**SELF-GUIDED PRACTICE WORKBOOK [N76]**
CST Transformational Learning

WORKBOOK TITLE:

# Nursing: Mental Health Emergency

*Last update: February 4, 2018 (v2)*

CLINICAL + SYSTEMS TRANSFORMATION
Our path to smarter, seamless care

TRANSFORMATIONAL LEARNING

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# SELF-GUIDED PRACTICE WORKBOOK

| | |
|---|---|
| **Duration** | **8 hours** |
| **Before getting started** | ■ Sign the attendance roster (this will ensure you get paid to attend the session)<br>■ Put your cell phones on silent mode |
| **Session Expectations** | ■ This is a self-paced learning session<br>■ 2 x 15 min + 30 min break time will be provided. You can take these breaks at any time during the session<br>■ The workbook provides a compilation of different scenarios that are applicable to your work setting<br>■ Work through different learning activities at your own pace |
| **Key Learning Review** | ■ At the end of the session, you will be required to complete a Key Learning Review<br>■ 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 – Multi-Patient Task List

**Learning Objectives**

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

- Create Patient Lists
- Navigate Multi-Patient Task List
- View and Complete Consults

## SCENARIO

In this scenario, you begin your shift and will be receiving a consult from the Emergency Department. To start, log into the Clinical Information System (CIS) with your provided username and password.

As a Mental Health Emergency Nurse you will be completing the following activities:

- Create a Location List
- Customize the Departmental View
- Review Multi-Patient Task List
- Review and complete consults from Multi-Patient Task List

# Activity 1.1 – Set Up Location List

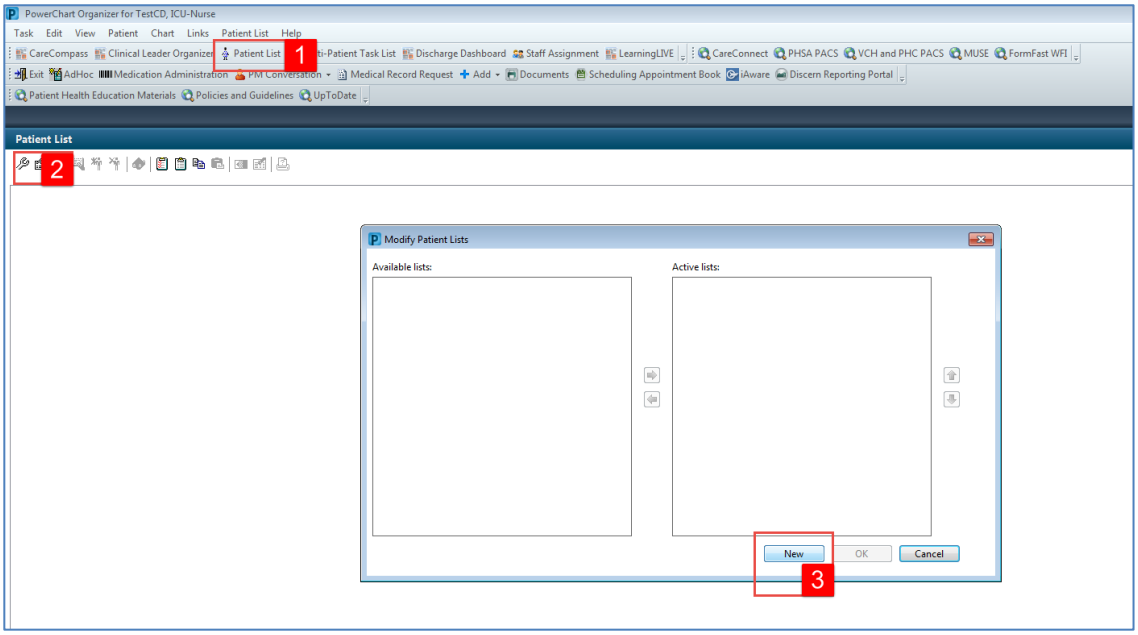
1

Upon logging in, you will land on **Multi-Patient Task List (MPTL)** which provides a list of the patients and consults from your department.

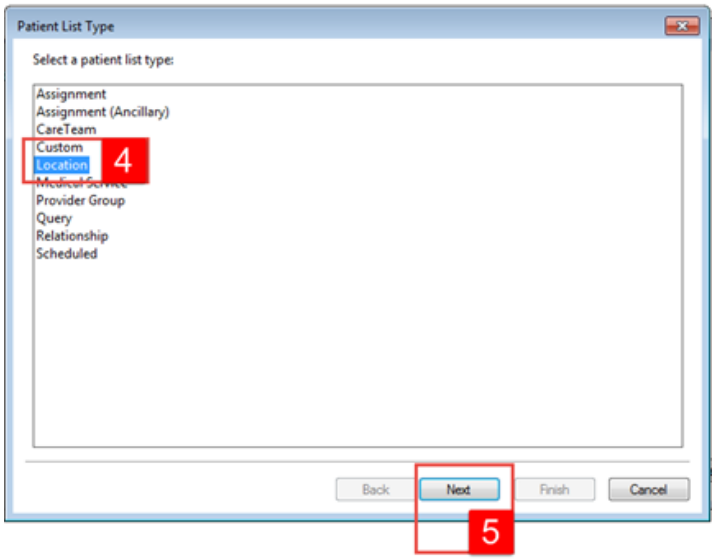
Before you can use the MPTL you will need to set up a patient list. The **Patient List** is a view of all the patients that are on a specific unit/department.

1. Select the **Patient List** 

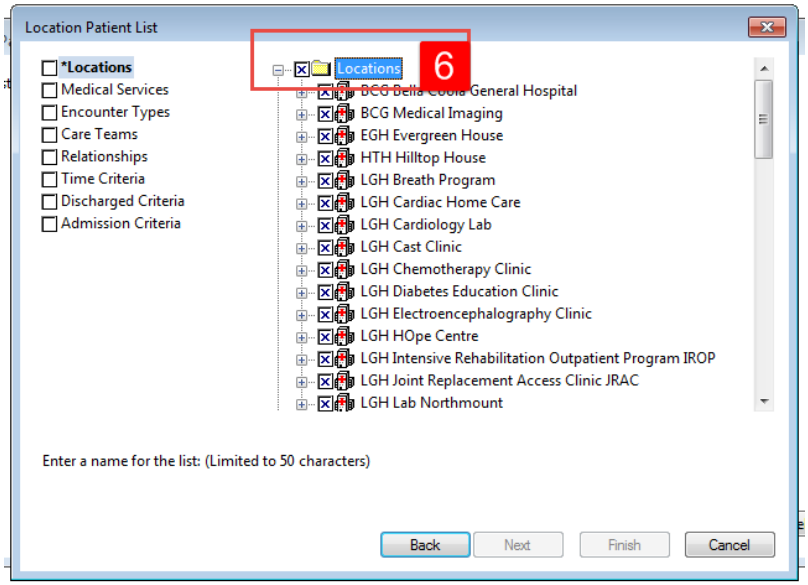
from the **Toolbar** at the top of the screen
2. The screen will be blank. To create a location list, click the **List Maintenance** icon  When you hover over the wrench it will say **List Maintenance**
3. Click the **New** button in the bottom right corner of the **Modify Patient Lists** window



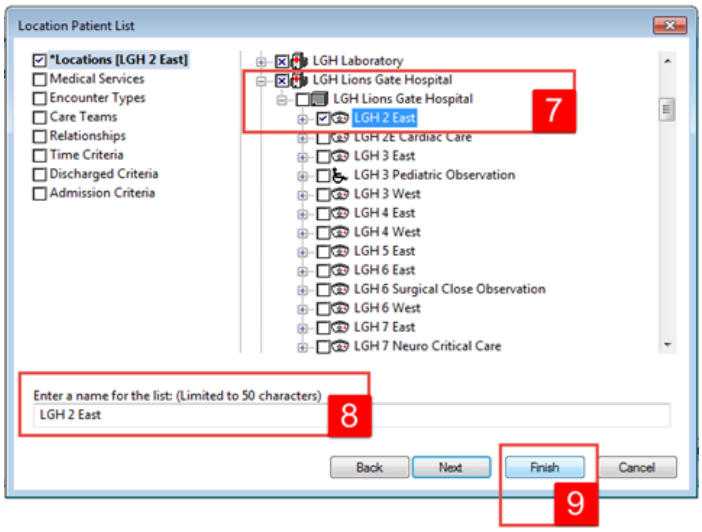
4. From the **Patient List Type** window select **Location**.
5. Click the **Next** button in the bottom right corner.



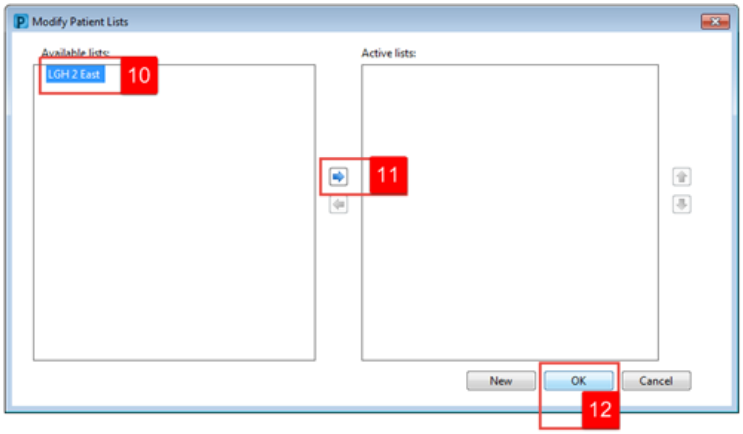

6. In the **Location Patient List** window, a location tree will be on the right hand side. Expand the list by clicking on the **plus** + sign next to the facility.



7. Scroll down until you find the provided location. Expand the location and select the provided unit during training by checking the box next to it
8. Note that location lists are automatically named by the Location, leave the name as is.
9. Click **Finish**




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



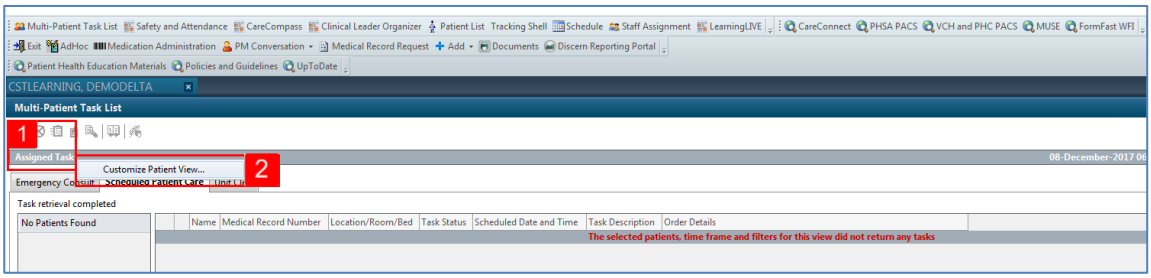

## Key Learning Points

- Patient List can be accessed by clicking on the Patient List icon in the Toolbar.
- You can set up a patient list based on location.

# Activity 1.2 – Set up your view of the Multi-Patient Task List

1 The first time you log in, you will need to set up the **MPTL**. To do this you need to select the appropriate **Patient List** and **Time Frame** to display.

1. Right-click on **Assigned Tasks** in the grey information bar
2. Select **Customize Patient View**

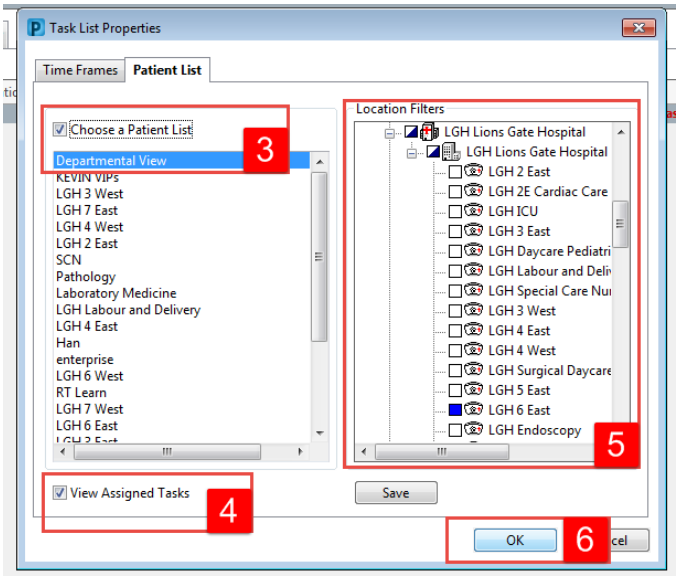



Within the **Task List Properties** window:

3. In the Patient List tab, select **Choose a Patient List** and select **Departmental View**
4. Select the appropriate location using the location filter (use the + symbol to expand the location tree until you find the desired unit)

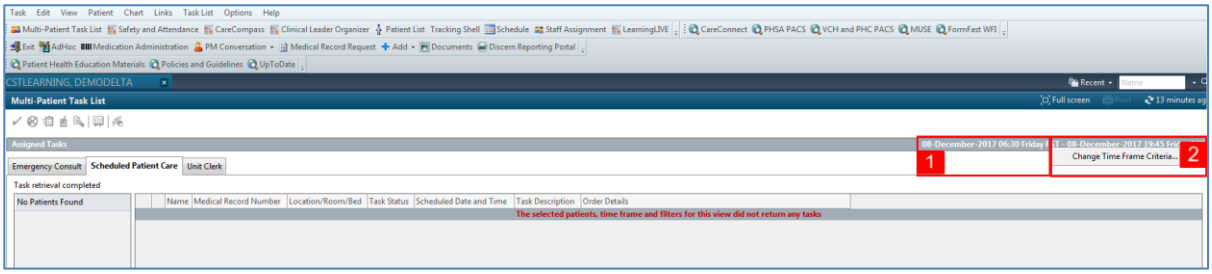
**Note**: Only choose locations for the department you are working on. If you choose an entire hospital or too many locations, the system might not be able process all the tasks in the MPTL

5. Ensure **View Assigned Tasks** is checked as this will ensure tasks display on your **MPTL**
6. Click the **OK** button



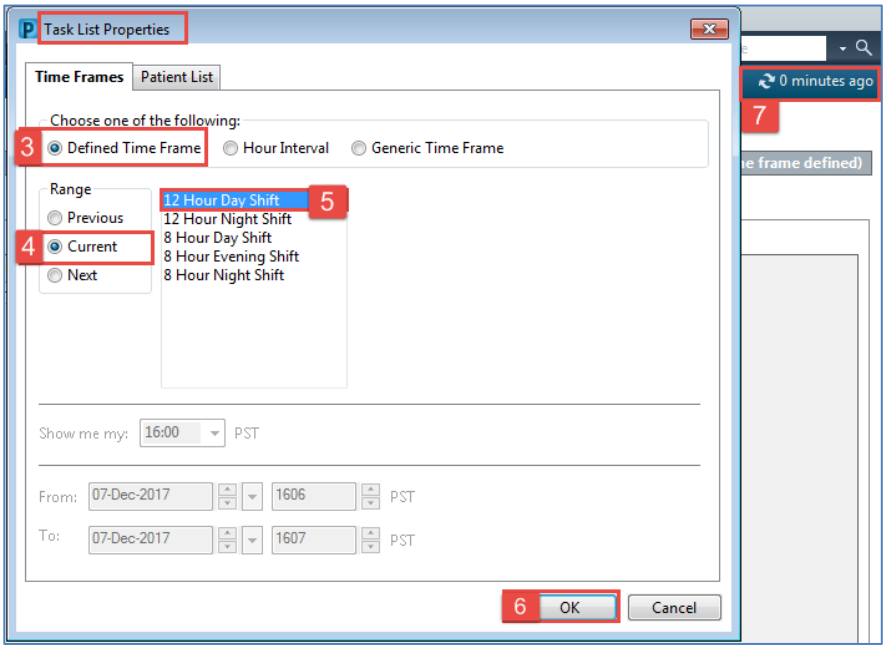
2 After selecting the appropriate Patient List you need to set up the **Defined Time Frame**.

1. Right-click the **(no time frame defined)** in the information bar
2. Select **Change Time frame Criteria**




The **Task List Properties** window opens.

3. In the **time frames** tab select the **Defined Time Frame** option
4. Select **Current**
5. Select the time from the list = *12 hour day shift*
6. Click the **OK** button
7. Click on the **Refresh** button near the top right corner of the window to ensure you can see the most current orders and tasks




The **MPTL** is now set to view consults.

## Key Learning Points

- You must select the appropriate time frame in order to see assigned tasks for your patients
- Ensure you set up the correct view for each tab in the MPTL so you can see all of your tasks
- Click refresh to ensure you can see the most current tasks

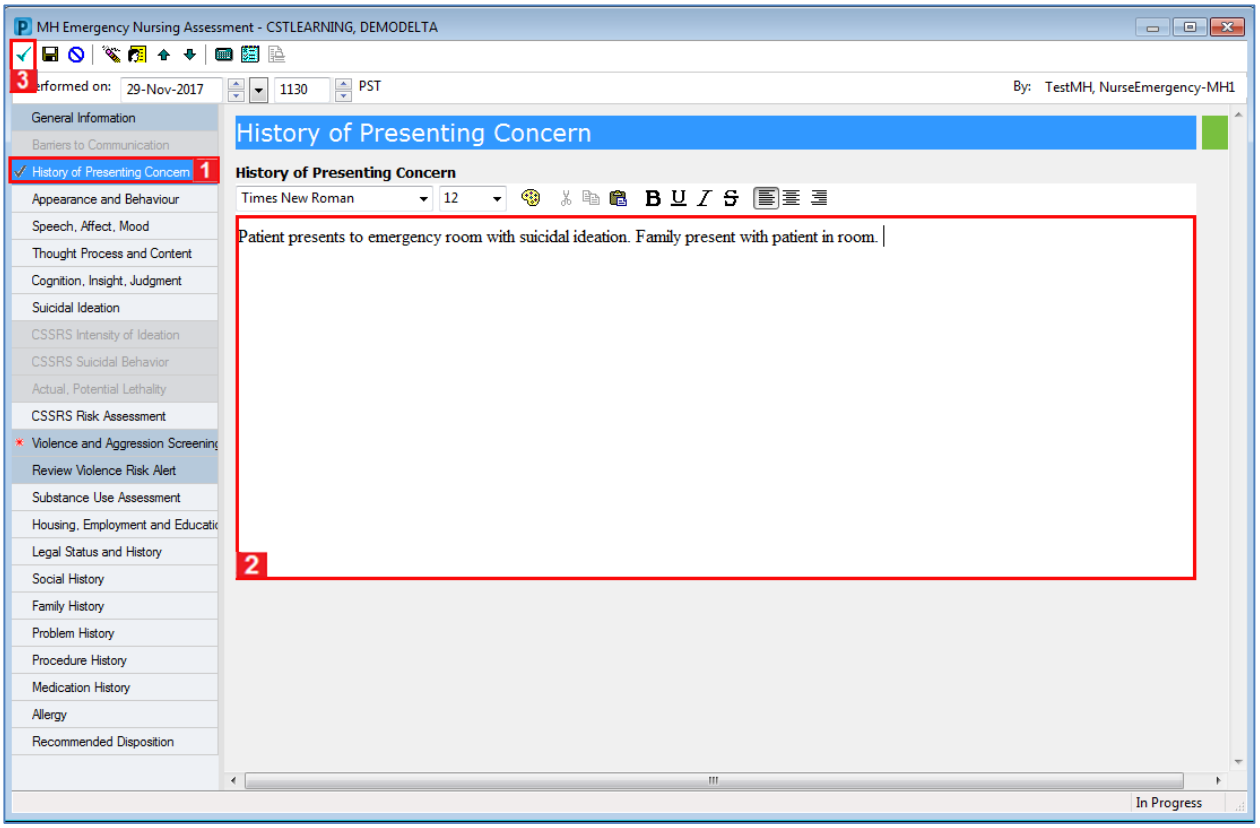
# Activity 1.3 - Complete Consult

1 To complete a consult, double-click on the patient name in the **Multi-Patient List.** This will bring you to the MH Emergency Nursing Assessment form. You will learn about this form of documentation in more detail later on in this workbook.

**Note:** You must establish a relationship with a patient in order to access the patient chart. A relationship will last for 16 hours, after which the nurse will need to re-establish the relationship. Select **Nurse** as your relationship from the drop-down menu.

Let's enter some information into the form.

1. Select **History of Presenting Concern** from the list on the left
2. Enter = *Patient presents to the emergency room with suicidal ideation. Family present with the patient in the room.*
3. Click the green checkmark ✓ to sign your document




Upon signing the document, you will be brought back to the Multi-Patient Task List. The consult will no longer be listed.

## Key Learning Points

- You can access the correct documentation directly from the consult by double-clicking on it
- Completing the documentation on a consult will remove the consult from the Multi-Patient Task List

# PATIENT SCENARIO 2 – Tracking Shell and Accessing the Chart

**Learning Objectives**

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

- Navigate Tracking Shell
- Review the Components of the Patient Chart

## SCENARIO

In this scenario, you will navigate Tracking Shell, its functionality, and how it can provide a snapshot of the patients in the emergency department. You will access the patient's electronic chart and view the major components.

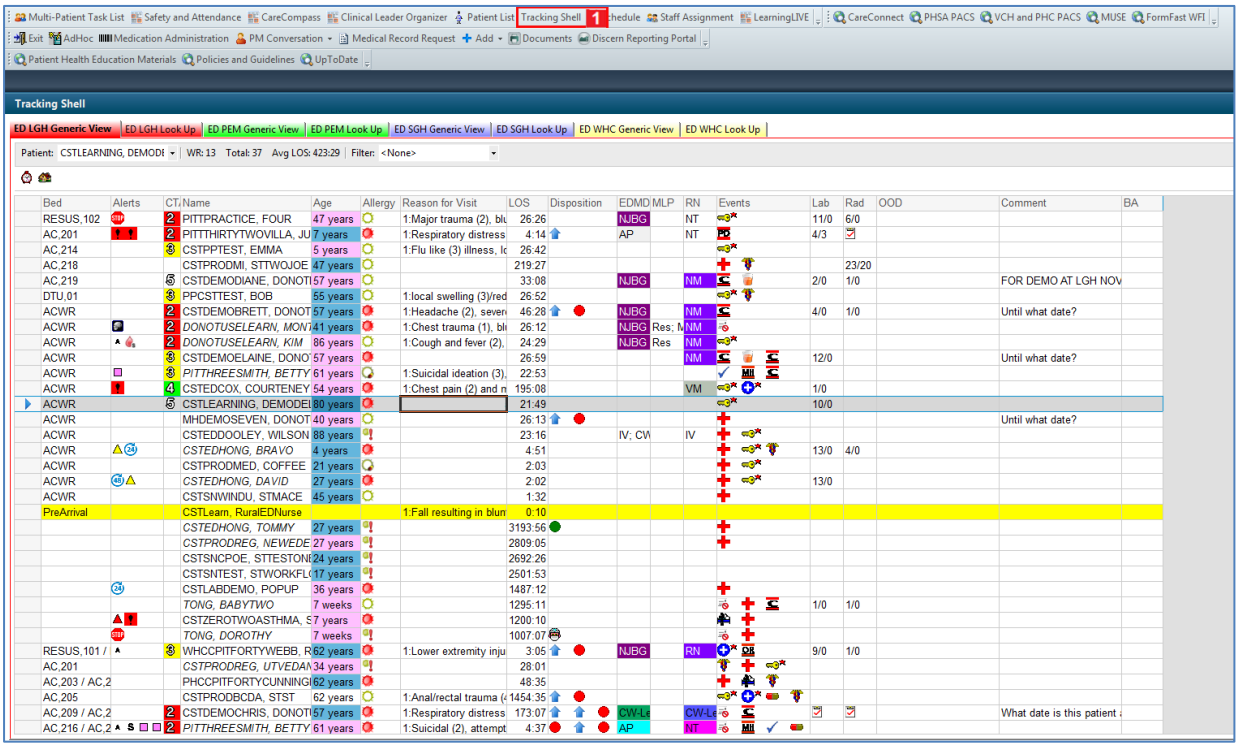
As a Mental Health Emergency Nurse you will be completing the following activities:

- Review patient information present in Tracking Shell
- Access a patient's chart from Tracking Shell
- Review the major components of the patient chart

# Activity 2.1 – Tracking Shell

1 Tracking Shell is an electronic list that gives a snapshot of patient information for all patients in the ED in real time.

1. Click **Tracking Shell** from the organizer toolbar




Note the various icons that will be useful to you:

= Mental Health ED Nurse or Psychiatry Consult

= Certified

= Familiar Faces care plan in place

= Visitor Restriction

= Discharge order placed

You can hover over any icon to view more information. Take some time to hover over any icons you wish.

## Key Learning Points

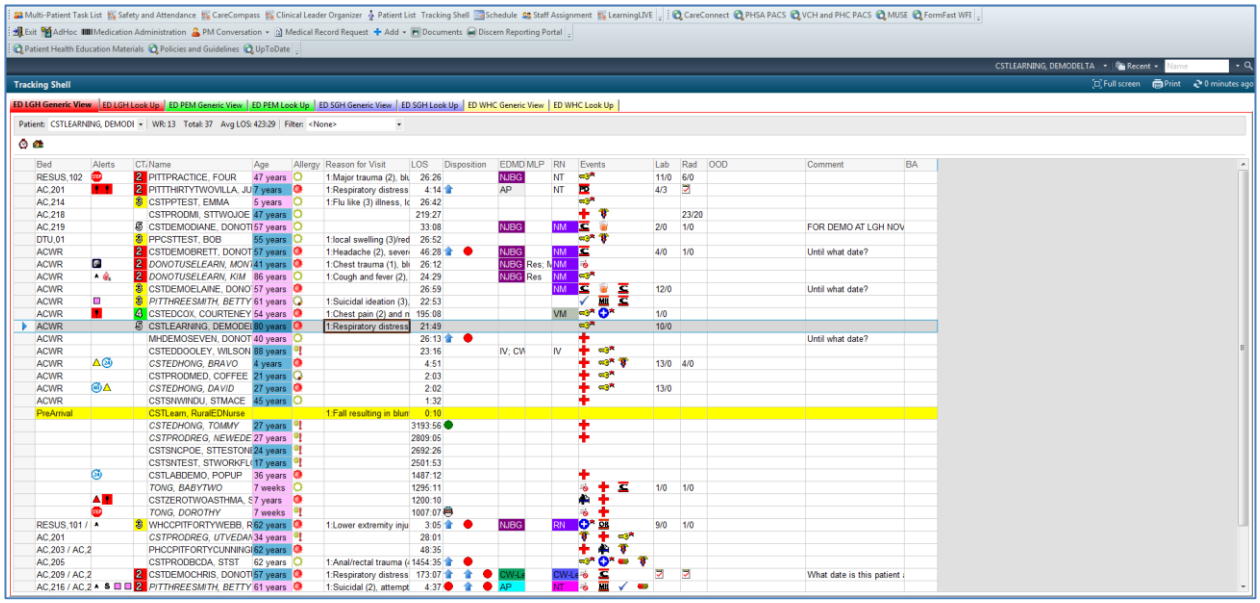
- Tracking Shell is an electronic list that gives a snapshot of patient information in real time
- Icons within the Tracking Shell give provide information at a glance. You can hover to discover on any icon to see more information

# Activity 2.2 – Accessing the Patient's Chart

1 You can access the patient chart through Tracking Shell

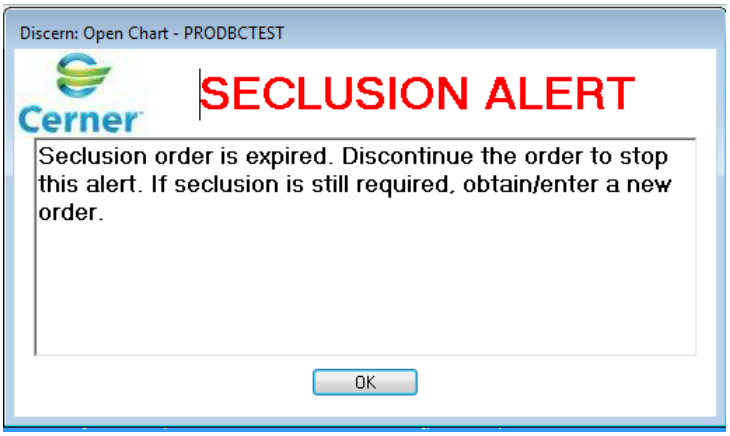
Click the blue arrow beside the patient's name in Tracking Shell to enter the chart.

1. From the Tracking Shell, click on patient's name to access the patient chart.



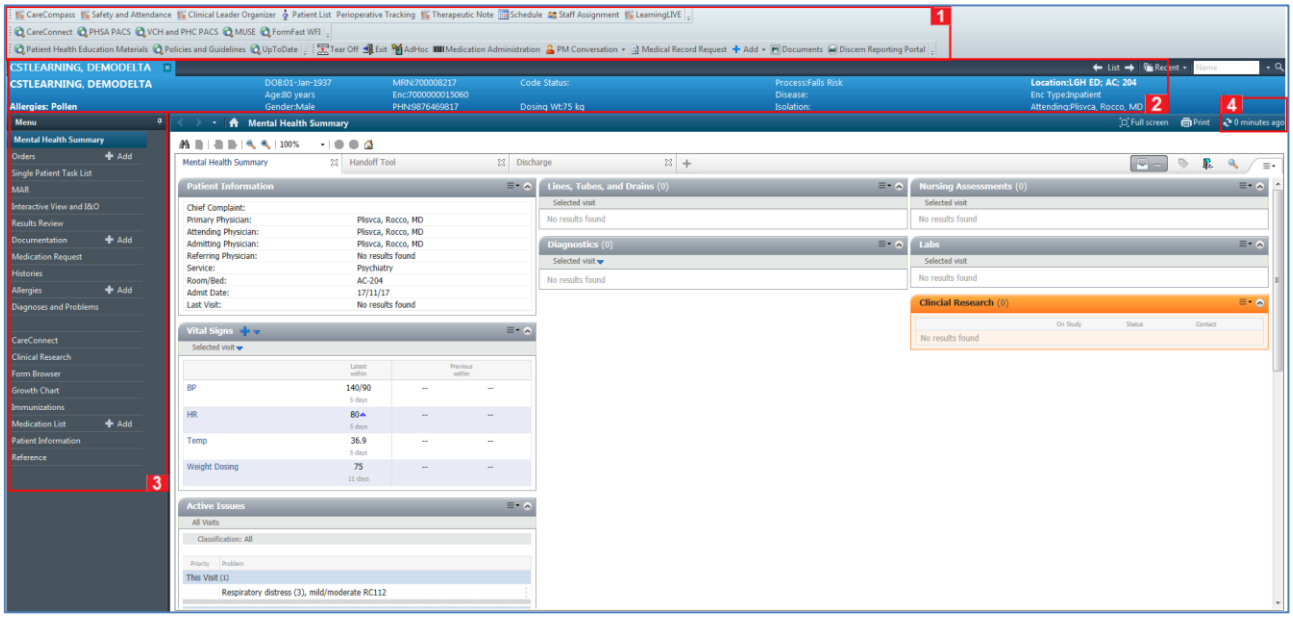

2 The patient's chart is now open.

**Note:** If your patient has been in restraints or seclusion and requires those orders to be re-ordered, you may receive a restraint or seclusion pop-up alert upon your first entry into the chart.



