SELF-GUIDED PRACTICE WORKBOOK [N91]
CST Transformational Learning

WORKBOOK TITLE:

Provider: Surgeon (Outpatient)

TABLE OF CONTENTS

SELF-GUIDED PRACTICE WORKBOOK

Duration	**3 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 – 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

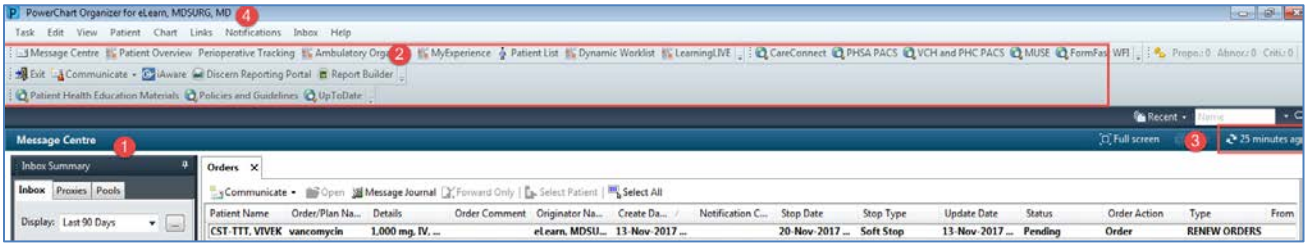
Activity 1.1 – Accessing the Patient's Chart

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:

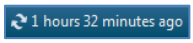
PowerChart

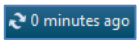


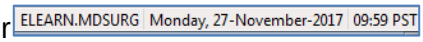
1 Message Centre - As a Provider, your default page upon logging in will be the Message Centre. PowerChart allows you to receive patient information electronically. It serves as a platform for sharing patient related information and responsibilities with other providers and clinicians. Message Centre 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!

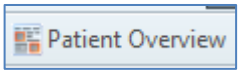
NOT Refreshed 

VS Refreshed 

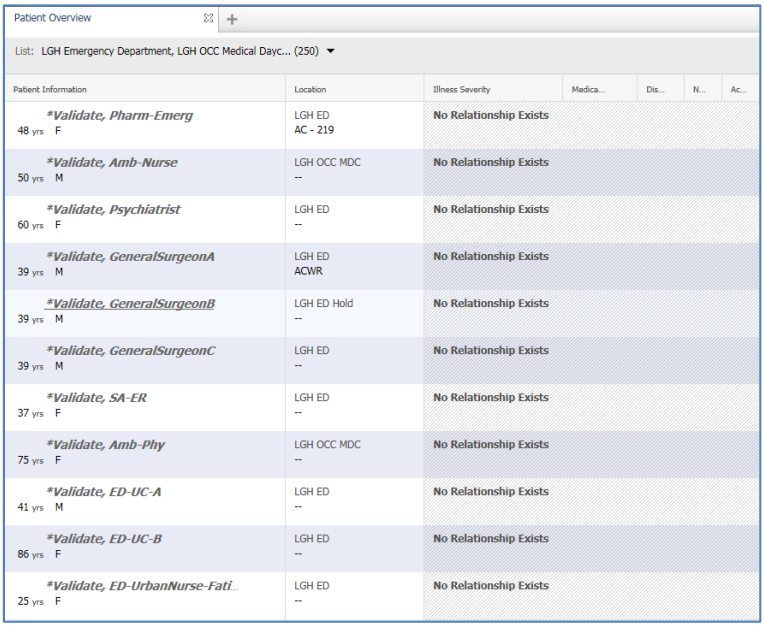
4 Login Information – You will always be able to tell who is logged into POWERCHART by either referring to the top left corner or the bottom right corner 

, always ensure you are documenting under your own login.

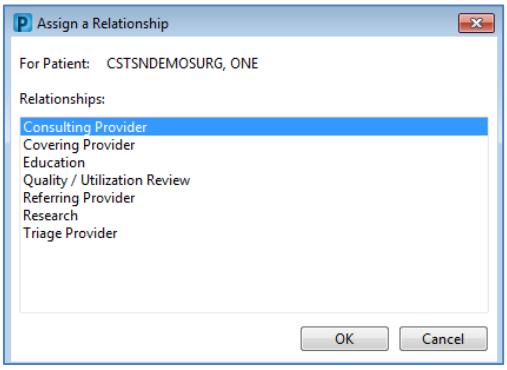
1 To access your patient select Patient Overview to view your patients and open the patient's chart:

Select  from the Toolbar

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



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

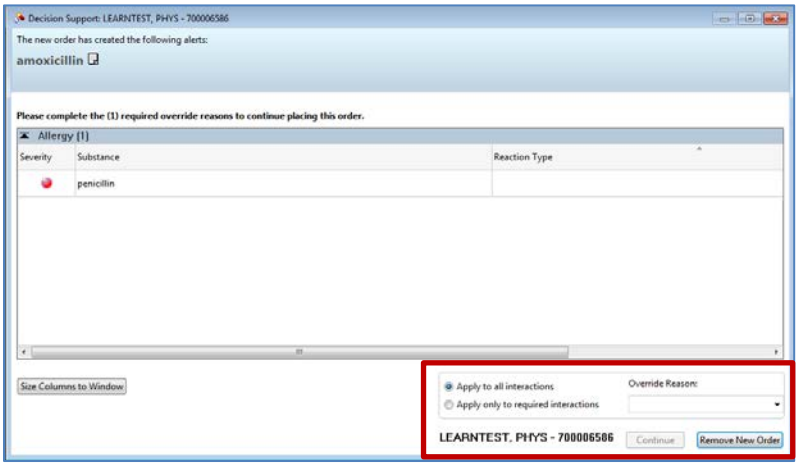
- “Relationships” are assigned when first accessing the patient’s chart or every 16 hours.

Activity 1.4– Allergies

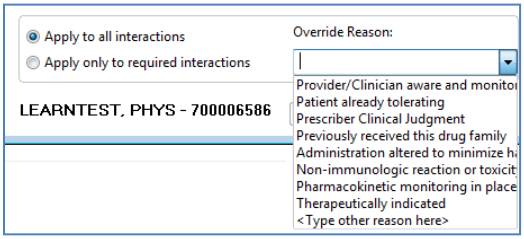
You review the patient's allergies and add an allergy to Penicillin. This information was provided by the patient but has not yet been entered into the patient's chart.

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:

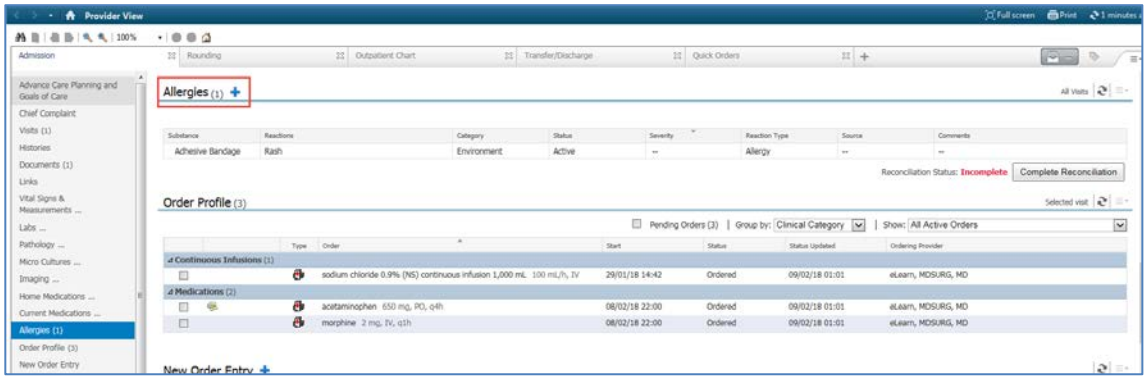


PowerChart allows you to check drug-to-drug interactions when ordering medications on the medication order page by clicking the **Check Interactions** button.

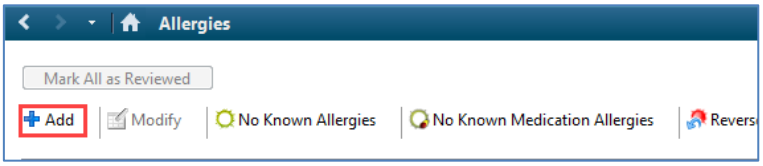
1 Click on the icon by the Menu to close the menu. Providers are not encouraged to use the menu at this time and the current training will not cover that functionality.

2 Select the Admission tab

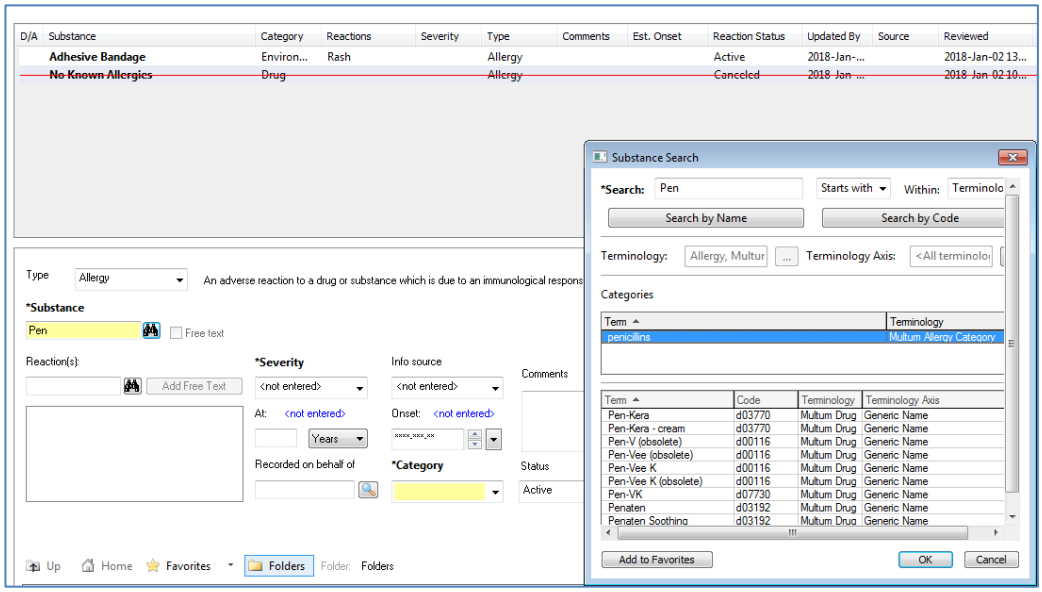
Then click the **Allergy** link to open the window where you will enter or update allergy information.



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

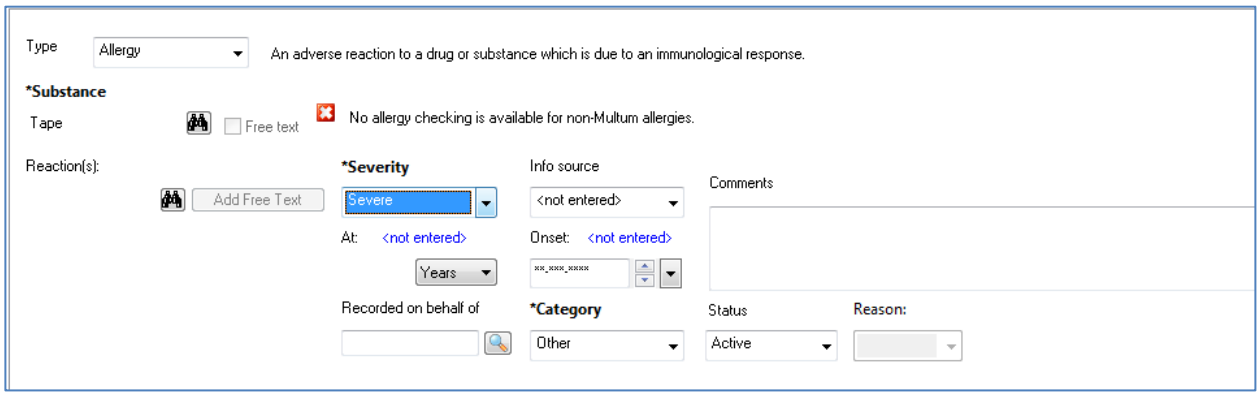


3 Search for Pen in the **Substance** box. Click on to execute the search and then select penicillins from the list. Click **OK** to return to the Add Allergy/Adverse Effect window.

