

SELF-GUIDED PRACTICE WORKBOOK [N63]
CST Transformational Learning

WORKBOOK TITLE:

Nursing: Rural (Squamish)- Inpatient



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SELF-GUIDED PRACTICE WORKBOOK

Duration	8 hours
Before getting started	<ul style="list-style-type: none"> ■ Sign the attendance roster (this will ensure you get paid to attend the session). ■ Put your cell phones on silent mode
Session Expectations	<ul style="list-style-type: none"> ■ This is a self-paced learning session. ■ A 15 min break time will be provided. You can take this break at any time during the session. ■ The workbook provides a compilation of different scenarios that are applicable to your work setting. ■ Work through the activities at your own pace
Key Learning Review	<ul style="list-style-type: none"> ■ At the end of the session, you will be required to complete a Key Learning Review ■ This will involve completion of 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).

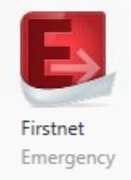


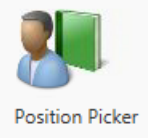
In this scenario, you will complete the following activities:

-  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
	Emergency Department (ED)
	Inpatient units (Including adult, pediatric, and maternity units)
	Pre-op/Intra-op/PACU units
	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

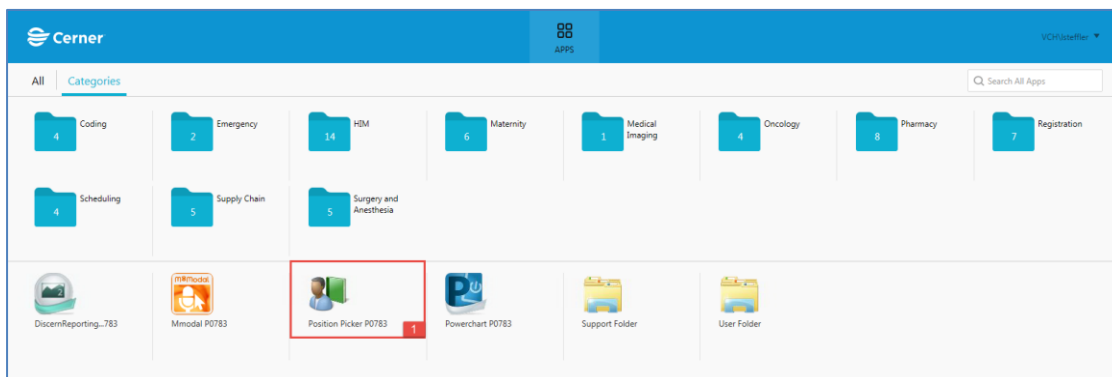
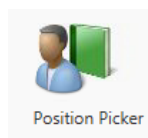
Let's say you started your day working in the Emergency Department. You logged into **Position Picker** at the start of your ED shift and selected **Emergency – Nurse** as your position. Now you are being asked to float to the *inpatient* unit to take care of a patient admitted with pneumonia.

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**:

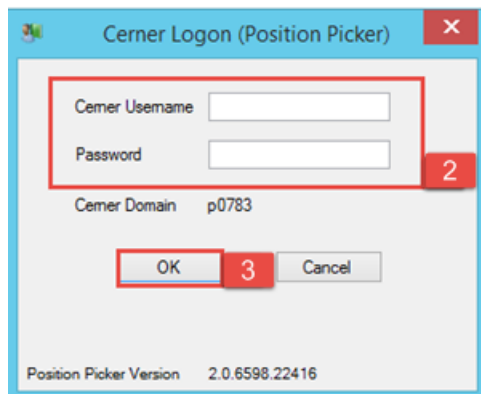
Note: The first step is to make sure you have logged *off* of any Cerner applications including FirstNet or PowerChart.

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

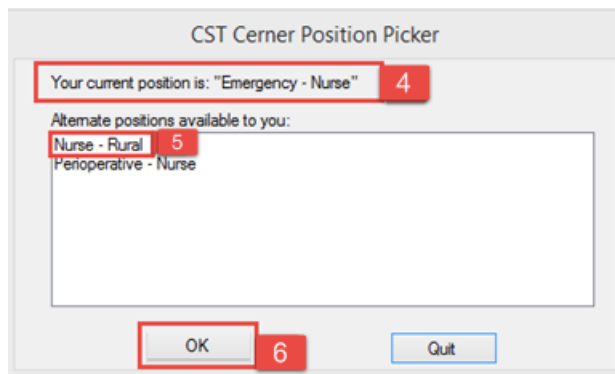


A Cerner Logon (Position Picker) window will open

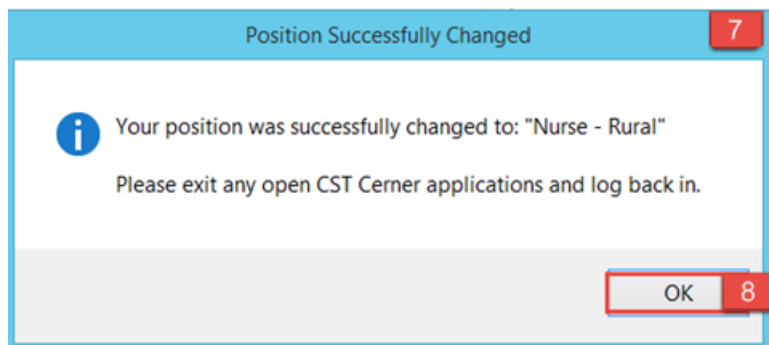
2. Type your assigned **username** and **password**
3. Click **OK**



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.

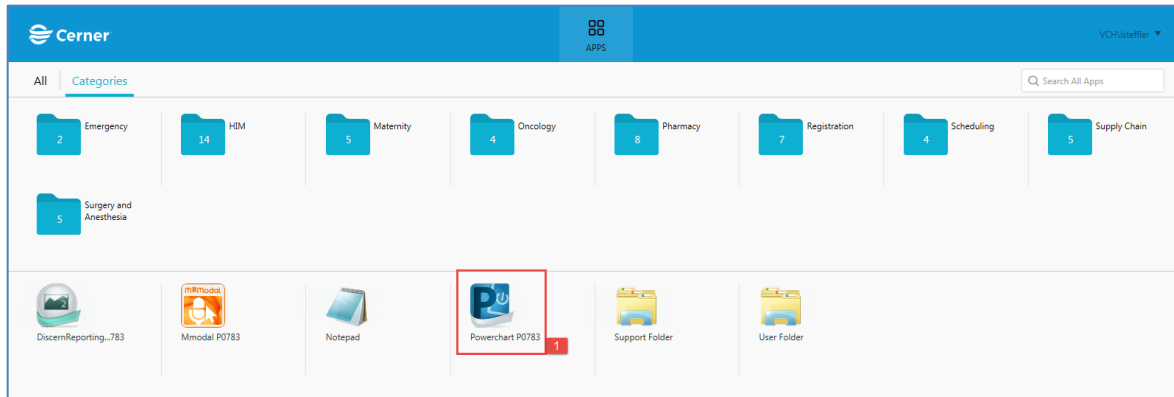
As an Inpatient Rural Nurse you will complete the following activities:

- 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

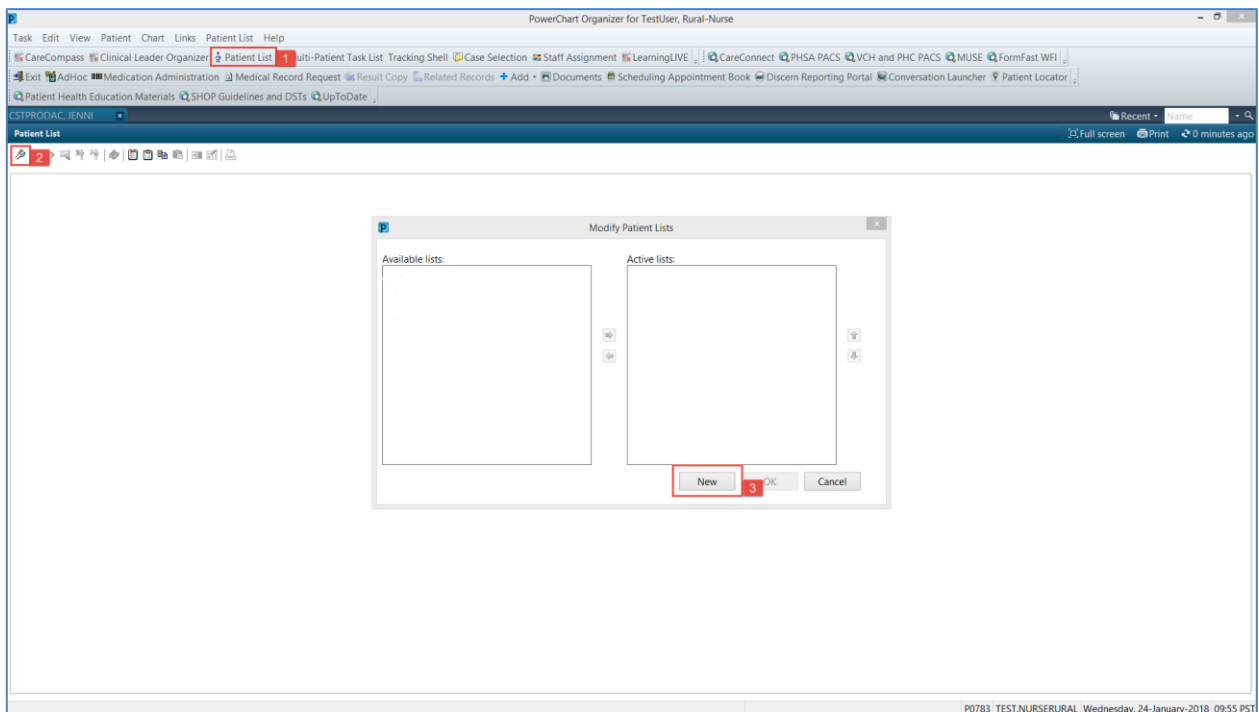
Activity 2.2 – Set Up a Location Patient List

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

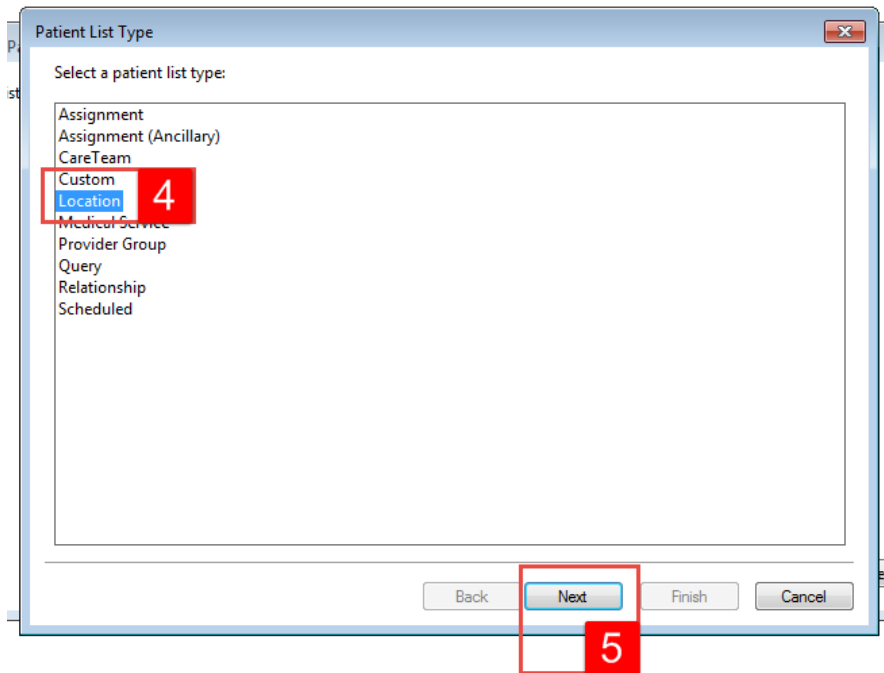
Note: if you are in a role where you are always in charge of a unit, your landing page may be the **Clinical Leader Organizer (CLO)**. This will be covered later if you are a Patient Care Coordinator, Charge Nurse or an inpatient nurse who takes on charge duties.



