SELF-GUIDED PRACTICE WORKBOOK [N90]
CST Transformational Learning

WORKBOOK TITLE:

Provider: Ophthalmology

TABLE OF CONTENTS

SELF-GUIDED PRACTICE WORKBOOK

Duration	**2 hours**
Before getting started	■ Sign the attendance roster (this will ensure you get paid to attend the session) ■ Put your cell phones on silent mode
Session Expectations	■ This is a self-paced learning session ■ 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 ■ Work through different learning activities at your own pace
Key Learning Review	■ At the end of the session, you will be required to complete a Key Learning Review ■ This will involve completion of some specific activities that you have had an opportunity to practice through the scenarios.

Using Train Domain

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

Please note:

- Scenarios and their activities demonstrate the CIS functionality not the actual workflow
- An attempt has been made to ensure scenarios are as clinically accurate as possible
- Some clinical scenario details have been simplified for training purposes
- Some screenshots may not be identical to what is seen on your screen and should be used for reference purposes only
- Follow all steps to be able to complete activities
- If you have trouble to follow the steps, immediately raise your hand for assistance to use classroom time efficiently
- Ask for assistance whenever needed

PATIENT SCENARIO 1

Learning Objectives

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

- Access the Patient Chart through Ambulatory Organizer
- Plan Day of Surgery Orders
- Complete a Clinic Note

SCENARIO

Your patient is assessed and requires cataract surgery. This requires the planning a Pre-Operative (Day of Surgery) PowerPlan so that there are orders ready for the patient on the morning of their surgery.

- You will then update the patient's chart and plan their Day of Surgery orders
- Finally, you will complete a Clinic Note – documenting the visit

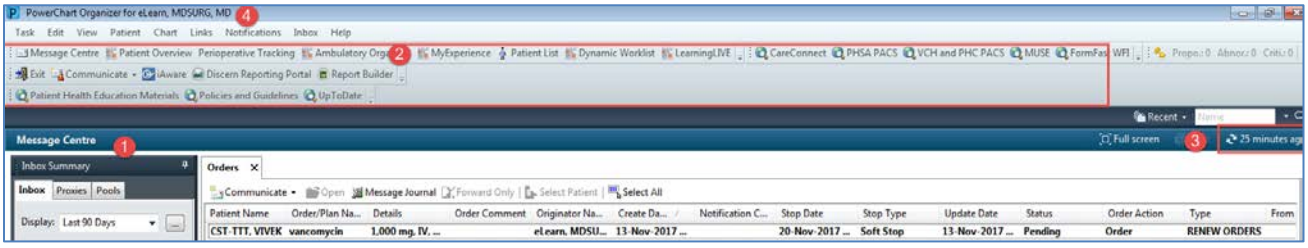
Activity 1.1 – Accessing the Patient's Chart

In PowerChart, there are several ways to access a specific patient's chart, Ambulatory Organizer provides a display of scheduled appointments; it provides staff with a framework to organize workflows at the day, week, or month level.

The term Ambulatory Organizer is a misnomer as it is not used strictly in the Ambulatory department; all clinicians who operate based on a schedule may utilize it. As a surgeon this is important as Ambulatory Organizer can pull up your O.R. slate for the day; or if you run a clinic within the hospital, you can pull the slate and view your patients at the same time.

With your login as a provider, your landing page will be Message Centre:

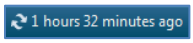
PowerChart

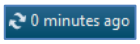


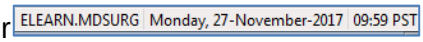
1 Message Centre - As a Provider, your default page upon logging in will be the Message Centre. PowerChart allows you to receive patient information electronically. It serves as a platform for sharing patient related information and responsibilities with other providers and clinicians. Message Centre helps you to electronically manage your workflow. Detailed instruction on Message Centre will be covered in a later activity.

2 Toolbar – Access different functionalities with the PowerChart using the Toolbar, what appears in the Toolbar differs depending on the type of clinician you are.

3 Refresh Icon – Any time changes are made to the patient's chart in POWERCHART, it is recommended that you click refresh to ensure your display is up to date. The time will display how long ago the information on your screen was last updated. Remember to refresh frequently!

NOT Refreshed 

VS Refreshed 

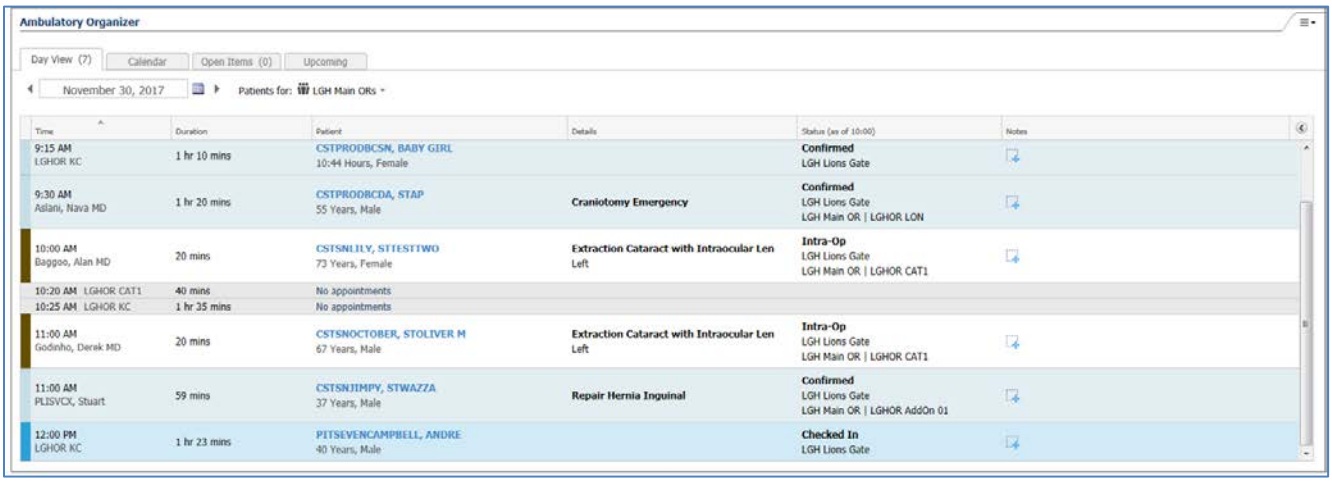
4 Login Information – You will always be able to tell who is logged into POWERCHART by either referring to the top left corner or the bottom right corner 

, always ensure you are documenting under your own login.

In PowerChart, there are several ways to access a specific patient's chart, Ambulatory Organizer provides a display of scheduled appointments; it provides staff with a framework to organize workflows at the day, week, or month level.

The term Ambulatory Organizer is a misnomer as it is not used strictly in the Ambulatory department; all clinicians who operate based on a schedule may utilize it. As a surgeon this is important as Ambulatory Organizer can pull up your O.R. slate for the day; or if you run a clinic within the hospital, you can pull the slate and view your patients at the same time.

Day View - displays today's appointments. The day view is the default view you see when you first log in but going forward, the last view you were on will display when you open Ambulatory Organizer.



The Color Status Bar provides an at a glance view of the appointment status:

Light Blue: Confirmed appointment

Medium Blue: Checked in appointment

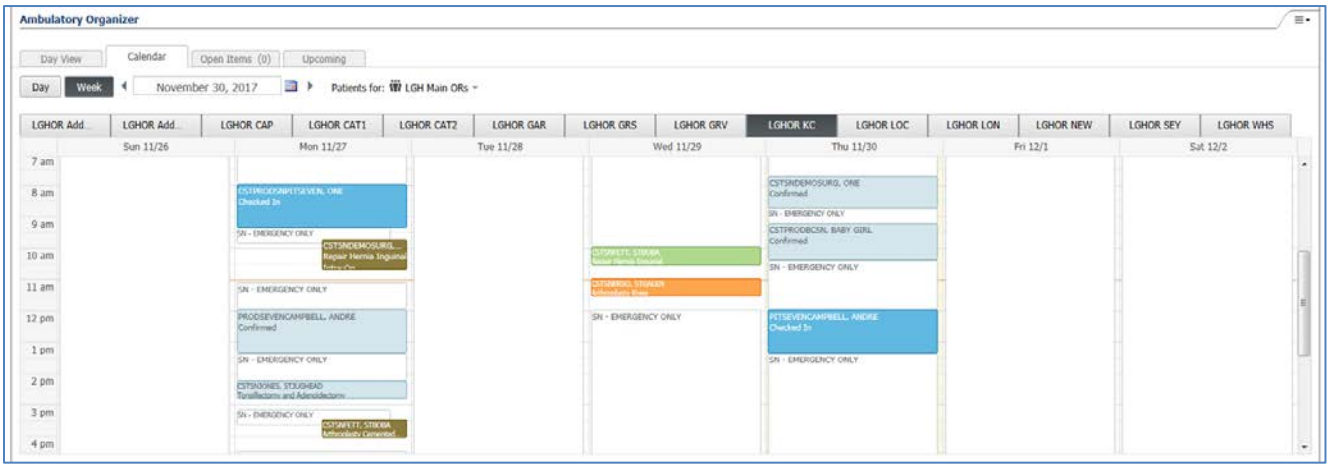
Green: Seen by nurse or medical student

Orange: Seen by physician or resident

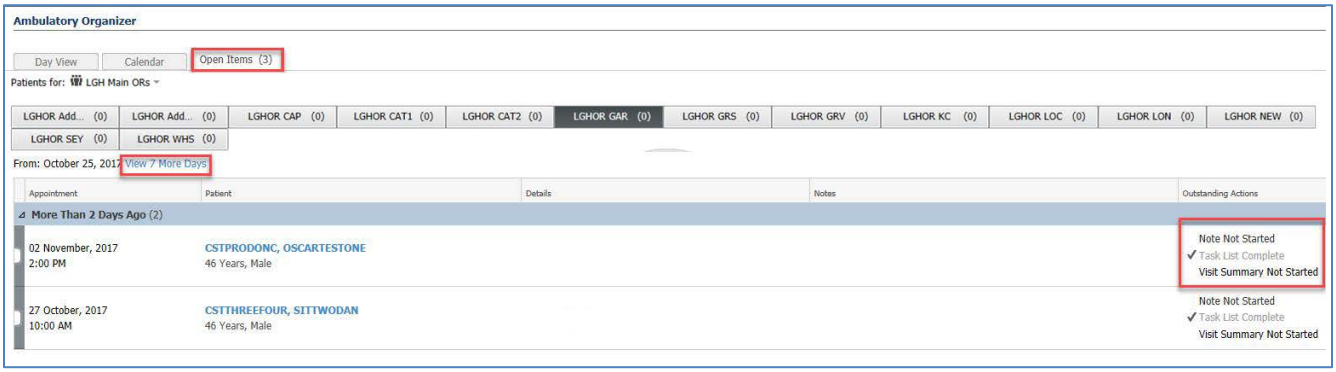
Dark Grey: Discharged

White: No Show, Hold, or Cancelled appointment

Calendar View - View displays a resource's schedule for a day or a week. The colour status applies to this view as well

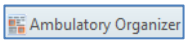


Open Items View - displays unfinished tasks for the resources displayed for a selected amount of days



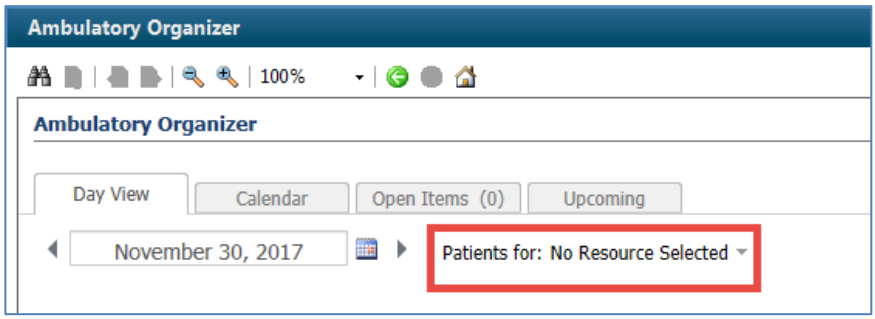
We will cover other useful ways to access patient charts in a later activity (i.e. for rounding), but for now **Ambulatory Organizer** is the most useful for this scenario. Your patient is on the slate for surgery next week, your login to pre-emptively place your surgical order set.

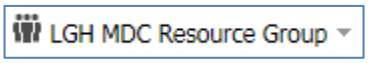
1 To access Ambulatory Organizer to view your slate and open the patient's chart:

Select Ambulatory Organizer  from the Toolbar

When you first open Ambulatory Organizer, you must set it to display what you need, this is done by selecting one or multiple 'Resource(s)'. A resource can be a clinician and/or a location.

