPMH completed, move to the next component – **Current Medications** – indicating the status of medication management in patient's chart.

Current Me	edications 🕂		 			Selec	ted visit 🔁
				Status: ✔ Med	s History 🖌 🖌 Adn	nission Transfer	() Discharge
Order				Order Start		Status	
⊿ Scheduled	d (1) Next 12 hours						
acetaminop	ohen (TYLENOL) 975	mg, PO, QID		Today 12:00		Ordered	
⊿ Continuo	us (0)						
⊿ PRN/Unse	cheduled Available ((0) Last 48 hours					
 Administer 	red (0) Last 24 hours						
Discontinu	ued (4) Last 24 hours						



Note: Hover over the Meds History Status line to display who and when has reconciled this record. Hover to discover is a standard technique used across the CIS displaying additional details.

Status: 🛩	Meds History
Status: Complete	itus
Last Documented: 29/12/2017 08:08	
Last Documented By: TestUser, ICU-Nurse	
	1

15 To complete transfer medication reconciliation, click the **Transfer** button under the **Current Medications** component.

Current Medications +				Select	ted visit [🎗]
	9	itus: 🖌 Meds History	Admission	Transfer	Oischarge
Order	Order Start	Status			
4 Scheduled (0) Next 12 hours					

16 Transfer reconciliation screen displays documented home medications and medications ordered for your patient.

P Order Recon	ciliation: Transfer - LEARNING	DEMO, JOHN							
LEARNINGE Allergies: mor	DEMO, JOHN	DOB:01-Jan-1970 Age:47 years Gender:Male	MRN:700008684 Enc:7000000016209 PHN:9876415442	Code Status: Dosing Wt:			Process: Disease: Isolation:	Location:LGH 4W: 405; 04 Enc Typednpatient Attending:Plisvcs, Jame, ME	5
🕂 Add 🎆 Ma	anage Plans Transfer To: (N	one) -						Reconciliation Status Meds History Admissio	n 🚯 Discharge
1		Orders Prior to Recor	ciliation	~			Orders /	After Reconciliation	
37	Order Name/Details			Status			□ 🖓 Ϋ Order Name/Details		Status
⊿ Medicat	ons								
9 O	cetaminophen (TYLENOL) 175 mg, PO, QID			Ordered	0	0			
	<mark>tenolol</mark> 10 mg, PO, qdaily, for 30 day, 3	0 tab, 0 Refill(s)		Documented	0	0			
	torvastatin (atorvastatin 10 tab, PO, qdaily, 30 tab, 0 Refi	mg oral tablet) ill(s)		Documented	0	0			
a 0	IonazePAM mg, PO, BID, for 15 day, 30 to	b, 0 Refill(s)		Documented	0	0			
e 😒	YDROmorphone (DILAUDIE mg, IV, g2h, PRN: pain	PRN range dose)		Ordered	0	0			
a 😋	sinopril (lisinopril 5 mg oral t tab, PO, gdaily, 30 tab, 0 Refi	ablet) ill(s)		Documented	0	0			
a 😋	anitidine 50 mg, PO, gHS, for 30 day, 30) tab, 0 Refill(s)		Documented	0	0			
⊿ Patient	are				ALL	ALL			
90	Braden Assessment 17-Dec-2017 08:44 PST, Stop: 0.	7-Dec-2017 08:44 PST		Ordered	0	0			
G 📀	Norse Fall Risk Assessment 7-Dec-2017 08:44 PST, Stop: 0	7-Dec-2017 08:44 PST		Ordered	0	0			
T Details									
Dotails	equied Details 3 Required Unit	econciled Order(s)					Reconci	ile and Plan Sign	



17 In the Transfer Reconciliation, continue the following medications:

• lisinopril 5 mg PO daily

Note: You will be notified that lisinopril will be substituted with trandolapril. Accept the suggested replacement or choose a reason to decline it and this will be communicated to the pharmacy.

- atenolol 50 mg PO daily
- ranitidine 150mg PO qHS
- atorvastatin 10mg daily
- hydromorphone 0.5-1 mg IV Q2H PRN
- acetaminophen 975mg PO q6h

	Orders Prior to Reconciliation					Meds History Ad Orders After Reconciliation	Imission 😲 Discharg
97	Order Name/Details	Status			57	Order Name/Details	Status
⊿ Medical	tions						
9	acetaminophen (TYLENOL) 975 mg, PO, QID	Ordered	۲	0	ø	acetaminophen (TYLENOL) 975 mg, PO, QID	Ordered
3	atenoiol 50 mg, PO, qdaily, for 30 day, 30 tab, 0 Refill(s)	Documented	۲	0	e !	atenoiol 50 mg, PO, qdaily	Order
2	atorvastatin (atorvastatin 10 mg oral tablet) 1 tob, PO, qdoily, 30 tob, 0 Refill(s)	Documented	۲	0	e !	atorvastatin 10 mg, PO, qdaily	Order
2	clonazePAM 1 mg, PO, BiD, for 15 day, 30 tab, 0 Refill(s)	Documented	0	۲			
0	heparin 5.000 unit, subcutaneous, a12h	Discontinue	0	۲			
0	HYDROmorphone (DILAUDID PRN range dose) 1 mg. IV. g2h. PRN: pgin	Ordered	۲	0	ø	HYDROmorphone (DILAUDID PRN range dose) 1 mg. N. a.Zh. PRNk pain	Ordered
3	lisinopril (lisinopril 5 mg oral tablet) 1 tab. PO. adaily, 30 tab. 0 Refill(s)	Documented	۲	0	Ø !	trandolapril 0.5 mg. PO. adaily	Order
3	ranitidine 150 mg, PO, aHS, for 30 day, 30 tab, 0 Refill(s)	Documented	۲	0	0	ranitidine 150 mg, PO, gHS	Order
⊿ Patient	Care		ALL .	ALL			
0	Braden Assessment 07-Dec-2017 08:44 PST, Stop: 07-Dec-2017 08:44 PST	Ordered	۲	0	Ø	Braden Assessment 07-Dec-2017 08:44 PST, Stop: 07-Dec-2017 08:44 PST	Ordered
•	Morse Fall Risk Assessment 07-Dec-2017 08:44 PST, Stop: 07-Dec-2017 08:44 PST	Ordered	۲	0	•	Morse Fall Risk Assessment 07-Dec-2017 08:44 PST, Stop: 07-Dec-2017 08:44 PST	Ordered
🛣 Details							

18 If a home medication is not available, a therapeutic substitution dialog box will appear. Select the therapeutic substitution and click **OK**.



Therapeutic	Substitution - L	EARNTEST, PHYS		
LEARNTES	DOB:12- Aqe:76 . Gender:	MRN:70Code Status Enc:700 PHN:00Dosing Wt:8	Atte Process: Disease: O kg Isolation:Conta	Location:LGH E Enc Type:Inpatient ct Attending:TestCST.
Selec	ted Ord	der:		
lisin	opril: 10 mg	g, PO, qdaily, drug f	orm: tab	
Choo	se Ther	apeutic Sub	stitution:	
trandi Equival Comm EXCEPT	olapril: 1 m ent to: lisinop ents: ON: Pediatric	ig, cap, PO, qdaily nil 10 mg, tab, PO, qda c Patients	łγ	
-01	t-			
Choo	se Decl	ine Reason:	•	
				OK Cascal



19 Discontinue the following medications:

- Clonazepam 1mg PO
- Heparin 5000 units Subcutaneous BID

Review the list of Orders After Reconciliation on the right side of this window.

Note: Some medications might be marked by **?**. Click the line to display the **Details** window, and then click **Review Schedule** to check if details are correct for drug administration. You will be able to adjust the first dose time if appropriate.

m3 4	Order Name/De	etails			Status			13	R.	Order Name/Details	Status
Medicati	ons										
8	acetaminopher 975 mg, PO, Qill	n (TYLENOL) D			Ordered	۲	0	0		acetaminophen (TYLENOL) 975 mg, PO, QID	Ordered
4	atenolol 50 mg, PO, qda	ily, for 30 day, 30 tab, 0	Refill(s)		Documented	۲	0	ð		atenolol 50 mg, PO, gdaily	Order
<i>6</i> °	atorvastatin (a 1 tob, PO, gdail	torvastatin 10 mg ora	I tablet)		Documented	۲	0	•	1	atorvastatin 10 mg, PO, gdaily	Order
3	clonazePAM	, for 15 day, 30 tab, 0 Re	fill(s)		Documented	0	0				
0	heparin 5,000 unit, subc	utaneous, q12h			Discontinue	0	۲				
8	HYDROmorphe 1 mg, IV, q2h, P	one (DILAUDID PRN r RN: pain	ange dose)		Ordered	۲	0	8		HYDROmorphone (DILAUDID PRN range dose) 1 mg, IV, q2h, PRN: pain	Ordered
									A 10-0		
r Details fo	atenolol	Start Date/Time (First	Administration):							î.
C Details fo	r atenolol	Start Date/Time (First	Administration): PST							
Details fo Details	r atenolol Order Comme	Start Date/Time (First	Administration): v PST							5
Details fo Details	r atenolol	Start Date/Time (First	Administration 1033 CORR 0800): PST PST	Skip administration					Review Schedule Remaining Administrations: (Un	known) Stop: (Unknow
Details fo Details	atenolol Order Comme L Duration:	Start Date/Time (First 07-Dec-2017) Next administration: 08-Dec-2017 Following administrat	Administration 1033 0800 ion:): PST PST	Skip administration			unation Un	nit:	Review Schedule Remaining Administrations: (Unl	known) Stop: (Unknow
Details fo Details	r atenolol Order Comme L Duration: Drug Form:	Start Date/Time (First 272052017) Nest administration: 08-Dec-2017 Following administrat 09-Dec-2017	Administration 1033 1030 0800 ion: 1 0000): • PST • PST	Skip administration			ose Priorit	it:	Review Schedule Remaining Administrations: (Uni	known) Stop: (Unknow

20

Click **Sign** to complete the process. You cannot sign off until you address all medications listed. The unreconciled orders button in the bottom left corner provides a count of any medications that still require reconciliation.

🕱 Details		
(D Missing Required Date] [5Ureconciled Oxfor(a)]	Reconcile and Plan	Sign

Note: It is recommended to complete admission medication reconciliation before placing any new orders. This way you are only reconciling the patient's documented home meds and recently ordered meds.



Key Learning Points

- When searching for any order, type the first few characters of the term to bring up list of possible entries
- BPMH must be completed before admission medication reconciliation can occur
- Home medications once documented can be updated at any time
- The Admission Medication Reconciliation screen displays both home and hospital medications. You can choose to continue or discontinue any listed medications
- It is recommended to complete admission medication reconciliation prior to entering additional admission orders



ACTIVITY 1.4 b- Medication Reconciliation for Direct ICU admission

The BPMH must be completed before proceeding with the admission medication reconciliation. The best possible medication history is generally documented by a pharmacy technician. When a pharmacy technician is not available, it can be completed by a nurse, medical student, resident, or by you as the patient's most responsible physician.

In this activity, you will need to search and open a new patient chart. You can leave the newly transferred patient's chart open so you can resume once this activity is completed.





2 Type in the name of your new patient in the **Encounter Search** name field.

BC PUN	VIP	Deceased	Alerta	BC PHN	MEN	Name		-	DOB
DC FRN.		Deceased	Process Alert	9976497657	700007920	LEAD		CARE	01.00
MRN:	2		Process Merc	9876415442	700008684	LEAR	NINGDEMO, JO	OHN	01 Jan
Last Name:									
Learning									
First Name:									
DOB:									
ки, ини, ини									
Gender:									
Postal/Zip Code:	-		m						,
Any Phone Number:	Facil	ity	Encounter #	Visit #	En	с Туре	Med Service	Unit/Cli	nic Ro
	SIL	GH Lions Ga	te 700000001	5209 700000	0016209 Inp	atient	Critical Care	LGH 4V	√ 40
Encounter #:									
Visit #:									
Historical MRN:									
Search Reset	-								
	in the second								- 11-

Note: The above screenshot may not be the same as your current screen.



- 3 Locate the appropriate patient and the encounter number
- 4 Select OK
- 5 From the **Admission** tab, navigate to the **Home Medications** component to view the patient's home medications.

Medication	Responsible Provider	Compliance	Estimated Supply Remaining
* atenolol 50 mg, PO, qdaily, for 30 day, 30 tab, 0 Refill(s)		Taking as prescribed	30 days remaining
* ranitidine 150 mg, PO, qHS, for 30 day, 30 tab, 0 Refili(s)		Taking as prescribed	30 days remaining
* simvastatin 10 mg, PO, qdaily, for 30 day, 30 tab, 0 Refill(s)	-	Taking as prescribed	30 days remaining
warfarin (Coumadin 5 mg oral tablet) 1 tab, PO, gdaily, 30 tab, 0 Refill(s)			

6 Navigate to the **Current Medications** component. Note that the **Meds History** status is complete.

	Selected visit									
Status: ✔ Meds History	Admission	Transfer 🕒 Discharge								

7 Select the **Admission** link. Notice that there are 4 unreconciled orders



8 Discontinue the medication: *Coumadin* and continue the following medications: *Atenolol, atorvastatin and ranitidine.*

	fanage Plans							Reconciliation St Meds History	tatus Admission	Discharg
	Orders Prior to Reconciliation		-	-			Orders After Reco	onciliation		
103 6	Order Name/Details	Status			E3 6	Order Name/Details				Status
Media	itions		-							
a'	atenolol 50 ma PO adaily for 30 day 30 tab 0 Refill(s)	Documented	۲	0	6	tenolol 0 ma PO adaily				Order
4	atorvastatin (atorvastatin 10 mg oral tablet) 1 tab, PO, gdaily, 30 tab, 0 Refill(s)	Documented	۲	0	0	atorvastatin 10 mg, PO, gdaily				Order
3	ranitidine 150 mg, PO, qHS, for 30 day, 30 tab, 0 Refill(s)	Documented	۲	0	0	ranitidine 150 mg, PO, qHS				Order
3	warfarin (Coumadin 5 mg oral tablet) 1 tab. PO, adaily, 30 tab. 0 Refill(s)	Documented	0	•						
Detail										

- The review message icon I may appear under Orders After Reconciliation. If it's present, expand the order details. You will select the Review Schedule.
- The review schedule details will allow you to modify start date/time and administration schedule.
- The therapeutic substitution dialog box may appear select the therapeutic substitution if applicable.
- Complete this for any orders with the icon.
- Click Sign
- Click Refresh icon
- Now, the Status shows Admission is complete.
- 9 Now you can close this patient's chart by clicking the close Karling is a second

LEARNINGDEMO, JOHN	×	CS	TDE	M	D, Z	EUS	×	
CSTDEMO, ZEUS			D	DB:0	1-Fe	b-19	79	MRN:70
			Ag	je:3	8 yea	rs		Enc:7000
Allergies: Egg, cloNIDine, Adhes	ive	Ba.	Ge	ende	er:Ma	ale		PHN:987
Menu P				•	A	Pro	ovide	r View

Note: The current patient chart that is open has the yellow banner.



ACTIVITY 1.5- Review Allergies

Now you review your first patient's allergies and add an allergy to morphine. This information was provided by the patient's daughter after admission.

In the CIS, patient allergies can be added and updated by the providers and clinicians. In the inpatient setting, a patient's allergies are to be reviewed by a provider on admission, at every transition of care, or annually. Allergy information is carried forward from one patient visit to the next.

The CIS keeps track of the allergy status and will automatically prompt you when the information is not up-todate. It will also track allergy-to-drug interactions. When placing an order with allergy contradictions, an alert will display:

Decision S	Support: LEARNTEST, PHYS - 700006586	
The new ord	der has created the following alerts:	
amoxicil	llin 🛛	
DI		
Allerg	plete the (1) required override reasons to continue placing t iv (1)	s order.
Severity	Substance	Reaction Type
۲	penicillin	
•		
Size Colum	ins to Window	Apply to all interactions Override Reason:
		Apply only to required interactions
		LEARNTEST, PHYS - 700006586 Continue Remove New Order

1



You can either remove the order and select another medication, or continue with the order by overriding the alert and documenting the reason:

 Apply to all interactions Apply only to required interactions 	Override Reason:
LEARNTEST, PHYS - 700006586	Provider/Clinician aware and monitor Patient already tolerating Prescriber Clinical Judgment
	Administration altered to minimize h Non-immunologic reaction or toxicit Pharmacokinetic monitoring in place Therapeutically indicated <type here="" other="" reason=""></type>

The CIS allows you to check drug-to-drug interactions when ordering medications by clicking the **Check Interactions** button.

Add Check Intelaction by Fix Reconciliation • @• Check Intelactions

Click the **Allergy** link to open the window where you will enter or update allergy information.

< 🔹 🖌 👬 Provider View							
🗚 🗋 🖶 📄 🔍 🥄 100%	- • • 🗳						
Admission	8 Rounding	X Transfer/Discharge	23 Quick Orders	🛛 Out	patient Chart	× +	
Advance Care Planning and Goals of Care Chief Complaint	Allergies (3)						
Histories	Substance	Reactions	Category	Status	Severity	Reaction Type	Source
Allergies (3)	Peanuts		Food	Active	Severe	Allergy	Patient
Visits (4)	penicillin		Drug	Active	Moderate	Allergy	Family

2 To add the morphine allergy to your first patient's record, click the + Add icon on the toolbar.

Task Allergy										
Mark All as Reviewed Add Modify No Known Allergies No Known Medication Allergies Reverse Allergy Check Display All										
Ac	dd 🗹 Modify 💭 No Known Aller	gies 🛛 🖓 No	o Known Medicatio	n Allergies	💦 Reverse A	Allergy Check	Display	All 👻		
P Ac	dd Modify 🔅 No Known Allers	category	o Known Medicatio	n Allergies Severity	Reverse A	Allergy Check Comments	Display Est. Onset	All Reaction Status	Update	
P Ac	dd Modify No Known Allerg Substance Peanuts	Category Food	o Known Medicatio	n Allergies Severity Severe	Reverse A	Allergy Check Comments	Display Est. Onset	All Reaction Status Active	Update 2017-S	



3 Search for morphine in the **Substance** box. Remember to use **M** to execute the search, and then select one of the options from the list. Click **OK** to return to the Add Allergy/Adverse Effect window.

ype Allergy - Substance	An adverse reaction to a drug or sul	bstance which is due t	Substance Search				
morph 🧖 Fr	ee text		*Search: morph		Starts with	▼ Within: T	erminology
eaction(s):	*Severity	Info source	Search by Na	ime		Search by Code	
Add Fre	ee Text <not entered=""></not>	(not entered) Onset: < not e	Terminology: Allergy, M	ultum Allı 🛄	. Terminology /	Axis: <a>All termin	nology ax
	Years -	· *****_***	Categories				
	Descendent auf behalf of		T			Terminology	
	hecorded on behair or	*Category	lem ≜			reminology	
	necorded on benair or	*Category	Iem * <no categories="" foun<="" matching="" p=""></no>	d>		renimilology	
🛚 Up 🗂 Home 🚖 Favori	ites • Glders Folder:	*Category Drug Favorites	Tem ▲	d> Code	Terminology	Terminology Axis	
🛚 Up 🖾 Home 🙀 Favori 🛾 System Tracked	ites • Golders Folder:	*Category Drug Favorites	Term A	d> Code d00308	Terminology Multum Drug	Terminology Axis Generic Name	
집 Up 🖾 Home 🚖 Favori g System Tracked	ites • Glders Folder:	*Category	Term A	d> Code d00308 d00308 d00308	Teminology Multum Drug Multum Drug	Terminology Avis Generic Name Generic Name	
🛾 Up 🕼 Home 🙀 Favori System Tracked	ites - Folders Folder:	Category Drug Favorites	Tem A	d> Code d00308 d00308 d00308 d00308	Terminology Multum Drug Multum Drug Multum Drug Multum Drug	Terminology Axis Generic Name Generic Name Generic Name	
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🛯 Up 🖆 Home 🙀 Favori 🛯 System Tracked	ites - Folders Folder: 1	Category Category Drug	Term ▲ Image: Term ▲ morphine morphine morphine extended release Morphine Extra Forte Morphine IR Morphine IR Morphine IR Morphine IR Morphine IS Morphine State Morphine State Morphine State Morphine Sulfate Morphine Sulfate Morphine Sulfate Morphine Sulfate Morphine Sulfate Morphine Sulfate SR	d> Code d00308 d00308 d00308 d00308 d00308 d00308 d00308 d00308 d00308 d00308 d00308 d00308 d00308	Terminology Multum Drug Multum Drug	Terminology Axis Generic Name Generic Name	

- 4 Add appropriate options in the other two mandatory fields:
 - Select *Severe* for the **Severity**
 - Select Drug for the Category
 - Search for *Rash* in the **Reaction**(s) box (recommended)

5 Click **OK** to save the information.

LEARNTEST, PHYS (MRN: 700006586) - A	dd Allergy/Adverse Effect					×
Type Allergy → An ad	verse reaction to a drug or substa	nce which is due to an immu	nological response.			
morphine 🙀 🗌 Free text					[Add Comment
Reaction(s): Add Free Text	*Severity Severe -	<pre>chie source </pre>	Comments			*
₽ ~~ Rash	At: <not entered=""></not>					~
	Recorded on behalf of	*Category	Otatus Active 🗸	Reason:		
					OK OK & Add Ne	ew Cancel



6 Patient's allergy record is updated. The green checkmark next to morphine indicates drug allergies. Click **Mark All as Reviewed** to complete the review.

