

SELF-GUIDED PRACTICE WORKBOOK [N91]
CST Transformational Learning

WORKBOOK TITLE:

Provider: Surgeon (Outpatient)



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SELF-GUIDED PRACTICE WORKBOOK

Duration	3 hours
Before getting started	<ul style="list-style-type: none">  Sign the attendance roster (this will ensure you get paid to attend the session)  Put your cell phones on silent mode
Session Expectations	<ul style="list-style-type: none">  This is a self-paced learning session  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	<ul style="list-style-type: none">  At the end of the session, you will be required to complete a Key Learning Review  This will involve completion of some specific activities that you have had an opportunity to practice through the scenarios.

■ Using Train Domain

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

Please note:

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

PATIENT SCENARIO 1 – Pre-Operative Clinic Visit

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
-  Update the patient's chart appropriately
-  Complete a Clinic Note

SCENARIO

A 39-year-old male is seeing you in the clinic and you have decided she is to have hardware removal from the tibia. 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

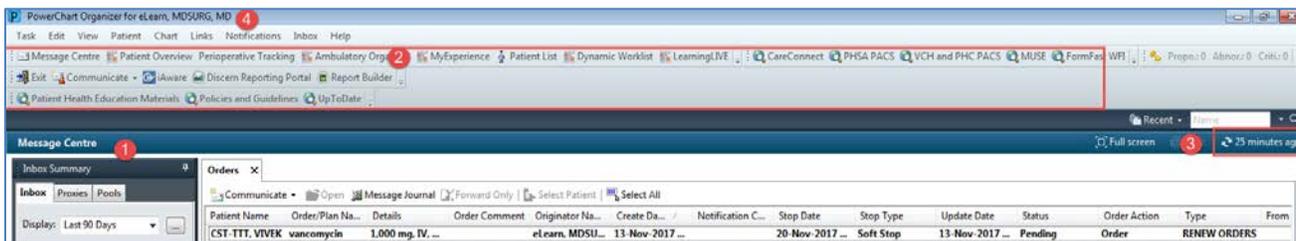
Activity 1.1 – Accessing the Patient’s Chart

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:

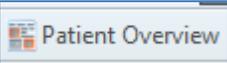
PowerChart



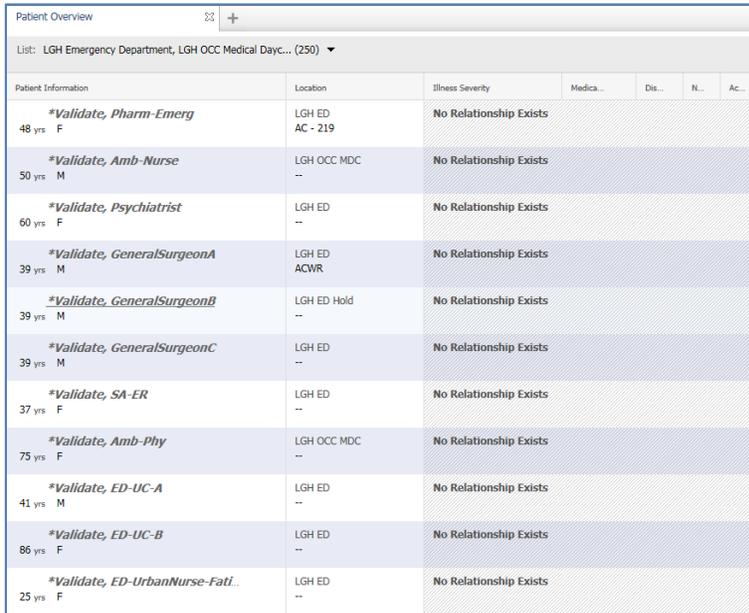
- 1 Message Centre - As a Provider, your default page upon logging in will be the Message Centre. PowerChart allows you to receive patient information electronically. It serves as a platform for sharing patient related information and responsibilities with other providers and clinicians. Message Centre 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  1 hours 32 minutes ago VS Refreshed  0 minutes ago
- 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 ELEARN.MDSURG Monday, 27-November-2017 09:59 PST, always ensure you are documenting under your own login.

1 To access your patient select Patient Overview to view your patients and open the patient’s chart:

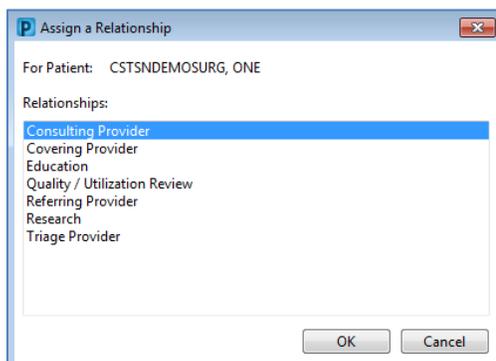
Select  from the Toolbar

2 Scroll down through the list and select your Patient. Click on the name.



Patient Information	Location	Illness Severity	Medica...	Dis...	N...	Ac...
*Validate, Pharm-Emerg 48 yrs F	LGH ED AC - 219	No Relationship Exists				
*Validate, Amb-Nurse 50 yrs M	LGH OCC MDC --	No Relationship Exists				
*Validate, Psychiatrist 60 yrs F	LGH ED --	No Relationship Exists				
*Validate, GeneralSurgeonA 39 yrs M	LGH ED ACWR	No Relationship Exists				
*Validate, GeneralSurgeonB 39 yrs M	LGH ED Hold --	No Relationship Exists				
*Validate, GeneralSurgeonC 39 yrs M	LGH ED --	No Relationship Exists				
*Validate, SA-ER 37 yrs F	LGH ED --	No Relationship Exists				
*Validate, Amb-Phy 75 yrs F	LGH OCC MDC --	No Relationship Exists				
*Validate, ED-UC-A 41 yrs M	LGH ED --	No Relationship Exists				
*Validate, ED-UC-B 86 yrs F	LGH ED --	No Relationship Exists				
*Validate, ED-UrbanNurse-Fati... 25 yrs F	LGH ED --	No Relationship Exists				

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



Select Consulting Provider.

Note: 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

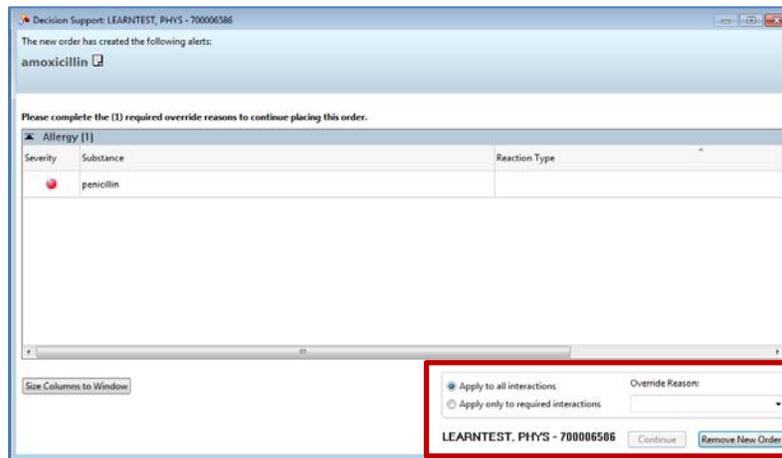
- “Relationships” are assigned when first accessing the patient’s chart or every 16 hours.

Activity 1.4– Allergies

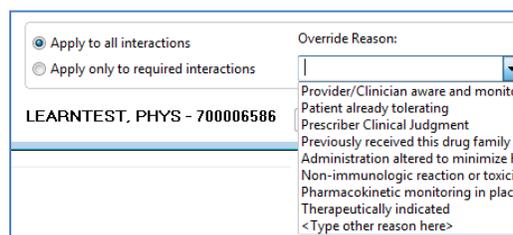
You review the patient’s allergies and add an allergy to Penicillin. This information was provided by the patient but has not yet been entered into the patient’s chart.

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.

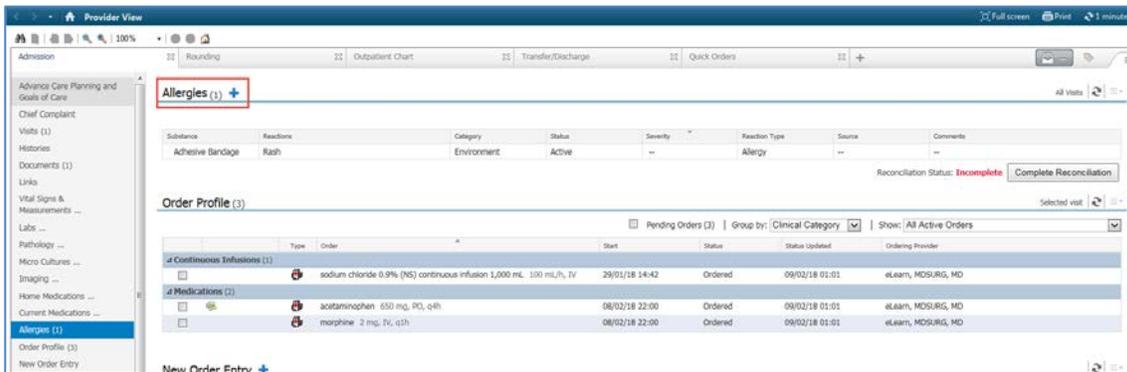


- 1 Click on the icon by the Menu to close the menu. Providers are not encouraged to use the menu at this time and the current training will not cover that functionality.

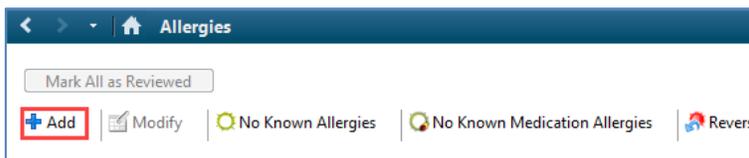


- 2 Select the Admission tab

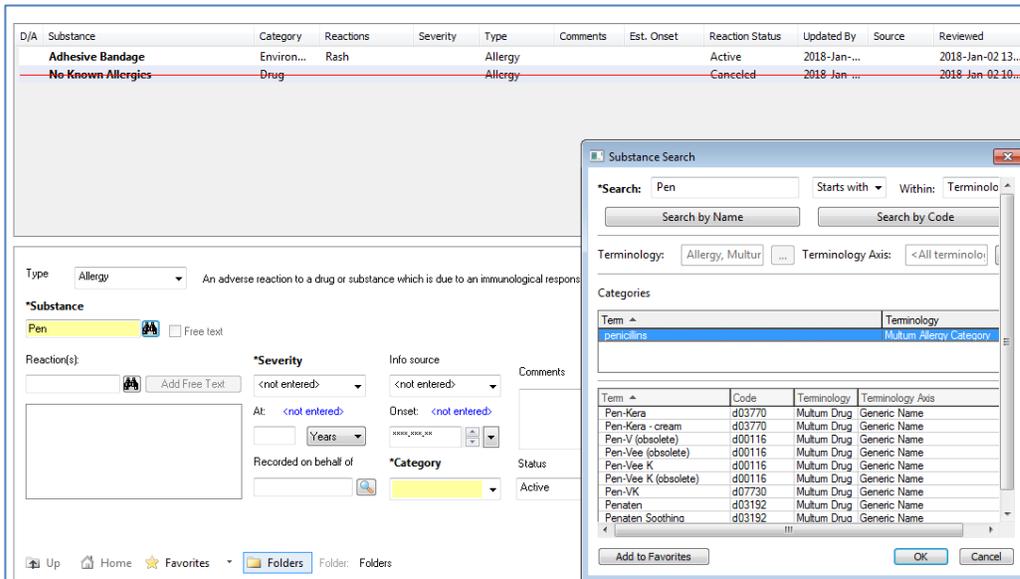
Then click the **Allergy** link to open the window where you will enter or update allergy information.



