

SELF-GUIDED PRACTICE WORKBOOK [N49]
CST Transformational Learning

WORKBOOK TITLE:

Provider: Emergency

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UNDERSTANDING YOUR WORKBOOK

This is a self-paced classroom; your workbook is designed to introduce you to different steps in the system. Your learning is organized into **Activities** and **Key Learning Points** that are based on **Patient Scenarios**.

You will receive scenarios for two patients in this workbook. Each scenario is intended to mimic various activities you perform in the Emergency Department. Some activities might be organized differently than your typical practice, however this is to build the skills needed to move to more complex activities.

Each activity contains a brief introduction and a series of numbered steps. Screenshots of the system will be included. Match the numbered steps with the numbers shown in the screenshot:

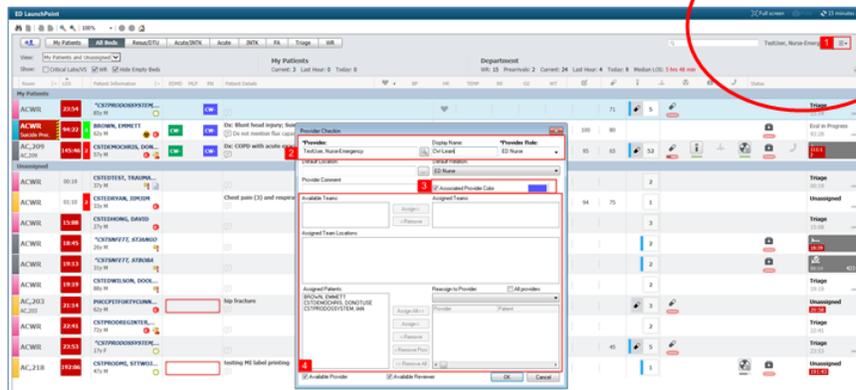
- 1 Check in is required at the start of shift.

After logging-in, you may receive an automatic prompt to Check In or you will need to do so manually.

1. To manually Check In, select the menu icon in the upper right hand corner of the ED LaunchPoint screen. Select **Check In**.
2. In the Provider Check In window, the Provider and Provider Role fields are automatically populated and should be reviewed. You are able to input a *Display Name* that can be seen by all users on ED LaunchPoint to easily identify which patients you are assigned to. Only the first three characters will be displayed.
3. You can *colour customize* the Display Name.
4. More fields are available to add further relevant details.

Be mindful of the mandatory fields highlighted in yellow and marked with an asterisk*.

Once all relevant fields are completed, select **OK**.



Icons are shown within the text to indicate what to look for in the system (such as the Check-In icon).

Bolded text indicates that you need to click on something or pay attention to a feature in the system.

If you have any questions, do not hesitate to talk to your Instructor. Remember, your classroom learning is only *one* portion of the different activities you will engage in to learn the system.

SELF-GUIDED PRACTICE WORKBOOK

Duration	4 hours
Before getting started	<p>Sign the attendance roster (this will ensure you get paid to attend the session)</p> <p>Put your cell phones on silent mode</p>
Session Expectations	<p>This is a self-paced learning session</p> <p>A 15 min break time will be provided. You can take this break at any time during the session</p> <p>The workbook provides a compilation of different scenarios that are applicable to your work setting</p> <p>Work through different learning activities at your own pace</p>
Key Learning Review	<p>At the end of the session, you will be required to complete a Key Learning Review</p> <p>This will involve completion of some specific activities that you have had an opportunity to practice through the scenarios.</p>

USING TRAIN DOMAIN

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

Please note:

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

PATIENT SCENARIO 1

Learning Objectives

This scenario will take you through the workflow for a single simulated patient from arrival to discharge. At the end of this Scenario, you will be able to:

-  Navigate ED LaunchPoint Multi-Patient List
-  Access a patient's chart and review patient care information
-  Document your history and physical exam, impression, diagnoses, and care plan
-  Enter orders
-  Document patient care
-  Discharge patient

SCENARIO

Patient Monty Pylon is a 41-year-old male who fell 15 feet onto a concrete floor.

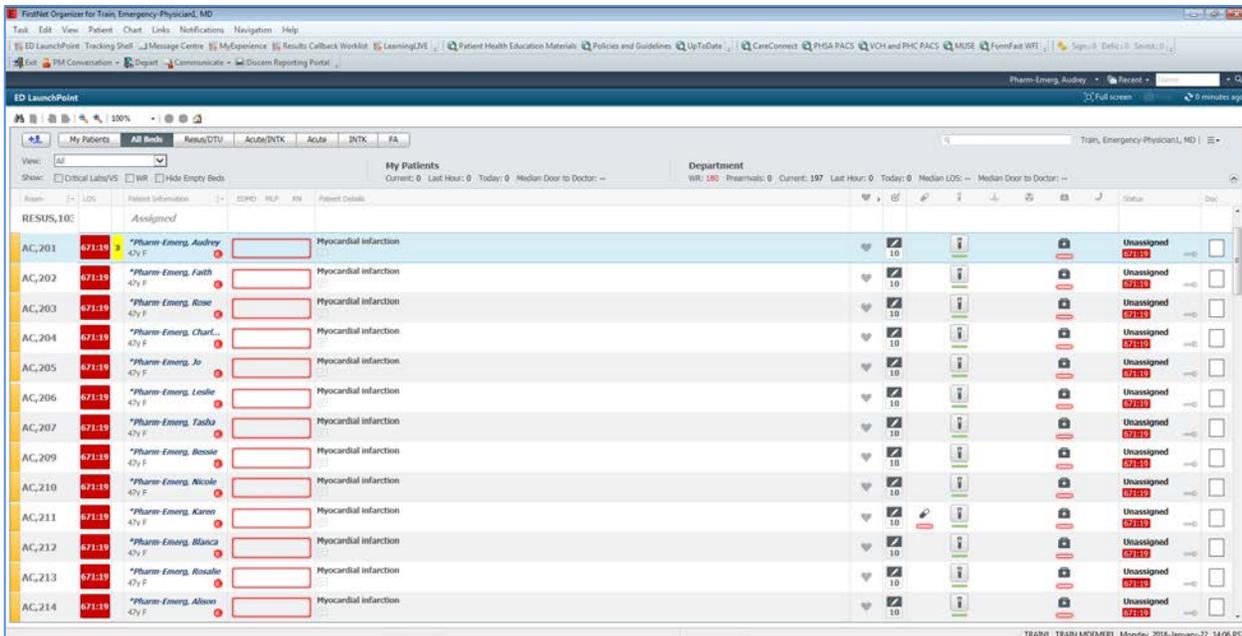
He suffered a blunt force injury to the chest. The patient just arrived at the Emergency Department with a BCAS ambulance crew who were dispatched immediately after the incident.

His wife denied any LOC. The paramedics say the patient only complains of 7/10 chest pain that is sharp and stabbing in nature. The chest pain worsens on inspiration, but was able to ambulate in to the ambulance.

Activity 1.1 – ED LaunchPoint Multi-Patient List Overview

Emergency Providers and Clinicians use a Cerner application called FirstNet. Within FirstNet, the ED LaunchPoint Multi-Patient List displays all of the patients on the unit and helps you easily access your patient’s chart.

If you need a refresher on this concept, you can review the e-Learning module called “Introduction to the Clinical Information System” on the CCRS-Learning Hub Website.



When you first login to the FirstNet system, the **ED LaunchPoint Multi-Patient List**

ED LaunchPoint will be your landing page. We will refer to this as ED LaunchPoint. **ED LaunchPoint** refreshes automatically every 60 seconds offering important, up-to-date information at a glance, which allows you to see an overview of the status of all of your patients while also providing quick access to more specific patient information.

Part A – Toolbars

At the top of your screen are Toolbars. They give you options for the FirstNet software and can also navigate you outside of FirstNet.

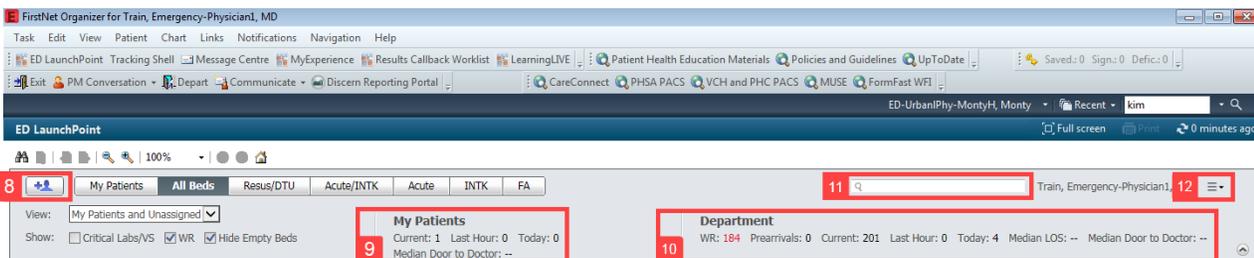
1. Options Toolbar
2. Navigation Toolbar
3. Action Area Toolbar



4. Recent Patients Drop Down Menu
5. Full Screen (minimizes Toolbars)
6. Refresh Icon
7. View Navigation



8. Add Patient Icon (Perrival and ED Quick Reg)
9. Provider Statistics
10. Department Statistics
11. ED LaunchPoint Search Bar
12. Menu Icon (Change Location and Check In)

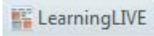


You can rearrange your Toolbars to fit your preferences by clicking and holding the **vertical row of dots** beside each Toolbar. Drag the section to where you like. Ideally, you will maximize your viewing area, so the toolbars take up two rows (rather than three).

To get to know the different high-level areas within your **ED LaunchPoint Multi-Patient List**, let's walk through the following activities.

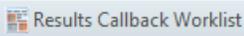
LearningLIVE

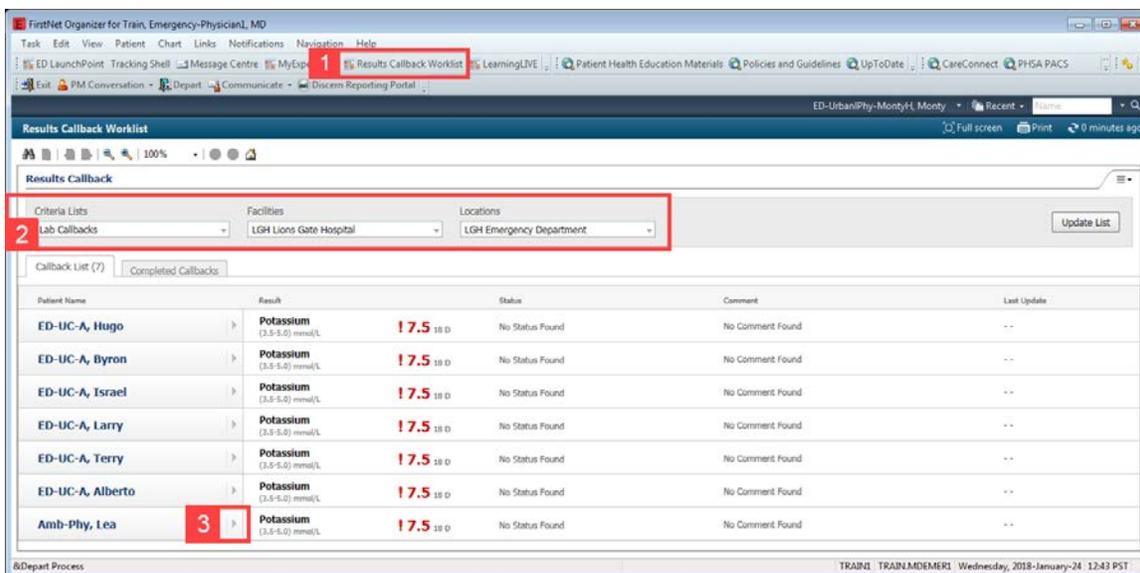
In future, you will be able to access **Quick Reference Guides** and short tutorial videos based on common workflows through **eCoach**. This section of the system is currently being developed, so there may not be anything to view in current state.

To navigate from the **ED LaunchPoint** toolbar, click the **Learning Live**  icon. Here you can access **eCoach** 

Results Callback Worklist

The **Results Callback Worklist** is a tool used to follow up on positive culture results on patients who have been discharged from the ED. Your Department will decide who follows up on these results.

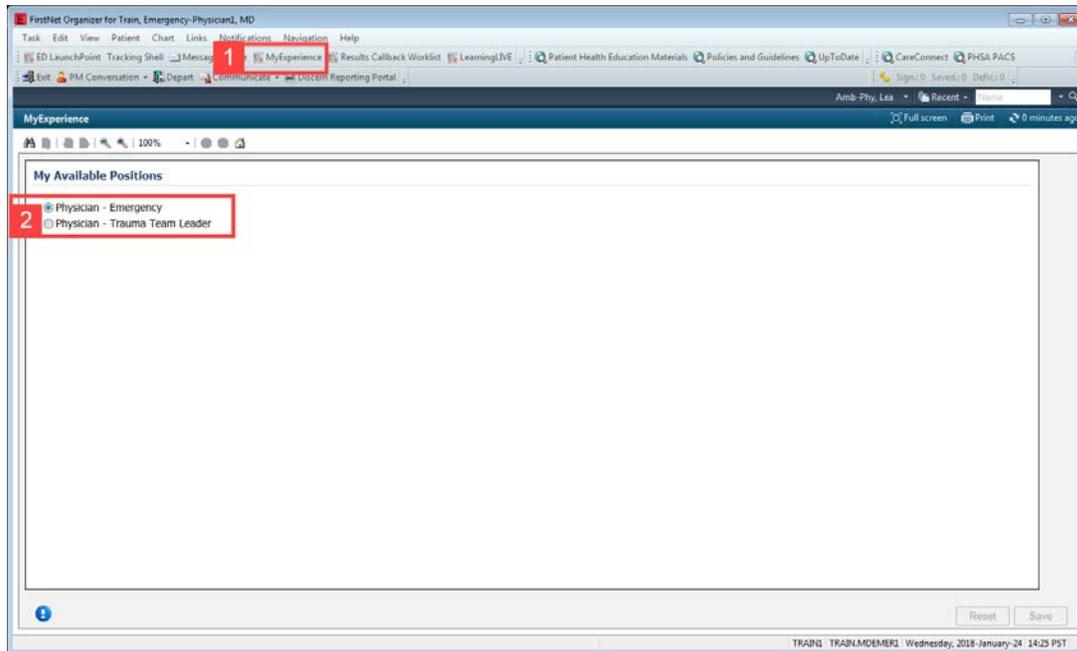
1. Click the **Results Callback Worklist**  icon. The Results Callback Worklist screen displays results on patients who have been discharged.
2. Set the Criteria Lists, Facilities, and Locations filters to accurately reflect the kinds of results you would like displayed, such as desired results to view, facility and department.
3. Click the **arrow**  icon to the right of your patient's name to view the patient's contact information and to document your callback. The **Banner Bar** is displayed within the **Single Patient View** window to ensure you are documenting on the right patient, for the right encounter.



My Experience

If you work as an Emergency Physician but also as a Trauma Team Lead, you can select the **My Experience** tool to change your role in the system. This function impacts your ordering ability and departmental statistics, so it is important you use it when applicable.

1. Click on the **My Experience**  icon.
2. In **My Available Positions** select appropriate position.

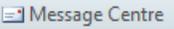


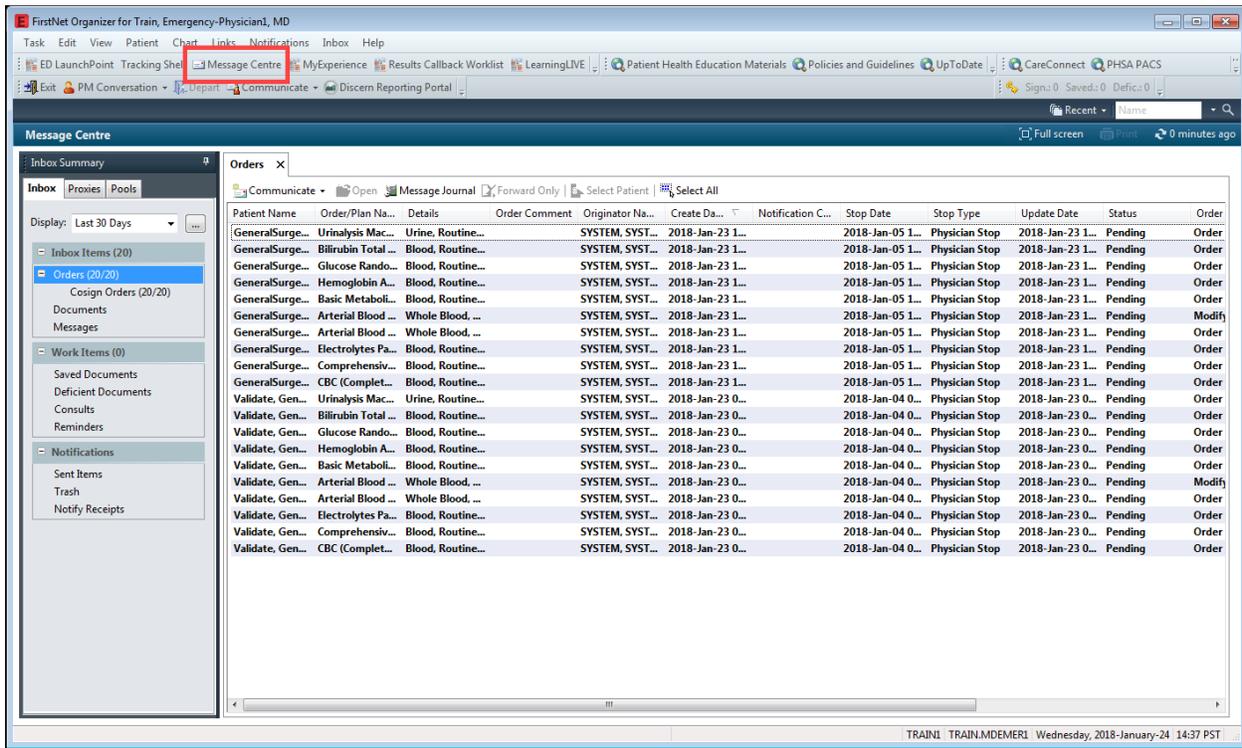
Message Centre

As an ED Provider, you will use your **ED LaunchPoint** screen for the majority of your communication, however you will occasionally need to access **Message Centre** to:

- Co-Sign Orders
- Finish incomplete documentation
- Accept or refuse proposed orders from residents, medical students, or NPs when you cannot review in person
- Review documents cc'd to you by another Provider

Message Centre features are more commonly used in Inpatient and Ambulatory settings, however you will still need to access your Message Centre on a regular basis.

Clicking the **Message Centre**  icon will bring you to the system’s “inbox.”



Click the **ED LaunchPoint**  icon at any time to return to LaunchPoint.

Knowledge Check:

- Describe how to rearrange your Toolbars.
- Identify the purpose of the Results Callback Worklist.
- When might you need to use the My Experience function?

Part B – Patient List

From the **ED LaunchPoint Multi-Patient List** there are different ways to view patient information. From left to right, you will notice a number of different column headers that organize patient information. You can always hover over these visual indicators to learn more.

1. Throughput Status Column

The narrow colour bars indicate the patient's throughput status.



2. Room Column

Displays the patient location and important alerts.



Noncritical alerts do not change to colour of the cell.



Critical alerts will display cells in red. Multiple alerts will show a folded corner.

3. LOS Column (Length of Stay)

Identifies how long a patient has been in the unit.

4. Acuity Level Column

The patient's CTAS Score.

5. Patient Information Column

Displays basic patient demographics and visual alert icons. Hover over icons for icon definition. Here are some examples:



Allergies



Isolation

Right-clicking in the Patient Information Column displays a list of actions and areas of the chart you can launch. This list acts as a shortcut, navigating you directly to where you need to go.

Organize your patients alphabetically by clicking the Sort Column  icon in the column header.

A screenshot of ED LaunchPoint highlighting the above columns is on the following page.

ED Alerts Overview

We are able to notify and display care plans for patients who typically have management issues and are frequent patients in the ED, have a history of reacting violently to care, or whose care might require additional considerations.

The following alerts will be displayed on your ED LaunchPoint Screen. Alerts are at-a-glance alerts that are hierarchically organized in the following order (meaning you will see a Violence Alert before you would see a WSBC Alert):

- Violence,
- Section 28,
- Mental Health Act Certified,
- Medically Cleared,
- Domestic Concerns,
- No Visitors,
- Familiar Faces Care Plan (FFSCP) Exists,
- Hospital High Utilizer,
- Patients with a WorkSafe BC (WSBC) claim

Hovering over the room will bring up a list of alerts:



Because there are a number different considerations that may flag additional alerts, Process Alerts are also used to give you a visual cue.

Process Alerts will also appear on the Banner Bar:



- Violence Risk
- Difficult Intubation/Airway
- Fall Risk
- Seizure Precautions
- Gender Sensitivity
- Communication Barrier
- Special Care Plan
- No Ceiling Lift
- Visitor Restrictions
- Cytotoxic
- Palliative Flag
- On research study

6. Assignment Column

Displays initials of the Provider, Mid-Level Provider (Nurse Practitioner, Resident, and Medical Student), and Nurse assigned to the patient.

Click in a patient's Assignment column to Assign/Unassign yourself to a patient or to view additional details about who is currently Assigned

7. Patient Details Column

Shows the Coded Chief Complaint documented during Triage until the attending Provider documents a Diagnosis. The Provider's Diagnosis will be displayed in capital letters

preceded by "Dx": **Dx: CELLULITIS FOREARM**

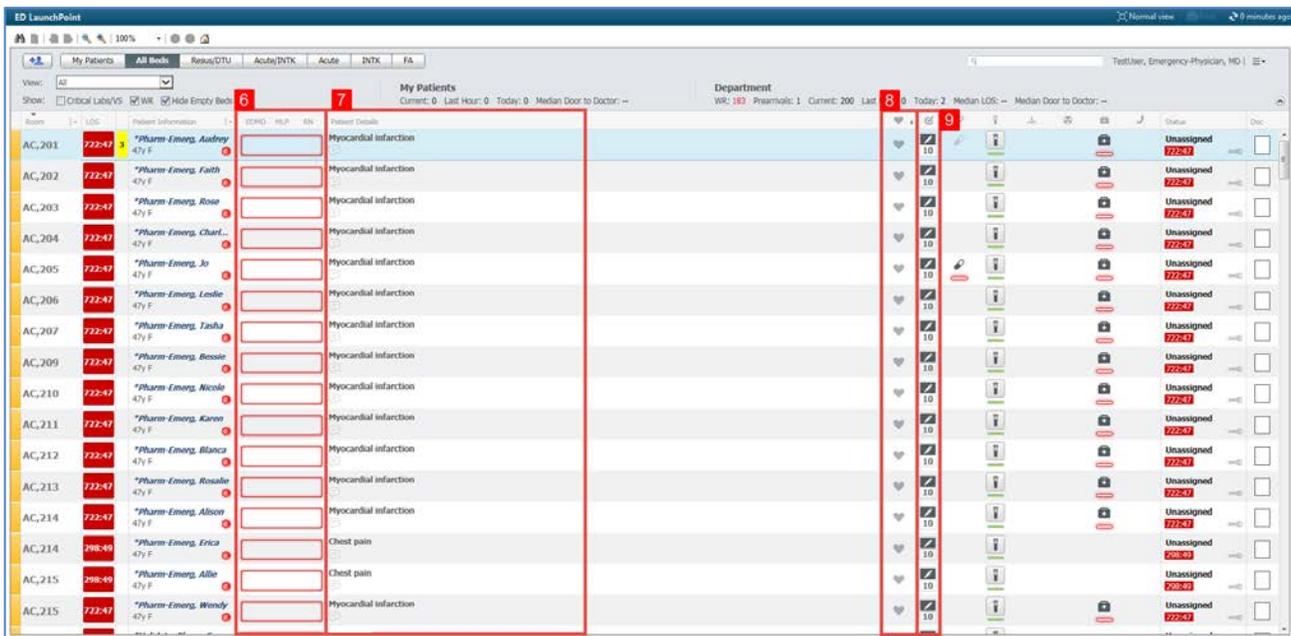
The Comment button allows users to display a comment to other Providers or to all staff.

8. Vital Signs Column

Clicking the arrow  beside the Vital Signs Column header allows you to expand and collapse the display showing patients' most recent vital signs.

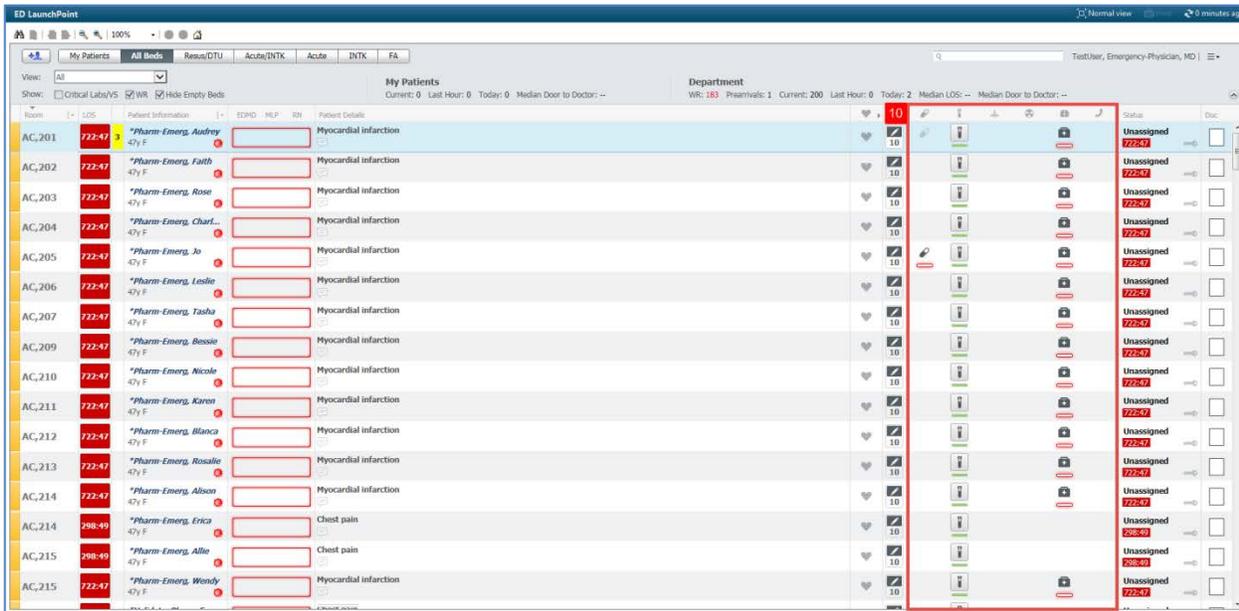
9. Physician Notification Column

Outstanding activities that require attention.



10. Patient Care Activities Column

- 💊 Medications
 👤 Patient Care
- 🧪 Labs
 📞 Consult
- 📶 ECG
 📄 Documentation in Workflow
- 📷 Imaging



When Providers input orders that are applicable to one of the above categories a status bar will display to show the order's progress.

- 📶
—

An unfilled status bar outlined in red indicates the order was recently entered but has not yet been attended to.
- 💊
—

Partially filled status bars indicate the order's progress.
- 🧪
—

Full green status bars indicate a completed or resulted order.
- 🧪
—

Orders with critical results will be highlighted in red.
- 📷
—

An Imaging icon layered with a document indicates the Radiologist's report is complete.

You can hover over these icons to see the basic details on what was ordered.

Order Name	Date/Time	Ordered By	Status
Urinalysis Macroscopic (dipstick) with Microscopic if indicated	05/01/18 19:02:21	Plisvcw, Tyler, MD	Completed
Bilirubin Total and Direct	05/01/18 19:02:19	Plisvcw, Tyler, MD	Completed
Glucose Random	05/01/18 19:02:16	Plisvcw, Tyler, MD	Completed
Hemoglobin A1C	05/01/18 19:02:13	Plisvcw, Tyler, MD	Completed
Basic Metabolic Panel (Lytes, Urea, Creat, Gluc)	05/01/18 19:02:10	Plisvcw, Tyler, MD	Completed
Arterial Blood Gas	05/01/18 19:02:07	Plisvcw, Tyler, MD	Completed
Electrolytes Panel (Na, K, Cl, CO2, Anion Gap)	05/01/18 19:02:03	Plisvcw, Tyler, MD	Completed
Comprehensive Metabolic Panel - Emerg	05/01/18 19:02:00	Plisvcw, Tyler, MD	Completed
CBC	05/01/18 19:01:57	Plisvcw, Tyler, MD	Completed

11. Status Column

Like the Throughput Column (1), the Status Column identifies the patient's stage of care in the unit. A key icon indicates the patient requires registration by a clerk.

Triage 647:59 	Awaiting Triage 	Unassigned 	No ED Provider Assigned 	Eval in Progress 00:00 	Provider Assigned, Orders Pending
Orders Completed 504:24 	Discharge Ordered 00:00 	Admitted to Hospital 00:00 			

12. Document Column

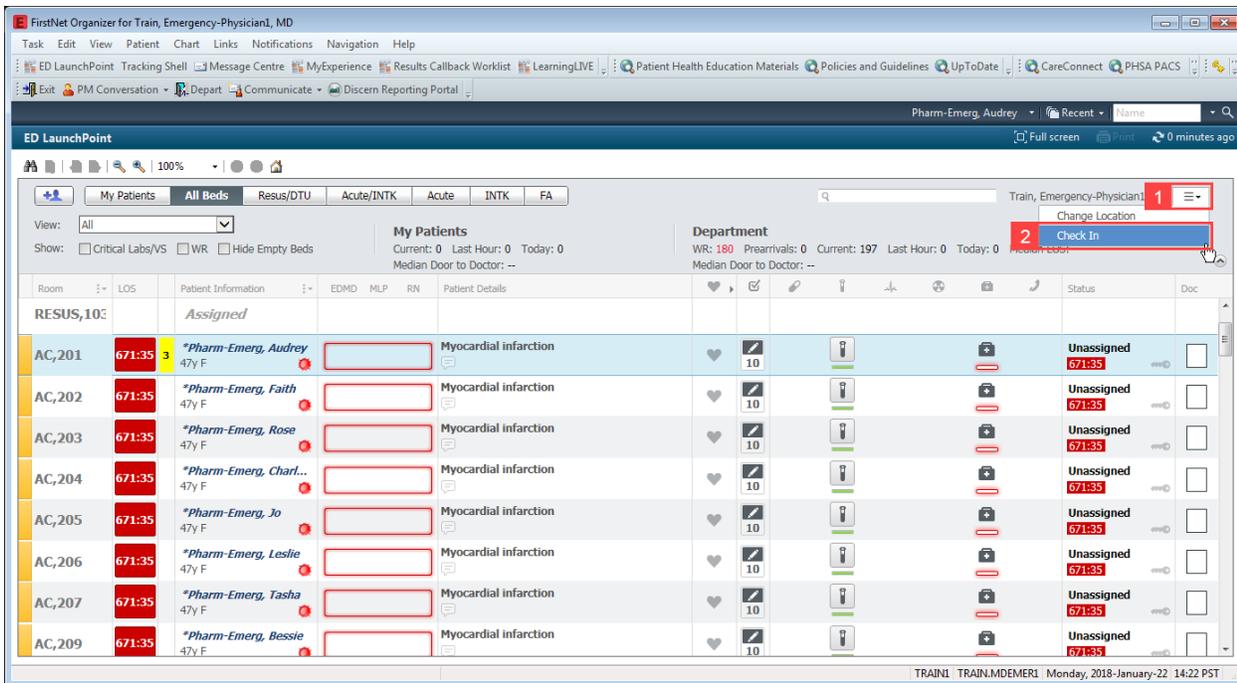
Displays the status of your workflow. A blank icon shows no documentation has occurred. A chart icon indicates work has started and some documentation has taken place. A checked icon shows work is complete and your ED Note is signed. Clicking an icon in this column will bring you to the Documentation section of your patient's chart.

You will learn more about workflow and creating notes as the scenario progresses.

Activity 1.2 – Check-In and Patient Handover

You need to Check-In as an available Provider before you can access patient charts.

1. From the **ED LaunchPoint** screen, click the **menu**  icon in the upper right corner.
2. Select **Check In**.



The screenshot shows the 'FirstNet Organizer for Train, Emergency-Physician, MD' interface. The 'ED LaunchPoint' section is active, displaying a list of patients. The 'Check In' button is highlighted in red, and a red box labeled '2' is around it. Another red box labeled '1' is around the menu icon in the top right corner. The patient list includes columns for Room, LOS, Patient Information, EDMD, MLP, RN, Patient Details, Status, and Doc.

Room	LOS	Patient Information	EDMD	MLP	RN	Patient Details	Status	Doc
RESUS,103		Assigned						
AC,201	671:35	*Pharm-Emerg, Audrey 47y F				Myocardial infarction	Unassigned 671:35	
AC,202	671:35	*Pharm-Emerg, Faith 47y F				Myocardial infarction	Unassigned 671:35	
AC,203	671:35	*Pharm-Emerg, Rose 47y F				Myocardial infarction	Unassigned 671:35	
AC,204	671:35	*Pharm-Emerg, Charl... 47y F				Myocardial infarction	Unassigned 671:35	
AC,205	671:35	*Pharm-Emerg, Jo 47y F				Myocardial infarction	Unassigned 671:35	
AC,206	671:35	*Pharm-Emerg, Leslie 47y F				Myocardial infarction	Unassigned 671:35	
AC,207	671:35	*Pharm-Emerg, Tasha 47y F				Myocardial infarction	Unassigned 671:35	
AC,209	671:35	*Pharm-Emerg, Bessie 47y F				Myocardial infarction	Unassigned 671:35	

3. The **Provider Check In** window appears. Confirm that your name and role are correct. Enter your initials or other identifier in the **Display Name** field. The system will only display 3 characters, which can be viewed by the whole department.

