SELF-GUIDED PRACTICE WORKBOOK [N68]
CST Transformational Learning

WORKBOOK TITLE:

Nursing: OB Inpatient (Antepartum, L&D, Postpartum)

TABLE OF CONTENTS

✠ SELF-GUIDED PRACTICE WORKBOOK

Before getting started	■ Sign the attendance roster (this will ensure you get paid to attend the session). ■ Put your cell phones on silent mode.
Session Expectations	■ This is a self-paced learning session. ■ A 15 min break time will be provided. You can take this break at any time during the session. ■ The workbook provides a compilation of different scenarios that are applicable to your work setting. ■ Each scenario will allow you to work through different learning activities at your own pace to ensure you are able to practice and consolidate the skills and competencies required throughout the session.
Key Learning Review	■ At the end of the session, you will be required to complete a Key Learning Review ■ This will involve completion of some specific activities that you have had an opportunity to practice through the scenarios.

▰ Using Train Domain

You will be using the train domain to complete activities in this workbook. It has been designed to match the actual Clinical Information System (CIS) as closely as possible.

Please note:

■ Scenarios and their activities demonstrate the CIS functionality not the actual workflow

■ An attempt has been made to ensure scenarios are as clinically accurate as possible

■ Some clinical scenario details have been simplified for training purposes

■ Some screenshots may not be identical to what is seen on your screen and should be used for reference purposes only

■ Follow all steps to be able to complete activities

■ If you have trouble to follow the steps, immediately raise your hand for assistance to use classroom time efficiently

■ Ask for assistance whenever needed

🎬 PATIENT SCENARIO 1 – Tracking Shell

Learning Objectives
At the end of this Scenario, you will be able to: 🟩 Understand the basic functionalities of the Tracking Shell   🟩 Access a patient's chart from the Tracking Shell

SCENARIO
Your patient has just presented to the labour and delivery unit for a labour assessment. She has already been full registered by the main registration clerk and has been placed in a bed. Locate your patient on the Tracking Shell.   In this scenario, we will review the functionalities of the Tracking Shell.   As an inpatient nurse you will be completing the following activities: 🟩 Access the Tracking Shell from CareCompass   🟩 Select the status of your patient on the Tracking Shell   🟩 Add a communications alert to your patient on the Tracking Shell

Note: If your patient presents to main registration for full registration, your patient will be placed in a virtual LDL bed by the main registration clerk. You will be able to see the patient's name on the LGH L&D tab on the Tracking Shell. You will need to perform a bed transfer to transfer the patient to the appropriate bed via the PM Conversations icon on the Tracking Shell toolbar.   To transfer a patient on the Tracking Shell (Note these steps are here as an FYI only; you will not need to complete these steps for this workbook since your patient has already been placed in a bed):   1. Click on the patient's name to highlight the patient's row. Click on the PM Conversation button and select Bed Transfer.   2. Complete the required fields. Remember to select an "M" bed for the patient.   Now that your patient is in a physical bed (versus a virtual bed), you are ready to start documentation on your patient

Activity 1.1 – Using the Tracking Shell

1 The **Tracking Shell** allows you to see a status overview of mothers and babies. You can access any portion of a patient's chart, from documentation to orders, from the Tracking Shell.

As an OB Nurse, your landing page when logging into the **Clinical Information System** (CIS) is the Tracking Shell.

As a Postpartum Nurse, your landing page is **CareCompass** (more about CareCompass later). To navigate to the Tracking Shell at any time, click on the Tracking Shell button in the Toolbar.

1. The **Location Tabs** display a variety of Tracking Shell views. These **Location Tabs** allow you to move between different views, such as L&D, Postpartum and All Beds.

   Note: Depending on your role, you may not see all of the **OB Location Tabs**.

   - Replace the second sentence: The icon Toolbar displays a variety of key buttons such as Quick Registration [icon] and Open Chart [icon]

2 The Tracking Shell **Columns** display the patients for the selected area with specific patient details. Notice that the columns 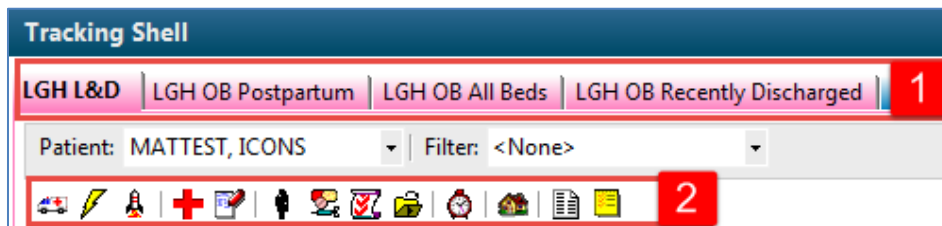vary depending on the location view. For example, the LGH OB All Beds view does not contain labour specific columns such as Cervical Dilation (Dil) and Length.

Navigate to the LGH L&D location tab:

1. The **Bed** column displays the patient's bed location.

   M = Mom bed
   A = Baby A bed
   B = Baby B bed
   C = Baby C bed

2. The **Status** column reflects the patient's status as she moves through her care.

3. The **A** column displays allergies. You can hover over the icons to tell you the exact allergy status.

Note: You can double click on the patient's allergy icon to update or modify the allergies directly from the Tracking Shell.

4. The **To Do** column displays icons indicating an important task needs to be completed. For example, the Red Cross Icon [icon] indicates the OB Triage and Assessment PowerForm (for moms) or the Newborn Admission History PowerForm (for newborns) needs to be completed.

5. The **Communications** column displays important alerts and communications (e.g. Diabetes, Hepatitis B Positive, Isolation, and Rh Negative). Some of these Communication icons autopopulate from documentation in the chart and some are manually inputted.

6. The **NR (Nurse Review)** column indicates if there are new orders for the nurse to review.

You can double click on the nurse review icon and the Actions Requiring Review window will open for you to review orders.

7. The **Lab** column shows the status of lab orders.

8. The **MAR** column displays the number of medications as well as medication orders details.

Note: The Status column can be updated to reflect the mom as she moves through her care.

Note: Certain nursing and provider documentation (for example, cervical exam details documented in iView) pulls data forward into these columns**.**

3 Remember that everyone can see the Tracking Shell, so any changes made are visible to everyone looking at the Tracking Shell.

Note: The blue forward arrow opens the chart as does right clicking on the patient's name.

Let's practice adding a communication alert to the Tracking Shell:

1. Locate the **Communications** column

2. Right click on the **Communications** cell for your patient

3. The **Events** window will open.
    - From the Current box, select: **Hep B Positive**
    - Click **OK**

The Hep B Positive icon populates on the Communications Column.

🔑 Key Learning Points

- The Tracking Shell is accessible from the Toolbar.

- Hover to discover the meaning of the different icons on the Tracking Shell.

- The patient's chart is accessible from the Tracking Shell.

PATIENT SCENARIO 2 - PowerForms

Learning Objectives
At the end of this Scenario, you will be able to: ■ Document in PowerForms ■ View and Modify existing PowerForms
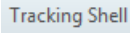
SCENARIO
Your patient has arrived for a labour assessment. You need to document your assessment on your patient. In this scenario, we will review PowerForm documentation. As an inpatient nurse you will be completing the following activities: ■ Opening and Documenting on Blank PowerForms ■ Viewing an existing PowerForm ■ Modifying an existing PowerForm ■ Uncharting an existing PowerForm
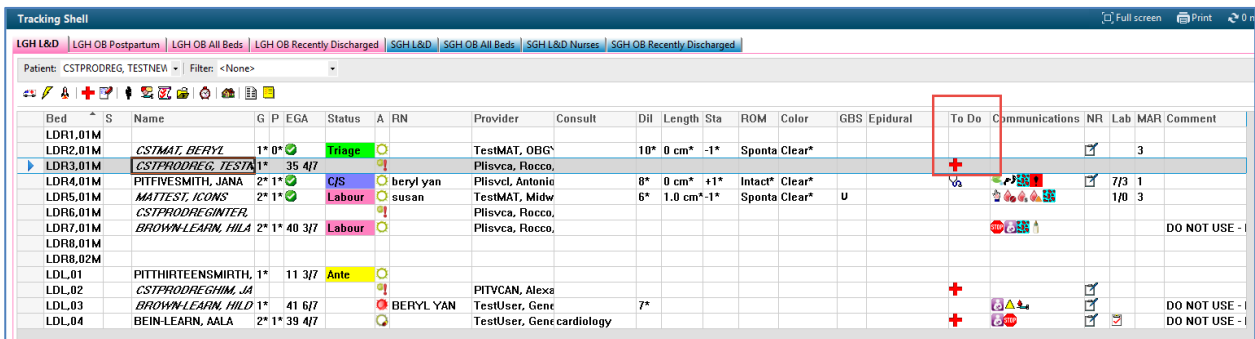
Activity 2.1 –Documenting on PowerForms

1 Let's first return to the Tracking Shell. Click on the **Tracking Shell** button `Tracking Shell` in the Toolbar. Locate your patient on the Tracking Shell. Hover over the **Red Cross** icon ✚ under the **To Do** column of your patient's name. This icon indicates that the **OB Triage and Assessment** PowerForm needs to be completed on your patient.

PowerForms are the electronic equivalent of paper forms currently used to chart patient information. Data entered in PowerForms can flow between iView flowsheets, Clinical Notes, Problem Lists, Allergy Profile, and Medication Profile.

Note: For newborns, the **Red Cross** icon ✚ in the **To Do** column indicates that the **Newborn Admission History** PowerForm needs to be completed. The Newborn Admission History PowerForm needs to be completed for all newborns once during the initial postpartum period.

Note: The **OB Triage and Assessment** PowerForm replaces the **BC Perinatal Triage and Assessment Record**.

To open and document on the **OB Triage and Assessment** PowerForm:

1. Highlight your patient's name in the Tracking Shell. Click the Red Cross icon ✚ in the Icon Toolbar and select **OB Triage and Assessment**.
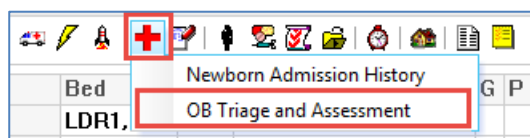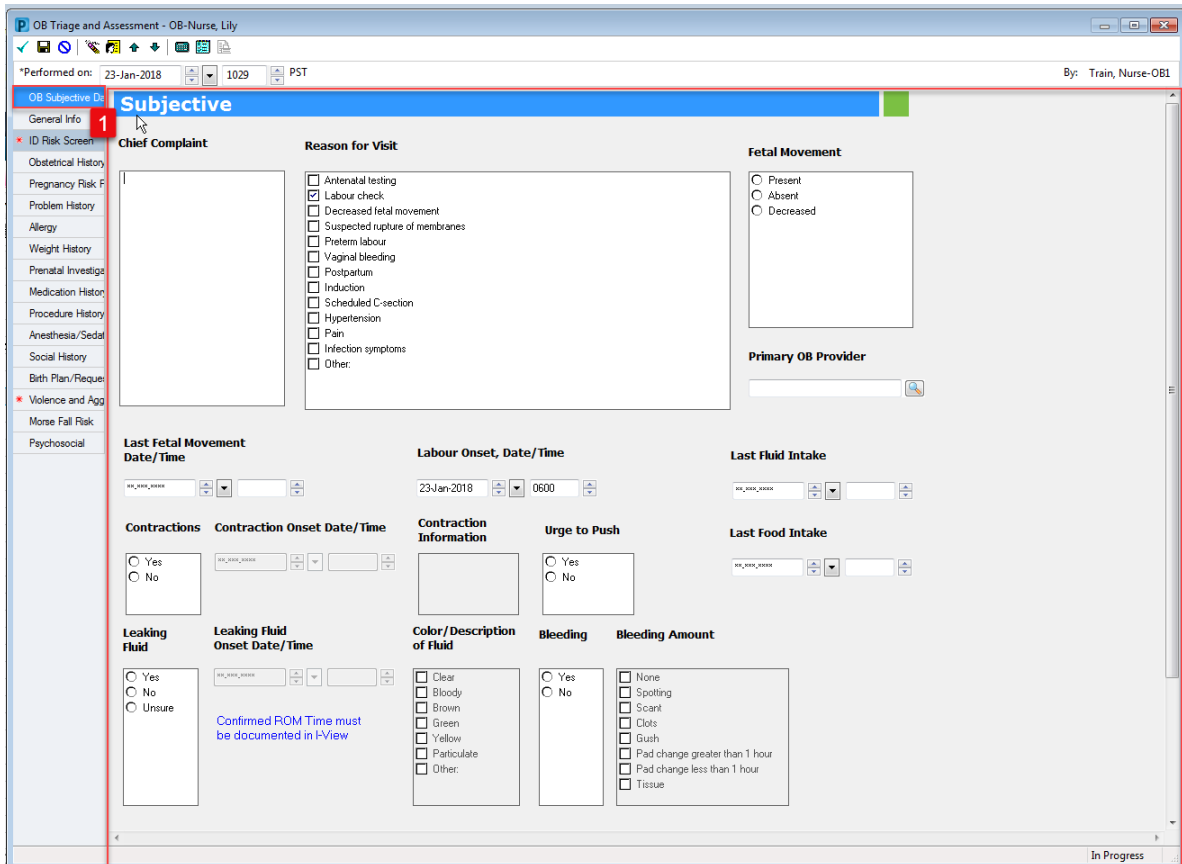
2. The **OB Triage and Assessment** PowerForm opens.

Document in the following sections:

1. **OB Subjective Data** section:
   - Reason for Visit = Labour check
   - Labour Onset, Date/Time = T/0600 (note that this is the patient's first stage of labour)

   - **Note:** Do not sign ✓ until you have completed **all** the sections below.

2. ***ID Risk Screen** section (* indicates mandatory field):
   - Select **No** for all fields
3. **Pregnancy Risk Factors** section:
   - Pregnancy Risk Factors, Current Pregnancy = Group B Streptococcus
4. ***Violence and Aggression Screening** section (* indicates mandatory field):
   - Click- No risk assessed at this time
5. **Prenatal Investigations and Results** section:
   - Blood Type = A positive
   - Antibody Screen = Negative

Note: In this section, you will see any previously documented labs transcribed by the OB unit clerk from the BC Antenatal Record Part 3, Section 13. Review and update or modify the information as needed.

6. Click ![check icon] once documentation is complete.

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

You will return to the Tracking Shell. Note that the Red Cross icon ➕ under the To Do column in your patient's row is no longer present, signaling that the OB Triage and Assessment PowerForm has been completed on your patient.
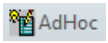
Note that for newborns, completion of the Newborn Admission History PowerForm will trigger the Red Cross icon to fall off the To Do column.

🔑 **Key Learning Points**

■ PowerForms are the electronic equivalent of paper forms currently used to chart patient information.

■ When the Red Cross icon ✚ under the To Do column in your patient's row is no longer present, it indicates that the OB Triage and Assessment PowerForm has been completed on your patient.

Activity 2.2 – Documenting on PowerForms from Ad hoc

Although the OB Triage and Assessment PowerForm and the Newborn Admission History PowerForm can be accessed from the Tracking Shell, you will need to access additional PowerForms from the AdHoc folder. The AdHoc folder is an electronic filing cabinet that holds any PowerForm you may need to document on.

1. Highlight your patient's name in the **Tracking Shell**.

2. Click on the **AdHoc** button [AdHoc] in the Toolbar.

3. The Ad Hoc Charting window opens for your patient. Various folders containing different PowerForms are categorized to the left of the window.

4. Click on the **OB Documentation** folder.

5. The **OB Documentation** folder opens to the right and contains the most commonly used Powerforms for Obstetrics, including the Perioperative Preprocedure Checklist and the Oxytocin Safety Checklist.
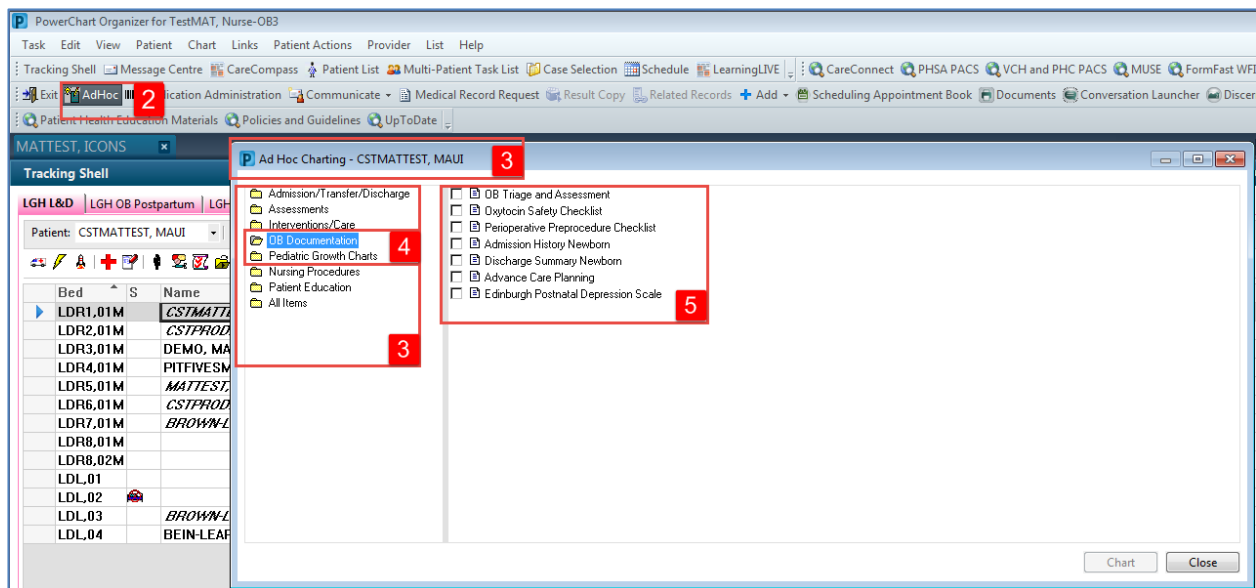
6. For this activity, select Advance Care Planning from OB Documentation folder and click

   Chart

7. The Advanced Care Planning window will open. In the yellow field titled **Advance Care**

   Plan, select **No** then sign ✓
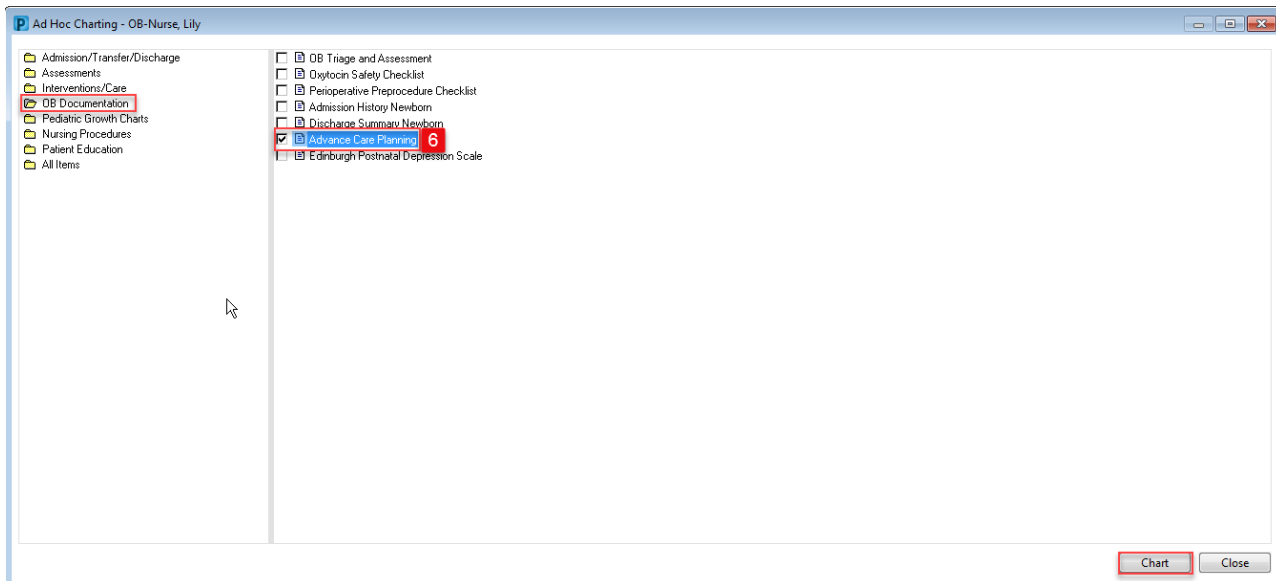
Note: Although you can access the OB Triage and Assessment PowerForm and the Newborn Admission History PowerForm from the AdHoc folder, doing so will not trigger the Red Cross Icon ✚ to fall off the To Do column in the Tracking Shell.

🔑 Key Learning Points

■ PowerForms are forms used to chart patient information

■ The OB Triage and Assessment PowerForm and Newborn Admission History PowerForm are accessible from the Tracking Shell via the Red Cross icon in the Icon Toolbar

■ Other PowerForms are accessible from the AdHoc button in the toolbar

Activity 2.3 – Viewing an Existing PowerForm

1 Throughout your shift, you may need to view previously documented PowerForms. First open your patient's chart.

From the Tracking Shell:

1. Click on your patient's name to highlight the row

2. Double click on the blue forward arrow [▶] beside your patient's name

3. Note: The first time you access a patient's chart, you will be prompted to assign a relationship. Select Nurse then click OK.
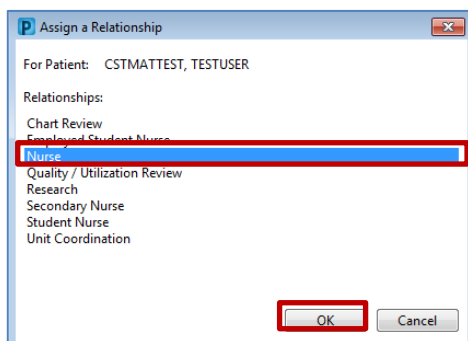
Your default view upon opening a patient's chart is the **Women's Health Overview**. The **Women's Health Overview** provides access and views of key clinical patient information. If you are ever lost and need to return to this view, click on the house icon [🏠] and you will return to the **Women's Health Overview.**
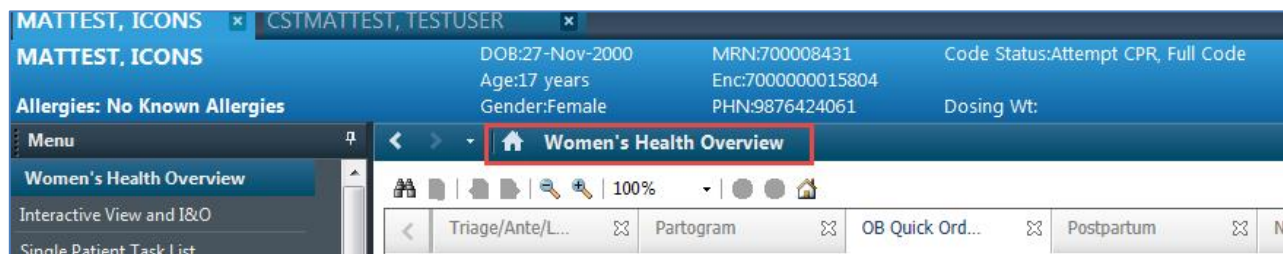
To view a **PowerForm**:

1. Select **Form Browser** in the **Menu** to the left of the screen.
2. 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.
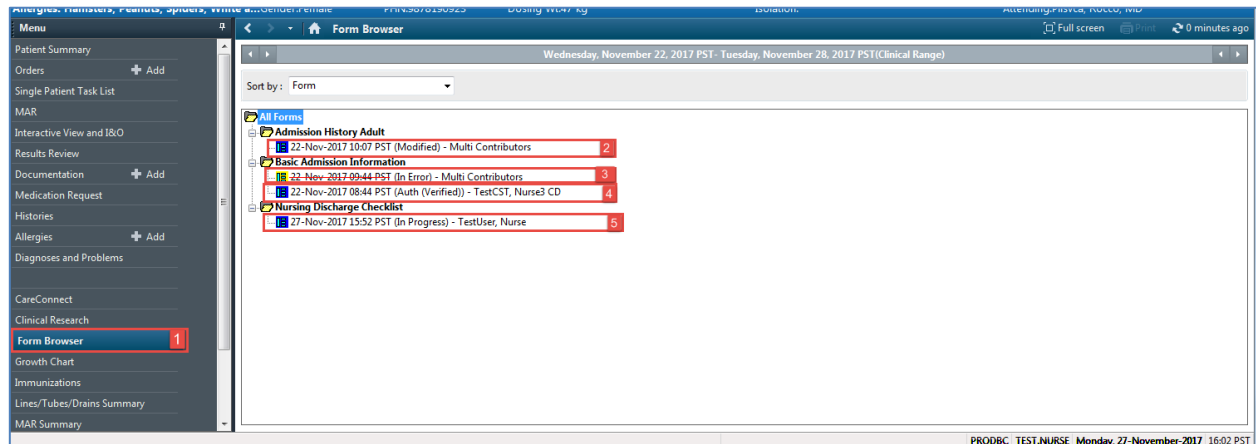
🔑 **Key Learning Points**

🟩 Existing PowerForms can be accessed through the Form Browser.

🟩 A form can have different statuses (e.g. Modified, In Error, Auth Verified and In Progress).

🧩 **Activity 2.4 – Modify an Existing PowerForm**

1 It may be necessary to modify PowerForms if information was entered incorrectly.

Note: If new or updated information needs to be documented, it is recommended to start a new PowerForm and not to modify an already existing PowerForm.

Your patient mentions that she has a history of frequent urinary tract infections and you want to document this on the OB Triage and Assessment PowerForm. Let's modify the OB Triage and Assessment PowerForm.

To **modify** a **PowerForm** select it from within **Form Browser**:
1. Right-click on the most recently completed **OB Triage and Assessment** form within **Form Browser.**
2. Select **Modify.**
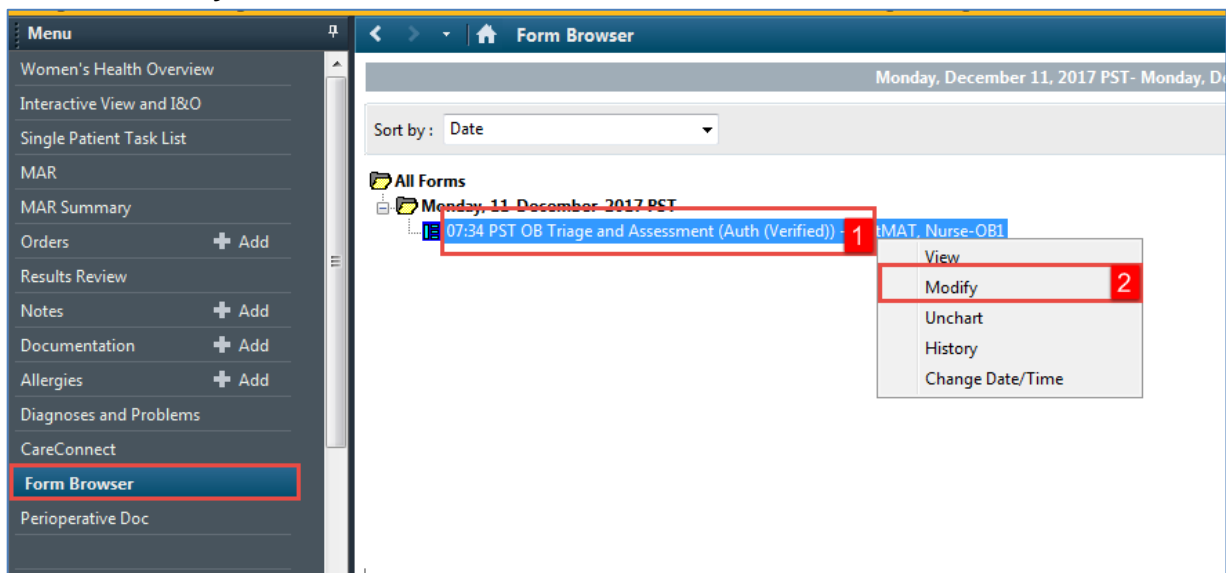
3. Click on the **Pregnancy Risk Factors** section. In Pregnancy Risk Factors, **Current Pregnancy**, select **Urinary tract Infections, frequent**.

1. Click **Sign** ✓ to complete the documentation and then **Refresh** the screen.

When you return to this document in the form browser, it will show the document has been modified.

🔑 Key Learning Points

▪ A document can be modified if needed.

▪ A modified document will show up as (Modified) in the Form Browser.

🧩 Activity 2.5 – Unchart an existing PowerForm
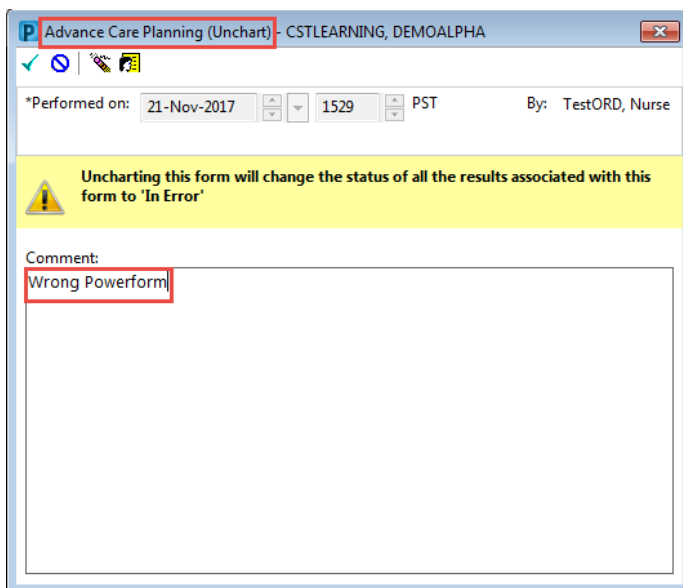
1 It may be necessary to **Unchart** an existing PowerForm if, for example, the PowerForm was completed on the wrong patient or it was the wrong PowerForm. Let's say the **Advanced Care Planning** form was documented in error.

To unchart the PowerForm, within Form Browser:

1. Right-click on **Advance Care Planning**
2. Select **Unchart**
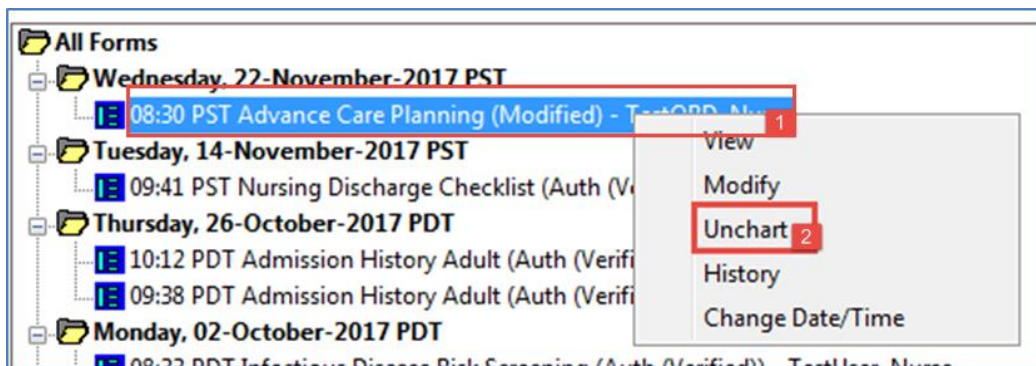
3. The Unchart window opens. Enter a reason for uncharting in the **Comment** box = *Wrong PowerForm.*

4. **Sign** ✓ the documentation and then **Refresh** 🔄 your screen.

