SELF-GUIDED PRACTICE WORKBOOK [N63] CST Transformational Learning

WORKBOOK TITLE:

Nursing: Rural (Squamish)- Inpatient







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\$ SELF-GUIDED PRACTICE WORKBOOK

Duration	8 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 thorugh the activities at your own pace
Key Learining Review	 At the end of the session, you will be required to complete a Key Learning Review This will involve completion of 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 – CST Cerner Applications – FirstNet, PowerChart and Position Picker

Learning Objectives

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

- Understand the use case for FirstNet and PowerChart applications
- Log into Position Picker
- Understand when and how to use Position Picker

SCENARIO

As a Nurse at a rural hospital, you may often float from working in the Emergency Department to working on an inpatient unit within the same shift. Changing roles within the hospital necessitates being able to change applications and positions within the Clinical Information System (CIS).

In this scenario, you will complete the following activities:

Review CST Cerner Applications – FirstNet, PowerChart and Position Picker

Access Position Picker and Select the Appropriate Position



Activity 1.1 – Review CST Cerner Applications – FirstNet, PowerChart, and Position Picker

If you are a nurse who works in multiple areas of the hospital, you will need to become familiar with a few CST Cerner Applications. These applications are the ones you will log into in order to do your work and care for patients in that care area.

Below is a list of CST Cerner Applications and the corresponding care areas in which they're used:

Application	Care Areas
FirstNet	Emergency Department (ED)
	Inpatient units
	(Including adult, pediatric, and
Powerchart Powerchart	maternity units)
	Pre-op/Intra-op/PACU units
Powerchart Powerchart	
	All
Position Picker	

As a nurse at a rural site, you probably work in more than one care area. For example, you may work in the ED and then float to an inpatient unit.

As an **ED Nurse** you will use the **FirstNet** application to care for your patients. **FirstNet** functionality will be covered in another workbook.

As an **Inpatient Nurse**, you will use the **PowerChart** application. **PowerChart** functionality will be covered in this workbook.



As a nurse who floats between areas, you will also have to use the **Cerner Position Picker** application, which will be explained in the following activity.

Key Learning Points

- FirstNet is the application used in the ED by Emergency Nurses
- PowerChart is the application used by inpatient nurses in their inpatient units (Nurse Rural)
- You may have to switch your position in the CIS whenever you float to different areas of the hospital. For example, from the ED to an inpatient unit



Activity 1.2 – Access Position Picker and Select the Appropriate Position

In this activity, you will learn how to use the application **Position Picker** to change positions in the CIS to reflect the change in your role when you float to different parts of the hospital.

The positions that you will commonly switch between at SGH are:

- Emergency Nurse: Use in the Emergency Department
- Nurse Rural: Use in inpatient units for adult/pediatric/maternity/newborn patients
- Perioperative Nurse: Use in the pre-op/intra-op/PACU units

Let's say you started your day working in the Emergency Department. You logged into **Position Picker** at the start of your ED shift and selected **Emergency – Nurse** as your position. Now you are being asked to float to the *inpatient* unit to take care of a patient admitted with pneumonia.

You now need to log into **Position Picker** and select the inpatient nurse position of **Nurse – Rural.**

Review the following steps to see how you will switch your position from **Emergency - Nurse** to **Nurse-Rural** using **Position Picker**:

Note: The first step is to make sure you have logged *off* of any Cerner applications including FirstNet or PowerChart.

1. To access position picker from Cerner Citrix Store Front, click on the **Position Picker** application.



1

😂 Cerner				APPS			VCH\lsteffler 🔻
All Categories							Q Search All Apps
4 Coding	2 Emergency	14 HIM	6 Maternity	1 Medical Imaging	4 Oncology	Pharmacy	7 Registration
4 Scheduling	Supply Chain	Surgery and Anesthesia					
DiscernReporting_783	Mmodal P0783	Position Picker P0783 1	Powerchart P0783	Support Folder	User Folder		

A Cerner Logon (Position Picker) window will open



- 2. Type your assigned username and password
- 3. Click OK

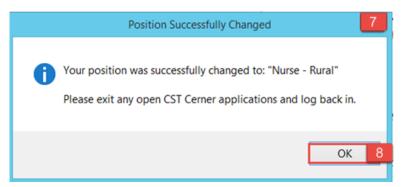
<u>8</u> 1	Cerner Logon (Position Picker)					
	Cerner Usemame					
	Cemer Domain p0783					
Pos	ition Picker Version 2.0.6598.22416					

- 4. A CST Cerner Position Picker window displays stating "Your current position is: 'Emergency – Nurse"
- 5. You want to switch your position because you are now working on an inpatient unit, so select *Nurse Rural*
- 6. Click OK

CST Cerner Position Picker
Your current position is: "Emergency - Nurse"
Atemate positions available to you: Nurse - Rural 5 Perioperative - Nurse
OK 6 Quit

- 7. A window will display: "Your position was successfully changed to: "Nurse Rural" Please exit any open CST Cerner applications and log back in."
- 8. Click OK





Congratulations! You've switched your position from **Emergency – Nurse** to **Nurse – Rural** and are now ready to start your work on the inpatient unit.

Note: You must log out of any open CST Cerner application (FirstNet or PowerChart) when you switch to a different position in **Cerner Position Picker**.

It's important to get into the habit of logging into **Cerner Position Picker** at the start of every shift at SGH to check which position you are logged in as before you start your day!

Key Learning Points

- Cerner Position Picker is the application you will use to switch positions within the CIS to reflect the change in your role throughout your shift
- Log out of any open CST Cerner application (FirstNet or PowerChart) when you switch to a different position using Cerner Position Picker
- At the start of every shift, first log into Cerner Position Picker and make sure you have selected the appropriate position
- The Nurse-Rural position is used when working on inpatient units to care for adult/pediatric/maternity/L&D/newborn patients.



PATIENT SCENARIO 2 – Log into PowerChart and Create Patient Lists

Learning Objectives

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

- Log into the PowerChart application
- Create a Location Patient List
- Create a Custom Patient List
- Find your patient on your Location Patient List and move them onto your Custom Patient List

SCENARIO

You started your shift in the ED, but you're now floating to the inpatient unit to look after an 80 year old male who has been admitted with a diagnosis of pneumonia and prescribed IV antibiotics.

You've already logged onto **Cerner Position Picker** to switch from the Position of Emergency –Nurse to **Nurse – Rural**, and you are now receiving the inpatient into your care.

As an Inpatient Rural Nurse you will complete the following activities:

- Log into PowerChart
- Set-up a Location Patient List
- Create a Custom Patient List



Activity 2.1 – Log into PowerChart

To log into PowerChart, complete the following steps:

1. From the Cerner Citrix Store Front, double click on the PowerChart application.

😂 Cerner			APPS		VCH\lsteffler 🔻
All Categories					Q Search All Apps
2 Emergency HIM	5 Maternity	4 Oncology	Pharmacy	7 Registration 4 Scheduling	5 Supply Chain
Surgery and Anesthesia					
DiscernReporting_783	Notepad	Powerchart P0783	Support Folder	User Folder	

2. A login window will open. Type in the assigned **username and password** and click **OK**

⊖ Cerner Cer	ner Millennium [.]	
	Username :	
	~	
	Password :	
	Domain :	
	p0783 🗸	
	OK Cancel	
PowerChart		
Unauthorized use, access, reproduction, disp	erved. ding components thereof) require, and are governed by, license(s) from Cerner Corporati slay or distribution of any portion of this solution or the data contained therein may result Further information may be found in Help About.	

You are now logged into **PowerChart** in the position of **Nurse – Rural**.

Note: The **Nurse- Rural** position is the position that will allow you to take care of inpatient adult, pediatric, labour and delivery (obstetric) or newborn patients.



Key Learning Points

- Make sure you have selected to correct position (Nurse-Rural) in Position Picker before logging into PowerChart
- Access PowerChart from Cerner Citrix Store Front
- Log-in using your username and password



Activity 2.2 – Set Up a Location Patient List

1 Upon logging into **PowerChart**, you will land on **CareCompass. CareCompass** provides a quick overview of select patient information.

Note: if you are in a role where you are always in charge of a unit, your landing page may be the **Clinical Leader Organizer (CLO)**. This will be covered later if you are a Patient Care Coordinator, Charge Nurse or an inpatient nurse who takes on charge duties.

2 At the start of your first shift (or when working in a new location), you will create a **Location List** that will consist of all of the patients in that location/unit.

- 1. Select the **Patient List** icon I Patient List from the **Toolbar** at the top of the screen
- 2. The screen will be blank. To create a location list, click the List Maintenance icon
- 3. Click the New button in the bottom right corner of the Modify Patient Lists window

P	PowerChart O	ganizer for TestUser, Rural-Nurse	- 8 ×
Task Edit View Patient Chart Links PatientList Help			
📽 CareCompass 📽 Clinical Leader Organizer 🎍 Patient List 🚹 ulti-Patient Task	List Tracking Shell @Case Selection Staff Assig	ment 🎬 LearningLIVE 🚽 🛱 CareConnect 💐 PHSA PACS 🎕 VCH and PHC PACS 🎕 MUSE 💐 FormFas	t WFI _
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- 4. From the Patient List Type window select Location
- 5. Click the Next button in the bottom right corner

Patient List Type	×	F
Select a patient list type: Assignment Assignment (Ancillary) CareTeam Custom Location Provider Group Query Relationship Scheduled		6
	2	el
	Select a patient list type: Assignment Assignment (Ancillary) CareTeam Costom Medical Scritte Provider Group Query Relationship Scheduled	Select a patient list type: Assignment Assignment (Ancillary) CareTeam Cocation A Medical Source Provider Group Query Relationship Scheduled Back Next Finish Cancel

6. In the **Location Patient List** window, open the **Locations** folder by clicking the **Plus Sign**

Location Patient List		×	ŀ
Iocations Medical Services Encounter Types Care Teams Relationships Time Criteria Discharged Criteria Admission Criteria	Cotation: Cotation:		
Enter a name for the list: (Limited to	o 50 characters)		
	Back Next Finish Can	icel	

7. For this activity, use LGH Lions Gate Hospital as a selected location. Expand the location by clicking the Plus Sign:



- 8. Then, click the next Plus Sign: IGH Lions Gate Hospital
- 9. For your practice, select LGH 4 East by checking the box next to the unit in CH4 East

Patient Lists need a name to differentiate them. Location lists are automatically named by the Location.

10. Click the **Finish** button Finish in the bottom right corner.

Location Patient List		×
 *Locations [LGH 4 East] Medical Services Encounter Types Care Teams Relationships Time Criteria Discharged Criteria Admission Criteria 	Generation Content of the second secon	* III
Enter a name for the list: (Limited LGH 4 East	to 50 characters) Back Next Finish 10 Can	icel

- 11. In the Modify Patient Lists window click on the available list LGH 4 East.
- 12. Click the **Blue Arrow** icon icon to move **LGH 4 East** from the **Available List** column to the **Active List** column on the right side.
- 13. Click the **OK** button in the bottom right corner to return to **Patient List** page.

P Modify Patient Lists	
Available lists: LGH 4 East 11	Active list:
	New OK 13 Icel



14. Your Location list of **LGH 4 East** should now appear, listing all the patients that are currently on this unit.

Patient L	ist									
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LGH 4 Eas										
All Patien	ts - LGH 2 East									
	P Sec Name	Roon	Bed	Nurse Unit	Building	Facility		DOB	Age	Sex
1	CSTLABAUTOMATION, TSWESLEY	220	02	LGH 2E	LGH Lions Gate	LGH Lions	Gate	19-Jul-1934	83 years	Undifferentiated
	CSTPRODMED, LAB-HIGH			LGH 2E	LGH Lions Gate	LGH Lions	Gate	01-Jan-1998	20 years	Female
2	CSTLABAUTOMATION, TSWASHINGTON	214	01	LGH 2E	LGH Lions Gate	LGH Lions	Gate	24-Jul-1925	92 years	Male
	CSTDEMOALEXANDER, DONOTUSE			LGH 2E	LGH Lions Gate	LGH Lions	Gate	01-Jun-1970	47 years	Male
2	SEXSMITH-LEARN, NATALIE	224	01	LGH 2E	LGH Lions Gate	LGH Lions	Gate	14-Apr-1955	62 years	Female
	CST-TTT, ISLA	2EL	02	LGH 2E	LGH Lions Gate	LGH Lions	Gate	08-Jan-1946	72 years	Female
	CST-TTT, TOBIAS	2EL	01	LGH 2E	LGH Lions Gate	LGH Lions	Gate	13-Jan-1944	74 years	Male
	CSTPRODONC, KRISTINE			LGH 2E	LGH Lions Gate	LGH Lions	Gate	12-Jan-2010	8 years	Female
	CSTONCPHARM, STTWO			LGH 2E	LGH Lions Gate	LGH Lions	Gate	21-Nov-1996	21 years	Female
	CSTDEVONC, TESTONE	204		LGH 2E	LGH Lions Gate	LGH Lions	Gate	01-Jan-1960	58 years	Male
	CSTLABAUTOMATION, TSWAYNE	224	02	LGH 2E	LGH Lions Gate	LGH Lions	Gate	18-May-1934	83 years	Male
	CST-TTT, RUTH	2EL	03	LGH 2E	LGH Lions Gate	LGH Lions	Gate	10-Jan-1946	72 years	Female
	CSTPRODREG, OUTPATIENTIN			LGH 2E	LGH Lions Gate	LGH Lions	Gate	10-May-1990	27 years	Female
🌣	CSTPRODREGHIM, CHANDLER	212	03	LGH 2E	LGH Lions Gate	LGH Lions	Gate	12-Feb-1975	43 years	Male
📩	CSTADTJAMTHREE, ADTONE ENTRY			LGH 2E	LGH Lions Gate	LGH Lions	Gate	21-Apr-1956	61 years	Undifferentiated
	CSTPRODMED, JAMIE	204	01	LGH 2E	LGH Lions Gate	LGH Lions	Gate	28-Sep-1992	25 years	Female
2	LEE-LEARN, PETER	222	02	LGH 2E	LGH Lions Gate	LGH Lions	Gate	17-Mar-1950	67 years	Male
	CSTPRODREG, SELFPAYTWO			LGH 2E	LGH Lions Gate	LGH Lions	Gate	10-May-1990	27 years	Female
	CSTPRODAC_MEGAN	206	02	LGH 2F	IGH Lions Gate	IGH Lions	Gate	11-Jan-1987	31 years	Female

Note: As a rural nurse, you probably float to multiple areas of the hospital. It is appropriate for you to create multiple location lists if this is the case.



- Patient List can be accessed by clicking on the Patient List icon in the Toolbar
- You can set up a patient list based on location
 - A Location List displays all patients that are currently in that location



Activity 2.2 – Create a Custom Patient List

1 Next, create a **Custom List** that will contain only the patients that you are caring for. Note: you can also add patients that you will be covering for during your partner's break.

- 1. To create a Custom List, click the List Maintenance icon
- 2. Click the New button in the bottom right corner of the Modify Patient Lists window
- 3. Select Custom from the Patient List Type window
- 4. Click the **Next** button

Patie	nt List										5
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All D	tients - LGH 2 East										
All P		Modify Patient Lists						1			
0	Name							r Visit	Primary Care Physician	Visitor	Status
Ō		Available lists:		Active lists:				n testing	Plisvca, Rocco, MD		
1	CSTPRODMED, LAB-HIGH			LGH 2 East				tis	TestCST, GeneralMedicine-P	hysician1 ORD, MD	
	CSTLABAUTOMATION, TS							n testing	Plisvca, Rocco, MD		
20	CSTDEMOALEXANDER, D										
0	SEXSMITH-LEARN, NATALI CST-TTT. ISLA							y Acquired Pnuemor polasty Shoulder	hia Plisvco, Wesley, MD Plisvcv, Charise, NP		
9	CST-TIT, TOBIAS							pplasty Shoulder	Plisvey, Charise, NP Plisvey, Charise, NP		
HH	CST-TTT, KIMBERLY							pplasty Shoulder	Plisvoy, Charise, NP Plisvoy, Charise, NP		_
	CSTPRODOS, ORDERSET		100 M		(Sharry program	PRIVAT, Charline, HP		
	CSTPRODONC, KRISTINE		44			Patient List Type					×
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	CSTDEVONC, TESTONE					Select a patrent	and type.				- H
	CSTPRODCD, EMILY CERN					Assignment					
	CSTLABAUTOMATION, TS					Assignment (A	incillary)				
0	CST-TTT, RUTH					CareTeam					
_	CSTPRODREG, OUTPATIES					Location	3				
1	CSTADTJAMTHREE, ADTO					Medical Servic					
	CSTPRODMED, JAMIE					Provider Group					
10	LEE-LEARN, PETER					Query					
	CSTPRODREG, SELFPAYTV			Ne		Relationship Scheduled					
0	BROWN-LEARN, HENRY			ive		scheduled					
	CSTPRODREGINTER, HOP				2						
	CSTPRODMED, LAB-NORMA CSTPRODML SITS/INGO		04178 700000006054 21 years								
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H	CSTSYNGOTEST, FRANK			11-Feb-1960 02-Nov-2017 14:27 P							
	CSTAMBTEST, JAMIE			28-Feb-1992 26-Oct-2017 13:56 Pl							
	CSTPRODREGHIM, FRANK		04995 7000000008263 37 years		DT Plisvia, P						
	CSTPRODREG, OUTPATIENTC		02490 7000000004418 27 years								
	CSTPRODREG, OUTTOOUT		01856 7000000004416 27 years								
	CSTONCPHARM, STONE			27-Nov-1979 08-Nov-2016 14:32 P	ST	-					<u> </u>
10	JONES-LEARN, JULIO			29-Aug-1946 16-Nov-2017 09:42 P							
8	MCCOY-LEARN, SHAUNA			17-Feb-1958 14-Nov-2017 13:03 P					Back Next	Finish Cano	*
	CSTPRODREG, PREWORK	70000	03725 700000005160 27 years	10-May-1990							
	CSTPRODHIM, STESTSIX	70000	07350 7000000015682 17 years	01-Oct-2000 29-Nov-2017 08:25 P	ST Plisvca, Ro	cco, MD	test		Plisvch, Max MD 4		
	CSTRRODMED TEST.SIERRA	20000	08220 70000001 5082 30 wears	17.Nov.1987 18.Nov.2017 72:42 P	ST Ricura Ro	cco_MD	tect curre	w.	Riora Rocco MD		

- 5. **The Custom Patient List** window opens. In the **Enter a name for the list:** Type *YourName_Custom* (i.e. John_Custom)
- 6. Click the **Finish** button

	Custom Patient List		II F F F
	Admission Criteria Discharged Criteria Use Best Encounter		
rs rs rs rs rs	Enter a name for the list: (Limited to 50 characters) JohnDoe_Custom List Back Next Finish	ן	



- 7. In the Modify Patient Lists window select your Custom List (i.e. YourName_Custom)
- 8. Click the **Blue Arrow** icon 🖻 to move your **Custom List** to the **Active List** on the right side
- 9. Click the **OK** button

X
/e lists:
H 2 East
4
New OK 9el
New OK 9 el

10. You will now see a tab for your Custom List

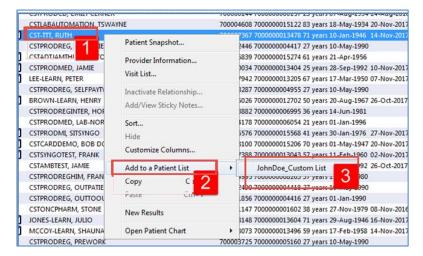
Patien	t List						
Þ	' >> 💐 🌴 🌴 🕼 🕼 🖺 💼 🛍 🗎	A 10 10 10 10 10 10 10 10 10 10 10 10 10					
SGH M	edical Surgery JohnDoe_Custom List	10					
1	Patient Name	Location	MRN	Encounter #	Age	DOB	Gender
1	CSTRHOREG, WINRECSADT	SGH MS 106 02	700020889	700000201397	30 years	03-Mar-1987	Female
2	TESTSQBB, MICHAEL	SGH MS 108 01	700002627	700000004242	77 years	31-Dec-1940	Male
	CSTHRCM, TWENTY	SGH MS 109 01	700009019	700000016839	34 years	18-Jan-1984	Female
1	CSTCD, TESTAB	SGH MS 103 02	700000734	700000201003	83 years	13-Oct-1934	Female
	CSTPRODREG, SHANNON	SGH MS MSL 02	700002491	700000007018	32 years	30-May-1985	Female
1	CSTLABSQ, TESTSIX	SGH MS MSL 03	700020206	700000200335	63 years	23-Jan-1955	Unknown
	CSTHARDING, JAMES	SGH MS 114 01	700008753	700000016359	22 years	08-Sep-1995	Male

Note: Your custom list will be empty as you have not yet added any patients.

- 2 At the beginning of each shift or assignment change, you will need to add your patients to your custom list from your location list.
 - 1. From the **Patient List** window make sure your location list tab is displayed (i.e. LGH 4 East). Find your assigned patient's name in the location list.
 - 2. Right click on your assigned patient's name and select Add to a Patient List



3. Select YourName_Custom List



- 4. Return to Patient List window. Select YourName_Custom tab.
- 5. Click the **Refresh** icon **to** update the **Patient List** window.
- 6. Now your patient will appear in your Custom List.

Patient List	10 Full screen I Frint 00 minutes ago
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LGH2 East SubaDue, Cauton Lis	└ ─ [∨]
Constrom Name MRN Encounter App 008 Admitted Admitting Physician Reason for Visit Primary Care Physician/Visitor Status Const 20, 02 051777, NUTH 2000070547 200000003470 312 years 10-Jan-1346 14-Nov-2017 10:45 PDT Prince, Reacon for Visit	
	11

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

Key Learning Points

- You can create a Custom List that will consist of only patients that you are caring for on your shift
- Add patients to your Custom List from a Location List this helps to ensure you have the correct patient and the correct patient encounter
- When you are no longer caring for a patient on your custom list, you can remove the patient using the Remove Patient icon



PATIENT SCENARIO 3 – CareCompass

Learning Objectives

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

- Navigate to and within CareCompass and understand how it fits into your daily workflow
- Establish a relationship with your patient(s) and review the patient's information

SCENARIO

As an Inpatient Rural Nurse, you will complete the following activities:

- Navigate in and around CareCompass
- Establish a relationship with your patient(s) and review patient information



Activity 3.1 – Introduction to CareCompass

1

CareCompass is an innovative, interdisciplinary, summary workflow solution that guides you, as a clinician, to organize, plan and prioritize care for your patients. CareCompass displays important details such as allergies, planned physician order sets, plans of care, resuscitation status, reason for visit, and more.

- 1. Navigate back to **CareCompass** by clicking on the **CareCompass** icon in the **Toolbar**
- 2. Click the **Refresh** 🔁 icon
- 3. From the Patient List dropdown, Select YourName_Custom list

PowerChart Organizer for TestCD, ICU-Nurse					- 4
ask Edit View Patient Chart Links Navigation Help					
👫 CareCompass 👖 nical Leader Organizer 🤺 Patient List 🚨 Multi-	-Patient Task List 🎬 Discharge Dashboard 😭	Staff Assignment 🎬 LearningLIVE 🖕 🗄 😋 CareConnect 🔮	🕽 PHSA PACS 🐧 VCH and PHC PACS 🐧 MUSE 🐧 F	ormFast WFI 🝦	
🖟 Exit 🎬 AdHoc 🎟 Medication Administration 🔒 PM Conversation	🔹 🗟 Medical Record Request 💠 Add 👻 📻 E	Documents 🗂 Scheduling Appointment Book 💽 iAware 🧯	Discern Reporting Portal		
🞝 Patient Health Education Materials 🐧 Policies and Guidelines 🔇 Up	ToDate 🛫				
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Patient List JohnDoe_Custom List 🖌 💥 List Maintenance 🕂	Add Patient 🔹 😵 Establish Relationships				
Location JohnDoe_Custom List 3	Visit	Care Team	Activities	Plan of Care	
2EL - 03 CST-TTT, RUTH	-			-	
71yrs F			-		
No Relationship Exists					

Now the patients that you have moved onto your Custom List are displayed in CareCompass.



Let's review CareCompass

- 1. The **Toolbar** is a quick way to navigate the Clinical Information System (CIS) using the various buttons.
- 2. The **Patient List** drop-down menu enables you to select the appropriate custom patient lists you would like to view.
- 3. Until you establish a relationship with your patients in the system, the only information visible about them is their location, name and basic demographics.

Note: You will establish a relationship in the next activity.

PowerChart Organizer for TestCD, ICU-Nurse				
Task Edit View Patient Chart Links Navigation Help				
🎬 CareCompass 🎬 Clinical Leader Organizer 🎍 Patient List 🚨 Multi-Patient Task List 🎬	Discharge Dashboard 🔉 Staff Assignment 📗	LearningLIVE 🝦 🗄 😋 CareConnect 😋 PHSA PACS 😋 VCH and P	HC PACS 🜊 MUSE 🜊 FormFast V	VFI -
🏨 Exit 🦉 AdHoc 🎟 Medication Administration 🔒 PM Conversation 👻 🗎 Medical Record	d Request 🔸 Add 👻 📻 Documents 🗮 Schee	luling Appointment Book 💽 iAware 🧉 Discem Reporting Portal 💡		
🕄 😋 Patient Health Education Materials 🔌 Policies and Guidelines 🔌 UpToDate 🖕				
CareCompass				[田] Full screen
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Patient List: JohnDoe_Custom List 🔽 2 t Maintenance 💠 Add Patient 💰	Establish Relationships			
Location Patient	Vait	Care Team	Activities	Plan of Care
2EL - 03 CST-TTT, RUTH 71yrs F No Relationship Exists 3	-	-	-	-



Key Learning Points

- CareCompass provides a quick overview of patient information
- Prior to establishing a relationship with the patient, the only information visible about a patient is location, name and basic demographics

1



Activity 3.2 – Establish a Relationship and Review Patient Information

Now that you have created your custom patient list, you must establish a relationship with your patients in order to view more patient information or access their chart.

1. Click Establish Relationships

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areCompass				uj rui screen (⊜) Print	ing≓ 5 Hours I	,5 minutes a
Patient List: LG	3 3 100% - ● ● △ HICU V List Mainten	ance 🕂 Add Patient 🕏 Establish Relationsh	ine 1		a 0	2
	• • •					-
Location	Patient CSTADTJAMTWO, PATIENTSEVEN 50yrs F No Relationship Exists	-	Care Team -	Activities		ŕ
IC06 - 01	CSTDEMO, ZEUS 38yrs M No Relationship Exists	-	-	-		E
IC01 - 01	CSTEDPARK, SEAN 27yrs M No Relationship Exists	-	-	-		
IC02 - 01	CSTEICIA, BRIAN 32yrs M No Relationship Exists	-	-	-		
IC10 - 01	CSTLABAUTOMATION, TSAD 41yrs M No Relationship Exists	-	-	-		
IC09 - 01	CSTLABAUTOMATION, TSAD 50yrs F No Relationship Exists		-	-		

- An Establish Relationships window opens. Select all or individual patients as appropriate.
 Note: In this case, you will only have the one patient to establish a relationship with.
- 3. Once patients are selected, you will see a checkmark beside each patient's name.
- 4. From the Relationship dropdown menu, select Nurse.
- 5. Click the **Establish** button.

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

Establish Relationships					
* Relationship	✓				
Name Student Nurse		Date of Birth	MRN	Encounter #	-
CSTADTJA / Quality / Utiliza PATIENTSE Research	tion Review 4	02/28/1967	700005400	700000008221	
3 TDEMO Unit Coordinatio	on 4	02/01/1979	700004780	700000013571	
CSTEDPARK, SEAN	М	05/26/1990	700003792	700000005313	=
CSTEICIA, BRIAN	м	01/05/1985	700007877	700000013058	
CSTLABAUTOMATION, TSADLEY	М	03/28/1976	700004427	700000015168	
CSTLABAUTOMATION, TSADRIEN	F	06/23/1967	700004428	700000015165	
CSTLABAUTOMATION, TSAIKEN	F	11/15/1947	700004430	700000015162	
CSTPRODEMPI, TESTICIPATIENT	F	03/01/1988	700007747	700000012682	-



Once a relationship is established with your patients, additional information will appear on CareCompass.

Note: **Establishing a Relationship** allows others to know why you were entering the patient's chart. It is important to select the most appropriate relationship. If you are the Charge Nurse, you would select "Unit Coordination".

2

3

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

- 1. You can hover your cursor over icons, buttons, and patient information to discover additional details.
- Activity Timeline appears at the bottom of CareCompass. Click the green or red boxes on the timeline. They provide a visual representation of certain activities that are due for the patients on your list. Green colour means Scheduled Activities. Red colour means Overdue Activities.
- 3. Note that there is also an exclamation mark on the top right corner of the **CareCompass** page. This shows the total numbers of new orders or results that you need to review.

🕄 PACS 🔇 Formi 📲 Exit 🍟 AdHoc									
🖁 Exit 🎽 AdHoc	IIII Medication Administration								
		onversation 👻 🚰 Communicate 👻 🗎 N	Medical Record Request 🚦 Add 🔸	Documents 🗎 Sc	heduling Appointment Book	Discern Reporting Portal			
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CareCompass									🗇 Full screen 🛛 👘 Print 🛛 🎝 Pours 10 minutes -
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Patient List: Pati	ient list 💌 💥 List Mai	ntenance 🕂 Add Patient 💰 Est	ablish Relationships						3 9 2 9
Location	Patient		Vat	Care Tea	am .		Isolatio	Activities	Plan of Care
624 - 04	CSTLEARNING, DEMOTHETA 80yrs M No Allergies Recorded	-11	Pneumonia LOS: 3d		Rocco, MD 88 (322)366-4896			- 7	Add Plans
620 - 02	CSTLEARNING, DEMODELTA 80yrs M No Allergies Recorded	CSTLEARNING, DEMODELTA Age 80 years	Pneumonia IS: 3d		Rocco, MD ss (322)366-4896			-7 Scheduled/Unschedul	Add Plans
624 - 03	CSTLEARNING, DEMOBETA 80yrs M Allergies	DOB 01/01/1937 Sex M MRN 700008217 Encounter # 700000015060 Diet	eumonia IS: 3d		Rocco, MD 88 (322)366-4896			PRN/Contine Assessment	: 2 (1)
624 - 02	CSTLEARNING, DEMOALPHA 80yrs M No Known Allergies	Resuscitation Status	eumonia LOS: 3d		Rocco, MD ss (322)366-4896			0the	Red Blood Cell (RBC) Transfusion (Module) (Validated)
Activity Timeline	2								
Overdue		12:00 13:00	14:00	15:00	16:00	17:00 18		19:00	20:00 21:00 22:00

Notice there may be a **red [@]or orange [@] exclamation** icon next to the patient's name.

Note: WIndicates new non-critical results or orders for a patient requiring review.

Indicates new critical results or STAT/NOW orders requiring review.

1. Click the **Exclamation** icon.



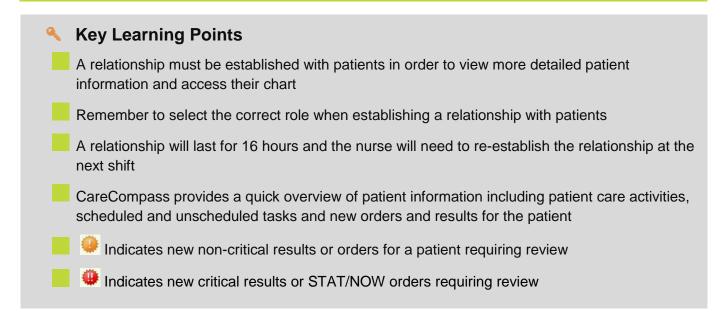
CareCompass					
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Patient List: Pa	tient list 🔽 🔀 List Maintenance 🚦 Add Patient 💰	Est	ablish Relationships		
Location			Visit	Care Te	am
624 - 04	CSTLEARNING, DEMOTHETA 80yrs M - No Allergies Recorded -		Pneumonia LOS: 3d		, Rocco, MD ss (322)366-4
620 - 02	CSTLEARNING, DEMODELTA 80yrs M No Allergies Recorded		Pneumonia LOS: 3d		, Rocco, MD ss (322)366-4
624 - 03	CSTLEARNING, DEMOBETA 80yrs M Allergies	Þ	Pneumonia LOS: 3d		, Rocco, MD ss (322)366-4
624 - 02			Its/Orders w results and orders.		, Rocco, MD ss (322)366-4

- 2. Review the list of new orders and results in the Items for Review window
- 3. Click **Mark as Reviewed** when done. This indicates that as the nurse looking after this patient, you are aware of the new orders that have been placed, or recent results that can now be reviewed.

🐛 100% 🗸 🜑 🜑 🖾				
Items for Review				z
CSTDEMO, ZEUS M 38yrs				IC06 - 01
Results No new results	Order	S	Ordered By	Entered By
	~	& Respiratory NAT Panel BCCDC Nasopharyngeal Swab, Routine, Unit co∥ec	Test User, Physician	Test User, Physici 18:00 Today
	~	Select All		
			3 Mark a	s Reviewed Cancel

4. Once you have marked the orders/results as reviewed, you are taken back to **CareCompass** and the red or orange exclamation icon will disappear.







Activity 3.3 – Review and Complete Tasks in CareCompass

Tasks are activities that need to be completed for the patient. Tasks are generated by certain orders or rules in the system and are displayed in a list format so clinicians are reminded to complete specific patient care activities. They are meant to supplement your current paper to-do list and highlight activities that are outside of regular care.

Note: Not all orders trigger tasks. For example, vital signs assessments are part of routine daily care and are not tasked. Sputum specimen collection however is not a regular occurrence and is tasked.

Let's locate tasks for your patient:

- 1. Ensure you are viewing **CareCompass**.
- 2. Scheduled tasks for multiple patients are summarized in the **Activity Timeline**. (You can click on the red or green shaded bars to view task details.)
- 3. Click the **grey forward arrow** to the right of your patient's name to open the single patient task list.
- 4. Review the tasks for your patient in the task box.

Task Edit View	Patient Chart Links Navigation Help							
	1 inical Leader Organizer 🛓 Patient List 🚨 Multi-Patient Task							
🔅 😋 CareConnect 🗯	CPHSA PACS 🐧 VCH and PHC PACS 🐧 MUSE 🐧 FormFast Wi	I 🝦 İ 📲 Exit 🎽 Ad	Hoc 🎟Medication Administration 🍰 PM Co	wersation 👻 🔄 Medical Record Request 👎	Add 👻 💽 Documents 🏥 Sci	heduling Appointment Book 🝙 Discern	Reporting Portal 🖕	
🕴 🙀 Patient Health E	ducation Materials 🔃 Policies and Guidelines 🕄 UpToDate 💡							
CSTLEARNING, D							CSTPRODOST, JU	STINE - Recent - Name -
CareCompass								Full screen 🛛 🗇 Print 🛛 🎝 4 hours 58 minutes
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Patient List: Lori	S 💌 💥 List Maintenance 💠 Add Patient 💰 Establish	Relationships						۵۰ و
Location	Patient		CSTPRODOST, JUSTINE	Age: 26yrs	Sex: F	DOB: 01/19/1991	MRN: 700002377	Encounter #: 0
-	CSTPROD, CHECK EMPI 17yrs F No Allergies Recorded			us Plans of Care Patient Information				10000000000
PACU 1 - 27	CSTPRODOST, JUSTINE 26yrs F No Known Alergies	¢	Current	4 Hours 12 Hours				
			Urinalysis Macroscopic (dipstick) with	h Microscopic Nurse Collect Urine, Routin	ne, Unit collect, Collection: 201	7-May-10 10:56 PDT, once		
619 - 01	9m 2w F	3	Unscheduled					
	No Known Allergies		Medication History					
301 - 01M	LINESTUBESDRAINS, MAX		18:00 (No Activities)					
	32yrs M Allergies		Interdisciplinary (No Activities)					
Activity Timeline								
								Done Not Done Document
Overdue	17:00 18:00	19:00 2	l					4



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

To see different information you can navigate between:

- 1. Scheduled/Unscheduled tasks tab
- 2. **PRN/Continuous** tab
- 3. Plans of Care tab
- 4. Patient Information tab

			stboard 🏭 Staff Assignment 🎬 LearningLNE 💡 		
CSTLEARNING, I				EARNING, DEMODELTA 🔹 🌇 Recent 🔹 Na	ame • 0
CareCompass				(C) Full screen 👘 Print	it 🛛 🥭 10 minutes ag
ADIADI	a, a, 100% - 🔿 🔿 🖄				
Patient List: Pra		List Maintenance 🛛 💠 Add Patient	Establish Relationships		93 0
÷	Patient		CSTLEARNING, DEMODELTA Age: 80vrs Sec: M D08: 01/01/1937 M811:700	Encounter #:	0
Location 620 - 02	Source Stream Stre Stream Stream Stre	<	Concerning Deproduction Age Bays Concerning Concernin	008217 7000000015060	
624 - 02	CSTLEARNING, DEMOALPHA 80yrs M - No Known Allergies		Current		1
624 - 03	CSTLEARNING, DEMOBETA 80yrs M Allergies	٥	Commett Order entre 4 secondary to ngaleert admission. Admission History Adult 17-kilov-2017 14-28 PGT. Biop: 17-kilov-2017 14-28 PGT. Commet: Order entre 4 secondary to ngaleert admission.		
624 - 04	CSTLEARNING, DEMOTHETA 80yrs M Allergies -		Braden Assessment 17:40:007 H 128 PDI, 1000 17:400:2017 H 128 PDI Commant: Order entred association to inputerial admission. Methodison Diseas Screening 17:40:007 H 128 PDI T		
			Comment: Order entered secondary to inputient admission. Monser fail fittes Assessment Mone Fail fittes Could in 174ev/2017 1428 PST, (Stop: 174ev/2017 1428 PST, Comment: Order entered secondary to inputient admission.		
			Unscheduled		
			🔂 Valuables and Belongings		
			Admission Discharge Outcomes Assessment		
			15:00 (No Activities)		
			Interdisciplinary (No Activities)		
Activity Timeline					
				Done Not Done	e Document
Overdue	14:00	15:00 16:00		Done	roodment

Note: When a patient is admitted, the Clinical Information System automatically generates multiple admission tasks. These tasks are tailored to the patient's age and location. **Basic Admission Information Adult** is one of these tasks. If you were admitting a pediatric patient the admission task would appear as **Basic Admission Information Pediatric.**



Complete the Basic Admission Information Adult task:

- 5. Select Basic Admission Information Adult
- 6. Click **Document**

					[□] Full screen	г 🕹 10 m	ninutes ag
😵 Establish Relationships						93	0
CSTLEARNING, DEMODELTA	Age: 80yrs	Sex: M	DOB: 01/01/1937	MRN: 700008217	Encounter #: 7000000015060		8
Scheduled/Unscheduled PRN/Continuous	Plans of Care Patient Information	n					
🖌 🗄 🖹 🗹 🛛 2 Hours	4 Hours 12 Hours						
Current							*
Basic Admission Information Adult Basic Comment: Order entered secondary to		14:28 PST, Stop: 17-Nov-2017	^{7 14:28 PST} 5				
Admission History Adult 17-Nov-2017 14 Comment: Order entered secondary to		r					
Braden Assessment 17-Nov-2017 14:28 Comment: Order entered secondary to							
Infectious Disease Screening 17-Nov-20 Comment: Order entered secondary to							
Morse Fall Risk Assessment Morse Fall Comment: Order entered secondary to		op: 17-Nov-2017 14:28 PST					
Unscheduled							
Valuables and Belongings							
Admission Discharge Outcomes Assess	sment						
15:00 (No Activities)							
Interdisciplinary (No Activities)							
						0	*
					Done Not Don	6 Docu	ment

Note: If a task is associated with documentation, clicking **Document** takes you directly to the appropriate documentation within the patient's chart. **Basic Admission Information** is documented using a PowerForm (a standardized electronic documentation form). Clicking **Document** takes you directly to the form.



3 Once you click **Document**, the **Basic Admission Information** PowerForm opens. This form is used to document a patient's allergies, weight, and to review and document home medications.

Note: Patient information that stays relatively static may be pre-populated throughout the chart if it was previously entered by another clinician. In this case, allergies and weight are pre-populated as they were entered while the patient was in ED.

To complete this PowerForm:

- 1. Review any allergies and select Mark All as Reviewed.
- 2. Select Weight and review the previously documented weight of 70 kg.

P Basic Admission In	nformation - CSTLEARNING, DEMODELTA		
🖌 🖬 🚫 🔌 🕅	🛧 🕂 📾 🖾 🖻		
*Performed on: 20-1	-Nov-2017 💌 🕇 1537 👘 PST		By: TestUser, Nurse
Medication Histor	Allergies		*
1	Mark All as Reviewed Add Modify O No Known Allergies	No Known Medication Allergies Reverse Allergy Check Display All	
	D/A Substance	Category Severity Reactions Interaction Comments Source Reaction Status	
	No Known Allergies	Drug Active	
	٠ [,	
•			In Progress





1. Select Medication History

- 2. Review current medications that are ordered for your patient.
- 3. Click the **green checkmark** ✓ to sign your documentation and **Refresh** icon ^{SSI} to refresh the page. After signing the **PowerForm**, you will be brought back to **CareCompass**. Completing this documentation has removed the **Basic Admission Information Adult** task from the patient's task list.

