SELF-GUIDED PRACTICE WORKBOOK [N48]
CST Transformational Learning

WORKBOOK TITLE:

Nursing: Emergency

Last update: February 12, 2018 (v2)

CLINICAL + SYSTEMS TRANSFORMATION
Our path to smarter, seamless care

TRANSFORMATIONAL LEARNING

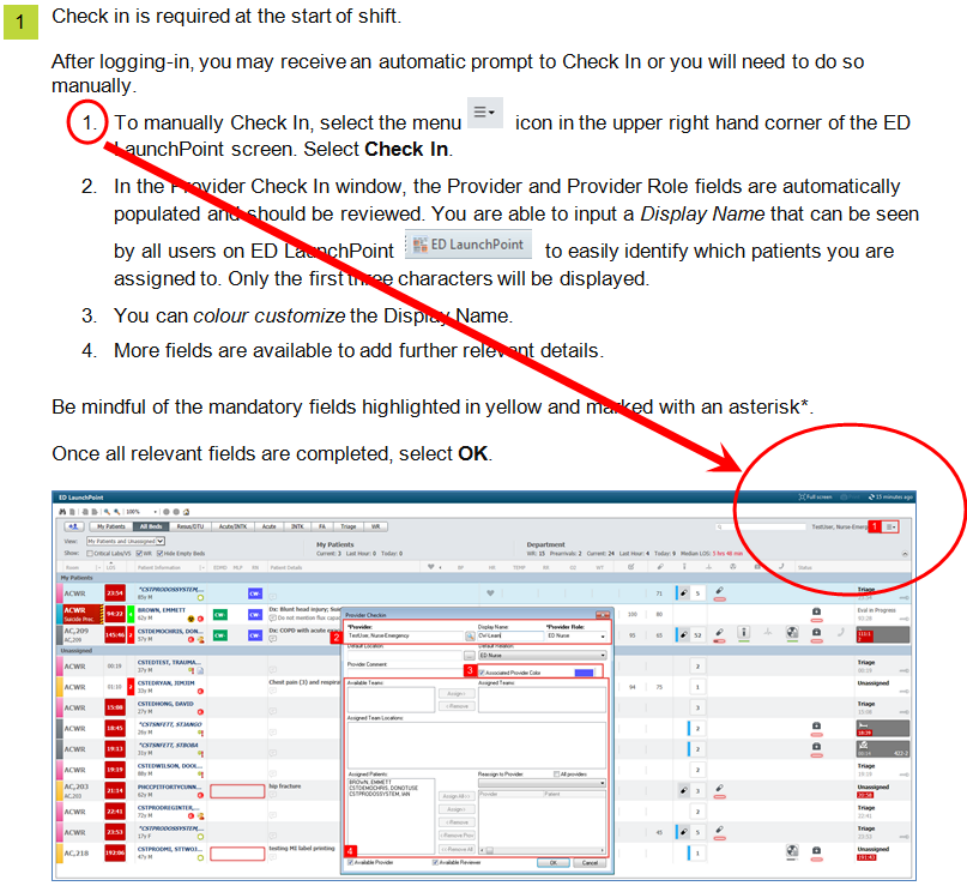
TABLE OF CONTENTS

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:



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	**12 hours (3 sessions of 4 hours)**
Before getting started	Sign the attendance roster (this will ensure you get paid to attend the session) Put your cell phones on silent mode
Session Expectations	This is a self-paced learning session A 15 min break time will be provided. You can take this break at any time during the session The workbook provides a compilation of different scenarios that are applicable to your work setting Work through different learning activities at your own pace
Key Learning Review	At the end of each session, you will complete a Key Learning Review This will involve completion of some specific activities that you have had an opportunity to practice through the scenarios.

USING TRAIN DOMAIN

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

Please note:

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

PATIENT SCENARIO 1

Learning Objectives

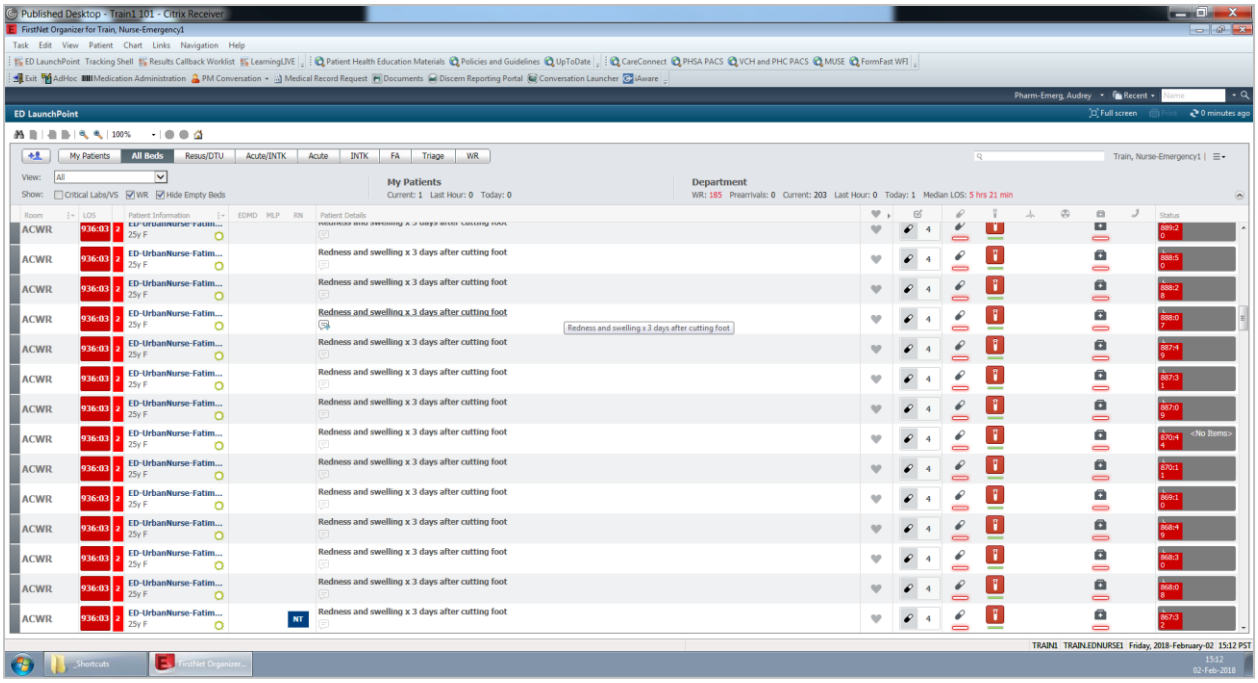
At the end of this Scenario, you will be familiar with:

- Check In
- Patient Assignment
- Locating a patient and establishing a relationship
- ED Patient Summary Page in your patient's chart
- Reviewing orders and medications
- Charting, rescheduling and retracting medication administration
- ED Nursing Quick Orders
- Documenting a patient's home medications and history
- Entering telephone orders

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.

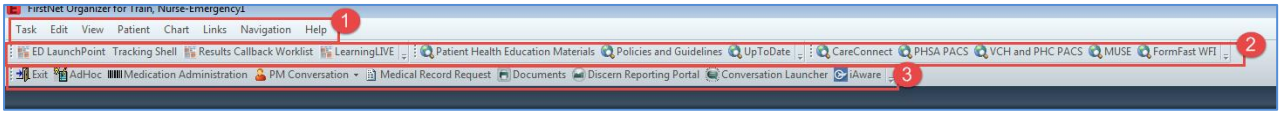


When you first login to the FirstNet system, the **ED LaunchPoint Multi-Patient List** ED LaunchPoint will be your landing page. We will refer to this as ED LaunchPoint. **ED LaunchPoint** refreshes automatically every 60 seconds offering important, up-to-date information at a glance, which allows you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

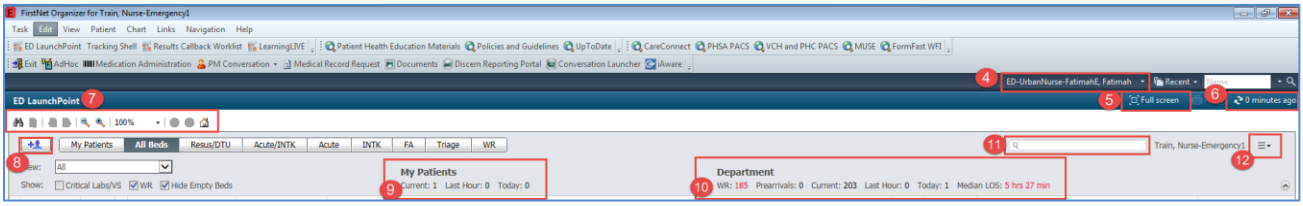
Part A - Toolbars

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

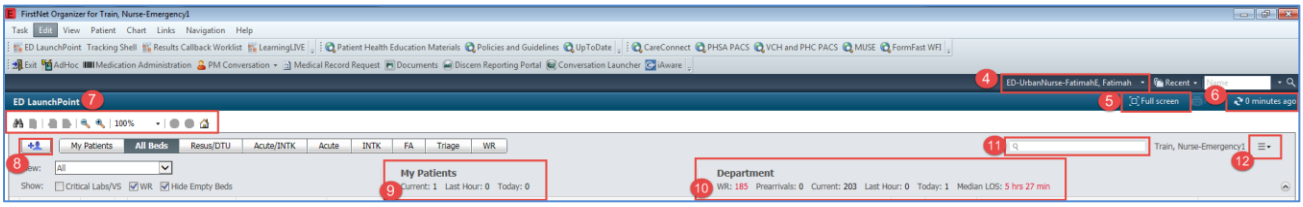
1. Options Toolbar
2. Navigation Toolbar
3. Action Area Toolbar



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



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

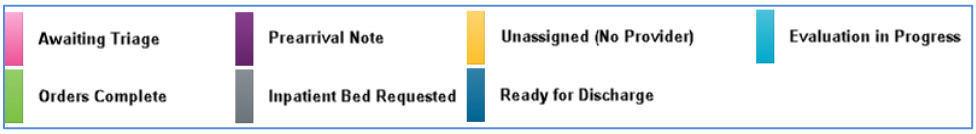


You can rearrange your Toolbars to fit your preferences by clicking and holding the **vertical row of dots** beside each Toolbar. Drag the section to where you like. Ideally, you will maximize your viewing area, so the toolbars take up two rows (rather than three).

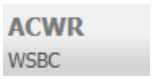
Part B – Patient List

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:

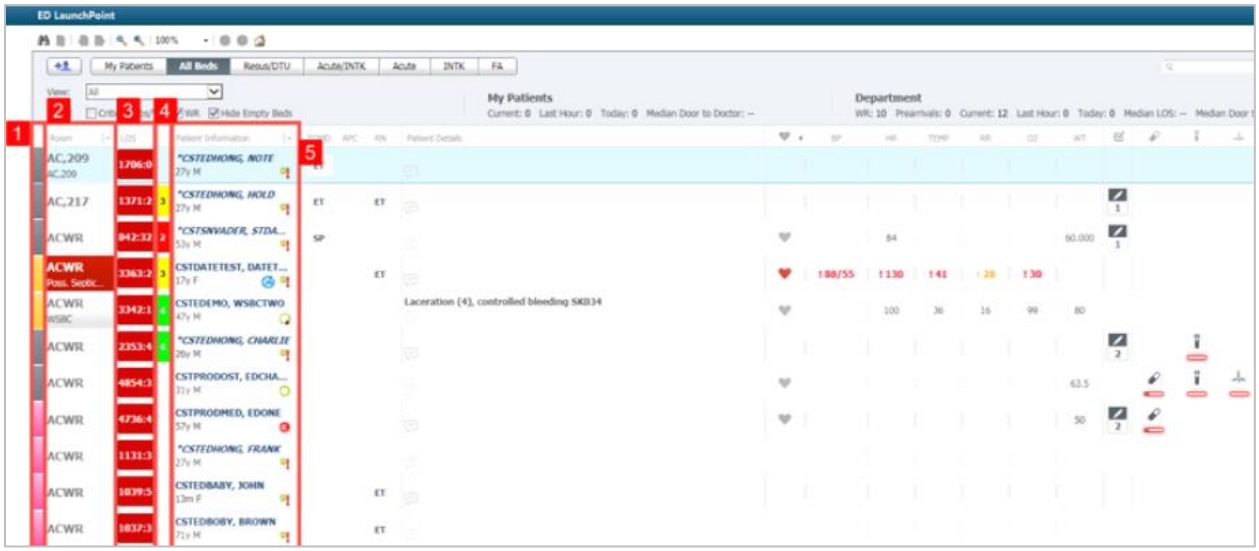

Allergies


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 can be found on the next page.


ED LaunchPoint
My Patients
All Beds
Resus/DTU
Acute/INTK
Acute
INTK
FA
My Patients
Department
1
2
3
4
5

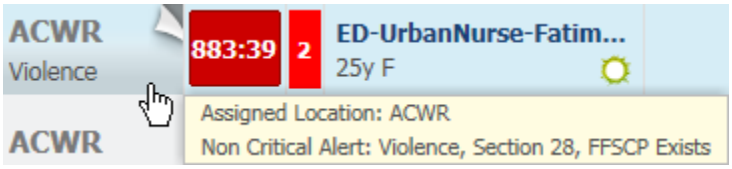
ED Alerts Overview

It is possible to notify and display care plans for patients who have management issues and are frequent patients in the ED.

Alerts can be displayed in **ED LaunchPoint**. Alerts are hierarchically organized, for instance, a Violence Alert is displayed before a WSBC Alert. Alerts will display in the following order:

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 appear on the **Banner Bar**:

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

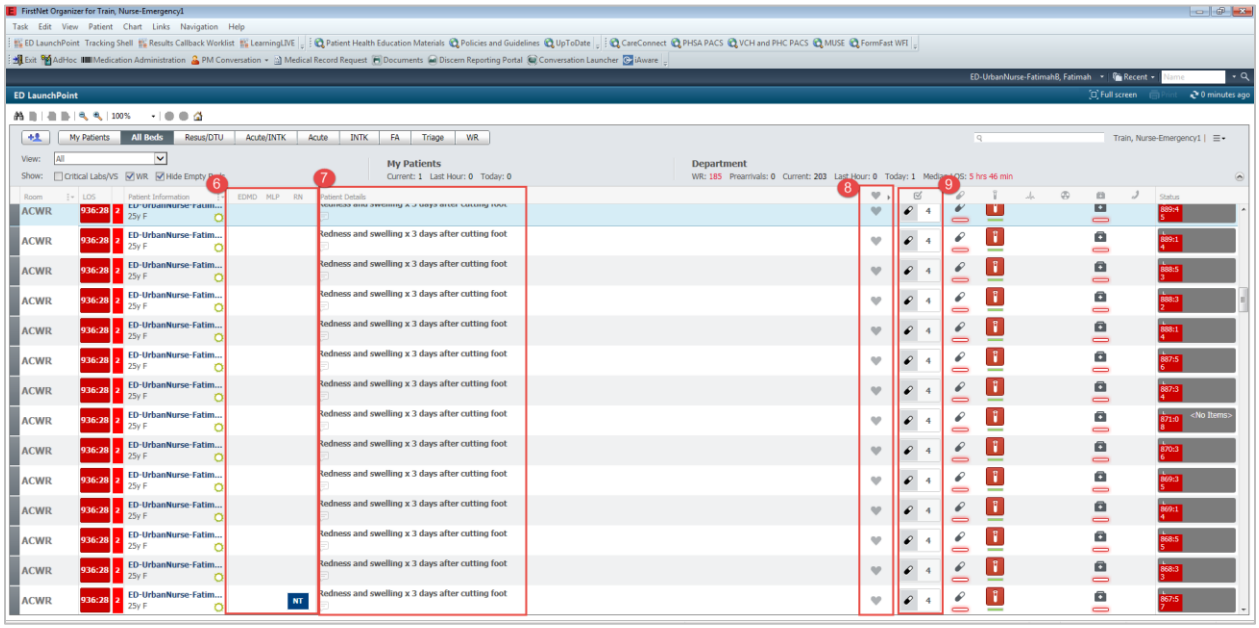
6. **Assignment Column**
   Displays initials of the Provider, Mid-Level Provider (Nurse Practitioner, Resident, and Medical Student), and Nurse assigned to the patient.

   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 staff.

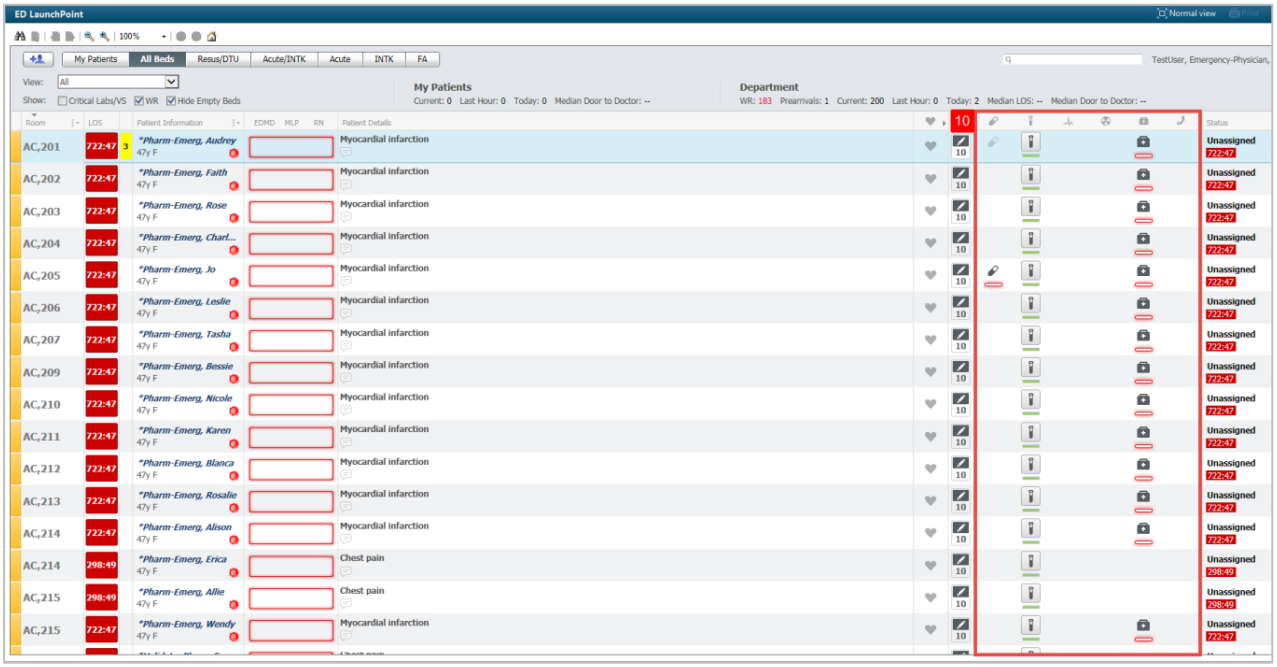
8. **Vital Signs Column**
   Clicking the arrow beside the Vital Signs Column header allows you to expand and collapse the display showing patients' most recent vital signs.

9. **Nurse Activities Column**
   Outstanding activities that require attention.



10. **Patient Care Activities Column**

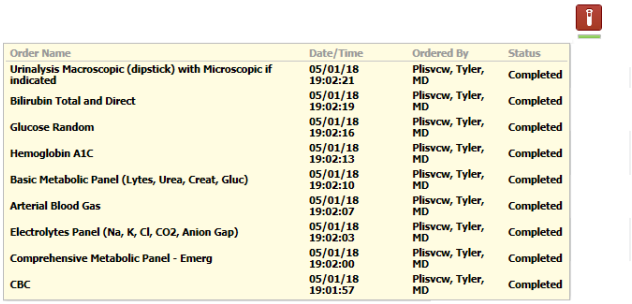
	Medications		Patient Care
	Labs		Consult
	ECG		
	Imaging		



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.

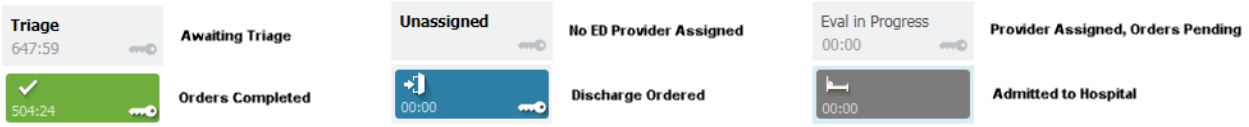
You can hover over these icons to see the basic details on what was ordered.



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.



Activity 1.2 – Check In

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.

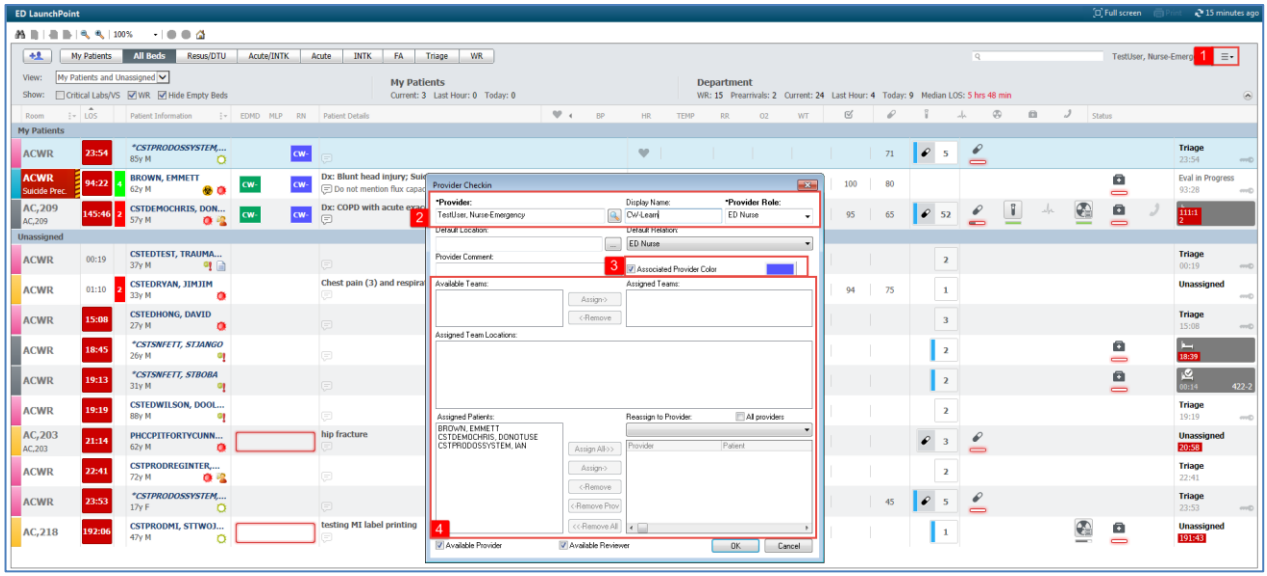
1. To manually **Check In**, select the **menu**  icon in the upper right hand corner of the ED LaunchPoint screen. Select **Check In**.
2. In the **Provider Check In** window, the Provider and Provider Role fields automatically populate but should be reviewed.

   Enter a *Display Name* which will be seen by all users on **ED LaunchPoint** to easily identify which patients are assigned to you. Only the first three characters will be displayed.

   Although not mandatory, it is recommended to set a Default Relationship.
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**. You will only need to fill out your details once, as all changes are saved until you manually change them.



You have now successfully checked in as an available clinician[1].

[1] To reflect the language utilized by the CIS, Nurses may be referred to as clinicians. Physicians may be referred to as Providers. Midlevel Providers includes Nurse Practitioners, Medical Students, and Residents.

Activity 1.3 – Customizing ED LaunchPoint

When checked in, you will be able to view your Patient List on **ED LaunchPoint Multi-Patient List**. ED LaunchPoint is a tool used to assign yourself patients. Filter your view according to the criteria in the steps below:

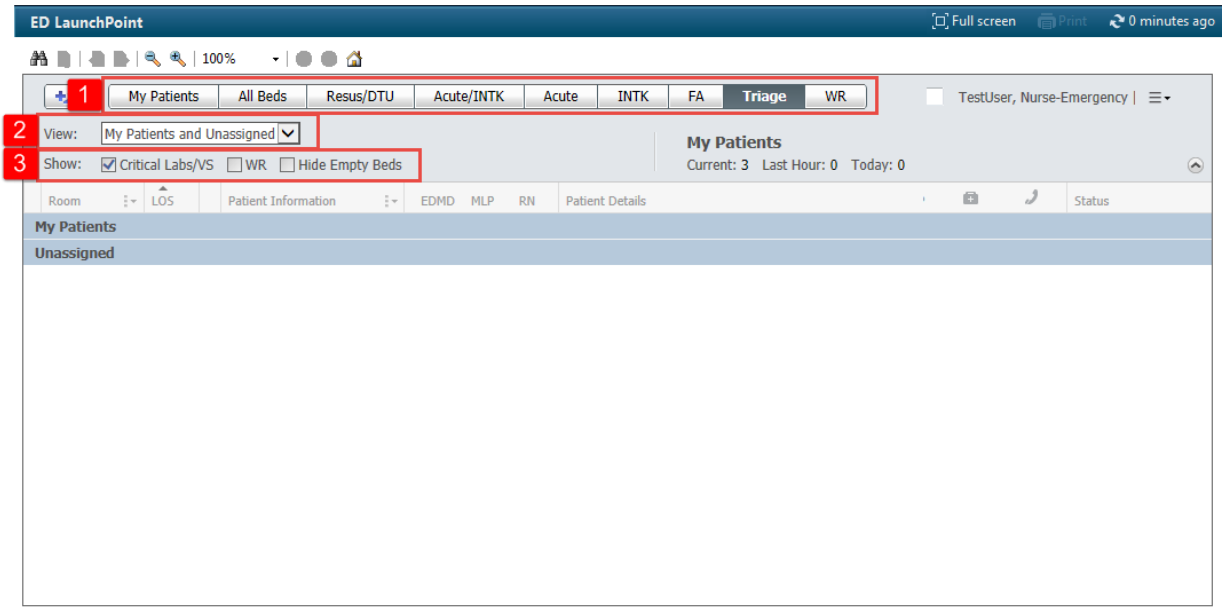
Take a moment to review the tabs at the top of ED LaunchPoint.

1. Try selecting different tabs such as **My Patients**, **All Beds**, and **Triage**.
2. Below the tabs, there is a drop-down list that you can use to further specify your view. Select the **drop-down arrow** and chose your desired view.
3. Below the drop-down view options, you can choose additional options such as **Critical Labs/VS**, **WR (Waiting Room)**, and to **Hide Empty Beds**.

   To view patients in the waiting room, be sure the Waiting Room check box is selected ☑ WR

Let's try the following steps:

1. Select the **Triage** tab Triage.
2. Change the view drop-down list to **My Patients and Unassigned**.
3. From the additional check box options, choose to show the patients with **Critical Labs/VS**.



To make the patients in ED LaunchPoint reappear, Select **All Beds** tab, View **All** and check the **WR** box.

After Go Live, Quick Reference Guides (QRGs) will be available on hand until you get used to the customization functions.

SCENARIO

Fatimah Abassi is a 25 year old UBC student who arrived to the Emergency Department (ED) shortly before your shift.

After cutting her foot a few days ago, the area around the wound has become progressively redder, hot to the touch, and is now draining purulent exudate. She attended a walk-in clinic immediately after the injury and was advised there were likely no breaks or fractures, but was prescribed Tylenol 3.

Today, walking causes severe pain; she was feeling weak and had a fever. Her only medical history is mild asthma, for which she occasionally uses an inhaler, and hyperthyroidism, which she regulates with medication.

You'll need to establish a relationship and gather some history on Fatimah and document her home medications as the Provider is considering admission. Additionally, you will need to administer medication.

Note: For the training session, Fatimah Abassi will be displayed as a variation of "ED-Nursing-Fatimah, Fatimah".

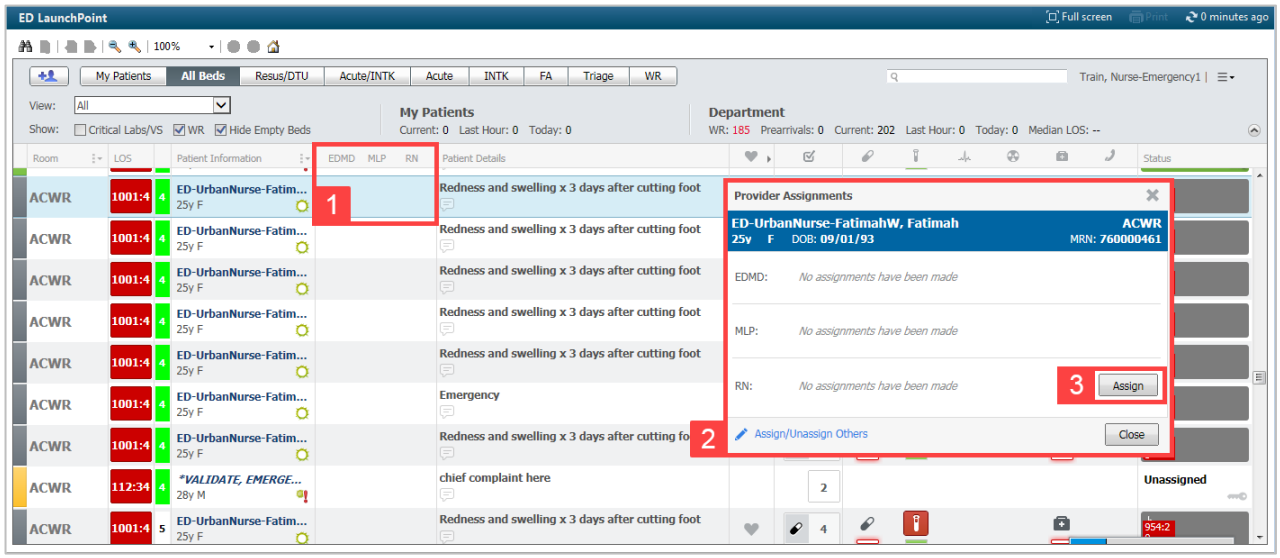
Activity 1.4 – Establish Relationship

To access a patient's chart, you will either need to be assigned to the patient or will need to manually **Establish a Relationship**.

You can assign yourself to patients using the Assignment column in **ED LaunchPoint**. The **Assignment Column** is useful as it displays the Nurses and Providers that are assigned to each patient.

To manually Establish a Relationship, locate Fatimah on the ED FirstNet LaunchPoint and continue with the following steps:

1. To the right of the patient's name, click in the **blank space** of the **Assignment Column**.
2. A **Provider Assignments** window will appear.
3. Select the **Assign** button to assign yourself as the **RN**.



You can repeat these steps to **Unassign** yourself from a patient.

The display name you entered when you checked in now appears in the **Assignment Column** beside Fatimah's name. Now everyone who views the **ED LaunchPoint Multi-Patient List** will know you are Fatimah's Nurse. You can hover over display names to view the first and last name of the associated user.

Activity 1.5 – Patient Chart Overview

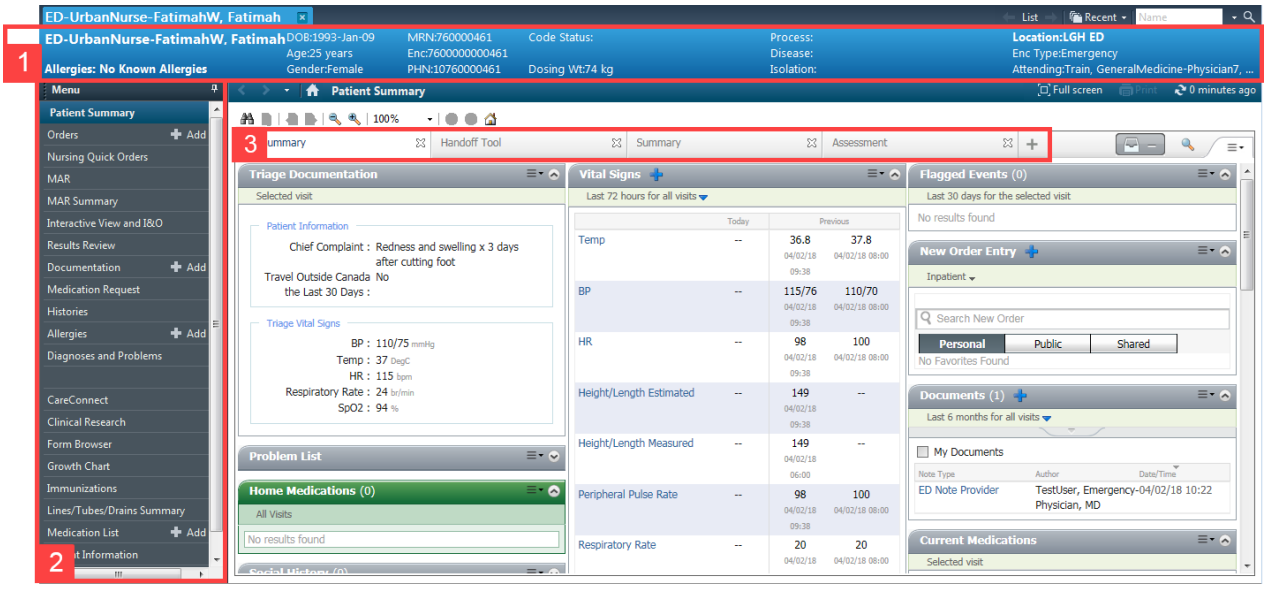
Clicking on Fatimah's name from **ED LaunchPoint** will open the patient's chart. The **Patient Summary Page** will always be the user landing page when initially opening a chart.

The **Patient Summary Page** pulls information from other areas of the chart and gathers them in one place to review.

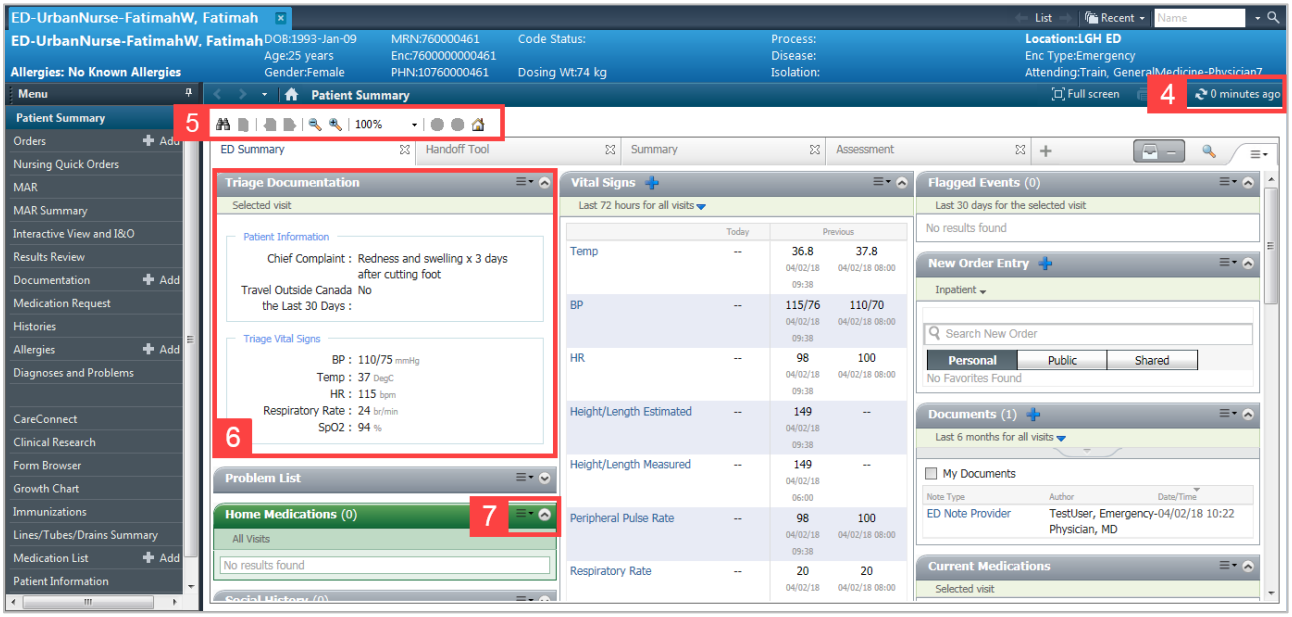
Before moving on, orientate yourself to the Patient Summary page. Some of this overview might be familiar from the eLearning modules.

The **Banner Bar** at the top of the screen shows patient demographic information and alerts. Information that you need quick access to is available at-a-glance. If you have multiple charts open (maximum 4 charts at a time), the Banner Bar will display in different colours to help differentiate between charts.

1. The **Menu** allows you to navigate to different parts of the patient chart. Clicking the thumbtack icon allows you to unpin the Menu to maximize your viewing area.
2. The **Tabs** at the top of the Patient Summary page organize viewable content based on activities.
    - The ED Summary tab is your "home" tab.
    - The Handoff tab gathers pertinent patient information for shift handover.
    - Both the Summary and Assessment tabs are intended to mimic the SBAR format.



4. **CIS** allows for collective documentation, meaning your colleagues can be documenting in the same chart at the same time as you. The **Refresh** button updates the page to ensure the most up-to-date information is available, as the Patient Chart does not auto-refresh.
5. **Navigation Icons**
    i. Search specific text on screen
    ii. Change the magnification
    iii. Return Home
6. The **Components** in the Patient Summary page helps organize patient information based on clinical topic areas.
7. The Icon allows you to minimize **Components** to organize your view as needed. The Icon allows you to change different settings, such as the **Default Expanded** setting.

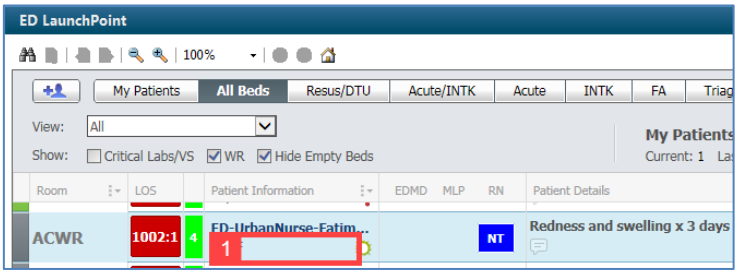


Now that you have learned a bit about the Patient Summary page, you can move on to the next activity.

Activity 1.6 – Conduct Nurse Review

When the user conducts a **Nurse Review**, it is the act of acknowledging you are aware of an outstanding activity. You will still need to document the activity is completed in the system.

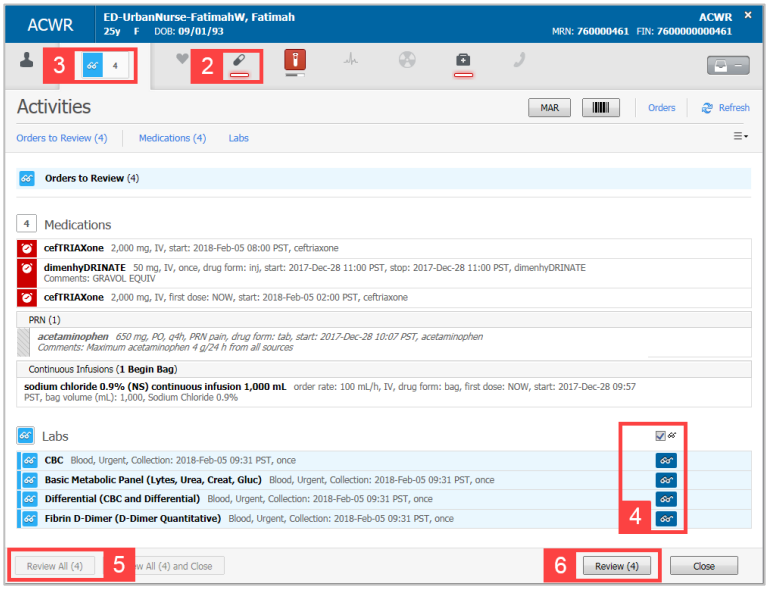
1. Starting from the ED LaunchPoint screen, click the **white space** below Fatimah's name. The **Single Patient View** will open to the **Patient Summary** Tab.



2. Click the **Pill**  icon in the Single Patient View to see outstanding activities.
3. Click the number/glasses icon in the **Nurse Activities Column** to open Single Patient View.
4. Click the **Nurse Review**  buttons associated with the oustanding orders (medications, labs, or patient care). The button will highlight.

   If more than one activity is outstanding, click the **Review All**  checkbox to highlight all orders under a heading at once.

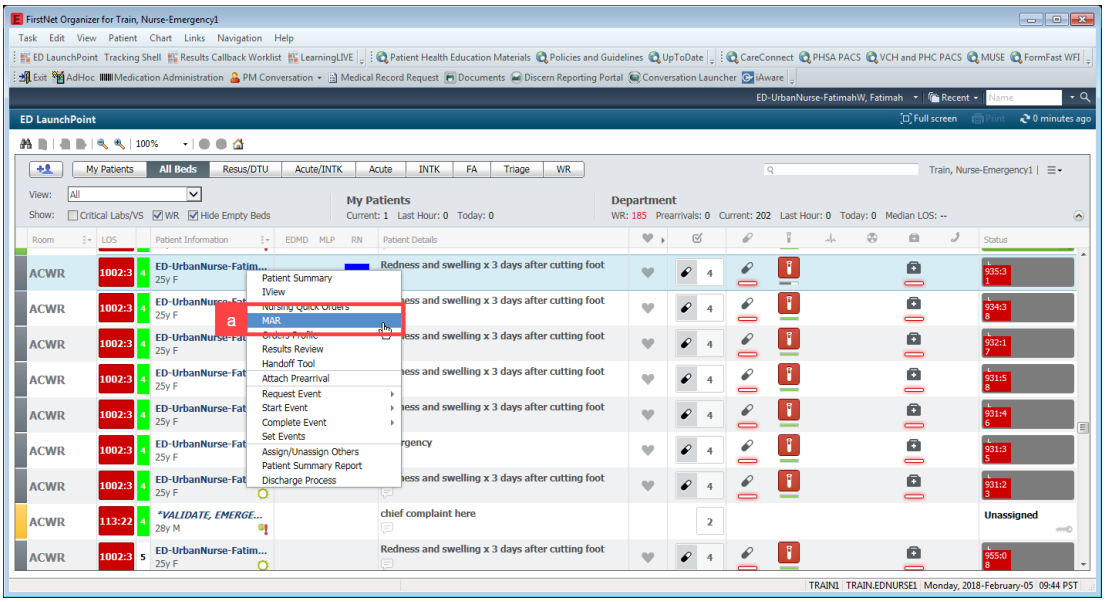
5. The **Review All**  buttons will review all pending orders. Only use this if you are ready to act on all the orders given.
6. Click **Review**. Your orders will be ready for action.



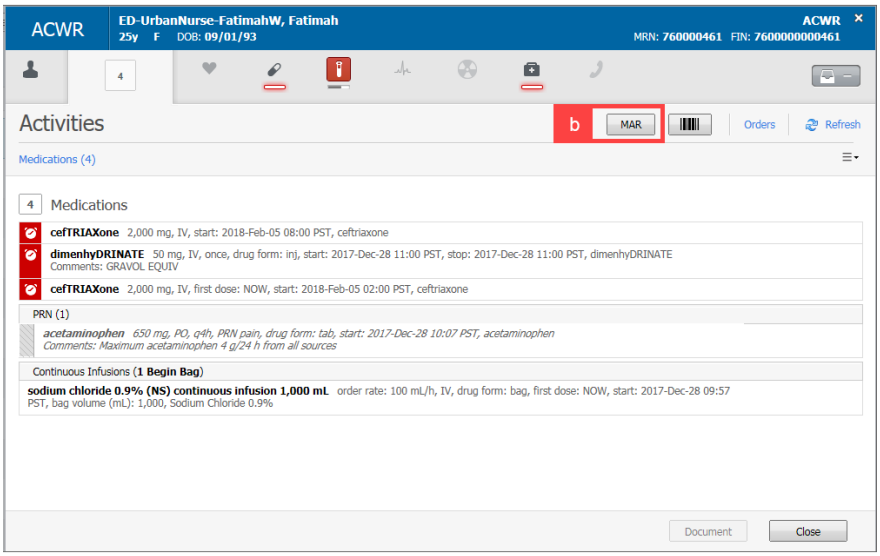
Activity 1.7 – Medication Administration Record (MAR) Overview

To administer medications, you must navigate to the **MAR** screen. There are multiple ways to get there:

a. Right-click on your patient's name from the **ED LaunchPoint Multi-Patient List**.



b. Click on the **MAR** or **Wizard** button in **Single Patient View** after reviewing medications.

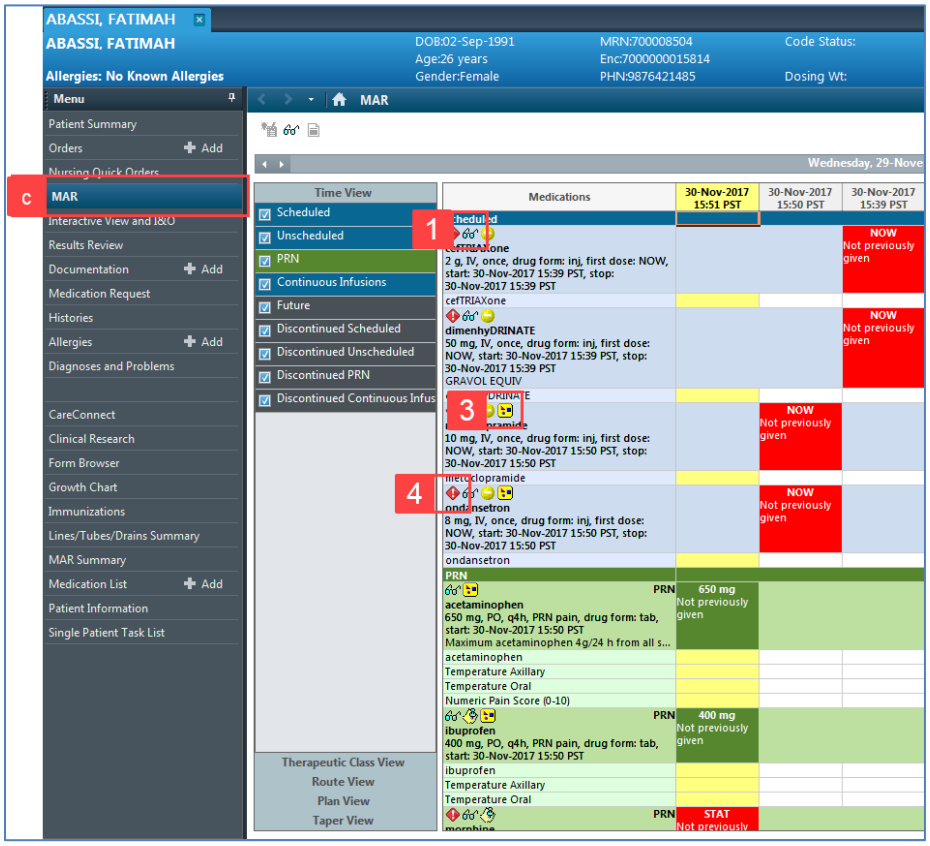


c. From the patient chart, you can click on the **MAR** band from the menu.

The **Medication Schedule Table** lists the names of medications and the times to be given like a paper MAR. Scheduled medications are highlighted blue in the menu, PRN medications are green.

