

SELF-GUIDED PRACTICE WORKBOOK [N75]
CST Transformational Learning

WORKBOOK TITLE:









NURSING: MENTAL HEALTH INPATIENT

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SELF-GUIDED PRACTICE WORKBOOK

Duration	8 hours
Before getting started	<ul style="list-style-type: none">  Sign the attendance roster (this will ensure you get paid to attend the session)  Put your cell phones on silent mode
Session Expectations	<ul style="list-style-type: none">  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	<ul style="list-style-type: none">  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 questions or trouble following the steps, immediately raise your hand for assistance to use classroom time efficiently
- Ask for assistance whenever needed

PATIENT SCENARIO 1 – Patient List




Learning Objectives

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

-  Create a Location Patient List
-  Create a Custom Patient List

SCENARIO

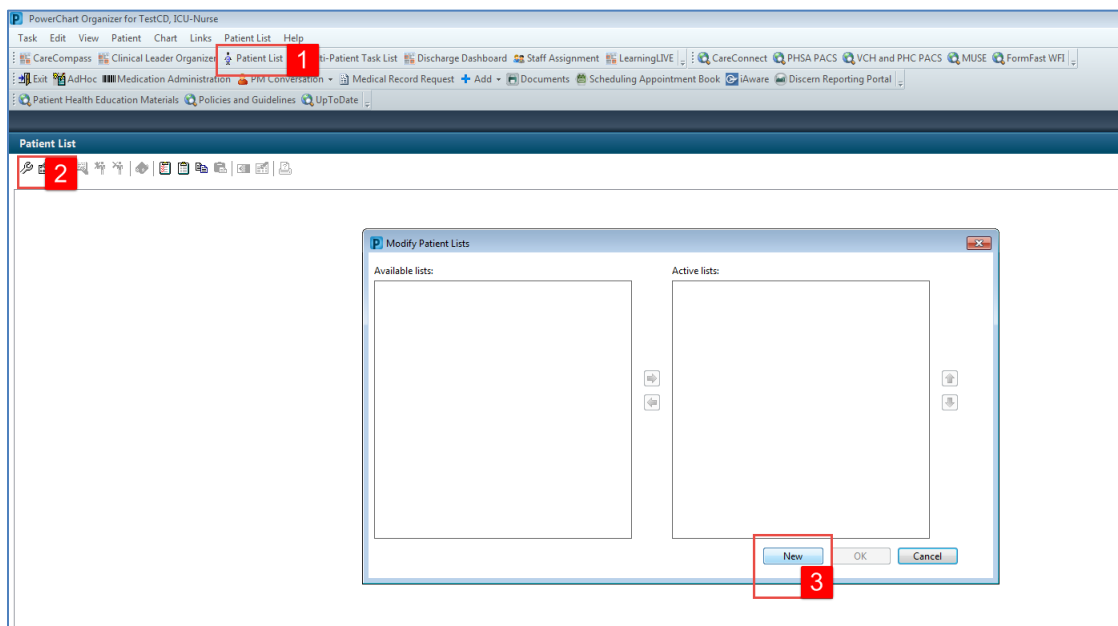
You are starting your first shift on the unit with the new clinical information system (CIS). As a mental health nurse you will be completing the following activities:

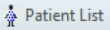

-  Set-up a Location Patient List
-  Create a Custom Patient List
-  Move patients from your location list onto your Custom Patient List

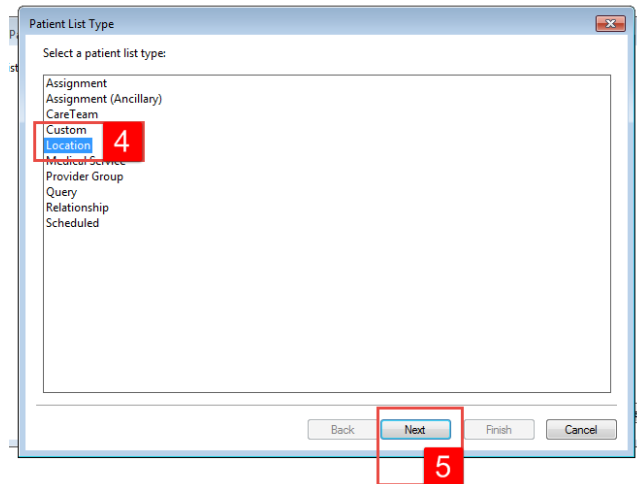
Activity 1.1 – Set Up a Location Patient List

- 1 Upon logging in, you will land on **CareCompass**. **CareCompass** provides a quick overview of select patient information.

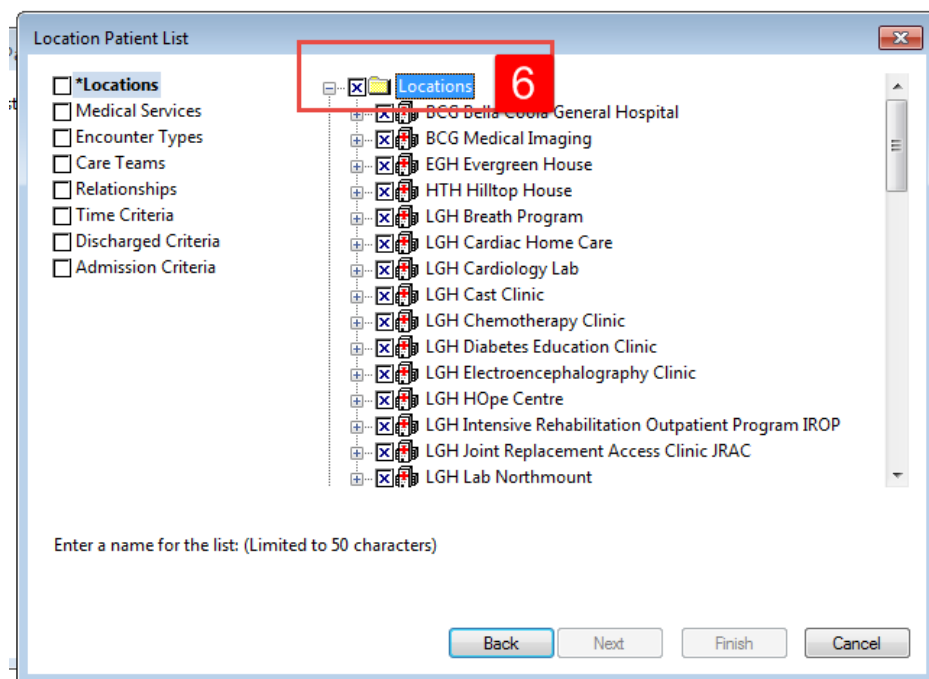
At the start of your first shift (or when working in a new location), you will create a **Location List** that will consist of all patients assigned to your unit.



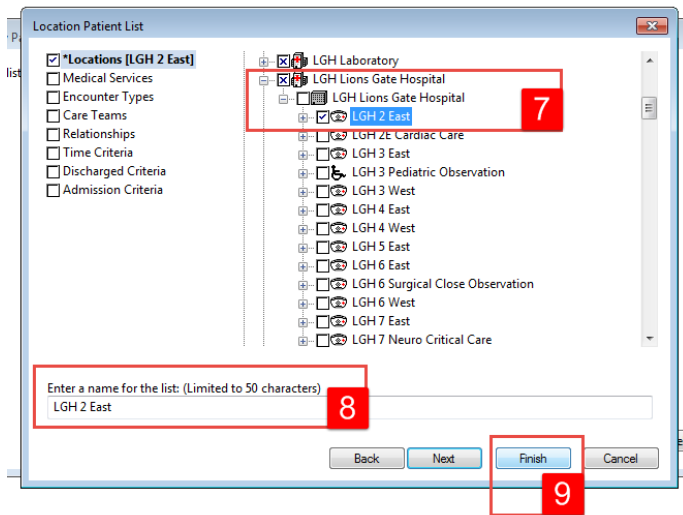
1. Select the **Patient List** icon  from the **Toolbar**
2. The screen will be blank. To create a location list, click the **List Maintenance** icon . When you hover on the wrench it will say List Maintenance.
3. Click **New** in the **Modify Patient Lists** window



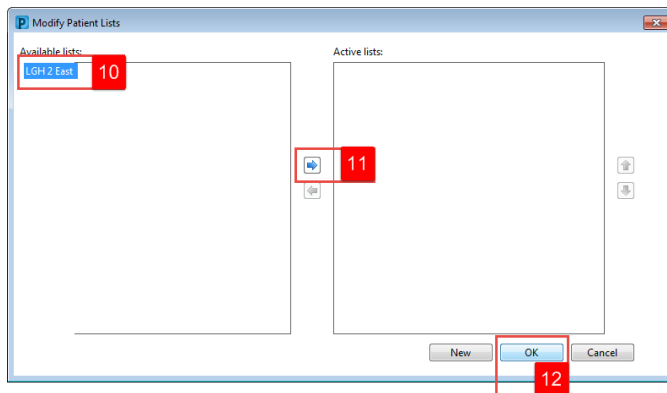
4. From the Patient List Type window select **Location**
5. Click **Next**




6. In the location tree within **Location Patient List** window, expand the list by clicking on the **plus +** sign next to the Location folder





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**



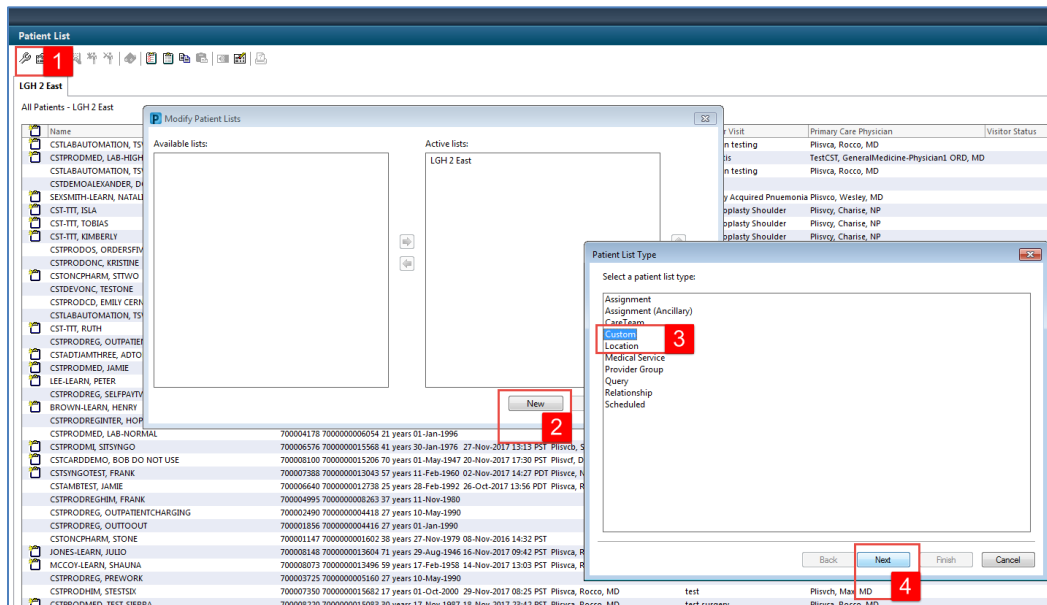
10. In the **Modify Patient Lists** window select your **Location** list
11. Click the **Blue Arrow**  to move the **Location** to the **Active Lists** window
12. Click **OK** to return to **Patient Lists**. Your Location list should now appear


Key Learning Points

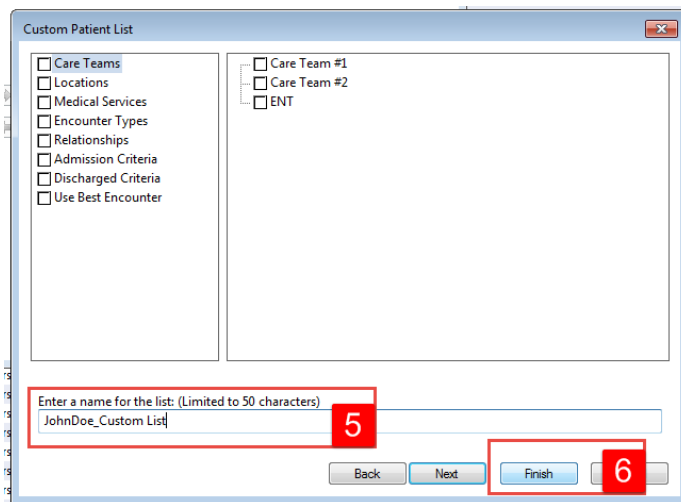
-  Patient List can be accessed by clicking on the Patient List icon in the Toolbar
-  You can set up a patient list based on location

Activity 1.2 – Create a Custom Patient List

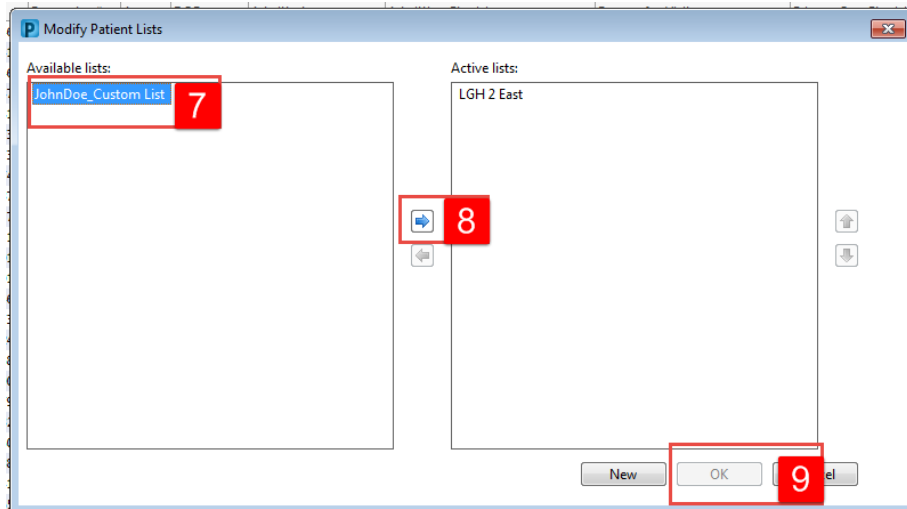
- Next, you need to create a **Custom List** that will contain only the patients that you are providing care for.




- Click **List Maintenance** 
- Click **New**
- Select **Custom**
- Click **Next**

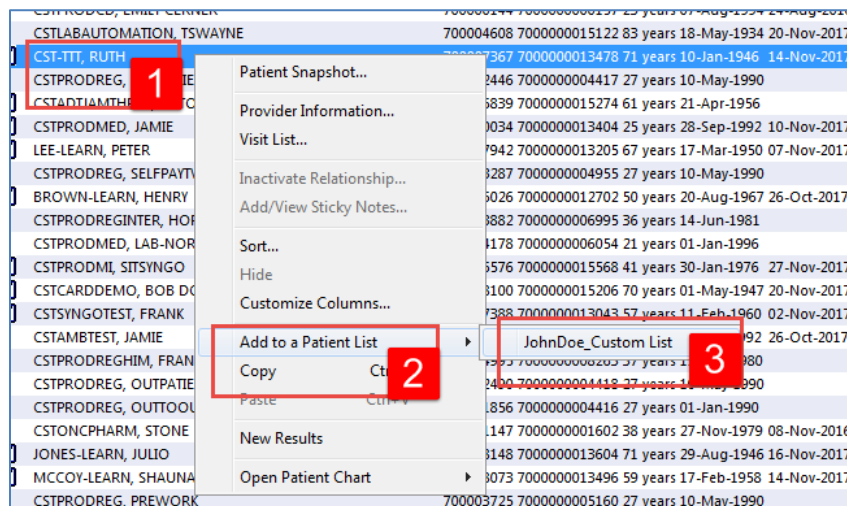


- The **Custom Patient List** window opens. **Custom Lists** need a unique name. Type YourName_Custom (for example, Sara_Custom)
- Click **Finish**

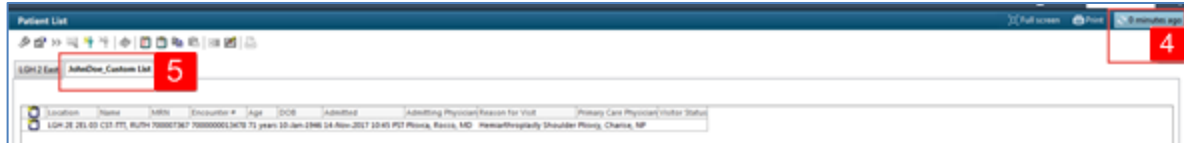



7. In the **Modify Patient Lists** window select your Custom List
8. Click the **Blue Arrow**  to move the **Location** to **Active List**
9. Click **OK**

- 2 At the beginning of each shift or assignment change, you will add your patients to your custom list from your location list




1. First, find your patient on your **Location List**. Right-click on your patient's name
2. Select **Add to a Patient List**
3. Select **YourName_Custom List**




4. Select **YourName_Custom Tab**. The Tab will be empty
5. Click the **Refresh** icon  to refresh your screen. Now your patient will appear in your Custom List

*Please check to ensure this is the patient assigned to you today

Note: you can remove a patient from your custom list by highlighting the patient and clicking the Remove Patient  icon



Key Learning Points

-  You can create a Custom List that can consist of only the patients that you are caring for on your shift

SCENARIO 2 - CareCompass




Learning Objectives

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

-  Navigate CareCompass
-  Review and complete tasked activities

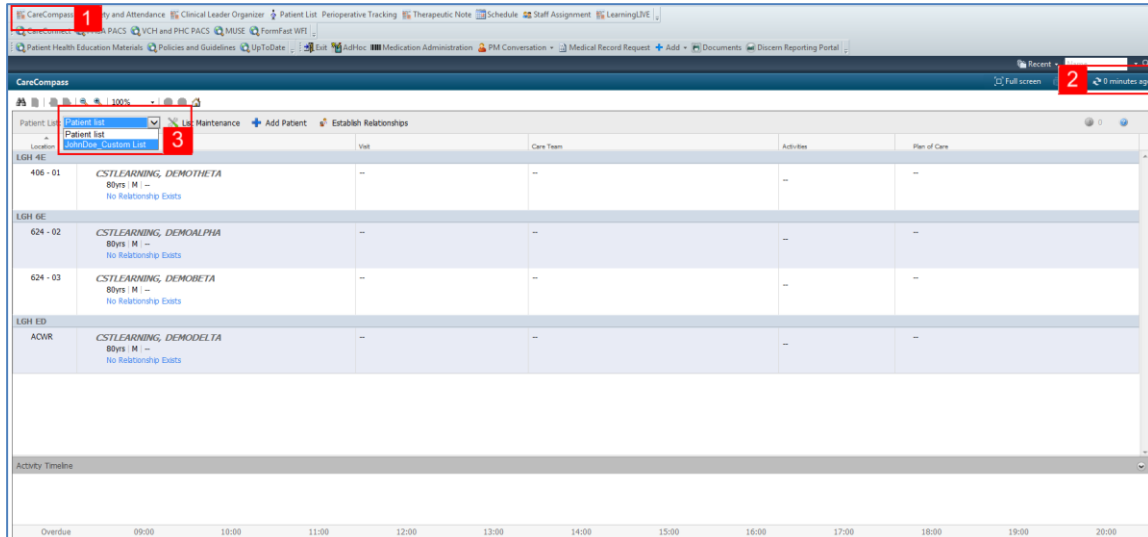
SCENARIO

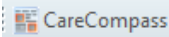

As a mental health nurse you will complete the following activities:

-  Review CareCompass
-  Establish an electronic relationship in the system with your patients and review patient information
-  Review and complete tasks in CareCompass

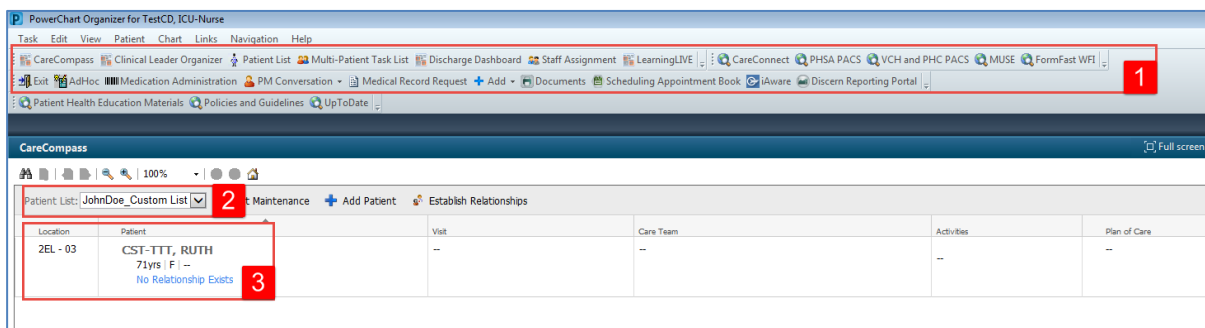
Activity 2.1 - Review CareCompass

- CareCompass** displays information you need for your patients directly, including important details such as allergies, resuscitation status, reason for visit, and scheduled medications/tasks, orders, and results.



- Navigate back to **CareCompass** by clicking on the **CareCompass** icon  in the **Toolbar**
- Click **Refresh**  Your selected patients are now visible on your custom list
- Select **YourName_Custom** from the **Patient List** drop-down

Let's review CareCompass



- The **Toolbar** is a quick way to navigate the Clinical Information System (CIS) using the various buttons
- The **Patient List** drop-down menu enables you to select the appropriate patient list you would like to view
- The only information visible about a patient is their location, name and basic demographics until you establish a relationship

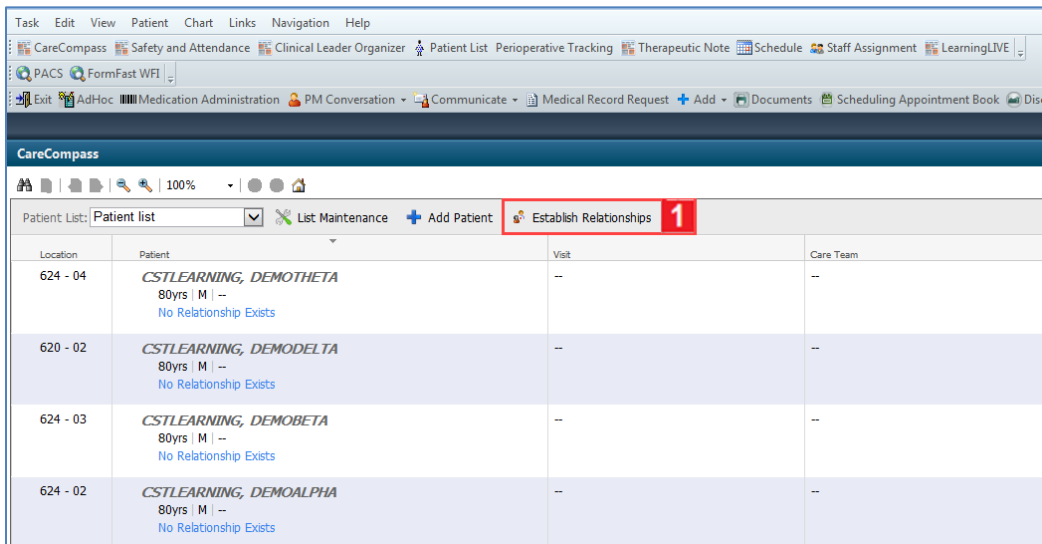
Key Learning Points

- CareCompass provides a quick overview of patient information
- Prior to establishing a relationship with the patient, the only information visible about a patient is their location, name and basic demographics

Activity 2.2 – Establish a Relationship and Review Patient Information in CareCompass

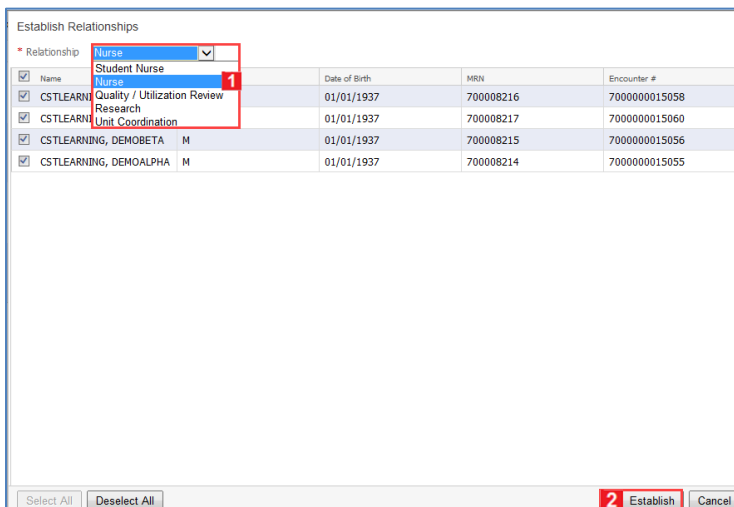
1

Now that you have created your custom list, you must establish a relationship with each of your patients in order to view more patient information or access patient charts.



1. Click **Establish Relationships** 

2



1. From the **Relationship** drop-down select **Nurse**

2. Click **Establish**


Once a relationship is established with your patients, additional information will appear on CareCompass.

Note: A relationship will last for 16 hours after which the nurse will need to re-establish the relationship.

- 3 **CareCompass** provides a quick overview of select patient information including patient care activities and orders that require review.

1. You can hover your cursor over icons, buttons, and patient information to discover additional details

Activity Timeline appears at the bottom of CareCompass. It provides a visual representation of certain activities that are due for the patients on your list

- 4 Notice the **exclamation**  symbol next to your patient's name. This indicates that there are new orders and/or results requiring review.

Note:  Indicates new non-critical results or orders for a patient.

 Indicates new critical results or STAT/NOW orders.

Click the **exclamation**  symbol.

5

Items for Review

CSTLEARNING, DEMODELTA 80yrs 624 - 03

Results
No new results

Orders



	Ordered By	Entered By
<input checked="" type="checkbox"/> heparin 25000 unit + dextrose 5% premix 500 mL... (Modify) ttrate, IV, 18 unit/kg/h starting rate, 8 unit/kg/h minimum r... Comment: - Initial starting rate not to exceed 40 mL/h (2...	Dhingra, Vinay	Test User, Nurse 10:43 Today
<input checked="" type="checkbox"/> HYDRomorphine (HYDRomorphine PRN range dose) dose range: 1 to 2 mg, PO, q4h, PRN pain, drug form: tab, s... Comment: DILAUDID EQUIV	Dhingra, Vinay	Test User, Nurse - ICU 11:54 Today
<input checked="" type="checkbox"/> HYDRomorphine (HYDRomorphine PRN ra... (Discontinue) dose range: 0.1 to 0.5 mg, IV, q4h, PRN pain, drug form: inj... Comment: DILAUDID EQUIV	Dhingra, Vinay	Test User, Nurse - ICU 11:54 Today
<input checked="" type="checkbox"/> Select All		

2 Mark as Reviewed Cancel

1. Review new orders and results in the **Items for Review** window
2. Click **Mark as Reviewed** when done

Once you have marked the orders as reviewed, you are taken back to CareCompass and the orange exclamation symbol will disappear.

Key Learning Points

- A relationship must be established with patients in order to access their chart
- A relationship will last for 16 hours after which the nurse will need to re-establish the relationship
- CareCompass provides a quick overview of patient information including patient care activities, scheduled and unscheduled tasks and new orders and results for the patient
-  Indicates new non-critical results or orders for a patient
-  Indicates new critical results or STAT/NOW orders

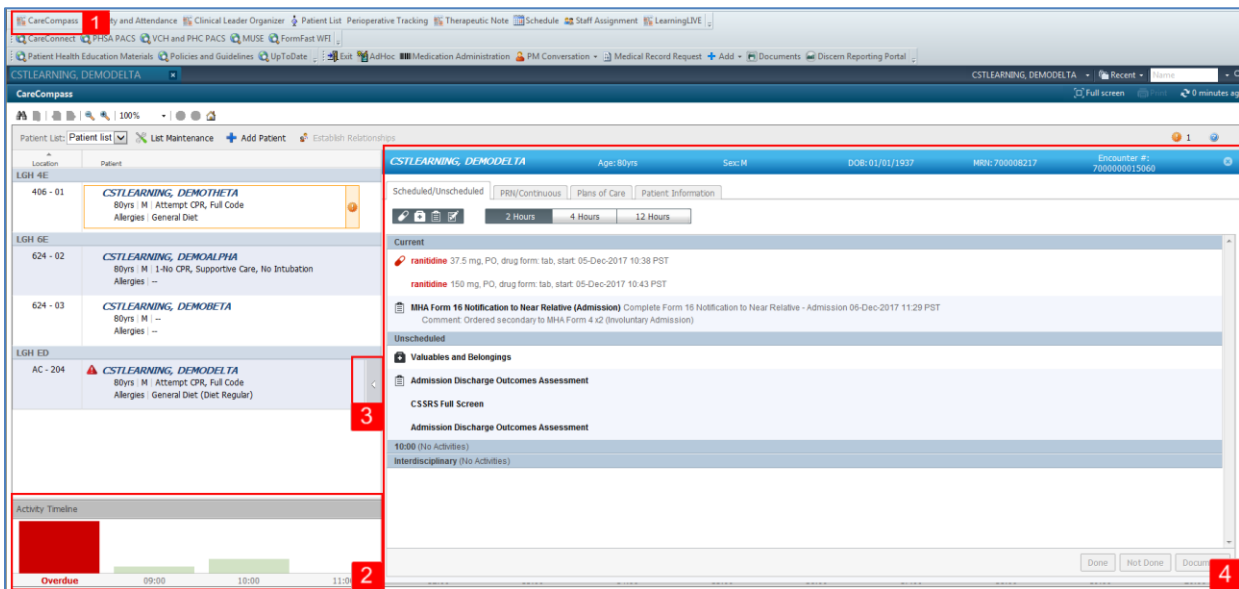
Activity 2.3 – Review and Complete Tasks in CareCompass

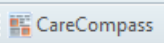

- 1 Tasks are activities that need to be completed for the patient. Tasks are generated by certain orders in the system to notify the clinician to complete specific patient care activities. They are meant to replace your current paper to-do list and highlight activities that are outside of regular care.

Note: Not all orders trigger tasks. For example, collecting a sputum sample is tasked as it is not a regular occurrence, whereas vital signs are part of routine daily care and therefore are not tasked.

It is important to frequently check your task list throughout your shift and to complete activities on your task list in a timely manner so that they do not become overdue.

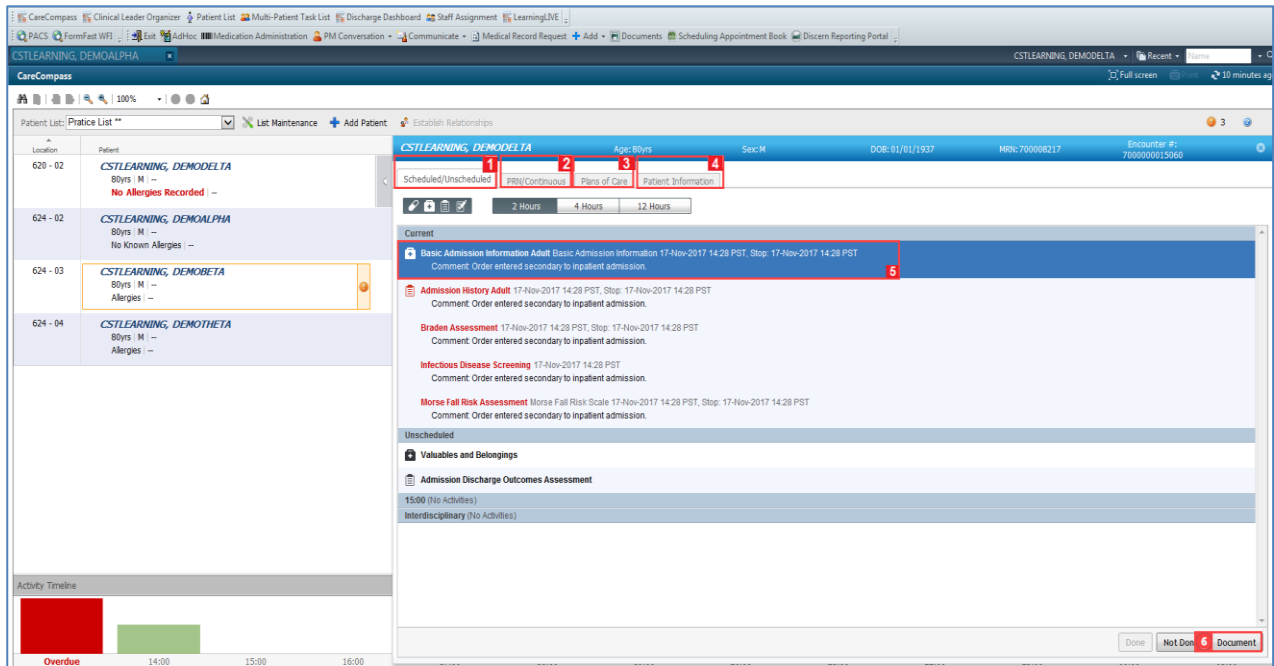
Let's locate tasks on your patient:



1. Click CareCompass  to navigate back to CareCompass
2. Scheduled tasks for multiple patients are summarized in the **Activity Timeline**
3. Click the grey forward arrow  to the right of your patient's name to open the single patient task list
4. Review the tasks for your patient in the task box

2 The task box contains different tabs which help to categorize patient tasks.

To see the different information you can navigate to:



1. **Scheduled/Unscheduled** tasks tab
2. **PRN/Continuous** tab
3. **Plans of Care** tab
4. **Patient Information** tab

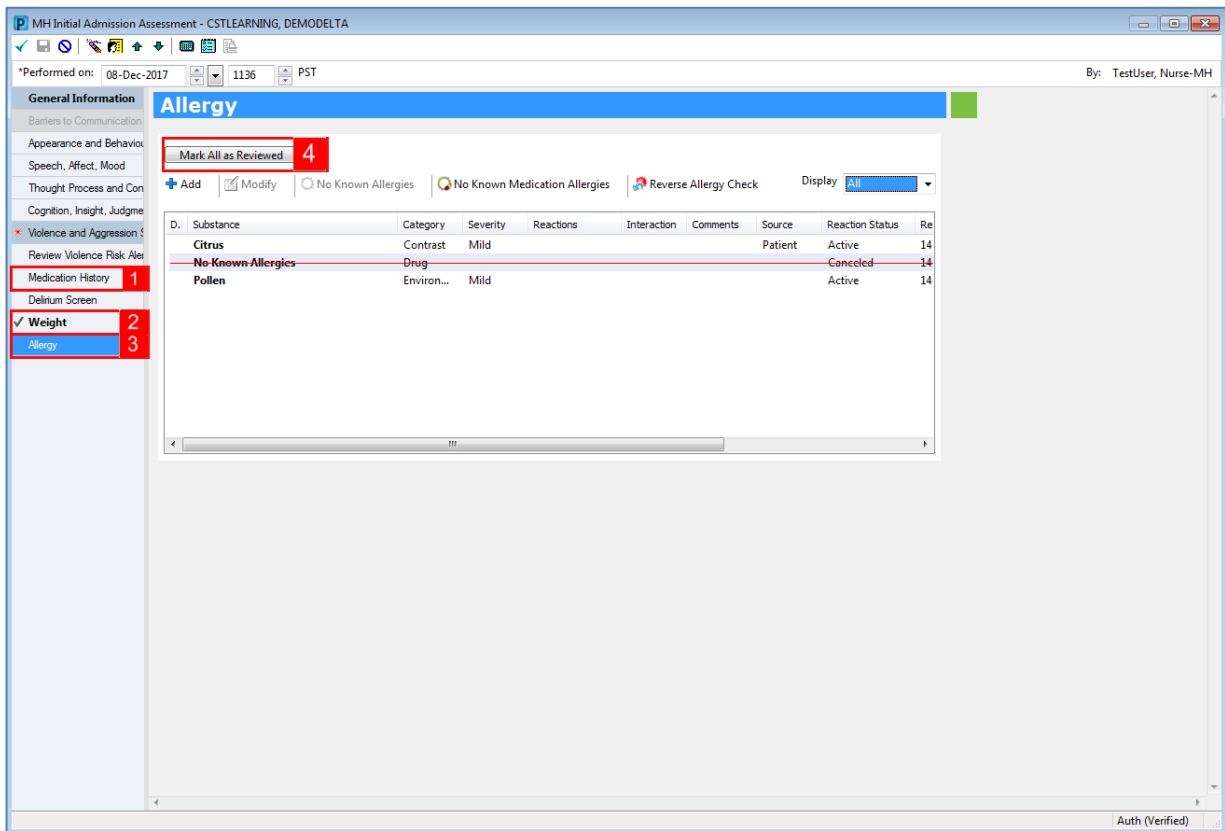
When a patient is admitted to an inpatient unit, a number of admission tasks are generated to show up on the nurse's task list. These tasks are tailored to the patient's age and location. **MH Initial Admission Assessment** is one of these tasks.