Basic Admission Information - CSTLEARNING, DEMOBETA		
🔽 🖬 🛇 🕱 🗖 🛧 🔸 🎟 🛅 🖻		
3 formed on: 29-Nov-2017 💌 🔽 1532 🗼 PST		By: TestORD, Nurse
Allergies Medication History		·
* Weight		
Medication Histon 1		📑 Print 💸 0 minutes ago
🕂 Add 🖓 Document Medication by Hx Recor		Reconciliation Status Meds History Admission Discharge
View	Displayed: All Active Orders All Inactive Orders All Active Medications	All Inactive Medications 24 Hrs Back* Show More Orders
Orders for Signature	🔊 🕅 Order Name Status 🔺	Dose Details
Admit/Transfer/Discharge	⊿ Medications	
- Status	Vancomycin Ordered	1,000 mg, IV, q12h, start: 29-Nov-2017 15:29 PST
Patient Care	HYDROmorphone Ordered (HYDROmorphone P	dose range: 0.1 to 0.5 mg, IV, q4h, PRN pain, drug form: inj, start: 29-Nov-2 DILAUDID EQUIV
- Activity	🗹 🍘 acetaminophen Ordered	650 mg, PO, g4h, drug form: tab, start: 29-Nov-2017 15:24 PST
Diet/Nutrition Continuous Infusions	(TYLENOL)	Maximum acetaminophen 4 g/24 h from all sources
Medications		=
Blood Products		
- Laboratory		
- Diagnostic Tests		
- Procedures Respiratory		
Allied Health		
Consults/Referrals		
- Communication Orders		
- Supplies		
Non Categorized		
Medication History Medication History Snapshot		
Reconciliation History		
	2	
•	m	In Progress

Note: An accurate and comprehensive medication history is needed before medication reconciliation can be completed by the provider. This is known as the Best Possible Medication History (BPMH). For patients admitted from the ED, a pharmacy technician will complete the BPMH where possible. Where a pharmacy tech is unable to do so, the BPMH may need to be completed by the admitting nurse. Please refer to the BPMH Quick Reference Guide (QRG) for detailed instructions on how to complete this when necessary.

Information documented in the BPMH pulls forward into the Admission Medication Reconciliation that the provider will complete.



5 Let's complete another admission task for your adult patient.

Complete the Morse Fall Risk Assessment task:

Note: For Pediatric Patients, the **Humpty Dumpty Fall Risk Assessment** will be tasked on admission.

- 1. Select Morse Fall Risk Assessment
- 2. Click Document

CareCompass									(D) Full screen 🛛 📋 Print	∂ 32 mi	inutes ago
	🔍 🔍 100% 🛛 🔹 💧										
Patient List: Pra	tice List **	💌 💥 List M	Maintenance 🛛 💠 Add I	Patient 💰 Establish Relationships						@ 0	0
_ Location	Patient			CSTLEARNING, DEMODELTA	Age: 80yrs	Sex: M	DOB: 01/01/1937	MRN: 700008217	Encounter #: 7000000015060		8
620 - 02	CSTLEARNING, DEMODE 80yrs M – No Known Allergies –	ELTA		Scheduled/Unscheduled PRN/Continuo	4 Hours 12 Hours	Information			,		
624 - 02	CSTLEARNING, DEMOAL 80yrs M Allergies	PHA		Current	14:28 PST, Stop: 17-Nov-2017	1428 PST					*
624 - 03	CSTLEARNING, DEMOBE 80yrs M Allergies	TA		Comment: Order entered secondar Braden Assessment 17-Nov-2017 14 Comment: Order entered secondar	:28 PST, Stop: 17-Nov-2017 14:	28 PST					
624 - 04	CSTLEARNING, DEMOTH 80yrs M Allergies	IETA		Infectious Disease Screening 17-Nov Comment: Order entered secondar							
				Morse Fall Risk Assessment Morse F Comment: Order entered secondar		28 PST, Stop: 17-Nov-2017 14-28 PST		1			
				Unscheduled							
				Valuables and Belongings							
				Admission Discharge Outcomes Ass	essment						
				10:00 (No Activities)							
				Interdisciplinary (No Activities)							
Activity Timeline	_										
									Done Not Dor	2 Docum	nent
Overdue	09:00	10:00	11:00								_

Note: Clicking Document for Morse Fall Risk Assessment takes you directly to Interactive View and I&O to complete the appropriate documentation. Interactive View and I&O provides access to a variety of electronic flowsheets for documenting patient care, assessments, vital signs and intake/output.

Clicking **Document** takes you into the patient chart and to the appropriate documentation section.

1. Double-click the blue box next to the section name **Morse Fall Score**. The entire section is now active for documentation, allowing you to move through the cells by pressing Enter on the keyboard after entering a value.

Document using the following data:

- History of Fall in Last 3 Months Morse = Yes
- **Type of Fall Morse** = Unanticipated physiological
- Activity at Time of Fall Morse = Dressing/undressing
- Secondary Diagnosis Morse = Yes
- Use of Ambulatory Aid Morse = Crutches, cane, walker
- IV or IV Lock = No

6



- Gait Weak or Impaired Fall Risk Morse = Weak
- Mental Status Fall Risk Morse = Oriented to own ability

A **Morse Fall Risk Score** is automatically calculated based on information input during documentation. Note for this activity the calculated score is **65.** A score >45 means the patient is at high risk for falls. A **Falls Risk** alert should be placed on the patient's chart which will be covered in Acitivity 5.2.

2. Click the **green checkmark** \checkmark to sign your documentation. You will notice that your documentation changes from purple text to black text. This means it is now recorded in the patient chart.

Ad	ult Quick view		
Ad	ult Systems Assessment		
	NEUROLOGICAL	Find Item 👻 🕅 Critical	High Low Abnormal Unau
	Morse Fall Scale		
	Fall Prevention Interventions	Result	Comments Flag Date
	Post Fall Evaluation		
	Pupils Assessment		
	Glasgow Coma Assessment	14 H	29-Nov-2017 28-Nov-2017
	CIWA-Ar	R 🗹 🗗	17:45 PST 18:17 PST 18:13 PST
	Neurovascular Check	Morse Fall Scale	
	Neuromuscular/Extremities Assessment	History of Fall in Last 3 Months	Yes
	CARDIOVASCULAR		Unanticipat
	Cardiac Rhythm Analysis	Activity at Time of Fail	Activity at Time of Fall
	Pulses	Secondary Diagnosis	Ambulating
	Edema Assessment	Use of Ambulatory Aid	Bathing
	Pacemaker	IV or IV Lock	Dressing/undressing
1	RESPIRATORY	Gait	Fall from arms
	Breath Sounds Assessment	Mental Status	Fall from bed
	Mobilization of Secretions	Morse Fall Score	Fall from chair
	Ventilation Assessment	⊿ Fall Prevention Interventions	Fall from commode
	VAP Bundle	Fall Intervention - Mobility	Fall from play device
	Ventilation	Fall Prevention - Environment	Fall from Rehab Therapy device
	GASTROINTESTINAL	Fall Prevention - Elimination	Fall from stretcher/exam table
	GENITOURINARY	Manage Sensory Impairment	Transferring
	INTEGUMENTARY	⊿ RESPIRATORY	Undergoing diagnostic procedure
	Braden Assessment	Respiratory Symptoms Reported	Unknown

Note: When text appears in blue it means there is a hyperlink attached. Clicking on the hyperlink opens a window that provides additional information to clarify or support documentation decisions.

7 Let's complete one final task. You have collected a urine sample from your patient.

- 1. Navigate back to **CareCompass** by clicking in the Toolbar
- 2. Open the single patient task list by clicking **grey forward arrow** to the right of your patient's name
- 3. Select Urine Culture (Urine C&S)
- 4. Click Done. A Nurse Collect box appears. Review the information and click OK.



P N	lurse Collect (Chart Done) - CSTL	LEARNING, DEMOALPHA	
	e/Time: 15-Feb-2018	▼ 1041 ► PST	
Perf	ormed by: TestUser, Nurse		
		OK Cancel	
PACS CForm		ion 🔹 🚽 Communicate 🖌 🔄 Medical Record Request 💠 Add 🔹 📆 Documents 👼 Scheduling Appointment Book 🔓 Discern Reporting Portal 🚊	
CSTLEARNING, CareCompass	DEMODELTA .	CSTIEARANA DIMODELTA + 🐚 Provent + Official screent →	Name • Q
A 8 4 8			
Patient List: Pra	atice List **		99
Location	Patient	CSTLEARNING, DEMODELTA Age:80yrs Sex:N DOI:01/01/1937 MRI: 700008217 Encounter #: 700008217 700008217	0
624 - 02	CSTLEARNING, DEMOALPHA 80yrs M	Scheduled/Unscheduled PPEN/Continuous Plans of Care Patient Information	
	Allergies	2 Hours 4 Hours 12 Hours	
624 - 03	CSTLEARNING, DEMOBETA 80vrs M -		191
	Allergies -	2 Admission History Adult 17-Nov-2017 14-28 PST, Stop: 17-Hov-2017 14-28 PST	
620 - 02	CSTLEARNING, DEMODELTA 80yrs IM - No Known Alergies -	Commet: Oxfore effeted secondary to inpatient admission.	
624 - 04	CSTLEARNING, DEMOTHETA	Infectious Disease Screening 17-Nov-2017 14:28 PST	
	80yrs M - Alergies -	Commet: Order entered secondary to ingatient admission. Insert Perghenal IV Cathered 22-Nov-2017 11 UD PS17, into dansky inserted Inserted Into dansky needs.	
		Commert Examum actaminapher 4/24 h from all sources	
		Mone Calaver (Mine CAS) Nurse Collect Unite (specify site), Routine, Unit Collect, Collection: 22-Nov-2017;17:05 PST, unce Comment: SPECIAL: COLLECTION RECURRENTS: Please refer to specific site Laboratory Test Nanual.	
		Unscheduled	
		Valuables and Belongings	1
		Admission Discharge Outcomes Assessment 1600	
		Acetaminophen 550 mg, PO, drug form: tab, start 22-Nov-2017 18:00 PST	
		Comment: Maximum acetaminophen 4 g/24 h from all sources	
		Interdisciplinary IP Consult to Pharmacy Consult to Pharmacy 22-Nov-2017 11:00 PST, Reason for Consult. Other per Details, Discontinue all previous anticoagulants when heparin infusion is initiated. Heparin Infusion Standard (M	
		IP Consult to Pharmacy Consult by Pharmacy 22-Nov2017 11:00 PST, Reason for Consult Other per Details, Discontinue all previous anticologulants when heparin infusion is initiated, Heparin Infusion Standard (In Instruction, Discontinue all previous anticologulants when heparin infusion is initiated	(
Actury Treelne		4 Done Not D	Done Document

Once you document the task as Done, it will no longer appear on the task list!

Note: For the purpose of this workbook, all additional Admission tasks will not be addressed. In your clinical setting these admission tasks will need to be completed. It is important to review CareCompass and patient task lists throughout your shift to ensure timely review of new orders, tasks and more.

Key Learning Points

- Tasks are electronic notifications that alert nurses to patient-related activities that require completion
- Tasks can be viewed and completed from CareCompass by clicking "Document" or "Done"
 - Completing a task will remove it from the patient task list
- CareCompass task lists should be reviewed frequently throughout the shift



PATIENT SCENARIO 4 – Access and Navigate the Patient Chart

Learning Objectives

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

- Access the patient's chart from CareCompass
 - Navigate the patient's chart to learn more about the patient

SCENARIO

In this scenario, we will review how to access the patient's chart and navigate the different parts of the chart to learn more about the patient.

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

Introduction to Banner Bar, Toolbar, and Menu

Introduction to Patient Summary



Activity 4.1 – Introduction to Banner Bar, Toolbar, and Menu

If you have completed Nursing Emergency workbook, you may skip over this activity

CareCompass									(D) Full	screen (🗒 Print 🛛 🎝 1 hours	s 30 minute
	🔍 🌯 100% 🔹 🌑 🖬 🕍											
Patient List: LG	H 6 East 🗹 🕅	List Maintenance	💠 Add Patient 🛛 🔹 E	Establish Relationships								31 🥝
Location	Patient		Vat.				Care Team	300 1050		Isolatio	Activities	
624 - 01	CSTPRODMI, LGH-SDX-EAST 60yrs F - No Allergies Recorde	d	Pain LOS: 4w 2d				-				0	
624 - 02	CSTLEARNING, DEMOALPHA 80yrs M No Known Allergies	0	Pneumonia LOS: 1hrs				Plisvca, Rocco, Business (322)				9	
624 - 03	CSTLEARNING, DEMOBETA 80yrs M - Allergies	0	Pneumonia LOS: 1hrs				Plisvca, Rocco, Business (322)				=13 PRN/Continuous	
624 - 04	CSTLEARNING, DEMOTHETA 80yrs M - No Allergies Recorde	d	Pneumonia LOS: 1hrs				Plisvca, Rocco, Business (322)				7	
628 - 01	CSTLABNEWBORN, UTNEONATE 10m 2w M No Allergies Recor	ded	testing LOS: 9m 3w				Plisvcm, Gerard Business (290)				12	
630 - 02	CSTPRODGOSLING, SNRYAN 40yrs M Attempt CPR, Full Code Al	lergies	STUFF LOS: 2m 3w				Plisvcc, Trevor, Business (399)				= 2	
6EL - 01	CSTLEARNINGDEMO, TEAMQR 45yrs U 5-No CPR, Critical Care, May	Intu Allergies	Stuff LOS: 24d				Plisvcb, Stuart, Business (261)				PRN/Continuous	= 32
6EL - 03	CSTPRODREG, CMTESTQUICK J/ 51yrs F No Allergies Recorder		idk LOS: 22d				Caulton, NOLD	AP, Greg			0	
6EL - 05	CSTPRODBUCKET, SNLIST		STUFF					eralMedicine-Physician1	AMB, MD		2	24
Activity Timeline												
Overdue	15:00 16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	00:00		01:00	02:00

From CareCompass, click on patient's name to access the patient chart.

2

1

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

- 1. The **Toolbar** is located above the patient's chart and it contains buttons that allow you to access various tools within the Clinical Informatics System.
- 2. The **Banner Bar** displays patient demographics and important information that is visible to anyone accessing the patient's chart. Information displayed includes:
 - Name
 - Allergies
 - Age, date of birth, etc.
 - Encounter type and number
 - Code status
 - Weight
 - Process, disease and isolation alerts
 - Location of patient
 - Attending Physician
- The Menu on the left allows access to different sections of the patient chart. This is similar to the coloured dividers within a paper-based patient chart. Examples of sections include Orders, Medication Administration Record (MAR) and more.



4. The **Refresh** icon refresh the patient chart when clicked. It is important to refresh the chart frequently especially as other clinicians may be accessing and documenting in the patient chart simultaneously.

Note: The chart does not automatically get updated until you click the Refresh icon 2.

CSTLEARNING, DEMOTHETA - 7000	08216 Opened by TestUser, Nurse										ė 🗙
Task Edit View Patient Chart										_	
🌇 CareCompass 👫 Clinical Leader C	Organizer 🛓 Patient List 🔐 Multi-Patie	ent Task List 🎬 Discharge Dashboard	d 🞎 Staff Assignm	ent 🌇 LearningLIVE 🝦							
😋 PACS 😋 FormFast WFI 🝦 🛣 Te	ear Off 🗐 Exit 🍟 AdHoc 💵 Medicati	ion Administration 🔒 PM Conversat	ion 👻 🕌 Commun	icate 👻 🔝 Medical Reco	rd Request 🔸 Add 👻	🕞 Doo	cuments Bcheduling Appoin	tment Book 🥃 Discern Reporting I	ortal 👳		
CSTLEARNING, DEMOTHETA									Recent 👻 N	lame	- Q
CSTLEARNING, DEMOTHETA								Location:LGH			
Allergies: Allergies Not Recorded	Age:80 years Gender:Male	Enc:700000015058 PHN:9876469824	Dosing Wt:			sease: plation:		Enc Type:Inpatie Attending:Plisvo		2	
Menu 9	🔍 👻 🕇 🚹 Patient Summa	ry						(D) F	ull screen 🛛 🖨 P	int 🛛 🏖 0 mir	inutes ago
Patient Summary	A 100%	-1004									4
Orders 🕂 Add	Handoff Tool	Summary	11	Assessment	54	Discha	arno	× +		D 0	
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MAR	Informal Team	Informal Team Comm	unication							2	-
Interactive View and I&O	Communication	Informal ream comm	unication			_				~	- 11
Results Review	Active Issues	Add new action					Add new comment				=
Documentation 🛛 🕂 Add	Allergies (0)										
Medication Request	Vital Signs and Measurements	No actions documented					No comments documented				
Histories	Documents (0)	All Teams					All Teams				
Allergies 🕂 Add	Transfer/Transport/Accompan iment										
Diagnoses and Problems	Assessments								1.	I Visits [🖓 🗐	
	Lines/Tubes/Drains	Active Issues						Classification: Medical and Patie	nt Stated 🔻 🛛 A	li Visits 🕊 =	
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Form Browser	Imaging	No results found									
Growth Chart	Medications										
Immunizations	Home Medications										
Lines/Tubes/Drains Summary	Orders	Allergies (0)							A	ll Visits ∂ =	
MAR Summary	Oxygenation and	3 Allergies not recorded.	Add on olloray								
Medication List 🕂 Add	Ventilation	W Allergies not recorded.	add an allergy.								-
Patient Information	Pathology										
Reference 3	Histories	No results found						Reconciliation Status: Incomple	e Complete F	econciliation	a I
	Create Note							reconciliation status, meomple	C Complete A	concilation	-
<	Create Note										-

Note: The Clinical Information System (CIS) will allow you to have up to two patient charts open at a time

🔦 Key learning Points

The Toolbar is used to access various tools within the Clinical Information System (CIS)

The Banner Bar displays patient demographics and important information

The Menu contains sections of the chart similar to your current paper chart

The patient chart should be refreshed regularly to view the most up-to-date information



Activity 4.2 – Introduction to Patient Summary

If you have completed Nursing Emergency workbook, you may skip over this activity

- When the patient's chart is first opened, you will see the **Patient Summary** page. The **Patient Summary** summarizes key clinical patient information, orders, medications, lab results, and so on. This will be the place in the chart that is accessed during handover for nurses to review critical patient information.
 - There are different tabs including Handoff Tool, Summary, Assessment, Discharge and Quick Orders that can be used to learn more about the patient. Click on the different tabs to see an overview of the patient.

Note: The **Quick Orders** tab can be used to enter orders for the patient. Order entry will be covered later on in this book.

- 2. Each tab has different components of information. You can use the scroll bar on the right hand side to look at all the components on the page.
- 3. The **Handoff Tool** tab has a list of the components on the left hand side. You can click on any item in this list and it will bring you to that component rather than using the scroll bar on the far right of the screen.

Task Edit View Patient C	hart Links Navig	gation Help									
👫 CareCompass 👫 Clinical Le	ader Organizer 🛉 F	Patient List 🚨	Multi-Patient Task List Track	king Shell 📁 Case Sele	ction 🍇 Staff Assignment	÷ 🕄	CareConnect 🔇	PHSA PACS 🔇	VCH and PHC	PACS 🔍 MUSE 🄇	🕽 FormFast WFI 🍦
🖾 Tear Off 🗐 Exit 🏙 AdHoc 🛚	Medication Adm	inistration 🗎	Medical Record Request 👒	Result Copy 💁 Related	i Records 🕂 Add 👻 🖻 Docu	iments 🗎 Schedu	ling Appointme	ent Book 🗃 Disc	ern Reporting I	Portal Convers	ation Launcher 🍟
Realth Education Ma	aterials 🕄 SHOP Gu	idelines and [OSTs 🕄 UpToDate 🝦								
CSTCD, QUEENSYLVIA 🛛 🛛									← List →	🕮 Recent 📲 Nar	me • ९
CSTCD, QUEENSYLVIA		B:17-Oct-1977 e:40 years	MRN:700002071 Enc:7000000011916			Process:Violence F Disease:			Location:LGH C Enc Type:Outpat		
Allergies: Hamsters, Peanuts, Spic			PHN:9878190923	Dosing Wt:47 kg		Isolation:			Attending:		
Menu 9	K > - 🔥 P	atient Summar	y						(므) Full scre	en 🗇 Print 💰	🎗 11 minutes ago
Patient Summary ^		₹ 100%									
Women's Health Overview Orders + Ad	Handoff Tool	22		X Assessment	23 Discharge	22	Quick Orders		8		Q =-
Single Patient Task List									1		· =•
MAR	Informal Team Communication	<u>^</u>	Informal Team Comm	nunication							e =- 🛆
MAR Summary	Active Issues		Add new action			Add new	commont				
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Results Review	Vital Signs and		No actions documented			No comm	ents documented				2
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Diagnoses and Problems	Lines/Tubes/Drains					Add new as:	This Visit 👻 🤉				
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CareConnect	Micro Cultures		Pregnant			Medica	1	This Visit	Chronic		
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Immunizations	Orders Oxygenation and										
Lines/Tubes/Drains Summ 🗸	Ventilation	\sim	3			v					\sim
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Note: When looking after a maternity patient you will use the **Women's Health Overview** page instead of the **Patient Summary** page. This will be covered in the OB workbook.





- Patient Summary provides a summary of critical patient information that can be utilized during handover for medical/surgical patients
- Clicking on the tabs within the Patient Summary (such as Handoff Tool, Summary, Assessment, Discharge, and Quick Orders) will provide an extensive overview of the patient's status
- Using the scroll bar will allow you to view all of the components within each tab



PATIENT SCENARIO 5 – Patient Management Conversation (PM Conversation) and Conversation Launcher

Learning Objectives

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

- Print Specimen Labels in PM Conversation
- Understand and add Process Alerts in PM Conversation
- Bed Transfer

SCENARIO

Patient labels and patient specimen labels will print on admission, but throughout your shift you may need to reprint some of these labels. As a nurse, it is also important to know how to add a process alert, record patient transfers and discharge a patient in the CIS.

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

- Print specimen labels using PM Conversation
- Add a process alert using PM Conversation
- Transfer a patient to a different bed



b Activity 5.1 – Printing Printing Specimen Labels in PM Conversation

1 The following steps show you how to print specimen labels using PM Conversation.

Note: Please read the following steps only. Do not do this in the system as a means of saving paper/labels.

1. With your patient's chart already opened, click on the **downward arrow** to the right

of PM Conversation in the toolbar

2. Select the **Print Specimen Labels** conversation

📲 🖺 CareCompass 👫 Clinical Leader Organizer 🛔 Patient List 🚨 Multi-Patient Task L	ist T	racking Shell 💯 Case Selection 🏼	Staff Assignment	🙄 🕄 🕄 CareConnect 🕄 PHSA PAC	S 🔍 VCH and PHC PACS 🔍 N	/USE 💐 FormFast WFI 🍦
🖾 Tear Off 🐠 Exit 🎬 AdHoc 🎟 Medication Administration 🖹 Medical Record Reg	uest	🗟 Result Copy 🛃 Related Record	ds 🛨 Add 👻 🖻 Documents	🛱 Scheduling Appointment Book 🖨	Discern Reporting Portal 🥮	Conversation Launcher 🍹
🛱 Patient Health Education Materials 💐 SHOP Guidelines and DSTs 💐 UpToDate	۵.	PM Conversation - 1				
		Print Specimen Labels	2			
		Process Alert	_			

3. A Print Specimen Labels window will open up with patient specific data pre-filled

1	[Print Specimen Labels	3	_ 🗆 🛛	
Medical Record Number: 700002368	Encounter Number: 700000200389	Last Name: CSTCD	First Name: QUEENSYLVIAZERO	Middle Name:	^
Preferred Name:	Previous Last Name:	Date of Birth: 14-Jan-1977	Age: 41Y	Gender: Female	
BC PHN: 9878174753					
Facility:	Building: LGH Lions Gate V	Unit/Clinic:	Room: 408 ✓	Bed: 01	
 Current Encounter Information - Encounter Type: Inpatient 					
				OK 4 Cancel	~
Ready			P0783 TEST.N	URSE 26-Jan-2018 10:14	

4. Review the patient specific data and click **OK**

2. Collect your labels at the corresponding label printer on your unit

Key Learning Points

Using PM Conversation allows you to print specimen labels which contain patient specific information



Activity 5.2 – Adding a Process Alert in PM Conversation

If you have completed Nursing Emergency workbook, you may skip over this activity

Process Alerts are alerts about patient information that should be quickly conveyed to care providers to prevent critical physical or mental harm to the patient or care providers.

The purpose of **process alerts** is to quickly provide the user significant "face up" information about the patient. These alerts can appear in multiple areas of the chart including the banner bar, CareCompass, Summary Pages, and Tracking Boards.

Examples of these alerts include:

- Communication Barrier
- Cytotoxic

1

- Difficult Intubation/Airway
- Falls Risk
- Family Development
- Gender Sensitivity
- No ceiling lift
- On Research Study
- Palliative Flag
- Seizure Precautions
- Special Care Plan
- Violence Risk
- Visitor Restrictions

In Activity 3.3, you documented your patient's Morse Fall Score as 65 which puts him at high risk for falls. You need to place a process alert for Falls Risk on his chart.

Follow steps below to add process alert to your patient's chart using PM Conversation:

- 1. Click the drop-down arrow to the right of **PM Conversation** button ^{A PM Conversation} in the toolbar
- 2. Select Process Alert from the drop down menu



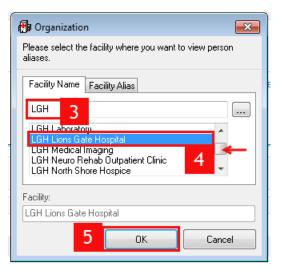
CSTLEARNING, DEMOALPHA - 700008214 O	pened by TestUser, Nu	rse						
Task Edit View Patient Chart Links	Navigation Help							
📲 CareCompass 📲 Clinical Leader Organizer	🛓 Patient List 🚨 M	ulti-Patient Task List	Staff Assig	inment 🎬 LearningLIVE 🖕	🕄 Care	Connect 🜊 PHSA PACS	🕄 VCH and PHC PA	cs 🕰 Muse
🔀 Tear Off 📲 Exit र AdHoc 💵 Medication	n Administration 🚨 P	M Conversation -	al Rec	ord Request 🕂 Add 👻 🕞 Do	ocument	s 🛗 Scheduling Appointr	ment Book 🥃 Discen	n Reporting Po
CSTLEARNING, DEMOALPHA 🛛 🗷		Bed Transfer						
CSTLEARNING, DEMOALPHA		Cancel Discharge		MRN:700008214		Code Status:1-No CPR,	Supportive Care, N	o Intubation
		Cancel Pending Dischar	ge	Enc:700000015055				
Allergies: Pollen, Bees/Stinging Insects		Cancel Pending Transfe	r	PHN:9876469856		Dosing Wt:		
Menu 7	< > - 1	Cancel Transfer						
Patient Summary		Discharge Encounter						
Orders 🕂 Add	Handoff Tool	Facility Transfer		70	X	Assessment	×	Quick Orders
Single Patient Task List		Leave of Absence		ye.	~	Absessment	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	Quick Orders
MAR	Informal Team	Modify Discharge						
MAR Summary	Active Issues	Pending Discharge		Team Communication	on			
,		Pending Facility Transfe		4				
Interactive View and I&O	Allergies (2)	Pending Transfer		tion				
Results Review	Vital Signs and	Print Specimen Labels		_				
Documentation 🕂 Add	Documents (6	Process Alert	_ 2	mily will come visit this ev	vening			
Medication Request	Transfer/Trans	Update Patient Informat	ion	althCareWorker-MH 14/12/1	17 14:47			
Histories	ent (0)	View Encounter						
Allergies 🕂 Add	Assessments (View Person						Show (
Diagnoses and Problems	Lines/Tubes/Drains							
	Intake and Output	Act	ive Iss	ues				

The Organization window will display to select a location.

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

Note: Alternatively, you may type **LGH** and click on the **Search** icon — to look for the full name of the facility by scrolling down.

- 4. Select LGH Lions Gate Hospital
- 5. Click OK





2 The **Process Alert** window displays. To activate the **Falls Risk** process alert on the patient's chart:

- 1. Click into the empty **Process Alert** box. A list of available alerts that can be applied to the patient will display. (The box will turn green when you click into it).
- 2. Select Falls Risk
- 3. Click Move. The alert will now display within the To Selected box
- 4. Click Complete

Note: Multiple alerts can be activated at once. Alerts can be removed using the same process. Site policies and practices should be followed with regards to adding and removing alerts.

٩		Process Alert		_ 🗆 🗡
Medical Record Number: 700002368	Encounter Number:	Last Name: CSTCD	First Name: QUEENSYLVIAZERO	Middle Name:
Preferred Name:	Previous Last Name:	Date of Birth: 14-Jan-1977	Age: 41Y	Gender: Female
BC PHN: 9878174753				
ALERTS Process Alert:				
From Available: Communication Barrier Cytotoxic Difficult Intubation/Airway Falls Risk 2 Famly Development Gender Sensitivity	To Move > 3 Select All	Selected:		
,				Complete 4 Cancel
Ready			P0783 TEST.NU	RSE 26-Jan-2018 16:16 🦼

1. Click **Refresh** icon **N** to update the chart

3

2. Once complete, the **Falls Risk** process alert will appear within the banner bar of the chart where it is visible to all those who access the patient's chart.

CSTCD, QUEENSYLVIAZERO 🛛					← List → @Recent • Name • ९
CSTCD, QUEENSYLVIAZERO	DOB:14-Jan-1977	MRN:700002368	Code Status:	Process:Falls Risk 2	Location:LGH 4E; 408; 01
	Age:41 years	Enc:7000000200389			Enc Type:Inpatient
Allergies: Adhesive Bandage, penicillin	Gender:Female	PHN:9878174753	Dosing Wt:52.1 kg	Isolation:	Attending:Plisvcb, Stuart, MD
Menu 🔍 🧹 💎	🔒 🔒 Patient Summary				🗇 Full screen 👘 Р 👖 🍣 0 minutes ago

Congratulations! You just activated a Falls Risk process alert on your patient's chart!

Note: Similar steps can be taken in PM Conversation to remove a process alert.



Key Learning Points

- Using PM Conversation allows you to print specimen labels which contain patient specific information
- A Process Alerts indicates "face up" critical information about a patient that can help to prevent physical or mental harm to the patient or care providers
- A process alert can be activated or removed using PM conversation



Activity 5.3 – Conversation Launcher –Bed Transfers and Update Patient Information

Conversation Launcher Conversation Launcher is used to enter Bed Transfers, Facility Transfer, Discharge Encounter, or Quick Register a patient in the CIS.

Let's say you receive notification that a patient is being transferred from the ED to your inpatient unit and there is no unit clerk available to enter the bed transfer for you. You've been given the patient's demographics (name, DOB and MRN).

You will need to locate the patient in ED bed using **Conversation Launcher**. This is located in the **toolbar**.

1. Click Conversation Launcher from the toolbar.

Task Edit View Patient C	hart Links Navigation Hel	р			
🎬 CareCompass 👫 Clinical Lea	ider Organizer 🛔 Patient List 🕯	Multi-Patient Task List Trac	:king Shell 🛱 Case Selection 🗯 Staff Assignmer	nt 💡 🕄 🕄 CareConnect 🔍	PHSA PACS 🖏 VCH and PHC PACS 🖏 MUSE 💐 FormFast WFI
🖾 Tear Off 🗐 Exit 🎽 AdHoc 🗉	Medication Administration	🕯 Medical Record Request 🍯	Result Copy 🌄 Related Records 🕇 Add 👻 🗐 D	ocuments 🗎 Scheduling Appointmen	t Book 🗃 Discern Reporting Porta 🗐 Conversation Launcher
🔾 Patient Health Education Ma	terials 🔍 SHOP Guidelines and	i DSTs 🕄 UpToDate 🝦			1
CSTCD, QUEENSYLVIA 🛛 🗷					← List → Mane - Q
CSTCD, QUEENSYLVIA	DOB:17-Oct-197 Age:40 years	7 MRN:700002071 Enc:7000000011916		e.28Process:Violence Risk Falls Risk Disease:	Location:LGH Cardiac Lab Enc Type:Outpatient
Allergies: Hamsters, Peanuts, Spid		PHN:9878190923	Dosing Wt:47 kg	Isolation:	Attending:
Menu ^a	< > , 👫 🛛 Patient Summa	ary			🛱 Full screen 👘 Print 📌 1 hours 26 minutes ago
Patient Summary ^	A 🗎 📥 🛋 🔍 100%	4			
Women's Health Overview		Summary	X Assessment X Discharge	🛛 Ouick Orders	x +
Orders + Ad Single Patient Task List					
MAR	Informal Team	Informal Team Comm	nunication		≳ =- ^
MAR Summary	Active Issues	Letter and			
Interactive View and I&O	Allergies (4)	Add new action		Add new comment	
Results Review	Vital Signs and	No actions documented		No comments documented	
Documentation 🕂 Ad	Measurements	All Teams		All Teams	
Notes 🕂 Ad	Documents (0) Transfer/Transport/Accompa				
Medication Request Histories	niment (0)				
Allergies + Ad	Assessments	Active Issues			Classification: Medical and Patient Stated 👻 All Visits 🍭 =-
Diagnoses and Problems	Lines/Tubes/Drains			Add new as: This Visit 👻 🍳	
Perioperative Doc	Intake and Output				
	Labs	Name Pregnant		Classification Medical	Actions This Visit Chronic
CareConnect	Micro Cultures	Historical		Medical	Show Previous Visits
Clinical Research	Diagnostics Current Medications	• historical			
Form Browser Growth Chart	Home Medications				
Immunizations	Orders	Allergies (4) 🕂			All Visits 🏖 🔤
Lines/Tubes/Drains Summ	Oxygenation and				
< >	Ventilation		La contra da contra d	· · · · · · · · ·	· · · ·

- 2. A Person Mgmt: Conversation Launcher window will open. Click Bed Transfer
- 3. Click OK

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9			Person Mgn	nt: Convers	ation Launch	ner		<mark>></mark>
S Add/Modify	Bed Transfer	X Cancel	Cancel	X Cancel	X Cancel	X Cancel	Discharge	Facility
Person	Modify	2 Newborn	Encounter	Pending Pending	Pendi Pending	Transfer	Encounter P re-Register	Transfer G Pre-Register
Absence	Discharge	Modify	Quick Reg		Facilit	Transfer	Outpatient	Patient To
Print Specimen Labels	Process Alert	Quick Reg	Referral Management	Register Outpatient	Register Patient To	Stillborn	Update Patient Information	View Encounter
View Person	WH Quick Reg							
						3	OK	Cancel

The Encounter Search window will open.

****Note**: You will not be able to complete the following steps in the classroom setting. Please only review the following steps and screenshots for your learning purposes.

- 4. At this point, you would search for the patient using three identifiers: the patient's first name, last name and DOB.
- 5. Click **Search.** All the patients that match your search criteria will be listed in the top half of the window, with their corresponding encounters in the bottom half of the window
- 6. Click on the name of the correct patient and verify MRN and DOB to ensure this is the correct patient.
- 7. A patient may have more than one encounter on their file. The correct **Inpatient** encounter *mus*t be selected. (In this case the encounter would be the active inpatient encounter in SGH Squamish Emergency)

Note: The Bed Transfer conversation only works for Inpatient encounter types

8. After clicking to select the correct patient and encounter, click OK.



V	IP Deceased	Alerts	BC PHN	MBN	Name		DOB	Age	Gender	Address	Address (2)	City	Postal/Zip Coo	ie Hom	ne Phone	Historical MRN
£	2		9876394958	700009077	CSTEDDEMC	, SGHCHESTPAIN	19-Feb-1979	38 Years	Male	123		surrey				
E 4																
~																
F	acility	Enco	unter# V	isit #	Enc Type	Med Service	Unit/C	inic Roor	n Be	d Est Arri	val Date Re	o Date	Disch	Date A	Attending P	rovider
I	SGH Squami	h 70000	00016919 7	00000001692		General Internal Me							7 18:12			YSTEM Cerner

- 1. The Bed Transfer window will open. Yellow fields are mandatory. Please enter:
 - Medical Service= General Internal Medicine
 - Unit/Clinic= SGH MS
 - Attending Provider= Plisvcl, Antonio (begin typing and it will auto-complete)
 - Acommodation Reason= Not Applicable
- 2. Click Bed Availability.

#				Be	d Transfer			_ 🗖 🛛
Medical Record Number: 700020359	Encounter Number: 7000000200710	Full Name: CSTTHIRTY, SITTHREE:	Date of Bith: 01-Jul-1966	Age: 51Y	Gender: Male	BC PHN: 9876320868		
- Current Encounter Information								
Encounter Type:	Medical Service:							
Emergency V	Emergency							
 Current Location Data —— 								
Facility:	Building:	Unit/Clinic:	Room:	Bed:	Accommodation:	Accommodation Reason: Patient Accom F	lequested	
SGH Squamish	SGH Squamish	SGH ED	AC	06		×		
- New Encounter Information -								
Encounter Type:	Medical Service:							
Emergency V	General Internal Medicine	1						
 New Location Data 								
Building:	Unit/Clinic:	7	Room:	Bed:	Accommodation:	Accommodation Reason:		
SGH Squamish 🗸 🗸	SGH MS	Bed Availability 2			V Not Applicable	v -		
 Current Physician Information 						1		
Attending Provider: Provider, Emergency	Admitting Provider:							
Transfer Information		N						
	Terrates Times	Bed Transfer User Name:						
Transfer Date:	Transfer Time:	TestUser, Rural-Nurse						
								mplete Cancel
Readv							P0783 TEST.NURSERURAL	01-Feb-2018 13:01

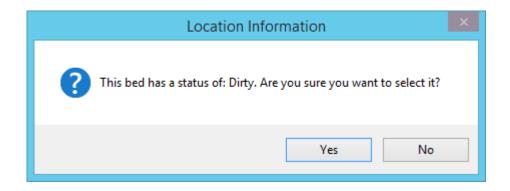


The **Bed Availability** window will open.

3. Select a bed that is either Available or Dirty. Click OK.

6	Bed Availability —									
Facility: S	GH Sq	uamish								
Building: S	SGH So	quamish								
Room	Bed	Nurse unit	Isolation	Person	Bed status	In	Out	Sex	Medical rec	1
📺 103	01	SGH MS		INFECTIONCONTROL, SECOND	Assigned			Female	700004946	
📺 103	02	SGH MS		TESTSQBB, FELICITY	Assigned			Female	700002625	
📺 105	01	SGH MS		CSTPRODEMPI, SGHSWAPBED	Assigned			Female	700004732	
📺 105	02	SGH MS		CSTRHOED-NONSURVIVOR, UNMERGE CANDY	Assigned			Female	700020356	
📺 106	01	SGH MS		INFECTIONCONTROL, THIRD	Assigned			Male	700004947	
📺 106	02	SGH MS			Dirty					
📺 107	01	SGH MS		CSTLABMEKOEMPI, UTWU	Assigned			Male	700001810	
📺 107	02	SGH MS								
📺 108	01	SGH MS		TESTSQBB, MICHAEL	Assigned			Male	700002627	
📺 109	01	SGH MS		CSTHRCM, TWENTY	Assigned			Female	700009019	
📺 110	01	SGH MS		CSTPRODMED, TEST-FOUR	Assigned			Male	700000511	
📺 111	01	SGH MS		TESTCSTSQ, TEN TEN	Assigned			Male	700003210	
<									>	
								_		_
							0	IK –	Cancel	

If you selected a bed that is listed as Dirty, you will get a **Location Information** window asking you to confirm the selection. Click **Yes**.





You will now be returned to the Bed Transfer window. Note that the **Room** and **Bed** mandatory fields are now filled in. Now you need to complete the transfer.

1. Enter the following:

Transfer Date: type "T" as a shortcut for *Today*

Transfer Time: type "N" as a shortcut for Now

2. Click **Complete**

		Bed	Transfer		_ □	×	
700020359	700000200710	CSTTHIRTY, SITTHRE	01-Jul-1966 📮 🗸	51Y	Male		~
BC PHN:							
9876320868							
Current Encounter Information							
Encounter Type:	Medical Service:						
Encounter Type.	Emergency						
	Emergency						
 Current Location Data 							
Facility:	Building:	Unit/Clinic:	Room:	Bed:	Accommodation:		
SGH Squamish	SGH Squamish	SGH ED	AC	06			
Accommodation Reason:	Patient Accom Requested:						
¥	·						
 New Encounter Information 							
Encounter Type:	Medical Service:						
Emergency V	General Internal Medi V						
 New Location Data 			_	. .			
Building:	Unit/Clinic:		Room:	Bed:	Accommodation:		
SGH Squamish 🗸 🗸	SGH MS	Bed Availability	103 🗸	02 🗸	Ward	~	
Accommodation Reason:							
×							
- Current Physician Information							
Attending Provider:	Admitting Provider:						
Provider, Emergency							
Transfer Information		5 IT (11 N					
Transfer Date: 01-Feb-2018	Transfer Time:	Bed Transfer User Name:					
	16:26	1 Coser, nural-nuise					v
					Complete 2	Cancel	
Ready				P0783 TEST.NURSER	3UBAL 01-Feb-2018 1	6:26	
,							-

The patient will now viewable on the SGH Medical Surgery location list.

