SELF-GUIDED PRACTICE WORKBOOK [N48] CST Transformational Learning

WORKBOOK TITLE: Nursing: Emergency





Last update: February 12, 2018 (v2)

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UNDERSTANDING YOUR WORKBOOK

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

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

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

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 aunchPoint screen. Select Check In.
- In the Devider Check In window, the Provider and Provider Role fields are automatically populated and should be reviewed. You are able to input a *Display Name* that can be seen by all users on ED LacachPoint www.ebu.automatically populated and should be reviewed. You are able to input a *Display Name* that can be seen by all users on ED LacachPoint www.ebu.automatically populated and should be reviewed. You are able to input a *Display Name* that can be seen by all users on ED LacachPoint www.ebu.automatically to easily identify which patients you are assigned to. Only the first three characters will be displayed.
- 3. You can colour customize the Display Name.
- 4. More fields are available to add further relevant details.

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

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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.

F 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.

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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

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- 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)

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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.

Awaiting Triage	Prearrival Note	Unassigned (No Provider)	Evaluation in Progress
Orders Complete	Inpatient Bed Requested	Ready for Discharge	

2. Room Column

Displays the patient location and important alerts.

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WSBC	change to colour of the	Poss. SIRS	red.
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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:



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 is icon in the column header.

A screenshot of **ED LaunchPoint** highlighting the above columns can be found on the next page.

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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:



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.

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ACWR	936:28 2 ED-UrbanNurse-Fatim 25y F O	Redness and swelling x 3 days after cutting foot	v 0	4	2		٥	887:5 6	
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ACWR	936:28 2 ED-UrbanNurse-Fatim 25y F O	Redness and swelling x 3 days after cutting foot	v v	4	2		0	871:0 8	
ACWR	936:28 2 ED-UrbanNurse-Fatim 25y F O	Redness and swelling x 3 days after cutting foot	* 0	4	۶ 🚺		0	870:3 6	
ACWR	936:28 2 ED-UrbanNurse-Fatim 25y F O	Redness and swelling x 3 days after cutting foot	v e	4	۹ 🚺		0	8(9:3 5	
ACWR	936:28 2 ED-UrbanNurse-Fatim 25y F O	Redness and swelling x 3 days after cutting foot	v e	4	۹ 🚺		0	869:1	
ACWR	936:28 2 ED-UrbanNurse-Fatim 25y F O	tedness and swelling x 3 days after cutting foot	v v	4	P 🚺		٥	868:5	
ACWR	936:28 2 ED-UrbanNurse-Fatim 25y F O	Redness and swelling x 3 days after cutting foot		4	2 🚺		۵	868:3	
ACWR	936:28 2 ED-UrbanNurse-Fatim 25y F O	Redness and swelling x 3 days after cutting foot	v e	4	P 🚺		<u> </u>	867:5	

10. Patient Care Activities Column



ED LaunchPoint				(□) Norm	al view 👘 Print
1 My Patients All Beds Resus/DTU Acute/DNTK Acute INTK FA		Q		TestUser, I	Emergency-Physician,
View All Y students Department					
Show: Critical Labs/VS Ø WR Ø Hide Empty Beds Current: 0 Last Hour: 0 Today: 0 Median Door to Doctor: WR: 183 Prearityles: 1 Current: 24	00 Last Hour: 0 Today	: 2 Median LOS: -	Median Door	to Doctor:	
Room i + LOS Patient Information i + EDMD MLP RN Patient Details	🖤 » <mark>1</mark> 0	Ø 1	-h-	8 a /	Status
AC ₇ 201 722-77 3 "Pharm-Emerg, Audrey Myocardial infarction	v 10	0		0	Unassigned
AC,202 722-77 "Pharm-Emergy, Faith Myocardial infarction	V 10	1		0	Unassigned
AC,203 722-47 "Pharm-Emerg, Rose Hyocardial infarction	•	1		Ô	Unassigned
AC,204 722.47 "Pharm-Emerg, Charl Myocardial infarction	•	1		Ô	Unassigned
AC,205 722-37 "Pharm-Emerg. Jo 47: F	•	<i>e</i> 1		0	Unassigned
AC,206 722-47 "Pharm-Emerg. Lesle Hyocardial infarction	•	ĩ		0	Unassigned
AC,207 722-47 "Pharm-Emerg. Tasha 47: F	•	1		0	Unassigned
AC,209 722-47 "Pharm-Emerge Bessie Myocardial Infarction	•	1		Ô	Unassigned
AC,210 722-07 "Pharm-Emerg, Nicole Myocardial infarction	•	1		0	Unassigned
AC,211 722-77 "Pharm-Emerg, Karen Myocardiai infarction	V 10	1		0	Unassigned
AC,212 772-97 *Pharm-Emergy, Blaca Ay F	•	1		0	Unassigned
AC,213 722-07 "Pharm-Emerg, Rosalie Myocardial infarction	•	Ĩ		Ô	Unassigned
AC,214 722-07 "Pharm-Emerg, Alson Myocardial infarction	•	ĩ		0	Unassigned
AC,214 298.49 47 F Chest pain	V 10	1			Unassigned
AC,215 288:49 "Pharm-Emerg. Alle Chest pain	•	1			Unassigned
AC,215 722-97 *Pharm-Emerg, Wendy	•	ĩ		Ô	Unassigned

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.
- Î Г

Full green status bars indicate a completed or resulted order.

Î

P

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.

ED LaunchPoint													(D) Fu	ill screen 🛛 👼	Print 🔹 🤌 15 minutes ago
務員(単語)(本)(2005 - 1)(●● 位															
My Patients	All Beds Resus/DTU	Acute/INTK Acute	INTK FA T	riage WR							٩			TestUser, Nurse	-Emerg <mark>1</mark> ≡•
View: My Patients and Unas	ssigned 🔽		My Patie	nts		Dep	artment								
Show: Critical Labs/VS	WR I Hide Empty Beds		Current: 3	Last Hour: 0 Today: 0		WR:	15 Prearrivals: 2 Cu	rrent: 24 Las	t Hour: 4 Today:	9 Median LOS	t 5 hrs 48 min				۲
Room :- LOS	Patient Information	EDMD MLP RN Patie	ent Details		♥ ← BP	HR TEMP	RR 02	WT	c 🖌	1 -	4 ®	α.	9 Status		
My Patients	torrange operation	_									0				Talaas
ACWR 23:54	85y M	cw-				P			71		-				23:54 mD
ACWR Suicide Prec. 94:22 4	BROWN, EMMETT 62y M 😵 🔅	CW- CW- CW-	Blunt head injury; Suid Do not mention flux capac	Provider Checkin	1				100 80					0	Eval in Progress 93:28 emp
AC,209 AC,209 145:46 2	CSTDEMOCHRIS, DON 57y M O 2	cw- cw- 💬	COPD with acute erac	Provider: TestUser, Nurse-Emergency	Displ	ay Name: Leam)	Provider Role: ED Nurse	•	95 65		2	-de		0 2	111:1
Unassigned				Default Location:	Deta	ult Helation: Nume		-							
ACWR 00:19	CSTEDTEST, TRAUMA 37y M ºl 📄			Provider Comment:	3	ssociated Provider Colo	, _			2					Triage 00:19D
ACWR 01:10 2	CSTEDRYAN, JIMJIM 33y M	Ches	st pain (3) and respira	Available Teams:	Assi	ned Teams:		-	94 75	1					Unassigned
ACWR 15:08	CSTEDHONG, DAVID				<-Remove			1		3					Triage
ACWR 18:45	*CSTSNFETT, STJANGO			Assigned Team Locations:						2				0	H
ACWR 19:13	*CSTSNFETT, STBOBA							1		2				0	00:14 422-2
ACWR 19:19	CSTEDWILSON, DOOL			Assigned Patients:	Rea	sign to Provider:	Al providers	- 1		2				_	Triage 19:19 mp
AC,203 21:14	PHCCPITFORTYCUNN	hip f	fracture	BROWN, EMMETT CSTDEMOCHRIS, DONOTUSE CSTPRODOSSYSTEM, IAN	Assign All->>	ider	Patient	-		€ 3	<i>•</i>				Unassigned
ACWR 22:41	CSTPRODREGINTER, 72y M				Assign>			1		2					Triage 22:41
ACWR 23:53	*CSTPRODOSSYSTEM, 17y F Q				<-Remove <-Remove Prov			1	45	₽ 5	<i>•</i>				Triage 23:53 ••••D
AC,218 192:06	CSTPRODMI, STTWOJ	testi	ing MI label printing	4	<<-Remove All		0K	-		1					Unassigned
				IN Available Provider	Avalable Heviewer		UK Cano	C1							

You have now successfully checked in as an available clinician¹.

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 WWR

Let's try the following steps:

- 1. Select the **Triage** tab
- 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.

ED LaunchPoint			🗇 Full screen 🛛 Print 🛛 🗞 0 minutes ago
🏔 🐚 🖶 🗎 🔍 🔍 100% 🛛 + 🌑 🖓			
My Patients All Beds Resus/DTU	Acute/INTK Acute INTK FA Triage WR	Q	Train, Nurse-Emergency1 =-
View: All	My Patients De	epartment	
Show: Critical Labs/VS VR VR Hide Empty Bed	Current: 0 Last Hour: 0 Today: 0 WR	R: 185 Prearrivals: 0 Current: 202 Last Hour: 0 Today: 0 N	Aedian LOS: 💿
Room : LOS Patient Information	EDMD MLP RN Patient Details	🖤 , 🧭 👔 🥠 🕲	🗈 🤳 Status
ACWR 1001:4 4 ED-UrbanNurse-Fatim 25y F	Redness and swelling x 3 days after cutting foot	Provider Assignments	×
ACWR 1001:4 25y F	Redness and swelling x 3 days after cutting foot	ED-UrbanNurse-FatimahW, Fatimah 25y F DOB: 09/01/93	ACWR MRN: 760000461
ACWR 1001:4 4 ED-UrbanNurse-Fatim 25y F O	Redness and swelling x 3 days after cutting foot	EDMD: No assignments have been made	
ACWR 1001:4 2 ED-UrbanNurse-Fatim 25y F	Redness and swelling x 3 days after cutting foot	MLP: No assignments have been made	
ACWR 1001:4 4 ED-UrbanNurse-Fatim 25y F O	Redness and swelling x 3 days after cutting foot	Dife and an and the second second second	
ACWR 1001:4 4 ED-UrbanNurse-Fatim 25y F Q	Emergency	KN: NO assignments have been made	3 Assign
ACWR 1001:4 4 ED-UrbanNurse-Fatim 25y F O	Redness and swelling x 3 days after cutting fo	Assign/Unassign Others	Close
ACWR 112:34 4 *VALIDATE, EMERGE 28y M	chief complaint here	2	Unassigned
ACWR 1001:4 5 ED-UrbanNurse-Fatim 25y F	Redness and swelling x 3 days after cutting foot	🖤 🖌 4 🖉 📋	954:2

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 **H** 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.

	ED-UrbanNurse-FatimahW,	Fatimah 💌				$\leftarrow \text{List} \rightarrow \texttt{Im} \text{Recent} \bullet \texttt{Name} \bullet Q$
	ED-UrbanNurse-FatimahW	, FatimahDOB:1993-Jan-09 MRN:760000461 Code			Process:	Location:LGH ED
1	Allergies: No Known Allergies	Age:25 years Enc:/60000000461 Gender:Female PHN:10760000461 Dosin	ig Wt:74 kg		Disease: Isolation:	Enc Type:Emergency Attending:Train, GeneralMedicine-Physician7,
	Menu P	< > - 🏫 Patient Summary				🖸 Full screen 🛛 Print 🛛 🔊 0 minutes ago
	Patient Summary					
	Orders 🕂 Add	3 ummary 52 Handoff Tool	Summary		S? Assessment	
	Nursing Quick Orders	J minury by minute too			0.0	
	MAR	Triage Documentation =• a	Vital Signs 💠		≡- ∾	Flagged Events (0)
	MAR Summary	Selected visit	Last 72 hours for all visits -			Last 30 days for the selected visit
	Interactive View and I&O	Patient Information		Today	Previous	No results found
	Results Review	Chief Complaint : Redness and swelling x 3 days	Temp		36.8 37.8	New Order Entry
	Documentation 🕂 Add	after cutting foot			09:38	Instant
	Medication Request	the Last 30 Days :	BP		115/76 110/70	
	Histories				04/02/18 04/02/18 08:00	Q Search New Order
	Allergies 🕂 Add	PD + 110/75	HR		98 100	Deseased Dublic Chand
	Diagnoses and Problems	Temp: 37 DegC			04/02/18 04/02/18 08:00	No Favorites Found
		HR : 115 bpm			09:38	·
	CareConnect	Respiratory Rate : 24 br/min	Height/Length Estimated		149	Documents (1) 💠 📃 = 🔹 👁
	Clinical Research	3002. 51 10			09:38	Last 6 months for all visits 🗸
	Form Browser		Height/Length Measured		149	My Documents
	Growth Chart	Problem List =• G	,		04/02/18	Note Type Author Date/Time
	Immunizations	Home Medications (0) =	Peripheral Pulse Rate		98 100	ED Note Provider TestUser, Emergency-04/02/18 10:22
	Lines/Tubes/Drains Summary	All Visits			04/02/18 04/02/18 08:00	Physician, MD
	Medication List 🛛 🕂 Add	No results found			09:38	
	🥤 it Information 🖕		Respiratory Rate		20 20 04/02/18 04/02/18 08:00	Salected visit
	<u>ک</u>	Social History (0) =- 6			0 11 0 12 10 00 100	Scienced visit

 CIS allows for collective documentation, meaning your colleagues can be documenting in the same chart at the same time as you. The **Refresh** subtron updates the page to ensure the most up-to-date information is available, as the Patient Chart does not autorefresh.

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.
- 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.

ED LaunchPoint													
	🗚 🖿 🔍 🍕 100% 🛛 - 🌑 🜑 🟠												
+1	M	/ Patients	All B	leds	Resus/	DTU	Acut	e/INTK	A	cute	INTK	FA	Triag
View: All						My P Curren	atients t: 1 La						
Room	ļ.	LOS	Patien	t Inform	ation	1-	EDMD	MLP	RN	Patier	t Details		
ACWR		1002:1	4 ED-U	rbanN	urse-Fati	þ			NT	Redn	ess and sv	velling x	3 days

- 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** for 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** $\square^{\&}$ checkbox to highlight all orders under a heading at once.

- 5. The **Review All** 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.

ACWR	ED-UrbanNurse-FatimahW, Fatimal 25y F DOB: 09/01/93	n		A MRN: 760000461 FIN: 76000000	CWR ×
- 3	× 4 × 2 🖉	- she 💽	<u> </u>		
Activities			MA	र 🛄 Orders 🖨	🖗 Refresh
Orders to Review	(4) Medications (4) Labs				≣∙
🦝 Orders to	Review (4)				
4 Medicati	ions				
📀 cefTRIAXo	ne 2,000 mg, IV, start: 2018-Feb-05 08:00 PST,	ceftriaxone			
Comments:	RINATE 50 mg, IV, once, drug form: inj, start: 2 GRAVOL EQUIV	2017-Dec-28 11:00 PST, stop: 20	017-Dec-28 11:00 PST, dimenhyD	RINATE	
CefTRIAX0	ne 2,000 mg, IV, first dose: NOW, start: 2018-F	eb-05 02:00 PST, ceftriaxone			
PRN (1)					
acetaminop Comments: N	hen 650 mg, PO, q4h, PRN pain, drug form: tab, Naximum acetaminophen 4 g/24 h from all sources	, start: 2017-Dec-28 10:07 PST, ; ;	acetaminophen		
Continuous Infu	usions (1 Begin Bag)				
sodium chlorid PST, bag volume	e 0.9% (NS) continuous infusion 1,000 mL e (mL): 1,000, Sodium Chloride 0.9%	order rate: 100 mL/h, IV, drug f	form: bag, first dose: NOW, start:	2017-Dec-28 09:57	
🚳 Labs				V 46	
66 CBC Blood	d, Urgent, Collection: 2018-Feb-05 09:31 PST, onc	e		65	
🦝 Basic Meta	abolic Panel (Lytes, Urea, Creat, Gluc) Blood	, Urgent, Collection: 2018-Feb-0	5 09:31 PST, once	66	
offerentia	al (CBC and Differential) Blood, Urgent, Collect	tion: 2018-Feb-05 09:31 PST, or	nce	68	
🥳 Fibrin D-D	imer (D-Dimer Quantitative) Blood, Urgent, (Collection: 2018-Feb-05 09:31 PS	ST, once	4 💽	
Review All (4)	5 w All (4) and Close			6 Review (4) Clo	5e

Activity 1.7 – Medication Administration Record (MAR) Overview

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

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

E FirstNet Organizer for Train, Nurse-Emergency1									
Task Edit View Patient Chart Links Navigation Help									
🗄 🎬 ED LaunchPoint Tracking Shell 📲 Results Callback Worklist 👫 Learnin	ngLIVE 📮 🤅 😋 Patient Health Education Materials 😋 Policies and Guid	delines 🕄 UpToDate 📮 🤅 🕄 CareConne	ct 🔃 PHSA PACS 🔃 VCH and PHC	PACS 🛱 MUSE 🧟 FormFast WFI					
🗄 📶 Exit 🎬 AdHoc 💵 Medication Administration 🔒 PM Conversation 👻	🖹 Medical Record Request 📻 Documents 🥌 Discern Reporting Port	al 🔘 Conversation Launcher 💽 iAware	Ŧ						
		ED-Urb	anNurse-FatimahW, Fatimah 🔹 🏻 🍅	Recent - Name - Q					
ED LaunchPoint			 Full sc 	reen 👘 Print 🍣 0 minutes ago					
👫 🗎 📥 🔍 🍕 100% 🛛 🗸									
Hy Patients All Beds Resus/DTU Acute/IN	ITK Acute INTK FA Triage WR	9	Tra	ain, Nurse-Emergency1 🗧 •					
View: All	My Datients)enartment							
Show: Critical Labs/VS VR VR Hide Empty Beds	Current: 1 Last Hour: 0 Today: 0 W	VR: 185 Preamvals: 0 Current: 202 La	ast Hour: 0 Today: 0 Median LOS:	- 🔿					
Room : + LOS Patient Information : + EDMD ML	.P RN Patient Details	♥, ♂ ₽	1 .4 . 4 . 6	J Status					
ACWR 1002:3 4 ED-UrbanNurse-Fatim 25y F Patient Summar	Redness and swelling x 3 days after cutting foot	V P 4 🖉	1 🔒	935:3 1					
ACWR 1002:3 4 ED-UrbanNurse, Fat Nurse, Fat	uers and swelling x 3 days after cutting foot	V P 4	1	934:3 8					
ACWR 1002:3 4 ED-UrbanNurse-Fau Cideo Holic 25y F Results Review	ess and swelling x 3 days after cutting foot	👻 🖌 4 🖉	1	932:1 7					
ACWR 1002:3 4 ED-UrbanNurse-Fat Attach Prearrival 25y F Request Event	ess and swelling x 3 days after cutting foot	👻 🖌 4 🖉		931:5 8					
ACWR 1002:3 4 ED-UrbanNurse-Fat Start Event Complete Event	 ress and swelling x 3 days after cutting foot 	👻 🖌 4 🖉		931:4 6					
ACWR 1002:3 4 ED-UrbanNurse-Fat 25y F Assign/Unassign	Others v Report	🖤 🖌 4 🖉	1 🚊	931:3 5					
ACWR 1002:3 4 ED-UrbanNurse-Fat Discharge Proce	ess and swelling x 3 days after cutting foot	🌳 🖌 4 🖉	1 🚊	931:2 3					
ACWR 113:22 4 *VALIDATE, EMERGE 289 M	chief complaint here	2		Unassigned					
ACWR 1002:3 5 ED-UrbanNurse-Fatim 25y F O	Redness and swelling x 3 days after cutting foot	🖤 🖌 4 🥖	1	955:0 8					
			TRAIN1 TRAIN.EDNURSE1 Mor	nday, 2018-February-05 09:44 PST					

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

ACWR	ED-UrbanNurse-FatimahW, Fatimah 25y F DO8: 09/01/93	ACWR × MRN: 760000461 FIN: 760000000461
+	4 * 2 1 4 3	
Activities	-	b MAR Orders 2 Refresh
Medications (4)		≣-
4 Medicati	ions	
🙆 cefTRIAXo	one 2,000 mg, IV, start: 2018-Feb-05 08:00 PST, ceftriaxone	
dimenhyDl Comments:	RINATE 50 mg, IV, once, drug form: inj, start: 2017-Dec-28 11:00 PST, stop: GRAVOL EOUIV	2017-Dec-28 11:00 PST, dimenhyDRINATE
CefTRIAX0	ne 2,000 mg, IV, first dose: NOW, start: 2018-Feb-05 02:00 PST, ceftriaxone	
PRN (1)		
Comments: M	vhen 650 mg, PO, q4h, PRN pain, drug form: tab, start: 2017-Dec-28 10:07 PST Maximum acetaminophen 4 g/24 h from all sources	, acetaminophen
Continuous Infu	usions (1 Begin Bag)	
sodium chlorid	le 0.9% (NS) continuous infusion 1,000 mL order rate: 100 mL/h, IV, drug e (mL): 1.000. Sodium Chloride 0.9%	form: bag, first dose: NOW, start: 2017-Dec-28 09:57
,		
		Document

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 60
- 2. Overdue Activities 🕮
- 3. PowerPlan 🕒
- 4. STAT/NOW Order 📀
- 5. Request Pharmacy Verification 🛅

	ABASSI, FATIMAH	×						
	ABASSI, FATIMAH		DO Age	B:02-Sep-1991 26 vears	MRN:700008 Enc:7000000	504)15814	Code Stat	us:
	Allergies: No Known Al	llergies	Ger	ider:Female	PHN:9876421	485	Dosing W	t:
	Menu		< > - 🏦 MAR					
	Patient Summary		*16 60' 📄					
	Orders	🕂 Add						
	Nursing Quick Orders						Wedn	esday, 29-Nove
с	MAR		Time View	Medications		30-Nov-2017 15:51 PST	30-Nov-2017 15:50 PST	30-Nov-2017 15:39 PST
	Interactive View and I&O		Scheduled	:hedul :d				
	Results Review		Unscheduled	60 P				NOW Not previously
	Documentation	🕂 Add	Continuous Infusions	2 g, IV, once, drug form: inj, f start: 30-Nov-2017 15:39 PST, : 20 Nov-2017 15:39 PST, :	irst dose: NOW, stop:			given
	Medication Request		E Future	cefTRIAXone				
	Histories		Discontinued Scheduled	🔶 ởơ' 🤤				NOW Not previously
	Allergies	🖶 Add	Discontinued Upscheduled	50 mg, IV, once, drug form: in	j, first dose:			given
	Diagnoses and Problems		Discontinued PRN	NOW, start: 30-Nov-2017 15:3 30-Nov-2017 15:39 PST GRAVOL EOUIV	9 PST, stop:			
			👿 Discontinued Continuous Infus				1011/	
	CareConnect						NOW Not previously	
	Clinical Research			10 mg, IV, once, drug form: in NOW, start: 30-Nov-2017 15:5	j, first dose: 0 PST, stop:		given	
	Form Browser			30-Nov-2017 15:50 PST				
	Growth Chart		4	€ 60° > 1			NOW	
	Immunizations			8 mg, IV, once, drug form: inj,	first dose:		given	
	Lines/Tubes/Drains Summ	nary		NOW, start: 30-Nov-2017 15:5 30-Nov-2017 15:50 PST	0 PST, stop:			
	MAR Summary			ondansetron				
	Medication List	🖶 Add		PKN Arr te	PRN	650 mg		
	Patient Information			acetaminophen	rug form: tab	Not previously given		
	Single Patient Task List			start: 30-Nov-2017 15:50 PST Maximum acetaminophen 4g/	24 h from all s			
				acetaminophen				
				Temperature Axillary				
				Numeric Pain Score (0-10)				
				60' 🛞 🔁	PRN	400 mg		
				400 mg, PO, q4h, PRN pain, d	rug form: tab,	given		
			Therapeutic Class View	ibuprofen				
			Route View	Temperature Axillary				
			Plan View	Temperature Oral	DDN	STAT		
			Taper View	morphine	PKN	Not previously		

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. Practice 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.

