SELF-GUIDED PRACTICE WORKBOOK [N63]
CST Transformational Learning

WORKBOOK TITLE:

Nursing: Rural (Squamish)- Inpatient

Last update: February 23, 2018

CLINICAL + SYSTEMS TRANSFORMATION
Our path to smarter, seamless care

TRANSFORMATIONAL LEARNING

TABLE OF CONTENTS

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).

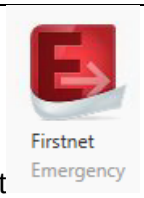
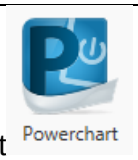
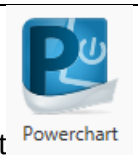
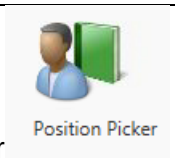
In this scenario, you will complete the following activities:

- 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

1 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)
Powerchart 	Inpatient units (Including adult, pediatric, and maternity units)
Powerchart 	Pre-op/Intra-op/PACU units
Position Picker 	All

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

1

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

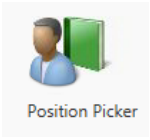
Let's say you started your day working in the Emergency Department. You logged into **Position Picker** at the start of your ED shift and selected **Emergency – Nurse** as your position. Now you are being asked to float to the *inpatient* unit to take care of a patient admitted with pneumonia.

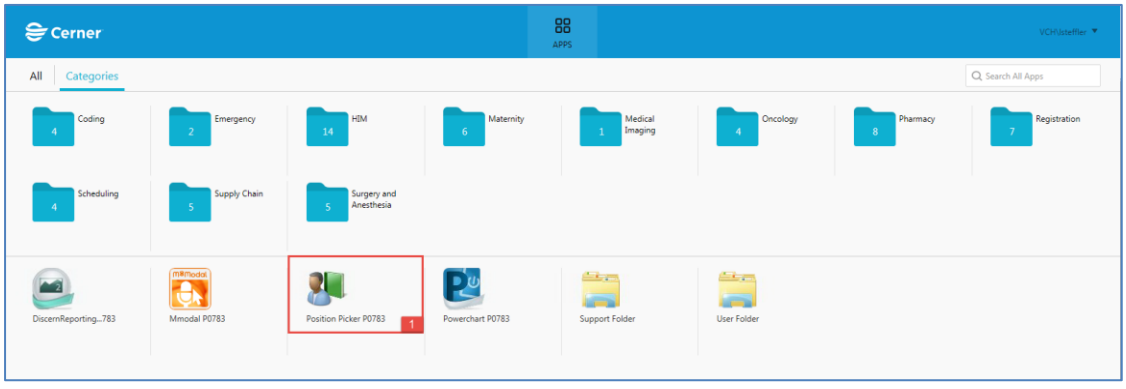
You now need to log into **Position Picker** and select the inpatient nurse position of **Nurse – Rural.**

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.

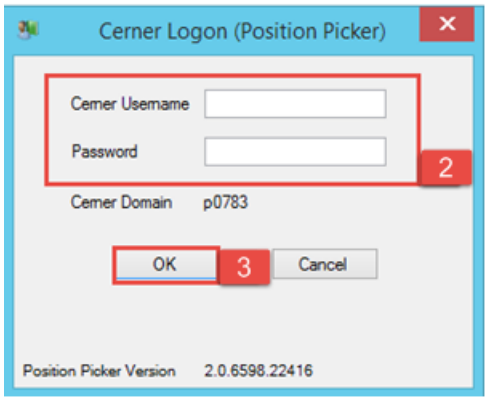
1. To access position picker from Cerner Citrix Store Front, click on the **Position Picker** application.



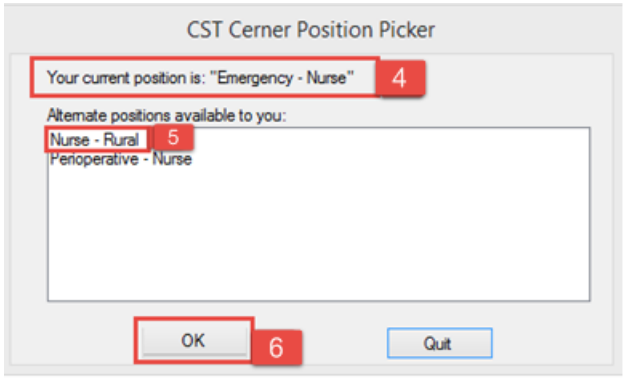


A Cerner Logon (Position Picker) window will open

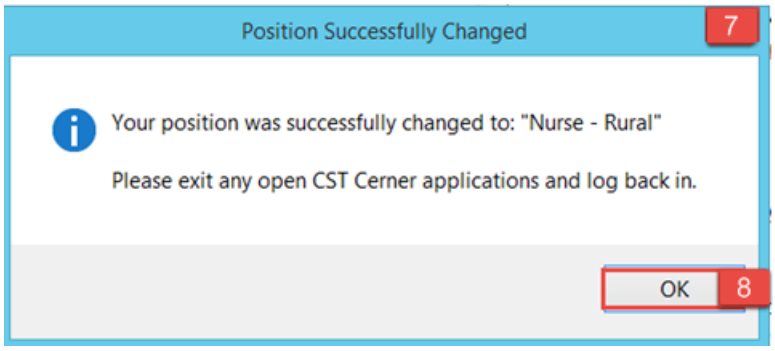
2. Type your assigned **username** and **password**
3. Click **OK**



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**



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.

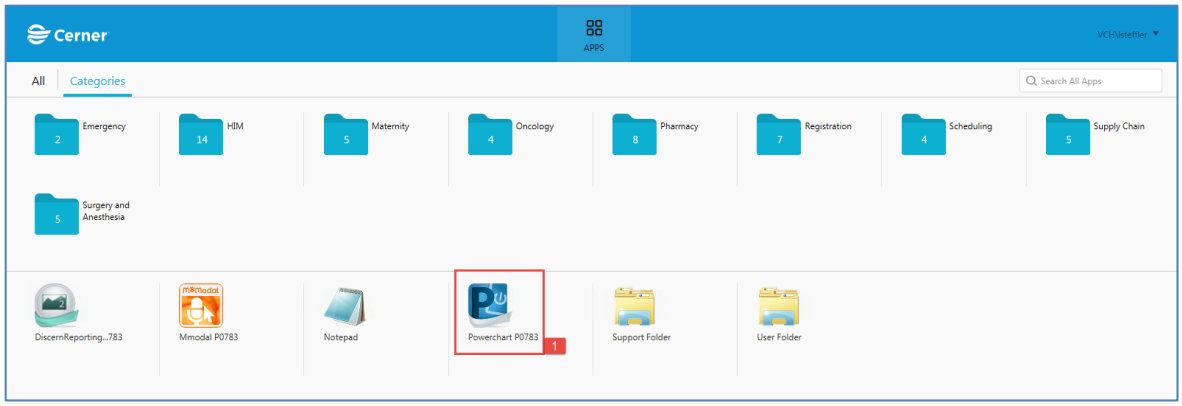
As an Inpatient Rural Nurse you will complete the following activities:

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

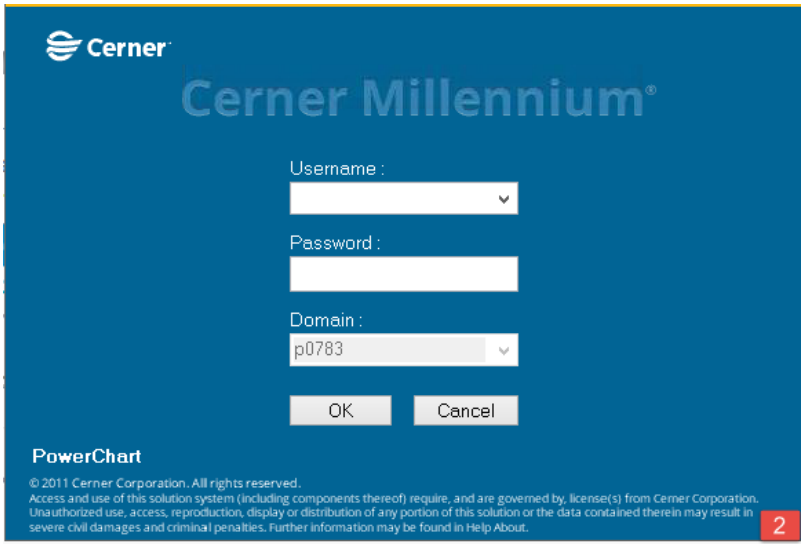
Activity 2.1 – Log into PowerChart

1 To log into PowerChart, complete the following steps:

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



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



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

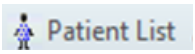
- Make sure you have selected to correct position (Nurse-Rural) in Position Picker before logging into PowerChart
- Access PowerChart from Cerner Citrix Store Front
- Log-in using your username and password

Activity 2.2 – Set Up a Location Patient List

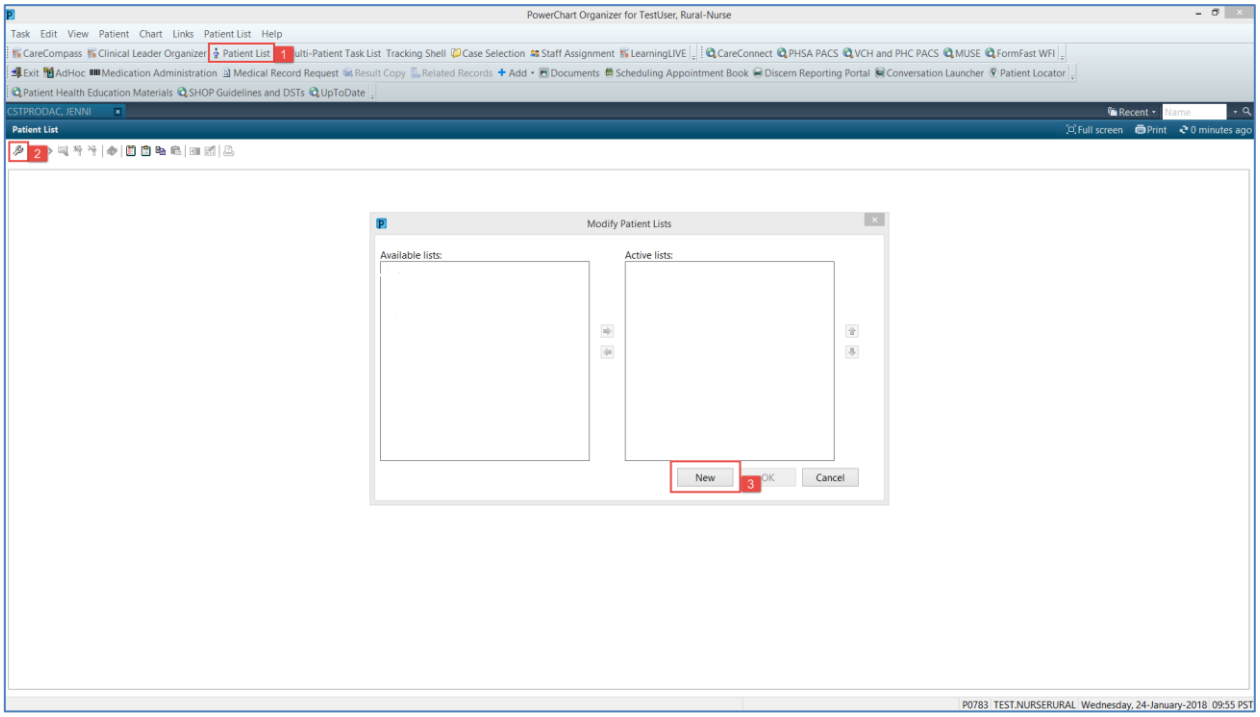
1 Upon logging into **PowerChart**, you will land on **CareCompass. CareCompass** provides a quick overview of select patient information.

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.

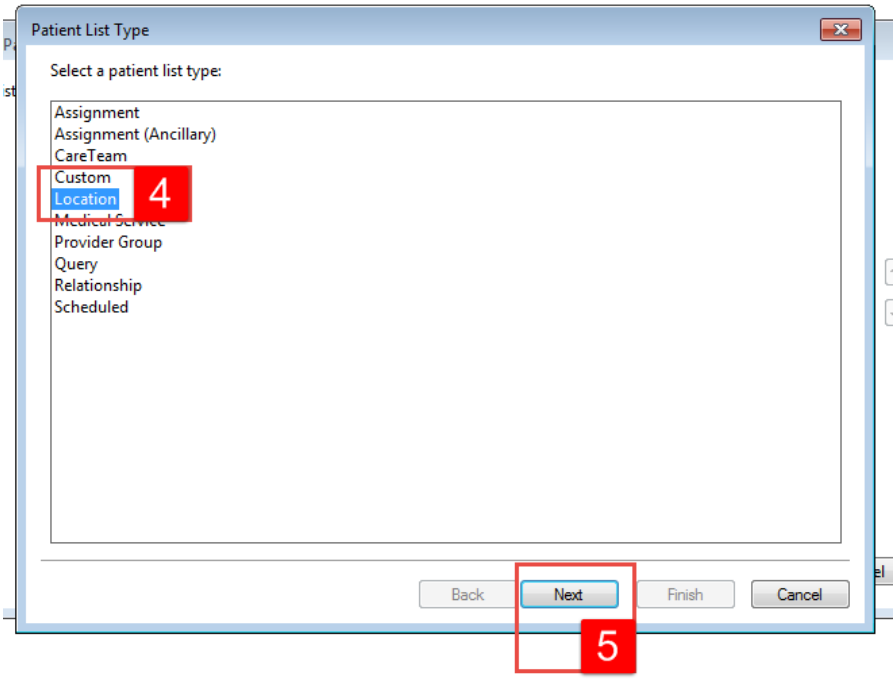
2 At the start of your first shift (or when working in a new location), you will create a **Location List** that will consist of all of the patients in that location/unit.

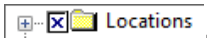
1. Select the **Patient List** icon 

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

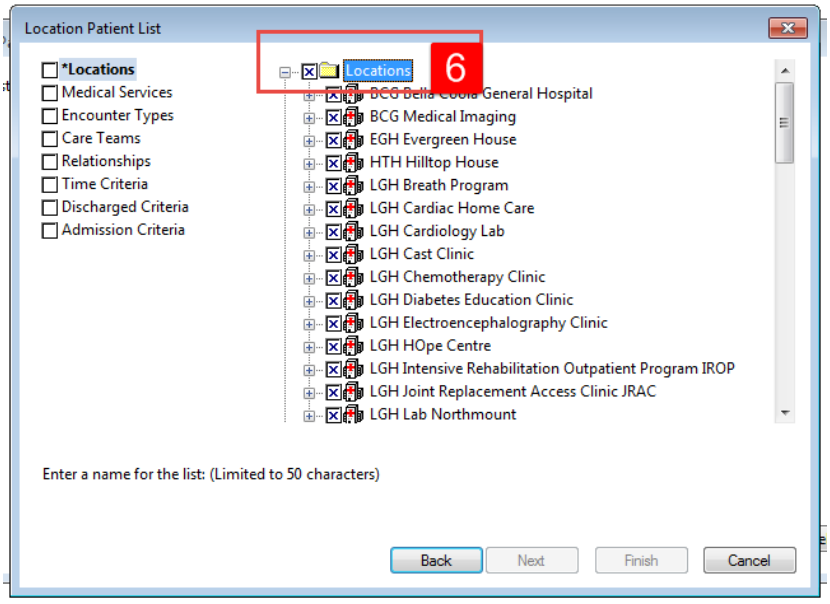


4. From the **Patient List Type** window select **Location**
5. Click the **Next** button in the bottom right corner



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

. A location tree will be displayed.

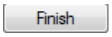


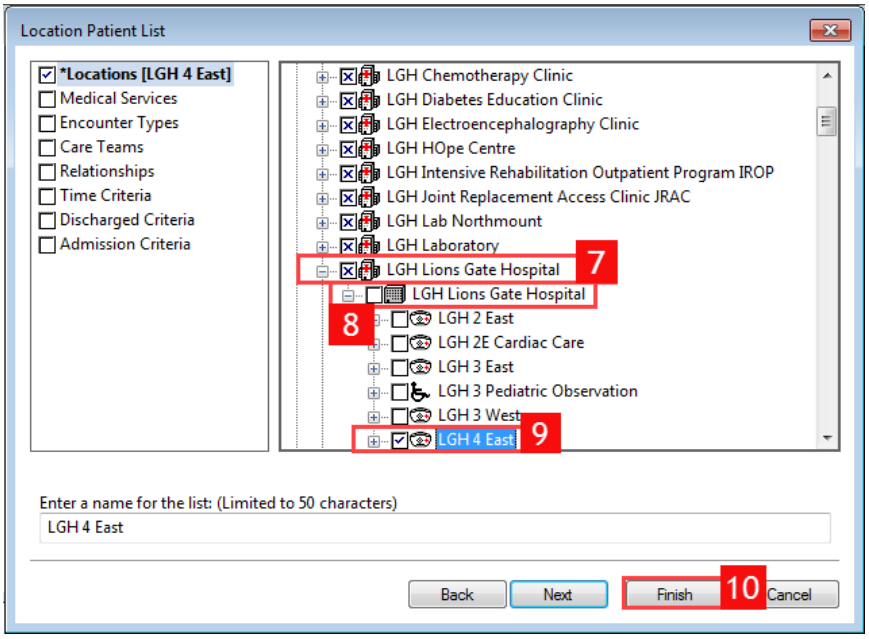
7. For this activity, use **LGH Lions Gate Hospital** as a selected location. Expand the location by clicking the **Plus Sign:** 

8. Then, click the next **Plus Sign:** 

9. For your practice, select **LGH 4 East** by checking the box next to the unit 

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

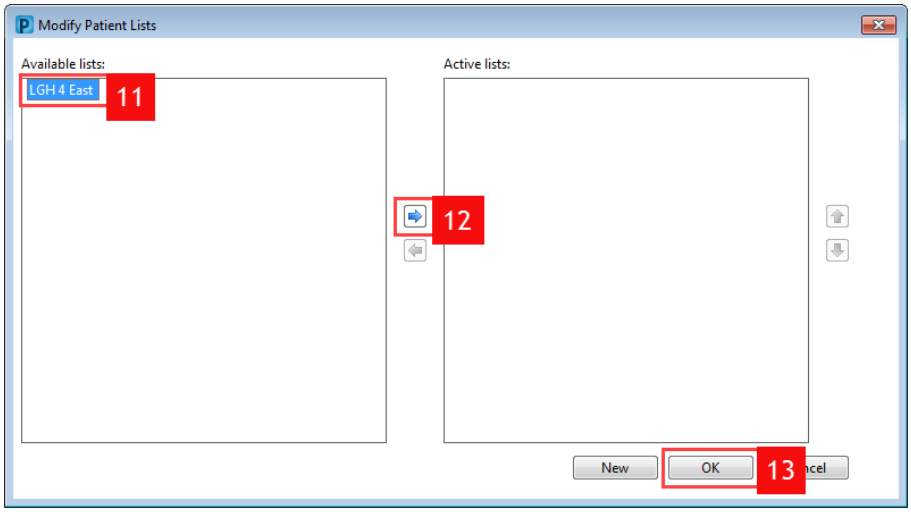
10. Click the **Finish** button  in the bottom right corner.



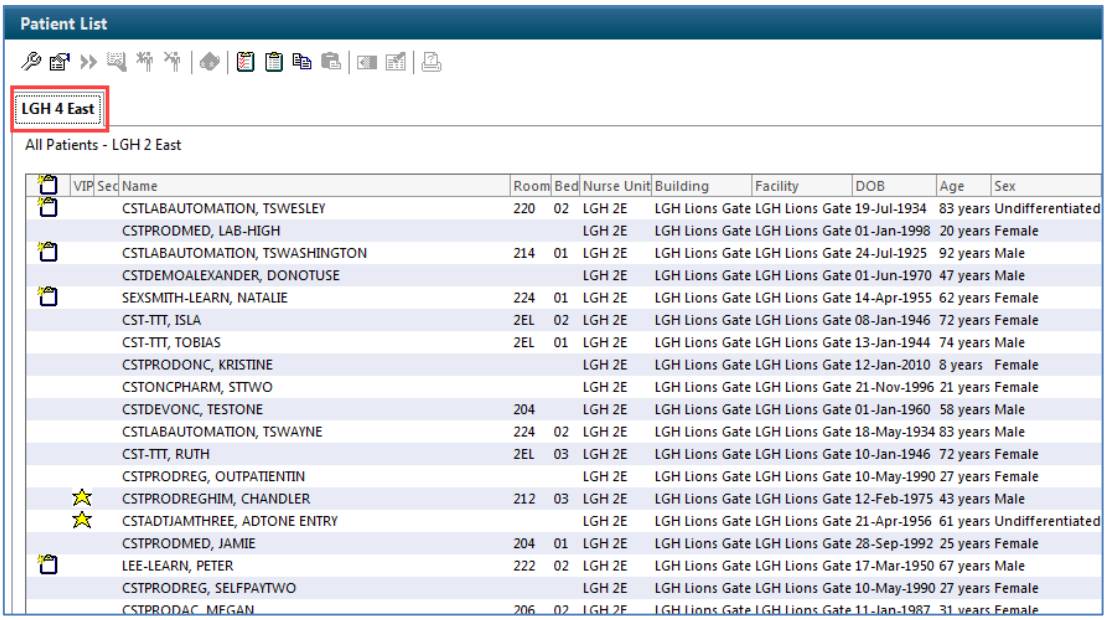
11. In the **Modify Patient Lists** window click on the available list **LGH 4 East**.

12. Click the **Blue Arrow** 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.



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



VIP	Sec	Name	Room	Bed	Nurse Unit	Building	Facility	DOB	Age	Sex
		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
		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
		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
		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 2E	LGH Lions Gate	LGH 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.

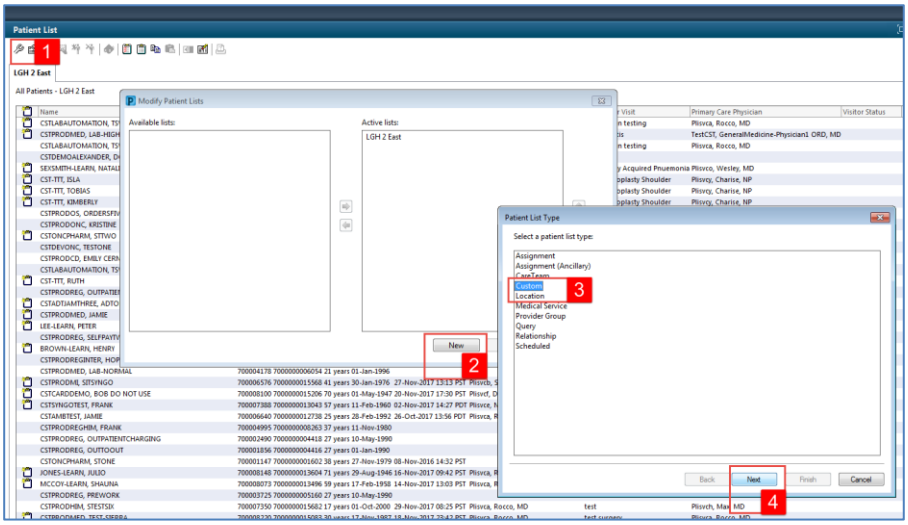
Key Learning Points

- 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

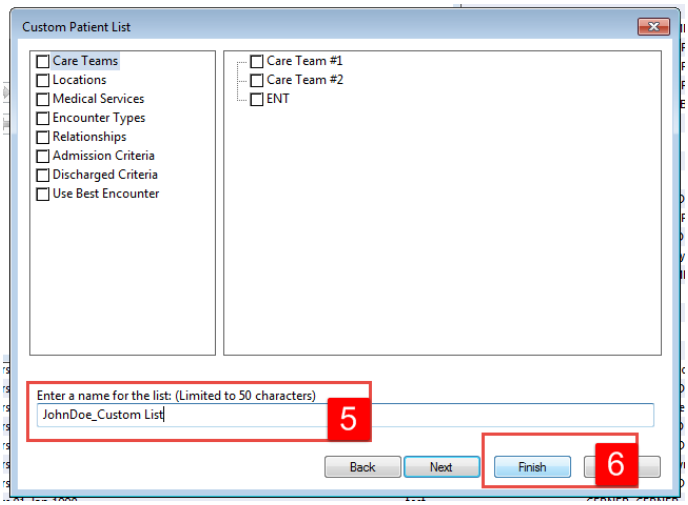
Activity 2.2 – Create a Custom Patient List

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.

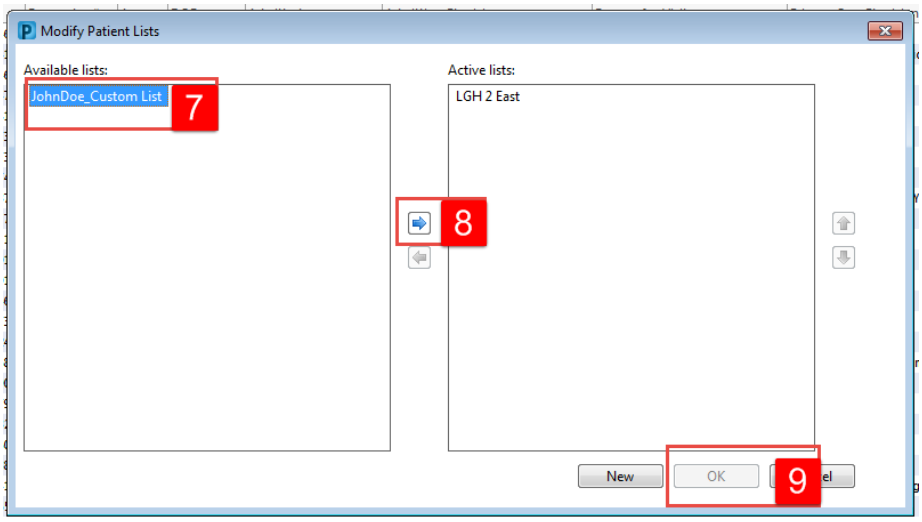
1. To create a **Custom List**, click the **List Maintenance** icon 
2. Click the **New** button in the bottom right corner of the **Modify Patient Lists** window
3. Select **Custom** from the **Patient List Type** window
4. Click the **Next** button



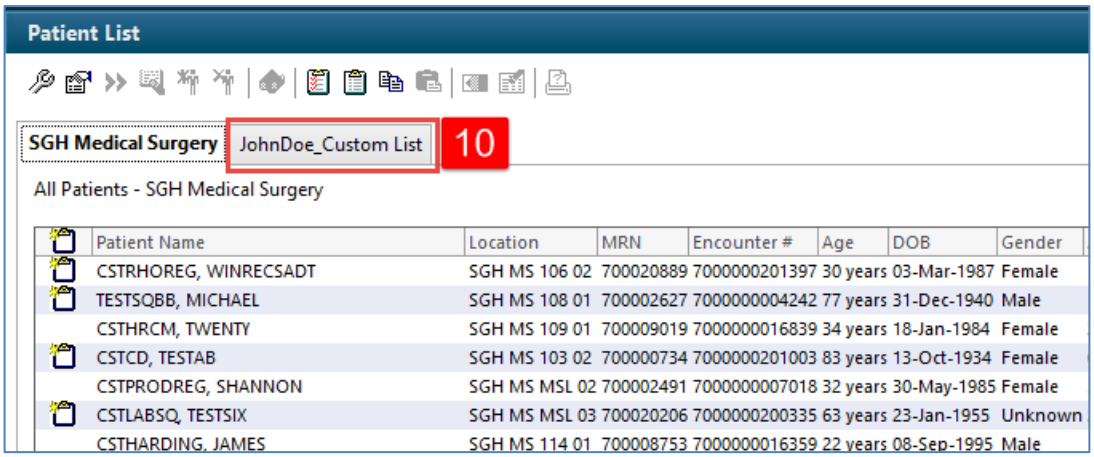
5. **The Custom Patient List** window opens. In the **Enter a name for the list:** Type *YourName_Custom* (i.e. John_Custom)
6. Click the **Finish** button



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



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

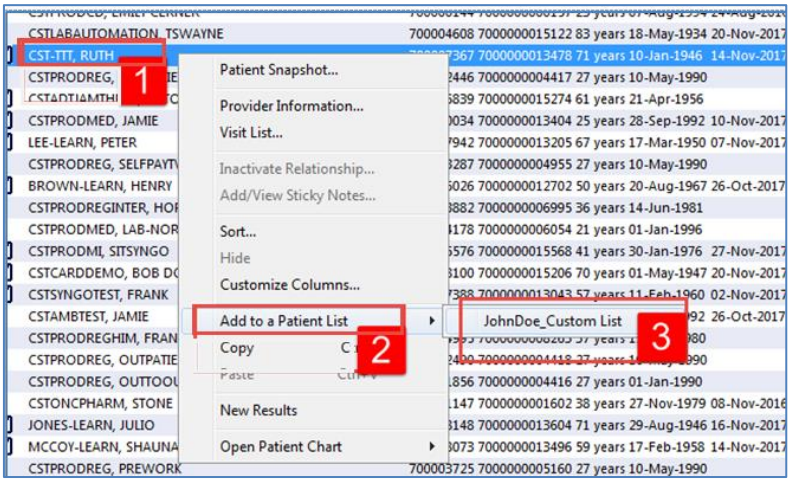


Note: Your custom list will be empty as you have not yet added any patients.

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.

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

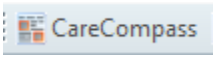
Learning Objectives
At the end of this Scenario, you will be able to: ■ Navigate to and within CareCompass and understand how it fits into your daily workflow ■ Establish a relationship with your patient(s) and review the patient's information

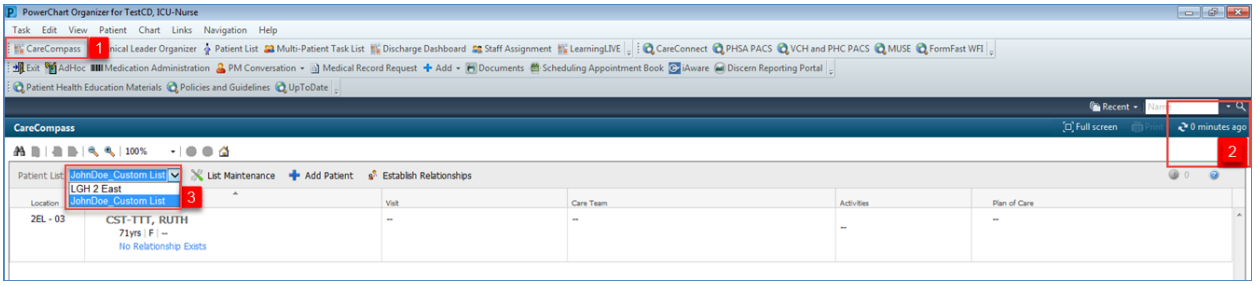
SCENARIO
As an Inpatient Rural Nurse, you will complete the following activities: ■ Navigate in and around CareCompass ■ Establish a relationship with your patient(s) and review patient information

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



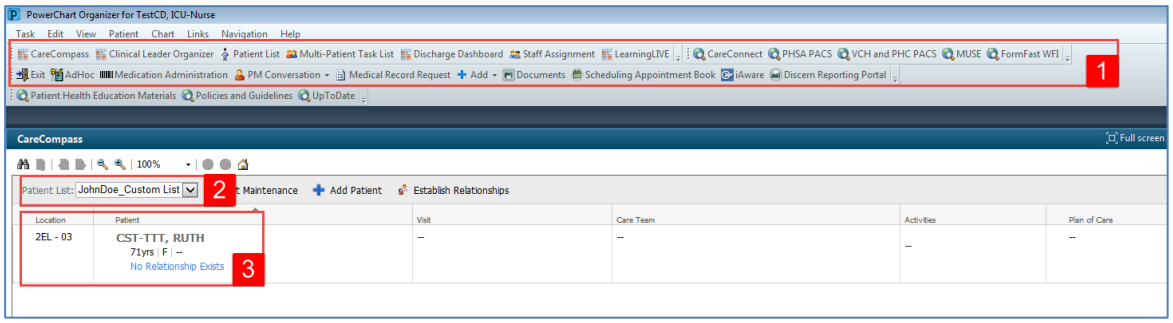
Now the patients that you have moved onto your Custom List are displayed in **CareCompass.**

2

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.



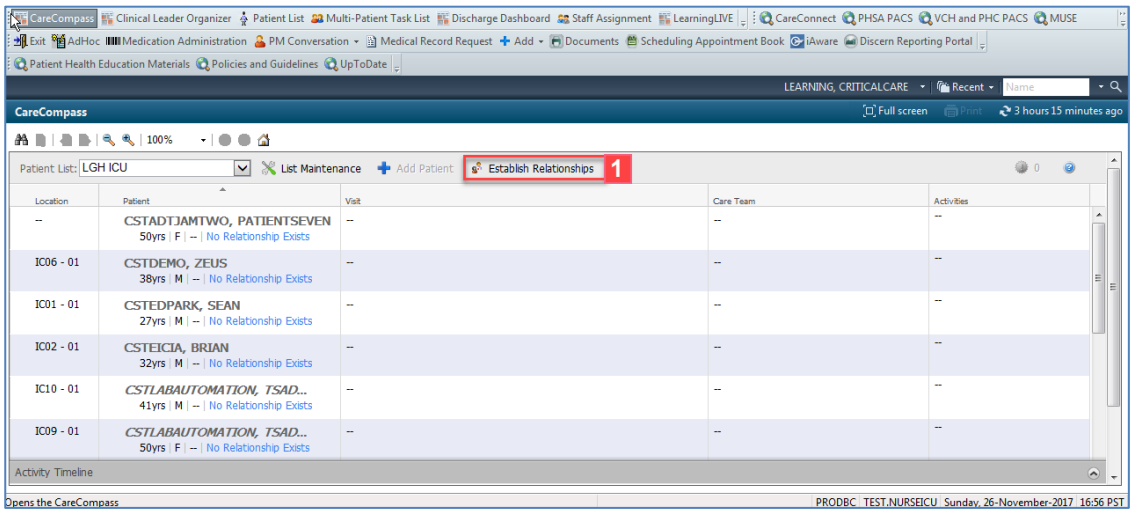
Key Learning Points

- 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

Activity 3.2 – Establish a Relationship and Review Patient Information

1 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**



2. An **Establish Relationships** window opens. Select all or individual patients as appropriate.

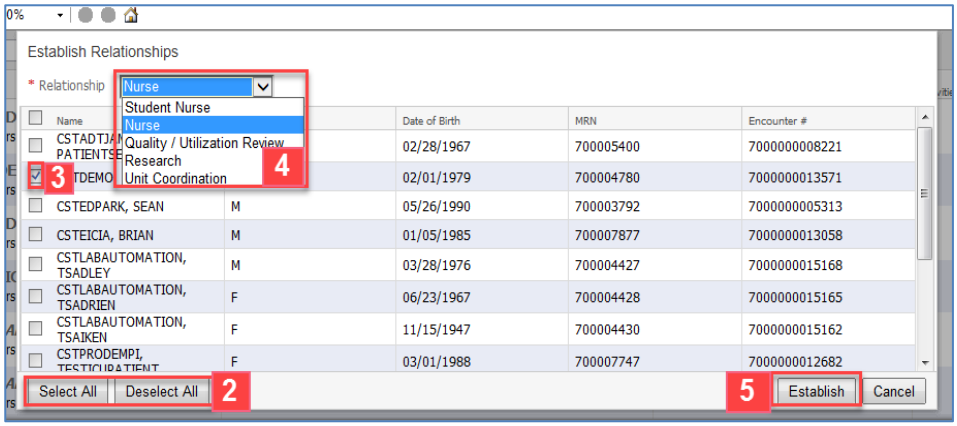
   Note: In this case, you will only have the one patient to establish a relationship with.

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.

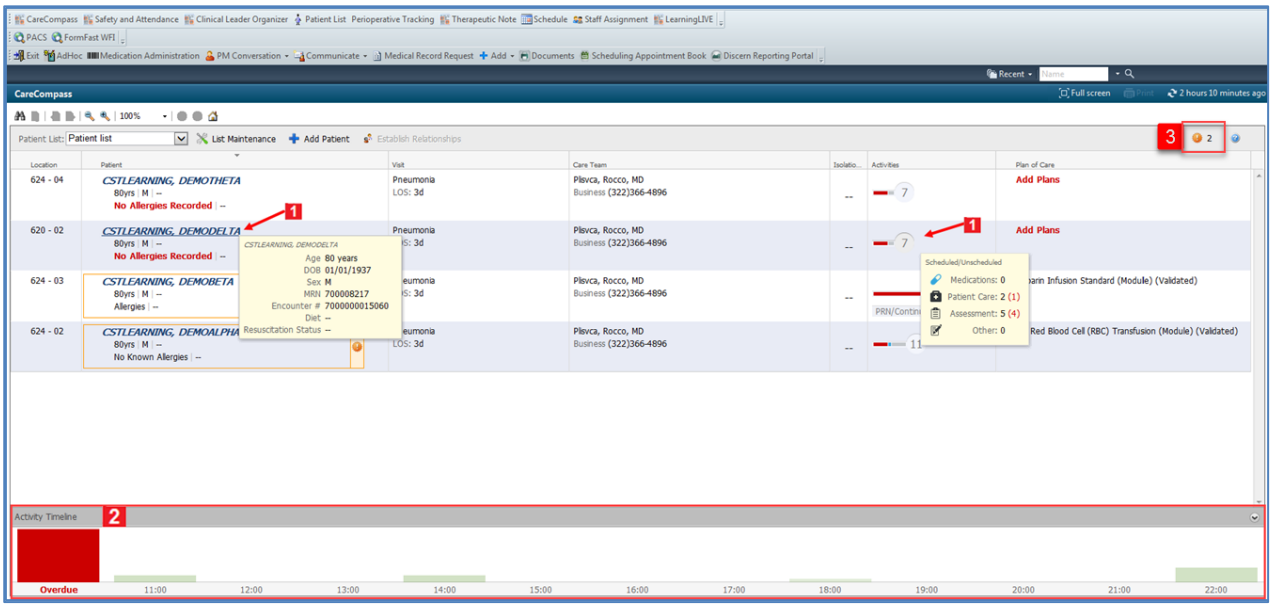


Once a relationship is established with your patients, additional information will appear on CareCompass.

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

1. You can hover your cursor over icons, buttons, and patient information to discover additional details.
2. **Activity Timeline** appears at the bottom of **CareCompass**. 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.

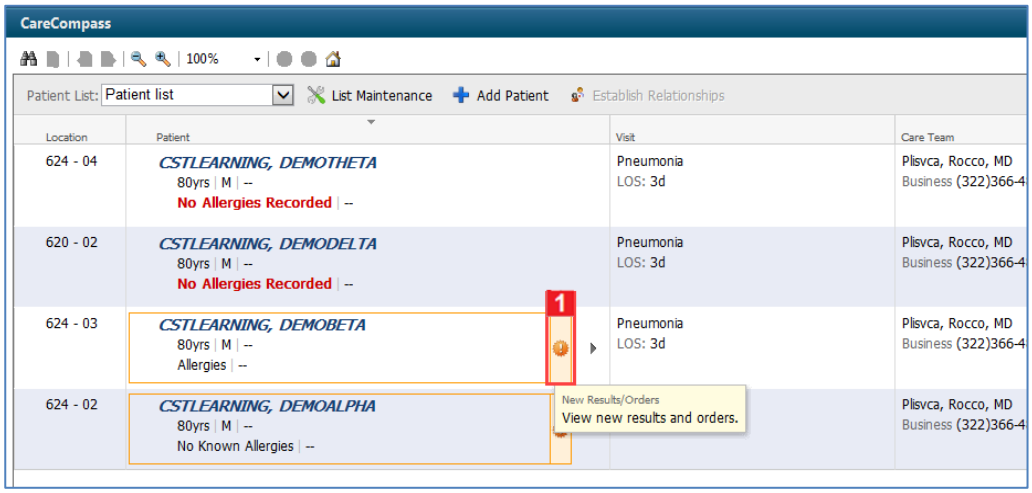


3 Notice there may be a **red** **or orange** **exclamation** icon next to the patient's name.

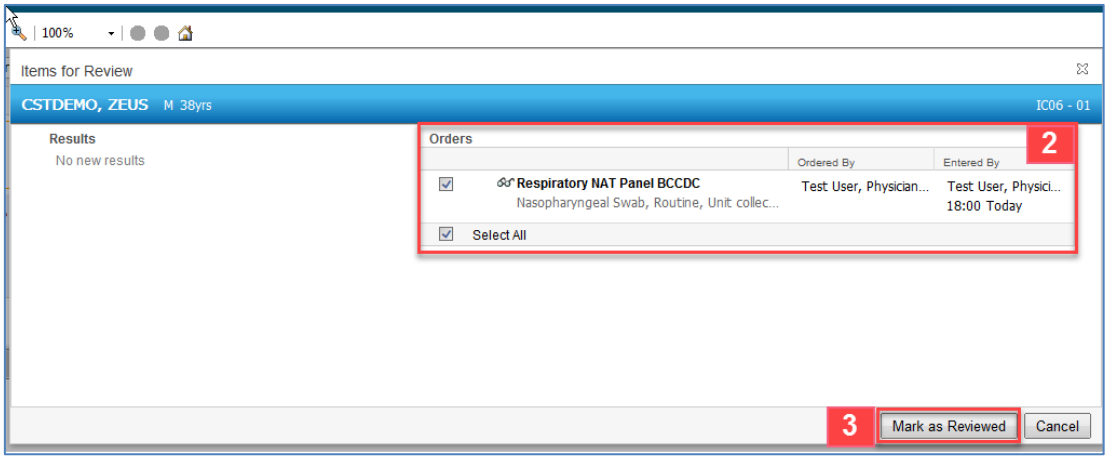
Note: Indicates new non-critical results or orders for a patient requiring review.

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

1. Click the **Exclamation** icon.



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.



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.

Key Learning Points

- A relationship must be established with patients in order to view more detailed patient information and access their chart
- Remember to select the correct role when establishing a relationship with patients
- A relationship will last for 16 hours and the nurse will need to re-establish the relationship at the next shift
- CareCompass provides a quick overview of patient information including patient care activities, scheduled and unscheduled tasks and new orders and results for the patient
-  Indicates new non-critical results or orders for a patient requiring review
-  Indicates new critical results or STAT/NOW orders requiring review

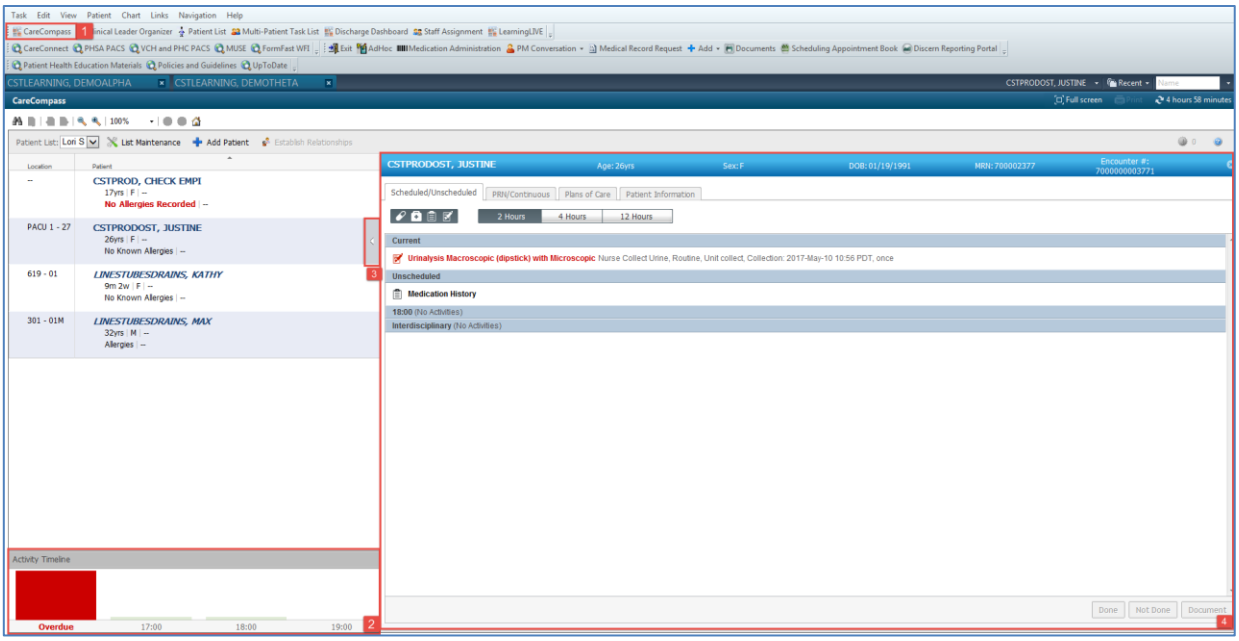
Activity 3.3 – Review and Complete Tasks in CareCompass

1 Tasks are activities that need to be completed for the patient. Tasks are generated by certain orders or rules in the system and 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:

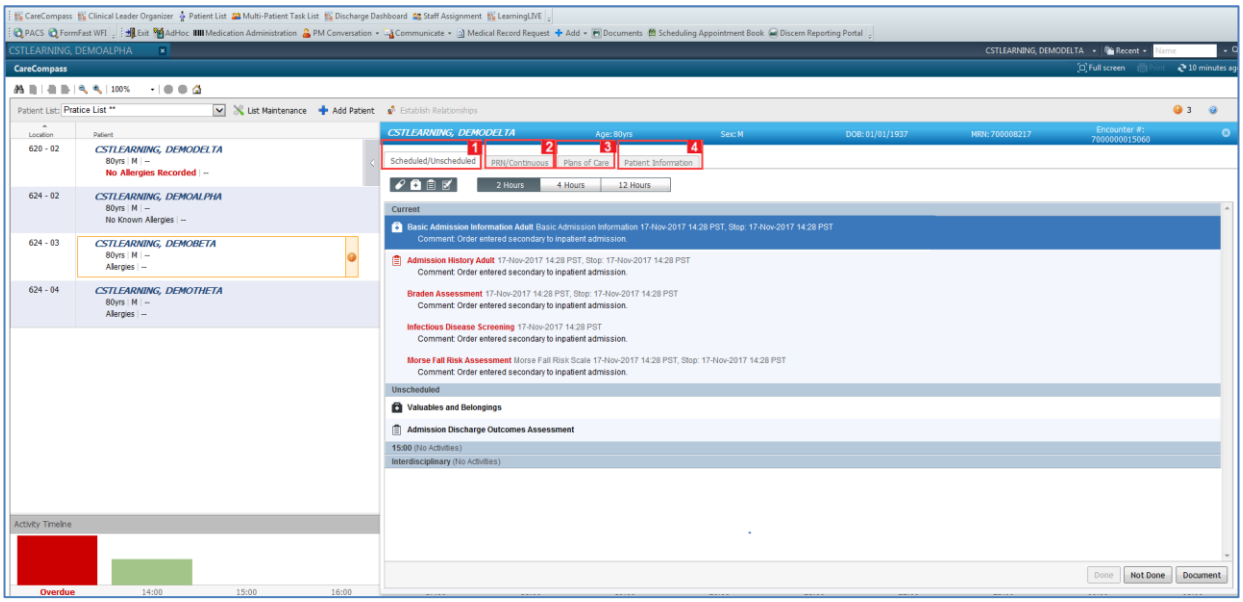
1. Ensure you are viewing **CareCompass**.
2. Scheduled tasks for multiple patients are summarized in the **Activity Timeline.** (You can click on the red or green shaded bars to view task details.)
3. Click the **grey forward arrow** to the right of your patient's name to open the single patient task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



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

To see different information you can navigate between:

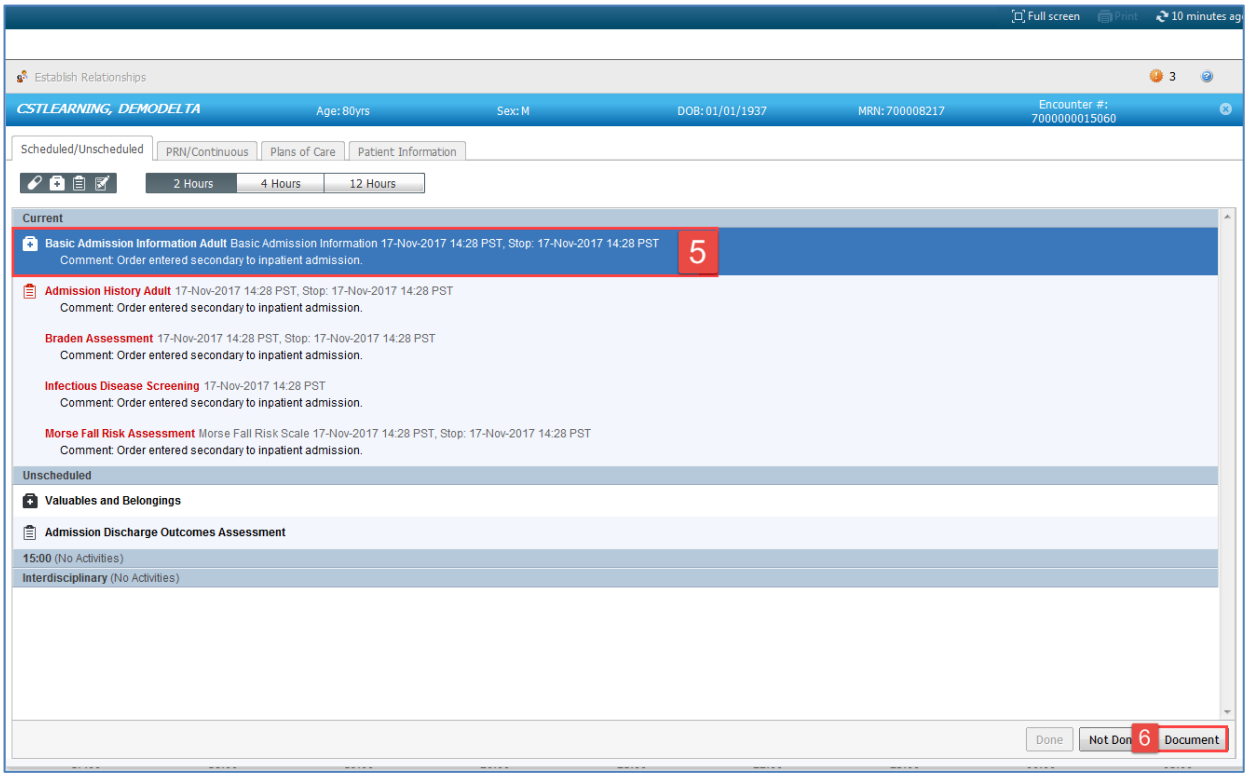
1. **Scheduled/Unscheduled** tasks tab
2. **PRN/Continuous** tab
3. **Plans of Care** tab
4. **Patient Information** tab



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**



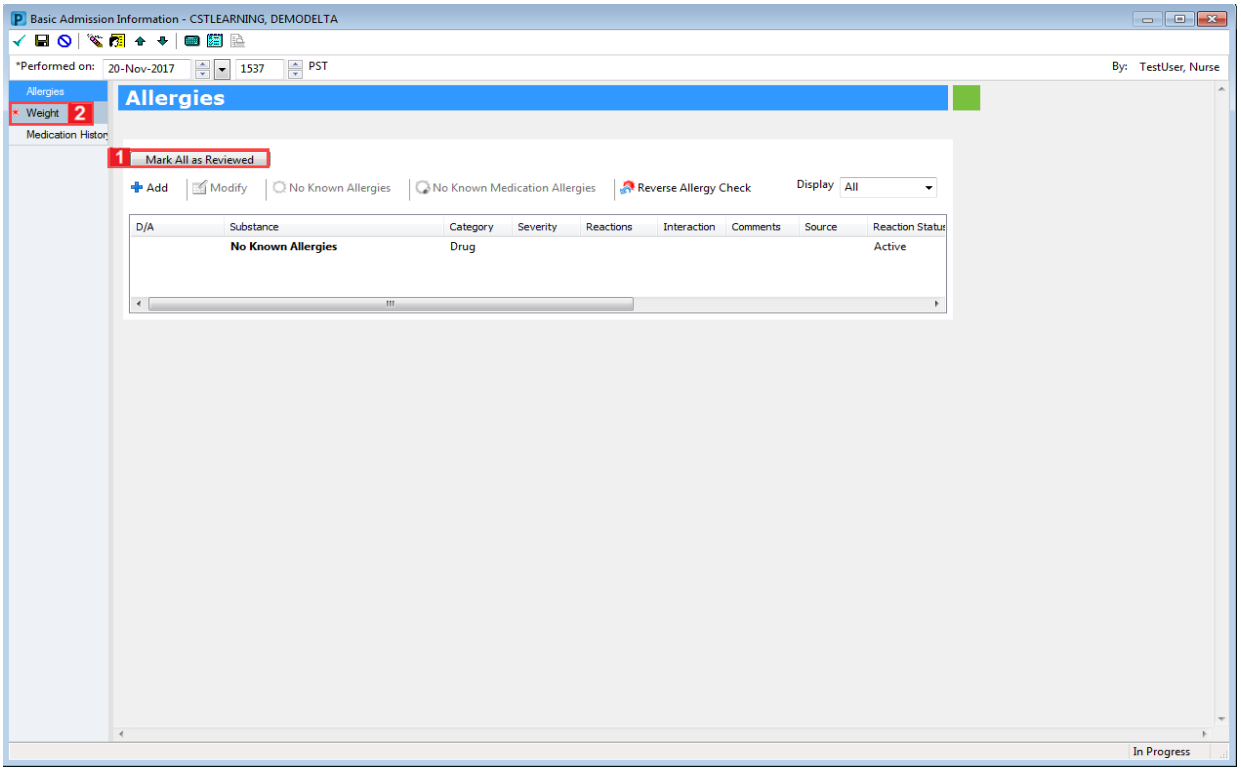
Note: If a task is associated with documentation, clicking **Document** takes you directly to the appropriate documentation within the patient's chart. **Basic Admission Information** is documented using a PowerForm (a standardized electronic documentation form). Clicking **Document** takes you directly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

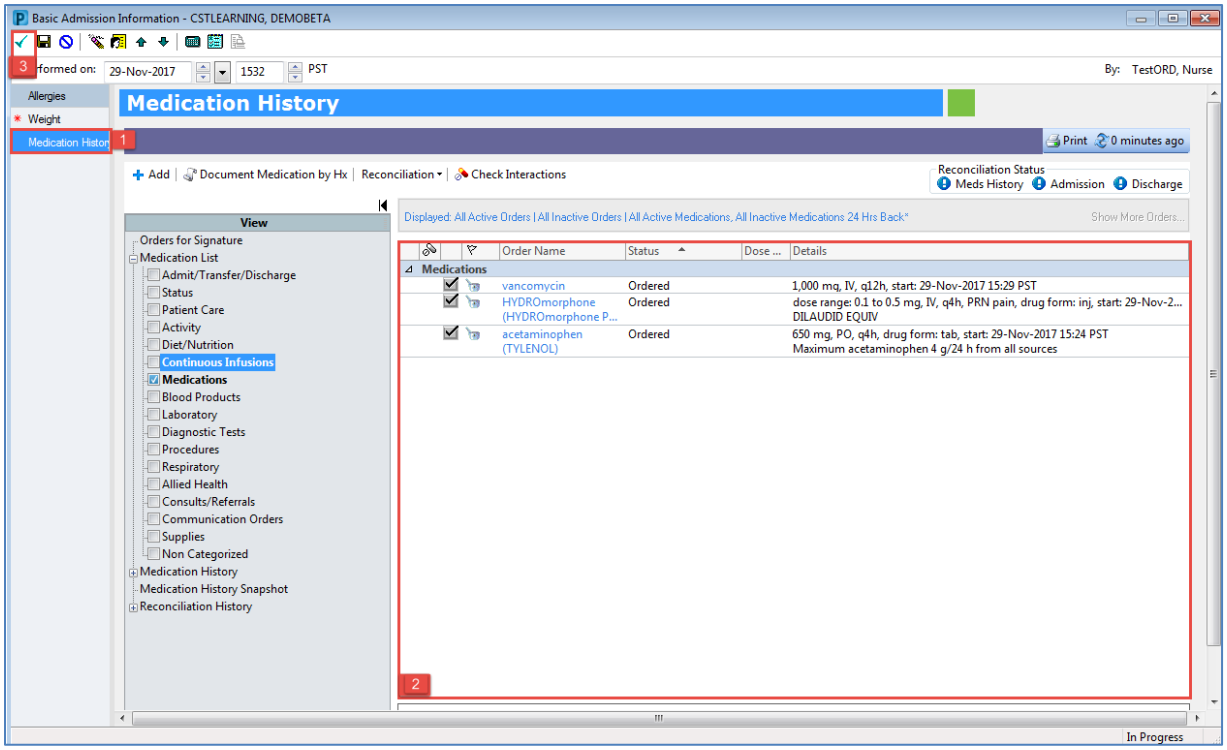
To complete this PowerForm:

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



4

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 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.