Let's review the key parts of this screen:

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




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

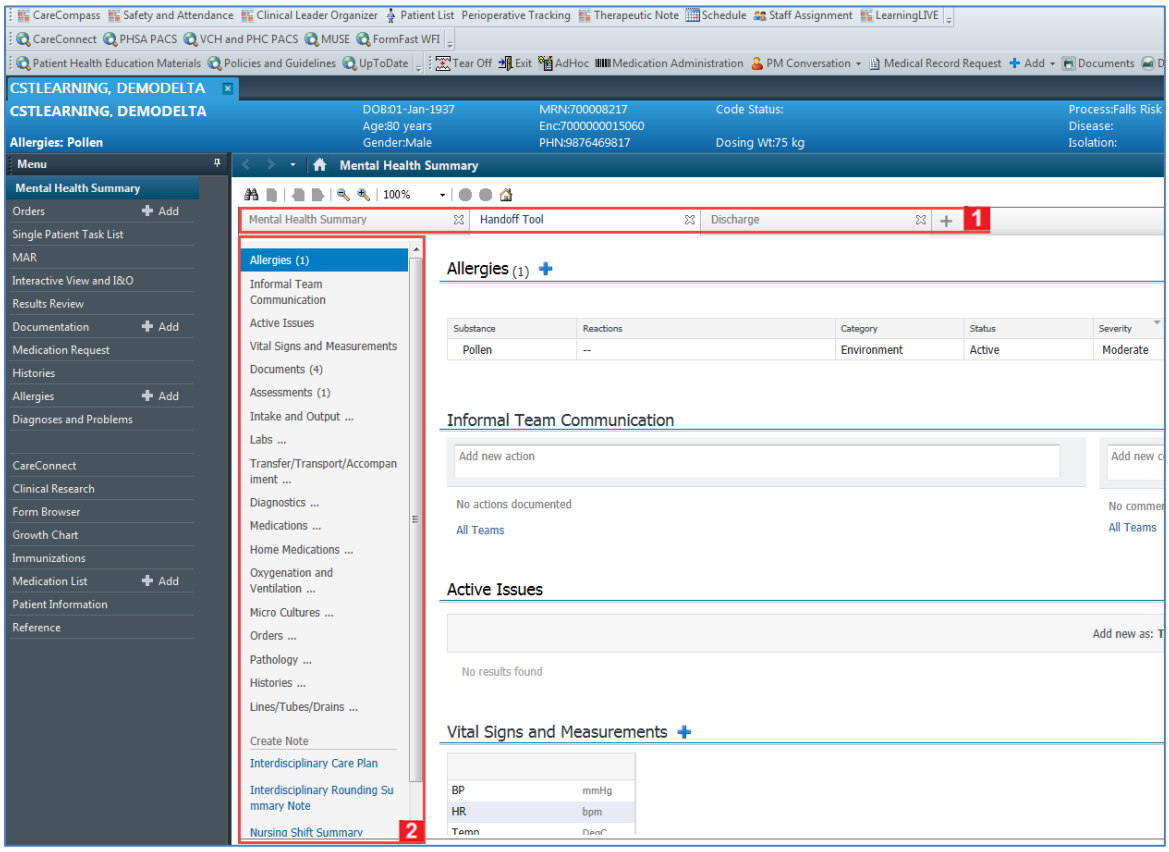
## Key Learning Points

- The Toolbar is used to access various tools within the Clinical Information System
- The Banner Bar displays patient demographics and important information
- The Menu contains sections of the chart similar to your current paper chart
- Click the Refresh icon to get the most updated information on the patient

# Activity 2.3 – Introduction to Patient Summary

1 Upon accessing the patient's chart you will see the **Mental Health Summary** section open. The **Mental Health Summary** will provide views of key clinical patient information.

1. There are different tabs including **Handoff Tool** and **Discharge** that can be used to learn more about the patient. Click on the different tabs to see a quick overview of the patient
2. Within the **Handoff Tool** tab, you will notice the different components. You can navigate through these using the component list on the **Handoff** and **Discharge** tabs




## Key Learning Points

- Patient Summary provides access to key information about the patient
- There are different tabs that can be used to learn more about the patient

# PATIENT SCENARIO 3 - PM Conversation

| Learning Objectives |
| --- |
| At the end of this Scenario, you will be able to:<br>- Utilize PM Conversation |

| SCENARIO |
| --- |
| In this scenario, you will be reviewing PM Conversation and some of its functionalities. You will then learn to place a process alert.<br><br>As a nurse, you will be completing the following activities:<br>- Activating a process alert |

# Activity 3.1 – PM Conversation

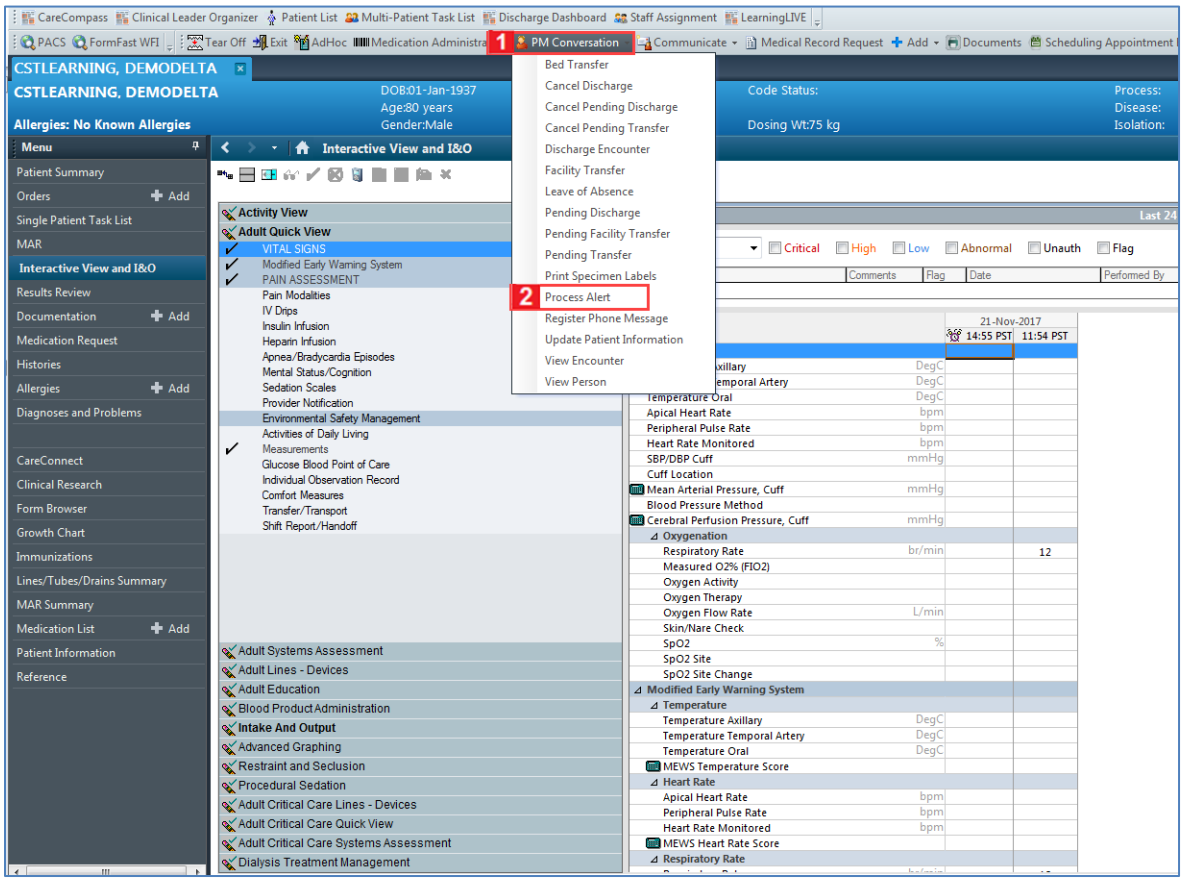
1

Patient Management Conversation (PM Conversation) provides access to manage alerts, patient location, encounter information and demographics. It is also the place to record patient leaves such as passes. Let's look at how alerts are managed.

Within the system, process alerts are flags that highlight specific concerns about a patient. These alerts display on the banner bar and can be activated by certain clinician including nurses.

Since the patient has a high Morse Fall score a **Falls Risk** process alert should be added to the patient's chart. To do this:

1. Click the drop-down arrow to right of **PM Conversation** PM Conversation in the toolbar
2. Select **Process Alert** from the drop-down menu

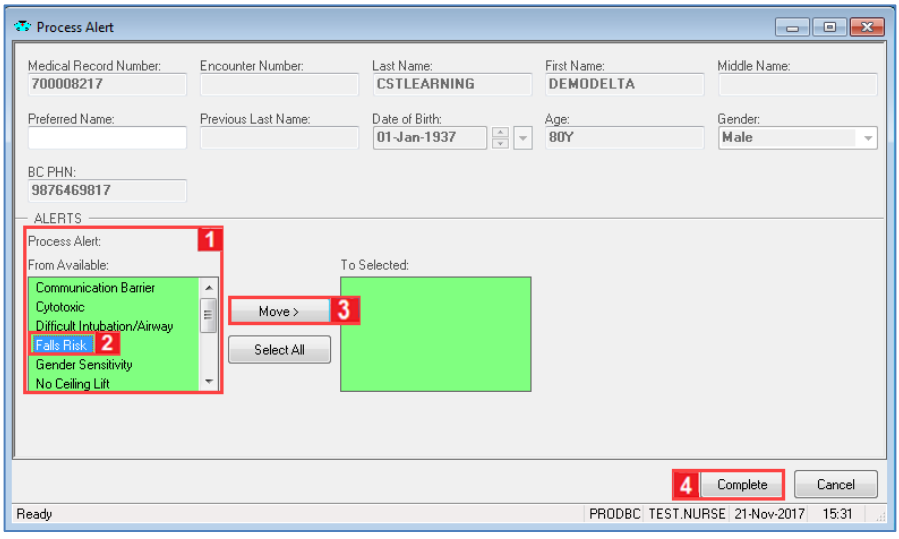


An organization window will display to select location.

1. In the Facility Name field, type = *LGH Lions Gate* and press **Enter** on your keyboard
2. Select **LGH Lions Gate Hospital**
3. Click **OK**


2 The Process Alert window displays. To activate the Falls Risk process alert on the patient's chart:

1. Click on the empty **Process Alert** box. A list of alerts that can be applied to the patient will display. (This box will be empty until you click on it).
2. Select **Falls Risk**
3. Click **Move** The alert will now display within the **To Selected** box
4. Click **Complete**




**Note:** Multiple alerts can be activated at once. Alerts can be removed using the same process. Site policies and practices should be followed with regards to adding and removing flags and alerts.

3

1. Click **Refresh** to update the chart
2. Once complete, the process alert will appear within the banner bar of the chart where it is visible to all who access the patient's chart


## Key Learning Points

- Process Alerts are important in alerting staff members to specific concerns related to the patient
- Use refresh after adding an alert to confirm it has been added to the patient's banner bar

# PATIENT SCENARIO 4 - Orders

## Learning Objectives

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

- Review the Orders Page and Place Orders
- Complete an Order
- Review the General Layout of a PowerPlan

## SCENARIO

As a nurse, you will need to be able to review orders for your patient. You will also need to place orders for your patient in certain situations. To do so you will complete the following activities:

- Review Orders Page
- Review Order Statuses and Details
- Place a Verbal Order
- Place a No Cosignature Required Order
- Enter the through MPTL
- Cancel/Discontinue an order
- Review Components of a PowerPlan

# Activity 4.1 – Review Orders Page

1 Throughout your shift, you will review your patient's orders. The Orders Page is where you will access a full list of the patient's orders.

To navigate to the **Order Page** and review the orders:

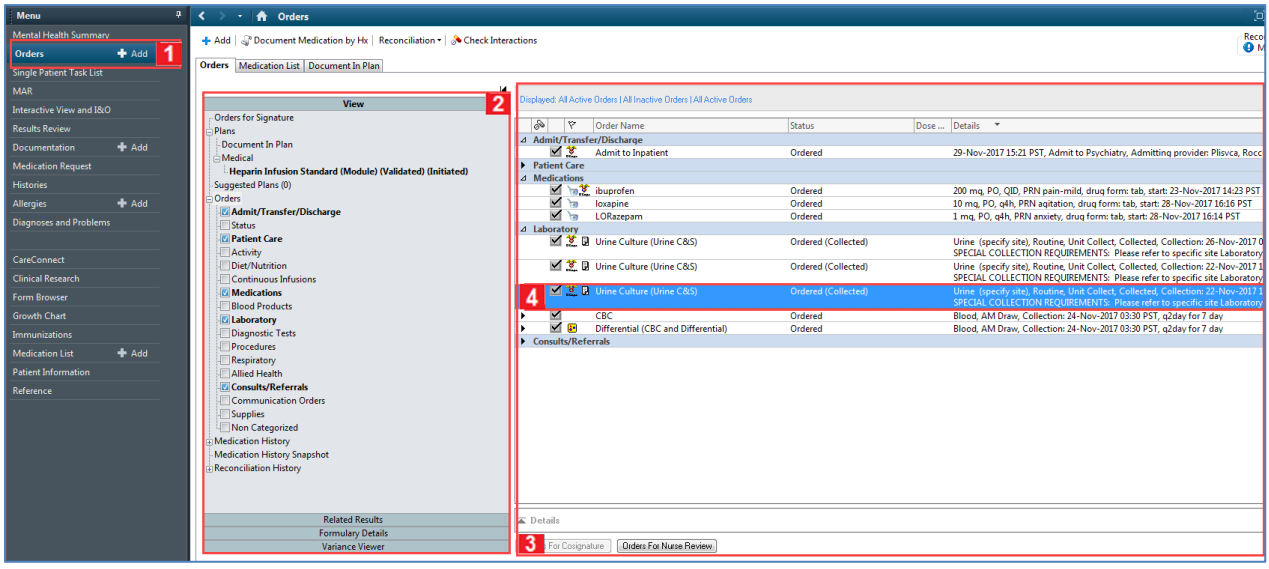
1. Select **Orders** from the **Menu**
2. On the left side of the Orders Page is the Navigator (**View**) which includes several categories including:
    - **Plans**
    - **Categories of Orders**
    - **Medication History**
    - **Reconciliation History**
3. On the right side is the **Order Profile** you can:
    - Review the list of orders

Moving the mouse over order icons allows you to **hover to discover** additional information.

Some examples of icons are:

- Order for nurse to review
- Additional reference text available
- Order part of a PowerPlan
- Order waiting for Pharmacy verification

4. Locate the **Urine Culture** order and review the details



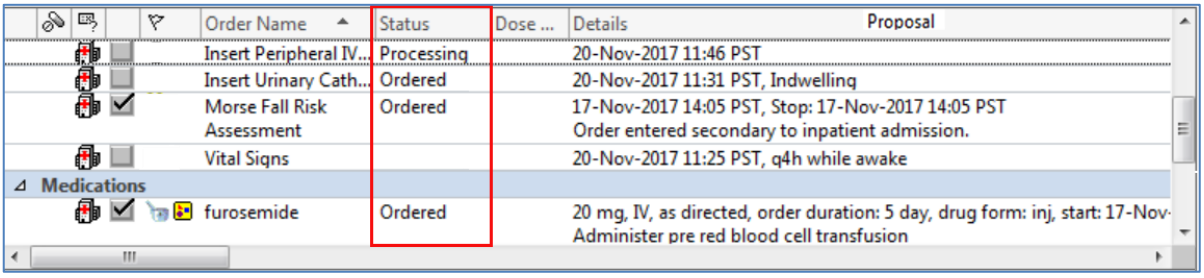
## Key Learning Points

- The Order Page consists of the Orders View (Navigator) and the order profile
- The Orders View displays the lists of PowerPlans and clinical categories of orders
- The Order Profile page displays all of the orders for a patient

# Activity 4.2 – Review Order Status and Details

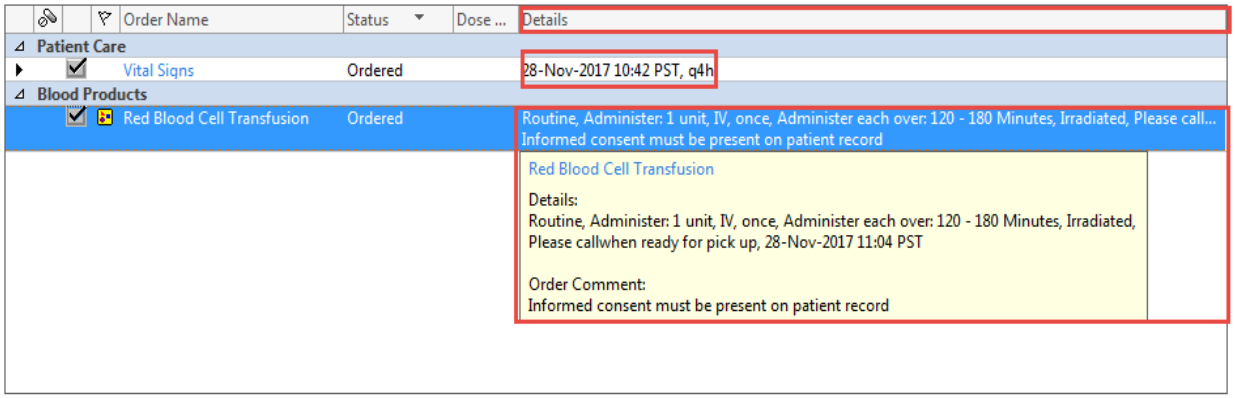
1 Orders are classified by status including:

- **Processing** - order has been placed or discontinued but the page needs to be refreshed to view updated status
- **Ordered** - active order that can be acted upon



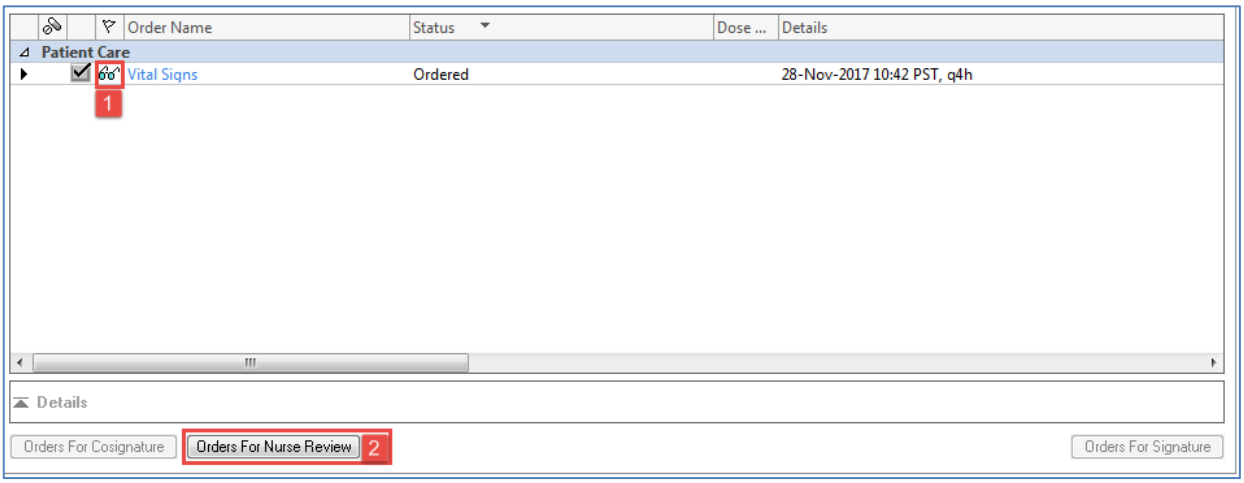

To see examples of order details review the image below:

- Focus on the **Details** column of the Orders page
- Hover your cursor over specific orders to discover additional information that is not otherwise visible. **Note:** This only applies to more complex orders not currently visible for your screen, refer to example below
- Note the start date and that orders are organized by clinical category

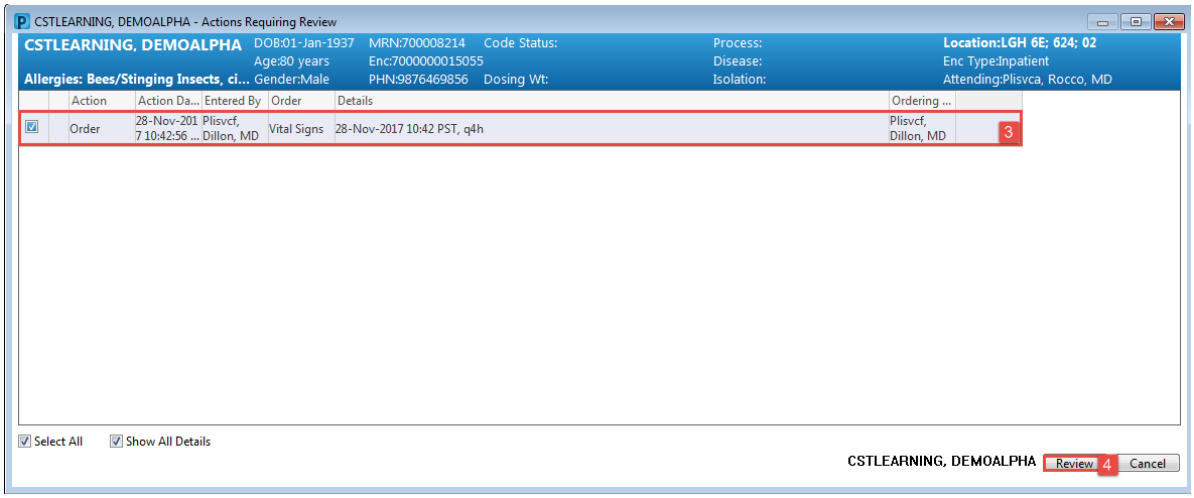


When new orders are placed in the chart, a nurse must acknowledge reviewing these new orders.

1. A Nurse Review icon appears to the left of the order. This serves to acknowledge that this order needs to be reviewed by a nurse, similar to the “nurse check” flag in the paper chart
2. Click the **Orders for Nurse Review** button to open the Review window




3. Review order details
4. Click **Review**




## Key Learning Points

- Orders can be one of three statuses: processing, ordered, proposed
- Always ensure to verify the status of orders

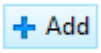
# Activity 4.3 – Place a Phone Order

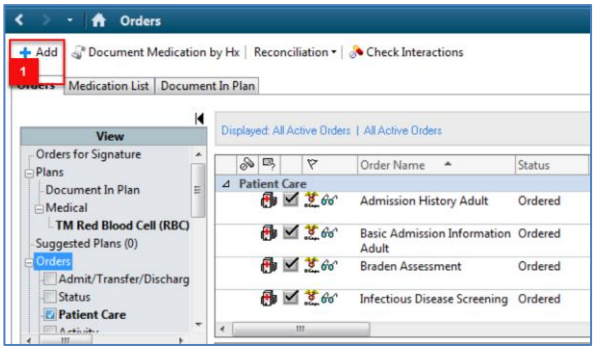
1

Just like in current practice, nurses can place verbal and telephone orders. In this activity, we are going to practice placing a verbal order. **Verbal and Phone Orders** are only encouraged when there is no reasonable alternative for the provider to place the order in the Clinical Information System (CIS) themselves, for example, in urgent situations.

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

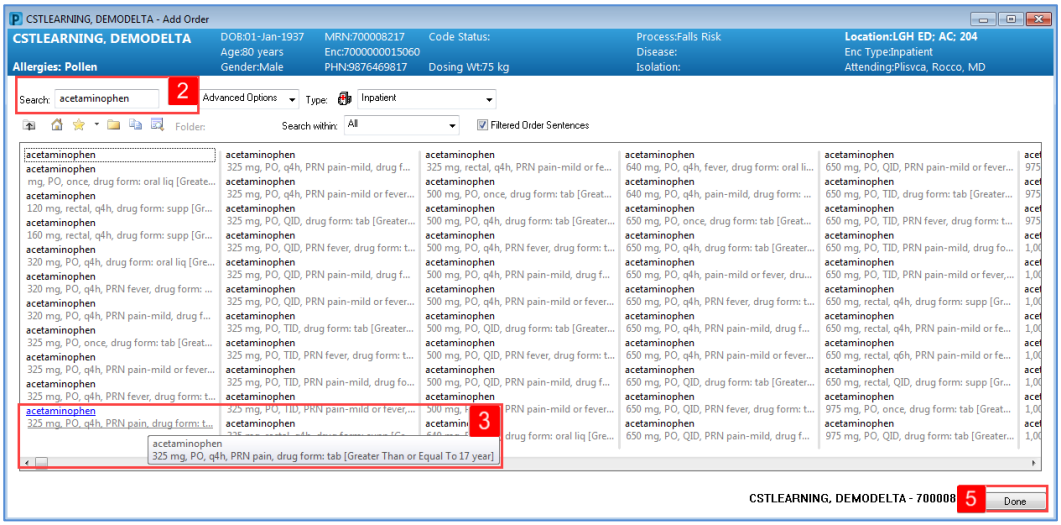
To place a verbal order:

1. Click Add 


2. In the Add Order window, type = *acetaminophen* in the search field and press **enter** to search

3. Select **acetaminophen, 325, PO, q4h, PRN pain, drug form: tab [Greater Than or Equal To 17 year**

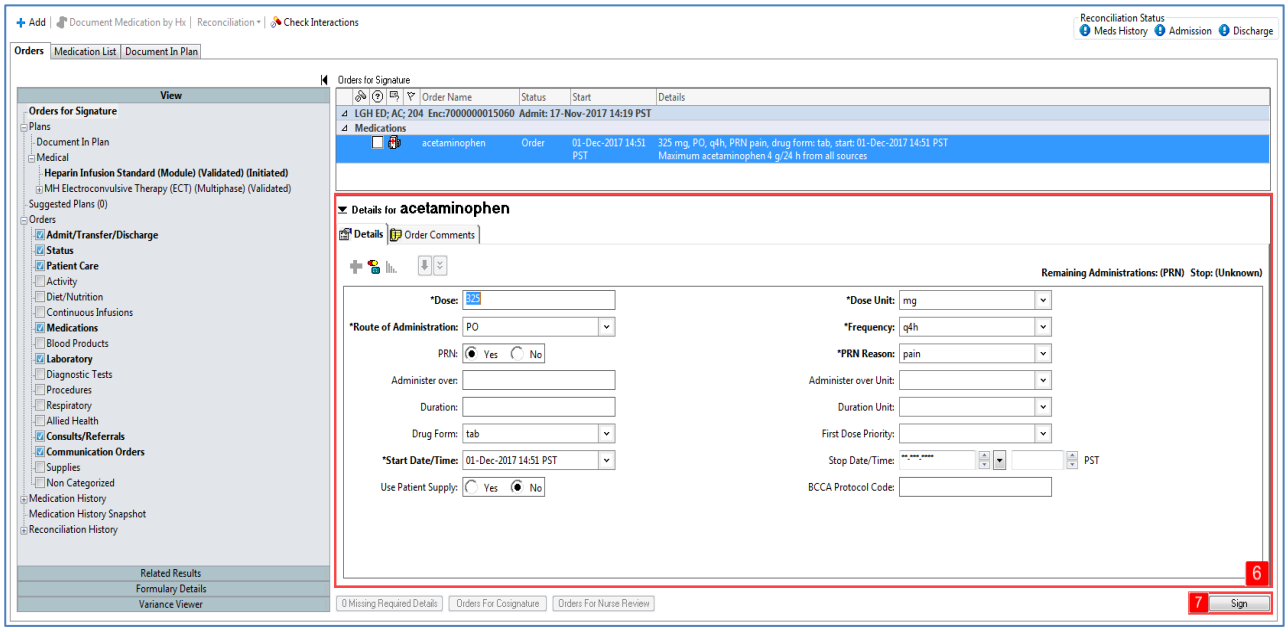


The Ordering Physician pop-up window will appear

4. Fill out required fields highlighted yellow**:**
    - **Physician name** = *type name of Attending Physician (last name, first name)*
    - **Communication type** = *Phone*
    - Click **OK**
    - You are brought back to the orders window.
5. Click **Done**
6. You are brought to the Orders Review window. Review the order details

You will notice that information is pre-populated into the order details section from the order you selected. You may change information at this point if you wish.

7. Click **Sign** The orders profile now displays the acetaminophen with a status of **Ordered**




## Key Learning Points

- A nurse may enter orders in urgent situations when a provider is unable to enter the CIS
- Verbal and phone orders that are entered in the CIS automatically get routed to the provider for co-signature

# Activity 4.4 – Place a No Cosignature Required Order

1

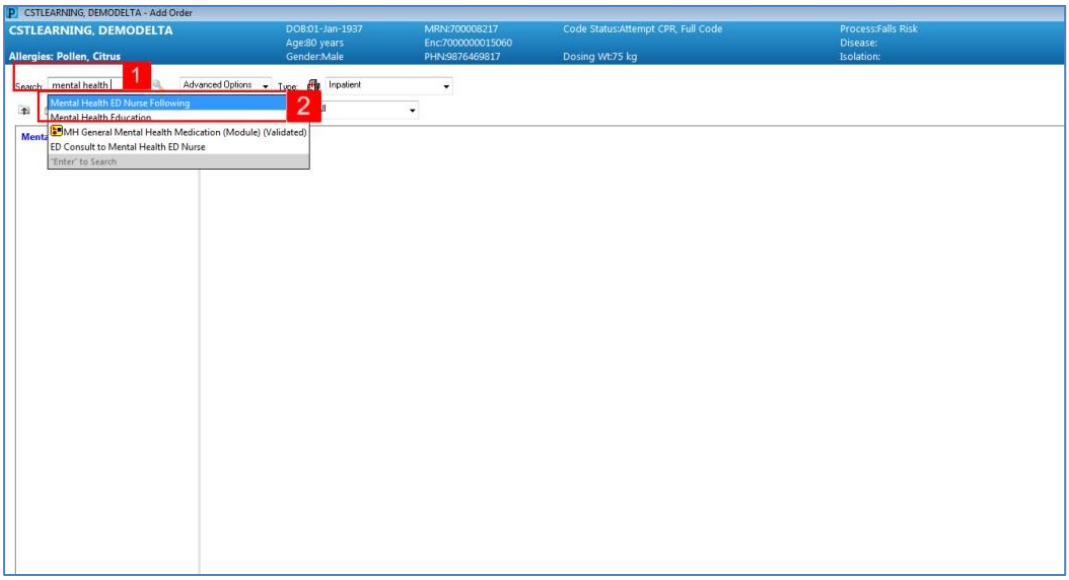
Staff who consult on a patient for a period of time have the ability to place **a Following Order**. This order lets others know that you are involved in the patient's care. It also places the patient back on your Multi-Patient Task List for easy access to their chart. This task will stay on your task list as long as the order is active. It will never have a status of overdue.