- 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.

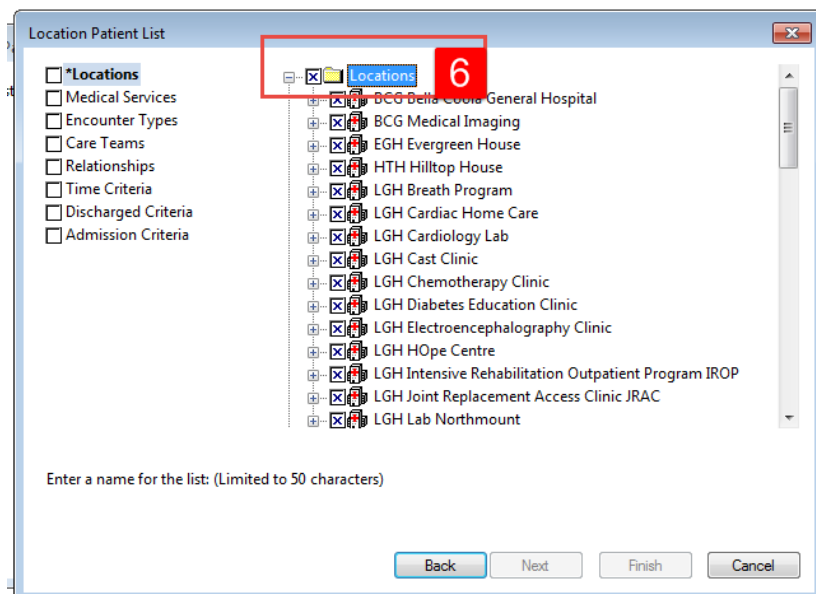
1. Select the **Patient List** icon  **Patient List** from the **Toolbar** at the top of the screen
2. The screen will be blank. To create a location list, click the **List Maintenance** icon 
3. Click the **New** button in the bottom right corner of the **Modify Patient Lists** window








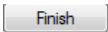
4. From the **Patient List Type** window select **Location**
5. Click the **Next** button in the bottom right corner

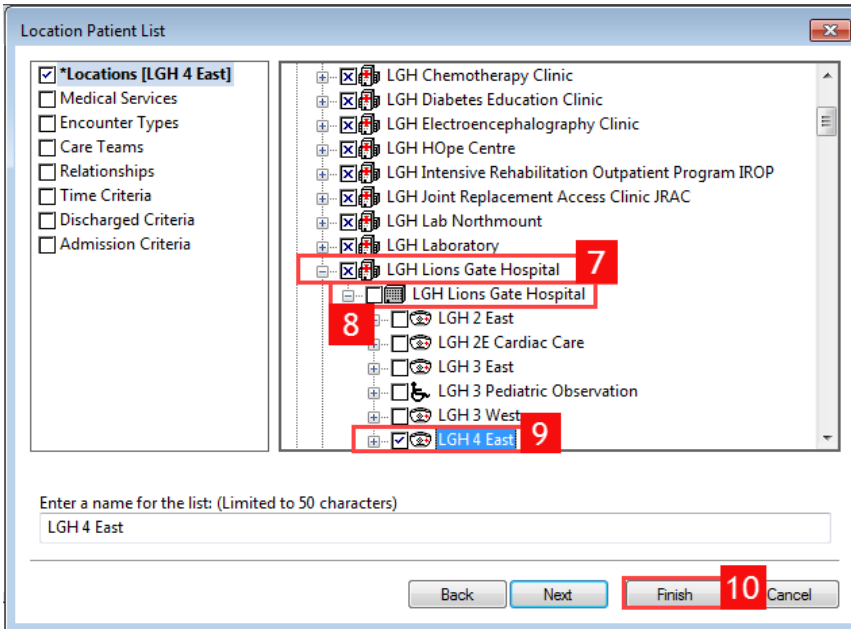


6. In the **Location Patient List** window, open the **Locations** folder by clicking the **Plus Sign**   **Locations**. A location tree will be displayed.



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

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





Location Patient List

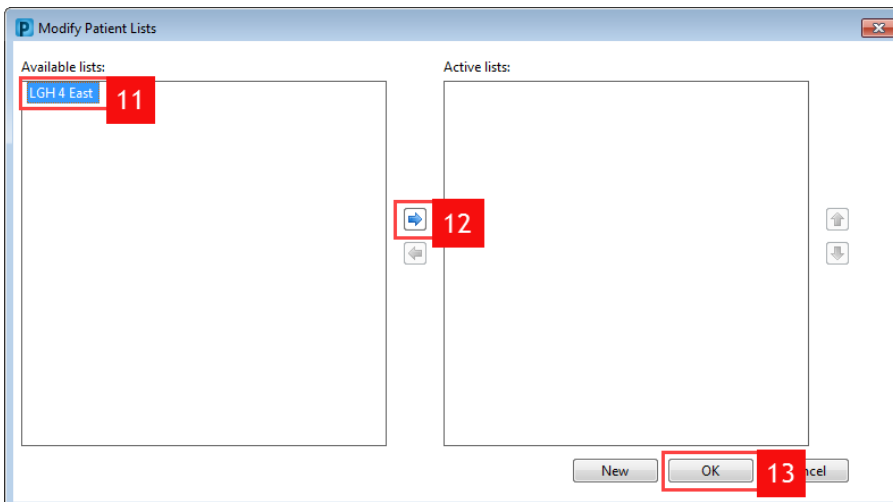
☒ *Locations [LGH 4 East]
☐ Medical Services
☐ Encounter Types
☐ Care Teams
☐ Relationships
☐ Time Criteria
☐ Discharged Criteria
☐ Admission Criteria

LGH Chemotherapy Clinic
LGH Diabetes Education Clinic
LGH Electroencephalography Clinic
LGH Hope Centre
LGH Intensive Rehabilitation Outpatient Program IROP
LGH Joint Replacement Access Clinic JRAC
LGH Lab Northmount
LGH Laboratory
LGH Lions Gate Hospital
LGH Lions Gate Hospital
LGH 2 East
LGH 2E Cardiac Care
LGH 3 East
LGH 3 Pediatric Observation
LGH 3 West
LGH 4 East

Enter a name for the list: (Limited to 50 characters)
LGH 4 East

Back Next Finish Cancel

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.
















Modify Patient Lists

Available lists:
LGH 4 East

Active lists:




New OK Cancel

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

Patient List										
      										
LGH 4 East										
All Patients - LGH 2 East										
VIP	Seq	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
		CSTPRODME, 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
		CSTDAMOALEXANDER, 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-TIT, ISLA	2EL	02	LGH 2E	LGH Lions Gate	LGH Lions Gate	08-Jan-1946	72 years	Female
		CST-TIT, 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-TIT, 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
		CSTPRODME, 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, SELFPAITWO			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.

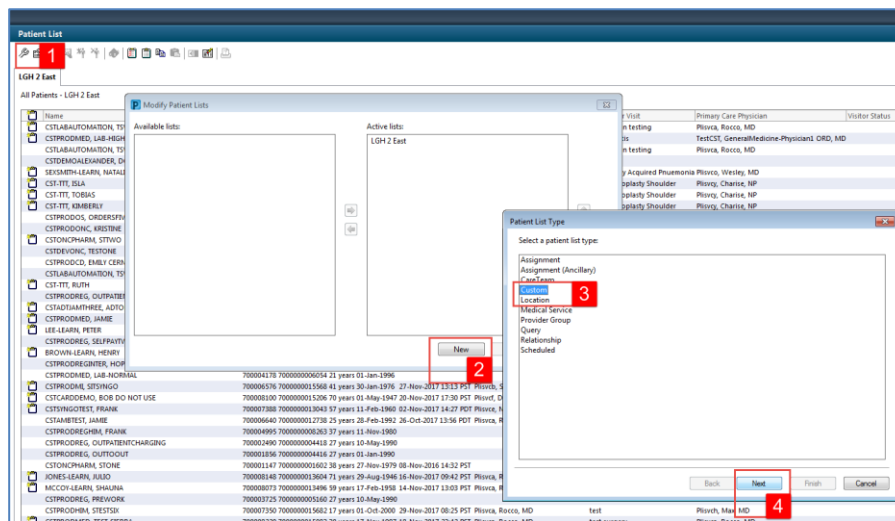
Key Learning Points

-  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

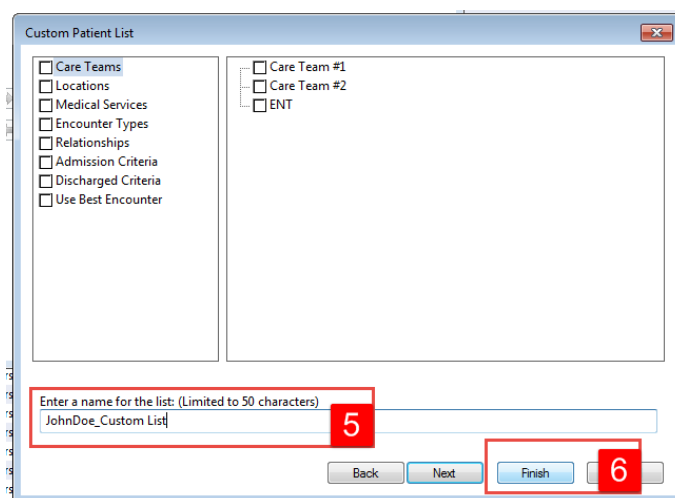
Activity 2.2 – Create a Custom Patient List


- 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.