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.

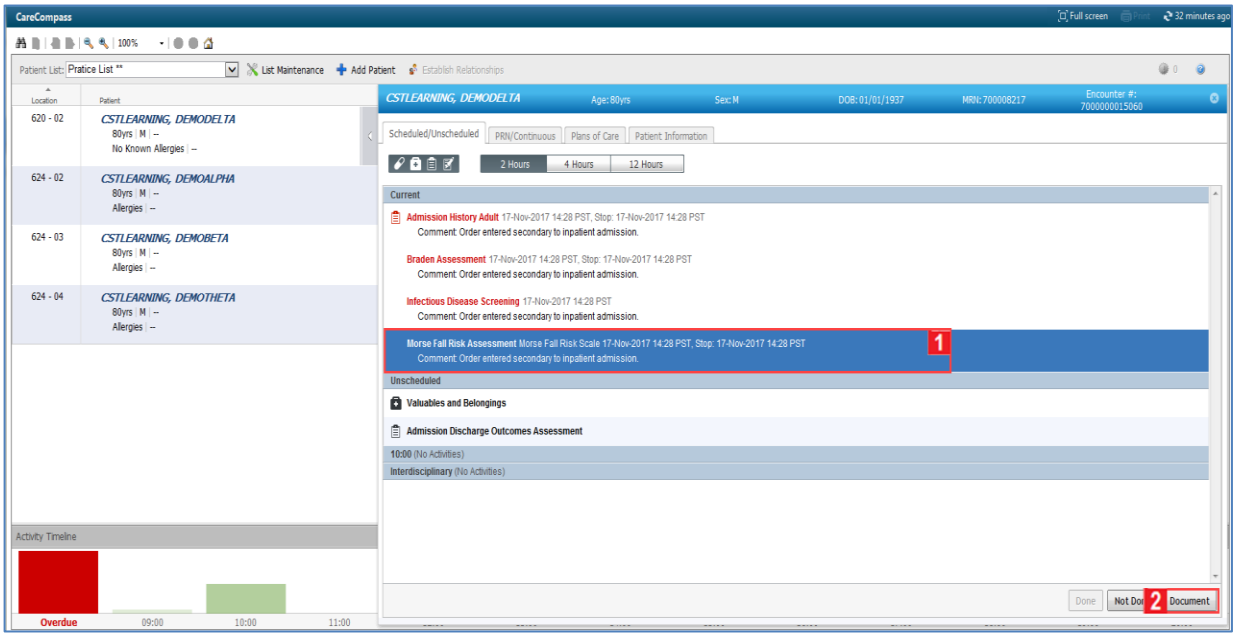
Information documented in the BPMH pulls forward into the Admission Medication Reconciliation that the provider will complete.

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**



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.

6 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.

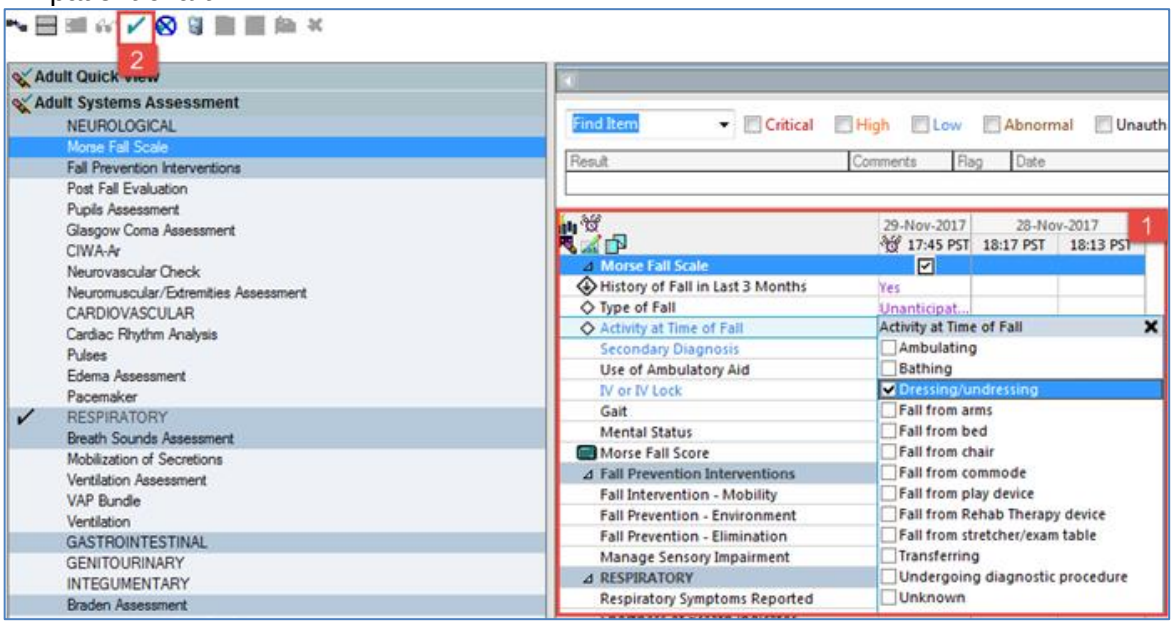
   Document using the following data:

   - **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*

- **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.

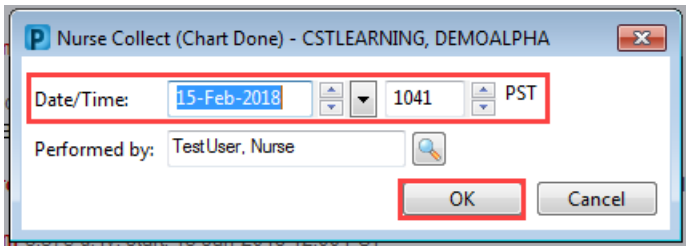
2. Click the **green checkmark** ✓ to sign your documentation. You will notice that your documentation changes from purple text to black text. This means it is now recorded in the patient chart.

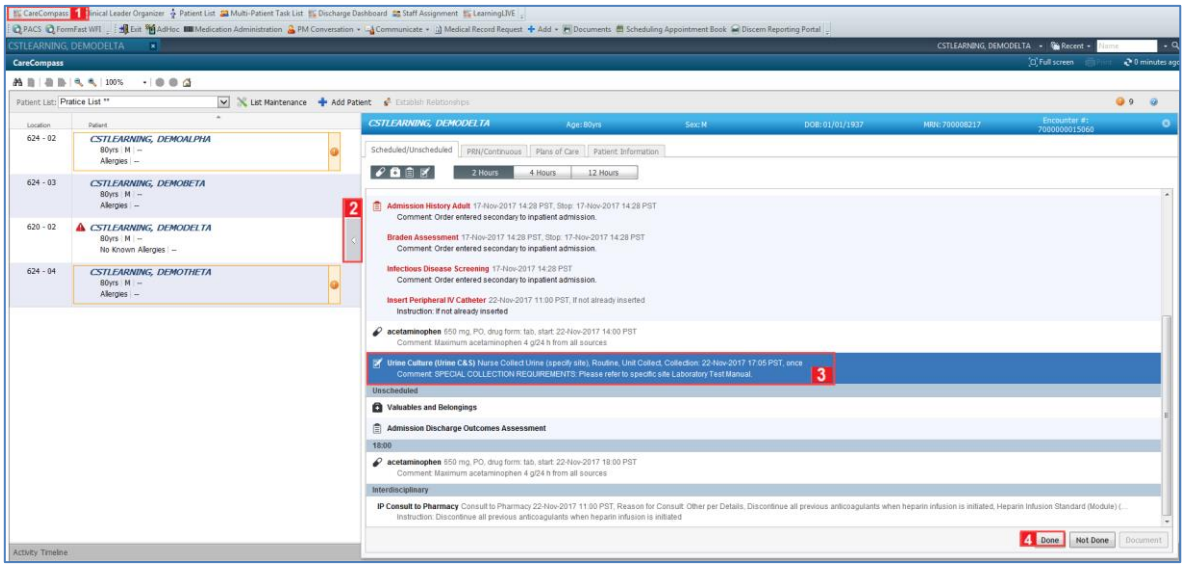


Note: When text appears in blue it means there is a hyperlink attached. Clicking on the hyperlink opens a window that provides additional information to clarify or support documentation decisions.

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

1. Navigate back to **CareCompass** by clicking CareCompass 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.**





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.

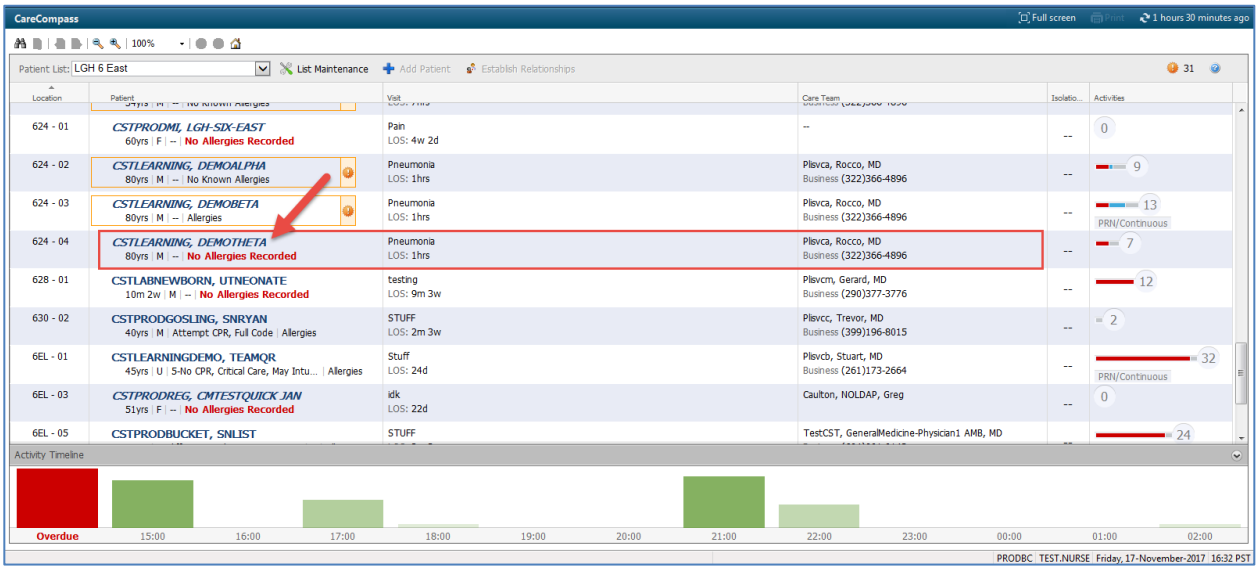
As an inpatient nurse you will be completing the following activities:

- 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

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

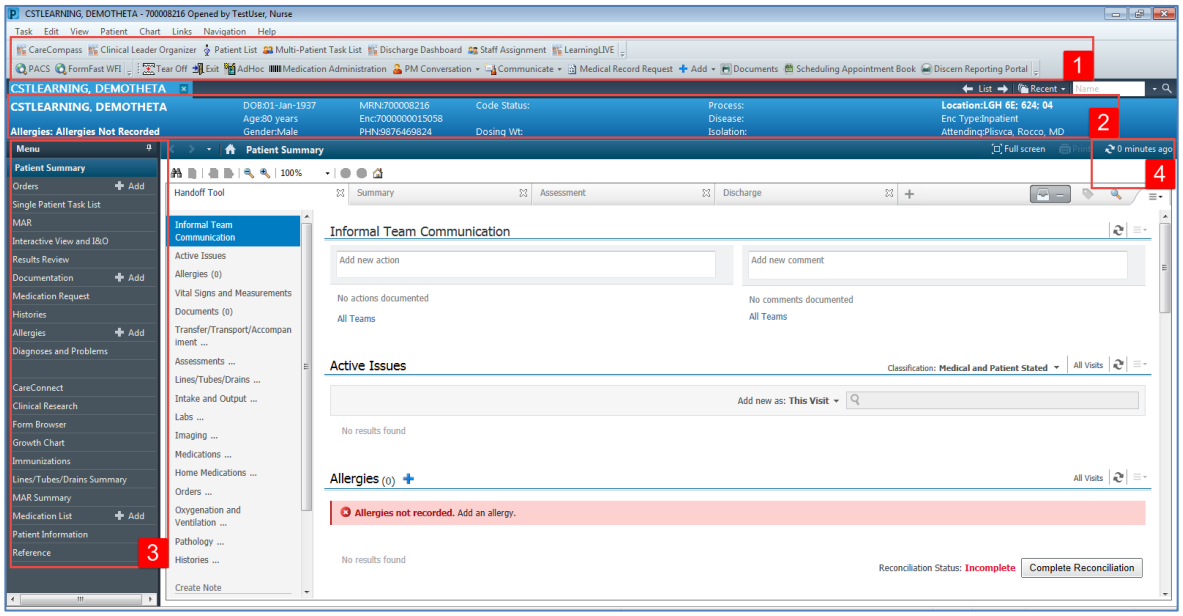


2 The patient's chart is now open. Let's review the key parts of the screen.

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
3. 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 updates 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 .



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

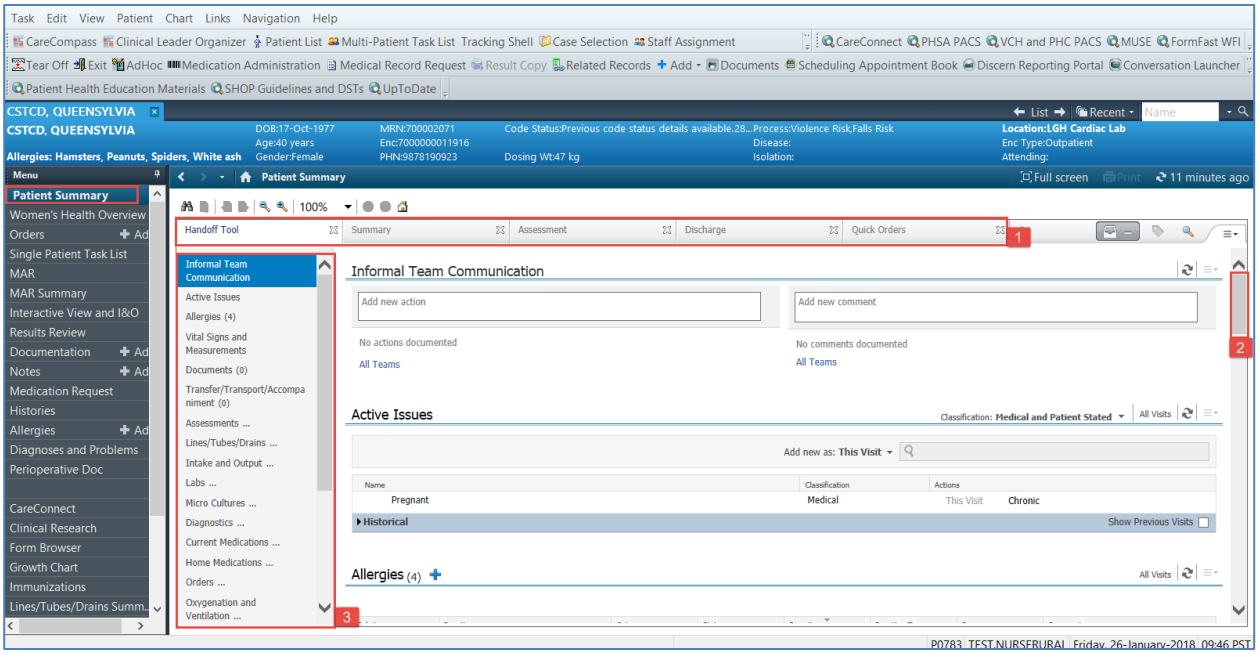
1 When the patient's chart is first opened, you will see the **Patient Summary** page. The **Patient Summary** summarizes key clinical patient information, orders, medications, lab results, and so on. This will be the place in the chart that is accessed during handover for nurses to review critical patient information.

1. 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.



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.

Key Learning Points

- 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.

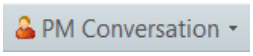
As an inpatient nurse, you will complete the following activities:

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

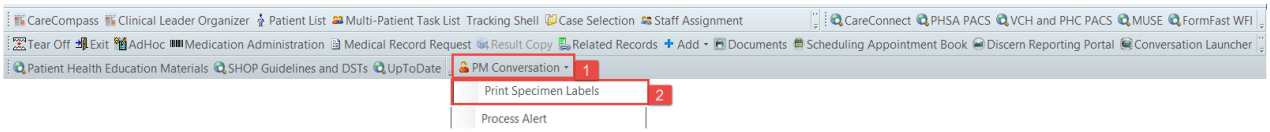
Activity 5.1 – Printing Printing Specimen Labels in PM Conversation

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

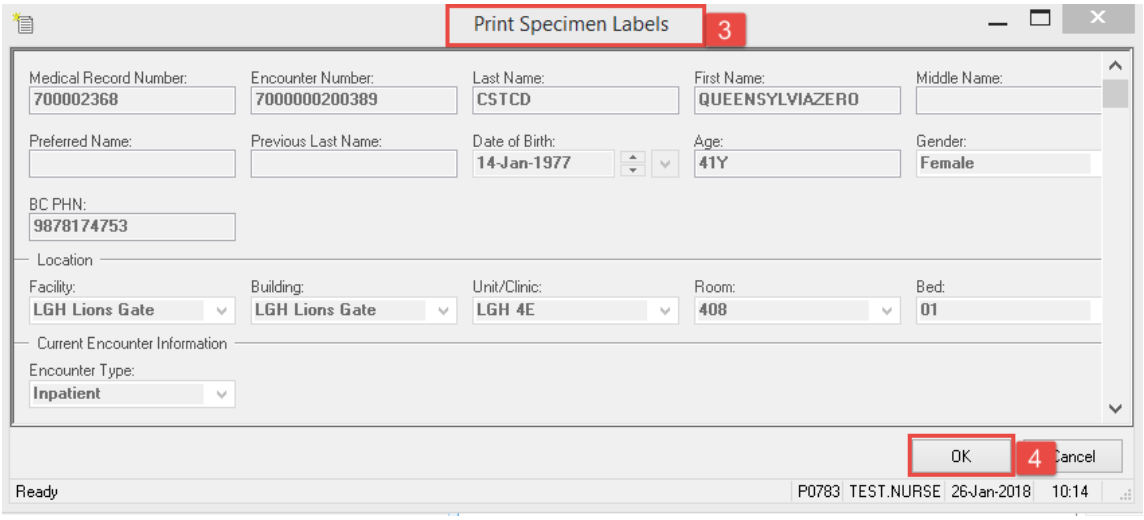
Note: Please read the following steps only. Do not do this in the system as a means of saving paper/labels.

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



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

1 **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.

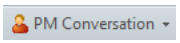
The purpose of **process alerts** is to quickly provide the user significant "face up" information about the patient. These alerts can appear in multiple areas of the chart including the banner bar, CareCompass, Summary Pages, and Tracking Boards.

Examples of these alerts include:

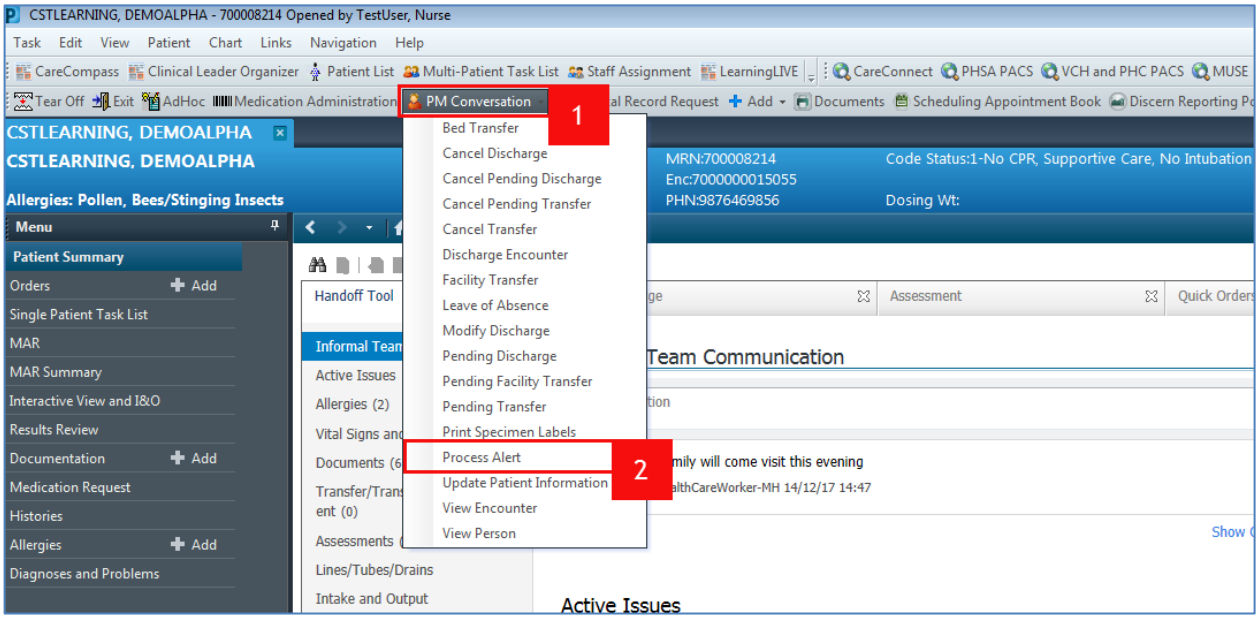
- Communication Barrier
- Cytotoxic
- Difficult Intubation/Airway
- Falls Risk
- Family Development
- Gender Sensitivity
- No ceiling lift
- On Research Study
- Palliative Flag
- Seizure Precautions
- Special Care Plan
- Violence Risk
- Visitor Restrictions

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 

in the toolbar
2. Select **Process Alert** from the drop down menu

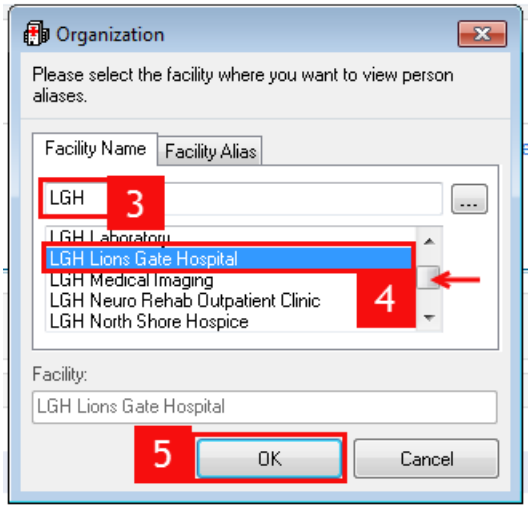


The **Organization** window will display to select a location.

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.

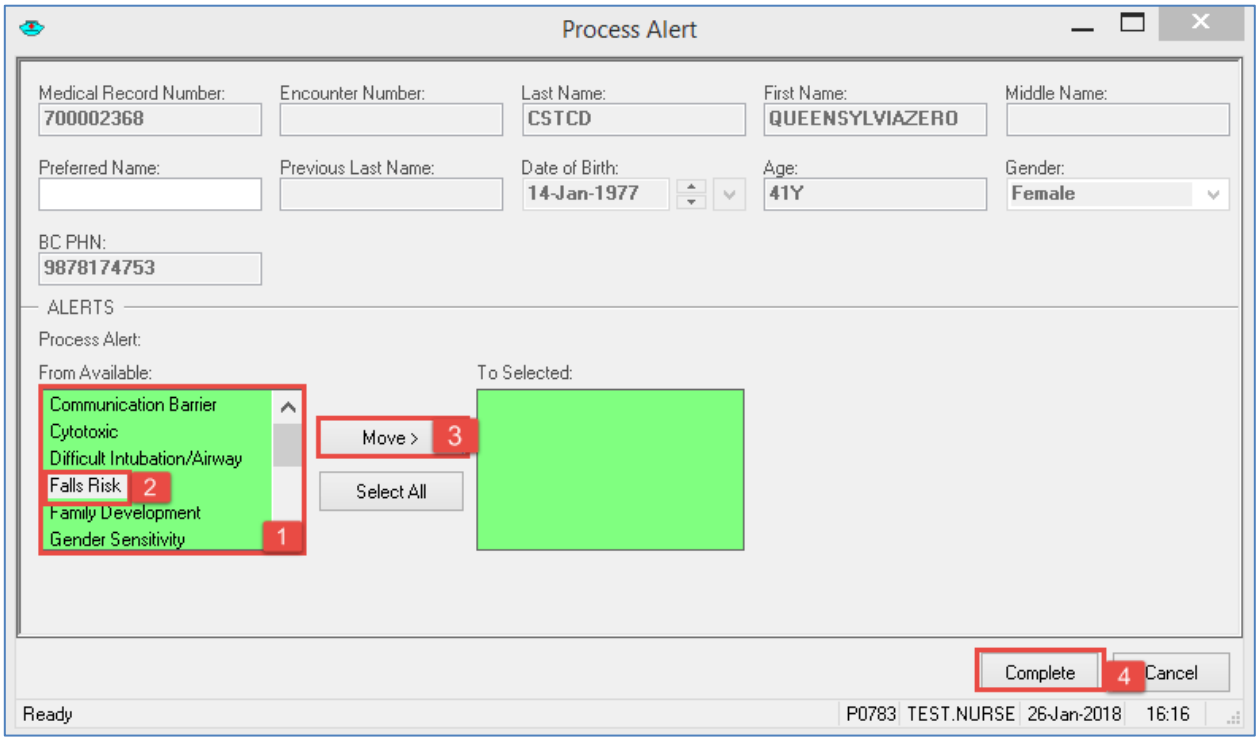
4. Select **LGH Lions Gate Hospital**
5. Click **OK**



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

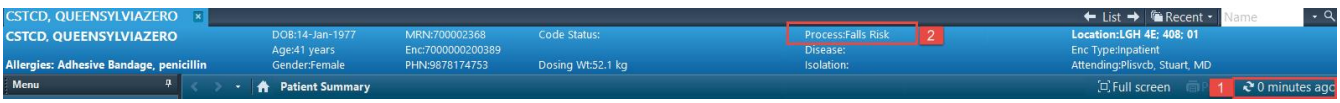
1. Click into the empty **Process Alert** box. A list of available alerts that can be applied to the patient will display. (The box will turn green when you click into it).
2. Select **Falls Risk**
3. Click **Move.** The alert will now display within the **To Selected** box
4. Click **Complete**

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.



3

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



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

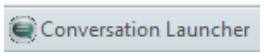
Note: Similar steps can be taken in PM Conversation to remove a process alert.

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

1

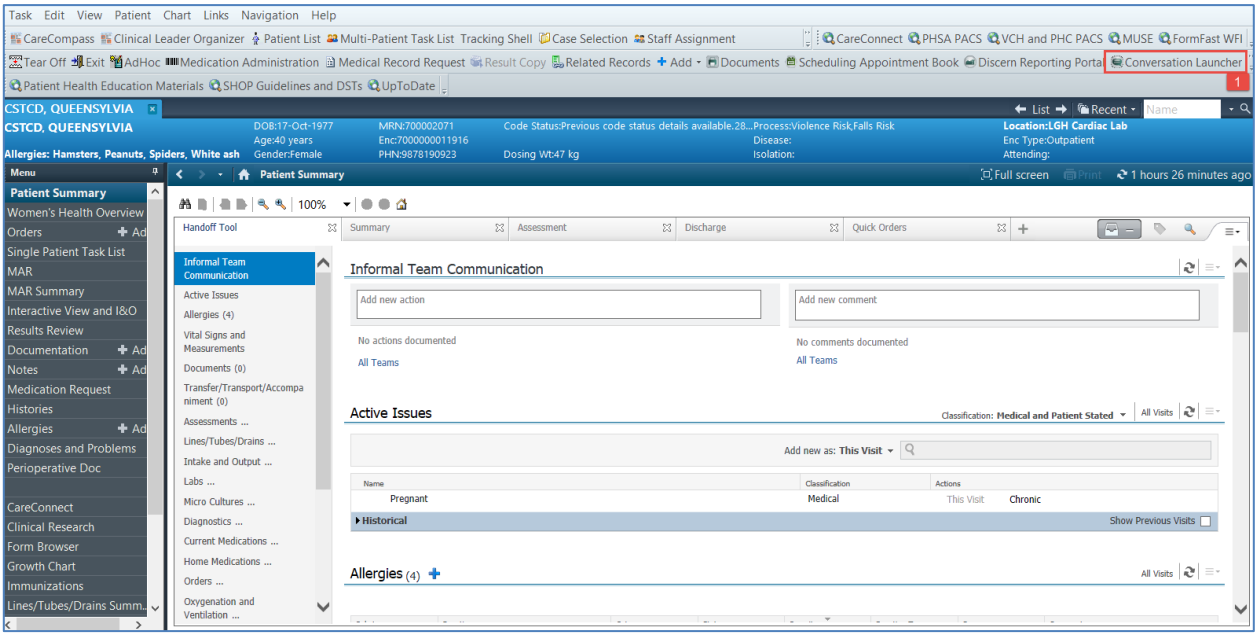
Conversation Launcher 

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

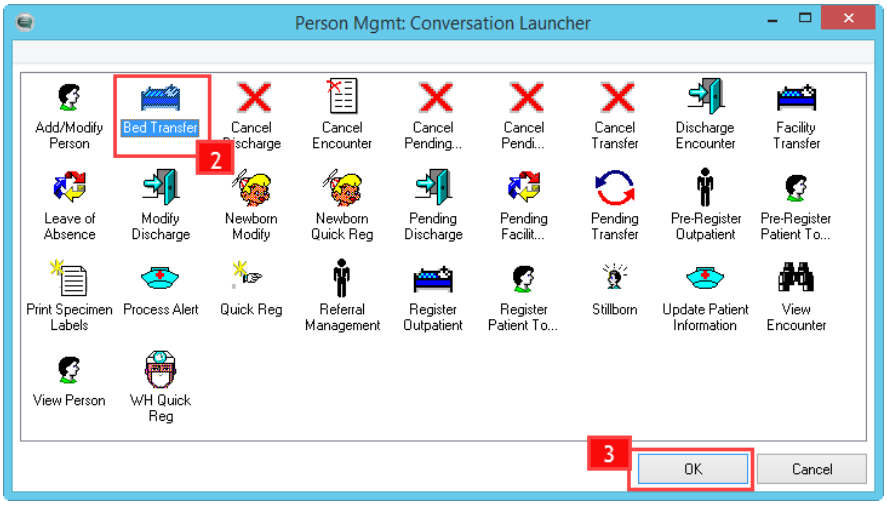
Let's say you receive notification that a patient is being transferred from the ED to your inpatient unit and there is no unit clerk available to enter the bed transfer for you. You've been given the patient's demographics (name, DOB and MRN).

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**.**



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



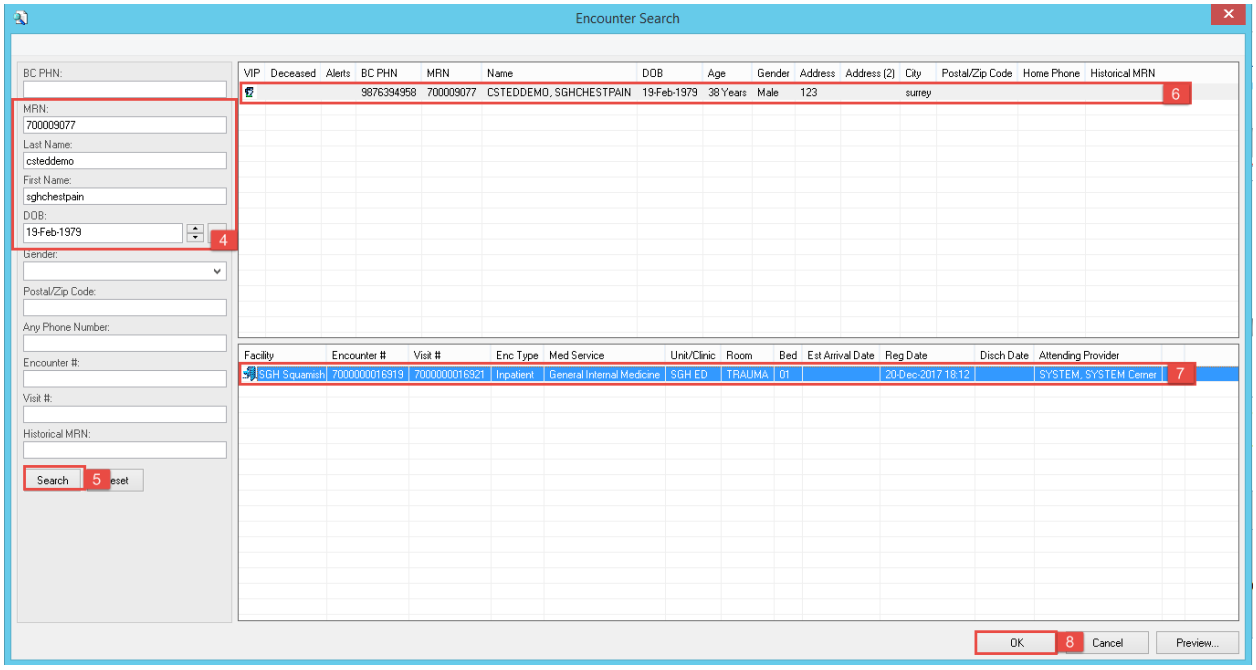
The **Encounter Search** window will open.

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.

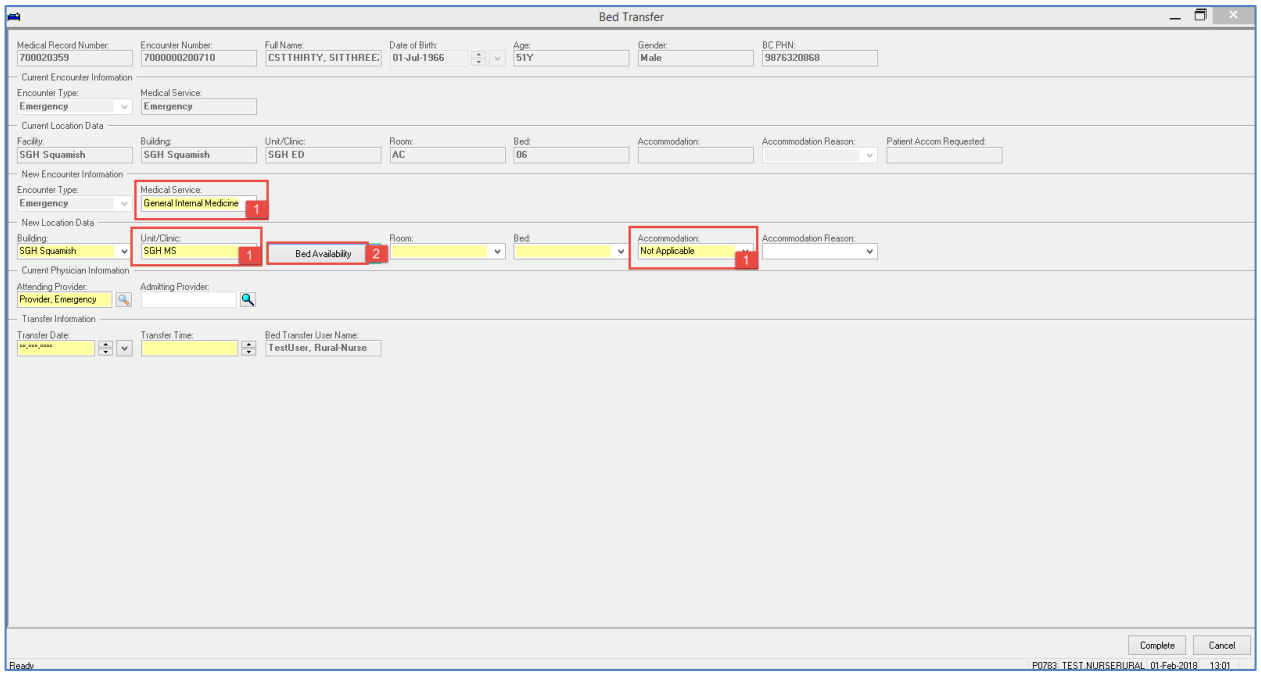
4. At this point, you would search for the patient using three identifiers: the patient's first name, last name and DOB.
5. Click **Search.** All the patients that match your search criteria will be listed in the top half of the window, with their corresponding encounters in the bottom half of the window
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**.

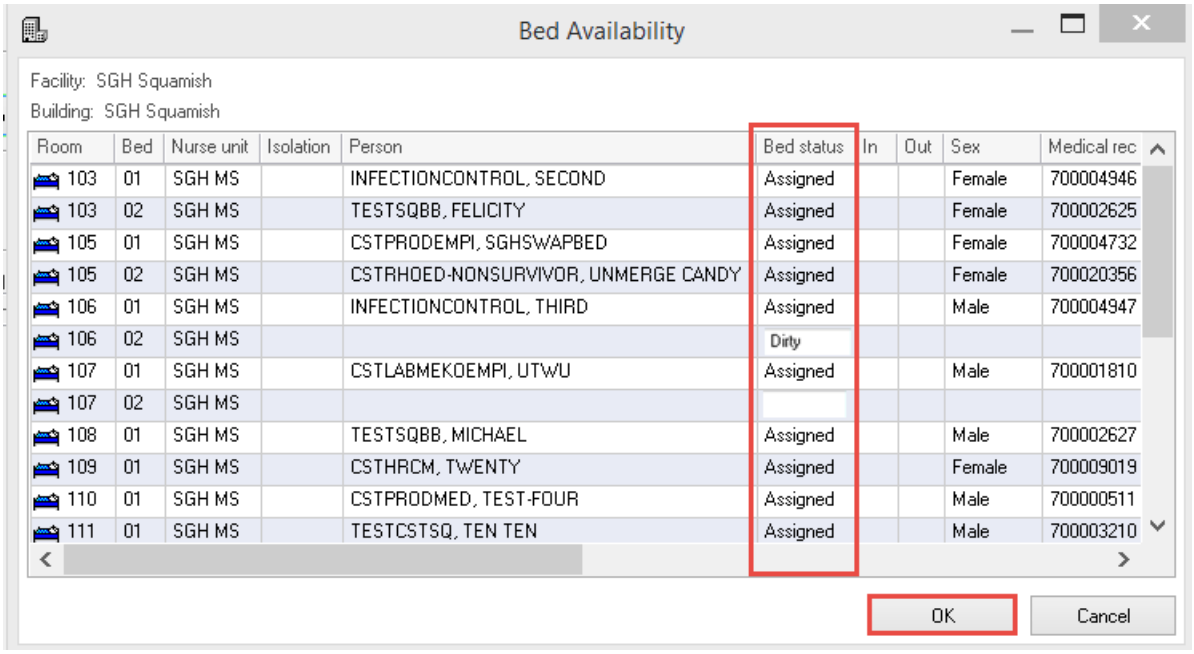


1. The **Bed Transfer** window will open. Yellow fields are mandatory. Please enter:
    - **Medical Service**= General Internal Medicine
    - **Unit/Clinic**= SGH MS
    - **Attending Provider**= Plisvcl, Antonio (begin typing and it will auto-complete)
    - **Acommodation Reason**= Not Applicable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

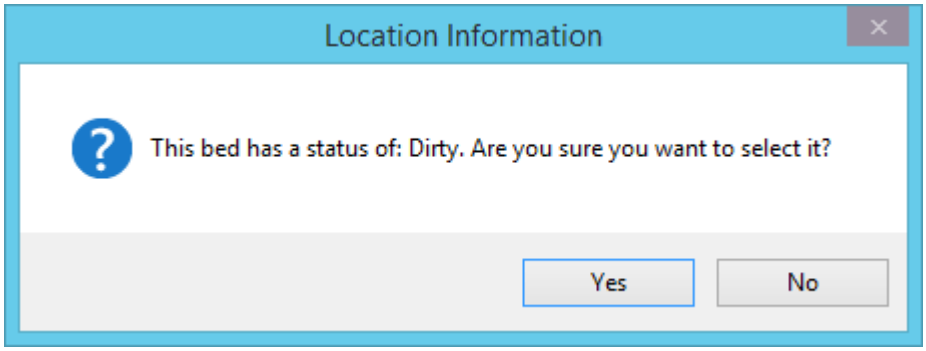


The **Bed Availability** window will open.

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



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**.



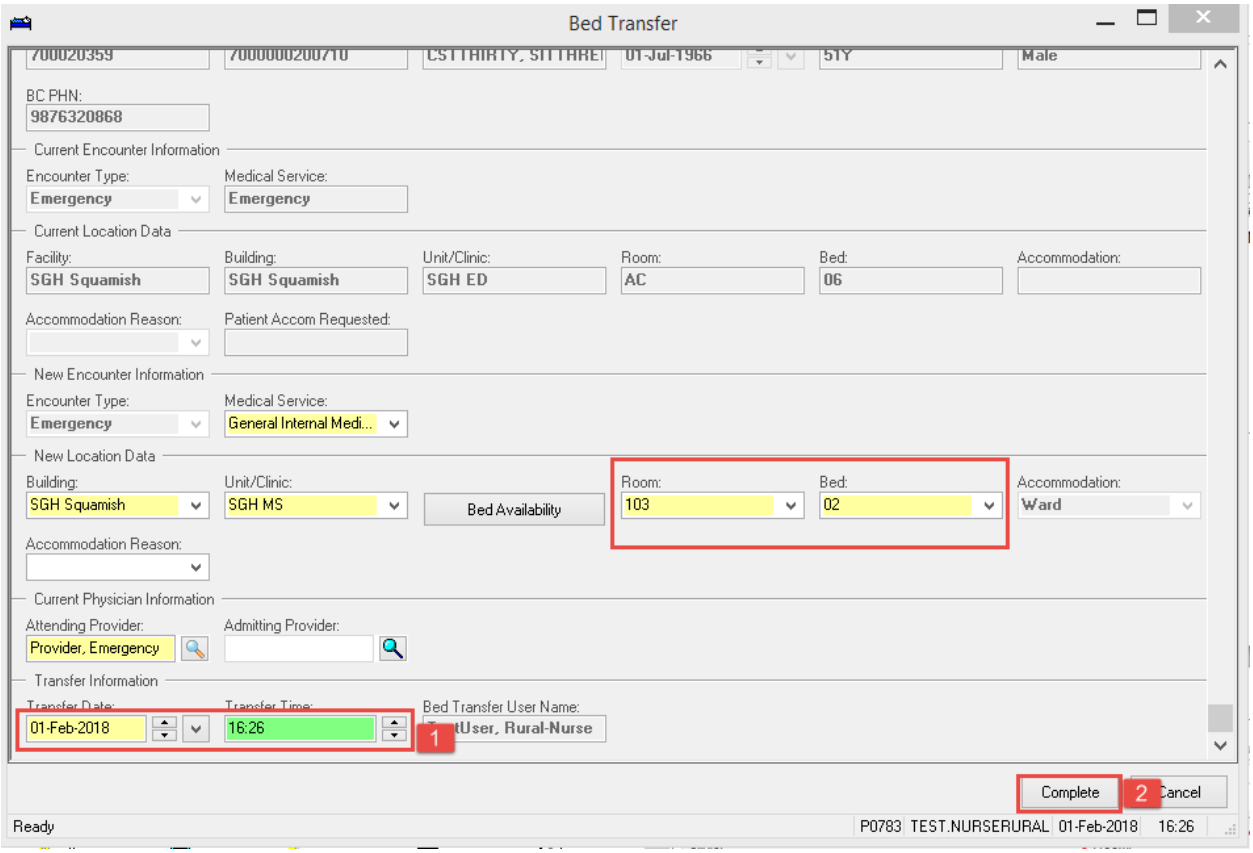
You will now be returned to the Bed Transfer window. Note that the **Room** and **Bed** mandatory fields are now filled in. Now you need to complete the transfer.