Note: The fields marked with an **asterisk*** and/or yellow highlighted fields are considered mandatory fields.

Although not a mandatory field, setting a Default Relation will automatically set the type of Relationship you establish with new patients. You can also set your default location if you work at multiple sites.

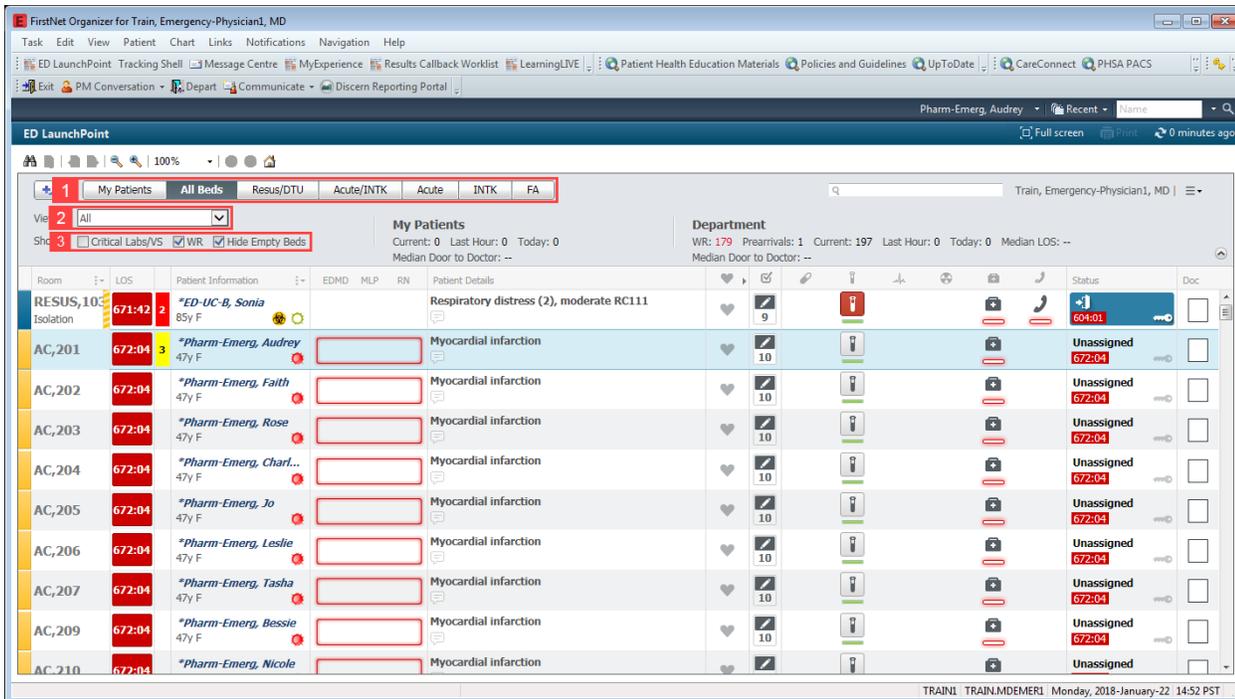
4. Click **OK**.

The screenshot shows the 'Provider Checkin' dialog box. At the top, there are three main sections: 'Provider', 'Display Name', and 'Provider Role'. The 'Provider' field contains 'Train, Emergency-Physician1, MD'. The 'Display Name' field contains 'ET'. The 'Provider Role' dropdown is set to 'ED Provider'. Below these are 'Default Location' and 'Default Relation' (set to '(none)'). A red box with the number '3' highlights the 'Display Name' field. Further down, there is a 'Provider Comment' field, a checked 'Associated Provider Color' checkbox with a green color swatch, and two lists: 'Available Teams' and 'Assigned Teams' with 'Assign>' and '<-Remove' buttons. Below these are 'Assigned Team Locations' and 'Assigned Patients' lists. The 'Assigned Patients' list has 'Assign All->', 'Assign>', '<-Remove', '<-Remove Prov', and '<<-Remove All' buttons. To the right of the 'Assigned Patients' list is a 'Reassign to Provider' dropdown set to 'All providers' and a table with 'Provider' and 'Patient' columns. At the bottom, there are checkboxes for 'Available Provider' (checked) and 'Available Reviewer', and two buttons: 'OK' and 'Cancel'. A red box with the number '4' highlights the 'OK' button.

You have now Checked In as an available Provider and can receive Handoff from the outgoing Provider. You need to filter your **ED LaunchPoint Multi-Patient List** before you can get started.

You can filter your view of ED LaunchPoint multiple ways:

- The **Tabs** across the top of the screen filter by assignment or location.
- The **View** option is a drop-down list with further view options.
- The **Show** checkboxes offer additional options to modify the Patient List view.



Using these features, filter your Multi-Patient List as follows:

1. From the **Tabs** available, select **All Beds**.
2. Use the **View** drop-down list to select **All**.
3. Ensure both **WR** (Waiting Room patients) and **Hide Empty Beds** are checked.

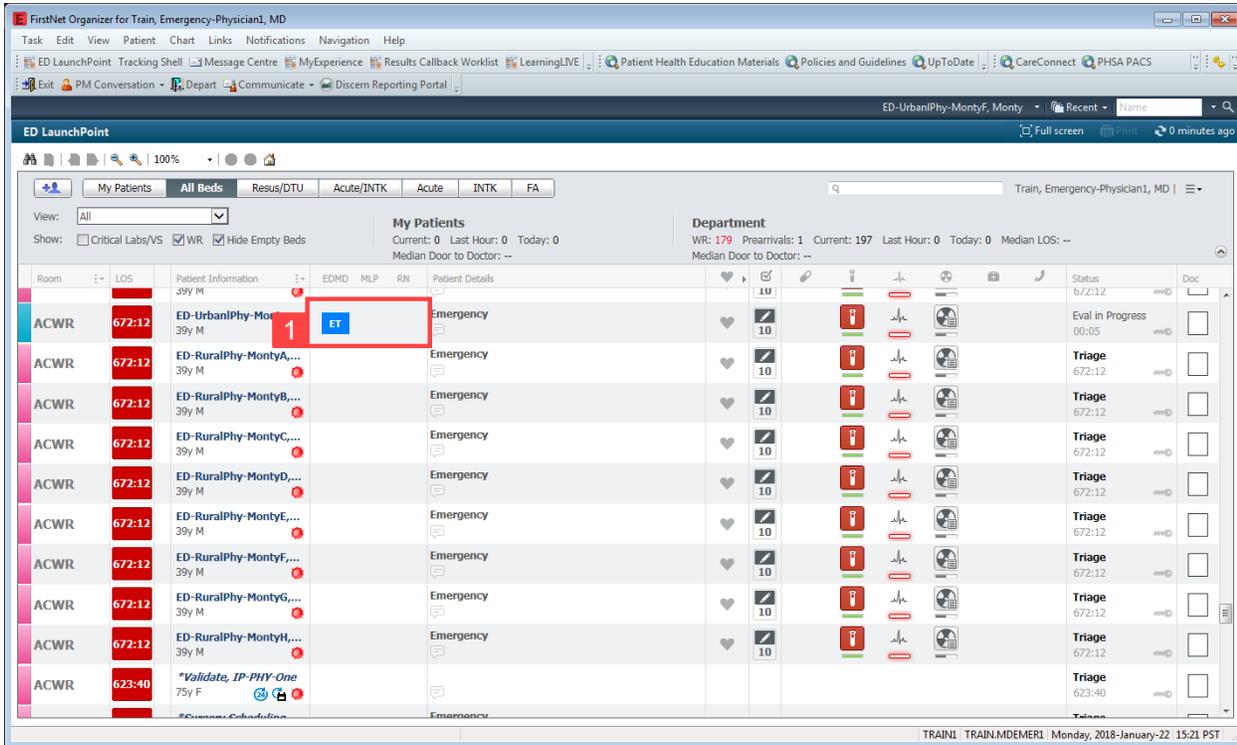
Note: If you cannot find a patient on your **ED LaunchPoint Multi-Patient List**, ensure all filter settings are set to **All Patients** and make sure the **WR** box is checked.

If you still cannot find your patient, use the **ED Launch Point Multi-Patient Search** bar.



Next, you will need to receive Handover from the outgoing Provider. After you receive a summary of the patient's care, you need to **Assign** yourself to the patient.

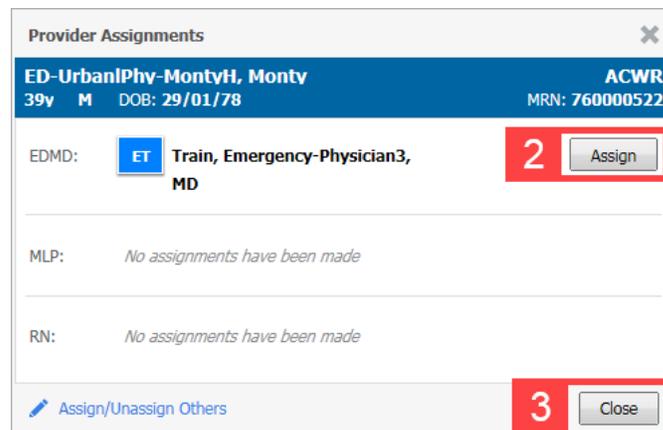
1. Navigate to the **Assignment Column** and click in the **column**.



2. The Provider Assignments window appears.

Click the **Assign** button. You are now assigned as Mr. Pylon's Provider. The initials you entered during Check-In will appear in the Assignment column.

3. Click the **Close** button.



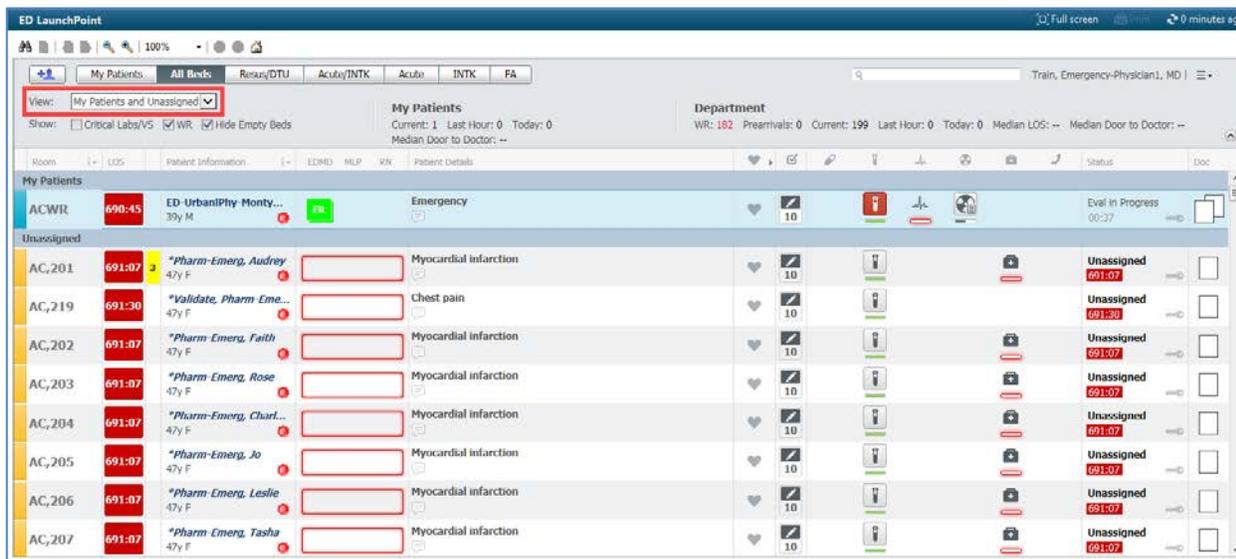
You will notice that your initials are layered **ER** with the outgoing provider. This acts as a visual cue to others that handover is occurring on this patient.

Note: The first Provider assigned to a patient will always be noted as the first Provider and cannot be “bumped” from that assignment. The only way to remove their name is if they Unassign themselves.

For example, Dr. Smith is the first Provider assigned to a patient but did not Unassign herself. Her colleague, Dr. Chan comes on shift and assigns himself to the same patient; his initials will be layered over Dr. Smith’s in the **Assignment** column. Now Dr. Ahmed, the third Provider, comes on shift and assigns herself to the patient. Dr. Chan will be unassigned from the patient, while Dr. Smith will remain assigned since they were the first Provider assigned. The primary Provider will remain constant and any Providers assigned afterward will be dynamic.

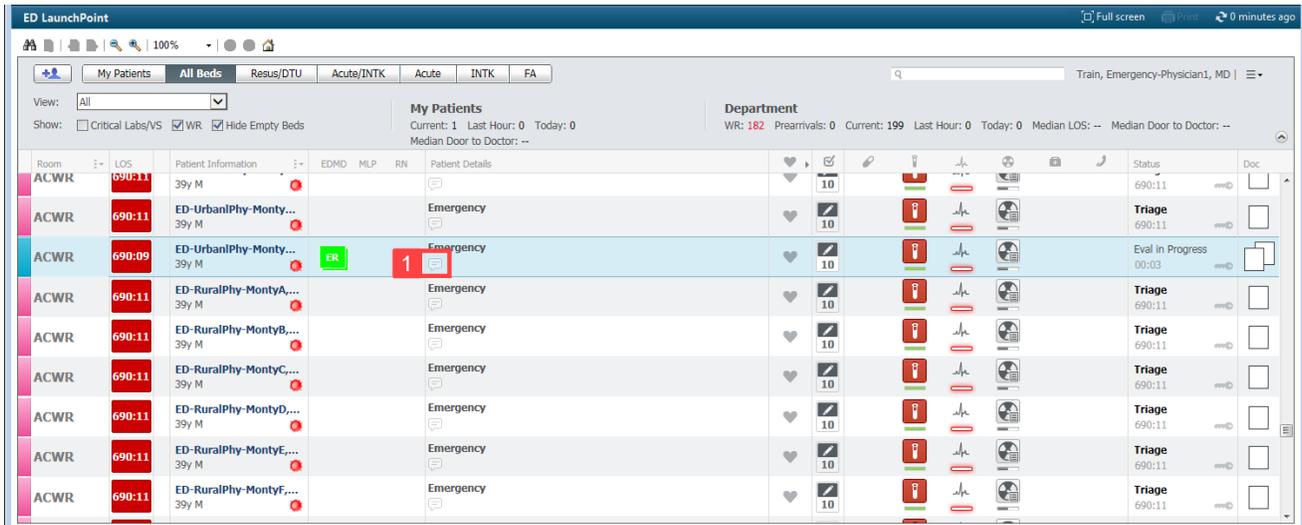
After assigning yourself to your patients, change the View in the dropdown menu to **My Patients and Unassigned**.

This view organizes your Assigned patients to the top of the screen while still allowing you to visualize the rest of the department.



The outgoing Provider tells you there should be results for Mr. Pylon coming in soon, so you decide to enter a **Comment** as a prompt for yourself.

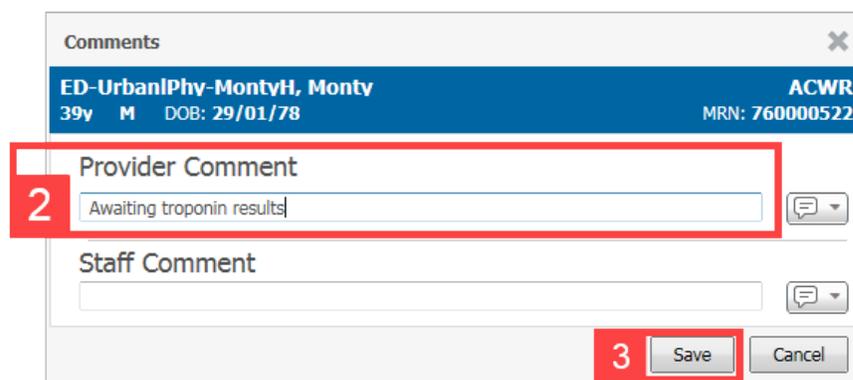
1. From your **ED LaunchPoint** screen, click the **Comments**  icon in your patient's row.



2. The **Comments**  box appears. In the **Provider Comment** section, enter the following text: **Awaiting critical Lab results.**

Provider Comments can only be seen by Providers while Staff Comments can be seen by everyone in the department.

3. Click **Save**.

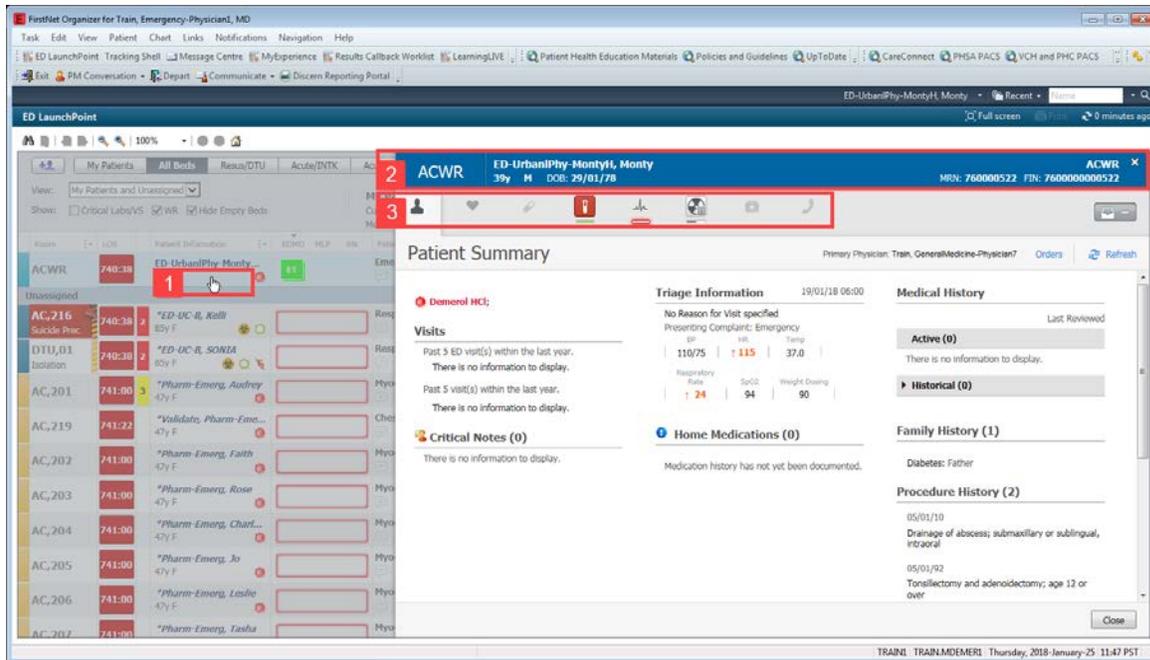


Your comment now appears in the patient row. You can click the same button to access the Comment window at any point.

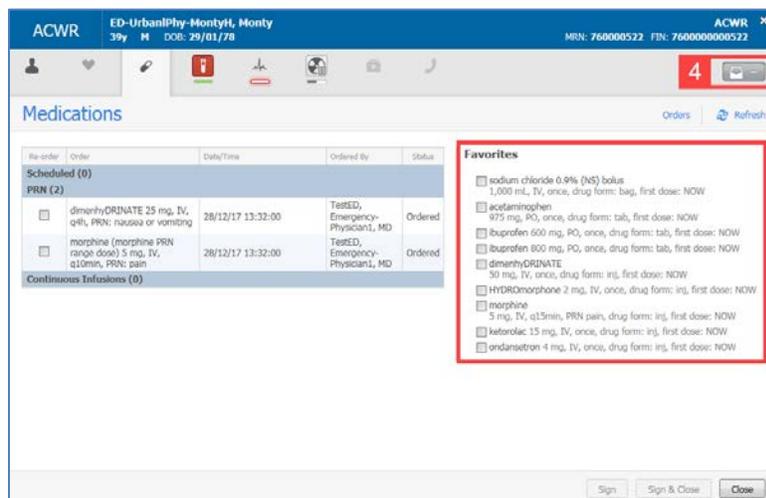
Single Patient View

1. Clicking the white area around your patient's name will open **Single Patient View**.
2. A Banner Bar spans across the top of the window. Confirm you have the right patient and the right encounter.
3. The Patient Summary Tab includes information on past visits, Triage Information, Home Medications, and other information.

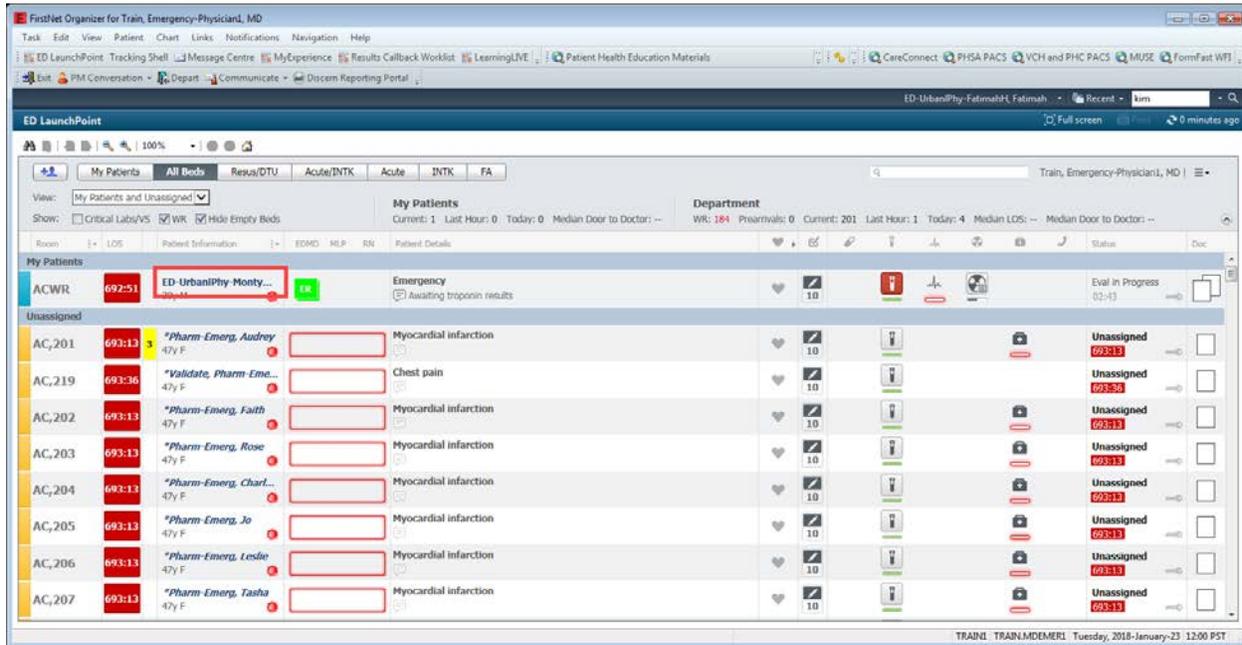
Explore the different tabs to view different information about the patient.



4. Some tabs have a Favorites List of common orders. You can enter orders from the **Single Patient View**. Orders you have selected will be added to your Inbox  and will display outstanding Orders for Signature for to this patient. You can therefore select multiple orders and sign off the group, rather than one-by-one. Do not order anything for now.



You are ready to review your patient's chart. To access Mr. Pylon's chart, click on Monty's name from in **ED LaunchPoint**.



Knowledge Check

- Name the three primary ways to filter your ED LaunchPoint **Multi-Patient List**.
- What should you do if you cannot find your patient on your ED LaunchPoint **Multi-Patient List**?
- How do you assign yourself to a patient?

Activity 1.3 – Patient Chart Overview

Once you open the patient's chart there are several sections to review:

1. The **Banner Bar** at the top of the screen shows patient demographic information and alerts. Use the banner to ensure you are viewing the correct patient and encounter. Many Providers find it helpful to choose three patient demographics to check for each time, such as name, encounter number, and encounter type.
2. The **Menu** allows you to navigate to different parts of the patient chart. However, it is recommended to unpin  the Menu to minimize this section as the majority of your work will be done in the ED Workflow page.
3. The **Emergency Workflow** screen is the default landing page when initially opening a patient chart. The Emergency Workflow screen and tabs were designed to support the majority of your work. Relevant clinical information gets pulled from other areas in the chart for review onto the workflow page. This page allows you to document patient care in real time, such as Physical Examinations, Diagnoses, and Impression and Plan.

Emergency Workflow

Triage Documentation

Emergency

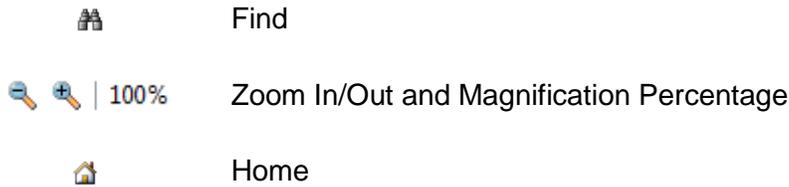
Temperature 37 DegC 22/01/18 06:45	Heart Rate ↑ 115 bpm 22/01/18 06:45	Blood Pressure -- / --	Respiratory Rate ↑ 24 br/min 22/01/18 06:45	O2 Saturation 94 % 22/01/18 06:45	Pain --
Height 186 cm 22/01/18 06:00	Weight 90 kg 22/01/18 06:00	Body Mass Index --	Visual Acuity: L:-- R:--	Glasgow Coma Scale --	

Vital Signs & Measurements

	Jan 22, 2018 07:52	06:45	06:00
BP	mmHg 98 / 54	110 / 75	--
HR	bpm 69	↑ 115	--
Temp	DegC ↓ 36.2	37	--
SpO2	% --	94	--
Respiratory Rate	br/min ↑ 24	↑ 24	--
Weight Dosing	kg --	--	90
Weight Measured	kg 90	--	--
Height/Length Measured	cm 186	--	186

* (Previous record results up to 15 columns of information for the last 12 months)

4. The **Toolbar** offers navigation tools and different options to change your view.



5. The Emergency Workflow screen is made up of a number of **Tabs** that contains information pertinent to the activity described in the tab title.

Clicking the Add icon allows you to modify or add additional tabs.

6. The **Refresh** icon updates the chart to display the latest information. If you have entered any information that does not display, click the refresh button. Be sure to utilize this icon frequently as chart pages do not automatically refresh.

7. The ED Workflow **Table of Contents** allows you to navigate directly to the sections of the workflow page. As you scroll through the chart the section you are on will highlight.

The screenshot shows the Emergency Workflow interface for patient ED-UrbaniPhy-MontyH, Monty. The interface includes a top navigation bar with patient information, a left sidebar menu, and a main content area with multiple tabs. Red boxes and numbers highlight specific features: 4 points to the toolbar icons, 5 points to the tab bar, 6 points to the refresh icon in the Triage Documentation tab, and 7 points to the Table of Contents in the left sidebar.

Triage Documentation

Emergency					
Temperature	Heart Rate	Blood Pressure	Respiratory Rate	O2 Saturation	Pain
37 DegC	↑ 115 bpm	-- / --	↑ 24 br/min	94 %	--
22/01/18 06:45	22/01/18 06:45		22/01/18 06:45	22/01/18 06:45	
Height	Weight	Body Mass Index	Visual Acuities	Glasgow Coma Scale	
186 cm	90 kg	--	L-- R--	--	
22/01/18 06:00	22/01/18 06:00				

Vital Signs & Measurements

		JAN 22, 2018 07:32	06:45	06:00
BP	mmHg	98 / 54	110 / 75	--
HR	bpm	69	↑ 115	--
Temp	DegC	↓ 36.2	37	--
SpO2	%	--	94	--
Respiratory Rate	br/min	↑ 24	↑ 24	--
Weight Dosing	kg	--	--	90
Weight Measured	kg	90	--	--
Height/Length Measured	cm	186	--	186

Review the prepopulated content in the **ED Workflow** sections, as you would prior to assessing a patient. In the next activity you will document your assessment findings.

- Triage Documentation
Vital Signs displayed here are from Triage and are not the most recent
- Vital Signs & Measurements
Most recent Vital Signs are displayed from left to right

Triage Documentation All Visits

Emergency

Temperature 37 DegC <small>22/01/18 06:45</small>	Heart Rate ↑ 115 bpm <small>22/01/18 06:45</small>	Blood Pressure -- / --	Respiratory Rate ↑ 24 br/min <small>22/01/18 06:45</small>	O2 Saturation 94 % <small>22/01/18 06:45</small>	Pain --
Height 186 cm <small>22/01/18 06:00</small>	Weight 90 kg <small>22/01/18 06:00</small>	Body Mass Index --	Visual Acutities L:-- R:--	Glasgow Coma Scale --	

Vital Signs & Measurements Latest* Last 12 months Last 24 hours More

		JAN 22, 2018 07:52	06:45	06:00
BP	mmHg	98 / 54	110 / 75	--
HR	bpm	69	↑ 115	--
Temp	DegC	↓ 36.2	37	--
SpO2	%	--	94	--
Respiratory Rate	br/min	↑ 24	↑ 24	--
Weight Dosing	kg	--	--	90
Weight Measured	kg	--	--	--
Height/Length Measured	cm	186	--	186

* Displaying recent results up to 11 columns of information for the last 12 months

- Histories
Click the tabs in this section to review the patient's Medical, Surgical, Family, and Social History.

Histories All Visits

Medical History (0)
Surgical History (2)
Family History (1)
Social History (2)

CPT4

Procedure	Surgeon	Implant	Date
Surgeal Records (0)			
No results found			
Procedures (2)			
Drainage of abscess; submaxillary or sublingual, intraoral	--	--	2010
Tonsillectomy and adenoidectomy; age 12 or over	--	--	1992

- Allergies
- Home Medications

Allergies (1) All Visits

Substance	Reactions	Category	Status	Severity	Reaction Type	Source	Comments
Demerol HCl	--	Drug	Active	Severe	Allergy	--	--

Reconciliation Status: Incomplete Complete Reconciliation

Home Medications (0) All Visits

Status: i Meds History | i Admission | i Discharge

No results found

Document History: Incomplete Complete History...

- Visits
- Links: PharmaNet and CareConnect
- Lab Results
- Order Profile

Each section of the **ED Workflow** has a heading. Some headings are links that can bring you directly to that part of the patient’s chart. Hover your cursor over a heading, if the hand  icon appears that heading is a link.

Lab Results Selected visit: Latest* Selected visit Last 24 hours More    

	JAN 24, 2018 09:00	08:45	07:45	07:30	07:15	07:00
Laboratory						
WBC Count	--	--	--	--	--	↑ 10.3
RBC Count	--	--	--	--	--	↓ 4.12
Hemoglobin g/L	--	--	--	--	--	↓ 120
Hematocrit	--	--	--	--	--	↓ 0.36
MCV fL	--	--	--	--	--	88
MCH pg	--	--	--	--	--	29
RDW-CV %	--	--	--	--	--	13.3
Platelet Count	--	--	--	--	--	216
MPV fL	--	--	--	--	--	↑ 11.8

Each section contains options to change your view. For example, the Vital Signs section has a Flowsheet  or Ambulatory  view. Use the view that suits you best.

Vital Signs & Measurements Latest* Last 12 months Last 24 hours More    

	JAN 24, 2018 07:52	06:45	06:00
BP mmHg	98 / 54	110 / 75	--
HR bpm	69	↑ 115	--
Temp DegC	↓ 36.2	37	--
SpO2 %	--	94	--
Respiratory Rate br/min	↑ 24	↑ 24	--
Weight Dosing kg	--	--	90
Weight Measured kg	90	--	--
Height/Length Measured cm	186	--	186

* Displaying recent results up to 16 columns of information for the last 12 months

All sections have a Refresh  icon. You can refresh a particular section if you would like to ensure you are viewing the most current information without losing you place. Clicking the Main Refresh  icon will reload the whole page and will bring you to the beginning of the ED Workflow page.

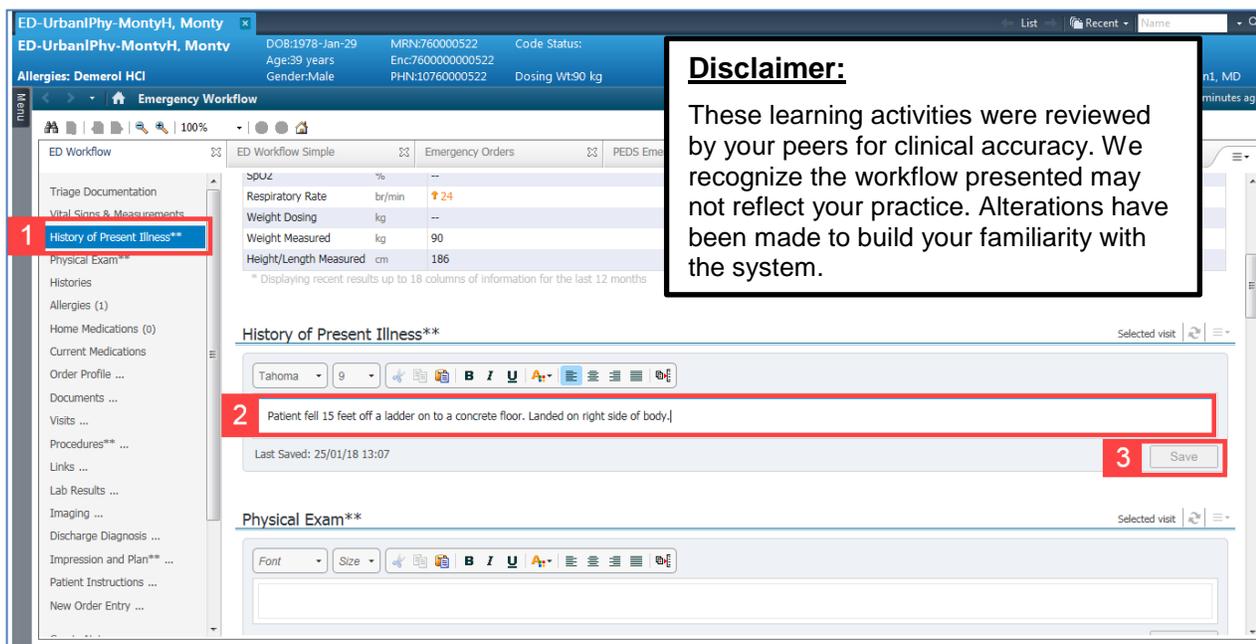
Activity 1.4 – Documenting History of Present Illness

After assessing Monty Pylon, you wish to document your findings.