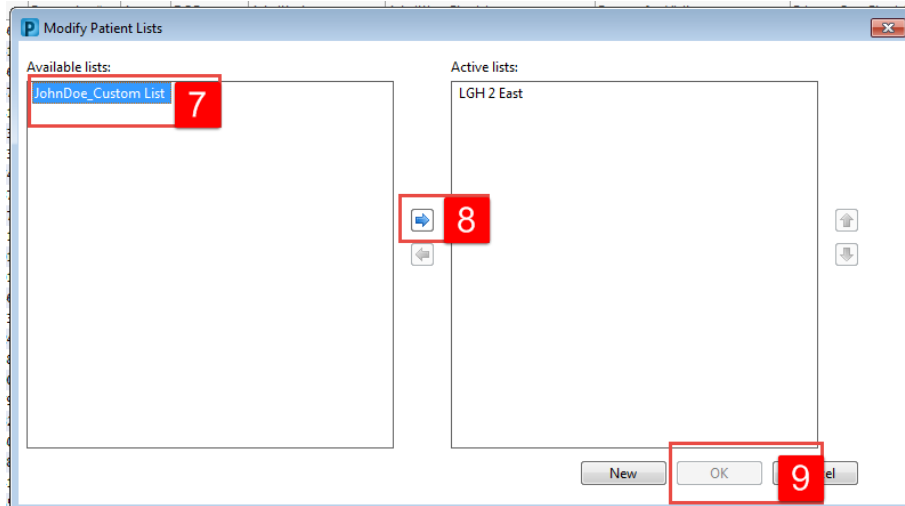
- To create a **Custom List**, click the **List Maintenance** icon .
- Click the **New** button in the bottom right corner of the **Modify Patient Lists** window
- Select **Custom** from the **Patient List Type** window
- Click the **Next** button



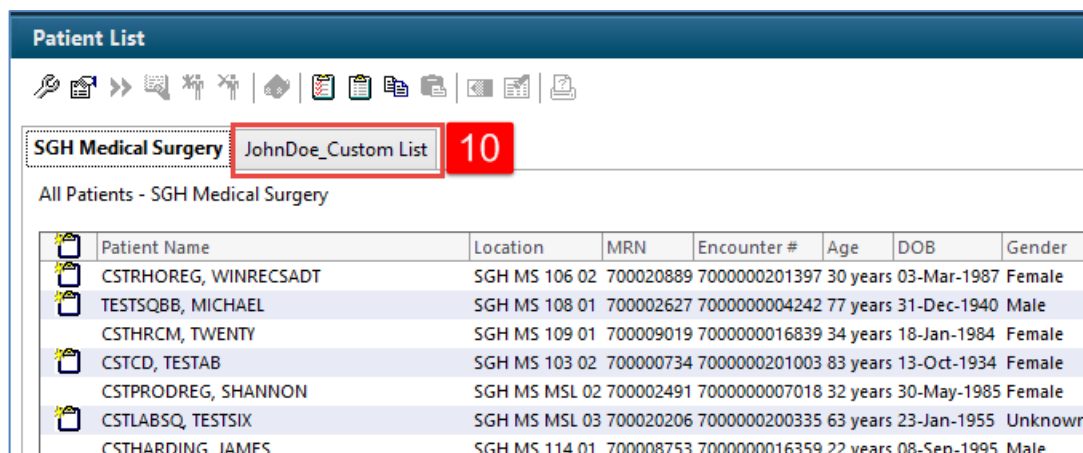
- The **Custom Patient List** window opens. In the **Enter a name for the list:** Type *YourName_Custom* (i.e. John_Custom)
- Click the **Finish** button



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

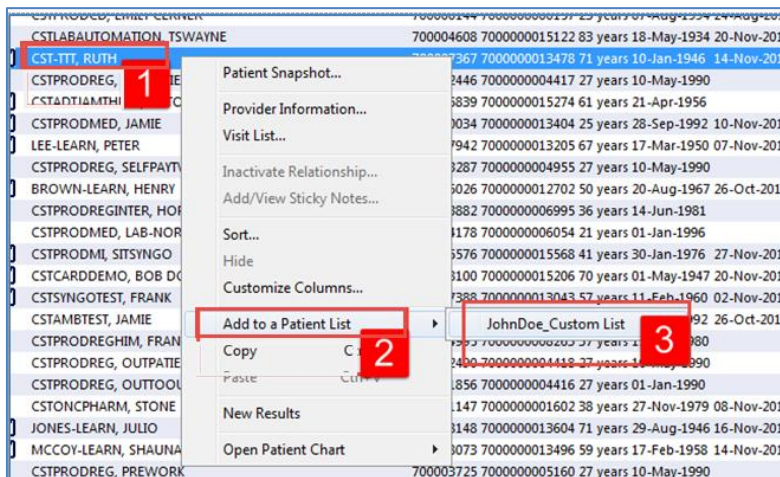


Note: Your custom list will be empty as you have not yet added any patients.


- 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

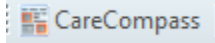

SCENARIO

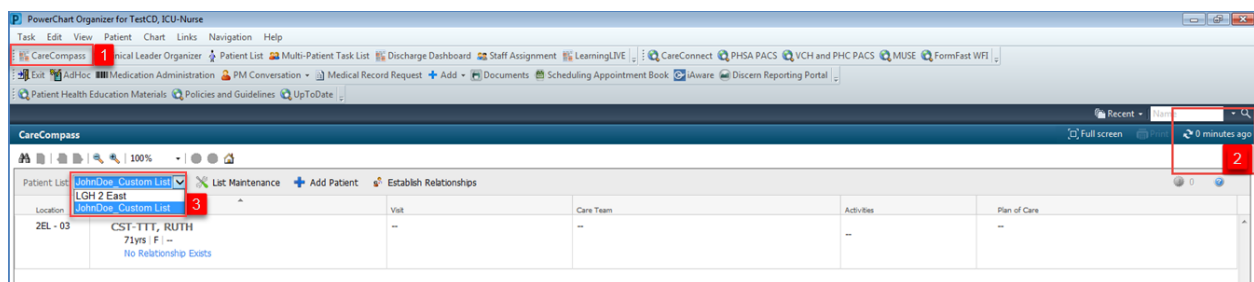
As an Inpatient Rural Nurse, you will complete the following activities:

-  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

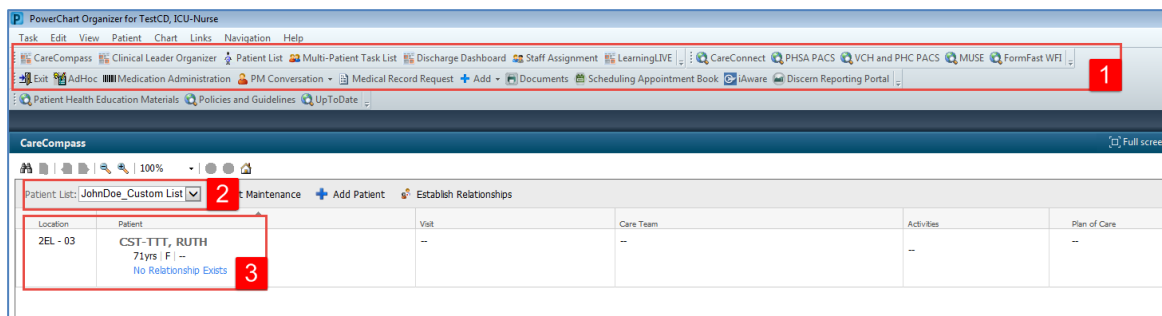


Now the patients that you have moved onto your Custom List are displayed in **CareCompass**.

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.



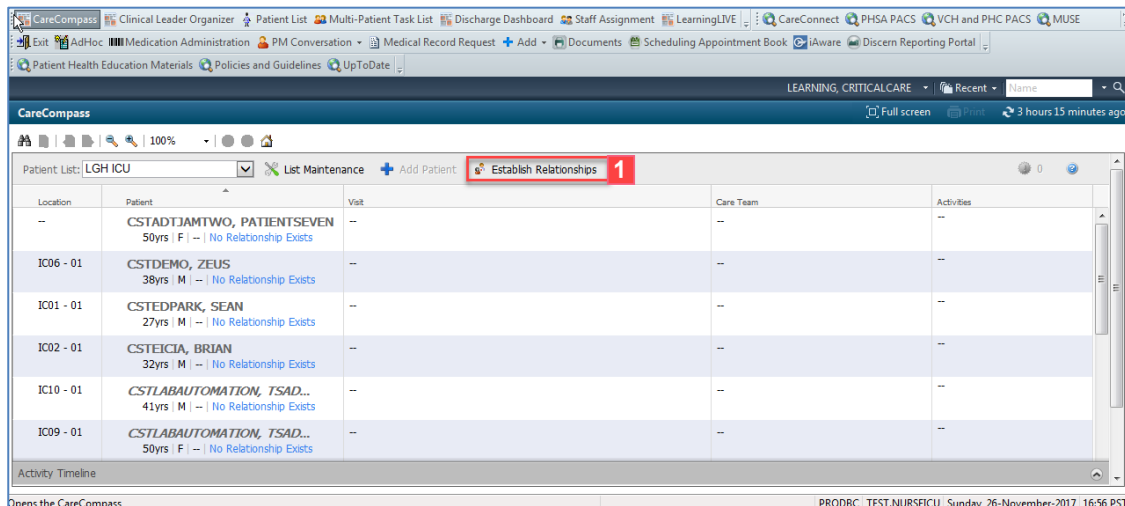
Key Learning Points

- 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

- 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**

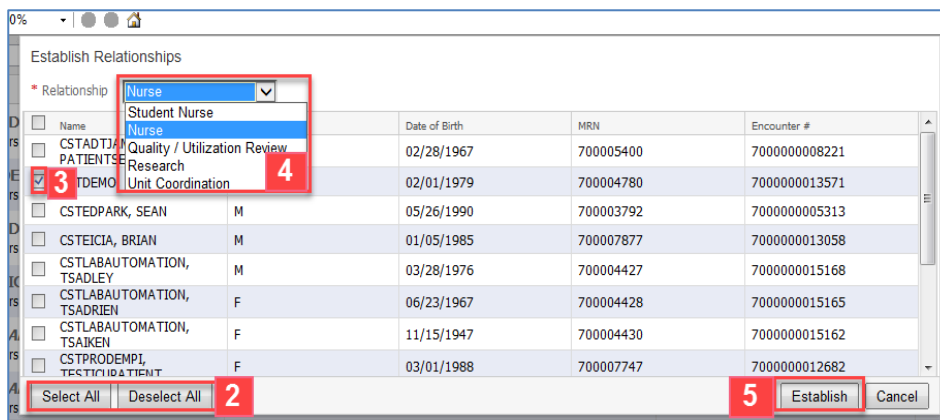


- An **Establish Relationships** window opens. Select all or individual patients as appropriate.

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

- Once patients are selected, you will see a checkmark beside each patient's name.
- From the **Relationship** dropdown menu, select **Nurse**.
- 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.

The screenshot displays the CareCompass software interface. At the top, there's a navigation bar with various icons and a search bar. Below this is a patient list table. The table has columns for Location, Patient, Visit, Care Team, Isolator, Activities, and Plan of Care. The patient list shows several patients, including 'CSTLEARNING, DEMOTHEA' and 'CSTLEARNING, DEMODELTA'. A red exclamation mark icon is visible in the top right corner of the interface. Below the patient list is an 'Activity Timeline' section, which shows a red bar for 'Overdue' and green bars for 'Scheduled' activities. A red exclamation mark icon is also visible in the top right corner of the activity timeline section.