Ma 🕂 Ad	ark All as Reviewed	ies 🛛 📿 No	Known Medicatio	n Allergies	💦 Reverse Al	llergy Check	Display	All 🗸	
D/A	Substance	Category	Reactions	Severity	Туре	Comments	Est. Onset	Reaction Status	Updated By
\checkmark	morphine	Drug			Allergy			Active	30-Sep-2017 TestPET, Gene
	Peanuts	Food		Severe	Allergy			Active	30-Sep-2017 TestPET, Gene
~	penicillin	Drug		Moderate	Allergy			Active	30-Sep-2017 TestPET, Gene

Note: In order for the pharmacy to dispense, they must see that the allergy record has been reviewed by a provider. When there is no information available, you can use other the toolbar options:

- No Known Allergies
- No Known Medication Allergies

Mark	All as Reviewed			
🕂 Add	🛒 Modify	💭 No Known Allergies	🖓 No Known Medication Allergies	

7 To modify the existing allergy, select the appropriate line and click **Modify**. For our example, change the severity level for penicillin from moderate to mild.

											[0] Full screen	@Point-	217 minute
D/A Substance	Category Read	tons Severity	Type	Conments	Est. Orset Reactor	Status Updated By	Source	Reviewed	Reviewed By	Interaction			
✓ morphine	Drug		Allergy		Active	30-Sep-2017 TestPET, General/Medicine-Physician,	Patient	30-Sep-2017 09:39 PDT	TestPET, GeneralMe				
Peanuts	Feed	Severe	Allergy		Active	30-Sep-2017 TestPET, GeneralMedicine-Physician,	Patient	30-Sep-2017 09:40 PDT	TestPET, GeneralMe				
🗸 penialin	Drug.	Moderate	Allergy		Antive	30-Sep 2017 TextPET, GeneralMedicine Physician,	Tamily	30-Sep-2007-09:40 PDT	TestPET, GeneralMe	•			
Type Allengy • An ad	verse reaction to a drug or	substance which is due to a	n munological	(response.									
Type Allergy • An ad "Substance periodin 🙀 🗋 Free Inst	ense reaction to a drug or	substance which is due to a cation is currently prescribed	an inmunological Horthis allergy	l response. Please review the	e patient's medications							[^	Add Comment
Type Allergy - An ad "Substance periodin - Reactor(d)	 Interaction to a drug or Interaction - A media "Severity 	substance which is due to a cation is currently prescribed Info source	an instructiogical Lice this allergy	l response. Please review the	e patient's medications								Add Comment
Type Allergy - An ad "Substance periodin - Free text Reactor(c) Add Free Text	 Interaction to a drug or Interaction - A media "Severity 	substance which is due to a cation is currently prescribed Info source Family	on immunological Hor this allergy 1 Com	l response. Please review the nerks	e palieri's medications,								Add Comment
Type Allergy An ad Substance periodin Reactor(c) Reactor(c) Reactor(c)	 Interaction to a drug or Interaction - A media Severity 100 	substance which is due to o cation is currently prescribed Info source Family Decet	an immunological Live this allergy 1	l response. Please review the nerks	e patient's medications.								Add Comment
Type Allergy - An ed "Substance provide Allergy - Free text Reactor(c) All Add Free Text	Interaction to a drug or Interaction - A media Sevenity At and entered:	Indestance which is due to a cation is currently prescribed Info source Family Drote (not end	an mmunological l for this allergy Comm	(response, Please review the ner/s	e palient'i medications.								Add Comment
Tipo Allerge • An ad Substance periodin • • • • • An ad Reactor(d) • • • • • • • • • • • • • • • • • • •	Interaction to a drug or Interaction - A medi "Severity At root entered: Years	Industance which is due to o calion is currently prescribed in Family Oncet incident in manual prescribed	n intersectory of the this allergy (Come and Dig (l response. Please review the ner/s	e palient's medications								Add Comment
Type Allergy - An ad "Substance periodin All resolution Reactor(c) Add Free Tear	Interaction to a drug or Interaction - A medi 'Sevenity At cost entered Yeas Recorded on behall or	Industance which is due to o calion is currently prescribed info source Family Oncet inclined m.m.m.m of *Category	an innurokogical Morithis allergy (Comm anod) El Col Statu	l response. Please review the ner/s	e patent's medications Reason:								Add Comment
Type Allway - An us Substance periodin All resolution Reactor(d) Add Free Tear	Interaction to a drug or Interaction - A media "Severity Az onci entered Years Recorded on behalf of	Industance which is due to o cation is currently prescribed info source Panity Onact inclined an <u>ument</u> Category Dhug Dhug	n mmunological Hor this allenge 1 Come Statu Statu	l vesponse. Please review liv nerds e	e paleeri's medications Reason:								Add Comment






ACTIVITY 1.6- Place a PowerPlan (Order Set) for Patient Admission

Now you are ready to place orders for your patient. You will use a PowerPlan that is specifically designed for admitting patients to the Intensive Care Unit.

PowerPlans are similar to pre-printed orders (PPOs), allowing you to plan and coordinate care in the acute care environment by defining sets of orders that are often used together. You can adapt PowerPlans to fit your needs:

- You can select and deselect individual orders from the PowerPlan list
- You can add orders that are not listed in the PowerPlan
- You can add other modules (orders sets) that are a listed in a PowerPlan

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.

The best option for placing PowerPlans and orders is via the Quick Orders tab. This view is a one-stop shop for common orders and PowerPlans organized in separate categories.

ARNINGDEMO, JOHN							List	Recent - Milme
ARNINGDEMO, JOHN	DO601-Jan-1970	MRN:700006684	Code Status:	1	Process:		Location:LGH 4W: 405: 04	
rigies: Allergies Not Recorded	Gender Male	PHN/9876415442	Dosing Wt:	1	briease: isolation:		AttendingPlistes, Jame, MD	
🔿 🔹 👘 Provider View							D Full screen	Print 2 hours 35 million
A B B B 100%	P							
Admission SI Round	ing 11	Transfer/Discharge	12 Quick Orders 12	+				
V								Concernant of the second se
Venue: Ingutient *								
PowerPlans	Medications		Et a Lubs	0	Imaging and Diagnostics	8 · 0	New Order Entry	10
Admission	 Analgesics 		Eleod Products / Transfusion		► XR		Consults	E.
 Neurology 	 Anturrythmics 		 Bloodwork Routine 		• ECG			
 Respiratory 	 Anticoogulants 		Sloodwork STAT		► CT		Patient Care	H.
▶ Trauma	 Antiepleptics 		Microbiology		Echozandiogram		and the second se	
Management	 Antihypertensives/Be 	eta Blockers	Unine Studies		▶ US		 Patient Disposition 	
Consfort Care / Death	a defendencia						Code Status	
	 Application opeans 		 SCOOL 2017048 	11	►R.		Contraction of the second second	
	Boonchodialators		Stool Studies Huid Anatom		► DR. ► MAR		Critical Care Goals	
Frequent Conditions	Bronchodialistors Corticesteroids/Mine	ralocorticoids	stool Studies Fluid Analyze		► IR > MR > FEG		Critical Care Goals Influbation	

Under each category, there are folders. For example, under the medication category is the analgesics folder which contains individual orders for analgesic medications such as acetaminophen. Orders may allow you to add additional details regarding dose, frequency, route, etc., or may have these details pre-determined for ease of



ordering as an order sentence. Categories and folders can be collapsed or expanded by clicking the expansion arrows and **N**

Admission	23	Rounding	X	Transfer/Discharge	X	Quick Orders	23	
Venue: Inpatient 🔻					1			
PowerPlans		≡• ⊗	Medications		≣∙⊗	Labs		
► Admission			⊿ Analgesics			Blood Products / Transfusion		
▶ Neurology			acetaminophen 650 m	ng, NG-tube, q4h, drug form: tab		Bloodwork Routine		
Respiratory			acetaminophen 650 m	ng, NG-tube, q4h, PRN pain, drug fo	orm: tab	Bloodwork STAT		
▶ Trauma			rais days formulat	1969 daar oo gaa 26 ta 60 mag Ni		Microbiology		
Management			abbanentin No ho			Urine Studies		
Comfort Care / Death			HVDROmorphone are NG-tube, ath days forms tab			► Stool Studies		
			HYDROmorphone mg	, NG-tube, q4h, PRN pain, drug forr	n: tab	► Fluid Analysis		
Frequent Conditions		≡• 🙆	HYDROmorphone ma	, subcutaneous, o4h, PRN pain-brea	akthrough, drug			

Order availability and organization may differ depending on your specialty.

Placing the PowerPlan:

- 1 In the **Quick Orders** tab, expand the **Admission** folder
- 2 Select ICU Admission Neurology. PowerPlans are marked by the 🛃 icon.

🗚 🗎 📥 🖿 🔍 🔍 100'	% • (
Admission	23	Rounding	23	Transfer/Discharge	23	Quick Orders	
Venue: Inpatient *							
PowerPlans	=- 🔊	Medications	≣∙⊘	Labs	≣•⊗	Imaging and Diagnostics	=-
⊿ Admission		Analgesics		Blood Products / Transfusi	on		_
Admit to Inpatient Admit to Critic	al Care	Antiarrythmics		Bloodwork Routine		▶ XR	
ICU General Admission Me	dical /	Anticoagulants		Bloodwork STAT		▶ ECG	
Surgical (Validated) ICU Ge	neral	Antiepileptics		Microbiology		• CT	
Admission Medical / Surgical (Validat	(bed	Antihypertensives/Beta	Blockers	Urine Studies		Echocardiogram	
ICU Admission Trauma (Valida	ted)	Antimicrobials		Stool Studies		▶ US	
ICU Admission Neurolo	gy	Bronchodialators		Fluid Analysis		▶ IR	
(excluding Traumatic B	rain	Corticosteroids/Mineral	ocorticoids	Based of the Second Second		▶ MR	
Injury) (Validated) ICU Admission	ission	Delirium Agents/HS Sedation				▶ EEG	
Neurology (excluding Traumatic	Brain	Diuretics				▶ NM	
Injury) (Validated)						L	

3 Click the Orders for Signature icon.



4 Click Modify.

Orders for Signature (1)			×
DeueoDane			
runeiriais			
🔀 ICU Admission Neurology (excluding Traumatic Brain Injury) (Validated) (ICU Admission Neurology (excluding Traumatic Brain Injury) (Validated))			
	Sign Save	Modify	Cancel

5 The PowerPlan window displays. Hover over the icons along the top toolbar:

∢	Merge View – Displays the plan components with those already ordered for the patient and active on the patient profile.
:@ :	Initiate Plan or Phase – Initiates the selected plan or phase. Orders do not become active or route to ancillary departments until you initiate.
Ø	View Excluded – Displays components of the predefined plan that were not included in the initiated plan.
0	Discontinue – Opens the Discontinue dialog box so that you can discontinue the plan or phase (individual components can be kept).
0]	Plan Comment – Adds a note to a PowerPlan phase. Plan comments allow you to communicate decisions made regarding the phase to other clinicians who can view or take action on the phase. You can add a comment to a phase in any status.
A Check Alerts	Check Alerts – Allows you to check for Quality Measure Alerts.

6 PowerPlans open in the Plan Navigator. Scroll through to locate visual cues organizing orders:

- Bright blue highlighted text for critical reminders
- Bright yellow highlights for clinical decision support information
- Light blue highlights that separate categories of orders

4	8	01	Add to	Phase 🗸 🛕 Check Alerts 🛄 Comments	Start:	Now		Duration:	None		
	S	Offset	8	Component			State	JS	Dose		Details
ICU	Adı	nission	Neurolo	gy (excluding Traumatic Brain Injury) (Va	lidated) (Plann	ed Per	nding)			
⊿	Adr	nit/Trai	nsfer/Disc	harge							
			<	Verify that an 'Admit to' Order has been	entered	d prior to	com	pleting the	powerplar	1	
			~ ~	Complete Admission or Transfer Medic	ation Re	concilia	tion				
2			0 🕻	Communication Order							Research
⊿	Stat	us									



Modifying the PowerPlan:

1

Click the corresponding box to select or deselect individual orders from the PowerPlan. Some orders are already pre-selected for efficiency but you can click the box to deselect, if necessary.

Offset 🖓	Component	Status Dose Details
CU Admission Neur	rology (excluding Traumatic Brain Injury) (Validated) (Plann	d Pending)
⊿ Admit/Transfer/	Discharge	
	Verify that an 'Admit to' Order has been entered prior to	completing the powerplan
	Complete Admission or Transfer Medication Reconcilia	tion
v 🕐	🖄 Communication Order	Research coordinator is able to screen patient for study eligibility
⊿ Status		
▼ 26	Code Status	Select an order sentence
⊿ Patient Care		
	Critical Care Goals	MAP goal: 65 mmHg or greater, Sodium goal: 140 to 150 mmol/L, pH goal: 7.3 to 7.45, SpO2 goal: 92% or greater, Temperature target 36 to 38 deg
<u> </u>	Cardiorespiratory Monitoring	Remains on at all times
	Intracranial Pressure Monitoring (ICP Monitoring)	
	Vital Signs	
	Oximetry - Continuous (Pulse Oximetry Continuous)	
	Weight	■ Un admission
	Maritas Intela and Output	
	Notify Treating Provider	▼ qui If using autout greater than 250 ml /b for 2 consecutive hours
- 0	Nourovital Signs	
	Pain Accessment	• 441 adh if national expression and use Numeric Ration Scale (goal less than //) If national exhibits signs of nation use Rehavioural Dain Scale (goal less tha
	Sedation Hold for Accessment	editiv
-	Patient Isolation	▼ Select an order sentence
	Seizure Precautions	
Line /Tubes/Dra	ains	
1	Insert Peripheral IV Catheter	Insert 2 large bore IV's unless already in place
	Insert Arterial Catheter	T:N
	Contraindications to nasal insertion include facial or he	ad trauma. Order X-ray post tube placement to confirm position, if required
- O	Insert Orogastric (OG) Tube	Tube to Low Intermittent Suction, insert large bore
	🖄 Insert Nasogastric Tube	 Tube to Low Intermittent Suction, insert large bore
1	📝 Insert Urinary Catheter	Indwelling
⊿ Activity		
	E ICU Cervical Spine Precautions (Module) (Validated)	
	ICU Cervical Thoracic Lumbar Precautions (Module) (
	Communication Order	No spinal precautions
2 0	Maintain Head of Bed	30 degrees or greater, if no thoracic / lumbar spine precautions
	ICU Early Mobilization Goal	▼ Stages 1 to 2
	Communication Order	Discontinue cervical, thoracic and lumbar precautions
⊿ Diet, Nutrition	/8	
_	Refer to your organization's enteral nutritional guideline	s and policies
	Enteral Feeding Continuous	▼ Isosource1.2, Start Rate (mL/h): 25, advance to goal as per guidelines
	M NPO	No Exceptions
Details		
	Course Har Francis	
	TO DO DO DO DO DOU N DO CONTROL I	37 Initiate Sign Lancel

2 Click toolbar icons to flex the display of the PowerPlan to facilitate easier review. For example:

- Collapses or expands the list of order categories on the left side of the screen. Collapsing the list creates more room for the PowerPlan Navigator
- 🐱 Displays pre-selected defaulted orders only
- Merges your planned orders with existing orders to avoid duplicating an order. However, the CIS will warn about an attempted duplicate.





3 Code Status order is pre-selected but the order sentence for the appropriate option needs to be chosen. Click T to select one of the options.

Note: The 😢 icon next to the order indicates missing details. This is a standard icon across the entire CIS.

🔹 😪 🛇 🕂 Add to Phase 🗸 🛆 Check Alerts 🚇 Comments	Start:	Now	Durat	tion:	None	
Source of the Component Co			Status	D	ose	Details
ICU Admission Neurology (excluding Traumatic Brain Injury) (Va	lidated)	(Planne	d Pending)			
⊿ Admit/Transfer/Discharge						
🏈 Verify that an 'Admit to' Order has been	entered	prior to	completing	the po	werplar	1
💮 Complete Admission or Transfer Medic	ation Rec	conciliat	tion			
Communication Order						Research coordinator is able to screen patient for study eligibility
⊿ Status						
🗹 📴 🐼 🗭 Code Status						Select an order sentence
⊿ Patient Care						Attempt CPR, Full Code
Critical Care Goals						1-No CPR, Supportive Care, No Intubation
Cardiorespiratory Monitoring						2-No CPR. Therapeutic Care.No Intubation
Intracranial Pressure Monitoring (ICP M	Ionitoring	g)				3-No CPR Acute Transfer No Intubation
Vital Signs						A-No CDR Critical Care No Intubation
🗹 🛛 🖉 Oximetry - Continuous (Pulse Oximetry	Continu	ious)				F No CPR, Critical Care, No Intubation
🗹 💆 Weight						S-INO CPR, Critical Care, May Intubate
🗹 🔀 Height/Length						once, on admission

4 Continue adding the following orders to the PowerPlan:

Remember to click the Details button to expand or collapse the order details view.

- Insert Peripheral IV Catheter
- Insert Arterial Catheter
- Insert Nasogastric Tube
- Insert Urinary Catheter
- Acetaminophen 650 mg NG Q4H
- Hydromorphone 0.1- 0.5 mg IV q5min PRN
- Chemistry: Magnesium, phosphate, calcium ionized, troponin, lactate and CK levels
- Blood culture x2
- Urinalysis Microscopic
- Electrocardiogram 12 Lead
- XR Chest

Note: You can select details provided by the order sentence or change details manually in the Details view.



Adding to Phase while in PowerPlan:

1

You want to add some orders that are not part of the PowerPlan. Click + Add to Phase button

🕂 Add 📲 Document Medication by Hx Reconciliation 🛛 🕭 Check Interactions									
Orders Medicat	Orders Medication List Document In Plan								
▶ ∢ % ⊘	🕂 Add to Phase 🗸 🛆 Check Alerts 🚇 Co	omments Start: Now							
7 6	Add Order	Status							
	Add Outcome / Intervention								
	Add Prescription								
	IP Consult to Diabetic Educator								

2 Search the order catalogue for:

- Dopamine titratable infusion (1.6 mg/mL) standard
- Ciprofloxacin 400mg IV q12h
- CVC insertion

🕂 Add 🦨 Document Medication b	• Add 🖑 Document Medication by Hx Reconciliation - 🚴 Check Interactions								
Orders Medication List Document	ders Medication List Document In Plan								
 Add to Phase - Offset V Comp Offset V PT Chemistry 	LEARNINGDEMO, JOHN - Add Order LEARNINGDEMO, JOHN D08:01-Jan-19 MRN:700008684 (Age:47 years Allergies: Allergies Not RecorGender:Male PHN:98764154 [Children]	ode Status: Process Disease Dosing Wt: Isolatic	s: Location:LGH 4V): 405; 04 e: Enc Type:Inpatient n: Attending:Plisvcs, Jame, MD						
Image: Constraint of the second se	Search: dopam Advanced Options Type: ODPamine continuous infusion (1.6 mg/mL) standard DOPamine NEO/PED continuous infusion (3.2 mg/mL) Cor DOPamine NEO/PED continuous infusion (3.2 mg/mL) Free DOPamine NEO/PED titratable infusion (3.2 mg/mL) Lab DOPamine titratable infusion (1.6 mg/mL) standard Me DOPamine titratable infusion (3.2 mg/mL) Lab DOPamine titratable infusion (3.2 mg/mL)	Inpatient							
Comparison of the second	Admiti dextroamphetamine (5 mg, PO, BID, drug form: tab) Admiti dextroamphetamine (5 mg, PO, qAM, drug form: tab) Discha dextroamphetamine (5 mg, PO, qAM, drug form: tab) Bed Tr dextroamphetamine (10 mg, PO, qAM, drug form: tab) dextroamphetamine (10 mg, PO, qdaily, drug form: tab) dextroamphetamine long acting "Enter" to Search		LEARNINGDEMO, JOHN - 70000868						



3 Once you have selected the orders above, click **Done** at the lower right corner. Then, the **Details for Central Venous Catheter Insertion (CVC Insertion)** appears, as it is the last order you entered in the catalogue search.

		Duration. Non	
o onser s	Component	Status Dose .	Details
	HIV 1/2 Antibody and p24 Antigen BCCDC		Blood, Urgent, Collection: T;N, once
Diagnostic Tests	5		
	Electrocardiogram 12 Lead		Urgent, Reason: Other (please specify), Critical Care Admission
	🔀 XR Chest		Urgent, Reason: Critical Care Admission, line and tube placement, Transport: Portable
	🖄 XR Chest		T+1;0530, Timed, Transport: Portable
	🖄 XR Chest		T+2;0530, Timed, Transport: Portable
	🖄 CT Head w/o Contrast		Urgent
	🖄 CT Head w/ Contrast		Urgent
	🖄 CT Angio Head and Neck		Urgent
	Electroencephalogram		 Urgent, Seizures
	🖄 MRI Head w/o Contrast		Urgent
Procedures			
	Central Venous Catheter Insertion (CVC Insertion)		T:N, Routine, As per order
Pernivatory			
- 1	₩¥		
Request	ted Start Date/Time:	PST	*Priority: Routine
Primary Rea	son for Central Line:	•	Number of Lumens:
tremity Restrict	tion (please specify):		Order for future visit: Urgent
,	Special instructions:	7	Scheduling Location:
	L	_	
		_	
		_	
	L		
	L		
		_	
		_	

Fill in the following information:

- **Requested Start Date/Time:** type "t" for date and type "n" for time. (This will automatically enters today's date and current time)
- Primary Reason for Central Line: Difficult IV Access
- **Priority:** STAT



4 Do not Sign here yet. Click the **Details** icon to hide the Details for CVC Insertion. Notice the **Details** is now collapsed at the bottom of your PowerPlan Order Screen.