E FirstNet Organizer for Train, Nurse-Emergency1								
Task Edit View Patient Chart Links Navigation Help								
🗄 🎬 ED LaynchPoint-Trackinn Shell. 🛒 Reutits Callback Worklist 🎬 LearningLIVE 🍦 🕄 🖏 Patient Health Education Materials 🖏 Policies and Guidelines 🐧 UpToDate 🍦 🕄 CareConnect 🐧 PHSA PACS 🐧 VCH and PHC PACS 🐧 MUSE 👘								
🗄 📲 Exit 背 🧻 c 🎟 Medication Administration 🤷 PN	M Conversation 👻 🖄 Medical Record Request 📄 Documents 🝙 Discern Reporting Portal 🏾 Conversation Launcher 💽 Aware 🖕							
	ED-UrbanNurse-FatimahW, Fatimah 👻 🇌	cent • Name • Q						
ED LaunchPoint	(D) Full scree	n 🗇 Print 🕹 0 minutes ago						
🗚 🗎 📥 🔍 🔍 100% 🔹 🖬 🖬 😭								
My Patients All Beds Resus/E	ACWR ED-UrbanNurse-FatimahW, Fatimah 25y F DOB: 09/01/93 MRN: 760000461	ACWR ×						
View: All								
Poom in 105 Patient Information								
ACWR 1002:4 4 ED-UrbanNurse-Fatin 25y F	Activities	Orders 🥏 Refresh						
ACWR 1002:4 4 ED-UrbanNurse-Fatin 25y F	Medications (4)	≣∙						
ACWR 1002:4 4 ED-UrbanNurse-Fatin	Medications ceffratAxone 2.000 mo. IV. start: 2018-Feb-05 08:00 PST. ceffriaxone							
ACWR 1002:4 4 ED-UrbanNurse-Fatin	in CommentyDRINATE Song, IV, once, drug form: inj, start: 2017-Dec-28 11:00 PST, stop: 2017-Dec-28 11:00 PST, dimenhyDRINATE Comments: GRAVOL EQUIV							
ACWR 1002:4 4 ED-UrbanNurse-Fatin 25y F	in CefTRIAXone 2,000 mg, IV, first dose: NOW, start: 2018-Feb-05 02:00 PST, ceftriaxone							
ACWR 1002:4 4 ED-UrbanNurse-Fatin	m acctaminophen 650 mg, PO, q4h, PRN pain, drug form: tab, start: 2017-Dec-28 10:07 PST, acetaminophen Comments: Maximum acetaminophen 4 g/24 h from all sources							
ACWR 1002:4 4 ED-UrbanNurse-Fatin	in Continuous Infusions (1 Begin Bag) sodium chloride 0.9% (NS) continuous infusion 1,000 mL order rate: 100 mL/h, IV, drug form: bag, first dose: NOW, start: 2017-Dec-28 09:1	57						
ACWR 113:32 4 *VALIDATE, EMERGE	VE PST, bag volume (mL): 1,000, Sodium Chloride 0.9%							
ACWR 1002:4 5 ED-UrbanNurse-Fatin	n en							
ACWR 1002:4 5 ED-UrbanNurse-Fatin	n							
ACWR 910:22 5 *Validate, IP-PHY-Fit	54 Docume	Close						
Open Ad Hoc charting dialog	TRAINI TRAIN.EDNURSEI Monda	ay, 2018-February-05 09:54 PST						

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.

E Medication Administration			
ED-UrbanNurse-Fatimah	W, Fati MRN: 760000461 FIN#: 760000000461	DOB: 1993-Jan-09 Age: 25 years	Loc: ; ** No Known Allergies **
Alternatis	Please scan the patient's wrist rely, select the patient profile manually by	Sand. dicking the (Next) button.	
Ready to Scan	1 of 2		2 Next

- 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.

< > - 🖌 MAR					[I] Full screen	Print	∂ 1 minutes ago
*11 66' 🗎							
	CJ 2010 F.L	T	19 F-h 06	10.07 DET (CI::			
	Sulluay, 2010-rebitary-04 10.07 F31	- Tuesday, 201	to-rebitialy-ot	5 10.07 F31 (Clillio	car Kange)		
Time View	Medications	2018-Feb-06	2018-Feb-05	2018-Feb-05	2018-Feb-05		
🔽 Scheduled	Scheduled	08:00 PST	10:07 PST	08:00 PST	07:00 PST		
Unscheduled	No. Contraction of the second	2,000 mg		2,000 mg			
PRN	cefTRIAXone 2 000 mg IV gdaily first dose: NOW start:	Last given: 2018-Feb-05		Last given: 2018-Feb-05			
Continuous Infusions	2017-Dec-28 09:56 PST	10:07 PST		10:07 PST			
	cefTRIAXone dimenbyDRINATE		* 2,000 mg Aut	th	50 mg		
V Future	50 mg, IV, once, drug form: inj, start:				Not previously		
Discontinued Scheduled	2017-Dec-28 11:00 PST, stop: 2017-Dec-28 11:00 PST				given		
Discontinued Unscheduled	GRAVOL EQUIV						
👿 Discontinued PRN	PRN						
👿 Discontinued Continuous Infus	PRN		650 mg				
	acetaminopnen 650 mg, PO, q4h, PRN pain, drug form: tab,		not previously given				
	start: 2017-Dec-28 10:07 PST Maximum acetaminophen 4 g/24 h from all s	2					
	acetaminophen		EI	D-UrbanNurse-	FatimahW, Fat	imah - 76(0000000461
	Temperature Axillary		ac	etaminophen Las	t Given:		
	Numeric Pain Score (0-10)		1 No	o result within 7 da	ays		
	Continuous Infusions			_			
	sodium chloride 0.9% (NS) continuous infus		NOW Not previously				
Therapeutic Class View	order rate: 100 mL/h, IV, drug form: bag, first		given				
Route View	dose: NOW, start: 2017-Dec-28 09:57 PST, bag volume (mL): 1,000						
Plan View	Administration Information						
Taper View	sodium chloride 0.9%						

3. The Charting Form will open.

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

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

acetaminophen 650 mg, PO, q4h, PRN pain, Maximum acetaminophen 4g	drug form: tab, start: 30-Nov-2017 15:50 PST //24 h from all sources
*Performed date / time :	01-Dec-2017 🔹 🗸 0803 🔺 PST
*Performed by :	TestUser, Nurse-Emergency
Witnessed by :	
No record of last docume	nted administration.
Temperature Axillary	: DegC <u>Trend</u>
Temperature Oral	DegC Trend
Numeric Pain Score (0-10)	· Trend
Diluent: commune.com *Route: PO Reason : pain	site:
	Infused Over: 0
Not Given	

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.

PRN				
PRN acetaminophen 650 mg, PO, q4h, PRN pain, drug form: tab, start: 2017-Dec-28 10:07 PST Maximum acetaminophen 4 g/24 h from all s	Med Response	650 mg Last given: 2018-Feb-05 10:13 PST		
acetaminophen		4	* 650 mg Auth (\	
Temperature Axillary				
Temperature Oral				
Numeric Pain Score (0-10)				

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 Nursing 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.

	ED-UrbanNurse-Fatim	ahW, I	Fatimah 🗵							(List –	Recent - Name -	- Q
	ED-UrbanNurse-Fatim	nahW,	Fatimah DOB:1993-Jan-09	MRN	760000461					L	ocatio	n:LGH ED	
	Allergies: No Known Allerg	jies	Age:25 years Gender:Female	PHN:	10760000461	Dosing Wt:7	4 kg		Disease: Isolation:	El	ttendin	e:Emergency g:Train, GeneralMedicine-Physician	
	Menu	4	< 🖂 🖌 👫 🛛 Nursing Qui	ck Orde	rs						[0]	Full screen 👘 Print 🏞 1 minutes	s ago
	Patient Summary	^											
	Orderr 📥 /	۸dd	Nurring Quick Orders			urging Ordorg		M .					_
1	Nursing Quick Orders		Nursing Quick Orders		23 ED PEDS IN	ursing orders		~ +					2 -
-	MAR		Venue: Inpatient v										
	MAR Summary			_	<u> </u>		- 0						-
	Interactive View and I&O		PowerPlans	• •	Medications		=• 🔊	Labs\ECG	=- 📀	Imaging = •		ew Order Entry 🛛 🔿	
	Results Review		General Orders		IV Fluids			ECG 12 Lead Urgent		XR Lower Extremity Right		Inpatient 🗸	
	Documentation 🕂 A	Add	Triage Adult				_	► ECG		XR Lower Exremity Left			Ξ
	Medication Request		Frequent	=- @	Critical Care		=• 🔊	Consults	=- 🔊	Patient Care =		ketorolac 30 🛞	
	Histories		Conditions	🔊	Code / ACLS			Gonzaito		Patient Care –		etorolac 30 mg, IM, once, drug form:	
	Allergies 🕂 A	Add	Asthma/COPD		Intubation			ED Perform Best Possible M History (BPMH)	Medication	Difficult Airway/Intubation Please	in	j, first dose: NOW	
	Diagnoses and Problems		Cardiac / Chest Pain		Pressors Sodation Dr	ocodural		Allied Health		Equipment/Supplies		etorolac 30 mg, 1V, once, drug form: i. first dose: NOW	
			Neuro / Stroke / TIA		· Seuduon - Fi	ocedulai				Injuries			
	CareConnect		Sepsis / Fever							Isolation	Di	scharge Patient T;N, Discharged Home	
	Clinical Research		▶ Trauma								Di	scharge to External Site T:N	
	Form Browser												
	Growth Chart												
	Immunizations												
	Lines/Tubes/Drains Summary												
	Medication List 🕂 🕂	Add											
	Patient Information	Ŧ											*
	•	•	L										

- 2. The Inbox has now turned green a. 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.

Orders for Signature (1)	×
Medications	
ketorolac (30 mg, IV, once, drug form: inj, first dose: NOW)	
	Sign 4 Modify Cancel

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

Select the **Order** ^(a) 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.

ED-UrbanNurse-FatimahW, Fatimah						
ED-UrbanNurse-FatimahW,	DOB:1993-Jan-09	MRN:760000461	Code Status:		Process:	Location:LGH ED
	Age:25 years	Enc:7600000004			Disease:	Enc Type:Emergency
Allergies: No Known Allergies	Gender:Female	PHN:10760000461	Dosing Wt://	1 kg	Isolation:	Attending:Train, GeneralMedicine-Ph
🛧 Add 🦨 Document Medication by Hx	Reconciliation -	Check Interaction:	5			Reconciliation Status Meds History Admission Discharge
Orders Medication List Document In P	lan					
10	Urders for Signature					
View Orders for Classifier	00 (?) Lis (Order Name	Status	Start	Details	
Diana	△ LGH ED Enc:	7600000000461 Adn	nit: 2018-Jan-(02 07:45 PST		
Document In Plan 7		. Instancian	Order	2019 5-6 05 10:20	20 m = 11/ =6h deve (-:
Suggested Plans (0)		Ketorolac	Order	2018-Peb-03 10:50 .	50 mg, 1V, qon, arug roim: i	nj, filst dose: NOW, statt: 2018-PED-05 10:50 PS1
Orders						
Admit/Transfer/Discharge						
Status						
Patient Care						
Activity						
Diet/Nutrition						
Continuous Infusions						
Medications						
Blood Products						
Laboratory						
Diagnostic Tests						
- Procedures						
- Respiratory						
Allied Health	▼ Details for K	etorolac				
Consults/Referrals	Petails 🗐 0	rder Comments				
Communication Orders						
- Supplies	🔶 🔶 🐘 👘					
Non Categorized					Review Schedule R	emaining Administrations: (Unknown) Stop: (Unknown)
Medication History	8	Frequency: q6h		~		A
Medication History Snapshot			-			
Reconciliation History		PRN: 🔿 Yes	(No			
Diagnoses & Problems		RN Reason:		×		*
Related Results						
Variance Viewer	0 Missing Required	Details Orders For 0	Cosignature			Sign Cancel

E Ordering Physician
Order
O Proposal
*Physician name
*Order Date/Time
2017-Aug-04
*Communication type
Phone Verbal Proposed No Cosignature Required Cosignature Required Paper/Fax Electronic
OK Cancel

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 + Add
 - ^d 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.

ED-UrbanNurse-FatimahW, Fatimah - Add Order		
ED-UrbanNurse-Fatima DOB:1993-Jan MRN:760000461Code Status:	Process:	Location:LGH ED
Age:25 years Enc:76000000	Disease:	Enc Type:Emergency
Allergies: No Known Allergies Gender:Female PHN:10760000 Dosing Wt:74 kg	Isolation:	Attending:Train, GeneralMedici
4 Search: methim Search: Type: 🖓 Document Medication by Hx 👻		
methIMAzole (5 mg, PO, qdaily, order duration: 30 day, drug form: tab, dispense qty: 30 tab)		
a met Mit ede (5 mg, P.O., TID, order datation 20 day, drag form tab, dispense day 20 dab)		
methIMAzole (10 mg, PO, qdaily, order duration: 30 day, drug form: tab, dispense qty: 30 tab)	
methimazole 5 mg oral tablet		
methimazole 5 mg oral tablet (1 tab, PO, q8h, drug form: tab, dispense qty: 90 tab)		
methimazole 5 mg oral tablet (1 tab, PO, q8h, drug form: tab, dispense qty: 270 tab)		
methimazole 10 mg oral tablet		
methimazole 10 mg oral tablet (1 tab, PO, q8h, drug form: tab, dispense qty: 90 tab)		
methimazole 10 mg oral tablet (1 tab, PO, q8h, drug form: tab, dispense qty: 270 tab)		
methotrimeprazine		
methotrimeprazine (0.08 mg/kg, PO, TID, drug form: tab, dispense qty: 30 day)		
methotrimeprazine (0.12 mg/kg, PO, BID, drug form: tab, dispense qty: 30 day)		
methotrimeprazine (2 mg, PO, TID with food, PRN agitation, order duration: 30 day, drug for	m: tab, dispense qty: 90 tab)	
"Enter" to Search		
	ED-UrbanNurse-Fati	mahW, Fatimah - 760000461 Done

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.

📕 ED-UrbanNurse-Fatir	nahW, Fatimah - Add Orde			
ED-UrbanNurse- Allergies: No Known	Fatima DOB:1993-Jai Age:25 years Allergies Gender:Fema	MRN:760000461Code Status: Enc:760000000 le PHN:10760000 Dosing Wt:74 kg	Process: Disease: Isolation:	Location:LGH ED Enc Type:Emergency Attending:Train, GeneralMedici
Search: formoterol	🔍 Туре: 🎝	Document Medication by Hx 🚽		
formoterol 6 formoterol 6	ncg inhalation powder ncg/puff inhaler ncg/puff inhaler (1 cap, inh	alation, q12h, drug form: cap)	_	
Cor formoterol 6 Cor formoterol 6 formoterol 12	ncg/puff inhaler (1 puff, inl ncg/puff inhaler (2 cap, inh mcg inhalation powder	alation, BID, order duration: 30 day, drug for alation, q12h, drug form: cap)	m: inhaler, dispense qty: 1 inhaler)	
formoterol 12 formoterol 12 formoterol 12 formoterol 12	mcg/puff inhaler mcg/puff inhaler (1 cap, in mcg/puff inhaler (1 cap, in mcg/puff inhaler (1 puff, ir	halation, q12h, drug form: cap, dispense qty: halation, q12h, drug form: cap, dispense qty: halation, BID, order duration: 30 day, drug fo	60 cap) 180 cap) yrm: inhaler, dispense qty: 1 inhaler)	
6 formateral 12	haler (12 mcg, inhalation, B)	halation, BID, order duration: 30 day, drug fo D, order duration: 30 day, drug form: cap, dis	orm: inhaler, dispense qty: 1 inhaler) spense qty: 60 cap)	
formoterol in formoterol in	haler (24 mcg, inhalation, Bl haler device	D, order duration: 30 day, drug form: cap, di	spense qty: 60 cap)	
Linter to sea	ui .			
			ED-UrbanNurse-Fatima	ahW, Fatimah - 760000461 Done

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**

Document Medication by Hx				- • • ×
ED-UrbanNurse-Fatimah DOB:1993-Jan-09 MRN:760000461 Cod	le Status:	Process:	Lo	ocation:LGH ED
Age:25 years Enc:760000000		Disease:	Er	nc Type:Emergency
Allergies: No Known Allergies Gender:Female PHN:107600004Dos	ing Wt:/4 kg	Isolation:	At	ttending:Train, GeneralMedicine
+ Add Medication History			- Reconciliati	ion Status
Desument Medication by Hy			Ulleus H	istory 🐨 Admission 🐨 Discharge
			1	
Crder Name Status Details		Last Dose Date/Time	Information Source	Complian Compliance Comm
Medication history has not yet been docu	umented. Please document t	ne medication history	for this patient encou	unter.
Prending nome medications and methIMAzole Document 10 mg. PO. adaily. order duration	n: 30 day, drug form: tab, di			
Jaineterol (saineterom Bocarrent 1 pair, initialation, DB), order dan	dion 20 day, drag form inn	1		
9 🛷 formoterol (formoter Document 12 mcg, inhalation, qdaily, PRN s	shortness of breath, refill(s):			
Details for formoterol (formoterol inhaler)				
Petails 🗑 Order Comm 11 Compliance				
Dose Route of Administr Frequency Duration	Dispense	Refill		
◆ 12 mcg ● inhalation		• 0	1+:	I ×
		1.		
10 PRN: shortness of breath	s	pecial Instructions:		*
				T
O Missing Required Details		I eave Med History In	complete - Finish	Document History Cancel
Commoning models and bronding				Callee

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 \checkmark .