1. In the **ED Workflow Tab** of your patient’s chart, scroll to the **History of Present Illness**** section or click on the title in the Table of Contents.
2. Enter the following information in the text box: *Patient fell 15 feet off a ladder onto a concrete floor, landing on the right side of his body.*

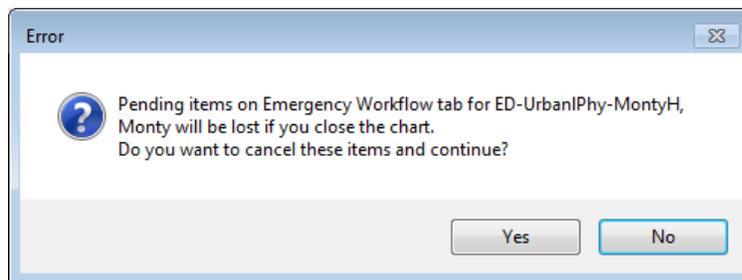
If you have **Front End Speech Recognition (FESR)** microphone, you may use it to enter the text, per any FESR learning you received. Any section title followed with two asterisks** indicates a free text field where you can use FESR.

3. Click **Save** . Sections like this will auto-save periodically to ensure work is not lost if you step away from your workstation, however it is recommended you save as soon as you finish a section.



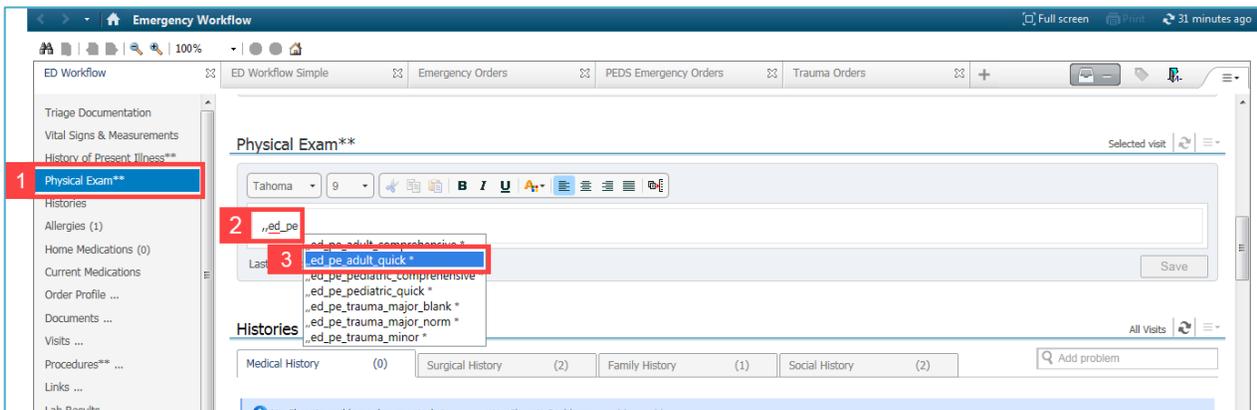
Disclaimer:
These learning activities were reviewed by your peers for clinical accuracy. We recognize the workflow presented may not reflect your practice. Alterations have been made to build your familiarity with the system.

If you attempt to navigate away from this screen without saving, an error message will appear asking if you wish to cancel anything entered or return to the ED Workflow page to save your work.



Activity 1.5 – Documenting Physical Exam Using Autotext

1. Scroll to the **Physical Exam**** section of your **ED Workflow** screen.
2. Document Monty’s exam in the text box of the **Physical Exam**** section. Although you can use FESR in this section, this activity is intended to show Auto-text functionality, so do not use FESR. Type `„ed_pe` in the text box and a drop-down menu will appear.
3. Choose `„ed_pe_adult_quick*`.

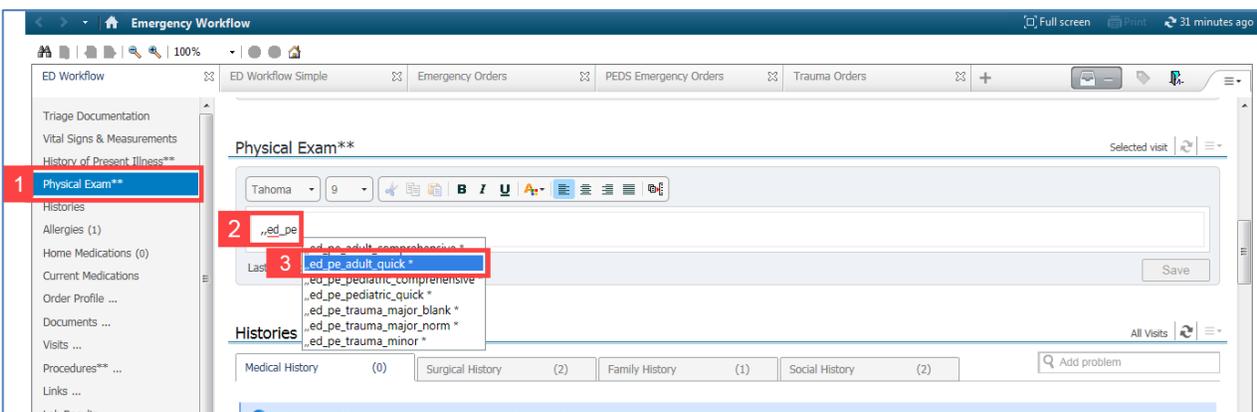


4. A pre-populated assessment containing normal findings will appear. The terminology in the global auto-text entries was developed by multiple provider groups to provide consistent charting among individuals.

Change the following fields:

- *CONSTITUTIONAL: appears in mild respiratory distress*
- *PULMONARY: decreased breath sounds to right lungs, pain to right side on inspiration*
- *MUSCULOSKELETAL: pain and ecchymosis to right leg above knee, pain to right elbow*

5. Click **Save**

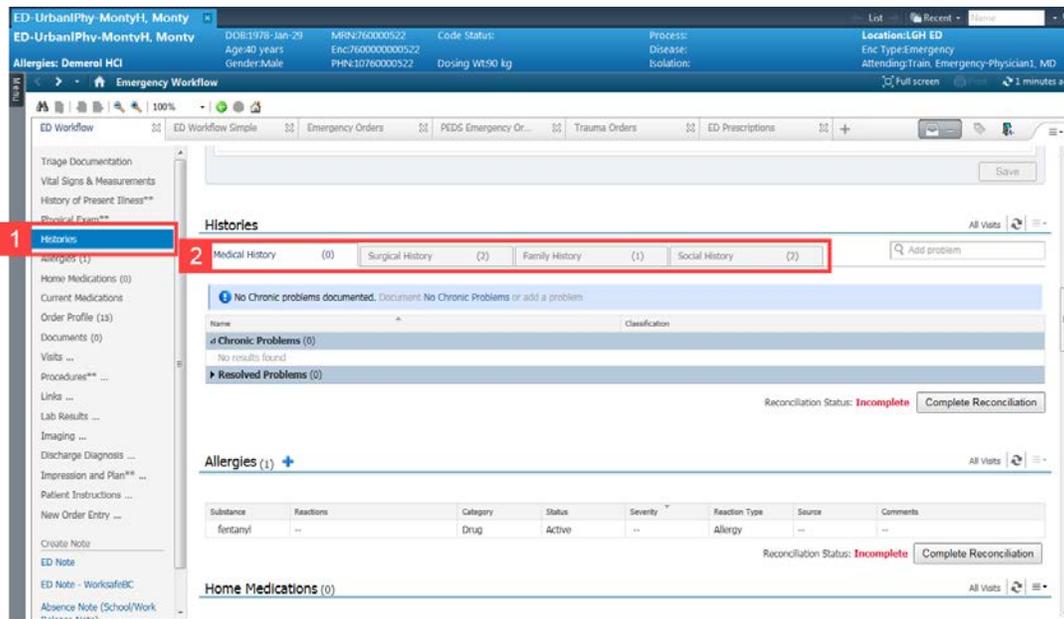


It is possible to create your own auto-text messages, but that is beyond the scope of this education session.

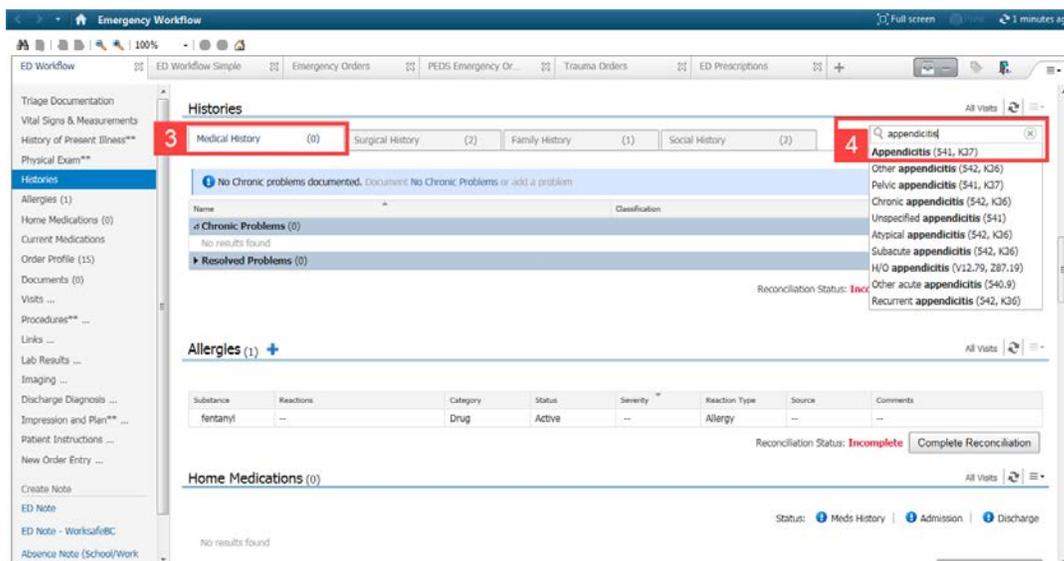
Activity 1.6 – Documenting Past Medical History

Monty relayed his past history during your exam. His surgical, family, and social history were documented, but his appendicitis (resolved with antibiotics) in 2004 was not. You need to update this in your workflow.

1. Scroll to the **Histories** section of your **ED Workflow** screen.
2. Review the tabs in this section: **Medical History**, **Surgical History**, **Family History**, and **Social History**.

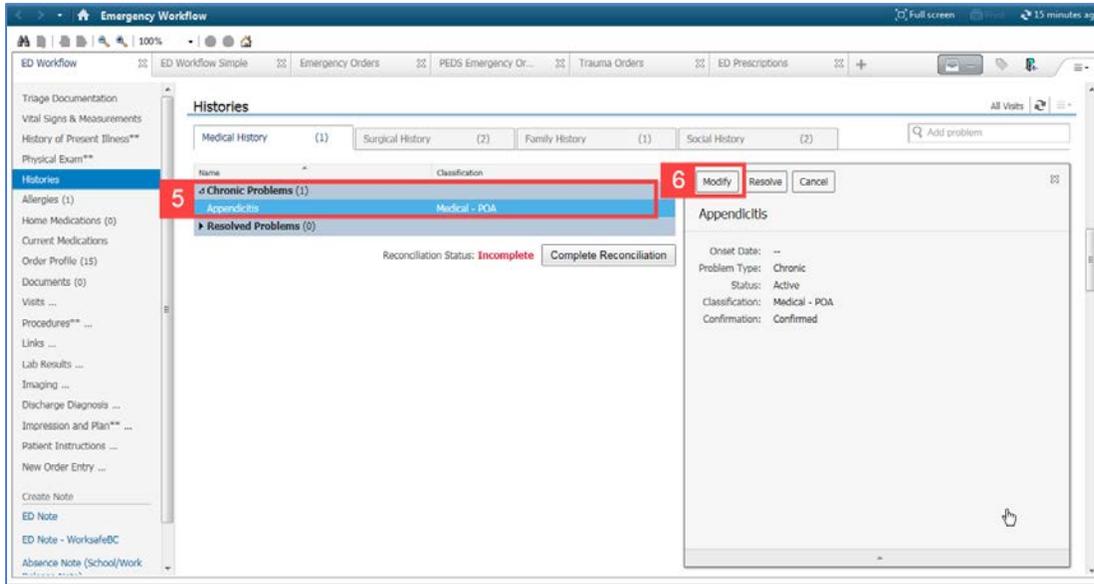


3. Return to the **Medical History** tab.
4. Search and select **Appendicitis** in the **Add Problem** search bar.



5. Appendicitis will populate under **Chronic Problems**. Select **Appendicitis** to open the **Problem Details** window.

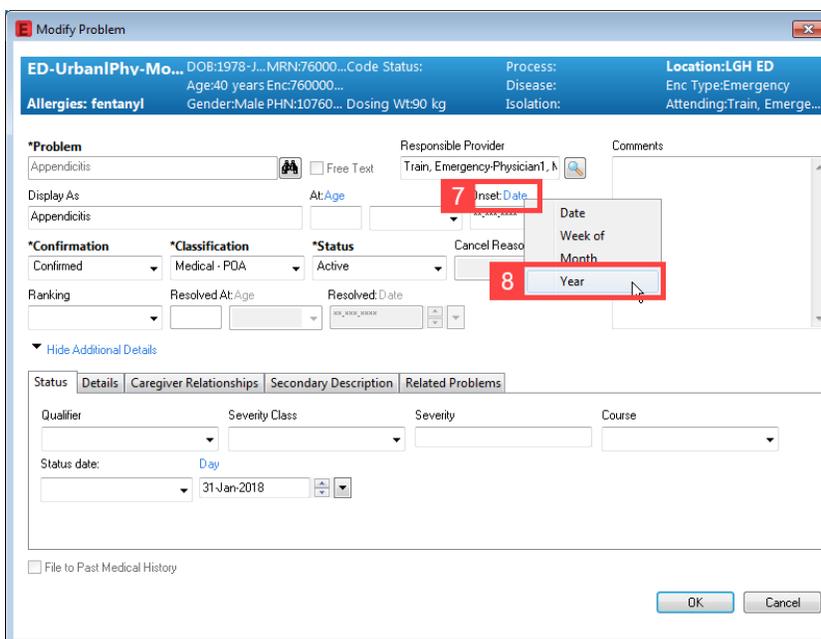
6. Click **Modify**.



7. The **Modify Problem** window appears.

Click **Date** in blue font.

8. Choose **Year** from the dropdown options.



9. Enter **2004** in the **Onset Year** field.
10. Change the status from **Active** to **Resolved**.
11. Click **OK**.

The screenshot shows the 'Modify Problem' window for a patient with Appendicitis. The 'Onset Year' is set to 2004. The status dropdown menu is open, and 'Resolved' is selected. The 'OK' button is highlighted.

12. Appendicitis will now appear in **Resolved Problems**.

Currently, the **Reconciliation Status** will display as **Incomplete**. Click **Complete Reconciliation** to finalize your documentation.

The Reconciliation Status will now display as **Completed** followed by your name and date.

The screenshot shows the 'Emergency Workflow' interface. Under the 'Resolved Problems' section, 'Appendicitis' is listed with a 'Reconciliation Status: Incomplete' and a 'Complete Reconciliation' button. The 'Allergies' section also shows 'fentanyl' with a 'Reconciliation Status: Incomplete' and a 'Complete Reconciliation' button.

Activity 1.7 – Entering Orders and Documenting Patient Care

Part A – Individual Orders

You have documented a physical exam and now know enough about the patient’s condition to plan immediate care. There is a concern of a possible pneumothorax and broken ribs. You would like to order some diagnostic tests.

First, we’ll learn about **Individual Orders**.

1. In the **ED Workflow** screen of the patient’s chart, click the **Emergency Orders** tab. If you are located at a rural site the tab will read **ED Rural Orders**.

The screenshot displays the ED Workflow interface for patient ED-UrbaniPhy-MontyH, Monty. The patient's information at the top includes DOB: 1978-Jan-13, MRN: 760000522, Code Status, Process, Disease, Isolation, and Location: LGH ED. The 'Emergency Orders' tab is highlighted in red in the top navigation bar. The main content area is divided into several panels: Frequent Conditions/Power Plans, Medications, Labs / ECG, Imaging, Patient Care, Disposition Orders, and New Order Entry. The 'New Order Entry' panel is currently active, showing a search bar and buttons for 'Mine', 'Public', and 'Shared'. Other panels like 'Medications' and 'Labs / ECG' show lists of available order types.

Each component has a different heading based on order categories and can be further divided by sub-components.

Clicking the **black arrow** next to each heading allows you to expand and collapse sub-components.

Look through the components and add the following orders to your **Orders for Signature Inbox** by clicking:

2. Medications

▾ IV Fluids

- Sodium chloride 0.9% (NS) bolus

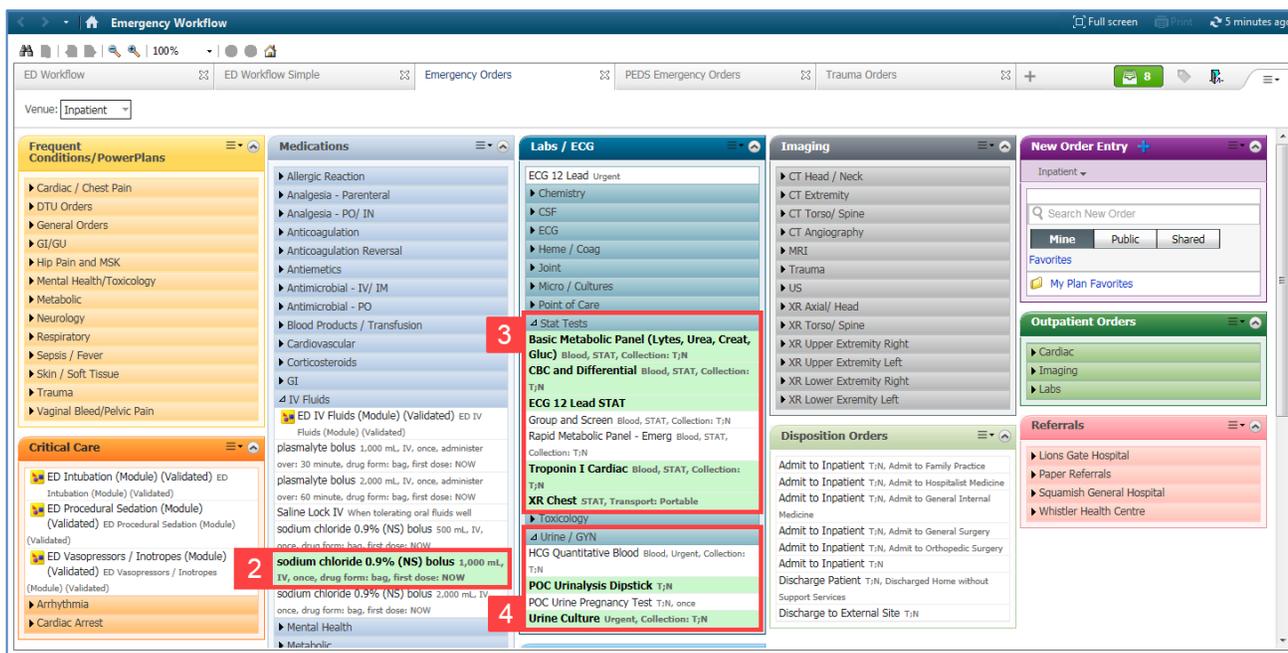
3. Labs/ECG

▾ Stat Tests

- Basic Metabolic Panel STAT
- CBC and Differential, STAT
- ECG 12 Lead STAT
- Troponin I Cardiac
- XR Chest, STAT, Transport: Portable

4. ▾ Urine/GYN

- POC Urinalysis Dipstick
- Urine Culture

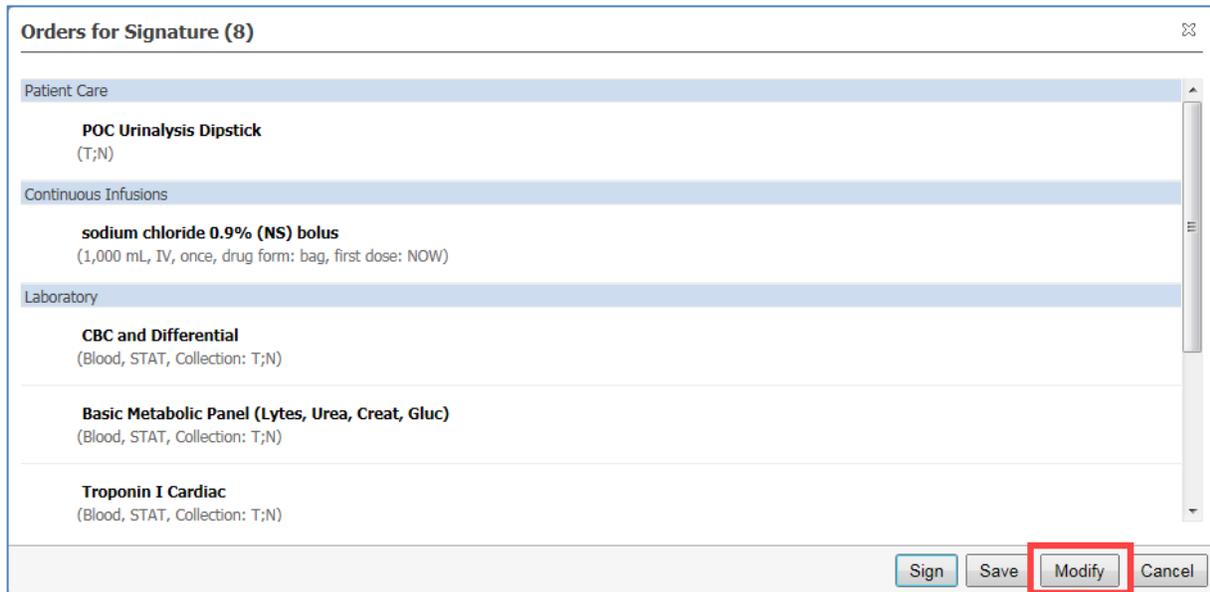


5. When done selecting **Orders** click the green **Orders for Signature inbox** icon.

The **Orders for Signature Summary** window will open.

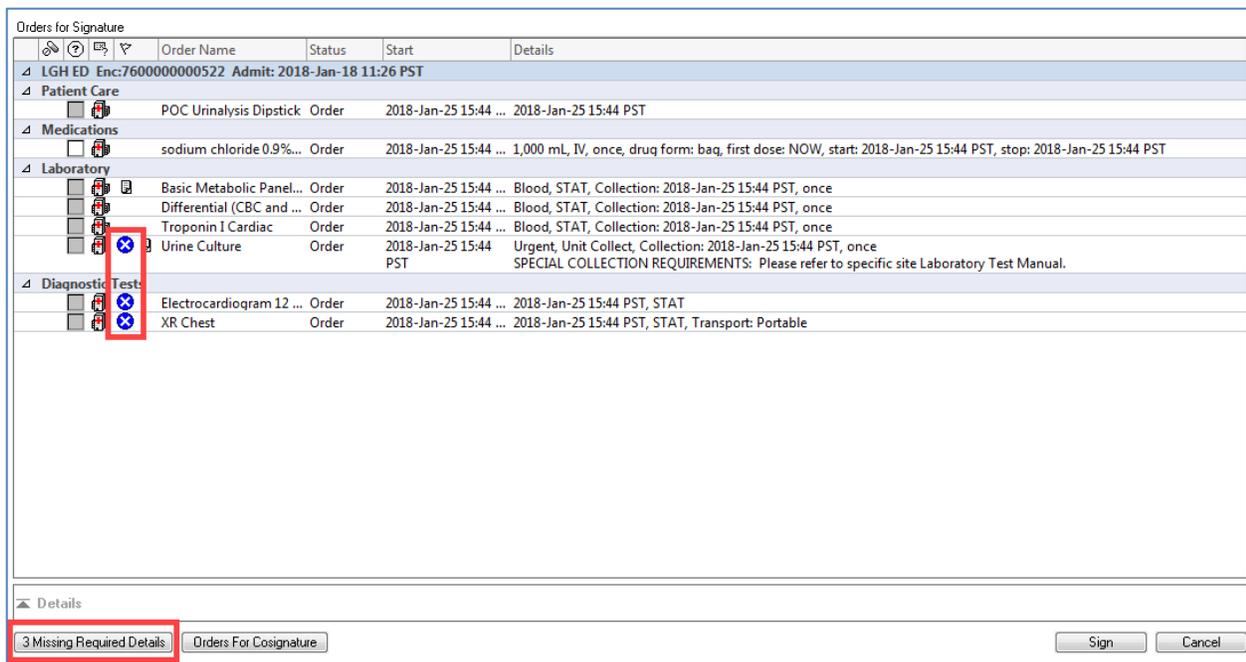
Clicking the **Modify** button will take you to order details for review.

While it is possible to directly Sign orders from this window, it is considered best practice to always Modify orders to ensure the order details are correct.



The **Order Details** window will open.

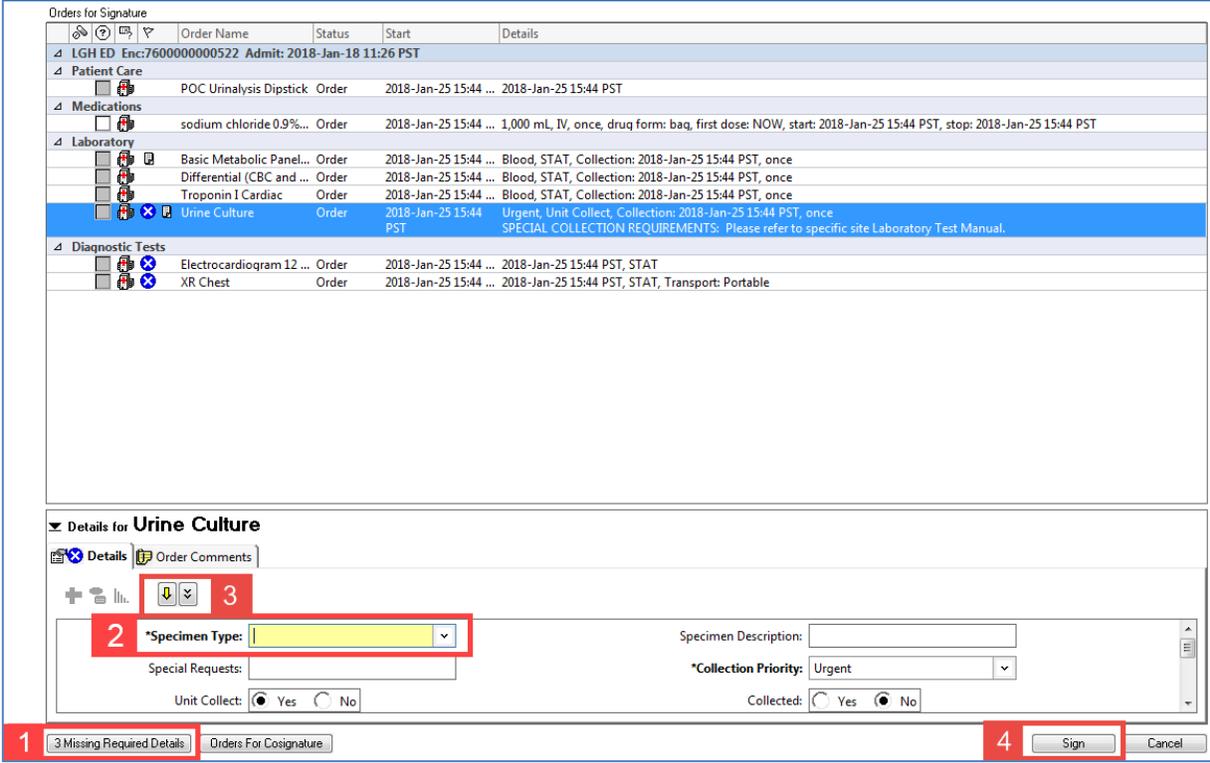
Orders with a missing mandatory field will be marked with a blue  icon and will be identified in the Missing Required Details button in the lower left portion of the window.



1. Click the **3 Missing Required Details** button.
2. Complete the required Mandatory Fields for the Urine Culture order.
3. Use these icons to navigate to the next Mandatory field that needs to be completed:
The **Yellow Arrow**  icon will navigate to the Next Missing Required Detail, while the **Double Chevron**  icon will bring you to the Next Order.

You can use the **Orders for Signature** window to modify other orders without Mandatory Fields or other fields to suit the patient's needs. Do so by selecting the order you wish to modify from the list.

Keep in mind: you can adjust the window panes if you find the window is not displaying enough information. You will know if the screen is adjustable when you see the cursor icon change .



The screenshot shows the 'Orders for Signature' interface. At the top, there is a table of orders with columns for Order Name, Status, Start, and Details. The 'Urine Culture' order is highlighted in blue. Below the table, the 'Details for Urine Culture' section is expanded, showing fields for Specimen Type, Specimen Description, Collection Priority, and Unit/Collected status. A red box highlights the '3 Missing Required Details' button at the bottom left, and another red box highlights the 'Sign' button at the bottom right. A yellow box highlights the 'Specimen Type' dropdown menu, and a red box highlights the 'Yellow Arrow' and 'Double Chevron' navigation icons.

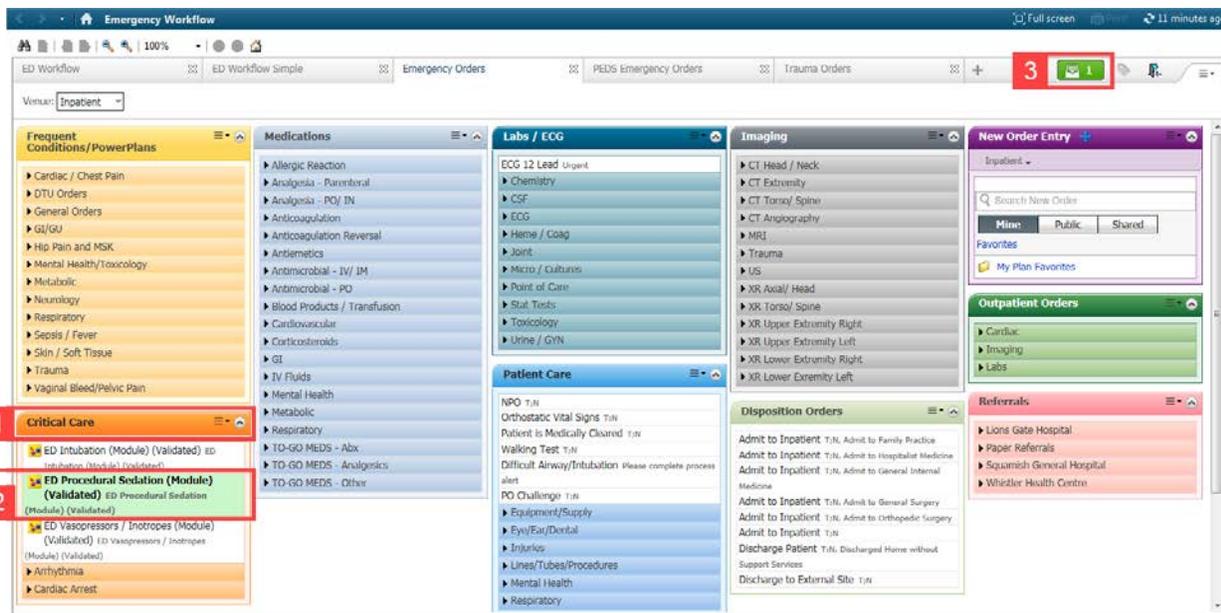
4. Once all the Mandatory Fields are complete for all orders, click the **Sign** button.
You will return to the Emergency Orders screen.

Part B – PowerPlans

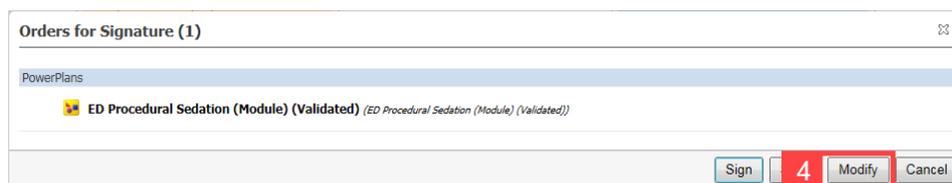
PowerPlans organize sets of orders that are often used together. They are similar to Pre-Printed Order Sets (PPOs). The PowerPlan icon  acts as a visual cue.