2 Click the arrow next to ‘No Resources’ Selected

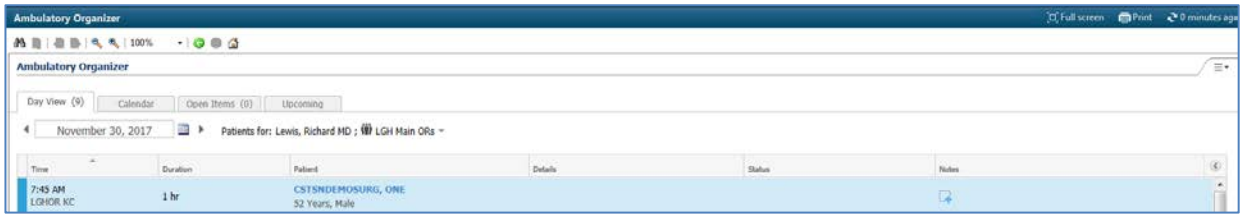


3 In the search box, Type *LGH MDC* and select 

Note: indicates a group of resources, grouped by location or people

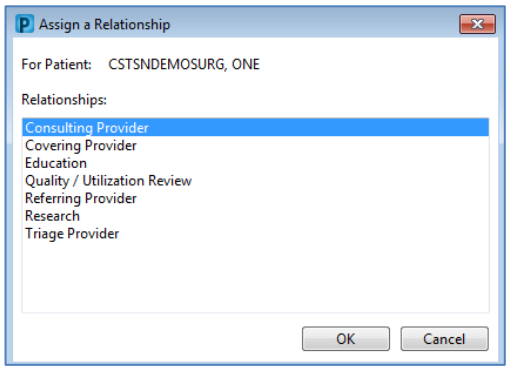
4 Check the box for LGH MDC Resource Group

5 To further filter by Resource, you may enter yourself to show only your patients on a certain day.



6 Hover over the patient’s name will bring up basic information on the patient, Click the patient’s name to open their chart

7 Notice that 'No Relationship Exists' displays on your patient, the system will prompt you to Establish a Relationship with the patient.



For the Purposes of this workbook we will not Establish relationship, this will be done in the next scenario.

8 The first time you access a patient's chart or after a 16 hour time lapse, the system will prompt you to assign a relationship to the patient. Select the most appropriate relationship.

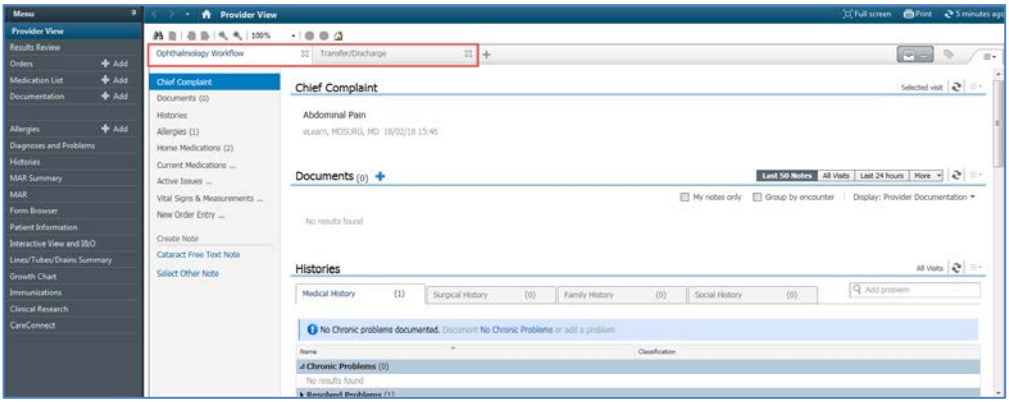
Key Learning Points

- Ambulatory Organizer is used for clinicians who utilize a schedule to organize their day
- "Relationships" are assigned when first accessing the patients chart or every 16 hours.

Activity 1.2 Navigating the Chart

1 The patient's chart opens to the **Provider View** which is your current default screen when accessing a patient's chart.

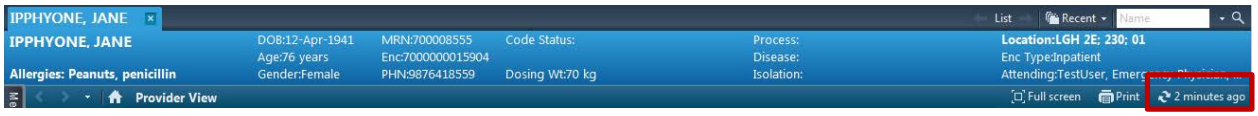
It is organized into several tabs. Each tab is designed to support a specific workflow. Click each tab to open a specific view.



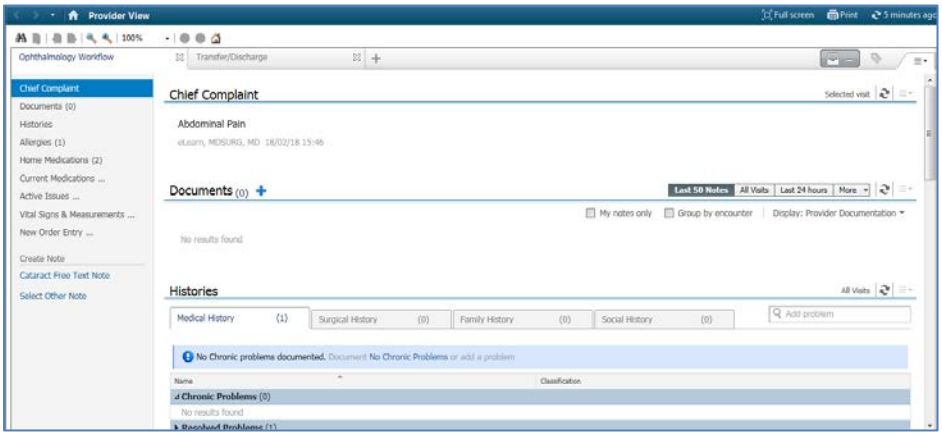
2 Click on the icon by the Menu to close the menu. Providers are not encouraged to use the menu at this time and the current training will not cover that functionality.

3 The **Banner Bar** located at the top of the screen displays demographic data, alerts, information about the patient's location, and current encounter.

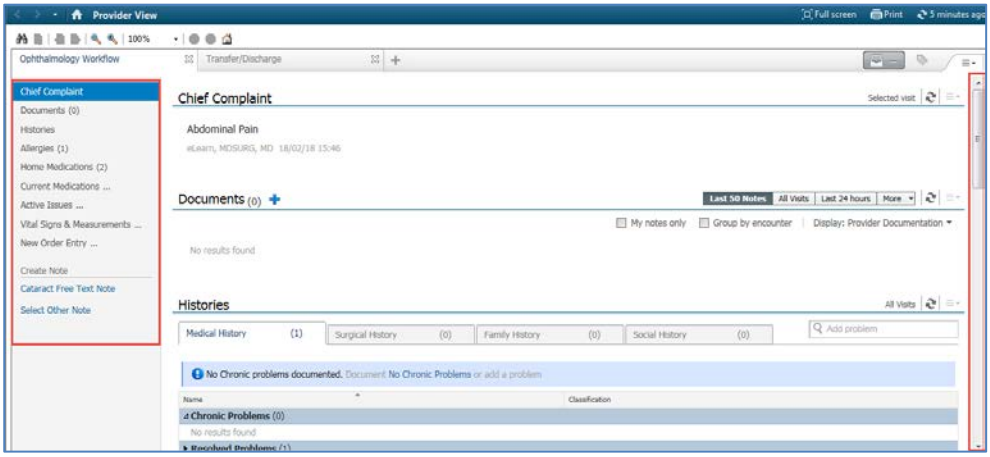
Click the **Refresh** icon to ensure that your display is up-to-date. A timer shows how long ago the information on your screen was last updated. Refresh frequently.



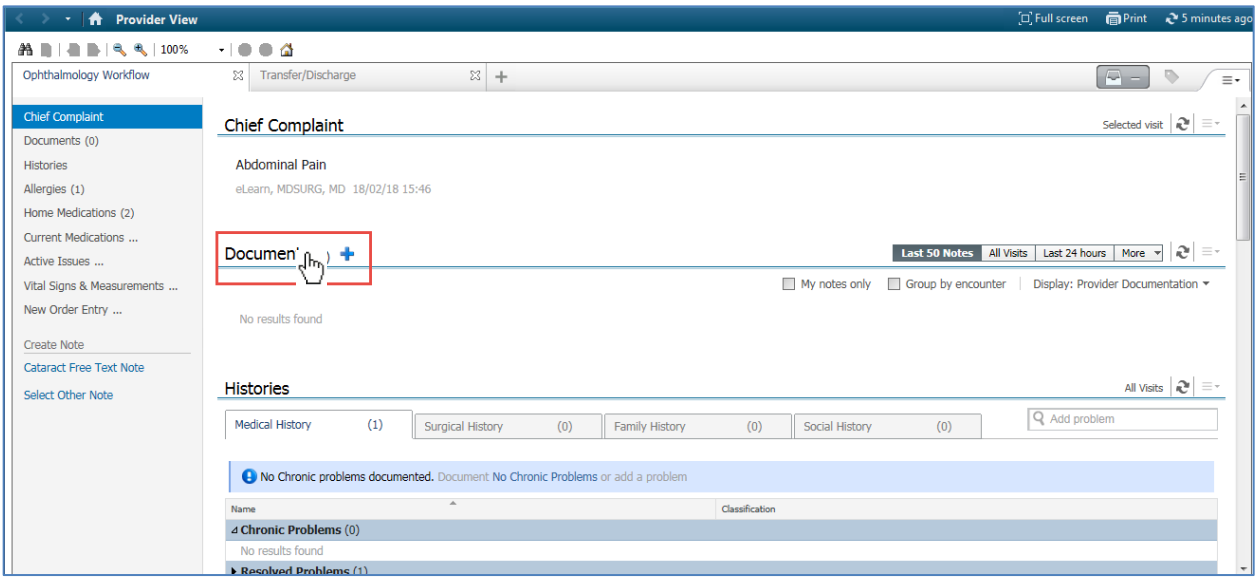
4 Open the **Admission** tab to start the admission process.



5 On the left side of the screen, there is a list of components representing workflow steps specific to your specialty. Click the component name or use the scroll bar to view specific information within each of the components.



6 Each component has a heading. Place the cursor over the heading. This icon means the heading is an active link. Click this heading to open a comprehensive window with more options.



7 Each window display more options to review or enter patient's information. You will learn more about each window from other resources.

Click the icon to return to your default view – Provider View.

Key Learning Points

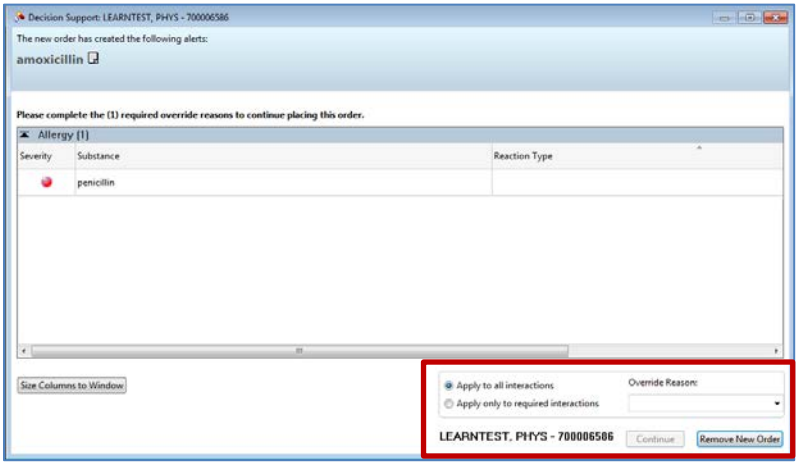
- When admitting a patient it is critical to place the **Admit to Inpatient** order prior to entering additional orders
- Use the **Patient Overview** and specific patient lists to access patient charts
- Review **Banner Bar** information to ensure you have selected the right patient and the right encounter
- Remember to **refresh** your screen frequently to view the most up-to-date information
- The **Provider View** provides access to various workflow tabs

Activity 1.3– Allergies

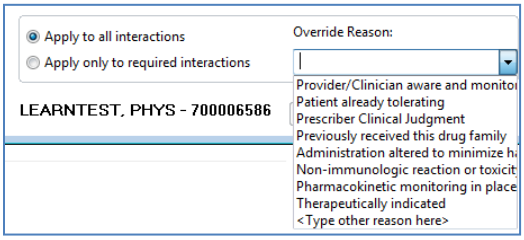
You review the patient's allergies and add an allergy to Penicillin. This information was provided by the patient but has not yet been entered into the patient's chart.

In PowerChart, patient allergies can be added and updated by providers and clinicians. In the inpatient setting, a patient's allergies are to be reviewed by a provider on admission, at every transition of care, or annually. Allergy information is carried forward from one patient visit to the next.