ABASSI, FATIMAH 🛛 🛛						👌 🖀 Recent 👻	Name
ABASSI, FATIMAH					Loca	tion:LGH ED; A	CWR
All	Age:26 years	Enc:700000015814		Disease:	Enc 1	ype:Emergency	
Allergies: No Known Allergies	Gender:Female	PHN:9876421485	Dosing Wt:	Isolation:	Atter	ding:Provider, E	mergency
Menu 9	< > 🔹 📅 Medicatio	on List			j.	Full screen 🛛 🗐	Print 🏾 ぞ 5 minutes
Patient Summary	🕂 Add 🍣 Document Medi	cation by Hx Reconcilia	tion • 🔊 Check Interactions		Reco	nciliation Status	
Orders 🕂 Add					V N	leas History	amission 😈 Dischar
Nursing Quick Orders	Orders Medication List Do	cument In Plan					
MAR		н	Former All Colores All	This	C Martha	1 Ver	AI)6/20
Interactive View and I&O	View		Expand will conapse wi		0 Morkins	1100	MITTERS
Results Review	-Orders for Signature Medication List	M	edication History Snapshot				
Documentation + Add	Admit/Transfer/Discha	rge	Order Name/Details				Last Updated
Madiantian Demund	C Status	-	4 30-Nov-2017 12:27 PST - Te	stUser, Nurse-Emergency			
medication Request	Patient Care		ar formoterol (formoterol ini ar methIMAzole, 10 mg PO)	naler) 12 mcg, inhalation, gdaily, 0 Ketill(s) gdaily, for 30 day, 30 tab, 0 Refill(s)			30-Nov-2017 12:27 P 30-Nov-2017 12:27 P
Histories	Activity		salmeterol (salmeterol inh	aler device) 50 mcq, inhalation, BID, PRN: sho	rtness of breath, 0 Refill(s)		30-Nov-2017 12:27 P
Allergies 🕂 Add	Continuous Infusions						
Diagnoses and Problems	Medications						
	Blood Products						
CareConnect	Laboratory						
Clinical Research	Procedures						
E D	Respiratory						
	Allied Health						
Growth Chart	Consults/Referrals						
Immunizations	Communication Orde	rs					
Lines/Tubes/Drains Summary	Non Categorized						
MAR Summary	Medication History	_				N	
Medication List 🛛 🕂 Add	Medication History Snapsh	ot				16	
Patient Information	E Reconciliation History						
Single Patient Task List							
				m			
	Related Resu	ilts					
	Formulary De	tails					

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

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

ABASSI, FATIMAH 🛛 🛛				🔶 List 🔿 🛍 Recent 🗸 Name 🗸 🔍
ABASSI, FATIMAH	DOB:02-Sep-1991 MRN:700008504 Code : Age:26 years Enc:700000015814	Status: Proc Dise	cess: ease:	Location:LGH ED; ACWR Enc Type:Emergency
Allergies: No Known Allergies	Gender:Female PHN:9876421485 Dosing	j Wt: Isola	ation:	Attending:Provider, Emergency
Menu 🕈	< 👻 🛉 Patient Summary			🖽 Full screen 👘 Print ಿ 0 minutes ago
Patient Summary	👫 📄 🔍 🔍 100% 🔹 🔵 🖬 🟠			
Orders 🕂 Add	ED Summary 💥 Handoff Tool	Summary	XX Assessment	
Nursing Quick Orders	PF , 144/79 mmm			
MAR	Temp: 36.8 DegC	30/11/17	9	Search New Order
Interactive View and I&O	HR: 84 bpm	HR 84		Personal Public Shared
Results Review	SpO2: 100 %	30/11/17	Fay	vorites
Documentation 🛛 🕂 Add		11:01		My Plan Favorites
Medication Request	Pain Documented at Triage	Peripheral Pulse Rate 84 30/11/17		
Histories	(0-10) :	11:01	De	ocuments (2) 💠 📃 🗐 🗐
Allergies 🕂 Add		Respiratory Rate 16	L	ast 6 months for all visits 🔷
Diagnoses and Problems	Problem List =• •	30/11/17		
		SpO2 100		My Documents
CareConnect	Home Medications (3) = - 🛇	30/11/17	Not	e Type Author Date/Time Screening - Adult - TestUser, Nurse- 30/11/17
Clinical Research	All Visits	11:01	Te	xt Emergency 11:01
Form Browser	Hx: formoterol (formoterol inhaler) 12 mcg,	Labs	ET A	Triage - Adult - TestUser, Nurse- 30/11/17
Growth Chart	inhalation, qdaily, 0 Refill(s)	Last 72 hours for all visits	16	Lineigency 11.01
Immunizations	Hx: methIMAzole 10 mg, PO, qdaily, for 30 day, 30 tab. 0 Refill(s)		M	edications 🕂 🗧 🗧
Lines/Tubes/Drains Summary	Hx: salmeterol (salmeterol inhaler device) 50	No results found	S	elected visit
MAR Summary	mcg, inhalation, BID, PRN: shortness of breath, 0 Refill	Diagnostics (0)	=• •	Scheduled (0)
Medication List 🛛 🕂 Add	(5)	Last 18 months for all visits	4	Continuous (0)
Patient Information	Renew O Cancel/DC O Complete	No results found		PRN/Unscheduled Available (U)
Single Patient Task List	Routing: None Defined Sign		4	Suspended (0)
		Significant Events 🚽	≡-⊗	Discontinued (0) Last 24 hours
	Social History (0) = • 😁	Selected visit		
	Visits (1) ≡• ♥	No results found		
	Procedure History (0) =• 😪			
		-		

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**.

ED-UrbanNurse-FatimahW,	Fatimah 🛛			← List → Mi Recent • Name • Q
ED-UrbanNurse-FatimahW,	Fati DOB:1993-Jan-09	MRN:760000461 Code Status:	Process:	Location:LGH ED
Allensies Ne Kasum Allensies	Age:25 years	Enc:760000000461	Disease:	Enc Type:Emergency
Allergies: No Known Allergies	Gender:Female	PHIN:10760000461 Dosing Wt:74	kg Isolation:	Attending: Train, GeneralMedicine-Physician
T Menu	T Histories			juj run screen 🕞 Print 🥐 I minutes ago
Patient Summary	Family Procedure Social	History Implants		
Orders 🕈 Add				
Nursing Quick Orders	Mark all as Reviewed			
MAR	Family			
MAR Summary	📥 Add 🖂 Modifu	Display: Condition View		Negative Unknown Unable to Obtain Patient &dopted
Interactive View and I&O	- Hud - Hodaiy			
Results Review				
Documentation 🛛 🕂 Add	Condition A			
Medication Request		•		
Histories				
Allergies 🛨 Add				
Diagnoses and Problems				
CareConnect				
Clinical Research				
Form Browser				
Growth Chart				
Immunizations				
Lines/Tubes/Drains Summary				
Medication List 🛛 🕂 Add				
Patient Information				
Single Patient Task List				
	L			

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 +** Add **i**con 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.

	Relat	ionship	Fat	her	Mother	ra	ndmother (N	Grandfath	er (M§r	andmother (P	Grandfa	ther (P)
		Name										
	Health	1 Status		•		•	<u>-</u>		•	•		•
3 QuickList	Q											
3 General Family Hist	ory 🔍											
Alcohol abuse.		-				Т						
Alzheimer's disease.		-										
Breast cancer.		-										
Cancer.		-										
Colon cancer		-										
Dementia.		-										
Developmental delay	r.	-										
Diabetes	double click for details	-	2	+								
Heart attack.		-			[
Hypertension.		-										
Mental disability.		-										
Osteoporosis.		-										
Prostate cancer		-										
Seizures		-										
Stroke.		-										
Substance abuse.		-										
Suicide.		-										
Tuberculosis.		-										

- 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.

First Name:	Last Name:		Sex	Birth: Date	
			a de la	-	
Decement	Age at Death: Ar	20	Cause of Deaths	•	
Decessed		10			
Condition		Onset Ag	e: Age		
Diabetes		0			
Comment					
Life Cycle:	Seventy		Course:		
Life Cycle: Active	Seventy Mid		Course:		•
Life Cycle: Active Hide Conditional Details	Mild Severe		Course:		•
Hide Conditional Details Hide Conditional Details Include All Children	Severity Mild Severe		Course:		•
Document Surgical History

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

🔿 🕆 🚹 Histories	🔲 Full screen 🛛 🖨 Prin	t 🛛 🥏 4 min
mily Procedure Social History Implants		
Procedure Last Neviewed Procedure Date		
l R		
Provider Comments		
Tonsilectony A Free Text		
Display As At Age Age Date Date		
Free Text		
		au Can
		Can
🔊 Un 🖄 Home 🔶 Favorites 💌 🥅 Folders Folder		

Clicking the **Search icon** A 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.

	Procedure Search			
	*Search: Tonsillectomy	Starts with	• Within:	Terminology 👻
	Search by Name		Search by Co	ode
	Terminology: SNOMED CT	Terminology A	xis: <all terr<="" th=""><th>minology ax 🛄</th></all>	minology ax 🛄
a	🖫 View Synonym 🛛 🍋 Concept Family	📲 Multi Axial	Cross Map	ping
	Tem 🔺	Code	Terminology	Terminology Axis
	Tonsillectomy	268484012	SNOMED CT	Procedure
	onsilectomy	BZ12F2B8-8768-4	SNOMEDICT	PET Finding
	3 Tonsillectomy and adenoidectomy	484011019	SNOMED CT	Procedure
	fonsiliectomy and adenoidectomy	308035CC-EDDA	SNOMED CT	FFT Finding
	Tonsillectomy planned	284207019	SNOMED CT	Context-depend
	Tonsillectomy planned	21F1FD46-4AB1	SNOMED CT	IMO Context-dep
	Tonsillectomy sample	452546013	SNOMED CT	Specimen
	Tonsillectomy with adenoidectomy	48410019	SNOMED CT	Procedure
	Tonsillectomy with adenoidectomy	9C8F3DAF-61F4	SNOMED CT	PFT Finding
	Add to Favorites			K Cancel

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

Fam	ily Procedure Social H	istory Implants				
F	rocedures					
	Procedure	Last Reviewed	Procedure Date			
*P	rocedure		Provider	Comments		
To	onsillectomy and adenoidector	ny 🏄 🗖 F	ree Text 📃 🔍 🔲 Free Te	t		*
Dis	play As	A. A.	ge Age Date Year			
To	onsillectomy and adenoidector	w 4 11	'ears ← 2002	×		
Lo	cation					
		Free Text				~
					5 OK OK & Add New	Cancel

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 + \blacksquare or \blacksquare signs open and hide sections.
- 2. Once you have completed filing in these sections, click **OK**.

< > 🕘 者 Histories		(D) Full screen 🛛 🛱 Print 🕹 4 minutes ag
Family Procedure Social History Implants		
[⊟] Exercise		*
Minutes per days Days per weak Physical Activity Intensity 1	60 Physical Activity Consultation Counseled to start physical activity 7 Counseled to increase physical activity 0 Other: 0 Other: 0 Counseled to increase physical activity 0 Counseled to increase physical a	Sleep number of hours per night: why Education About Screen Time Giver: Ves No No No Comment:
H Tobacco		
Use Туре	Never smoker Tobacco use per day Cigarettes Smokelers Cigarettes Cigarettes Smokelers Spin Tobacco Oral SNUS Pauches Pipe Othen Total pack years	Comment:
► More		
[⊟] Alcohol		
Use Туре	Current user	Comment:

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

ABASSI, FATIMAH 🛛										🔶 List 🔶 🍋 Recent	Name	• ٩
ABASSI, FATIMAH		DOB:02-Sep-1991	MRN:700008504	Code S	Status:					Location:LGH ED; ACWR		
Allergies: No Known Allergies		Age:26 years Gender:Female	Enc:7000000015814 PHN:9876421485	Dosing			Disease: Isolation:			Enc Type:Emergency Attending:Provider, Emergency		
Menu 🕴	< > • 🔒 Patient S	Summary								(D) Full screen	Print 🔹 🍣 16 minu	tes ago
Patient Summary	ADDADISSI	00% • • • 🐴										
Orders 🖶 Add	ED Summary	23 Handoff Tool	23	Summary		23 Assessment	23 +					
Nursing Quick Orders				_			1				•	
MAR	Triage Documentation			∎• © Vit	tal Signs 🔶		_	=• @	Flagged Events (0)		=	10
Interactive View and I&O	Problem List			∎• ♥	ast 72 hours for all visits 🔫				Last 30 days for the selected vi	isit		
Results Review						Today	Previous		No results found			
Documentation 🔹 Add	Home Medications (3)			Ter	mp	36.8		-	New Order Entry 🔶		=	• •
Medication Request	All Visits			BP		122/76			Too Miest -			
Histories	Htc: formoterol (formoterol	inhaler) 12 mcg, inhalation, qdail	r, 0 Refill(s)			30/11/17 11:01			inpotent •			
Allergies 🕂 Add	Hb: methIMAzole 10 mg, P	O, qdaily, for 30 day, 30 tab, 0 Re	vfill(s)	HR		84			Q Search New Order			-11
Diagnoses and Problems	Hbc salmeterol (salmeterol i	inhaler device) 50 mcg, inhalation	, BID, PRN:	Der	risharal Duka Pata	30/11/17 11:01			Perropal	Dublic Sharad		
	snormess or bream, o Ken	1(8/			righter of Plaise Plaise	30/11/17 11:01			Esvorites	Public Shared		
CareConnect	Qr Renew ⊘ Cancel/D	C Omplete		Res	spiratory Rate	16			Mu Ban Exercitor			- 11
Clinical Research	Routing: None Defined		5	ign		30/11/17 11:01			Phy Plan Pavolices			
Form Browser				Spt	02	30/11/17 11:01			Documents (2) 🔶		=	• •
Growth Chart	Social History (3)			=•					Last 6 months for all visits -			
Immunizations	All Visits			La	bs			≡• ⊙				
Lines/Tubes/Drains Summary	Alcohol:		De	tails La	ast 72 hours for all visits 👻				My Documents			
MAR Summary	Tobacco:		De	tails	conduction for and				Note Type ED Correspond - Adult - Text	Author Day Text I loss Nurse Emergency 20	20/Time	- 1
Medication List 🔹 🖶 Add				NO	results round				ED Triage - Adult - Text	TestUser, Nurse-Emergency 30	/11/17 11:01	
Patient Information	Visits (1)			=• 👻 Dia	agnostics (0)			=- ~	1			_
Single Patient Task List	Procedure History (1)			=• ^ Li	ast 18 months for all visits 🔻				Medications 💠		=	• •
	All Visits			No	results found				Selected visit			
	Name	Implant	Date Time Since						⊿ Scheduled (0)			
	OR Record (0)			Sig	gnincant Events 🔶			=• @	⊿ continuous (0) ⊿ PRN/Unscheduled Available	(0)		
	Procedures (1)			Se	elected visit				Administered (0) Last 24 hor	urs		
	Tonsillectomy and adenoid	ectomy	2002 15 years	NO	results found				⊿ Suspended (0)			
									 Discontinued (0) Last 24 hot 	urs		

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.

- 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.

(Unchart)	PYLON, MONTY				
1 🛇 🕅	<u>38</u>				
*Performed o	01-Dec-2017	× 0951	PST	By:	TestUser, Nurse-Emerg
Unch	rting this form w	ill change the stat	tus of all the result	ts associ	ated with this form to '
Error					
Commont					
Manual altern		and an altern from d	the second second second		
Wrong char	selected, same	order given for d	lifferent patient.		
Wrong char	selected, same	order given for d	lifferent patient.		
Wrong char	selected, same	order given for d	lifferent patient.		
Wrong char	selected, same	order given for d	lifferent patient.		
Wrong char	selected, same	order given for d	lifferent patient.		
Wrong char	selected, same	order given for d	lifferent patient.		
Wrong char	selected, same	order given for d	lifferent patient.		
Wrong char	selected, same	order given for d	ifferent patient.		
Wrong char	selected, same	order given for d	lifferent patient.		
Wrong char	selected, same	order given for d	lifferent patient.		

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.

PRN acetaminophen 325 mg, PO, q4h, PRN pain, drug form: tab, start: 01-Dec-2017 09:30 PST Maximum acetaminophen 4 g/24 h from all s		325 mg Last given: 30-Nov-2017 11:13 PST		
acetaminophen			* In Error	
Temperature Axillary				
Temperature Oral				
Numeric Pain Score (0-10)				

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.

ED Summary 🔯 Handoff Tool 😂 Sum	mary 🛛	Assessment	X	+		4	
Triage Documentation	🔊 🖉 Vital Signs 🖕			≡• ∞	Flagged Events (0)		≡• ∾
Selected visit	Last 72 hours for all visits 🔫				Last 30 days for the selected visit		
No results found		Today	Pr	revious	No results found		
Problem List =-	Temp		36.8 30/11/17 10:58		New Order Entry 🖕		≡• ⊘
Home Medications (5)	BP		120/77 30/11/17 14:09	134/77 30/11/17 10:58	Inpatient 🗸		
All Visits	HR	-	90 30/11/17 14:09	86 20/11/17 10:58 2	Q XR Che		8
Hx: ASA (ASA Daily Low Dose 81 mg oral delayed release tablet) 1 tab, PO, qdaily, 0 Refill(s)	Peripheral Pulse Rate	-	110	-	XR Chest XR Chest Immigration		
Hx: formoterol (formoterol inhaler) 0 Refill(s) Hx: methIMAzole (methimazole 10 mg oral tablet) 0 Refill(s)	Respiratory Rate	-	19	-	XR Chest PH Probe XR Chest Staff		
Ho: NIFEdipine (NIFEdipine 10 mg oral capsule) 1 cap, PO, T1D, 0 Refill(s) Ho: salmeterol (salmeterol inhaler device) See Instructions, 50 mcg inhalation	SpO2	-	99 20/11/17 10/58		XR Chest TB		-
as directed, 0 Refill(s)			30/11/17 10:30	2	XR Chesronnomen Single From	t 1 View	
	Labs				NR Abdollien 2 views and Cites	fee O devely (Medule)	
Renew (Cancel/DC) Complete	Last 72 hours for all visits				My Documents		
Routing: None Defined Sign					Note Type	Author	Date/Time
	No results found				ED Patient Summary	TestED, Nurse-Emergency3	30/11/17 15:10
Social History (2)					ED Screening - Adult - Text	TestED, Nurse-Emergency1	29/11/17 15:52
(x0-it- (x) =-	Diagnostics (0)			≡• ∾	ED Triage - Adult - Text	TestED, Nurse-Emergency1	29/11/17 15:03
Visits (+)	Last 18 months for all visits 🔻				ED Pre Arrival Note	TestED, Nurse-Emergency1	29/11/17 14:32
Procedure History (1)	No results found				ED Patient Summary	MD	1, 22/11/1/ 15:2/
					ED Screening - Adult - Text	TestUser, Nurse-Emergency	21/11/17 09:37
	Significant Events 👍			≡•⊗	ED Triage - Adult - Text	TestUser, Nurse-Emergency	21/11/17 09:37
	Selected visit				ED Screening - Adult - Text	TestUser, Nurse-Emergency	21/11/17 09:37
	Subjects and				ED Triage - Adult - Text	TestUser, Nurse-Emergency	21/11/17 09:37
	No results tourid				ED Patient Summary	TestUser, Resident	20/11/17 15:54

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

Orders for Signature (1)		×
Diagnostic Tests		
XR Abdomen 2 Views and Chest 1 View		
	5 Sign	Save Modify Cancel

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** solution to select the provider's name from a list.

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

	Crdering Physician
	*Physician name
6	
	*Order Date/Time 01-Dec-2017 v 1018 v PST
	*Communication type
7	Phone Verbal No Cosignature Required Cosignature Required Paper/Fax Electronic
	8 ОК Сапсе

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.

Details 0rder Comments]			
+ • In. 💷				
*Requested Start Date/Time:	01-Dec-2017	PST 11 *Priority:	STAT 🗸]
10 *Reason for Exam:	Trauma	Special Instructions / Notes to Scheduler:		–
Provider Callback Number:				
Pregnant:	C Yes C No	Transport Mode:	×	
Special Handling:	~	If Portable, specify reason:	~	
Other Reason for Portable:		CC Provider 1:		
0 Missing Required Details 0rder:	s For Cosignature		12 Sign	Car

The order status appears as "processing".

Click the **Refresh** refresh **Refresh** contoupdate 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 1.9 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

FowerForms at any time by clicking the Ad Hoc button in the toolbar.	PowerForms at any time b	y clicking the Ad Hoc	AdHoc	button in the toolbar.
---	--------------------------	-----------------------	-------	------------------------

ED LaunchPol	nt																,U,	, Full Screet	n Elsi	nt i i co o minu	tes ago
	1 🔍 🔍 1	00% • 🖲 🖨 🗳											_								
+1	My Patients	All Beds Resus/DTU	Pre-Arrival Forr	n									-	Q				TestUser	r, Nurse-E	mergency $ \equiv \cdot$	
Add Pream	rival		Referring Source	Last No	me	First Nam	e	Age	Gender		Room Assignment										
1 ED Quick I	Reg	Hide Empty Beds								·	T Ioniinai (o)	•	av: 5	Median I O	5: 1 hrs 50	min					
	*		Estimated Date 29 May 2017	E stimat	ed Time								c/	0	9				4		
Room :	+ LOS	Patient Information ; *	231107 2017	*										e e	1	sh	₩		1	Status	
My Patients			Presenting Problem												8			_			
AC,209	170:15	2 57y M 0 2											E 62	-			1	<u> </u>	1	135:4 0	
Unassigned			Pulse Resp	p SBP	DBP	Sats	02	Pain	Temp	Weight	Glucose			-				_			
AC,201	1	PITTTHIRTYTWOVILL																8		Unassigned	
Isolation	01:22	2 7у М 🛛 🚷 🔅	GLS Stok	LPH I	n Progress	Trauma Team.A	Activation						<u> </u>					-		00:15	
EA EOG	01-50	CSTEDHONG, BRAVO			•		•							0	1					Unassigned	
FA _F 300	01.39	4y M 🔕 🧶	EHS Interventions											_	<u> </u>		_			01:58	D
AC.214	23:50	CSTPPTEST, EMMA																		Assigned	
HOPERT		5y F Q	Allergies																	23:43	0
DTU,01	24:00	3 PPCSTTEST, BOB	N 14 5																	Unassigned	
40.000		3.54 Q	Provider/Re	ferral Info:																	
AC,203	45:43	62y M											1	2						Unassigned	
H64600	=	CETERODMI STTWOI												_				-		Unaccioned	
AC,218	216:35	47y M Q	Nursing/EH	S Addition	al Info:								1					-		216:11	
													-								
												OK Current									
			2									Canba									

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**.

ED LaunchPoint			[II] Full screen	🖨 Print 🧉	🕈 9 minutes a	go
🗚 🗎 🖷 🖿 🔍 🔍 100	0% • 🖷 🖷 😭					
Add Prearrival ED Quick Reg	All Beds Resus/	DTU Acute/INTK Q	TestUser, I	Nurse-Emergeno	cyl≡•	
			1		e	2
Room I~ LOS AC,218 219:19	Patient Information CSTPRODMI, STTW 47y M	BC PHN: No persons found from the MPI Search.		Status Unassign 218:56	Jed -	*
INTK,302 303:20 3	CSTEDDEMO, GI 72y M	Last Name:	🚊 🧳	211:2 5		
INTK,301 INTK,301 309:05 2	CSTEDDEMOSTONE 47y M	First Name:	a 2	289:5 0		
PreArrival	CSTLearn, RuralED			Pre-Arriv ETA 00:19	/al .9	Ш
RESUS,103	Available	Gender.			L	
AC,202	Available	Anv Phone Number: No encounters found				
AC,204	Available	Encounter #:				
AC,205	Available	Viiit #				
AC,206	Available	Historical MRN:				
AC,207	Available	Search Reset				
AC,210	Available	MPI Search				
AC,211	Available	OK Cancel Add Person Add Encounter				
AC,212	Available					
AC,213	Available					
AC,215	Available					÷

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.