The x-ray ordered by the outgoing Provider shows a large right pneumothorax. You decide to insert a chest tube under Procedural Sedation.

1. From the Emergency Orders tab, expand the **Sedation-Procedural** subcomponent under the **Critical Care** section.
2. Select the **ED Procedural Sedation (Module)**.
3. Click the green **Orders for Signature** inbox  icon



4. In the **Orders for Signature** pop-up window, select **Modify** as modifying a PowerPlan is mandatory.



5. Choose the appropriate drugs by checking the boxes. For example, Propofol and Ketamine.
6. Click **Orders for Signature**.

ED Procedural Sedation (Module) (Validated) (Initiated Pending)

Component	Status	Dose ...	Details
Patient Care			
<input type="checkbox"/> Nitrous Oxide Gas Administration			PRN, for sedation
Medications			
<input type="checkbox"/> ketamine		200 mg, IV, as directed, drug form: inj	Have ketamine 200 mg IV drawn up for ED procedural sedation at bedside. Hold first dose until directed
<input type="checkbox"/> proPOFol		200 mg, IV, as directed, drug form: inj	Have proPOFol 200 mg IV drawn up for ED procedural sedation at bedside. Hold first dose until directed
<input type="checkbox"/> fentanyl		100 mcg, IV, as directed, drug form: inj	Have fentanyl 100 mcg IV drawn up for ED procedural sedation at bedside. Hold first dose until directed
To order ketofol, select both ketamine and proPOFol			
<input type="checkbox"/> ketamine		100 mg, IV, as directed, drug form: inj	Have ketamine vial(s) ready at bedside to be mixed with proPOFol. Hold first dose until directed
<input type="checkbox"/> proPOFol		100 mg, IV, as directed, drug form: inj	Have proPOFol vial(s) ready at bedside to be mixed with ketamine. Hold first dose until directed

0 Missing Required Details Orders For Cosignature **6** Orders For Signature Cancel

7. A screen to review your selected orders will appear. Click **Sign** when done.

Order Name	Status	Start	Details
ED Procedural Sedation (Module) (V...	Initiated Pending		placing 2 order(s)
4 LGH ED Enc:7600000000522 Admit: 2018-Jan-18 11:26 PST			
Medications			
<input checked="" type="checkbox"/> ketamine	Order	2018-Jan-26 11:00 PST	200 mg, IV, as directed, drug form: inj, start: 2018-Jan-26 11:00 PST Have ketamine 200 mg IV drawn up for ED procedural sedation at bedside. Hold first dose until directed
<input checked="" type="checkbox"/> proPOFol	Order	2018-Jan-26 11:00 PST	200 mg, IV, as directed, drug form: inj, start: 2018-Jan-26 11:00 PST, stop: 2018-Feb-02 10:59 PST Have proPOFol 200 mg IV drawn up for ED procedural sedation at bedside. Hold first dose until directed

0 Missing Required Details Orders For Cosignature **7** Sign Cancel

- The window will populate with a complete list of patient orders and their status.
Click **Done** to close this window and return to the Emergency Workflow page.

ED-UrbanIPhy-MontyH, Monty DOB:1978-Jan-29 MRN:760000522 Code Status: Process: Location:LGH ED
 Allergies: Demerol HCl Age:39 years Enc:760000000522 Disease: Enc Type:Emergency
 Gender:Male PHN:10760000522 Dosing Wt:90 kg Isolation: Attending:Train, Emergency-Physician1, MD

Reconciliation Status: Meds History | Admission | Discharge

Orders Medication List Document In Plan

View

Plans
 Document In Plan
 Medical
 ED Procedural Sedation (Module) (Vali)
 ED Pain / Nausea / Vomiting (Module)
 Suggested Plans (0)
 Orders
 Admit/Transfer/Discharge
 Status
 Patient Care
 Activity
 Diet/Nutrition
 Continuous Infusions
 Medications
 Blood Products
 Laboratory
 Diagnostic Tests
 Procedures
 Respiratory
 Allied Health
 Consults/Referrals
 Communication Orders
 Supplies
 Non Categorized
 Medication History
 Medication History Snapshot
 Reconciliation History

Diagnoses & Problems
 Related Results
 Variance Viewer

Displayed: All Active Orders | All Inactive Orders | All Active Orders Show More Orders...

Order Name	Status	Dose ...	Details
Patient Care			
POC Urinalysis Dipstick	Ordered	2018-Jan-26 09:39 PST	
Medications			
ketamine	Ordered	200 mg, IV, as directed, drug form: inj, start: 2018-Jan-26 11:00 PST	Have ketamine 200 mg IV drawn up for ED procedural sedation at bedside. Hold first dose until directed
proPOFol	Ordered	200 mg, IV, as directed, drug form: inj, start: 2018-Jan-26 11:00 PST	Have proPOFol 200 mg IV drawn up for ED procedural sedation at bedside. Hold first dose until directed
sodium chloride 0.9%...	Ordered	1,000 mL, IV, once, drug form: bag, first dose: NOW, start: 2018-Jan-26 09:39 PST, stop: 2018-Jan-26 09:39 PST	
dimenhydrINATE	Ordered	25 mg, IV, q4h, PRN nausea or vomiting, drug form: inj, start: 2017-Dec-28 13:32 PST	GRAVOL EQUIV.
morphine (morphine ...)	Ordered	dose range: 1 to 5 mg, IV, q10min, PRN pain, drug form: inj, start: 2017-Dec-28 13:32 PST	
Laboratory			
Basic Metabolic Panel...	Ordered	Blood, STAT, Collection: 2018-Jan-26 09:39 PST, once	
CBC	Ordered	Blood, STAT, Collection: 2018-Jan-26 09:39 PST, once	
Differential (CBC and ...)	Ordered	Blood, STAT, Collection: 2018-Jan-26 09:39 PST, once	
Troponin I Cardiac	Ordered	Blood, STAT, Collection: 2018-Jan-26 09:39 PST, once	
Urine Culture	Ordered (Pending ...)	Urine, Midstream, Urgent, Unit Collect, Collection: 2018-Jan-26 09:39 PST, once	SPECIAL COLLECTION REQUIREMENTS: Please refer to specific site Laboratory Test Manual.
Diagnostic Tests			
Electrocardiogram 12 ...	Ordered	2018-Jan-26 09:39 PST, STAT, Reason: Chest Pain	
XR Chest	Ordered (...)	2018-Jan-26 09:39 PST, STAT, Reason: Chest Trauma, Transport: Portable	
XR Chest	Ordered (...)	2017-Dec-28 14:20 PST, STAT, Reason: 15 ft fall	
Electrocardiogram 12 ...	Ordered	2017-Dec-28 13:33 PST, Urgent	

Orders For Cosignature Orders For Sign **8** Done

You perform the chest tube insertion with assistance from the nurse with no complications.

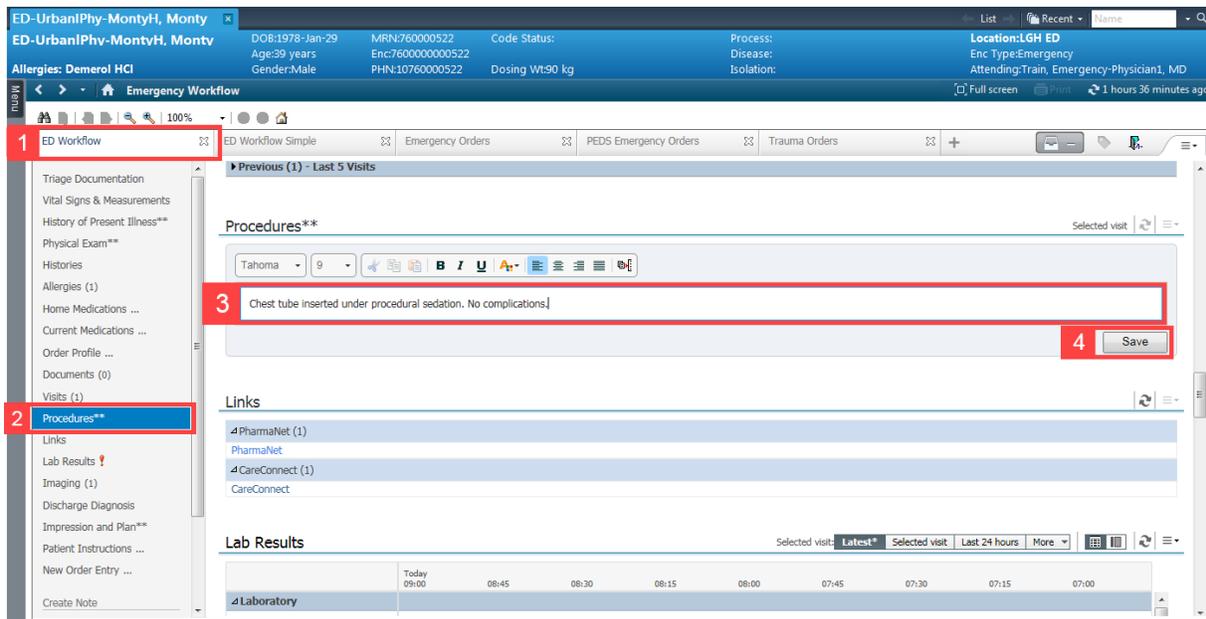
The nurse documents the sedation doses. If you wish to view the medication documentation it is visible in the **MAR** from the **Menu**.

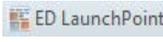
You will now document the Procedural Sedation in the ED Workflow tab.

✚ Part C – Documenting a Procedure

For the purpose of this activity you will document the chest tube insertion in the Procedures** section of the **ED Workflow** Tab. If you would not normally use this section, you are free to document this elsewhere, such as the Impression and Plan** section.

1. Click the ED Workflow Tab.
2. Scroll to or click on **Procedures****.
3. In the **Procedures**** text box type, *Chest tube inserted under procedural sedation.* You may use FESR if able.
4. Click Save. Note: the auto-save function may render this button inactive.



Return to **ED LaunchPoint** by utilizing the  icon in the **Toolbar**.

Activity 1.8 – Accessing Patient Results

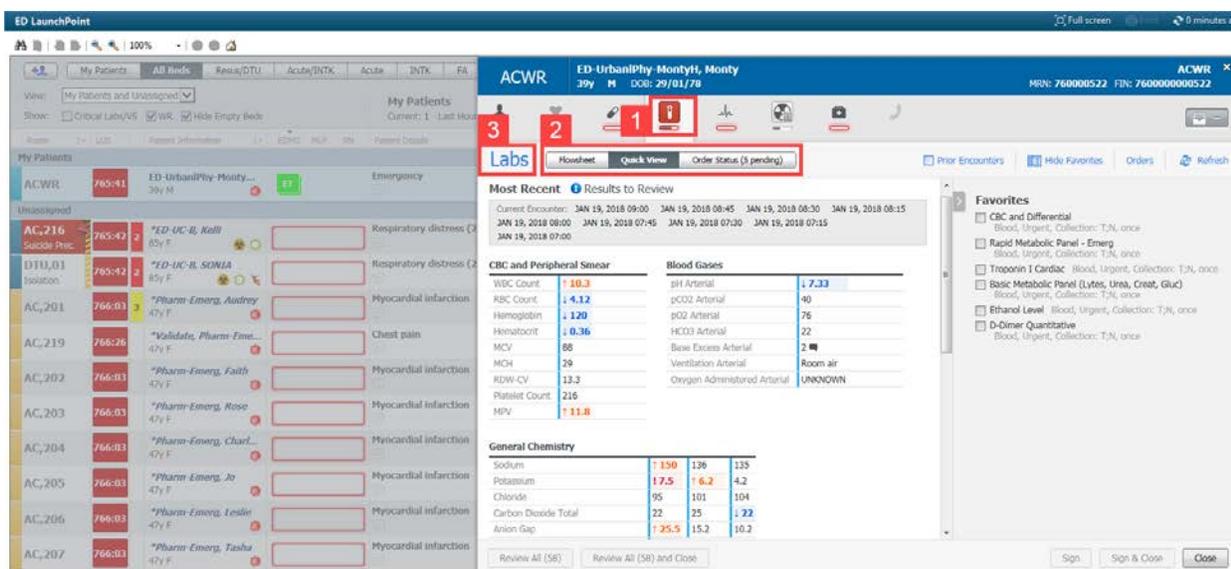
On ED LaunchPoint you notice Monty Pylon has critical lab values indicated by the Critical Lab  icon. You can access a quick view of your patient’s results using the **Single Patient View**.

1. Click the **Critical Lab**  icon on ED LaunchPoint.
2. Review each tab to familiarize yourself with the display.

Flowsheet with display results by time

Quick View will show the most recent results grouped by type.

Order Status shows the progress of an order, such as Ordered, Pending, and Complete.



The screenshot displays the ED LaunchPoint interface for patient Monty Pylon. On the left, a list of patients is shown, with 'ACWR 766-03 ED-UrbaniPhy-Monty...' highlighted. A red box highlights the 'Critical Lab' icon next to this patient. The main area shows the 'Labs' tab selected, with a 'Quick View' sub-tab also highlighted. The results are organized into sections: 'CBC and Peripheral Smear', 'Blood Gases', and 'General Chemistry'. A 'Favorites' panel is visible on the right side of the screen.

WBC Count	↑ 18.3
RBC Count	↓ 4.12
Hemoglobin	↓ 1.20
Hematocrit	↓ 0.36
MCV	88
MCH	29
RDW-CV	13.3
Platelet Count	216
MPV	↑ 11.8

pH Arterial	↓ 7.33
pO2 Arterial	49
pCO2 Arterial	76
HCO3 Arterial	22
Base Excess Arterial	2
Ventilation Arterial	Room air
Oxygen Administered Arterial	UNKNOWN

Sodium	↑ 130	136	135
Potassium	↑ 7.5	↑ 6.2	4.2
Chloride	95	101	104
Carbon Dioxide Total	22	25	↓ 22
Anion Gap	↑ 25.5	15.2	10.2

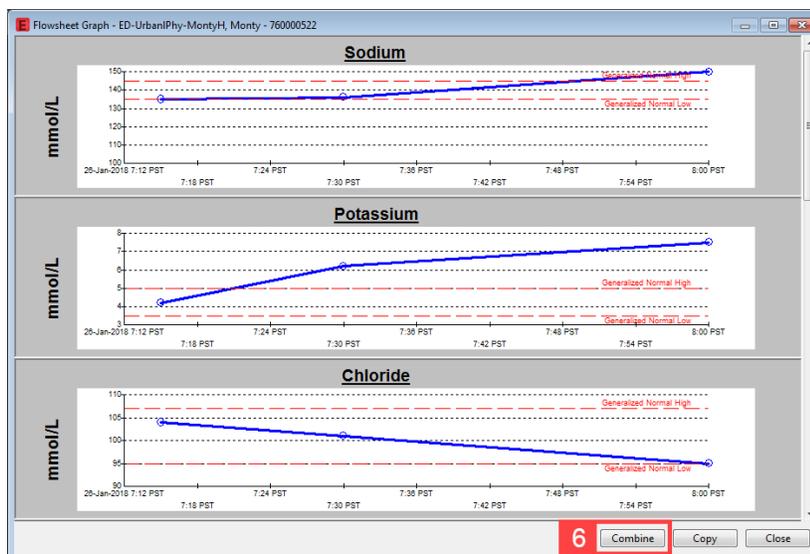
3. Clicking **Labs** will navigate you directly to **Results Review** in the patient’s chart. In this section, there are a number of different options to organize how you check patient results.

Various results can be seen in the Results Review section of the patient's chart. You have the option to review results in graph form.

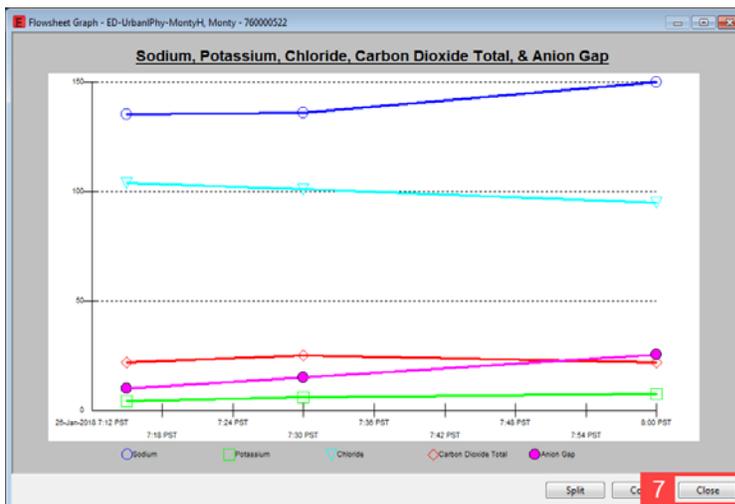
4. Select the labs you wish to view.
5. Click the **Graph** icon.

The screenshot shows the 'Results Review' section for patient 'ED-UrbaniPhy-MontyH, Monty'. The interface includes a top navigation bar with patient information and a main area with tabs for 'Recent Results', 'Advance Care Planning', 'Lab - Recent', etc. A 'Navigator' pane on the left allows selecting lab categories. A table of results is displayed for the period 'Friday, 2018-January-19 13:23 PST - Saturday, 2018-January-27 13:23 PST (Clinical Range)'. A red box labeled '5' points to the 'Graph' icon, and another red box labeled '4' points to the 'General Chemistry' section in the Navigator.

6. Individual graphs showing the selected labs will appear. Click the **Combine** button to generate a graph that displays all results together.



7. Close the window when done.



When you have finished reviewing the patient’s lab results return to **ED LaunchPoint** by utilizing the  button in the **Toolbar**.

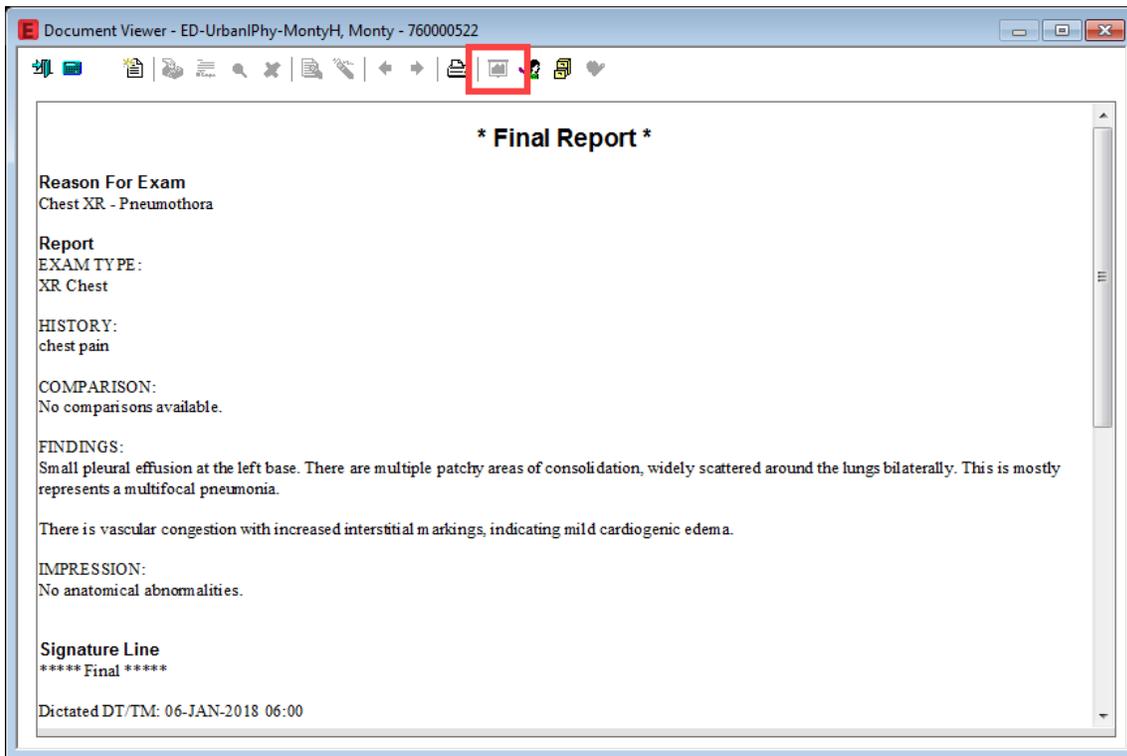
After reviewing Monty Pylon’s lab results and returning to **ED LaunchPoint**; you notice the **Radiology** icon with a layered document .

1. Continuing from the **Single Patient View**; click the **Radiology**  icon.
2. Click on the completed **XR Chest** indicated by blue text.
Take care to avoid selecting the checkbox as this will reorder the test.

The **Final Report** from the Radiologist will appear. Close the window when finished.

To perform a Wet Read on the XR Chest, you can click the  icon on the Radiology report. You can also navigate to PACS at any time by clicking the **PHSA PACS**  icon from the **Toolbar**.

Currently, the Training Domain does not support PACS but will be available for Go-Live.



Radiology reports can also be accessed through **Results Review** like lab test by clicking the **Radiology** heading in Single Patient View.

Exit **Single Patient View**

Activity 1.9 – Documenting Patient Diagnosis

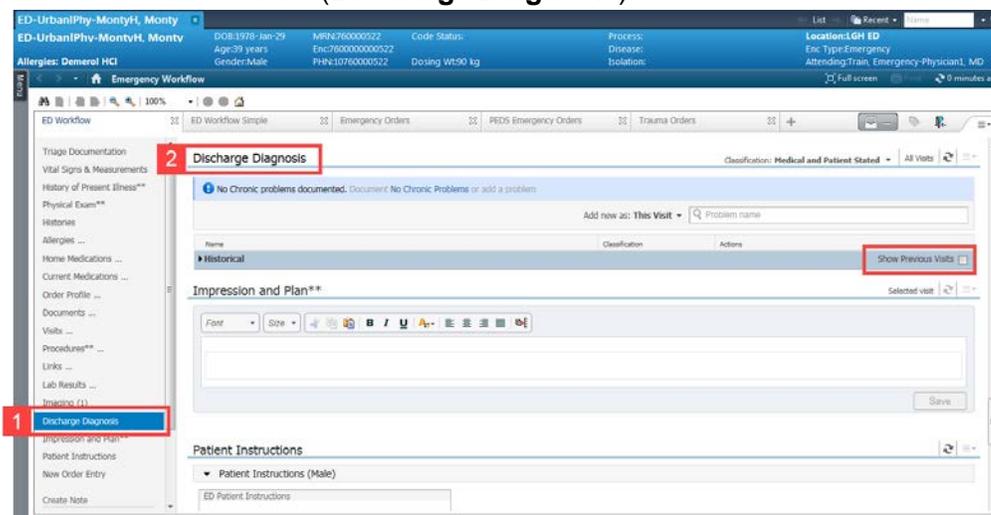
It is time to document a diagnosis From **ED LaunchPoint** click the patient’s name to enter the chart.

1. Navigate to the **Discharge Diagnosis** section on the ED Workflow tab.

Important: Do not use the Search Bar in this section as the diagnoses therein are not coded correctly and will disrupt department statistics. For now, coded diagnoses appear in all-capital letters, while non-coded do not. This is currently being configured and will be resolved.

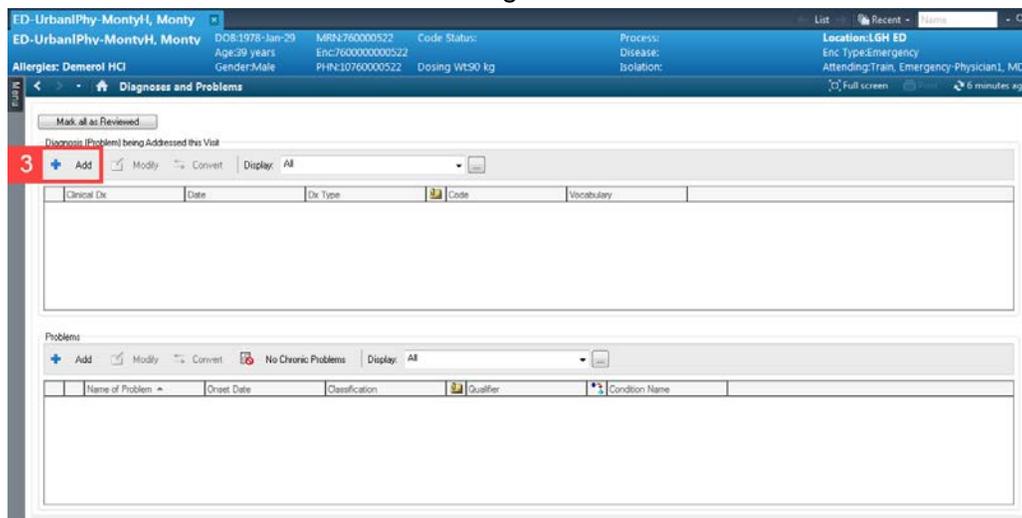
If a patient has past encounters in the system, a Show Previous Visits option will be displayed. To view a summary of past visits click the checkbox.

2. Click the section header (**Discharge Diagnosis**).

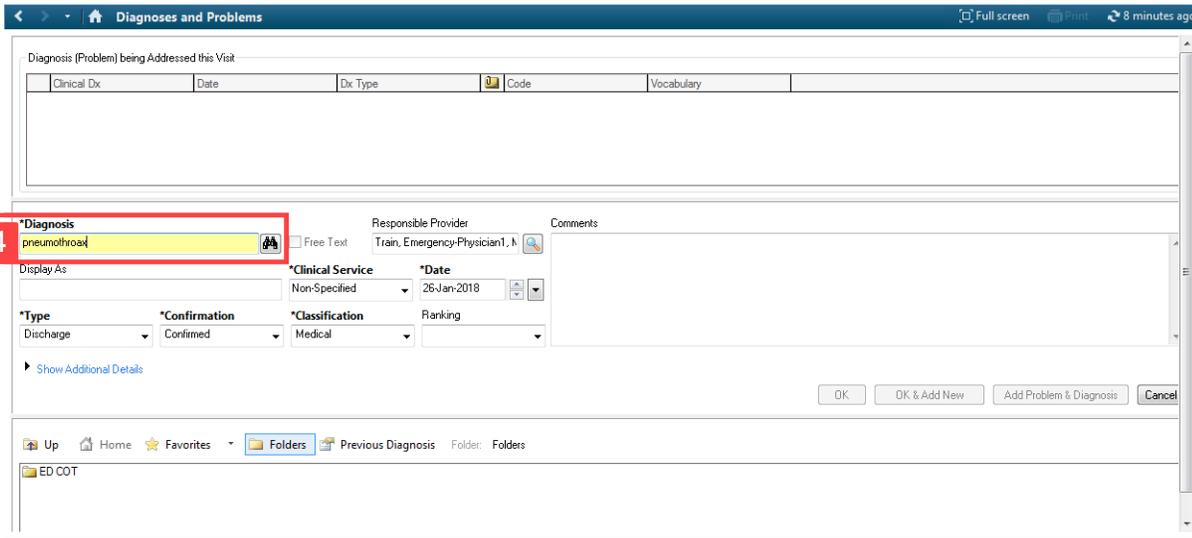


3. The system will open the chart to the Diagnosis and Problems section.

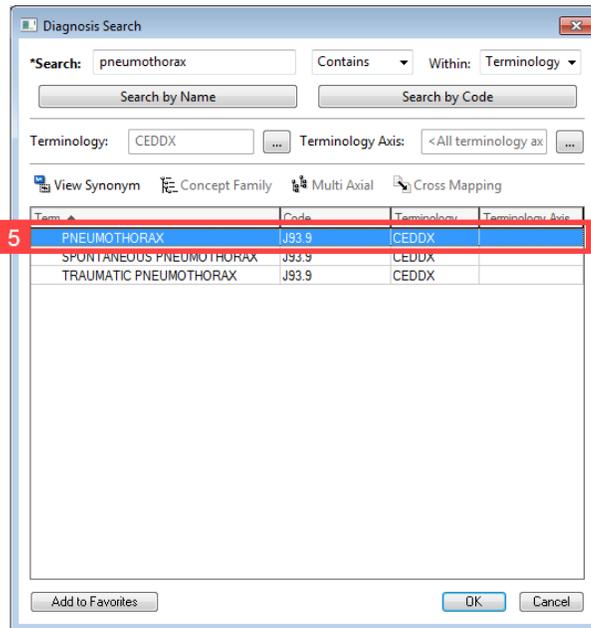
Click the **Add**  icon to add a new diagnosis.



4. Search *Pneumothorax*.



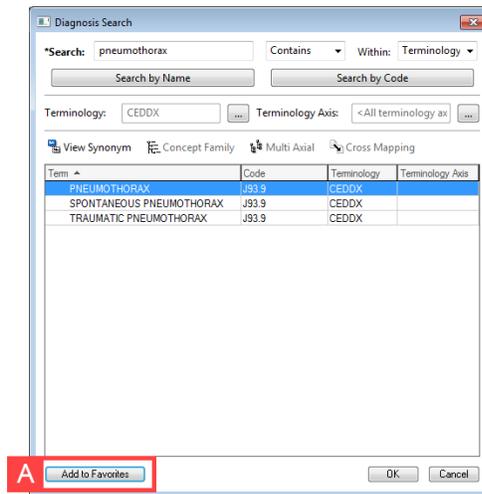
5. The **Diagnosis Search** window will appear. Select **Pneumothorax** from the search list (notice Pneumothorax is capitalized).



BONUS

If you find there are diagnoses that you use consistently and do not want to search every time, you can add these diagnoses to a favorite's folder for easy access.

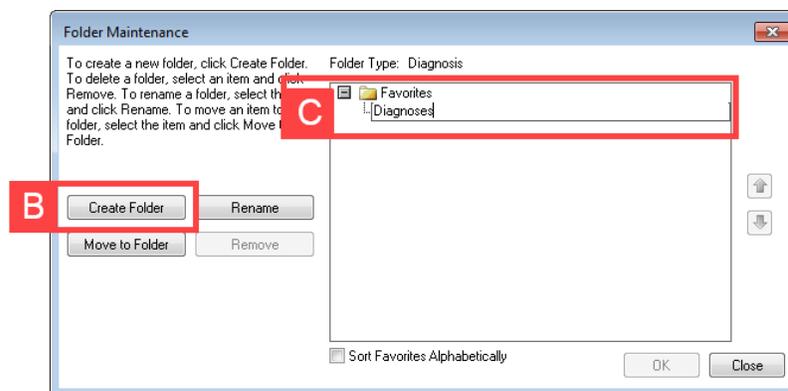
A. In the **Diagnosis Search** window, click **Add to Favorites**.



B. The Folder Maintenance Screen window will appear.

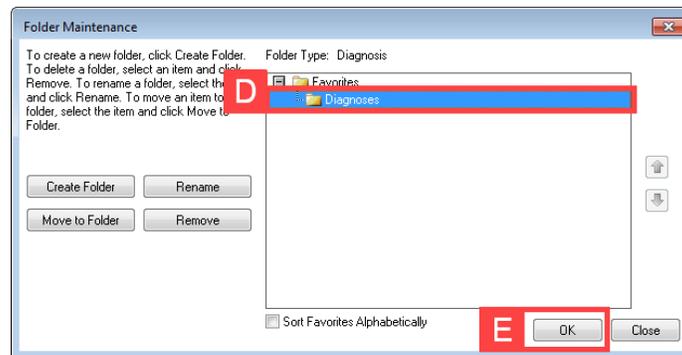
Click **Create Folder**.

C. In the text box that appears, name your folder and press the Enter key.

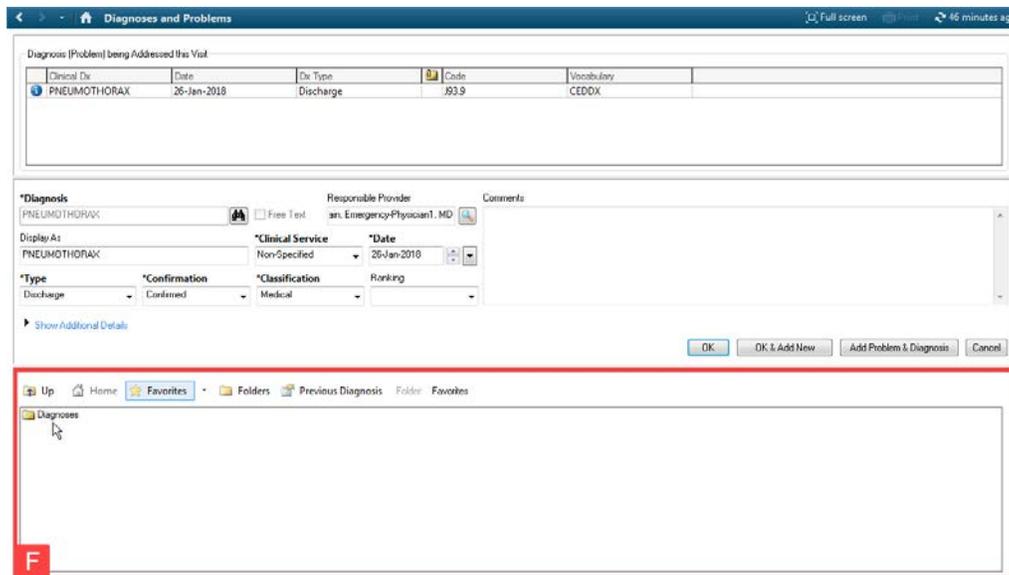


D. Highlight the newly created folder. This is a one-time step unless you are creating multiple Favorite Folders.

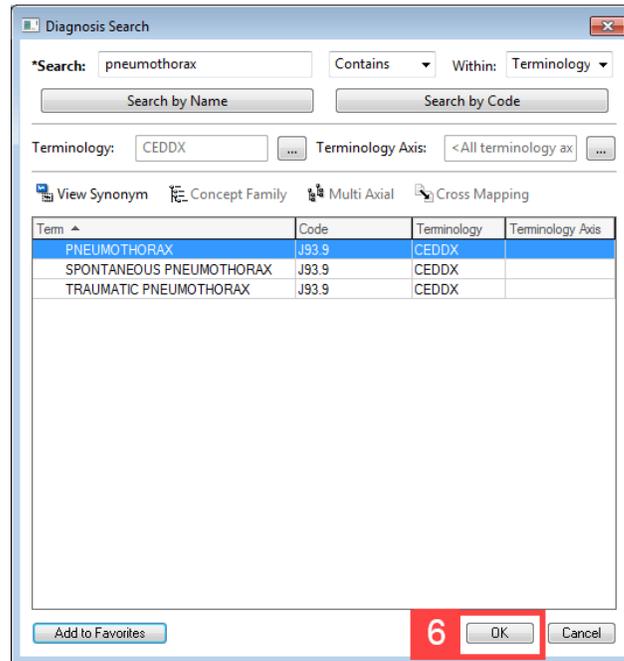
E. Click **OK**.



