SELF-GUIDED PRACTICE WORKBOOK [N76] CST Transformational Learning

WORKBOOK TITLE:

Nursing: Mental Health Emergency



Last update: February 4, 2018 (v2)



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Using Train Domain



***** SELF-GUIDED PRACTICE WORKBOOK

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



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

1



Activity 1.1 – Set Up Location List

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

PowerChart Organizer for TestCD, ICU-Nurse			
Task Edit View Patient Chart Links PatientList Help			
🗄 🎬 CareCompass 🎬 Clinical Leader Organizer 🎄 Patient List 🚺 ti-Patient T	'ask List 🎬 Discharge Dashboard 🔉 Staff Assignment 🎬 Le	tarningLIVE 🖕 🗄 😋 CareConnect 😋 PHSA PACS 😋 VCH and PHC PA	ACS 🕄 MUSE 🕄 FormFast WFI 🝦
🗄 🏨 Exit 🏙 AdHoc 💵 Medication Administration 🚡 PM Conversation 👻 🗎 Me	dical Record Request 🔸 Add 👻 🖪 Documents 🗎 Schedulir	ng Appointment Book 💽 iAware 🥃 Discern Reporting Portal 🝦	
🗄 😋 Patient Health Education Materials 😋 Policies and Guidelines 😋 UpToDate	Ŧ		
Patient List			
<mark>ፇ⋷</mark> 2 <mark>╕ѷѷӏѻӏ┇Ҍҽҩ҄ӀҩӡӀѽ</mark>			
Í	P Modify Patient Lists		
	Available lists:	Active lists:	
		New OK Car	ncel



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

Patient List Type				
Patient List Type Select a patient list type: Assignment Assignment (Ancillary) Care Team Custom Custom Provider Group Query Relationship Scheduled				
	Back	Next	Finish	Cancel

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.

	Location Patient List		×
t	□ Locations □ Medical Services □ Encounter Types □ Care Teams □ Relationships □ Time Criteria □ Discharged Criteria □ Admission Criteria	Image: Construction of the system Image: Construction of the system	× H
	Enter a name for the list: (Limited	d to 50 characters)	
		Back Next Finish Can	cel



- 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 icon to move the **Location** to the right **Active List**
- 12. Click OK to return to Patient Lists. Your Location list should now appear

P Modify Patient Lists		
Avvilable lists LCH-2 East 10	Active lists	() ()
	New OK Cance	el



- 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

	1
a Multi-Patient Task List 🏬 Safety and Attendance 🞬 CareCompass 📫 Clinical Leader Organizer 🛓 Patient List Tracking Shell 🔤 Schedule 🙇 Staff Assignment 🙀 LearningLNE 📄 😋 CareConnect 🕲 PHSA PACS 🕲 VCH and PHC PACS 🕲	MUSE 🜊 FormFast WFI 🝦
🚽 bit 🎬 AdHoc 💵 Medication Administration 🔒 PM Conversation 🔹 📄 Medical Record Request 💠 Add 🗢 🗑 Documents 📾 Discern Reporting Portal 🖕	
🔯 🗛 Patient Health Education Materials 🔯 Policies and Guidelines 🕲 UpToDate 💡	
CSTLEARNING, DEMODELTA	
Multi-Patient Task List	
1 3 自由 气间 / 杨	
Assigned Task Emergency Consult - Schooling Patient View	08-December-2017 06
Task retrieval completed	
No Patients Found Name Medical Record Number Location/Room/Bed Task Status Scheduled Date and Time Task Description Order Details	
The selected patients, time frame and filters for this view did not return any tasks	

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

Task Edit View Patient Chart Links TaskList Options Help	
😫 Multi-Patient Task List 脳 Safety and Attendance 脳 CareCompass 🜇 Clinical Leader Organizer 🎍 Patient List. Tracking Shell 🔤 Schedule 🚓 Staff Assignment 🌇 Learning LIVE 🖕 🛱 CareConnect 🛱 PHSA PACS 🛱 VCH and PHC PACS 🛱	MUSE 🔃 FormFast WFI 🛫
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Multi-Patient Task List	(O) Full screen 🛛 Print 💸 13 minutes ag
✓ ⊗ 值 省 鸣, [朝] 兆	
Assigned Tasks	08-December-2017 06:30 Friday F T - 08-December-2017 19:45 Frid
Emergency Consult Scheduled Patient Care Unit Clerk	Change Time Frame Criteria Z
Task retrieval completed	
No Patients Found Name Medical Record Number Location/Room/Bed Task Status Scheduled Date and Time Task Description Order Details	
The selected patients, time frame and filters for this view did not return any tasks	

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

P Task List Properties	
	e - Q
Time Frames Patient List	🍣 0 minutes ago
Choose one of the following: 3 O Defined Time Frame O Hour Interval O Generic Time Frame	7
Range 12 Hour Day Shift 5 Image: Previous 12 Hour Night Shift 12 Hour Night Shift Image: Hour Day Shift 8 Hour Day Shift 8 Hour Evening Shift Image: Next 8 Hour Night Shift 8 Hour Night Shift	
Show me my: 16:00 V PST	
From: 07-Dec-2017 🔭 💌 1606 👘 PST	
To: 07-Dec-2017 (*) v 1607 (*) PST	
6 OK Cancel	

The MPTL is now set to view consults.

11 | 108



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 \checkmark to sign your document

P MH Emergency Nursing Assess	ment - CSTLEARNING, DEMODELTA	
🖌 🖬 🛇 🖏 🗗 🛧 🖉 🖩		
3 erformed on: 29-Nov-2017	▼ 1130 ♠ PST	By: TestMH, NurseEmergency-MHJ
General Information Barriers to Communication	History of Presenting Concern	
✓ History of Presenting Concern 1	History of Presenting Concern	
Appearance and Behaviour	Times New Roman 🔹 12 🔹 🧐 🐰 🛍 🛍 🔀 💆 🖌 🖺 🧮 🗄	
Speech, Affect, Mood	Patient presents to emergency room with spicidal ideation. Family present with patient in room	
Thought Process and Content	auch presents to entrigency room with succed recedent. I amay present with placin in room.	
Cognition, Insight, Judgment		
Suicidal Ideation		
CSSRS Intensity of Ideation		
CSSRS Suicidal Behavior		
Actual, Potential Lethality		
CSSRS Risk Assessment		
 Violence and Aggression Screening 		
Review Violence Risk Alert		
Substance Use Assessment		
Housing, Employment and Education		
Legal Status and History	2	
Social History		
Family History		
Problem History		
Procedure History		
Medication History		
Allergy		
Recommended Disposition		
	4 m	•
		In Progress

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

1



PATIENT SCENARIO 2 – Tracking Shell and Accessing the Chart

Activity 2.1 – Tracking Shell

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

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ient Health Edi	ucation Mat	erials 🙀 Policies and Guidelines	😋 UpToDate	Ŧ											
king Shell															
				and the						a na 1					
ton delienc vie	ED LG	LOOK UP ED PEM Generic View	ED PEIN LO		D SGH Generic View ED	SGH LOOK UP ED WH	ic Generic v	ew ED	WHC LOO	ок ор					
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AC 201	Ť.		1 7 years	ŏ	1:Respiratory distress	4:14	ΔP	NT	PD		4/3	3			
AC 214		3 CSTPPTEST EMMA	5 years	õ	1:Flu like (3) illness lo	26:42			~ 3*						
AC,218		CSTPRODMI, STTWOJO	E 47 years	0		219:27			+	*		23/20			
AC,219		S CSTDEMODIANE, DONO	TI 57 years	0		33:08	NJBG	NN	2	6	2/0	1/0		FOR DEMO AT LGH NOV	
DTU,01		PPCSTTEST, BOB	55 years	0	1:local swelling (3)/red	26:52			~3 *	*					
ACWR		2 CSTDEMOBRETT, DONG	OT 57 years	۰	1:Headache (2), seven	46:28 🞓 🛛 🔴	NJBG	NN	2		4/0	1/0		Until what date?	
ACWR	a	2 DONOTUSELEARN, MO	N141 years	0	1:Chest trauma (1), bl	26:12	NJBG R	es; N <mark>NN</mark>	0						
ACWR	* 🕜	2 DONOTUSELEARN, KIN	86 years	0	1:Cough and fever (2),	24:29	NJBG R	es NN	<u>~</u> 3*	_					
ACWR	_	CSTDEMOELAINE, DON	O'57 years	0		26:59		NN	2	<u> </u>	12/0			Until what date?	
ACWR		S PITHREESMITH, BETT	Y 61 years	2	1:Suicidal ideation (3),	22:53			×						
ACWR		G COTIEDCOX, COURTENE	T 54 years	ă	T:Unest pain (2) and n	195:08		VIV		V	1/0				
ACWR		MHDEMOSEVEN DOM	T 40 years	õ		21.49			-		10/0			Lintil what date?	
ACWR		CSTEDDOOLEY, WILSO	N 88 years	ă		23:16	IV: CW	IV	÷.	~3 *				Onthi What date?	
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ACWR		CSTSNWINDU, STMACE	45 years	0		1:32			+						
PreArrival		CSTLearn, RuralEDNurse	1		1:Fall resulting in blum	0:10									
		CSTEDHONG, TOMMY	27 years	ai		3193:56 🔴			- †						
		CSTPRODREG, NEWEL	E 27 years	q		2809:05									
		CSTSNCPOE, STTESTO	NE24 years	9		2692:26									
	G	USISNIESI, SIWORKE	LC17 years	-1		2501:53									
	9	TONG RARYTMO	Jo years	<u>~</u>		1407:12			-	- 7	1/0	1/0			
		CSTZEROTWOASTHMA	57 years	ŏ		1200:10			*	1 *	1/0	1/0			
	a	TONG DOROTHY	7 weeks	9		1007:07			-	÷		-			
RESUS, 101		8 WHCCPITFORTYWEBB	R62 years	0	1:Lower extremity iniu	3:05 🞓 🔴	NJBG.	RN	0 *	OR	9/0	1/0			
AC.201		CSTPRODREG, UTVED	AA 34 years	q		28:01			Ť	∓ ⊸*					
AC,203 / AC,	2	PHCCPITFORTYCUNNIN	GI62 years	0		48:35			÷	🏟 🌹 –					
AC,205		CSTPRODBCDA, STST	62 years	Q	1:Anal/rectal trauma (4	1454:35 🞓 🛛 🔴			~3 *	0* 🖷 1	r				
AC,209 / AC,	2	2 CSTDEMOCHRIS, DONO	OTI 57 years	٥	1:Respiratory distress	173:07 🞓 🎓 🧧	CW-Le	CV	/-Le 🔞	2	7	7		What date is this patient	
AC 216 / AC	2	2 PITTHREESMITH BETT	V 61 years	0	1:Suicidal (2) attempt	4:37 🔴 🔶 🥚	AD	NIT	6	MH 🖌 🖷					

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

1

CLINICAL+SYSTEMS Our path to smartice seamless care

Activity 2.2 – Accessing the Patient's Chart

PATIENT SCENARIO 2 – Tracking Shell and Accessing the Chart

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 reordered, you may receive a restraint or seclusion pop-up alert upon your first entry into the chart.

Discern: Open Chart - PRODBCTEST	
SECLUSION ALERT	
Seclusion order is expired. Discontinue the order to stop this alert. If seclusion is still required, obtain/enter a new order.	
OK	



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 with 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.

: IEC CareCompass IEC Safety a	and Attendance	Clinical Leader Ornanizer	ient List Perionerative Tr	acking III Th	eraneutic Note	Schedu	ale 🗢 Staff Assignment 🕮 Learning IVE							
CoreConnect Collision			WEI		copense increase in	Perices	are an annound an annound an a							
Caleconnect Cernskers	ACS QVCHB	INTERACE CONTRACTOR	i filler og affiner i				0 mil 6 mil		and I					
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Allergies: Pollen		Gender:M	ale	PHN:987646	9817		sing Wt:75 kg	Isolation:		Attending:Plisvca, Rocco,	мр 2		4	
Menu		< 🔿 🔹 🔒 Mental Healti	n Summary								Full screen	Print	2 0 minut	es ago
Mental Health Summary			10.0.0											_
Orders 🕂		ana 📖 📲 📑 🔍 🔧 100%	•											_
Single Patient Task List		Mental Health Summary	23 Handoff Too	Ы	ε	3 Discr	harge 23 +					⊗ 1€.	<u> </u>	=-
MAR		Patient Information				≣• ⊘	Lines, Tubes, and Drains (0)	≡• ⊗	Nursing Assessments (0				≡• 6	
Interactive View and I&O		Chief Complaint:				_	Selected visit		Selected visit					11
Parulte Paview		Primary Physician:	Plisvca, R	ICCO, MD			No results found		No results found					
	A 44	Attending Physician:	Plisvca, R	occo, MD					ć					- 11
Madiantian Damant		Admitting Physician: Referring Physician:	Plisvca, Ri	ICCO, MD			Diagnostics (0)	≡• ⊙	Labs		_	_	=• 6	
Medication Request		Service:	Psychiatry	- Contra			Selected visit 🖝		Selected visit					411
Plistories		Room/Bed:	AC-204				No results found		No results found					8
Allergies	Add	Admit Date:	17/11/17	found					Clincial Research (0)				=- 6	
Diagnoses and Problems		Last VISIC	NO RESULTS	round					cinician resources (o)					-
		Vital Signs 💠 👻				≣• ⊘				On Study 1	katus	Contact		
CareConnect		Selected visit -		_	_	-			No results found					
Clinical Research			Lature		Devicest		1							
Form Browser			within		within									
Growth Chart		BP	140/90											
Immunizations		up	90.											
Medication List 🔹 🕂			5 days											
Patient Information		Temp	36.9		-									
Reference			5 days											
	_	Weight Dosing	75											
	3													
		Active Issues				≣• ⊘								
		All Visits				_								
		Classification: All												
		Priority Problem												
		Parairstan, distress (2)	mid/mederate PC112											
		exespiratory distress (3)	, milloy mouerate RC112			;								-
		and the second se												

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



PATIENT SCENARIO 2 – Tracking Shell and Accessing the Chart

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

🗄 🎬 CareCompass 🎬 Safe	ty and Attendance	🎬 Clinical Leader Organizer 🛔 Patie	ent List Perioperative 7	racking 🎬 Therapeutic No	te 🛄 Schedule 🛭 🏭 Staff Assig	Inment 🎬 LearningLIVE 🝦		
🖁 😋 CareConnect 😋 PHSA	A PACS 伐 VCH an	id PHC PACS 🜊 MUSE 🜊 FormFast)	WFI 🝦					
🕴 😋 Patient Health Educatio	on Materials QPo	licies and Guidelines 🔇 UpToDate 🖕	🕴 💽 Tear Off 📲 Exit	AdHoc IIII Medication	Administration 🔒 PM Conve	rsation 👻 🗎 Medical Recor	rd Request 🚦 Add	🕶 🕞 Documents 📾 D
CSTLEARNING, DEM	IODELTA 🛛 🗵							
CSTLEARNING, DEM	IODELTA	DOB:01-Jan	1-1937	MRN:700008217	Code Status:			Process:Falls Risk
Allergies: Pollen		Age:80 yea Gender:Ma	rs le	Enc:/00000015060 PHN:9876469817	Dosing Wt:75 kg			Disease: Isolation:
Menu		< 🔿 🔹 者 Mental Health	Summary					
Mental Health Summary		A						
Orders	🖶 Add	Mental Health Summary	Handoff To	ol	22 Discharge	× +	1	
Single Patient Task List			1					
MAR		Allergies (1)	Allergies (1)	±				
Interactive View and I&O		Informal Team	Allergies (1)	т				
Results Review		Communication						
Documentation •	+ Add	Active Issues	Substance	Reactions		Category	Status	Severity
Medication Request		Vital Signs and Measurements	Pollen	-		Environment	Active	Moderate
Histories		Documents (4)						
Allergies	🖶 Add	Assessments (1)						
Diagnoses and Problems		Intake and Output	Informal Te	am Communicatio	<u>ו</u>			
		Labs	Add nous action					Add any a
CareConnect		Transfer/Transport/Accompan iment	Add new action					Add new o
Clinical Research		Diagnostics	No actions docu	mented				No commer
Form Browser		Medications	All Teams					All Teams
Growth Chart		Home Medications						
Medication List	L Add	Oxygenation and						
Patient Information	- Aud	Ventilation	Active Issue	s				
Reference		Micro Cultures						
		Orders						Add new as: T
		Pathology	No results four	nd				
		Histories						
		Lines/Tubes/Drains						
		Create Note	Vital Signs a	and Measurements	+			
		Interdisciplinary Care Plan						
		Interdisciplinary Rounding Su	BP	mmHg				
		mmary Note	HR	bpm				
		Nursing Shift Summarv 2	Temn	DenC				

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:

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.