5 Now, scroll up to locate all the orders that have this icon. Notice that you have to complete one for **Code Status** and **Dopamine additive 400 mg (mcg/kg/min).**

% (</th <th>🛇 🕂 Add to I</th> <th>Phase 🗸 🛆 Check Alerts 🛄 Comments Start: Now 🛄</th> <th>Duration: None</th> <th></th>	🛇 🕂 Add to I	Phase 🗸 🛆 Check Alerts 🛄 Comments Start: Now 🛄	Duration: None	
l 🔊 O	ffset 🕅	Component Status	s Dose	Details
	1	S Complete Admission or Transfer Medication Reconciliation		
	Č	Communication Order		Research coordinator is able to screen patient for study eligibility
⊿ Status				
▼	u 😣 🖸	Code Status		 Select an order sentence
⊿ Patien	it Care			
V	Ľ	Critical Care Goals		MAP goal: 65 mmHg or greater, Sodium goal: 140 to 150 mmol/L, pH goal: 7.3 to 7.45, Sg
v	Ľ	Cardiorespiratory Monitoring		Remains on at all times
	Ľ	Intracranial Pressure Monitoring (ICP Monitoring)		T;N
	Ľ	🕈 Vital Signs		▼ q1h
	Ľ	Oximetry - Continuous (Pulse Oximetry Continuous)		T;N
	Ľ	🖉 Weight		 On admission
	Ľ	Height/Length		once, on admission
	6	2 Monitor Intake and Output		▼ q1h
	Ľ.	2 Notify Treating Provider		If urine output greater than 250 mL/h for 2 consecutive hours
	6	2 Neurovital Signs		▼ q1h
		Pain Assessment		q4h, if patient expresses pain, use Numeric Rating Scale (goal less than 4). If patient exhib
		2 Sedation Hold for Assessment		qdaily
		2 Patient Isolation		 Select an order sentence
	2	Z Seizure Precautions		T;N
Lines/	Tubes/Drains	~		
	2	Insert Peripheral IV Catheter		Insert 2 large bore IV's unless already in place
	Ę	Insert Arterial Catheter		T;N
		Contraindications to nasal insertion include facial or head trau	ma. Order X-ray pos	t tube placement to confirm position, if required
		Insert Orogastric (OG) Tube		Tube to Low Intermittent Suction, insert large bore
<u> </u>		Insert Nasogastric Tube		Tube to Low Intermittent Suction, insert large bore
	2	Insert Urinary Catheter		Indwelling
⊿ Activit	ty			
		ICU Cervical Spine Precautions (Module) (Validated)		
		ICU Cervical Thoracic Lumbar Precautions (Module) (
		Communication Order		No spinal precautions
		Maintain Head of Bed		30 degrees or greater, if no thoracic / lumbar spine precautions
		ICU Early Mobilization Goal		▼ Stages 1 to 2
	L	Communication Order		Discontinue cervical, thoracic and lumbar precautions
⊿ Diet/N	utrition	Rec		
		Kerer to your organization's enteral nutritional guidelines and p Retend Facility Continuous	onicies	The second state of the second
H		Enteral reeging Continuous		Isosource 1.2, start Kate (mL/n): 25, advance to goal as per guidelines
	<u>نا</u>			
	8	DOPamine additive 400 mg [mcg/kg/min] + dextrose		IV, bag volume (mL): 250



6 For practice, let's go ahead and complete the **Code Status** and select **Attempt CPR, Full Code** by clicking on

the drop-down \blacksquare icon. This again will take you to the sign here and simply collapse the **Details** \blacksquare icon.

■ Details for Code Status

Remember not to

	🗟 🔀 🛣 Code Status	Select an order sentence
⊿ Patier	it Care	Attempt CPR, Full Code
	🕎 Critical Care Goals	1-No CPR, Supportive Care, No Intubation
	Cardiorespiratory Monitoring	2-No CPR, Therapeutic Care, No Intubation
	Intracranial Pressure Monitoring (ICP Monito	ring) 3-No CPR Acute Transfer No Intubation
	💆 Vital Signs	▲ A No CDR Critical Care No Intubation
	💙 Oximetry - Continuous (Pulse Oximetry Cont	inuous)
	🖄 Weight	5-No CPR, Critical Care, May Intubate

7

Next, locate the **Dopamine** under **Continuous Infusions.** The details default in the **Continuous Details** tab, type **5** in the **Normalized Rate** field. If the patient's weight has not yet been entered in the chart, go ahead and enter **65 kg** in the **Weight** field below the infusion details. You can also type in the **Infusion Instructions** within the free text box.

■ Details for DOPamir	ne additive 400) mg [5 mcg/kg/m	nin] + dextros	se 5% premix o	continuous 250 mL
Details	Details				
Base Solution	Bag Volume	Rate	Infuse Over		
dextrose 5% premix continu	ious 250 mL	🕾 12.19 mL/h	20.5 hour		
Additive	Additive Dose	Normalized Rate	Delivers	Occurrence	
× DOPamine additive	400 mg	🗧 5 mcg/kg/min	325 mcg/min	Every Bag	
1		8			
Total Bag Volume	250 mL				
Weight: W	/eight Type:	Result dt/tm:			
65 kg 🔻 M	1anually Entered	2018-Jan-19 15:03:17	P		
Infusion instructions					
					×
					Ŧ
0 Missing Required Details 0	rders For Cosignature				Sign Cancel



- 8 1. Now, click the **Details** tab. Fill in the following information:
 - Duration = 1
 - **Duration Unit** = *day*
 - Drug Form = bag
 - First Dose Priority = Now

	[5 mcg/kg/min] + dextrose 5% premix continuous 250 mL
Details 🛅 📴 Continuous Details	
+ ≅ III. ↓ ≥	
*Route of Administration: IV	•
Duration: 1	
Duration Unit: day	•
Drug Form: bag	•
First Dose Priority: NOW	•
Start Date/Time: 19-Jan-2018	2 A PST
Stop Date/Time: 20-Jan-2018	PST PST
BCCA Protocol Code:	
Orders For Cosignature	Sign Cancel

9 Now that you have completed all the required Details, let's minimize the order details using this \mathbf{x} icon.

Note: Once all the necessary fields are completed, you will notice that the Details icon 🕺 next to Dopamine and Code Status disappear.



10 Next, add Cipro to the PowerPlan. Select + Add to Phase and choose Add Order...





11 Search the order catalogue for Cipro 400mg IV q12hr. Select the appropriate order and click **Done.**

ergies: morphine	Age:47 years Enc:700000001 Gender:Male PHN:98764154 Dosing Wt:	Disease: Isolation:	Enc Type:Inpatient Attending:Plisvcs, Jame, MD
earch: ciprol	Advanced Options • Type: Inpatient • Search within: All • []	Filtered Order Sentences	
ciprofloxacin ciprofloxacin 200 mg, IV, q12h, o ciprofloxacin 250 mg, PO, BID, d ciprofloxacin 250 mg, PO, BID, d ciprofloxacin 250 mg, PO, qdaily giprofloxacin 250 mg, PO, qdaily ciprofloxacin 400 mg, IV, q12h, o ciprofloxacin 400 mg, IV, q12h, o	drug form: bag [Greater Than or Equal To 17 year] frug form: oral liq [Greater Than or Equal To 17 year] frug form: tab [Greater Than or Equal To 17 year] ill to OR, drug form: tab [Greater Than or Equal To 17 year] y, drug form: tab [Greater Than or Equal To 17 year] drug form: bag [Greater Than or Equal To 12 year] drug form: bag [Greater Than or Equal To 12 year] drug form: bag [Greater Than or Equal To 12 year] drug form: bag [Greater Than or Equal To 12 year] drug form: bag [Greater Than or Equal To 12 year] drug form: bag [Greater Than or Equal To 12 year] drug form: bag [Greater Than or Equal To 12 year] drug form: bag [Greater Than or Equal To 12 year] drug form: bag [Greater Than or Equal To 12 year]	ciprofloxacin 500 ciprofloxacin 500 ciprofloxacin 500 ciprofloxacin 750 ciprofloxacin 750 ciprofloxacin 750 ciprofloxacin 0.3% ciprofloxacin 0.3% drop, eye-both,	mg, PO, on call to OR, drug form: tab [Great mg, PO, once, drug form: tab [Greater Than mg, PO, qdaily, drug form: tab [Greater Than mg, PO, BID, drug form: tab [Greater Than mg, PO, on call to OR, drug form: tab [Great mg, PO, TID, drug form: tab [Greater Than eye drop eye drop q2h while awake, drug form: eye drop [Greater hand a stable of the stable of the stable of the stable stable of the stable of the stable of the stable of the stable stable of the stable of the stable of the stable of the stable stable of the stable of the stable of the stable of the stable stable of the stable of the stable of the stable of the stable of the stable stable of the stable of th
ciprofloxacin 400 mg, IV, q8h, di	rug form: bag [q ciprofloxacin 400 mg, IV, qL2n, drug form: b śrug form: oral liq [Greater Than or Equal To 12 year] drug form: tab [Greater Than or Equal To 12 year]	ciprofloxacin 0.3% 1 drop, eye-left, q	eye drop eye drop 2h while awake, drug form: eye drop [Great

12 View the order details. Minimize the order details once finished.

Noffset V Ci	omponent		Status	Dose Details	
Medications					
(Š) Al he aj	I patients in ICU are considered n emorrhage and subarachnoid hen proved by critical care, neurolog	noderate or high ris morrhage are high i y or neurosurgery	sk for VTE; order ant risk for bleeding. Se	coagulant prophylaxis unless contraindicated. Intrac uential compression devices recommended as DVT	erebral prophylaxis until
e ve	enous Thromboembolism (VTE) P	Prophylaxis (Modul	Planned Pen	0 components selected	
💆 SI	EPSIS ADVISOR			T;N	
🗖 a	profloxacin			400 mg, IV, g12h, drug form: bag	
Petails 📴 Order Comn	ents Coffset Details				
* Details 🔢 Order Comn + 🖀 III. III 🔆 *Dose	s 400				i
* Dose Unit	e 400	~			E
Tetails Torre Comm	ents @ Offset Details = 400 = mg = IV	v			
Petails Corder Comm + Sh. E Dose Dose Unit Route of Administration "Frequency	ents () Offset Details 400 mg N q12h				I
Potails Order Comm Pose Pose Pose Unit Route of Administration Frequency PRN	ents ♥ Offset Details = 400 = mg = IV = q12h = ↓ Yes ● No	▼ ▼ ▼			=



Modifying a Module:

1

Scroll down to locate **Venous Thromboembolism Prophylaxis** Module and modify by clicking the module link

ers	Medication List					
4	😵 🛇 🕂 Add to P	hase 🗸 🛆 Check Alerts 🛺 Comments Start: Now 📖 D	Juration: None			
	🔊 Offset 🕅	Component Status	Dose		Details	
	C	dextrose 5%-sodium chloride 0.9% (dextrose 5%-sodi		•	order rate: 25 mL/h, IV, drug form: bag	
	6	lactated ringers (lactated ringers continuous infusion)		•	order rate: 25 mL/h, IV, drug form: bag	
N	Č	All patients in ICU are considered moderate or high risk for VTE; Venous Thromboembolism (VTE) Prophylaxis (Modul Planne senets Anvisore	ed Pen	nt pr	ophylaxis unless contraindicated T;N	
	Analgesics				CO	
-		acetaminophen			Maximum acetaminophen 4 g/24 h from all sources	
					650 ma NG-tube odb PRN pain-mild or fever drug form: tab	

2 Select Apply Full Leg Sequential Compression Devices

00	8	Component	Status	Dose	1	Details
		Communication Order			-	For surgical patients, give first post-op rivaroxaban dose at h (
		rivaroxaban			1	10 mg, PO, qdaily, order duration: 14 day, drug form: tab Total Knee Replacement. Commence first dose at 1000h post-op
		rivaroxaban			1	10 mg, PO, qdaily, order duration: 35 day, drug form: tab Total Hip Replacement. Commence first dose at 1000h post-op d
	3	VTE RISK IS MODERATE OR HIGH WITH CONTRAINDICAT	TION TO A	NTICOAGULA	NTS	
		- Skin breakdown, ulcers, gangrene, cellulitis, or dermatiti	is			
_		 Skin gratting within last 5 months Allergy to stocking or compression cuff materials Unable to size or apply properly due to deformity, recent Only graduated compression stocking is contraindicated 	t surgery o d for acute	r trauma stroke with in	nmob	ility (unable to walk independently to the toilet)
Г	Ø	Skin gratting within last 3 months Allergy to stocking or compression cuff materials Unable to size or apply properly due to deformity, recent Only graduated compression stocking is contraindicated Apply Full Leg Sequential Compression Devices	t surgery o d for acute	r trauma stroke with in	nmob	ility (unable to walk independently to the toilet) Apply to lower limb(s) continuously until anticoaqulant prophyla
	Û	Skin gratting within last 5 months Allergy to stocking or compression cuff materials Unable to size or apply properly due to deformity, recent Only graduated compression stocking is contraindicated Apply Full Leg Sequential Compression Devices Apply Below the Knee Sequential Compression Devices	t surgery o d for acute	r trauma stroke with in	nmob	ility (unable to walk independently to the toilet) Apply to lower limb(s) continuously until anticoaqulant prophyla Apply to lower limb(s) continuously until anticoagulant prophyla Contraindicated for stroke patients, use full leg sequential compr
C	1 D D D	Skin gratting within last 5 months Allergy to stocking or compression cuff materials Unable to size or apply properly due to deformity, recent Only graduated compression stocking is contraindicated Apply Full Leg Sequential Compression Devices Apply Below the Knee Sequential Compression Devices Communication Order	t surgery o d for acute	r trauma stroke with in	nmob , , , ,	ility (unable to walk independently to the toilet) Apply to lower limb(s) continuously until anticoagulant prophyla Apply to lower limb(s) continuously until anticoagulant prophyla Contraindicated for stroke patients, use full leg sequential compr No mechanical prophylaxis because of contraindication(s)
C	ti D ti	Skin gratting within last 3 months Allergy to stocking or compression cuff materials Unable to size or apply properly due to deformity, recent Only graduated compression stocking is contraindicated Apply Full Leg Sequential Compression Devices Apply Below the Knee Sequential Compression Devices Communication Order ASA chewable for post hip or knee surgery if on mechanic	t surgery o d for acute	r trauma stroke with in laxis only	nmob , , , ,	ility (unable to walk independently to the toilet) Apply to lower limb(s) continuously until anticoaqulant prophyla Apply to lower limb(s) continuously until anticoagulant prophyla Contraindicated for stroke patients, use full leg sequential compr No mechanical prophylaxis because of contraindication(s)
	d D D	Skin grating within last 5 months Allergy to stocking or compression cuff materials Unable to size or apply properly due to deformity, recent Only graduated compression stocking is contraindicated Apply Full Leg Sequential Compression Devices Apply Below the Knee Sequential Compression Devices Communication Order ASA chewable for post hip or knee surgery if on mechanic ASA (ASA chewable)	t surgery o d for acute cal prophyl	r trauma stroke with in laxis only	imob i i i	ility (unable to walk independently to the toilet) Apply to lower limb(s) continuously until anticoagulant prophyla Apply to lower limb(s) continuously until anticoagulant prophyla Contraindicated for stroke patients, use full leg sequential compr No mechanical prophylaxis because of contraindication(s) 160 mg, PO, gdaily with food, drug form: tab-chew
I I Re	C C C C C C C C C C C	Skin gratting within last 5 months Allergy to stocking or compression cuff materials Unable to size or apply properly due to deformity, recent Only graduated compression stocking is contraindicated Apply Full Leg Sequential Compression Devices Apply Below the Knee Sequential Compression Devices Communication Order ASA chewable for post hip or knee surgery if on mechanic ASA chewable) U Admission Neurology (excluding Traumatic Brain Injury)	t surgery o d for acute cal prophyl	r trauma stroke with in laxis only	imob i i i	ility (unable to walk independently to the toilet) Apply to lower limb(s) continuously until anticoagulant prophyla Apply to lower limb(s) continuously until anticoagulant prophyla. Contraindicated for stroke patients, use full leg sequential compr No mechanical prophylaxis because of contraindication(s) 160 mg, PO, qdaily with food, drug form: tab-chew
Re	C C C C C C C C C C C C C C C C C C C	Skin grating within last 5 months Allergy to stocking or compression cuff materials Unable to size or apply properly due to deformity, recent Only graduated compression stocking is contraindicated Apply Full Leg Sequential Compression Devices Apply Below the Knee Sequential Compression Devices Communication Order ASA chewable for post hip or knee surgery if on mechanic ASA (ASA chewable) U Admission Neurology (excluding Traumatic Brain Injury)	t surgery o d for acute cal prophyl	r trauma stroke with in laxis only d)	nmob i i	vility (unable to walk independently to the toilet) Apply to lower limb(s) continuously until anticoagulant prophyla. Apply to lower limb(s) continuously until anticoagulant prophyla. Contraindicated for stroke patients, use full leg sequential compr. No mechanical prophylaxis because of contraindication(s) 160 mg, PO, gdaily with food, drug form: tab-chew
	D D D C C C C C C C C C C C C C C C C C	Skin grating within last 5 months Allergy to stocking or compression cuff materials Unable to size or apply properly due to deformity, recent Only graduated compression stocking is contraindicated Apply Full Leg Sequential Compression Devices Apply Below the Knee Sequential Compression Devices Communication Order ASA chewable for post hip or knee surgery if on mechanic ASA (ASA chewable) U Admission Neurology (excluding Traumatic Brain Injury)	t surgery o d for acute cal prophyl	r trauma stroke with in laxis only d)	imob i i i i i i i i i i i i i i i i i i i	ility (unable to walk independently to the toilet) Apply to lower limb(s) continuously until anticoagulant prophyla Apply to lower limb(s) continuously until anticoagulant prophyla. Contraindicated for stroke patients, use full leg sequential compr No mechanical prophylaxis because of contraindication(s) 160 mg, PO, qdaily with food, drug form: tab-chew
]]] Re	Carro IC Carro IC Carro IC Carro IC	Skin grating within last 5 months Allergy to stocking or compression cuff materials Unable to size or apply properly due to deformity, recent Only graduated compression stocking is contraindicated Apply Full Leg Sequential Compression Devices Apply Below the Knee Sequential Compression Devices Communication Order ASA chewable for post hip or knee surgery if on mechanic ASA chewable) U Admission Neurology (excluding Traumatic Brain Injury)	t surgery o d for acute cal prophyl	r trauma stroke with in laxis only d)	innob i i i i i i i i i i i i i i i i i i i	vility (unable to walk independently to the toilet) Apply to lower limb(s) continuously until anticoagulant prophyla. Apply to lower limb(s) continuously until anticoagulant prophyla. Contraindicated for stroke patients, use full leg sequential compr. No mechanical prophylaxis because of contraindication(s) 160 mg, PO, qdaily with food, drug form: tab-chew



3 Once you have made your selections for this module, **do not** sign yet. You need to return to the main PowerPlan by selecting **Return to ICU General Admission Neurology** to sign off the entire PowerPlan.

8	Retur	n to ICU Admission Neurology (exclud	ing Traumatic Brain Injury) (Validate	.d)
So -	8	Component	Status	Do

4 Now, all your orders are selected and you are ready to sign off. Remember to use 🐨 to see what has been selected so far and <1 to merge your plan with other current orders. This will help to identify any duplication.

Note: Click **Initiate** first to ensure that all selected orders are immediately active. If you **do not** Initiate the PowerPlan and click **Sign only**, the orders are **not** active. The PowerPlan remains in a planned state until it is activated later by a provider or a nurse assigned to this patient. For example, the provider created the PowerPlan in a planned state when the patient was still in ED. The receiving nurse will initiate the PowerPlan order upon patient's arrival on the unit, and the orders will then become active.

& Offset	P Component 5	tus Dose Details	
Admission Ne	surology (excluding Traumatic Brain Injury) (Validated) (Planned Pe	Seq.	
Idmit/Transfe	ar/Discharge		
	S Verify that an 'Admit to' Order has been entered prior to cr	ngleting the powerplan	
	Complete Admission or Transfer Medication Reconciliation		
	Communication Order	Research coordinator is able to screen patient for study eligibility	
itatus:			
	😥 📝 Code Statue	Attempt CPE, Full Cade, Perioperative status: Attempt CPE, Full Code, During chemotherapy: Attempt CPE, Full Code	
atient Care			
	Critical Care Goals	MAP goal: 65 mmHg or greater, Sodium goal: 140 to 150 mmoUL, pH goal: 7.3 to 7.45, SpO2 goal: 92% or greater, Temperature target 36 to 38 degrees Celsius	
	Cardiorespiratory Monitoring	Remains on at all times	
	Intracranial Pressure Monitoring (ICP Monitoring)	TIN	
	Vital Signs	▼ alh	
	Oximetry - Continuous (Pulse Oximetry Continuous)	TN	
	Weight	Via admission	
	Height/Length	Ence, on admission	
	Monitor Intake and Output	▼ qlh	
	Notify Treating Provider	If urine output greater than 250 mL/h for 2 consecutive hours	
	Neurovital Signs	▼]alb	
	Pain Assessment	alb. If nativest excrements pain, use Numeric Rating Scale (anal less than 5). If patient exhibits sizes of pain, use Rehavioural Pain Scale (anal less than 6)	
	Sedation Hold for Assessment	odaly	
	Patient Isolation	▼ Select an order sentence	
	Seizure Precautions	TH	
es/Tubes/T	Desires		
	Insert Perinheral IV Catheter	Inset 2 later hore B/s unless already in place	
	Insert Arterial Catheter	TN	
	Contraindications to natal insertion include facial or head	auma. Order X-ray port tube placement to confirm position. If required	
	Inset Orosastric (OG) Tube	▼ Tube to Low Intermittent Suction, intert large bare	
	Inset Necessitic Tube	Tube to Low Intermittent Surface, insert lange here	
	Inset Usinary Catheter	Industing	
tivity			
	So ICU Censical Spine Precautions (Module) (Validated)		
	So ICU Cervical Theracic Lumbar Precautions (Medule) I		
	Communication Order	No seval precadors	
	Maintain Head of Bed	10 deares or areater if no tharacic / lumbar spine precations	
	101 Early Mobilization Goal	▼ Store 1 to 2	
	Communication Order	Discretional cancel thoracic and lumbal mechanisms	
et /Martin		a second s	
	A today to your conscipation's entered out it is not midelines	Another .	
	Interal Freeding Continuous	Ibosource 1.2 Start Rate (ml/b): 25 advance to onal as ner nuidelines.	
	100	We have the second seco	
- in the		The events	
stails for C	ode Status		
			Description of the second seco
es For Caught	sture Save as My Favorite		Sign Sign

For your first patient, **Initiate** the ICU Admission Neurology PowerPlan.