PowerChart keeps track of the allergy status and will automatically prompt you when the information is not up-to-date. It will also track allergy-to-drug interactions. When placing an order with allergy contradictions, an alert will display:

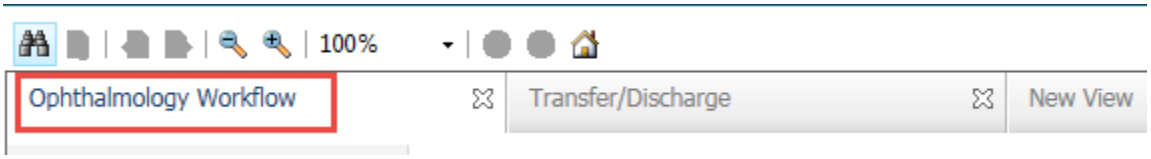


You can either remove the order and select another medication, or continue with the order by overriding the alert and documenting the reason:

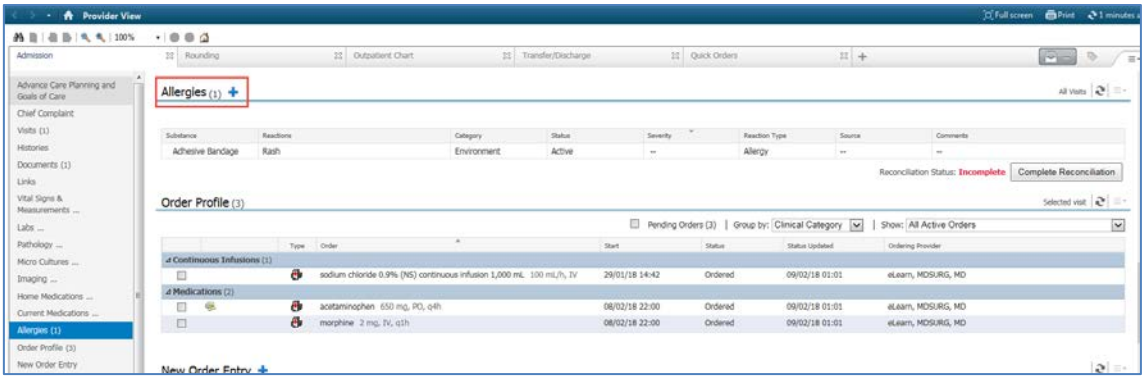


PowerChart allows you to check drug-to-drug interactions when ordering medications on the medication order page by clicking the **Check Interactions** button.

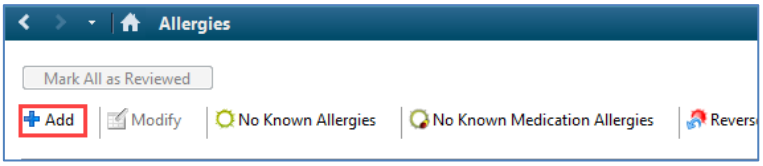
1 Select the Ophthalmology Workflow tab



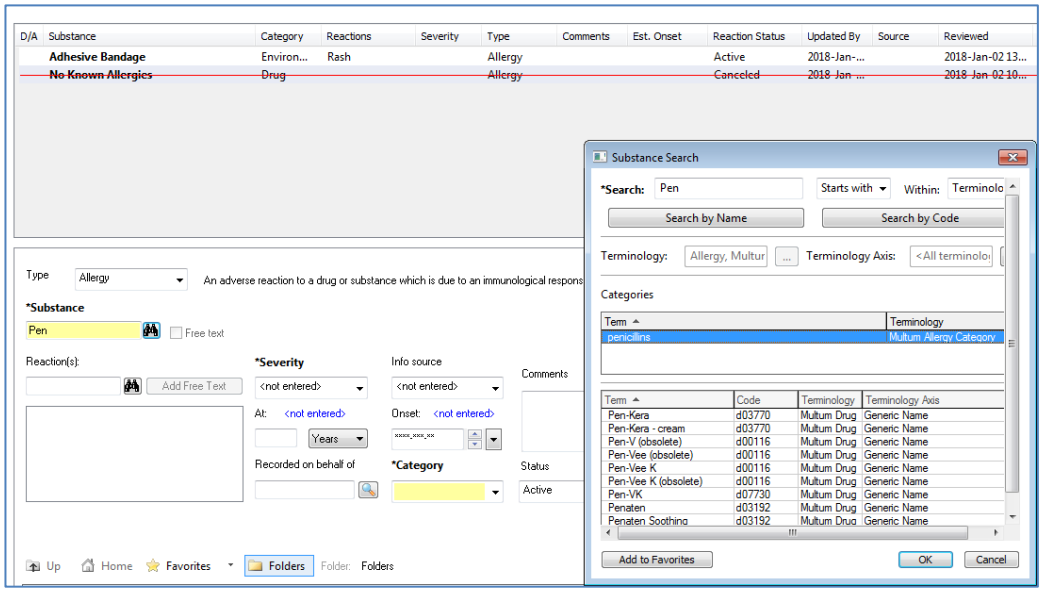
Then click the **Allergy** link to open the window where you will enter or update allergy information.



2 To add the penicillin allergy to patient's record, click the Add icon on the toolbar.

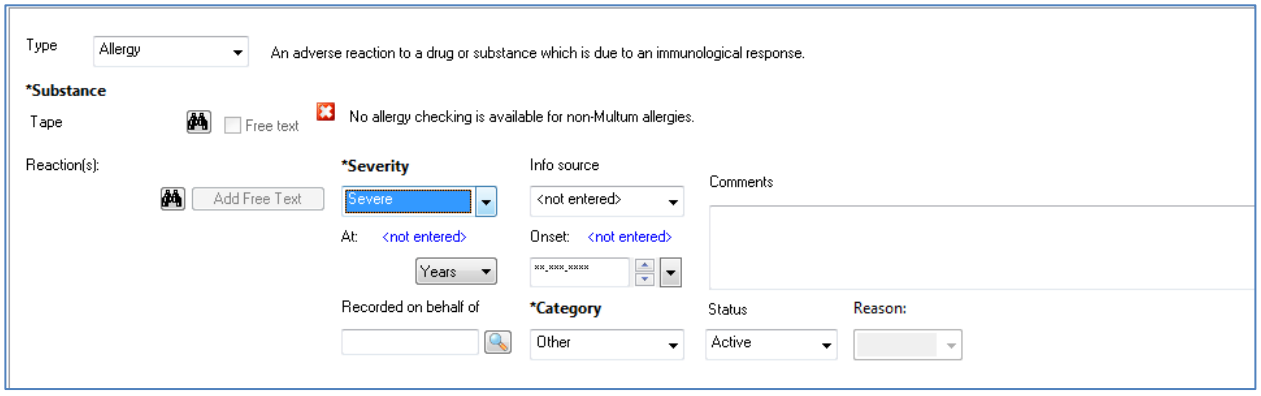


3 Search for Pen in the **Substance** box. Click on to execute the search and then select penicillin's from the list. Click **OK** to return to the Add Allergy/Adverse Effect window.

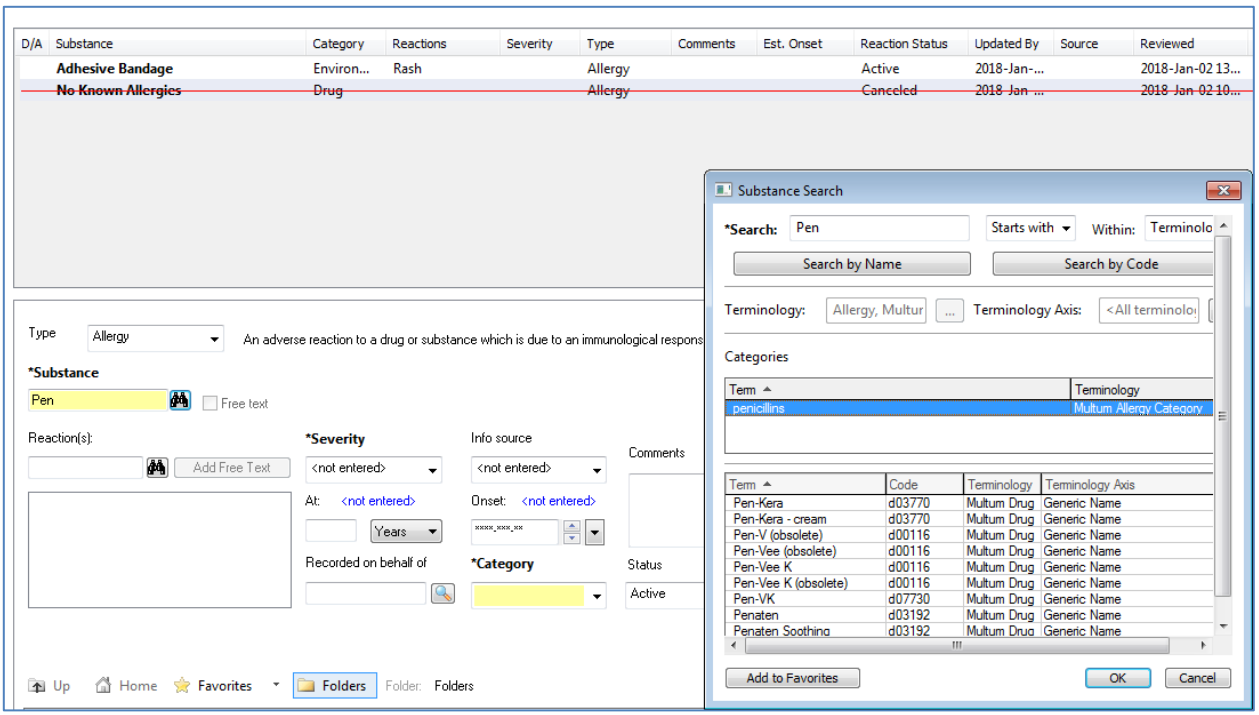


4 Add appropriate options in the other two mandatory fields:

- Select *Severe* for the **Severity**
- Select *Drug* for the **Category**



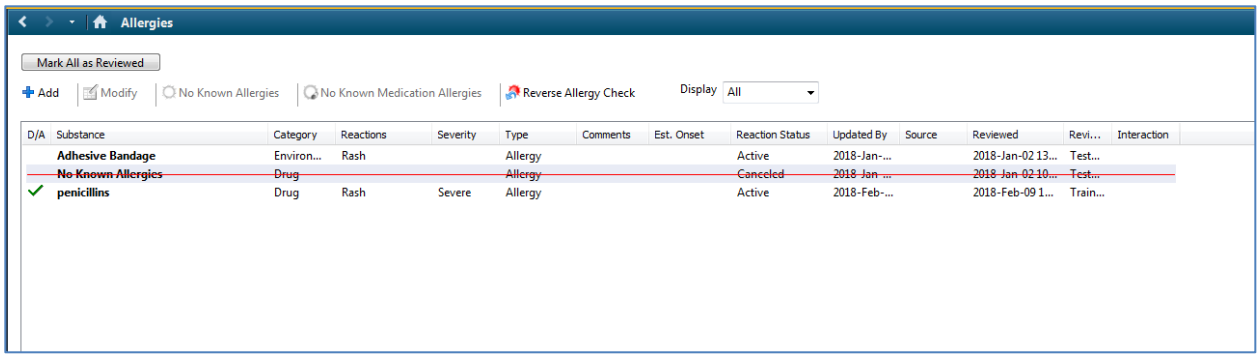
5 Type rash and click on the icon to search. Select the reaction that fits the patient, in this case just rash, and click **OK.**



6 Click **OK.**

Note: If there are additional allergies, click **OK & Add New**. **Cancel** exits back to the allergy list and does not record the information.

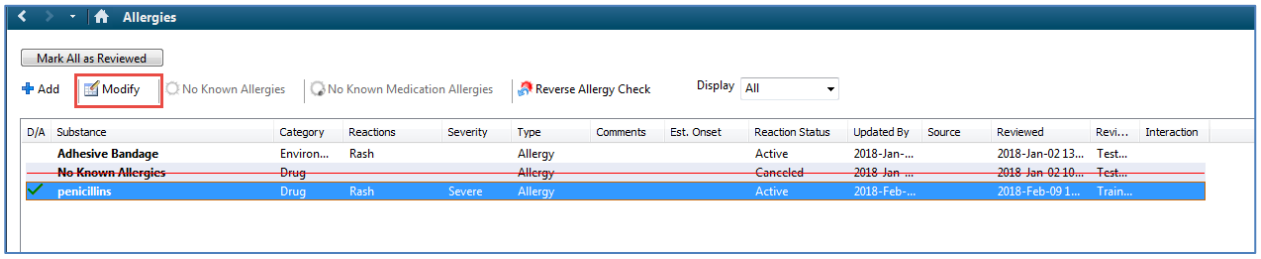
7 Patient's allergy record is updated. The green checkmark next to Penicillin indicates drug allergies. Click **Mark All as Reviewed** to complete the review.



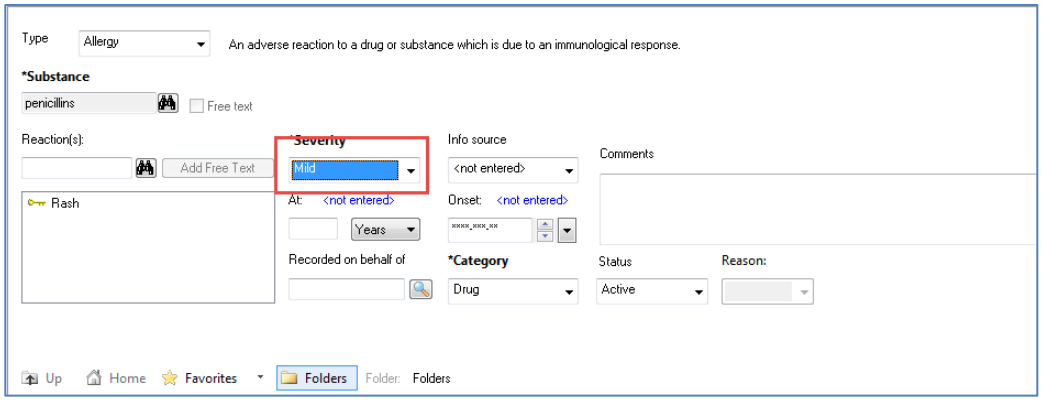
Note: In order for the pharmacy to dispense, they must see that the allergy record has been reviewed by a provider. When there is no information available, you can use the other toolbar options:

- **No Known Allergies**
- **No Known Medication Allergies**

8 To modify the existing allergy select the appropriate line, in this case penicillin's and click Modify:



9 For this example, we will change the Severity to Mild.



10 Then, click **OK.**

Key Learning Points

- Patient allergies and interactions are monitored by PowerChart
- Patient's allergies need to be reviewed on a regular basis
- Review of allergies is complete when Mark All as Reviewed is selected

Activity 1.4 – Best Possible Medication History (BPMH)

As part of reviewing your patient's chart, you will review their best possible medication history (BPMH).