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

Activating a process alert

1



Activity 3.1 – PM Conversation

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 Arrow restion right of PM Conversation right of PM Conversation
- 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

🚯 Organization
Please select the facility where you want to view person aliases.
Facility Name Facility Alias
LGH Lions Gate 1
LGH Lions Gate Hospital 2
Facility:
LGH Lions Gate Hospital
3 OK Cancel

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

🍜 Process Alert				- • •
Medical Record Number: 700008217	Encounter Number:	Last Name: CSTLEARNING	First Name: DEMODELTA	Middle Name:
Preferred Name:	Previous Last Name:	Date of Birth: 01-Jan-1937	Age: 80Y	Gender: Male
BC PHN: 9876469817				
- ALERTS				
Process Alert: From Available: Communication Barrier Cytotoxic Difficult Intubation/Airway Faste Rick Gender Sensitivity No Ceiling Lift	To: Move > 3 Select All	Selected:		
			4	Complete Cancel
Ready			PRODBC TEST.NU	IRSE 21-Nov-2017 15:31

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.

PATIENT SCENARIO 4 - Orders



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





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



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:

- Grder 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

PATIENT SCENARIO 4 - Orders

1



Activity 4.2 – Review Order Status and Details

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

🔊 🖳 🦻 Order Nam	e 🔺 Status	Dose [Details Proposal ^
Insert Perip	heral IV Processing	2	20-Nov-2017 11:46 PST
👘 🔲 🛛 Insert Urina	ry Cath Ordered	2	20-Nov-2017 11:31 PST, Indwelling
Morse Fall Assessment	Risk Ordered t	1	17-Nov-2017 14:05 PST, Stop: 17-Nov-2017 14:05 PST Order entered secondary to inpatient admission.
👘 🛄 🛛 Vital Signs		2	20-Nov-2017 11:25 PST, q4h while awake
⊿ Medications			
👘 🗹 🍗 🖬 furosemide	Ordered	2	20 mg, IV, as directed, order duration: 5 day, drug form: inj, start: 17-Nov- Administer pre red blood cell transfusion
< III			P. C.

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 *m* 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

	S	Ÿ	Order Name	Status 🔻	Dose	Details	٦
2	Pat	ient Car	e				
•		66	Vital Signs	Ordered		28-Nov-2017 10:42 PST, q4h	
		1					
•			III				Þ
	Deta	ails					
	Orders	For Cosig	nature Orders For Nurse Review 2			Orders For Signature	

- 3. Review order details
- 4. Click Review

CSTLEARNING	6, DEMOALPHA - Actions Re	equiring Review					- • • ×
CSTLEARNI	NG, DEMOALPHA	DOB:01-Jan-193 Age:80 years	7 MRN:700008214 Enc:700000001505	Code Status: 5	Process: Disease:	Location:LG Enc Type:Inp	iH 6E; 624; 02 Datient
Allergies: Bee	s/Stinging Insects, ci	Gender:Male	PHN:9876469856	Dosing Wt:	Isolation:	Attending:Pl	isvca, Rocco, MD
Action	Action Da Entered B	y Order De	etails			Ordering	
Crder	28-Nov-201 Plisvcf, 7 10:42:56 Dillon, MI	Vital Signs 28	-Nov-2017 10:42 PST, q4	h		Plisvcf, Dillon, MD 3	
Select All	Show All Details					CSTLEARNING, DEMOALF	PHA Review 4 Cancel

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

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:

Add Cocument Medication					
	by Hx F	Reconcil	iation •	Check Interactions	
Medication List Documon	t In Dian	1			
Medication List Documen	t in Pian				
View	Displaye	ed: All Ac	tive Orders	s All Active Orders	
Orders for Signature	R	5	8	Order Name 🔺	Status
Document In Plan	⊿ Pati	ient Car	e		
		⊕ ⊻	2 60	Admission History Adult	Ordered
TM Red Blood Cell (RBC) Suggested Plans (0)		⊕ ⊻	2.60	Basic Admission Information	Ordered
				Hadan	

- 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

P CSTLEARNING, DEMODELTA - Add Order) x
CSTLEARNING, DEMODELTA	DOB:01-Jan-1937 MR	RN:700008217	Code Status:	Process:Falls Risk	Location:LGH ED; AC; 204	
	Age:80 years End	:700000015060		Disease:	Enc Type:Inpatient	
Allergies: Pollen	Gender:Male PHI	N:9876469817	Dosing Wt:75 kg	Isolation:	Attending:Plisvca, Rocco, MD	
2						
Search: acetaminophen	vanced Options 👻 Type: 🕻	Inpatient	-			
💿 🖆 🚖 🔹 🗎 🗟 Folder:	Search within:	Al				
acetaminophen	acetaminophen		acetaminophen	acetaminophen	acetaminophen	Lacel
acetaminophen	325 mg, PO, g4h, PRN pai	in-mild, drug f	325 mg, rectal, g4h, PRN pain-mild or fe	640 mg, PO, g4h, fever, drug form: oral li	650 mg, PO, OID, PRN pain-mild or fever	975
mg. PO. once. drug form: oral lig [Greate	acetaminophen		acetaminophen	acetaminophen	acetaminophen	acet
acetaminophen	325 mg, PO, g4h, PRN pai	in-mild or fever	500 mg, PO, once, drug form: tab [Great	640 mg, PO, g4h, pain-mild, drug form:	650 mg, PO, TID, drug form: tab [Greater	975
120 mg, rectal, g4h, drug form: supp [Gr	acetaminophen		acetaminophen	acetaminophen	acetaminophen	acet
acetaminophen	325 mg, PO, QID, drug for	rm: tab [Greater	500 mg, PO, q4h, drug form: tab [Greater	650 mg, PO, once, drug form: tab [Great	650 mg, PO, TID, PRN fever, drug form: t	975
160 mg, rectal, g4h, drug form: supp [Gr	acetaminophen		acetaminophen	acetaminophen	acetaminophen	acet
acetaminophen	325 mg, PO, QID, PRN fev	er, drug form: t	500 mg, PO, q4h, PRN fever, drug form: t	650 mg, PO, q4h, drug form: tab [Greater	650 mg, PO, TID, PRN pain-mild, drug fo	1,00
320 mg, PO, g4h, drug form: oral lig [Gre	acetaminophen		acetaminophen	acetaminophen	acetaminophen	acet
acetaminophen	325 mg, PO, QID, PRN pai	in-mild, drug f	500 mg, PO, q4h, PRN pain-mild, drug f	650 mg, PO, q4h, pain-mild or fever, dru	650 mg, PO, TID, PRN pain-mild or fever,	1,00
320 mg, PO, q4h, PRN fever, drug form:	acetaminophen		acetaminophen	acetaminophen	acetaminophen	acet
acetaminophen	325 mg, PO, QID, PRN pai	in-mild or fever	500 mg, PO, q4h, PRN pain-mild or fever	650 mg, PO, q4h, PRN fever, drug form: t	650 mg, rectal, q4h, drug form: supp [Gr	1,00
320 mg, PO, q4h, PRN pain-mild, drug f	acetaminophen		acetaminophen	acetaminophen	acetaminophen	acet
acetaminophen	325 mg, PO, TID, drug for	m: tab [Greater	500 mg, PO, QID, drug form: tab [Greater	650 mg, PO, q4h, PRN pain-mild, drug f	650 mg, rectal, q4h, PRN pain-mild or fe	1,00
325 mg, PO, once, drug form: tab [Great	acetaminophen		acetaminophen	acetaminophen	acetaminophen	acet
acetaminophen	325 mg, PO, TID, PRN fev	er, drug form: t	500 mg, PO, QID, PRN fever, drug form: t	650 mg, PO, q4h, PRN pain-mild or fever	650 mg, rectal, q6h, PRN pain-mild or fe	1,00
325 mg, PO, q4h, PRN pain-mild or fever	acetaminophen		acetaminophen	acetaminophen	acetaminophen	acet
acetaminophen	325 mg, PO, TID, PRN pai	n-mild, drug fo	500 mg, PO, QID, PRN pain-mild, drug f	650 mg, PO, QID, drug form: tab [Greater	650 mg, rectal, QID, drug form: supp [Gr	1,00
325 mg, PO, q4h, PRN fever, drug form: t	acetaminophen		acetaminophen	acetaminophen	acetaminophen	acet
acetaminophen	325 mg, PO, TID, PRN pai	n-mild or fever,	500 mg, F PRN pain-mild or fever	650 mg, PO, QID, PRN fever, drug form: t	975 mg, PO, once, drug form: tab [Great	1,00
325 mg, PO, q4h, PRN pain, drug form: t	acetaminophen		acetamine 3	acetaminophen	acetaminophen	acet
acetaminophe	n n har and the state of the st	fame and ICa	drug form: oral liq [Gre	650 mg, PO, QID, PRN pain-mild, drug f	975 mg, PO, QID, drug form: tab [Greater	1,00
325 mg, PO, g4	h, PRN pain, drug form: tab	Greater Than or B	gual To 17 year]			
×			<u> </u>			
				CSTLEARNIN	IG. DEMODELTA - 700008 5	-
						A 10

PATIENT SCENARIO 4 - Orders



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

🕂 Add 🕼 Document Medication by Hx Reconciliation * À Check I	nteractions				Reconciliation Status Heds History Admission
Orders Medication List Document In Plan					
	Orders for Signature				
View	🔊 🕑 🖳 Ϋ Order Name	Status Start	Details		
Orders for Signature	⊿ LGH ED; AC; 204 Enc:7000000	015060 Admit: 17-Nov-2017 14	1:19 PST		
Plans	⊿ Medications				
-Document In Plan	🔲 🤀 acetaminopher		7 14:51 325 mg, PO, q4h, PRN pain, drug form: tab, start: 01-Dec-20		
Medical		PST	Maximum acetaminophen 4 g/24 h from all sources		
Heparin Infusion Standard (Module) (Validated) (Initiated)					
MH Electroconvulsive Therapy (ECT) (Multiphase) (Validated)					
- Suggested Plans (0)	Details for acetaminop	hen			
Orders					
Admit/Transfer/Discharge	Details Details Order Comments				
C Status					
V Patient Care	🛑 📫 🛍 lin. 🛛 🗜 ど			Re	maining Administrations: (PRN) Stop: (Unknow
- Activity					
Diet/Nutrition	*Dose: 325		*Dose Unit:	mg 👻	
Continuous Infusions					
- Medications	*Route of Administration: PO	~	*Frequency:	q4h 👻	
Blood Products	DRN-	Var. O No	*PRN Beacon	nain	
Laboratory	1144		The first fi	puin	
Diagnostic Tests	Administer over:		Administer over Unit:	*	
Procedures					
Respiratory	Duration:		Duration Unit:	~	
Allied Health	Drug Form: tab	×	First Dose Priority	×	
	biugrom. tab	<u>`</u>	This base Filolity.		
Supplier	*Start Date/Time: 01-D	Dec-2017 14:51 PST 🗸 🗸	Stop Date/Time:	•••••	🌩 PST
Non Categorized	Lice Patient Supplie	Ver No	BCCA Protocol Code:		
Medication History			000111010101000		
Medication History Snapshot					
Reconciliation History					
Related Results					
Formulary Details					7
Variance Viewer	U Missing Hequired Details Orders I	or Cosignature	Heview		Z Sign

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

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

CSTLEARNING, DEMODELTA	DOB:01-Jan-1937 Age:80 years	MRN:700008217 Enc:7000000015060	Code Status:Attempt CPR, Full Code	Process:Falls Risk Disease:
Allergies: Pollen, Citrus	Gender:Male	PHN:9876469817	Dosing Wt:75 kg	Isolation:
Search mental health Advanced Opt	ions 👻 Type 🏭 Inpatient	¥		
Mental Health ED Nurse Following Mental Health Education	2			
Menta	odule) (Validated)			
"Enter" to Search				
Line of a second				



PATIENT SCENARIO 4 - Orders

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

P Ordering Physician		
 Order Proposal 		
*Physician name		
Plisvca, Rocco, MD		
der Date/Time 0/Dec-2017 ▲ 1055 ▲ PST		
Phone		
Verhal		
4 signature Required per/Fax Electronic		
5 OK Cancel		

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

🕂 Add 💣 Document Medication by Hx Reconciliation 🛛 🚴 C	ck Interactions	Reconciliation Status Meds History Admission Discharge		
Orders Medication List Document In Plan				
	K ⊗ ⑦ □ V Order Name Status Start Details			
View	△ LGH MIU; M007; 02 Enc;700000015060 Admit: 17-Nov-2017 14:19 PST			
Orders for Signature	▲ Consults/Referrals			
🖃 Plans	Mental Health ED Nur Order 08-Dec-2017 14:52 08-Dec-2017 14:52 PST			
Document In Plan				
⊡ Medical				
MH Psychiatric Admission (Validated) (Initiated)				
MH Psychiatric Admission (Validated) (Discontinued)				
MH Psychiatric Admission (Validated) (Discontinued)				
- Suggested Plans (0)				
⊖ Orders	■ Details for Mental Health ED Nurse Following			
Admit/Transfer/Discharge				
Z Status	Totais B Order Comments			
Patient Care				
Activity				
Diet/Nutrition				
Continuous infusions	*Requested Start Date/Time: D8-Dec-2017 + 1452 FST Reason for Follow-Up:			
Disad Desiduate				
Disgnortic Tertr				
Procedures				
Respiratory				
Allied Health				
Consults/Referrals				
Communication Orders				
Supplies				
Non Categorized				
Related Results				
Formulary Details		7		
Variance Viewer	O Missing Required Details Orders For Cosignature Orders For Nurse Review	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"