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.

Location	Patient	Visit	Care Team
624 - 04	CSTLEARNING, DEMOTHETA 80yrs M -- No Allergies Recorded --	Pneumonia LOS: 3d	Plisvca, Rocco, MD Business (322)366-4
620 - 02	CSTLEARNING, DEMODELTA 80yrs M -- No Allergies Recorded --	Pneumonia LOS: 3d	Plisvca, Rocco, MD Business (322)366-4
624 - 03	CSTLEARNING, DEMOBETA 80yrs M -- Allergies --	Pneumonia LOS: 3d	Plisvca, Rocco, MD Business (322)366-4
624 - 02	CSTLEARNING, DEMOALPHA 80yrs M -- No Known Allergies --		Plisvca, Rocco, MD Business (322)366-4

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

Items for Review

CSTDEMO, ZEUS M 38yrs IC06 - 01

Results
No new results









Orders

	Ordered By	Entered By
<input checked="" type="checkbox"/> Respiratory NAT Panel BCCDC Nasopharyngeal Swab, Routine, Unit collec...	Test User, Physician...	Test User, Physi...
<input checked="" type="checkbox"/> Select All		

3 Mark as Reviewed Cancel

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

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

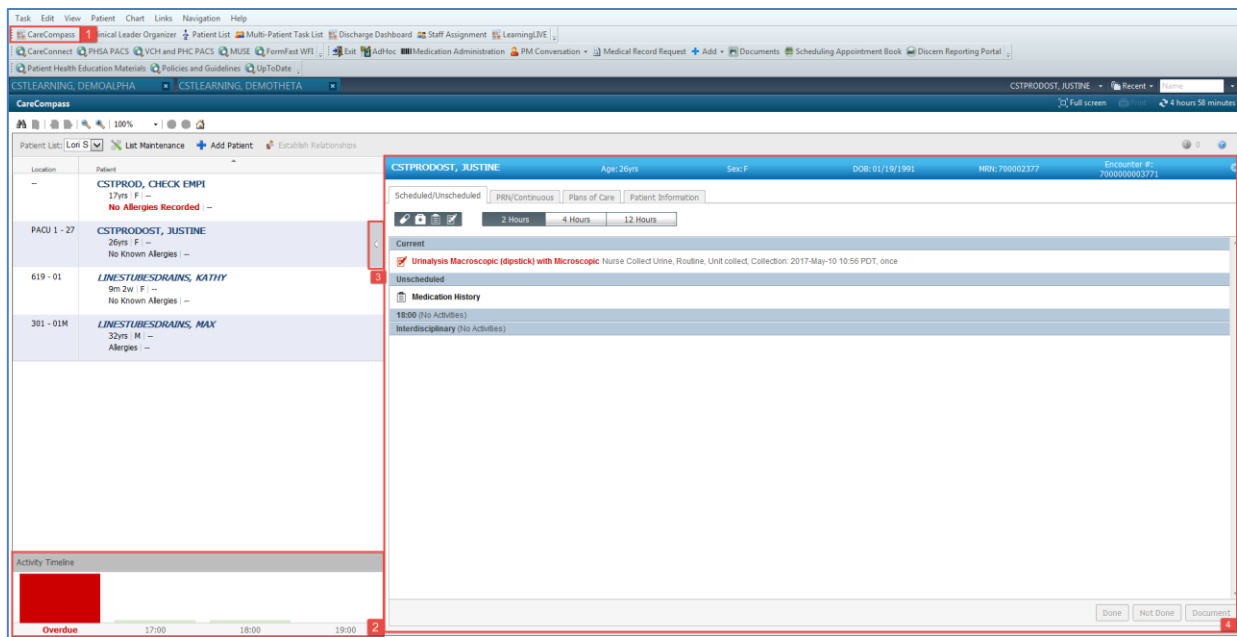
Activity 3.3 – Review and Complete Tasks in CareCompass

- 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.

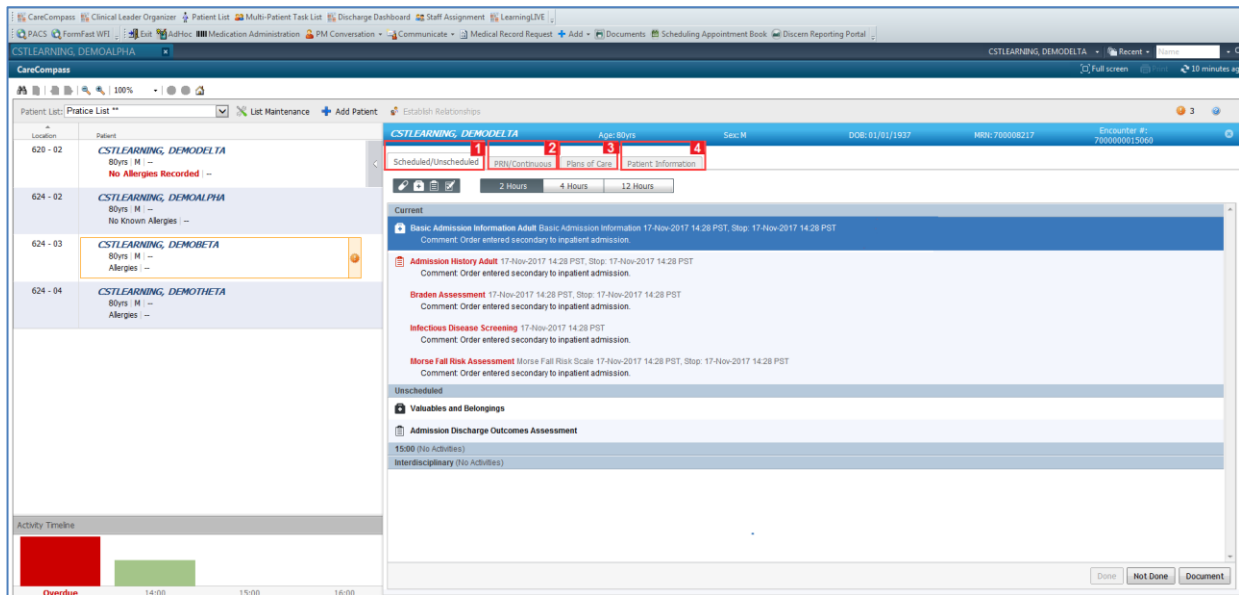


The screenshot displays the CareCompass web application. The top navigation bar includes options like Task, Edit, View, Patient, Chart, Links, and Navigation. Below this, a patient list is visible with columns for Location, Patient, and a forward arrow icon. The patient list includes entries for CSTPROD, CHECK EMPI, CSTPRODOST, JUSTINE, LINESTUBSDRAINS, KATHY, and LINESTUBSDRAINS, MAX. The patient CSTPRODOST, JUSTINE is selected, and the right-hand pane shows a detailed view of their tasks. The task view includes a header with patient information (Age: 26yrs, Sex: F, DOB: 01/19/1991, MRN: 700002377, Encounter #: 700000001771) and tabs for Scheduled/Unscheduled, Plans of Care, and Patient Information. The task list shows a current task: Urinalysis Macroscopic (dipstick) with Microscopic, Nurse Collect Urine, Routine, Unit collect, Collection: 2017-May-10 10:56 PDT, once. Below this, there are sections for Unscheduled tasks, Medication History, and Interdisciplinary (No Activities). At the bottom, an Activity Timeline shows a red bar indicating an overdue task at 17:00.

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

To see different information you can navigate between:

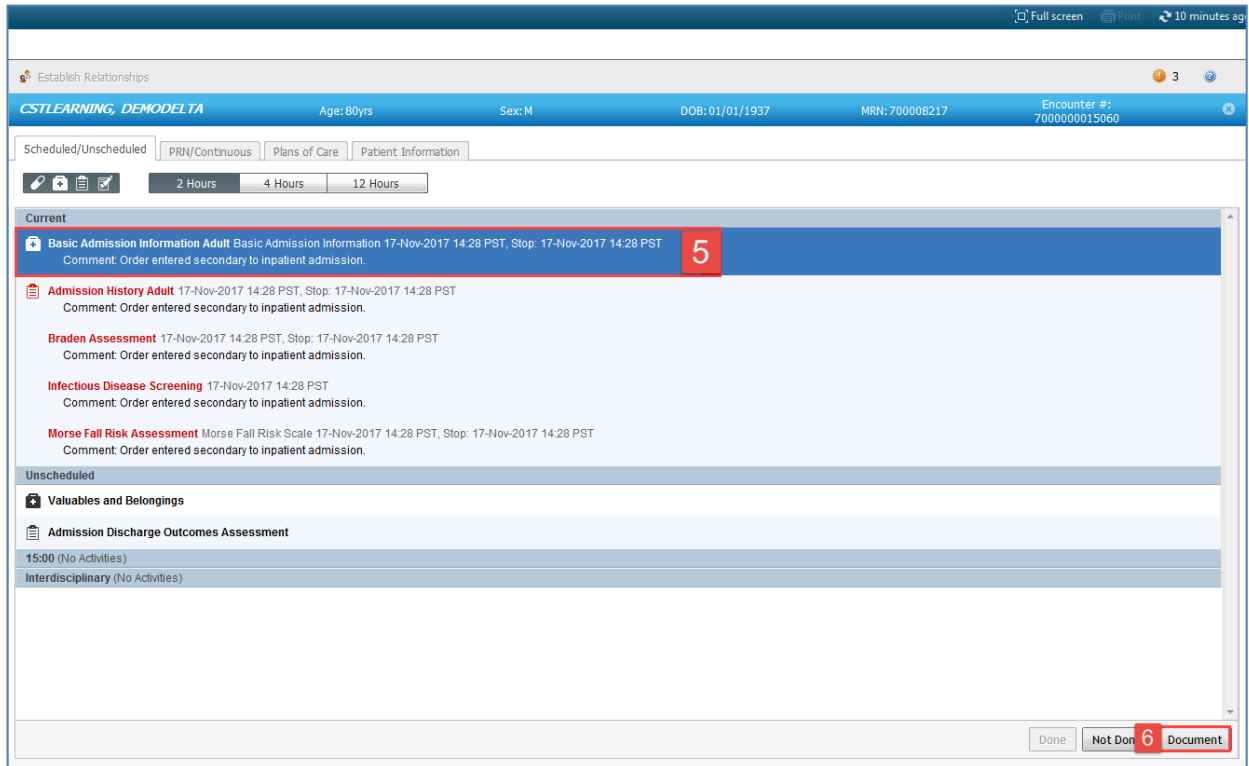
1. **Scheduled/Unscheduled** tasks tab
2. **PRN/Continuous** tab
3. **Plans of Care** tab
4. **Patient Information** tab



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**



The screenshot shows the CareCompass patient chart interface. At the top, there is a header bar with patient information: Age: 80yrs, Sex: M, DOB: 01/01/1937, MRN: 700008217, and Encounter #: 7000000015060. Below the header, there are tabs for 'Scheduled/Unscheduled', 'PRN/Continuous', 'Plans of Care', and 'Patient Information'. The 'Patient Information' tab is selected. Under this tab, there are buttons for '2 Hours', '4 Hours', and '12 Hours'. The main content area is divided into 'Current' and 'Unscheduled' sections. In the 'Current' section, the 'Basic Admission Information Adult' task is highlighted with a red box and a red '5'. Below it, there are other tasks like 'Admission History Adult', 'Braden Assessment', 'Infectious Disease Screening', and 'Morse Fall Risk Assessment'. In the 'Unscheduled' section, there are tasks like 'Valuables and Belongings', 'Admission Discharge Outcomes Assessment', '15:00 (No Activities)', and 'Interdisciplinary (No Activities)'. At the bottom right, there are buttons for 'Done', 'Not Done', and 'Document'. The 'Document' button is highlighted with a red box and a red '6'.

