

**SELF-GUIDED PRACTICE WORKBOOK [N86]**  
CST Transformational Learning

WORKBOOK TITLE:

**Nurse: Medical Imaging**



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## SELF-GUIDED PRACTICE WORKBOOK

<b>Duration</b>	8 hours
<b>Before getting started</b>	<ul style="list-style-type: none"> <li>■ Sign the attendance roster (this will ensure you get paid to attend the session).</li> <li>■ Put your cell phones on silent mode.</li> </ul>
<b>Session Expectations</b>	<ul style="list-style-type: none"> <li>■ This is a self-paced learning session.</li> <li>■ A 15 min break time will be provided. You can take this break at any time during the session.</li> <li>■ The workbook provides a compilation of different scenarios that are applicable to your work setting.</li> <li>■ Each scenario will allow you to work through different learning activities at your own.</li> </ul>
<b>Key Learning Review</b>	<ul style="list-style-type: none"> <li>■ At the end of the session, you will be required to complete a Key Learning Review.</li> <li>■ This will involve completion of some specific activities that you have had an opportunity to practice through the scenarios.</li> </ul>

## ■ 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**
- Some clinical scenario **details have been simplified** for training purposes
- Some screenshots may not be identical to what is seen on your screen and should be used for reference purposes only
- **Follow all steps** to be able to complete activities
- If you have trouble to follow the steps, immediately **raise your hand for assistance** to use classroom time efficiently

## PATIENT SCENARIO 1 – Ambulatory Organizer

### Learning Objectives

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

- Review and Learn the Layout of Ambulatory Organizer

### SCENARIO

An 80 year old male, admitted with Pneumonia, comes to Medical Imaging for CT Chest with contrast. You begin your shift and will be receiving the patient into your care. To start, log into the Clinical Information System (CIS) with your provided username and password.

As a MI nurse you will be completing the following 2 activities:

- Locate your landing page and review Ambulatory Organizer
- Establish a relationship with your patient(s)

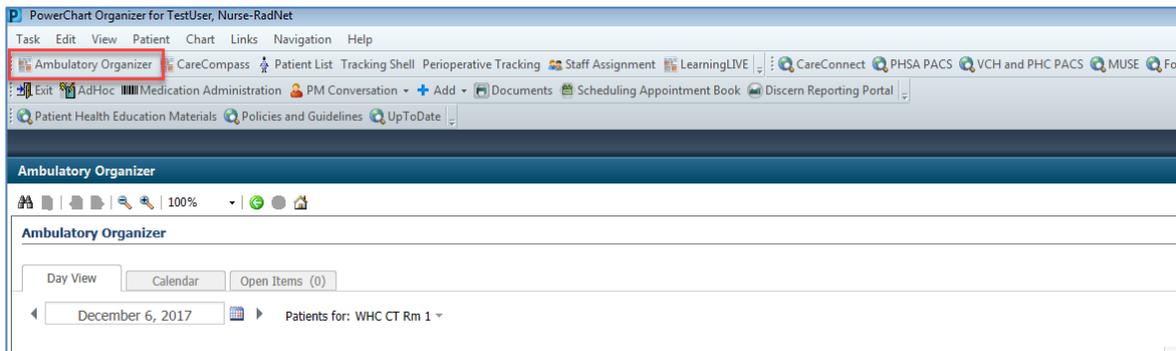
## Activity 1.1 – Review Ambulatory Organizer

1 Log in with the Username and Password provided into PowerChart.

Upon logging in as an MI Nurse, you will land on **Ambulatory Organizer**. **Ambulatory Organizer** provides an overview of scheduled appointments for the day.

The Ambulatory Organizer button located in the toolbar can be used to navigate back to the Ambulatory Organizer page at any time.

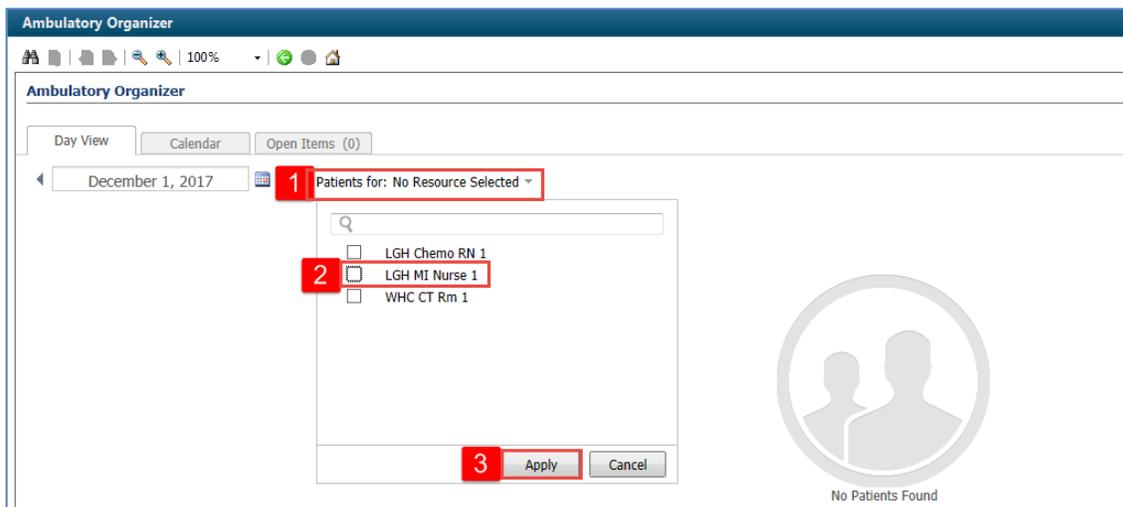
In addition, for the most part the outpatient and inpatient view will be the same for both locations.



2 To view the scheduled appointments for the day, you need to locate your patients.

Locate your patient assignment of **LGH MI Nurse 1** and **LGH CT Rm 1**:

1. Ensure you are in the **Day View** tab and on today's date.
2. Click the No Resource Selected **Patients for: No Resource Selected** button.
3. Type in **LGH MI Nurse 1** as well as **LGH CT Rm 1** and select the tick boxes.
4. Click Apply.



This is the list of patient(s) for today.

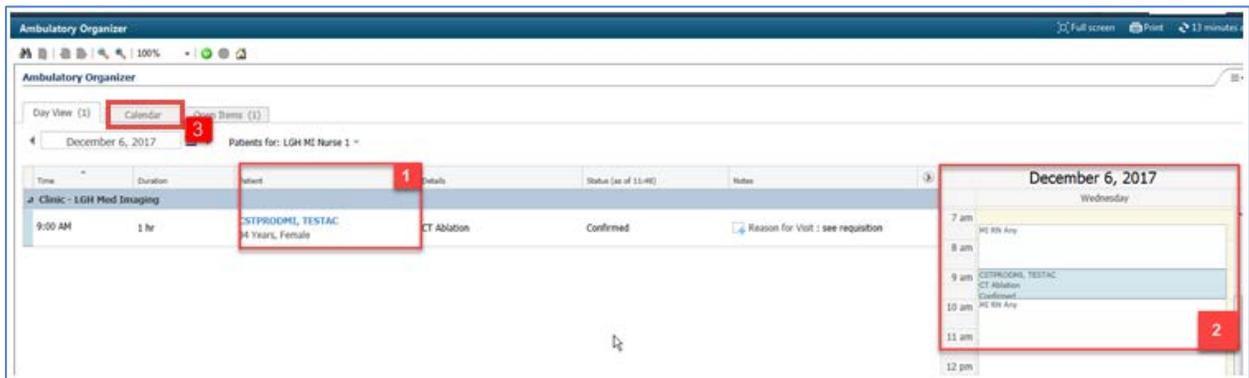


**NOTE:** There are many ways to locate patients, in the hospital your peer mentor will assist you to use the Ambulatory Organizer landing page to select patient(s) best suited to your specialty area

3

The Ambulatory Organizer displays:

1. A list of patient(s).
2. Patient's appointments are highlighted in blue. Review your patient's appointment times.
3. Use Calendar view to see appointments for a Med Imaging room. You must add resources to each tab as you open them.



### Key Learning Points



Ambulatory Organizer allows user to view patient list and appointment time.

## Activity 1.2 – Establish a Relationship

- 1 Now that you have reviewed your patient’s scheduled appointments for today, you are now ready to review your patient’s chart.

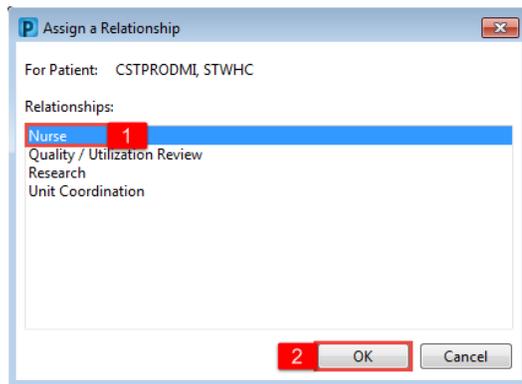
Click on your **patient’s name** from your Login Card. This will open up the patient’s chart.



Time	Duration	Patient	Details
<b>Clinic - WHC Med Imaging</b>			
11:28 AM	15 mins	<b>CSTPRODML, STWHC</b> 63 Years, Female	CT Abdomen
11:43 AM	17 mins	No appointments	
12:00 PM	15 mins	<b>TEST, MIPIT</b> 37 Years, Male	CT Abdomen

- 2 In order to view more patient information or access patient charts, you must establish a relationship with each of your patients. This relationship maintains for ~16 hours. Each time you open a new patient, you must establish a relationship.

1. Select **Nurse** from the **Assign a Relationship** window
2. Click **OK**.



Clicking **OK** will open the patient’s chart to the Imaging Nurse page.

### Key Learning Points

- Establishing a relationship with your patient allows you to access PowerChart.
- Review with your peer mentor the best approach to gain access to your patient(s).

## PATIENT SCENARIO 2 – Navigating Imaging Nurse Page in the Patient Chart

### Learning Objectives

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

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

### SCENARIO

Your patient has arrived for their appointment. You are going to access the patient chart and learn more about the patient.

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

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

## Activity 2.1 – Introduction to Banner Bar, Toolbar, and Menu

1 The patient's chart is now open. Let's review the key parts of this screen.

1. The **Toolbar** is located above the patient's chart and it contains buttons that allow you to access various tools within the Clinical Informatics System. This will open areas not in patient context.
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, etc.
  - 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**  0 minutes ago icon updates the patient chart with the most up to date entries when clicked. It is important to click the **Refresh** icon frequently especially as other clinicians may be accessing and documenting in the patient chart simultaneously.

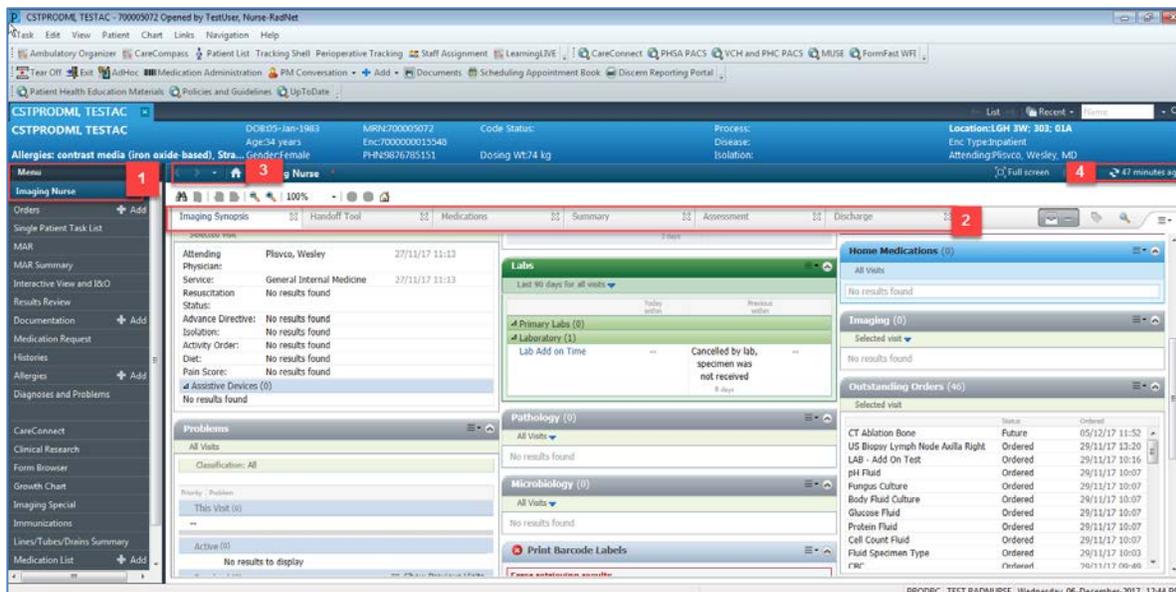
The screenshot displays the Banner EHR patient chart interface. At the top, there is a toolbar with various icons for navigation and actions. Below the toolbar is the banner bar, which displays patient demographics and key information. On the left side, there is a menu with various sections like 'Imaging Nurse', 'Orders', 'MAR', etc. The main content area is divided into several tabs, including 'Imaging Synopsis', 'Allergies', 'Documents', 'Medications', 'Vital Signs/Weights and Measurements', 'Labs', 'Pathology', and 'Microbiology'. Red callout boxes 1, 2, 3, and 4 highlight the toolbar, banner bar, menu, and refresh icon respectively.

## 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.
- The Refresh icon should be used regularly.

## Activity 2.2 – Introduction to Imaging Nurse Page

1. **Navigate to Imaging Nurse** from the **Menu** (1). You will see the **Imaging Nurse Page** section open.
2. There are different workflow tabs including **Imaging Synopsis, Medications, Summary, Assessment, Handoff Tool** (2) etc. that can be used to learn more about the patient. Click on the different tabs to see a quick overview of the patient. If you are missing tabs, you can add them using the + button.
3. There are three icons below the banner (3):
  - Home page icon  : return to **Imaging Nurse** page (default view)
  - Back page icon  : take you back to previous screen
  - Recent view icon  : display a list of recently visited screens for an easy jump
4. Click Refresh icon  (4) to update patient information in the screen



### Key Learning Points

- Imaging Nurse page provides a summary about the patient and is an way to access to key information about the patient.
- Click the Refresh icon regularly to get the most updated information on the patient.

## PATIENT SCENARIO 3 – Orders

### Learning Objectives

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

- Review the Orders Page and Place Orders
- Complete or Cancel/Discontinue an Order
- Review the General Layout of a PowerPlan

### SCENARIO

The physician has given you orders that apply during the diagnostic test. You will need to be able to review orders on your patient. You will also need to place orders on your patient in certain situations. To do so you will complete the following activities:

- Review Orders Page
- Place an Order with or without Cosignature (verbal/phone)
- Review Order Statuses and Details
- Complete or Cancel/Discontinue an Order
- Review Components of a PowerPlan

## Activity 3.1 – Review Orders Profile

1 The **Orders** Profile is where you will access a full list of the patient's orders.

To navigate to the Orders profile and review the orders:

1. Select **Orders** from the **Menu**.
2. On the left side of the Orders profile is the navigator (**View**) which includes several categories including:
  - Plans
  - Categories of Orders
  - Medication History Snapshot
  - Reconciliation History
3. On the right side is the list of orders where you can:
  - Review the list of **All Active 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

Notice the display filter default setting is set to display All Active Orders. This can be modified to display other order statuses by clicking on the blue hyperlink.

The screenshot displays the EHR interface for patient CSTPRODMI, TESTAC. The 'Orders' section is active, showing a list of orders. A red box labeled '1' points to the 'Orders' menu item. Another red box labeled '2' points to the 'View' filter dropdown, which is currently set to 'All Active Orders'. A third red box labeled '3' points to the 'Details' column in the orders table, which shows information for a medication order. A fourth red box labeled '4' points to the 'Details' link for a specific medication order.

Order Name	Status	Dose	Details
Admission History Adult	Ordered	27-Nov-2017 11:13 PST, Stop: 27-Nov-2017 11:13 PST	Order entered secondary to inpatient admission.
Basic Admission Information Adult	Ordered	27-Nov-2017 11:13 PST, Stop: 27-Nov-2017 11:13 PST	Order entered secondary to inpatient admission.
Braden Assessment	Ordered	27-Nov-2017 11:13 PST, Stop: 27-Nov-2017 11:13 PST	Order entered secondary to inpatient admission.
Hospital High Utilizer	Ordered	27-Nov-2017 11:13 PST, Stop: 27-Nov-2017 11:13 PST	Order placed due to patient having 3+ hospitalizations in the last 12 months.
Infectious Disease Screening	Ordered	27-Nov-2017 11:13 PST	Order entered secondary to inpatient admission.
Insert Peripheral IV Ca...	Ordered	27-Nov-2017 13:32 PST, Insert 20 gauge catheter in right antecubital fossa (ACF)	27-Nov-2017 11:13 PST, Stop: 27-Nov-2017 11:13 PST
Monor Fall Risk Assessment	Ordered	27-Nov-2017 11:13 PST, Stop: 27-Nov-2017 11:13 PST	Order entered secondary to inpatient admission.
capTOPKI	Ordered	25 mg, PO, once, drug form tab, start: 01-Dec-2017 12:00 PST, stop: 01-Dec-2017 12:00 PST	
diazoxide	Ordered	12 mL, PO, once, drug form oral liq, start: 01-Dec-2017 15:00 PST, stop: 01-Dec-2017 15:00 PST	
(Gastrografin) [constr...		12 mL, PO, once, drug form oral liq, start: 01-Dec-2017 15:00 PST, stop: 01-Dec-2017 15:00 PST	Do not drink

### Key Learning Points

- The Order Profile consists of the orders view (Navigator) and the list of orders.
- The Orders View displays the lists of PowerPlans and clinical categories of orders.
- The Order Profile page displays All Active Orders for a patient.

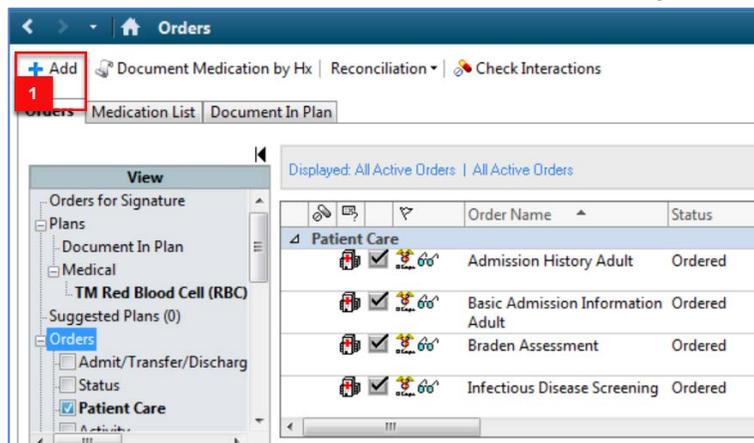
## Activity 3.2 – Place an Order With or Without Cosignature Required (Verbal/Phone)

Nurses can place the following types of orders:

- Orders requiring a cosignature of the provider e.g. telephone and verbal orders
- Orders that do not require a cosignature e.g. order within nursing scope, RNIA

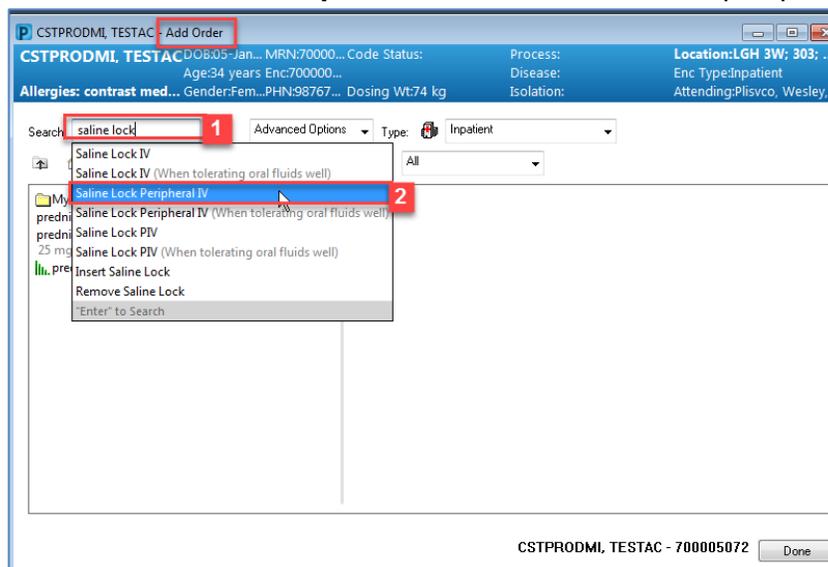
1 To place an order that does **not** require a cosignature (Registered Nurse Initiated Orders):

1. Click the **Add** button  within the **Orders** page. The **Add Order** window opens.

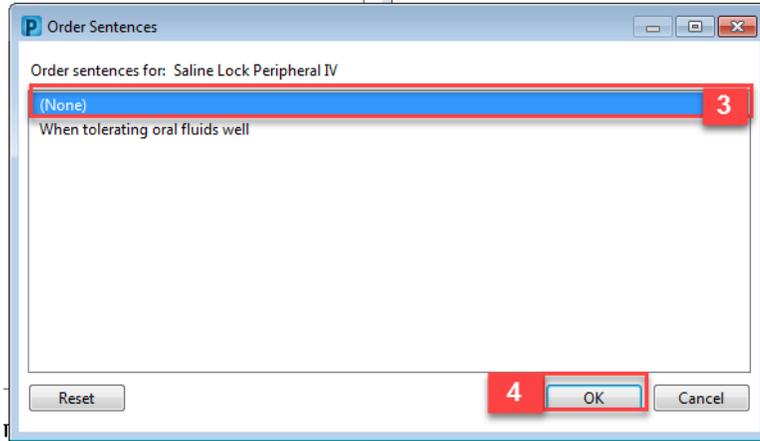


The **Add Order** window is open.

1. Type *saline lock* into the search window and a list of choices will display.
2. Select **Saline Lock Peripheral IV**. Order sentences help to pre-fill order details.

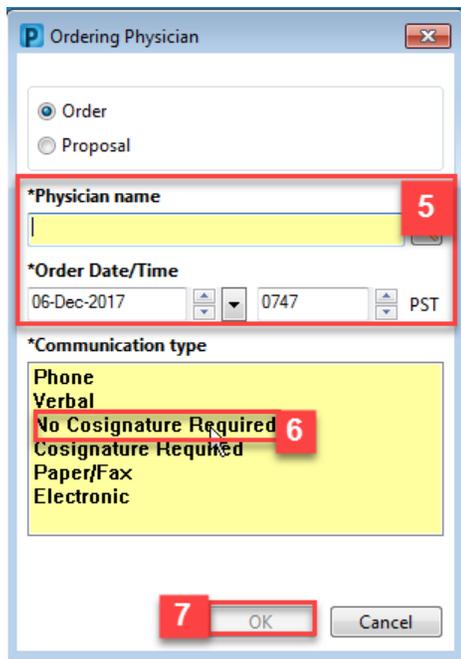


3. An **Order Sentences** window opens and asks you to clarify the Saline Lock Peripheral IV order. Select *None* in this scenario.
4. Click **OK**.



The **Ordering Physician** window opens.

- 5. Type in the name of the Physician: **Smith, Jenni**.
- 6. Select **No Cosignature Required**.
- 7. Click **OK**.



- 8. Click **Done** in the **Add Orders** window.



**NOTE:** You will not see any changes to the Add Order page before you click **Done**.

9. Click **Sign**.

10. After signing, you can view that the active order of Saline Lock Peripheral IV has a status of “Processing”. Click **Refresh** . The status will change to “Ordered”.



**NOTE:** The same steps will be used when placing orders requiring cosignature, as well as phone and verbal orders. Please note the mandatory yellow fields.

### Key Learning Points

- Nurses can place orders with or without cosignature according to standard policy.
- Order sentences help to pre-fill additional information/details for an order.

## Activity 3.3 – Review Order Statuses and Details

1 Orders are classified by status including:

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

Order Name	Status	Dose ...	Details
iron sucrose	Ordered		100 mg, IV, once, drug form: inj, first dose: Routine, Infuse IV at 100mg/hr, If signs of hypersensitivity/
LORazepam	Processing		1 mg, sublingual, once, start: 11-Dec-2017 09:00 P



**NOTE:** The blue question mark icon  appears for Processing order statuses

To review order details:

- The **Details** column of the Orders page contains the majority of the information.
- If the information is detailed, select the order to highlight it in blue and hover over the details. More information will populate.

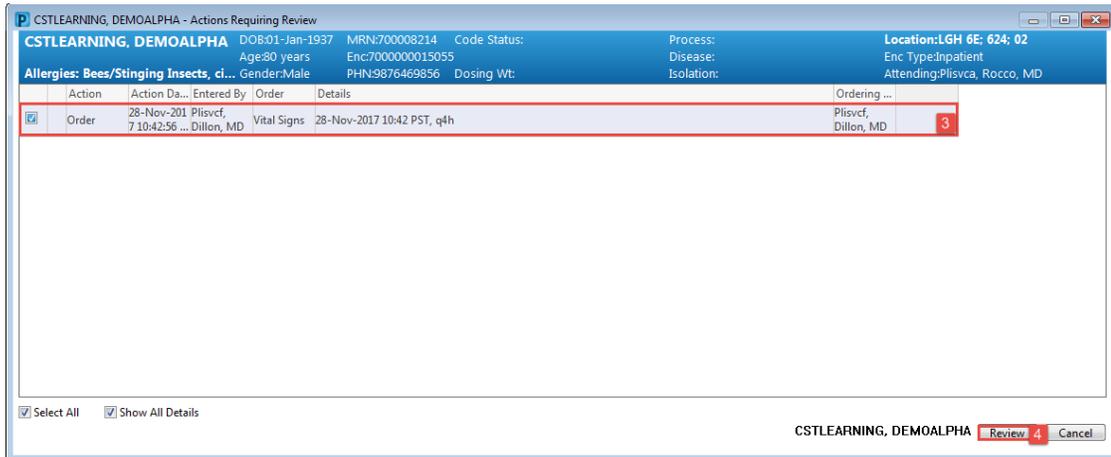
Order Name	Status	Dose ...	Details
Vital Signs	Ordered		28-Nov-2017 10:42 PST, q4h
Red Blood Cell Transfusion	Ordered		Routine, Administer: 1 unit, IV, once, Administer each over: 120 - 180 Minutes, Irradiated, Please call... Informed consent must be present on patient record Red Blood Cell Transfusion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

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

1. A Nurse Review icon  appears to the left of the order under the Notifications flag column. This identifies the order as one that needs to be reviewed by a nurse.
2. The nurse should click the **Orders for Nurse Review** button to open the review window.

The screenshot shows the 'Orders' page with a table of orders. The 'Vital Signs' order is highlighted in blue. A red box labeled '1' highlights the Nurse Review icon (a blue question mark with a person) next to the order. Below the table, a red box labeled '2' highlights the 'Orders For Nurse Review' button in the bottom navigation bar.

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



Action	Action Da...	Entered By	Order	Details	Ordering ...
<input checked="" type="checkbox"/>	28-Nov-2017 10:42:56 ...	Dillon, MD	Vital Signs	28-Nov-2017 10:42 PST, q4h	Plisvcf, Dillon, MD <span style="border: 1px solid red; padding: 2px;">3</span>

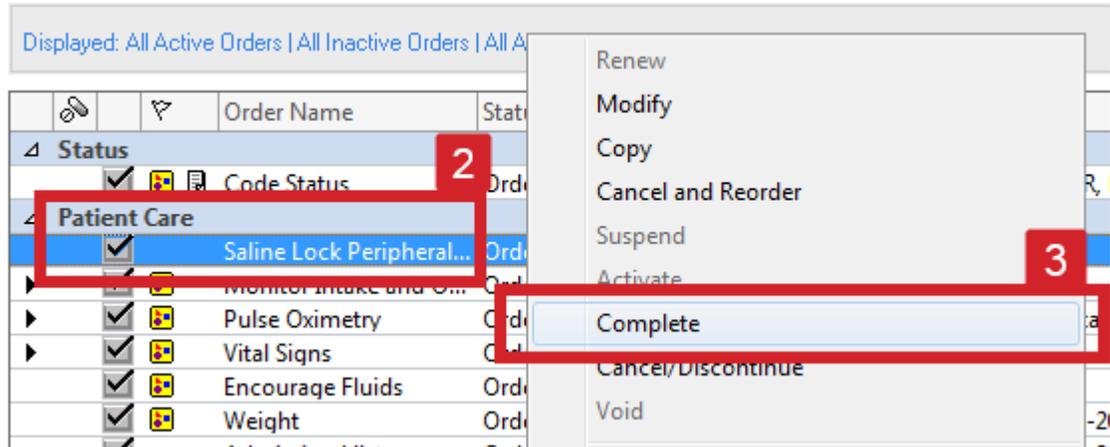
### Key Learning Points

-  Nurses should always verify the status of orders.
-  Hover to Discover to view additional order information.