Complete the MH Initial Admission Assessment task:

5. Select **MH Initial Admission Assessment**
6. Click **Document**

Note: If a task is associated with documentation, clicking Document takes you directly to the appropriate documentation within the patient's chart. Basic Admission Information Adult is a PowerForm. PowerForms are standardized electronic documentation forms. You will learn about PowerForms in more detail later in this workbook.

3 To complete this PowerForm:



General Information

Barriers to Communication

Appearance and Behavior

Speech, Affect, Mood

Thought Process and Content

Cognition, Insight, Judgment

Violence and Aggression

Review Violence Risk Assessment

Medication History 1

Delirium Screen

Weight 2

Allergy 3

Allergy


Mark All as Reviewed 4

+ Add | Modify | No Known Allergies | No Known Medication Allergies | Reverse Allergy Check | Display All

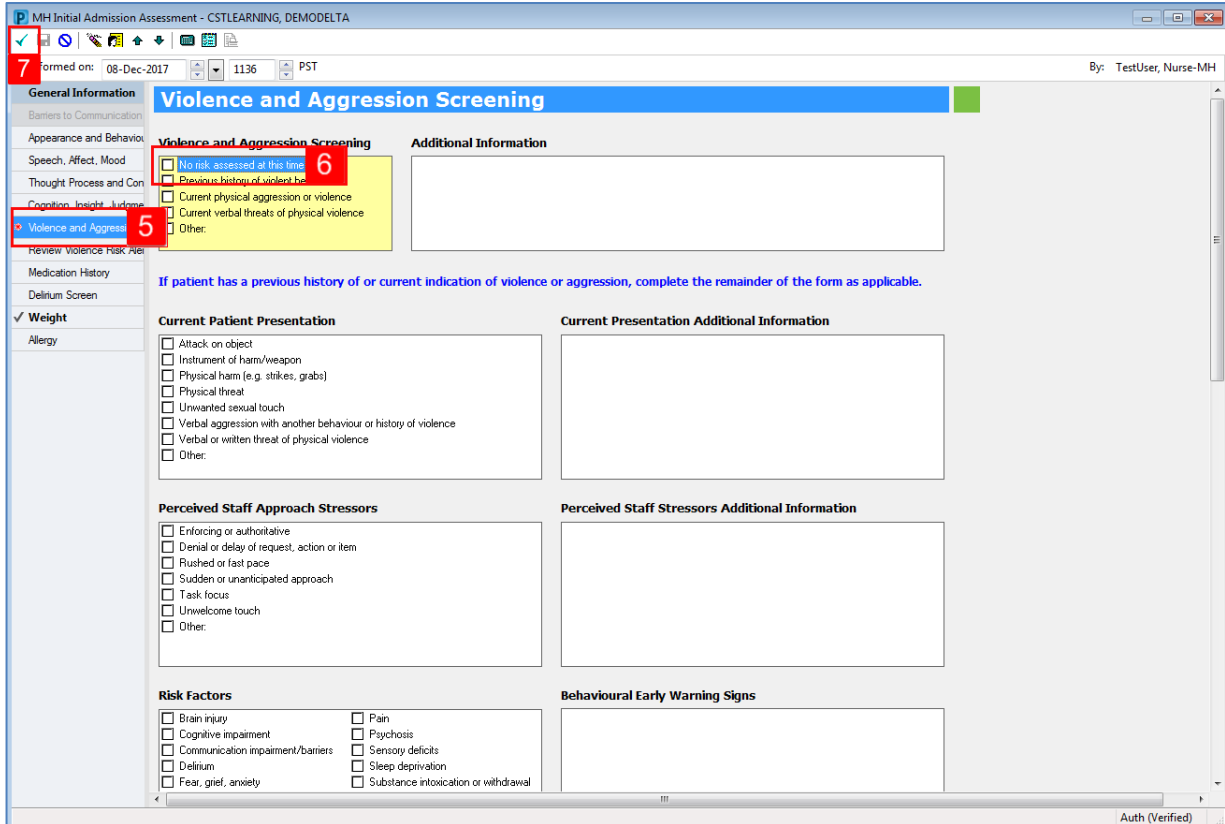
D.	Substance	Category	Severity	Reactions	Interaction	Comments	Source	Reaction Status	Re
	Citrus	Contrast	Mild				Patient	Active	14
	No Known Allergies	Drug						Canceled	14
	Pollen	Environ...	Mild					Active	14

Auth (Verified)

1. Select **Medication History** and review current medications that are ordered for your patient
2. Select **Weight** and review the previously documented weight

Note: Patient information that stays relatively static may be pre-populated throughout the chart if it was previously entered by another clinician and will be pulled forward . In this case, weight and allergies.

3. Select **Allergies** and review the allergies
4. Click **Mark All as Reviewed**



MH Initial Admission Assessment - CSTLEARNING, DEMODELTA

formed on: 08-Dec-2017 1136 PST By: TestUser, Nurse-MH

Violence and Aggression Screening

☐ No risk assessed at this time **6**

☐ Previous history of violent behavior

☐ Current physical aggression or violence

☐ Current verbal threats of physical violence

☐ Other:

Additional Information

If patient has a previous history of or current indication of violence or aggression, complete the remainder of the form as applicable.

Current Patient Presentation

☐ Attack on object

☐ Instrument of harm/weapon

☐ Physical harm (e.g. strikes, grabs)

☐ Physical threat

☐ Unwanted sexual touch

☐ Verbal aggression with another behaviour or history of violence

☐ Verbal or written threat of physical violence

☐ Other:

Current Presentation Additional Information

Perceived Staff Approach Stressors

☐ Enforcing or authoritative

☐ Denial or delay of request, action or item

☐ Rushed or fast pace

☐ Sudden or unanticipated approach

☐ Task focus

☐ Unwelcome touch

☐ Other:

Perceived Staff Stressors Additional Information

Risk Factors

☐ Brain injury

☐ Cognitive impairment

☐ Communication impairment/barriers

☐ Delirium

☐ Fear, grief, anxiety

☐ Pain

☐ Psychosis

☐ Sensory deficits

☐ Sleep deprivation

☐ Substance intoxication or withdrawal

Behavioural Early Warning Signs

Auth (Verified)

5. Select **Violence and Aggression Screening**

6. Select the checkbox next to **No risk assessed at this time**

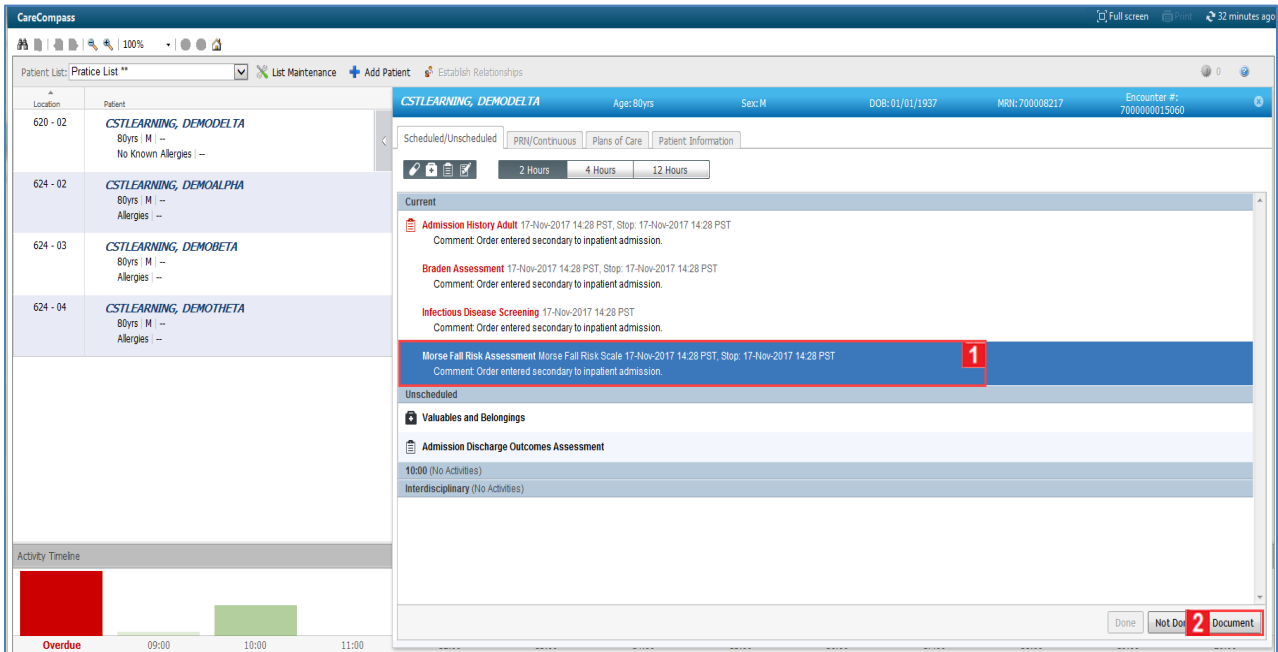
7. Click the green check mark to sign your documentation and refresh screen.

After signing the PowerForm, you will be brought back to CareCompass.

Note: This task will disappear from the patient's task list once complete.

4 Let's complete another admission task.

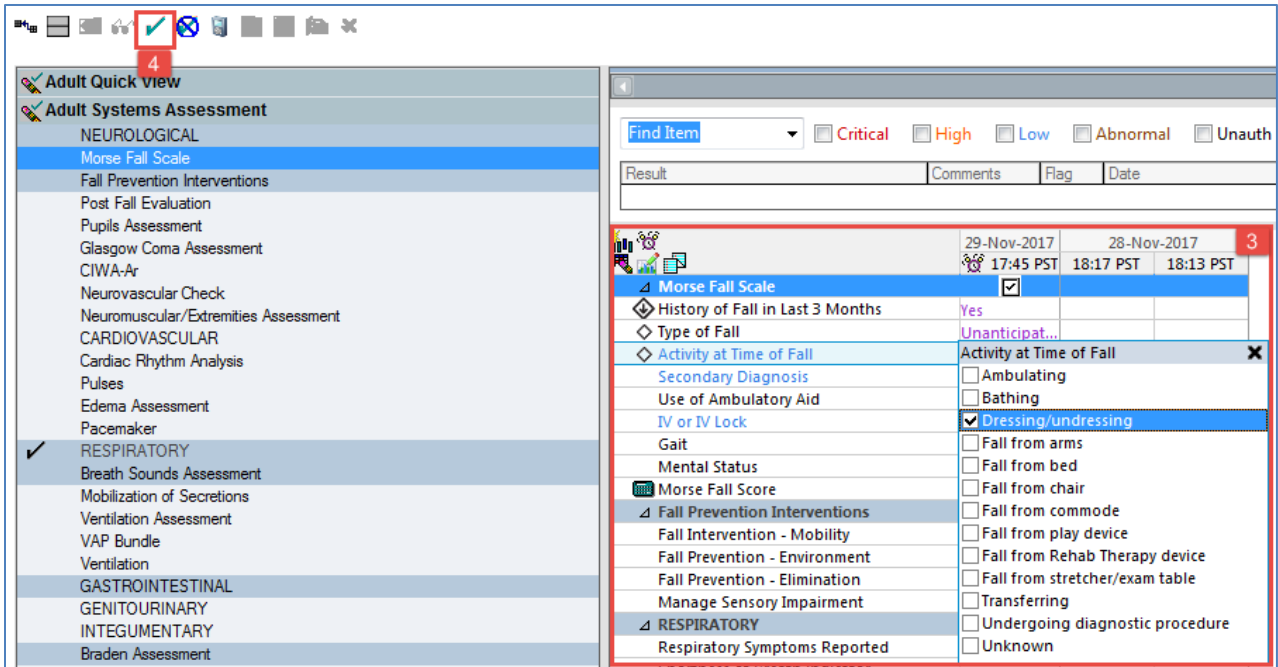
Complete the **Morse Fall Risk Assessment** task:



The screenshot shows the CareCompass interface. On the left is a patient list with columns for Location and Patient. The main area displays patient information for CSTLEARNING, DEMODELTA, including Age, Sex, DOB, MRN, and Encounter #. Below this is a list of tasks with tabs for Scheduled/Unscheduled, PBN/Continuous, Plans of Care, and Patient Information. The 'Morse Fall Risk Assessment' task is highlighted in blue and marked with a red '1'. Below the task list, there are buttons for 'Done', 'Not Done', and 'Document', with the 'Document' button marked with a red '2'.

1. Select **Morse Fall Risk Assessment**
2. Click **Document**

Note: Clicking **Document** for **Morse Fall Risk Assessment** takes you directly to **Interactive View and I&O**. Interactive View and I&O provides access to a variety of electronic flowsheets for documentation of care and assessments such as vital signs and mental status exam.



Adult Quick view

Adult Systems Assessment

NEUROLOGICAL

Morse Fall Scale

Fall Prevention Interventions

Post Fall Evaluation

Pupils Assessment

Glasgow Coma Assessment

CIWA-Ar

Neurovascular Check

Neuromuscular/Extremities Assessment

CARDIOVASCULAR

Cardiac Rhythm Analysis

Pulses

Edema Assessment

Pacemaker

✓ RESPIRATORY

Breath Sounds Assessment

Mobilization of Secretions

Ventilation Assessment

VAP Bundle

Ventilation

GASTROINTESTINAL

GENITOURINARY

INTEGUMENTARY

Braden Assessment

Find Item

Result

Comments

Flag

Date

29-Nov-2017 17:45 PST

28-Nov-2017 18:17 PST

3

✓ Morse Fall Scale

History of Fall in Last 3 Months Yes

Type of Fall Unanticipat...

Activity at Time of Fall Activity at Time of Fall

Secondary Diagnosis

Use of Ambulatory Aid

IV or IV Lock

Gait

Mental Status

Morse Fall Score

Fall Prevention Interventions

Fall Intervention - Mobility

Fall Prevention - Environment

Fall Prevention - Elimination

Manage Sensory Impairment

RESPIRATORY

Respiratory Symptoms Reported

Unknown

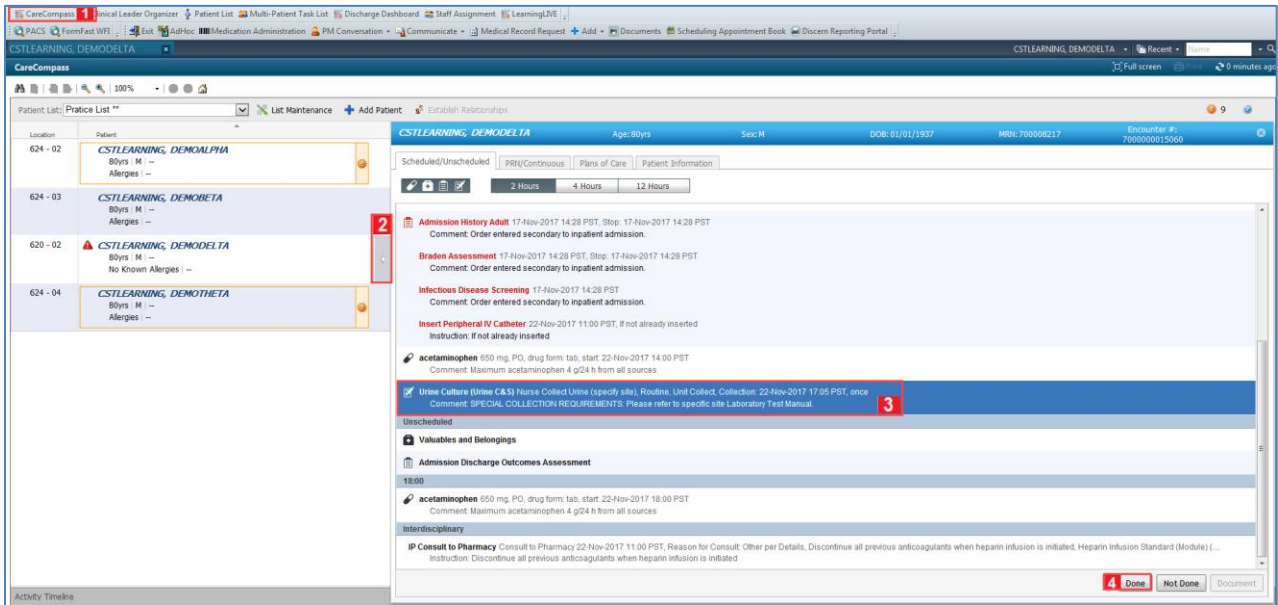
3. Document using the following data:


- **History of Fall in Last 3 Months Morse** = Yes
- **Type of Fall Morse** = *Unanticipated physiological*
- **Activity at Time of Fall Morse** = *Dressing/undressing*
- **Secondary Diagnosis Morse** = Yes
- **Use of Ambulatory Aid Morse** = *Crutches, cane, walker*
- **IV or IV Lock** = No
- **Gait Weak or Impaired Fall Risk Morse** = *Weak*
- **Mental Status Fall Risk Morse** = *Oriented to own ability*

A **Morse Fall Risk Score** is automatically calculated based on the information inputted during documentation. Note for this activity the calculated score is **65**.

4. Click the **green check mark** ✓ to sign your documentation. You will notice that your documentation changes from purple text to black text once signed.

- 5 Let's complete one final task. You have collected a urine sample from your patient as per the order.



1. Navigate back to **CareCompass** by clicking **CareCompass**
2. Click the grey arrow  to open the task box
3. Select **Urine Culture (Urine C&S)**
4. Click **Done**

A **Nurse Collect** box appears. Review the information and click **OK**

Note: For the purpose of this workbook, the additional Admission tasks will not be addressed but will need to be completed in your clinical setting. It is important to review CareCompass and patient task lists throughout your shift to view new orders and results, tasks and more.

Key Learning Points

- Tasks are activities that are meant to replace your current paper to-do list
- Tasks are generated by certain orders in the system to notify the clinician to complete specific patient care activities
- Completing a task will remove it from the Patient Task List
- CareCompass should be reviewed frequently throughout the shift

PATIENT SCENARIO 3 – Accessing and Navigating the Patient Chart

Learning Objectives

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

- Access the patient's chart from CareCompass
- Navigate the patient's chart

SCENARIO

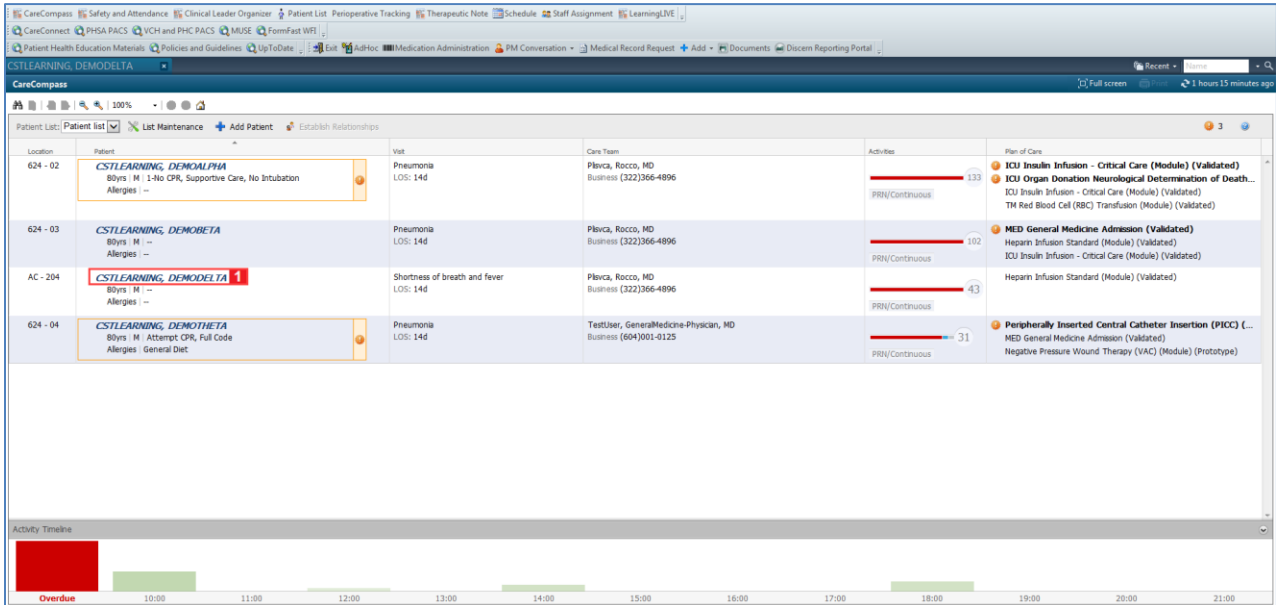
In this scenario, you will review how to access the patient's chart and navigate the different pages of the chart to learn more about the patient.

As a mental health nurse you will be completing the following activities:

- Introduction to Banner Bar, Toolbar, and Menu
- Introduction to Patient Summary

Activity 3.1 – Introduction to Banner Bar, Toolbar, and Menu

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



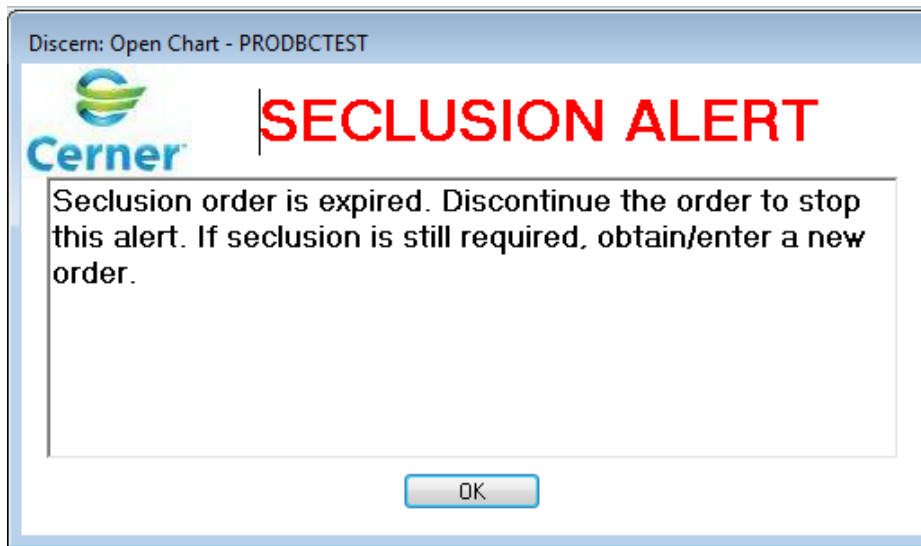
The screenshot displays the CareCompass Patient List. The table lists four patients:

Location	Patient	Visit	Care Team	Activities	Plan of Care
624 - 02	CSTLEARNING, DEMOALPHA 80yrs M 1-No CPR, Supportive Care, No Intubation Allergies -	Pneumonia LOS: 14d	Plavca, Rocco, MD Business (322)366-4896	PRN/Continuous 133	ICU Insulin Infusion - Critical Care (Module) (Validated) ICU Organ Donation Neurological Determination of Death... ICU Insulin Infusion - Critical Care (Module) (Validated) TM Red Blood Cell (RBC) Transfusion (Module) (Validated)
624 - 03	CSTLEARNING, DEMOBETA 80yrs M --- Allergies -	Pneumonia LOS: 14d	Plavca, Rocco, MD Business (322)366-4896	PRN/Continuous 102	MED General Medicine Admission (Validated) Heparin Infusion Standard (Module) (Validated) ICU Insulin Infusion - Critical Care (Module) (Validated)
AC - 204	CSTLEARNING, DEMODELTA 1 80yrs M --- Allergies -	Shortness of breath and fever LOS: 14d	Plavca, Rocco, MD Business (322)366-4896	PRN/Continuous 43	Heparin Infusion Standard (Module) (Validated)
624 - 04	CSTLEARNING, DEMOTHETA 80yrs M 1-Attempt CPR, Full Code Allergies General Diet	Pneumonia LOS: 14d	TestUser, GeneralMedicine-Physician, MD Business (604)801-8125	PRN/Continuous 31	Peripherally Inserted Central Catheter Insertion (PICC) (...) MED General Medicine Admission (Validated) Negative Pressure Wound Therapy (VAC) (Module) (Prototype)

The Activity Timeline at the bottom shows a red bar for 'Overdue' status.

- 2 The patient's chart is now open.

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



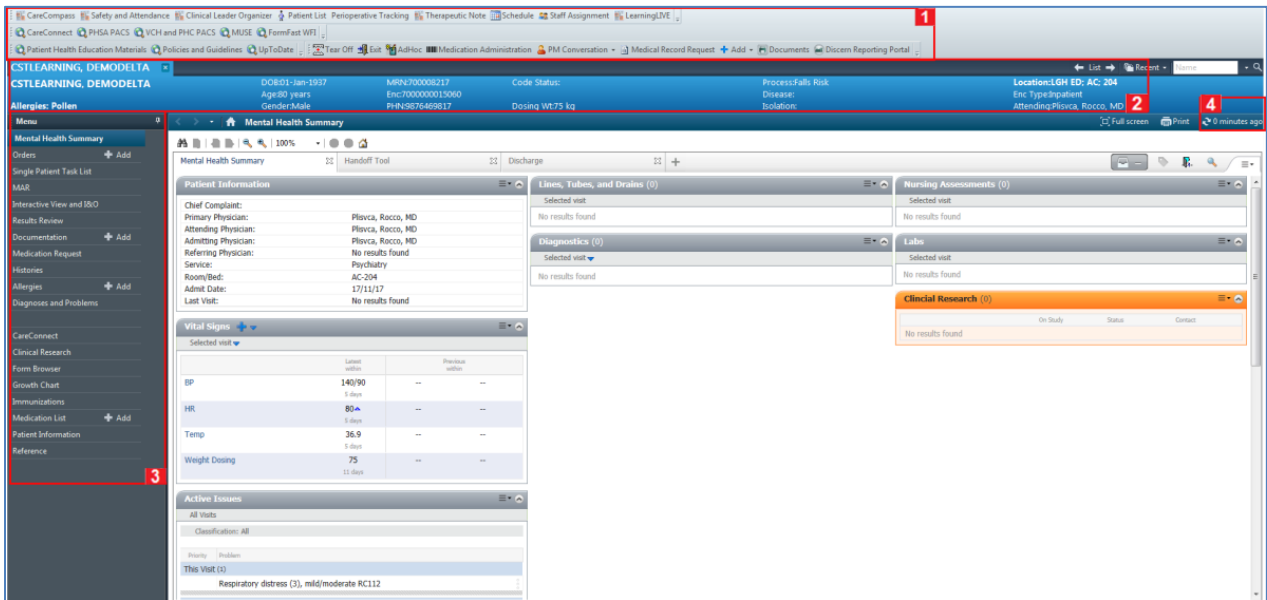
Discern: Open Chart - PRODBCTEST


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

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



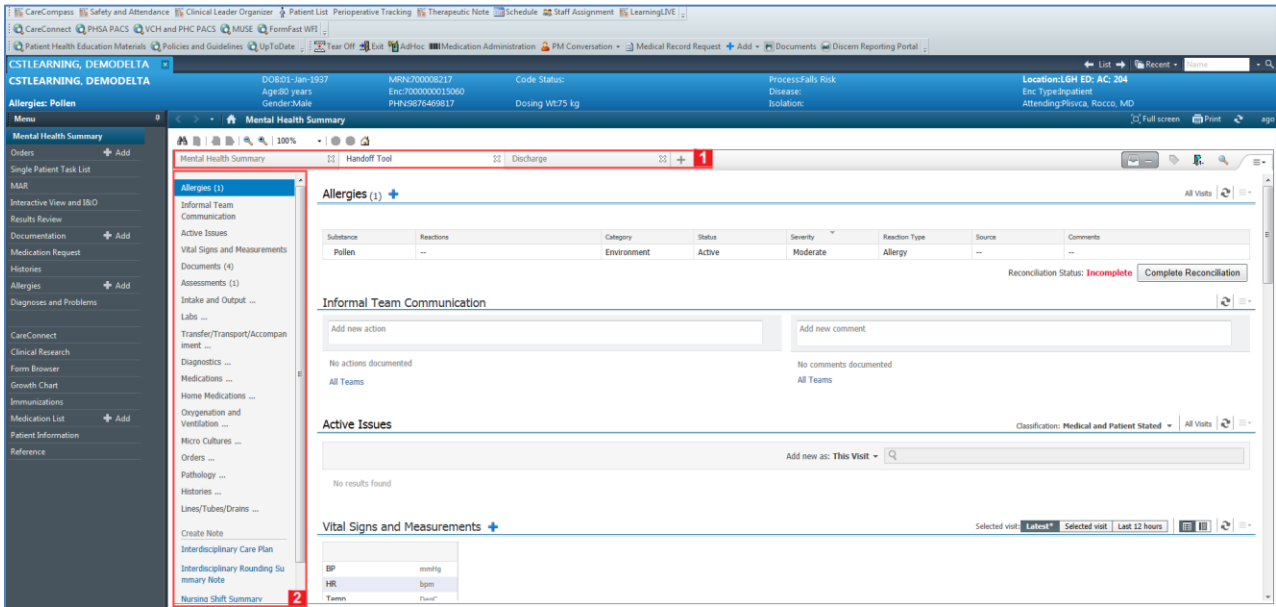
Key Learning Points

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

Activity 3.2 – 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. Click on the **Handoff Tool** tab. Note the different components. You can navigate through these using the component list on the **Handoff** and **Discharge** tabs




Key Learning Points

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

PATIENT SCENARIO 4 - 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.

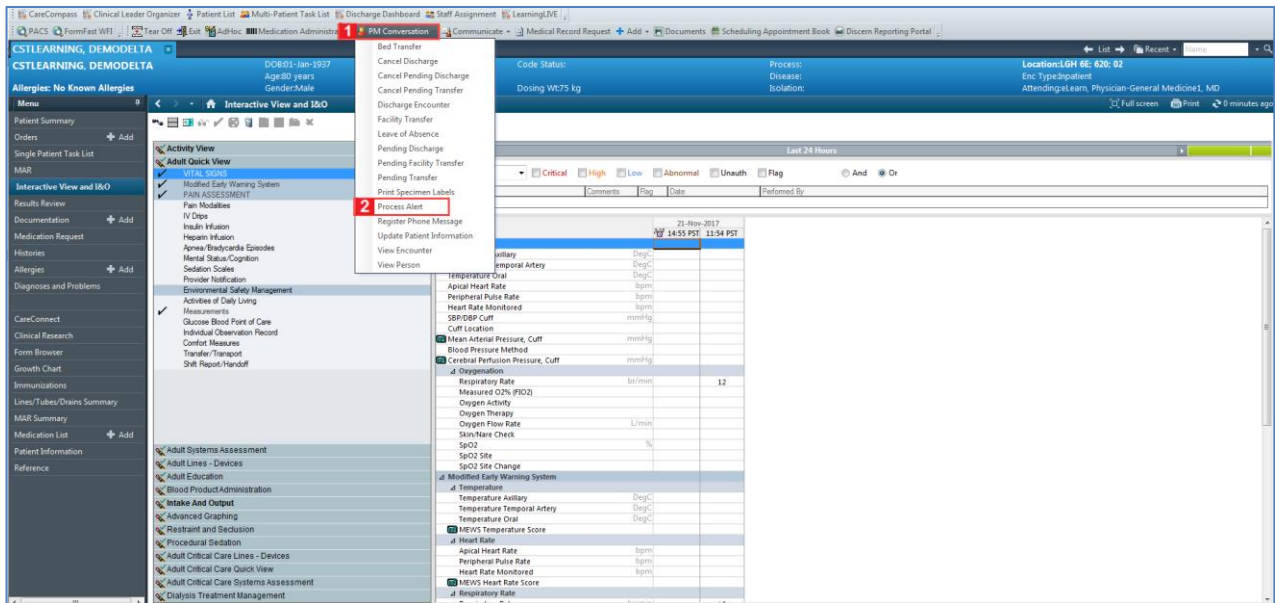
As a mental health nurse, you will be completing the following activities:

-  Activating a process alert

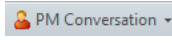
Activity 4.1 – PM Conversation

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

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



The screenshot shows the 'PM Conversation' interface. The top toolbar includes tabs for 'PACS', 'FormFast WFI', 'Tear Off', 'Add', 'PM Conversation', 'Communicate', 'Medical Record Request', 'Add', 'Documents', 'Scheduling Appointment Book', and 'Discontinuation Reporting Portal'. The 'PM Conversation' tab is active. The left sidebar shows a menu with options like 'Patient Summary', 'Orders', 'Single Patient Task List', 'MAR', 'Interactive View and I&O', 'Results Review', 'Documentation', 'Medication Request', 'Histories', 'Allergies', 'Diagnoses and Problems', 'CareConnect', 'Clinical Research', 'Form Browser', 'Growth Chart', 'Immunizations', 'Lines/Tubes/Drains Summary', 'MAR Summary', 'Medication List', 'Patient Information', and 'Reference'. The main content area displays a patient's chart with various tabs and a list of alerts. A red box highlights the 'Process Alert' option in the 'PM Conversation' dropdown menu.