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**



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

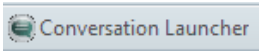
Activity 5.4 – Update Patient Information

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

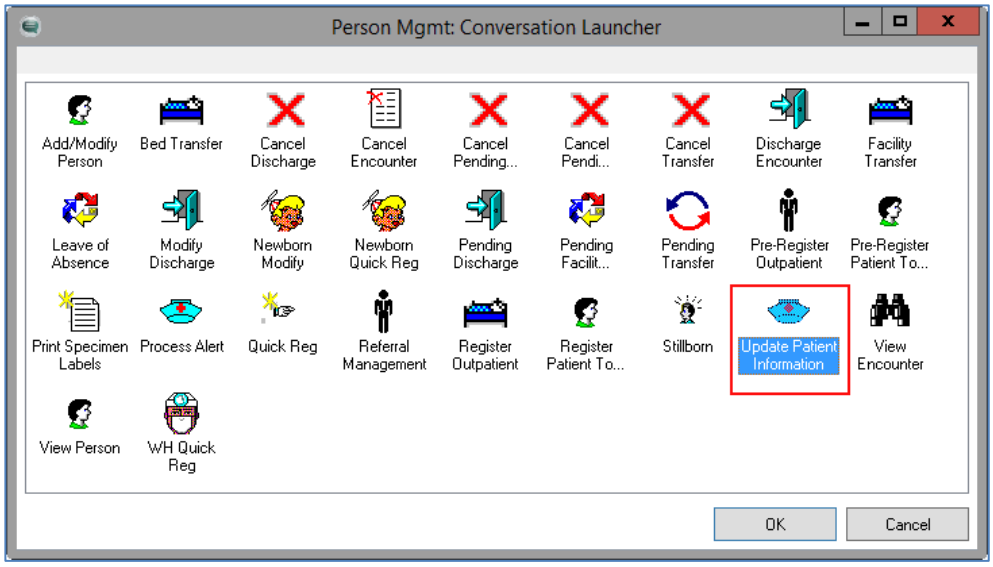
Some of this information will display on the banner bar of the patient's chart and you will need to update this information so that other clinicians or departments are aware of any changes.

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:

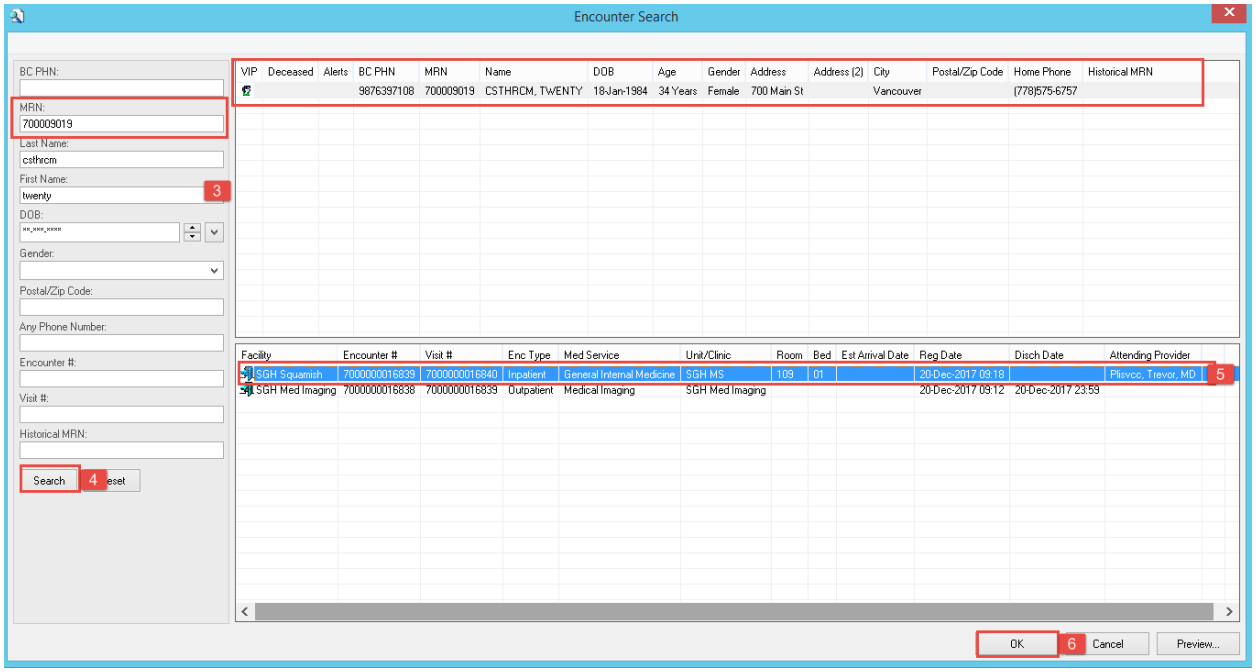
1. Click **Conversation Launcher** 

in the **Toolbar**.
2. Select **Update Patient Information**.



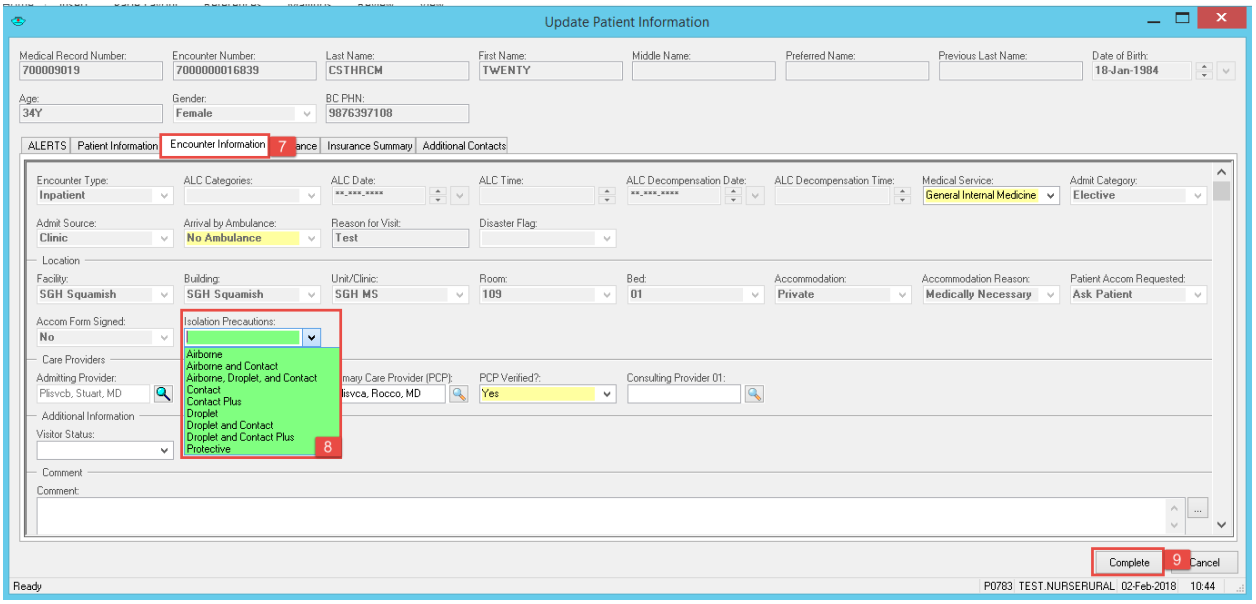
The **Encounter Search** window opens.

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



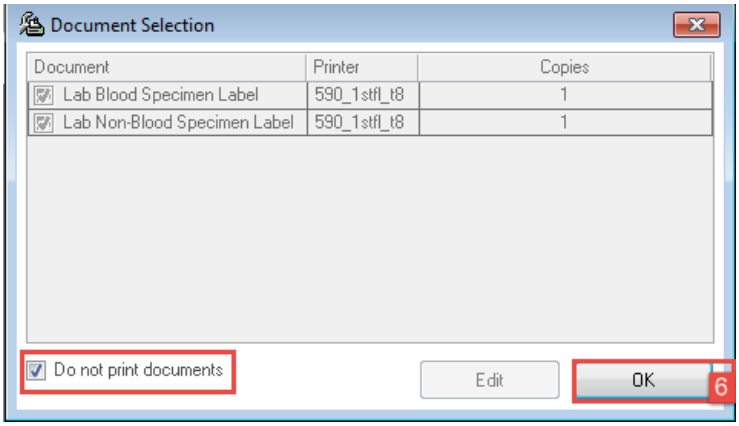
The **Update Patient Information** window opens.

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**.



Document Selection window opens.

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



Isolation information is now updated on the Banner Bar.

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

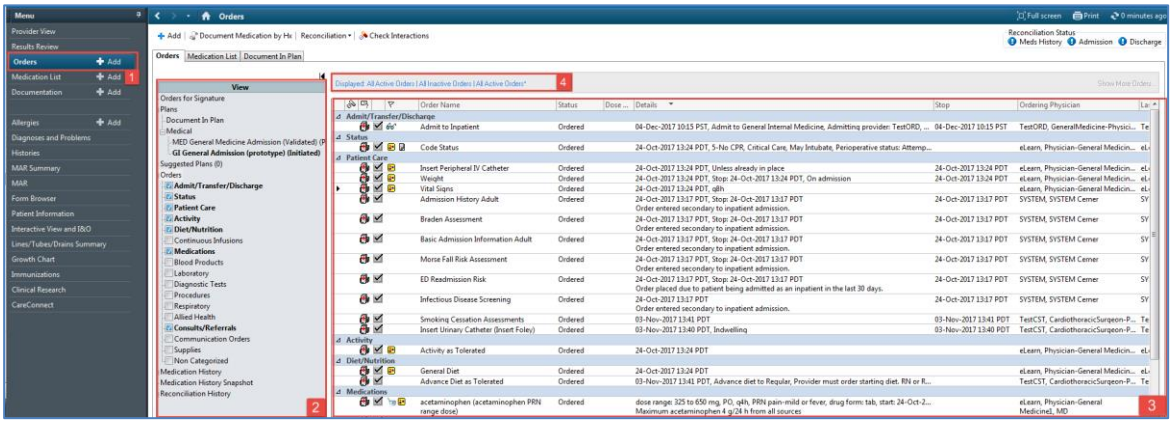
Activity 6.1 – Review Orders Profile

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.



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

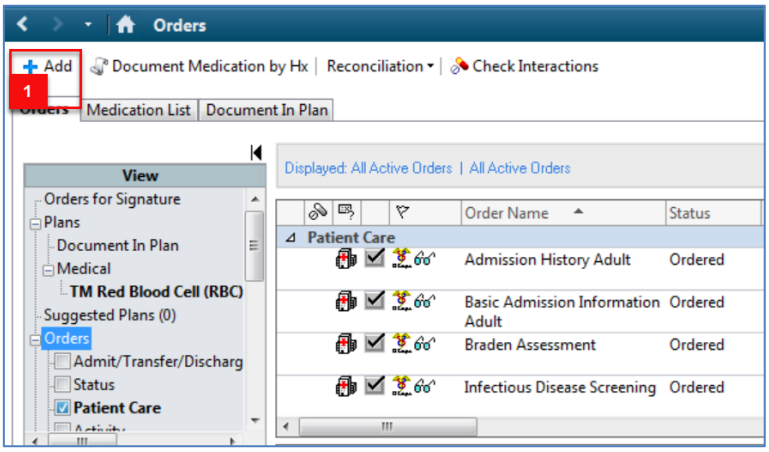
Activity 6.2 – Place an Order

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:

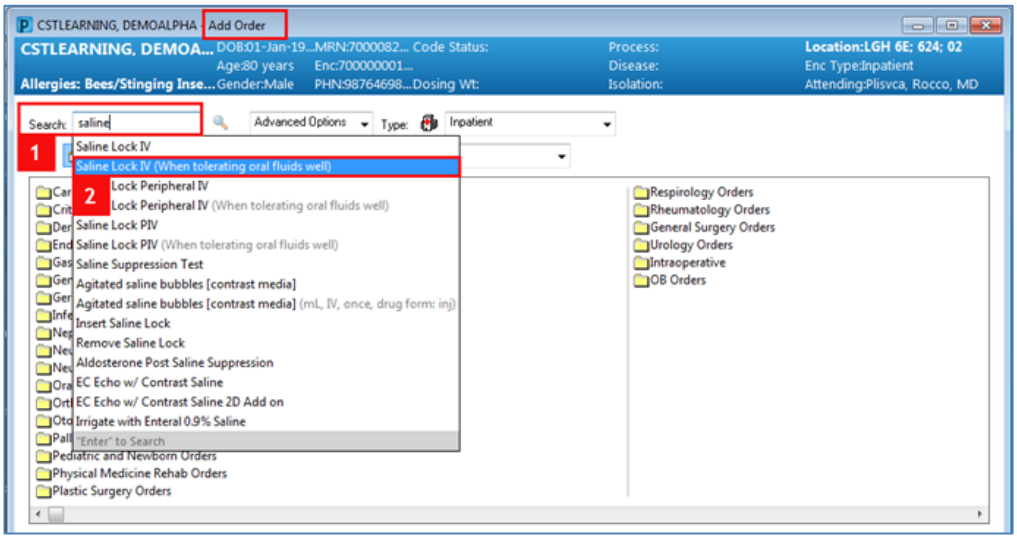
1. Click **Add** within the **Orders** page



The **Add Order** window opens

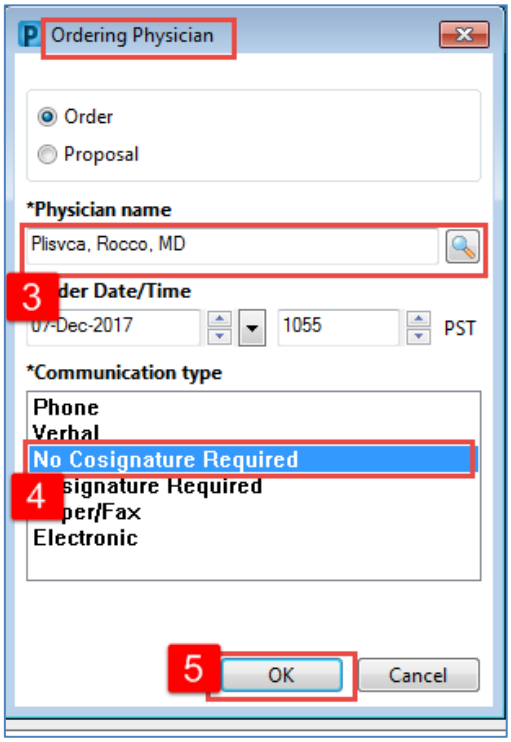
1. Type ***saline lock*** into the search window and a list of choices will display
2. Select **Saline Lock Peripheral IV (when tolerating oral fluids well)**

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.

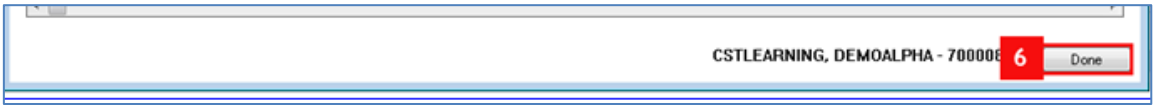


The **Ordering Physician** window opens.

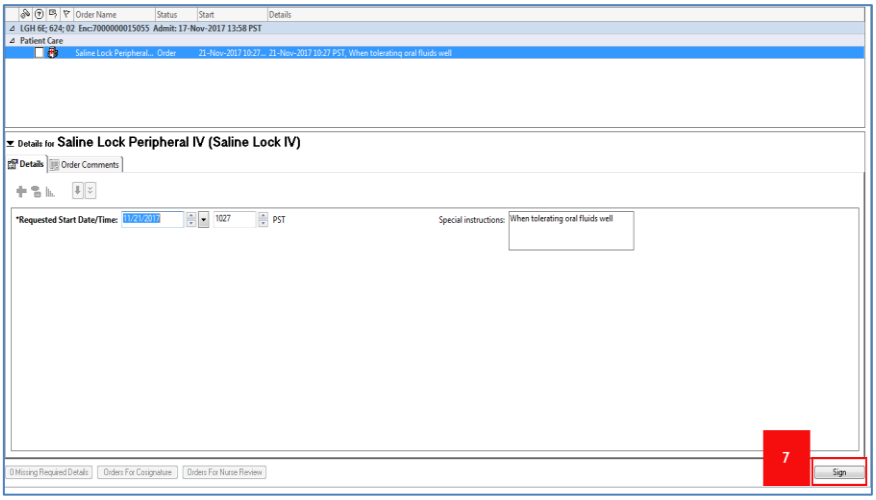
3. Type in the name of the patient's Attending Physician (Last name, First name)
4. Select **No Cosignature Required**
5. Click **OK**



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.**



8. Click **Refresh** 

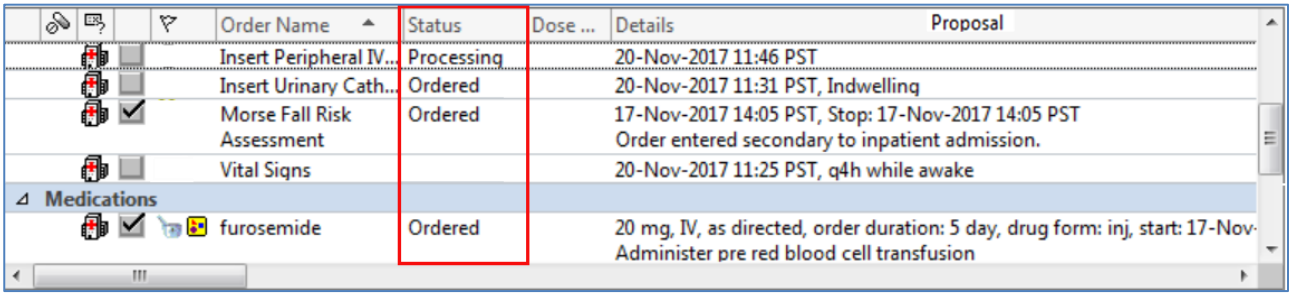
Key Learning Points

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

Activity 6.3 – Review Order Statuses and Details

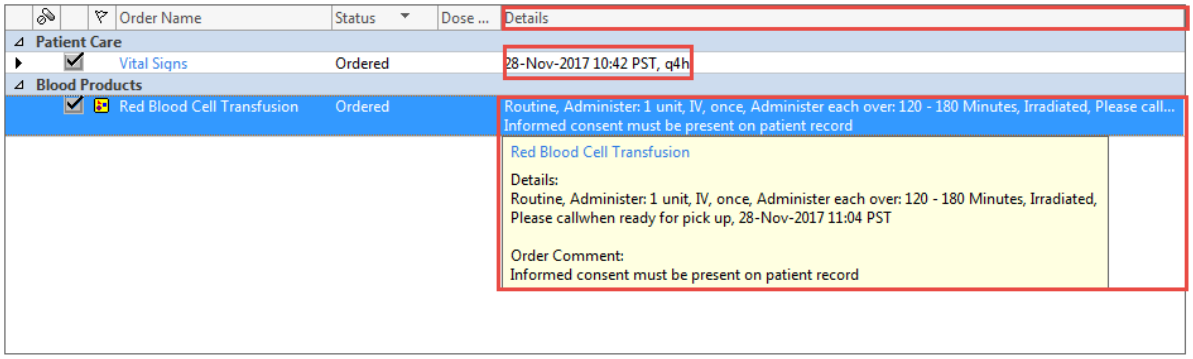
1 To see examples of different order statuses, review the image below:

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



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

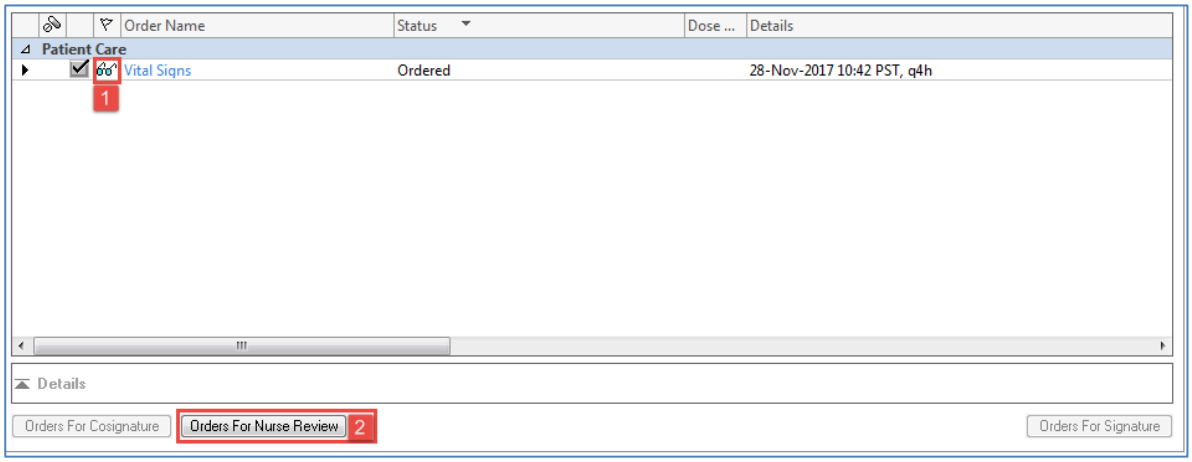
- Focus on the **Details** column of the **Orders Profile**
- Hover your cursor over certain order details to see complete order information
- Note the start date and that orders are organized by clinical category



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.

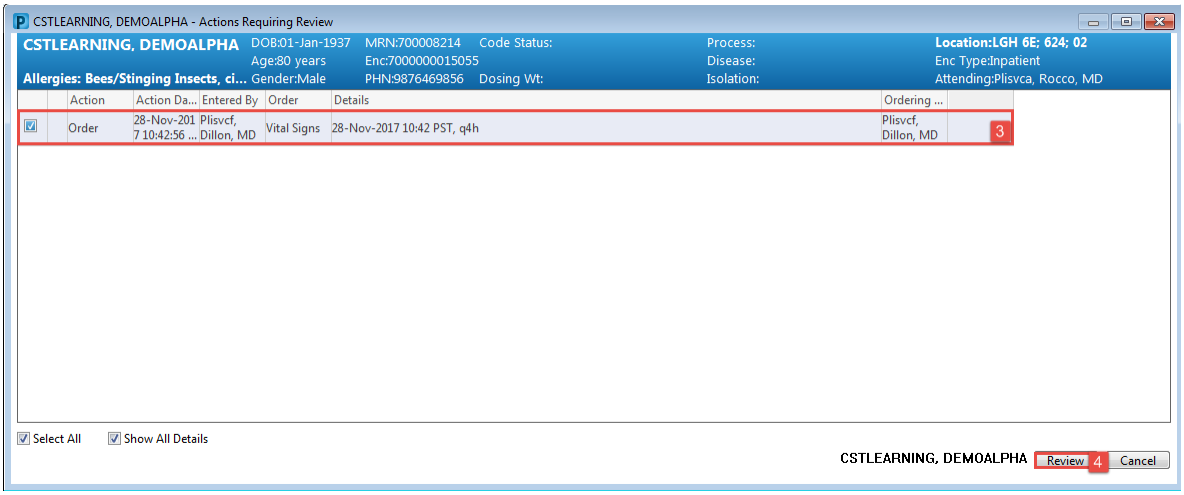
Note: Do not follow these steps in the system, instead refer to the screenshots to understand the process.

1. A **Nurse Review** icon 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.



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



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

Key Learning Points

- Always review and verify the status of orders
- Hover over items in the chart to view additional order information

Activity 6.4 – Place a Verbal Order Using Quick Orders

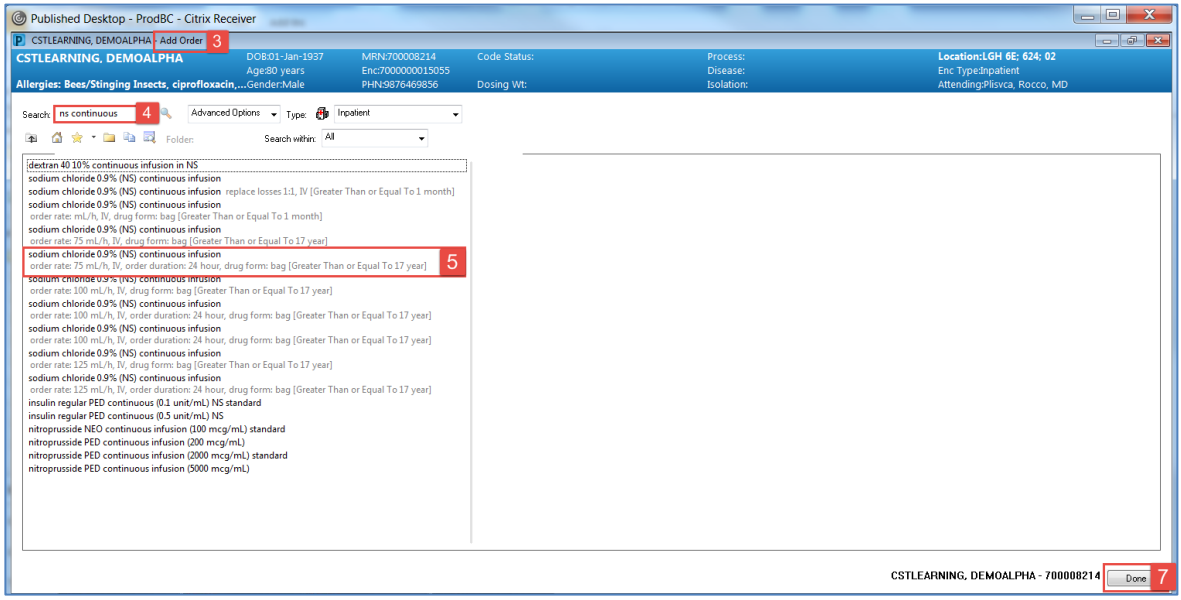
1

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.

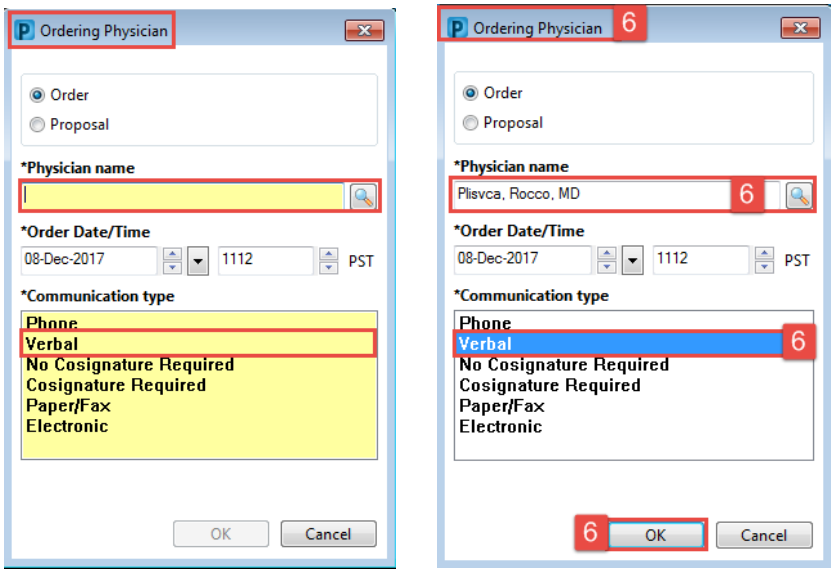
Place a verbal order:

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]**



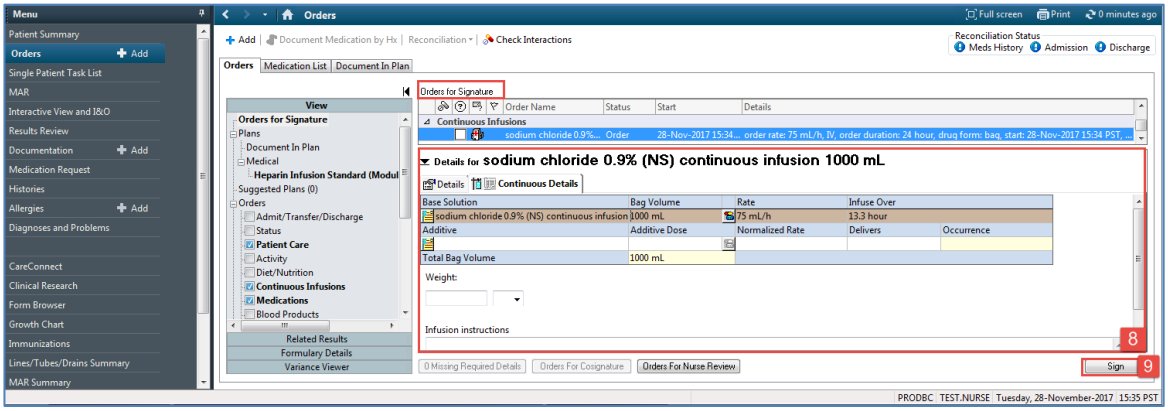
The Ordering Physician window opens.

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*

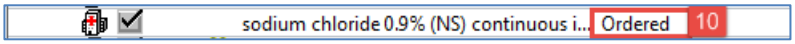


Note: If this were a telephone order, the communication type of Phone would be selected.

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



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



Key Learning Points

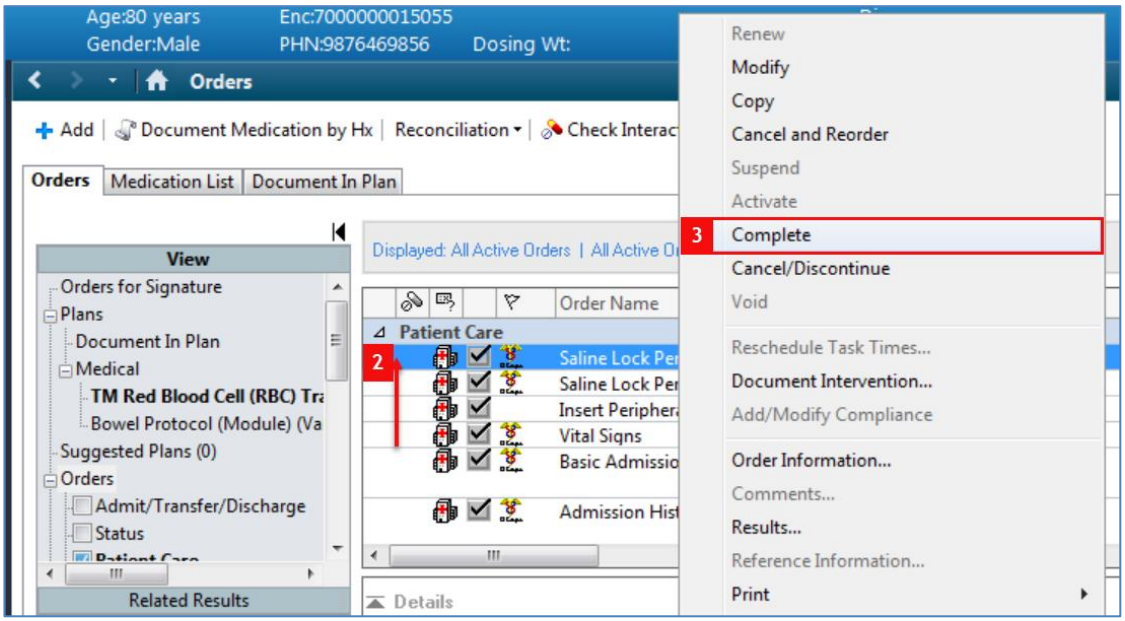
- Verbal orders are only encouraged to be entered when a physician cannot enter the order directly into the CIS themselves, for example in an emergency situation or when the physician is sterile in mid procedure
- Required fields are always highlighted yellow
- Verbal and phone orders that are entered in the CIS automatically get routed to the ordering provider for co-signature

Activity 6.5 – Complete or Cancel/Discontinue an Order

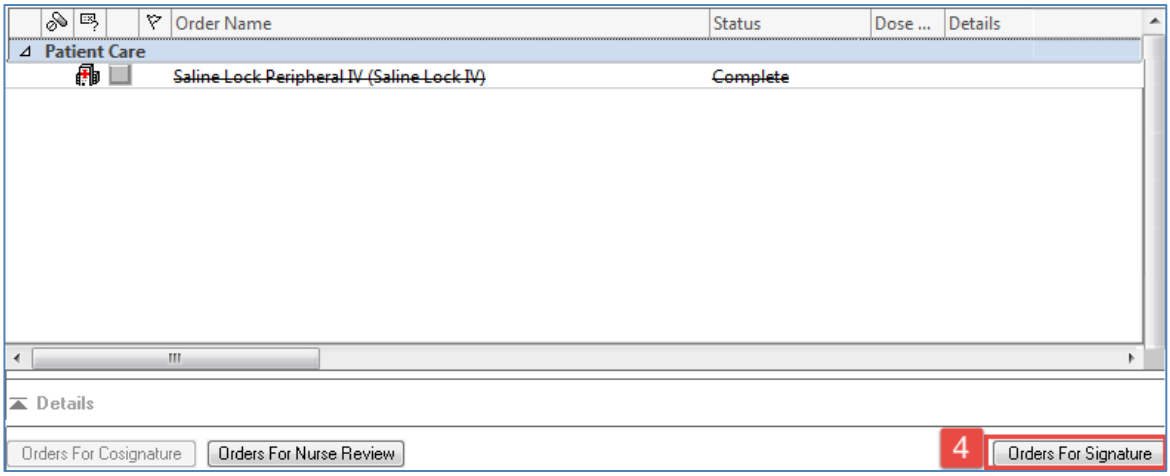
1 When a one-time order has been carried out, the order needs to be removed from the patient's order profile. This is done by completing the order.

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

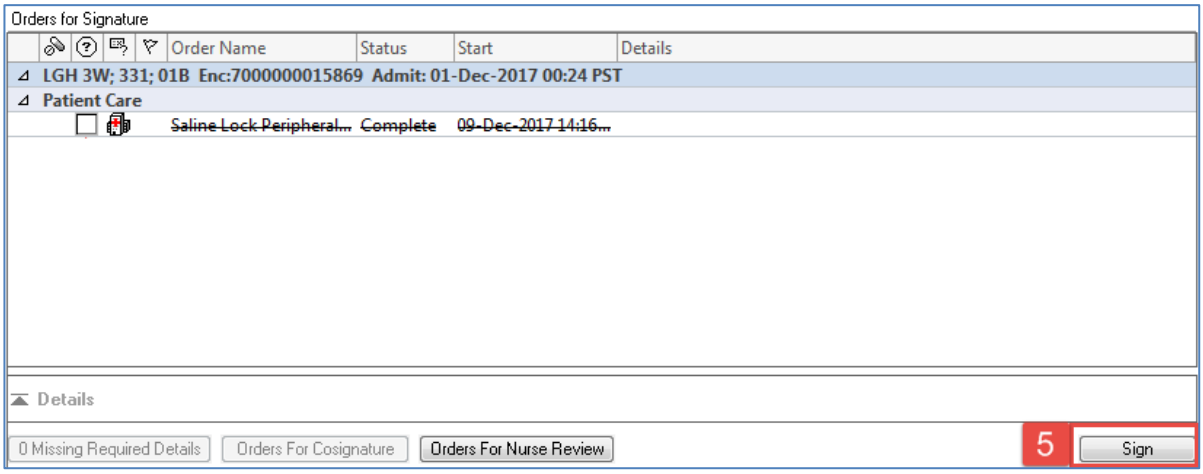
1. Review the **Orders Profile**
2. Right-click the order **Saline Lock Peripheral IV**
3. Select **Complete**



4. Click the **Orders for Signature** button.



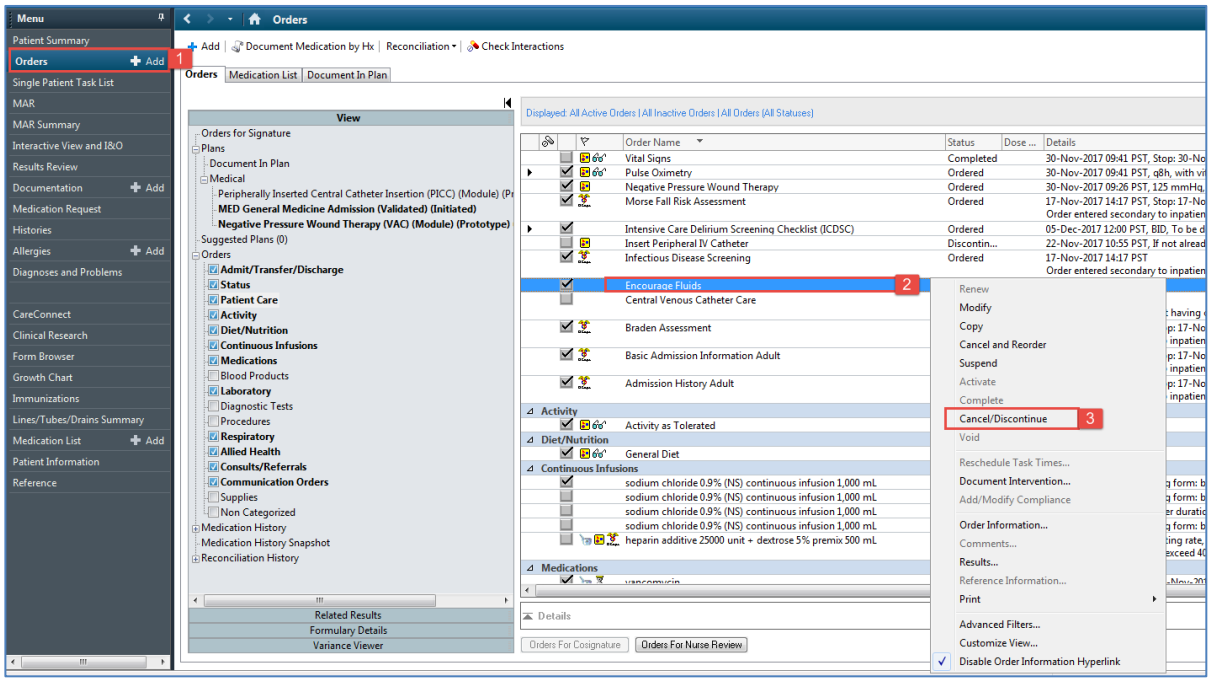
5. Review order for signature and click **Sign**. You will return to the orders profile where the order will show as processing.



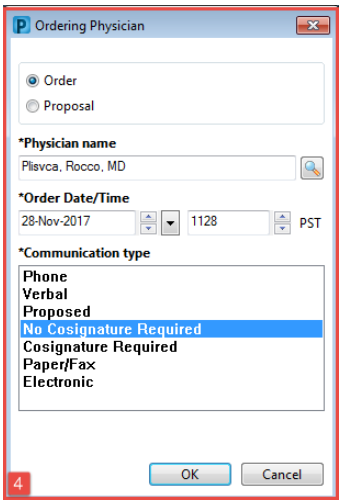
6. **Refresh**  the screen and the order will no longer be visible on the Orders Profile.

2 Now let's **Cancel/Discontinue** an order.

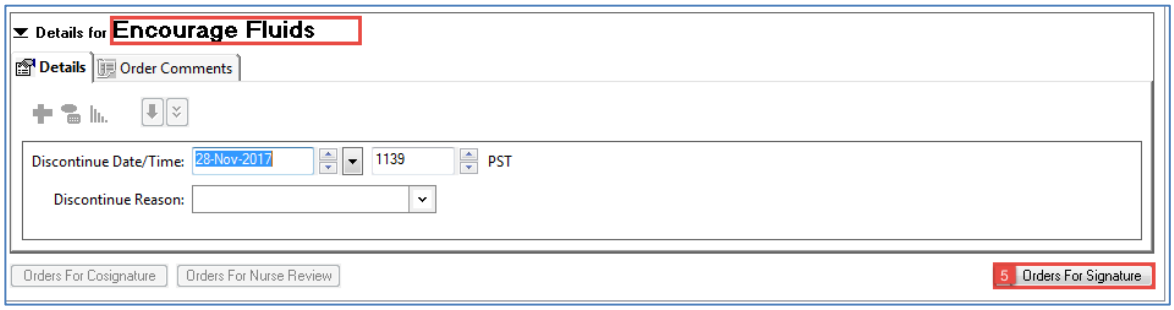
1. Review the **Orders Profile**
2. Right-click order **Encourage Fluids**
3. Select **Cancel/Discontinue**



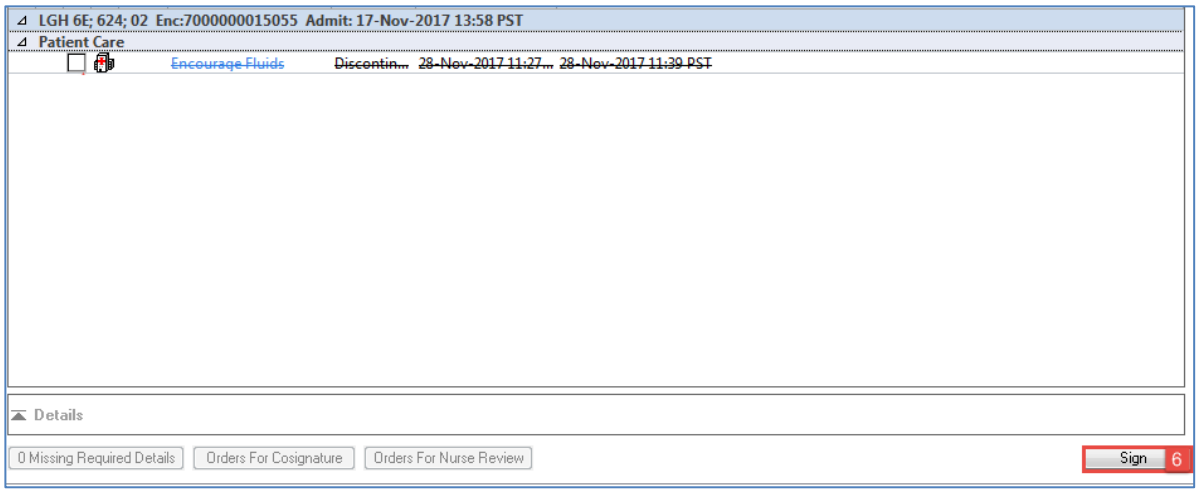
4. **Ordering Physician** window will appear. Fill out required fields highlighted yellow below and then click **OK**
   - **Physician name** = *Type name of Attending Physician (last name, first name)*
   - **Communication type** = *No Cosignature Required*



5. Review order to discontinue and click **Orders For Signature**



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



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

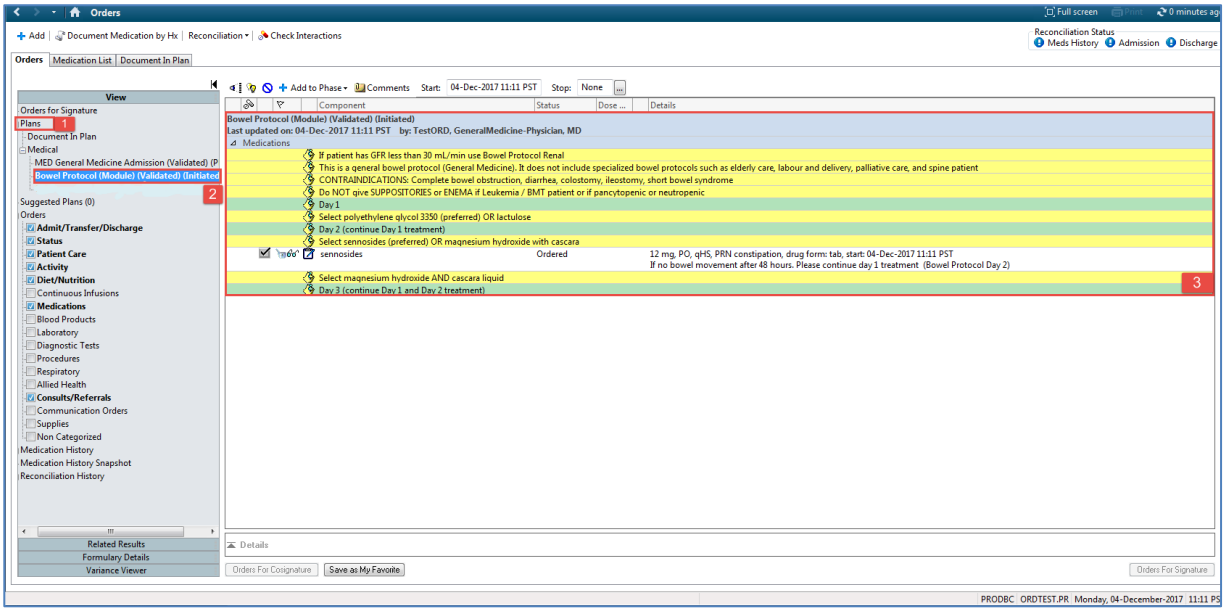
Activity 6.6 – Review Components of a PowerPlan

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

1 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)*



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:

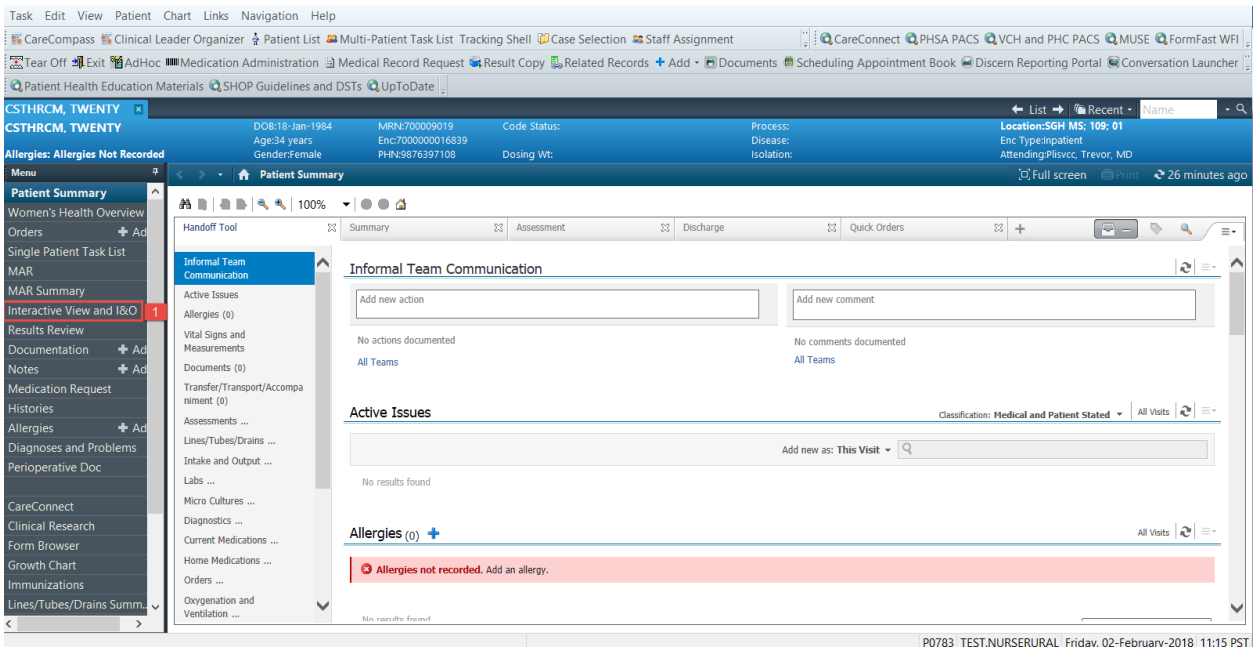
- Navigate to Interactive View and I&O (iView)
- Document in iView
- Change the time of documentation
- Document a dynamic group in iView
- Modify, unchart or add a comment in iView

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.

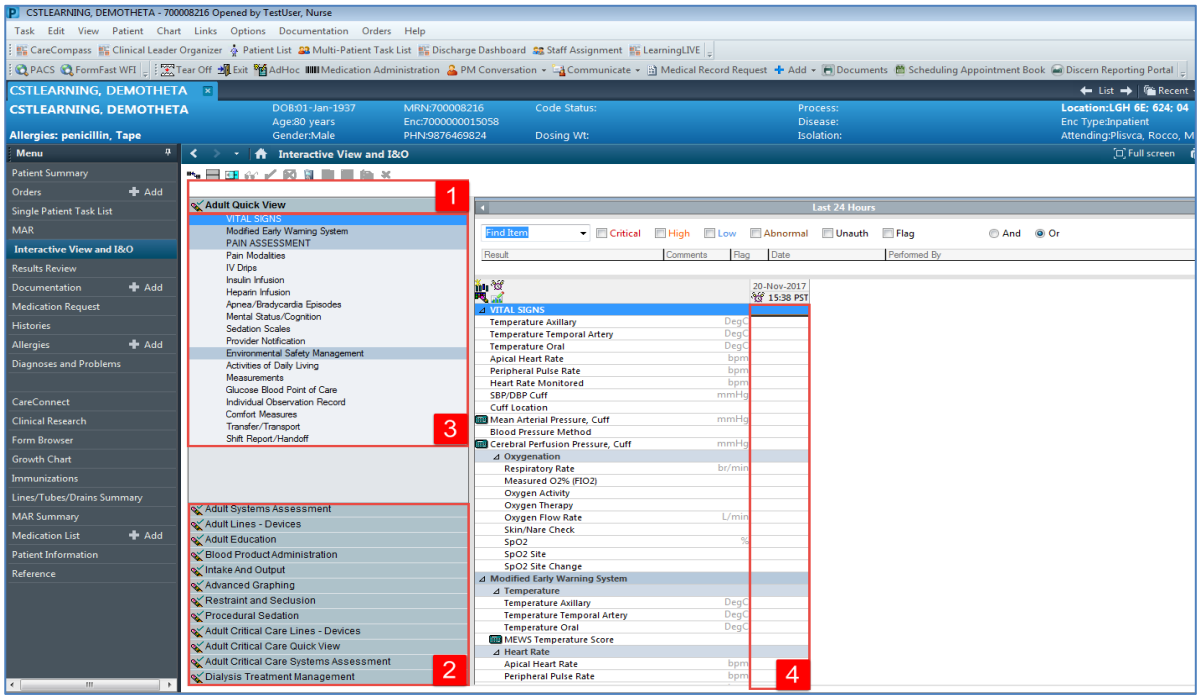
You are currently on the Orders profile page. To navigate to iView:

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



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

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



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

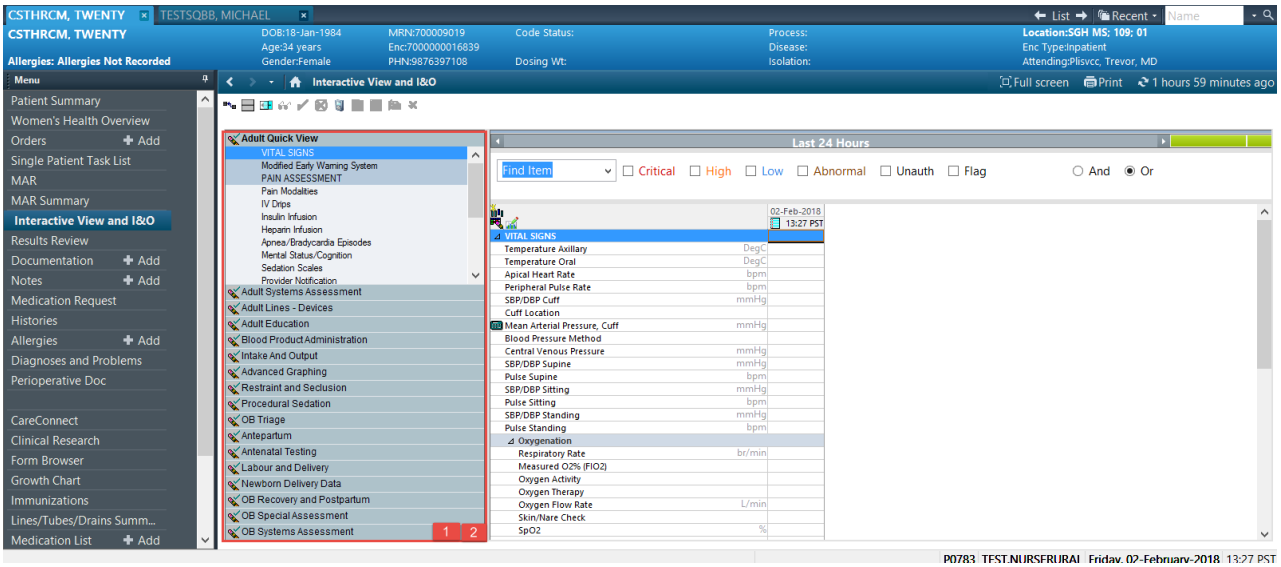
1. Notice the list of **bands** that you see in your iView currently include:

- 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.