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.

Basic Admission Information - CSTLEARNING, DEMODELTA

*Performed on: 20-Nov-2017 1537 PST By: TestUser, Nurse

Allergies

1 Mark All as Reviewed


2 Weight

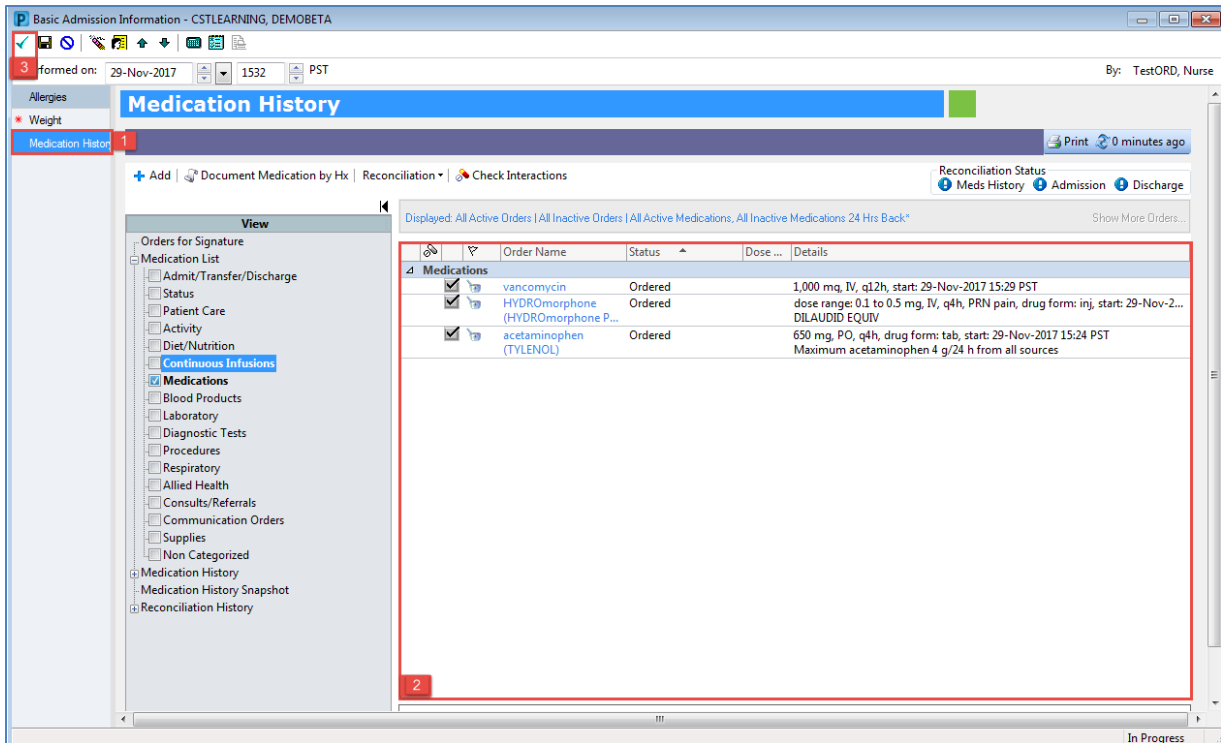
+ Add | Modify | No Known Allergies | No Known Medication Allergies | Reverse Allergy Check | Display: All

D/A	Substance	Category	Severity	Reactions	Interaction	Comments	Source	Reaction Status
	No Known Allergies	Drug						Active

In Progress

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.



Basic Admission Information - CSTLEARNING, DEMOBETA

formed on: 29-Nov-2017 1532 PST By: TestORD, Nurse

Medication History

Reconciliation Status: Meds History Admission Discharge

Displayed: All Active Orders | All Inactive Orders | All Active Medications | All Inactive Medications 24 Hrs Back

Medications	Order Name	Status	Dose ...	Details
<input checked="" type="checkbox"/>	vancomycin	Ordered	1,000 mg, IV, q12h, start: 29-Nov-2017 15:29 PST	
<input checked="" type="checkbox"/>	HYDROMORPHONE (HYDROMORPHONE P...)	Ordered	dose range: 0.1 to 0.5 mg, IV, q4h, PRN pain, drug form: inj, start: 29-Nov-2...	
<input checked="" type="checkbox"/>	acetaminophen (TYLENOL)	Ordered	650 mg, PO, q4h, drug form: tab, start: 29-Nov-2017 15:24 PST	Maximum acetaminophen 4 g/24 h from all sources

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:

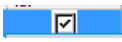
Note: For Pediatric Patients, the **Humpty Dumpty Fall Risk Assessment** will be tasked on admission.

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

The screenshot shows the CareCompass interface. On the left, a patient list displays several patients, including CSTLEARNING, DEMODELTA. The main area shows the patient's chart for CSTLEARNING, DEMODELTA. The 'Current' section is active, showing various assessments. The 'Morse Fall Risk Assessment' is highlighted with a red box and a red '1'. At the bottom right, a red box with a red '2' highlights the 'Document' button.

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.

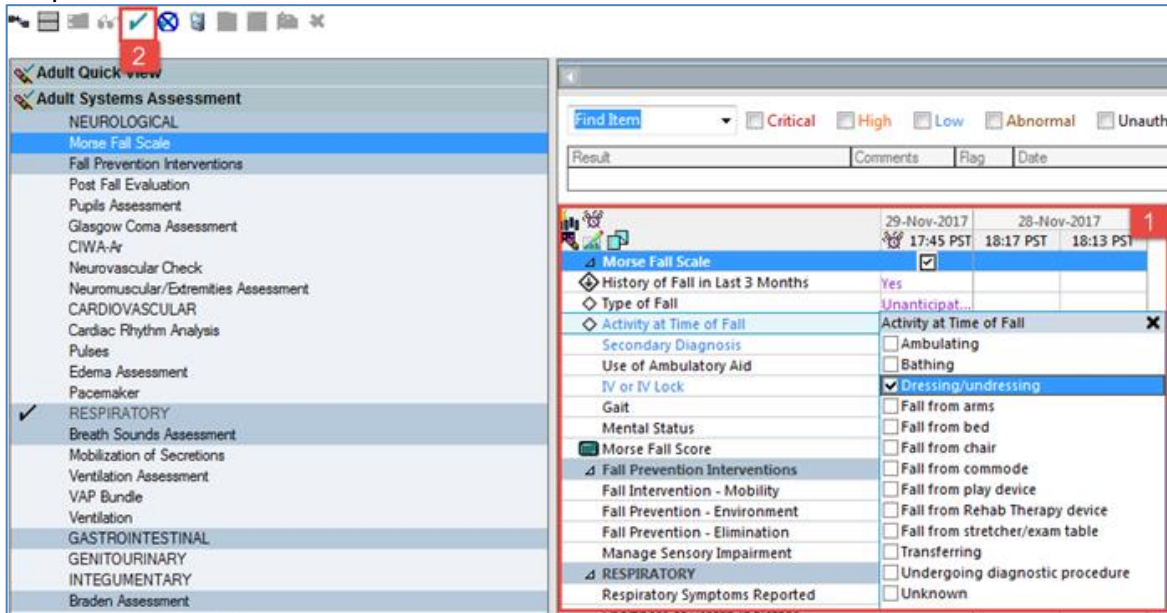
Document using the following data:

- **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*

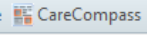
A **Morse Fall Risk Score** is automatically calculated based on information input during documentation. Note for this activity the calculated score is **65**. A score >45 means the patient is at high risk for falls. A **Falls Risk** alert should be placed on the patient's chart which will be covered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

- 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.

- Navigate back to **CareCompass** by clicking  in the Toolbar
- Open the single patient task list by clicking **grey forward arrow** ▶ to the right of your patient's name
- Select **Urine Culture (Urine C&S)**
- 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.

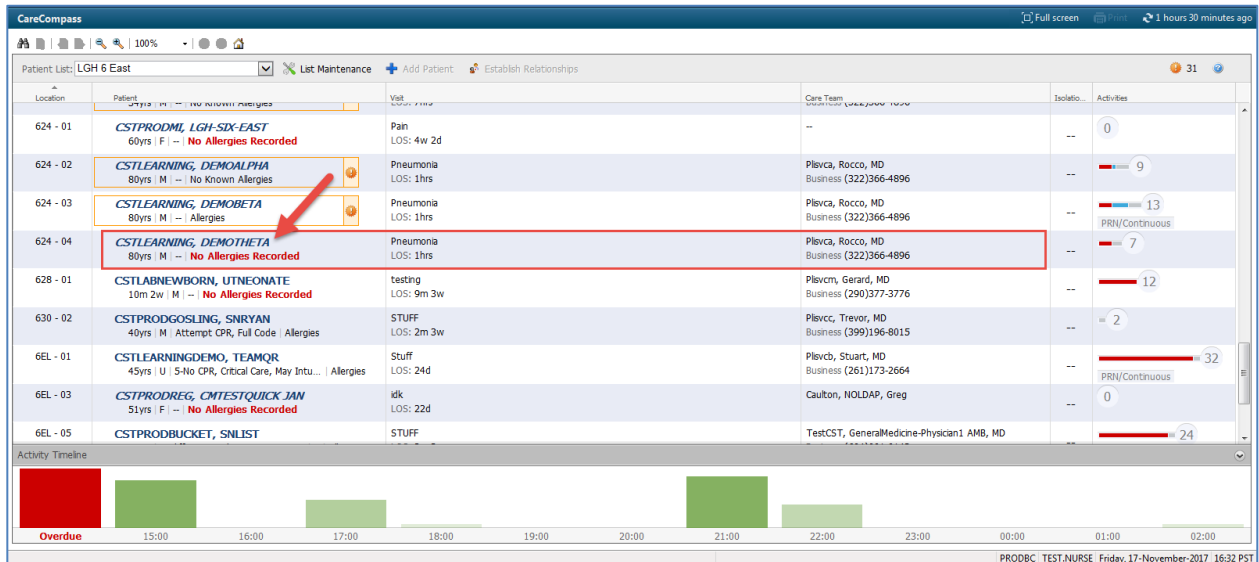
As an inpatient nurse you will be completing the following activities:

-  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.