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

An organization window will display to select location



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

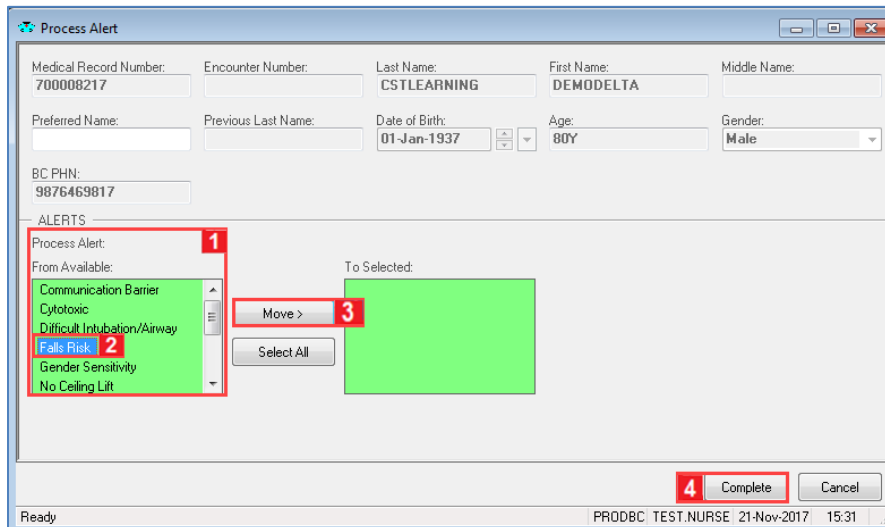
Facility:
LGH Lions Gate Hospital

3 OK Cancel

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

2

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



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: 1

From Available:

Communication Barrier

Cytotoxic

Difficult Intubation/Airway

Falls Risk 2

Gender Sensitivity

No Ceiling Lift

To Selected:

Move > 3

Select All


4 Complete Cancel

Ready PRODBC TEST.NURSE 21-Nov-2017 15:31

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

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



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




Key Learning Points

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

PATIENT SCENARIO 5 - 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

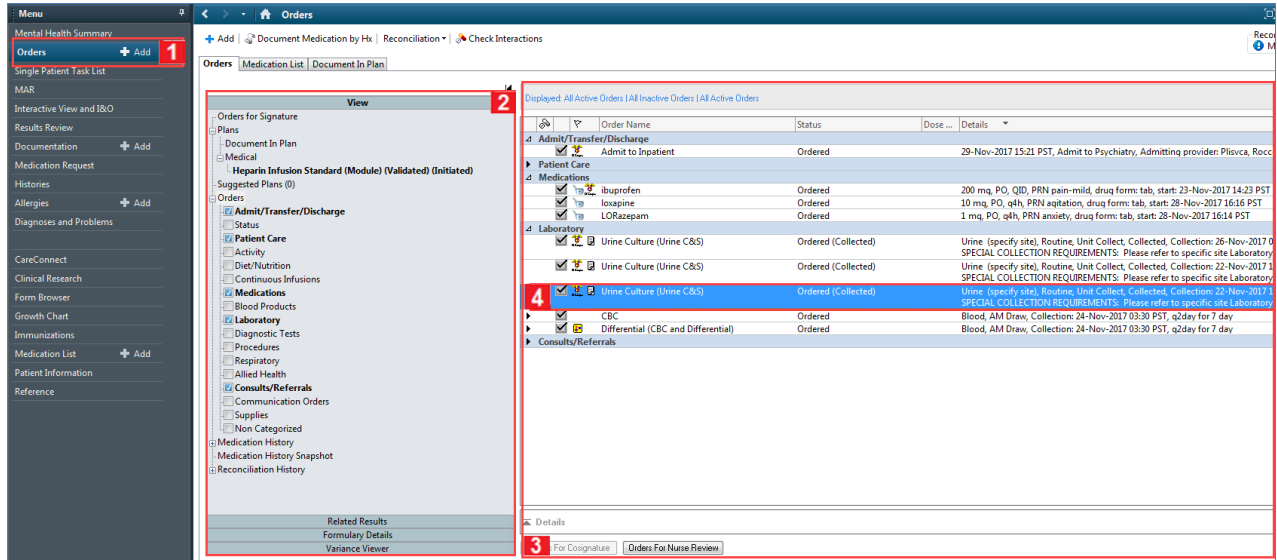
As a mental health nurse, you will need to be able to review orders for your patient. You will also need to place orders for your patient in certain situations. To do so you will complete the following activities:

-  Review Orders Page
-  Place a No Cosignature Required Order
-  Review Order Statuses and Details
-  Place a Verbal Order
-  Complete an Order
-  Review Components of a PowerPlan

Activity 5.1 – Review Orders Profile

- 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:



- Select **Orders** from the **Menu**
- 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
- On the right side is the **Order Profile** you can:
 - Review the list of orders

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

Some examples of icons are:

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

- Locate the **Urine Culture** order and review the details

Key Learning Points

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

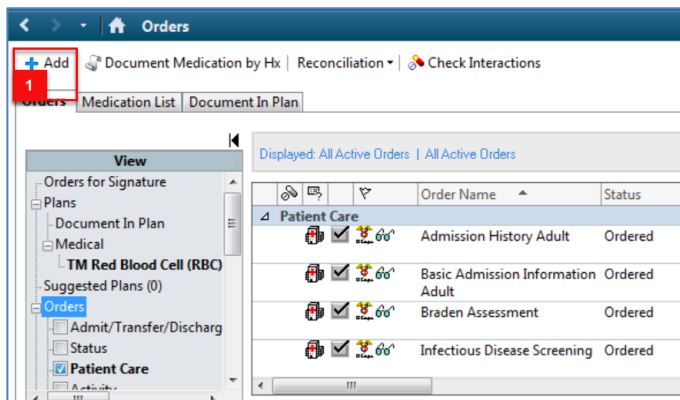
Activity 5.2 – Place a No Cosignature Required Order

1 Throughout your shift, you will review your patient's orders.

Nurses can place the following types of orders:

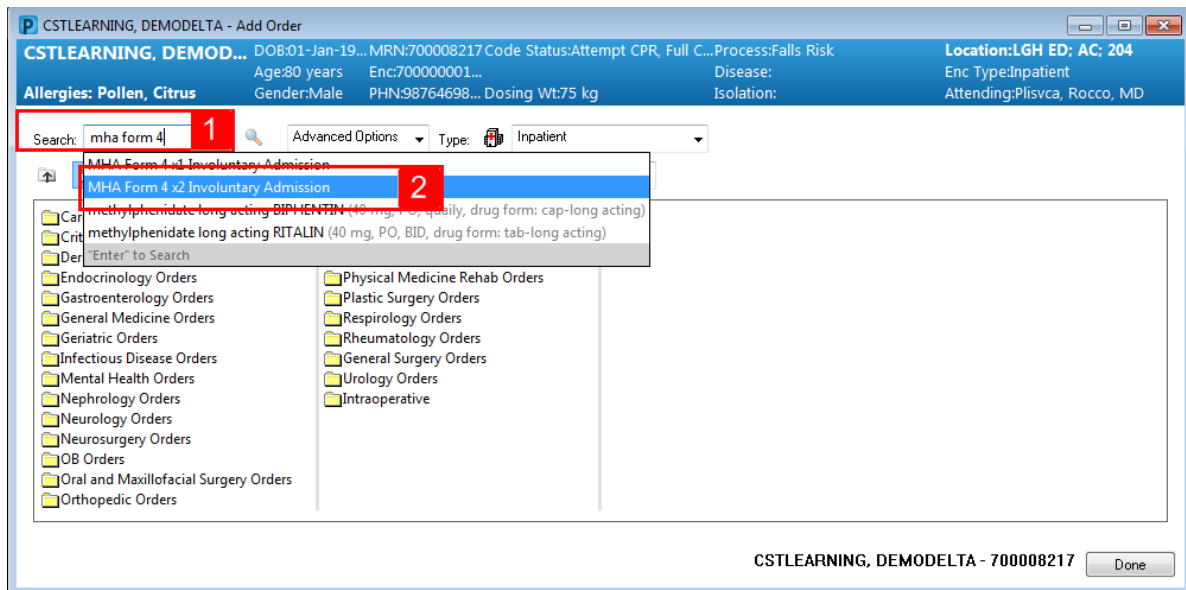
- Orders requiring a cosignature of the provider (for example, telephone and verbal orders)
- Orders that do not require a cosignature (for example, order within nursing scope, nurse initiated orders)

To place an order that does **not** require a cosignature (nurse initiated order):



1. Click the **Add** button  on the **Orders** Page

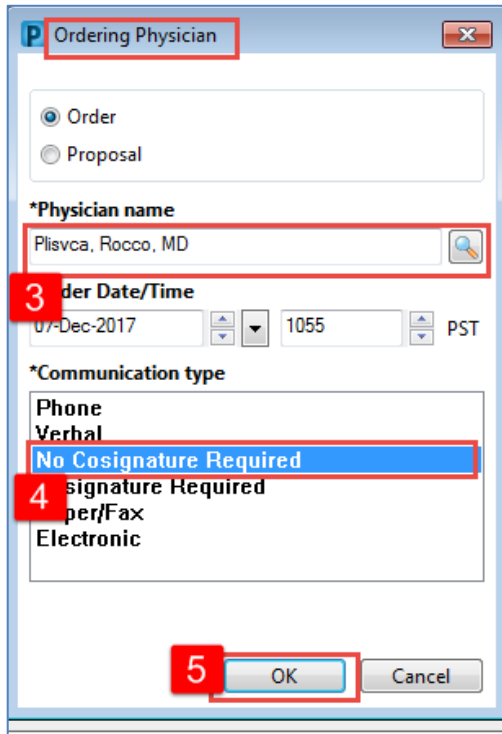
The add order window will open.



1. Type = *MHA Form 4* into the search window and a list of choices will display


2. Select **MHA Form 4 x2 Involuntary Admission**

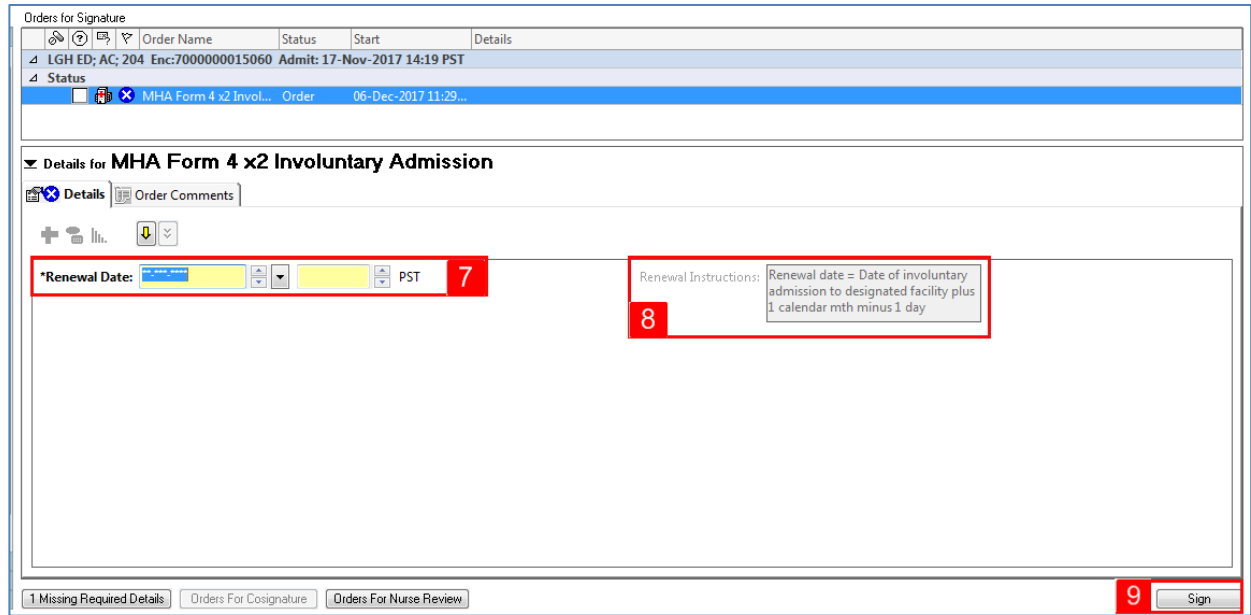
The **Ordering Physician** window opens



The screenshot shows the 'Ordering Physician' window. At the top, the title bar says 'Ordering Physician'. Below it, there are two radio buttons: 'Order' (selected) and 'Proposal'. Underneath is a field for '*Physician name' containing 'Plisvca, Rocco, MD'. Below that is a section for 'Order Date/Time' with a date of '07-Dec-2017', a time of '1055', and a time zone of 'PST'. Below this is a section for '*Communication type' with a list of options: 'Phone', 'Verbal', 'No Cosignature Required' (highlighted in blue), 'Signature Required', 'Paper/Fax', and 'Electronic'. At the bottom, there are 'OK' and 'Cancel' buttons. Red callout boxes with numbers 3, 4, and 5 point to the physician name field, the 'No Cosignature Required' option, and the 'OK' button, respectively.


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

You will be returned to the Orders Page and see the order details. Notice that in the order has a blue X icon  next to it. This alerts you that the order requires additional details. In some cases, this might be a reason for the order or a time for completion of the order. In this case, you must enter an expiry date for the Form 4.





7. Enter a renewal date = *30 days from today's date* and time = 2359
8. Note the Renewal instructions appear as a comment in the order details window. Order comments can be modified and reviewed for most orders
9. Click **Sign**

You are brought back to the patient's Orders page. The MHA Form 4 x2 order has a status of "processing".

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






Key Learning Points

-  Nurses can place Nurse Initiated orders as No Cosignature Required Orders
-  Order details help to provide additional information/details for an order



Activity 5.3 – Review Order Status and Details

1 Orders are classified by status including:

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

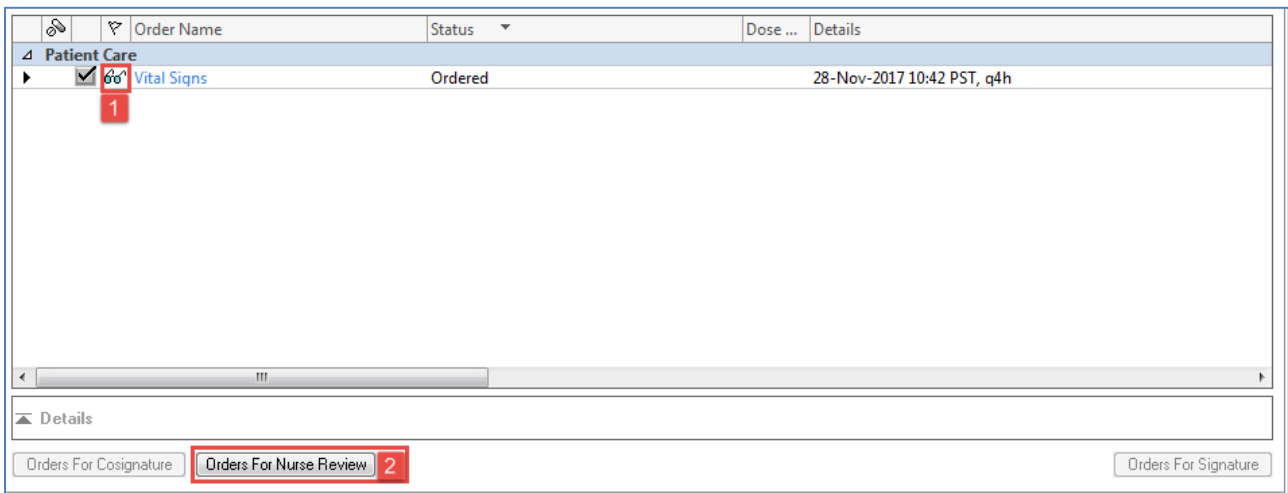
	Order Name	Status	Dose ...	Details	Proposal
	Insert Peripheral IV...	Processing		20-Nov-2017 11:46 PST	
	Insert Urinary Cath...	Ordered		20-Nov-2017 11:31 PST, Indwelling	
	Morse Fall Risk Assessment	Ordered		17-Nov-2017 14:05 PST, Stop: 17-Nov-2017 14:05 PST Order entered secondary to inpatient admission.	
	Vital Signs			20-Nov-2017 11:25 PST, q4h while awake	
Medications					
	furosemide	Ordered		20 mg, IV, as directed, order duration: 5 day, drug form: inj, start: 17-Nov- Administer pre red blood cell transfusion	

To see examples of order details review the image below:

	Order Name	Status	Dose ...	Details
Patient Care				
	Vital Signs	Ordered		28-Nov-2017 10:42 PST, q4h
Blood Products				
	Red Blood Cell Transfusion	Ordered		Routine, Administer: 1 unit, IV, once, Administer each over: 120 - 180 Minutes, Irradiated, Please call... Informed consent must be present on patient record
				Red Blood Cell Transfusion Details: Routine, Administer: 1 unit, IV, once, Administer each over: 120 - 180 Minutes, Irradiated, Please callwhen ready for pick up, 28-Nov-2017 11:04 PST Order Comment: Informed consent must be present on patient record

- 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 on 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.

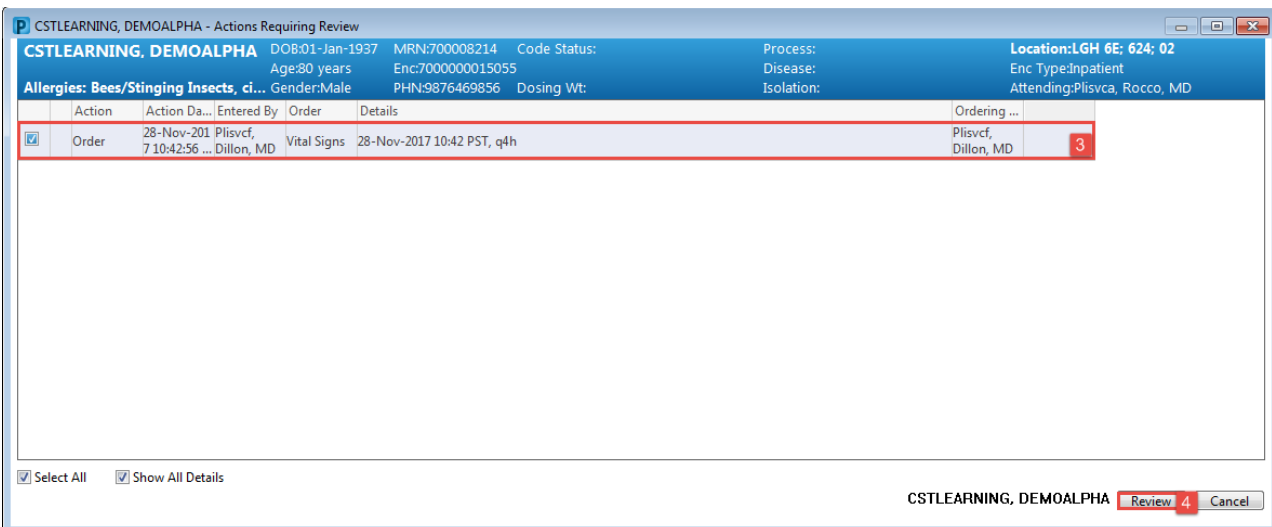


Order Name	Status	Dose ...	Details
<input checked="" type="checkbox"/> Vital Signs	Ordered		28-Nov-2017 10:42 PST, q4h

Details

Orders For Cosignature **Orders For Nurse Review** Orders For Signature

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



CSTLEARNING, DEMOALPHA - Actions Requiring Review

CSTLEARNING, DEMOALPHA		DOB: 01-Jan-1937	MRN: 700008214	Code Status:	Process:	Location: LGH 6E: 624: 02
		Age: 80 years	Enc: 7000000015055		Disease:	Enc Type: Inpatient
Allergies: Bees/Stinging Insects, ci...		Gender: Male	PHN: 9876469856	Dosing Wt:	Isolation:	Attending: Plisvca, Rocco, MD

	Action	Action Da...	Entered By	Order	Details	Ordering ...
<input checked="" type="checkbox"/>	Order	28-Nov-201 7 10:42:56 ...	Plisvcf, Dillon, MD	Vital Signs	28-Nov-2017 10:42 PST, q4h	Plisvcf, Dillon, MD

☒ Select All ☒ Show All Details

CSTLEARNING, DEMOALPHA **Review** Cancel

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

Key Learning Points

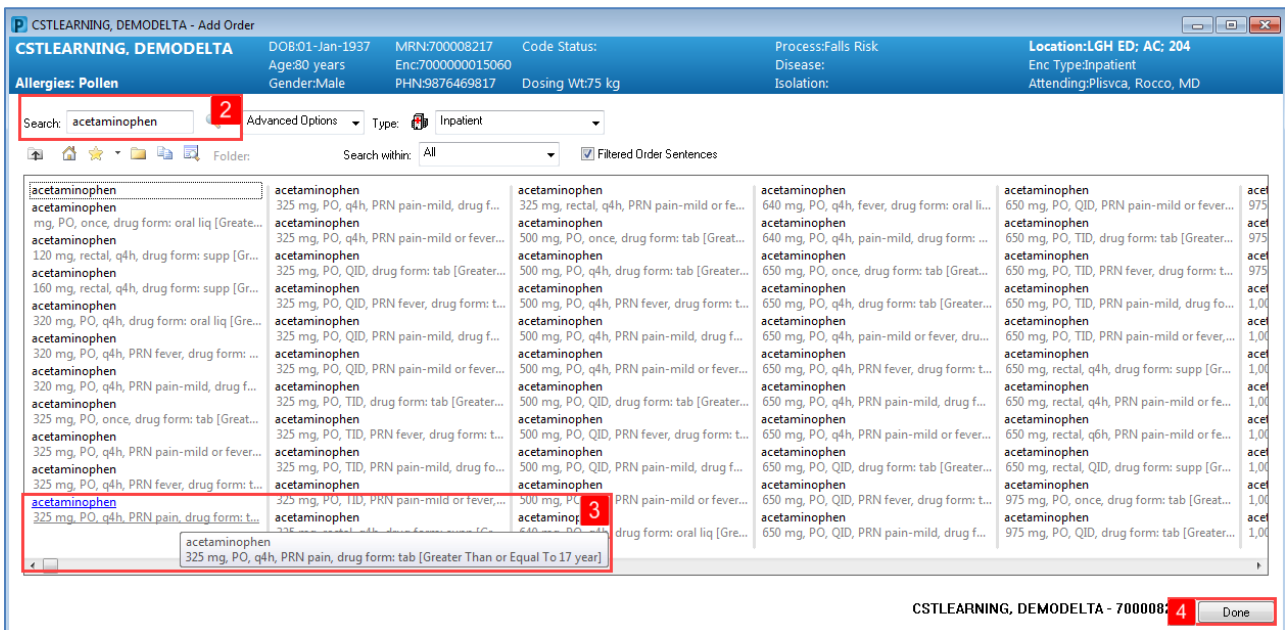
- Orders can be one of three statuses: processing, ordered, proposed
- Always ensure to verify the status of orders

Activity 5.4 – 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:



The screenshot shows the 'CSTLEARNING, DEMODELTA - Add Order' window. At the top, patient information is displayed: DOB:01-Jan-1937, MRN:700008217, Code Status: Process:Falls Risk, Location:LGH ED: AC: 204, Age:80 years, Enc:7000000015060, Disease: Enc Type:Inpatient, Gender:Male, PHN:9876469817, Dosing Wt:75 kg, Allergies: Pollen, and Attending:Plisvca, Rocco, MD. Below this is a search bar with 'acetaminophen' entered. A red box highlights the search bar and the first result. Another red box highlights the 'Add' button at the bottom right.

- Click Add 
- In the Add Order window, type = *acetaminophen* in the search field and press **enter** to search
- Select **acetaminophen, 325, PO, q4h, PRN pain, drug form: tab [Greater Than or Equal To 17 year]**

The Ordering Physician pop-up window will appear

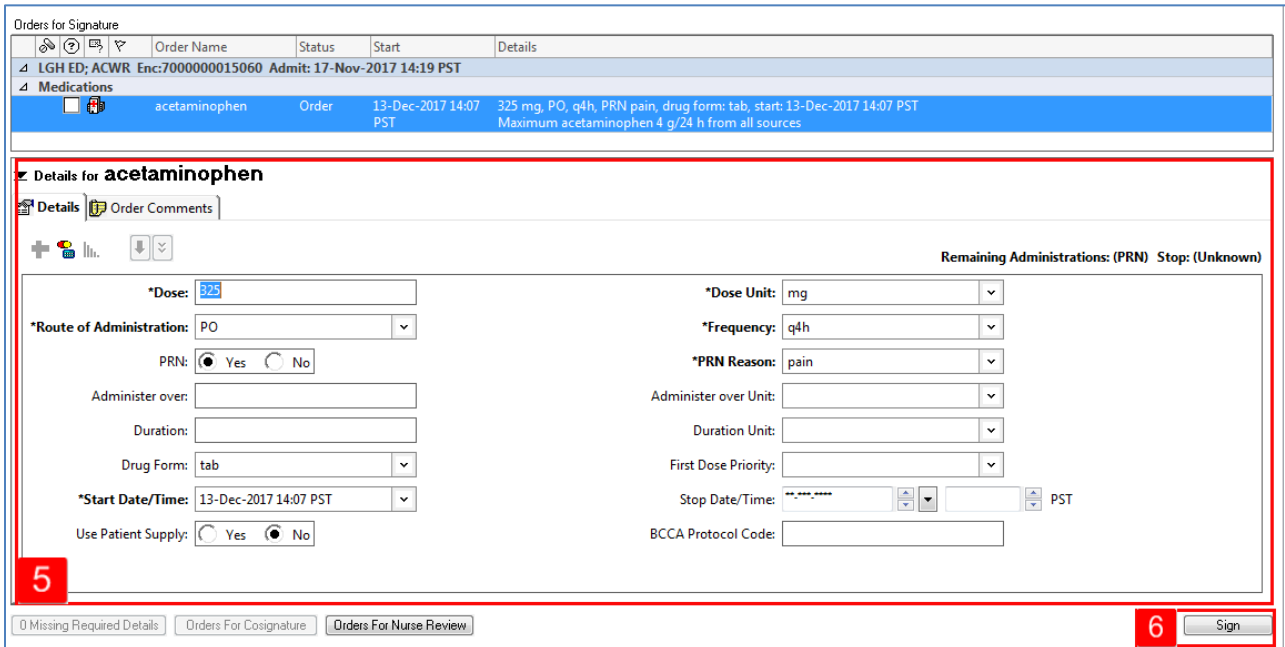
Fill out required fields highlighted yellow:

- Physician name** = *type name of Attending Physician (last name, first name)*
- Communication type** = *Phone*
- Click **OK**

You are brought back to the orders window.

4. Click **Done**

You are brought to the Orders Review window. Review the order details



Orders for Signature

Order Name	Status	Start	Details
LGH ED; ACWR Enc:7000000015060 Admit: 17-Nov-2017 14:19 PST			
Medications			
acetaminophen	Order	13-Dec-2017 14:07 PST	325 mg, PO, q4h, PRN pain, drug form: tab, start: 13-Dec-2017 14:07 PST Maximum acetaminophen 4 g/24 h from all sources

Details for acetaminophen

Details | Order Comments

Remaining Administrations: (PRN) Stop: (Unknown)

*Dose: 325 *Dose Unit: mg

*Route of Administration: PO *Frequency: q4h

PRN: ☒ Yes ☐ No *PRN Reason: pain

Administer over: Administer over Unit:

Duration: Duration Unit:

Drug Form: tab First Dose Priority:

*Start Date/Time: 13-Dec-2017 14:07 PST Stop Date/Time: PST

Use Patient Supply: ☐ Yes ☒ No BCCA Protocol Code:

5

0 Missing Required Details Orders For Cosignature Orders For Nurse Review 6 Sign

5. You will notice that information is pre-populated into the order details section of the order you selected. You may change information at this point if you wish.
6. Click **Sign** The orders profile now displays the acetaminophen with a status of **Processing**
Click Refresh to see the order change to **Ordered**

Key Learning Points

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

Activity 5.5 – Complete an Order

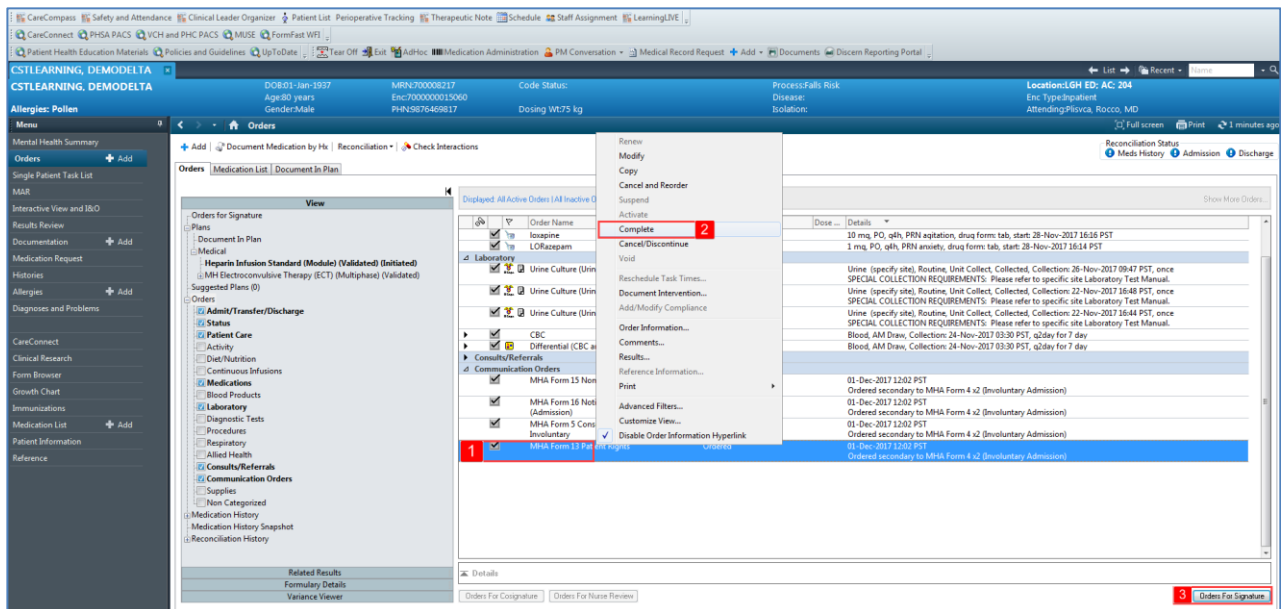
1

Orders can be documented as completed or discontinued depending on the type of order. One type of order that you can complete is the Mental Health Act (MHA) orders.

Age-appropriate MHA forms are automatically generated for patients based on their age according to the Mental Health Act.

For your patient, MHA Forms 5, 13, 15 and 16 are automatically generated by the system from the MHA Form 4 x2 Involuntary Admission order that you previously ordered. This is to document the paper forms being completed, as you might have documented in the paper chart.

To complete an order:



The screenshot shows the EHR interface for a patient named CSTLEARNING, DEMODELTA. The patient's information is displayed at the top, including DOB, age, gender, and MRN. The left sidebar contains a menu with various options like 'Mental Health Summary', 'Orders', 'Single Patient Task List', etc. The central workspace shows a list of orders, including 'Heparin Infusion Standard (Module) (Validated) (Initiated)', 'MH Electroconvulsive Therapy (ECT) (Multiphasic) (Validated)', and 'MHA Form 13 Patient Rights'. The right sidebar shows details for the selected order, including 'Dose', 'Details', and 'Reconciliation Status'. A context menu is open over the 'MHA Form 13 Patient Rights' order, with the 'Complete' option highlighted. Red numbers 1, 2, and 3 indicate the steps: 1. Right-click MHA Form 13 Patient Rights, 2. Select Complete, 3. Click Orders for Signature.

1. Right-click **MHA Form 13 Patient Rights**
2. Select **Complete**
3. Click **Orders for Signature**

Orders for Signature


Order Name	Status	Start	Details
LGH 6E; 624; 02 Enc:7000000015055 Admit: 17-Nov-2017 13:58 PST			
Saline Lock Peripheral... Complete	Complete	20-Nov-2017 15:11...	