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

Key Learning Points

- 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

1 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)*

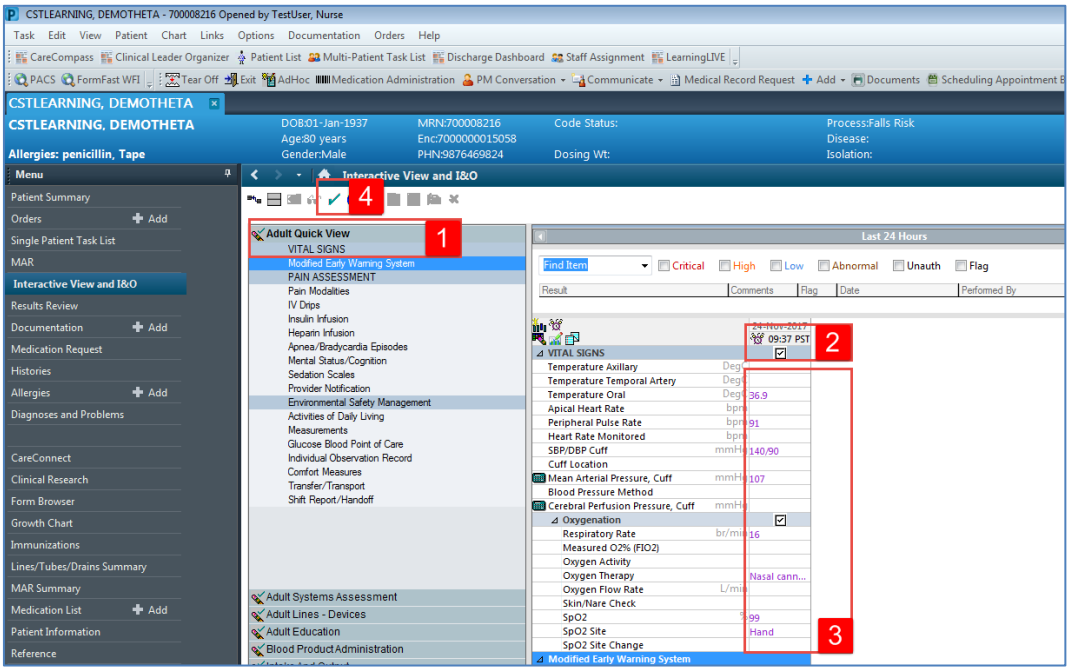
Note: The Calculation icon denotes that the cell will populate a result based on a calculation associated with it. Hover over the calculation icon to view the cells required for the calculation to function. For example, Systolic Blood Pressure (SBP) and Diastolic Blood Pressure (DBP) are required cells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

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

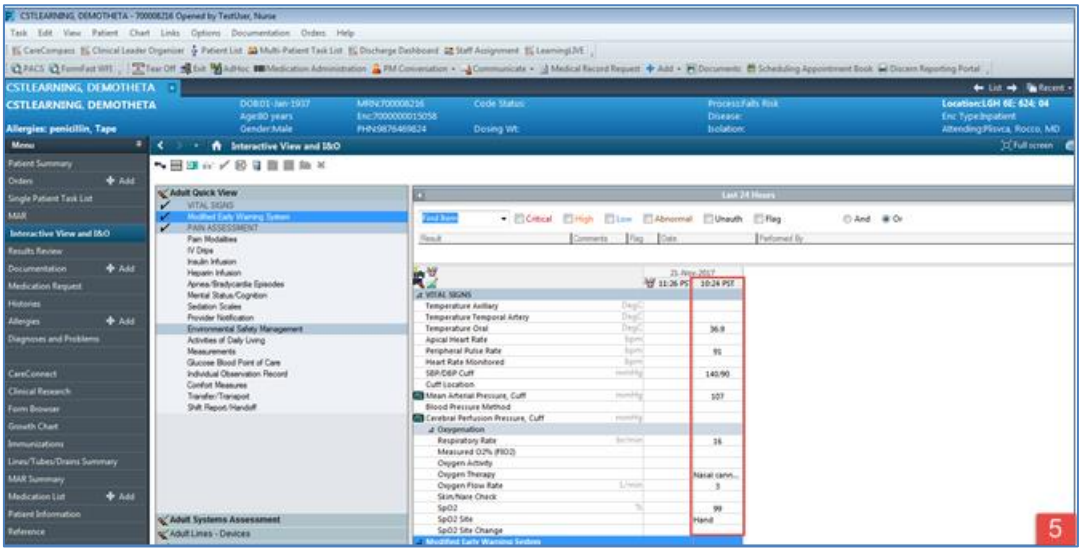
Notice that the text is purple upon entering. This means that the documentation has not been signed and is not part of the chart yet.

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



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.

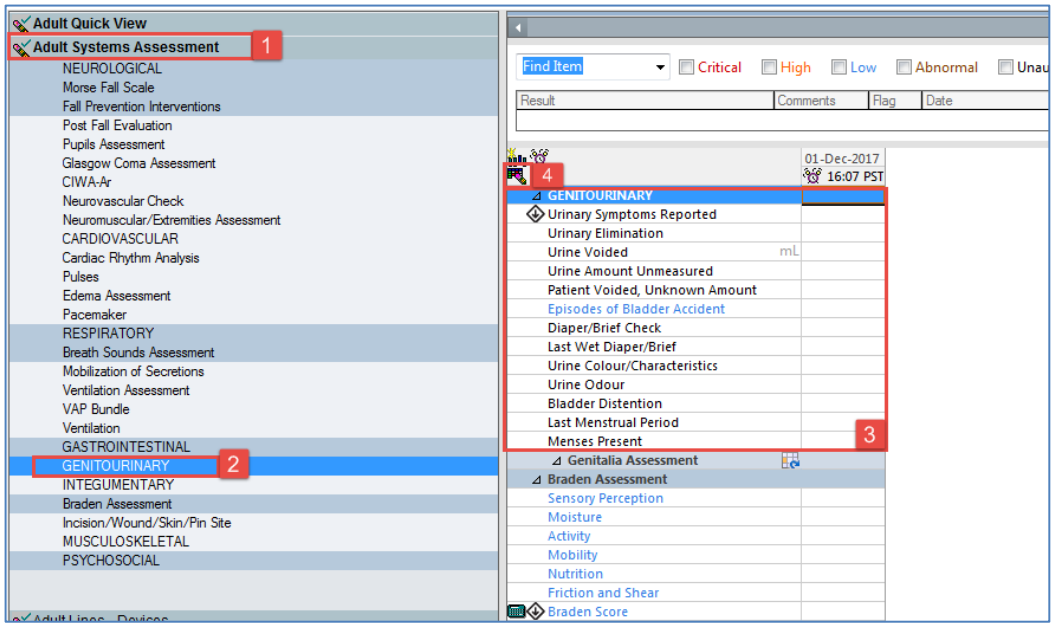


Note: You do not have to document in every cell. Only document to what is appropriate for your assessment and follow appropriate documentation policies and guidelines at your site.

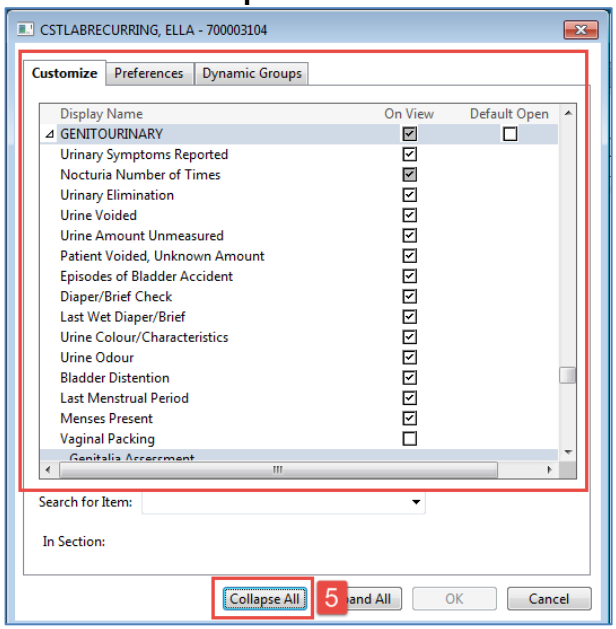
2

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

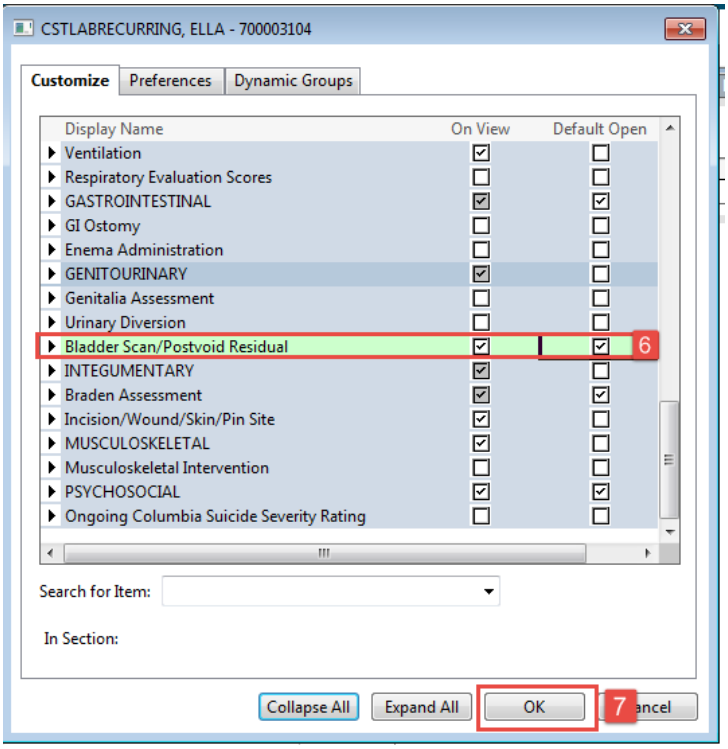
1. Click the **Adult Systems Assessment** Band in **iView**
2. Click the **Genitourinary** section in the **Adult Systems Assessment** band
3. Notice that there is nothing in this section that you can see about bladder scanning
4. Click the **Customize View** icon to search for a section regarding bladder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



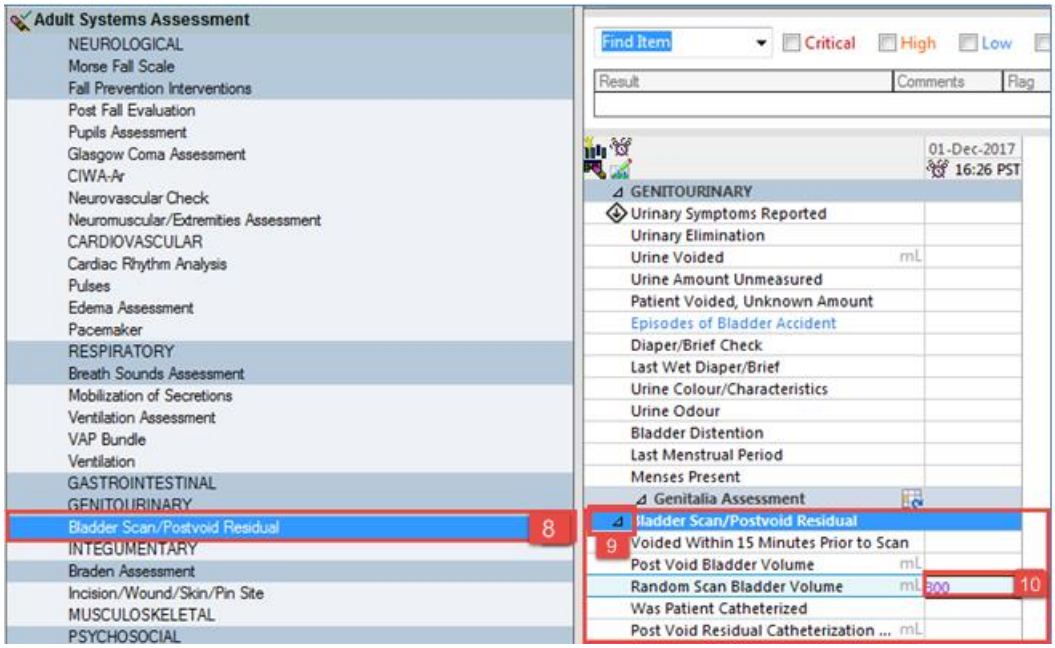
5. A **Customize** window opens displaying all the content within the Genitourinary section. Click the **Collapse All** button to see all of the section names at a glance.



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**



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



Key Learning Points

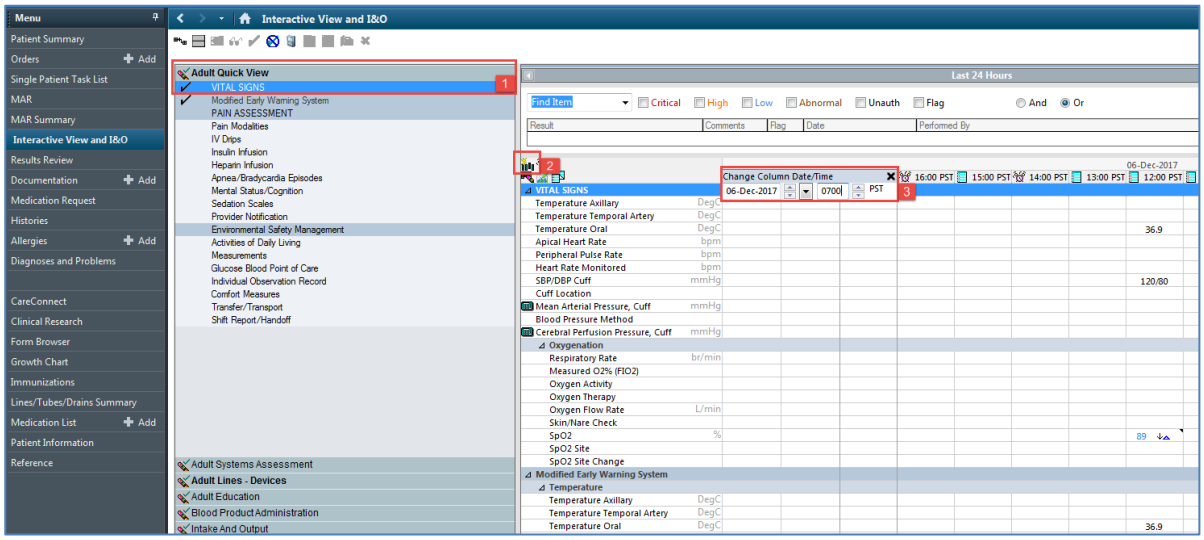
- Documentation will appear in purple until signed. Once signed, the documented text will become black and be recorded to the patient chart
- The latest documentation displays in the left most column
- Double-click the blue box next to the name of the section to document in several cells, the section 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

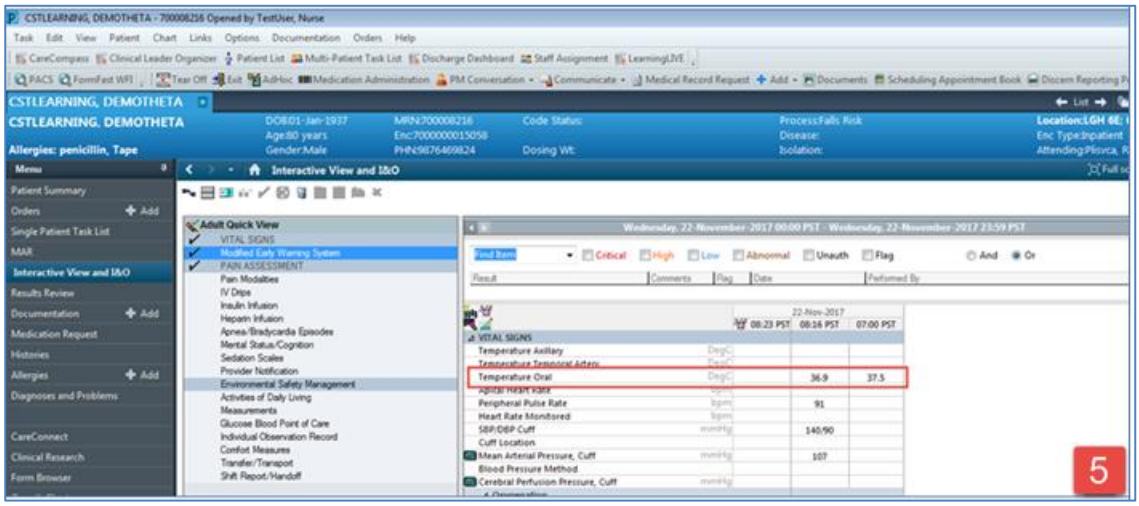
If you have completed Nursing Emergency workbook, you may skip over this activity

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
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



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



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

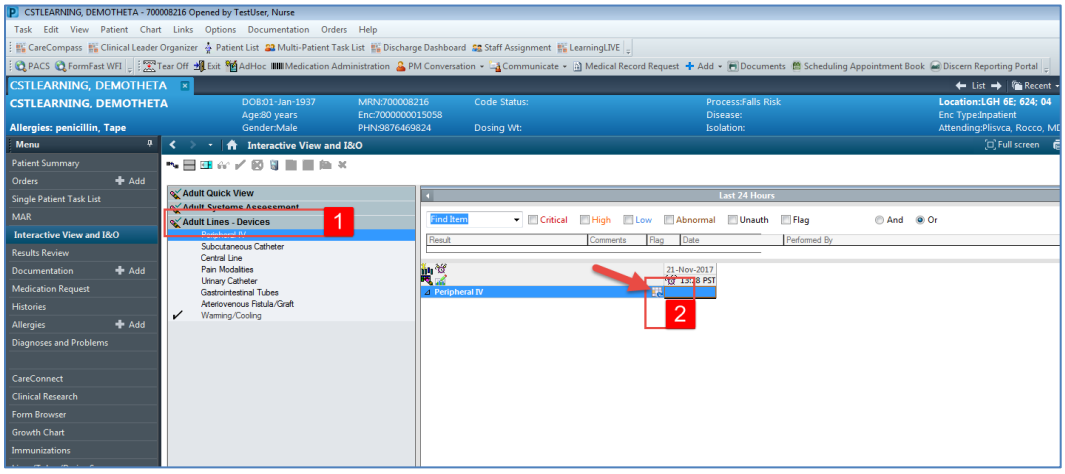
If you have completed Nursing Emergency workbook, you may skip over this activity

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.



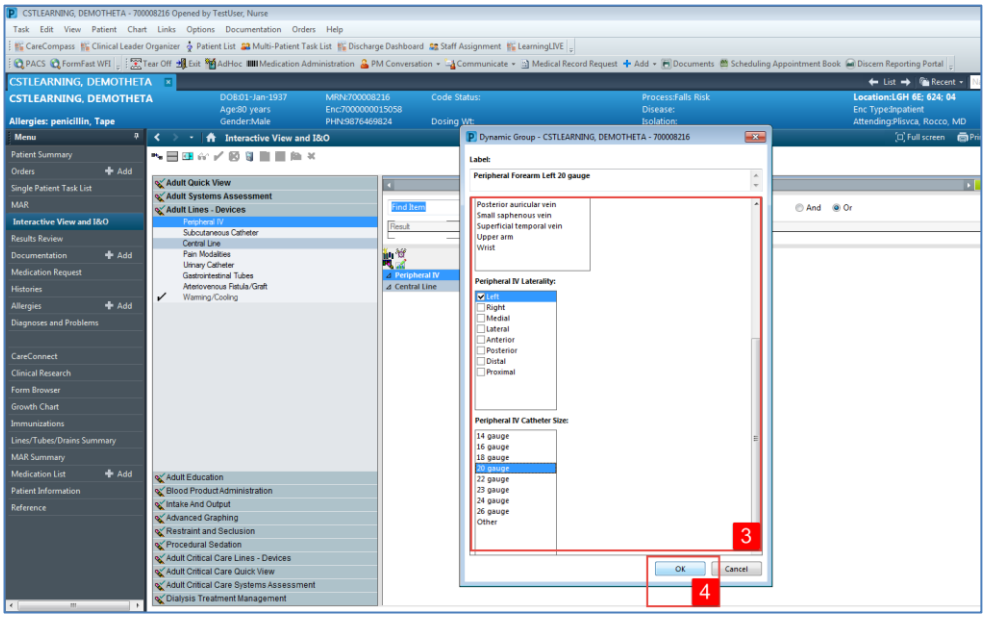
3. The **Dynamic Group** window appears. A dynamic group allows you to label a line, wound, or drain with unique identifying details.

   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**



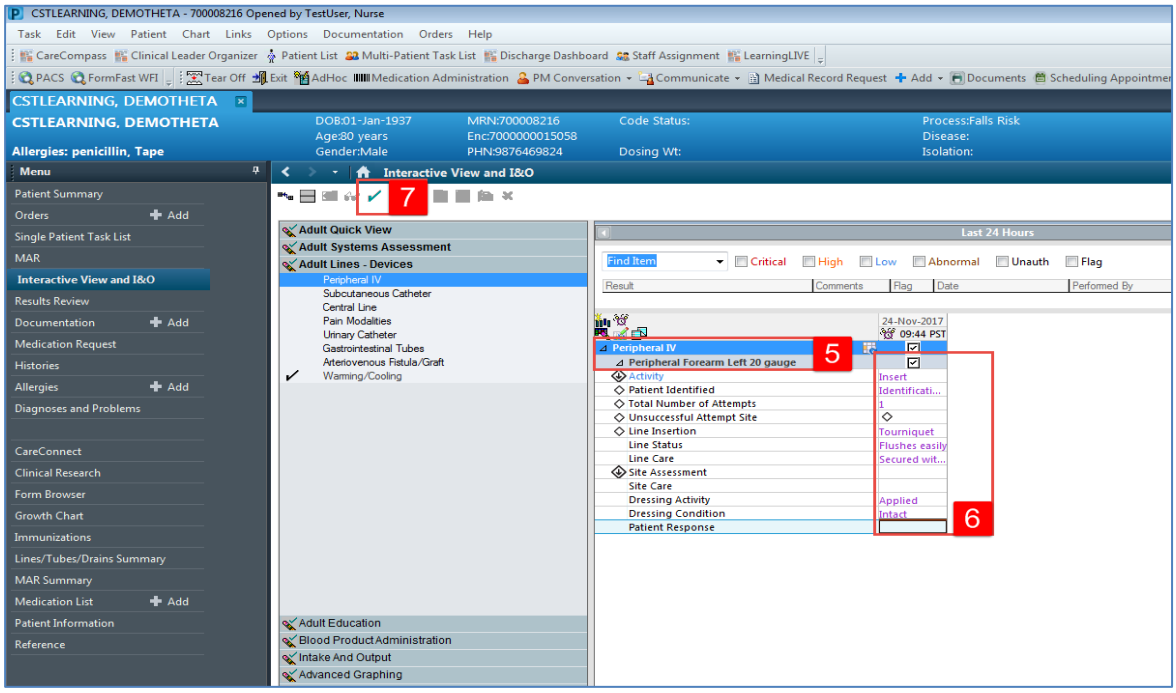
5. The label created ⊿ <Peripheral Forearm Left 20 gauge> will display at the top, under the Peripheral IV section heading. Now other users will know which dynamic group represents this particular IV.

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*

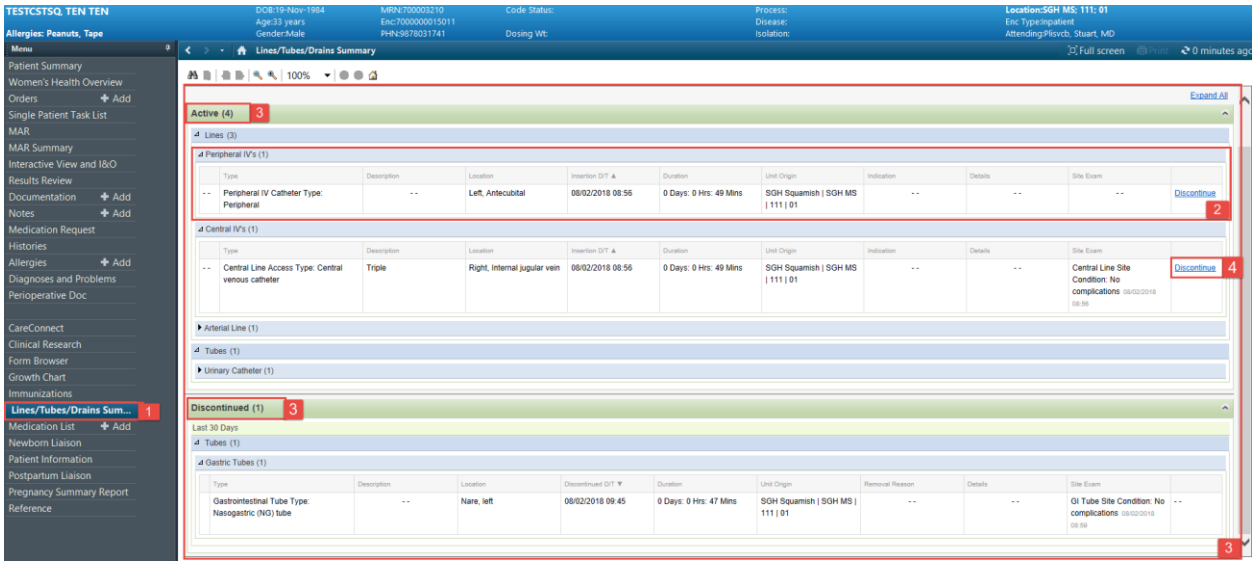
7. Click **green checkmark** icon ✓ to sign your documentation. Once signed the label will be accessible for other clinicians to complete further documentation within the same dynamic group.



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

2 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**.



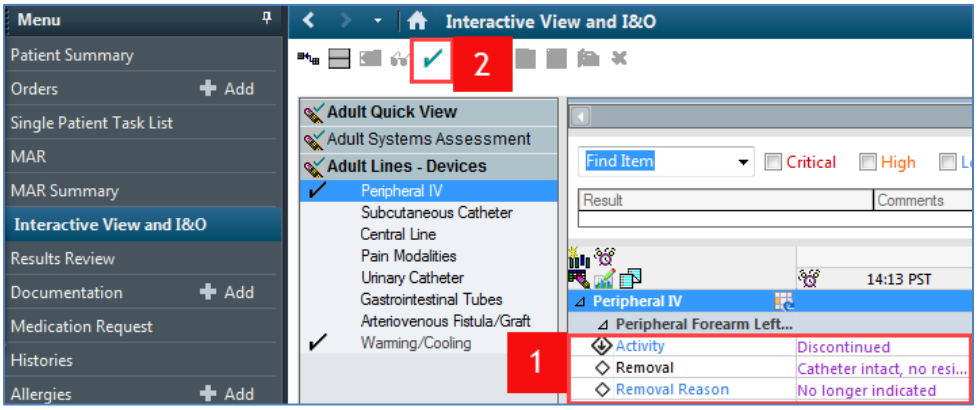
4. Click on Discontinue and the system will take you back to the iView section for further documention.

3

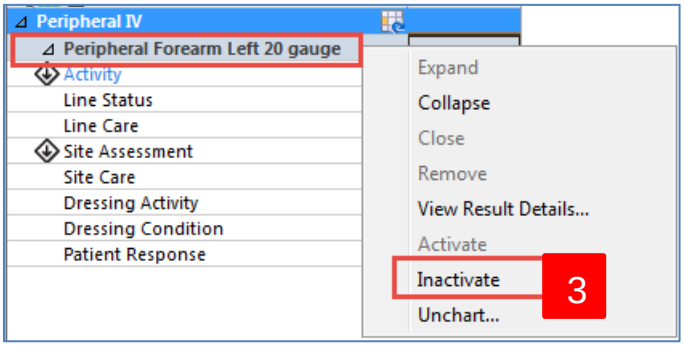
You can **inactivate** a dynamic group when it is no longer in use, such as when a drain or tube is removed.

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

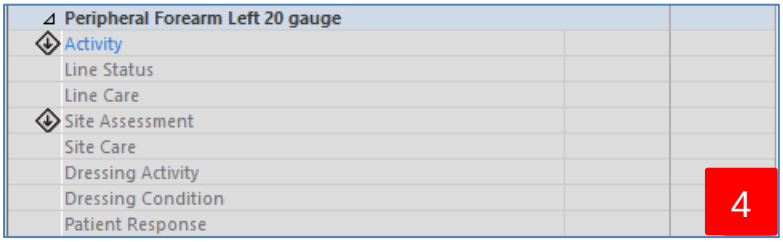
1. Document that the line was discontinued using the following date:
   - **Acivity** = *Discontinued*
   - **Removal** = *Catheter intact, no resistance*
   - **Removal Reason** = *No longer indicated*
2. Click **green checkmark** icon ✓ to sign your documentation



3. Right-click the **dynamic group label** <Peripheral Forearm Left 20 gauge> and select **Inactivate**.



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

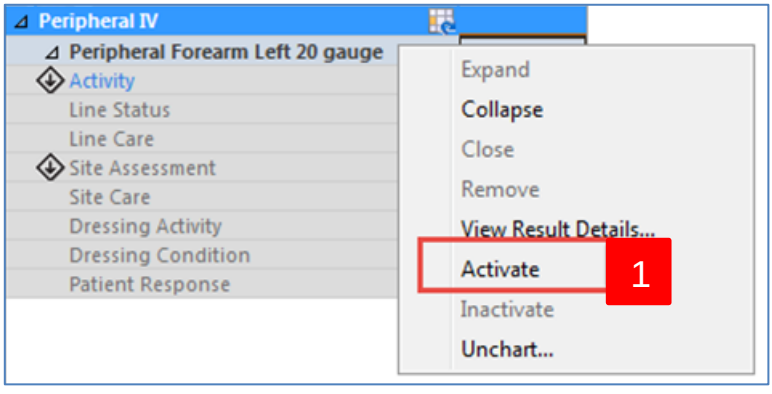


Note: The inactivated dynamic group remains in the view, but is unavailable, meaning clinicians cannot document on it. If there are no results for the time frame displayed, the inactive dynamic group is automatically removed from the display.

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.

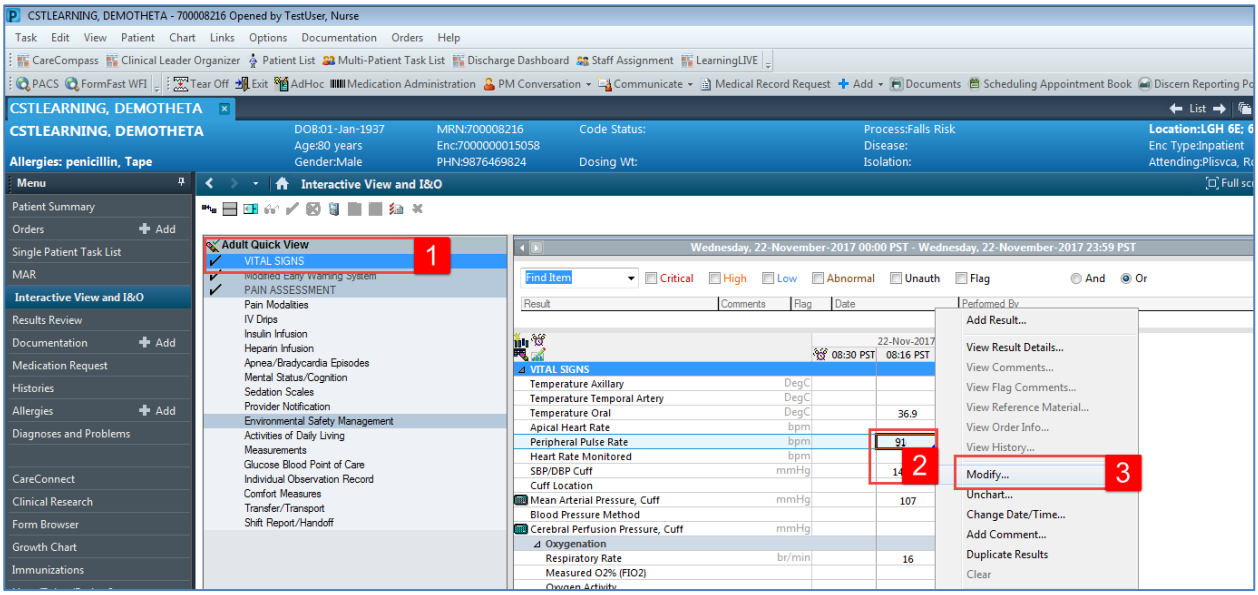
Key Learning Points

- 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.

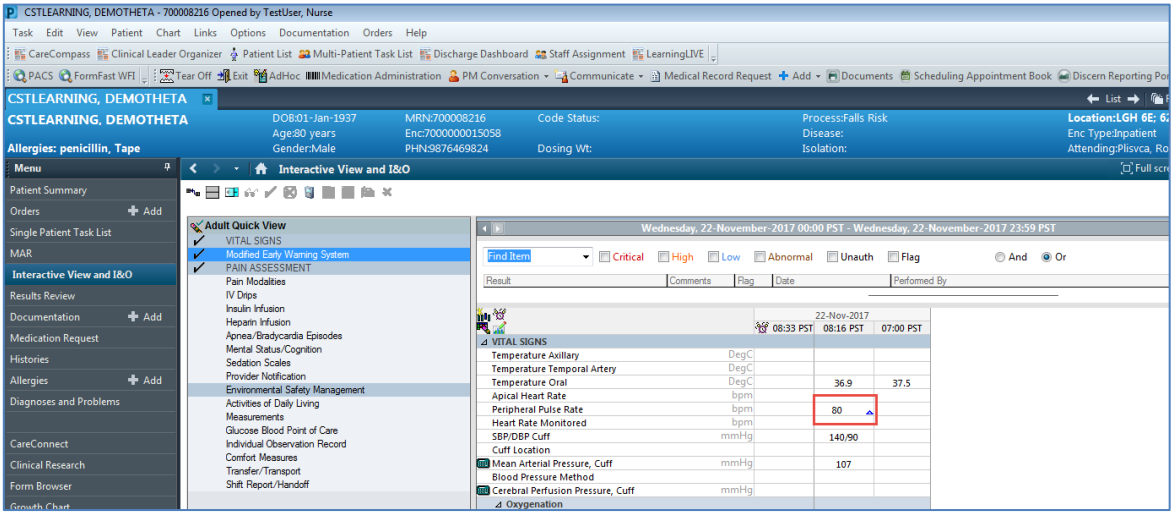
Activity 7.5 – Modify, Unchart or Add a Comment in Interactive View

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…**



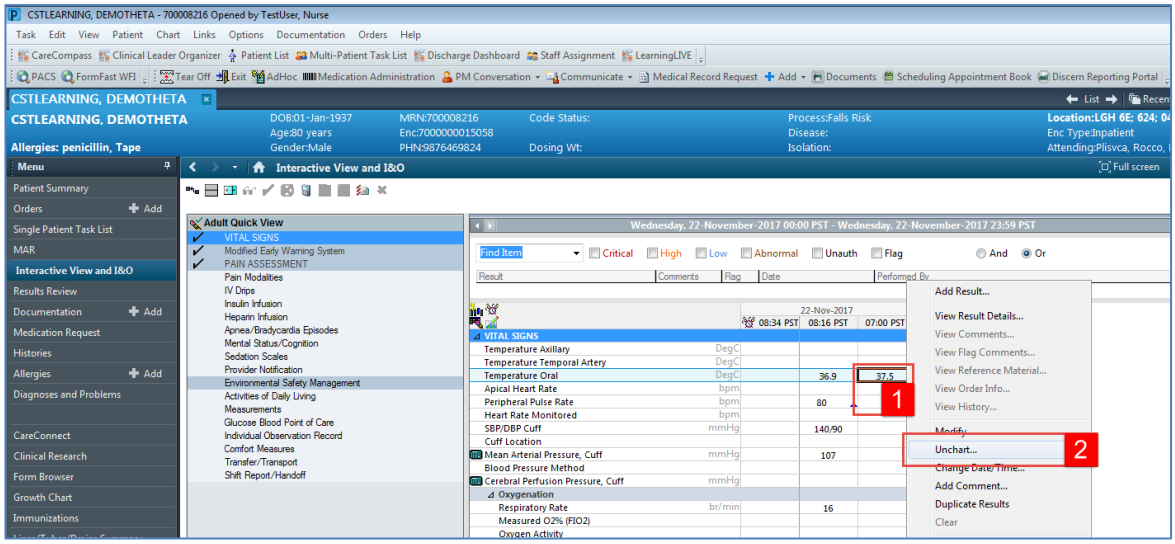
4. Enter in new **Peripheral Pulse Rate** = *80* and then click **green checkmark** icon ✓ to sign your documentation.
5. **80** now appears in the cell and an icon will automatically appear on bottom right corner to denote a modification has been made.



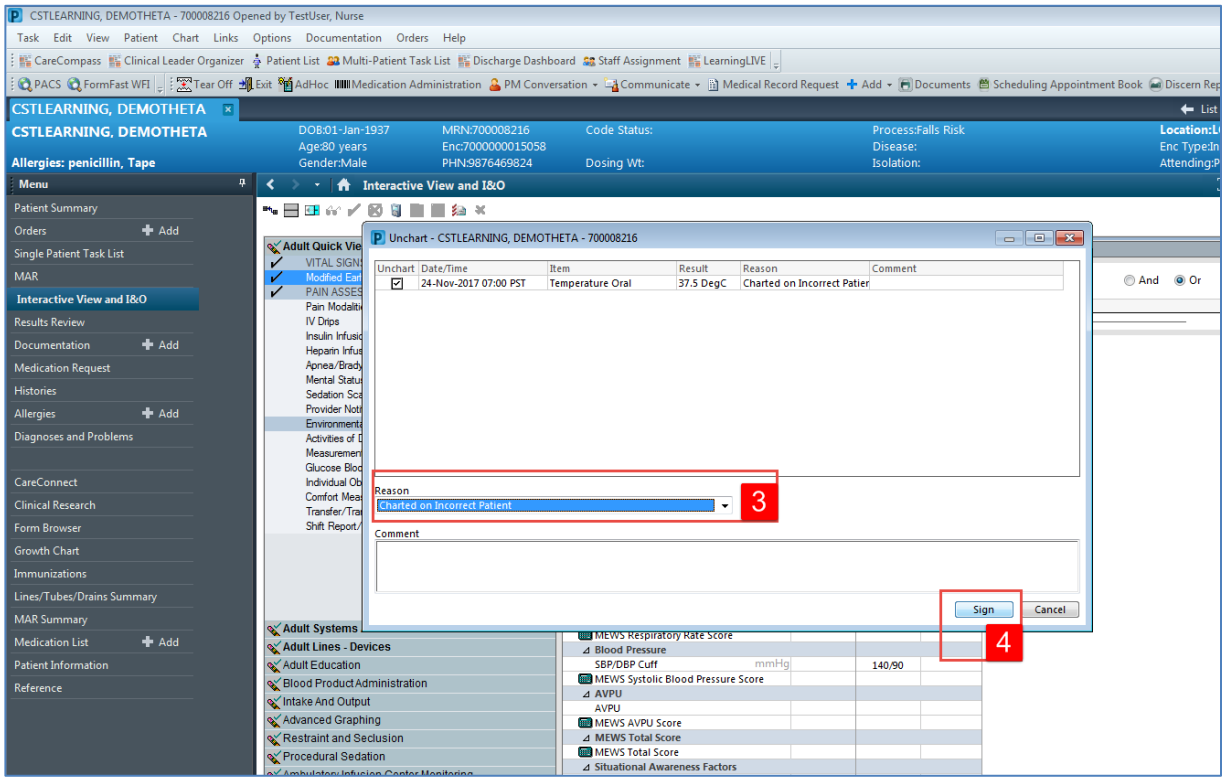
2 The unchart function will be used when information has been charted in error and needs to be removed. For example, a set of vital signs is charted in the wrong patient's chart.

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.

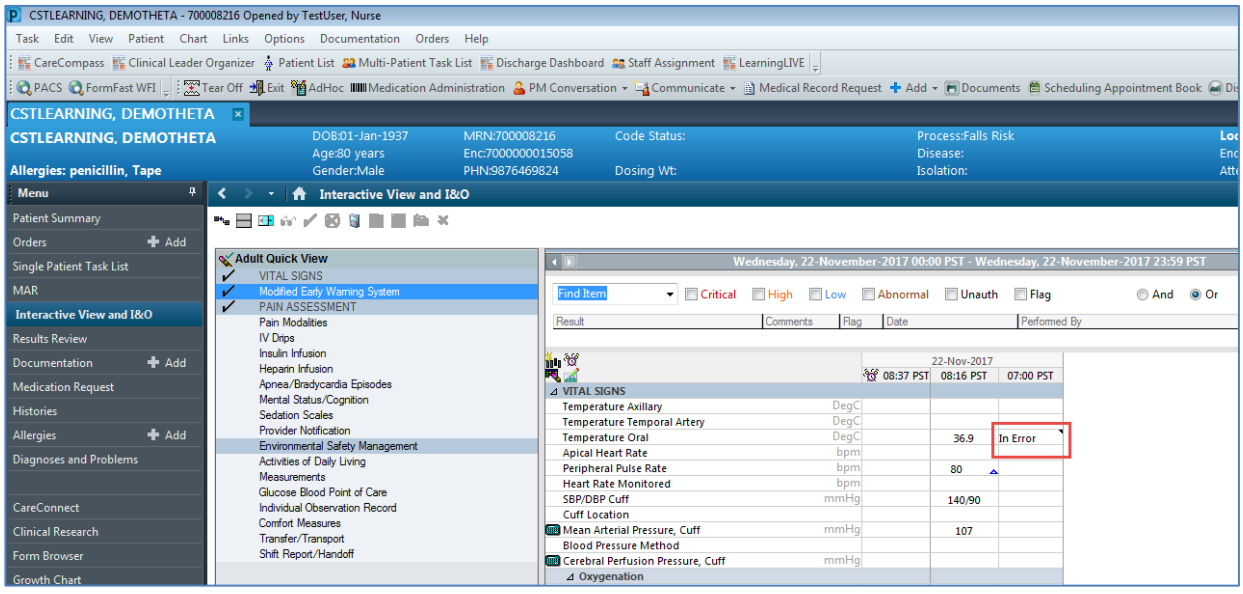
1. Right-click on the documented value of **37.5** for Temperature Oral
2. Select **Unchart**



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



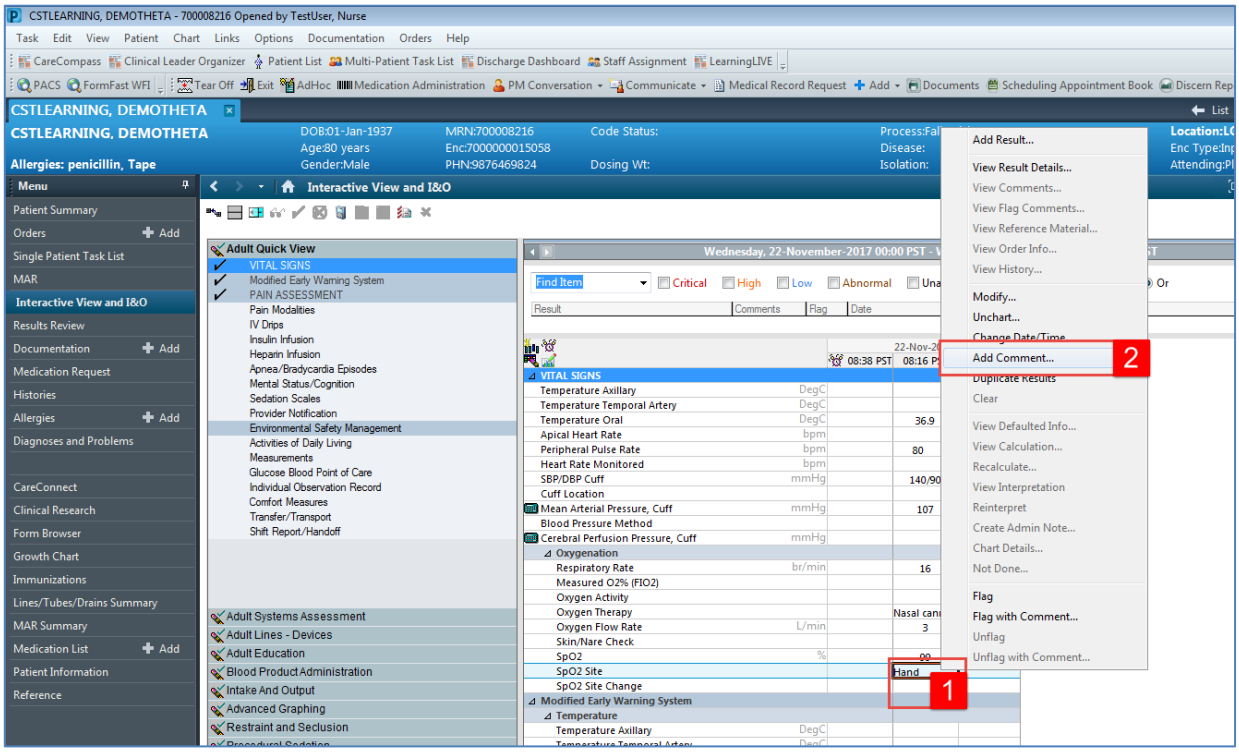
5. You will see **In Error** displayed in the uncharted cell. The result comment or annotation icon will also appear in the cell.



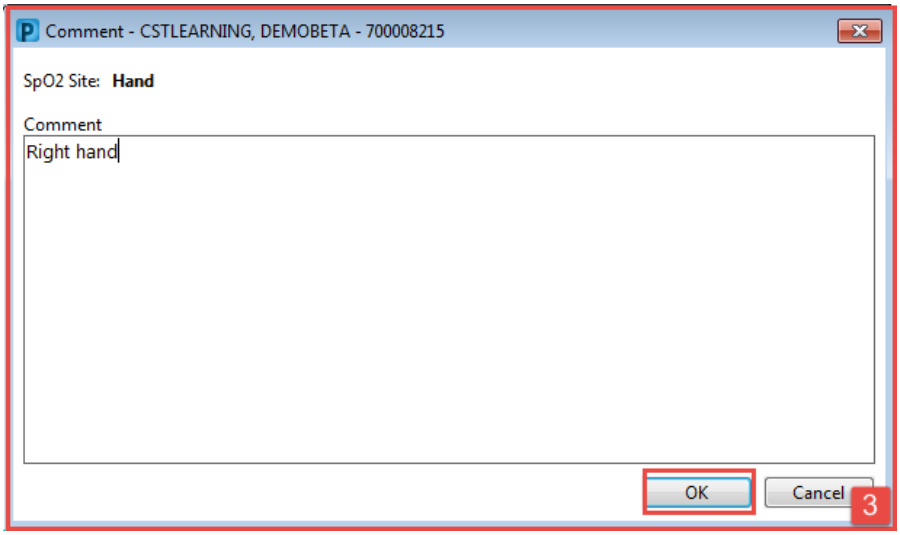
3 A comment can be added to any cell to provide additional information. For example, you want to clarify that the SpO2 site that you documented was on the patient's right hand.

Let's add this comment.

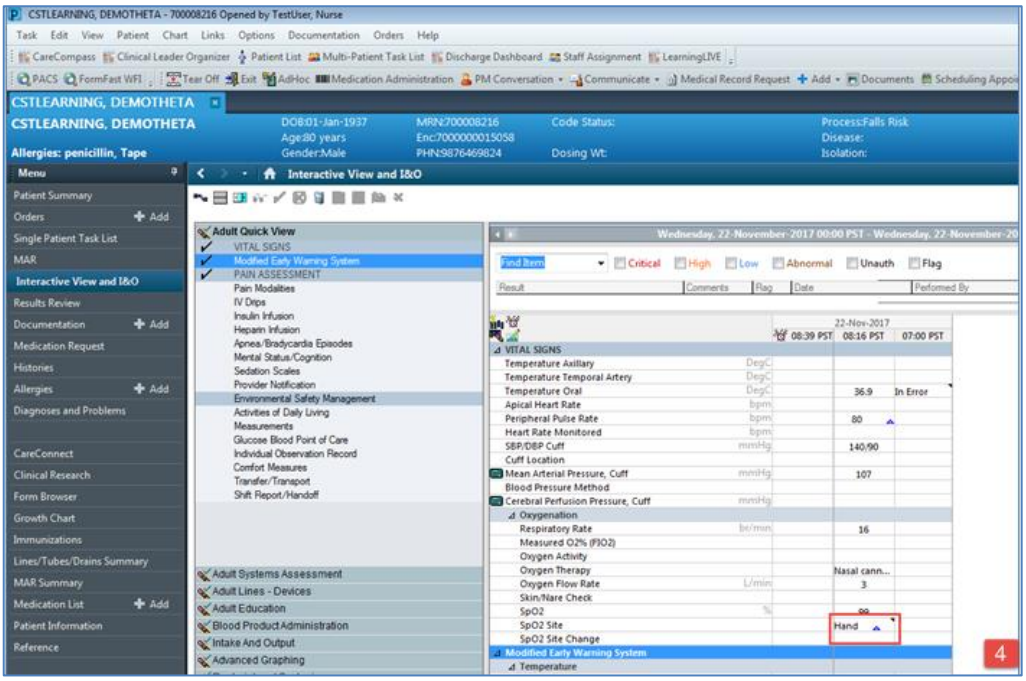
1. Right click on the documented value for SPO2 site, **hand**
2. Select **Add Comment**



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



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.