The icons on the table designate different types of orders and statuses:

1. Nurse Review
2. Overdue Activities
3. PowerPlan
4. STAT/NOW Order
5. Request Pharmacy Verification



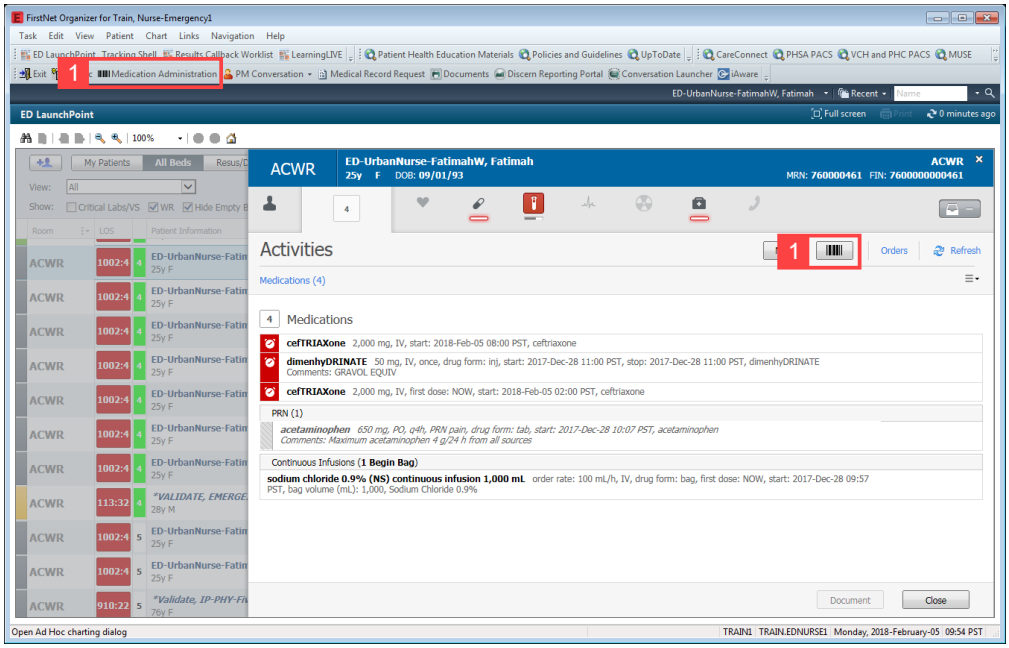
See your *CIS Icon Quick Reference Guide* for more information.

Activity 1.8 – Chart Medications

Now that you have reviewed Fatimah's orders, you are ready to administer medications.

The **Medication** *Administration Wizard (MAW) is the most common method of documenting medications. Pra*ctice administering IV Ceftriaxone using this method.

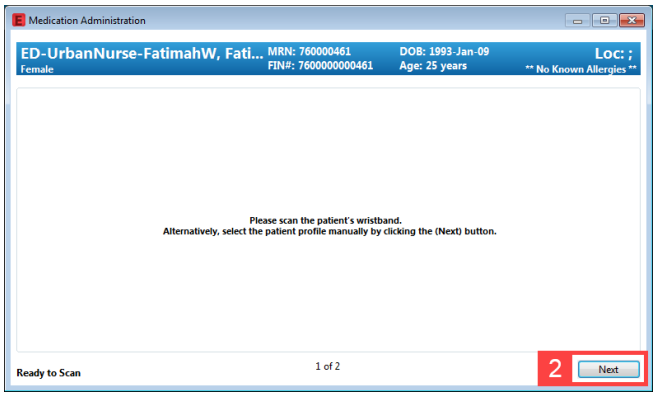
1. Access the *MAW by clicking the Medication Administration button or opening the Single Patient View* and clicking the barcode  icon.



2. A new window opens requesting you to scan the patient's wristband.

For IV medications you mix yourself, this will not work, as the minibags do not have compatible barcodes.

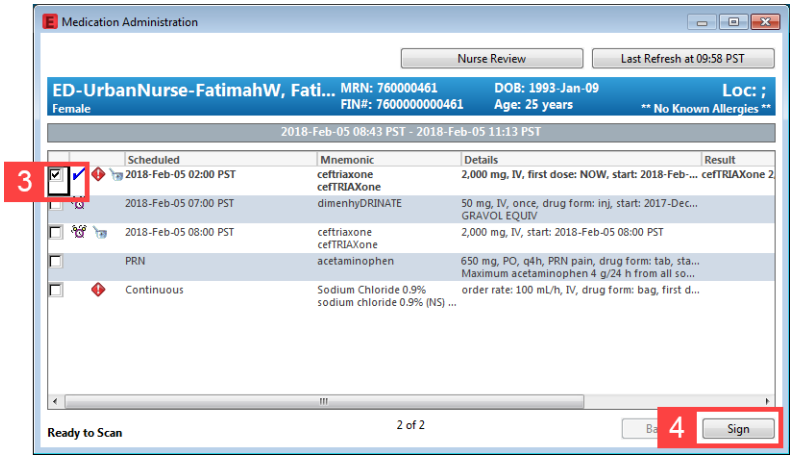
If no wristband is available, click **Next**. If wristbands are available in your classroom, scan the appropriate wristband.



3. The next screen displays a list of medications ordered that are available for administration.

   Select **Ceftriaxone**.

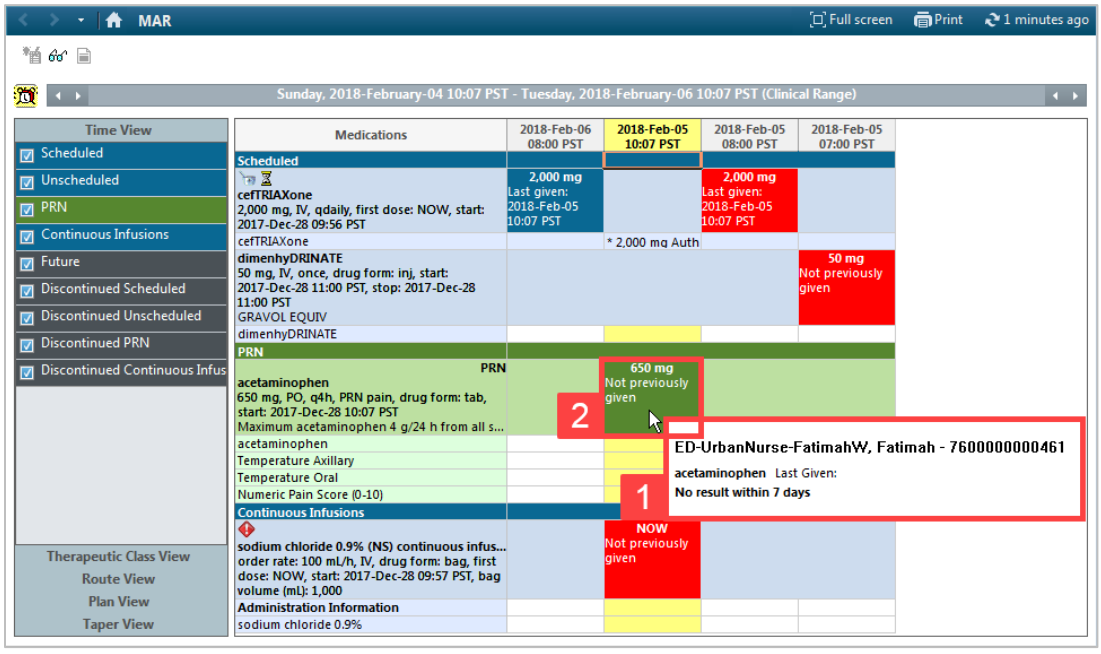
4. Click **Sign.**



An alternate way to document medication administration is directly through the **MAR**.

Use this method to chart Fatimah's acetaminophen dose.

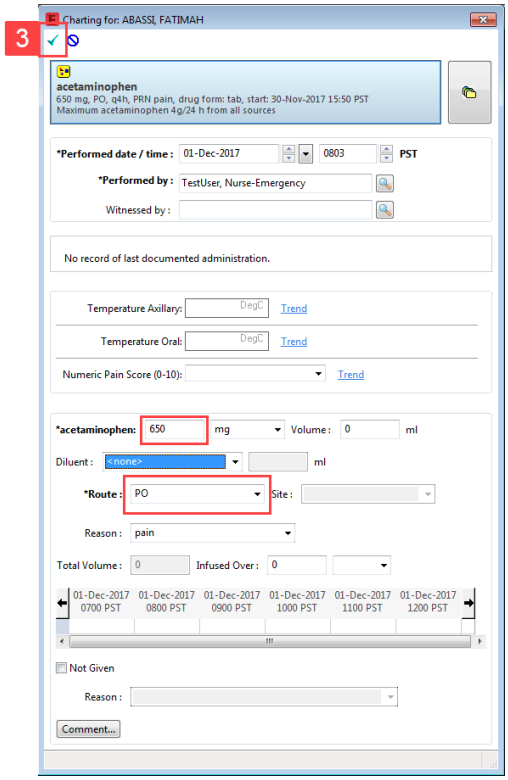
1. **Hover** over acetaminophen in the Medications Column to see additional information, such as the dosage amount, the delivery method, and when the first dose was administered.
2. Double-click the **acetaminophen cell** you are hovering on to administer the medication.



3. The **Charting Form** will open.

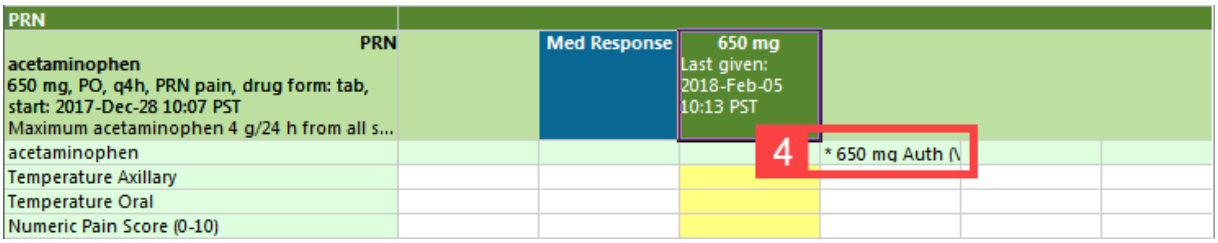
Review any information that auto-populated and change or add information as necessary.

Click the green **Checkmark**  to sign for the medication administration.



You may be prompted to enter a reason the dose is late, as the training system clock does not reset with the rest of the system. Choose a reason you feel is appropriate.

4. This dose is now complete and this activity will fall from the MAR. The administration time will be recorded with a date and time stamps to differentiate between outstanding and administered medications.



Activity 1.9 – ED Nursing Quick Orders: New Order Entry

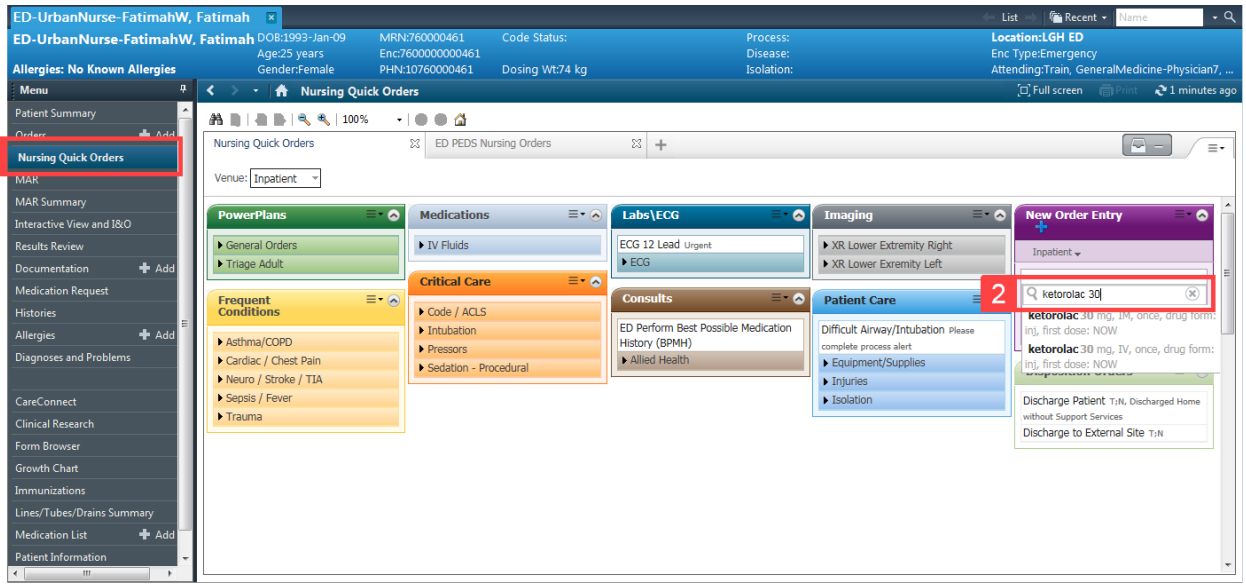
Despite the acetaminophen, Fatimah's foot pain persists and she needs additional analgesia.

The physician tells you to give her 30 mg ketorolac IV, but does not have time to enter the order herself. Providers are expected to enter their own orders. However, there are instances when Nurses may need to place verbal/telephone orders in the system.

1. Select N**ursing Quick Orders** from the menu.

   Take a moment to explore this part of the system. The heading of each Component will help identify the various categories on this page.

2. Search and select **Ketorolac 30mg, IV, once** in the search bar of the **New Order Entry** component.



2. The Inbox  has now turned green  . Select the green **Orders for Signature Inbox**.

3. The **Orders for Signature window** will appear. You will notice the options: **Sign, Save, Modify**, and **Cancel**.

   The **Save** option is used to plan orders in situations such as for when a patient who has not yet arrived or will need care after a procedure.

   For now, select **Modify** to change order details such as dose and frequency.

4. An **Ordering Physician** window will appear asking for the name of the ordering **Provider** and **Communication Type**.

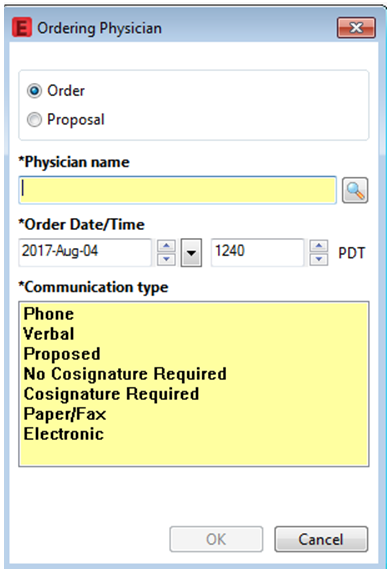
   Select the **Order** (Order) button. These Orders will activate immediately.

   Proposals (Proposal) are suggestions Nurses send to the Provider for review and signing. These are not active until the Provider signs them.

   Physician Name: *(provided by your instructors)*

   Date and Time: *Default to T; N (today and now)*

   Communication Type: *Verbal*



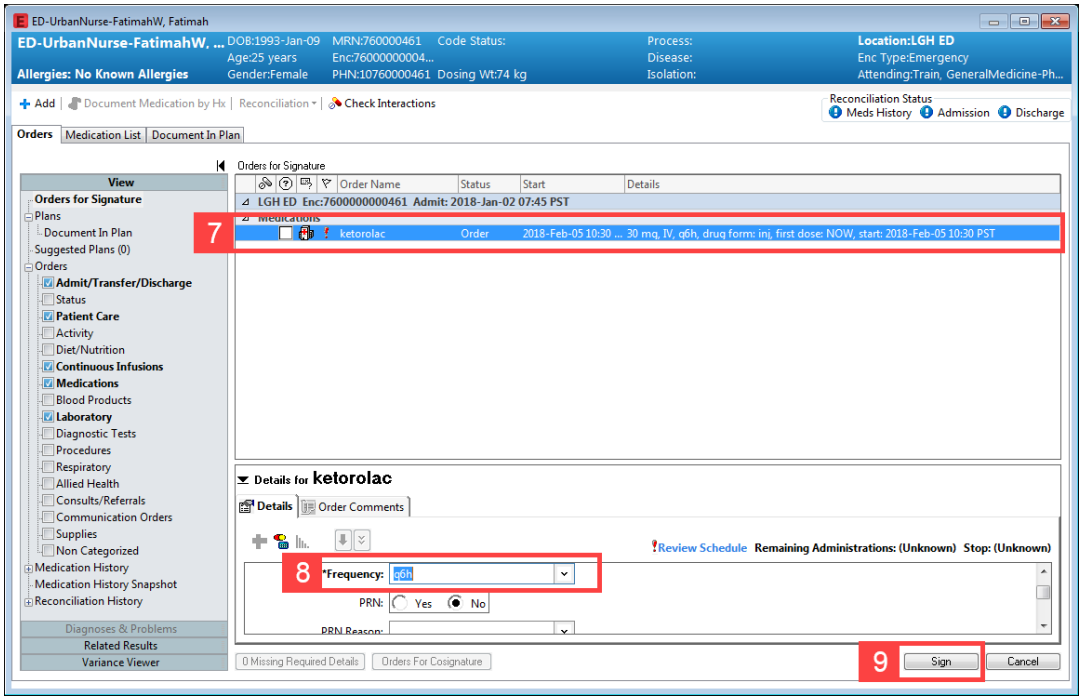
Hospital Policy and Protocols govern the level of sign-off privilege you have regarding **Order Communication Type**.

5. Select **OK**.

6. The **Order Details** window will open and allow you to tailor this order to meet the patient's needs. Select the order name and the Details for Ketorolac section will appear.

7. Change the **Frequency** to q6h by selecting the dropdown arrow and scrolling through to find your selection. Review the order details for accuracy

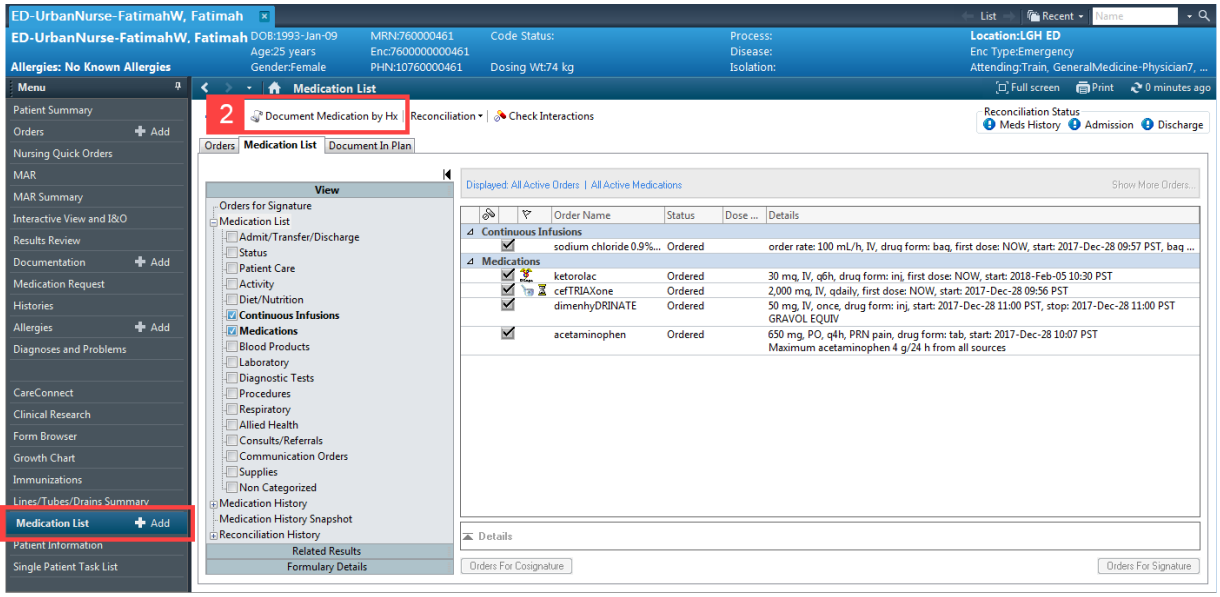
8. Select **Sign**.



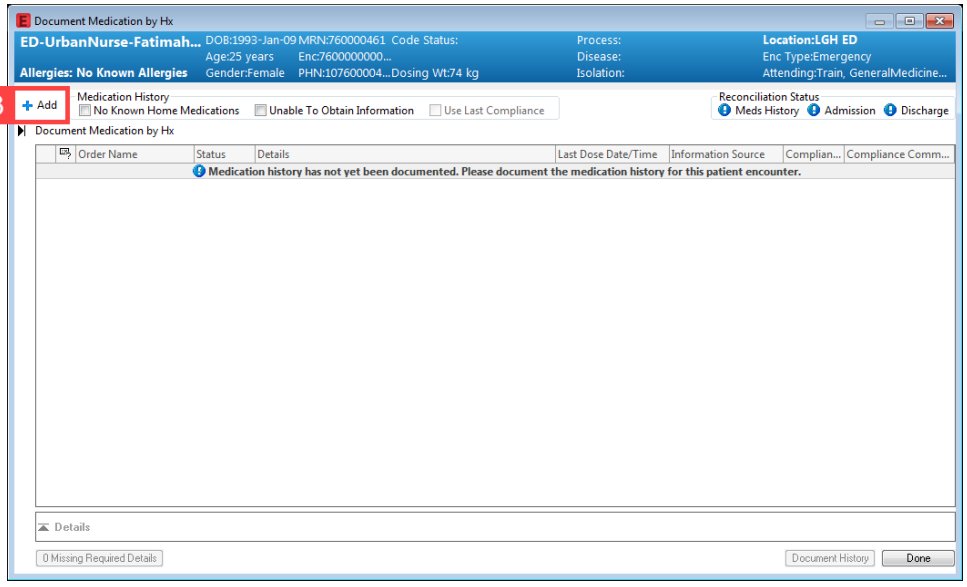
Activity 1.10 – Best Possible Medication History (BPMH)

While often performed by a Pharmacy Technician (when available), Nurses should be familiar with **BPMH**, as they share responsibility for collecting this information.

1. Select **Medication List** from the chart **Menu**.
2. Click the **Document Medication by Hx** button in the upper left corner of the Medication List screen.



3. In the next window, click the **+Add**  button in the upper left-hand corner.



4. Fatimah tells you that she takes **10 mg of Methimazole daily** for Hyperthyroidism.

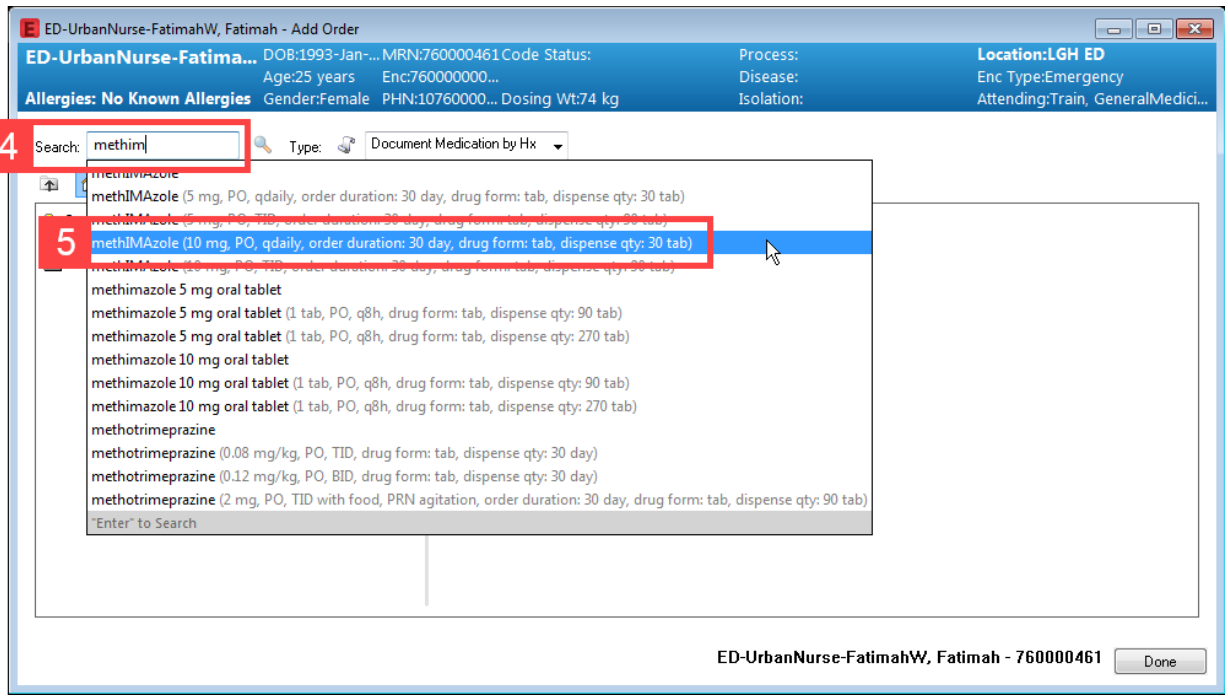
   Type *Methimazole* in the **Search Field**.

   Options will appear while you type as the system will try to predict the order you require based on what is being entered into the Search Field.

   Notice some results have a medication name with **Order Details** in grey text.

   These are referred to **Order Sentences**. Selecting one of these options will automatically populate Order Details. This is in opposed to selecting an option with no Order Sentence, which the user would need to manually enter the detail for the order.

5. Select the first option **methimazole**.

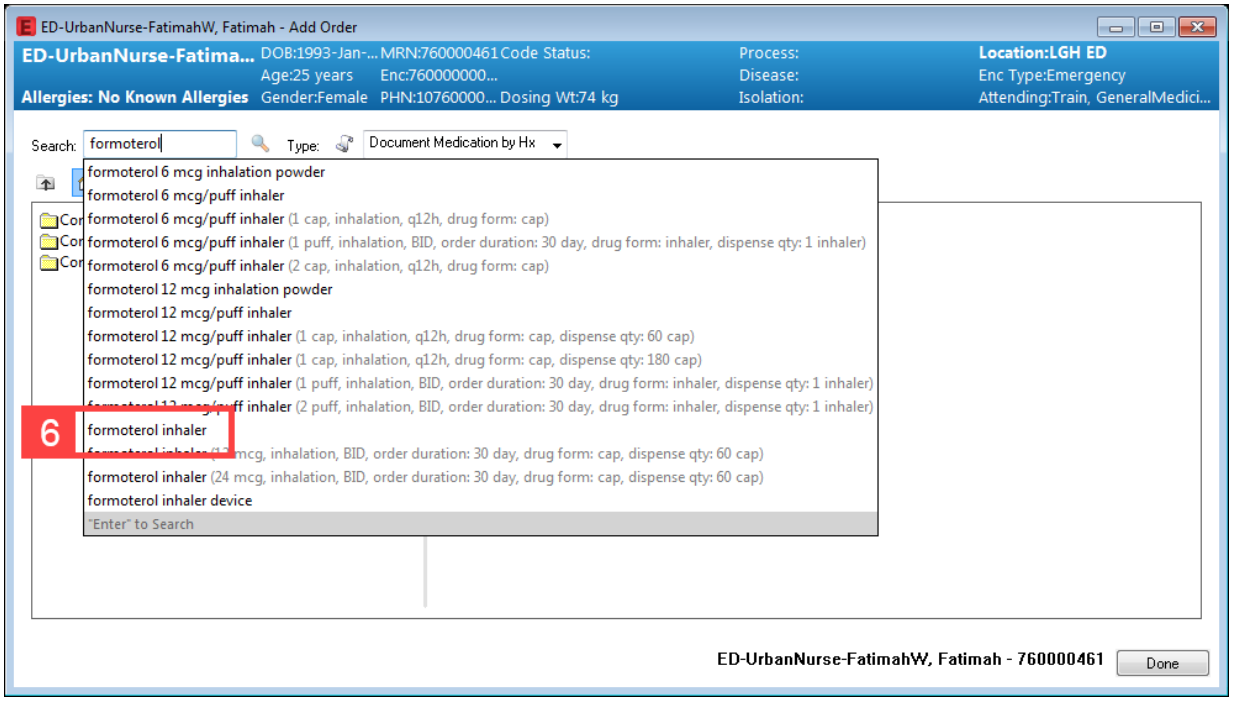


6. Using the same steps, document the inhalers Fatimah uses to control her asthma.

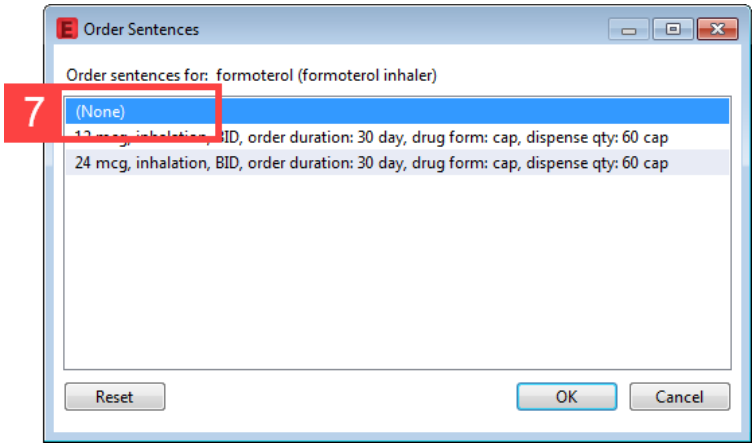
   Salmeterol 50 mcg inhaler twice daily as needed

   Formoterol 12 mcg inhaler once daily

   If you don't see an accurate sentence press the Enter key or select the Magnifying Glass icon to bring up all options. If no options appear correct, choose only the drug's name.

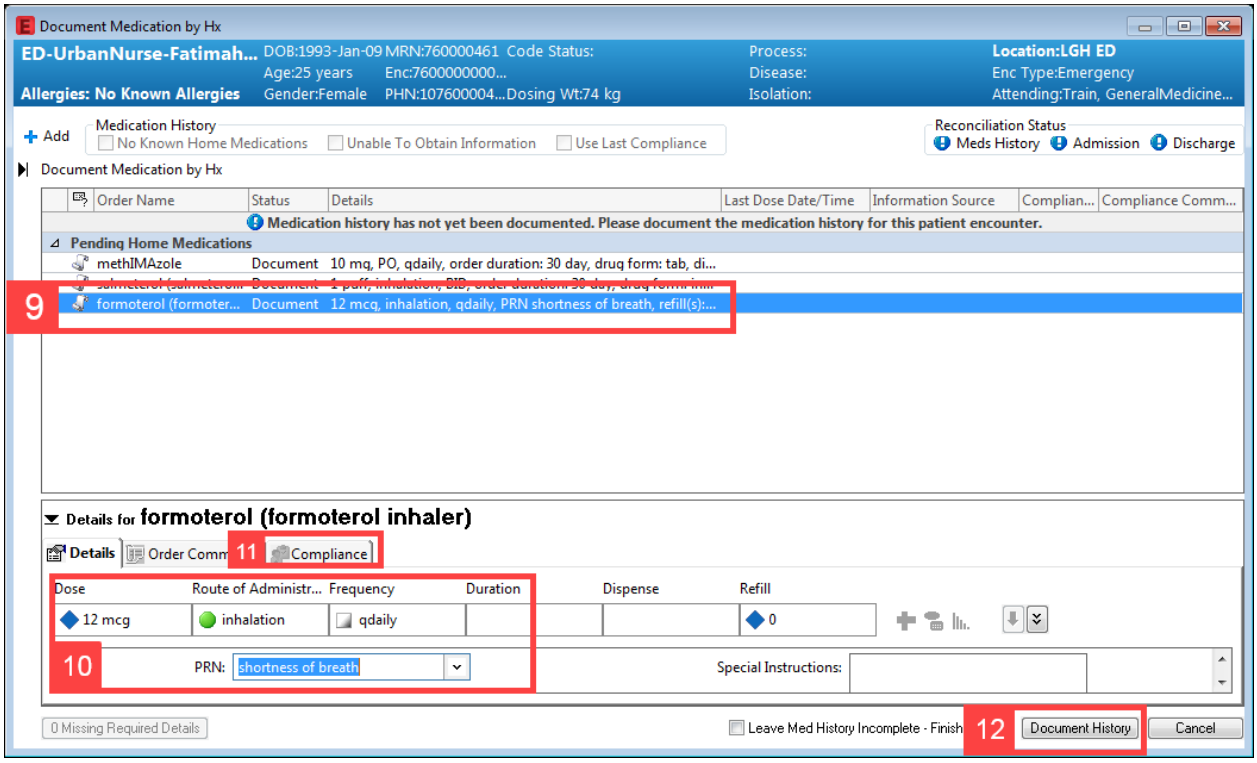


7. A pop-up window appears. Select **(None)**, as no options match Fatima's regimen.



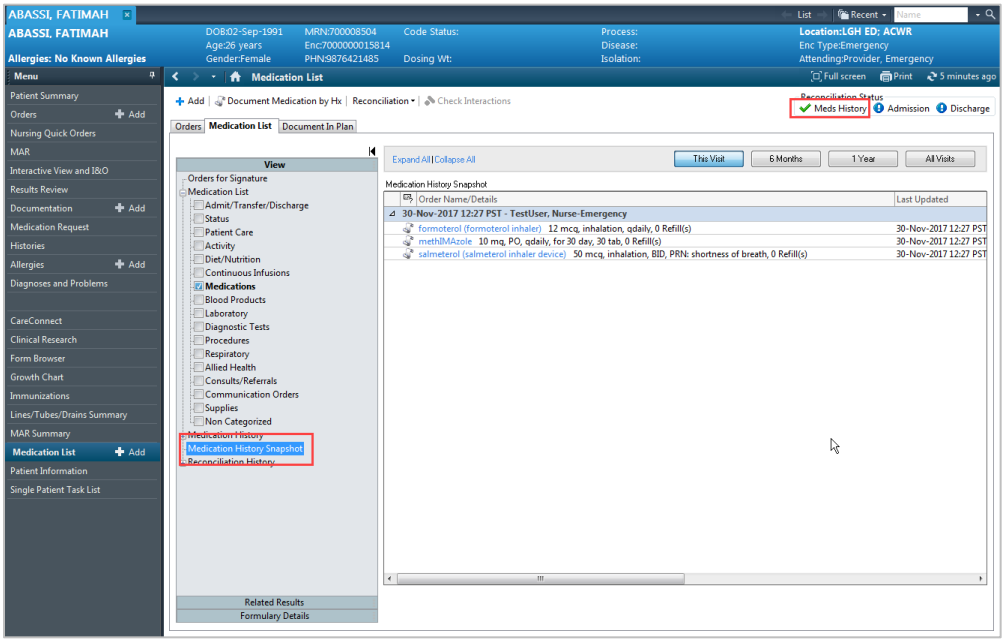
8. Click **Done**

9. Select **Formoterol** to bring up the details.
10. The inhaler reads "*12 mcg, two inhalations qdaily, PRN Shortness of Breath*". Document this in the appropriate fields using the drop down menus that appear when you click the fields. Typing the beginning of your desired detail will shorten the list.
11. Click on the **Compliance Tab** and fill in today's date using t under **Last dose date/time.**
12. Click **Document History**



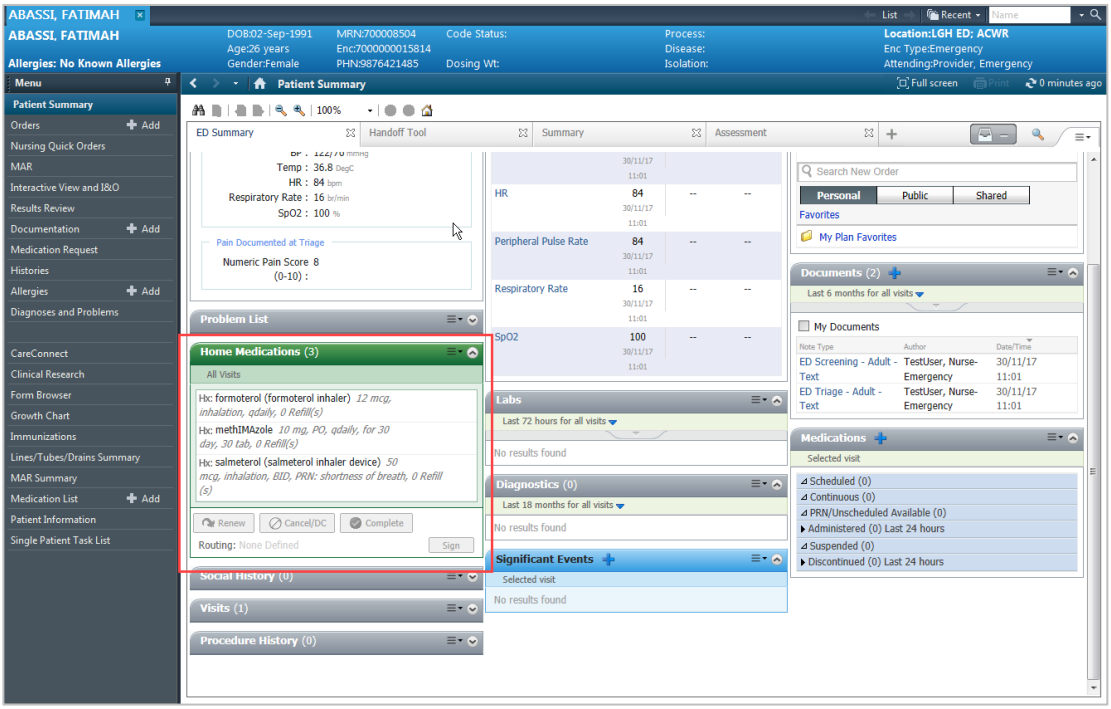
Click **Medication History Snapshot** to view the medications you documented.

The patient's **Med History Reconciliation** status will now show as complete with a checkmark ✓.



The patient's **Home Medications** is also visible on the **Patient Summary** page.

Click the **Refresh** button to update the page if the changes are not seen.



Activity 1.11 – Documenting Patient History

Documenting a **Social**, **Family**, and **Procedure History** is not a mandatory task, however, documenting patient history helps all clinicians and providers get a complete picture of the patient.

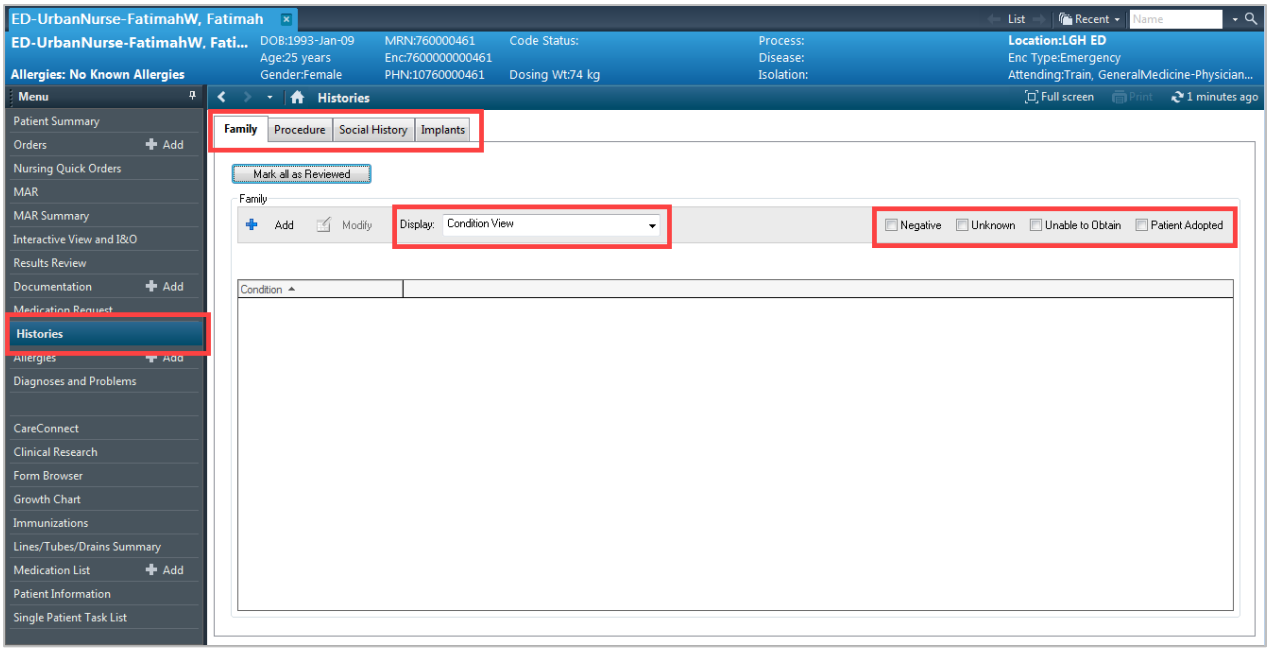
Documenting a patient's procedural history does not replicate the Provider's documentation of a patient's medical/problem history.

Select **Histories** from the **Menu**.

The patient's history is organized by the **Family**, **Procedure**, **Social History**, and **Implants Tabs**.

The **Display** drop-down options allow you to organize existing information within this section.

The **Checkboxes** on the right side of the screen allows documentation of **Negative**, **Unknown**, **Unable to Obtain**, and/or **Patient Adopted**.



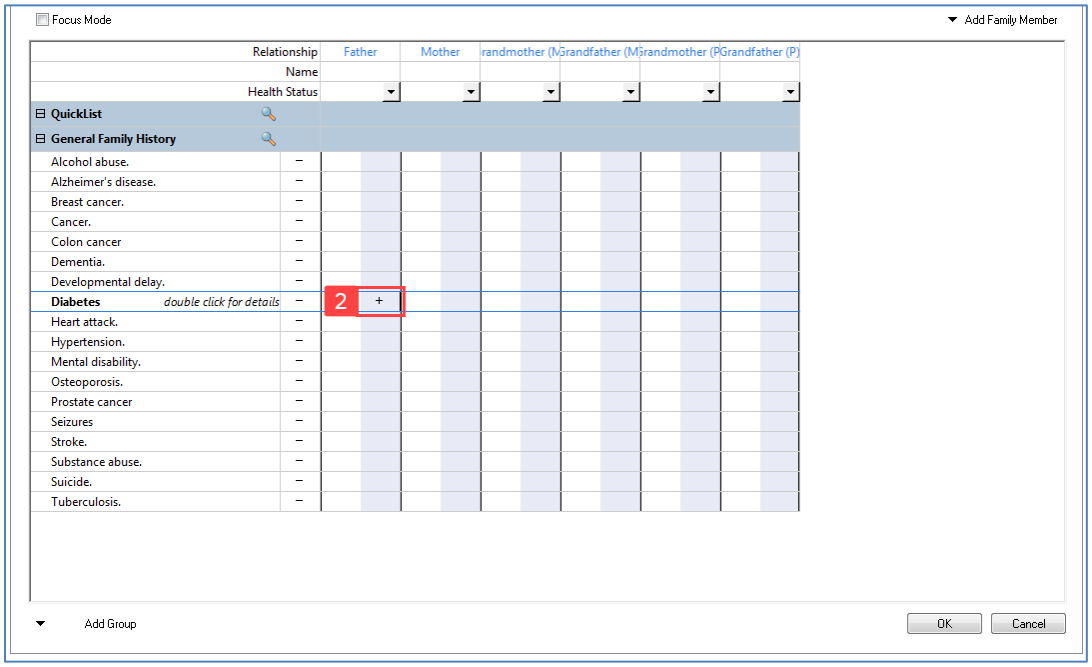
Fatimah reports the following history:

- Her father has Type 2 diabetes
- She had her tonsils removed when she was 11 years old.
- She exercises an hour a day, drinks socially (1-2 glasses of wine with friends) and doesn't smoke.

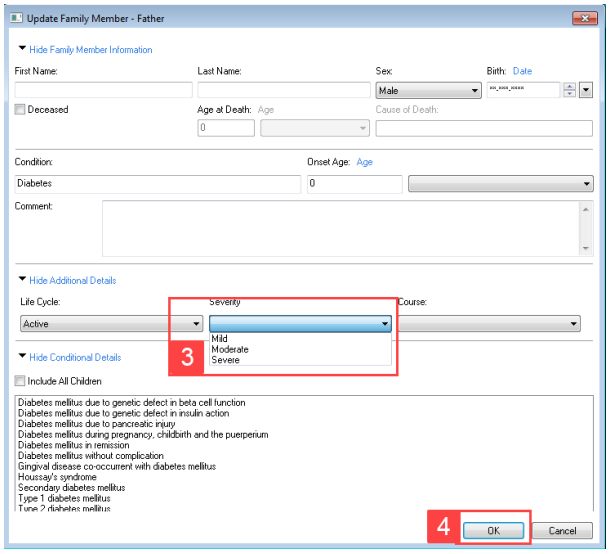
Add Family History

1. Click the **+ Add**  icon in the **Family Tab**.
2. Click the **Father** column to make the **+** sign appear next to the **Diabetes** row.

   If you accidentally click in the wrong section, just click in the unshaded side of the column to remove your selection.

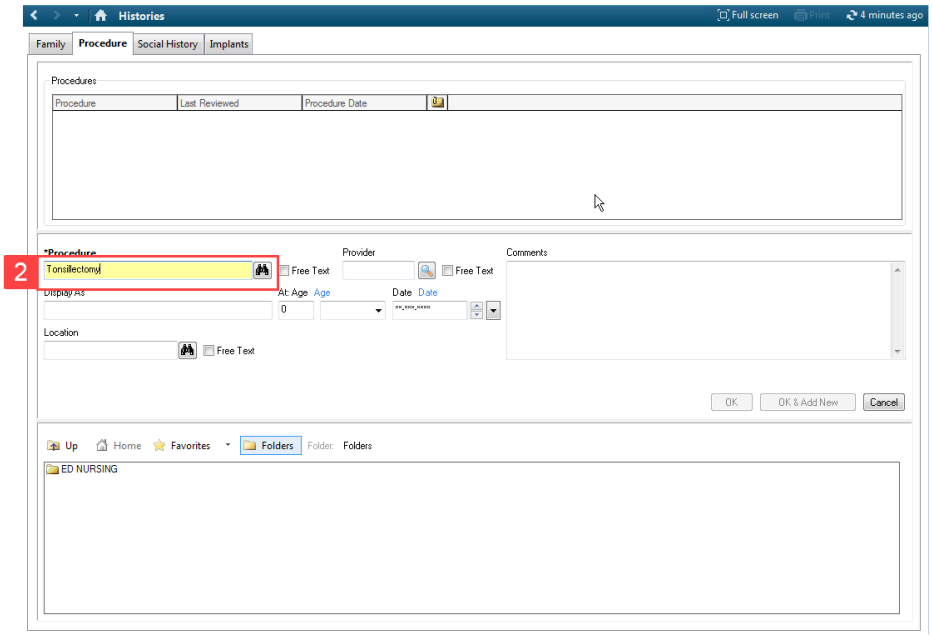


3. Double-click the family member's **+ sign** to open the **Update Family Member** window and enter some additional details in the **Life Cycle** and **Severity** drop-down options.
4. Click **OK** to save this section.



Document Surgical History

1. Click the **Procedure Tab** and click the **+Add**  button.
2. Type *Tonsillectomy* in the yellow ***Procedure** field and click the **Search** icon.



Clicking the **Search icon**  next to mandatory fields ensures the data entered is properly coded in CIS.

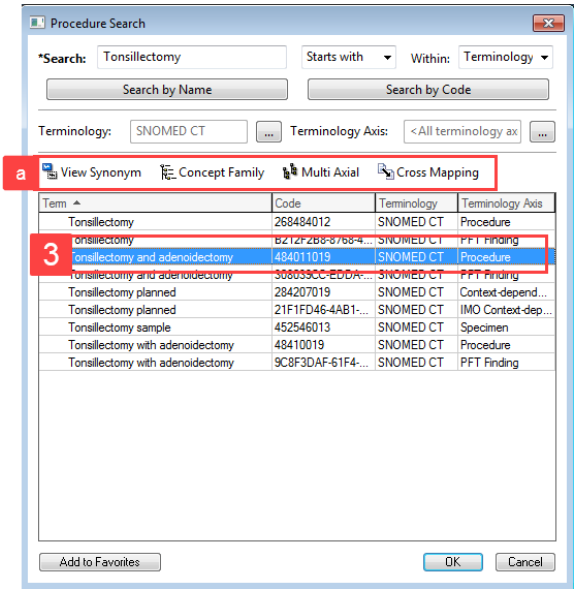
The **Common Surgeries** and **Procedures** folders in the lower half of your screen can be customized for ease of use.