Key Learning Points Conversation Launcher from the toolbar can be used to transfer a patient to a new bed The Bed Transfer Conversation only works for patients with Inpatient Encounter types



Activity 5.4 – Update Patient Information

1 During hospitalization, a patient may have a changeover of attending physician, medical service, isolation status and so on.

Some of this information will display on the banner bar of the patient's chart and you will need to update this information so that other clinicians or departments are aware of any changes.

In this activity, you will learn how to update the isolation precaution for a patient but note that this same Conversation (Update Patient Information) can be used to update the Attending Physician and Medical Service.

From the Patient Chart, do the following:

- 1. Click **Conversation Launcher** Conversation Launcher in the **Toolbar**.
- 2. Select Update Patient Information.

ē			Person Mgm	nt: Convers	ation Launch	ner		_ 🗆 X
5	6	×	X	×	×	×	-	in the second s
Add/Modify Person	Bed Transfer	Cancel Discharge	Cancel Encounter	Cancel Pending	Cancel Pendi	Cancel Transfer	Discharge Encounter	Facility Transfer
7	3	1	100	-	7	G	ŵ	S
Leave of Absence	Modify Discharge	Newborn Modify	Newborn Quick Reg	Pending Discharge	Pending Facilit	Pending Transfer	Pre-Register Outpatient	Pre-Register Patient To
*		ל	Ŵ	<u> </u>	5	<u>ک</u>	۲	# \$
Print Specimen Labels	Process Alert	Quick Reg	Referral Management	Register Outpatient	Register Patient To	Stillborn	Update Patient Information	View Encounter
g	A							1
View Person	WH Quick Reg							
I							OK	Cancel

The Encounter Search window opens.

- 3. Type your patient's MRN, First Name and Last Name
- 4. Click Search
- 5. Select the appropriate active patient encounter
- 6. Click OK



							Ene	ounter Se	arch							
	VIP 2	Deceased	Alerts		MRN 700009019	Name CSTHRCM, TW		DOB 18-Jan-1984	Age 34 Years		Address 700 Main St	Address (2)	City Vancouver	Postal/Zip Code	Home Phone (778)575-6757	Historical MRN
MBN:	-		_			-	-					-			. ,	
700009019																
ast Name:																
esthrem																
rst Name:																
venty 3																
0B:																
N,NRE,NRM																
Gender:																
~																
Postal/Zip Code:																
Any Phone Number:																
	Facil			ncounter #	Visit #	Enc Type				t/Clinic	0	Bed Est A			Disch Date	Attending Provider
						840 Inpatient					109			neg Date 20-Dec-2017 09:18		Plisvcc, Trevor, MI
		GH Med Imer	aina 7		7000000016	839 Outpatient	Medic	al Internal Met al Imaging	icine 50	H Med Ima		01		20-Dec-2017 09:12		
/isit #:	- Alto	arr mod inidg	ging re	100000010000	1000000010	ooo oopoient	modic	armaging	50	in nearma	Jging			2010-00-2011-03-12	2000020112	
Historical MRN:																
Search 4 eset																
	_	_	_													
	<															

The Update Patient Information window opens.

- 7. Click the Encounter Information tab
- 8. From the Isolation Precautions dropdown, select Airborne.
- 9. Yellow fields are mandatory fields that need to be entered. Review any yellow fields and click **Complete**.

►			Update Pati	ent Information			_ 🗆 🗡
	ncounter Number: 7000000016839	Last Name: CSTHRCM	First Name: TWENTY	Middle Name:	Preferred Name:	Previous Last Name:	Date of Birth: 18-Jan-1984
	iender: Female V	BC PHN: 9876397108					
ALERTS Patient Information	ncounter Information 7 ance	Insurance Summary Additional (Contacts				
Encounter Type: Inpatient V	ALC Categories:	ALC Date:	ALC Time:	ALC Decompensation Date:	ALC Decompensation Time:	Medical Service: General Internal Medicine 🗸 🗸	Admit Category: Admit Category:
Admit Source: Clinic V	Arrival by Ambulance: No Ambulance V	Reason for Visit: Test	Disaster Flag:				
─ Location Facilty: SGH Squamish ✓	Building: SGH Squamish 🗸 🗸	Unit/Clinic: SGH MS	Room: 109 V	Bed: 01 V	Accommodation: Private	Accommodation Reason: Medically Necessary	Patient Accom Requested: Ask Patient
Accom Form Signed: No Care Providers Admitting Provider: Plisvob, Stuart, MD	Aiborne Aiborne and Contact Aiborne, Droplet, and Contact Contact Contact Plus	mary Care Provider (PCP): Isvca, Rocco, MD	PCP Verified?: Yes v	Consulting Provider 01:			
Additional Information Visitor Status: Comment	Droplet Droplet and Contact Droplet and Contact Plus Protective	8					
Comment:							Ĵ
eady						P0793 TEST NU	Complete 9 Cancel



Document Selection window opens.

6. Click **OK** if no new specimen labels are needed.

	•
Printer	Copies
590_1stfl_t8	1
590_1stfl_t8	1
	Edit OK 6
	590_1stfl_t8

Isolation information is now updated on the Banner Bar.

CSTPRODREG, MATINAEMPI ED					← List → 🎬 Recent - Name - 🤉
CSTPRODREG, MATINAEMPI ED	DOB:05-Sep-2005	MRN:700006585	Code Status:	Process:	Location:LGH 2E; 212; 03
	Age:12 years	Enc:700000016045		Disease:	Enc Type:Inpatient
Allergies: No Known Allergies	Gender:Female	PHN:9876703548	Dosing Wt:	Isolation:Protective	Attending:Plisvcb, Stuart, MD

Key Learning Points

Isolation Precautions are updated via the Conversation Launcher in the toolbar via the Update Patient Information conversation

Isolation Precautions can be located in the Encounter Information tab of Update Patient Information.



PATIENT SCENARIO 6 - Orders

Duration	Learning Objectives
40 minutes	At the end of this Scenario, you will be able to:
	Review the Orders Profile and Place Orders
	Complete an Order
	Review the General Layout of a PowerPlan

SCENARIO

As an inpatient nurse, you will need to be able to review orders on your patient. You will also need to place orders on your patient in certain situations.

As an inpatient nurse you will complete the following activities:

- Review the Orders Profile
- Place a no co-signature required order
- Review order statuses and details
- Place a verbal order
- Complete an order
- Review components of a PowerPlan



Activity 6.1 – Review Orders Profile

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

To navigate to the **Orders Profile** and review the orders:

- 1. Select Orders from the Menu
- 2. On the left side of the Orders Profile is the navigator (**View**) which includes several categories including:
 - Plans
 - Categories of Orders
 - Medication History
 - Reconciliation History
- 3. On the right side is the Orders Profile where you can:
 - Review the list of All Active Orders
 - Move the mouse over order icons to hover to discover additional information.

Some examples of icons and their meanings are:

- Order requires nurse review
- Additional reference text available
- Order is part of a PowerPlan (Order Set)
- Order requires Pharmacy verification
- 4. Notice the display filter default setting is set to display **All Active Orders**. This can be modified to display other order statuses by clicking on the blue hyperlink.

Menu	,	< > • 🔐 Orders						O Full screen Print 20 m	ninute
		+ Add 2 Document Medication by Hs Reconci	iation •	tions			-	leconciliation Status	
Results Review		•	and the succession					Meds History () Admission () I	Disch
Orders	+ Add	Orders Medication List Document In Plan							
	+ Add								
Documentation	+ Add	View	Displayed All Active Diden	Al Inactive Orders (ALActive Orders*	4				
		Orders for Signature Plans	89 7	Order Name	Status	Dose Details	Stop	Ordering Physician	La
	+ Add	Plans Document In Plan	⊿ Admit/Transfer/Dis	charge					
	T Add	Medical	🔂 🗹 😂	Admit to Inpatient	Ordered	04-Dec-2017 10:15 PST, Admit to General Internal Medicine, Admitting provider: TestORD, -	04-Dec-2017 10:15 PST	TestORD, GeneralMedicine-Physici.	3 Te
Diagnoses and Probl		MED General Medicine Admission (Validated) (P	4 Status						
Histories		GI General Admission (prototype) (Initiated)	🔁 M 🖻 D	Code Status	Ordered	24-Oct-2017 13:24 PDT, 5-No CPR, Critical Care, May Intubate, Perioperative status: Attemp		eLearn, Physician-General Medicin.	s_ el
		Suggested Plans (0)	d Patient Care	Insert Perinheral IV Catheter					
		Orders	828		Ordered	24-Oct-2017 13:24 PDT, Unless already in place	24-Oct-2017 13:24 PDT	eLearn, Physician-General Medicin-	
		Admit/Transfer/Discharge		Weight Vital Signs	Ordered	24-Oct-2017 13:24 PDT, Stop: 24-Oct-2017 13:24 PDT, On admission 24-Oct-2017 13:24 PDT, oth	24-Oct-2017 13:24 PDT	eLearn, Physician-General Medicin, eLearn, Physician-General Medicin,	
Form Browser		C Status		Admission History Adult	Ordered	24-Oct-2017 13:24 PD1, dph 24-Oct-2017 13:17 PDT, Stop: 24-Oct-2017 13:17 PDT	24-Oct-2017 13:17 PDT	eLearn, Physician-General Medicin. SYSTEM, SYSTEM Cemer	<u>ه د</u>
		Patient Care	() M	Admission History Adult	Urdered	Order entered secondary to inpatient admission.	24-00-2017 13:17 PD1	STSTEM, STSTEM Cemer	3
Patient Information		2 Activity	<u>e</u> 🗹	Braden Assessment	Ordered	24-Oct-2017 13:17 PDT, Stop: 24-Oct-2017 13:17 PDT	24-Oct-2017 13:17 PDT	SYSTEM, SYSTEM Cerner	5
		Diet/Nutrition	av	Rasic Admission Information Adult	Ordered	Order entered secondary to inpatient admission. 24-Oct-2017 13:17 PDT. Stop: 24-Oct-2017 13:17 PDT	24-Oct-2017 13:17 PDT	SYSTEM, SYSTEM Cerner	S
		Continuous Infusions	C M	basic admission Information Adult	Urdered	Order entered secondary to inpatient admission.	24-00-2017 1317 PD1	STSTEM, STSTEM Cerner	2
		Blood Products	⊕ ⊻	Morse Fall Risk Assessment	Ordered	24-Oct-2017 13:17 PDT, Stop: 24-Oct-2017 13:17 PDT	24-Oct-2017 13:17 PDT	SYSTEM, SYSTEM Cemer	S
		Laboratory	e 1	FD Readmission Risk	Ordered	Order entered secondary to inpatient admission. 24-Oct-2017 13:17 PDT. Stop: 24-Oct-2017 13:17 PDT	24-Oct-2017 13:17 PDT	SYSTEM, SYSTEM Cerner	S
Clinical Research		Diagnostic Tests		ED Readmission Risk	Urdered	Order placed due to patient being admitted as an inpatient in the last 30 days.	24-Oct-2017 13:17 PD1	STSTEM, STSTEM Lemer	2
		Procedures Respiratory	⊕ ⊻	Infectious Disease Screening	Ordered	24-Oct-2017 13:17 PDT Order entered secondary to insatient admission.	24-Oct-2017 13:17 PDT	SYSTEM, SYSTEM Cerner	5
		Allied Health	25	Smoking Cessation Assessments	Ordered	03-Nev-2017 13-41 PDT	03-Nev-2017 13:41 PDT	TestCST, CardiothoracicSurgeon-P.	2 T
		Consults/Referrals	ê 🗹	Insert Urinary Catheter (Insert Foley)	Ordered	03-Nov-2017 13:40 PDT, Indwelling	03-Nov-2017 13:40 PDT	TestCST, CardiothoracicSurgeon-P.	2- T
		Communication Orders	a Activity						
		Supplies	📵 🗹 😖	Activity as Tolerated	Ordered	24-Oct-2017 13:24 PDT		eLearn, Physician-General Medicin.	L_ el
		Non Categorized	⊿ Diet/Nutrition						
		Medication History	@ M @	General Diet	Ordered	24-Oct-2017 13:24 PDT		eLearn, Physician-General Medicin.	
		Medication History Snapshot	<u>e</u> 🖌	Advance Diet as Tolerated	Ordered	03-Nov-2017 13:41 PDT, Advance diet to Regular, Provider must order starting diet. RN or R		TestCST, CardiothoracicSurgeon-P.	4
		Reconciliation History	4 Medications						
		2	🔁 🗹 👦 🔁	acetaminophen (acetaminophen PRN range dose)	Ordered	dose range: 325 to 650 mg, PO, q4h, PRN pain-mild or fever, drug form: tab, start: 24-Oct-2 Maximum acetaminophen 4 g/24 h from all sources	an (eLearn, Physician-General Medicine1. MD	

Note: Changing the display filter settings may allow you to see orders with other statuses such as discontinued, completed, cancelled, and pending.



Key Learning Points

- The Orders page consists of the orders view (Navigator) and the order profile
 - The Orders View displays the lists of PowerPlans (order sets) and clinical categories of orders
- The Order Profile displays All Active Orders for a patient and can be filtered



Activity 6.2 – Place an Order

1 Throughout your shift, you will review your patient's orders. Nurses can place the following types of orders:

- Orders that require a cosignature from the provider e.g. telephone and verbal orders
- Orders that do not require a cosignature e.g. order within nursing scope, Nurse Initiated Activities (NIA)

To place an order that does **not** require a cosignature:

1. Click Add within the Orders page

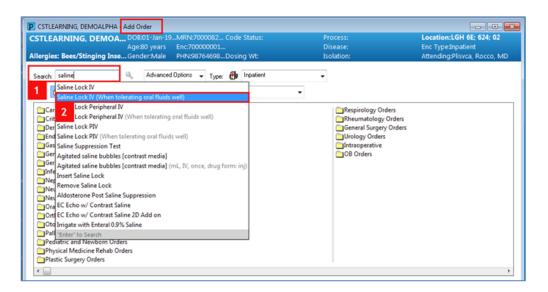
< > 🕘 者 Orders							
+ Add Document Medication			econ	nciliat	tion 🕶 👌	Check Interactions	
View	Di	splaye	d: All	Activ	ve Orders	All Active Orders	
Orders for Signature		S	₿.		8	Order Name 🔺	Status
Document In Plan	⊿						
- Medical			🔁 i	≤.	£.60^	Admission History Adult	Ordered
TM Red Blood Cell (RBC)			a . i	/ 1	<u>8</u> 66'	Basic Admission Information	Ordered
Suggested Plans (0)			<pre>U</pre>	⊻.	2.00	Adult	Ordered
<mark>⊨</mark> Orders			Ð I	≤.	<u>8</u> 66'	Braden Assessment	Ordered
- Admit/Transfer/Discharg			-		-		
- Status			Ð I	✓ :	£ 66^	Infectious Disease Screening	Ordered
Patient Care							
A articites	٠	_					

The Add Order window opens

- 1. Type *saline lock* into the search window and a list of choices will display
- 2. Select Saline Lock Peripheral IV (when tolerating oral fluids well)

Note: In this example "(when tolerating oral fluids well)" is an order sentence. Order sentences help to pre-fill order details. Also, you will see 3 similar orders, select any one of these. All 3 orders will lead to the same order but allow for variation in search terms used.





The Ordering Physician window opens.

- 3. Type in the name of the patient's Attending Physician (Last name, First name)
- 4. Select No Cosignature Required
- 5. Click OK

P Ordering Physician
Order
Proposal
*Physician name
Plisvca, Rocco, MD
3 der Date/Time
07-Dec-2017
*Communication type
Phone Verbal
No Cosignature Required
signature Required per/Fax
Electronic
5 OK Cancel



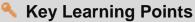
6. Click Done and you will be returned to the Orders Profile and see the order details.



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

🖓 😨 🖳 🏹 Order Name	Status Start	Details			
d LGH 6E; 624; 02 Enc:7000000015055					
Patient Care					
Saline Lock Peripheral	Order 21-Nov-2017 10	27 21-Nov-2017 10:27 PST, When tole	erating oral fluids well		
Details for Saline Lock Peri	pheral IV (Saline	Lock IV)			
Details 🔠 Order Comments					
+ % h. 🖡 🗉					
*Requested Start Date/Time: 11/21/20	1027	PST PST	Special instructions:	When tolerating oral fluids well	
					7
D Missing Required Details Orders For Cosig	nature Orders For Nurse Rev	es.vi			Sig

8. Click Refresh



- Nurses can place nurse initiated orders as no cosignature required orders
- Order sentences help to pre-fill additional information or details for an order

1



Activity 6.3 – Review Order Statuses and Details

To see examples of different order statuses, review the image below:

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

	S	₽?		8	Order Name	•	Status	Dose	Details	Proposal	*
		fb.			Insert Peripheral	IV	Processing		20-Nov-20	17 11:46 PST	
		₽ ₽			Insert Urinary Ca	th	Ordered		20-Nov-20	17 11:31 PST, Indwelling	
		()	~		Morse Fall Risk Assessment		Ordered			17 14:05 PST, Stop: 17-Nov-2017 14:05 PST red secondary to inpatient admission.	
		()			Vital Signs				20-Nov-20	17 11:25 PST, q4h while awake	
⊿	Med	dicat	ions	;							
		e	\checkmark	1	furosemide		Ordered			as directed, order duration: 5 day, drug form: inj, start: 17-Nov- r pre red blood cell transfusion	-
•	_		111								

To see examples of order details review the screenshot below (your screen may be different):

- Focus on the Details column of the Orders Profile
- · Hover your cursor over certain order details to see complete order information
- Note the start date and that orders are organized by clinical category

	S		٣	Order Name	Status	-	Dose	Details	
⊿	Patie	ent	Car	2					
Þ		\checkmark		Vital Signs	Ordered			28-Nov-2017 10:42 PST, q4h	
△ Blood Products									
			•	Red Blood Cell Transfusion	Ordered			Routine, Administer: 1 unit, IV, once, Administer each over: 120 - 180 Minutes, Irradiated, Please Informed consent must be present on patient record	e call
								Red Blood Cell Transfusion	
								Details: Routine, Administer: 1 unit, IV, once, Administer each over: 120 - 180 Minutes, Irradiated, Please callwhen ready for pick up, 28-Nov-2017 11:04 PST	
								Order Comment: Informed consent must be present on patient record	

When new orders are placed in the chart, a nurse must review these new orders and document their review. Below we outline the steps for how this should be done.

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



- 1. A **Nurse Review** icon *m* appears to the left of the order. This identifies the order as one that needs to be reviewed by a nurse.
- 2. As a nurse you would click the **Orders for Nurse Review** button to open the review window.

Solution of the second	Status 🔻 Dos	e Details
⊿ Patient Care		
Vital Signs	Ordered	28-Nov-2017 10:42 PST, q4h
1		
٠ III		•
- D-1-3-		
Totails		
Orders For Cosignature Orders For Nurse Review 2		Orders For Signature

An **Actions Requiring Review** window opens. This window displays any new orders that have been placed by other clinicians that need to be acknowledged as reviewed by the nurse.

- 3. Read through the list of new orders
- 4. Click Review to acknowledge that you are aware of the new orders

SI	LEARNING	G, DEMOALPHA	OB:01-Jan-: Age:80 years		Code Status:	Process: Disease:		ation:LGH 6E; 624; 02 Type:Inpatient
lle	rgies: Bees/S	tinging Insects, ci 🤇				Isolation:		ending:Plisvca, Rocco, MD
	Action	Action Da Entered By	Order	Details			Ordering	
1	Order	28-Nov-201 Plisvcf, 7 10:42:56 Dillon, MD	Vital Signs	28-Nov-2017 10:42 PST, q4ł	h		Plisvcf, Dillon, MD	3
	ect All	Show All Details						

All new orders have now been reviewed and the Orders for Nurse Review button is no longer available.





Activity 6.4 – Place a Verbal Order Using Quick Orders

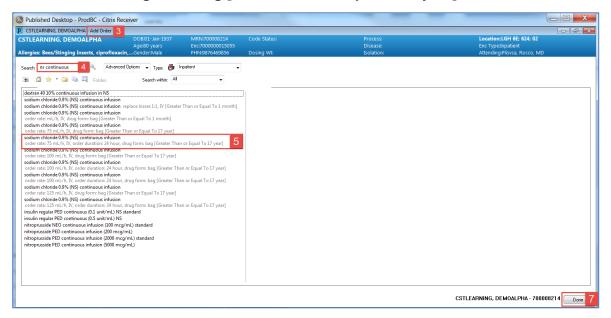
1

Similar to current practice, nurses can place verbal and telephone orders. In this activity we are going to practice placing a verbal order. **Verbal Orders** are only encouraged when there is no reasonable alternative for the provider to place the order in the CIS themselves. For example, in emergency situations.

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

Place a verbal order:

- 1. Select Orders from the Menu
- 2. Click + Add
- 3. The Add Order window opens
- 4. Type **ns continuous** in the search field and press **Enter** on the keyboard to view search results
- 5. Select sodium chloride 0.9% (NS) continuous infusion with order sentence order rate: 75mL/hr, IV drug form: bag [Greater than or equal to 17 year]





The Ordering Physician window opens.

- 6. Fill out required fields highlighted yellow with details below and click OK
 - **Physician name** = type name of Attending Physician (last name, first name)
 - **Communication type** = Verbal

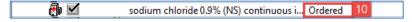
P Ordering Physician	P Ordering Physician 6
 Order Proposal 	 Order Proposal
*Physician name	*Physician name
I 🔍	Plisvca, Rocco, MD 6
*Order Date/Time 08-Dec-2017 🔍 🔽 1112 🔍 PST	*Order Date/Time 08-Dec-2017
*Communication type	*Communication type
Phone	Phone
Verbal No Cosignature Required Cosignature Required Paper/Fax Electronic	Verbal 6 No Cosignature Required Cosignature Required Paper/Fax Electronic
OK Cancel	6 OK Cancel

Note: If this were a telephone order, the communication type of Phone would be selected.

- 7. Click Done to close the Add Order window (refer to first screenshot within this activity)
- 8. **Orders for Signature** window opens and order details are displayed. Fill out data entry fields as needed

Menu		🔻 < 👻 🛧 Orders					 Full screen 	🛱 Print	€ 0 minutes
Patient Summary		Add Document Medication by Hx	Reconciliation * A Check Interactions				Reconciliation State		
Orders	🕂 Add						Meds History	Admissi	on 🕒 Dischar
single Patient Task List		Orders Medication List Document In Plan	1						
MAR		H K	Orders for Signature						
nteractive View and I8		View		Status Start	Details				
		Orders for Signature	△ Continuous Infusions						
Results Review		Plans	sodium chloride 0.9%	Order 28-Nov-201	7 15:34 order rate: 75 mL/h,	IV, order duration: 24 h	hour, drug form: bag, start: 2	8-Nov-2017	/ 15:34 PST,
ocumentation	+ Add	- Document In Plan							
Aedication Request		i⊟Medical	🛨 Details for sodium chloride	0.9% (NS) con	tinuous infusion	1000 mL			
		E Heparin Infusion Standard (Modul	19 Details						
istories		- Suggested Plans (0)						_	
lleraies	+ Add	Orders	Base Solution	Bag Volume	Rate	Infuse Over			
iagnoses and Problem		Admit/Transfer/Discharge	sodium chloride 0.9% (NS) continuous ir		15 mL/h	13.3 hour			
lagnoses and Problem	ns	Status	Additive	Additive Dose	Normalized Rate	Delivers	Occurrence		
		Patient Care			8				
areConnect		Activity	Total Bag Volume	1000 mL					1
		Diet/Nutrition	Weight:						
linical Research		Continuous Infusions							
		Medications	· · · · ·						
rowth Chart		Blood Products							
		Related Results	Infusion instructions						8
nmunizations		Formulary Details							2 0
nes/Tubes/Drains Su		Variance Viewer	0 Missing Required Details Orders For Cosig	nature Orders For Nurse	Review				Sign
1AR Summary		+ I							<u> </u>
						PRO	DBC TEST.NURSE Tuesday,	28-Novem	ber-2017 15:3

- 9. Click Sign and click Refresh
- 10. The orders profile now displays the continuous infusion with a status of Ordered.





Key Learning Points

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

Required fields are always highlighted yellow

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



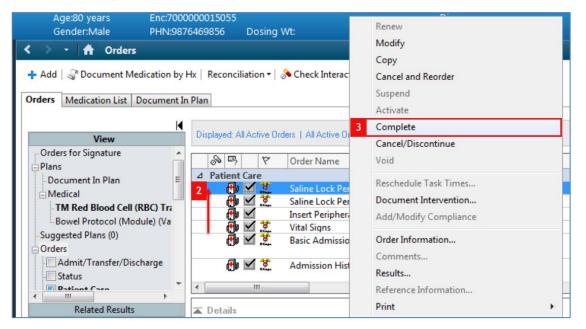
Activity 6.5 – Complete or Cancel/Discontinue an Order

1

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

Assuming we have inserted a saline lock PIV for our patient. Let's complete the order.

- 1. Review the **Orders Profile**
- 2. Right-click the order Saline Lock Peripheral IV
- 3. Select Complete



4. Click the Orders for Signature button.

	<i>⊳</i> ⊑	3	7	Order Name		Status	Dose	Details		*
⊿	Patie		e							
	e e e e e e e e e e e e e e e e e e e	b 🗆		Saline Lock Periph	eral IV (Saline Lock IV)	Complete				
										Ш
										L
										L
										Ш
										Ш
										Ш
•				1						
- 1		_							,	_
	Detail	s								
						 		-		_
0	rders Fa	r Cosig	gnatur	 Orders For Null 	se Review			4	Orders For Signatu	re



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

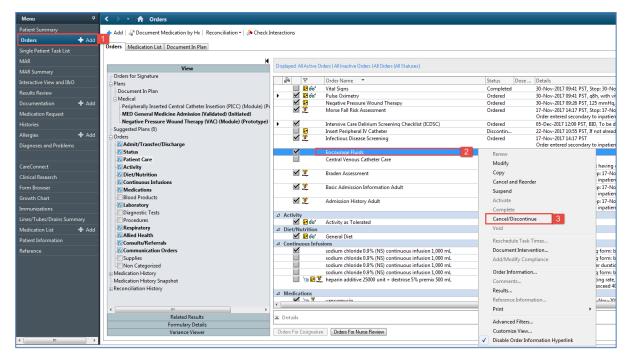
Ord	lers for Sig	gnature							
	2 0	\$7	Order Name	Status	Start	Details			
⊿	LGH 3V	V; 331; 0	1B Enc:700000001586	9 Admit: 01	-Dec-2017 00:24 PS	T			
⊿	Patient								
		@	Saline Lock Peripheral	Complete	09-Dec-2017 14:16				
	T Details								
0	Missing R	equired D	etails Orders For Cosig	nature 0r	ders For Nurse Review		5	Sign	

6. **Refresh** the screen and the order will no longer be visible on the Orders Profile.



2

- Now let's Cancel/Discontinue an order.
 - 1. Review the Orders Profile
 - 2. Right-click order Encourage Fluids
 - 3. Select Cancel/Discontinue



- 4. **Ordering Physician** window will appear. Fill out required fields highlighted yellow below and then click **OK**
 - **Physician name** = Type name of Attending Physician (last name, first name)
 - Communication type = No Cosignature Required

P Ordering Physician
Order
Proposal
*Physician name
Plisvca, Rocco, MD
*Order Date/Time
28-Nov-2017 🛉 🗸 1128 🚔 PST
*Communication type
Phone Verbal
Proposed
No Cosignature Required
Cosignature Required Paper/Fax
Electronic
4 OK Cancel



5. Review order to discontinue and click Orders For Signature

■ Details for Encourage Fluids ☐ Details ☐ Order Comments	
Discontinue Date/Time: 28-Nov-2017	
Orders For Cosignature Orders For Nurse Review	5 Orders For Signature

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

⊿ LGH 6E: 624: 02	Enc:7000000015055 A	Admit: 17-Nov-2017 13:58 PST	
⊿ Patient Care			
	Encourage Fluids	Discontin 28-Nov-2017 11:27 28-Nov-2017 11:39 PST	
			
🛣 Details			
0 Missing Required D	etails Orders For Cosign	nature Orders For Nurse Review	Sign 6

7. **Refresh** the screen and your order will no longer be visible on the order profile.

Key Learning Points

- Right-click to mark an order as completed or cancel/discontinued
- Once an order is cancelled or discontinued the order will be removed from the patient's Order Profile



Activity 6.6 – Review Components of a PowerPlan

If you have completed Nursing Emergency workbook, you may skip over this activity

A PowerPlan in the CIS is the equivalent of pre-printed orders in current state and is often referred to as an order set. At times it may be useful to review a PowerPlan to distinguish its orders from stand-alone orders. Doing this allows a user to group orders by PowerPlan.

Let's review a PowerPlan. From the Orders Profile:

- 1. Locate the Plans category to the left side of the screen under View
- 2. Select the Bowel Protocol PowerPlan
- 3. Review the orders within the PowerPlan (e.g. Sennosides 12mg, PO, qHS, PRN)

< > - 👔 Orders		🛄 Full screen 🛛 🔄 Print 📌 0 minutes agi
🕂 Add 🦨 Document Medication by Hx Reconcil	iation * 🔊 Check Interactions	Reconciliation Status Meds History Admission Discharge
Orders Medication List Document In Plan		
KK	🛋 🙀 🚫 🕂 Add to Phase 🛛 🛄 Comments Start: 04-Dec-2017 11:11 PST Stop: None 📖	
View	Status Dose Details	1
Orders for Signature	Bowel Protocol (Module) (Validated) (Initiated)	
Plans 1	Last updated on: 04-Dec.2017 11:11 PST by: TestORD, GeneralMedicine-Physician, MD	
-Document In Plan	∠ Medications	
Medical	(5) If patient has GFR less than 30 mL/min use Bowel Protocol Renal	
MED General Medicine Admission (Validated) (P Bowel Protocol (Module) (Validated) (Initiated	This is a general bowel protocol (General Medicine). It does not include specialized bowel protocols such as elderly care, labour and delivery, palliative care, and spine patient	
	CONTRAINDICATIONS: Complete bowel obstruction, diarrhea, colostomy, ileostomy, short bowel syndrome	
Suggested Plans (0)	👰 Do NOT give SUPPOSITORIES or ENEMA if Leukemia / BMT patient or if pancytopenic or neutropenic	
Orders	(§ Day1	
Admit/Transfer/Discharge	Select polyethylene glycol 3350 (preferred) OR lactulose Day 2 (continue Day 1 treatment)	
	Sector Support Continue Usy It treatment)	
Patient Care	Seecce semicologic preference) VK magnesium nydrobae wini cascala V molof 2 semicolides preference) VK magnesium nydrobae wini cascala Ordered 12 mg, PO, qHS, PRN constipation, drug form: tab, start: 04-Dec-2017 11:11 PST	
2 Activity	If no bowl movement after 48 hours, Please continue day 1 treatment (8ovel Protocol Day 2)	
Diet/Nutrition	Select magnesium hydroxide AND cascara liquid	3
Continuous Infusions	🛞 Day 3 (continue Day 1 and Day 2 treatment)	J
Medications		
Blood Products		
Laboratory		
Diagnostic Tests		
Procedures		
Respiratory		
- Allied Health		
Consults/Referrals		
Communication Orders		
Supplies		
Non Categorized		
Medication History		
Medication History Snapshot		
Reconciliation History		
4 m b		
Related Results		
Formulary Details	▲ Datouz	
Variance Viewer	Orders For Cosignature Save as My Favorite	Orders For Signature
Constitute viewer		Charlet of organite
	pronect and a second	ORDTEST.PR Monday, 04-December-2017 11:11 PS
	PRODEC	onorconaria Monday, 04-December-2017 11:11 PS

🔦 Key Learning Points

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



PATIENT SCENARIO 7 - Interactive View and I&O

Learning Objectives

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

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

SCENARIO

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

As an inpatient nurse you will complete the following activities:

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



Activity 7.1 – Navigate to Interactive View and I&O

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

You are currently on the Orders profile page. To navigate to iView:

1. Click Interactive View and I&O within the Menu.

Task Edit View Patient Ch	hart Links Navigation He	elp					
👫 CareCompass 👫 Clinical Lea	der Organizer 🎍 Patient List	🚨 Multi-Patient Task List	Tracking Shell DCase Select	ion 🚨 Staff Assignment	🖞 🕄 CareConnect 🕄 PHSA I	PACS 💐 VCH and PHC PACS 💐 MU	SE 🕄 FormFast WFI 💡
🖾 Tear Off 🗐 Exit 🎬 AdHoc 💷	Medication Administration	Medical Record Reques	st 🛸 Result Copy 🎩 Related I	Records 🕂 Add 👻 🖪 Documen	nts 👼 Scheduling Appointment Bool	c 🗃 Discern Reporting Portal 🗐 Cor	nversation Launcher 🍟
Realth Education Mat	terials 🔍 SHOP Guidelines ar	nd DSTs 🔍 UpToDate 💡					
CSTHRCM, TWENTY 🛛 🛛						🗲 List 🔿 🌾 Recent -	Name 🗸 🔍
CSTHRCM, TWENTY	DOB:18-Jan-19 Age:34 years	84 MRN:700009019 Enc:7000000168			cess: ease:	Location:SGH MS; 109; 01 Enc Type:Inpatient	
Allergies: Allergies Not Recorded	Gender:Female		Dosing Wt:		lation:	Attending:Plisvcc, Trevor, MD	
Menu 🕈	< 🔿 👻 者 🛛 Patient Summ	mary				💭 Full screen 🗇 Print	🗧 🍣 26 minutes ago
Patient Summary	A 100%	< - ● ● ☆					
Women's Health Overview	Handoff Tool	Summary	X Assessment	🛛 Discharge	22 Quick Orders	× + -	
Orders + Ad	Tiandon Tool	25 Summary	23 Appendiment	23 Discharge	23 Quick orders	× +	▼ <] = ·
Single Patient Task List MAR	Informal Team	Informal Team Co	ommunication				a =- ^
MAR Summary	Communication Active Issues		Shintanicadon	1			
Interactive View and I&O	Allergies (0)	Add new action			Add new comment		
Results Review	Vital Signs and						
Documentation 🕂 Ad	Measurements	No actions documented			No comments documented All Teams		
Notes 🕂 Ad	Documents (0)	All Teams			All reams		
Medication Request	Transfer/Transport/Accompa niment (0)						
Histories	Assessments	Active Issues			Clas	sification: Medical and Patient Stated 🔻	All Visits 🏖 💷
Allergies + Ad	Lines/Tubes/Drains						
Diagnoses and Problems Perioperative Doc	Intake and Output				Add new as: This Visit 👻 🍳		
	Labs	No results found					
CareConnect	Micro Cultures						
Clinical Research	Diagnostics	Allergies (0) 🕂					All Visits 🛛 🕄 🖃 –
Form Browser	Current Medications	Allergies (0) T					
Growth Chart	Home Medications	Allergies not reco	rded. Add an allergy.				
Immunizations	Orders						
Lines/Tubes/Drains Summ 🗸	Oxygenation and Ventilation	No results found					~
	L				P0783	TEST.NURSERURAL Friday, 02-Feb	ruary-2018 11:15 PST

Now that the iView page is displayed, let's review the layout.

2

- A band is a heading that has a collection of flowsheets (sections) organized beneath it. In the image below, the Adult Quick View band is expanded displaying the sections within it.
- 2. The set of bands below **Adult Quick View** are collapsed. Bands can be expanded or collapsed by clicking on their name.
- 3. A **section** is an individual flowsheet that contains related assessment and intervention documentation. For example, **VITAL SIGNS** is a **section** within the **Adult Quick View band**.
- 4. Cells are fields within the flowsheet where data is documented.



CSTLEARNING, DEMOTHETA - 7000	008216 Opened by TestUser, Nurse								
Task Edit View Patient Chart	Links Options Documentation Orders He	In							
	Organizer 🍐 Patient List 🔐 Multi-Patient Task List		Staff Assignment	aminal IVE					
	ear Off 📲 Exit 🎬 AdHoc 💵 Medication Administ				uest 📥 Add	• Docume	nte 🕅 Scheduling A	Innointment Br	ook Ge Discern Reporting Portal
		auon 🍊 Pin Conversau	on • 📲 communicate • (in Medical Record Requ	iest - Add	• E bocume	nts i Schedding A	oppointment be	
CSTLEARNING, DEMOTHET									🗲 List 🔿 🖀 Recent ·
CSTLEARNING, DEMOTHET		RN:700008216 c:700000015058				ocess: sease:			Location:LGH 6E; 624; 04
Allergies: penicillin, Tape		C:700000015058	Dosing Wt:			lation:			Enc Type:Inpatient Attending:Plisvca, Rocco, M
Menu 4	Interactive View and I&O								[□] Full screen
Patient Summary	™日回☆✔Ø3■■●×								
Orders 🕂 Add									
	X Adult Quick View					Last 24 Hours			
Single Patient Task List	VITAL SIGNS					Last 24 mours			
MAR	Modified Early Warning System	Find Item	- Critical	High Low	Abnormal	📃 Unauth	📰 Flag	And	Or
Interactive View and I&O	PAIN ASSESSMENT Pain Modalities	Result		Comments Flag	Date		Performed By		
Results Review	IV Drips								
Documentation 🕂 Add	Insulin Infusion Hepatin Infusion	in 19			20-Nov-2017				
Medication Request	Apnea/Bradycardia Episodes		CNIC		🕱 15:38 PST				
Histories	Mental Status/Cognition		ture Axillary	DegC					
	Sedation Scales Provider Notification		ture Temporal Artery	DegC					
Allergies 🕂 Add	Environmental Safety Management		ture Oral	DegC					
Diagnoses and Problems	Activities of Daily Living	Apical H Peripher	eart Kate al Pulse Rate	bpm					
	Measurements		te Monitored	bpm					
CareConnect	Glucose Blood Point of Care Individual Observation Record	SBP/DBP	Cuff	mmHg					
	Comfort Measures	Cuff Loc							
Clinical Research	Transfer/Transport		terial Pressure, Cuff	mmHg					
Form Browser	Shift Report/Handoff		essure Method Perfusion Pressure, Cuff	mmHa					
Growth Chart			enation	i i i i i i i i i i i i i i i i i i i					
Immunizations			iratory Rate	br/min					
			ured O2% (FIO2) en Activity						
Lines/Tubes/Drains Summary	& Adult Systems Assessment		en Therapy						
MAR Summary	Adult Lines - Devices		en Flow Rate	L/min					
Medication List 🕂 Add	Adult Education		Nare Check	0/					
Patient Information	Selood Product Administration	SpO2 SpO2		70					
Reference	Vintake And Output		Site Change						
Kererence	Advanced Graphing		d Early Warning System						
	Restraint and Seclusion	⊿ Temp	erature erature Axillary	DegC					
	Procedural Sedation		erature Temporal Artery	DegC					
	Adult Critical Care Lines - Devices		erature Oral	DegC					
	Adult Critical Care Lines - Devices		S Temperature Score						
	Adult Critical Care Systems Assessment	⊿ Heart							
	Dialysis Treatment Management		il Heart Rate heral Pulse Rate	bpm bpm	4				
< III >>	Charysis Treatment Management	Perip	neiai ruise nate	opm.	- 4				

3 As an inpatient nurse at Squamish General Hospital, you may take care of any or all of the following types of patients:

- Adults
- Pediatrics
- Labour & Delivery
- Newborns
- 1. Notice the list of **bands** that you see in your iView currently include:
 - Adult bands or Pediatric bands
 - OB bands
 - Antepartum/Antenatal bands

Note: The age of the patient will automatically default the system to display either Adult bands or Pediatric bands. In this scenario you are looking after an adult patient, which is why you only see Adult and OB bands. If your patient is a child, the system will default to display only Pediatric bands.



2. Click into these bands to familiarize yourself with the documentation content within them.

Note: It is not possible to omit the OB bands for male patients. As a nurse looking after a male patient you just won't need to click into any of these bands.