DO NOT CHECK

Details

0 Missing Required Details Orders For Cosignature Orders For Nurse Review Sign 4

- Review order for signature and click **Sign** You will return to the orders profile where the order will show as processing

Click Refresh  The order will no longer be visible in the order profile

Key Learning Points

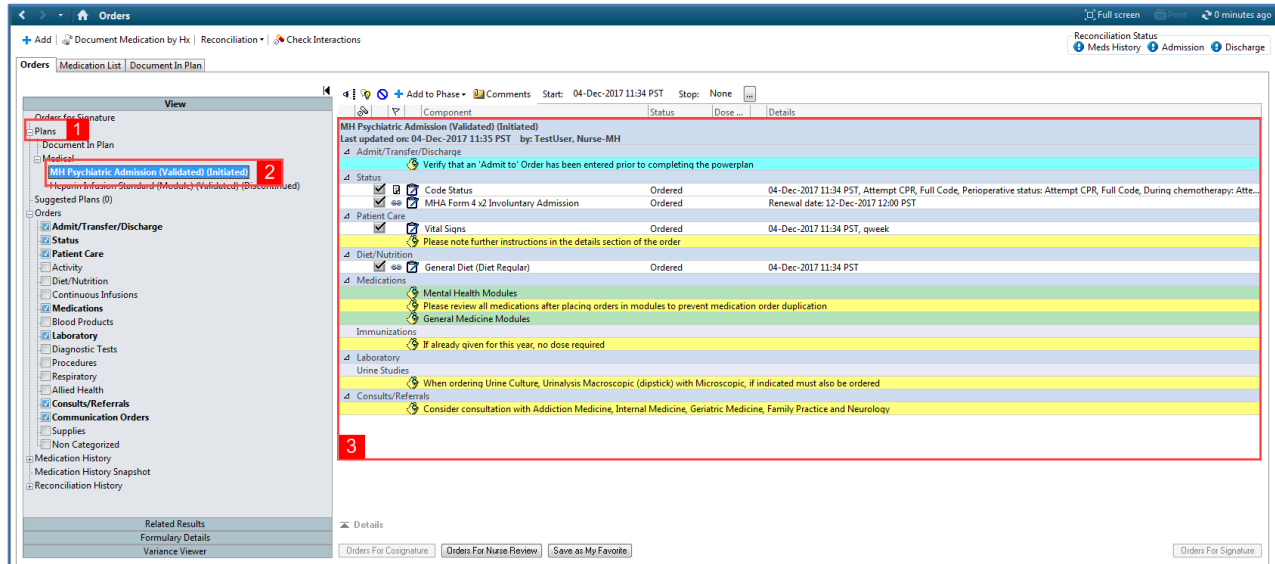
- Age-appropriate MHA forms are automatically generated for patients based on their age according to the Mental Health Act
- Right click to complete an order

Activity 5.6 – Review Components of a PowerPlan

- 1 A PowerPlan is the equivalent of preprinted orders in the current state. PowerPlans consist of orders that are frequently placed at the same time, such as during admission or ECT.

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

While on the Orders page:



1. Locate the **Plans** category to the left side of the screen under **View**
2. Select the **MH Psychiatric Admission**

Review the orders within the PowerPlan



Key Learning Points

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

PATIENT SCENARIO 6 - 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.

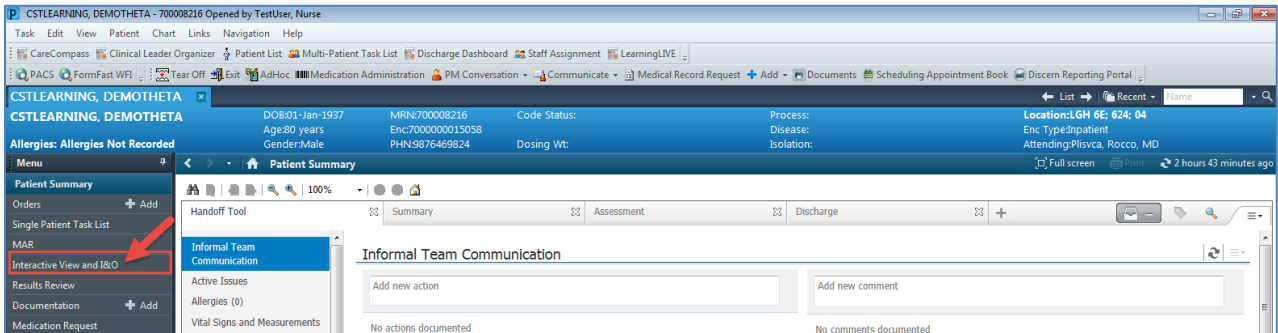
You will be completing the following activities:

-  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

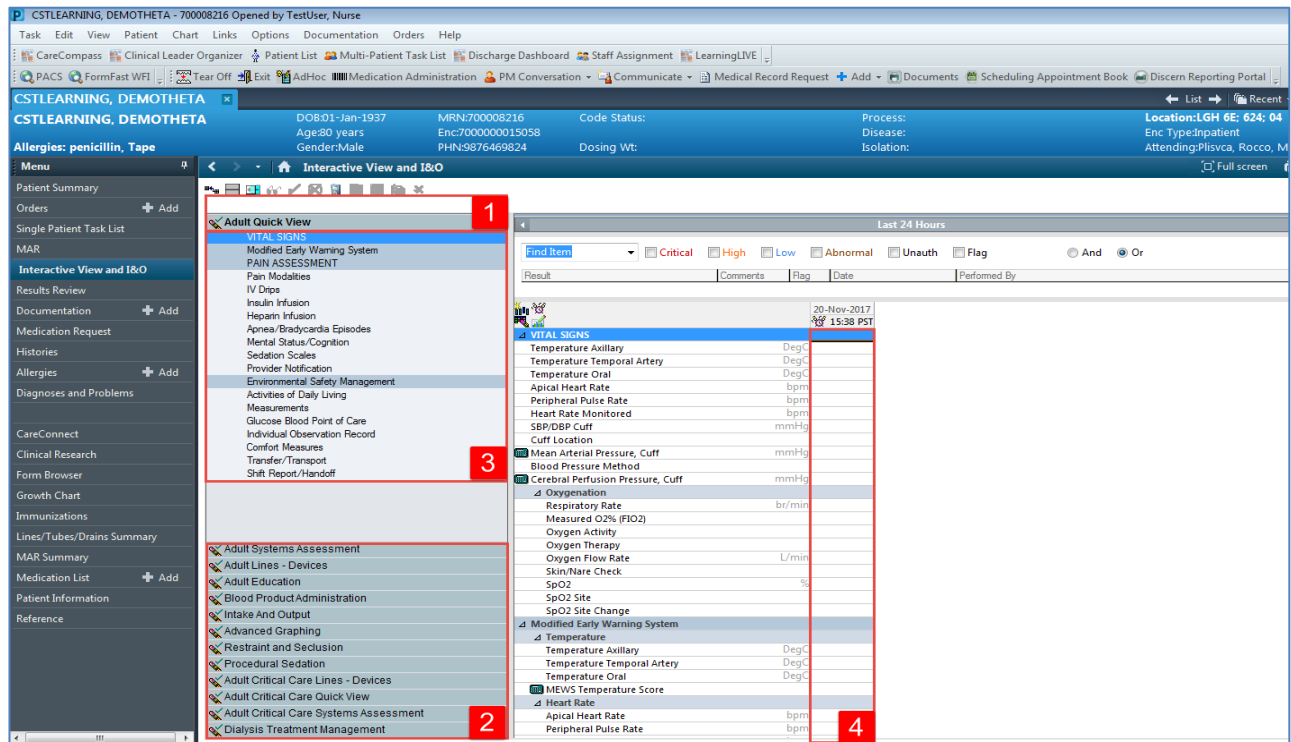
Activity 6.1 – Review the Layout of Interactive View and I&O

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

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



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





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

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

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

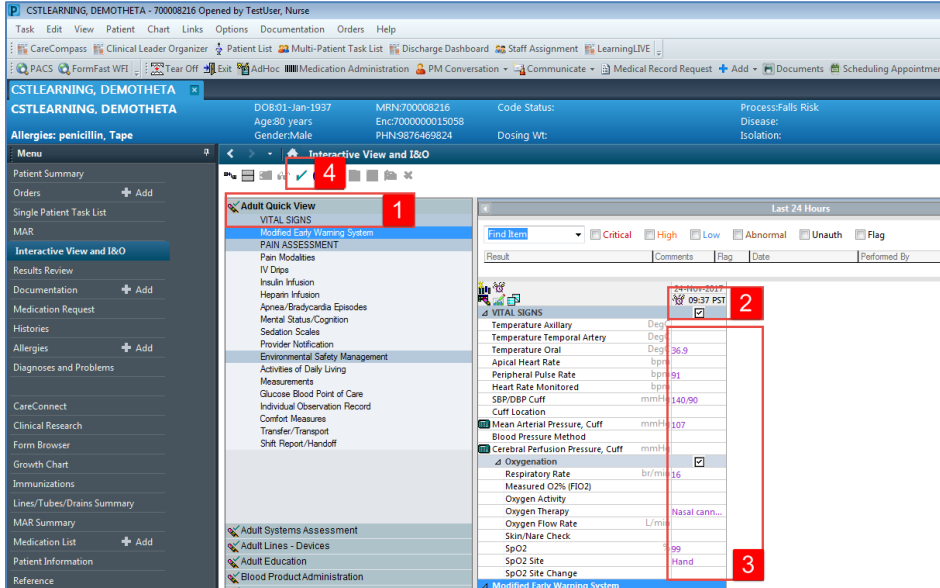
Take some time to explore the various sections within the **MH Adult Quick View** band. Notice that your common assessments are located here, such as vital signs, Mental Status Exam and ongoing Columbia Suicide Severity Rating.

Key Learning Points

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


Activity 6.2 – 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.



The screenshot shows the iView interface for a patient named CSTLEARNING, DEMOTHETA. The 'MH Adult Quick View' band is active, displaying the 'VITAL SIGNS' section. The interface includes a menu on the left, a patient summary at the top, and a central area for documenting vital signs. Red boxes and numbers 1, 2, and 3 highlight specific areas: 1 points to the 'VITAL SIGNS' component, 2 points to the 'VITAL SIGNS' section header, and 3 points to the 'SpO2 Site' field.

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.

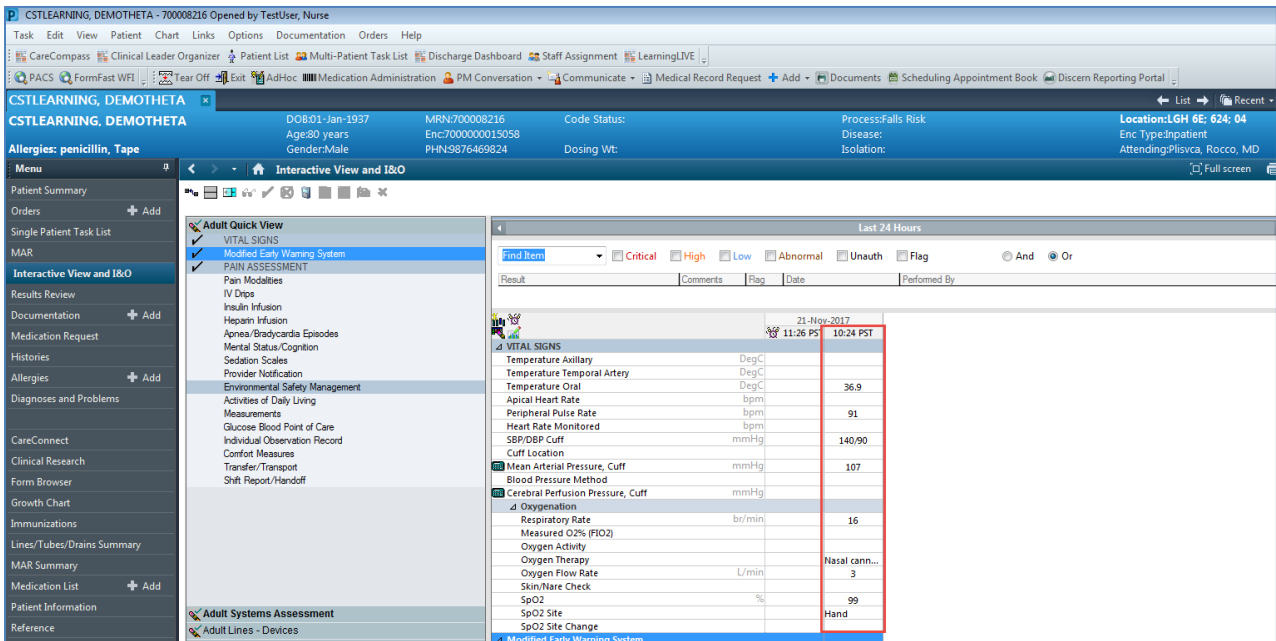
- **Respiratory Rate** = 16
- **SpO2** = 99
- **SpO2 Site** = Hand

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 Check mark** icon 

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



CSTLEARNING, DEMOTHEA - 700008216 Opened by TestUser, Nurse

Task Edit View Patient Chart Links Options Documentation Orders Help

EncType: Inpatient
Location: LGH 6E: 624: 04
Attending: Plisvca, Rocco, MD

Interactive View and I&O

Adult Quick View

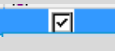
- VITAL SIGNS
 - Modified Early Warning System
- PAIN ASSESSMENT
 - Pain Modalities
 - IV Drips
 - Insulin Infusion
 - Hepatin Infusion
 - Apnea/Bradycardia Episodes
 - Mental Status/Cognition
 - Sedation Scales
 - Provider Notification
- Environmental Safety Management
 - Activities of Daily Living
 - Measurements
 - Glucose Blood Point of Care
 - Individual Observation Record
 - Comfort Measures
 - Transfer/Transport
 - Shift Report/Handoff
- Adult Systems Assessment
- Adult Lines - Devices

VITAL SIGNS

Find Item	Critical	High	Low	Abnormal	Unauth	Flag	Date	Performed By
Temperature Axillary								
Temperature Temporal Artery								
Temperature Oral							36.9	
Apical Heart Rate								
Peripheral Pulse Rate							91	
Heart Rate Monitored								
SBP/DBP Cuff							140/90	
Cuff Location								
Mean Arterial Pressure, Cuff							107	
Blood Pressure Method								
Cerebral Perfusion Pressure, Cuff								
Oxygenation								
Respiratory Rate							16	
Measured O2% (FI02)								
Oxygen Activity								
Oxygen Therapy							Nasal cann...	
Oxygen Flow Rate							3	
Skin/Nare Check								
SpO2							99	
SpO2 Site								
SpO2 Site Change							Hand	

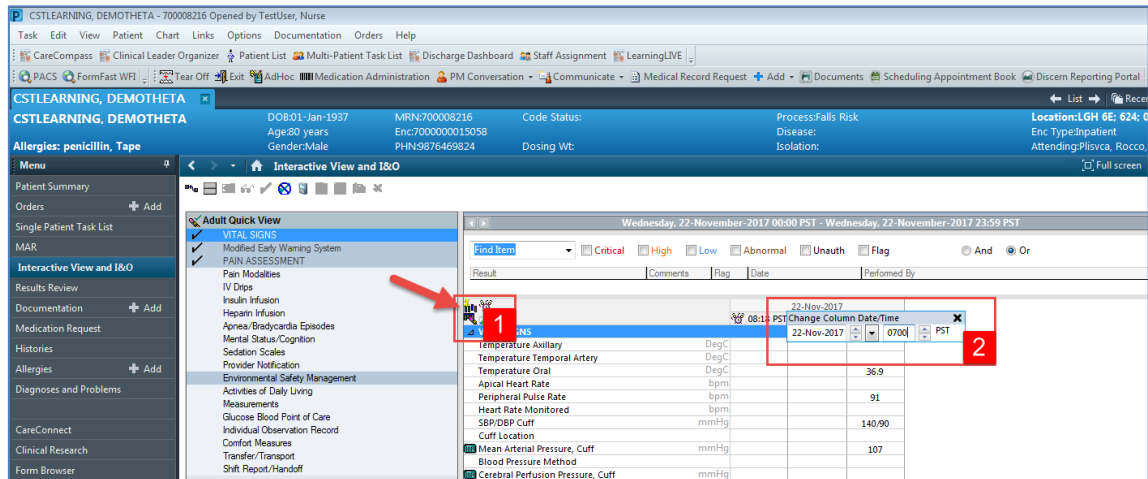
Note: You do not have to document in every cell. Only document to what is appropriate for your assessment and follow appropriate documentation policies and guidelines at your site.


Key Learning Points

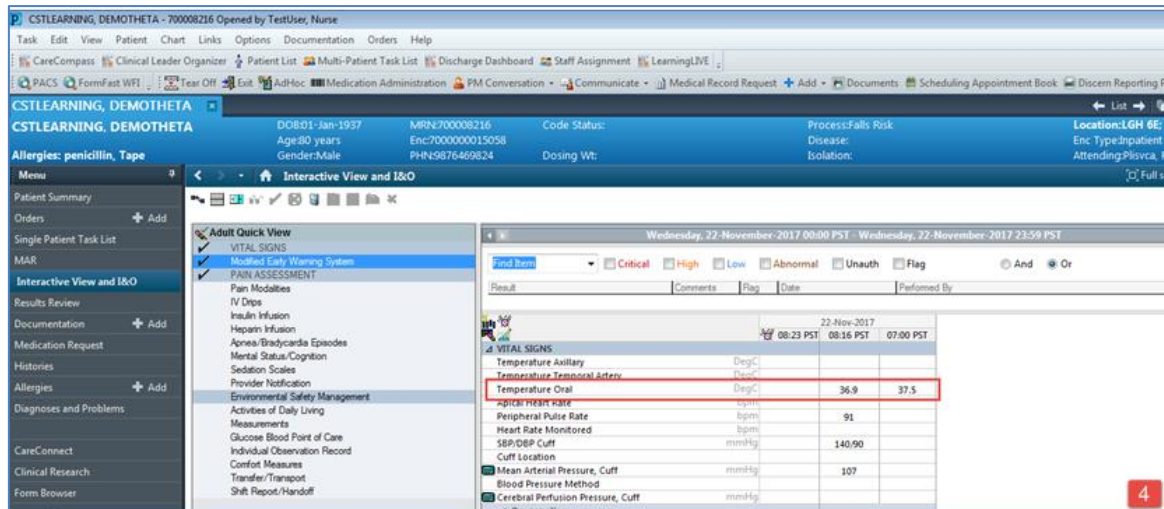
- Double-click the blue box  next to the name of the section to document in several cells. The section will then be activated for charting
- Documentation will appear in purple until signed. Once signed, the documentation will become black
- The newest documentation displays in the left-most column
-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

Activity 6.3 – Change the Time Column

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




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



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

Key Learning Points

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

Activity 6.4 – Modify, Unchart and Add a Comment in Interactive View

1


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

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

The screenshot shows the CSTLEARNING DEMOTHETA patient chart. The 'Vital Signs' section is expanded, showing various vital signs. The 'Peripheral Pulse Rate' is currently 91. A red box highlights the 'VITAL SIGNS' section heading (1), the value '91' (2), and the 'Modify...' option in the right-click context menu (3).

1. Click on the **Vital Signs** section heading in the **MH Adult Quick View** band
2. Right-click on the documented value of **91** for Peripheral Pulse Rate
3. Select **Modify...**

The screenshot shows the CSTLEARNING DEMOTHETA patient chart. The 'Vital Signs' section is expanded, showing various vital signs. The 'Peripheral Pulse Rate' is now 80. A red box highlights the new value '80' and the modified icon (4).

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

2

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

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

The screenshot shows the CSTLEARNING DEMOTHETA interface. In the 'Interactive View and I&O' section, a table lists vital signs. The 'Temperature Oral' row shows a value of '37.5'. A right-click context menu is open over this value, with the 'Unchart...' option highlighted. A red box and the number '2' are placed over the 'Unchart...' option.

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

The screenshot shows the 'Unchart' pop-up window. The 'Reason' dropdown menu is open, and 'Charted on Incorrect Patient' is selected. A red box and the number '3' are placed over the dropdown. The 'Sign' button is highlighted with a red box and the number '4'.

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

CSLEARNING, DEMOTHETA - 70008216 Opened by TestUser, Nurse

Task Edit View Patient Chart Links Options Documentation Orders 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

CSLEARNING, DEMOTHETA

DOB: 01-Jan-1937 MRN: 70008216 Code Status: Process: Falls Risk

Age: 80 years Enc: 7000000015058 Disease: End

Gender: Male PHN: 9876469824 Dosing Wt: Isolation: Att

Allergies: penicillin, Tape

Menu

Patient Summary

Orders + Add

Single Patient Task List

MAR

Interactive View and I&O

Results Review

Documentation + Add

Medication Request

Histories

Allergies + Add

Diagnoses and Problems

CareConnect

Clinical Research

Form Browser

Growth Chart

Adult Quick View

VITAL SIGNS

Modified Early Warning System

PAIN ASSESSMENT

Pain Modalities

IV Drips

Insulin Infusion

Heparin Infusion

Apnea/Bradycardia Episodes

Mental Status/Cognition

Sedation Scales

Provider Notification

Environmental Safety Management

Activities of Daily Living

Measurements

Glucose Blood Point of Care

Individual Observation Record

Comfort Measures

Transfer/Transport

Shift Report/Handoff

Wednesday, 22-November-2017 00:00 PST - Wednesday, 22-November-2017 23:59 PST

Find Item

Critical High Low Abnormal Unauth Flag

Result Comments Flag Date Performed By

22-Nov-2017

08:37 PST 08:16 PST 07:00 PST

VITAL SIGNS

Temperature Axillary DegC

Temperature Temporal Artery DegC

Temperature Oral DegC

Apical Heart Rate bpm

Peripheral Pulse Rate bpm

Heart Rate Monitored bpm

SBP/DBP Cuff mmHg

Cuff Location


Mean Arterial Pressure, Cuff mmHg

Blood Pressure Method

Cerebral Perfusion Pressure, Cuff mmHg

Oxygenation

In Error

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

3

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

CSLEARNING, DEMOTHETA - 70008216 Opened by TestUser, Nurse

Task Edit View Patient Chart Links Options Documentation Orders 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

CSLEARNING, DEMOTHETA

DOB: 01-Jan-1937 MRN: 70008216 Code Status: Process: Falls Risk

Age: 80 years Enc: 7000000015058 Disease: End

Gender: Male PHN: 9876469824 Dosing Wt: Isolation: Att

Allergies: penicillin, Tape

Menu

Patient Summary

Orders + Add

Single Patient Task List

MAR

Interactive View and I&O

Results Review

Documentation + Add

Medication Request

Histories

Allergies + Add

Diagnoses and Problems

CareConnect

Clinical Research

Form Browser

Growth Chart

Immunizations

Lines/Tubes/Drains Summary

MAR Summary

Medication List + Add

Patient Information

Reference

Adult Quick View

VITAL SIGNS

Modified Early Warning System

PAIN ASSESSMENT

Pain Modalities

IV Drips

Insulin Infusion

Heparin Infusion

Apnea/Bradycardia Episodes

Mental Status/Cognition

Sedation Scales

Provider Notification

Environmental Safety Management

Activities of Daily Living

Measurements

Glucose Blood Point of Care

Individual Observation Record

Comfort Measures

Transfer/Transport

Shift Report/Handoff

Wednesday, 22-November-2017 00:00 PST - Wednesday, 22-November-2017 23:59 PST

Find Item

Critical High Low Abnormal Unauth Flag

Result Comments Flag Date Performed By

22-Nov-2017

08:37 PST 08:16 PST 07:00 PST

VITAL SIGNS

Temperature Axillary DegC

Temperature Temporal Artery DegC

Temperature Oral DegC

Apical Heart Rate bpm

Peripheral Pulse Rate bpm

Heart Rate Monitored bpm

SBP/DBP Cuff mmHg

Cuff Location

Mean Arterial Pressure, Cuff mmHg

Blood Pressure Method

Cerebral Perfusion Pressure, Cuff mmHg

Oxygenation

Respiratory Rate br/min

Measured O2% (FIO2)

Oxygen Activity

Oxygen Therapy

Oxygen Flow Rate L/min

Skin/Nare Check

SpO2 %

SpO2 Site

SpO2 Site Change

Modified Early Warning System

Temperature

Temperature Axillary DegC

Temperature Temporal Artery DegC

In Error

Add Result...

View Result Details...

View Comments...

View Flag Comments...

View Reference Material...

View Order Info...

View History...

Modify...

Unchart...

Change Date/Time

Add Comment...

Duplicate Results

Clear

View Defaulted Info...

View Calculation...

Recalculate...

View Interpretation

Reinterpret

Create Admin Note...

Chart Details...

Not Done...

Flag

Flag with Comment...

Unflag

Unflag with Comment...

1. Right click on the documented value for **SpO2** site, hand

2. Select **Add Comment**

Comment - CSTLEARNING, DEMOBETA - 700008215

SpO2 Site: **Hand**

Comment
Right hand

OK Cancel 3

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

CSTLEARNING, DEMOBETA - 700008215

DOB: 01-Jan-1937 MRN: 700008215 Code Status: Process: Falls Risk
Age: 80 years Enc: 7000000015058 Disease:
Gender: Male PHN: 9876409824 Isolation:

Allergies: penicillin, Tape

Menu

Patient Summary
Orders + Add
Single Patient Task List
MAR
Interactive View and I&O
Results Review
Documentation + Add
Medication Request
Histories
Allergies + Add
Diagnoses and Problems
CareConnect
Clinical Research
Form Browser
Growth Chart
Immunizations
Lines/Tubes/Drains Summary
MAR Summary + Add
Medication List + Add
Patient Information
Reference

Adult Quick View
VITAL SIGNS
Modified Early Warning System
PAIN ASSESSMENT
Pain Modalities
IV Drips
Insulin Infusion
Hepatin Infusion
Apnea/Bradycardia Episodes
Mental Status/Cognition
Sedation Scales
Provider Notification
Environmental Safety Management
Activities of Daily Living
Measurements
Glucose Blood Point of Care
Individual Observation Record
Comfort Measures
Transfer/Transport
Shift Report/Handoff

Adult Systems Assessment
Adult Lines - Devices
Adult Education
Blood Product Administration
Intake And Output
Advanced Graphing

Wednesday, 22-November-2017 00:00 PST - Wednesday, 22-November-2017 00:00 PST

Find Item Critical High Low Abnormal Unauth Flag



Result Comments Flag Date Performed By

22-Nov-2017
08:39 PST 08:16 PST 07:00 PST

VITAL SIGNS
Temperature Axillary DegC
Temperature Temporal Artery DegC
Temperature Oral DegC 36.9 In Error
Apical Heart Rate bpm
Peripheral Pulse Rate bpm
Heart Rate Monitored bpm
SBP/DBP Cuff mmHg 140/90
Cuff Location
Mean Arterial Pressure, Cuff mmHg 107
Blood Pressure Method
Cerebral Perfusion Pressure, Cuff mmHg
Respiratory Rate br/min 16
Measured O2% (FIO2)
Oxygen Activity
Oxygen Flow Rate L/min Nasal cann...
Skin/Nare Check
SpO2
SpO2 Site Hand
SpO2 Site Change

Modified Early Warning System
Temperature

4

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 7 - PowerForm

Learning Objectives





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

-  Document in PowerForms through AdHoc Charting
-  View and Modify Existing PowerForms

SCENARIO

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

As a mental health nurse you will be completing the following activities:

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

Activity 7.1 – Opening and Documenting on PowerForms

1

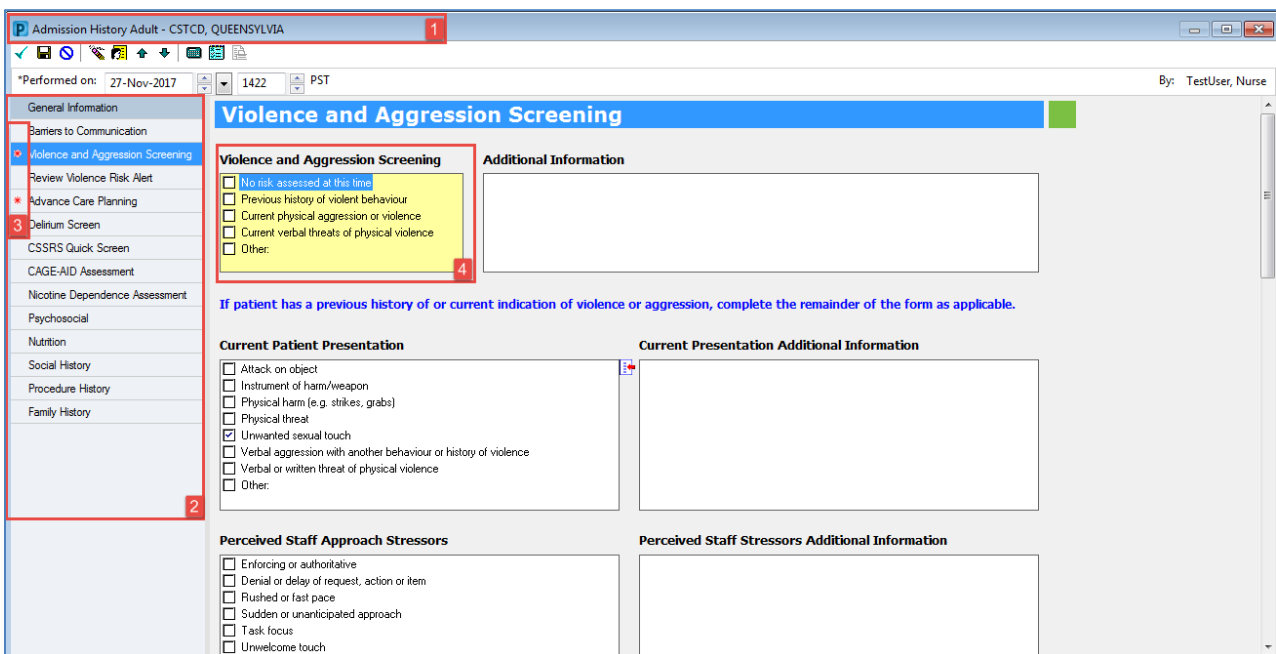
PowerForms are the electronic equivalent of standardized documentation forms.

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

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

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

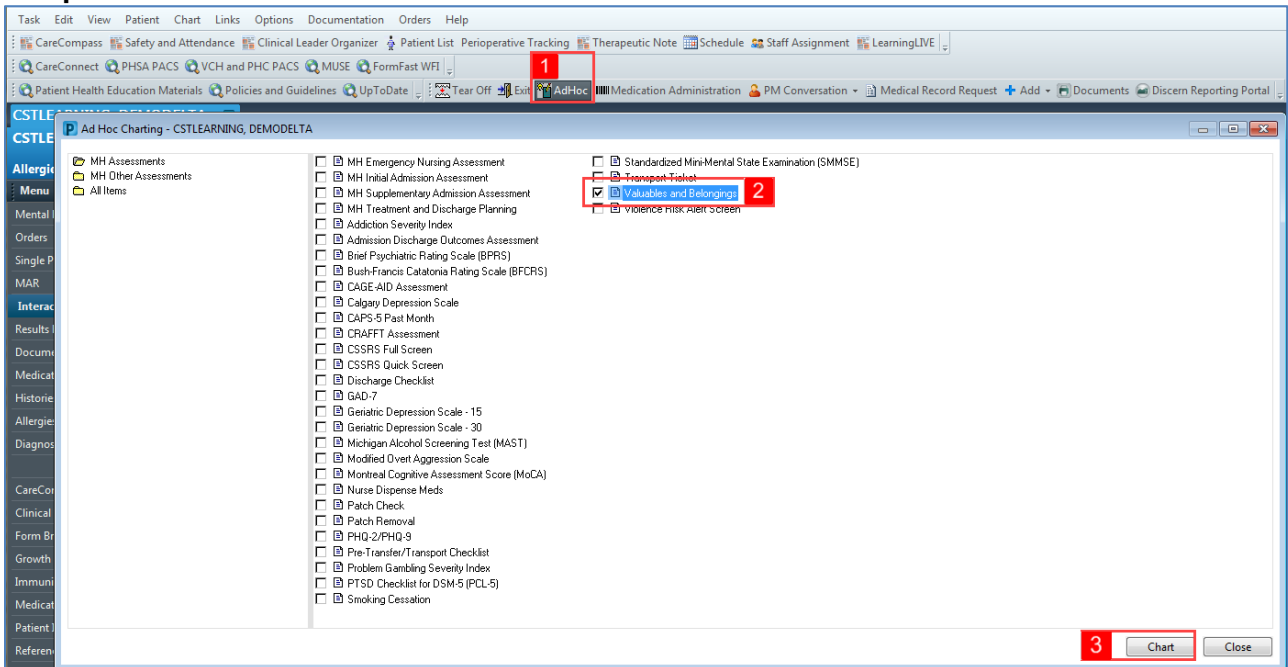
Let's explore the different components of a **PowerForm**:




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

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

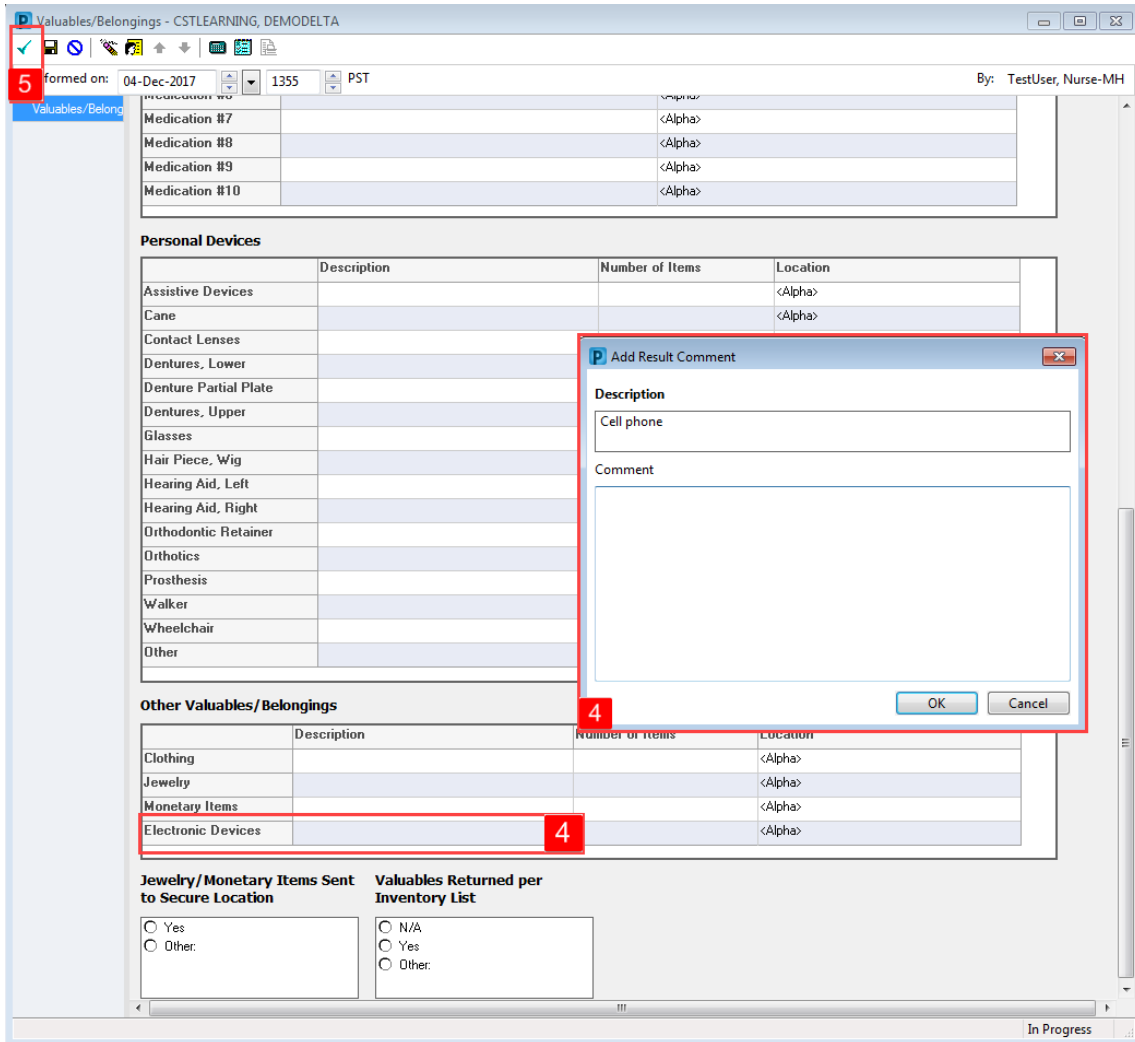
To **open** and **document** on a new PowerForm:





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

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





4. Fill in the following fields:
 - **Does the patient have any valuables/belongings with them?** = Yes
 - Under **Other Valuables/Belongings**, double click in the description column beside **Electronic Devices** = *Cell phone*. Click **OK**



5. To complete PowerForm, click the **green check mark** to sign  and then refresh the screen .

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

Key Learning Points

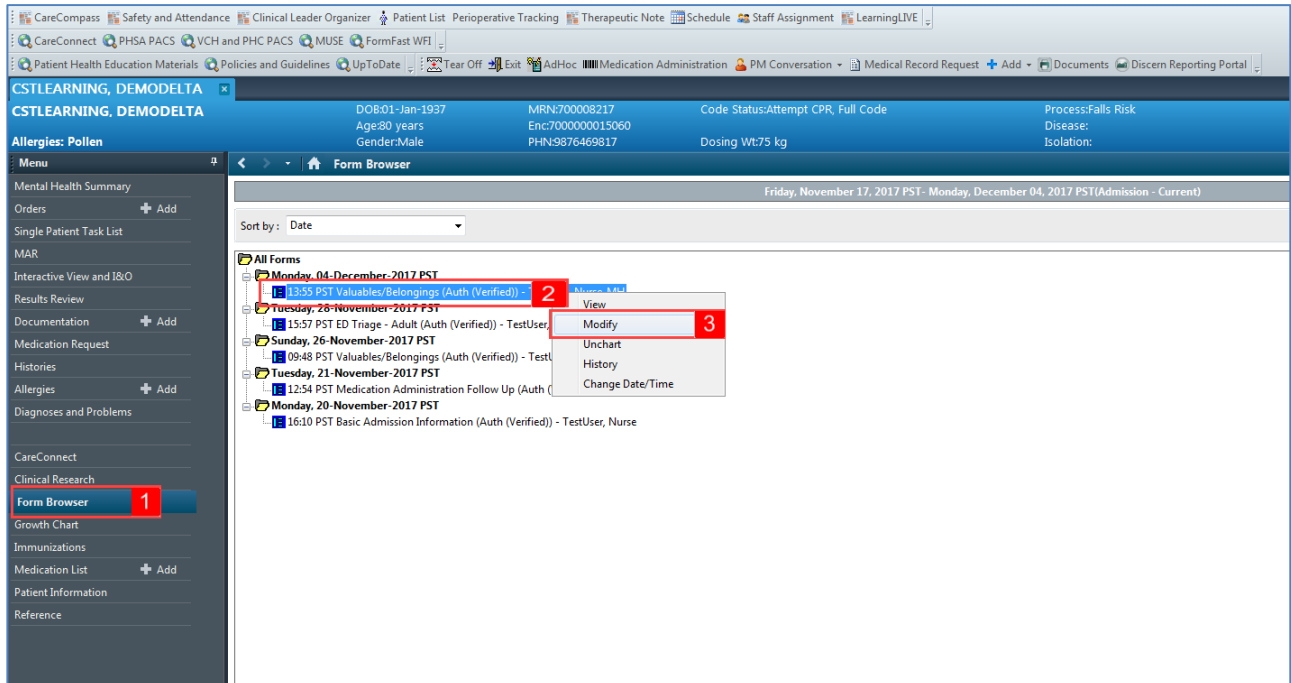
-  PowerForms are the electronic equivalent of standardized documentation forms
-  The AdHoc button in the toolbar is one way to locate a new Powerform
-  PowerForms may be broken up into several sections. Section headings are displayed to the left side of PowerForm
-  Documents that are saved will not be viewable to anyone except the author. Use the Sign form icon whenever possible

Activity 7.2 – Modify an existing PowerForm

- 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

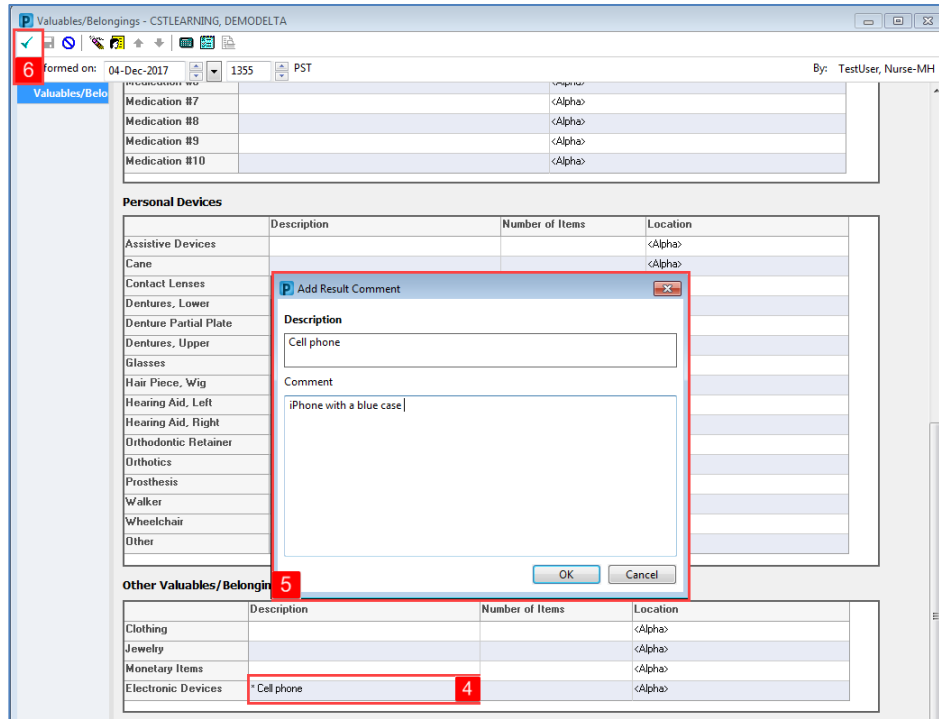
Let's modify the **Valuables and Belongings** form:



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

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

- Select **Modify**



Valuables/Belongings - CSTLEARNING, DEMODELTA

formed on: 04-Dec-2017 1355 PST By: TestUser, Nurse-MH

Medication #	Description	Number of Items	Location
Medication #7			<Alpha>
Medication #8			<Alpha>
Medication #9			<Alpha>
Medication #10			<Alpha>

Personal Devices

Description	Number of Items	Location
Assistive Devices		<Alpha>
Cane		<Alpha>
Contact Lenses		
Dentures, Lower		
Denture Partial Plate		
Dentures, Upper		
Glasses		
Hair Piece, Wig		
Hearing Aid, Left		
Hearing Aid, Right		
Orthodontic Retainer		
Orthotics		
Prosthesis		
Walker		
Wheelchair		
Other		

Other Valuables/Belongings

Description	Number of Items	Location
Clothing		<Alpha>
Jewelry		<Alpha>
Monetary Items		<Alpha>
Electronic Devices	Cell phone	<Alpha>

Add Result Comment

Description: Cell phone




Comment: iPhone with a blue case

OK Cancel

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 check mark** icon ✓ to sign and complete the documentation and then refresh the screen.

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

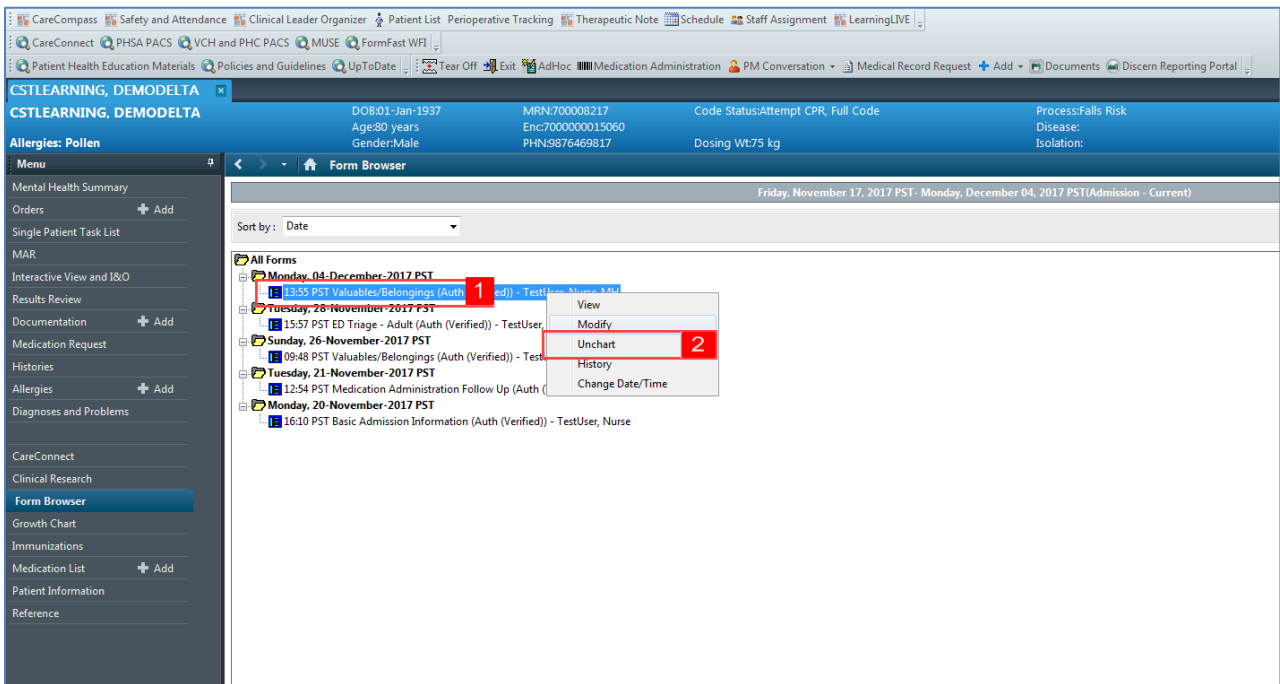
Key Learning Points


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

Activity 7.3 – Unchart an existing PowerForm

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

To unchart the PowerForm:





1. Right-click on **Valuables and Belongings** in Form Browser
2. Select **Unchart**
3. The Unchart window opens. Enter a reason for uncharting in the **Comment** box = *Wrong PowerForm*
4. Click sign  and then refresh your screen

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





Key Learning Points

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

PATIENT SCENARIO 8 – Dynamic Documentation

Learning Objectives




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

-  Create a Dynamic Document
-  Modify a Dynamic Document

SCENARIO

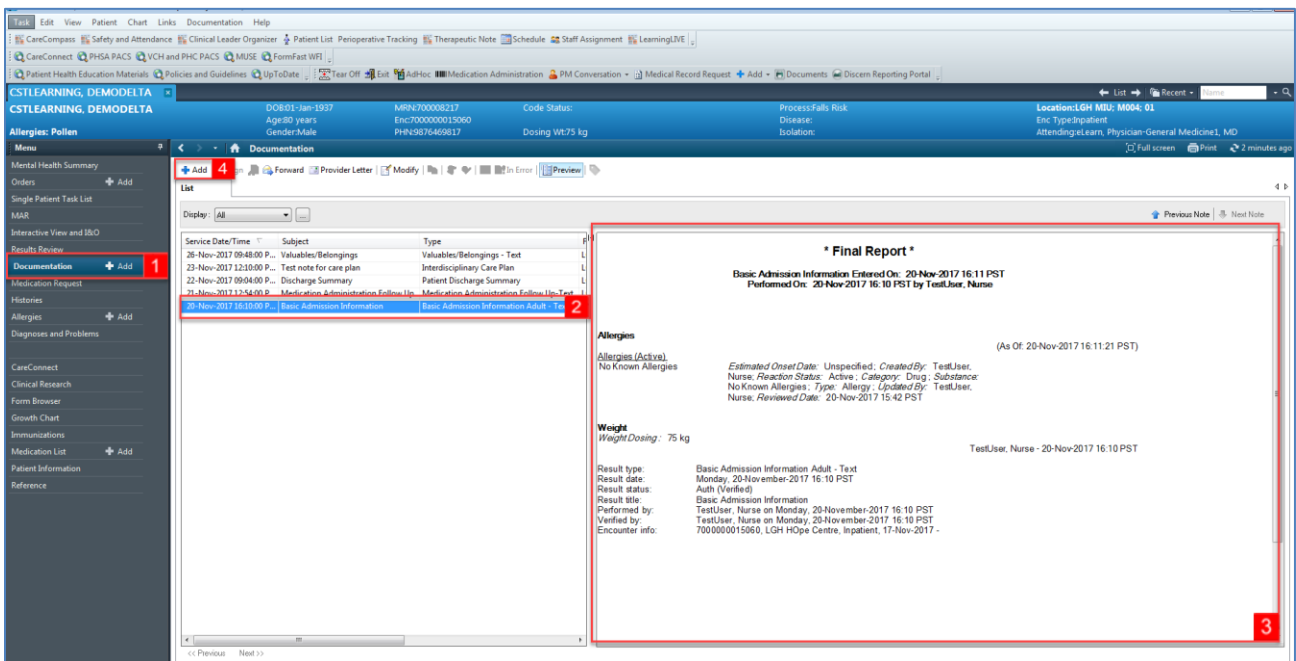
In this scenario, you will be creating a progress note for your patient.

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

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

Activity 8.1 - 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.



The screenshot shows the EHR interface with the following components:

- Menu:** A sidebar on the left with various options. The **Documentation** option is highlighted with a red box and a red number 1.
- Documentation List:** A table in the center showing a list of documents. The document **20-Nov-2017 16:10:00 P - Basic Admission Information** is selected with a red box and a red number 2.
- Preview Box:** A large area on the right showing the content of the selected document. It is titled *** Final Report *** and contains details about the admission, allergies, and weight/dosing. A red box and red number 3 highlight the bottom right corner of the preview area.

- Select **Documentation** from the Menu
- Select **MH Initial Admission Assessment** from the list of documents

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

- Review document in Preview Box

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

- Click **Add** 

Activity 8.1 - Dynamic Documentation

2

The screenshot shows the 'New Note' screen in the EHR system. The left sidebar contains a 'Menu' with various options like 'Mental Health Summary', 'Orders', 'Single Patient Task List', etc. The main area is titled 'Documentation' and shows patient information at the top: DOB 01-Jan-1937, Age 80 years, Gender Male, MRN 7000003217, Code Status, Process Falls Risk, Disease, Isolation, Location LGH MRU: M004: 01. Below this, there's a 'Note Type List Filter' section with a 'Type' dropdown menu. The dropdown is open, and 'Nursing Narrative Note' is selected (1). To the right, there's a 'Note Templates' list. The 'Free Text Note' template is selected (2). At the bottom right, the 'OK' button is highlighted (3).

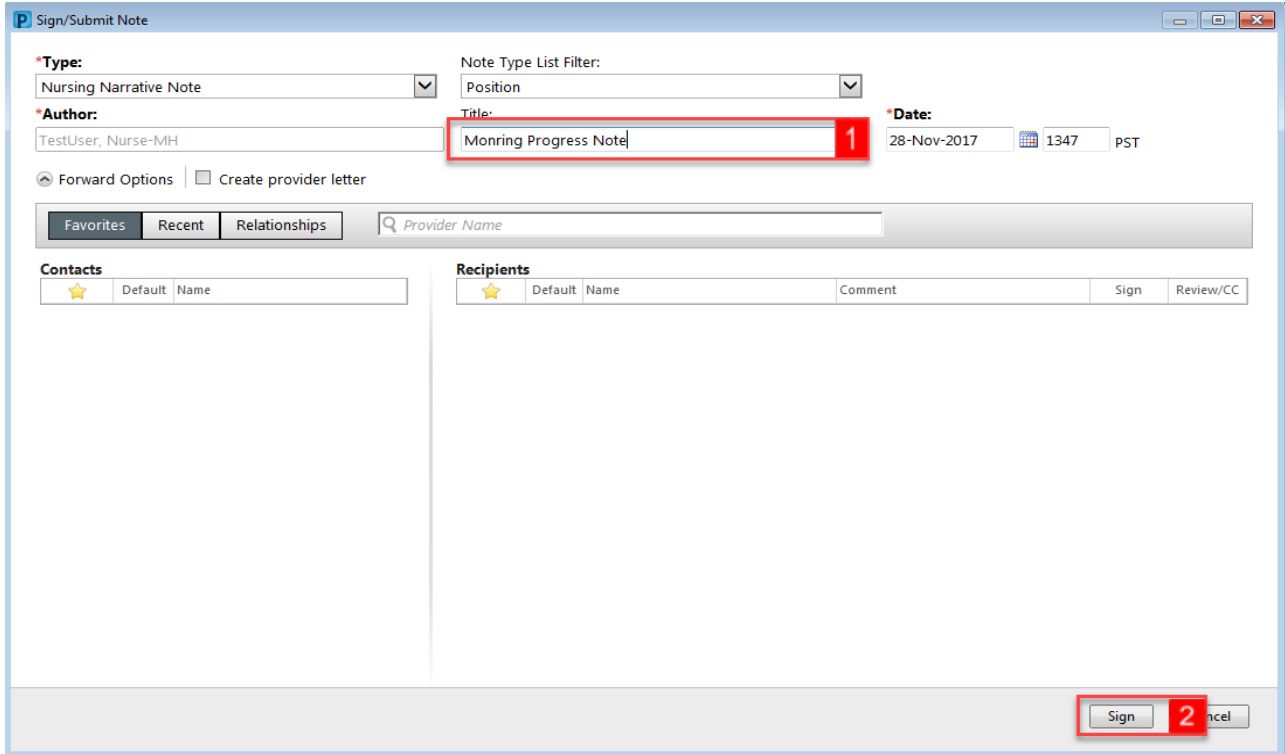
1. Select **Nursing Narrative Note** from the **Type** drop-down list
2. Select **Free Text Note** from **Note Templates** list
3. Click **OK**

3

The screenshot shows the 'Free Text Note' screen. The left sidebar is the same as in the previous screenshot. The main area is titled 'Free Text Note' and shows a text editor with a toolbar. The text 'Family visited, patient tearful. Support provided.' is entered in the text area (1). At the bottom right, the 'Sign/Submit' button is highlighted (2).

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

4



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

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

2. Click **Sign**



Key Learning Points

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

PATIENT SCENARIO 9 - 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 by using Results Review.

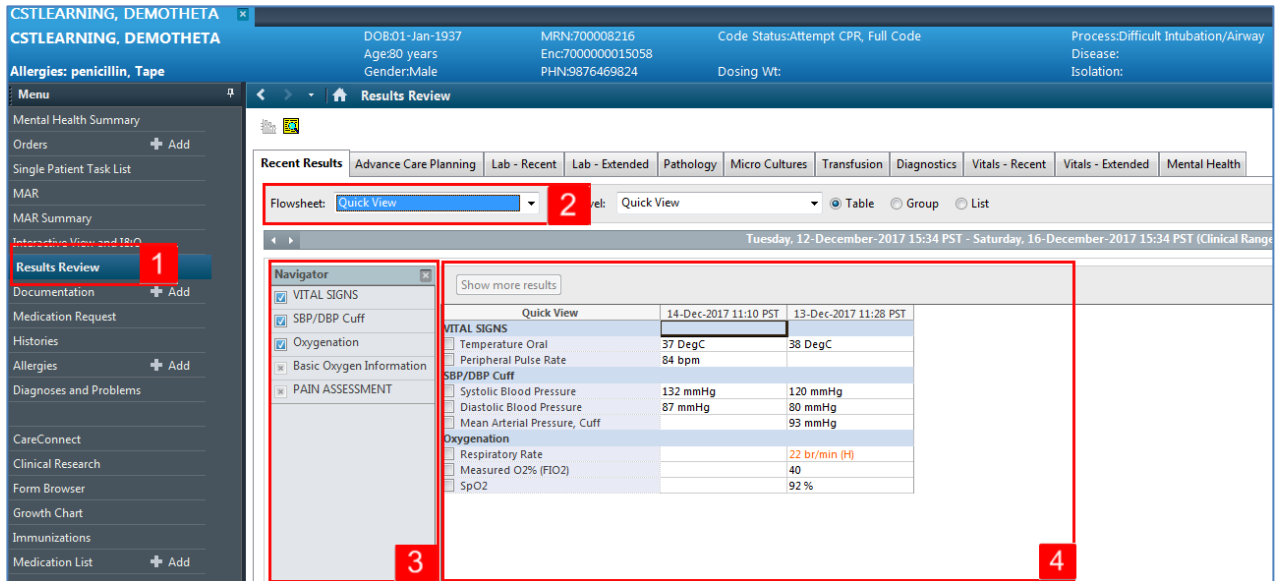
You will complete the following activity:

-  Review results using Results Review

Activity 9.1 – 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**



CSTLEARNING, DEMOTHETA






DOB: 01-Jan-1937 MRN: 700008216 Code Status: Attempt CPR, Full Code Process: Difficult Intubation/Airway

Age: 80 years Enc: 7000000015058 Disease: Isolation:

Gender: Male PHN: 9876469824 Dosing Wt:

Allergies: penicillin, Tape

Menu

- Mental Health Summary
- Orders 
- Single Patient Task List
- MAR
- MAR Summary
- Results Review** 
- Documentation 
- Medication Request
- Histories
- Allergies 
- Diagnoses and Problems
- CareConnect
- Clinical Research
- Form Browser
- Growth Chart
- Immunizations
- Medication List 

Results Review

Recent Results Advance Care Planning Lab - Recent Lab - Extended Pathology Micro Cultures Transfusion Diagnostics Vitals - Recent Vitals - Extended Mental Health

Flowsheet: **Quick View** **2** Quick View Table Group List

Tuesday, 12-December-2017 15:34 PST - Saturday, 16-December-2017 15:34 PST (Clinical Range)

Navigator

- ☒ VITAL SIGNS
- ☒ SBP/DBP Cuff
- ☒ Oxygenation
- ☐ Basic Oxygen Information
- ☐ PAIN ASSESSMENT

Results Display

Quick View		14-Dec-2017 11:10 PST	13-Dec-2017 11:28 PST
VITAL SIGNS			
Temperature Oral		37 DegC	38 DegC
Peripheral Pulse Rate		84 bpm	
SBP/DBP Cuff			
Systolic Blood Pressure		132 mmHg	120 mmHg
Diastolic Blood Pressure		87 mmHg	80 mmHg
Mean Arterial Pressure, Cuff			93 mmHg
Oxygenation			
Respiratory Rate			22 br/min (H)
Measured O2% (FIO2)			40
SpO2			92 %

- Navigate to **Results Review** from the **Menu**
- 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**.
- Navigator**: you can select a category within the navigator to view related results
- Results Display**: display related results

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

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

Review the results of your patient's bloodwork:

1. Select **Lab – Recent** tab

CBC and Peripheral Smear	
<input type="checkbox"/> WBC Count	1.5 x10 ⁹ /L (L)
<input type="checkbox"/> RBC Count	2.00 x10 ¹² /L (L)
<input type="checkbox"/> Hemoglobin	70 g/L (L)
<input type="checkbox"/> Hematocrit	0.15 (L)
<input type="checkbox"/> MCV	98 fL
<input type="checkbox"/> MCH	28 pg
<input type="checkbox"/> RDW-CV	15.3 % (H)
<input type="checkbox"/> Platelet Count	10 x10 ⁹ /L (L)
<input type="checkbox"/> NRBC Absolute	5.0 x10 ⁹ /L (H)
<input type="checkbox"/> Neutrophils	0.04 x10 ⁹ /L (L)
<input type="checkbox"/> Lymphocytes	0.15 x10 ⁹ /L (L)
<input type="checkbox"/> Monocytes	0.23 x10 ⁹ /L
<input type="checkbox"/> Eosinophils	0.01 x10 ⁹ /L
<input type="checkbox"/> Basophils	0.01 x10 ⁹ /L
<input type="checkbox"/> Metamyelocytes	0.73 x10 ⁹ /L (H)
<input type="checkbox"/> Myelocytes	0.23 x10 ⁹ /L (H)
<input type="checkbox"/> Promyelocytes	0.08 x10 ⁹ /L (H)
<input type="checkbox"/> Blast Cells	0.02 x10 ⁹ /L (H)
Blood Film Comment	Platelet Estimate - Decreased
Coagulation and Thrombophilia	
<input type="checkbox"/> INR	1.2
<input type="checkbox"/> APTT	30 second
Blood Gases	
<input type="checkbox"/> pH Venous	7.41
<input type="checkbox"/> HCO ₃ 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 10 - 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.

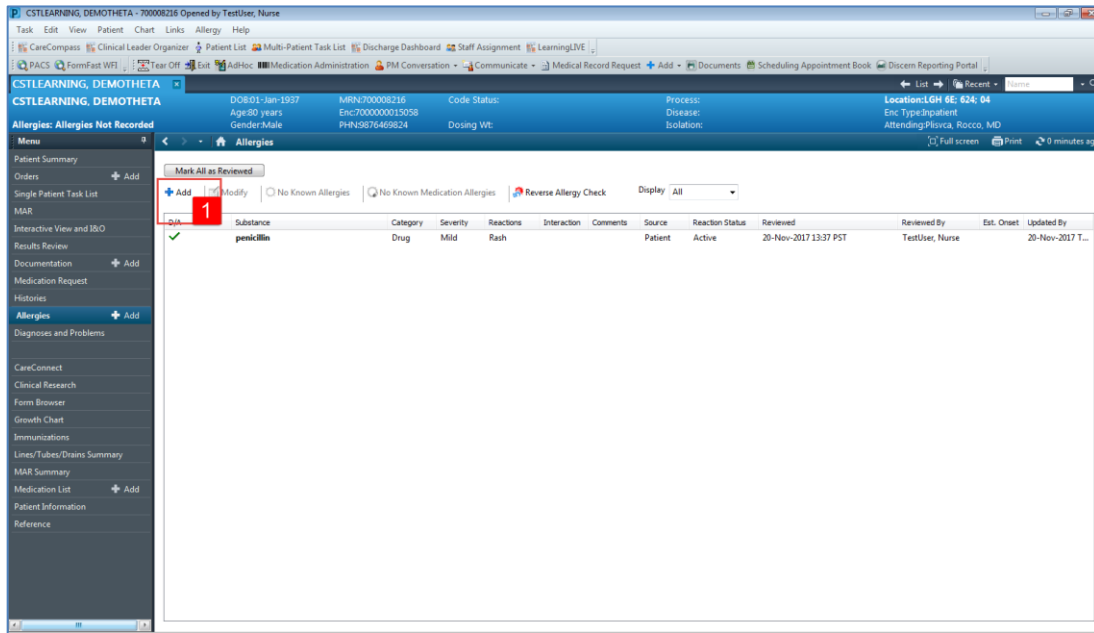
As a mental health nurse you will be complete the following activity:

-  Add an allergy

Activity 10.1 – Add an Allergy

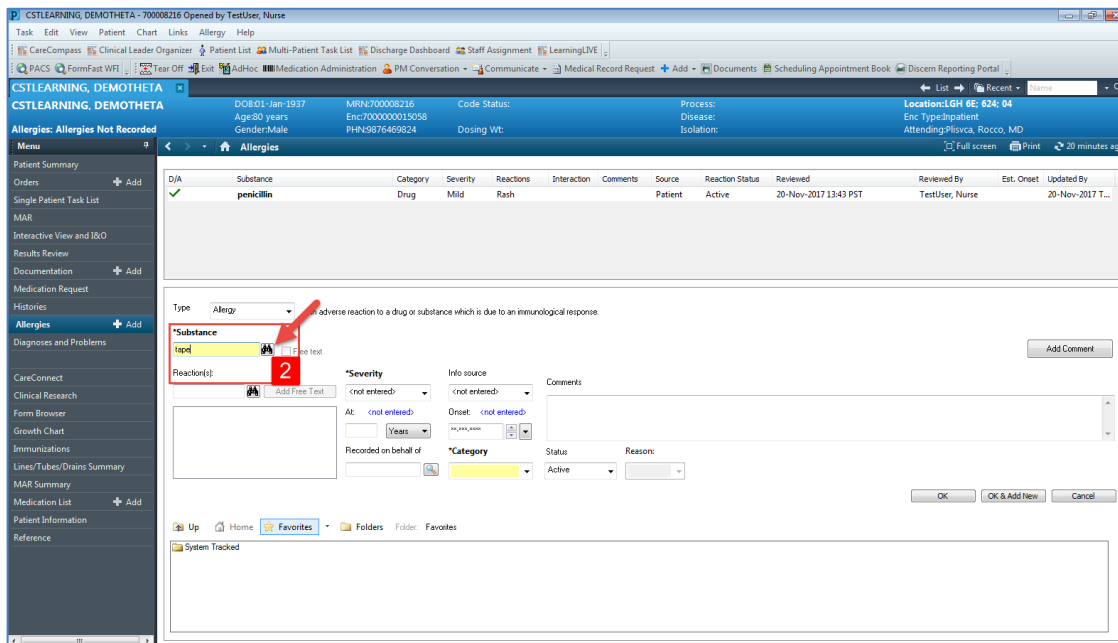
1

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




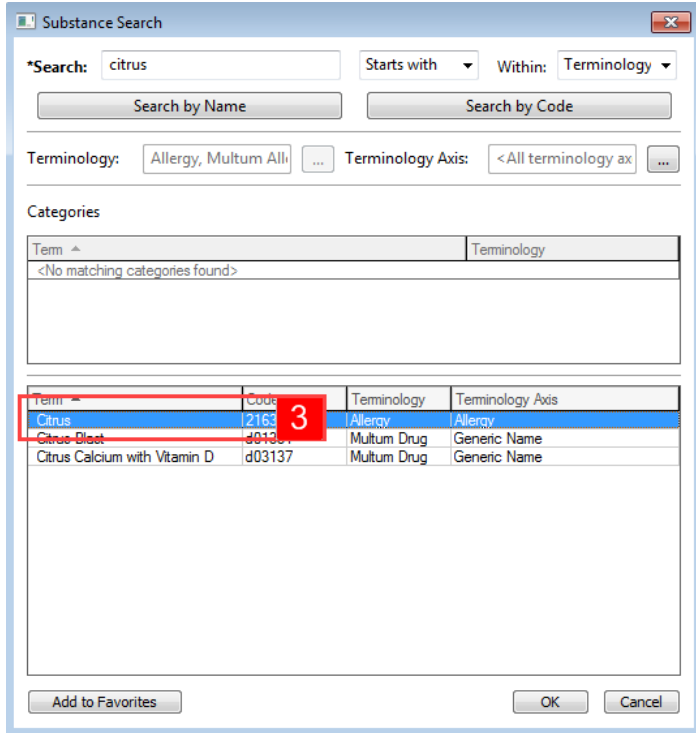
The screenshot shows the 'Allergies' section of the CSTLEARNING, DEMOTHEA interface. The patient information at the top includes DOB: 01-Jan-1937, MRN: 700008216, and Location: GH 6E 624; 04. The left sidebar contains a 'Menu' with 'Allergies' highlighted. The main area displays a table of allergies with one entry: 'penicillin' (Drug, Mild, Rash). The 'Add' button in the top left of the table is highlighted with a red box and a red number 1.

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



The screenshot shows the 'Add Allergy' form in the CSTLEARNING, DEMOTHEA interface. The form includes fields for 'Substance', 'Category', 'Severity', 'Reactions', 'Interaction', 'Comments', 'Source', 'Reaction Status', 'Reviewed', 'Reviewed By', 'Est. Onset', and 'Updated By'. The 'Substance' field is highlighted with a red box and a red number 2. Below the form, there are buttons for 'OK', 'OK & Add New', and 'Cancel'.

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



Substance Search

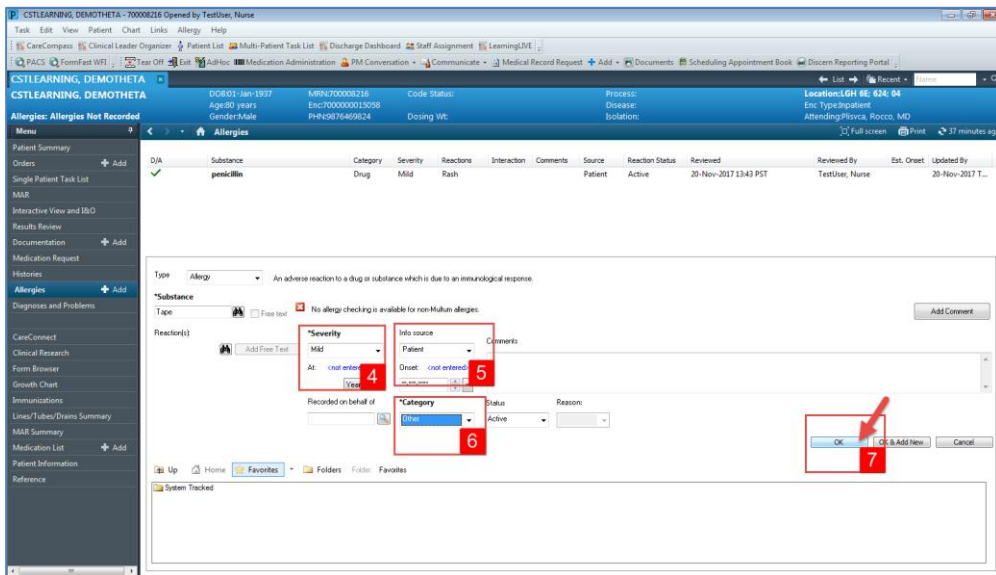
*Search: Starts with: Within:

Terminology: Terminology Axis:

Categories

Term	Code	Terminology	Terminology Axis
<No matching categories found>			
Citrus	2163	Allergy	Allergy
Citrus Dye	d0137	Multum Drug	Generic Name
Citrus Calcium with Vitamin D	d03137	Multum Drug	Generic Name

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



CSLEARNING, DEMOTHETA - 70008216 Opened by TestUser, Nurse

Task Edit View Patient Chart Links Allergy Help

CSLEARNING, DEMOTHETA DOB: 01-Jan-1997 MRN: 70008216 Code Status: Active Location: LGH 8E: 624: 04
Age: 80 years Gender: Male Enc: 7000000012018 Attending: Pivnicka, Rocco, MD
PHN: 9076499924 Dosing: Wt. Process: Discharge Isolations

Allegies: Allergies Not Recorded

D/A	Substance	Category	Severity	Reactions	Interaction	Comments	Source	Reaction Status	Reviewed	Reviewed By	Est. Onset	Updated By
✓	penicillin	Drug	Mild	Rash			Patient	Active	20-Nov-2017 13:43 PST	TestUser, Nurse		20-Nov-2017 T...