1. The **Procedure Search** window opens.

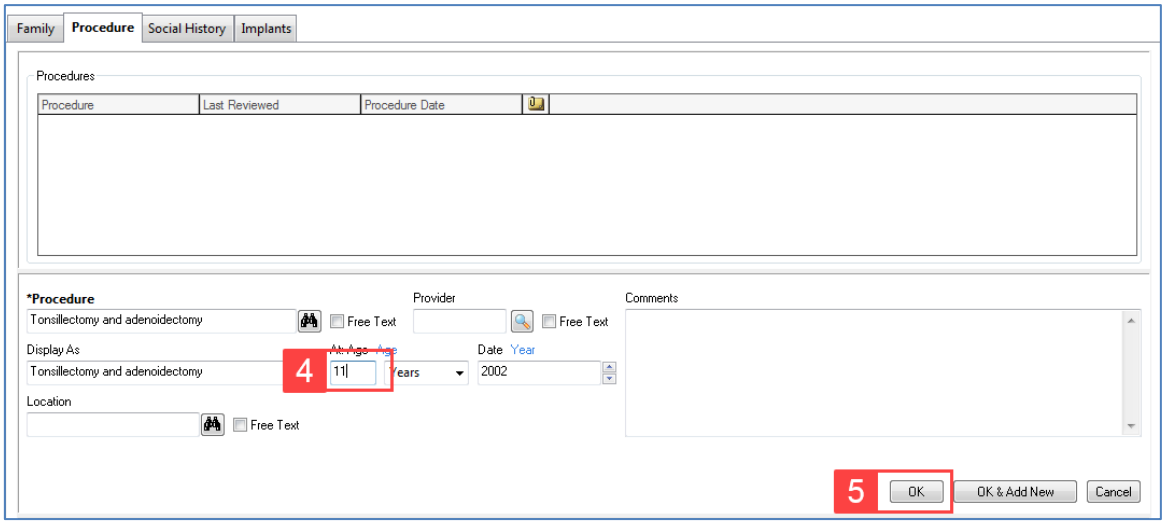
   From Fatimah's description, she had a Tonsillectomy and adenoidectomy.

   Select this procedure and then click **OK**.

   a. When searching for a procedure, there are assistance icons available. These functions are useful when taking verbal history or a patient is unsure of a procedure's details.



4. Returning to the **Histories** page, enter *11* in the **Age** section.
5. Click **OK**

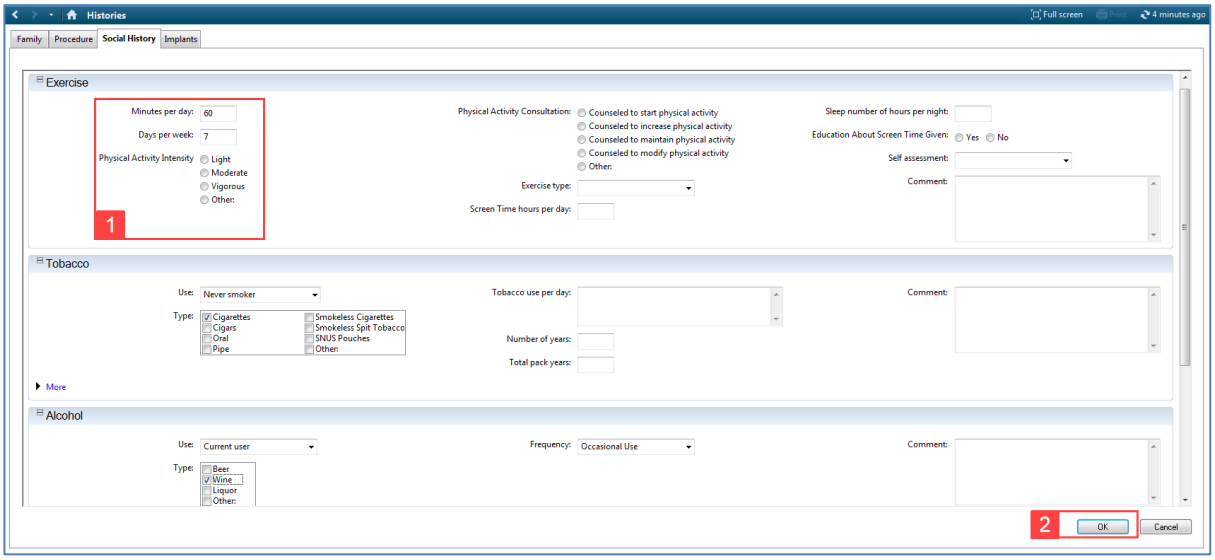


Document Social History

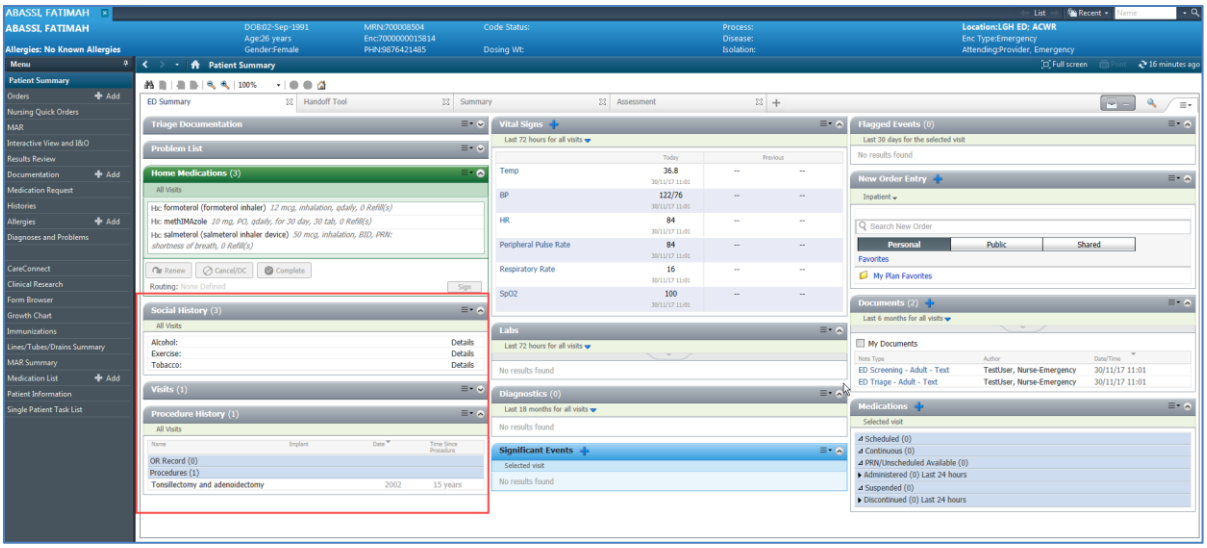
Select the **Social History Tab** and click the **+ Add** button.

Fatimah mentioned that she exercises daily, drinks a few glasses of wine with friends, and does not smoke.

1. Fill out each component. The **+** or **–** signs open and hide sections.
2. Once you have completed filing in these sections, click **OK**.



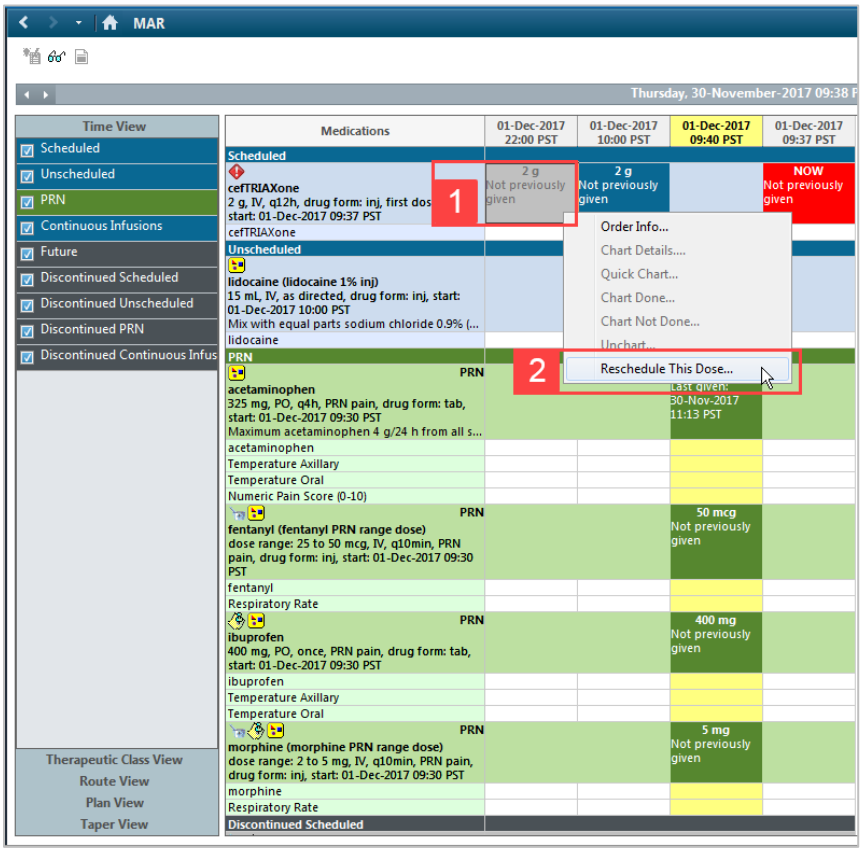
Click **Refresh** . The documented history is now visible in the **Patient Summary** page.



Activity 1.12 – Rescheduling and Uncharting Medications

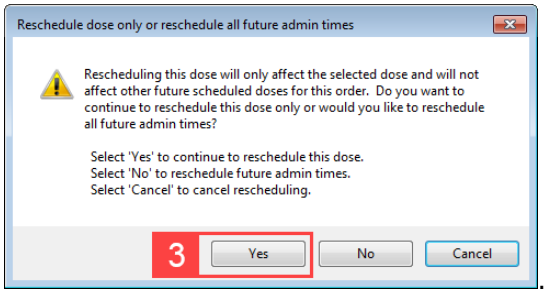
Fatimah went for imaging and you have to reschedule her medication:

1. In the **MAR** screen, right-click the [Medication].
2. Select **Reschedule This Dose**.

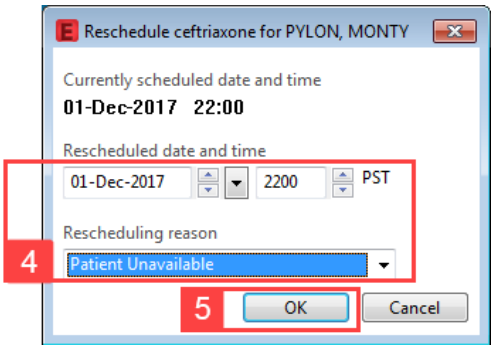


3. A pop-up window opens. Selecting **Yes** will reschedule only this dose. Choosing **No** will reschedule all future administration times.

   Click **Yes**.



4. Enter the **Rescheduled date and time** and **Rescheduling reason**.
5. Click the **OK** button.

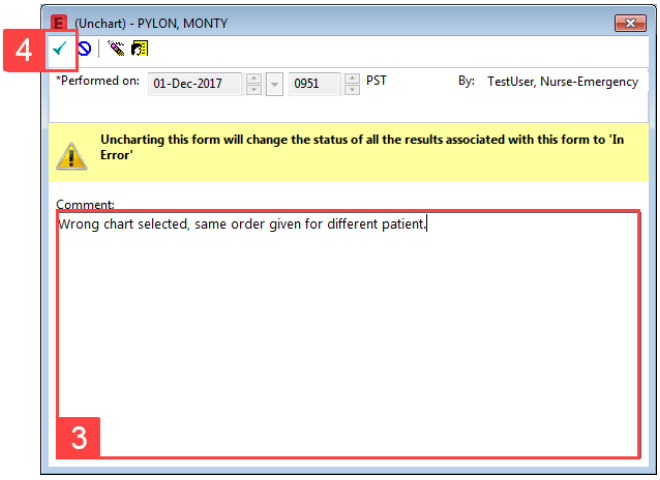


The medication task will appear at the later time on the **Medication Schedule Table.**

1. Document the reason for uncharting using the free text field.

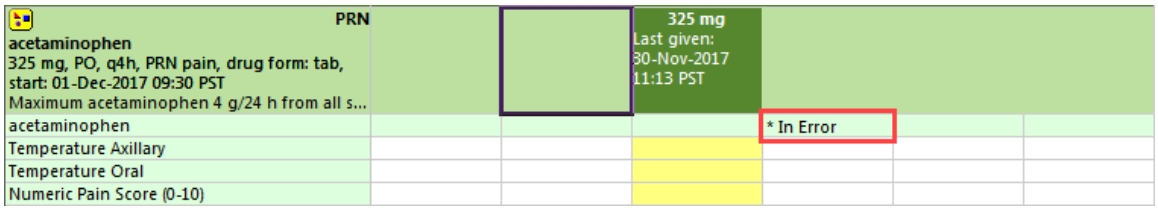
   For the purpose of this activity, document “Wrong chart” in the Comment section.

2. Click the green **Checkmark** icon to sign.



The erroneous entry will be changed to ***In Error** and the task returned to its original scheduled date and time.

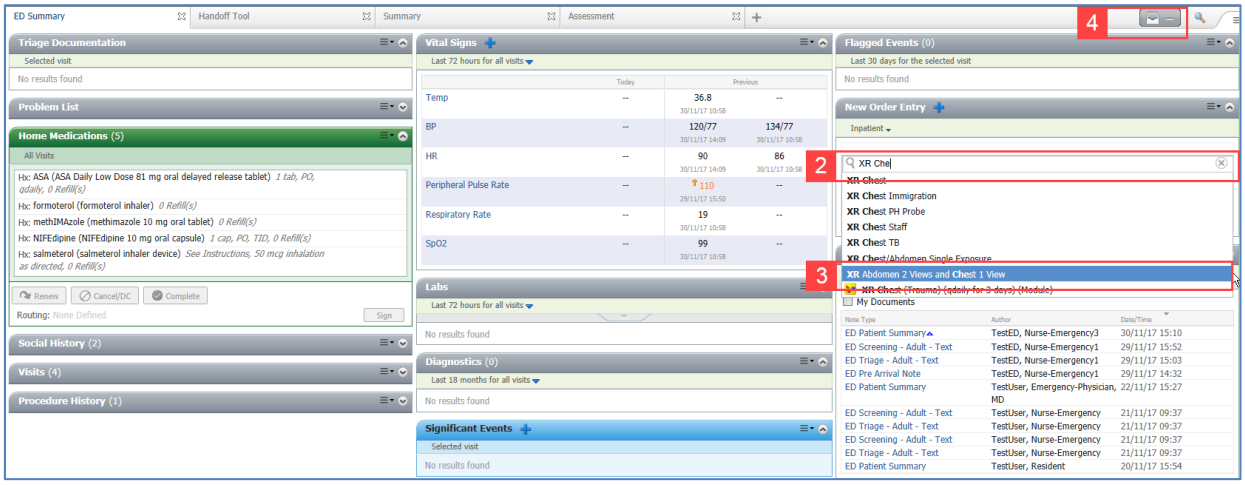
Double-clicking the ***In Error** field will bring up a **Result Details** window where information about the charting error details are available.



Activity 1.13 – Add a Telephone Order

The physician calls to order a Chest X-Ray for Fatimah, which you must now enter into the chart.

1. From the patient's chart, open the **Patient Summary** screen.
2. Under the **New Order Entry** component, type *XR Chest* in the search field and a drop down menu with associated orders will appear.
3. Select **XR Abdomen 2 Views and Chest 1 View** from the list.
4. Click the **Orders for Signature**  **Inbox**.



5. The **Orders for Signature** window will open. Click **Sign**.

The **Ordering Physician** window opens asking you to identify the details.

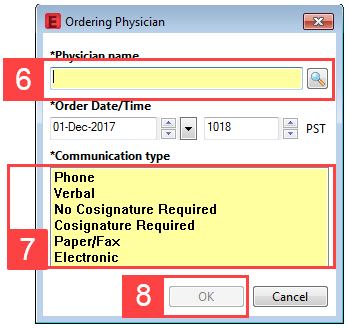
As above, the option of **Order** or **Proposal** are given. Selecting the **Order** option makes orders immediately active. **Proposals** are Nursing suggestions the Provider can accept or reject and are not active until signed by a provider.

Imaging tests are automatically **Orders**.

6. Enter the *Physician name*

   If the name is unique, it will fill in as you type. If multiple matches are detected, click the **Magnifying Glass** to select the provider's name from a list.

7. Select **Phone** for **Communication type**.
8. Click **OK**.



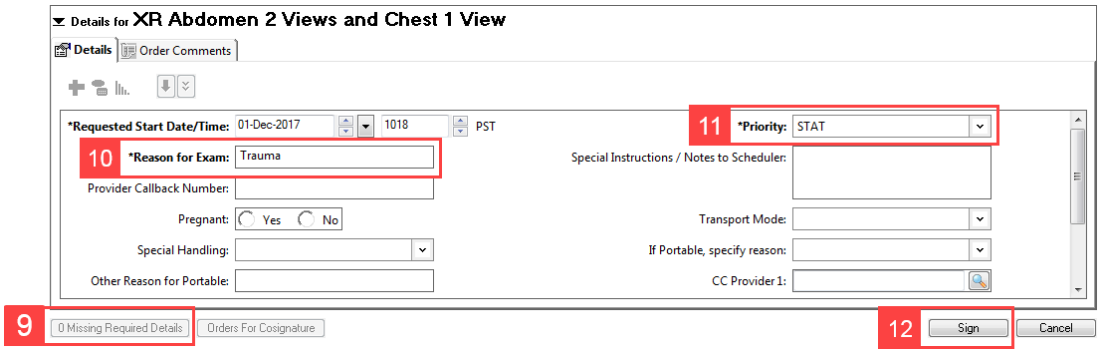
9. If details are missing from the order, it will not process until they are filled in.

   Click **1 Missing Required Details** 1 Missing Required Details at the bottom of the screen.

10. On returning to the **Order Details** screen, fill in the **Reason for Exam** as *Rule out Pneumonia.*

11. Next, change the ***Priority** of the exam to **STAT**.

12. Click the **Sign** button.

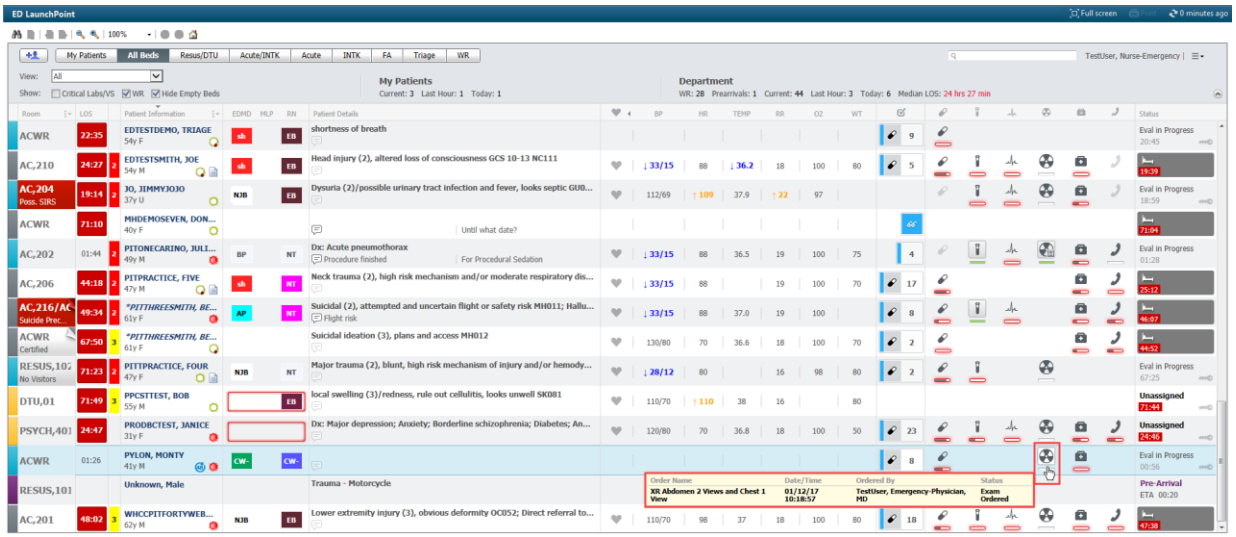


The order status appears as “processing”.

Click the **Refresh** icon to update the order status.

It should now display as **Ordered (Exam Ordered)**.

Review the order status on **ED LaunchPoint** by hovering over the **Radiology** icon. The bar under the icon shows the order’s completion status.



Patient Scenario 1 Summary: Key Learning Points

Activity 1.1 ED LaunchPoint Multi-Patient List Overview

- 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
- Click and hold the vertical row of dots beside each section of icons to rearrange the Toolbar
- 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

- The menu  icon leads to opening the Provider Check In window
- The Provider Check In window allows quick information entry relevant to the user's role
- Sections marked with an asterisk* identify mandatory fields

Activity 1.3 Customizing ED LaunchPoint

- The ED LaunchPoint Multi-Patient List is used to track patients in the ED
- You can customize the Multi-Patient List view by navigating the tabs at the top of the page
- The Multi-Patient List can be further customized by using the drop-down view options
- **In addition, you can choose to show patients who have Critical Labs/VS, are in the WR (Waiting Room), and Hide Empty Beds**

Activity 1.4 Establish Relationship

- Relationship must be established to view patient information and patient orders
- Click in the Assignment column to the right of a patient's name to Assign yourself as a clinician
- An abbreviated notation of the assigned clinicians' names will appear in the Assignment column beside the patient's name

- An abbreviated notation of a clinician's name will appear in the Assignment column beside the patient's name
- Hover over the abbreviated name will show more details about the associated user
- **Using the same steps will allow you to Unassign from patients**

Activity 1.5 Patient Chart Overview

- The Patient Summary page pulls information from other areas of the chart into one place to view
- The Banner Bar highlights important, at-a-glance information you need to know about the patient
- The Menu list displays different areas of the patient's chart
- The tabs at the top of the Patient Summary page organize viewable content based on activities
- The Refresh  button updates your page to ensure the most recent information is available
- Navigation Icons search specific text, change the magnification, and return to the Home screen
- Components in the Patient Summary page organize patient information based on clinical topic areas

Activity 1.6 Conduct Nurse Review

- Single Patient View provides a quick way to review orders
- The glasses  icon demonstrates orders requiring **Nurse Review**

Activity 1.7 Medication Administration Record (MAR) Overview

- There are three ways to navigate to the MAR. Choose what is easiest for you
- The Medication Schedule Table functions the same way as a paper MAR
- Most medications have associated icons (ie. STAT orders are indicated by )

Activity 1.8 Chart Medications

- There are different ways to document medications
- The Medication Administration Wizard is barcode scanner compatible
- IV minibags you mix will not work with the barcode scanner
- Double-clicking in the time column for a medication will open the **Charting Form**
- **Once you have completed the Charting Form, the medication will show as Complete**

Activity 1.9 ED Nursing Quick Orders: New Order Entry

- Nurses may enter verbal/telephone orders when providers are unable, though this practice is discouraged
- Access to ED Nursing Quick Orders is through the Patient's Chart
- **Any orders not appearing in a component can be searched out using the New Order Entry component**

Activity 1.10 Best Possible Medication History (BPMH)

- Access your patient's Medication List from the Menu on the left side of your patient's chart.
- Use the Document Medication by Hx button to enter your patient's home medications.
- The Search bar will autofill as you type the medication name. You can select from the drop-down list that appears or click enter to search for an appropriate regimen.
- Add additional details such as dose, frequency, and compliance in Order Details.
- Documented home medications appear in the Medication History Snapshot and the Home Medications component of the Patient Summary page.

Activity 1.11 Documenting Patient History

- Patient history is organized by Family, Procedure, Social, and Implants
- The Checkboxes on the right side of the Histories screen allow you to quickly document a lack of available history (i.e. No history or unable to obtain)
- The +Add button lets you document your findings
- Clicking the Search (binoculars) icon ensures all entered data is properly tracked in the system

Activity 1.12 Rescheduling and Uncharting Medications

- Right-clicking in the MAR allows you to reschedule, unchart, or modify medication administration
- Medications can be rescheduled once or every time following, be sure to choose the correct option
- Uncharting is a way to show erroneous entries
- Uncharted medications will still appear in the MAR, but will appear ***In Error**
- **Additional data on an uncharted item can be found in the Result Details**

Activity 1.13 Add a Telephone Order

- Search for orders using the New Order Entry search box on the Patient Summary screen
- “Order” will be active when complete, “Proposal” needs a physician signature to activate
- Orders will not be filled until all mandatory fields are completed
- **Any nurse-initiated orders will be sent to the physician for a co-signature**

PATIENT SCENARIO 2

Learning Objectives

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

- Write a pre-arrival note and attach it to a patient chart
- Use ED Quick Reg to enter a patient into CIS
- Triage a Patient
- Use the Interactive View (IView) and Ins & Outs: Patient Charting (IView) to document assessments
- Enter Nursing Quick Orders
- Chart procedural sedation
- Document lines, tubes, drains and infusions using IView

SCENARIO

Monty Pylon is a 41 year old male who accidentally slipped and fell down a flight of stairs onto a concrete pylon.

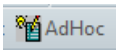
Due to the fall, he sustained a blunt force injury to the chest. Monty's wife called 911 immediately, reporting the patient had lost consciousness for about a minute.

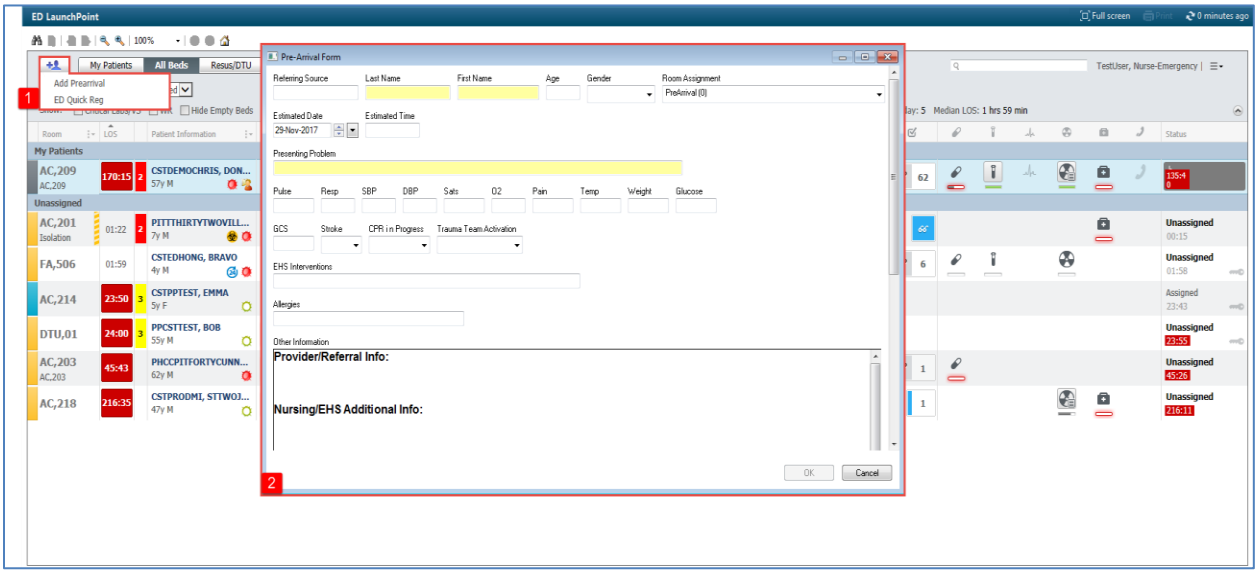
Activity 2.1 – Pre-Arrive Your Patient

The paramedics call the ED while on route and give a brief report of the 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**. Documenting a Pre-Arrival is not a mandatory activity. Using the Pre-Arrival function is a tool you can use if you chose.

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 at any time by clicking the **Ad Hoc**  button in the toolbar.



Use the *italicized* patient information provided below to complete the **Pre-Arrival Form**.

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

Last Name: *Pylon*
First Name: *Monty*
Gender: *Male*

Presenting Problem: *Fall resulting in blunt force chest injury and elbow laceration.*

Click **OK** when done.

Activity 2.2 – Incoming ED Patient: ED Quick Reg

The responsibility for **ED Quick Reg** varies from site to site. It is important to know this procedure in case you are ever called upon to perform it, regardless of your role.

The paramedics arrive with Monty Pylon. Use ED Quick Reg to put Monty in the system:

1. Starting from the ED LaunchPoint Multi-Patient List, click the **Add Patient**  icon and select **ED Quick Reg**.

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

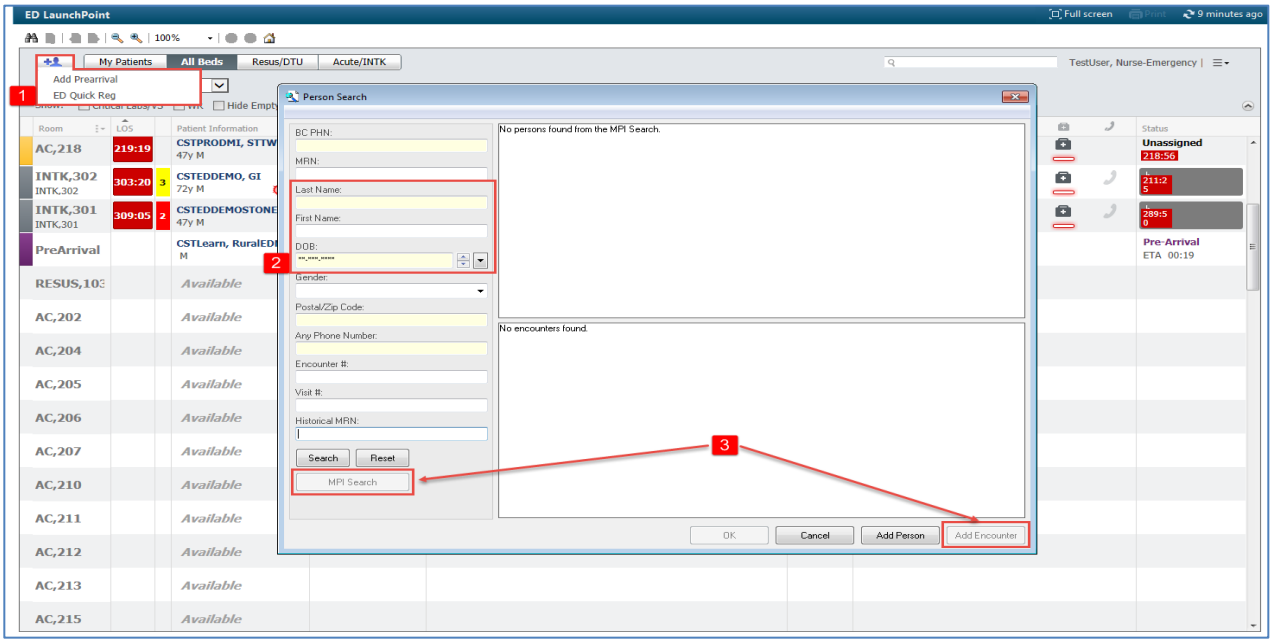
   Though you might typically enter a patient's **PHN**, for the purposes of this learning activity you will enter some basic demographics.

   Input Monty's first name, last name, and date of birth. The patient informs you his birthday is *June 30, 1976*.

   Click **Search**.

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

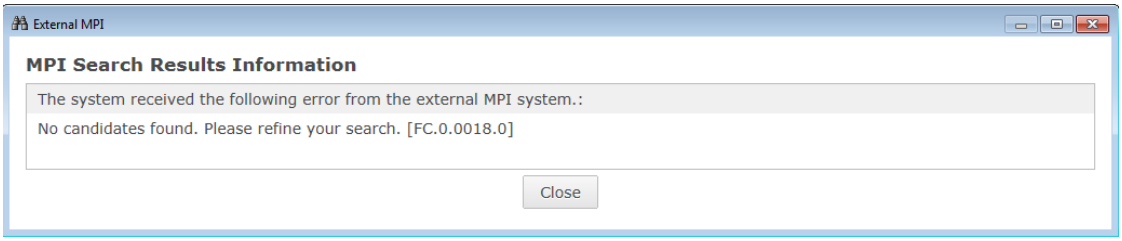
   For this scenario, you find Monty does not have any previous encounters. Select **MPI Search**.



4. The **External Master Patient Index (MPI)** pop-up message will populate with search results identifying “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** and you will now be able to click the **Add Person** button in the **Person Search** window.



5. An **External MPI** window opens to **Request PHN**. Again, mandatory fields are highlighted in yellow. Enter the details as provided.

   Select **Submit** when done.

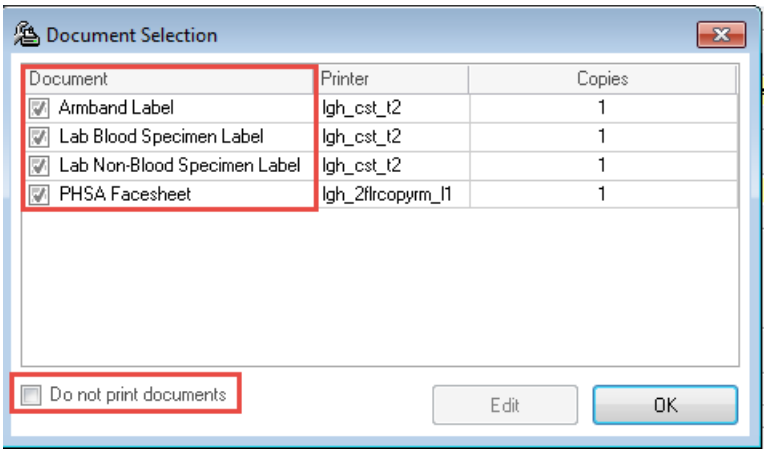
6. The **ED Quick Reg** window will populate. Enter the mandatory patient information.

   Click **Complete**.

7. A **Document Selection** prompt will appear asking to print patient documents.

   Choose which documents and labels to print or choose to print nothing in this window. It is possible to access these documents at a later point in time if needed.

   For this activity choose to print nothing.



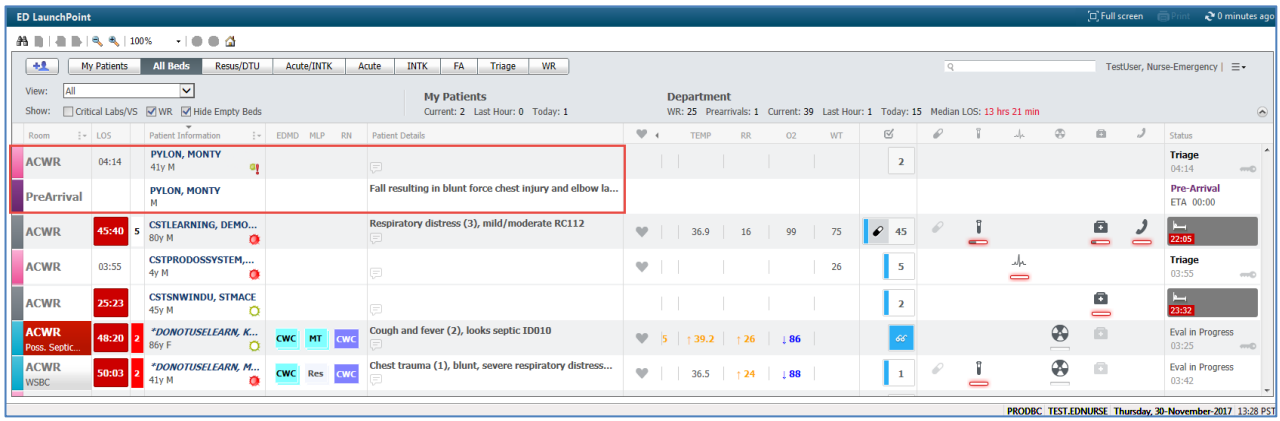
Monty Pylon is now in the **Waiting Room** in **ED LaunchPoint**.

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 the work that you do, you will learn about registration in CIS in a different workbook.

Currently, Monty appears on **ED LaunchPoint** twice – once as a **PreArrival** and the other in the **Acute Waiting Room**.

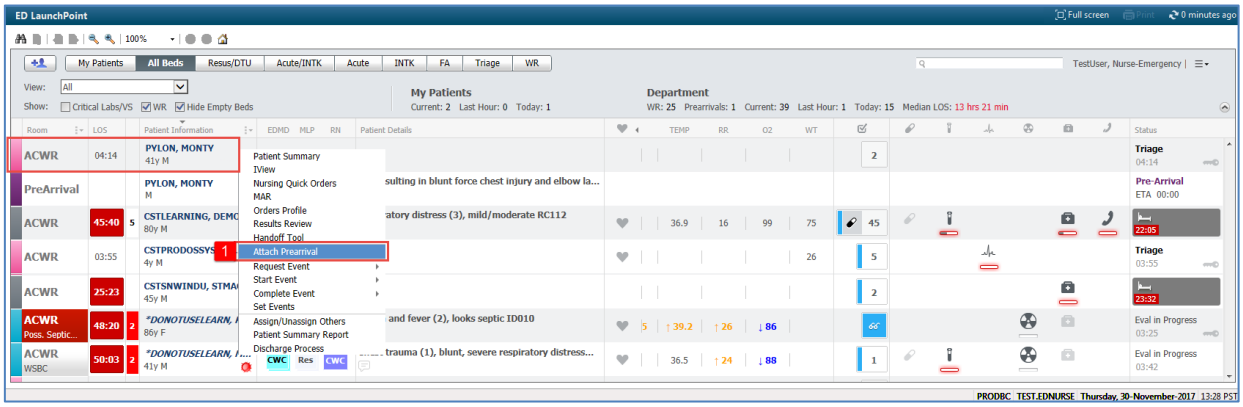
Notice patients with similar names have their names *italicized*. This way, users are visually alerted to patients with similar names to avoid charting on the wrong patient.



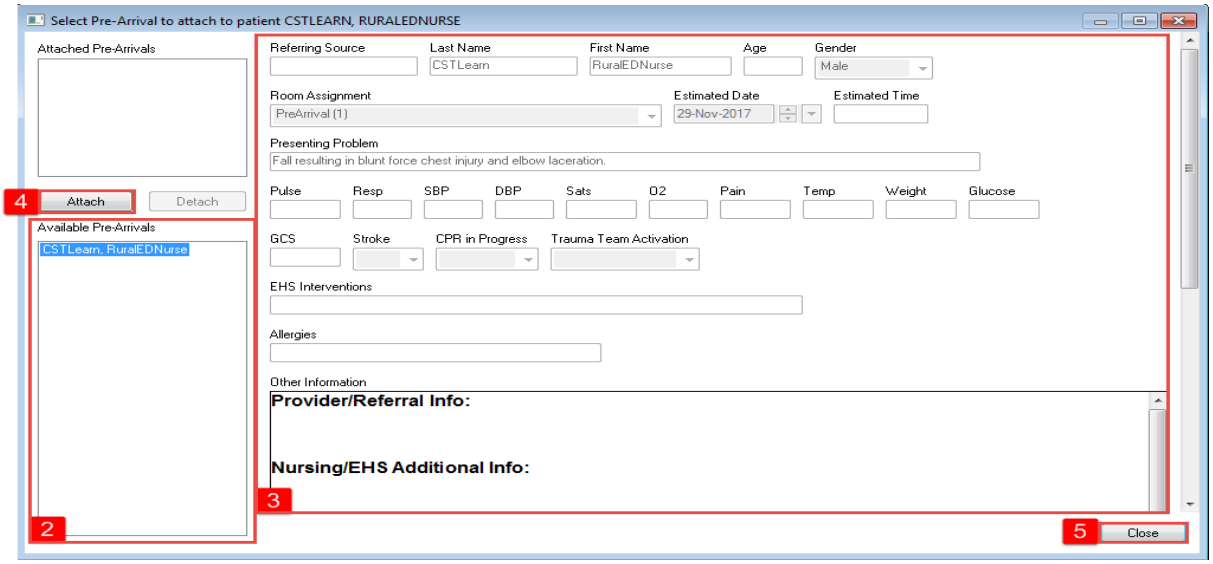
Activity 2.3 – Attaching a Pre-Arrival

You will now attach Monty Pylon's **PreArrival** to his associated **ED Quick Reg**: This saves on duplicate documentation and creates a clear history of Monty's arrival to the ED.

1. Right-click on the name of the patient you **ED Quick Registered**. This will be the Monty Pylon in the **ACWR**. Select **Attach PreArrival.**



2. A window will appear to select the **Pre-Arrival** to attach to Monty. Select the appropriate patient name from the **Available Pre-Arrivals** section.
3. The information you captured during the **PreArrival** documentation will appear. Review the displayed information ensuring correctness before attaching.
4. Once reviewed, select **Attach**. Monty's name will move from the **Available Pre-Arrivals** section to **Attached Pre-Arrivals**.
5. Click **Close** when complete.



If you cannot find your PreArrival or ED Quick Reg patient, click on the **All Beds** tab and select the WR box as the patient may not appear until the "WR" box at the top is checked.

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

The information is now combined into the Quick Registered file; you can select **Close** and begin the Triage process.

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

Activity 2.4 – Triage

Monty Pylon has been ED quick registered, and is now ready to be Triaged.

Triaging patients may not be part of your role, but you will learn how to use this functionality.

Always confirm with your Unit Supervisor if you are unsure of your responsibilities.

1. Monty's name appears on **ED** LaunchPoint with a "2" marked in the **Nurse Activities Column**.

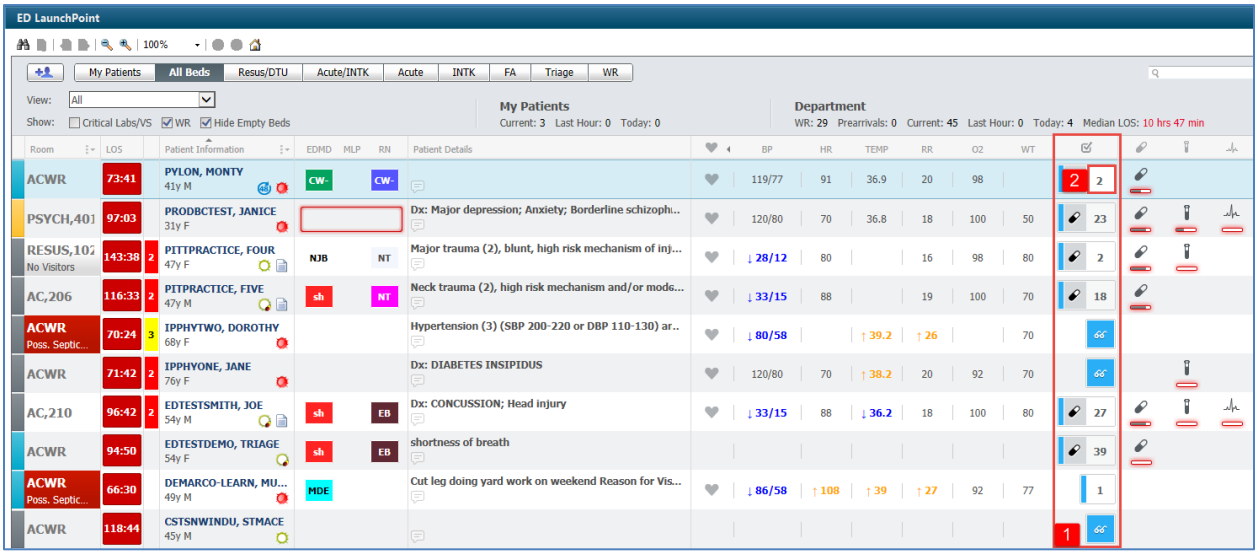
   This means there are 2 activities outstanding for this patient.

2. Click the **Task icon** in the **Nurse Activities Column**.

   The **Single-Patient View,** a summary window of the patient's information, will open.

   The Single-Patient View allows you to quickly access documentation, overviews of outstanding orders and tasks, and notice any alerts without having to open the patient's chart.

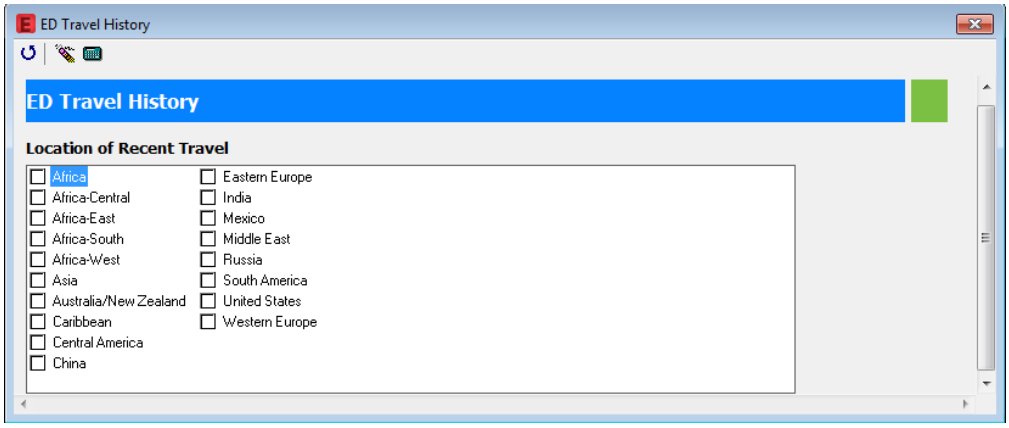
   You can also access the Single-Patient View by clicking the white space around the patient's name.



3. Monty Pylon reports he recently returned from Addis Ababa, Ethiopia three days ago.

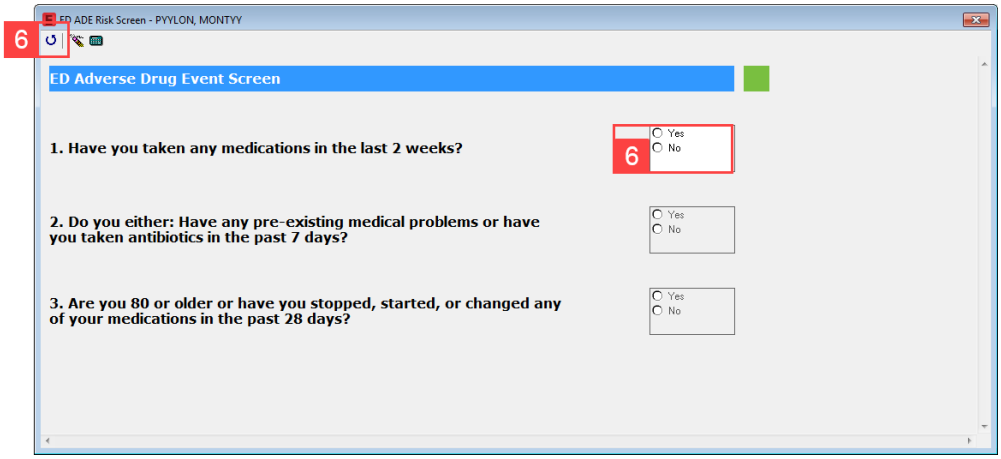
   When you select **Yes, patient** in the **Travel Outside Canada last 30 days**, a new window will appear asking for details. Fill them out appropriately, and then click the arrow icon in the top left.

   The travel information you enter here will automatically be pulled into the **Infectious Disease Screening** section of your patient's chart.



4. The **ADE Risk Screen** will follow the same procedure. In this case, Monty tells you he has not taken any medications in the last two weeks.

   Click the **No** button and close the window with .



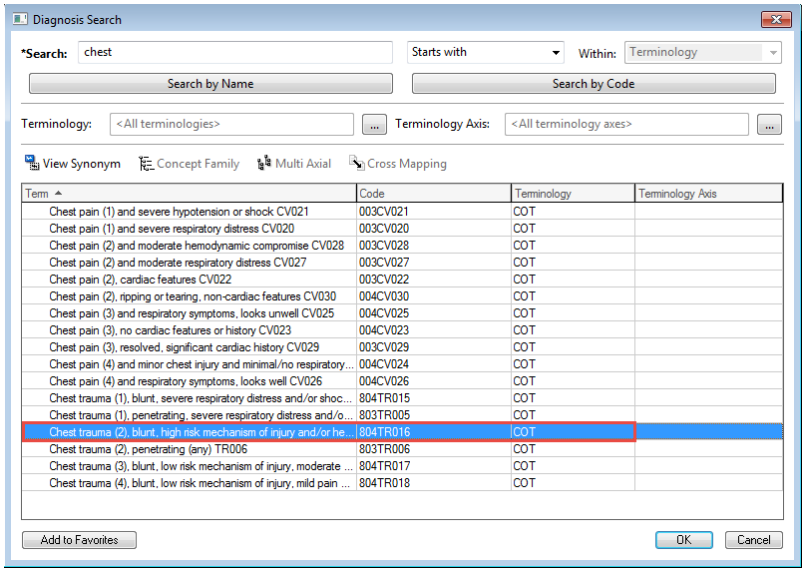
5. Enter vital signs (use your discretion) and select "**No Known Allergies**" under the **Document Allergies** field.

6. **Complaint-Oriented Triage (COT)** is the standard Canadian triage listing and descriptors are now mandatory for all ED patients per Health Authority policy.