Key Learning Points

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

Activity 8.1 – Opening and Documenting on PowerForms

1

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

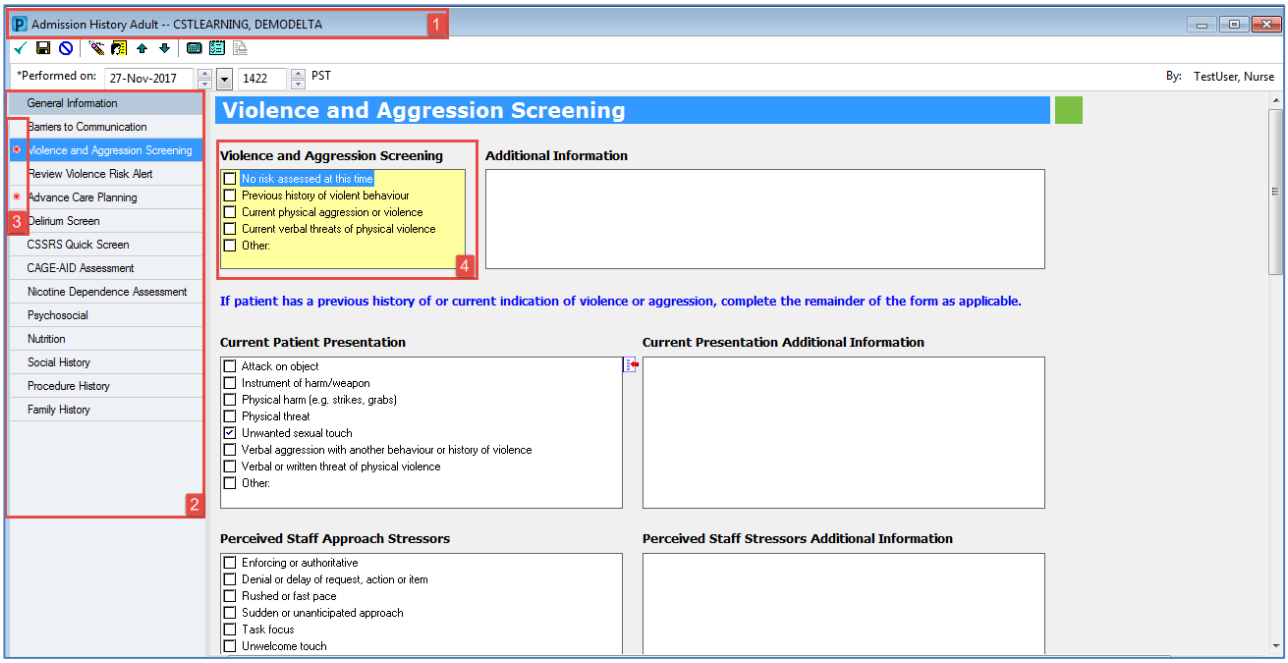
PowerForms are the electronic equivalent of paper forms currently used to document patient information. Data entered in **PowerForms** can flow between other parts of the chart including iView flowsheets, Clinical Notes, Allergy Profile, and Medication Profile.

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.

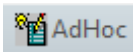
Review the screenshot below for a general overview of PowerForm features:

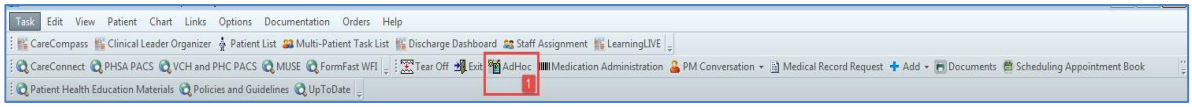
1. Title of the current PowerForm you are documenting on
2. List of sections within the PowerForm for documentation
3. A red asterix denotes sections that have required field(s)
4. Required field(s) within the PowerForm will be highlighted in yellow. You will be unable to sign a PowerForm unless all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



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

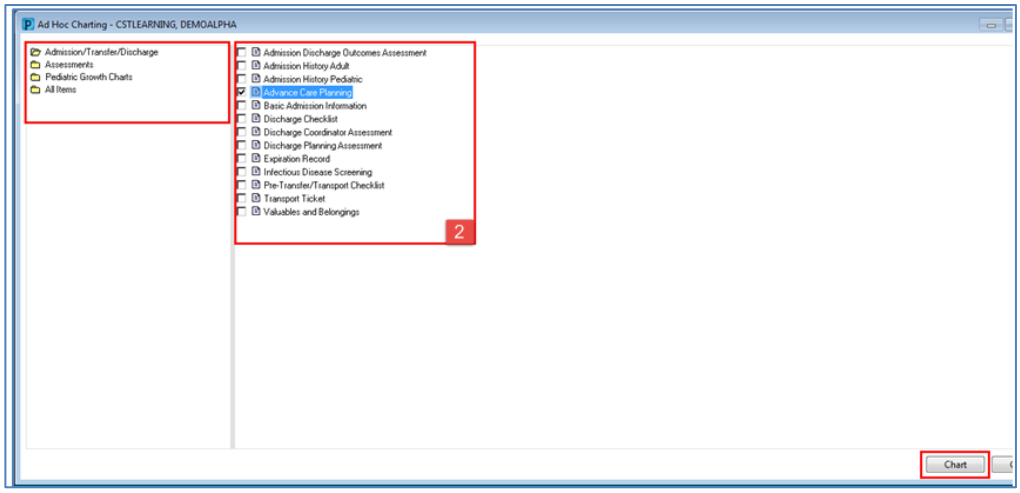
To open and document on a new PowerForm:

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



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.

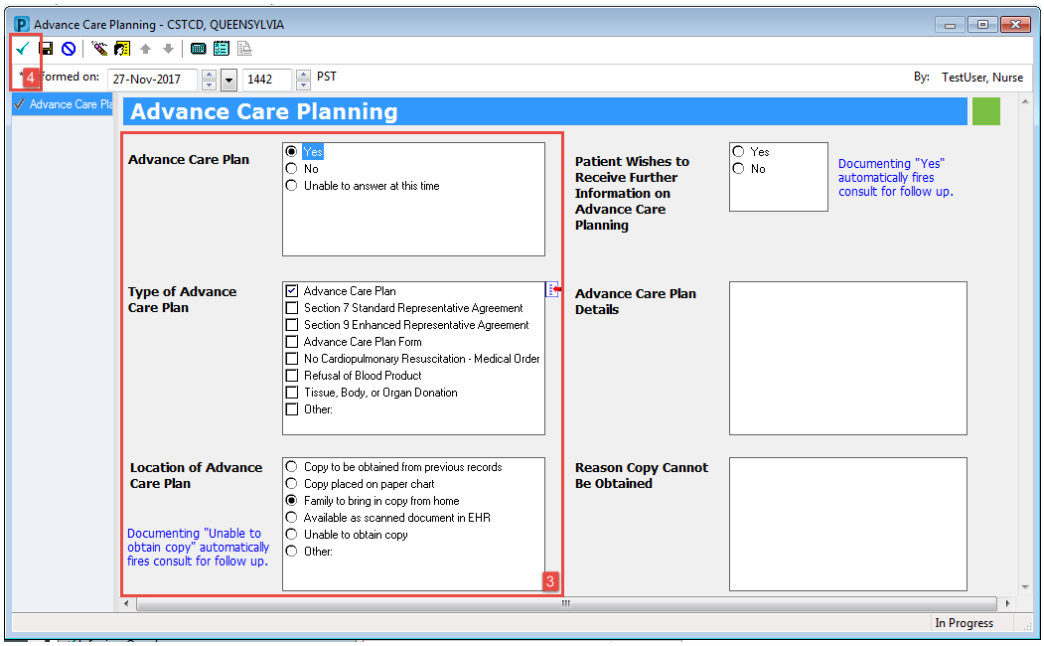
2. Select the **Advance Care Planning** PowerForm by selecting the title and clicking Chart



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*

4. To complete PowerForm, click **green checkmark** icon ✓ to sign and then click the **Refresh** icon .



Note: using the Save Form 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 ✓.

Key Learning Points

- PowerForms are electronic forms used to chart patient information
- The AdHoc button AdHoc 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

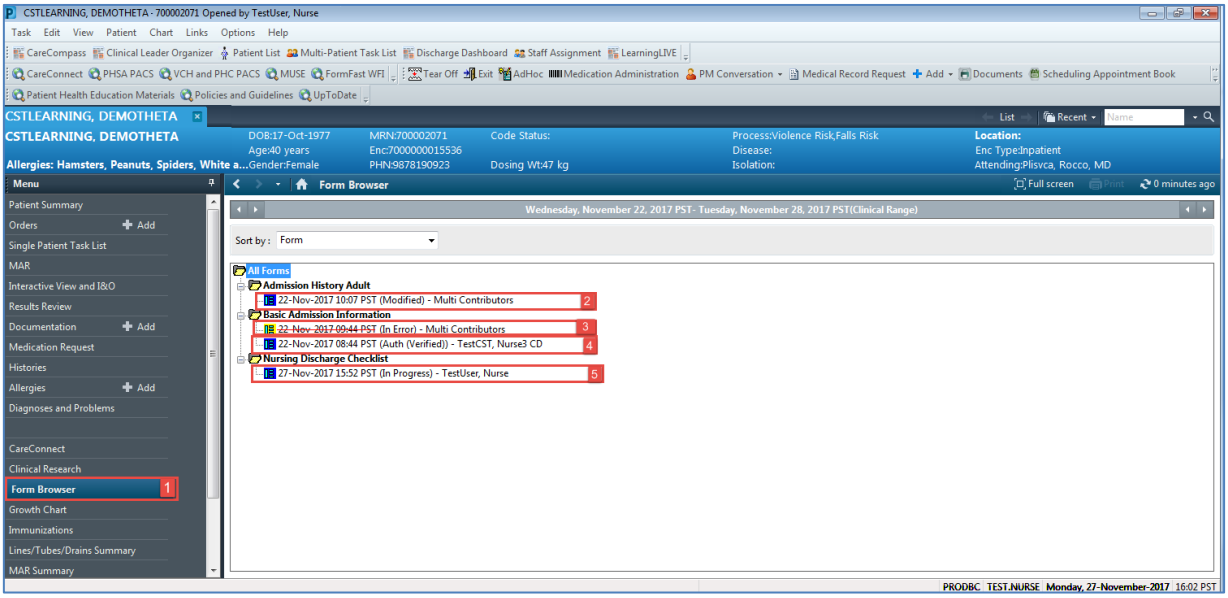
Activity 8.2 – Viewing an existing PowerForm

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.



Key Learning Points

- 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

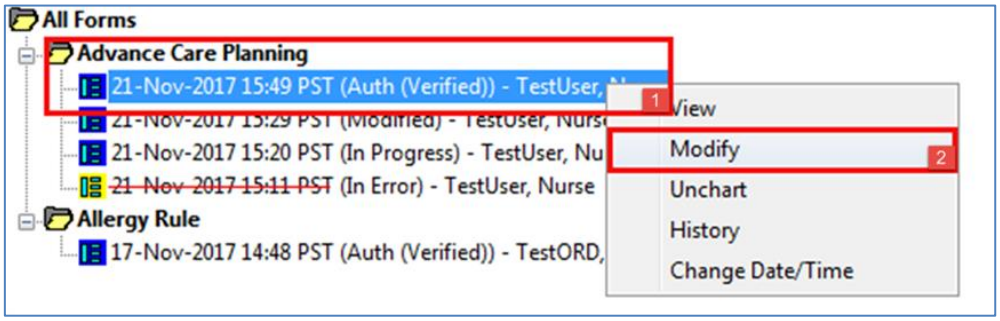
It may be necessary to modify PowerForms if information was entered incorrectly.

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.

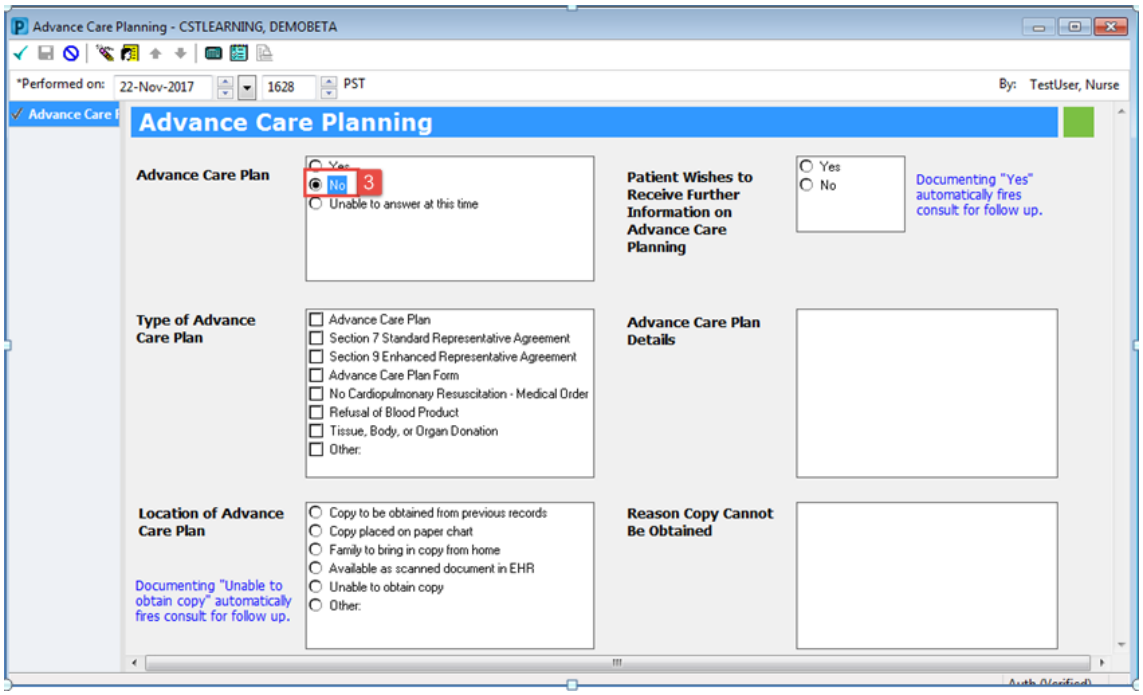
Let's modify the **Advanced Care Planning** form.

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**



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



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

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

Key Learning Points

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

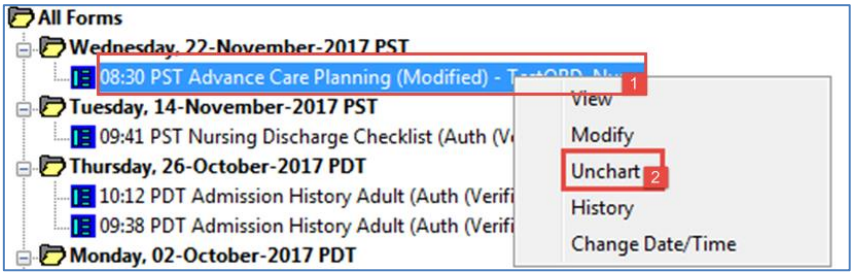
Activity 8.4 – Uncharting an existing PowerForm

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.

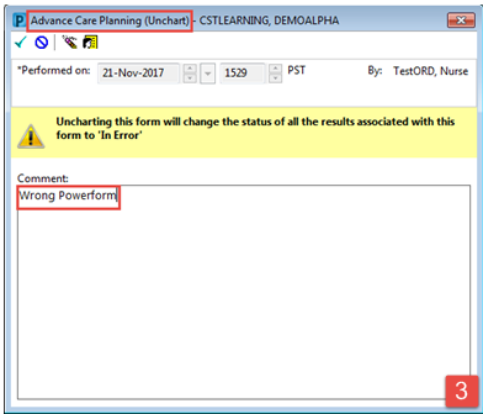
To unchart the PowerForm, within Form Browser:

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



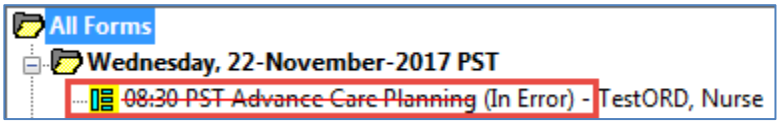
3. The Unchart window opens.

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



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.

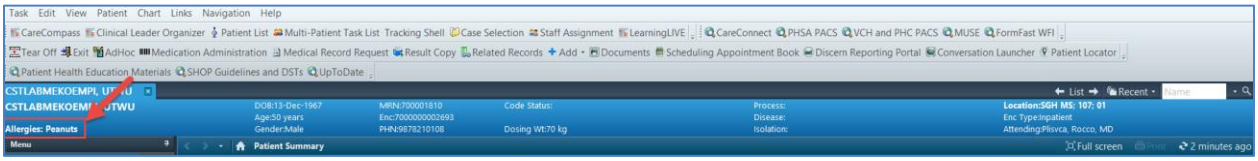
As an inpatient rural nurse you will complete the following activity:

- Review allergies
- Add an allergy

Activity 9.1 – Review Allergies

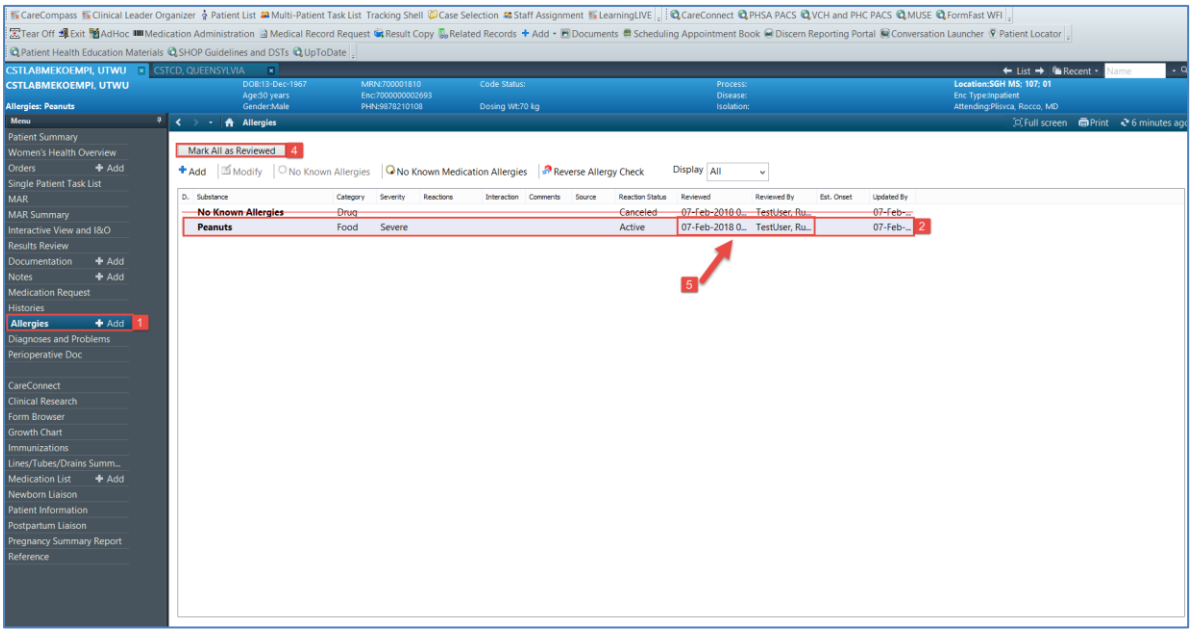
1 When your patient is admitted, you need to review his allergies. **Allergies** in the CIS carry forward from previous encounters.

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



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



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

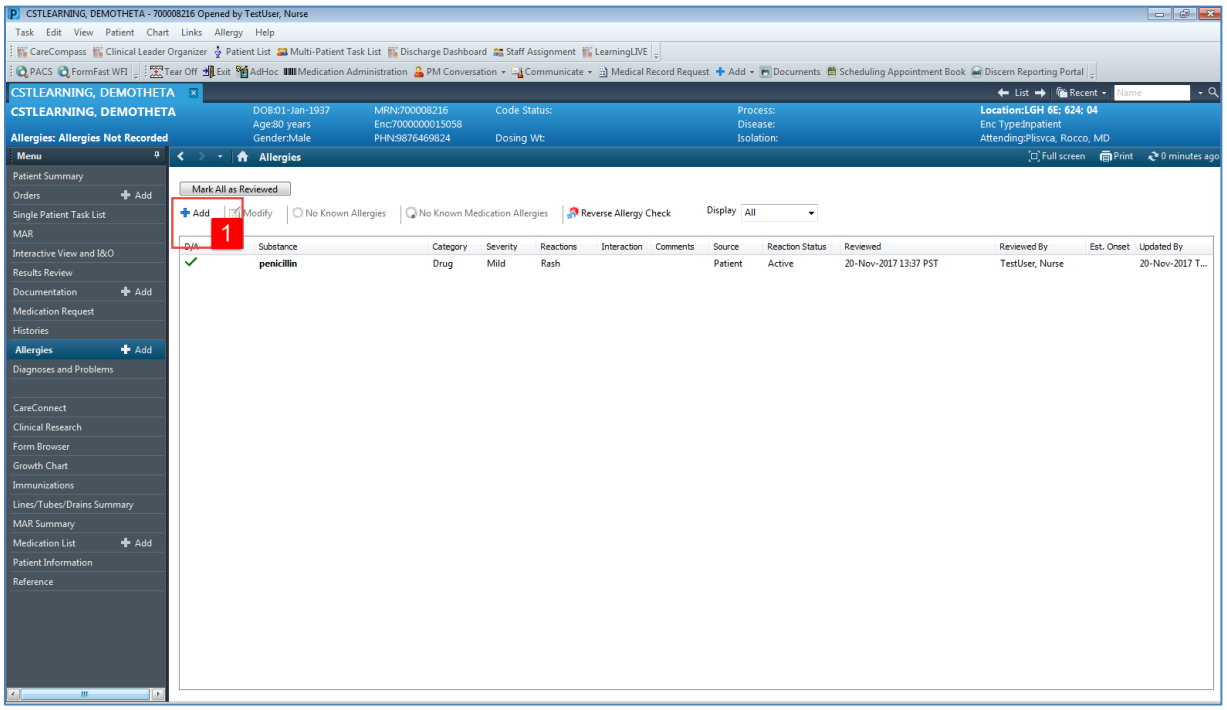
Key Learning Points

- 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

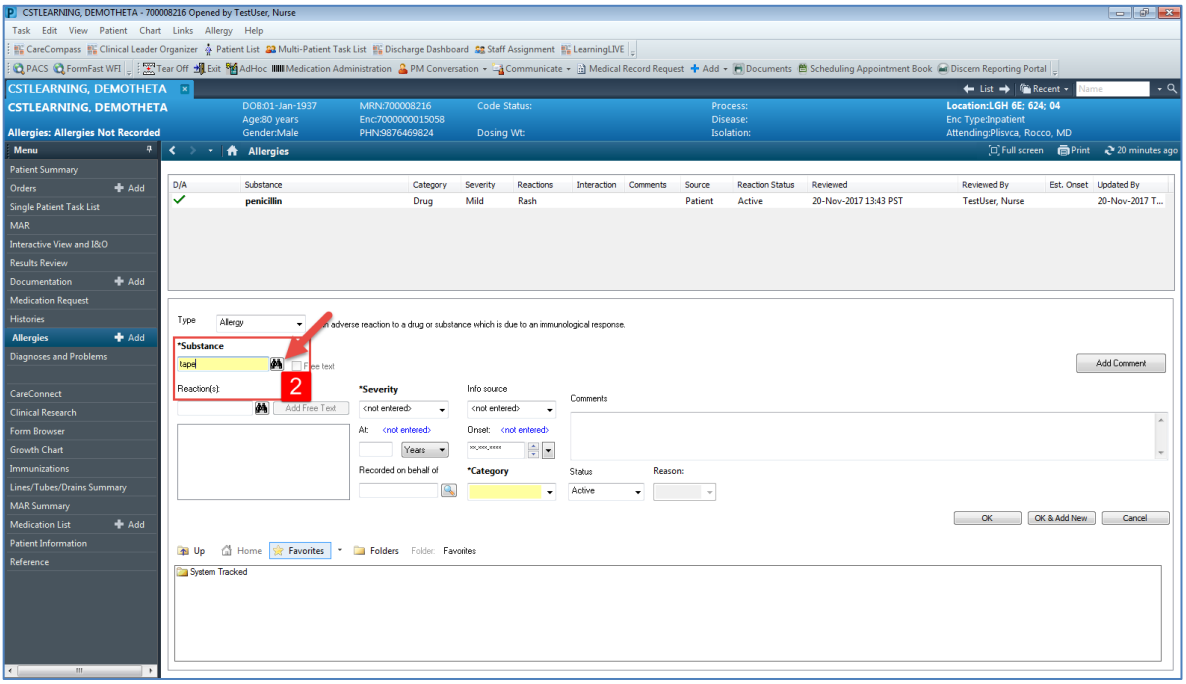
Activity 9.2 – Add an Allergy

1 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:

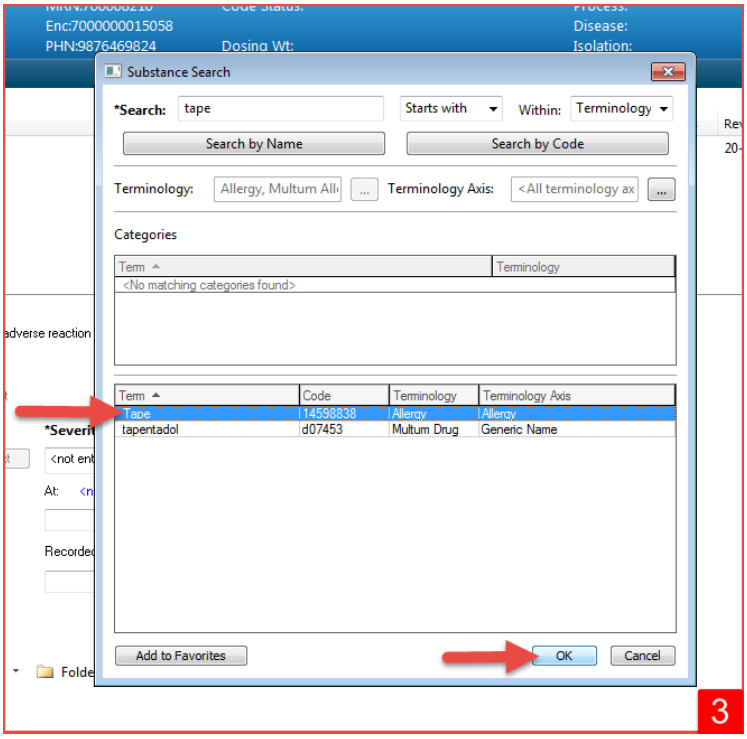
1. From the **Allergies** page, click **Add**



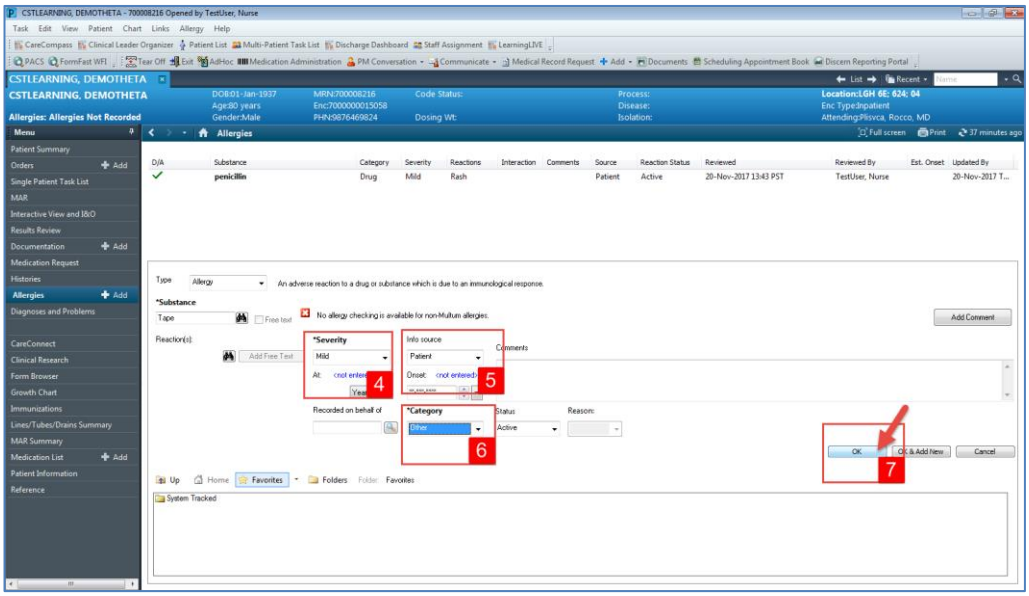
2. In the **Substance** field type *tape* and click the **Search** icon .
   Note: Yellow highlighted fields including substance and category are mandatory fields that need to be completed.



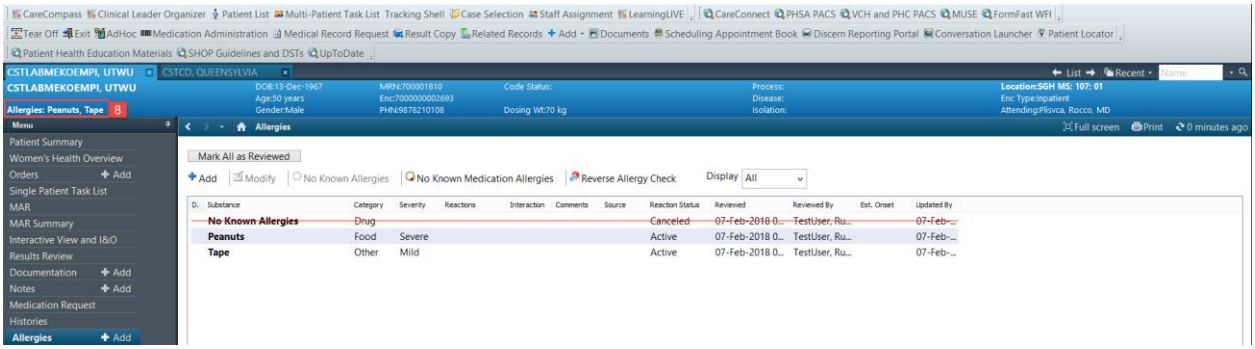
3. The **Substance Search** window opens. Select **Tape** and click **OK**.



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



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



Note: Allergies in the banner bar are sorted by severity (most 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:

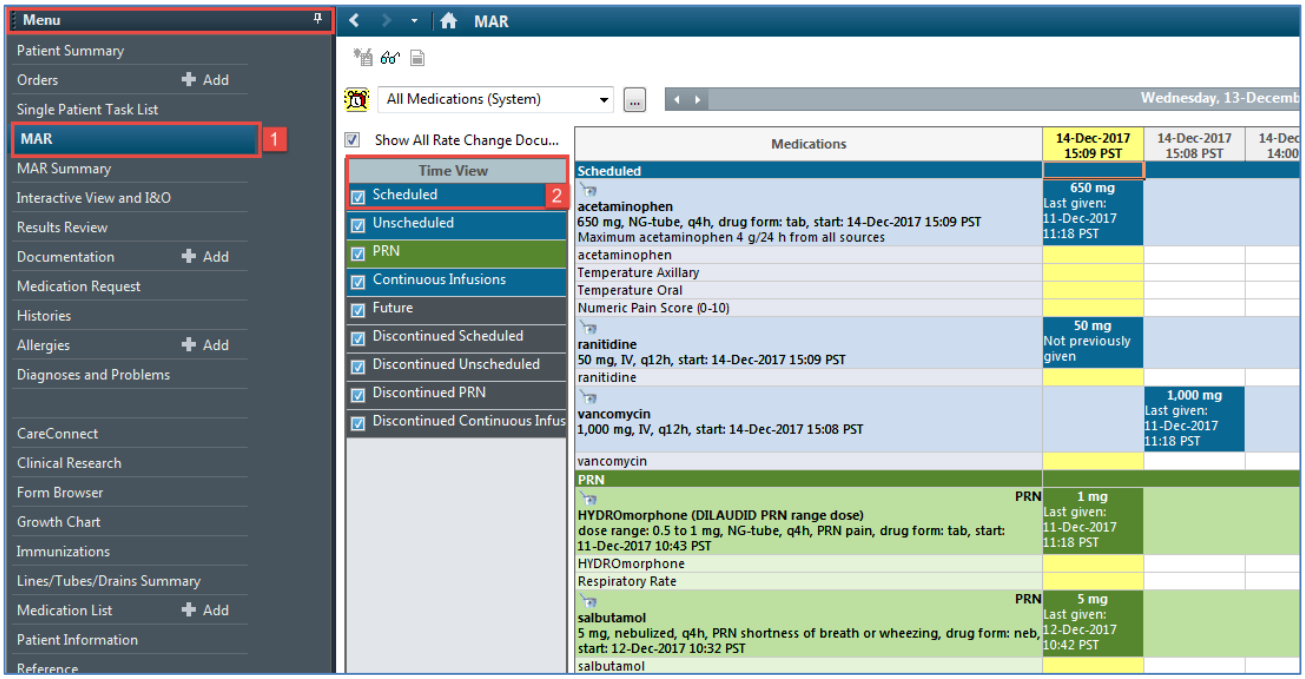
- Review the layout of the MAR
- Request a medication from pharmacy
- Reschedule a Single Dose of a Medication
- Reschedule all future doses of a medication

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.

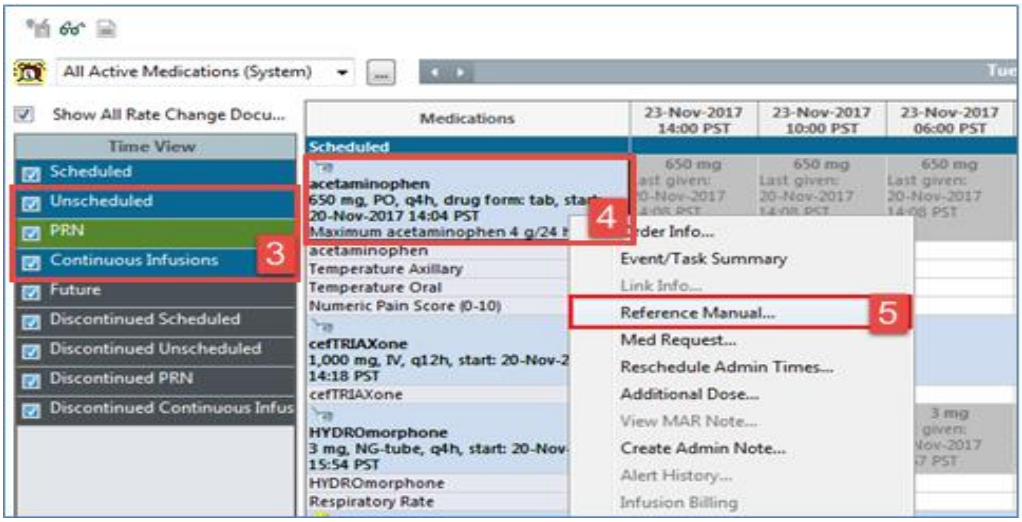
1. Go to the **Menu** and click **MAR**
2. Under **Time View** locate and ensure the **Scheduled** category is selected and is displaying at the top of the MAR list.



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**.

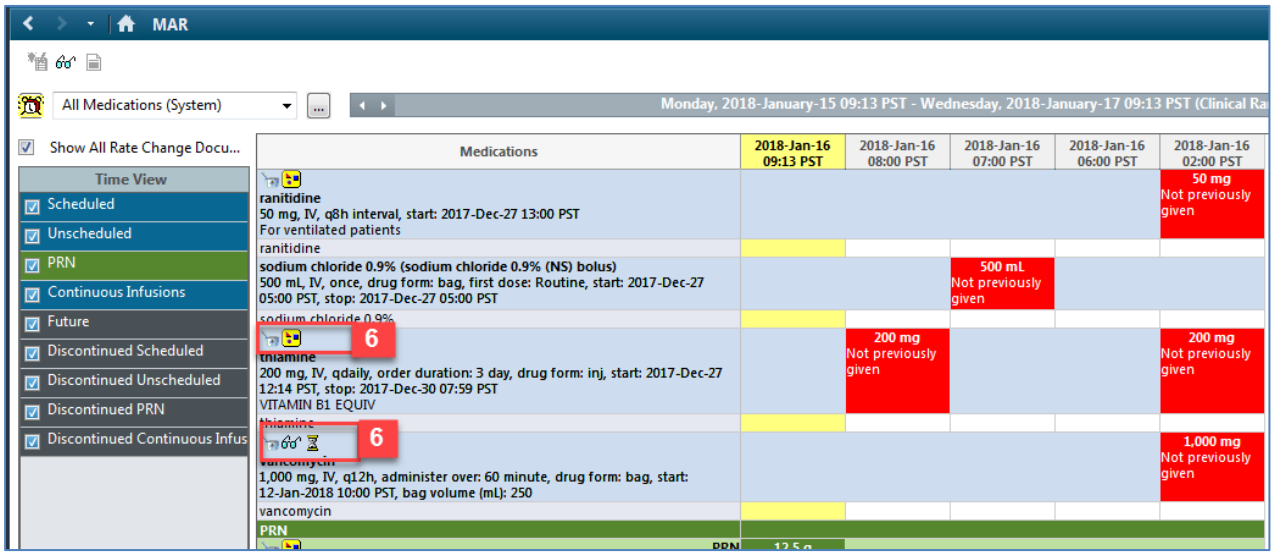


6. Note the icons that may appear on the MAR. Examples include:

 – Indicates the medication order has not been verified by pharmacy

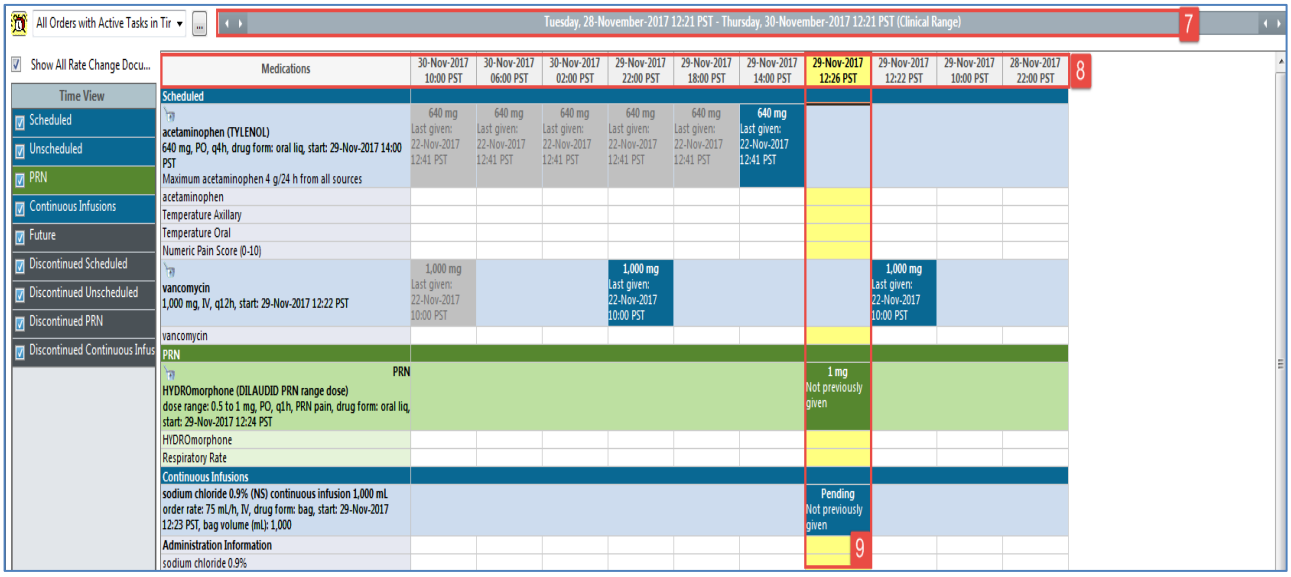
 – Indicates the order needs to be reviewed by the nurse

 – Indicates the medication is part of a PowerPlan



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

7. The Clinical Range is defaulted to display 24 hours 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.



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

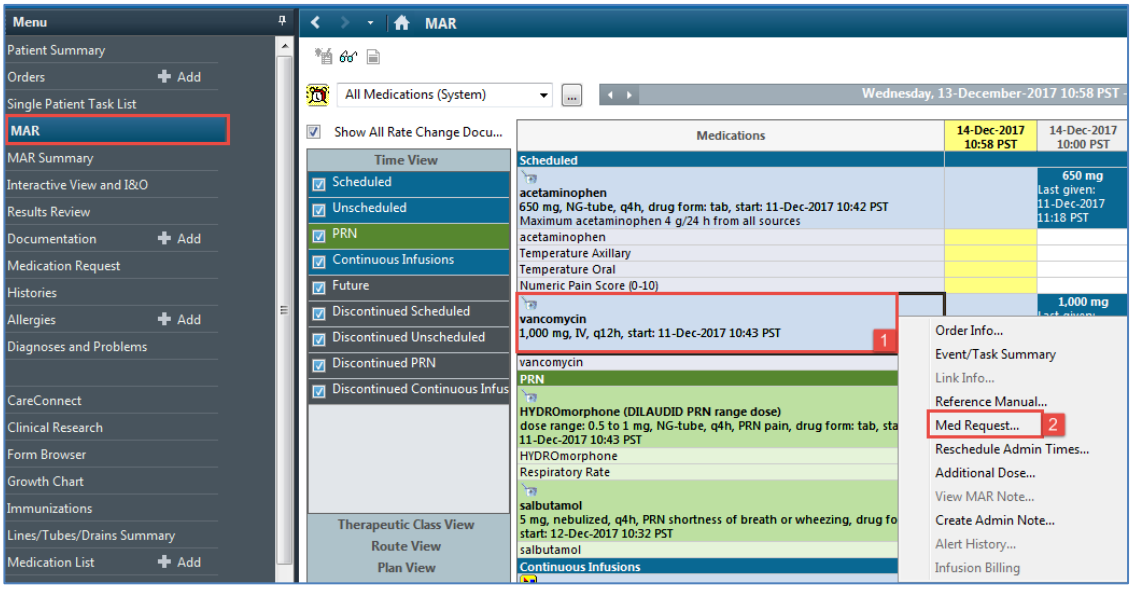
Key Learning Points

- 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

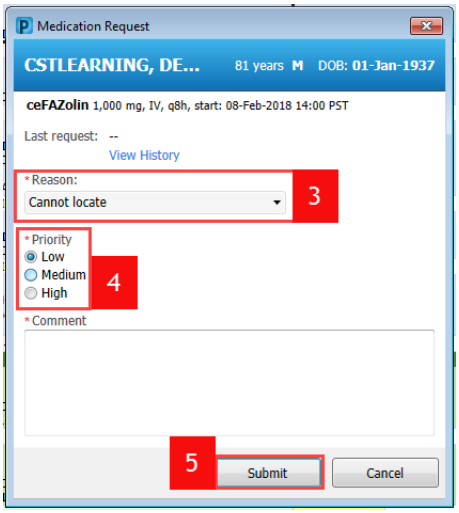
Activity 10.2 – Request a Medication and Rescheduling Medication Administration Times

1 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…**



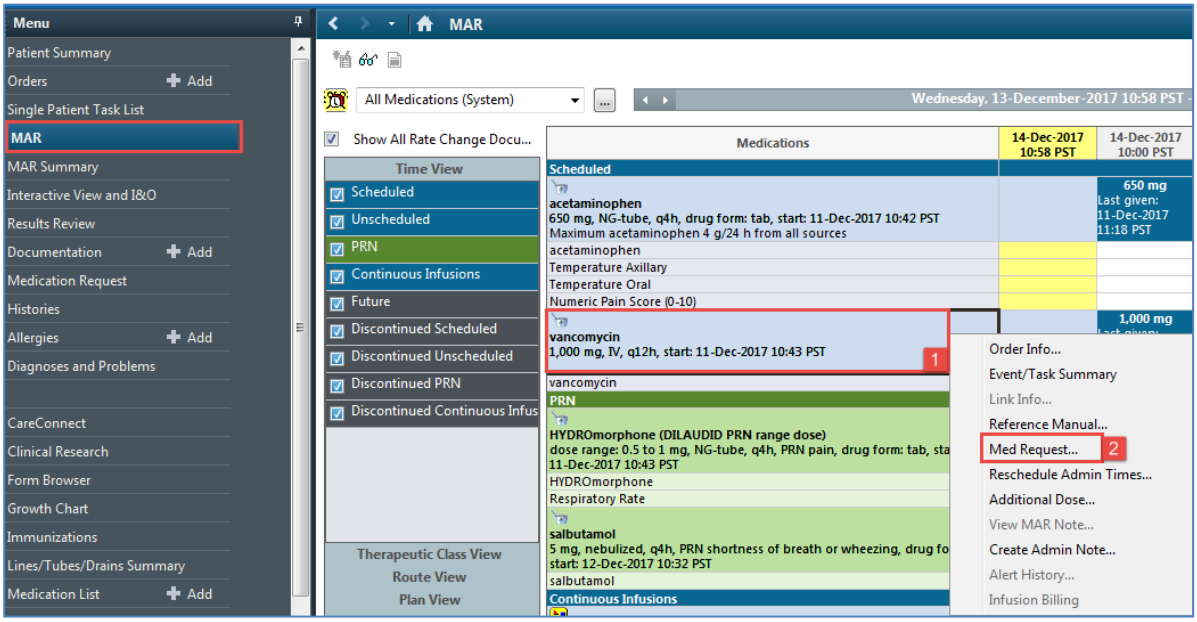
3. In the **Reason** dropdown menu, select **Cannot locate**.
4. Select a priority option. Select **Low**.
5. Click **Submit**



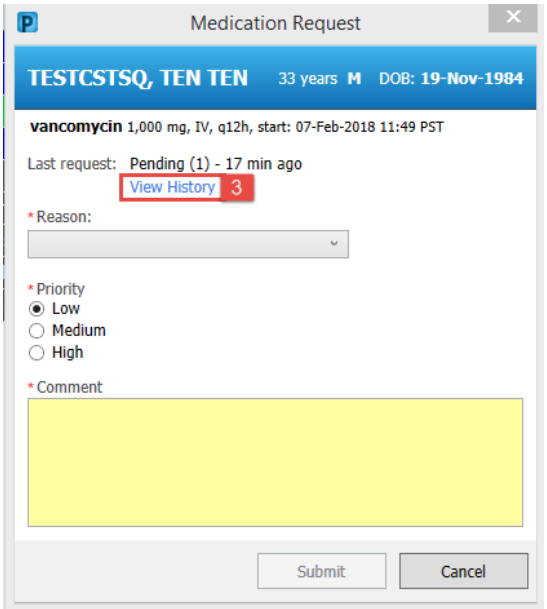
Note: Only enter Low for Priority of Medication Request unless absolutely necessary. Pharmacy will receive this Medication Request message and be aware that they need to send the medication to the patient's location!

2 If you are wondering what the status is on a Medication Request, you can find out by following these steps:

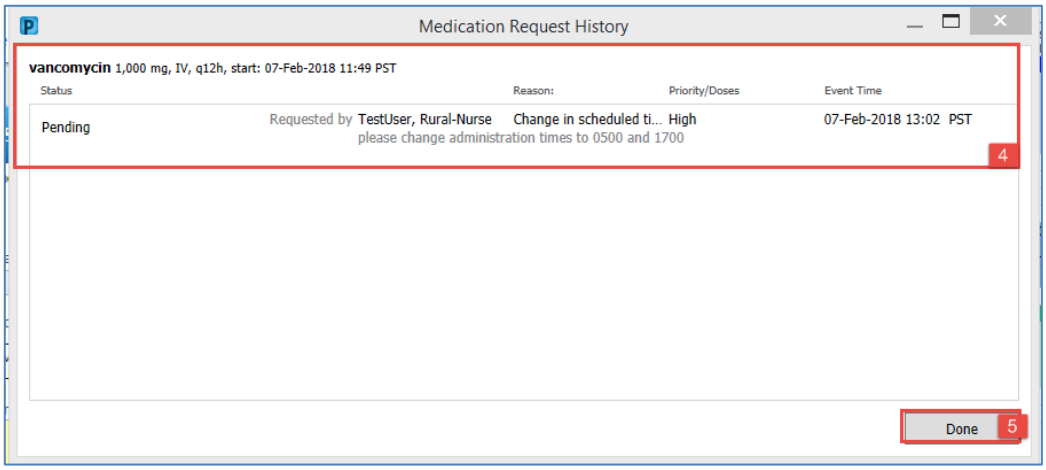
1. Right click on the medication order name **vancomycin 1,000mg, IV, q12h**
2. Select **Med Request…**



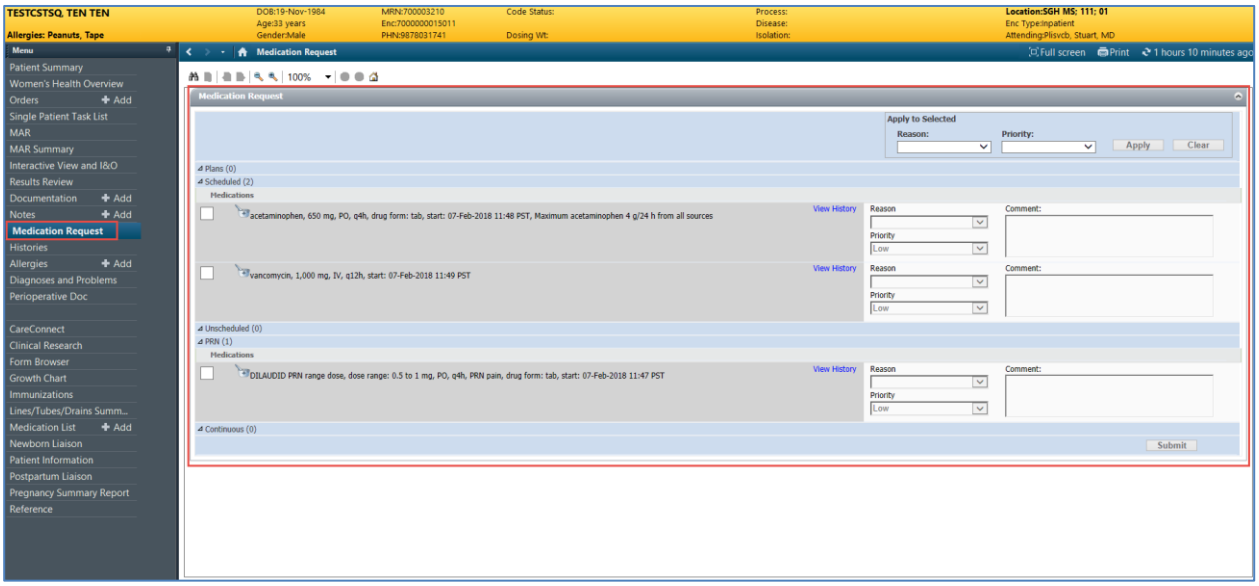
3. Click on the View History blue text View History.