CSTHRCM, TWENTY CSTHRCM, TWENTY		DOB:18-Jan-1984 Age:34 years	MRN:700009019 Enc:700000016839	Code Status:		Process: Disease:		← List → @ R Location:SGH MS; 1 Enc Type:Inpatient	09; 01	- 0
Allergies: Allergies Not I		Gender:Female	PHN:9876397108	Dosing Wt:		solation:		Attending:Plisvcc, Tre		
Menu	9		ew and I&O					🗩 Full screen 🛛 🖨 Prin	it 🛛 🍣 1 hours 59 m	hinutes ag
Patient Summary	^		l 飾 X							
Women's Health Oven	view									
Orders •	+ Add	🗙 Adult Quick View		4		Last 24 Hour			×	
Single Patient Task Lis	•	VITAL SIGNS	^			Last 24 Hour	3			
		Modified Early Warning System		Find Item 🗸 🗆 🕻	ritical 🗌 High 🔲 Lo	w 🗌 Abnorma	🗌 🗌 Unauth 🔄 Flag	⊖ And	Or	
MAR		PAIN ASSESSMENT Pain Modalties								
MAR Summary		IV Drips								
Interactive View and	1180	Insulin Infusion		n 🕂 🖌		13:27 PST				1
	100	Heparin Infusion		✓ VITAL SIGNS		13:27 PST				
Results Review		Apnea/Bradycardia Episodes		Temperature Axillary	DegC					
Ocumentation	Add	Mental Status/Cognition Sedation Scales		Temperature Oral	DegC					
Notes -	+ Add	Provider Notification	×	Apical Heart Rate	bpm					
	- Add	Adult Systems Assessment		Peripheral Pulse Rate	bpm					
Medication Request		Adult Lines - Devices		SBP/DBP Cuff	mmHg					
Histories		Adult Education		Cuff Location Mean Arterial Pressure, Cuff	mmHa					
	+ Add	Sour Education		Blood Pressure Method	mmrg					
		V Intake And Output		Central Venous Pressure	mmHg					
Diagnoses and Proble	ms	×		SBP/DBP Supine	mmHg					
erioperative Doc		X Advanced Graphing		Pulse Supine	bpm					
choperative bloc		Kestraint and Seclusion		SBP/DBP Sitting	mmHg					
		Yerocedural Sedation		Pulse Sitting	bpm					
CareConnect		🗙 OB Triage		SBP/DBP Standing Pulse Standing	mmHg bpm					
Clinical Research		🗙 Antepartum		2 Oxygenation						
		Antenatal Testing		Respiratory Rate	br/min					
orm Browser		Labour and Delivery		Measured O2% (FIO2)						
Growth Chart		Newborn Delivery Data		Oxygen Activity						
mmunizations		CB Recovery and Postpartum		Oxygen Therapy						
		CB Recovery and Postpartum		Oxygen Flow Rate	L/min					
ines/Tubes/Drains Su	ımm			Skin/Nare Check SpO2	e/					
Medication List	🕈 Add 🗸 🗸	💊 OB Systems Assessment	1 2	SpU2	76					

Note: Maternity documentation and functionality will be covered in the OB workbook.

- Nurses will complete most of their documentation in iView
- iView contains flowsheet type charting
- As an Inpatient Rural Nurse, you will see documentation content for adults, pediatrics and maternity patients in iView



Activity 7.2 – Documenting in Interactive View and I&O

Let's practice documenting in iView:

- 1. Click on the Adult Quick View band and then click on the Vital Signs section.
- 2. In the flowsheet on the right, double-click the **blue box** next to Vital Signs, section to document in several cells. You can move through the cells by pressing the **Enter** key.
- 3. Document using the following data:
 - **Temperature Oral** = 36.9
 - Peripheral Pulse Rate = 91
 - **SBP/DBP Cuff** = 140/90
 - **Mean Arterial Pressure, Cuff** = 107 (Auto populated result)

Note: The Calculation icon denotes that the cell will populate a result based on a calculation associated with it. Hover over the calculation icon to view the cells required for the calculation to function. For example, Systolic Blood Pressure (SBP) and Diastolic Blood Pressure (DBP) are required cells for the Mean Arterial Pressure calculation to function.

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

Notice that the text is purple upon entering. This means that the documentation has not been signed and is not part of the chart yet.

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

4. To sign your documentation, click the green checkmark icon 🖌



CSTLEARNING, DEMOTHETA - 700008216 Op	ened by TestUser, Nurse					
Task Edit View Patient Chart Links	Options Documentation Orders	Help				
🗄 🎬 CareCompass 📲 Clinical Leader Organizer	🛓 Patient List 🔉 Multi-Patient Task	List 🎬 Discharge Dashb	oard Staff Assignment 🎬 LearningL	IVE 📮		
🕴 😋 PACS 😋 FormFast WFI 📮 🗄 🎛 Tear Off 🛃	Exit 🎽 AdHoc 🎟 Medication Adm	inistration 🔒 PM Conve	rsation 👻 🔄 Communicate 👻 🛗 Medic	al Record Request 📲	Add 👻 💽 Docume	ents 🖀 Scheduling Appointment B
CSTLEARNING, DEMOTHETA 🛛 🛛						
CSTLEARNING, DEMOTHETA	DOB:01-Jan-1937	MRN:700008216	Code Status:		Process:Falls Ri	isk
	Age:80 years	Enc:7000000015058			Disease:	
Allergies: penicillin, Tape	Gender:Male	PHN:9876469824	Dosing Wt:		Isolation:	
Menu P	< 🔶 🕘 🌰 Interactive \	/iew and I&O				
Patient Summary	-~⊟≡a° / (4 ■	III 角 ×				
Orders 🕂 Add		_				
Single Patient Task List	🗙 Adult Quick View	1			Last 24 F	lours
MAR	VITAL SIGNS Modified Early Warning Syste	m	Find Item	High Low	Abnormal	Unauth 🔲 Flag
Interactive View and I&O	PAIN ASSESSMENT Pain Modalities		Result	Comments Fia		Performed By
Results Review	IV Drips		Titoduk	Commonta	ig Date	I GIGINGO BY
Documentation + Add	Insulin Infusion		50 39	24-Nov-2017	_	
Medication Request	Heparin Infusion Apnea/Bradycardia Episodes		iu 12 ™ 2 ⊡	්ල් 09:37 PST	2	
· · · · · · · · · · · · · · · · · · ·	Mental Status/Cognition		⊿ VITAL SIGNS Temperature Axillary	DegC		
Histories	Sedation Scales		Temperature Temporal Artery	Deg		
Allergies 🕂 Add	Provider Notification		Temperature Oral	Deg@36.9		
Diagnoses and Problems	Environmental Safety Manage Activities of Daily Living	ement	Apical Heart Rate	bpn		
	Measurements		Peripheral Pulse Rate	bpm 91		
	Glucose Blood Point of Care		Heart Rate Monitored	bpn		
CareConnect	Individual Observation Recor	d	Cuff Location	mmHg140/90		
Clinical Research	Comfort Measures		Mean Arterial Pressure, Cuff	mmHe 107		
	Transfer/Transport		Blood Pressure Method			
Form Browser	Shift Report/Handoff		E Cerebral Perfusion Pressure, Cuff	mmH		
Growth Chart			⊿ Oxygenation	2		
Immunizations			Respiratory Rate	br/min16		
			Measured O2% (FIO2) Oxygen Activity			
Lines/Tubes/Drains Summary			Oxygen Therapy	Nasal cann		
MAR Summary			Oxygen Flow Rate	L/min		
Medication List + Add	Adult Systems Assessment		Skin/Nare Check			
	X Adult Lines - Devices		SpO2	⁵ 99		
Patient Information	X Adult Education		SpO2 Site	Hand	3	
Reference	Slood Product Administration		SpO2 Site Change Modified Early Warning System	L		
	111111110111		a mouthed carry warning system			

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

	Christel Leader	Organisar & Patient List 22 Multi-Patient Task 1	List III Discharge Dashboard, 22.5	Leff Accigroment The Lear	ningLNE .				
Quests Question		lear Off State MadHoc MMedication Admi	nistration 🔒 PM Conversation +	ACommicate - A	Medical Record Report + Add + 1	Decuments	Et Scheduling App	ortrart Book 🖬 Dacara	Reporting Portal
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Note: You do not have to document in every cell. Only document to what is appropriate for your assessment and follow appropriate documentation policies and guidelines at your site.

2



Let's pretend that you just did a bladder scan on your patient and now you want to document.

- 1. Click the Adult Systems Assessment Band in iView
- 2. Click the Genitourinary section in the Adult Systems Assessment band
- 3. Notice that there is nothing in this section that you can see about bladder scanning
- 4. Click the **Customize View** icon To search for a section regarding bladder scanning

🗙 Adult Quick View 🔄	4
Adult Systems Assessment	
NEUROLOGICAL	Find Item Critical High Low Abnormal Unau
Morse Fall Scale	
Fall Prevention Interventions	Result Comments Flag Date
Post Fall Evaluation	
Pupils Assessment	W 6/2
Glasgow Coma Assessment	01-Dec-2017
CIWA-Ar	💐 4
Neurovascular Check	
Neuromuscular/Extremities Assessment	Urinary Symptoms Reported
CARDIOVASCULAR	Urinary Elimination
Cardiac Rhythm Analysis	
Pulses	Urine Amount Unmeasured
Edema Assessment	Patient Voided, Unknown Amount
Pacemaker	Episodes of Bladder Accident
RESPIRATORY	Diaper/Brief Check Last Wet Diaper/Brief
Breath Sounds Assessment	Urine Colour/Characteristics
Mobilization of Secretions	Urine Odour
Ventilation Assessment	Bladder Distention
VAP Bundle	Last Menstrual Period
Ventilation	Menses Present 3
GASTROINTESTINAL	⊿ Genitalia Assessment
GENITOURINARY 2	∠ Braden Assessment
IN LEGUMEN LARY Braden Assessment	Sensory Perception
Braden Assessment Incision/Wound/Skin/Pin Site	Moisture
MUSCULOSKELETAL	Activity
PSYCHOSOCIAL	Mobility
FSTURUSULIAL	Nutrition
	Friction and Shear
Adult Lines Devices	Braden Score

5. A **Customize** window opens displaying all the content within the Genitourinary section. Click the **Collapse All** button to see all of the section names at a glance.

	Preferences	Dynamic Groups			
Display	Name		On View	Default Ope	n 🔺
⊿ GENITO	OURINARY		V		
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In Section					
In Section	:				



- 6. Now that all the sections are collapsed, find the **Bladder Scan/Postvoid Residual** section and click on the box ☑ under the **Default Open** column.
- 7. Click OK

	CURRING, ELLA	700003104			×
Customize	Preferences	Dynamic Groups			
 GASTRG GI Osto Enema GENITC Genitali Urinary Bladder INTEGU Braden Incision MUSCU Muscul PSYCHG 	ion tory Evaluation ! DINTESTINAL my Administration DURINARY a Assessment Diversion Scan/Postvoid MENTARY Assessment //Wound/Skin/P LOSKELETAL oskeletal Interve DSOCIAL g Columbia Sui	Residual in Site	On View	Default Open	4 m
		Collapse All	Expand All	OK 7 an	cel

- 8. You will now see that the **Bladder Scan/Postvoid Residual** section is listed under the Adult Systems Assessment Band
- 9. Click the small arrow next to the **Bladder Scan/PostVoid Residual** section to expand the section.
- 10. Document the following assessment findings:
 - Random Scan Bladder Volume = 300
 - Press Enter on the keyboard and click green checkmark icon ✓ to sign your documentation



Adult Systems Assessment		
NEUROLOGICAL	Find Item - Critical High Lo	W
Morse Fall Scale		
Fall Prevention Interventions	Result Comments	Flag
Post Fall Evaluation		
Pupils Assessment		
Glasgow Coma Assessment	01-Dec-20	
CIWA-Ar	R 🖌 😽 16:26	PST
Neurovascular Check	△ GENITOURINARY	
Neuromuscular/Extremities Assessment	Urinary Symptoms Reported	_
CARDIOVASCULAR	Urinary Elimination	
Cardiac Rhythm Analysis	Urine Voided mL	_
Pulses	Urine Amount Unmeasured	
Edema Assessment	Patient Voided, Unknown Amount	
Pacemaker	Episodes of Bladder Accident	
RESPIRATORY	Diaper/Brief Check	
Breath Sounds Assessment	Last Wet Diaper/Brief	
Mobilization of Secretions	Urine Colour/Characteristics	
Ventilation Assessment	Urine Odour	_
VAP Bundle	Bladder Distention	
Ventilation	Last Menstrual Period	
GASTROINTESTINAL	Menses Present	
GENITOURINARY	△ Genitalia Assessment	
Bladder Scan/Postvoid Residual	8 Adder Scan/Postvoid Residual	
INTEGUMENTARY	9 Voided Within 15 Minutes Prior to Scan	
Braden Assessment	Post Void Bladder Volume mL	-
Incision/Wound/Skin/Pin Ste	Random Scan Bladder Volume ml. 800	1
MUSCULOSKELETAL	Was Patient Catheterized	
PSYCHOSOCIAL	Post Void Residual Catheterization mL	

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



Activity 7.3 – Change the Time Column in iView

If you have completed Nursing Emergency workbook, you may skip over this activity

- 1 You can create a new time column and document under a specific time. For example, let's pretend it is now 12:00 pm and you still need to document your patient's 07:00am temperature.
 - 1. Click on the Adult Quick View Band and select the Vital Signs section
 - 2. Click the Insert Date/Time icon in
 - 3. A new column and **Change Column Date/Time** window appears. Choose the appropriate date and time you wish to document under. In this example, use today's date and time of *0700*.
 - 4. Press the **Enter** key

Menu		< 🖂 🔸 Interactive View and I&O								
Patient Summary		🛰 🔜 💷 🔐 🖌 🚫 🦉 📑 📰 🎘 🛪								
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		Sedation Scales Provider Notification	Temperature Axillary Temperature Temporal Artery	DegC	×					
Histories		Environmental Safety Management	Temperature Oral	DegC						36.9
Allergies	+ Add	Activities of Daily Living	Apical Heart Rate	bpm						50.9
		Measurements	Peripheral Pulse Rate	bpm						
Diagnoses and Problems		Glucose Blood Point of Care	Heart Rate Monitored	bpm						
		Individual Observation Record	SBP/DBP Cuff	mmHg						120/80
		Comfort Measures	Cuff Location							
CareConnect		Transfer/Transport	Mean Arterial Pressure, Cuff	mmHg						
Clinical Research		Shift Report/Handoff	Blood Pressure Method							
Form Browser			Cerebral Perfusion Pressure, Cuff	mmHg						
Form Browser			⊿ Oxygenation							
Growth Chart			Respiratory Rate	br/min						
Immunizations			Measured O2% (FIO2)							
Immunizations			Oxygen Activity							
Lines/Tubes/Drains Sum	mary		Oxygen Therapy Oxygen Flow Rate							
Medication List	+ Add		Skin/Nare Check	L/11111						
	- Aud		SpO2	%						89 🗤
Patient Information			SpO2 Site							
Reference		Adult Systems Assessment	SpO2 Site Change							
		Adult Lines - Devices	⊿ Modified Early Warning System							
			⊿ Temperature							
		X Adult Education	Temperature Axillary	DegC						
		K Blood Product Administration	Temperature Temporal Artery	DegC						
		🗙 Intake And Output	Temperature Oral	DegC	-					36.9

5. In the new column, enter **Temperature Oral** = 37.5 and click green checkmark icon \checkmark to sign your documentation. The documented text is now black and recorded in the chart.



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		Transfer/Transport		Pressure Method		107		5
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🔦 Key Learning Points

Documentation time can be adjusted in iView

If required, you can create a new time column and document under a specific time



Activity 7.4 – Document a Dynamic Group in iView

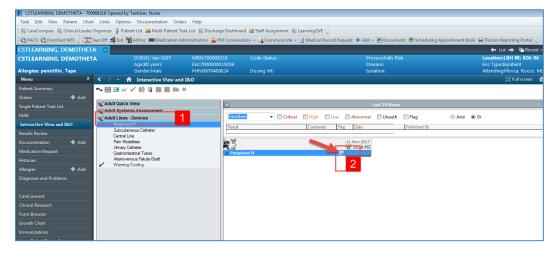
If you have completed Nursing Emergency workbook, you may skip over this activity

1

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

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

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



3. The **Dynamic Group** window appears. A dynamic group allows you to label a line, wound, or drain with unique identifying details.

Note: You can add as many dynamic groups as you need for your patient. For example, if a patient has two peripheral IVs, you can add a dynamic group for each IV.

Select the following data to create a label for your IV:

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



4. Click OK

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🕄 PACS 🕄 FormFast WFI 💡 📰	ear Off 📲 Exit 🎬 AdHoc 🎟 Medication Ad	ministration 🄒 PM Conversation 👻 🕌	Communicate 👻 🔄 Medical Record Req	uest 🕂 Add 🔹 🕞 Documents	🛗 Scheduling Appointm	ent Book 📾 Discern Reporting Portal 🥫
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	Age:80 years Gender:Male	Enc:700000015058		Disease: Isolation:		Enc TypeInpatient
Allergies: penicillin, Tape		PHN:9876469824 Dosin	_			Attending:Plisvca, Rocco, MD
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	Adult Lines - Devices	Find Item	Posterior auricular vein		^	And 💿 Or
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	Subcutaneous Catheter		Upper arm			
Documentation + Add	Central Line Pain Modalities	1 M	Wrist			
Medication Request	Urinary Catheter	10 10 10 10 10 10 10 10 10 10 10 10 10 1				
	Gastrointestinal Tubes Arteriovenous Fistula/Graft	⊿ Peripheral IV ⊿ Central Line	Peripheral IV Laterality:			
	Warming/Cooling	2 Central Line	₩ Left			
Allergies 🕂 Add			Right			
			Medial Lateral			
			Anterior			
			Posterior Distal			
Clinical Research			Proximal			
Form Browser						
Growth Chart						
Immunizations			Peripheral IV Catheter Size:			
Lines/Tubes/Drains Summary			14 gauge		=	
MAR Summary			16 gauge 18 gauge			
			20 gauge			
	Adult Education		22 gauge			
	Second Product Administration		23 gauge 24 gauge			
Reference	Vintake And Output		26 gauge			
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	Adult Critical Care Quick View			ОК	Cancel	
	Adult Critical Care Systems Assessmen	t		4		
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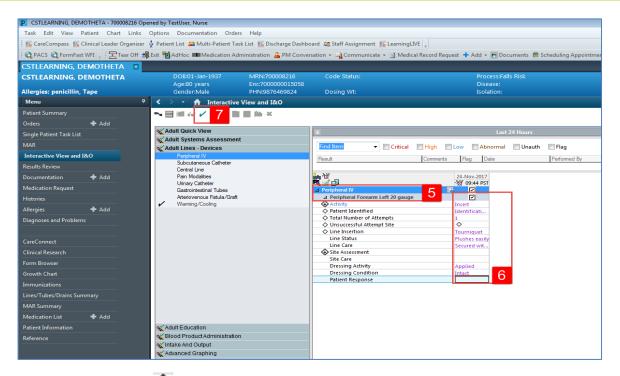
- 5. The label created <u>⊿ <Peripheral Forearm Left 20 gauge></u> will display at the top, under the Peripheral IV section heading. Now other users will know which dynamic group represents this particular IV.
- 6. Double-click the **blue box** next to the name of the section to document in several cells. You can move through the cells by pressing **Enter** on the keyboard.

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

- Activity = Insert
- **Patient Identified** = Identification band
- Total Number of Attempts = 1
- **Line Insertion** = *Tourniquet*
- Line Status = Flushes easily
- Line Care = Secured with tape
- Site Assessment = No phlebitis/infiltration present, catheter patent
- **Dressing Activity** = Applied
- **Dressing Condition** = Intact
- 7. Click **green checkmark** icon ✓ to sign your documentation. Once signed the label will be accessible for other clinicians to complete further documentation within the same dynamic group.

2





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

When a line/tube/drain is documented as 'insterted' you will see it display in the **Lines/Tubes/Drains Summary** Page from the **Menu**.

- 1. Click on Lines/Tubes/Drains Summary from the menu
- 2. Notice that the **Peripheral Forearm Left 20 gauge** IV is now listed here with the insertion date and time listed, as well as where the line was placed (Unit Origin).
- 3. Look at the screenshot below. Notice that the Lines/Tubes/Drains Summary page displays information about any Active or Discontinued Lines/Tubes/Drains that have been documented on for your patient. Here you see when and where the line was inserted, how long it's been insitu, the indication, other details and the site exam.



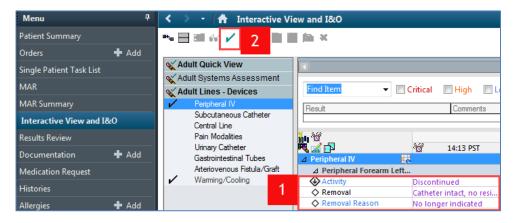
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llergies: Peanuts, Tape		Gender:Male	PHN:9878031741	Dosing Wt:					Attendi	ng:Plisvcb, Stuart, MD	
Menu a	$\langle \rangle$	 tines/Tubes/Drains Sun 	nmary							(D) Full screen 🗇 Prin	: 🍣 0 minutes
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ingle Patient Task List	Activ	e (4) 3									^
AR		nes (3)									
AR Summary											
eractive View and I&O	⊿Pe	eripheral IV's (1)									
sults Review		Туре	Description	Location	Insertion D/T A	Duration	Unit Origin	Indication	Details	Site Exam	
ocumentation 🕂 Add		Peripheral IV Catheter Type:		Left, Antecubital	08/02/2018 08:56	0 Days: 0 Hrs: 49 Mins	SGH Squamish SGH MS				Discontinue
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ergies 🕂 Add		Central Line Access Type: Central	Triple	Right, Internal jugular vein		0 Davs: 0 Hrs: 49 Mins	SGH Squamish SGH MS			Central Line Site	Discontinue
agnoses and Problems		venous catheter	11000	rogin, morner jegener rem	000212010 00.00	0 0090. 0 110. 40 1110	111 01			Condition: No	And the second second
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nes/Tubes/Drains Sum 1	Disco	ontinued (1)									^
dication List 🔸 Add	Last 3	0 Days									
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		Type	Description	Location	Discontinued D/T V	Duration	Unit Origin	Removal Reason	Details	Site Ecom	
		Gastrointestinal Tube Type:			08/02/2018 09:45	0 Days: 0 Hrs: 47 Mins	SGH Squamish SGH MS			GI Tube Site Condition: No	
ference		Nasogastric (NG) tube			0000201000.40	0 Days. 0 His. 47 Hills	111 01			complications 08/02/2018 08:59	

4. Click on and the system will take you back to the iView section for further documention.

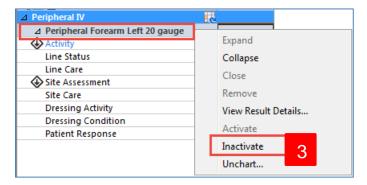
3 You can **inactivate** a dynamic group when it is no longer in use, such as when a drain or tube is removed.

Let's say your PIV has been discontinued. To **inactivate** your Pheripheral Line dynamic group complete the following steps:

- 1. Document that the line was discontinued using the following date:
 - **Acivity** = *Discontinued*
 - **Removal** = Catheter intact, no resistance
 - **Removal Reason** = No longer indicated
- 2. Click green checkmark icon \checkmark to sign your documentation







4. The section is now greyed out and inactive for documentation.

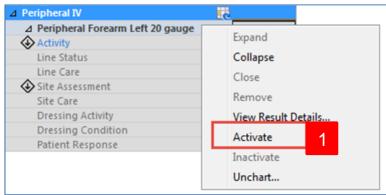
	Peripheral Forearm Left 20 gauge	
\odot	Activity	
	Line Status	
	Line Care	
٩	Site Assessment	
	Site Care	
	Dressing Activity	
	Dressing Condition	Δ
	Patient Response	

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

4 If you accidently inactivate the wrong dynamic group you can re-activate the dynamic group.

To do this:

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



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

Note: Any user can re-activate an inavtive dynamic group if necessary.

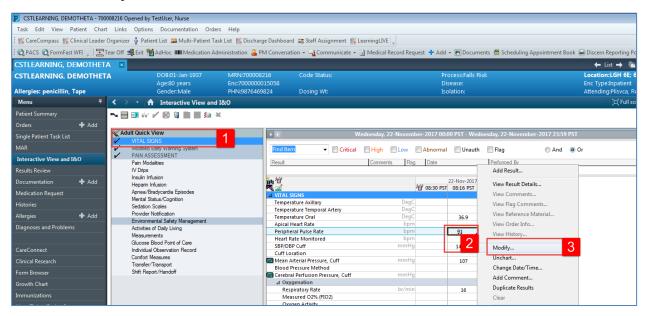


- Examples of dynamic groups include wound assessments, IV sites, chest tubes, and other lines or drains
- Once documentation within a dynamic group is signed the label will be accessible for other clinicians to complete further documentation within the same dynamic group
- When a line, tube or drain is removed, it should be documented as **discontinued** and the dynamic group should be **inactivated** so that other users know not to keep documenting on it.
 - Right click to activate the dynamic group. Any user can activate an inactive dynamic group.



Activity 7.5 – Modify, Unchart or Add a Comment in Interactive View

- 1 You realize upon reviewing your earlier charting that you wrote the incorrect Peripheral Pulse Rate value. Let's modify the Peripheral Pulse Rate.
 - 1. Click on the Vital Signs section heading in the Adult Quick View band
 - 2. Right-click on the documented value of 91 for Peripheral Pulse Rate
 - 3. Select Modify...



- 4. Enter in new **Peripheral Pulse Rate** = 80 and then click **green checkmark** icon ✓ to sign your documentation.
- 5. **80** now appears in the cell and an icon <u>will automatically appear on bottom right corner to denote a modification has been made.</u>

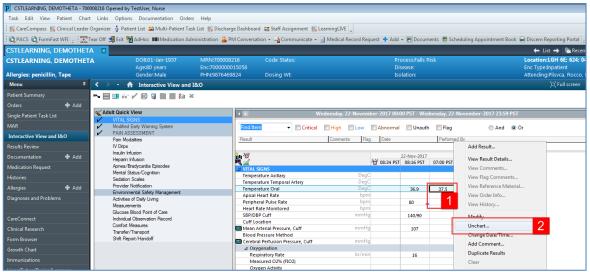
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CSTLEARNING, DEMOTHETA	DOB:01-Jan-1937 Age:80 years	MRN:700008216 Enc:7000000015058	Code Status:		Process:Falls Ri Disease:	isk	Location:LGH 6E; 67 Enc Type:Inpatient
Allergies: penicillin, Tape	Gender:Male	PHN:9876469824	Dosing Wt:		Isolation:		Attending:Plisvca, Ro
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CareConnect	Glucose Blood Point of Care	SBP/D	BP Cuff	mmHg	140/90		
	Individual Observation Record Comfort Measures		ocation				
Clinical Research	Transfer/Transport		Arterial Pressure, Cuff	mmHg	107		
Form Browser	Shift Report/Handoff		Pressure Method				
			al Perfusion Pressure, Cuff genation	mmHg			
Growth Chart		2 UX	rychauon				



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

For this scenario, let's say the temperature documented earlier was meant to be documented on one of your other patient's charts and needs to be uncharted.

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



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



CSTLEARNING, DEMOTHETA - 700008216 Ope	ned by TestUser, Nurse									
Task Edit View Patient Chart Links	Options Documentation Orders	Help								
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CSTLEARNING, DEMOTHETA	DOB:01-Jan-1937	MRN:700008216	Code Status:			Process:Falls	Risk			ocation:L
Allergies: penicillin, Tape	Age:80 years Gender:Male	Enc:7000000015058 PHN:9876469824				Disease: Isolation:				nc Type:In
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Patient Information	Adult Education		SBP/DBP Cuff		mmHg	140/90				
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	🔨 Intake And Output		△ AVPU AVPU							
	Advanced Graphing		MEWS AVPU Sc	ore						
	Restraint and Seclusion		⊿ MEWS Total Sc							
	Procedural Sedation		MEWS Total Sco	ore						
	~		4 Situational Awa	reness Factors						

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

CSTLEARNING, DEMOTHETA - 7000	08216 Opened by TestUser, Nurse					
Task Edit View Patient Chart	Links Options Documentation Orders	Help				
🗄 🎬 CareCompass 📲 Clinical Leader (Organizer 🛔 Patient List 🚨 Multi-Patient Task l	List 📲 Discharge Dashboard	🤐 Staff Assignment 📲 Le	earningLIVE 🖕		
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CSTLEARNING, DEMOTHET	DOB:01-Jan-1937 Age:80 years	MRN:700008216 Enc:7000000015058	Code Status:		ocess:Falls Risk sease:	Loc Enc
Allergies: penicillin, Tape	Gender:Male	PHN:9876469824	Dosing Wt:	Isc	olation:	Atte
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Documentation 🕂 Add	Insulin Infusion Heparin Infusion	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			22-Nov-2017	
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	Sedation Scales Provider Notification	Temperat	ture Temporal Artery	DegC		
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	Measurements		al Pulse Rate te Monitored	bpm bpm	80 🔺	
	Glucose Blood Point of Care	SBP/DBP		mmHg	140/90	
CareConnect	Individual Observation Record	Cuff Loca			140/50	
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	Transfer/Transport Shift Report/Handoff		essure Method			
Form Browser	Shirt Neputz hardolf		Perfusion Pressure, Cuff	mmHg		
Growth Chart		⊿ Oxyg	enation			

92 | 186



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

Let's add this comment.

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

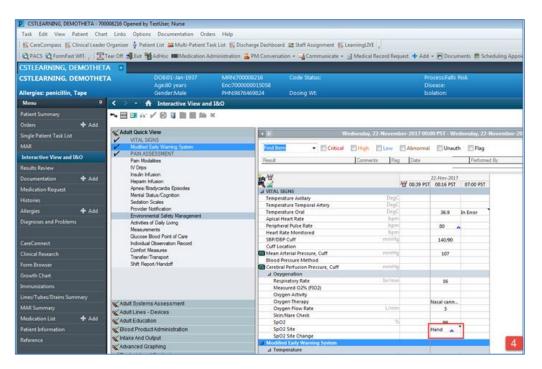
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Task Edit View Patient Ch	aart Links Options Documentation Orders	Help				
🌇 CareCompass 📲 Clinical Lead	ler Organizer 🔺 Patient List 🚨 Multi-Patient Task L	ist 🎬 Discharge Dashboard 🔉 Staff Assignment 🎬 Learr	ingLIVE _			
PACS R FormFast WEI	Tear Off 📲 Evit 🏁 AdHoc 💵 Medication Admir	nistration 🔒 PM Conversation 👻 🔄 Communicate 👻 🗎 N	Aedical Record Request 📥 Ad	d 🛪 🗐 Docum	nents 🖉 Scheduling Annointment	Book Discern R
CSTLEARNING, DEMOTH				u · 🕜 bocan	inter El seriedaning Appointment	← Li
		MRN:700008216 Code Status:)		Location
CSTLEARNING, DEMOTH	Age:80 years	Enc:700000015058		Process:Fali Disease:	Add Result	Enc Type:
Allergies: penicillin, Tape	Gender:Male	PHN:9876469824 Dosing Wt:		solation:	View Result Details	Attending
	A Constructive View and I&			Solution		, teterioini
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Orders 🕂 Add					View Reference Material	
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Histories	Mental Status/Cognition	Temperature Axillary	DegC			
	Sedation Scales Provider Notification	Temperature Temporal Artery	DegC		Clear	
Allergies 🕂 Add	Environmental Safety Management	Temperature Oral	DegC	36.9	View Defaulted Info	
Diagnoses and Problems	Activities of Daily Living	Apical Heart Rate	bpm		View Calculation	
	Measurements	Peripheral Pulse Rate Heart Rate Monitored	bpm	80		
	Glucose Blood Point of Care	SBP/DBP Cuff	mmHg	140/90	Recalculate	
CareConnect	Individual Observation Record	Cuff Location		140/50	View Interpretation	
Clinical Research	Comfort Measures	Mean Arterial Pressure, Cuff	mmHg	107	Reinterpret	
Form Browser	Transfer/Transport Shift Report/Handoff	Blood Pressure Method			Create Admin Note	
	Shire hepoter handon	Cerebral Perfusion Pressure, Cuff	mmHg		Chart Details	
Growth Chart			br/min	16	Not Done	
Immunizations		Measured O2% (FIO2)	M/1100	16	Not Done	
Lines/Tubes/Drains Summary		Oxygen Activity			Flag	
	Adult Systems Assessment	Oxygen Therapy		Nasal cani	Flag with Comment	
MAR Summary	Adult Lines - Devices	Oxygen Flow Rate	L/min	3	Unflag	
Medication List 🛛 🕂 Add	Adult Education	Skin/Nare Check	%			
Patient Information	Section Section	SpO2 SpO2 Site	76	00	Unflag with Comment	
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Reference	Vintake And Output	△ Modified Early Warning System				
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	ov Dracadural Codation	Temperature Temporal Arteny	DeaC			

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

P Comment - CSTLEARNING, DEMOBETA - 700008215	×
SpO2 Site: Hand	
Comment	
Right hand	
OK Car	ncel 3



4. An icon indicating the documentation has been modified ^ will display and another icon indicating comments can be found will display in the cell. Right-click on the cell and select View Comments... to view a comment.



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



PATIENT SCENARIO 8 – PowerForms

Learning Objectives

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

- Document in PowerForms through AdHoc Charting
- View and Modify existing PowerForms

SCENARIO

In this scenario, we will review another method of documentation.

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

- Opening and documenting on a new PowerForm on an AdHoc or as needed basis
- Viewing an existing PowerForm
- Modifying an existing PowerForm
- Uncharting an existing PowerForm

1



Activity 8.1 – Opening and Documenting on PowerForms

Throughout your shift, you will document on your patient. One way of documenting on your patient is to complete PowerForms.

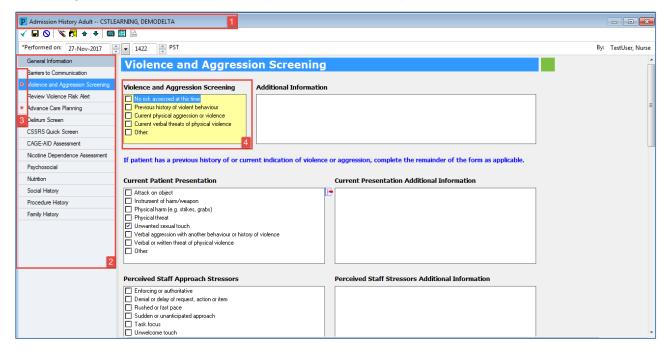
PowerForms are the electronic equivalent of paper forms currently used to document patient information. Data entered in **PowerForms** can flow between other parts of the chart including iView flowsheets, Clinical Notes, Allergy Profile, and Medication Profile.

The **AdHoc** folder in the toolbar is an electronic filing cabinet that allows you to find any PowerForm on an as needed basis.

Note: Do not attempt the next 4 steps, in the system and instead review the screenshot below.

Review the screenshot below for a general overview of PowerForm features:

- 1. Title of the current PowerForm you are documenting on
- 2. List of sections within the PowerForm for documentation
- 3. A red asterix denotes sections that have required field(s)
- 4. Required field(s) within the PowerForm will be highlighted in yellow. You will be unable to sign a PowerForm unless all required fields are completed.



In this example you are going to document on the Advance Care Planning PowerForm.



To open and document on a new PowerForm:

1. Click **AdHoc** from the **Toolbar.** (Remember that **AdHoc** is your filing cabinet for different forms.)

Task Edit View Patient Chart Links Options Documentation Orders Help
🛿 🙀 CareCompass 🎉 Clinical Leader Organizer 🎍 Patient List 😂 Multi-Patient Task List 🎬 Discharge Dashboard 📾 Staff Assignment 🎇 LearningLNE
🛱 CareConnect 🔃 PHSA PACS 🔃 VCH and PHC PACS 🖏 MUSE 🛱 FormFast WFI 🕴 🔀 Tear Off 📲 Eak 🎬 Add+or 💷 Mulledication Administration 🔮 PM Conversation + 📓 Medical Record Request 💠 Add + 📆 Documents 着 Scheduling Appointment Book
C Q Patient Health Education Materials Q Policies and Guidelines Q UpToDate

Note: The Ad Hoc window contains two panes. The left side displays folders that group similar forms together. The right side displays a list of PowerForms within the selected folder.

l	P Ad Hoc Charting - CSTLEARNING, DEMOALPH	на	
	Advission/Transler/Discharge Assessments Gestine (Servet Charts All Rems	B Admission Discharge Outcomes Assessment B Admission Histoy Adu B Admission Histoy Adu B Bark Admission Histoy Pedate Discharge Dencklat Discharge Condents Assessment Discharge Pavning Assessment Discharge Pavning Assessment Discharge Tavning D	
			Chart

2. Select the **Advance Care Planning** PowerForm by selecting the title and clicking Chart

You want to document that your patient has an advanced care plan but it's at home and his family will bring it in.

- 3. Fill in the following fields:
 - Advanced Care Plan = Yes
 - Type of Advance Care Plan = Advance Care Plan
 - Location Of Advance Care Plan = Family to bring in copy from home



P Advance Care Planning - CSTCD, QUEENSYLVI	A				
🖌 🖬 🛇 🧏 🗖 🛧 🔸 💷 🖽 🗎					
* formed on: 27-Nov-2017 📮 🕶 1442	PST PST			By: TestUser,	, Nurse
✓ Advance Care Pla Advance Car	e Planning				*
Advance Care Plan	Yes No Unable to answer at this time	Patient Wishes to Receive Further Information on Advance Care Planning	O Yes O No	Documenting "Yes" automatically fires consult for follow up.	
Type of Advance Care Plan	Advance Care Plan Section 7 Standard Representative Agreement Section 9 Enhanced Representative Agreement Advance Care Plan Form No Cardiopulmonary Resuscitation - Medical Order Retural of Blood Product Tissue, Body, or Organ Donation Other:	Advance Care Plan Details			
Location of Advance Care Plan Documenting "Unable to obtain copy" automatically fires consult for follow up.	Copy to be obtained from previous records Copy placed on paper chait Family to bring in copy from home Available as scarned document in EHR Unable to obtain copy Other:	Reason Copy Cannot Be Obtained			
	3				
				In Progres	s i

Note: using the Save Form \blacksquare icon is discouraged because no other user will be able to view your saved documentation until it is signed. To sign use the green checkmark icon \checkmark .

- PowerForms are electronic forms used to chart patient information
- The AdHoc button MAdHoc in the Toolbar allows you to locate a new Powerform on an as needed basis
- PowerForms may be broken up into several sections. Section headings are displayed to the left side of PowerForm
- Always Sign the PowerForm using green checkmark 🖌 so that other users can see it in the chart



Activity 8.2 – Viewing an existing PowerForm

1

Throughout your shift, you may need to view previously documented PowerForms. **FormBrowser** is where you can find any PowerForm that has been signed by any user.

To view a **PowerForm**:

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

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Task Edit View Patient Chart Links	Options Help				
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🖸 😋 CareConnect 😋 PHSA PACS 🔇 VCH and	i PHC PACS 🔇 MUSE 🔇 FormFast WFI 🝦 🗄 🎛 Tear Off	최 Exit 🎬 AdHoc 🎟 Medication Admi	nistration 🔒 PM Conversation 👻 🗎 Medical Record Request 🔸 Ad	d 👻 🖲 Documents 🗂 Scheduling Appoints	ment Book
🕄 😋 Patient Health Education Materials 🜊 Pol	icies and Guidelines 🜊 UpToDate 🖕				
CSTLEARNING, DEMOTHETA 🛛 🗷				🔶 List 🔿 🎢 Recent 🕶 Name	<u>+ م</u>
CSTLEARNING, DEMOTHETA	DOB:17-Oct-1977 MRN:700002071	Code Status:	Process:Violence Risk,Falls Risk	Location:	
Allergies: Hamsters, Peanuts, Spiders, W	Age:40 years Enc:700000001553 hite aGender:Female PHN:9878190923	5 Dosing Wt:47 kg	Disease: Isolation:	Enc Type:Inpatient Attending:Plisvca, Rocco, MD	
Menu	C C Form Browser	bosing may kg		[I] Full screen	₽ 0 minutes ago
Patient Summary			2, 2017 PST- Tuesday, November 28, 2017 PST(Clinical Range)		1.1
Orders + Add		wednesday, November 2	2, 2017 PST- Tuesday, November 28, 2017 PST(Clinical Range)		
Single Patient Task List	Sort by: Form 👻				
MAR	All Forms				
Interactive View and I&O	Admission History Adult				
Results Review	Basic Admission Information	Contributors 2			
Documentation 🕂 Add	22 Nov 2017 09:44 PST (In Error) - Multi C	ontributors 3			
Medication Request	22-Nov-2017 08:44 PST (Auth (Verified)) -	TestCST, Nurse3 CD 4			
Histories	Nursing Discharge Checklist 217-Nov-2017 15:52 PST (In Progress) - Tes	User, Nurse 5			
Allergies 🕂 Add					
Diagnoses and Problems					
CareConnect					
Clinical Research					
Form Browser					
Growth Chart					
Immunizations					
Lines/Tubes/Drains Summary					
MAR Summary	•				
				PRODBC TEST.NURSE Monday, 27-Noverr	ber-2017 16:02 PST

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



Activity 8.3 – Modify an existing PowerForm

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

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

Let's modify the Advanced Care Planning form.