Type: An adverse reaction to a drug or substance which is due to an immunological response.

*Substance:

Type:

Reaction(s):


Recorded on behalf of: Status: Reason:

4. Select **Mild** in the **Severity** drop-down

5. Select **Patient** in the **Info source** drop-down

6. Select **Food** in the **Category** drop-down

7. Click **OK**

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

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






Key Learning Points

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

PATIENT SCENARIO 11 - Medication Administration Record (MAR)

Learning Objectives




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

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

SCENARIO

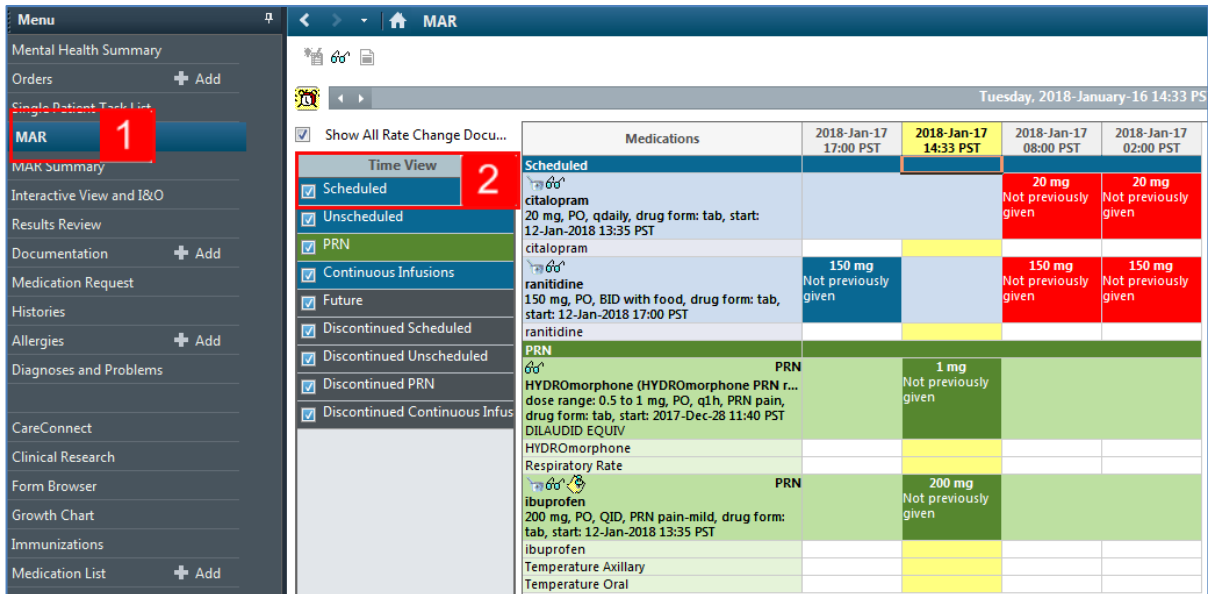
In this scenario, you will be reviewing the scheduled and PRN medications for your patient.

As a nurse, you will complete the following activities:

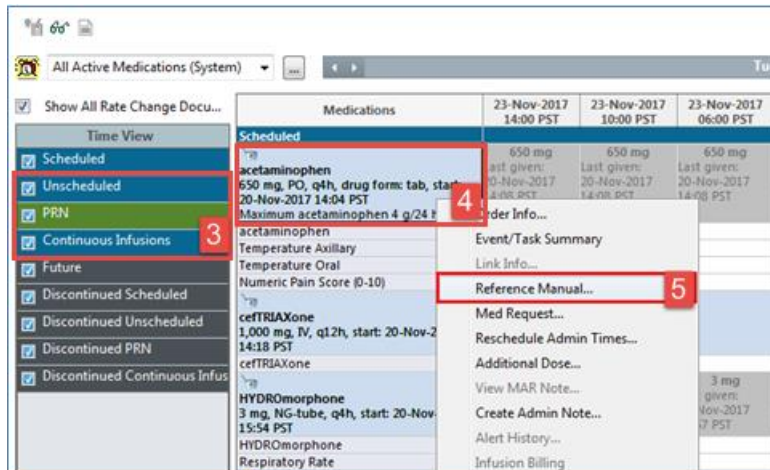
-  Review the MAR using both the time view and reverse chronological order settings
-  Reschedule a medication
-  Request a medication in the MAR

Activity 11.1 – Review the Medication Administration Record (MAR)

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



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



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

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



medication order has not been verified by pharmacy

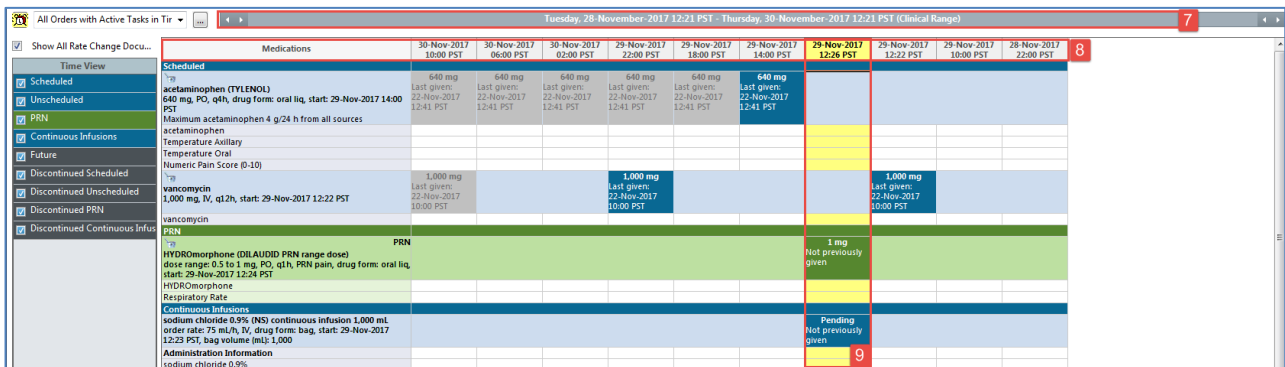


nurse review of the order is required



medication is part of a PowerPlan

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



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 12:00 PST	29-Nov-2017 12:00 PST	29-Nov-2017 10:00 PST	29-Nov-2017 08:00 PST	29-Nov-2017 06:00 PST	29-Nov-2017 04:00 PST	29-Nov-2017 02:00 PST	29-Nov-2017 00:00 PST
Scheduled acetaminophen (TYLENOL) 640 mg, PO, q4h, drug form: oral liq, start: 29-Nov-2017 14:00 PST Maximum acetaminophen 4 g/24 h from all sources	640 mg Last given: 22-Nov-2017 12:41 PST	640 mg Last given: 22-Nov-2017 12:41 PST	640 mg Last given: 22-Nov-2017 12:41 PST	640 mg Last given: 22-Nov-2017 12:41 PST	640 mg Last given: 22-Nov-2017 12:41 PST	640 mg Last given: 22-Nov-2017 12:41 PST	640 mg Last given: 22-Nov-2017 12:41 PST							
PRN acetaminophen Temperature Axillary Numeric Pain Score (0-10)														
Discontinued Scheduled vancomycin 1,000 mg, IV, q12h, start: 29-Nov-2017 12:22 PST	1,000 mg Last given: 22-Nov-2017 10:00 PST			1,000 mg Last given: 22-Nov-2017 10:00 PST					1,000 mg Last given: 22-Nov-2017 10:00 PST					
Discontinued PRN vancomycin														
Discontinued Continuous Infusions HYDROMORPHONE (DILAUDID PRN range dose) dose range: 0.5 to 1 mg, PO, q1h, PRN pain, drug form: oral liq, start: 29-Nov-2017 12:24 PST HYDROMORPHONE Respiratory Rate Continuous Infusions 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 Administration Information sodium chloride 0.9%														

- 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.
- The dates/times are displayed in **reverse chronological order**. This differs from the current state paper MARs
- The current time and date column will always be highlighted in **yellow**

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

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



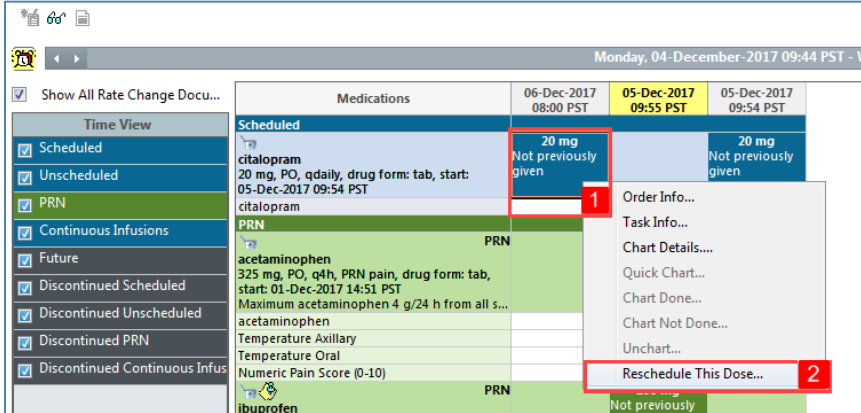
Key Learning Points

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

Activity 11.2 – Reschedule a Medication

1

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



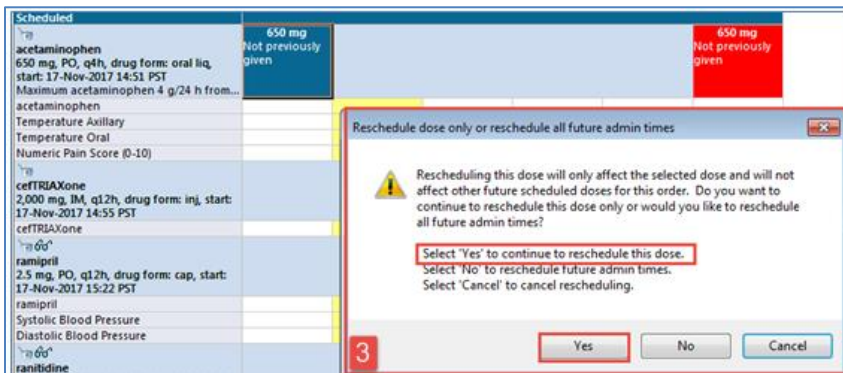
Monday, 04-December-2017 09:44 PST - W

☒ Show All Rate Change Docu...

	Medications	06-Dec-2017 08:00 PST	05-Dec-2017 09:55 PST	05-Dec-2017 09:54 PST
<input checked="" type="checkbox"/> Scheduled	Scheduled		20 mg Not previously given	20 mg Not previously given
<input checked="" type="checkbox"/> Unscheduled	citalopram 20 mg, PO, qdaily, drug form: tab, start: 05-Dec-2017 09:54 PST			
<input checked="" type="checkbox"/> PRN	citalopram			
<input checked="" type="checkbox"/> Continuous Infusions	PRN			
<input checked="" type="checkbox"/> Future	acetaminophen 325 mg, PO, q4h, PRN pain, drug form: tab, start: 01-Dec-2017 14:51 PST			
<input checked="" type="checkbox"/> Discontinued Scheduled	Maximum acetaminophen 4 g/24 h from all s...			
<input checked="" type="checkbox"/> Discontinued Unscheduled	acetaminophen			
<input checked="" type="checkbox"/> Discontinued PRN	Temperature Axillary			
<input checked="" type="checkbox"/> Discontinued Continuous Infus	Temperature Oral			
	Numeric Pain Score (0-10)			
	ibuprofen		Not previously	

Order Info...
Task Info...
Chart Details...
Quick Chart...
Chart Done...
Chart Not Done...
Unchart...
Reschedule This Dose...

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



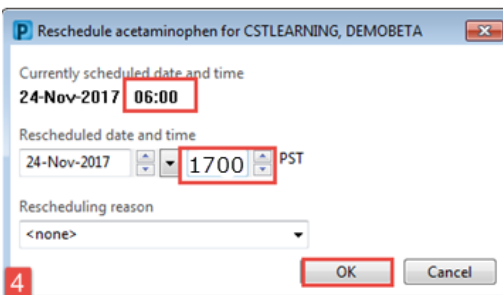
Reschedule dose only or reschedule all future admin times

Rescheduling this dose will only affect the selected dose and will not affect other future scheduled doses for this order. Do you want to continue to reschedule this dose only or would you like to reschedule all future admin times?

Select 'Yes' to continue to reschedule this dose.
Select 'No' to reschedule future admin times.
Select 'Cancel' to cancel rescheduling.

Yes No Cancel

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



Reschedule acetaminophen for CSTLEARNING, DEMOBETA

Currently scheduled date and time
24-Nov-2017 06:00

Rescheduled date and time
24-Nov-2017 17:00 PST

Rescheduling reason
<none>

OK Cancel

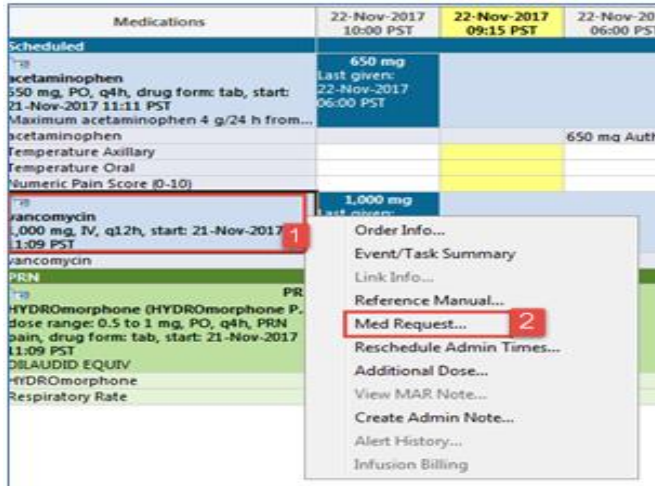
4. You want to reschedule the medication administration time to a later time. Change the time field to 1700 and click **OK**.

Key Learning Points

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



Activity 11.3 – Request a Medication via MAR

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



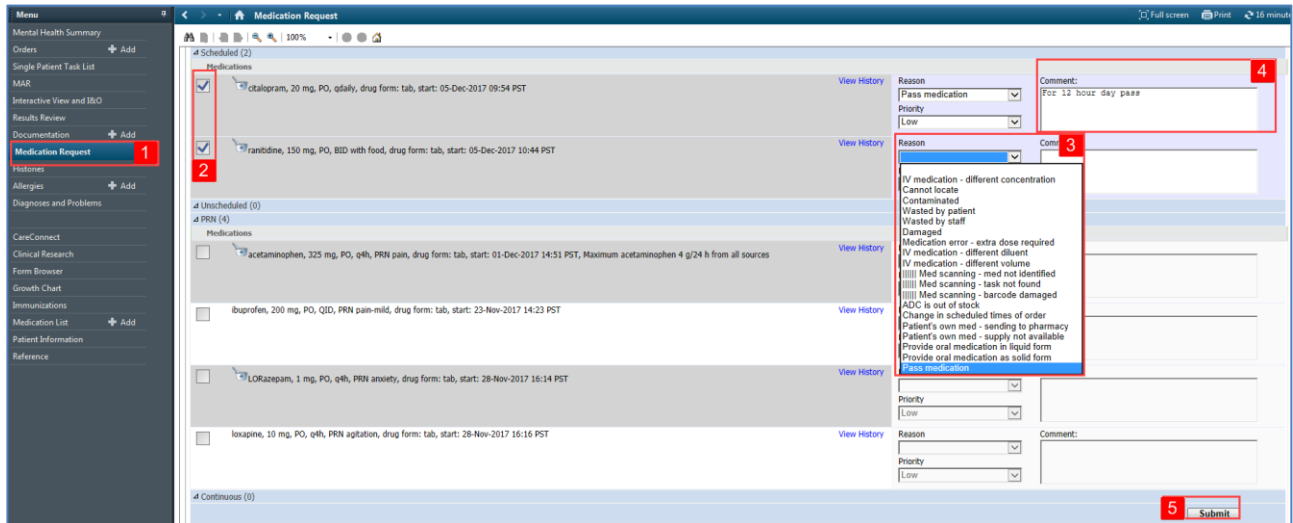
1. Right click on the medication order name
2. Select **Med Request**
3. Select **Cannot Locate** under reason
4. Click **Submit**

Key Learning Points

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

Activity 11.4 – Request Multiple Medications via Medication Request Function

- 1 The patient is going on a pass and requires pass medications for the next 12 hours. You need to submit a Med Request to Pharmacy for multiple medications at once.



The screenshot displays the 'Medication Request' window. On the left, a 'Menu' sidebar lists various functions, with 'Medication Request' highlighted and numbered 1. The main area shows a list of 'Scheduled (2)' medications: citalopram and ranitidine. The ranitidine entry is checked with a red box numbered 2. Below this is a list of 'Unscheduled (0)' medications. To the right, a form allows selecting a 'Reason' (numbered 3) from a dropdown menu, with 'Pass medication' selected. A 'Comment' field (numbered 4) contains the text 'For 12 hour day pass'. At the bottom right, a red 'Submit' button is numbered 5.

1. Select **Medication Request** in the Menu
2. Check the box beside the scheduled medications that the patient will require in the next 24 hours
3. From drop down menu under Reason, select **Pass medication**
4. Under Comment, enter = *For overnight pass*
5. Click **Submit**



Key Learning Points





You can request multiple medications at once for a variety of reasons through the Medication Request Menu function

PATIENT SCENARIO 12 - 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 12.1 – Administering Medication using the Medication Administration Wizard (MAW) and the Barcode Scanner

- 1 Medications will be administered and recorded electronically by scanning the patient's wristband and the medication barcode. Scanning of the patient's wrist band 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.

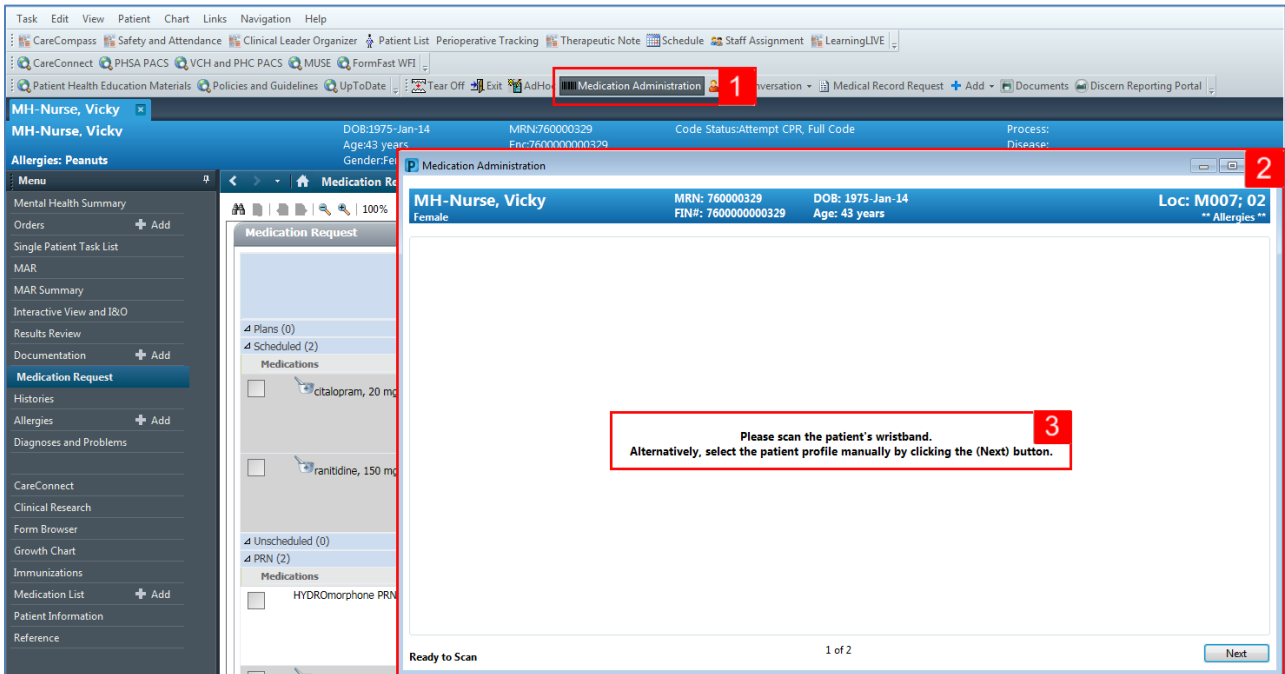
Note: Occasionally a dose requires scanning two pills to make up the full dose. At other times, the dose requires only part of a pill.

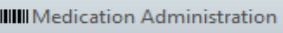
- PO medication: **citalopram, 20mg, PO qdaily, drug form: tab**
- Range dose medication: **hydromorphone 0.5 mg PO, PRN for pain**, using hydromorphone 1 mg tab product barcode

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

Activity 12.1 – Administering Medication using the Medication Administration Wizard (MAW) and the Barcode Scanner



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

Scan the medication barcode for citalopram 20 mg tab

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

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 Access
NPO
Patient Condition
Patient Request
Patient unavailable 4
Provider consultation required
Other :

Cancel

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

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

Now let's administer the next medication.

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

Discern: CSTLEARNING, DEMODELTA (1 of 1)

Cerner | **Range Dose Warning**

You are administering a Range Dose order for HYDROMORPHONE. The range is from 0.5 mg to 1 mg.

Please verify you are administering the correct dose.

OK

 3

3. Click **OK** to acknowledge the alert

Activity 12.1 – Administering Medication using the Medication Administration Wizard (MAW) and the Barcode Scanner

4. Click the **Missing Details**  icon

5. A charting window will appear. Enter the following details:

- Respiratory Rate = 12
- HYDROMORPHONE = 0.5 (*changed from 1*)

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

6. Click **OK**
7. Click **Sign** on the MAW

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

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

MAR										
Monday, 04-December-2017 09:44 PST - Wednesday, 06-December-2017 09:44 PST (Clinical Range)										
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		
Scheduled										
citalopram 20 mg, PO, qdaily, drug form: tab, start: 05-Dec-2017 09:54 PST	20 mg Last given: 05-Dec-2017 12:15 PST									
citalopram										
Continuous Infusions										
ranitidine 150 mg, PO, BID with food, drug form: tab, start: 05-Dec-2017 10:44 PST	150 mg Not previously given	150 mg Not previously given								
ranitidine										
PRN										
acetaminophen 325 mg, PO, q4h, PRN pain, drug form: tab, start: 01-Dec-2017 14:51 PST Maximum acetaminophen 4 g/24 h from all ...					325 mg Not previously given					
acetaminophen										
Temperature Axillary										
Temperature Oral										
Numeric Pain Score (0-10)										
PRN										
HYDROMORPHONE (HYDROMORPHONE PRN r... dose range: 0.5 to 1 mg, PO, q4h, PRN pain, drug form: tab, start: 05-Dec-2017 13:10 PST DILAUDID EQUIV			Med Response	Med Response	1 mg Last given: 05-Dec-2017 13:32 PST					
HYDROMORPHONE										
Respiratory Rate										
PRN										
LORAZEPAM 1 mg, PO, q4h, PRN anxiety, drug form: tab, start: 28-Nov-2017 16:14 PST					1 mg Not previously given					
LORAZEPAM										
PRN										
LOXAPINE 10 mg, PO, q4h, PRN agitation, drug form: tab, start: 28-Nov-2017 16:16 PST					10 mg Not previously given					
LOXAPINE										

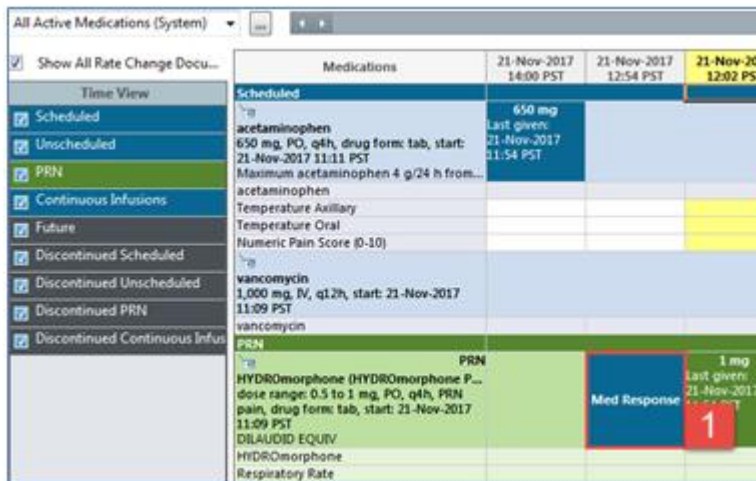
Note: there is a new **Med Response** for the PRN medication Hydromorphone. For some PRN medications, the system will ask you to complete a medication response assessment.

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

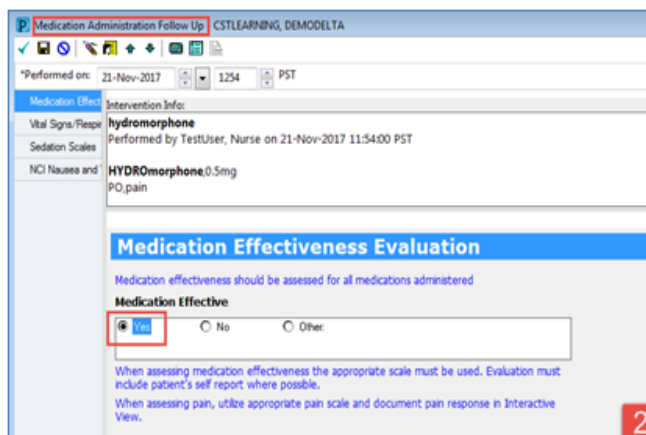
Activity 12.2 – Documenting Patient Response to Medication (Medication Response)

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



Medications	21-Nov-2017 14:00 PST	21-Nov-2017 12:54 PST	21-Nov-2017 12:02 PST
Scheduled			
acetaminophen 650 mg, PO, q4h, drug form: tab, start: 21-Nov-2017 11:11 PST	650 mg	Last given: 21-Nov-2017 11:54 PST	
Maximum acetaminophen 4 g/24 h from...			
PRN			
acetaminophen			
Temperature Axillary			
Temperature Oral			
Numeric Pain Score (0-10)			
Discontinued Scheduled			
Discontinued Unscheduled			
Discontinued PRN			
Discontinued Continuous Infus			
vancomycin 1,000 mg, IV, q12h, start: 21-Nov-2017 11:09 PST			
vancomycin			
PRN			
HYDROmorphone (HYDROmorphone P... dose range: 0.5 to 1 mg, PO, q4h, PRN pain, drug form: tab, start: 21-Nov-2017 11:09 PST			1 mg Last given: 21-Nov-2017 11:54 PST
DILAUDID EQUIV			
HYDROmorphone			
Respiratory Rate			

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



Medication Administration Follow Up CSTLEARNING, DEMODELTA

*Performed on: 21-Nov-2017 1254 PST

Medication Effectiveness Evaluation

Medication effectiveness should be assessed for all medications administered

Medication Effective

☒ Yes ☐ No ☐ Other

When assessing medication effectiveness the appropriate scale must be used. Evaluation must include patient's self report where possible.

When assessing pain, utilize appropriate pain scale and document pain response in Interactive View.

2. In the **Medication Effectiveness Evaluation** field, click **Yes**
3. **Sign** and refresh the screen. Now that you have documented the medication response it has disappeared from the MAR.




Key Learning Points

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

PATIENT SCENARIO 13 - Modified Early Warning System (MEWS)

Learning Objectives




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

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

SCENARIO

In this scenario, you will be managing a Modified Early Warning System (MEWS) alert for your patient and how it relates to deterioration of health status.

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 13.1 – Document on MEWS Section in iView to Trigger a MEWS Alert

1

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

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

Note:

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


Let's review MEWS documentation:

The screenshot shows the iView interface for documenting MEWS. The left sidebar (Menu) has 'Interactive View and I&O' highlighted with a red box and the number 1. The middle section (Interactive View and I&O) has 'MH Adult Quick View' highlighted with a red box and the number 2. The right section (VITAL SIGNS) has a table for documenting vital signs. The table has columns for 'Find Item', 'Critical', 'High', 'Low', 'Abnormal', 'Unauth', and 'Flag'. The table lists various vital signs and their units. The 'Respiratory Rate' row is highlighted with a red box and the number 3.

Find Item	Critical	High	Low	Abnormal	Unauth	Flag
Temperature Axillary						
Temperature Temporal Artery						
Temperature Oral						
Temperature Tympanic						
Apical Heart Rate						
Peripheral Pulse Rate						
Heart Rate Monitored						
SBP/DBP Cuff						
Cuff Location						
Mean Arterial Pressure, Cuff						
Mean Arterial Pressure, Manual						
Blood Pressure Method						
SBP/DBP Supine						
Pulse Supine						
SBP/DBP Sitting						
Pulse Sitting						
SBP/DBP Standing						
Pulse Standing						
Cerebral Perfusion Pressure, Cuff						
Oxygenation						
Respiratory Rate						

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


Activity 13.1 – Document on MEWS Section in iView to Trigger a MEWS Alert

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

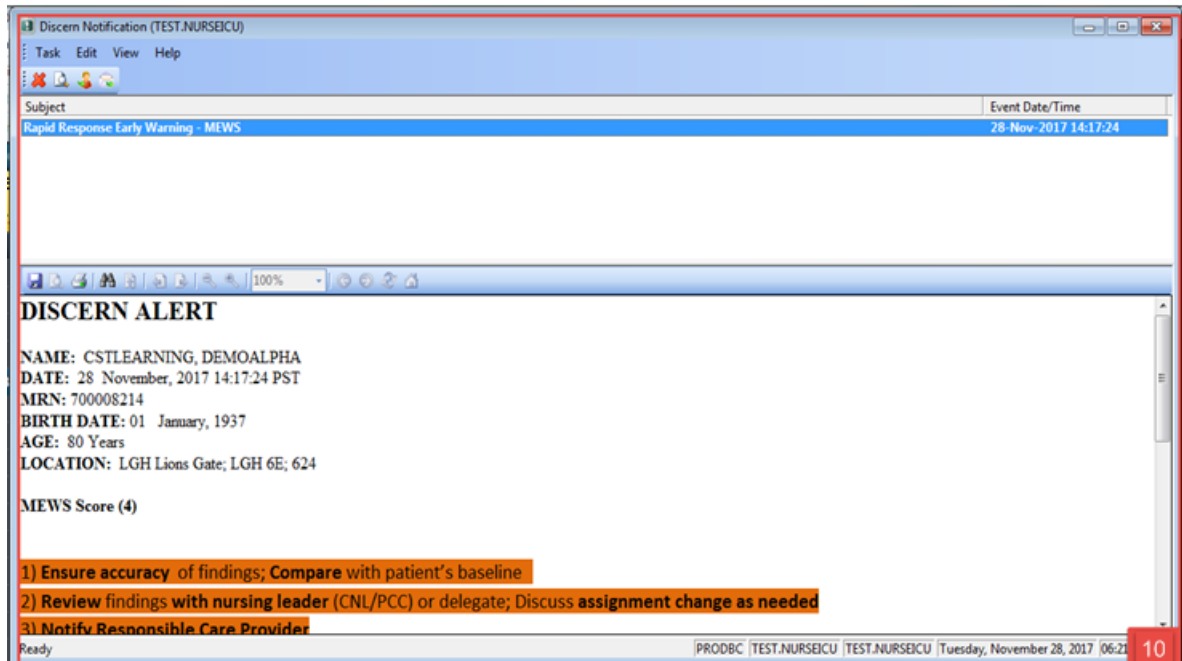
Note: MEWS score will not auto-populate if above score is not completed

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

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

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

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



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

Key Learning Points

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

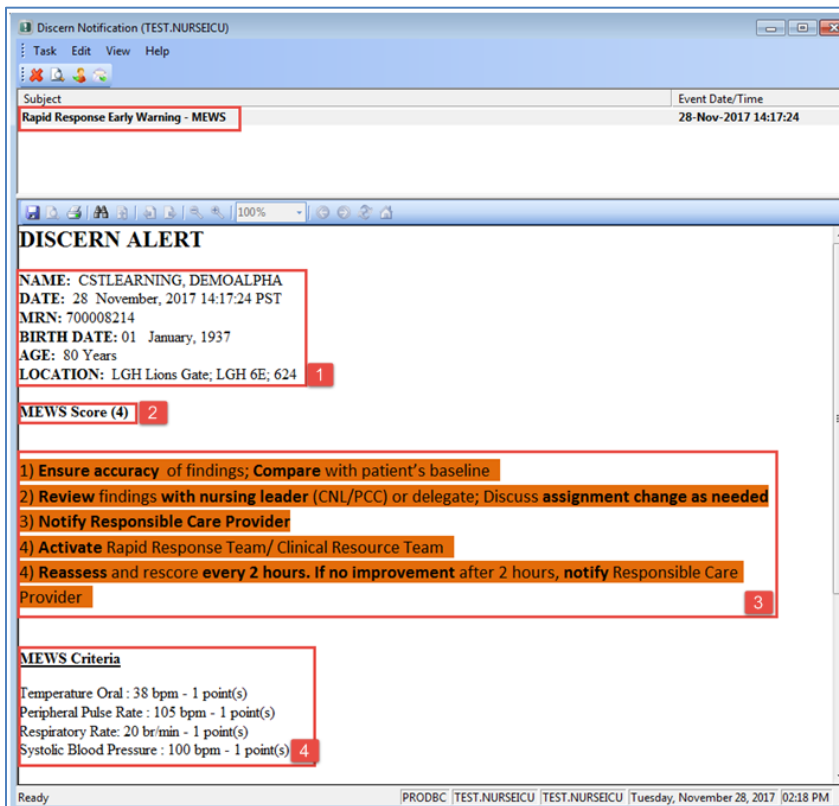
Activity 13.2 – Review the MEWS Alert

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

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

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

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



Discern Notification (TEST.NURSEICU)

Task Edit View Help

Subject: Rapid Response Early Warning - MEWS Event Date/Time: 28-Nov-2017 14:17:24

DISCERN ALERT

NAME: CSTLEARNING, DEMOALPHA
 DATE: 28 November, 2017 14:17:24 PST
 MRN: 700008214
 BIRTH DATE: 01 January, 1937
 AGE: 80 Years
 LOCATION: LGH Lions Gate; LGH 6E; 624 **1**

MEWS Score (4) **2**

1) Ensure accuracy of findings; Compare with patient's baseline
 2) Review findings with nursing leader (CNL/PCC) or delegate; Discuss assignment change as needed
 3) Notify Responsible Care Provider
 4) Activate Rapid Response Team/ Clinical Resource Team
 4) Reassess and rescore every 2 hours. If no improvement after 2 hours, notify Responsible Care Provider **3**


MEWS Criteria

Temperature Oral : 38 bpm - 1 point(s)
 Peripheral Pulse Rate : 105 bpm - 1 point(s)
 Respiratory Rate : 20 br/min - 1 point(s)
 Systolic Blood Pressure : 100 bpm - 1 point(s) **4**

Ready | PRODBC | TEST.NURSEICU | TEST.NURSEICU | Tuesday, November 28, 2017 | 02:18 PM

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 Criteria**

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

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

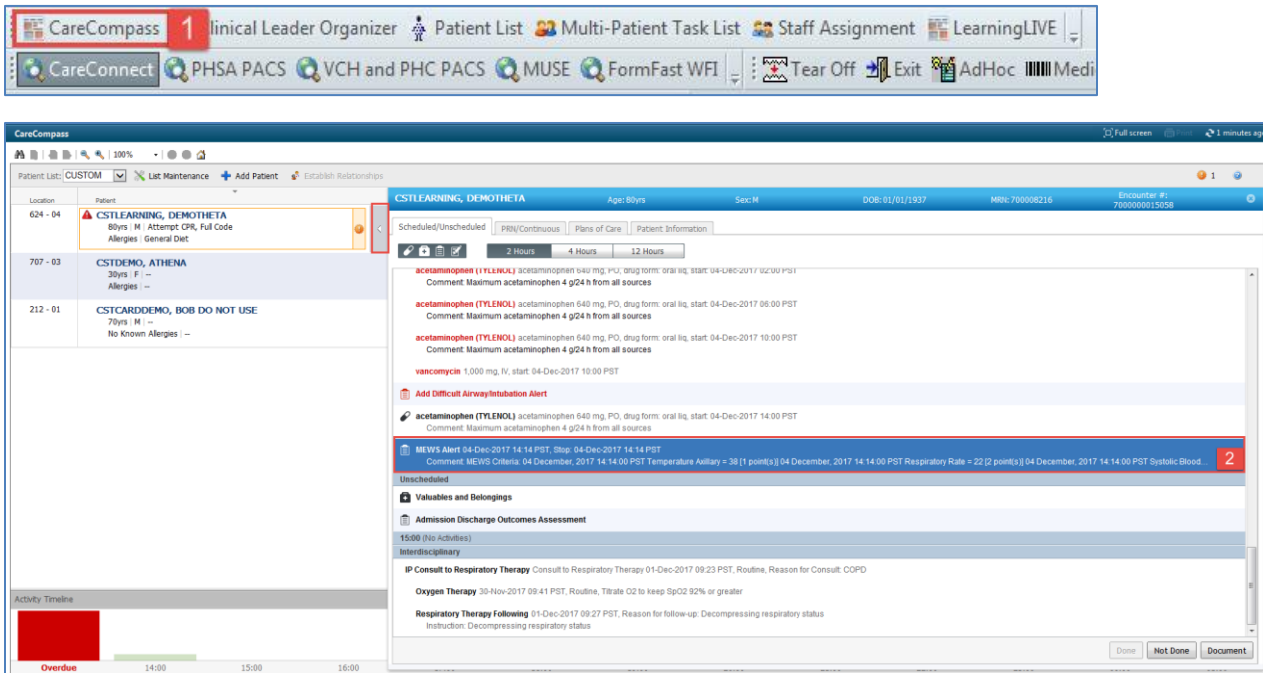
Key Learning Points

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



Activity 13.3 – 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.