5



6 Once *Initiate* is selected, a lightbulb icon is displayed beside each of the checked orders and allergy checking and drug-drug interaction checking occurs. Click **Orders for Signature.**

4	Se la	Offset	8		Component	Status	Dose	Details
ICU (Genera	Admission Medical / Surgical (Va	alidated) (I	nitiat	ed Pending)			
4 4	Admit/	Transfer/Discharge		Sea and				
9	111				Communication Order	Order		30-Nov-2017 08:22 PST, Research coordinator is able to screen patien
Adm	it/Tran	sfer/Discharge (Other)						
	\sim		60		Admit to Inpatient	Ordered		29-Nov-2017 10:10 PST, Admit to General Internal Medicine, Admitti.
	~				Discharge Patient	Ordered		27-Nov-2017 07:32 PST
4 5	itatus							
\$	10		R		Code Status	Order		30-Nov-2017 08:22 PST, Attempt CPR, Full Code, Perioperative status
Statu	s (Oth	er)						
	~		🗈 66° 🖬		Code Status	Ordered		30-Nov-2017 07:50 PST, Attempt CPR, Full Code, Perioperative status
1 F	atient	Care		1				
\$					Critical Care Goals	Order		30-Nov-2017 08:22 PST, MAP goal: 65 mmHg or greater, pH goal: greater
Q :	111			Ø	Cardiorespiratory Monitoring	Order		30-Nov-2017 08:22 PST, Remains on at all times
\$	10				Vital Signs	Order		▼ 30-Nov-2017 08:22 PST, q1h
-Q-					Oximetry - Continuous (Pulse Oximetry Continuous)	Order		30-Nov-2017 08:22 PST
Q :	112				Weight	Order		 30-Nov-2017 08:22 PST, On admission
Q :	111				Height/Length	Order		30-Nov-2017 08:22 PST, once, Stop: 30-Nov-2017 08:22 PST, on admi

7 Click **Sign** to complete the process. Your orders will become active and all related tasks for your first patient's care will be created for the appropriate clinician.

Note: If you click Cancel at this point, no orders will be placed and actioned.

8 Navigate back to the Admission tab and click the **Order Profile** component. The order profile allows you to review all currently active orders for your first patient.

< 🔹 🔹 🔒 Provider Vi	ew								D Normal view	Print	2 43 minu
🗚 🏢 🖣 🏬 🔍 🔦 100	× •	• 4									
Admission	23 R	ounding		23	Transfer/Discharge	23	Quick Orders		8 +	-	
Allergies	Orde	r Profile	(51)							Selected v	nsit $ \boldsymbol{\vartheta} \equiv \cdot$
Review of Systems					Pending Orders (51) Group	by: Clinical	Category 🗸	Show: All Active	Orders		V
Vital Signs			Туре	Order	*	Start	Status	Status Updated	Ordering Provider		
Physical Exam	⊿ Adr	nit/Transfe	er/Discha	arge (3)							•
Labs Imaging			0	Admit to Inpatient to General Internal TestUser, General	29-Nov-2017 10:10 PST, Admit Medicine, Admitting provider: Iedicine-Physician, MD	29/11/17 10	0:10 Ordered	29/11/17 10:10	TestUser, GeneralMedicine- Physician, MD		
Lines/Tubes/Drains			٠	Bed Transfer Requ	est 17-Oct-2017 11:09 PDT	17/10/17 11	1:09 Ordered	17/10/17 11:09	Abedi, Nasim		
Active Issues			0	Discharge Patient	27-Nov-2017 07:32 PST	27/11/17 02	7:32 Ordered	27/11/17 07:32	Abedi, Nasim		
Assessment and Plan	⊿Sta	tus (2)				_					
Order Profile (51) New Order Entry		28	ð	Code Status 30-N CPR, Full Code, Per Full Code, During of Code	ov-2017 07:50 PST, Attempt ioperative status: Attempt CPR, hemotherapy: Attempt CPR, Full	30/11/17 07	7:50 Ordered	30/11/17 07:50	TestUser, CriticalCare- Physician, MD		
Create Note ICU Admission Note		9	۲	SIRS Alert 19-Oct 2017 08:43 PDT	2017 08:43 PDT, Stop: 19-Oct-	19/10/17 08	8:43 Ordered	19/10/17 08:43	SYSTEM, SYSTEM Cerner		
ICU Consult Note	⊿Pat	ient Care (20)								
Select Other Note	in in	****	A	Admission History	Adult 2017-04-11 15:32 DOT	11/10/17 1	5:37 Ordered	11/10/17 15-37	SYSTEM SYSTEM		17

Note: This view lists individual orders. The 📴 icon indicates that the order is part of the PowerPlan.



9 PowerPlans in a *planned* status (signed but not initiated) are not listed under Orders Profile. Click on the Order Profile heading to review orders including those in a planned state.

Key Learning Points

- PowerPlans are similar to pre-printed orders
- You can select and add new orders not listed in the PowerPlan by using Add to Phase functionality
- You can select from available order details using drop-down lists or modify order sentences manually where needed
- Initiate means that PowerPlan orders are immediately active and as such, can be actioned right away by the appropriate individuals
- To ensure orders within a PowerPlan are immediately active, click *Initiate* first and then Sign
- Sign will place orders into a planned state for future activation



ACTIVITY 1.7- Complete an ICU Admission Note

As the last step of admitting your first patient to the Intensive Care Unit, you create the admission note.

The Clinical Information System (CIS) uses Dynamic Documentation to pull all existing and relevant information into a comprehensive document using a standard template.

Dynamic Documentation can save you time by allowing you to populate your documentation with items you have reviewed and entered in the Admission workflow tab. This is why it is more efficient to create the note as the last step of the admission process. You can also add new information by typing or dictating.

Workflows such as Admission, Rounding, and Transfer/Discharge have the Create Note section displaying relevant note types represented by links. With one click on the desired note type link, the CIS generates a charting note.

Navigate to the Create Note section

2 To document an admission, click ICU Admission Note.

< 🔹 👻 👫 🛛 Provider View									
A 🗎 📥 🗎 🔍 🔍 100%	- 🌀	• 🗳							
Admission	23	Rounding		23	Transfer/Discharge	23	Quick Orde	ers	* 🛙
Advance Care Planning and Goals of Care	Orde	er Profile	e (36)						
Histories								Pending Orders (25)	Group by:
Current Medications			Turce	Order	*			Short	Chabur
Home Medications	⊿Sta	itus (2)	Type	order				Juli	Status
Allergies		28	Ð	Code Status Perioperativ Attempt CP	2017-Oct-11 11:35 PDT, Attemp e status: Attempt CPR, Full Code, R, Full Code	pt CPR, Full Co During chemo	ode, otherapy:	11/10/17 11:35	Ordered
Review of Systems		Ð	Ð	Septic Shoc	k Alert 2017-Oct-11 10:23 PDT, 5	Stop: 2017-Oc	t-11 10:23	11/10/17 10:23	Ordered
Vital Signs	⊿Pat	tient Care (12)						
Physical Exam		ē	@	Admission H 10:20 PDT	listory Adult 2017-Oct-11 10:20	PDT, Stop: 20	17-0ct-11	11/10/17 10:20	Ordered
Imaging		9	•	Basic Admis 2017-Oct-1	sion Information Adult 2017-Oct 1 10:20 PDT	-11 10:20 PDT	, Stop:	11/10/17 10:20	Ordered
Lines/Tubes/Drains		9	@	Braden Ass 10:20 PDT	essment 2017-Oct-11 10:20 PDT,	, Stop: 2017-0)ct-11	11/10/17 10:20	Ordered
Active Issues Assessment and Plan		9	•	ED Readmis 10:20 PDT	sion Risk 2017-Oct-11 10:20 PD	T, Stop: 2017-	0ct-11	11/10/17 10:20	Ordered
Order Profile (36)		ę	B	Infectious D	visease Screening 2017-Oct-11 1	0:20 PDT		11/10/17 10:20	Ordered
New Order Entry		28		Insert IV 0	1-Nov-2017			01/11/17 08:00	Future (On
Create Note		54		Insert IV 0	2-Nov-2017			02/11/17 08:00	Future (On
ICU Consult Note		2		Insert IV 0	3-Nov-2017			03/11/17 08:00	Future (On
Select Other Note		9	Ð	Morse Fall F	Risk Assessment 2017-Oct-11 10:	20 PDT, Stop	2017-	11/10/17 10:20	Ordered



3 The draft note displays in edit mode populated with the information captured by you and other clinicians. Review different sections of this note.



4 Position your cursor over the heading of any section to activate a small toolbar:

refreshes the dynamic information in the box

activates the box for edits or new entries

removes the entire section or content of the box

5 For editing the existing text, click into the box, for example **History of Present Illness**. It becomes active and you can select the text to add or delete as needed.



Note: CIS offers **Auto-Text** phrases that can be used within Provider documentation to quickly and easily insert note templates, and pull in patient data with smart templates. Let's go ahead and practice.



6 While you are in History of Present Illness, type ",,cc" ("comma, comma cc") and a list of auto-text phrases related to critical care appears. If you only type in "comma, comma", it will display a list of all available auto-text phrases. Let's go ahead and try it.

< 🖂 - 🏦 Documentation	
🕂 Add 💷 📕 📝	
ICU Admission/Consultation × List	
Tahon all_codestatus * all_umbarpuncture * all_umbarpuncture * all_action * cc_ardioversion * cc_ardioversion * cc_creating line * cc_ardioversion * cc_creating line * cc_creating line * cc_familycon_sterile * cc_feeding_tube * * cc_ideution * cc_intube* cc_pacemaker_epicardial_adjust * cc_pacemaker_transvenous_adjust * cc_percutaneous_trach_insertion * cc_phys_ex_intubated * cphys_ex_intubated *	B I U obe Ar. E = = 06 BP: 110/70 0)

7 Select **",,cc_familycon_purpose**" and then double-click. Notice that a phrase regarding family meeting is auto-populated into the text box.

History of Present Illness 💿 📼 🗙

Patient present with dry cough but states he was producing tan coloured phlegm a few days ago. While being treated on Medicine Unit, patient had a fall incident and his level of consciousness decreased.

ICU Follow Up:

8

The purpose of the family conference today was to review the clinical status of the patient as well as answer all pertinent questions from the family.

You can remove section that are not required or are currently blank. For example, place the cursor over the heading and click 🔝 to remove the entire section.

Problem List/Past Medical History
Back injury
Tobacco use
Historical
No historical problems
Procedure/Surgical History C C C Appendectomy (07/26/2017), Hip replacement (2016).
Medications
Inpatient
acetaminophen, 325 mg, 1 tab, PO, q4h, PRN



9 Activate the text box and click 💽 to remove the entire content of this section. For example, you can remove the content in the History of Present Illness and type a new text.



10 Review the **Assessment/Plan** section. It is populated with the diagnosis you have entered. Enter new text to practice.

To complete your note, click Sign/Submit.

Sign/Submit	Save	Save & Close	Cancel

Note: You have also an option to click Save or Save & Close to continue to work on this document later. Saved document is not visible to other care team members.

11 In the **Sign/Submit** window, typically no changes are required if you use the link to create your document. Note type and title are already populated if you use a link to create your document but can be altered. You will learn later how to use the **Forward** option to send copies of the admission note to other providers.Click **Sign** to complete the process.



Note: The Date box auto-populates with the current date. Ensure that it indicates the date of the patient's admission, not the date the note is created.



12 Once the note is signed, it cannot be edited. Any changes require creating an addendum. You will practice adding an addendum later.

After signing the note, you are transferred back to the Admission tab. Remember to click the **Refresh** button on documents component. The admission note is now listed under Documents and is visible to the entire care team.

F/	FANI-LEARN, HOMA 🛛 List 🐔 Recent - Name • Q							
FANI-LEARN, HOMA DOB:1941-Apr-12 Age:76 years		MRN:700005033 Code Status: Enc:700000008064		Process: Disease:	Lo Er	Location:LGH 7E; 724; 02 Enc Type:Inpatient		
AI	lergies: Peanuts, iodine, penicillin	Gender:Female	PHN:9876788092 D	osing Wt:68 kg	Isolation:	At	tending:Plisvcb, Stuart, MD	
😰 < 🔪 - 🛉 Provider View 🔅		(¤) Full	screen 🛱 Print 🎅 1 hours 18 minutes :	ago				
5	🗚 🗎 🖶 🖿 🔍 🔍 100%	- 🖷 🖷 🗳						
	Admission 🔀	Rounding	🔀 Transfer/Discharge	🔀 Quick Orders	23 Outpatient Chart	× +	🖃 — 🕒 🔍 (=	•
	Chief Complaint	Documents (6)	•			Last 50 Notes All V	/isits Last 24 hours More 2 = -	^
	Allergies (3)				My notes only	Group by encounter	Display: Provider Documentation 🔻	
	Visits (3)	Time of Service	Subject	Note Type	Author	Last Updated	Last Updated By	
	Documents (6)	13/07/17 15:03	ED Supervision/Handoff Note	ED Note Provider	Test User, Physician - Emergency	13/07/17 15:34	Test User, Physician - Emergency	
	Links E Vital Signs	13/07/17 14:14	ED Note	ED Note Provider	Test User, Physician - Emergency	13/07/17 14:18	Test User, Physician - Emergency	
	Labs	13/07/17 13:36	ED Screening - Adult	ED Triage Note	Test User, Emergency - Nurse	13/07/17 13:36	Test User, Emergency - Nurse	
	Microbiology	13/07/17 13:31	ED Triage - Adult	ED Triage Note	Test User, Emergency - Nurse	13/07/17 13:31	Test User, Emergency - Nurse	
	Pathology	12/07/17 16:03	ED Triage - Adult	ED Triage Note	Test User, Emergency - Nurse	12/07/17 16:03	Test User, Emergency - Nurse	
	Imaging	12/07/17 15:50	ED Screening - Adult	ED Triage Note	Test User, Emergency - Nurse	12/07/17 15:50	Test User, Emergency - Nurse	
	Home Medications	* Displaying up to the	last 50 recent notes for all visits					

13 To close this patient chart, click the x icon on the Banner Bar.

P LEARNINGDEMO, JOHN - 700008684 Opened by TestUser, Criti	calCare-Physician, MD	
Task Edit View Patient Chart Links Notifications	Documentation Help	
Message Centre 🎬 Patient Overview 📲 Ambulatory Organi	izer 🎬 MyExperience 🛔 Patient	List 🎬 Dynamic Worklist 📲
🗄 🔀 Tear Off 📲 Exit 📲 Communicate 👻 🍙 Discern Reporting F	Portal 🚱 iAware 🖕	
🗄 😋 Patient Health Education Materials 🔇 Policies and Guideline	s 🔍 UpToDate 🦕	
LEARNINGDEMO, JOHN		
LEARNINGDEMO, JOHN	DOB:01-Jan-1970	MRN:700008684
Allergies: morphine	Age:47 years Gender:Male	Enc:7000000016209 PHN:9876415442

Key Learning Points Use Dynamic Documentation to prepare notes standardizes documentation practices. Use note links listed under the Create Note sections to produce documents efficiently. Only when a note is signed will it be visible to the care team. Saved notes remain in a draft format and are visible only to you. Once you sign and submit a note, further edits can be added but will appear as an addendum.



SCENARIO 2- Managing Your Patient During Rounding

Learning Objectives

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

- Update patient information.
- Modify current orders.
- Review documents and create a progress note.

SCENARIO

Your first patient was admitted yesterday to the Intensive Care Unit. His level of consciousness is unchanged since admission to the ICU. The Chest X-ray confirmed aspiration pneumonia and mild cardiogenic edema.

You round on your patients and examine your patient. You want to replace the IV ciprofloxacin with IV piperacillin-tazobactam and place electrolyte panel and CT head orders to re-evaluate your patient post fall. You also learn that your patient had a hip replacement last year and that he had an allergic reaction to morphine. As a heavy smoker, he has suffered from gradually worsening shortness of breath, and cough since last winter.

You will complete the following 7 activities:

- Review informal team communication
- Review documents, labs and imaging
- Review CareAware Critical Care (iAware)
- Add an individual order and modify the existing order
- Update Active Issues
- Create a progress and use an auto-text entry
 - Create a procedure note



ACTIVITY 2.1- Review Informal Team Communication

The **Informal Team Communication** is a tool that allows providers to communicate information to other clinicians. It is considered an informal communication tool as it will not be saved into the patient's chart. It is found in the Rounding tab as the very first component option. For example, you can add "Page Dr. X when patient's family arrives."

Admission	23	Rounding	23	Transfer/Discharge S	X	Quick Orders	٤	X	+
Informal Team Communication	Inf	ormal Team Communication							
History of Present Illness								_	
Documents (0)	I								
Vital Signs & Measurements									
Lines/Tubes/Drains							255 characters	left	:
Physical Exam						Available to All	Save	cel	

Note: *Communicate* icon found in your toolbar does not have similar functionality as the Informal Team Communication. This Communicate toolbar will be discussed further at a later point in this workbook along with the Message Centre.



1 Select the **Rounding** tab within the Provider view.

Menu	🤋 < 🔹 👘 Provider View
Provider View	A
Results Review	Admission St Rounding S3 Transfer/Discharge
Orders 🕂 Add	
Medication List 🕂 Add	Informal Team Communication
Documentation 🛛 🕂 Add	
	Add new action
Allergies 🕂 Add	
Diagnoses and Problems	No actions documented
Histories	All Teams
MAR Summary	
MAR	
Form Browser	History of Present Illness
Patient Information	
Interactive View and I&O	



2 Locate the Informal Team Communication component

3 Begin typing in the text box and write:

• Page Dr. X when the patient's family members arrive.

Admission	8 Rounding	X	Transfer/Discharge	53	Quick	Orders		×	+
Informal Team Communication	Informal Team Comm	nunication							
History of Present Illness									
Documents (0)	Please page Dr. X when the	patient's family mem	bers arrive.						
Vital Signs & Measurements						J			
Lines/Tubes/Drains							196 charact	ers lef	t
Physical Exam					✓ A	vailable to All	Save	ancel	
Intake and Output	No actions documented								
Labs	All Teams								

4 Click **Save** button. Then, the communication details will appear below.



5 Hover over the message you just saved and you will notice these icons:

= means to edit the message

= means to delete the message

nformal Team Communication	
Add new action	
Page Dr. X when the patient's family members arrive.	
TestUser, CriticalCare-Physician, MD 07/12/17 16:06	



6 By clicking on the tick box next to the message, this indicates that you have completed it. Notice your message has been crossed out.

Informal Team Communication	
Add new action	
No active actions documented Page Dr. X when the patient's family members arrive.	
TestUser, CriticalCare-Physician, MD 15/12/17 12:52	
All Teams	Hide Completed (1)

7 You can hide the completed message by clicking on the **Hide Completed (1)** link shown above. To view the completed link, simply click on the **Show Completed (1)** link.

Note: The number next to the Hide or Show Completed link indicates how many messages are present.

Informal Team Communication					
Add new action					
No active actions documented					
All Teams	Show Completed (1)				

8

Now, click on the **All Teams** link below the message area. The **Actions** pop-up screen appears and shows you the default **Active** tab with No results found.

Actions	Active C molete	M All SS
No results found		
		Close



Within the same screen, select the **Completed** tab and it will show you the previous message.

			Active Comple	rired 43 2
Action	Author	Date/Time *	Status	_
Page Dr. X when the patient's family members arrive.	TestUser, CriticalCare-Physician, MD	15/12/17 12:52	Completed	
	Action Page Dr. X when the patient's family members arrive.	Adon Autor Page Dr. X when the patient's family members arrive. TextUser, CriticalCare-Physician, MD	Action Author Dotar/Time * Page Dr. X when the patient's family members arrive. TestIser, CriticalCare-Physician, 15/12/17 12:52 MD	Action Author Dear/Time * Statue Page Dr. X when the patient's family members arrive. TextUser, CriticalCare-Physician, 15/12/17 12:52 Completed MD

10 Once done, click the **Close** button.

Key Learning Points

9

- Informal Team Communication allows providers to communicate information to other clinicians.
- It is an informal communication tool as actions or comments documented will not be saved into the patient's chart
- Completed actions should be checked off and comments addressed should be deleted



ACTIVITY 2.2- Review Documents

Continue reviewing the patient's chart by following the Rounding tab list of components. When using the Clinical Information System (CIS), you might be faced with a large amount of information.

For many components, you can filter in many ways. For example, in the Documents component you can:

- Display notes from the Last 24 hours or My notes only
- Use Group by encounter to see notes for the current encounter only
- Limit documents to Last 50 notes
- Access notes for All Visits

	Last 50 Notes	All Visits	Last 24 hours	More 🔻	∂ ≡-
My notes only	Group by encou	unter	Display: Provide	r Documer	ntation 🔻

You can also change the displayed note types by selecting **Provider Documentation**.

My notes only	Group	by encounter Displar: Provider Documentation 👻
	Last Up	Provider Documentation
3	TestP	ED Documentation
1	TestP	Nursing & Allied Health Documentation
		Surgical Documentation
3	TestP	Reset All Apply Cancel
_		

The display time range can be changed by expanding options under More



Remember that if you select a specific filter, the selection narrows and you might not display all relevant information. Ensure that the filter type corresponds with your current needs.



Click **Documents** to display a list of documents.

Select the document line to display the content of the document without leaving the screen. Clicking tab closes the split screen.