Nurses can place the following types of orders:

- Orders requiring a cosignature of the provider (for example, telephone and verbal orders)
- Orders that do not require a cosignature (for example, order within nursing scope, nurse initiated orders)

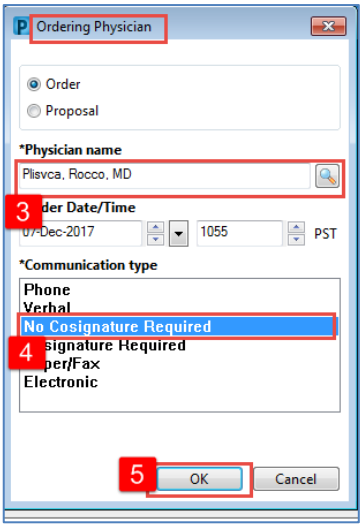
To place an order that does **not** require a cosignature (a Following Order). Click the **Add** button on the **Orders** Page. The add order window will open.

1. Type = *Mental Health ED* into the search window and a list of choices will display
2. Select **Mental Health ED Nurse Following**



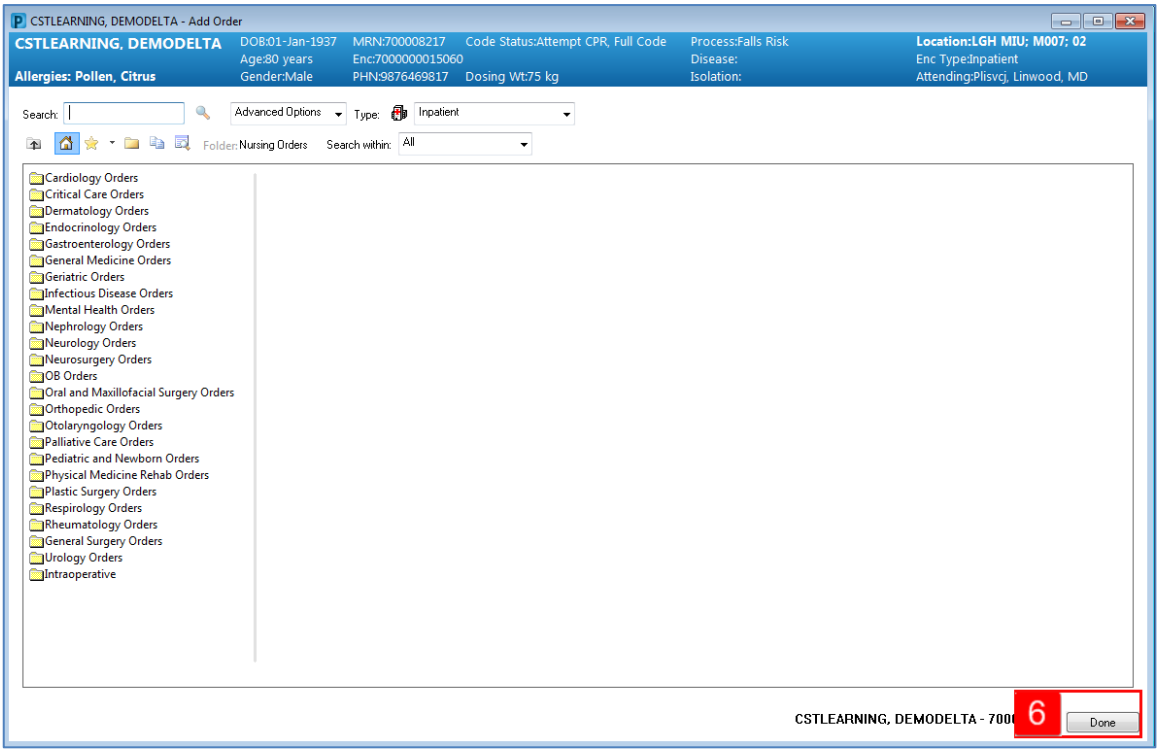
The **Ordering Physician** window opens.

3. Type in the full name of the patient's Attending Physician
4. Select **No Cosignature Required**
5. Click **OK**



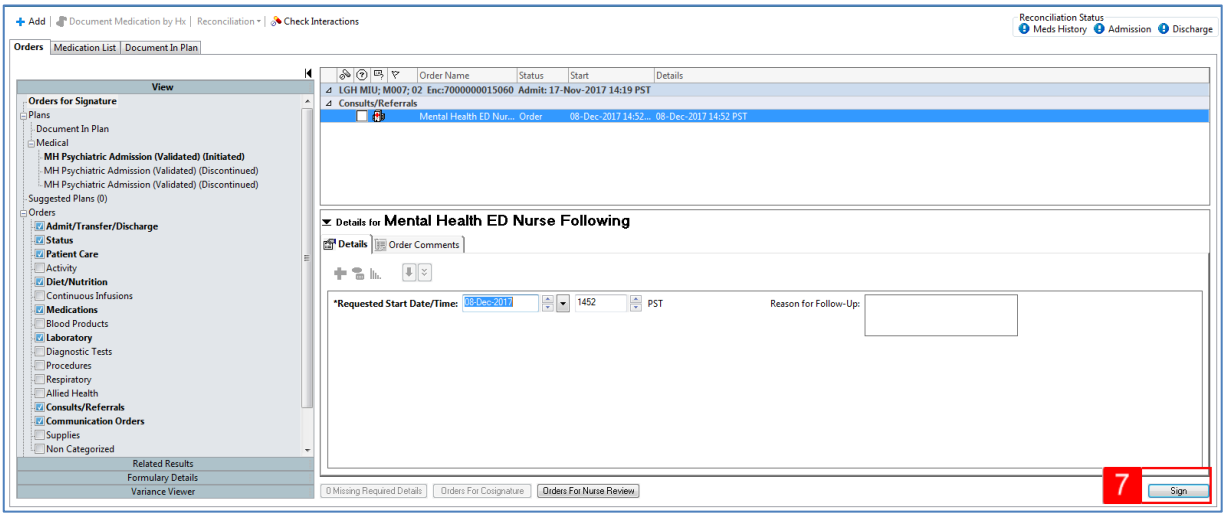

You will be returned to the blank Add Order Page

6. Click **Done**



You will be returned to the Orders Page and see the order details

7. Click **Sign**



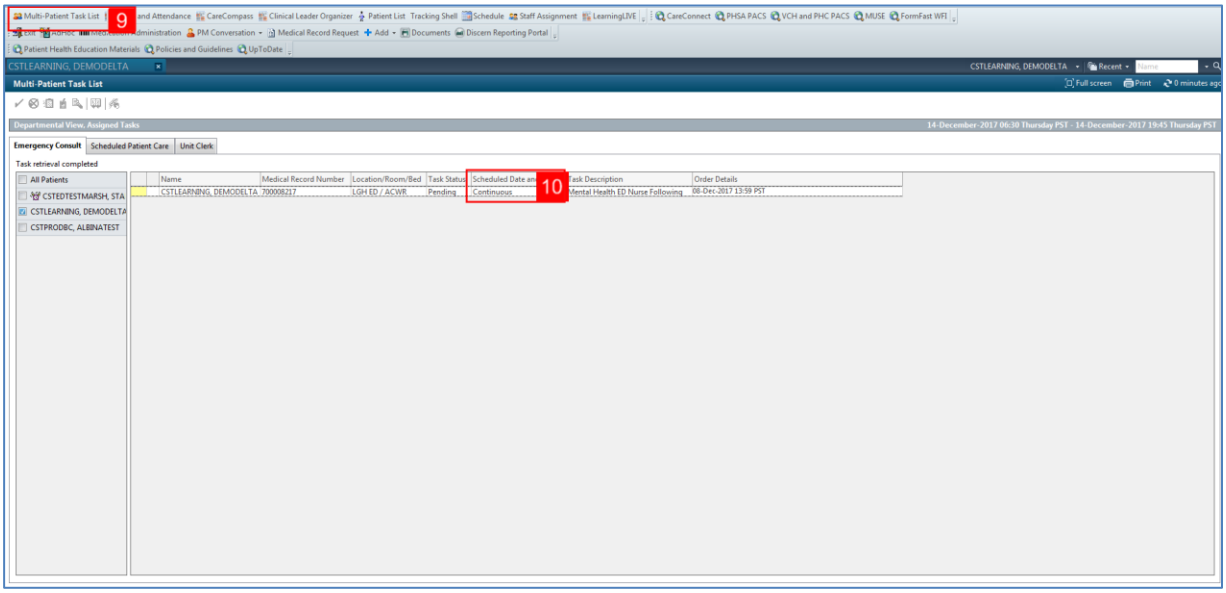

You are brought back to the patient's Orders page. The Mental Health ED Nurse Following Order has a status of "processing".

8. Click **Refresh**  This will change the status to "Ordered"

You can now view the Following Order on your MPTL

9. Navigate to Multi-Patient Task List from the organizer toolbar

10. Note the order now has a scheduled date and time of "Continuous"



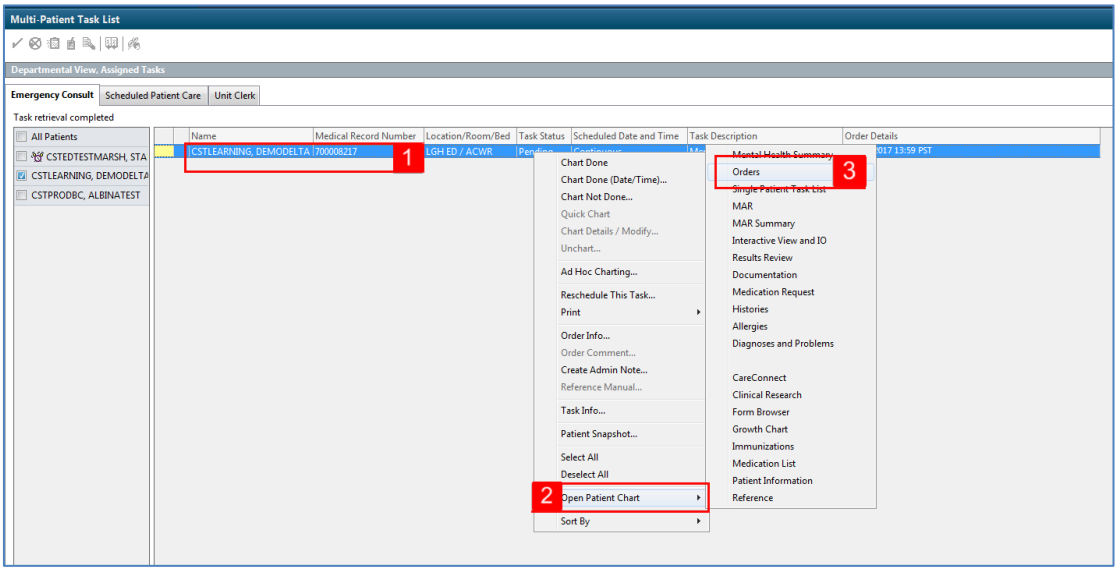
## Key Learning Points

- Nurses can place No Cosignature Required order
- A Following order is a No Cosignature Required order that lets others know that you are involved in the patient's care
- A Following order places the patient back on your Multi-Patient Task List for easy access to their chart

# Activity 4.5 – Enter the Chart through a Following Order

1 You can enter the patient's chart through the consult or a Following Order by right clicking on it. Let's practice entering the chart.

1. Right click on the task to open the right click menu
2. Hover over **Open Patient Chart.** A menu appears with various chart components from which you can navigate directly. Let's go back to the Orders Profile
3. Select **Orders**




You are brought directly to the orders profile once again.

## Key Learning Points

- You can enter many components of the patient's chart through the consult or following order through the right click menu

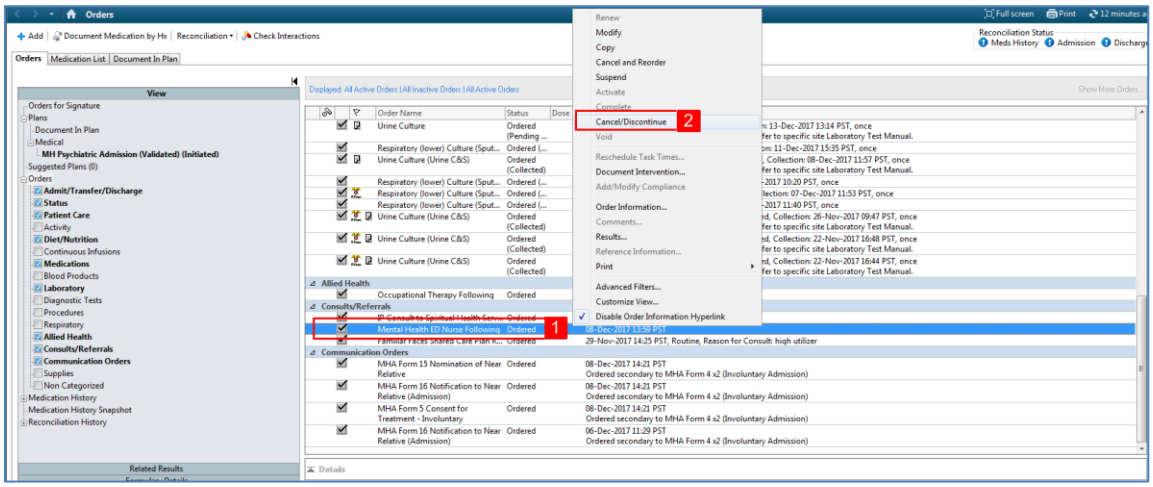
# Activity 4.6 – Cancel/Discontinue an Order

1

A Following order is a continuous order that will stay on your MPTL until it is cancelled or discontinued. You will need to cancel/discontinue this order when you are no longer involved in the patient's care.

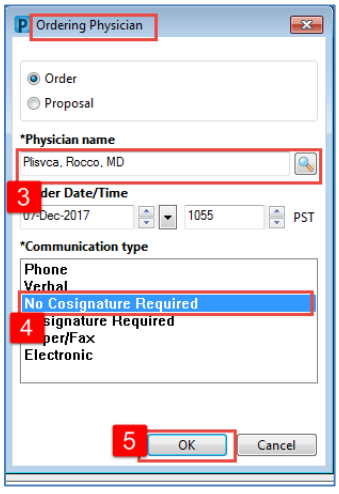
To discontinue the Mental Health ED Nurse Following order:

1. Right-click **Mental Health ED Nurse Following** order
2. Select **Cancel/Discontinue**

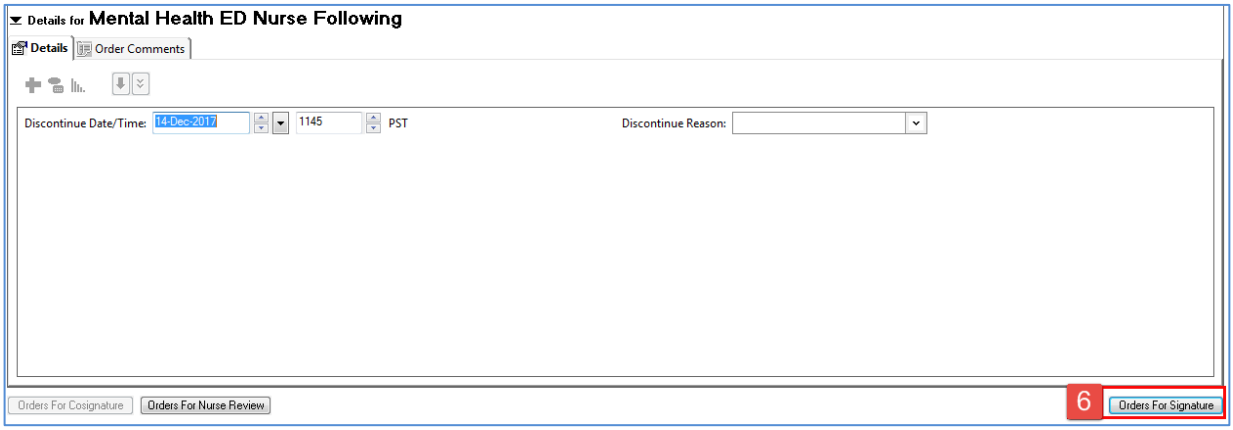



The **Ordering Physician** window opens.

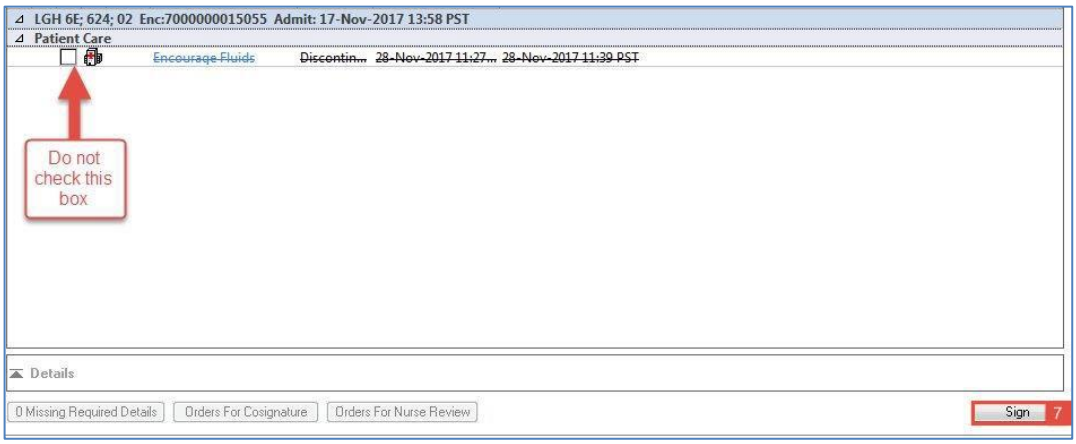
3. Type in the name of the patient's Attending Physician (Last name, First name)
4. Select **No Cosignature Required**
5. Click **OK**




6. Review order and click **Orders For Signature**




7. Review Order for signature and click **Sign**. You will return to the order profile.




8. **Refresh** page. Order will no longer be visible on the MPTL

## Key Learning Points

- A following order is a continuous order that will stay on your MPTL until it is cancelled or discontinued
- Once an order is cancelled or discontinued the order will be removed from the patient's Order Profile

# Activity 4.7 – Review Components of a PowerPlan

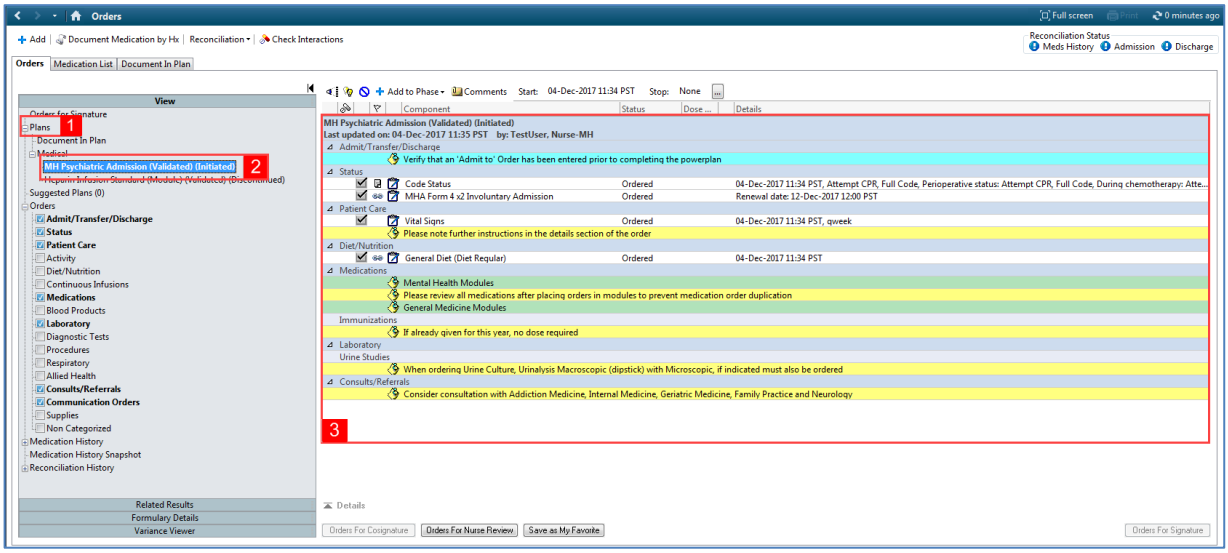
1

A PowerPlan is the equivalent of preprinted orders in the current state. They are frequently ordered at the same time, such as during admission or ECT.

At times it may be useful to review a PowerPlan to distinguish it from single orders. Doing this allows a user to group orders by PowerPlan.

While on the Orders page:

1. Locate the **Plans** category to the left side of the screen under **View**
2. Select the **MH Admission**
3. Review the orders within the PowerPlan




## Key Learning Points

- PowerPlans are the equivalent of preprinted orders in current state
- PowerPlans can be found in the Navigator (View) under the “Plans” category

# PATIENT SCENARIO 5 - Interactive View and I&O

| Learning Objectives |
| --- |
| At the end of this Scenario, you will be able to:<br>- Review the Layout of Interactive View and I&O (iView)<br>- Document and Modify your Documentation in iView |

## SCENARIO

In this scenario, you will be charting on your patient.

You will be completing the following activities:

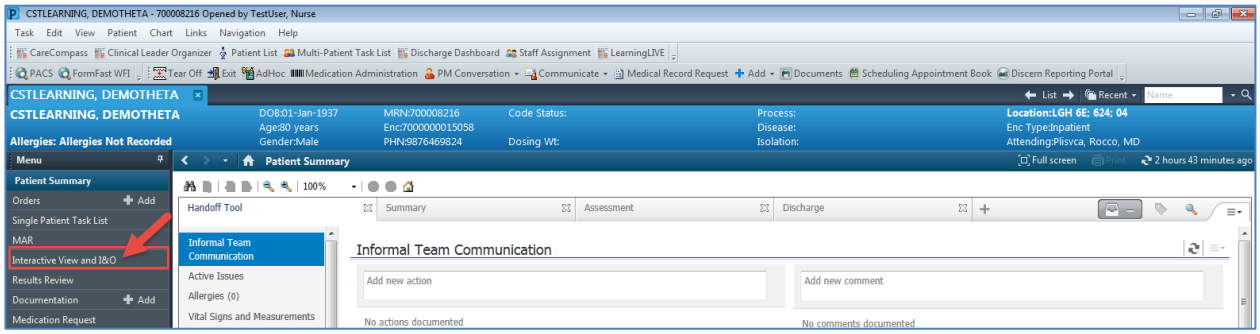
- Review the layout of Interactive View and I&O (iView)
- Document in iView
- Modify the time column
- Modify, unchart and add a comment in iView

# Activity 5.1 – Review the Layout of Interactive View and I&O

1

Nurses will complete the majority of their documentation in **Interactive View and I&O (iView)**. iView is the electronic equivalent of current state paper flow sheets. For example, vital signs and mental status will be charted in iView.

Select **Interactive View and I&O** within the **Menu**.




2

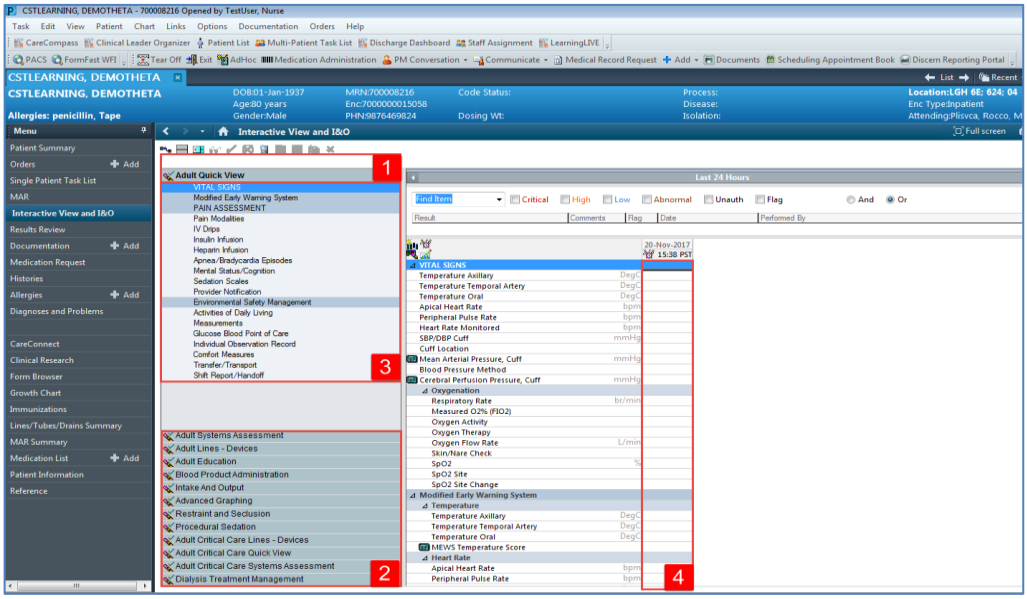
Now that the iView page is displayed, let's view the layout.

1. A **band** is a heading that has a collection of flowsheets (**sections**) organized beneath it. In the image below, the **MH Adult Quick View** band is expanded, displaying the sections within it
2. The set of bands below **MH Adult Quick View** are collapsed. Bands can be expanded or collapsed by clicking on their name

**Note:** For pediatric patients, you will find age-appropriate assessments within the **MH Pediatric Quick View** band

3. A **section** is an individual flowsheet that contains related assessment and intervention documentation
4. A **cell** is a field where data is documented

Take some time to explore the various sections within the **MH Adult Quick View** band. Notice that your common assessments are located here, such as vital signs, Mental Status Exam and ongoing Columbia Suicide Severity Rating.




## Key Learning Points

- Nurses will complete the majority of their documentation in iView
- iView contains flowsheet type charting

## Activity 5.2 – Documenting in Interactive View and I&O

1 With the **MH Adult Quick View** band, you will see the **Vital Signs** section. Let's practice documenting in iView.

1. Select the **VITAL SIGNS** component under **MH Adult Quick View**
2. Double-click the **blue box** next to the name of the section to document in several cells. You can move through the cells by pressing the **Enter** key
3. Document the following data:
    - **Temperature Oral** = *36.9*
    - **Peripheral Pulse Rate** = *91*
    - **SBP/DBP Cuff** = *140/90*

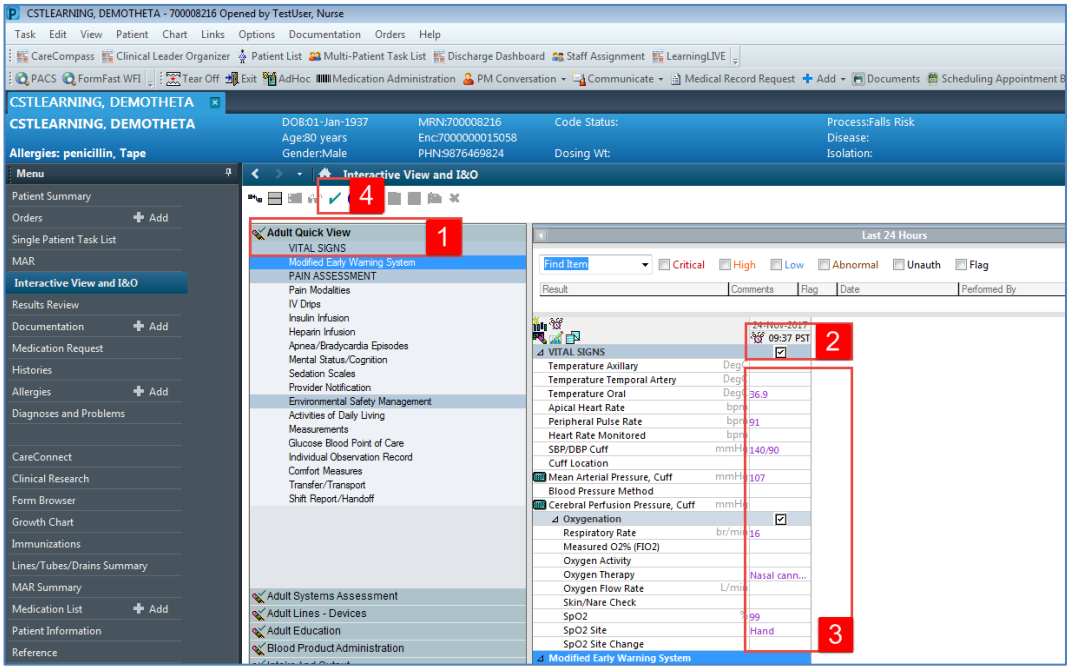
**Note:** The **Calculation** icon denotes that the cell will populate a result based on a calculation associated with it. Hover over the calculation icon to view the cells required for the calculation to function. For example, Systolic Blood Pressure (SBP) and Diastolic Blood Pressure (DBP) are required cells for the Mean Arterial Pressure calculation to function.

- **Respiratory Rate** = *16*
- **SpO2**= *99*
- **SpO2 Site**= *Hand*

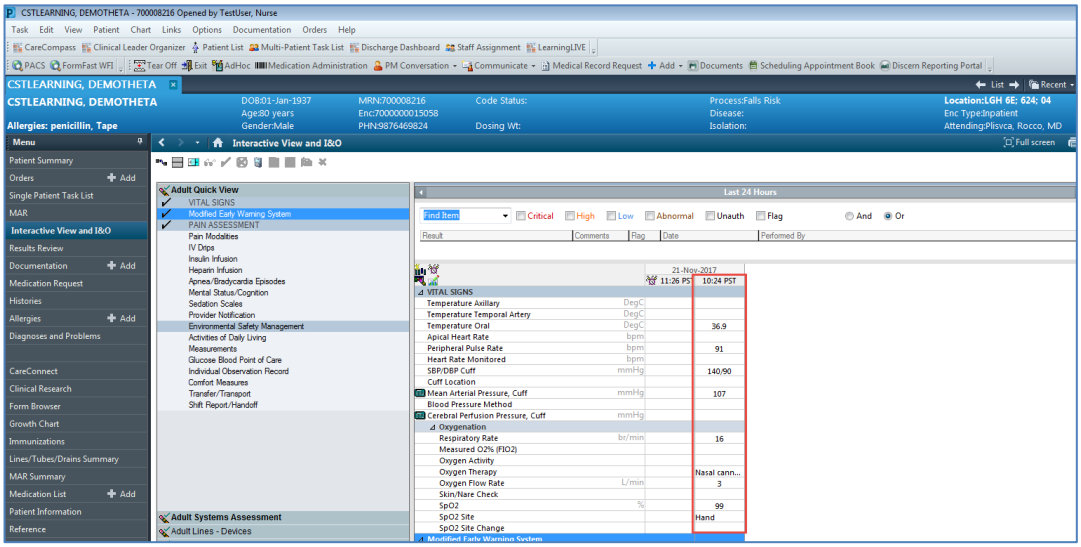
Notice that the text is purple upon entering. This means that the documentation has not been signed and is not part of the chart yet.

**Note:** Please disregard the values that are populated in the cells under the Modified Early Warning System (MEWS) section. More information about MEWS documentation will be provided later in this workbook

4. To sign your documentation, click the **Green Checkmark** icon




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




**Note:** You do not have to document in every cell. Only document to what is appropriate for your assessment and follow appropriate documentation policies and guidelines at your site.