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

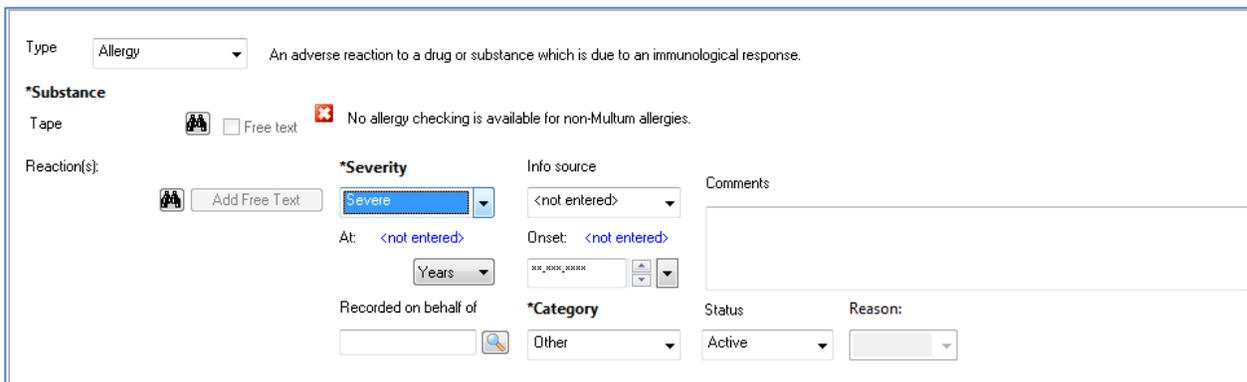


3 Search for Pen in the **Substance** box. Click on  to execute the search and then select penicillins from the list. Click **OK** to return to the Add Allergy/Adverse Effect window.



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**.

D/A	Substance	Category	Reactions	Severity	Type	Comments	Est. Onset	Reaction Status	Updated By	Source	Reviewed
	Adhesive Bandage	Environ...	Rash		Allergy			Active	2018-Jan-...		2018-Jan-02 13:...
	No Known Allergies	Drug			Allergy			Canceled	2018-Jan ...		2018-Jan-02 10:...

Term	Code	Terminology	Terminology Axis
Pen-Kera	d03770	Multum Drug	Generic Name
Pen-Kera - cream	d03770	Multum Drug	Generic Name
Pen-V (obsolete)	d00116	Multum Drug	Generic Name
Pen-Vee (obsolete)	d00116	Multum Drug	Generic Name
Pen-Vee K	d00116	Multum Drug	Generic Name
Pen-Vee K (obsolete)	d00116	Multum Drug	Generic Name
Pen-VK	d07730	Multum Drug	Generic Name
Penaten	d03192	Multum Drug	Generic Name
Penaten Soothing	d03192	Multum Drug	Generic Name

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.

D/A	Substance	Category	Reactions	Severity	Type	Comments	Est. Onset	Reaction Status	Updated By	Source	Reviewed	Revi...	Interaction
	Adhesive Bandage	Environ...	Rash		Allergy			Active	2018-Jan-...		2018-Jan-02 13...	Test...	
	No Known Allergies	Drug			Allergy			Canceled	2018-Jan-...		2018-Jan-02 10...	Test...	
✓	penicillins	Drug	Rash	Severe	Allergy			Active	2018-Feb-...		2018-Feb-09 1...	Train...	

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 penicillins and click Modify:

D/A	Substance	Category	Reactions	Severity	Type	Comments	Est. Onset	Reaction Status	Updated By	Source	Reviewed	Revi...	Interaction
	Adhesive Bandage	Environ...	Rash		Allergy			Active	2018-Jan-...		2018-Jan-02 13...	Test...	
	No Known Allergies	Drug			Allergy			Canceled	2018-Jan-...		2018-Jan-02 10...	Test...	
✓	penicillins	Drug	Rash	Severe	Allergy			Active	2018-Feb-...		2018-Feb-09 1...	Train...	

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

The screenshot shows a form for entering an allergy. The 'Type' is 'Allergy'. The 'Substance' is 'penicillins'. The 'Reaction(s)' is 'Rash'. The 'Severity' dropdown is highlighted with a red box and set to 'Mild'. Other fields include 'Info source' (not entered), 'Onset' (not entered), 'Recorded on behalf of' (empty), 'Category' (Drug), 'Status' (Active), and 'Reason' (empty). The bottom navigation bar includes 'Up', 'Home', 'Favorites', and 'Folders'.

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:

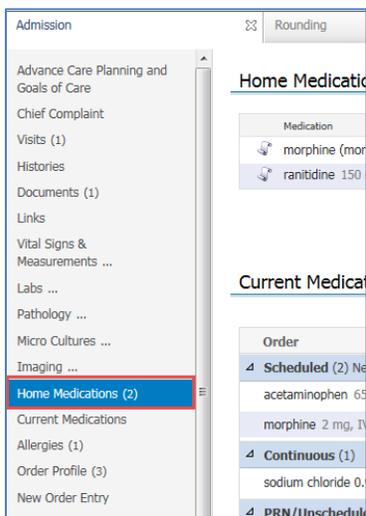
- **Home Medications** – this component lists home medications documented for this visit and carried over from previous encounters

The BPMH must be completed before proceeding with admission medication reconciliation. The best possible medication history is generally documented by a pharmacy technician or nursing staff. 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.

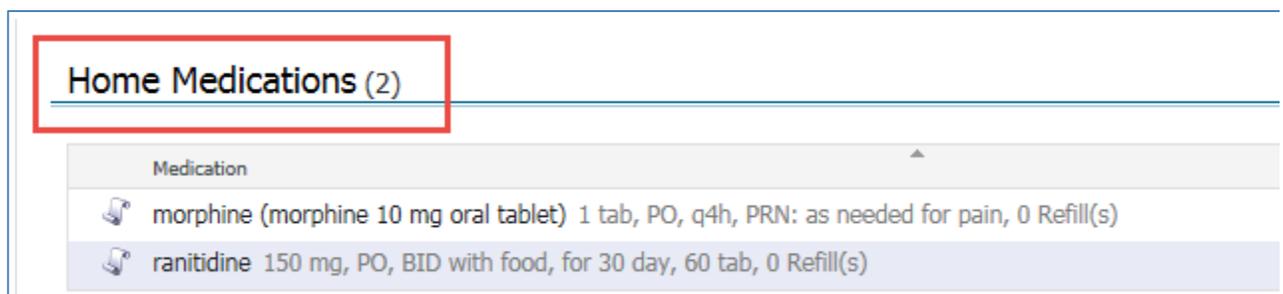
1

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



2

Click **Home Medications** heading.



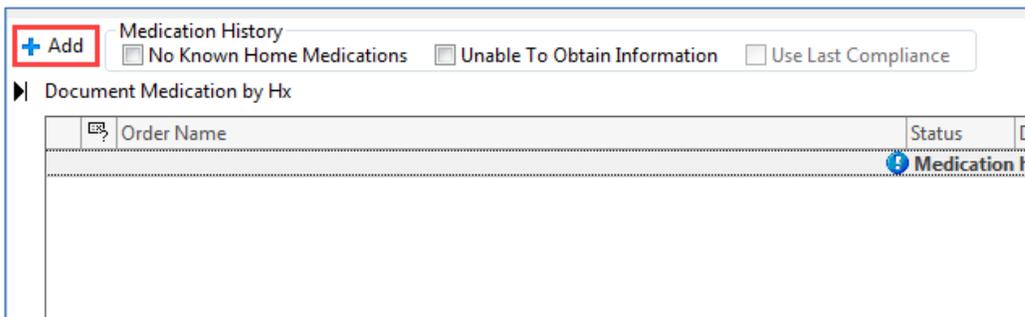
3 In the **Medication List** window, click **Document Medication by Hx**.



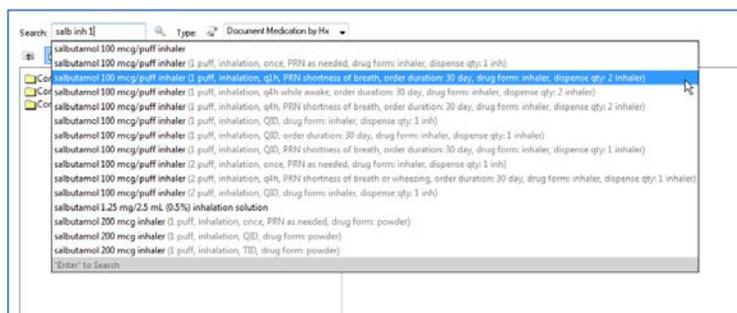
Note: Clicking the **+ Add** will add an order, not add history.

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

salbutamol 100 mcg/puff inhaler (1 puff, inhalation, q1h, PRN shortness of breath, order duration: 30 day, drug form: inhaler, dispense qty: 2 inhaler)

Tip: 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.

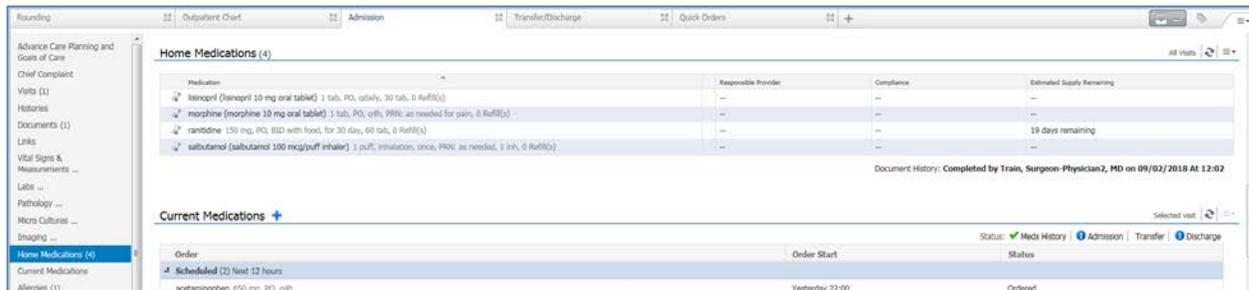
For this practice click on the



If in doubt refresh the page!

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.