   Start by selecting the Add icon in this section. Search '*chest*' in the diagnosis field.

7. Select **Chest trauma (2), blunt, high risk mechanism of injury and/or hemodynamic compromise**.

   The number 2 represent the **CTAS** level for this specific item. You will be returned to the ED Triage - Adult PowerForm.



8. Select **OK** within the COT section to add Diagnosis.

   Be certain that you complete the **COT Descriptor**, or you will receive a **Pending Actions Exist** message when you sign the form.

9. Use the CTAS score from the COT descriptor to assign a **Tracking Acuity**.

   The scrolling function on a computer mouse is not compatible with the system. If used, previous selections will be altered.

10. Select the **Checkmark** to sign and complete the PowerForm

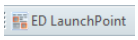
You will be returned to the **Assessments Tab** in the **Single-Patient View**. The **ED Triage - Adult** task should fall from the task list. If it does not drop away, click the Refresh icon in the upper right corner of Single-Patient View.

Overdue **Nurse Activities** are marked with a red bar below the associated task's icon. The colour bar below each icon will help prioritize your tasks at a glance.

Activity 2.5 – Documenting Multiple ED Nursing Activities

In the next activity, you will build on your documentation skills to complete multiple Nursing Activities.

Before we get started, take a moment to think of some of the icons you are becoming familiar with or might recall from your eLearning:

- ED LaunchPoint Multi-patient List 

- Overdue Activity 
- Nurse Review/ Orders to Review 
- Activities 

- Medications 
- Labs 
- ECG 
- Radiology 
- Patient Care 
- Consult 
- Orders for Signature Inbox 
- Add Order button 
- Refresh button 
- PowerPlans 
- Orders for Signature 

- Sign 

The next activities required for Monty should be ED Screening-Adult and ED Assessment Adult.

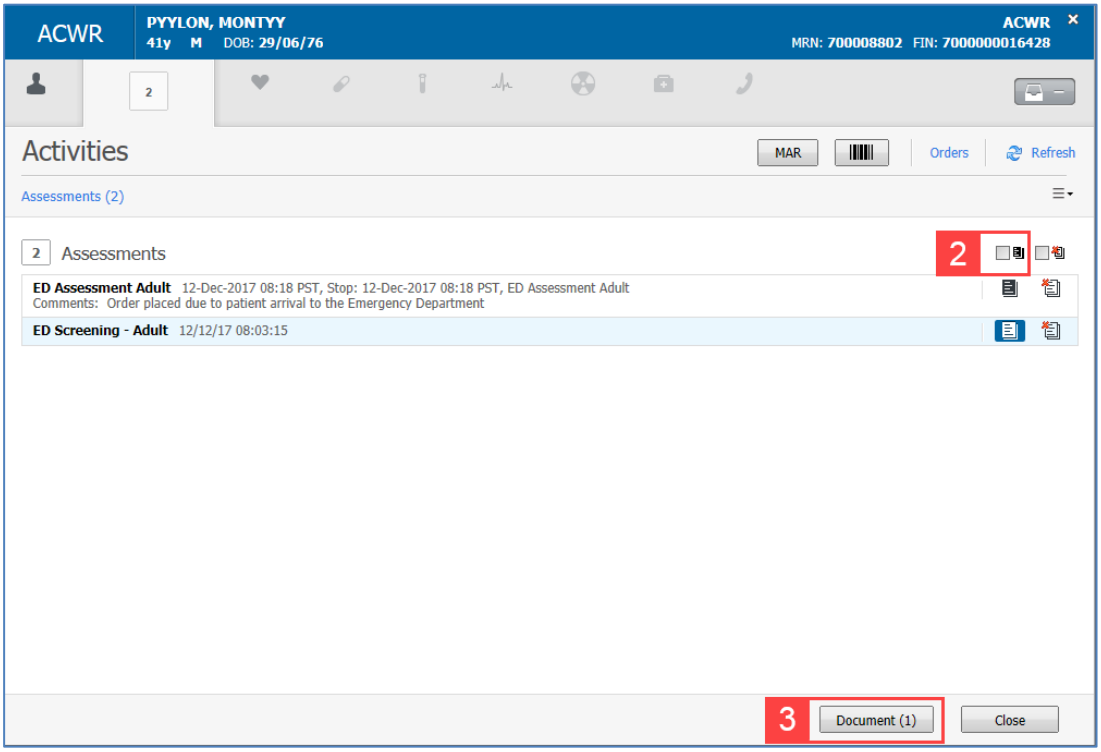
Note: Remember that your unit's workflow and the patient's condition will always determine the order in which your provide care. The order presented here is an example used to build your skills using this system.

In the last documentation activity, you were asked to complete only one Nurse Activity. In this activity, we'll attend to multiple activities:

1. Click on the **Nurse Activities** icon on **ED LaunchPoint.**

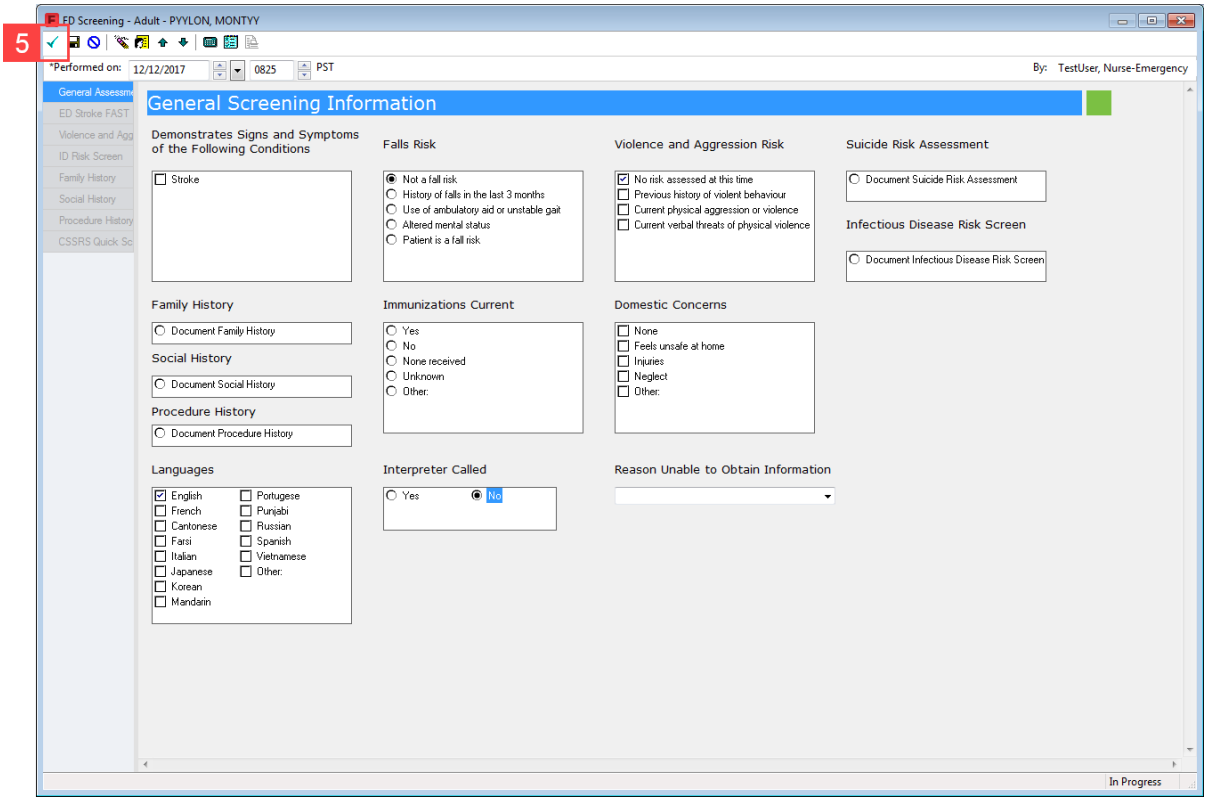
2. Click the **Document all** icon associated with **ER Screening-Adult** and **ED Assessment-Adult**. Clicking the checkbox beside the Document icon will select all documentation activities.

3. Click on the **Document** button in the bottom right corner of the Single-Patient View.



4. The **ED Screening - Adult PowerForm** will open automatically. Enter information relevant to Monty's condition based on your clinical knowledge.

5. Review the information you've entered and select the **checkmark** to Sign the document.



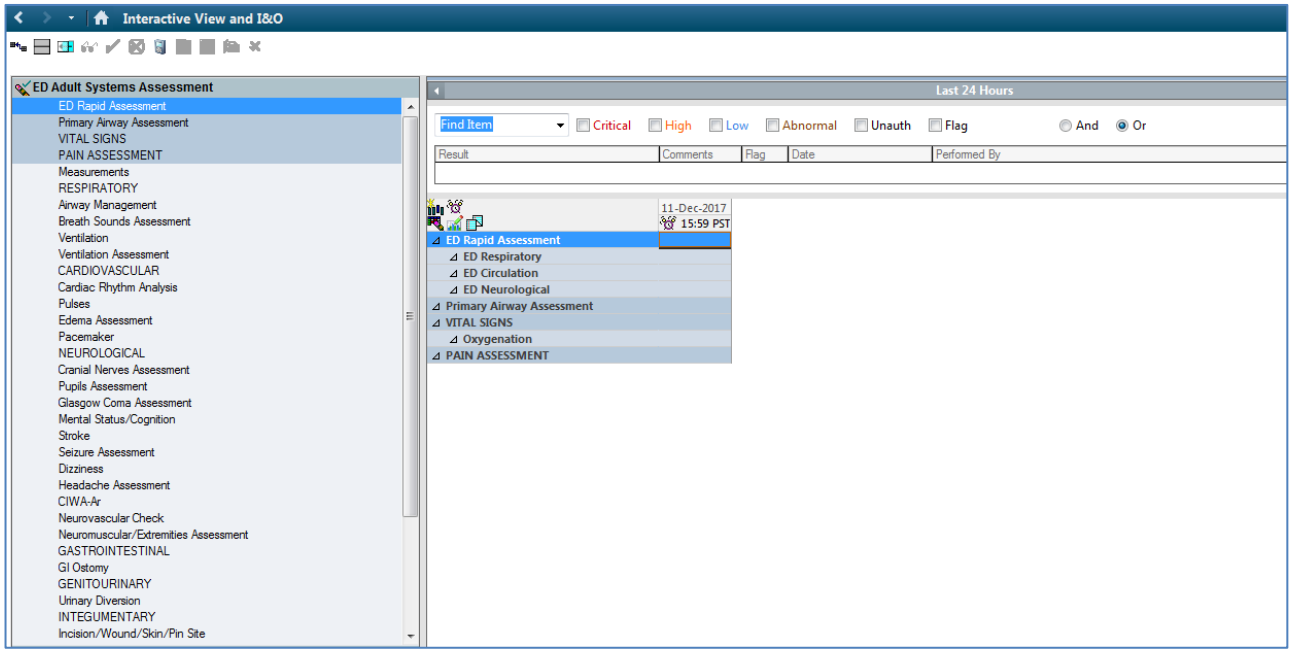
In the Clinical Information System (CIS) there are several different ways to sign documentation.

For example, in PowerForms signing-off is done with a **Checkmark** ✔. In Orders you click **Sign**. These different methods mimic current state and differentiate between clinical documentation activities.

It is possible to Save and continue with documentation later.

Once the **ED Screening- Adult PowerForm** is signed, the system will bring up **Interactive View** and **Ins & Outs (I & O)** section of your patient's chart to complete the **ED Rapid Assessment**.

The Rapid Assessment must be completed, or it will remain as an outstanding item on **ED LaunchPoint.** This section of the Interactive View (or IView) is intended to document the **Emergency Primary Assessment** used in everyday practice.



Notice some of the information you previously documented in the **ED Triage Adult PowerForm** has been pulled into your IView documentation.

To complete the **ED Rapid Assessment** section of **IView**, do the following steps:

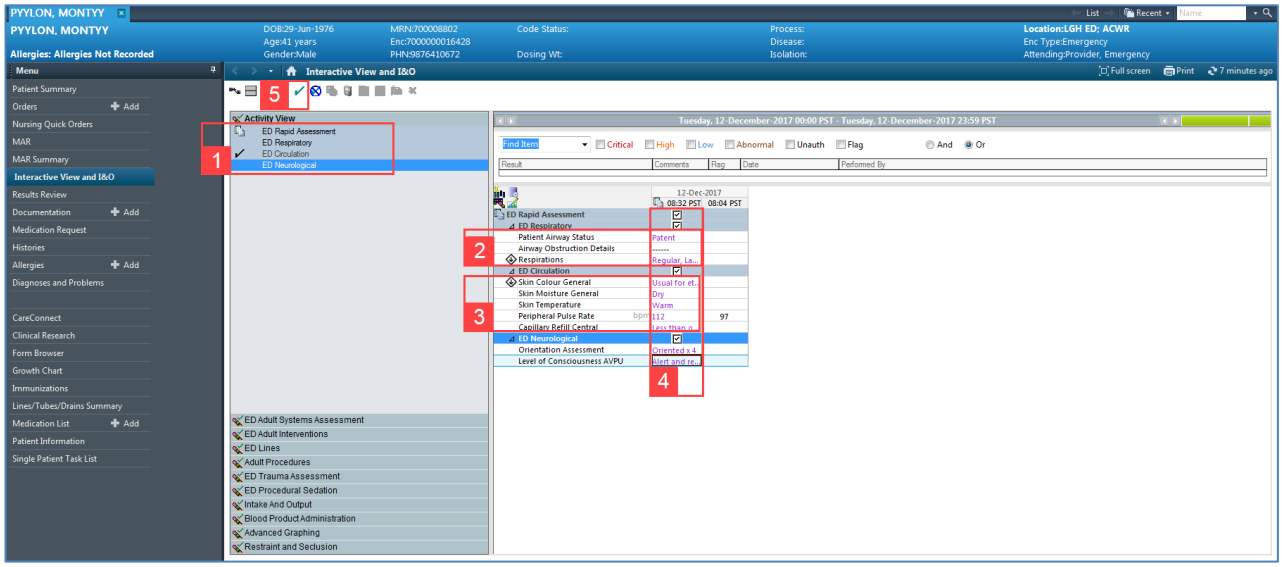
ED Assessment Adult will automatically open the **ED Rapid Assessment** fields for completion.

Use the mouse, tab or arrow keys to navigate through the cells.

In some cases, selecting an option will automatically move to the next field.

Unsaved information appears in purple, indicating it is unsigned. Once signed, the text will turn black.

Click the Checkmark ✓ to Sign your ED Rapid Assessment.



Below average range results appear in blue once you have signed your documentation.
Abnormally high results will be highlighted orange and critically high results will appear in red.

Activity 2.6 – ED Bed Assignment

As a CTAS 2, Monty should be seen by a physician within 15 minutes. You direct the paramedics to take Mr. Pylon to the Resuscitation room, but need to move him in the system. He is currently listed as ACWR, meaning he is in the Waiting Room. You return to the ED LaunchPoint Multi-Patient List and walk through the following steps:

1. Review the Room column. If ACWR appears beside patient name, assign appropriate bed/room to that patient by double-clicking under the Room column beside the patient's name.
2. Click the bed from the list and click the OK button.
3. Your patient is now assigned to a bed. The bed assignment you selected should show up in the Room column next to your patient's name.

Tip: The numbers shown in brackets shows the number of patients in the room, *not* the number of beds available.

Activity 2.7 – ED Trauma Assessment and Documentation

1. From **ED LaunchPoint**, right-click on Monty's name and select **IView**.
2. This opens the **Navigation Pane** within **IView**. Select **ED Trauma Assessment**.
3. Using the text below, complete the **ED Trauma Assessment** fields. Double-clicking at the top of a column allows you to Tab through each of the fields rapidly.

ED Trauma Activation:

- Trauma Team Activated: *Activation depends on your facility and the severity of the injury.*

  Clicking **Yes** on the **Trauma Team Activation** field will send a task out to call for the Trauma team if your site has one.

  This task could be sent to the Unit Clerk or Charge Nurse to act on depending on your unit's procedures.

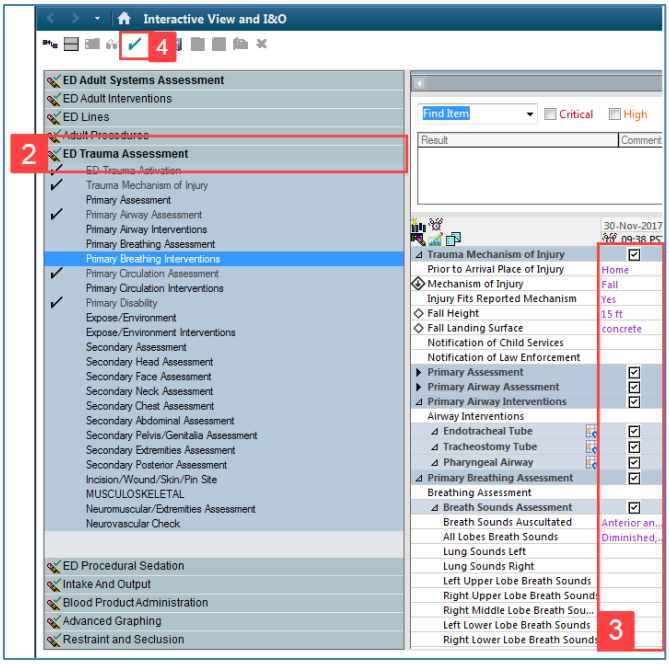
Trauma Mechanism of Injury*:*

- Prior to Arrival Place of Injury: *Home*
- Mechanism of Injury: *Fall*
- Injury Fits Reported Mechanism: *Yes*
- Fall Height: 15ft
- Fall Landing Surface: *concrete*

Primary Breathing Assessment:

- Breath Sounds Assessment: *Breathing spontaneous*
- Breath Sounds Auscultated: *Anterior and Posterior*
- All Lobes Breath Sounds: *Diminished, Moderately decreased*
- Breathing Depth: *Shallow*

When entering a date or time, using the shortcuts **t** (today) or **n** (now) will auto-populate the field with today's date or the current time, respectively.



4. Once you have entered the information above, click **Sign** ✔ .

   If you leave the band you are charting in prior to signing, you will be prompted to save your work.

Activity 2.8 – ED Nursing Quick Orders: PowerPlans

After completing triage and assessment, you may want to enter orders for Mr. Pylon.

Rural nurses have a different workflow. The on-call physician might not be on site, you would potentially be juggling to call in nursing staff or, if you are in Squamish, pull nurses from other units. This activity may not mimic how you do things exactly---the idea is to teach you the skills you need to get your work done.

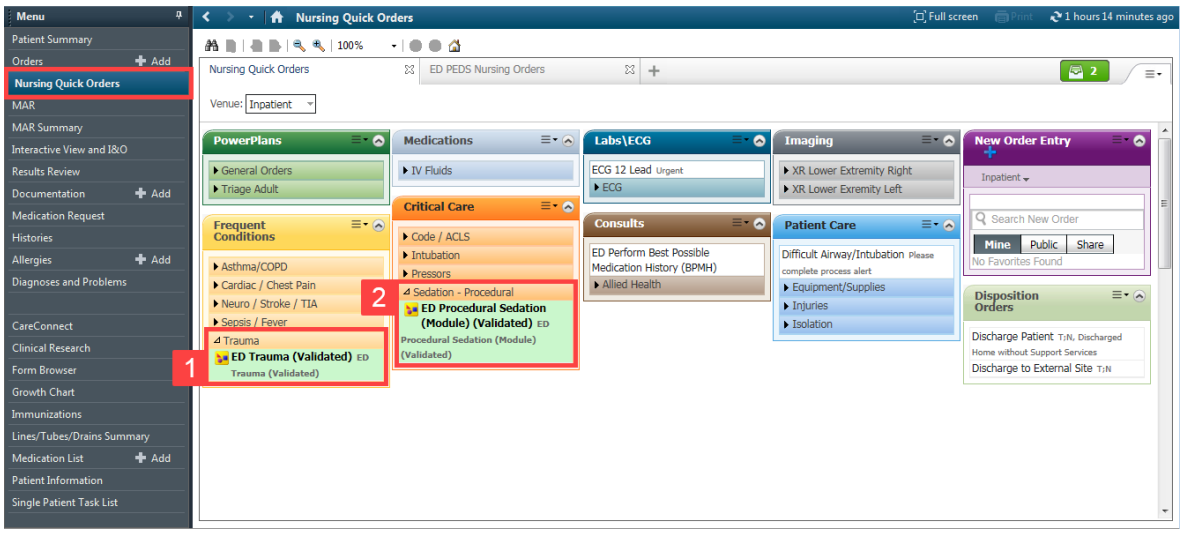
In Scenario 1, you placed a single Nursing Quick Order. In this section of the activity, you will learn to search, select, and modify a PowerPlan.

PowerPlans are a set of orders related to common conditions, similar to Pre-Printed Order Sets (PPOS) you may currently use in practice. The rules and policies governing your scope of practice in regards to PPOS are the same here.

Common Orders and PowerPlans are listed in the Nursing Quick Orders screen, however you can also quickly search for specific Orders and PowerPlans using the New Order Entry Component.

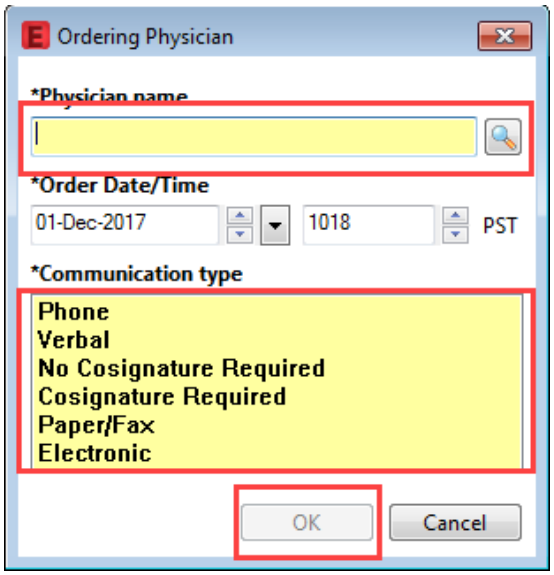
Dr. Hong orders the ED Trauma PowerPlan for Mr. Pylon. He verbally dictates the order to you:

1. From the Nursing Quick Orders band, click on the **Frequent Conditions** component and select **Trauma.** Select the **ED Trauma** PowerPlan Next, open **Sedation-**Procedural in the **Critical** Care component. Select **ED Procedural Sedation (Module)** and proceed by clicking the green Orders for Signature 2 icon.



The Orders for Signature window will appear. Click on **Modify**. Modify is mandatory for all PowerPlans.

4. The Ordering Physician window appears next. Enter the Provider's name, and the type of communication required. As this is a trauma, select **Verbal** order. Click **OK.**



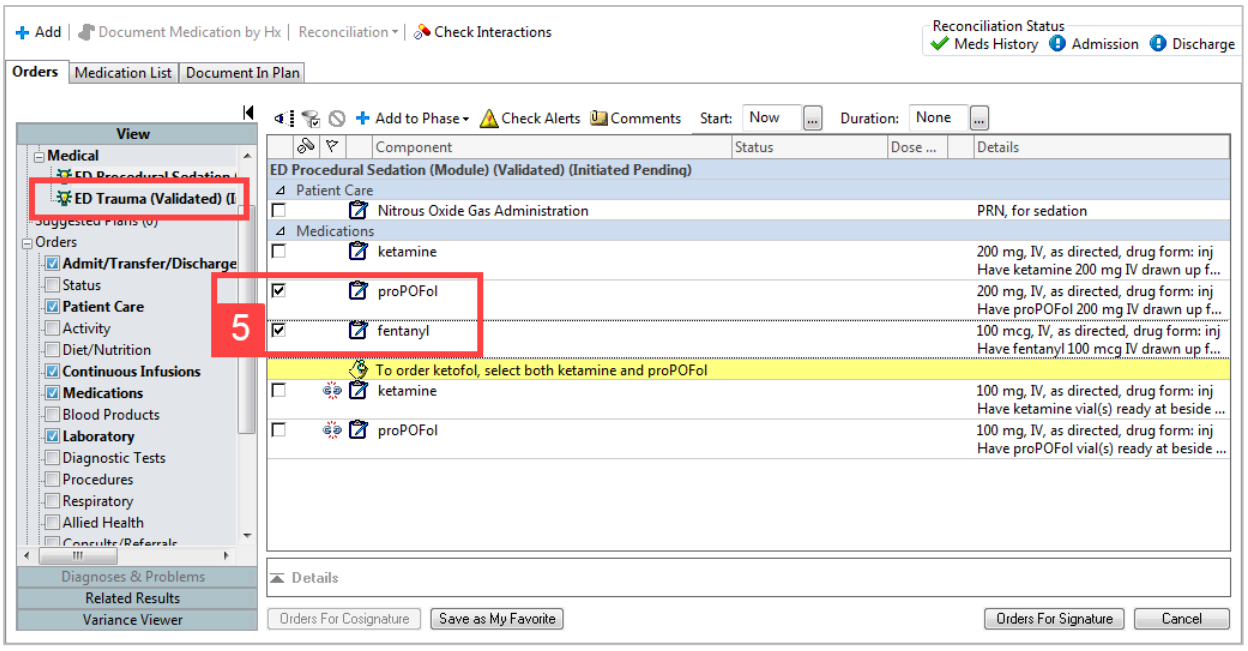
5. The Order Details window will appear. Familiarize yourself with this window:

   To the left is the View panel where orders are separated into categories. Since you ordered a PowerPlan, you can see the ED Trauma PowerPlan is filed under Plans.

   The right side is individual order choices within the PowerPlan, grouped by type.

   Inside the PowerPlan, there are *modules*, which act like a "Plan within a Plan", that is, an order set for a specific problem.

Select Propofol and Fentanyl from check boxes. Next, click **ED Trauma (Validated)** from the list on the left.

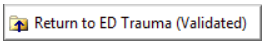


Dr. Hong tells you to select the following:

6. ED IV Fluids (Module): Click the checkbox beside the module. A list of bolus and maintenance fluids will open. Select the following fluids:

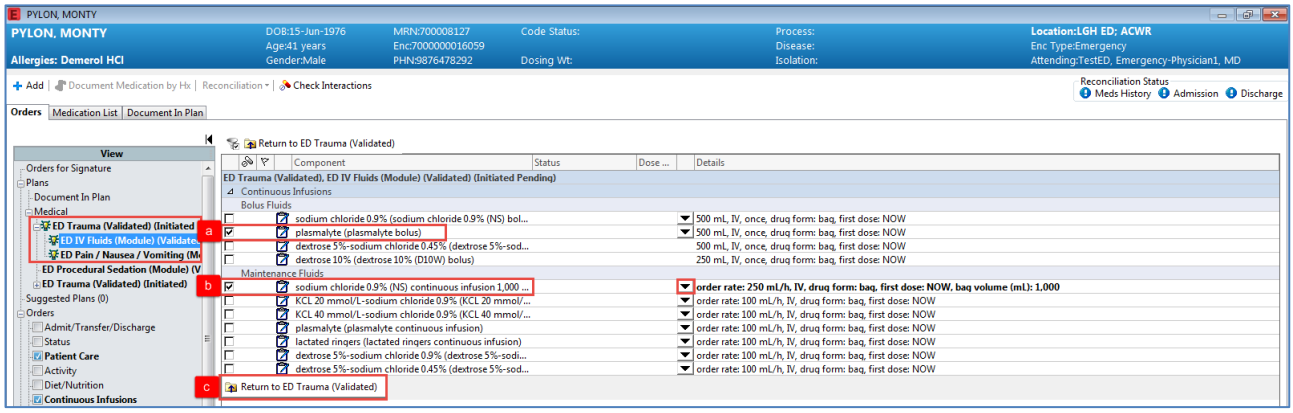
a. Plasmalyte (plasmalyte bolus)

b. Sodium chloride 0.9% (sodium chloride 0.9% (NS) con… You must then choose the correct order sentence (*250 mL/h, IV, drug form: Bag, first dose: NOW, bag volume (mL): 1000*) from a drop down menu.

c. Once you have finished selecting the ED IV Fluids details, you'll need to select the Return to ED Trauma 

button to get back to your previous window.

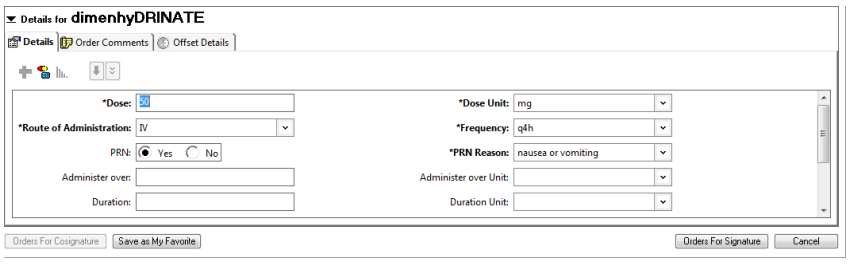
Note: Notice how the ED IV Fluids is written in blue now to indicate this component of the PowerPlan has been modified and is pending your signature. The View panel will now show modules you have modified for quick access if further revision is needed.



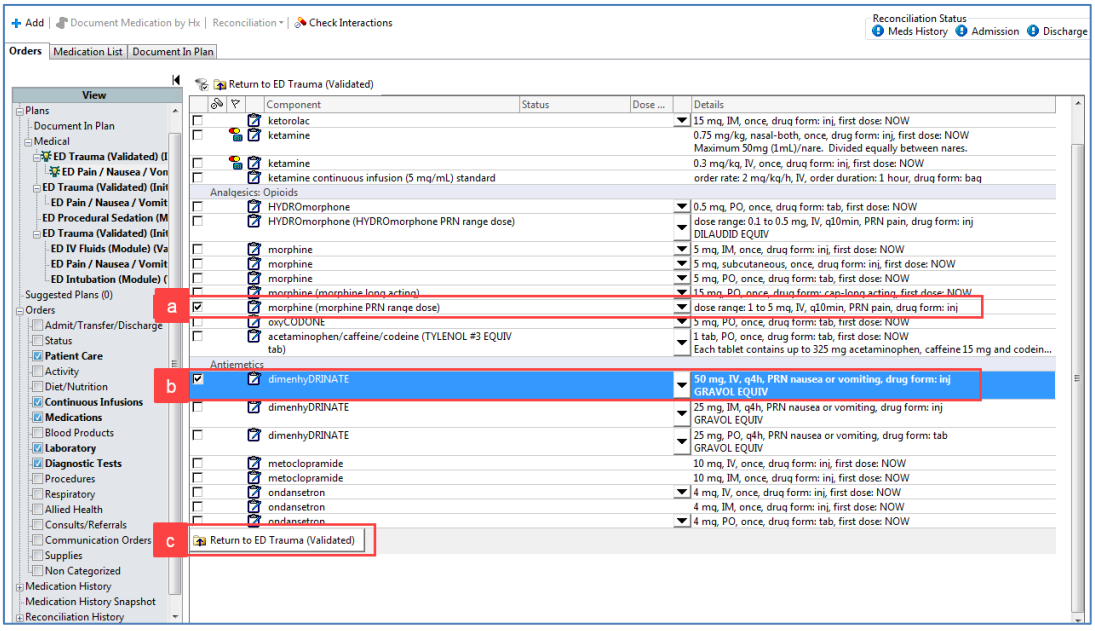
7. ED Pain/Nausea/Vomiting (Module)

a. Choose *Morphine (morphine PRN dose range*) and select *dose range: 1 to 5 mg, IV, q10min, PRN pain, dose form: inj.*

b. *dimenhyDRINATE* –Select the drop-down arrow and choose the higher dosage: *50 mgh, IV, q4h, PRN nausea or vomiting, drug form; inj, first dose: NOW GRAVOL EQUIV*. The Order Details window will open to confirm the change you've selected for the dimenhyDRINATE portion of your ED Trauma PowerPlan.



c. Scroll down on the right side or press the down arrow ▼ to collapse the Order Details window, then select **Return to ED Trauma** Return to ED Trauma (Validated).



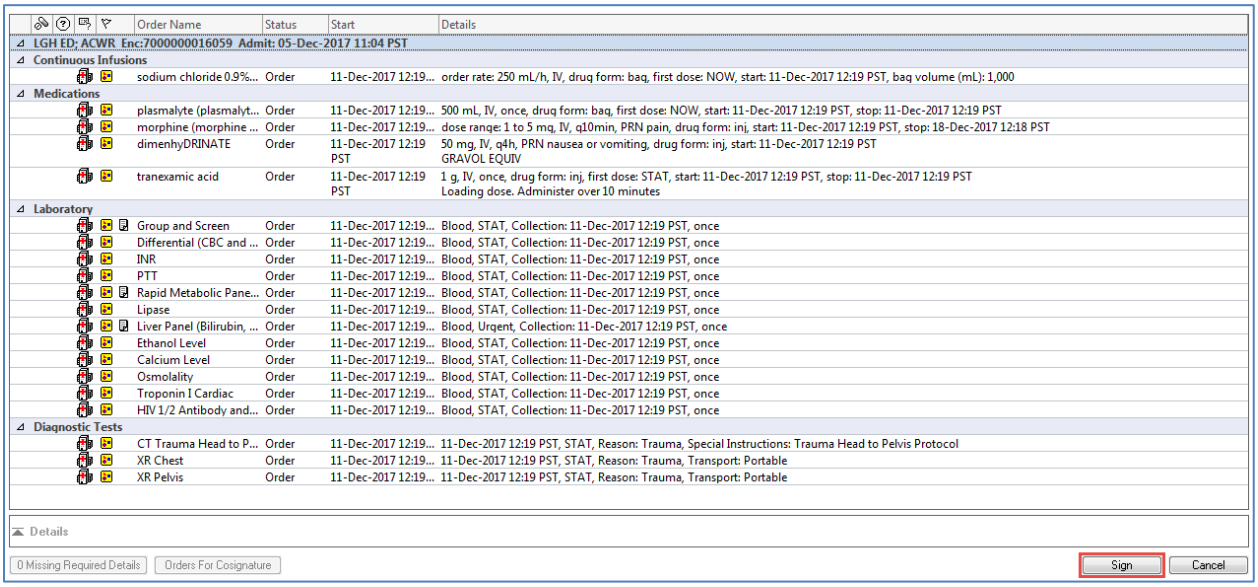
8. Anticoagulants
    a. *Tranexamic acid –1 g, IV, once, drug form: inj, first dose: STAT Loading dose/Administer over 10 minutes.*

Review and confirm the changes you've made and select **Return to ED Trauma**.

9. Hematology
    a. Review and confirm the auto-selections made are appropriate for Mr. Pylon.
10. Chemistry
    a. Deselect: HCG Quantitative Blood and review the remaining Chemistry Order Details.
11. Virology
    a. HIV – ensure this is selected
12. Urine Studies
    a. Review and confirm no Urine Studies are required.
13. Diagnostic Tests
    a. *CT - Trauma Head to Pelvis*
    b. *XR - Chest*
    c. *XR – Pelvis*

14. Cardiac
    a. *Electrocardiogram 12 Lead STAT*
15. ED Consult to Trauma Services[2]
16. Click **Orders for Signature** from the lower right corner. If any medications ordered have the potential for an adverse reaction with your patient's allergies or home medication, a Decision Support Alert would be triggered.

A summarized list of the Order Details you have selected will appear. Take a moment and review and confirm the Order Details for your ED Trauma PowerPlan, click **Sign** in the lower right corner.



Order Name	Status	Start	Details
LGH ED; ACWR Enc:7000000016059 Admit: 05-Dec-2017 11:04 PST			
Continuous Infusions			
sodium chloride 0.9%...	Order	11-Dec-2017 12:19...	order rate: 250 mL/h, IV, druq form: baq, first dose: NOW, start: 11-Dec-2017 12:19 PST, baq volume (mL): 1,000
Medications			
plasmalyte (plasmalyt...	Order	11-Dec-2017 12:19...	500 mL, IV, once, druq form: baq, first dose: NOW, start: 11-Dec-2017 12:19 PST, stop: 11-Dec-2017 12:19 PST
morphine (morphine ...	Order	11-Dec-2017 12:19...	dose range: 1 to 5 mq, IV, q10min, PRN pain, druq form: inj, start: 11-Dec-2017 12:19 PST, stop: 18-Dec-2017 12:18 PST
dimenhyDRINATE	Order	11-Dec-2017 12:19 PST	50 mg, IV, q4h, PRN nausea or vomiting, drug form: inj, start: 11-Dec-2017 12:19 PST GRAVOL EQUIV
tranexamic acid	Order	11-Dec-2017 12:19 PST	1 g, IV, once, drug form: inj, first dose: STAT, start: 11-Dec-2017 12:19 PST, stop: 11-Dec-2017 12:19 PST Loading dose. Administer over 10 minutes
Laboratory			
Group and Screen	Order	11-Dec-2017 12:19...	Blood, STAT, Collection: 11-Dec-2017 12:19 PST, once
Differential (CBC and ...	Order	11-Dec-2017 12:19...	Blood, STAT, Collection: 11-Dec-2017 12:19 PST, once
INR	Order	11-Dec-2017 12:19...	Blood, STAT, Collection: 11-Dec-2017 12:19 PST, once
PTT	Order	11-Dec-2017 12:19...	Blood, STAT, Collection: 11-Dec-2017 12:19 PST, once
Rapid Metabolic Pane...	Order	11-Dec-2017 12:19...	Blood, STAT, Collection: 11-Dec-2017 12:19 PST, once
Lipase	Order	11-Dec-2017 12:19...	Blood, STAT, Collection: 11-Dec-2017 12:19 PST, once
Liver Panel (Bilirubin, ...	Order	11-Dec-2017 12:19...	Blood, Urqent, Collection: 11-Dec-2017 12:19 PST, once
Ethanol Level	Order	11-Dec-2017 12:19...	Blood, STAT, Collection: 11-Dec-2017 12:19 PST, once
Calcium Level	Order	11-Dec-2017 12:19...	Blood, STAT, Collection: 11-Dec-2017 12:19 PST, once
Osmolality	Order	11-Dec-2017 12:19...	Blood, STAT, Collection: 11-Dec-2017 12:19 PST, once
Troponin I Cardiac	Order	11-Dec-2017 12:19...	Blood, STAT, Collection: 11-Dec-2017 12:19 PST, once
HIV 1/2 Antibody and...	Order	11-Dec-2017 12:19...	Blood, STAT, Collection: 11-Dec-2017 12:19 PST, once
Diagnostic Tests			
CT Trauma Head to P...	Order	11-Dec-2017 12:19...	11-Dec-2017 12:19 PST, STAT, Reason: Trauma, Special Instructions: Trauma Head to Pelvis Protocol
XR Chest	Order	11-Dec-2017 12:19...	11-Dec-2017 12:19 PST, STAT, Reason: Trauma, Transport: Portable
XR Pelvis	Order	11-Dec-2017 12:19...	11-Dec-2017 12:19 PST, STAT, Reason: Trauma, Transport: Portable

Details

0 Missing Required Details | Orders For Cosignature | Sign | Cancel

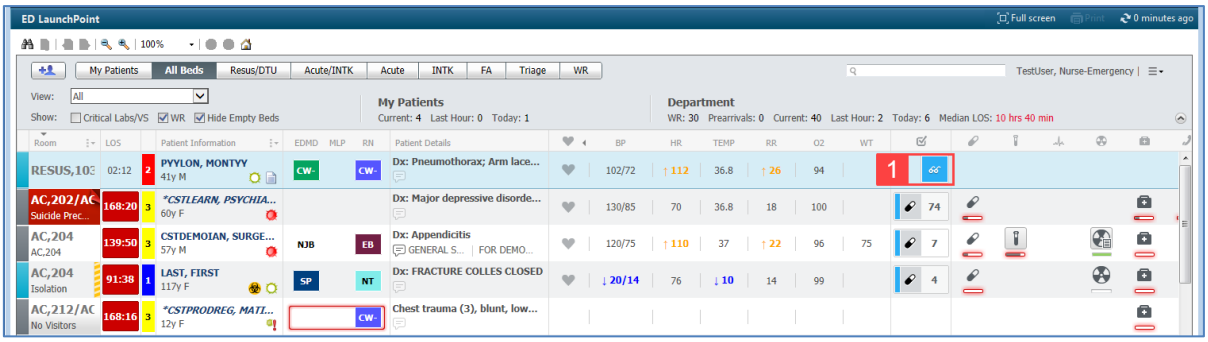
Note: For additional assistance with entering Orders, refer to your Nursing Quick Orders Reference Guide.

[2] Note: If this is not relevant to your site, disregard this step.

Activity 2.9 – Documenting Procedural Sedation

Your patient requires procedural sedation for the insertion of a chest tube.

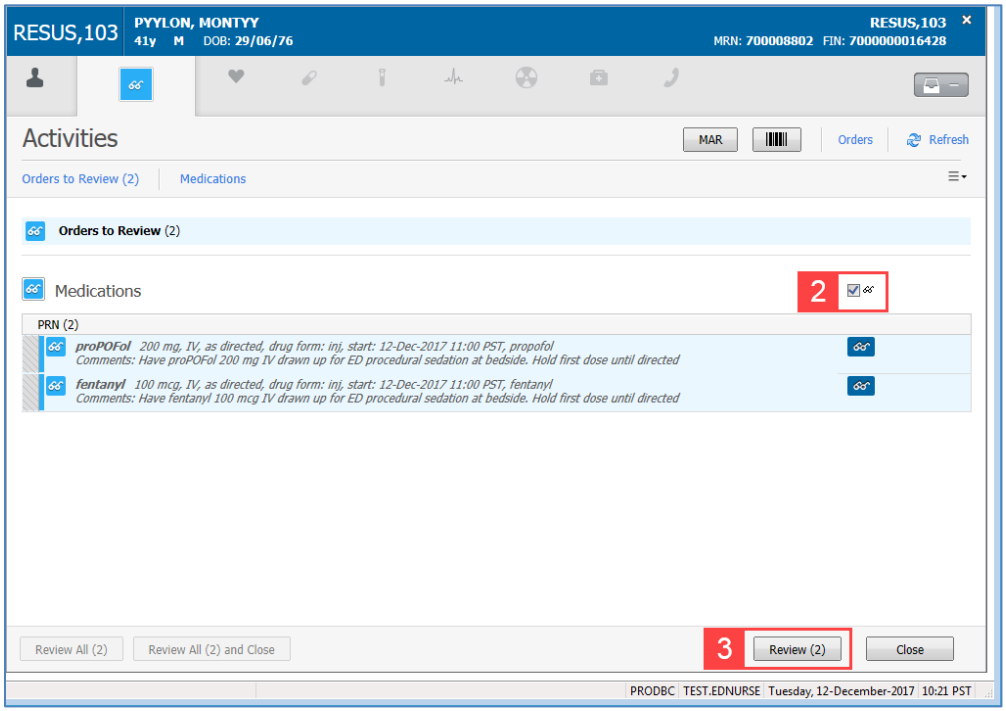
1. In ED LaunchPoint, click Mr. Pylon's *Nurse Activities* column to open the Single Patient View.



2. Click the *checkbox* beside the eyeglasses icon to review your outstanding orders. Both medication orders will highlight.

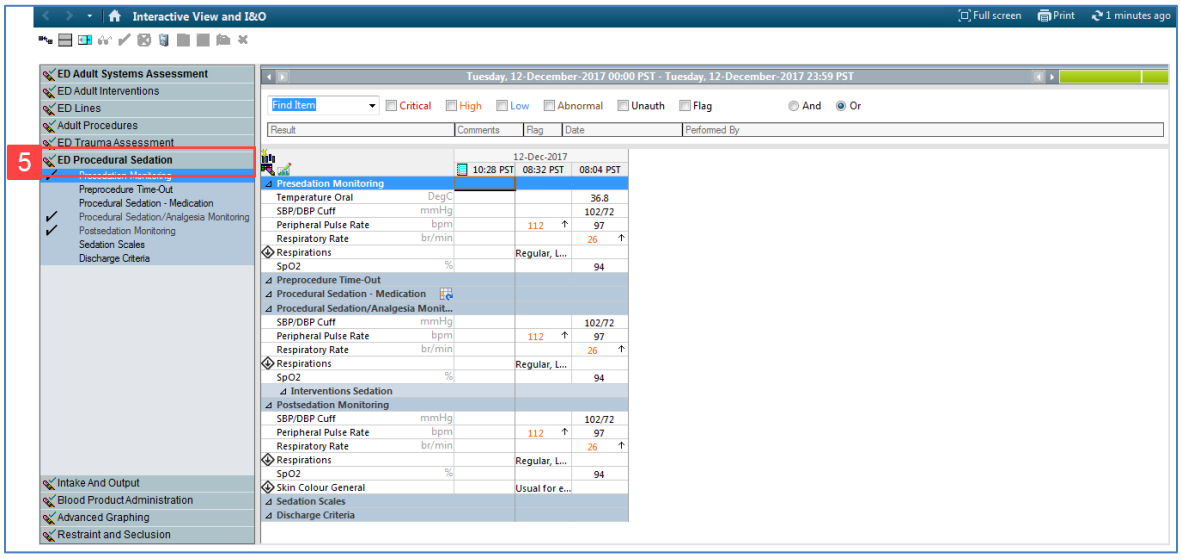
You review the Provider's analgesic selections for procedural sedations and prepare the syringes.

3. Click **Review (2)**. Exit Single Patient View by clicking the **x** or outside the window.



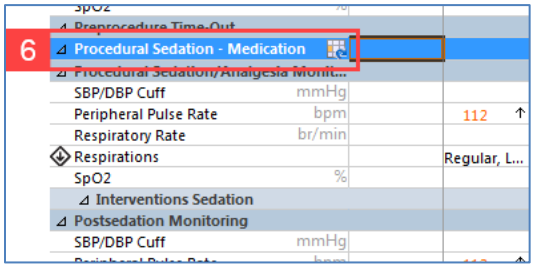
4. Right-click on Monty's name and select **IView**.

5. Select the ED Procedural Sedation band.

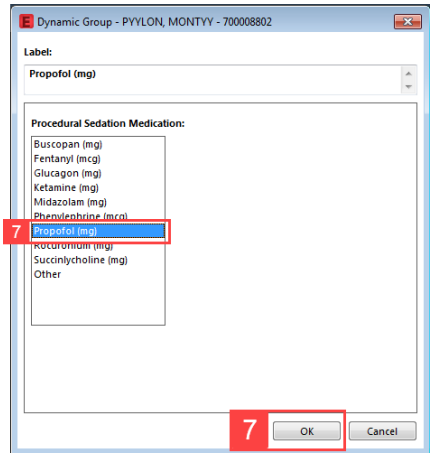


The ED Procedural Sedation band allows documentation of the administration for multiple medications and monitors patient vital signs.

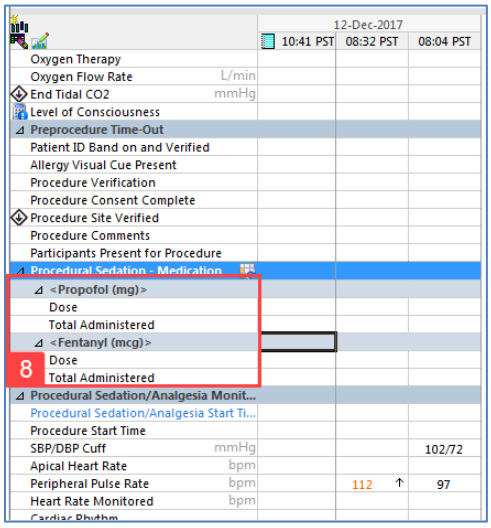
6. You can label your medications with Dynamic Grouping before beginning the procedure. Click the **Dynamic Grouping** icon next to Procedural Sedation – Medication.



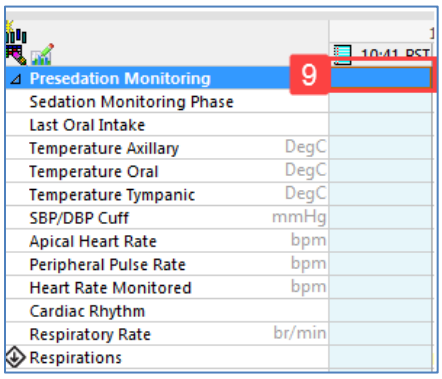
7. The Dynamic Group window appears. Select the ordered medication (proPOFol) and click OK.