🗃 Multi-Patient Task Link 👖 🗛 und Attendance 🎬 CareCompass 🎬 Clinical Leader Organizer 🛓 Patient Lint Tracking Shell 🔤 Schedule 😂 Staff Assignment 🕌 LeamingUNE 📄 🔍 CareConnect 🔍 PHSA PACS 🖏 VCH and PHC PACS 🌚 ADDEE 🖓 FormFast WFI	
😒 con 😹 nenoc na meto com Administration 🔒 PM Conversation - 👔 Medical Record Request 💠 Add - 🔚 Documents 📾 Discern Reporting Portal	
🖸 Patient Health Education Materials 🛱 Policies and Guidelines 🙀 UpToDate	
CSTLEARNING, DEMODELTA	CSTLEARNING, DEMODELTA + C Recent + Name + Q
Multi-Patient Task List	🗇 Full screen 🛛 👼 Print 🛛 🗞 0 minutes ago
> ② 自 当 [1] [系	
Departmental View, Assigned Tasks 14-Dec	ember-2017 06:30 Thursday PST - 14-December-2017 19:45 Thursday PST
Emergency Comult Scheduled Patient Care Unit Clerk	
Task retrieval completed	
All Patients Name Medical Record Number Location/Room/Bed Task Status Scheduled Date and To Feek Description Order Details	
STELEARNING, DEMODELTA, 700098237 LGH ED / ACWR. Pending Centinuous.	
C STLEARNING, DEMODELTA	
CSTPROBE, ALBINATEST	

PATIENT SCENARIO 4 - Orders



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
PATIENT SCENARIO 4 - Orders



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

Multi-Patient Task List									
✔ ⊗ 痼 直 ጫ 興 兆									
Departmental View, Assigned Tasks									
Energency Consult Scheduled Patient Care Unit Clerk Scheduled Patients All Patients CSTEDTSTMARSH, STA CSTEDTSTMARSH, STA CSTERSOBC, ALBINATEST	Attus Scheduled Date and Time T. Charl Done Charl Done (Date/Time) Le Charl Done (Date/Time) Charl Charl Le Charl Done (Date/Time) Charl Not Done Quick Charl Charl Done Charl Done Quick Charl Le Charl Done Charling Ad Hoc Charling Reschedule This Task Print O'der Info O'der Comment Order Comment Create Admin Note Reference Manual Task Info Patient Snapshot Select All Deselect All Sort By Le	Inst. Description Order Details Inst. Machine Concenter 0 Orders 3 Imple Patient Text bits MAR MARSummary Interactive View and IO Results Review Documentation Medication Request Histories Allergies Diagnozes and Problems CareConnect Clinical Research Form Browser Growth Chart Immunizations Medication List Patient Information Reference							

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

< > 🔹 者 Orders					Renew		[D] Full screen	🛱 Print 🛛 🕹 12 minutes a
+ Add 2 Document Medication by Hx Reconciliation - A Check Interac	tions			1	Modify		Reconciliation Sta	itus
					Сору		Meds History	Admission Discharge
Orders Medication List Document In Plan					Cancel and Reorder			
					Suspend			
View	Displayed: All Activ	e Orders (All Inactive Orders (All Active C	Orders		Activate			Show More Orders
Orders for Signature					Complete			
Plans	9 8	Order Name	Status Dose		Constitutions 2			^
Document In Plan		Urine Culture	Ordered		Cance/Discontinue	n: 13-Dec-2017 13:14 PST, once		
Medical			(Pending		Void	fer to specific site Laboratory Test Manual.		
MH Psychiatric Admission (Validated) (Initiated)	× 0	Respiratory (lower) Culture (Sput	Ordered (Reschedule Task Times	pn: 11-Dec-201/ 15:55 PST, once		
- Suggested Plans (0)	E 0	Unine Culture (Unine Cols)	(Collected)		Document letenuention	fer to specific site Laboratory Test Manual.		
Orders	×	Respiratory (lower) Culture (Sput	Ordered (Document intervention	-2017 10:20 PST_once		
Admit/Transfer/Discharge	× 3	Respiratory (lower) Culture (Sput	Ordered (Add/Modify Compliance	lection: 07-Dec-2017 11:53 PST, once		
- Status		Respiratory (lower) Culture (Sput	Ordered (Order Information-	-2017 11:40 PST, once		
2 Patient Care	🗹 🇶 G	Urine Culture (Urine C&S)	Ordered		Comments	rd, Collection: 26-Nov-2017 09:47 PST, once		
Activity			(Collected)		Comments	fer to specific site Laboratory Test Manual.		
C Diet/Nutrition	M 🐮 🛙	Urine Culture (Urine C&S)	Ordered		Results	ed, Collection: 22-Nov-2017 16:48 PST, once		
- Continuous Infusions			(Collected)		Reference Information	fer to specific site Laboratory Test Manual.		
- C Medications	× .2, ⊑	Unine Culture (Unine C&S)	(Collected)		Print +	ed, Collection: 22-Nov-2017 16:44 PST, once		
Blood Products	Allied Health		(conceed)			for to specific site caboratory fest mandal.		
- Laboratory		Occupational Therapy Following	Ordered		Advanced Filters			
- Diagnostic Tests	⊿ Consults/Ref	errals			Customize View			
Procedures	<u></u>	IP Consult to Spiritual Health Serve	Ordered	1	Disable Order Information Hyperlink			
Respiratory			Ordered	- (08-Dec-2017 13:59 PST			
C Allied Health		Familiar Faces Shared Care Plan K.	Urdered		29-Nov-2017 14:25 PST, Routine, Reason for Con	nsult: high utilizer		
	⊿ Communicati	on Orders						
Communication Orders	×	MHA Form 15 Nomination of Near	Ordered		08-Dec-2017 14:21 PST	and Administration (
Non Categorized		Mild Earn 16 Natification to Nate	Ordered	-	Ordered secondary to MPIA Form 4 x2 (Involunta 09. Dec 2017 14:21 DCT	ary Admission)		
Medication History		Relative (Admission)	Ordered	- 6	Ordered secondary to MHA Form 4 x2 (Involunta	arv Admission)		
Medication History Spanshot		MHA Form 5 Consent for	Ordered	0	08-Dec-2017 14:21 PST			
Reconciliation History	_	Treatment - Involuntary		(Ordered secondary to MHA Form 4 x2 (Involunta	ary Admission)		
		MHA Form 16 Notification to Near	Ordered	0	06-Dec-2017 11:29 PST			
		Relative (Admission)		(Ordered secondary to MHA Form 4 x2 (Involunta	ary Admission)		
								10
Related Results	🛣 Details							
Formulan Datails								

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

P Ordering Physician
Order
Proposal
*Physician name
Plisvca, Rocco, MD
3 der Date/Time 07-Dec-2017 ↓ 1055 ↓ PST
*Communication type
Phone Verhal
No Cosignature Required
4 signature Required
Electronic
5 OK Cancel
OK Cancel

6. Review order and click Orders For Signature

38 | 108

PATIENT SCENARIO 4 - Orders



Details for Mental Health ED Nurse Following	
Details 📴 Order Comments	
+ 🕤 lh. VV	
Discontinue Date/Time: 14-Dec-2017	Discontinue Reason:
Orders For Cosignature Orders For Nurse Review	6 Orders For Signature

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

	Engenning Eluide	Discontine 28 New 2017 11:27 28 New 2017 11:20 DET	
	encourage manas	Discontinum Ed flot Edit Talerin Ed flot Edit Taler Stat	
T			
Do not			
box			
tails			

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

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

- 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

< 👻 者 Orders			💭 Full screen 👘 Print 🛛 🤤	0 minutes ago
🕂 Add 🎝 Document Medication by Hx Reconciliation 🕶 🚴 Check Inte	eractions		Reconciliation Status Meds History Admission	Discharge
Orders Medication List Document In Plan				
Order Medication List Document In Plan View View Catance for Similar to Management View of Medication Plan 2 Description Plan 2 2 Marce for Similar to Management View of Medication (Biomenet @ 2 2 2 Supported Plane Administry View of Medication (Biomenet @ 2 2 2 Supported Plane Administry View of Medication (Biomenet @ 2 2 2 Orders 3 3 3 Orders 6 4	4 10 0 0 + Add to Phase + ≧Comments Start: 04-Dec-34 (a) 1 - Component MH Prycharic Admission (Valdated) Unidated) Late updated on 40-Dec-2012 113587 bp. TestUser, Nurse-N 4 Admit Transfer (Voctaria) (b) 1 - Code Status (c) 2 -	212 11:34 PST Stop: None Status Does Status Ordered Ordered Ordered Ordered Ordered Ordered ordered ordered ordered ordered sin modules to prevent medication scopic (slipstick) with Microscopic, internal Medicine, Geriatric Medic		erapy: Atte
Related Results	A Details			
Formulary Details				
Variance Viewer	Orders For Cosignature Orders For Nurse Review Save as My Fav	onte	Orders F	for Signature
1				

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:

- Review the Layout of Interactive View and I&O (iView)
- 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

2

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.

CSTLEARNING, DEMOTHETA - 7000	2 CSTLEARNING, DEMOTHETA - 700008226 Opened by TestUser, Nurse									
Task Edit View Patient Chart Links Navigation Help										
🗄 🕼 CareCompass 🐘 Clinical Leader Organizer 🎍 Patient List 🚙 Multi-Patient Task List 🐘 Discharge Dashboard 📾 Staff Assignment 🎼 LearningLIVE _										
🔯 PACS 🔞 FormFast WFI 📄 📰 Tear Off 📲 Exit 👹 AdHoc 🞟 Medication Administration 💪 PM Conversation + 🔒 Communicate + 🗟 Medical Record Request 💠 Add + 📆 Documents 🍏 Scheduling Appointment Book 📾 Discent Reporting Portal 👃										
CSTLEARNING, DEMOTHETA	CSTLEARNING, DEMOTHETA 💌 ← List → Manecent ~ Name - 9									
CSTLEARNING, DEMOTHETA	DOB:01-Jan-1937	MRN:700008216	Code Status:	Process:	Location:	LGH 6E; 624; 04				
Allergies: Allergies Not Recorded	Age:80 years Gender:Male	Enc:7000000015058 PHN:9876469824	Dosing Wt:	Disease: Isolation:	Enc Type: Attending	Inpatient :Plisvca, Rocco, MD				
Menu 🕈	< 🔹 🔹 者 🛛 Patient Summa	ıry			(D) Full :	screen 🗇 Print 🤞	🎙 2 hours 43 minutes ago			
Patient Summary	A 100%	- • • 4								
Orders 🕂 Add	Handoff Tool	52 Summary	22 Assessment	23 Discharge	1 22					
Single Patient Task List 🛛 🥒			24							
MAR	Informal Team	Toformal Tarm Comm					2 =,			
Interactive View and I&O	Communication	Informal realif Comm	unication							
Results Review	Active Issues	Add new action		Add new comment						
Documentation 🕂 Add	Allergies (0)									
Medication Request	Vital Signs and Measurements	No actions documented		No comments documented						

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



PATIENT SCENARIO 5 - Interactive View and I&O

CSTLEARNING, DEMOTHETA - 7000	08216 Opened by TestUser, Nurse					
Task Edit View Patient Chart	Links Options Documentation Orders	Help				
👫 CareCompass 👫 Clinical Leader O	Irganizer 👍 Patient List 🚨 Multi-Patient Task	List 👫 Discharge Dashboar	d 🔐 Staff Assignment 👫 L	earningLIVE _		
😋 PACS 🕤 FormFast WFI 🚏 🏋 Te	ar Off 🚽 Exit 🌇 AdHoc 🎟 Medication Adm	inistration 🔒 PM Conversal	tion + 🔓 Communicate +	Medical Record Request	• Add • 📻 Documents 🛗 Schee	duling Appointment Book 📾 Discern Reporting Portal
CSTI FARNING, DEMOTHETA		-				← List → 🏻 🌤 Recent
CSTLEADNING DEMOTHETA	DOB:01-Jap-1937	MRN:700008216	Code Status:		Process:	Location:LGH 6F: 624: 04
CSTELAKINING, DEMOTHETA	Age:80 years	Enc:7000000015058			Disease:	Enc Type:Inpatient
Allergies: penicillin, Tape	Gender:Male	PHN:9876469824	Dosing Wt:		Isolation:	Attending:Plisvca, Rocco, M
Menu 7	< > - 👘 Interactive View and I8	kO				(□) Full screen (
Patient Summary						
Orders + Add		1				
Single Datient Tack Lict	🗙 Adult Quick View				Last 24 Hours	
	VITAL SIGNS					
MAR	Modified Early Warning System	Find Iter	n 👻 🔝 Critical	📰 High 🔄 Low 🔄 Abn	ormal 🔄 Unauth 📰 Flag	And Or
Interactive View and I&O	Pain Modalities	Result		Comments Rag Da	te Performed	By
Results Review	IV Drips					·
Documentation 🕂 Add	Insulin Infusion	1 1		20-Nov	-2017	
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medication nequest	Mental Status/Cognition	2 VIIALS	IGNS ature Avillani	DeaC	_	
Histories	Sedation Scales	Temper	ature Temporal Artery	DegC		
Allergies 🕂 Add	Provider Notification	Temper	ature Oral	DegC		
Diagnoses and Problems	Activities of Daily Living	Apical F	leart Rate	bpm		
-	Measurements	Periphe	ral Pulse Rate	bpm		
	Glucose Blood Point of Care	SBP/DB	P Cuff	mmHa		
CareConnect	Individual Observation Record	Cuff Lo	cation			
Clinical Research	Comfort Measures Transfer/Transport	🔁 💷 Mean A	rterial Pressure, Cuff	mmHg		
Form Browser	Shift Report/Handoff	Blood	Pressure Method	mmbla		
County Chool		d Oxy	renation Pressure, Curr	mmrig		
Growth Chart		Res	piratory Rate	br/min		
Immunizations		Mea	sured O2% (FIO2)			
Lines/Tubes/Drains Summary		Oxy	gen Activity			
MAR Summary	X Adult Systems Assessment	Oxy Oxy	gen Inerapy gen Flow Pate	L/min		
Mandianation Line alle Autor	Adult Lines - Devices	Skin	/Nare Check			
Medication List - Add	Adult Education	SpC	2	%		
Patient Information	Slood Product Administration	SpC	2 Site			
Reference	Tintake And Output	4 Modifie	ed Early Warning System			
	X Advanced Graphing	⊿ Tem	perature			
	Kestraint and Seclusion	Tem	perature Axillary	DegC		
	Contract Sedation	Tem	perature Temporal Artery	DegC		
	X Adult Critical Care Lines - Devices	Tem	perature Oral	Degic		
	X Adult Critical Care Quick View	4 Hea	rt Rate			
	Adult Critical Care Systems Assessment	2 Apie	al Heart Rate	bpm		
	🗙 Dialysis Treatment Management	Peri Peri	pheral Pulse Rate	bpm	4	

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



PATIENT SCENARIO 5 - Interactive View and I&O

CSTLEARNING, DEMOTHETA - 700008216 Opened by	/ TestUser. Nurse									
Task Edit View Patient Chart Links Ontion	as Documentation Orders Help									
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CSTLEARNING, DEMOTHETA 🛛 🛛										
CSTLEARNING, DEMOTHETA	DOB:01-Jan-1937 MRN:700008216		Process:Falls Risk							
	Age:80 years Enc:700000015058		Disease:							
Allergies: penicillin, Tape	Gender:Male PHN:9876469824	Dosing Wt:	Isolation:							
Menu 🕂 🗸	 Interactive View and I&O 									
Patient Summary	🖃 📾 🖓 🖌 (<mark>4</mark> 📄 📰 📾 ×									
Orders 🕂 Add										
Single Patient Task List 💊	Adult Quick View		Last 24 Hours							
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Interactive View and I&O	PAIN ASSESSMENT Pain Medalitics	Barut	Commente Bag Date Performed By							
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	Heparin Infusion	N 🗟 🗗	後 09:37 PST 2							
Medication Request	Apnea/Bradycardia Episodes Mental Status/Cognition	⊿ VITAL SIGNS								
Histories	Sedation Scales	Temperature Axillary	DegC							
Allergies 📥 Add	Provider Notification	Temperature Temporal Artery	Dege							
	Environmental Safety Management	Anical Heart Pate	bon							
Diagnoses and Problems	Activities of Daily Living	Peripheral Pulse Rate	bpni 91							
	Measurements	Heart Rate Monitored	bpn							
CareConnect	Glucose blood Point of Care	SBP/DBP Cuff	mmHe 140/90							
	Comfort Measures	Cuff Location								
Clinical Research	Transfer/Transport	Mean Arterial Pressure, Cuff	mmHe 107							
Form Browser	Shift Report/Handoff	Blood Pressure Method	mmHe							
Growth Chart		⊿ Oxygenation								
		Respiratory Rate	br/mi 16							
Immunizations		Measured O2% (FIO2)								
Lines/Tubes/Drains Summary		Oxygen Activity Oxygen Therapy	Nasal cann							
MAR Summary		Oxygen Flow Rate	L/min							
Medication List 🕂 Add	Adult Systems Assessment	Skin/Nare Check								
	Adult Lines - Devices	SpO2	³ 99							
Patient Information	Adult Education	SpO2 Site	Hand 3							
Reference	Blood Product Administration	A Modified Farly Warning System								

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.