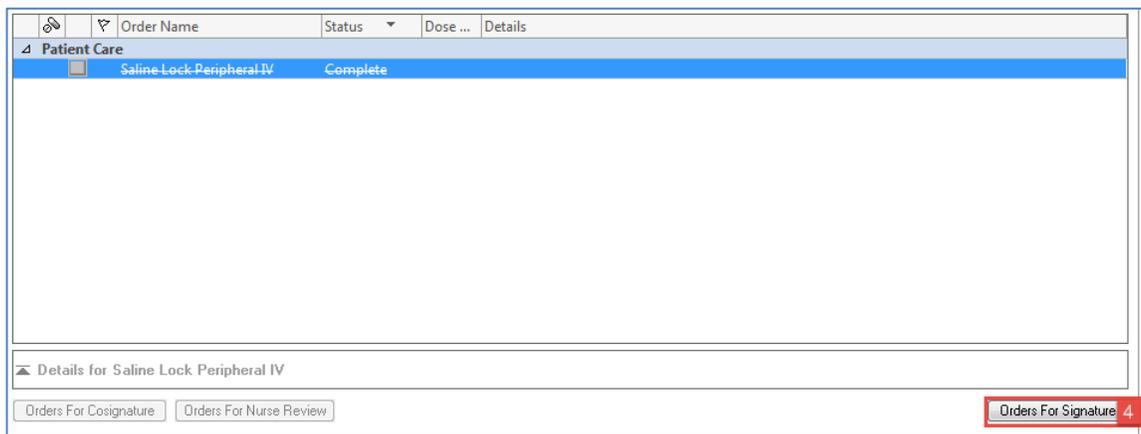
## Activity 3.4 – Complete or Cancel/Discontinue an Order

1 To complete an order:

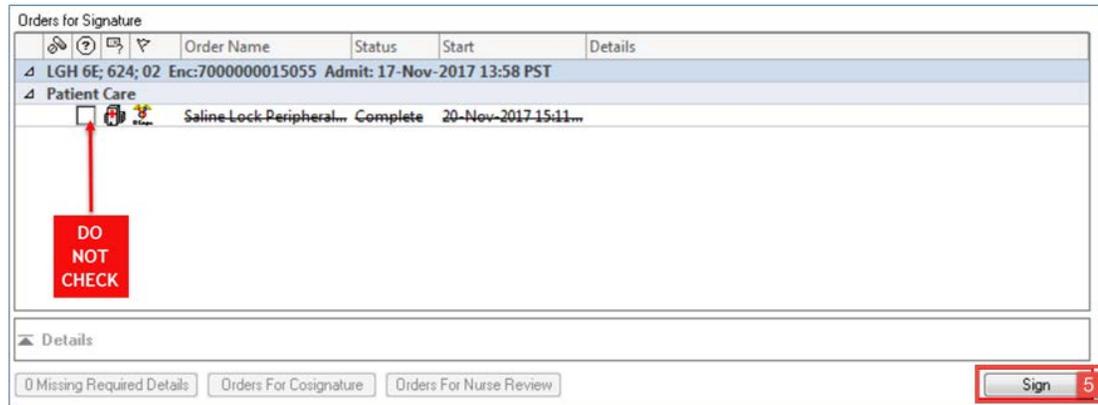
1. Review **Order Profile**.
2. Right-click order to **Saline Lock Peripheral IV**.
3. Select **Complete**. The order will now be striked through.



4. Click the **Orders for Signature** button.



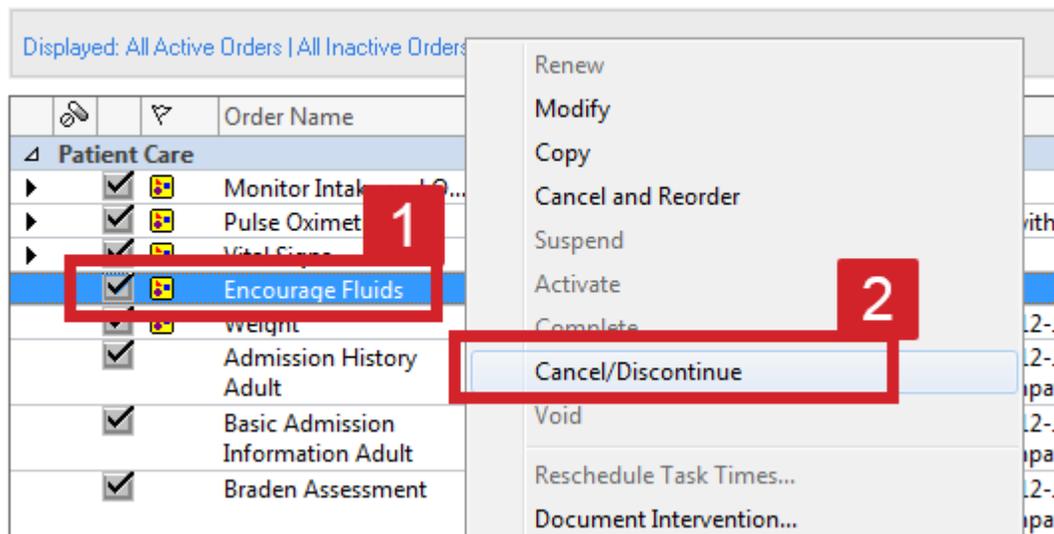
5. Review order for signature and click **Sign**. You will return to the orders profile where order will show as processing.



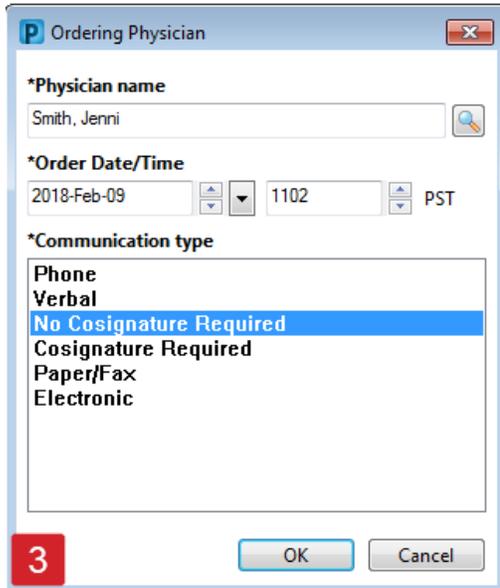
6. Refresh  the page and the order will no longer be visible on the order profile.

2 To **Cancel/Discontinue** an order:

1. Right-click order **Encourage Fluids**.
2. Select **Cancel/Discontinue**.



3. **Ordering Physician** window will appear. Fill out the required fields highlighted yellow below and then click **OK**.
  - Physician name – **Smith, Jenni**.
  - Communication type - **No Cosignature Required**.

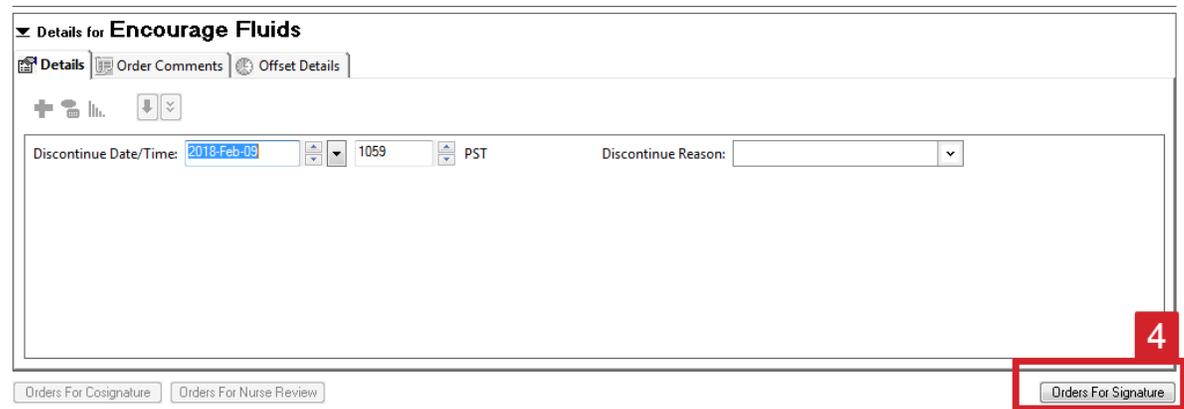


The 'Ordering Physician' dialog box contains the following fields:

- \*Physician name:** A text field containing 'Smith, Jenni' with a search icon to the right.
- \*Order Date/Time:** A date field set to '2018-Feb-09', a time field set to '1102', and a time zone dropdown set to 'PST'.
- \*Communication type:** A list box with the following options: 'Phone', 'Verbal', 'No Cosignature Required' (highlighted in blue), 'Cosignature Required', 'Paper/Fax', and 'Electronic'.

At the bottom of the dialog are 'OK' and 'Cancel' buttons. A red box with the number '3' is located in the bottom-left corner.

- The order will populate into the window below the orders. Review order to discontinue and click **Orders For Signature**.

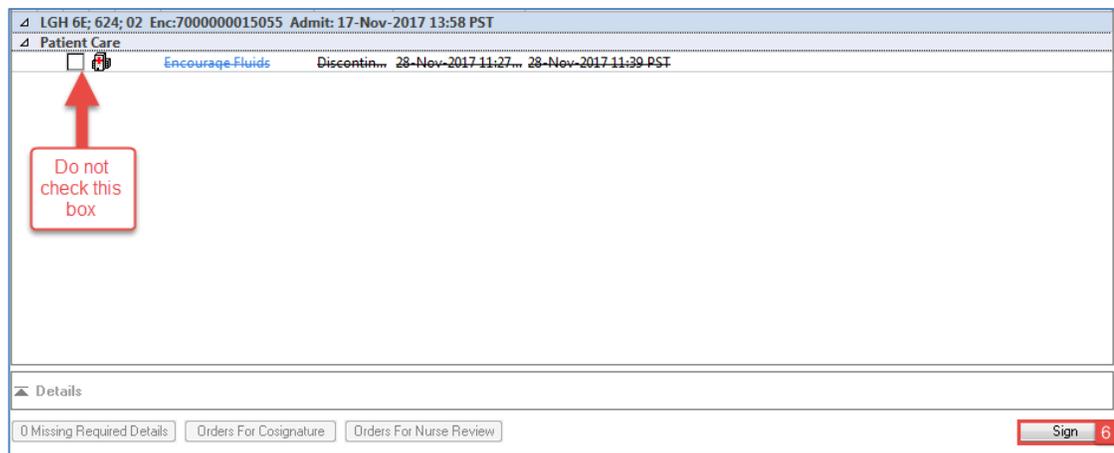


The 'Details for Encourage Fluids' dialog box shows the following information:

- Buttons: 'Details', 'Order Comments', 'Offset Details'.
- Discontinue Date/Time: '2018-Feb-09', '1059', 'PST'.
- Discontinue Reason: A dropdown menu.

At the bottom, there are three buttons: 'Orders For Cosignature', 'Orders For Nurse Review', and 'Orders For Signature' (highlighted with a red box). A red box with the number '4' is in the bottom-right corner.

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



The 'Patient Care' order profile shows the following details:

- Header: 'LGH 6E; 624; 02 Enc:7000000015055 Admit: 17-Nov-2017 13:58 PST'.
- Order: 'Encourage Fluids' with a status of 'Discontin...' and dates '28-Nov-2017 11:27...' and '28-Nov-2017 11:39 PST'.
- Checkbox: An unchecked checkbox with a red arrow pointing to it and a callout box that says 'Do not check this box'.

At the bottom, there are buttons for '0 Missing Required Details', 'Orders For Cosignature', 'Orders For Nurse Review', and 'Sign' (highlighted with a red box). A red box with the number '6' is in the bottom-right corner.

- Refresh page. Order will no longer be visible on order profile.

### Key Learning Points

-  Right click to mark an order as completed or cancel/discontinued.
-  Both of these actions will remove orders from patient's Order Profile.

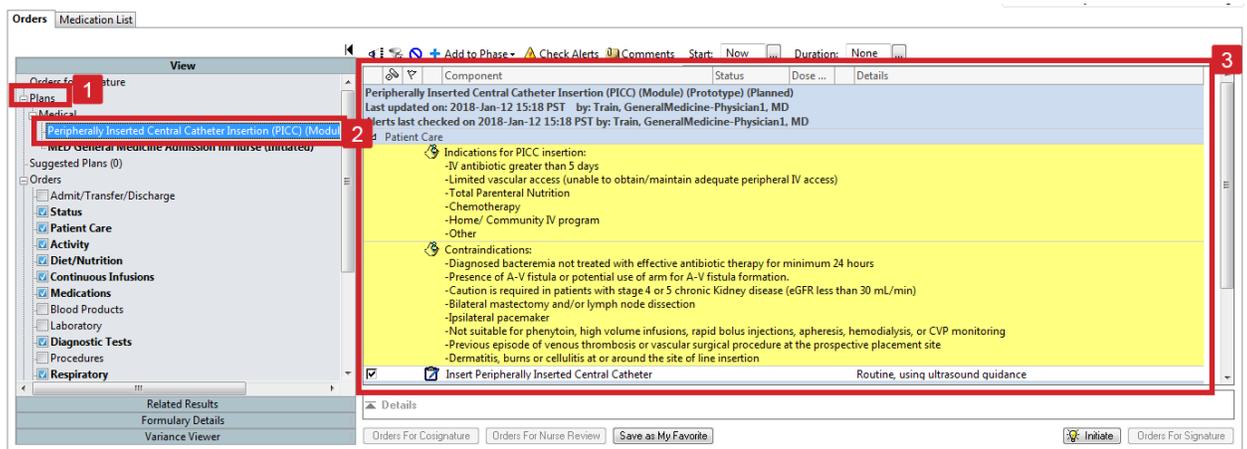
## Activity 3.5 – Review Components of a PowerPlan

A PowerPlan in the CIS is the equivalent of preprinted orders in current state.

- 1 At times it may be useful to review a PowerPlan to distinguish its orders from stand-alone 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 **Peripherally Inserted Central Catheter Insertion PowerPlan**.
3. Review orders within the PowerPlan.



The screenshot shows the 'Orders Medication List' interface. On the left, under the 'View' tab, the 'Plans' category is selected. The main area displays the details for the 'Peripherally Inserted Central Catheter Insertion (PICC) (Module) (Prototype) (Planned)' PowerPlan. The details include the component name, status, last updated date, and a list of indications and contraindications. At the bottom right, there is an 'Initiate' button.

 **NOTE:** PowerPlans can be Initiated or in a Planned State. To initiate the plan right-click and click Initiate. You will still need to click Orders for Signature and Sign for it to become active.

### Key Learning Points

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

## PATIENT SCENARIO 4 – Medication Administration

### Learning Objectives

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

-  Review the Medication Administration Record ( MAR)
-  Administer Medication Using Medication Administration Wizard (MAW)
-  Document Patient’s Response to Medication
-  Document Continuous Infusion (Non-Barcoded)

### SCENARIO

Your Patient is on several medications. You will be administering and managing various types of medications including PO medication, PRN medication, intermittent IV medication, and continuous infusions. You will be using a Barcode Scanner prior to administering medications. The scanner scans both your patient’s wristband and medication barcodes to correctly populate the MAR.

As an MI nurse, you will complete the following activities:

-  Review the Medication Administration Record (MAR)
-  Administer medication using Medication Administration Wizard (MAW) and barcode scanner
-  Document administration of different types of medications
-  Documenting patient response to medication on MAR
-  Document continuous infusion (non-barcoded)

## Activity 4.1 – Review the MAR

1

The MAR is a record of medications administered to the patient by clinician. The MAR displays medication orders, tasks, and documented administrations for the selected time frame.

You will be locating and reviewing your patient’s scheduled, unscheduled, PRN medications and continuous infusions.

1. Click **MAR** on the **Menu**
2. Under **Time View**, there are different tabs including **Scheduled, Unscheduled, PRN, and Continuous Infusion**. Click on different tabs to review medications in each category.
3. There are icons located above the medication names on the MAR. Here are some examples:

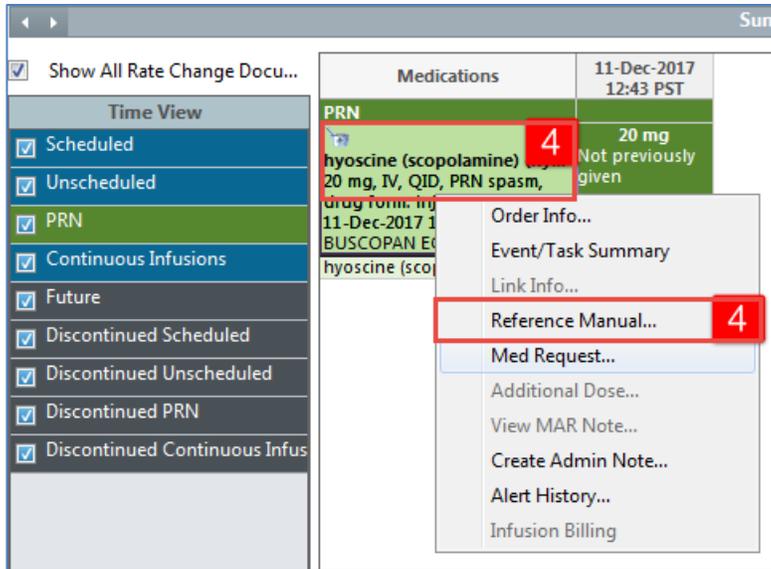
- **Request Pharmacy Verification**  - The medication order has not been verified by pharmacy
- **Nurse Review**  – indicates that nurse review of the order is required
- **PowerPlan**  – Indicates the medication is part of a PowerPlan



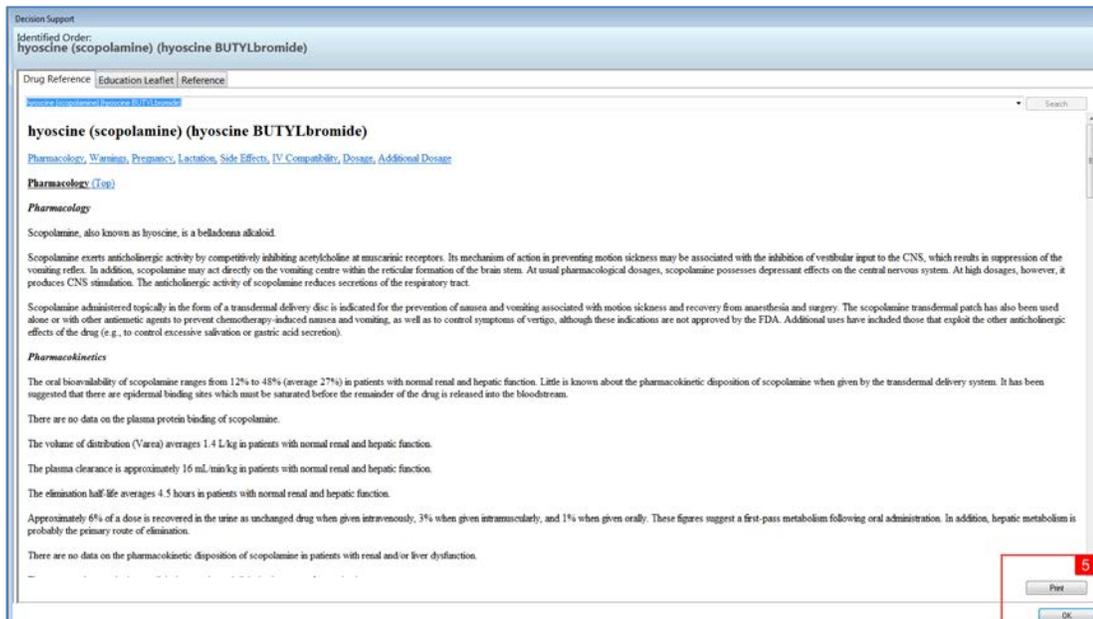
**NOTE:** Different sections of the MAR and statuses of medication administration are colour coded:

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

4. To find out detailed information of a medication, right-click on the medication name and select **Reference Manual**.



5. The Decision Support window opens. It allows a user to view and print detailed information on a selected medication.

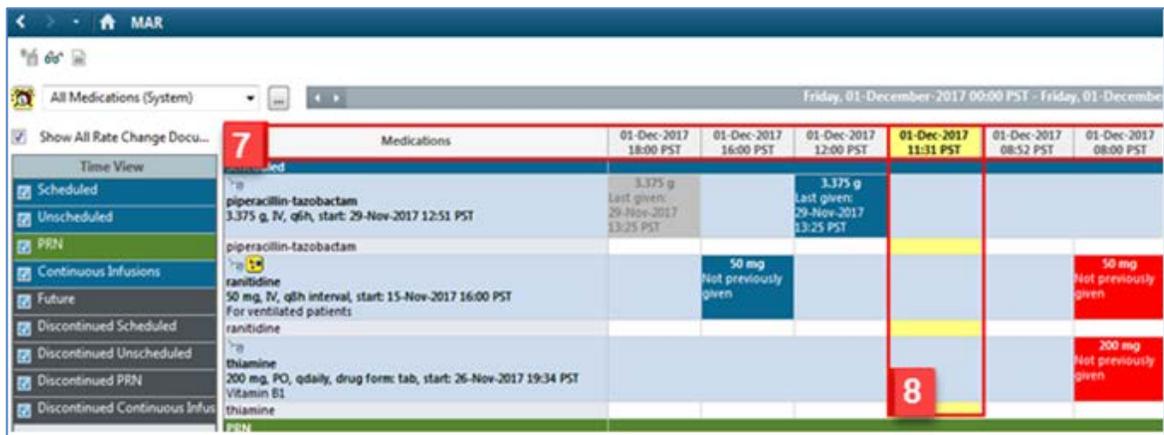


Upon further review of the MAR you will note the following:

6. The **Clinical Range** is defaulted to display 48-hour time frame. Right click on the Clinical Range bar to adjust the time frame to **Today**.



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



### Key Learning Points

- The MAR is a record of the medication administered to the patient by a clinician.
- The MAR lists medication in reverse chronological order.
- The MAR displays all medications, medication orders, tasks, and documented administrations for the selected time frame.

## Activity 4.2 – Barcode Scanner and Administering Medication using Medication Administration Wizard (MAW)

Medications are 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.

### 1 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 the following medications to your patient. You will scan the medications sequentially.

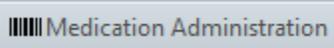
Occasionally a dose requires scanning two pills to make up the full dose. At other times, the dose requires only part of a pill.

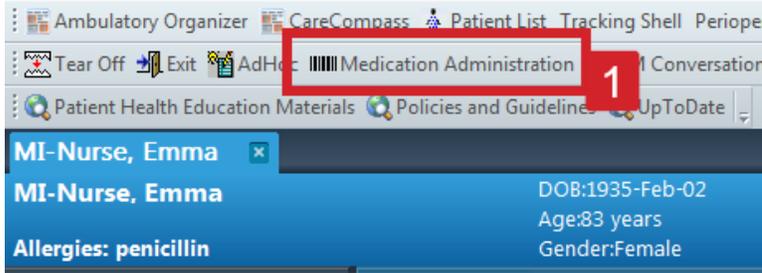
- PO medication: **acetaminophen 650 mg PO**, the drug form is tablet (acetaminophen 325 mg x 2 tabs).
- IV medication: **vancomycin 1 g, IV**, mixed by the nurse.



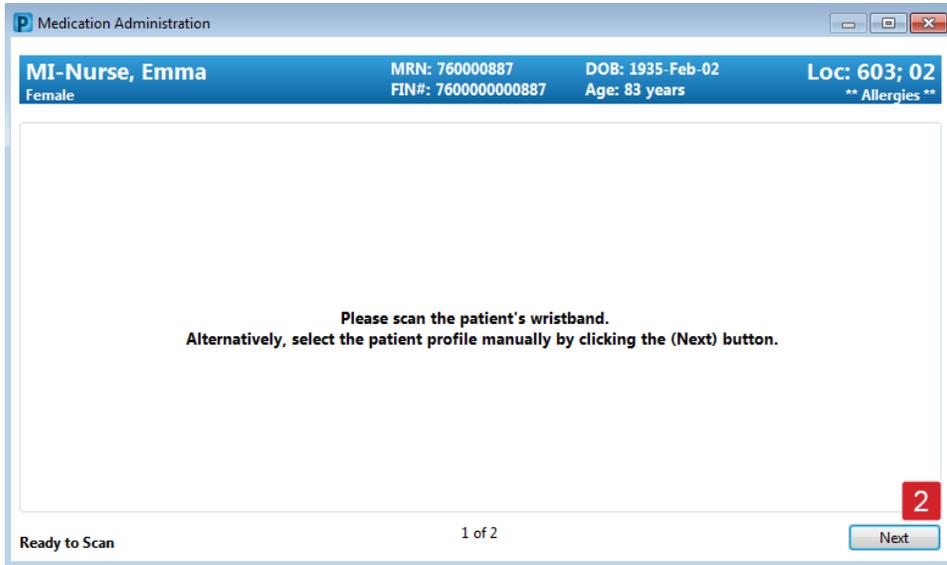
**NOTE:** IV normal saline does not have a barcode to be scanned just like Radiopharms as it is a Stores Item. Stores items are documented on the MAR differently.

Let’s begin the medication administration following the steps below.

1. Review medication information in the **MAR** and identify medications that are due. Click **Medication Administration Wizard (MAW)**  in the Toolbar.



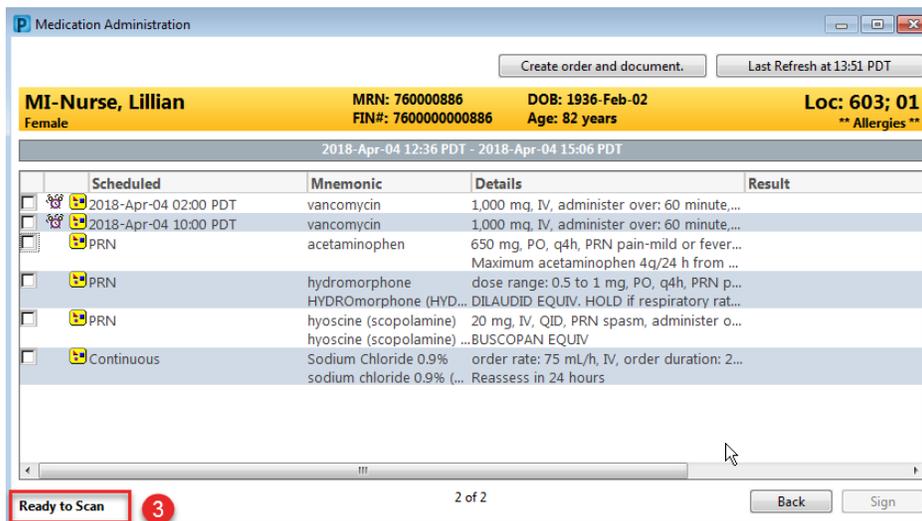
2. The Medication Administration window will open



3. Scan the patient's wristband, a window will open displaying the medications that you can administer.



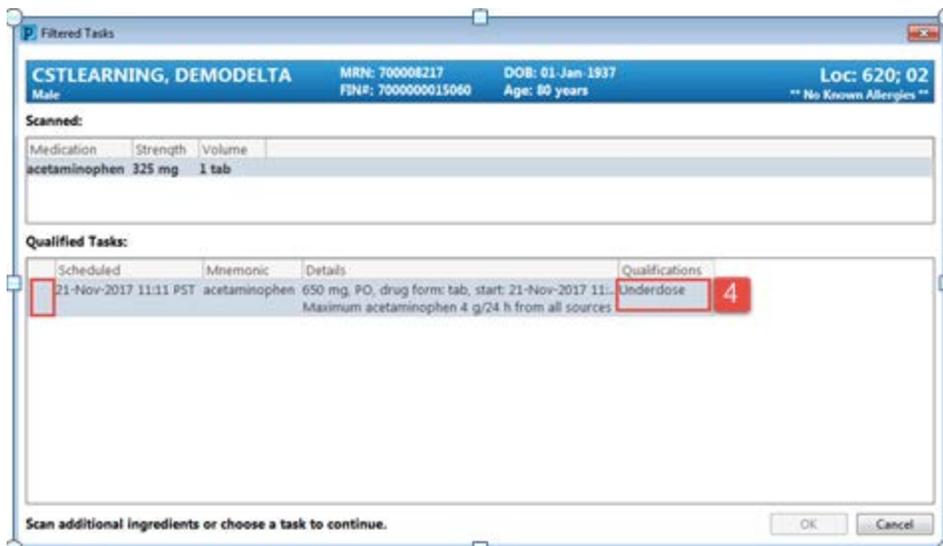
**NOTE:** This list populates with medications that are scheduled for 1 hour ahead and any overdue medications from up to 7 days in the past.