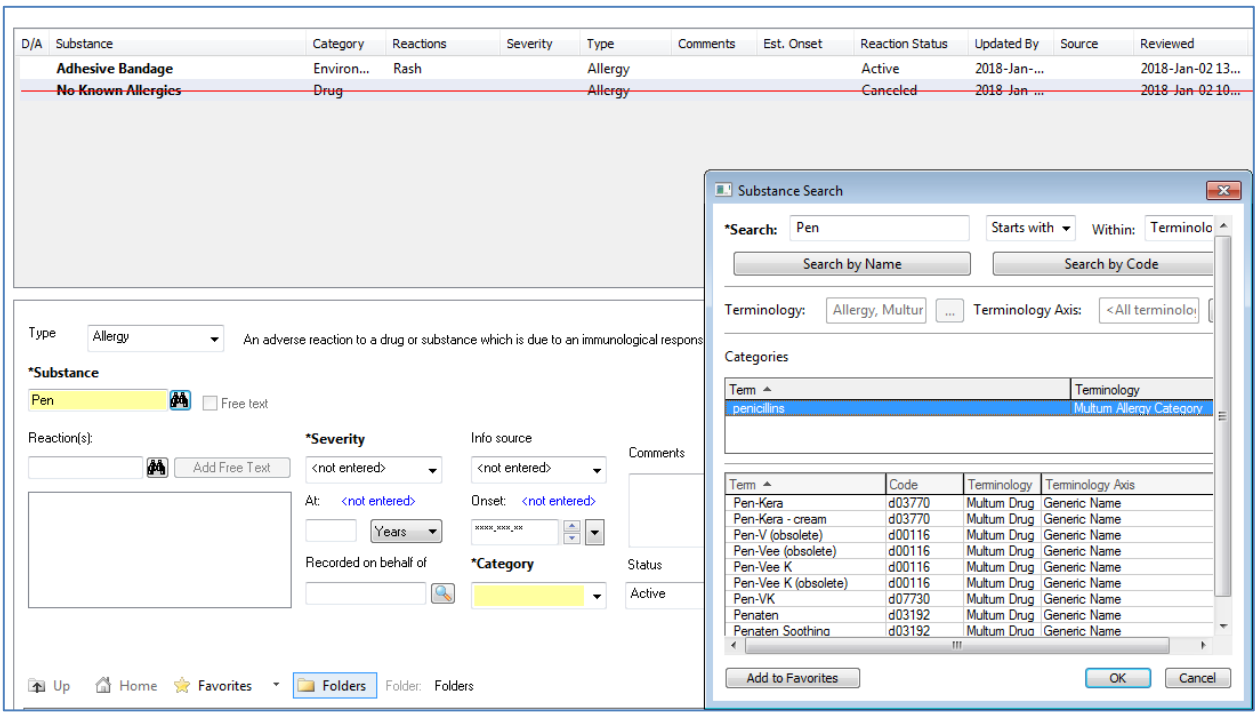


4 Add appropriate options in the other two mandatory fields:

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



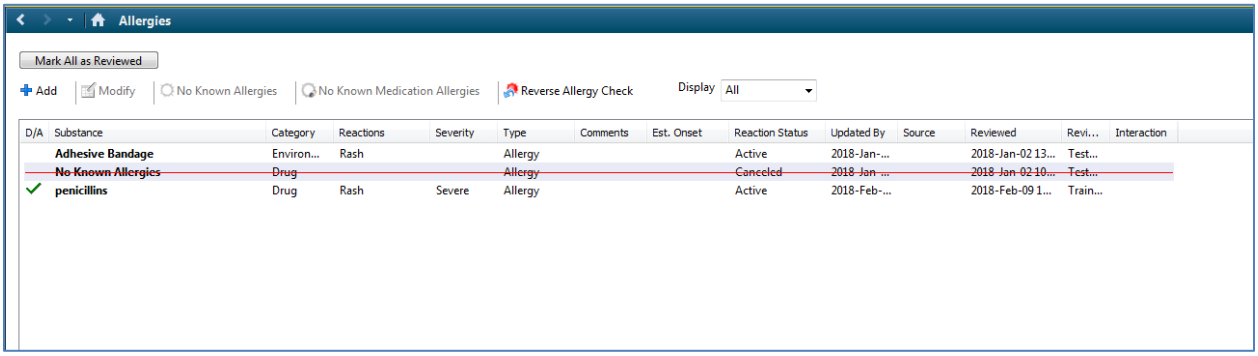
5 Type rash and click on the icon to search. Select the reaction that fits the patient, in this case just rash, and click **OK.**



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.

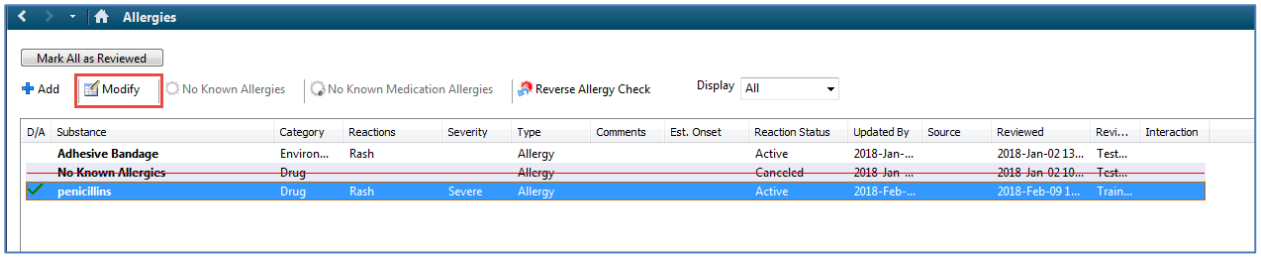
7 Patient's allergy record is updated. The green checkmark next to Penicillin indicates drug allergies. Click **Mark All as Reviewed** to complete the review.



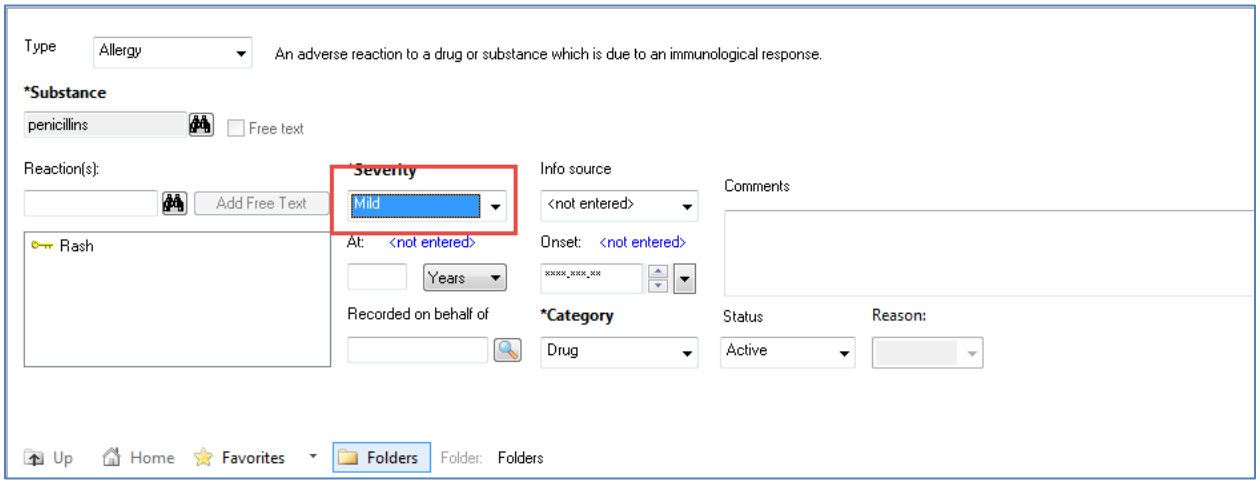
Note: In order for the pharmacy to dispense, they must see that the allergy record has been reviewed by a provider. When there is no information available, you can use the other toolbar options:

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

8 To modify the existing allergy select the appropriate line, in this case penicillins 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).

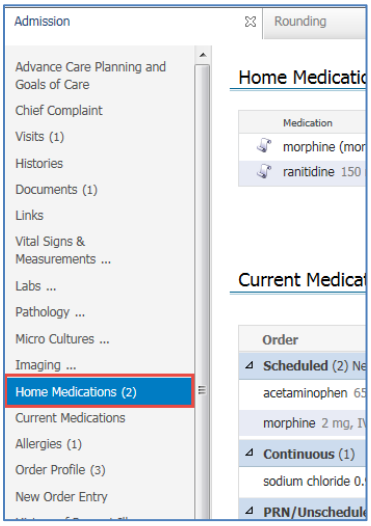
Within your workflow tabs, there are a few tools to help with this:

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

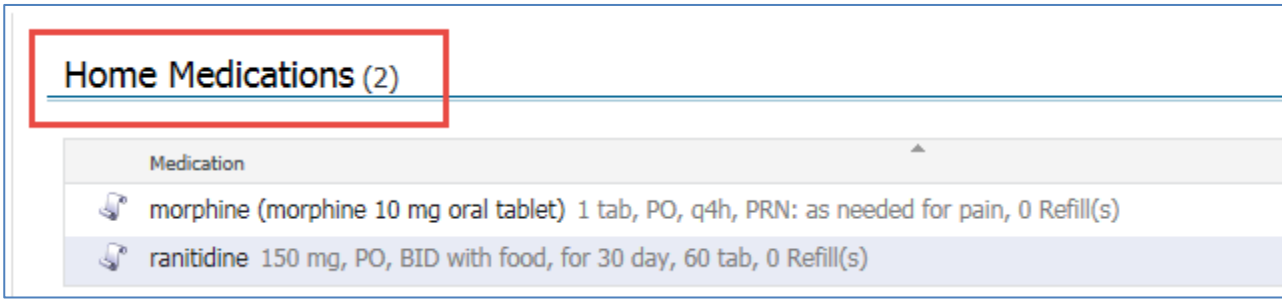
The BPMH must be completed before proceeding with admission medication reconciliation. The best possible medication history is generally documented by a pharmacy technician or nursing staff. When a pharmacy technician is not available, it can be completed by a nurse, medical student, resident, or by 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.

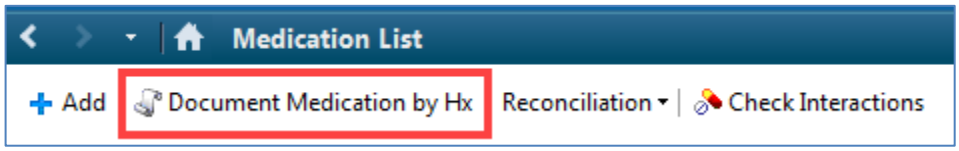
1 Select the **Home Medications** component from the list to view what has been documented.



2 Click **Home Medications** heading.



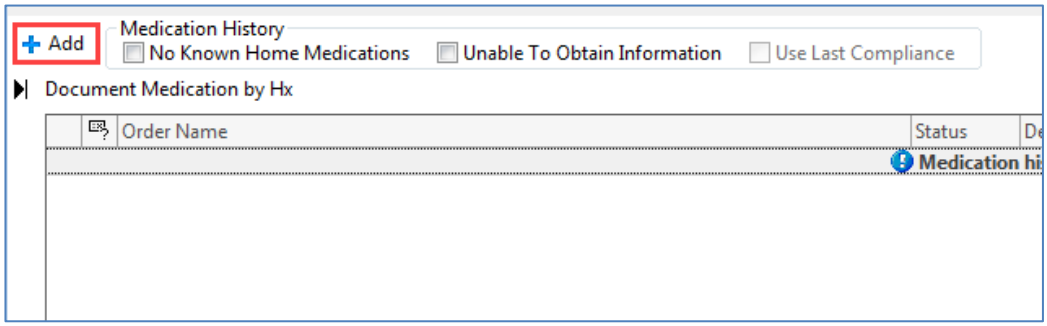
3 In the **Medication List** window, click **Document Medication by Hx**.