To modify a PowerForm select it from within Form Browser:

- 1. Right-click on the most recently completed **Advance Care Planning** form within **Form Browser**
- 2. Select Modify

All Forms	
🖨 🗗 Advance Care Planning	
- 21-Nov-2017 15:49 PST (Auth (Verified)) - TestUser, **	1 View
- 🖪 21-Nov-2017 15:20 PST (In Progress) - TestUser, Nu	Modify 2
Allergy Rule TestORD, TestORD, TestORD,	Unchart History Change Date/Time

3. Change the selection for Advance Care Plan from Yes to No



P Advance Care Planning - CSTLEARNING, DEMO	BETA		
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*Performed on: 22-Nov-2017 💌 🕶 1628	PST V		By: TestUser, Nurse
Advance Care Advance Care	Planning		^
Advance Care Plan	Vec INO I	Patient Wishes to Receive Further Information on Advance Care Planning	O Yes O No Documenting "Yes" automatically fires consult for follow up.
Care Plan	Advance Care Plan Section 7 Standard Representative Agreement Section 7 Enhanced Representative Agreement Advance Care Plan Form No Cardiopulmonary Resuccitation - Medical Order Refusal of Blood Product Tissue, Body, or Organ Donation Other:	Advance Care Plan Details	
Care Plan Documenting "Unable to	Copy to be obtained from previous records Copy placed on paper chart Family to bring in copy from home Available as scanned document in EHR Unable to obtain copy Other:	Reason Copy Cannot Be Obtained	
	L]	111	· · · · · · · · · · · · · · · · · · ·

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

- A document can be modified if needed
- A modified document will show up as (Modified) in the Form Browser



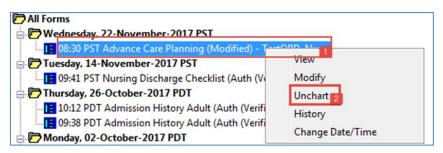
Activity 8.4 – Uncharting an existing PowerForm

1

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

To unchart the PowerForm, within Form Browser:

- 1. Right-click on Advance Care Planning
- 2. Select Unchart



Enter a reason for uncharting in the comment box = Wrong PowerForm

3. The Unchart window opens.

4. Click green checkmark < to sign the documentation and then click the Refresh icon <

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





Key Learning Points

A document can be uncharted if needed

An uncharted document will show up as In Error in the Form Browser



PATIENT SCENARIO 9 – Document an Allergy

Duration	Learning Objectives
5 minutes	At the end of this Scenario, you will be able to:
	Document Allergies

SCENARIO

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

As an inpatient rural nurse you will complete the following activity:

Review allergies

Add an allergy



Activity 9.1 – Review Allergies

1

When your patient is admitted, you need to review his allergies. **Allergies** in the CIS carry forward from previous encounters.

First notice that an allergy to **Peanuts** appears in the top left corner of the banner bar:

Task Edit View Patient Chart Links	Navigation Help				
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🖾 Tear Off 💐 Exit 🏙 AdHoc 🎟 Medicatio	n Administration 🗟 Medical Record	l Request 💐 Result Copy ይ F	elated Records 🔸 Add + 🖻 Documents	🛱 Scheduling Appointment Book 🗃 Discem Reporting	Portal Conversation Launcher 🔮 Patient Locator
Realist Health Education Materials	OP Guidelines and DSTs QUPTOD	ate :			
CSTLABMEKOEMPI, UT U					+ List + Mane • •
CSTLABMEKOEMIN JTWU	DO8:13-Dec-1967	MRN:700001810	Code Status:	Process:	Location:SGH MS; 107; 01
	Age:50 years				Enc Type.inpatient
Allergies: Peanuts	Gender:Male	PHN:9878210108	Dosing Wt:70 kg	Isolation:	Attending:Plisvca, Rocco, MD
Menu	🔉 🔸 🛉 Patient Summary				🔅 Full screen 👘 Prost 💐 2 minutes age

You need to verify that **Peanuts** is still an active allergy for your patient and that it has been recorded correctly in the CIS.

- 1. Click on the Allergies control from the Menu
- 2. The **Allergies** page opens and you note that the patient has an active, severe food allergy to Peanuts
- 3. You confirm this information with the patient
- 4. Click the Mark All as Reviewed button
- 5. Notice that the Reviewed date and the Reviewed By columns have been updated

👫 CareCompass 🌇 Clinical Lead	er Organizer 🧍 Patient List 🖴 Multi-Pa	atient Task List Tracking Shell 💯 Case S	election 📽 Staff Assignment 腦 Le	arningLIVE 💡 🕄 CareConn	ect 🕄 PHSA PACS 💐 VCH and PHC PA	ACS 🞕 MUSE 💐 FormFast WFI 💡
🖾 Tear Off 📲 Exit 🎽 AdHoc 🎟	Medication Administration 📓 Medical	Record Request 🛸 Result Copy 🎩 Rela	ted Records 🔸 Add 🛛 🖻 Docume	nts 🛎 Scheduling Appointm	ent Book 🗃 Discern Reporting Portal	Conversation Launcher 😨 Patient Locator
Real Patient Health Education Mat	rials 🔍 SHOP Guidelines and DSTs 🔌	UpToDate _				
CSTLABMEKOEMPI, UTWU	CSTCD, QUEENSYLVIA					← List → @Recent - Name - Q
CSTLABMEKOEMPI, UTWU	DOB:13-Dec-196		Code Status:		ocess:	Location:SGH MS; 107; 01
Allergies: Peanuts	Age:50 years Gender:Male	Enc:700000002693 PHN:9878210108	Dosing Wt:70 kg		isease: olation:	Enc Type:Inpatient Attending:Plisvca, Rocco, MD
Menu	a 🗸 🗦 - 👫 Allergies					💭 Full screen 🖷 Print 💸 6 minutes ago
Patient Summary						
Women's Health Overview	Mark All as Reviewed 4					
Orders 🕈 Add	+Add Modify No	Known Allergies ON Known Medic	ation Allergies 🛛 🧖 Reverse Aller	gy Check Display All	~	
Single Patient Task List						
MAR	D. Substance No Known Allergies	Category Severity Reactions	Interaction Comments Source	Reaction Status Reviewed Canceled 07-Feb-20		pdated By 7-Feb
MAR Summary	Peanuts	Food Severe				7-Feb 2
Interactive View and I&O Results Review		iood serere				
Documentation + Add				1		
Notes + Add				_/		
Medication Request				5		
Histories						
Allergies + Add 1						
Diagnoses and Problems						
Perioperative Doc						
CareConnect						
Clinical Research						
Form Browser Growth Chart						
Immunizations						
Lines/Tubes/Drains Summ_						
Medication List + Add						
Newborn Liaison						
Patient Information						
Postpartum Liaison						
Pregnancy Summary Report						
Reference						

Note: Refer to your site policies for further information about patient allergies

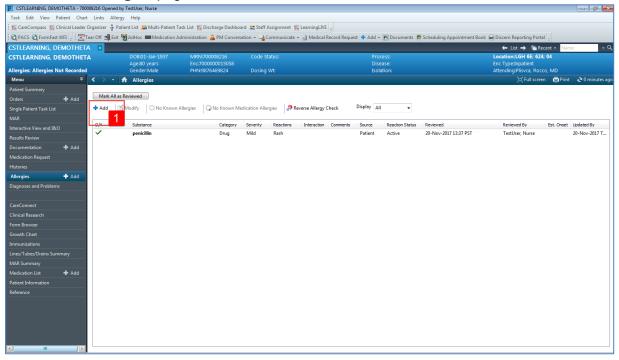


- You can review patient's allergies by accessing the **Allergies** control from the menu
- Verifying Allergies with patients is an important part of the admission process
- Clicking the Mark All as Reviewed button in the **Allergies** control lets other users know when the patient's allergies were last reviewed and by who



🔹 Activity 9.2 – Add an Allergy

- You notice mild redness to the patient's skin where there is tape applied. The patient then states that he remembers having a similar allergic reaction years ago to tape, but he forgot to mention it in the ED. To document this tape allergy:
 - 1. From the Allergies page, click + Add



In the Substance field type *tape* and click the Search icon .
 Note: Yellow highlighted fields including substance and category are mandatory fields that need to be completed.



CSTLEARNING, DEMOTHETA - 7000	08216 Opened by	r TestUser, Nurse											
Task Edit View Patient Chart Links Allergy Help													
🗄 🌇 CareCompass 📲 Clinical Leader C	Organizer 🛉 Pati	ient List 🔉 Multi-Patient Task	List 📲 Discharge Dashboa	ard 🗝 Staff	Assignment	👫 LearningLIV	i 🖕						
🕴 😋 PACS 🔞 FormFast WFI 🝦 🗄 🏋 To	ear Off 📆 Exit 🎙	AdHoc IIIII Medication Adm	inistration 🔒 PM Convers	ation 👻 🔩	Communicate	🔹 🗄 Medical	Record Reque	st 🕂 Add	- 🖲 Documents 🛛	Scheduling Appointment Bo	ok 🗃 Discern Reporting Port	tal 🤤	
CSTLEARNING, DEMOTHET#											🔶 List 🔶 🍋 R	ecent 👻 Nar	ne 🗸 🗸
CSTLEARNING, DEMOTHET	A	DOB:01-Jan-1937	MRN:700008216								Location:LGH 6E; 62	4; 04	
Allergies: Allergies Not Recorded		Age:80 years Gender:Male	Enc:700000015058 PHN:9876469824	Dosing					ease: lation:		Enc Type:Inpatient Attending:Plisvca, Roo	co, MD	
Menu ^a	< > - I	Allergies									[0] Full scree	n 🛱 Print	₽ 20 minutes ago
Patient Summary													
Orders 🕂 Add	D/A	Substance	Category	Severity	Reactions	Interaction	Comments	Source	Reaction Status	Reviewed	Reviewed By	Est. Onset	Updated By
Single Patient Task List	~	penicillin	Drug	Mild	Rash			Patient	Active	20-Nov-2017 13:43 PST	TestUser, Nurse		20-Nov-2017 T
MAR													
Interactive View and I&O													
Results Review													
Documentation 🛛 🕂 Add													
Medication Request													
Histories	Type Alle	ergy 🗸 🖌 adver	e reaction to a drug or substa	nce which is d	lue to an immur	iological response							
Allergies 🕂 Add	*Substance												
Diagnoses and Problems	tape	A Fee text											Add Comment
	Reaction(s)	2	*Severity	Info source									
CareConnect	Treaction(s):	Add Free Text		<not enter<="" td=""><td></td><td>Comments</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></not>		Comments							
Clinical Research		Ma Hee reat											*
Form Browser			At: <not entered=""></not>	Unset: <r< td=""><td>not entered></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></r<>	not entered>								
Growth Chart			Years 🔻		× •								*
Immunizations			Recorded on behalf of	*Category		Status	Reaso	n:					
Lines/Tubes/Drains Summary MAR Summary					•	Active	•	*					
Medication List + Add											ОК	X & Add New	Cancel
Patient Information													
Reference	🐴 Up 🖆	Home 🚖 Favorites 🔹	Folders Folder: Faw	orites									
	Canal System Trac	cked											
< ►	L												

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

Enc:7000 PHN:987	000015058	sina Wt:			Disease: Isolation:	
PHIN:967	Substance Search	sind wi:				
	*Search: tape		Starts with	• Within:	Terminology 👻	F
	Searc	h by Name		Search by Co	de	2
	Terminology: Alle	ergy, Multum Allı	Terminology Axis	<all td="" term<=""><td>ninology ax</td><td></td></all>	ninology ax	
	Categories					L
	Term	ies found >		Terminology		
adverse reaction						
	Tem 🔺	Code	Terminology T	erminology Axis		
	Таре	14598838	Allergy Al	lergy		
*Severit	tapentadol	d07453	Multum Drug G	eneric Name		
t <not ent<="" td=""><td></td><td></td><td></td><td></td><td></td><td></td></not>						
At: <n< td=""><td></td><td></td><td></td><td></td><td></td><td></td></n<>						
Recorded						
🔹 🚞 Folde	Add to Favorites			ОК	Cancel	
						3



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

CSTLEARNING, DEMOTHETA - 7000	08216 Opened by TestUser, Nurse											
Task Edit View Patient Chart	Links Allergy Help											
🗄 🌇 CareCompass 👖 Clinical Leader C	rganizer 👌 Patient List 👪 Multi-Patient Tas	k List 🌇 Discharge Dashboa	erd 🚟 Staff A	kssignment 📳	LearningLIV	E						
QPACS Q FormFast WFI	ar Off 📲 Exit 🐞 AdHoc 💵 Medication Ad	ministration 🔒 PM Convers	ation - 🛁 C	ommunicate	- 📄 Medical	Record Requ	est 🕂 Add -	Documents	Scheduling Appointment Bo	ok 🗃 Discern Reporting Porti	1	
CSTLEARNING, DEMOTHETA										🗲 List 🔿 🛍 Re	cent + Nam	* Q
CSTLEARNING, DEMOTHETA		MRN:700008216								Location:LGH 6E: 624	: 04	
Allergies: Allergies Not Recorded	Age:80 years Gender:Male	Enc:7000000015058 PHN:9876469824	Dosing					ease: ation:		Enc Type:Inpatient Attending:Plisyca, Roc	:o, MD	
Menu #	< > 🔸 Allergies									(D) Full screer	Print	ninutes ago
Patient Summary	the second s		116.00		and the second	11.2 · ····	11.5.2	10000-0000	11.6297 M	11925 702		
Orders 🕂 Add	D/A Substance	Category	Severity	Reactions	Interaction	Comments	Source	Reaction Status	Reviewed	Reviewed By	Est. Onset	
Single Patient Task List	✓ penicillin	Drug	Mild	Rash			Patient	Active	20-Nov-2017 13:43 PST	TestUser, Nurse		20-Nov-2017 T
MAR												
Interactive View and I&O												
Results Review												
Documentation 🕂 Add												
Medication Request												
Histories	Type Allergy + An adv	erse reaction to a drug or substan	nce which is du	ue to an immuno	logical respons							
Allergies 🕂 Add	*Substance											
Diagnoses and Problems	Tape 🙀 🗇 Free test	No allergy checking is avail	lable for non-M	ultum allergies.								Add Comment
CareConnect	Reaction(s):	*Severity	Info source		Comments							
Clinical Research	Add Free Test	Mid 👻	Patient	-	Cumours							
Form Browser		At crist entere	Onset on	ok enkered> 5								· · ·
Growth Chart		Year 4										
Immunizations		Recorded on behalf of	*Category		Status	Reaso	onc.					
Lines/Tubes/Drains Summary			Biher	-	Active							
MAR Summary				6								
Medication List 🛉 Add				0						OK O	C & Add New	Cancel
Patient Information	😝 Up 🖾 Home 😭 Favorites 🔹	Folders Frider Favo	vites							1		
Reference	System Tracked											
4	gyanni Havani											

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

STLABMEKOEMPI, UTWU	als Q SHOP Guidelines and DSTs QU CSTCD, OUEENSYLVIA										← List → 🎕 R	ecent • N	ame •
STLABMEKOEMPI, UTWU	DOB:13-Dec-1967 Age:50 years Gender:Male		4:700001810 7000000002693 1:9878210108	Code Statu			Process: Disease: Isolation:				Location:SGH MS; 107; 01 Enc TypeInpatient		
Menu	P C > + Allergies	PHE	19878210108	Dosing Wt	/0 kg		Isolation				Attending Plisyca, Rocco, MD		O minutes a
											, un screen	tager filling	
	A CONTRACT OF A												
	Mark All as Reviewed												
Vomen's Health Overview	Mark All as Reviewed		-										
Patient Summary Nomen's Health Overview Orders + Add	Mark All as Reviewed	own Allergies	O No Known N	ledication Allergi	es 🧖 Reverse A	Allergy Check	Display All	v					
Vomen's Health Overview Orders + Add Jingle Patient Task List	◆Add II Modify I No Ki			-				v					
Vomen's Health Overview Orders + Add ingle Patient Task List MAR	 Add I Modify □ No Ki D. Substance 	Category	No Known N Severity Reactor	-	es Reverse A	rce Reaction Status	Reviewed	v Reviewed By	Est. Onset	Updated By			
Vomen's Health Overview Irders + Add ingle Patient Task List IAR	Add Modify No Ke Substance No Known Allergies	Category Drug	Sevenity Reaction	-		rce Reaction Status Canceled	Reviewed 07-Feb-2018-0	TestUser, Ru		07-Feb			
Vomen's Health Overview Orders + Add ingle Patient Task List	 Add I Modify □ No Ki D. Substance 	Category	Severity Reactor	-		rce Reaction Status	Reviewed 07-Feb-2018 0	TestUser, Ru TestUser, Ru		07-Feb			
Vomen's Health Overview Orders + Add ingle Patient Task List MAR MAR Summary	Add Modify No Ke Substance No Known Allergies	Category Drug	Sevenity Reaction	-		rce Reaction Status Canceled	Reviewed 07-Feb-2018-0	TestUser, Ru TestUser, Ru		07-Feb			
Vomen's Health Overview vrders + Add ingle Patient Task List MAR MAR Summary steractive View and I&O	Add Modify No Ki Substance No Known Allergies Peanuts	Category Drug Food	Severity Reactor	-		rce Reaction Status Canceled Active	Reviewed 07-Feb-2018 0	TestUser, Ru TestUser, Ru		07-Feb			
tomen's Health Overview rders ♣ Add ngle Patient Task List AR AR Summary teractive View and I&O esults Review	Add Modify No Ki Substance No Known Allergies Peanuts	Category Drug Food	Severity Reactor	-		rce Reaction Status Canceled Active	Reviewed 07-Feb-2018 0	TestUser, Ru TestUser, Ru		07-Feb			

Note: Allergies in the banner bar are sorted by severity (most to least). In this case **Peanuts** causes a more severe reaction than **Tape**. If the allergies listed are longer than the space available, the text will be truncated. Hovering over the truncated text will display the complete allergies list.



Key Learning Points

Documented allergies are displayed in the Banner Bar for all who access the patient's chart

Allergies will display with the most severe allergy listed first



PATIENT SCENARIO 10 - Review Medication Administration Record (MAR)

Duration	Learning Objectives
10 minutes	At the end of this Scenario, you will be able to: Review the Layout of the MAR
	Request a Medication from Pharmacy
	Reschedule a Single Dose of a Medication
	Reschedule all administration times of a medication

SCENARIO
In this scenario, you will be reviewing the scheduled and PRN medications for your patient today.
As a rural inpatient nurse, you will complete the following activities:
Review the layout of the MAR
Request a medication from pharmacy
Reschedule a Single Dose of a Medication
Reschedule all future doses of a medication



b Activity 10.1 – Review the MAR

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

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

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

Menu		Ф	<	> -	A MAR				
Patient Summary			*6	66 📄					
Orders	🕂 Add								
Single Patient Task Li	st		2	All Medi	ications (System)	▼ … < >		Wednesday, 13	-Decemb
MAR		1	V	Show All F	Rate Change Docu	Medications	14-Dec-2017 15:09 PST	14-Dec-2017 15:08 PST	14-Dec 14:00
MAR Summary				Tin	ne View	Scheduled		15:06 PST	14:00
Interactive View and I	1&0			Scheduled	2	acetaminophen	650 mg Last given:		
Results Review				Unschedu	led	650 mg, NG-tube, q4h, drug form: tab, start: 14-Dec-2017 15:09 PST Maximum acetaminophen 4 g/24 h from all sources	11-Dec-2017 11:18 PST		
Documentation	🕇 Add			PRN		acetaminophen			
Medication Request				Continuou	us Infusions	Temperature Axillary Temperature Oral			
Histories				Future		Numeric Pain Score (0-10)	50 ma		
Allergies	🕂 Add			Discontinu	ied Scheduled	ranitidine	Not previously		
Diagnoses and Proble	ems			Discontinu	ued Unscheduled	50 mg, IV, q12h, start: 14-Dec-2017 15:09 PST ranitidine	given		
				Discontinu	ied PRN	т.		1,000 mg Last given:	
CareConnect				Discontinu	ied Continuous Infu	vancomycin 1,000 mg, IV, q12h, start: 14-Dec-2017 15:08 PST		Last given: 11-Dec-2017 11:18 PST	
Clinical Research						vancomycin			
Form Browser						PRN PRI			_
Growth Chart						HYDROmorphone (DILAUDID PRN range dose) dose range: 0.5 to 1 mg, NG-tube, q4h, PRN pain, drug form: tab, start:	Last given: 11-Dec-2017 11:18 PST		
Immunizations						11-Dec-2017 10:43 PST HYDROmorphone	11:10 P31		
Lines/Tubes/Drains S	ummary					Respiratory Rate	N 5 mg		
Medication List	🕇 Add					salbutamol	Last given:		
Patient Information						5 mg, nebulized, q4h, PRN shortness of breath or wheezing, drug form: neb start: 12-Dec-2017 10:32 PST	12-Dec-2017 10:42 PST		
Reference						salbutamol			

3. Next, select in order, **Unscheduled**, **PRN** and **Continuous Infusions**, bringing each section to the top of the list for your review. (Your patient may not have any unscheduled medications ordered at this time.)

Note: Unscheduled means that there is no specific date and time associtated with administering a medication. An example of an **Unscheduled** medication is one that is meant to be administered prior to a procedure, but the procedure date/time is undetermined.



- 4. Review the medications on the MAR e.g. acetaminophen 650 mg PO Q4H. Be sure to review all medication information.
- 5. If you wish to review the Reference Manual right-click on the medication name and select the **Reference Manual**.

All Active Medications (Syster	n) 👻 🔜 🔹 🕨			1	
Show All Rate Change Docu	Medications	23-Nov-2017 14:00 PST	23-Nov-2017 10:00 PST	23-Nov-2012 06:00 PST	
Time View	Scheduled	and the second sec	A CONTRACTOR OFFICE	de la composition de	
Scheduled	10	650 mg	650 mg	650 mg	
Unscheduled	acetaminophen 650 mg, PO, q4h, drug form: tab, star 20-Nov-2017 14:04 PST		20-Nov-2017 14-08-057	20-Nov-2017 14-08 PST	
PRN .	Maximum acetaminophen 4 g/24 t	rder Info			
Continuous Infusions 3	acetaminophen Temperature Axillary	Event/Task Summ			
Future	Temperature Oral	Link Info	10		
Discontinued Scheduled	Numeric Pain Score (0-10)	Reference Manua	5		
Discontinued Unscheduled	cefTRIAXone	Med Request	-		
	1,000 mg, IV, q12h, start: 20-Nov-2 14:18 PST	Reschedule Adm			
Discontinued PRN	cefTRIAXone	Additional Dose.			
Discontinued Continuous Infus	ेव	View MAR Note.		3 mg	
	HYDROmorphone 3 mg, NG-tube, q4h, start: 20-Nov- 15:54 PST	Create Admin No	Nov-2017 7 PST		
	HYDROmorphone	Alert History			
	Respiratory Rate	Infusion Billing			

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

______ – Indicates the medication order has not been verified by pharmacy

60 - Indicates the order needs to be reviewed by the nurse

Indicates the medication is part of a PowerPlan

< > - ₼ MAR						
*** 6** 🗎						
MI Medications (System)	▼ ▲ Monday, 20	18-January-15 (09:13 PST - Wee	dnesday, 2018-J	anuary-17 09:13	3 PST (Clinical Ra
Show All Rate Change Docu	Medications	2018-Jan-16 09:13 PST	2018-Jan-16 08:00 PST	2018-Jan-16 07:00 PST	2018-Jan-16 06:00 PST	2018-Jan-16 02:00 PST
Time View Scheduled	ranitidine 50 mg, IV, q8h interval, start: 2017-Dec-27 13:00 PST					50 mg Not previously given
Unscheduled	For ventilated patients ranitidine					
PRN Continuous Infusions	sodium chloride 0.9% (sodium chloride 0.9% (NS) bolus) 500 mL, IV, once, drug form: bag, first dose: Routine, start: 2017-Dec-27 05:00 PST, stop: 2017-Dec-27 05:00 PST			500 mL Not previously given		
	sodium chloride 0.9% mainie 200 mg, IV, qdaily, order duration: 3 day, drug form: inj, start: 2017-Dec-27 12:14 PST, stop: 2017-Dec-30 07:59 PST VTTAMIN BL EQUIV		200 mg Not previously given			200 mg Not previously given
 Discontinued Continuous Infus 	1,000 mg, IV, q12h, administer over: 60 minute, drug form: bag, start: 12-Jan-2018 10:00 PST, bag volume (ml.): 250					1,000 mg Not previously given
	vancomycin PRN Na Den Den	125.0				



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

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

All Orders with Active Tasks in	n Tir ▼ 📖 🗘			Tuesday, 28-N	lovember-2017	12:21 PST - Thu	ırsday, 30-Noven	nber-2017 12:2	1 PST (Clinical R	ange)			
Show All Rate Change Docu	Medications	30-Nov-2017 10:00 PST	30-Nov-2017 06:00 PST	30-Nov-2017 02:00 PST	29-Nov-2017 22:00 PST	29-Nov-2017 18:00 PST	29-Nov-2017 14:00 PST	29-Nov-2017 12:26 PST	29-Nov-2017 12:22 PST	29-Nov-2017 10:00 PST	28-Nov-2017 22:00 PST	8	
Time View	Scheduled											_	
Scheduled	ेल acetaminophen (TYLENOL)	640 mg Last given:	640 mg Last given:	640 mg Last given:	640 mg Last given:	640 mg Last given:	640 mg Last given: 22-Nov-2017						
Unscheduled PRN	640 mg, PO, q4h, drug form: oral liq, start: 29-Nov-2017 14:00 PST Maximum acetaminophen 4 g/24 h from all sources	22-Nov-2017 12:41 PST	22-Nov-2017 12:41 PST	22-Nov-2017 12:41 PST	22-Nov-2017 12:41 PST		22-NOV-2017 12:41 PST						
Continuous Infusions	acetaminophen Temperature Axillary												
Future	Temperature Oral Numeric Pain Score (0-10)												
Discontinued Scheduled	Transier Pain Score (0-20)	1.000 ma			1,000 mg		1		1,000 mg				
Discontinued Unscheduled	vancomycin 1,000 mg, IV, q12h, start: 29-Nov-2017 12:22 PST	Last given: 22-Nov-2017			Last given: 22-Nov-2017				Last given: 22-Nov-2017				
Discontinued PRN	vancomycin	10:00 PST			10:00 PST				10:00 PST				
iscontinued Continuous Infus	PRN												
	PRN HYDROmorphone (DILAUDID PRN range dose) dose range: 0.5 to 1 mg, PO, q1h, PRN pain, drug form: oral liq start: 29-Nov-2017 12:24 PST							1 mg Not previously given					
	HYDROmorphone												
	Respiratory Rate												
	Continuous Infusions sodium chloride 0.9% (NS) continuous infusion 1,000 mL order rate: 75 mL/h, IV, drug form: bag, start: 29-Nov-2017 12:23 PST, bag volume (mL): 1,000							Pending Not previously given					
	Administration Information sodium chloride 0.9%							9					

Note: different sections of the MAR and statuses of medication administration are identified using color coding:

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

Key Learning Points

- The MAR is a record of the medication to be administered to the patient by a clinician
 - The MAR lists medication in reverse chronological order

The MAR displays all medication orders, tasks, and documented administrations for the selected time frame



Activity 10.2 – Request a Medication and Rescheduling Medication Administration Times

- Let's say you can't find the Vancomycin IV medication vial. You need to submit a **Med Request** to Pharmacy.
 - 1. Right click on the medication order name vancomycin 1,000mg, IV, q12h
 - 2. Select Med Request...

1

Menu		< > - 者 MAR									
Patient Summary	<u>^</u>	166 🗎									
Orders	🖶 Add										
Single Patient Task List		All Medications (System)	▼ Vednesday, 13-December-2017 10:58								
MAR		Show All Rate Change Docu	Medications	14-Dec-2017 10:58 PST 10:00 PST							
MAR Summary		Time View	Scheduled								
Interactive View and I&O		Scheduled	acetaminophen	650 mg Last given:							
Results Review		Unscheduled	650 mg, NG-tube, q4h, drug form: tab, start: 11-Dec-2017 10:42 PST Maximum acetaminophen 4 g/24 h from all sources	11-Dec-2017 11:18 PST							
Documentation	🖶 Add	PRN	acetaminophen								
Medication Request		Continuous Infusions	Temperature Axillary Temperature Oral								
Histories		👿 Future	Numeric Pain Score (0-10)								
Allergies	+ Add	Discontinued Scheduled	vancomvcin	1,000 mg							
Diagnoses and Problems		Discontinued Unscheduled	1,000 mg, IV, q12h, start: 11-Dec-2017 10:43 PST	Order Info							
Diagnoses and Problems		Discontinued PRN	vancomycin	Event/Task Summary							
		Discontinued Continuous Infus	PRN	Link Info							
CareConnect			HYDROmorphone (DILAUDID PRN range dose)	Reference Manual							
Clinical Research			dose range: 0.5 to 1 mg, NG-tube, q4h, PRN pain, drug form: tab, sta 11-Dec-2017 10:43 PST	Med Request 2							
Form Browser			HYDROmorphone	Reschedule Admin Times							
Growth Chart			Respiratory Rate	Additional Dose							
			Salbutamol	View MAR Note							
Immunizations		Therapeutic Class View	5 mg, nebulized, q4h, PRN shortness of breath or wheezing, drug fo	Create Admin Note							
Lines/Tubes/Drains Summ	hary	Route View	start: 12-Dec-2017 10:32 PST salbutamol	Alert History							
Medication List	🕈 Add	Plan View	Salbutamol Continuous Infusions	Infusion Billing							

- 3. In the Reason dropdown menu, select Cannot locate.
- 4. Select a priority option. Select Low.
- 5. Click **Submit**

P Medication Request
CSTLEARNING, DE 81 years M DOB: 01-Jan-1937
ceFAZolin 1,000 mg, IV, q8h, start: 08-Feb-2018 14:00 PST
Last request: View History
*Reason: Cannot locate
Priority Low Medium High Comment
Comment
5 Submit Cancel



Note: Only enter Low for Priority of Medication Request unless absolutely necessary. Pharmacy will receive this Medication Request message and be aware that they need to send the medication to the patient's location!

- 2 If you are wondering what the status is on a Medication Request, you can find out by following these steps:
 - 1. Right click on the medication order name vancomycin 1,000mg, IV, q12h
 - 2. Select Med Request...

Menu	4	🕻 > 🕌 者 MAR			
Patient Summary	1	*i 60° 🗎			
Orders 🕂 Add					
Single Patient Task List		All Medications (System)	▼ …	lay, 13-December-2	2017 10:58 PST -
MAR		Show All Rate Change Docu	Medications	14-Dec-2017 10:58 PST	14-Dec-2017 10:00 PST
MAR Summary		Time View	Scheduled	10.501.51	
Interactive View and I&O	10	Scheduled	acetaminophen		650 mg Last given:
Results Review		Unscheduled	650 mg, NG-tube, q4h, drug form: tab, start: 11-Dec-2017 10:42 PST Maximum acetaminophen 4 g/24 h from all sources		11-Dec-2017 11:18 PST
Documentation 🛛 🕂 Add	11	PRN	acetaminophen		
Medication Request		Continuous Infusions	Temperature Axillary Temperature Oral		
Histories	10	🛛 Future	Numeric Pain Score (0-10)		4 000
Allergies 🕂 Add		Discontinued Scheduled	vancomycin		1,000 mg
Diagnoses and Problems		Discontinued Unscheduled	1,000 mg, IV, q12h, start: 11-Dec-2017 10:43 PST	Order Info	
	10	Discontinued PRN	vancomycin	Event/Task Sumr	nary
CareConnect	Цĉ	对 Discontinued Continuous Infus	PRN	Link Info Reference Manua	ıl
Clinical Research	ш		HYDROmorphone (DILAUDID PRN range dose) dose range: 0.5 to 1 mg, NG-tube, g4h, PRN pain, drug form: tab, sta	Med Request	2
Form Browser	ш		11-Dec-2017 10:43 PST HYDROmorphone	Reschedule Adm	in Times
			Respiratory Rate	Additional Dose.	
Growth Chart			ेस	View MAR Note	
Immunizations		Therapeutic Class View	salbutamol 5 mg, nebulized, q4h, PRN shortness of breath or wheezing, drug fo	Create Admin No	te
Lines/Tubes/Drains Summary		Route View	start: 12-Dec-2017 10:32 PST salbutamol	Alert History	
Medication List 🕂 Add		Plan View	Continuous Infusions	Infusion Billing	

3. Click on the View History blue text View History

P	Medicati	on Request		Х
TESTCSTSQ,	TEN TEN	33 years M	DOB: 19-Nov	-1984
vancomycin 1,00	0 mg, IV, q12h, s	tart: 07-Feb-201	8 11:49 PST	
Last request: Per Vie	nding (1) - 17 mi w History 3	n ago		
*Reason:				
		÷		
* Priority				
Low Medium				
⊖ High				
* Comment				
		Submit	Cance	el



- 4. The **Medication Request History** window appears. You can review information about any medication requests here.
- 5. When you are finished reviewing, click **Done**

1	P		Medication	Request History				×
ſ	vancomycin 1,000 mg	, IV, q12h, start: 07-Feb-2018 11:4	9 PST					
L	Status			Reason:	Priority/Doses	Event Time		
	Pending			Change in scheduled ti. ation times to 0500 and		07-Feb-2018 1	13:02 PST	4
Ì								
							Done	5

Note: You will also find a Medication Request tab in the Menu. This page will give you medication request information about multiple medications at a time.

TESTCSTSQ, TEN TEN	DO8:19-Nov-1984 Age:33 years	MRN:700003210 Enc:7000000015011	Code Status:	Process: Disease:			Location:SGH MS; 111; 01 Enc Type:Inpatient	
Allergies: Peanuts, Tape	Gender:Male	PHN:9878031741	Dosing Wt:	Isolation:			Attending:Plisvcb, Stuart, MD	
Menu P	< 🕞 🔸 🛖 Medication Request						(¤) Full screen 🖷 Pr	int 🛛 😌 1 hours 10 minutes ago
Patient Summary		0.4						
Women's Health Overview	A D D S S 100% - O	• a						
Orders 🕂 Add	Medication Request							۰
Single Patient Task List						Apply to Selected		
MAR						Reason:	Priority:	
MAR Summary						×	× .	Apply Clear
Interactive View and I&O	⊿ Plans (0)							
Results Review	4 Scheduled (2)							
Documentation + Add	Medications				iew History Rea:	100	Comment:	
Notes 🕂 Add	acetaminophen, 650 mg, PO,	q4h, drug form: tab, start: 07-Feb-2018 11	:48 PST, Maximum acetaminophen 4 g/24 h from all so	urces	ien nacory icea.	×	Comment.	
Medication Request					Prior	ity		
Histories					Lov	v V		
Allergies 🕂 Add	Tunnenmurin 1 000 mg IV at	2h, start: 07-Feb-2018 11:49 PST		v	iew History Rea:		Comment:	
Diagnoses and Problems		210 30810 07 1 60-2010 11.49 131				×		
Perioperative Doc					Prior			
	⊿ Unscheduled (0)				1		1	
CareConnect Clinical Research	⊿ PRN (1)							
Clinical Research Form Browser	Medications							
Growth Chart	DI AUDID PRN range dose, d	ose ranne: 0.5 to 1 mg. PO. o4h. PRN pain	, drug form: tab, start: 07-Feb-2018 11:47 PST	v	lew History Reas		Comment:	
Immunizations					Prior	×		
Lines/Tubes/Drains Summ					Lov			
Medication List + Add	1 Continuous (O)				1	·	1	
Newborn Liaison	▲ Continuous (0)							Submit
Patient Information								Submit
Postpartum Liaison	·							
Pregnancy Summary Report								
Reference								



Key Learning Points

- Right clicking on the medication order name in the MAR provides options such as Med Request
- Med Request sends a message to pharmacy about the medication
- Click on View History from the Medication Request window to review any medication requests that have already been made.
- Accessing Medication Request from the Menu gives you information about multiple medications at a time.



1,000 mg Not given within 7 davs.

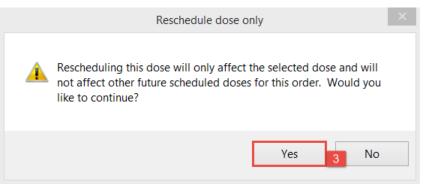
▲ Activity 10.3 – Reschedule a Single Dose of a Medication

1 Let's say your patient wasn't available to receive a medication when it was due. In cases like this, you may need to reschedule a single dose of a medication on the MAR.

To reschedule a single dose of Vancomycin, complete the following steps:

- 1. Right click on the blue medication task for vancomycin 1,000mg, IV, q12h

3. A **Reschedule dose only** window appears. This warning tells you that only one dose will be rescheduled and not all future doses. Click **Yes**.



Note: you may see a different message on your screen, but in the future you will see this message

2. Select **Reschedule This Dose...**



- 4. A **Reschedule vancomycin** window appears. Fill in the time that you are rescheduling this dose to.
- 5. Select Patient Unavailable from the Rescheduling reason drop down list
- 6. Click OK

P Reschedule vancomycin for TESTCSTSQ, T ×
Currently scheduled date and time 07-Feb-2018 11:49
Rescheduled date and time 07-Feb-2018 v 1300 v
Rescheduling reason
Patient Unavailable Y 5
OK 6 Cancel

This dose of Vancomycin has now been rescheduled to the new time on the MAR.

Key Learning Points

Right clicking on the medication task on the MAR provides options such as Reschedule This Dose...

Using this function will only reschedule one dose and not all future doses



Activity 10.4 – Reschedule All Future Doses of a Medication

- 1 In some cases, all administration times of a medication may have to be completely adjusted. If this is the case, you can either call pharmacy, or notify pharmacy through the CIS by following these steps:
 - 1. Right click on the medication order name vancomycin 1,000mg, IV, q12h
 - 2. Select Med Request...

Menu	4	< > - 🕇 MAR		
Patient Summary	<u>^</u>	*** 66* 🗎		
Orders	🕂 Add			
Single Patient Task List		All Medications (System)	▼ Wednesday	, 13-December-2017 10:58 PST -
MAR		Show All Rate Change Docu	Medications	14-Dec-2017 10:58 PST 10:00 PST
MAR Summary		Time View	Scheduled	
Interactive View and I&O		🔽 Scheduled	ेख acetaminophen	650 mg Last given:
Results Review		Unscheduled	650 mg, NG-tube, q4h, drug form: tab, start: 11-Dec-2017 10:42 PST Maximum acetaminophen 4 g/24 h from all sources	11-Dec-2017 11:18 PST
Documentation	🖶 Add	PRN	acetaminophen	
Medication Request		Continuous Infusions	Temperature Axillary Temperature Oral	
Histories		🔽 Future	Numeric Pain Score (0-10)	
	+ Add	Discontinued Scheduled	vancomycin	1,000 mg
· ····		Discontinued Unscheduled	1,000 mg, IV, q12h, start: 11-Dec-2017 10:43 PST	Order Info
Diagnoses and Problems		Discontinued PRN	vancomycin	Event/Task Summary
		Discontinued Continuous Infus	PRN	Link Info
CareConnect		Siscontinued continuous finus	HYDROmorphone (DILAUDID PRN range dose)	Reference Manual
Clinical Research			dose range: 0.5 to 1 mg, NG-tube, q4h, PRN pain, drug form: tab, sta 11-Dec-2017 10:43 PST	Med Request 2
Form Browser			HYDROmorphone	Reschedule Admin Times
Growth Chart			Respiratory Rate	Additional Dose
Immunizations			salbutamol	View MAR Note
		Therapeutic Class View	5 mg, nebulized, q4h, PRN shortness of breath or wheezing, drug fo	Create Admin Note
Lines/Tubes/Drains Summ	hary	Route View	start: 12-Dec-2017 10:32 PST salbutamol	Alert History
Medication List	+ Add	Plan View	Continuous Infusions	Infusion Billing

- 3. In the Reason dropdown menu, select Change in scheduled times of order
- 4. Select a priority option. Select High.
- 5. Write a Comment "please change administration times to 0500 and 1700
- 6. Click Submit

P	Medica	tion Request		X
TESTCSTS	GQ, TEN TEN	33 years M	DOB: 19-Nov	-1984
vancomycin	1,000 mg, IV, q12h,	start: 07-Feb-201	8 11:49 PST	
	 View History			
*Reason:				
Change in sch	neduled times of or	der ~	3	
* Priority Cow Medium High 4				
* Comment				
please change	administration tin	ies to 0500 and	1700 5	
		Submit	6 Cance	el



You have now submitted a request to pharmacy to change the existing scheduled medication administration times. When pharmacy completes this request, the administration times will be updated on the MAR.

Key Learning Points

From the MAR, right click on a medication and select Med Request to ask pharmacy to reschedule administration times for a medication

Once pharmacy completes the request, the MAR will be updated with the new administration times.



PATIENT SCENARIO 11 - Medication Administration

Learning Objectives

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

- Administer medications using Medication Administration Wizard
- Document administration of different types of medications
- Document patient's response to a medication
- Document continuous infusions (non-barcoded)
- Document titratable medication infusions

SCENARIO

Your patient is on several medications including PO medications, PRN medications, intermittent IV medications, and continuous infusions. You will be using a Barcode Scanner to administer these medications. The barcode scanner is meant to scan both your patient's wristband and medication barcodes to correctly populate the MAR.

As a critical care nurse, you will complete the following activities:

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



Activity 11.1 – Administering Medication Using Medication Administration Wizard (MAW) and the Barcode Scanner

1 Medications will be administered and recorded electronically by scanning the patient's wristband and the medication barcode. Scanning of the patient's wrist band helps to ensure the correct patient is identified. Scanning the medication also ensures the correct medication is being administered. Once a medication is scanned, applicable allergy and drug interaction alerts may be triggered, further enhancing your patient's safety. This process is known as **closed loop medication administration**.