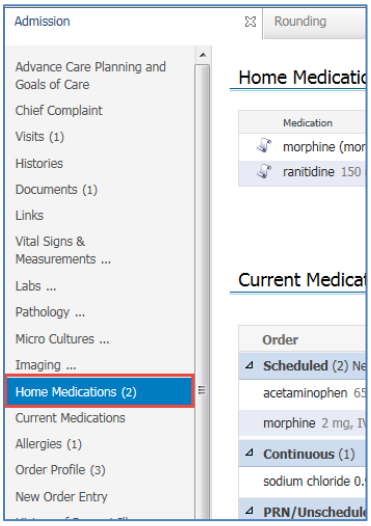
Within your workflow tabs, there are a few tools to help with this:

- **Home Medications** – this component lists home medications documented for this visit and carried over from previous encounters

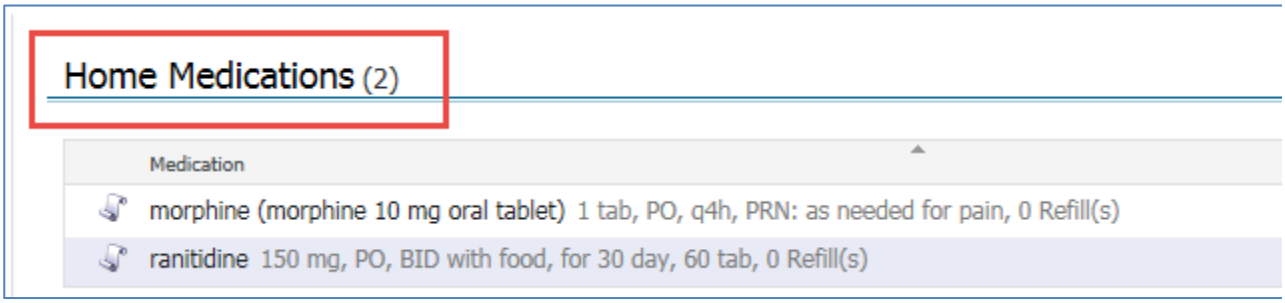
The BPMH must be completed before proceeding with admission medication reconciliation. The best possible medication history is generally documented by a pharmacy technician. When a pharmacy technician is not available, it can be completed by a nurse, medical student, resident, or by you as the patient's most responsible physician.

During your discussion with the patient, you learn that they use a Salbutamol inhaler 1 puff QID PRN and need to update their BPMH.

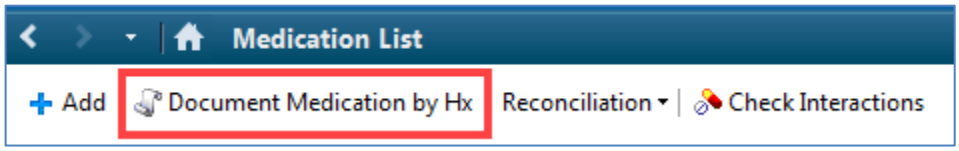
1 Select the **Home Medications** component from the list to view what has been documented.



2 Click **Home Medications** heading.



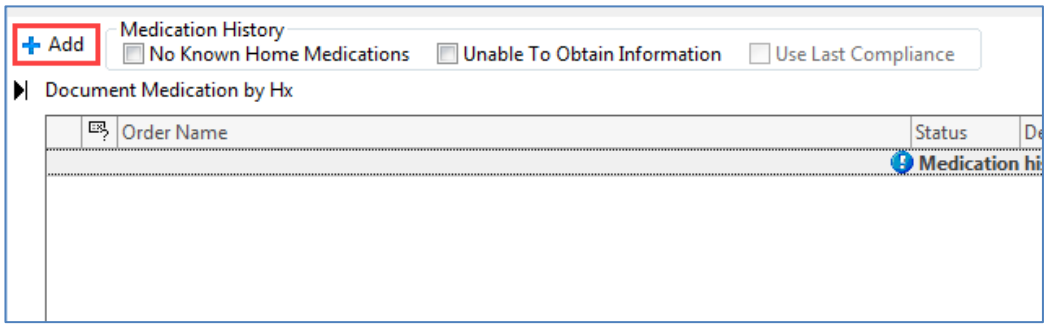
3 In the **Medication List** window, click **Document Medication by H_x**.



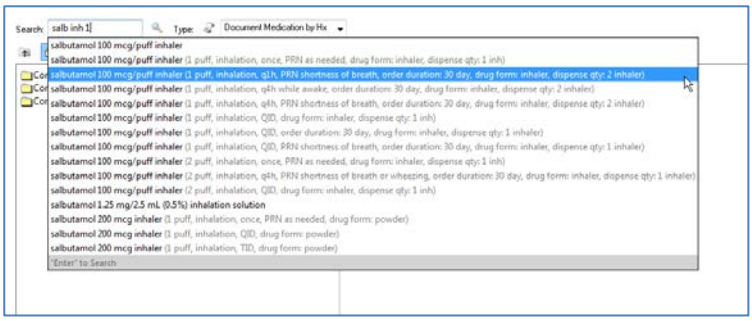
Note: Clicking the Add will add an order, not add history.

4 Click the Add button on the Medication History toolbar.

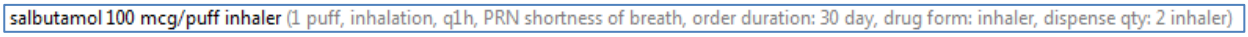
Note: Even though the button looks the same as the last page it has different functionality.



5 Type ***salbu inh 1*** and pause in the search box. A list of frequently used salbutamol order sentences displays.



To truncate the list further, add more details. For this example, type ***salbu inh 1*** and select



Note: If the drop-down menu does not contain the order sentence that you are looking for press enter on the keyboard and the system will bring up a list of all order sentences that match the search term.

6 You can continue searching and add more medications if needed. In our example, you only need to add one. Click **Done**.

7 For practice, repeat steps to add Lisinopril 10 mg PO daily.

8 Click **Document History** to complete the process.

9 Click on the  to take you back to Provider View

The navigation buttons have the following function

 takes you back one screen

 takes you to your default view – the **Provider View**

 displays a list of recently visited screens for an easy jump back

11 Refresh the workflow page by clicking the minutes ago button.

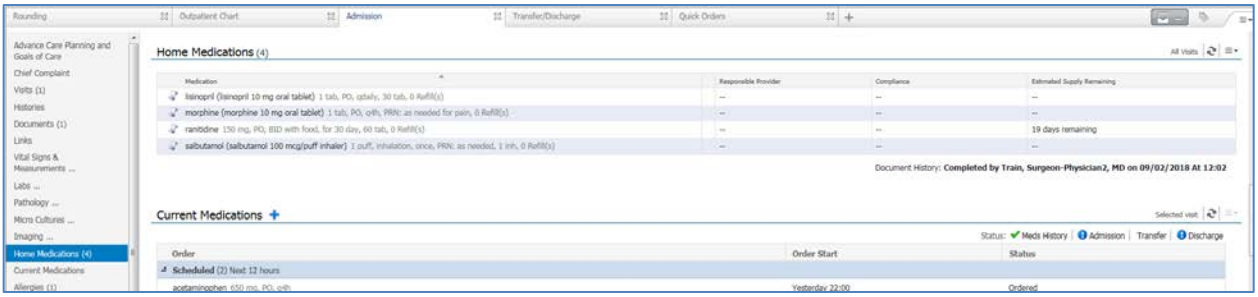
button will refresh the entire page

Will Refresh just the section.

For this practice click on the 

<u>If in doubt refresh the page!</u>

12 Click on the Home Medications link in the list of components to now see the documented home medications.



Note: Home medications can be updated at any time, even if the Meds History status states complete. In some cases, you may document that the patient has no home medications or you are unable to obtain information. Click the Home Medications heading and select **No Known Home Medications** or **Unable to Obtain Information** respectively.

Key Learning Points

- When searching for an order, type the first few characters of the term to bring up the list of possible entries.
- The BPMH has to be done.

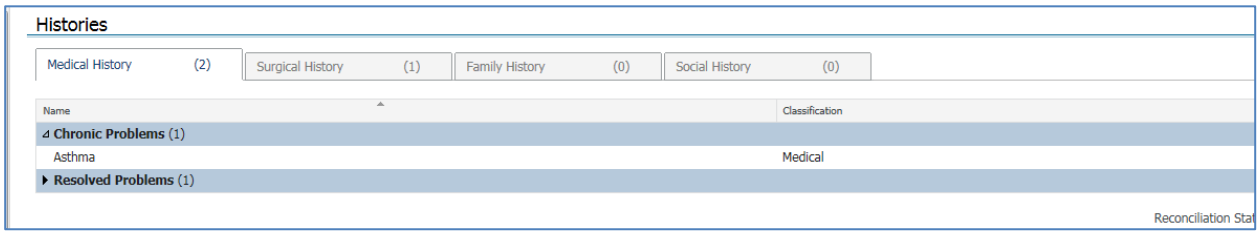
Activity 1.5 – Review History

In this section of the chart, you can review and update your patient's Medical, Surgical, Family, Social history.

During your discussion with the patient you determine they had an appendectomy 2 years ago. Let's go ahead and document this.

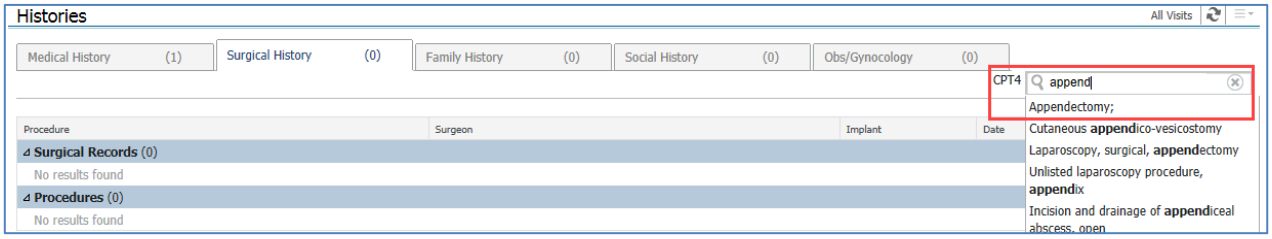
1 Clicking on Medical history brings you to the Medical History page. Clicking on the other tabs brings you to the relevant pages and you can switch between the other tabs within the page.

For now click on the Surgical History tab and then the History link.

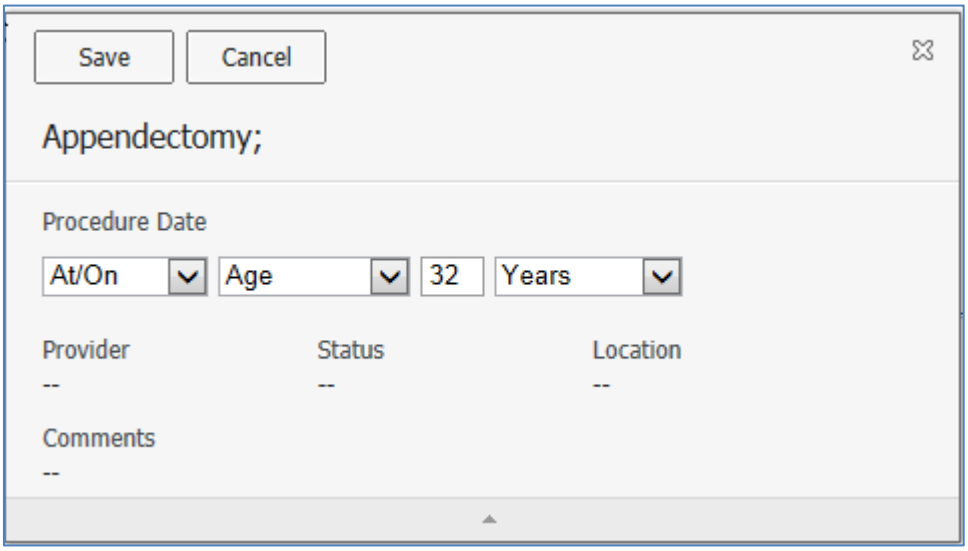


There is a separate tab for each history type. The number in brackets indicates how many entries are in each tab.

2 Click on the Surgical History tab, click in the search box and type **append**. A list of options will appear. Select *Appendectomy*



3 Enter procedure date information of *Age 32* years and click **Save.**



Note: To add **Family or Social History**, click on the *Histories* heading in order to add information. For additional information regarding patient history documentation, refer to the reference guide(s).