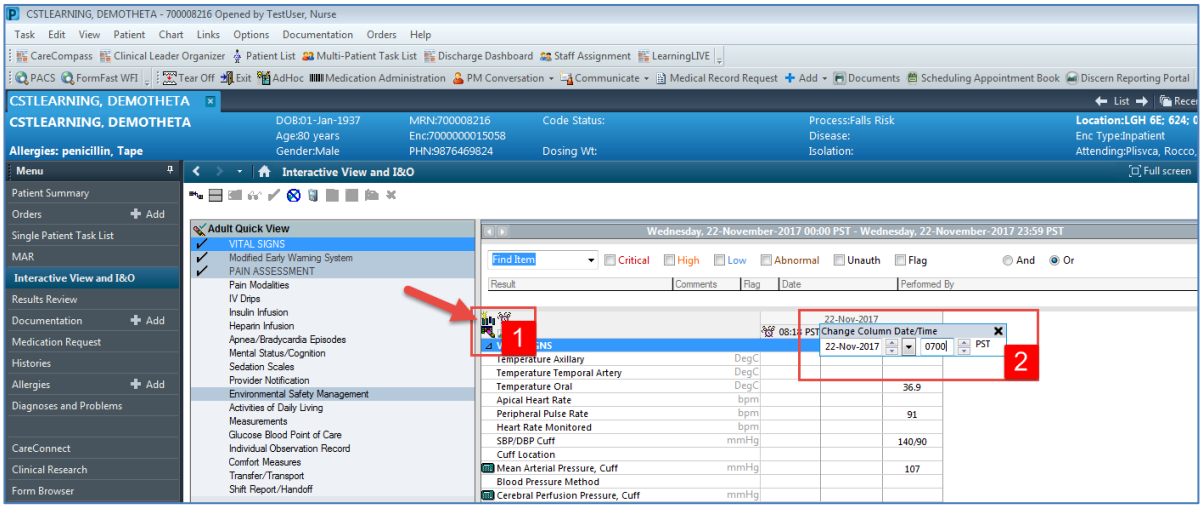
## Key Learning Points

- Double-click the blue box  next to the name of the section to document in several cells. The section will then be activated for charting
- Documentation will appear in purple until signed. Once signed, the documentation will become black
- The newest documentation displays in the left-most column
- You do not have to document in every cell. Only document to what is appropriate to your assessment

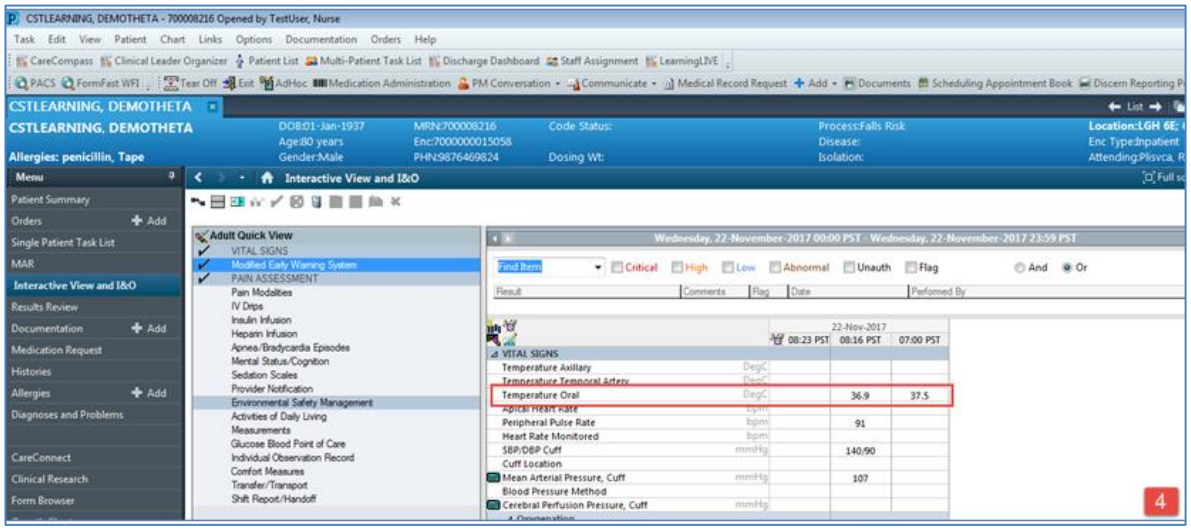
# Activity 5.3 – Change the Time Column

1 You can create a new time column and document under a specific time. For example, it is now 12:00 pm and you still need to document your patient's 10:00 am temperature.

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




4. In the new column, enter **Temperature Oral** = *37.5* and **Sign** the documentation. The documentation is now black and saved into the chart




## Key Learning Points

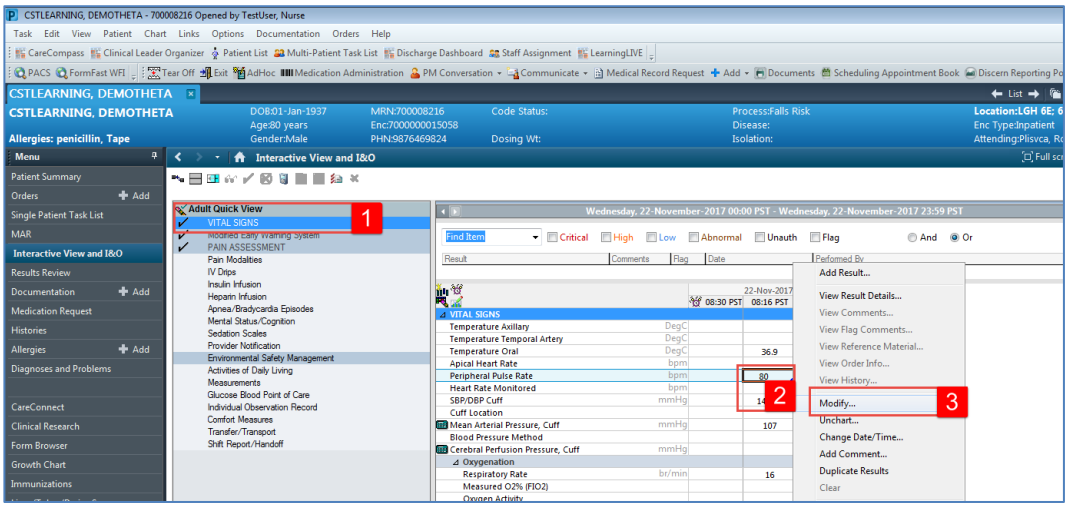
- You can create a new time column and document under a specific time in iView

# Activity 5.4 – Modify, Unchart and Add a Comment in Interactive View

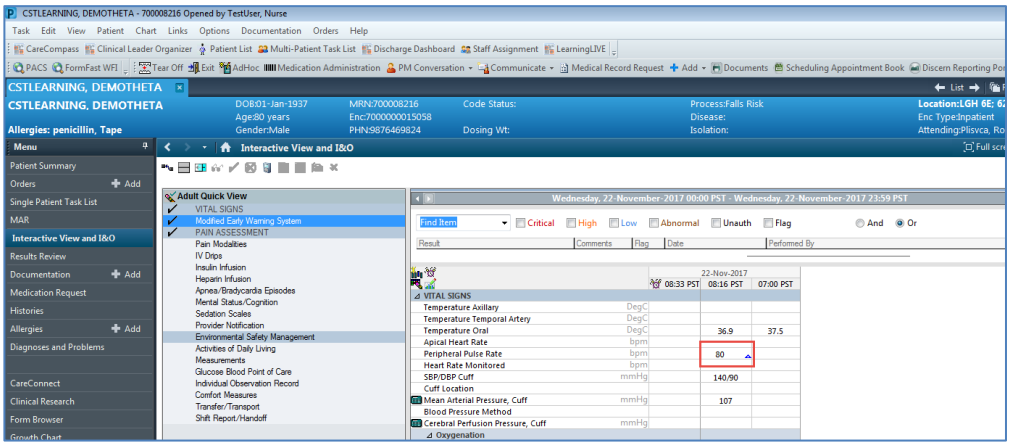
1 You realize upon reviewing your earlier charting that you wrote the incorrect Peripheral Pulse Rate value.

Let's modify the Peripheral Pulse Rate originally documented in Activity 6.2.

1. Click on the **Vital Signs** section heading in the **MH Adult Quick View** band
2. Right-click on the documented value of **80** for Peripheral Pulse Rate
3. Select **Modify…**



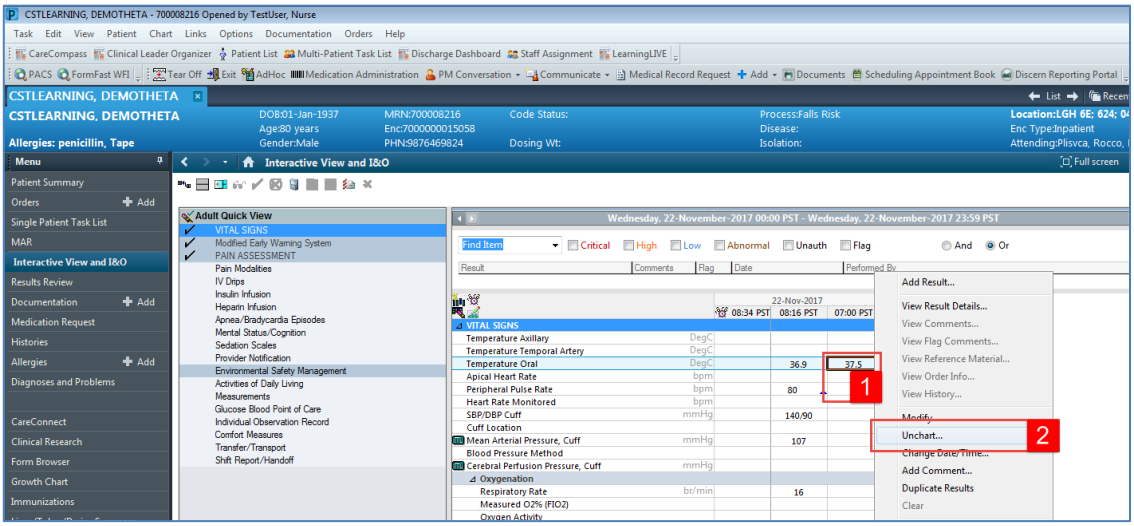

4. Enter in new **Peripheral Pulse Rate** = *80* and then sign documentation
5. **80** now appears in the cell and the corrected icon will automatically appear on bottom right corner to denote a modification has been made



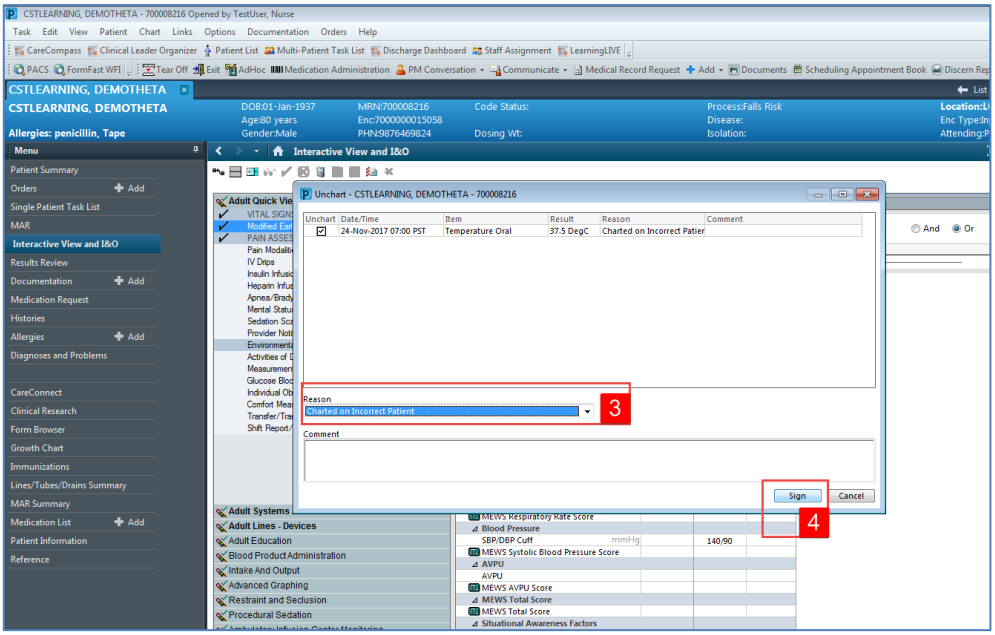
2 The unchart function will be used when information has been charted in error and needs to be removed.

For example, the temperature documented earlier was meant to be documented in another patient's chart. It needs to be uncharted.

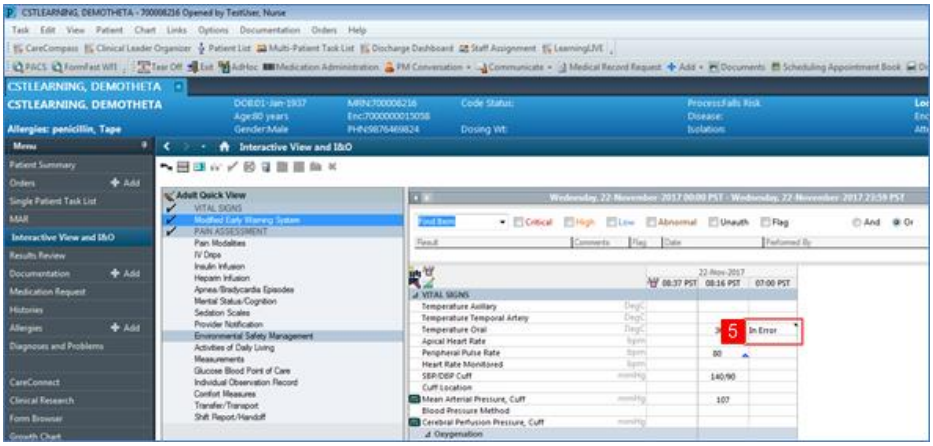
1. Right-click on the documented value of **37.5** for Temperature Oral
2. Select **Unchart**




3. Select **Charted on Incorrect Patient** from the reason drop-down in the Unchart pop-up window
4. Click **Sign**

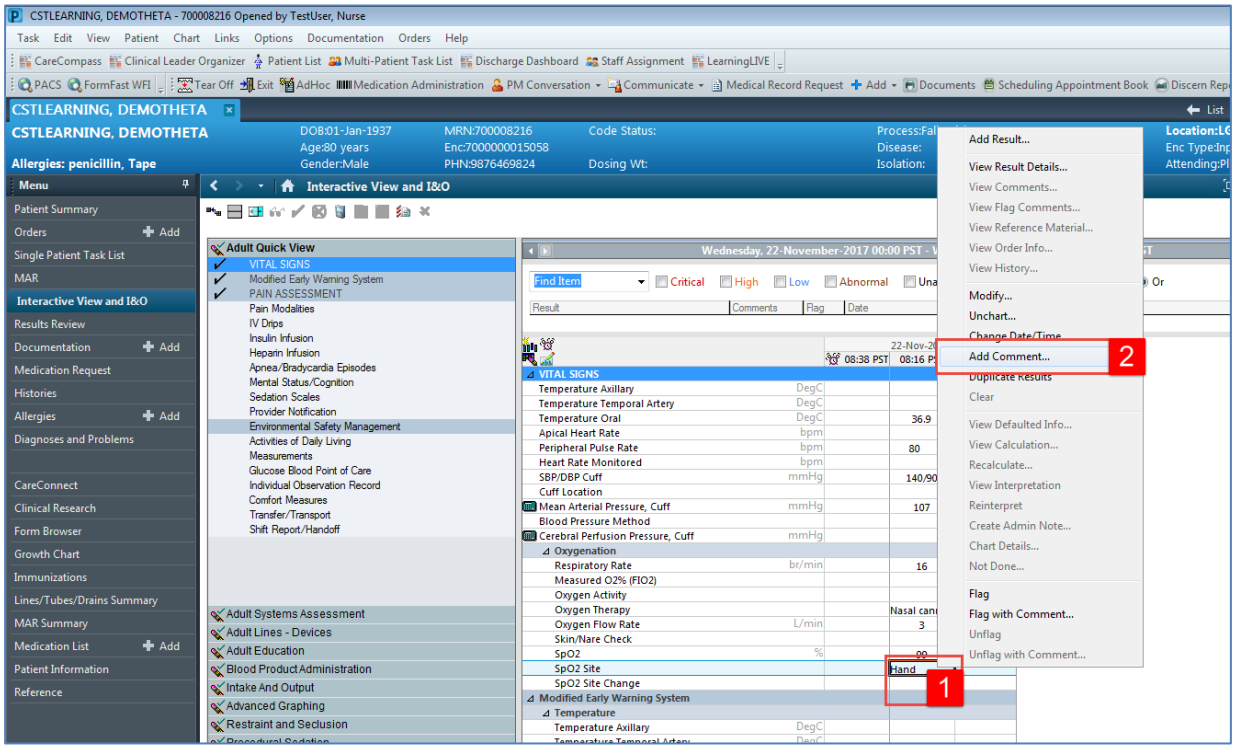


5. You will see **In Error** displayed in the uncharted cell. The result comment or annotation icon will also appear in the cell

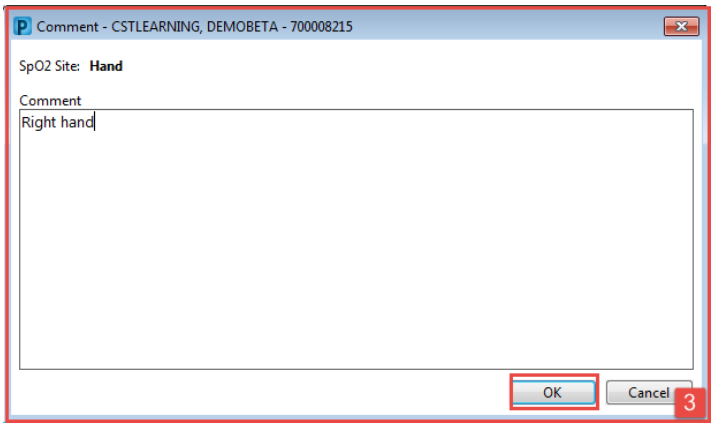



3 A comment can be added to any cell to provide additional information. For example, you want to clarify that the SpO2 site that you documented was on the patient's right hand.

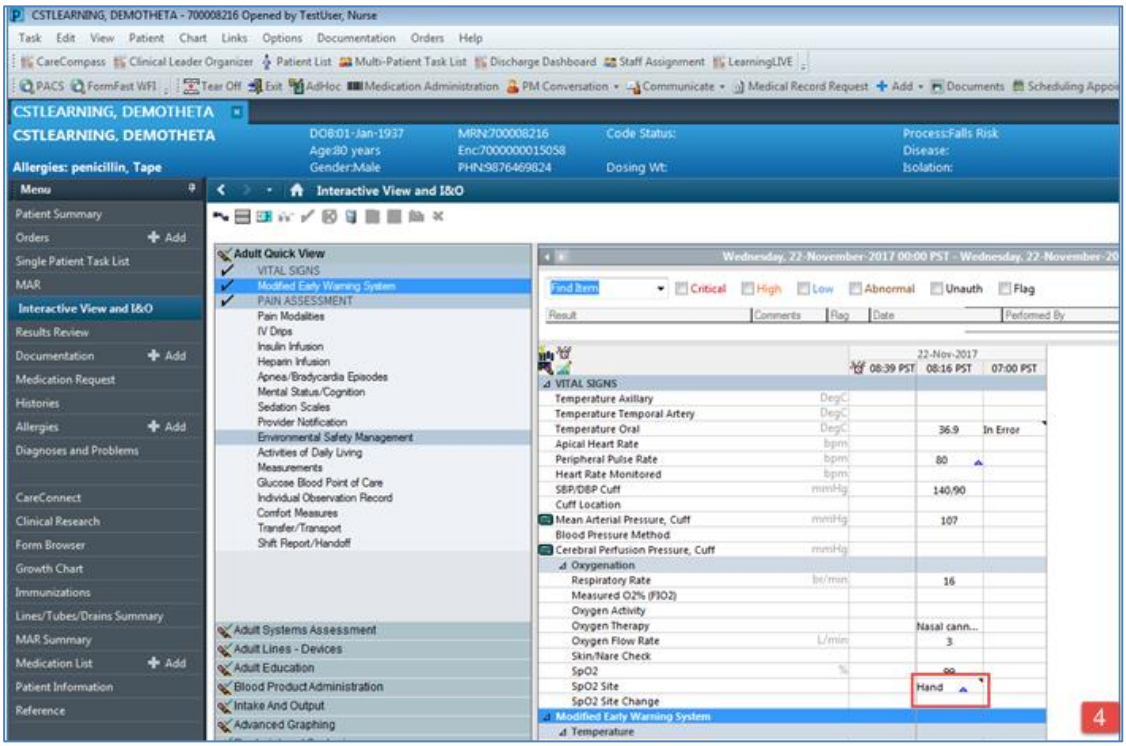
1. Right click on the documented value for **SpO2 site, hand**
2. Select **Add Comment**



3. Type comment = *Right hand* and click **OK** in the Comment pop-up window




4. An icon indicating the documentation has been modified will display and another icon indicating comments can be found will display in the cell. Right-click on the cell to view comments




## Key Learning Points

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

# PATIENT SCENARIO 6 - PowerForm

**Learning Objectives**

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

- Document in PowerForms through Ad Hoc Charting
- View and Modify Existing PowerForms

## SCENARIO

In this scenario, we will review another method of documentation.

As a nurse you will be completing the following activities:

- Opening and documenting on blank PowerForms
- Viewing an existing PowerForm
- Modifying an existing PowerForm
- Uncharting an existing PowerForm

# Activity 6.1 – Opening and Documenting on PowerForms

1 **PowerForms** are the electronic equivalent of standardized documentation forms.

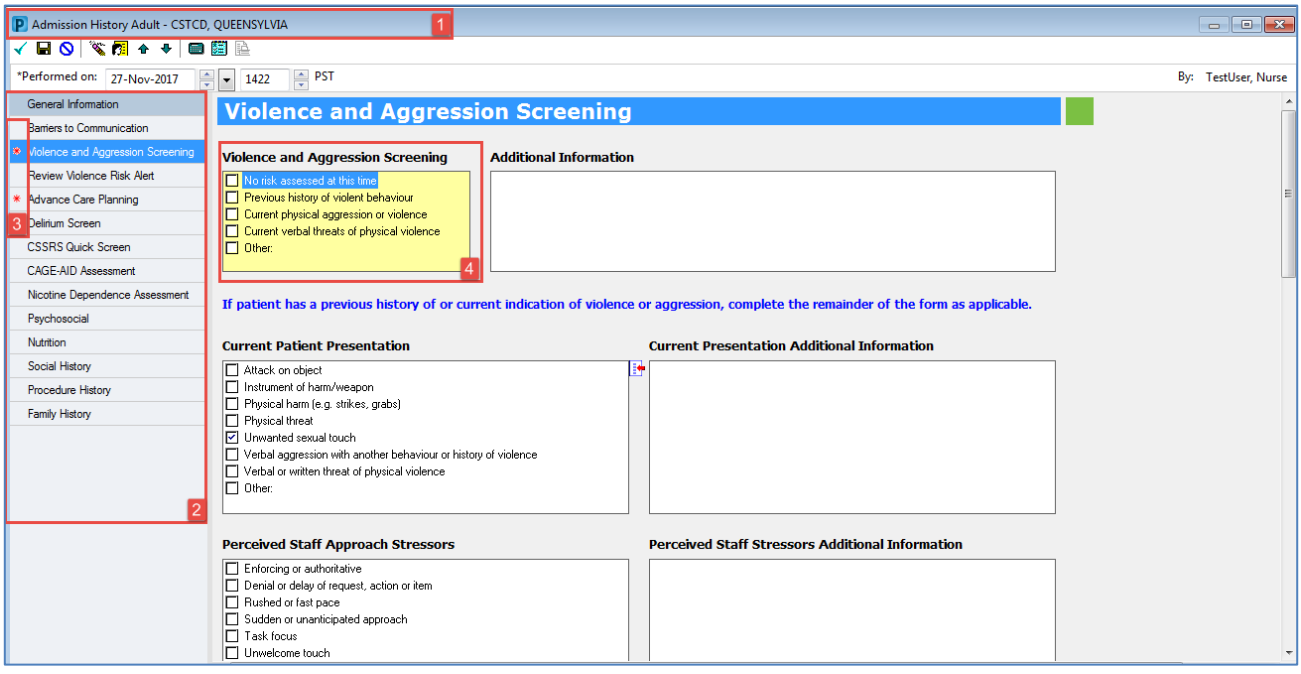
Data entered in **PowerForms** can flow between iView, problems and diagnosis list, allergy profile, and medication profile.

The **AdHoc** folder is an electronic filing cabinet that holds any **PowerForms** you may need to document.

**Note:** The next 4 steps refer to only the screenshot below. After reviewing a **PowerForm** you will then practice completing one.

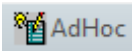
Let's explore the different components of a **PowerForm**:

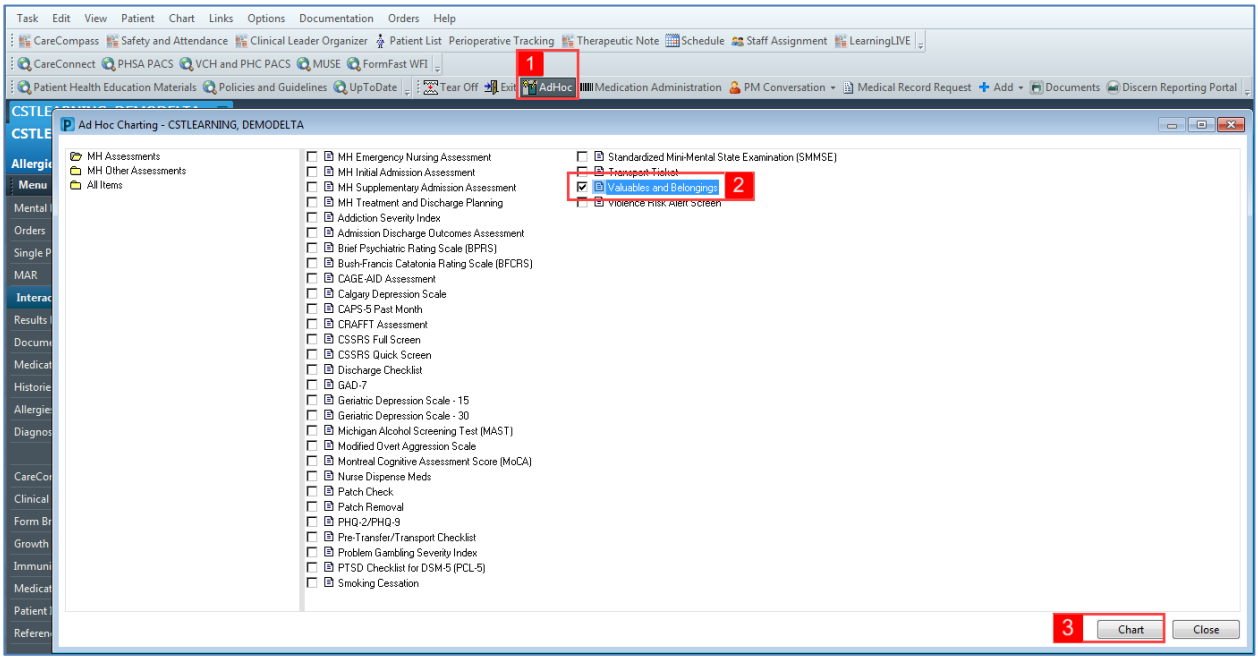
1. The title of the **PowerForm** and the patient you are documenting on
2. A list of **sections** that can be documented
3. Sections that have a red asterisk contain required field(s) that are mandatory
4. The mandatory field(s) within the **PowerForm** will be highlighted in yellow. In some cases, you will be unable to sign a **PowerForm** unless all required fields are completed



2 In this example, we are going to document on the **Valuables and Belongings** PowerForm.

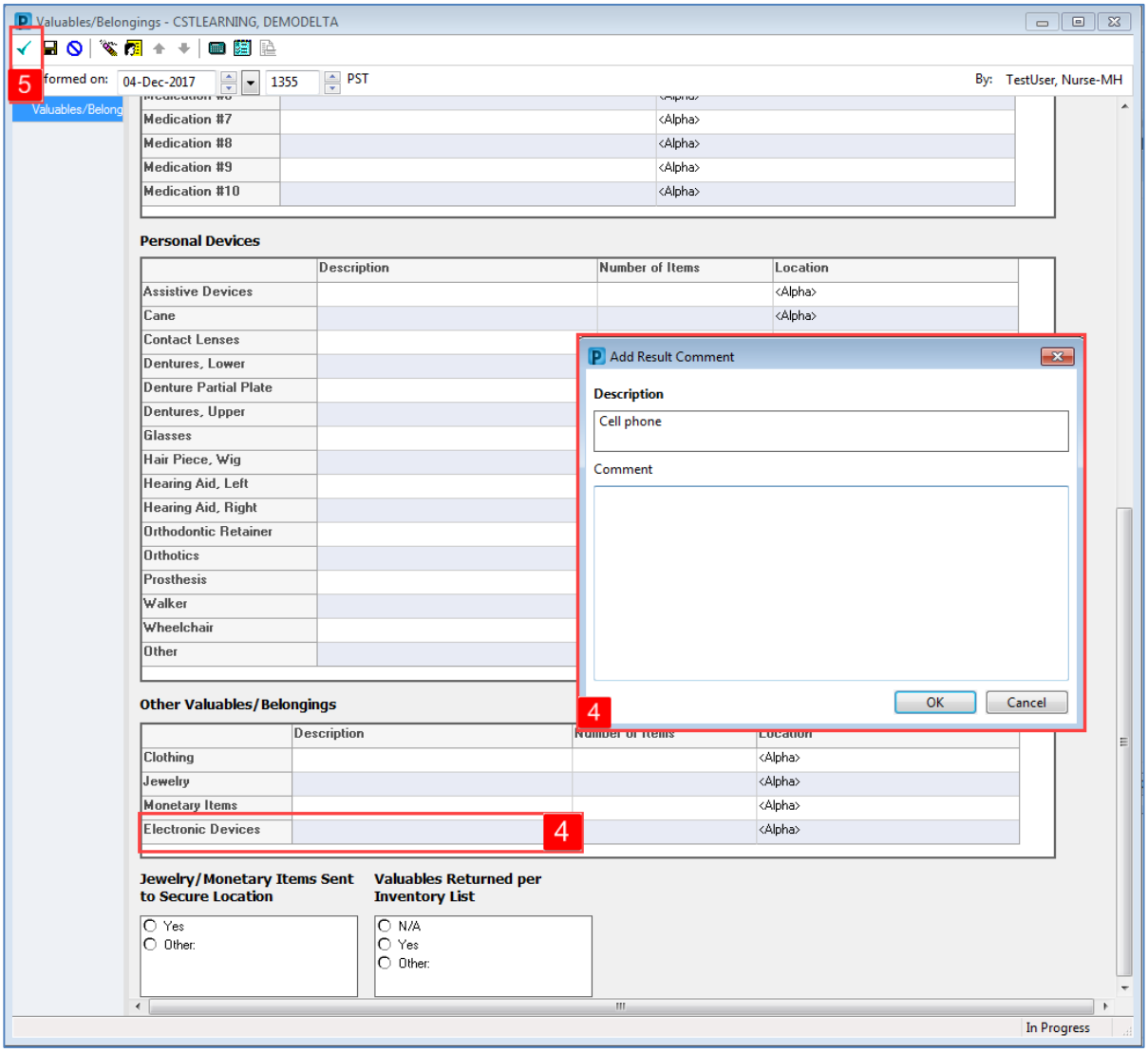
To **open** and **document** on a new PowerForm:

1. Click the **AdHoc** button  from the **toolbar**
2. Select the **Valuables and Belongings** PowerForm by selecting the title
3. Click **Chart**




**Note:** The Ad Hoc window contains two panes. The left side displays folders that group similar forms together. The right side displays a list of forms within the selected folder.