8. Repeat the process for fentanyl. Both medications should have rows in IView now. You can enter doses individually, and IView will automatically track the total medication given.

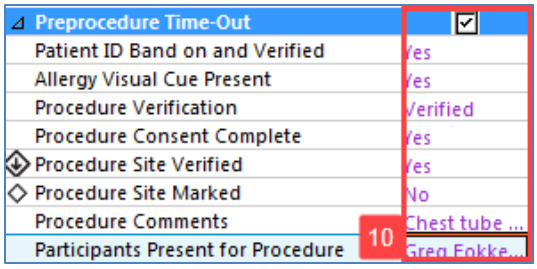


9. Double-click the column header to begin pre-sedation monitoring. As with other IView sections, you can use Tab or the arrow keys to navigate more rapidly through the fields. Enter vitals that would be common to this patient's condition.



In practice, vital signs are automatically entered by the Bedside Medical Device Integration device (BMDI) – the monitoring equipment will feed vital signs into CIS automatically.

10. Click on the Preprocedure Time-Out column header to complete your verification sections.

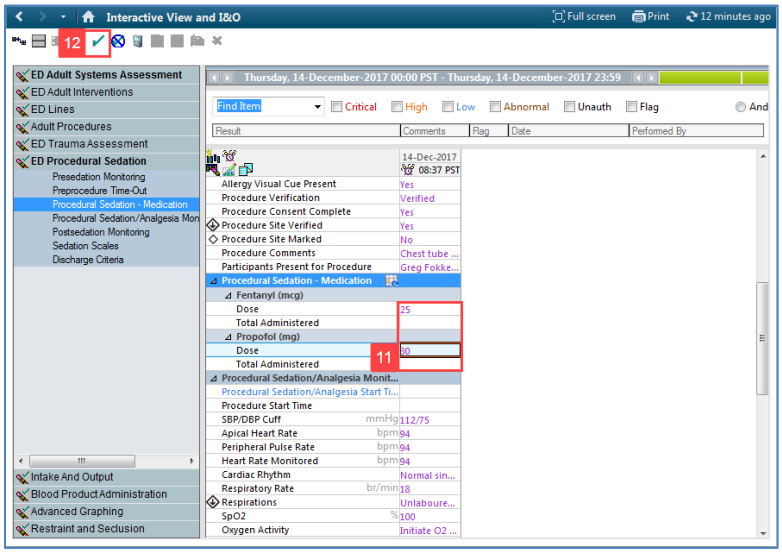


11. The Provider directs you to begin sedation. You administer and document the following in the *Procedural Sedation – Medication* band:

    a. ProPOFol: *30* mcg

    b. Fentanyl: *25 mcg*

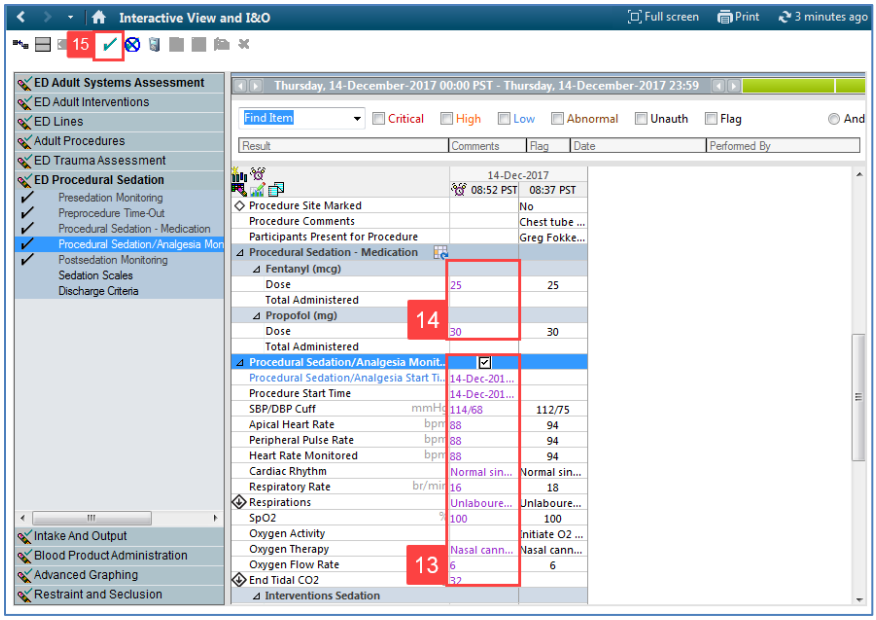
12. Click the green checkmark in the upper left corner to sign after each administration of analgesic to ensure your administration times are accurate.



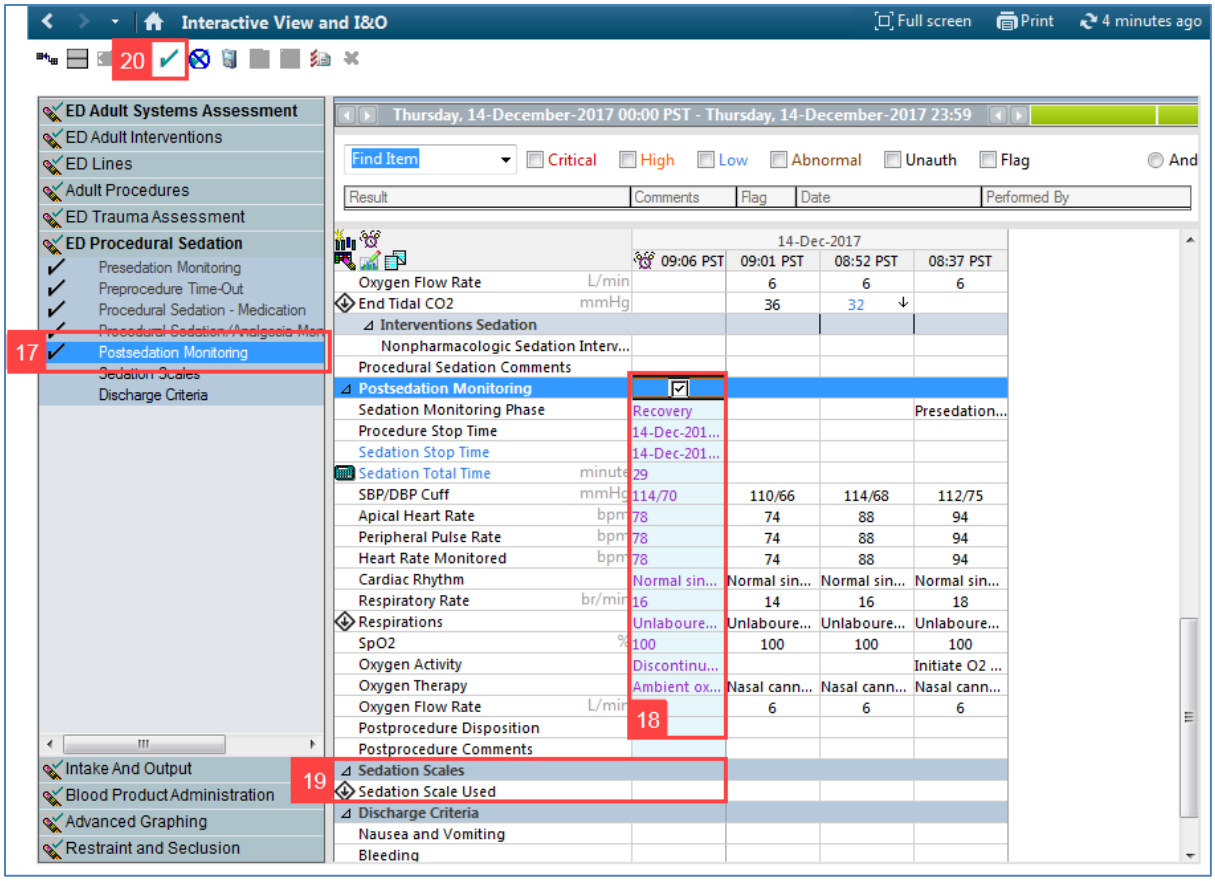
13. Click the Procedural Sedation/Analgesia Monitoring band below to document your vitals.

14. Return to the Procedural Sedation-Medication band and administer another round of sedative and analgesic, repeating the same doses you entered above.

15. Sign for this administration.



16. Enter another set of vitals within the Procedural Sedation/Analgesia Monitoring and sign.
17. The Provider completes the procedure. Navigate to the Postsedation Monitoring band.
18. Click on the column header to document the Sedation Monitoring Phase, the Procedure Stop Time, and post-sedation vitals. Entering “t” in the date field automatically enters today’s date, and entering an “n” will insert the current time (i.e. now).
19. In the Sedation Scales band, there are multiple sedation scales below the Sedation Monitoring Phase section. Use whichever scale is dictated by your unit protocol to monitor Monty’s post-sedation recovery. Following the same Post-Sedation Monitoring steps as above, document Monty’s recovery as you would using your unit’s protocol.
20. Complete the activity by signing your document.


Interactive View and I&O
Full screen
Print
4 minutes ago
20
ED Adult Systems Assessment
ED Adult Interventions
ED Lines
Adult Procedures
ED Trauma Assessment
ED Procedural Sedation
Presedation Monitoring
Preprocedure Time-Out
Procedural Sedation - Medication
Procedural Sedation/Analgesia Mon...
17
Postsedation Monitoring
Sedation Scales
Discharge Criteria
Intake And Output
Blood Product Administration
Advanced Graphing
Restraint and Seclusion
Thursday, 14-December-2017 00:00 PST - Thursday, 14-December-2017 23:59
Find Item
Critical
High
Low
Abnormal
Unauth
Flag
And
Result
Comments
Flag
Date
Performed By
14-Dec-2017
09:06 PST
09:01 PST
08:52 PST
08:37 PST
Oxygen Flow Rate L/min 6 6 6
End Tidal CO2 mmHg 36 32
Interventions Sedation
Nonpharmacologic Sedation Interv...
Procedural Sedation Comments
Postsedation Monitoring
Sedation Monitoring Phase Recovery Presedation...
Procedure Stop Time 14-Dec-201...
Sedation Stop Time 14-Dec-201...
Sedation Total Time minute 29
SBP/DBP Cuff mmHg 114/70 110/66 114/68 112/75
Apical Heart Rate bpm 78 74 88 94
Peripheral Pulse Rate bpm 78 74 88 94
Heart Rate Monitored bpm 78 74 88 94
Cardiac Rhythm Normal sin... Normal sin... Normal sin... Normal sin...
Respiratory Rate br/min 16 14 16 18
Respirations Unlaboure... Unlaboure... Unlaboure... Unlaboure...
SpO2 % 100 100 100 100
Oxygen Activity Discontinu... Initiate O2 ...
Oxygen Therapy Ambient ox... Nasal cann... Nasal cann... Nasal cann...
Oxygen Flow Rate L/min 6 6 6
18
Postprocedure Disposition
Postprocedure Comments
19
Sedation Scales
Sedation Scale Used
Discharge Criteria
Nausea and Vomiting
Bleeding

Activity 2.10 – Documenting Lines, Tubes, and Drains

The paramedics inform you they inserted an 18 gauge peripheral intravenous line into Mr. Pylon's left forearm in the field. This will need to be documented.

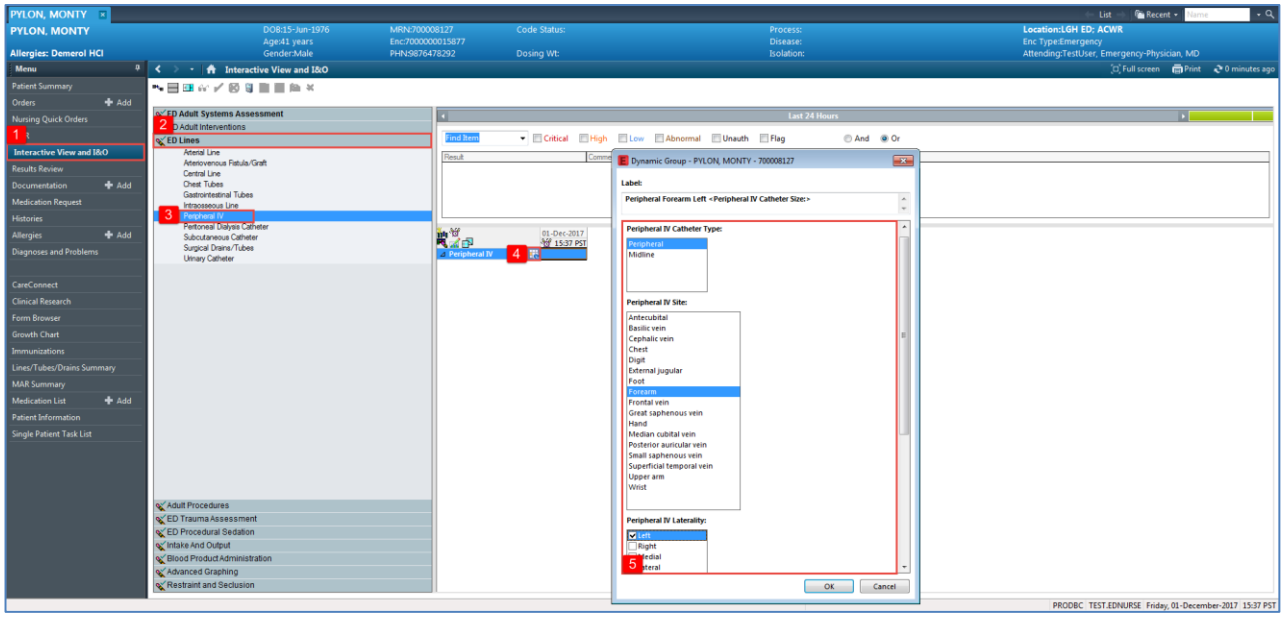
IV Line Insertion

1. In the patient's chart, select **Interactive View and I&O** from the menu.
   (Interactive View can be abbreviated to IView; I&O stands for Ins & Outs)

   Alternatively, if you are in LaunchPoint, right clicking on Mr. Pylon's name will open a drop-down menu where you can select IView.

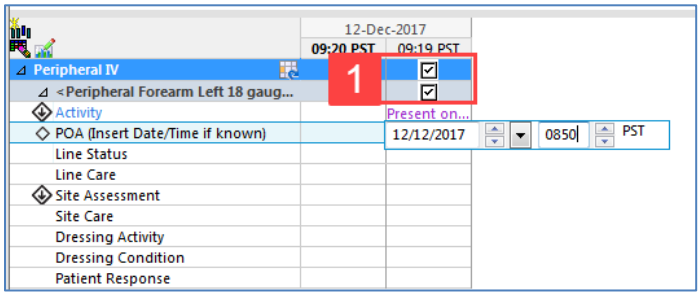
2. Click the **ED Lines** ED Lines band.
3. Select **Peripheral IV** Peripheral IV from the navigation pane**.**
4. Click the **Add Dynamic Group** icon i.e. the line label. A Dynamic Group window will open.
5. Fill in the fields as per the paramedic's report:
   - Peripheral IV Catheter Type: *Peripheral*
   - Peripheral IV Site: *Forearm*
   - Peripheral IV Laterality: *Left*
   - Peripheral IV Catheter Size: *18 Gauge*

Click **OK**. If you need to modify this, you will need to click the name of the label (ie. **<Peripheral Forearm Left 18 gauge>**).



More fields will populate under the Peripheral IV section.

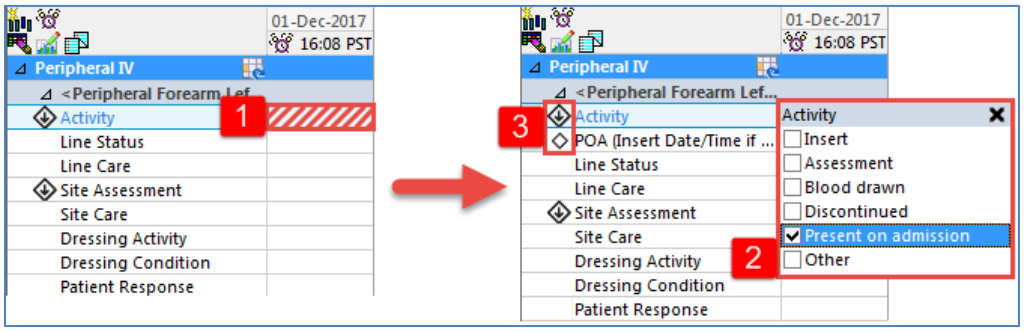
1. To begin documenting, double-click the outlined field beside the label of the section in which you would like to document. This will allow you to use Tab/Arrow functionality.



2. A drop-down menu will present you with options for documentation.
3. Notice how some topics have a ◈ icon, this indicates this field has conditional logic. This means certain responses will generate additional fields.

   Document *Present on admission* in the Activity field (it is sometimes possible to select multiple items to document).

   You will now see additional fields have appeared with a ◇ icon, indicating a field is associated with a conditional logic response.



Use the following information to complete the rest of your documentation:

You recall the paramedics telling you they inserted the IV around *0740*. Upon assessing the site, it is *saline-locked* and *flushes easily*.

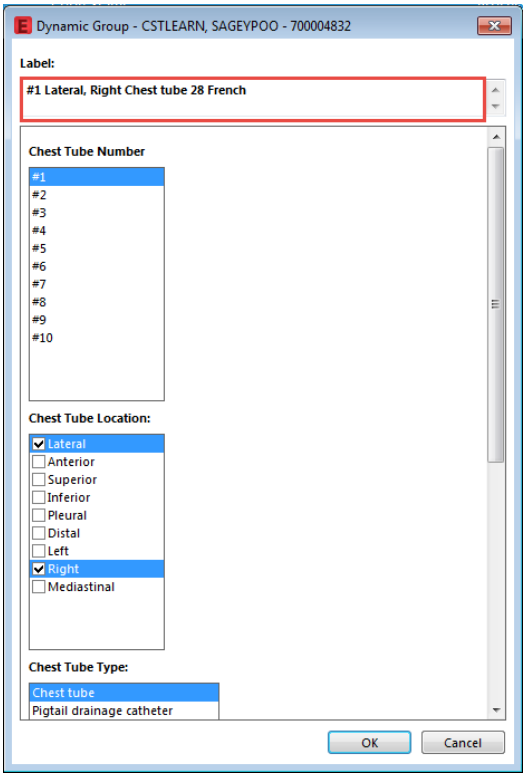
Note: if "*t*" (representing today) is input into a date field, the current date will automatically enter. When "n" (representing now) is input into a time field, the current time will automatically enter.

Remember text will appear purple until your form is signed. To sign, click the **checkmark** ✔ in the upper-left corner to sign your documentation.

Chest Tube Insertion

You will also need to document the chest tube you helped Dr. Hong insert.

1. In IView, click the **ED Lines** band and locate **Chest Tubes** in the navigation pane.
2. Add a **Dynamic Group** and use the following information:
   Chest Tube Number: *#1*
   - Chest Tube Location: *Lateral, Right*
   - Chest Tube Type: *Chest tube*
   - Chest Tube Size: *28 French*



Notice how the Label in the Dynamic Group window changes based on the information entered. This process is called Dynamic Grouping. The system automatically generates this label to differentiate this chest tube from other lines, tubes, and drains.

Once you have entered the Chest Tube information, click **OK**.

The Chest Tube is now labelled based on the data you entered and is available within your ED Lines subsection for charting.

Using the following information to document the #1 Lateral, Right Chest Tube French insertion in the subsection that is now available:

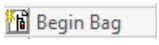
- **Activity:** *Insert*
- **Chest Tube Collection Device:** *Pleural drainage system*
- **Suction Chamber Centimeters:** *-20 cm water suction*
- **Air Leak:** ***Continuous***
- **Drainage Description:** *Air*
- **Dressing:** *Gauze, Sterile petroleum gauze*
- **Patient Response:** *Tolerated procedure.*

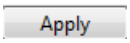
Once completed, click the green checkmark ✔ to sign your documentation. The lines you documented will follow the patient throughout their encounter (to the inpatient unit, for example) until discontinued.

Activity 2.11 – Chart IV Events and Continuous Infusions

In this activity, you will document the initiation of a Normal Saline (NS) infusion and how to document any changes made to that infusion. Unlike most medications, infusions do not have a bar-code compatible with CIS, and must be entered manually. The provider has ordered a normal saline infusion for Fatimah Abassi.

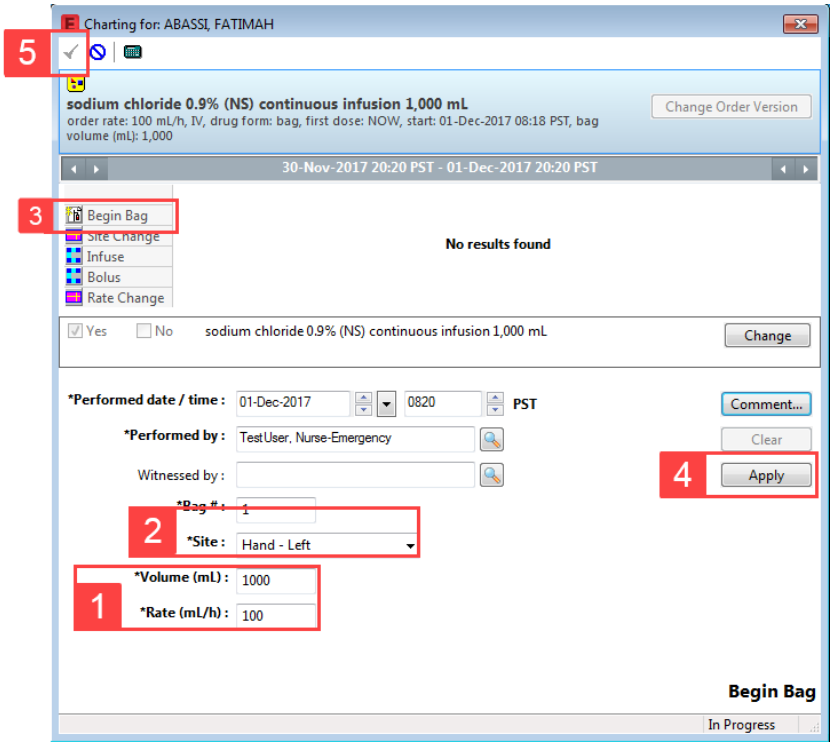
Navigate to the MAR screen, and click **Continuous Infusions.** Double-click the current time for sodium chloride. The **Charting Form** window will open.

1. Verify the defaulted information and enter any additional information. Remember, yellow fields marked with an asterisk (*) are mandatory.
2. Choose the **left hand** for the IV Site, and add a **comment** regarding site care/insertion.
3. Click **Begin Bag**  button.

4. Click the **Apply**  button.

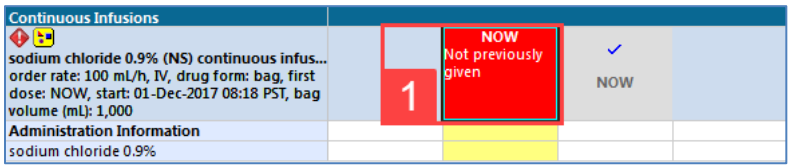
The upper portion of the window is now populated with the bag information you've just entered, and will update/change as you add information.

5. Click the green **Check-mark**  to **Sign** when finished.

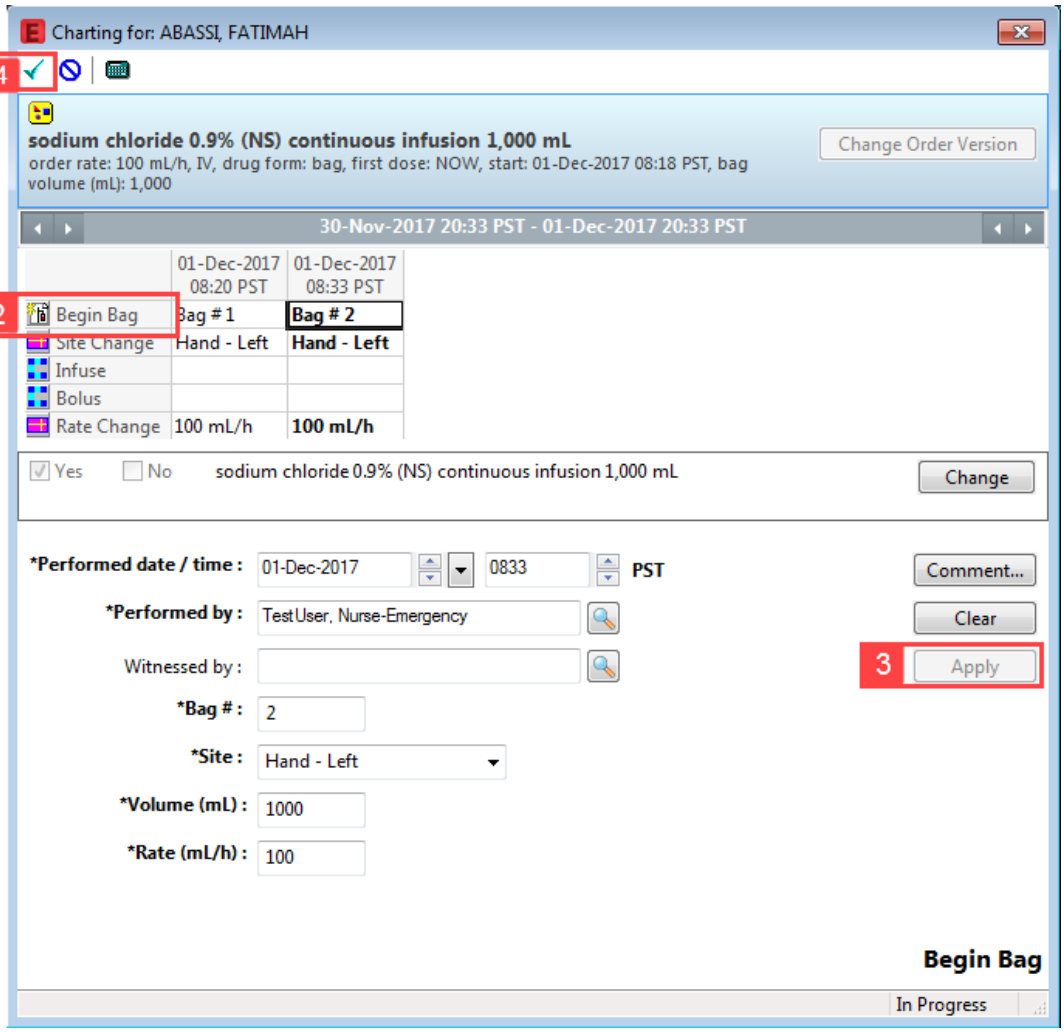


Next, you will document additional infusion bags, rate changes, and an IV site change from the Charting Form window.

1. Double-click the current column of the **Continuous Infusion**.



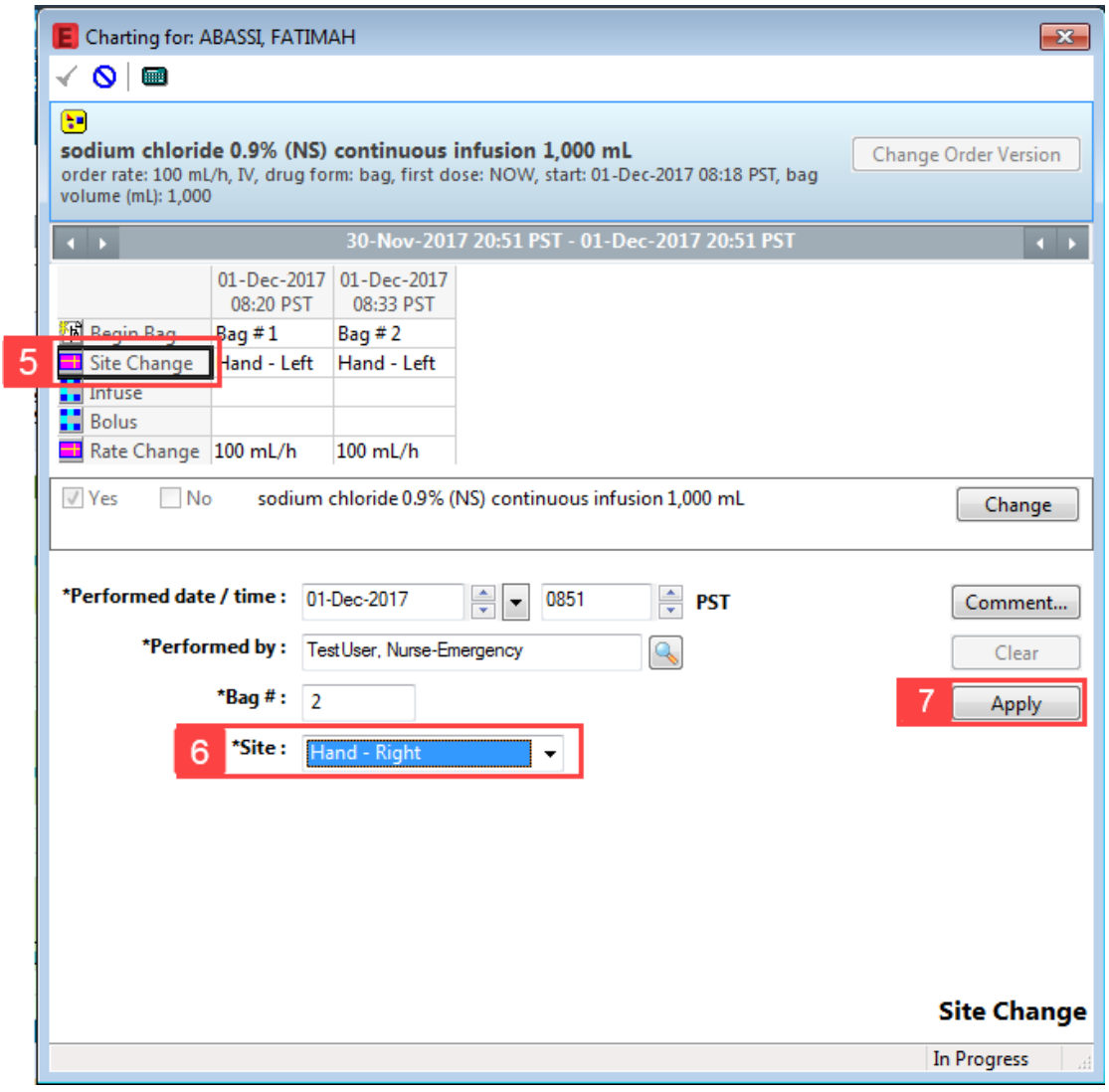
2. Click **Begin Bag** when the Charting Form appears. A second bag will populate.
3. Click **Apply**. A new column appears with information about the second infusion.
4. Click the green **Check-mark** to **Sign**.



To document an IV site change, bring up the Charting Form as in the previous examples:

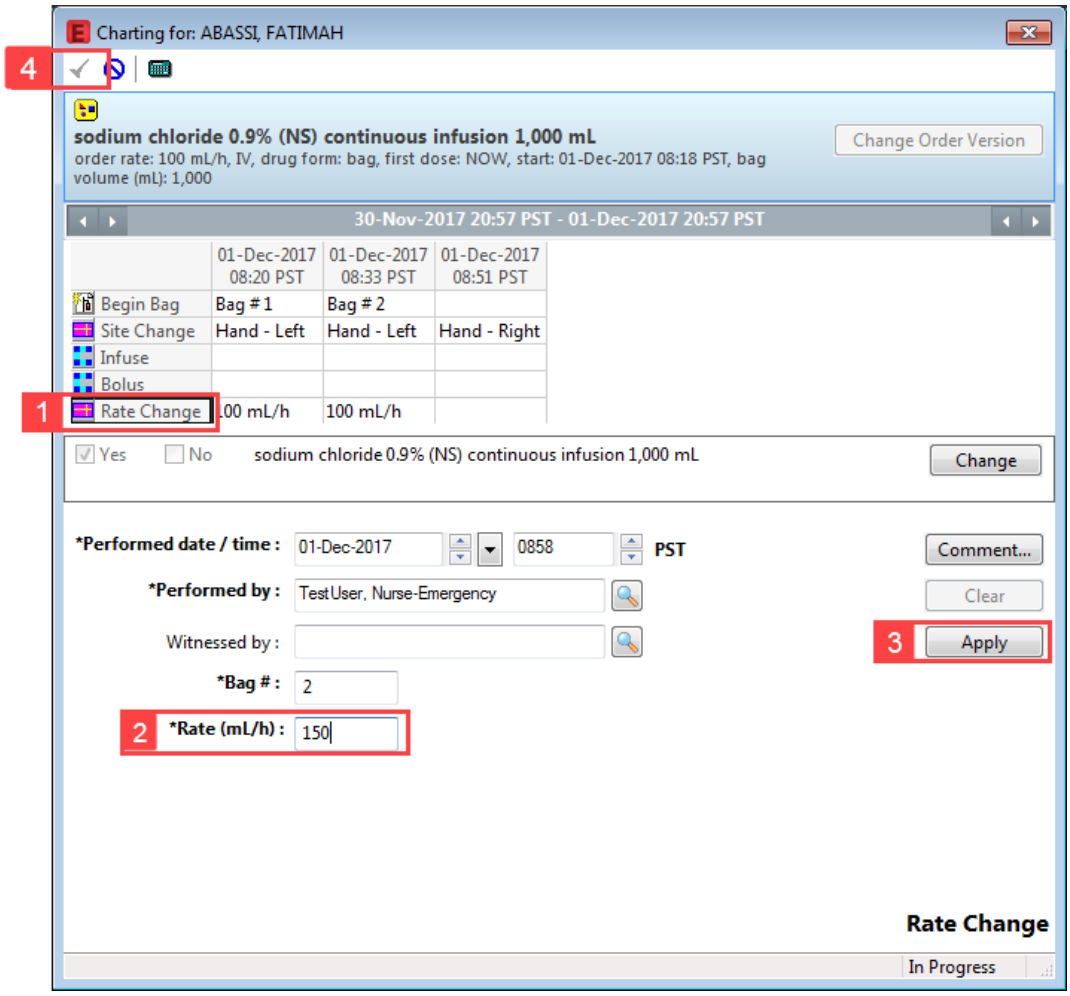
5. Select **Site Change** 

.
6. Select the new site in the lower half of the window.
7. Click **Apply**. The site will change in the upper window.

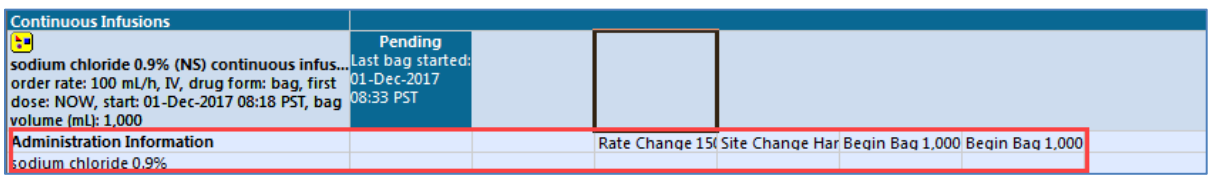


To alter the infusion rate for the current IV bag:

1. Click **Rate Change**  to bring up additional fields.
2. Enter the new *Rate (mL/h) of 150.
3. Click **Apply**.
4. Click the green **Check-mark** to Sign your charting and make changes permanent.

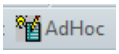


Details about the new bag and site/rate changes appear as **Administration Information** on the MAR. This information is also visible in the **Interactive View and I&O** under the **Adult Quick View** band > **IV Drips.**



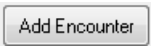
Patient Scenario 2 Summary: Key Learning Points

Activity 2.1 Pre-Arrive Your Patient

- Documenting a Pre-Arrival is not a mandatory activity. Using the Pre-Arrival function is a tool that is available for your use.
- To document a Pre-Arrival, click the **Add Patient**  icon and select **Add Prearrival**. The Pre-arrival PowerForm will open. Fill out the appropriate fields.
- PowerForms are electronic versions of common forms used by hospital personnel. Access PowerForms at any time by clicking the Ad Hoc 

button in the toolbar.

Activity 2.1 Incoming ED Patient: ED Quick Reg

- Click the **Add Patient**  icon and select **ED Quick Reg** to begin quick registration process
- If patient has previous encounters, select **Add Encounter** 

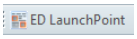
- If patient has no previous encounters, select **MPI Search** 

- Fields highlighted in yellow are mandatory
- If your patient does not appear, try clicking the Refresh  button
- Right-click on the name of the patient you ED Quick Registered and select Attach Prearrival
- If you are unable to locate a PreArrived or Quick Registered patient, select the **All Beds** tab. Select the **WR** box as patient may not appear until the “WR” box is checked

Activity 2.4 Triage

- LaunchPoint will show outstanding tasks in the Nurse Activities column
- Access the Triage PowerForm by opening the Single-Patient View and clicking the  icon
- Within the PowerForm, complete the COT Descriptor and Problems, Tracking Acuity and screening forms
- Do not use your mouse wheel to scroll, as it will change your entry on a drop down menu
- If the ED Triage Adult tasks does not disappear once completed, click the refresh button located in upper right-hand corner of the Single-Patient View
- Access the Single-Patient View by clicking the white space around the patient’s name
- Overdue Nurse Activities are marked with a red bar  below the associated task’s icon

Activity 2.5 Documenting Multiple ED Nursing Activities

- Common icons:
  - ED LaunchPoint Multi-patient List 
  - Overdue Activity 
  - Nurse Review/ Orders to Review 
  - Activities 
  - Medications 
  - Labs 
  - ECG 
  - Radiology 
  - Patient Care 
  - Consult 
  - Orders for Signature Inbox 
  - Add Order button 
  - Refresh button 
  - PowerPlans 
  - Orders for Signature 
  - Sign ✔
- ED Screening-Adult is allows you to chart any precautions your patients may have
- Signing documents is completed with different buttons (i.e. ✔,  , and ), depending on the form used
- In iView, you can use the Tab key or arrow keys to move more rapidly through assessment fields (cells) or you can click on fields as required
- Purple text indicates an unsigned form. Once signed, normal values will turn black, below normal range values blue, above normal values orange and critical values will be red

Activity 2.6 ED Bed Assignment

- Review the Room column. If ACWR appears beside patient name, your patient is not in an assigned bed
- Double-clicking ACWR in the Room column next to your patient's name. This will open the Room Assignment window. Here you will be able to choose the appropriate bed.
- The numbers shown in brackets shows the number of patients in the room. For example, Room AC 204(0).

Activity 2.7 ED Trauma Assessment and Documentation

- The **ED Trauma Assessment** is accessed through the iView Navigation Pane
- Double-clicking the top of the column allows you to toggle through the fields using your Tab button
- Clicking the Trauma Team Activation field sends a task to notify the Trauma Team
- Use "**t**" as a shortcut to enter today's date and **"n"** to enter the current time when prompted

Activity 2.8 ED Nursing Quick Orders: PowerPlans

- PowerPlans are sets of orders related to common conditions, similar to the Pre-Printed Order Sets (PPOS) you might already be familiar with
- Orders conflicting with the patient's allergies or condition will trigger a Decision Support Alert
- You can modify PowerPlans within the Order Details window
- Modules are used to group orders for similar conditions within the PowerPlan

Activity 2.9 Documenting Procedural Sedation

- The Provider's orders for administering Procedural Sedation will appear as a task in your activities column.
- Clicking within the activities column will open the Single Patient View.
- Click the *checkbox* beside the  icon to review your outstanding orders. Both medication orders will highlight.
- Navigate to the ED Procedural Sedation section in iView
- Click the Dynamic Group icon  to prepare a Dynamic Group for each analgesic to be administered

Activity 2.10 Documenting Lines, Tubes, and Drains

- Document on lines, tubes, and drains by selecting the ED Lines band in iView
- The Add Dynamic Group  icon will prompt a window where descriptors of a line, tube, or drain is entered that will auto generate an identifying label in the system

Activity 2.11 Chart IV Events and Continuous Infusions

- Continuous infusions are accessed through the MAR
- The Charting Form allows you to initiate an infusion
- **Once started, you can change the bag, site and rate for a particular infusion with the Charting Form**

PATIENT SCENARIO 3

Learning Objectives

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

- Collect specimens for POC testing and lab tests
- Review test results
- Prepare transfer documentation for a patient
- Document “to go” medications
- Discharge and Admit ED patients
- Perform nursing handoff

SCENARIO

Monty Pylon is a 41 y.o. male who suffered a blunt force injury to the chest and elbow laceration due to falling down a flight of stairs onto a concrete pylon. His injuries are being treated, and diagnostics are processing.

Your second patient, Fatimah Abassi, has been in your unit all day. The area on her foot around the wound is red, tender, hot to the touch, and has some purulent drainage. She has been receiving antibiotics.

Kim Wong, an 86 year old woman just arrived, complaining of fever, cough, and shortness of breath. She lives independently with regular support from community services. Her vital signs at triage are:

Pulse = 110, BP = 110/60, PO temp = 38.4, RR = 20 and SpO2 = 94% on Room Air.

She is assessed by the nurse as having a patent airway, laboured respirations with a regular respiratory pattern. Her skin colour is normal for ethnicity and is dry and warm. Her capillary refill is less than 2 seconds. She is oriented x4 and alert and responsive.

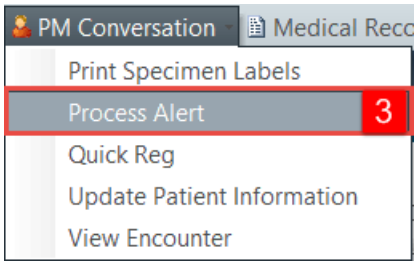
Activity 3.1 - Alerts

The CIS has a number of different ways to display alerts on your patient. You will remember from your eLearning that alerts are displayed within the Banner Bar, the patient room column, and the patient information column. In this activity, you will learn how to add a process alert on a patient.

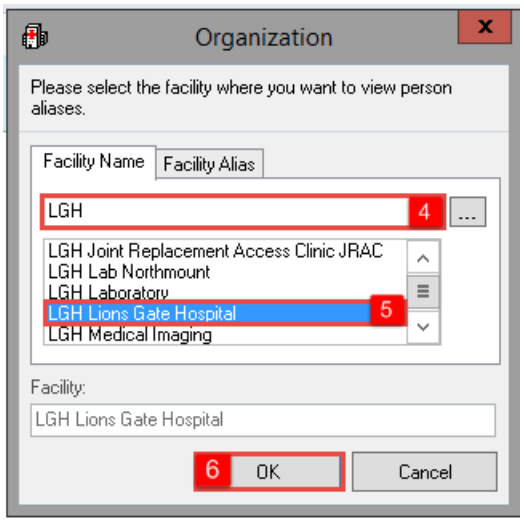
Ms. Wong fell as she was trying to get out of bed to go to the bathroom. One of the other Nurses found her on the floor in her room and she is currently being assessed by the Physician for injuries. You want to alert others that she is a Falls Risk. To add the Falls Risk alert to Ms. Wong's Chart, you will need to complete the following steps:

1. Click on Ms. Wong's name on the **ED LaunchPoint** screen.
2. Ms. Wong's chart will open. Click the **arrow** next to the PM Conversation 

button on your Toolbar.
3. From the drop-down list that appears, select **Process Alert.**

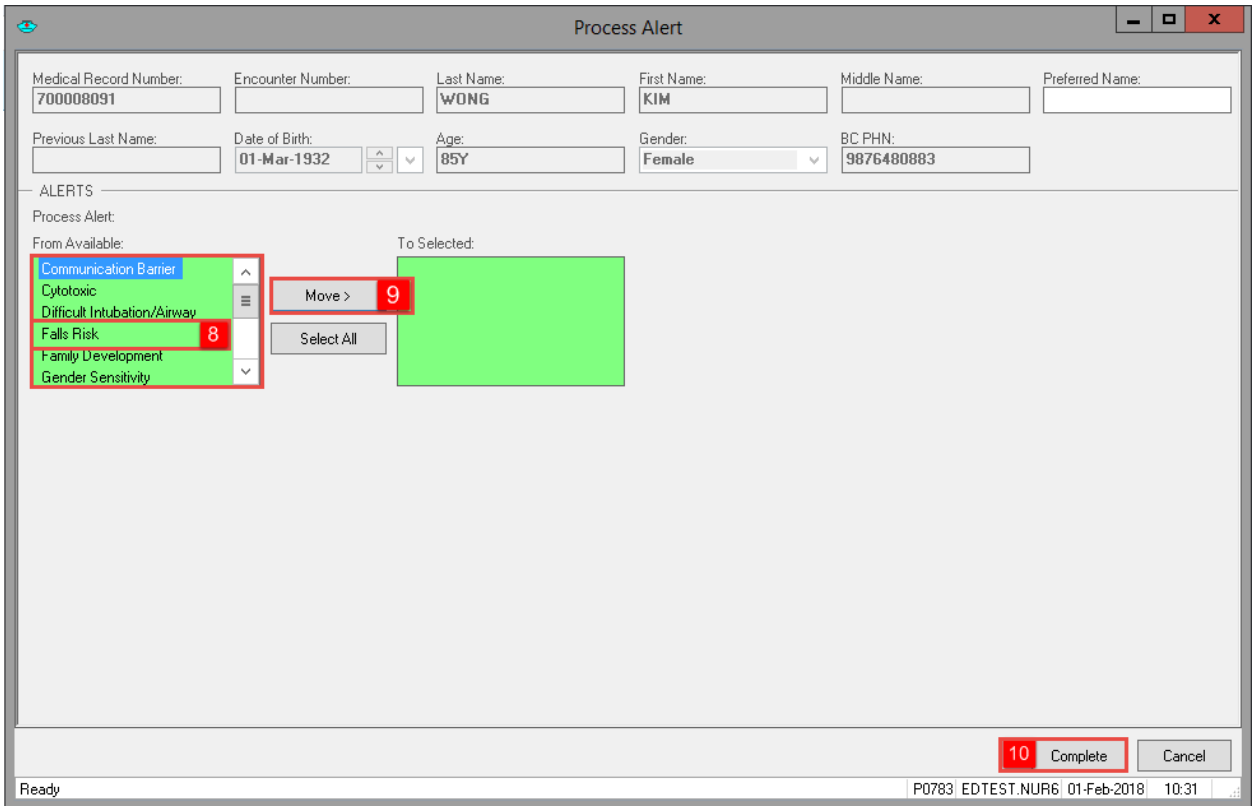


4. The Organization window will appear. In the Search Bar, enter **LGH** and hit Enter.
5. Ensure you click on **LGH Lions Gate Hospital**.
6. Select **OK**.



7. The Process Alert window will open. Click within the white square marked **Process Alert**.

8. The various alerts available will appear. Select **Falls Risk**.
9. Select **Move** to activate this alert.
10. Select **Complete**.