Key Learning Points

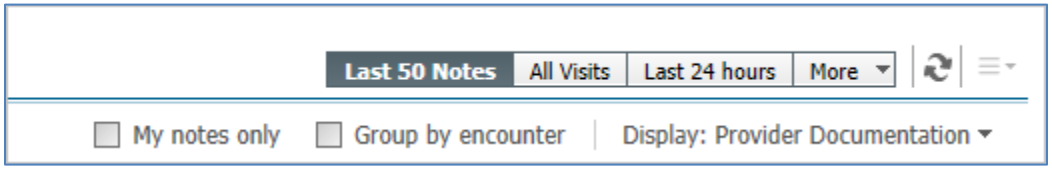
- Histories information including surgical procedures can be added when taking a patient's history

Activity 1.6 – Review Documents, Labs and Diagnostics

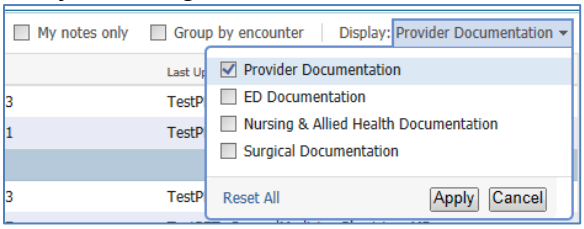
Continue reviewing the patient's chart. When using PowerChart, you might be faced with a large amount of information.

For many components, you can filter documents in many ways. For example, in the Documents component you can:

- Display notes from the **Last 24 hours** or **My notes only**
- Use **Group by encounter** to see notes for the current encounter only
- Limit documents to **Last 50 notes**
- Access notes for **All Visits**



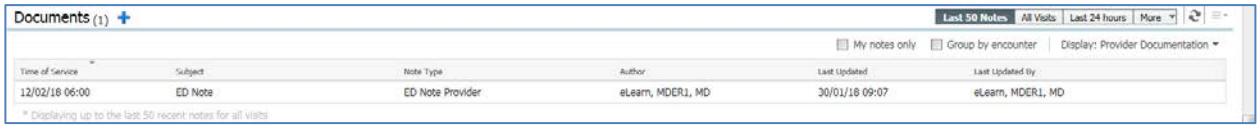
You can also display note types by selecting **Provider Documentation**.

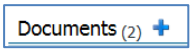


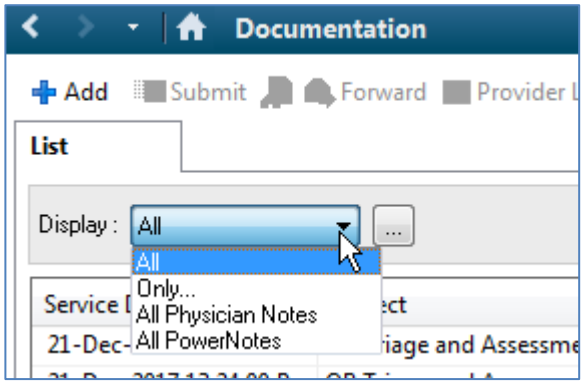
You can also select a custom time range by expanding options under **More**.

Remember that if you select a specific filter, the selection narrows and you might not display all relevant information. Ensure that the filter type corresponds to your current needs.

1 Click **Documents** to display a list of documents.
Select the document line to display the content of the document without leaving the screen.
Clicking tab closes the split screen.



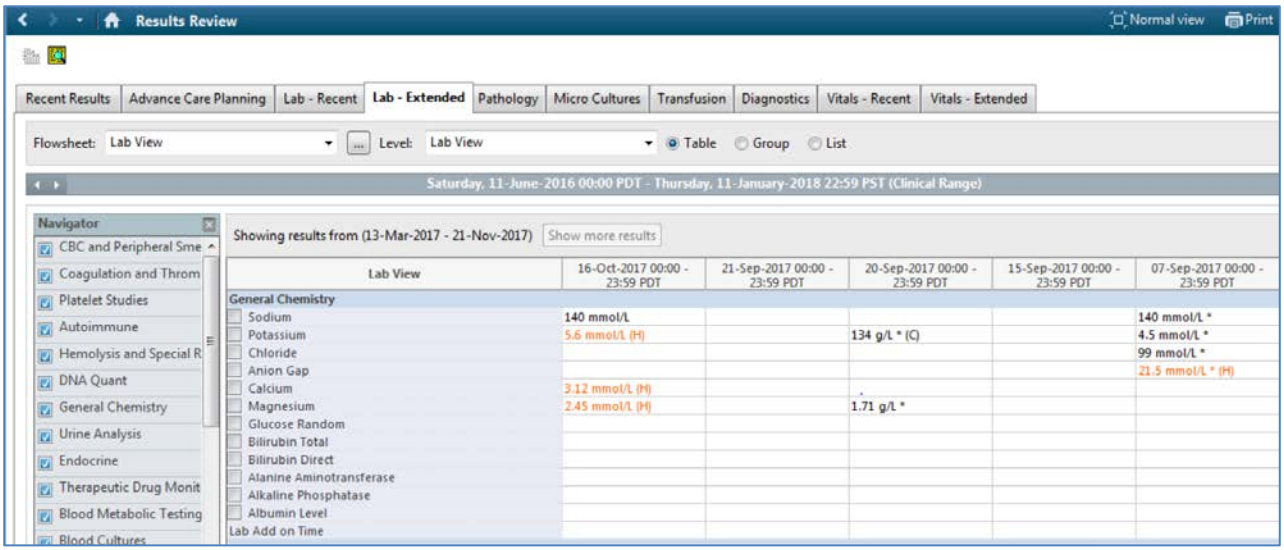
Note: Clicking the component heading  to view a comprehensive display with more options. For example, the Documentation view provides a list of all documents



2 Use the navigation buttons  to return to the Provider View.

3 For labs and other diagnostics click on the Vital Signs & Measurements

4 An example of the comprehensive display of patient results grouped in separate tabs can be found below:



Key Learning Points

- Using filters will display only pertinent information. Remember to check what filter is currently selected to ensure that it fits your current needs

Activity 1.7 – Planning the Pre-Operative PowerPlan

Now you are ready to place Day of Surgery orders for your patient. You will use a PowerPlan that is specifically designed for the day of surgery for Ophthalmology patients.

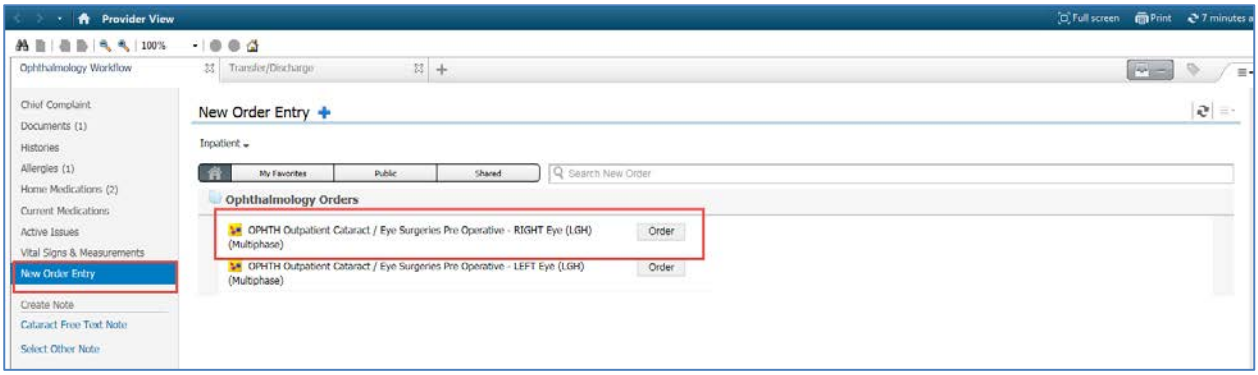
PowerPlans are similar to pre-printed orders (PPOs), allowing you to plan and coordinate care in the acute care environment by defining sets of orders that are often used together. You can adapt PowerPlans to fit your needs:

- You can select and deselect individual orders from the PowerPlan list
- You can add orders that are not listed in the PowerPlan
- You can add other modules (orders sets) that are a listed in a PowerPlan

Initiated PowerPlan becomes active immediately and its orders create respective tasks and actions for other care team members.

A PowerPlan that is **not** initiated remains in a planned stage allowing orders for a future activation as needed.

1 In the Ophthalmology Workflow page, click on the **New Order Entry**.



2 Under Ophthalmology Outpatient Orders Click Order next to the **OPTH Outpatient Cataract/ Eye Surgeries Pre-Operative – Right Eye (LGH)** plan, marked by the icon. Note the **Orders for Signature** 1 button has turned green and number 1 is displayed.

3 Click the Orders for Signature icon 1 to display the Orders for Signature window.

4 Click the Modify button.

5 The PowerPlan window displays. Hover over the icons along the top toolbar:

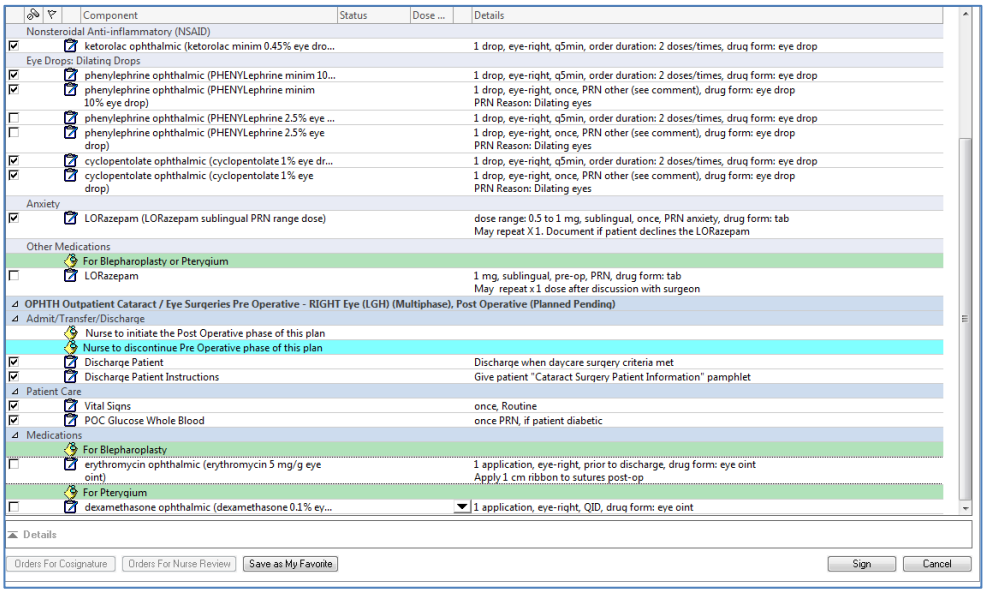
Click to select one of the options.

Note: Clicking this icon opens a window with additional clinical decision support information. The icon next to the order indicates missing details. This is a standard icon across the CIS.

PowerPlans open in the Plan Navigator. Scroll through to locate Visual cues organizing orders:

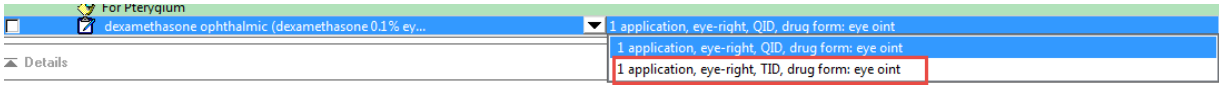
- Bright blue highlighted text for critical reminders
- Bright yellow highlights for clinical decision support information
- Light blue highlights that separate categories of orders

6 Here you can modify the orders in the plan by checking or unchecking orders and modifying the details of the orders by using the drop-down or by right clicking on the order and selecting **Modify.**



7 Select additional orders for the Ophthalmology PowerPlan as listed below:

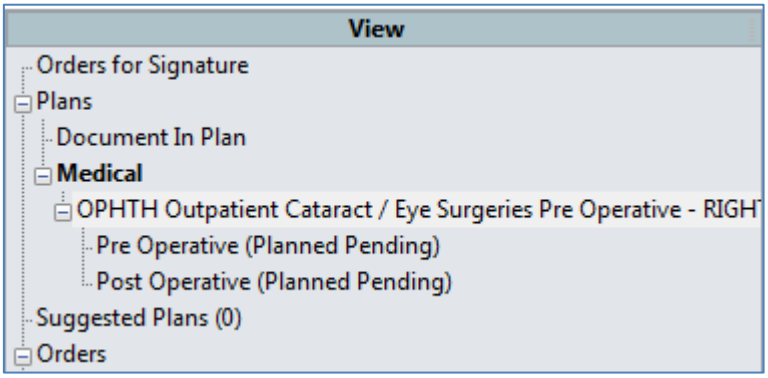
- Erythromycin ophthalmic
- Dexamethasone Ophthalmic select the highlighted option



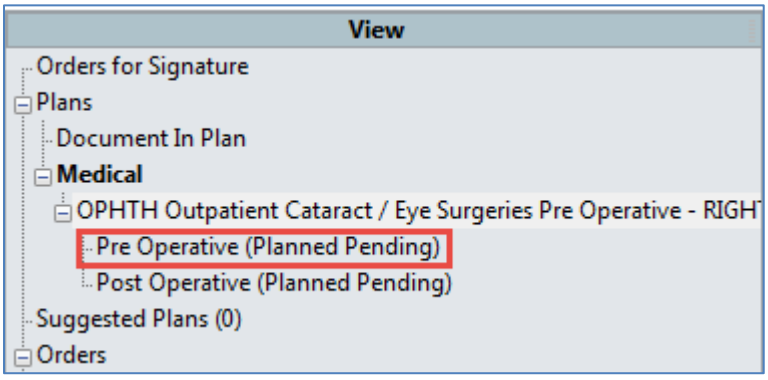
8 Remove the following Items:

- POC Blood Glucose
- Lorazepam

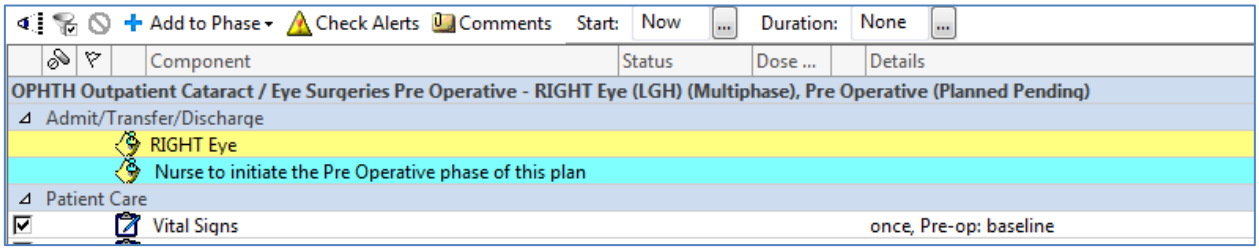
9 The Cataract PowerPlan is separated into Phases. A phase linked to a time during the patients care. In this case there is a Pre Operative and a Post Operative. These correlate to the preoperative timeframe and the Post Operative time frame respectively.