4. Fill in the following fields:
   - **Does the patient have any valuables/belongings with them?** = *Yes*
   - Under **Other Valuables/Belongings**, double click in the description column beside **Electronic Devices** = *Cell phone.* Click **OK**
5. To complete PowerForm, click the **green checkmark**  to sign and then refresh the screen 




**Note:** using the Save Form icon is discouraged because no other user will be able to view your documentation until it is signed using the green checkmark ✓ icon.

## Key Learning Points

- PowerForms are the electronic equivalent of standardized documentation forms
- The AdHoc button in the toolbar is one way to locate a new Powerform
- PowerForms may be broken up into several sections. Section headings are displayed to the left side of PowerForm
- Documents that are saved will not be viewable to anyone except the author. Using the Save Form icon is discouraged for this reason

# Activity 6.2 – Modify an existing PowerForm

1 Existing PowerForms can be found in **Form Browser**. Here, you can view, modify or unchart PowerForms. It may be necessary to modify PowerForms if the information was entered incorrectly.

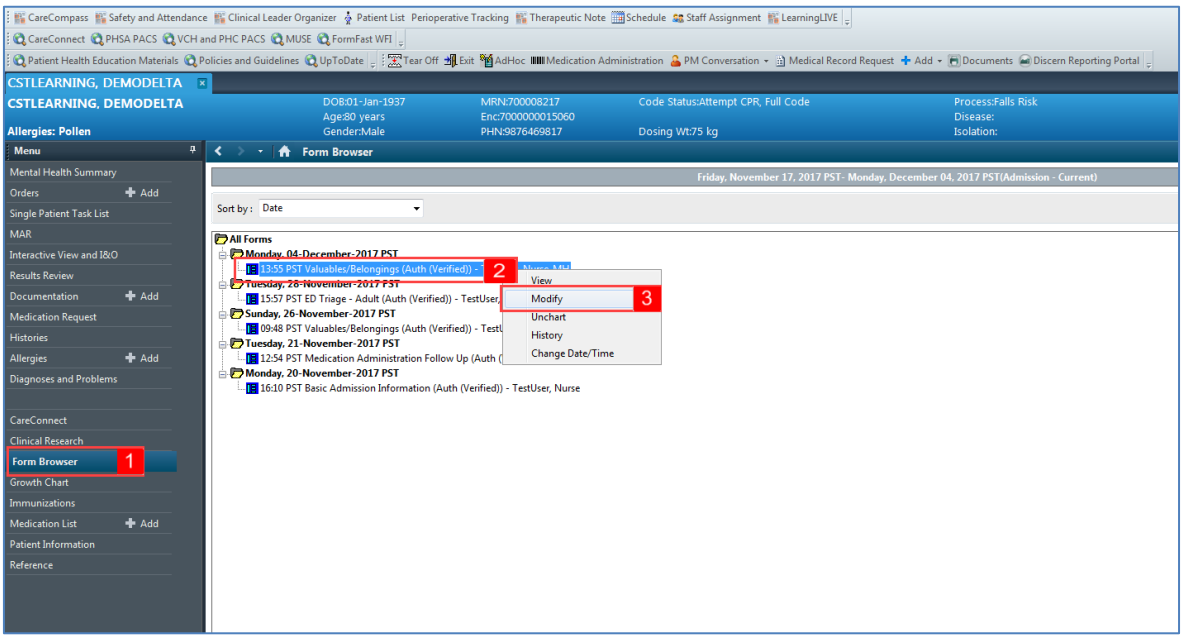
**Note:** to document or update information, it is recommended to start a new PowerForm and not to modify an already existing PowerForm

Let's modify the **Valuables and Belongings** form:

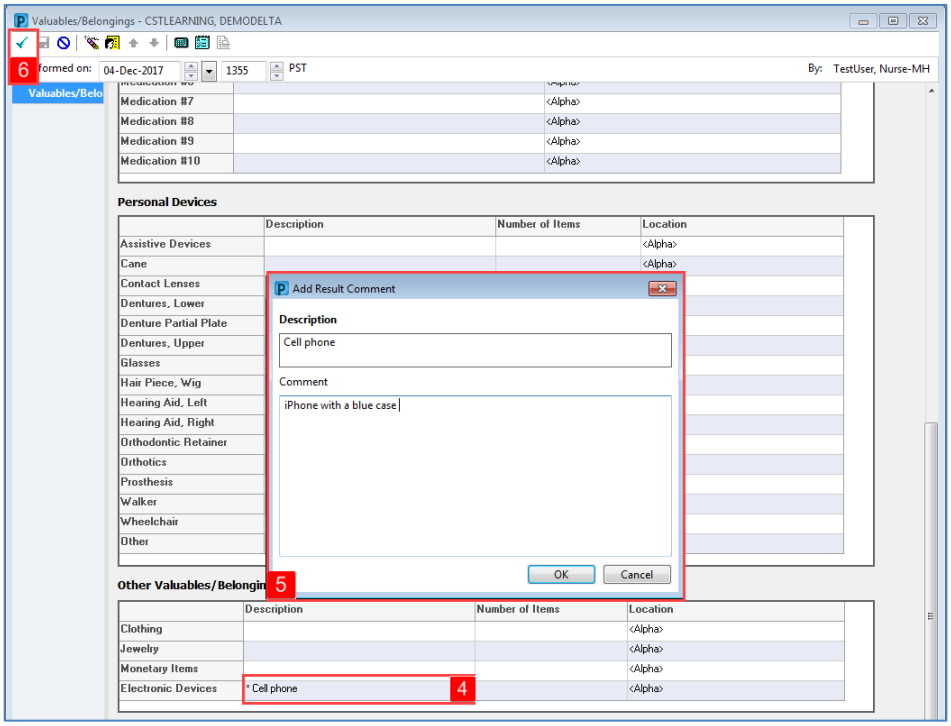
1. Navigate to **Form Browser** from the Menu
2. Right-click on the most recently completed **Valuables and Belongings** form

**Note:** For a PowerForm that has been completed and signed ✓ (Auth (Verified)) appears next to the title of the document. A saved PowerForm that has not been signed will display (In Progress) will appear next to the title

3. Select **Modify**




4. Double click your previous response "Cell phone" under **Other Valuables/Belongings**
5. Enter = *iPhone with a blue case* Into the **Comment** field. Click **OK**
6. Click **green checkmark** icon ✓ to sign and complete the documentation and then refresh the screen.




**Note:** A form that has been modified will display (Modified) next to the title of the document in Form Browser

## Key Learning Points

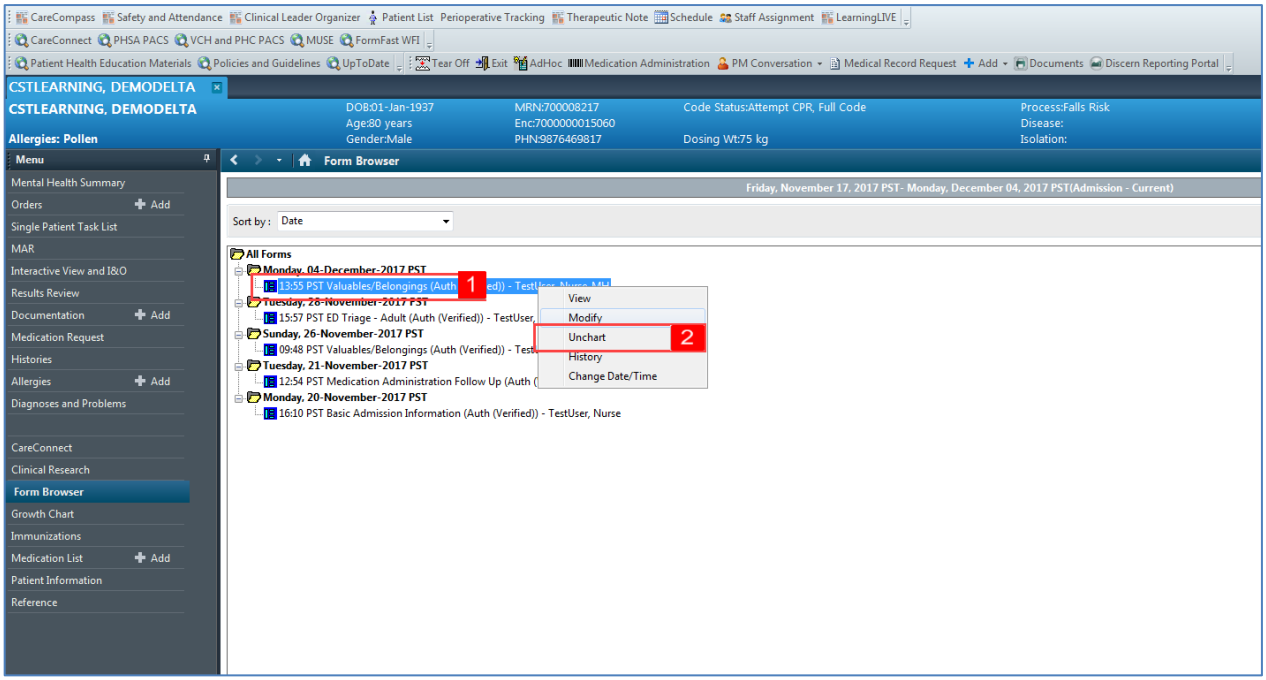
- Existing PowerForms can be accessed through the Form Browser
- A document can be modified if needed
- A modified document will show up as (Modified) in the Form Browser

# Activity 6.3 – Unchart an Existing PowerForm

1 It may be necessary to **Unchart** an existing PowerForm, for example, if the PowerForm was completed on the wrong patient or it was the wrong PowerForm. Let's say the **Valuables and Belongings** PowerForm was documented in error.

To unchart the PowerForm:

1. Right-click on **Valuables and Belongings** in Form Browser
2. Select **Unchart**




3. The Unchart window opens. Enter a reason for uncharting in the **Comment** box = *Wrong PowerForm*
4. Click sign ✓ and then refresh your screen

**Note:** Uncharting the form will change the status of all the results associated with the form to (In Error). A red-strike through will also show up across the title of the PowerForm.

## Key Learning Points

- A document can be uncharted if necessary
- An uncharted document will show up as In Error in the Form Browser

# PATIENT SCENARIO 7 – Dynamic Documentation

| Learning Objectives |
| --- |
| At the end of this Scenario, you will be able to:<br>■ Create a Dynamic Document<br>■ Modify a Dynamic Document |

## SCENARIO

In this scenario, you will be creating a progress note for your patient.

As a nurse, you will be completing the following activities:

- Access Documentation from the Menu
- Create a new document
- Modify your document

# Activity 7.1 - Dynamic Documentation

1 Dynamic Documentation is similar to written progress notes. In a dynamic document, you have the ability to enter free text to document narrative information such as one-to-one sessions or family meetings.

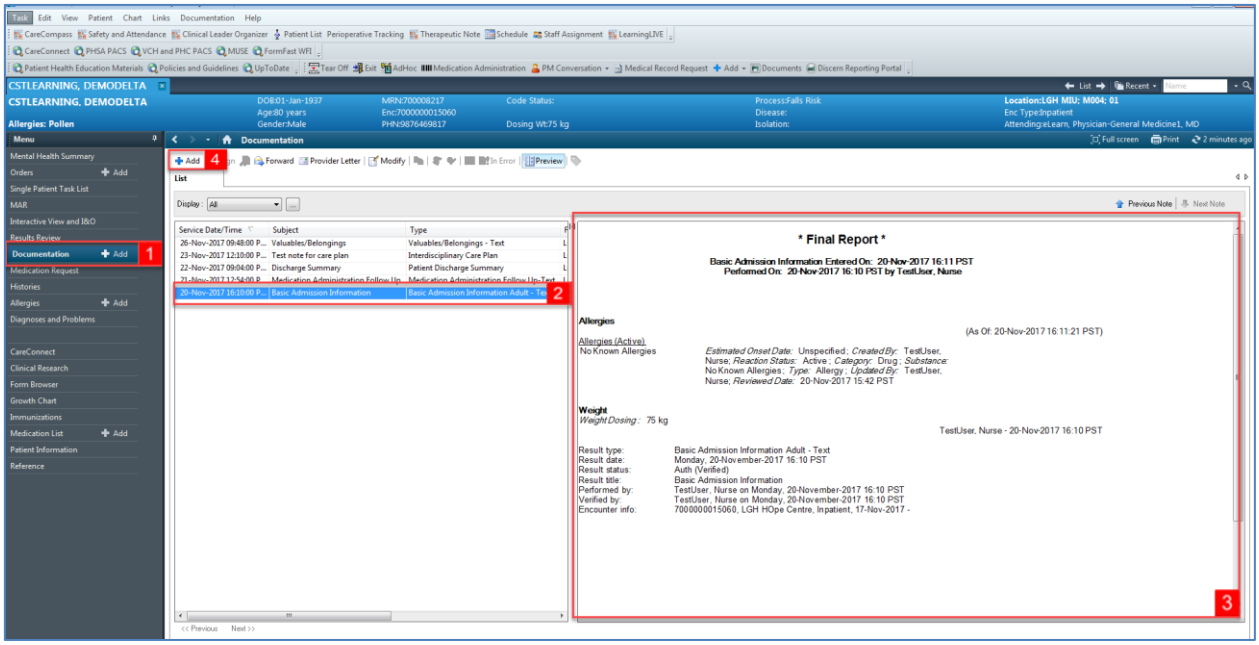
1. Select **Documentation** from the Menu
2. Select **MH Initial Admission Assessment** from the list of documents

**Note:** Clicking Refresh will ensure the most recent documents are viewable

3. Review document in Preview Box

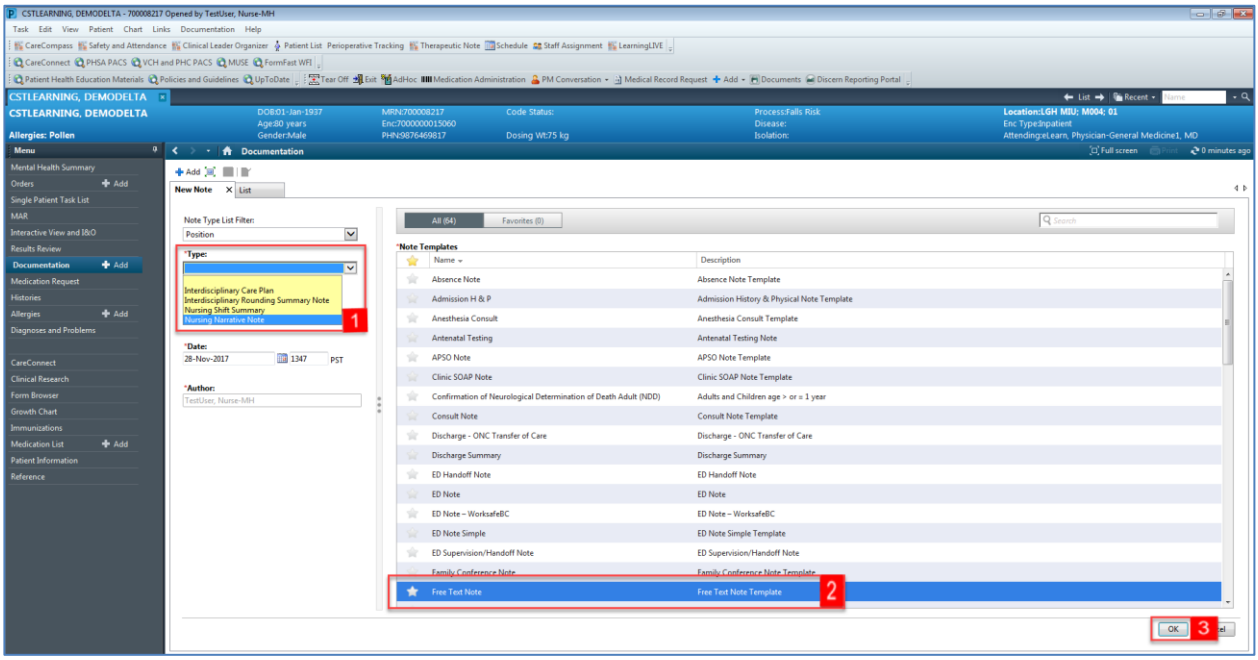
**Note:** Dynamic Documents, PowerForms and group therapy notes can be found here

4. Click **Add** Add



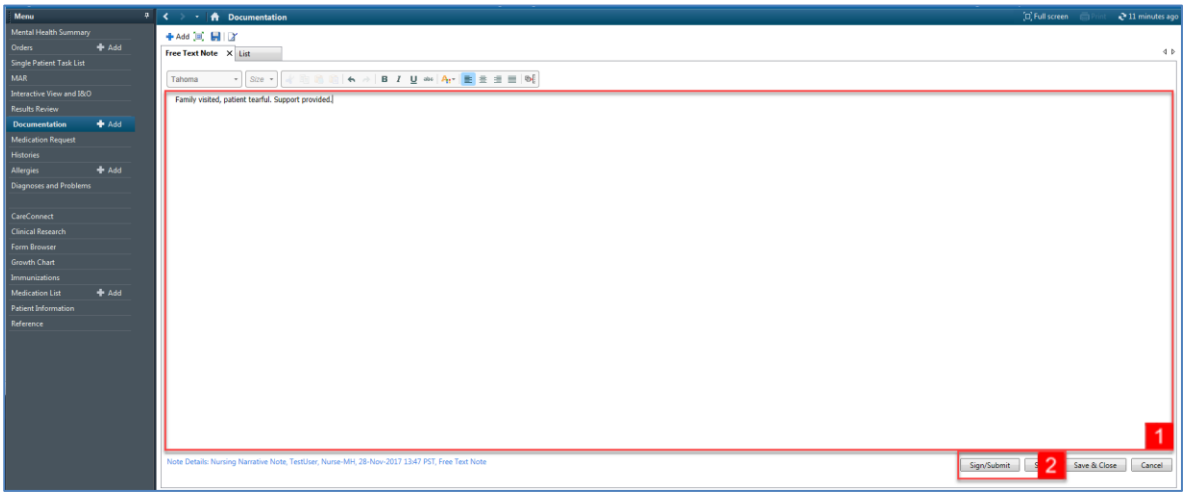
**2**

1. Select **Nursing Narrative Note** from the **Type** drop-down list
2. Select **Free Text Note** from **Note Templates** list
3. Click **OK**




**3**

1. Type = *Family visited, patient tearful. Support provided.*
2. Click **Sign/Submit**

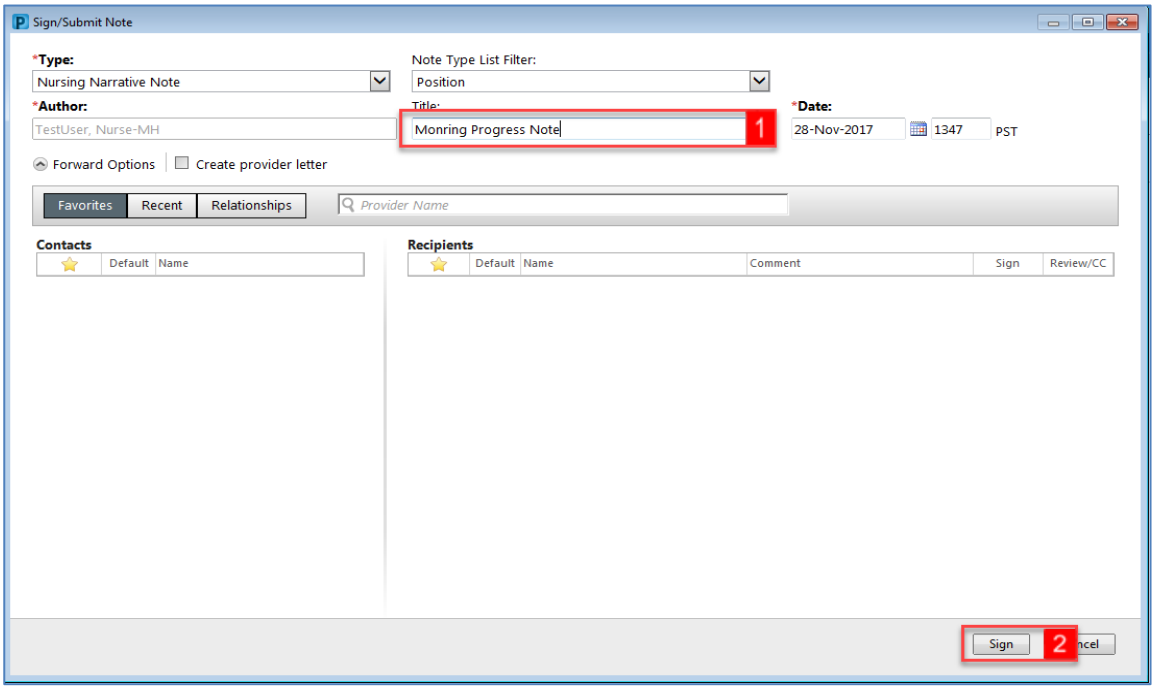


4

1. Type = *Morning Progress Note* in **Title** text box

**Note:** You can forward notes to select users by entering the user's name into the **Provider Name** text box

2. Click **Sign**




## Key Learning Points

- Dynamic Documents, PowerForms and group therapy notes can be found in the Documentation section of the Menu
- You can create several types of nursing documents, including a narrative note
- You can send notes to other users when you have completed your note

# PATIENT SCENARIO 8 - Results Review

| Learning Objectives |
| --- |
| At the end of this Scenario, you will be able to:<br>- Review Patient Results<br>- Identify Abnormal Results |

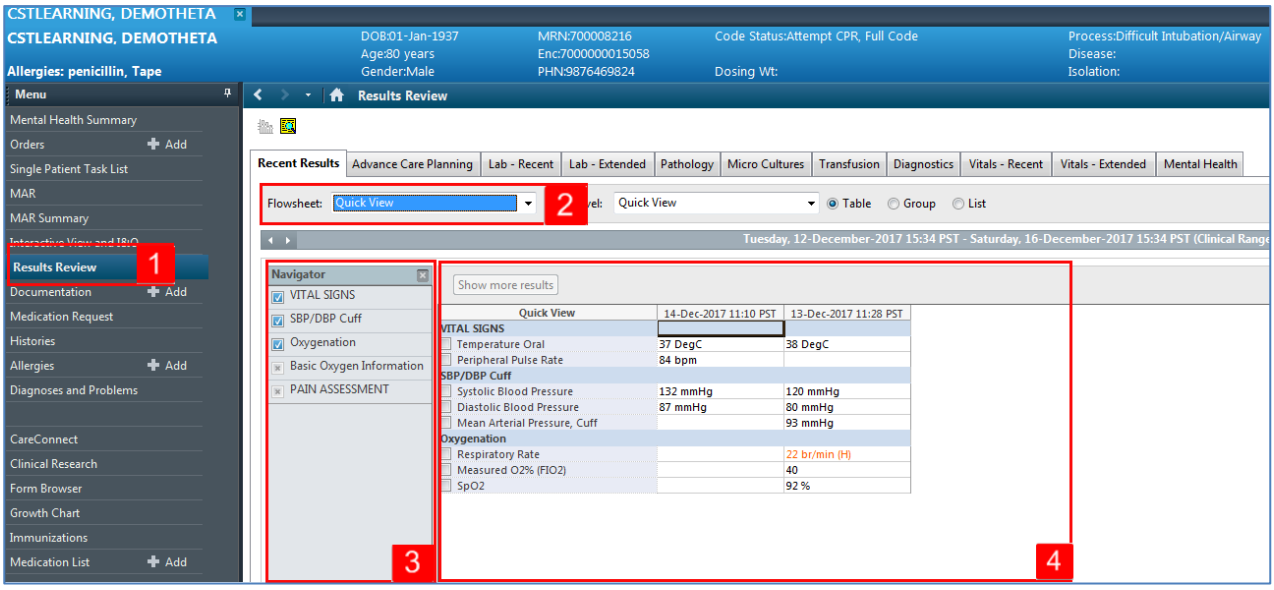
| SCENARIO |
| --- |
| In this scenario, you will review your patient's results. One way to do this is to use the Result Review.<br><br>You will complete the following activity:<br>- Review results using Results Review |

# Activity 8.1 – Using Results Review

1 Throughout your shift, you will need to review results for your patient. You can do this through **Results Review**.

Let's review the components of **Results Review**

1. Navigate to **Results Review** from the **Menu**
2. **Flowsheets**: display clinical information recorded for a person such as labs, cultures, transfusions, diagnostic imaging, and vital signs. Flowsheets contain both a **Navigator** and the **Results Display**.
3. **Navigator**: you can select a category within the navigator to view related results
4. **Results Display**: display related results

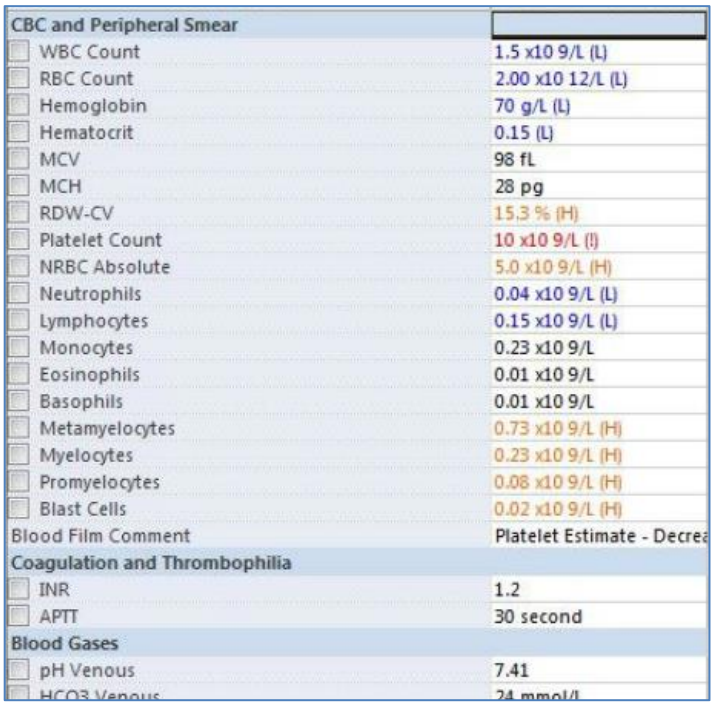



Review the most recent results for your patient in the **Results Display**:

| | | | | | |
|---|---|---|---|---|---|
| **Diagnostic Radiology** | | | | | |
| XR Chest | | | | | XR Chest * |
| **Vital Signs** | | | | | |
| Temperature Oral | 36 DegC (L) | | | 36.5 DegC | |
| Peripheral Pulse Rate | 80 bpm | | | | |
| Heart Rate Monitored | 60 bpm | | | 60 bpm | |
| Respiratory Rate | 20 br/min | | 0 br/min (L) | 0 br/min (L) | |
| Systolic Blood Pressure | 110 mmHg | | | | |
| Diastolic Blood Pressure | 70 mmHg | | | | |
| Mean Arterial Pressure, Cuff | 83 mmHg | | | | |
| Cuff Location | Right arm | | | Left arm | |
| **Basic Oxygen Information** | | | | | |
| Oxygen Flow Rate | | 3 L/min | 3 L/min | | |
| Oxygen Therapy | | Nasal cannula | Nasal cannula | | |
| SpO2 | 98 % | | | | |

Review the results of your patient's bloodwork:

1. Select **Lab – Recent** tab



| CBC and Peripheral Smear | |
|---|---|
| WBC Count | 1.5 x10 9/L (L) |
| RBC Count | 2.00 x10 12/L (L) |
| Hemoglobin | 70 g/L (L) |
| Hematocrit | 0.15 (L) |
| MCV | 98 fL |
| MCH | 28 pg |
| RDW-CV | 15.3 % (H) |
| Platelet Count | 10 x10 9/L (!) |
| NRBC Absolute | 5.0 x10 9/L (H) |
| Neutrophils | 0.04 x10 9/L (L) |
| Lymphocytes | 0.15 x10 9/L (L) |
| Monocytes | 0.23 x10 9/L |
| Eosinophils | 0.01 x10 9/L |
| Basophils | 0.01 x10 9/L |
| Metamyelocytes | 0.73 x10 9/L (H) |
| Myelocytes | 0.23 x10 9/L (H) |
| Promyelocytes | 0.08 x10 9/L (H) |
| Blast Cells | 0.02 x10 9/L (H) |
| Blood Film Comment | Platelet Estimate - Decrea |
| **Coagulation and Thrombophilia** | |
| INR | 1.2 |
| APTT | 30 second |
| **Blood Gases** | |
| pH Venous | 7.41 |
| HCO3 Venous | 24 mmol/L |

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

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

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

## Key Learning Points

- Flowsheets display clinical information recorded for a patient such as labs, cultures, transfusions, medical imaging, and vital signs
- The Navigator allows you to filter certain results in the Results Display
- Bloodwork is coloured to represent low, normal, high and critical values
- View additional details of a result by double-clicking the value

# PATIENT SCENARIO 9 - Allergies

**Learning Objectives**

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

- Document Allergies

## SCENARIO

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

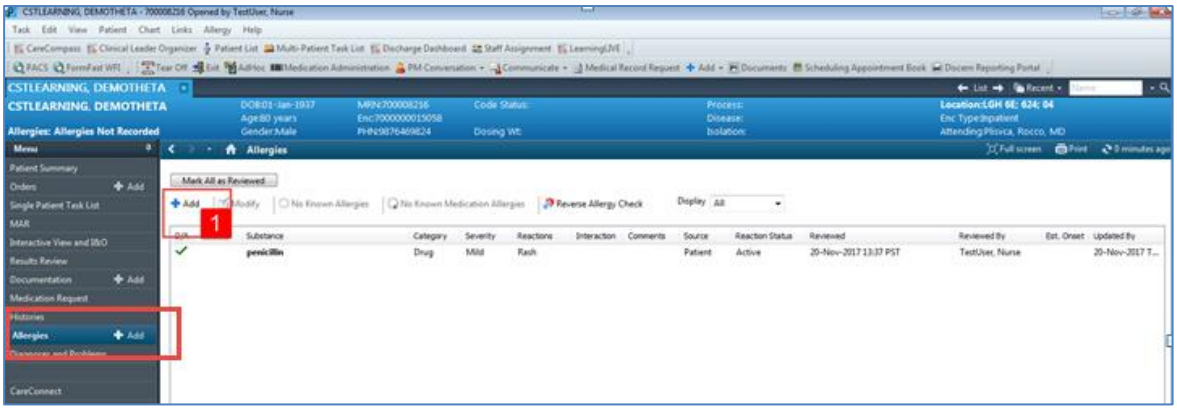
As a nurse you will be complete the following activity:

- Add an allergy

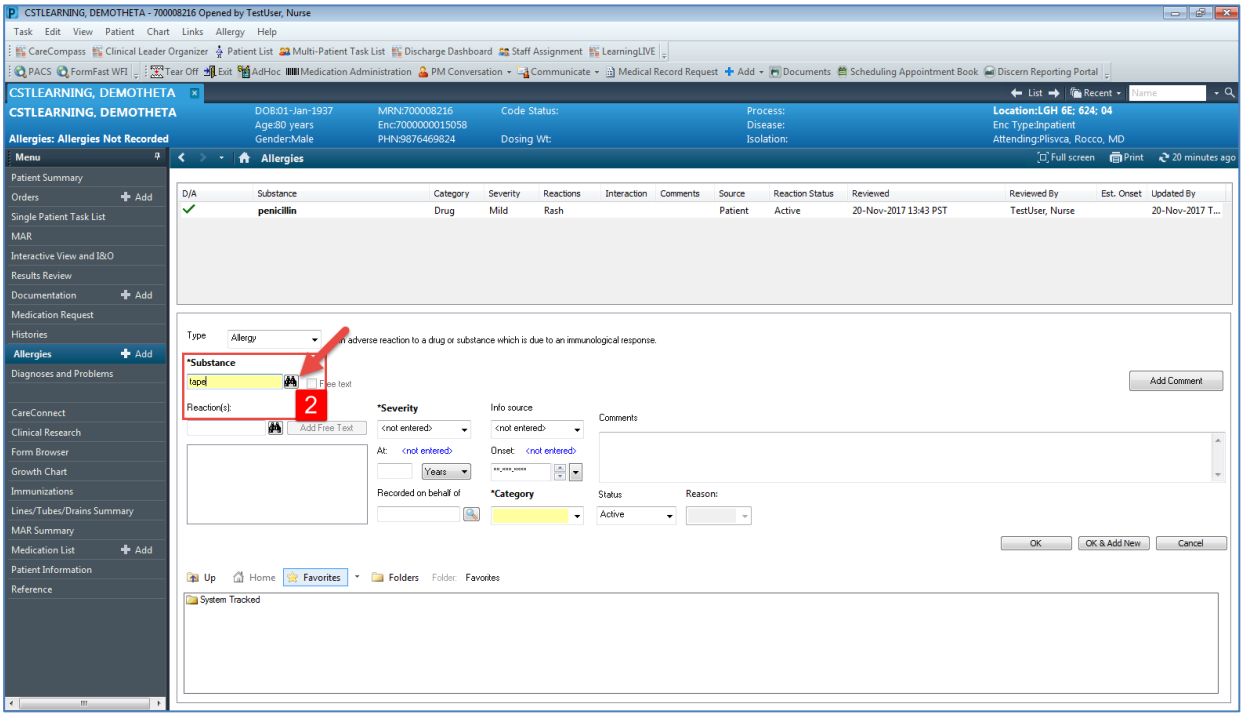
# Activity 9.1 – Add an Allergy

1 The patient states that they remember having an allergic reaction to citrus, but forgot to mention this previously.

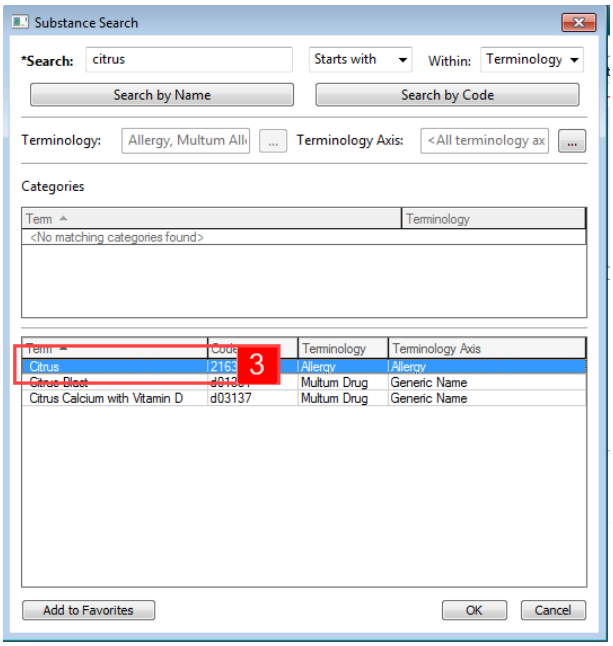
1. To document this allergy, navigate to the **Allergies** section of the Menu and click **Add**



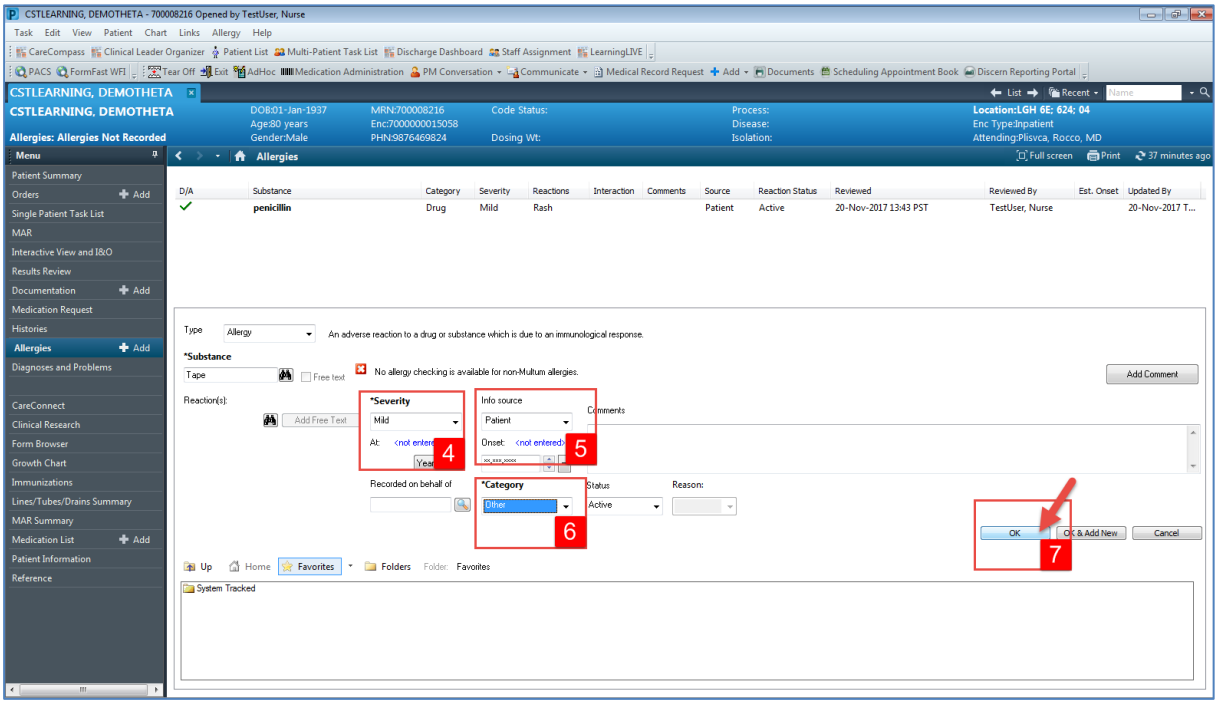

2. In the **Substance** field enter **Citrus** and click the **Search** icon **Note:** Yellow highlighted fields including substance and category are mandatory fields



3. The **Substance Search** window opens. Select **Citrus** and click **OK**




4. Select **Mild** in the **Severity** drop-down
5. Select **Patient** in the **Info source** drop-down
6. Select **Food** in the **Category** drop-down
7. Click **OK**



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

**Note:** Allergies in the banner bar are sorted by severity (most to least). If the allergies listed are longer than the space available, the text will be truncated. Hovering over the truncated text will display the complete allergies list.

## Key Learning Points

- Documented allergies are displayed in the Banner Bar
- Allergies will display with the most severe allergy listed first

# PATIENT SCENARIO 10 - Medication Administration Record (MAR)

**Learning Objectives**

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

- Review and Learn the Layout of the MAR
- Reschedule a Medication Dose
- Request a Medication

## SCENARIO

In this scenario, you will be reviewing the scheduled and PRN medications for your patient.

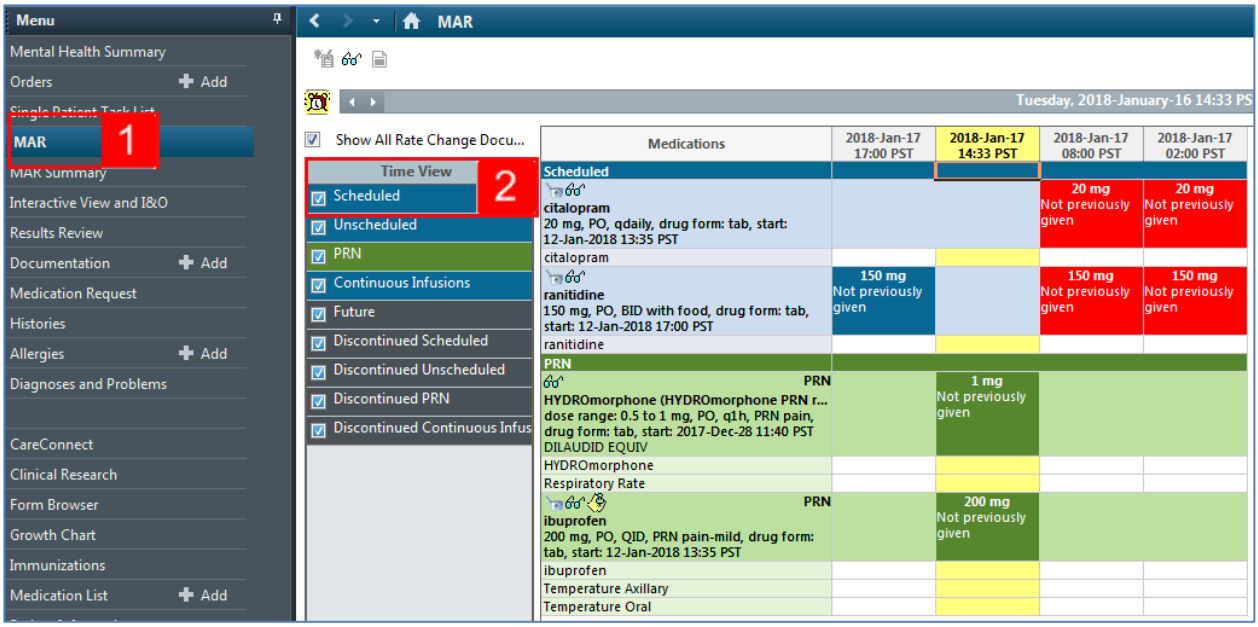
As a nurse, you will complete the following activities:

- Review the MAR using both the time view and reverse chronological order settings
- Reschedule a medication
- Request a medication in the MAR

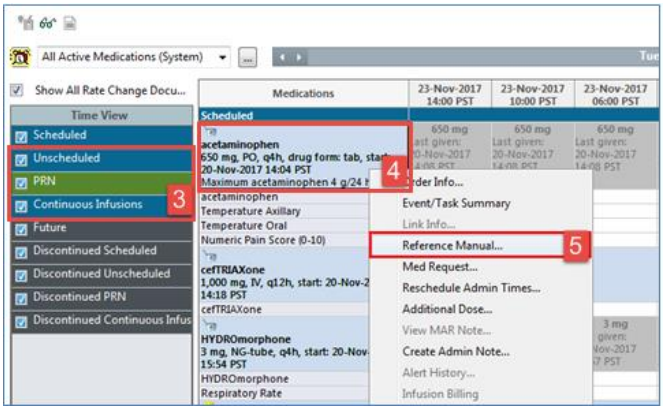
# Activity 10.1 – Review the Medication Administration Record (MAR)

1 You will be locating and reviewing your patient's scheduled, unscheduled and PRN medications.

1. Go to the Menu and click **MAR**
2. Under **Time View** locate and ensure the **Scheduled** category is selected and is displaying at the top of the MAR list




3. Next, select in order, **Unscheduled**, **PRN** and **Continuous Infusions**, bringing each section to the top of the list for your review
4. Review the medications on the MAR. Be sure to review all medication information
5. If you wish to review the Reference Manual right-click on the medication name and select **Reference Manual**



6. Note the icons that may appear on the MAR. Examples include:

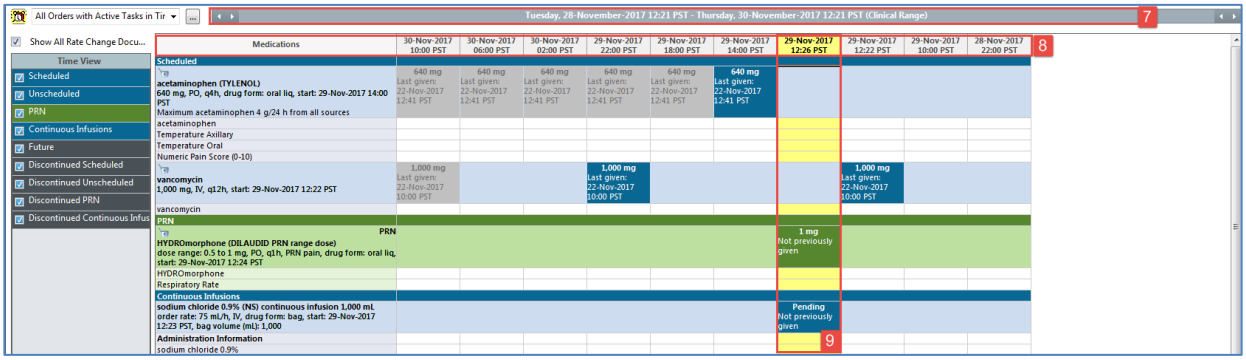
   medication order has not been verified by pharmacy

   nurse review of the order is required

   medication is part of a PowerPlan

Upon further review of the MAR you will note the following:

7. The clinical range is defaulted to display 24 hours in the past and 24 hours into the future. This totals a period of 48 hours. If you prefer to see only your 12 hour shift, you can right click on the Clinical Range bar to adjust the time frame that is displayed.
8. The dates/times are displayed in **reverse chronological order**. This differs from current state paper MARs
9. The current time and date column will always be highlighted in yellow




Note that different sections of the MAR and statuses of medication are identified using colour coding**:**

- **Scheduled medications -** blue
- **PRN medications -** green
- **Future medications -** grey
- **Discontinued medications** - grey
- **Overdue** - red

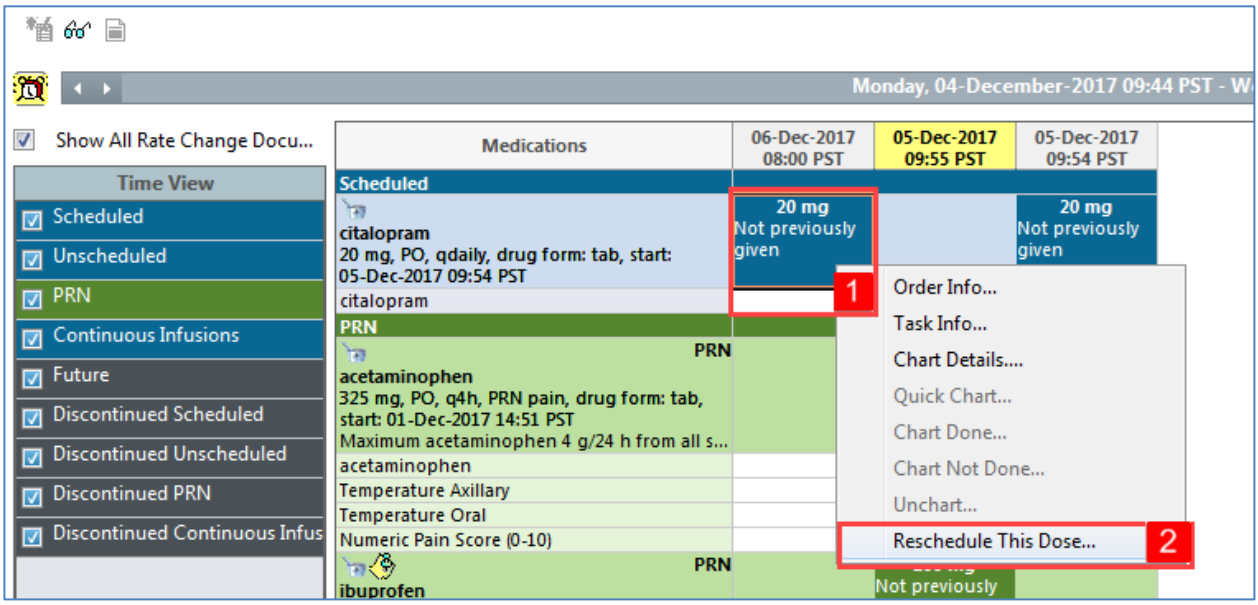
## Key Learning Points

- The MAR lists medications in reverse chronological order
- Icons indicate the statuses of medication
- You can right click on the Clinical Range bar to adjust the time frame that is displayed

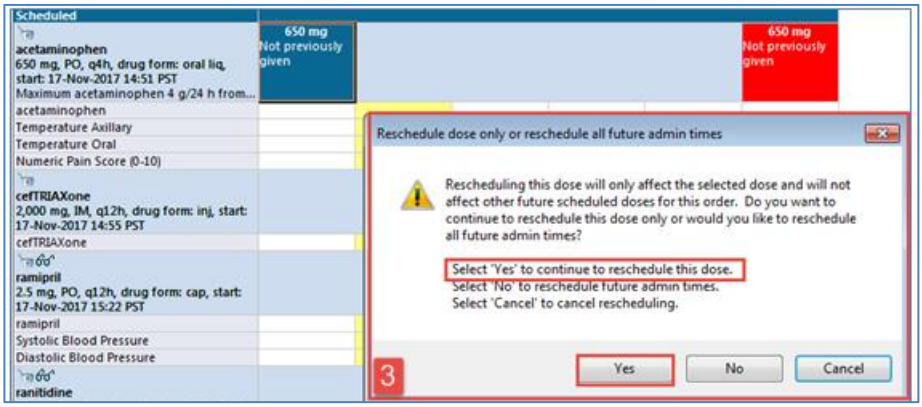
## Activity 10.2 – Reschedule a Medication

1 Your patient is nauseated and so you need to reschedule their citalopram

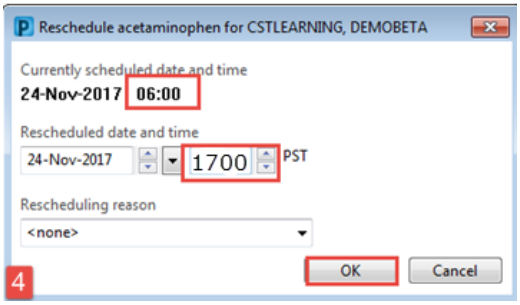
1. Right-click on the next dose which you want to reschedule
2. Select **Reschedule This Dose**




3. Review the pop-up and click **Yes** to continue to reschedule this dose.



4. You want to reschedule the medication administration time to a later time. Change the time field to 1700 and click **OK.**



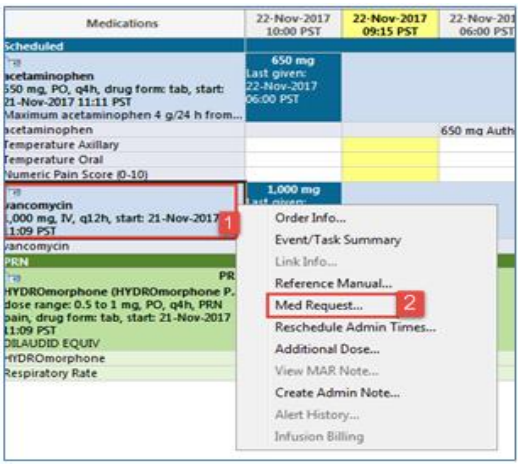

## Key Learning Points

- Right clicking on medication task provides options such as rescheduling a medication dose

## Activity 10.3 – Request a Medication via MAR

1 The daily dose of citalopram is missing. You need to submit a **Med Request** to Pharmacy.

1. Right click on the medication order name
2. Select **Med Request**




3. Select **Cannot Locate** under reason
4. Click **Submit**

### Key Learning Points

- Right clicking on medication order provides options such as Med Request
- Med Request sends a message to pharmacy to send the medication

# PATIENT SCENARIO 11 - Medication Administration

**Learning Objectives**

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

- Administer Medication Using the Medication Administration Wizard
- Document Administration of Different Types of Medication

## SCENARIO

In this scenario, you will be administering a scheduled and unscheduled medication.

As a nurse, you will complete the following activity:

- Administer medication using the Medication Administration Wizard (MAW) and the barcode scanner
- Documenting patient response to medication (Med Response)
- Uncharting a medication

# Activity 11.1 – Administering Medication using the Medication Administration Wizard (MAW) and the Barcode Scanner

1

Medications will be administered and recorded electronically by scanning the patient's wristband and the medication barcode. Scanning of the patient's wristband helps to ensure the correct patient is identified. Scanning the medication helps to ensure the correct medication is being administered. Once a medication is scanned, applicable allergy and drug interaction alerts may be triggered, further enhancing your patient's safety. This process is known as closed loop medication administration.

Tips for using the barcode scanner:

- Point the barcode scanner toward the barcode on the patient's wristband and/or the medication (Automated Unit Dose- AUD) package and pull the trigger button located on the barcode scanner handle
- To determine if the scan is successful, there will be a vibration in the handle of the barcode scanner and/or, simultaneously, a beep sound
- When the barcode scanner is not in use, wipe down the device and place it back in the charging station

2

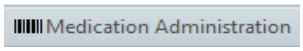
It is time to administer medications to your patient. You will scan all medications sequentially.

**Note:** Occasionally a dose requires scanning two pills to make up the full dose. At other times, the dose requires only part of a pill.

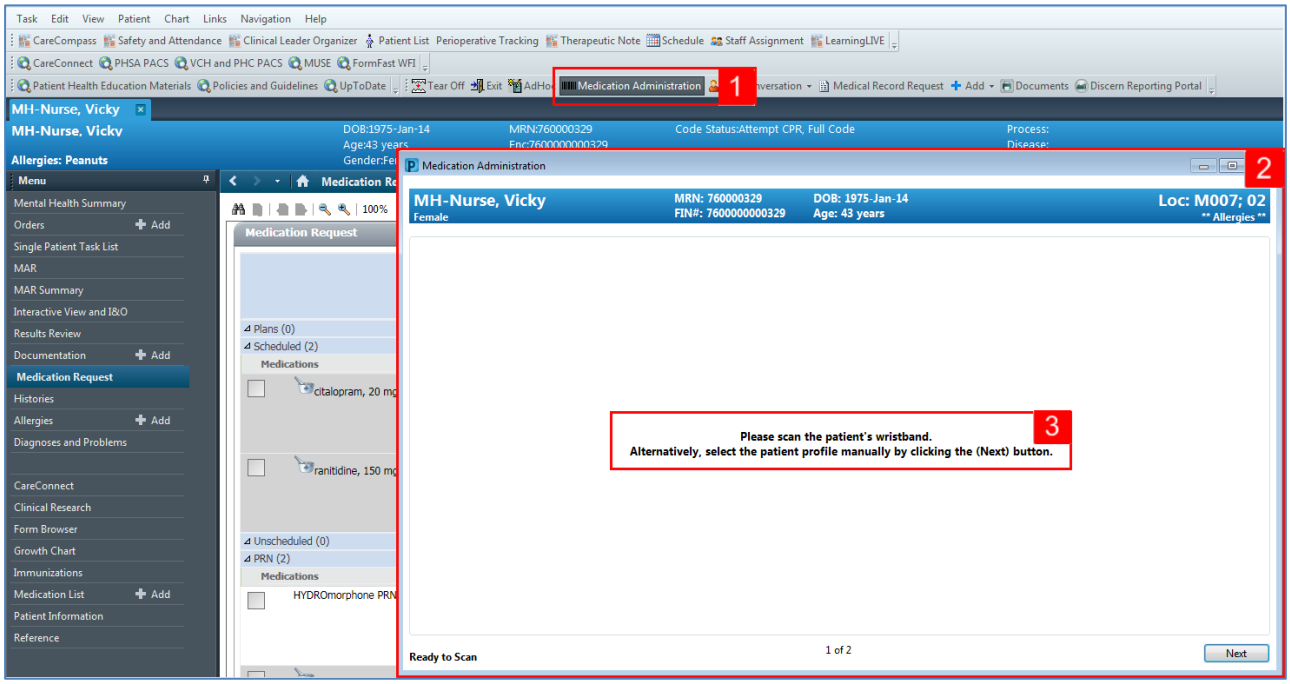
- PO medication: **citalopram, 20mg, PO qdaily, drug form: tab**
- Range dose medication: **hydromorphone 0.5 mg PO, PRN for pain**, using hydromorphone 1 mg tab product barcode

**Note:** IV medication and fluid administration can be reviewed with your peer mentor on your unit

Let's begin the medication administration following the steps below

1. Click Medication Administration Wizard (MAW) 

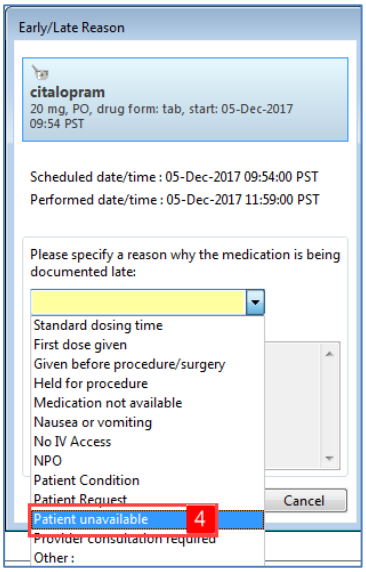
in the toolbar
2. The **Medication Administration** pop-up window will appear.
3. Scan the **patient's wristband**. A window will pop-up displaying the medications that you can administer. This list populates with medications that are scheduled for 1 hour ahead of the current time and any overdue meds up to 7 days in the past




**Scan the medication barcode for citalopram 20 mg tab**

**Note:** Since you are administering a medication that is outside of the scheduled time, you may receive an Early/Late Reason pop-up box

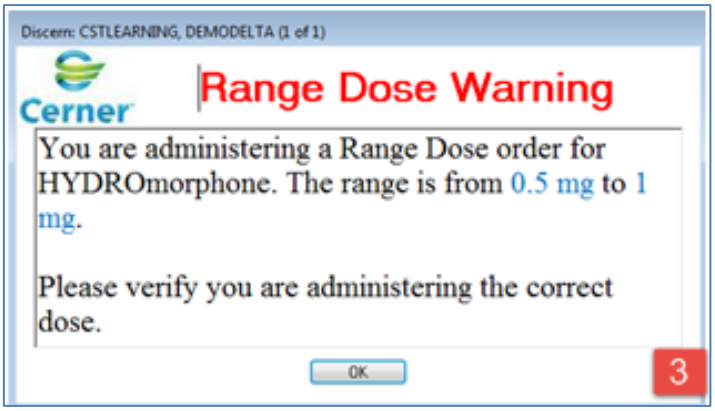
4. Select “Patient unavailable” for the reason the medication is being given early or late



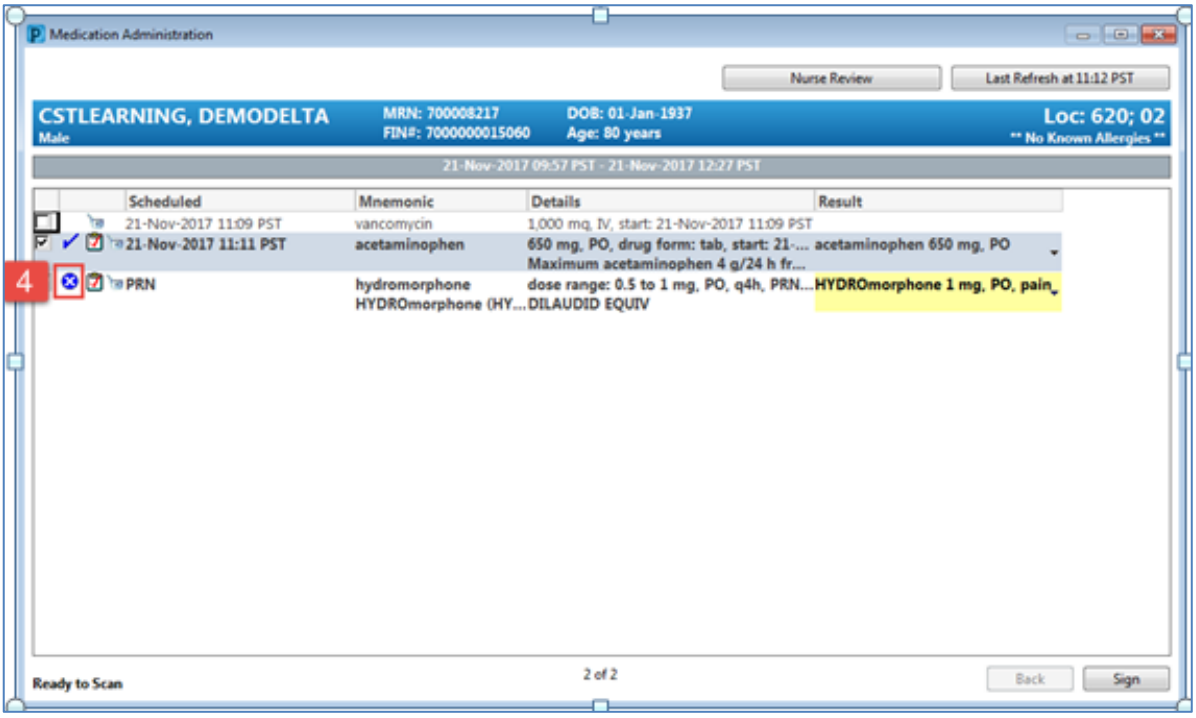

**Note:** If you required two tablets to make a required dose, you would scan both to complete the 2 tablet drug administration. After the second scan, the system finds an exact match for the prescribed dose.

Now let's administer the next medication.