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

All Forms
Wednesday, 22-November-2017 PST
08:30 PST Advance Care Planning (In Error) - TestORD, Nurse
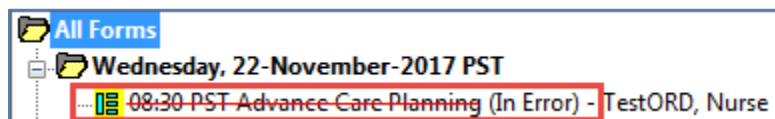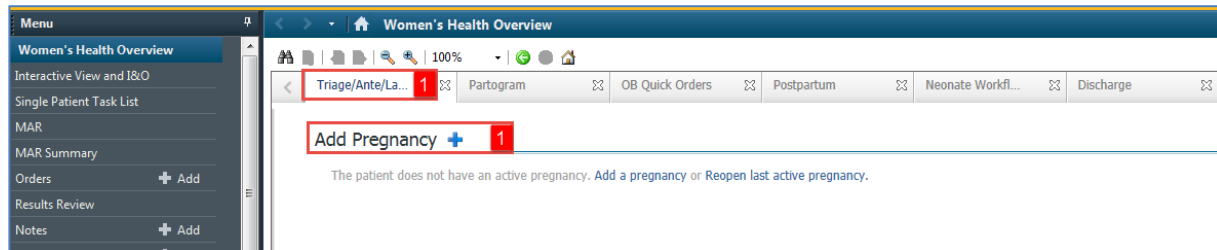
🔑 Key Learning Points

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

Activity 2.6 – Add a Pregnancy

1 You notice that your patient does not have a pregnancy added yet so you will need to add a pregnancy. You need to add a pregnancy in order to activate and view components in the **Women's Health Overview**, as well as populate the **Gravida (G), Parity (P),** and **Estimated Gestational Age (EGA)** columns in the **Tracking Shell**.

1. From the Triage/Ante/Labour Page, click the Blue Cross icon ✚ beside Add Pregnancy.
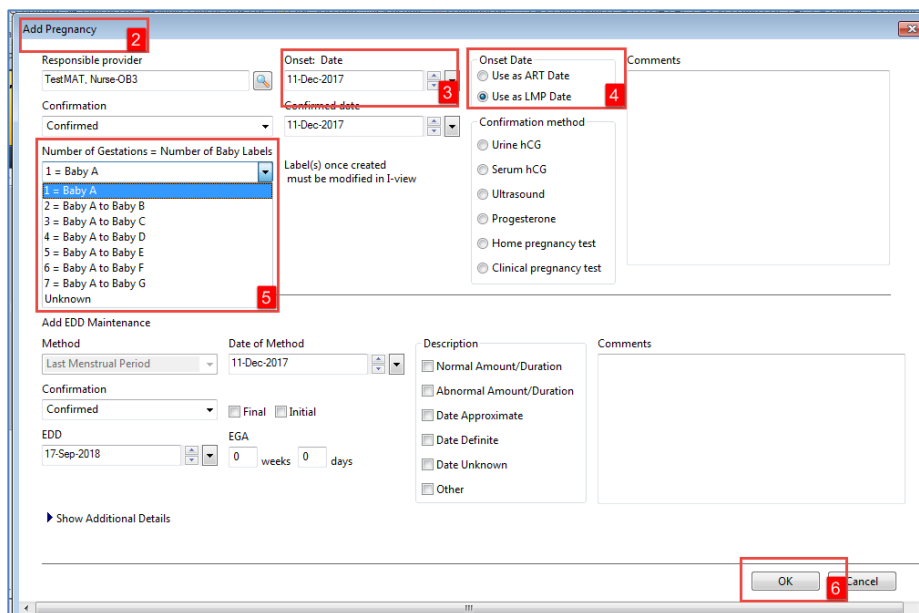
2. The **Add Pregnancy** window opens.

3. In the **Onset: Date** field, choose a date about 10 months ago.

   Note: In real life, you would enter the LMP date from the BC Antenatal Record Part 1, Section 4.
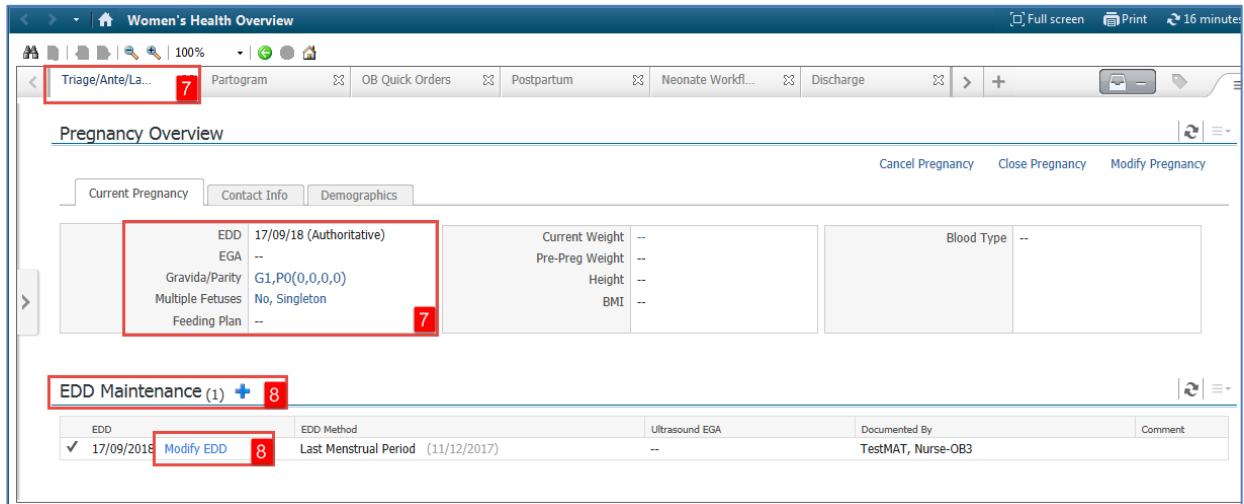
4. In the **Onset Date** field, select "Use as LMP Date"

5. Ensure the **Number of Gestations = Number of Baby Labels** is correct

   Note: This field is defaulted to 1 = Baby A for singletons; for multiples gestations, select the appropriate number of babies.

6. Click **OK**

7. You will return to the Triage/Ante/Labour Page with the **Pregnancy Overview** populated.

8. To modify the EDD, scroll to the **EDD Maintenance** component and click on **Modify EDD** (highlighted in blue).

9. The **EDD Maintenance** window will open.

10. In the **Method** section, select Ultrasound from the dropdown list. The **Date of Method** and **EGA by Ultrasound** fields will become mandatory fields (highlighted in yellow).

11. In the **Date of Method** field, select a date about 6 months ago.

    Note: In real life, you would enter the 1st US date from the BC Antenatal Record (Section 4).

12. In the **EGA by Ultrasound** field, document 8 weeks.

    Note: In real life, you would enter the GA by US from the BC Antenatal Record (Section 4).

13. The **EDD** and **Current EGA** will auto-calculate. Adjust the EDD as needed in the EDD field.

14. Click **OK**

15. The Pregnancy Overview will now show the updated EDD and EGA.

Note: You will only need to add a pregnancy once for a patient. For the majority of patients, this Add Pregnancy and EDD Maintenance step will already be completed as part of the pre-registration process by the OB unit clerk.

Now that a pregnancy has been added, you will be able to view all the different pages and components from the Women's Health Overview. Continue to the next activity to explore the Women's Health Overview.

Note: Most patients will already be pre-registered in the system. The pre-registration process includes:

1. Pre-registering a patient and creating a "Pre-Outpatient in a Bed" encounter (completed by main registration clerk when he/she receives patient's registration forms).

2. Attaching the BC Antenatal Record Part 1 and 2 forms to the system (completed by OB unit clerk)

3. Adding a pregnancy and modifying the EDD (completed by OB unit clerk)

4. Transcribing information from the BC Antenatal Record Part 1 and 2 to the Antenatal Record PowerForm (completed by OB unit clerk)

    a. Obstetrical History (Section 3)

    b. Prenatal Investigations and Results (Section 13)

    c. Weight History (Pre-pregnant Weight and Height) (Section 14)

Note that this "Pre-Outpatient in a Bed" encounter is to be used when the patient presents in labour. If this "Pre-Outpatient in a Bed" encounter is used and the patient is discharged home (for example, in early labour), then another "Pre-Outpatient in a Bed" encounter will need to be created for use when the patient returns for subsequent labour assessments.

🔑 Key Learning Points

- A pregnancy needs to be added to activate and view the different component of the Women's Health Overview section.

- The necessary information will populate on the Tracking Shell when a pregnancy has been added.

PATIENT SCENARIO 3 - Interactive View and I&O

Learning Objectives

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

- Navigate to the iView and I&O
- Document in iView
- Change the time column
- Document a dynamic group in iView
- Modify, unchart or add a comment in iView

SCENARIO

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

As an inpatient nurse 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 3.1 – Overview of Interactive View and I&O

1. Although you have completed your documentation in the OB Triage and Assessment PowerForm, you will need to document the remainder of your assessment in **Interactive View and I&O, or iView.**

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

2. Select **Interactive View and I&O w**ithin the **Menu**.
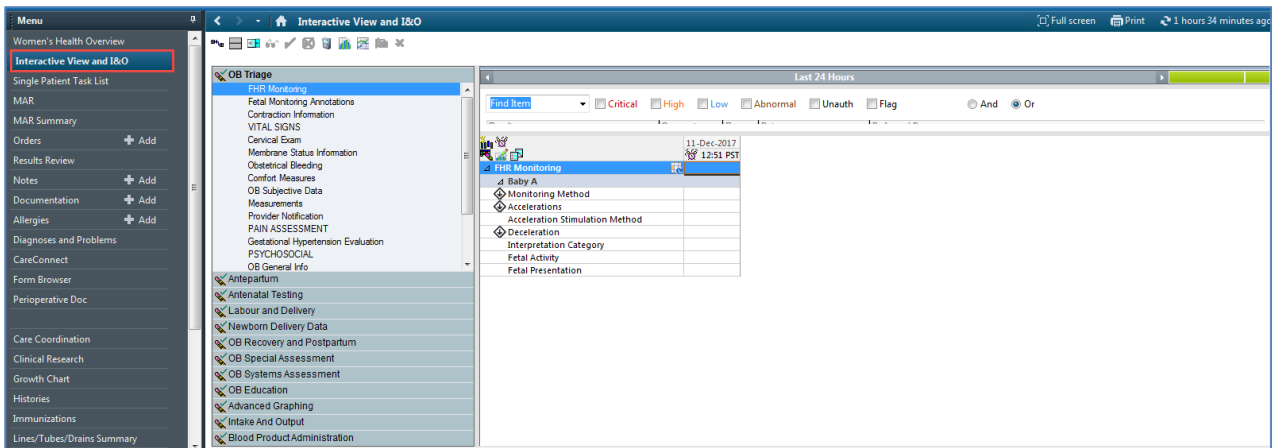
3. Now that the iView page is displayed, let's review the layout.

   1. A **band** is a heading that has a collection of flowsheets (**sections**) organized beneath it. In the image below, the **OB Triage** band is expanded displaying the sections within it.

   2. The set of bands below **OB Triage** 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.

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Activity 3.2 – Documenting in Interactive View and I&O

1 Let's practice documenting in iView. With the **OB Triage** band expanded, you will document your FHR Monitoring and Cervical Exam assessments. First, **Refresh** the screen (top right hand corner) to ensure that previously documented data pulls through so that you are viewing the most up to date information.

1. Select the **FHR Monitoring** section in the **OB Triage** band.
2. Double-click the **blue box** next to the name of the section to document in several cells. You can move through the cells by pressing the **Enter** key.
3. Document the following data in the **FHR Monitoring** Section:
   - **Monitoring Method** = Intermittent Auscultation
   - **FHR** = 130
   - **FHR Rhythm** = Regular

4. Now go to the **Cervical Exam** Section of the OB Triage Band and document the following:
   - **Cervix Dilation** = 6cm
   - **Cervical Length** = 1cm
   - **Fetal Station** = -1
   - **Cervical Consistency** = Soft
   - **Cervical Position** = Anterior
   - **Fetal Position** = Occiput Anterior

The Calculator icon is an autocalculation based on data entered. Note that the Bishop's Score autocalculates = 11.

Note that the Labor Onset Date/Time that you previously entered in the OB Triage and Assessment PowerForm autopopulates here. Documentation of Labour Onset Date/Time will activate the Partogram (more about the Partogram later).

Note: Information documented in PowerForms can flow through to iView (for example, Labor Onset Date/Time). Certain information documented in IView can also flow through to PowerForms.

5. **Sign** ✔ your documentation.

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.

🔑 Key Learning Points

■ Documentation will appear in purple until signed. Once signed, the documentation will become black.

■ The newest 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.

Activity 3.3 – Change the Time Column

1 Navigate to **Interactive View and I&O** by selecting it from the Menu. You will notice that Interactive View is divided into stages of labour, eg Triage, Antepartum, Labour & Delivery, etc. If the patient is on monitoring, results will be automatically fed from the device into the chart using **BMDI**. You will learn more about BMDI in a hands-on practice at the bedside. Follow the steps below for times you may need to manually enter vital signs.
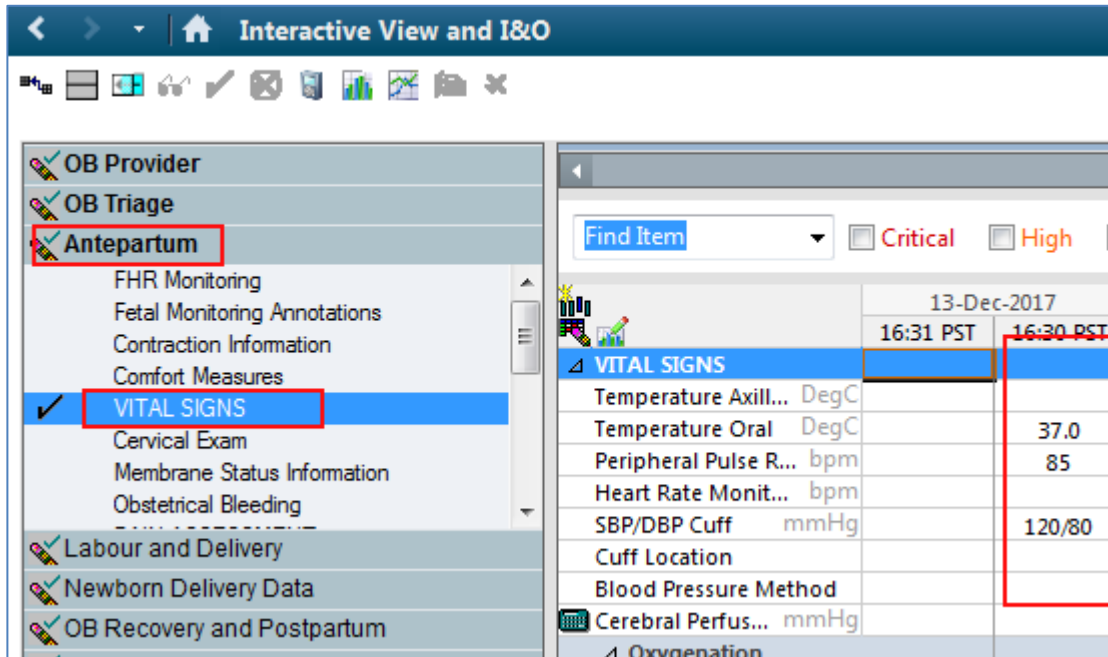
1. Select the **OB Triage** and choose **VITAL SIGNS** component from the sub-menu.

2. Double-click the **blue box** next to the name of the section to document in several cells. You can move through the cells by pressing the **Enter** key.

3. Document the following data:

   - Temperature Oral = *37.1*
   - PPeripheral Pulse Rate = *88*
   - SBP/DBP Cuff = *120/80*

4. Click [✓] to sign your documentation.

Now assume your patient has proceeded from Triage to Antepartum and you wish to document another set of vitals.

- Click **the Antepartum** band and again select **VITAL SIGNS** from the sub-menu.

- Click **Refresh** [↻] to refresh your view and you will see that the vitals entered in Triage have been carried over.

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 Cerebral Perfusion calculation to function.

5. It is required to sign the *first* set of vital signs entered in the **OB Triage** Vital Signs prior to documenting future vital signs in the **Antepartum** section.

6. To sign your documentation, **Sign**

Note: When the newborn's chart is created, you will follow this same procedure within the newborn chart by returning to **Interactive View and I&O**, selecting **Quick View**, and documenting in the **Newborn Vital Signs** section.

🔑 Key Learning Points

- The first set of vital signs must be recorded in the OB Triage tab prior to documenting in Labour and Antepartum.
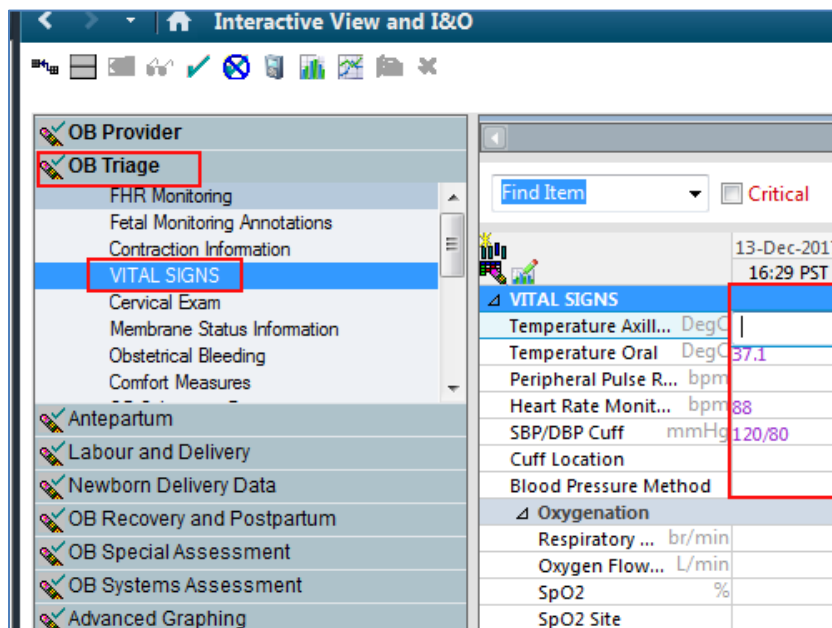
- Documentation will appear in purple until signed. Once signed, the documentation will become black.

- The newest 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.

Activity 3.4 – 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, and more.

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 **OB Special Assessment** band

2. Click on the **Peripheral IV** section

3. Click on the **Dynamic Group** icon to the right of the Peripheral IV (PIV) heading in the flowsheet.
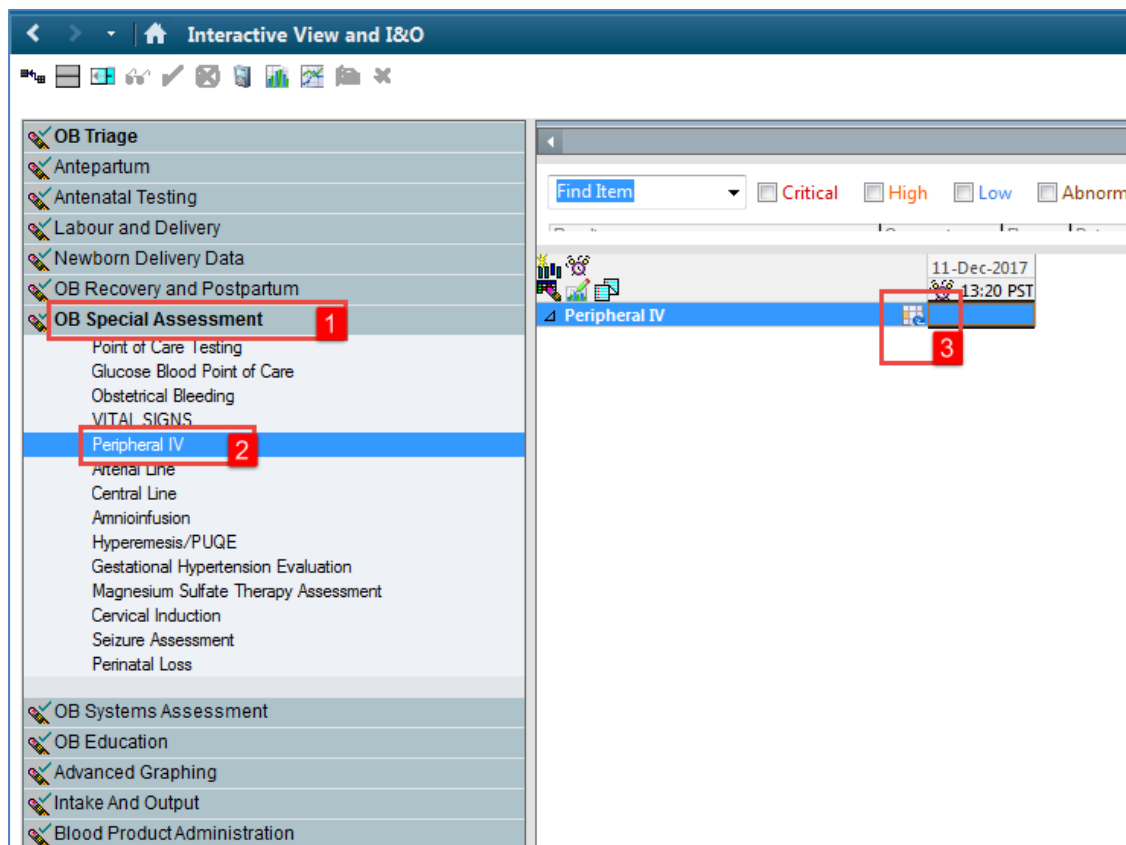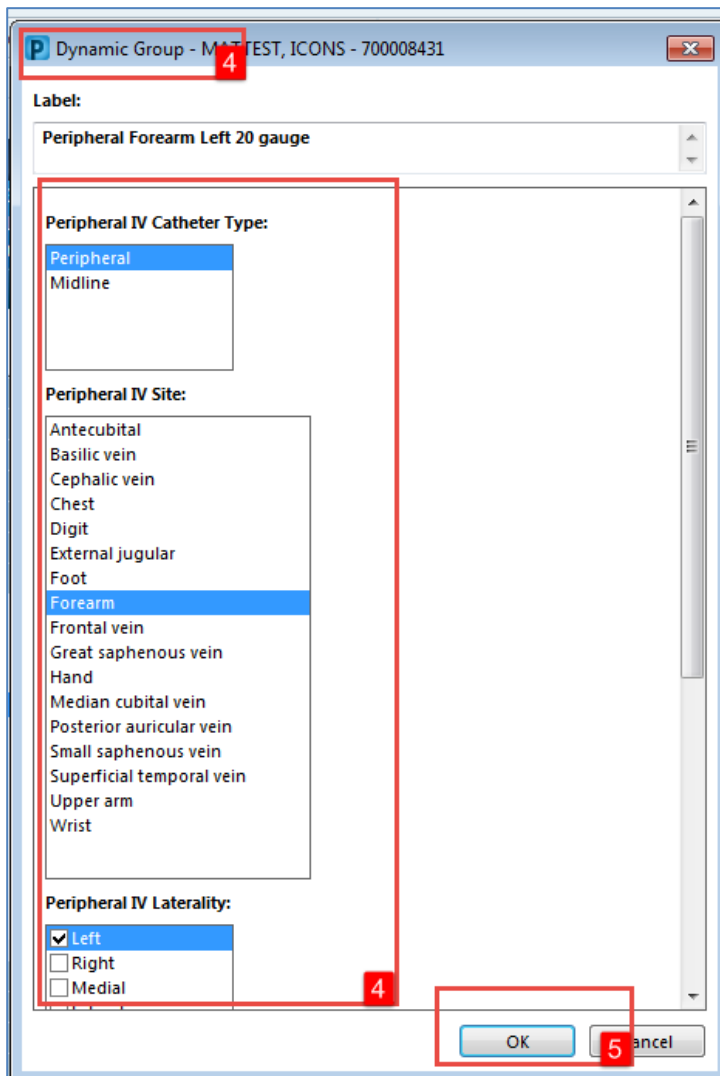
4. The Dynamic Group window appears. A dynamic group allows you to label a line, wound, or other patient care with specific details. You can add as many dynamic groups as you need for your patient. For example, if a patient has two peripheral IVs, you can add a dynamic group for each IV.

Select the following to create a label:
- **Peripheral IV Catheter Type** = Peripheral
- **Peripheral IV Site** =Forearm
- **Peripheral IV Laterality** = Left
- **Peripheral IV Catheter Size** = 20 gauge

5. Click **OK.**

6. The label created will display at the top, under the Peripheral IV section heading.

7. 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.
   Now document the activities related to this PIV:
   - **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*

8. Sign when complete. Once signed the label will be accessible for other clinicians to complete further documentation within the same dynamic group. The label does not need to be re-created.

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.
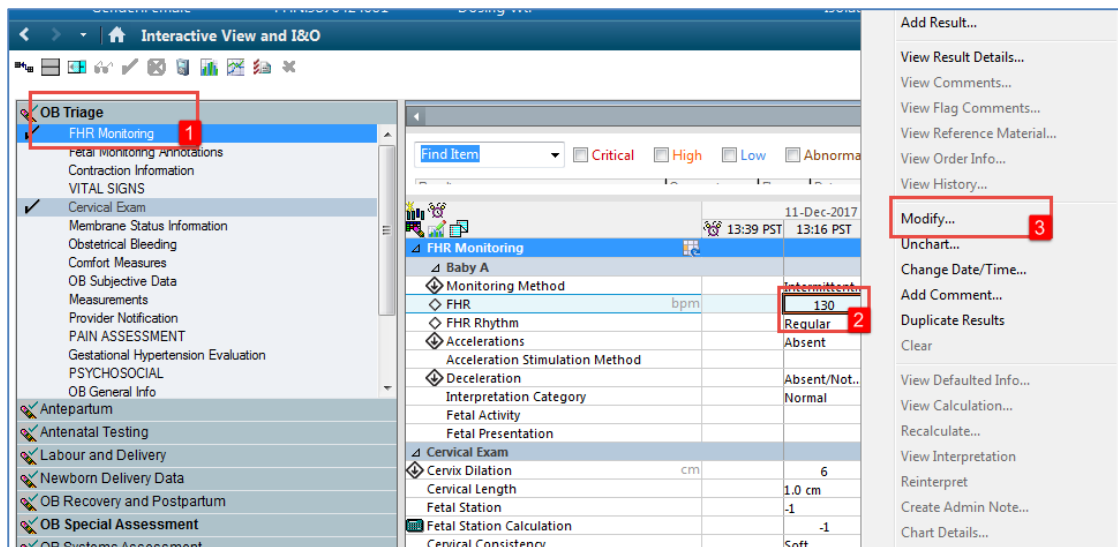
🔑 Key Learning Points

- Examples of Dynamic Groups include wound assessments, IV sites, and FHR monitoring (for multiple gestations).

- 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.

- Dynamic groups are created within specific sections of iView

- Dynamic groups allow for the documentation and display of grouped data elements such as multiple IV or wound sites

Activity 3.5 – Modify, Unchart or Add a Comment in Interactive View
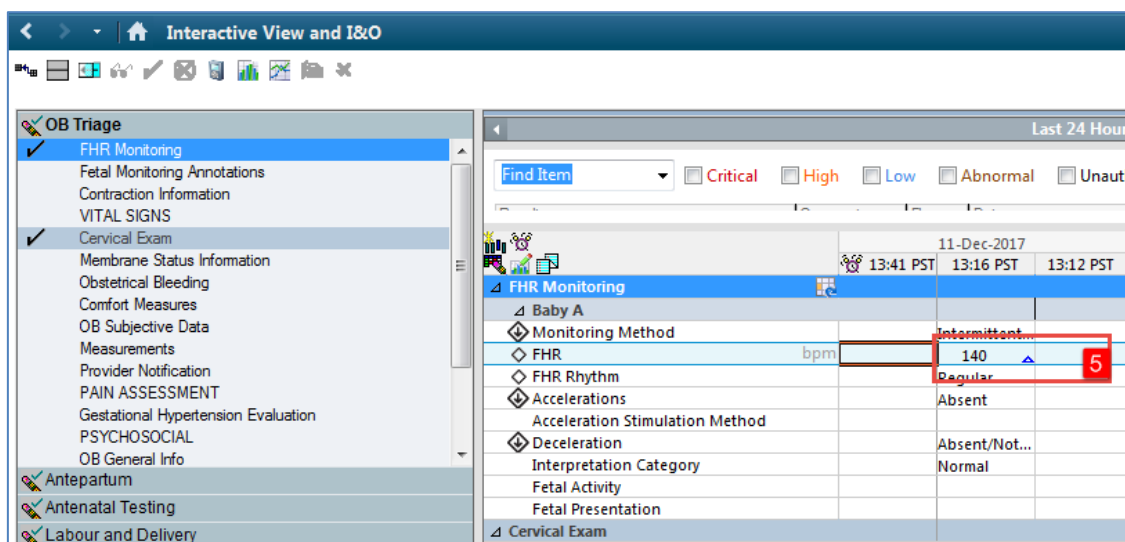
1 You realize upon reviewing your earlier charting that you documented the incorrect FHR. Let's modify the FHR you previously documented.

1. Click on the **FHR Monitoring** section in the OB Triage band.

2. Right-click on the documented value of **130 for FHR.**

3. Select **Modify.**

4. Enter in new **FHR** = 140 and sign

5. **140** now appears in the cell and the corrected icon ▲ will automatically appear on bottom right corner to denote a modification has been made

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

Let's pretend the temperature documented earlier was meant to be documented on one of your other patient's charts. It needs to be uncharted. Navigate to the Vital Signs section.