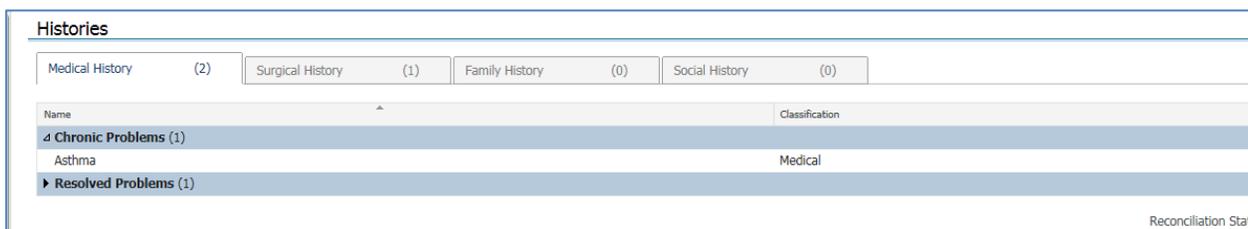
Activity 1.5 – Review History

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.

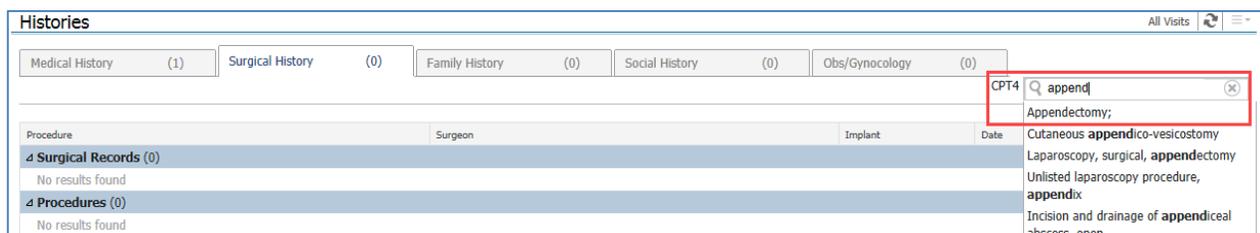
For now click on the Surgical History tab and then the History link.



The screenshot shows a 'Histories' interface with four tabs: Medical History (2), Surgical History (1), Family History (0), and Social History (0). The Medical History section is expanded, showing 'Chronic Problems (1)' with 'Asthma' listed as 'Medical', and 'Resolved Problems (1)'. A 'Reconciliation Stat' link is visible at the bottom right.

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*



The screenshot shows the 'Histories' interface with the 'Surgical History (0)' tab selected. A search box contains the text 'append'. A dropdown menu is open, showing search results for 'CPT4' with the following options: 'Appendectomy;', 'Cutaneous appendico-vesicostomy', 'Laparoscopy, surgical, appendectomy', 'Unlisted laparoscopy procedure, appendix', and 'Incision and drainage of appendiceal abscess, open'. The 'Appendectomy;' option is highlighted.

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

Save Cancel

Appendectomy;

Procedure Date

At/On Age 32 Years

Provider Status Location

-- -- --

Comments

--

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.

Key Learning Points

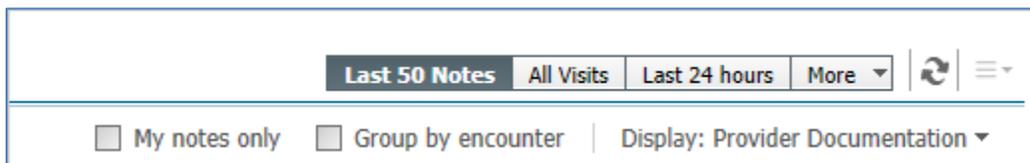
- Histories information including surgical procedures can be added when taking a patient's history

Activity 1.6 – Review Documents, Labs and Diagnostics

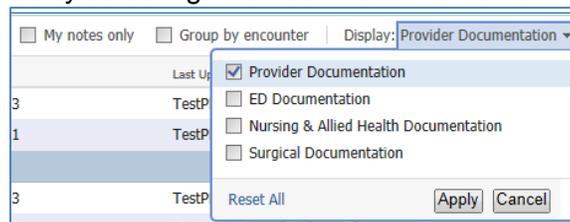
Continue reviewing the patient’s chart by following the Rounding tab list of components. When using PowerChart, you might be faced with a large amount of information.

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**.

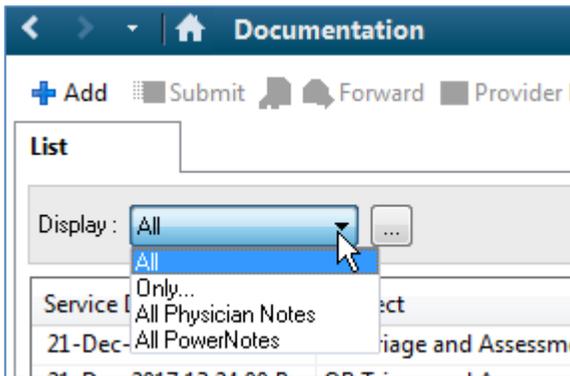


Remember that if you select a specific filter, the selection narrows and you might not display all relevant information. Ensure that the filter type corresponds to your current needs.

- 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.

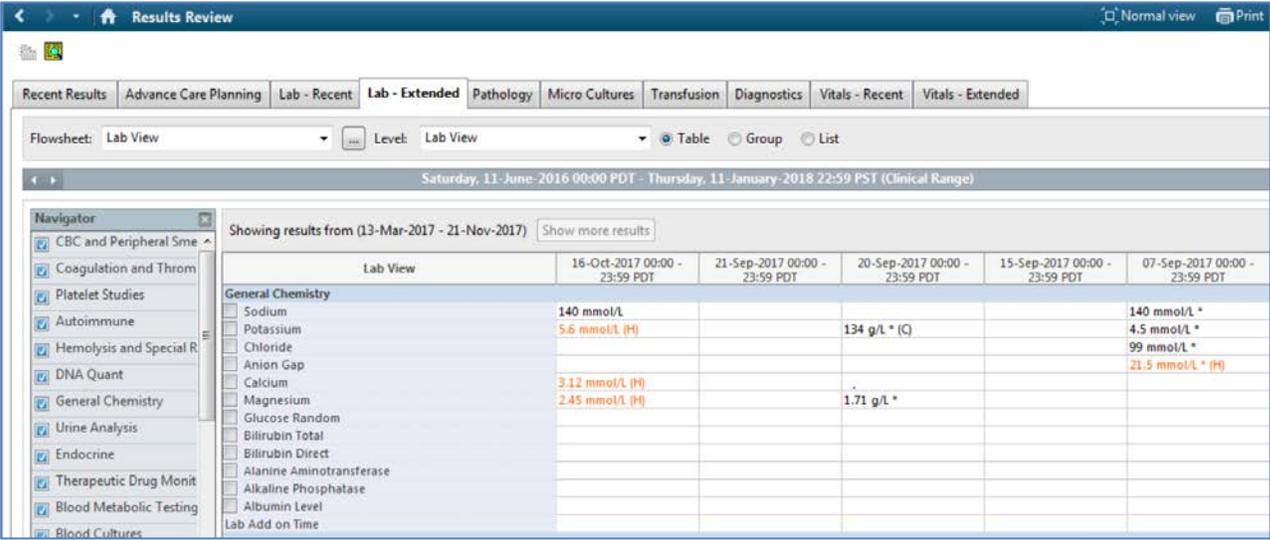
- 3 For labs and other diagnostics – use filters to display results that are relevant to you.

- 4 Click the refresh icon to update the information just for this component.



5

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



The screenshot shows a 'Results Review' window with a navigation pane on the left and a main table of results. The table is titled 'Showing results from (13-Mar-2017 - 21-Nov-2017)'. The columns represent dates: 16-Oct-2017 00:00 - 23:59 PDT, 21-Sep-2017 00:00 - 23:59 PDT, 20-Sep-2017 00:00 - 23:59 PDT, 15-Sep-2017 00:00 - 23:59 PDT, and 07-Sep-2017 00:00 - 23:59 PDT. The rows list various lab tests under 'General Chemistry'. Values are displayed in the table cells, with some highlighted in red to indicate abnormal results.

	16-Oct-2017 00:00 - 23:59 PDT	21-Sep-2017 00:00 - 23:59 PDT	20-Sep-2017 00:00 - 23:59 PDT	15-Sep-2017 00:00 - 23:59 PDT	07-Sep-2017 00:00 - 23:59 PDT
General Chemistry					
Sodium	140 mmol/L				140 mmol/L *
Potassium	5.6 mmol/L (H)		134 g/L * (C)		4.5 mmol/L *
Chloride					99 mmol/L *
Anion Gap					21.5 mmol/L * (H)
Calcium	3.12 mmol/L (H)				
Magnesium	2.45 mmol/L (H)		1.71 g/L *		
Glucose Random					
Bilirubin Total					
Bilirubin Direct					
Alanine Aminotransferase					
Alkaline Phosphatase					
Albumin Level					
Lab Add on Time					

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 Gynecology patients.

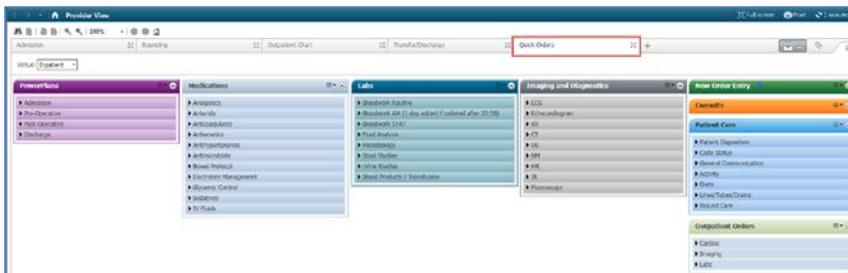
PowerPlans are similar to pre-printed orders (PPOs), allowing you to plan and coordinate care in the acute care environment by defining sets of orders that are often used together. You can adapt PowerPlans to fit your needs:

- 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

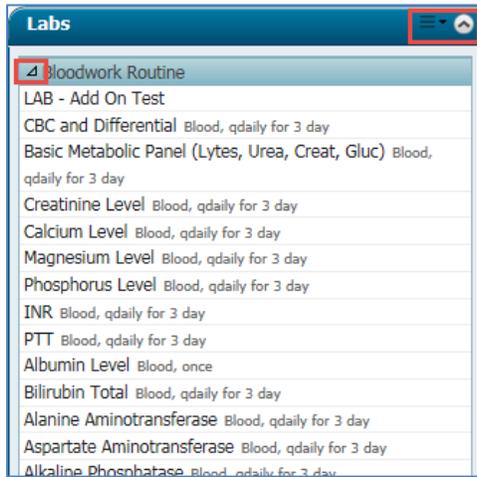
Initiated PowerPlan becomes active immediately and its orders create respective tasks and actions for other care team members.

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

The best option for placing PowerPlans and orders is via the Quick Orders tab. This view is a one-stop shop for common orders and PowerPlans organized in separate categories.