Tips for using the Barcode Scanner:

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

2 It is time to administer the following medications to your patient. You will scan all three medications sequentially.

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

- PO medication: **acetaminophen 650 mg PO**, the drug form is tablet (acetaminophen 325 mg x 2 tabs)
- Range dose medication: **hydromorphone 0.5 mg PO**, PRN for pain, using hydromorphone 1 mg tab product barcode
- IV medication: vancomycin 1 g, IV, premixed bag

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

Let's begin the medication administration following the steps below:

1. Review medication information in the **MAR** and identify medications that are due. Click



IIIII Medication Administration in the Toolbar Medication Administration Wizard (MAW) 🌃 CareCompass 📲 Clinical Leader Organizer 🍦 Patient List 😂 Multi-Patient Task List 🎬 Disch 🔾 PACS 🔃 FormFast WFI 🚊 📰 Tear Off 📲 Exit. 🎬 AdHoc 💷 Medication Administration CSTLEARNING, DEMOBETA DOB:01-Jan-1937 CSTLEARNING, DEMOBETA Age:80 years Enc:70000 Allergies: penicillin Gender:Male PHN:9876 φ. Menu . A MAR

2. The Medication Administration window opens.

P Medication Administration			
LINESTUBESDRAINS, MAX Male	MRN: 700002077 FIN#: 700000003266	DOB: 23-Feb-1985 Age: 32 years	Loc: 301; 01M ** Allergies **
	Plane con	the patient's wristband.	
	Alternatively, select the patient	profile manually by clicking the (Next) button.	
Ready to Scan		1 of 2	Next 2

3. Scan the patient's wristband barcode and the **Medication Administration** window will open displaying the medications that you can administer.

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



						Nurse Review	Last Refresh at 11:0	2 PST
C ST Male	LEAR	NING, DEMOTHE	TA MRN: 700008216 FIN#: 700000015058	DOB: 01-Jan-1937 Age: 80 years				106; 01 Allergies *
			11-[0ec-2017 09:47 PST - 11-Dec-	2017 12:17 PST			
		Scheduled	Mnemonic		Details			Result
	E.	11-Dec-2017 10:42 PST	acetaminophen			ig form: tab, start: 11-Dec-20 ohen 4 g/24 h from all source		
	6	11-Dec-2017 10:43 PST	vancomycin		1,000 mg, IV, start: 11	-Dec-2017 10:43 PST		
	स	PRN	hydromorphone HYDROmorphone (DILAUDID PRN ra	ange dose)	dose range: 0.5 to 1 r	ng, NG-tube, q4h, PRN pain,	drug form: tab, start: 11	
	'ভ ্টি	Continuous	insulin regular insulin regular (human) additive 100	unit + sodium chloride 0.9		ting rate, 0 unit/h minimum r OT currently receiving insulin		
	••	Continuous	norepinephrine norepinephrine additive 8 mg + dex	trose 5% (D5W) titratable i		minimum rate, 20 mcg/min m	aximum rate, titrate instr	
	1	Continuous	Sodium Chloride 0.9% sodium chloride 0.9% (NS) continuo	us infusion 1,000 mL	order rate: 125 mL/h,	IV, drug form: bag, start: 10-	Dec-2017 15:52 PST, bag.	
		Continuous	Sodium Chloride 0.9% sodium chloride 0.9% (NS) continuo	us infusion 1,000 mL	order rate: 75 mL/h, I	/, drug form: bag, start: 11-D	ec-2017 10:43 PST, bag	. :
(•

4. Scan the medication barcode for **acetaminophen 325 mg** tab. **Filtered Tasks** window opens.

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

- 5. Now scan the second **acetaminophen 325 mg** tab barcode to complete the 2 tablet drug administration. After the second scan, the system may find more than one exact matches. In this activity, the system displays three exact matches for the prescribed dose of acetaminophen at 02:00, 06:00, and 10:00.
- 6. Select the one that is close to the current time you administering acetaminophen. In this Activity, let's select 06:00.
- 7. Click OK



P Filtered Tasks						×
IP-Critical Male	CareNu	rse, Terry	MRN: 760000277 FIN#: 7600000000277	DOB: 1977-Jan-1 Age: 41 years	3	Loc: 710; 04 ** No Known Medication Allergies **
Scanned:						
Medication	Strength	Volume				
acetaminophen	650 mg	2 tab				
Qualified Tasks:						
Scheduled		Mnemonic	Details		Qualifications	
2018-Jan-17	02:00 PST	acetaminophen	650 mg, NG-tube, drug form: ta Maximum acetaminophen 4 g/2		Exact match	
2018-Jan-17 6	06:00 PST	acetaminophen	650 mg, NG-tube, drug form: ta Maximum acetaminophen 4 g/2		Exact match	
2018-Jan-17	10:00 PST	acetaminophen	650 mg, NG-tube, drug form: ta Maximum acetaminophen 4 g/2-		Exact match	
Scan additional	ingredient	s or choose a ta	sk to continue.			OK 7 ancel

8. The **Early/Late Reason** window opens and asks why the medication is being documented early or late. This is a mandatory field to be filled out. For this activity, select **First dose given**. Then click **OK**.

Early/Late Reason
acetaminophen Image: Comparison of the start of th
Scheduled date/time : 2018-Jan-17 06:00:00 PST Performed date/time : 2018-Jan-17 09:06:00 PST
Please specify a reason why the medication is being documented late:
First dose given
Comment :
OK 8 Cancel

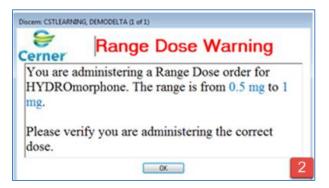
9. You will return to **Medication Administration** window. The blue checkmark **r** indicates the task for scanning the prescribed dose of acetaminophen is completed.



					Nurse Review	Last Refresh at 11:21 PST
[P- Male		lCareNurse, Juan	MRN: 760000270 FIN#: 7600000000270	DOB: 1977-Jan-13 Age: 41 years		Loc: 706; (** No Known Allergie
			2018-Jan-17 1	10:06 PST - 2018-Jan-17 12:3	6 PST	
		Scheduled	Mnemonic	Details	Result	
	1 🕅 🔛	2018-Jan-17 06:00 PST	acetaminophen	650 mg, NG-tube, drug Maximum acetaminoph	form: tab, star acetaminophen 6 en 4 g/24 h fr	550 mg, NG-tube <mark>.</mark> 9
	<u> </u>	2018-Jan-17 10:00 PST	acetaminophen	650 mg, NG-tube, drug to Maximum acetaminopher		
1 1	9 60°	2018-Jan-17 10:00 PST	vancomycin	1,000 mg, IV, administer o	over: 60 minute,	
1	60' 🞦	PRN	Dextrose 50% in Water dextrose 50% (dextrose.	12.5 g, IV, q15min, PRN h For blood glucose 4 mm		
	൵	PRN	hydromorphone HYDROmorphone (HYD	dose range: 0.5 to 1 mg,		
]	••	PRN	magnesium sulfate	5 g, IV, once, PRN hypom Dose as per ICU Electroly		
1	60 ()	PRN	potassium chloride	20 mmol, IV, q30min, PRN Dose as per ICU Electroly		
1	60 (🕒	PRN	potassium chloride	40 mmol, NG-tube, TID, P Dose as per ICU Electroly		
1	5	PRN	sodium phosphate SODIUM phosphate	15 mmol, IV, q4h interval, Dose as per ICU Electroly		
1	60	Continuous	insulin regular insulin regular (human)	titrate, IV, 1 unit/h starting Protocol for Patient NOT		
	60° 🞦	Continuous	norepinephrine norepinephrine additive.	titrate, IV, 0 mcg/min mini		
1	൵	Continuous	vasopressin	titrate, IV, 0 unit/min minir	mum rate, 0.04	

Now let's scan the next medication.

- 1. Scan your medication barcode for hydromorphone 1 mg tab
- 2. You are using the hydromorphone 1 mg tab product barcode. Note that this medication is a range dose order. A **Range Dose Warning** screen will display to remind you of this dose range. Click **OK** to acknowledge the alert.





3. You want to give hydromorphone 0.5 mg NG. Click the **Missing Details** icon to fill in pertinent information about hydromorphone.

				Nurse Review	Last Re	efresh at 11:02 PST
STLEARI	NING, DEMOTHETA	MRN: 700008216 FIN#: 7000000015058	DOB: 01-Jan-1937 Age: 80 years			Loc: 406; " Allergi
		11	-Dec-2017 09:47 PST - 11-Dec-20	017 12:17 PST		
	Scheduled	Mnemonic	Details	Result		
/ 🕅 🕞	11-Dec-2017 10:42 PST	acetaminophen	650 mg, NG-tube, drug form: Maximum acetaminophen 4 g	: tab, star acetaminophen 650 mg, NG g/24 h fr	-tube 👻	
6	11-Dec-2017 10:43 PST	vancomycin	1,000 mg, IV, start: 11-Dec-201	7 10:43 PST		
S 🕄 🕫	PRN	hydromorphone HYDROmorphone (DI		tube, q4h <mark>HYDROmorphone 1 mg, NG</mark>	i-tube, pain_	
\n \}	Continuous	insulin regular insulin regular (human)	titrate, IV, 1 unit/h starting rate, . Protocol for Patient NOT current			
1	Continuous	norepinephrine norepinephrine additive.	titrate, IV, 0 mcg/min minimum	rate, 20		
	Continuous	Sodium Chloride 0.9% sodium chloride 0.9% (order rate: 125 mL/h, IV, drug	form: bag,		
	Continuous	Sodium Chloride 0.9% sodium chloride 0.9% (order rate: 75 mL/h, IV, drug fo	orm: bag,		

 A charting window will appear. Notice that the HYDROmorphone dose field is pre-filled with 1 mg. This is because you scanned a 1mg barcode. It is essential that you change this entry because you are giving 0.5mg.

		Charting for: TESTCSTSQ, TEN TEN
		DID PRN range dose) , PRN pain, drug form: tab, start: 07-Feb-2018 11:47 PST
*Perform	ed date / time	: 07-Feb-2018 • V 1506 • PST
	Performed by	: TestUser, Rural-Nurse
	Witnessed by :	:
	wledge Kespir	ratory Rate No Result found in previous 5 minutes. Trenc
	norphone: 1	ratory Rate No Result found in previous 5 minutes. <u>Trens</u> mg Volume : 0 ml
* HYDROn Diluent :	norphone: 1	mg v Volume : 0 ml
*HYDROn Diluent : *Ro	norphone: 1 <none></none>	mg v Volume: 0 ml
*HYDROn Diluent : *Ro	norphone: 1 <none> ute : PO son : pain</none>	mg v Volume: 0 ml
*HYDROn Diluent : *Ro Rea Total Volu	norphone: 1 <none> ute : PO son : pain ume : 0 -2018 07-Feb-</none>	mg Volume: 0 ml v ml v v v Site: v v Infused Over: 0 v 2018 07-Feb-2018 07-Feb-2018 07-Feb-2018



- 5. Enter the following details:
 - **Respiratory Rate** = 20 breaths/min
 - **Hydromorphone** = 0.5 mg (changed from 1 mg)
- 6. Click **OK.** You will return to **Medication Administration** window.

P	Charting for: TESTCSTSQ, TEN TEN — 🗖 🗙
HYDROmorphone (DILAUD dose range: 0.5 to 1 mg, PO, q4h,	ID PRN range dose) PRN pain, drug form: tab, start: 07-Feb-2018 11:47 PST
*Performed date / time	: 07-Feb-2018 文 🗸 1521 🗘 PST
*Performed by	TestUser, Rural-Nurse
Witnessed by :	
Medication not given wi	thin the last 5 days.
*HYDROmorphone: 0.	5 mg v Volume: 0 ml 6
Diluent : <none></none>	→ mi
*Route : PO	✓ Site :
Reason: pain	~
Total Volume : 0	Infused Over: 0 minut
◆ 07-Feb-2018 07-Feb- 1400 PST 1500 F	2018 07-Feb-2018 07-Feb-2018 07-Feb-2018 07-Feb-2 'ST 1600 PST 1700 PST 1800 PST 1900 PS
	OK 6 Cancel

Let's scan your last medication.

- 1. Scan the barcode for vancomycin 1 g IV bag.
- 2. The system finds an exact match for IV vancomycin showing in Filtered Task window.

Note: If the system finds more than one exact matches of prescribed dose for IV vancomycin, select the one that is close to the current administering time. Enter reason in **Early/Late Reason** window when appropriate (see steps in above activity that demonstrated scanning acetaminophen).



IP-CriticalCareNurse, Juan	MRN: 760000270 FIN#: 7600000000270	DOB: 1977-Jan-13 Age: 41 years	Loc: 706; 01 ** No Known Allergies *
canned:			
Medication Strength Volume			
ancomycin 1,000 mg 250 mL			
ualified Tasks:			
Scheduled Mnemonic Deta	ils	Qualifications	
2018-Jan-17 02:00 PST vancomycin 1,000) mg, IV, administer over: 60 m	inute, drug for Exact match	
2018-Jan-17 10:00 PST vancomycin 1,000) mg, IV, administer over: 60 m	inute, drug for Exact match	

3. Click vancomycin 1,000 mg IV bag in the Results column.

					Nurse Review	Last Refresh at 11:02 PST
CS Male		IING, DEMOTHETA	MRN: 700008216 FIN#: 7000000015058	DOB: 01-Jan-1937 Age: 80 years		Loc: 406; 0 " Allergies
-			u	Dec-2017 09:47 PST - 11-Dec-2017	12:17 PST	
		Scheduled	Mnemonic	Details	Result	
7	er 🖸 🔪	11-Dec-2017 10:42 PST	acetaminophen	650 mg, NG-tube, drug form: tal Maximum acetaminophen 4 g/24	b, star acetaminophen 650 mg, NG-tube 4 h fr	• •
7 1	er 🖌	11-Dec-2017 10:43 PST	vancomycin	1,000 mg, IV, start: 11-Dec-2017	10:43 vancomycin 1,000 mg, IV	3
~		PRN	hydromorphone HYDROmorphone (DI		e, q4hHYDROmorphone 0.5 mg, No Respiratory Rate : 12 br/min	be, pain
1	10 () E	Continuous	insulin regular insulin regular (human)	titrate, IV, 1 unit/h starting rate, 0 u Protocol for Patient NOT currently		
	, a 🖬	Continuous	norepinephrine norepinephrine additive	titrate, IV, 0 mcg/min minimum rate	e, 20	
1		Continuous	Sodium Chloride 0.9% sodium chloride 0.9% (order rate: 125 mL/h, IV, drug form	n: bag	
h		Continuous	Sodium Chloride 0.9% sodium chloride 0.9% (order rate: 75 mL/h, IV, drug form	c bag,	

- 4. The **Charting** window opens. The premixed volume (250 mL) of Vancomycin prepared by pharmacy is auto-populated and will flow to Intake section of I&O.
- 5. Click **OK** after verification.

Note: If the **volume** has to be manually entered by the nurse, the value will not flow to the Intake section of I&O.



Vancomycin 1,000 mg, IV, adı volume (mt.): 250	ninister ove	r: 60 minute, drug	g form: bag,	start: 2018-J	an-16 02:00 F	rst, bag
*Performed da	te/time:	16-Jan-2018		• 1039	PS	r 😽
*Perfe	ormed by :	TestUser, ICU-N	urse			
Witn	essed by :					
*vancomycin:	1,000	mg	- Volum	e: 250	ml	4
Diluent : <no< td=""><td>ne></td><td>-</td><td></td><td>ml</td><td></td><td></td></no<>	ne>	-		ml		
*Route :	IV		▼ Site :			•
Total Volume :	250	Infused Over	: 60	minu	rte 👻	
+ 2018-Jan-16 0900 PST	2018-Jan 1000 PS		2018-Jan 1200 PS			lan-16 PST
	87.5	162.5				
Not Given Reason :	[×	
Comment						

Note: When nurses mix their own medications, the barcode on the **vial** of the medication will be scanned. In this case, the nurse will have to manually enter the following information into the charting window:

- The Diluent Type
- The Diluent Volume

When the **Diluent Volume** is manually entered, the value will flow to the Intake section of I&O. If the diluent volume is left blank, no medication volume will be populated in I&O.



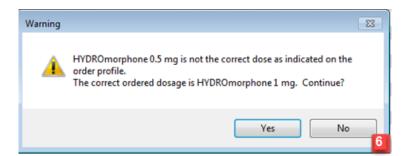
P Charting for: V	alidate, IP-CriticalCareNurse 🕞 💷 💌
vancomycin 1,000 mg, IV, dru	g form: inj, start: 2018-Jan-16 10:24 PST
*Performed dat	
	rmed by: TestUser, ICU-Nurse
*vancomycin:	1,000 mg 🗸 Volume: 0 ml
Diluent : dextr	ose 5% 👻 ml
*Route :	IV Site:
Total Volume :	0 Infused Over: 0 minute -
◆ 2018-Jan-16 0900 PST	2018-Jan-16 2018-Jan-16 2018-Jan-16 2018-Jan-16 2018-Jan-16 1000 PST 1100 PST 1200 PST 1300 PST 1400 PST →
•	۰ (۱۰۰۰) ۲۰۰۰ (۲۰۰۰) ۲۰۰۰ (۲۰۰۰) ۲۰۰۰ (۲۰۰۰) ۲۰۰۰ (۲۰۰۰) ۲۰۰۰ (۲۰۰۰) ۲۰۰۰ (۲۰۰۰) ۲۰۰۰ (۲۰۰۰) ۲
Not Given	
Reason :	Ψ.
Comment	
	OK Cancel

6. Now that you have scanned all the medications that you will be administering at this time, you can complete your medication checks and administer the medications to the patient. Then, click the **Sign** button sign off the medications as administered.

						Nurse Review	Last Refr	esh at 11:02 PST
CS Ma		NING, DEMOTHETA	MRN: 700008216 FIN#: 7000000015058	DOB: 01-Jan-1937 Age: 80 years				Loc: 406; 01 "Allergies"
			11	Dec-2017 09:47 PST - 11-Dec-20	17 12:17 PST			
		Scheduled	Mnemonic	Details	Result			
2	r 🖸 🖌	11-Dec-2017 10:42 PST	acetaminophen	650 mg, NG-tube, drug form: Maximum acetaminophen 4 g		en 650 mg, NG-tube	-	
2	1 10	11-Dec-2017 10:43 PST	vancomycin	1,000 mg, IV, start: 11-Dec-20	7 10:43 vancomycin	1,000 mg, IV	-	
2	er 🖸 🖌	PRN	hydromorphone HYDROmorphone (DL	dose range: 0.5 to 1 mg, NG-t		hone 0.5 mg, NG-tube, pa Rate : 12 br/min	ain,	
1) B () E	Continuous	insulin regular insulin regular (human)	titrate, IV, 1 unit/h starting rate, Protocol for Patient NOT curren				
	-18 E	Continuous	norepinephrine norepinephrine additive	titrate, IV, 0 mcg/min minimum .	ate, 20			
		Continuous	Sodium Chloride 0.9% sodium chloride 0.9% (order rate: 125 mL/h, IV, drug f	orm: bag,			
-11		Continuous	Sodium Chloride 0.9% sodium chloride 0.9% (order rate: 75 mL/h, IV, drug fo	m: bag,			[
	dy to Scan			2 of 2			Bac	5 Sign

7. A warning window opens stating that a partial dose of hydromorphone was given, do you want to continue? Click **Yes.** (This is to remind you to document the correct dose administered **0.5mg** in the previous charting window).





Congratulations, you have successfully administered three medications!

8. The medications will now appear as **Complete** on the MAR.

Medications	21-Nov-2017 14:00 PST	21-Nov-2017 12:54 PST	21-Nov-2017 11:57 PST	21-Nov-2017 11:54 PST	21-Nov-2017 11:11 PST	21-Nov-2017 11:09 PST
Scheduled	Concernance of the local division of the loc					2
retaminophen scetaminophen 550 mg, PO, q4h, drug form: tab, start: 21-Nov-2017 11:11 PST Maximum acetaminophen 4 g/24 h from	650 mg Not previously given				Complete	
cetaminophen						
emperature Axillary						
emperature Oral Numeric Pain Score (0-10)						
'n vancomycin 1,000 mg, IV, g12h, start: 21-Nov-2017 11.09 PST						Complete
rancomycin						
RN						
TO PED HYDROmorphone OYDROmorphone P., dosr range: 0.5 to 1 mg. PO, oth, PM pain, drug form tab, start: 21.Mov-2017 11:09 PS1 DIAUOD FQUIV		Med Response	1 mg Not previously given	Complete		7
HDROmorphone .			-			- 1
Respiratory Rate						12.00

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

Show All Rate Change Docu	Medications	21-Nov-2017	21-Nov-2017	21-Nov-2017	21-Nov-2017
Time View	Scheduled	14:00 PST	12:54 PST	12:02 PST	11:54 PST
Scheduled	14	650 mg Last givers		22	5
Unscheduled	acetaminophen 650 mg, PO, q4h, drug form: tab, start:	21-Nov-2017			
PRN	21-Nov-2017 11:11 PST Maximum acetaminophen 4 g/24 h from	and the second			
Continuous Infusions	acetaminophen Temperature Axillary				650 ma Auth (Ve
Future	Temperature Oral				
Discontinued Scheduled	Numeric Pain Score (0-10)				
Discontinued Unscheduled	vancomycin 1,000 mg, IV, g12h, start: 21-Nov-2017				
Discontinued PRN	11:09 PST				
Discontinued Continuous Infus	vancomycin PRN				1,000 mg Auth (
	PR2 HYDROmorphone (HYDROmorphone P., dose range: 0.5 to 1 mg, PO, 94h, PRN pain, drug form: tab, start: 21-Nov-2017 11:09 PST DRAUDD EQUIV		Med Response	1 mg Last given: 21-Nov-2017 11:54 PST	
8	HIDROmorphone			1	+ 0.5 mg Auth ()
	Respiratory Rate				12 Auth (Verifie

Note: there is a new Med Response box that displays for the PRN medication hydromorphone. For some PRN medications, the system will ask you to complete a medication response assessment. We will address this in the next activity.



Key Learning Points

- **Closed Loop Medication Administration** is the process of scanning the patient's wristband barcode to identify the correct patient, followed by scanning the barcodes of any medications being administered to match the medications to the medication orders.
- When scanning the barcode of a pre-mixed IV medication that has been verified by pharmacy, a volume will automatically populate and flow to I&O.
- When scanning a vial of an IV medication that needs to be mixed by a nurse, the **diluent volume** needs to be entered in order for the medication volume to flow to I&O.
- If you need to administer more than one medication, scan all of the medications and then sign them off rather than scanning and signing off one at a time.

1



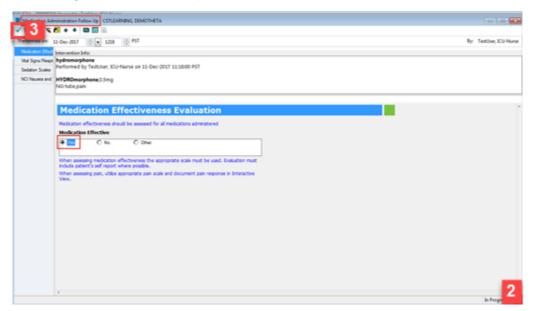
Activity 11.2 – Documenting Patient Response to Medication (Medication Response)

When you administer some PRN medications, it is necessary to document how the patient responds to the medication. You can do this directly in the MAR.

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

Medications	11-Dec-2017 18:00 PST	11-Dec-2017 14:00 PST	11-Dec-2017 12:18 PST	11-Dec-2017 11:19 PST	11-Dec-2017 11:18 PST	11-Dec-2017 08:00 PST
Scheduled						
त्र acetaminophen 650 mg, NG-tube, q4h, drug form: tab, start: 11-Dec-2017 10:42 PST Maximum acetaminophen 4 g/24 h from all sources	650 mg Last given: 11-Dec-2017 11:18 PST	650 mg Last given: 11-Dec-2017 11:18 PST				
acetaminophen					650 mg Auth (Ve	
Temperature Axillary						
Temperature Oral						
Numeric Pain Score (0-10)						
vancomycin 1,000 mg, IV, q12h, start: 11-Dec-2017 10:43 PST						
vancomycin					1,000 mg Auth (
PRN				_		
HVDROmorphone (DILAUDID PRN range dose) dose range: 0.5 to 1 mg, NG-tube, q4h, PRN pain, drug form: tab, start: 11-Dec-2017 10:43 PST	PRN	1	Med Response	1 mg Last given: 11-Dec-2017 11:18 PST		
HYDROmorphone					* 0.5 mg Auth (V	
Respiratory Rate					12 Auth (Verifier	

- 2. Let's say the 0.5mg tablet of Hydromorphone relieved your patient's pain. In the **Medication Effectiveness Evaluation** field, click **Yes** to indicate the medication was effective.
- 3. Click **Sign** icon 🚩 to complete the document. You will return to MAR.



4. Click the **Refresh** icon **C** to update the screen. Now that you have documented the medication response it has disappeared from the MAR.



Medications	11-Dec-2017 22:00 PST	11-Dec-2017 18:00 PST	11-Dec-2017 14:00 PST	11-Dec-2017 11:26 PST	11-Dec-2017 1 11:18 PST
Scheduled					
acetaminophen 650 mg, NG-tube, q4h, drug form: tab, start: 11-Dec-2017 10:42 PST Maximum acetaminophen 4 g/24 h from all sources	650 mg Last given: 11-Dec-2017 11:18 PST	650 mg Last given: 11-Dec-2017 11:18 PST	650 mg Last given: 11-Dec-2017 11:18 PST		
acetaminophen					650 mg Auth (Ve
Temperature Axillary					
Temperature Oral					
Numeric Pain Score (0-10)					
vancomycin 1,000 mg, IV, q12h, start: 11-Dec-2017 10:43 PST	1,000 mg Last given: 11-Dec-2017 11:18 PST				
vancomycin					1,000 mg Auth ()
PRN					56.
PRN HYDROmorphone (DILAUDID PRN range dose) dose range: 0.5 to 1 mg, NG-tube, q4h, PRN pain, drug form: tab, start: 11-Dec-2017 10:43 PST	I			1 mg Last given: 11-Dec-2017 11:18 PST	
HYDROmorphone					* 0.5 mg Auth (V
Respiratory Rate					12 Auth (Verified

Key Learnings Points

Some PRN medications require further documentation on how the patient responds to the drugs. This can be done under Med Response from the MAR. 1



Activity 11.3 – Administering Continuous IV Fluids (Non-barcoded) and Documenting in I&O

To administer normal saline continuous IV infusion, complete the following steps:

1. From the **MAR**, notice the **Continuous Infusions** section. Review the order details for the **sodium chloride 0.9% continuous infusion**.

Note: the status is Pending meaning it has not been administered yet.

Menu		ą	≺ > - 🛧 MAR							[0] Full screen	Print 🗑	€1 minutes ago
Patient Summary		^	1966 🗎									
Orders	🕇 Add											
Single Patient Task List			All Orders with Active Tasks in	n Tir 👻 📖 🔺 Monday, 2	?7-November-20	017 13:45 PST -	Wednesday, 29	-November-20	17 13:45 PST (CI	inical Range)		• •
MAR			Show All Rate Change Docu	Medications	28-Nov-2017 13:45 PST	28-Nov-2017 12:09 PST	28-Nov-2017 12:00 PST	28-Nov-2017 10:00 PST	28-Nov-2017 08:59 PST	28-Nov-2017 08:48 PST	28-Nov-2017 08:00 PST	28-Nov-201 ^ 07:56 PST
Interactive View and I&O			Time View	sodium chloride 0.9%		12107101	22.001.01	20100101	0000101	001101101	001001101	
Results Review			👿 Scheduled	sodium chloride 0.9% (NS) continuous infusion 1,000 mL order rate: 75 mL/h, IV, drug form: bag, start: 28-Nov-2017	Pending Not previously							
Documentation	🕂 Add		👿 Unscheduled	13:43 PST, bag volume (mL): 1,000	given							
Medication Request			PRN	Administration Information sodium chloride 0.9%	1							
Histories		1	Continuous Infusions	Discontinued Scheduled sodium chloride 0.9% (sodium chloride 0.9% (NS) bolus)								
Allergies	+ Add		🗹 Future	250 mL, IV, once, administer over: 60 minute, drug form: bag, start: 20-Nov-2017 14:00 PST stop: 20-Nov-2017 14:00 PST								
Diagnoses and Problem			Discontinued Scheduled	sodium chloride 0.9%								
			Discontinued Unscheduled	Discontinued Continuous Infusions								
CareConnect			Discontinued PRN	BUpivacaine-fentanyl 0.08%-2 mcg/mL epidural (maternity) . 6 mL/h continuous rate. 0 mL intermittent bolus. 0 min to first								
Clinical Research			Discontinued Continuous Infus	bolus, 0 min bolus frequency, 5 mL PCEA dose, 5 min PCEA lockout interval, max PCEA doses/h: 5, epidural, drug form:								_
Form Browser				bag, start: 24-Nov-2017 15:55 PST, pump type: CADD Solis, therapy: epi								
Growth Chart			Therapeutic Class View	Administration Information BUpivacaine-fentanyl								E
Immunizations			Route View	sodium chloride 0.9% (NS) continuous infusion 1,000 mL					1			<u></u> _
Lines/Tubes/Drains Sum	imary		Plan View	50, IV, drug form: bag, start: 21-Nov-2017 12:10 PST, bag volume (mL): 1,000								
MAD Summan/			Taper View	•	III							- F

2. To administer the infusion, click on **Medication Administration** from the toolbar.

CSTLEARNING, DEMOALPHA - 700008214 Opened by TestUser, Nurse	
Task Edit View Patient Chart Links Options Help	
🎬 CareCompass 🌇 Clinical Leader Organizer 🎍 Patient List 😫 Multi-Patient Task List 🐒 Discharge Dashboard 😂 Staff Assignment 🜇 LearningLIVE	
🔾 CareConnect 🐧 PHSA PACS 🍳 VCH and PHC PACS 🐧 MUSE 🐧 FormFast WFI 💡 🛣 Tear Off 🖧 Exit, 🎽 AdHoc 🎟 Medicution Administration	2 Conversation -
Q Patient Health Education Materials Q Policies and Guidelines Q UpToDate	
CSTLEARNING, DEMOALPHA	



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

P Medication Administration			
LINESTUBESDRAINS, MAX Male	MRN: 700002077 FIN#: 7000000003266	DOB: 23-Feb-1985 Age: 32 years	Loc: 301; 01M ** Allergies **
4	Please scan Alternatively, select the patient	the patient's wristband. profile manually by clicking the (Next) button.	
Ready to Scan		1 of 2	Next 3

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

Medio	cation Administration					
					Nurse Review	Last Refresh at 13:53 PST
STL ale	LEARNING, DEMOALF	PHA MRN: 700008214 FIN#: 70000001	DOB: 01-Jan-19 5055 Age: 80 years	937		Loc: 624; ** Allergi
			28-Nov-2017 12:38 PS	T - 28-Nov-2017 15:08 PST		
	Scheduled	Mnemonic	Details	Result		
	328-Nov-2017 10:00 PST	ciprofloxacin	200 mg, IV, administer o	ver: 60 minute, d		
ď	28-Nov-2017 10:00 PST	hydromorphone HYDROmorphone	3 mg, NG-tube, start: 28	Nov-2017 10:00		
ିଙ୍କ	328-Nov-2017 10:00 PST	vancomycin	1,000 mg, IV, start: 28-N	ov-2017 10:00 PST		
്ന്	328-Nov-2017 12:00 PST	piperacillin-tazobactam	3.375 g, IV, start: 28-Nov	-2017 12:00 PST		
	328-Nov-2017 14:00 PST	acetaminophen	650 mg, PO, drug form: Maximum acetaminophe			
	28-Nov-2017 14:00 PST	hydromorphone HYDROmorphone	3 mg, NG-tube, start: 28	Nov-2017 14:00		
	328-Nov-2017 15:00 PST	moxifloxacin MOXIfloxacin	400 mg, IV, administer o	ver: 60 minute, d		
	PRN	fentanyl fentanyl (fentanyl PRN r	dose range: 25 to 50 mc	g, IV, q5min, PR		
	词 Continuous	norepinephrine norepinephrine additive.	titrate, IV, 0 mcg/min mir	imum rate, 20		
	Continuous	Sodium Chloride 0.9%	order rate: 50 mL/h, IV, o	drug form: bag,		
8	Continuous	Sodium Chloride 0.9% sodium chloride 0.9%		drug form: ba <mark>1,000 mL, IV,</mark>	75 mL/h, <site>_</site>	



- 6. Fill in the following information, in this case:
 - **Performed time** = 0600
 - **Site** = *Arm, Lower Left*
- 7. Click OK

Charting for: CSTLEARNING, DEMOTHETA sodium chloride 0.9% (NS) continuous infusion 1,000 mL order rate: 75 mL/h, IV, drug form: bag, start: 11-Dec-2017 10:43 PST, bag volume (mL): 1,000 Yes No sodium chloride 0.9% (NS) continuous infusion 1,000 mL Change *Performed date / time : 11-Dec-2017 Image: Performed by : TestUser, ICU-Nurse Witnessed by : Image: Performed by: *Bag # : 1 *Site : Image: Performed form content *Volume (mL): <show all=""> Antecubital Fossa - Left Arm, Lower - Left Arm, Upper - Left Arm, Upper - Left Arm, Upper - Left Arm, Upper - Left Arm, Upper - Left Arm, Upper - Left</show>
order rate: 75 mL/h, IV, drug form: bag, start: 11-Dec-2017 10:43 PST, bag volume (mL): 1,000 Yes No sodium chloride 0.9% (NS) continuous infusion 1,000 mL Change Performed date / time : 11-Dec-2017 • • 0600 6 PST Comment Performed by : TestUser, ICU-Nurse Witnessed by : *Bag # : 1 *Site : *Comment - Center
Yes No sodium chloride 0.9% (NS) continuous infusion 1,000 mL Change "Performed date / time : 11-Dec-2017 0600 6 PST Comment "Performed by : TestUser, ICU-Nurse Image Image Image Image Witnessed by : Image Image Image Image Image Image "Bag # : 1 Image
*Performed date / time : 11-Dec-2017 *Performed by : TestUser, ICU-Nurse Witnessed by : *Bag # : 1 *Site : *Volume (mL) : *Show All> Antecubital Fossa - Left Antecubital Fossa - Left Arm, Lower - Right Arm, Upper - Right *Rate (mL/h) : *Rate (m
*Performed date / time : 11-Dec-2017 *Performed by : TestUser, ICU-Nurse Witnessed by : *Bag # : 1 *Site : *Volume (mL) : *Show All> Antecubital Fossa - Left Antecubital Fossa - Left Arm, Lower - Right Arm, Upper - Right *Rate (mL/h) : *Rate (m
*Performed by: TestUser, ICU-Nurse Witnessed by: *Bag #: 1 *Site : *Volume (mL): <show all=""> Antecubital Fossa - Left Arm, Lower - Right Arm, Lower - Right Arm, Upper - Left Arm, Upper - Right</show>
*Performed by: TestUser, ICU-Nurse Witnessed by: *Bag #: 1 *Site : *Volume (mL): <show all=""> Antecubital Fossa - Left Arm, Lower - Right Arm, Lower - Right Arm, Upper - Left Arm, Upper - Right</show>
*Performed by: TestUser, ICU-Nurse Witnessed by: *Bag #: 1 *Site : *Volume (mL): <show all=""> Antecubital Fossa - Left Arm, Lower - Right Arm, Lower - Right Arm, Upper - Left Arm, Upper - Right</show>
Witnessed by: *Bag #: 1 *Site : *Volume (mL) : Antecubital Fossa - Left Antecubital Fossa - Right Antecubital Fossa - Right Arm, Lower - Left Arm, Lower - Left Arm, Upper - Left Arm, Upper - Right Arm, Upper - Right
*Bag #: 1 *Site: *Volume (mL): Antecubital Fossa - Left *Rate (mL/h): Arm, Lower - Left Arm, Lower - Right Arm, Upper - Left Arm, Upper - Right Arm, Upper - Right
*Bag #: 1 *Site: *Volume (mL): Antecubital Fossa - Left *Rate (mL/h): Arm, Lower - Left Arm, Upper - Left Arm, Upper - Right Arm, Upper - Right
*Site : *Volume (mL) : *Rate (mL/h) : Antecubital Fossa - Left Antecubital Fossa - Left Arm, Lower - Left Arm, Lower - Right Arm, Upper - Left Arm, Upper - Right Arm, Upper - Right
*Volume (mL) : *Rate (mL/h) : Antecubital Fossa - Left Arm, Lower - Left Arm, Lower - Right Arm, Upper - Left Arm, Upper - Right Reasin Reasin
*Volume (mL) : *Rate (mL/h) : Antecubital Fossa - Left Arm, Lower - Left Arm, Lower - Right Arm, Upper - Left Arm, Upper - Right Reasin Reasin
*Volume (mL): Antecubital Fossa - Left *Rate (mL/h): Antecubital Fossa - Right Arm, Lower - Left 6 Arm, Lower - Right Arm, Upper - Left Arm, Upper - Right Parein Parei
*Rate (mL/h) : Antecubital Fossa - Right Arm, Lower - Left 6 Arm, Lower - Right Arm, Upper - Left Arm, Upper - Right Resin Res
Arm, Lower - Left 6 Arm, Lower - Right Arm, Upper - Left Arm, Upper - Right Roosin Roosin
Arm, Lower - Right Arm, Upper - Left Arm, Upper - Right
Arm, Upper - Left Arm, Upper - Right
Arm, Upper - Right
Pogin Pag
Chest, Anterior - Left Degin Dag
Chest Anterior - Right
Foot - Left OK 7 Cancel
Foot - Right
"I Groin - Left
Groin - Right
Hand - Left
Hand - Right
Jugular, External - Left
Jugular, External - Right

8. Click the Sign button

					Nurse Review	Last Refresh at 11:24 PST
CST Male	DEMO	D, ZEUS	MRN: 700004780 FIN#: 7000000013571	DOB: 01-Feb-1979 Age: 38 years		Loc: IC06; 0 ** Allergies
			02-Dec-2017 1	.0:09 PST - 02-Dec-2017 12:39	PST	
		Scheduled	Mnemonic	Details	Result	
 16	িভ	02-Dec-2017 08:00 PST	thiamine	200 mg, PO, drug form: tab Vitamin B1	, start: 02-De	
	্র 🖉	02-Dec-2017 12:00 PST	piperacillin-tazobactam	3.375 g, IV, start: 02-Dec-20	17 12:00 PST	
	च्च 🖬	PRN		12.5 g, IV, q15min, PRN hyp For blood glucose 4 mmol/		
	্র 🖉	PRN	fentanyl	25 mcg, IV, q5min, PRN pair	n-breakthrou	
	জ	PRN	fentanyl fentanyl (fentanyl PRN r	dose range: 25 to 50 mcg, 1	IV, q5min, PR	
	জ	PRN	hydromorphone HYDROmorphone (HYD	dose range: 0.5 to 1 mg, IV, . DILAUDID EQUIV	, q1h, PRN pa	
	म	PRN	salbutamol salbutamol (salbutamol .	100 mcg = 1 puff, inhalation	n, q1h, PRN s	
	5	PRN	sodium citrate sodium citrate (sodium .	3 mL, instillation, q4h interv PRN Reason: For capping o		
		Continuous	insulin regular insulin regular (human)	titrate, IV, 1 unit/h starting r . Protocol for Patient NOT cu		
	ख	Continuous	norepinephrine norepinephrine additive.	titrate, IV, 0 mcg/min minim	um rate, 20	
₹ ✓	* 59	Continuous	Sodium Chloride 0.9% sodium chloride 0.9% .		rug form: ba 1,000 m	L, IV, 25 mL/h, Jugular, Internal - Rig
•						



9. You will return to the **MAR** where the sodium chloride 0.9% continuous infusion at 75mL/h is now shown as complete.

SIVE Da Genueraviare	. F1	111.3010010333	Dosing WL/D Kg	isolation.			Attenungens	Range) 02-Dec-2017 02-f 11:15 PST 10	
🗙 > - 🔒 MAR							[🗆] Full screen	Print	∂ 1 n
*** 6** 📄									
All Medications (System)	▼ ∢	► Friday, 0	1-December-2017 09:36 PST - 5	Sunday, 03-Dec	ember-2017 09	:36 PST (Clinical I	Range)	
Show All Rate Change Docu			Medications		02-Dec-2017 12:00 PST	02-Dec-2017 11:24 PST	02-Dec-2017 11:16 PST		
Time View		ba 🔁					Pending		
Scheduled	^	norepinephrine ad dextrose 5% (D5W	lditive 8 mg) titratable infusion 250 mL				Last bag started: 15-Nov-2017		
Unscheduled		titrate, IV, 0 mcg/m		aximum rate, titrate instructions:			16:04 PST		
PRN	Ε	Administration Inf		.10131, bug volume (me). 230					
👿 Continuous Infusions		NORepinephrine dextrose 5%							_
🔽 Future		5				1,000 mL		~	
Discontinued Scheduled	-		9% (NS) continuous infusion 1, n, IV, drug form: bag, start: 15-N			Last bag starte 02-Dec-2017 11:15 PST	9	Complete	
Therapeutic Class View		Administration Inf						Begin Bag 1,00	0
Route View		sodium chloride 0.							
Plan View		Discontinued Sche	duled						

You have now documented that the Sodium Chloride infusion was initiated at **0600** at a rate of 75mL/hr.