1. Right-click on the documented value of **37.1** for Temperature Oral
2. Select **Unchart**
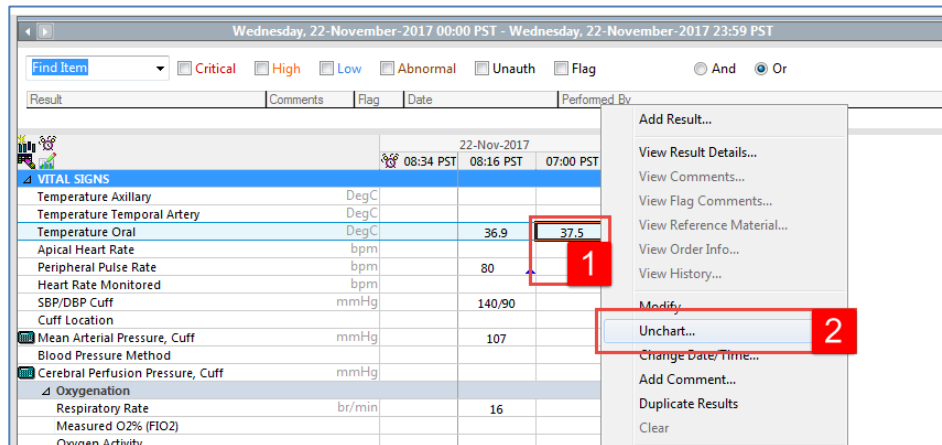
3. The Unchart window opens, select **Charted on Incorrect Patient** from the Reason drop-down.
4. Click **Sign**
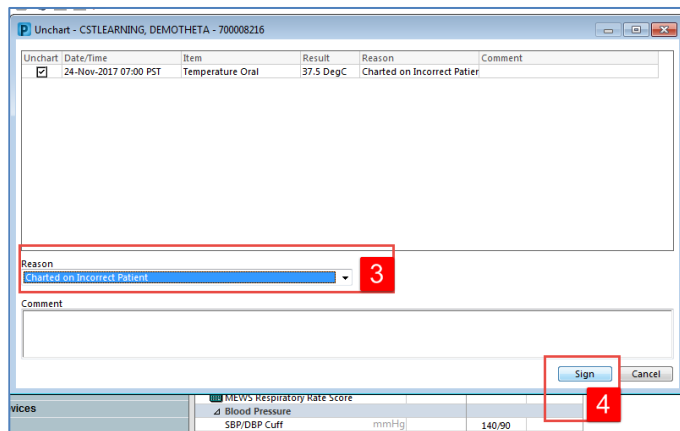
5. You will see **In Error** displayed in the uncharted cell. The result comment or annotation icon ⌐ will also appear in the cell.
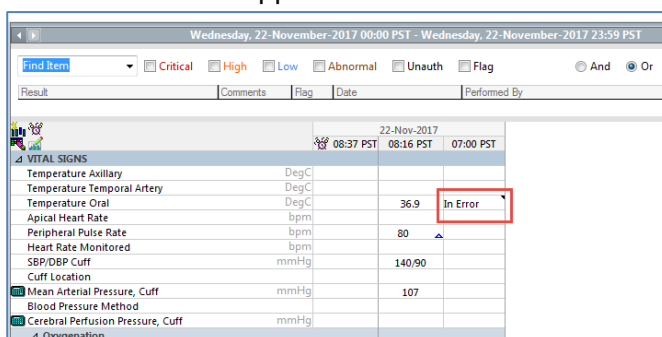
3 A comment can be added to any cell to provide additional information. For example, you want to comment that the cervix is thinner on the right.
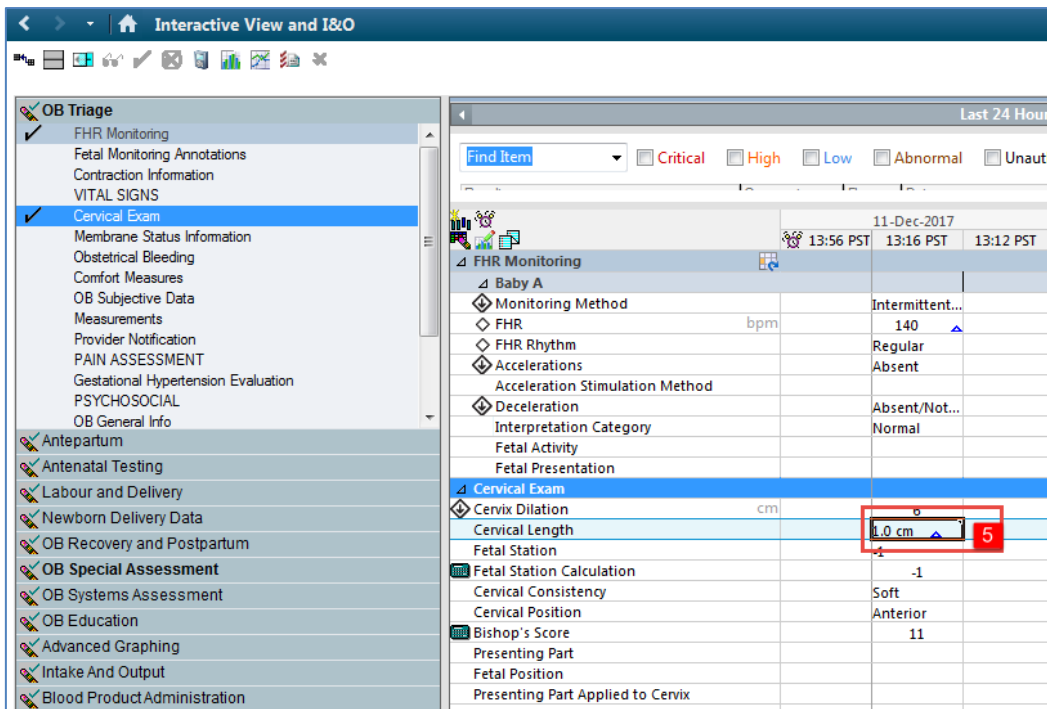
1. Navigate to the Cervical Exam section.

2. Right click on the documented value for the Cervical Length, **1 cm**.

3. Select add comment.
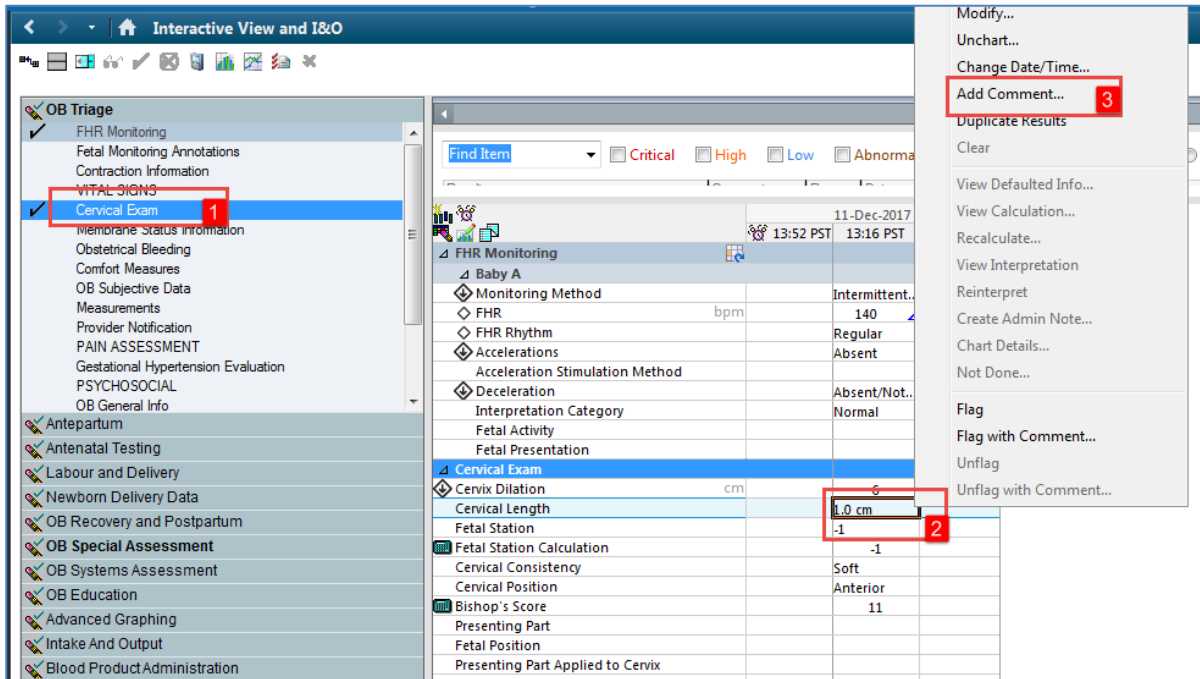
4. The comment window opens, type comment **Thinner on right** and click **OK**.
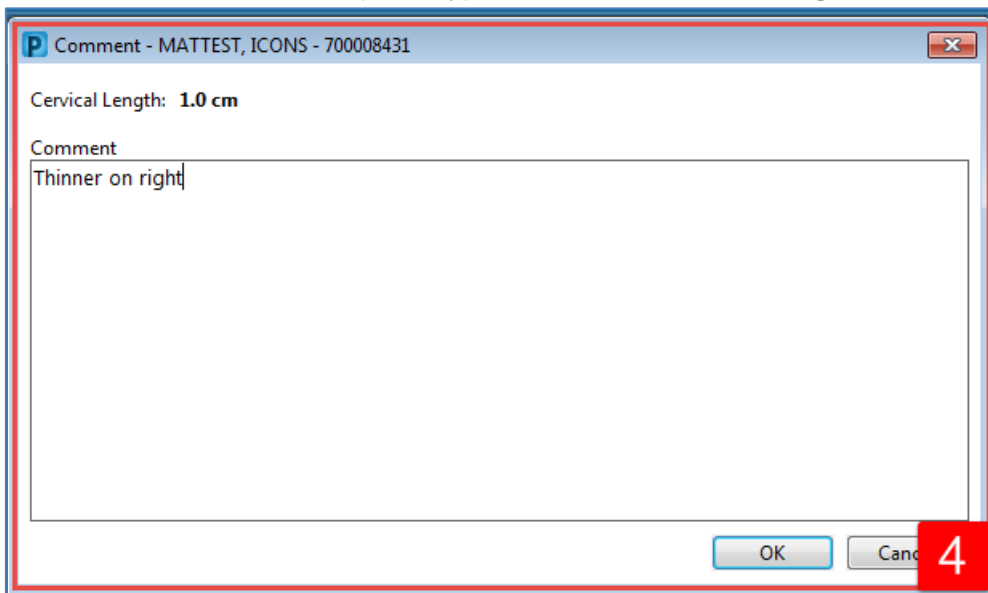
5. The Corrected icon ▲ and Result Comment or Annotation icon ⬒ will display in the cell.

6. In order to view the comment, right click on the cell and click View Comments.

7. The Result Details window will open with the comment displayed. Click Close to return to IView.

🔑 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.

PATIENT SCENARIO 4 – Partogram

Learning Objectives
At the end of this Scenario, you will be able to: ■ Access the partogram to view necessary labour information.

SCENARIO
In this scenario, we will access the Partogram from the Women's Health Overview. As an inpatient nurse you will be completing the following activities: ■ Locate the Partogram Overview ■ Locate the Partogram FHR ■ Locate the Partogram Labour Graph

Activity 4.1 – Viewing the Partogram

1 The Partogram is a graphical display of data that has been charted on a labouring patient. It provides an overview of useful information such as the current Oxytocin rate and current epidural rate. You can also view a graphical display of fetal heart rates as well as the labour curve graph.

The Partogram can be accessed from the Partogram page in the Women's Health Overview.

Note: If not already done, you will be prompted to document the labour onset date and time (the first stage of labour) before you can view the Partogram. If you are commencing Oxytocin and the patient has not yet entered the first stage of labour, document the Oxytocin start Date and Time in the Labour Onset, Date/Time field to populate the Partogram. You will need to update the Labor Onset, Date/Time field once you can confirm the date/time of the patient's first stage of labour since this is used for the Stages of Labour autocalculation.

Explore the Partogram:

1. Navigate to the **Women's Health Overview** (Remember you can click on the House icon 🏠 from anywhere in the chart to return to your default view, the Women's Health Overview).

2. Click on the **Partogram** tab.

Note: If the Partogram tab is not in view, click on the + sign. A list of Views will populate. Select Partogram.

3. The Partogram page opens. Various components of the Partogram are listed to the left, including Overview, Fetal Heart Rate, Labour Curve and Maternal Vital Signs.
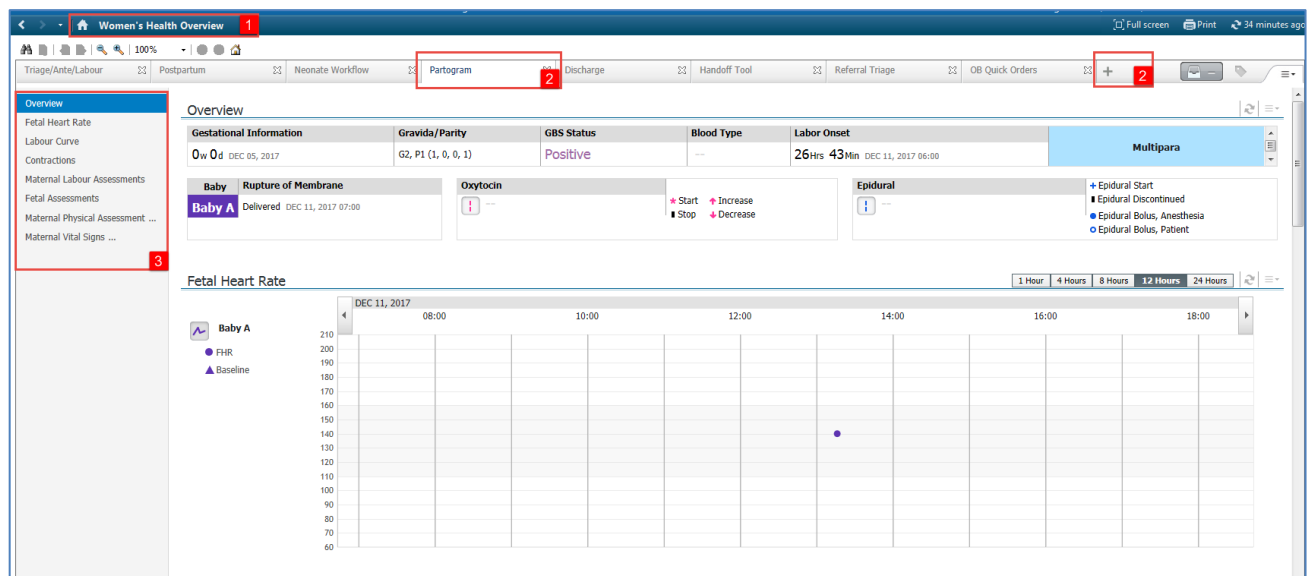
4. Click on the Fetal Heart Rate component. Note that the FHR you documented in IView populates here in a graphical format.
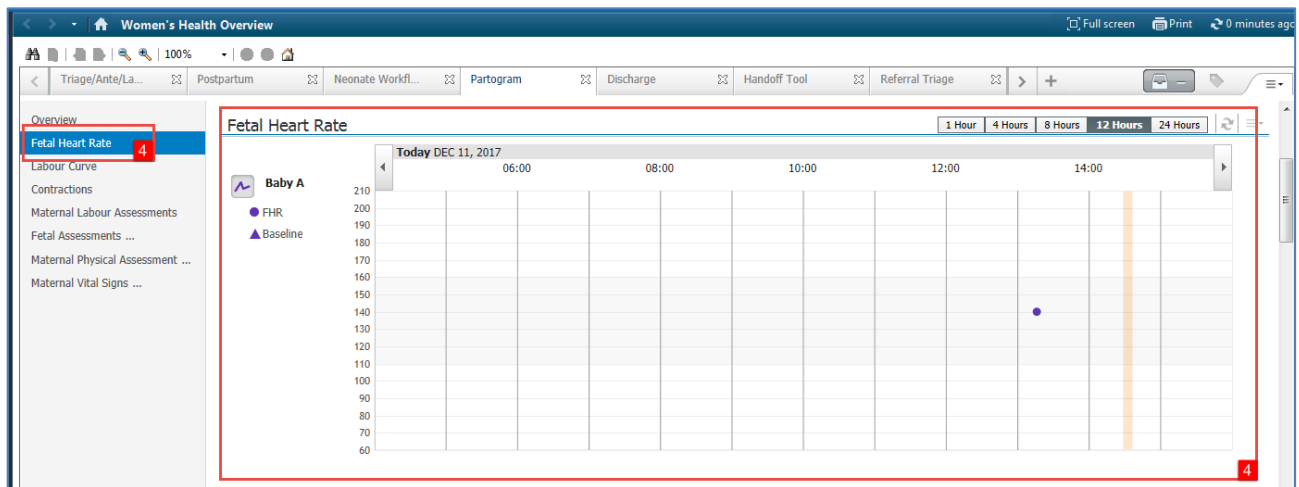
Note: The Partogram only displays IView documented FHRs; it is not a display of electronic fetal heart rate tracings.

5. Now click on the Labour Curve component. The cervical exam you documented in iView populates here.
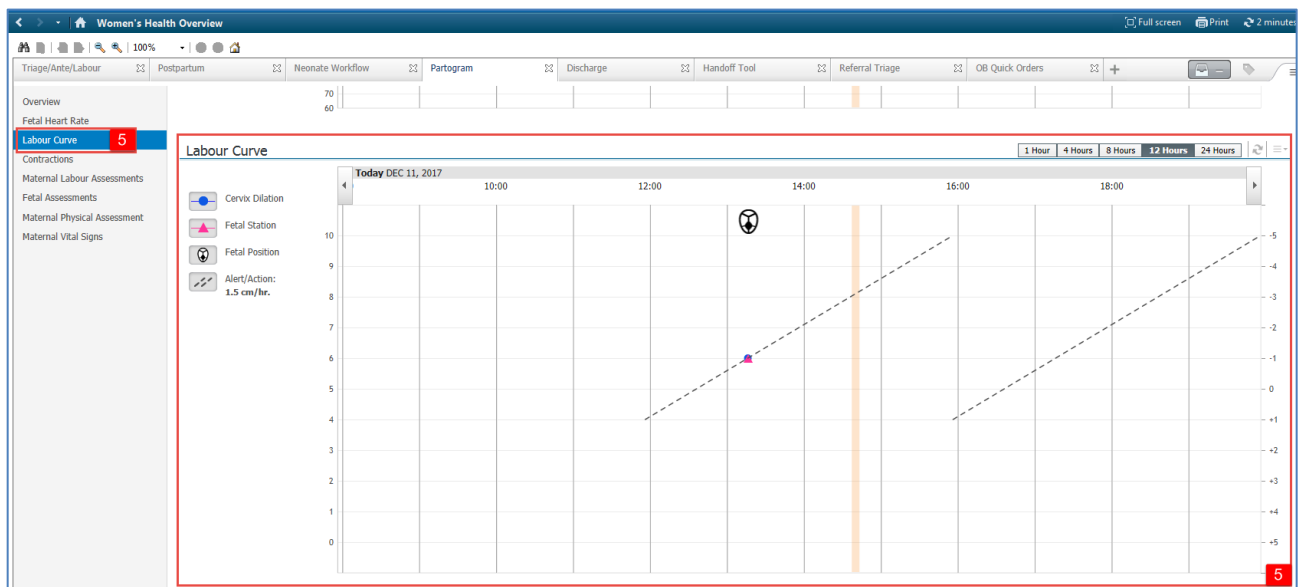
Note: You cannot chart directly on the Partogram; it is view only. The more information you document in iView, the more data will populate on the Partogram.

🔑 Key Learning Points

- The Partogram is accessible from the Women's Health Overview.

- It provides pertinent information such as an overview, the FHR, and the labour curve graph.

PATIENT SCENARIO 5 – Orders

Learning Objectives
At the end of this Scenario, you will be able to: ■ Place quick orders   ■ Place a no cosignature required order   ■ Review order statuses and details   ■ Place a verbal order   ■ Complete an order

SCENARIO
As an OB nurse, you will need 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: As an inpatient nurse you will be completing the following activities: ■ Place Quick Orders   ■ Place a No Cosignature Required Order   ■ Review Order Statuses and Details   ■ Place a Verbal Order   ■ Complete an Order

Activity 5.1 – Overview of the OB Quick Orders Page

1 The **OB Quick Orders** Page houses the most commonly used orders in obstetrics. You can order Powerplans (equivalent to PPOs, or preprinted orders) as well as stand-alone orders (for example, vital signs q4h). Orders are categorized into different colour-coded sections, for example, **OB PowerPlans, OB Medications, OB Labs** and **OB Patient Care.**

Explore the **OB Quick Orders** Page:

1. Navigate to the **Women's Health Overview** (Remember you can click on the House icon 🏠 from anywhere in the chart to return to your default view, the Women's Health Overview).
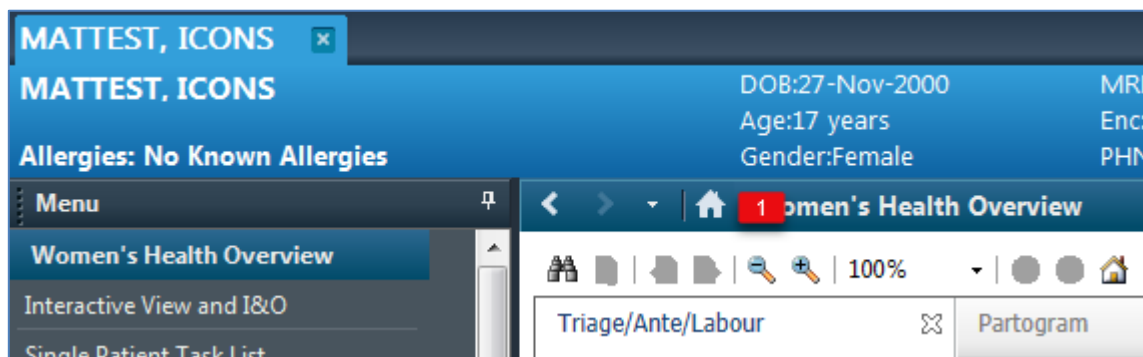
2. Click on the **OB Quick Orders** tab.

3. Note: If the OB Quick Orders tab is not in view, click on the + sign. A list of Views will populate. Select OB Quick Orders.

4. The OB Quick Orders Page opens. Different orders are categorized into different sections. You can click on the arrow to the left of any order type to open up a list of related orders.

5. Click on the arrow beside **Analgesics** in the OB Medications section. A list of the most commonly used OB analgesics will open.
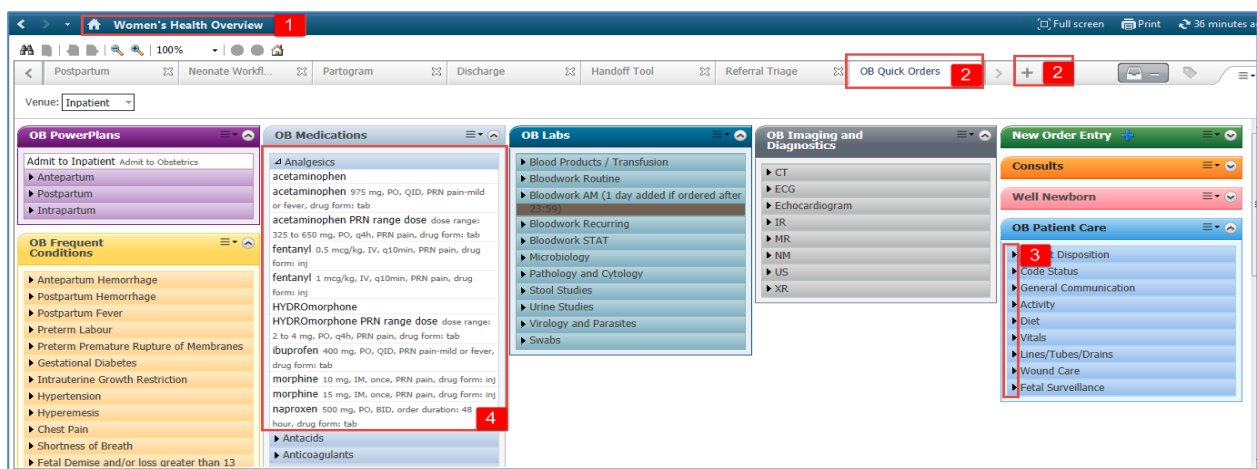
Activity 5.2 – Place an OB Quick Order

1 Your patient is in active labour. You have called the OB Provider and the decision has been made to admit the patient. Your patient's current encounter type is Outpatient in a Bed; this encounter type is used for all OB patient assessments (Note that for scheduled outpatient activities such as NSTs or Iron Sucrose Infusions, the encounter type will be Outpatient OB).

You will need to place an order to admit her as an Inpatient. Let's practice placing an order from the **OB Quick Orders** Page.

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

1. If not already done, open the **OB Quick Orders** Page from the **Women's Health Overview**.
2. Click on the **Admit to Inpatient** order under the **OB PowerPlans s**ection.

Click the **Orders for Signature** icon (Green Orders Tray) [📥 1] . This tray acts like an orders "shopping cart" and is updated when you select different orders from the OB Quick Orders Page.
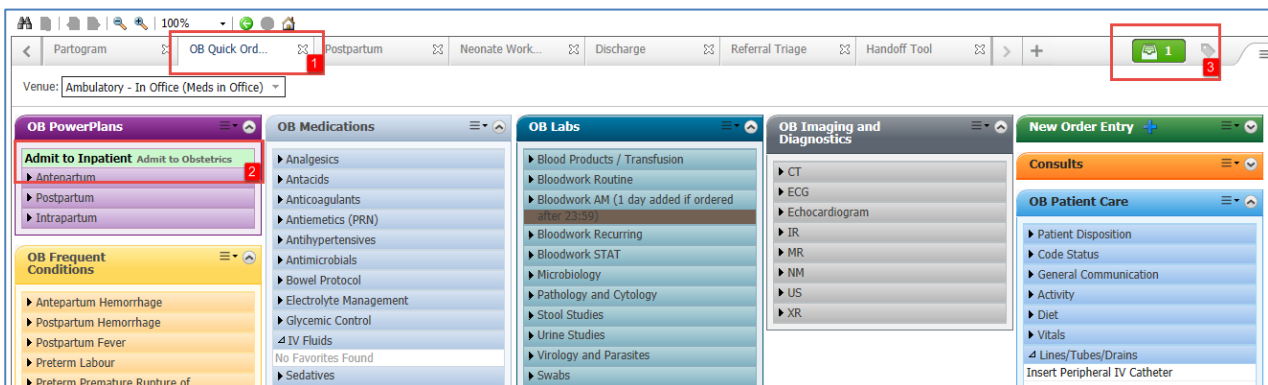
3. The **Orders for Signature** window will open. It will list all the orders you have placed in your "shopping cart".
4. Click **Sign**
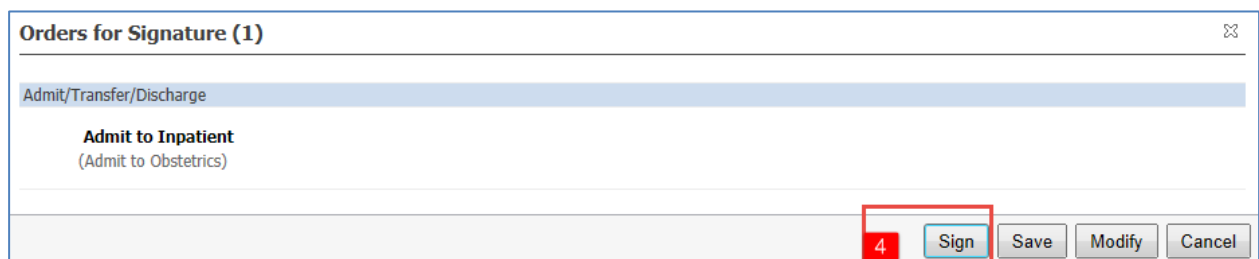
5. The Ordering Physician window will open. Document:
   - Physician Name = xxx
   - Communication Type = Verbal

Remember that fields highlighted in yellow are mandatory. Select OK.

You will return to the **OB Quick Orders** Page.

Refresh your screen. Your patient's Encounter will now be updated **from Outpatient in a Bed** to **Inpatient** in the Banner Bar.

🧩 Activity 5.3 – Place an Order via Add Order

1 Some orders do not require a cosignature by physician. Let's practice placing an order that requires a cosignature.

1. Navigate to the **OB Quick Orders** Page.

2. Click the **New Order Entry** button [New Order Entry] at the top right hand corner.
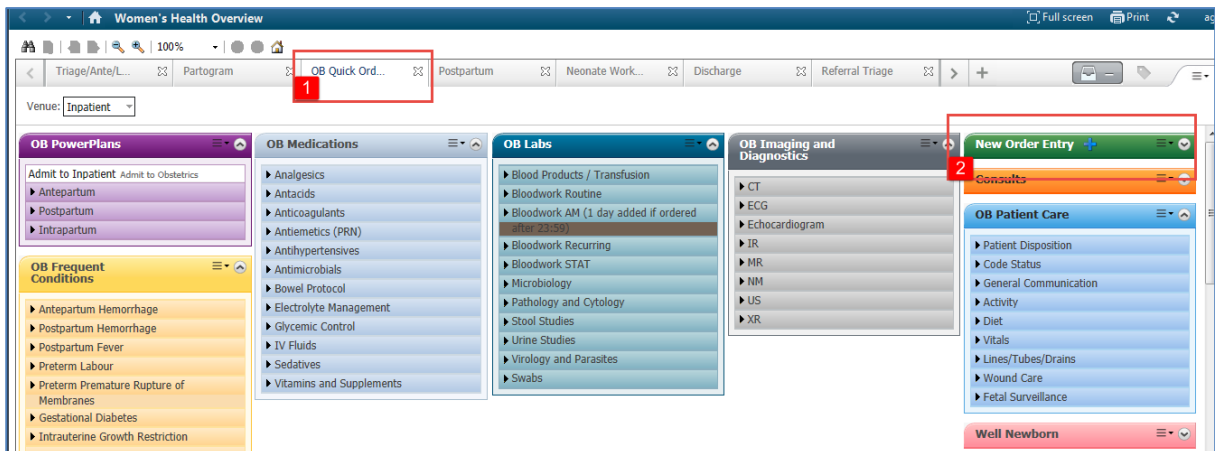
3. The **Orders** Page will open. Click the **Add** icon [+ Add]
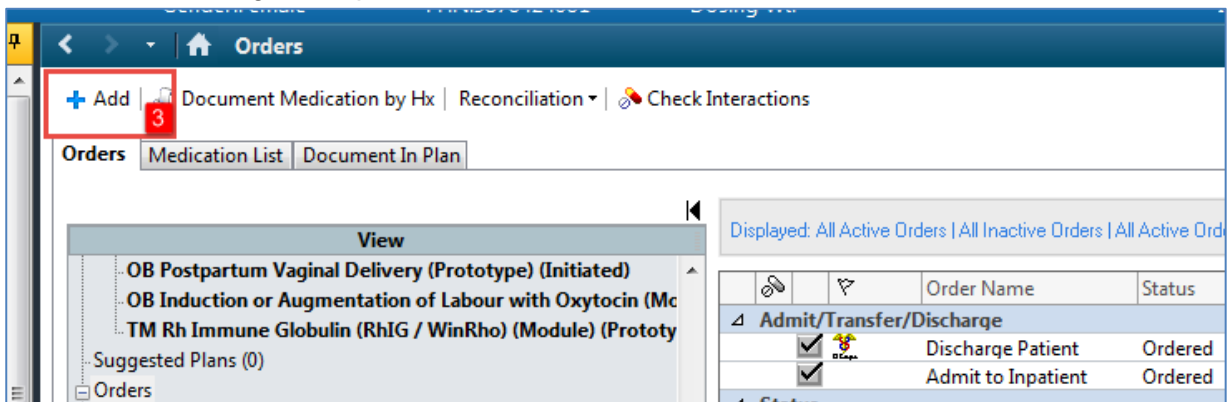
The **Add Order** window will open.

4. Type *saline lock* into the search window and a list of choices will display.

5. Select **Saline Lock Peripheral IV** with order sentence of (*when tolerating oral fluids well*).

   Order sentences help to pre-fill order details.

6. The **Ordering Physician** window opens.

7. Type in the name of the patient's Attending Physician

8. Select **No Cosignature Required** and click **OK.**

9. Click **Done** and you will be returned to the **Orders Page** and see the order details in the Orders Profile.

10. Notice that the **Special instructions** box is pre-filled with **When tolerating oral fluids well**. Click **Sign.**

11. Click **Refresh**

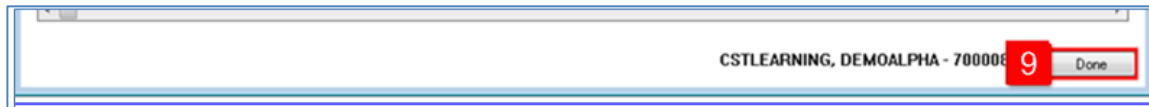### 🔑 Key Learning Points

🟨 Although the OB Quick Orders Page contains the majority of orders you will need for an obstetrical patient, you can also search for and add an order using the Add Order function.