Documents (13) 🕇			Last 50 Notes All Visits Last 24 hours More V 🔁 =-
			My notes only Group by encounter Display: Provider Documentation -
Time of Service	Subject		Onen Document Print
24/08/17 11:42	Discharge Summary		open bocament Think
08/08/17 15:14	Admission H & P	Admission H & P	Admission Note Provider (In Progress)
Completed		Fest, Pet, MD	Last Updated: 08/08/1/ 15:1/
20/0R/17 15-42	Admission H & D		T

2

Click the component heading to view a comprehensive display with more options. For example, the Documentation view provides a list of all documents.

🕻 🔪 🔹 👘 Documenta	ion
🕂 Add 🛛 Submit 🔎 🏔 For	vard 🔳 Provider Letter 🎬 Modify 🏊 🛊 🎔 📰 💽 In Error 🛄 Preview
List	
Display : All 👻	
All Only	
Arrange All Physician Notes	07-Dec-2017 09:04:00 PST
Allergy Rule	TestUser, CriticalCare-Physician, MD

3 Use the navigation buttons <

4 For labs and other diagnostics – use filters to display results that are relevant to you. Click the refresh \gtrsim icon to update the information just for this component

Labs	Latest* Last 6 months Last 3 months More 👻 🏢 🛄 🖛
No results found	





ACTIVITY 2.3- Review Labs and Imaging

1 Click the **Labs** component heading to display comprehensive summaries of patient's results grouped in separate tabs.

An example of the comprehensive display of patient results grouped in separate tabs can be found below:

🔹 🕈 Results Revi	iew								(o)	Normal view	O Pt
in 🞑											
ecent Results Advance Care	Planning Lab - Recent	Lab - Extended	Pathology	Micro Cultures	Transfusion	Diagnostics	Vitals - Recent	Vitals - Extende	ed		
Flowsheet: Lab View	• [Level: Lab Vi	ew		• Table	⊙ Group ⊙	List				
K - F		Saturd	ay, 11-June-	2016 00:00 PDT -	Thursday, 1	1-January-2018	22:59 PST (Clini	ical Range)			
Navigator											
CBC and Peripheral Sme *	Showing results from	(13-Mar-2017 - 21	-Nov-2017)	Show more result	s						
Coagulation and Throm		Lab View		16-Oct-2017 23:59 Pl	00:00 - 1	21-Sep-2017 00:00 23:59 PDT	- 20-Sep-20 23:55	017 00:00 - 11 9 PDT	5-Sep-2017 00:00 - 23:59 PDT	07-Sep-20 23:59	17 00:00 PDT
Platelet Studies	General Chemistry										
Autoimmune	Sodium			140 mmol/L			-			140 mmol/L *	5
III Manakais and Couriel D	Potassium			5.6 mmol/L (H)			134 g/L * (C)			4.5 mmol/L *	
riemolysis and special K	Anion Gap									21.5 mmol/L	* (H)
DNA Quant	Calcium			3.12 mmol/L (H)		14				
👩 General Chemistry	Magnesium			2.45 mmol/L (H			1.71 g/L*				
Urine Analysis	Glucose Random										
D Endocrine	Bilirubin Direct										
Therapeutic Drug Monit	Alanine Aminotrans	lerase e						_			
👩 Blood Metabolic Testing	Albumin Level										
Pland Culturer	Lab Add on Time										

Key Learning Points

Different filters and tabs can be used to review information within results review



ACTIVITY 2.4- Review CareAware Critical Care

CareAware Critical Care CareAware Critical Care Launches a separate application when selected within PowerChart. It provides an interactive dashboard that aggregates critical patient information from multiple sources. This helps providers and clinicians gain understanding of the patient's current condition. You can toggle between PowerChart and iAware tabs.

If you are searching for a patient that is not assigned to you yet and would like to see their recent findings, a **Declare a Relationship** pop-up window will appear. You may select the appropriate response based on your relationship with the patient (i.e. consulting provider).

The **A**iAware features the following functionality:

- You can select to access individual patient that is in your MyList
- You can select to search patient
- You can select to review patient medications, vitals/infusions, I/O, and Blood Glucose
- You can personalize how you like to view the patient information

Note: The illustrations below will not be similar to the patient you are currently working on.

While you are currently in your patient's chart, click the **iAware** icon from the toolbar.



Note: The details of CareAware Critical Care functionality will not be discussed here but will be in separate reference guide.



2 A separate window appears and the view defaults in the **ICU Summary** screen.

📮 Young. Jim - CareAware Critical Care					EN English (C	anada) 🕐 Help 🚦 💷 🗐 💼
MyList Patient Search TCU Summary Meds Review Vitals/Infusions (24hr) 1/0 Blood Glucose					Reset	Perspective
Young, Jim 62 years M DOB: 3/25/1955 MRN: 01022014	FIN: 00000	0775 Adm	it: 11/26/201	7 Unit LOS:	2 days Lo	cation: ICU/01
Dose Weight: 86kg (11/27/2017 09 35) Actual Weight: 85.8kg (11/27/2017 0	9:35) Aller	gies: Latex				
Vitals, CV, Neuro, Infusions (12 hr)		1/O (3 day)				2
Viet Saw 13 (RCM77045	0	* Not (ml.)	11/26	11/27	11/28*	Range totr
Image: Space of the state of the s		4,000 3,000 2,000 1,000 -1,000 -2,000			-	Continuous Infusion Medication J Tube Feeding Nat Urine NG Tube Output
Image: solution of the	12:00	3,000 -4,000 * Indicates a day	07 00-06:59 without a full 24 hol	07:00-06:59 measurement period	07 00-06 59	- Stool ChestTube
№ - CVP [2/3] № № - PAS [20.30] № № - PAD [5/4] 25	*	Labs Blood Gases (Last 2	(in 24 hours)	* *	Respiratory Respiratory	
Blood Pressures (11/28/2017 00:55> Current)	2	Lab	11/28 08:35	11/27 20:05	PP	08:53
Aline SBP[110-120] MaxP[71-88] DRP (66-69 DRP (10-66-90 DRP	12:00	PO2 PCO2 HCO3 BE	79 1 39 23 1	791 37 22 1	SpO2 FiO2 Venblator	90 35% (8.53
Code Code Constante	III	Chemitry Lab	Latest	Previous	Mode TV Set	SIMV 700 690 ml

3 By hovering over the actual time interval, detailed clinical information will be displayed.



Note: Besides being able to view patient's clinical data during shift report and handoff, CareAware Critical Care can also be applied in rounds for clinical decision-making and care planning.

Key Learning Points

CareAware Critical Care provides critical patient information from multiple sources that helps providers and clinicians gain understanding of the patient's current condition. This helps providers and clinicians make clinical decision for treatment plan, etc.



ACTIVITY 2.5- Add an Individual Order and Modify an Existing Order

You have learned how to review and update your patient's information. One of the most important tasks is to manage orders and medications. This includes assessing, adjusting, and checking for duplicates and outdated orders. Your next step is to review the patient's current medications and orders and make necessary modifications.

In this activity, you will:

- Discontinue Ciprofloxacin
- Change Acetaminophen 650 mg PO QID to PRN
- Add piperacillin-tazobactam IV
- Add electrolytes panel, sputum culture and XR chest

When using Clinical Information System (CIS), there are recommended practices for manage medications better. When replacing a medication order with another or altering medication dosages, you should discontinue the current order and place a new one.

1 The first step is to stop the oral ciprofloxacin. In the Rounding tab, select **Order Profile** component and locate **ciprofloxacin** on the list. Select the check boxes next to these medications and click **Cancel/DC**.

Provider view										and the second s
M 🖹 🗄 🐘 🔍 🔍 100%	- 00	3								
Admission	EI Rour	ding		12 Transfer/Discharge	33 Quick Orders	14 +				
Informul Team Communication	Order P	rofile (54)								Selected voit 2
locuments (II)						1	Pending Orders	(54) Group by: Clinical Catego	y M Show: All Act	ive-Orders
Vital Signs & Measurements		40	7,04	Onlaw Infusion 100 mL Utratis, IV	* 100	Start				Cancel/DC Clier
uney Tubey Drams Physical Exam	Ξ	8	ð	norepinephrine additive 8 mg + di titrate, IV	extrose 5% (DSW) titratable influsion 250 mL	07/12/17 13:50		ciprofloxacin		
ntake and Output		18	0	sodium chloride 0.9% (NS) contin	uous infusion 1,000 mL 25 mi/h, IV	07/12/17 13:50		415p		
abi	4 Medica	Lions (14)					10			
Non Cultures				acetaminophen (TYLENOL) 975 a	ng, PO, QID	07/12/17 12:00		Dose	Route	Frequency
uthology	-	1	0	acetaminophen 650 mg, PO, g4h		06/12/17 10:00		490.000	**	drau
maging	3			ciprofloxacin 400 mg = 200 mL, i	200 mL/b, IV, q125	15/12/17 13:28		18.00		A second s
	0	18	8	folic acid 5 mg, TV; odaly		07/12/17 13:50		Inputient	Ordered	15/12/17 13:28
rder Profile (54)	0		ø	heparin 5,000 unit, subcutaneous	i, q12h	07/12/17 10:33				
ether Texture			0	HYDROmorphone (DELAUDED PRN	range dose) 1 mg, TV, q2h, PRN; pain	07/12/17 10:10		Perhapson Distances	0.0	90mm
movement and Ran	0	-	0	HYDROmorphone (HYDROmorpho	ne PRN range dose) 0.5 mg, TV, q5min, PRN: pain	08/12/17 09:11	13	TestUser, CriticalCare-Physician, M	and the second s	
and Onder Entry	1	Mar.	0	magnesium sulfate 5 g = 100 mil	, 33.33 mL/h, IV, once, PRN: hypomagnesemia	07/12/17 13:50		D	15/12/17 13:28	22/12/17 09:59
ien une cint		28		multivitamin (multivitamins inj) 1	0 mL, IV, gdaily	07/12/17 13:50	1			
Create Note		100	0	potassium chloride 40 mmol, NG	tube, TID, PRN: hypokalemia	07/12/17 13:50		Category.		
ICU Daily Progress Note		100	8	potassium chloride 20 mmol, IV.	q30min, PRN: hypokalemia	07/12/17 13:50		Medications		



2 Now, do the same for Acetaminophen (Tylenol) 650mg PO QID and click Cancel/DC.

Note: The **Orders for Signature** icon is now green and displays the number of orders currently waiting to be reviewed and signed.

Adminion	12 Rounding	11 Transfer/Discharge	31 Quick Orders	21 +	2 / =-
Informal Team Communication	Order Profile (53)				Selected voit 🔁 💷

3 The third step is to place new orders. Go to your **Quick Orders** tab and select the new orders:

Admission Cardiology				
Enformation Enformation Conduct Hodore Conduct Prequent Conditions	Analogicia: Additional Analogicia:	A Biosthork Routes CoC and Differential Block data(for 3 for Biost-back Paral (Block, CL), CLO, Anton Gao), Block, Block, Biost-back Paral (Block, CL), CLO, Anton Gao), Block, Block, CostRome Level Block, Cathory for 3 day Characteres Random Block, Block, Block, Biost, Block, Block, Block, Block, Biost, Block, Biost, Block, Biost, Biost,	ECG Schooldragspan, d38; XR OHet fraction XR Address Status XR Address Strate XR Address Strate XR Address 2 Views Strate School 2 Views Strate School 2 Views Strate School 2 Views School 2 Vi	Consolts Patient Care Patient Care Code Status Consumication to Nursing Code Status Communication to Nursing Code Status Code



4 Expand the Antimicrobial group within the Medications column header. Select the **piperacillin-tazobactam 3.375 g IV q6h**.

Admission	23 Rounding	23	Transfer/Discharge	23	Quick Orders	23	
Venue: Inpatient ~							
PowerPlans	=•	Medications		≡•⊙	Labs		
Admission		Analgesics			Blood Products / Transfusion		
► Neurology		Antiarrythmics			Bloodwork Routine		
Respiratory		Anticoagulants			Bloodwork STAT		
▶ Trauma		► Antiepileptics	Antiepileptics			Microbiology	
Management		Antihypertensives/R	Antihypertensives/Reta Blockers				
Comfort Care / Death		⊿ Antimicrobials	⊿ Antimicrobials				
		acyclovir 10 mg/kg, IV,	g8h, drug form: inj		Fluid Analysis		
Frequent Conditions	Frequent Conditions =• 😞		ampicilin 2.000 mg. IV. q/h				
		azithromycin soo mg, i	IV, qdaily				
 Decreased Level of Consciousne 	55	CEPAZOIIN 1.000 mg. IV	, q6h				
 Increased Intracranial Pressure 		ceFA20ID 2,000 mg, IV	, gin				
Cerebral Vasospasm		cefTRIAXone 2.000 mp	cefTRIAXone 2.000 ms. tv. don				
Acute Coronary Syndrome/Ches	t Pain	cefuroxime 750 mg. IV	, g8h				
 Arrhythmia 		ciprofloxacin 400 mg. t	V, q12h, drug form: bag				
Heart Failure/Pulmonary Edema		clindamycin 900 mp. IV	clindamycin 900 mg. IV. g8h				
 Severe Hypoxemic Respiratory Failure 		fluconazole soo mg. IV	fluconazole 600 mg. IV. once. drug form: bag				
Hypercarbic Respiratory Failure		fluconazole 400 mg, IV	fluconazole 400 mg, IV, q24h, drug form: bag				
Pulmonary Embolism		linezolid 600 mg. IV. q1	linezolid 600 mg. IV. q12h, drug formi bag				
Liver Failure		meropenem 500 mg, I	7, q6h				
Abdominal Pain/Distention		metroNIDAZOLE 500	ng, IV, q5h, drug formi bag				
Refeeding Syndrome		micarungin 100 mg, tV,	micarungin 100 mg, IV, qdaly				
• GI Bleed			piperacilin-tazobactam 3.375 g. tV, geh				

- 5 Continue adding the following orders:
 - Electrolytes Panel under Labs > Bloodwork Routine
 - **Sputum Culture** under Labs > Microbiology
 - XR Chest under Imaging and Diagnostics > XR
 - Acetaminophen under Medications > Analgesics

Note: If you cannot locate an order under your folders, the New Order Entry component can be expanded.

Rounding	23 Quick Orders	23 Transfer/Discharge 23 C	autpatient Chart 🛛 🕹 🕂	• •••••
0	Medications	Labs 👘 🔿	Tmaging and Diagnostics	New Order Entry 🕴 👘 🔿
	Analgesics	Bloodwork Routine	▶ ECG	Inpublient .
	Anticoagulants	Bloodwork in Morning.	Echocardiogram	
	► Antiemetics	Bloodwork STAT	► XR	Q Search New Order
	Antihypertensives	Microbiology	•ст	Personal Public Shared
	Antimicrobials	Stool Studies	▶ US	Counciliant Council and Counciliant
	Beta Blockers	Unine Studies	▶ MR	Parolices
	Bronchodilators	Fluid Analysis	▶ IR	😡 My Plan Favorites
	Conticosteroids	Blood Products / Transfusion	C	G Med Favorites
	Diuretics			G Referrals
	Electrolyte Management			d tabantan
	Gastrointestinal Agents			Canal and A



6 Once all the orders are selected, click Orders for Signature [27] icon.

In the Orders for Signature box, click **Modify** to make adjustments to order sentences and/or complete mandatory fields.

Alternately you can click **Sign** and if there are missing required details you will be brought to the scratchpad to complete them.

7 You will be prompted to add missing order details that are required. In our example, you need to add the reason for the chest x-ray. Go ahead and type in the **Reason for Exam.**

Orders for Signature							
🔊 🕐 🖳 🕅 Order Name Sta	atus Start	Details					
△ LGH 4W; 405; 04 Enc:7000000016209 Ac	dmit: 07-Dec-2017 08:39 PST						
△ Medications	15 Dec 2017 14:00	SEO and NC table of h DBN and data form table start 15 Day 2017 14:00 DET Assisting and an	and the sector is a Destinition in LCEPD (sector sector				
Diperacillin-tazobactam Or	rder 15-Dec-2017 14:09	IS-Dec-20171430 b00 mg, NG-tube, q4h, PKN pain, drugtom: tab, start: IS-Dec-201714309 PS1, Aspiration pneumonia Hypertension Dyslipidemia GERU (qastroesphageal reflux disease) IS-Dec-20171409 3125 a) V dbh start IS-Dec-201714309 PS1 cmix (Hao Percentral Integration pneumonia) Hypertension Dyslipidemia GERU (qastroesphageal reflux disease)					
△ Laboratory		4 · · · 4 · · · · · · · · · · · · · · ·					
🔲 🛃 🕃 Electrolytes Panel (Na Or	rder 15-Dec-2017 14:09	Blood, Urgent, Collection: 15-Dec-2017 14:09 PST, gdaily for 3 day					
A Disence the second se	E Brance Control Contr						
XR Chest Or	rder 15-Dec-2017 14:09	15-Dec-2017 14:09 PST, Urgent, Transport: Portable					
Details for XR Chest							
Details Order Comments							
🕇 🖀 In. 🔍 🎽							
*Requested Start Date/Time: 15-Dec-2017	🔹 💌 1409	PST *Priority:	Urgent 🗸				
*Reason for Exam:		Special Instructions / Notes to Scheduler:					
Provider Callback Number:							
Pregnant: 🔿 Yes 🤇	🗋 No	Transport Mode:	Portable 🗸				
Special Handling:	~	If Portable, specify reason:	×				
Other Reason for Portable:		CC Provider 1:					
CC Provider 2:		CC Provider 3:					
Order for future visit: 🔿 Yes 🤅	No						
1 Missing Required Details Orders For Cosignatu	ne			Sign	Cancel		



8 Next, display details for the sputum culture test. **Note:** For Unit Collect, **Yes** is preselected. This means that the unit collects the specimen and is responsible for printing the label and delivering the specimen to the lab. There is also an option to indicate if the specimen has already been collected.

Details for Respiratory (lower) Culture (Sputum C	ulture)
Details	
+ • III. 🔍 🔋	
Supervising Physician:	*Specimen Type: Sputum
Specimen Description:	Special Requests:
*Collection Priority: Routine	Unit Collect: 💽 Yes 🔿 No
Collected: 🔿 Yes 💿 No	*Collection Date/Time: 06-Oct-2017
*Frequency: once 🗸	Duration:
Duration Unit:	Order for future visit: 🜔 Yes 🌉 💿 No

- 9 Click **Sign** when you have completed all necessary details and you will be returned to the **Quick Orders** page.
- 10 If you would like to review all orders for your patient, click the **Order Profile** heading within the **Rounding** tab. Here you can review PowerPlans that have been initiated and those in a planned status. Orders are organized into different categories.

RNINGDEMO, JOHN						List 👘 Recent + 💷
RNINGDEMO, JOHN	D08/01-Jan-1970	MRN/7000	Code Status:Attempt CPR, Full (Code	Process	Location:LGH 4W; 405; 04
	Age:47 years	Enc/700000	0016209		Disease	Enc Typedopatient
pies: morphine	GenderMale	PHN298764	15442 Dosing Wt		Isolation:	Attending:Plisvca, Rocco, MD
Orders						(0, Full screen 🚔 Print 📀 D minut
Add 2 Document Medication by Hx Reconciliation	· Check Interactions					Reconciliation Status
Orders Medication List						
	н					
View		Distribution of Active Code	The process former the former of the pace			
Disfers for Vonature		34 × 17	Order Name	Status Dr	sie Details	
Madeal		a Medications				
CITI Admission Neurology (excluding Traumatic B	rain Iniural (Validated) (In	M	ciprofloxacin (Cipro 500 mg oral tablet)	Prescribed	1 tab, PO, g12h, order duration: 10 day, drug form: tab, d	ispense pty: 20 tab, refill(s): 0, start: 08-Dec-2017 09/26 PST, stop: 18-Dec-2017
Venous Thromboembolism (VTE) Prophylaxis (N	lodule) (Validated) (Initiat	M > 1 60.	HYDROmorphone (HYDROmorphone PRN range dose)	Ordered	dose range: 0.1 to 0.5 mg, IV, q5min, PRN pain, drug form DILAUDID EQUIV	n: inj. start: 08-Dec-2017 09:11 PST
ICU Insulin Infusion - Critical Care (Module) (Validate ICU Electrolyte Replacement (Module) (Validate	idated) (Initiated) ed) (Initiated)	N #860	ranitidine	Ordered	50 mg, TV, q8h interval, start: 07-Dec-2017 14:00 PST For ventilated patients	
Orden		N #844	magnesium sulfate	Ordered	5 g. IV, once, PRN hypomagnesemia, administer over. 180 Dose as per ICU Electrolyte Replacement protocol if creat	0 minute, drug form: bag, start: 07-Dec-2017 13:50 PST, bag volume (mL): 100 inine less than 150 urmol/L and urine output greater than 0.5ml/kg/hr for 2 consecutive hours:
Admit/Transfer/Discharge		M	potassium chloride	Ordered	40 mmol, NG-tube, TID, PRN hypokalemia, drug form or Dose as per ICU Electrolyte Replacement Protocol if creat	ral ling, start: 07-Dec-2017 13:50 PST inine less than 150 umol/L and urine output greater than 0.5ml/kg/hr for 2 consecutive hours:
C Patient Care		A	destrose 50% (destrose 50% inj)	Ordered	12.5 g. IV, q15min, PRN hypoglycemia, drug form: inj, sta For blood glucose 4 mmoUL or LESS: administer 12.5 g. (wt 07-Dec-2017 13:50 PST 25 mL) of dextrose 50% IV push and notify provider. Check blood glucose in 15 mins. 25 g = 5.
Diet/Nutrition		N	potassium chloride	Ordered	20 mmol, IV, gl0min, PRN hypokalemia, administer over Dose as per ICU Electrolyte Replacement Protocol if creat	: 30 minute, drug form: bag, start: 07-Dec-2017 13:50 PST inine less than 150 umol/L and urine output greater than 0.5ml/kg/hr for 2 consecutive hours:
Medications		M / 860	SCOUM phosphate	Ordered	15 mmol, IV, q4h interval, PRN hypophosphatemia, admir Dose as per ICU Electrolyte Replacement Protocol if creat	nister over 120 minute, order duration: 3 doses/times, drug form: bag, start: 07-Dec-2017 13:5 inine less than 150 urnol/L and urine output greater than 0.5ml/kg/hr for 2 consecutive hours:
Elood Products		1000°	heparin	Ordered	5,000 unit, subcutaneous, g12h, drug form: inj, start: 07-0	Dec-2007 10:33 PST
Caboratory		10 TO 2 60	HYDROmorphone (DILAUDID PRN range dose)	Ordered	dose range 0.5 to 1 mg, 1V, q2h, PRN pain, drug form inj	, start: 07-Dec-2017 10:10 PST
Lungnoux reis		200	acetaminophen	Discontin	650 mg, NG-bube, g4h, drug form: tab, start: 15-Dec-2017	714:00 PST, Aspiration pneumonia Hypertension Dyslipidemia GERD (gastroesophageal ref.
Frocedures		1 1960°	ciprofloxacin	Discontin	400 mg, N, g12h, administer over: 60 minute, drug form:	bag, start: 15-Dec-2017 13-51 PST, bag volume (ml.): 200
cc Respiratory		1000	ciprofloxacin	Discentin	400 mg, IV, g12h, administer over. 60 minute, drug form:	bag, start: 15-Dec-2017 13:28 PST, bag volume (mL): 200
Alled Health		10 1940.	acetaminophen	Discentinu	650 mg, PO, q4h, drug form: tab, start: 08-Dec-2017 10:00) PST
Consults/Referrals		100 5 44		ed	Maximum acetaminophen 4 g/24 h from all sources	
Communication Orders		E 2000.	acetaminophen (TYLENOL)	Discontinu	975 mg, PO, QID, drug form: tab, start: 07-Dec-2017 1200	1PST
Couppies		d Inheritere			mannan actamophen e green north an active	
Non Categorized		A Laboratory	VRE Culture	Outward	Barbaron Routine Hall Collect Collection 07-Dec 2017	13.00 DCT musek for 5 mark
Medication History		·	The constru	Ordered	SPECIAL COLLECTION REQUIREMENTS: Please refer to a	pecific site Laboratory Test Manual.
Medication History Snapshot		 M Réf 	MRSA Culture	Ordered	Nares (5. aureus only), Routine, Unit Collect, Collection (17-Dec-2017 13:50 PST, gweek for 5 week
Reconciliation History				Sectore Co.	SPECIAL COLLECTION REQUIREMENTS. Please refer to a	pecific site Laboratory Test Manual.
Participant in the second	1	and the second				
Related Results		A Distant				
Formulary Defaits		Dates For Contemption				Paders For Track
Valuance Viewer		unues nu cosgnature				Lindert For Signat


11 Use the arrow I to collapse or expand the Navigator View on the left side for more screen space.



Key Learning Points

There are many ways to place a new order. Use the method that is the most convenient for your current situation.