10 Click on the Pre Operative



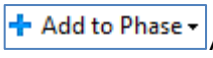
11 After Selecting the Pre Operative new icons populate the top of the page:



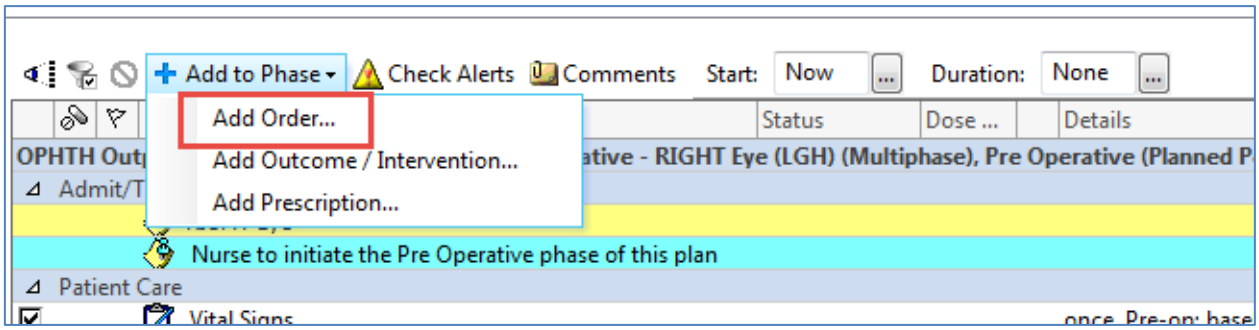
Collapses or expands the list of order categories on the left side of the screen. Collapsing the list creates more room for the PowerPlan orders list.

Merges your planned orders with existing orders to avoid duplicating an order. However, the CIS will warn you about order duplications for specific types of orders.

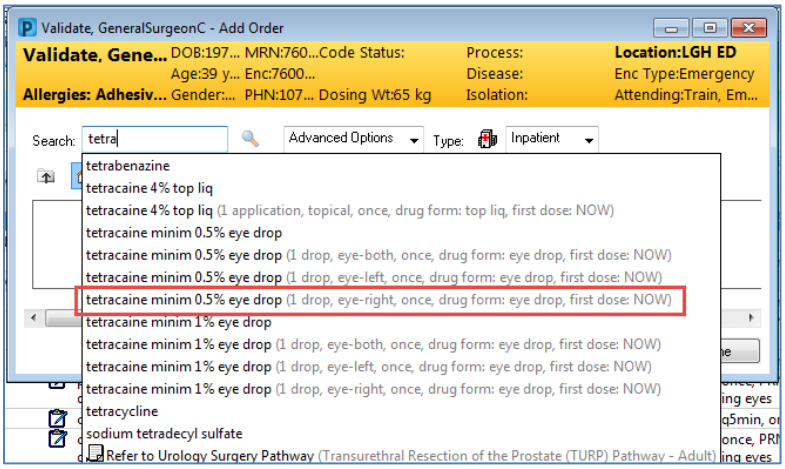
Displays selected orders only. Click that button to review what orders have been selected

12 Selecting a Phase allows new orders to be placed for that particular period and not placed as a generic order for the entire course in hospital. Click on the 

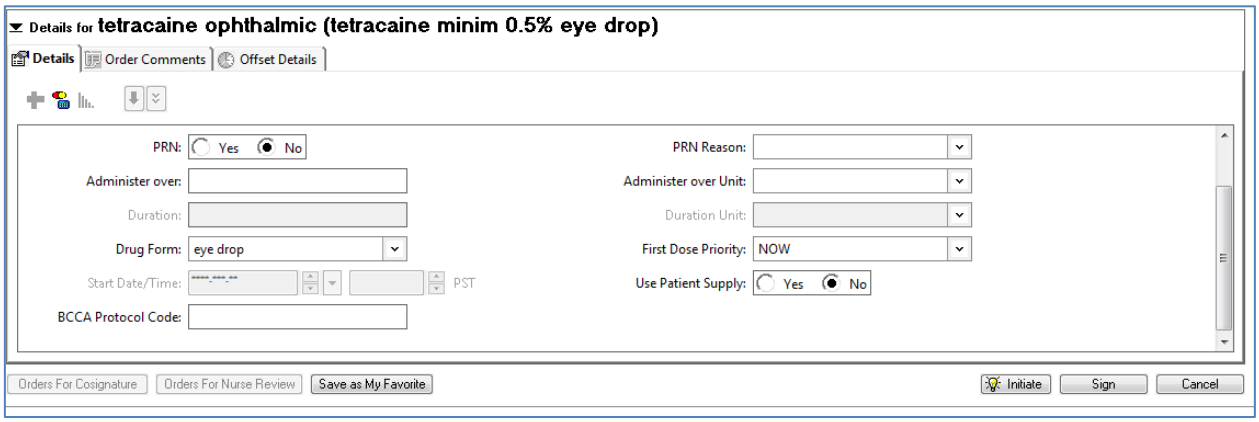
Add to Phase and select Add Order



13 Type *tretra* and select the highlighted order sentence.



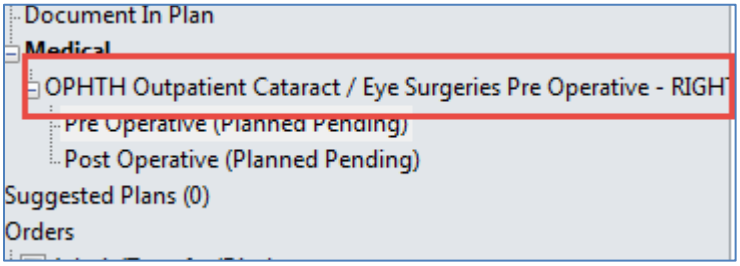
14 As with any order you can modify the order to best reflect the needs of the patient.



In this example there is no need to change any of the details.

If necessary you can add orders to the post op phase.

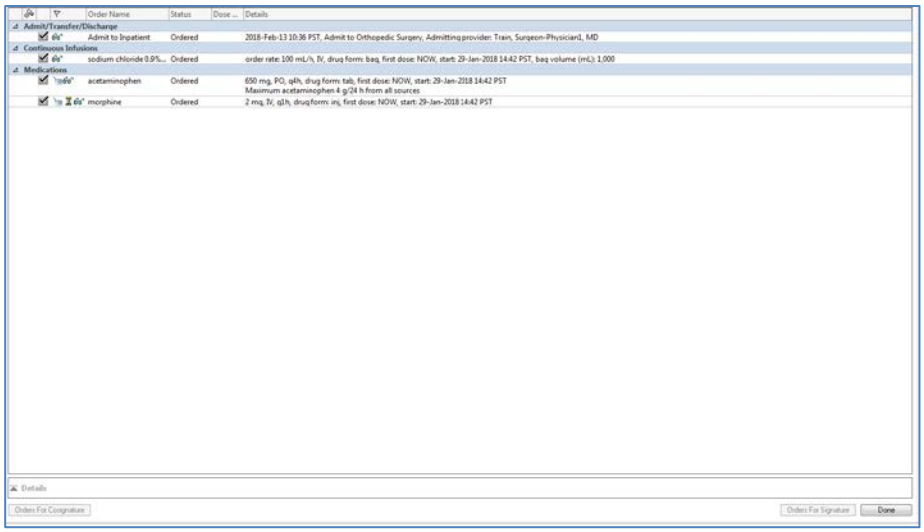
15 Once done adding orders click on the PowerPlan as highlighted, to review the PowerPlan



16 Click the **Sign** button to *plan* the PowerPlan. It will be activated on the day or surgery by the pre-operative nursing staff.

NB If you go to click Sign and you see an Initiate Button, do not click on this as the system will process the orders as opposed to the day of surgery.

17



Then click **Done**.

Key Learning Points

- PowerPlans are similar to pre-printed orders
- You can select from available order details using drop-down lists or modify order sentences manually where needed
- Phases allow orders to be targeted to a specific time frame within the patients stay
- Sign will place orders into a planned state for future activation

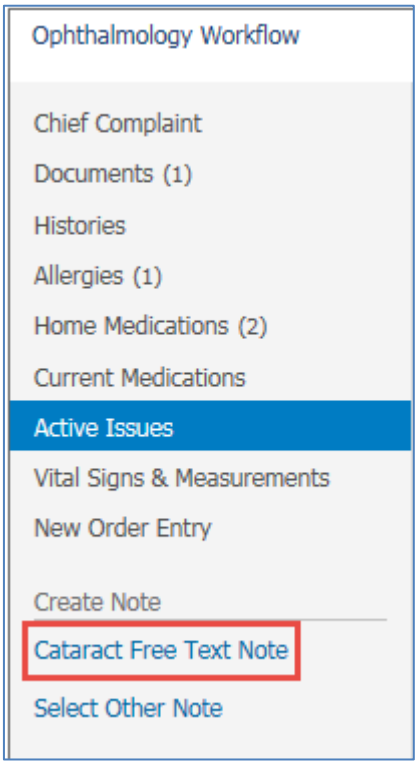
Activity 1.8 – Documentation

PowerChart uses Dynamic Documentation to pull all existing and relevant information into a comprehensive document, using a standard template.

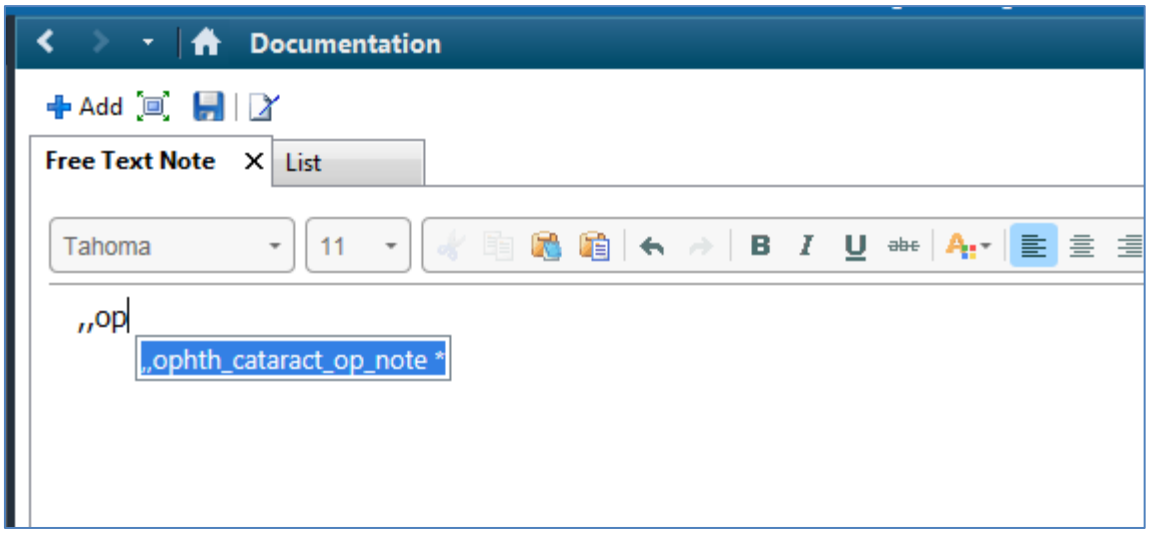
Dynamic Documentation can save you time by allowing you to populate your documentation with items you have reviewed and entered in the Admission workflow tab. This is why it is more efficient to create the note as the last step in the process. You can also add new information by typing or dictating directly into the note.

Workflows Tabs such as Ophthalmology and Transfer/Discharge have the Create Note section displaying relevant note types represented by links. With one-click on the desired note type link, PowerChart generates a note.