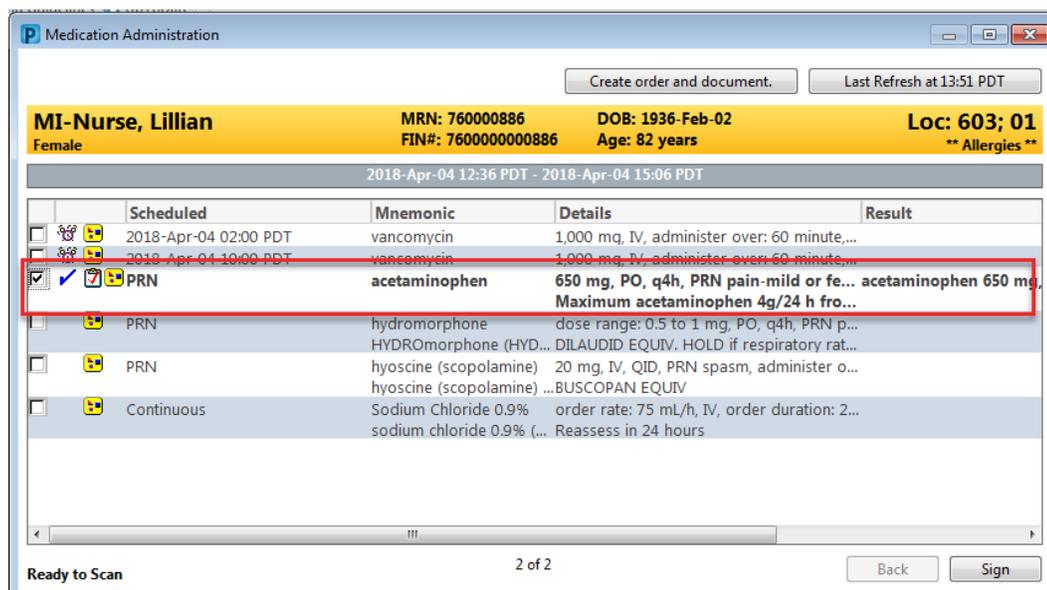
4. Scan the medication barcode for **acetaminophen 325 mg tabs**.



**NOTE:** Underdose appears in the qualifications column for the medication. This is because you have only scanned 325mg of the total 650 mg of acetaminophen required.



- Now scan the second **acetaminophen 325 mg** tab barcode to complete the 2 tablet drug administration. After the second scan, the system finds an exact match for the prescribed dose.



Let's scan the next medication.

- Scan the barcode for **vancomycin 1 g IV**. The system finds an exact match of the IV medication.
- Since this medication is reconstituted in 500 ml D5W, you will need to enter this information so that the volume of 500 mL will be captured in the intake and output record. Click **vancomycin 1,000 mg IV** in the Results column and a charting window will appear.

Medication Administration

Create order and document. Last Refresh at 13:51 PDT

**MI-Nurse, Lillian** MRN: 760000886 DOB: 1936-Feb-02 Loc: 603; 01  
Female FIN#: 760000000886 Age: 82 years \*\* Allergies \*\*

2018-Apr-04 12:36 PDT - 2018-Apr-04 15:06 PDT

Scheduled	Mnemonic	Details	Result
<input checked="" type="checkbox"/> 2018-Apr-04 02:00 PDT	vancomycin	1,000 mg, IV, administer over: 60 min...	vancomycin 1,000 mg, IV
<input type="checkbox"/> 2018-Apr-04 10:00 PDT	vancomycin	1,000 mg, IV, administer over: 60 minute...	
<input type="checkbox"/> PRN	acetaminophen	650 mg, PO, q4h, PRN pain-mild or fever... Maximum acetaminophen 4q/24 h from ...	
<input type="checkbox"/> PRN	hydromorphone	dose range: 0.5 to 1 mg, PO, q4h, PRN p... HYDromorphone (HYD... DILAUDID EQUIV. HOLD if respiratory rat...	
<input type="checkbox"/> PRN	hyoscine (scopolamine)	20 mg, IV, QID, PRN spasm, administer o...	
<input type="checkbox"/> PRN	hyoscine (scopolamine)	...BUSCOPAN EQUIV	
<input type="checkbox"/> Continuous	Sodium Chloride 0.9%	order rate: 75 mL/h, IV, order duration: 2...	
	sodium chloride 0.9% (...)	Reassess in 24 hours	

Ready to Scan 2 of 3 Back Next

3. Fill in the following Diluent Volume (which will flow to I&O) and click **OK**.

- Diluent = Dextrose 5% 500 ml



**NOTE:** If the Diluent Volume is left blank, the medication volume will not flow to the I&O section.

Medication Administration

MI-Nurse, Lillian MRN: 760000886 DOB: 1936-Feb-02 Loc: 603; 01  
Female FIN#: 760000000886 Age: 82 years \*\* Allergies \*\*

vancomycin  
1,000 mg, IV, administer over: 60 minute, drug form: bag, start: 2018-Apr-04 10:00 PDT, bag volume (mL): 250

Performed Date/Time : 2018-Apr-04 1354 P... Diluent : dextrose 5% 500 mL

Performed By : Train, MedicalImagin... Total Volume : 750 Infused Over : 60 minute

vancomycin : 1,000 mg

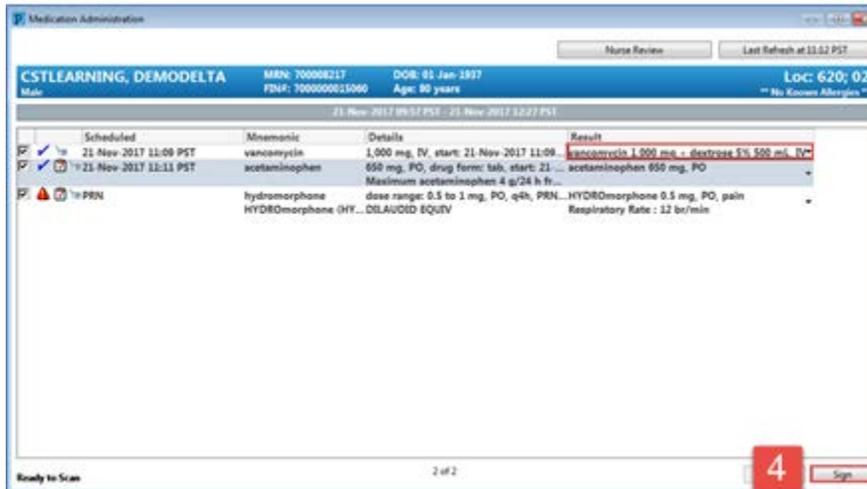
Route : IV

2018-Apr-04 1200 PDT	2018-Apr-04 1300 PDT	2018-Apr-04 1400 PDT	2018-Apr-04 1500 PDT	2018-Apr-04 1600 PDT	2018-Apr-04 1700 PDT
	75	675			

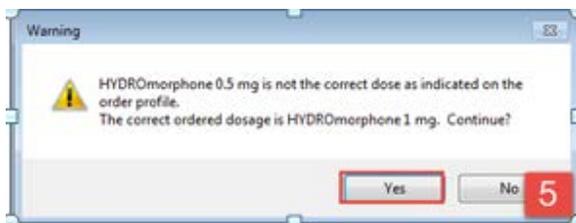
Ready to Scan 3 of 3 Back Sign

4. Now that you have scanned the patient and scanned all the medications, you can complete

your medication checks and administer the medication. Assuming this is complete, now sign for the medications administered.



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



- Congratulations, you have successfully administered these medications! The medications will now appear as **Complete** on the MAR.

Medications	21-Nov-2017 14:00 PST	21-Nov-2017 12:54 PST	21-Nov-2017 11:57 PST	21-Nov-2017 11:54 PST	21-Nov-2017 11:11 PST	21-Nov-2017 11:09 PST
<b>Scheduled</b>						
acetaminophen 650 mg, PO, q4h, drug form: tab, start: 21-Nov-2017 11:11 PST Maximum acetaminophen 4 g/24 h from acetaminophen	Not previously given				Complete	
Temperature Axillary						
Temperature Oral						
Numeric Pain Score (0-10)						
<b>PRN</b>						
vancomycin 1,000 mg, IV, q12h, start: 21-Nov-2017 11:09 PST					Complete	
vancomycin						
HYDRomorphone (HYDRomorphone P... dose range: 0.5 to 1 mg, PO, q4h, PRN pain, drug form: tab, start: 21-Nov-2017 11:09 PST DILAUDID EQUIV		Med Response	1 mg Not previously given	Complete		
HYDRomorphone						
Respiratory Rate						

- Click the **Refresh** icon  and you will be able to see more details including the time the last dose was given.

Medications	21-Nov-2017 14:00 PST	21-Nov-2017 12:54 PST	21-Nov-2017 12:02 PST	21-Nov-2017 11:54 PST
<b>Scheduled</b>				
acetaminophen 650 mg, PO, q4h, drug form: tab, start: 21-Nov-2017 11:11 PST	650 mg			
Maximum acetaminophen 4 g/24 h from...				
acetaminophen Temperature Axillary				650 mg Auth (Ve)
Temperature Oral				
Numeric Pain Score (0-10)				
<b>Discontinued Scheduled</b>				
vancomycin 1,000 mg, IV, q12h, start: 21-Nov-2017 11:09 PST				
vancomycin				1,000 mg Auth (V'
<b>Discontinued PRN</b>				
HYDRoMorphone (HYDRoMorphone P... dose range: 0.5 to 1 mg, PO, q4h, PRN pain, drug form: tab, start: 21-Nov-2017 11:09 PST		Med Response	1 mg	
DILAUDID EQUIV				
HYDRoMorphone				*0.5 mg Auth IV
Respiratory Rate				12 Auth Verified

**Practice** Administering the Continuous Normal Saline Infusion. Remember it cannot be scanned.



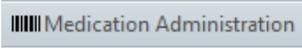
**NOTE:** There is a Med Response box that displays for some PRN medications like hydromorphone after they have been administered. You would click on the box to document if you administer drugs like this.

3

Prior to the diagnostic test, your patient appears anxious and requests Lorazepam. You receive a phone order from the Provider for Lorazepam. Let's practice creating an order and documenting administration of this drug, which you will be doing most of the time.

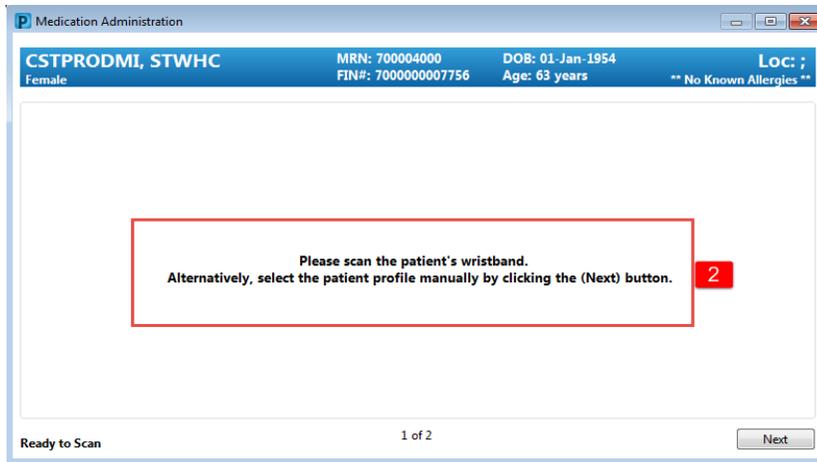


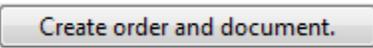
**NOTE:** Unique to the MI nurse, supervisor and technologist is functionality to order and document medications directly from the Medication Administration Wizard (MAW).

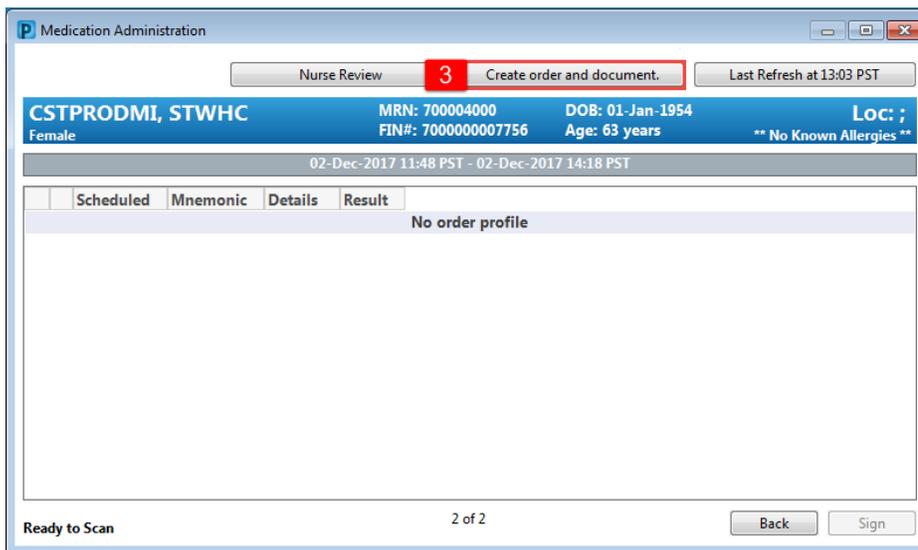
1. Click **Medication Administration Wizard (MAW)**  in the toolbar



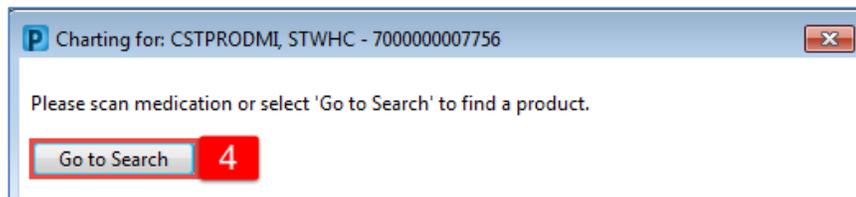
2. The **Medication Administration** pop-up window will appear. Scan the patient's wristband.

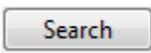


3. Click the **Create order and document**  button.



4. Since you received a phone order for Lorazepam, it will not be pre-populated and ready for scan. Therefore you are required to add this medication to the patient's chart. Click the **Go to Search** button.



5. In the Search bar, enter = *Lorazepam*.
6. Click the Search  button.
7. Select **LORazepam 1 mg tab** from the Search Results.

8. Click the **Add Order** button.

The screenshot shows a software window titled "Charting for: CSTPRODMI, STWHC - 700000007756". It contains a search bar with "Lorazepam" entered, a "Search" button, and a list of search results. The first result, "LORazepam 1 mg tab", is highlighted. Below the list, there is a detailed view of the selected medication with an "Add Order" button.

Please search for a medication.

Search for

Search Results

- LORazepam 1 mg tab**
- LORazepam 4 mg/mL inj
- LORazepam sublingual 0.5 mg tab

Description : LORazepam 1 mg tab  
Strength : 1 mg  
Volume : 1 tab  
Form : tab

- 9. Enter the **Ordering Provider** = *type in provider name (Last, First)*.
- 10. Communication Type = *Phone*.
- 11. Select **sublingual** from the **Route** drop-down.
- 12. Click **Sign** once you have administered the medication.



**NOTE:** Mandatory fields are highlighted in yellow.

Charting for: CSTPRODMI, TESTAC - 700000015548

Document and place One-Time Order for: LORazepam 1 mg tab

Performed date / time: 06-Dec-2017 1611 PST

\*Ordering Provider: Fine, David Edgar 9

Communication Type: Phone 10

Performed by: TestUser, Nurse-RadNet

Witnessed by:

Dose: 1 mg

Volume: 0 mL

\*Route: sublingual 11

Form: tab

Site:

Infuse Over:

06-Dec-2017 1500 PST	06-Dec-2017 1600 PST	06-Dec-2017 1700 PST	06-Dec-2017 1800 PST	06-Dec-2017 1900 PST	06-Dec-2017 2000 PST
-------------------------	-------------------------	-------------------------	-------------------------	-------------------------	-------------------------

Comment... Return to Search Cancell 12 Sign

13. Close out of the MAW by clicking the close button

Medication Administration 13

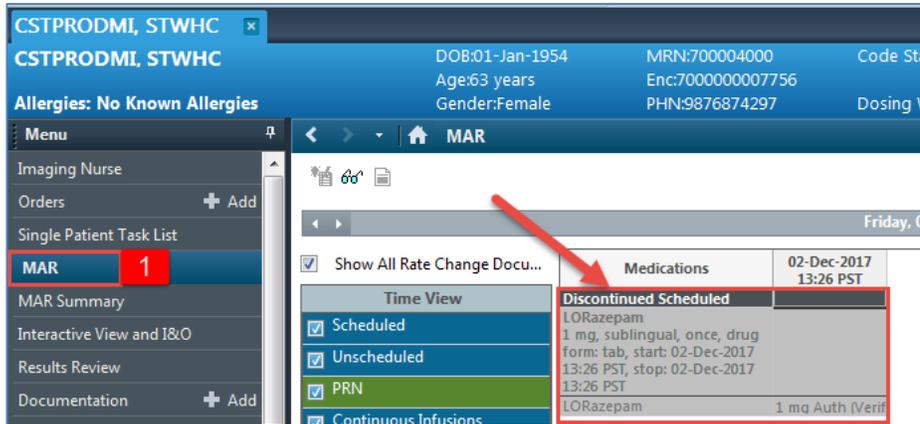
Nurse Review Create order and document. Last Refresh at 13:34 PST

CSTPRODMI, STWHC Female MIRN: 700004000 FIN#: 700000007756 DOB: 01-Jan-1954 Age: 63 years Loc: ; \*\* No Known Allergies \*\*

4

To confirm and review that Lorazepam is documented as administered, review the **MAR**.

1. Navigate to the **MAR** from the Menu and note that Lorazepam is displayed as discontinued. This is because the system recognizes that this was a one-time dose.



### Key Learning Points

- The MAW offers functionality to order and document medications; this is unique to MI.
- The MAR should be reviewed to confirm that the medication is correctly documented as administered.

## PATIENT SCENARIO 5 – Interactive View and I&O

### Learning Objectives

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

- Review the Layout of Interactive View and I&O (iView)
- Document and Modify your Documentation in iView

### SCENARIO

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

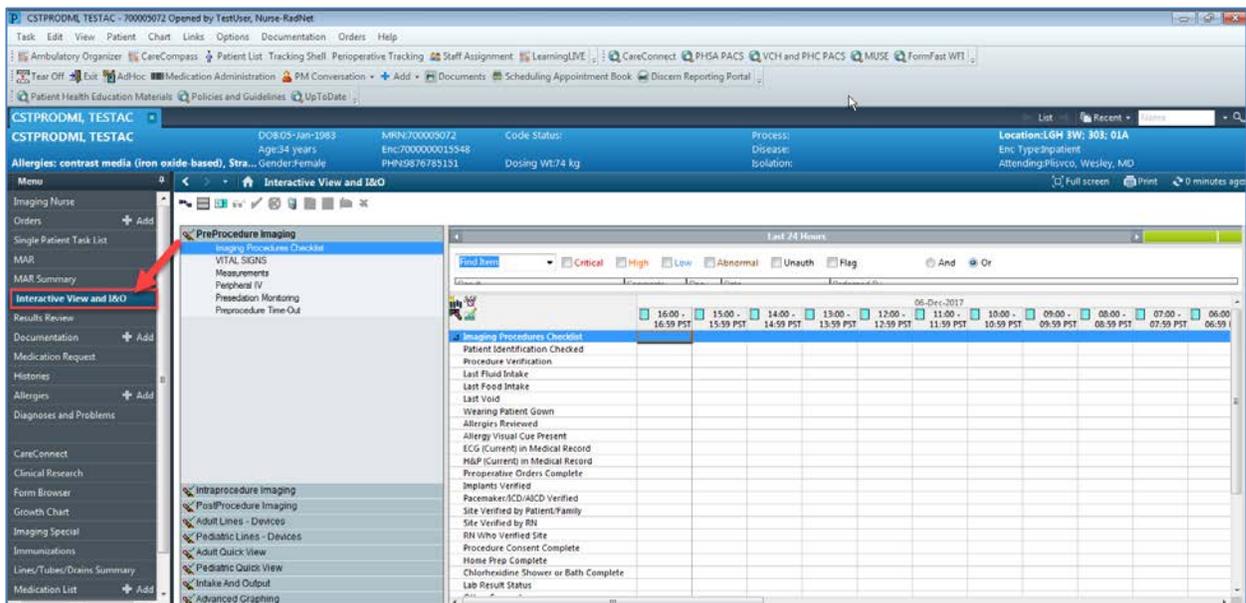
You will be completing the following activities:

- Navigate to Interactive View and I&O (iView)
- Document in iView
- Change the time column
- Document a dynamic group in iView
- Modify, Unchart or add a comment in iView

## Activity 5.1 – Navigate to Interactive View and I&O

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

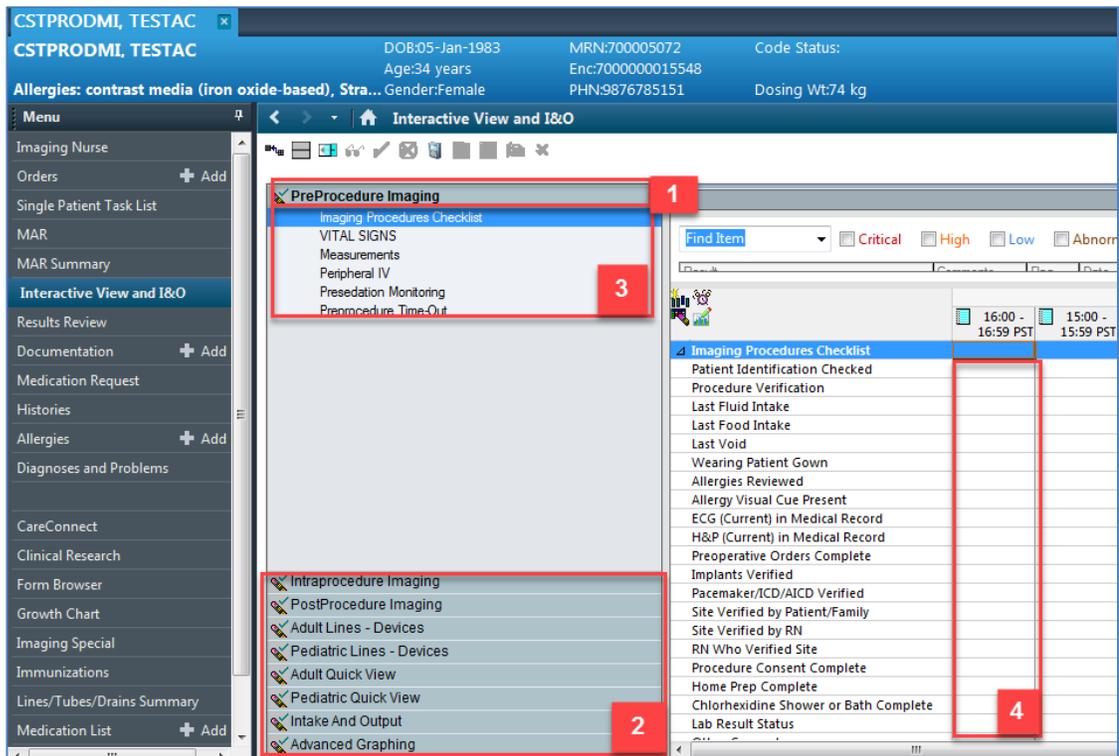
### 1 Select **Interactive View and I&O** from within the **Menu**.



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 **PreProcedure Imaging** band is expanded displaying the sections within it.
2. The set of bands below **PreProcedure Imaging** are collapsed. Bands can be expanded or collapsed by clicking on their name.
3. A **section** is an individual flowsheet that contains related assessment and intervention documentation.
4. A **cell** is the individual field where data is documented.

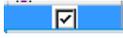


### Key Learning Points

- Nurses will complete most of their documentation in Interactive View and I&O (iView).
- iView contains flowsheet type charting.

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

1 With the **PreProcedure Imaging** band expanded you will see the **Vital Signs** section. Let's practice documenting in iView. Select the **Vital Signs** component under **PreProcedure Imaging**.

1. 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 and using the space key to make selections.
2. Document using the following data:
  - **Temperature Oral** = 36.9
  - **Peripheral Pulse Rate** = 91
  - **SBP/DBP Cuff** = 140/90
  - **Mean Arterial Pressure, Cuff** = *double-click the empty cell for automated result*



**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.

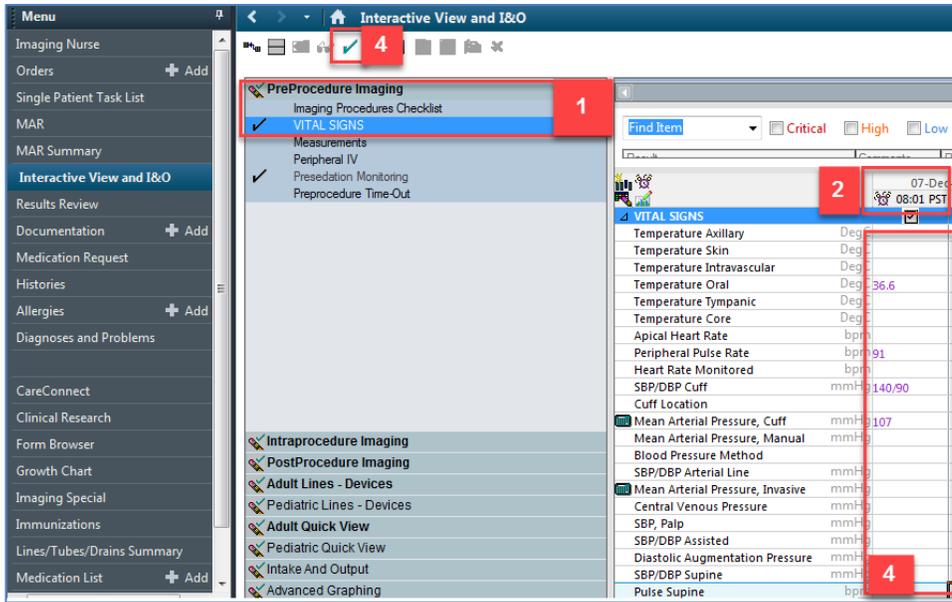
- **Respiratory Rate** = 16
- **Oxygen Therapy** = *Nasal cannula*
- **Oxygen Flow Rate** = 3
- **SpO2** = 99
- **SpO2 Site** = *Hand*

3. 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.