To replace a medication, start by discontinuing the existing order and then place a new one.



ACTIVITY 2.6- Update Active Issues

Active Issues is one of the components on the Rounding tab. Now, you will add aspiration pneumonia post fall incident to your first patient's active issues.

For each issue documented under the Active Issues component, you can select the following descriptor:

- **This Visit** issue is a focus of the current encounter it is not shared between encounters and not carried over to the next encounter.
- Chronic issue is ongoing and can be active or resolved. Chronic problems are shared across encounters and carried over to the next encounter. Chronic issues will appear under Medical History.
- **This Visit and Chronic** is both and is carried over to the next encounter. Note the difference when adding Diagnosis versus Problems. Diagnoses are for the current encounter (reason for visit) and problems are chronic issues (i.e. medical, social, or others).

The diagnoses and problems recorded here will carry over from visit to visit, which builds a comprehensive summary of the patient's health record. Keeping a patient's problems and diagnosis up-to-date is important.

To add aspiration pneumonia to your patient's issues, select **This Visit** and begin typing aspiration pn.

Active Issues	Classification: Medical and Patient Stated 👻 $ $ All Visits $ $ $\ref{eq:alpha} $
	Add new as: This Visit + Q aspiration pn ()
Name 1 • Hypertension	Classifica Aspiration pneumonitis (507.0, J69.0) Medica Pneumonia, aspiration (507.0, J69.0)
2 • Dyslipidemia	Medica Oil aspiration pneumonia (507.1, 369.1)
COPD without exacerbation Tobacco use	Medica H/O aspiration pneumonitis (V12.69, 287.09) Medica
▶ Historical	Hx of aspiration pneumonitis (V10.16, P24.9) Hx of aspiration pneumonitis (V12.69, 287.09)
	Recurrent aspiration pneumonia (507.0, J69.0) Meconium aspiration pneumonia (770.12, P24.01)

2 You can also update problems as displayed in the workflow view:

tiv	e Issues	
Nam	e	
1	Aspiration pneumonia	
2	Hypertension	
3	Dyslipidemia	
	COPD without exacerbation	

• This visit diagnoses are numbered as primary, secondary, tertiary, etc. You can easily rearrange this order by clicking the digit and selecting a different number.



Actions		
This Visit	Chronic	
This Visit	Chronic	Resolve
This Visit	Chronic	Resolve
This Visit	Chronic	
This Visit	Chronic	Resolve

- You can change any diagnosis from this visit to a chronic problem or both by clicking the appropriate buttons.
- You can also click **Resolve** to move a problem to the Historical section.

3 Click the active issue to display more details. Without leaving this view, you can:

- Cancel this problem
- Type Comments
- Change the Status

Active Issues		Classification: Medical and P	Patient Stated Visits
		Add new as: This Visit - Q Problem name	
Name 1 • Aspiration pneumonia		This Visit Chronic C	ancel Modify Resolve
2 • Hypertension		GERD (dastroesophageal reflux disease)	
3 • Dyslipidemia		Gene (guod desophagea renar discuse)	
4 - GERD (gastroesophage	al reflux disease)	Condition ture This Visit and Chronic	
COPD without exacerb	ation	Consideration Medical	
Tobacco use			
Historical	Show Previous Visits 📃	Onset Date 05/12/2017	
		Status Active	
		Confirmation Confirmed	

For your practice, resolve GERD active issue. Remember to click the tab to collapse and remove the split screen.

Active Issues		Classification: Medical and Patient Stated + All Visits	3
		Add new as: This Visit + Q Problem name	
Name 1 - Aspiration pneumonia		This Visit Chronic Cancel Modify Reso	vive
2 - Hypertension		GERD (dastroesonbadeal reflux disease)	
3 * Dyslipidemia		OLIO (gustocsophugeur renux disease)	
4 · GERD (gastroesophag	eal reflux disease)	Condition have This Welt and Chanie	
COPD without exacert	ation	Condition type This visit and Chronic	
Tobacco use		Disanasis Tuna Admittina	
Historical	Show Previous Visits	Onset Date 05/12/2017	
		Status Active	
		Confirmation Confirmed	



5 To modify details, select the line and click **Modify** button.

For your practice:

- Add *lower back pain* as an active issue and change it to a chronic problem.
- Add *obesity* as chronic problem and resolve it.

Key Learning Points

- Use Active Issues to manage problems and diagnosis for patient's current visit
- This Visit refers to diagnosis or problems for this current hospitalization. Chronic refers to past medical history that may be active during this hospitalization or may have already resolved prior to admission.



ACTIVITY 2.7- Create a Progress Note and Use Auto Text Entry

Similar to the Admission tab, the Rounding tab also provides one click access to the most relevant note type. You already know how to remove sections or edit text. Now let's learn how to avoid entering repetitive information by using the auto text feature.

- From the list under Create Note, select ICU Daily Progress Note which will pull existing relevant information.
- 2 To activate a free text box under the **Objective** heading, type *,,med*. A list of auto text entries starting with "comma comma med" are displayed. Double-click on *,,med_pe_complete**.

🔹 🛉 Documentation
• Add 🔟 🔚 📝
U Daily Progress Note × List
Tahoma 🔹 👂 🔹 😹 🝓 🎼 📥 🧀 🛛 B 🖌 🖳 🖦 🗛 💼 🗮 🗮 🚳 📳
ICU Day #
Subjective me
phys _med_pe_complete *
med_pe_snort * med_ros_complete *
vita "med_ros_short *



3 The programmed auto text entry populates in the box. Edit this text to complete your note.

Subjective 🖃 🗵	
General: Alert and oriented x 3, no acute distress.	
Neck: Supple, non-tender, no carotid bruits, no lymphadenopathy, no goiter.	
Cardiac: Normal S1 &S2, no gallops, no murmurs, no rubs, normal JVP, no pedal edema.	
Respiratory: Good air entry bilaterally, no adventitious sounds.	
Musculoskeletal: No active joint tenderness or swelling.	
Skin: Skin is warm, dry and pink, no rashes or lesions.	
Neurologic: <u>CN</u> II-XII intact, motor 5/5, sensory intact, reflexes 2+, no cerebellar findings, normal gait.	

Auto text entries are shared across the organization helping to adhere to agreed standards. You can also create your own auto text entries. You will learn how to create auto text entries in a more personalized learning session.

Click Sign/Submit.

Key Learning Points

- Use auto text entries for commonly entered information
- Auto text entries shared between all providers help to maintain standards when documenting patient's care



ACTIVITY 2.8- Create a Procedure Note

While you are still in the Rounding tab, you need to document the procedure that you performed on this patient (i.e. insertion of CVC). It will be the same steps as Activity 2.6 except you select procedure note.

Note: When you click on **Select Other Note,** ensure to choose within the **Note Templates** in order for the correct document template to populate.

- **1** From the workflow component list under Create Note, click on **Select Other Note**.
- 2 In the mandatory Type field, click on the drop-down $\overline{\mathbf{v}}$ icon and select Critical Care Procedure Note.
- 3 In the **Search** field, type in **Proc** and it displays a list of notes under **Note Templates.**

Note: You can also scroll down to see what available templates are listed in the Note Templates.

d 2	• I n Documentation			(0) Put screen	20 mi
bit * Type Lid File: * Type Lid File: <th>4 💢 🎟 🔤 '</th> <th></th> <th></th> <th></th> <th></th>	4 💢 🎟 🔤 '				
Type Lis Far: Alon Pre- data Far: Alon Pre- data Far: Alon Pre- data Far: Pre- data Far: </th <th>Note × List</th> <th></th> <th></th> <th></th> <th></th>	Note × List				
Allow Inter Int	e Type List Filter:	All (67) Feverites (7)		prod 3	_
prince of the second se	uition 🔽				-
too Car Pocedue Note image: Car Pocedue Note image: Car Pocedue Note image: Car Pocedue Note Pocedue Note	Det C	"Note Templates			
	tical Care Procedure Note	Name -	Description		
and hote ter ter n. Orbital Const Physical (105)		Procedure Note	Procedure Note Template		
		Procedure Note - Short	Procedure Note - Short 4		
	ence Note	L			
** ** ** ** ** ** ** **					
	te.				
	8-Jan-19 1615 PST				
	thor:	÷			
	n, CriticalCere-Physiciard, MD	÷			
				00	G

4 Select Procedure Note Short.

Click **OK**. This will take you to the actual template.





5 To activate a free text box under the **Procedure Name** heading,, type ,,*cc*. A list of auto text entries starting with "comma comma cc" are displayed. Double-click on ,,*cc_cvc_insertion_sterile**.



6 For your practice, click **F3** on your keyboard. This will take your cursor to the very first underscore data entry. In this example, it will be **Location.** Press F3 again and this will take you to the next data entry.



For practice, type in a sentence in this document.

Click Sign/Submit once your documentation is complete.



ACTIVITY 2.9- Code Blue

In the event of a code blue, as a critical care provider, you have access to the Code Blue orders under the Quick Orders tab. Depending on the code blue situation, you can immediately enter the Code Blue orders at the time of the event. However, if entering orders at the time of the code blue event is not feasible, verbal orders may be given to the clinical staff involved in the direct patient care.

At the end of the code blue event, you will back enter orders as soon as possible as the patient's condition permits. For example, all continuous IV infusion, all adverse drug and intervention reactions during code, and ongoing medication orders, etc. Further examples are shown in the diagram below. Note that code blue medications that were administered only at the time of event (i.e. epinephrine) may not require you to back enter those orders.

Recommended data elements that should be back entered	Recommended Role responsible for entering data	When
All continuous infusion rates such as NS, D5W, Levophed, Insulin, Heparin entered into I&O	Clinicians	Back entry of data elements would occur as soon as possible as the patient's condition permits. Infusion informatio nwould be documented on the eMAR and in the IV drips section of iView
All Point of Care test results such as capilliary blood glucose, ABGs, electrolytes	Clinicians	Back entry of data elements not required if patient death occurs during the Code Blue. All POC enteries would be documented on the appropriate POC DTA in iView.
All Intake and output – NG losses, fluid boluses, urine output, emesis	Clinicians	Back entry of data elements would occur as soon as possible as the patient's condition permits.
All Adverse drug and intervention reactions during code	Shared by Provider and Clinicians	Back entry of data elements would occur as soon as possible as the patient's condition permits.
Orders – lab tests and ongoing medication orders (i.e. vasoactives, antibiotics, etc.)	Providers	Back entry of data elements would occur as soon as possible as the patient's condition permits.



The hard copy Code Blue record will be the source of truth which will be placed in the patient's chart-let. It is recommended that the time of the Code Blue event be a "flag" in iView with a comment of "Code Blue event see Code Blue Record" by the nursing staff. In addition to this flag, you, as a critical care provider, need to document the summary of the event in the **Resuscitation Note**. It is the same steps as **Activity 2.7**.

ew Note X List				
Note Type List Filter	AX (67) Favorites (7)		res	
Position	Note Templates			
"Type:	👷 Name -	Description		
×	General Surgery Progress/SOAP Note	General Surgery Progress/SOAP Note Template		
Title	CU Daily Progress Note	ICU Daily Progress Note Template		
Absence Note	Newborn Progress Note	Newborn Progress Note		
10-t-	08 Labour Progress Note	OB Labour Progress Note Template		
06-Dec-2017 3 1118 PST	1 Progress Note	Daily Progress Note		
Second and Second Second Second	Psychiatry Progress Note	Psychiatry Progress Note Template		
*Author: TextUse, CriticalCase Physician, MD	👾 Resuscitation Note	Resuscitation Note Template		

Note: For further details on back entry orders, refer to your hospital's policy and procedures.

In this activity, you will review the Code Blue component and look at each section to see what is available. At this point, you already have experienced entering orders under the Quick Orders tab. It will be the same steps when ordering Code Blue orders. Let's go ahead and practice.

Click **Quick Orders** tab and select the **Code Blue** component.

2

Click the expand icon to display the list under Lines/Tubes/Drains. To hide the list, simply click the same expand icon 4.

Code Blue ≡• ⊙
⊿ L nes/Tubes/Drains
Insert Peripheral IV Catheter large bore
RT to Insert Arterial Line
Insert Nasogastric Tube
Insert Orogastric (OG) Tube
Insert Urinary Catheter
Communication Order T;N, Transvenous Pacemaker to bedside



For more practice, click on all the remaining sections listed below:

Code Blue ≡• ⊙
∠ Lines/Tubes/Drains
Insert Peripheral IV Catheter large bore
RT to Insert Arterial Line
Insert Nasogastric Tube
Insert Orogastric (OG) Tube
Insert Urinary Catheter
Communication Order T;N, Transvenous Pacemaker to bedside
▶ Labs
► IV Fluids
▶ Imaging and Diagnostics
► Medications

3 Assuming that the code blue event is completed, you can now back enter orders for the following:

- Sodium chloride 0.9% (NS) continuous infusion
- Amiodarone Continuous Infusion (Module)

4 Once all the orders are selected, click **Orders for Signature** icon.

In the Orders for Signature box, click **Modify** to make adjustments to order sentences and/or complete mandatory fields.

Alternately you can click **Sign** and if there are missing required details you will be brought to the scratchpad to complete them.

5 Go ahead and add information in the missing order details for Amiodarone similar to what you did in *Activity 1.6 – Adding to Phase*.

Once completed, click Sign.

Note: When the nurse sees the above orders in the patient's chart, he/she will acknowledge the medication orders by indicating the time it was administered, not the time it was ordered.



Key Learning Points

In the event of a code blue, as a critical care provider, you have access to Code Blue Quick Orders

Where entry of orders is not possible during a code blue event, orders should be back entered as soon as possible.

A resuscitation note also needs to be completed post a code blue event



PATIENT SCENARIO 3- Transferring a Patient Within Internal Site

Learning Objectives

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

Complete patient transfer related tasks in the Clinical Information System

SCENARIO

Your patient has been in the ICU for several days now and has shown improvements. He remains hemodynamically stable and is more alert and awake. The receiving provider has accepted the patient upon your request for transfer back to the Medicine unit.

Transfer scenarios are difficult to recreate in a training situation as both internal and external transfers involve many health care professionals. Keeping this limitation in mind, you will complete the following activities:

Initiate a transfer from ICU to inpatient and place a **Bed Transfer Request** order.

Reconcile medication and non-medication orders at transfer of care.



ACTIVITY 3.1- Initiate Transfer from ICU to Inpatient Within Internal Site

Once the decision to transfer a patient is made by the provider, communication takes place outside of the Clinical Information System (CIS) to ensure proper transfer of responsibilities. It is important that the sending physician still discusses all aspects of care and shares any concerns with the receiving physician.

You notify the ICU charge nurse of the plan to transfer patient out of ICU to Medicine Unit. Note that this is a shared responsibility between you and other clinicians who have the ability to initiate a **Bed Transfer Request** order.



Place the Bed Transfer Order from the Quick Orders tab > Patient Disposition folder.

Labs =- 📀	Imaging and Diagnostics 🔤 - 🕤	New Order Entry 🕂 📃 = 📀
Bloodwork Routine Bloodwork in Morning	► ECG	Consults ≡• ⊙
Bloodwork STAT	► XR	Patient Care =• 📀
Microbiology Stool Studies	► CI ► US	✓ Patient Disposition
Urine Studies Fluid Analysis	► MR ► IR	Admit to Inpatient Admit to General Internal Medicine Channe Attending to Dedite Second
Blood Products / Transfusion		Bed Transfer Request Discharge Patient
		Discharge to External Site Patient Deceased
		Nurse May Pronounce Death Exception to Transfer
		Code Status Activity

2 In the **Orders for Signature** window, click **Modify** to add details that you think are necessary:

- Name of the new attending provider
- Bed type
- Medical Service
- If patient has been accepted by the new provider



A Document Medication by Hx Re	conciliation *	🛛 🚴 Check Inter	ractions				Reconciliation St Meds History	Admission	\rm \rm Discha
Medication List Document In Plan									
ders for Signature									
8 ⑦ □ ♥ Order Name	Status	Start	Details						
LGH ED Hold; AC; 204 Enc:70000000	13214 Adm	it: 07-Nov-2017	13:13 PST						
Admit/Transfer/Discharge									
🔜 🤔 🛛 Bed Transfer Request	Order	06-Dec-2017 0	8:56 06-Dec-2017 0	8:56 PST, Admit to General I	nternal Medicine, New	attending providen T	estDEMO, GeneralMed	icine-Physician	L MD, Nev
Details for Bed Transfer R	equest								
Details for Bed Transfer R Details () Order Comments) P Calls ()	equest								
Details for Bed Transfer R Details I Order Comments I Totalis I Order Comments I Totalis I Order Comments I I 2007	oquest	0856	PST		Medical Service:	General Internal Med	licine v		
Details for Bed Transfer R Details I Order Comments Totals I Order Comments Total Start Date/Time: 12/06/7 New Attending Provide: Tet DE	oli7	edicine Physi	PST	New Attendi	Medical Service:	General Internal Meta	iten:		
Details for Bed Transfer R Details I Order Comments Paralle I Order	oli7	edicine-Physi	PST	New Attendi	Medical Service: ng Provider Accepted:	General Internal Med	ficine) ×		
Details for Bed Transfer R ¹ Details III Order Comments ¹ Context ¹	oli7	edcine-Physi 💽	PST	New Attendi	Medical Service: ng Provider Accepted: Telemetry:	Seneral Internal Med Yes No Yes No	licinic) v		
Details for Bed Transfer R Details III Order Comments Totalis The construction of the second seco	017 10. GeneralM	edcine-Physi Q	PST	New Attendi	Medical Service: ng Provider Accepted: Telemetry:	Seneral Internal Med Yes No Yes No	ficine v		

Click **Sign** to complete the process.

Key Learning Points

- The **Bed Transfer Request** order initiates the process of searching for a bed. It also allows for identifying new medical service and transferring responsibility of care.
- Verbal communication between units is critical.



ACTIVITY 3.2- Reconcile Medication and Non-Medication Orders at Transfer of Care Within the Site

When transferring a patient to an acute inpatient area within the site, all current medications and orders must be reconciled.

The transfer medication reconciliation is similar to the admission reconciliation; however, it also includes **non-medication orders**. In the Clinical Information System (CIS), this task may be performed as many times as necessary, including whenever the patient is transferred.

The critical care provider is the one responsible for planning transfer medication reconciliation when the patient is being transferred out of the critical care area. The receiving provider will review and sign it to initiate orders once the patient has arrived to their new unit/patient care area.

When your first patient is being transferred back to the Medicine Unit, the Critical Care provider plans the transfer reconciliation.

The transfer reconciliation displays all orders, not only medication orders. On transfer within the hospital, you can continue orders that are already in place. This allows for safe and effective transfer of care. It works the same way as admission and discharge reconciliation.



In the **Transfer/Discharge** tab, locate the **Medication Reconciliation** component.

Click Transfer.