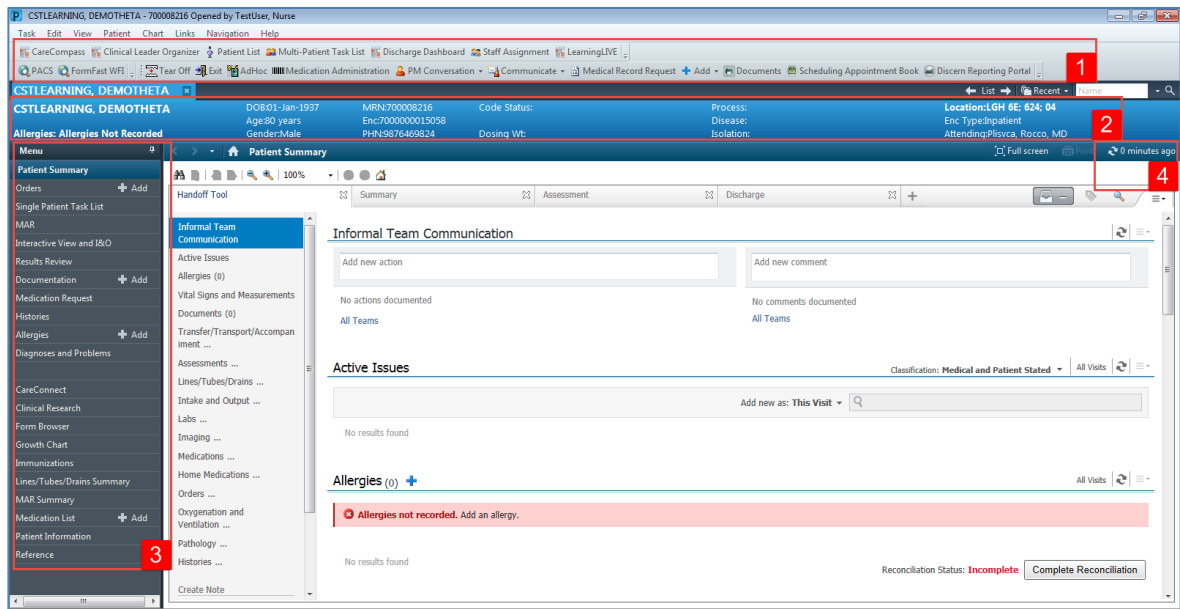


- 2 The patient's chart is now open. Let's review the key parts of the screen.

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.

- 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

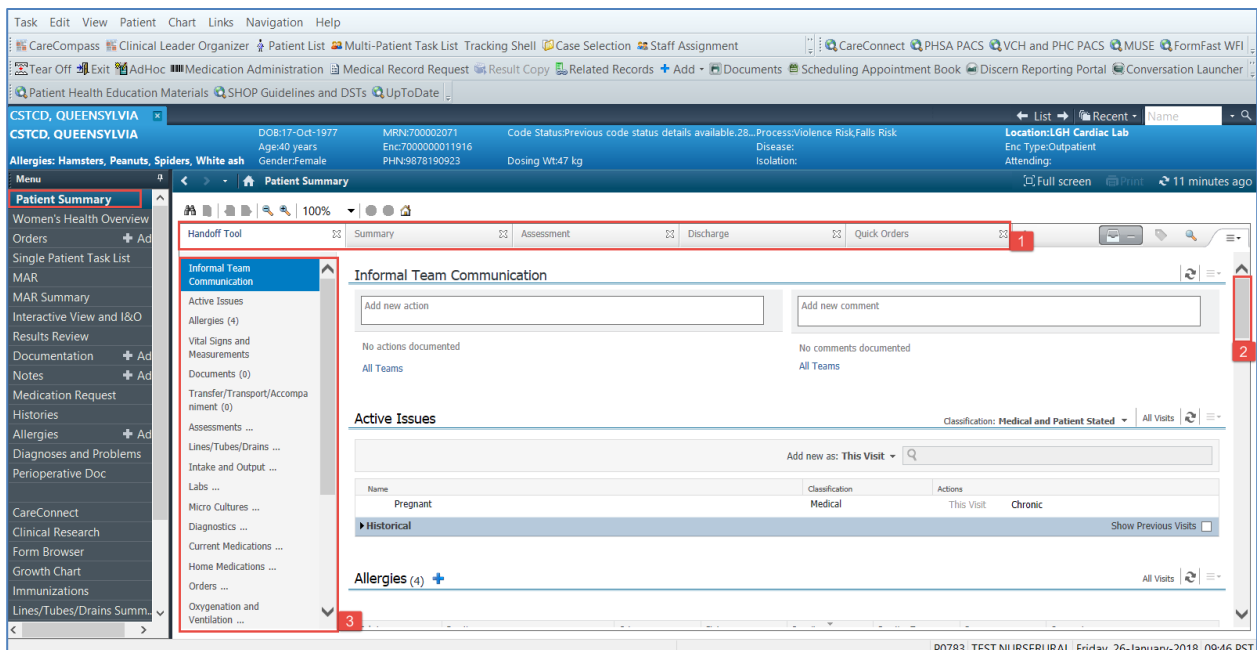
Activity 4.2 – Introduction to Patient Summary

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.

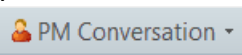
As an inpatient nurse, you will complete the following activities:

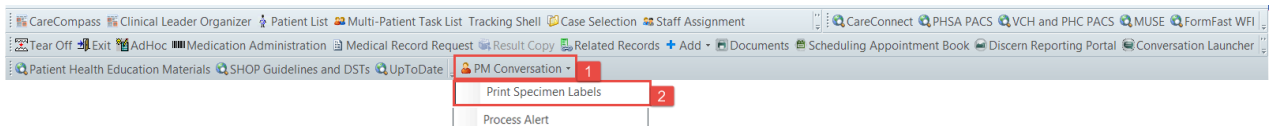
-  Print specimen labels using PM Conversation
-  Add a process alert using PM Conversation
-  Transfer a patient to a different bed

Activity 5.1 – Printing Printing Specimen Labels in PM Conversation

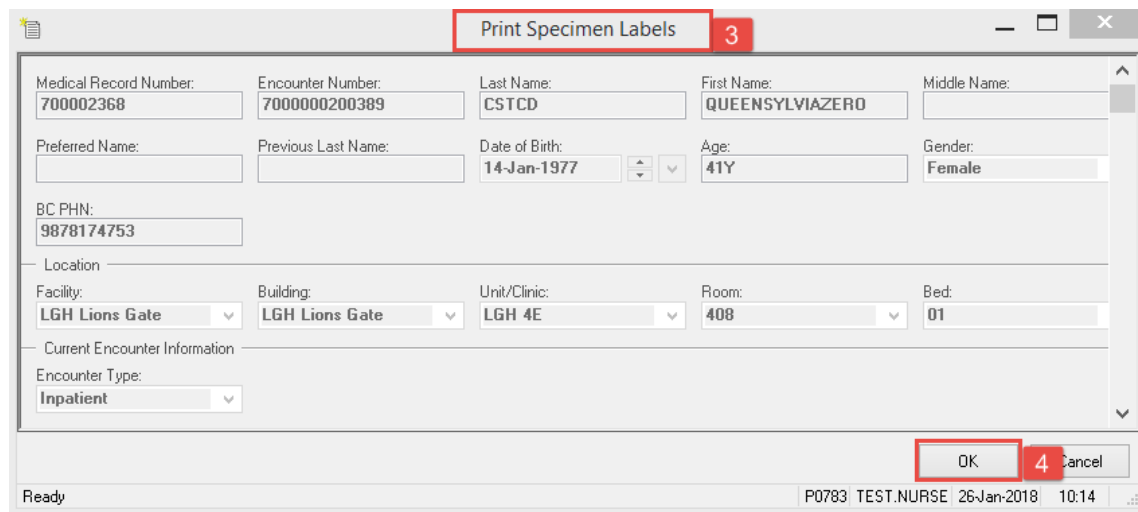
1 The following steps show you how to print specimen labels using PM Conversation.

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.

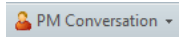
The purpose of **process alerts** is to quickly provide the user significant “face up” information about the patient. These alerts can appear in multiple areas of the chart including the banner bar, CareCompass, Summary Pages, and Tracking Boards.

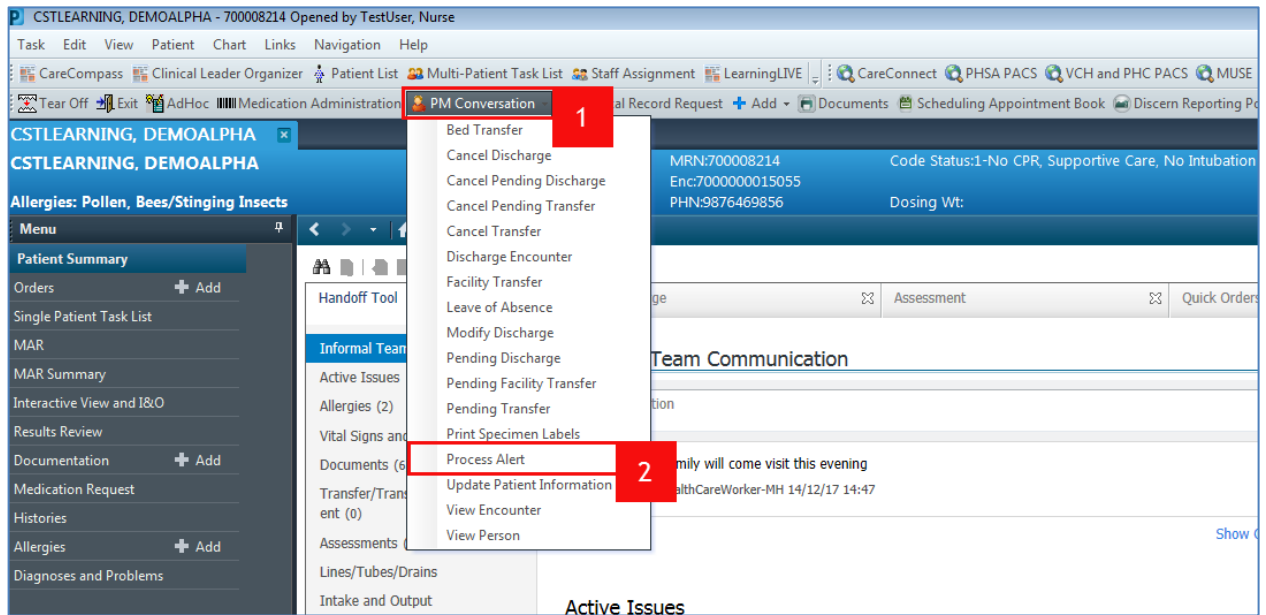
Examples of these alerts include:

- 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

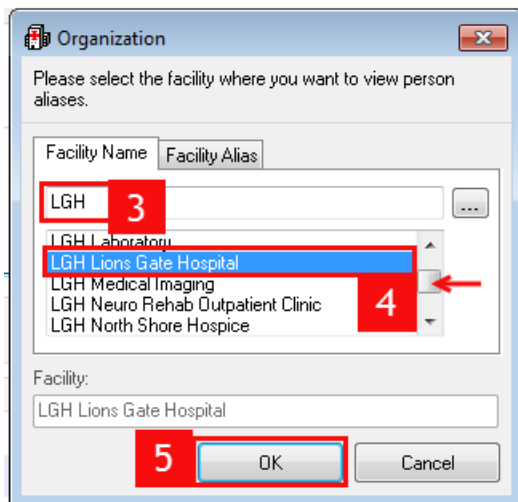


The **Organization** window will display to select a location.