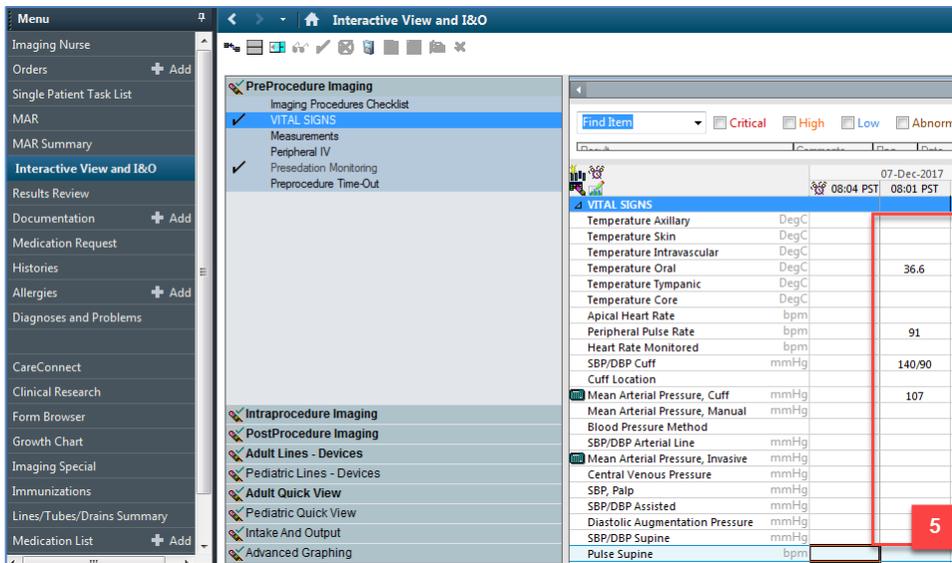


**NOTE:** Please disregard the values that are populated in the cells under the MEWS section. More information about MEWS documentation will be provided later in this workbook.

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



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

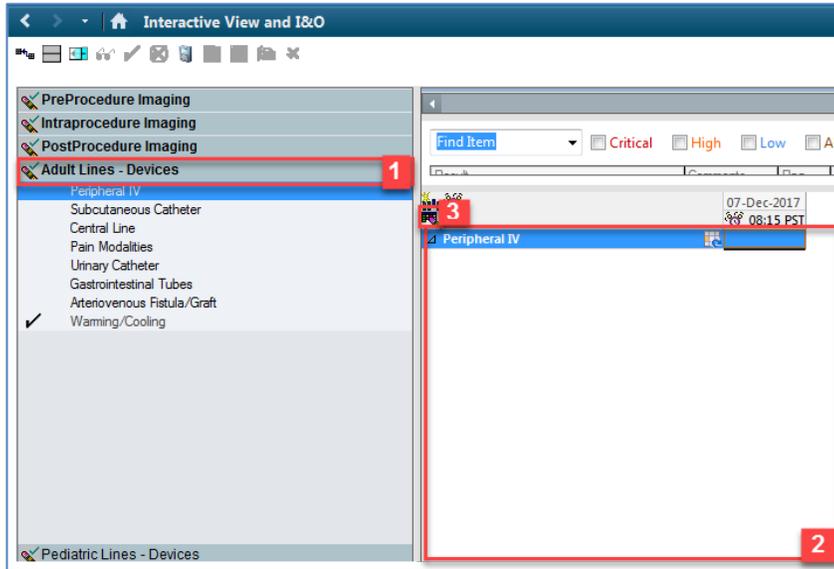


**NOTE:** In areas with Bedside Medical Device Interfaces (BMDI) for monitoring and uploading vital signs, these will be directly populated into iView to be validated once a device is associated. For areas without BMDI, vital signs will be manually entered as per the above process.

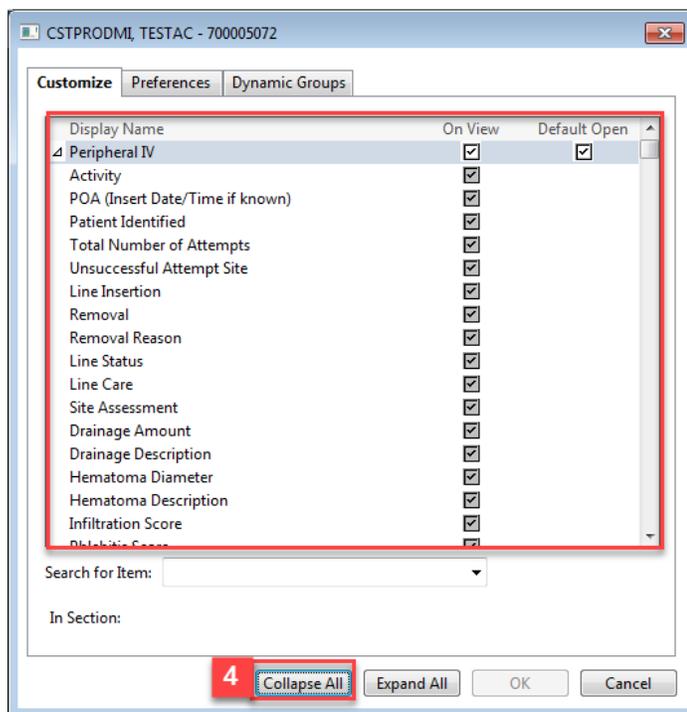
You do not have to document in every cell. Only document to what is appropriate for your assessment and follow appropriate documentation policies and guidelines at your site.

2 Your patient has a chest tube and now you want to document.

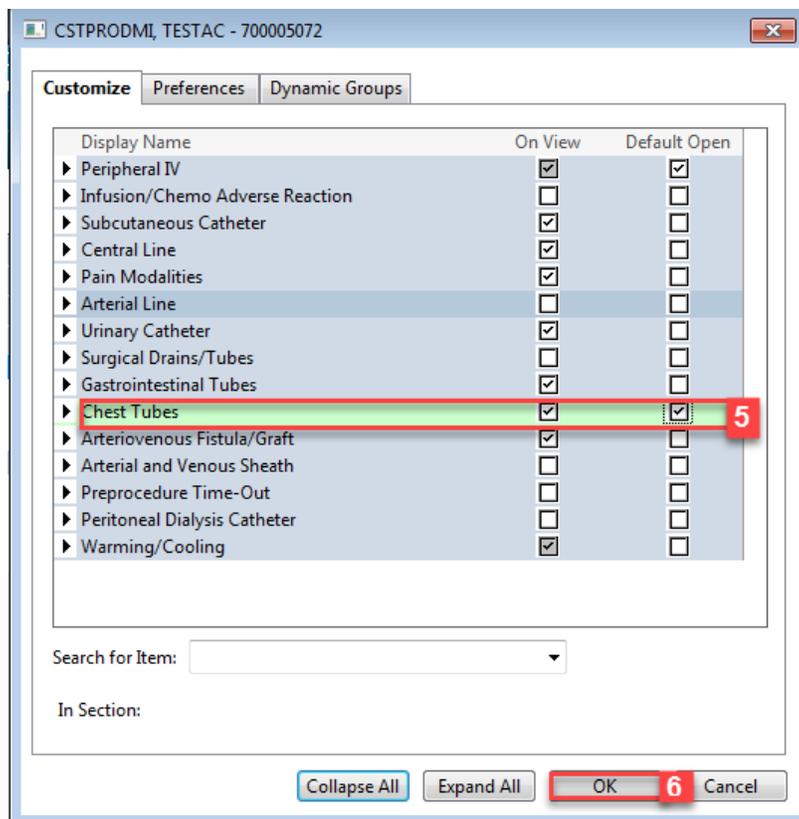
1. Click the **Adult Lines-Devices** Band in **iView**.
2. Notice that there is nothing in this section that you can see about chest tube.
3. Click the **Customize View** icon  to search for a section regarding chest tube.



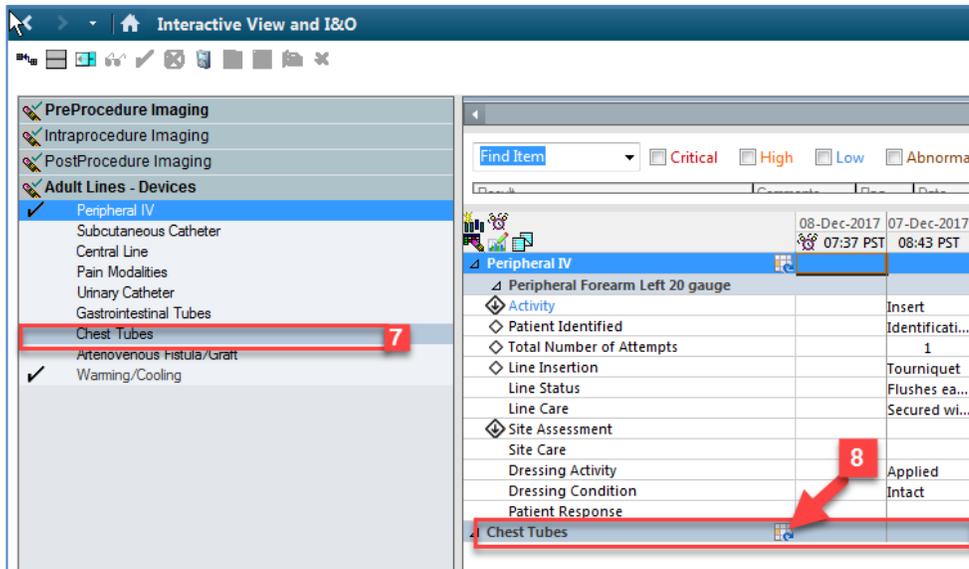
4. A Customise window opens displaying all the contents within the Adult Lines-Devices band with peripheral IV, central line, and so on. Click the **Collapse All** button to see all of the section names at a glance.



- Now that all the sections are collapsed, find the **Chest tube** section and click on the box  under the **Default Open** column.
- Click **OK**



7. You will now see that the **Chest Tubes** section is available to document on in iView.
8. Fill in the information about the chest tube by adding a dynamic group. Click **Add a Dynamic Group** icon.

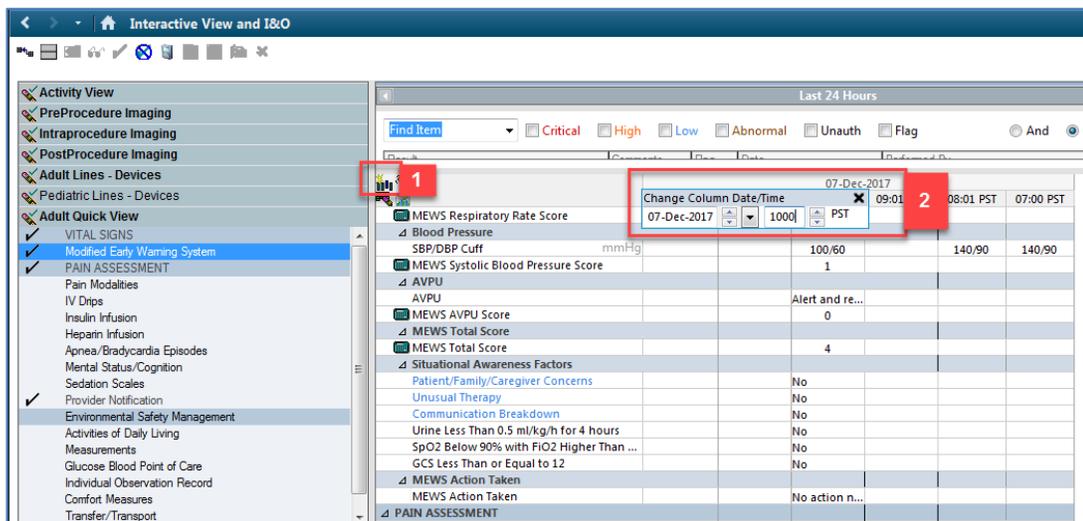


### Key Learning Points

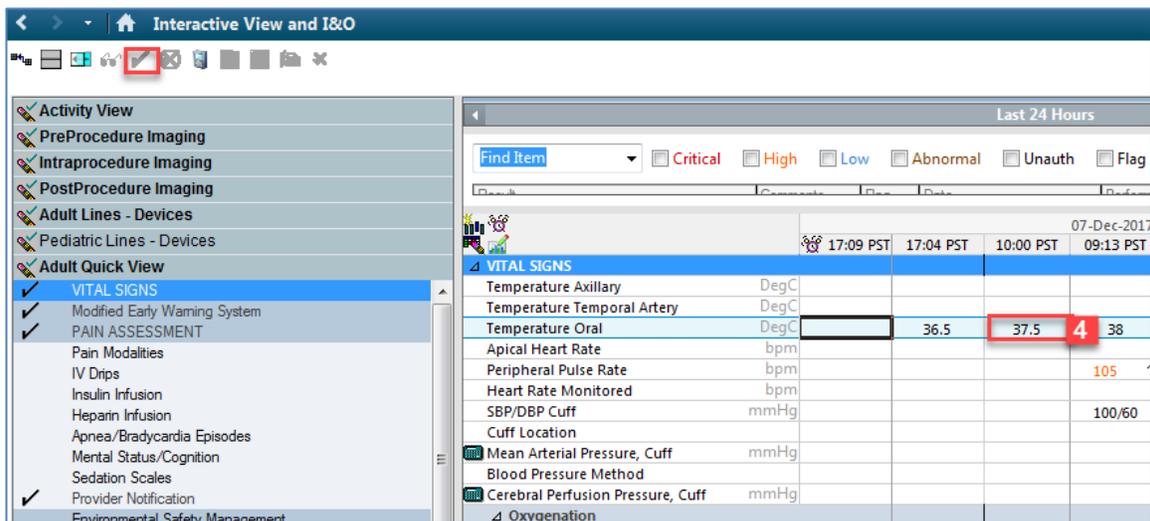
- Documentation will appear in purple until signed. Once signed, the documentation will become black.
- The latest documentation displays in the left most column.
- Double-click the blue box next to the name of the section to document in several cells, the section will then be activated for charting.
- You do not have to document in every cell. Only document what is appropriate to your assessment (chart by exception).
- Use the Customize View icon to find additional documentation that isn't automatically visible.

## Activity 5.3 – Change the Time Column

- 1 You can create a new time column and document under a specific time. For example, it is now 12:00 pm and you still need to document your patient’s 10:00 am temperature.
  1. Click the **Insert Date/Time** icon .
  2. A new column and **Change Column Date/Time** window appears. Choose the appropriate date and time you wish to document under. In this example, use today’s date and time of 1000.
  3. Click the **Enter** key



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

- Documentation time can be changed in iView.
- If required, you can create a new time column and document under a specific time.

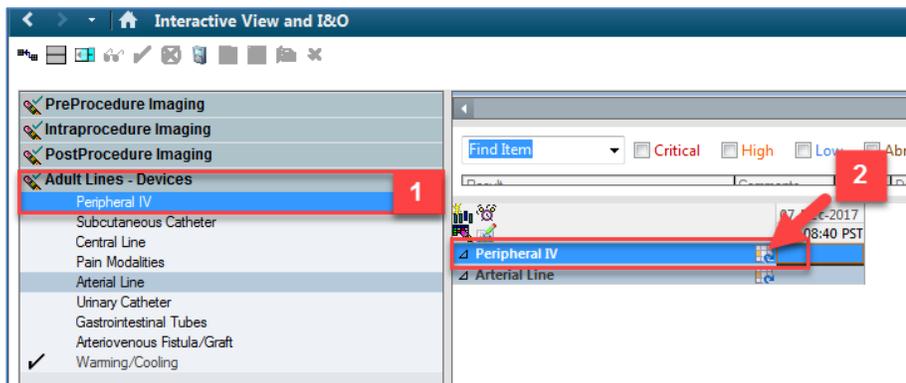
## Activity 5.4 – Document a Dynamic Group in iView

1

Dynamic groups allow the documentation and display of multiple instances of the same grouping of data elements. Examples of dynamic groups include wound assessments, IV Sites, chest tubes and more.

For the purposes of this scenario, let's assume that your patient requires a peripheral IV to be inserted. After inserting the IV successfully, you are now ready to document the details of the IV insertion.

1. Click on the **Adult Lines – Devices** band.
2. Now that the band is expanded, click on the **Dynamic Group** icon  to the right of the Peripheral IV (PIV) heading in the flowsheet.

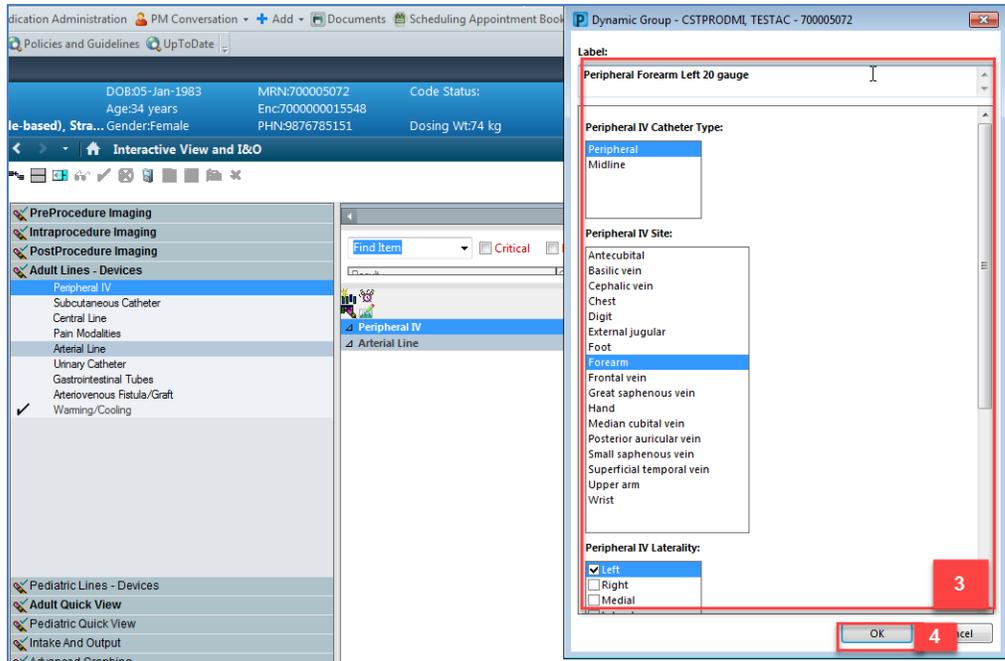


3. The **Dynamic Group** window appears. A dynamic group allows you to label a line, wound, or drain with unique identifying details. You can add as many dynamic groups as you need for your patient. For example, if a patient has two peripheral IVs, you can add a dynamic group for each IV.

Select the following data to create a label:

- Peripheral IV Catheter Type: **Peripheral**
- Peripheral IV Site: **Forearm**
- Peripheral IV Laterality: **Left**
- Peripheral IV Catheter Size: **20 gauge**

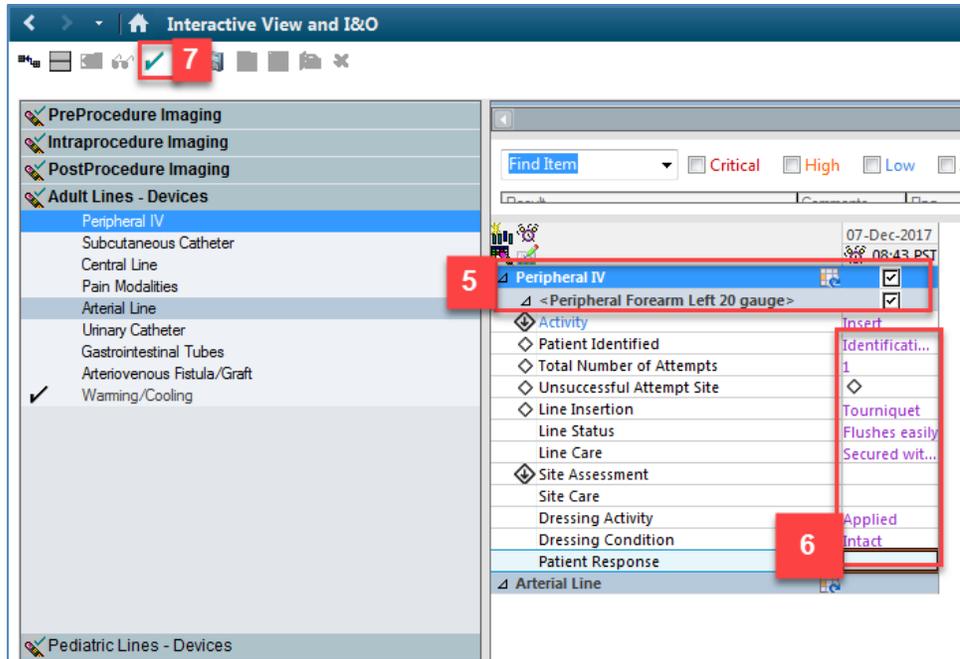
4. Click **OK**.



5. The label created will display at the top, under the Peripheral IV section heading.
6. 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 **Enter** on the keyboard.

Now document the activities related to this PIV using the following data:

- **Activity** = *Insert*
  - **Patient Identified** = *Identification band*
  - **Total Number of Attempts** = 1
  - **Line Insertion** = *Tourniquet*
  - **Line Status** = *Flushes easily*
  - **Line Care** = *Secured with tape*
  - **Dressing Activity** = *Applied*
  - **Dressing Condition** = *Intact*
7. Click **green checkmark** icon  to sign your documentation. Once signed the label will be accessible for other clinicians to complete further documentation within the same dynamic group.



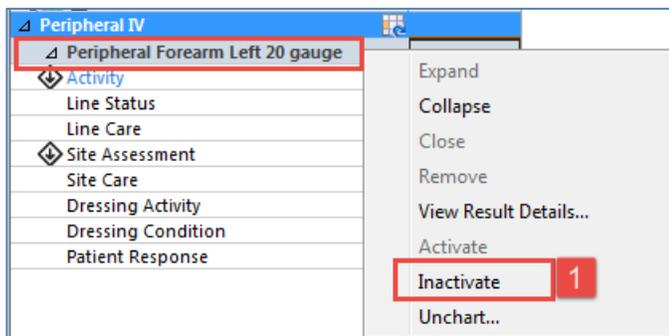
**NOTE:** A trigger icon  can be seen in some cells, such as Activity, indicating that there is additional documentation to be completed if certain responses are selected. The diamond icon  indicates the additional documentation cells that appear as a result of these responses being selected. These cells are not mandatory.

2

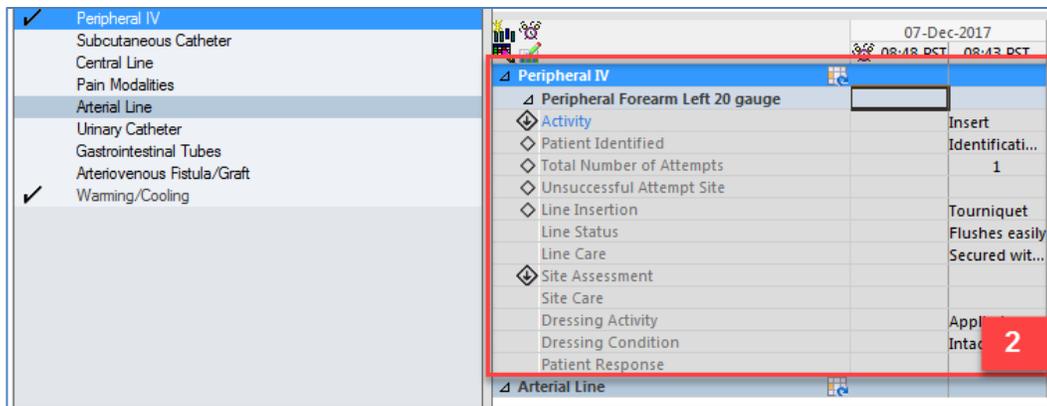
You can inactivate a dynamic group when it is no longer in use. For example, when a Peripheral IV is removed complete the following steps.

Let's inactivate your PIV dynamic group section:

1. Right-click the dynamic group label for the **Peripheral Forearm Left 20 gauge**, and select **Inactivate**.

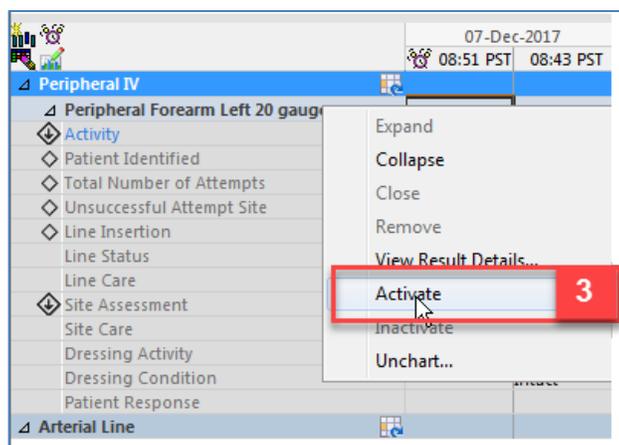


2. The inactivated dynamic group remains in the view, but is unavailable (the section turns grey), meaning clinicians cannot document on it. If there are no results for the time frame displayed, the inactive dynamic group is automatically removed from the display.



Now let's say you accidentally inactivated the wrong dynamic group. Don't worry! You can re-activate a dynamic group!

3. Right-click the dynamic group label for the **Peripheral Forearm Left 20 gauge**, select **Activate**.



You and other users can now access this dynamic group for documentation.

### Key Learning Points

- Examples of dynamic groups include wound assessments, IV sites, chest tubes, and other lines or drains.
- Once documentation within a dynamic group is signed the label will be accessible for other clinicians to complete further documentation within the same dynamic group.
- When a dynamic group is no longer in use, such as when a drain or tube is removed, you can inactivate it.

## Activity 5.5 – Modify, Unchart or 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.

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

The screenshot shows the 'Interactive View and I&O' interface. On the left, the 'PreProcedure Imaging' band is expanded to show 'VITAL SIGNS'. A red box labeled '1' highlights the 'VITAL SIGNS' heading. In the main data table, the 'Peripheral Pulse Rate' row is selected, and the value '91' is highlighted with a red box labeled '2'. A context menu is open over the '91', with the 'Modify...' option highlighted by a red box labeled '3'. Other vital signs listed include Temperature Axillary, Skin, Intravascular, Oral, Tympanic, and Core, as well as Apical Heart Rate, Heart Rate Monitored, SBP/DBP Cuff, and Mean Arterial Pressure.

4. Enter in new **Peripheral Pulse Rate = 80** and then click **green checkmark icon** ✓ to sign your 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.

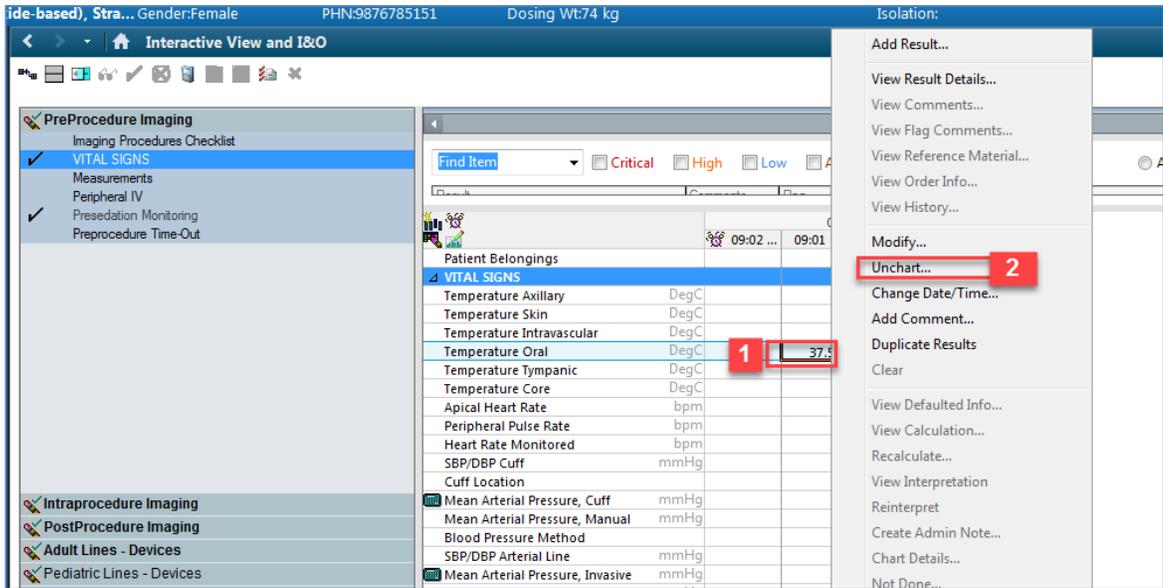
The screenshot shows the 'Interactive View and I&O' interface after the modification. The 'Peripheral Pulse Rate' value has been updated to '80', which is highlighted with a red box labeled '5'. A green checkmark icon is now visible in the bottom right corner of the cell. The context menu is no longer open. The rest of the vital signs table remains the same as in the previous screenshot.