CSTLEARNING, DEMOTHETA - 7000	08216 Opened by TestUser, Nurse							
Task Edit View Patient Chart	Links Options Documentation Orders Hel	lp						
🗄 🎬 CareCompass 📲 Clinical Leader C	Organizer 🛔 Patient List 🚨 Multi-Patient Task List	🎬 Discharge Dashboard 🛛 🎎 S	taff Assignment 🏭 Learn	ingLIVE 🝦				
🖸 🔍 PACS 🔍 FormFast WFI 🖉 😨 To	ear Off 📲 Exit Mathec 💵 Medication Administra	ation 🔒 PM Conversation 👻	🕞 Communicate 👻 👸 N	ledical Record Request	🕂 Add 👻 📻 Docum	ents 📋 Scheduling App	ointment Book 🗃 Discem P	eporting Portal
CSTLEARNING, DEMOTHETA	V 🗵							🔶 List 🔿 🛍 Recent -
CSTLEARNING, DEMOTHET	DOB:01-Jan-1937	MRN:700008216	Code Status:		Proc	ess:Falls Risk		Location:LGH 6E; 624; 04
	Age:80 years	Enc:700000015058			Dise	ase:		Enc Type:Inpatient
Allergies: peniciliin, Tape	Gender:Male	PHIN:9876469824	Dosing wt:		15018	tion:		Attending:Plisvca, Rocco, MD
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Deserved at the second se	Insulin Infusion							
Documentation 🕂 Add	Heparin Infusion	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			21-Nov-2017			
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Histories	Sedation Scales	Temperat	ure Axillary	DegC				
Allergies 🕂 Add	Provider Notification	Temperat	ure Temporal Artery	DegC				
Discourse of Dashland	Environmental Safety Management	Temperat	ure Oral	DegC	36.9	_		
Diagnoses and Problems	Activities of Daily Living	Apical He	art Kate L Duke Date	bpm		_		
	Gucose Blood Point of Care	Heart Bat	e Monitored	bpm	91			
CareConnect	Individual Observation Record	SBP/DBP	Cuff	mmHg	140/9)		
CT : 10 1	Comfort Measures	Cuff Loca	tion					
Clinical Research	Transfer/Transport	💷 Mean Art	erial Pressure, Cuff	mmHg	107			
Form Browser	Shift Report/Handoff	Blood Pre	ssure Method	and be		_		
Growth Chart		4 Oxyo	nation					
Immunizations		Respir	atory Rate	br/min	16			
		Measu	ared O2% (FIO2)					
Lines/Tubes/Drains Summary		Oxyge	n Activity			_		
MAR Summary		Oxyge	n Therapy		Nasal car	n		
Medication List 📥 Add		Oxyge Skip/2	n riow kate		3	-		
- Aud		SpO2	are eneck	%	99			
Patient Information	Adult Systems Assessment	SpO2	Site		Hand			
Reference	Adult Lines - Devices	SpO2	Site Change					

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

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

1



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

P CSTLEARNING, DEMOTHETA - 70000	3216 Opened by TestUser, Nurse						
Task Edit View Patient Chart	Links Options Documentation Orde	ers Help					
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CSTLEARNING, DEMOTHETA							← Lat → 🍋
CSTLEARNING, DEMOTHETA	DO8:01-Jan-1937	MRN:700008216			Process:Falls F		Location:LGH 6E;
Allegales essiville Tree	Age80 years	Enc/00000015058			Disease		Enc TypeInpatient
Allergies: penicilin, Tape	GendertMale	PPHY2670409624	Doving we		Donation:		Attending Prisvia, H
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Patient Summary		*					
Orders 🕂 Add							
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man	PAIN ASSESSMENT	pind It	• E Critical	High Low Abox	unaut?	Flag	C And Or
Interactive View and I&O	Pain Modalities	Result		Comments Rag Dat		Performed By	
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Lange of the second s	Mental Status/Cognition	Tempi	erature Axillary	DegC	_		
Protones	Sedation Scales	Temp	erature Temporal Artery	Deac			
Allergies 🛨 Add	Environmental Safety Management	Tempe	erature Oral	DegC	36.9	37.5	
Diagnoses and Problems	Activities of Daily Living	Perior	peral Pulse Rate	bom	91		
	Measurements	Heart	Rate Monitored	bpm			
CareConnect	Individual Observation Record	58P/0	8P Cuff	mmHg	140/90		
Clinical Departure	Comfort Measures	Cuff L	Arterial Pressure Cuff	mmHa	107		
Chinical Research	Transfer/Transport	Blood	Pressure Method		107		
Form Browser	Shit Hepot/Handoff	Cereb	ral Perfusion Pressure, Cuff	mmHg			4
		1.04	nonenation				

Key Learning Points

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

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

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...

1



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

CSTLEARNING, DEMOTHETA - 7000	08216 Opened by TestUser, Nurse						
Task Edit View Patient Chart	Links Options Documentation Order	s Help					
: WC CareCompass WC Clinical Leader (Proanizer & Patient List 🔐 Multi-Patient Ta	sk List K Discharge Dashboarg	d 😂 Staff Assignment 📧	Learning IVE			
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CSTLEARNING, DEMOTHET	V 🗷						← List → 🎬 F
CSTLEARNING, DEMOTHET	DOB:01-Jan-1937						Location:LGH 6E; 62
	Age:80 years	Enc:700000015058					Enc Type:Inpatient
Allergies: penicillin, Tape	Gender:Male	PHN:9876469824	Dosing Wt:		Isolation:		Attending:Plisvca, Ro
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Interactive View and I&O	Pain Modelities	Result		Comments Flag	Date	Performed	l By
Results Review	IV Drips				-		· · · · · · · · · · · · · · · · · · ·
Documentation 📥 Add	Insulin Infusion	See. 387			22-Nov-2017		
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	Transfer/Transport	Blood P	Pressure Method		107		
Form Browser	Shift nepot/nandoff	Cerebra	I Perfusion Pressure, Cuff	mmHg			
Growth Chart		⊿ Oxy	genation				



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

CSTLEARNING, DEMOTHETA - 700008216 Open	ned by TestUser, Nurse			
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	Vintake And Output	⊿ AVPU		
	Advanced Graphing	AVPO		
	Restraint and Seclusion	A MEWS Total Score		
	av Procedural Sedation	MEWS Total Score		
	Ambulatan Jafuaian Cantan Manitarina	⊿ Situational Awareness Factors	\$	



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

P. CSTLEARNING, DEMOTHETA - 700008216 Op	ened by TestUser, Nurse						7
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Form Browser	Shift Report/Handoff	Cereb	al Perfusion Pressure, Cutt	manifi	19 C		
Growth Chart.		4 Or	rpenation				

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

CSTLEARNING, DEMOTHETA - 700008216 Opened by TestUser, Nurse							
Task Edit View Patient Chart	Links Options Documentation Orders Help						
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Allergies: penicillin, Tape	Gender:Male PHN:9	876469824 Dosing Wt:	Isolation:	View Result Details Atter	nding:Pl		
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CareConnect	Individual Observation Record	SBP/DBP Cuff	mmHg 140/90	View Interpretation			
Careconnect	Comfort Measures	Cuff Location		view interpretation			
Clinical Research	Transfer/Transport	Mean Arterial Pressure, Cuff	mmHg 107	Reinterpret			
Form Browser	Shift Report/Handoff	Blood Pressure Method	mmHa	Create Admin Note			
Growth Chart		∠ Oxygenation	19	Chart Details			
Glowin Chart		Respiratory Rate	br/min 16	Not Done			
Immunizations		Measured O2% (FIO2)					
Lines/Tubes/Drains Summary		Oxygen Activity		Flag			
MAR Summan	X Adult Systems Assessment	Oxygen Therapy	Nasal cani	Flag with Comment			
MAR Summary	Adult Lines - Devices	Oxygen Plow Kate	5	Unflag			
Medication List 🛛 🕂 Add	Adult Education	SpO2	%	Unflag with Comment			
Patient Information	Blood Product Administration	SpO2 Site	Hand				
Defense er	Vintake And Output	SpO2 Site Change	1				
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	& Restraint and Seclusion	Temperature Axillary	DegC				
	av Dracadural Cadatian	Temperature Temporal Arten	DeaCl				



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

Comment - CSTLEARNING, DEMOBETA - 700008215	×
SpO2 Site: Hand	
Comment	
Right hand	
	OK Cancel 3

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

1



Activity 6.1 – Opening and Documenting on PowerForms

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





PATIENT SCENARIO 6 - PowerForm

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 ^{MAdHoc} 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** \checkmark to sign and then refresh the screen

PATIENT SCENARIO 6 - PowerForm



Medication #7 Medication #8 Medication #9 Medication #10		(Alakas		
Medication #9 Medication #10		S MILITIA 2		
Medication #9		<alpha></alpha>		
Medication #10				
Fredication #10		<alpha></alpha>		
Personal Devices				
	Description	Number of Items	Location	
Assistive Devices			<alpha></alpha>	
Cane			<alpha></alpha>	
Contact Lenses				
Dentures, Lower		P Add Result Comment		
Denture Partial Plate		Description		
Dentures, Upper		Cell share		
Glasses		Cell phone		
Hair Piece, Wig		Germant		
Hearing Aid, Left		Comment		
Hearing Aid, Right				
Orthodontic Retainer				
Orthotics				
Prosthesis				
Walker				
Wheelchair				
Other				
Other Valuables/Be	longings	4	ОК	Ci
	Description	Number or items	LUCAUUN	
Clothing			<alpha></alpha>	
Jewelry			<alpha></alpha>	
-			<alpha></alpha>	
Monetary Items				

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 \checkmark (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

🗄 🎬 CareCompass 📲 Sa	fety and Attendan	ce 👫 Clinical Leader	Organizer 🐇 Patient List Perioperati	ve Tracking 👫 Therapeutic Note	Schedule 😂 Staff Assignment	🌇 LearningLIVE 🝦		
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😧 Patient Health Education Materials 🔃 Policies and Guidelines 🔃 UpToDate 📜 🖾 Tear Off 📲 Exit 🧌 AdHoc. 🎟 Medication Administration 🔒 PM Conversation - 🔄 Medical Record Request 🕇 Add - 🐻 Documents 🚇 Discern Reporting Portal 👃								
CSTLEARNING, DE	MODELTA	×						
CSTLEARNING, DE	MODELTA		DOB:01-Jan-1937	MRN:700008217	Code Status:Attempt CPR, I	Full Code	Process:Falls Risk	
Allergies: Pollen			Age:80 years Gender:Male	Enc:/00000015060 PHN:9876469817	Dosing Wt:75 kg		Disease: Isolation:	
Menu		< > - fr	Form Browser					
Mental Health Summary					Friday, Novemb	per 17. 2017 PST- Monday, Decembe	er 04. 2017 PST(Admission - Current)	
Orders	🖶 Add				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,		
Single Patient Task List		Sort by : Date	•					
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Results Review		<mark>13:55 P</mark>	ST Valuables/Belongings (Auth (Verifie	d)) - 2 Nurse Mill				
Documentation	🛨 Add	15:57 P	ST ED Triage - Adult (Auth (Verified)) -	TestUser, Modify	3			
Medication Request		🖶 🗁 Sunday, 26	5-November-2017 PST	Unchart				
Histories		- 7 Tuesday, 2	1-November-2017 PST	a)) - Festi History				
Allergies	🛨 Add	- 🖪 12:54 P	ST Medication Administration Follow	Jp (Auth (Change Date/Time	2			
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CareConnect								
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Growth Chart								
Immunizations								
Medication List	🖶 Add							
Patient Information								
Reference								

- 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.