1

Administra	12 Rounding	11	Transfer/Discharge	20 Quack Orders	× +			
Order Profile (0)	Medication Reconciliation	m						S tev back
Medication Reconciliation							Status: ✔ Meds History ✔ Admissio	Transfer ODischarge
Descharge Order Entry	Order					Order Start	Status	
Lober	4 Scheduled (0)							
Druzoino (8)	A Continuous (0)							
Hicro Cultures (2)	d PRN/Unscheduled Available	le (0)						
Pathology	4 Suspended (0)							
Discharge Diagnosis	 Discontinued (0) Last 24 hour 	15						

Note: You must reconcile every order and ensure to select which orders you want to continue or discontinue. Some group of orders will have an **All** button option; you may choose this if it is appropriate for patient care.

		WITH WITH A TRANSPORT AND A TRANSPORT				VINCIPITUS INCOMPANY	
0	38	Order Name/Details	Status			Order Name/Details	Status
⊿ P	atient	Care		ALL	ALL		
ê	•	Apply Full Leg Sequential Compression Devices 07-Dec-2017 13:55 PST, Apply to lower limb(s) continuously until anticoag	Ordered	0	0		
đ	• •	Braden Assessment 07-Dec-2017 08:44 PST, Stop: 07-Dec-2017 08:44 PST	Ordered	0	0		
e		Cardiorespiratory Monitoring 07-Dec-2017 13:50 PST, Remains on at all times	Ordered	0	0		
đ	b 🖻 (Critical Care Goals 07-Dec-2017 13:50 PST, MAP goal: 65 mmHg or greater. Sodium goal: 140	Ordered	0	0		
ê	•	Height/Length 07-Dec-2017 13:50 PST, once. Stop: 07-Dec-2017 13:50 PST, on admission	Ordered	0	0		
đ	•	CU Early Mobilization Goal	Ordered	0	0		

For your practice, continue all home and active medication orders by clicking the radio buttons in the Continue (Green Arrow) column.

Select the Do Not Continue (Red Box) radio buttons for all non-medication orders by using the ALL checkboxes at the top of each group of non-medication orders.

Note: Until you reconcile all orders, the **Sign** as well as **Plan** button will remain inactive. When the provider chooses **Plan**, his or her decisions remain saved in the Transfer Reconciliation window but orders and order changes will not be activated. Patient care is continued per current state orders until the transfer reconciliation is signed.



2 For our scenario, click **Plan**.



The status of planned transfer reconciliation is **partial pending** indicated by 💱 icon.



The receiving provider reviews orders and makes decisions to continue, discontinue, or add orders. The receiving provider will Sign once the orders have been reviewed. Sometimes it might be appropriate to stop all current orders and place new ones.





PATIENT SCENARIO 4- Discharging a Patient

Learning Objectives

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

- Complete discharge steps, reconcile orders and medications.
- Update discharge diagnosis.
- Complete discharge documentation.

SCENARIO

This activity may not be relevant to your current critical care setting. However, if you are covering at other areas within the hospital where you do get to discharge a patient home, you have this tool to guide you on how to do so.

In this activity, you will complete the necessary steps and following activities for patient discharge:

- Review orders
- Reconcile medications at discharge and create prescriptions
- Place a 'Discharge Patient' order and future order
- Update discharge diagnoses
- Discharge patient to external site
- Complete discharge documentation



ACTIVITY 4.1- Review Orders

You can use Patient Overview to communicate with other providers about the patient's status. Although it does not create any action items, it serves as a communication tool during patient handoff. It provides a snapshot of patient's status and also helps you manage your work:

- You can see where the patient is located: unit / room / and bed number
- You can make a note of patient's illness severity
- You can see the discharge status
- You can track medication reconciliation completion



You can select a patient list and click a column heading such as Location to display all patients in the same unit together. Clicking Patient Information will place names in alphabetical order.

Patient Overview also displays a snapshot of patient status under the **Illness Severity** column. You can easily add or change your patient status by clicking the corresponding space under this column and selecting one of the options from the list. You can click the column heading to sort all patients.



1 To begin the process of discharging the patient, locate your second patient from the Attending Provider list under Patient Overview and mark the illness severity as discharging. Then open the patient's chart by selecting the patient name.

	o. 4			
Patient Overview	• @ +			
List: Hospitalist (15) Group by: Non	e 🔻 🛛 Add Patient			
Patient Information	Location	Illness Severity	Dis	Medica
LEARNINGDEMO, JOHN 47 yrs M DOB: Jan 1, 1970	LGH 4W 405 - 04	-		~~0
*SCOTT-LEARN, MARY 72 yrs F DOB: Mar 7, 1945	LGH 3W 321 - 01B	Illness Severity	R	~00
*SCOTT-LEARN, MARY 72 yrs F DOB: Mar 7, 1945	LGH OCC MDC	Watch Stable	R	000
*TEST, CSTPRODBC 15 m F DOB: Aug 16, 2016	LGH 3E	• Uischarging	ſ	× 0 ×

Note: The screenshot may not be similar as your current screen.

2 In the **Discharge/Transfer** tab, navigate to the **Order Profile** component.

ission	23	Rounding	🕄 Transfer/Disch	narge 🛛 🕅	Quick On	ders	23 +		• /
Order F	Profile (58)						L	Selected visit	2 ≡-
		Pending Or	ders (58) Group b	oy: Clinical Categ	jory 🔽	Show: All Active	Orders		V
	Type	Order		Start	Status	Status Updated	Ordering Provider		
⊿ Admit	/Transfer/Discha	arge (1)							4
	0	Admit to Inpatient 08-Dec-20 to Critical Care, Admitting prov CriticalCare-Physician, MD	17 08:56 PST, Admit vider: TestUser,	08/12/17 08:56	Ordered	08/12/17 08:56	TestUser, CriticalCare- Physician, MD		
⊿ Status	(1)								
	• @•	Code Status 07-Dec-2017 13: CPR, Full Code, Perioperative : Full Code, During chemothera	50 PST, Attempt status: Attempt CPR, py: Attempt CPR,	07/12/17 13:50	Ordered	07/12/17 14:14	TestUser, CriticalCare- Physician, MD		



3 Review patient's orders to be aware of any outstanding lab or imaging orders. Visual cues provide additional information.

			Pending Orders (58) Group	by: Clinical Cate	gory 🔽	Show: All Active	Orders	×
		Type	Order	Start	Status	Status Updated	Ordering Provider	
⊿ Adı	nit/Transfe	er/Discha	arge (1)					-
			Admit to Inpatient 08-Dec-2017 08:56 PST, Admit to Critical Care, Admitting provider: TestUser, CriticalCare-Physician, MD	08/12/17 08:56	Ordered	08/12/17 08:56	TestUser, CriticalCare- Physician, MD	
⊿ Sta	tus (1)							
	28	()	Code Status 07-Dec-2017 13:50 PST, Attempt CPR, Full Code, Perioperative status: Attempt CPR, Full Code, During chemotherapy: Attempt CPR, Full Code	07/12/17 13:50	Ordered	07/12/17 14:14	TestUser, CriticalCare- Physician, MD	
⊿ Pat	ient Care (20)						
	9	0	Admission History Adult 07-Dec-2017 08:44 PST, Stop: 07-Dec-2017 08:44 PST	07/12/17 08:44	Ordered	07/12/17 08:44	SYSTEM, SYSTEM Cerner	
	28	0	Apply Full Leg Sequential Compression Devices 07-Dec-2017 13:55 PST, Apply to lower limb(s) continuously until anticoagulant prophylaxis starts	07/12/17 13:55	Ordered	07/12/17 14:14	TestUser, CriticalCare- Physician, MD	

Note: No manual action is required to stop orders at discharge. When a patient physically leaves the unit and is discharged from the system by the unit clerk or nurse, their encounter becomes closed. This will automatically discontinue their orders. Any orders to be completed in the future or orders with pending results that you have placed prior to discharge will remain active.

Key Learning Points

Outstanding orders are automatically discontinued after discharge except for future orders and orders with pending results



ACTIVITY 4.2- Reconcile Medications at Discharge and Create Prescriptions

Now that you have reviewed the current orders, you are ready to complete your discharge medication reconciliation. The list of medications to reconcile includes:

- **Home Medications** medications that the patient was taking at home prior to admission. These medications were documented with BPMH but were not continued during the hospital visit.
- Continued Home Medications- medications the patient was taking at home prior to admission and continued during this admission. Note that this section clearly highlights which medications were substituted by an equivalent hospital formulary medication. Substitutions are marked by icon. The home medication and the substituted medication will appear together in the medication list. In this case the home medication, lisinopril, is listed above the substituted medication, trandolapril.
- Medications new medications that the patient started during this inpatient stay.
- **Continuous Infusions** -inpatient fluids and medications that were given by continuous infusion. (Note: These cannot be continued in the Discharge Medication Reconciliation tool).

You will determine which home medications and inpatient medications your patient should continue after discharge. Continued medications will be carried forward and available as documented home medications within the patient's medication history. This will be viewable at the patient's next visit.

You can also create a prescription for the existing or new medications directly in the reconciliation screen.

ARNINGDEMO, JOHN 🔳						List	Recent - Name
ARNINGDEMO, JOHN	DOB:01-Jan-1970 Age:47 years Gender:Male	MRN:700008684 Enc:7000000016209 PHN:9876415442	Code Status:Attempt CPR, Full Code	Proc Disea Isolat	ess: ase: tion:	Locati Enc Ty Attend	on:LGH 4W; 405; 04 be:Inpatient ing:TestUser, CriticalCare-Physic
< > - A Provider View						D Normal view	Print 21 hours 26 minute
🗚 🖹 🖓 🐘 🔍 🔍 100%	• 😋 📾 🖾						
Admission	었 Rounding	٤	Transfer/Discharge	23 Quick	Orders	8 +	
Order Profile (S8) Discharge Order Entry	Medication Rec	onciliation					Selected visit
Medication Reconciliation					Status: ✔ Med	s History Admissio	n Transfer S Discharge
Documents (0)	Order	avt 12 hours			Order Start	Status	
Labs	acetaminophen 6	50 mg, PO, q4h			Today 10:00	Ordered	1
Imaging (0) Micro Cultures	acetaminophen (T	YLENOL) 975 mg, PO, Q	ID		Yesterday 12:00	Ordered	1
Pathology	ciprofloxacin 400	mg = 200 mL, 200 mL/h	, IV, q12h		Today 10:00	Ordered	í l
Discharge Diagnosis	heparin 5,000 uni	t, subcutaneous, q12h			Yesterday 10:33	Ordered	1
Hospital Course	ranitidine 50 mg,	IV, q8h interval			Yesterday 14:00	Ordered	£
Procedures and Treatment Provided	⊿ Continuous (5)						

Navigate to the Medication Reconciliation component and click Discharge.

3



2 The reconciliation window displays the current status of medications.

ergies	s: m	orph	Age:47 years Enc:70000 hine Gender:Male PHN:9876	000 415 Dosing V	Vt:	uemp	L CFIX	. rui	Dis Iso	sease: plation:	Enc Type:Inpatie Attending:TestL	ent Jser, Critical
Add		Mana	age Plans							Recon	ciliation Status ds History ✔ Admissio	n 😗 Discha
D	1 12		Orders Prior to Reconciliation	Onlar	E.	T.		ER.	17	Orders After	Reconciliation	Chatur
- 11	1 1		Porder Name/Details	Status		-		177	1.8	Order Name/Details		Status
0 H	ome	Med	atenolol 50 ma, PO, adaily, for 30 day, 30 tab, 0 Refil	Documented	0	0	0					
9	° C)	atorvastatin (atorvastatin 10 mg oral tabl. 1 tab, PO, qdaily, 30 tab, 0 Refill(s)	Documented	0	0	0					
9	C		clonazePAM 1 mg, PO, BID, for 15 day, 30 tab, 0 Refill(s)	Documented	0	0	0					
9	0	•	lisinopril (lisinopril 5 mg oral tablet) 1 tab, PO, qdaily, 30 tab, 0 Refill(s)	Documented	0	0	0					
4 0	ontin	ued	Home Medications									
9	G		ranitidine 150 mg, PO, qHS, for 30 day, 30 tab, 0 Refill.	Documented	0	0	0					
Ĉ	þ 🖭	0	ranitidine 50 mg, IV, q8h interval	Ordered	0	0	0					
AM	ledic	ation	ns			1						
đ			acetaminophen 650 mg, PO, q4h	Ordered	0	0	0					
e			acetaminophen (TYLENOL) 975 mg, PO, QID	Ordered	0	0	0					
e		-	ciprofloxacin 400 mg = 200 mL, 200 mL/h, IV, q12h	Ordered	0	0	0					
e		0	dextrose 50% (dextrose 50% inj) 12.5 g, IV, q15min, PRN: hypoglycemia	Ordered	0	0	0					
	b (2*	0	folir acid	Ordered	-	-	-					

For **Home Medications** that have been stopped while in hospital, select which ones the patient should stop taking permanently and which ones the patient should return to taking at home.

EAF	RN gie	NINGD	EMO, JOHN DOB:01-Jan-1 MRN:70000 Age:47 years Enc:700000 phine Gender:Male PHN:98764	086Code Sta 100 15 Dosing V	itus:A	ttempl	CPR,		Diseas	is: Location:LGH ie: Enc Type:Inpati on: Attending:Test	4W; 405; 04 ient User, Critical(
Ad	Id	Ma	nage Plans							Reconciliation Status Meds History Admission	on 🔒 Discha
<u> </u>	1	B 17	Orders Prior to Reconciliation	Chattage		Ξ.		DR.	87	Orders After Reconciliation	Chature
	-	7 4	didei Name/ Details	Status	-	H ⁶		-1			Status
4	-	S.	atenolol 50 mg, PO, qdaily, for 30 day, 30 tab, 0 Refil	Documented	۰	0	0	3	ł	atenolol 50 mg, PO, qdaily, for 30 day, 3 < Notes>	Documented
	8	3	atorvastatin (atorvastatin 10 mg oral tabl 1 tab, PO, qdaily, 30 tab, 0 Refill(s)	Documented	۲	0	0	3	ء ر	atorvastatin (atorvastatin 10 mg oral tabl 1 tab, PO, qdaily, 30 tab, 0 Refill < Notes >	Documented
	4	<i>a</i>	clonazePAM 1 mg, PO, BID, for 15 day, 30 tab, 0 Refill(s)	Discontinue	0	0	۲				
		S.	lisinopril (lisinopril 5 mg oral tablet)	Documented		0	0	3	1	lisinopril (lisinopril 5 mg oral tablet)	Documented



4 For **Continued Home Medications**– continue all of the patient's documented home versions of the medications listed below and discontinue inpatient versions of the same medications including trandalopril which was a substitution.

		1 tab, PO, qaauy, 30 tab, 0 kejuu(s)			1			1 tab, PO, qaaliy, 30 tab, 0 kejill < Notes >	
⊿	Continued	Home Medications							- E,
	G	ranitidine 150 mg, PO, qHS, for 30 day, 30 tab, 0 Refill	Documented	۲	0	0	C.	ranitidine Documented 150 mg, PO, gHS, for 30 day, 30 < Notes >	air
	()	ranitidine 50 mg, IV, q8h interval	Ordered	0	0	۲			4:0
⊿	Medicatio	ins					1		g f

Note: The patient discharge summary clearly identifies which home medications are continued and which must be stopped.

Patient Discharge Summary X List
Tahoma 🔹 🚺 🔹 😹 👔 🕤 🎓 I
Medications
Home Medications - Continue Taking
Medication
atenolol
atorvastatin (atorvastatin 10 mg oral tablet)
lisinopril (lisinopril 5 mg oral tablet)
ranitidine
Stop Taking the Following Home Medications
Medication
clonazePAM

5 Discontinue all inpatient medications.



6 Next, you will create a prescription for oral Cipro. Click the + Add icon to add ciprofloxacin once daily. Search for Cipro and select Cipro 500mg oral tablet, 1 tablet, PO, q12h, 10 day.

Search:	cipro 500	٩,	Advanced Options 👻 Type: 🛅 Discharge 👻					
-	Cipro 500 mg oral t	ablet						
	Cipro 500 mg oral t	ablet (1 tab,	PO, q12h, order duration: 10 day, drug form: tab)					
Dis	Cipro 500 mg oral t	ablet (1 tab,	PO, q18h, order duration: 10 day, drug form: tab)					
	Cipro 500 mg oral tablet (1 tab, PO, q24h, after completed dialysis, order duration: 10 day, drug form: tab							
	Cipro 500 mg oral t	ablet (10 mg	J/kg, PO, q12h, order duration: 10 day, drug form: tab)					
	Cipro 500 mg oral t	ablet (15 mg	y/kg, PO, q8h, order duration: 10 day, drug form: tab)					
	Cipro 500 mg oral tablet (15 mg/kg, PO, q12h, order duration: 10 day, drug form: tab)							
	Cipro 500 mg oral tablet (20 mg/kg, PO, q12h, order duration: 10 day, drug form: tab)							
	Cipro 500 mg/5 mL	oral liquid						
	Cipro XL 500 mg or	al tablet, ext	ended release					
	ciprofloxacin (500 n	ng, PO, BID,	order duration: 7 day, drug form: tab, dispense qty: 14 tab)					
	ciprofloxacin (500 n	ng, PO, qdai	ly, order duration: 7 day, drug form: tab, dispense qty: 7 tab)					
	ciprofloxacin 500 m	g oral table						
	ciprofloxacin 500 m	g oral table	: (1 tab, PO, q12h, order duration: 10 day, drug form: tab)					
	ciprofloxacin 500 m	g oral table	: (1 tab, PO, q18h, order duration: 10 day, drug form: tab)					
	"Enter" to Search							

Select Done



7 The Cipro prescription details appear. Complete any yellow, required fields.

Add	4 📴 M	lanage Plans								Reconciliati Meds Hi	on Status istory ✔ Admis	sion 🤤 Discl
		Orders Pri	ior to Reconciliation						0	rders After Reco	nciliation	
	38	Order Name/Details		Status				3	7 Order Nam	e/Details		Status
Δ	Home	Medications						1				la construction de la constructi
	6	atenolol 50 mg, PO, qdaily, for 30	day, 30 tab, 0 Refill(s	Documented	۲	0	0	3	atenolol 50 mg, PO,	qdaily, for 30 day,	30 ta < Notes	Documente
	3	atorvastatin (atorvastat 1 tab, PO, qdaily, 30 tab,	in 10 mg oral tablet 0 Refill(s)	Documented	۲	0	0	3	atorvastati 1 tab. PO. a	n (atorvastatin 1) daily, 30 tab, 0 Re	0 mg oral tablet) fill(s) < Notes f	Documente >
					۲	۲	۲	. 0	ciprofloxad 1 tab, PO, q	in (Cipro 500 mg 12h, for 10 day, 2	oral tablet) 0 tab, < Notes	
	3	lisinopril (lisinopril 5 mg 1 tab, PO, qdaily, 30 tab,	oral tablet) O Refill(s)	Documented	۲	0	0	9	lisinopril (li 1 tab, PO, q	sinopril 5 mg oral daily, 30 tab, 0 Re	tablet) fill(s) < Notes f	Documente >
Δ	Continu	ued Home Medications										
	3	ranitidine 150 mg, PO, qHS, for 30 d	lay, <mark>30</mark> tab, 0 Refill(s)	Documented	۲	0	0	C.	ranitidine 150 mg, PO	, qHS, for 30 day, .	30 tab < Notes	Document
	A 🗈	ranitidine		Ordered	0	0	0				_	
▼ Do	Details Details ose	Tor CIPTOTIOXACI	*Frequency	Duration	able •c	et) Dispens	se 30	90 *R	lefill		Send To: Sen	ect routing
	🔵 1 tab	PO	🔲 q12h	🥥 10 day	2	0 tab			• 0	🚽 🕈 🖬 In.	₽ ≈	
Г		PRN:		~								
		Special Instructions:										

Select the *Send To* drop-down. For training purposes, select Do Not Send: Other Reason. **Note:** printer selection is identified in this drop-down

8 As you are finalizing your review you remember the patient indicated they were almost out of their Atenolol at home and have asked for a new prescription for it.

	Or	ders Prior to Reconciliation						Orders After Reconciliation	
57	Order Name/Details		Status		D •		₿ Ÿ	Order Name/Details	Status
⊿ Home	Medications								
^a	atenolol 50 mg, PO, qdaily, for 30	0 day, 30 tab, 0 Refill(s)	Discontinue	0	۲	0	∎• ⊗	atenolol (atenolol 50 mg oral tablet) 50 mg, PO, qdaily, 0 Refill(s) < Notes for Patient >	Prescribe
J.	atorvastatin (atorvasta 1 tab, PO, qdaily, 30 tab	itin 10 mg oral tablet) o, 0 Refill(s)	Documented	۲	0	0	3	atorvastatin (atorvastatin 10 mg oral tablet) 1 tab, PO, qdaily, 30 tab, 0 Refill(s) < Notes for Patient >	Documented
				۲	0	0	۵.	ciprofloxacin (Cipro 500 mg oral tablet) 1 tab, PO, q12h, for 10 day, 20 tab, 0 Refill(s) < Notes for P >	Prescribed
J.	lisinopril (lisinopril 5 m 1 tab, PO, qdaily, 30 tat	g oral tablet) o, 0 Refill(s)	Documented	۲	0	0	4	lisinopril (lisinopril 5 mg oral tablet) 1 tab, PO, qdaily, 30 tab, 0 Refill(s) < Notes for Patient >	Documented
⊿ Contin	ued Home Medications								
¹	ranitidine 150 mg, PO, qHS, for 30	day, 30 tab, 0 Refill(s)	Documented	۲	0	0	3	ranitidine 150 mg, PO, qHS, for 30 day, 30 tab, 0 Refill(s) < Notes for >	Documented
i	Forme N/ - 9h interest		Ordered	0	0	۲			
🗹 Details 膏 🚫 Deta	ails Order Comment	s	tabletj *					Send For Do Not Send: of	
*Dose	*Route of /								
		administ "Frequency	Duration	*Di	ispense	30	90 *	Refill	
🔵 50 m	ig 🥥 PO	administ Frequency	Duration	*Di	ispense	<u>3</u> 0	90 •	Refill ♦ 0	
6 50 m	ig PO PRN:	qdaily	Duration	*Di	ispense k Spe	e 🔢	• 90 •	Refil ◆ 0	ŕ
9 50 m	ng PO PRN: Drug Form:	administ *rrequency	Duration	*Di	spense	e <u>3</u> 0 cial In:	truction	Refil ● 0	
🥥 50 m	PRN: Drug Form: *Start Date/Time:	administ "Frequency addity tab 18-Dec-2017	Duration	*Di	spense Spe	e <u>B</u> cial In:	truction	Refil ● 0	E
🥥 50 m	PRN: Drug Form: *Start Date/Time: Stop Date/Time:	tab 18-Dec-2017 r v 075	Duration	*Di	Spensor	cial In:	f Therap	Refil 0 + S In. B × 15: yr C Acute (Maintenance	E

Click on the radio button in the prescription column beside the Atenolol and complete the missing required field(s).