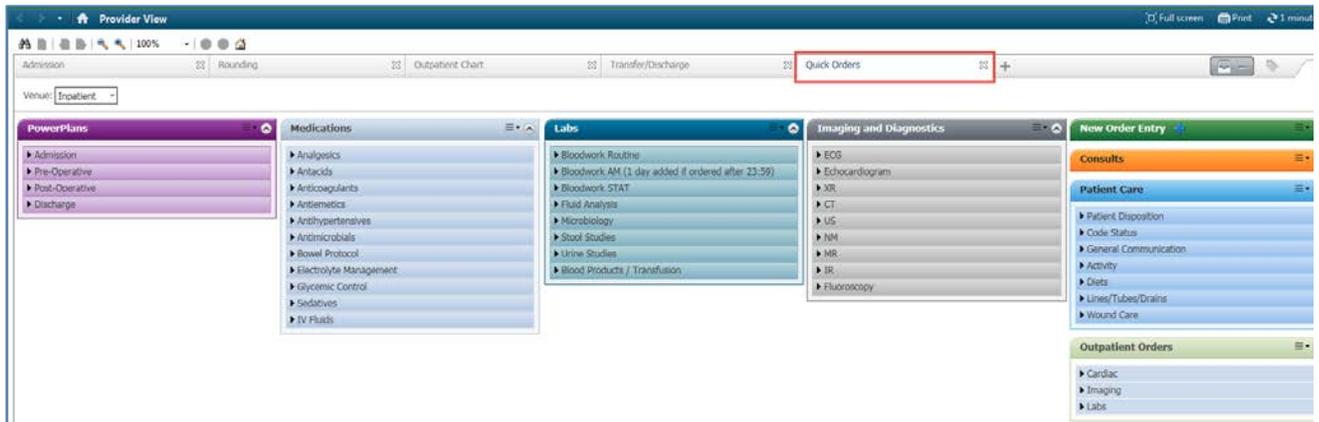


Under each category, there are folders. For example, under the medication category is the analgesics folder which contains individual orders for analgesic medications such as acetaminophen. Orders may allow you to add additional details regarding dose, frequency, route, etc., or may have these details pre-determined for ease of ordering an order sentence. Categories and folders can be collapsed or expanded by clicking the expansion arrows  and .

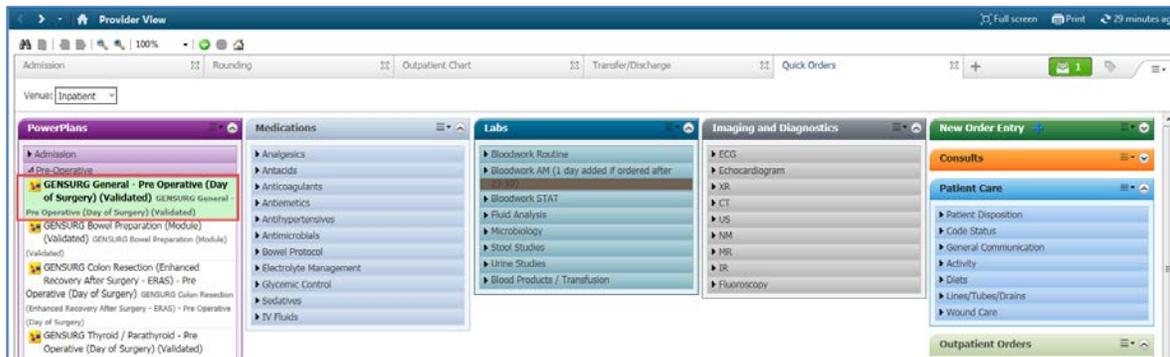


Each specialty has their own quick orders page and they may differ in which orders are available and how those orders are organized.

- 1 In the Provider View page, click on the **Quick Orders** tab.

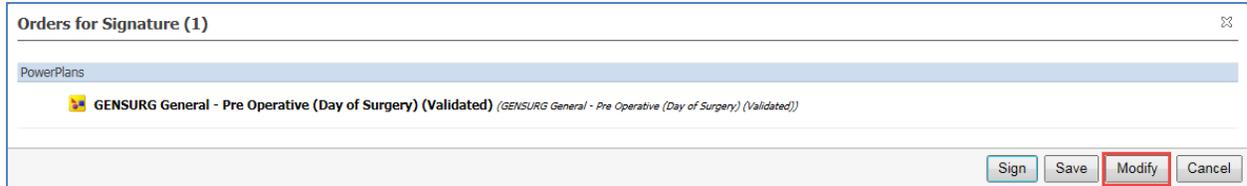


- 2 In the PowerPlans folder, click on Pre-Operative to expand the folder and click on the **GENSURG Operative (Day of Surgery)** plan, marked by the  icon. Note the **Orders for Signature** button has turned green and number 1 is displayed 



- 3 Click the Orders for Signature icon  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:

	Collapse – Allows you to collapse the View pane, leaving more space for viewing PowerPlan details
	Expand – Allows you to expand the View pane
	Show Only Selected Items - Displays the selected orders only to assist in reviewing what has been selected
	Merge View – Displays the plan components with those already ordered for the patient and active on the patient profile.
	Initiate Plan or Phase – Initiates the selected plan or phase. Orders do not become active or route to ancillary departments until you initiate.
	View Excluded – Displays components of the predefined plan that were not included in the initiated plan.
	Discontinue – Opens the Discontinue dialog box so that you can discontinue the plan or phase (individual components can be kept).
	Plan Comment – Adds a note to a PowerPlan phase. Plan comments allow you to communicate decisions made regarding the phase to other clinicians who can view or take action on the phase. You can add a comment to a phase in any status.
 Check Alerts	Check Alerts – Allows you to check for Quality Measure Alerts.

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

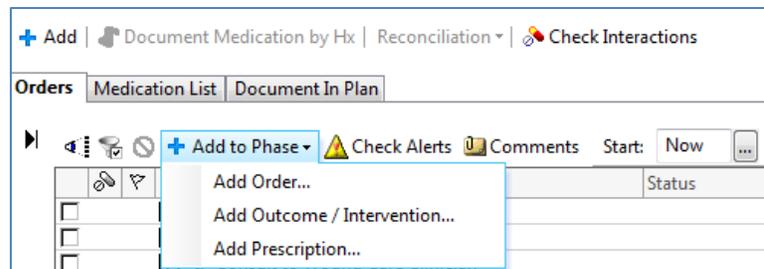
6 Here you can modify the orders in the plan by checking or unchecking orders and modifying the details of the orders by using the drop-down ▼ or by right-clicking on the order and selecting **Modify**.

Component	Status	Dose ...	Details
GENSURG General - Pre Operative (Day of Surgery) (Validated) (Planned Pending)			
Patient Care			
<input checked="" type="checkbox"/> Refer to General Surgery Pathway		T,N	
<input checked="" type="checkbox"/> Vital Signs		once	
<input checked="" type="checkbox"/> Weight		once	
<input checked="" type="checkbox"/> Height/Length		once	
Medications			
VTE Prophylaxis			
<input checked="" type="checkbox"/> heparin		5,000 unit, subcutaneous, pre-op, drug form: inj	Hold until further direction by Anesthesia. If patient requires epidural catheter, heparin to be administered after epidural in situ.
<input type="checkbox"/> Apply Below the Knee Sequential Compression Devices		T,N	To be initiated in the operating room
Antimicrobials			
For clean procedures only			
<input type="checkbox"/> cefAZolin		1,000 mg, IV, pre-op	For weight less than 80 kg. Administer in pre-op area / operating room
If severe penicillin or cephalosporin allergy (e.g. anaphylaxis)			
<input type="checkbox"/> vancomycin		1000 mg, IV, pre-op	For weight less than 80 kg. Administer in pre-op area / operating room
For clean-contaminated procedure, select [cefAZolin and metroNIDAZOLE]			
<input type="checkbox"/> cefAZolin		1,000 mg, IV, pre-op	For weight less than 80 kg. Repeat cefAZolin 1 g IV q4h if surgery is greater than 4 hours. Administer in pre-op area / operating room
<input type="checkbox"/> metroNIDAZOLE		500 mg, IV, pre-op, drug form: bag	Administer in pre-op area / operating room
If severe penicillin or cephalosporin allergy (e.g. anaphylaxis), select [metroNIDAZOLE and gentamicin] OR [metroNIDAZOLE and ciprofloxacin]			
<input type="checkbox"/> metroNIDAZOLE		500 mg, IV, pre-op, drug form: bag	Administer in pre-op area / operating room
<input type="checkbox"/> gentamicin		5 mg/kg, IV, pre-op	Maximum 500 mg/dose. Administer in pre-op area / operating room
<input type="checkbox"/> ciprofloxacin		400 mg, IV, pre-op, drug form: bag	If significant renal dysfunction. Administer in pre-op area / operating room

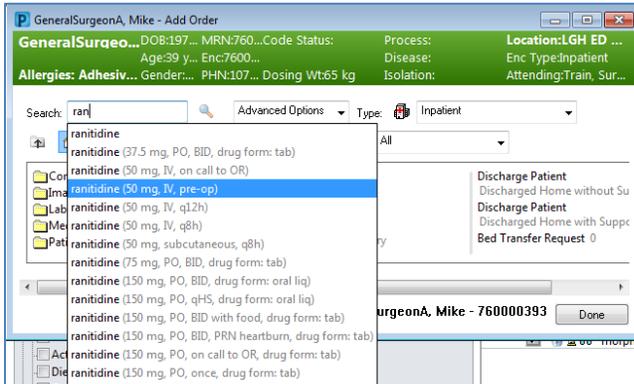
7 Continue to select additional orders for the day of surgery plan as listed below:

- Heparin
- Cefazolin (2000 mg, IV pre-op)

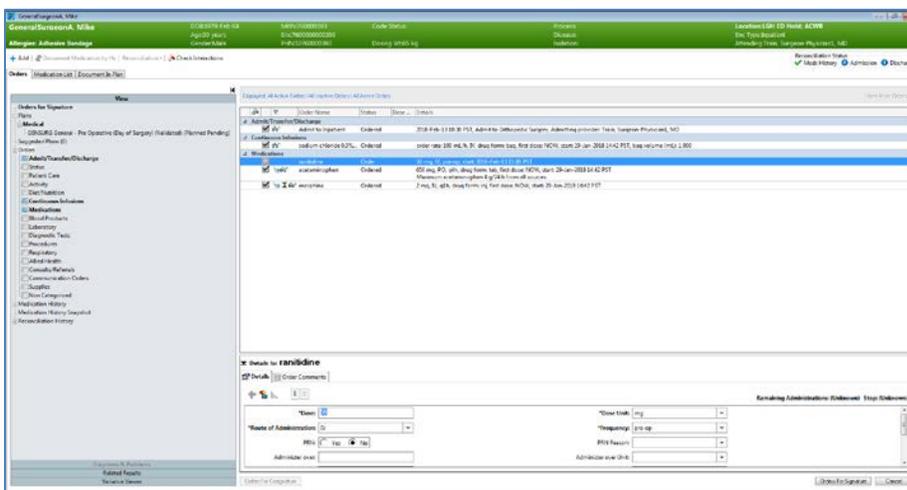
8 You want to add orders that are not part of the PowerPlan. Click the **+ Add to Phase** button and select **Add Order...**



- In the search field start typing in the name of the drug you are searching for. In this case type in *ran* to get a list of the ranitidine orders. Select the ranitidine (50 mg, IV, pre-op). Then click the **Done** button.



- You are then returned to the plan with the new order displayed along with the details.