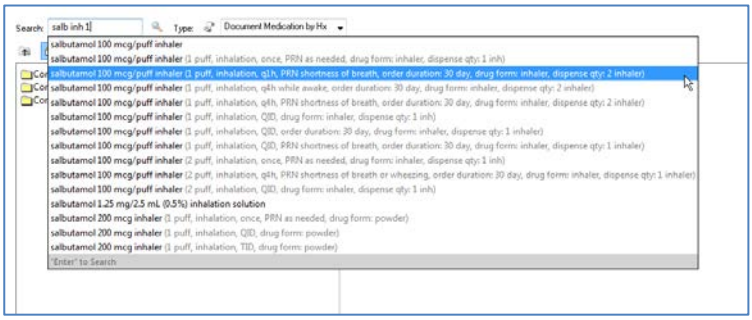
Note: Clicking the Add will add an order, not add history.

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

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.

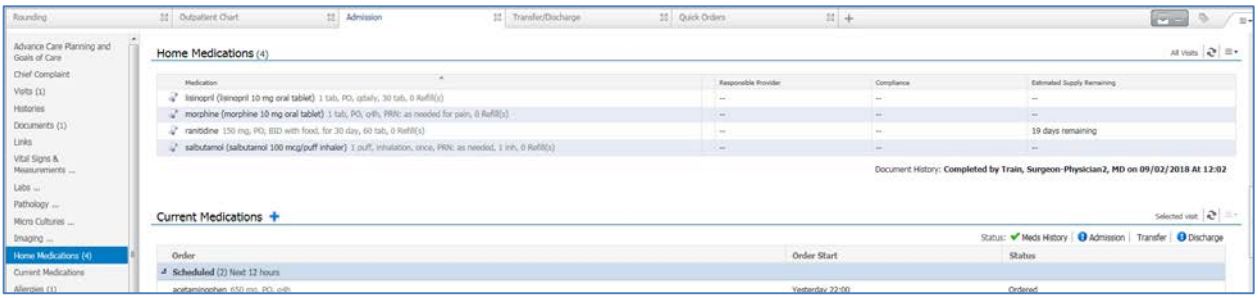
button will refresh the entire page

Will Refresh just the section.

For this practice click on the 

<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.

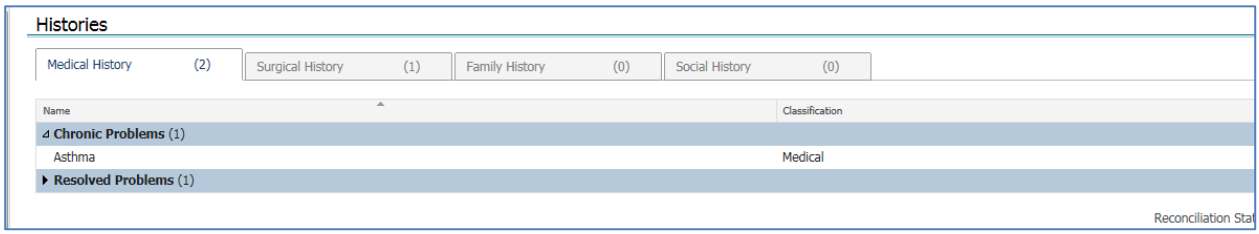
Activity 1.5 – Review History

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.

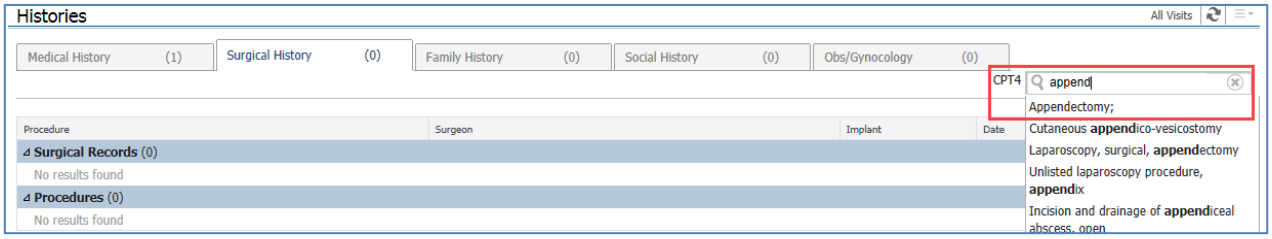
1 Clicking on Medical history brings you to the Medical History page. Clicking on the other tabs brings you to the relevant pages and you can switch between the other tabs within the page.

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

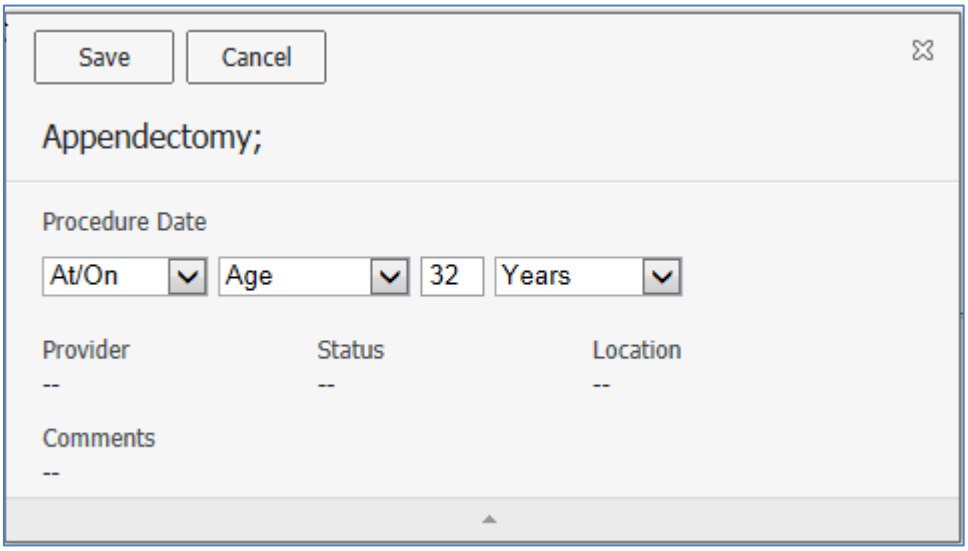


There is a separate tab for each history type. The number in brackets indicates how many entries are in each tab.

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.

Key Learning Points

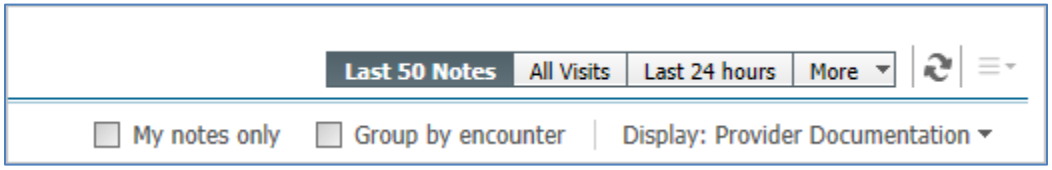
- Histories information including surgical procedures can be added when taking a patient's history

Activity 1.6 – Review Documents, Labs and Diagnostics

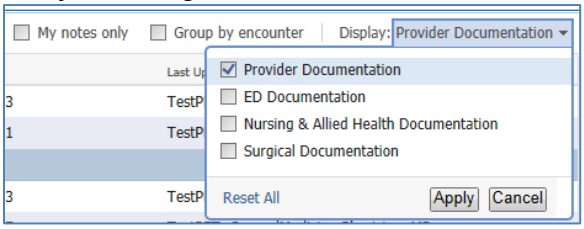
Continue reviewing the patient's chart by following the Rounding tab list of components. When using PowerChart, you might be faced with a large amount of information.

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**



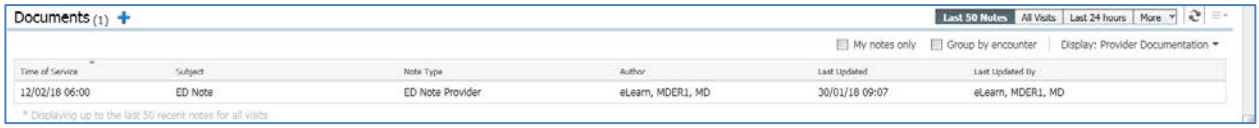
You can also display note types by selecting **Provider Documentation**.

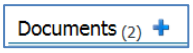


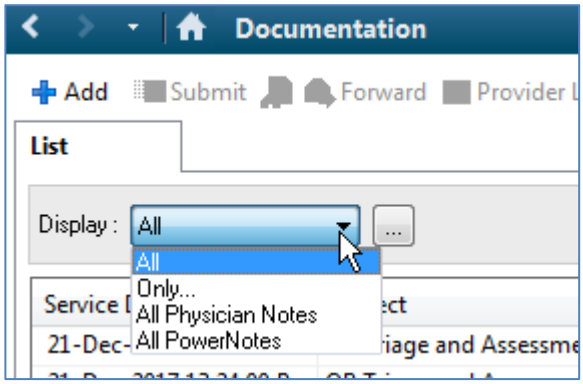
You can also select a custom time range by expanding options under **More**.

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

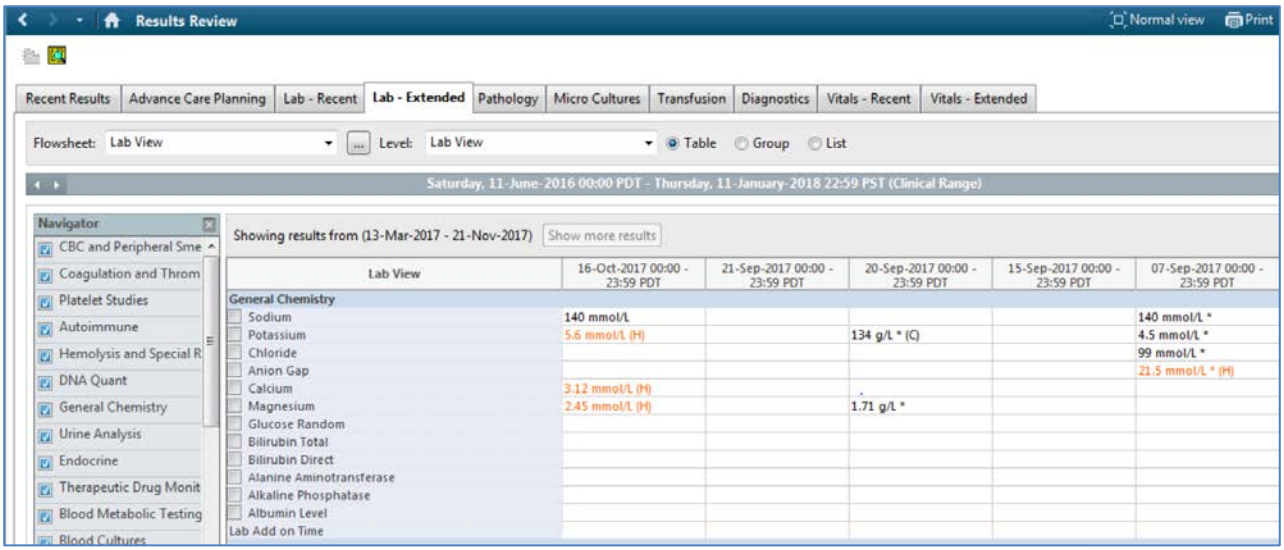


2 Use the navigation buttons  to return to the Provider View.

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:



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.