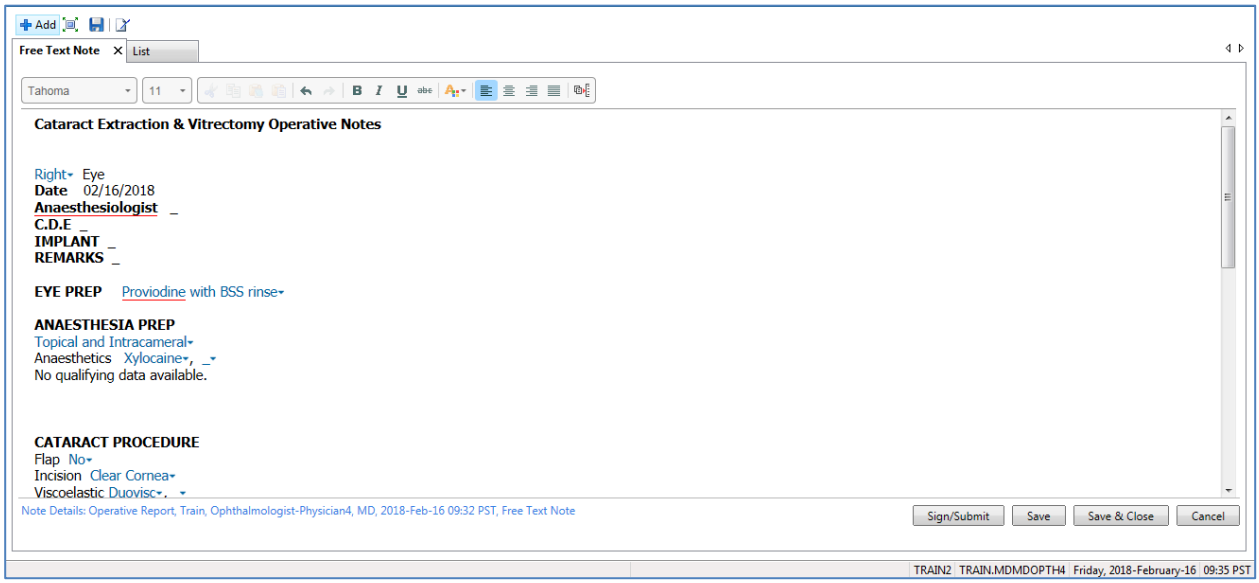
1 Navigate to the **Create Note** section. Select **Cataract Free Text Note**



2 The draft note displays in edit mode populated with the information captured by you and other clinicians. With the Note open type ,,*op* and select the option.

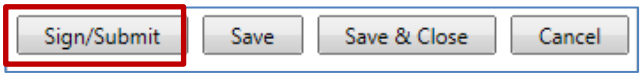


5



For Practice fill in the particulars as you see fit.

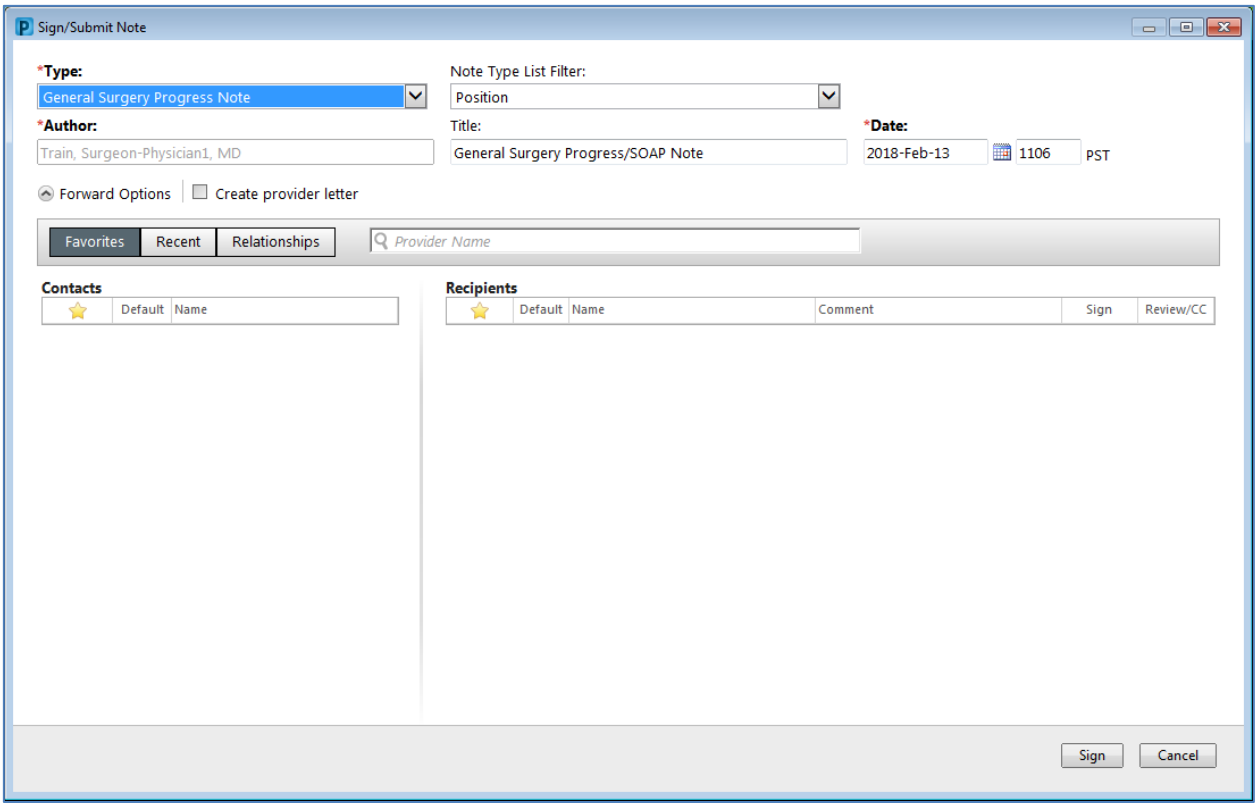
8 To complete your note, click **Sign/Submit.**



Note: You have also an option to click Save or Save & Close to continue to work on this document later. Saved documents are not visible to other care team members.

9 In the **Sign/Submit window**, typically no changes are required if you use the link to create your document. Note type and title are already populated if you use a link to create your document but can be altered. You will learn later how to use the **Forward** option to send copies of the admission note to other providers.

Click **Sign** to complete the process.

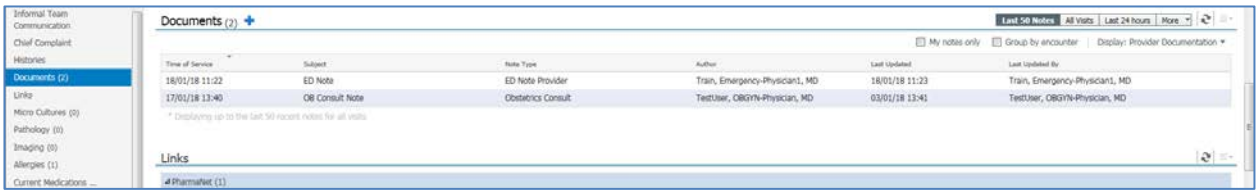


Note:

- The Date auto-populates with the current date. Ensure that it indicates the date of the patient's admission, not the date the note is created.
- Patients primary provider will be sent a copy of all reports

10 Once the note is signed, any modifications will be added as an addendum. You will practice adding an addendum later.

After signing the note, you are transferred back to the Admission Tab. Remember to click the **Refresh** button on documents component. The admission note is now listed under Documents and is visible to the entire care team.



11 To close this patient chart, click the **X** icon on the Banner Bar.

Key Learning Points

- Use note links listed under the Create Note within your workflow pages.
- Only when a note is signed will it be visible to the care team.
- Saved notes remain in a draft format and are only visible to you.
- Once you sign and submit a note, further edits can be added but will appear as an addendum.

PATIENT SCENARIO 2 – Discharge Patient home

Learning Objectives

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

- Complete discharge steps, reconcile orders and medications.
- Update discharge diagnosis.

SCENARIO

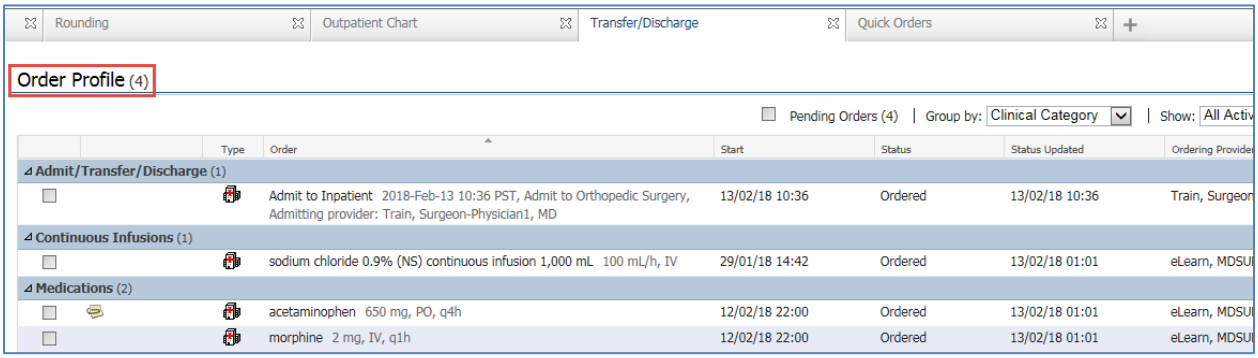
The patient has met all discharge criteria and you already placed the Discharge Patient order as part of your Post-Operative PowerPlan. You still need to complete the discharge documentation, prescriptions and diagnosis entry.

You will complete the following activities:

- Review Orders
- Reconcile Medications at discharge and create prescriptions
- Update discharge diagnoses
- Complete discharge summaries

Activity 2.1 – Review Orders

1 In the Discharge/Transfer tab, select the **Order Profile** component.



2 Review your patient's orders to be aware of any outstanding lab or imaging orders. Visual cues provide additional information.

? Describe the following icons:

 _____  _____  _____

Note: No manual action is required to stop orders at discharge. When a patient physically leaves the unit and is discharged from the system by the unit clerk or nurse, their encounter becomes closed. This will automatically discontinue their orders. Any orders to be completed in the future or orders with pending results that you have placed prior to discharge will remain active.

Key Learning Points

- Outstanding orders are automatically closed after discharge except for future orders and orders with pending results

Activity 2.2 – Reconcile Medications at Discharge and Create Prescriptions

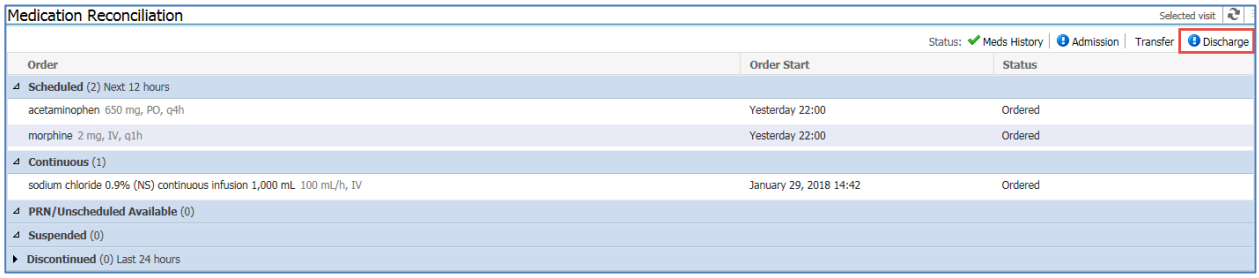
Now that you have reviewed the current orders, you are ready to complete your discharge medication reconciliation. The list of medications to reconcile includes:

- **Home Medications** - medications that the patient was taking at home prior to admission. These medications were documented with BPMH but were not continued during the hospital visit.
- **Continued Home Medications**- medications the patient was taking at home prior to admission and continued during this admission. Note that this section clearly highlights which medications were substituted by an equivalent hospital formulary medication. Substitutions are marked by icon. The home medication and the substituted medication always appear together on the medication list. In this case, the home medication, Lisinopril, is listed above the substituted medication, trandolapril.
- **Medications** - new medications that the patient started during this inpatient stay.
- **Continuous Infusions** -inpatient fluids and medications that were given by continuous infusion.

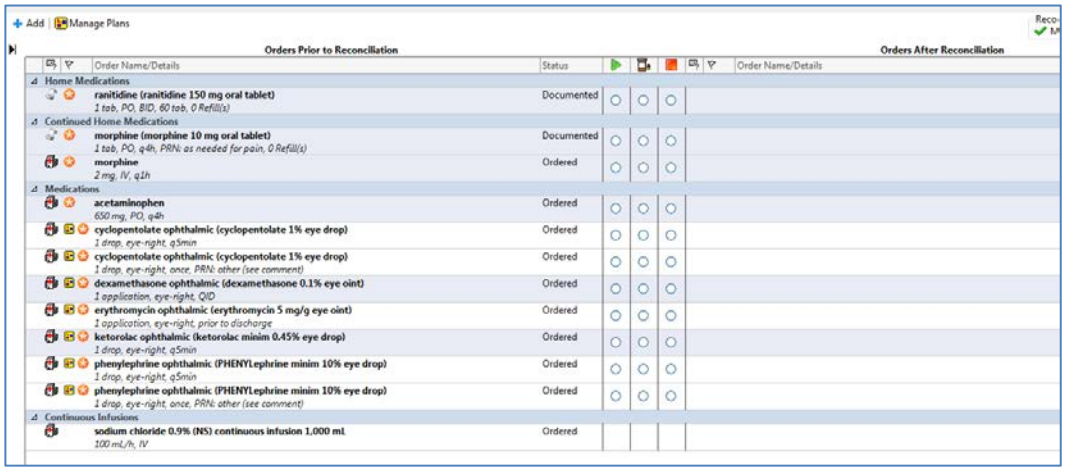
You will determine which home medications and inpatient medications your patient should continue after discharge. Continued medications will be carried forward and available as documented home medications within the patient's medication history. This will be viewable at the patient's next visit.