2

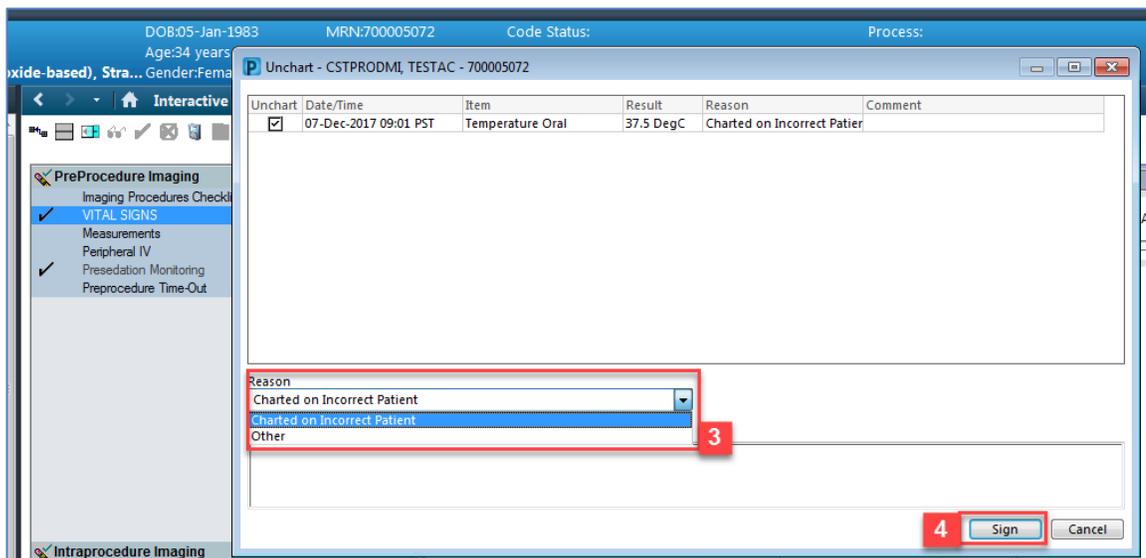
The unchart function will be used when information has been charted in error and needs to be removed. For example, a set of vital signs is charted in the wrong patient’s chart.

Let’s say the temperature documented earlier was meant to be documented on one of your other patient’s charts. Therefore, it needs to be uncharted.

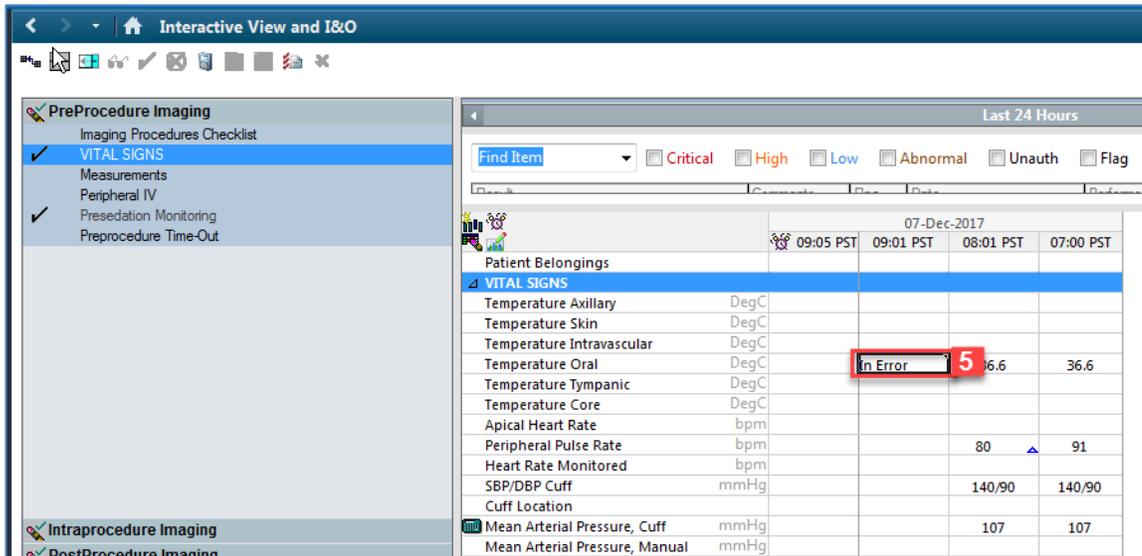
1. Right-click on the documented value of **37.5** for Temperature Oral.
2. Select **Unchart**.



3. The **Unchart** window opens, select **Charted on Incorrect Patient** from the reason dropdown.
4. Click **Sign**.



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

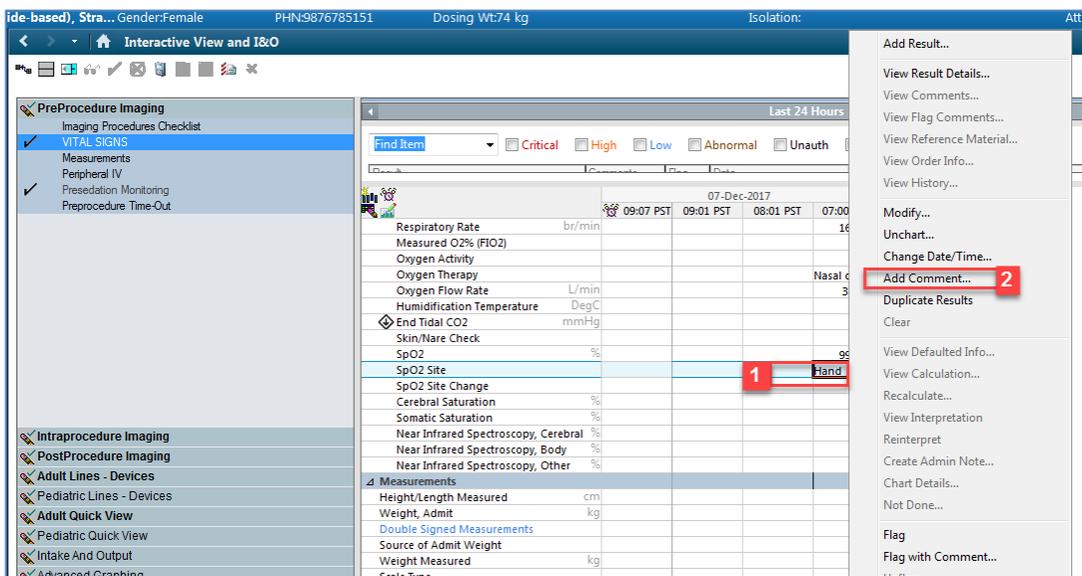


3

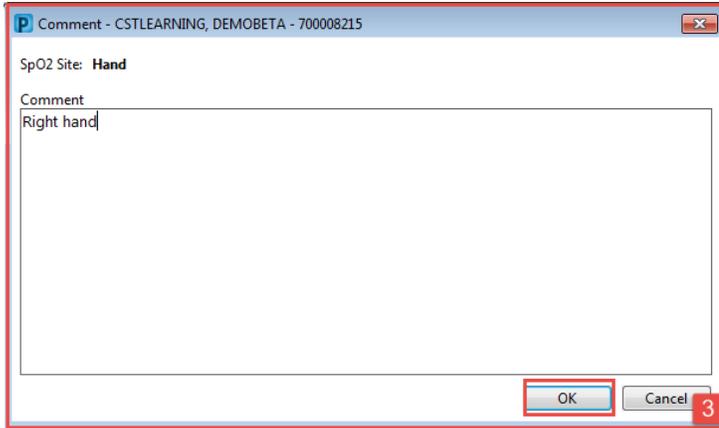
A comment can be added to any cell to provide additional information. For example, you want to clarify that the SpO2 site that you documented was on the patient's right hand.

Let's add this comment.

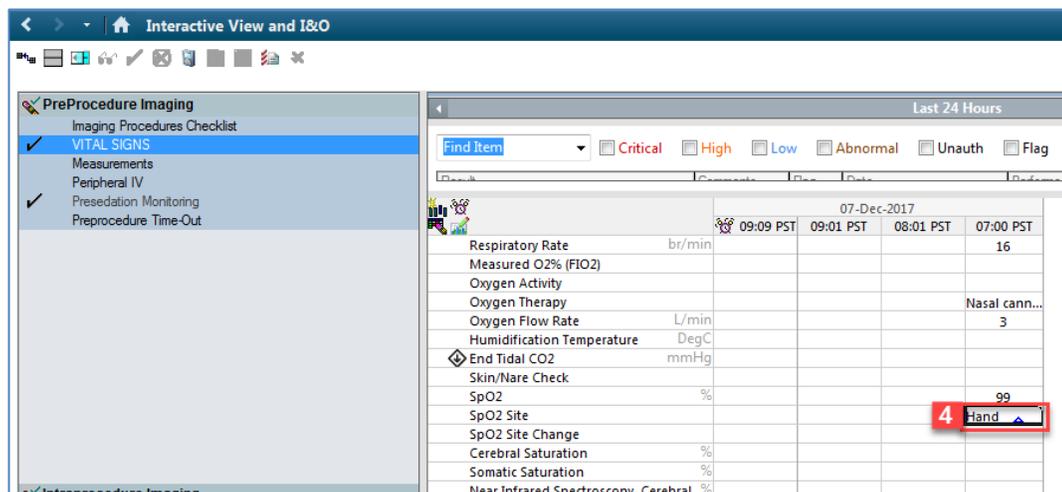
- Right-click on the documented value for SPO2 site, **hand**.
- Select **Add Comment**.



- The comment window opens, type= *Right hand* and click **OK**.



- 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

- Always sign your documentation once completed.
- Results can be modified and uncharted within iView.
- A comment can be added to any cell in iView.

## PATIENT SCENARIO 6 – Modified Early Warning System (MEWS)

### Learning Objectives

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

- Understand the purpose of using the Modified Early Warning System
- Document on MEWS
- Manage a MEWS alert

### SCENARIO

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

You will complete the following activities:

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

## Activity 6.1 – Document on MEWS Section in iView to Trigger a MEWS Alert

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

MEWS is scored based on 5 key assessment parameters: **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, or if new documentation for situational awareness factors indicates a change for the worse, an electronic alert will be triggered to warn nurses that the patient may be deteriorating and require timely attention.

### 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

1 You will navigate to and review MEWS documentation.

1. Select **Interactive View and I&O** from the menu.
2. Click on the **Adult Quick View** Band.
3. Document the following vital signs in the **VITAL SIGNS** section.
  - **Temperature Oral = 38**
  - **Peripheral Pulse Rate = 105**
  - **SBP/DBP = 100/60**
  - **Respiratory Rate = 20**
4. Select the **Modified Early Warning System** section.
5. Note the vital signs documentation has flowed to the MEWS section.
6. Double-click the blue band for **Modified Early Warning System**. A check mark  will display, indicating the whole section is activated and the MEWS scores will be automatically calculate
7. Document **AVPU**.
  - *AVPU = Alert and responsive*
8. Document on the Situational Awareness Factors:

For the purpose of this practice scenario, click **No** for all cells in this section.

- **Patient Family/Caregiver = No**
- **Unusual Therapy = No**
- **Communication breakdown = No**
- **Urine less than 0.5 mL/kg/h for 4 hours = No**
- **SpO2 below 90% with FiO2 higher than 50% = No**
- **GCG less than or equal 12 = No**



**NOTE:** The purpose of this section of documentation is to gather more information related to how the patient is doing, which provides context for those who see the MEWS alert.

9. Sign your documentation . The purple text changes to black and is now saved in the chart.

Find Item	Critical	High	Low	Abnormal	Unauth	Flag	Date	Performed By
SpO2 Site Change								
Modified Early Warning System	<input checked="" type="checkbox"/>							
Temperature								
Temperature Axillary								
Temperature Temporal Artery								
Temperature Oral							38	36.6
MEWS Temperature Score							1	
Heart Rate								
Apical Heart Rate							105 ↑	80
Peripheral Pulse Rate								91
Heart Rate Monitored								
MEWS Heart Rate Score							1	
Respiratory Rate								
Respiratory Rate							20	16
MEWS Respiratory Rate Score							1	
Blood Pressure								
SBP/DBP Cuff							100/60	140/90
MEWS Systolic Blood Pressure Score							1	
AVPU								
AVPU							Alert and re...	
MEWS AVPU Score							0	
MEWS Total Score							4	
MEWS Total Score							4	
Situational Awareness Factors								
Patient/Family/Caregiver Concerns							No	
Unusual Therapy							No	
Communication Breakdown							No	
Urine Less Than 0.5 ml/kg/h for 4 hours							No	
SCOP Below 98% with ECG Higher Than							No	

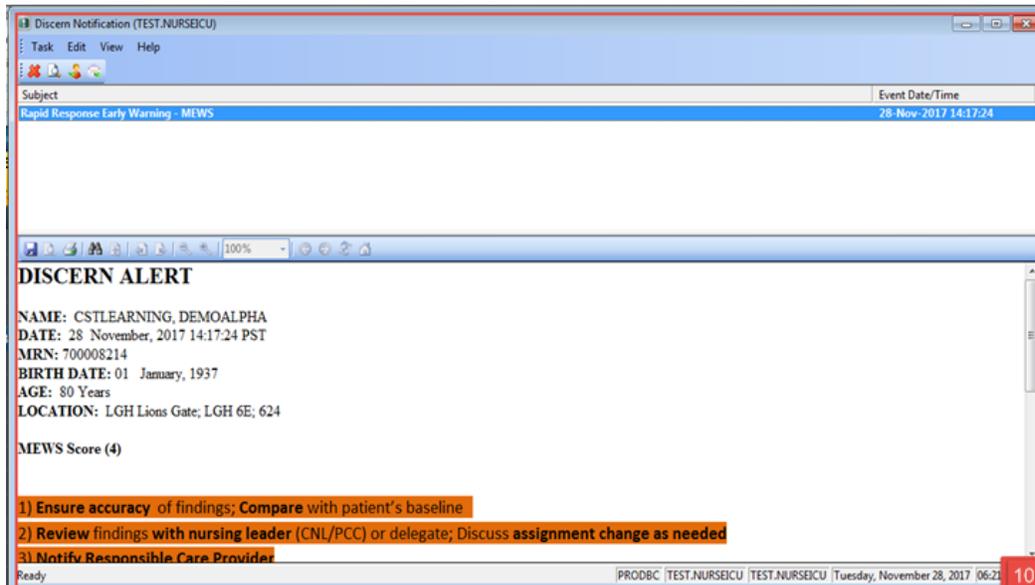


**NOTE:** The patient has a slight fever with a soft BP and a higher heart rate, indicating that they may be getting sicker and need timely attention from the health care team.

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

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

Follow the guidelines highlighted in Orange, see the next activity.



## Key Learning Points

- MEWS stands for Modified Early Warning System and is a scoring system that can trigger an electric alert in the CIS.
- If the MEWS score is out of normal range, an alert will be triggered in the CIS to warn the health care 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 ICU.

## Activity 6.2 – Review the MEWS Alert

1

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

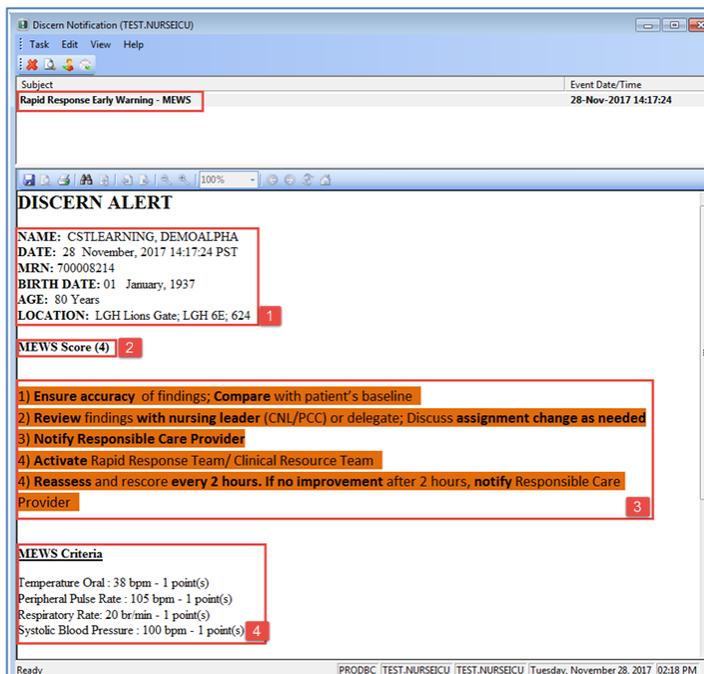
All nurses who have established a relationship with the patient in the CIS will receive the MEWS alert upon logging into the system. In this scenario, you will follow the MEWS protocol to complete the MEWS alert task and document provider notification.



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

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

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



Discern Notification (TEST.NURSEICU)

Task Edit View Help

Subject	Event Date/Time
Rapid Response Early Warning - MEWS	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 hr/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



**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.

5. 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 6.3 – Document Provider Notification

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 task you have done so.

1

The MEWS alert automatically creates a task that can be viewed in **Single Patient Task List** in Menu. The task is called MEWS Alert.

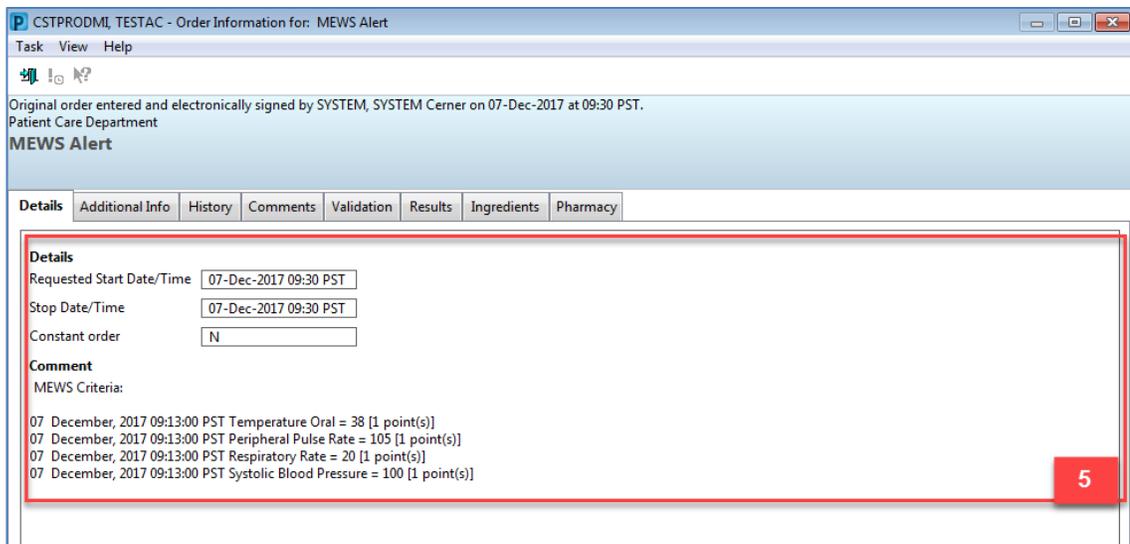
1. Navigate to **Single Patient Task List** in the Menu.
2. The MEWS Alert task is displayed as *Pending*. This means the task is waiting for the nurse to complete.

Task Status	Scheduled Date and Time	Task Description	Order Details
Overdue	28-Nov-2017 14:55 PST	Nurse Collect	Pleural fluid, Routine, Unit Collect, Collection: 28-Nov-2017 14:55 PST, once SPECIAL COLLECTION REQUIREMENTS: Please refer to specific site Laborator...
Overdue	29-Nov-2017 10:03 PST	Nurse Collect	Pleural fluid, Routine, Unit Collect, Collection: 29-Nov-2017 10:03 PST, once SPECIAL COLLECTION REQUIREMENTS: Please refer to specific site Laborator...
Pending	07-Dec-2017 09:30 PST	MEWS Alert	07-Dec-2017 09:30 PST, Stop: 07-Dec-2017 09:30 PST MEWS Criteria: 07 December, 2017 09:13:00 PST Temperature Oral = 38 [1
Pending	07-Dec-2017 09:30 PST	Add Difficult Airway/Intubation Alert	
Pending	Unscheduled	Admission Discharge Outcomes Assessment	
Pending	Unscheduled	Valuables and Belongings	
Pending	Unscheduled	Admission Discharge Outcomes Assessment	
Pending	Unscheduled	Valuables and Belongings	
Pending	Unscheduled	Admission Discharge Outcomes Assessment	
Pending	Unscheduled	Valuables and Belongings	

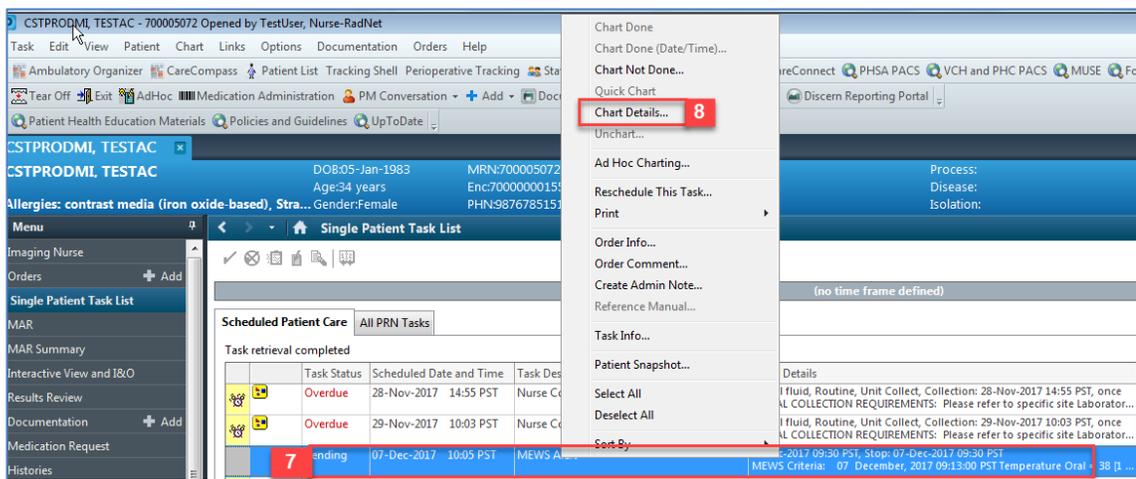
3. Right-click **MEWS Alert** task to review more information of MEWS Alert task.
4. Select **Order Info**.

Task Status	Scheduled Date and Time	Task Description
Overdue	28-Nov-2017 14:55 PST	Nurse Collect
Overdue	29-Nov-2017 10:03 PST	Nurse Collect
Pending	07-Dec-2017 09:30 PST	MEWS Alert

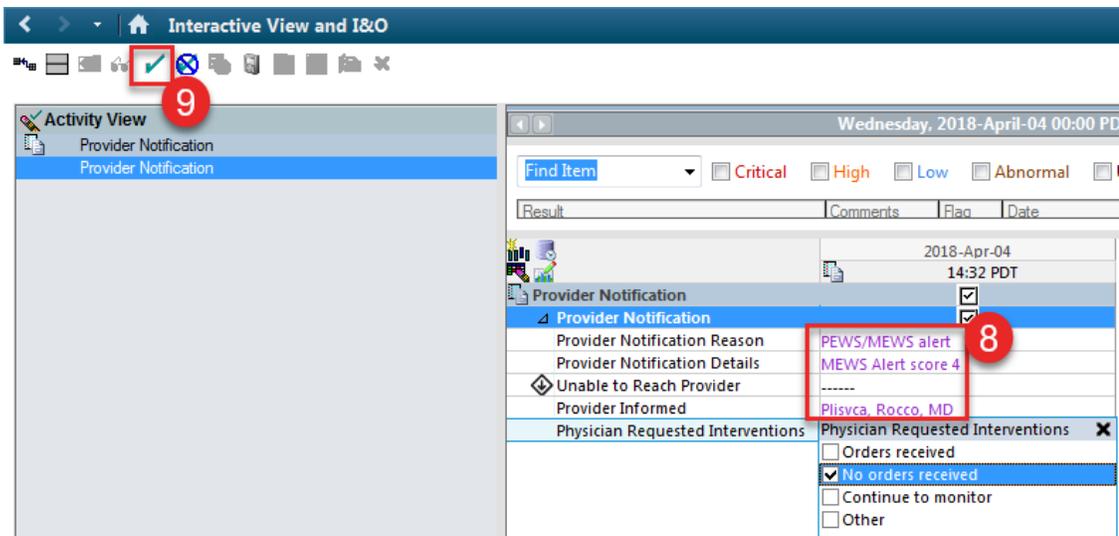
5. Order information window opens and shows detailed information about MEWS Alert for this patient. After reviewing, click **Close**.



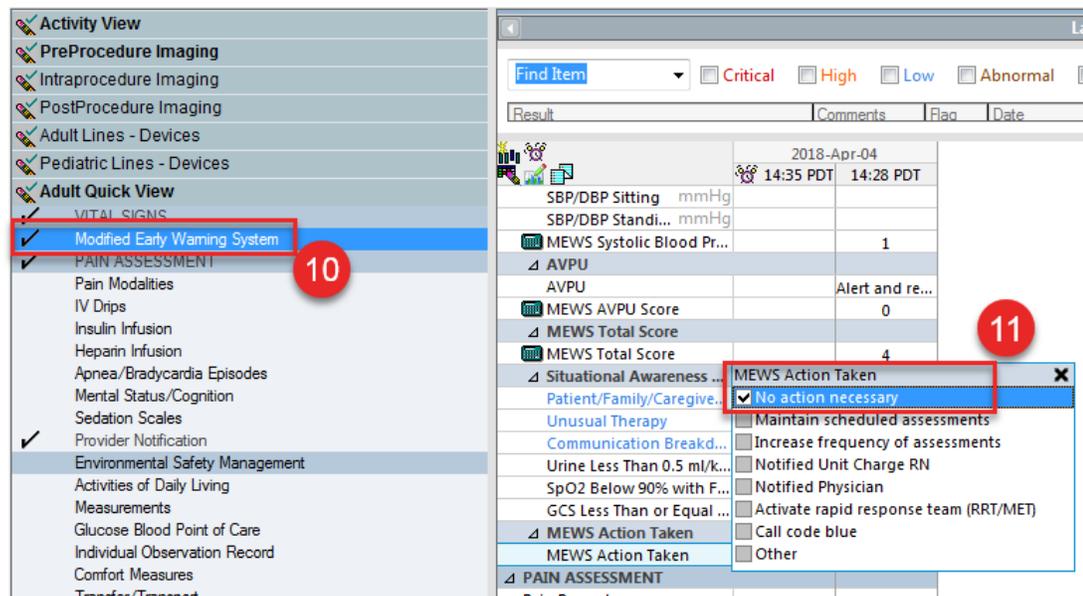
6. Go back to **Single Patient Task List**. To document response and intervention(s) for MEWS alert, right-click MEWS alert task.
7. Select **Chart Details**.



8. The system automatically directs you to iView. In the **Provider Notification** section under **Activity View** band, document the following information:
  - **Provider Notification Reason** = *PEWS/MEWS Alert*
  - **Providers Notification Details** = *MEWS Alert score 4*
  - **Provider informed** = *Plisvca, Rocco*
  - **Physician Requested Interventions** = *No orders received, Continue to Monitor*
9. Click **Sign** icon . Completing this documentation will automatically clear the MEWS Alert task from the patient's task list.