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



12

<input type="checkbox"/>	<input type="checkbox"/>	Order Name	Status	Dose ...	Details
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Admit to Inpatient	Ordered	2018-Feb-13 10:36 PST, Admit to Orthopedic Surgery, Admitting provider: Train, Surgeon-Physician, MD	
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Continuous Infusions	Ordered	order rate: 100 mL/h, IV, drug form: bag, first dose: NOW, start: 29-Jan-2018 14:42 PST, bag volume (mL): 1,000	
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	sodium chloride 0.9%	Ordered		
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	acetaminophen	Ordered	650 mg, PO, q6h, drug form: tab, first dose: NOW, start: 29-Jan-2018 14:42 PST Maximum acetaminophen 4 g/24 h from all sources	
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	oxycodone	Ordered	2 mg, IV, q4h, drug form: inq, first dose: NOW, start: 29-Jan-2018 14:42 PST	

Details

Orders For Signature

Then click **Done**.

Key Learning Points

- PowerPlans are similar to pre-printed orders
- You can add orders not listed in the PowerPlan by using Add to Phase functionality
- You can select from available order details using drop-down lists or modify order sentences manually where needed
- Initiate means that PowerPlan orders are immediately active and as such, can be actioned right away by the appropriate individuals
- To ensure orders within a PowerPlan are immediately active, click Initiate first and then Sign
- Sign will place orders into a planned state for future activation

Activity 1.8 – Complete your Documentation on HPI, Physical Exam, and Active Issues

Now that you have completed your exam and history and planned your day of surgery orders, you are ready to continue with your documentation. The next components are:

- History of Present Illness
- Physical Exam
- Assessment and Plan
- Active Issues

The above components are called free text components. You can type or dictate directly into them. There is no limitation on length. Front End Speech Recognition (FESR) software captures your dictation directly into PowerChart. Note that FESR will not be part of this activity but is covered in other training.

They serve as a notepad where you may enter your notes without leaving the workflow tab. Information entered here is saved until you are ready to create a formal note. With one-click, this information will be transferred into the note. Until then, any information captured will only be visible to you.

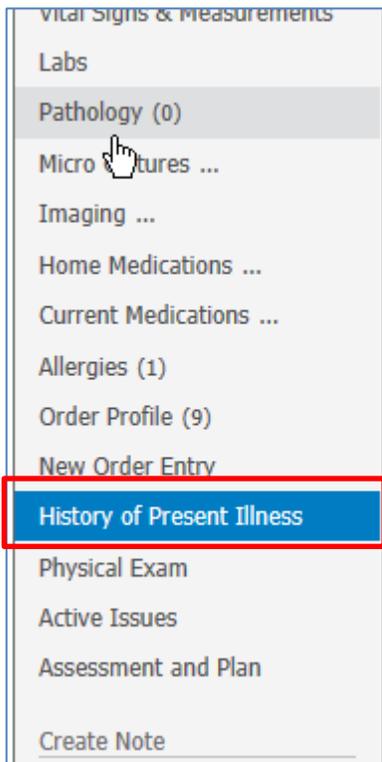
The other type of data entry requires selecting information from lists or catalogues pre-defined in PowerChart. This entry type improves data quality and can be used to generate reports.

When you reach the Active Issues component, you can select the following descriptor:

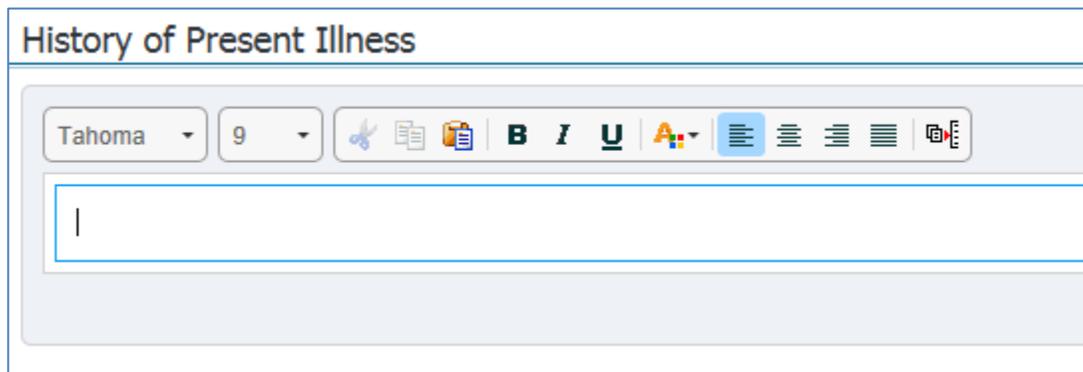
- **This Visit** – the issue is a focus of the current encounter - it is not shared between encounters and not carried over to the next encounter.
- **Chronic** – the issue is ongoing and can be active or resolved. Chronic problems are shared across encounters and carried over to the next encounter. Chronic issues will appear in Medical History on the Active Issue page.
- **This Visit and Chronic** – is both and is carried over to the next encounter. Note the difference when adding Diagnosis versus Problems. Diagnoses are for the current encounter (reason for visit) and problems are chronic issues (i.e. medical, social, or others).

The diagnoses and problems recorded here will carry over from visit to visit, which builds a comprehensive summary of the patient's health record. Keeping a patient's problems and diagnosis up-to-date is important.

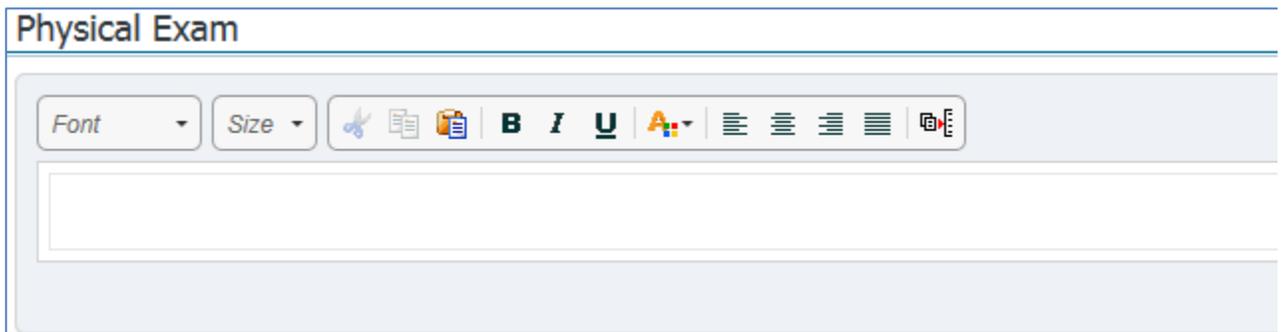
- 1 Click on the **History of Present Illness** component from the component list from the Admission tab.



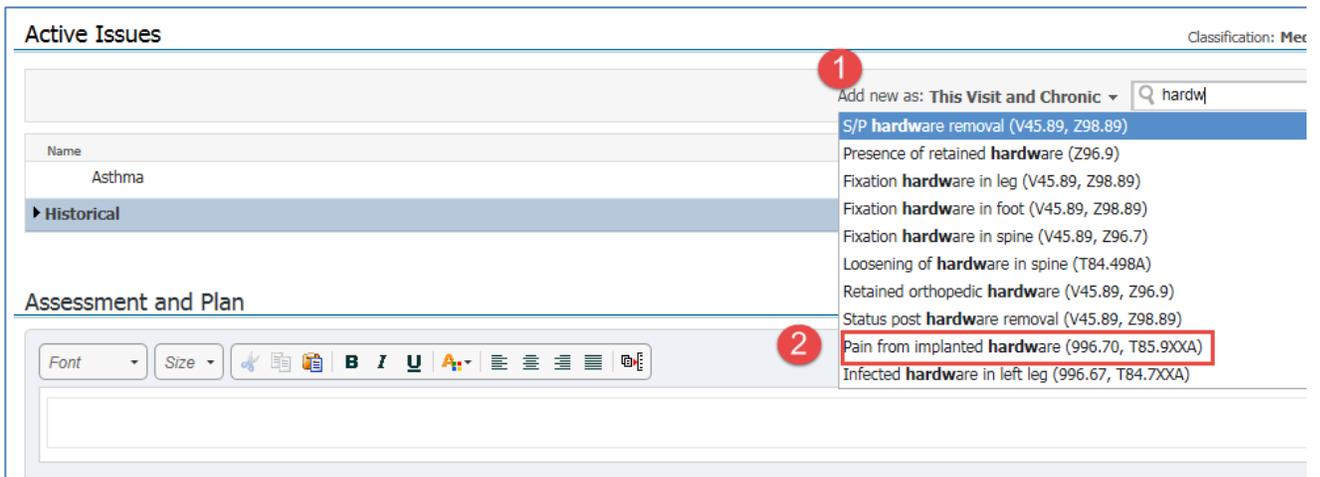
- 2 Click the blank space under **History of Present Illness** to activate the free text box and type some text. For example *Two month history of shin pain.*



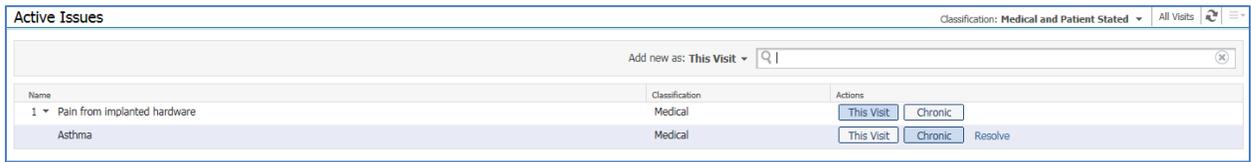
- 3 Continue adding your notes in the **Physical Exam** component. For example *Physical exam non-contributory*.



- 4 Next, select **Active Issues** component. To add Pain from hardware to the list of your patient's issues, select **This Visit and Chronic** and begin typing *hardw*.



5 You can also update problems as displayed in the workflow view:

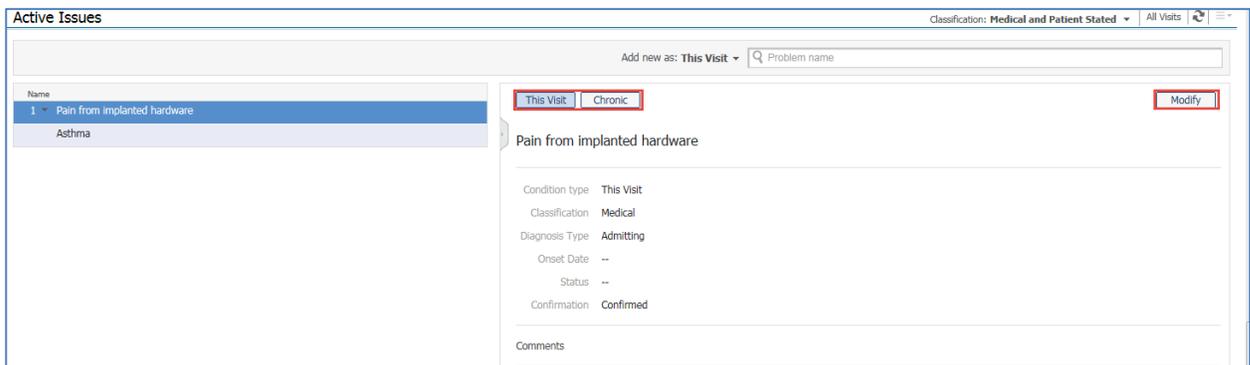


- These visit diagnoses are numbered as primary, secondary, tertiary, etc. You can easily rearrange this order by clicking the digit and selecting a different number.