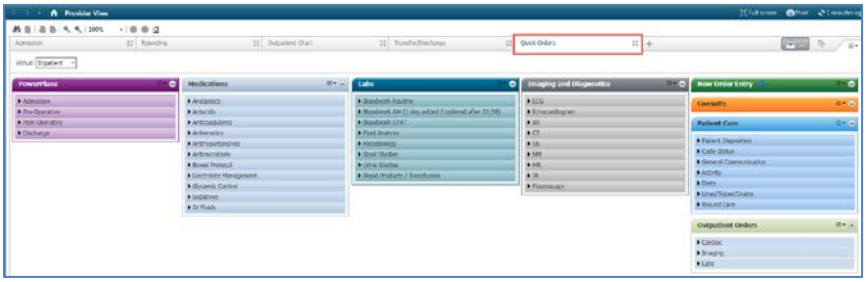
PowerPlans are similar to pre-printed orders (PPOs), allowing you to plan and coordinate care in the acute care environment by defining sets of orders that are often used together. You can adapt PowerPlans to fit your needs:

- 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

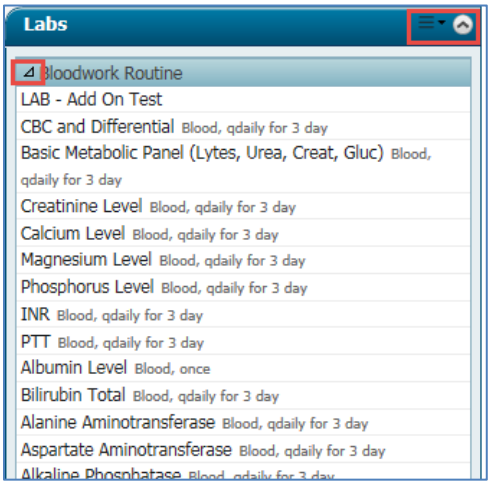
Initiated PowerPlan becomes active immediately and its orders create respective tasks and actions for other care team members.

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.

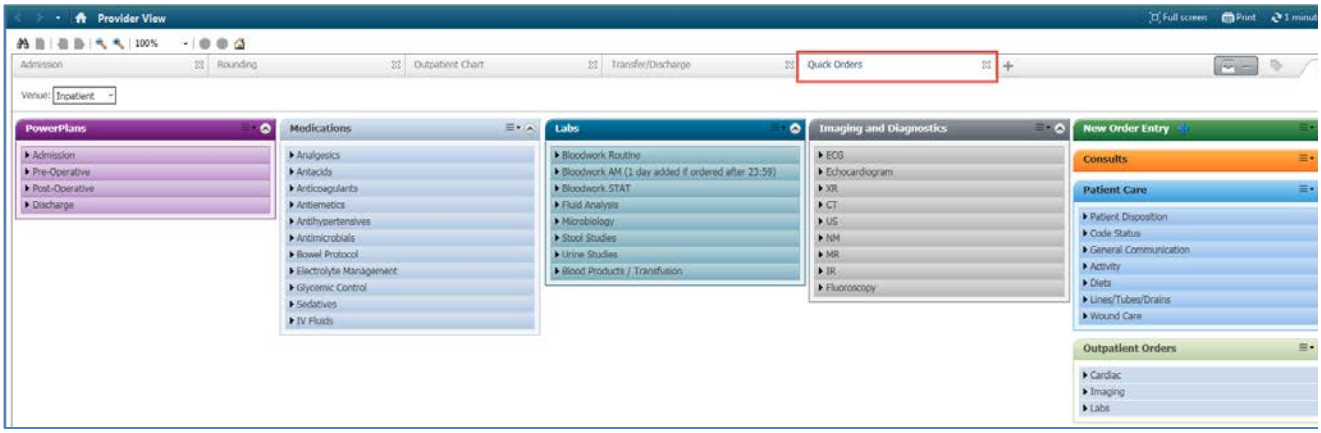


Under each category, there are folders. For example, under the medication category is the analgesics folder which contains individual orders for analgesic medications such as acetaminophen. Orders may allow you to add additional details regarding dose, frequency, route, etc., or may have these details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

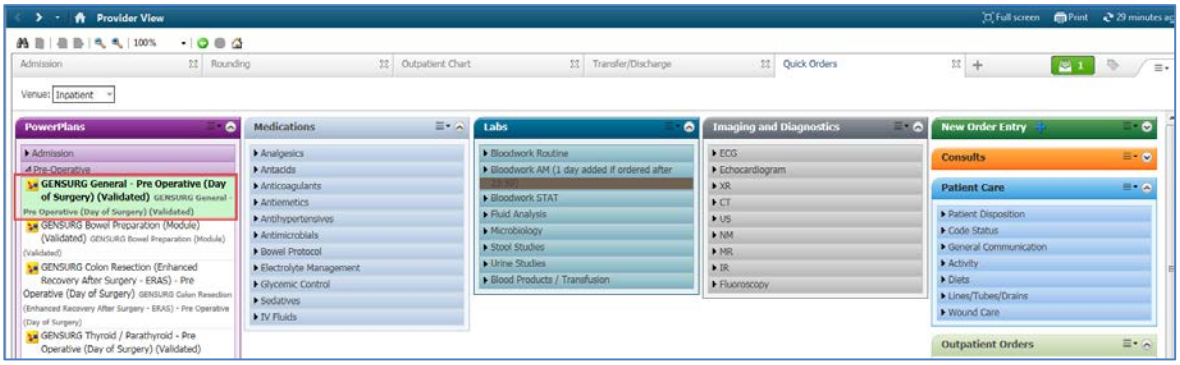


Each specialty has their own quick orders page and they may differ in which orders are available and how those orders are organized.

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

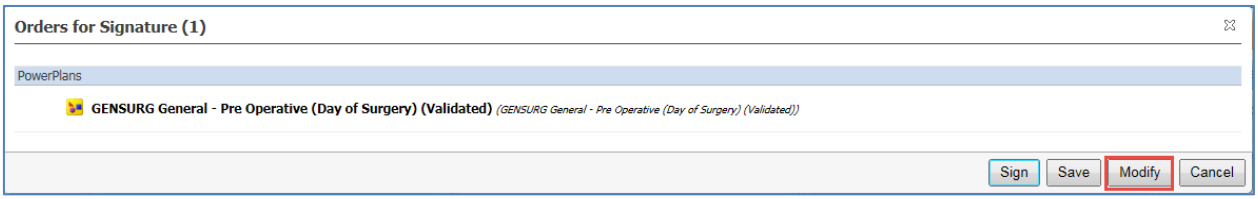


2 In the PowerPlans folder, click on Pre-Operative to expand the folder and click on the **GENSURG Operative (Day of Surgery)** plan, marked by the icon. Note the **Orders for Signature** 1 button has turned green and number 1 is displayed.

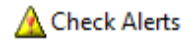


3 Click the Orders for Signature icon 1 to display the Orders for Signature window.

4 Click the Modify button.



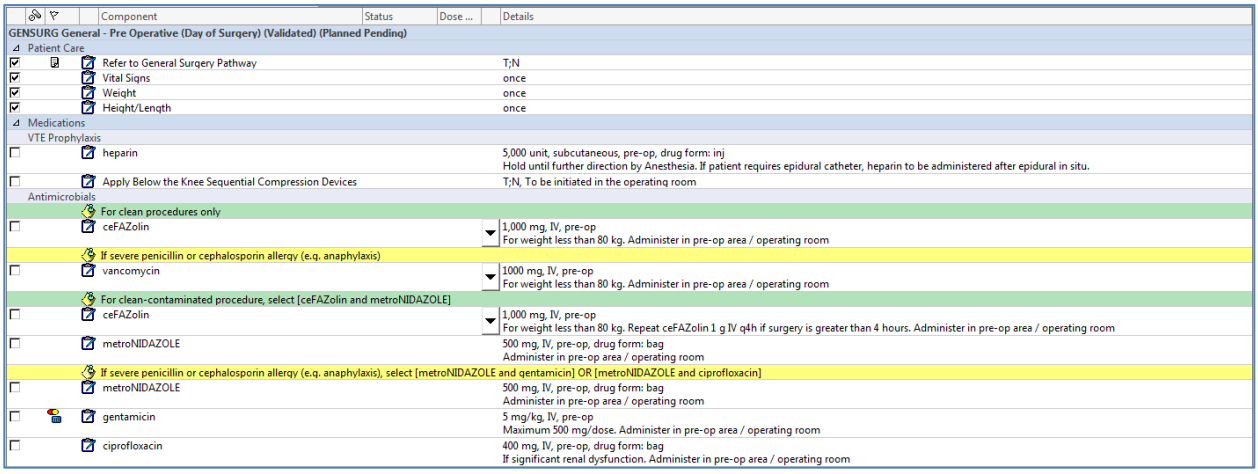
5 The PowerPlan window displays. Hover over the icons along the top toolbar:

	**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 –** 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

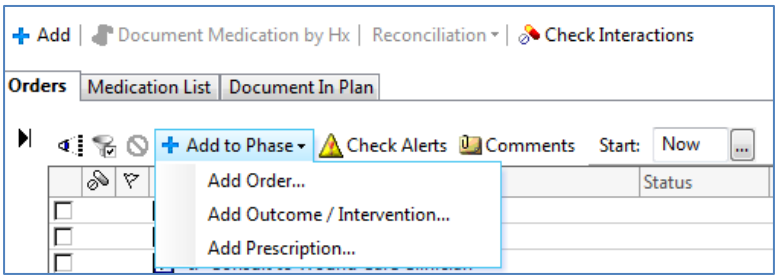
6 Here you can modify the orders in the plan by checking or unchecking orders and modifying the details of the orders by using the drop-down or by right-clicking on the order and selecting **Modify.**



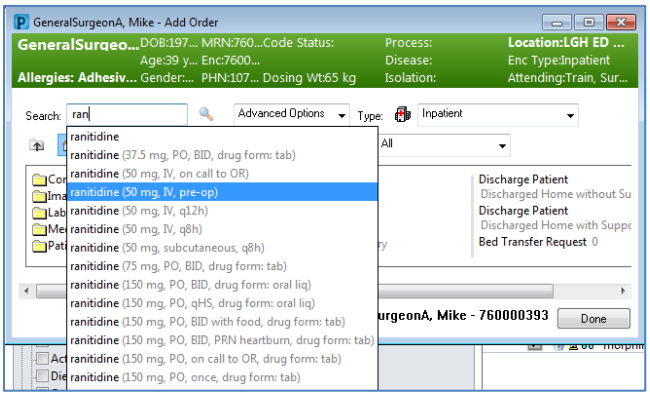
7 Continue to select additional orders for the day of surgery plan as listed below:

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

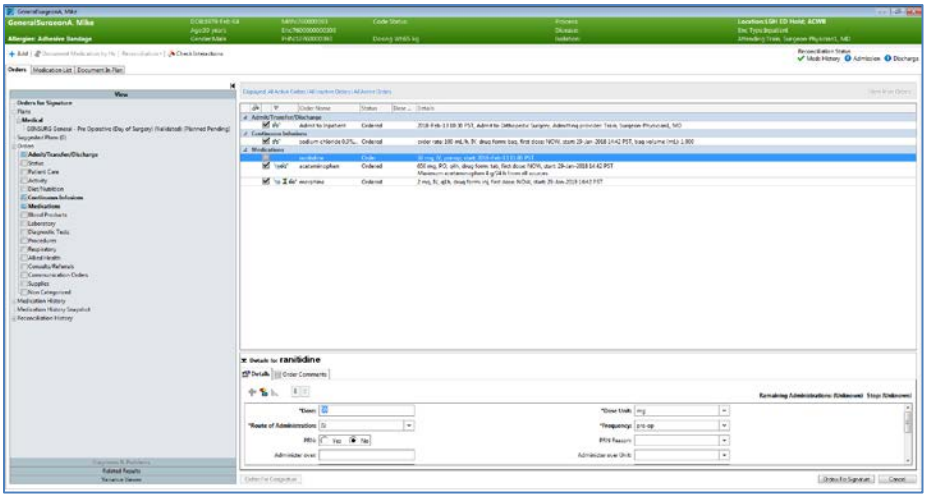
8 You want to add orders that are not part of the PowerPlan. Click the **+ Add to Phase** button and select **Add Order…**



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

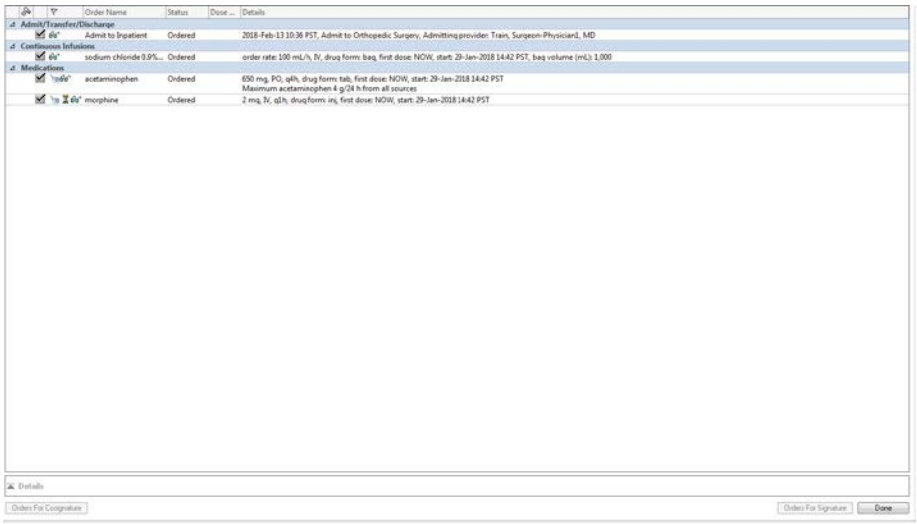


10 You are then returned to the plan with the new order displayed along with the details.



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

12



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.