과 External MPI	- • •
MPI Search Results Information	
The system received the following error from the external MPI system.:	
No candidates found. Please refine your search. [FC.0.0018.0]	
Close	

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.

🚇 Document Selection		×
Document	Printer	Copies
🐼 Armband Label	lgh_cst_t2	1
🐼 Lab Blood Specimen Label	lgh_cst_t2	1
🐼 Lab Non-Blood Specimen Label	lgh_cst_t2	1
PHSA Facesheet	lgh_2flrcopyrm_l1	1
Do not print documents		Edit OK

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**.

ED LaunchPoint				🗇 Full screen 🛛 Print 👌 0 minutes ago					
A ≋ a ≥ 4 € 2005 - 10 € 2									
My Patients All Bods Resus/DTU Acute/INTK Acute INTK FA Triage WR Q TestUser/Nurse-Emergency I=+									
View: All My Patients Department Show: Critical Labs/VS W.R. Ø Hide Empty Beds Current: 2 Last Hour: 0 Today: 1 WR: 25 Preamvals: 1 Current: 39 Last Hour: 1 Today: 15 Median LOS: 13 hrs 21 min									
Room + LOS Patient Information + EDMD MLP RN Patient	ent Details	🖤 i temp rr 02 wt	C & i .h @	🛍 🥒 Status					
ACWR 04:14 PYLON, MONTY 41y M Patient Summary Tyliew			2	Triage 04:14					
PreArrival PYLON, MONTY Nursing Quick Orders	sulting in blunt force chest injury and elbow la			Pre-Arrival ETA 00:00					
ACWR 45:40 5 CSTLEARNING, DEMC 80y M Handref Tool	atory distress (3), mild/moderate RC112	36.9 16 99 75							
ACWR 03:55 CSTPRODOSSYS 1 Attach Prearrival 4y M Request Event	•	♥ 26	5 ماد	Triage 03:55					
ACWR 25:23 CSTSNWINDU, STMA 45y M Start Event Set Events	Þ Þ		2	■ 23:32					
ACWR Poss. Septic 48:20 2 *DONOTUSELEARN, A Roy F Assign/Unassign Others Patient Summary Report	and fever (2), looks septic ID010	♥ 5 ↑ 39.2 ↑ 26 ↓ 86	<u>66</u>	Eval in Progress 03:25					
ACWR S0:03 2 *DONOTUSELEARN, J Discharge Process	trauma (1), blunt, severe respiratory distress	♥ 36.5 <u>†</u> 24 ↓ 88	1 🖉 📙 🗳	Eval in Progress 03:42					
			PRODBC TEST	EDNURSE Thursday 30-November-2017 13:28 PST					

- 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.

Select Pre-Arrival to attach to particular to particula	atient CSTLEARN, RURALEDNURSE	
Attached Pre-Arrivals	Referring Source Last Name First Name Age Gender CSTLearn RuralEDNurse Male -	
	Room Assignment Estimated Date Estimated Time PreArrival (1) 29-Nov-2017	
4 Attach Detach Available Pre-Arrivals	Fall resulting in blunt force chest injury and elbow laceration. Pulse Resp SBP DBP Sats 0.2 Pain Temp Weight Glucose	
CSTLearn, RuralEDNurse	GCS Stroke CPR in Progress Trauma Team Activation	
	Allergies	
	Provider/Referral Info: Nursing/EHS Additional Info:	
	3	
2		5 Close

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 2 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.

ED LaunchPoint										
My Patients All Beds Resus/DTU Acute/INTK Acute INTK FA Triage WR										
View: All My Patients Department Show: Crtical Labs/VS WR Ø Hide Empty Beds Current: 3 Last Hour: 0 Today: 0 WR: 29 Preartwals: 0 Current: 45 Last Hour: 0 Today: 4 Median LOS: 10 hrs 47 min										
Room :- LOS Patient Information	EDMD MLP RN	Patient Details	🖤 i 🛛 BP	HR TEMP	RR 02 WT	ď	Ø 1	.de		
ACWR 73:41 PYLON, MONTY 41y M	👩 cw- cw-		♥ 119/7	77 91 36.9	20 98	2 2	2			
PSYCH,401 97:03 PRODBCTEST, JANI 31y F	E	Dx: Major depression; Anxiety; Borderline schizoph	• 120/8	30 70 36.8	18 100 50	✓ 23	2 1	Jr.		
RESUS,102 143:38 2 PITTPRACTICE, FOU No Visitors 2 47y F	R NJB NT	Major trauma (2), blunt, high risk mechanism of inj	♥ ↓ 28/	12 80	16 98 80	 ₽ 2 	2 1			
AC,206 116:33 2 PITPRACTICE, FIVE 47y M	sh NT	Neck trauma (2), high risk mechanism and/or mode	♥ ↓33/	15 88	19 100 70	✓ 18	2			
ACWR Poss. Septic 70:24 3 IPPHYTWO, DOROT	iy O	Hypertension (3) (SBP 200-220 or DBP 110-130) ar	♥ ↓ 80/	58 † 39.2	↑ 26 70	66				
ACWR 71:42 2 1PPHYONE, JANE 76y F	0	Dx: DIABETES INSIPIDUS	• 120/8	30 70 † 38.2	20 92 70	66	1			
AC,210 96:42 2 EDTESTSMITH, JOE 54y M	sh EB	Dx: CONCUSSION; Head injury	♥ ↓ 33/	15 88 ↓ 36.2	18 100 80	✔ 27	2 1	. In		
ACWR 94:50 EDTESTDEMO, TRIA	GE sh EB	shortness of breath				✓ 39	2			
ACWR Poss. Septic 66:30 DEMARCO-LEARN, 1 49y M	U MDE	Cut leg doing yard work on weekend Reason for Vis \boxdot	♥ ↓86/	58 ↑ 108 ↑ 39	† 27 92 77	1				
ACWR 118:44 CSTSNWINDU, STM 45y M	CE O	Ę				1				

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 ^o 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.

ED Travel History		×
U 🕅 💥 📾		
ED Travel Histor	,	-
LD Have mistory		
Location of Recent Tr	avel	
Africa	Eastern Europe	
Africa-Central	🗌 India	
Africa-East	Mexico	
Africa-South	🔲 Middle East	E
Africa-West	🗖 Russia	
🗖 Asia	South America	
Australia/New Zealand	United States	
Caribbean	🔲 Western Europe	
Central America		
🗖 China		
		Ŧ
		- F

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 ^o.

	ED ADE Risk Screen - PYYLON, MONTYY		
6	U 🗞 🎟		
	ED Adverse Drug Event Screen		*
	1. Have you taken any medications in the last 2 weeks?	6 ^O Yes	
	2. Do you either: Have any pre-existing medical problems or have you taken antibiotics in the past 7 days?	O Yes O No	
	3. Are you 80 or older or have you stopped, started, or changed any of your medications in the past 28 days?	O Yes O No	
	<		

- 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.

earch: chest	Starts with	 Within: 	Terminology
Search by Name		Search by Co	de
rminology: <all terminologies=""></all>	Terminology Axis:	<all axe<="" td="" terminology=""><td>></td></all>	>
g View Synonym 🎘 Concept Family 🗯 Multi Axial 🛛	Cross Mapping		
em 🔺	Code	Terminology	Terminology Axis
Chest pain (1) and severe hypotension or shock CV021	003CV021	COT	
Chest pain (1) and severe respiratory distress CV020	003CV020	COT	
Chest pain (2) and moderate hemodynamic compromise CV028	003CV028	COT	
Chest pain (2) and moderate respiratory distress CV027	003CV027	COT	
Chest pain (2), cardiac features CV022	003CV022	COT	
Chest pain (2), ripping or tearing, non-cardiac features CV030	004CV030	COT	
Chest pain (3) and respiratory symptoms, looks unwell CV025	004CV025	COT	
Chest pain (3), no cardiac features or history CV023	004CV023	COT	
Chest pain (3), resolved, significant cardiac history CV029	003CV029	COT	
Chest pain (4) and minor chest injury and minimal/no respiratory	. 004CV024	COT	
Chest pain (4) and respiratory symptoms, looks well CV026	004CV026	COT	
Chest trauma (1), blunt, severe respiratory distress and/or shoc	804TR015	COT	
Chest trauma (1), penetrating, severe respiratory distress and/o	803TR005	COT	
Chest trauma (2), blunt, high risk mechanism of injury and/or he			
Chest trauma (2), penetrating (any) TR006	803TR006	COT	
Chest trauma (3), blunt, low risk mechanism of injury, moderate	. 804TR017	COT	
Chest trauma (4), blunt, low risk mechanism of injury, mild pain	804TR018	COT	

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 solution 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 ²
- 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 2 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.

ACWR	PYYLON, 41y M	MONTYY DOB: 29/06/	76			MRI	N: 700008802 FIN: 7	ACWR × 7000000016428
±	2	۷	Ø Î	/ ₁		2		
Activities						MAR	Or	ders 🥏 Refresh
Assessments (2)								≣⊷
2 Assessme	ents							2
ED Assessment Comments: Orde	Adult 12-De er placed due t	c-2017 08:18 P o patient arrival	ST, Stop: 12-Dec-201 to the Emergency De	7 08:18 PST, ED / epartment	Assessment Adult			i t
ED Screening -	Adult 12/12,	17 08:03:15						
						3	Document (1)	Close

- 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.

*Performed on: 11	8 1 T ▼ 1 1 2 2 2 1 2 2 2 2 2 2 2 2 2 2 2 2 2			Bv:	TestUser Nurse-Emergen
General Assessme	0825 101			53.	restose, Nuise Emerge
ED Stroke FAST	General Screening Infor	mation			
Violence and Agg ID Risk Screen	Demonstrates Signs and Symptoms of the Following Conditions	Falls Risk	Violence and Aggression Risk	Suicide Risk Assessment	
Family History Social History	Stroke	Not a fall risk History of falls in the last 3 months History and a statement of a statement of the statement of	No risk assessed at this time Previous history of violent behaviour Current pluvical apgression or violence	O Document Suicide Risk Assessment	
Procedure History CSSRS Quick Sc		Altered mental status Patient is a fall risk	Current verbal threats of physical violence	Infectious Disease Risk Screen	
				O Document Infectious Disease Risk Screen	
	Family History	Immunizations Current	Domestic Concerns		
	O Document Family History	O Yes O No	None		
	Social History	O None received			
	O Document Social History	O Unknown O Other:	Neglect Other:		
	Procedure History				
	O Document Procedure History				
	Languages	Interpreter Called	Reason Unable to Obtain Information	1	
	Ørglish Portugese French Punjabi Cantonese Russian Fotri Spanish Italian Vietnamese Japanese Other: Korean Mandarin	C Yes 🖲 🚻			
	4				

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** \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.

🏎 🔜 📾 🖓 🖌 🥂 🚛 🖿 📾 🛪		
		_
CED Adult Systems Assessment		
CED Adult Interventions		
V ED Lines	Find Item - Critical	н
Adult Dragaduran		0
TED Trauma Accoccmont	Hesuit	.0
ED Trauma Astronom		
Travers Masharing of Johns		
Primer Assessment		
Primary Assessment		-
Primary Aniway Assessment	30-N	10
Primary Preathing Assessment	🗮 🚮 🗗 🛛 🕺 🖓	19
Primary Breathing Interventions	⊿ Trauma Mechanism of Injury	Ŀ
Primary Circulation Assessment	Prior to Arrival Place of Injury Hom	e
Primary Circulation Interventions	Mechanism of Injury Fall	
Primary Disability	Injury Fits Reported Mechanism Yes	
Expose/Environment	♦ Fall Height 15 ft	
Expose/Environment Interventions	Fall Landing Surface conc	re
Secondary Assessment	Notification of Child Services	
Secondary Head Assessment	Notification of Law Enforcement	
Secondary Face Assessment	Primary Assessment	E
Secondary Neck Assessment	Primary Airway Assessment	Ē
Secondary Chest Assessment	⊿ Primary Airway Interventions	Ŀ
Secondary Abdominal Assessment	Airway Interventions	L.
Secondary Pelvis/Genitalia Assessment	∠ Endotracheal Tube	Ŀ
Secondary Extremities Assessment	⊿ Tracheostomy Tube	Ŀ
Secondary Posterior Assessment	⊿ Pharyngeal Airway Lc	E
Incision/Wound/Skin/Pin Site	⊿ Primary Breathing Assessment	E
MUSCULOSKELETAL	Breathing Assessment	
Neuromuscular/Extremities Assessment	⊿ Breath Sounds Assessment	Ŀ
Neurovascular Check	Breath Sounds Auscultated Anter	ric
	All Lobes Breath Sounds Dimit	ni
TO Prese trail Or define	Lung Sounds Left	
ED Procedural Sedation	Lung Sounds Right	
🔨 Intake And Output	Lett Upper Lobe Breath Sounds	
Slood Product Administration	Right Upper Lobe Breath Sounds	
Advanced Graphing	Left Lower Lobe Breath Sou	
Destroist and Ocalusian	Diskt Jower Lobe Breath Sounds 3	

4. Once you have entered the information above, click Sign \checkmark .

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 Section Section 2.

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 More for Mr. Pylon. He verbally dictates the order to you:

 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.

Menu		< 🔹 👻 👫 🛛 Nursing Quick Or	ders		[□] Full sci	reen 👘 Print 🎝 1 hours 14 minutes ago
Patient Summary		AA 100%	• • • • •			
Orders	🕈 Add	Nursing Quick Orders	S? ED PEDS Nursing Orders	57 1		
Nursing Quick Orders		Harding Quick orders	N LD I LDD Halbing Orderb	T		
MAR		Venue: Inpatient 👻				
MAR Summary						(
Interactive View and I&O		PowerPlans 🔤 🐼	Medications =• (A)	Labs\ECG = * 🔗	Imaging = * 🔊	New Order Entry
Results Review		► General Orders	IV Fluids	ECG 12 Lead Urgent	XR Lower Extremity Right	Inpatient -
Documentation	🕂 Add	Triage Adult		▶ ECG	XR Lower Exremity Left	
Medication Request		(Furning) = 0	Critical Care =• 🐼	Consults =	Destingt Come == 0	Q Search New Order
Histories		Conditions	Code / ACLS		Patient Care = · o	Mine Public Share
Allergies	🕂 Add	Acthma/COPD	 Intubation 	ED Perform Best Possible Medication History (RDMH)	Difficult Airway/Intubation Please	No Favorites Found
Diagnoses and Problems		Cardiac / Chest Pain	Pressors	Allied Health	complete process alert Equipment/Supplies	
		Neuro / Stroke / TIA 2	ED Procedural Sedation		► Injuries	Disposition =• 🔿 Orders
CareConnect		Sepsis / Fever	(Module) (Validated) ED		▶ Isolation	
Clinical Research		4 Trauma 50 Trauma (Validated) a	Procedural Sedation (Module)			Discharge Patient T;N, Discharged Home without Support Services
Form Browser		Trauma (Validated)	(vullddccd)			Discharge to External Site T;N
Growth Chart						
Immunizations						
Lines/Tubes/Drains Sum	imary					
Medication List	🕇 Add					
Patient Information						
Single Patient Task List						_
						*

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

E Ordering Physician
*Physician name
*Order Date/Time
01-Dec-2017
*Communication type
Phone Verbal No Cosignature Required Cosignature Required Paper/Fax Electronic
OK Cancel

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.

+ Add Tocument Medication by	Add T Document Medication by Hx Reconciliation * 🔊 Check Interactions								
Orders Medication List Document	n Plan								
Norma (∢፤ % 🛇 🕇 Add to Phase - 🛕 Check Alerts 🎍 Comments Start: Now 📖 Duration: None								
	🔊 🕅 Component Status Dose	Details							
The International Societion	ED Procedural Sedation (Module) (Validated) (Initiated Pending)								
Trauma (Validated) (I	⊿ Patient Care								
	Nitrous Oxide Gas Administration	PRN, for sedation							
Orders	△ Medications								
Mait/Transfer/Discharge	ketamine	200 mg, IV, as directed, drug form: inj Have ketamine 200 mg IV drawn up f							
- Status	🗹 💆 proPOFol	200 mg, IV, as directed, drug form: inj							
Patient Care		Have proPOFol 200 mg IV drawn up f							
- Activity O	🗹 💆 fentanyl	100 mcg, IV, as directed, drug form: inj							
Diet/Nutrition		Have fentanyl 100 mcg IV drawn up f							
Continuous Infusions	Jo order ketofol, select both ketamine and proPOFol	100 mars B(an discrete di deven former ini							
	ketamine	Have ketamine vial(s) ready at beside							
- Blood Products	sie 🕅 proPOFol	100 mg IV as directed drug form; ini							
		Have proPOFol vial(s) ready at beside							
Respiratory									
Consults/Referrals									
 ✓ Ⅲ → 									
Diagnoses & Problems	▲ Details								
Related Results									
Variance Viewer	Orders For Cosignature Save as My Favorite	Orders For Signature Cancel							

- 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 Return to ED Trauma (Validated) 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.

E PYLON, MONTY						- Ø -
PYLON, MONTY	DOB:15-Jun-1976	MRN:700008127	Code Status:			Location:LGH ED; ACWR
	Age:41 years	Enc:7000000016059			Disease:	Enc Type:Emergency
Allergies: Demerol HCI	Gender:Male	PHN:9876478292	Dosing Wt:		Isolation:	Attending:TestED, Emergency-Physician1, MD
+ Add Document Medication by Hx Rec	onciliation - 🔈 Check Interactions					Reconciliation Status Ø Meds History Ø Admission Ø Discharge
Orders Medication List Document In Plan						
H	S - Datas to 50 Taxan (1/1/1	D				
View	Return to ED Trauma (valid	sted)				
Orders for Signature	Some Component		Status	Dose	Details	
Plans	ED Trauma (Validated), ED IV Fluid	s (Module) (Validated) (Initia	ed Pending)			
- Document In Plan	Continuous Infusions					
- Medical	Bolus Fluids					
ED Trauma (Validated) (Initiated	sodium chloride 0.	9% (sodium chloride 0.9% (NS) bol		 500 mL, IV, once, drug form: bag, first dose: NOW 	
St ED IV Eluids (Module) (Validate	Plasmalyte (plasma	ilyte bolus)			500 mL, IV, once, drug form: bag, first dose: NOW	
ED Pain / Nausea / Vomiting (Me	dextrose 5%-sodiu	m chloride 0.45% (dextrose 5%	-sod		500 mL, IV, once, drug form: bag, first dose: NOW	
ED Procedural Sedation (Module) (V	dextrose 10% (dext	rose 10% (D10W) bolus)			250 mL, IV, once, drug form: bag, first dose: NOW	
ED Trauma (Validated) (Initiated)	Maintenance Fluids	D9((b)C)	000			NOW
Suggested Plans (0)	Sodium chioride 0.	9% (NS) continuous infusion 1	,000		 order rate: 250 mL/n, IV, drug form: bag, first d 	NOW
Orders	KCL 20 mmol/L-so KCL 40 mmol/L-so	dium chloride 0.9% (KCL 40 m	mol/		 order rate: 100 mL/h, IV, drug form: bag, first dose order rate: 100 mL/h, IV, drug form: bag, first dose 	NOW
Admit/Transfer/Discharge	Rec 40 minor 2-30	didni chionae 0.5 % (RCE 40 m	inov		 order rate: 100 mL/h, IV, drug form: bag, first dose 	NOW
Status	plasmatyce (plasmatyce (plasmatyce))	stated ringers continuous infu	tion)		 order rate: 100 mL/h, IV, drug form: bag, first dose 	NOW
Patient Care	C destrose 5%-sodiu	m chloride 0.9% (devtrose 5%-	sodi		order rate: 100 mL/h, IV, drug form: bag, first dose	NOW
Activity	dextrose 5%-sodiu	m chloride 0.45% (dextrose 5%	-sod		order rate: 100 mL/h. IV. drug form: bag, first dose	NOW
Dist/Nutrition	See Datum to ED Trauma (Validated					
Continuous Infusions	Return to ED Trauma (Validated					
Continuous infusions	T					

- 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.

▪ Details for dimenhy	DRINATE			
😭 Details 🗊 Order Comme	nts 🕅 🛞 Offset Details 🗎			
🕂 🔓 In. 🛛 🔍				
*Dose:	50	*Dose Unit:	mg 🗸	<u>^</u>
*Route of Administration:	Ⅳ	*Frequency:	q4h 🗸	E
PRN:	Yes O No	*PRN Reason:	nausea or vomiting 🔹	
Administer over:		Administer over Unit:	•	
Duration:		Duration Unit:	`	-
Orders For Cosignature Save	e as My Favorite			Orders For Signature Cancel

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).