1. Scan your medication barcode for **hydromorphone 0.5 mg PO**
2. You are using the hydromorphone 1 mg tab product barcode. Note that this medication is a range dose order. A **Range Dose Warning** pop-up screen will show to remind you of this dose range.
3. Click **OK** to acknowledge the alert



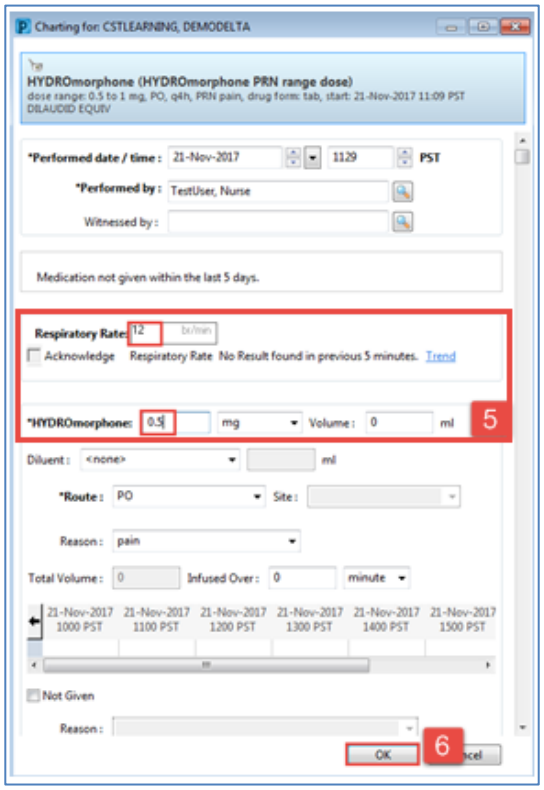

4. Click the **Missing Details** icon



5. A charting window will appear. Enter the following details:
    - Respiratory Rate = *12*
    - HYDROmorphone = *0.5 (changed from 1)*

**Note:** when administering a range dose, the CIS will automatically record the highest possible range dose. This means that if you administer a dose that is below the highest dose available, you will need to modify your documentation.

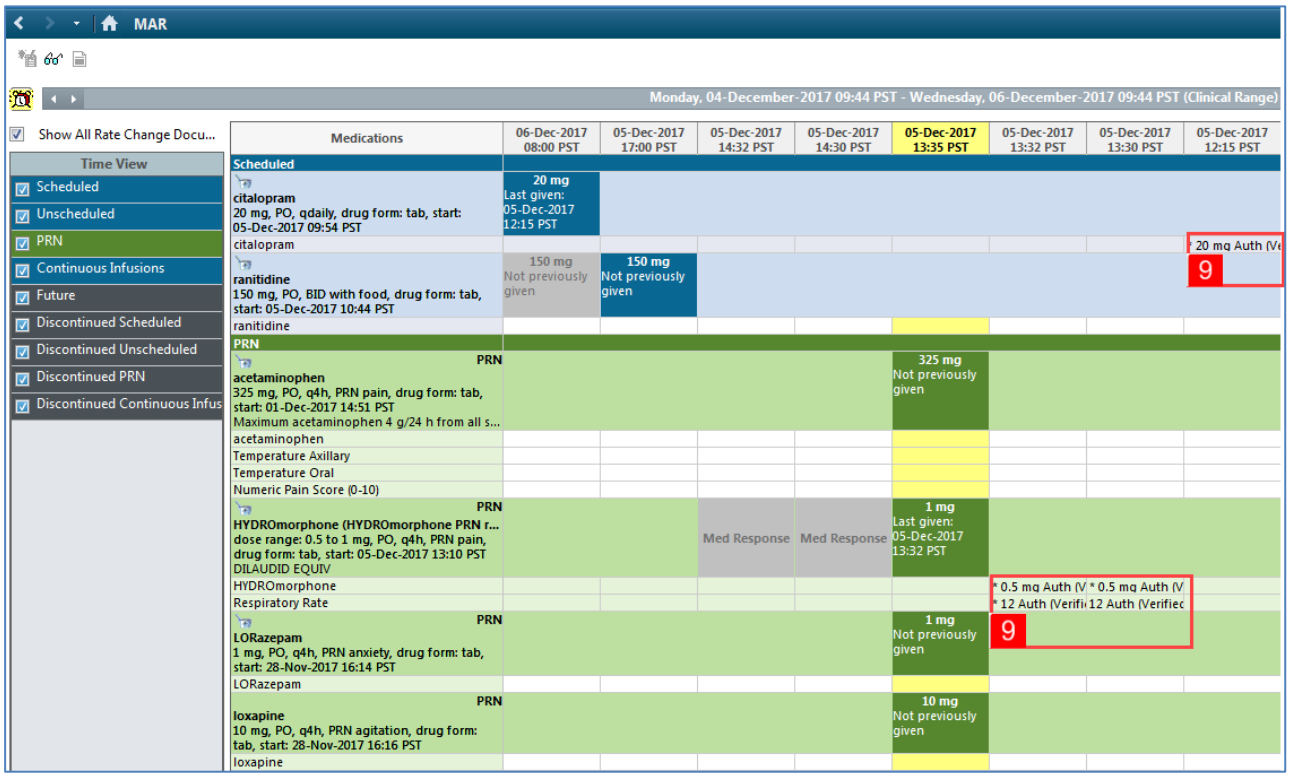
6. Click **OK**




7. Click **Sign** on the MAW

After you click Sign, a warning window displays for you to double check the range dose medication. Click **Yes** to continue.

8. Navigate back to the MAR from the Menu. The medications will appear as complete on the MAR.
9. Refresh the page and you will be able to see more details including the time the last dose was given.




**Note:** there is a new Med Response for the PRN medication hydromorphone. For some PRN medications, the system will ask you to complete a medication response assessment.

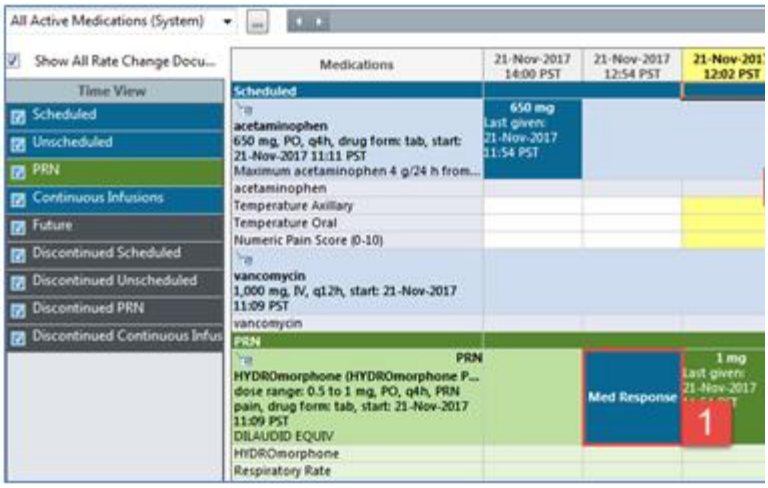
## Key Learning Points

- Use the barcode scanner to administer medications
- Often times, additional information will be required upon administration such as dose ranges and vital signs

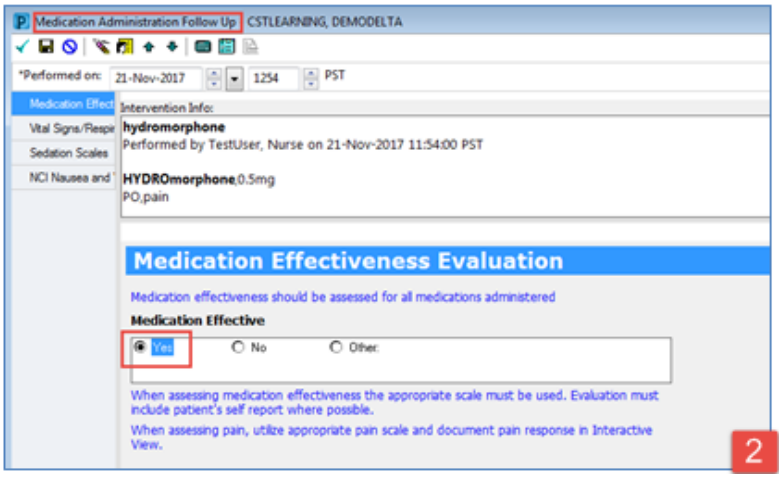
# Activity 11.2 – Documenting Patient Response to Medication (Medication Response)

1 When you administer some PRN medications, it is necessary to document how the patient responds to the medication. You can do this directly in the MAR.

1. Click on the Medication Response cell in the HYDROmorphone row and a Medication Administration Follow Up window will display.




2. In the **Medication Effectiveness Evaluation** field, click **Yes**




3. **Sign** and refresh the screen. Now that you have documented the medication response it has disappeared from the MAR.

## Key Learning Points

- Medication responses can be documented from the MAR under Med Response

# PATIENT SCENARIO 12 - Modified Early Warning System (MEWS)

**Learning Objectives**

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

- Understand the Purpose of Using the Modified Early Warning System
- Document on MEWS
- Manage a MEWS Alert

## SCENARIO

In this scenario, you will be managing a MEWS alert for your patient.

You will complete the following activities:

- Document on the MEWS section in iView to trigger a MEWS alert
- Review the MEWS alert
- Document provider notification

# Activity 12.1 – Document on MEWS Section in iView to Trigger a MEWS Alert

1

The purpose of the Modified Early Warning System (MEWS) is to aid in the early detection of patient deterioration so that timely attention can be provided to the patient by healthcare professionals.

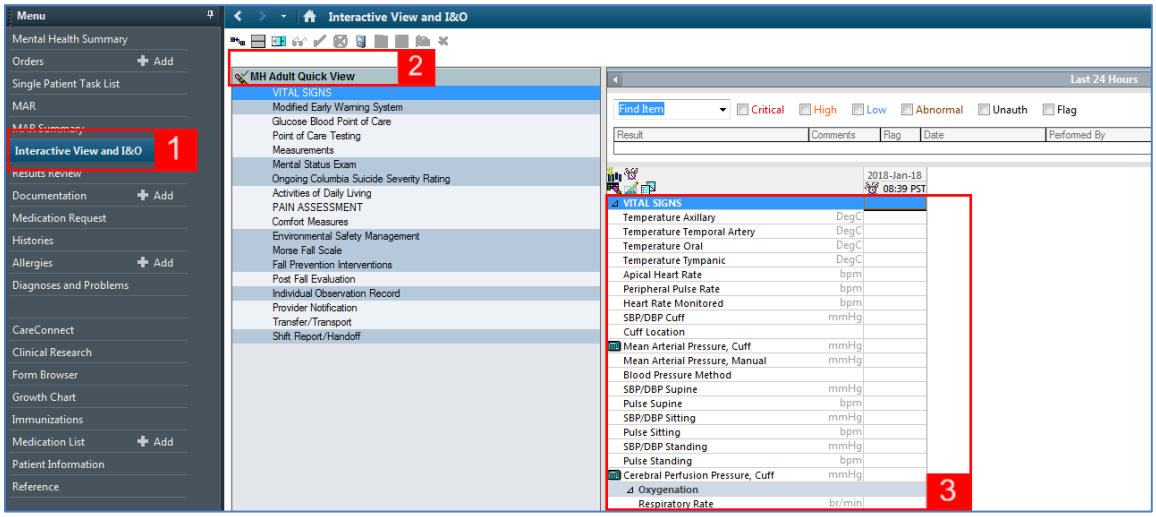
MEWS is scored based on 5 key assessments: Systolic BP, Heart Rate, Respiratory Rate, Temperature, and level of consciousness. A score is then totaled based on the values documented. If the score is out of normal or expected range, an electronic alert will be triggered.

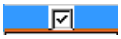
**Note:**

- For MEWS, level of consciousness is assessed using **AVPU**, which is an acronym for "alert, voice, pain, unresponsive".
- The MEWS alert is suppressed in some situations such as in palliative/comfort care patients, and in the ICU
- Pediatric Early Warning System (PEWS) is the equivalent of MEWS for children and youth aged 16 and younger

Let's review MEWS documentation:

1. Select **Interactive View and I&O** from the menu
2. Click on the **MH Adult Quick View** Band
3. Document the following vital signs in the **VITAL SIGNS** section
    - **Temperature Oral** = *38*
    - **Peripheral Pulse Rate** = *105*
    - **SBP/DBP** = *100/60*
    - **Respiratory Rate** = *20*



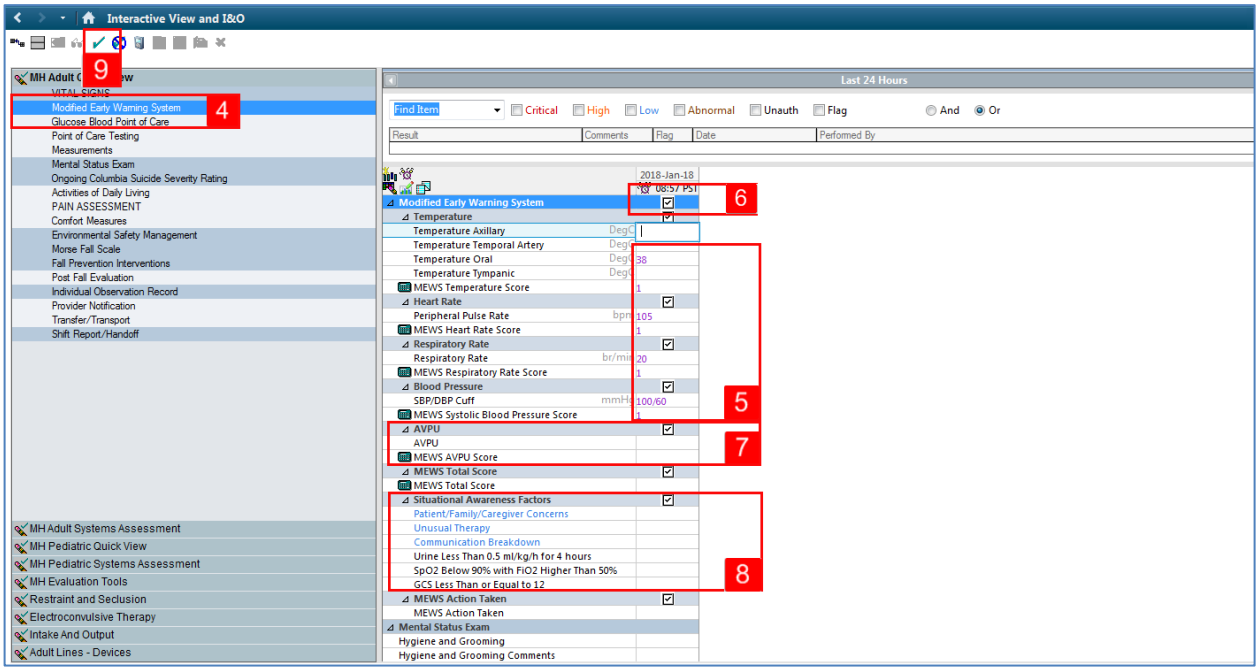

4. Select the **Modified Early Warning System** section
5. Note the vital signs documentation has flowed to the MEWS section
6. Double-click the blue band for **Modified Early Warning System.** A check mark  will display, indicating the whole section is activated and the MEWS scores will be automatically calculate

**Note:** MEWS score will not auto-populate if above score is not completed

7. Document **AVPU**
    - **AVPU** = *Alert and responsive*
8. Document on the Situational Awareness Factors for all cells in this section:
    - **Select** = *No.*

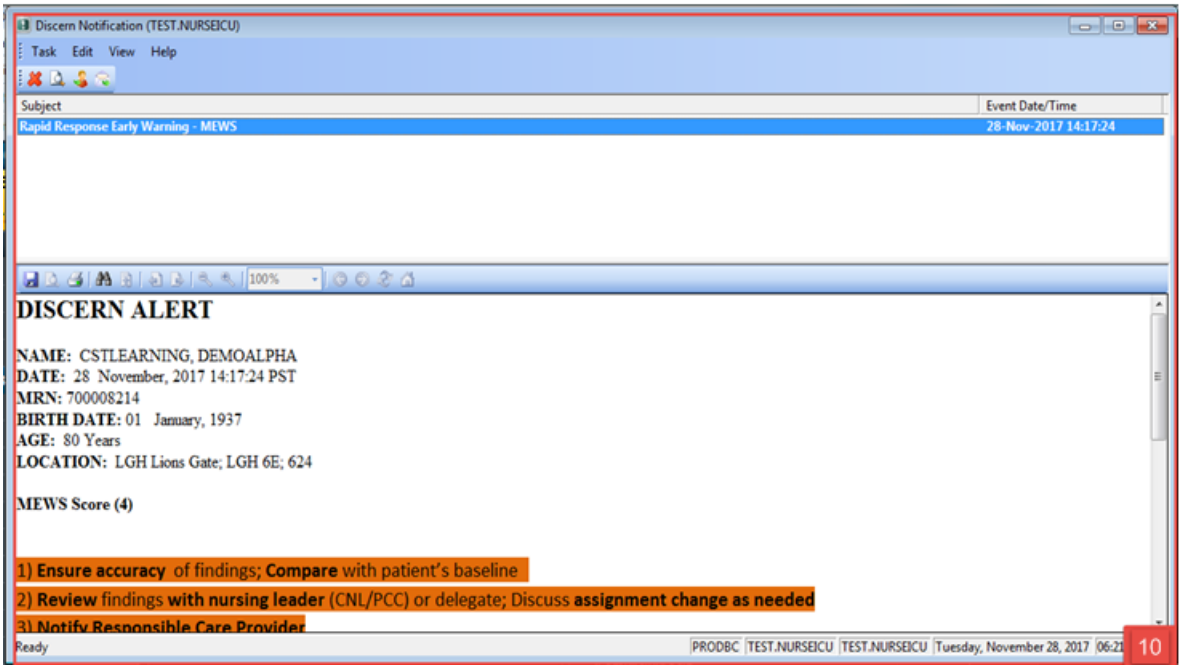
**Note:** The purpose of this section of documentation is to gather more information related to the patient's status, which provides context for those who see the MEWS alert.

9. Click the green check mark  to sign your documentation. The purple text changes to black and is now saved in the chart.




**Note:** The calculated MEWS Total Score is 4, which will automatically trigger a MEWS alert in the system.

10. A Discern Notification window will appear. This is the MEW



## Key Learning Points

- MEWS/PEWS is a scoring system that can trigger an electronic alert in the CIS
- The MEWS score is based on SBP, HR, RR, temperature, and level of consciousness (AVPU = alert, voice, pain, unresponsive)
- If the MEWS score is out of normal range, an alert will be triggered in the CIS to warn the healthcare team that the patient may be deteriorating and require timely attention
- The MEWS alert is suppressed in some situations, such as for palliative/comfort care patients and in the ICU

## Activity 12.2 – Review the MEWS Alert

1

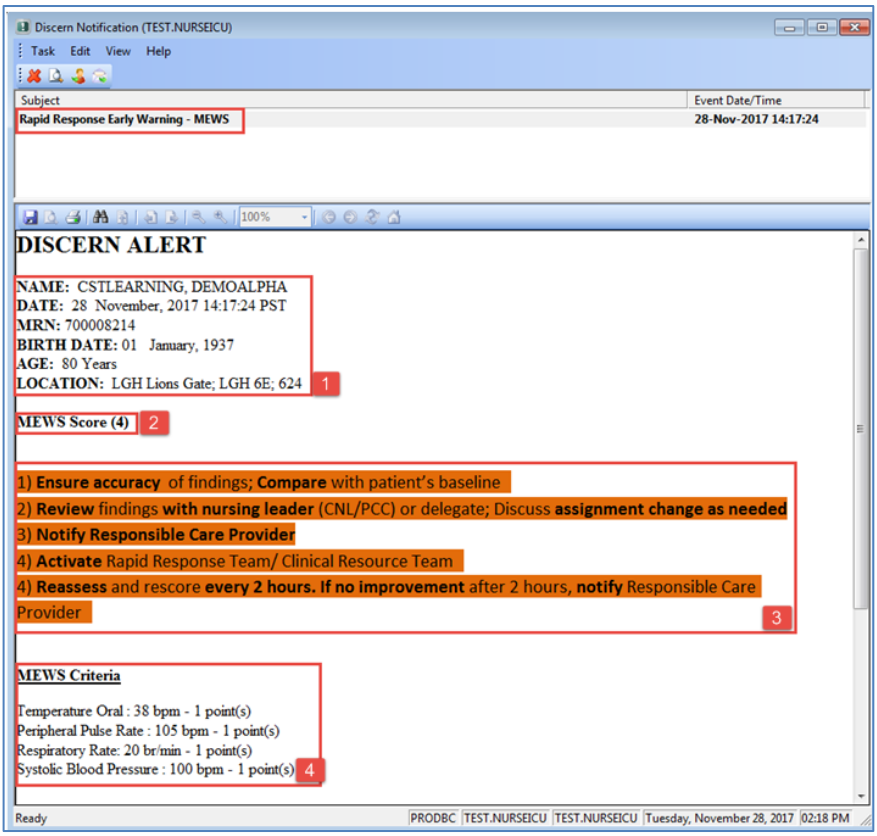
The MEWS alert appears when a MEWS score is calculated to be out of normal range for the patient. The alert itself provides the following information: patient demographics, the MEWS score, clinical decision support, and the score criteria.

All nurses who have established a relationship with the patient in the CIS will receive the MEWS alert upon logging into the system. In this scenario, you will follow the MEWS protocol to complete the MEWS alert task and document provider notification.

**Note:** Providers do NOT receive MEWS alerts, therefore it is the nurse's responsibility to follow up appropriately with the provider when alerted.

Review the MEWS alert which will help to identify what type of response is appropriate to initiate.

1. Review the **Patient Demographics**
2. Review the **MEWS Score**
3. Review the coloured **Clinical Decision Support** list to initiate appropriate action
4. Review the **MEWS Criter**



**Note:** It is up to the clinician to take the appropriate clinical steps after receiving a MEWS alert for a patient. In some cases, the patient may just need to be closely observed and re-assessed. In others, the Rapid Response Team may need to be called to come and assess the patient immediately.

You can now click the red X icon  to delete the Discern Notification for the MEWS Alert.

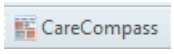
## Key Learning Points

- MEWS alerts display patient information, MEWS score and score criteria
- All nurses who have established a relationship with the patient in the CIS will receive the MEWS alert
- The clinical decision making support in the MEWS alert helps guide the clinician in taking the appropriate next steps in caring for the patient

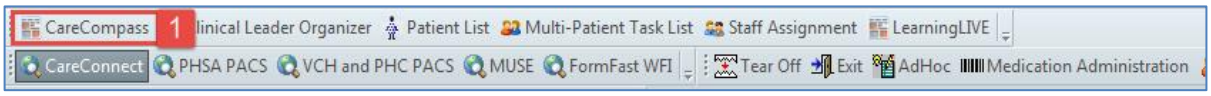
## Activity 12.3 – Document Provider Notification

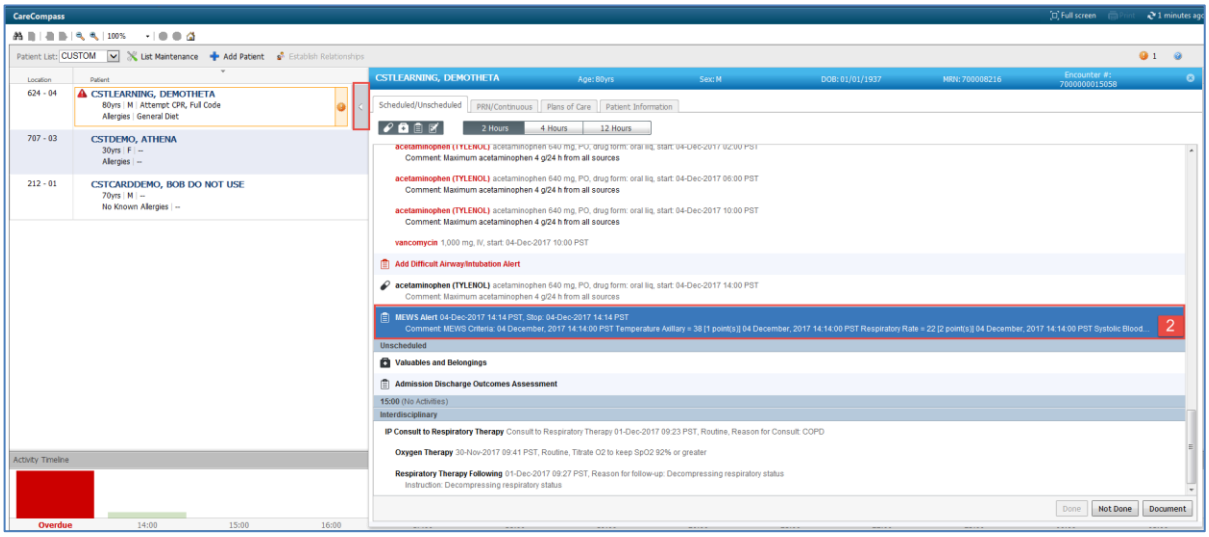
1 Once you receive a MEWS alert, you assess the patient and decide on further actions to take. In this scenario, we will contact the most responsible provider to let them know about the MEWS alert After you notify the provider, you need to document that you have done so.

The MEWS alert automatically creates a task that can be viewed in Care Compass. The task is called MEWS Alert.

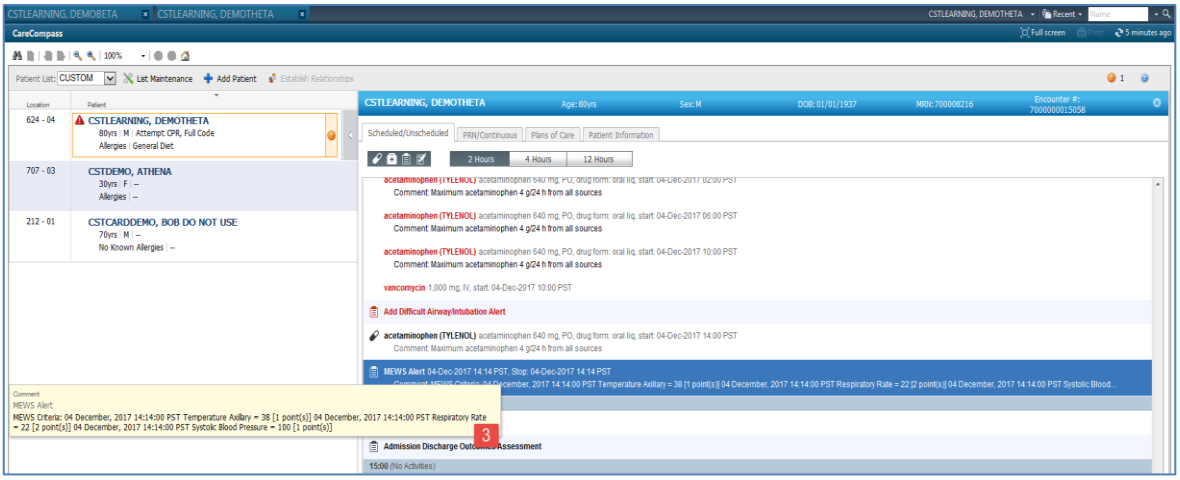
1. Navigate to Care Compass  from the toolbar
2. Locate your patient. Hover your cursor over the grey bar to the right of your patient's name and click the forward arrow  to open the task box. Note the **MEWS Alert** task.

**Note:** You may need to refresh your screen to see this task.

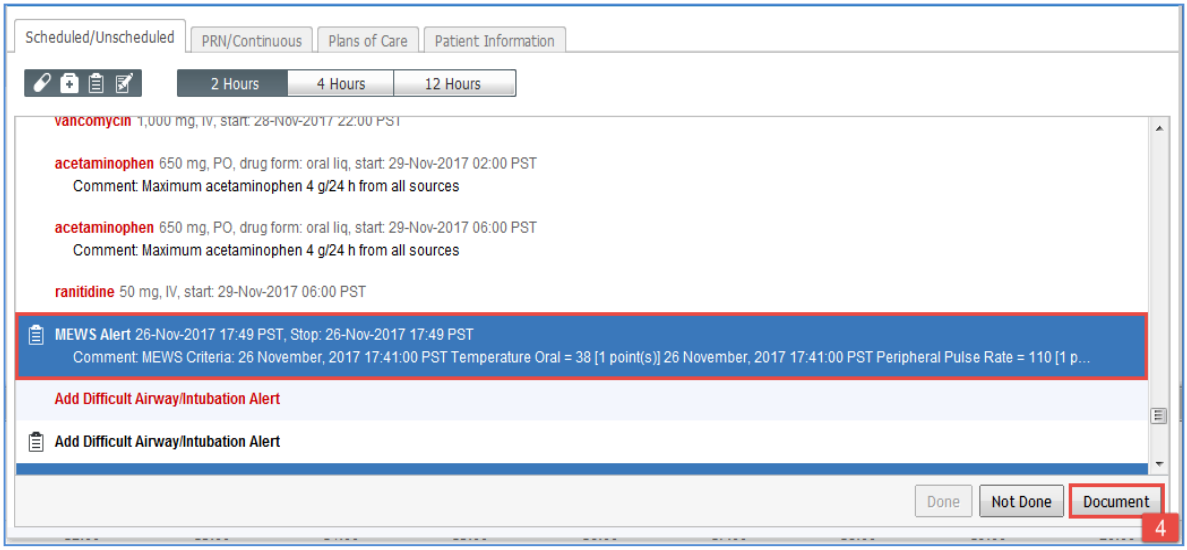


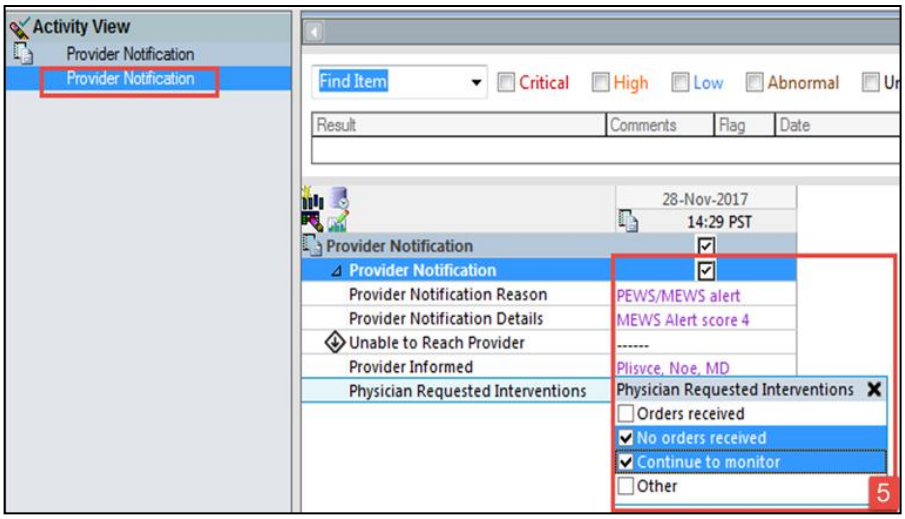
3. Hover over the task to display more information about the alert.