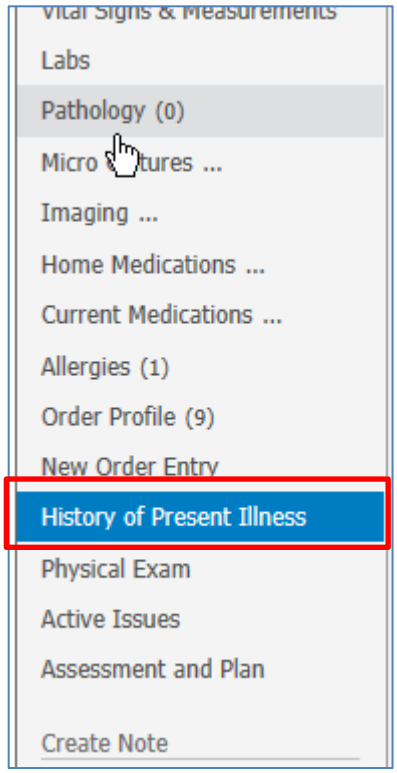
The other type of data entry requires selecting information from lists or catalogues pre-defined in PowerChart. This entry type improves data quality and can be used to generate reports.

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

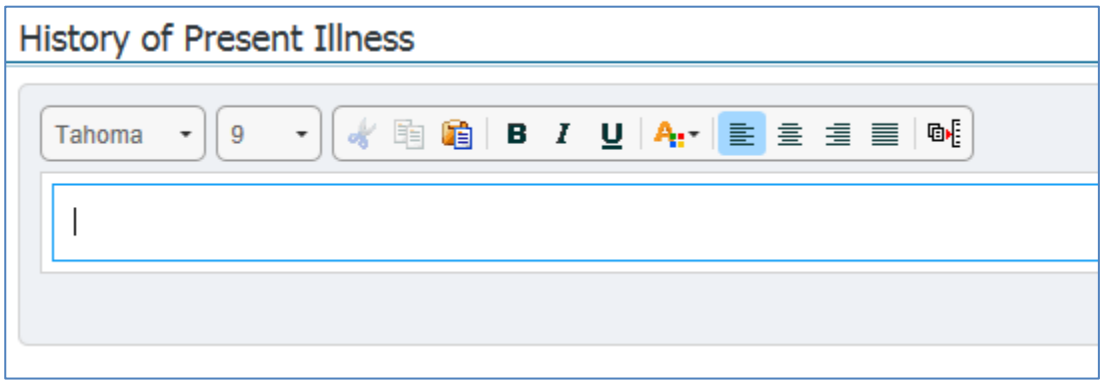
- **This Visit** – the issue is a focus of the current encounter - it is not shared between encounters and not carried over to the next encounter.
- **Chronic** – the issue is ongoing and can be active or resolved. Chronic problems are shared across encounters and carried over to the next encounter. 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.

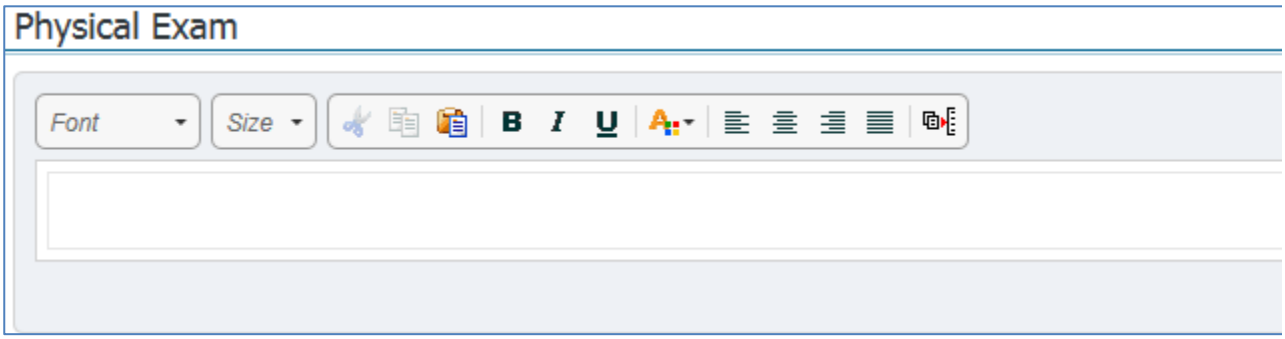
1 Click on the **History of Present Illness** component from the component list from the Admission tab.



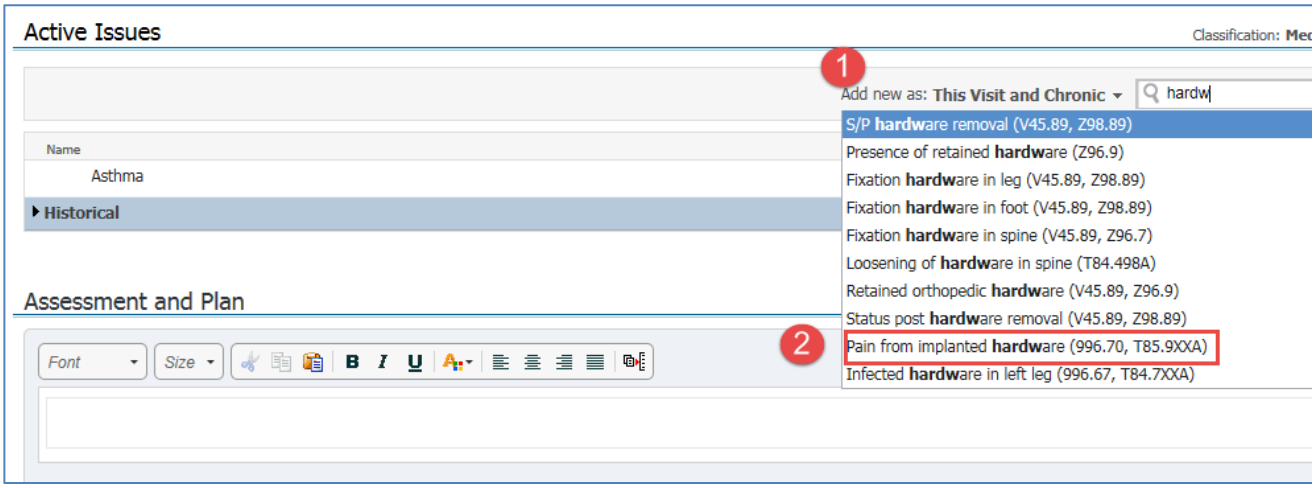
2 Click the blank space under **History of Present Illness** to activate the free text box and type some text. For example *Two month history of shin pain.*



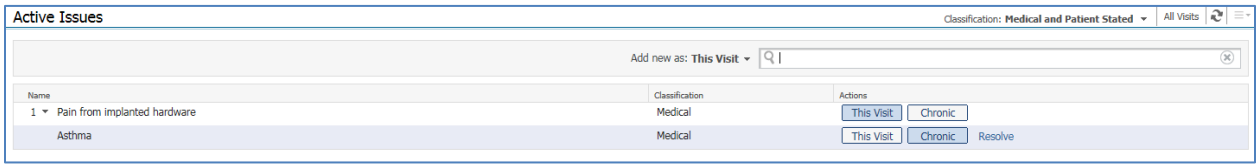
3 Continue adding your notes in the **Physical Exam** component. For example *Physical exam non-contributory.*



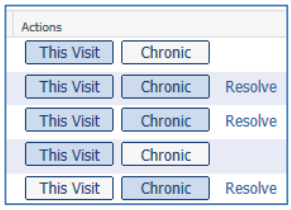
4 Next, select **Active Issues** component**.** To add Pain from hardware to the list of your patient's issues, select **This Visit and Chronic** and begin typing *hardw.*



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

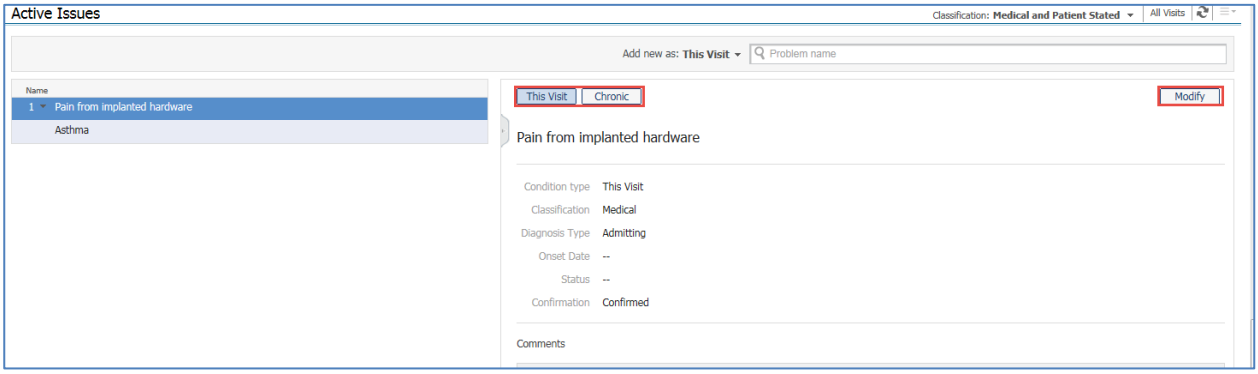


- These visit diagnoses are numbered as primary, secondary, tertiary, etc. You can easily rearrange this order by clicking the digit and selecting a different number.



- 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.

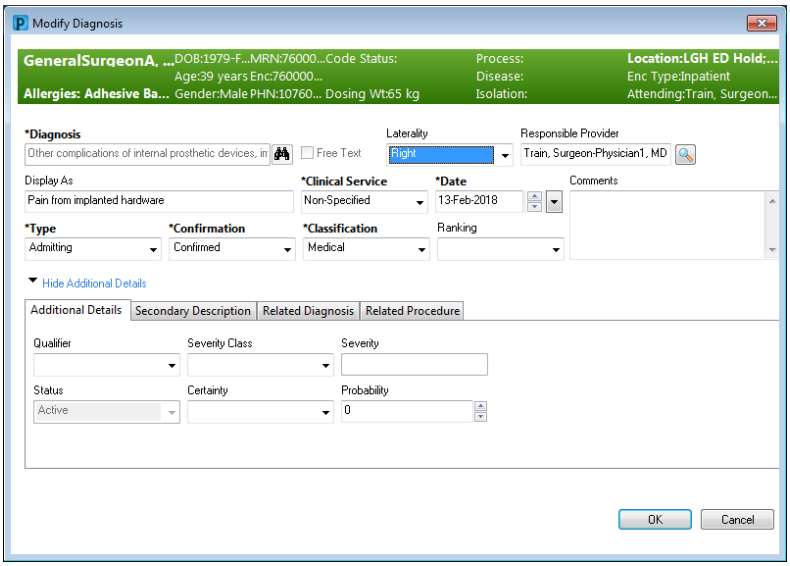
6 Click the active issue to display more details. Without leaving this view, you can:



- **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

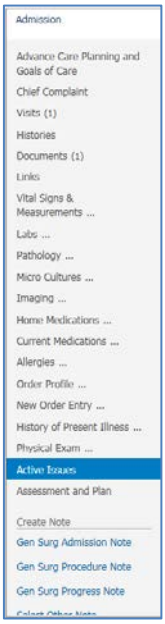
As the last step in assessing your patient, you create your note about the visit.