🕂 Add 🦨 Document Medication b	y Hx Rei	concilia	tion - 🚴 Check Interac	tions				Reconciliation Status • Meds History	Admission	Discharge
Orders Medication List Document	In Plan									
4										
View	1	Return	to ED Trauma (Validated	I)						
Plans	S	7	Component		Status	Dose		Details		*
- Document In Plan		2	ketorolac				▼	15 mg, IM, once, drug form: inj, first dose: NOW		
Medical		% 🖄	ketamine					0.75 mg/kg, nasal-both, once, drug form: inj, first dose: NOV	1	
ED Trauma (Validated) (I								Maximum 50mg (1mL)/nare. Divided equally between nares.		
ED Pain / Nausea / Von		🎽 💆	ketamine					0.3 mg/kg, IV, once, drug form: inj, first dose: NOW		
ED Trauma (Validated) (Init			ketamine continuous i	nfusion (5 mg/mL) standard				order rate: 2 mg/kg/h, IV, order duration: 1 hour, drug form:	baq	
ED Pain / Nausea / Vomit	Ana	algesics	Opioids							
ED Procedural Sedation (M			HYDROmorphone				-	0.5 mg, PO, once, drug form: tab, first dose: NOW		
ED Trauma (Validated) (Init		4	HYDROmorphone (HY	DROmorphone PRN range dose)			-	dose range: 0.1 to 0.5 mg, IV, q10min, PKN pain, drug form: I	nj	
ED IV Fluids (Module) (Va		r de la comercia de l	mombine				Ŧ	5 mg IM once drug form ini first dose NOW		
ED Pain / Nausea / Vomit	E -	Ř	morphine				Ŧ	5 mg subcutaneous once drug form; ini first dose: NOW		
ED Intubation (Module) (Ē	Ř	morphine				▼	5 mg PO once drug form: tab first dose: NOW		
Suggested Plans (0)	Π	Ř	morphine (morphine l	opg acting)			T	15 mg PO, once, drug form; can-long acting, first dose; NOV	v	
Orders	2	r R	morphine (morphine P	PRN range dose)			-	dose range: 1 to 5 mg. IV. g10min. PRN pain. drug form; ini		
Admit/Transfer/Dircharge	-	10	OXYCODONE				-	5 mg, PO, once, drug form: tab, first dose: NOW		
Status		2	acetaminophen/caffeir	ne/codeine (TYLENOL #3 EQUIV				1 tab, PO, once, drug form: tab, first dose: NOW		
Patient Care			tab)				_	Each tablet contains up to 325 mg acetaminophen, caffeine 1	.5 mg and co	odein
Activity	Ant	iemetic	s				_		_	
Diet/Nutrition			dimenhyDRINATE				Ŧ	50 mg, IV, q4h, PRN nausea or vomiting, drug form: inj		E
Continuous Infusions		547						GRAVOL EQUIV		
			dimenhyDRINATE				-	25 mg, IM, q4h, PRN nausea or vomiting, drug form: inj		
Blood Products		6	A STATE OF THE OWNER TO				\neg	DRAVOL EQUIV		
		4	dimennyDRINATE				•	GRAVOL FOLITV		
Diagnostic Tests		r an	metoclonramide				_	10 mg IV once drug form ini first dose NOW		
Procedures	E -	Ř	metoclopramide					10 mg IM once drug form ini first dose NOW		
Respiratory	Ē	Ř	ondansetron				V	4 mg IV once drug form: ini first dose: NOW		
Allied Health	Ē	Ř	ondansetron				_	4 mg. IM. once. drug form: ini. first dose: NOW		
Concults/Referrals	Ē	Ē.	ondansetron	_			V	4 mg, PO, once, drug form; tab, first dose; NOW		
Communication Orders	Con Ret	urn to F	D Trauma (Validated)							
Supplies	ing wet	a.m to E	S							
Non Categorized										
Medication History										
Medication History										
Reconciliation History										

- 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. <u>Deselect</u>: 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 Services²
- 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.

	<u></u>	৯ 🖂 👳	Order Name	Chattan	Charat	Dataile			
	LCII				2017 11-04 PCT				
2	Cart	ED; ACWK EI	1C:7000000016059 Adn	nit: US-Dec	2017 11:04 PST				
2	Cont		ons	Orden	11 D 2017 12:10	and a rate (250 m) (b, B) drug forms have first dama NOW start 11 Day 2017 12:10 DET, have used on b 1:000			
	Mad		sodium chioride 0.9 /6	Order	11-Dec-2017 12:19	order rate: 250 mL/n, 1V, drug form: bag, first dose: NOW, start: 11-bec-2017 12:19 PS1; bag volume (mL): 1,000			
2	wear		nlasmah ta (nlasmah t	Order	11 Dec 2017 12:10	500 ml IV and drug formulas first data NOW start 11 Day 2017 12:10 DST start 11 Day 2017 12:10 DST			
			plasmalyte (plasmalyt	Order	11-Dec-2017 12:19	Job mic, w, once, and nome, bady mist above: Now, starts in Dec 2017 12:19 PS1, stop: in Dec 2017 12:19 PS1, does not a start and the stop and the s			
			dimonhyDPINATE	Order	11-Dec-2017 12:19	abserange i to 5 mg, iy, quinnin, riky pain, ang rom, in, start 11 Dec 2017 12:19 F31, stop: 10-bet-2017 12:10 F31			
			dimennyDraiNATE	Order	PST	GRAVOL EQUIV			
		f r 🗈	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			
⊿	Labo	ratory							
		- 🔁 🕑 🛛	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, Urgent, 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			
		ft 🗈	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			
⊿	Diag	nostic 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			
	Detai	ls							
01	dissing	Required Deta	ils Orders For Cosignate	ure			Sign	Canc	el

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.

ED LaunchPoint				(고) Full screen
🗚 🗋 📥 🔍 🔍 100% 🔹 🔿 🖾				
My Patients All Beds Resus/DTU	Acute/INTK Acute INTK FA Triage	WR	Q	TestUser, Nurse-Emergency ≡ •
View: All Show: Critical Labs/VS VR Hide Empty Beds	My Patients Current: 4 Last Hour: 0 Today: 1		Department WR: 30 Prearrivals: 0 Current: 40 Last Hour: 2	Today: 6 Median LOS: 10 hrs 40 min
Room : LOS Patient Information :	EDMD MLP RN Patient Details	♥ ← BP	HR TEMP RR O2 WT	✓ ℓ i 49 mm
RESUS,103 02:12 2 PYYLON, MONTYY 41y M O	CW- CW- Dx: Pneumothorax; Arm lace	• 102/72	† 112 36.8 † 26 94	66
AC,202/AC Suicide Prec 3 *CSTLEARN, PSYCHIA 60y F	Dx: Major depressive disorde	• 130/85	70 36.8 18 100	₽ 74
AC,204 139:50 3 CSTDEMOIAN, SURGE AC,204 57y M	NJB EB Dx: Appendicitis	• 120/75	↑ 110 37 ↑ 22 96 75	🖌 7 🔮 📋 🔮 📮
AC,204 91:38 1 LAST, FIRST Isolation 2 1177 F 🛞 📿	SP Dx: FRACTURE COLLES CLOSED	♥ ↓20/14	76 ↓ 10 14 99	🖌 4 🔮 🚊
AC,212/AC No Visitors 168:16 3 *CSTPRODREG, MATL 12y F	CW-CHest trauma (3), blunt, low			

2. Click the *checkbox* beside the eyeglasses icon storeview 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.

< 🔹 🛉 Interactive View and I&	0					[□] Full screen	🛱 Print	€1 minutes
** 🔜 🖽 &* 🖌 😥 🖉 📰 🖿 🍋 🗶								
av/ED Adult Sustama Assessment								
ED Aduit Systems Assessment		Tuesday, 12-Decen	nber-2017 00:0) PST - Tuesday, 12-Decer	nber-2017 23:59 PST			
C ED Adult Interventions								
🔨 ED Lines	Find Item Critical Hi	ligh 🔄 Low 📃	Abnormal	Unauth 🔄 Flag	Or			
Adult Procedures	Result Con	mments Flan	Date	Performed By				
C ED Trauma Assessment	i noon oo	internet integra	Date	r ononiou by				
ED Procedural Sedation	šu –	12-Dec-20	17					
	R 🖌 🔲	10:28 PST 08:32 P	ST 08:04 PST					
Preprocedure Time-Out	Presedation Monitoring							
Procedural Sedation - Medication	Temperature Oral DegC		36.8					
Procedural Sedation / Analgesia Monitoring	SBP/DBP Cuff mmHg		102/72					
Postsedation Monitoring	Peripheral Pulse Rate bpm	112	↑ 97					
Sedation Scales	Respiratory Rate br/min		26 个					
Discharge Criteria	Respirations	Regular,	L					
	SpO2 %		94					
	⊿ Preprocedure Time-Out							
	⊿ Procedural Sedation - Medication							
	⊿ Procedural Sedation/Analgesia Monit							
	SBP/DBP Cuff mmHg		102/72					
	Peripheral Pulse Rate bpm	112	↑ 97					
	Respiratory Rate br/min		26 ↑					
	Respirations	Regular,	L					
	Sp02 %		94					
	⊿ Interventions sedation							
	2 Possedation Monitoring		402.02					
	Designment Pulse Pate hom		102/72					
	Perpiraton Pate br/min	112	. 9/					
	A Perpirations	Pequiar	20					
	5p02 %	Regular,	94					
🔨 Intake And Output	Skin Colour General	Lisual for	e					
Second Product Administration	∠ Sedation Scales	03001101						
Advanced Graphing	⊿ Discharge Criteria							
Kestraint and Seclusion								

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 Relation Procedural Sedation – Medication.

	3002	20	
	A Preprocedure Time.Out		
6	⊿ Procedural Sedation - M	edication	
	21 Procedural Sedation/An	aigesia ivionit	
	SBP/DBP Cuff	mmHg	
	Peripheral Pulse Rate	bpm	112 个
	Respiratory Rate	br/min	
	Respirations		Regular, L
	SpO2	%	
	⊿ Interventions Sedation	n	
	⊿ Postsedation Monitoring	g	
	SBP/DBP Cuff	mmHg	
	Desirals and Distan Date	la ra raa	A

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

Propofol (mg)			* *
Procedural Sedation M	Medication:		
Buscopan (mg)			
Fentanyl (mcg)			
Glucagon (mg)			
Ketamine (mg)			
Midazolam (mg)			
Phenylephrine (mca)			
Propotol (mg)			
Rocuronium (mg)			
Other			
ould			

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.

w							
<u></u>		-			12-Dec-2	2017	
			10:41	PST	08:32	PST	08:04 PST
Oxygen Therapy							
Oxygen Flow Rate	/min						
End Tidal CO2 mi	mHg						
Level of Consciousness							
⊿ Preprocedure Time-Out							
Patient ID Band on and Verified							
Allergy Visual Cue Present							
Procedure Verification							
Procedure Consent Complete							
Procedure Site Verified							
Procedure Comments							
Participants Present for Procedure							
Procedural Sedation - Medication							
⊿ <propofol (mg)=""></propofol>							
Dose							
Total Administered							
⊿ <fentanyl (mcg)=""></fentanyl>							
o Dose							
 Total Administered 							
⊿ Procedural Sedation/Analgesia Mo	nit						
Procedural Sedation/Analgesia Star	t Ti						
Procedure Start Time							
SBP/DBP Cuff mi	mHg						102/72
Apical Heart Rate	bpm						
Peripheral Pulse Rate	bpm				112	\uparrow	97
Heart Rate Monitored	bpm						
Cardiac Dhuthm							

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.

iu 民 M		1 10-41 PST
Presedation Monitoring	9	
Sedation Monitoring Phase		
Last Oral Intake		
Temperature Axillary	DegC	
Temperature Oral	DegC	
Temperature Tympanic	DegC	
SBP/DBP Cuff	mmHg	
Apical Heart Rate	bpm	
Peripheral Pulse Rate	bpm	
Heart Rate Monitored	bpm	
Cardiac Rhythm		
Respiratory Rate	br/min	
Respirations		

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.

⊿ Preprocedure T	īme-Out		 ✓
Patient ID Band	on and Verified		(es
Allergy Visual C	ue Present		(es
Procedure Verif	ication		/erified
Procedure Cons	ent Complete		(es
Procedure Site	Verified		(es
Procedure Site I	Marked		No
Procedure Com	ments	40	Chest tube
Participants Pre	sent for Procedure	10	Grea Fokke

- 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.

< 🔹 - 者 Interactive View :	and I&O			[D] Full screen	🖨 Print	€ 3 minutes ago
🏎 🖃 🖬 <mark>15 🖌 </mark> 🖉 🕷 🔳 🖷	h X					
CED Adult Systems Assessment	Thursday, 14-December-2017	00:00 PST - Th	ursdav. 14-Dece	mber-2017 23:59		
ED Adult Interventions						
ED Lines	Find Item	High 🔲	.ow Abnorm	nal 🔲 Unauth	Flag	And
a Adult Dropaduran						
Addit Procedures	Result	Comments	Flag Date		Performed By	/
C ED Trauma Assessment	¥. 30	11.0	2017			
CED Procedural Sedation		14-De	C-2017			
 Presedation Monitoring 	Procedure Site Marked	-10 00.52 P31	00.37 F31			
 Preprocedure Time-Out 	Procedure Comments		Cherttube			
Procedural Sedation - Medication	Participants Present for Procedure		Grea Fokke			
Procedural Sedation/Analgesia Mor	⊿ Procedural Sedation - Medication	3	oreg rokkelin			
 Postsedation Monitoring 	∠ Fentanyl (mcg)	·				
Sedation Scales	Dose	25	25			
Discharge Untena	Total Administered					
	⊿ Propofol (mg) 1 /					
	Dose	30	30			
	Total Administered					
	Procedural Sedation/Analgesia Monit.					
	Procedural Sedation/Analgesia Start Ti.	14-Dec-201				
	Procedure Start Time	14-Dec-201				=
	SBP/DBP Cuff mmH	114/68	112/75			
	Apical Heart Rate bpr	88	94			
	Peripheral Pulse Rate bpr	88	94			
	Heart Rate Monitored bpr	88	94			
	Cardiac Rhythm	Normal sin	Normal sin			
	Respiratory Rate br/mi	16	18			
	Respirations	Unlaboure	Unlaboure			
	Sp02	100	100			
🗙 Intake And Output	Oxygen Activity	Name and	initiate 02			
Slood Product Administration	Owgen Flow Pate 12	rvasar cann				
X Advanced Graphing	Dep Tidal CO2	32	0			
Restraint and Seclusion	✓ Interventions Sedation	12				
A rest and occupient	a interventions sedadon					Ŧ

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 a	and I&O			(D) Fi	ull screen	Print	₽ 4 minutes ago
➡ 🗖 🗖 20 🖌 🐼 📓 🔳 🕷	a ×						
	-						
🗙 ED Adult Systems Assessment	Thursday, 14-December-2017 0	0:00 PST - Th	ursdav. 14-D	ecember-20	17 23:59		
ED Adult Interventions							
ED Lines	Find Item - Critical	High 🔳	.ow 📃 Abr	normal 🛛 🔳 l	Jnauth 📃	Flag	And
Adult Procedures		-				-	
ED Trauma Assessment	Result	Comments	Hag Da	ite	1	erformed By	1
CD Frauma Assessment	X		14-De	c-2017			
ED Procedural Sedation		ିଖି 09:06 PST	09:01 PST	08:52 PST	08:37 PST		
Presedation Monitoring Preprocedure Time-Out	Oxygen Flow Rate L/mir	1	6	6	6		
Procedural Sedation - Medication	End Tidal CO2 mmHg	3	36	32 ↓			
Presedual Codetion /Acalencia Mar	⊿ Interventions Sedation						
17 Postsedation Monitoring	Nonpharmacologic Sedation Interv.						
Sedation Scales	Procedural Sedation Comments						
Discharge Criteria	Postsedation Monitoring						
	Sedation Monitoring Phase	Recovery			Presedation	1	
	Procedure Stop Time	14-Dec-201					
	Sedation Stop Time	14-Dec-201					
	Sedation Total Time minute	29					
	SBP/DBP Cutt home	114//0	110/66	114/68	112//5		
	Apical Heart Rate Dph	/8	74	88	94		
	Heart Pate Monitored hnn	78	74	00	94		
	Cardiac Rhythm	70 Normal sin	/4 Normal sin	oo Normal sin	94 Normal cin		
	Bespiratory Bate br/mir	16	14	16	18		
	Respirations	Unlaboure	Unlaboure	Unlaboure	Unlaboure.		
	SpO2 9	100	100	100	100		
	Oxygen Activity	Discontinu			Initiate O2		
	Oxygen Therapy	Ambient ox	Nasal cann	Nasal cann	Nasal cann		
	Oxygen Flow Rate L/mir	40	6	6	6		-
	Postprocedure Disposition	18					-
	Postprocedure Comments						
VINTAKE And Output	⊿ Sedation Scales						
🗙 Blood Product Administration	Sedation Scale Used						
Advanced Graphing	⊿ Discharge Criteria						
Restraint and Seclusion	Nausea and Vomiting					_	
Koonann and Occidioion	Bleeding						Ψ.

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

 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 dropdown menu where you can select IView.

- 2. Click the ED Lines **CED** Lines band.
- 3. Select **Peripheral IV** Peripheral IV from the navigation pane.
- 4. Click the **Add Dynamic Group** Review 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>**).

PYLON, MONTY D08:15-lun-1976 MRV:200008127 Code Status: Process: Location:LGH ED: ACWR	
Agra yara Encrossoria Alegies: Denerol HCl GenderAluk PH/Sp2747522 Dosing Vit: Solution: Attendig?Eliter_Energency	hysician, MD
Menu 🕴 < > - 🍵 Interactive View and I&O	en 🖷 Print 💸 0 minutes ago
Patient Summary	
Orders + Add	
Nursing Quick Orders Last 24 Hours	• •
2 Adult Interventions	
Interactive View and I&O	
Recults Brojew Adelovencus Fabla/Graft	
Inconstantion & Cetral Line Label:	
Decumentation and Constraint Tubes Perioheral Foream Left - Perioheral Michaeler Sters	
Medicebon Kequest	
Histories Personal Datas Chiter A A A A A A A A A A A A A A A A A A A	
Allergies + Add Subcutaneous Catheter 01.0ec.2017 Perspectator Catheter pro-	
Disgnoses and Problems Surgical Deniar Tubes Problems 4 70 1507 PDI Program 4 7007 PDI Progra	
Unary Lanxer	
CareConnect	
Chick Branch	
Concerningeneous Examplement Aman Danate	
Term Dones Ball vein Ball	
Cophrit cein C	
ummutatoris Digit	
Line2/ ube2/Dans summary	
MAR Summary Foreign	
Frontal vein	
Patient Information Hannel	
Single Patient Task List	
Posterior auricultar tenn Small ashehous tein	
Superficial temporal vein	
Upper arm	
VIID.	
Adult Procedures	
Q EU Traumassessment Peripheral IV Laterality: Provide and Peripheral IV Laterality:	
Vertile deserver Vertile Vertile Vertile	
C Florid Product & Administration	
St Advanced Granhing	
Restraint and Seclusion OK Cancel	

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.

80	12-De	c-2017	
S 🖬	09:20 PST	09:19 PST	
🛛 Peripheral IV 🛛 👯	1	$\overline{\mathbf{v}}$	
⊿ <peripheral 18="" forearm="" gaug<="" left="" p=""></peripheral>			
Activity		Present on	
POA (Insert Date/Time if known)		12/12/2017	🚔 👻 0850 🚔 PST
Line Status			
Line Care			
Site Assessment			
Site Care			
Dressing Activity			
Dressing Condition			
Patient Response			

- 2. A drop-down menu will present you with options for documentation.
- 3. Notice how some topics have a *w* 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 \diamond icon, indicating a field is associated with a conditional logic response.

₩.₩ 	01-Dec-2017	11 1, 3) / = 1	01-Dec-2017
A Peripheral IV	10:08 PS1		aripheral IV	NO 10:00 PST
⊿ <peripheral forearm="" lef<="" p=""></peripheral>	-		Peripheral Forearm Log	ef
Activity 1	1111111	2 4	Activity	Activity
Line Status			POA (Insert Date/Time i	f 🗌 Insert
Line Care			Line Status	Assessment
Site Assessment			Line Care	Blood drawn
Site Care		4	Site Assessment	Discontinued
Dressing Activity			Site Care 🛛 🗧	Present on admis
Dressing Condition			Dressing Activity	Other
Patient Response			Dressing Condition	
			Patient 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** \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** shand and locate **Chest Tubes** in the navigation pane.
- 2. Add a **Dynamic Group** R and use the following information: Chest Tube Number: #1
 - Chest Tube Location: Lateral, Right
 - Chest Tube Type: Chest tube
 - Chest Tube Size: 28 French

#1 Eateral, Right Chest	tube 28 F	rench		
Chest Tube Number				- 1
#1				
#2				
#3				
#4				
#D #C				
#7				
#8				
#9				1
#10				
Chest Tube Location:				
✓ Lateral				
Pleural				
Distal				
Left				
Right				
Mediastinal]			
Chest Tube Type:				
Chest Tube Type:				

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 \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** ^{M Begin Bag} button.
- 4. Click the **Apply** 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** \checkmark to **Sign** when finished.

	E Charting for: ABASSI, FA	ЛТІМАН	—
5	 ✓ O ■ 		
	sodium chloride 0.9% (order rate: 100 mL/h, IV, dru volume (mL): 1,000	Change Order Version	
	4 Þ	30-Nov-2017 20:20 PST - 01-Dec-2017 20:20 PST	4 Þ.
3	Begin Bag Site Change Infuse Bolus Rate Change	No results found	
	Ves No sod	ium chloride 0.9% (NS) continuous infusion 1,000 mL	Change
	*Performed date / time :	01-Dec-2017 0820 PST	Comment
	Witnessed by :	lest User, Nurse-Emergency	Clear 4 Apply
	2 *Bag # . *Site :	1 Hand - Left	
	*Volume (mL) : 1 *Rate (mL/h) :	1000 100	
			Begin Bag

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**.

Continuous Infusions sodium chloride 0.9% (NS) continuous infus order rate: 100 mL/n, IV, drug form: bag, first dose: NOW, start: 01-Dec-2017 08:18 PST, bag	1	NOW Not previously given	NOW	
volume (mL): 1,000				
Administration Information				
sodium chloride 0.9%				

- 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** \checkmark to **Sign**.