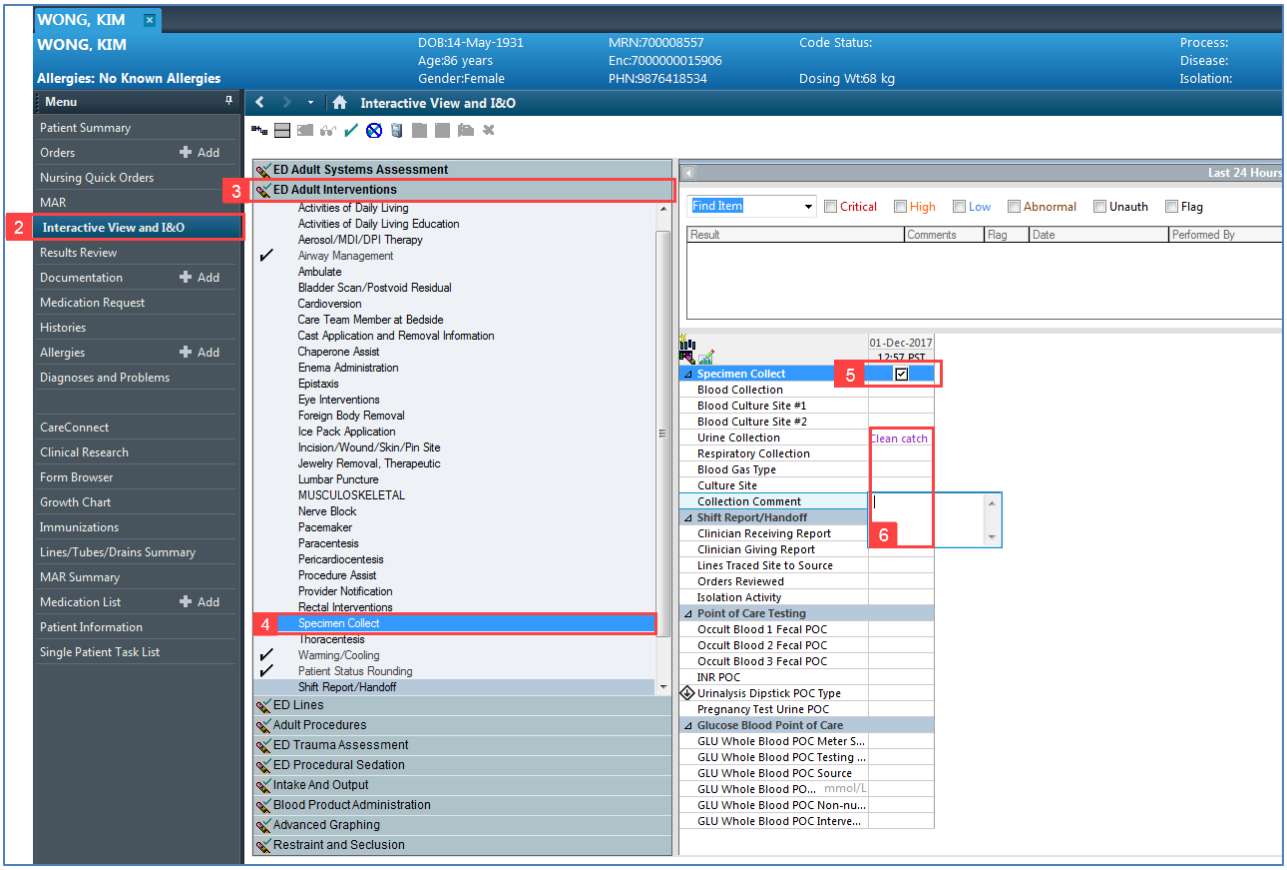
Look to your patient's Banner Bar to ensure "Falls Risk" displays within the Process Alerts section.

Activity 3.2 – Nurse Specimen Collection

The **Interactive View and Ins & Outs** (“**IView**”) screen documents continuous infusion administration, Vital Signs, and head-to-toe assessments. In this activity, you’ll use **IView** to document the collection of patient lab specimens. You can document any point of care specimen collection in IView.

Ms. Wong still needs to go to the bathroom, so you decide to do a Point-of-Care urine test (“Urine dip”). After assisting her to the facilities and back, you test the urine. To document your collection:

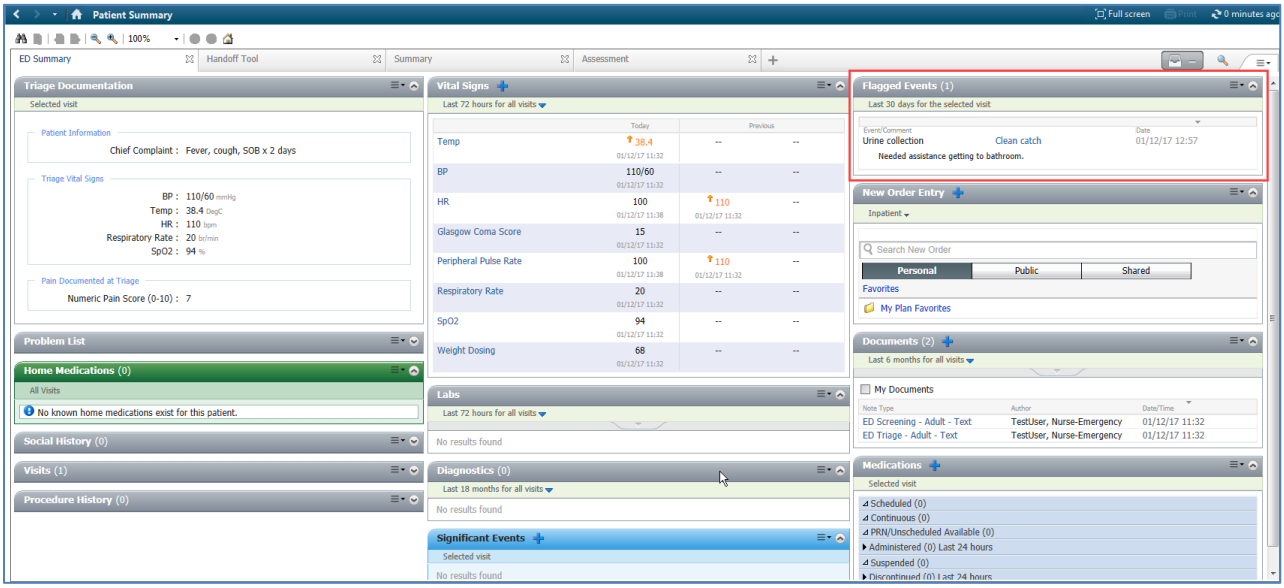
1. Open Ms. Wong’s chart by clicking her name in **ED LaunchPoint**.
2. Open the Interactive View and I&O band.
3. Select **Adult Interventions** on the menu**.**
4. Select **Specimen Collect.**
5. Click the column header, and then select the field in the **Urine Collection** row.
6. Select **Clean Catch**, then highlight **Collection Comment** and write *Patient required assistance to bathroom*.



7. Click the green check mark ✔ to **sign**. The text should change from purple to black.

To flag this procedure so other clinicians are aware Ms. Wong required assistance providing a sample, right-click on the field in IView and select **Flag with Comment…** Write “Needed assistance to bathroom”.

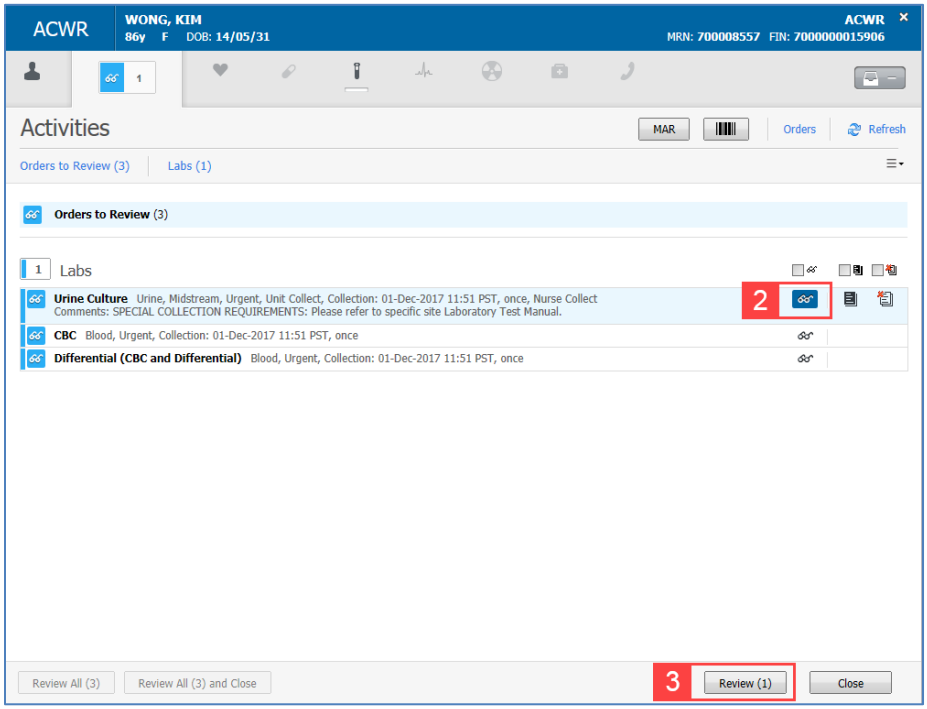
Your comment will be visible in the Patient Summary screen to all clinicians under the Flagged Events Component. This can be done with any procedure or event. In combination with the Process Alert you added in the previous activity, you can see how your documentation creates guidance for Ms. Wong’s care.



The urine scan reads high in leukocytes. After notifying the provider, she orders a urine culture on the sample you collected.

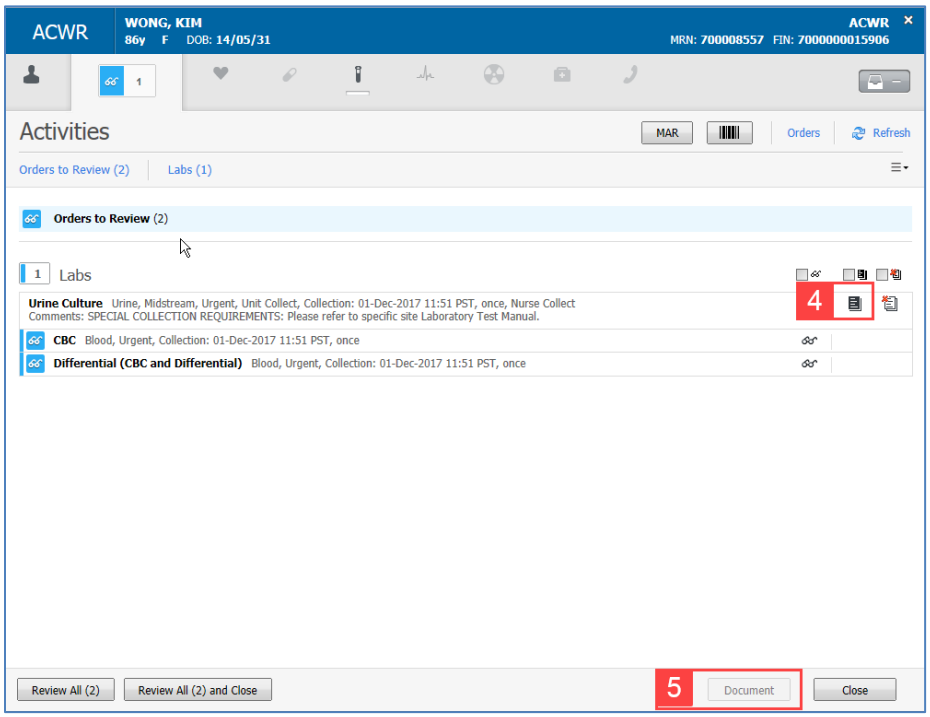
On **ED LaunchPoint,** there are new orders for Ms. Wong indicated by the **task number** 1 in the **Nurse Activities** column. Hover-to-discover the outstanding activities. To document completion of this task:

1. Click the task number 1 in the Nurse Activities column to open the Single Patient View.
2. There is an outstanding Urine Culture Lab collection required. Click the **Nurse Review** icon .
3. Click **Review** Review (2).

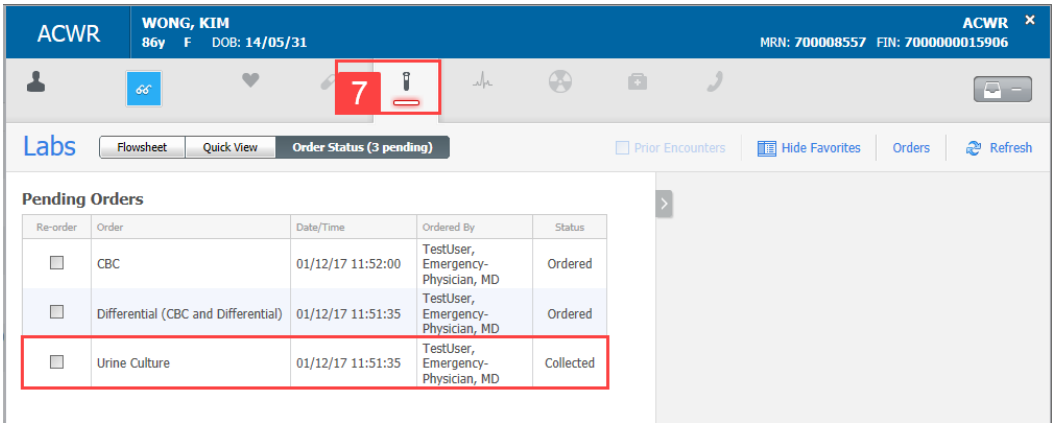


Note: If you review an outstanding activity, but cannot attend to it right away, click the **Not Done** icon (or **Not Done all** for multiple activities). This ensures activities don't drop off your "to-do" list.

4. Once reviewed, the specimen collection must be documented. Click on the **Document** **icon.**
5. Click the **Document (1)** button.



6. The **Nurse Collect** window appears. Ensure the date and time is correct and click **OK**.
7. Review the **Pending lab orders** . The Urine culture's status is now "Collected".

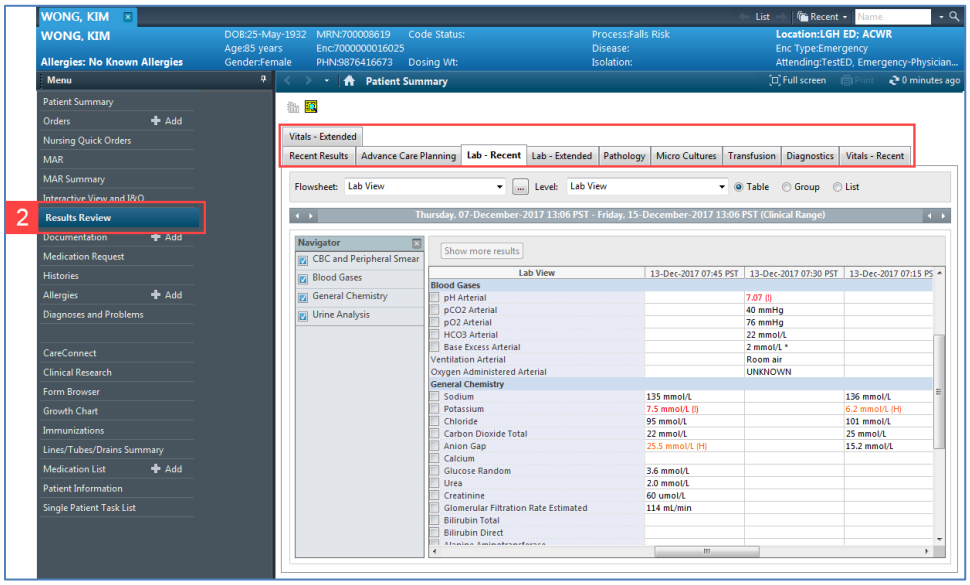


Activity 3.3 –Results Review

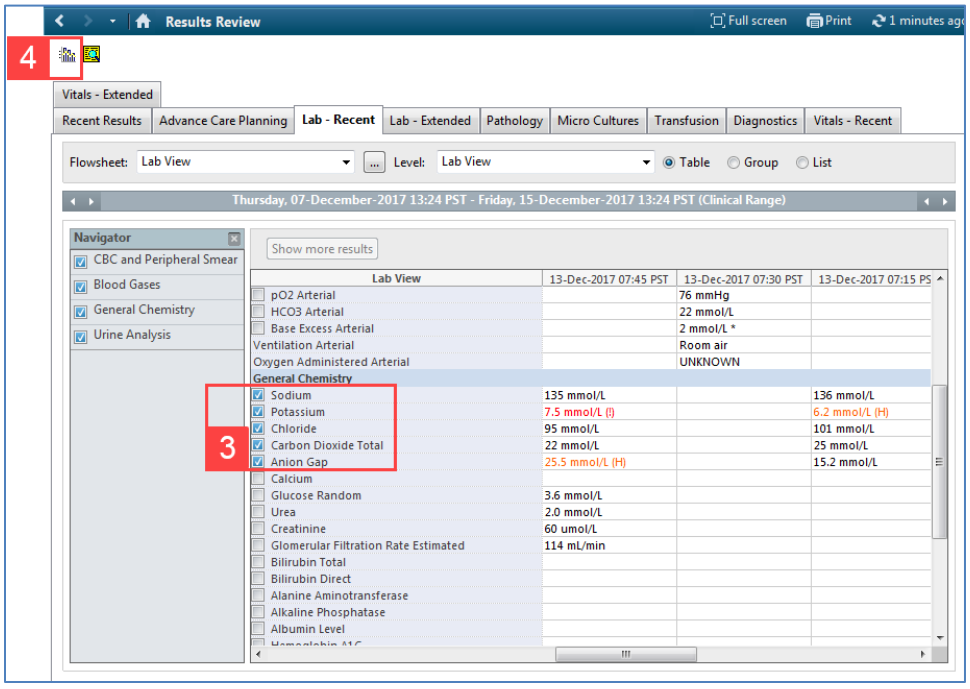
You want to review Ms. Wong's lab tests.

1. Click on Kim Wong's name in ED LaunchPoint.
2. Select **Results Review** on the Menu.

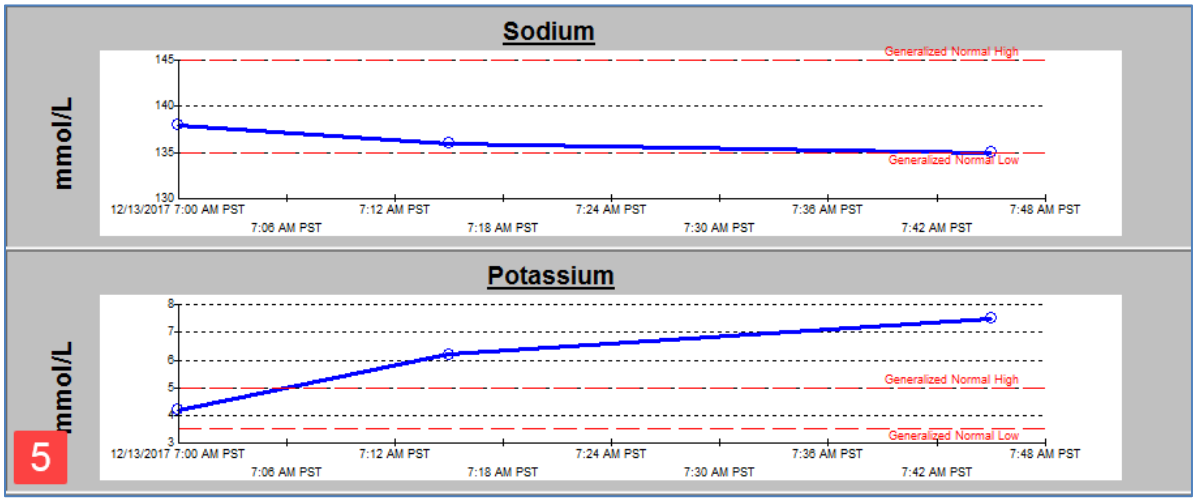
Results Review is arranged with tabs along the top of the screen for various lab results.



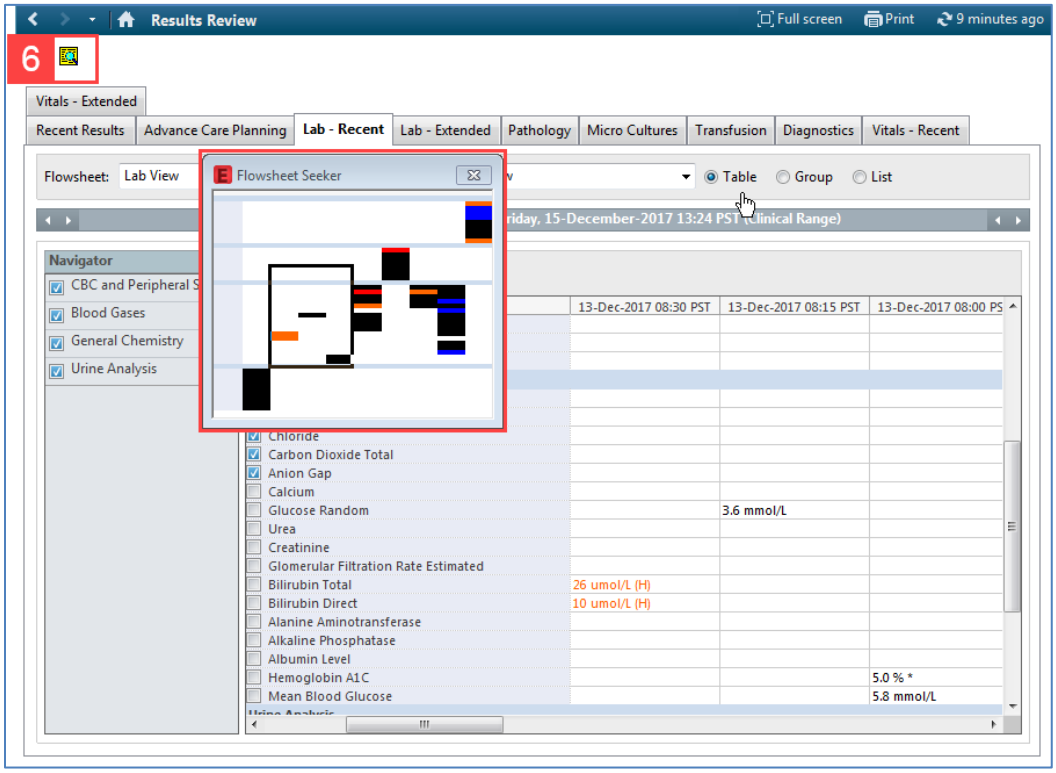
3. To show a graphical view of the results, select the results of interest.
4. Click in the left corner.



5. A graphing screen will appear showing the values' trend over time.

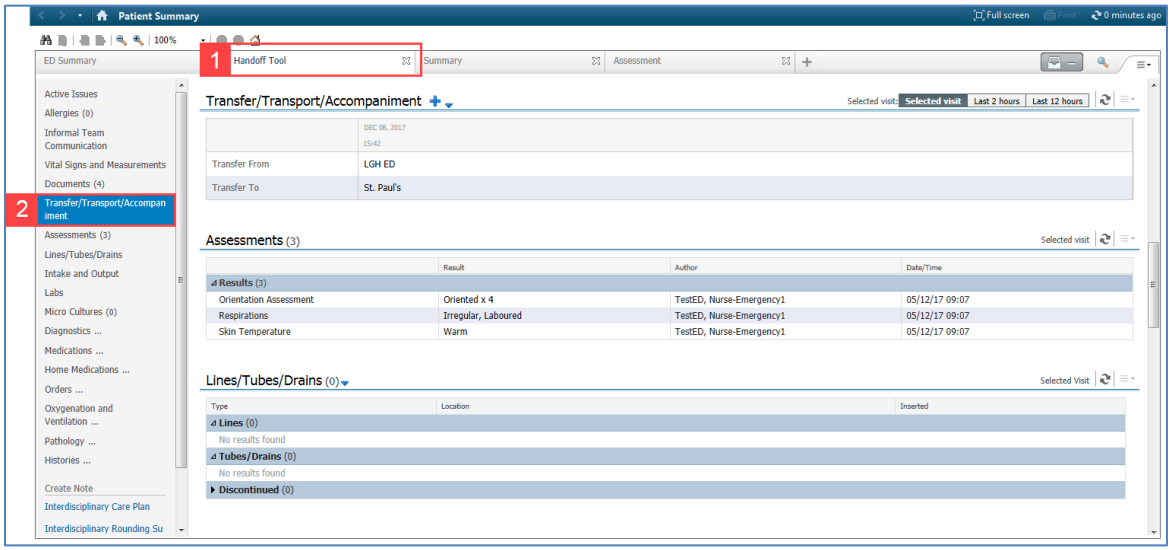


6. The **Flowsheet Seeker**  , beside the graphing icon, creates a window that allows you to navigate the Results Review flowsheet. As with the text equivalents, black areas are normal values, blue are abnormally low, orange abnormally high and red are critical values.



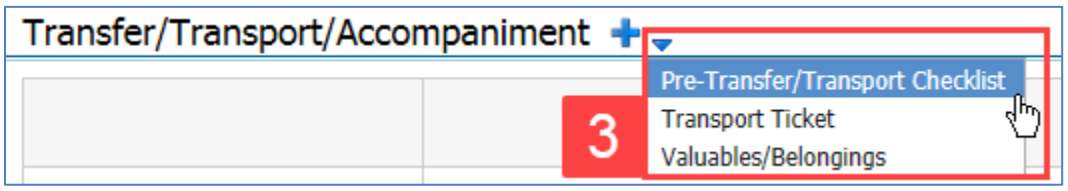
Activity 3.4 – Patient Transport Ticket

1. From ED LaunchPoint, right-click on Ms. Wong's name and select the Handoff Tool.
2. Select *Transfer/Transport/Accompaniment* from the Table of Contents on the left.

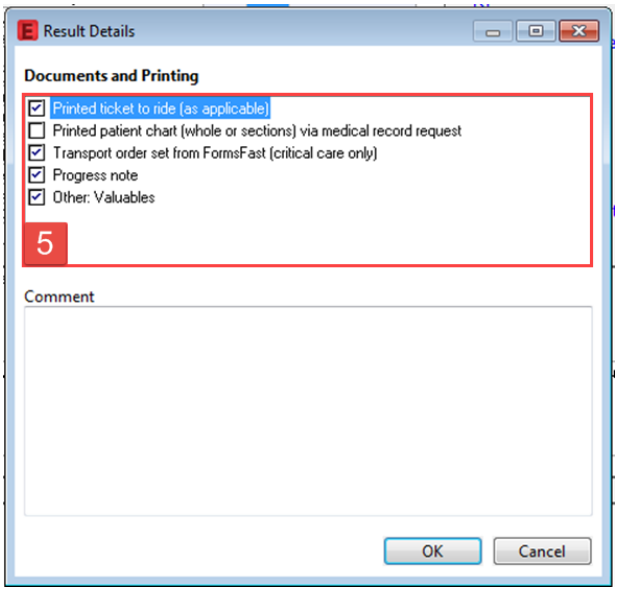


3. The Handoff tool is to help provide handover.

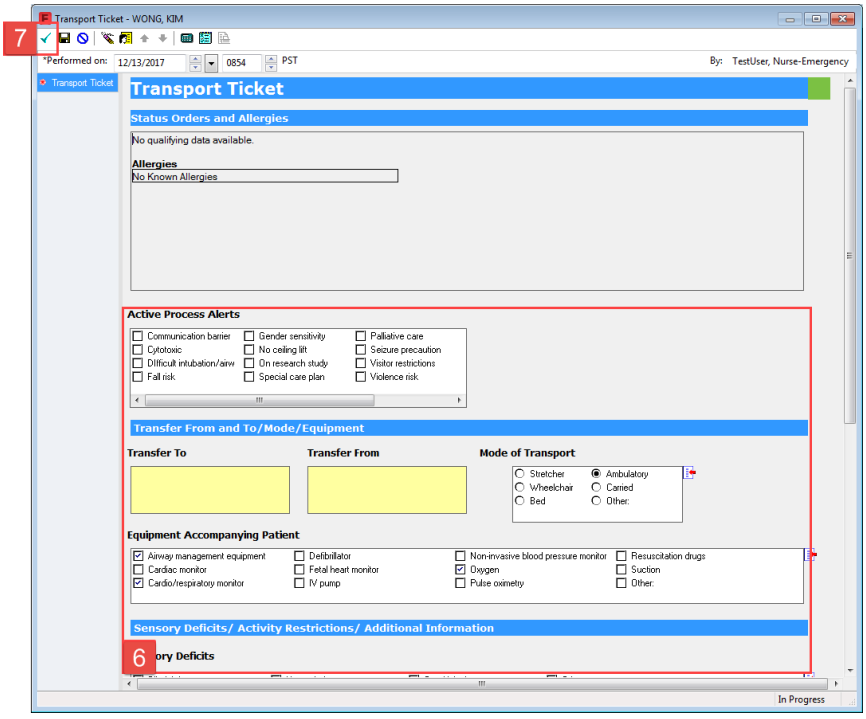
   In the Transfer/Transport/Accompaniment section, select the blue downward arrow to review documentation options available to you. Select *Pre-Transfer/Transport Checklist*.



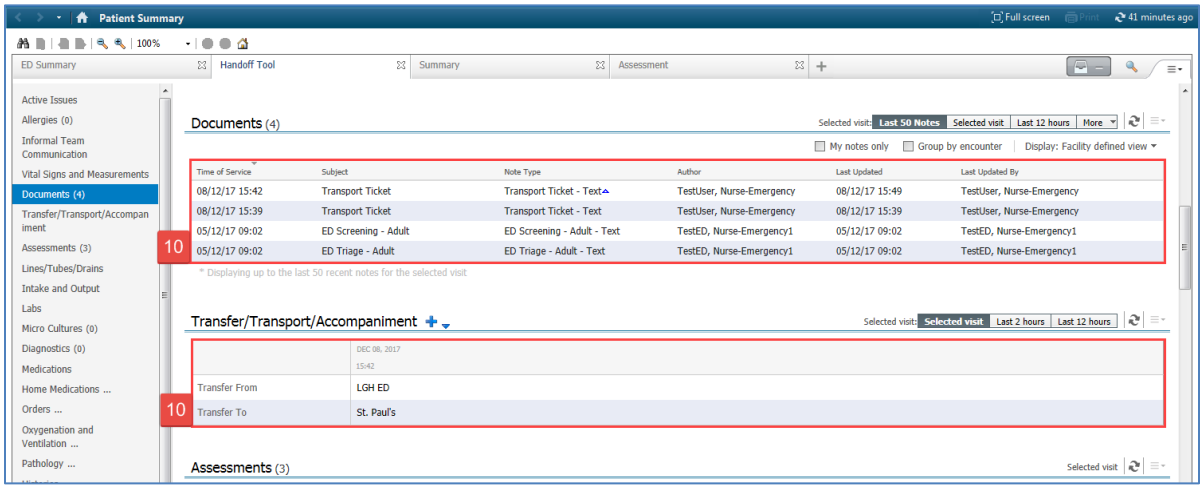
4. Click the **<MultiAlpha>** field below the Documents and Printing section to display a checklist of documents that need to accompany the patient.
5. In the Results Details window, select documents relevant to the patient's condition. For critical patients, you may want print a portion of the patients chart via Medical Record Request. Click **OK** when finished entering information.



6. Select the blue downward arrow to open the Transport Ticket PowerForm. Complete the relevant information, being sure to scroll down to review all fields.
7. Sign the document when done.

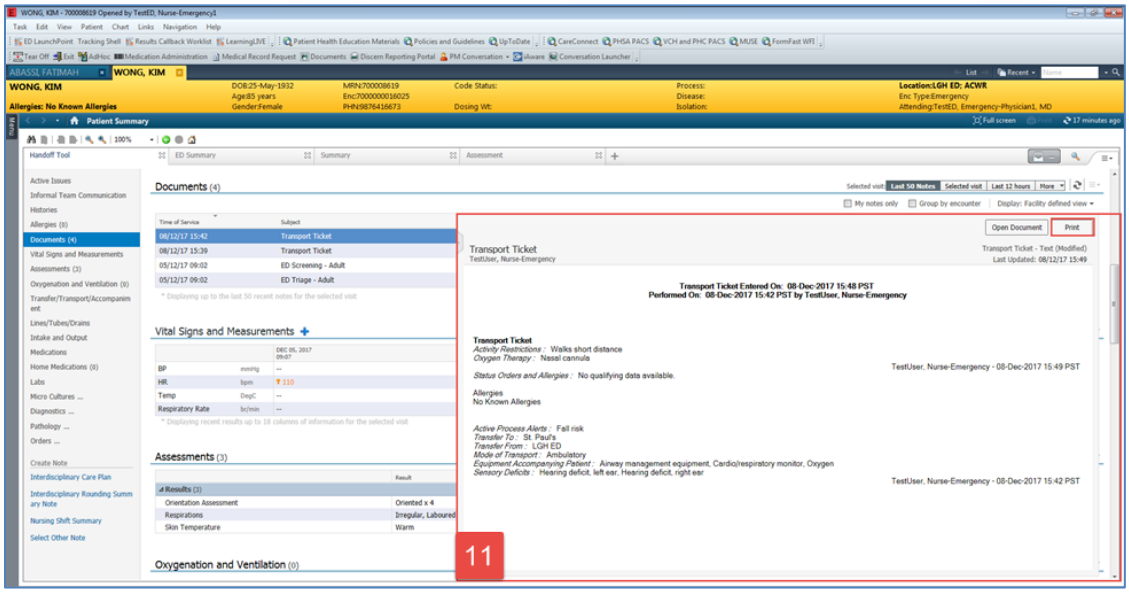


8. You know Ms. Wong came to the department with belongings. Open the Valuables and BelongingsPowerForm with the blue downward arrow to confirm she has everything with her.
9. When you are finished with each PowerForm, be sure to sign with the green checkmark ✔.
10. All completed Powerforms are available for print in the Documents section and the transport is now listed in the patient chart.



11. These documents need to be printed for transport and Unit Clerk is not available.

    Scroll up the patient's chart in the Handoff Tool to the Documents section and click the name of the document to print. A preview window will open with options to Open, Review, or Print.



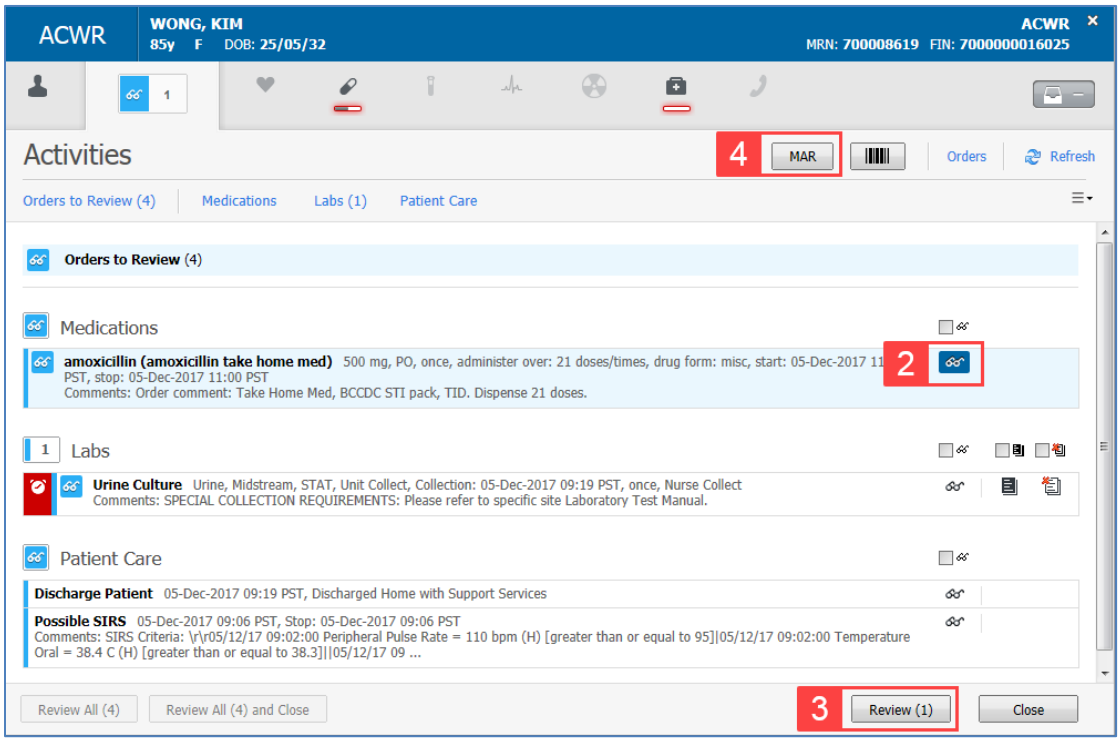
Repeat the same steps to print all of the documents needed for transport.

Activity 3.5 – Nurse Dispensed Medications

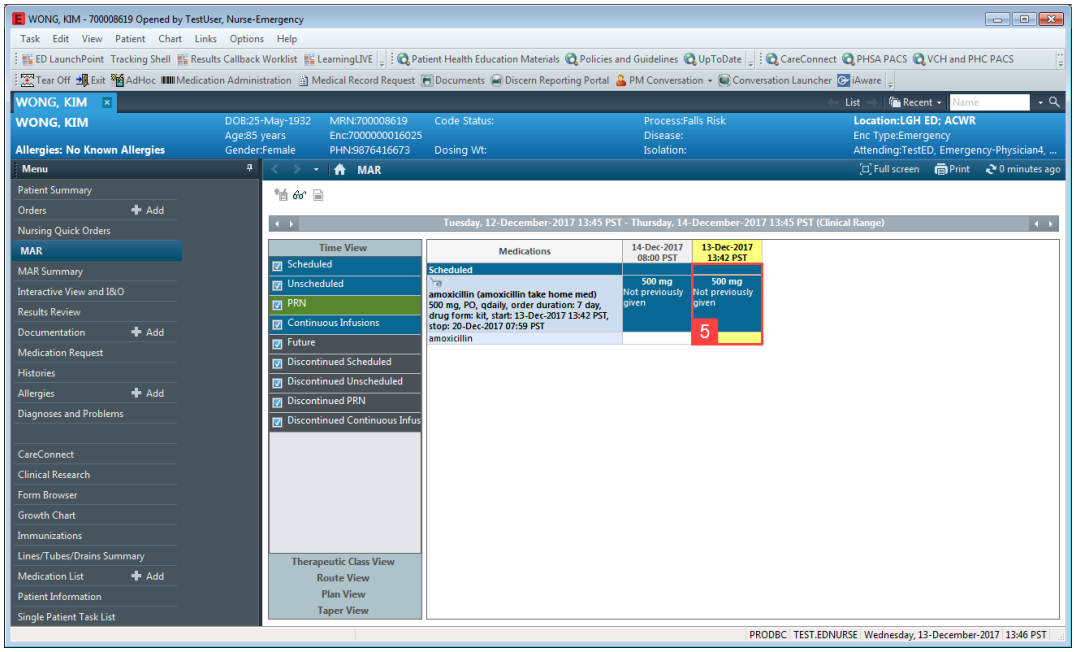
Ms. Wong is ready to be discharged; however she will take home antibiotics. When issuing “Meds to Go”, depending on where you work, you might make a note in the patient’s chart, having a peer sign off distributed meds, or working with the Pharmacy Tech to have meds dispensed for the patient to take home.

In CIS, you document “to go” medications in both a PowerForm and the MAR. Use the following steps to issue Meds to Go for Ms. Wong.

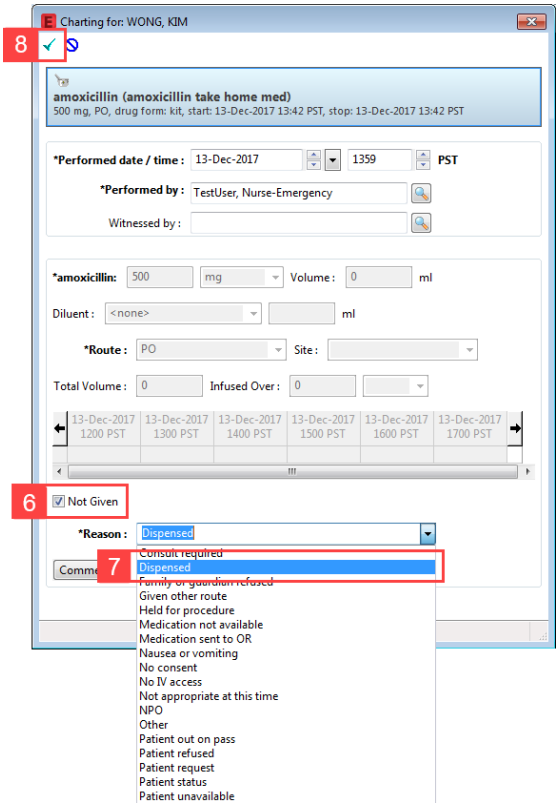
1. Ms. Wong has outstanding tasks in ED LaunchPoint. Click the *Nurse Activities icon* to open Single Patient View.
2. Review the Amoxicillin Take Home Med order.
3. Click the **Review** button**.**
4. Click the *MAR icon* from the Single Patient View to be brought to the MAR.



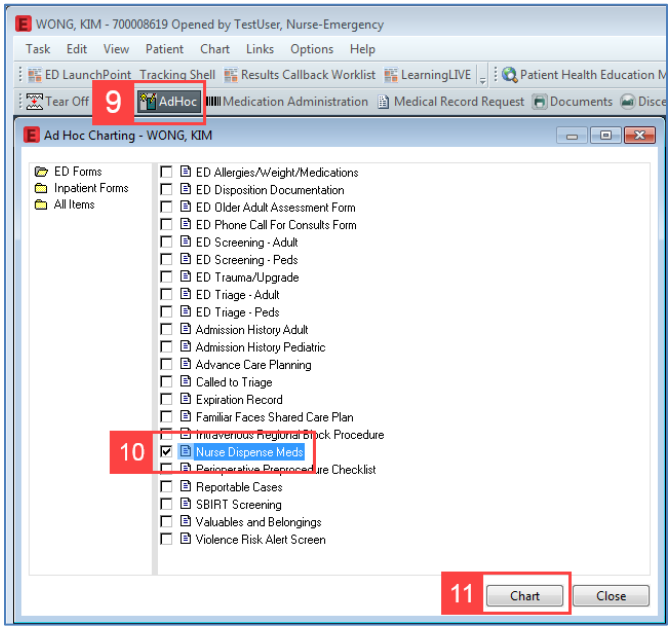
5. Prepare the medications you will be sending with Ms. Wong. Click the field within the **Amoxicillin Take Home Meds** row in the MAR.



6. As you are not witnessing the patient take the medication, check the **Not Given** box.
7. Enter *Dispensed* in the reason field, as the medication was given to the patient.
8. Sign your MAR documentation by clicking the green checkmark in the Charting window.

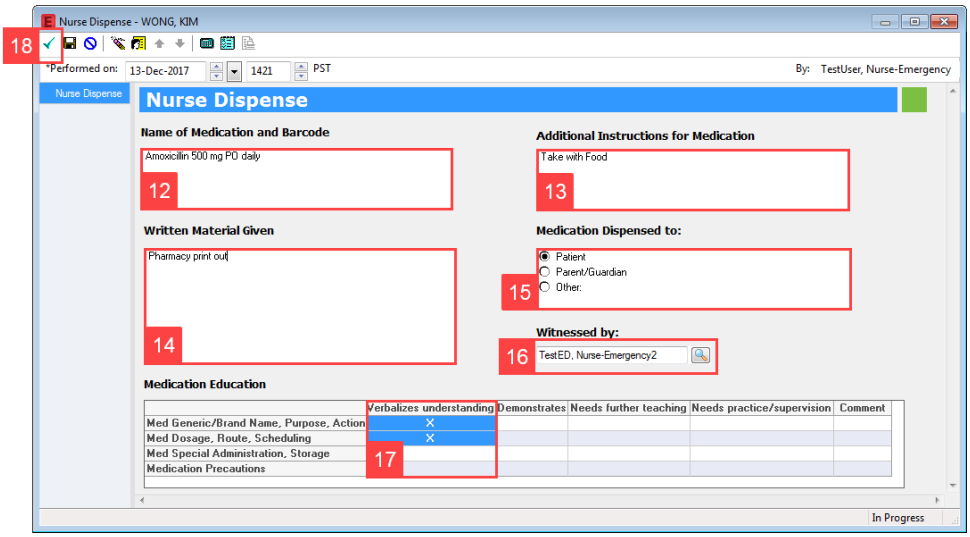


9. Click the *Ad Hoc button* from your Toolbar.
10. Select *Nurse Dispense Meds.*
11. Click *Chart* in the lower right corner.

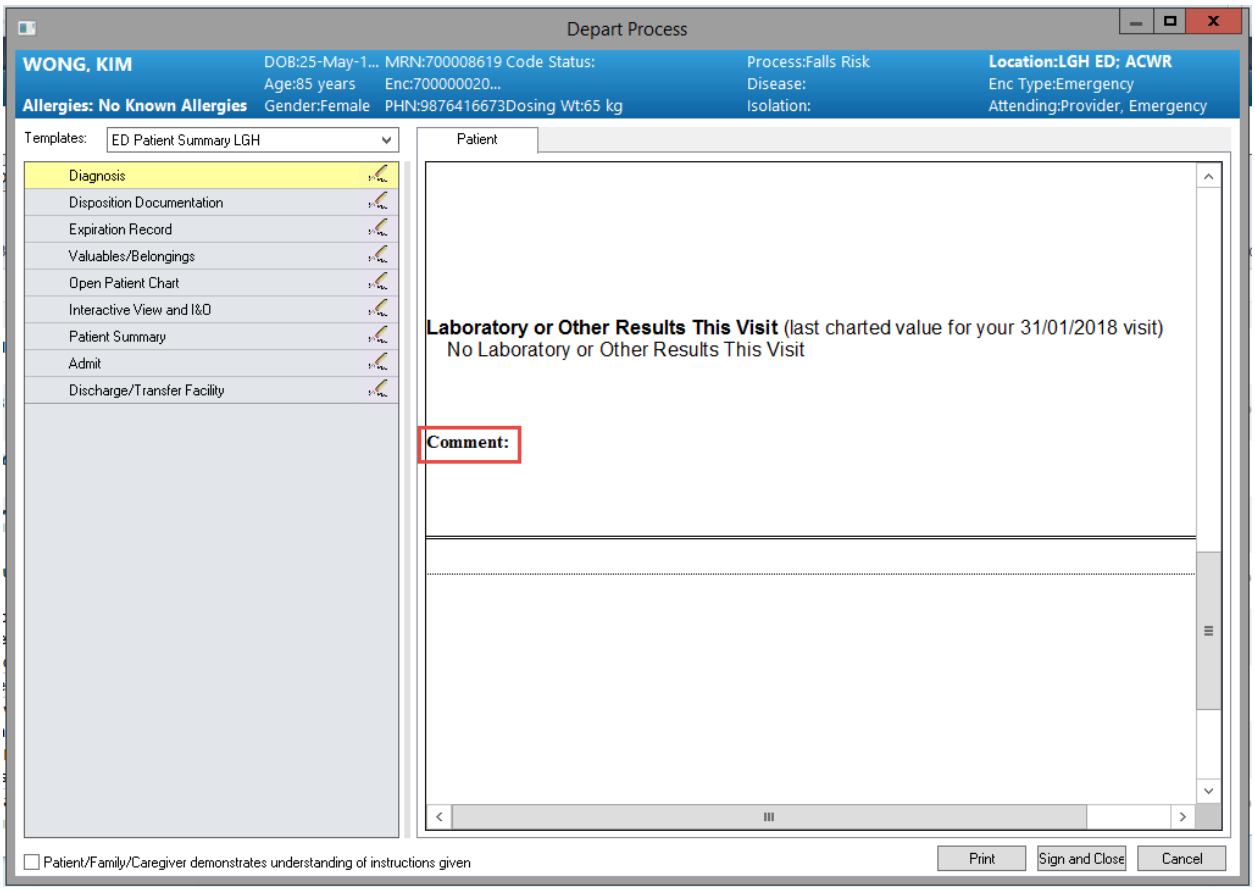


12. Fill in the Medication Name (*Amoxicillin, 500mg tablets*).
13. Enter instructions for the patient (*Take with food*).
14. Note any written material provided (*Pharmacy print out*).

15. Select the person to whom you gave the medication (*Patient*).
16. Enter a peer's name in the "**Witnessed by**:" searchable field to document your witness.
17. Click the relevant fields in the Medication Education section given your patient's age and support needs. An *X* will appear in the selected field. Click again to remove, if needed.
18. Click the green checkmark to sign your documentation.



You have completed documentation for Nurse Dispensed Medications.
When you discharge Ms. Wong, you can click on the "*Comment*" header in the Patient Summary/Instructions page of the Depart Process window if you would like to add more written instructions for your patient. You will have to scroll down to find this section within the Depart Process window.