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



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.



Key Learning Points

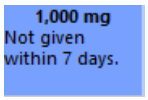
- Right clicking on the medication order name in the MAR provides options such as Med Request
- Med Request sends a message to pharmacy about the medication
- Click on View History from the Medication Request window to review any medication requests that have already been made.
- Accessing Medication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

Activity 10.3 – Reschedule a Single Dose of a Medication

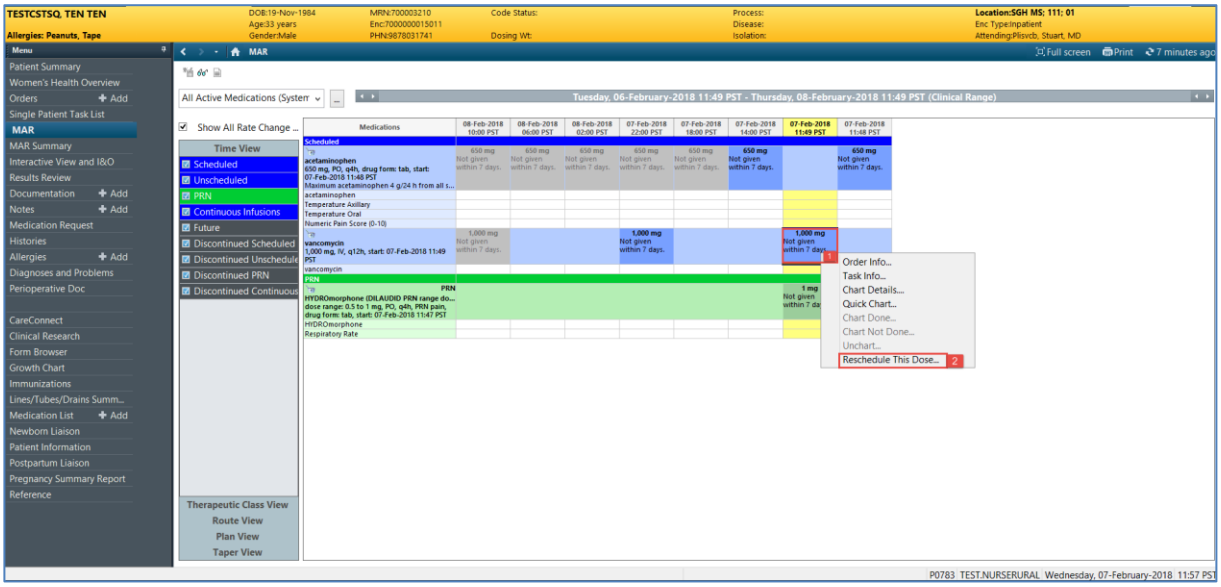
1 Let's say your patient wasn't available to receive a medication when it was due. In cases like this, you may need to reschedule a single dose of a medication on the MAR.

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

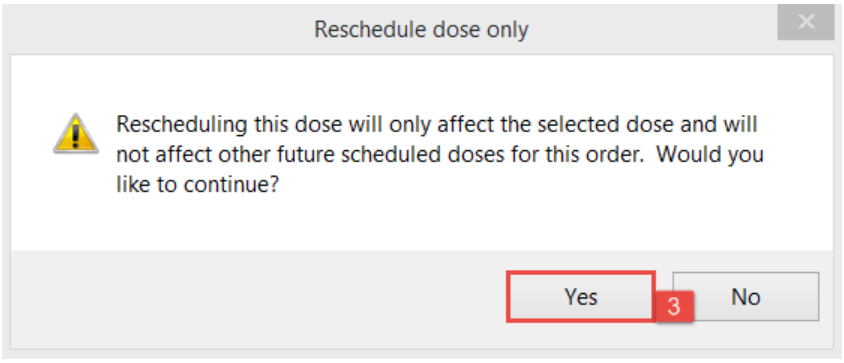
1. Right click on the blue medication task for **vancomycin 1,000mg, IV, q12h**



2. Select **Reschedule This Dose…**

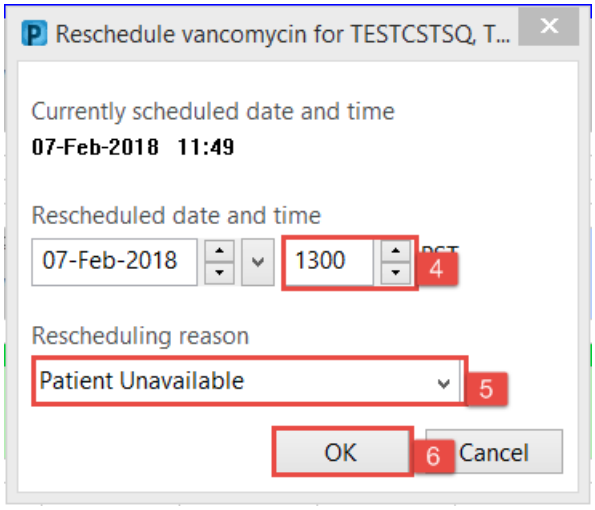


3. A **Reschedule dose only** window appears. This warning tells you that only one dose will be rescheduled and not all future doses. Click **Yes**.



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

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



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

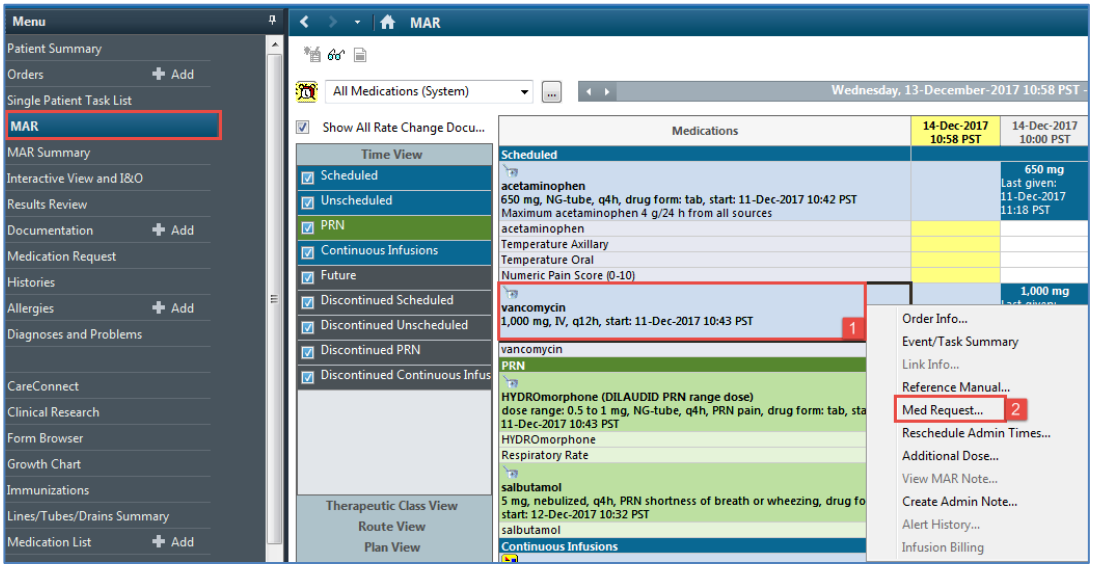
Key Learning Points

- 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

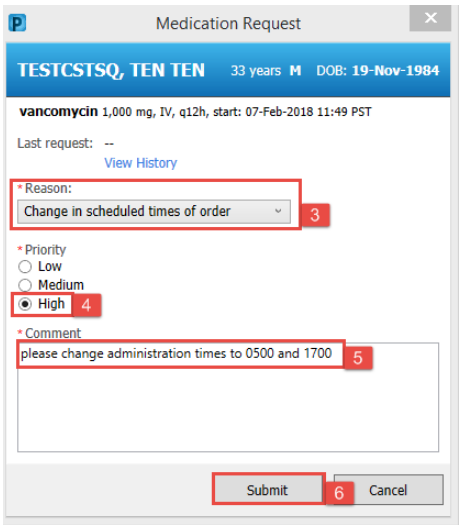
Activity 10.4 –Reschedule All Future Doses of a Medication

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…**



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**



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.

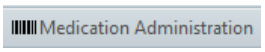
Occasionally a dose requires scanning two pills to make up the full dose. At other times, the dose requires only part of a pill.

- 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

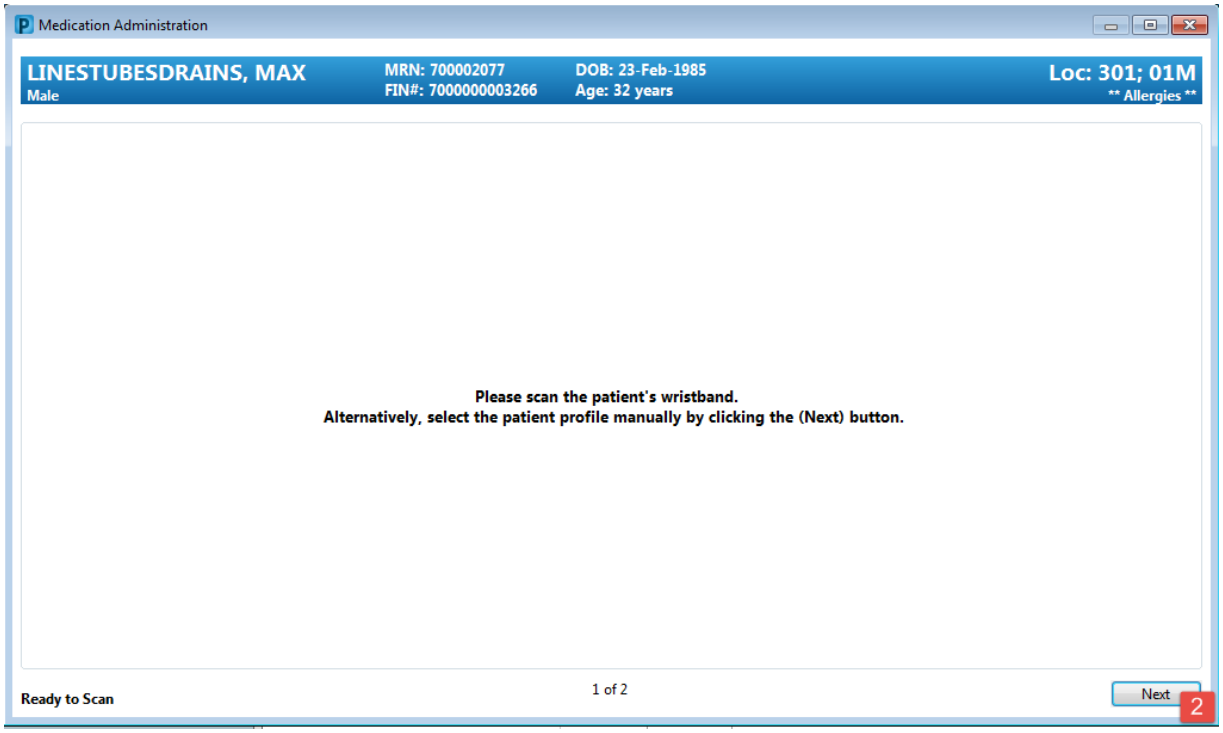
Note: IV normal saline does not have a barcode to be scanned as it is a Stores Item. Stores items are documented on the MAR differently and we will practice this later on.

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

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

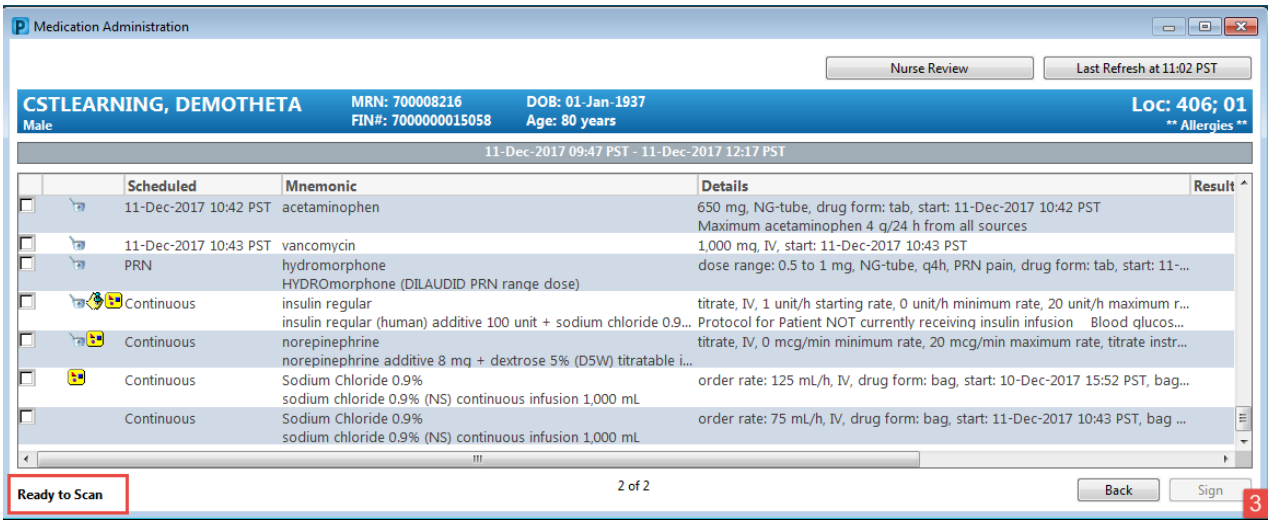
Medication Administration Wizard (MAW)  in the Toolbar

2. The **Medication Administration** window opens.



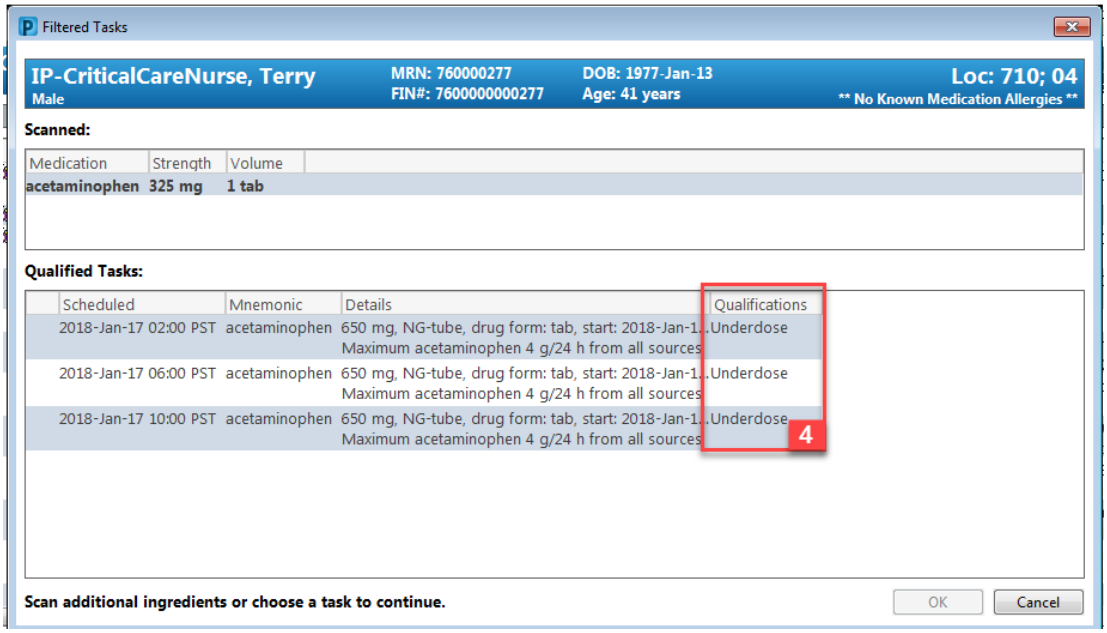
3. Scan the patient's wristband barcode and the **Medication Administration** window will open displaying the medications that you can administer.

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.

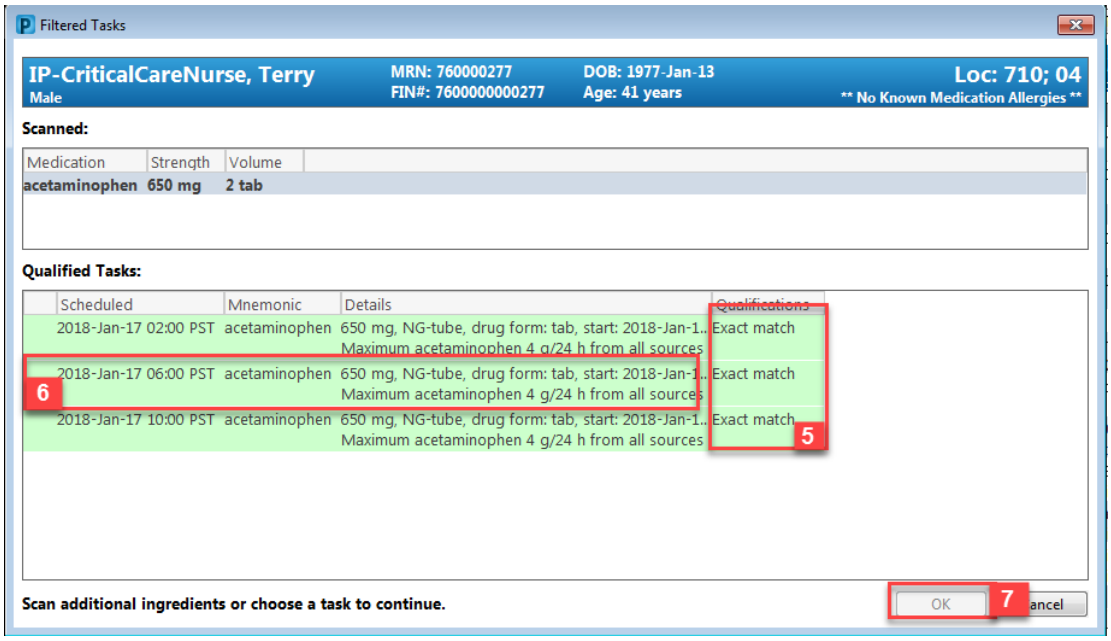


4. Scan the medication barcode for **acetaminophen 325 mg** tab. **Filtered Tasks** window opens.

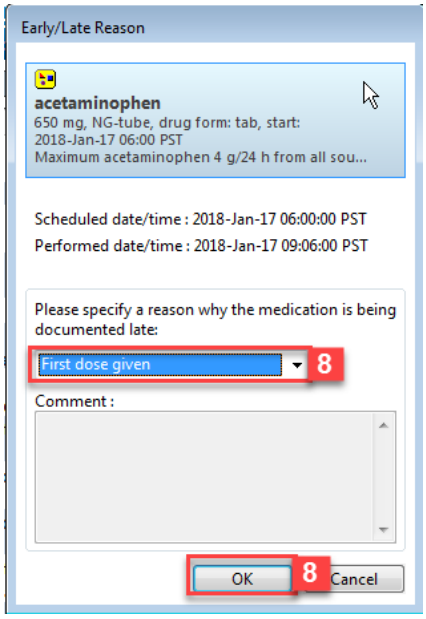
Note: Underdose appears in the qualifications column for the medication. This is because you have only scanned 325 mg of the total 650 mg of acetaminophen required.



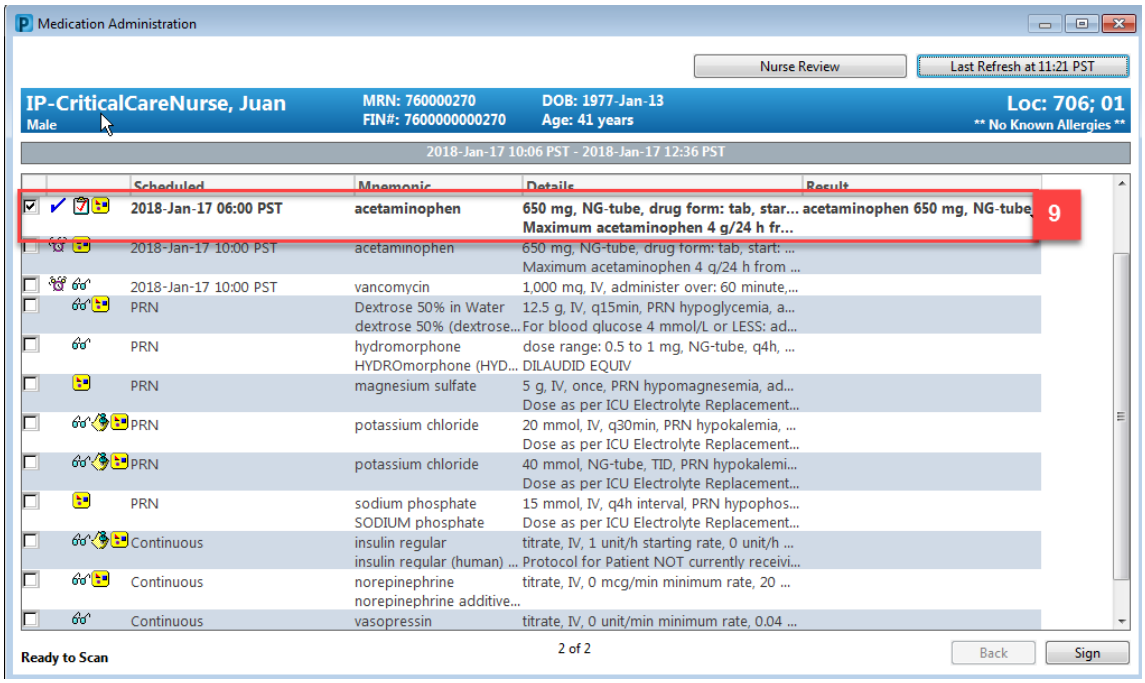
5. Now scan the second **acetaminophen 325 mg** tab barcode to complete the 2 tablet drug administration. After the second scan, the system may find more than one exact matches. In this activity, the system displays three exact matches for the prescribed dose of acetaminophen at 02:00, 06:00, and 10:00.
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**



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**.

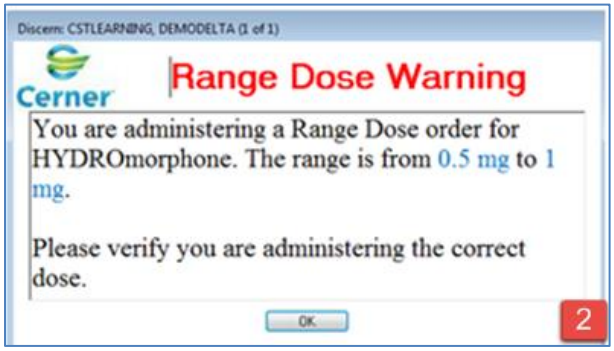


9. You will return to **Medication Administration** window. The blue checkmark ✔ indicates the task for scanning the prescribed dose of acetaminophen is completed.

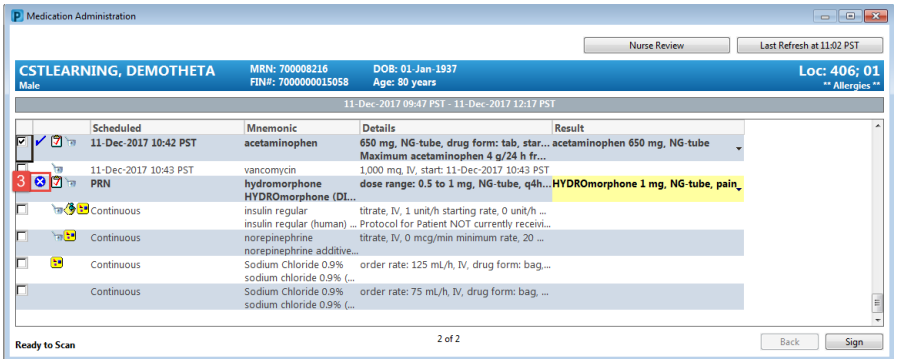


Now let's scan the next medication.

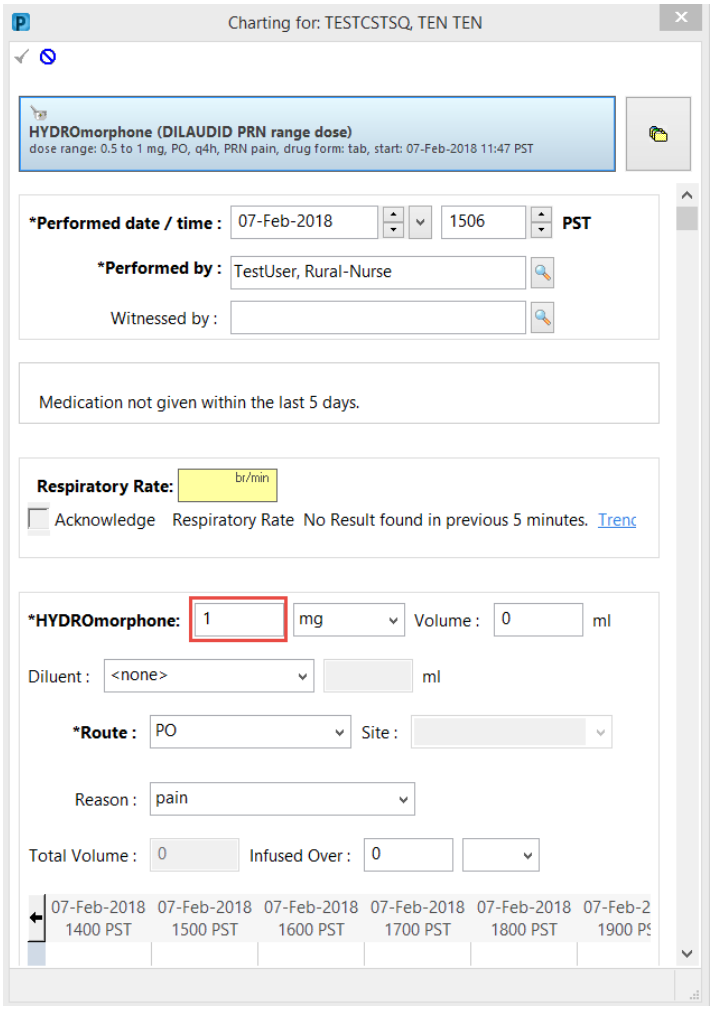
1. Scan your medication barcode for **hydromorphone 1 mg tab**
2. You are using the hydromorphone 1 mg tab product barcode. Note that this medication is a range dose order. A **Range Dose Warning** screen will display to remind you of this dose range. Click **OK** to acknowledge the alert.



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

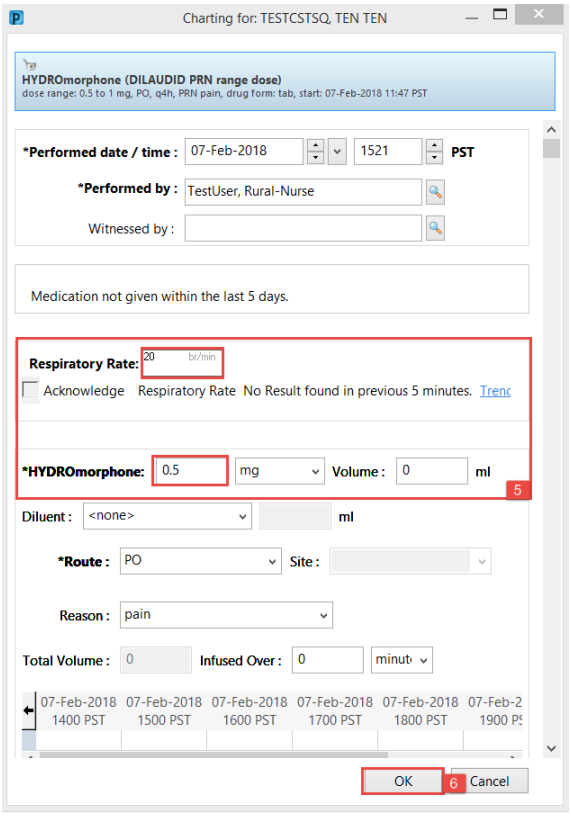


4. A charting window will appear. Notice that the **HYDROmorphone dose** field is pre-filled with **1 mg**. This is because you scanned a 1mg barcode. It is essential that you change this entry because you are giving **0.5mg**.



5. Enter the following details:
    - **Respiratory Rate** = *20 breaths/min*
    - **Hydromorphone** = *0.5 mg (changed from 1 mg)*

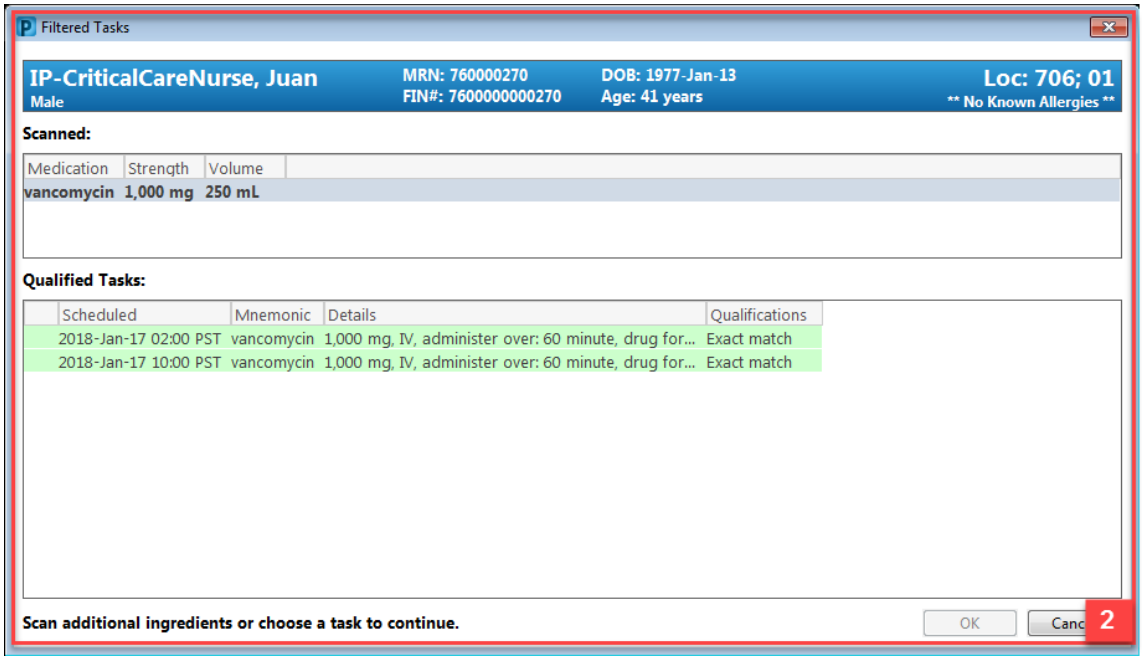
6. Click **OK.** You will return to **Medication Administration** window.



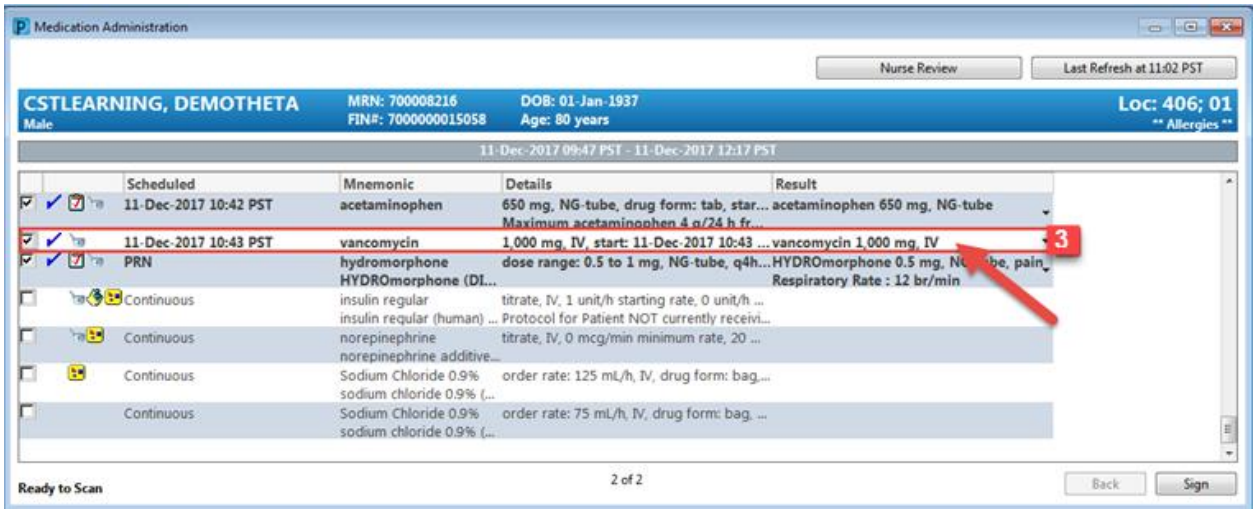
Let's scan your last medication.

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).

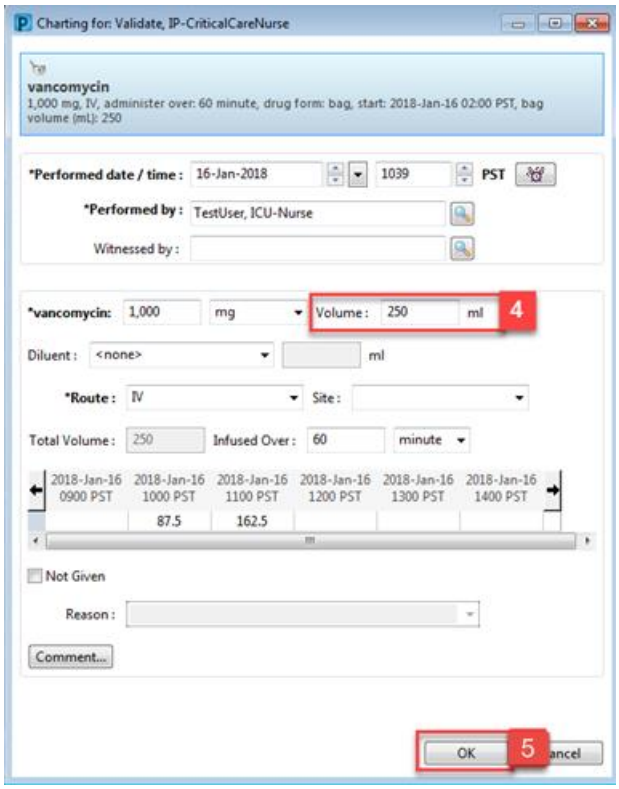


3. Click **vancomycin 1,000 mg IV bag** in the **Results** column.



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.

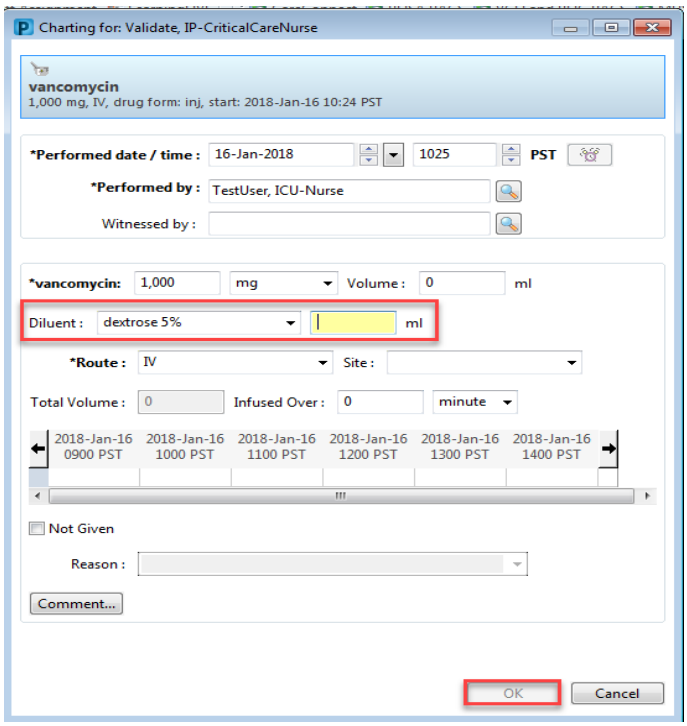
Note: If the **volume** has to be manually entered by the nurse, the value will not flow to the Intake section of I&O.



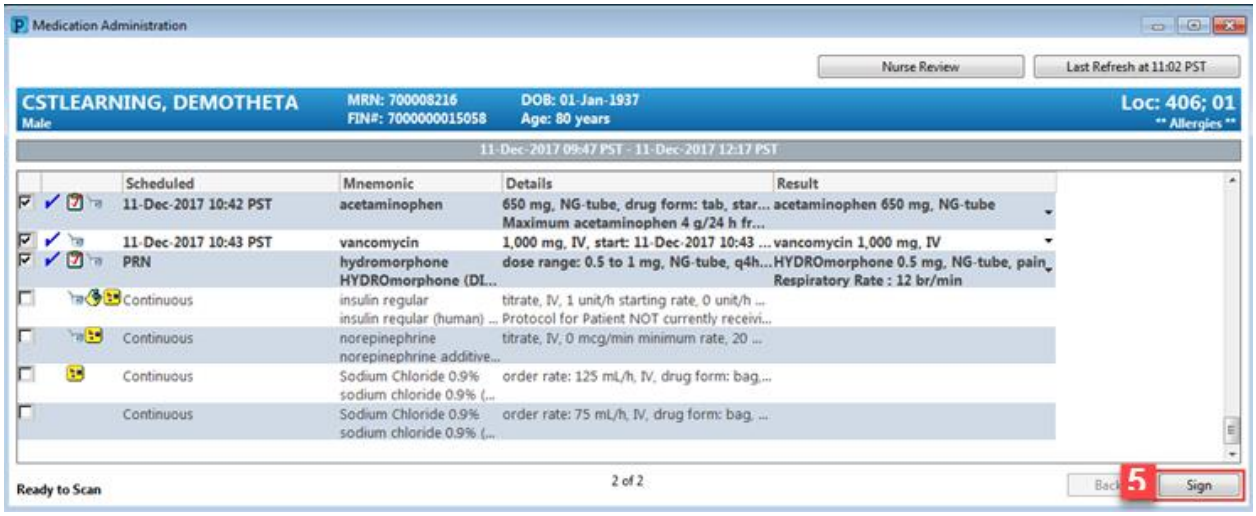
Note: When nurses mix their own medications, the barcode on the **vial** of the medication will be scanned. In this case, the nurse will have to manually enter the following information into the charting window:

- The **Diluent Type**
- The **Diluent Volume**

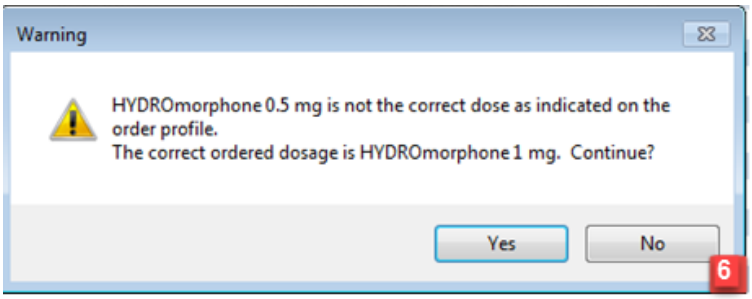
When the **Diluent Volume** is manually entered, the value will flow to the Intake section of I&O. If the diluent volume is left blank, no medication volume will be populated in I&O.



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 to sign off the medications as administered.



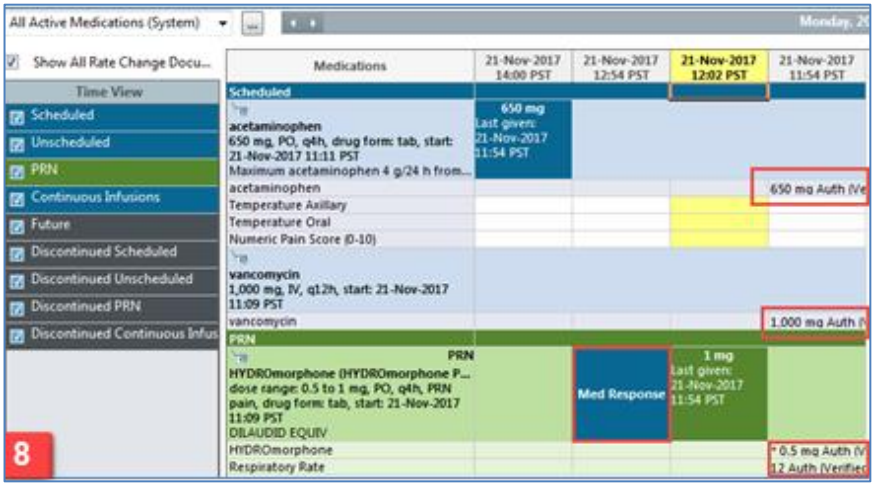
7. A warning window opens stating that a partial dose of hydromorphone was given, do you want to continue? Click **Yes.** (This is to remind you to document the correct dose administered **0.5mg** in the previous charting window).



Congratulations, you have successfully administered three medications!

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

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



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.

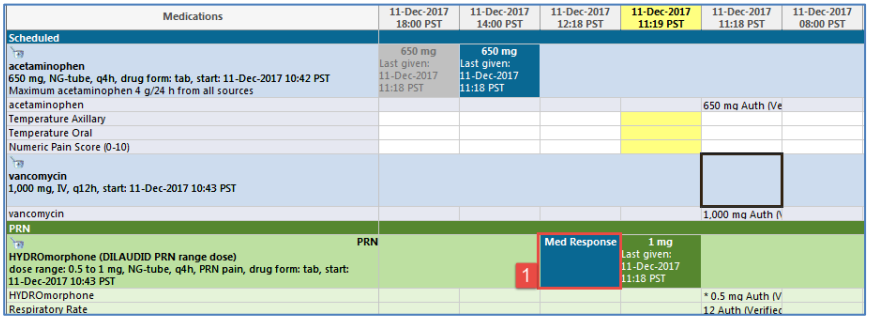
Key Learning Points

- **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.

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

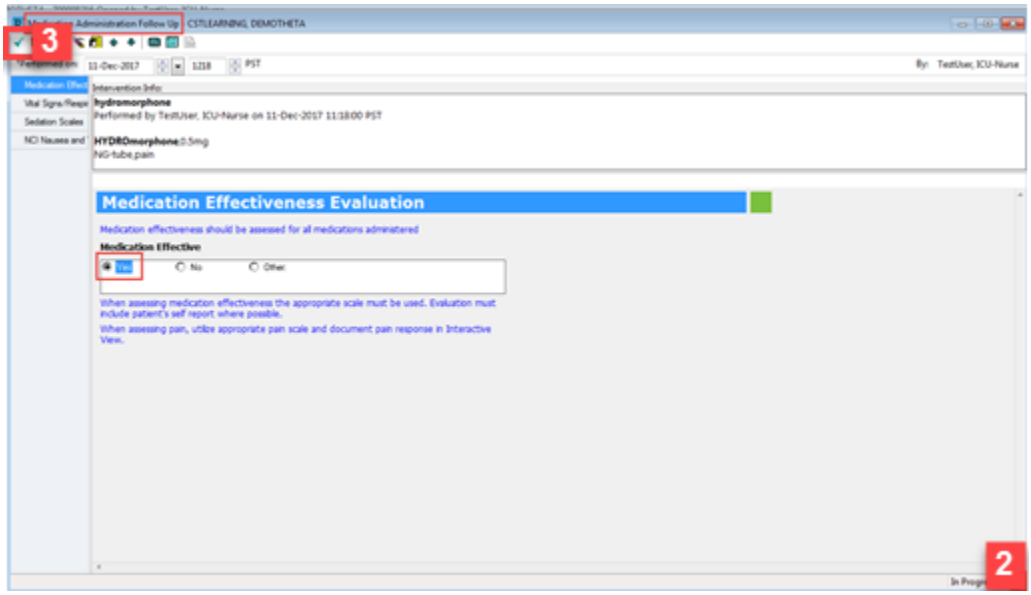
1 When you administer some PRN medications, it is necessary to document how the patient responds to the medication. You can do this directly in the MAR.

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

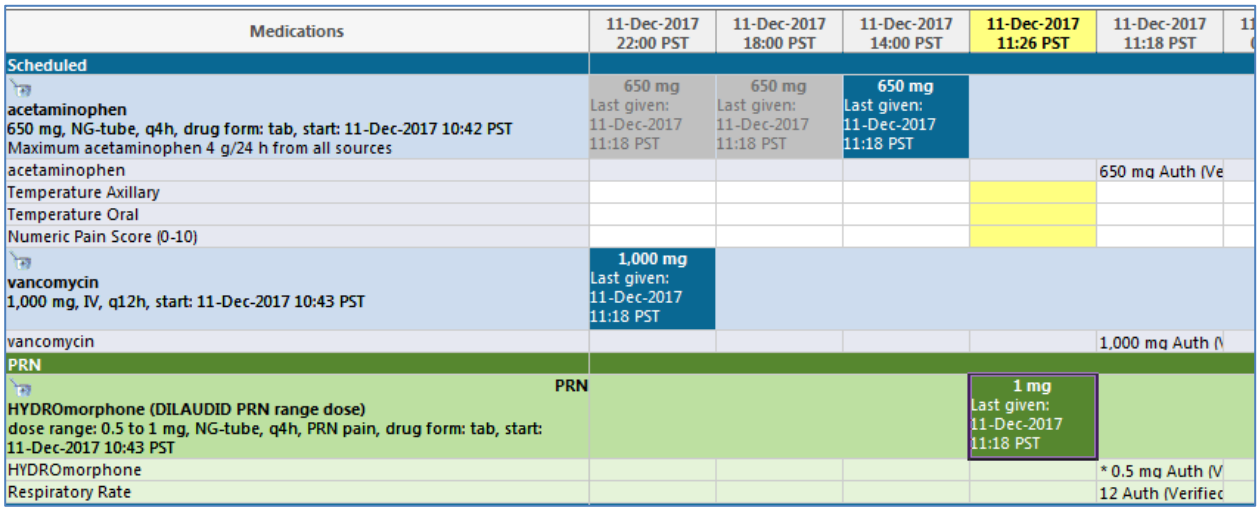


2. Let's say the 0.5mg tablet of Hydromorphone relieved your patient's pain. In the **Medication Effectiveness Evaluation** field, click **Yes** to indicate the medication was effective**.**

3. Click **Sign** icon ✔ to complete the document. You will return to MAR.



4. Click the **Refresh** icon 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 11:18 PST	11
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						
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**				**1 mg** Last given: 11-Dec-2017 11:18 PST		
HYDROmorphone					* 0.5 mg Auth (V	
Respiratory Rate					12 Auth (Verifiec	

Key Learnings Points

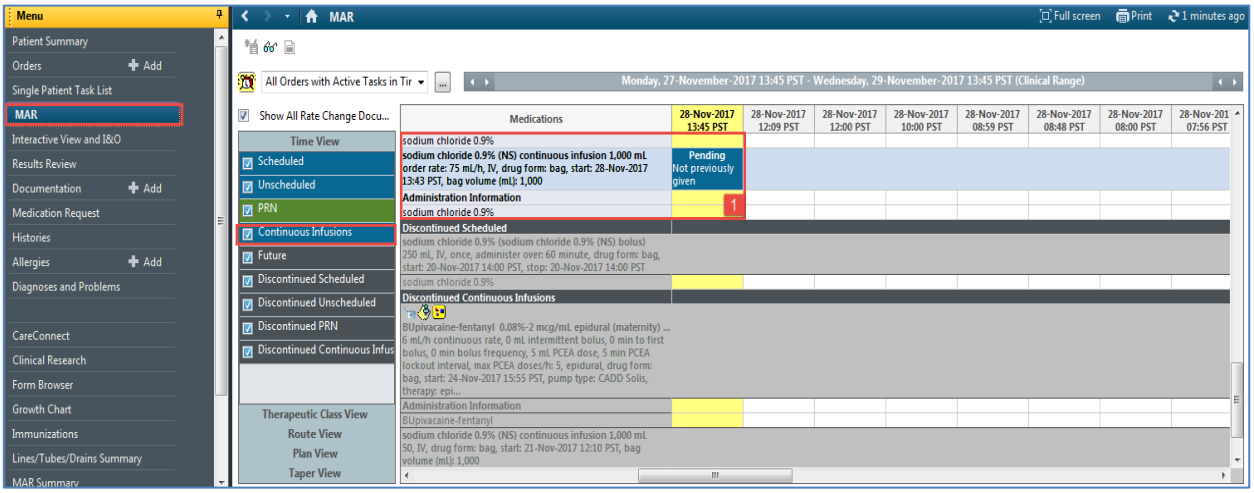
- Some PRN medications require further documentation on how the patient responds to the drugs. This can be done under Med Response from the MAR.