F. Your new folder will appear at the bottom of the screen. Clicking your folder will bring up any diagnoses you saved.



6. Click **OK**.



Pneumothorax will now appear on the Diagnosis List.

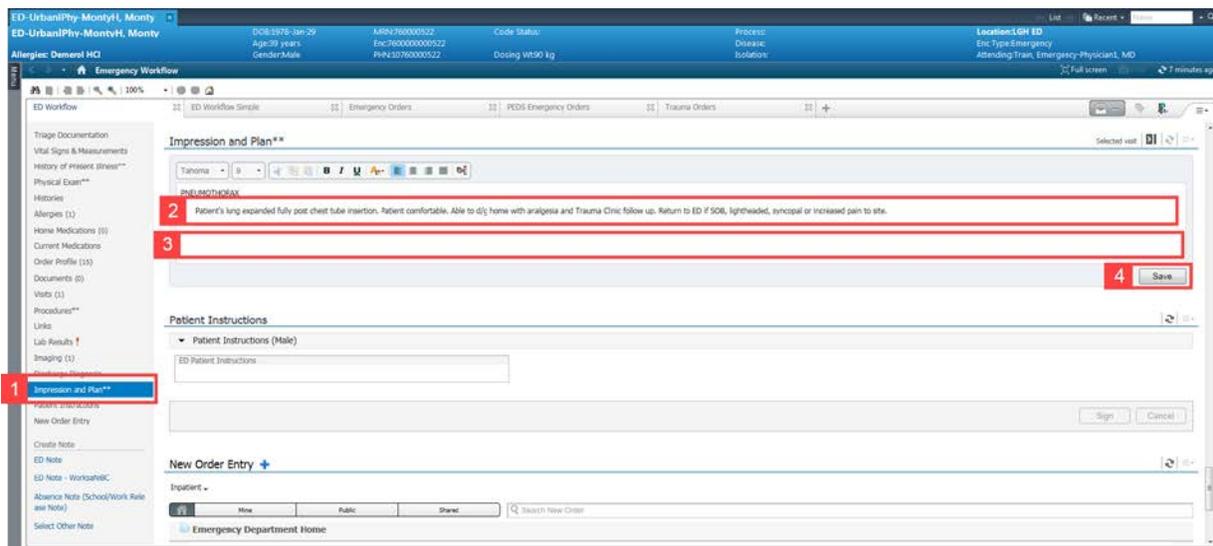
Activity 1.10 – Documenting Your Impression and Plan

Continuing from the ED Workflow page you need to document your Impression and Plan.

1. From the ED Workflow Tab's Table of Contents, click **Impression and Plan****.
2. You will notice 2 separate text boxes. The first box is related to your recently determined diagnosis. Document the following:

Patient lung expanded fully post chest tube insertion. Patient comfortable. Can be d/c'd home with analgesia and Trauma Clinic follow up. Return to ED if SOB, lightheadedness, syncope, or increased pain.

3. The second free text box is used to summarize the patient's overall care in the event of multiple diagnoses.
4. Click **Save** when done.



To demonstrate an additional function, click the **grey arrow**  to the far right of the section header.

The **Impression and Plan** section will pop-out for ease of scrolling between sections to allow the review of relevant patient information while documenting.

Knowledge Check

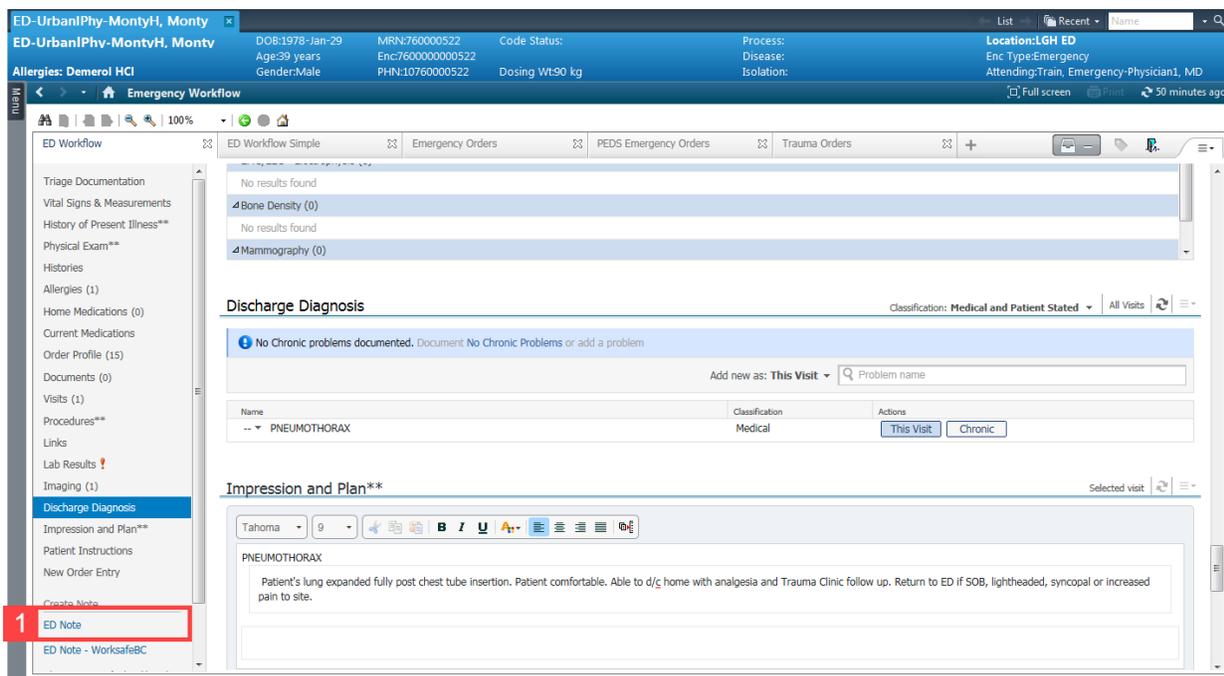
- What button separates the **Impression and Plan** section to allow scrolling up and down your **ED Workflow** screen?
- Why do some section titles in the **ED Workflow** screen have two **asterisks**** beside them?

Activity 1.11 – Completing an ED Note

The ED Note compiles all the documentation you entered in the ED Workflow page, as well as diagnostic results and information entered by other health professionals.

In this activity you can use CIS to easily complete Fatimah’s WSBC documentation using Dynamic Documentation. Dynamic Documentation templates standardize documentation practices and limit possible errors.

1. Click **ED Note** in the ED Workflow Table of Contents.



The screenshot shows the 'Emergency Workflow' interface for patient 'ED-UrbaniPhy-MontyH, Monty'. The patient's information is displayed at the top, including DOB (1978-Jan-29), MRN (7600000522), and location (LGH ED). The left sidebar contains a 'Table of Contents' with various sections like 'Triage Documentation', 'Vital Signs & Measurements', and 'Discharge Diagnosis'. The 'ED Note' option is highlighted with a red box and a red number '1'. The main content area shows 'Discharge Diagnosis' with a message: 'No Chronic problems documented. Document No Chronic Problems or add a problem.' Below this, there is a table with one entry: 'PNEUMOTHORAX' classified as 'Medical'. The 'Impression and Plan**' section is also visible, containing a text area with the following text: 'PNEUMOTHORAX Patient's lung expanded fully post chest tube insertion. Patient comfortable. Able to d/c home with analgesia and Trauma Clinic follow up. Return to ED if SOB, lightheaded, syncopal or increased pain to site.'

- The **ED Note** will populate with information entered in the chart. You may add additional information, if necessary.

Review the information in the ED Note carefully. Once you sign the document, it cannot be altered.

An **Addenda** can be added if changes to the patient condition or care occur.

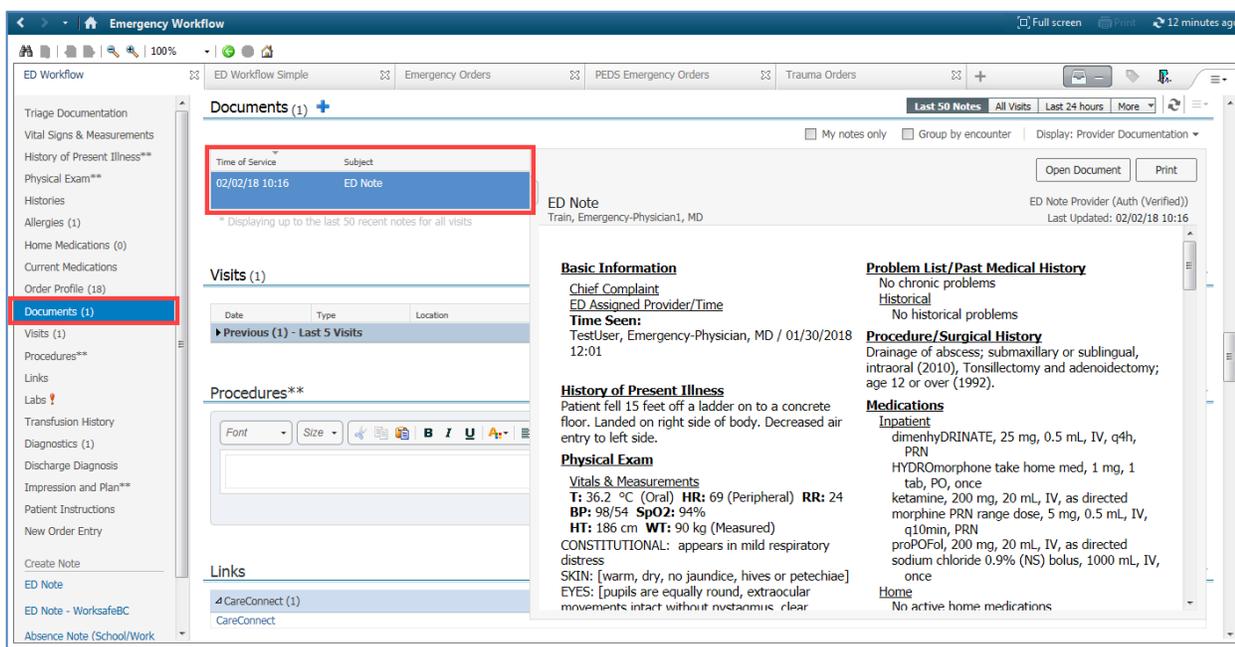
- Click **Sign/Submit** to sign your note.

The screenshot shows a web-based interface for an ED Note. At the top, there is a header with patient information: ED-UrbaniPhy-MontvH, Monty. Below this, a blue bar contains various fields: Allergies: Demerol HCl, DOB: 1978-Jan-29, MRN: 7600000522, Code Status, Process: Disease: Isolation, Location: LGH ED, Enc Type: Emergency, and Attending: Train, Emergency-Physician1, MD. The main content area is titled 'ED Note' and contains several sections: 'Basic Information' (Chief Complaint, ED Assigned Provider/Time, Time Seen), 'History of Present Illness' (Patient fell 15 feet off a ladder), 'Physical Exam' (Vitals & Measurements, CONSTITUTIONAL, SKIN, EYES, HENT, NECK, PULMONARY, CARDIOVASCULAR, GASTROINTESTINAL, GENITOURINARY, NEUROLOGIC, MUSCULOSKELETAL, PSYCHIATRIC), 'Problem List/Past Medical History', 'Procedure/Surgical History', 'Medications', 'Allergies', and 'Social History'. At the bottom right, there is a red box with the number '3' and a 'Sign/Submit' button, along with 'Save', 'Save & Close', and 'Cancel' buttons.

Note: If you are called away before you can finish your note, clicking **Save** keeps a copy as “in progress”, still viewable but not finalized. ED Providers requested this feature so important clinical information is accessible to other clinical staff, even if a Provider cannot complete their documentation.

You can open an “in progress” document at any time, but be aware opening a note “in progress” will lock out all other users. If you wish to view such a note, a single click or hovering over a Document title in the Document section of the ED Workflow screen opens a preview pane that does not lock the note.

Keep in mind, if you are viewing a colleague’s note outside of the preview mode, you lock them out of their note and prevent them from completing their documentation.

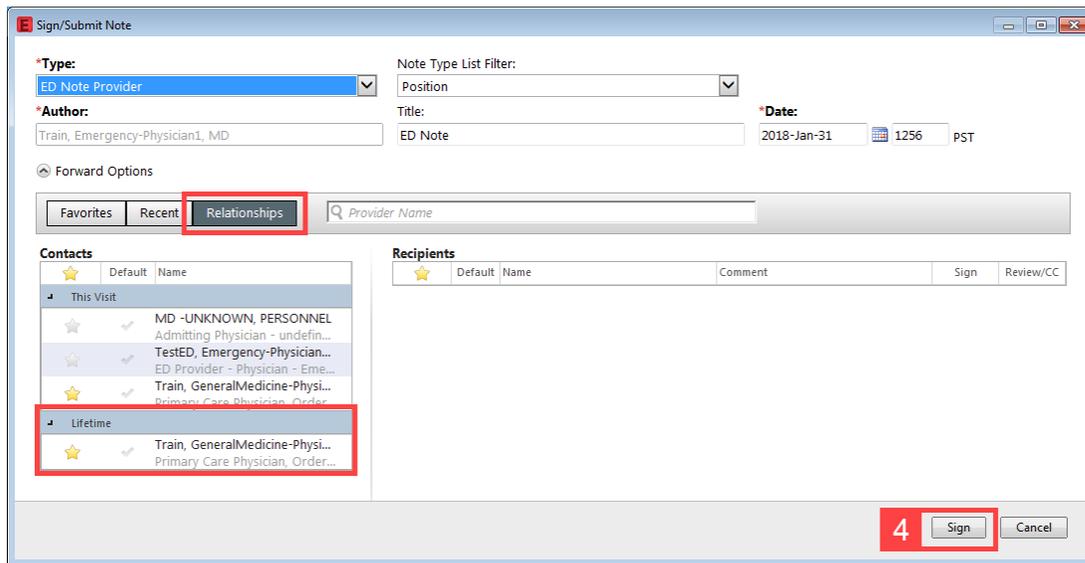


4. The **Sign/Submit Note** window will open, allowing you to forward the note to any provider on CIS. They will be able to read your note in their **Message Center**.

The **Relationships** tab displays any Provider that came in contact with the patient this visit, as well as any lifetime Providers they have (such as GP, OBGYN or oncologist).

The **Provider Name** Search Bar allows you to search out a specific provider to whom you may wish to forward the note. The searchable list will contain anyone listed in the College of Physicians of BC.

Click **Sign** when you are ready.



The ED Note is now available in the patient's chart under **Documents**. Single-click the note to open the preview pane.

Activity 1.12 – Patient Discharge with Meds to Go

Monty Pylon has been stabilized and is now unlikely to require admission. You would like to order a consult to the Trauma Clinic and issue Meds to Go, and then send him home.

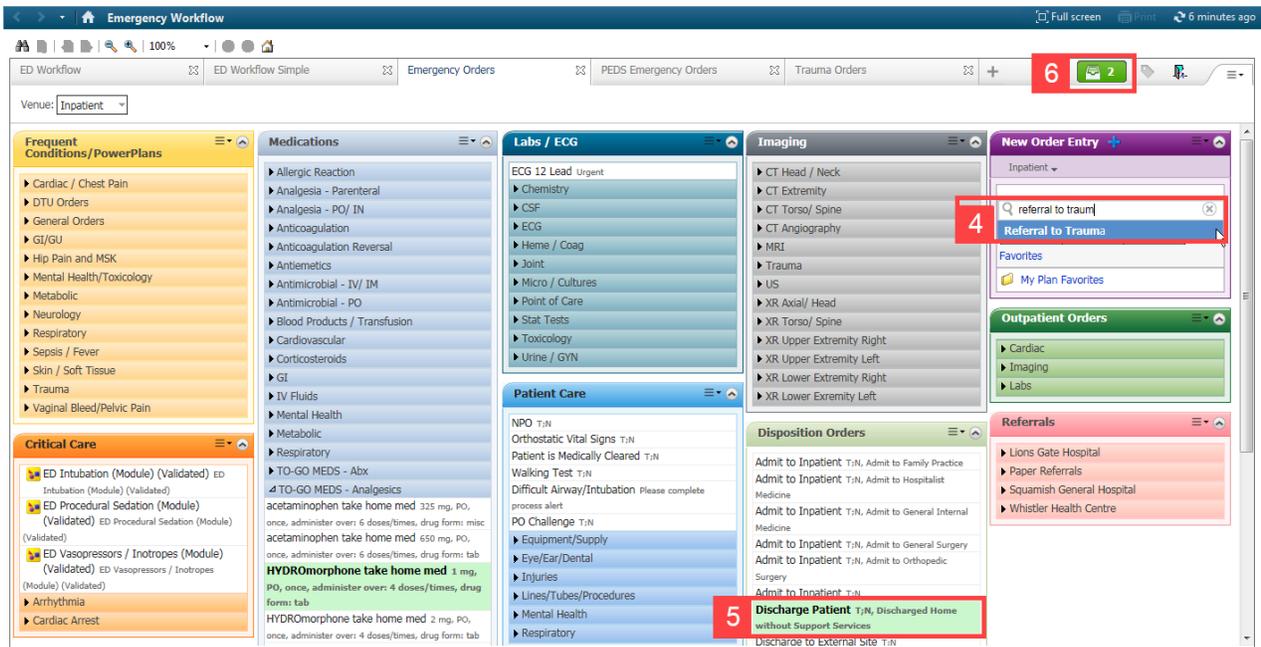
1. In the patient's chart navigate to the **Emergency Orders** Tab from the **Emergency Workflow** page.
2. Under the Medications component, expand **TO-GO MEDS – Analgesics** by clicking the **black arrow** icon.
3. Select **HYDRomorphone take home med 1 mg, PO, once, administer over: 4 dose/times, drug form: tab.**

The screenshot displays the Emergency Workflow interface for patient Monty Pylon. At the top, patient information is shown: ED-UrbaniPhy-MontyH, Monty, DOB: 1978-Jun-29, MRN: J760000522, Code Status: [blank], Process: [blank], Disease: [blank], Isolation: [blank], Location: LGH ED, Enc Type: Emergency, Attending: Train, Emergency-Physician1, MD. Allergies: Demerol HCl. The interface is divided into several panels: PowerPlans, Medications, Labs / ECG, Imaging, New Order Entry, Disposition Orders, and Patient Care. The Medications panel is expanded to show 'TO-GO MEDS - Analgesics'. The 'Emergency Orders' tab is selected and highlighted with a red box labeled '1'. The 'TO-GO MEDS - Analgesics' category is expanded, and the option 'HYDRomorphone take home med 1 mg, PO, once, administer over: 4 doses/times, drug form: tab.' is highlighted with a red box labeled '3'. Other options in the list include acetaminophen take home med 650 mg, PO, and HYDRomorphone take home med 2 mg, etc. The Patient Care panel shows various tasks like NPO, Orthostatic Vital Signs, Patient is Medically Cleared, Walking Test, PO Challenge, Eye/Ear/Dental, Injuries, Lines/Tubes/Procedures, and Respiratory.

4. Search and select for the order *Referral to Trauma* in the **New Order Entry** component search bar.

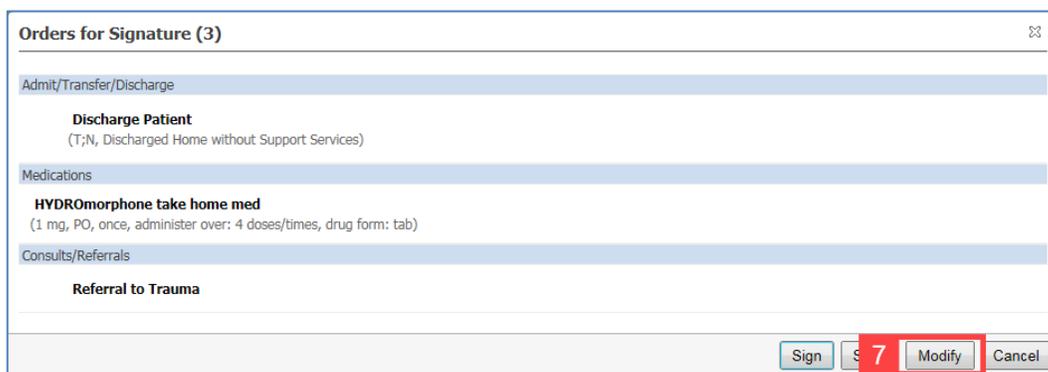
Note the difference between Referral versus Consult. Referrals are for outpatient follow-up while Consults are for inpatient services.

5. From the **Disposition Orders** component, select **Discharge Patient**.
6. Click the green **Orders for Signature Inbox**  icon.



7. The **Orders for Signature Summary** window will appear.

Click **Modify**.



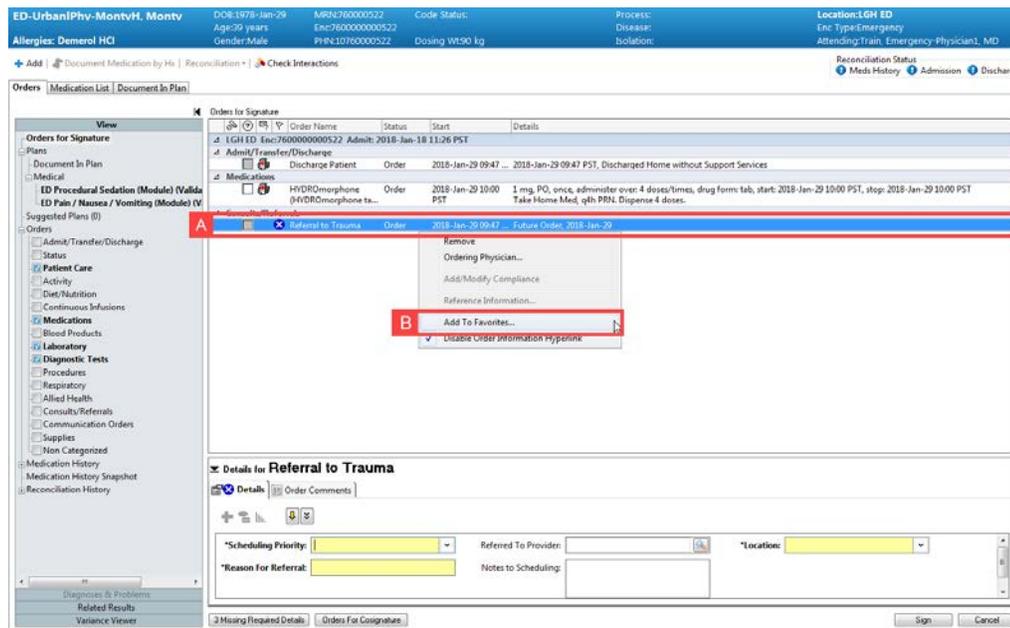
The **Orders for Signature** window will open.

BONUS

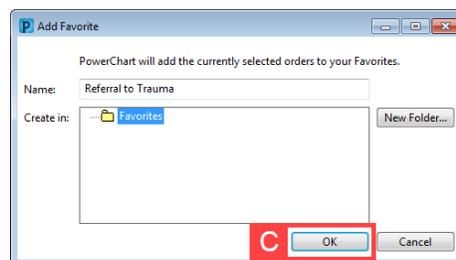
In the previous bonus activity, you learned about **Favorites Folders** for diagnoses. If there is an order you need to enter often, consider saving it as a favorite.

Add **Referral to Trauma** as one of your favorite orders.

- A. Continuing from the **Orders for Signature** window, right click on the **Referral to Trauma** order.
- B. Select **Add to Favorites** from the drop-down list that appears.



- C. The **Add Favorite** window will appear. Click **OK**.



BONUS

- D. Your favorite orders can be accessed from the **New Order Entry** component in the **Emergency Orders** Tab. You will also get the opportunity to build your Favorites Folders during the Favorites Fair.

The screenshot displays the 'Emergency Workflow' application interface. The top navigation bar includes tabs for 'ED Workflow', 'ED Workflow Simple', 'Emergency Orders', 'Peds Emergency Orders', and 'Trauma Orders'. The 'Emergency Orders' tab is active. On the left, there are panels for 'Frequent Conditions/PowerPlans' and 'Critical Care'. The main area is divided into several columns: 'Medications', 'Labs / ECG', 'Imaging', and 'Patient Care'. On the right, the 'New Order Entry' panel is open, showing a search bar and a list of 'Favorites'. A red box highlights the 'My Plan Favorites' option, with a red letter 'D' next to it. Below this, there is a 'Refer to Trauma Future Order' button. Other panels include 'Outpatient Orders' and 'Referrals'.

8. From the **Orders for Signature** window, click the **Missing Required Details** button.
9. The **Details for Referral to Trauma** section will populate. Adjust the window pane if the window size is preventing you from seeing all of the order fields.

Complete the order fields as follows:

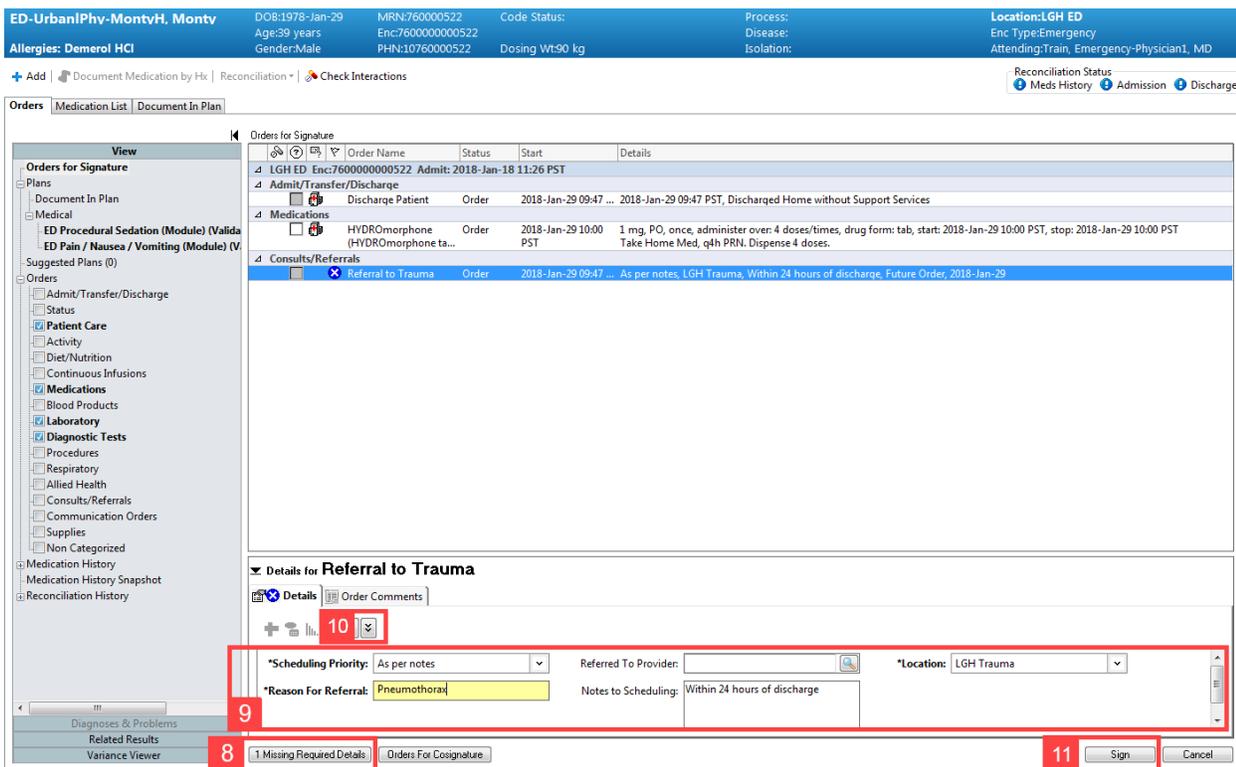
*Scheduling Priority: *As per notes.*

Notes to Scheduling: *Within 24 hours of discharge.*

Location: *LGH Trauma*

Reason for Referral: *Pneumothorax*

10. Click the **Double Chevron**  icon to ensure there are no further missing details.
11. When you are satisfied with all orders and details click **Sign**.



The screenshot displays the patient information for ED-UrbanIPhy-MontyH, Monty. The patient's DOB is 1978-Jan-29, MRN is 7600000522, and they are currently in the LGH ED. The patient has an allergy to Demerol HCl. The interface shows a list of orders for signature, including a referral to trauma. The details for the referral to trauma are expanded, showing a scheduling priority of 'As per notes', a location of 'LGH Trauma', and a reason for referral of 'Pneumothorax'. The notes to scheduling are 'Within 24 hours of discharge'. The interface also shows a 'Missing Required Details' button and a 'Sign' button.

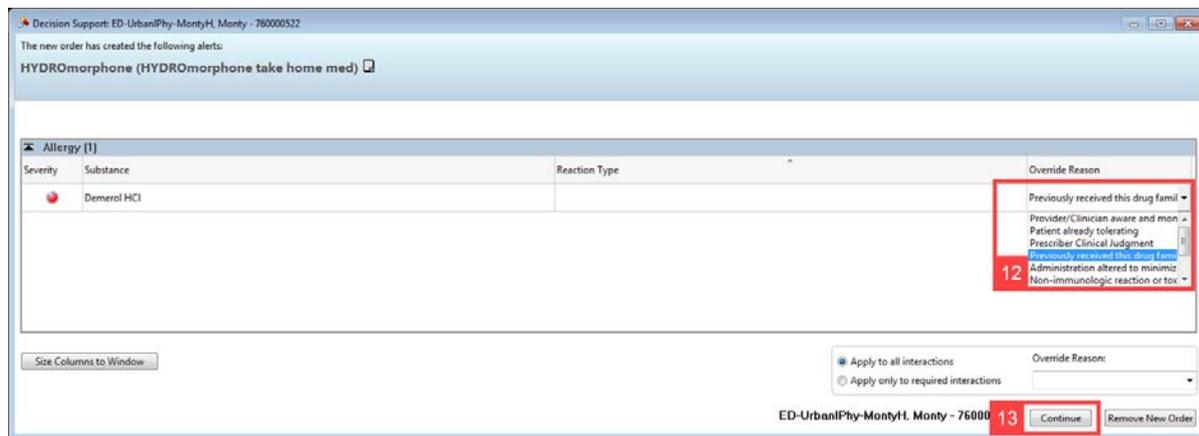
Monty Pylon has a recorded allergy to Fentanyl.

An alert will appear stating this. You inquire about his reaction to Hydromorphone, and Monty reports he has had Hydromorphone in the past with no adverse reaction.

12. In the Override Reason column, click the black downward arrow  to open a dropdown menu of available options.

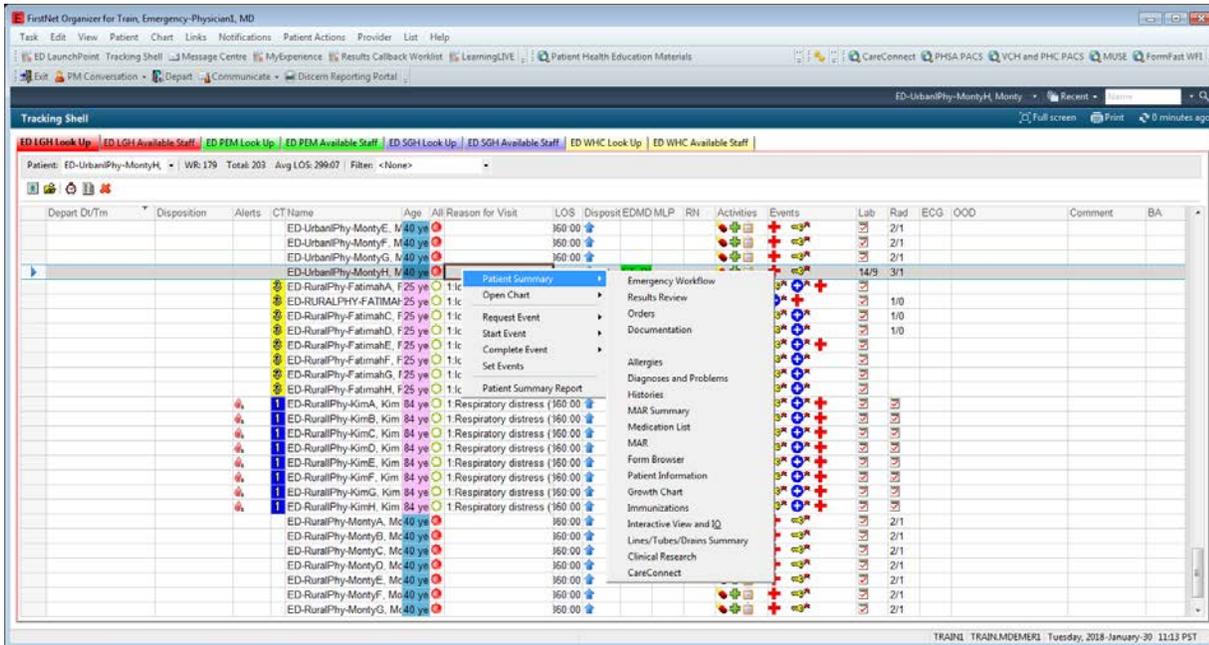
Select **Previously received this drug family**.