Note: Making sure the hourly volumes are recorder in the Intake and Output record will be covered in the next activity.

٩	Key	Learnings	Points
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- Continuous infusions are administered using MAR and MAW
- Non-barcoded IV fluids cannot be scanned, but the patient's wrist band should still be scanned through MAW to help identify the correct patient
- All fluids administered through MAR and MAW should flow to the Intake and Output record within iView. Always double check the volumes flow correctly. (Sometimes manual entry is necessary)



PATIENT SCENARIO 12 – Document Intake and Output

Learning Objectives

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

Review and Document Intake and Output

SCENARIO

As a nurse, you will complete the following activities:

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



Activity 12.1 – Navigate to Intake and Output Flowsheets Within iView

Intake and Output (I&O) is found as a band within iView and is where a patient's intake and output will be documented. From here, you are able to review specific fluid balance data including 1 hour totals, 12 hour totals, 24 hour totals, and even cumulative balances over the patient's entire hospital stay.

The I&O window is structured like other flowsheets in iView. Values representing a patient's I&O are displayed in a spreadsheet layout with subtotals and totals for specific time ranges. The left portion of the I&O screen lists different intake and output categories.

Notice that the time columns in I&O are set to hourly ranges (e.g. 0600-06:59). You will need to document under the correct hourly range column.

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

1

ESTCSTSQ, TEN	Age:33 years Enc:70000000150										Location:SGH MS; 111; 01 Enc Type:Inpatient Attending/Bisvcb, Stuart, MD									
Menu		🔻 < 🔹 🏦 Interactive View and I&O													D. Full scre	een 🖬 P	rint 20) minutes a		
Patient Summary		N E Z ® × 9																		
Women's Health C	Wanniaw																			
Orders	+ Add	Adult Quick View													-	_		_		
		Adult Systems Assessment		 ✓ Wedn 		ebruary-2	018 06:00) PST - Sa	turday, 10	-February	/-2018 0	5:59 PST			•	•				
ingle Patient Task		Adult Lines - Devices		Today's Intake: 250 mL Output: 0 ml	Balance:	250 ml.	Yesterday	's Intake:	O mL Ou	tout: 0 mL	Balance	e: O mL								
		Adult Education		S in						b-2018								08-Feb-2018		
MAR Summary		Blood Product Administration	r	6 Hd	15:00 -	14:00 -	13:00 -	12:00 -	11:00 -	10:00 -	09:00 -	08:00 -	07:00 -	06:00 -	24 Hour	Night Shift	05:00 -	04:00 -		
Interactive View	and I&O	Intake And Output	2		15:59 PST	14:59 PST	13:59 PST	12:59 PST	11:59 PST	10:59 PST	09:59 PST	08:59 PST	07:59 PST	06:59 PST	Total	Total	05:59 PST	04:59 PST		
		Continuous Infusions		Intake Total Continuous Infusions	250															
esults Review		 Medications 		sodium chloride 0.9% (NS) continuous		1														
	🕂 Add	Chest Tubes Enteral		infusion 1,000 mL	mL															
	+ Add	GITube		⊿ Medications vancomycin + dextrose 5%	250															
edication Reque		GI Ostomy Intake		vancomycin + dextrose 5% ⊿ Oral	mL 250															
		Urinary Diversion Intake																		
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iagnoses and Pro	oblems	Surgical Drain. Tube Inputs		Stool Count (Number of Stools)																
rioperative Doc		Transfusions		△ Urine Output Urine Voided																
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		Pre-Antval Fluid Output																		
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orm Browser		Continuous Renal Replacement Therapy Emeries Output																		
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		CB Recovery and Postpartum																		
		🗙 OB Special Assessment																		
		🗙 OB Systems Assessment																		
		Vediatric Systems Assessment		<																



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

The intake and output screen can be described per below:

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

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

- To add other Intake or Output sources, you will need to click on the Customize View icon to select the appropriate section to be added in.
- 3. The **grey information bar** indicates the date/time range that is currently set to be displayed.
- 4. To change the date/time range being displayed:
 - Right-click on the grey bar and select a new date/time range (Admission to Current, Today's Results or Other)
- 5. The I&O summary at the top of the flowsheet displays a quick overview of today's intake, output, balance, and more.

Adult Quick View		Vec	inesday, 07-Fe	bruary-2	018 06:00	PST - Sat	urday, 10	-February	-2018 05:	59 PST	Adm	ission to	Current			
Adult Systems Assessment												ay's Result				
Adult Lines - Devices		Today's Intake: 0 mL Output: 0 mL	Balance: 0	T Yes	terday's In	itake: • mu	Output:	U mu Ba	lance: 0	^L 5			5	4		
Adult Education		P8				08-Feb-2018					Othe	er		4 8-Feb	-2018	
Blood Product Administration	L. L	2	12:00 -	11:00 -	10:00 -	09:00 -	08:00 -	07:00 -	06:00 -		Night Shift	05:00 -	04:00 -	03:00 -	02:00 -	01:00 -
Intake And Output			12:59 PST	11:59 PST	10:59 PST	09:59 PST	08:59 PST	07:59 PST	06:59 PST	Total	Total	05:59 PST	04:59 PST	03:59 PST	02:59 PST	01:59 PS
Continuous Infusions	<u>^</u>	⊿ Intake Total ⊿ Continuous Infusions														
Medications		sodium chloride 0.9% (NS) continuous			<u> </u>											
Chest Tubes		infusion 1,000 mL	mL													
Enteral		⊿ Oral														
GITube		Oral Intake	mL													
GIOstomy Intake		⊿ Output Total														
Urinary Diversion Intake Oral		⊿ Stool Output														
Other Intake Sources		Stool Count (Number of Stools)														
Negative Pressure Wound Therapy		⊿ Urine Output														
Surgical Drain. Tube Inputs		Urine Voided	mL													
Transfusions		В	alance													
Urinary Catheter, Intake																
Pre-Arrival Fluid																
Output																
Blood Output																
Chest Tube Output																
Continuous Renal Replacement Therapy																
Emesis Output																
GI Tube																
GI Ostomy Output	1															
Other Output Sources																
Advanced Graphing																
Restraint and Seclusion																
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Vewborn Delivery Data																
OB Recovery and Postpartum																
OB Recovery and Postpartum																
OB Recovery and Postpartum OB Special Assessment OB Systems Assessment																

Key Learning Point

Intake and Output (I&O) is found as a band within iView and is where a patient's intake and output will be documented and reviewed.



Activity 12.2 – Review and Document in the Intake and Output Record

1

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

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

Review to ensure the appropriate values are displaying in the I&O record.

1. Continuous Infusions: sodium chloride 0.9%

Double-click in each hourly time column since the sodium chloride infusion was initiated (at 0600). Values will populate to reflect the order of 75mL/hr.

Note: a partial volume will display if the infusion was not initiated on the hour.

2. Medications: vancomycin

- Value should display as a single dose amount
- Values will pull from Medication Administration Wizard (MAW) documentation

Today's Intake: 250 mL Output: 0 mL	Balance:		resteruty	o marca	0 mL Out		Balance							
\$ ñu					08-Feb									08-Feb-201
	15:00 - 15:59 PST	14:00 - 14:59 PST	13:00 - 13:59 PST	12:00 - 12:59 PST	11:00 - 11:59 PST	10:00 - 10:59 PST	09:00 - 09:59 PST	08:00 - 08:59 PST	07:00 - 07:59 PST	06:00 - 06:59 PST	24 Hour Total	Night Shift Total	05:00 - 05:59 PST	04:00 - 04:59 PST
1 Intake Total	250													
⊿ Continuous Infusions														
sodium chloride 0.9% (NS) continuous infusion 1,000 mL	mL					75	75	75	75	75				
⊿ Medications	250													
vancomycin + dextrose 5%	mL 250	2												
⊿ Oral														
Oral Intake	mL													
⊿ Output Total														
⊿ Stool Output						Once	you dou	ble click	in)					
Stool Count (Number of Stools)						the bla	ank cells	, the hou	urly					
⊿ Urine Output								continuo						
Urine Voided	mL													
Bala	nce 250 mL					Intu	sion will	populate						

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

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



🖌 Adult Quick View		Wedness	lav 07-Ec	bruary-2	018 06:00	PST - Sat	urday 10		-2018 05	-59 PST						
Adult Systems Assessment		weaters	му, от те	braary E	010 00.00	1 51 54	araay, ro	T CIDI dul	201003						_	
Adult Lines - Devices	Today's Intake: 250	nL Output: 0 mL	Balance: 4	250 mL	Yesterday	's Intake:	0 mL Ou	tput: 0 mL	Balance	e 0 mL						
Adult Education	R in							b-2018								08-Feb-201
Blood Product Administration	P 8 10		15:00 -	14:00 -	13:00 -	12:00 -	11:00 -	10:00 -	09:00 -	08:00 -	07:00 -	06:00 -	24 Hour	Night Shift		08-Feb-201 04:00 -
Intake And Output			15:59 PST	14:59 PST	13:59 PST	12:59 PST		10:59 PST		08:59 PST		06:59 PST	Total	Total	05:59 PST	04:59 PST
Oral	⊿ Intake Total		250													
Other Intake Sources	▲ Continuous Infusions															
Negative Pressure Wound Therapy	sodium chloride 0.9% (f	4S) continuous														
Surgical Drain, Tube Inputs	infusion 1,000 mL	ml														
Transfusions	⊿ Medications	PA	250													
Urinary Catheter, Intake	vancomycin + dextrose	5% ml.	250												_	
Pre-Arrival Fluid	2 Oral Oral Intake														(
Output		ml	50	2												
Blood Output	⊿ Output Total															
Chest Tube Output	⊿ Stool Output Stool Count (Number or															
Continuous Renal Replacement Therapy		r 5t00is)														
Emesis Output	⊿ Urine Output															
GI Tube	Urine Voided		375	4												
GI Ostomy Output		Balance	250mL													
Other Output Sources																
Paracentesis Output																
Pericardiocentesis Output																
Negative Pressure Wound Therapy																
Stool Output																
Surgical Drain, Tube Outputs																
Thoracentesis Output																
Urinary Catheter, Output	~															

Now you can see fluid balances for your patient:

- 1. 12 hour Day/Night Shift Total
- 2. Hourly Total

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llergies: penicillin,	Таре	Gender:Male	PHN:987646	9824 Dosing Wt:			Isolatic					Attend	ing:Plisvca, F	locco, MD	
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		Adult Systems Assessment		Today's Intake: 1366 mL Output: 375 mL Balar										_	
/IAR		Adult Lines - Devices			ice: 991 m.	res	terday s 1	ntake: 0 mi	Output:	U mil Balar	ice: U mu				
Interactive View and	I&O	Adult Education		R in	Day St		7:00 -	16:00 -	15:00 -	14:00 -	13:00 -	22-Nov-2017 12:00 -	11:00 -	0:00 -	09:00 -
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		Vintake And Output		⊿ Intake Total	1366								428	528	103
ocumentation	🕈 Add	GI Tube		⊿ Continuous Infusions	466								28	28	103
ledication Request		GI Ostomy Intake		heparin additive 25000 unit + dextrose 5% premix											
listories		Urinary Diversion Intake		500 mL	mL 166								28	28	28
		V Oral		sodium chloride 0.9% (NS) continuous infusion 1,00											
llergies	🕈 Add	Other Intake Sources Negative Pressure Wound Therapy		mL	mL 300										75
iagnoses and Probler		Surgical Drain, Tube Inputs		⊿ Medications vancomycin + dextrose 5%	500									500	
		Transfusions		⊿ GI Tube	mL 500								350	500	
		Urinary Catheter, Intake		△ Gastrostomy (G) tube Left upper quadrant 12 F									530	-	
areConnect		Pre-Arrival Fluid		Intake	mL 300								300		
linical Research		Output Blood Output		Flush	mL 50								50		
orm Browser		Chest Tube Output		Irrigant In	nL										
		Continuous Renal Replacement Therapy		⊿ Oral	50								50		
		Emesis Output		Oral Intake	mL 50								50		
mmunizations		GI Tube	-				-							-	
ines/Tubes/Drains Su	mman/	GI Ostomy Output		⊿ Output Total	375								375		
		Other Output Sources Paracentesis Output		△ Emesis Output	5/5								5/5		
MAR Summary		Percardiocentesis Output		⊿ GI Tube	8										
ledication List	🕇 Add	Negative Pressure Wound Therapy		⊿ Gastrostomy (G) tube Left upper quadrant 12 F	ren <mark>th</mark>										
atient Information		Stool Output		Output	nL										
		Surgical Drain, Tube Outputs		Irrigant Out	mL										
ference		Thoracentesis Output		Residual Discarded	mL										
		Urinary Catheter, Output Urinary Diversion												-	
		Urinary Diversion Urine Output	_	Stool Count (Number of Stools)											
		Urine Output mL/kg/hr	-	⊿ Urine Output	375								375		
		Advanced Graphing		Urine Voided	mL 375								375		
		Restraint and Seclusion		⊿ Urine Output mL/kg/hr		_									
		Procedural Sedation		в	alance 991 "	1_							53 m 🤈	28 mL	103 m
		Adult Critical Care Lines - Devices											²		
		Adult Critical Care Quick View													

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



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

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

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	Systems Assessment		Today's Intake: 1366 ==	Output: 375 == Balance: 9	91	Vesterday's	Intake 0 mi	Output: 0	mi Balari	ce: 0 =
	Lines - Devices	1	PL 104				22-160	v-2017		
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	d Product Administration		at Intake Total		11-59 PST	10:59 PST		08-59 PST	07:59 P5T	06:59 PS
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Allengies + Add	Other Intake Sources		and million surface to the lact	i continuous antatain 2,000 ml			75	75	25	75
	Negative Pressure Wound Therapy		d Medications			500				
	Surgical Drain, Tube Inputs		sancomycin + dextrose 55	s		500				-
	Tranefusions Utmary Catheter, Intoke		a Gattabe	le .	356					
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2 - 2 - 2	Blood Output		Brigant In			1.000	Result Details		-	
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CONTRACTOR AND	GI Ostomy Output		⊿ Surgical Drain, Tube Inpu	ds Co		16.0	art.			
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	Thoracentesis Output		Residual Discarded	ied.		Cien			_	
	Umary Catheter, Output	1.1	d Other Output Sources			10.011	Done			
	Unnary Diversion		4 Stool Output Stool Count (Number of 5	the state		1000				
	Unie Output Unie Output mL/kg/hr		at Unine Output	xoedi	575	0.000	Interpretation		-	
	nced Graphing	Sec.	Urine Voided			Reint	sepret -			
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	edural Bedation			Balance	53 111	528	a 103 ···· a	105	102-1	102
× Add	Critical Care Lines - Devices		-14-							

Now let's say your patient just vomited and you need to document the **Emesis Amount**. You need to add in this section because it is not yet active in the I&O band

- 1. Click on the **customize view** icon
- 2. A **Customize window** will open, listing all available sections that can be manually added
- 3. Scroll down to the **Emesis Output** section and click the box ☑ under the **Default Open** column
- 4. Open the **Emesis Output** section by clicking the arrow \blacktriangleright to expand the section.
- 5. You want to document the volume the patient vomited, so click the box ☑ next to **Emesis Amount.** Click **OK**
- 6. Click the **Refresh** icon



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Once you refresh your page, you will see the **Emesis Output** section is now available in I&O and you can document against **Emesis Amount**.

In the appropriate time column, document **Emesis Amount** = *Moderate* in the cell

- 2. Enter the following volume **Emesis/Projectile Volume**, **Est** = *150* and press **Enter** on your keyboard.
- 3. Click **green checkmark** icon ✓ to sign. You will now see this volume displayed in the patient's fluid balance.



tult Systems Assessment fult Lines - Devices Jult Education	Today's Intake: 300 mL Output: 525	esday, 07-Fe													
fult Education	Today's Intake: 300 mL Output: 525											•			
		mL Balance	-225 mL	Yestero	day's Intal	te: 0 mL	Output: 0	mL Balar	nce: 0 mL						
	PQ in				-	08-Fel	2019								08-Feb-201
ood Product Administration		15:00 -	14:00 -	13:00 -	12:00 -	11:00 -	10:00 -	09:00 -	08:00 -	07:00 -	06:00 -	24 Hour	Night Shift	05:00 -	04:00 -
take And Output		15:59 PST	14:59 PST	13:59 PST	12:59 PST	11:59 PST	10:59 PST	09:59 PST	08:59 PST	07:59 PST	06:59 PST	Total	Total	05:59 PST	04:59 PST
Oral	⊿ Intake Total	300													
Other Intake Sources	▲ Continuous Infusions														
Negative Pressure Wound Therapy	sodium chloride 0.9% (NS) continuous	mL													
Surgical Drain, Tube Inputs	infusion 1,000 mL d Medications		_												
Transfusions		250													
Urinary Catheter, Intake	⊿ Oral	mL 250													
Pre-Antival Fluid		mL 50													
Output	△ Output Total	525													-
Blood Output	∠ Emesis Output	150													-
Chest Tube Output	2 Emesis Amount	Moderate	1				_	_							
Continuous Renal Replacement Therapy		mL 150													
	A Stool Output	150	- 3												
GI Tube	Stool Count (Number of Stools)		_												
GI Ostomy Output	∠ Urine Output	375													
Other Output Sources		mL 375													
Paracentesis Output		nce -225mL													
Pericardiocentesis Output	bala	100 223													
Negative Pressure Wound Therapy Stool Output															

Key Learning Points

- Time columns are organized into hourly intervals with a column for a 12 hour (Day/Night Shift) Total and 24 Hour Total
- Continuous infusion volumes will flow into I&O by double clicking on each hourly cell
- IV medications need to have the **Diluent Volume** entered upon administration in order for the volume of the med to flow to I&O
- Some values will require direct charting in the Intake and Output band e.g. oral intake

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



PATIENT SCENARIO 13 - Modified Early Warning System (MEWS)

Learning Objectives

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

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

SCENARIO

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

You will complete the following activities:

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



Activity 13.1 – Document on MEWS Section in iView to Trigger a MEWS Alert

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

MEWS is scored based on **5 key assessment parameters**: systolic blood pressure, heart rate, respiratory rate, temperature, and level of consciousness. A score is then totaled based on the values documented. If the score is out of normal or expected range, or if new documentation for situational awareness factors indicates a change for the worse, an electronic **alert** will be triggered to warn nurses that the patient may be deteriorating and require timely attention.

Note:

1

- For MEWS, level of consciousness is assessed using **AVPU**, which is an acronym for "alert, voice, pain, unresponsive".
- The MEWS alert is suppressed in some situations such as in palliative/comfort care patients, and in critical care areas

You will navigate to and review MEWS documentation.

- 1. Select Interactive View and I&O from the menu
- 2. Click on the Adult Quick View Band
- 3. Document the following vital signs in the VITAL SIGNS section
 - **Temperature Oral** = 38
 - Peripheral Pulse Rate = 105
 - **SBP/DBP** = 100/60
 - Respiratory Rate = 20

Menu	ф.	< 🔹 者 Interactive View and I&O		
Mental Health Summa	ary	** 🔜 🖽 🖓 🖌 😥 🍓 🖿 🖬 🎘 X		
Orders	+ Add			
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Single Patient Task Lis	t	VITAL SIGNS		Lust 24 Hours
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MAP Summan		Glucose Blood Point of Care		laden 🔄 Hag
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Histories		Environmental Safety Management	Temperature Oral DegC	
	+ Add	Morse Fall Scale	Temperature Tympanic DegC	
Allergies	Add	Fall Prevention Interventions	Apical Heart Rate bpm	
Diagnoses and Proble	ms	Post Fall Evaluation	Peripheral Pulse Rate bpm	
		Individual Observation Record	Heart Rate Monitored bpm	
		Provider Notification	SBP/DBP Cuff mmHg	
CareConnect		Transfer/Transport Shift Report/Handoff	Cuff Location	
		Shift Report/Handoff	Mean Arterial Pressure, Cuff mmHg	
Clinical Research			Mean Arterial Pressure, Manual mmHg	
Form Browser			Blood Pressure Method	
Growth Chart			SBP/DBP Supine mmHg	
Growth Chart			Pulse Supine bpm	
Immunizations			SBP/DBP Sitting mmHg	
Medication List	+ Add		Pulse Sitting bpm	
Medication List	T Add		SBP/DBP Standing mmHg	
Patient Information			Pulse Standing bpm	
D-(Cerebral Perfusion Pressure, Cuff mmHg	
Reference			⊿ Oxygenation 3	
			Respiratory Rate br/min	



4. Select the Modified Early Warning System section

Note: The vital signs documentation has flowed into the MEWS section

5. **Double-click** the blue band to the right of the **Modified Early Warning System** section, under the current time column. A check mark will display, indicating the whole section is activated and the MEWS scores will be automatically calculated

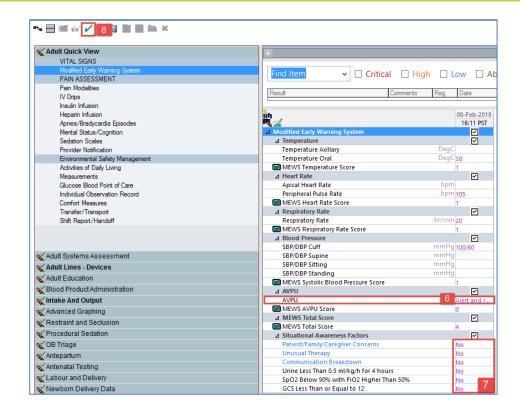
🗙 Adult Quick View		
VITAL SIGNS		
Modified Early Warning System 4 PAIN ASSESSMENT	Find Item	w 🗌 Abnorma
Pain Modalities	Result Comments Flag	Date
IV Drips	Thesair Comments Thag	Date
Insulin Infusion		
Heparin Infusion		8-Feb-2018 16:11 PST
Apnea/Bradycardia Episodes Mental Status/Cognition	▲ Modified Early Warning System	
Sedation Scales	∠ Temperature	
Provider Notification	Temperature Axillary DegC	
Environmental Safety Management	Temperature Oral DegC3	8
Activities of Daily Living	MEWS Temperature Score	
Measurements	⊿ Heart Rate	V
Glucose Blood Point of Care	Apical Heart Rate bpm	
Individual Observation Record	Peripheral Pulse Rate bpm 1	
Comfort Measures	MEWS Heart Rate Score 1	
Transfer/Transport	∠ Respiratory Rate	
Shift Report/Handoff	Respiratory Rate br/min 2	0
	∠ Blood Pressure	
	SBP/DBP Cuff mmHg 1	
🖌 Adult Systems Assessment	SBP/DBP Supine mmHg	00/00
Adult Lines - Devices	SBP/DBP Sitting mmHg	
<u></u>	SBP/DBP Standing mmHg	
Adult Education	MEWS Systolic Blood Pressure Score 1	
K Blood Product Administration	⊿ AVPU	~
🖌 Intake And Output	AVPU	
🗙 Advanced Graphing	MEWS AVPU Score	-
Restraint and Seclusion		
Procedural Sedation	A Situational Awareness Factors	2
V OB Triage	Patient/Family/Caregiver Concerns	Ľ
Antepartum	Unusual Therapy	
× · ·	Communication Breakdown	
Antenatal Testing	Urine Less Than 0.5 ml/kg/h for 4 hours	
🖌 Labour and Delivery	SpO2 Below 90% with FiO2 Higher Than 50%	
🗙 Newborn Delivery Data	GCS Less Than or Equal to 12	
CB Recovery and Postpartum	⊿ MEWS Action Taken	✓
OB Special Assessment	MEWS Action Taken	
OB Systems Assessment		
Pediatric Systems Assessment	Respiratory Rate br/min 2	

- 6. Document AVPU
 - **AVPU** = Alert and responsive
- 7. Document on the Situational Awareness Factors:
 - For the purpose of this practice scenario, select **No** for all cells in this section.

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

8. Click the green check mark 🖌 to sign your documentation. The purple text changes to black and is now saved in the chart.





Note: The patient has a slight fever with a soft BP and a higher heart rate, indicating that they may be getting sicker and need timely attention from the health care team. The calculated MEWS Total Score is 4, which will automatically trigger a MEWS alert in the system.

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



8	Discern Notification (TEST.NURSERURAL)	_ 🗆 🗙
Task Edit View Help		
Subject		Event Date/Time
Rapid Response Early Warning - MEWS		08-Feb-2018 4:20:35
🔄 🗅 🥌 🖻 🕘 🗟 🔍 💐 100% 🔻 🌀 🔗 🏵	<u>۵</u>	
DISCERN ALERT		^
NAME: TESTCSTSQ, TEN TEN		
DATE: 08 February, 2018 16:20:35 PST MRN: 700003210		
BIRTH DATE: 19 November, 1984		
AGE: 33 Years		
LOCATION: SGH Squamish; SGH MS; 111		
MEWS Score (4)		
1) Ensure accuracy of findings; Compare with pa	stient's baseline	
, , , , ,		
	C) or delegate; Discuss assignment change as needed	
3) Notify Responsible Care Provider		
4) Activate Rapid Response Team/ Clinical Resou		
· · · · · · · · · · · · · · · · · · ·	provement after 2 hours, notify Responsible Care	
Provider		
1		
MEWS Criteria		
Ready	P0783 TEST.NURSERURAL TEST.NURSERURAL Th	ursday, February 08, 2018 04:23 P 9

The next activity will provide you with more information about this alert.

Key Learning Points
MEWS stands for Modified Early Warning System and is a scoring system that can trigger an electronic alert in the CIS
The MEWS score is based on systolic blood pressure, heart rate, respiratory rate, temperature, and level of consciousness (AVPU = alert, voice, pain, unresponsive)
If the MEWS score is out of normal range, an alert will be triggered in the CIS to warn nurses that the patient may be deteriorating and require timely attention
The MEWS alert is suppressed in some situations, such as for palliative/comfort care patients and in critical care areas



Activity 13.2 – Review the MEWS Alert

1

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

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

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

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

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



Discern Notification (TEST.NURSEICU)	
Task Edit View Help	
# D. S. C.	
Subject	Event Date/Time
Rapid Response Early Warning - MEWS	28-Nov-2017 14:17:24
Rapid Response carry warning - MEWS	20-W0V-201/ 14:1/:24
J G G A R R R R R R R R R R R R R R R R R	0
DISCERN ALERT	
NAME: CSTLEARNING, DEMOALPHA DATE: 28 November, 2017 14:17:24 PST	
MRN: 700008214	
BIRTH DATE: 01 January, 1937	
AGE: 80 Years	
OCATION: LGH Lions Gate: LGH 6E: 624	
Control Contents Care, Forrole, 024	
MEWS Score (4) 2	
L) Ensure accuracy of findings; Compare with p	atient's baseline
Review findings with nursing leader (CNI /PC	CC) or delegate; Discuss assignment change as needed
	ter of delegate, biscuss assignment change as needed
B) Notify Responsible Care Provider	
 Activate Rapid Response Team/ Clinical Reso 	
1) Reassess and rescore every 2 hours. If no im	provement after 2 hours, notify Responsible Care
Provider	_
Torraci	3
MEWS Criteria	
emperature Oral : 38 bpm - 1 point(s)	
eripheral Pulse Rate : 105 bpm - 1 point(s)	
espiratory Rate: 20 br/min - 1 point(s)	
systolic Blood Pressure : 100 bpm - 1 point(s) 4	
eady	PRODBC TEST.NURSEICU TEST.NURSEICU Tuesday, November 28, 2017 02:18 PM

Note: It is up to the nurse to take the appropriate clinical steps after receiving a MEWS alert for a patient. In some cases, the patient may just need to be closely observed and re-assessed. In others, the provider or Rapid Response Team (where available) may need to be called to come and assess the patient immediately.

You can now click the red x icon *in the top left hand corner to delete the Discern* Notification for the MEWS Alert.

Key Learning Points MEWS alerts display patient information, MEWS score, and score criteria All nurses who have established a relationship with the patient in the CIS will receive the MEWS alert

The clinical decision making support in the MEWS alert helps guide nurses in taking the appropriate next steps in caring for the patient



Activity 13.3 – Document Provider Notification

Once you receive a MEWS alert, you assess the patient and decide on further actions to take. In this scenario, we will contact the most responsible provider to let them know about the MEWS alert. After you notify the provider, you need to document that you have done so.



The MEWS alert automatically creates a task that can be viewed in **CareCompass**. The task is called MEWS Alert.

1. Navigate to CareCompass ^{III CareCompass} from the Toolbar

👫 CareCompass 🚹 Inical Leader Organizer 🎍 Patient List 🚨 Multi-Patient Task List 😹 Staff Assignment 🎬 LearningLIVE 🔤	
😋 CareConnect 🔃 PHSA PACS 🔃 VCH and PHC PACS 🔃 MUSE 🔍 FormFast WFI 🚽 🗄 🛣 Tear Off 📲 Exit 🎬 AdHoc 💷 Medication Administration 🐣 PM Conversation 👻 🗎 Medical Record R	equest 💠 Add 👻 🛅 Documents 🖀 Scheduling Appointment Book 🖬 Discern Reporting Portal 🖕

2. Locate your patient and open the task box. Note the **MEWS Alert** task.

CareCompass			(D) Full screen 🔅 Print	∂ 1 m	ninute
25 M - M - M - M -	🔍 🔍 100% 🔹 🕘 🖨 🙆				
Patient List: Cl	USTOM 💟 💥 List Maintenance 💠 Add Patient 💰 Estab	th Relationships		9 1	0
Location	v Patient	CSTLEARNING, DEMOTHETA Age: 80yrs Sex: M DOB:01/01/1937 MRII: 700008216	Encounter #: 7000000015058		
624 - 04	CSTLEARNING, DEMOTHETA 80yrs M Attempt CPR, Full Code Allergies General Diet	c Scheduld/unscheduler PR0/Contrusus. Fless of Care. Patent Information. 2 ch Dir. 2 2000. 4 Nov. 12 Nov.	10000013030		
707 - 03	CSTDEMO, ATHENA 30yrs F Alergies	A B B Z Alexa 4 Nors 12 Nors Comment National Accounting Net (4 CHO 2017 10200 PS1 Comment National Accounting Net (4 CHO 2017 10200 PS1 Comment National Accounting Net (4 CHO 2017 10200 PS1			
212 - 01	CSTCARDDEMO, BOB DO NOT USE 70yrs M - No Known Allergies -	acetaminophen (TTLBIOL) acetaminophen 40 mg PO, dup ferm: orali la, start 04-Dec-2017 05:00 PST Comment I.Nasimum acetaminophen 4 g24 b from all sources acetaminophen (TTLBIOL) acetaminophen 40 mg PO, dup ferm: orali la, start: 04-Dec-2017 10:00 PST Comment Nasimum acetaminophen 4 g24 b from all sources			
		vancomych 1.000 mg. W, Jatri 04-Dec.2017 10.00 PBT			
		sectamingben (TVLBIQ), acitamingben 640 mg PO, quig fam: oalis, start 64-Dec2017 14:00 PBT Commet: Liatamina calcimaghten 4 g/2 h thm all sources		_	
		Comment, NEWS Oriteria: 04 December, 2017 14 14 00 PST Temperature Aviitary = 38 (1 point(s)) 04 December, 2017 14 14 00 PST Temperature Aviitary = 38 (1 point(s)) 04 December, 2017 14 14 00 PST Temperature Aviitary = 38 (1 point(s)) 04 December, 2017 14 14 00 PST Temperature Aviitary = 38 (1 point(s)) 04 December, 2017 14 14 00 PST Temperature Aviitary = 38 (1 point(s)) 04 December, 2017 14 14 00 PST Temperature Aviitary = 38 (1 point(s)) 04 December, 2017 14 14 00 PST Temperature Aviitary = 38 (1 point(s)) 04 December, 2017 14 14 00 PST Temperature Aviitary = 38 (1 point(s)) 04 December, 2017 14 14 00 PST Temperature Aviitary = 38 (1 point(s)) 04 December, 2017 14 14 00 PST Temperature Aviitary = 38 (1 point(s)) 04 December, 2017 14 14 00 PST Temperature Aviitary = 38 (1 point(s)) 04 December, 2017 14 14 00 PST Temperature Aviitary = 38 (1 point(s)) 04 December, 2017 14 14 00 PST Temperature Aviitary = 38 (1 point(s)) 04 December, 2017 14 14 00 PST Temperature Aviitary = 38 (1 point(s)) 04 December, 2017 14 14 00 PST Temperature Aviitary = 38 (1 point(s)) 04 December, 2017 14 14 00 PST Temperature Aviitary = 38 (1 point(s)) 04 December, 2017 14 14 00 PST Temperature Aviitary = 38 (1 point(s)) 04 December, 2017 14 14 00 PST Temperature Aviitary = 38 (1 point(s)) 04 December, 2017 14 14 00 PST Temperature Aviitary = 38 (1 point(s)) 04 December, 2017 14 14 00 PST Temperature Aviitary = 38 (1 point(s)) 04 December, 2017 14 14 00 PST Temperature Aviitary = 38 (1 point(s)) 04 December, 2017 14 14 00 PST Temperature Aviitary = 38 (1 point(s)) 04 December, 2017 14 14 00 PST Temperature Aviitary = 38 (1 point(s)) 04 December, 2017 14 14 00 PST Temperature Aviitary = 38 (1 point(s)) 04 December, 2017 14 14 00 PST Temperature Aviitary = 38 (1 point(s)) 04 December, 2017 14 14 00 PST Temperature Aviitary = 38 (1 point(s)) 04 December, 2017 14 14 00 PST Temperature Aviitary = 38 (1 point(s)) 04 December, 2017 14 14 00 PST Temperature Aviitary = 38 (1 point(s)) 04 December, 2017 14 14 00 PST Temperature Aviitary = 38 (1 po	2017 14:14:00 PST Systolic Blo	d	2
		Valuables and Belongings			
		Admission Discharge Outcomes Assessment			
		15:00 (No Activities)			
		Interdisciplinary IP Consult to Respiratory Therapy Consult to Respiratory Therapy 01-Dec 2017 09:23 PST, Routine, Reason for Consult COPD			
ictivity Timeline	2	Oxygen Therapy 30-Nov-2017 09:41 PST, Routine, Titrate O2 to keep SpO2 92% or greater			
		Respiratory Therapy Following 01-Oe-2017 09 27 PST, Reason for follow-up: Decompressing respiratory status Instruction: Decompressing respiratory status			
Overdue	e 14:00 15:00	16.00	Done Not Done	Docur	men

3. Hover over the task to display more information about the alert.



CSTLEARNING	. DEMOBETA 🔹 CSTLEARNING, DEMOTHETA 🔹					CSTLEARNING, DEM	DTHETA 🔹 🌇 Recent + 🔤	árme.	• 9
CareCompass							D Full screen 👘 👘	2 5n	minutes ago
A 8 4 8	🔍 🔍 100% - 🔘 🕲 🖾								
Patient List:	USTOM 👿 💥 List Maintenance 🕂 Add Patient 💰 Establish Relations	hps						91	
Location	* Patient	CSTLEARNING, DEMOTHETA	Age: 80yrs	Sex: M	D08:01/01/1937	MRN: 700008216	Encounter #: 2000000015058		0
624 - 04	CSTLEARNING, DEMOTHETA B0yrs M Attempt CPR, Ful Code Alergies General Diet		Plans of Care Patient Information	1			100000010000		
707 - 03	CSTDEMO, ATHENA 30yrs F Alergies	Acetaminophen (TYLENOL) acetaminophen Comment, Maximum acetaminophen	4 Hours 12 Hours men o4u mg, PO, orug torm: orai ing, scan 4 g/24 h from all sources	04-D85-2017-02-00 PS1					
212 - 01	CSTCARDDEMO, BOB DO NOT USE 70ms /M No Known Allergies	Comment: Maximum acetaminophen	shen 840 mg, PO, drug form: oral liq, start 4 gi24 h from all sources						
		Add Difficult AirwayIntubation Alert							
		acetaminophen (TYLENOL) acetaminop Comment: Maximum acetaminophen		04-Dec-2017 14:00 PST					
120000		MEWS Alert 04-Dec-2017 14 14 PST, S Commont NEWS College 04 Decem	top: 04-Dec-2017 14 14 PST iber, 2017 14 14 00 PST Temperature Axi	lary = 38 (1 point(s)) 04 Decemb	er, 2017 14:14:00 PST Respiratory Rat	te = 22 [2 point(s)] 04 December,	2017 14 14:00 PST Systolic B	lopd	
Comment MEWS Alert MEWS Orberia: - 22 [2 point(s	04 December, 2017 14:14:00 PST Temperature Axilary = 38 [1 point(s)] 04 Dece)] 04 December, 2017 14:14:00 PST Systolic Blood Pressure = 100 [1 point(s)]								
		Admission Discharge Outcome Asse	ssment						
		15:00 (No Activities)							

4. Click on the **MEWS Alert** task and then click **Document**. You will automatically be taken to the Provider Notification section for documentation.

ſ	eduled/Unscheduled PRN/Continuous Plans of Care Patient Information	
	2 Hours 4 Hours 12 Hours	
ſ	Vancomycin 1,000 mg,1V, start 28-N0V-2017 22:00 PST	*
	acetaminophen 650 mg, PO, drug form: oral liq, start: 29-Nov-2017 02:00 PST Comment: Maximum acetaminophen 4 g/24 h from all sources	
	acetaminophen 650 mg, PO, drug form: oral liq, start: 29-Nov-2017 06:00 PST Comment: Maximum acetaminophen 4 g/24 h from all sources	
	ranitidine 50 mg, IV, start: 29-Nov-2017 06:00 PST	
	MEWS Alert 26-Nov-2017 17:49 PST, Stop: 26-Nov-2017 17:49 PST Comment: MEWS Criteria: 26 November, 2017 17:41:00 PST Temperature Oral = 38 [1 point(s)] 26 November, 2017 17:41:00 PST Peripheral Pulse Rate = 110 [1 p	
	Add Difficult Airway/Intubation Alert	E
	Add Difficult Airway/Intubation Alert	
	Done Not Done Docume	ent 4



- 5. In the Provider Notification section, document the following information:
 - **Provider Notification Reason** = *PEWS/MEWS Alert*
 - **Providers Notification Details** = MEWS Alert score 4
 - **Provider informed** = type name of Attending Provider (last name, first name)
 - Physician Requested Interventions = No orders received and Continue to Monitor

Activity View Provider Notification Provider Notification	Find Item Critical	High Low Abnormal L Comments Flag Date				
	Provider Notification	28-Nov-2017 14:29 PST				
	Provider Notification Reason Provider Notification Details	PEWS/MEWS alert MEWS Alert score 4				
	Provider Informed Physician Requested Interventions	Plisvce, Noe, MD Physician Requested Interventions X				
		Orders received Continue to monitor Other				

- 6. **Sign** documentation. Completing this documentation will automatically clear the MEWS Alert task from the patient's task list.
- 7. In iView, navigate to Adult Quick View. Click on Modified Early Warning System
- 8. Complete documentation for **MEWS Action Taken** = Notified Physician. Then Sign.

🗙 Adult Quick View				Last 2	4 Hours	
VITAL SIGNS						
Modified Early Warning System 7		Find Item	Low	Abnormal	🔲 Unauth	Flag
✓ PAIN ASSESSMENT				_		
Pain Modalities						
IV Drips		<mark>йц Ж</mark>	29-No		28-Nov-2017	
Insulin Infusion	=	💌 🖬 🗗	ີ 👸 10:13 PST	09:29 PST	15:00 PST	
Heparin Infusion	-	Unusual Therapy				
Apnea/Bradycardia Episodes		Communication Breakdown				
Mental Status/Cognition		Urine Less Than 0.5 ml/kg/h for 4 hours				
Sedation Scales		SpO2 Below 90% with FiO2 Higher Than 50%				
Provider Notification		GCS Less Than or Equal to 12				
Environmental Safety Management		⊿ MEWS Action Taken				_
Activities of Daily Living		MEWS Action Taken	MEWS Action			×
Measurements		⊿ PAIN ASSESSMENT	No action	-		_ I.
Additional Measurements		Pain Present		cheduled ass	essments	_ I.
Point of Care Testing	Ŧ	Respiratory Rate br/mir				_ I.
X Adult Systems Assessment		Onset		nit Charge RI	V	
Adult Lines - Devices		Provoking	Notified P			
Adult Education		Palliating			team (RRT/ME	T)
· · · · · · · · · · · · · · · · · · ·		Quality	Call code I	blue		
Slood Product Administration		Location	Other			8
🗙 Intake And Output		Laterality				
X Advanced Graphing		Radiation Characteristics				
Restraint and Seclusion		Pain Comment				
· · · · · · · · · · · · · · · · · · ·		🐼 Secondary Pain Site				
X Procedural Sedation		Additional Pain Sites				



Key Learning Points

- It is the nurse's responsibility to notify the most responsible provider of MEWS alerts
- All provider notification can be documented in iView
- The MEWS Alert creates a task that drives the nurse to document about Provider Notification. Once the documentation is complete, the task drops off the patient's task list.