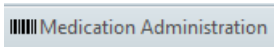
Activity 11.3 – Administering Continuous IV Fluids (Non-barcoded) and Documenting in I&O

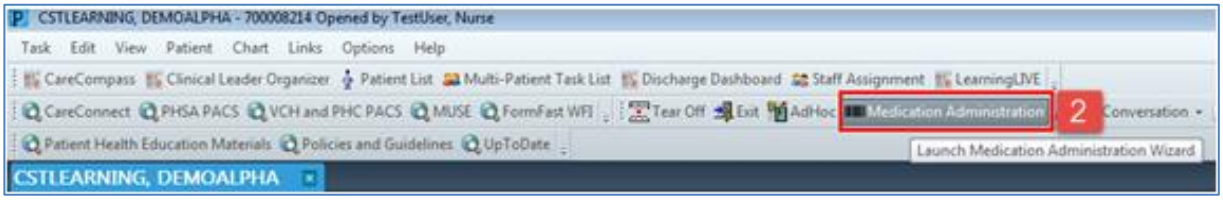
1 To administer normal saline continuous IV infusion, complete the following steps:

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

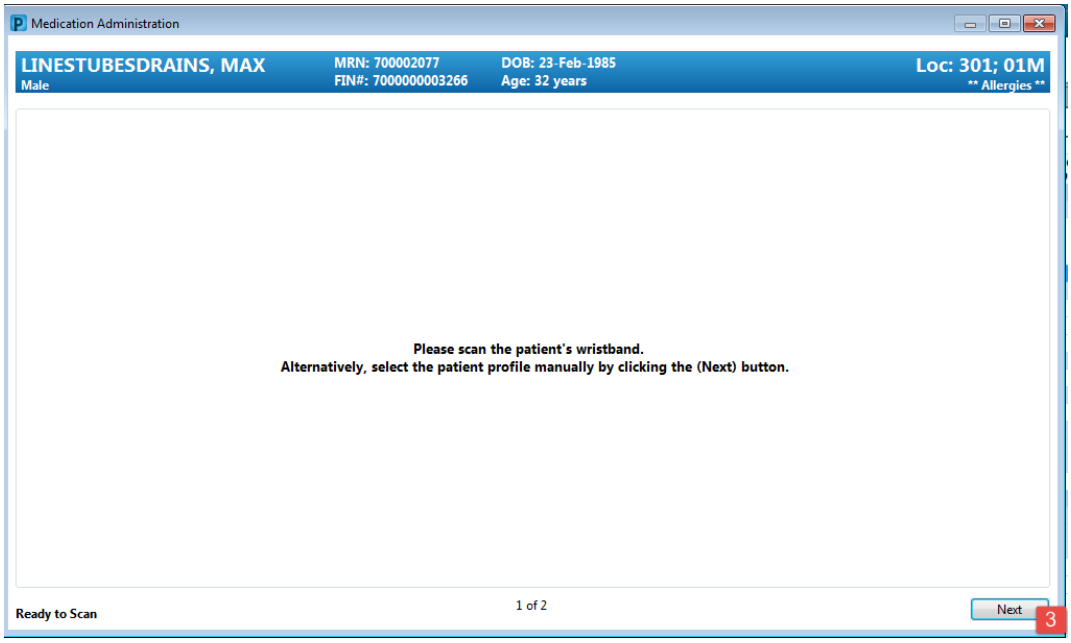
Note: the status is **Pending** meaning it has not been administered yet.



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

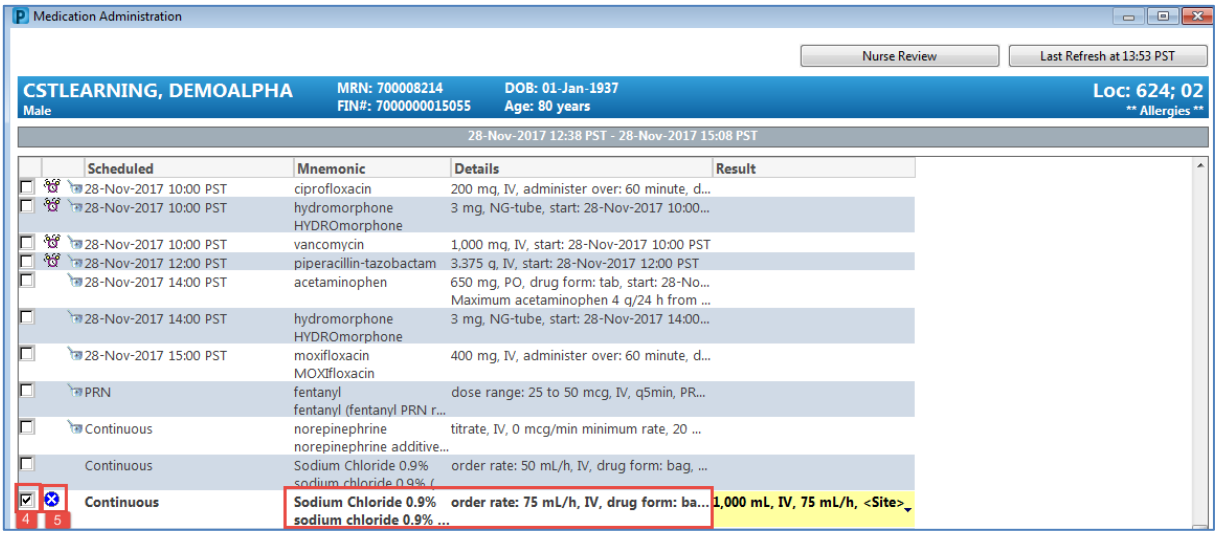


3. The **Medication Administration** window opens prompting you to scan the patient's wristband. Scan the barcode on the patient's wristband.

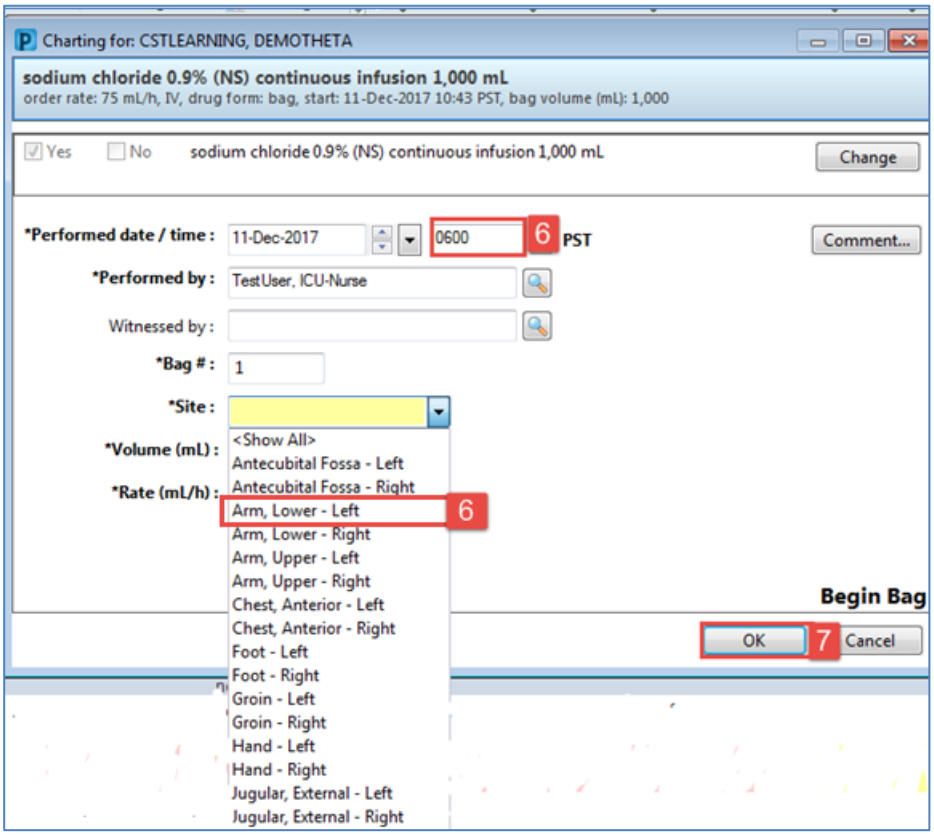


4. A list of ordered medications that can be administered appears in the **Medication Administration** window. The next step would be to scan the barcode on the medication, but with items that do not have a barcode, such as Normal Saline, we cannot do this. Instead, scroll down to manually select the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

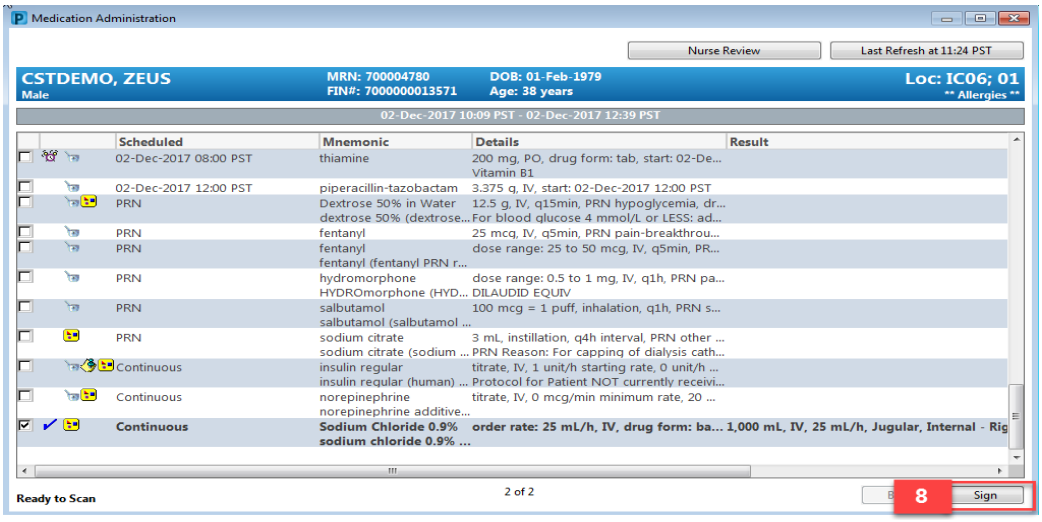
5. Click on the **Task Incomplete** icon and the **Charting** window will open for the sodium chloride 0.9% (NS) continuous infusion 1,000mL



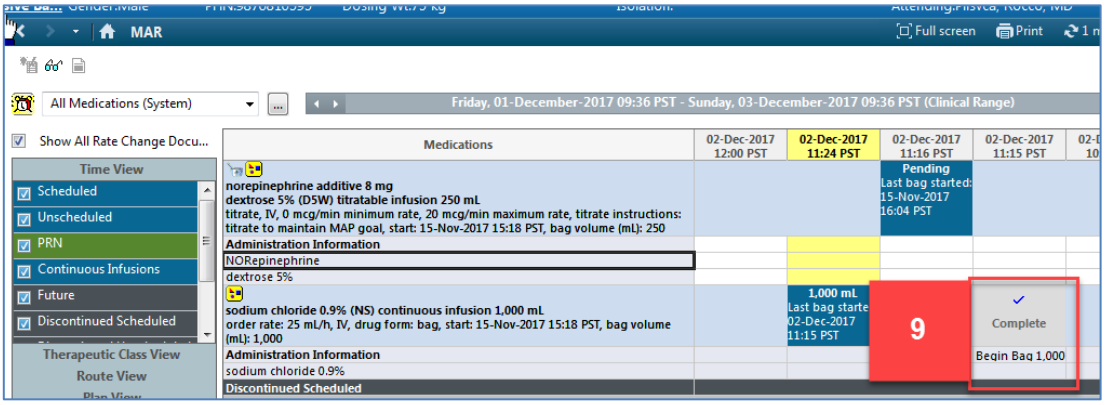
6. Fill in the following information, in this case:
    - **Performed time** = *0600*
    - **Site** = *Arm, Lower - Left*
7. Click **OK**



8. Click the **Sign** button 



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



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.

Key Learnings Points

- Continuous infusions are administered using MAR and MAW
- Non-barcoded IV fluids cannot be scanned, but the patient's wrist band should still be scanned through MAW to help identify the correct patient
- All 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

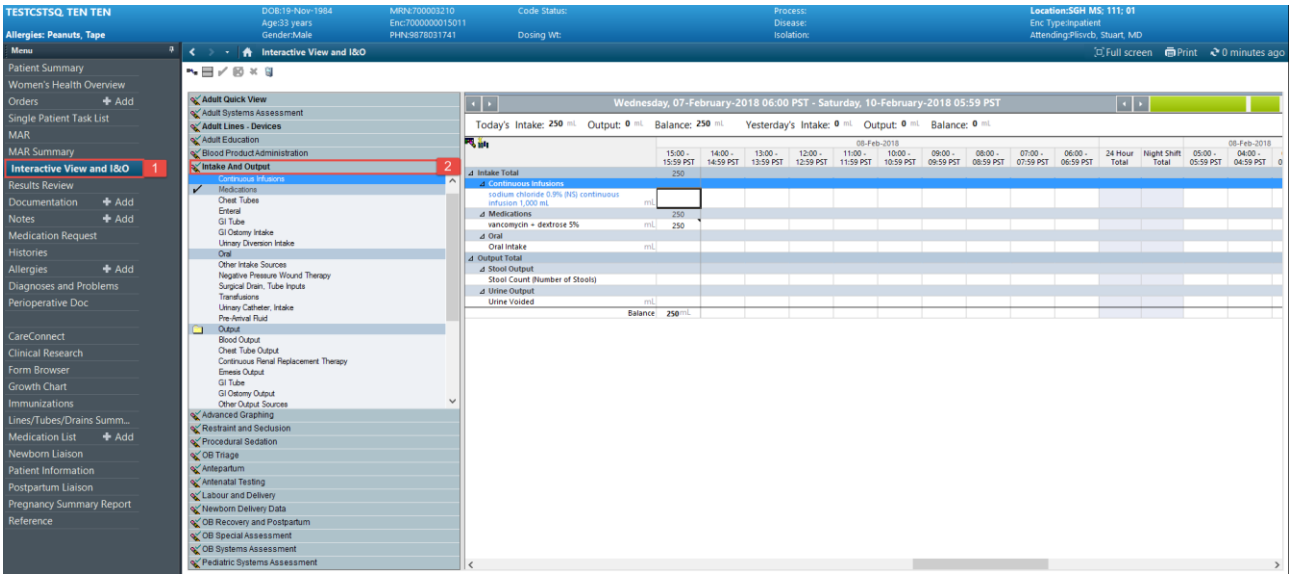
Intake and Output (I&O) is found as a band within iView and is where a patient's intake and output will be documented. From here, you are able to review specific fluid balance data including 1 hour totals, 12 hour totals, 24 hour totals, and even cumulative balances over the patient's entire hospital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

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



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

The intake and output screen can be described per below:

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

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

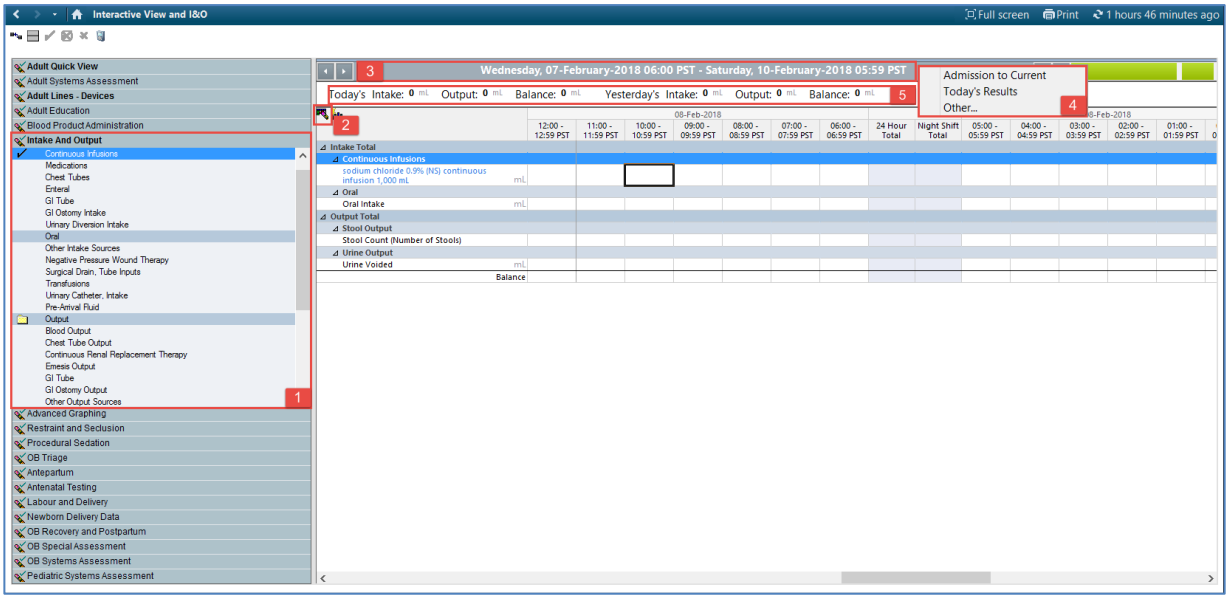
2. To add other **Intake or Output sources**, you will need to click on the **Customize View icon**  to select the appropriate section to be added in.

3. The **grey information bar** indicates the date/time range that is currently set to be displayed.

4. To change the date/time range being displayed:

   - Right-click on the **grey bar** and select **a new date/time range** (Admission to Current, Today's Results or Other)

5. The I&O summary at the top of the flowsheet displays a quick overview of today's intake, output, balance, and more.



Key Learning 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.

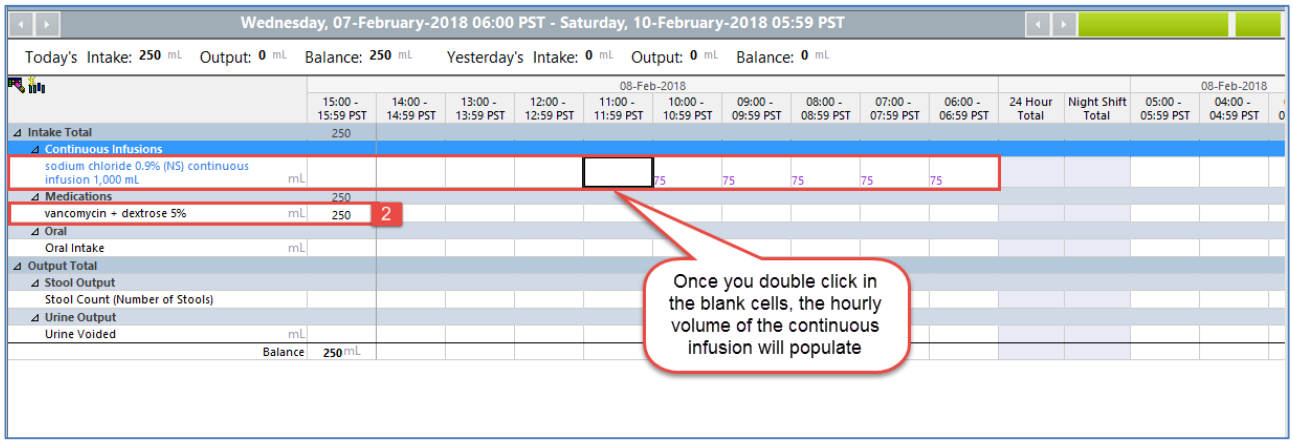
Previously a peripheral IV and sodium chloride infusion were initiated. An IV vancomycin dose was also given.

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.

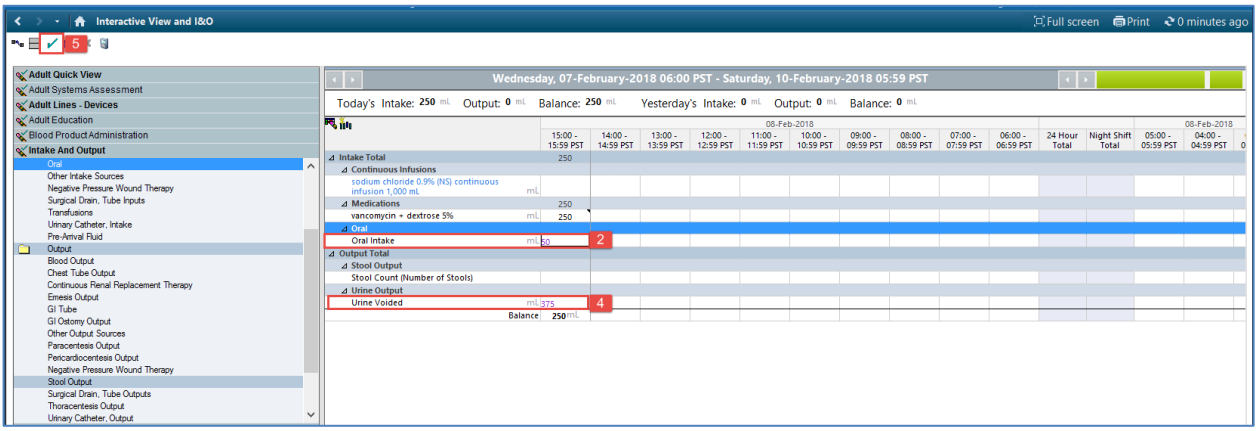
Note: a partial volume will display if the infusion was not initiated on the hour.

2. **Medications: vancomycin**
    - Value should display as a single dose amount
    - Values will pull from Medication Administration Wizard (MAW) documentation



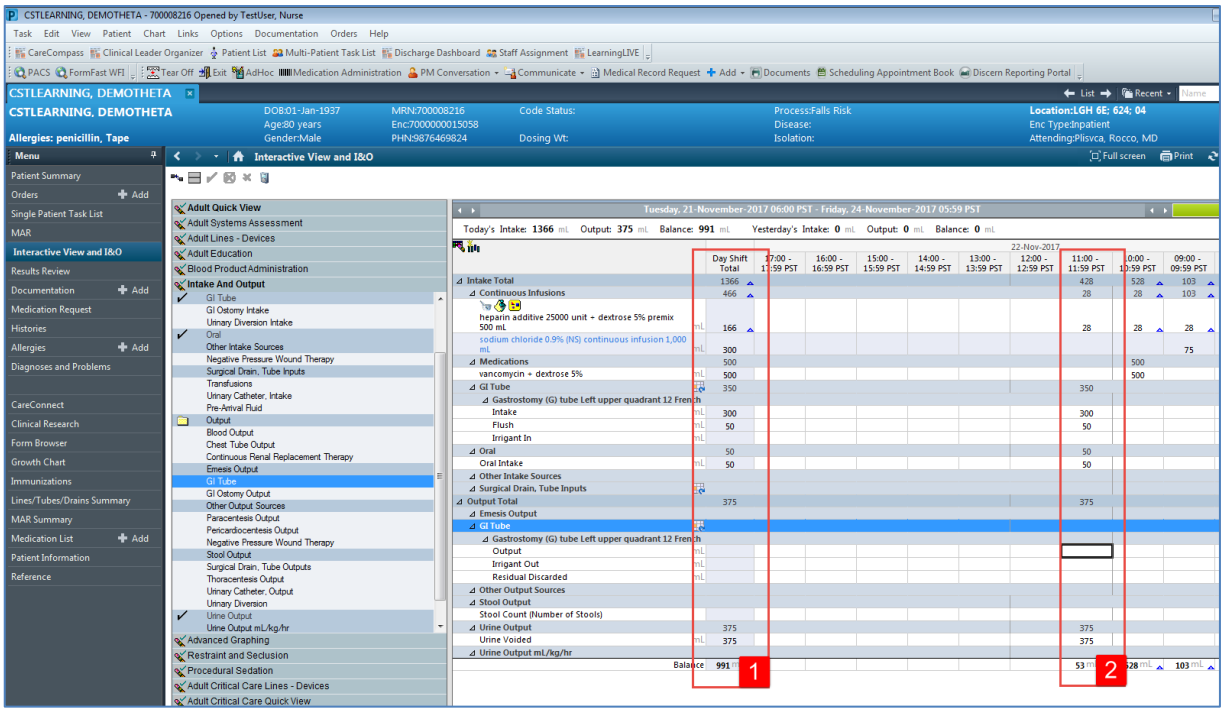
Now let's practice documenting some intake and output values. For this activity, your patient drank **50 mL** and voided **375 mL** and now you need to document these values.

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**



Now you can see fluid balances for your patient:

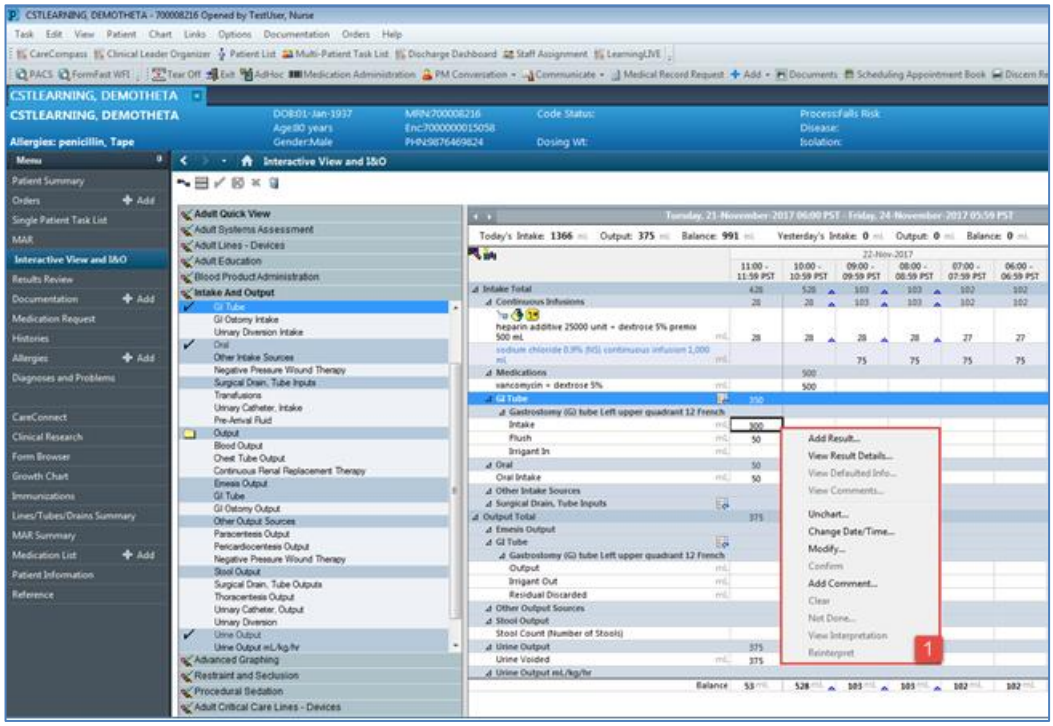
1. **12 hour Day/Night Shift Total**
2. **Hourly Total**



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

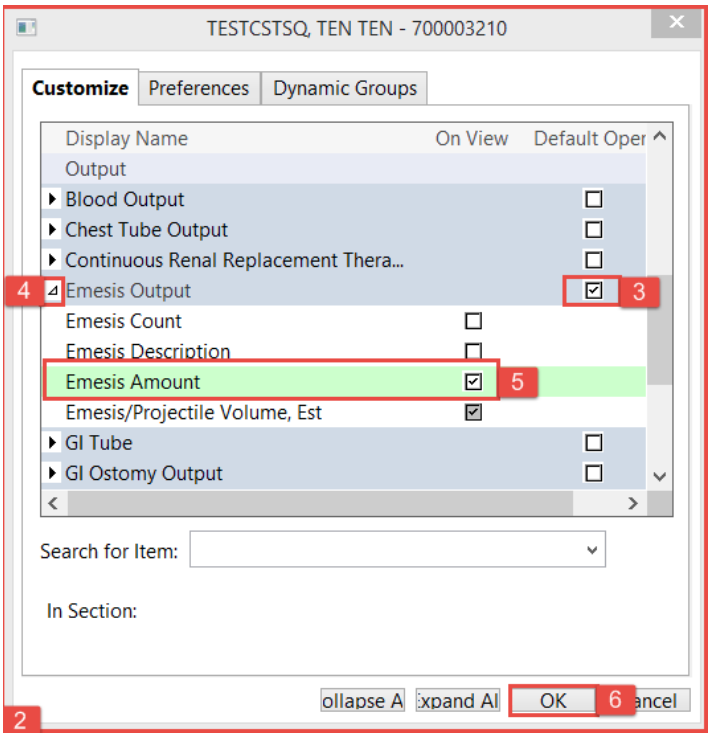
You can also unchart, modify or add a comment to any result.

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



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

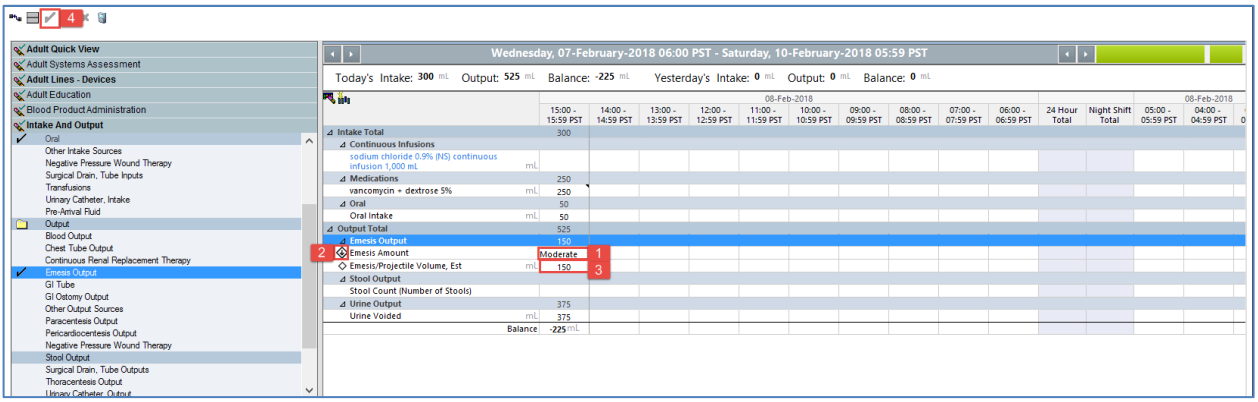
1. Click on the **customize view** icon 
2. A **Customize window** will open, listing all available sections that can be manually added
3. Scroll down to the **Emesis Output** section and click the box ☑ under the **Default Open** column
4. Open the **Emesis Output** section by clicking the arrow ▸ to 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  .



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

1. Notice the downward arrow icon next to **Emesis Amount**, this means there are conditional cells that display if **Emesis Amount** is documented on. In this case, **Emesis/Projectile Volume, Estimated** is the conditional field that is now available to document on.
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.



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.

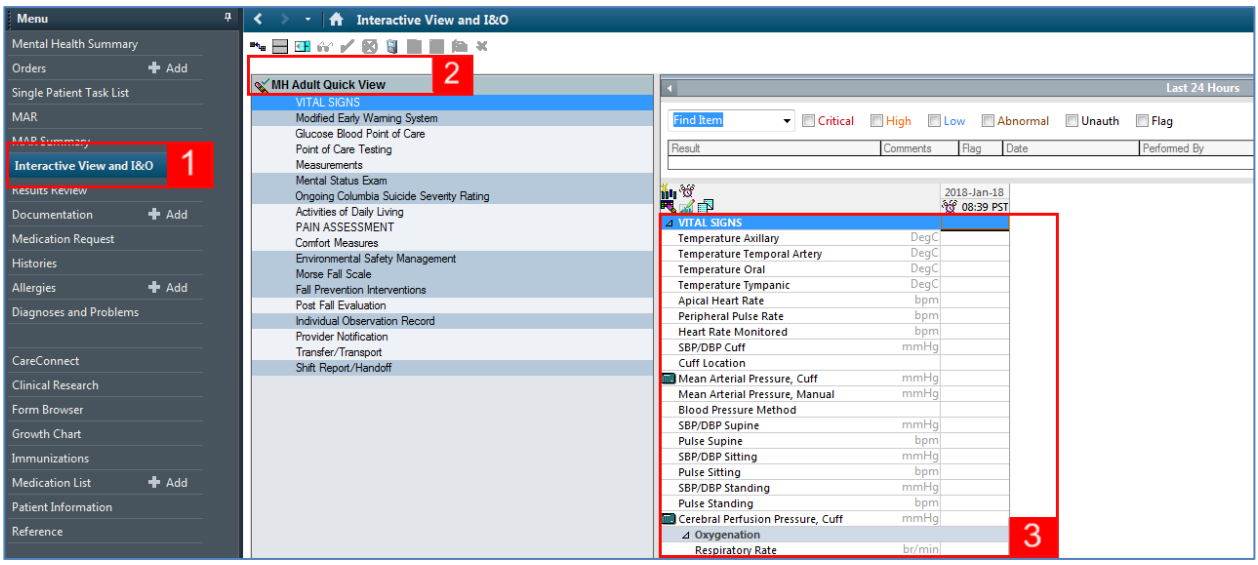
MEWS is scored based on **5 key assessment parameters**: systolic blood pressure, heart rate, respiratory rate, temperature, and level of consciousness. A score is then totaled based on the values documented. If the score is out of normal or expected range, or if new documentation for situational awareness 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:

- 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

1 You will navigate to and review MEWS documentation.

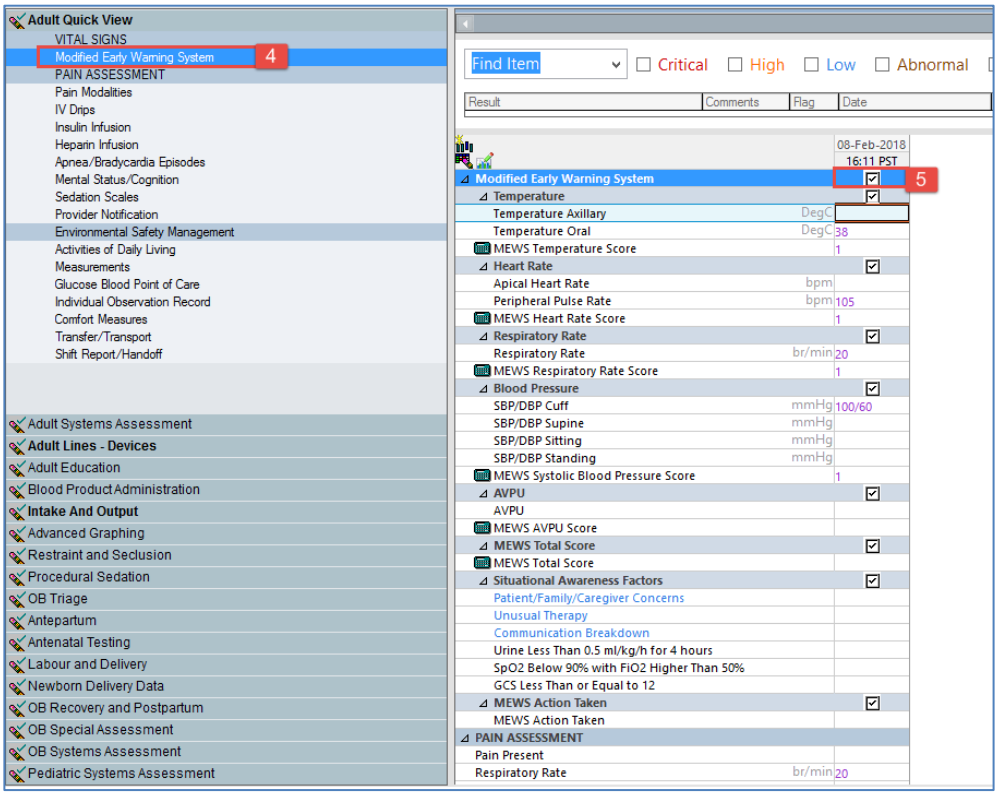
1. Select **Interactive View and I&O** from the menu
2. Click on the **Adult Quick View** Band
3. Document the following vital signs in the **VITAL SIGNS** section
    - **Temperature Oral** = *38*
    - **Peripheral Pulse Rate** = *105*
    - **SBP/DBP** = *100/60*
    - **Respiratory Rate** = *20*



4. Select the **Modified Early Warning System** section

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

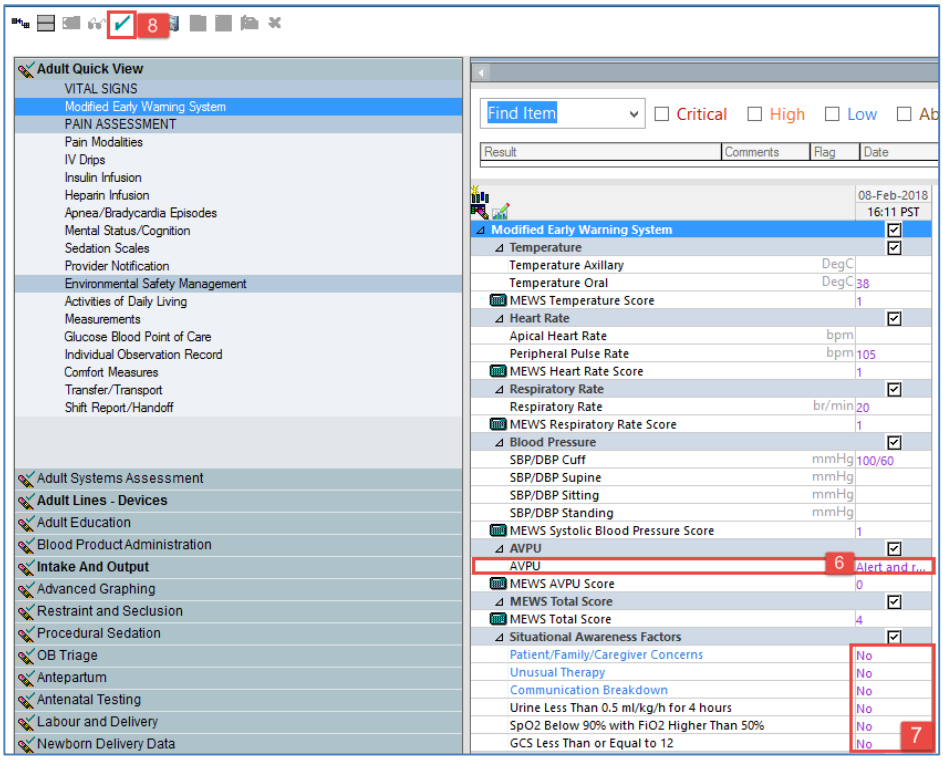
5. **Double-click** the blue band to the right of the **Modified Early Warning System** section, under the current time column**.** A check mark will display, indicating the whole section is activated and the MEWS scores will be automatically calculated



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.

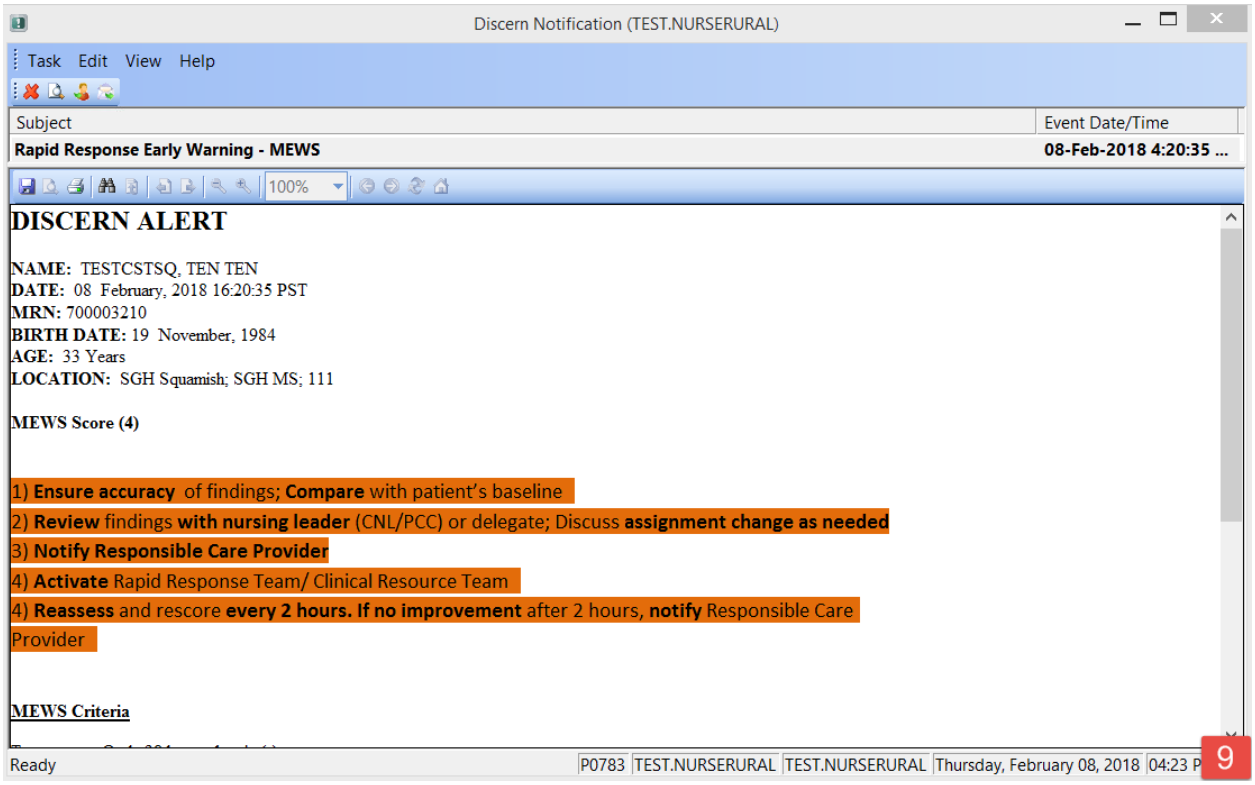
Note: The purpose of this section of documentation is to gather more information related to how the patient is doing, which provides context for those who see the MEWS alert.

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**.



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

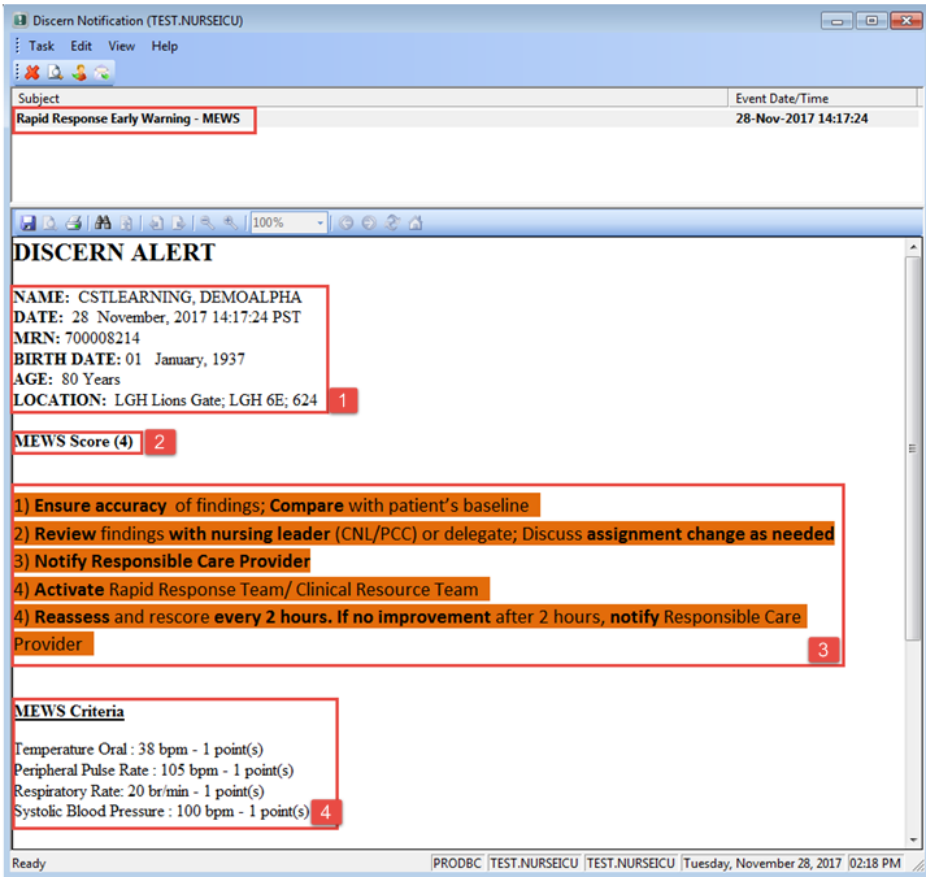
The MEWS alert appears when a MEWS score is calculated to be out of normal range for the patient. The alert itself provides the following information: patient demographics, the MEWS score, clinical decision support, and the score criteria.

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**



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.

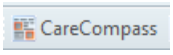
Key Learning Points

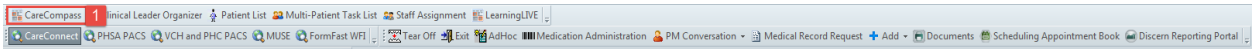
- MEWS alerts display patient information, MEWS score, and score criteria
- All nurses who have established a relationship with the patient in the CIS will receive the MEWS alert
- The clinical decision making support in the MEWS alert helps guide nurses in taking the appropriate next steps in caring for the patient

Activity 13.3 – Document Provider Notification

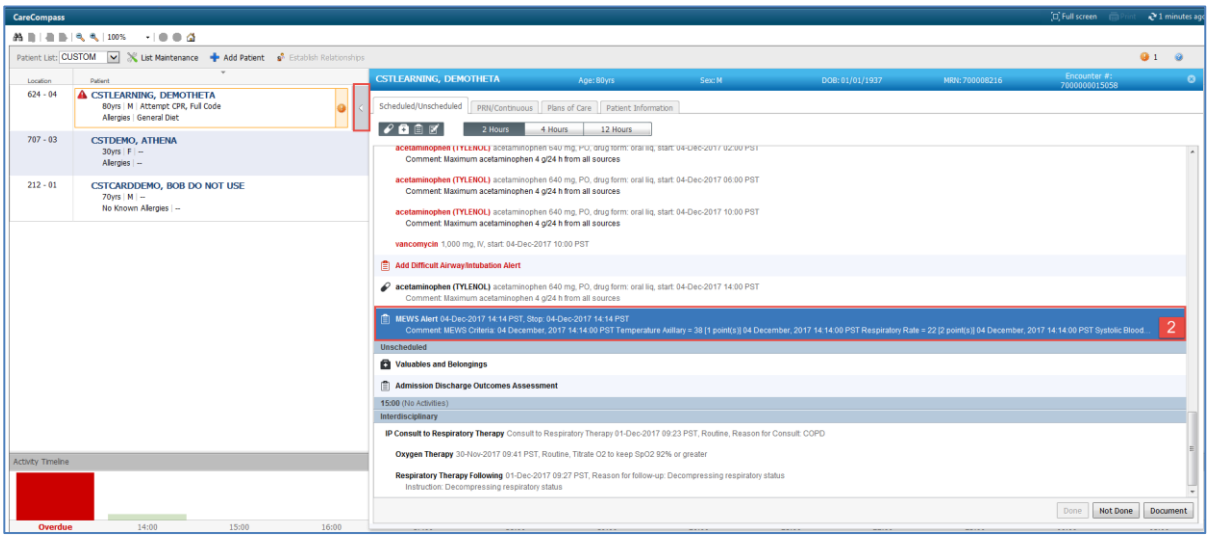
Once you receive a MEWS alert, you assess the patient and decide on further actions to take. In this scenario, we will contact the most responsible provider to let them know about the MEWS alert. After you notify the provider, you need to document that you have done so.

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

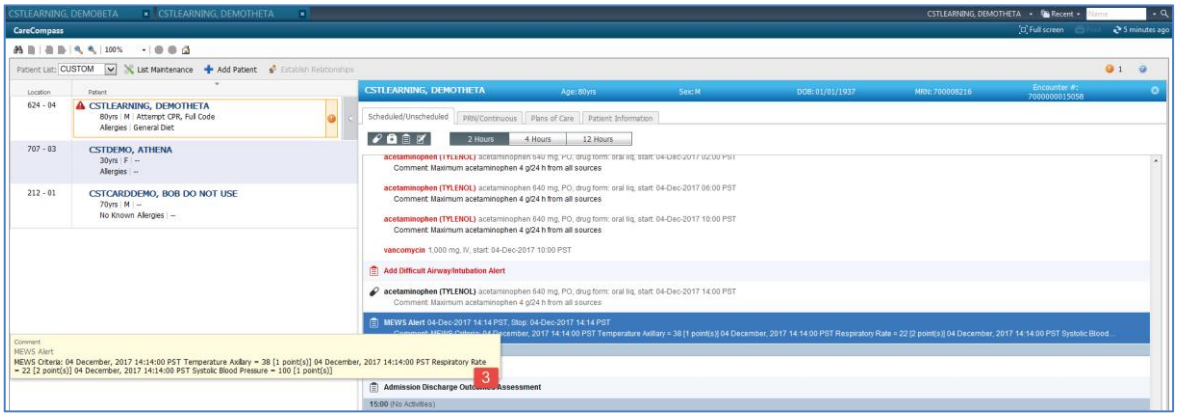
1. Navigate to CareCompass  from the Toolbar



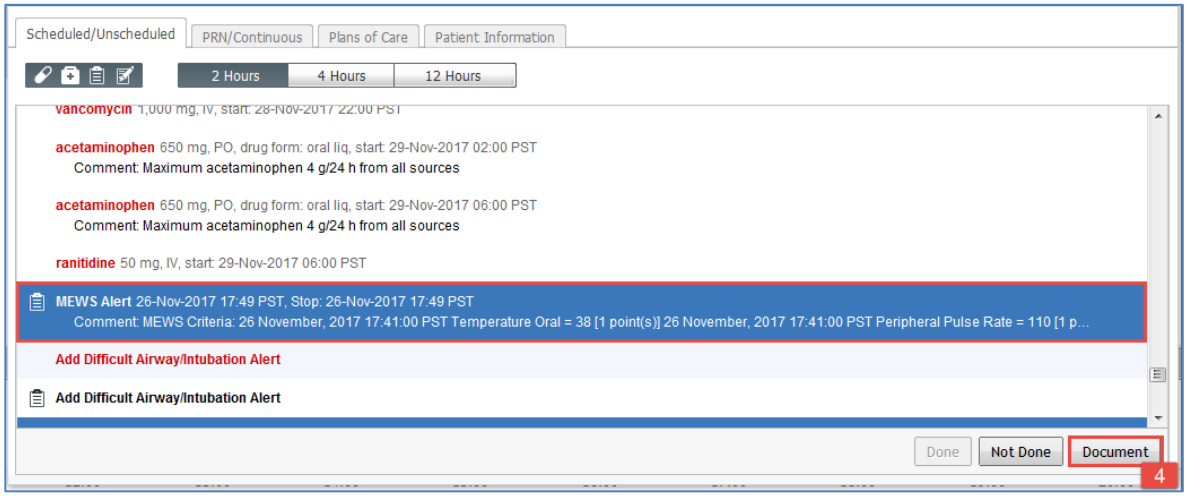
2. Locate your patient and open the task box. Note the **MEWS Alert** task.