🟨 Verbal orders are only encouraged to be entered when a physician cannot enter the order directly into the CIS themselves, for example in an emergency situation or when the physician is sterile in mid procedure

🟨 Required fields are always highlighted yellow

🟨 Verbal and phone orders that are entered in the CIS automatically get routed to the ordering provider for co-signature

🟨 Order sentences help to pre-fill additional information/details for an order

PATIENT SCENARIO 6 – Single Patient Task List

Learning Objectives
At the end of this Scenario, you will be able to: ■ Access the Single Patient Task List

SCENARIO

In this scenario, we will use access the Single Patient Task List.

As an inpatient nurse you will be completing the following activities:

■ Review the Single Patient Task List
■ Complete a Task

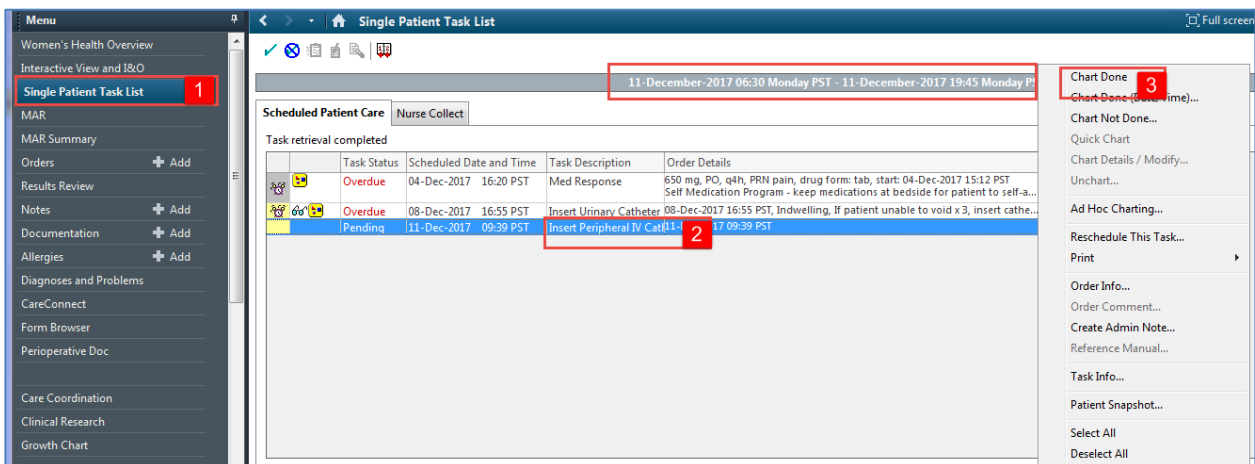## Activity 6.1 – Review Single Patient Task List and Complete Task

1 The Single Patient Task List displays the list of tasks associated to the patient from within the patient's chart. As an OB Nurse, you should access the Single Patient Task List from the Menu throughout your shift to view pending tasks and mark them as completed when done.

Note: As a postpartum nurse, you will access single patient tasks from CareCompass.

Complete the **Insert Periperhal IV Catheter** task from the Single Patient Task List.

1. Select **Single Patient Task List** from the **Menu**
2. Right click **Insert Peripheral IV Catheter** task
3. Select **Chart Done**
   - Click the **OK** button in the pop-window that displays

Task will be marked as complete

🔑 Key Learning Points

- The Single Patient Task List displays the list of tasks associated to the patient from within the patient's chart.

- Ensure the date and time is correct and/or current within the Single Patient Task List page.

📥 PATIENT SCENARIO 7 - Scheduling an OB Anesthesia/Epidural Appointment

Learning Objectives

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

- Schedule an OB Anesthesia /Epidural appointment.

In this scenario, we will use the scheduling appointment book to schedule an OB Anesthesia/ Epidural appointment.

As an inpatient nurse you will be completing the following activities:

- Use the scheduling appointment book to schedule an OB Anesthesia/ Epidural appointment

Activity 7.1 – Scheduling an OB Anesthesia/Epidural Appointment

1 All admitted patients in labour will need to be scheduled for an OB Anesthesia/Epidural appointment, regardless if they need one or not. In the event that surgical services are required, Anesthesia will be able to find the patient on their patient list.

Let's practice how to schedule an OB Anesthesia/Epidural appointment:

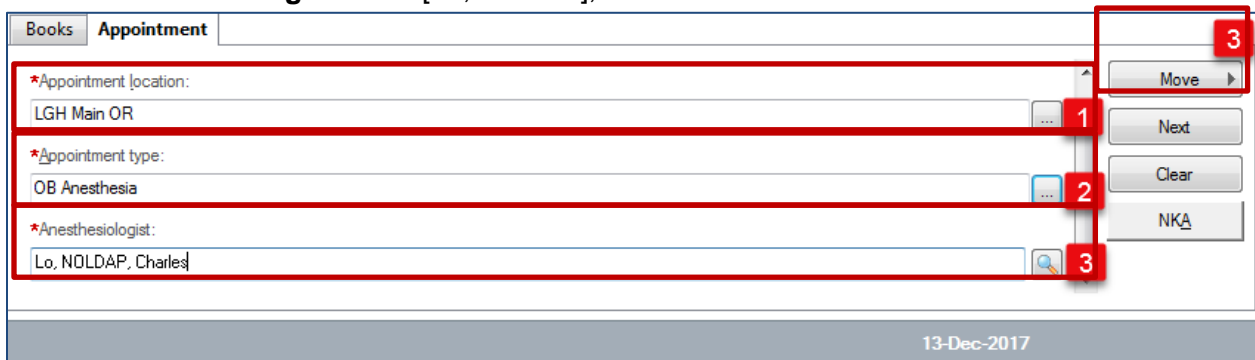Once in the patient's chart, select the Scheduling Appointment Book button from the Toolbar.
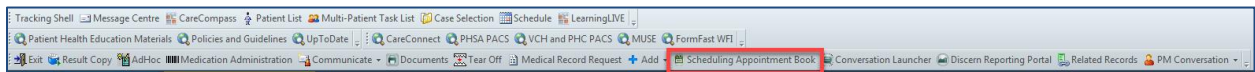
The Scheduling Appointment Book (also called SchAppt Book) launches and opens to the main page. Your patient's name auto-populates in the **Person name** field in the **Appointment** tab.

Note: Pressing **Enter** on your **keyboard** after each entry will move to the next section.

Complete required fields:

1. **Appointment location** = LGH Main OR. (press Enter to move to next field)

2. **Appointment type** = OB Anesthesia (press Enter to move to next field)

3. **Anesthesiologist** = xxx [Lo, Charles], then click on the **Move** button.

4. **The Appointment Attributes** window opens.

- Double- click on **Labour Epidural** in Optional tab and select **OK**.

5. The scheduling item now appears in the Work in Progress box (located beside the "Move" button). Click LGH OB Anesthesia in the Work in progress box and click on the Schedule button.

6. **Schedule – OB Anesthesia** window opens. Complete the Time for 30 minutes from now and click **OK**

(**Note**: it does not matter what time you choose; you are only placing the patient on the list).

7. Click **Confirm**. The Confirm window opens with a summary of the appointment details.
8. Click **OK**. The Confirmation window closes and returns to a blank Scheduling Appointment Book main page.

9. Click on the close button on the Scheduling Appointment Book to close the application.

Note: yellow highlight means an appointment is booked. All of the scheduling book icons turn red, indicating all required fields are filled out.

🔑 **Key Learning Points**

■ Every admitted woman in labour will get a scheduled OB Anesthesia/ Epidural appointment, just in case they need it.

■ The OB Anesthesia / Epidural appointment is scheduled through the Scheduling Appointment Book.

PATIENT SCENARIO 8 – Delivery Documentation & Newborn Quick Registration

Learning Objectives

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

- Document delivery data in iView.
- Quick Reg a newborn to create a chart and populate the patient on the Tracking Shell.

SCENARIO

In this scenario, you will use the WH Quick Registration to Quick Register a patient.

As an inpatient nurse you will be completing the following activities:

- Document delivery data in iView.
- Quick Reg a newborn

Activity 8.1 – Document Delivery Information (iView)

1 Note that for the purposes of this classroom exercise, you will only be documenting in a few fields. In real practice, is important to make documentation as complete as possible since IView documentation flows to Provider's Dynamic Documentation (for example, the OB Admission H&P) as well as to the Labour and Birth Summary Record and the Newborn Record.
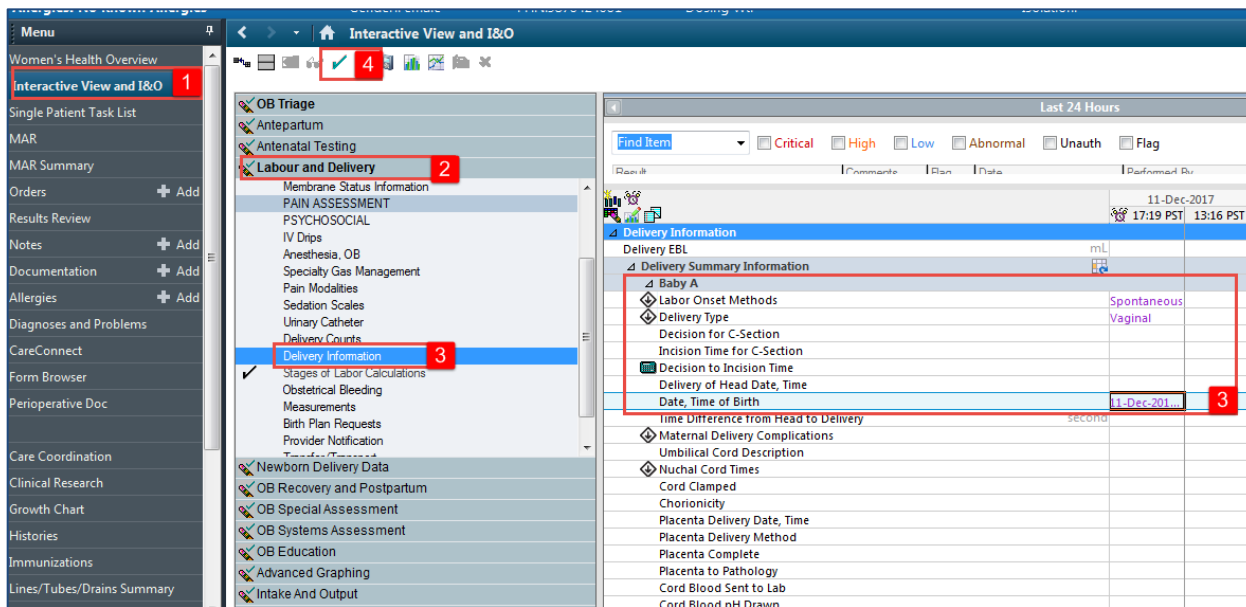
1. Navigate **to Interactive View and I&O** from the menu.

2. Click on the Labour and Delivery iView band.

3. Scroll down to and click on the Delivery Information section. This is where you will document your delivery data. Document the following for Baby A:

Labour Onset Methods = Spontaneous
Delivery Type = Vaginal
Date, Time of birth: Today/0800

4. Click the **green check mark** ✓ to sign.

5. Now navigate to the **Newborn Delivery Data** iView band.

6. Click on the **Newborn Delivery Data** section and document the following for Baby A:

- Heart Rate Apgar 1 Minute = Greater than 100 beats per minute
- Respirations Apgar 1 Minute = Good, strong cry
- Muscle Tone Apgar 1 Minute = Active motion
- Reflex Irritability Apgar 1 Minute = Cry or active withdrawal
- Color Apgar 1 Minute = Body pink, extremities blue
- Apgar score 1 Minute (autocalculation) = 9

7. Now click on **the Newborn Exam** section and document the following:

   - Gender = Female
   - Birth Weight (g) = 3200

8. Click the **green check mark** to sign.

Note: The Delivery Information section is a shared iView section with OB Providers; ie, some fields will be completed by nurses and some fields will be completed by providers.

The Newborn Delivery Data and Newborn Exam sections are also shared iView sections with Newborn Providers. **Note** that newborn delivery documentation including gender, APGARs, weight, length, and head circumference are documented in the *mom's* chart and then result copied into the newborn's chart (you will learn more about Result Copy later).

Note: For a multiples birth, you will need to document delivery information and newborn delivery data for Baby A and Baby B (etc.) separately.

🔑 Key Learning Points

■ Newborn delivery data can be documented via iView.

Activity 8.2 – Quick Registering the Newborn

1 Once a baby is born, it is necessary to complete the **Newborn Quick Reg** (Registration) to create an electronic chart for the baby. Orders cannot be placed for the newborn (since the chart does not exist yet) if the newborn quick registration has not been completed.

The newborn must be quick registered prior to transfer to the postpartum unit.

Let's practice completing the **Newborn Quick Registration**:

1. Click on the **Conversation Launcher** [Conversation Launcher] on the Toolbar.

2. The **Person Mgmt: Conversation Launcher** window opens. Double click on the **Newborn Quick Reg** icon
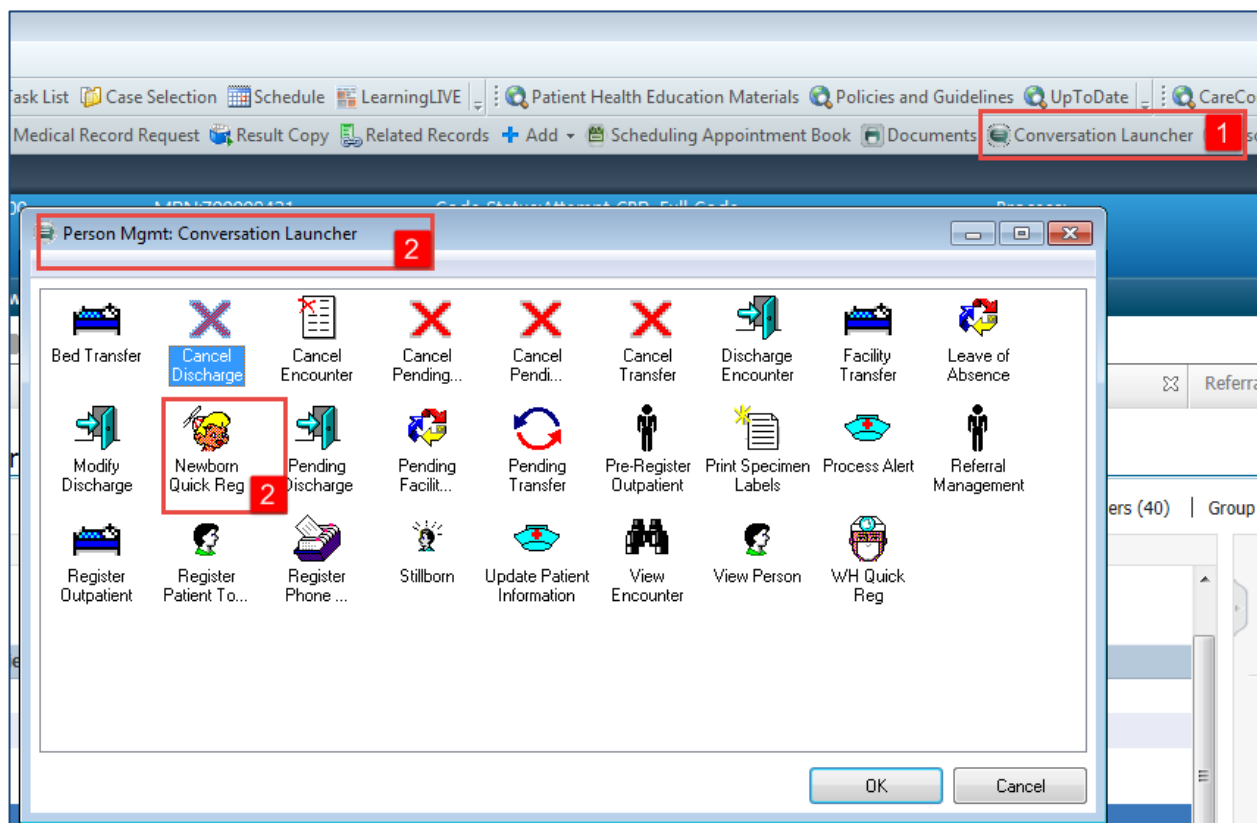
3. The **Encounter Search** window opens. Type in the patient's (mother's) Encounter number (located in the Banner bar) in the "Encounter #" field. Note: You can also search by the patient's name.

4. Click on the Search button.

5. Your patient's name will populate on the right. Verify the details to ensure you have the

correct patient.

6. Click on the correct Inpatient Encounter type

7. Click on the **OK** button

8. The External MPI window opens with a **Newborn Request PHN**. Enter the following
    information:
    - Sex = Female
    - Baby last name = autopopulates with the mother's last name
    - Baby first name = autopopulates with Baby Girl (based on selection from Sex field)
    - Date of birth = Today's Date
    - Birth time = 0800

9. Click **Submit**

Note: For multiple births, you must check off the Multiple births box and select a letter corresponding to the Baby's birth order. This field must be left blank for singletons.

A **Newborn Quick Reg: Newborn 1 of 1** window will pop up. Fill in all the necessary fields (yellow highlight)

10. **Multiple Birth**: No

11. **Unit/Clinic:** LGH Labour and Delivery

12. Click Bed Availability and search for the room that the mother is admitted in. Select an available baby bed (not assigned or dirty). Choose Bed A for Baby A (for Baby B or C, choose Bed B and C accordingly)

PATIENT SCENARIO 8 – Delivery Documentation & Newborn
Quick Registration

CLINICAL + SYSTEMS
TRANSFORMATION
Our path to smarter, seamless care

TRANSFORMATIONAL
LEARNING

13. **Admitting Provider:** Plisvca, Rocco.

14. **Attending Provider:** Plisvca, Rocco.

15. Click **OK**

16. The Document Selection window opens. This window provides options to print Armband labels, Lab Blood Specimen Labels, and Lab Non-Blood Specimen Label. In practice, you would click **OK** to print the documents. However in class, because you are not synced with a printer, please close the window without clicking OK.

The baby has now been quick registered.

To see the baby on the Tracking Shell, click on the Tracking Shell button on the Toolbar. Select the LGH OB All Beds location tab (remember that only the OB All Beds tab shows baby beds). **Refresh** the screen. Your baby should appear on the Tracking Shell in the bed that you placed them in.

Note: After a baby has been quick registered, the OB unit clerk or Registration Clerk needs to be notified to perform a full registration on the baby. Documentation in the newborn's chart is not dependent on this full registration.

Your patient has delivered a baby girl vaginally with APGARs of 9,9 and weight= 3200g.

🔑 **Key Learning Points**

- Newborn Quick Registration can be completed through the Conversation Launcher.
- Newborn Quick Registration is required prior to the baby being transferred to a different unit.

PATIENT SCENARIO 9 – Review, Initiate, Complete and Discontinue Orders

Learning Objectives

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

- Review Orders
- Initiate Orders
- Complete Orders
- Discontinue Orders

SCENARIO

In this scenario, we will review orders.

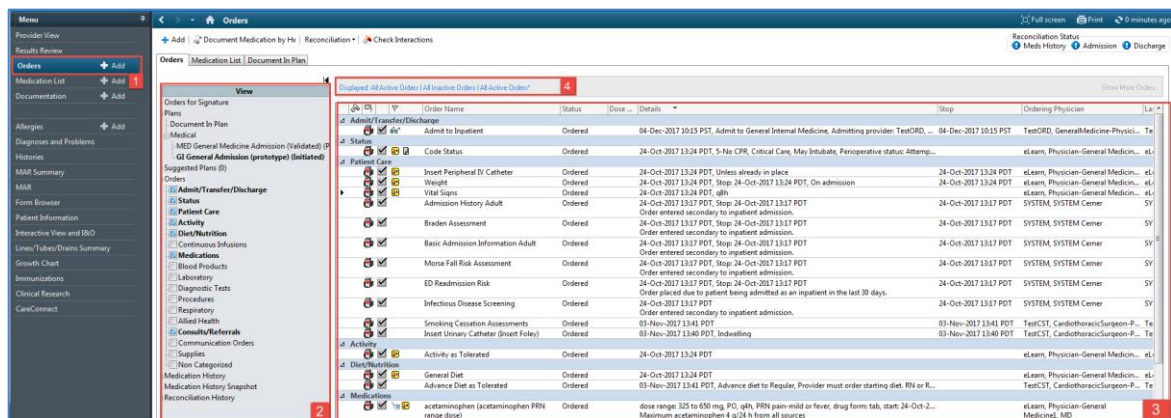As an inpatient nurse you will be completing the following activities:

- Review an order
- Initiate an order
- Complete an order
- Discontinue an order

🧩 Activity 9.1 – Review Orders Page

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

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

1. Select **Orders** from the **Menu**

2. On the left side of the Orders Page is the navigator (**View**) which includes several categories including:

   - **Plans**
   - **Categories of Orders**
   - **Medication History**
   - **Reconciliation History**

3. On the right side is the **Order Profile** where you can:

   - Review the list of 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

4. 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.

Note:
- Orders Page is the entire page
- Orders View (Navigator) is labelled 2.
- Orders Profile is labelled 3.

🔑 **Key Learning Points**

🟩 The Order page consists of the orders view (Navigator) and the order profile.

🟩 The Order Profile page displays All Active Orders for a patient.

Activity 9.2 – 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
Status					
		MEWS Alert	Processing		
✓		Code Status	Ordered		30-Nov-2017 09:41 PST, Attempt CPR, Full Code, Perioperative status: Attempt CPR, Full Code, Du...
Patient Care					
✓		Weight	Ordered		30-Nov-2017 09:41 PST, Stop: 30-Nov-2017 09:41 PST, On admission, standing weight is preferred
✓		Vital Signs	Ordered		06-Dec-2017 12:51 PST, q4h
✓		Pulse Oximetry	Ordered		30-Nov-2017 09:41 PST, q8h, with vital signs
✓		Negative Pressure Wound Therapy	Ordered		30-Nov-2017 09:26 PST, 125 mmHg, Pressure interval: Continuous, Filler: Black Foam, Dressing ch...
✓		Morse Fall Risk Assessment	Ordered		17-Nov-2017 14:17 PST, Stop: 17-Nov-2017 14:17 PST Order entered secondary to inpatient admission.
✓		Intensive Care Delirium Screening Checklist (ICDSC)	Ordered		05-Dec-2017 12:00 PST, BID, To be done at 0600 and 1600 and as needed.

To review order details:
- Focus on the **Details** column of the Orders page
- Hover your cursor over specific orders to discover additional information
- Note the start date and that orders are organized by clinical category

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

Note: Do NOT follow these steps in the system but instead refer to the screenshots to understand the process.

1. A **Nurse Review** icon 👓 appears to the left of the order. This serves to acknowledge the orders have been seen but not necessarily carried out yet.
2. Click the **Orders for Nurse Review** button to open the **Actions Requiring Review** window.

		Order Name	Status ▼	Dose ...	Details
⊿ **Patient Care**					
► ✓	👓	Vital Signs	Ordered		28-Nov-2017 10:42 PST, q4h

[Orders For Cosignature] [Orders For Nurse Review] **2**   [Orders For Signature]

3. Review order details. If there are multiple orders for review, you can review them all at once, or only select the ones that you wish to mark off as reviewed.

4. Click **Review**

Note: that you can also review orders directly from the Tracking Shell.

If you double click on the Nurse Review icon in the **NR** column, the **Actions Requiring Review** window will open and list all the orders for you to review. Once you have reviewed all the orders, the Nurse Review icon in the **NR** column of the Tracking Shell will disappear.

🔑 **Key Learning Points**
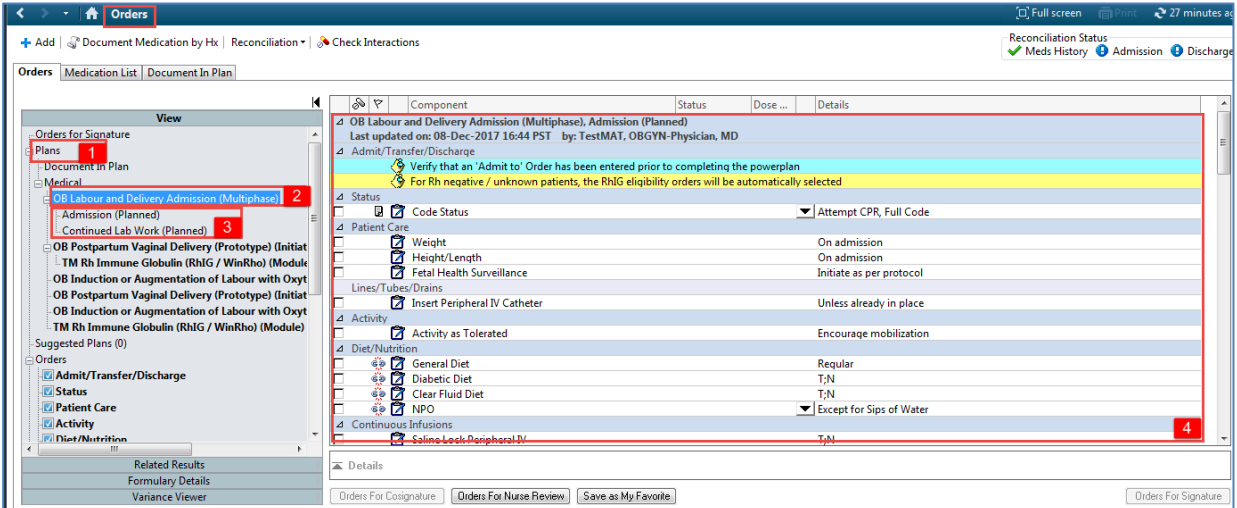
☐ Nurses should always verify the status of orders.

☐ Hover to Discover to view additional order information.

☐ Nurses should regularly review orders to acknowledge that they have been seen, but not necessarily carried out.

Activity 9.3 – Review Components of a PowerPlan

1 A PowerPlan in the Clinical Information System is the equivalent of preprinted orders (PPOs) in current state. An example is the **OB Labour and Delivery Admission (Multiphase) Powerplan**. 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 a PowerPlan.

While on the Orders Page:

1. Locate the **Plans** category to the left side of the screen under **View**

2. Select the OB Labour and Delivery Admission (Multiphase) PowerPlan**.**

3. Note that this PowerPlan has two separate phases: Admission and Continued Lab Work.

4. Review orders within the PowerPlan.

🔑 Key Learning Points

A PowerPlan is the equivalent of preprinted orders.

Activity 9.4 – Initiate an Order

1 The OB Provider has placed the **OB Labour and Delivery Admission (Multiphase) PowerPlan** in a planned state. You will need to initiate the PowerPlan in order to act on the orders. Because this is a multiphase PowerPlan, you will need to initiate (as well as discontinue) the different phases separately.

1. Click on the **Orders** band from the Menu.

2. Locate the **OB Labour and Delivery Admission (Multiphase) PowerPlan** in the Navigator (View). The Admission phases and Continued Lab Work phases are both in planned statuses.
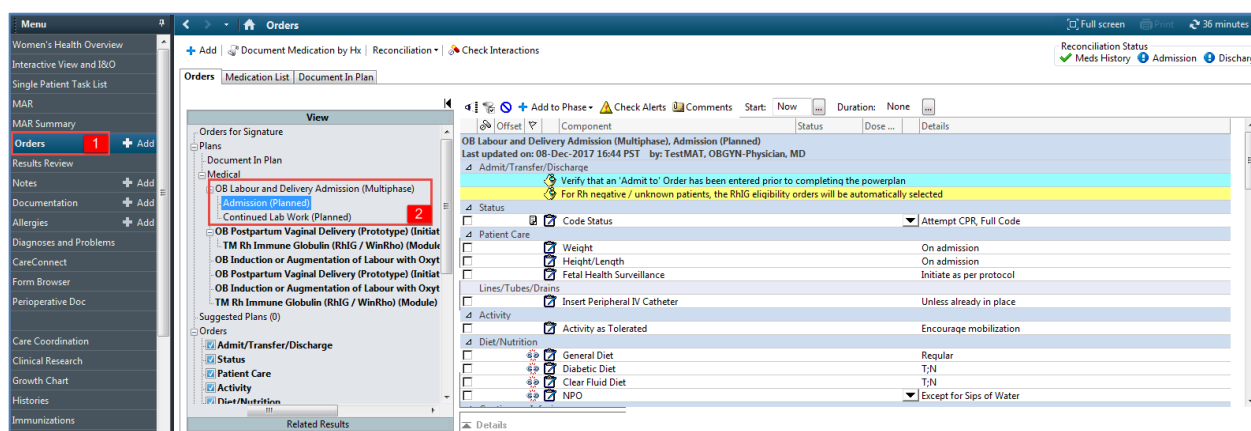
3. Right click on the **Admission (Planned)** phase and select Initiate from the drop down list.
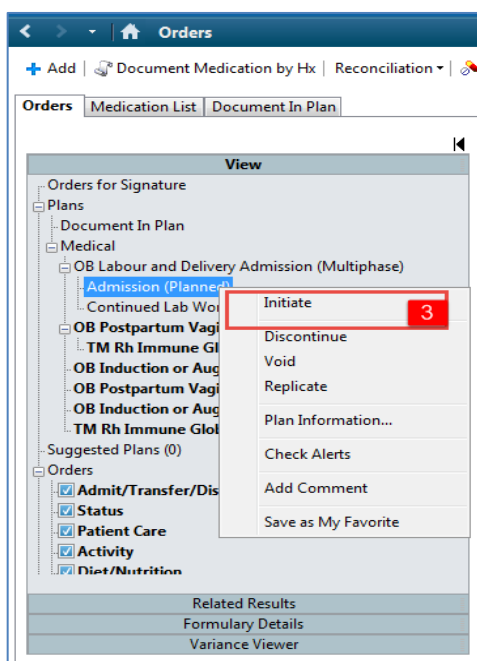
4. The **Ordering Physician Window** opens with the provider name automatically prepopulated. Select No Cosignature required and click **OK**.

5. The Admission phase will now be updated with the status as Initiated Pending.

6. Click **Orders for Signature** from the Orders Profile.

7. The Orders Profile will update and display only the selected orders.

8. Click **Sign**.

9. The Admission phase status will be updated to Initiated.
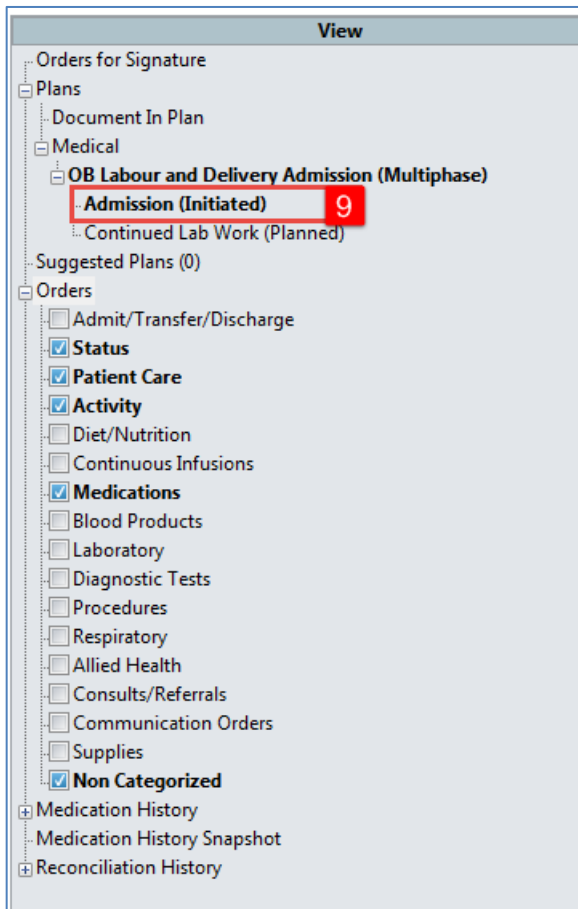
Repeat Steps 3 - 9 to initiate the Continued Lab Work (Planned) phase.