PATIENT SCENARIO 14 - Results Review

If you have completed Nursing Emergency workbook, you may skip over this activity

Duration	Learning Objectives
5 minutes	 At the end of this Scenario, you will be able to: Review Patient Results Identify any Abnormal Results

SCENARIO
In this scenario, you will review your patient's results. One way to do this is from Results Review .
You will complete the following activity:
Review results using Results Review



Activity 14.1 – Review Results Using Results Review

Throughout your shift, you will need to review your patient's results. One way to do this is to navigate to **Results Review** from the **Menu**.

Results are presented using **flowsheets**. Flowsheets display clinical information recorded for a patient including lab results, iView entries (e.g. vital signs), cultures, transfusions and diagnostic imaging.

Flowsheets are divided into two major sections.

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

Advance	Care Planning Lab - Recent Lab	- Extended Pathology N	Aicrobiology Cultu	res Microbiology (Other Transfusion	Diagnostics Vi	tals - Recent Vital	s - Extended Deli	very Record	
wsheet: Quick View	 … Level: Q 	uick View	• Table OG	roup 🔿 List						
		Wednesday, 22-Novem	per-2017 08:35 PS	T - Thursday, 08-Fe	bruary-2018 12:3	4 PST (Admit to C	urrent Date)			
. –										
avigator 🛛 🖾	Showing results from (22-Nov-20	17 - 01-Eeb-2019) Show p	ore results							
Coagulation and Thre	showing results from (22-1404-20	17 - 01-Peb-2016) Show II	Iore results							
Measurements	Quick View	01-Feb-2018 09:27 PST	25-Jan-2018 09:52 PST	24-Jan-2018 13:03 PST	23-Jan-2018 15:26 PST	19-Jan-2018 13:00 PST	18-Jan-2018 15:57 PST	17-Jan-2018 13:07 PST	16-Jan-2018 10:07 PST	09-Jan-2018
	Coagulation and Thrombophilia	0111201201003121131	23-341-2010 03:321-31	243411201013103131						
VITAL SIGNS	INR POC		3.5 (H)							
SBP/DBP Cuff	Measurements									
	Height/Length Measured					149 cm	149 cm		149 cm	
Oxygenation	Birth Length			45 cm						
Basic Oxygen Informa	Weight Measured			6 kg					60 kg	
	Weight Dosing									
PAIN ASSESSMENT	Source of Dosing Weight									
1	Birth Weight			5 kg						
	Birth Head Circumference			33 cm						
	Weight Discharge				6 kg					
	/ITAL SIGNS									
	Temperature Axillary	37 DegC						36 DegC		
	Temperature Oral	36 DegC (L)								
	Apical Heart Rate							57 bpm		
	Peripheral Pulse Rate	70 bpm								
	Heart Rate Monitored	69 bpm						80 bpm		
	SBP/DBP Cuff									
	Systolic Blood Pressure	120 mmHg						120 mmHg	120 mmHg	
	Diastolic Blood Pressure	70 mmHg						80 mmHg	80 mmHg	
	Luff Location	Right leg						Left arm		
	Mean Arterial Pressure, Cuff Blood Pressure Method	Automatic						93 mmHg		
		Automatic								
	Dxygenation Respiratory Rate							79 br/min (H)		
	Measured O2% (FIO2)	22 br/min (H)						79 bi/min (n) 89		
	Dxygen Activity							89 Initiate O2 Therapy		
	Divigen Therapy							Simple mask		
	Oxygen Flow Rate	7 L/min						20 L/min		
	- Oxygen now nate	r symmi					1	Lo cymmi		

- 3. Notice the different category tabs across the top of the resulst review page. You can select any of these tabs to see results for that category.
- 4. Also notice selection of items in the Flowsheet drop down menu. You can select any of these Flowsheets to see related results.



sheet	Quick View 4	Level: Qu	ick View	▼ Table O G	roup Olist						
	All Results				oup Clat						
_	Advance Care Planning View		Wednesday, 22-Novem	ber-2017 08:35 PS	T - Thursday, 08-Fe	bruary-2018 12:2	7 PST (Admit to C	urrent Date)			
	-							,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
igator	Activities of Daily Living										
		from (22-Nov-201	17 - 01-Feb-2018) Show r	nore results							
leasur	Anesthesiology View	Duick View	01 Ext. 2010 00:27 DET.	25 122 2010 00 52 055	24 100 2010 12:02 007	22 122 2010 15:20 057	10 10 - 2010 12:00 007	10 10 - 0010 10-07 007	17 1 2010 12-07 007	16-Jan-2018 10:07 PST	00 144 2010 1
	Anti-Coagulation	mbophilia	01-Feb-2018 09:27 PSI	25-Jan-2018 09:52 PSI	24-Jan-2018 13:03 PST	23-Jan-2018 15:26 PSI	19-Jan-2018 13:00 PST	18-Jan-2018 15:57 PST	17-Jan-2018 13:07 PSI	16-Jan-2018 10:07 PST	09-Jan-2018
ITAL S	Accessments View			3.5 (H)							
RP/DR											
augor		asured			45 cm		149 cm	149 cm		149 cm	
acie O	Diabetic Flowsheet				6 kg					60 kg	
AIN A	Diagnostics View										
AIN A	Dialysis View	ght									
	Early Warning Alerts Flowsheet	erence			5 kg 33 cm						
	Education View					6 kg					
	Forms View										
		o	37 DegC 36 DegC (L)						36 DegC		
	Infection Control View		So Dege (c)						57 bpm		
	Lab View	ate	70 bpm								
	LinesTubesDrains	red	69 bpm						80 bpm		
	Mental Health View	sure	120 mmHg						120 mmHa	120 mmHa	
		issure	70 mmHg						80 mmHg	80 mmHg	
	a		Right leg						Left arm		
		sure, Cuff	Automatic						93 mmHg		
	Orthopedic View	a	Automatic								
	Pain View		22 br/min (H)						79 br/min (H)		
	Respiratory View	D2)							89		
	Ouick View								Initiate O2 Therapy Simple mask		
	Transfusion View		7 L/min						20 L/min		
_	Trauma View										

Review the most recent results for your patient:

- 1. Navigate to **Results Review** from the **Menu**
- 2. Review the Recent Results tab
- 3. Review the Lab Recent tab

lenu	•	< 🔿 🕣 者 Results Revie	w								Full screen 🛛 🖨 Print	🗢 🕈 1 minu
		(h) 💶										
men's Health Overv	iew	112 10										
	Add		Care Planning Lab - Recent Lab	5				Diaman 100 100				
	Add	Recent Results Advance of	Lab - Recent Lab	- Extended Pathology I	Microbiology Culture	is Microbiology C	other Transfusion	Diagnostics Vita	als - Recent Vitals	- Extended Deliv	ery kecord	
gle Patient Task List		2	3									
		Flowsheet: Quick View	Level: Q	uick View	Table O Gro	oup 🔿 List						
ractive View and I8	.0			Wednesday, 22-Novem	ber-2017 08:35 PSI	- Thursday, 08-Fe	bruary-2018 12:3	4 PST (Admit to Cu	irrent Date)			
sults Review	1											
		Navigator 🛛	Showing results from (22-Nov-20	17 01 5-b 2010) Shawe	a new secondar							
	Add	Coagulation and Thro	showing results from (22-100v-20	17 - 01-Feb-2018) Show h	nore results							
es 🔹	Add	Measurements	Quick View	01 Exh 2018 00 27 PCT	25 Jan 2019 00-52 DCT	24 Jan 2018 12:02 DCT	22 Inc 2018 15/26 DET	10 Jan 2019 12:00 PCT	19 Inc 2018 15:57 DET	17 Jan 2019 12:07 DCT	16-Jan-2018 10:07 PST	00 Jan 2019 1
dication Request		VITAL SIGNS	Coagulation and Thrombophilia	011120-2010 03:27 P31	25-7811-2010 05-32 P31	24/38/1/2010 13:00 / 31	23-981-2010 13-20 - 51	1998112010 1940 191	10-981-2010 10-07 - 931	1 manual and taken Par	10/381/2010 10/07 / 31	09-9411-2010 14
			INR POC		3.5 (H)							
		SBP/DBP Cuff	Measurements									
gies 🚽	Add	Oxygenation	Height/Length Measured					149 cm	149 cm		149 cm	
noses and Problem		10	Birth Length Weight Measured			45 cm 6 kg					60 kg	
		Basic Oxygen Informa	Weight Dosing			okg					oukg	
		PAIN ASSESSMENT	Source of Dosing Weight									
			Birth Weight			5 kg						
Connect			Birth Head Circumference			33 cm						
			Weight Discharge				6 kg					
			VITAL SIGNS									
Browser			Temperature Axillary Temperature Oral	37 DegC 36 DegC (L)						36 DegC		
			Apical Heart Rate	36 Degc (L)						57 bpm		
wth Chart			Peripheral Pulse Rate	70 bpm						57 upm		
			Heart Rate Monitored	69 bpm						80 bom		
s/Tubes/Drains Su	0.00		SBP/DBP Cuff									
			Systolic Blood Pressure	120 mmHg							120 mmHg	
ication List 🚽	Add		Diastolic Blood Pressure	70 mmHg						80 mmHg	80 mmHg	
born Liaison			Cuff Location Mean Arterial Pressure, Cuff	Right leg						Left arm 93 mmHg		
nt Information			Blood Pressure Method	Automatic						ap mming		
			Oxygenation									
			Respiratory Rate	22 br/min (H)						79 br/min (H)		
nancy Summary R	port		Measured O2% (FIO2)							89		
rence	<u> </u>		Oxygen Activity							Initiate O2 Therapy		
rence			Oxygen Therapy							Simple mask		
			Oxygen Flow Rate	7 L/min						20 L/min		,



4. Review your patient's recent lab results.

C and Peripheral Smear	
WBC Count	1.5 x10 9/L (L)
RBC Count	2.00 x10 12/L (L)
Hemoglobin	70 g/L (L)
Hematocrit	0.15 (L)
MCV	98 fL
] MCH	28 pg
RDW-CV	15.3 % (29)
Platelet Count	10 ×10 9/L (1)
NRBC Absolute	5.0 x10 9/L (H)
Neutrophils	0.04 x10 9/L (L)
Lymphocytes	0.15 x10 9/L (L)
Monocytes	0.23 x10 9/L
Eosinophils	0.01 x10 9/L
Basophils	0.01 ×10 9/L
Metamyelocytes	0.73 x10 9/L (H)
Myelocytes	0.23 x10 9/L (H)
Promyelocytes	0.08 x10 9/L (H)
Blast Cells	0.02 x10 9/L (H)
lood Film Comment	Platelet Estimate

Note the colours of specific lab results and their indications:

- Blue values indicate results lower than normal range
- Black values indicate normal range
- Orange values indicate higher than normal range
- Red values indicate critical levels

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

Key Learning Points

- Flowsheets display clinical information recorded for a patient such as labs, transfusions, medical imaging, etc.
- The Navigator allows you to filter certain results in the Results Display
- Results are colour coded to represent low, normal, high and critical values
- View additional details of a result by double-clicking the value



PATIENT SCENARIO 15 – End of Shift Activities

Learning Objectives

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

Perform End of Shift Activities

SCENARIO

In this scenario, you will practice activities associated with giving report and documenting handover.

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

- Documenting Informal Team Communication
- Documenting a Nursing Shift Summary Note
- Handoff Tool
- Documenting Handoff in iView



Activity 15.1 – Documenting Informal Team Communication

1 Within the **Handoff Tool** there is an **Informal Team Communication** component that can be used for documentation of informal communication between all interdisciplinary care team members. Use the **Add new action** section to create a list of to-do action items. Use the **Add new action** section to create a list of to-do action items. Use the **Add new action** section to create a list of to-do action items. Use the **Add new action** section to create a list of to-do action items. Use the **Add new comment** section to leave a comment for the oncoming nurse or other team members.

Note: Items documented within the Informal Team Communication component are **NOT** part of the patient's legal chart.

From the Menu select Patient Summary

- 1. Within the Handoff Tool tab
- 2. Select the Informal Team Communication component
- 3. Under Add new action type Re-order Morphine. Click Save.

Menu 7	< 🗧 🛉 Patient Summary								
Patient Summary	👫 📄 📥 📄 🔍 🔍 1009	% ↓ ● ● 🏠							
Orders 🕂 Ada	Handoff Tool	Summary Summary Assessment S Discharge							
Single Patient Task List									
MAR	Informal Team	Informal Team Communication							
MAR Summary	Communication								
Interactive View and I&O	Active Issues	3 Re-order Morphine							
Results Review	Allergies (3)								
Documentation 🕂 Add	Vital Signs and Measurements	164 characters left							
Medication Request	Documents	Available to All Save Cancel							
Histories	Transfer/Transport/Accompan	E No actions documented							
Allergies 🕂 Add	iment								
Diagnoses and Problems	Assessments	All Teams							
	Lines/Tubes/Drains								
	Intake and Output								

4. Under Add new comment type Dressing changed. Will require new pain medication order tomorrow. Please re-order Morphine. Click Save

X	Handoff Tool	X	+	-	►	
					2	=-
Dressing cha	nged. Will require new pain m	edication to	morrow. Please re	-order Morphi	ne.	
						E
					racters left	
		\checkmark	Available to All	Save	4 ancel	



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

To do this:

5. Click the **small box** to the left of the action note, or the **small circle with the x** to the right of the note.

Informal Team Communication	
Add new action	
Re-order Morphine	× 😣
TestUser, Nurse 04/12/17 16:53	5

The note will now have disappeared from under the Informal Team Communication component.

Key Learning Points The Informal Team Communication component is a way to leave an informal message for another clinician You can leave an action item or a comment Any Informal Team Communication message will NOT be considered part of the patient's legal chart



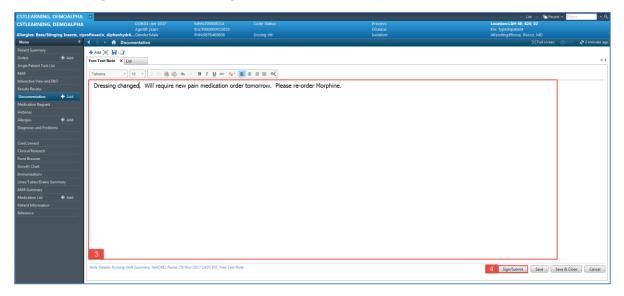
Activity 15.2 – Documenting Nursing Shift Summary

If you have completed Nursing Emergency workbook, you may skip over this activity

- 1 Nurses should document within PowerForms and iView as much as possible and should avoid duplicate documentation via narrative notes. However, a narrative note can be used to document information that may require more details than can be documented otherwise. If a **Nursing Shift Summary** note is required, follow these steps.
 - 1. Review patient information in the Handoff Tool
 - 2. Click on the Nursing Shift Summary blue link

Handoff Tool	Summary Summary	23	Assessment	83	Discharge	≈ +					
Informal Team Communication	Informal Team Co	ommunication									2 =
Active Issues Allergies (3)	Add new action					Add new com	tram				
Vital Signs and Measurements							inch.				
Documents (1)	No actions documented					No comments	documented				
Transfer/Transport/Accompanim ent (0)	All Teams					All Teams	uocamentea				
Assessments											
Lines/Tubes/Drains	Active Issues								Classificatio	on: All	🗸 🛛 All Visits 🛛 🤁 🗏
Intake and Output								0			
Labs						Add new as: This	Visit and Chronic 👻	4			
Imaging	Name					Classification		Actions			
Medications	Pneumonia					😔 Medical		This Visit	Chronic		
Home Medications	Diabetes					Medical		This Visit	Chronic		
Orders Oxygenation and Ventilation	Peripheral vascul	lar disease				Medical		This Visit	Chronic		
Pathology											
Histories	Allergies (3) 🕇										All Visits $ \mathfrak{T} \equiv$
Create Note											
Interdisciplinary Care Plan	Substance	Reactions		Category	Status	Severity	Reaction Type	Source		Comments	
Interdisciplinary Rounding Summ	Bees/Stinging Insects	-		Environment	Active	-	Allergy			-	
ary Note	ciprofloxacin	-		Drug	Active		Allergy				
Nursing Shift Summary 2	diphenhydrAMINE			Drug	Active		Allergy				
Select Other Note	1								Reconciliatio	n Status: Incomplete	Complete Reconciliation
	Vital Signs and Me	easurements 🕂						Selec	ted visit: Latest*	Selected visit Last	12 hours 🛛 🎟 🔟 🛛 🥹 😑

- 3. For this activity, type the following note = *Wife visited, very teary. Provided support and will follow up tomorrow.*
- 4. Click Sign/Submit and a Sign/Submit window will pop up.





5. Click Sign in the Sign/Submit note window

2	Sign/Submit Note		- 🗆 ×
Type: Nutsing Shift Summary Author: FettUser, RunahNurse © Forward Options Create provider letter	Note Type List Filter: Position Title: Free Text Note	*Date: 08-Feb-2018 1651	PST
Favorites Recent Relationships Q Provide			
Contacts Contacts Contacts	Recipients	omment	Sign Review/CC
		[Sign 5 ancel

- 6. Click the **Refresh** icon 🜊
- 7. Once the page is refreshed, you will be able to see your **Nursing Shift Summary** note saved under **Documents** in the **Handoff Tool**.

🔷 🔹 者 🛛 Patient Su	ımmar	1							(D) Full s	creen 🗇 Print 🕹 0 minute
M 🖿 🖶 🖿 🔍 🔨 10	00%									
Handoff Tool		Summary Summary	23 Assessment	23	Discharge	53	Quick Orders	23	+	• • •
Informal Team Communication	^	Documents (1)						Selected visit: La	st 50 Notes Selected visit	Last 12 hours More 👻 🤁 =-
Active Issues								My notes only	Group by encounter	Display: Facility defined view -
Allergies (2)		Time of Service	Subject	Note Type		Author		Last Updated	Last Updated By	
/ital Signs and		08/02/18 16:47	Free Text Note	Nursing Shift S	ummary	TestUser, Rural	-Nurse	08/02/18 16:49	TestUser, Rural-N	lurse
leasurements		* Displaying up to the last	0 recent notes for the selected visit		,					
locuments (1)	7	manifest and obtain and a								
ransfer/Transport/Accompa iment (0)		Transfer/Transport/	Accompaniment (0) 🕂 🚽					Salarta	d visit: Selected visit Las	t 2 hours Last 12 hours 2 =-
ssessments (0)								50000		
nes/Tubes/Drains		No results found								
take and Output										
ibs		Assessments								Selected visit
thology										Survey find the
icrobiology C & S		No results found								
icrobiology Other										
ansfusion History		Lines/Tubes/Drains	(4)							Selected Visit 2 =-
agnostics				ation					Inserted	
rrent Medications		Type A Lines (3)	Loc	abon					Inserted	
ome Medications		Arterial Line	Ra	dial artery						
rders		Peripheral IV		ripheral Antecubital Left						
cygenation and		Central Line		ntral venous catheter Triple In	ternal jugular vein Rig	ht			FEB 08, 2018 08:56	
intilation		4 Tubes/Drains (1)								
stories		Urinary Catheter	Un	ethral Indwelling/Continuous 1	2 French				FEB 08, 2018 08:58	
		Discontinued (1)								
eate Note										
terdisciplinary Care Plan										
terdisciplinary Rounding	~	Intake and Output							Selected visit (24 ho	ur periods starting at 06:00)
	_									ursday, 08-February-2018 16:5

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

- 1. Click on the **Documentation tab** from the Menu
- 2. Find and click on the Nursing Shift Summary Note
- 3. Note the Final Report can be read on the right side of the screen



Menu 0	< 🔹 - 👘 Documentation	Full screen 💼 Print 🔾	2 minutes ago
Patient Summary	💠 Add 📓 Sign 🐊 💫 Forward 🗵 Provider Letter i 🗹 Modify 🐘 🕷 🖤 📰 Zin Error i 🔚 Provinev 📎		
Orders 🕂 Add	List		4 Þ
Single Patient Task List			
MAR	Dirphy: All Physican Notes 💌 🚃	☆ Previous Note 분 N	ext Note
MAR Summary	Anranged Byr Date Nevert Al Top 7 4 * Final Donost *		-
Interactive View and I&O	Innaged By Date NewsRAT Top * * Final Report * Naming Strike Summary 04-Dev-2017 12:0900 PT		
Results Review	Free Test Note TestNers, Nume; Fending Refrest Wife visited, very teary. Provided support; will follow up tamorrow		
Documentation 🕂 Add			
Medication Request	Result type: Nursing Shift Summary		
Histories	Result date: Monday, 04-December-2017 17:09 PST		
Allergies 🕈 Add	Result status: Auth (Verfied) Result title: Free Text Note		
Diagnoses and Problems	Performed by: TestUser, Nurse on Monday, 04-December-2017 12;10 PST Verified by: TestUser, Nurse on Monday, 04-December-2017 12;10 PST		
	Vermed by: 1estOver, Nutse on Monday, 0+-December 2017 17:0751 Encounter info 70000001558, [Cbi Lons Gate, Inpatient, 17-Nov-2017 -		
CareConnect			
Clinical Research			
Form Browser			
Growth Chart			
Immunizations			
Lines/Tubes/Drains Summary			
Medication List 🕈 🕂 Add			
Patient Information			
Reference			
			3
			-3

Key Learning Points

- A Nursing Shift Summary note is used to write a narrative note about what happened in a given shift for oncoming nurses
- The note must be signed in order for it to be recorded to the patient chart and viewable by other team members
 - Nurses and other team members can view signed notes from the Documentation tab in the Menu



Activity 15.3 – Handoff Tool

1

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

From the Menu select Patient Summary. From the Handoff Tool Tab:

- 1. Scroll down the page or access each component by clicking within the Handoff components on the left
- 2. It will be helpful to review these components to provide clear patient information when giving handover to another nurse.

lenu		📍 < , - 👘 Patient Summ	hary					💭 Full screen 🖷 Print 🛷 3 mi
tient Summary	У	A 🗎 🖶 🖿 🔍 🔨 100%						
men's Health C	Overview							
	+ Add	Handoff Tool	Summary Summary	X Assessment	23 Discharge	23 Quick Orders	23	+ 🔍 🔤 🔍 🔍
le Patient Task		Informal Team						
		Communication	Documents (1)				Selected visit: Las	st 50 Notes Selected visit Last 12 hours More 💌 発
		Active Issues					My notes only	Group by encounter Display: Facility defined view
		Allergies (2)	Time of Service	Subject	Note Type	Author	Last Updated	Last Updated By
		Vital Signs and	08/02/18 16:47	Free Text Note	Nursing Shift Summary	TestUser, Rural-Nurse	08/02/18 16:49	TestUser, Rural-Nurse
umentation	+ Add	Measurements		ast 50 recent notes for the selected visit	the only office outside y	research hard harde	00/02/10 10:15	reacose, hard-harde
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cation Reque		Transfer/Transport/Accompa						
		niment (0)	Transfer/Transpo	rt/Accompaniment (0) 💠 🚽			Selecte	ed visit: Selected visit Last 2 hours Last 12 hours 🤁
	+ Add	Assessments (0)	No results found					
		Lines/Tubes/Drains						
		Intake and Output						
		Labs	Assessments					Selected visit 🏾 🤁
		Pathology	No results found					
al Research		Microbiology C & S						Scroll to view more
		Microbiology Other						information
		Transfusion History	Lines/Tubes/Drai	ns (4) 🗸				Selected Visit 🏾 🤁
		Diagnostics	Туря	L	scation		1	Inserted
Tubes/Drain		Current Medications	⊿ Lines (3)					
	+ Add	Home Medications	Arterial Line		adial artery			
		Orders	Peripheral IV		eripheral Antecubital Left			
		Oxygenation and Ventilation	Central Line	c	entral venous catheter Triple Internal jugular vein Rigl	ht		FEB 08, 2018 08:56
		Ventilation Histories	⊿ Tubes/Drains (1) Urinary Catheter		rethral Indwelling/Continuous 12 French			FEB 08, 2018 08:58
ancy Summa	ary Report	ristories	 Discontinued (1) 	U	rearran anowening conunuous 12 French			FED 00, 2010 00:30
ence		Create Note	· Discontinueu (1)					
		Interdisciplinary Care Plan						
		Interdisciplinary Rounding	1					1.1
			Intake and Outro	it .				Selected visit (24 hour periods starting at 06:00)

Key Learning Point

Use the Handoff Tool (within the Patient Summary page) to review detailed patient information when giving handover to another nurse



Activity 15.4 – Documenting Handoff in iView

1

As an inpatient rural nurse, you can document that you have given eeport or handover in iView by completing the following steps:

- 1. Select Interactive View and I&O from the Menu
- 2. Select Shift Report/Handoff section from Adult Quick View
- 3. Document using the following data:
 - Clinician Receiving Report = Name of Nurse 1
 - Clinician Giving Report = Name of Nurse 2
 - Lines Traced Site to Source = Yes
 - Orders Reviewed = Yes
 - Isolation Activity = leave blank if not on isolation

4. Sign your documentation

Menu 🏾 🖓	< 🔹 🛉 Interactive View and I&O		
Patient Summary	🐜 🚍 💷 🌮 🖌 🚳 🛄 🛄 🎘 🛪		
Orders 🕂 Add	4		
Single Patient Task List	Adult Quick View		
MAR	Modified Early Warning System	Find Item	High Low Abnormal
MAR Summary	PAIN ASSESSMENT Pain Modalities	Result	Comments Flag Date
Interactive View and I&O	IV Drips	1 WORK	connicito riag Dato
Results Review	Insulin Infusion Heparin Infusion	14 W	01-Dec-2017
Documentation 🕂 Add	Apnea/Bradycardia Episodes	A Shift Report/Handoff	12:06 PST
Medication Request	Mental Status/Cognition Sedation Scales	Clinician Receiving Report	Lana Williams
Histories	Provider Notification	Clinician Giving Report	Sara Smith
Allergies 🕂 Add	Environmental Safety Management Activities of Daily Living	Lines Traced Site to Source Orders Reviewed	Yes
Diagnoses and Problems	Measurements	Isolation Activity	3
	Glucose Blood Point of Care Individual Observation Record		
CareConnect	Comfort Measures		
Clinical Research	Transfer/Transport Shift Report/Handoff 2		
Form Browser			
Growth Chart			
Immunizations			
Lines/Tubes/Drains Summary			
Medication List 🛛 🕂 Add			

Key Learning Point

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



PATIENT SCENARIO 16 - Printing a Discharge Summary

Learning Objectives

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

Print a Discharge Summary

SCENARIO

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

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

Printing a patient discharge summary



Activity 16.1 – Printing a Patient Discharge Summary

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

- 1. Navigate to the Patient Summary Workflow Page from the Menu
- 2. Select the **Discharge** tab

1

- 3. Scroll to find the Provider Discharge Documents component
- 4. Select **Patient Discharge Summary** document. The Patient Discharge Summary appears in a window on the right side of the screen.

PACS 🐧 FormFast WFI 💡 🛣 Tear O	Iff 📲 Exit 🍟 AdHoc 🎟 I	Medication Administration 🔒	PM Conversation + 🕌 Communi	cate 👻 🚵 Medical Record Request 💠 Add 🗸	🖶 Documents 🛗 Schedu	iling Appointment Book 🥃 Disc	ern Reporting Portal 💡		
TLEARNING, DEMODELTA	×							🔶 List	🔿 🛍 Recent 👻 Name
TLEARNING, DEMODELTA		DOB:01-Jan-1937	MRN:700008217	Code Status:		Process:Falls Risk			02
rgies: No Known Allergies				Decise WE75 ke					in Consel Medicinal MD
<									
ana 📰 i 🖷 📑 i 🖌 🖌 100%	• 🙂 🖷 🕍								
Handoff Tool	Summary Summary	23	Assessment	23 Discharge	2 +				
Active Issues									1 1.1
Provider Discharge	Active Issues							Classification: Medical and Pa	atient Stated 👻 🛛 All Visits 🛛 🕄
Documents (1)						-			
Social Histories					Add new	as: Chronic +			
Orders (7)	No results found								
Discharge Documentation (0)									
Discharge Medications (0)			3						
	Provider Discha	rge Documents (1)						Selected visit: Last 50 Notes Se	ected visit Last 1 months 2
								My notes only Group by encounter	Display: Facility defined view *
	Time of Service	Subject		Note Type 4	Author		Last Updated	Last Updated By	
	22/11/17 09:04	Discharge St	immary	Patient Discharge Summary	TestUser,	GeneralMedicine-Physician, MD	22/11/17 09:08	TestUser, GeneralMedicin	e-Physician, MD
	* Displaying up to the	a last 50 recent notes for the s	elected visit						
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	010010(/)								
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			*		Start	Status	Status Updated	Ordering Provider	
			wit to Innoticet 20 Nov 2017 14/2	DET. Admit to General Internal Medicine	20/11/17 14:26	Ordered	20/11/17 14:27	el este fibraicise General	
					20/11/1/ 14:30	ordered	20/11/1/ 19:37		
	⊿ Patient Care (3)								



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

- 1. From the Template drop-down list, choose Document Template
- 2. From the Purpose drop-down list, choose Continuing Care

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

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

Medical Record Request - CSTLE	ARNING, DEMODELTA - 700008217 - Discharge Summary	
	Template Document Template Document Template Inpatient/General Transfer Template	Purpose Continuing Care 🗸 2
	NICU Transfer Template	Proper authorization received? Destination
Related Providers Sections		Requester
Name Relationship	Device E	
TestUser, Nurse Nurse TestUser, Nurse Nurse TestUser, Nurse Nurse		-
Device selected	Device cross referenced	Device Copies
	Preview	Send 3

Key Learning Points

- The patient discharge summary is completed by the provider to summarize for the patient, information about their hospital stay, follow-up appointments and medications
 - You can preview documents by clicking on them in the respective workflow page component
 - You may print documents from the same preview window

SELF-GUIDED PRACTICE WORKBOOK [N54] CST Transformational Learning

WORKBOOK TITLE:

Nursing: Supervisor

Complete the following activities if you are one of the following:

- Patient Care Coordinator
- Charge Nurse
- Inpatient Nurse who takes on charge duties







PATIENT SCENARIO 17 – Clinical Leader Organizer (CLO)

Learning Objectives

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

Review the Clinical Leader Organizer

SCENARIO

As an inpatient charge nurse, you will be completing the following activities in order to review your patients for the day:

Review the Clinical Leader Organizer (CLO)

1



Activity 17.1 – Review Clinical Leader Organizer (CLO)

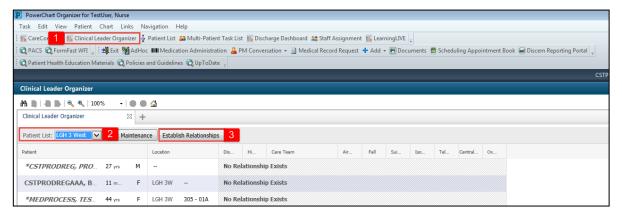
Clinical Leader Organizer (CLO) is an interactive organizer that supports communication and coordination across the continuum of care. Clinical Leader Organizer provides a high-level overview of patient data which is useful for understanding patient care goals and assists charge nurses in assigning appropriate patients to nurses.

With **CLO**, charge nurses, nursing managers and other users can view the following data for each patient: patient name; location; active discharge orders; high risks; isolation precautions; restraint information; elopement risk; pending transfer; diet order; falls risk; suicide precaution; skin integrity; ventilator; airway information; telemetry order; central line insitu; catheter insitu; visitor information; care team; non-invasive ventilation; and oxygen therapy.

Note: Patient Care Coordinators and nurses who are always in charge will land on the **CLO** page when logging into the system. Inpatient nurses who are only occasionally in charge will land on **CareCompass** but can navigate to CLO when necessary.

Let's review Clinical Leader Organizer:

- 1. Select Clinical Leader Organizer from the toolbar
- 2. Confirm that the displayed **Patient List** is your unit. In this Activity, use SGH Medical Surgery
- 3. Click Establish Relationship





Establish relationships with all of the unit's patients as a **Nurse**.

- 1. Select Unit Coordination from the Relationship drop-down
- 2. Click top checkbox to select all patients
- 3. Click Establish

E	stablis	sh Relationships				23
F	Relatio	nship Unit Coordination	<mark>√</mark> 1			
		2 Pe	Sex	DOB	MRN	~
	✓	CSTLABMEKOEMPI,	М	Dec 13, 1967	700001810	
	✓	TESTSQBB, MICHAEL	М	Dec 31, 1940	700002627	
	✓	CSTLABAUTOMATIO	F	Aug 7, 1989	700004649	
	✓	CSTPRODEMPI, SGH	F	Jan 1, 1950	700004732	
	✓	CSTPRODREG, SHA	F	May 30, 1985	700002491	
	✓	CSTPRODMED, TES	М	Oct 19, 1983	700000511	
		CSTDEMOTOM, DON	М	Jan 1, 1966	700005615	~
			Sel	ect All Deselect All	Establish 3	ncel

3

CLO contains several different columns displaying patient data. The first time you access CLO, all columns in the configuration are displayed in the dashboard. You can customize your columns to view relevant patient data. Hovering over the column titles enables you to see the full name of the column.

- 1. Hover over a column heading to see the full title of the column
- 2. Click the Menu icon
- 3. Click the green checkmark beside a viewable topic(s) of your choice to de-select it from the viewable columns
- 4. Click Apply

Note: Columns can also be reordered by dragging the column name into the order you prefer.

2



STPRODPE, RAV. 94 yrs F GATA GAT GAT <th>2 =</th>	2 =		
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CSTSCHHARVEY, ST. 26 ys M L6H 7E - <td< td=""><td>1DCOW, SNT 104 yrs M LGH 7E Care</td><td>Team</td><td>0</td></td<>	1DCOW, SNT 104 yrs M LGH 7E Care	Team	0
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*TESTSQB8VP, SA. 89 ys M LH 7E S 55 S S Length of Stay: 6 months 2 weeks Isolation 1 *TESTSQB8VP, SA. 66 ys M LH 7E S S S S Length of Stay: 6 months 2 weeks Isolation 1 *TESTSQB8VP, SA. 66 ys M LH 7E S S S S Length of Stay: 6 months 2 weeks Control Line 1 *TESTSQB8VP, SA. 45 ys M LH 7E S S S S S Length of Stay: 6 months 2 weeks Solation Control Line 1 *TESTSQB8VP, SA. 45 ys M LH 7E S S S S Length of Stay: 6 months 2 weeks Solation interary O *TESTSQB8VP, SA. 45 ys M LH 7E S S S S Length of Stay: 6 months 2 weeks Solation interary Ventilator 1 CSTLABADDON, DEM 33 ys F LH 7E 25 S Length of Stay: 5 months Weeks Rela	Innext, Si 20 yrs M. Curiz - Fall		0
*TESTSQBBVPP, SA. 69 ys M LGH 7E			0
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	ECS, INPATIE 67 yrs F LGH 7E 708 - 01 Length of Stay: 5 months NOC In V	3W	
*CSTLABAUTOMATL 41 vrs M LGH 7E Calcel	A AP	ply Cano	cel

4 Clicking on icons within CLO provides additional information. The system displays a pop-up box when an icon is clicked.

- 1. The topic(s) that you de-selected previously are no longer viewable columns in your CLO view
- 2. Click on an icon within the CLO to see additional information

Clinical Leader Organizer																	(c) F	ull screen	🖨 Prir	t 28	3 minutes a
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Clinical Leader Organizer	Σ	3 +																			
Patient List: LGH 7 East 🗸	List Mai	intenan	ce Establ	ish Relationship	s																≡-
Patient			Location	1	Dis	Ні	Care Team	-	ir Fall	Iso	Tel	Central	Ox	Ski	Ve	Visit	Са	Re	Elo	Pe	Diet
*CSTPRODPET, RAV	34 yrs	F	LGH 7E	718 - 01	F	A	-		75			V.				Length of Stay: 2 months					۲L
*CSTPRODREG, HLS	27 yrs	F					-		Isolation							Length of Stay:					
CSTPRODCOW, SNT	104 yrs	м	LGH 7E				-		Patient Isolation							Length of Stay:					
CSTSCHHARVEY, ST	26 yrs	м	LGH 7E				-		31-Oct-2017 08:52 PDT, Contact Plus Ordered at: 10/31/2017 8:52 AM						Length of Stay:						
*TESTSQBBVPP, SA	37 yrs	м	LGH 7E									M				Length of Stay: 6 months 2 weeks					
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TESTCSTSQ, SIX LAU	17 yrs	F	LGH 7E													Length of Stay: 6 months 2 weeks					
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CSTPRODOSLAB, DE	53 yrs	м	LGH 7E	724 - 01			-									Length of Stay: 5 months					۲ł
*WINRECS, INPATIE	67 yrs	F	LGH 7E	708 - 01			-									Length of Stay: 5 months					

Note: Customization of the CLO is only visible to the user customizing their views.



Key Learning Points

- Clinical Leader Organizer (CLO) is an interactive organizer that supports communication and coordination across the continuum of care
- CLO provides a high-level overview of patient data
- **CLO** can be customized to display patient information pertinent to your workflow



PATIENT SCENARIO 18 – Reports

Learning Objectives

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

Run a report in the CIS

SCENARIO

As an inpatient charge nurse or nurse manager, you will be completing the following activities:

Run a report for your unit/organization in the CIS



Activity 18.1 – Running Reports for your Unit/Organization

The reporting functionality in the Clinical Information System (CIS) allows users to run reports at a unit and/or organizational level. Reports are important for performing audits and in informing safe patient care. Some of the reports that can be generated include the following: number of falls; catheterized patients; and isolated patients.

Assuming you are a charge nurse, generate a report for **Patient Census by Location**.

1. Navigate to **Discern Reporting** by selecting the Discern Reporting Portal button in the Toolbar to open the Reporting Portal window

Task Edit View Patient Chart Links Options Documentation Orders Help

Note: It may take a moment for the Reporting Portal window to open.

2. Locate **Patient Census by Location** by typing it into the search box

Note: This report can also be located by scrolling down the page

Reporting Portal				
Reporting Portal				
😂 Cerner				Welcome: TestORD, Nurse Settings Help
Reporting Portal			2 QBearch for Report Title	
Filters	All Reports (37) My Favorites (0)			1 2 > Last >> 🖸
	Report Name	▼ Categories	¢ Source	🗢 Favorite 🗢 🔶
Source	Arterial Line	Nursing Supervisor	Public	T.
Categories	Bed Status	Nursing Supervisor	Public	\$
Descent Descents	Braden Assessment - Current Inpatients	Nursing Supervisor	Public	×.
Recent Reports Moderate Sedation	Braden Q Assessment - Current Inpatients	Nursing Supervisor	Public	*
Braden Assessment - Current Inpatients Diet Orders - Current Patients	Central Line Days - Current Inpatients	Nursing Supervisor	Public	$\stackrel{\frown}{\simeq}$
Braden Q Assessment - Current Inpatients	Central Line Days - Discharged Inpatients	Nursing Supervisor	Public	
Patient Census by Location	Charting After Discharge	Nursing Supervisor	Public	~~

- 3. Click the name of the report to expand the field
- 4. Click Run Report



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2

The **Discern Prompt** window opens. This window is where you indicate the information you would like in the report.

Select the following information:

- 1. **Encounter Type** = *Inpatient*
- 2. Site = Squamish General Hospital
- 3. Facility = SGH Squamish General Hospital
- 4. Unit/Clinic(s) = All Nurse Units
- 5. Click Execute

E .	Discern Prompt: BC_ALL_PM_CENSUS_LOCN_LYT:DBA
*Output to File/Printer/MINE *Output Type	MINE Exportable(CSV) Printable(PDF)
*Encounter Type(s)	Emergency Inpatient Minor Surgery < > 1
Health Organization	Vancouver Coastal Health Authority 🗸 🗸
*Site	Squamish General Hospital
*Facility	All Facilities HTH Hilliop House SGH Squamish General Hospital
Unit/Clinic(s)	All Nurse Units GH Emergency Department GGH Emergency Department Hold GGH Emergency Department Hold GGH Maternity GGH Maternity GGH Medical Surgery
Include VIP Patients?	Yes 🗸
Page break on Unit?	No Y
Return to prompts on close of out	Execute 5 Cancel
Ready	

The Patient Census by Location report will now display.



Review the Report.

3

- 1. Navigate the Report by clicking the **Next Page** icon
- 2. To print the report, click on the **Print** icon. **Note:** For this activity, we will only view and not print the actual report.

Reporting Port	tal										
porting Portal	Diet O	rders - Current Patients	Braden Q Asses	sment - Cu	rrent Inpatients	atient Census by L	ocation	×			
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					ter Type: Inpatient						
	By: TestOR			Unit/Clir							
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Room/ Bed	MRN	Patient	Age	Gender	Service	Admit Date/Time	LOS	Attending Provider	LOA	Encounter Type	Visitor Status
Unit/Clinic:	LGH 2E										
204-01	70000034	CSTPRODMED, JAMIE	25 Years	Female	General Internal Medicine	10-NOV-2017 10:52	20 days	Pillev cf, Dillon, MD		Inpatient	
204-02	700006576	CSTPRODMI, SITSYNGO	41 Years	Female	General Internal Medicine	27-NOV-2017 13:13	3 days	Plievoc, Trevor, MD		Inpatient	

Key Learning Points	
The Discern Reporting Portal functionality in the CIS allows users to run reports	
Specific information can be selected to be included in each report	



End of Workbook

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