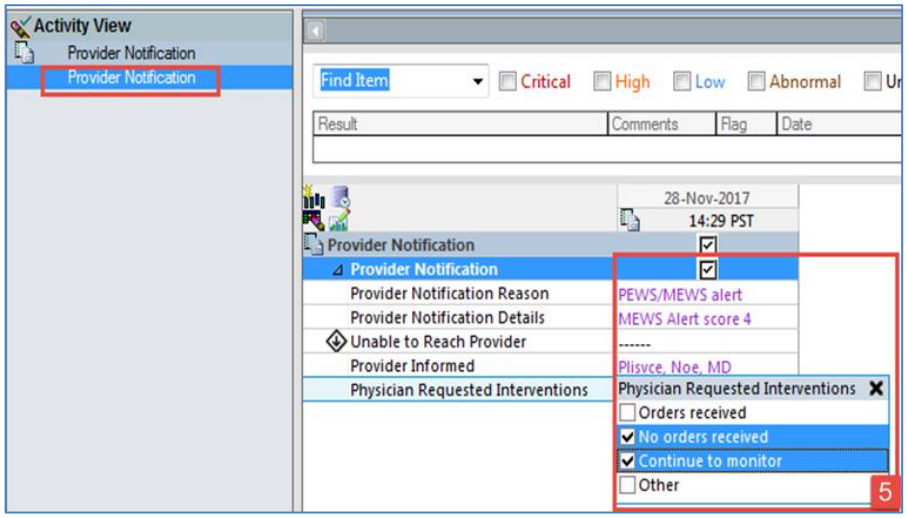
3. Hover over the task to display more information about the alert.



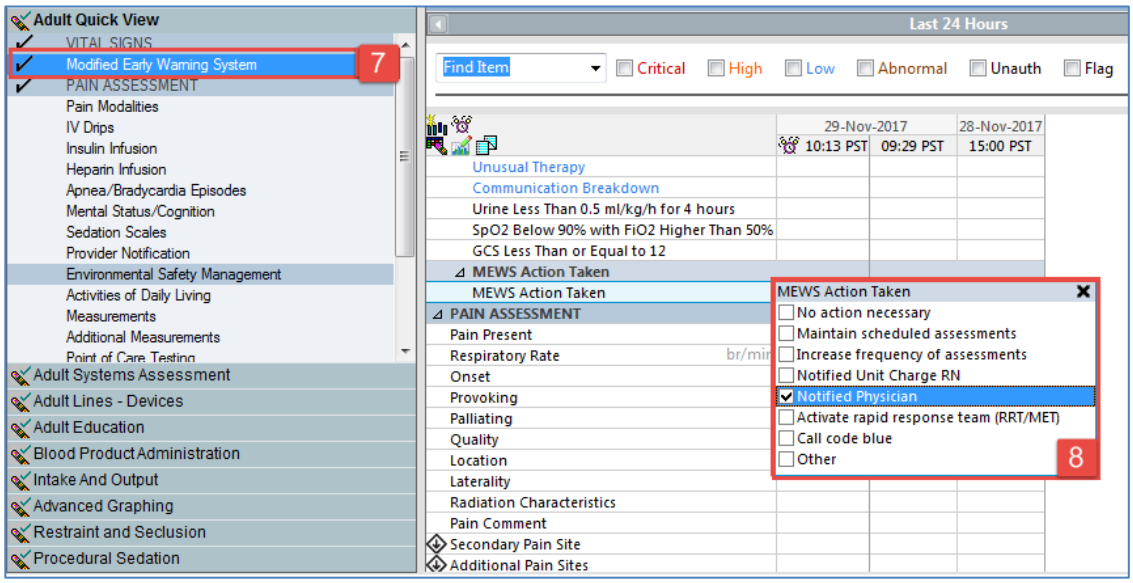
4. Click on the **MEWS Alert** task and then click **Document**. You will automatically be taken to the Provider Notification section for documentation.



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*



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.**



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

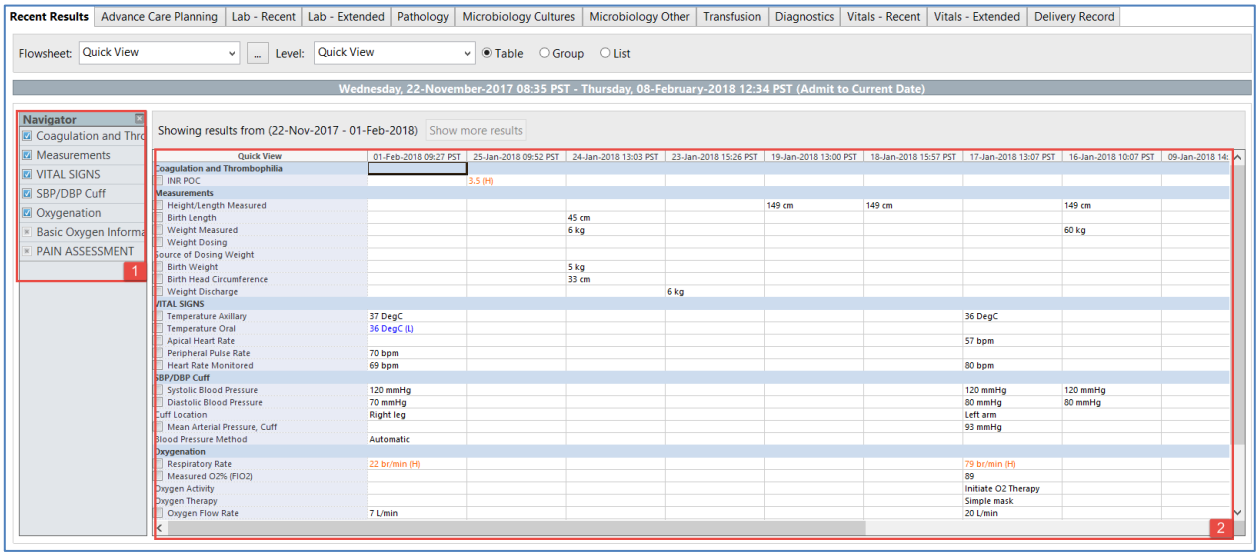
Activity 14.1 – Review Results Using Results Review

1 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**.

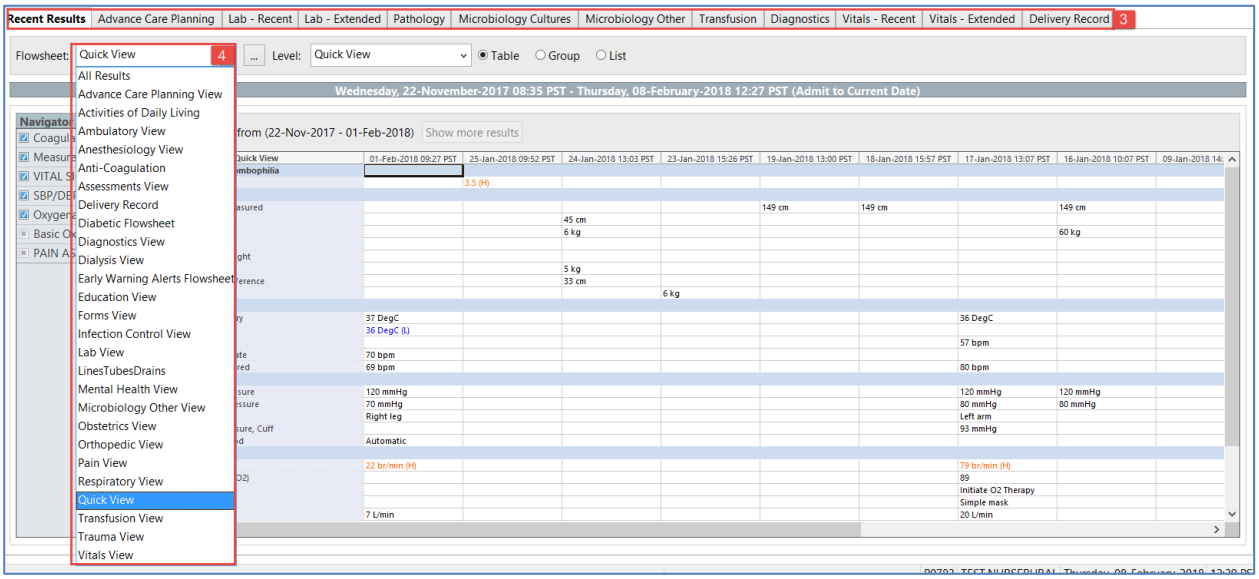
Results are presented using **flowsheets**. Flowsheets display clinical information recorded for a patient including lab results, iView entries (e.g. vital signs), cultures, transfusions and diagnostic imaging.

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**.

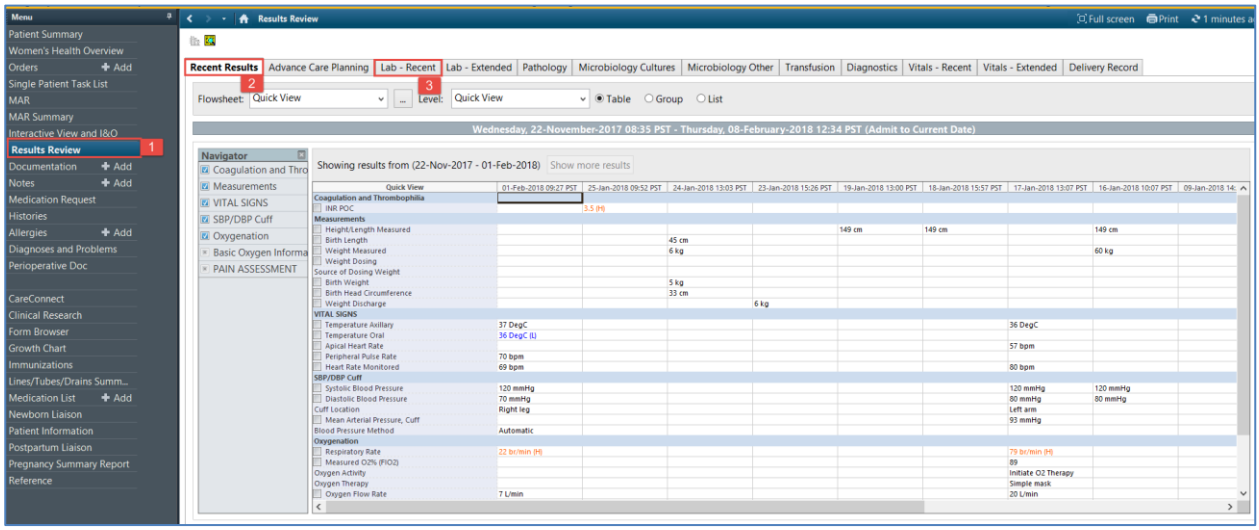


3. Notice the different category tabs across the top of the resulst review page. You can select any of these tabs to see results for that category.
4. Also notice selection of items in the Flowsheet drop down menu. You can select any of these Flowsheets to see related results.

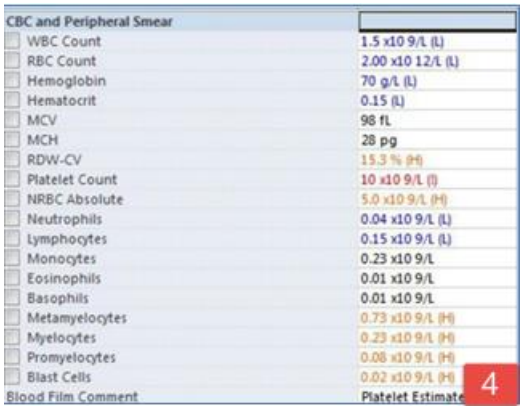


Review the most recent results for your patient:

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



4. Review your patient's recent lab results.



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

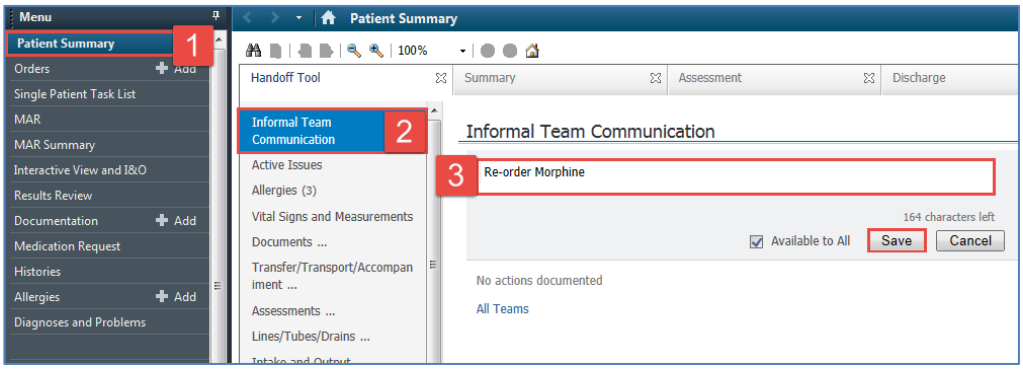
Activity 15.1 – Documenting Informal Team Communication

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 comment** section to leave a comment for the oncoming nurse or other team members.

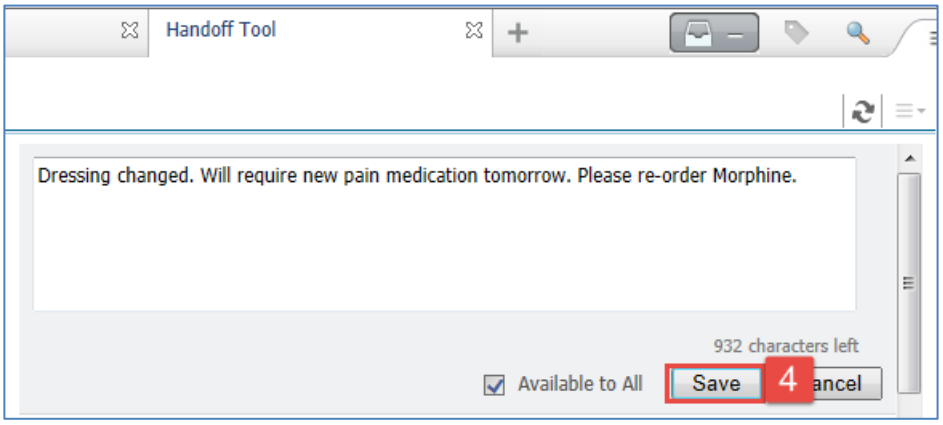
Note: Items documented within the Informal Team Communication component are **NOT** part of the patient's legal chart.

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**.



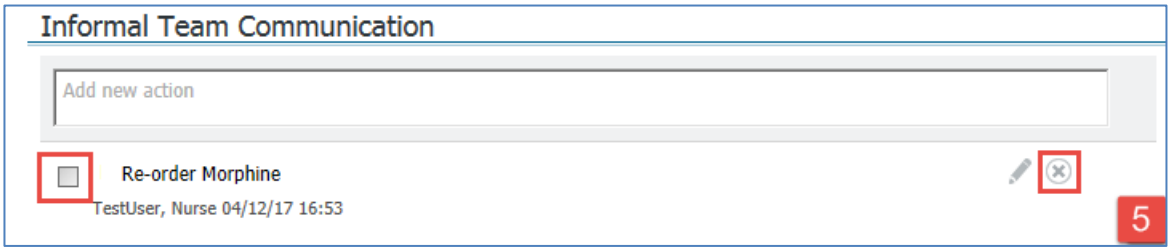
4. Under **Add new comment** type *Dressing changed. Will require new pain medication order tomorrow. Please re-order Morphine.* Click **Save**



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

To do this:

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



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

Key Learning Points

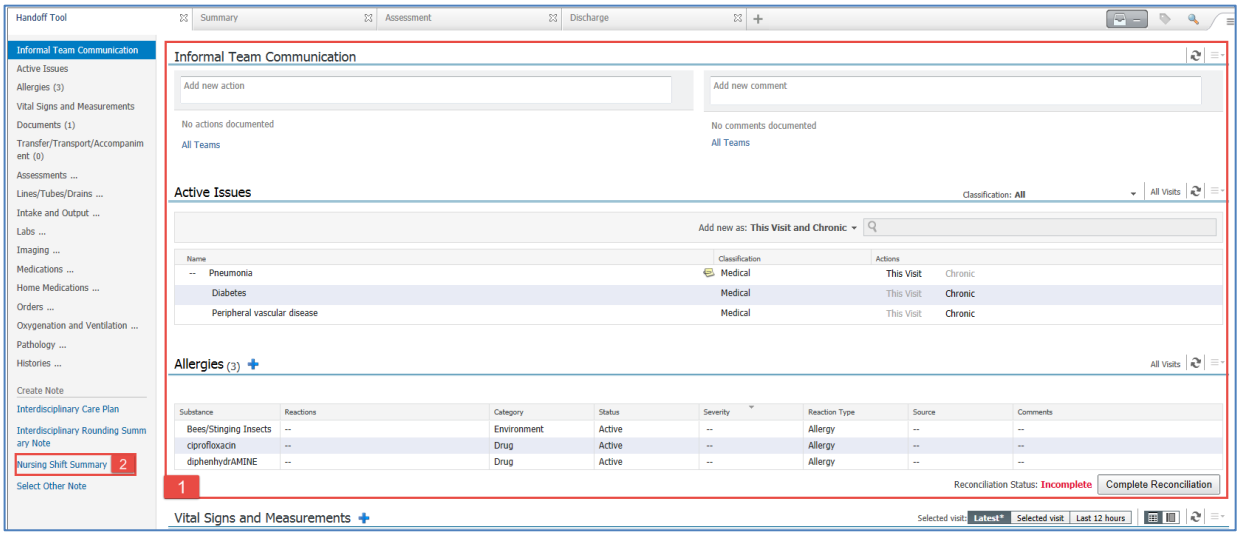
- The Informal Team Communication component is a way to leave an informal message for another clinician
- You can leave an **action item** or a **comment**
- Any Informal Team Communication message will **NOT** be considered part of the patient's legal chart

Activity 15.2 – Documenting Nursing Shift Summary

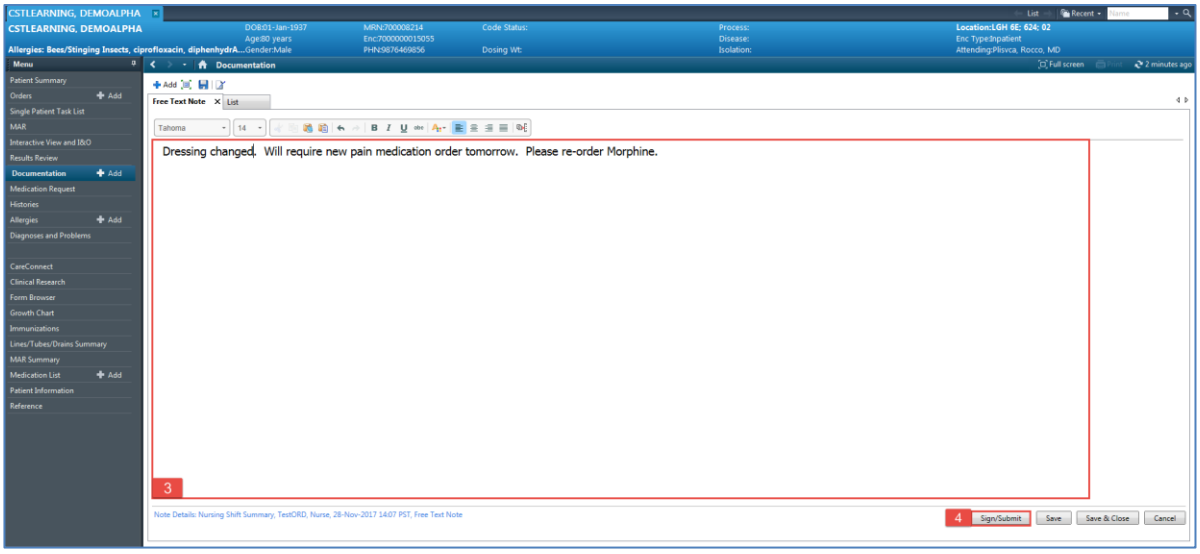
If you have completed Nursing Emergency workbook, you may skip over this activity

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.

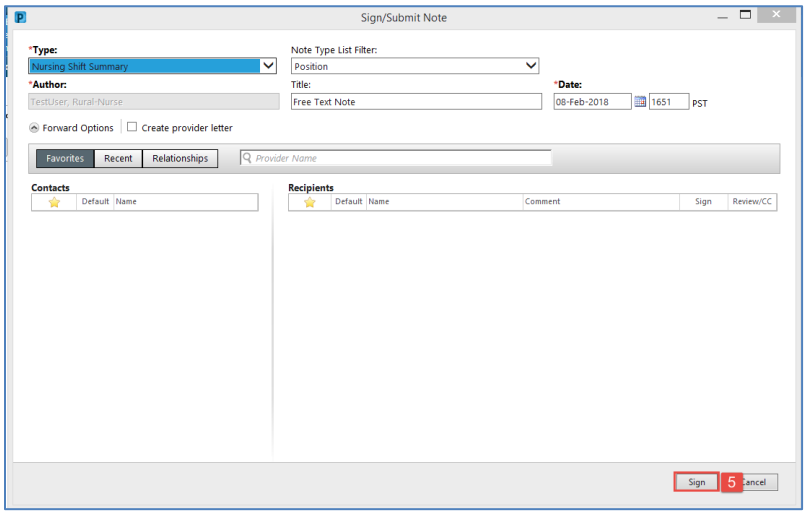
1. Review patient information in the **Handoff Tool**
2. Click on the **Nursing Shift Summary** blue link



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.

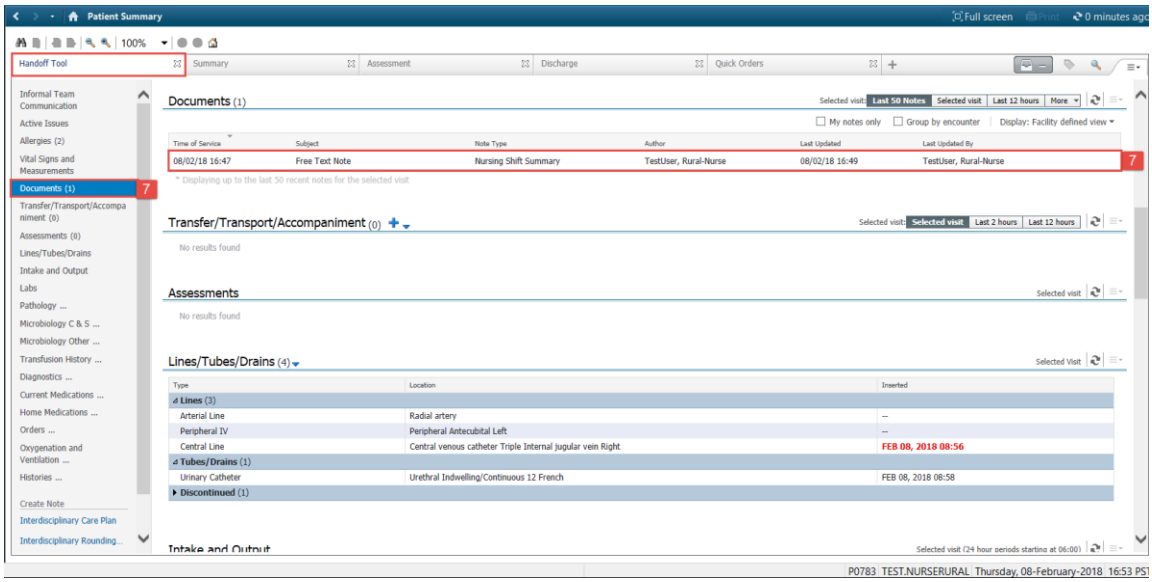


5. Click **Sign** in the Sign/Submit note window



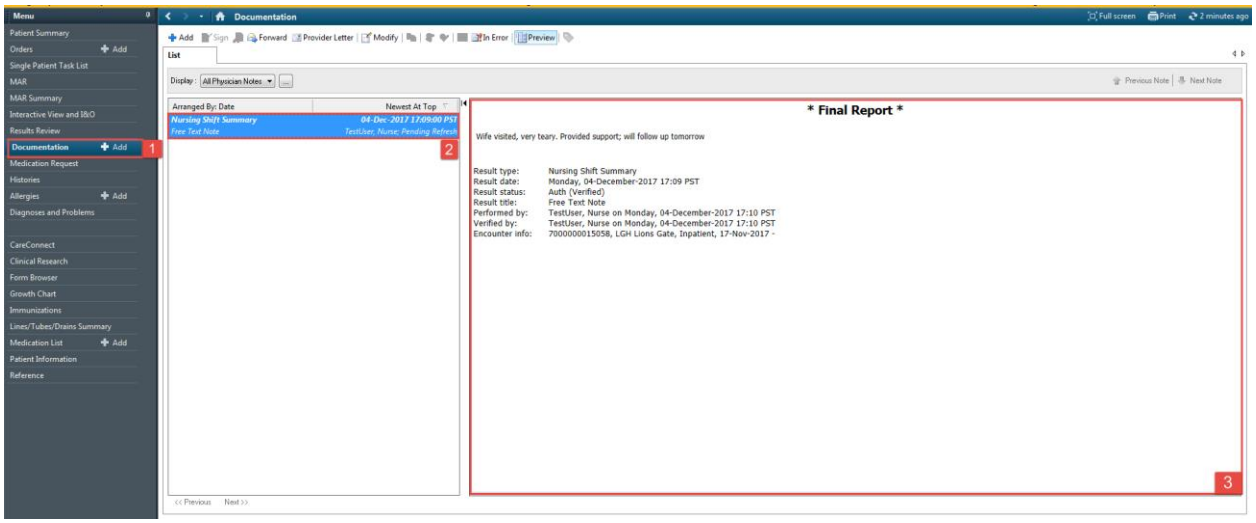
6. Click the **Refresh** icon 

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



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



Key Learning Points

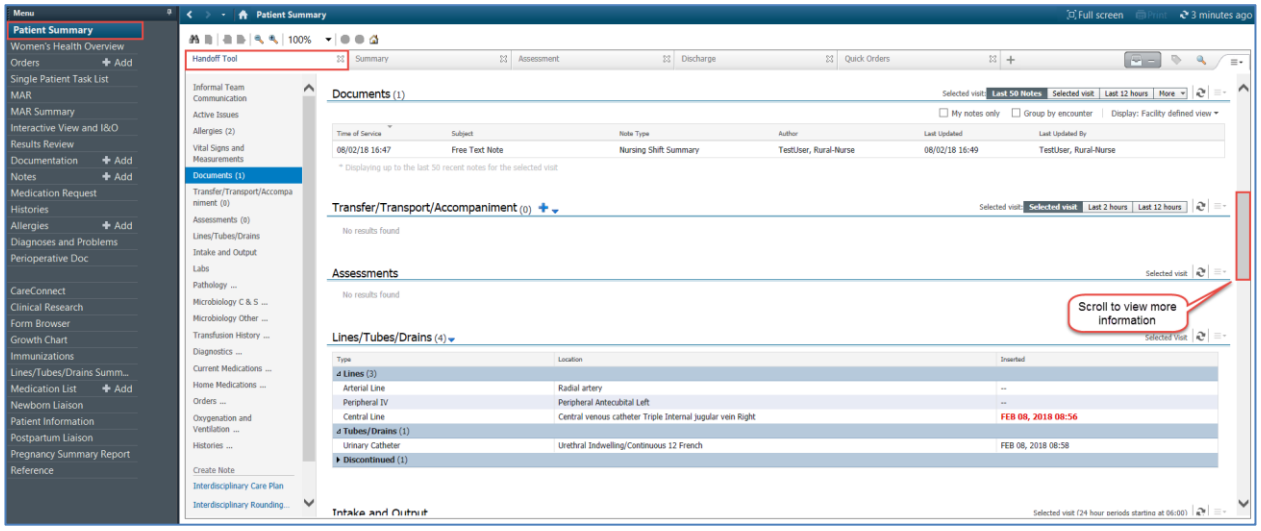
- A Nursing Shift Summary note is used to write a narrative note about what happened in a given shift for oncoming nurses
- The note must be signed in order for it to be recorded to the patient chart and viewable by other team members
- Nurses and other team members can view signed notes from the Documentation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



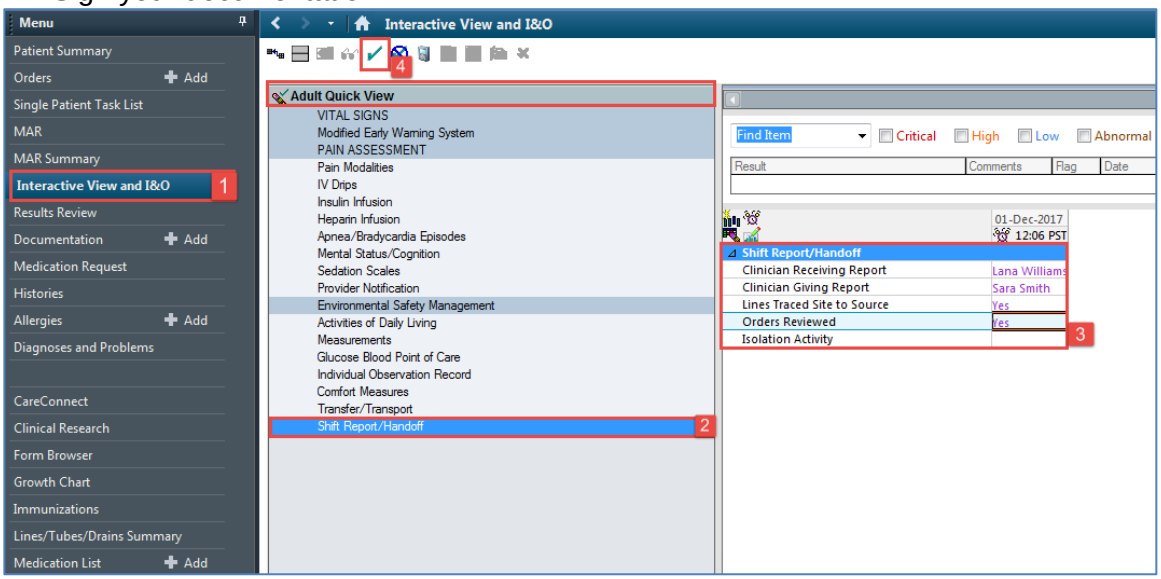
Key Learning Point

- 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



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

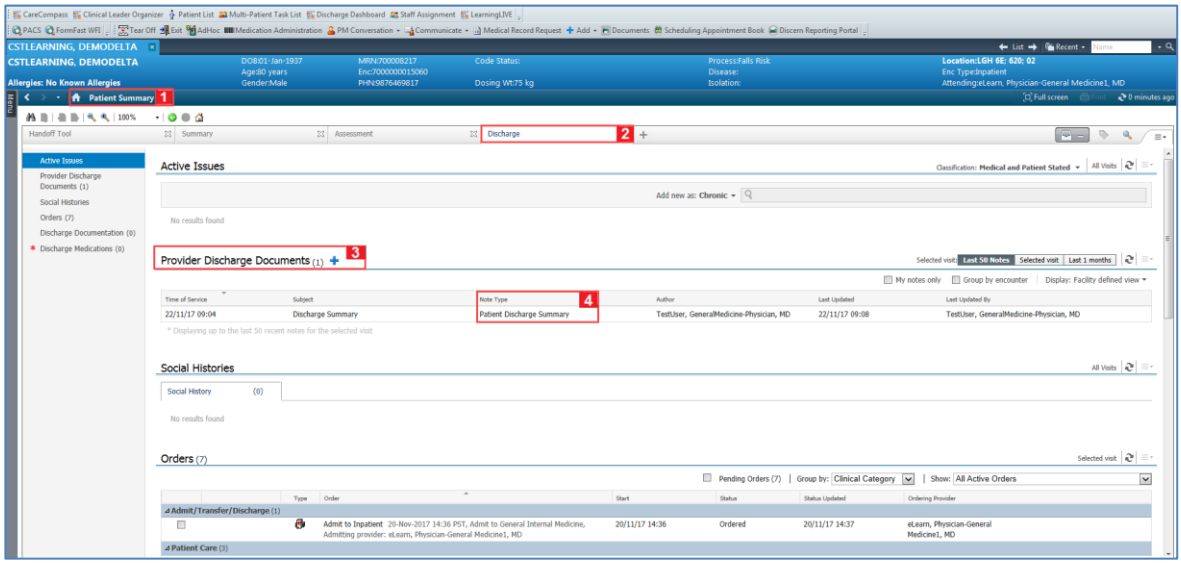
SCENARIO
In this scenario, you will be reviewing how to print a discharge summary. As a nurse, you will be completing the following activity: - Printing a patient discharge summary

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

1. Navigate to the **Patient Summary** Workflow Page from the Menu
2. Select the **Discharge** tab
3. Scroll to find the **Provider Discharge Documents** component
4. Select **Patient Discharge Summary** document. The Patient Discharge Summary appears in a window on the right side of the screen.

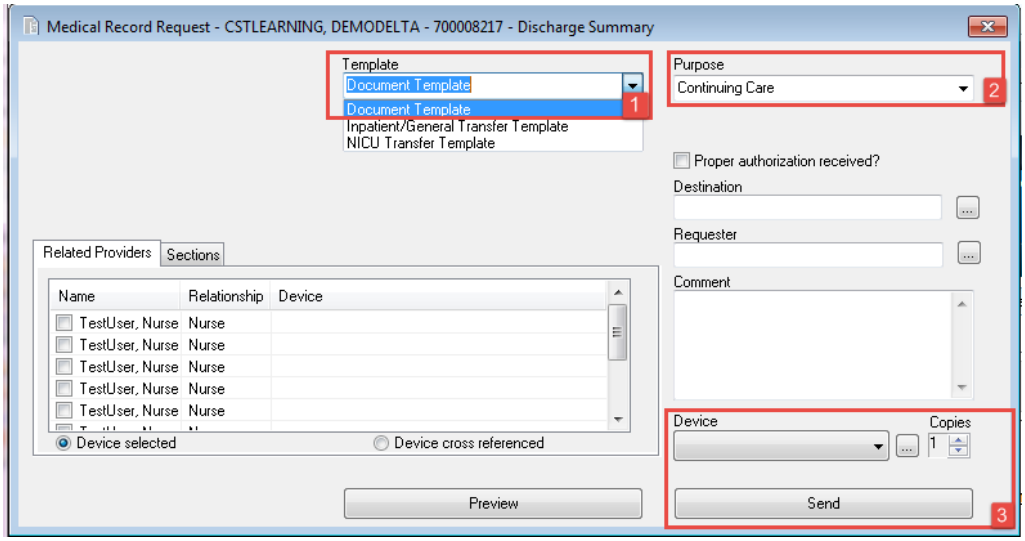


2 Navigate to the top right of the document and click **Print.**

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.**



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)

Activity 17.1 – Review Clinical Leader Organizer (CLO)

1

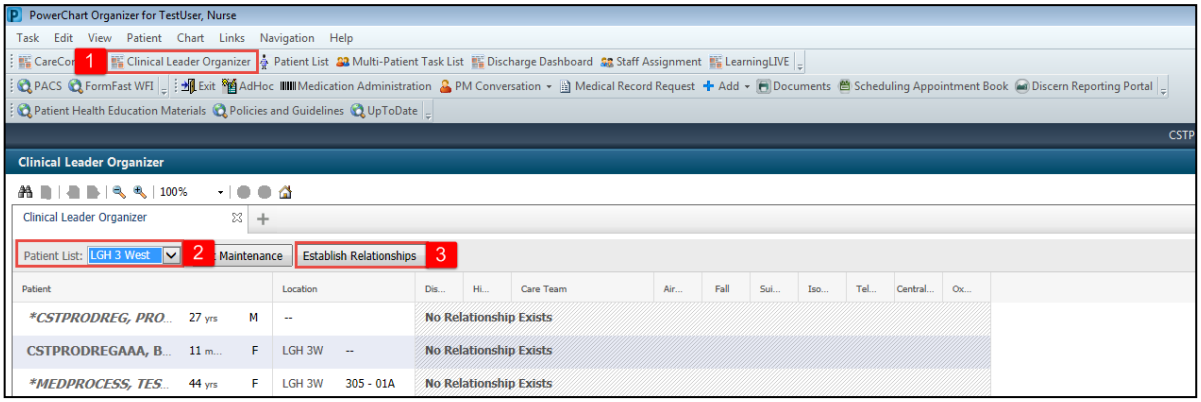
Clinical Leader Organizer (CLO) is an interactive organizer that supports communication and coordination across the continuum of care. Clinical Leader Organizer provides a high-level overview of patient data which is useful for understanding patient care goals and assists charge nurses in assigning appropriate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

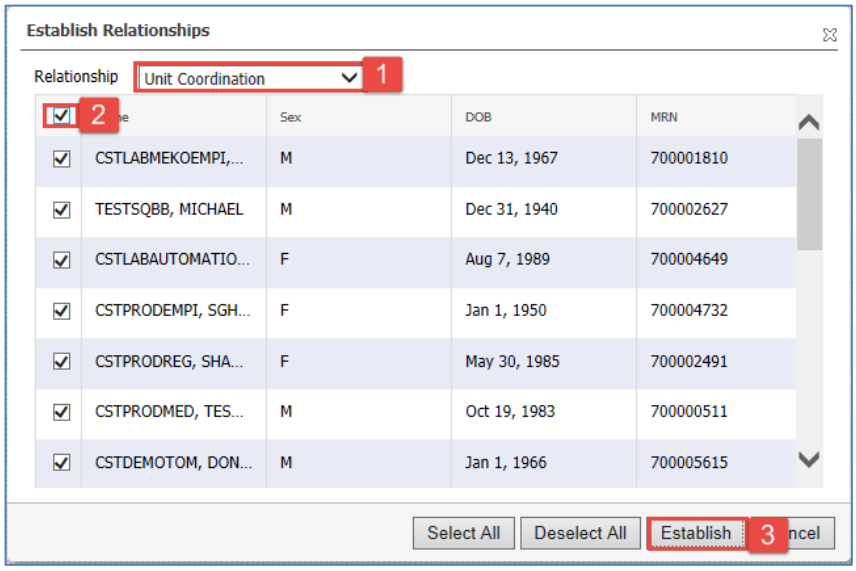
Let's review **Clinical Leader Organizer**:

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**



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

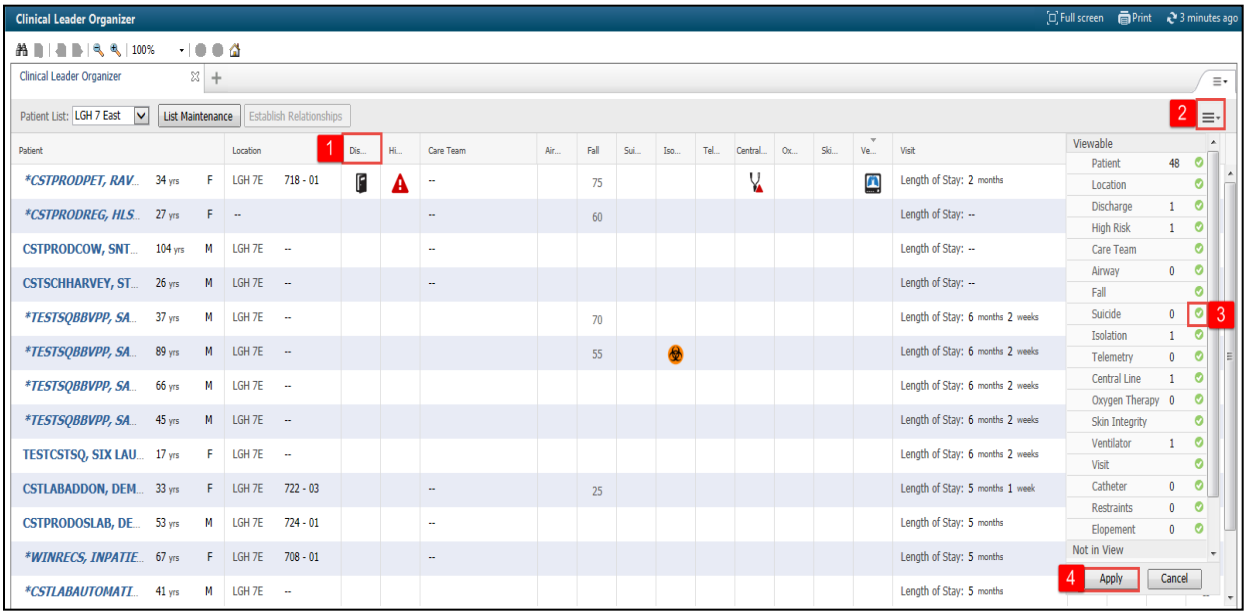
1. Select **Unit Coordination** from the **Relationship** drop-down
2. Click top checkbox to select all patients
3. Click **Establish**



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.

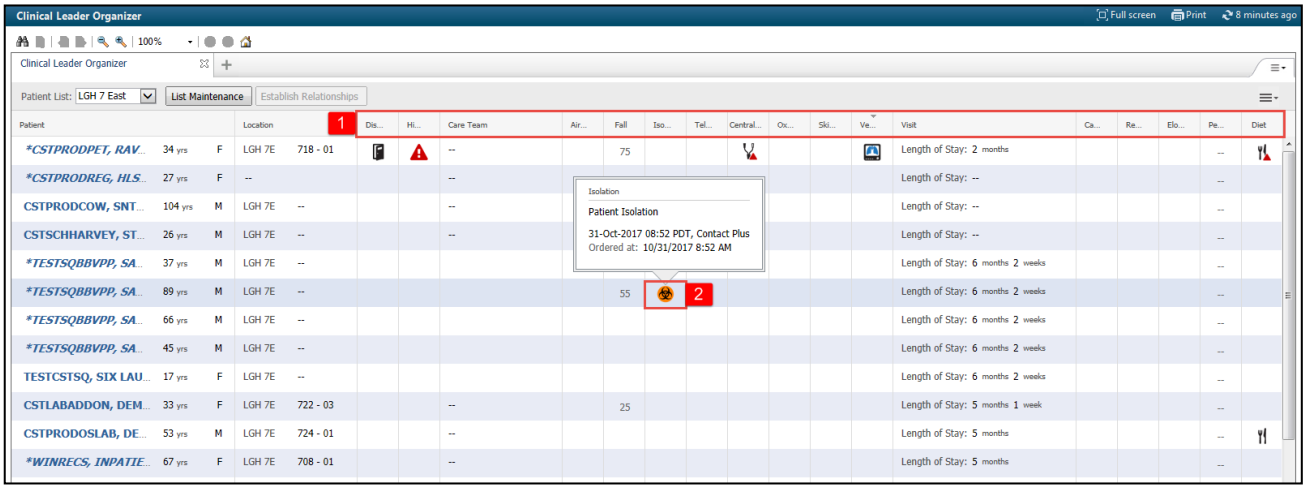
1. Hover over a column heading to see the full title of the column
2. Click the **Menu** icon
3. Click the green checkmark beside a viewable topic(s) of your choice to de-select it from the viewable columns
4. Click **Apply**

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



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



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

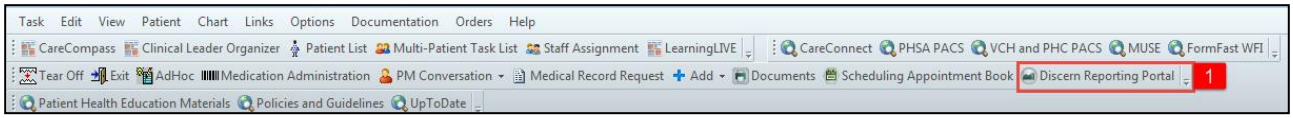
SCENARIO
As an inpatient charge nurse or nurse manager, you will be completing the following activities: ■ Run a report for your unit/organization in the CIS

Activity 18.1 – Running Reports for your Unit/Organization

1 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**.

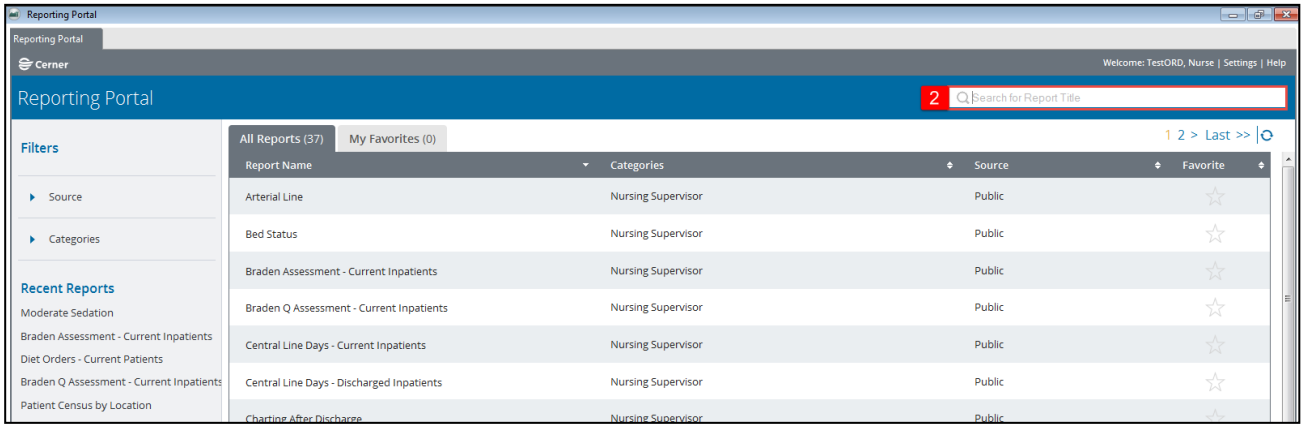
1. Navigate to **Discern Reporting** by selecting the Discern Reporting Portal button in the Toolbar to open the Reporting Portal window



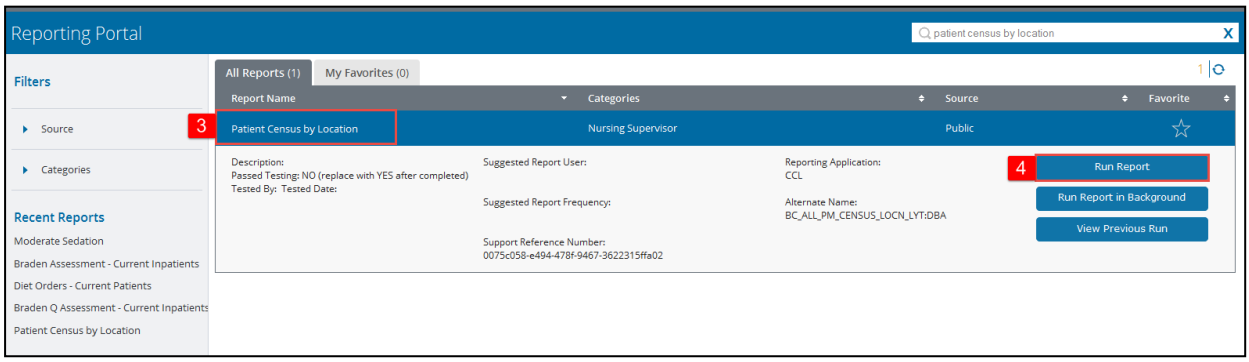
Note: It may take a moment for the Reporting Portal window to open.

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



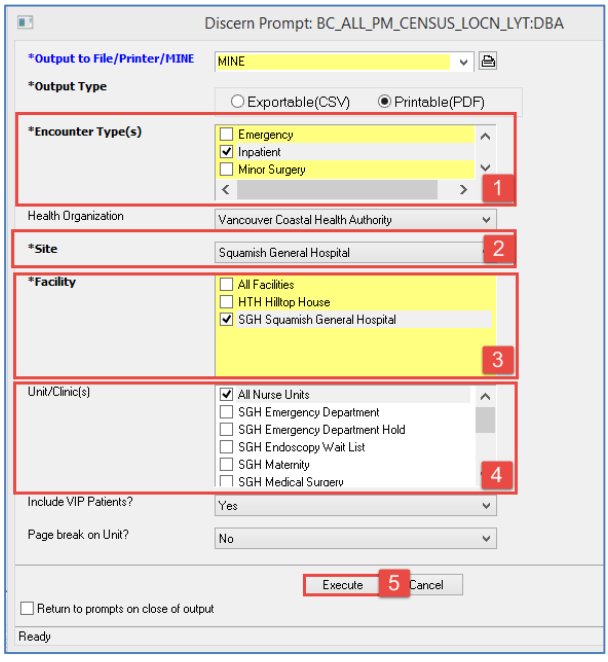
3. Click the name of the report to expand the field
4. Click **Run Report**



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

Select the following information:

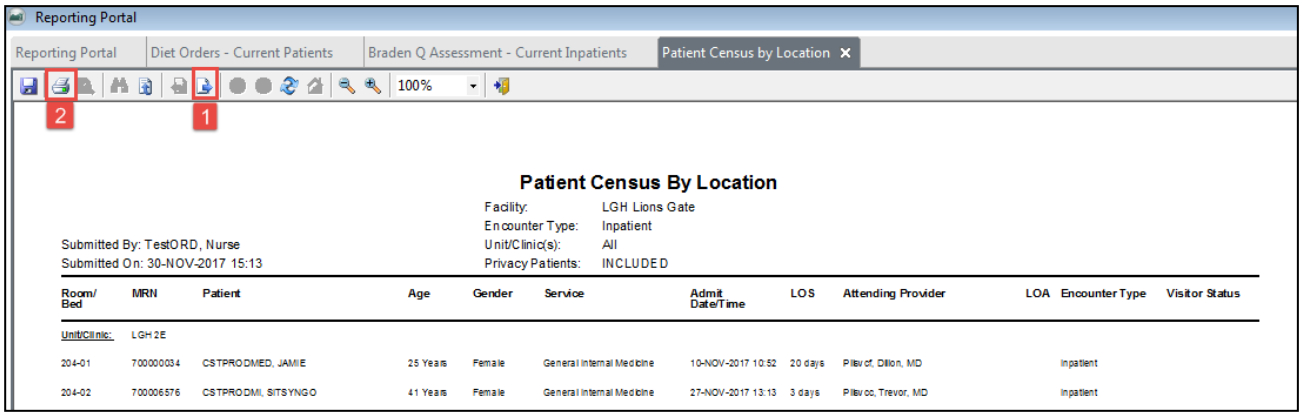
1. **Encounter Type** = *Inpatient*
2. **Site** = *Squamish General Hospital*
3. **Facility** = *SGH Squamish General Hospital*
4. **Unit/Clinic(s)** = *All Nurse Units*
5. Click **Execute**



The **Patient Census by Location** report will now display.

3 Review the Report.

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.



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.