13. Select **Continue** when done.



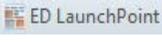
Monty Pylon is now ready to be discharged with Meds to Go and follow-up care at the Trauma Clinic.

There are a number of ways to access discharged patients' information. Incomplete documentation and Orders for Cosignature will go to your Message Centre Inbox. If you need to access Monty's chart after he has left the department, you can also use the **Tracking Shell** button on your Toolbar. The screen looks similar to ED Launchpoint, and the Chart components can be brought up by right-clicking the patient's name.

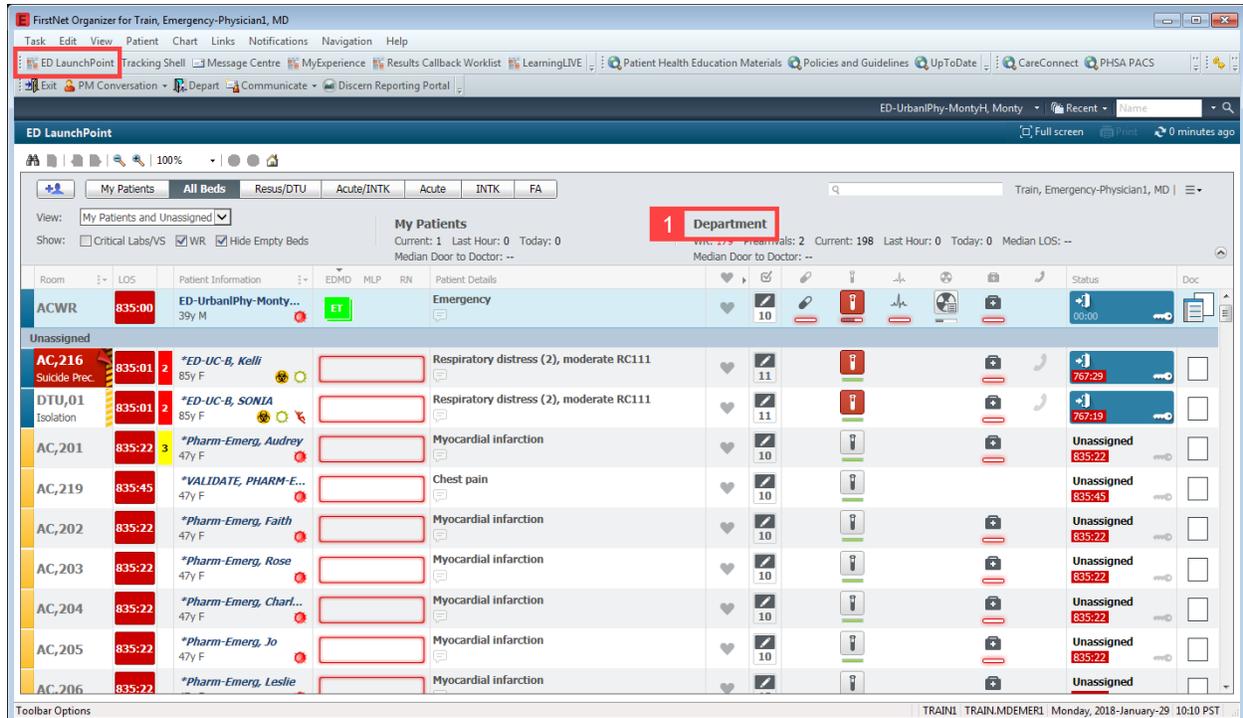


Activity 1.13 – Patient List Report

If needed, the system is able to print a report of the patients seen by a Provider in a given time period. Fee-for-Service Providers may find this function especially useful. This can also help at the end-of-shift to ensure you have no outstanding patients.

Return to **ED LaunchPoint** by clicking the  icon in the **Toolbar**.

1. Click **Department**.



2. The **Launch Report** window will open. Select **Emergency** as the Report Type.

3. Select **Patient for Care Provider** for the desired report.

4. Click **OK**.



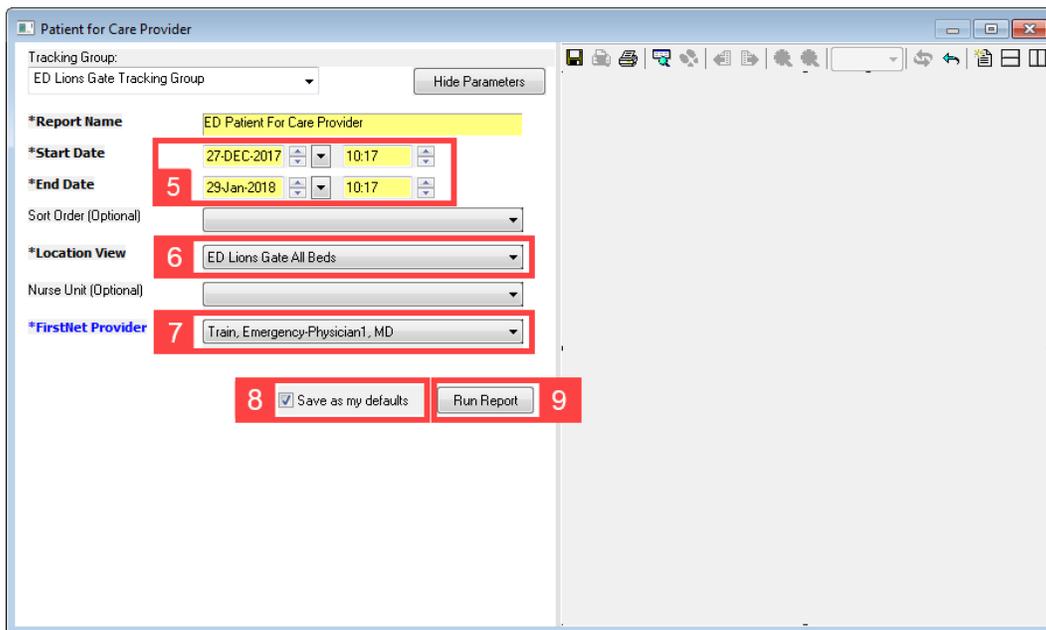
The **Patient for Care Provider** window will open.

5. When entering a ***Start Date**, the time should accurately reflect the start of your shift or what you want the report to reflect.

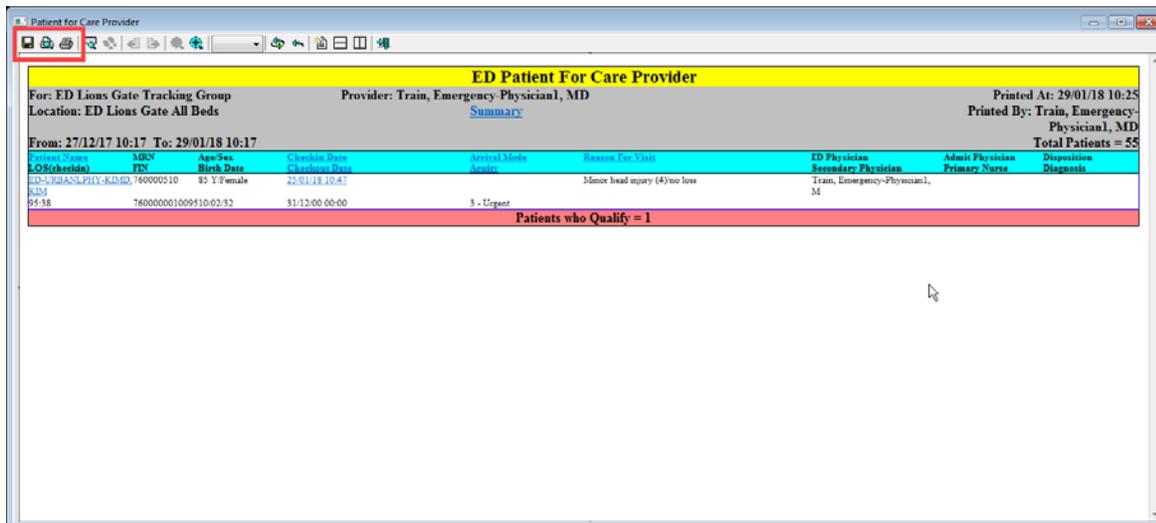
For the purpose of this activity, set the ***Start Date** to *2017-Dec-01*.

The ***End Date** will default to the current date and time but should reflect the end of your shift or what you want the report to reflect.

6. From the ***Location View** dropdown list, select **ED Lions Gate All Beds**.
7. From the ***FirstNet Provider** dropdown list, find and select your **name**.
8. If you typically work in this location, you can select **Save as my defaults**.
9. Click **Run Report**



The **Report Window** will open titled with the type of report you have requested. You can **Print** or **Save** your report.



You can open multiple reports at once by using the Split Window icons  to divide your screen and run a new report.

Knowledge Check

- What do you have to click on the **ED LaunchPoint** screen to open the Launch Report window?

SCENARIO 1 Key Learning Points

Activity 1.1 ED LaunchPoint Multi-Patient List Overview

PART A

- The ED LaunchPoint Multi-Patient List functions as a tracker for all patients in the ED
- Much of the information you need about patients is available from ED LaunchPoint
- Filter using Zone Tabs, the View menu or Show checkboxes
- You can access Message Center, Results Callback and LearningLive from the upper toolbars
- Use Message Centre to Co-Sign Orders, finish documentation, and refuse proposed orders
- Follow up on patients with positive culture results using Results Callback Worklist
- Use the My Experience function to switch between multiple roles
- Click and hold the vertical row of dots beside each section of icons to rearrange the Toolbar

PART B

- Each column in ED LaunchPoint contains important information
- Alerts are found in the Room column (colours and text) and patient information column (as icons)
- ED LaunchPoint shows associated providers and clinicians, as well as orders' status at-a-glance
- Patient disposition and documentation status are also easily viewed

Activity 1.2 Check-In and Patient Handover

- Check-in at the start of shift is mandatory
- The Check-in screen allows you to set your screen presence (initials), role and location
- Providers must assign themselves to patients before charting on them
- The first Provider assigned will always remain assigned, and will layer if a second provider assigns themselves to a patient
- Click the white space around a patient's name to open **Single Patient View**
- Single Patient View offers quick access to patient information and common orders

<p>Activity 1.3 Patient Chart Overview</p>
<ul style="list-style-type: none"> ■ Initially opening a patient chart will automatically go to the Emergency Workflow screen ■ The Banner Bar displays patient information for users to check the patient name and encounter ■ The ED Workflow Tab pulls relevant clinical information forward from other areas in the chart for easier review and allows real time documentation ■ Refresh your screen often to keep the most current information visible
<p>Activity 1.4 Documenting History of Present Illness</p>
<ul style="list-style-type: none"> ■ Documentation is possible via Free-text or Front-End Speech Recognition ■ Click Save after documenting so your work is not lost ■ Auto-save will dither the Save button after a preset time
<p>Activity 1.5 Documenting Physical Exam Using Autotext</p>
<ul style="list-style-type: none"> ■ Documentation is possible via Free-text or Front-End Speech Recognition ■ Click Save after documenting so your work is not lost ■ Auto-save will dither the Save button after a preset time
<p>Activity 1.6 Documenting Past Medical History</p>
<ul style="list-style-type: none"> ■ Record the patient’s past medical, surgical, family or social history in the Histories section ■ Information entered will not be finalized until you click Complete Reconciliation
<p>Activity 1.7 Entering Orders and Documenting Patient Care</p>
<ul style="list-style-type: none"> ■ The ED Orders Tab is organized into Components and sub-components ■ Click once on the Order to add it to the Orders for Signature Inbox ■ Select Modify to review and modify Orders as needed ■ The Missing Required Details button will take you directly to unfilled required order details
<p>Activity 1.8 Accessing Patient Results</p>
<ul style="list-style-type: none"> ■ The icons in ED LaunchPoint display the status of orders ■ Critical values will be indicated by red icons ■ You can view results in Single Patient View or Results Review in the patient chart ■ Results can be viewed in flowchart, graph or “quick view” modes

Activity 1.9 Documenting Patient Diagnosis

- In the **Discharge Diagnosis** section click the section header to add a Diagnosis
- Select the **Show Previous Visits** checkbox below the diagnoses listed to view problems from past encounters
- You can add common diagnoses to a Favorites folder for easy access

Activity 1.10 Documenting Your Impression and Plan

- In the **Impression and Plan**** section, the **grey arrow** creates a separate window to allow documentation while reviewing the **ED Workflow** screen
- Like the HPI and PE sections, documentation can be performed with Free Text or FESR

Activity 1.11 Completing an ED Note

- **Dynamic Documentation** templates standardize documentation practices and limit errors
- Links in the **Create Note** section produces documents in the most efficient way
- When a Note has been signed it cannot be edited, any changes require adding an **Addendum**
- Use the preview pane on ED Workflow to review other providers' notes in progress to avoid locking the document

Activity 1.12 Patient Discharge with Meds to Go

- Enter a Discharge Order and Meds-to-Go from the **Emergency Orders** tab
- *Referrals* are outpatient visits, *Consults* are for inpatients
- When ordering a medication that may trigger an allergy, an alert screen will appear before order completion
- As with diagnoses, orders can be added to a Favorites folder for easy access

Activity 1.13 Patient List Report

- Patient List Reports ensure you have no outstanding patients to deal with
- Click on the word **Department** from ED LaunchPoint to open the Launch Report window
- You can run multiple reports on one screen, if necessary

PATIENT SCENARIO 2

Learning Objectives

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

-  Use the order management system to initiate a PowerPlan
-  Access patient results
-  Update a patient diagnosis
-  Add an addendum to an existing ED Note
-  Initiate and modify a PowerPlan
-  Discharge a patient with Meds to Go

SCENARIO

Fatimah Abassi is a 25 year old female who works as a waitress.

Fatimah came to the Emergency Department a few days after cutting the top of her right foot at work. She states she accidentally dropped a water glass on the top of her foot, which broke causing the cut. The area around the wound has become red, hot to the touch, with purulent drainage. She attended a walk-in clinic after sustaining the injury, was advised there were no fractures and was prescribed Tylenol #3. She describes an onset of severe pain when walking this morning.

Her only medical history is mild asthma, which she regulates with a prescribed inhaler.

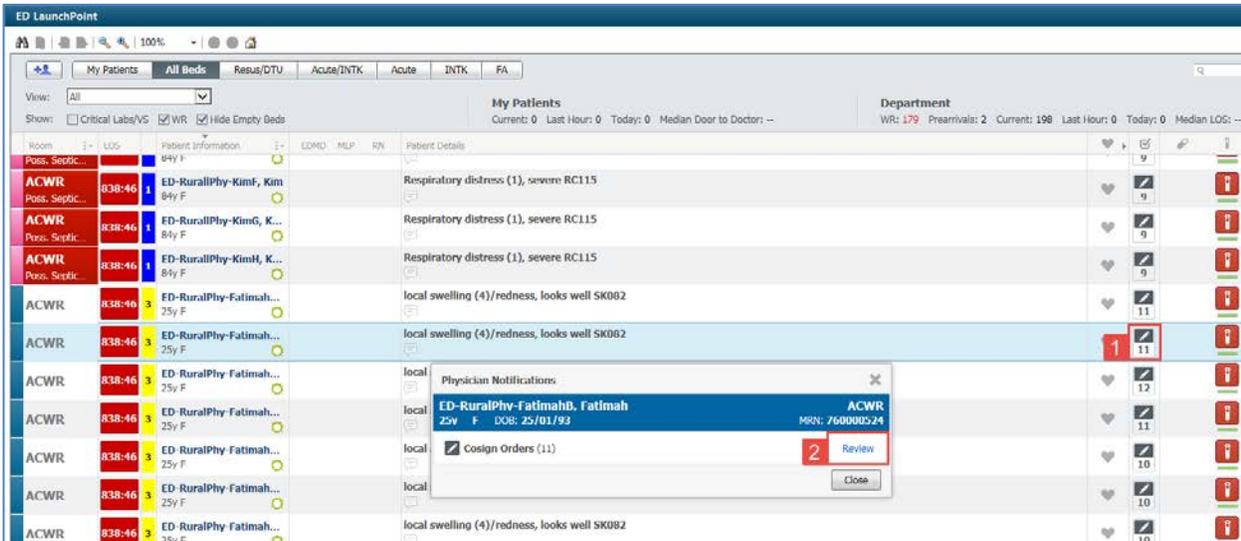
Activity 2.1 – Cosign Verbal Orders Entered

While you were occupied with another patient, the nurse took verbal orders for some tests for Fatimah.

Before interacting with Fatimah’s information, make sure you **Assign** yourself.

Viewing **ED LaunchPoint** you notice a **pencil**  icon with a number attached in the **Physician Notifications Column**. This indicates you have outstanding orders to **Cosign**.

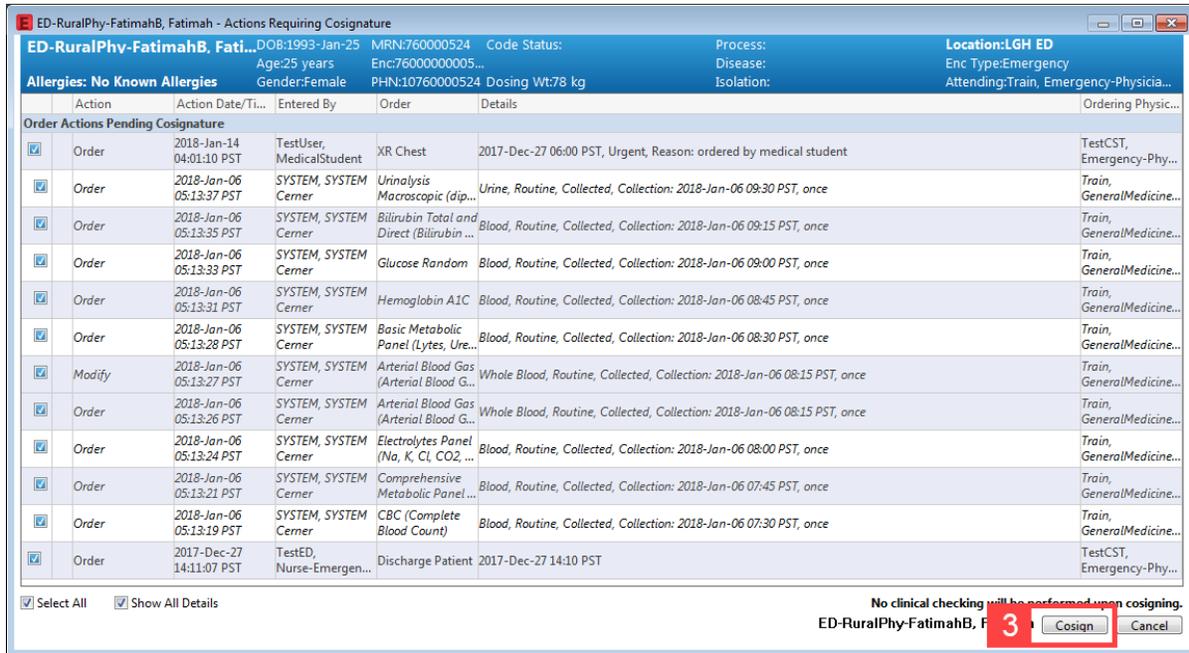
1. Click on the **pencil** icon.
2. The **Physician Notifications** window appears. Click **Review** in blue text to see the orders that require a cosignature.



The screenshot shows the ED LaunchPoint interface. At the top, there are navigation tabs: My Patients, All Beds, Resus/DTU, Acute/INTK, Acute, INTK, and FA. Below these, there are filters for 'View: All' and 'Show: Critical Labs/VS, WR, Hide Empty Beds'. The main area displays a table of patients with columns for Room, LOS, Patient Information, EDMD, MLP, RN, Patient Details, and Physician Notifications. A pop-up window titled 'Physician Notifications' is open over the patient 'ED-RuralPhy-FatimahB, Fatimah'. The pop-up shows the patient's name, age (25y), sex (F), DOB (25/01/93), and MRN (760000524). It lists 'Cosign Orders (11)' and has a red '2' next to a 'Review' button. A 'Close' button is also present.

Room	LOS	Patient Information	EDMD	MLP	RN	Patient Details	Physician Notifications
Pass. Septic...		84y F					
ACWR	838-46	1 ED-RuralPhy-KimF, Kim 84y F				Respiratory distress (1), severe RC115	1
ACWR	838-46	1 ED-RuralPhy-KimG, K... 84y F				Respiratory distress (1), severe RC115	1
ACWR	838-46	1 ED-RuralPhy-KimH, K... 84y F				Respiratory distress (1), severe RC115	1
ACWR	838-46	3 ED-RuralPhy-Fatimah... 25y F				local swelling (4)/redness, looks well SK002	1
ACWR	838-46	3 ED-RuralPhy-Fatimah... 25y F				local swelling (4)/redness, looks well SK002	1
ACWR	838-46	3 ED-RuralPhy-Fatimah... 25y F				local	2
ACWR	838-46	3 ED-RuralPhy-Fatimah... 25y F				local	2
ACWR	838-46	3 ED-RuralPhy-Fatimah... 25y F				local	2
ACWR	838-46	3 ED-RuralPhy-Fatimah... 25y F				local swelling (4)/redness, looks well SK002	2

- The **Actions Requiring Cosignature** window will appear.
Review and select orders that require Cosignatures.
When done, click **Cosign**.



ED-RuralPhy-FatimahB, Fatimah - Actions Requiring Cosignature

ED-RuralPhy-FatimahB, Fati... DOB:1993-Jan-25 MRN:760000524 Code Status: Process: Location:LGH ED
 Age:25 years Enc:7600000005... Disease: Enc Type:Emergency
 Allergies: No Known Allergies Gender:Female PHN:10760000524 Dosing Wt:78 kg Isolation: Attending:Train, Emergency-Physicia...

Action	Action Date/Ti...	Entered By	Order	Details	Ordering Physic...
<input checked="" type="checkbox"/>	2018-Jan-14 04:01:10 PST	TestUser, MedicalStudent	XR Chest	2017-Dec-27 06:00 PST, Urgent, Reason: ordered by medical student	TestCST, Emergency-Phy...
<input checked="" type="checkbox"/>	2018-Jan-06 05:13:37 PST	SYSTEM, SYSTEM Cerner	Urinalysis Macroscopic (dip...	Urine, Routine, Collected, Collection: 2018-Jan-06 09:30 PST, once	Train, GeneralMedicine...
<input checked="" type="checkbox"/>	2018-Jan-06 05:13:35 PST	SYSTEM, SYSTEM Cerner	Bilirubin Total and Direct (Bilirubin ...	Blood, Routine, Collected, Collection: 2018-Jan-06 09:15 PST, once	Train, GeneralMedicine...
<input checked="" type="checkbox"/>	2018-Jan-06 05:13:33 PST	SYSTEM, SYSTEM Cerner	Glucose Random	Blood, Routine, Collected, Collection: 2018-Jan-06 09:00 PST, once	Train, GeneralMedicine...
<input checked="" type="checkbox"/>	2018-Jan-06 05:13:31 PST	SYSTEM, SYSTEM Cerner	Hemoglobin A1C	Blood, Routine, Collected, Collection: 2018-Jan-06 08:45 PST, once	Train, GeneralMedicine...
<input checked="" type="checkbox"/>	2018-Jan-06 05:13:28 PST	SYSTEM, SYSTEM Cerner	Basic Metabolic Panel (Lytes, Ure...	Blood, Routine, Collected, Collection: 2018-Jan-06 08:30 PST, once	Train, GeneralMedicine...
<input checked="" type="checkbox"/>	2018-Jan-06 05:13:27 PST	SYSTEM, SYSTEM Cerner	Arterial Blood Gas (Arterial Blood G...	Whole Blood, Routine, Collected, Collection: 2018-Jan-06 08:15 PST, once	Train, GeneralMedicine...
<input checked="" type="checkbox"/>	2018-Jan-06 05:13:26 PST	SYSTEM, SYSTEM Cerner	Arterial Blood Gas (Arterial Blood G...	Whole Blood, Routine, Collected, Collection: 2018-Jan-06 08:15 PST, once	Train, GeneralMedicine...
<input checked="" type="checkbox"/>	2018-Jan-06 05:13:24 PST	SYSTEM, SYSTEM Cerner	Electrolytes Panel (Na, K, Cl, CO2, ...	Blood, Routine, Collected, Collection: 2018-Jan-06 08:00 PST, once	Train, GeneralMedicine...
<input checked="" type="checkbox"/>	2018-Jan-06 05:13:21 PST	SYSTEM, SYSTEM Cerner	Comprehensive Metabolic Panel...	Blood, Routine, Collected, Collection: 2018-Jan-06 07:45 PST, once	Train, GeneralMedicine...
<input checked="" type="checkbox"/>	2018-Jan-06 05:13:19 PST	SYSTEM, SYSTEM Cerner	CBC (Complete Blood Count)	Blood, Routine, Collected, Collection: 2018-Jan-06 07:30 PST, once	Train, GeneralMedicine...
<input checked="" type="checkbox"/>	2017-Dec-27 14:11:07 PST	TestED, Nurse-Emergen...	Discharge Patient	2017-Dec-27 14:10 PST	TestCST, Emergency-Phy...

Select All Show All Details

No clinical checking will be performed upon cosigning.
 ED-RuralPhy-FatimahB, F 3

When finished with Physician Notifications, click **Close**.
 You should be returned to **ED LaunchPoint**.

Activity 2.2 – Update a Patient Diagnosis

After updating your ED Note to reflect the latest findings, you now need to update Fatimah’s diagnosis. You notice you accidentally inputted **Cellulitis Forearm** instead of **Cellulitis Foot or Ankle**. This needs to be corrected.

Removing or changing a diagnosis is difficult; therefore it is best to enter diagnoses at the end of a patient visit. If you must change a diagnosis because of new information or editing purposes, here are the following steps:

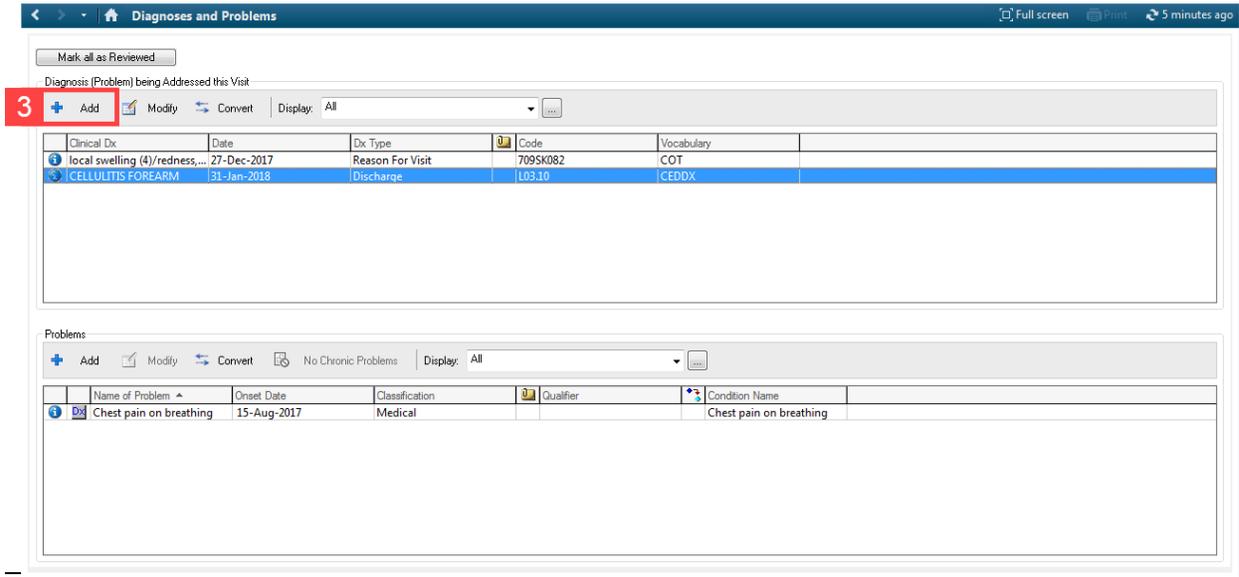
1. Select **Discharge Diagnosis** from the **ED Workflow Table of Contents**.
2. Click the **Discharge Diagnosis** header.

The screenshot displays the ED Workflow interface for patient Fatimah. The top navigation bar includes patient information: ED-RuralPhy-FatimahB, Fatimah; DOB: 1993-Jan-25; MRN: 7600000524; Code Status: Enc: 760000000524, PHN: 10760000524; Dosing Wt: 78 kg; Process: Disease: Isolation; Location: LGH ED; Enc Type: Emergency; Attending: Train, Emergency-Physician1, MD. The left sidebar contains a 'Table of Contents' with 'Discharge Diagnosis' highlighted by a red box and labeled '1'. The main content area shows the 'Discharge Diagnosis' section, with the header 'Discharge Diagnosis' highlighted by a red box and labeled '2'. Below the header, there is a table of diagnoses:

Name	Classification	Actions
CELLULITIS FOOT OR ANKLE	Medical	[This Visit] [Chronic]
Chest pain on breathing	Medical	[This Visit] [Chronic] [Resolve]

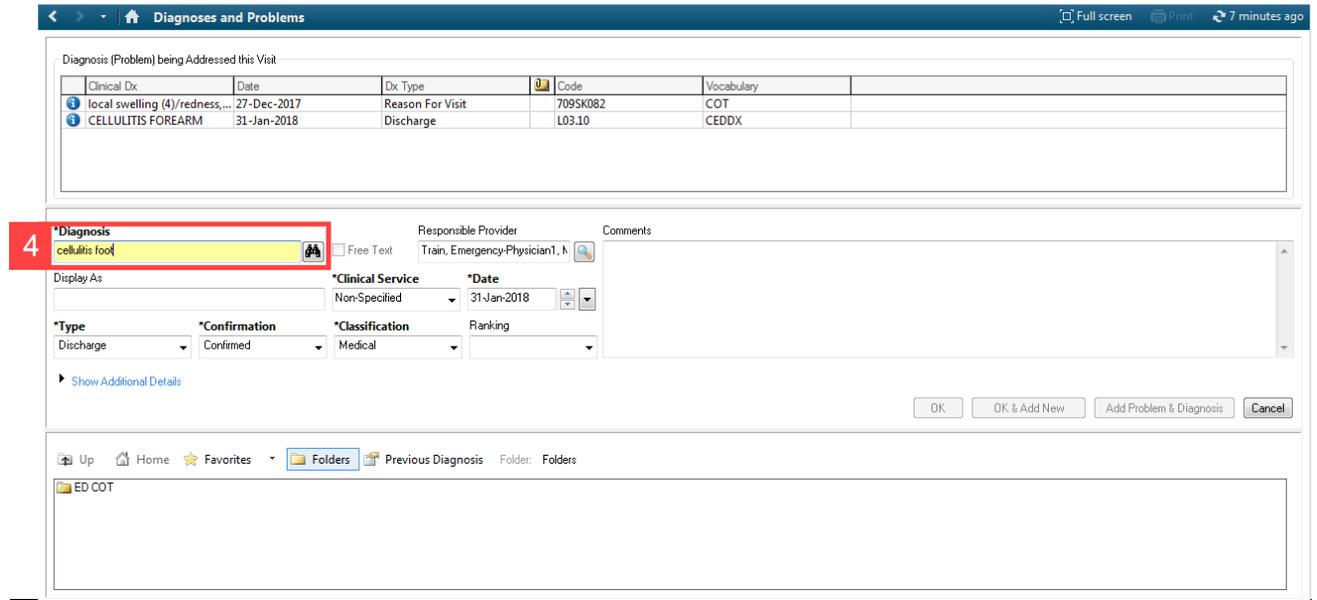
The 'CELLULITIS FOOT OR ANKLE' diagnosis is currently selected. Below the table, the 'Impression and Plan**' section is visible, showing the text 'CELLULITIS FOOT OR ANKLE'.