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

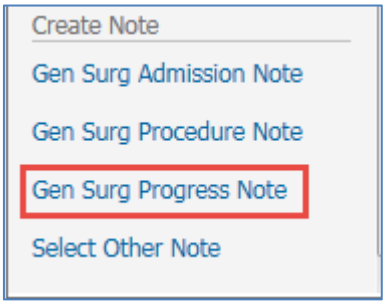
Dynamic Documentation can save you time by allowing you to populate your documentation with items you have reviewed and entered in the Admission workflow tab. This is why it is more efficient to create the note as the last step in the process. You can also add new information by typing or dictating directly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

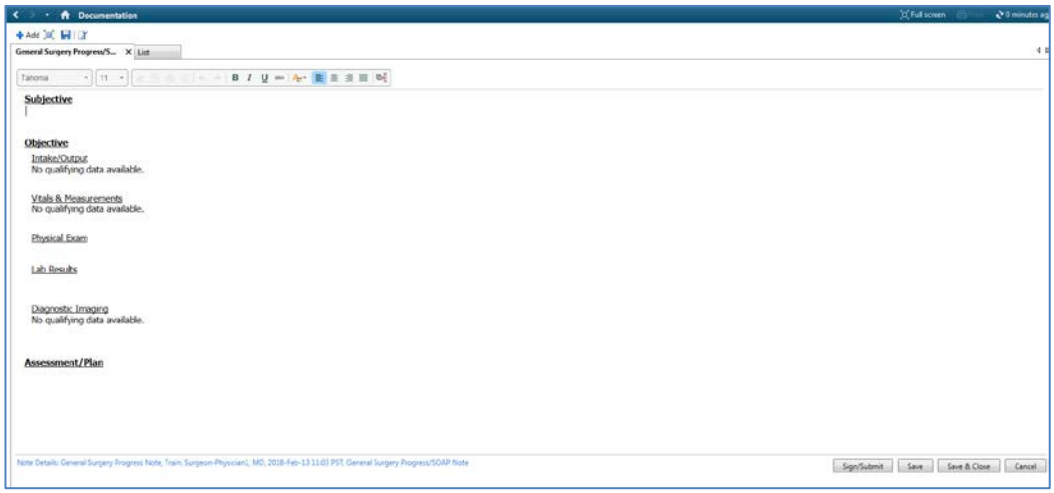
1 Navigate to the **Create Note** section.



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.

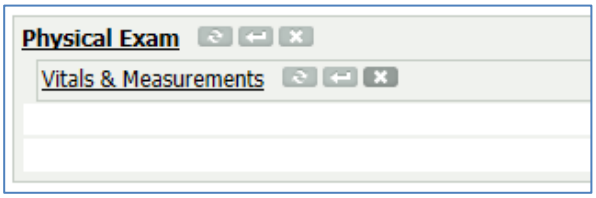


4 Position your cursor over the heading of any section to activate a small toolbar:

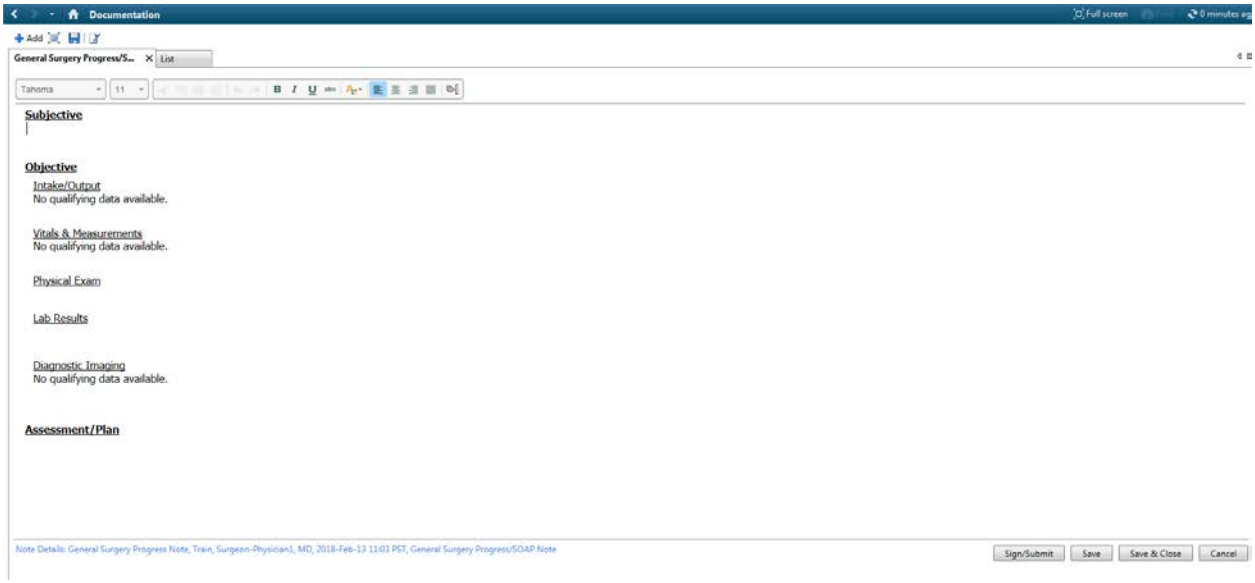
refreshes the dynamic information in the box

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

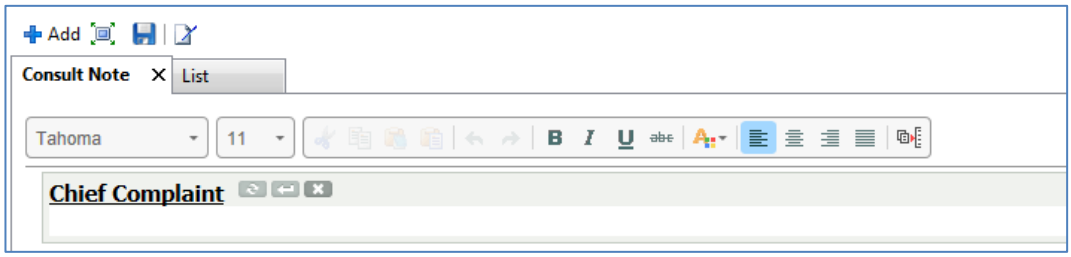


5 For editing existing text, click into the box, for example, **History of Present Illness**. It becomes active and you can select the text to add or delete as needed.



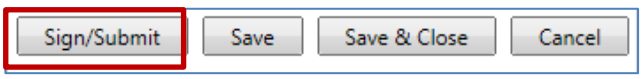
Note: PowerChart offers **Auto text** phrases that can be used within Provider documentation to quickly and easily insert note templates, and pull in patient data with smart templates. This will be discussed further in Activity 3.2.

6 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.



7 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."

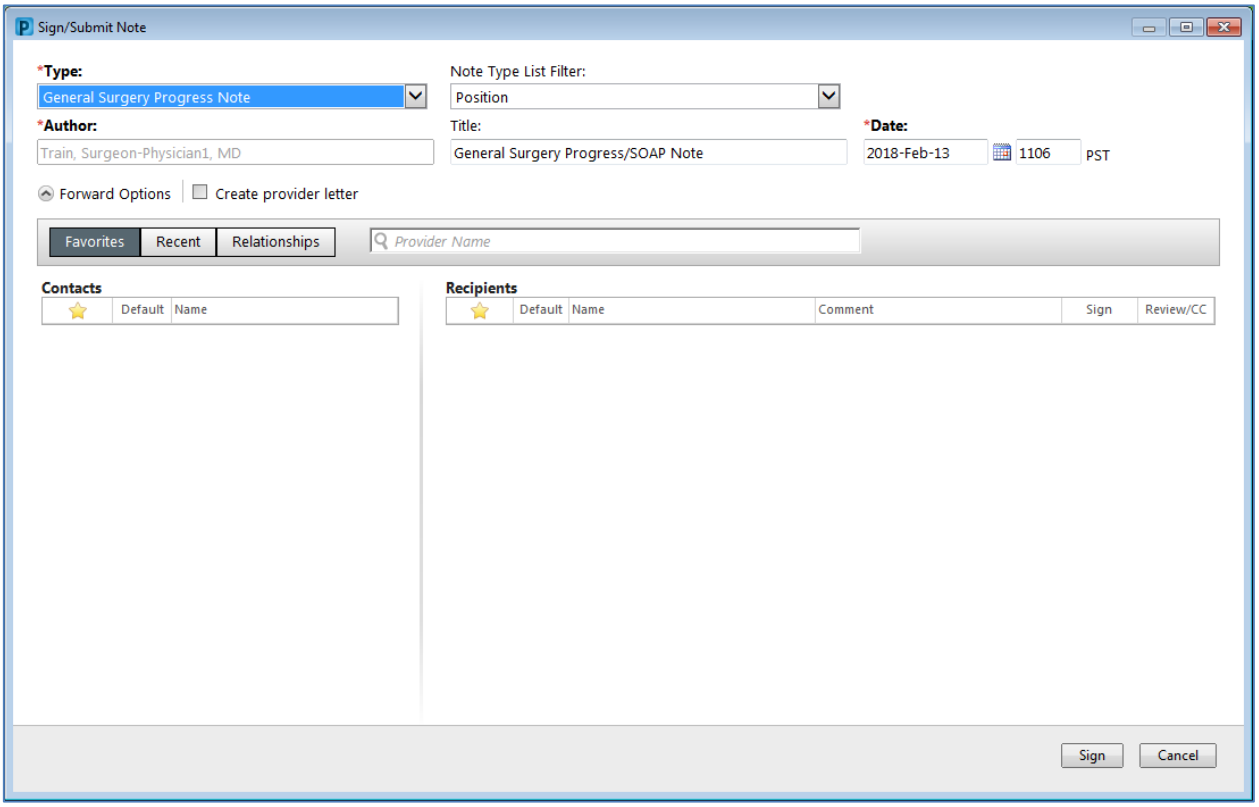
8 To complete your note, click **Sign/Submit.**



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.

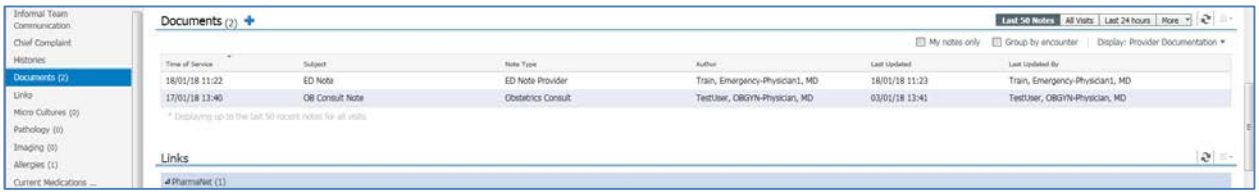


Note:

- 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 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:

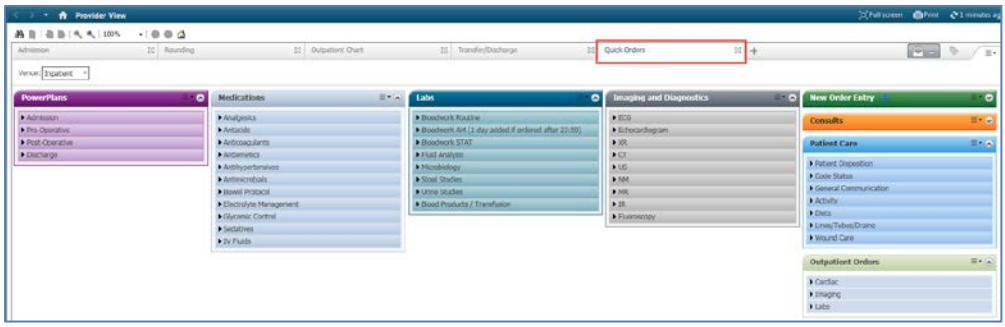
- Placing a PowerPlan in a planned state
- Create an Operative Report

Activity 2.1 – Plan a Post-operative PowerPlan

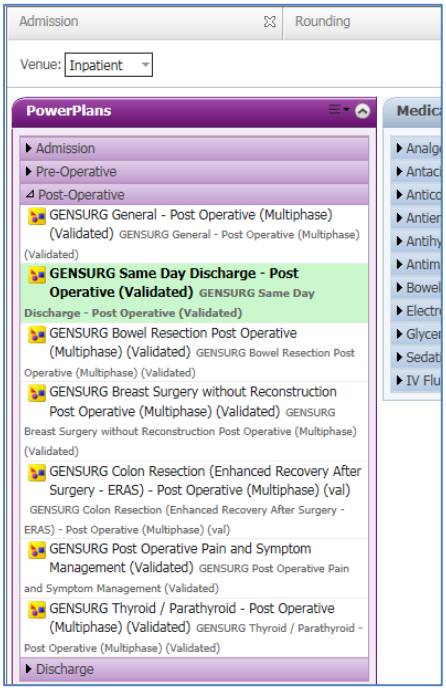
Your patient's post-operative orders need to plan for nursing staff to have them available to be initiated when appropriate.