	E Charting for: A	BASSI, FATIN	ИАН		
4	🗸 🚫 📾				
	sodium chlorid order rate: 100 ml volume (mL): 1,000	le 0.9% (NS /h, IV, drug f)) continuous orm: bag, first do	infusion 1,000 mL ose: NOW, start: 01-Dec-2017 08:18 PST, bag	Change Order Version
	< >		30-Nov-2	017 20:33 PST - 01-Dec-2017 20:33 PST	▲ ►
		01-Dec-201 08:20 PST	7 01-Dec-2017 08:33 PST		
2	🚹 Begin Bag	Bag #1	Bag # 2		
	Site Change	Hand - Left	Hand - Left		
	Rolus				
	Rate Change	100 ml /h	100 ml /h		
	Ves No	o sodium	n chloride 0.9% (NS) continuous infusion 1,000 mL	Change
	*Performed date	e / time : 0	1-Dec-2017	• 0833 • PST	Comment
	*Perfor	med by: T	estUser, Nurse-En	nergency	Clear
	Witne	essed by :			3 Apply
		*Bag # : 2	!		
		*Site: -	land - Left	▼	
	*Volu	me (mL): 1	.000		
	*Rate	e (mL/h) : 1	00		
					Begin Bag
					In Progress

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

- 5. Select Site Change 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.

ſ	-								
	E Charting for: ABASS	si, fatima	λH						×
	✓ ○ □								
	1								
	sodium chloride 0.9	9% (NS)	continuous	infusion	1,000 ml			Change Order Versio	n
	order rate: 100 mL/h, IV	/, drug for	m: bag, first do	ose: NOW	start: 01-D	ec-2017 08	:18 PST, bag		
	volume (me). 1,000								
	< >		30-Nov-201	7 20:51 F	ST - 01-D	ec-2017 2	0:51 PST	4	
	01-0	Dec-2017	01-Dec-2017						
	08:	:20 PST	08:33 PST						
5	Site Change Han	#1 d_left	Bag # 2 Hand - Left						
2	Infuse								
	Bolus								
	Rate Change 100	mL/h	100 mL/h						
	Vec No	sodium	bloride 0.9% ((NS) conti	nuous infu	sion 1 000	ml		
		souluinte		(NS) CONU	nuous iniu	51011 1,000		Change	
									_
	*Performed date / tir	me: 01.0	Dec.2017	·	0851	e pc	т	C	
		011	000 2017	•	0001	v 13		Comment	
	*Performed	by: Tes	User, Nurse-Emergency				Clear		
	*Bac	a#: 2						7 Analy	
		5 2			_			Арріу	
	6 *S	ite : Ha	nd - Right		•				
	_								
								Site Char	ige
								In Progress	d

To alter the infusion rate for the current IV bag:

- 1. Click **Rate Change** 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** \checkmark to Sign your charting and make changes permanent.

	Charting for /		N LI			
1		ADA331, FAT1IVII	нп			
4	sodium chloric order rate: 100 ml volume (mL): 1,000	le 0.9% (NS) ./h, IV, drug for)	continuous rm: bag, first do	infusion 1,0 ose: NOW, star	00 mL t: 01-Dec-2017 08:18 PST, bag	Change Order Version
	4 Þ		30-Nov-2	017 20:57 PS	「- 01-Dec-2017 20:57 PST	4 >
		01-Dec-2017 08:20 PST	01-Dec-2017 08:33 PST	01-Dec-2017 08:51 PST		
	🛅 Begin Bag	Bag #1	Bag # 2			
	📑 Site Change	Hand - Left	Hand - Left	Hand - Right		
	Infuse					
1	Bolus	00	100 1 /b			
	Rate Change	100 mL/n	100 mL/n			
	Ves No	sodium (chloride 0.9% ((NS) continuou	is infusion 1,000 mL	Change
	*Performed date	e/time: 01-	Dec-2017	▲ ▼ 085	8 PST	Comment
	*Perfor	med by: Tes	stUser, Nurse-En	mergency	Clear	
	Witne	essed by :				3 Apply
		*Bag #: 2				
	2 *Rate	e (mL/h) : 15	ol			
						Rate Change
						In Progress

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.**

Continuous Infusions			_		
sodium chloride 0.9% (NS) continuous infus, order rate: 100 ml/h, IV, drug form: bag, first dose: NOW, start: 01-Dec-2017 08:18 PST, bag volume (mL): 1.000	Pending Last bag started: 01-Dec-2017 08:33 PST				
Administration Information		Rate Change 15	Site Change Har	Begin Bag 1,000	Begin Bag 1,000
sodium chloride 0.9%					

Fatient 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 Mathematical 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 solution 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 ⁶⁰ Activities ¹ 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. *, ^o, and <u>Sign</u>), 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 <i>checkbox</i> beside the sicon 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



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.
- Ms. Wong's chart will open. Click the arrow next to the PM Conversation
 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**.

Ð		Proces	ss Alert			- 0	x
Medical Record Number: 700008091	Encounter Number:	Last Name: WONG	First Name: KIM	Middle Name:	Preferred Nan	18:	
Previous Last Name:	Date of Birth: 01-Mar-1932	Age: 85Y	Gender: Female V	BC PHN: 9876480883			
- ALERTS							
Process Alert:							
Communication Barrier Cytotoxic Difficult Intubation/Airway Falls Risk 8 Family Development Gender Sensitivity	Move > 9						
l							
				10	Complete	Car	ncel
Beadu				P0783 EDTEST N	UB6 01-Eeb-20	18 10	31

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*.

N	/ong, kim 🔺						
v	VONG, KIM	DOB:14-May-1931 Age:86 years	MRN:7000 Enc:700000	08557	Code Status:		Process: Disease:
A	llergies: No Known Allergies	Gender:Female	PHN:98764	18534	Dosing Wt:68 kg		Isolation:
1	Menu 7	< 🔹 👻 👘 Interactive View and I&O					
Pa	atient Summary						
0	Irders 🕂 Add						
N	lursing Ouick Orders	🗙 ED Adult Systems Assessment					Last 24 Hours
	3	X ED Adult Interventions					
		Activities of Daily Living	^	Find Item	 Critical High 	Low Abnormal	Unauth 🔄 Flag
2 1	nteractive View and I&O	Aerosol/MDI/DPI Therapy		Result	Comm	nents Flag Date	Performed By
R	esults Review	 Airway Management 					
D	ocumentation 🛛 🕂 Add	Ambulate Bladdas Saas /Bastuaid Basidual					
M	ledication Request	Cardioversion					
н	listories	Care Team Member at Bedside					
	Hannian 📕 Asta	Cast Application and Removal Information		<u>ňu</u>	01-Dec-2017		
		Enema Administration		R M	12:57 PST	1	
D	iagnoses and Problems	Epistaxis		Blood Collection	on S M	1	
		Eye Interventions		Blood Culture	Site #1		
С	areConnect	Ice Pack Application	=	Blood Culture	Site #2		
С	linical Research	Incision/Wound/Skin/Pin Site		Respiratory Co	n Llean catch		
E	orm Browner	Jewelry Removal, Therapeutic		Blood Gas Type			
	u et i	MUSCULOSKELETAL		Culture Site			
G	rowth Chart	Nerve Block		A Shift Report/H	andoff	^	
In	nmunizations	Pacemaker		Clinician Receiv	ving Report 6	~	
Li	ines/Tubes/Drains Summary	Paracentesis Pericardiocentesis		Clinician Giving	g Report		
M	1AR Summary	Procedure Assist		Lines Traced Sit	te to Source		
N	Addication List	Provider Notification		Isolation Activi	ty		
		A Specimen Collect	_	⊿ Point of Care T	esting		
Pa	atient information	Ihoracentesis		Occult Blood 1	Fecal POC		
Si	ingle Patient Task List	Warming/Cooling		Occult Blood 2	Fecal POC		
		Patient Status Rounding Shift Peneet /Uppdeff		INR POC			
		Shine Report/ Handon		Urinalysis Dips	tick POC Type		
		Adult Procedures		A Glucose Blood	Point of Care		
		ED Trauma Assessment		GLU Whole Blo	od POC Meter S		
		ED Procedural Sedation		GLU Whole Blo	od POC Testing		
		Vintake And Output		GLU Whole Blo	od POC Source		
		Second Product Administration		GLU Whole Blo	od POC Non-nu		
		Advanced Graphing		GLU Whole Blo	od POC Interve		
		Restraint and Seclusion					

7. Click the green check mark *lever* 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** in the **Nurse Activities** column. Hover-to-discover the outstanding activities. To document completion of this task:

- 1. Click the task number 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).

ACWR	WONG, 86y F	KIM DOB: 14/05/	31					MRN:	700008557 FIN:	ACWR 7000000015906	×
-	<u>ଟ</u> 1	۷	Ø					2		-	
Activities								MAR		rders 🥏 Refres	sh
Orders to Review	(3) Li	abs (1)								Ξ·	-
🧭 Orders to F	Review (3)										
1 Labs										_~]	
Urine Cultu Comments:	JIRE Urine, M SPECIAL COL	idstream, Urgen LECTION REOU	t, Unit Collect, (REMENTS: Plea	Collection: 01- ise refer to sp	-Dec-2017 11: ecific site Lab	51 PST, once oratory Test I	, Nurse Collect Manual.		2	er 🗄 🖏	
SS CBC Blood	, Urgent, Coll	ection: 01-Dec-2	017 11:51 PST,	once						66°	
Sifferentia	I (CBC and I	Differential)	Blood, Urgent, C	ollection: 01-	Dec-2017 11:	51 PST, once				ଟଟ	
Review All (3)	Review	All (3) and Close						3	Review (1)	Close	

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** sicon.
- 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".

ACW	R WONG, KIM 86y F DOB: 14/05,	/31				MRN: 7000085 5	ACWR × 57 FIN: 700000015906
*	66	7	- Ar		a	2	-
Labs	Flowsheet Quick View	Order Status (3 pend	ing)			ters Hide Favorite	s Orders 🥏 Refresh
Pending	Orders				>		
Re-order	Order	Date/Time	Ordered By	Status			
	CBC	01/12/17 11:52:00	TestUser, Emergency- Physician, MD	Ordered			
	Differential (CBC and Differential)	01/12/17 11:51:35	TestUser, Emergency- Physician, MD	Ordered			
	Urine Culture	01/12/17 11:51:35	TestUser, Emergency- Physician, MD	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.

	WONG, KIM 🛛 🛛						🔶 List 🔿 🎼 Recent 👻 Name	- Q
	WONG, KIM		DOB:25-May	(-1932 MRN:700008619 Co	ode Status:	Process:Falls Risk	Location:LGH ED; ACWR	
			Age:85 years	5 Enc:700000016025		Disease:	Enc Type:Emergency	
	Allergies: No Known A	Allergies	Gender:Fema	ale PHN:9876416673 D	osing Wt:	Isolation:	Attending:TestED, Emergency-Physic	cian
	Menu		9	< 🔺 🖌 🚹 Patient Sur	nmary		🔲 Full screen 👘 Print 🏾 🍣 0 minute	es ago
	Patient Summary			ile 🕱				
	Orders	🖶 Add						
	Nursing Quick Orders			Vitals - Extended				
	MAR			Recent Results Advance Care	Planning Lab - Recent Lab - Extend	ed Pathology Micro Cultures T	ransfusion Diagnostics Vitals - Recent	
	MAR Summary							
	Interactive View and 18/0			Flowsheet: Lab View	▼ Level: La	b View 👻	Table O Group O List	
2	Posulte Poulou			()	Thursday, 07-December-2017 13:06 P	5T - Friday, 15-December-2017 13:0	6 PST (Clinical Range)	
2	Results Review				,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	Documentation	+ Add		Navigator	Chow more results			
	Medication Request			CBC and Peripheral Smea	show more results			
	Histories			Blood Gases	Lab View	13-Dec-2017 07:45 P	T 13-Dec-2017 07:30 PST 13-Dec-2017 07:15 PS	^
	Allergies	🛨 Add		General Chemistry	pH Arterial		7.07 (1)	
	Disgnorer and Problems			E Urine Analyzia	pCO2 Arterial		40 mmHg	
	Diagnoses and Problems			Office Analysis	DO2 Arterial		76 mmHg	
					HCO3 Arterial		22 mmol/L	- L
	CareConnect				Base Excess Arterial		2 mmol/L *	
					Ventilation Arterial		Room air	
	Clinical Research				Oxygen Administered Arterial		UNKNOWN	
	Form Browser				General Chemistry	125 14	126	=
	0				Botaccium	7.5 mmol/L (f)	5.2 mmol/L	
	Growth Chart				Chlorida	P5 mmol/l	101 mmol/	
	Immunizations				Carbon Dioxide Total	22 mmol/l	25 mmol/1	
	Lines/Tubes/Drains Sumn	marv			Anion Gap	25.5 mmol/L (H)	15.2 mmol/L	
	Medication List	+ Add			Calcium	2.6 mmol/l		
					Urea	2.0 mmol/l		
	Patient Information				Creatinine	60 umol/L		
	Single Patient Task List				Glomerular Filtration Rate Estimate	d 114 mL/min		
					Bilirubin Total			
					Bilirubin Direct			
					Alanina Aminatransforasa			- T
							•	

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

< 🔹 🝷 者 Results Rev	iew		[D] Full screen	🛱 Print 🛛 🍣 1 mir
- 18 K				
Vitals - Extended				
Recent Results Advance Care	Planning Lab - Recent Lab - Extended Pat	hology Micro Cultures Tra	nsfusion Diagnostics	Vitals - Recent
Flowsheet: Lab View	▼	▼ @	Table Group	list
Howsheet. Coo Herr			Tuble O droup (
I > 1	hursday, 07-December-2017 13:24 PST - Frida	w, 15-December-2017 13:24	PST (Clinical Range)	

Navigator				
CBC and Peripheral Smear	Show more results			
	Lab View	13-Dec-2017 07:45 PST	13-Dec-2017 07:30 PST	13-Dec-2017 07:15
Blood Gases	pO2 Arterial	13-500-2017 07:451-51	76 mmHa	15-500-2017 07:15
General Chemistry	HCO3 Arterial		22 mmol/L	
Contraction in the second seco	Base Excess Arterial		2 mmol/L *	
Onne Analysis	Ventilation Arterial		Room air	
	Oxygen Administered Arterial		UNKNOWN	
	General Chemistry			
	Sodium	135 mmol/L		136 mmol/L
	Potassium	7.5 mmol/L (!)		6.2 mmol/L (H)
	Chloride	95 mmol/L		101 mmol/L
3	Carbon Dioxide Total	22 mmol/L		25 mmol/L
	🗹 Anion Gap	25.5 mmol/L (H)		15.2 mmol/L
	Calcium			
	Glucose Random	3.6 mmol/L		
	Urea	2.0 mmol/L		
	Creatinine	60 umol/L		
	Glomerular Filtration Rate Estimated	114 mL/min		
	Bilirubin Total			
	Bilirubin Direct			
	Alanine Aminotransferase			
	Alkaline Phosphatase			
	Albumin Level			
	Hamaalahin A1C			
	4	III		

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.

c > - ★	Results Review					[□] Full screen	n Print	€ 9 minutes
3 🖪								
Vitals - Extended	4							
		Lab Darant		Dull		T () D' (ACL D	
Recent Results	Advance Care Planni	ng Lab - Kecent	Lab - Extended	Pathology	Micro Cultures	Transfusion Diagnostic	Vitals - Ke	lent
Flowsheet:	ab View	heet Seeker	×			Table Group	○ Liet	
riowsheet -						la contration	U LIN	
4				riday. 15-D	ecember-2017 13	3:24 PST (clinical Range)		4
						,, <u>,</u> ,		
Navigator								
CBC and P	eripheral S							
Rigad Gar	or.				13-Dec-2017 08:30	PST 13-Dec-2017 08:15 P	T 13-Dec-20	17 08:00 PS
Diood Gase	es .							
General Ch	nemistry							
🔽 Urine Anal	ysis							
		.hloride						
		Carbon Dioxide Tota	1					
		nion Gap						
		aicium Slucose Random				3.6 mmol/l		
		Jrea				Sid million E		
		Ireatinine						
		Glomerular Filtration	n Rate Estimated					
	E	Bilirubin Total			26 umol/L (H)			
		Silirubin Direct	araca		10 umol/L (H)			
		Alkaline Phosphatas	e					
		Albumin Level						
	E F	lemoglobin A1C					5.0 % *	
	- N	lean Blood Glucose	2				5.8 mmol/L	
	1 Irin	o Applyric						F

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.

ED Summary	1 Handoff Tool	🛛 Su	mmary	S Assessment	× +		- 4
Active Issues Allergies (0)	Transfer/Transport/	Accompaniment	÷			Selected visit Selected visit Last 2 hor	urs Last 12 hours 2
Informal Team Communication		DEC 08, 2017 15:42					
Vital Signs and Measurements	Transfer From	LGH ED					
Documents (4)	Transfer To	St. Paul's					
Transfer/Transport/Accompan iment							
Assessments (3)	Assessments (3)						Selected visit ನಿ
Lines/Tubes/Drains							
Intake and Output	4 Poculte (2)		Result	Auti	ior	Date/Time	
Labs	Orientation Assessment		Oriented x 4	Tes	tED, Nurse-Emergency1	05/12/17 09:07	
Micro Cultures (0)	Respirations		Irregular, Laboured	Tes	tED, Nurse-Emergency1	05/12/17 09:07	
Diagnostics	Skin Temperature		Warm	Tes	tED, Nurse-Emergency1	05/12/17 09:07	
Medications							
Home Medications							
Orders	Lines/Tubes/Drains	(0) -					Selected Visit 🕊
Oxygenation and	Туре		Location			Inserted	
Ventilation	⊿ Lines (0)						
Pathology	No results found						
1 Haberlan	⊿ Tubes/Drains (0)						
Histories							

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*.

Transfer/Transport/Accompaniment 🕂 🤿								
		Pre-Transfer/Transport Checklist						
	2	Transport Ticket						
	ີ.	Valuables/Belongings						

- 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.

E Result Details	
Documents and Printing	
Printed ticket to ride (as applicable) Printed patient chart (whole or sections) via medical record request	
Transport order set from FormsFast (critical care only)	
Progress note Other: Valuables	
5	
Comment	
ОК	Cancel

- 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.

E Transport Ticket - WONG, KIM	
✓ 🖬 🛇 🖏 🛱 ÷ 🔸 📾 🖾	
*Performed on: 12/13/2017 💭 🔽 0854 🚔 PST	By: TestUser, Nurse-Emerge
Transport Ticket	
Status Orders and Allergies	
No qualifying data available.	
Allergies	
No Known Allergies	
Active Process Alerts	
Communication barrier Gender sensitivity Palliative care	
Cytotoxic No ceiling lift Seizure precaution Difficult intubation/airw On research study Visitor restrictions	
Fall risk Special care plan Violence risk	
۲ III.	
Transfer From and To/Mode/Equipment	
Transfer To Transfer From	Mode of Transport
	O Stretcher Ambulatory
	O Wheelchair O Carried O Bed O Other:
Equipment Accompanying Patient	
Airway management equipment Defibilitator Cardiac monitor	Non-invasive blood pressure monitor Resuscitation drugs Suction
Cardio/respiratory monitor	Pulse oximetry Other:
Sensory Deficits/ Activity Restrictions/ Additional Info	rmation
6 ory Deficits	
	In Progress

- 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.

< > 👻 者 🛛 Patient Summa	ry							(D) Ful	I screen 🗇 Print 🕹	41 minute
A 10%	- • • 🗳									
ED Summary	🛛 Handoff Tool	×	Summary	23	Assessment	Σ	· +		-	۹ (
Activo Iccuor										
Allergies (0)	Documents (4)						Selected visiting Law	t 50 Notor Salartad visit	art 12 hours More X	2 ≡-
Informal Team	Documents (4)								Diselaw Estility defined	~ -
Communication	Ť						My notes only	Group by encounter	Display: Facility defined	I VIEW +
Vital Signs and Measurements	Time of Service	Subject		Note Type		Author	Last Updated	Last Updated By		
Documents (4)	08/12/17 15:42	Transport Ticket		Transport Ticket - Text		TestUser, Nurse-Emergency	08/12/17 15:	49 TestUser, Nu	se-Emergency	
Transfer/Transport/Accompan	08/12/17 15:39	Transport Ticket		Transport Ticket - Text		TestUser, Nurse-Emergency	08/12/17 15:	39 TestUser, Nu	se-Emergency	
iment	05/12/17 09:02	ED Screening - Adult		ED Screening - Adult - Te	đ	TestED, Nurse-Emergency1	05/12/17 09:	02 TestED, Nurs	-Emergency1	
Assessments (3)	0 05/12/17 09:02	ED Triage - Adult		ED Triage - Adult - Text		TestED, Nurse-Emergency1	05/12/17 09:	02 TestED, Nurs	e-Emergency1	
Lines/Tubes/Drains	* Displaying up to the	last 50 recent notes for the s	elected visit							
Intake and Output										
Labs										
Micro Cultures (0)	Transfer/Transpo	ort/Accompaniment	+-				Selecter	visit: Selected visit Last	hours Last 12 hours	€ =-
Diagnostics (0)		DEC 08, 2017								
Medications		15:42								
Home Medications	Transfer From	LGH ED								
Orders 1	0 Transfer To	St. Paul's								
Oxygenation and Ventilation										
Pathology	Assessments (3)								Selected visit	∂=-

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.