10. Select **Modification Early Warning Signs** section in **Adult Quick View** band.
11. Complete documentation for **MEWS Action Taken = No action necessary**.



12. Click **Sign** ✓.
13. You have completed all required documentation related to MEWS alert. Go back to **Single Patient Task List**. Now you can see MEWS Alert task turn to **Complete**.

Task Status	Scheduled Date and Time	Task Description	Order Details
Overdue	2018-Apr-04 07:00 PDT	Basic Admission Information	12-Jan-2018 05:59 PST, Stop: 12-Jan-2018 0 Order entered secondary to inpatient adm
Overdue	2018-Apr-04 07:00 PDT	Admission History Adult	12-Jan-2018 05:59 PST, Stop: 12-Jan-2018 0 Order entered secondary to inpatient adm
Overdue	2018-Apr-04 07:00 PDT	Braden Assessment	12-Jan-2018 05:59 PST, Stop: 12-Jan-2018 0 Order entered secondary to inpatient adm
Overdue	2018-Apr-04 07:00 PDT	Infectious Disease Screening	12-Jan-2018 05:59 PST Order entered secondary to inpatient adm
Pending	2018-Apr-04 07:00 PDT	Morse Fall Risk Scale	12-Jan-2018 05:59 PST, Stop: 12-Jan-2018 0 Order entered secondary to inpatient adm
Complete	2018-Apr-04 14:32 PDT	MEWS Alert	2018-Apr-04 14:29 PDT, Stop: 2018-Apr-04 MEWS Criteria: 04 April, 2018 14:28:00
Pending	Unscheduled	Admission Discharge Outcomes Assessment	

14. Click Refresh icon  to update Single Patient Task List screen. The MEWS Alert task disappears.

Task Status	Scheduled Date and Time	Task Description	Order Details
InProcess	17-Aug-2017 15:24 PDT	Admission History Pediatric	
InProcess	06-Oct-2017 14:40 PDT	Valubles and Belongings	
Overdue	STAT	Nurse Collect	Whole Blood, STAT, Unit collect, Collection: 07-Nov-2017 10:48 PST, once SPECIAL COLLECTION REQUIREMENTS: Please refer to specific site Laboratory...
Overdue	STAT	Nurse Collect	Whole Blood, STAT, Unit collect, Collection: 07-Nov-2017 10:53 PST, once SPECIAL COLLECTION REQUIREMENTS: Please refer to specific site Laboratory...
Overdue	STAT	Nurse Collect	Whole Blood, STAT, Unit collect, Collection: 30-Nov-2017 15:14 PST, once SPECIAL COLLECTION REQUIREMENTS: Please refer to specific site Laboratory...

### Key Learning Points

- It is the nurse's responsibility to notify the most responsible provider of MEWS alerts.
- All notifications to providers can be documented in iView.
- The MEWS alert creates a task that drives the nurse to document about Notification to Providers. Once MEWS Alert Task documentation is done, ensure to refresh Single Patient Task List screen for task updates.

## PATIENT SCENARIO 7 – Document Intakes and Outputs

### Learning Objectives

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

- Document Intakes and Outputs

### SCENARIO

As a nurse, you will complete the following activities:

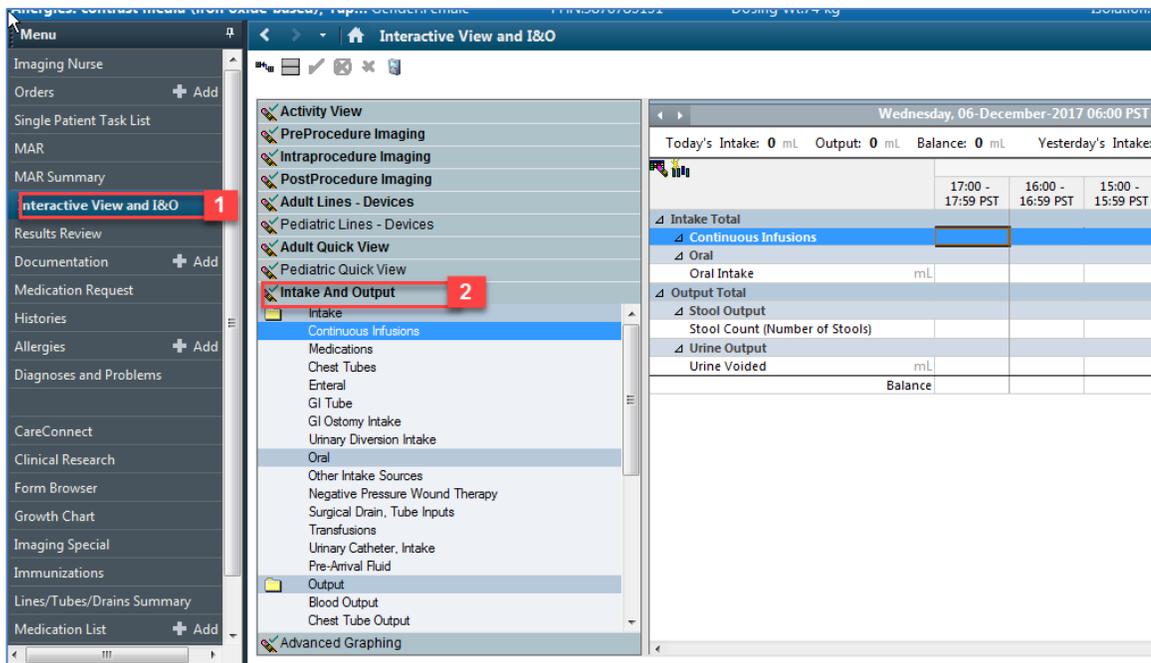
- Navigate to intake and output flowsheets within iView
- Review and document in the intake and output record
- Customize intake and output view

## Activity 7.1 – Navigate to Intake and Output Flowsheets Within iView

Intake and Output (I&O) is found as a band within iView and is where a patient’s intake and output will be documented. From here, you are able to review specific fluid balance data including 1 hour totals, 12 hour shift totals and daily (24 hour) totals.

The I&O window is structured like other flowsheets in iView. Values representing a patient’s I&O are displayed in a spreadsheet layout with subtotals and totals for specific time ranges. The left portion of the I&O screen lists different intake and output categories. Notice that the time columns in I&O are set to hourly ranges (e.g. 0600-06:59). You will need to document under the correct hourly range column.

1. Navigate to the **Interactive View and I&O** from the Menu.
2. Select the **Intake and Output** band.



2

The **Intake and Output** band expands displaying the sections within it, and the I&O window on the right. Let's review the layout of the page.

The intake and output screen can be described as per below:

1. The **I&O navigator** lists the sections of measurable I&O items.

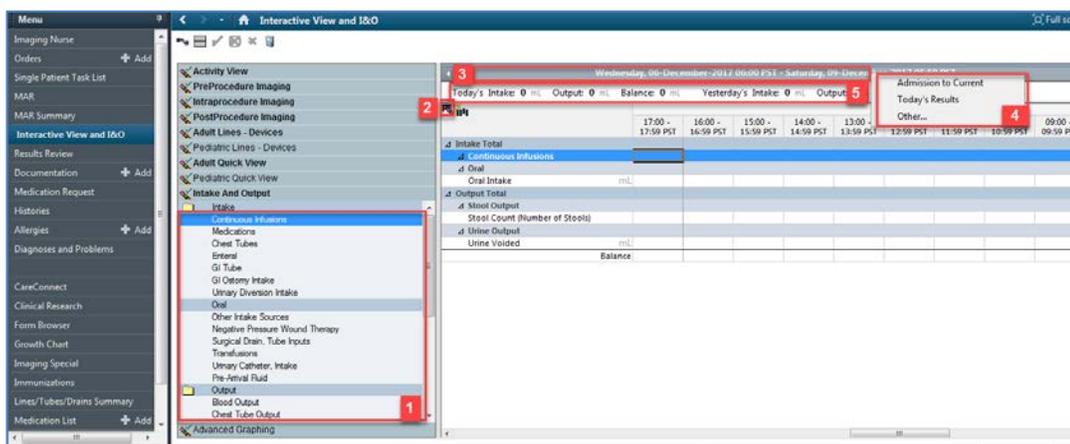
The dark grey highlighted sections (for example, Oral) are active and are automatically visible in the flowsheet.

2. To add other **Intake or Output sources**, you will need to click on the **Customize View icon**  to select the appropriate section to be added in.

3. The **grey information bar** indicates the date/time range that is currently set to be displayed.

4. To change the date/time range being displayed:
  - Right-click on the **grey bar** and select **a new date/time range** (Admission to Current, Today's Results or Other).

5. The I&O summary at the top of the flowsheet displays a quick overview of today's intake, output, balance, and more.



## Activity 7.2 – Review and Document in Intake and Output Record

1

Let's practice reviewing and documenting in the I&O record.

Previously a peripheral IV and sodium chloride infusion were initiated. An IV Vancomycin dose was also given.

Review that appropriate values are displayed in I&O record.

### 1. Continuous Infusions: sodium chloride 0.9%

- Double-click in each **hourly time column** since the sodium chloride infusion was initiated. Values will populate to reflect the order of 75mL/hr.



**NOTE:** A partial volume will display if the infusion was not initiated on the hour.

### 2. Medications: Vancomycin 1g

- Value should display as a single dose amount.

Values will pull from Medication Administration Wizard (MAW) documentation.

Wednesday, 13-December	
Today's Intake: 325 mL Output: 0 mL Balance: 325 mL	
16:00 - 16:59 PST	
<b>Intake Total</b>	325
<b>Continuous Infusions</b>	75
sodium chloride 0.9% (NS) continuous infusion 1,000 mL	mL 75
<b>Medications</b>	250
vancomycin + sodium chloride 0.9%	mL 250
Oral	
Oral Intake	mL
<b>Output Total</b>	
<b>Stool Output</b>	
Stool Count (Number of Stools)	
<b>Urine Output</b>	
Urine Voided	mL
<b>Balance</b>	325 mL

Now let's practice documenting some intake and output values. For this activity, your patient drank **50 mL** and voided **375 mL** and now you need to document these values.

1. Locate the **Oral and Urine Output** section in the I&O navigator.
2. In the flowsheet on the right, document the following by clicking into the appropriate cell.
  - Oral Intake = 50 mL
  - Urine Voided = 375 mL
3. Click **Sign**.

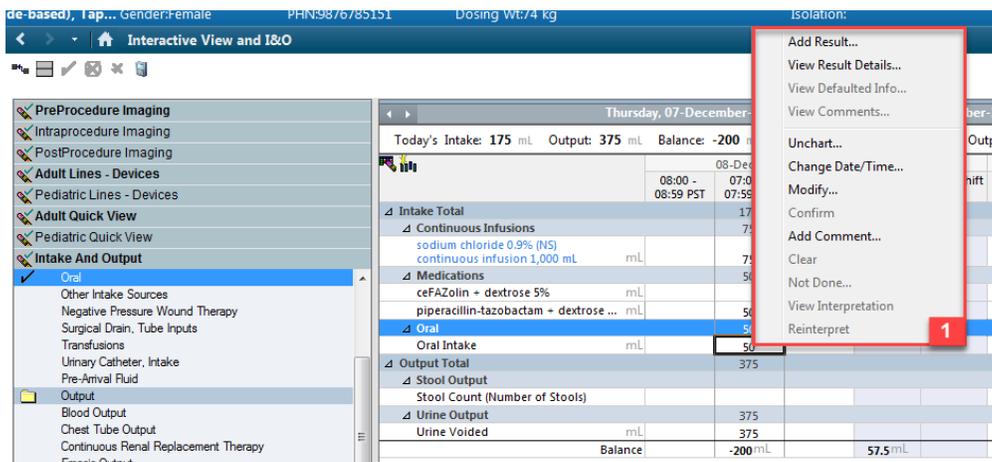
4. **12-hour shift balance** (0600-1759 hours & 1800-0559 hours) and **24-hour balance** are calculated by the system.



**NOTE:** It is important that you verify all volumes are entered correctly. The system automatically calculates fluid balances based on the volumes entered.

You can also unchart, modify or add a comment to any result.

1. Right-click on a cell to see additional functions.



### Key Learning Points

- Time columns are organized into hourly intervals with a column for a 12 hour (Day/Night Shift) Total and 24 Hour Total.
- Continuous infusion volumes will flow into I&O by double clicking on each hourly cell.
- IV medications need to have the Diluent Volume entered upon administration in order for the volume of the med to flow to I&O.
- Some values will require direct charting in the Intake and Output band e.g. oral intake
- It is important to verify all volumes in I&O are accurate. The system automatically calculates fluid balance totals based on these volumes.
- Values can be modified and uncharted within Interactive View and I&O.

## PATIENT SCENARIO 8 – PowerForms

### 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.

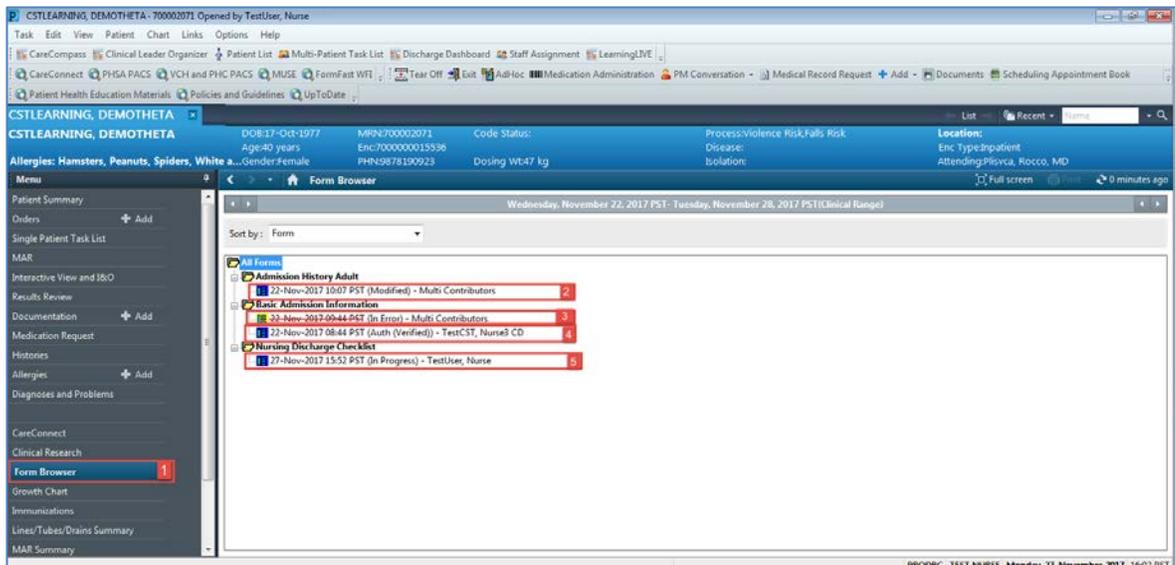
-  As a MI nurse you will be viewing the following PowerForms:
-  Viewing an existing PowerForm
-  Modifying an existing PowerForm
-  Uncharting an existing PowerForm

## Activity 8.1 – Viewing an Existing PowerForm

1 You may need to view previously documented PowerForms.

To view a **PowerForm**:

1. Select **Form Browser** in the **Menu**.
2. For a PowerForm that has been modified, (**Modified**) appears next to the title of the document.
3. For a PowerForm that has been entered incorrectly and has been uncharted, (**In Error**) appears next to the title of the document.
4. For a PowerForm that has been completed and signed, (**Auth (Verified)**) appears next to the title of the document.
5. When a PowerForm is saved, it is not complete and cannot be viewed by another user. (**In Progress**) appears next to the title of the document.



### Key Learning Points

- Existing PowerForms can be accessed through the Form Browser.
- A PowerForm can have different statuses (e.g. Modified, In Error, Auth Verified, and in Progress).

## PATIENT SCENARIO 9 – Document an Allergy

### Learning Objectives

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

- Document Allergies

### SCENARIO

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

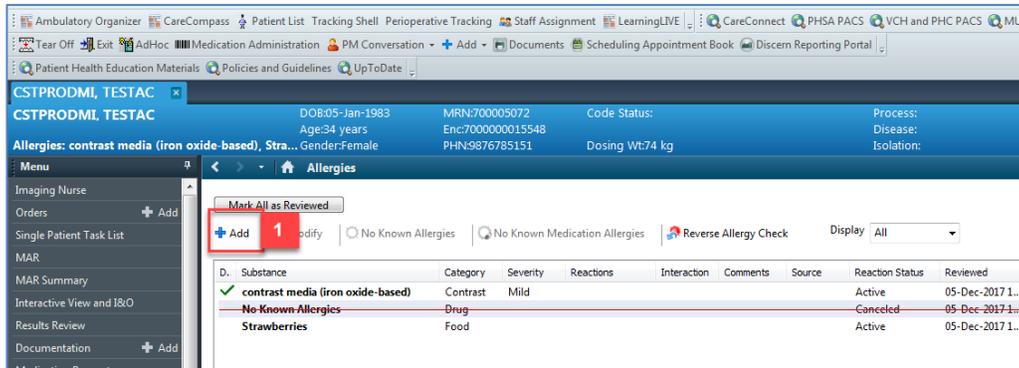
You will complete the following activity:

- Add an allergy

## Activity 9.1 – Add an Allergy

1 You notice mild redness to the patient’s skin where there is tape applied. The patient then states that he remembers having a similar allergic reaction years ago to tape, but forgot to mention it to the physician.

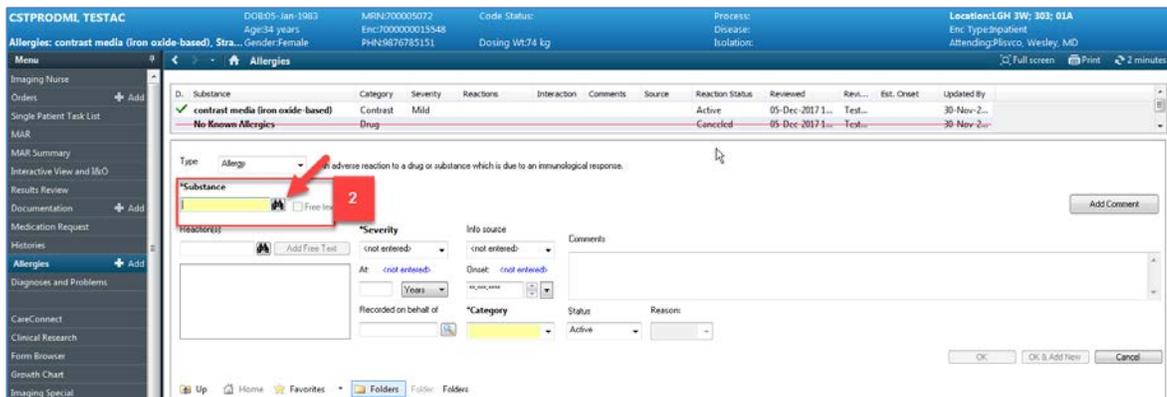
1. To document this tape as allergy, navigate to the Allergies section of the Menu and click **Add**.



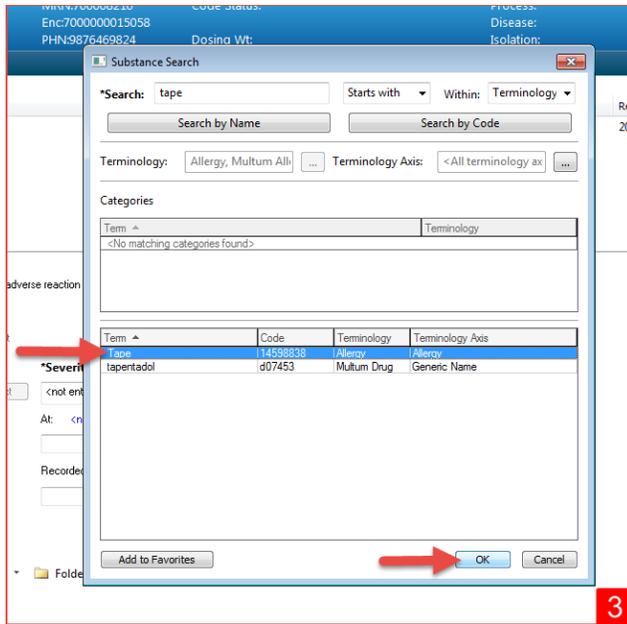
2. In the **Substance** field type = *Tape* and click the **Search** icon



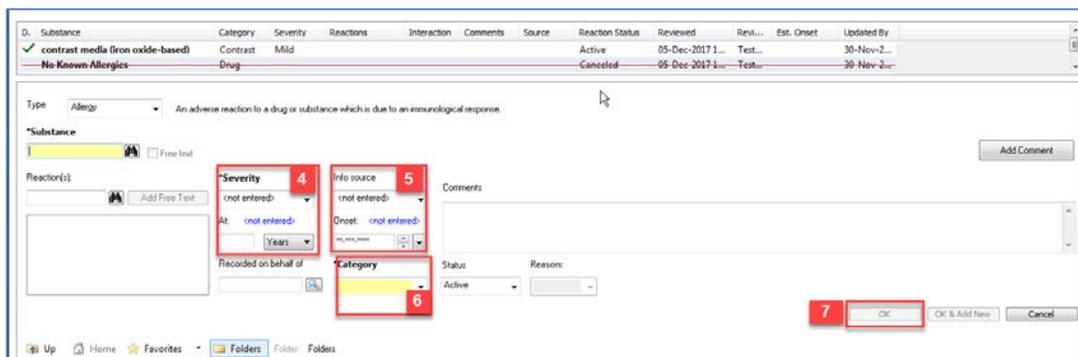
**NOTE:** Yellow highlighted fields including substance and category are mandatory fields that need to be completed.



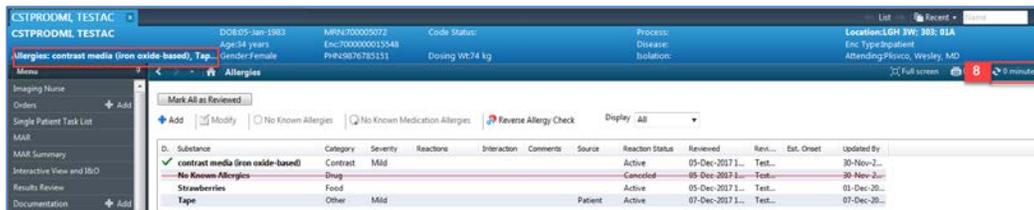
3. The **Substance Search** window opens. Select **Tape** and click **OK**.



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



8. Click the **Refresh** icon  and the tape allergy will now appear in the Banner Bar.



**NOTE:** Allergies in the banner bar are sorted by severity (most to least). In this case Penicillin causes a more severe reaction than Tape. 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 for all who access the patient's chart.
- Allergies will display with the most severe allergy listed first. Yellow fields are mandatory fields that need to be completed

## PATIENT SCENARIO 10 – Results Review

### Learning Objectives

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

- Review Patient Results
- Identify any Abnormal Results

### SCENARIO

In this scenario, you will review your patient’s results. One way to do this is result review.

You will complete the following activity:

- Review results using Results Review

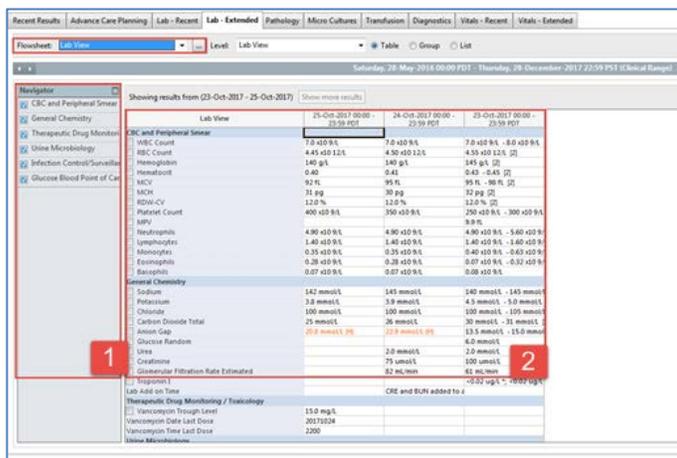
## Activity 10.1 – Using Results Review

Prior to an Interventional Radiology procedure, you may need to review your patient’s results. One way to do this is to navigate to **Results Review** from the Menu.

Results are presented using **flowsheets**. Flowsheets display clinical information recorded for a person such as labs, iView entries such as vital signs, cultures, transfusions and diagnostic imaging.

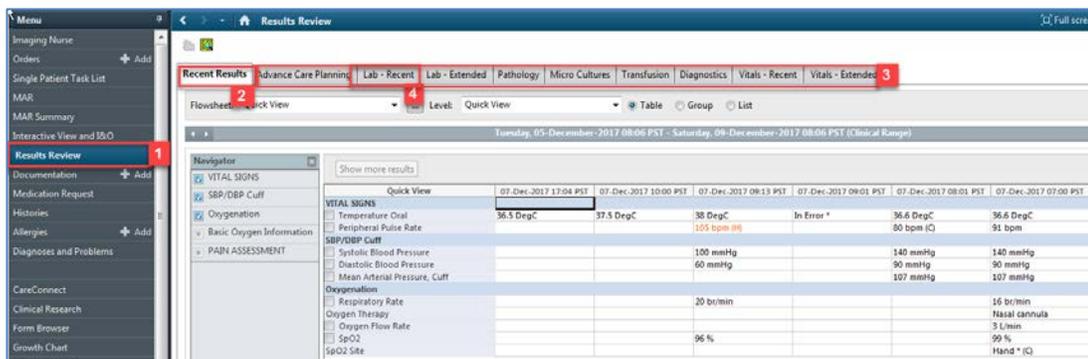
1 Flowsheets are divided into two major sections.

- The left section is the Navigator. By selecting a category within the navigator, you can view related results, which are displayed within the grid to the right.
- The grid to the right is known as Results Display.



Review the most recent results for your patient:

- Navigate to **Results Review** from the **Menu**.
- Review the **Recent Results** tab.
- Review each individual tab to see related results.
- Select **Lab - Recent**.



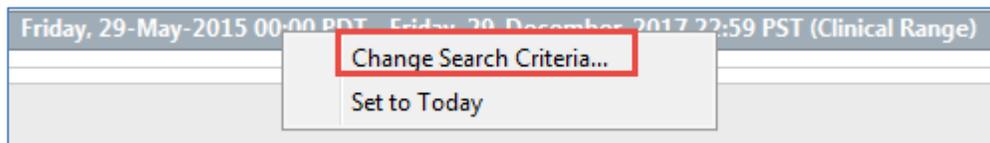
5. Review your patient’s recent lab results.

CBC and Peripheral Smear	
<input type="checkbox"/> WBC Count	1.5 x10 <sup>9</sup> /L (L)
<input type="checkbox"/> RBC Count	2.00 x10 <sup>12</sup> /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 <sup>9</sup> /L (L)
<input type="checkbox"/> NRBC Absolute	5.0 x10 <sup>9</sup> /L (H)
<input type="checkbox"/> Neutrophils	0.04 x10 <sup>9</sup> /L (L)
<input type="checkbox"/> Lymphocytes	0.15 x10 <sup>9</sup> /L (L)
<input type="checkbox"/> Monocytes	0.23 x10 <sup>9</sup> /L
<input type="checkbox"/> Eosinophils	0.01 x10 <sup>9</sup> /L
<input type="checkbox"/> Basophils	0.01 x10 <sup>9</sup> /L
<input type="checkbox"/> Metamyelocytes	0.73 x10 <sup>9</sup> /L (H)
<input type="checkbox"/> Myelocytes	0.23 x10 <sup>9</sup> /L (H)
<input type="checkbox"/> Promyelocytes	0.08 x10 <sup>9</sup> /L (H)
<input type="checkbox"/> Blast Cells	0.02 x10 <sup>9</sup> /L (H)
Blood Film Comment	Platelet Estimate - Decreased <span style="background-color: red; color: white; padding: 2px;">5</span>

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

6. Create a custom date range by right-clicking on the grey date bar and selecting **Change Search Criteria**.



7. Double-click on the results cell to get additional lab result details. for example a *Normal Low* or *Normal High* value, **double-click** the result.