🔑 **Key Learning Points**
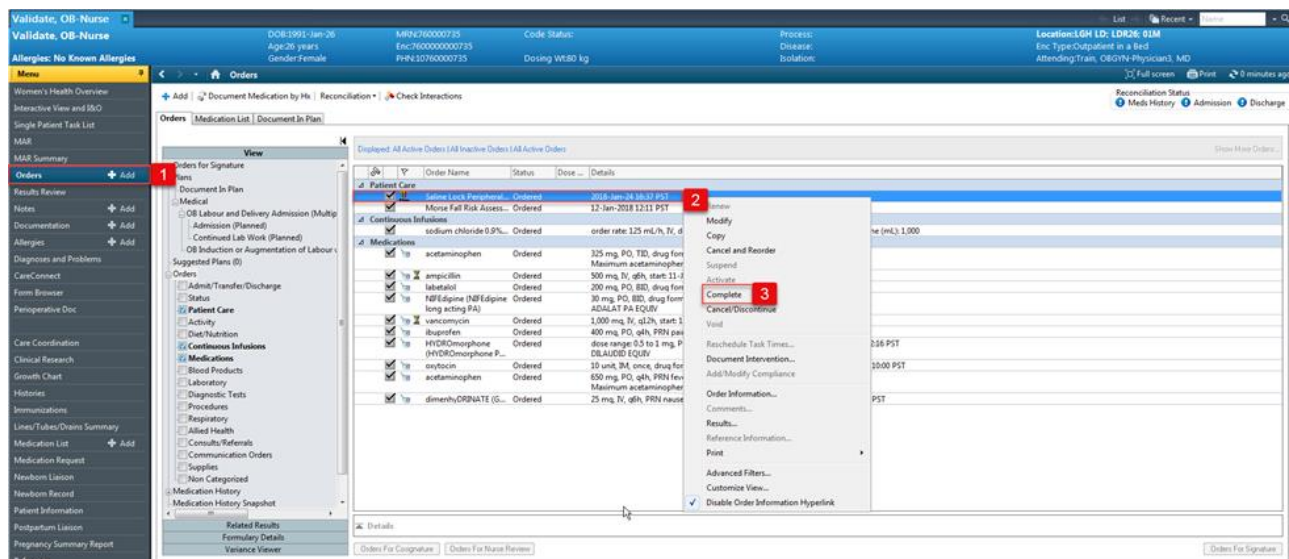
■ You will need to initiate the PowerPlan in order to act on the orders

Activity 9.5 – Complete or Cancel/Discontinue an Order

1 Orders can be documented as completed or discontinued depending on the type of order.

When a one-time order has been carried out, the orders needs to be removed from the patient's order profile. This is done by completing the order.
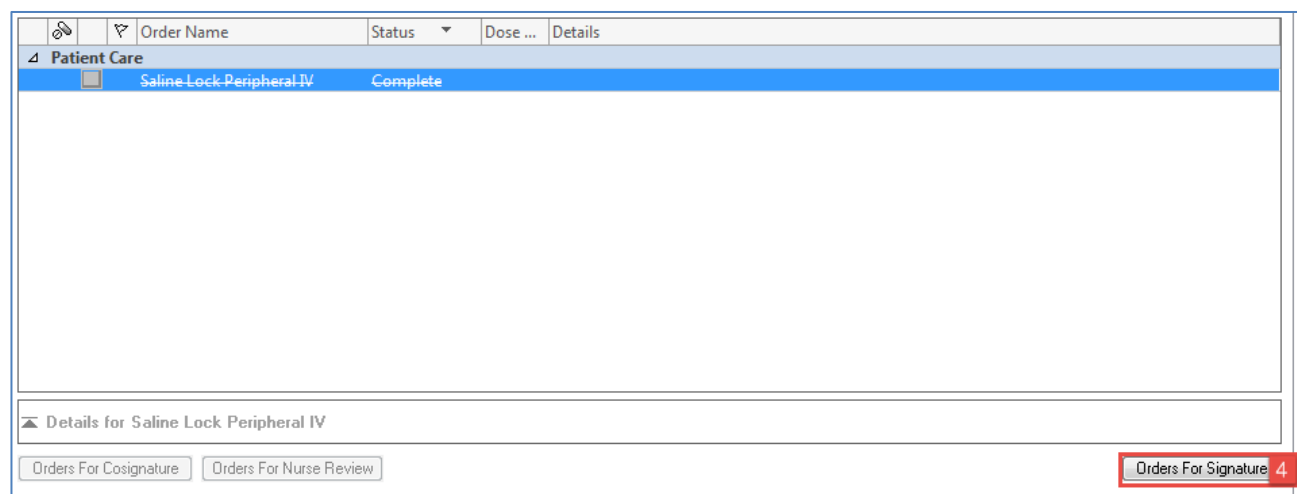
To complete an order:

1. Review the **Orders Profile**

2. Right-click order to **Saline Lock Peripheral IV**

3. Select **Complete**

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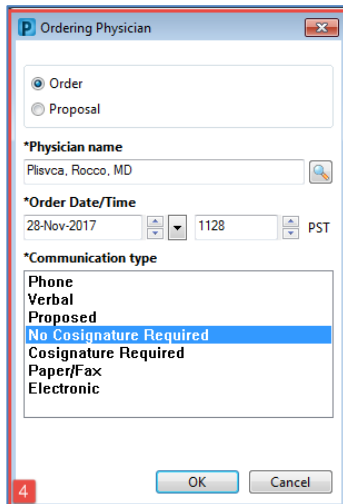
5. Review order for signature and click **Sign**. You will return to the orders profile where the order will show as processing.

Refresh the page. Order will no longer be visible on the Orders Profile.

2 Now let's try to discontinue an order.

1. Review order profile

2. Right-click order **Encourage Fluids**

3. Select **Cancel/Discontinue**

4. Ordering Physician pop-up window will appear. Fill out required fields highlighted yellow below and then click **OK**
    - Physician name = *type name of Attending Physician (last name, first name)*
    - Communication type = *No Cosignature Required*
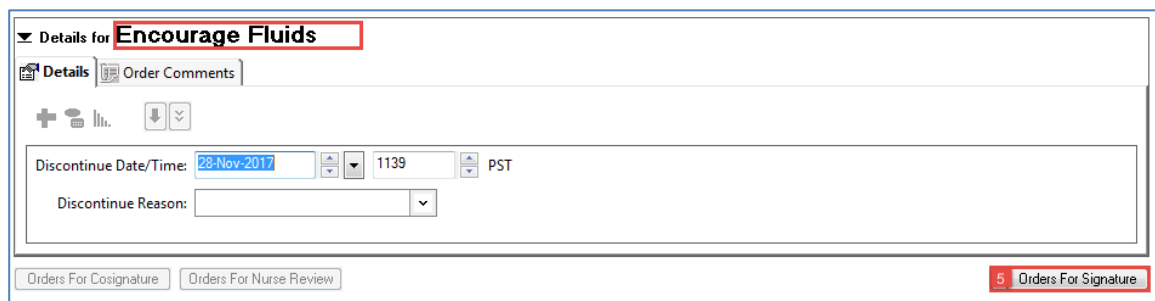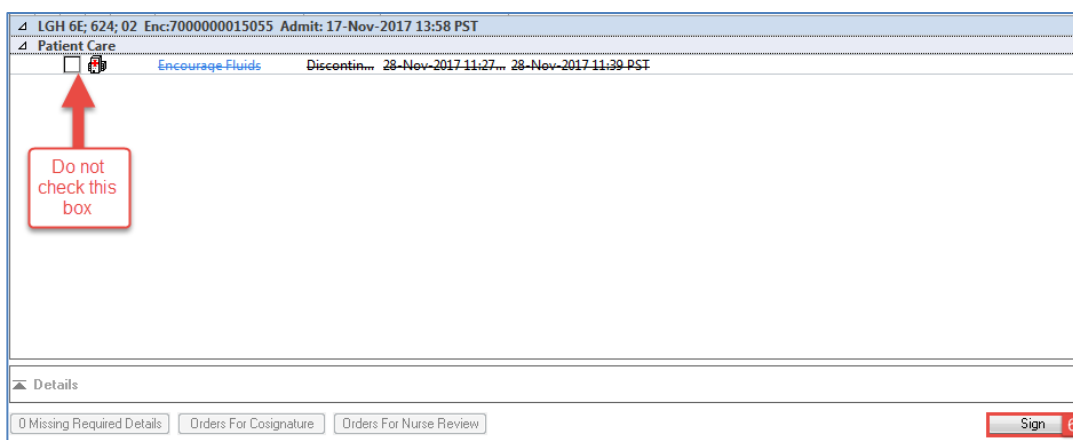
5. Review order to discontinue and click **Orders For Signature**

6. Review Order for signature and click **Sign**. You will return to the order profile. **Refresh** page. Order will no longer be visible on order profile.

Note: After your patient delivers, you should discontinue any antepartum and/or intrapartum orders (for example, the **OB Labour and Delivery Admission (Multiphase) Powerplan** since these orders are no longer applicable postpartum. Refer to the workbook section on discontinuing PowerPlans for more information.

Note if the PowerPlan is a multiphase plan, you will need to discontinue the appropriate phases separately. For example, after your patient delivers, you should discontinue the Admission phase of the OB Labour and Delivery Admission (Multiphase) Powerplan, but keep the Continued Lab Work phase active since this phase is still applicable postpartum.

🔑 Key Learning Points

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

CLINICAL + SYSTEMS TRANSFORMATION
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TRANSFORMATIONAL LEARNING

PATIENT SCENARIO 10 – Result Copy, Related Records, Transfer

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

- Result Copy from the mother's chart to the baby's chart.
- Access related records
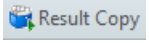- Transfer mother and baby from Labour & Delivery to Postpartum

SCENARIO

In this scenario, we will learn how to result copy for the baby. We will learn of when to use the result copy function.

As an inpatient nurse you will be completing the following activities:

- Result copy from the mother's chart to the newborn's chart, prior to transfer.
- Access related records
- **There are 3 minimal times when result copy is necessary:**
   1. After the baby has been quick registered
   2. When the mom and baby is being transferred from labour to postpartum
   3. Prior to the mom and baby being discharged from the hospital.
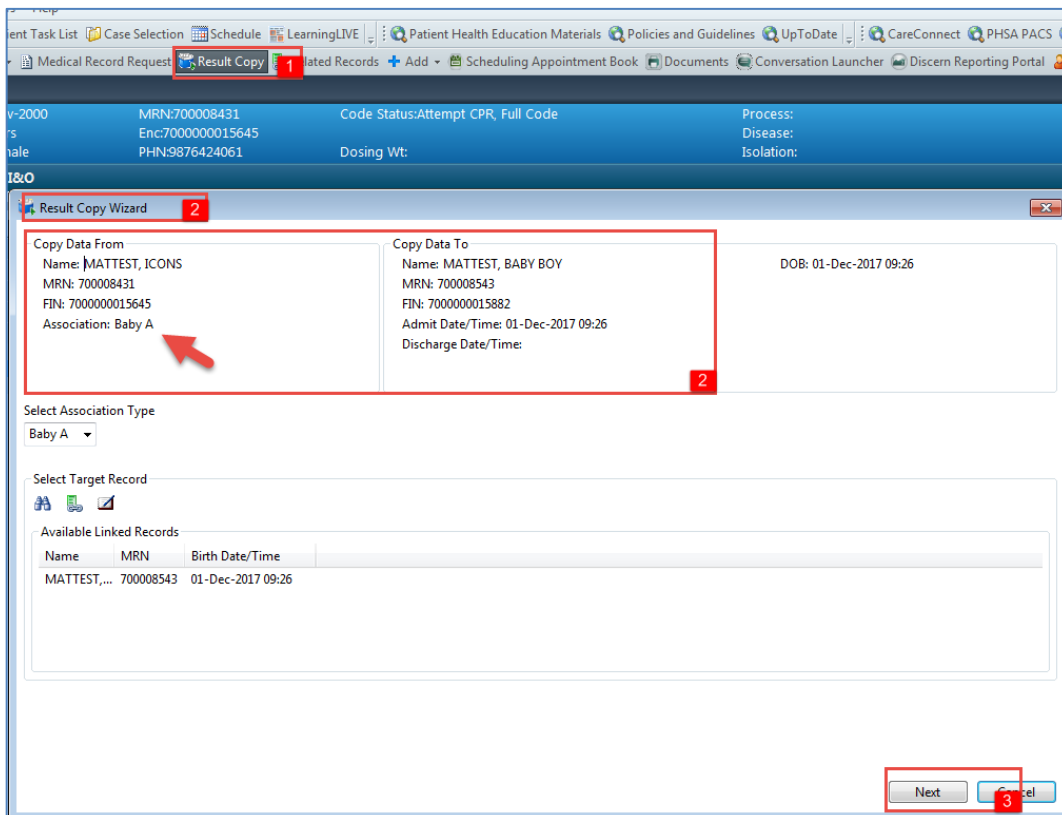
🧩 Activity 10.1 – Result Copy

1 After you have quick registered a baby, it is important to **Result Copy** from the mom's chart to the baby's chart. Performing Result Copy ensures that pertinent delivery and newborn information documented in the mom's chart is copied over to the baby's chart.

1. From the mom's chart, click the **Result Copy** 📋 Result Copy in the Toolbar.

2. The **Result Copy** Wizard window opens. Check to ensure the demographic information is correct for both the mom (in the Copy Data From box) and her newly quick registered newborn (in the Copy Data To box).

Note: for multiples, ensure the Association field in the Copy Data From box is referring to the correct Baby.

3. Select **Next**.

4. Information that will be copied over will show up once more; verify it is accurate. Any information that is highlighted green is newly documented information that will be copied over to the baby's chart. You can select or unselect any categories on the left.

   Select Next.

5. Click **Copy Data**

The Result Copy Wizard window will close and you will be taken back to your patient's (mom's) chart.

Note: Result Copy can be done at any time during nursing documentation, however, at a minimum, it should **always** be done at the following times in order for appropriate information to be viewable in the newborn chart (and therefore facilitate appropriate care):

1. After Quick Registration of a newborn (Labour and Delivery Nurse to do Result Copy)
2. When mother's status is switched from Labour to Postpartum (Labour and Delivery Nurse to do Result Copy)
3. Before mother/baby is discharged from hospital (Postpartum Nurse to do Result Copy)

Now that you have created an electronic chart for the baby (via Newborn Quick Reg) and you have performed result copy to copy pertinent delivery information from the mom's chart to the baby's chart, you can document on the baby. After a baby is born, the nurse needs to complete the Newborn Admission History PowerForm.

🔑 Key Learning Points

■ Result copy allows you to copy documented information from mom's chart over to the newborn's chart.

■ Result copy is necessary at minimum during the follow 3 situations:

1. When the newborn has been quick registered
2. When mom and baby are being transferred from labour to postpartum
3. When mom and baby are being discharged from the hospital

🧩 Activity 10.2 – Related Records

The **Related Records** function can be used to find and open a chart of a related patient. For example, if you are in a mom's chart and you wish to quickly find and open her baby's chart, you can use the Related Records function.

Let's practice using **Related Records** to open a baby's chart:

1. From the mom's chart, click on the **Related Records** ![Related Records] from the Toolbar.
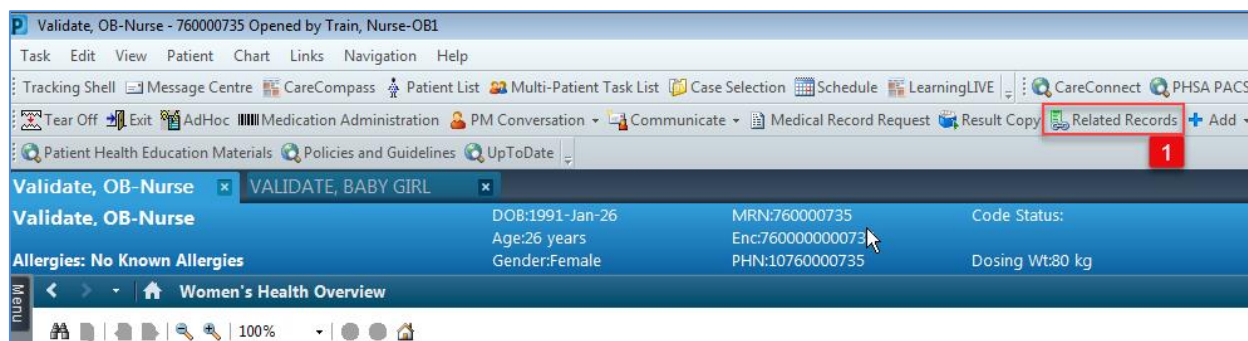
2. If this is your first time accessing the newborns chart, you will first be prompted to assign a relationship to the baby. Select Nurse. Click **OK**
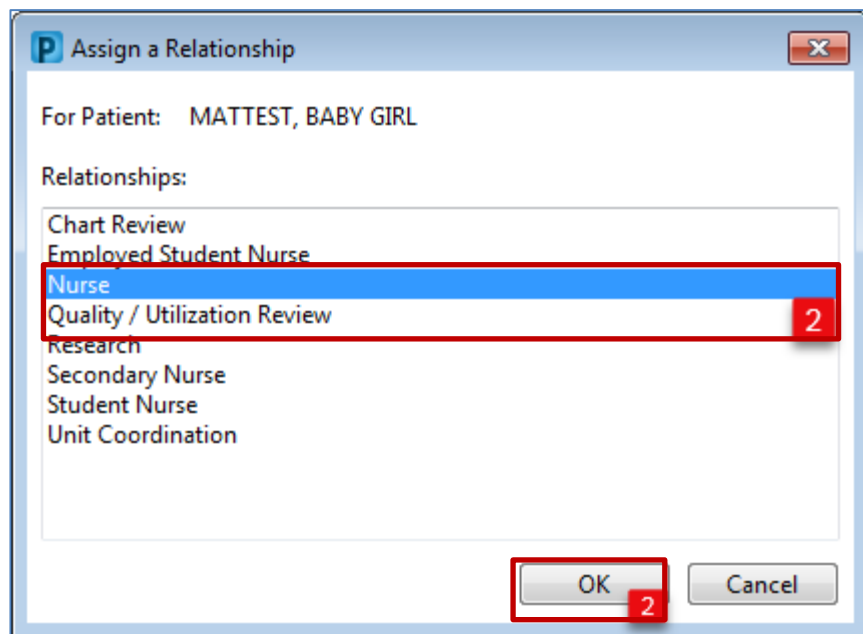
3. The Encounter Selection window will open. Select the correct encounter (note that because the newborn only has one encounter, it will already be selected). Click on the X icon ![X] to close the window.
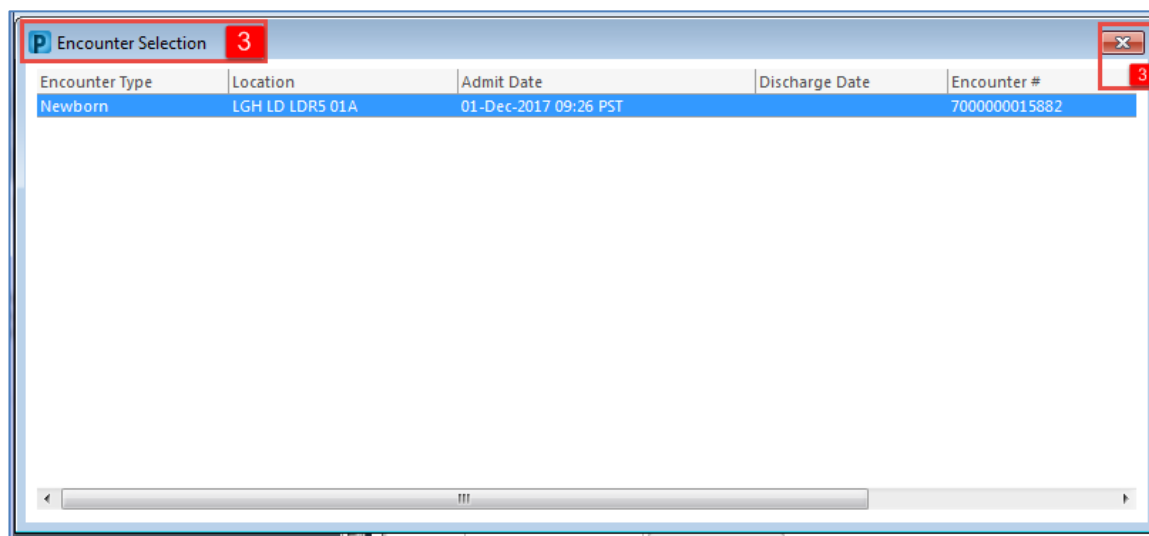
4. The baby's chart will open to the **Women's Health Overview** as the default landing view, with the **Neonate Overview** page open.
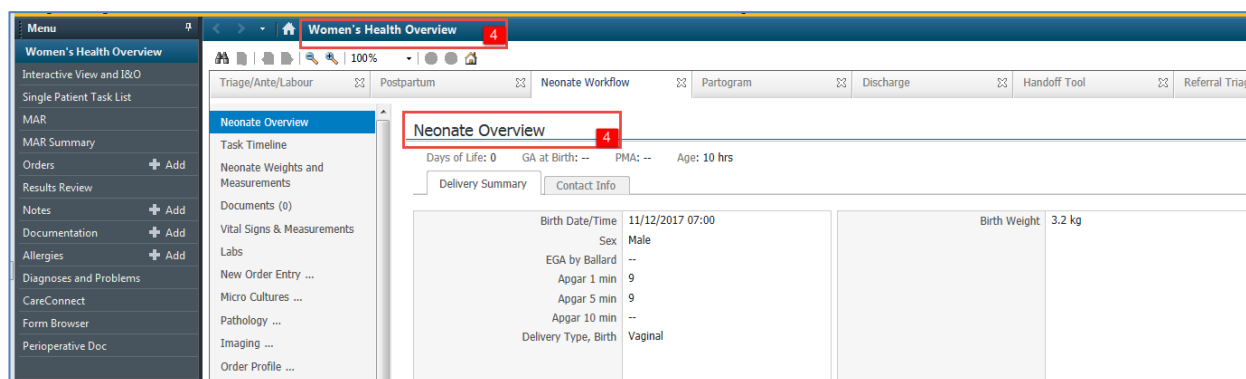
Activity 10.3 – Bed Transfer

1 The mother and the baby will need to be transferred from Labour & Delivery to Postpartum within the system. This can be done by a nurse or unit clerk.

To perform a bed transfer:

1. Navigate to the **Tracking Shell** and click the **LGH L&D** tab

2. Click on the patient to be transferred (the patient's row will be highlighted)

3. Click on the **rocketship** and select **Bed Transfer**

4. Complete all the yellow required fields which includes selecting the destination unit.

   Note: To check which beds are available on the Postpartum Unit, select the appropriate Unit in the "Unit/Clinic" field, then click on the **Bed Availability** button. All available beds will show as empty. Ensure you select an available "01M" bed for the mother with a corresponding available "01A" bed for the newborn as you will have to perform bed transfer on the newborn after.

5. After you have completed all the yellow required fields, click on the **Complete** button.

6. Refresh the screen. Your patient should now appear in the new bed on the Tracking Shell.
   Note: Ensure you are in the appropriate tab on the Tracking Shell to see your patient.
7. Repeat Steps 1 to 6 to transfer the newborn. Note: Be sure to transfer newborn into the same room as the mother, in a "01A" bed.

The mother and newborn are now transferred!

🔑 **Key Learning Points**

🟩 Mother and baby charts must be transferred from Labour & Delivery to Postpartum unit

🟩 Steps must be repeated for both mom and baby charts

🟩 Ensure baby is transferred to the same room as the mother

🎬 PATIENT SCENARIO 11 – Create a Custom Patient List

Learning Objectives
At the end of this Scenario, you will be able to: 🟩 Set up a location patient list 🟩 Create a Patient List

SCENARIO
Now that your patient has delivered, mom and baby will be transferred to the postpartum unit. As an inpatient nurse you will be completing the following activities: 🟩 Set up a location patient list 🟩 Create a custom patient list

🧩 Activity 11.1 – Create a Custom Location List

1

Creating **Custom Location Lists** allows you to see patients only listed in a particular unit.

1. To create a **Location List**, click the **List Maintenance** icon
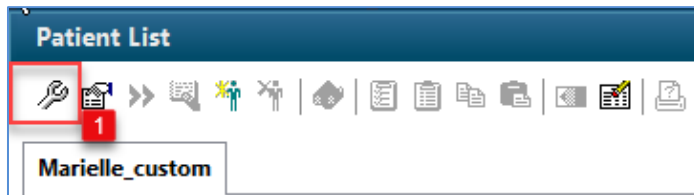
2. Click **New**
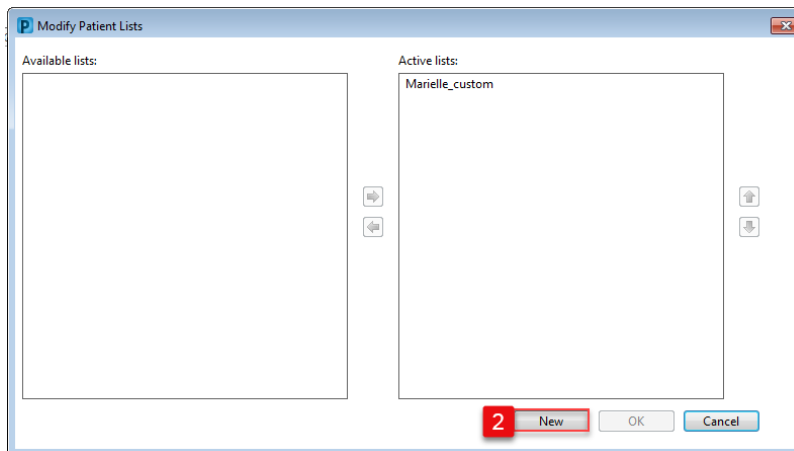
3. Select Location and click **Next**
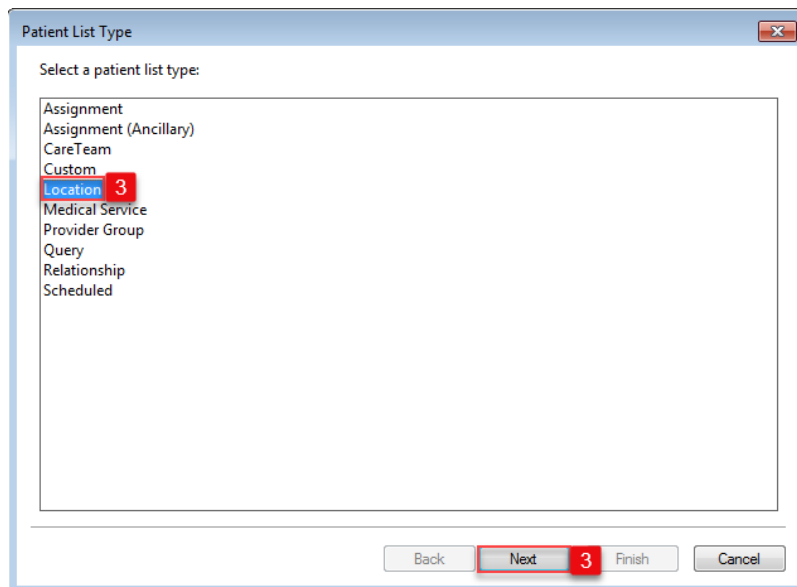
4. Click on the ⊞ sign beside Locations
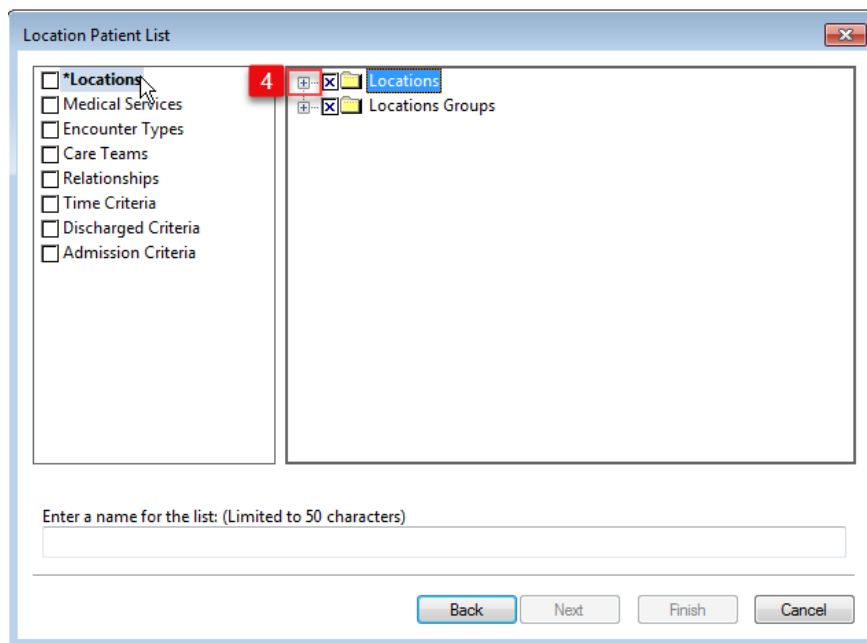
5. Scroll down and locate **LGH Lion's Gate Hospital** and click on the icon ⊞ beside LGH Lion's Gate Hospital.
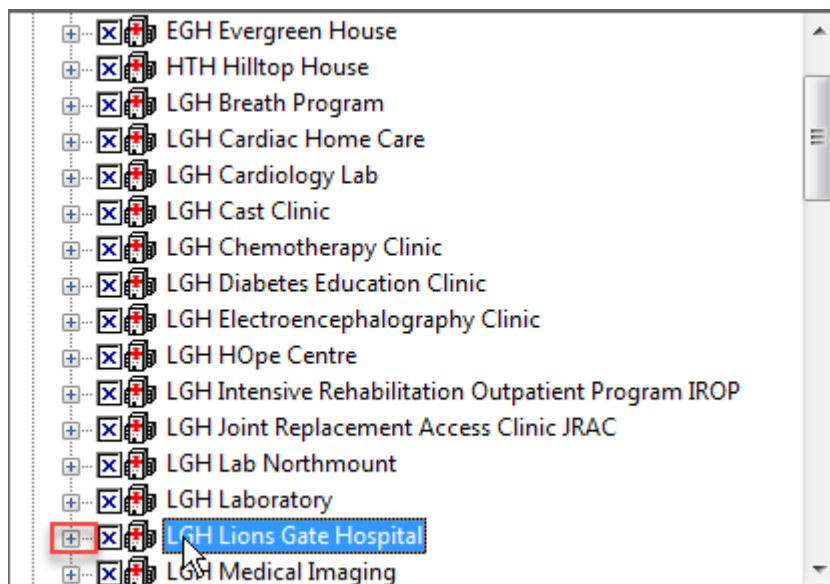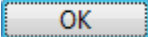
6. Click the ⊞ icon beside LGH Lion's Gate Hospital