9 All medications must be reconciled to successfully complete the discharge medication reconciliation process.

Once all medications are reconciled, click **Sign** to complete discharge reconciliation. The presciption prints automatically.

Reconcile and	Plan	Sign	Cancel

Here's an example of a prescription:

	PRES	CRIPTION	
_			
Vancouver		Lions Gate Hospital	
CoastalHealth		North Vancouver, BC, V7L 2L7	
Promoting wellness, Ensuring care			
Patient Name: LEARN	INGDEMO, JOHN		
DOB: 1970-JAN-01 Age: 4	47 years Weight:	Sex: Male	PHN: 9876415442
Allergies: morphine			
Aller	er liet een he inservalete. I	Die een en deur uite netient een een ein	
Aller	gy list may be incomplete. I ek cards; dispensecards at	rease review with patient or caregiv t a time; Repeat	er.
[] Non-Safety vials [] Other			
Faxed to Community Pharmacy:		Fax:	
Faxed to Family Physician:		Fax:	
	If you received this fax in er	rror, please contact the prescriber	
Patient Address: 590 W. 8th Av	enue.	Home Phone: (778) 999-9999	
Vancouver, Br	itish Columbia	Work Phone:	
Canada			
Any narco	tic medications need a du	plicate prescription form to be co	mpleted
Over the	counter medications can be	filled on PharmaNet at patient's disc	pretion
Prescription Details:		Date I	ssued: 2017-DEC-18
atenolol 50 mg oral tablet			
SIG:	50 mg PO qdaily		
Dispense/Supply:	30 tab		
Cipro 500 mg oral tablet			
	1 tab PO q12h for 10 day	1	
516.	20 tab		
Dispense/Supply:			
SIG. Dispense/Supply:			
SIG. Dispense/Supply: Prescriber's Signature			
Prescriber's Signature TestPET, CriticalCare-Physi	cian, MD		
Prescriber's Signature Prescriber's College Number:	cian, MD TEMP000282		

Note: Narcotics prescriptions will continue to be written manually on the secure triplicate paper prescriptions.



A medication summary will be included in the Patient Discharge Summary as well as in the Discharge Summary.

Medications New Medications to Start Taking								
Medication	How Much	How	When	Reason	Next Dose	Additional Instru	uctions	1
ciprofloxacin (Cipro 500 mg oral tablet)	1 tablet	by mouth	every 12 hours			Stop Date: 18-DEC	-2017	1
Home Medications - Continue Taking								
Medication	How Much	How	When	Reason	Next Dose	Additional Instru	uctions	=
Medication atenolol	How Much 50 milligram	How by mouth	When daily	Reason	Next Dose	Additional Instru	ictions	
Medication atenolol atorvastatin (atorvastatin 10 mg oral tablet)	How Much 50 milligram 1 tablet	How by mouth by mouth	When daily daily	Reason	Next Dose	Additional Instru	uctions	=
Medication atenolol atorvastatin (atorvastatin 10 mg oral tablet) lisinopril (lisinopril 5 mg oral tablet)	How Much 50 milligram 1 tablet 1 tablet	How by mouth by mouth by mouth	When daily daily daily	Reason	Next Dose	Additional Instru	uctions	
Medication atenolol atorvastatin (atorvastatin 10 mg oral tablet) lisinopril (lisinopril 5 mg oral tablet) ranitdine	How Much 50 milligram 1 tablet 1 tablet 150 milligram	How by mouth by mouth by mouth by mouth	When daily daily daily daily at bedtime	Reason	Next Dose	Additional Instru	uctions	
Medication atenolol atorvastatin (atorvastatin 10 mg oral tablet) lisinopril (lisinopril 5 mg oral tablet) ranitidine	How Much 50 milligram 1 tablet 1 tablet 150 milligram	How by mouth by mouth by mouth by mouth	When daily daily daily daily at bedtime	Reason	Next Dose	Additional Instru	ictions	

Key Learning Points

- Medication Reconciliation on discharge includes both home and hospital medications
- Both home and inpatient medications can be converted into prescriptions during the discharge reconciliation process
- Discontinued medications become historically documented on the chart
- Continued medications and prescriptions will be captured in the patient's documented medication history and carried forward to the next visit
- Discharge medication information is included in notes provided to the patient and patient's lifetime providers on record



ACTIVITY 4.3- Place a Discharge Order and Future Order

The **Discharge Patient** order creates tasks informing the team that the patient is ready to be discharged. The order is also required by Hospital Act Regulation. After the patient physically leaves the hospital, the encounter can be closed.

However, the CIS provides you the ability to create future orders to be completed after the patient has been discharged. If a specimen is expected to be collected either at home or at an external facility, a printed requisition should be given to the patient.

For your first patient you decide to place a future order for a CT head scan with contrast. You also want to provide him with a referral to Neurology.

1 In the Transfer/Discharge tab, select **Discharge Order Entry** and select the appropriate order sentence. For our example, click **Order** to select **Discharge Patient without Support Services**.

Admission	23	Rounding	23	Transfer/Discharge	X Quick Orders
Order Profile (35)	Di	scharge Order En	try 🕂		
Discharge Order Entry	Inp	atient 🗸			
Documents (4)		Personal	Public	Shared	Search New Order
Labs		General Medicine	Orders		
Imaging (0)	_	General Frederic	010010		
Micro Cultures		Powerplans			
Pathology		Frequent Condit	ions		
Discharge Diagnosis		Medications			
Significant Findings		📄 Labs			
Procedures and Treatment		📄 Imaging and Dia	gnostics		
Provided		Consults			
Post Discharge Follow Up		Patient Care			
Discharge Disposition		Future Orders			
Hospital Course		Discharge Patient Disch	arged Home witho	ut Support Services	Order
Create Note		Discharge Patient Disch	arged Home with S	Support Services	Order
Discharge Summary		Bed Transfer Request 0			ı Order
Batiant Discharge Cummany	•				- Cruci



Orders for Signature (1)					X
				c	lear All
Click a cell to associate a diagnosis to an order. Click a diagnosis name to associate it to all orders	(369.0) Aspiration pneumonia	(I10.0) Hypertension	(E78.5) Dyslipidemia	(K21.9) GERD (gastroesophag	
Admit/Transfer/Discharge					
Discharge Patient (Discharged Home without Support Services)	1	2	3	4	-
Show Diagnosis Table			Sign Save	Modify Ca	ancel

2 To add a **CT head scan** as a future order, search the catalogue directly from the current component. Search and select the order from the drop-down.

Discharge Order Entry 🕂								
Inpatient 🗸								
A Personal	Public	Shared	CT head w/					
CT Head w/ + w/o Contrast CT Head w/ Contrast CT Head w/o Contrast								

Repeat steps to add the **Referral to Neurology**.

3 Click the Orders for Signature icon and then click Modify.

Note: Place the cursor over the individual order in the Orders for Signature window, and click \bigotimes on the right side to remove the order placed in error.

Orders for Signature (1)	2
Consults/Referrals	
Referral to Neurology	\otimes
Show Diagnosis Table	Sign Save Modify Cancel



4 Click the order to display **Details** and add missing required details.

Note: There are certain orders (i.e. pulmonary function test) where you need to check Yes for Order for

future visit. If this was the case, click the calendar icon and specify the date you would like the test to be completed. These details are to guide appropriate booking, not to book the actual test.

Orders for Signature						
🔊 😨 🖳 Ϋ Order Name	Status	Start	Details			
△ LGH 4W; 405; 04 Enc:700000013059	Admit: 03-N	Nov-2017 10:07 PDT				
⊿ Respiratory						
Pulmonary Function	Order	04-Dec-2017 12:38	04-Dec-2017, Routine, Order for future visit, 04-Dec-	2017		
△ Consults/Referrals						
Referral to Respirology	Order	04-Dec-2017 12:38	Future Order, 04-Dec-2017			
■ Details for Pulmonary Func	tion Tes	st Complete				
		•				
Details Order Comments						
*Requested Start Date/Time: 04-Dec-20	017 📮	🔹 1238 🍦	PST	Priority:	Routine	~
] [
*Reason for Exam:				Frequency:		_
					<u> </u>	
Notes to Scheduler:				Order for future visit:	🕒 Yes 🎦 🕕 No	_ I
				Scheduling Location:		v
				Series any Ebelief.	L	

You have an option to select different details recommending when the test should be completed or if it has to be repeated.

Select one of the options:

- One time test (single order) or recurring
- An approximate time from now
- An approximate time before a specific date
- Time range in days for a grace period
- Exact date

E Future Order Details							
Single Order CRecurring Order							
Future single order for Pulmonary Function Test Complete							
● In Approximately day 05-05-2017 ♠ week month Grace Period (+/-) ★ day	Sometime Before day week month						
 On Exactly The earliest date allowed is 2017-Oct-07. 							
LEARNTEST, PHY	S - 700006586 OK Cancel						

uture r	ecurring order for Pulmonary Function Test Complete
Every	day For day week week month month Grace Period (+/-) Image: Add the start First occurrence estimated start 06-Oct-2017



From the **Location** drop-down, you can select any location that is part of the system. For our example, select LGH PF Lab. In real life, the lab selected will be prompted to proceed with the order.

Details for Pulmonary Function Test Com	plete	
😭 Details 📴 Order Comments		
+ * In. IV		
Requested Start Date/Time: 06-Dec-2017	Priority:	Routine
*Reason for Exam: COPD	Frequency:	×
Notes to Scheduler:	Order for future visit:	💽 Yes 🋐 🔿 No
	Scheduling Location:	·
		(None)
		LGH PF Lab
		Paper Referral



For your practice, add missing details for the referral.

Orders for Signature	
⊗ (𝔅) 🖾 V Order Name Status Start Details	
△ LGH 4W; 405; 04 Enc:7000000013059 Admit: 03-Nov-2017 10:07 PDT	
4 Consults/Referrals	
Reternal to Neurology Order 04-Dec-2017 11:43 Future Order, 04-Dec-2017	
Referal to Neurology	
Notifications:	
Order details are not complete.	
- N. N. / Deferred to Neurology	
📸 Details 🔢 Order Comments	
*Scheduling Priority: Keferred To Provide:	
*Reason For Referral Emergent (less than 1 week) Notes to Scheduling:	
Urgent (less than 1 month)	
Routine	
As Determined by Provider	
As periodes	
Patient to call	
3 Missing Required Details Orders For Coolgnature	Sign Cancel

Fill in the following data:

- Scheduling Priority: Emergent (less than 1 week)
- Reason for Referral: type in "follow-up post fall"
- Location: Paper referral



6 Click **Sign** to complete the process.

Note: For locations that are not part of the CIS, the **Paper Referral** option is to be selected. Although the process remains on paper, placing this order in the CIS informs care providers for this patient that the specific referral has been placed.

🔦 Key Learning Points

- A **Discharge Patient** order documents the decision to discharge a patient (required by the Hospital Act Regulation) and informs Patient Registration.
- Future orders can be placed in the system and remain active after patient is discharged.
- You can easily place recurring future orders using appropriate options
- Selecting a specific location prompts individuals at the location that the order has been placed. Selecting Paper Referral indicates that the process remains manual but the order is captured in the patient's electronic chart.
- Future orders remain active after a patient's discharge



ACTIVITY 4.4- Complete Patient Discharge to an External Site

In the event that your patient requires a higher level of care (i.e. services not available at your current facility) or patient repatriation, patient transfer to another site may be necessary. For this activity, you will learn how to transfer your patient to another site.

You contact Patient Transfer Network (PTN) to identify the receiving provider and arrange for provider to provider communication. This action takes place outside of the Clinical Information System (CIS). In this example, a receiving provider has been identified and has accepted the patient. You completed handover and the patient is now ready to be transferred.

To proceed with transfer, you will discharge the patient from your site. It is not possible to complete this scenario in the classroom but you are familiar with the discharge process from previous activities.

When the receiving provider accepts the patient, you initiate the process of discharging your patient by placing a **Discharge to External Site** order.

FANI-LEARN, HOMA DO Allergies: Peanuts, acetaminophen, iodiGet Allergies: Peanuts, acetaminophen, iodiGet Add Document Medication by Hk Reconc. Drders Medication List Document In Plan View Orders for Signature Plans Document In Plan MED General Medicine Admission (P) RESP Exacethation of COPD (Module Suggested Plans (0)	B:1941-Apr-12 MRN:70 E:76 years Enc:700 ider:Female PHN:987 iliation * A Check Interaction iders for Signature A @ ① P Y Order Name G IGH 7E:724;02 Enc:7000 A dmit/Transfer/Discharge Checkis for Discharge C Details for Discharge C Details for Discharge	0005033 Cod 0000008064 6788092 Dosi ons ve Status 0000088064 Admit: to External Order e to External Order	e Status:Attempt CP ing Wt:70 kg Start 2017-Jul-25 12:23 P 2017-Aug-31 11	Details DT 0:042017-Aug-31	Process: Disease: Isolation:	Location:LGH 7E; 724; 02 Enc Type:Anpatient Attending:Test, Pet, MD Reconciliation Status Meds History Admission & Transfer V Disch
Add P Document Medication by Hz Reconci Orders Medication List Document In Plan View Orders for Signature Plans Document In Plan Medical MED General Medicine Admission (P) MED General Medicine Admission (P) RESP Faxerbation of COPD (Module Suggested Plans (0)	iliation * A Check Interaction inders for Signature (Amit/Transfer/Discharge Chetails for Discharge Contails for Discharge Contails for Discharge Contails for Discharge	ons Status 0000008064 Admit: to External Order e to External	Start 2017-Jul-25 12:23 P 2017-Aug-31 10 2017-Site	Details DT 2017-Aug-31	1 10:04 PDT	Reconciliation Status Meds History Admission 🖏 Transfer ADischa
View Orders for Signature Plans Decument In Plan Medical MED General Medicine Admission (P) RESP Exacerbation of COPD (Module Suggested Plans (0)	Iders for Signature (Content of the second	e to External	Start 2017-Jul-25 12:23 P 2017-Aug-31 10 al Site	Details DT 0:04 2017-Aug-31	L 10:04 PDT	
View Orders for Signature Plans Occument In Plan Medical MED General Medicine Admission (P) RED General Medicine Admission (P)	O P P Conternance Order Name Order Name Order Name Order Name Order Conternance Order Conternance Order Conternance Order Conternance Order Conternance Order Conternance	e to External	Start 2017-Jul-25 12:23 P 2017-Aug-31 10 al Site	Details DT 0:04 2017-Aug-31	1 10:04 PDT	
Orders for Signature Plans Document In Plan MED General Medicine Admission (P) RESP Exacerbation of COPD (Module Suggested Plans (0)	LGH 7E; 724; 02 Enc:7000 Admit/Transfer/Discharge Discharge Details for Discharge Details [im Order Comm	000008064 Admit: to External Order e to Externa	2017-Jul-25 12:23 P 2017-Aug-31 10 al Site	DT 0:04 2017-Aug-31	10:04 PDT	
Ordes Ordes Admit/Transfer/Discharge Status Status Status Status Diet/Nutrition Continuous Infusions Medications Blood Products Laboratory Diagnostic Tests Procedures Respiratory Allied Health Consult/Referrals Communication Orders	+ Sh. Special Instruction	e: 2017.4ug-31 by:	1004 • • • •	PDT	*Accepting Provider:	

Use one of the techniques you have learned before and place a **Discharge to External Site** order.



Key Learning Points

- When transferring your patient to an external site, you discharge the patient from the current site.
- Discharge to External Site order initiates the process of moving your patient to another site
- If the external site uses the same CIS, the patient chart is available for the receiving team
- If the external site uses a different CIS, paper-based documentation may still be required as per organizational procedures


ACTIVITY 4.5- Complete Discharge Diagnosis and Discharge Documentation

Continue to work through the discharge workflow on the Discharge Patient tab.

Review the following:



Using Dynamic Documentation, you will create the Discharge Summary. It will be distributed through Excelleris to the list of automatically included providers. You can also select other providers who should receive a copy. You can also prepare the Patient Discharge Summary to be printed for the patient by the nurse once completed and handed to the patient.

Confirm the Discharge Diagnosis:

1 Expand details for aspiration pneumonia to ensure it states that this is a discharge diagnosis and note the status. Select **Modify**.

Admission	23 Rounding	23 Transfer/Discharge	12 Quick Orders	≅ +	
Order Profile (57) Medication Reconciliation	Discharge Diagnosis			lassification: Medical and Patient	Stated - All Visits 2
Discharge Order Entry Documents (8)			Add new as: This Visit +	Q Problem name	
Labs Imaging (0)	1 Aspiration pneumonia	1	This Visit Chronic		Modify
Micro Cultures Pathology (0)	E 2 * Hypertension 3 * Dyslipidemia		Aspiration pneumonia		
Discharge Diagnosis Hospital Course	4 * GERD (gastroesopha COPD without exacer	geal reflux disease) bation	Condition type This Visit		
Procedures and Treatment Provided	Tobacco use		Diagnosis Type Admitting		
Physical Exam Post Discharge Follow Up Discharge Disposition	▶ Historical	Show Previous Visits	Onset Date Status Confirmation Confirmed		
Create Note					



Ensure the Diagnosis Type reflects *discharge*.

Diagnosis				La	erality		Respons	ible Provider	
Pneumonitis due to food and vomit		🐴 🗌 Free	: Text		•	TestUse	r, CriticalCare-Physician	r 🔍	
isplay As			*Clinica	al Service		*Date		Comments	
Aspiration pneumoni	la		Non-S	pecified	•	05-Dec-2017	-		
Туре	*Co	ofirmation	*Classi	ification		Ranking			
	and the second se	Anninacion	CIUST						
Discharge • Hide Additional D Additional Details	etais Secondary	y Description R	Medic	osis Related	• d Proc	edure	·		
Discharge Hide Additional D Additional Details Qualifier	Co Ietails Secondary	y Description R	Medic elated Diagn	al osis Related Sevenity	• I Proc	edure	•		
Discharge Hide Additional D Additional Details Qualifier	Co letals Secondary	y Description R Severity Class	Medic elated Diagn	osis Related	• i Proc	edure	•		
Discharge Hide Additional D Additional Details Qualifier Status	Co letait Secondary	y Description R Severity Class Certainty	Medic	osis Related Severity Probability	↓ i Proc	edure	-		

Note: You can add comments for better communication with other care team members.

Discharge Diagnosis	Classification: Medical and Patient Stated 👻 All Visits 🕏
	Add new as: This Visit + Q Problem name
Name 1 * Aspiration pneumonia	This Visit Chronic Modify
2 ▼ Hypertension 3 ▼ Dyslipidemia	Aspiration pneumonia
4 GERD (gastroesophageal reflux disease) COPD without exacerbation	Condition type This Visit Classification Medical
Tobacco use Historical Show Previous Visits	Diagnosis Type Discharge Onset Date Status
	Confirmation Confirmed



2 Start documenting patient's discharge by typing information under:

- Significant Findings
- Procedures and Treatment Provided
- Hospital Course (This component allows multiple providers to add text to it, making your job at discharge simpler as you will be able to see what others have entered through the patient's stay.)

Entries made in these components will auto-populate the appropriate sections in your discharge summary.

Remember that you can use auto text entry to speed up the process.



The Manage Auto Text window will appear.

/lanage Auto Text			- 8
My Phrases Public Phras	es Q. Search Auto Text	Edt Dupicate Delete	🔳 Show Auto Text Notifica
Abbreviation	▲ Description	Abbreviation Description	
"careplan	Care Plan		
"critical_nursingsummary	Critical Care Nursing Shift Summary	Auto Text Phrase	
"icu_rounds_checklist	ICU Rounds Checklist for Nurses		
"maid_assessments	Medical Assistance in Dying		
"maid_planning	Meidcal Assistance in Dying Contemplation a		
,,all_codestatus	Code Status Order		
,,all_mmse_score	Mini Mental Status Exam		
,,card_cardioversion	Cardioversion Procedure Note		
,,cc_arterial_line	ICU Arterial line		
,,cc_bronch	ICU Bronchoscopy Procedure		
,,cc_cardioversion	ICU Cardioversion Note		
,,cc_chest_tube_insertion	ICU Chest Tube Insertion Note		
Previous 1 2 3 4 5 13	Next		



- 3 Once you are ready to create discharge notes, click the note links provided under **Create Note**. There are two note links available there:
 - Discharge Summary create the note but Instead of clicking Sign/Submit, click Save & Close to finish the note later in the Message Centre
 - Complete the Patient Discharge Summary and click Sign/Submit when complete.

Note: The CIS will automatically send a saved document to your Message Centre. The document will be saved as a draft and will only be visible to you.

Key Learning Points

- A **Discharge Patient** order documents the decision to discharge a patient (required by the Hospital Act Regulation) and informs Patient Registration.
- Future orders can be placed in the system and remain active after patient is discharged.
- You can easily place recurring future orders using appropriate options
- Selecting a specific location prompts individuals at the location that the order has been placed. Selecting Paper Referral indicates that the process remains manual but the order is captured in the patient's electronic chart.
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Thank you for completing the Critical Care Provider workbook!

Please contact your instructor for your Key Learning Review.