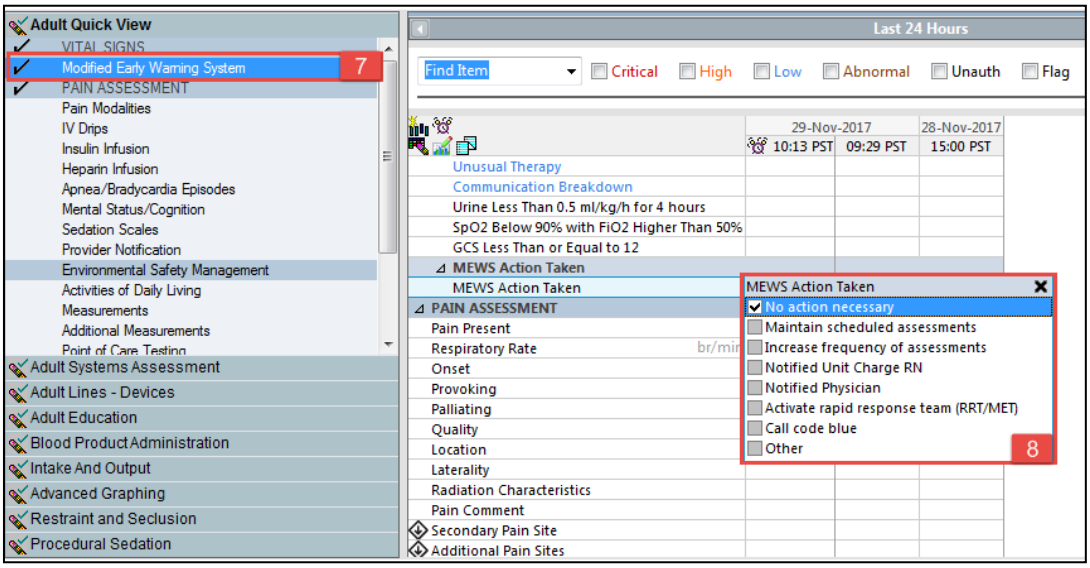

4. Click on the **MEWS Alert** task and then click **Document**. You will automatically be taken to the Provider Notification section for documentation.



5. In the Provider Notification section, document the following information:
    - **Provider Notification Reason** = *PEWS/MEWS Alert*
    - **Providers Notification Details** = *MEWS Alert score 4*
    - **Provider informed** = *name of patient's physician*
    - **Physician Requested Interventions** = *No orders received, Continue to Monitor*




6. Click the green check mark to sign  Completing this documentation will automatically clear the MEWS Alert task from the patient's task list
7. Click on the **Modified Early Warning System** section in the **MH Adult Quick View** band within iView
8. Complete documentation for **MEWS Action Taken** = *No action necessary.* Then click the green check mark to sign



## Key Learning Points

- It is the nurse's responsibility to notify the most responsible provider of MEWS alerts
- All provider notification can be documented in iView
- The MEWS Alert creates a task that drives the nurse to document Provider Notification

# PATIENT SCENARIO 13 – Handoff Tool

**Learning Objectives**

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

- Use Handoff Tool

## SCENARIO

In this scenario, you will practice activities associated with giving report and documenting handover.

As a nurse, you will be completing the following activities:

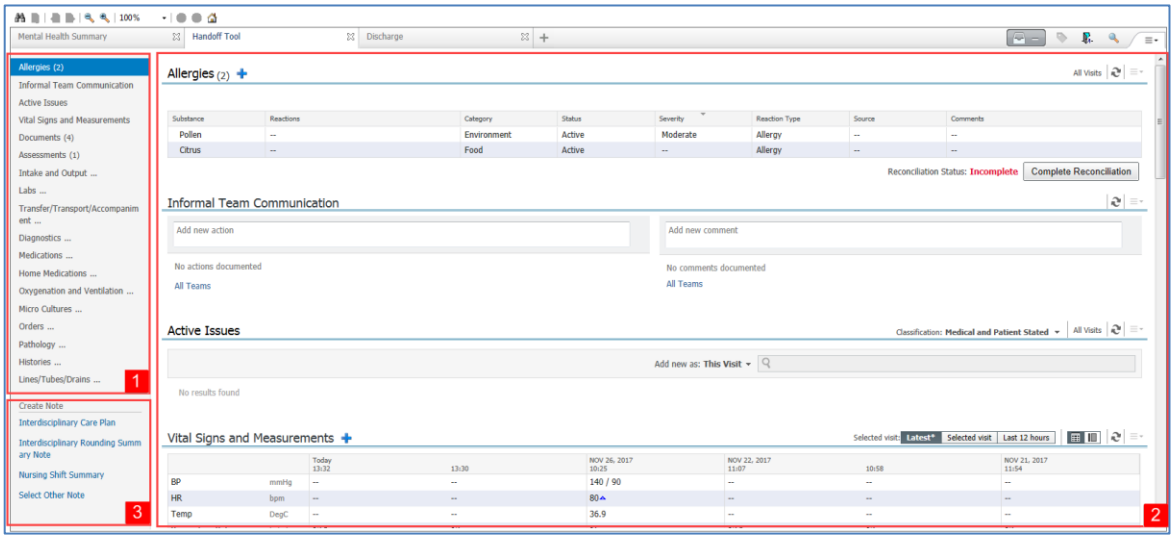
- Navigate Handoff Tool
- Document Informal Team Communication

# Activity 13.1 – Handoff Tool

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

From the **Menu** select **Mental Health Summary**. Select the **Handoff Tool** tab**:**

1. You can scroll down the page or access each component by clicking on the Handoff components on the left
2. You can add any missing information if required directly into the components on the page
3. You can navigate to commonly used note types from this page using the links below the components




## Key Learning Points

- Use the Handoff Tool to review patient information with the oncoming nurse
- You can add information or create commonly note types directly from the Handoff Tool

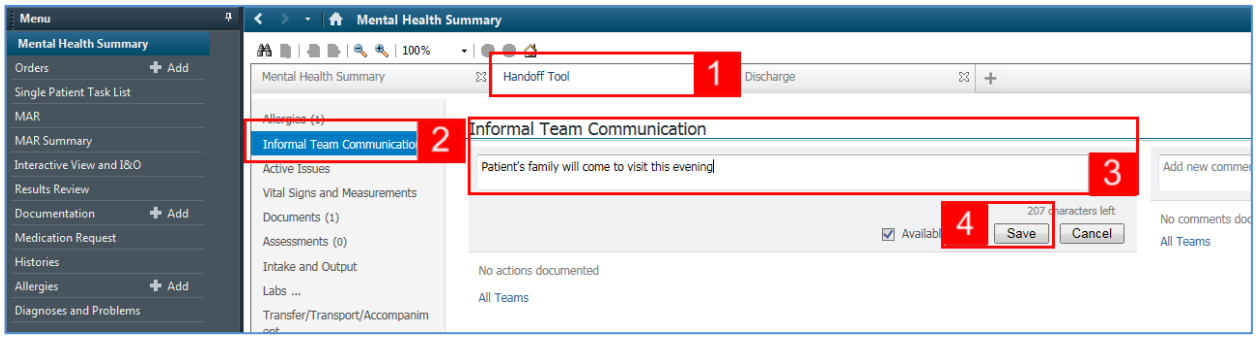
# Activity 13.2 – Documenting Informal Team Communication

1 The **Informal Team Communication** Tool can be used to add actions or comments to hand over to your colleagues much like you would in a Kardex.

**Note**: The Informal Team Communication is NOT part of the patient's legal chart. This is not to be used for legal documentation purposes.

From the Menu select **Mental Health Summary**

1. Select the **Handoff Tool** tab
2. Navigate to the **Informal Team Communication** component
3. Type the following = *Patient's family will come to visit this evening*
4. Click **Save**




You may complete or delete these informal team communications when they no longer apply.

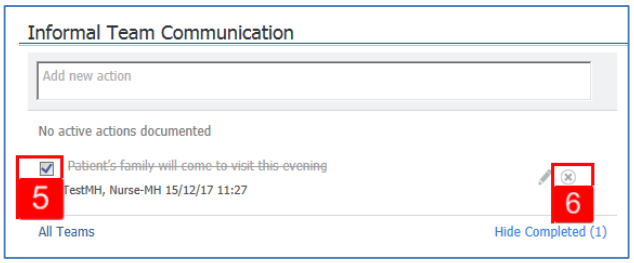
To complete a task in Informal Team Communication:

5. Click the checkbox to the left of the note. The task will appear as completed and is still viewable.

To delete a task in Informal Team Communication:

6. Click the small circle with the x to the right of the note

**Note:** It is important to remove/delete these informal team communications when they no longer apply.




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

## Key Learning Points

- The Informal Team Communication component is a way to leave a message for another clinician
- An Informal Team Communication message is NOT part of the patient's legal chart

# PATIENT SCENARIO 14 - Printing a Document

**Learning Objectives**

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

- Print a Document

## SCENARIO

In this scenario, you will be reviewing how to print a discharge summary.

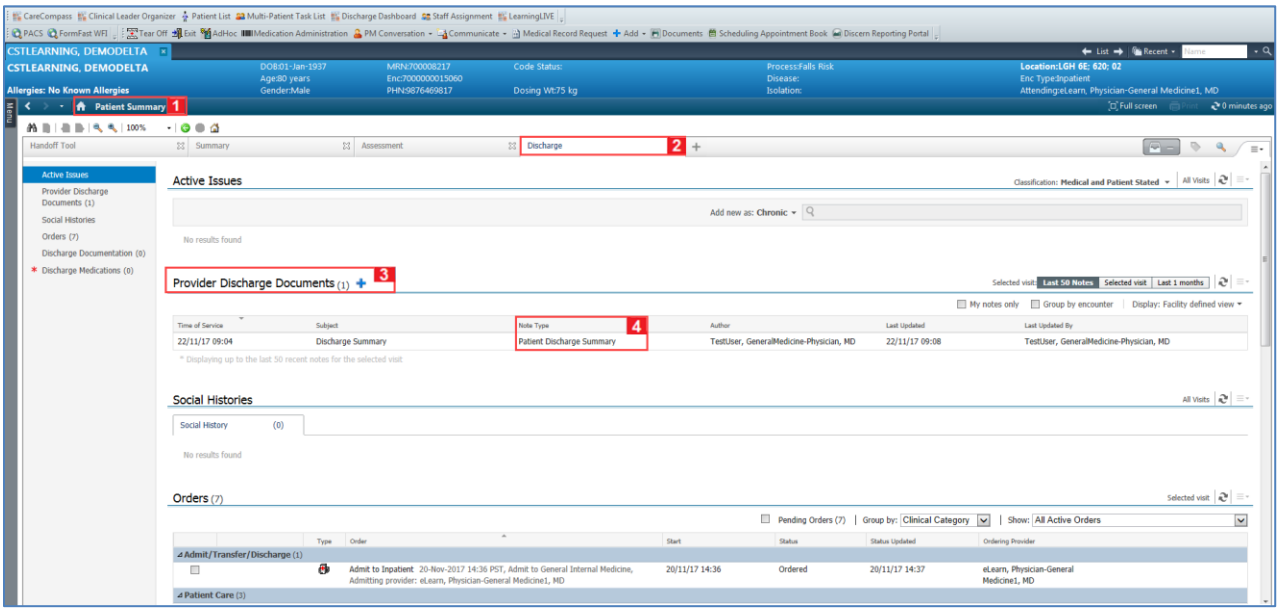
As a nurse, you will be complete the following activity:

- Printing a patient a discharge summary

# Activity 14.1 – Printing a Patient Discharge Summary

1 The Patient Discharge Summary is completed by the provider and summarizes information for patients about their stay in the hospital. It also includes follow-up appointments and medication information. It can be found in the Discharge tab of the Patient Summary section of the chart.

1. Navigate to the **MH Patient Summary** Workflow Page from the Menu
2. Select the **Discharge** tab
3. Scroll to find the **Provider Discharge Documents** component
4. Select **Patient Discharge Summary** document. The Patient Discharge Summary appears in a window on the right side of the screen

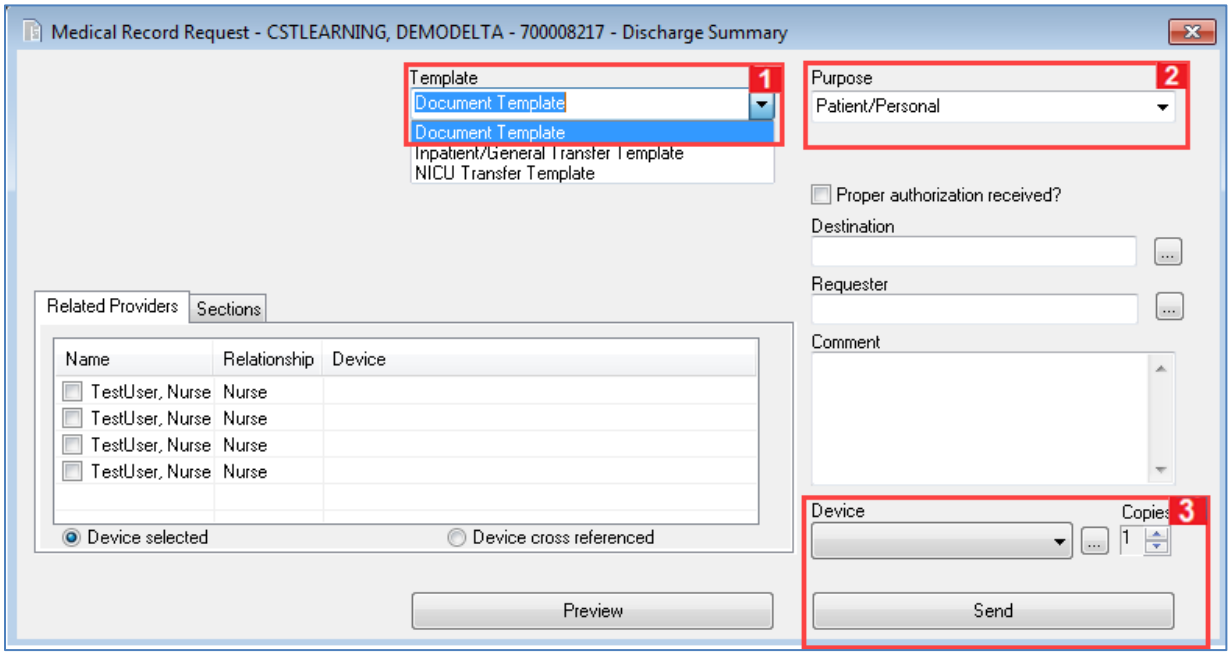


2 Navigate to the top right of the document and click **Print**

1. From the Template drop-down list, choose **Document Template**
2. From the Purpose drop-down list, choose **Patient/Personal**

**Note:** Please only practice the next step and do not send anything to print. Click in place of clicking **Send.**

3. Ensure you choose the correct printer from the **Device** drop list click **Send**




## Key Learning Points

- The patient discharge summary is completed by the provider to summarize patient information such as follow-up appointments and medications.
- You can preview documents by clicking on it in the respective workflow page component
- You may print documents from the same preview window

# PATIENT SCENARIO 15 – Transfer and Discharge from ED

## Learning Objectives

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

- Complete the Depart Process
- Initiate a Facility Transfer

## SCENARIO

In this scenario, your patient is ready for admission to the HOpe Centre. You will complete the depart processes to discharge the patient from ED, and transfer them to a bed in the HOpe Centre.

As a Mental Health Emergency Nurse you will be completing the following activities:

- Initiate a pending facility transfer to the HOpe Centre
- Review patient disposition in Tracking Shell
- Complete the Depart Process to discharge the patient from ED

# Activity 15.1 – Patient Disposition and Facility Transfer

1

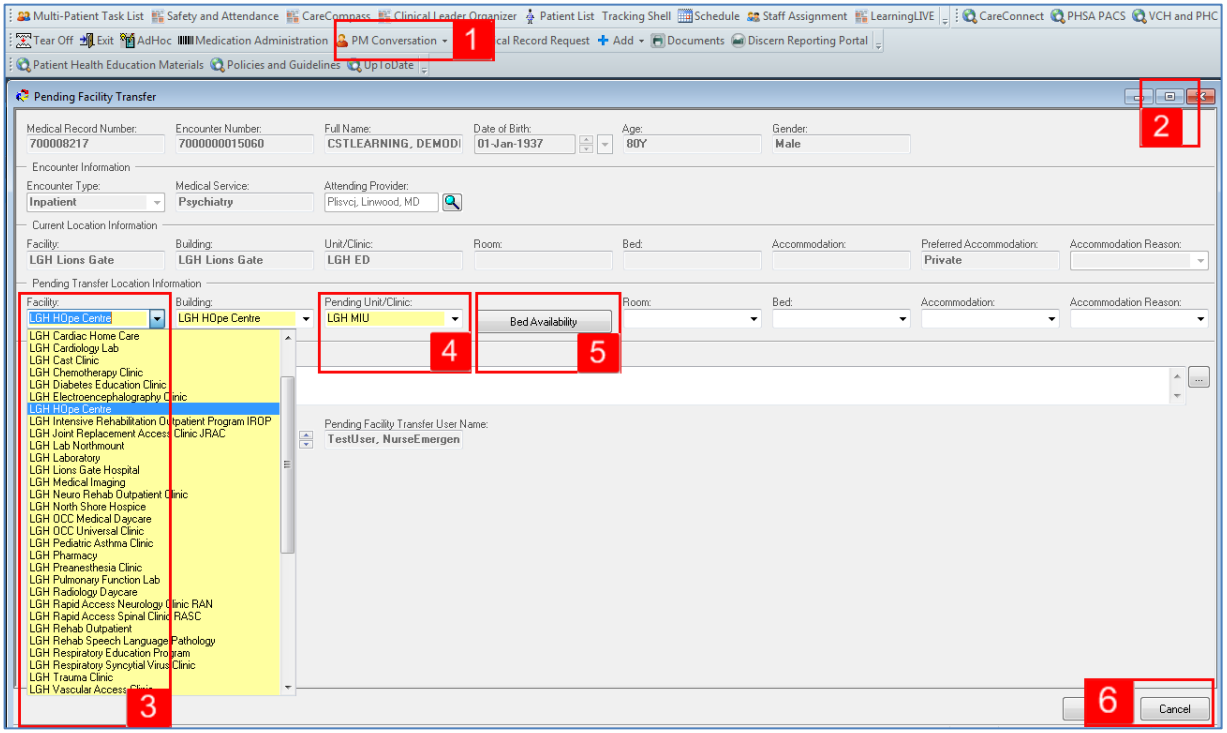
A facility transfer entails a patient transfer between buildings within the same hospital campus, such as to the HOpe Centre. Use a Pending Facility Transfer when you know that the patient will leave your facility, but has not yet left your department. The receiving unit will complete the transfer.

To start the transfer process, a **Pending Facility Transfer** must be initiated. Enter the patient's chart by selecting their name and double-clicking the blue arrow to the left of their name.

1. Click the arrow next to **PM Conversation**
2. Select **Pending Facility Transfer.** Expand the Pending Facility transfer window to see all fields
3. In the Facility field, choose **LGH HOpe Centre**. Note that the **Building** field automatically changes to LGH HOpe Centre as well
4. In the Pending Unit/Clinic field, choose **LGH MIU**
5. Click **Bed Availability**

**Note:** At this time, you would complete the facility transfer initiation process by choosing the bed allocated to the patient. For training purposes, we will not complete this process.

6. Click **Cancel** to return to Tracking Shell



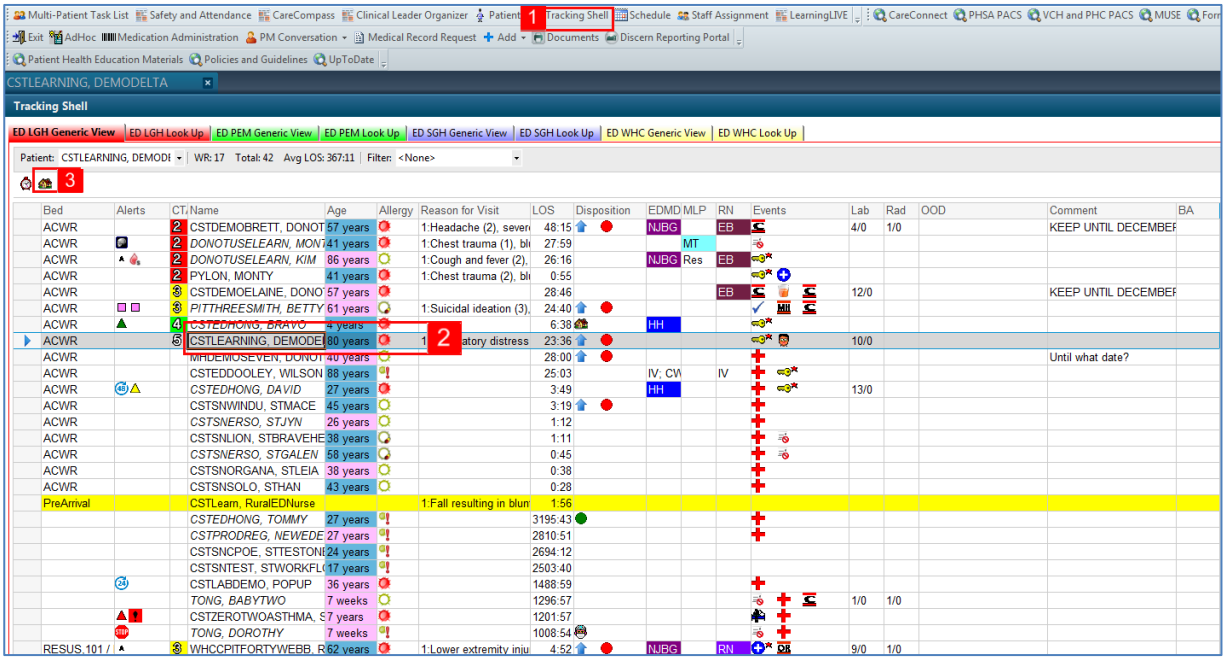
## Key Learning Points

- A facility transfer entails a patient transfer between buildings within the same hospital campus, such as to the HOpe Centre
- Use a Pending Facility Transfer when you know that the patient will leave your facility, but has not yet left your department

# Activity 15.2 –The Depart Process

1 When your patient is leaving the unit for either admission or discharge you must begin the Depart Process.

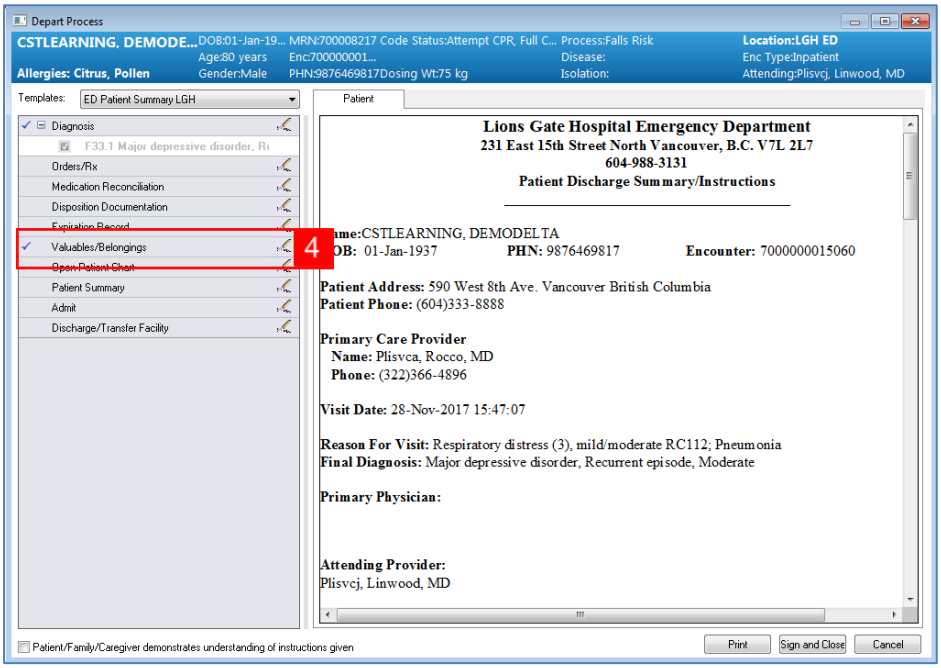
1. Navigate to Tracking Shell from the Organizer Toolbar
2. Select your patient from the list
3. Click the house icon to begin the Depart Process




To complete a discharge from the emergency department, you will need to complete the depart process. The depart process allows the clinician to review pertinent patient information before the patient leaves the department, such as diagnosis, recommendations, and valuables and belongings.

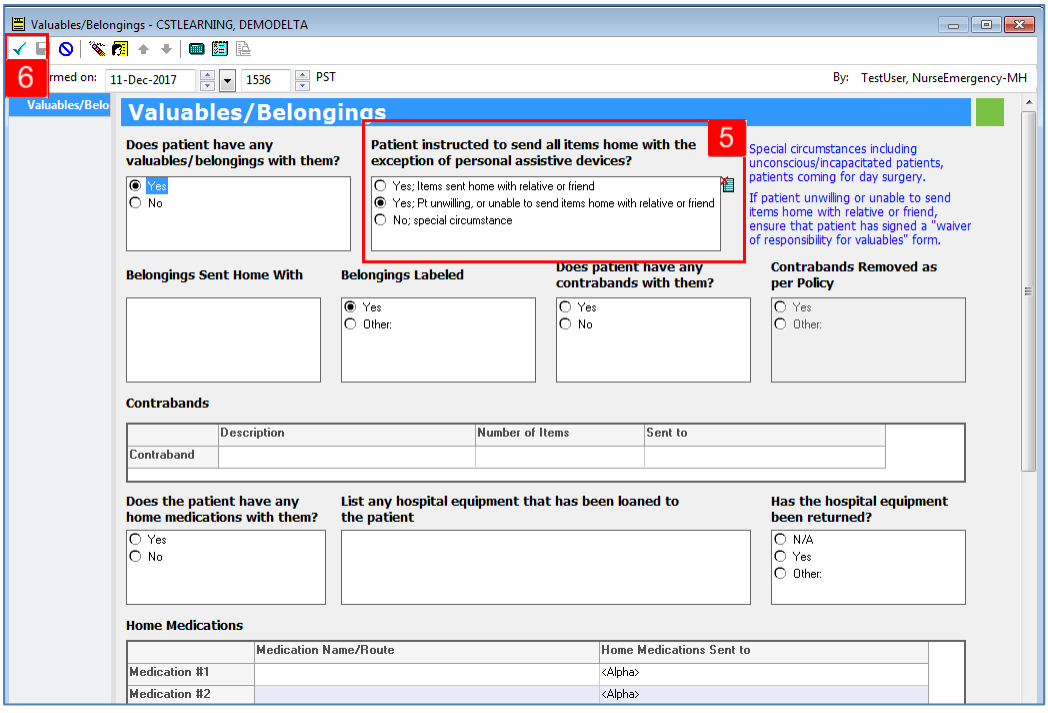
**Note:** You can review and edit sections of the **Depart Process** window by selecting the **pencil**  icons on the menu. While not always part of a normal workflow, editing discharge information can often be necessary

4. Select the pencil icon  next to Valuables/Belongings



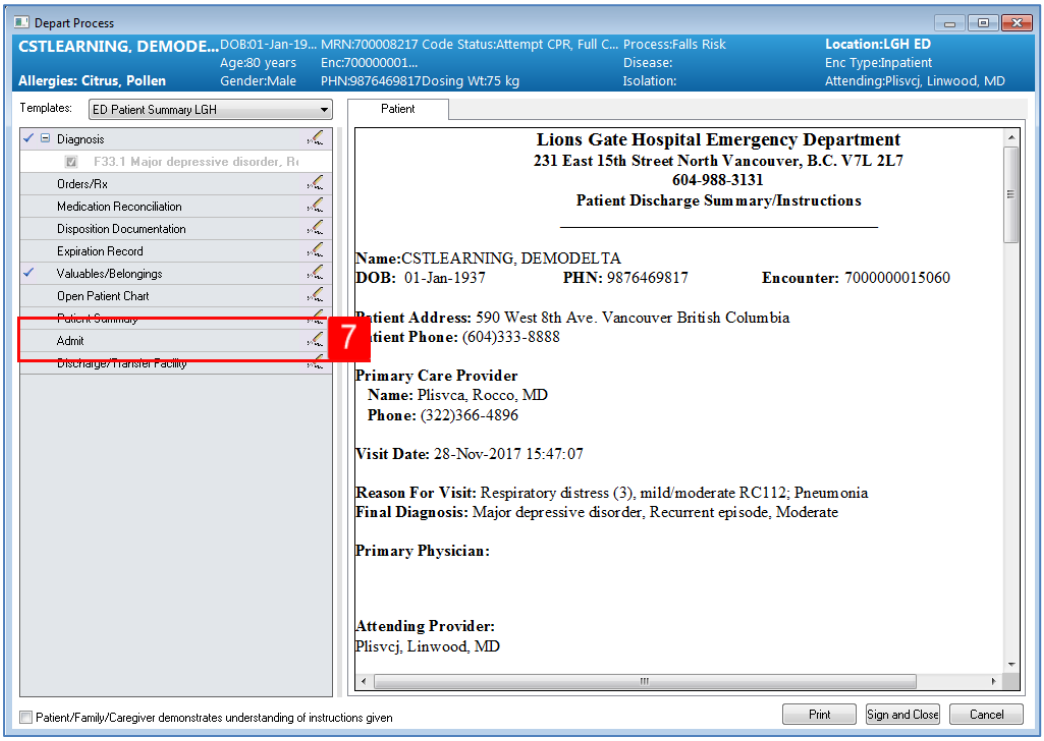

5. Select **Yes; Pt unwilling, or unable to send items home with relative or friend** in the Valuables/Belongings PowerForm

6. Click the green checkmark ✓ to sign your documentation

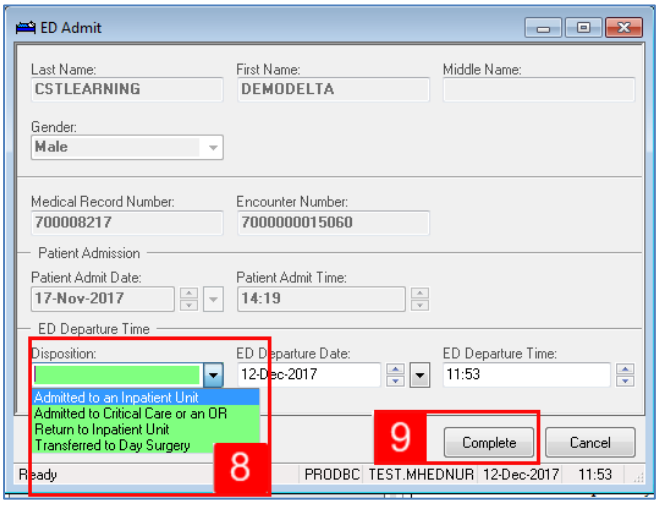


**Note:** You may choose to print the Patient Discharge Summary/Instructions at this time if you wish. This form contains information regarding the patient's visit to the ED.

7. Select the **pencil icon**  next to **Admit**




8. Select **Admitted to an Inpatient Unit** in the Disposition drop-down list
9. Click **Cancel**




**Note:** At this time, you would complete the admission process by clicking Complete. For training purposes, we will not complete this process as this will remove the patient from the Tracking Shell. Departed patients can be found in the ED LGH Lookup tab up to 24 hours after departure.

**Note:** To discharge your patient home or to an external facility, you would choose Discharge/Transfer Facility.

10. Click **Cancel** to return to Tracking Shell

## Key Learning Points

- Review the disposition column of the Tracking Shell for current disposition status
- The depart process allows the clinician to review pertinent patient information before the patient leaves the department
- The Discharge/Transfer Facility or Admit fields must be filled out to successfully discharge a patient

## End of Workbook

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