7. Scroll down and locate **LGH Labour and Delivery**, then click on the box beside it to select LGH Labour and Delivery and click **Finish**.
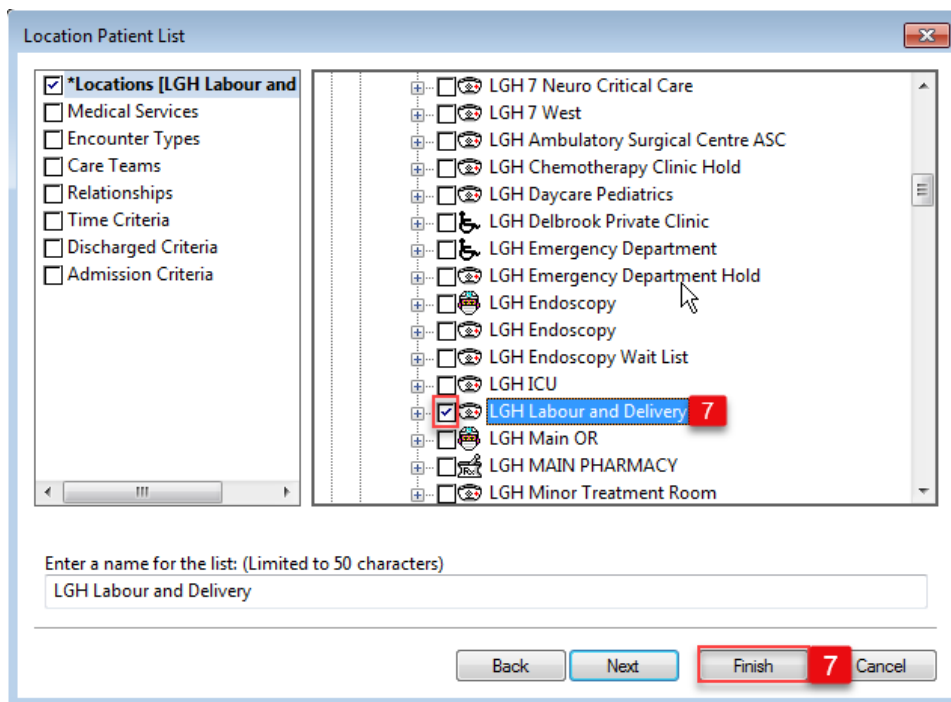
8. Select LGH Labour and Delivery from Available Lists and click on the ➡ to move list to Active Lists then click **OK**
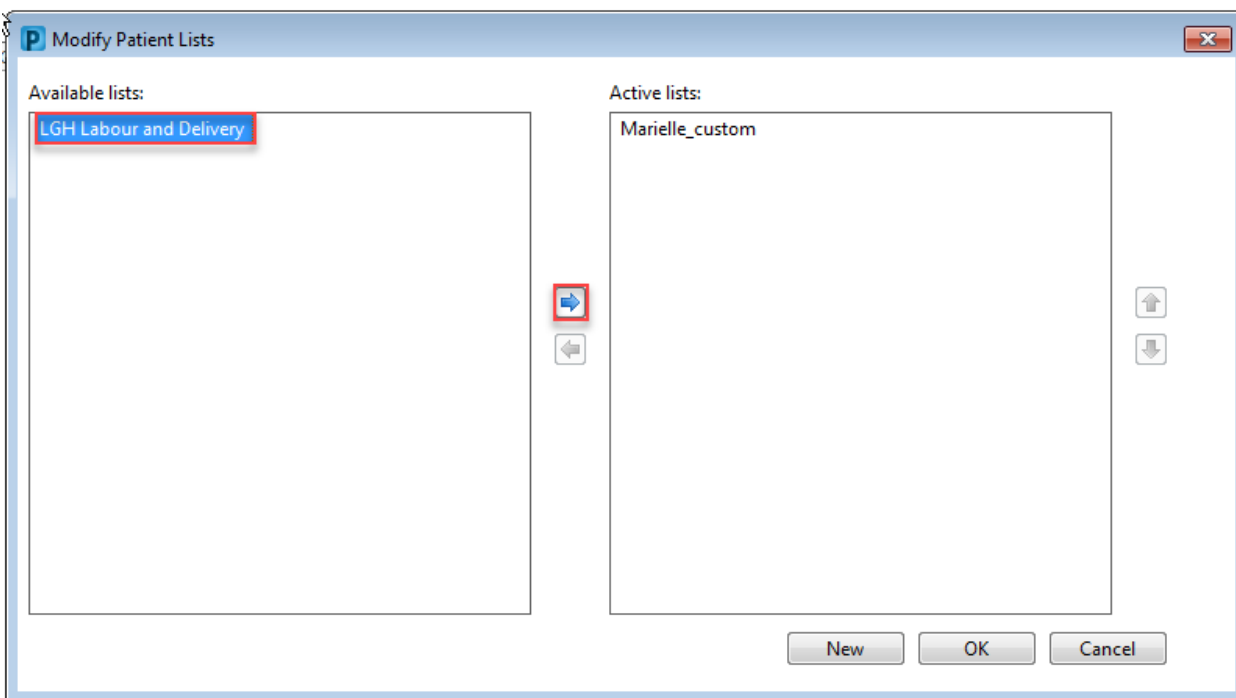
🔑 Key Learning Points

■ You can create a Custom Location List that can consist of only the patients that are on a specific unit.

🧩 Activity 11.2 – Create a Custom Patient List

1 Next you need to create a **Custom List** that will contain only the patients that you are caring for on your shift.

1. Locate the Patient List [👤 Patient List] and click the **List Maintenance** icon.
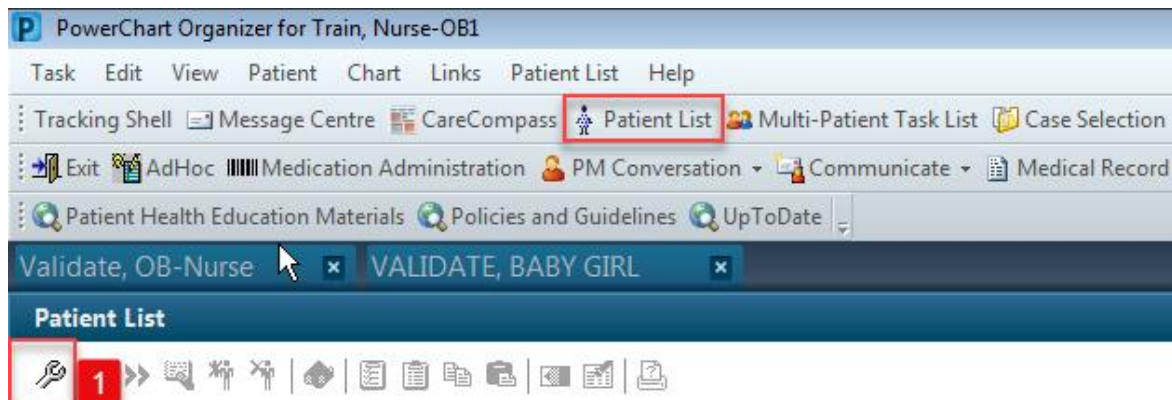
2. Click the **New** button in the bottom right corner of the **Modify Patient Lists** window.

3. From the Patient List Type window select Custom.

4. Click the **Next** button in the bottom right corner.
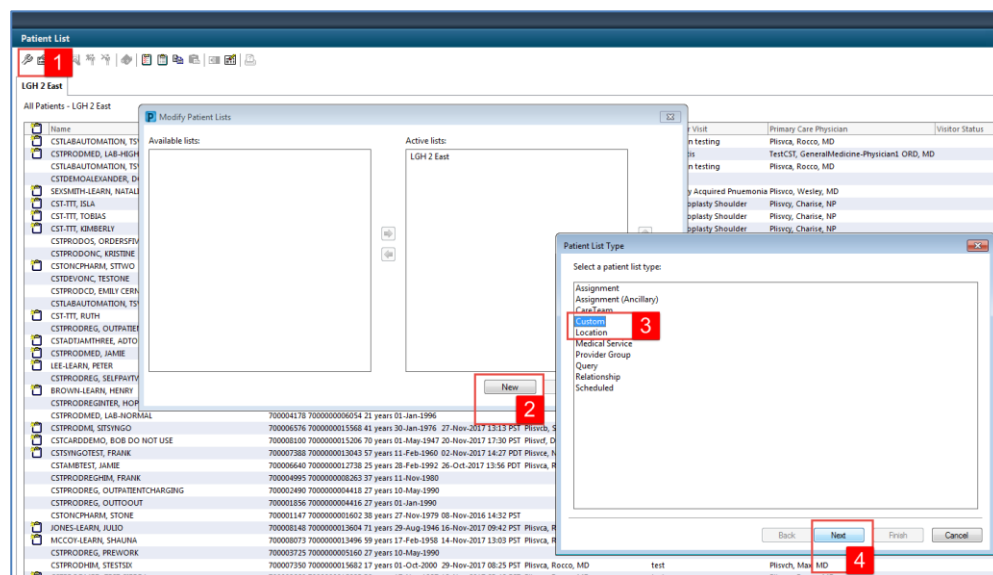
5. The **Custom Patient List** window opens. **Custom Lists** need a unique name. Type YourName_Custom (for example Sara_Custom).

6. Click the **Finish** button.

7. In the **Modify Patient Lists** window select your Custom List.

8. Click the **Blue Arrow** icon ➡ to move your **Custom List** to the right **Active List**.

9. Click the **OK** button in the bottom right.

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

1. First find your patient. Your patient is located on your **Location List**. Right click on **patient name**.

2. Select **Add to a Patient List**.

3. Select **YourName_Custom List**

4. Select YourName_Custom Tab. The Tab will be empty.

5. Click the **Refresh** icon ⟳ to refresh your screen. Now your patient will appear in your Custom List.

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

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

🔑 **Key Learning Points**

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

PATIENT SCENARIO 12 - CareCompass

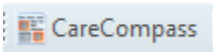| Learning Objectives |
| --- |
| At the end of this Scenario, you will be able to:

 ◼ Navigate CareCompass
 ◼ Select the correct Patient List
 ◼ Review and complete tasked activities |

| SCENARIO |
| --- |
| As an inpatient nurse you will complete the following activities:

 ◼ Review CareCompass

 ◼ Establish a relationship in the system with your patients and review patient information

 ◼ Review and complete tasks in CareCompass |

Activity 12.1 - Review CareCompass

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

When you have multiple patients assigned to you (for example, as a postpartum assignment), you can use CareCompass to organize your day.

2

1. Navigate back to **CareCompass** by clicking on the **CareCompass** [CareCompass] in the Toolbar.
2. Select **YourName_Custom** from the **Patient List** dropdown.
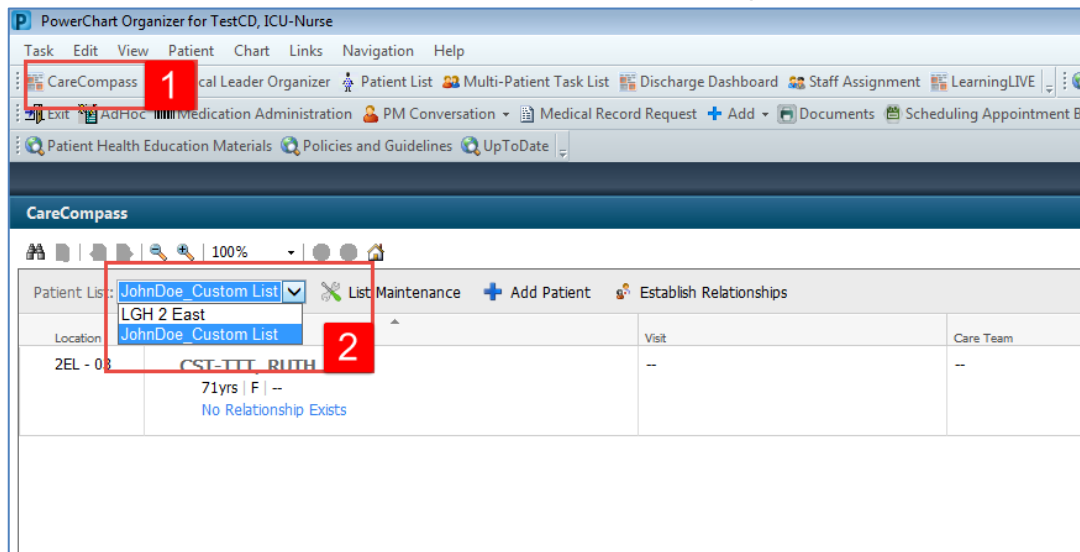
3 Click the **Refresh** icon . Your selected patients are now visible on your custom list.
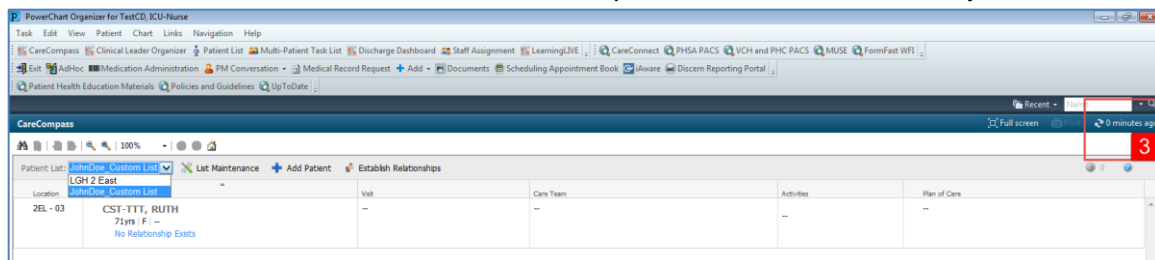
3 Let's review CareCompass

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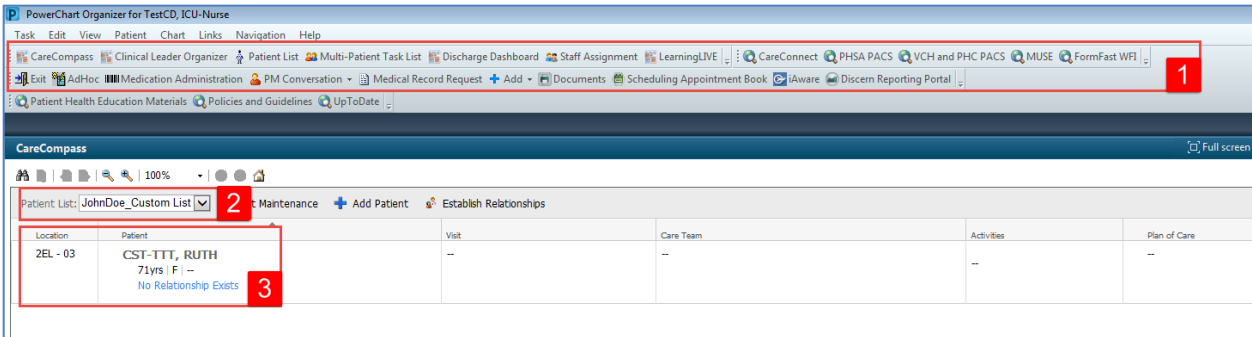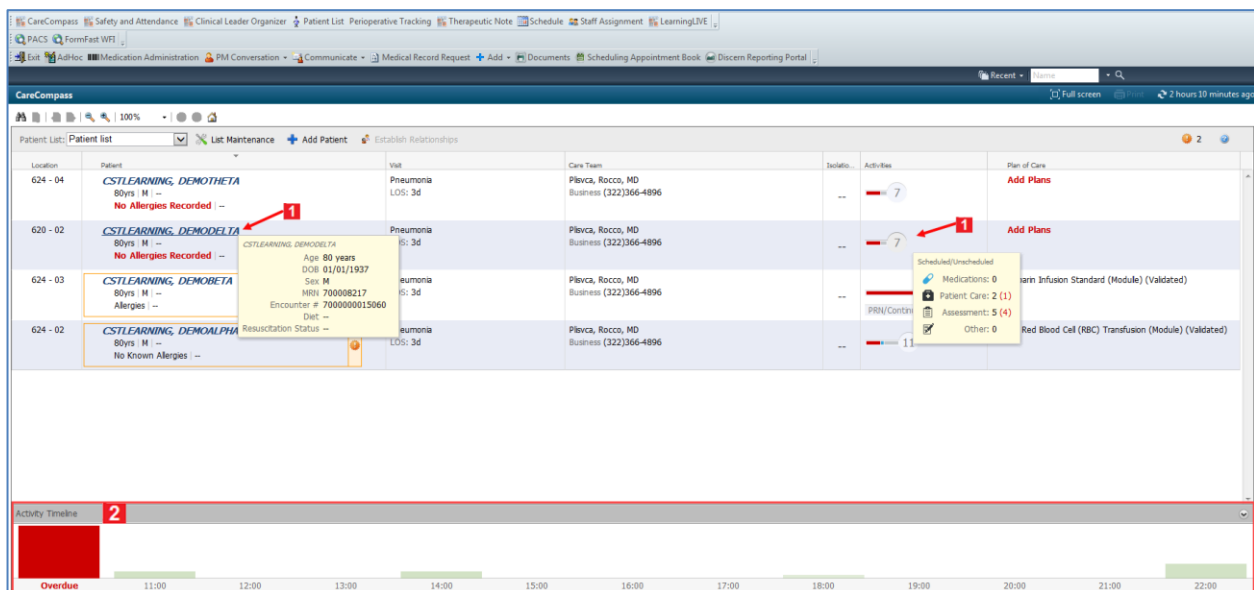

🔑 Key Learning Points

▪ CareCompass provides a quick overview of patient information

▪ Prior to establishing a relationship with the patient, the only information visible about a patient is their location, name and basic demographics

Activity 12.2 – Establish a Relationship and Review Patient Information in CareCompass

You must establish a relationship with each of your patients in order to view more patient information or access patient charts if you have not already done so from Tracking Shell.

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

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

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

2   Notice the **orange exclamation** symbol next to your patient's name. This indicates that there are new orders and/or results for a patient requiring review. Note that there is also an exclamation mark on the top right of the CareCompass page, this is the sum of patients with new orders.

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

Indicates new critical results or STAT/NOW orders.

  1. Click the **orange exclamation** symbol.

3

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

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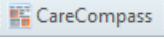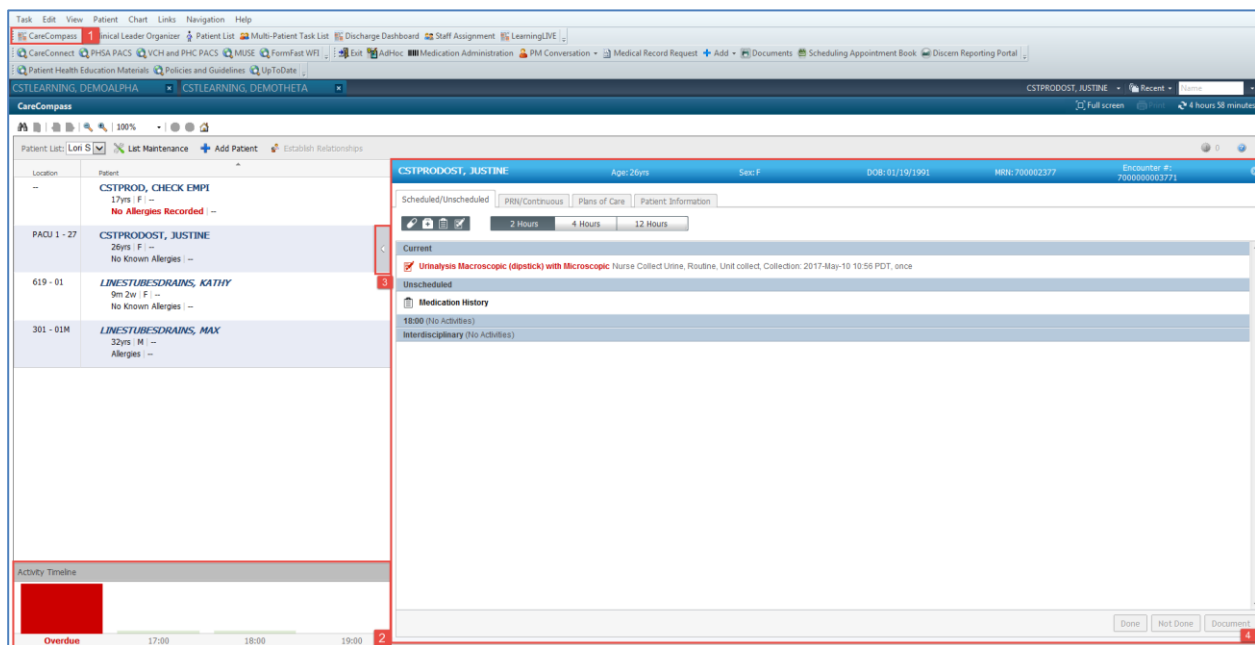
🔑 Key Learning Points

⬛ A relationship must be established with patients in order to access their patient chart

⬛ Remember to select the correct role when establishing your relationship with patients

⬛ A relationship will last for 16 hours and the nurse will need to re-establish the relationship at the next shift

⬛ CareCompass provides a quick overview of patient information including patient care activities, scheduled and unscheduled tasks and new orders and results for the patient

⬛ 🟠 Indicates new non-critical results or orders for a patient

⬛ 🔴 Indicates new critical results or STAT/NOW orders

Activity 12.3 – Review and Complete Tasks in CareCompass

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

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

Let's locate tasks on your patient:

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

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

To see different information you can navigate to:

1. **Scheduled/Unscheduled** tasks tab
2. **PRN/Continuous** tab
3. **Plans of Care** tab
4. **Patient Information** tab
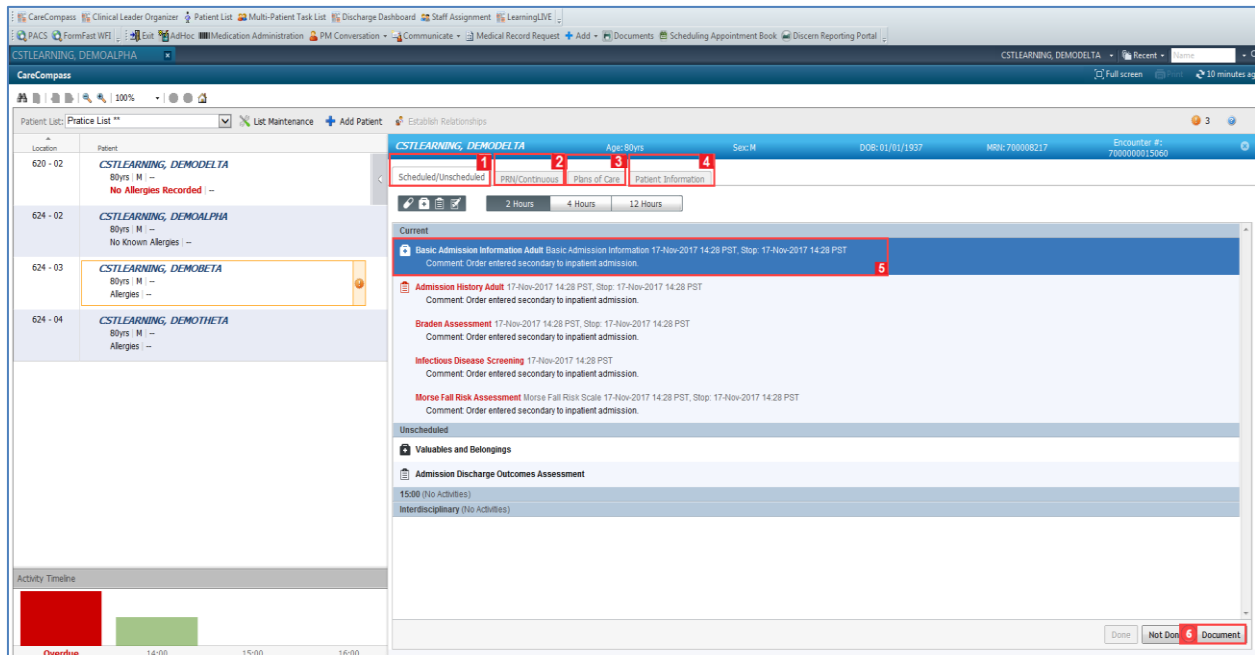
Note: When a patient is admitted, the Clinical Information System generates multiple admission tasks. These tasks are tailored to the patient's age and location.

3 Let's complete an admission task.

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

1. Select **PRN/Continuous** tab
2. Select **Morse Fall Risk Assessment**
3. Click **Document**

Note: Clicking **Document** for **Morse Fall Risk Assessment** takes you directly to **Interactive View and I&O** to complete the appropriate documentation. **Interactive View and I&O** provides access to a variety of electronic flowsheets for documenting patient care, assessments, vital signs and intake/output. Note that the Morse Fall Risk Assessment needs to be completed on admission and again in the postpartum period.

4 1. Double click the blue box next to the section name **Morse Fall Score**. The section is now active for documentation, allowing you to move through the cells by pressing Enter on the keyboard.
Document using the following data:
   - **History of Fall in Last 3 Months Morse** = *Yes*
   - **Type of Fall Morse** = *Unanticipated physiological*
   - **Activity at Time of Fall Morse** = *Dressing/undressing*
   - **Secondary Diagnosis Morse** = *Yes*
   - **Use of Ambulatory Aid Morse** = *Crutches, cane, walker*
   - **IV or IV Lock** = *No*
   - **Gait Weak or Impaired Fall Risk Morse** = *Weak*
   - **Mental Status Fall Risk Morse** = *Oriented to own ability*

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

2. Click the **green checkmark** ✔ to sign your documentation. You will notice that your documentation changes from purple text to black text once signed.

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

🔑 Key Learning Points

■ Tasks are activities that need to be completed for the patient

■ Tasks are generated by certain orders or rules in the system and show up in a list format to notify the clinician to complete specific patient care activities.

■ Tasks can be viewed and completed from CareCompass

■ Completing a task will remove it from the patient task list

■ CareCompass should be reviewed frequently throughout the shift

![puzzle] Activity 12.4– Using Results Review

1 Throughout your shift, you will need to review your patient's results. One way to do this is to navigate to **Results Review** on the **Menu**.
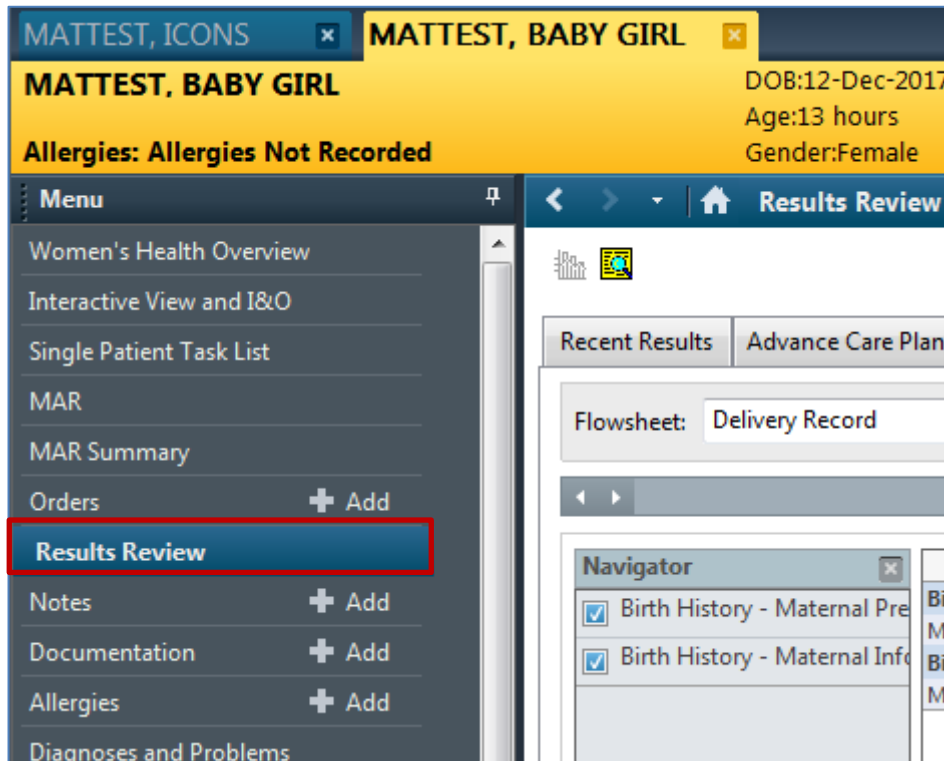
Results are presented using **flowsheets**. Flowsheets display clinical information recorded for a person such as labs, iView entries such as vital signs, cultures, transfusions and diagnostic imaging.

Flowsheets are divided into **two major sections**.

1. 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.

2. The grid to the right is known as Results Display.

Let's use Results Review to review the delivery information that was result copied to the baby's chart.

1. In the baby's chart, navigate to **Results Review** from the **Menu**

2. Select the **Delivery Record** tab.

3. The result copied delivery information from the mom's chart will display.

4. Review each individual tab to see related results

5. Select **Lab – Recent**

Review your patient's recent **lab result**.

CBC and Peripheral Smear	
WBC Count	1.5 x10 9/L (L)
RBC Count	2.00 x10 12/L (L)
Hemoglobin	70 g/L (L)
Hematocrit	0.15 (L)
MCV	98 fL
MCH	28 pg
RDW-CV	15.3 % (H)
Platelet Count	10 x10 9/L (!)
NRBC Absolute	5.0 x10 9/L (H)
Neutrophils	0.04 x10 9/L (L)
Lymphocytes	0.15 x10 9/L (L)
Monocytes	0.23 x10 9/L
Eosinophils	0.01 x10 9/L
Basophils	0.01 x10 9/L
Metamyelocytes	0.73 x10 9/L (H)
Myelocytes	0.23 x10 9/L (H)
Promyelocytes	0.08 x10 9/L (H)
Blast Cells	0.02 x10 9/L (H) 5
Blood Film Comment	Platelet Estimate - Decre

Note the colours of specific lab results and what they indicate:
- **Blue values** indicate results lower than normal range
- **Black values** indicate normal range
- **Orange values** indicate higher than normal range
- **Red values** indicate critical levels

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

🔑 Key Learning Points

- Flowsheets display clinical information recorded for a patient such as labs, cultures, transfusions, medical imaging, and vital signs.

- The Navigator allows you to filter certain results in the Results Display.

- Bloodwork is coloured to represent low, normal, high and critical values.

- View additional details of a result by double-clicking the value.

PATIENT SCENARIO 13 – Documentation within CareCompass

Learning Objectives
At the end of this Scenario, you will be able to: ■ Add an allergy ■ Navigate the Ins and Outs Flowsheet in iView ■ Document Ins & Outs

SCENARIO
In this scenario, you will add an allergy for your patient and document the Ins & Outs. As an inpatient nurse you will be completing the following activities: ■ Add an allergy ■ Navigate the Ins & Outs Flowsheet in iView ■ Document Ins & Outs
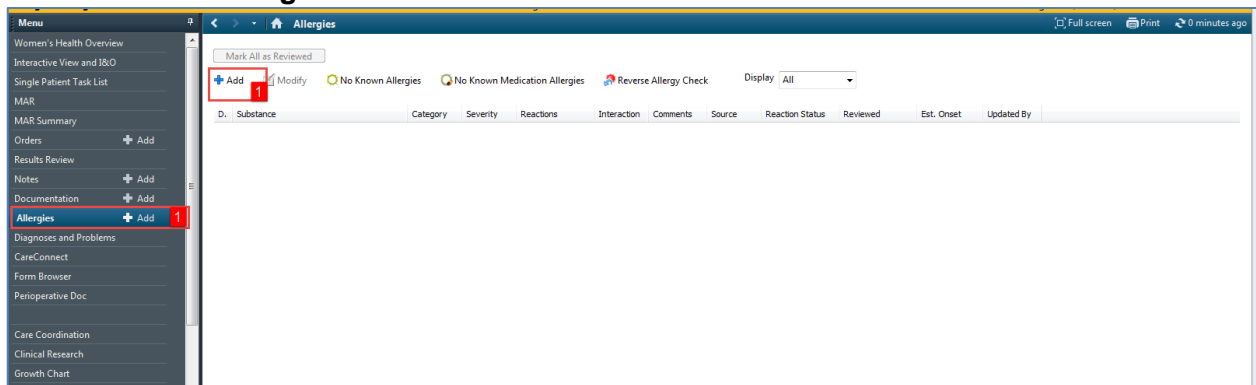
🧩 Activity 13.1 – Add an Allergy

1 You realize you did not previously document an allergy. Your patient mentions that she gets mild redness to the skin when tape is applied.