- You can change any diagnosis from this visit to a chronic problem or both by clicking the appropriate buttons.
- You can also click **Resolve** to move a problem to the Historical section.

6 Click the active issue to display more details. Without leaving this view, you can:



- **Cancel** this problem
- Type **Comments**
- Change the **Status**

7

To modify details, select the line and click **Modify** button. The **Modify Diagnosis** pop-up window appears. Simply familiarize yourself with the screen. This is where you can change the **Type** of this particular diagnosis (i.e. Admitting, Discharge, etc.). Go ahead and click on the **Type** drop-down menu and change to Admitting.

Then click **OK**

Key Learning Points

- Your findings and observations can be added directly to the documentation components within the workflow tabs
- Text entered in the free-text components is not visible to other care team members until you create and sign your document
- Document diagnoses and problems using the Active Issues component

Activity 1.9 – Complete your Documentation

As the last step in assessing your patient, you create your note about the visit.

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

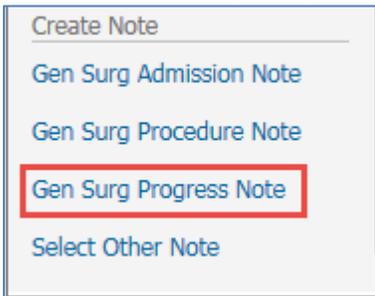
Dynamic Documentation can save you time by allowing you to populate your documentation with items you have reviewed and entered in the Admission workflow tab. This is why it is more efficient to create the note as the last step in the process. You can also add new information by typing or dictating directly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

Workflows such as Admission, Rounding, 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.

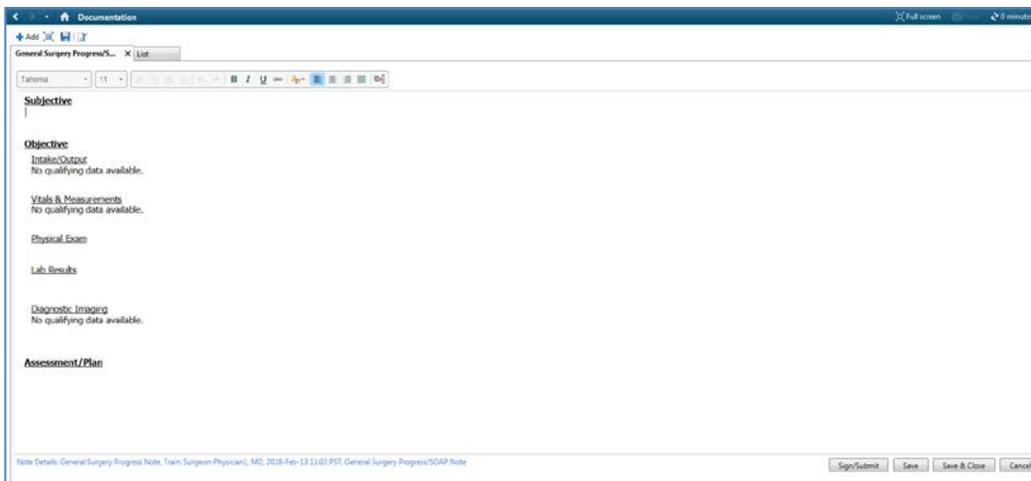
1 Navigate to the **Create Note** section.



2 Click on **Gen Surg Progress Note**

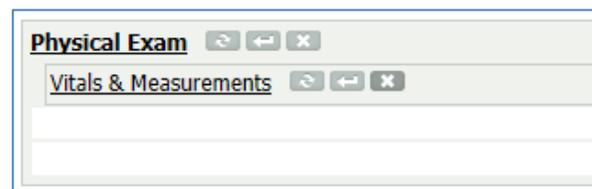


3 The draft note displays in edit mode populated with the information captured by you and other clinicians. Review the different sections of this example note.

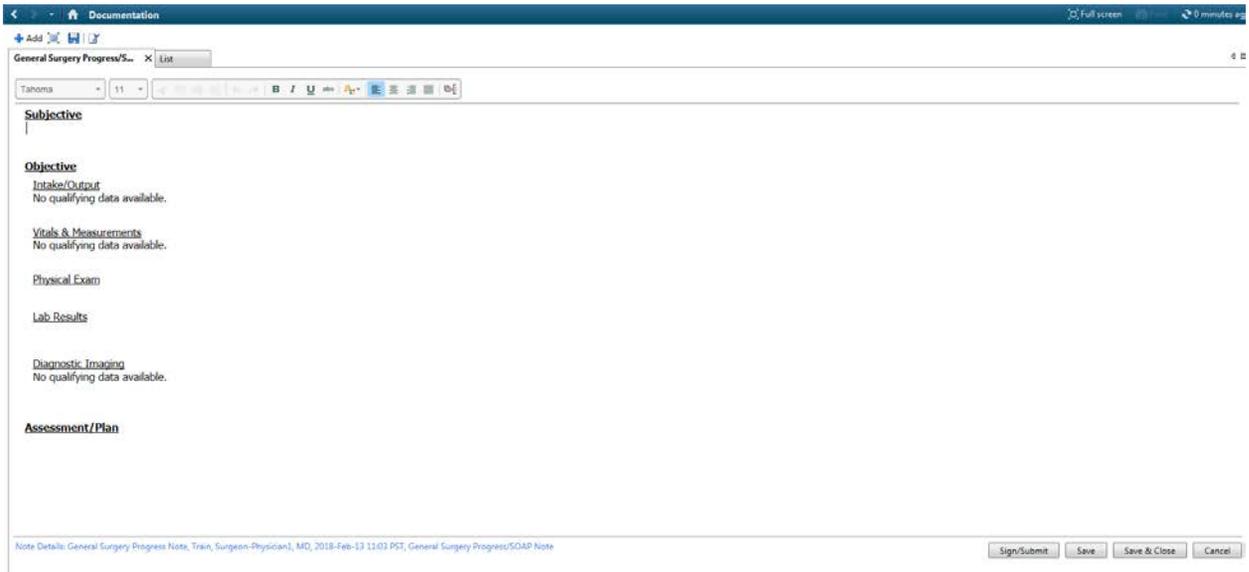


4 Position your cursor over the heading of any section to activate a small toolbar:

-  refreshes the dynamic information in the box
-  activates the box for edits or new entries
-  removes the entire section or content of the box, note that once removed it cannot be added back

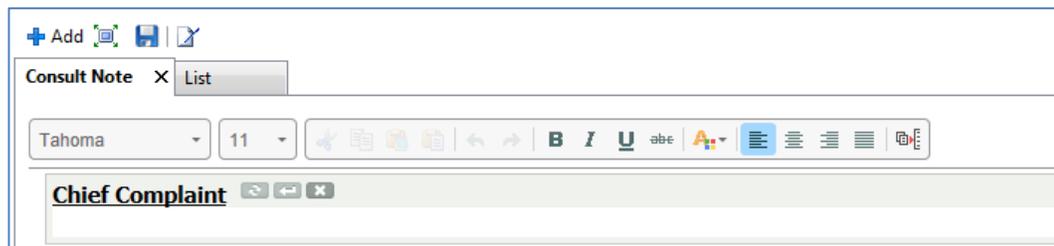


- For editing existing text, click into the box, for example, **History of Present Illness**. It becomes active and you can select the text to add or delete as needed.



Note: PowerChart offers **Auto text** phrases that can be used within Provider documentation to quickly and easily insert note templates, and pull in patient data with smart templates. This will be discussed further in Activity 3.2.

- You can remove sections that are not required or are currently blank. For example, place the cursor over the heading and click  to remove the entire section.



- Review the **Assessment/Plan** section. It is populated with the diagnosis you have entered. Enter new text to practice. Enter "Plan to take the patient to OR for hardware removal."

- 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.

The screenshot shows a software window titled "Sign/Submit Note". At the top, there are two dropdown menus: "Type:" with "General Surgery Progress Note" selected, and "Note Type List Filter:" with "Position" selected. Below these are input fields for "Author:" (containing "Train, Surgeon-Physician1, MD"), "Title:" (containing "General Surgery Progress/SOAP Note"), and "Date:" (containing "2018-Feb-13", "1106", and "PST"). There are also checkboxes for "Forward Options" and "Create provider letter". A search bar labeled "Provider Name" is present with tabs for "Favorites", "Recent", and "Relationships". Below the search bar are two tables: "Contacts" and "Recipients". The "Recipients" table has columns for "Default", "Name", "Comment", "Sign", and "Review/CC". At the bottom right of the window are "Sign" and "Cancel" buttons.

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.

Time of Service	Subject	Note Type	Author	Last Updated	Last Updated by
18/01/18 11:22	ED Note	ED Note Provider	Train, Emergency-Physician1, MD	18/01/18 11:23	Train, Emergency-Physician1, MD
17/01/18 13:40	OB Consult Note	Obstetrics Consult	TestUser, OB/GYN-Physician, MD	03/01/18 13:41	TestUser, OB/GYN-Physician, MD

* Displaying up to the last 50 recent notes for all visits

- 11 If you want to close this patient chart, click the **X** icon on the Banner Bar. You can have a maximum of four charts open at any given time.



Key Learning Points

- Use Dynamic Documentation to prepare notes standardizes documentation practices.
- 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 – Day of Surgery

Learning Objectives

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

- Place Post-Operative orders
- Create an Operative Report

SCENARIO

Your patient has arrived for their surgery. The pre-operative nursing staff has initiated the day of surgery plan that you previously planned.

The surgery is completed and the anesthesiologist is preparing the patient to move to PACU. You now plan your post-operative orders and create your operative report.

You will complete the following activities:

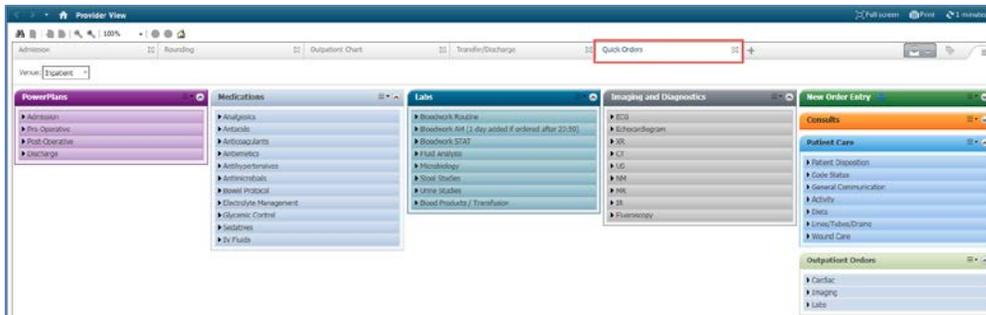
- Placing a PowerPlan in a planned state
- Create an Operative Report

Activity 2.1 – Plan a Post-operative PowerPlan

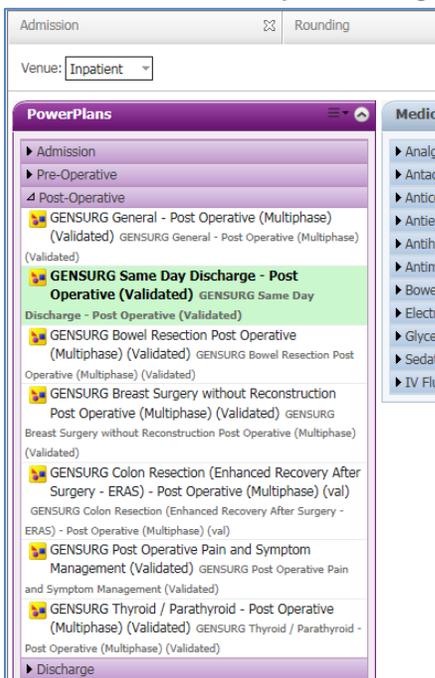
Your patient’s post-operative orders need to plan for nursing staff to have them available to be initiated when appropriate.