You can also create a prescription for the existing or new medications directly in the reconciliation screen.

1 Navigate to the **Medication Reconciliation** component and click **Discharge**

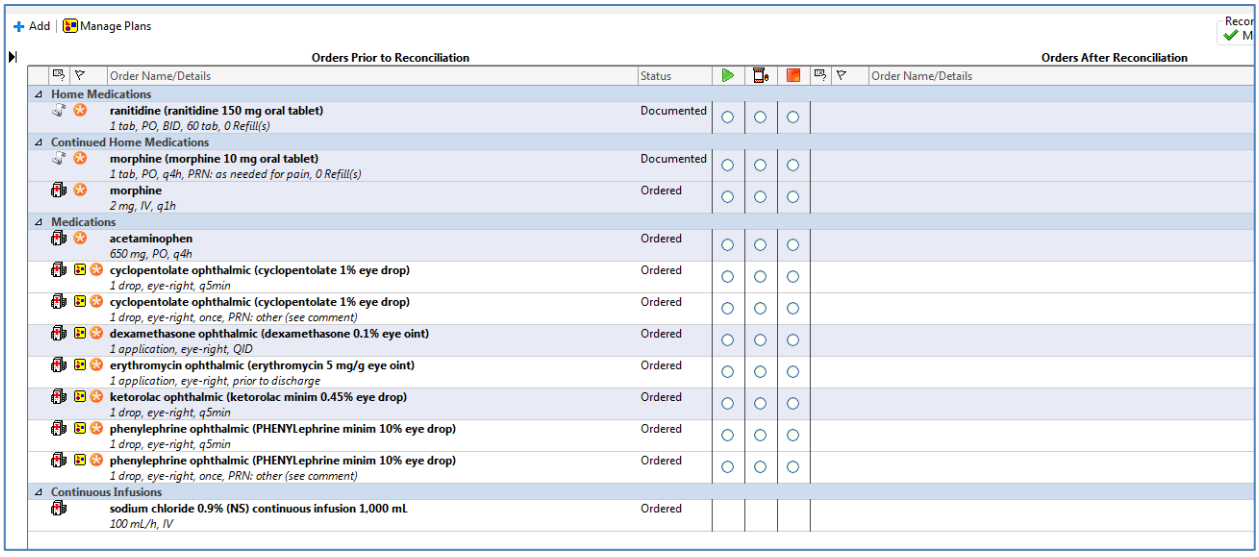


2 The reconciliation window displays the current status of medications.



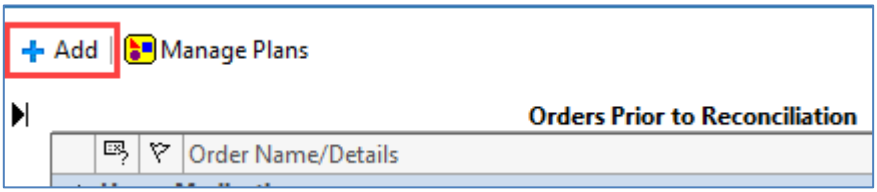
? Hover over the icons to discover what they indicate and add descriptions below:

3 Continue the patient's home medications. As indicated by the  icon.

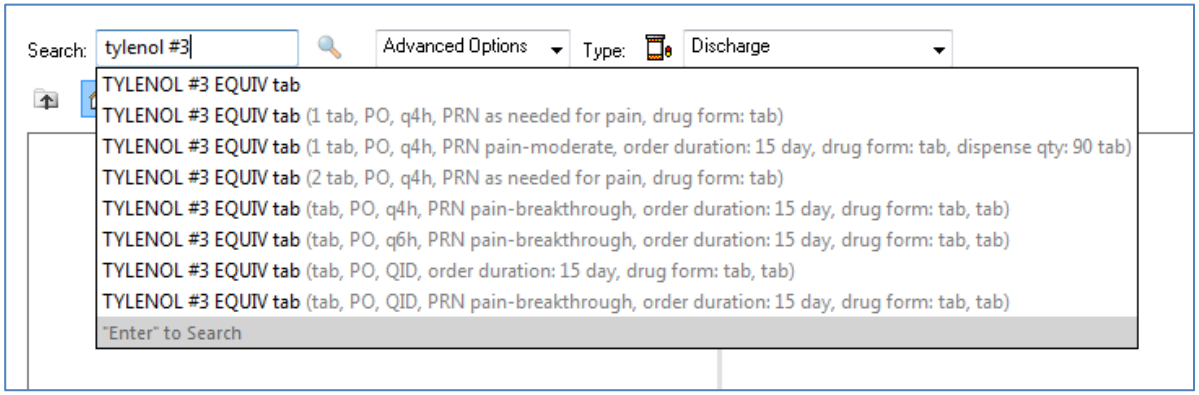


4 Discontinue all inpatient orders as indicated by the  icon.

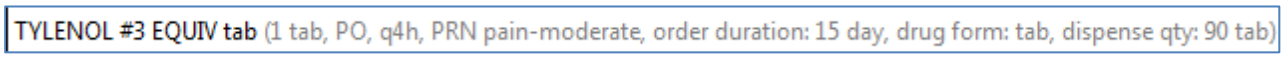
5 Create a new Prescription for Tylenol #3 by clicking the **+Add** button.



6 Search for Tylenol #3 in the **Search:** field.

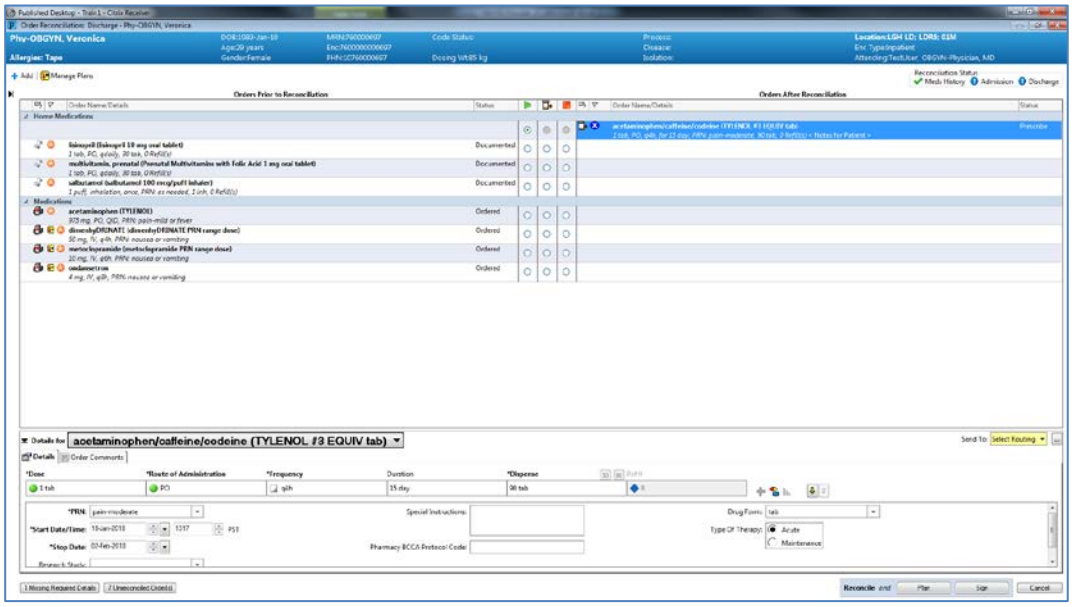


Select the appropriate sentence:

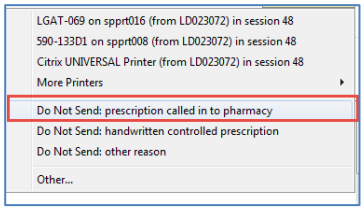


7 Click **Done**

8 Complete any missing details for the new prescription.



In this case select in the Send to box (the yellow highlighted), **Do Not Send: prescription called into pharmacy**



9 All medication must be reconciled to successfully complete the discharge medication reconciliation process.

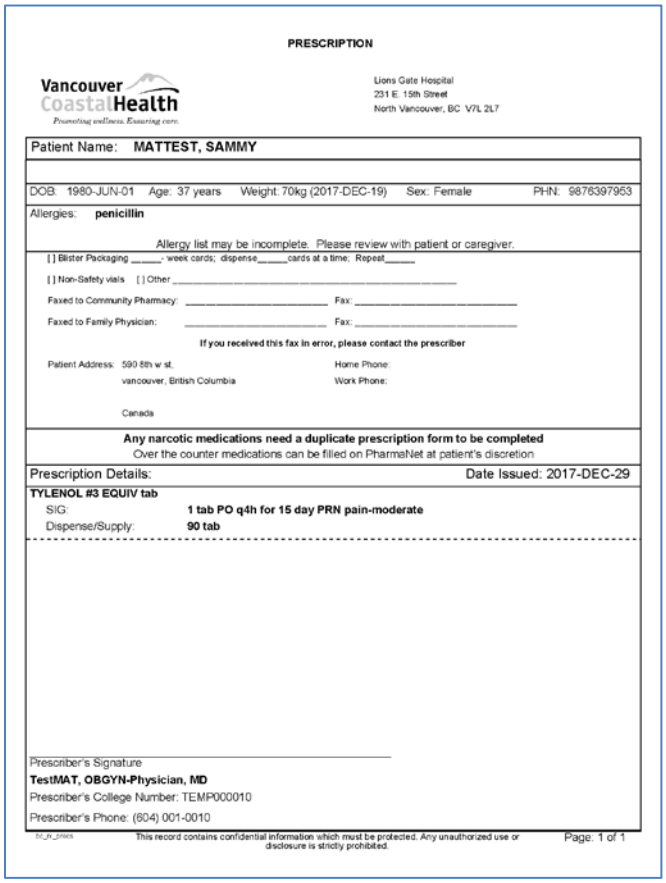
Once all medications are reconciled, click **Sign** to complete the discharge reconciliation.

Sign will process the reconciliation all items must be reconciled to be able to sign.

Plan will save your progress and you can come back at a later time to finish

Cancel with discard all work and will not save anything.

10 The prescription will print automatically. Below is an example.



PRESCRIPTION

Vancouver CoastalHealth
Promoting wellness. Ensuring care.

Lions Gate Hospital
231 E. 15th Street
North Vancouver, BC V7L 2L7

Patient Name: **MATTEST, SAMMY**

DOB: 1980-JUN-01 Age: 37 years Weight: 70kg (2017-DEC-19) Sex: Female PHN: 9876397953

Allergies: **penicillin**

Allergy list may be incomplete. Please review with patient or caregiver.

[ ] Blister Packaging _____- week cards; dispense_____cards at a time; Repeat_____

[ ] Non-Safety vials [ ] Other _____

Faxed to Community Pharmacy: _____ Fax: _____

Faxed to Family Physician: _____ Fax: _____

If you received this fax in error, please contact the prescriber

Patient Address: 590 8th w st, vancouver, British Columbia, Canada

Home Phone:

Work Phone:

Any narcotic medications need a duplicate prescription form to be completed
Over the counter medications can be filled on PharmaNet at patient's discretion

Prescription Details: Date Issued: 2017-DEC-29

TYLENOL #3 EQUIV tab

SIG: **1 tab PO q4h for 15 day PRN pain-moderate**

Dispense/Supply: **90 tab**

Prescriber's Signature

TestMAT, OBGYN-Physician, MD

Prescriber's College Number: TEMP000010

Prescriber's Phone: (604) 001-0010

This record contains confidential information which must be protected. Any unauthorized use or disclosure is strictly prohibited.

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Note: Narcotics still require triple pad prescriptions.

10 A medication summary will be included, as an example of dynamic documentation, in the Patient Discharge Summary as well as in the Discharge Summary. Below is an example of this.

New Medications to Start Taking

Medication	How Much	How	When	Reason	Next Dose	Additional Instructions
acetaminophen/caffeine/codeine (TYLENOL #3 EQUIV tab)	1 tablet	by mouth	every 4 hours as needed	pain-moderate		Stop Date: 13-JAN-2018

Home Medications - Continue Taking

Medication	How Much	How	When	Reason	Next Dose	Additional Instructions
lisinopril (lisinopril 10 mg oral tablet)	1 tablet	by mouth	daily			
salbutamol (salbutamol 100 mcg/puff inhaler)	1 puff	by inhalation	every 1 hour as needed	shortness of breath		

Key Learning Points

- Medication Reconciliation on discharge includes both home and hospital medications
- Both home and inpatient medications can be converted into prescriptions during the discharge reconciliation process
- Discontinued medications become historically documented on the chart
- Continued medications and prescriptions will be captured in the patient's documented medication history and carried forward to the next visit
- Discharge medication information is included in notes provided to the patient and patient's lifetime providers on record

End of Workbook

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