Lab View	2018-Mar-06 00:00 - 23:59 PST
CBC and Peripheral Smear	
<input type="checkbox"/> WBC Count	10.3 (H)
<input type="checkbox"/> RBC Count	4.12 (L)
<input type="checkbox"/> Hemoglobin	120 g/L (L)
<input type="checkbox"/> Hematocrit	0.36 (L)

Result History

Value	Valid From	Valid Until
4.12	2018-Mar-06 07:30 PST	Current

**Result**    Action List

**RBC Count 4.12 (LOW)**

Normal Low 4.41    Normal High 5.71

Date/Time **TUESDAY, 2018-MARCH-06 07:30 PST**

Contributor System **TRAINDB\_SYS**

Accession Number **T885**

Status **AUTH (VERIFIED)**

[Trend](#)

8. You can also review previous Medical Imaging reports by clicking on the Diagnostics tab and double-clicking in the appropriate cell to view the final report.

9. Click the View Image  icon to see the images.

The screenshot shows a software interface with a top navigation bar containing tabs: 'Planning', 'Lab - Recent', 'Lab - Extended', 'Pathology', 'Microbiology Cultures', 'Microbiology Other', 'Transfusion', 'Diagnostics', 'Vitals - Recent', and 'Vitals - Extended'. The 'Diagnostics' tab is selected and highlighted with a red box. Below the navigation bar, there is a 'Level: Diagnostics View' dropdown and a 'Table' radio button. A table displays various diagnostic results with columns for 'Diagnostics View', '14-Mar-2018 11:15 PDT', and '15-Feb-2018 09:30 PST'. The table includes rows for 'Bone Density', 'Computed Tomography', 'Diagnostic Radiology', and 'Interventional'. The 'Interventional' row, specifically 'IR Venogram Renal Bilateral', is highlighted with a red box. To the right of the table is a 'Document Viewer' window titled 'Document Viewer - CSTPRODMI, KIM - 700006948'. It contains a toolbar with a 'View Image' icon (a green square with a white image icon) highlighted with a red box. The document content shows a '\* Final Report \*' with sections for 'Reason For Exam', 'Report', 'EXAM TYPE', 'HISTORY', 'COMPARISON', and 'FINDINGS'.

### 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.
-  Lab results are coloured to represent low, normal, high and critical values.
-  View additional details of a result by double-clicking the value.

## PATIENT SCENARIO 11 – End of Medical Imaging Procedure Activities

### Learning Objectives

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

- Perform End of Medical Imaging Procedure Activities

### SCENARIO

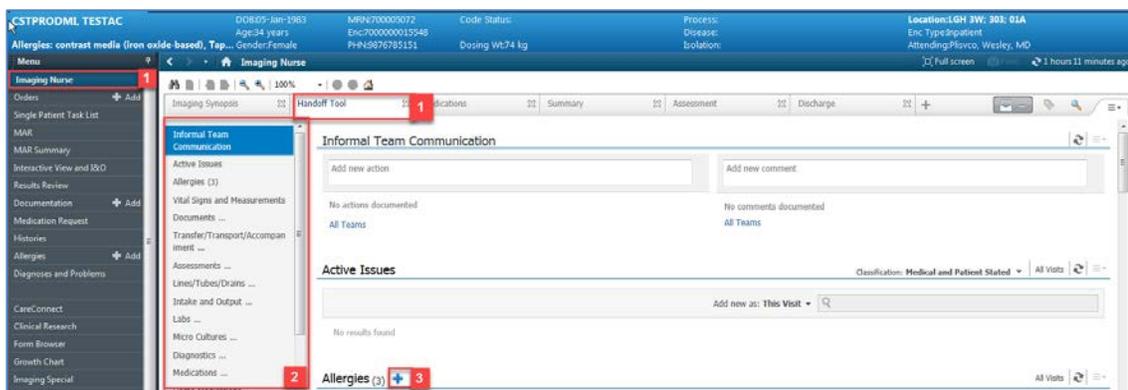
After a medical imaging procedure, you may either transfer a patient back to an inpatient unit or discharge an outpatient client home.

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

- Handoff Tool
- Documenting Handoff in iView
- Locate and complete a Transport Ticket for Patient Transfer
- Printing a patient discharge summary

## Activity 11.1 – Handoff Tool

- 1 Your patient's CT chest procedure has completed. They are ready to transfer back to the inpatient unit. You are going to use hand off tool to give report to patient's primary nurse.
  1. Navigate to **Imaging Nurse** from the Menu. In **Imaging Nurse** page, select **Handoff Tool Tab**.
  2. Scroll down the page or access each component by clicking within the Handoff components on the left.
  3. This is where you can add any missing information if required.



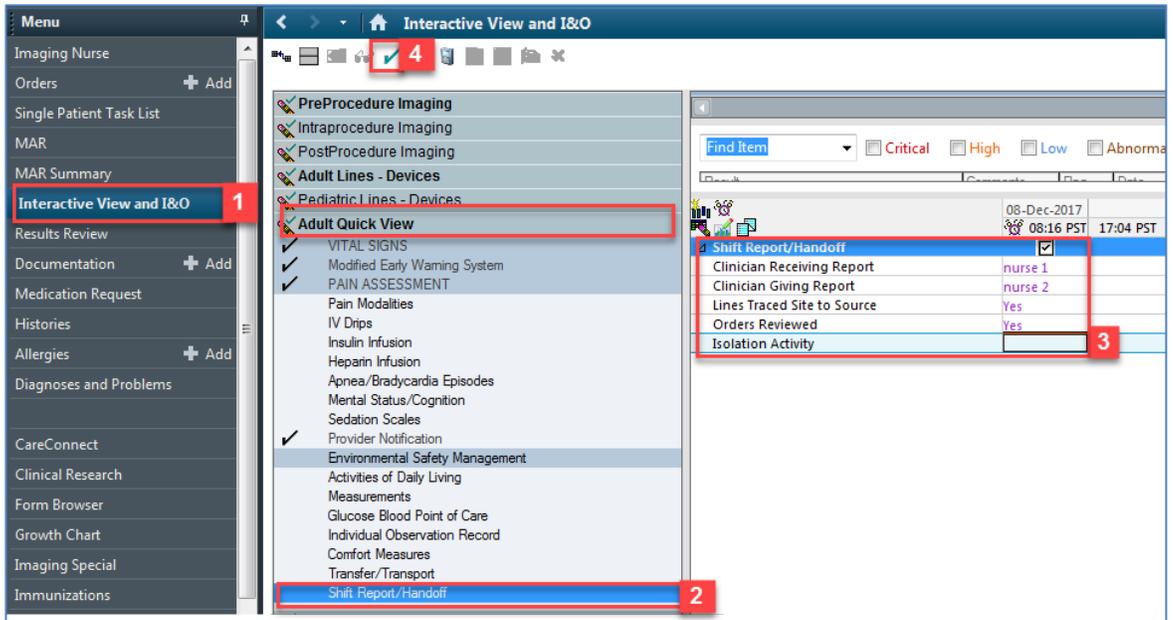
### Key Learning Points

- Prior to transferring patient back to inpatient unit after a medical imaging procedure has completed, use the Handoff Tool to review patient information with the primary nurse.

## Activity 11.2 – Documenting Handoff in iView

1 Document that you have given Report or Handoff in iView by completing the following steps:

1. Select **Interactive View and I&O** from the **Menu**.
2. Select **Shift Report/Handoff** section from **Adult Quick View**.
3. Document using the following data:
  10. Clinician Receiving Report = *Nurse 1*
  11. Clinician Giving Report = *Nurse 2*
  12. Lines Traced Site to Source = *Yes*
  13. Orders Reviewed = *Yes*
  14. Isolation Activity = *leave blank if not on isolation*
4. Sign  your documentation.



The screenshot shows the iView software interface. On the left is a 'Menu' sidebar with 'Interactive View and I&O' highlighted (marked with a red box and '1'). The main window is titled 'Interactive View and I&O' and shows a list of categories. 'Adult Quick View' is selected (marked with a red box and '2'), and 'Shift Report/Handoff' is selected at the bottom (marked with a red box and '2'). A form for 'Shift Report/Handoff' is displayed on the right, with the following data entered (marked with a red box and '3'):

Find Item	Critical	High	Low	Abnormal
Shift Report/Handoff	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinician Receiving Report				nurse 1
Clinician Giving Report				nurse 2
Lines Traced Site to Source				Yes
Orders Reviewed				Yes
Isolation Activity				

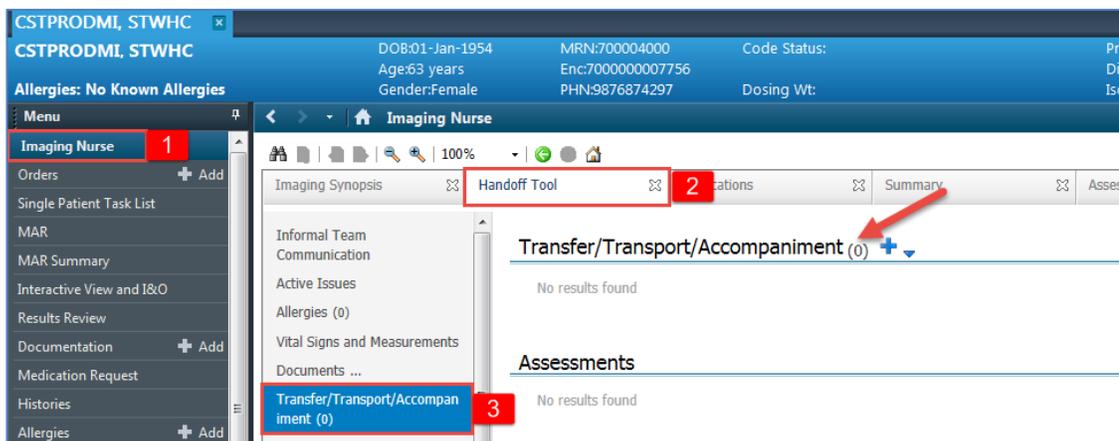
### Key Learning Points

-  Document that you have given or received report in the **Shift Report/Handoff** section in iView.

## Activity 11.3 – Transport Ticket

With the implementation of the Clinical Information System (CIS), porters or clinicians transporting the patient will no longer have a paper chart readily available for patient information. The **Transport Ticket** is a printable form that captures key patient information that is critical to the patient's condition and care needs. Some of this information includes allergies, transfer to and from, mode of transportation and equipment. This ticket travels with the patient during transport and allows information to be communicated to clinicians and porters.

- 1 Now that your patient is ready to return to their inpatient unit, you are required to complete a Transport Ticket. Let's locate the Transport Ticket
  1. Navigate to the **Imaging Nurse** page from the Menu.
  2. Select the **Handoff Tool** tab.
  3. Select the **Transfer/Transport/Accompaniment** component from the menu within the Handoff Tool.



4. Click the downward arrow ▼ icon, Do **not** click on the + sign.
5. Select **Transport Ticket** to open up the Transport Ticket PowerForm.



## Key Learning Points

- Prior to the porter or clinician transporting a patient back to their inpatient unit, a Transport Ticket must be completed.
- The Transport Ticket is a printable form that captures key patient information that is critical to the patient's condition and care needs.
- The Transport Ticket is located in the Handoff Tool tab of the Imaging Nurse page.

## Activity 11.4 – Complete a Transport Ticket

1 Now that you have located the Transport Ticket, let's complete the ticket and print it out for the porter so that the patient can return to his inpatient unit. For this scenario, let's assume your patient is returning to 4W. Enter the following information in the Transport Ticket:

1. In the **Transfer To** component, enter = *4 West*
2. In the **Transfer From** component, enter = *Medical Imaging*
3. In the **Mode of Transport** component, select: **Stretcher**
4. In the **Equipment Accompanying Patient** component, select: **IV pump**
5. After reviewing the ticket and its components, click the **Sign**  button and refresh the Imaging Nurse page by clicking the **Refresh**  0 minutes ago icon.

The screenshot shows a web browser window with the title "Transport Ticket - CSTPRODML, STWHC". The browser address bar shows "http://localhost:5000/TransportTicket.aspx?PatientID=1418&PST=PST". The page content includes a header "Transport Ticket" and several sections:

- Status Orders and Allergies:** "No qualifying data available." and "Allergies: No Known Allergies".
- Active Process Alerts:** A grid of checkboxes for various alerts such as "Communication barrier", "Gender sensitivity", "Palliative care", etc.
- Transfer From and To/Mode/Equipment:** This section contains three main areas:
  - Transfer To:** A text box containing "4 West" (highlighted with a red box and number 1).
  - Transfer From:** A text box containing "Radiology" (highlighted with a red box and number 2).
  - Mode of Transport:** A group box with radio buttons for "Stretcher" (selected), "Ambulatory", "Wheelchair", "Carried", "Bed", and "Other:" (highlighted with a red box and number 3).
- Equipment Accompanying Patient:** A grid of checkboxes for various pieces of equipment. The "IV pump" checkbox is checked (highlighted with a red box and number 4).



**NOTE:** There is a free-textbox at the bottom of the ticket that allows you to input any pertinent information. For example, patient was administered Lorazepam for anxiety prior to the diagnostic test.

2

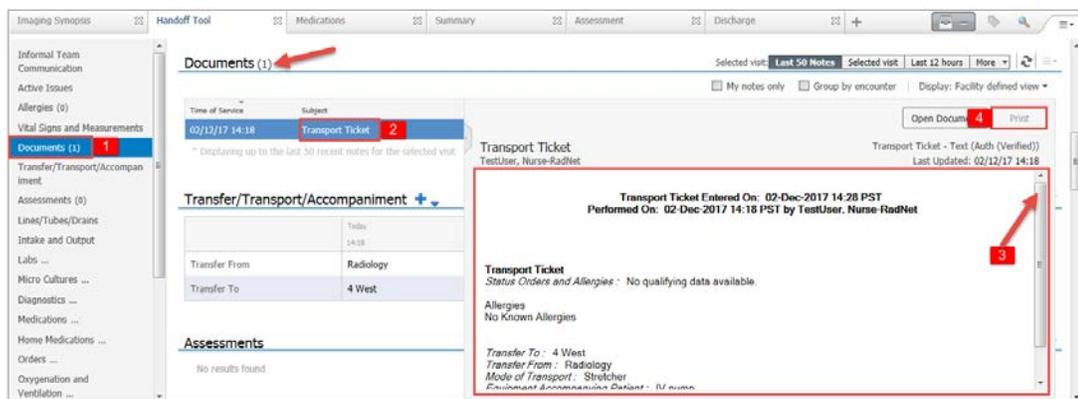
Now that you have completed the Transport Ticket, print a copy of this PowerForm for the porter prior to transport.

1. Select the **Documents** component from the menu within the Handoff Tool to navigate to the Documents section.
2. Click on the **Transport Ticket** that you just completed.
3. Review the Transport Ticket by using the scrolling feature.



**NOTE:** This is a quick view of the document. The full document can also be opened in a new window by clicking the Open Document  button.

4. Click the **Print**  button. Since you are not connected to a printer in the learning setting, the Print button is dithered.



Also note that transportation details including transfer to and from, and time that you documented are now present on the Handoff Tool for anyone accessing the patient's chart to see.



## Key Learning Points

- Information included on the Transport Ticket includes some of the following: allergies; transfer to and from; mode of transportation; and equipment.
- The Transport Ticket must be printed for the porter or clinician prior to transfer.
- The transportation details that you document in the PowerForm including transfer to and from, and time automatically flow to the Handoff Tool for anyone accessing the patient's chart to see.

## PATIENT SCENARIO 12 – Patient Management (PM) Conversation

### Learning Objectives

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

- Utilize PM Conversation

### SCENARIO

Unit clerks will often update the patient information in the system. In some situations, the nurse will need to update patient information such as process alerts (e.g. falls risk alert) in the chart or communicating with bed management in regards to transferring/discharging patients. In this scenario, you will be reviewing PM Conversation and some of its functionalities. You will then learn to add a process alert.

As an MI nurse you will complete the following activities:

- Use PM Conversation to process an alert
- Use PM Conversation to discharge a patient

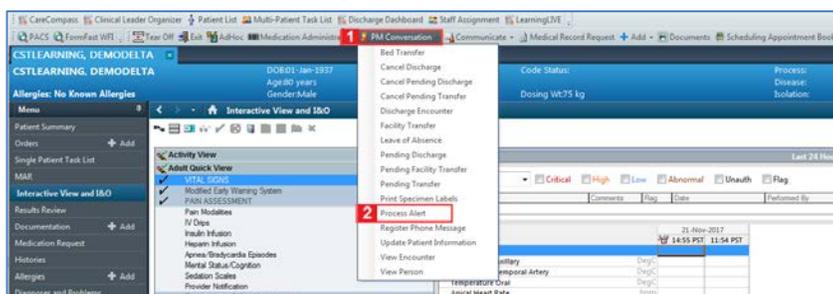
## Activity 12.1 – Process Alert

- 1 Patient Management (PM) Conversation provides access to manage alerts (such as violence risk, falls risk or isolation precautions), patient location, encounter information and demographics. 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 any clinician including nurses.

For instance, a patient presents with violent behaviours. The violence alert should be added to the patient's chart. To do this:

1. Click the drop-down arrow within **PM Conversation**  in the Toolbar.
2. Select **Process Alert** from the drop-down menu.



An organization window will display to select location.

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

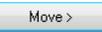


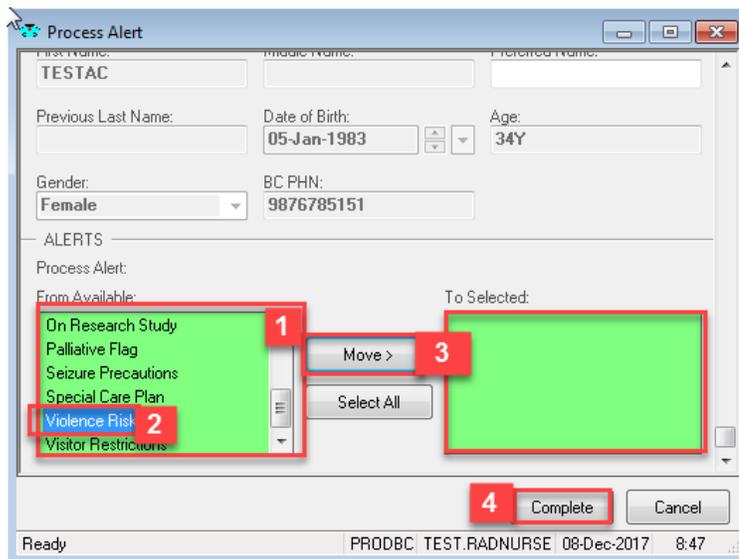
2 The **Process Alert** window displays. To activate the **Violence Alert** on the patient’s chart:

1. Click into the **Process Alert** box. A list of alerts that can be applied to the patient will display.



**NOTE:** The box will either contain previously recorded Process Alerts or this box will be empty until you click into it.

1. Select **Violence Risk**.
2. Click **Move**  The alert will now display within the **To Selected** box.
3. Click **Complete**.



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



**IMPORTANT:** Process alerts are Person level alerts that stay on the patient record across encounters until they are manually removed.

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 those who access the patient’s chart.



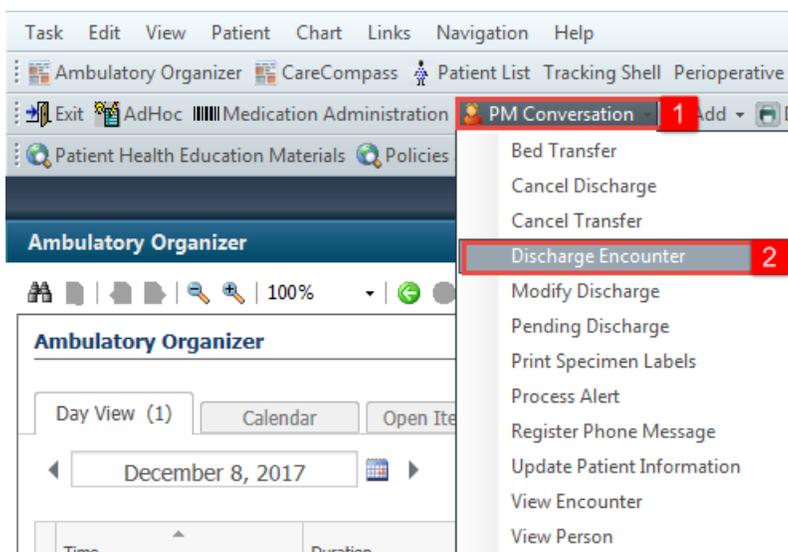
## Key Learning Points

- Using PM Conversation allows you to manage alerts, patient location, encounter information and demographics.
- Updating Process Alerts in PM Conversation allows clinicians to see specific concerns related to the patient in the Banner Bar.

## Activity 12.2 – Using PM Conversation to Complete Discharge Process [Review only, do not complete with your patient]

1 If the patient is registered for an IR procedure with an encounter type of Daycare Surgery, Outpatient in a Bed, or Minor Procedure, they must be manually discharged upon leaving the department. To do this:

1. Click the drop-down arrow within **PM Conversation**  in the Toolbar.
2. Select **Discharge Encounter** from the drop-down menu.



3. **Discharge Encounter** window. Enter the following in the yellow highlighted mandatory fields:

15. **Discharge Disposition** = Discharge home without support services.

16. **Discharge Date** = Today's date.

17. **Discharge Time** = Time when patient left.

4. Click **Complete** button when done.

The screenshot shows the 'Discharge Encounter' window. The 'Discharge Disposition', 'Discharge Date', and 'Discharge Time' fields are highlighted in yellow. The 'Complete' button is also highlighted with a red box. The window contains the following information:

Medical Record Number: 760000886	Encounter Number: 760000000886	Full Name: MI-Nurse, Lillian	Date of Birth: 02-Feb-1936	Age: 82Y	Gender: Female
BC PHN: 0760000886					
Encounter Type: Inpatient	Medical Service: General Internal Medicine	Facility: LGH Lions Gate	Building: LGH Lions Gate	Unit/Clinic: LGH 6W	Room: 603
Bed: 01	Isolation Precautions:				
Registration Date: 11-Jan-2018	Registration Time: 05:56	Patient Admit Date: **_**_****	Patient Admit Time:		
Discharge Information					
Discharge Disposition:	Discharge Date: **_**_****	Discharge Time: **_**_****	Discharge Username: Train, Nurse-RADNET2		
Deceased Details					
<input type="button" value="Complete"/> <input type="button" value="Cancel"/>					

### Key Learning Points

- Using PM Conversation to complete patient discharge process.

## PATIENT SCENARIO 13 – Exploring RadNet and Completing an Exam

### Learning Objectives

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

- View RadNet and Online Worklist
- Start and Complete an exam in RadNet

### SCENARIO

As an MI nurse you will complete the following activities:

- Start and Complete an exam in RadNet

## Activity 13.1 - Exploring RadNet

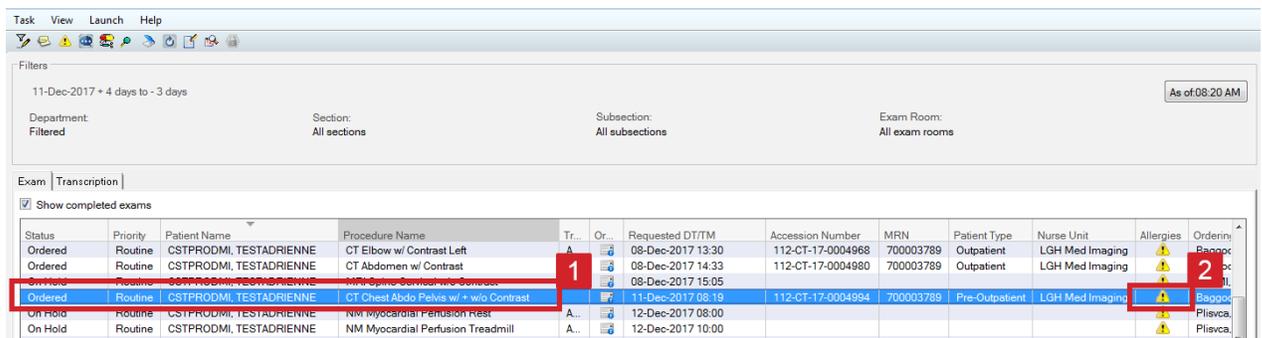
This software is a Radiology Information System (RIS) and is used by clerical staff and technologists to manage daily tasks in your department. As an MI Nurse you will likely not be working in RadNet that often however for situations when you do not have access to a tech or clerk you will need to **start** and **complete** an exam.

For further Education regarding **RadNet**, please consider taking the e-learning module, which will go over the main functionalities of **RadNet** including: **Department Order Entry (DOE), Online WorkList, Exam Management, and Order Viewer.**

Sign in and open RadNet **Online Work List**. Ask your instructor about filters if you cannot find your patient.

1

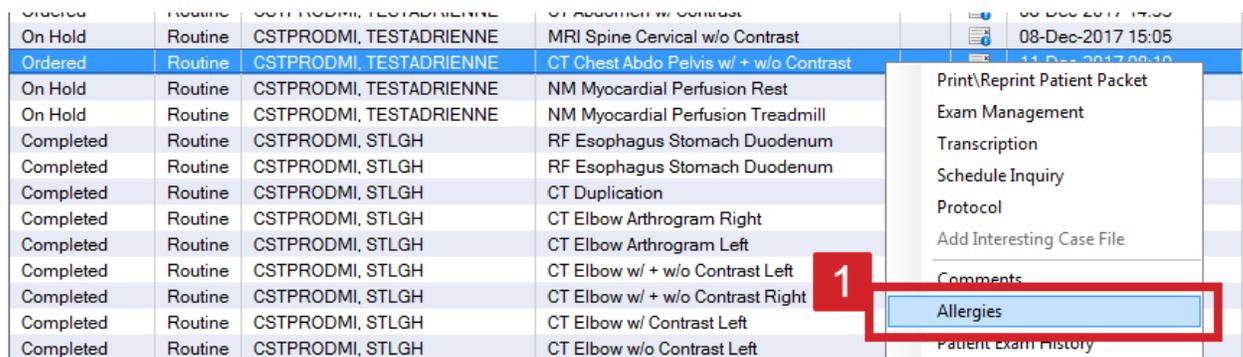
Open the **Online Work List**  from Store Front. Review the exams placed on your patient (1). You observe the **Allergy Alert** (2) and as per guidelines, you check the allergies.



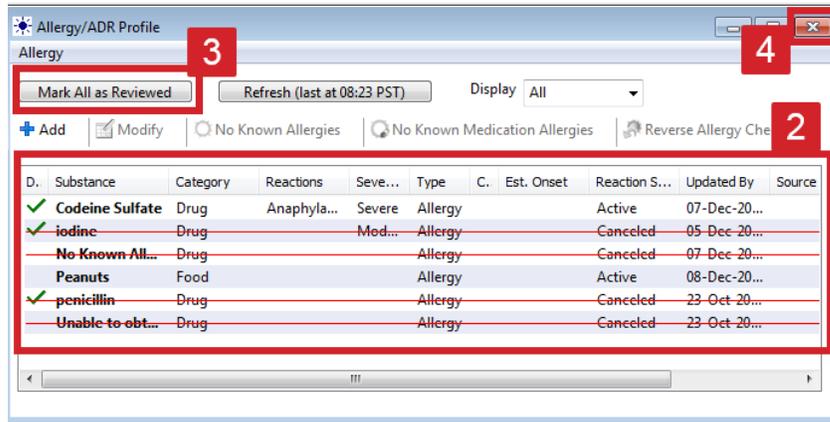
Status	Priority	Patient Name	Procedure Name	Tr...	Or...	Requested DT/TTM	Accession Number	MRN	Patient Type	Nurse Unit	Allergies	Orderin...
Ordered	Routine	CSTPRODMI, TESTADRIENNE	CT Elbow w/ Contrast Left			08-Dec-2017 13:30	112-CT-17-0004968	700003789	Outpatient	LGH Med Imaging		2
Ordered	Routine	CSTPRODMI, TESTADRIENNE	CT Abdomen w/ Contrast			08-Dec-2017 14:33	112-CT-17-0004980	700003789	Outpatient	LGH Med Imaging		
Ordered	Routine	CSTPRODMI, TESTADRIENNE	CT Chest Abdo Pelvis w/ + w/o Contrast			11-Dec-2017 08:15	112-CT-17-0004994	700003789	Pre-Outpatient	LGH Med Imaging		
On Hold	Routine	CSTPRODMI, TESTADRIENNE	NM Myocardial Perfusion Rest	A...		12-Dec-2017 08:00						
On Hold	Routine	CSTPRODMI, TESTADRIENNE	NM Myocardial Perfusion Treadmill	A...		12-Dec-2017 10:00						

2

Select your patient to highlight it in blue, right-click and select **Allergies**. The Allergy/ ADR Profile will open. Review the Allergies. Click on **Mark All as Reviewed** and close the pop-up window.