The best way to access your PowerPlans is through your Quick Orders page, as we reviewed when placing the Day of Surgery plan earlier.

- 1 In the Provider View page, click on the **Quick Orders** tab.

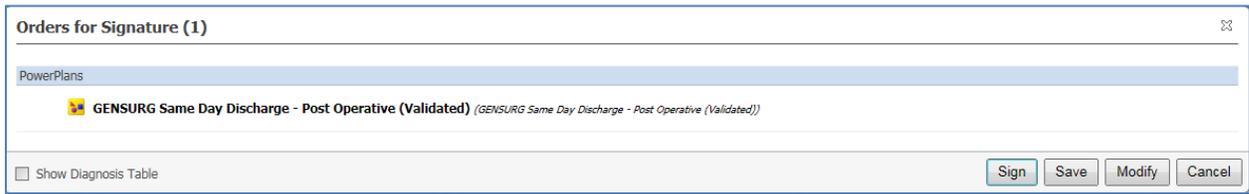


- 2 In the PowerPlans folder, click on the Post-Operative title to expand the folder and click on the **GENSURG Same Day Discharge – Post Operative** plan, marked by the  icon.

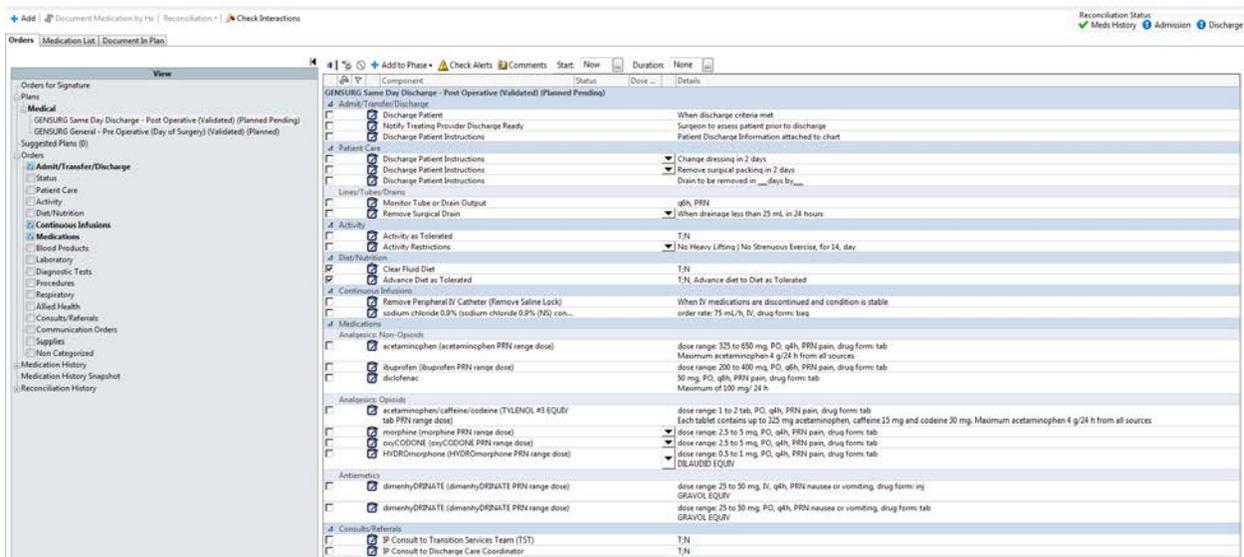


- 3 Click the Orders for the Signature icon  to display the Orders for Signature window.

4 Click the Modify button.



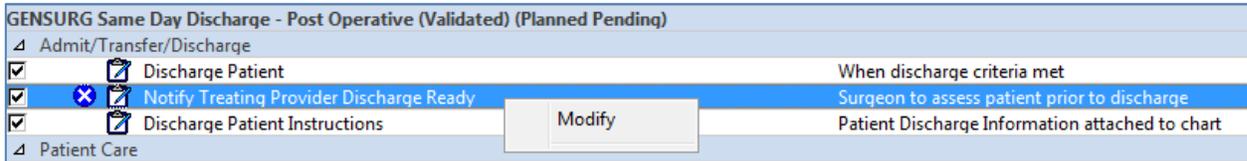
5 Here you can modify the orders in the plan by checking or unchecking orders and modifying the details of the orders by using the drop-down or by right-clicking on the order and selecting **Modify**.



6 Continue to select additional orders for the post-operative plan as listed below:

- Discharge Patient
- Notify Treating Provider Discharge Ready
- Discharge Patient Instructions
- Remove Peripheral IV Catheter
- Acetaminophen
- Oxycodone with dose range 5 to 10 mg

- 7 Note that we never completed the missing details for Notify Treating Provider Discharge Ready, indicated by the  icon.



Right click on the order and click the Modify link that appears.

- 8 Complete the necessary details highlighted with yellow fields and/or **bold** text.



In this case enter *Dressing dry and intact* in the **Discharge Criteria:** field.

Remember to click the  button to expand or collapse the order details view.

- 9 Click the **Sign** button to *plan* the PowerPlan. It will be activated by the PACU staff at the appropriate time.



10



After clicking on Sign this alert pops up. It is known as a discern alert and it is the systems way of notifying you that additional input is needed.

Click on Place discharge order anyway. We will be addressing this issue later in the book.

Then Click **OK**.

Note: Discern Alerts alert the user that the order they are attempting conflicts with an order or policy within the system.

11

Then click **Done**

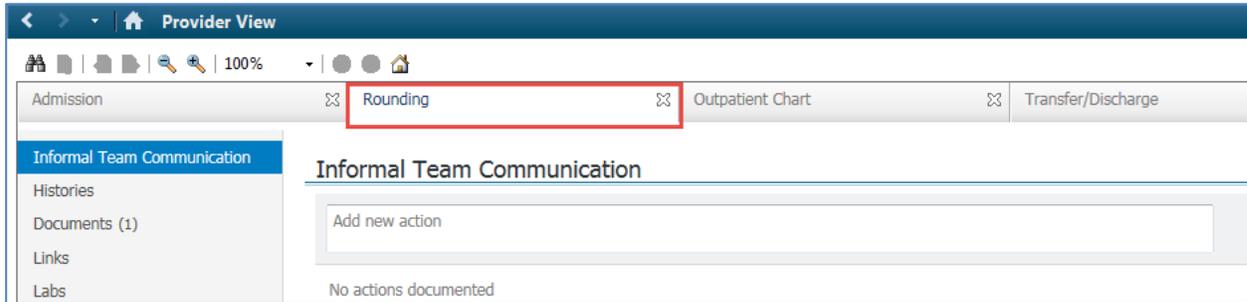
Key Learning Points

- PowerPlans are similar to pre-printed orders
- You can add orders not listed in the PowerPlans by using Add to Phase functionality
- You can select from available order details using drop-down lists or modify order sentences manually where needed
- Initiate means that PowerPlans orders are immediately active and as such, can be actioned right away by the appropriate individuals
- To ensure orders within a PowerPlans are immediately active, click Initiate first and then Sign
- Sign will place orders into a planned state for future activation

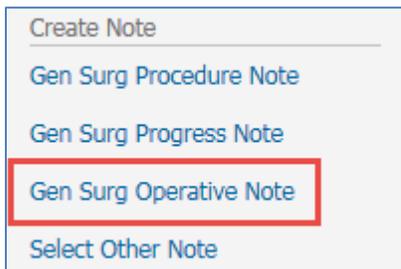
Activity 2.2 – Complete an Operative Note with Autotext

Most tabs in the Provider view allow one-click access to the most relevant note types. You already know how to create an Admission Note, let's quickly create an Operative Note using the same process and add in the use of autotext to avoid entering repetitive information.

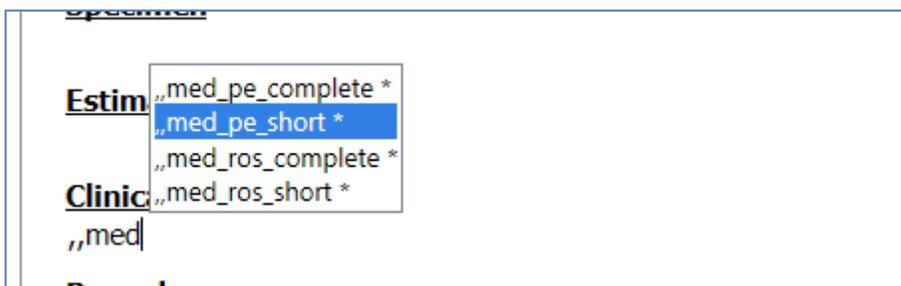
- 1 Navigate to the Rounding.



- 2 From the list under Create Note, select **Operative Report** which will pull existing relevant information from the note.



- 3 To activate a free text box under the **Clinical Preamble** heading, then click on the text box and type **„med**. A list of Auto text entries starting with “comma comma med” will be displayed. Double click on **„med_pe_short***. (It is recognized that this would not be what would be charted, this is done here to teach functionality, not workflow.)



- 4 The programmed Auto text entry populates in the box. You can edit this text if necessary.

Clinical Preamble

General: Alert and oriented x 3, no acute distress.

Cardiac: Normal S1 & S2, no gallops, no murmurs, no rubs, normal JVP, no pedal edema.

Respiratory: Good air entry bilaterally, no adventitious sounds.

Abdomen: No bowel sounds, distended, soft, tender, no hepatosplenomegaly.

The built in Auto text entries are shared across the organization helping to adhere to agreed standards. You can also create your own Auto text entries. You will learn how to create Auto text entries in a personalized learning session at a future date.

Complete any other relevant documentation in the appropriate sections.

- 5 Click **Sign/Submit** and then **Sign** to complete your note.

 **Key Learning Points**

- Use Auto text entries for commonly entered information
- Auto text entries shared between all providers help to maintain standards when documenting patient's care

PATIENT SCENARIO 3 – 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.
- Complete discharge documentation.