PATIENT SCENARIO 6 - PowerForm

: 04-Dec-2017	 1355 PST 			By: TestUser, f
ala Predication wo		vehice.		
Medication #7		<alpha></alpha>		
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Medication #9		<alpha></alpha>		
Medication #10		<alpha></alpha>		
Personal Devic	es			
	Description	Number of Items	Location	
Assistive Device	21		<alpha></alpha>	
Cane			<alpha></alpha>	
Contact Lenses	P Add Result Comme	nt		
Dentures, Lower				
Denture Partial F	Plate Description			
Dentures, Upper	Cell phone			
Glasses				
Hair Piece, Wig	Comment			
Hearing Aid, Lef	t iPhone with a blue ca	ise		
Hearing Aid, Rig	ht			
Orthodontic Reta	ainer			
Orthotics				
Prosthesis				
Walker				
Wheelchair				
Other				
Other Valuable	s/Belongin 5	ОК	Cancel	
	Description	Number of Items	Location	
Clothing			<alpha></alpha>	
Jewelry			<alpha></alpha>	
			Allel as	

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

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

1



- 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:

- Create a Dynamic Document
 - 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

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 S 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

1

The Edit View Patient Chart Links Documentation Help							
🗄 🎬 CareCompass 👫 Safety and Attendance 👔	Clinical Leader Organizer 🎍 Patient List Perioperative	e Tracking 🏗 Therapeutic Note 🛅	Schedule 🔉 Staff Ass	ignment 🌇 LearningLIVE			
CareConnect 🔃 PHSA PACS 🕄 VCH and F	PHC PACS 💐 MUSE 💐 FormFast WFI 🝦						
🛿 😋 Patient Health Education Materials 🔇 Polici	ies and Guidelines 🜊 UpToDate 🝦 🗄 🛣 Tear Off 🖼 E	it 🎽 AdHoc IIII Medication Admir	nistration 🔒 PM Com	versation 👻 📄 Medical Rec	ord Request 🔸 Add 👻 🖪 Documents 🗃 Discern Reporting Portal 🖕		
CSTLEARNING, DEMODELTA						🗲 List 🔿 👫 Recent 🔹 Name 🔹 🔍	
CSTLEARNING, DEMODELTA	DO8:01-Jan-1937	MRN:700008217	Code Status:		Process:Falls Risk	Location:LGH MIU; M004; 01	
Allergies: Pollen	Age:80 years Gender:Male	Enc:/00000015060 PHN:9876469817	Dosina Wt:75 ka		Disease: Isolation:	Enc TypesInpatient AttendincieLearn. Physician-General Medicine1. MD	
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Orders 🕂 Add	int		Citer (Directer)	~		4.6	
Single Patient Task List							
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Interactive View and I&O	Service Date/Time T Subject	Time	2	(
Results Review	26-Nov-2017 09:48:00 P Valuables/Belongings	Valuables/Belongings - T	ext L		* Final Report *		
Documentation + Add	23-Nov-2017 12:10:00 P Test note for care plan	Interdisciplinary Care Plan	n L		Basic Admission Information Entered On: 20-Nov-2017	7 16:11 PST	
Medication Request	22-Nov-2017 09:04:00 P Discharge Summary 21-Nov-2017 12:54:00 P. Medication Administration Fi	Patient Discharge Summa ollow Un Medication Administratio	ary L In Follow Un-Text		Performed On: 20-Nov-2017 16:10 PST by TestUs	er, Nurse	
Histories	20-Nov-2017 16:10:00 P Basic Admission Information	Basic Admission Informat	tion Adult - Te 2				
Allergies 🕂 Add			_				
Diagnoses and Problems				Allergies		(As Of 20-Nov-2017 16:11:21 PST)	
				Allergies (Active)	Estimated Operational University of Country days, Tariat		
CareConnect				No Known Allergies	Nurse; Reaction Status: Active ; Category: Drug ; Subst	tance:	
Clinical Research					No Known Allergies; <i>Type:</i> Allergy; <i>Updated By:</i> TestU Nurse: <i>Reviewed Date</i> : 20-Nov-2017 15:42 PST	lser, ß	
Growth Chart							
Impunizations				Weight			
Medication List 🕂 Add				Weight Dosing : 75 kg		TestUser, Nurse - 20-Nov-2017 16:10 PST	
Patient Information				Result type:	Basic Admission Information Adult - Text		
Reference				Result date:	Monday, 20-November-2017 16:10 PST		
				Result title:	Basic Admission Information		
				Performed by: Verified by:	TestUser, Nurse on Monday, 20-November-2017 16:10 PST TestUser, Nurse on Monday, 20-November-2017 16:10 PST		
				Encounter info:	7000000015060, LGH HOpe Centre, Inpatient, 17-Nov-2017 -		
						3	
	•		Þ	L			
	<< Previous Next>>						



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

2

3



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



PATIENT SCENARIO 7 – Dynamic Documentation



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

P Sign/Submit Note			- • •
*Type: Nursing Narrative Note *Author: TestUser, Nurse-MH © Forward Options Create provider letter	Note Type List Filter: Position Title: Monring Progress Note	• • • • • • • • • • • • • • • • • • •	PST
Favorites Recent Relationships Q Provid	ler Name		
Contacts Default Name	Recipients	Comment	Sign Review/CC
		[Sign 2 ncel

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:

Review Patient Results

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.

You will complete the following activity:

Review results using Results Review



Activity 8.1 – Using Results Review

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

CSTLEARNING, DEMOTHET						
CSTLEARNING, DEMOTHET	DOB:01-Jan- Age:80 year:	-1937 MRN:700008216 s Enc:700000015058				Process:Difficult Intubation/Airway Disease:
Allergies: penicillin, Tape	Gender:Mal	e PHN:9876469824	Dosing Wt:			Isolation:
Menu	😃 < 🔸 🔸 者 Results Revi	iew .				
Mental Health Summary	-ite. 20					
Orders 🕂 Add						
Single Patient Task List	Recent Results Advance Care F	Planning Lab - Recent Lab - Extended	Pathology Micro Cult	tures Transfusion Diagnosti	ics Vitals - Recent	Vitals - Extended Mental Health
MAR	Flowsheet Ouick View		View	Table Group	○ List	
MAR Summary	Thowsheet Quick free		The second se	· · · · · · · · · · · · · · · · · · ·	U List	
Interactive View and IRIO	 ▲ 		Tuesda	y, 12-December-2017 15:34	PST - Saturday, 16-Dec	ember-2017 15:34 PST (Clinical Range:
Results Review	Navigator					
Documentation 🛛 🕈 Add	VITAL SIGNS	Show more results				
Medication Request	SBP/DBP Cuff	Quick View	14-Dec-2017 11:10 PST	13-Dec-2017 11:28 PST		
Histories	Oxygenation	VITAL SIGNS	37 DegC	38 DegC		
Allergies 🕂 Add	Basic Oxygen Information	Peripheral Pulse Rate	84 bpm	55 Brige		
Diagnoses and Problems	PAIN ASSESSMENT	Systolic Blood Pressure	132 mmHa	120 mmHg		
		Diastolic Blood Pressure	87 mmHg	80 mmHg		
		Mean Arterial Pressure, Cuff		93 mmHg		
CareConnect		Oxygenation		22 hadmin (LD		
Clinical Research		Measured Q2% (FIQ2)		40		
Form Browser		SpO2		92 %		
Growth Chart						
Immunizations						
Medication List 🕂 Add	3				4	

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

Diagnostic Radiology					S
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 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



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

PATIENT SCENARIO 9 - Allergies

1



Activity 9.1 – Add an Allergy

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 🕇

CSTLEARNING, DEMOTHETA - 7000	06236 Opened by	TextUser, Nurse				1 mil							0 0 0
Task Edit View Patient Chart	Links Allergy	Help											
The CareCompany It's Clinical Leader C	Deganizer 🎍 Patie	et List 🚔 Multi-Patient Ta	ek List 🐒 Discharge Dashboar	al Staff Ass	gernert 1	LearningLNE	. · · ·						
QPACS QPomPatt WEL . ST	ear OF State	Adrice Milledeation A	Aministration 🔒 PM Conversa	nen + -LCen	municity	• J Medical II	cont Reso	nt 🕈 Add -	EDocuments #	Scheduling Appointment Bo	ok 🖨 Docern Reporting Portal		
CSTLEARNING, DEMOTHETA		-		0,000							- List -> Calleo	ent of Married	- 9
CSTLEARNING, DEMOTHETA		DCIE01-Jan-3937 MRPe200008236 Code Status Age80 years Enc/200000013058						Proc Dise	Location:LGH 6E: 624: 04 Enc Type:signifient				
Allergies: Allergies Not Recorded		GenderMale	PH/N29876469824	Dosing W				biolu	Rox.		Attending Pisrica, Rocco	(MD	
Menu #	< - A	Allergies									(C) Fell screen	Ohiel	 O minutes apr
Patient Summary Ordens & Add Single Patient Tesk List	Mark All as R	eviewed	llargies Q70s Known Me	fication Allergi		everse Allergy O	week	Display All					
MAR	1	E Automa	Patrone			Partners and and	Accession in	194-114		A	and the	Part Prints	induces.
Interactive View and 18:0 Results Review	~	penicillin	Drug	Mild	Rash	510818C501	Connects	Patient	Active	20-Nov-2017 13:37 PST	TestUser, Nurse	ER. ONER	20-Nov-2017 T
Documentation + Add Medication Request													
Histories													
Allergies + Add	-												l.

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

CSTLEARNING, DEMOTHETA - 7000	08216 Opened by	TestUser, Nurse											- B -X-
Task Edit View Patient Chart	Links Allergy	Help											
🗄 🎬 CareCompass 📲 Clinical Leader (Organizer 👍 Patie	ent List 🔉 Multi-Patient Task	List 🜇 Discharge Dashboa	ard 🞎 Staff /	Assignment	👫 LearningLIVI	E 📮						
🕴 😋 PACS 😋 FormFast WFI 🝦 🗄 🎛 T	ear Off 📲 Exit 🍟	AdHoc IIIIIMedication Adm	inistration 🔒 PM Convers	ation 👻 🕞	Communicate	👻 🖻 Medical	Record Requi	est 🕂 Add	- 🕞 Documents	Scheduling Appointment Bo	ok 🝙 Discern Reporting Port	al 🝦	
CSTLEARNING, DEMOTHET											🔶 List 🛶 🌾 R	ecent - Nar	ne 🗸
CSTLEARNING, DEMOTHET	A	DOB:01-Jan-1937	MRN:700008216			Pro	ocess:		Location:LGH 6E; 62	4; 04			
Allergies: Allergies Not Recorded		Age:80 years Gender:Male	Enc:7000000015058 PHN:9876469824	Docing With				Dis	ease: lation:		Enc Type:Inpatient	ro MD	
Menu 4	< > • 4	Allergies									[D] Full screet	n mPrint	₽ 20 minutes ago
Patient Summary												_	
Orders 🕂 Add	D/A	Substance	Category	Severity	Reactions	Interaction	Comments	Source	Reaction Status	Reviewed	Reviewed By	Est. Onset	Updated By
Single Patient Task List	~	penicillin	Drug	Mild	Rash			Patient	Active	20-Nov-2017 13:43 PST	TestUser, Nurse		20-Nov-2017 T
MAR													
Interactive View and I&O													
Results Review													
Documentation 🛛 🕂 Add													
Medication Request													
Histories	Type Aller	19/ 🗸 🖌 adver	se reaction to a drug or substa	nce which is d	ue to an immun	iological response	a.						
Allergies 🕂 Add	Printman M												
Diagnoses and Problems	tape	A Fee levi											Add Comment
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CareConnect	Heaction(s):		Severity	into source		Comments							
Clinical Research			<not entered=""></not>	<not entere<="" td=""><td>• <0</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>*</td></not>	• <0								*
Form Browser			At: <not entered=""></not>	Onset (n	ot entered>								
Growth Chart			Years 🔻	**,***,****	÷ -								*
Immunizations			Recorded on behalf of	*Category		Status	Reaso	in:					
Lines/Tubes/Drains Summary					-	Active	-	~					
MAR Summary											ОК	K & Add New	Cancel
Detication List Add													
Patienciniormation	📬 Up 🛗	Home 👷 Favorites 🔹	Difference Folder: Faw	orites									
Reference	System Track	ked											
< III >				-	-	-	-	-	-			-	



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

👂 CSTLEARNING, DEMOTHETA - 70008216 Opened by Testiker, Nurse 🕞 🐼														
Task Edit View Patient Chart Links Allergy Help														
🗄 🎬 CareCompass 🎬 Clinical Leader Organizer 👷 Patient List 🏙 Multi-Patient Task List 🎬 Discharge Dashboard 🏫 Staff Assignment 🎬 LearningLIVE 💡														
🛿 🔍 PACS 🔃 FormFast WFI 📙 📰 Tear Off 🤹 Ent 🎬 AdHoc 💷 Medication Administration 🆀 PM Conversation 🔸 😭 Medical Record Request 🕂 Add 🔹 📆 Documents 🏥 Scheduling Appointment Book 🖨 Discens Reporting Portal 🚽														
CSTLEARNING, DEMOTHETA 🖪								← List → അRecent + Name - २						
CSTLEARNING, DEM	IOTHETA		DOB:01-Jan-1937	MRN:700008216					Pro			Location:LGH 6E; 624; 04		
Allergies: Allergies Not I	Recorded		Age:80 years Gender:Male	PHN:9876469824	Dosino) Wt:			Iso	ease: lation:		Attending:Plisvca, Roc	co, MD	
Menu		く > - 合	Allergies									[II] Full screer	n 💼 Print	real 37 minutes ago
Patient Summary														
Orders 🚽	Add	D/A	Substance	Category	Severity	Reactions	Interaction	Comments	Source	Reaction Status	Reviewed	Reviewed By	Est. Onset	Updated By
Single Patient Task List		~	penicillin	Drug	Mild	Rash			Patient	Active	20-Nov-2017 13:43 PST	TestUser, Nurse		20-Nov-2017 T
MAR														
Interactive View and I&O														
Results Review														
Documentation •	Add													
Medication Request														
Histories		Type Allerg	₩ 👻 An adver	se reaction to a drug or substa	nce which is	due to an immuno	logical response	e.						
Allergies	Add	*Substance												
Diagnoses and Problems		Tape	Free text	No allergy checking is avai	lable for non-	Multum allergies.								Add Comment
CareConnect		Reaction(s):		*Severity	Info source	,	C							
Clinical Research			Add Free Text	Mild 🖵	Patient	-	Lomments							
Form Browser				At <not entere<="" td=""><td>Onset <</td><td>not entered</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td><u>^</u></td></not>	Onset <	not entered								<u>^</u>
Growth Chart				Year 4	******		2							-
Immunizations				Recorded on behalf of	*Categor	y	Status	Reaso	n:					
Lines/Tubes/Drains Summa	ry				Other	.	Active	.	Ŧ					
MAR Summary						6								
Medication List	Add					б						ОКО	K & Add New	Cancel
Patient Information		🔊 Un 🖓 🗄	Home 🔶 Favorites 🔹	Eolders Folder Fav.	nites							1		
Reference		Con Sustan Tatal	ad		54405									
<u>د (</u> ۳.		Jystem Irack	ed											



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



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

(MAR)

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

1

PATIENT SCENARIO 10 - Medication Administration Record (MAR)



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

CLINICAL + SYSTEMS TRANSFORMATION

TRANSFORMATIONAL

Menu 7	< > 🕘 者 MAR					
Mental Health Summary	₩660 🗎					
Orders 🕂 Add						
Single Patient Tack List				Tu	esday, 2018-Jan	uary-16 14:33 PS
mar 1	Show All Rate Change Docu	Medications	2018-Jan-17 17:00 PST	2018-Jan-17 14:33 PST	2018-Jan-17 08:00 PST	2018-Jan-17 02:00 PST
MAR Summary	Time View	Scheduled				20
Interactive View and I&O	Scheduled	citalopram			20 mg Not previously	Not previously
Results Review	Unscheduled	20 mg, PO, qdaily, drug form: tab, start: 12-Jan-2018 13:35 PST			given	given
Documentation 🕂 Add	PRN	citalopram	450		450	450
Medication Request	Continuous Infusions	ាទាប់ថ ranitidine	Not previously		Not previously	Not previously
Histories	Verture	150 mg, PO, BID with food, drug form: tab, start: 12-Jan-2018 17:00 PST	given		given	given
Allergies 🕂 Add	Discontinued Scheduled	ranitidine				
Diagnoses and Problems	Discontinued Unscheduled	PRN 66 PRN		1 mg		
	Discontinued PRN	HYDROmorphone (HYDROmorphone PRN r		Not previously		
CareConnect	Discontinued Continuous Infus	drug form: tab, start: 2017-Dec-28 11:40 PST DILAUDID FOUTV		giren.		
Clinical Research		HYDROmorphone				
Form Provisor		Respiratory Rate		200 mg		
		ibuprofen		Not previously		
Slowin Chart		tab, start: 12-Jan-2018 13:35 PST		given		
Immunizations		ibuprofen				
Medication List 🕂 Add		Temperature Axillary Temperature Oral				