On Hold	Routine	CSTPRODMI, TESTADRIENNE	MRI Spine Cervical w/o Contrast			08-Dec-2017 15:05						
Ordered	Routine	CSTPRODMI, TESTADRIENNE	CT Chest Abdo Pelvis w/ + w/o Contrast			11-Dec-2017 08:15						
On Hold	Routine	CSTPRODMI, TESTADRIENNE	NM Myocardial Perfusion Rest									
On Hold	Routine	CSTPRODMI, TESTADRIENNE	NM Myocardial Perfusion Treadmill									
Completed	Routine	CSTPRODMI, STLGH	RF Esophagus Stomach Duodenum									
Completed	Routine	CSTPRODMI, STLGH	RF Esophagus Stomach Duodenum									
Completed	Routine	CSTPRODMI, STLGH	CT Duplication									
Completed	Routine	CSTPRODMI, STLGH	CT Elbow Arthrogram Right									
Completed	Routine	CSTPRODMI, STLGH	CT Elbow Arthrogram Left									
Completed	Routine	CSTPRODMI, STLGH	CT Elbow w/ + w/o Contrast Left									
Completed	Routine	CSTPRODMI, STLGH	CT Elbow w/ + w/o Contrast Right									
Completed	Routine	CSTPRODMI, STLGH	CT Elbow w/ Contrast Left									
Completed	Routine	CSTPRODMI, STLGH	CT Elbow w/o Contrast Left									



3

Check your patient’s exam history in order to see what other orders were placed and completed on this patient. From any of the orders placed on the patient, right-click to access the drop-down menu and click on **Patient Exam History**.

Status	Priority	Patient Name	Procedure Name	Tr...	Or...	Requested DT/TM
On Hold	Routine	CSTPRODMI, TESTADRIENNE	MRI Spine Cervical w/o Contrast			08-Dec-2017 15:05
Ordered	Routine	CSTPRODMI, TESTADRIENNE	CT Chest Abdo Pelvis w/ + w/o Contrast			
On Hold	Routine	CSTPRODMI, TESTADRIENNE	NM Myocardial Perfusion Rest			
On Hold	Routine	CSTPRODMI, TESTADRIENNE	NM Myocardial Perfusion Treadmill			
Completed	Routine	CSTPRODMI, STLGH	RF Esophagus Stomach Duodenum			
Completed	Routine	CSTPRODMI, STLGH	RF Esophagus Stomach Duodenum			
Completed	Routine	CSTPRODMI, STLGH	CT Duplication			
Completed	Routine	CSTPRODMI, STLGH	CT Elbow Arthrogram Left			
Completed	Routine	CSTPRODMI, STLGH	CT Elbow Arthrogram Right			
Completed	Routine	CSTPRODMI, STLGH	CT Elbow w/ + w/o Contrast Right			
Completed	Routine	CSTPRODMI, STLGH	CT Elbow w/ + w/o Contrast Left			
Completed	Routine	CSTPRODMI, STLGH	CT Elbow w/ Contrast Right			
Completed	Routine	CSTPRODMI, STLGH	CT Elbow w/ Contrast Left			

Print/Reprint Patient Packet

Exam Management

Transcription

Schedule Inquiry

Protocol

Add Interesting Case File

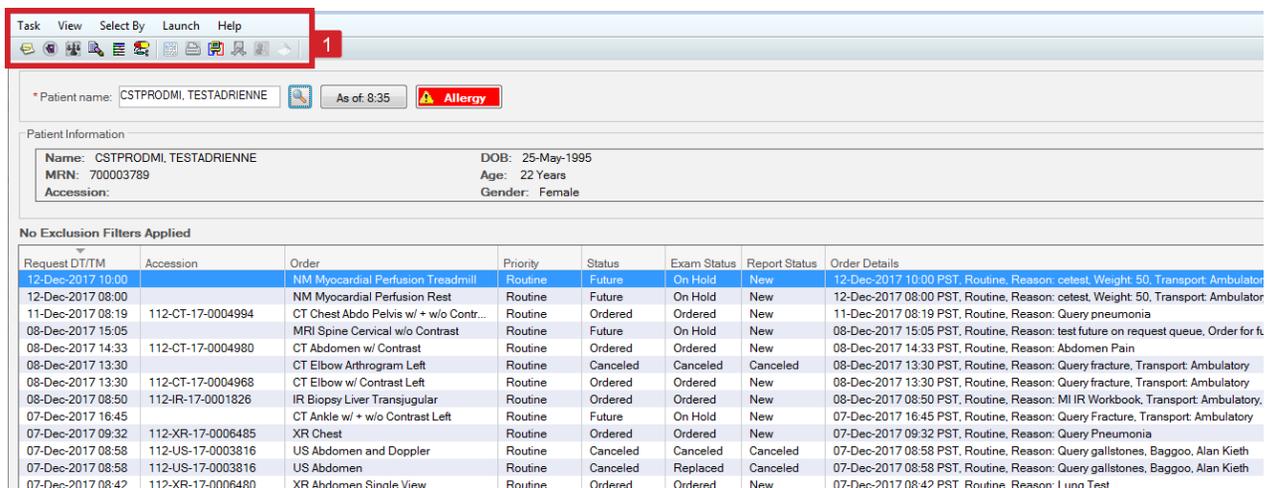
Comments

Allergies

**Patient Exam History**

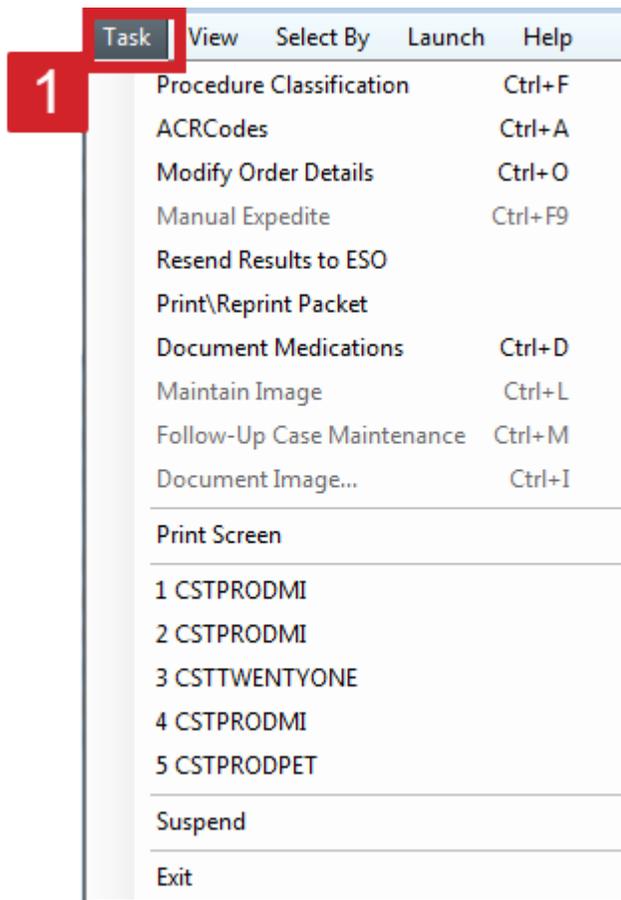
4

The **Order Viewer** will open. Here you can see displayed the entire list of orders placed on the patient, and their status. The **menu bar** (1) allows you to see what other functions you are able to do from here. Click to explore.

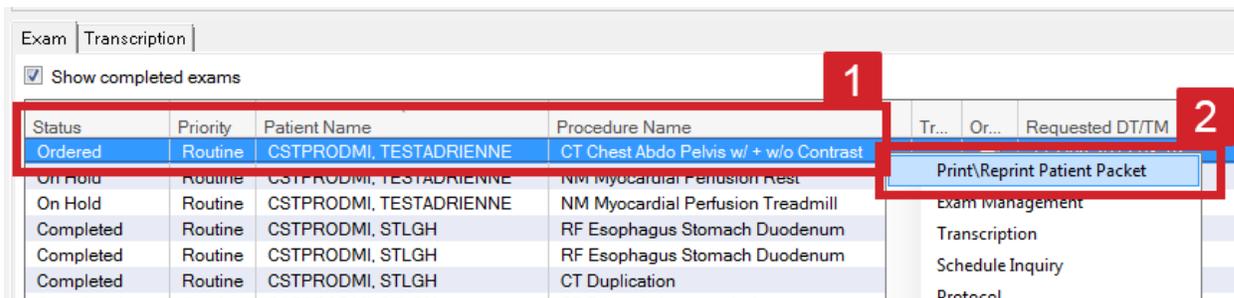


5 Click on **Task** (1) in the menu bar.

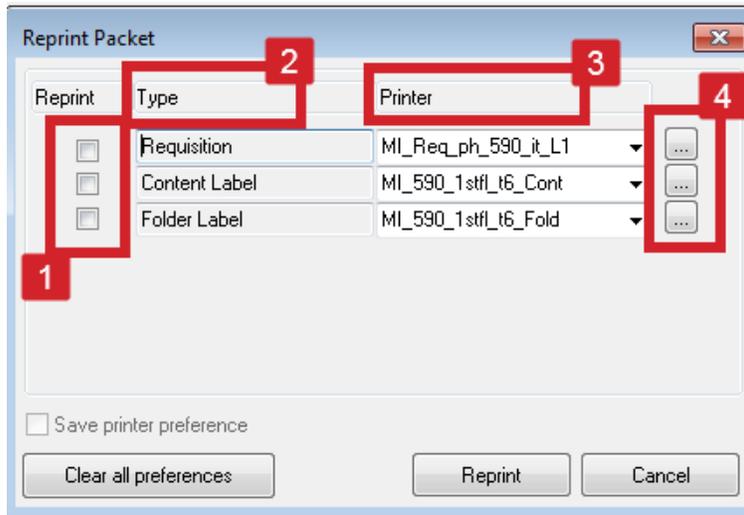
Note that there are a series of tasks that can be performed from the **Order List** in **Order Viewer**, such as **Modify Order Details** or **Print\Reprint the Patient Packet**. When you are finished looking these over. Click to close the **Order Viewer** and return to the **Online Work List**.



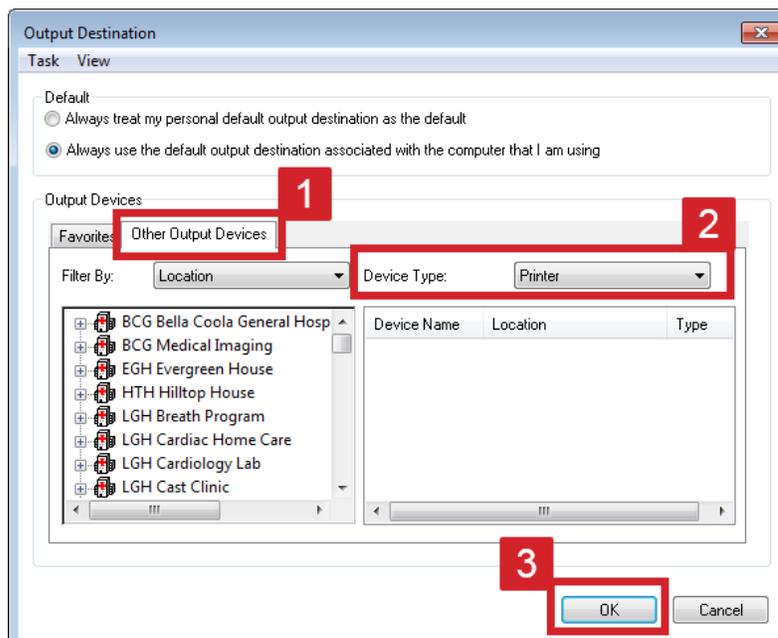
6 You can also do some of these functions directly from the Online Work List. You need to re-print the patient packet (requisition and labels) from the CT chest w/ Contrast. Select the exam (1), right-click on the exam and select **Print\Reprint Patient Packet** (2).



- 7 The **Reprint Packet** window opens. Click on checkboxes to choose the document you want to print (1). The type of document can be selected (2) as well as the specific printer (3). Click on the ellipsis button (4) to choose the printer and the location. It will automatically default to the pre-selected printer.



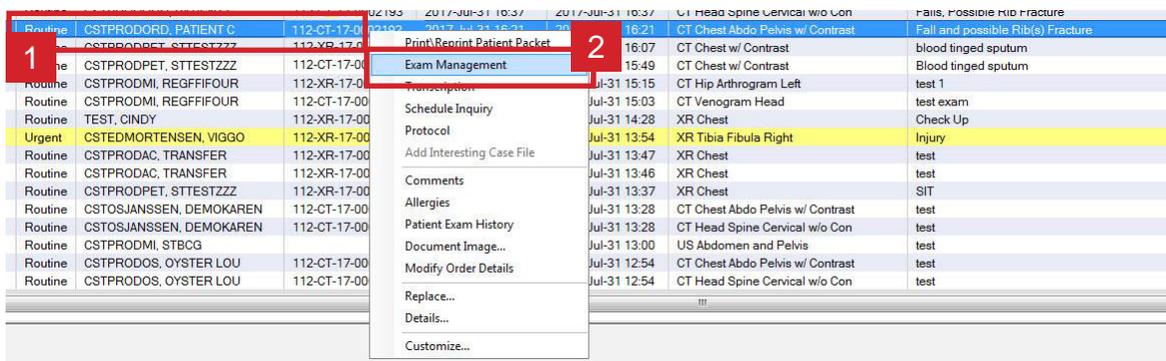
- 8 If you need to change the printer location, from the **Output Destination** pop up window you can choose new output device (1), the location, and the type (2). Click **OK** when you are done (3).



## Activity 13.2 – Start and Complete an Exam

Finally you will now learn to start and complete exams.

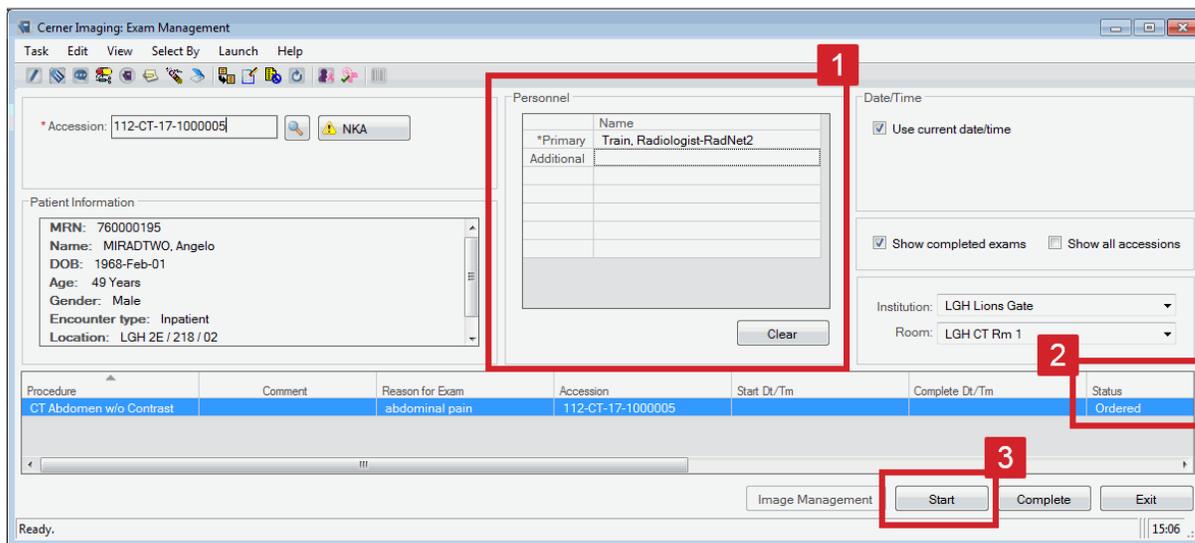
- 1 From the Online Worklist, you will choose the **CT Chest w/ Contrast** in order to complete the exam. Select the exam (1), right-click and choose **Exam Management** from the drop-down menu (2).



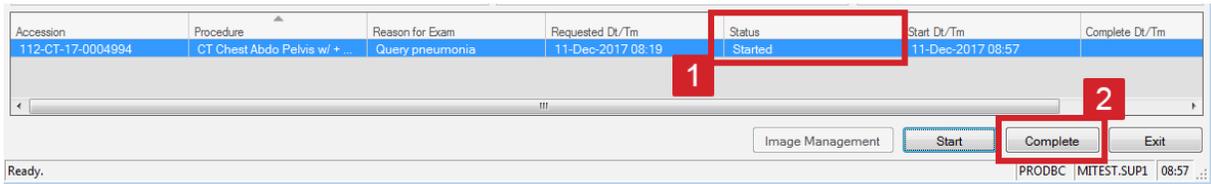
- 2 Verify the **Personnel** list (1) to ensure all relevant personnel are included. The exam appears listed in the working window (2) with the status of **Ordered**. Click on **Start** (3).



**NOTE:** it is important to click on **Start** before the patient comes into the room in order to avoid non-MI staff cancelling or modifying the exam while it is in progress.

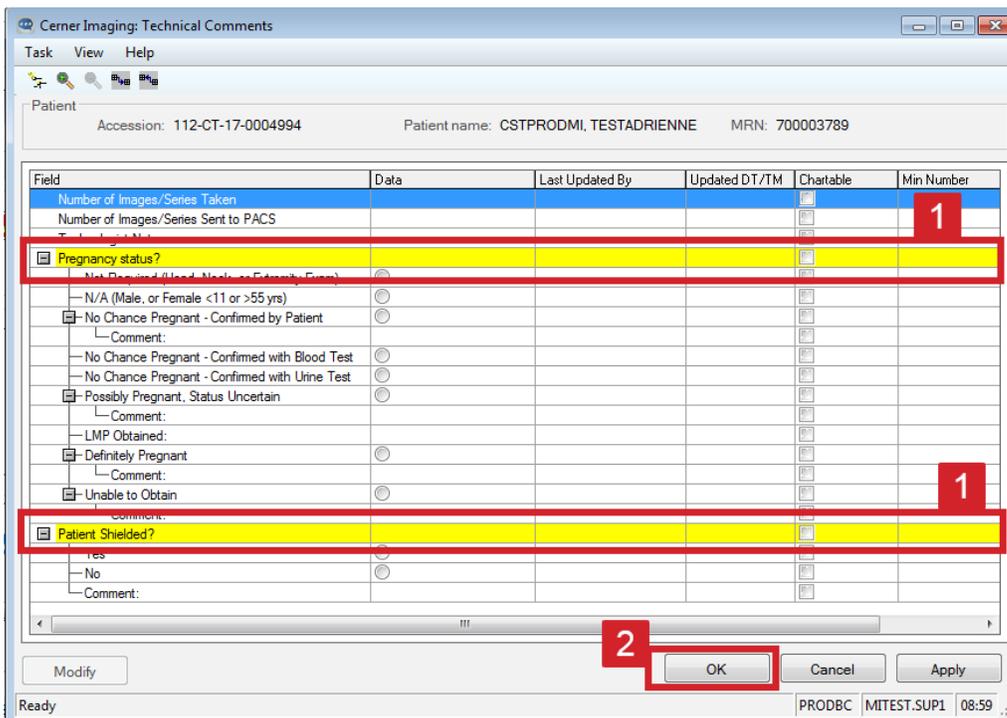


3 The exam status changes to Started (1). When the exam is done, click **Complete** (2).



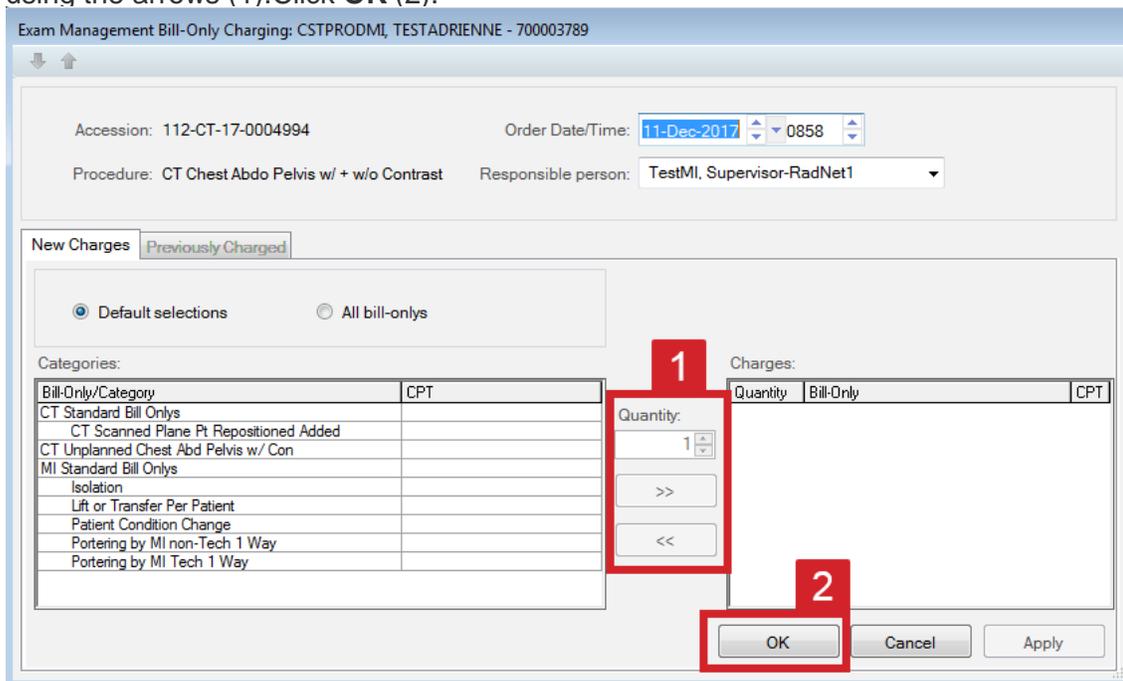
4 The **Technical Comments** window pops-up. Complete the yellow highlighted required fields: **Pregnancy Status** (1) and **Patient Shielded** (2). When done click OK (3).

**NOTE:** There are different required fields depending on the modality and/or the exam.



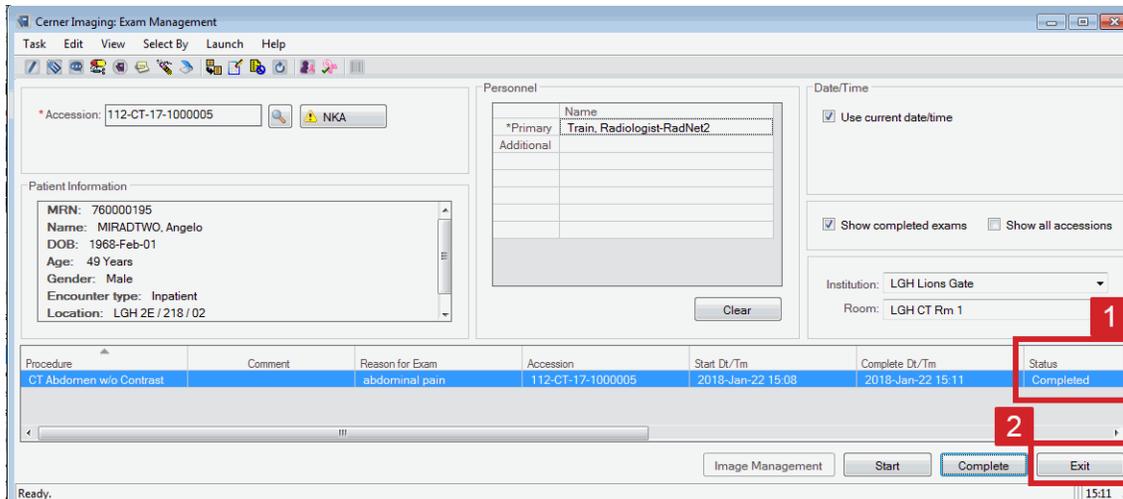
5

The **Bill Only Charging** window opens. If needed, select the Bill-Only Categories to be attached to the exam and move them into the **Charges** window specifying the Quantity and using the arrows (1). Click **OK** (2).



6

After completion, the exam will say completed in the working space. Click **Exit**.



7

On the **Online Work List**, the exam status will be changed to **Completed** (1) if the Show completed exams (2) is selected. Click **Refresh** if you don't see the exam. Click **Exit** (3).

Show completed exams

Status	Priority	Name	Procedure Name	Transport Mode	Or...	Requested DT/TM	Accession Number	MRN	Patient Type	Nurse
Ordered	Urgent	CSTDEMOBRADLEY, DONOTDI...	XR Chest			21-Nov-2017 16:38	112-XR-17-0006275	700008147	Emergency	LGH E
Ordered	Urgent	CSTDEMOCHRIS, DONOTUSE	XR Chest			22-Nov-2017 08:54	112-XR-17-0006282	700008281	Emergency	LGH E
Completed	Urgent	CSTEDHONG, JACK	RF Wrist Right			21-Nov-2017 21:16	425-RF-17-0001964	700005980	Emergency	WHC I
Ordered	Urgent	CSTEDTEST, LUCY	XR Forearm Left			23-Nov-2017 09:14	112-XR-17-0006294	700007742	Emergency	LGH E
Canceled	Urgent	CSTEDTEST, LUCY	XR Wrist Left			23-Nov-2017 09:14	112-XR-17-0006293	700007742	Emergency	LGH E
Ordered	STAT	CSTEDTEST, TANYA	CT Spine Cervical w/o Contrast			23-Nov-2017 09:38	112-CT-17-0004419	700008285	Emergency	LGH E
Ordered	STAT	CSTEDTEST, TANYA	CT Head w/o Contrast			23-Nov-2017 09:38	112-CT-17-0004418	700008285	Emergency	LGH E
Ordered	STAT	CSTEDTEST, TANYA	XR Wrist Right			23-Nov-2017 09:38	112-XR-17-0006296	700008285	Emergency	LGH E
Ordered	STAT	CSTEDTEST, TANYA	XR Chest	Portable		23-Nov-2017 09:38	112-XR-17-0006295	700008285	Emergency	LGH E
Ordered	STAT	CSTEDTEST, TANYA	CT Chest/Abdo Pelvis w/ Contrast			23-Nov-2017 09:38	112-CT-17-0004420	700008285	Emergency	LGH E
Ordered	Routine	CSTOSVECINA, DEMORAISA	XR Pelvis			23-Nov-2017 09:55	112-XR-17-0006299	700001191	Inpatient	LGH 3
Canceled	Urgent	CSTOSVECINA, DEMORAISA	XR Chest			23-Nov-2017 09:56	112-XR-17-0006298	700001191	Inpatient	LGH 3
Ordered	Routine	CSTPRODME, TEST-DELTA	MRI Abdomen Adrenal w/o Contrast			22-Nov-2017 15:05	112-MR-17-00021...	700006504	Inpatient	LGH 7
Ordered	Routine	CSTPRODME, TEST-DELTA	CT IACs w/o Contrast			22-Nov-2017 15:19	112-CT-17-0004417	700006504	Inpatient	LGH 7
Replaced	Routine	CSTPRODML, GRAHAM CRACK...	IR Cementoplasty			23-Nov-2017 07:49	112-IR-17-0001742	700006830	Pre-Outpatient	LGH 1

Total cases: 224

Details Exit

For all modalities except ECHO, the order will not be available to be reported on in Fluency for Imaging (FFI) until you click on COMPLETE. It is very important to do this step.

## End Book One

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