FATIMAH WONG	KIM 🔲			-		- v		- List -> Recent + Name
, KIM		DO6:25-May-1932	MRN:700008619	Code Status:		Process:	Location:LG	H ED; ACWR
s: No Known Allernies		Age:85 years GenderFemale	Enc/700000016025 PHN/9876416673	Dosing Wt		Disease: Isolation:	Enc Type.Em Attending.Te	ergency HED Emergency-Physician1 MD
> - 🔒 Patient Summar	v							0 Full screen Christ 217 s
D D D S S 1005	- 0 = 4							
ndoff Tool	11 ED Summary		22 Summary	21 Assessment	22 +			
ive Issues	Documents (4)						Selected visit: Last 50 Notes	Selected visit Last 12 hours More 💌 🥸
ormal Team Communication							My notes only Group I	by encounter Display: Facility defined view
tories	Time of Service	Schiert						
rgies (o)	08/12/17 15:42	Trans	ort Ticket					Open Document Print
uments (4)	08/12/17 15:39	Trans	ort Ticket	Transport	Ticket			Transport Ticket - Text (Modified
Signs and Measurements	05/12/17 09:02	ED So	eening - Adult	TestUser, Nu	se-Emergency			Last Updated: 08/12/17 15:4
esoments (J)	05/12/17 09:02	ED Tri	age - Adult					
nsfer/Transport/Accompanim	* Displaying up to the last 50 recent notes for the selected visit				Performed On: 08-Dec-2017 15:42 PST	8-Dec-2017 15:48 PS1 by TestUser, Nurse-Emergency		
t								
es/Tubes/Drains	Vital Signs and	Measurements	•					
ake and Output	That orgino and			Transport	Ticket			
dications		09:07	NL7	Oxygen Ti	erapy: Nasal cannula			
ne Medications (0)	BP	mmitig		Status Oro	ers and Allergies : No qualifying	data available.	TestUser, Nurs	Je-Emergency - 08-Dec-2017 15:49 PST
6	HR	bpm † 110		Allernies				
o Cultures	Temp	DegC		No Known	Allergies			
prostics	* Displaying recent	results up to 18 columns.						
hology				Active Pro Transfer T	ess Alexts : Fall risk			
Sers				Transfer F	om: LGH ED			
ate Note	Assessments (:	3)		Mode of Tr Equipment	ansport: Ambulatory Accompanying Patient: Airway	management equipment. Cardio/respiratory moni	tor. Oxygen	
rdsciplinary Care Plan			Result	Sensory D	Micits : Hearing deficit, left ear, H	learing deficit, right ear	Teelliner Nor	se-Emergency - 08-Dec-2017 15-42 DOT
rdsciplinary Rounding Summ	4 Results (3)						Testoler, Nor	recompany - or officially love for
Note	Orientation Assess	sment	Oriente	dx4				
sing Shift Summary	Respirations		Irregula	ir, Laboured				
	skin Temperature		Warm					

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 ⁶⁶ 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.

Charting for:	WONG, KIM
amoxicillin (500 mg, PO, dr	amoxicillin take home med) ug form: kit, start: 13-Dec-2017 13:42 PST, stop: 13-Dec-2017 13:42 PST
*Performed d *Perf Wit	ette / time : 13-Dec-2017 v 1359 v PST ormed by : TestUser, Nurse-Emergency
*amoxicillin:	500 mg v Volume: 0 ml
Diluent : <n< td=""><td>v mi</td></n<>	v mi
*Route :	PO v Site: v
Total Volume :	0 Infused Over: 0 v
← 13-Dec-201 1200 PST	7 13-Dec-2017 13-D
📝 Not Given	
*Reason :	Dispensed
Comme 7	Consolir required Dispensed Family or guardian refused Given other route Held for procedure Medication not available Medication not available Nedication on tavailable Nedi
	NPO Other Patient out on pass Patient refused Patient request Patient status

- 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.

E Nurse Dispense	- WONG, KIM	
8 🗸 🖬 🛇 🕅	🗖 🛧 🔸 💷 🔛 🗎	
*Performed on:	13-Dec-2017 🔄 💌 1421 🚔 PST	By: TestUser, Nurse-Emergency
Nurse Dispense	Nurse Dispense	
	Name of Medication and Barcode	Additional Instructions for Medication
	Amoxicilin 500 mg PO daily	Take with Food
	12	13
	Written Material Given	Medication Dispensed to:
	Pharmacy print out	Palent Parnt/Guardan Diter:
	14	Witnessed by: 16 TestED, Nurse-Emergency2 Image: Compared to the second secon
	Medication Education	
	Verbalizes under	standing Demonstrates Needs further teaching Needs practice/supervision Comment
	Med Dosage, Route, Scheduling	
	Med Special Administration, Storage 17 Medication Precautions	
	4	Þ
		In Progress

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.

8	Depart P	rocess	_ D X
WONG, KIM DOB:25 Age:85 Allergies: No Known Allergies Gender	-May-1 MRN:700008619 Code Status: years Enc:700000020 :Female PHN:9876416673Dosing Wt:65 kg	Process:Falls Risk Disease: Isolation:	Location:LGH ED; ACWR Enc Type:Emergency Attending:Provider, Emergency
Templates: ED Patient Summary LGH Disposition Documentation Expiration Record Valuables/Belongings Open Patient Chart Interactive View and I&O Patient Summary Admit Discharge/Transfer Facility	Patient A	esults This Visit (last charted valuer Results This Visit	Je for your 31/01/2018 visit)
Patient/Family/Caregiver demonstrates understa	anding 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.

. Depart Process						
WONG, KIM	DOB:25-May-193	2 MRN:700008619	Code Status:	Process:	Location:LGH ED; A	CWR
Allergies: No Known Allergies	Age:85 years Gender:Female	PHN:9876416673	Dosina Wt:	Disease: Isolation:	Attending:TestED_Em	eraency-Physi
Templates: ED Patient Summary I GH	▼	Patient	bosing tra	130iditorii	,	ergeney rijs
		·	Ti	one Cate Hospital Eme	argency Department	
	prime.		23	l Fast 15th Street North Va	inconver BC V7L 2L7	
Disposition Documentation	.l.			604-988-3	131	
Expiration Becord				Patient Discharge Summ	nary/Instructions	
Valuables/Belongings						=
Open Patient Chart						
Interactive View and I&D		Name:WONG	, KIM			
Patient Summarv		DOB: 25-Ma	y-1932	PHN: 98/64166/3	Encounter: 7000000016025	
Admit		Patient Addre	ss · 123 First N	et Street Vancouver British Co	humbia	
3 Discharge/Transfer Facility		Patient Phone		et Succer v ancouver Bridsh et	stantola	
		Phone: Visit Date: 05	-Dec-2017 09:0	01:00		
		Reason For V Final Diagnos	isit: Respirator is: PNEUMON	ry distress (2), moderate RC11 NIA	1; fever, cough, & SOB	
		Primary Phys Test, ED Phy	ician: sician - Emerg	gency Four		
		Attending Pro TestED, Emerg	ovider: gency-Physician	14, MD		
						-
		Concernel Inches	mationes Diseas		at an and the the second second state of the second s	

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*

🗸 🖬 🛇 🖄 🕅	3 🛧 🔸 📾 🔛 🖳		
*Performed on: 0	1-Dec-2017 📑 💌 15	34 🍦 PST	
 Disposition Docur Vital Signs 	Disposition		
Valuables/Belong	Patient Condition	Disposition	Vital Signs
Admission	Stable	O Admit	O Open vital signs documentation
Discharge	Unstable Other:	Discharge	
	F I		Valuables/Belongings
	1	2	O Open valuables/belongings
	AMA/LWBS		
	AMA/IWBS commen		

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.

ſ	Discharge - WONG, KIM
8	ا الم الم الم الم الم الم الم الم الم ال
	Discharge
	Discharged to care of Mode of Discharge Mode of Transportation Family/Support Contacted Regarding Discharge
	Image: Parally member Image: Wheelchair Image: Personal vehicle Law Enforcement Image: Other: Image: Other:
	3 4 5 6
	Discharge Comments
	Ms. Wong's daughter, Amy Wong, has arrived to pick up her mother.]
	7

- 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.

🗸 🖃 🔕 i 🗞 🖡	5 🛧 🔸 🖬 🖾 🗎			
*Performed on: 0	1-Dec-2017 🚔 💌 15	34 🍨 PST		
Disposition Doc Vital Signs	Disposition			
Valuables/Belong	Patient Condition	Disposition	Vital Signs	
Admission	Stable	O Admit	Open vital signs documentation	
Discharge	Unstable Other:	Discharge	3	
			Valuables/Belongings	
			4 O Open valuables/belongings	
	AMA/LWBS			
	AMA/LWBS commen	t		

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 E 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 ^H Valuables/Belongings •</sup> 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** field and an **Add Result Comment** window opens. Note that Ms. Wong's only jewelry on her person is her wedding ring. Then click **OK** \bigcirc You will now see Ms. Wong's jewelry description updated.

 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.

Prodicación wo		seeping.		
Medication #4		<alpha></alpha>		
Medication #5		<alpha></alpha>		
Medication #6		<alpha></alpha>		
Medication #7		<alpha></alpha>		
Medication #8		<alpha></alpha>		
Medication #9		<alpha></alpha>		
Medication #10		<alpha></alpha>		
Personal Devices				
	Description	Number of Items	Location	
Assistive Devices			<alpha></alpha>	
Cane			<alpha></alpha>	
Contact Lenses			<alpha></alpha>	
Dentures, Lower		1	On person	
Denture Partial Plate			<alpha></alpha>	
Dentures, Upper		1	On person	
Glasses		1	On person	
Hair Piece, Wig			<alpha></alpha>	
Hearing Aid, Left			<alpha></alpha>	
Hearing Aid, Right			<alpha></alpha>	
Orthodontic Retainer			<alpha></alpha>	
Orthotics			<alpha></alpha>	
Prosthesis			<alpha></alpha>	
Walker			<alpha></alpha>	
Wheelchair			<alpha></alpha>	
Other			<alpha></alpha>	
Other Valuables/Belor	igings			
	Description	Number of Items	Location	
Clothing			<alpha></alpha>	
Jewelry		1	On person	
Monetary Items			<alpha></alpha>	
Electronic Devices			<alpha></alpha>	
lowely (Menetany Ite	ma Cont - Valuablas Batum	nod nor		
to Secure Location	Inventory List	lea per		
O Yes	O N/A			

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

- 8. Click the green checkmark \checkmark to Sign your documentation.
- 9. Click the pencil *solution* 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.**

- Discharge Encounter					
Medical Record Number: 700008557	Encounter Number: 7000000015906	Full Name: WONG, KIM	Date of Bith: 14-May-1931	Age: 86Y	Gender: Female
BC PHN: 9876418534		X			
Encounter Type: Emergency	Medical Service: Emergency	Facility: LGH Lions Gate	Building: LGH Lions Gate	Unit/Clinic: LGH ED	Room: ACWR
Bed:	Isolation Precautions:				
Registration Date: 01-Dec-2017 v	Registration Time:				
Uscharge Disposition: Home with Support Services	Discharge Date: 01-Dec-2017	Discharge Time: 16:20	Discharge Username: TestUser, Nurse-Emergency		
— Deceased Details —	<u> </u>				
L				11	Complete Cancel
Ready				PRODBC TEST.EL	NURSE 01-Dec-2017 16:20

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.

Depart Process					
WONG, KIM	DOB:14-May	y-1931 MRN:700008557	Code Status:	Process:	Location:LGH ED; ACWR
Allowing No Kenning Allowing	Age:86 year:	rs Enc:700000015906	Desire unco les	Disease:	Enc Type:Emergency
Anergies. No known Anergies	Gendersrein	Tale PHIN.9670418334	Dosing wilde kg	ISOIdtion.	Attending.restoser, Enlergency-Physician,
Templates: ED Patient Summary LGH	•	Patient			
✓	, S		Lions Gate Hospital En	nergency Department	<u>*</u>
J18.9 Pneumonia			231 East 15th Street North	Vancouver, B.C. V7L 2L7	
 Disposition Documentation 			004-988 Patient Dischange Su	-3131	
Expiration Record			ratient Discharge Su	n mary/mstructions	
Valuables/Belongings	sh.				
Open Patient Chart	1.5	Name:WONG, KIM			
Interactive View and I&O		DOB: 14-May-1931	PHN: 9876418534	Encounter: 7000000015906	E
Patient Summary	she.				
Admit		Patient Address: 590 Mo	ffat Drive Richmond British C	olumbia	
Discharge/Transfer Facility	s %	Patient Phone: (604)2/8-	4848		
		Name: Pisved, Mohami Phone: (363)272-3603 Visit Date: 01-Dec-2017 Reason For Visit: Respir Final Diagnosis: 1-heum Primary Physician: Ext Rest User, Physician - Er Attending Provider: TestUser, Emergency-Phy General Instructions: Ph doctor, or if your condition Patient Instructions Rest, fluids, Amoxicillin. 1	ned, MD 11:29:00 ttory distress (3), mild/modera onia aergency sician, MD use follow up with your family a worsens, return to the Emerg Return to ED extremely SOB.	te RC112 v doctor/specialist. If you cannot foll ency Department.	ow up with your
	r (* 1 r				12 Sim and Print Sim Cancel
Patient/Family/Caregiver demonstrates underst	anding of instruction	ions given			Sign and mint Sign Cancel

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

b 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**.

ACWR	ABASSI, 26y F	FATIMAH DOB: 02/09/9	1					MR	N: 700008504 FIN: 7	ACWR × 7000000016560
+	66 2	٣	P	Ĩ	Jp.			2		-
Activitie	es							MAR	Ore	ders 🥏 Refresh
Orders to Revi	ew (1) As	sessments (2)	Patient C	Care						≣∙
🧉 Patient	t Care									- ee
Admit to Inp	patient 13-Dec-2	2017 09:24 PST,	Admit to Criti	ical Care, Adr	nitting provide	r: TestUser, E	mergency-Phys	sician, MD	2	65
Review All (1) Review A	ll (1) and Close							Review (1)	Close

- 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.

Depart Process	8
ABASSI FATIMAH D08/02-Sep-1991 MRN/700008504 Code Status: Process: Location:LGH ED; ACWR	
Age:26 years Enc:7000000016560 Disease: Enc Type:Emergency	
Allergies: No Known Allergies Gender:Female PHN:9876421435 Dosing Wt: Isolation: Attending:TestUser, Emergency-Physic	a
Tenplete: ED Patient Summary LGH Patient Patient	
Diagnosis VC	-
Disposition Documentation	
Expiration Record Stop Taking the Following Home Medications	
Valuables/Belongings vs. None	
Open Patient Chart	
Interactive View and 180 , K Med ications managed by another provider. Follow their direction regarding the use of these medications.	
Patient Summary	
Admit 🦟	
Discharge/Transfer Facility	
Administered Medications: Laboratory or Other Results This Vi No Laboratory or Other Results This Comment: Comme	
Patient/Family/Caregiver demonstrates understanding of instructions given Print Sign and Close Cancel	

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 *k* 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

Diagnosis	m
Disposition Documentation	n
Expiration Record	m
Valuables/Belongings	n
Open Patient Chart	s.m.
Interactive View and I&O	s. Sec.
Patient Summary	s. Sec.
Admit	s na
Discharge/Transfer Facility 5	n na

6. Sign \checkmark 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.

🚔 ED Admit				
Last Name: ABASSI	First Name: FATIMAH	Middle Name:	Gender: Female	
Medical Record Number: 700008504	Encounter Number: 7000000016560			
Patient Admission Patient Admit Date: 13-Dec-2017 ▼	Patient Admit Time:			
ED Departure Time Disposition: ed to Critical Care or an OF Admitted to an Inpatient Unit Admitted to Critical Care or an OF Porture to Departure Unit	ED Departure Date: 13-D pc-2017	ED Departure Time: 12:15		
Transferred to Day Surgery				
			10 Comple	te Cancel
Ready			PRODBC TEST.EDNURSE 13-D	ec-2017 12:16

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.

ED LaunchPoint	
👬 🗋 🖥 🖿 🔍 🖏 100% 🛛 🖌 💭 🟠	
My Patients All Beds Resus/DTU Acute/INTK Acute INTK FA Triage WR	
View: All My Patients Show: □ Critical Labs/VS ☑ WR ☑ Hide Empty Beds Current: 3 Last Hour: 0 Today: 0	Department WR: 29 Prearrivals: 0
Room :- LOS Patient Information :- EDMD MLP RN Patient Details	♥ BP HR TEMP RR
AC,201 118:20 3 WHCCPITFORTYWEB (Dever extremity injury (3), obvious deformity OC05	 110/70 98 37 18
ACWR Poss. SIRS 64:33 3 REID-LEARN, MARCUS 47y M	♥ 140/70 ↑ 108 ↑ 38.4 ↑ 26
ACWR 71:42 PYLON, MONTY CW- CW-	
PSYCH,401 95:06 PRODBCTEST, JANI 31y F Nursing Quick Orders Major depression; Anxiety; Borderline schizophr	♥ 120/80 70 36.8 18
RESUS,102 No Visitors 141:41 2 PITTPRACTICE, FOI 47y F 47y F Codes Profile Pr	♥ ↓ 28/12 80 16
AC,206 114:36 2 PITPRACTICE 2 Handoff Tool trauma (2), high risk mechanism and/or mode	♥ ↓ 33/15 88 19
ACWR Poss. Septic B8:27 B8:27 B8:27 B8:27 BIPHYTWO, DOROT Request Event Start Event Start Event Start Event Start Event ACW B8:20 Complete Complete Compl	♥ ↓ 80/58 ↓ ↑ 39.2 ↓ ↑ 26
ACWR 69:45 2 IPPHYONE, JANE 76y F Set Events DIABETES INSIPIDUS	♥ 120/80 70 ↑ 38.2 20
AC,210 94:45 2 EDTESTSMITH, JOE Patient Summary Report Discharge Process	♥ ↓ 33/15 88 ↓ 36.2 18
ACWR 92:53 EDTESTDEMO, TRIAGE 54y F 6 54y F 6	

- 3. With a peer, review the sections within the **Handoff Tool.** You can skip sections using the Menu on the left. **Refresh** review 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**.

	/0	• I 🖝 🖝 🖬					
ED Summary		🖾 Handoff Tool	z	Summary	23	Assessment	Σ
Active Issues	Â	Active Teches					
Allergies (1)		Active Issues					
Informal Team Communication							Add new
Vital Signs and Measurements		Name					Clas
Documents (0)		No Chronic Pro	blems				
Transfer/Transport/Accompan iment (0)		Historical					
Assessments (0)							
Lines/Tubes/Drains		Allergies (1) 🕂					
Intake and Output							
Labs							
Micro Cultures (0)		Substance	Reactions		Category	Status	Severity
Diagnostics (0)	=	Demerol HCI	-		Drug	Active	
Medications							
Home Medications (5)		Informal Team (Communication				
Orders (13)							_
Oxygenation and Ventilation (0)		Add new action					Add r
Dathology (0)		No actions documente	đ				No co
3 ies		All Teams					All Te
Create Note							
Interdisciplinary Care Plan		Vital Signs and M	leasurements 📥				
Interdisciplinary Rounding Su mmary Note		No results found					
Nursing Shift Summary							
Select Other Note	-	.					

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 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

Sign/Submit Note									
Sign/Submit Hote									
*Type:	_	Note Typ	e List Fil	ter:					
Nursing Shift Summary	~	All			\sim				
*Author:		Title:				*Date:			
TestUser, Nurse-Emergency		Free Tex	t Note			04-Dec-2017	0929	PST	
Forward Options									
Favorites Recent Relationship 8	ovide	r Name							
Contacts		Recipient	s						
🚖 Default Name		^	Default	Name	Comm	ient		Sign	Review/CC
		*	~	TestUser, Float-Physician, MD Unspecified - Physician - Float				\circ	۲
				onspecifica ingolaan noac					
							9	Sign	Cancel

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.

	🕻 🖒 ᠇ 🛉 🚹 Docun	nentation				[□] Full screen 🖷 Print 💸 21 minutes a	igo
Γ	🕂 Add 📄 Sign 📗 🙈 List	Forward 📑 Modify	🍋 🤻 🎔 📰 😭 In Erro	r 🛄 Preview 🎙		4	Þ
	Display : All	▼				👚 Previous Note 🛛 🦊 Next Note	
	Service Date/Time	Subject	Туре	Facility	I	* Final Deport *	
	04-Dec-2017 09:29:00 PST	Free Text Note	Nursing Shift Summary	Pending Refresh			
	30-Nov-2017 15:10:45 P	ED Patient Summary	ED Patient Summary	LGH Lions Gate		CONSTITUTIONAL: [well appearing in no acute distress]	
	29-Nov-2017 15:52:00 P	ED Screening - Adult	ED Screening - Adult - Text	LGH Lions Gate		SKIN: [Warm, dry, and intact without rash]	
	29-Nov-2017 15:03:00 P	ED Triage - Adult	ED Triage - Adult - Text	LGH Lions Gate		EYES: [extraocular movements are grossly intact, clear conjunctiva]	
	29-Nov-2017 14:32:35 P	ED Pre Arrival Note	ED Pre Arrival Note	LGH Lions Gate		HENT: [Normocephalic, atraumatic, moist mucus membranes]	
	22-Nov-2017 15:27:58 P	ED Patient Summary	ED Patient Summary	LGH Lions Gate		PULMONARY: [normal chest rise and fall, no respiratory distress or stridor	
	21-Nov-2017 09:37:00 P	ED Screening - Adult	ED Screening - Adult - Text	LGH Lions Gate		CARDIOVASCULAR: [regular rate, distal extremities are warm and well perfused]	
	21-Nov-2017 09:37:00 P	ED Triage - Adult	ED Triage - Adult - Text	LGH Lions Gate		GASTROINSTESTINAL: [nondistended, non-tender] GENITOLIRINARY: [deferred]	
	21-Nov-2017 09:37:00 P	ED Screening - Adult	ED Screening - Adult - Text	LGH Lions Gate		NEUROLOGIC: [normal speech, moves all extremities]	
	21-Nov-2017 09:37:00 P	ED Triage - Adult	ED Triage - Adult - Text	LGH Lions Gate		MUSCULOSKELETAL: [no gross deformities, atraumatic]	
	20-Nov-2017 15:54:47 P	ED Patient Summary	ED Patient Summary	WHC Whistler	1	PSYCHIATRIC: [normal mood and affect]	
	15-Nov-2017 16:07:00 P	Allergy Rule	Allergy Rule - Text	WHC Whistler			
	•	111				Result type: Nursing Shift Summary Result date: Monday, 04-December-2017 09:29 PST Result status: Auth (Verified) Result title: Free Text Note Performed TestUser, Nurse-Emergency on Monday, 04-December- by: Verified by: TestUser, Nurse-Emergency on Monday, 04-December- 2017 09:49 PST Verified by: TestUser, Nurse-Emergency on Monday, 04-December- 2017 09:49 PST Encounter 700000015877, LGH Lions Gate, Emergency, 01-Dec-	
	< Destinue Masters	III		•		Circounter 700000013077, Cart Libits Gate, Energency, 01-Dec-	
	<< Previous Next>>						

Patient Scenario 3 Summary: Key Learning Points



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 administration 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

FATIENT SCENARIO 4 – Documenting a Critical Scenario

Learning Objectives
Review Quick Reg
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.