3. Click the **Add**  icon.



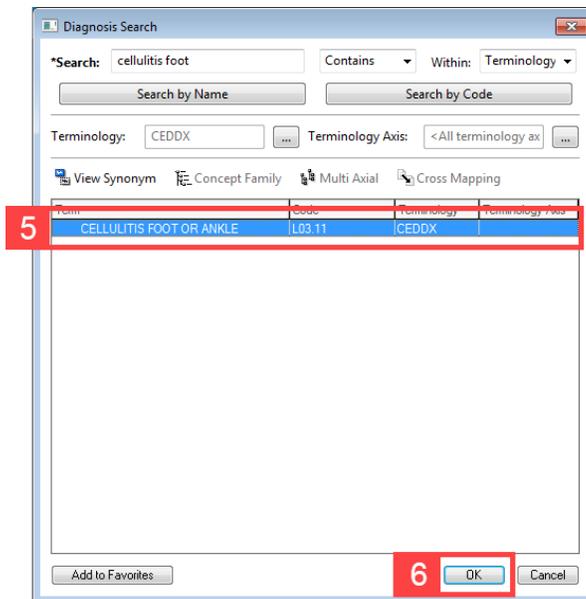
The screenshot shows the 'Diagnoses and Problems' interface. At the top, there is a 'Mark all as Reviewed' button. Below it, a section titled 'Diagnosis (Problem) being Addressed this Visit' contains a table with columns: Clinical Dx, Date, Dx Type, Code, and Vocabulary. The table lists two entries: 'local swelling (4)/redness, ...' and 'CELLULITIS FOREARM'. A red box with the number '3' highlights the '+ Add' button in the toolbar above the table. Below the table is a 'Problems' section with a similar toolbar and table. The 'Problems' table has columns: Name of Problem, Onset Date, Classification, Qualifier, and Condition Name. It lists 'Chest pain on breathing'.

4. In the yellow mandatory field search for *cellulitis foot* in the Diagnosis search bar.

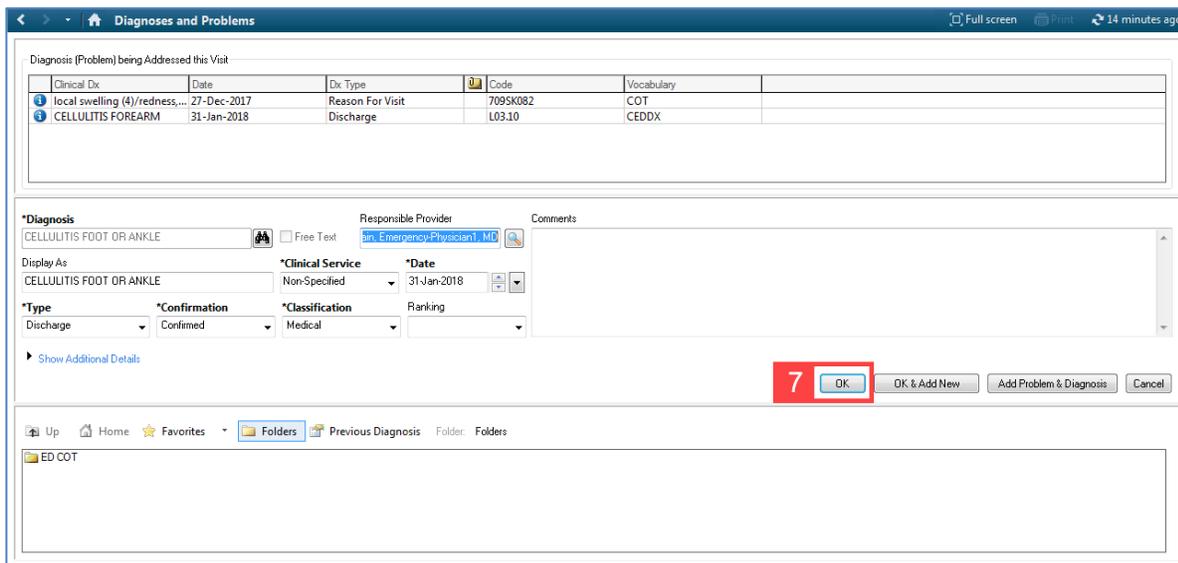


The screenshot shows the 'Diagnosis' form. At the top, there is a 'Diagnosis (Problem) being Addressed this Visit' section with a table listing 'local swelling (4)/redness, ...' and 'CELLULITIS FOREARM'. Below this is a form for adding a new diagnosis. A red box with the number '4' highlights the search bar, which contains the text 'cellulitis foot'. The form includes fields for 'Display As', 'Clinical Service', 'Date', 'Type', 'Confirmation', 'Classification', and 'Ranking'. The 'Date' field is set to '31-Jan-2018'. The 'Type' is 'Discharge', 'Confirmation' is 'Confirmed', and 'Classification' is 'Medical'. At the bottom, there are buttons for 'OK', 'OK & Add New', 'Add Problem & Diagnosis', and 'Cancel'. Below the form is a 'Folders' section with a tree view showing 'ED COT'.

5. Select the most appropriate **Diagnosis** from the Diagnosis Search list (Remember, coded Diagnoses are capitalized). For this instance, it would be **Cellulitis Foot and Ankle**.
6. Click **OK**.

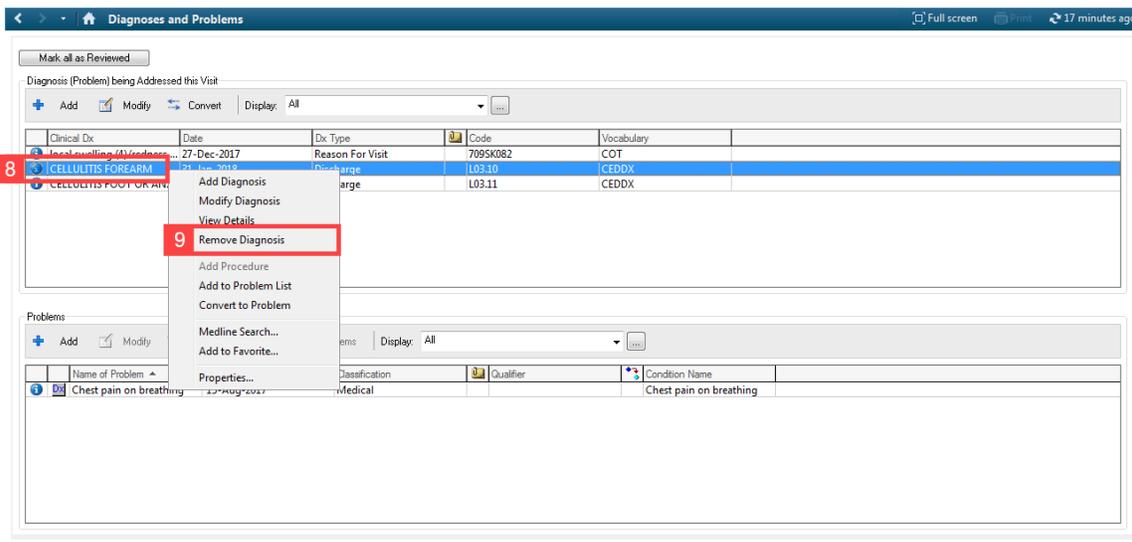


7. The Diagnosis Search window will close.
Click **OK** a second time to finalize the updated Diagnoses List.

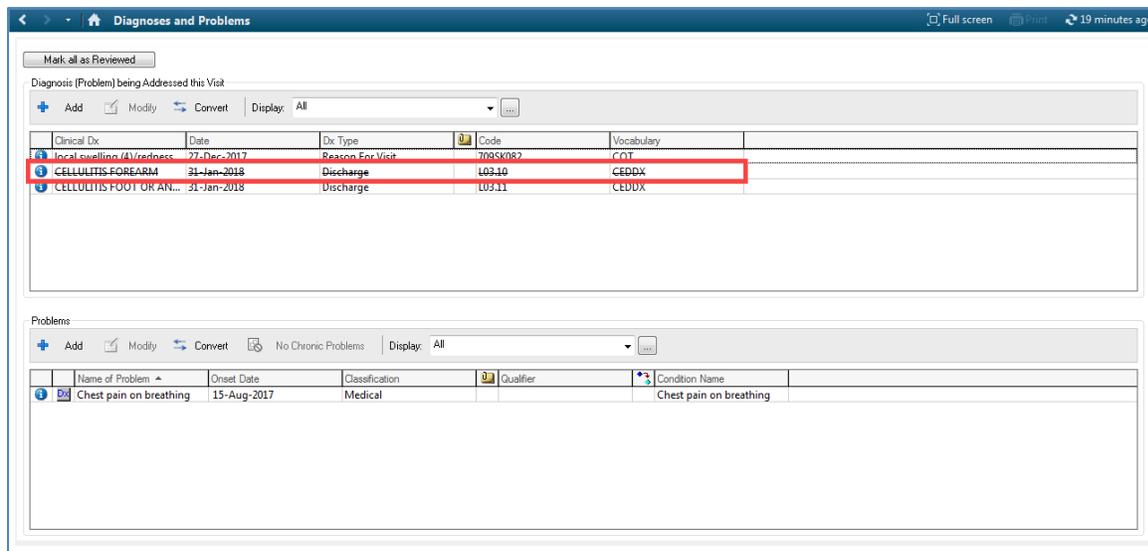


Now you must discontinue the incorrect Diagnosis.

8. Right click on the **Diagnosis** you wish to remove. For this activity, right click **Cellulitis Forearm**.
9. Select **Remove Diagnosis**.



The removed diagnosis will now display with a strikethrough.



Return to the **ED Workflow** page.

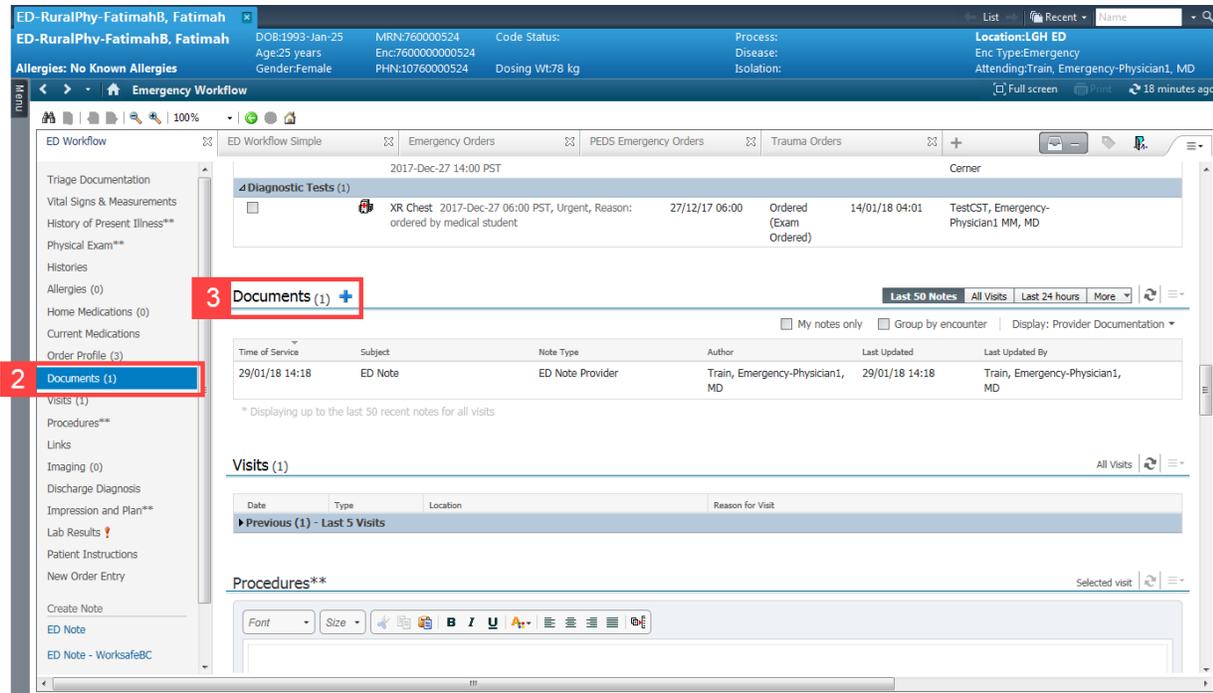
Knowledge Check

- Name an alternate way to navigate to the Documentation section.

Activity 2.3 – Add Addenda to existing ED Note

You previously completed and signed an **ED Note** for Fatimah, but now you need to revise it due to the prior incorrect diagnosis. Update the patient's **ED Note** using an **Addendum**.

1. Return to the **ED Workflow** page.
2. Navigate to **Documents** in the **ED Workflow** page.
3. Click on the **Documents** header.



The screenshot shows the ED Workflow interface for patient Fatimah. The left sidebar contains a navigation menu with 'Documents (1)' highlighted in blue and a red box labeled '2'. The main content area shows a table of documents with one entry: '29/01/18 14:18 ED Note ED Note Provider Train, Emergency-Physician1, MD'. The 'Documents (1)' header is highlighted with a red box and a red '3'. Below the table, there are sections for 'Visits (1)' and 'Procedures**'. The interface includes a top navigation bar with patient information and a bottom toolbar with editing options.

- You will be brought to the **Documentation** section of your patient's chart.

Double click the **ED Note** you want to add an **Addendum** to. A single click will allow you to view the existing document in Preview mode.

The screenshot shows the 'Documentation' section of a patient's chart. At the top, patient information is displayed: ED-RuralPhy-FatimahB, Fatimah, DOB: 1993-Jan-25, MRN: 7600000524, Code Status: Process: Location: LGH ED, Enc Type: Emergency, Attending: Train, Emergency-Physician1, MD. A list of notes is shown below, with the first note selected and highlighted in red. The note details are: Service Date: 2018-Jan-29 14:18:00 P., Subject: ED Note, Type: ED Note Provider, Facility: LGH Lions Gate, Author/Contributor: Train, Emergency-Physician1. The main content area displays the 'Final Report' for this note, including sections for Basic Information, Problem List/Past Medical History, History of Present Illness, Physical Exam, and ED Lab Results.

- Click **Modify** at the top of the page, then Click the free text area below ***Insert Addendum Here** and type the following:

Correction: Diagnosis is CELLULITIS FOOT OR ANKLE.

- Click **Sign** when done.

This screenshot shows the 'Modify' view of the documentation interface. The text area below the 'Final Report' is active, and the text 'Correction: Diagnosis is CELLULITIS FOOT OR ANKLE.' has been entered. The text area is highlighted with a red box and labeled with a red '5'. At the bottom of the interface, the 'Sign' button is highlighted with a red box and labeled with a red '6'. Other buttons visible include 'Save', 'Save & Close', and 'Cancel'. The patient details at the bottom of the screen are: Note Details: ED Note Provider, Train, Emergency-Physician1, MD, 2018-Jan-31 13:46 PST, Auth (Verified), ED Note.

The final **ED Note** will indicate in **red** text that an Addendum is included.

7. Use the **Navigation Toolbar** to return to the **ED Workflow** page.

The screenshot shows a medical software interface for a patient named Fatimah. The top navigation bar includes a 'Documentation' tab with a red '7' icon. Below the patient information, a 'List' table shows several notes, with the most recent one highlighted in red. The main content area displays a 'Final Report' with a red banner stating 'Document Contains Addenda'. The report includes sections for Basic Information, History of Present Illness, Physical Exam, Impression/Plan, Problem List/Past Medical History, Medications, Allergies, and ED Lab Results.

Service Date/Time	Subject	Type	Facility	Author/Contrib
2018-Jan-29 14:18:00 P...	ED Note	ED Note Provider	LGH Lions Gate	Train, Emergen
2018-Jan-28 14:00:00 P...	ED Triage - Adult	ED Triage - Adult - Text	LGH Lions Gate	TestED, Nurse-E
2018-Jan-28 09:55:00 P...	ED Screening - Adult	ED Screening - Adult - Text	LGH Lions Gate	TestED, Nurse-E

*** Final Report ***
Document Contains Addenda

Basic Information
 Chief Complaint: Redness and swelling x 3 days after cutting foot
 ED Assigned Provider/Time: Train, Emergency-Physician1, MD / 01/29/2018 14:03

History of Present Illness
 Patient cut foot 3 days ago after glass broke at work. Now red, swollen and limited weight bearing.

Physical Exam
 Vitals & Measurements: T: 36.8 °C (Oral) HR: 98 (Peripheral) RR: 20 BP: 115/76 SpO2: 100%
 HT: 168 cm
 Well-looking with redness around foot wound radiating to ankle. Tender and hot on palpation. Purulent drainage present. Afebrile, no other signs/symptoms present.

Impression/Plan
 CELLULITIS FOOT OR ANKLE
 XR to r/o foreign body. Outpatient antibiotics at LGH MDC. Apply dressing to wound.

Problem List/Past Medical History
 Chest pain on breathing
 Historical: No historical problems

Medications
 Inpatient: No active inpatient medications
 Home: No active home medications

Allergies
 No Known Allergies

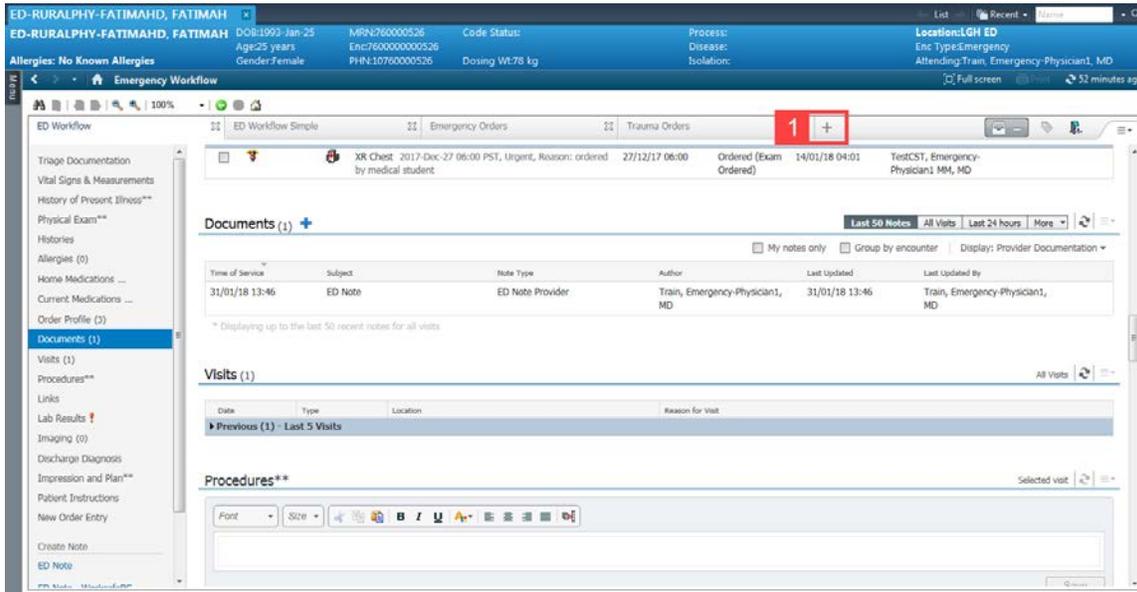
ED Lab Results

Hematology	Chemistry	Urine
Hematocrit: 0.36	Low Alanine Aminotransferase: 18 U/L	Strip: Negative.
Hemoglobin: 120 g/L	Low	Clarity: Clear
MCH: 29 pg	Alkaline Phosphatase: 90 U/L	Color Urine: Yellow
MCV: 88 fL	Anion Gap: 25.5	Glucose

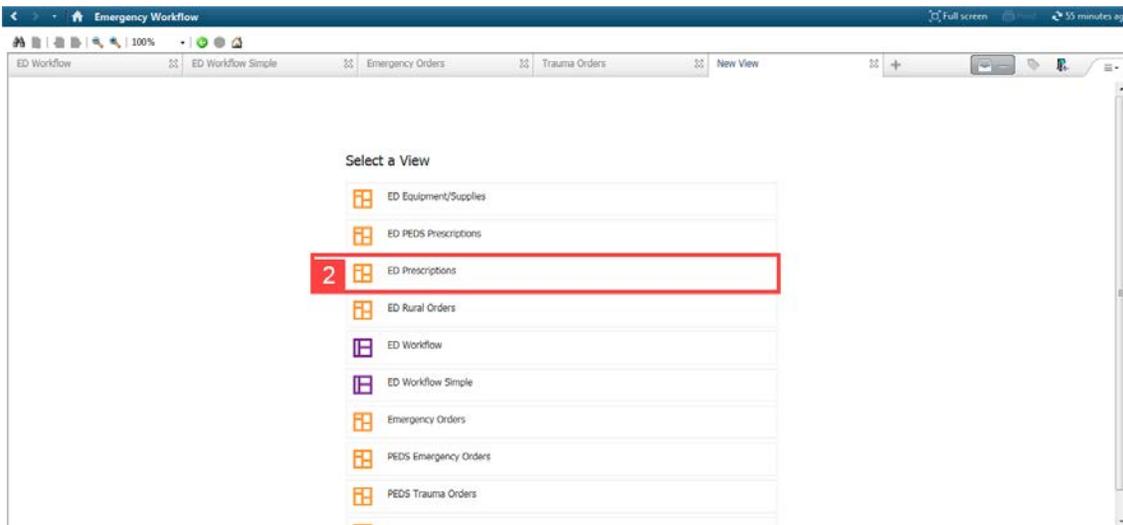
Activity 2.4 – Writing a Prescription

Fatimah is ready to be discharged. She needs a prescription for oral antibiotics.

1. If the Prescription Tab is not already displayed on your Emergency Workflow screen, click the grey **Add**  icon to the right of the **Emergency Workflow** tabs.



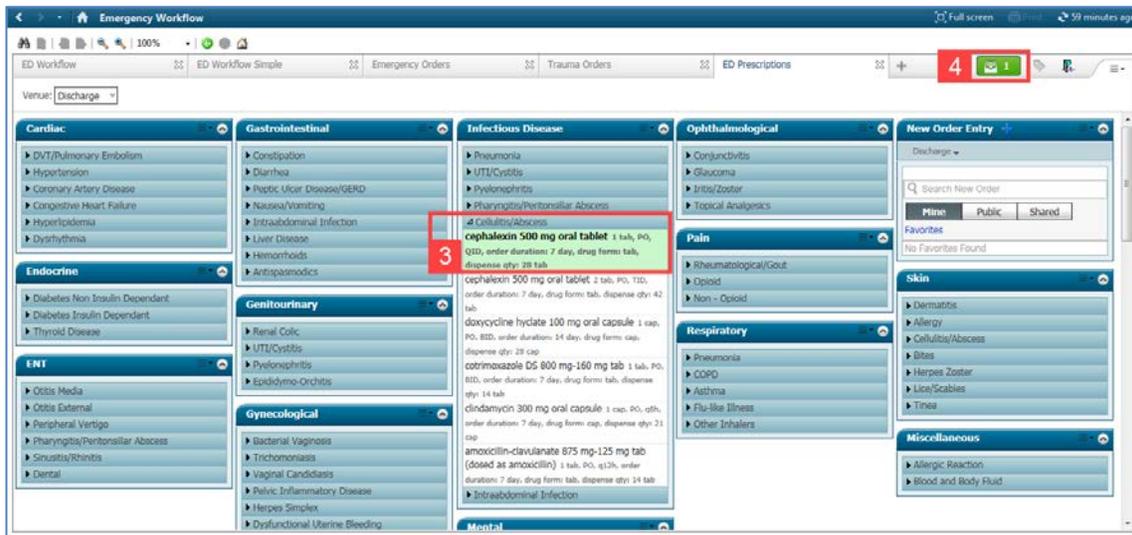
2. Select the **ED Prescriptions View**.



- The **ED Prescription** tab looks and functions similar to the **Emergency Orders** tab.
Under the **Infectious Disease** component, expand **Cellulitis/Abscess** by clicking the **black arrow** icon.

Select **Cephalexin 500mg oral tablet 1 tab, PO, QID**

- Click the green **Orders for Signature Inbox** icon.

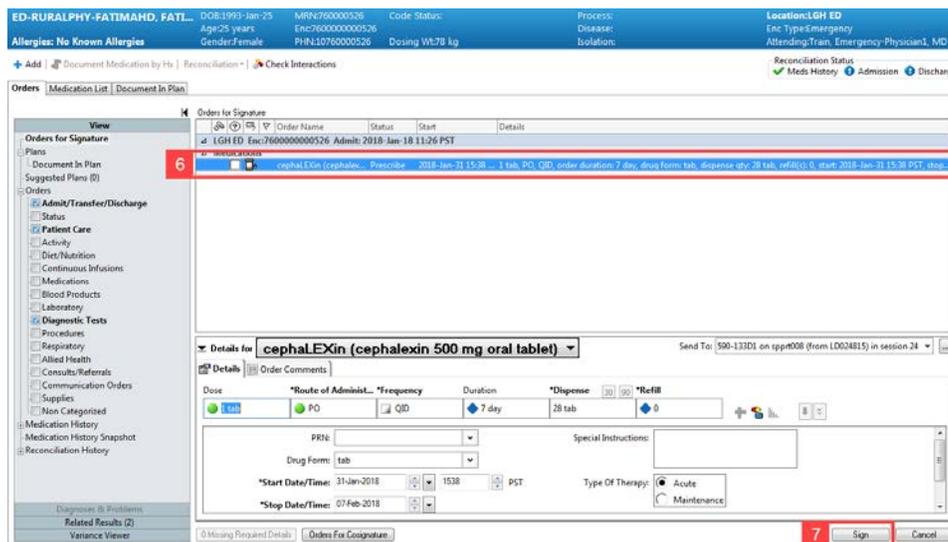


- The **Orders for Signature Summary** window will appear.

Click **Modify**.

- To change any prescription details, select the order and enter changes in the detail fields.

- Click **Sign**.



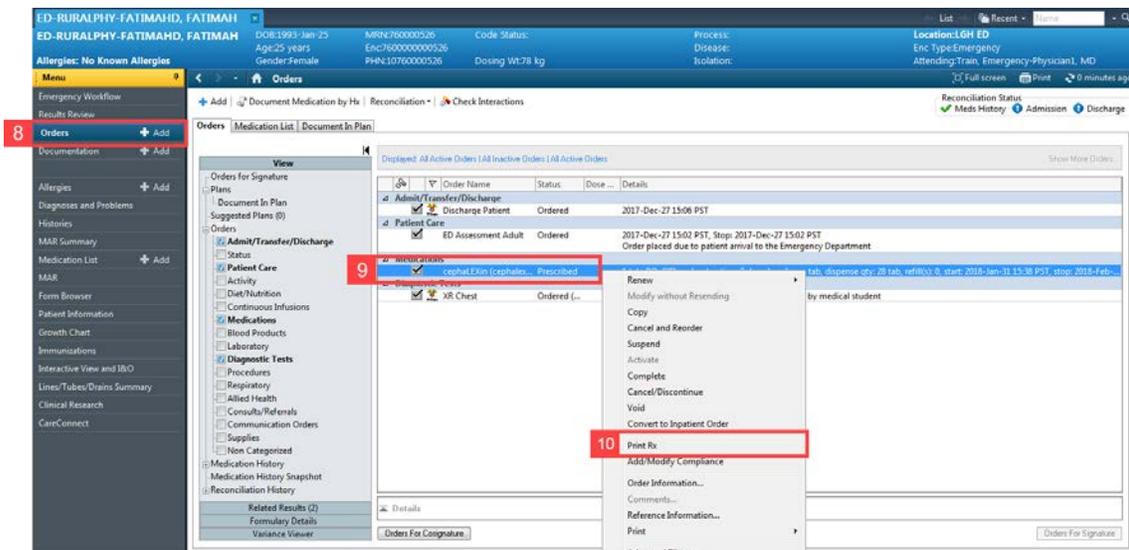
After signing, the prescription will automatically be printed from the printer that is connected to the device you are using.

The system will return you to the ED Prescriptions tab.

When printing a prescription that includes a controlled substance, you may need to print a duplicate copy. Automatic duplicate printing is currently being configured.

8. Navigate to the **Orders** page using the **Table of Contents**.
9. Right click the prescription that requires printing.
10. Selct **Print Rx**.

The duplicate copy will now print.



See next page for prescription sample.

Activity 2.5 – Completing an ED WorkSafe BC Note

1. In the ED Workflow tab, click on **ED Note – WorkSafeBC**.

The screenshot displays the ED WorkSafeBC interface for patient ED-RuralPhy-FatimahB, Fatimah. The top header shows patient information: DOB: 1993-Jan-25, MRN: 7600000524, Code Status, Process: Emergency, Location: LGH ED, Enc Type: Emergency, and Attending: Train, Emergency-Physician1, MD. The left sidebar contains a navigation menu with options like Triage Documentation, Vital Signs & Measurements, Discharge Diagnosis, and ED Note. The 'ED Note - WorkSafeBC' option is highlighted with a red box and a red number '1'. The main content area shows a list of tests (Interventional, EMG/EEG, Bone Density, Mammography) and a 'Discharge Diagnosis' section with a table listing 'FOREIGN BODY FOOT' and 'Chest pain on breathing' with classification and action buttons. Below is an 'Impression and Plan' section with a rich text editor.

Name	Classification	Actions
FOREIGN BODY FOOT	Medical	This Visit Chronic
Chest pain on breathing	Medical	This Visit Chronic Resolve

- The ED WSBC note will populate with Fatimah’s details, much like the note you created earlier. Scroll down to *Physician’s Report*. You can fill in the answers as appropriate for this case using **X**.

Physician's Report
SELECT ONE ONLY: Physician's First Report (F8): **X** The worker's condition or treatment has changed (F11): _
 Who rendered first treatment? _
 Are you the worker's regular practitioner? YES: _ NO: **X**
 If YES, how long has the worker been your patient: 0-6 months: _ 7-12months: _ >1 year: _
 From injury or last, report, has the worker been disabled from work? YES: _ NO: **X**
 If YES, as of what date? (dd-mm-yyyy)
 _
 2 Are there prior or other problems affecting injury, recovery, and disability? _NO

Procedure
Reexamination/Reevaluation
Medications
 Inpatient
 No active inpatient medications
 Home
 No active home medications
Allergies
 No Known Allergies
Imaging Results
 No qualifying data available.
Pending Orders
 XR Chest - Ordered
 -- 2017-Dec-27 06:00 PST, Urgent, Reason: ordered by medical student

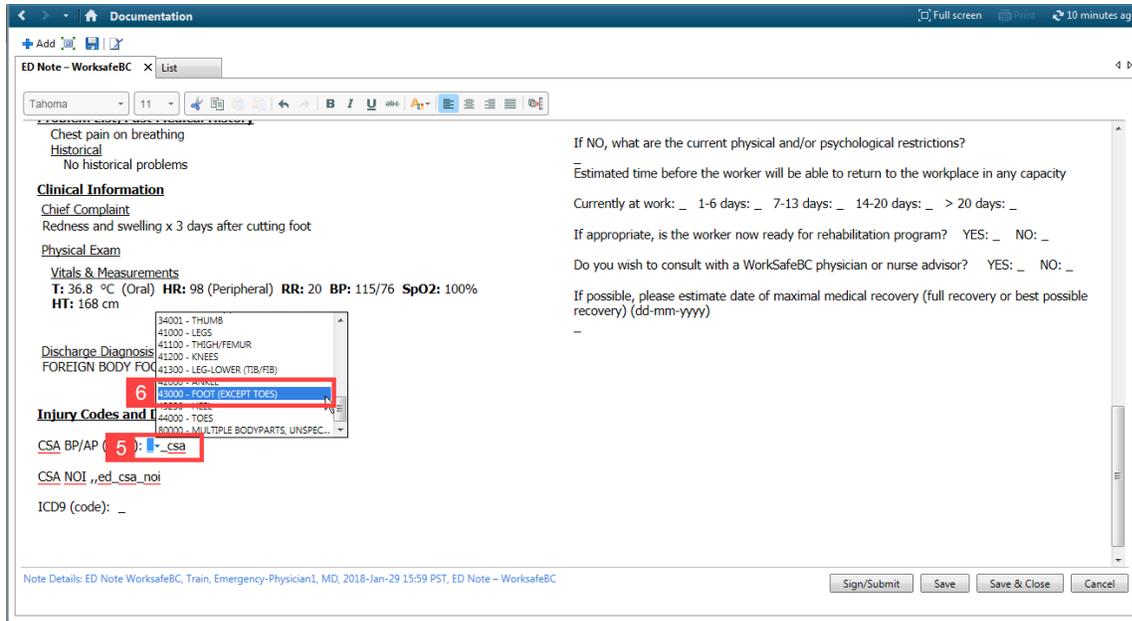
- Continue scrolling and fill out *Return-to-work Planning* as above.
- The *Injury Codes and Descriptions* are special codes relating to Body Part/Anatomical Position (CSA BP/AP) and Nature of Injury (CSA NOI).