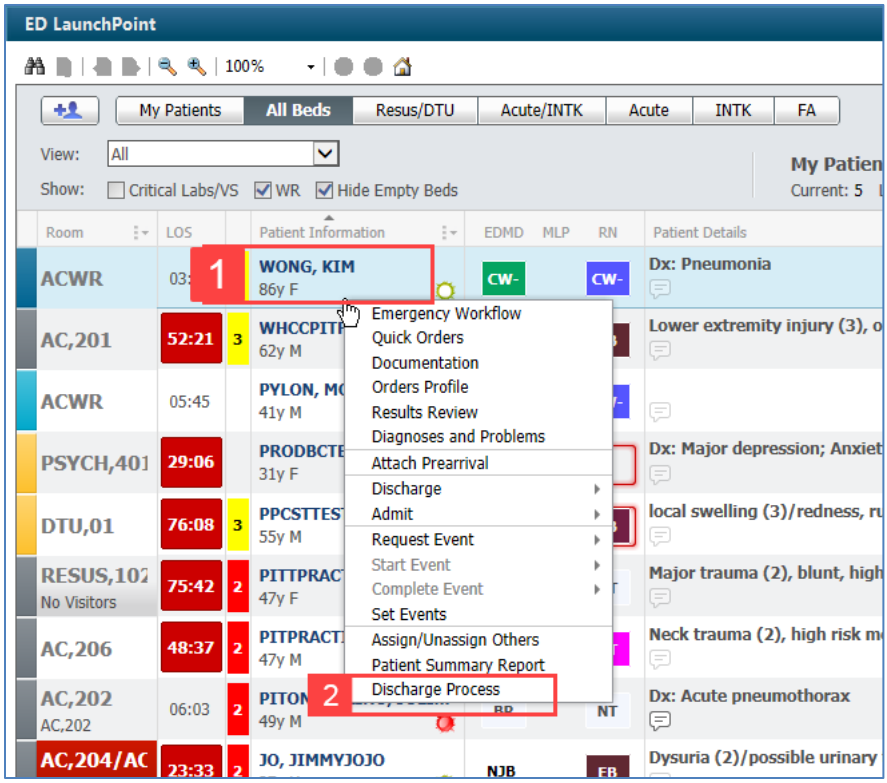

Depart Process
WONG, KIM
DOB:25-May-1...
MRN:700008619
Code Status:
Process:Falls Risk
Location:LGH ED; ACWR
Age:85 years
Enc:700000020...
Disease:
Enc Type:Emergency
Allergies: No Known Allergies
Gender:Female
PHN:9876416673
Dosing Wt:65 kg
Isolation:
Attending:Provider, Emergency
Templates:
ED Patient Summary LGH
Patient
Diagnosis
Disposition Documentation
Expiration Record
Valuables/Belongings
Open Patient Chart
Interactive View and I&O
Patient Summary
Admit
Discharge/Transfer Facility
Laboratory or Other Results This Visit (last charted value for your 31/01/2018 visit)
No Laboratory or Other Results This Visit
Comment:
Patient/Family/Caregiver demonstrates understanding of instructions given
Print
Sign and Close
Cancel

Activity 3.6 – Discharge Process

The ED Physician has visited Ms. Wong and determined she has pneumonia. Dr. Bonilla has prescribed a 7-day course of Amoxicillin and placed an **Order to Discharge**.

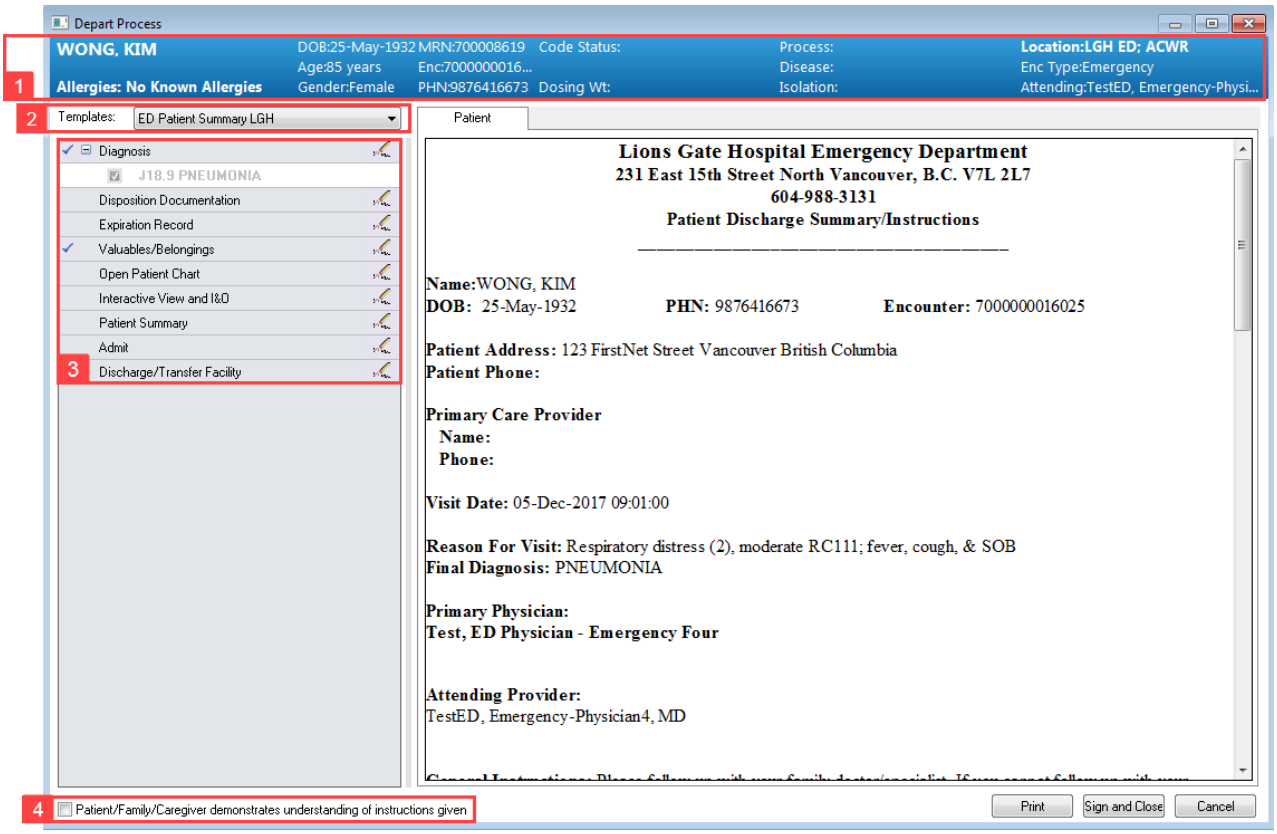
The patient **Status Column** on the far right of the screen indicates readiness to discharge with the  icon. The timer in the icon shows how long a discharge order has been in place.

1. Starting from **ED LaunchPoint**, **right click** on the white space around Ms. Wong's name.
2. From the drop-down list, select **Discharge Process** Discharge Process .



3. The **Depart Process** window opens. All documentation required to discharge Ms. Wong is located here. The components include:

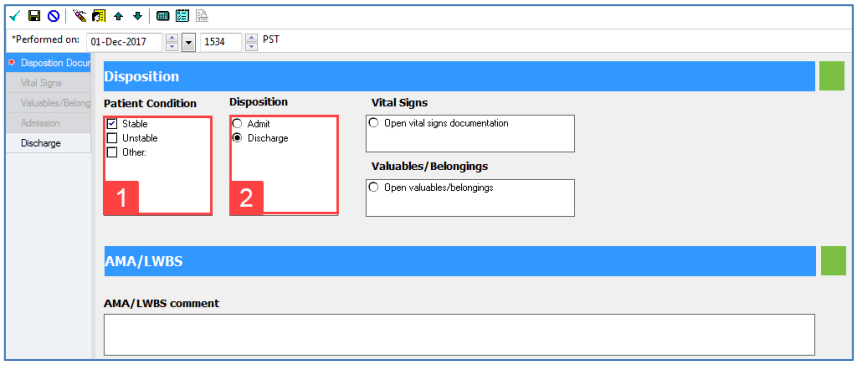
    1. The Patient Banner Bar at the top of the screen ensures important information is available
    2. The **Templates** menu offers a drop-down list of any unit discharge documents.
    3. The sections act as a menu for your discharge documentation
    4. A **Checkbox** where you can confirm you have attended to the patient's discharge instructions. This step is not mandatory, but helpful when discharging patients who need assistance or support.



Review the **Patient Discharge Summary/Instructions**. The information is automatically populated with information from the rest of the chart.

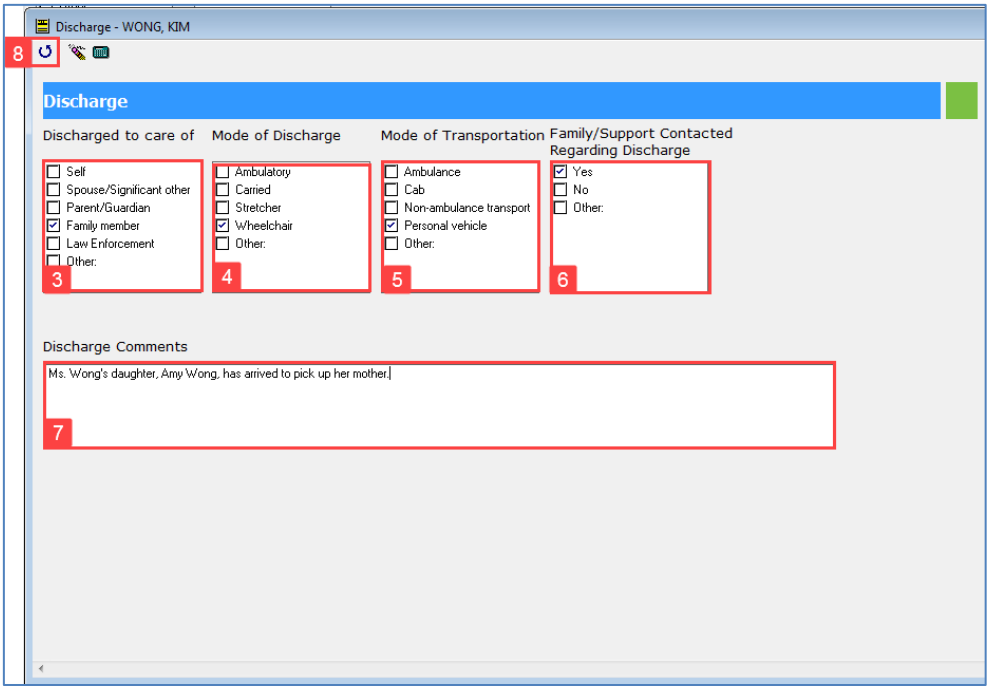
You can review and edit sections of the **Depart Process** window by selecting the **pencil**  icons on the menu. While not always part of a normal workflow, editing discharge information can often be necessary.

1. Click the **pencil**  icon next to **Disposition Documentation** Disposition Documentation .
2. The **ED Disposition Documentation PowerForm** opens. Use the following conditions to fill it out:
    1. Patient Condition: *Stable*
    2. Disposition: *Discharge*

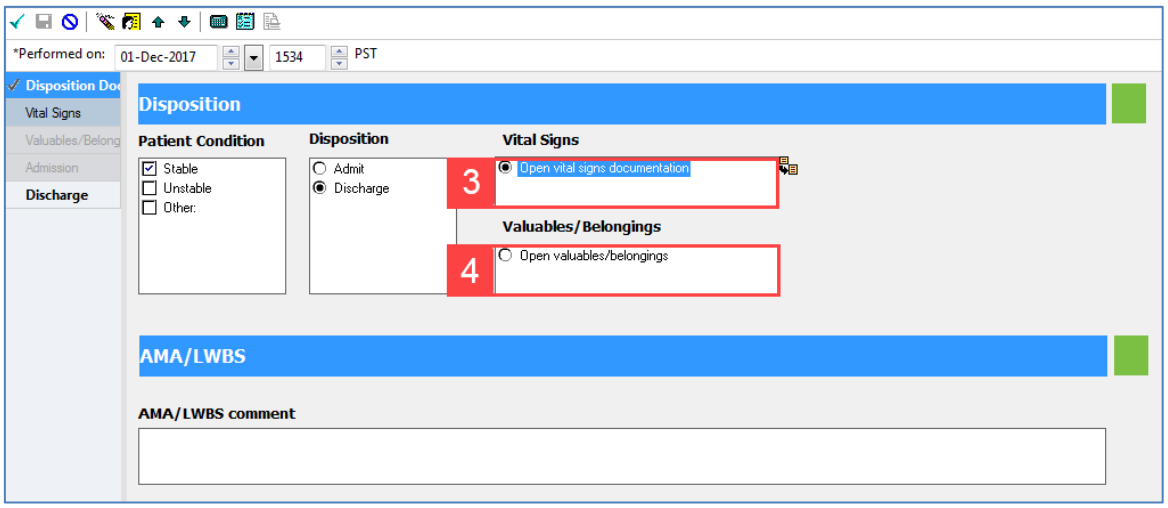


The Discharge PowerForm will open for your documentation:

3. Discharge to care of: *Family member*
4. Mode of Discharge: *Wheelchair*
5. Mode of Transportation: *Personal vehicle*
6. Family/Support Contacted Regarding Discharge: *Yes*
7. Discharge Comments: *Ms. Wong's daughter, Amy Wong has arrived to pick up her mother*.
8. Once you have completed these fields, click the **circular arrow**  to return
9. Click  to **sign.**



3. Click the **Vital Signs** button to **open the vital signs documentation**. Document Ms. Wong's Vitals within normal range. Then, click to **return.**
4. Next, confirm Ms. Wong's Valuables/Belongings. Click the field under **Valuables/Belongings** to **open valuables/belongings** documentation.



Note: Due to Ms. Wong's use of a hearing aid and dentures, the Nurse on the shift prior utilized the **Ad Hoc** AdHoc **Charting** function to document Ms. Wong's belongings. You will notice that the information previously documented has been pulled in to the **Valuables/Belongings** Valuables/Belongings **PowerForm** automatically.

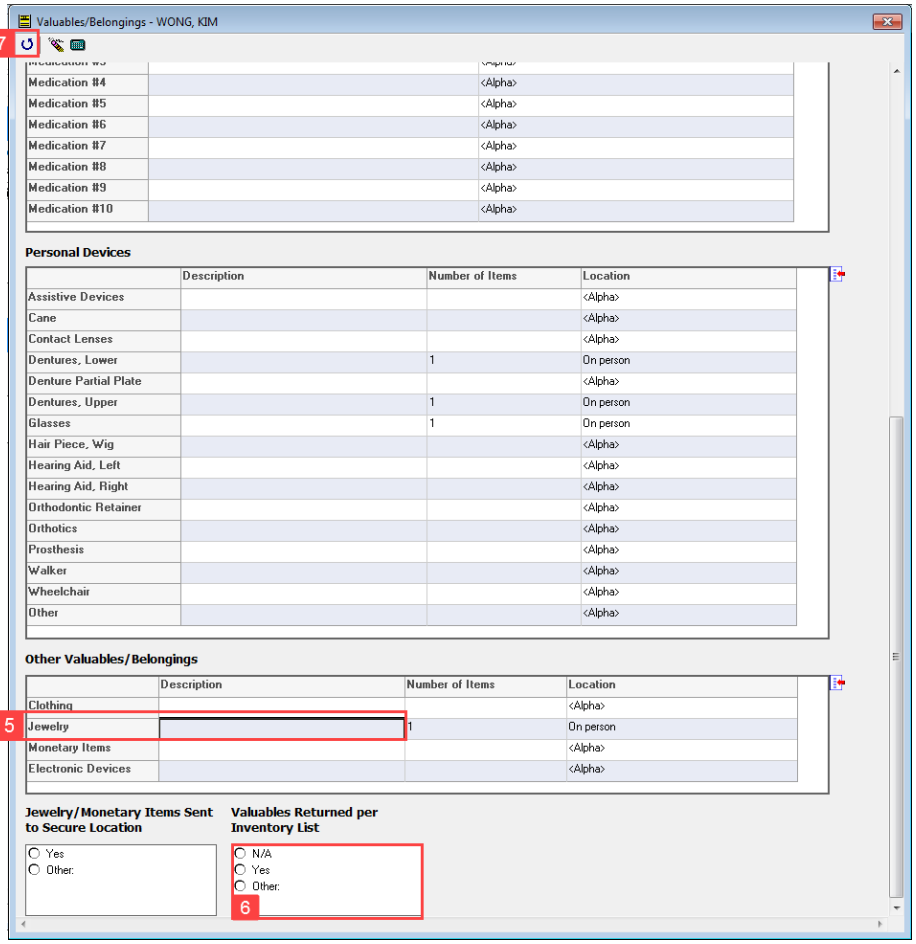
5. The nurse on shift used Ad Hoc charting to document Ms. Wong's belongings, so they should all appear in the PowerForm. Review the belongings that are documented within the **Valuables/Belongings** Valuables/Belongings **PowerForm** to ensure they include the following:

    - Dentures, Lower
    - Dentures, Upper
    - Glasses
    - Hearing Aid, Left
    - Jewelry

You notice that there is no detail regarding Ms. Wong's jewelry. You ask her what she arrived with, and she replies "Only my wedding ring!" You **double-click** the **Description** Description field and an **Add Result Comment** Add Result Comment window opens. Note that Ms. Wong's only jewelry on her person is her wedding ring. Then click **OK** OK. You will now see Ms. Wong's jewelry description updated.

6. Now that you have confirmed all of Ms. Wong's valuables and belongings, click the **Yes** field ◉ under the **Valuables Returned per Inventory List** section as Ms. Wong has all of her items on her person.

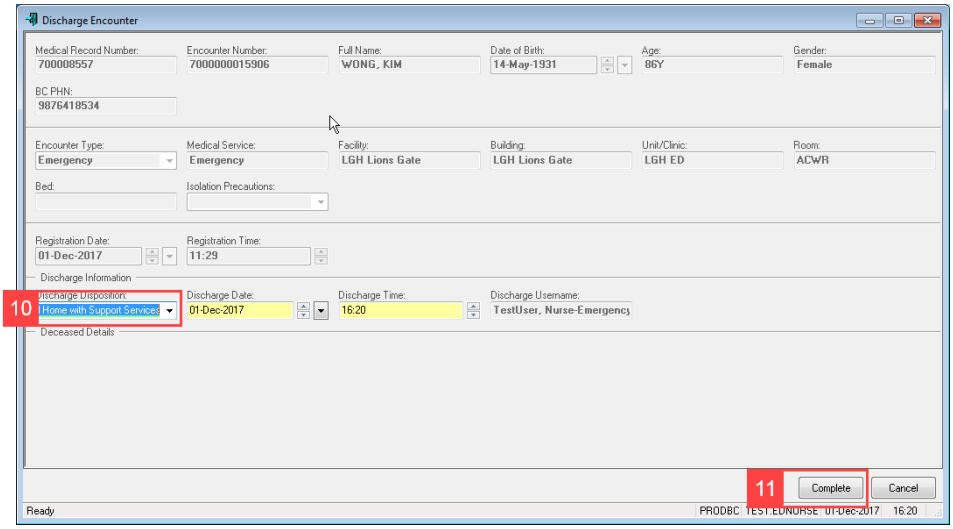
7. Click the return icon ↺ to return to **Disposition Documentation.**



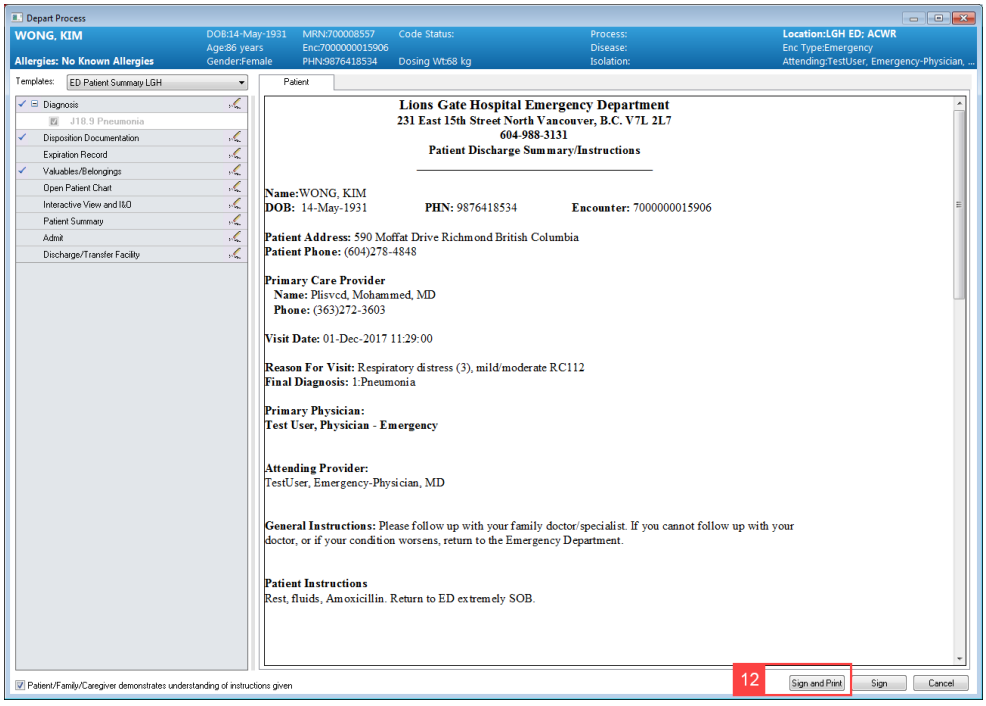
8. Click the **green checkmark** ✓ to **Sign** your documentation.

9. Click the pencil ✎ next to **Discharge/Transfer Facility**.

10. On the next screen, choose *Discharged Home without Support Services* from the **Discharge Disposition** drop down menu, as she is receiveing no formal community supports.
11. Click **Complete.**



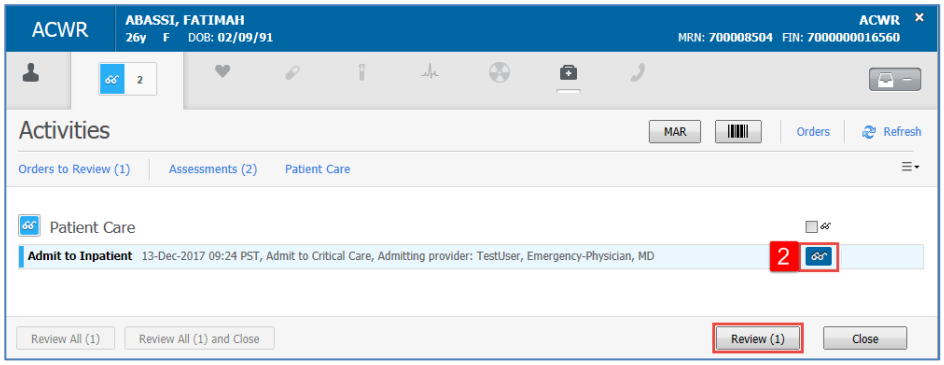
12. If you have additional comments to add to the Patient Discharge Summary/Instructions, scroll down this window and double-click on the section heading "*Comment"* to enter free text instructions. Then, click **Sign and Print** to discharge the patient and print instructions.



You will learn how to admit a patient to the inpatient unit in the next section.

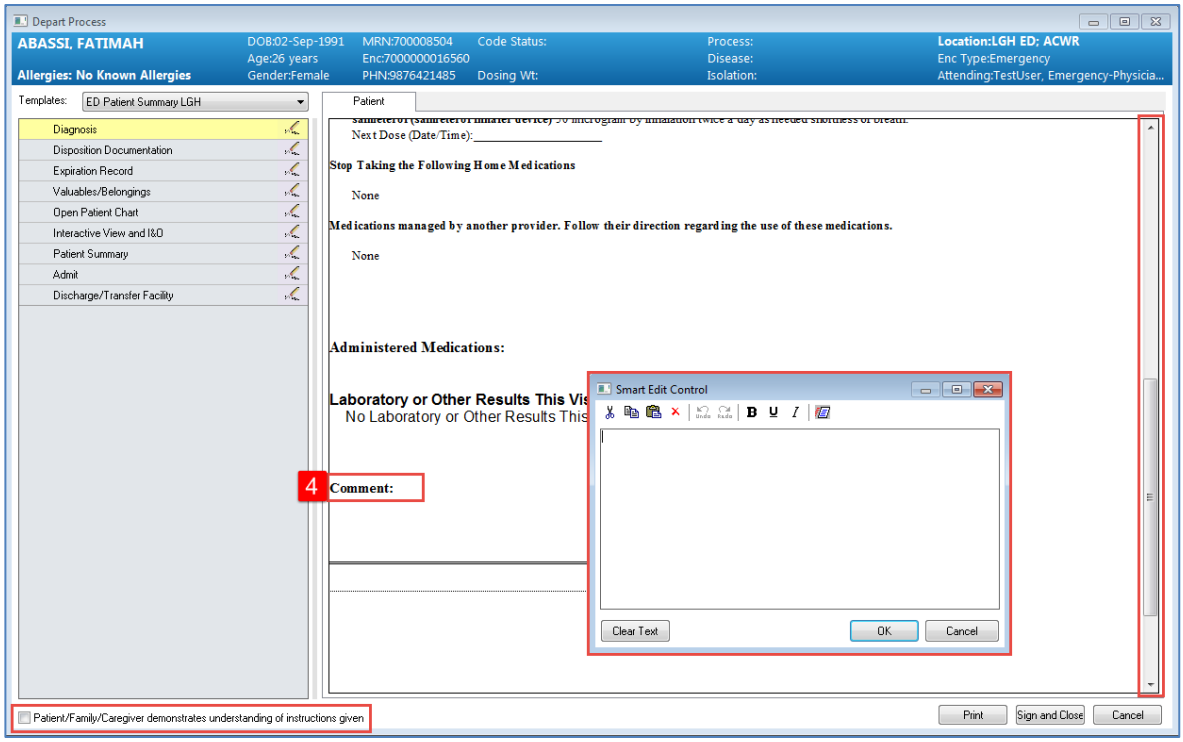
Activity 3.7 – Admit to Inpatient

1. You notice outstanding activities for Ms. Abassi. Click the Activities icon to open the Single Patient View. You see that Dr. Hong decides to admit Ms. Abassi to Critical Care.
2. Click the eyeglasses icon to review the Admit to Inpatient Order, and then click **Review**.



3. Close the Single Patient View and right-click on Ms. Abassi's name and select **Discharge Process**. In CIS, the process to discharge or admit a patient is often referred to as the "Depart Process."

4. As mentioned in the previous activity, in the Patient Discharge Summary/Instructions section scroll down and click on the word "*Comment"* to add instructions for your patient. Any comments you provide will be available to the patient when they are ultimately discharged from hospital on their discharge documentation.

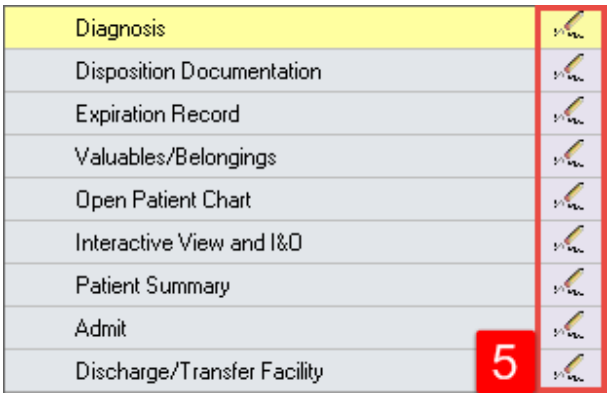


The Depart Process window has a banner bar to ensure users are charting on the right patient, for the right encounter.

5. Click the pencil icon  to edit sections as needed. Use the following information to document in the different sections of the Depart Process window:

- **ED Disposition Documentation**:
- Patient Condition: *Stable*
- Disposition: *Admit*
- **Admission Window**:
- Nurse Receiving Report: *Amy Tan, NP*
- Lines Traced to Source: *Yes*
- Orders Reviewed: *Yes*
- Patient ID band on and verified: *Yes*
- Allergy Sticker on and verified: *Yes*
- Transfer to: *LGH Critical Care*
- Mode of Transport: *Stretcher*
- Transportation Equipment: *IV pole*
- Accompanied by: *Porter & Nurse*
- Vital Signs: *document current vs*

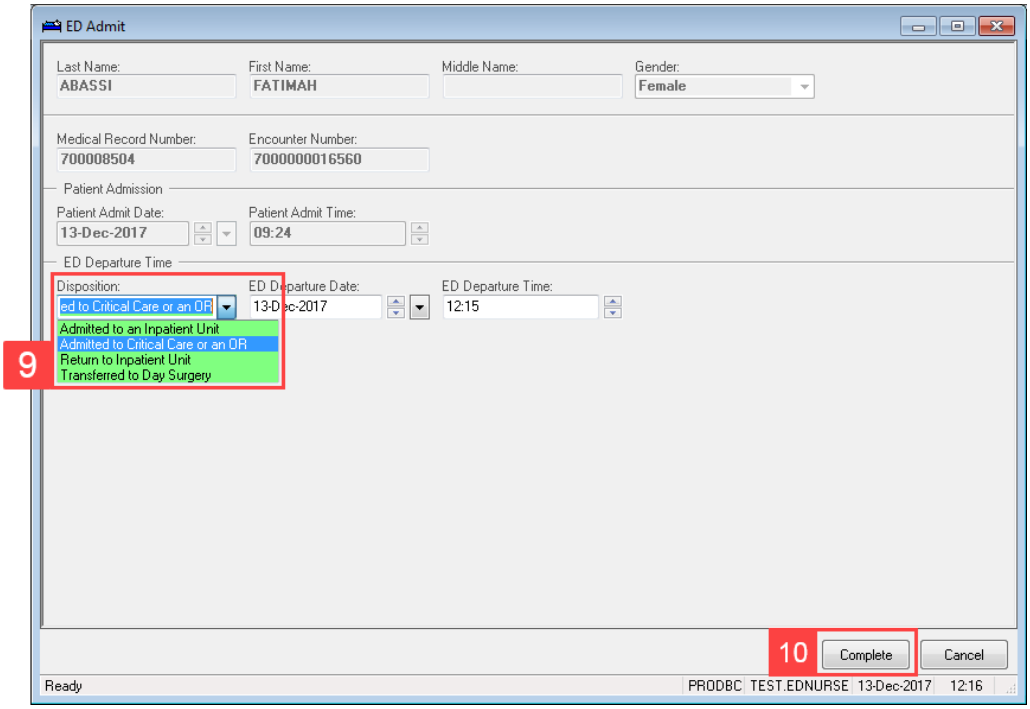
- Valuable/Belongings: *None. Family took home*



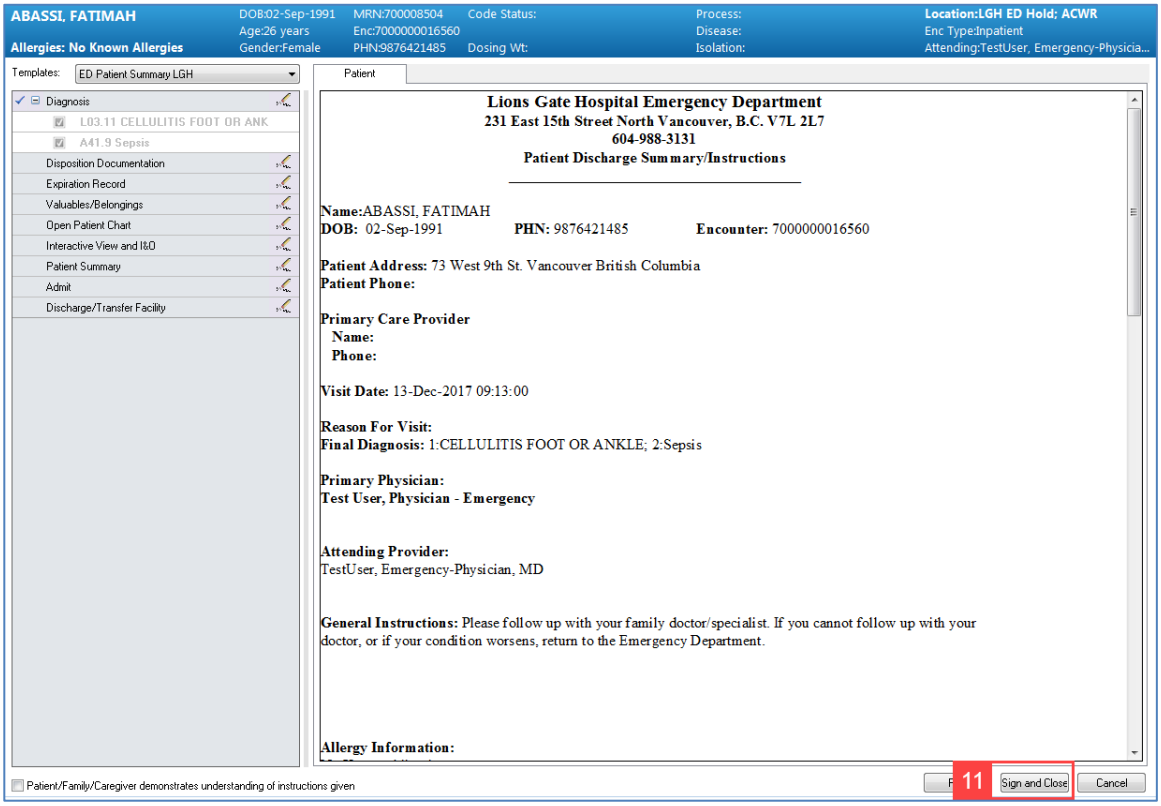
6. Sign ✓ each section before proceeding to the next.

   Review the Patient Summary to ensure the documentation on this patient is correct.

7. Click the **pencil icon** beside the Admit band to finalize the admitting process.
8. The ED Admit window will appear. Remember, sections highlighted in yellow are mandatory fields.
9. From the Disposition drop-down list, select *Admitted to Critical Care or an OR*. If the patient will not be moved for some time, estimate the expected departure time.
10. Click **Complete** in the lower right corner.



11. You will return to the Depart Process window. Click **Sign and Close.**



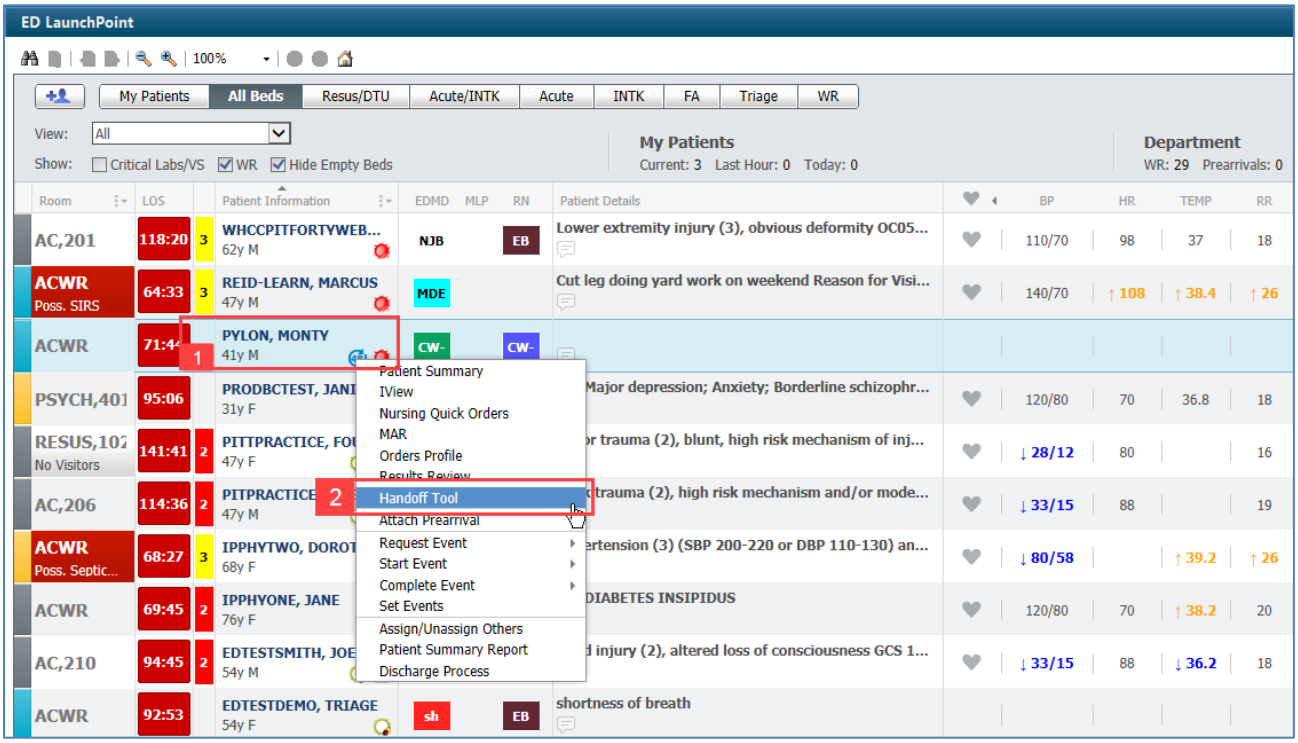
You have now successfully completed the Depart Process to admit this patient to Critical Care. The Unit Clerk will see this patient is waiting for transfer to Critical Care. The patient will fall off your ED LaunchPoint screen, but will remain on the Tracking Shell (visible in the department) for 48 hours.

Activity 3.8 – Nursing Handoff Documentation

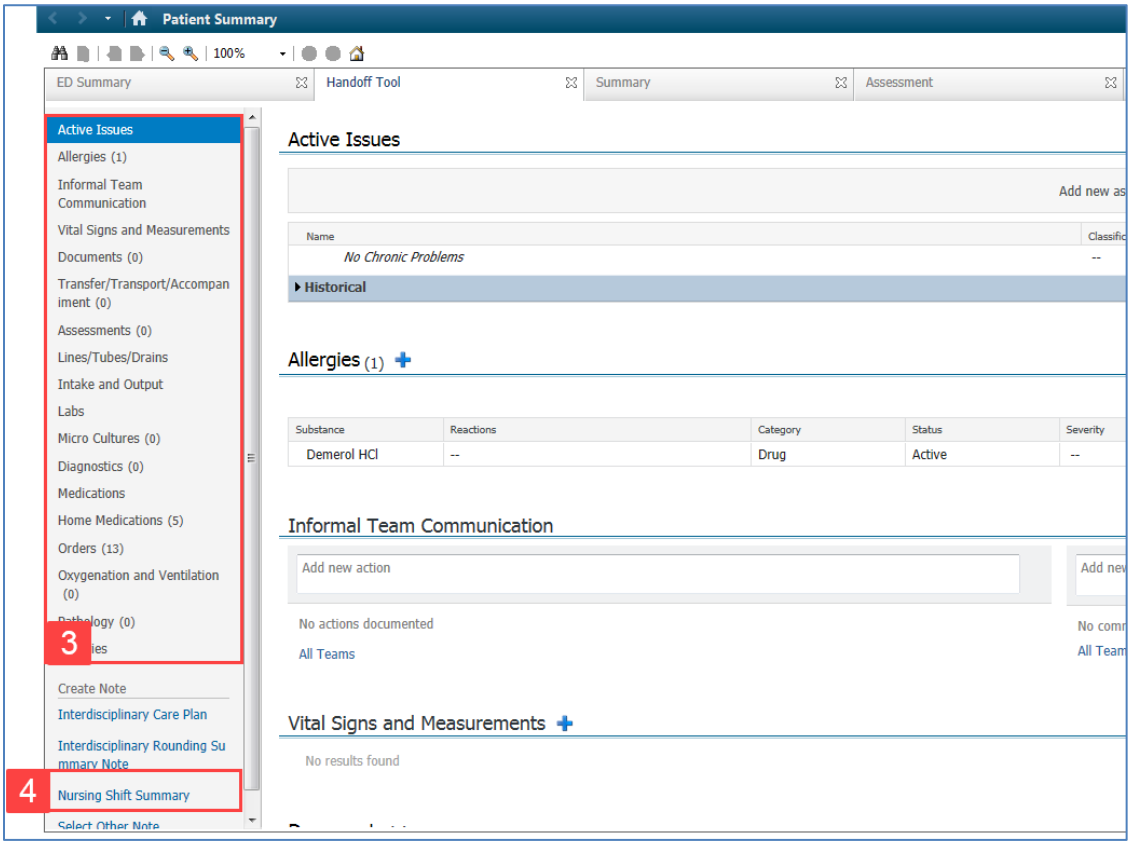
It's the end of shift, and time to report to the oncoming nurse. The **Handoff tool** offers a summary of your assignment to assist in transferring care.

To begin documenting the **Handoff** process:

1. Right-click on the white space around Monty Pylon's name in **ED LaunchPoint.**
2. Select **Handoff Tool** on the drop-down menu.



3. With a peer, review the sections within the **Handoff Tool.** You can skip sections using the Menu on the left. **Refresh** will bring up any important results you are waiting for.
4. Though this may not follow your typical workflow, you can use the **Create Note** function at the bottom of the menu to create a shift summary. Click **Nursing Shift Summary**.



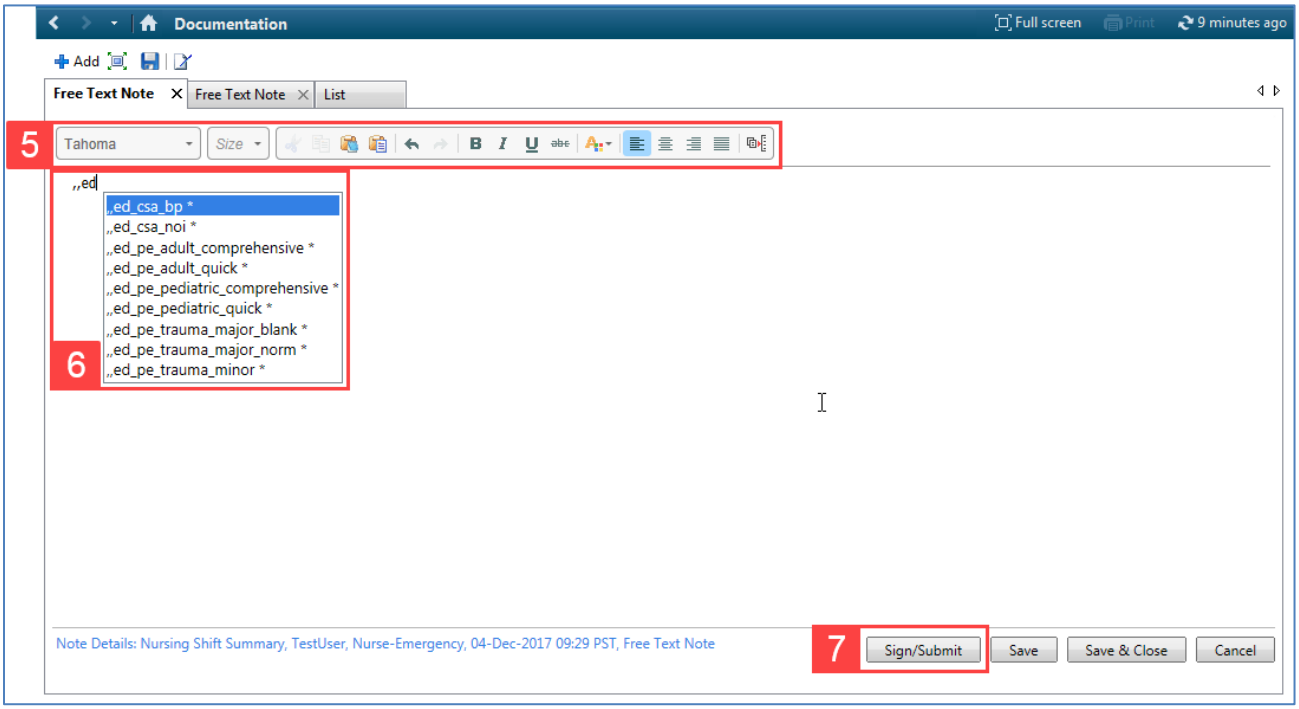
5. You will be brought to the **Documentation** section of Monty's chart. Using the information you've just reviewed with your peer, create your **Nursing Shift Summary**.

   Note: If you feel like you need to paint a picture of your patient's care, you can also use the **Nursing Shift Summary** Note or, for more complex cases, the **Nursing Shift Summary, Treatment Record** Note. Hovering over the icons on the toolbar will give you different options to highlight or format your documentation.

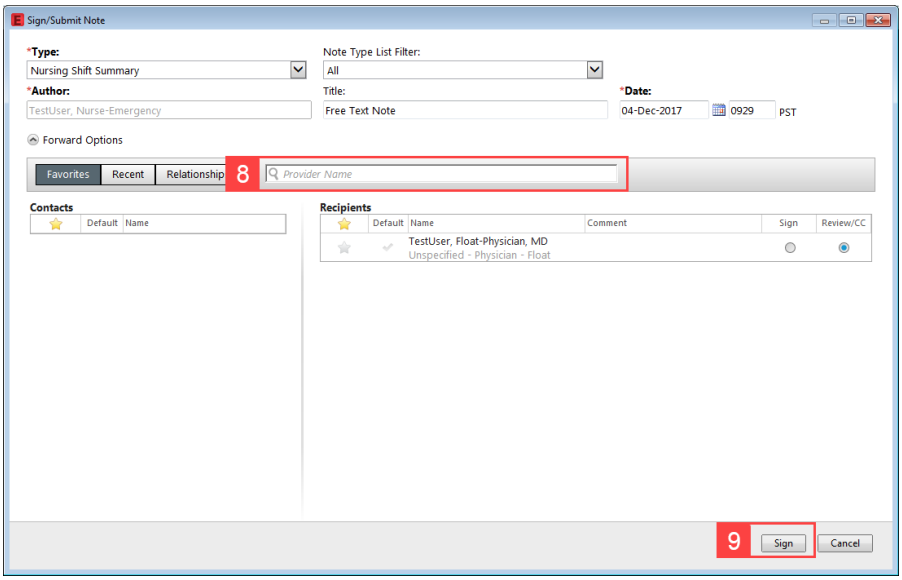
6. Typing ",," will bring up a menu of auto-text statements based on standards developed among health authorities. To narrow the field, start typing the area you'd like to note after the double-commas (ie. *",,ed"*). The field auto-populates with normal findings, so you will have to change any abnormal headings.

7. Once you have completed your **Nursing Shift Summary**, click **Sign/Submit** 

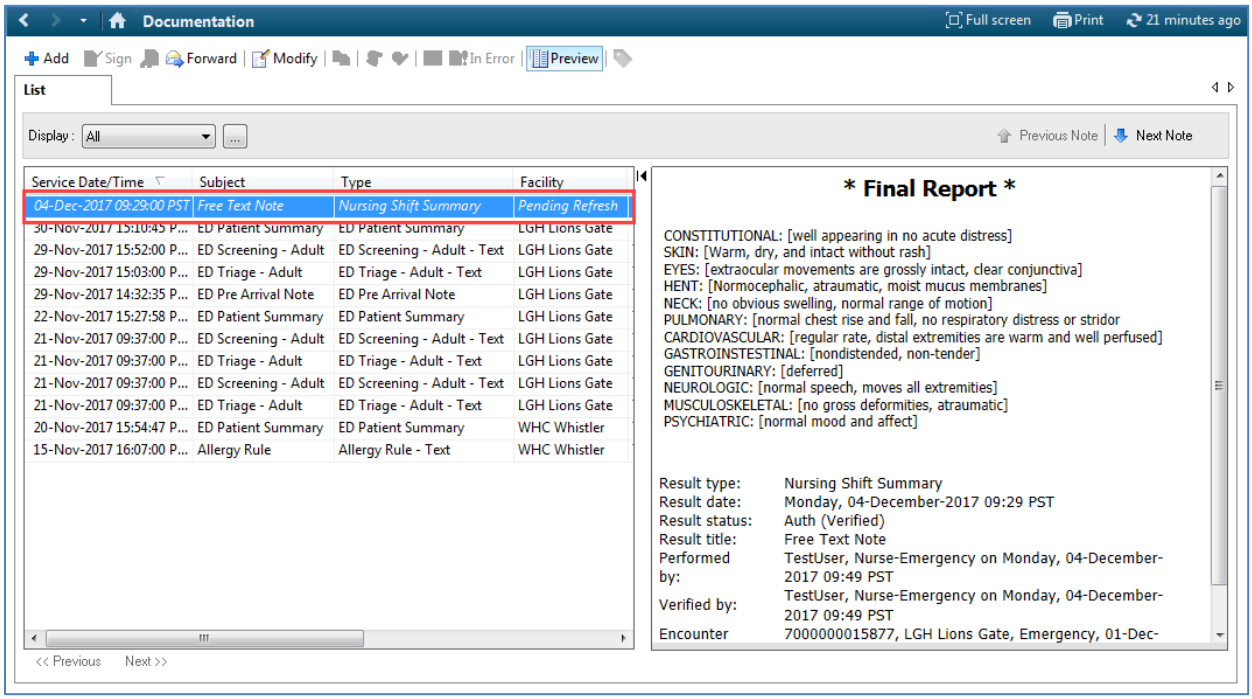
.