🔁 ED Quick Reg										
The PHN Request was successful.										
Last Name: MCDOWELL	First Name: TANYA	Middle Name:	Date of Birth: <mark>15-Jul-1980 💽 💽</mark>	Age: 37Y	Gender:					
BC PHN: 9876405964	Arrive Date: 14-Dec-2017	Arrive Time: 13:59	Medical Record Number: 700008957	Encounter Number:						
Primary Care Provider (PCP):	Attending Provider: Provider, Emergency	Reason for Visit: MVA	Visitor Status:							
─ Location Building: LGH Lions Gate	Unit/Clinic: LGH ED 🗸	Encounter Type: Emergency 🗸	Medical Service: Emergency	Disaster Flag: ▼						
VIP - Person Level:										
Registration Date: 14-Dec-2017	Registration Time:	ED Quick Reg User Name: TestUser, Nurse-Emergen(
Disease Alert:										
					Complete Cancel					

- 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.

ACWR	* <i>MCDO</i> 37y F	WELL, TANY, DOB: 15/07/	4 80				MRN: 700008957 FI	ACWR × 1: 7000000016705
*	2	•	ø	Ĩ	Ar.	D	2	-
Activities							MAR	Orders 🏾 🎅 Refresh
Assessments (2)								≣∙
2 Assessm	ents							
ED Triage - Adu	ult 14/12/17	14:03:07						
ED Screening -	Adult 14/13	2/17 14:03:07						8
							Document (1)	Close

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 ^{So Known Medication Allergies} This will prompt an Allergy window to appear, click **OK**.

Input patient's weight: 70kg, Estimated

ED Allergies/Weight/Meds - MCDOWELL, TANYA	.
Allergies	
Mark All as Reviewed	
D. Substance Category Type Severity Reactions Interaction Comments Source Reaction	
۲ <u>۲</u>	
Weight Dosing Weight Source of Dosing Weight	
70 kg © Heanwed O Reported • Estimated	

When complete, select the **Circle Back** icon ^{II} 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 🖶 Add.

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.

Allergies/Home Medication	S	CTAS				
Allergies/Home Medications Allergy Band	d On and Verified	Tracking Acuity: 1 · Resuscitation				
COT Descriptor and Proble	ms					
Diagnosis (Problem) being Addressed this Visit		Date	Dx Type			
Toiagnosis Major trauma (1), penetrating and shock and/or airw	Laterality	Responsible Provider				
Display As	*Clinical Service	*Date Comments				
Major trauma (1), penetrating and shock and/or airway cc	Non-Specified 🚽	14-Dec-2017 🚔 👻	^			
*Type *Confirmation	*Classification	Ranking				
Reason For Visit 🗸 Complaint of 🗸	Nursing 🗸	•	-			
Show Additional Details		OK OK & Add New	Add Problem & Diagnosis Cancel			
َ Up 🖆 Home 🚖 Fayorites 🔹 🗀 Fo	lders 🛛 😭 Previous <u>D</u> iagn	osis Folder: Favorites				
System Tracked						

Click the **green checkmark** \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 <a>[

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.

Orders for Signature (3)	×
	Clear All
Click a cell to associate a diagnosis to an order. Click a diagnosis name to associate it to all orders	(801TR001) Major trauma (1), penetrating and shock and/or airway compromise TR001
Continuous Infusions	
NORepinephrine titratable infusion (32 mcg/mL) standard	
proPOFol PED titratable infusion (10 mg/mL) standard	
sodium chloride 0.9% (NS) bolus (1,000 mL, IV, once, drug form: bag, first dose: NOW)	
Show Diagnosis Table	Sign Save Modify Cancel

- 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.

E MCDOWELL, TANYA					
MCDOWELL, TANYA					Location:LGH ED; ACWR
	Age:37 years	Enc:7000000016905		Disease:	Enc Type:Emergency
Allergies: No Known Medication	Aller Gender:Female	PHN:9876405964	Dosing Wt:70 kg	Isolation:	Attending:Provider, Emergency
Add Document Medication by Orders Medication List Document	/ Hx Reconciliation + 🕭 C In Plan	heck Interactions			Reconciliation Status Meds History Admission Discharge
K	Orders for Signature				
View	🔊 🕐 🖳 🕅 Order N	lame Status	Start	Details	
Orders for Signature	△ LGH ED; ACWR Enc:700	00000016905 Admit: 20	Dec-2017 14:00 PST		
Plans	⊿ Continuous Infusions				
Document In Plan	🗌 🗍 🔀 NORepi	nephrine addi Order	20-Dec-2017 14:07	titrate, IV, 0 mcg/min minimum rate, 20 mcg/min maxi	imum rate, start: 20-Dec-2017 14:07 PST, bag volume (mL): 2
- Suggested Plans (0)	📋 🕂 🔁 proPOF	ol additive 1,000 Order	20-Dec-2017 14:08	titrate, IV, 5 mcg/kg/min minimum rate, 300 mcg/kg/n	nin maximum rate, start: 20-Dec-2017 14:08 PST, bag volum
Orders	mg + to	otal volume. 1	PSI	concentration= 10 mg/mL	
Admit/Transfer/Discharge	2 medications	chloride 0.9% Order	20-Dec-2017 14:08	1,000 mL_IV once drug form; hag first dose; NOW sta	art: 20-Dec-2017 14:08 PST_stop: 20-Dec-2017 14:08 PST
- Status		chionae ois ian oraci	20 000 2017 14000	2,000 mil, 17, once, and form bud, mile dosen to 17, see	120 Dec 2017 1400 1017, 300 20 Dec 2017 1400 101
Activity					
Dist/Nutrition					
Medications					
Blood Products					
Laboratory					
Diagnostic Tests					
Procedures					
- Respiratory					
Allied Health					
Consults/Referrals					
Communication Orders					
- Supplies					
Non Categorized					
Medication History					
-Medication History Snapshot					
Reconciliation History	- Detaile				
Related Results	- Dotails				
Variance Viewer	2 Missing Required Details	Orders For Cosignature			Sign Cancel

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

E MCDOWELL, TANYA						
MCDOWELL, TANYA	DOB:15-Jul-1980	MRN:700008957	Code Status:	Process:	Loca	tion:LGH ED; ACWR
	Age:37 years	Enc:7000000016905		Disease:		Type:Emergency
Allergies: No Known Medication	Aller Gender:Female	PHN:9876405964	Dosing Wt:70 kg	Isolation:	Atte	nding:Provider, Emergency
+ Add Tocument Medication b Orders Medication List Document	y Hx Reconciliation * 🔈 C	heck Interactions			Reco N	nciliation Status Ieds History 😧 Admission 😲 Discharge
H I	Orders for Signature					
View	A O B V Order N	Jame Status	Start	Details		
Orders for Signature	△ LGH ED: ACWR Enc:70	00000016905 Admit: 20	-Dec-2017 14:00 PST			
Plans	∠ Continuous Infusions					
Document In Plan	🗌 🔂 🛛 NORepi	inephrine addi Order	20-Dec-2017 14:07	titrate, IV, 5 mcg/min starting rate, 0 r	mcg/min minimum rate, 20 mcg/min	maximum rate, titrate instructions: Titra
Suggested Plans (0)	🔲 🖶 😣 proPOF	ol additive 1,000 Order	20-Dec-2017 14:08	titrate, IV, 30 mcg/min starting rate, 5	mcg/kg/min minimum rate, 300 mcg	/kg/min maximum rate, start: 20-Dec-2
Orders	mg + to	otal volume. 1	PST	concentration= 10 mg/mL		
Admit/Transfer/Discharge	4 Medications					
- Status	👘 sodium	chloride 0.9% Order	20-Dec-2017 14:08	1,000 mL, IV, once, drug form: bag, fi	rst dose: NOW, start: 20-Dec-2017 14:0	8 PST, stop: 20-Dec-2017 14:08 PST
🗾 Patient Care						
Activity						
Diet/Nutrition						
Continuous Infusions						
Medications						
Blood Products						
Laboratory						
Diagnostic Tests						
Procedures						
Respiratory	■ Details for DroPOF	Fol additive 1.0	00 mg + total	volume. 100 mL		
Allied Health			•			
Consults/Referrals	Details 🛗 🗊 Contin	nuous Details				
Communication Orders						
Supplies	🕇 🖥 🐘 🛛 🖊 🛎					
Non Categorized						
Medication History	*Route of Administration	n: IV	~	Starting Rate:	30 mcg/min	
Medication History Snapshot	**************************************	5 mca/ka/min		the design of the second s	200 mcg/kg/min	
Keconciliation History	Minimum Kat	e: D meg kg/mm		Maximum Kate:		
	Q *Titrate Instruction	s:		Duration:		
Diagnoses & Problems					L	
Related Results						10
Variance Viewer	1 Missing Hequired Details	Urders For Cosignature				Sign Cancel

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**.

Menu 👎 <	🕻 🔿 👻 者 Interactive View and I&O						(III) Full screen	C Print	₽ 0 minutes ago
Patient Summary	•								
Orders 🕂 Add									
Nursing Quick Orders	😧 ED Adult Systems Assessment	<		Last 24 Hour:				•	
MAR	ED Adult Interventions		-		- n				
	ED Lines	Critical	High Lov	Abnormal Unauth	E Flag	And Or			
MAR Summary	Adult Procedures	Result	Comments	Rag Date	Performed By				
Interactive View and I&O	ED Trauma Assessment	Y. 34	line and						
1 Its Review	ED Procedural Sedation	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	15-Dec-2017						
Documentation + Add	Intake And Output	⊿ Peripheral IV		Insert Date/Time					
Multipolice Descent	Blood Product Administration	⊿ VITAL SIGNS	-	Antural					
	Central Line	△ Oxygenation	· · · · · · · · · · · · · · · · · · ·	Actual					
Histories	VITAL SIGNS	2 mansiusion bata		Q30 sec					
Allergies 🕂 Add	Transfusion Data			Q1 min					
Diagnoses and Problems	Cell Saver Product			Q3 min					
				Q5 min					
				Q10 min					
CareConnect				Q15 min					
Clinical Research				Q30 min					
Form Browser				Q1 hr					
Growth Chart				Q2 hr					
Immunizations				Q4 hr					
Lines/Tubes/Drains Summary				Q8 hr					
Medication List 🕂 Add				Q12 hr					
Patient Information				Q24 hr					
Cincile Datiant Task List				Q48 hr					
Single Patient Task List				Q72 hr					
				Q120 hr					
4	X Advanced Graphing								
	Kestraint and Seclusion								

- 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.

**• 🚍 💷 🎶 🖌 🚫 🦉 🛄 📰 🏂 🛠	
ፍ ED Adult Systems Assessment	Last 24 Hours
ED Adult Interventions	
ED Lines	Find Item Critical High Low Abnormal Unauth Flag
Adult Procedures	Booutt Commonte Else Date Referred Ry
FD Trauma Assessment	result continients riag Date renotified by
ED Procedural Sedation	5-Dec-2017
V Intoke And Output	📆 🔐 07:06 PST 📃 04:00 PST
	Respiratory Rate br/min
Second Product Administration	Measured O2% (FIO2)
Peripheral IV	Oxygen Activity
Central Line	Oxygen Therapy
VITAL SIGNS	Oxygen Flow Rate L/min
9 Transfusion Data	Skin/Nare Check
Cell Saver Product	SpO2 %
Blood Products Transfusion Education	SpO2 Site
	SpO2 Site Change
	⊿ Transfusion Data
	Albumin 5% Volume Transfused mL
	Albumin 25% Volume Transfused mL
	Cryoprecipitate Volume Transfused mL
	Fibrinogen Volume Transfused mL
	Plasma Volume Transfused mL 320
	Platelets Volume Transfused mL
	Red Blood Cells Volume Transfused mL 1,680
10	IV Immune Globulin Volume Trans mL
10	Other Blood Volume Transfused mL

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

Menu		ģ	< > - ♠ MAR						(D) Full screen 🛛 👼 Print 🛛 🗞 1 minutes ago
			™ 6 ° ⊇						
	+ Add								
Nursing Quick Orders			< +	Thursd	ay, 14-Decemb	er-2017 07:56 P	ST - Saturday,	16-December-201	7 07:56 PST (Clinical Range)
MAR			Time View	Medications	15-Dec-2017 21:00 PST	15-Dec-2017 17:00 PST	15-Dec-2017 08:24 PST	15-Dec-2017 08:02 PST	Charting for: MCDOWELL, TANYA
1 Summary			Scheduled	Scheduled	20.000	20.000		4	
Interactive View and I&O			Unscheduled	30 mcg, IV, TID, drug form: inj, start:	Not previously	Not previously		Not previously	
			PRN	15-Dec-2017 08:02 PST Target Dose: proPOFol 30 mcg/kg 15-Dec-20	given	given		given	M sodium chlavida 0.9% (sodium chlavida 0.9% (NS) balus)
	+ Add		Continuous Infusions	proPOFol				NOW	1,000 ml, TV, once, drug form: bag, first dose: NOW, start: 15-Dec-2017 08:02 PST, stop:
Medication Request			Future	sodium chloride 0.9% (sodium chloride 0.9				Not previously	15-Dec-2017 08:02 PST
			Discontinued Scheduled	NOW, start: 15-Dec-2017 08:02 PST, stop:			2	1	
Allergies	+ Add		Discontinued Unscheduled	15-Dec-2017 08:02 PST sodium chloride 0.9%			2		*Performed date / time : ***********************************
Diagnoses and Problems			Discontinued Print	Continuous Infusions			Peodina		3 *Performed by : TestUser, Nurse-Emergency
			Discontinued Continuous ands	norepinephrine additive 0.625 mg [0.02 mcg			Not previously		Witnessed by :
CareConnect				dextrose 5% (DSW) 24.38 mL total volume 25 mL			given		
Clinical Research				order rate: 3.36 mL/h, IV, start: 15-Dec-2017 08:01 PST, bag volume (mL): 25					
Form Browser				concentration= 25 mcg/mL Administration Information					*sodium chloride 0.9%: 1,000 mL Volume : ml
Growth Chart				NORepinephrine					Diluent : <none> • ml</none>
Immunizations				total volume					
Lines/Tubes/Drains Sum									*Route: N v Site: v
Medication List	+ Add								Total Volume : 1000 Infused Over : 0 💌
									15 Dec 2017, 15 Dec 2017
Single Patient Task List									← 0700 PST 0800 PST 0900 PST 1000 PST 1100 PST 1200 PST →
			Therapeutic Class View						1000
			Plan View						K
			Taper View						Not Given

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 \checkmark the document.

E Charting for: MCDOWEL	, TANYA	×
✓ 🛇 🎟		
proPOFol additive 1,000 titrate, IV, 30 mcg/min startir rate, titrate instructions: Titr concentration= 10 mg/mL	9 mg + total volume. 100 mL g rate, 5 mcg/kg/min minimum rate, 300 mcg/kg/min maximum ite per protocol, start: 20-Dec-2017 14:08 PST, bag volume (mL): 100	Change Order Version
< >	20-Dec-2017 02:30 PST - 21-Dec-2017 02:30 PST	< • •
 Begin Bag Site Change Infuse Bolus Rate Change proPOFol 	No results found	
Ves No proP	OFol additive 1,000 mg volume. 100 mL	Change
*Performed date / time :	20-Dec-2017	Comment
*Performed by :	Test User, Nurse-Emergency	Clear
Witnessed by :		Apply
*Bag # :	1	
*Site :	Wrist - Right 👻	
*Volume (mL) :	100	
*Rate (mL/h) :	0.18	
*proPOFol Dose :	30 mcg/min ▼	
		Begin Bag
		In Progress

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.

< 👻 者 Interactive View and I&O									[D] Full scre	en 👼 Prir	nt 🔑 0 r	ninutes ago
**• 🖿 🖌 🕺 X 🧃												
CED Adult Systems Assessment	↓ Tuesday, 3	19-Decembe	r-2017 06:0	0 PST - Frida	ıy, 22-Decer	nber-2017 ()5:59 PST					
C ED Adult Interventions	Today's Intake: 1000 mL Output: 0 mL	Balance: 1	000 mL	Vesterday's	Intake: 0 m	Output:	0 mt Bala	ance: 0 ml				
🗙 ED Lines	PR. 51					20-Dec-2017						
Adult Procedures	S 104	14:00 -	13:00 -	12:00 -	11:00 -	10:00 -	09:00 -	08:00 -	07:00 -	06:00 -	24 Hour	Night Shif
📡 ED Trauma Assessment		14:59 PST	13:59 PST	12:59 PST	11:59 PST	10:59 PST	09:59 PST	08:59 PST	07:59 PST	06:59 PST	Total	Total
CED Procedural Sedation	⊿ Intake Total		1000									
🔨 Intake And Output												
Continuous Infusions	NORepinephrine additive 8 mg + dextrose 5% (D5W) titratable infusi m	L										
Medications Chest Tubes Enteral	proPOFol additive 1,000 mg + total volume. 100 mL m	L										
GI Tube	⊿ Medications		1000									
GI Ostomy Intake	sodium chloride 0.9% m		1000	View P	ocult Detaile							
Oral	Oral Intake m			VIEWIN	esuit Details.							
Other Intake Sources	A Output Total	-		View D	efaulted Info							
Negative Pressure Wound Therapy	⊿ Stool Output			View C	omments	N						
Surgical Drain, Tube Inputs	Stool Count (Number of Stools)			Uncha	+	43						
Transfusions	⊿ Urine Output			Uncha	16							
Urinary Catheter, Intake	Urine Voided m	L		Chang	e Date/Time.							
Pre-Arrival Huid	Balanc	e	1000 mL	Modify	/							
Blood O tout				Confin	m							
Chest Tube Output				Add O	omment							
Continuous Renal Replacement Therapy												
Emesis Output				Clear								
GI Tube				Not Do	ne							
GI Ostomy Output				View Ir	terpretation							
Other Output Sources				Reinte	met							
Solution Statistics			L									
X Advanced Graphing												
Restraint and Seclusion												Þ

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**.

Patient Summar	У							<u>,0</u> ,	Full screen 👘 Print 🔊 0 minutes
🗚 🗎 🖷 🖿 🔍 🔍 100%	• I 🖷 🖷 🏠								
ED Summary	🖾 Handoff Tool	🛛 Summar			23	+			🚍 🗕 🔍 🗇 🚍
Arthua Tecnuae									1 1-1
Allergies (0)	Active Issues Loa	ading					da	ssification: Medical and Pati	ent Stated \star All Visits $ \mathcal{X} \equiv \cdot$
Informal Team Communication									
Vital Signs and Measurements	Allergies (a) 📥								All Visits 🔐 🚍 -
Documents (1)	Allergies (0)								
Transfer/Transport/Accompanim					.				
Assessments	Substance	Reactions	Category	Status	Severity	Reaction Type	Source	Comments	
Lines/Tubes/Drains	Medication Allergies		Drug	Active		Allergy		-	
Intake and Output							Reco	nciliation Status: Incomple	te Complete Reconciliation
Labs									
Micro Cultures	Informal Team (Communication							∂ ≡-
Diagnostics	Add new action				Add new comme	ent			
Medications									
Home Medications	No actions documente	ed			No comments do	cumented			
Organization and Ventilation	All Teams				All Teams				
Pathology									
Histories	Vital Signs and N	Measurements 🕂					Selected visit:	Latest* Selected visit L	ist 12 hours 🛛 📰 🔟 🕹 🖃
Create Note	No results found								
Interdisciplinary Care Plan									
Interdisciplinary Rounding Summ	D								
ary Note	Documents (1)						Selected Visit: Las	at 50 Notes Selected Visit	Last 12 nours More + IC -
Nursing Shift Summary	~						My notes only	Group by encounter	Display: Facility defined view -
Select Other Note	Time of Service	Subject	Note Type		Author		Last Updated	Last Updated By	
	14/12/17 14:17	ED Triage - Adult	ED Triage - A	dult - Text	TestUser, Nurse-Em	ergency	14/12/17 14:17	TestUser, Nurse	Emergency
	* Displaying up to the	last 50 recent notes for the selected v	sit						

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.

+ Add () Free Text Note	List	
Arial	▼ 11 ▼ 😽 🗟 🖄 I ♠ ≫ B I U ಈ A _t τ 📄 Ξ Ξ Ξ I Φ	
I		

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.

E Sign/Submit Note			- • •
*Type: Nursing Shift Summary *Author: TestUser, Nurse-Emergency	Note Type List Filter: All Title: Free Text Note	*Date: 15-Dec-2017 III 0924	PST
Favorites Recent Relationships Q Provide	r Name Recipients		
Cefault Name	Ame Default Name	omment	Sign Review/CC
			Sign Cancel

Patient Scenario 4 Summary: Key Learning Points



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.