Let's practice documenting an allergy:
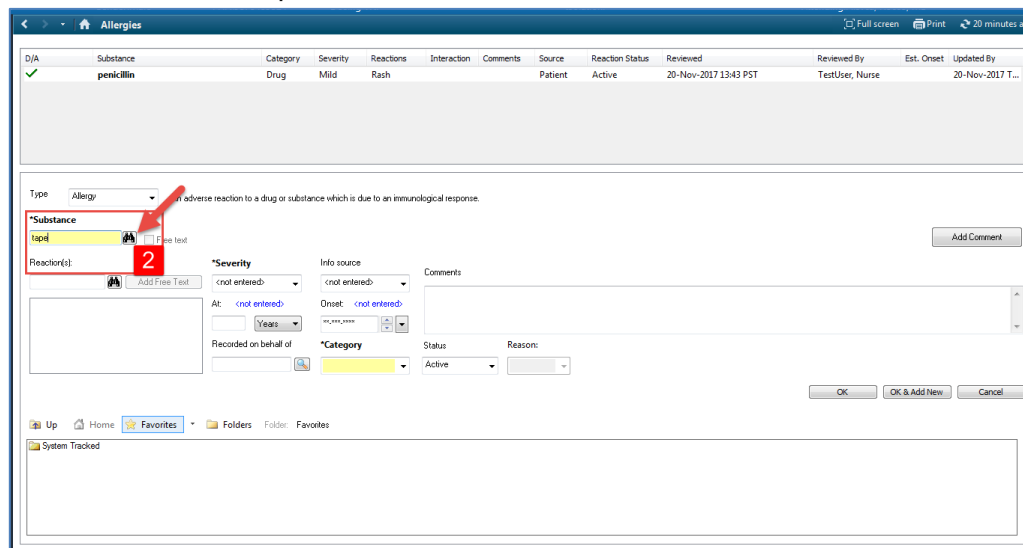
1. Click on the **Allergies** section of the **Menu** and click the ➕ **Add** button.

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**

Click the **Refresh** icon and the tape allergy will now appear in the Banner Bar.
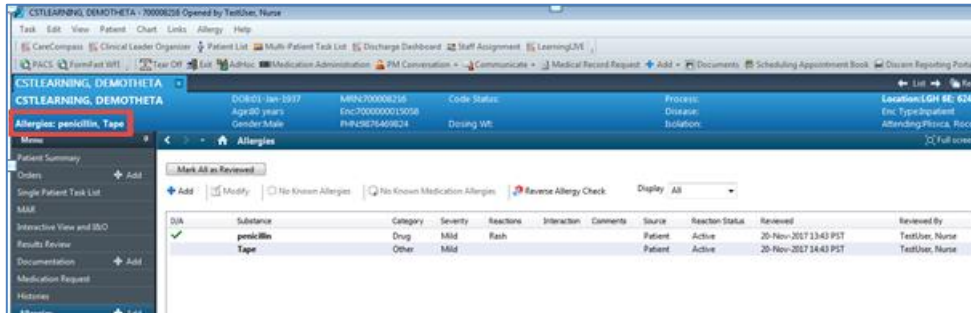
Note: Allergies in the banner bar are sorted by severity (most severe to least severe). If the allergies listed are longer than the space available, the text will be truncated. Hovering over the truncated text will display the complete allergies list.

🔑 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.

🧩 Activity 13.2 – Navigate to Intake and Output Flowsheets Within iView

1 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.

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.

🔑 **Key Learning Points**

■ Intake and Output (I&O) is where a patient's intake and output will be documented

🧩 Activity 13.3 – Review and Document in the Intake and Output Record

1 For this scenario, let's assume that previously a peripheral IV and sodium chloride infusion were initiated.

Review the example of Intake and Output continuous infusion documentation below.

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

   - Continuous infusions must be initiated before they will flow into documentation.

   - Double clicking the blank cells will cause an initiated continuous infusion volume to flow into the form. The volume is not shown until double-clicked.

Now let's practice documenting some intake and output values. For this activity, your patient drank **300 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** = *300 mL*
   - **Urine Voided** = *375* mL

3. Click the **green checkmark** icon ✔ to sign your documentation.
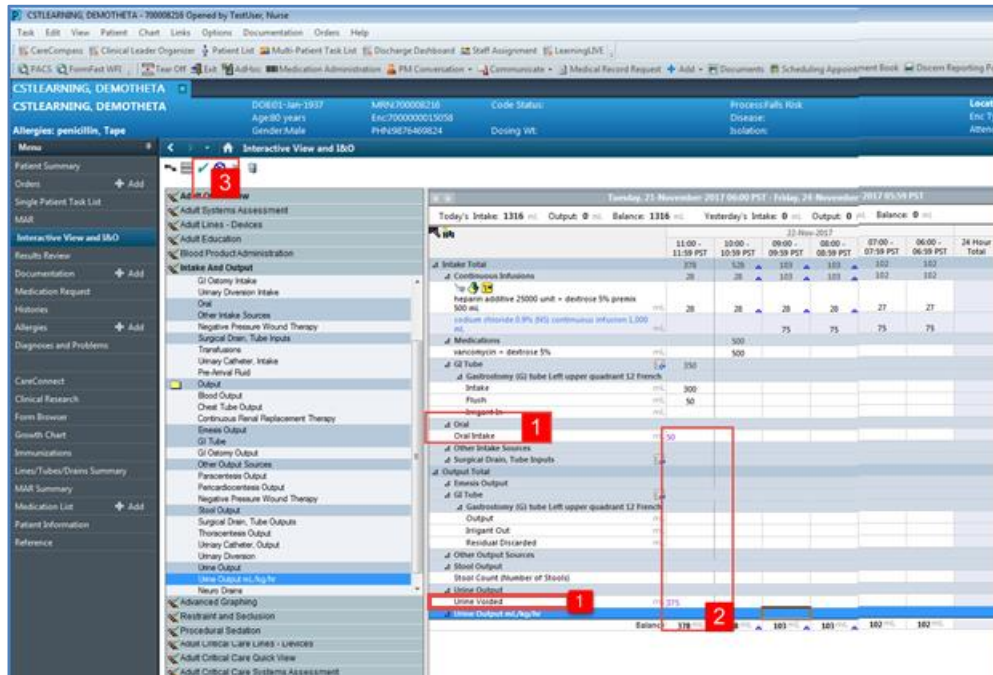
A separate column exists for the balance of your:

1. **12 hour Day/Night Shift Total**

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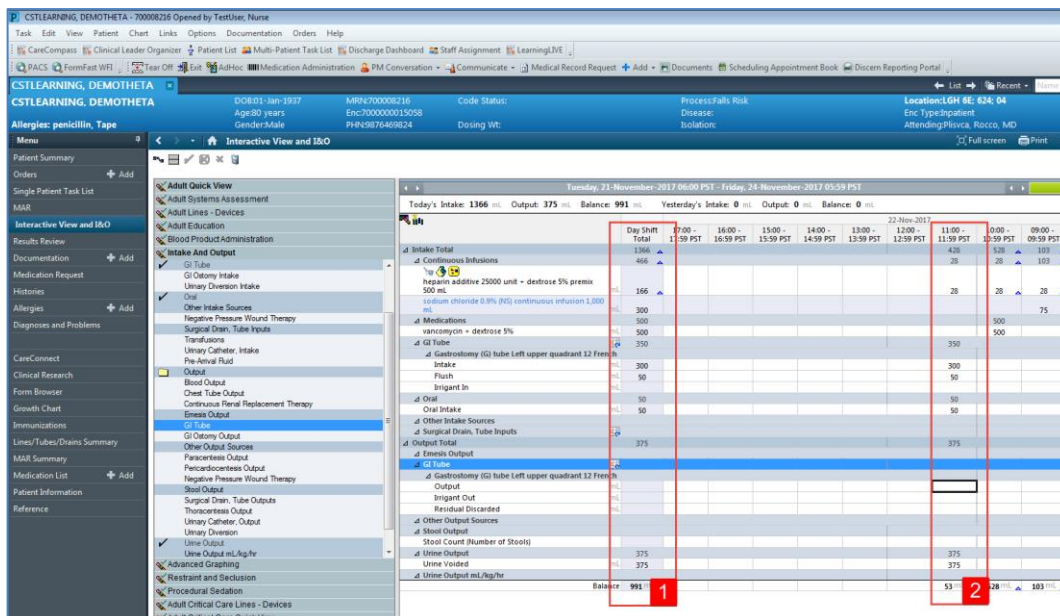
Note: It is important that you verify all volumes are entered correctly. The system automatically calculates fluid balances based on the volumes entered.

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

🔑 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.

- Use the Customize View icon   to add sections to I&O that may not already be active.

🎬 PATIENT SCENARIO 14 - Review Medication Administration Record (MAR)

Learning Objectives
At the end of this Scenario, you will be able to: ◼ Review and Learn the Layout of the MAR   ◼ Reschedule a Medication Dose   ◼ Request a Medication
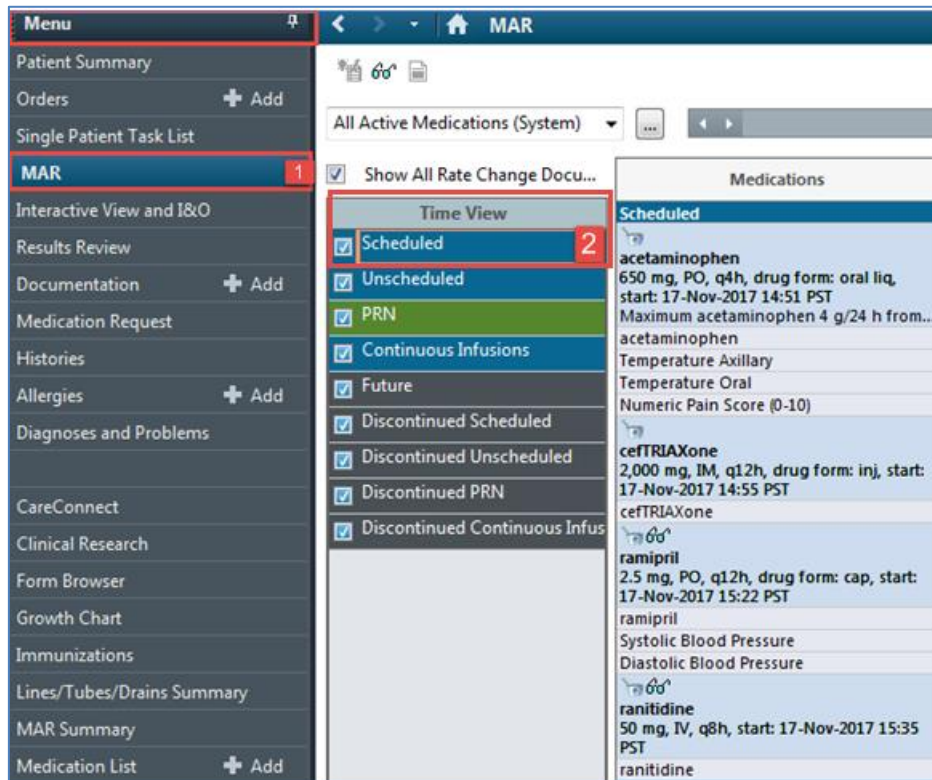
SCENARIO
In this scenario, you will be reviewing the scheduled and PRN medications for your patient today.   As an inpatient nurse you will be completing the following activities: ◼ Review the MAR using both the time view and reverse chronological order settings   ◼ Reschedule a medication   ◼ Request a medication in the MAR

Activity 14.1 – Review the MAR Using Both the Time View and Reverse Chronological Order Settings

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 and PRN medications.

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

3. Next, select in order, **Unscheduled**, **PRN** and **Continuous Infusions**, bringing each section to the top of the list for your review.
4. Review the medications on the MAR e.g. acetaminophen 650 mg PO Q4H. Be sure to review all medication information.
5. If you wish to review the Reference Manual right-click on the medication name and select the Reference Manual.

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

    - – The medication order has not been verified by pharmacy
    - – indicates that nurse review of the order is required
    - – Indicates the medication is part of a PowerPlan

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

7. The Clinical Range is defaulted to display 24 hours in the past and 24 hours into the future. This totals a period of 48 hours. (If you prefer to see only your 12 hour shift, you can right click on the Clinical Range bar to adjust the time frame that is displayed).
8. The dates/times are displayed in **reverse chronological order**. (this differs from current state paper MARs)
9. The current time and date column will always be highlighted in <mark>yellow</mark>.
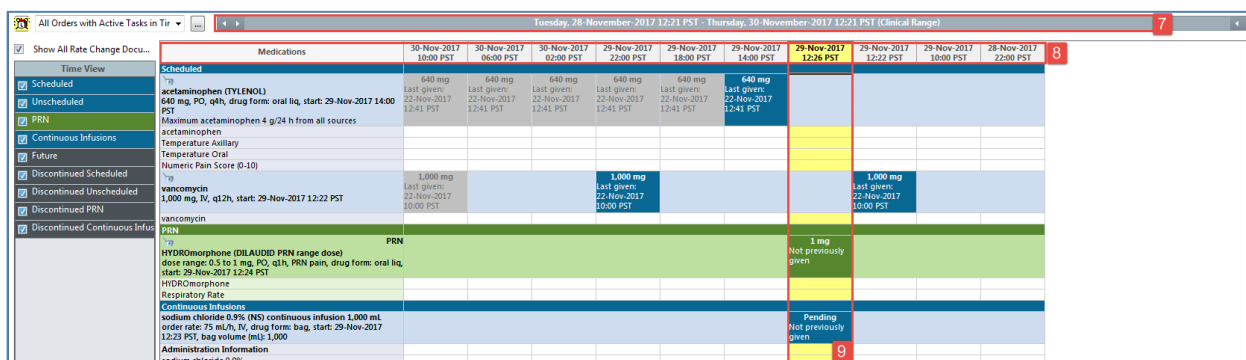
Note that different sections of the MAR and statuses of medication administration are identified using colour coding:

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

🔑 **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 14.2 – Reschedule a Medication

1 Your patient is nauseated and so you need to reschedule their acetaminophen medication.

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

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

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

Key Learning Points

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

Activity 14.3 – Request a Medication

1 You can't find the Vancomycin IV medication vial. You need to submit a **Med Request** to Pharmacy.

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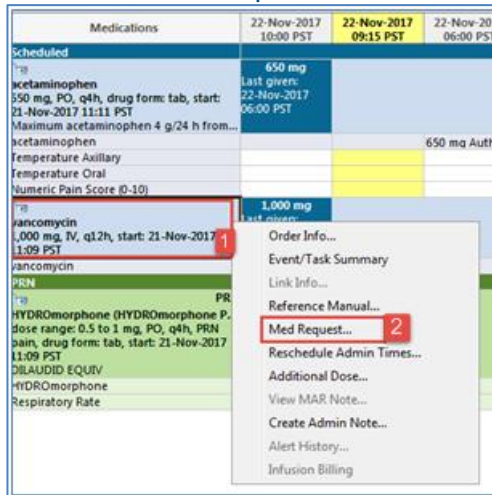
3. Select **Cannot Locate** under reason
4. Click **Submit**
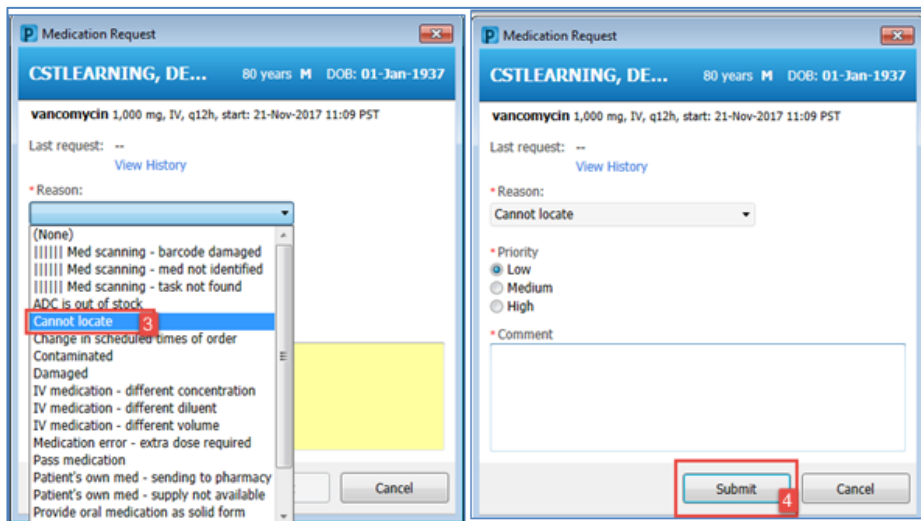
🔑 **Key Learning Points**

■ Right clicking on medication order provides options such as Med Request

■ Med Request sends a message to pharmacy to send the medication

PATIENT SCENARIO 15 - Medication Administration

Learning Objectives
At the end of this Scenario, you will be able to: ■ Administer Medication Using the Medication Administration Wizard ■ Document Administration of Different Types of Medication

SCENARIO
In this scenario, you will be administering IV intermittent, IV continuous and PO medications. You will be using a Barcode Scanner to administer medication. The scanner scans both your patient's wristband and medication barcodes to correctly populate the MAR. The medications to be administered are: acetaminophen 650 mg PO Q4H, hydromorphone 0.5 mg – 1 mg PO Q4h PRN, vancomycin 1 g IV Q12h and IV normal saline at 75 mL/hr. **Note**: For infant doses, nurses are still required to calculate safe dosages per policy. On the WOW, nurses can click the Windows button ⊞ in the lower left corner of the screen to access the Windows calculator. As an inpatient nurse you will be completing the following activities: ■ Administer medication using the Medication Administration Wizard (MAW) and the barcode scanner ■ Documenting patient response to medication (Med Response) ■ Uncharting a medication

Activity 15.1 – Administering Medication using the Medication Administration Wizard (MAW) and the Barcode Scanner

Medications will be administered and recorded electronically by scanning the patient's wristband and the medication barcode. Scanning of the patient's 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
Note: IV medication volumes will flow from the MAR directly into the intake and output section of iView.

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

2 It is time to administer the following medications to your patient. You will scan all three 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)
- Range dose medication: **hydromorphone 0.5 mg PO**, PRN for pain, using hydromorphone 1 mg/ 1 ml liquid product barcode
- IV medication: **vancomycin 1 g, IV**, mixed by the nurse

Note: IV normal saline does not have a barcode to be scanned as it is a Stores Item. Stores items are documented on the MAR differently and we will practice this later on.

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) |IIIII Medication Administration| in the toolbar.
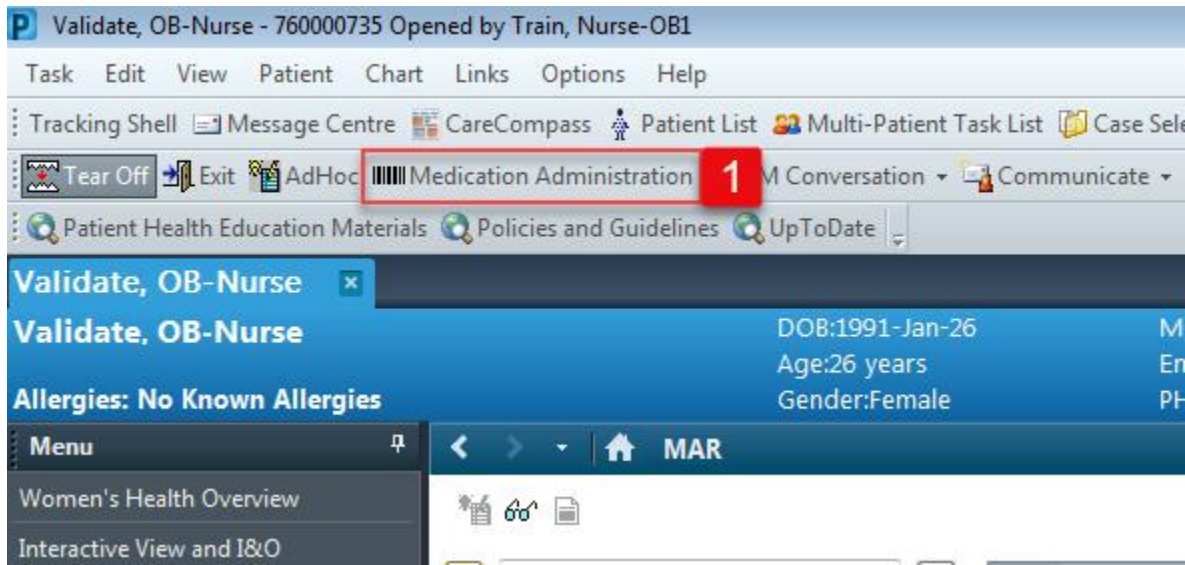
2. The **Medication Administration** pop-up window will appear.
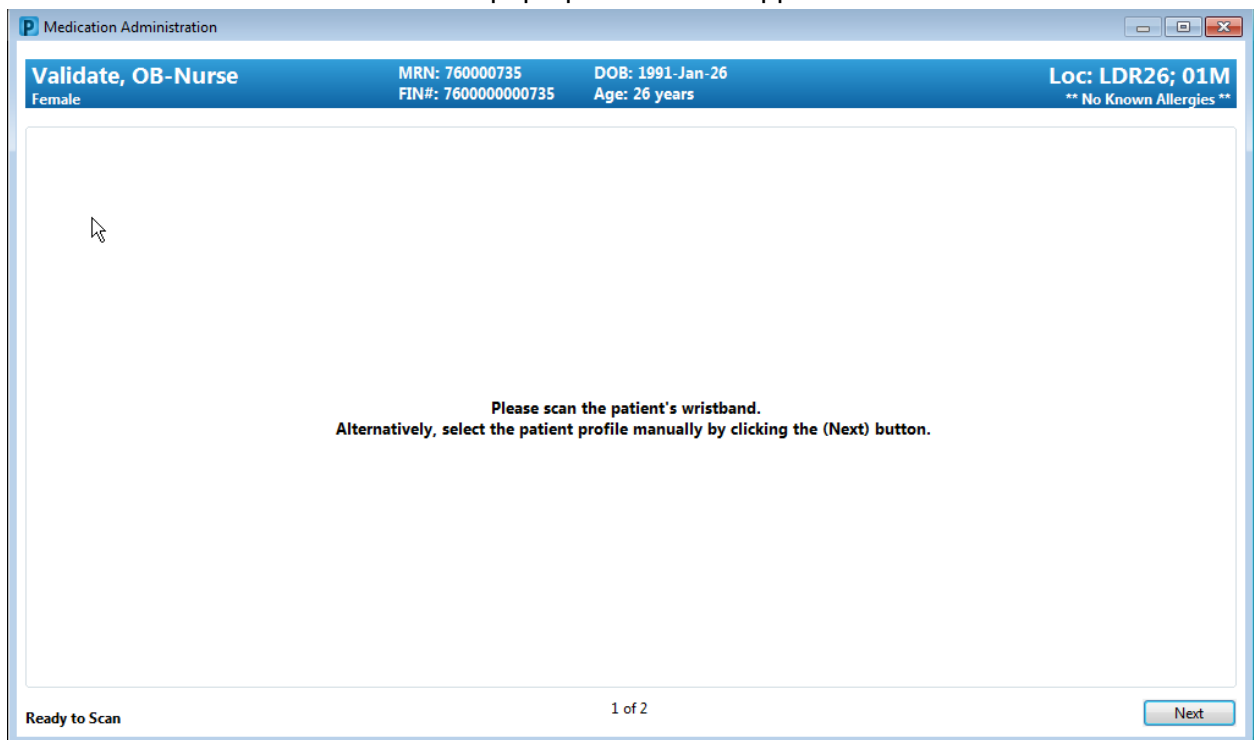
3. Scan the patient's wristband, a window will pop up displaying the medications that you can administer. (Note: this list populates with medications that are scheduled for 1 hour ahead or 1 hour behind the current time).

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.

5. 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.

Now let's administer the next medication.

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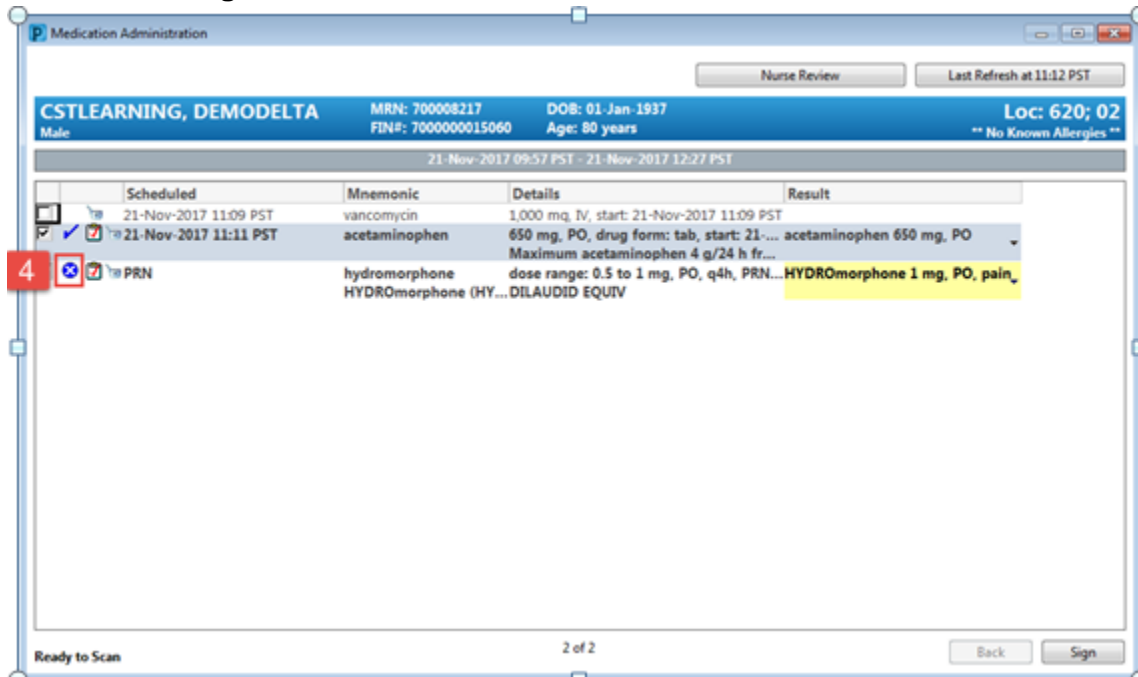
4. Click the **Missing Details** ⊗ icon

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

Let's administer your last medication.

1. Scan the barcode for **vancomycin 1 g IV**. The system finds a match of the IV medication.

2. Since this medication is reconstituted in 500 ml D5W (you can right click on medications on the MAR to view reference manuals, or you can check parenteral guide), you will need to enter this information so that the volume of 500 mL will be captured in the intake and output record.

   • Click the ▾ to the right of **vancomycin 1,000 mg IV** in the results column.

Validate, OB-Nurse
Female

MRN: 760000735
FIN#: 7600000000735

DOB: 1991-Jan-26
Age: 26 years

2018-Ja

			Scheduled	Mnemonic	Details	Result
☐			2018-Jan-24 02:00 PST	acetaminophen	325 mg, PO, drug form: tab, start: 2018-J... Maximum acetaminophen 4 g/24 h from ...	
☐			2018-Jan-24 02:00 PST	ampicillin	500 mg, IV, start: 2018-Jan-24 02:00 PST	
☐			2018-Jan-24 02:00 PST	labetalol	200 mg, PO, drug form: tab, start: 2018-J...	
☐			2018-Jan-24 02:00 PST	NIFEdipine NIFEdipine (NIFEdipine l...	30 mg, PO, drug form: tab-PA, start: 201... ADALAT PA EQUIV	
☐			2018-Jan-24 02:00 PST	vancomycin	1,000 mg, IV, start: 2018-Jan-24 02:00 PST	
☐			2018-Jan-24 06:00 PST	ampicillin	500 mg, IV, start: 2018-Jan-24 06:00 PST	
☐			2018-Jan-24 07:00 PST	ampicillin	500 mg, IV, start: 2018-Jan-25 00:00 PST	
☐			2018-Jan-24 07:00 PST	oxytocin	10 unit, IM, once, drug form: inj, start: 11...	
☐			2018-Jan-24 08:00 PST	acetaminophen	325 mg, PO, drug form: tab, start: 2018-J... Maximum acetaminophen 4 g/24 h from ...	
☐			2018-Jan-24 08:00 PST	labetalol	200 mg, PO, drug form: tab, start: 2018-J...	
☐			2018-Jan-24 08:00 PST	NIFEdipine NIFEdipine (NIFEdipine l...	30 mg, PO, drug form: tab-PA, start: 201... ADALAT PA EQUIV	
☑	✔		**2018-Jan-24 10:00 PST**	**vancomycin**	**1,000 mg, IV, start: 2018-Jan-24 10:00 ...**	vancomycin 1,000 mg, IV▾
☐			2018-Jan-24 12:00 PST	ampicillin	500 mg, IV, start: 2018-Jan-24 12:00 PST	
☐			2018-Jan-24 17:00 PST	acetaminophen	325 mg, PO, drug form: tab, start: 2018-J... Maximum acetaminophen 4 g/24 h from ...	
☐			2018-Jan-24 18:00 PST	ampicillin	500 mg, IV, start: 2018-Jan-24 18:00 PST	
☐			PRN	acetaminophen	650 mg, PO, q4h, PRN fever, drug form: t... Maximum acetaminophen 4 g/24 h from ...	
☐			PRN	dimenhyDRINATE dimenhyDRINATE (GRA...	25 mg, IV, q6h, PRN nausea or vomiting, ...	
☐			PRN	hydromorphone HYDROmorphone (HYD...	dose range: 0.5 to 1 mg, PO, q4h, PRN p... DILAUDID EQUIV	
☐			PRN	ibuprofen	400 mg, PO, q4h, PRN pain-mild, drug fo...	
☐			Continuous	Sodium Chloride 0.9% sodium chloride 0.9% (...	order rate: 125 mL/h, IV, drug form: bag,...	

3. Fill in the following details and click **OK**

    - **Diluent:** Dextrose 5% 500 ml. Note: This is the ONLY medication volume that flows into the Intake and Output section.

Note: Powdered and liquid medications may require dosage correction in this window as well in order to administer **partial doses**. This is because the medication barcode will be for the *entire contents* of the vial/bottle. You will *always* need to update the window to the actual dose administered and the diluent amount for accurate ins and outs.

4. Now that you have scanned the patient and scanned all the three medications. You would complete your medication checks and administer the medication.

5. Congratulations, you have successfully administered three medications! The medications will appear as complete on the MAR.

6. **Refresh** the page and you will be able to see more details including the time the last dose was given.

Note: there is a new **Med Response** for the PRN medication Hydromorphone. For some PRN medications, the system will ask you to complete a medication response assessment- usually in regards to fever or pain.