- 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**





PATIENT SCENARIO 10 - Medication Administration Record (MAR)

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

🗱 All Orders with Active Tasks in Ter 🗸 🔤 🔹 Tuesday, 28: November-2017 12:21 PST (Clinical Range) 7											7	$ \rightarrow $		
Show All Rate Change Docu	Medications	30-Nov-2017 10:00 PST	30-Nov-2017 06:00 PST	30-Nov-2017 02:00 PST	29-Nov-2017 22:00 PST	29-Nov-2017 18:00 PST	29-Nov-2017 14:00 PST	29-Nov-2017 12:26 PST	29-Nov-2017 12:22 PST	29-Nov-2017 10:00 PST	28-Nov-2017 22:00 PST	8		^
Time View	Scheduled											_		
👿 Scheduled	acetaminophen (TYLENOL)	640 mg Last given:	640 mg Last given:	640 mg Last given:	640 mg Last given:	640 mg Last given:	640 mg Last given:							
Unscheduled	640 mg, PO, q4h, drug form: oral liq, start: 29-Nov-2017 14:00 PST	22-Nov-2017 12:41 PST	22-Nov-2017 12:41 PST	22-Nov-2017 12:41 PST	22-Nov-2017 12:41 PST	22-Nov-2017 22-Nov-2017 12:41 PST 12:41 PST								
PRN PRN	Maximum acetaminophen 4 g/24 h from all sources													
👿 Continuous Infusions	acetaminophen Temperature Axillary													
👿 Future	Temperature Oral													
Discontinued Scheduled	The second score (0-10)	1,000 mg			1,000 mg				1,000 mg					
Discontinued Unscheduled	vancomycin 1,000 mg, IV, g12h, start: 29-Nov-2017 12:22 PST	Last given: 22-Nov-2017			Last given: 22-Nov-2017				Last given: 22-Nov-2017					
Discontinued PRN	vancomycin	10:00 PST			10:00 PST				10:00 PST					
Discontinued Continuous Infus	PRN	1												
	PRN HYDROmorphone (DILAUDID PRN range dose) dose range: 0.5 to 1 mg, PO, q1h, PRN pain, drug form: oral lig start: 29-Nov-2017 12:24 PST	4 L						1 mg Not previously given						
	HYDROmorphone Respiratory Rate													
	Continuous Infusions			1	1	1								
	sodium chloride 0.9% (NS) continuous infusion 1.000 mL order rate: 75 mL/h, IV, drug form: bag, start: 29-Nov-2017 12:23 PST, bag volume (mL): 1,000	n chloride 0.9% (NS) continuous infusion 1.000 mL rate: 75 mJ/h, IV, drug form bag, start: 29-Nov-2017 FS) bag volume (mit 1.000												
	Administration Information sodium chloride 0.9%							9						

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
1

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PATIENT SCENARIO 10 - Medication Administration Record (MAR)

Activity 10.2 – Reschedule a Medication

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

**** 🕞					
📆 🔹		N	londay, 04-Dece	mber-2017 09:4	4 PST - W
Show All Rate Change Docu	Medications	06-Dec-2017 08:00 PST	05-Dec-2017 09:55 PST	05-Dec-2017 09:54 PST	
Time View	Scheduled		-		
☑ Scheduled	ेल citalopram	20 mg Not previously		20 mg Not previously	
🔽 Unscheduled	20 mg, PO, qdaily, drug form: tab, start:	given		given	
PRN	citalopram	1	Order Info		
Continuous Infusions	PRN		Task Info		
	PRN PRN	1	Chart Details.		
🔽 Future	acetaminophen		Quick Chart		
Discontinued Scheduled	start: 01-Dec-2017 14:51 PST		Quick chart		
Discontinued Unscheduled	Maximum acetaminophen 4 g/24 h from all s		Chart Done		
	acetaminophen		Chart Not Do	ne	
Discontinued PRN	Temperature Axillary		Unchart		
👿 Discontinued Continuous Infus	Numeric Pain Score (0-10)		Reschedule T	his Dose	2
	PRN PRN	í L			<u> </u>
	ibuprofen		Not previously		

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





PATIENT SCENARIO 10 - Medication Administration Record (MAR)

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

P Reschedule acetaminophen for CSTLEARNING, DEMOBETA
Currently scheduled date and time 24-Nov-2017 06:00
Rescheduled date and time 24-Nov-2017
Rescheduling reason
<none></none>
4 OK Cancel

Key Learning Points

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

PATIENT SCENARIO 10 - Medication Administration Record (MAR)



Activity 10.3 – Request a Medication via MAR

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



1

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

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)
- 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



PATIENT SCENARIO 11 - Medication Administration

Task Edit View Patient Chart Links Navigation Hel	lp		
🗄 🎬 CareCompass 📲 Safety and Attendance 📲 Clinical Leader Or	Organizer 🛔 Patient List Perioperative Tracking 🎬 Therapeutic Note	🎬 Schedule 🔉 Staff Assignment 腦 LearningLIVE 🖕	
CareConnect 🖏 PHSA PACS 🔃 VCH and PHC PACS 🖏 MU	JSE 🕄 FormFast WFI 🝦		
🕴 🕄 Patient Health Education Materials 🕄 Policies and Guidelines	😋 UpToDate 🖕 🗄 🏋 Tear Off 🚽 Exit 🦉 AdHoe 💷 Medication Ad	Iministration 🔒 🧻 nversation 👻 🛗 Medical Record Request 🕂 Add	🔹 🖻 Documents 🝙 Discern Reporting Portal 🭦
MH-Nurse, Vicky			
MH-Nurse, Vicky	DOB:1975-Jan-14 MRN:760000329		Process:
Allergies: Peanuts	Age:43 years Enc:760000000329 Gender:Fei		Disease:
Menu 🕈 🕻 🔪 🔺	Medication Re		<u> </u>
Mental Health Summary	B B 100% MH-Nurse, Vicky	MRN: 760000329 DOB: 1975-Jan-14	Loc: M007; 02
Orders + Add	Female	FIN#: 760000000329 Age: 43 years	** Allergies **
Single Patient Task List	equest		
MAR			
MAR Summary			
Interactive View and I&O			
Results Review 4 Plans (0)			
Documentation + Add			
Medication Request			
Histories	citalopram, 20 mg		
Allergies 🕂 Add			3
Diagnoses and Problems	Alt	Please scan the patient's wristband. rematively, select the patient profile manually by clicking the (Next) button
	anitidine, 150 mg		
CareConnect			
Clinical Research			
Form Browser	(0)		
Growth Chart / PRN (2)			
Immunizations Medications	• · · · · · · · · · · · · · · · · · · ·		
Medication List + Add HYDR	ROmorphone PRN		
Patient Information			
Reference		1 of 2	Net
	Ready to Scan		IVEX

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

Early/Late Reason
citalopram 20 mg, PO, drug form: tab, start: 05-Dec-2017 09:54 PST
Scheduled date/time : 05-Dec-2017 09:54:00 PST Performed date/time : 05-Dec-2017 11:59:00 PST
Please specify a reason why the medication is being documented late:
Standard dosing time First dose given Given before procedure/surgery Held for procedure Medication not available Nausea or vomiting No IV Accers
NPO Patient Condition Patient Request Cancel Patient unavailable 4
Provider consultation required Other :

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.

78 | 108



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

C)					
Ì	P Medication	Administration				
					Nurse Review	Last Refresh at 11:12 PST
	CSTLEAI Male	RNING, DEMODELTA	MRN: 700008217 FIN#: 700000015060	DOB: 01-Jan-1937 Age: 80 years		Loc: 620; 02 ** No Known Allergies **
			21-Nov-2017	09:57 PST - 21-Nov-2017 12:	27 PST	
		Scheduled 21-Nov-2017 11:09 PST 21-Nov-2017 11:11 PST	Mnemonic vancomycin acetaminophen	Details 1,000 mg, IV, start: 21-Nov-2 650 mg, PO, drug form: tab Maximum acctamingohom	Result 017 11:09 PST 5, start: 21 acetaminophen 650 mg, 4 a/24 h fr	, PO 🖕
		PRN	hydromorphone HYDROmorphone (HY	dose range: 0.5 to 1 mg, PC DILAUDID EQUIV), q4h, PRN <mark>HYDROmorphone 1 mg</mark> ,	, PO, pain,
	Ready to Scan			2 of 2		Back Sign

PATIENT SCENARIO 11 - Medication Administration



- 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

lose range: 0.5 to NLAUDID EQUIV	1 mg, PO,	q4h, PRN pain, o	arug form: t	ab, start: 2	1-Nov-2017	11:09 PST
Performed date	e / time :	21-Nov-2017	-	• 1129	Â	PST
*Perfor	med by :	TestUser, Nurse			4	
Witne	ssed by :				9	
medication not						
Respiratory Ra Acknowledge HYDROmorpho Niuent: Noute:	Respire Respire ne: 0.5	tory Rate No Re	• Site :	in previous Volume : ml	5 minutes	ml 5
Respiratory Rat Acknowledge HYDROmorpho Niuent: com *Route:	e: 0.5 Respira e: 0.5 PO pain	bolinin tony Rate. No Re mg	suit found i v Site : v	in previous Volume : ml	5 minutes	mi 5
Respiratory Ra Acknowledge HYDROmorpho Niluent: non- "Route: Reason: [Total Volume: [e> PO 0	bultisin tory Rate No Re mg	Site:	in previous Volume : ml	5 minutes 0	m 5
HYDROmorpho Nilvent : Reson : fotal Volume : 1000 PST	e= 12 Respira ne: 0.5 e> PO pain 0 21-Nov- 1100 P	bultum tory Rate No Re mg v Infused Over 2017 21-Nov-20 St 1200 PS	Site: Site: T 1300	in previous Volume : ml mi mi v-2017 2: PST	5 minutes	ml 5

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.



PATIENT SCENARIO 11 - Medication Administration

≺ > - 者 MAR									
1664 🗎									
311			Monday	. 04-December	-2017 09:44 PS	T - Wednesday.	06-December-2	2017 09:44 PST (Clinical Range)
						· · · · · · · · · · · · · · · · · · ·			
Show All Rate Change Docu	Medications	06-Dec-2017 08:00 PST	05-Dec-2017 17:00 PST	05-Dec-2017 14:32 PST	05-Dec-2017 14:30 PST	05-Dec-2017 13:35 PST	05-Dec-2017 13:32 PST	05-Dec-2017 13:30 PST	05-Dec-2017 12:15 PST
Time View	Scheduled								
Scheduled	ेत	20 mg							
Unscheduled	citalopram 20 mg, PO, qdaily, drug form: tab, start: 05 Dec 2017 09:54 PST	Last given: 05-Dec-2017 12:15 PST							
PRN	citalopram								20 mg Auth (Ve
Continuous Infusions	ेत्र ranitidine	150 mg Not previously	150 mg Not previously						9
🔽 Future	150 mg, PO, BID with food, drug form: tab, start: 05-Dec-2017 10:44 PST	given	given						
Discontinued Scheduled	ranitidine								
Discontinued Unscheduled	PRN								
	PRN PRN					325 mg			
Discontinued PRN	acetaminophen					niven			
Discontinued Continuous Infus	start: 01-Dec-2017 14:51 PST Maximum acetaminophen 4 g/24 h from all s					9			
	acetaminophen								
	Temperature Axillary								
	Temperature Oral								
	Numeric Pain Score (0-10)								
	PRN HYDROmorphone (HYDROmorphone PRN r dose range: 0.5 to 1 mg. PO. g4b. PRN pain.			Med Response	Med Response	1 mg Last given: 05-Dec-2017			
	drug form: tab, start: 05-Dec-2017 13:10 PST DILAUDID EQUIV					13:32 PST			
	HYDROmorphone						* 0.5 mg Auth (V	* 0.5 mg Auth (V	
	Respiratory Rate						* 12 Auth (Verifi	12 Auth (Verified	
	PRN LORazepam					1 mg Not previously	9		
	1 mg, PO, q4h, PRN anxiety, drug form: tab, start: 28-Nov-2017 16:14 PST					given			
	LORazepam								
	PRN					10 mg			
	10 mg, PO, q4h, PRN agitation, drug form: tab. start: 28-Nov-2017 16:16 PST					given			
	loxapine								

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

1



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

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.



Medication responses can be documented from the MAR under Med Response



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

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:

(MEWS)

1

- 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



Menu		 A Interactive View and I&O 				
Mental Health Summary		™ 🗖 🖽 🖓 🖌 🗐 🖏 🐘 🕋 🖎				
Orders	🖶 Add	2				
Single Patient Task List		MH Adult Quick View				Last 24 Hours
		VITAL SIGNS				
MAR		Modified Early Warning System	Find Item 👻 🔄 Critical	📰 High 📰 Low	Abnormal	🔲 Unauth 🔄 Flag
		Glucose Blood Point of Care			0.1	0 (10
	. 1	Point of Care Testing	Result	Comments Flag	Date	Performed By
Interactive view and lo	&U	Medal Clature Event				
		Ongoing Columbia Suicide Severity Rating	11	2018-Ja	n-18	
Documentation	▲ Add	Activities of Daily Living		A 08:3	9 PST	
Documentation	T Add	PAIN ASSESSMENT	⊿ VITAL SIGNS			
Medication Request		Comfort Measures	Temperature Axillary	DegC		
Histories		Environmental Safety Management	Temperature Temporal Artery	DegC		
Thistories		Morse Fall Scale	Temperature Oral	DegC	_	
Allergies	🖶 Add	Fall Prevention Interventions	Temperature Tympanic	DegC	_	
Diagnoses and Problems		Post Fall Evaluation	Apical Heart Rate	bpm	_	
Diagnoses and Problems		Individual Observation Record	Peripheral Pulse Rate	bpm	_	
		Provider Notification	Heart Rate Monitored	opm	_	
CareConnect		Transfer/Transport	SBP/DBP Cuff	mming	_	
conceonnect		Shift Report/Handoff	Mean Arterial Pressure Cuff	mmHa	_	
Clinical Research			Mean Arterial Pressure, Curr	mmHa		
Form Browser			Blood Pressure Method			
			SBP/DBP Supine	mmHg		
Growth Chart			Pulse Supine	bpm		
Immunizations			SBP/DBP Sitting	mmHg		
			Pulse Sitting	bpm		
Medication List	Add		SBP/DBP Standing	mmHg		
Patient Information			Pulse Standing	bpm		
			Cerebral Perfusion Pressure, Cuff	mmHg		
Reference			⊿ Oxygenation		- 3	
			Respiratory Rate	br/min		

- 4. Select the Modified Early Warning System section
- 5. Note the vital signs documentation has flowed to the MEWS section
- 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.