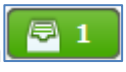
The best way to access your PowerPlans is through your Quick Orders page, as we reviewed when placing the Day of Surgery plan earlier.

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



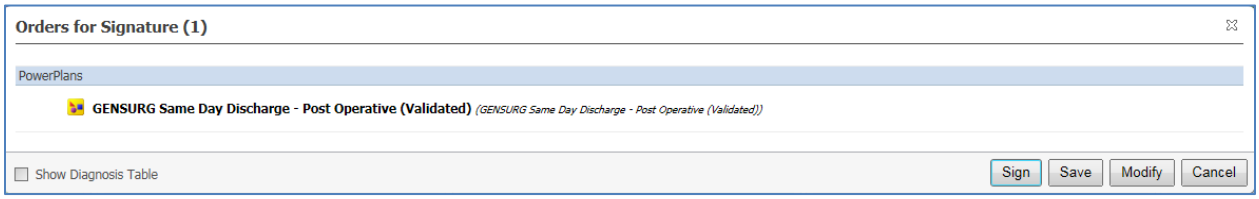
2 In the PowerPlans folder, click on the Post-Operative title to expand the folder and click on the **GENSURG Same Day Discharge – Post Operative** plan, marked by the icon.



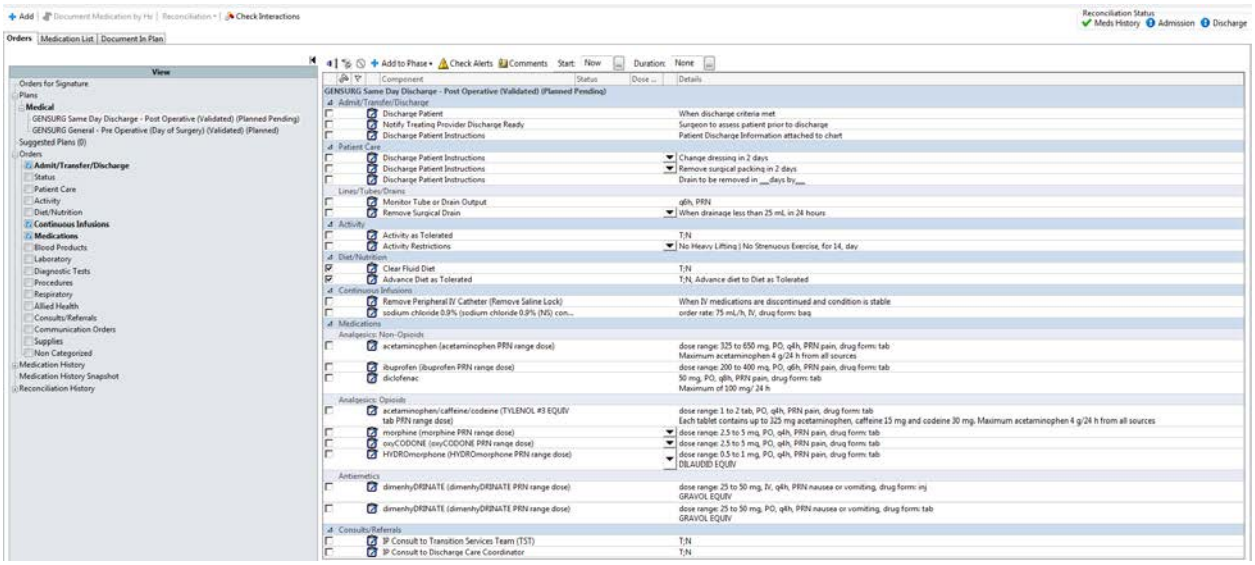
3 Click the Orders for the Signature icon 

to display the Orders for Signature window.

4 Click the Modify button.



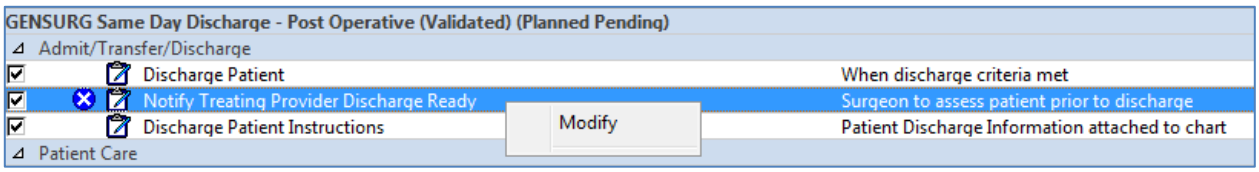
5 Here you can modify the orders in the plan by checking or unchecking orders and modifying the details of the orders by using the drop-down or by right-clicking on the order and selecting **Modify.**



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.

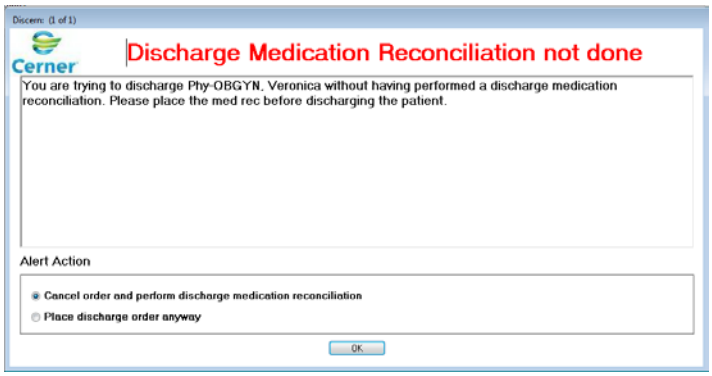
8 Complete the necessary details highlighted with yellow fields and/or **bold** text.

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

Remember to click the Details 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 

. 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**

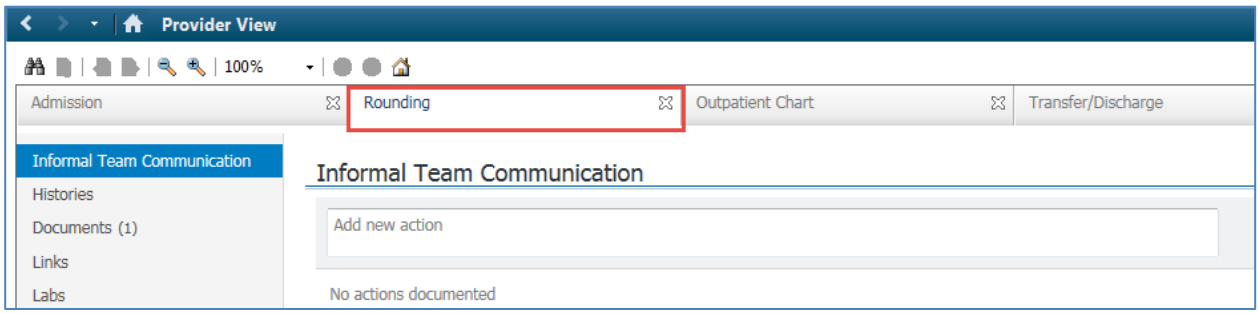
Key Learning Points

- 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

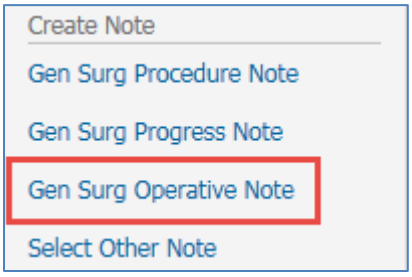
Activity 2.2 – Complete an Operative Note with Autotext

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.

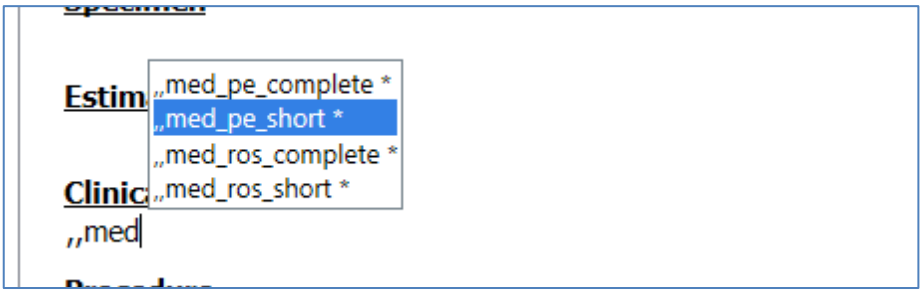
1 Navigate to the Rounding.



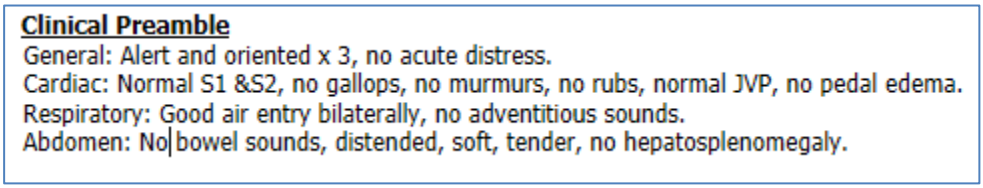
2 From the list under Create Note, select **Operative Report** which will pull existing relevant information from the note.



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.



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

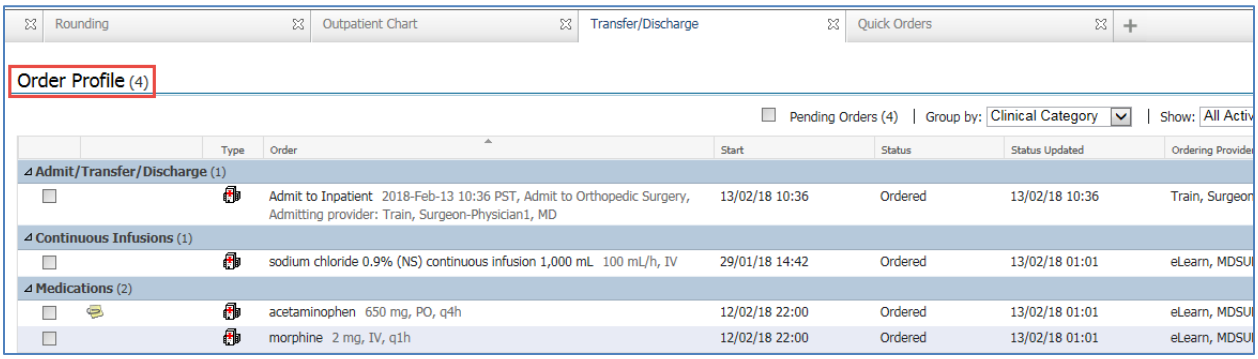
The patient has met all discharge criteria and you already placed the Discharge Patient order as part of your Post-Operative PowerPlan. You still need to complete the discharge documentation, prescriptions and diagnosis entry.