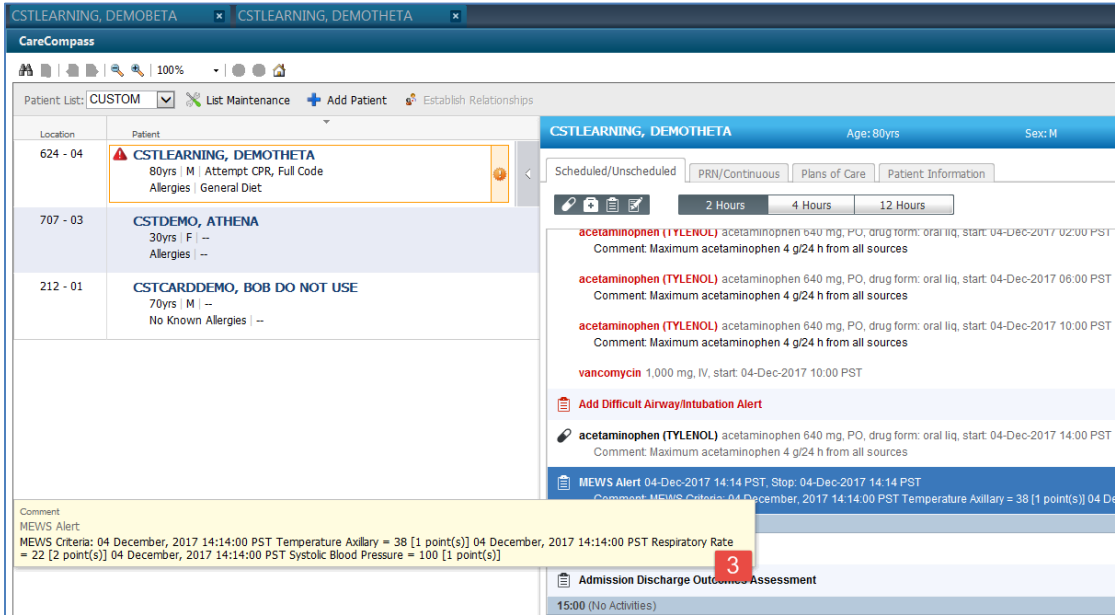
The MEWS alert automatically creates a task that can be viewed in Care Compass. The task is called MEWS Alert.



The screenshot displays the Care Compass software interface. At the top is a toolbar with icons for Clinical Leader Organizer, Patient List, Multi-Patient Task List, Staff Assignment, LearningLIVE, CareConnect, PHSA PACS, VCH and PHC PACS, MUSE, FormFast WFI, Tear Off, Exit, AdHoc, and Medi. Below the toolbar, the main window is divided into two panes. The left pane shows a patient list with three entries: CSTLEARNING, DEMOTHEA (80yrs, M, Attempt CPR, Full Code, Allergies: General Det), CSTDEMO, ATHENA (30yrs, F, Allergies: -), and CSTCARDDEMO, BOB DO NOT USE (70yrs, M, No Known Allergies). The right pane shows the detailed view for CSTLEARNING, DEMOTHEA, including a list of medical orders such as acetaminophen (TYLENOL) and vancomycin. A red box highlights a 'MEWS Alert' task at the bottom of the task list, with a red '2' in a box next to it.

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.



The screenshot shows the CareCompass interface for patient CSTLEARNING, DEMOTHETA. The patient's age is 80yrs and sex is M. The interface displays a list of tasks on the left and a detailed view of the selected task on the right. The task list includes:

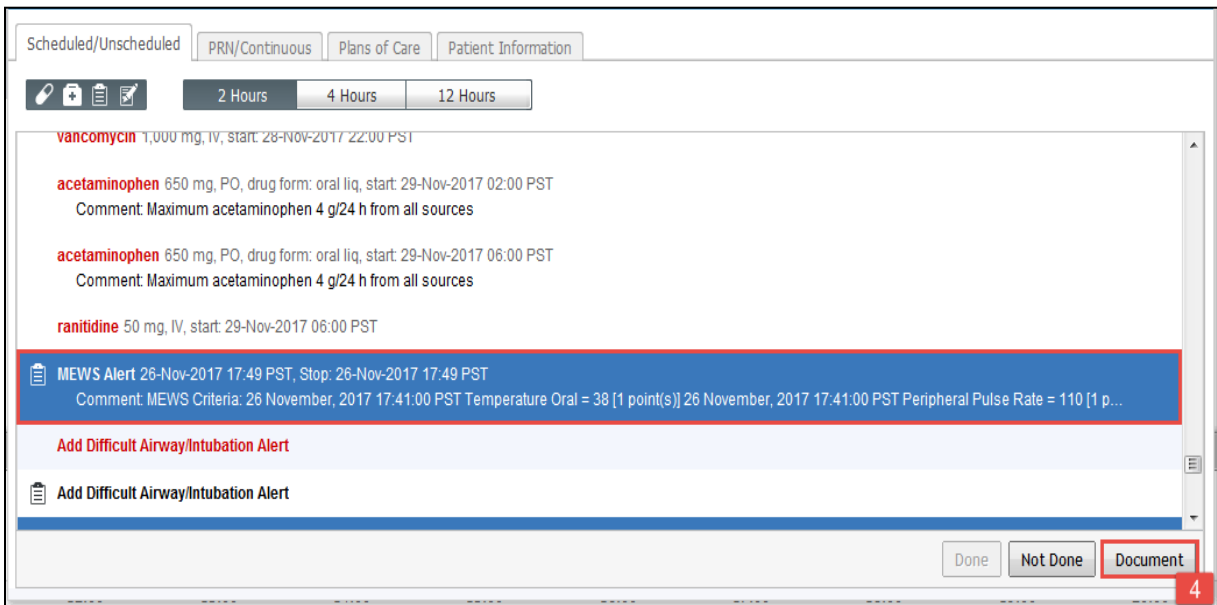
- 624 - 04: CSTLEARNING, DEMOTHETA (80yrs | M | Attempt CPR, Full Code | Allergies | General Diet)
- 707 - 03: CSTDEMO, ATHENA (30yrs | F | -- | Allergies | --)
- 212 - 01: CSTCARDDEMO, BOB DO NOT USE (70yrs | M | -- | No Known Allergies | --)

The detailed view on the right shows the following tasks:

- acetaminophen (TYLENOL)** acetaminophen 640 mg, PO, drug form: oral liq, start: 04-Dec-2017 02:00 PST
Comment: Maximum acetaminophen 4 g/24 h from all sources
- acetaminophen (TYLENOL)** acetaminophen 640 mg, PO, drug form: oral liq, start: 04-Dec-2017 06:00 PST
Comment: Maximum acetaminophen 4 g/24 h from all sources
- acetaminophen (TYLENOL)** acetaminophen 640 mg, PO, drug form: oral liq, start: 04-Dec-2017 10:00 PST
Comment: Maximum acetaminophen 4 g/24 h from all sources
- vancomycin** 1,000 mg, IV, start: 04-Dec-2017 10:00 PST
- Add Difficult Airway/Intubation Alert**
- acetaminophen (TYLENOL)** acetaminophen 640 mg, PO, drug form: oral liq, start: 04-Dec-2017 14:00 PST
Comment: Maximum acetaminophen 4 g/24 h from all sources
- MEWS Alert** 04-Dec-2017 14:14 PST, Stop: 04-Dec-2017 14:14 PST
Comment: MEWS Criteria: 04 December, 2017 14:14:00 PST Temperature Axillary = 38 [1 point(s)] 04 Dec...
- Admission Discharge Outcome Assessment**

A red box highlights the 'MEWS Alert' task, and a red circle with the number 3 is next to it.

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



The screenshot shows the CareCompass interface for patient CSTLEARNING, DEMOTHETA. The patient's age is 80yrs and sex is M. The interface displays a list of tasks on the left and a detailed view of the selected task on the right. The task list includes:

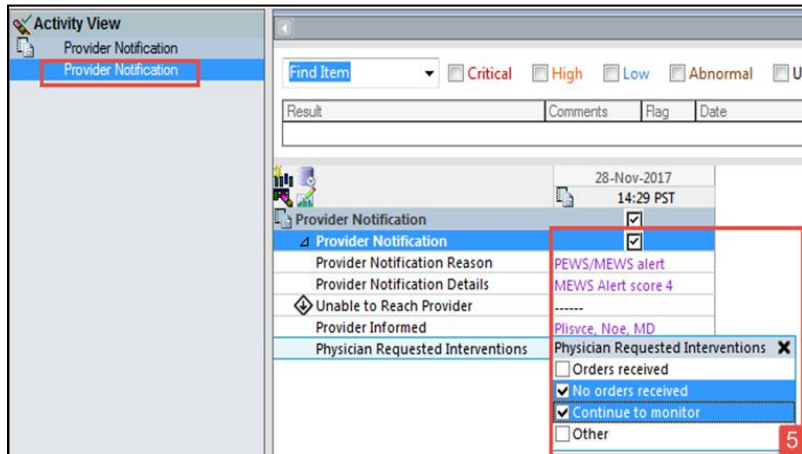
- 624 - 04: CSTLEARNING, DEMOTHETA (80yrs | M | Attempt CPR, Full Code | Allergies | General Diet)
- 707 - 03: CSTDEMO, ATHENA (30yrs | F | -- | Allergies | --)
- 212 - 01: CSTCARDDEMO, BOB DO NOT USE (70yrs | M | -- | No Known Allergies | --)

The detailed view on the right shows the following tasks:

- vancomycin** 1,000 mg, IV, start: 28-Nov-2017 22:00 PST
- 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**


A red box highlights the 'MEWS Alert' task, and a red circle with the number 4 is next to it.

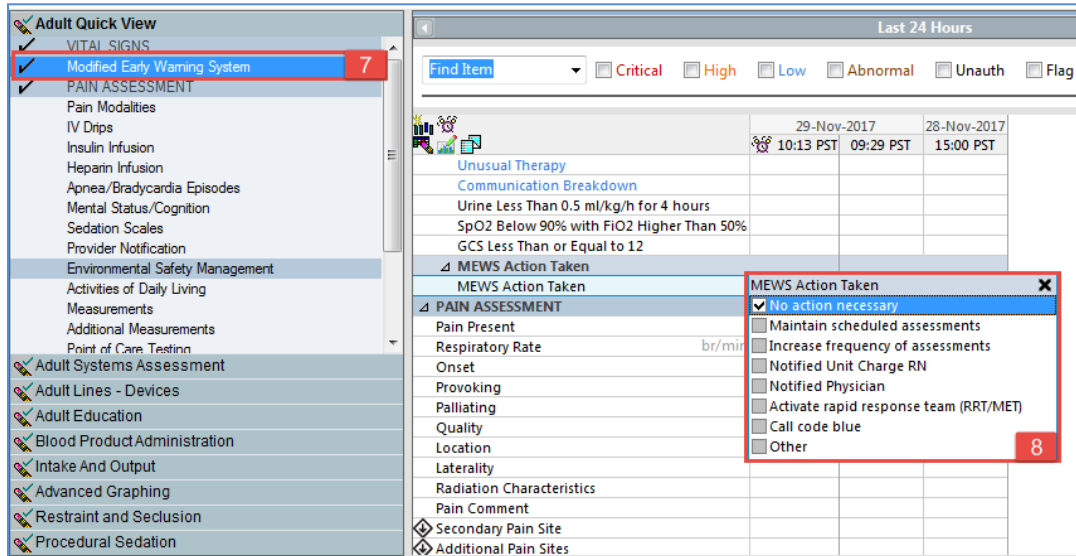
4. Click on the **MEWS Alert** task and then click **Document**. You will automatically be taken to the Provider Notification section for documentation.



5. In the Provider Notification section, document the following information:

- **Provider Notification Reason** = *PEWS/MEWS Alert*
- **Providers Notification Details** = *MEWS Alert score 4*
- **Provider informed** = *name of patient's physician*
- **Physician Requested Interventions** = *No orders received, Continue to Monitor*

6. Click the green check mark to sign  Completing this documentation will automatically clear the MEWS Alert task from the patient's task list



7. Click on the **Modified Early Warning System** section in the **MH Adult Quick View** band within iView

8. Complete documentation for **MEWS Action Taken** = *No action necessary*. Then click the green check mark to sign 


Key Learning Points

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

PATIENT SCENARIO 14 – Safety and Attendance

Learning Objectives



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

-  Document Patient Observations Through Safety and Attendance

SCENARIO

In this scenario, you will be performing a safety check for your patient list and documenting your observations.

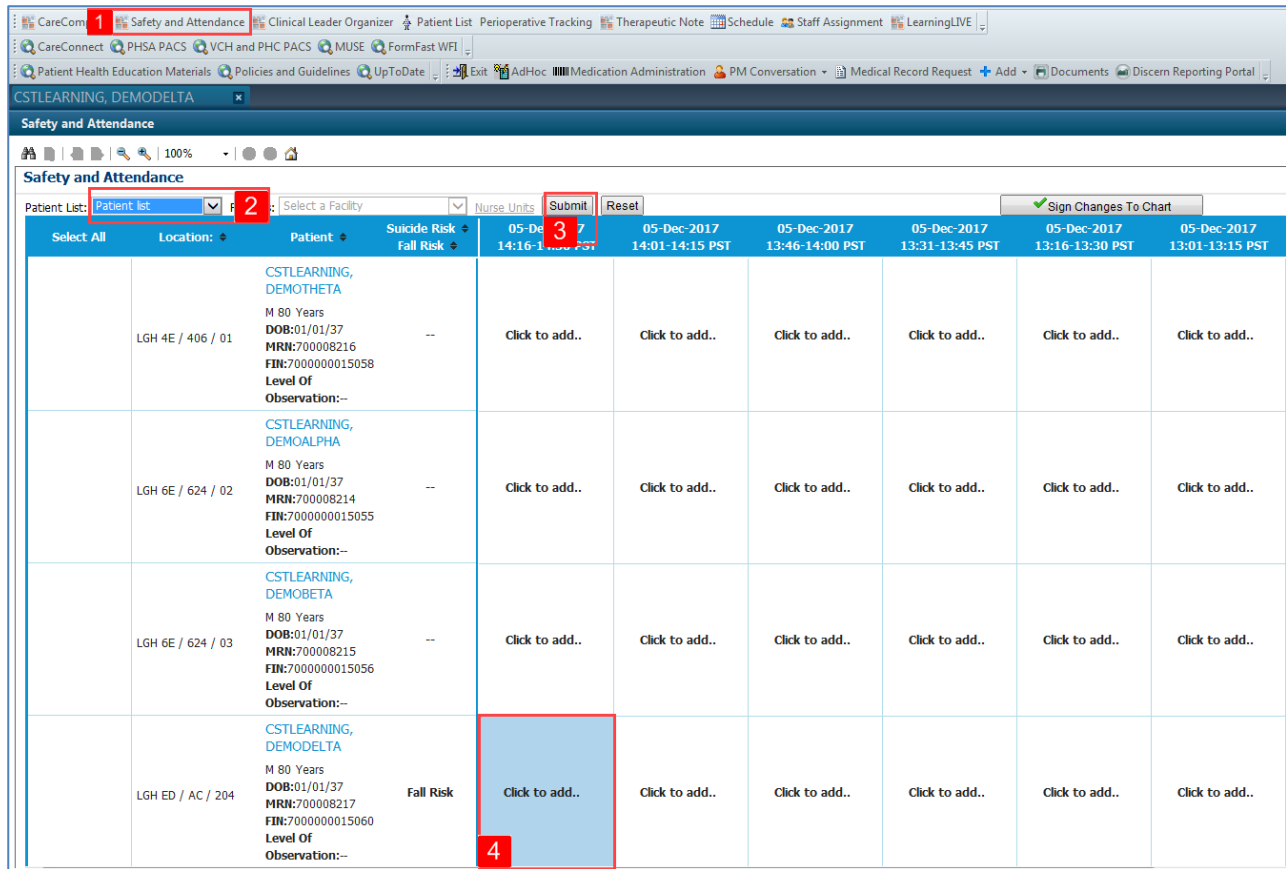
As a nurse you will be completing the following activities:

-  Access Safety and Attendance
-  Document and sign observations for multiple patients

Activity 14.1 – Documenting Safety and Attendance

1

You can document observations on many patients without going into their chart or establishing an electronic relationship with them.



Safety and Attendance

Patient List: **Patient List** Select a Facility Nurse Units **Submit** **Reset** **Sign Changes To Chart**

Select All	Location	Patient	Suicide Risk Fall Risk	05-Dec-2017 14:16-14:31 PST	05-Dec-2017 14:01-14:15 PST	05-Dec-2017 13:46-14:00 PST	05-Dec-2017 13:31-13:45 PST	05-Dec-2017 13:16-13:30 PST	05-Dec-2017 13:01-13:15 PST
	LGH 4E / 406 / 01	CSTLEARNING, DEMOTHETA M 80 Years DOB:01/01/37 MRN:700008216 FIN:7000000015058 Level Of Observation:--	--	Click to add..	Click to add..	Click to add..	Click to add..	Click to add..	Click to add..
	LGH 6E / 624 / 02	CSTLEARNING, DEMOALPHA M 80 Years DOB:01/01/37 MRN:700008214 FIN:7000000015055 Level Of Observation:--	--	Click to add..	Click to add..	Click to add..	Click to add..	Click to add..	Click to add..
	LGH 6E / 624 / 03	CSTLEARNING, DEMOBETA M 80 Years DOB:01/01/37 MRN:700008215 FIN:7000000015056 Level Of Observation:--	--	Click to add..	Click to add..	Click to add..	Click to add..	Click to add..	Click to add..
	LGH ED / AC / 204	CSTLEARNING, DEMODELTA M 80 Years DOB:01/01/37 MRN:700008217 FIN:7000000015060 Level Of Observation:--	Fall Risk	Click to add..	Click to add..	Click to add..	Click to add..	Click to add..	Click to add..

1. Click **Safety and Attendance** in the Organizer Tool Bar
2. Select **Patient List** from Patient List Drop-down **Patient List:**
3. Click **Submit**
4. Click **Click to Add** for your patient on the time column for the time closest to the current time

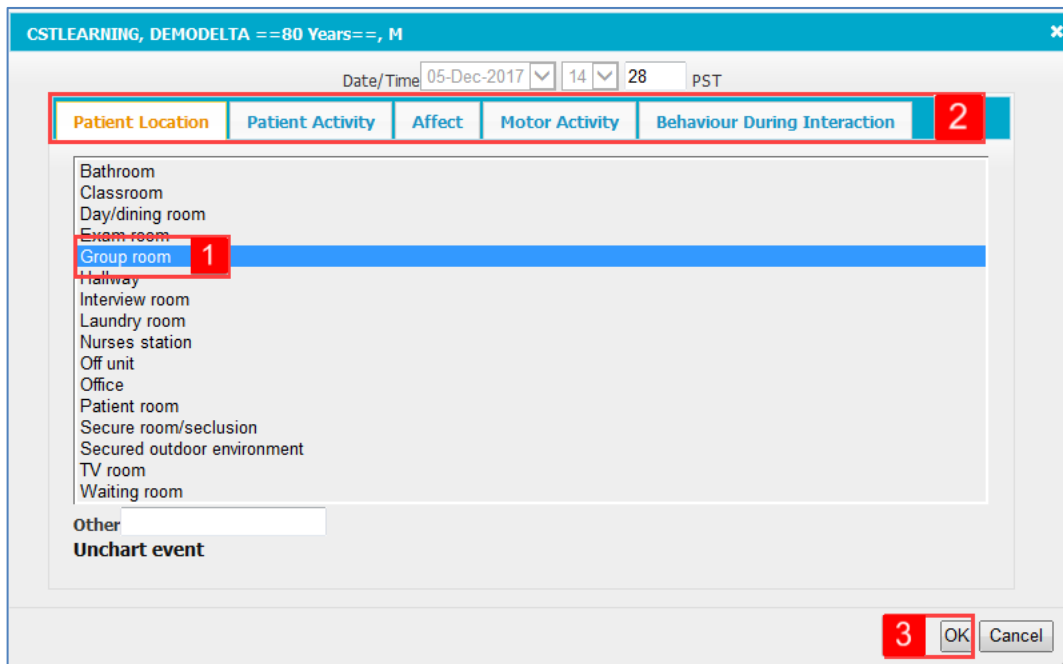
Note: Time columns are populated at 15 minute intervals

2

1. Select = Group room from the Patient Location tab
2. Spend some time reviewing the various options in the patient documentation tabs and select some values. To select multiple options, hold down the Ctrl key while choosing the appropriate options
3. Click OK

Note: If you notice an error, you can modify the value by clicking back into the appropriate box prior to signing documentation. If you entered text into the **Other** box, this will need to be reentered with any modifications.

3



The screenshot shows the 'CSTLEARNING, DEMODELTA ==80 Years==, M' window. At the top, the date/time is set to 05-Dec-2017, 14:28 PST. Below the date/time, there are five tabs: 'Patient Location', 'Patient Activity', 'Affect', 'Motor Activity', and 'Behaviour During Interaction'. The 'Patient Location' tab is selected and highlighted in orange. A red box labeled '2' is placed over the 'Patient Location' tab. Below the tabs, a list of locations is displayed: Bathroom, Classroom, Day/dining room, Exam room, Group room, Hallway, Interview room, Laundry room, Nurses station, Off unit, Office, Patient room, Secure room/seclusion, Secured outdoor environment, TV room, and Waiting room. The 'Group room' is highlighted in blue, and a red box labeled '1' is placed over it. Below the list, there is an 'Other' text box and an 'Unchart event' button. At the bottom right, there are 'OK' and 'Cancel' buttons, with a red box labeled '3' placed over the 'OK' button.

1. Select = *Group room* from the **Patient Location** tab
2. Spend some time reviewing the various options in the patient documentation tabs and select some values. To select multiple options, hold down the **Ctrl** key while choosing the appropriate options
3. Click **OK**

Note: If you notice an error, you can modify the value by clicking back into the appropriate box prior to signing documentation. If you entered text into the **Other** box, this will need to be reentered with any modifications.

4

Click **Sign Changes to Chart** to complete documentation

Safety and Attendance

100%

Safety and Attendance

Patient List: LGH HOPE Centre Facilities: Select a Facility Nurse Units Submit Reset **Sign Changes To Chart** Tim

Select All	Location: ▾	Patient ▾	Suicide Risk ▾ Fall Risk ▾	2017-Aug-01 14:46-15:00 PDT Click to add..	2017-Aug-01 14:31-14:45 PDT Click to add..	2017-Aug-01 14:16-14:30 PDT Click to add..	2017-Aug-01 14:01-14:15 PDT Click to add..
	LGH MIU / M007 / 01	U 36 Years DOB:05/01/81 MRN:700004332 FIN:7000000007079 Level Of Observation:--					
	LGH MIU / M007 / 02	CSTPRODBCMH, TAYLOR F 29 Years DOB:07/21/88 MRN:700002605 FIN:7000000005897 Level Of Observation:--	--	Click to add..	Click to add..	Click to add..	Click to add..
	LGH MIU / M008 / 01	MHTEST, JANJAN U 37 Years DOB:07/08/80 MRN:700004950 FIN:7000000007952 Level Of Observation:--	--	Hallway; Screaming; Downcast, Dysphoric ; Unremarkable	Click to add..	Click to add..	Click to add..
		CSTPRODBCMH, DEMO F 22 Years DOB:10/11/82					

Key Learning Points

- You can document observations on many patients without going into their chart or establishing an electronic relationship with them
- If you enter text into the **Other** box, it will need to be reentered with any modifications

PATIENT SCENARIO 15 – Therapeutic Note

Learning Objectives

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

- Document a Group Therapy Note

SCENARIO

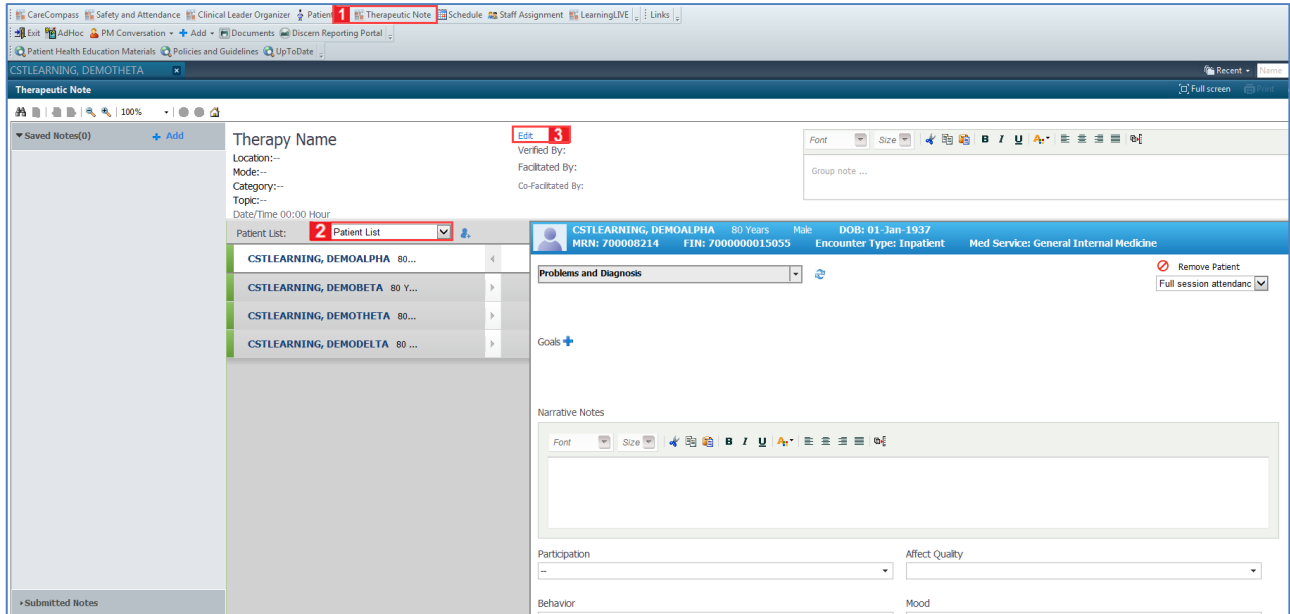
You have just completed running a therapeutic group. You will be documenting a group therapy note, also known as a Therapeutic Note.

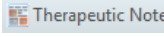

As the nurse you will be completing the following activities:

- Initiate a Therapeutic Note for multiple patients at once
- Document the details of the group therapy session
- Document progress for individual participants

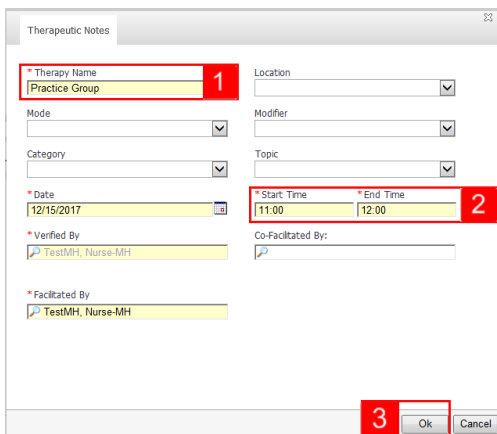
Activity 15.1 – Creating a Therapeutic Note

- 1 You can create a group note for multiple patients at once using the Therapeutic Note component in Powerchart. You can modify notes to reflect group content in addition to the progress of each patient.



1. Click Therapeutic Note  from the Organizer Toolbar
2. Select **YourName_Custom** from Patient List Drop-down
3. Click **Edit**  and a Therapeutic Notes pop-up window will appear

2



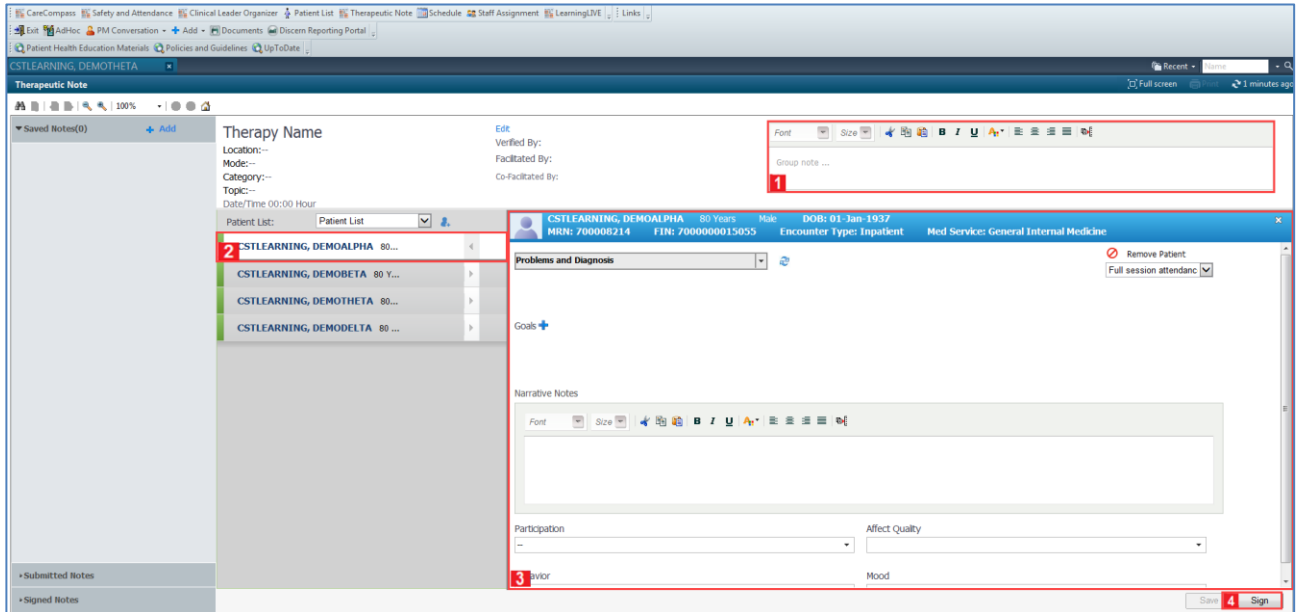
1. Enter into Therapy Name text box = *Practice Group*


Note: Start and End Times are both pre-populated to the current time. You will need to modify the time to ensure it aligns with the time the group was run. Other fields will be pre-populated. You

may modify these as necessary.