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 3.1 – Review Orders

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

Type	Order	Start	Status	Status Updated	Ordering Provider
Admit/Transfer/Discharge (1)	Admit to Inpatient 2018-Feb-13 10:36 PST, Admit to Orthopedic Surgery, Admitting provider: Train, Surgeon-Physician1, MD	13/02/18 10:36	Ordered	13/02/18 10:36	Train, Surgeon
Continuous Infusions (1)	sodium chloride 0.9% (NS) continuous infusion 1,000 mL 100 mL/h, IV	29/01/18 14:42	Ordered	13/02/18 01:01	eLearn, MDSU
Medications (2)	acetaminophen 650 mg, PO, q4h	12/02/18 22:00	Ordered	13/02/18 01:01	eLearn, MDSU
	morphine 2 mg, IV, q1h	12/02/18 22:00	Ordered	13/02/18 01:01	eLearn, MDSU

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:



Type	Order	Start	Status	Status Updated	Ordering Provider
Admit/Transfer/Discharge (2)	Admit to Inpatient 2018-Jan-03 13:21 PST, Admit to Obstetrics, Admitting provider: Testbar, OB/GYN-Physician, MD	03/01/18 13:23	Ordered	17/01/18 01:01	Testbar, OB/GYN-Physician, MD
	Discharge Patient 2018-Jan-18 13:36 PST, When discharge criteria met	18/01/18 13:06	Ordered	18/01/18 13:07	Train, OB/GYN-Physician1, MD
Patient Care (4)	Discharge Patient Instructions Patient meets discharge criteria when medically stable, pain managed with oral analgesics, voiding independently, bowels functioning tolerating regular diet, and independent with ADLs	18/01/18 13:06	Ordered	18/01/18 13:07	Train, OB/GYN-Physician1, MD
	Patient Educator 2018-Jan-18 13:36 PST, Give patient instruction sheet if applicable	18/01/18 13:06	Ordered	18/01/18 13:07	Train, OB/GYN-Physician1, MD
	Remove Peripheral IV Catheter 2018-Jan-18 13:06 PST, When tolerating oral fluids well	18/01/18 13:06	Ordered	18/01/18 13:07	Train, OB/GYN-Physician1, MD
	Vital Signs 2018-Jan-18 13:06 PST, Stop: 2018-Jan-18 13:06 PST, cih for 2 hour then q4h	18/01/18 13:06	Ordered	18/01/18 13:07	Train, OB/GYN-Physician1, MD
Activity (1)	Activity as Tolerated 2018-Jan-18 13:06 PST	18/01/18 13:06	Ordered	18/01/18 13:07	Train, OB/GYN-Physician1, MD
Diet/Nutrition (2)	Advance Diet as Tolerated 2018-Jan-18 13:06 PST, Advance diet to regular diet, Provider must order starting diet, RR or RD to place subsequent diet order.	18/01/18 13:06	Ordered	18/01/18 13:07	Train, OB/GYN-Physician1, MD
	Clear Fluid Diet 2018-Jan-18 13:06 PST	18/01/18 13:06	Ordered	18/01/18 13:07	Train, OB/GYN-Physician1, MD
Medications (4)	acetaminophen (TYLENOL) 675 mg, PO, QID, PRN: pain-mild or less	03/01/18 13:23	Ordered	18/01/18 01:00	Testbar, OB/GYN-Physician, MD
	dieneh/ORNATE (dieneh/ORNATE PRN range dose) 50 mg, IV, q4h, PRN:	18/01/18 13:06	Ordered	18/01/18 13:07	Train, OB/GYN-Physician1, MD

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 3.2 – 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**

Medication Reconciliation		
		Selected visit 
Status: ✔ Meds History ⓘ Admission Transfer ⓘ Discharge		
Order	Order Start	Status
⚡ Scheduled (2) Next 12 hours		
acetaminophen 650 mg, PO, q4h	Yesterday 22:00	Ordered
morphine 2 mg, IV, q1h	Yesterday 22:00	Ordered
⚡ Continuous (1)		
sodium chloride 0.9% (NS) continuous infusion 1,000 mL 100 mL/h, IV	January 29, 2018 14:42	Ordered
⚡ PRN/Unscheduled Available (0)		
⚡ Suspended (0)		
▶ Discontinued (0) Last 24 hours		

2 The reconciliation window displays the current status of medications.

Orders Prior to Reconciliation		Status	Orders After Reconciliation			Status
Home Medications						
lisinopril (lisinopril 10 mg oral tablet)	1 tab, PO, qdaily, 30 tab, 0 Refill(s)	Documented	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
multivitamin, prenatal (Prenatal Multivitamins with Folic Acid 1 mg oral tablet)	1 tab, PO, qdaily, 30 tab, 0 Refill(s)	Documented	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
salbutamol (salbutamol 100 mcg/puff inhaler)	1 puff, inhalation, once, PRN: as needed, 1 inh, 0 Refill(s)	Documented	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Medications						
acetaminophen (TYLENOL)	325 mg, PO, QID, PRN: pain-mild or fever	Ordered	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
dimenhydrinate (dimenhydrinate PRN range dose)	50 mg, IV, q6h, PRN: nausea or vomiting	Ordered	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
metoclopramide (metoclopramide PRN range dose)	10 mg, IV, q6h, PRN: nausea or vomiting	Ordered	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
ondansetron	4 mg, IV, q8h, PRN: nausea or vomiting	Ordered	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

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

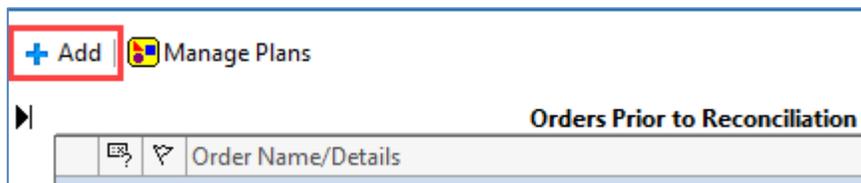


3 Continue the patient's home medications. As indicated by the  icon.

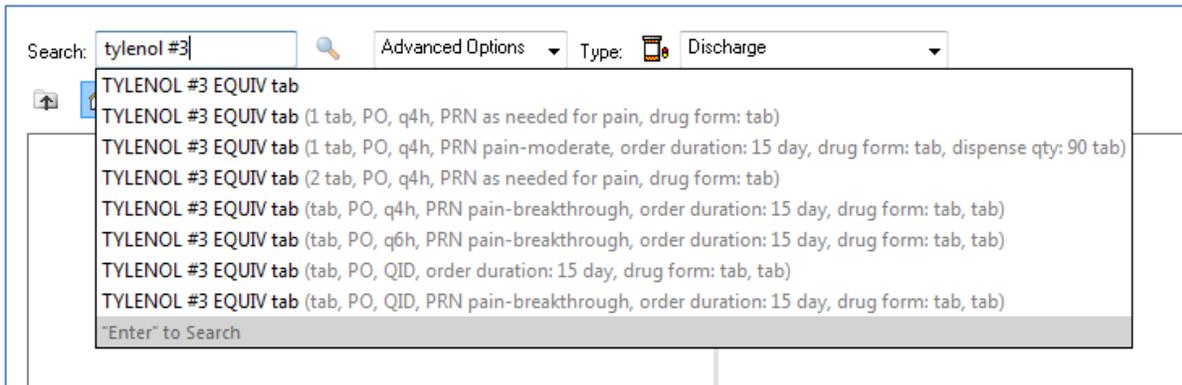
Orders Prior to Reconciliation		Status			
Home Medications					
	lisinopril (lisinopril 10 mg oral tablet)	Documented	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	multivitamin, prenatal (Prenatal Multivitamins with Folic Acid 1 mg oral tablet)	Documented	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	salbutamol (salbutamol 100 mcg/puff inhaler)	Documented	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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.

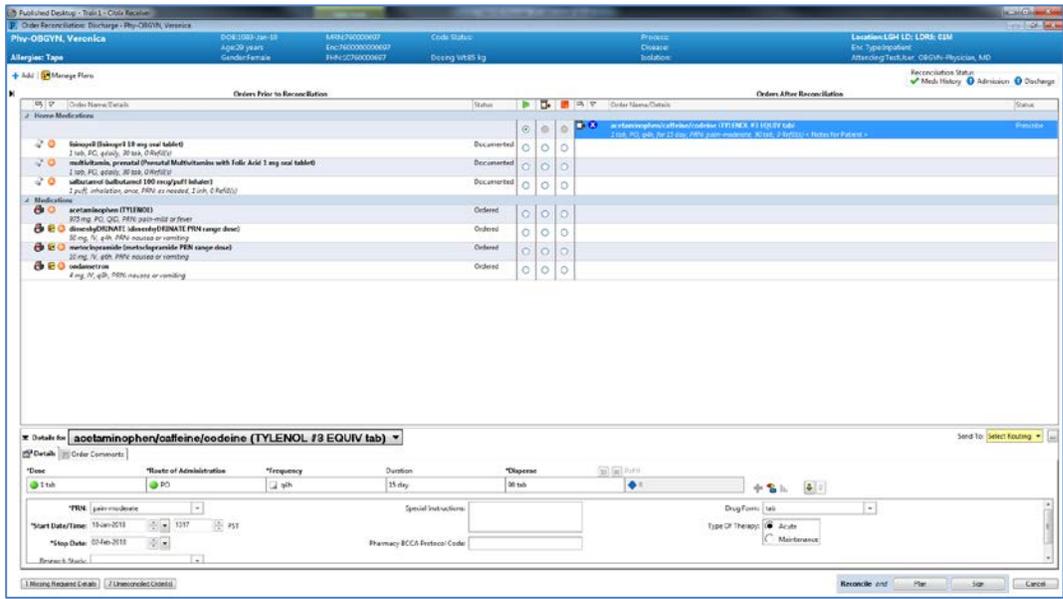


Select the appropriate sentence:

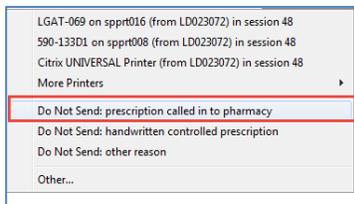
TYLENOL #3 EQUIV tab (1 tab, PO, q4h, PRN pain-moderate, order duration: 15 day, drug form: tab, dispense qty: 90 tab)

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 Coastal Health
Promoting wellness. Easing care.

Ulexis 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. Home Phone: _____
vancouver, British Columbia Work Phone: _____

Canada

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.

Page: 1 of 1

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

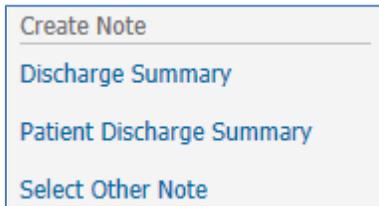
- Medication Reconciliation on discharge includes both home and hospital medications
- Both home and inpatient medications can be converted into prescriptions during the discharge reconciliation process
- Discontinued medications become historically documented on the chart
- Continued medications and 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

Activity 3.3 – Complete Discharge Diagnosis and Discharge Documentation

Using Dynamic Documentation, you will create the Discharge Summary. The discharge summary will be automatically sent to the patient’s lifetime providers such as their GP. You can also select other providers who should receive a copy. You can also prepare the Patient Discharge Summary to be printed for the patient by the nurse once completed and handed to the patient.

1

Click the **Discharge Summary** under the **Create Note** component under the Discharge



2

As before this is a dynamic documentation, it will pull relevant data from the patients encounter and auto populate the document. It can be modified in the same manner as the OR Note.

Click **Sign & Submit** and then **Sign**.

Key Learning Points

- You can fully manage discharge diagnosis right in the Transfer/Discharge tab.
- A Discharge Summary will be distributed to the providers who have documented lifetime relationships on the patient’s record and to any other providers selected by you
- Patient Discharge Summary is printed for the patient at discharge by nursing

End of Workbook

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