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.



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 3.2 – Reconcile Medications at Discharge and Create Prescriptions

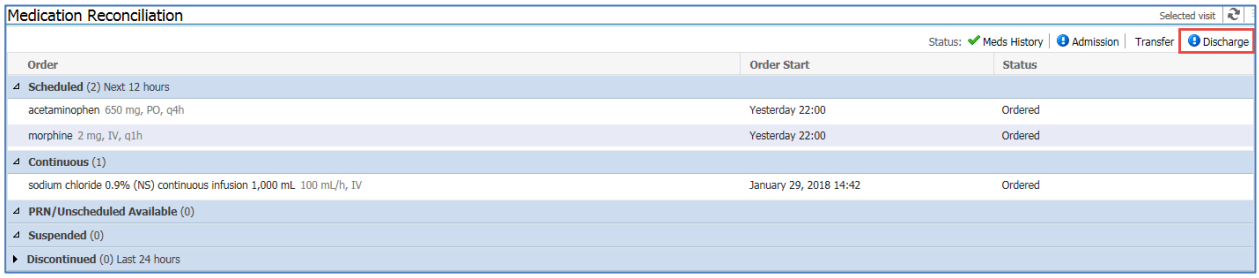
Now that you have reviewed the current orders, you are ready to complete your discharge medication reconciliation. The list of medications to reconcile includes:

- **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.

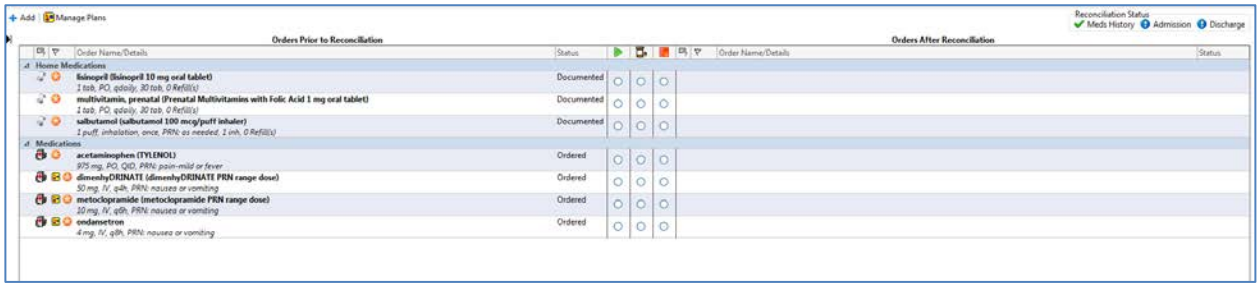
You will determine which home medications and inpatient medications your patient should continue after discharge. Continued medications will be carried forward and available as documented home medications within the patient's medication history. This will be viewable at the patient's next visit.

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**



2 The reconciliation window displays the current status of medications.



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

_____

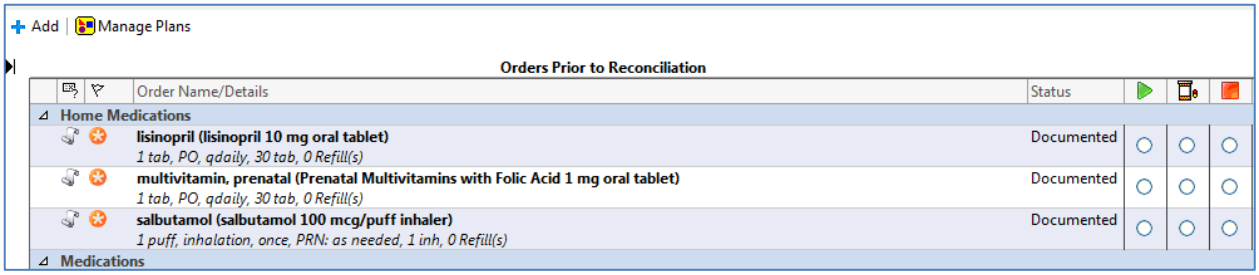
_____

_____

_____

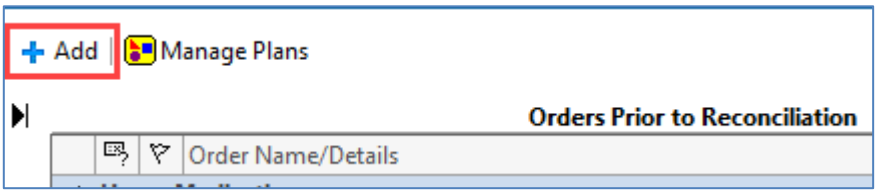
_____

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

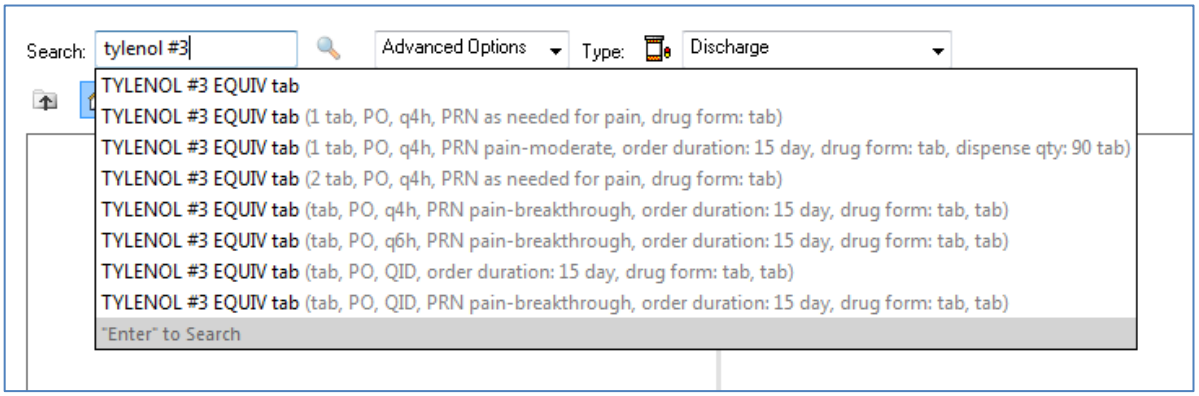


4 Discontinue all inpatient orders as indicated by the  icon.

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



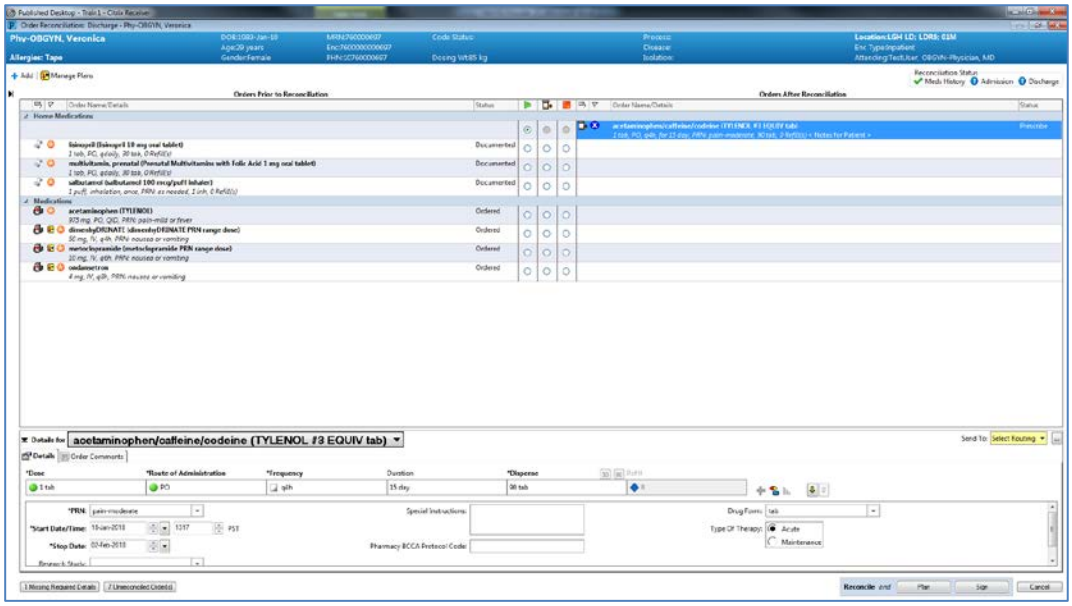
6 Search for Tylenol #3 in the **Search:** field.



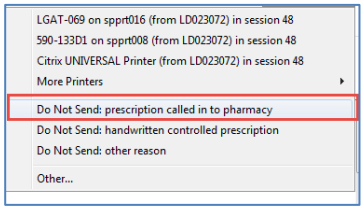
Select the appropriate sentence:

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.

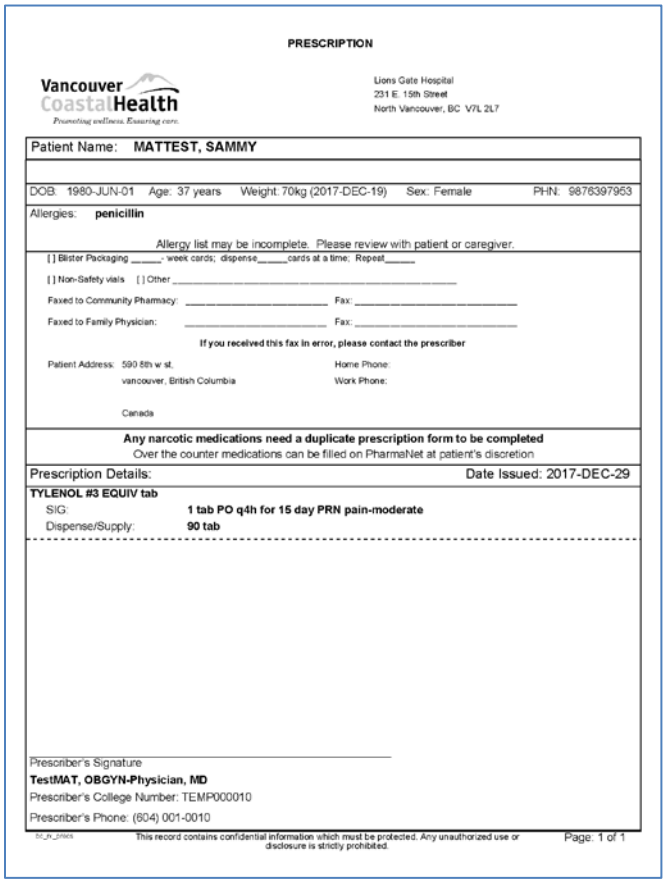
Once all medications are reconciled, click **Sign** to complete the discharge reconciliation.

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

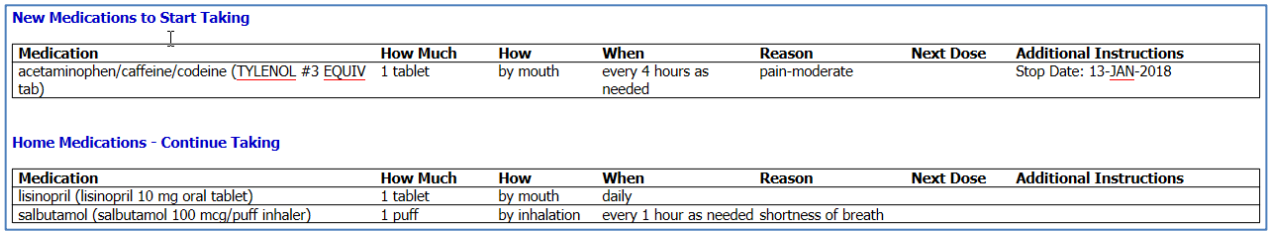
bc_in_prscs

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		

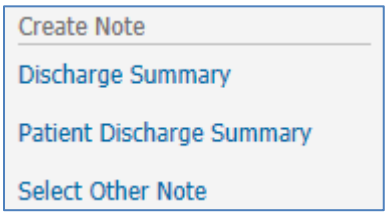
Key Learning Points

- 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.