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.

The screenshot shows the 'Process Alert' window for patient CSTCD, QUEENSYLVIAZERO. The patient's information is displayed at the top, including Medical Record Number (700002368), Date of Birth (14-Jan-1977), Age (41Y), and Gender (Female). Below this, there is a section for 'ALERTS' with a 'Process Alert' box. The 'From Available' list contains several alerts, with 'Falls Risk' highlighted. The 'To Selected' box is empty. The 'Move' button is highlighted, and the 'Complete' button is highlighted at the bottom right.

- 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.

The screenshot shows the patient chart banner bar for patient CSTCD, QUEENSYLVIAZERO. The banner bar displays patient information, including DOB, Age, Gender, MRN, Enc, PHN, Code Status, Dosing Wt, and Location. The 'Falls Risk' process alert is highlighted in the banner bar. The 'Refresh' icon is highlighted in the bottom right corner.

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

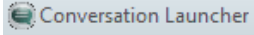
Note: Similar steps can be taken in PM Conversation to remove a process alert.



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

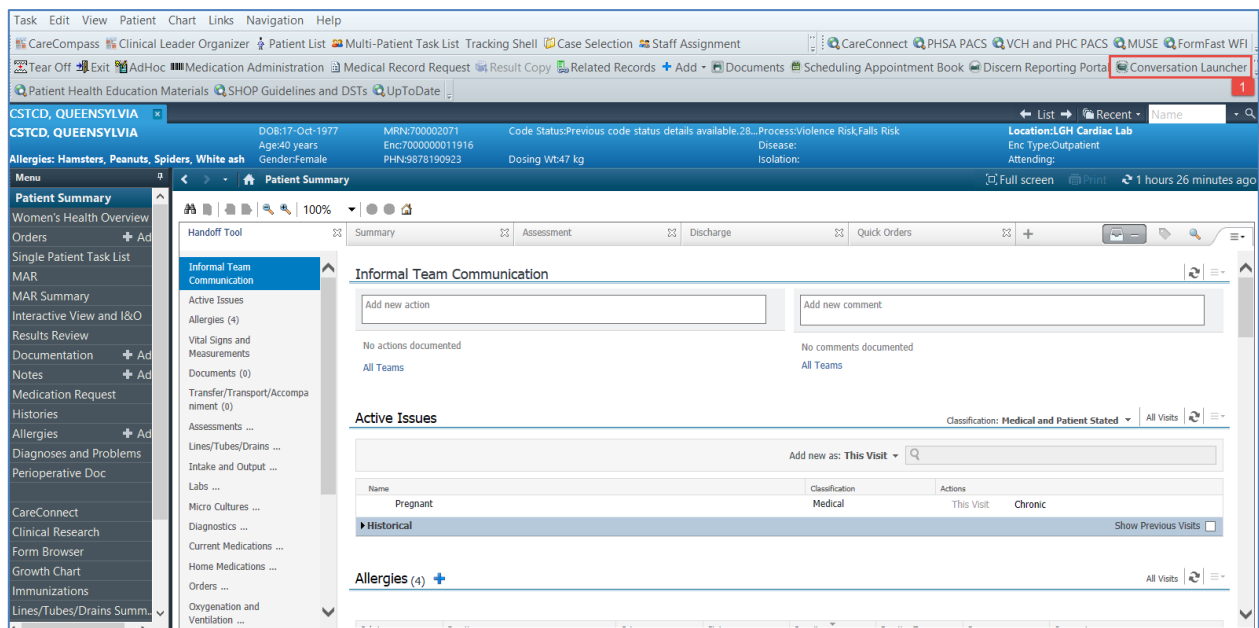
Activity 5.3 – Conversation Launcher –Bed Transfers and Update Patient Information

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

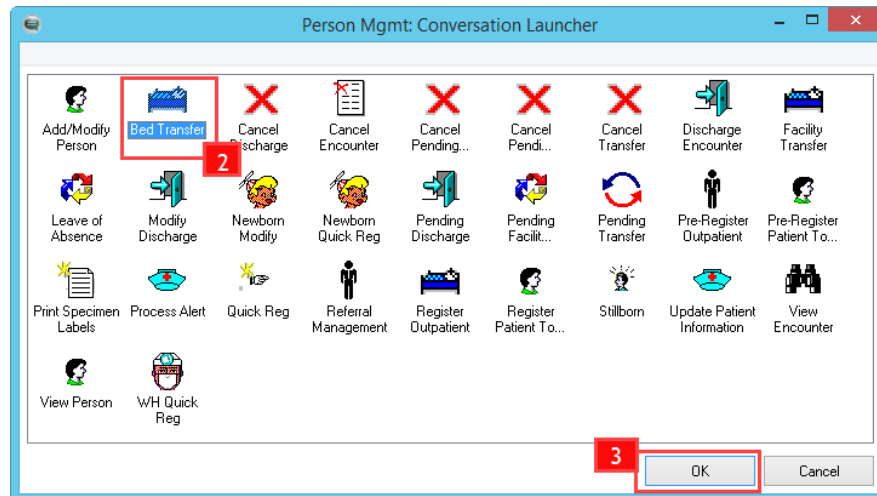
Let's say you receive notification that a patient is being transferred from the ED to your inpatient unit and there is no unit clerk available to enter the bed transfer for you. You've been given the patient's demographics (name, DOB and MRN).

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 *must* be selected. (In this case the encounter would be the active inpatient encounter in SGH Squamish Emergency)

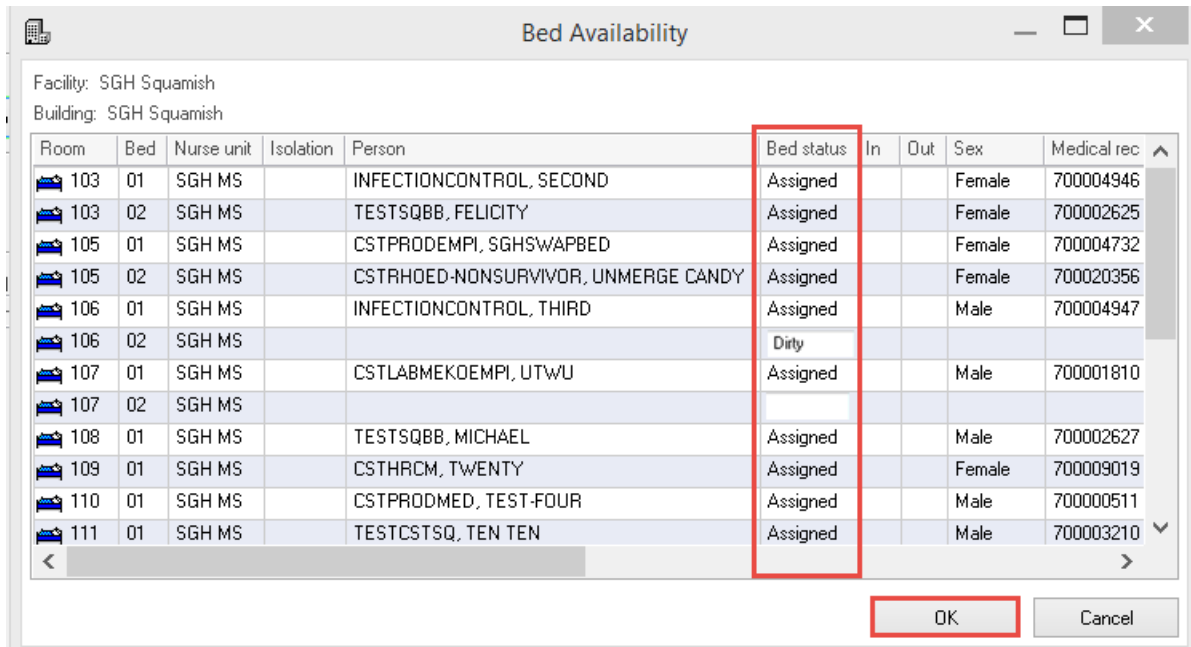
Note: The **Bed Transfer** conversation only works for **Inpatient** encounter types

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

- 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
- Click **Bed Availability**.

The **Bed Availability** window will open.

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

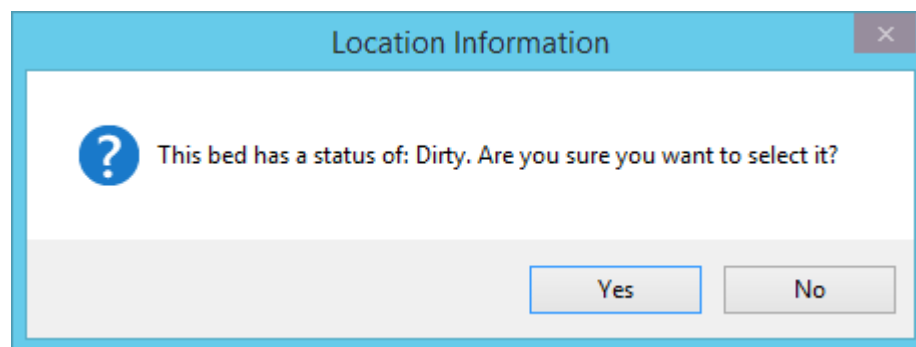


Facility: SGH Squamish
Building: SGH Squamish

Room	Bed	Nurse unit	Isolation	Person	Bed status	In	Out	Sex	Medical rec
103	01	SGH MS		INFECTIONCONTROL, SECOND	Assigned			Female	700004946
103	02	SGH MS		TESTSQBB, FELICITY	Assigned			Female	700002625
105	01	SGH MS		CSTPRODEMPI, SGHSWAPBED	Assigned			Female	700004732
105	02	SGH MS		CSTRHOED-NONSURVIVOR, UNMERGE CANDY	Assigned			Female	700020356
106	01	SGH MS		INFECTIONCONTROL, THIRD	Assigned			Male	700004947
106	02	SGH MS			Dirty				
107	01	SGH MS		CSTLABMEKDEMPI, UTWU	Assigned			Male	700001810
107	02	SGH MS							
108	01	SGH MS		TESTSQBB, MICHAEL	Assigned			Male	700002627
109	01	SGH MS		CSTHRCM, TWENTY	Assigned			Female	700009019
110	01	SGH MS		CSTPRODMED, TEST-FOUR	Assigned			Male	700000511
111	01	SGH MS		TESTCSTSQ, TEN TEN	Assigned			Male	700003210

OK Cancel

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



Location Information

? This bed has a status of: Dirty. Are you sure you want to select it?