< 👻 🛉 Interactive View and I&O	
== 🖶 🖬 🙀 🖌 🚯 🕲 🖿 🗰 🛤 ×	
🔨 MH Adult C 💙 🥺	Last 24 Hours
VITAL SIGNS	
Modified Early Warning System 2	Find Item - Critical High Low Abnormal Unauth Flag OAnd Or
Glucose Blood Point of Care	
Point of Care Testing	Pesuit Comments riag Date Penomea by
Meatal Status Evans	
Oppoing Columbia Suicide Severity Rating	2018-Jan-18
Activities of Daily Living	🗮 🚮 🔂 🕺 🕅 🕅 🕅 🕅
PAIN ASSESSMENT	⊿ Modified Early Warning System
Comfort Measures	△ Temperature
Environmental Safety Management	Temperature Axillary Degg
Morse Fall Scale	Temperature Temporal Artery Degr
Fall Prevention Interventions	Temperature Oral Degi 38
Post Fall Evaluation	Temperature tympanic Degu
Individual Observation Record	Merves temperature score 1
Provider Notification	
Transfer/Transport	Perpire a ruise rate optimise in the second se
Shift Report/Handoff	
	Respiratory Rate br/mil 20
	MEWS Respiratory Rate Score
	△ Blood Pressure
	SBP/DBP Cuff mmHi 100/60 5
	MEWS Systolic Blood Pressure Score
	⊿ AVPU ✓
	AVPU 7
	I MEWS AVPU Score
	△ MEWS Total Score
	MEWS Total Score
	△ Situational Awareness Factors
A MARKAN CONTRACT AND A CONTRACT	Patient/Paminy/Caregiver Concerns
MH Adult Systems Assessment	Onusual interapy
MH Pediatric Quick View	Communication Desculution
MH Pediatric Systems Assessment	Sp02 Below 90% with Fi02 Higher Than 50%
MH Evaluation Tools	GCS Less Than or Equal to 12
Restraint and Seclusion	⊿ MEWS Action Taken
ST Electroconvulsive Therapy	MEWS Action Taken
ev Inteke And Output	△ Mental Status Exam
	Hygiene and Grooming
Adult Lines - Devices	Hygiene and Grooming Comments

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

Discern Notification (TEST.NURSEICU)	
Task Edit View Help	
1 8 🕰 🗣 🔍	
Subject	Event Date/Time
Rapid Response Early Warning - MEWS	28-Nov-2017 14:17:24
DISCERN ALERT	A
NAME: CSTLEARNING, DEMOALPHA	
DATE: 28 November, 2017 14:17:24 PST	E
MRN: 700008214	
BIRTH DATE: 01 January, 1937	
LOCATION: LGH Lions Gate: LGH 6E: 624	
LOCATION: DOILLING ORC, DOILOL, VAT	
MEWS Score (4)	
1) Ensure accuracy of findings; Compare with patient's baseline	
2) Review findings with nursing leader (CNL/PCC) or delegate; Disc	cuss assignment change as needed
3) Notify Responsible Care Provider	
Ready	PRODBC TEST.NURSEICU TEST.NURSEICU Tuesday, November 28, 2017 06:21 10



🔦 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

Nursing: Mental Health Emergency

1

PATIENT SCENARIO 12 - Modified Early Warning System (MEWS)



Activity 12.2 – Review the MEWS Alert

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)

- 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.



CareCompass								(D) Full screen 🔅 Prin	@1m	inutes ago
台目目目	🔍 🔍 100% 🔷 🌑 🌑 🖾									
Patient List: C	USTOM 💌 💥 List Maintenance	💠 Add Patient 🛛 💰 Establish Relationships							<mark>9</mark> 1	0
Location	Patient	v	CSTLEARNING, DEMOTHETA	Age: 80yrs	Sex: M	DOB: 01/01/1937	MRN: 700008216	Encounter #: 7000000015058		
624 - 04	CSTLEARNING, DEMOTHET 80yrs M Attempt CPR, Full C Allergies General Diet	TA Code 🥹 <	Scheduled/Unscheduled PRN/Continuous	Plans of Care Patient Inform	ation			100000000000		
707 - 03	CSTDEMO, ATHENA 30yrs F Alergies	_	acetaminopinen (I TLENUL) acetaminopinen Comment: Maximum acetaminopinen	4 Hours 12 Hours nen 640 mg, PO, drug torm: oral lig, 4 g/24 h from all sources	star: 04-Dec-2017 02:00 PS1					*
212 - 01	CSTCARDDEMO, BOB DO	NOT USE	acetaminophen (TYLENOL) acetaminophen Comment: Maximum acetaminophen	hen 640 mg, PO, drug form: oral liq, 4 g/24 h from all sources	start: 04-Dec-2017 05:00 PST					
	No Known Allergies		acetaminophen (TYLENOL) acetaminophen Comment: Maximum acetaminophen	hen 640 mg, PO, drug form: oral liq, 4 g/24 h from all sources	start: 04-Dec-2017 10:00 PST					
			vancomycin 1,000 mg, IV, start: 04-Dec-	2017 10:00 PST						
			Add Difficult AirwayIntubation Alert							
			acetaminophen (TYLENOL) acetaminophen Comment: Maximum acetaminophen	hen 640 mg, PO, drug form: oral liq, 4 g/24 h from all sources	start: 04-Dec-2017 14:00 PST					
			MEWS Alert 04-Dec-2017 14:14 PST, St Comment: MEWS Criteria: 04 Decemi	op: 04-Dec-2017 14:14 PST ber, 2017 14:14:00 PST Temperatur						2
			Unscheduled							
			Valuables and Belongings							
			Admission Discharge Outcomes Asses	sment						
			15:00 (No Activities)							
			Interdisciplinary						_	-
			IP Consult to Respiratory Therapy Consult	to Respiratory Therapy 01-Dec-201	7 09:23 PST, Routine, Reason for C	Consult COPD				
Activity Timeline	1		Oxygen Therapy 30-Nov-2017 09:41 PS	T, Routine, Titrate O2 to keep SpO2	92% or greater					-
			Respiratory Therapy Following 01-Dec: Instruction: Decompressing respirator	2017 09:27 PST, Reason for follow- ry status	up: Decompressing respiratory stat	hus				
								Done Not Done	Docur	nent
Overdu	e 14:00	15:00 16:00								

(MEWS)



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

CSTLEARNING	DEMOBETA 🗶 CSTLEARNING, DEMOTHETA 💌					CSTLEARNING, DEMO	OTHETA 🔹 🛍 Recent 🔹 📐	Name	٠٩
CareCompass							(D) Full screen 🔅 Pr	rint 25	minutes ago
	🔍 🔍 100% 🔹 🕘 🔮 🟠								
Patient List: C	JSTOM 👿 💥 List Maintenance 🕴 Add Patient 💰 Establish Relationship	5						🥹 1	
Location	Patient	CSTLEARNING, DEMOTHETA	Age: 80yrs	Sec: M	DOB: 01/01/1937	MRN: 700008216	Encounter #: 7000000015058		0
624 - 04	CSTLEARNING, DEMOTHETA Soyrs M Attempt CPR, Full Code Allergies General Diet	Scheduled/Unscheduled PRN/Continuous	Plans of Care Patient Information						
707 - 03	CSTDEMO, ATHENA 30yrs F - Allergies -	Comment Maximum acetaminopher	4 Hours 12 Hours pnen 640 mg, PO, orug torm: oral lig, start 14 g/24 h from all sources	04-Dec-2017 02:00 PS1					•
212 - 01	CSTCARDDEMO, BOB DO NOT USE 70yrs N - No Known Allergies -	acetaminophen (TYLENOL) acetaminop Comment: Maximum acetaminophen acetaminophen (TYLENOL) acetaminop Comment: Maximum acetaminophen	phen 640 mg, PO, drug form: oral liq, start n 4 g/24 h from all sources phen 640 mg, PO, drug form: oral liq, start n 4 g/24 h from all sources	04-Dec-2017 06:00 PST 04-Dec-2017 10:00 PST					
		vancomycin 1,000 mg, IV, start 04-Dec	2017 10:00 PST						
		Add Difficult Airway/Intubation Alert							
		acetaminophen (TYLENOL) acetaminop Comment: Maximum acetaminophen	phen 640 mg, PO, drug form: oral liq, start n 4 g/24 h from all sources	04-Dec-2017 14:00 PST					
		MEWS Alert 04-Dec-2017 14:14 PST, S	Rop: 04-Dec-2017 14:14 PST shar: 2017 14:14:00 PST Temperature Avii	lary – 38 11 noint/s1104 Decemb	er 2017 14:14:00 PST Respiratory Date	- 22 12 point/s11 04 December 1	2017 14-14:00 PST Sustaile E	Blood	
Comment MEWS Alert MEWS Criteria: (= 22 [2 point(s)	14 December, 2017 14:14:00 PST Temperature Axilary = 38 [1 point(s)] 04 Decemb] 04 December, 2017 14:14:00 PST Systolc Blood Pressure = 100 [1 point(s)]	er, 2017 14:14:00 PST Respiratory Rate	Nor, 2011 19 19 10 19 19 19 19 19 19 19 19 19 19 19 19 19	ary - 30 (1 point(3)) 04 Decentor	- 2011 IN INVENDITION	e za ga pomiljanj 04 Discettiber, e	2011 ACTION FOR Systems 5		
		Admission Discharge Outcomer Asse	ssment						
		15:00 (No Activities)							

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

Scheduled/Unscheduled PRN/Continuous Plans of Care Patient Information								
🖌 🗟 📓 🖉 2 Hours 4 Hours 12 Hours								
Vancomycin 1,000 mg,1V, start 28-100/-2017 22:00 PS1	•							
acetaminophen 650 mg, PO, drug form: oral liq, start: 29-Nov-2017 02:00 PST Comment: Maximum acetaminophen 4 g/24 h from all sources								
acetaminophen 650 mg, PO, drug form: oral liq, start: 29-Nov-2017 06:00 PST Comment: Maximum acetaminophen 4 g/24 h from all sources								
ranitidine 50 mg, IV, start: 29-Nov-2017 06:00 PST								
MEWS Alert 26-Nov-2017 17:49 PST, Stop: 26-Nov-2017 17:49 PST Comment: MEWS Criteria: 26 November, 2017 17:41:00 PST Temperature Oral = 38 [1 point(s)] 26 November, 2017 17:41:00 PST Peripheral Pulse Rate = 110 [1 p								
Add Difficult Airway/Intubation Alert	=							
Add Difficult Airway/Intubation Alert								
	-							
Done Not Done Document	4							



- 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

Activity View		
Provider Notification Provider Notification	Find Item - Critical	High Low Abnormal Ur
	Result	Comments Flag Date
		28-Nov-2017
	Provider Notification	14:29 PSI
	⊿ Provider Notification	
	Provider Notification Reason	PEWS/MEWS alert
	Provider Notification Details	MEWS Alert score 4
	Unable to Reach Provider	
	Provider Informed	Plisvce, Noe, MD
	Physician Requested Interventions	Physician Requested Interventions 🗙
		Orders received
		✓ No orders received
		Continue to monitor
		Other 5

- 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

🗙 Adult Quick View				Last 2	4 Hours	
VITAL SIGNS						
Modified Early Warning System 7		Find Item	Low	Abnormal	🔲 Unauth	Flag
✓ PAIN ASSESSMENT						
Pain Modalities						
IV Drips		իս Ծ _	29-N	ov-2017	28-Nov-2017	
Insulin Infusion	=	R 🖬 🗗	ີ 🖞 10:13 P	ST 09:29 PST	15:00 PST	
Heparin Infusion	-	Unusual Therapy				
Apnea/Bradycardia Episodes		Communication Breakdown				
Mental Status/Cognition		Urine Less Than 0.5 ml/kg/h for 4 hours				
Sedation Scales		SpO2 Below 90% with FiO2 Higher Than 509	6			
Provider Notification		GCS Less Than or Equal to 12				
Environmental Safety Management		⊿ MEWS Action Taken				_
Activities of Daily Living		MEWS Action Taken	MEWS Actio	n Taken		×
Measurements		⊿ PAIN ASSESSMENT	✓ No actio	n necessary		
Additional Measurements		Pain Present	Maintair	scheduled as	sessments	
Point of Care Testing	Ŧ	Respiratory Rate br/mi	Increase Increase	frequency of a	assessments	
X Adult Systems Assessment		Onset	Notified	Unit Charge R	N	
X Adult Lines - Devices		Provoking	Notified	Physician		
Adult Education		Palliating	Activate rapid response team (RRT/MET)			T)
N Dia ad Draduct Administration		Quality	Call code blue			
S Blood Product Administration		Location	Other			8
🗙 Intake And Output		Laterality				
X Advanced Graphing		Radiation Characteristics				
Restraint and Seclusion		Pain Comment		_		
Procedural Sedation	Secondary Pain Site					
* Frocedural Sedation		Additional Pain Sites				



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

1



Activity 13.1 – Handoff Tool

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

🐴 🐘 🖣 🏬 🔍 🍕 100% 🔹	4									
Mental Health Summary	🛛 Handoff Tool		🔀 Discharge						🖂 — 🚿 🤱 🔌	_≡•
Allergies (2) Informal Team Communication	Allergies (2) 💠								All Visits 🤁	-
Active Issues Vital Signs and Measurements Documents (4)	Substance Pollen	Reactions		Category Environment	Status Active	Severity * Moderate	Reaction Type Allergy	Source	Comments	
Assessments (1)	Citrus			Food	Active		Allergy	Reconciliation 9		a
Labs Transfer/Transport/Accompanim ent	Informal Team Co	ommuni	ication			Add new commer	t	TO CONCIDENT A	@	
Diagnostics Medications Home Medications Oxygenation and Ventilation	No actions documented All Teams						No comments documented All Teams			
Micro Cultures Orders Pathology	Active Issues							Classification:	Medical and Patient Stated 👻 🛛 All Visits 🥹	-
Histories						Add new as: This Vi	sit 🕶 🔍			
Create Note	No results found									
Interdisciplinary Care Plan Interdisciplinary Rounding Summ	Vital Signs and M	easuren	nents 🕂					Selected visit: Latest*	Selected visit Last 12 hours	
Nursing Shift Summary	BP	mmHg	Today 13/32 11 	1:30	NOV 26, 2017 10:25 140 / 90	N 1	OV 22, 2017 1:07	10:58	NOV 21, 2017 11:54 	
Select Other Note	HR Temp	bpm DegC	••		80 ^ 36.9	-		**		2

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

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

1

Menu 7	< 🚿 🔸 🚹 Mental Health Summary	
Mental Health Summary		
Orders 🕂 Add	Mental Health Summary 23 Handoff Tool 1 Discharge 23 +	
Single Patient Task List		
MAR	Allergies (3)	
MAR Summary	Informal Team Communication	
Interactive View and I&O	Active Issues Patient's family will come to visit this evening Add new	commer
Results Review	Vital Signs and Measurements	_
Documentation 🕂 Add	Documents (1) 207 quaracters left No comme	ents doc
Medication Request	Assessments (0)	
Histories	Intake and Output No actions documented	
Allergies 🕂 Add	Labs All Torong	
Diagnoses and Problems	Au realits Transfer/Transport/Accompanim opt	