🔑 Key Learning Points
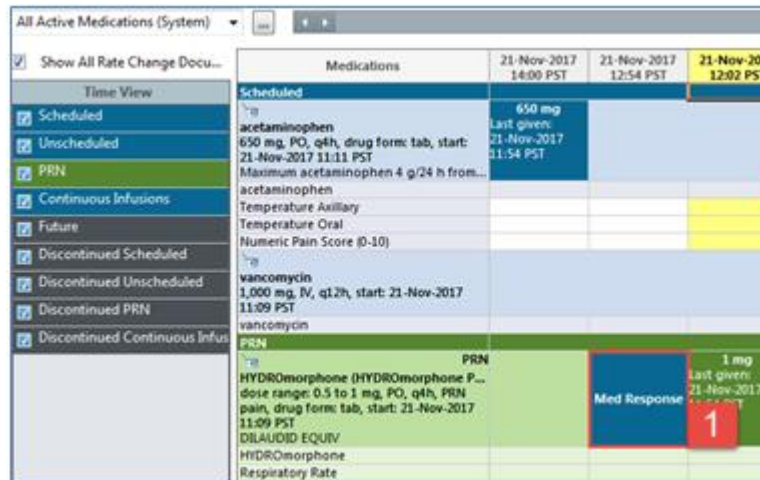
🟩 Use barcode scanner to administer medications

🟩 Medication volumes will flow from the MAR into the Intake and Output section of iView

🟩 Often times, additional information will be required upon administration

Activity 15.2 – Documenting Patient Response to Medication (Medication Response)
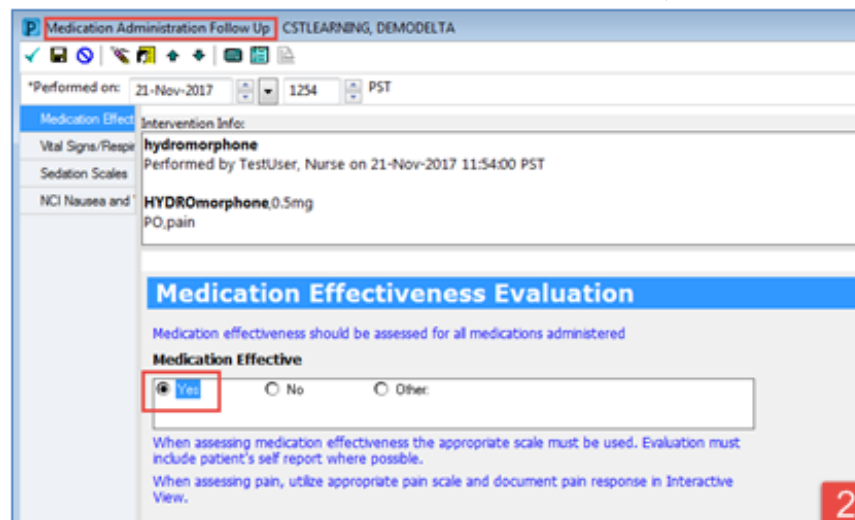
1 When you administer some PRN medications, it is necessary to document how the patient responds to the medication. You can do this directly in the MAR.

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

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

3. **Sign** ✔ and **Refresh** 🔁. Now that you have documented the medication response it has disappeared from the MAR.

All Active Medications (System)	Medications	21-Nov-2017 14:00 PST	21-Nov-2017 12:12 PST	21-Nov-2017 11:54 PST
☑ Show All Rate Change Docu...	**Scheduled**			
Time View	acetaminophen 650 mg, PO, q4h, drug form: tab, start: 21-Nov-2017 11:11 PST Maximum acetaminophen 4 g/24 h from...	650 mg Last given: 21-Nov-2017 11:54 PST		
☑ Scheduled				
☑ Unscheduled	acetaminophen			650 mg Auth (Ve
☑ PRN	Temperature Axillary			
☑ Continuous Infusions	Temperature Oral			
☑ Future	Numeric Pain Score (0-10)			
☑ Discontinued Scheduled	vancomycin 1,000 mg, IV, q12h, start: 21-Nov-2017 11:09 PST			
☑ Discontinued Unscheduled				
☑ Discontinued PRN	vancomycin			1,000 mg Auth (V
☑ Discontinued Continuous Infus	**PRN**			
	PRN HYDROmorphone (HYDROmorphone P... dose range: 0.5 to 1 mg, PO, q4h, PRN pain, drug form: tab, start: 21-Nov-2017 11:09 PST DILAUDID EQUIV		1 mg Last given: 21-Nov-2017 11:54 PST	
	HYDROmorphone			* 0.5 mg Auth (V
	Respiratory Rate			12 Auth (Verified

🔑 Key Learning Points
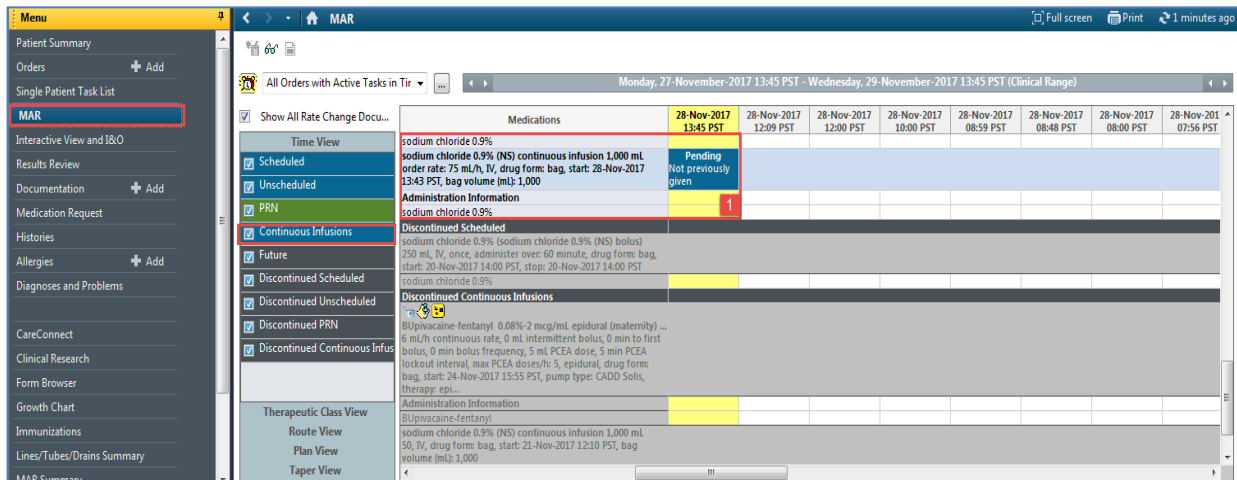
🟩 Some PRN medications require further documentation on how the patient responds to the medication. This can be done from the MAR under Med Response.
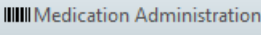
Activity 15.3 – Administering Continuous IV fluids (Non-barcoded)
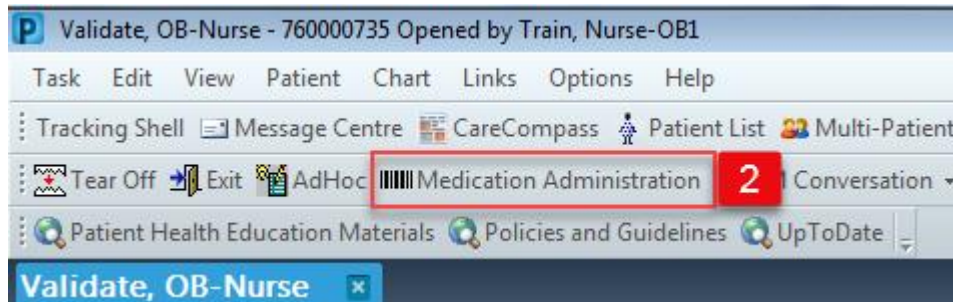
1 To administer the normal saline continuous IV infusion, from the MAR:

1. From the **MAR**, review the order details for the **sodium chloride 0.9% continuous infusion**. Note the status is **Pending** meaning it has not been administered yet.
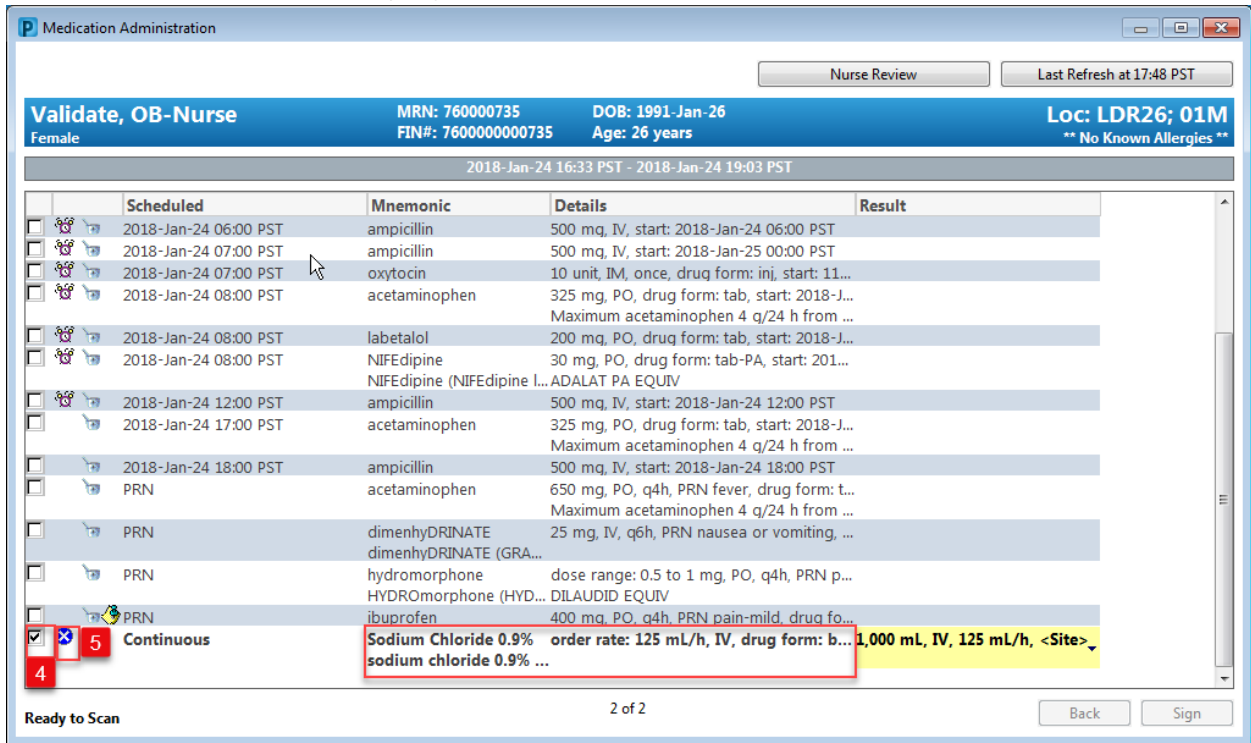
2. To administer the infusion, click on the ⦀ Medication Administration button from the tool bar at the top of the page.

3. The Medication Administration window pops up prompting you to scan the patient's wristband. Scan the barcode on the patient's wristband.

4. A list of ordered medications that can be administered appears in the Medication Administration window. The next step would be to scan the barcode on the medication, but with items that do not have a barcode, such as Normal Saline, we cannot do this. Instead, scroll down to manually select the small box on the left beside the order for the **Sodium Chloride 0.9% (NS) continuous infusion 1,000mL, order rate: 75ml/hr, IV**.

5. Click on the Task Incomplete ⊗ icon and another charting window will open for the sodium chloride 0.9% (NS) continuous infusion 1,000mL

6. Fill in the mandatory information, in this case: **Site** = *Arm, Lower-Left* and Click **OK**
   *For the purpose of this scenario, please fill in the **Performed time** = *0600*

7. Click on Sign and you will be brought back to the MAR where the sodium chloride 0.9% continuous infusion at 75mL/h is now shown as complete.

Note: All fluids administered through MAR and MAW will be visible in **Intake and Output** where you will be able to see your patient's fluid balance

🔑 Key Learning Points

- Continuous infusions are administered using MAR and MAW

- Non-barcoded IV fluids cannot be scanned, but the patient's wrist band should still be scanned through MAW to help identify the correct patient.

- All infusions administered through MAR pulls forward into Intake and Output

📋 PATIENT SCENARIO 16 – Self Administered Medications (SAM)

Learning Objectives
At the end of this Scenario, you will be able to: 🟩 Access the Maternity Self- Medication Record from FormFast.

SCENARIO
In this scenario, you will print the Maternity Self-Medication Record form for the mother to document when she is self-administering any medications. As an inpatient nurse you will be completing the following activities: 🟩 Access the Maternity Self – Medication Record from FormFast.
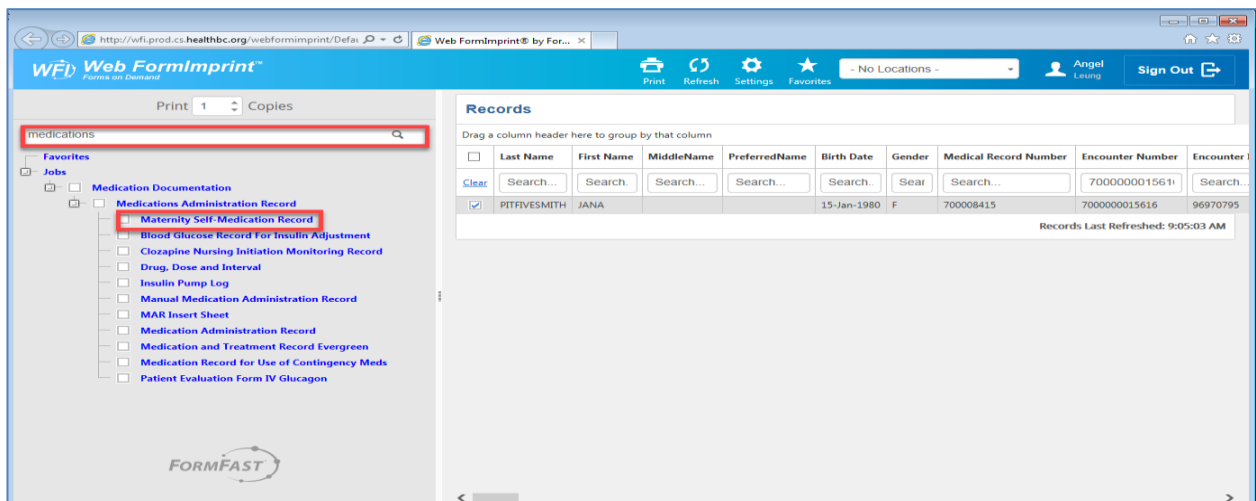
Activity 16.1 – Self-Administered Medication (SAM Pack)

1 The underlying concept of self-administered medications (SAMs) remains the same – you will provide a physical form for the mother to document when she is taking her medications.

To access the SAM form, you need to click on the FormFast button on the tool bar.
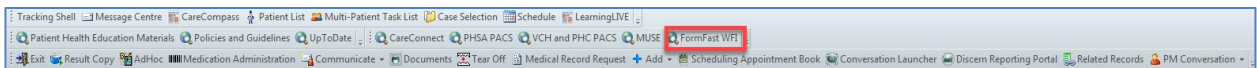
Type in "Medications" in the search bar on the top left corner. Select "Maternity Self- Medication Record".

Review the name to ensure it is the right patient and click Print.

At the end of every shift, best practice is to back enter the medications that your patient has taken during your shift.

1. Select MAR section from Menu column and scroll to PRN medications.

2. Click on the cell with Not previously given beside ibuprofen (ibuprofen self med) 400 mg.

3. A Charting for: Your Patient's Name window will open with the medication name (Ibuprofen) listed at the top. In the Performed Date/Time: field, back enter the patient's first dose taken on your shift. Enter = T/0500

4. In the Performed by: field, type = *Self* and the field will autopopulate with **Self-Administered, Self-Administered**.

5. Click **Sign** ✔ .

6. The **Medication Administration Follow Up** PowerForm will open. Select **Yes** in the **Medication Effectiveness** field. **Sign** ✔ .

7. Medication will display on MAR.

8. Repeat for subsequent self-administered medications.

Note: once the mom has completed the form/ has been discharged, you need to place the form into the patient's chartlet so the unit clerk can scan the document into the patient's chart in PowerChart.

🔑 Key Learning Points

▪ The Maternity Self Medication Record needs to be printed from FormFast to be given to the mother to document her medications.

▪ Best practice indicates nurses should back enter the information on the form into PowerChart at the end of each shift.

PATIENT SCENARIO 17 – End of Shift Activities

Learning Objectives
At the end of this Scenario, you will be able to: ■ Perform End of Shift Activities

SCENARIO
In this scenario, you will practice activities associated with giving report and documenting handover.   As an inpatient nurse you will be completing the following activities: ■ Documenting Informal Team Communication   ■ Documenting a Nursing Shift Summary Note   ■ Handoff Tool   ■ Documenting Handoff in iView

Activity 17.1 – Documenting Informal Team Communication

1 Within the **Handoff Tool** notice that there is an **Informal Team Communication** component that can be documented to and viewed by all team members to communicate in an informal way. Use this to leave a comment for the oncoming nurse or other team members.
Note: The **Informal Team Communication** is NOT part of the patient's legal chart.
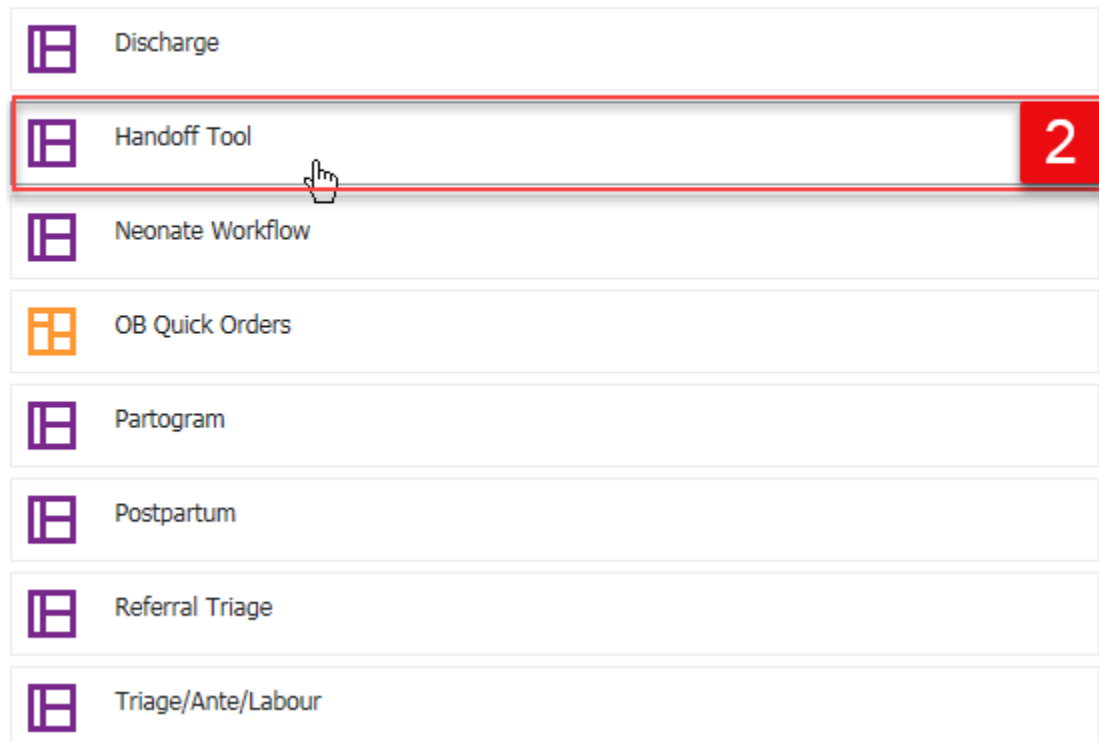Select **Women's Health Summary** from the **Menu.**

Create the **Handoff Tool** in the workflow tab by:

1. Click the ![+] sign on the workflow tab
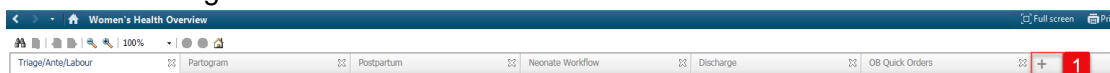
2. Click the **Handoff Tool**

3. **Handoff Tool** should now be visible in the workflow tab
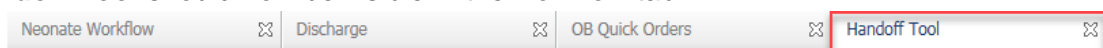
Now you can access the **Handoff Tool.**

1. Select the **Handoff Tool** tab

2. Select the **Informal Team Communication** component

3. Type the following information into the Informal Team Communication text-box: *Heat packs have been useful at epidural site for soreness*

4. Click **Save**
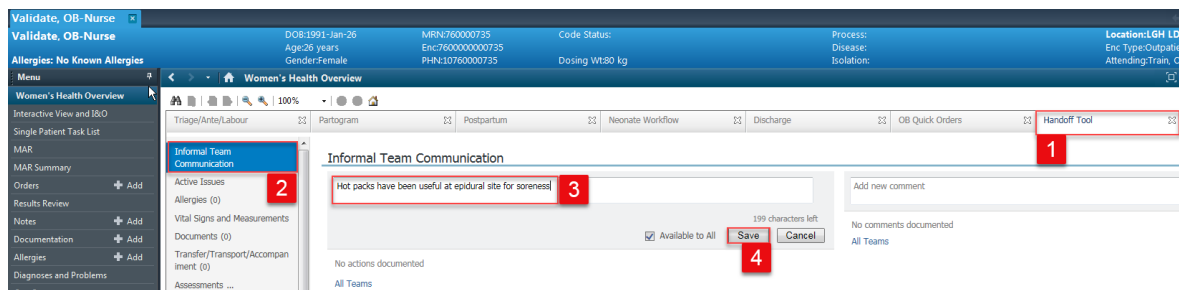
It is important to remove/delete these **Informal Team Communications** when they no longer apply.

To do this:

5. Click the small box to the left of the note, or the small circle with the x to the right of the note.
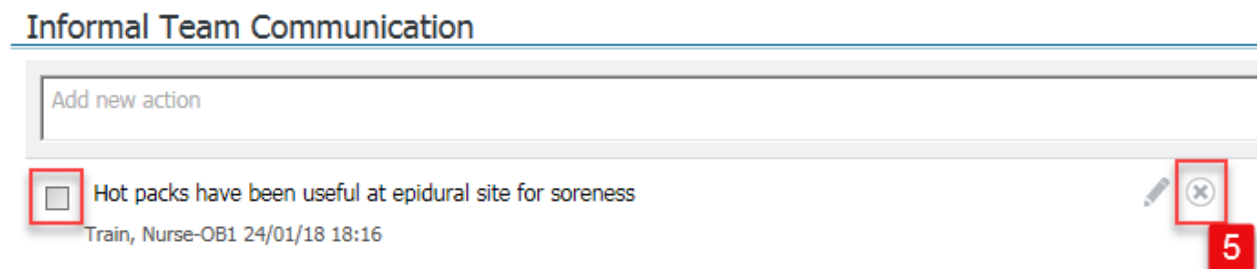
The note will now have disappeared from under the Informal Team Communication component.

🔑 Key Learning Points

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

🧩 Activity 17.2 – Opening and Documenting on PowerForms

1 Nurses should document within PowerForms and iView as much as possible and should avoid duplicate documentation via narrative notes. However, a narrative note can be used to document information that may require more details than can be documented otherwise. If a **Nursing Shift Summary** note is required, follow these steps.

1. Review patient information in the **Handoff Tool.**

2. Click on the **Nursing Shift Summary** blue link.

3. Type the following information within the Nursing Shift Summary template = *Pain well controlled, patient in good spirits. Many visitors.*

4. Click **Sign/Submit**

5. Click **Sign** in the Sign/Submit note window and **Refresh** icon

Once the page is refreshed, you will be able to see your **Nursing Shift Summary** note saved under **Documents** in the **Handoff Tool**.

Now this note is in the patient's chart and other nurses can view it by completing the following steps:

1. Select **Documentation** from the **Menu.**

2. Find and click on the **Nursing Shift Summary** Note.

3. Note the **Final Report** can be read on the right side of the screen.

🔑 Key Learning Points

🟩 A Nursing Shift Summary note is used to write a narrative note about what happened in a given shift for oncoming nurses.

🟩 The note must be signed in order for it to be in the chart.

🟩 Nurses can view notes like this from the Documentation tab in the Menu.

🧩 Activity 17.3 – 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 **OB Triage band**

3. Document using the following data:

   - **Clinician Receiving Report** = *Nurse 1*
   - **Clinician Giving Report** = *Nurse 2*
   - **Lines Traced Site to Source** = *Yes*
   - **Orders Reviewed** = *Yes*
   - **Isolation Activity** = *leave blank if not on isolation*

4. Click the **green checkmark** icon ✔ to sign your documentation.

🔑 Key Learning Points

🟩 Document that you have given or received report in the Shift Report/Handoff section in iView.
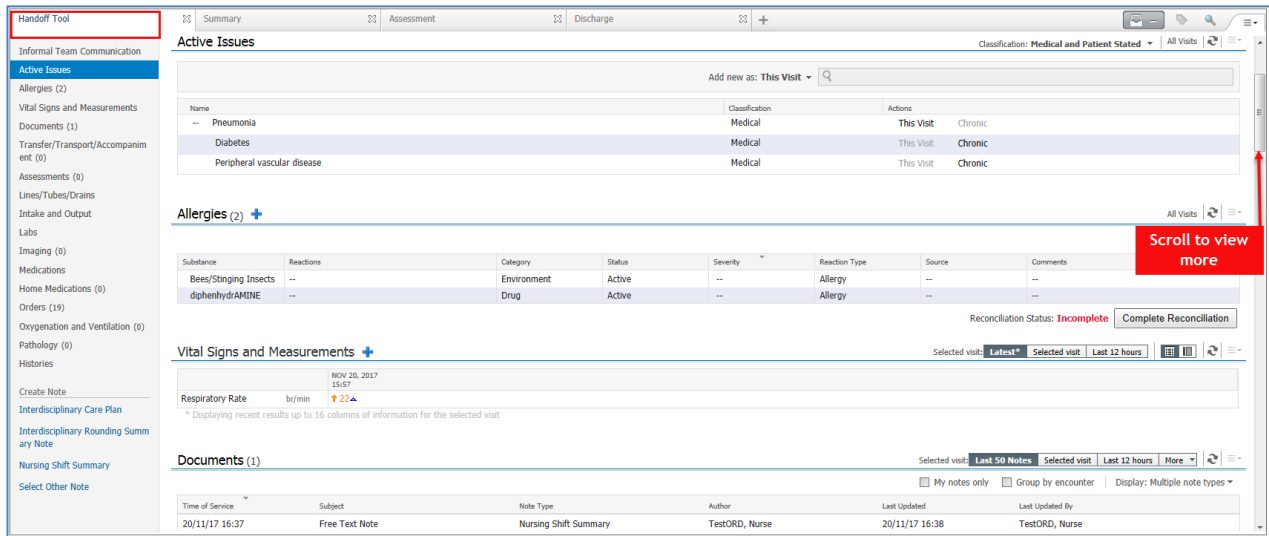
🧩 Activity 17.4 – Handoff Tool

1 Use the Handoff Tool to review patient information with the oncoming nurse.
From the **Menu** select **Women's Health Overview**. From the **Handoff Tool Tab:**

1. Scroll down the page or access each component by clicking within the Handoff components on the left.

This is where you can add any missing information if required.

🔑 Key Learning Points

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

PATIENT SCENARIO 18 - Printing a Document

Learning Objectives
At the end of this Scenario, you will be able to: ■ Print a Document

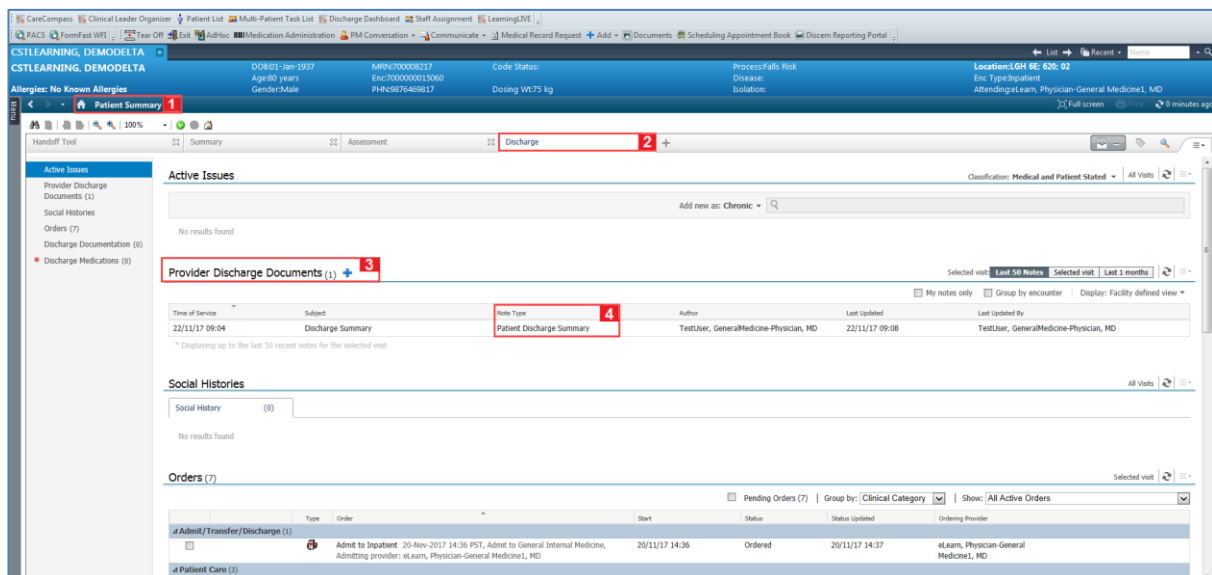| SCENARIO |
| --- |
| In this scenario, you will be reviewing how to print a discharge summary.

As an inpatient nurse you will be completing the following activities:

■ Printing a patient a discharge summary |

Activity 18.1 – Printing a Patient Discharge Summary

The patient discharge summary is completed by the provider to summarize for patients, information about their stay in hospital and includes follow-up appointment and medication information. It can be found in the Discharge tab of the Patient Summary section of the chart.

1

1. Navigate to the **Women's Health Overview** page 🏠 **Women's Health Overview**

2. Select the **Discharge** tab

3. Scroll to find the **Provider Discharge Documents** component

4. Select **Patient Discharge Summary** document. The Patient Discharge Summary appears in a window on the right side of the screen

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

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

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

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

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

🔑 Key Learning Points

■ The patient discharge summary is completed by the provider to summarize patient information such as follow-up appointments and medications.

■ You can preview documents by clicking on it in the respective workflow page component.

■ You may print documents from the same preview window.

◼ PATIENT SCENARIO 19 – Newborn Discharge Checklist

Learning Objectives
At the end of this Scenario, you will be able to: ◼ Be able to access the Newborn Discharge Checklist

SCENARIO
In this scenario, you will be accessing the Newborn Discharge Checklist. As an inpatient nurse you will be completing the following activities: ◼ Document the car seat check being completed in the Newborn Discharge Checklist

Activity 19.1 – Newborn Discharge Checklist

1 The newborn discharge checklist needs to be completed prior to the newborn's discharge.

To access the newborn discharge checklist from the baby's chart, select iView from the MENU. Click Newborn – Neonate Education section, and select the Newborn Discharge Checklist.

Click on the cell next to Car Seat Check and select Done. Click the check mark to sign the documentation.

Note: Anything that is documented in the Newborn Discharge Checklist will flow through to the Task Timeline in the Neonate Workflow landing page.

🧩 End of Workbook

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