2. Modify the **Start Time** to **one hour before the current time**. Modify the **End Time** to the **current time**.
3. Click **Ok**



3



1. Enter group note description into free text box = *Today we covered ...*
2. Select a patient from the list by clicking arrow  next to the patient's name to document individual patient progress
3. Explore the various elements that you can modify to reflect your patient's participation in the group and enter some values as you wish
4. Click **Sign**

Note: Each patient will now have a Therapeutic Note in their documentation section.

Key Learning Points

-  You can create a group note for multiple patients at once using the Therapeutic Note component
-  You can modify notes to reflect group content in addition to the individual progress of each patient

PATIENT SCENARIO 16 – Handoff Tool

Learning Objectives

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

- Use Handoff Tool

SCENARIO

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

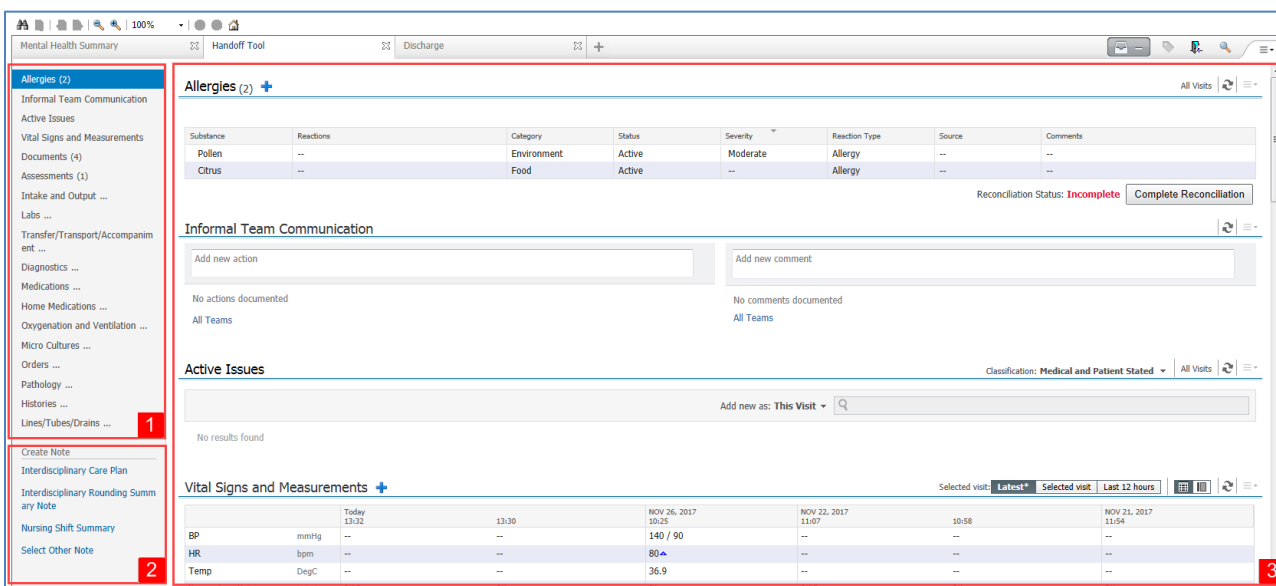
As a nurse, you will be completing the following activities:

- Navigate Handoff Tool
- Document Informal Team Communication

Activity 16.1 – Handoff Tool

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

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



The screenshot shows the Handoff Tool interface with the following sections:

- Left Menu (1):** Contains links to various patient information sections, including Allergies (2), Informal Team Communication, Active Issues, Vital Signs and Measurements, Documents (4), Assessments (1), Intake and Output, Labs, Transfer/Transport/Accompaniment, Diagnostics, Medications, Home Medications, Oxygenation and Ventilation, Micro Cultures, Orders, Pathology, Histories, and Lines/Tubes/Drains.
- Allergies (2):** A table listing allergies with columns for Substance, Reactions, Category, Status, Severity, Reaction Type, Source, and Comments. It shows two allergies: Pollen (Environment, Active, Moderate) and Citrus (Food, Active, Moderate). A Reconciliation Status of **Incomplete** is shown with a **Complete Reconciliation** button.
- Informal Team Communication:** A section for adding new actions and comments, with buttons for **Add new action** and **Add new comment**. It also shows **No actions documented** and **No comments documented** with **All Teams** links.
- Active Issues:** A section for adding new issues, with a button for **Add new as: This Visit** and a search bar. It shows **No results found**.
- Vital Signs and Measurements (3):** A table showing vital signs and measurements for today (11:30) and previous dates (NOV 26, 2017, NOV 22, 2017, NOV 21, 2017). It includes columns for BP, HR, and Temp, with values like 140 / 90, 80, and 36.9.

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

Note: Here you will find a quick link to your **Nursing Shift Summary** note

Key Learning Points

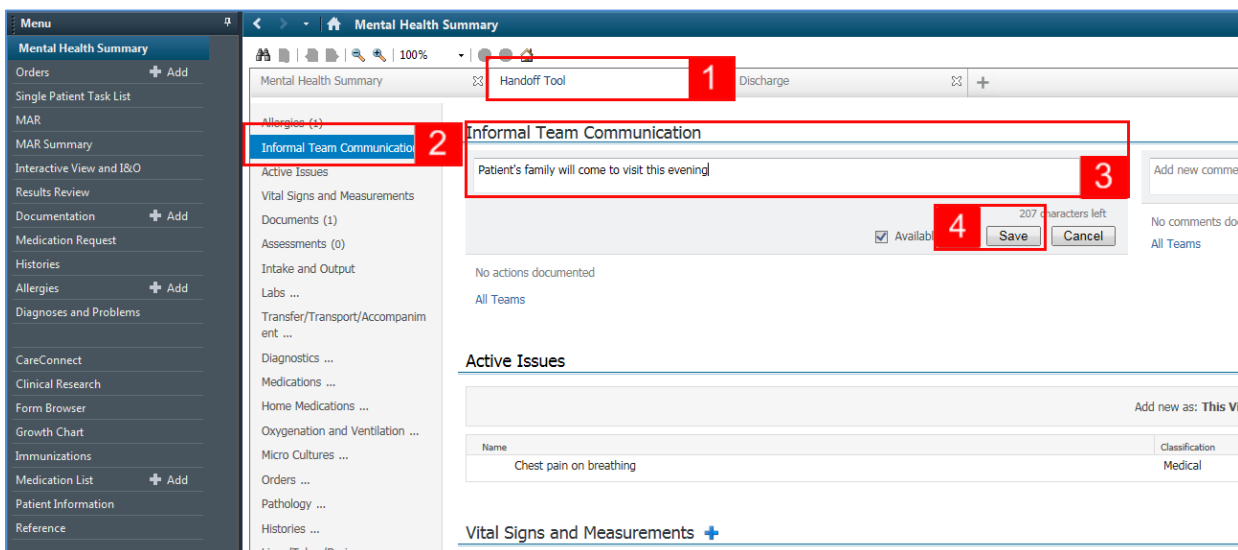
- Use the Handoff Tool to review patient information with the oncoming nurse
- You can add information or create commonly used note types directly from the Handoff Tool

Activity 16.2 – Documenting Informal Team Communication

- 1 The **Informal Team Communication** Tool can be used to add actions or comments to handover 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**

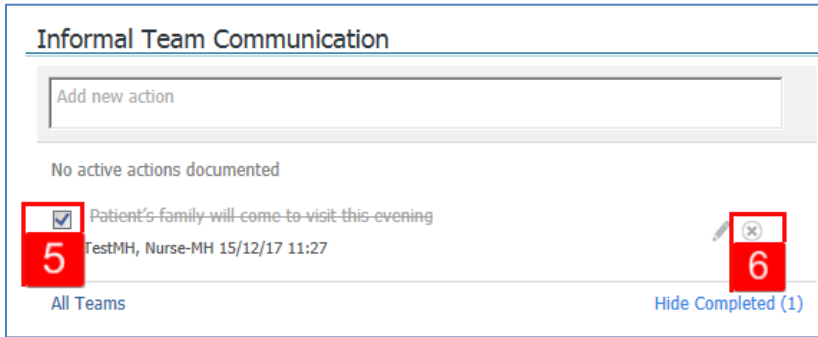


The screenshot shows the 'Mental Health Summary' interface. A red box labeled '1' highlights the 'Handoff Tool' tab. Another red box labeled '2' highlights the 'Informal Team Communication' component in the left sidebar. A third red box labeled '3' highlights the text input field containing 'Patient's family will come to visit this evening'. A fourth red box labeled '4' highlights the 'Save' button. The interface also shows a 'Discharge' tab, a '207 characters left' indicator, and a 'Save' button with a 'Cancel' button next to it. Below the input field, there are sections for 'Active Issues' and 'Vital Signs and Measurements'.

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

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

To complete a task in Informal Team Communication:



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

To delete a task in Informal Team Communication:

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

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

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


Key Learning Points

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

PATIENT SCENARIO 17 - Printing a Document

Learning Objectives


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

-  Print a Document

SCENARIO

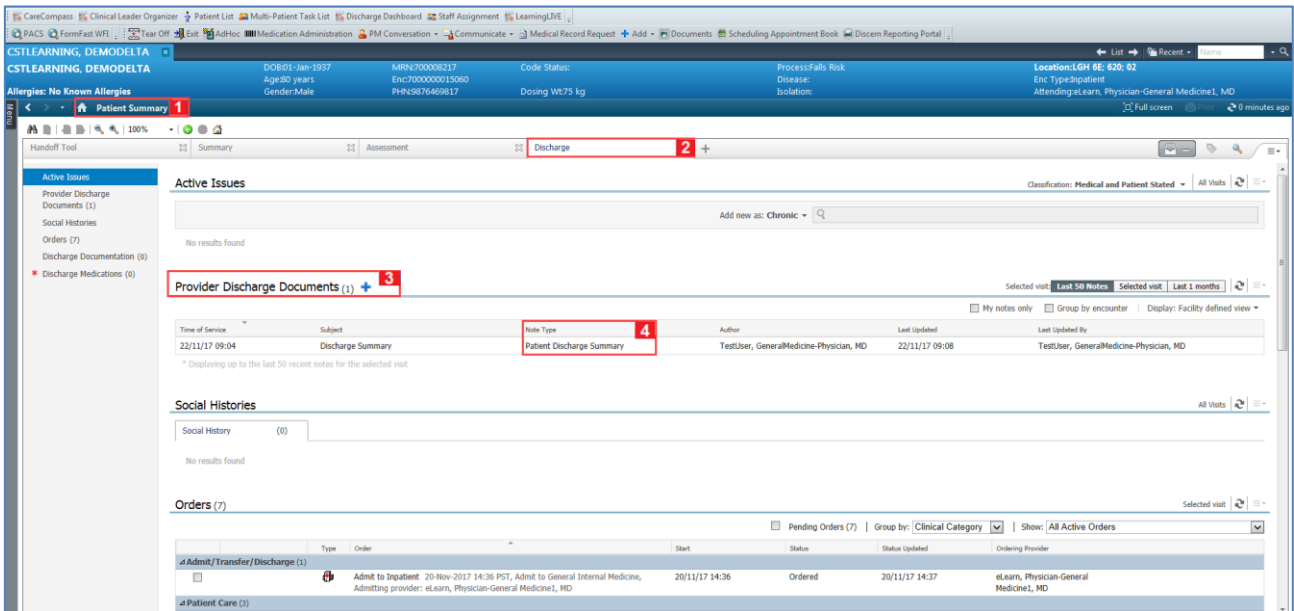
In this scenario, you will be reviewing how to print a discharge summary.

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

-  Printing a patient a discharge summary

Activity 17.1 – 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 appointment and medication information. It can be found in the Discharge tab of the Patient Summary section of the chart.

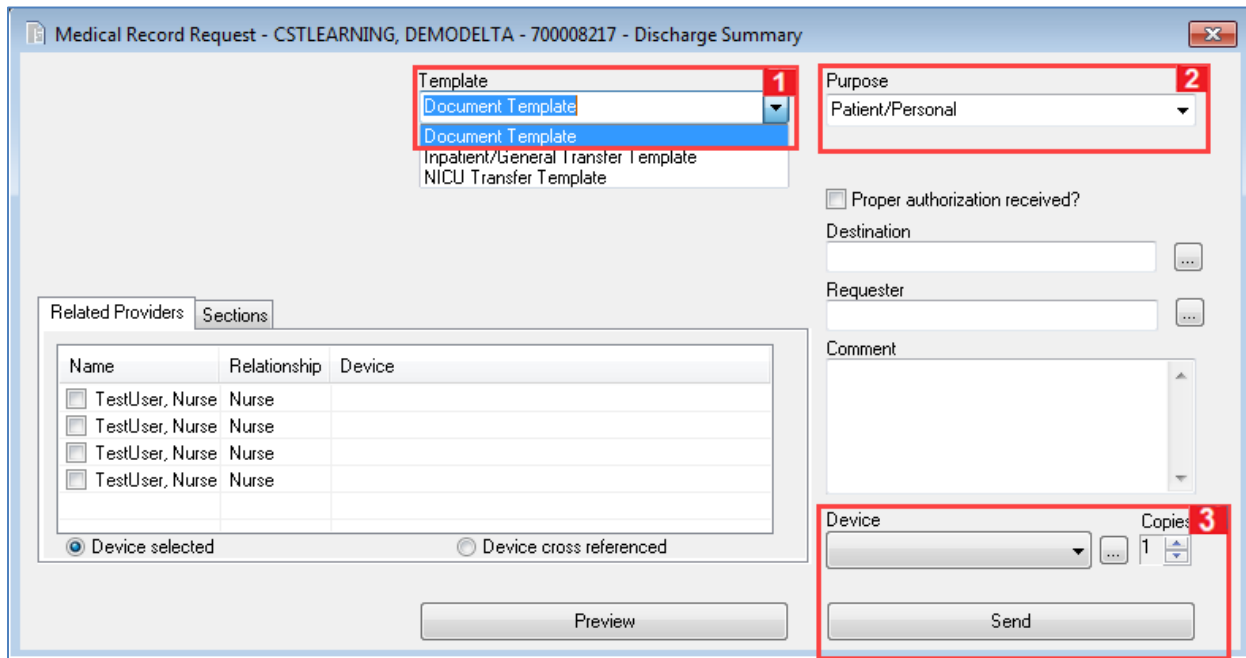


The screenshot displays the 'Patient Summary' workflow page. At the top, patient details are shown: DOB 01-Jan-1937, Age 80 years, Gender Male, MRN 7000008217, Enc 7000000015060, PHN 9876465817, Code Status, Process/Falls Risk, Disease: Isolation, Location LGH 6E 620, 62, Enc Type: Inpatient, Attending: eLearn, Physician-General Medicine1, MD. The 'Discharge' tab is selected, showing a list of 'Provider Discharge Documents' with one entry: 'Patient Discharge Summary' (Note Type: Patient Discharge Summary, Author: TestUser, GeneralMedicine-Physician, MD, Last Updated: 22/11/17 09:08). Below this, the 'Orders' section shows a list of orders, including 'Admit/Transfer/Discharge' and 'Patient Care'.

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


2

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






1. From the Template drop-down list, choose Document Template

2. From the Purpose drop-down list, choose Patient/Personal

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

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

Key Learning Points

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

SELF-GUIDED PRACTICE WORKBOOK

CST Transformational Learning

WORKBOOK TITLE:

Mental Health Charge Nurse/Supervisor Add On

Complete the following activities if you are one of the following:

- ☐ Patient Care Coordinator
- ☐ Charge Nurse
- ☐ Inpatient Nurse who takes on charge duties

Last update: February 12, 2018 (v2)



PATIENT SCENARIO 18 – Navigating Clinical Leader Organizer (CLO)

Learning Objectives

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

-  Review the Clinical Leader Organizer

SCENARIO

As a mental health charge nurse, you will be completing the following activities in order to review your patients for the day:

-  Review the Clinical Leader Organizer (CLO)

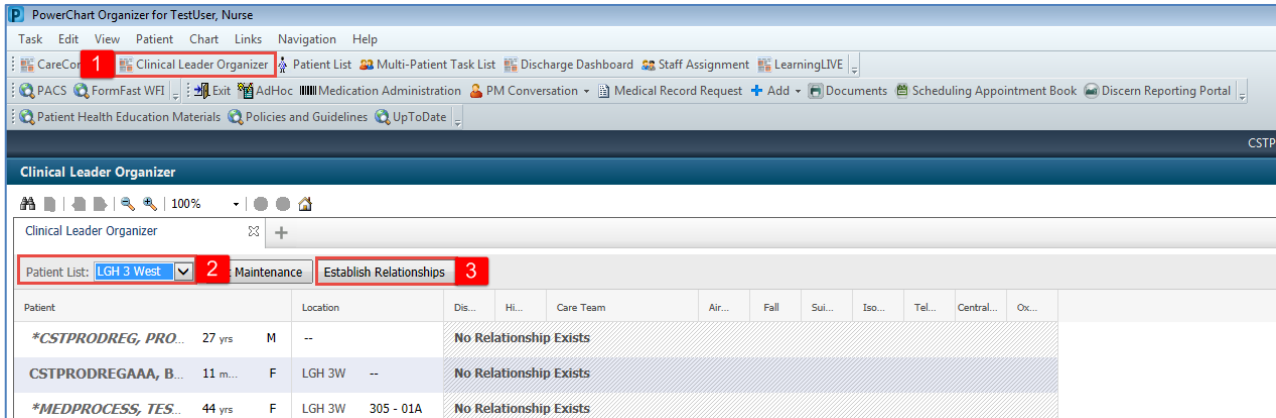
Activity 18.1 – Review Clinical Leader Organizer (CLO)

- 1 **Clinical Leader Organizer (CLO)** is an interactive organizer that supports communication and coordination across the continuum of care. It provides a high-level overview of patient data such as location, visit summary, risks and more. It is a useful tool for understanding patient care goals and assists charge nurses in assigning patients to nurses.

With **CLO**, charge nurses, nursing managers and other users can view the following data for each patient: patient name; location; active discharge orders; high risks; isolation precautions; restraint information; elopement risk; pending transfer; diet order; falls risk; suicide precaution; skin integrity; visitor information; care team; and other information such as oxygen therapy.

Note: Patient Care Coordinators and nurses who are always in charge will land on the CLO page when logging into the system. Inpatient nurses who are only occasionally in charge will land on Care Compass but can navigate to CLO when necessary.

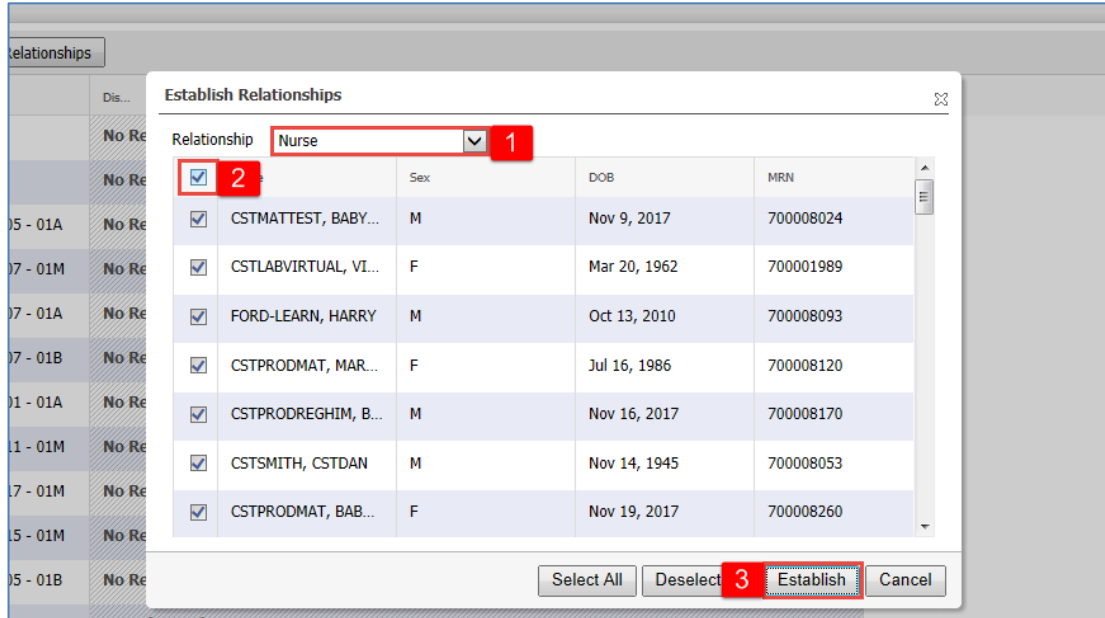
Let's review **Clinical Leader Organizer**:



Patient	Location	Dis	HI	Care Team	Air	Fall	Sui	Iso	Tel	Central	Ox
*CSTPRODREG, PRO...	27 yrs M	--		No Relationship Exists							
CSTPRODREGAAA, B...	11 m... F	LGH 3W	--	No Relationship Exists							
*MEDPROCESS, TES...	44 yrs F	LGH 3W	305 - 01A	No Relationship Exists							

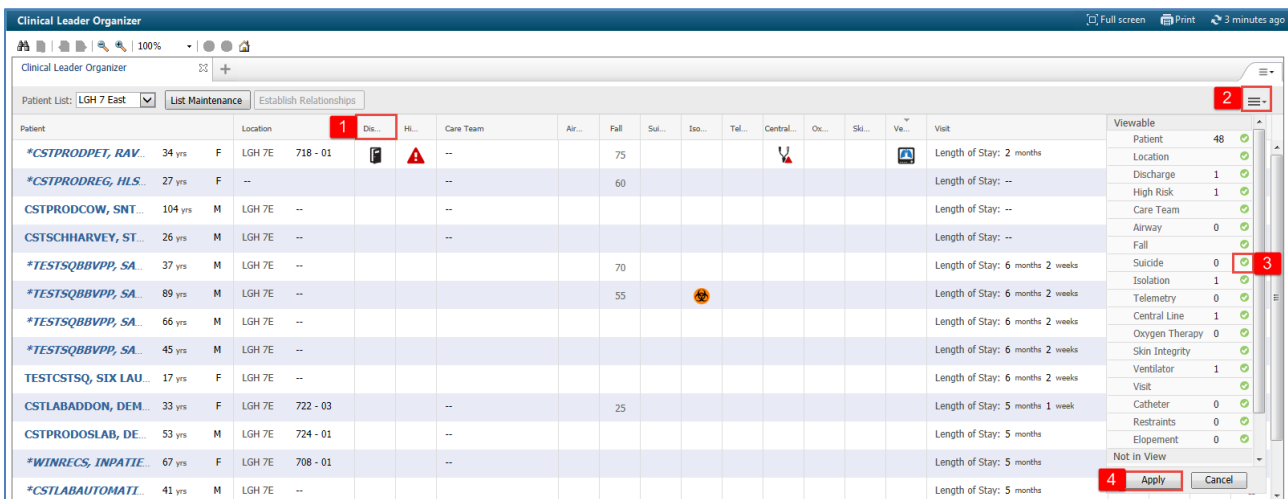
1. Select **Clinical Leader Organizer** from the toolbar
2. Confirm that the displayed **Patient List** is your unit's location list
3. Click **Establish Relationships**


2 Establish relationships with all of the unit's patients as a **Nurse**.



1. Select **Nurse** from the **Relationship** drop-down
2. Click top checkbox to select all patients
3. Click **Establish**

3 CLO contains several different columns displaying patient data. The first time you access CLO, all columns in the configuration are displayed in the dashboard. You can customize your columns to view relevant patient data. Hovering over the column titles enables you to see the full name of the column.



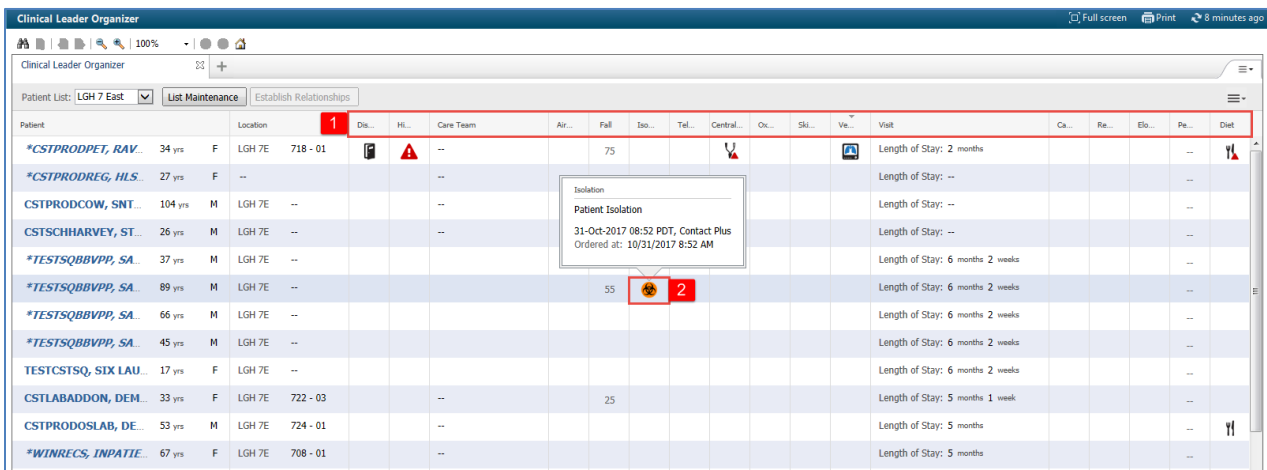
1. Hover over a column heading to see the full title of the column
2. Click the **Menu** icon 

- Click the green check mark beside a viewable topic(s) of your choice to de-select it from the viewable columns
- Click **Apply**

Note: Columns can also be reordered by dragging the column name into the order you prefer.

4

Clicking on icons within the CLO provides additional information. The system displays a pop-up box when an icon is clicked.



Patient	Location	Dis.	HI.	Care Team	Air.	Fall	Iso.	Tel.	Central.	Oc.	Ski.	Ve.	Visit	Ca.	Re.	Els.	Pe.	Diet
*CSTPRODPET, RAY...	34 yrs F LGH 7E 718 - 01	1				75							Length of Stay: 2 months					
*CSTPRODREG, HLS...	27 yrs F --												Length of Stay: --					
CSTPRODCOW, SNT...	104 yrs M LGH 7E --												Length of Stay: --					
CSTSCHHARVEY, ST...	26 yrs M LGH 7E --												Length of Stay: --					
*TESTSQBBVPP, SA...	37 yrs M LGH 7E --												Length of Stay: 6 months 2 weeks					
*TESTSQBBVPP, SA...	89 yrs M LGH 7E --					55	2						Length of Stay: 6 months 2 weeks					
*TESTSQBBVPP, SA...	66 yrs M LGH 7E --												Length of Stay: 6 months 2 weeks					
*TESTSQBBVPP, SA...	45 yrs M LGH 7E --												Length of Stay: 6 months 2 weeks					
TESTCSTSQ, SIX LAU...	17 yrs F LGH 7E --												Length of Stay: 6 months 2 weeks					
CSTLABADDON, DEM...	33 yrs F LGH 7E 722 - 03					25							Length of Stay: 5 months 1 week					
CSTPRODOSLAB, DE...	53 yrs M LGH 7E 724 - 01												Length of Stay: 5 months					
*WINRECS, INPATIE...	67 yrs F LGH 7E 708 - 01												Length of Stay: 5 months					

- The topic(s) that you de-selected previously are no longer viewable columns in your CLO view
- Click on an icon within the CLO to see additional information

Note: Customization of the CLO is only visible to the user customizing their views.

Key Learning Points

- Clinical Leader Organizer (CLO) is an interactive organizer that supports communication and coordination across the continuum of care
- CLO provides a high-level overview of patient data
- CLO can be customized to display patient information pertinent to your workflow

PATIENT SCENARIO 19 – Reports

Learning Objectives

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

- Run a report in the CIS

SCENARIO

As an inpatient charge nurse or nurse manager, you will be completing the following activities:

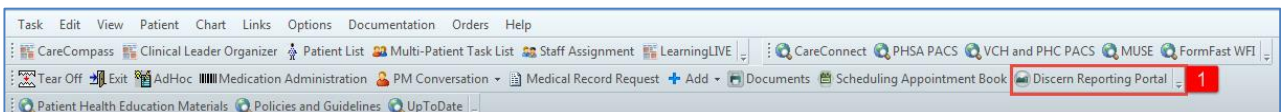
- Run a report for your unit/organization in the CIS

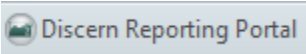
Activity 19.1 – Running Reports for your Unit

- The reporting functionality in the Clinical Information System (CIS) allows users to run reports at a unit and/or organizational level. Reports are important for performing audits and in informing safe patient care. Some of the reports that can be generated include the number of patients with Mental Health Act expiring within 24 hours and 28 day readmission report.

Note: Only Patient Care Coordinators, managers, educators, or nurses who are in charge will have the ability to run reports in the system.

Assuming you are a charge nurse, generate a report for **Mental Health Act Expiry**.

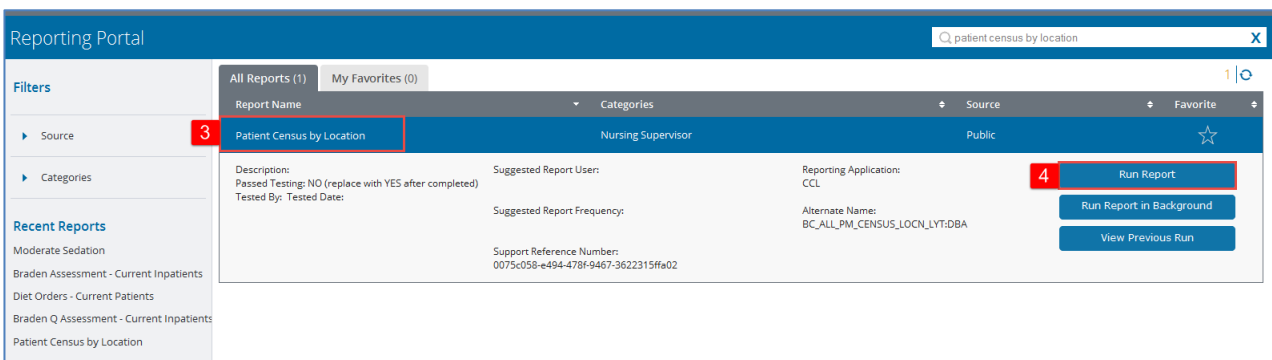


- Navigate to **Discern Reporting** by selecting the  button in the Toolbar to open the Reporting Portal window



- Locate **Mental Health Act Expiry** by typing it into the search box

Note: This report can also be located by navigating through the list



- Click the name of the report to expand the field
- Click **Run Report**

2

The **Mental Health Act Expiry** report window opens in a new tab. This page contains general information about the report such as the description and online reference pages.

Mental Health Act Expiry

Report Date & Time: 9/21/2017 12:33 PM Pages: 1 of 1

Current Patients Run By: cdunlop1

Facility: LGH HOPE Centre

Unit(s): LGH MIU

Encounter Type(s): Inpatient

Expiring Holds by Unit

Unit	1 Hour	Expired
LGH MIU	1	Expired

Expiring Holds by Provider

Provider	1 Hour	Expired
CERNER, CERNER	2	Expired
Plisvcj, Linwood, MD	0	Expired
Test, Pet, MD	0	Expired
Test User, Physician -	1	Expired

Document Summary

General

Type: Web Intelligence document

Author: DBA

Creation date: August 12, 2016 12:53:07 PM

07:00

Locale: English (United States)

Description:

Keywords:

Statistics

Last refresh date: September 21, 2017 12:00:00 GMT-07:00

Last modified: September 21, 2017 12:00:00 GMT-07:00

Last modified by: john.stahl

Duration of previous refresh: 8

Document Options

Refresh on open: Off

Permanent regional formatting: Off

Use query drill: Off

Enable query stripping: Off

Hide warning icons in chart: Off

Merge prompts (BEx or HANA Variables): On

Check for Shared Element update on open: On

Comment: Last comment

Report Instructions **Summary** 1 Hold Order Detail

1. Navigate to the **Summary** tab to see the report data

You will now be able to see the number of patients with a Mental Health Act expiring in the next 24 hours.

Mental Health Act Expiry

Report Date & Time: 9/21/2017 12:33 PM
Current Patients

Facility: LGH HOpe Centre
Unit(s): LGH MIU
Encounter Type(s): Inpatient

Pages: 1 of 3
Run By: cdunlop1

● Hold expires <= 1 hour
● Hold expires > 1 hour and <= 8 hours
● Hold expires > 8 hour and <= 24 hours

Patient Name	Provider	Hold Order	Order Date & Time	Projected Stop Date & Time	
CSTPRODBCMH, TESTGEORGE	CERNER, CERNER	MHA Form 4 x2 Involuntary Admission	06/12/2017 12:13	06/12/2017 12:14	Expired
CSTPRODBCMH, TESTGEORGE	Test, Pet, MD	MHA Form 4 x2 Involuntary Admission	06/12/2017 12:15	06/12/2017 12:15	Expired
CSTPRODBCMH, TESTGEORGE	Test, Pet, MD	MHA Form 4 x2 Involuntary Admission	06/12/2017 12:19	06/12/2017 12:19	Expired
CSTPRODBCMH, TESTGEORGE	Test, Pet, MD	MHA Form 4 x2 Involuntary Admission	06/12/2017 12:23	06/12/2017 12:23	Expired
CSTPRODBCMH, TAYLOR	Test, Pet, MD	MHA Form 4 x2 Involuntary Admission	06/13/2017 12:29	06/13/2017 12:29	Expired
CSTPRODBCMH, TAYLOR	Test, Pet, MD	MHA Form 4 x2 Involuntary Admission	06/13/2017 12:37	06/13/2017 12:37	Expired
CSTPRODBCMH, TAYLOR	Test, Pet, MD	MHA Form 4 x2 Involuntary Admission	06/13/2017 13:56	06/13/2017 13:57	Expired
CSTPRODBCMH, TAYLOR	Test, Pet, MD	MHA Form 4 x2 Involuntary Admission	06/13/2017 13:58	06/13/2017 14:00	Expired
CSTPRODBCMH, TAYLOR	Test, Pet, MD	MHA Form 4 x2 Involuntary Admission	06/13/2017 14:00	06/13/2017 14:00	Expired

Report Instructions | Summary | **Hold Order Detail**

2. Select the **Hold Order Detail** tab to see additional details of the report

You will now be able to see additional report details such as patient names, assigned provider and Mental Health Act form expiry date and time.

3. You can save or print this form using the toolbar at the top of the screen.

Key Learning Points

- The reporting functionality in the CIS allows users to run reports
- You can save or print reports using the toolbar at the top of the screen

End of Workbook

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