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. 96 | 108



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

🗄 🎬 CareCompass 🎬 Clinical Leader Orga	nizer 🛔 Patient List 🖴 N	fulti-Patient Task List i Disch	arge Dashboard 😭 Staff Assignme	ent 🌇 LearningLIVE 💡					
😋 PACS 🔇 FormFast WFI 💡 🖾 Tear 0	Off 📲 Exit 🏙 AdHoc 💵	Medication Administration	PM Conversation + 🔄 Communi	icate 👻 🗋 Medical Record Request 🕂 Add 🗕	🖻 Documents 🛗 Sched	luling Appointment Book 🗃 Disc	ern Reporting Portal		
CSTLEARNING, DEMODELTA								🗲 List 🔿	Recent + Name + Q
CSTLEARNING, DEMODELTA		DO8:01-Jan-1937 Age:80 years	MRN:700008217 Enc:7000000015060	Code Status:		Process:Falls Risk Disease:		Location:LGH 6E; 620; 02 Enc Type:Inpatient	
Allergies: No Known Allergies		Gender:Male	PHN:9876469817	Dosing Wt:75 kg		Isolation:		Attending:eLearn, Physicia	n-General Medicine1, MD
🖀 < 🔹 - 👘 Patient Summa	y 1							(D)	Full screen 🛛 🖶 Print 🛛 🍣 0 minutes ago
A	- 😋 🖷 🗳								
Handoff Tool	Standary Summary	22	Assessment	23 Discharge	2 +				💽 🗖 🦻 🔍 🔳 🖬
Active Issues	Active Issues							Classification: Medical and Pati	ent Stated 🗸 🛛 All Visits 🛛 🏖 📄 💼
Documents (1)					Add now	ar Chronic x			
Social Histories					Add liev	AS. CHIONIC *			
Orders (7)	No results found								
Discharge Documentation (0)									
* Discharge Medications (0)		- ·	. 3						- 10 -
	Provider Discha	arge Documents (1)	•					Selected visit: Last 50 Notes Selec	ted visit Last 1 months
								My notes only Group by encounter	Display: Facility defined view -
	Time of Service	Subject		Note Type 4	Author		Last Updated	Last Updated By	
	22/11/17 09:04	Discharge Si	ummary	Patient Discharge Summary	TestUse	r, GeneralMedicine-Physician, MD	22/11/17 09:08	TestUser, GeneralMedicine-	Physician, MD
	* Displaying up to th	e last 50 recent notes for the s	elected visit						
	Social Histories								All Visits 🏾 🖓 = -
	Social History	(0)							
	No results found								
	Orders (7)								Selected visit $ \boldsymbol{\vartheta} \equiv$
						Pending Orders (7)	Group by: Clinical Cat	egory 🖌 Show: All Active Orders	×
		Type On	ler	*	Start	Status	Status Updated	Ordering Provider	
	⊿ Admit/Transfer/	Discharge (1)							
		🔁 Ad Ad	mit to Inpatient 20-Nov-2017 14:3 mitting provider: eLearn, Physician-	6 PST, Admit to General Internal Medicine, General Medicine1, MD	20/11/17 14:36	Ordered	20/11/17 14:37	eLearn, Physician-General Medicine1, MD	
	⊿ Patient Care (3)								

PATIENT SCENARIO 15 – Transfer and Discharge from ED



- 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

Medical Record Request - CSTLEARNING, DEMODELTA - 700008217 - Discharge Summary								
Related Providers Se	rctions	Template Document Template Document Template Inpatient/General Transfer Template NICU Transfer Template	Purpose 2 Patient/Personal • Proper authorization received? • Destination • Requester •					
Name	Relationship	Device	Comment					
🔲 TestUser, Nurse	Nurse							
📃 🔲 TestUser, Nurse	Nurse							
📃 🔲 TestUser, Nurse	Nurse							
📃 📃 TestUser, Nurse	Nurse		· · · · · · · · · · · · · · · · · · ·					
			Device Copies 3					
Oevice selected		Device cross referenced						
		Preview	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

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

1

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

🗄 🔐 Multi-Patient Task List 📲 Safety and Attendance 🞬 Car	eCompass 🔢 Clinical Leader	Organizer 🛓 Patient List Tr	acking Shell 🧱 Schedule 😂	Staff Assignment 📲 Learning	LIVE 🝦 🤅 😋 CareConnect 🖿	PHSA PACS 🔃 VCH and PHC
🗄 🔀 Tear Off 📲 Exit 🎬 AdHoc 💵 Medication Administratio	on 🤮 PM Conversation 👻 🥤	cal Record Request 🕂	Add 👻 🗐 Documents 🗃 Die	cern Reporting Portal 🤤		
👯 😋 Patient Health Education Materials 🎕 Policies and Guidel	lines 😨 Up I oDate 🖕	.				
nt Pending Facility Transfer						
		D . (D)/				2
700008217 Encounter Number: 700000015060	CSTLEARNING, DEMODI	01-Jan-1937	Age: 80Y	Male		2
- Encounter Information						
Encounter Type: Medical Service:	Attending Provider:					
Inpatient Psychiatry	Plisvcj, Linwood, MD					
Current Location Information	11-3265-1	Deere	D-4	A	Destand Account define	A second stars Discours
LGH Lions Gate LGH Lions Gate	LGH ED	NUUIIL	beu.	Accommodation.	Private	Accommodation neason.
— Pending Transfer Location Information ————————————————————————————————————						
Facility: Building:	Pending Unit/Clinic:		Room:	Bed:	Accommodation:	Accommodation Reason:
LGH Hope Centre		Bed Availability	· ·	•	•	•
LGH Cardiology Lab	4	5				
LGH Clast Clinic						×
LGH Diabetes Education Clinic LGH Electroencephalography Clinic						*
LGH HOpe Centre LGH Intensive Rehabilitation Outpatient Program IROP	Pending Facility Transfer User N	ame:				
LGH Lab Northmount	TestUser, NurseEmergen					
LGH Laboratory LGH Lions Gate Hospital						
LGH Medical Imaging LGH Neuro Rehab Outpatient Clinic						
LGH North Shore Hospice LGH OCC Medical Daycare						
LGH OCC Universal Clinic LGH Pediatric Asthma Clinic						
LGH Pharmacy LGH Preanesthesia Clinic						
LGH Pulmonary Function Lab						
LGH Rapid Access Neurology Clinic RAN						
LGH Rehab Outpatient						
LGH Respiratory Education Program						
LGH Trauma Clinic						
Curr Vascular Access						6 Cancel



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



PATIENT SCENARIO 15 – Transfer and Discharge from ED

Activity 15.2 – The Depart Process

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

🔐 Multi-Patient Ta	sk List 📲 Sa	ety and Attendance 🎬 CareCompass 🚦	Clinical Lead	der Organizer 🛓 Patient	Tracking Shell	hedule Sta	ff Assign	ment 🎬 LearningLi	IVE 🝦 🗄 🔮	CareCo	nnect 🕄 PHSA PACS	🕄 VCH and PHC PACS 🕄 MU	SE 🔞 Forr
🛃 Exit 🎦 AdHoc I	IIII Medicatio	n Administration 🔒 PM Conversation 👻	B Medical R	Record Request 🕂 Add 🗸	🖱 Documents 🝙 Disce	ern Reporting I	ortal _						
🕄 Patient Health Ec	lucation Mat	erials 🔃 Policies and Guidelines 🔃 UpT	oDate 💂										
CSTLEARNING, D	EMODELT.	A ×											
Tracking Shell													
ED LGH Generic Vie	ED L GH	ED DEM Generic View ED D	EM Look Up	ED SGH Generic View		Generic View	L ED W	HC Look Up					
					Soffeed of Les Miles	ouncile men	100	ic cook op					
Patient: CSTLEAR	NING, DEMO	DE - WR: 17 Total: 42 Avg LOS: 367:	11 Filter: <n< td=""><td>lone> •</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></n<>	lone> •									
@ 🚈 😗													
Bed	Alerts	CT/Name Age	Allergy	Reason for Visit	LOS Disposition	EDMD MLP	RN	Events	Lab	Rad	OOD	Comment	BA
ACWR		2 CSTDEMOBRETT, DONOT 57 y	vears 🙋	1:Headache (2), sever	48:15 👚 🔶	NJBG	EB	2	4/0	1/0		KEEP UNTIL DECEMBE	F
ACWR	e	2 DONOTUSELEARN, MONT41 y	/ears 🧶	1:Chest trauma (1), bl	27:59	MT		-0					
ACWR	۸ 🍙	2 DONOTUSELEARN, KIM 86 y	/ears 📿	1:Cough and fever (2),	26:16	NJBG Res	EB	~ 3*					
ACWR		2 PYLON, MONTY 41 y	vears 🧶	1:Chest trauma (2), bl	0:55								
ACWR		STDEMOELAINE, DONO 57 y	/ears 🔍		28:46		EB	2 🗑 2	12/0			KEEP UNTIL DECEMBE	F
ACWR		8 PITTHREESMITH, BETTY 61 y	/ears 😡	1:Suicidal ideation (3)	24:40 🎓 🛛 🔴			🗸 🔟 🖸					
ACWR	A	4 ye	ars 🗢		6:38 🏙	HH		~3 *					
ACWR		S CSTLEARNING, DEMODE	vears 🔍	1 Z atory distress	23:36 👚 🔶			* 👰	10/0				
ACWR		MHDEWOSEVEN, DONOT 40 y	/ears 📿		28:00 👚 🔴			+				Until what date?	
ACWR		CSTEDDOOLEY, WILSON 88 y	/ears 🍳		25:03	IV; CW	IV	+ ~*					
ACWR	₫۵	CSTEDHONG, DAVID 27 y	vears 🔍		3:49	HH		+*	13/0				
ACWR		CSTSNWINDU, STMACE 45 y	/ears 📿		3:19 👚 🔴			*					
ACWR		CSTSNERSO, STJYN 26 y	rears O		1:12			*					
ACWR		CSTSNLION, STBRAVEHE 38 y	/ears 😡		1:11			•					
ACWR		CSTSNERSO, STGALEN 58 y	/ears 😡		0:45			•					
ACWR		CSTSNORGANA, STLEIA 38 y	/ears 📿		0:38			*					
ACWR		CSTSNSOLO, STHAN 43 y	vears 📿		0:28			+					
PreArrival		CSTLearn, RuralEDNurse		1:Fall resulting in blun	1:56								
		CSTEDHONG, TOMMY 27	/ears		3195:43 🗢			÷					
		CSTPRODREG, NEWEDE 27 y	/ears		2810:51			+					
		CSTSNCPOE, STTESTONE24 y	vears		2694:12								
	~	CSTSNTEST, STWORKFL(17)	/ears		2503:40								
	24)	CSTLABDEMO, POPUP 36 y	/ears 🧶		1488:59			T					
		TONG, BABYTWO 7 w	eeks 📿		1296:57		_	2 7 8	1/0	1/0			
		CSTZEROTWOASTHMA, \$7 ye	ars 😕		1201:57			T 1					
DEOLIG		TONG, DUROTHY 7 W	eeks 🧐	41 1 1 1 1 1 1	1008:54 😎		D.L.		0.00	4.10			
RESUS,101	/ [*	WHCCPIIFORTYWEBB, R 62	/ears 🔍	1:Lower extremity inju	4:52 👕 🧶	NJBG	IRN	10 28	9/0	1/0			

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



- PATIENT SCENARIO 15 Transfer and Discharge from ED
 - 4. Select the pencil icon key next to Valuables/Belongings

Depart Process	
CSTLEARNING, DEMODEDOB:01-Jan-19	I:700008217 Code Status:Attempt CPR, Full C Process:Falls Risk Location:LGH ED
Age:80 years E	70000001 Disease: Enc Type:Inpatient
Allergies: Citrus, Pollen Gender:Male F	.9876469817Dosing Wt:75 kg Isolation: Attending:Plisvcj, Linwood, MD
Templates: ED Patient Summary LGH	Patient
C Diagnosis C F33.1 Major depressive disorder, Ri Orders/Ri Medication Reconciliation C Disposition Documentation	Lions Gate Hospital Emergency Department 231 East 15th Street North Vancouver, B.C. V7L 2L7 604-988-3131 Patient Discharge Sum mary/Instructions
Expiration Record	THE ADVING DEMODELTA
✓ Valuables/Belongings 🥠	DB: 01-Jan-1937 PHN: 9876469817 Encounter: 7000000015060
Patient Summary Admit Discharge/Transfer Facility	Patient Address: 590 West 8th Ave. Vancouver British Columbia Patient Phone: (604)333-8888 Primary Care Provider Name: Plisvca, Rocco, MD Phone: (322)366-4896 Visit Date: 28-Nov-2017 15:47:07 Reason For Visit: Respiratory distress (3), mild/moderate RC112; Pneumonia Final Diagnosis: Major depressive disorder, Recurrent episode, Moderate Primary Physician: Attending Provider: Plisvcj, Linwood, MD
Patient/Family/Caregiver demonstrates understanding of inst	ons given Print Sign and Close Cancel
Polycolog F33.1 Major depressive disorder, R Orders/Rx Conders/Rx Medication Reconciliation * Disposition Documentation * Polycolog Polycolog	Print Plant (2) (2) (2) (2) (2) (2) (2) (2) (2) (2)

- 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 \checkmark to sign your documentation

Ualuables/Belongings - CSTLEARNING, DEMODELTA			
🖌 🖬 🛇 🥸 🕅 🛧 🔸 📾 🖾 🗎			
6 rmed on: 11-Dec-2017 💭 🕶 1536 🚔 PST			By: TestUser, NurseEmergency-M
Valuables/Belongin	as		
Does patient have any valuables/belongings with them? © Yes ○ No	Patient instructed to send all items exception of personal assistive dev O Yes; Items sent home with relative or friend Yes; Pt unwilling, or unable to send items h No; special circumstance	s home with the vices? ome with relative or friend	ecial circumstances including conscious/incapacitated patients, tients coming for day surgery. batient unwilling or unable to send ms home with relative or friend, sure that patient has signed a "waiver recompatibility in cubeblor" free more
Belongings Sent Home With Be	longings Labeled Does contra	batient have any abands with them?	Contrabands Removed as per Policy
Contrabands	Yes O Yes O Yes O No		O Yes O Other:
Description	Number of Items	Sent to	
Contraband			
Does the patient have any Lis home medications with them? the	t any hospital equipment that has be e patient	een loaned to	Has the hospital equipment been returned?
O Yes O No			O N/A O Yes O Other:
Home Medications			
Medication Name	/Route	Home Medications Sent to	
Medication #1		<alpha></alpha>	
Medication #2		<alpha></alpha>	



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 *k* next to Admit



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

🚔 ED Admit		_ • •
Last Name: CSTLEARNING	First Name: DEMODELTA	Middle Name:
Gender: Male		
Medical Record Number: 700008217	Encounter Number: 7000000015060	
- Patient Admission		
Patient Admit Date:	Patient Admit Time:	
- ED Departure Time		
Disposition: Admitted to an Inpatient Unit	ED Departure Date: 12-Dec-2017	ED Departure Time: 11:53
Admitted to Critical Care or an OR Return to Inpatient Unit Transferred to Day Surgery	9	Complete
Ready	PRODBC TEST.MHE	EDNUR 12-Dec-2017 11:53

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.