8. A pop-up **Sign/Submit Note** will give you the option to forward your note to a Provider. For this activity, enter a peer's name within the **search bar** and select the appropriate name from the list that appears.
9. Click **Sign**



Your **Nursing Shift Summary** Nursing Shift Summary will now be displayed in the **Documentation** section of Monty's chart. You can **modify** your documentation later, if needed. An electronic 'stamp' shows the changes you made and identifies a modification has been made, similar to drawing a line through and initialing errors on paper charting.



Patient Scenario 3 Summary: Key Learning Points

Activity 3.1 Process Alerts

- Process Alerts will display in a patient's Banner Bar, in the room column, and/or in the Patient Information column
- Click the arrow next to the PM Conversation 

button in the Toolbar to add a Process Alert. Be sure you have the right facility/unit selected

Activity 3.2 Nurse Specimen Collection

- The Nurse Activities column indicates any outstanding tasks remaining
- Clicking the task number icon will open single patient view, allowing you to review and document any lab specimen collection you performed
- Point of Care specimen collection should be documented in iView

Activity 3.3 Results Review

- The Results Review page is where all patient-related results are displayed
- Different tabs can be used to view specific results
- The graphing icon is used to easily visualize changes over time
- The Seeker icon helps navigate the Results Review page

Activity 3.4 Patient Transport Ticket

- Ticket to Ride is used for when a patient requires transport
- When completing Checklists, double-click a column-header to select all line items deselect or modify as needed
- Use the <MultiAlpha> fields to provide a list of equipment and supplies specific to this patient's care needs
- Chart printing can be done through Medical Record Request
- To print, scroll up the Documents section and click the name of the document to print

Activity 3.5 Nurse Dispensed Medication

- Document Meds to Go in a PowerForm and on the Medication Administration Record (MAR)
- Use the AdHoc Nurse Dispense PowerForm to document a peer witness for medication dispense
- Click on the "*Comment"* header within the Depart Process window to document additional administratio**n instructions for your patient**

Activity 3.6 Discharge Process

- Once a discharge order is given, the patient's **Status** column icon will change
- Use the pencil icons to fill out discharge charting as necessary
- Some fields will automatically populate from items in the patient's chart
- The **Discharge/Transfer Facility** fields must be filled out to successfully discharge a patient

Activity 3.7 Admit to Inpatient

- The Discharge Process ("Depart Process") is used to admit patients
- In the Depart Process window, click the pencil icon to edit sections as needed
- To finalize the admitting process click the pencil icon beside the Admit band
- Estimate the expected departure time when an admitted patient is awaiting for a bed

Activity 3.8 Nursing Handoff Documentation

- The Handoff tool summarizes patient information to help with handover reports
- The menu allows you to skip irrelevant sections in the report
- Nursing Shift summary Notes can be compiled from information in the patient chart with greatly reduced typing using the auto text feature

PATIENT SCENARIO 4 – Documenting a Critical Scenario

Learning Objectives

- Review Quick Reg
- Review Triage
- Back-Entry of Medications
- Back-Entry of Medical Interventions and Fluid Balance
- Nursing Shift Summary

You have explored the basic functionality of FirstNet, and will now learn how to apply these skills in a trauma scenario as well.

When a critical trauma comes onto the unit, you will use your clinical judgement to decide what is necessary.

Any charting your team needs to do on paper will be scanned into the system by Health Information Management (HIM), so the electronic record accurately depicts the patient's care. "Back-entry" for Ins & Outs, continuous infusions, and a Nurse Shift Summary explaining that you had to resort to paper documentation, and why, will be necessary. The ED Provider will document a summary of the care provided, coupled with your documentation and the scanned paper record, will provide a cohesive report of the care your patient received while avoiding duplicate documentation as much as possible.

SCENARIO

Paramedics rush into the ED with a patient involved in a high speed MVA.

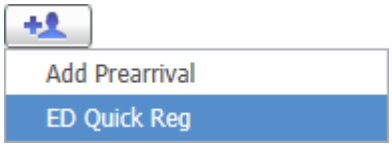
Patient presents with neurological symptoms including dizziness, nausea, and visual changes. Possible haemothorax, pelvic fracture, and numerous cuts and abrasions. Vital signs collected in the field: BP 98/palp, P 130, RR 30. Most of the external bleeding was controlled, but any relief of pressure causes the bleeding to restart.

She is taken directly to the Resus room and work begins rapidly.

Activity 4.1 – ED Quick Reg

1. ED Quick Reg the patient. While your colleagues work on the patient, you gather basic information from the paramedics.

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



2. Enter the following information into the Person Search window and then click **Search**:

   Last Name: *McDowell*

   First Name: *Tanya*

   DOB: *15-JUL-1980*

3. Click the **MPI Search** button to search for previous encounters in the provincial system.

   Click the **Add Person** button to enter Tanya into the system.

4. The External MPI window will appear. Enter the following information into the External MPI window and click **Submit**.

   Sex: *Female*

   Address 1: *122 Main Street*

   City: *Vancouver*

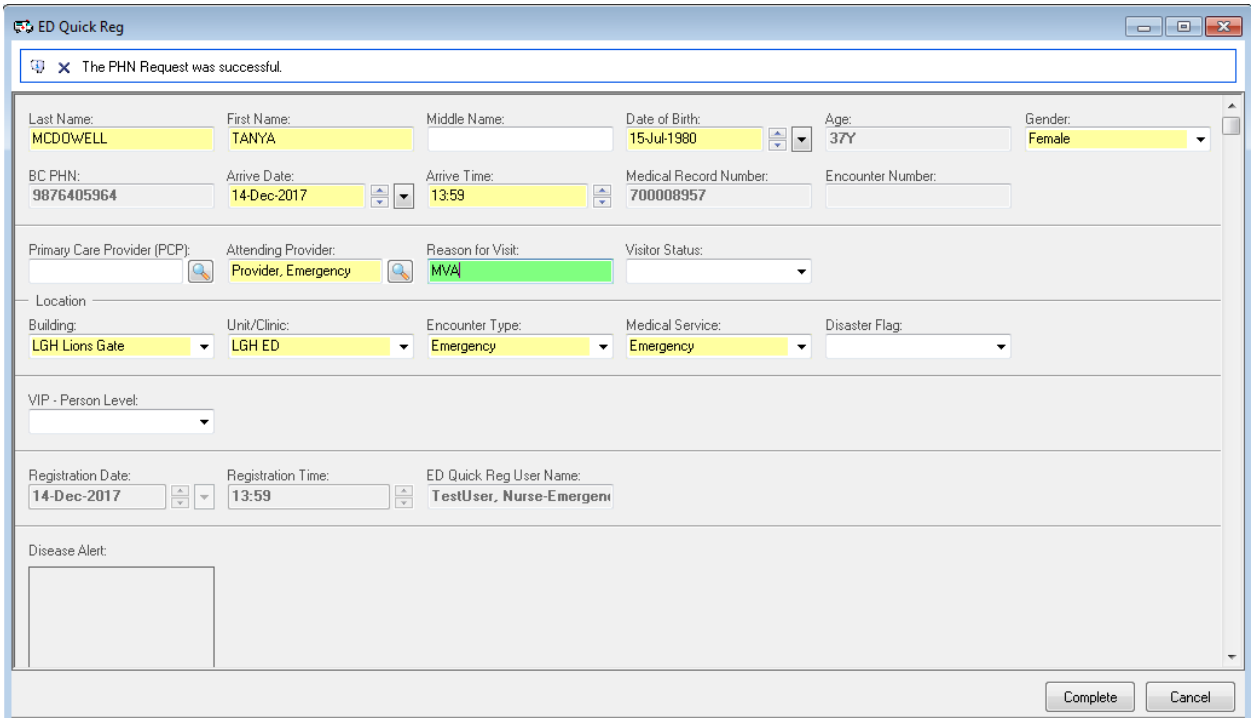
   Province/State: *British Columbia*

   Remember, only the yellow fields are mandatory.

5. The ED Quick Reg window will open.

   As this is a trauma situation, only enter mandatory information. Enter *MVA* as the Reason for Visit, and then click **Complete** in the lower right corner.

   Note: If your patient will be immediately triaged, you do not need to complete the Reason for Visit as the patient's chief complaint will be documented by the Triage Nurse.



6. The Document Selection window will open where you can print the patient's armband label, lab blood specimen label, lab non-blood specimen label, and facesheet.

7. Tanya appears on the ED LaunchPoint Multi-Patient List. Click in the **Assignment column** to assign yourself as Tanya's Nurse. When done, your initials will appear.

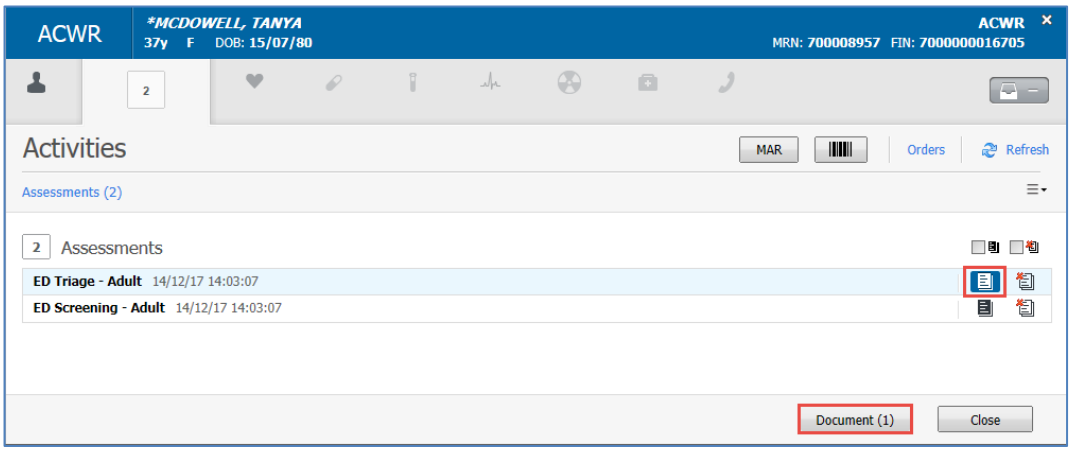
Activity 4.2 – Triage

The ED Quick Reg process is complete for Tanya. You will now Triage her by completing the minimum required documentation.

At any point in time, you can resort to paper documentation if you decide this is what the patient needs.

Let's complete Triage documentation, reflective of Tanya's status as a critical patient.

1. From the ED LaunchPoint screen, click the number **2** in the Nurse Activities column for Tanya McDowell.
2. The Single Patient View window will open. Click the **Document icon** next to the ED Triage-Adult Assessment and click **Document (1)** in the lower right corner of the window.



In this instance, you will not be attending to the ED Screening-Adult documentation as your colleagues are documenting their rapid assessment of Tanya on paper.

3. Completing only minimal documentation, enter the following information and then click the **green checkmark** ✓ to sign your Triage documentation:

    Chief Complaint: *MVA, Hypotensive Trauma*

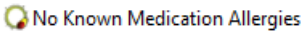
    Travel Outside Canada last 30 days: *Unable to Obtain*

    Direct to Care Space: *Yes*

    ADE Risk Screen: *Unable to Obtain*

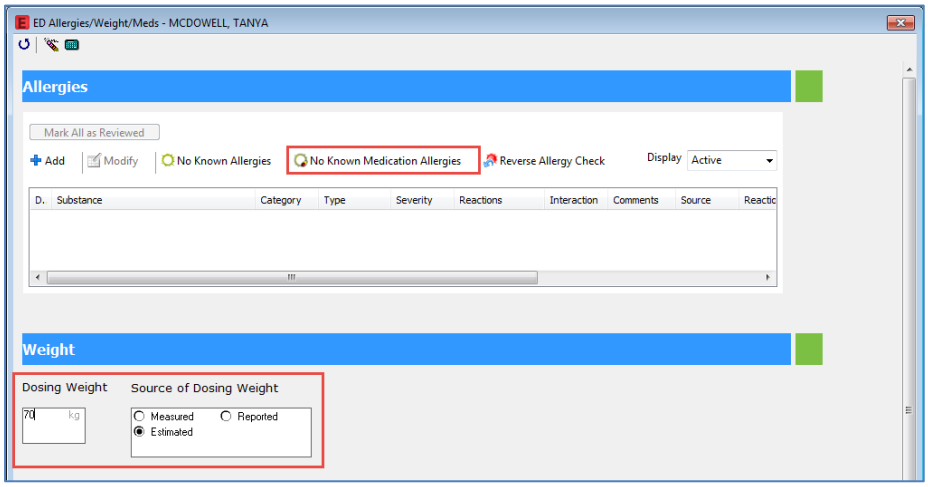
4. Under Allergies/Home Medications, select **Document Assessment**.

   The ED Allergies/Weight/Meds window will appear.

   Click the **No Known Medication Allergies** icon 

   This will prompt an Allergy window to appear, click **OK**.

   Input patient's weight: *70kg, Estimated*



When complete, select the **Circle Back** icon in the top left corner to return to the Triage PowerForm.

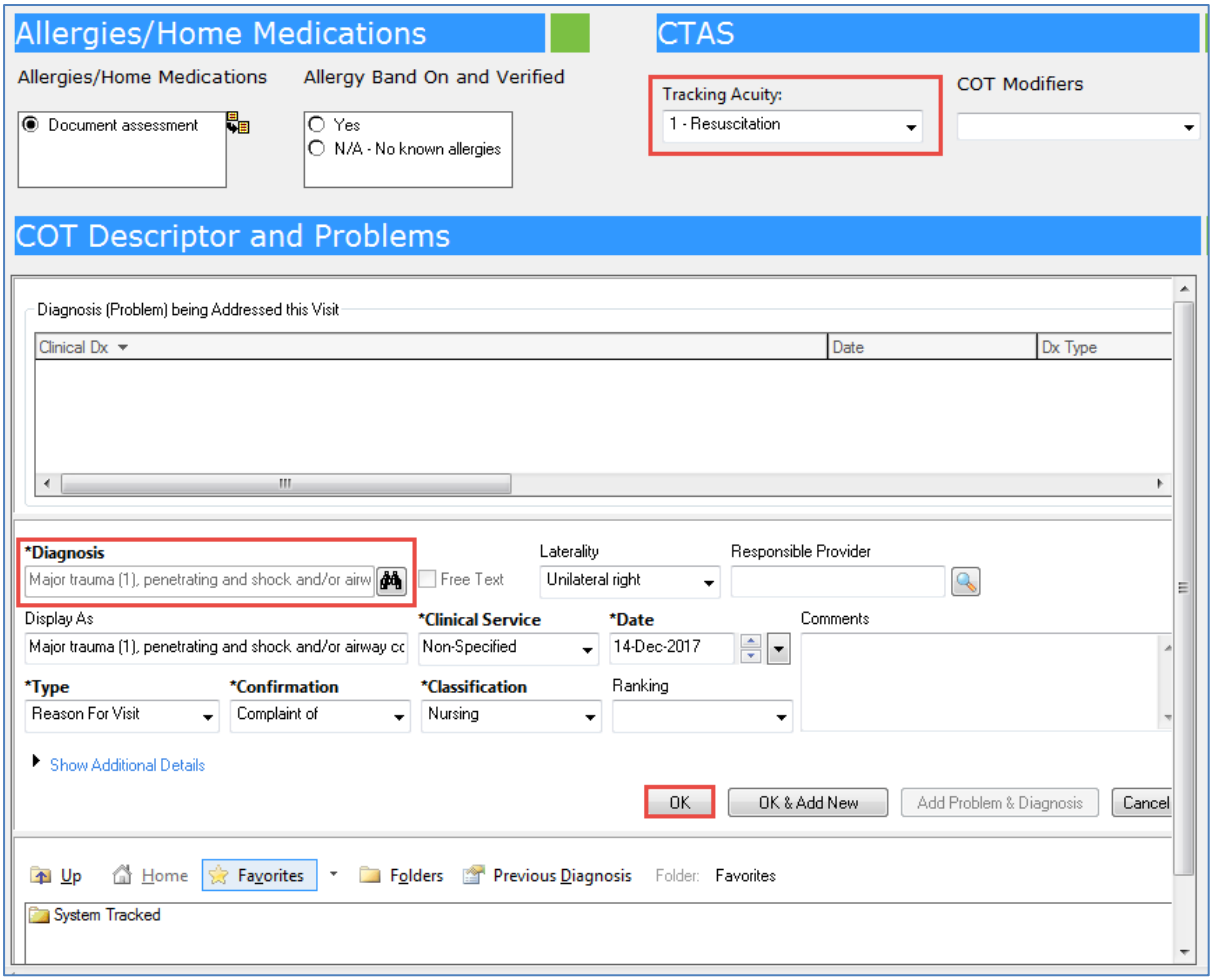
You will notice an icon appear. This indicates the information you entered in the ED Allergies/Weight/Meds window is being used to populate other fields on this form.

5. Under **COT Descriptor and Problems**, click the **Add icon** 
.

   Search and select *Major trauma (1) penetrating and shock and/or airway compromise TR001*. Ensure to select **OK** or you will be unable to complete the Triage form.

   Set the Acuity Score to 1 (as indicated in the bracketed number (1) within the COT Descriptor).

   Do not scroll with your mouse once you have selected the CTAS as you will change the CTAS score.



Click the **green checkmark** ✓ to sign your Triage documentation

Activity 4.3 – Back-Entry of Medications

At this point in Tanya's care, her blood pressure drops significantly so you resort to paper documentation.

Once Tanya's condition is stabilized, you return to the system to document a summary of Tanya's care, any continuous infusions, and a summary of the Ins & Outs. You received verbal orders from the Provider, started an IV, intubated your patient, and went through your trauma protocol. Only documentation of care needs that continue and a brief summary of the out of system care provided is required.

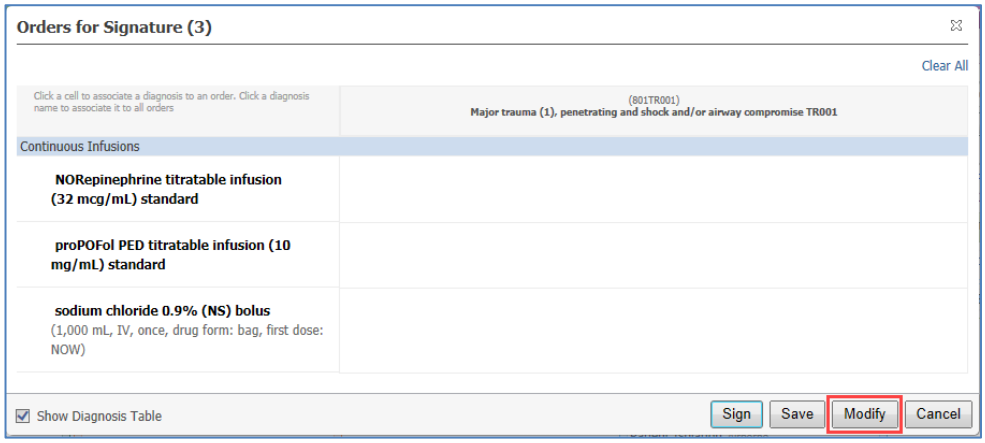
1. Document any continuous infusions so the oncoming Nurse knows to carry on these orders. From ED LaunchPoint, right-click on Tanya's name and select Nursing Quick Orders to document any verbal orders that will need to continue.
2. In the New Order Entry search field, type *NORepinephrine* and select **NORepinephrine titratable infusion (32 mcg/mL)**.

   This order will be added to your Orders for Signature Inbox 

.
3. Search and select ProPOFol titratable infusion (10mg/mL). You will modify the Order Details:

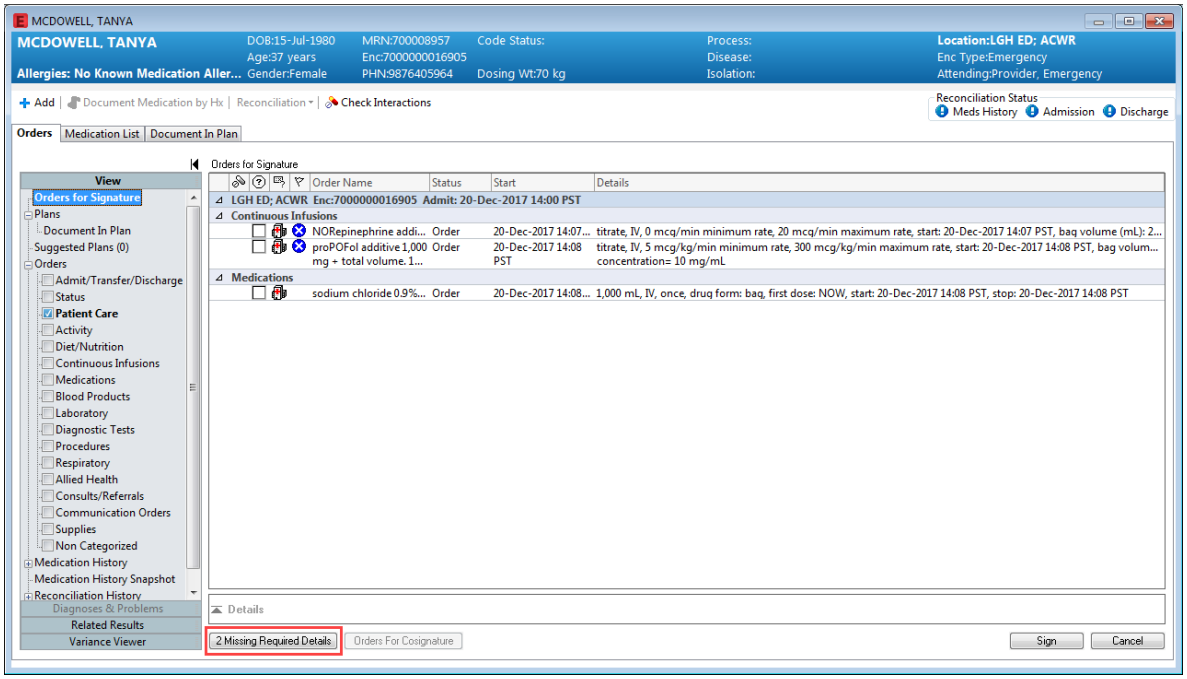
   Starting Rate: *30mcg/kg/minute*
   Titrate Instructions: *Titrate as per protocol*
4. From the Medications component, select sodium chloride 0.9% (NS) bolus 1,000mL. This should be documented as it impacts ongoing fluid balance calculations.
5. Click the **Orders for Signature Inbox** 

button to modify your Order Details.
6. Click **Modify**.



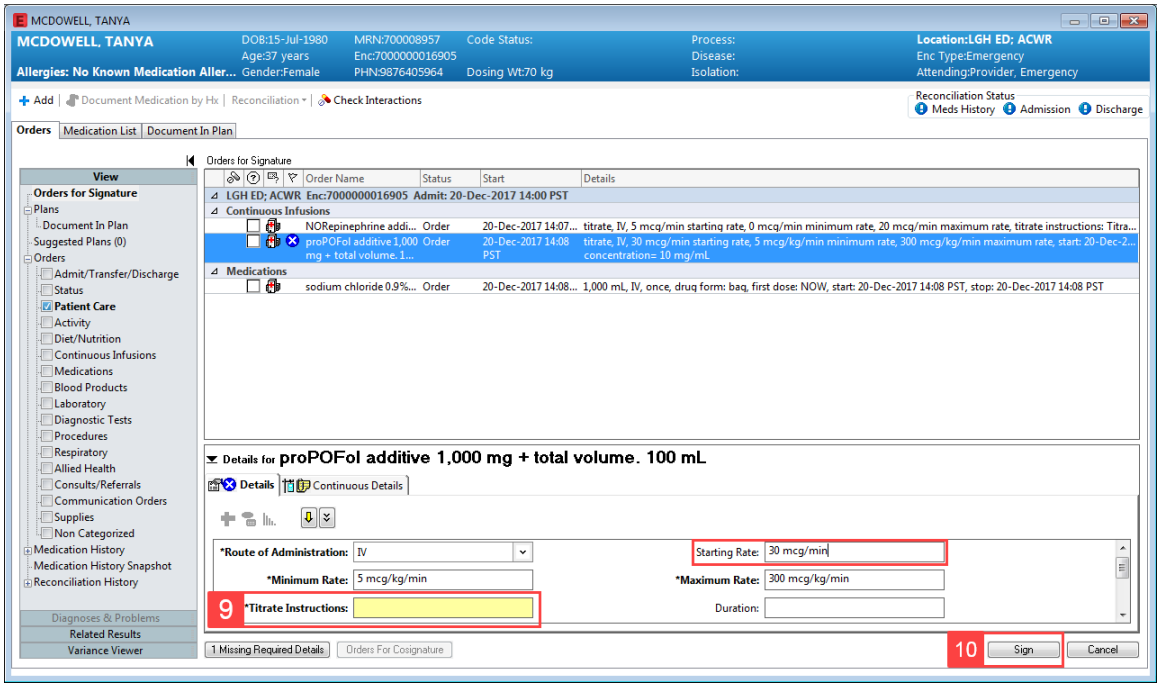
7. The Ordering Physician window will appear. Enter the Physician's name and define the Communication Type as *Verbal*.
8. You will be brought to the Orders Details window (or Scratchpad). Click the **Missing**

Required Details button in the lower left corner.



9. Enter the titration details as your facility policies dictate. (Bolded text marked with an asterisk indicates a mandatory field).

10. Click **Sign**.

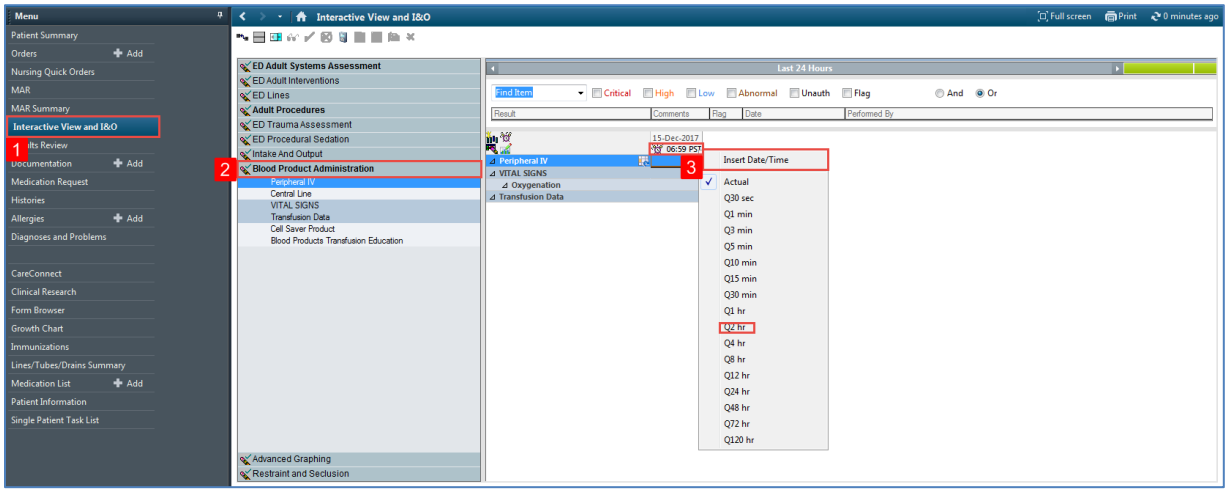


Activity 4.4 – Back-Entry of Interventions and Fluid Balance

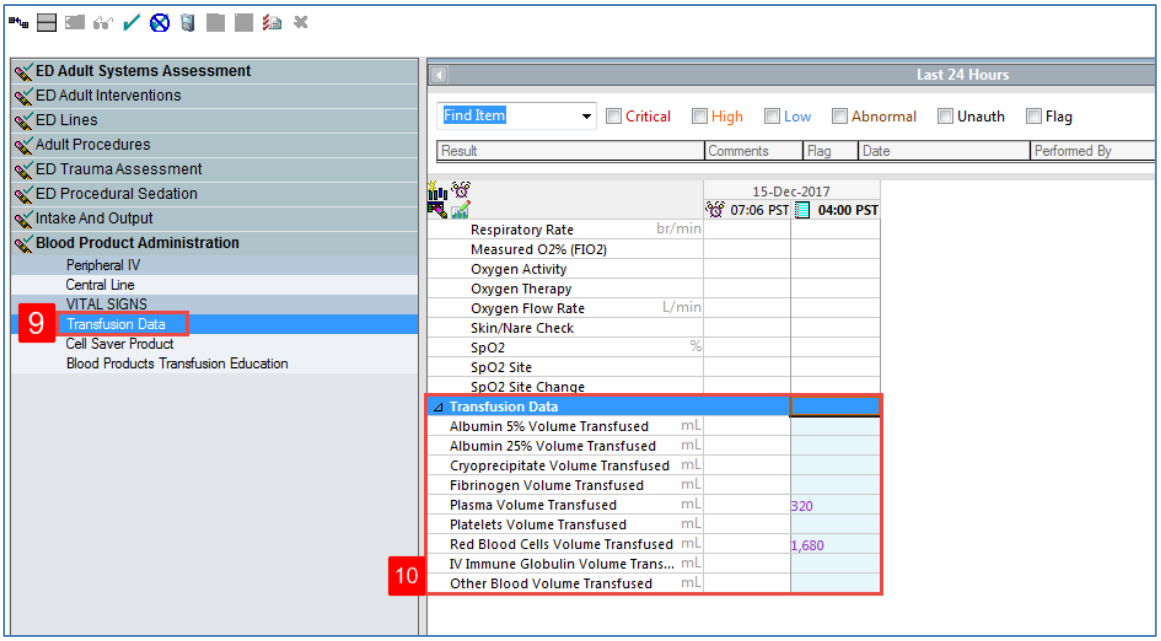
Fluids given during a trauma that are not continuous do not need to be entered in the system individually. However, you would need to document the total amount given so your team is aware what has been administered. Complete the following steps to document your Ins & Outs.

1. From the patient's chart, select **Interactive View and I & O** from the Menu on the left side of your screen.
2. From the IView Table of Contents, select **Blood Product Administration**.
3. Since documentation for this line is being done much later, you will need to change the time to accurately reflect when it occurred.

   To modify the time of your documentation, right-click on the Time column header and select **Insert Date/Time**.



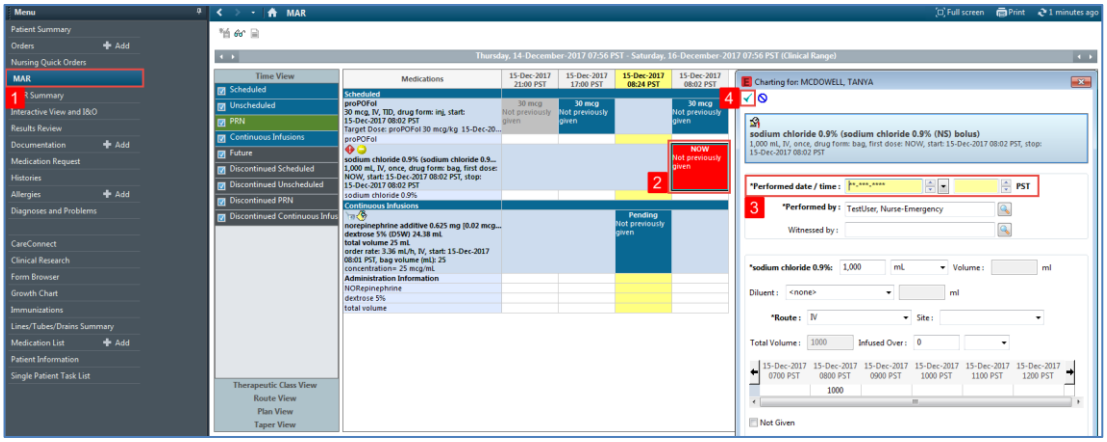
4. Enter a time that is about 3 hours ago. Then, hit **Enter**.
5. Click the **Dynamic Group icon** in the Peripheral IV band to document Tanya's IV.
6. In the Dynamic Group labelling window, document a typical IV you would insert during a Hypotensive trauma.
7. Double-click the field under the modified time within the Activity row and select **Insert** to indicate this record pertains to starting the IV.
8. Document any other items necessary for this IV insertion, such as Site Assessment or Line Status as you typically would using paper documentation. Save your charting when done.
9. Under the Blood Product Administration band, select **Transfusion Data**.
10. Your team administered 4 units of Red Blood Cells (*1380* mL) and 2 units of Plasma (*220* mL). Double click the fields for each administration, ensuring you are clicking below the modified time column.



Unsaved text will remain purple until you sign your documentation by clicking the green checkmark ✓.

Now, document the 1 L Normal Saline bolus that was administered.

1. From the Table of Contents, click **MAR**.
2. You will notice the norepinephrine, proPOFol, and sodium chloride display as outstanding. Double click the **sodium chloride field** that states “Not previously given.”
3. The charting window will open. Since documentation of this administration is delayed modify the *Performed date/time section*.
4. Review the remaining administration details and sign your charting.



5. Modifying the time of administration will trigger an Early/Late Reason window to appear.

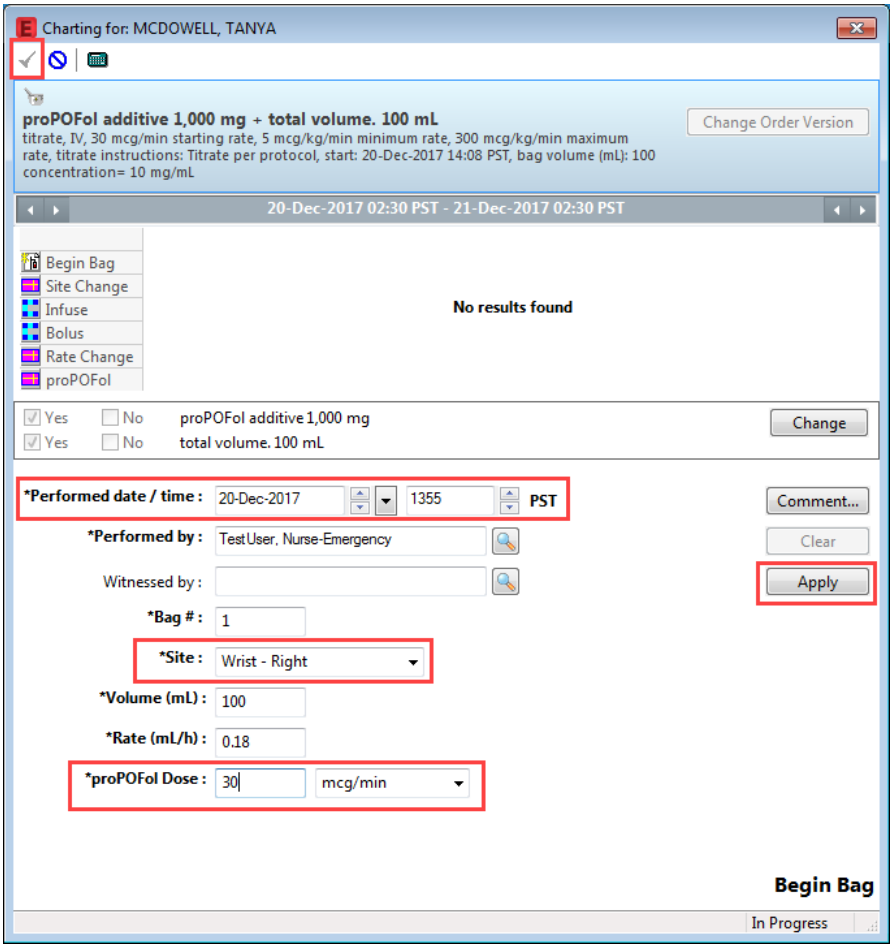
Select **Patient Condition** from the drop-down reason list and click **OK**.

Refresh the page and you will see Sodium Chloride has dropped off the MAR as a task and is now recorded as having been administered at the modified time.

6. Double-click the **most outstanding field for Propofol.** The charting window will appear.

   Change the Performed date/time to the actual start time and document the IV site, dose (rate). If desired, select the Comment button to indicate administration was out of system due to the patient's condition.

7. Click **Apply,** then **sign** ✓ the document.

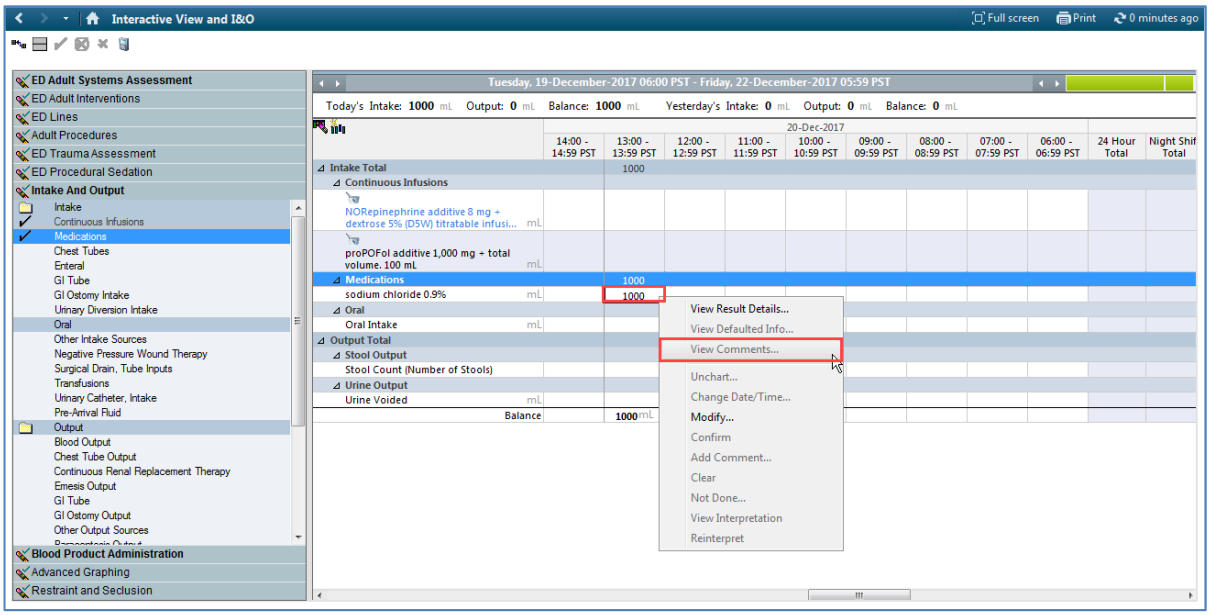


8. Repeat the process for Norepinephrine.

9. Navigate to the Interactive View and I&O section of your patient's chart. Select **Intake and Output**.

   Notice that all products administered when the patient was in critical condition are now accurately displayed.
   The black triangles in the upper corners of the cells indicate there are additional details or comments that can be viewed.

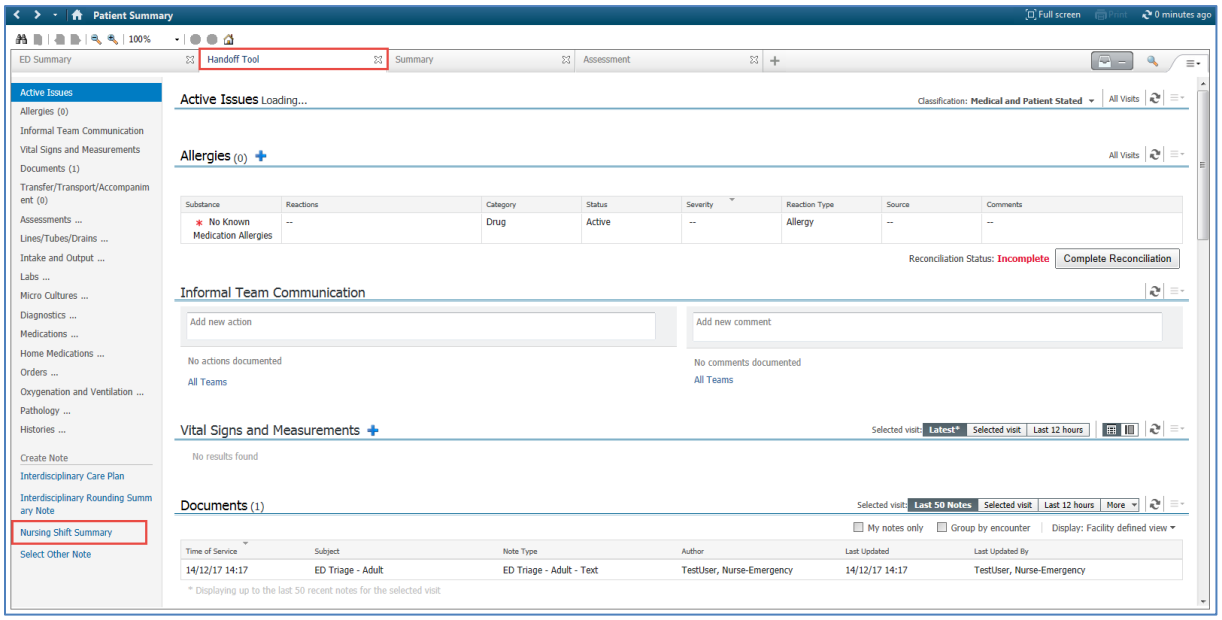
   Right-click and select View Comments to see the comment you entered for modifying this item's administration time.



Activity 4.5 – Nursing Shift Summary

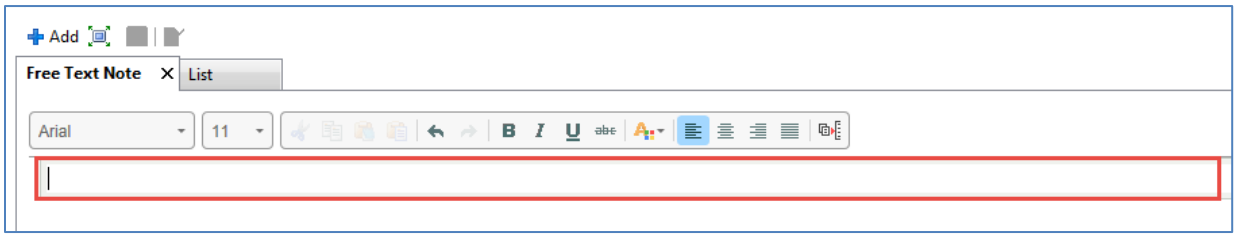
In this activity, we will summarize your activities while the patient was critical in a Nursing Shift Summary. Though you will follow your unit's policy and protocols, let's assume you need to create a note about Tanya's clinical progression on your unit.

1. Within the patient's chart, select **Patient Summary** from the Table of Contents.
2. Select the **Handoff Tool Tab**. In the Handoff Tool Tab of menu, find the "Create Note" heading and select **Nursing Shift Summary**.



3. The Documentation section of your patient's chart will open.

   A Free Text Note will open where you can write a summary of Tanya's progress and the out of system activities. Hover over and select the area outlined in the screenshot below to begin documenting. Write a typical *summary for a MVA Hypotensive Trauma* patient.

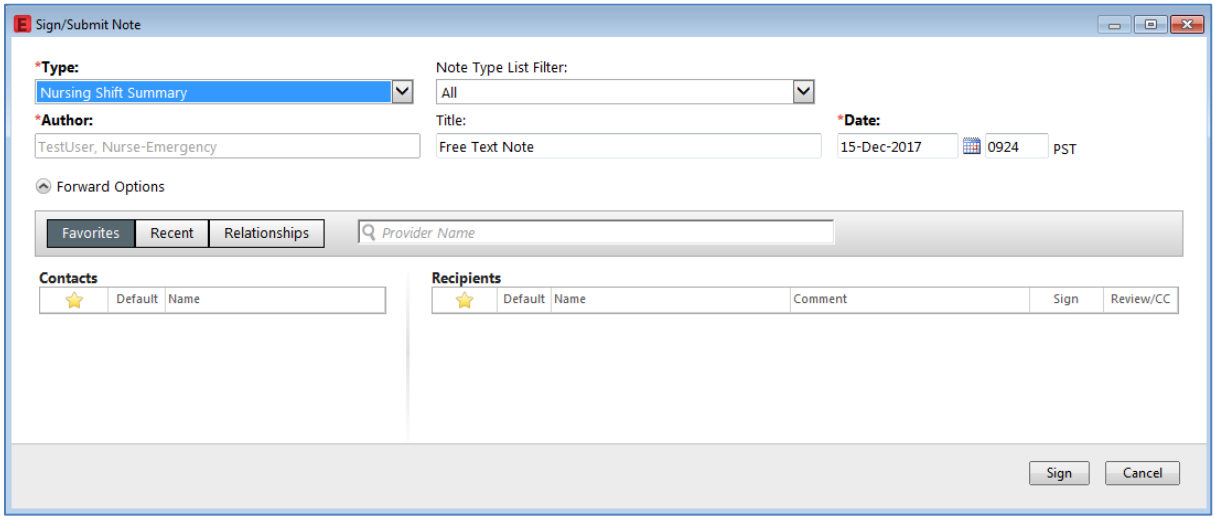


   Select **Sign/Submit** when complete.

4. The Sign/Submit Note window will appear.

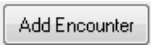
   You can forward your documentation to someone's attention if you chose. Your practice will govern whether this is necessary or not.

   Click **Sign** to complete your documentation.



Patient Scenario 4 Summary: Key Learning Points

Activity 4.1 ED Quick Reg

- During a trauma you only need to complete the mandatory fields highlighted in yellow
- Click in the Assignment Column to ensure you assign yourself as your patient's Nurse
- Click the Add Patient  icon and select ED Quick Reg to begin quick registration process
- If patient has previous encounters, select Add Encounter 

- If patient has no previous encounters, select MPI Search 

- Yellow fields are mandatory
- If your patient does not appear, try clicking the Refresh  button
- Right-click on the name of the patient you ED Quick Registered and select Attach Prearrival
- If unable to locate PreArrived or Quick Registered patient, select the All Beds tab and select the WR box as patient may not appear until the "WR" box is checked

Activity 4.2 Triage

- If a patient is unconscious, you can select unable to obtain as needed
- You can identify that a patient's weight is estimated if needed
- Access the Triage PowerForm by opening the Single-Patient View and clicking the  icon
- Within the PowerForm, complete the COT Descriptor and Problems, Tracking Acuity and screening forms
- Do not use your mouse wheel to scroll, as it will change your entry on a drop down menu
- If the ED Triage Adult tasking does not drop away, be sure to click the Refresh button in the upper right-hand corner of the Single-Patient View
- Access the Single-Patient View by clicking the white space around the patient's name
- Overdue Nurse Activities are marked with a red bar  below the associated task's icon

Activity 4.3 Back-Entry of Medication

- Only documentation of care needs that continue and a brief summary of the out-of-system-care provided are required
- Enter verbal orders given when out-of-system as you would in Activity 2.7

- Enter the titration details as your facility policies dictate, keeping in mind that bolded text marked with an asterisk indicates a mandatory field
- Sodium chloride (NS) bolus administered should be documented as it impacts ongoing fluid balance calculations

Activity 4.4 Back-Entry of Medical Interventions and Fluid Balance

- Fluids given during a trauma that are not continuous do not need to be entered in the system individually. You would only document the total amount given so your team is aware what has been administered.
- To document Blood Products given, navigate to the IView Table of Contents and select Blood Product Administration.
- Ensure you change the time to accurately reflect when it occurred. To modify the time of your documentation, right-click on the Time column header and select Insert Date/Time
- Document your IV within the Central Line section of the Blood Product Administration band by starting a Dynamic Group Label, just like you did in Activity 2.9
- Document Saline Bolus within the MAR by double-clicking the sodium chloride field that states “Not previously given”
- Back-entry of items administered within the MAR will require you to modify the Performed date/time section.
- Remember that modifying the time of administration will trigger an Early/Late Reason window to appear, so you will need to document the reason for late administration ex. Patient condition
- Review all products administered when the patient was in critical condition by navigating to the Intake and Output section of IView
- The black triangles in the supper corners of the cells indicate there are additional details or comments that can be viewed

Activity 4.5 Nursing Shift Summary

- Remember, Nursing Shift summary Notes can be compiled from information in the patient chart with greatly reduced typing using the auto text feature
- Within the Handoff Tool section of your patient’s chart, scroll down the Table of Contents on the left-hand side to create different types of documentation
- **When completing your documentation, you can decide to forward your department to the necessary Providers as desired**

End of Workbook

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