History of Present Illness
Problem List/Past Medical History
 Chest pain on breathing
 Historical
 No historical problems
Clinical Information
Chief Complaint
 Redness and swelling x 3 days after cutting foot
Physical Exam
Vitals & Measurements
 T: 36.8 °C (Oral) HR: 98 (Peripheral) RR: 20 BP: 115/76 SpO2: 100%
 HT: 168 cm
Discharge Diagnosis
 FOREIGN BODY FOOT S91.31

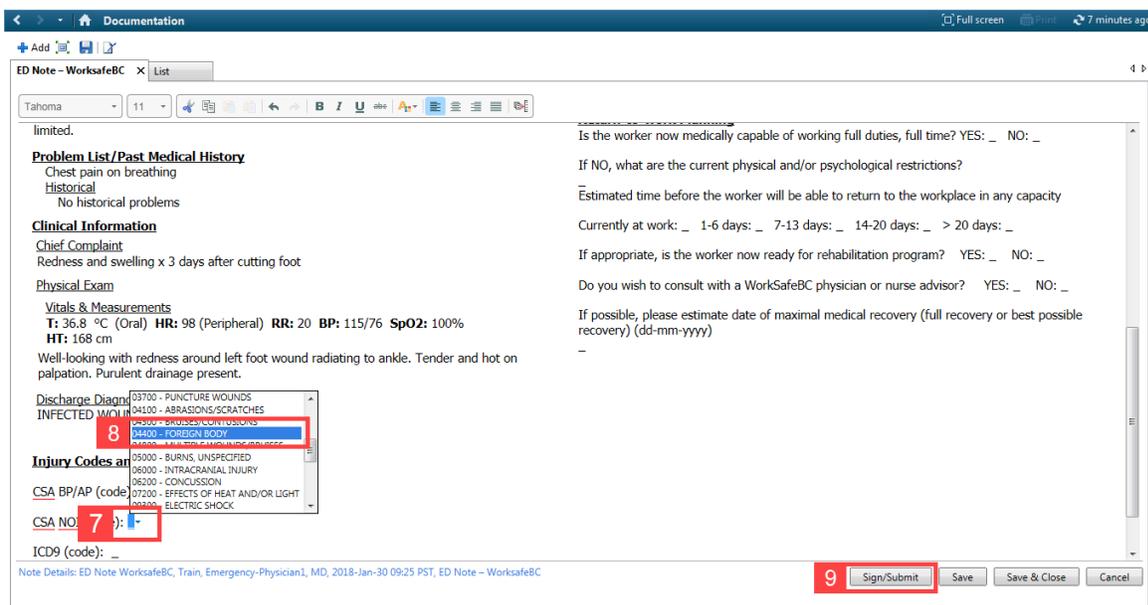
Return-to-work Planning
 Is the worker now medically capable of working full duties, full time? YES: _ NO: _
 If NO, what are the current physical and/or psychological restrictions?
 Estimated time before the worker will be able to return to the workplace in any capacity
 Currently at work: _ 1-6 days: _ 7-13 days: _ 14-20 days: _ > 20 days: _
 If appropriate, is the worker now ready for rehabilitation program? YES: _ NO: _
 Do you wish to consult with a WorksafeBC physician or nurse advisor? YES: _ NO: _
 3 If possible, please estimate date of maximal medical recovery (full recovery or best possible recovery) (dd-mm-yyyy)

Injury Codes and Descriptions
 4 CSA BP/AP „ed_csa
 CSA NOI „ed_csa_noi

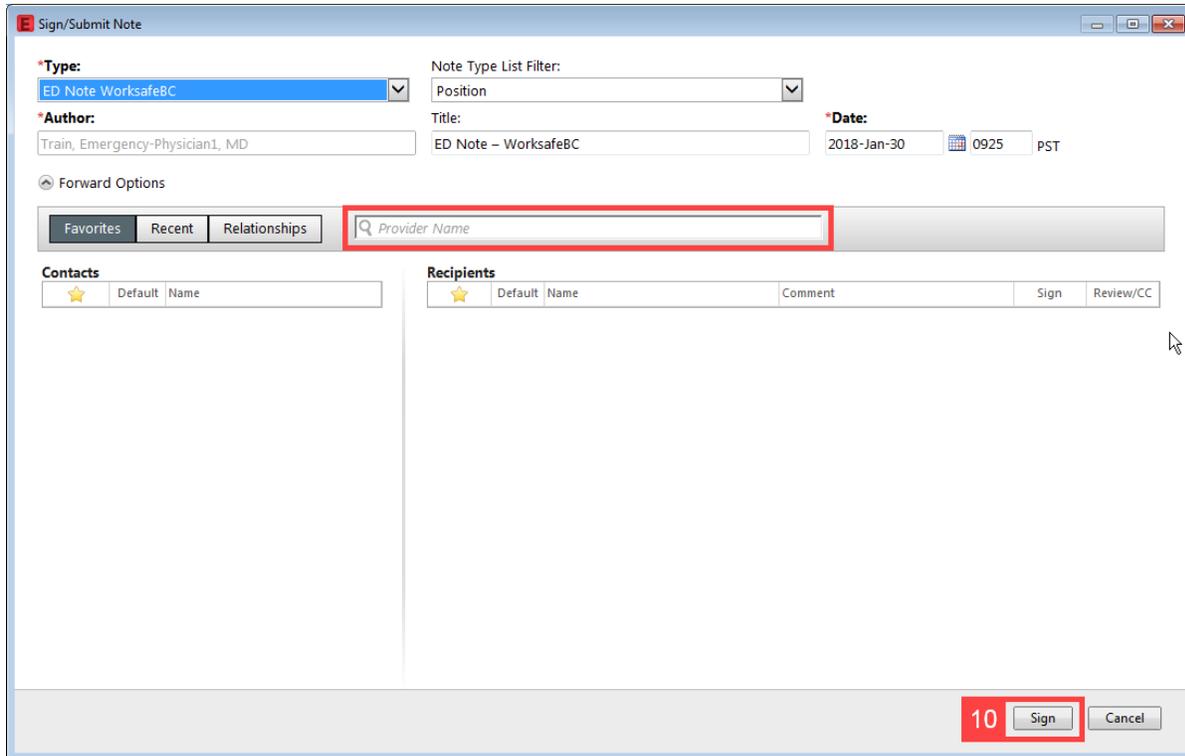
- Double click on „*ed_csa*“. Select *ed_csa_bp* from the menu and double click that option. A small icon -> will appear where „*ed*“ once was. Click the icon.
- Select code **43000-FOOT (EXCEPT TOES)**.



- Repeat the process for CSA NOI: Double click „*ed_csa_noi*“. Again, the writing will change to an icon -> .
- Select code **04400-FOREIGN BODY**.
If you are accustomed to completing the ICD-9 coding section, please do so. This section is currently being reviewed by WorkSafe BC to determine if Provider coding is required.
- When finished, click **Sign/Submit**.



10. The **Sign/Submit Note** window appears. If you wish to forward your note to another Provider, you can search their name in the search bar. The note will automatically forward to WorkSafe BC when you click **Sign**.



You will return to the ED Workflow screen.

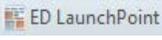
Activity 2.6 – End of Shift Patient Handoff

At the end of the shift you are preparing to give handoff to the incoming ED Provider.

Make sure there are no unsigned orders, complete ED notes on all your patients, and sign off on any “in progress” documentation.

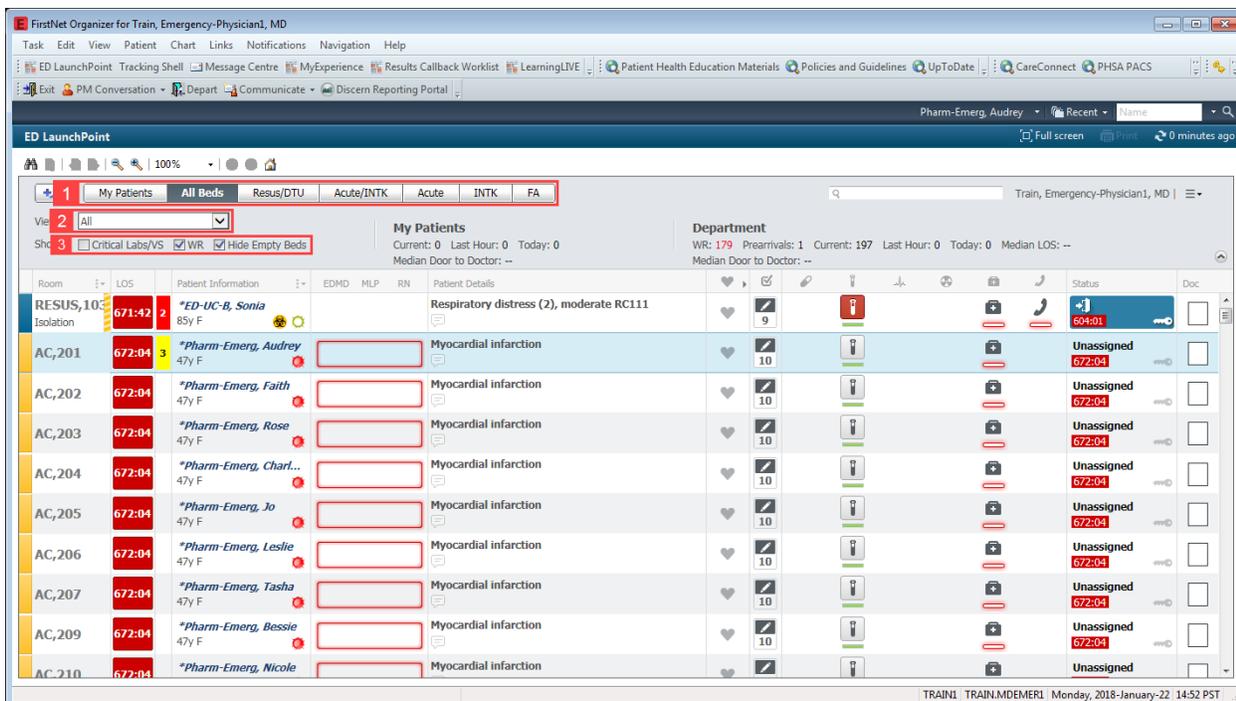
As the incoming Provider comes on shift and checks-in, you are ready to give handoff:

Part A

Return to **ED LaunchPoint** by clicking the  icon in the **Toolbar**.

At the **ED LaunchPoint Multi-Patient List**, change the filter settings to make sure you are viewing all your patients. Set to the following before you begin handoff:

1. Select **All Beds**.
2. Click the **View** dropdown list and select **My Patients**.
3. Select both **WR** and **Hide Empty Beds** from the **Show** checkboxes.



The screenshot displays the ED LaunchPoint Multi-Patient List interface. At the top, there are navigation tabs: My Patients, All Beds, Resus/DTU, Acute/INTK, Acute, INTK, and FA. The 'All Beds' tab is selected. Below the tabs, there are filter settings: 'View' is set to 'All', 'Show' is set to 'Critical Labs/VS', 'WR' is checked, and 'Hide Empty Beds' is checked. The main area shows a list of patients with columns for Room, LOS, Patient Information, EDMD, MLP, RN, Patient Details, Status, and Doc. The patient list includes patients with respiratory distress and myocardial infarction.

Room	LOS	Patient Information	EDMD	MLP	RN	Patient Details	Status	Doc
RESUS, 10	671:42	*ED-UC-B, Sonia 85y F				Respiratory distress (2), moderate RC111	604:01	
AC, 201	672:04	*Pharm-Emerg, Audrey 47y F				Myocardial infarction	Unassigned 672:04	
AC, 202	672:04	*Pharm-Emerg, Faith 47y F				Myocardial infarction	Unassigned 672:04	
AC, 203	672:04	*Pharm-Emerg, Rose 47y F				Myocardial infarction	Unassigned 672:04	
AC, 204	672:04	*Pharm-Emerg, Charl... 47y F				Myocardial infarction	Unassigned 672:04	
AC, 205	672:04	*Pharm-Emerg, Jo 47y F				Myocardial infarction	Unassigned 672:04	
AC, 206	672:04	*Pharm-Emerg, Leslie 47y F				Myocardial infarction	Unassigned 672:04	
AC, 207	672:04	*Pharm-Emerg, Tasha 47y F				Myocardial infarction	Unassigned 672:04	
AC, 209	672:04	*Pharm-Emerg, Bessie 47y F				Myocardial infarction	Unassigned 672:04	
AC, 210	672:04	*Pharm-Emerg, Nicole				Myocardial infarction	Unassigned	

Sitting next to your colleague, you can either review the patient by scrolling through **ED LaunchPoint** or by opening the **Single Patient View**.

The incoming Provider can make notes using the **Comment**  function

Part B

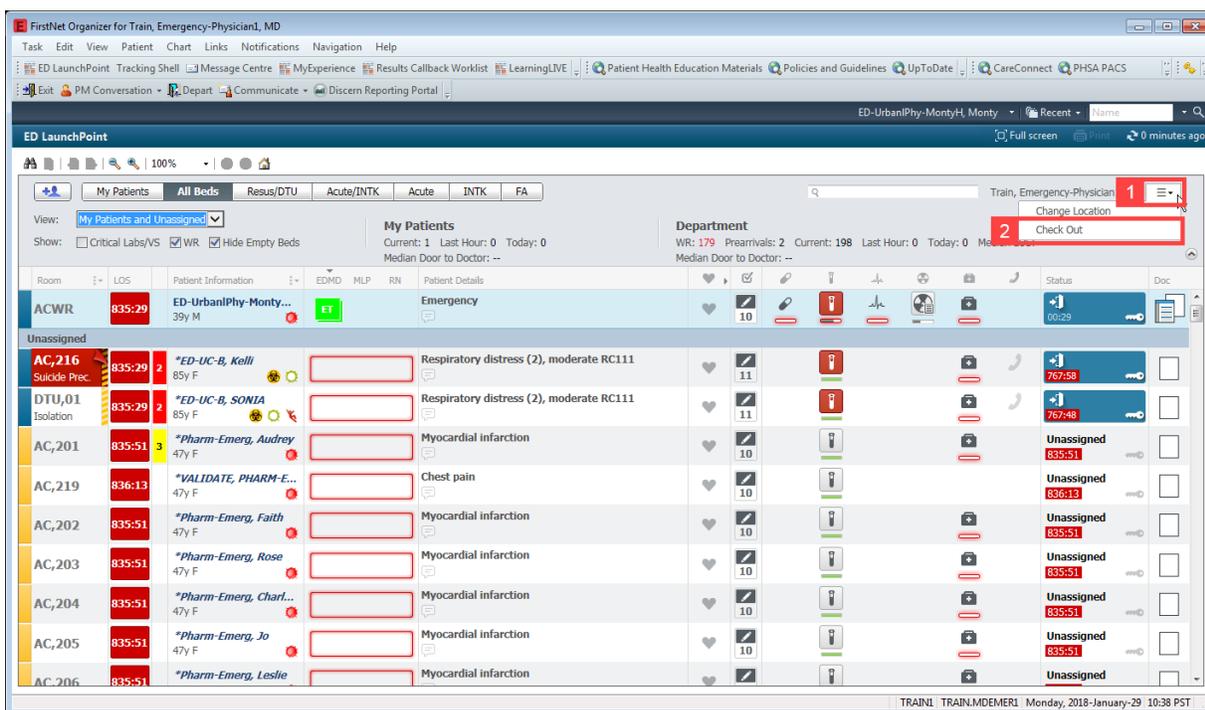
The system will automatically “Check Out” a user after 15 hours, but Providers may prefer to do it themselves at the end of a shift.

Remember, the first Provider assigned to a patient can never be replaced from the patient assignment like a secondary Provider could.

It is important to note that checking out will not forcefully Unassign you from a patient. You would have to manually Unassign yourself from a patient, which is not common practice.

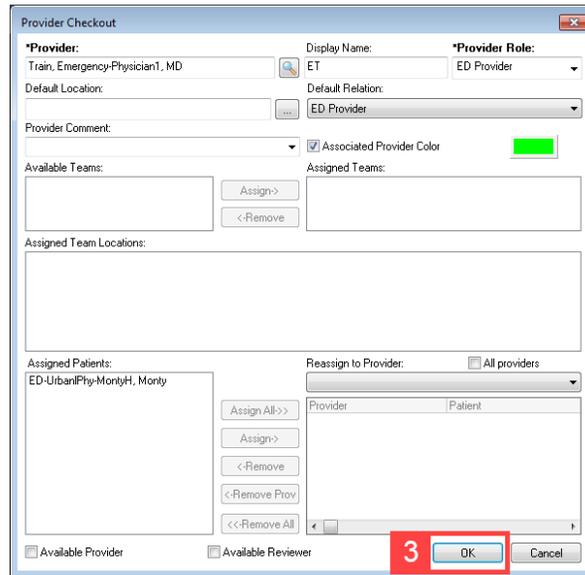
If you would like to checkout, complete the following steps:

1. From the **ED LaunchPoint** screen, click the **menu**  icon in the upper right corner.
2. Select **Check Out**.



The screenshot shows the 'ED LaunchPoint' interface. At the top right, there is a menu icon (three horizontal lines) and a 'Check Out' button. A red box highlights the 'Check Out' button, and a red arrow points to it from the text '2. Select Check Out.' in the instructions above. The main area displays a list of patients with columns for Room, LOS, Patient Information, ED/MD, MLP, RN, Patient Details, Status, and Doc. The patients listed are mostly 'Unassigned' and have various conditions like 'Respiratory distress' and 'Myocardial infarction'.

3. The Provider Checkout window will appear. Click **OK**.



Knowledge Check

- Before handing off, what must you do to properly view all your patients?
- If you were the first Provider assigned to a patient, will checking out automatically **Unassign** you from your patients?
- What button do you click to begin the **Check Out** process?

SCENARIO 2 Key Learning Points

Activity 2.1 Cosign Verbal Orders Entered

- A pencil paired with a number  icon in the **Physician Notifications Column** indicate outstanding orders to **Cosign**
- Access orders to Cosign by clicking the icon on ED LaunchPoint

Activity 2.2 Update a Patient Diagnosis

- Click the Discharge Diagnosis header on your ED Workflow to change diagnoses
- To remove a diagnosis right-click and select **Remove Diagnosis** from the drop-down list in the **Diagnosis and Problems** screen
- Add a diagnosis to the Favorites folder by selecting **Add to Favorites** from the **Diagnosis Search** window

Activity 2.3 Add Addenda to Existing ED Note

- In the Documents section of ED Workflow, a single click previews a document
- Double-clicking open a document to add an addendum

Activity 2.4 Writing a Prescription

- Creating a prescription uses the ED Prescriptions tab in ED Workflow
- Issue prescriptions in a similar manner to inpatient orders
- Narcotic duplicates must be manually printed

Activity 2.5 Completing an ED WorkSafe BC Note

- ED WorkSafe notes take the place of your ED Note in WSBC cases
- Double click the CSA codes to bring up a list of coding options for BP/AP and NOI
- Forms are automatically sent to WSBC when signed

Activity 2.6 End of Shift Patient Handoff

- Set the proper filters in ED LaunchPoint to view all patients in the department prior to handoff

■ Select **Check Out** from the menu drop-down list to check out as an available Provider

APPENDIX 1: INCOMING ED PATIENT

Part A - Prearrival

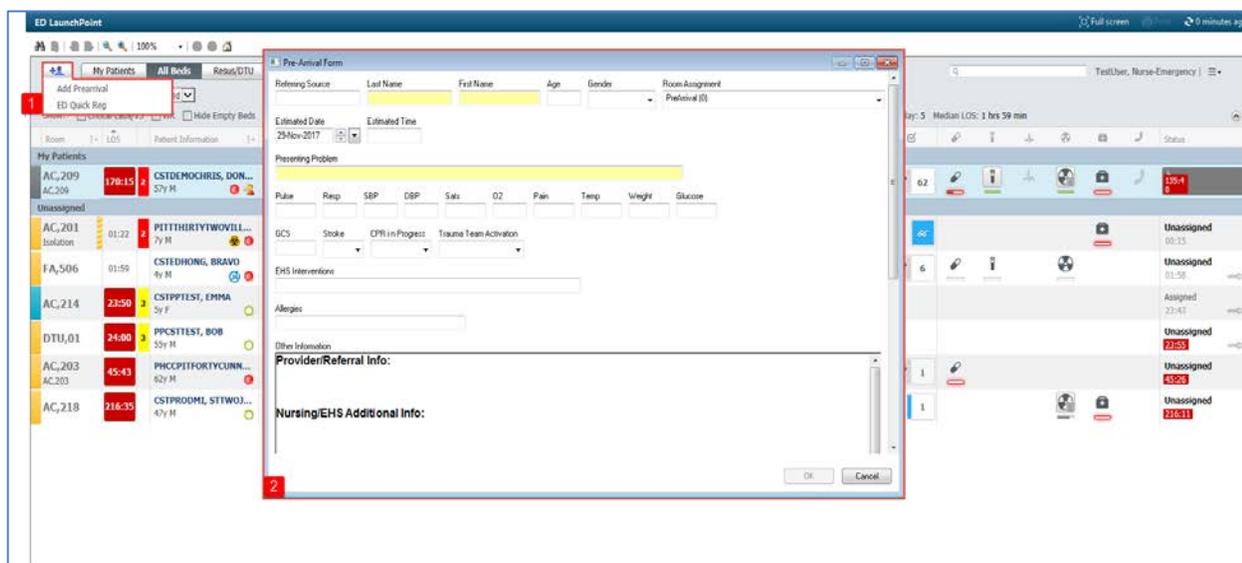
A family physician, Dr. Bains calls the ED, saying he is sending over a patient. The following process replaces written notes, books, or other method of recording incoming patient information.

You will document this incoming patient as a Pre-Arrival.

1. Starting from the ED LaunchPoint Multi-Patient List, click the **Add Patient**  icon and select **Add Prearrival**.
2. A PowerForm window will open. This PowerForm is for Pre-Arrival, where information about an incoming patient can be documented.

PowerForms are electronic versions of common forms used by hospital personnel.

Access PowerForms any time by clicking the Ad Hoc  button in the toolbar.



Create a patient to Pre-Arrive and fill out as much information as you like.

Areas highlighted in yellow indicate mandatory fields that need to be populated before completing the form. Non-highlighted areas are not required.

Click **OK** when done.

If you register patients in your practice, turn to Appendix 1, otherwise continue to Activity 2.2.

Part B – ED Quick Reg

The responsibility for ED Quick Reg varies from site to site. If you are responsible for registering patients in your practice (eg. After-hours).

The paramedics arrive with a patient. Use ED Quick Reg to enter them in the system:

1. From **ED LaunchPoint**, click the **Add Patient**  icon and select **ED Quick Reg**.

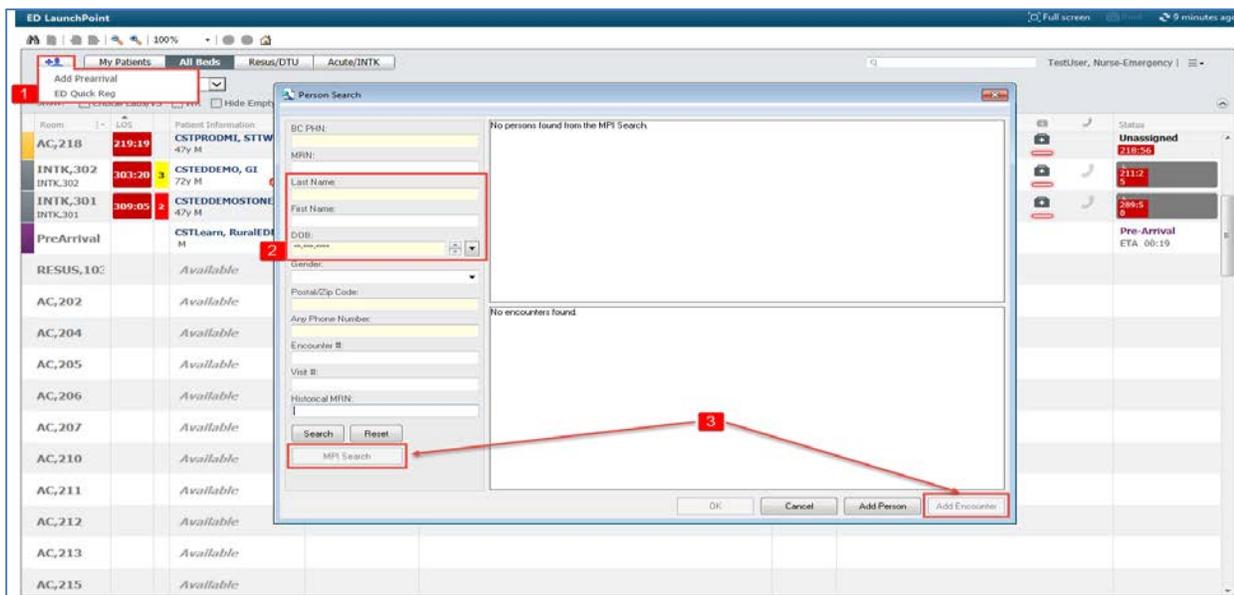
2. A pop-up window will prompt a Person Search.

Though you may typically enter a patient's PHN, for the purpose of this activity you will enter some basic demographics.

Input the same first and last name you chose in the previous activity for PreArrival. The patient informs you that his birthday is *June 30, 1976*. Click **Search**.

3. If the patient has previous encounters in CIS, the information will populate and you would select his name and click **Add Encounter**.

For this scenario, you find that your patient does not have any previous encounters. Select **MPI Search**.



1. The External Master Patient Index (MPI) message will populate with search results stating “No candidates found.”

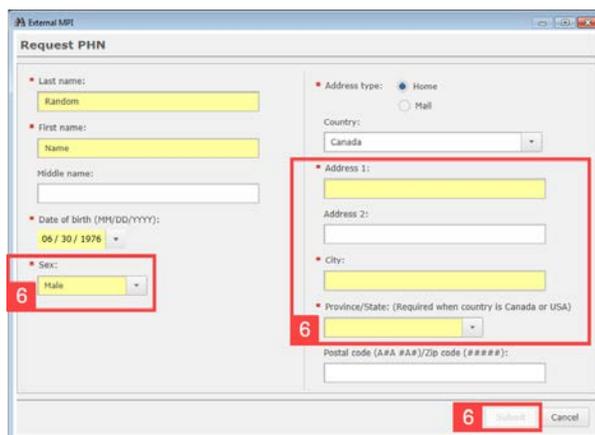
The MPI is a province-wide list of all PHNs. The training system does not allow access to this list, so no candidates will be found. In reality, any patient with a PHN would appear on this list, and you would **Add Encounter**.

Out of Province or Foreign patients would not have a PHN, so you would follow the procedure in this book.

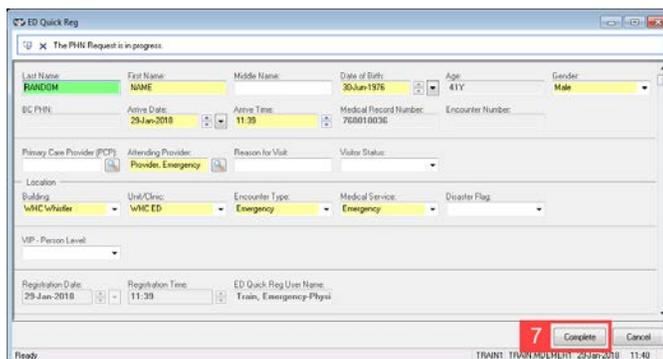
Click **Close**.



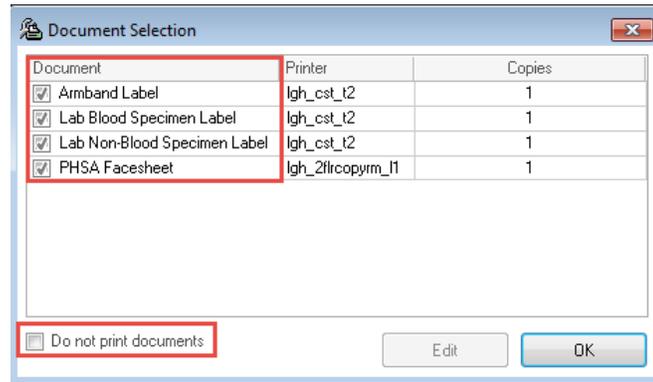
2. You will now be able to click the **Add Person** button in the **Person Search** window.
3. An External MPI window opens to **Request PHN**. Enter the details for your made-up patient. Select **Submit** when done.



4. The ED Quick Reg window will populate. Enter the mandatory patient information and click **Complete**.



- A Document Selection prompt will appear asking to print patient documents. You can choose which documents and labels to print or choose to print nothing.



- A notification will populate stating an Encounter Number has been created for your patient. Click **OK**.

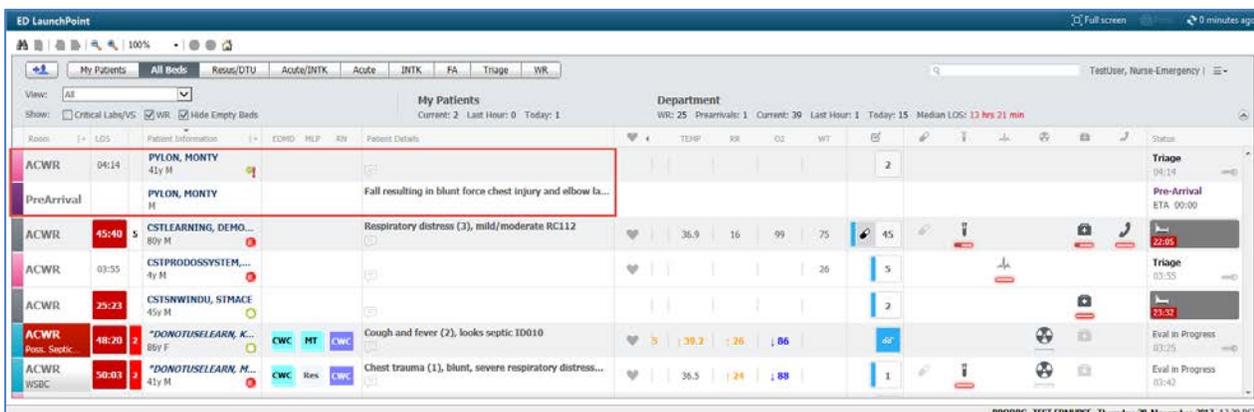


Your patient is now in the Waiting Room of **ED LaunchPoint**.

A key icon  appears in the Status Column indicating the patient needs full registration. If you are at a rural site and registration is part of your workflow, you will learn about registration in CIS in a different session.

Currently, your patient appears on LaunchPoint twice – once as a PreArrival and the other in the Acute Waiting Room.

You will notice that patients with similar names are italicized. This way, you are visually alerted to patients with similar names to avoid charting on the wrong patient.

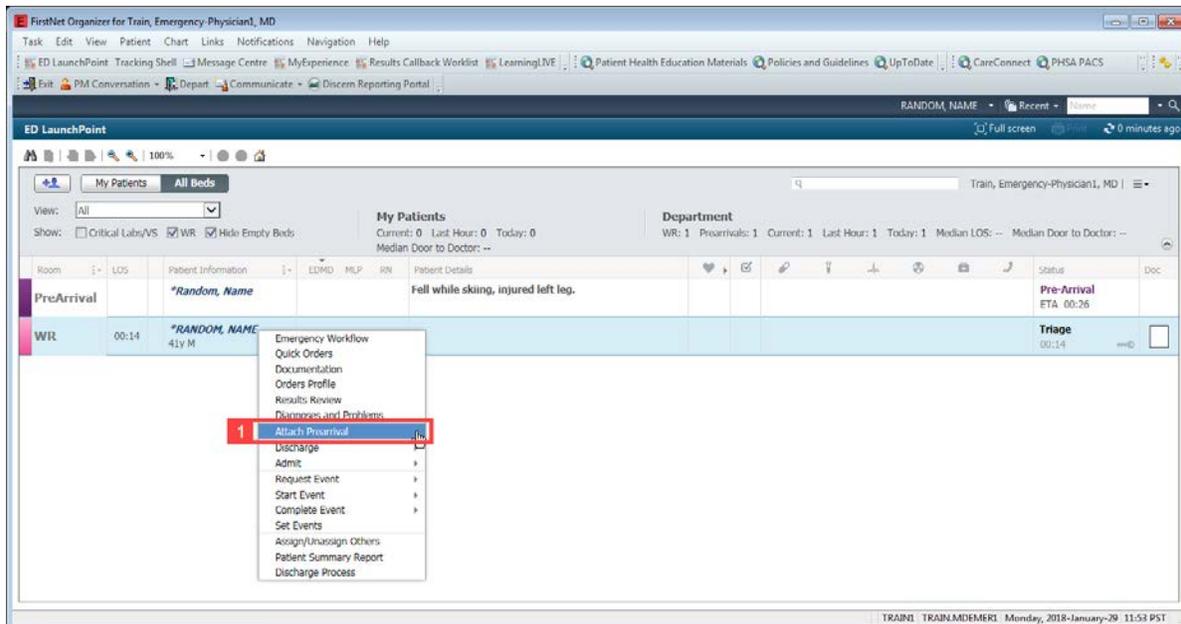


✚ Part C – Attaching a Pre-Arrival

Attaching the **Pre-Arrival** that was completed prior to Quick Reg prevents duplicate documentation and creates a clear history of the patient’s arrival to the ED. This is typically nurses’ responsibility, but is included here if you wish to use this function yourself.

You will now attach your patient’s PreArrival to their associated ED Quick Reg:

1. Right-click the patient’s name in ED LaunchPoint. Select **Attach PreArrival**.



2. The **Select Pre-Arrival to attach to patient** window opens. Select the appropriate patient name from the Available Pre-Arrivals section.

The information captured during the PreArrival documentation will populate. Review the displayed information before attaching.

3. Once you have reviewed the information, select **Attach**. The patient's name will move from the Available Pre-Arrivals section to Attached Pre-Arrivals section.
4. Click **Close** when complete.

If you cannot find your PreArrival or ED Quick Reg patient, try checking your view filter settings. Click on the **All Beds** tab and select the **WR** checkbox.

After successfully attaching the PreArrival to the ED Quick Registered patient the PreArrival encounter will disappear from the ED LaunchPoint screen.

The information is now combined with the Quick Registered file.

Remember to clean up pre-arrivals that do not get attached per your facility policy, as the lists will become cluttered if they do not get addressed.

End of Workbook

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