Yes No

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 screenshot shows the 'Bed Transfer' window with the following details:

- Patient Information:** BC PHN: 9876320868, Current Encounter Type: Emergency, Current Location: SGH Squamish, Building: SGH Squamish, Unit/Clinic: SGH ED, Room: AC, Bed: 06.
- New Location Data:** Building: SGH Squamish, Unit/Clinic: SGH MS, Room: 103, Bed: 02, Accommodation: Ward. (Red box highlights Room and Bed fields).
- Transfer Information:** Transfer Date: 01-Feb-2018, Transfer Time: 16:26, Bed Transfer User Name: User, Rural-Nurse. (Red box highlights Date and Time fields).
- Buttons:** 'Complete' button is highlighted with a red box and a red '2' next to it.

The patient will now be 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

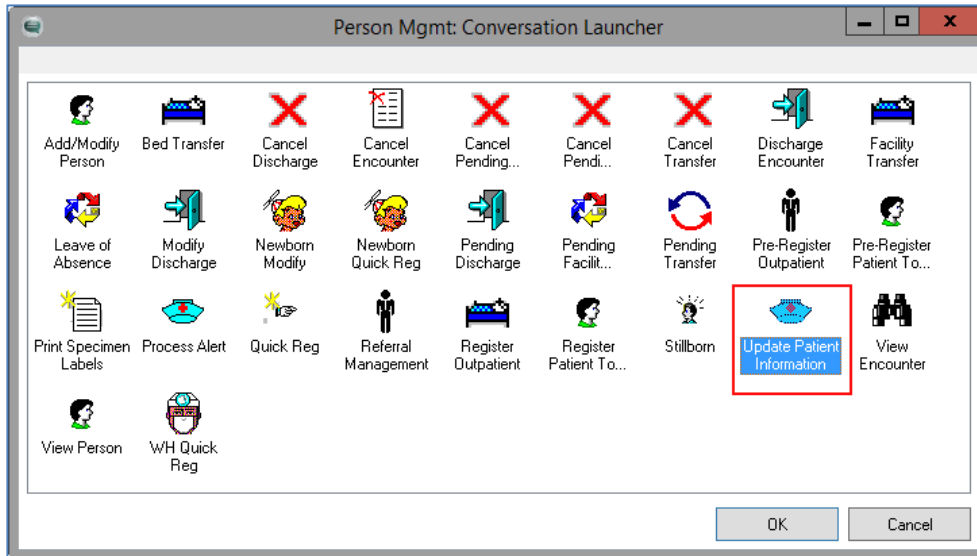
- 1 During hospitalization, a patient may have a changeover of attending physician, medical service, isolation status and so on.

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**

Encounter Search

BC PHN:

MRN:

Last Name:

First Name:

DOB:

Gender:

Postal/Zip Code:

Any Phone Number:

Encounter #:

Visit #:

Historical MRN:

Search 4 **Reset**

VIP	Deceased	Alerts	BC PHN	MRN	Name	DOB	Age	Gender	Address	Address (2)	City	Postal/Zip Code	Home Phone	Historical MRN
			9876397108	700009019	CSTHRCM, TWENTY	18-Jan-1984	34 Years	Female	700 Main St		Vancouver		(778)575-6757	

Facility	Encounter #	Visit #	Enc Type	Med Service	Unit/Clinic	Room	Bed	Est Arrival Date	Reg Date	Disch Date	Attending Provider
SGH Squamish	7000000016839	7000000016840	Inpatient	General Internal Medicine	SGH MS	109	01		20-Dec-2017 09:18		Pisavco, Trevor, MD
SGH Med Imaging	7000000016838	7000000016839	Outpatient	Medical Imaging	SGH Med Imaging				20-Dec-2017 09:12	20-Dec-2017 23:59	

OK 6 **Cancel** **Preview...**

The **Update Patient Information** window opens.

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

Update Patient Information

Medical Record Number:

Encounter Number:

Last Name:

First Name:

Middle Name:

Preferred Name:

Previous Last Name:

Date of Birth:

Age:

Gender:

BC PHN:

ALERTS **Patient Information** **Encounter Information** 7 **Insurance Summary** **Additional Contacts**

Encounter Type:

ALC Categories:

ALC Date:

ALC Time:

ALC Decompensation Date:

ALC Decompensation Time:

Medical Service:

Admit Category:

Admit Source:

Arrival by Ambulance:

Reason for Visit:

Disaster Flag:

Location

Facility:

Building:

Unit/Clinic:

Room:

Bed:

Accommodation:

Accommodation Reason:

Patient Accom Requested:

Accom Form Signed:

Care Providers

Admitting Provider:

Primary Care Provider (PCP):

PCP Verified?:

Consulting Provider 01:

Additional Information

Visitor Status:

Isolation Precautions:

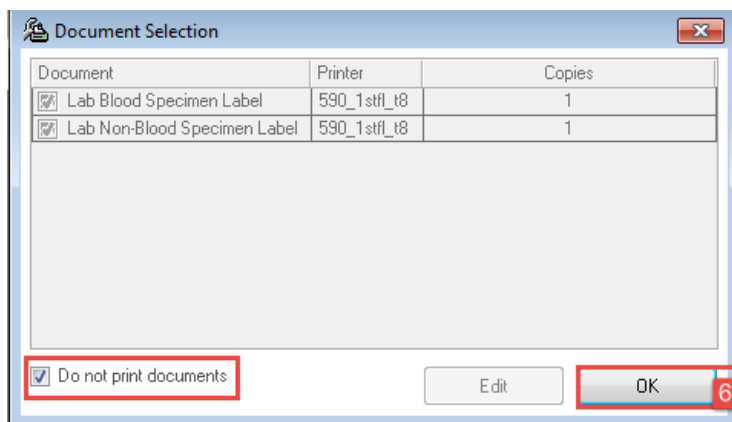
Comment:

Complete 9 **Cancel**

Ready P0783 TEST.NURSERURAL 02-Feb-2018 10:44

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	<p>At the end of this Scenario, you will be able to:</p> <ul style="list-style-type: none">■ 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

- 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.

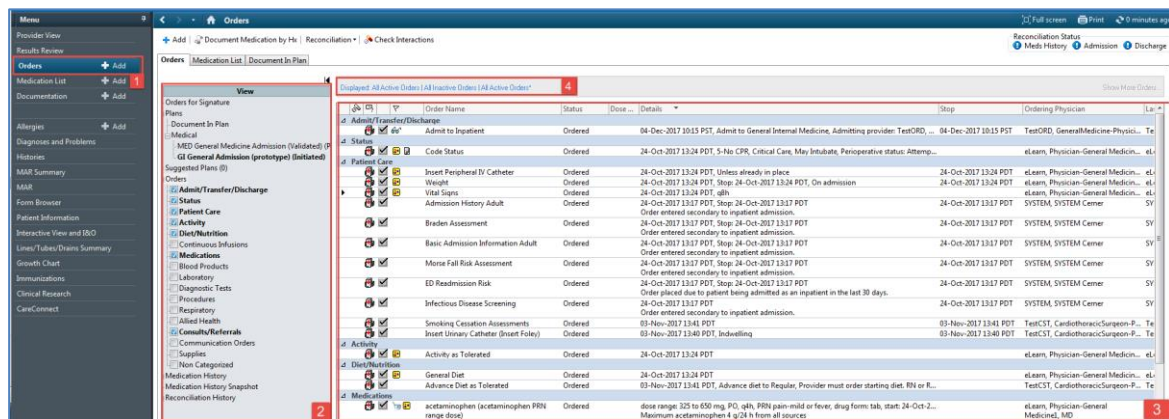
To navigate to the **Orders Profile** and review the orders:

- Select **Orders** from the **Menu**
- 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**
- 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

- 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.



The screenshot shows the 'Orders' profile for a patient. On the left is a 'View' sidebar with categories like 'Orders for Signature', 'Plans', 'Document in Plan', 'Medical', 'Medication History', 'Reconciliation History', 'Allergy/Transfer/Discharge', 'Patient Care', 'Activity', 'Diagnosis/Infusions', 'Medications', 'Laboratory', 'Diagnostic Tests', 'Procedures', 'Respiratory', 'Allied Health', 'Consults/Referrals', 'Communication Orders', 'Supplies', 'Non-Categorized', 'Medication History', 'Medication History Snapshot', and 'Reconciliation History'. The main area displays a table of orders with columns for Order Name, Status, Date, and Ordering Physician. The table is filtered to show 'All Active Orders'. Various icons are present next to the order names, indicating specific requirements or actions. A 'Filter' dropdown at the top of the table allows users to change the display filter from 'All Active Orders' to other statuses like 'Discontinued', 'Completed', 'Cancelled', or 'Pending'.

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

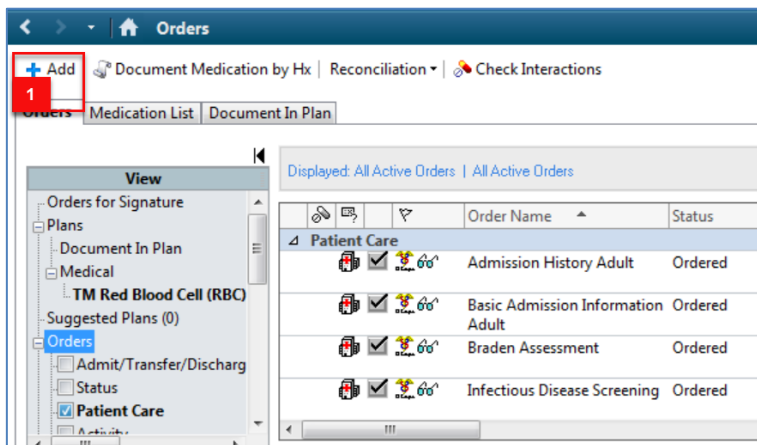
Activity 6.2 – Place an Order

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.

1 Add Order

2 Saline Lock IV

3 Saline Lock IV (When tolerating oral fluids well)

4 Saline Lock IV (When tolerating oral fluids well)

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**

1 Ordering Physician

2 Order

3 *Physician name

4 Plisvca, Rocco, MD

5 Order Date/Time

6 07-Dec-2017 1055 PST

7 *Communication type

8 Phone

9 Verbal

10 No Cosignature Required

11 Signature Required

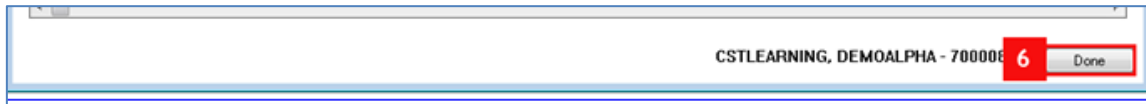
12 Paper/Fax

13 Electronic

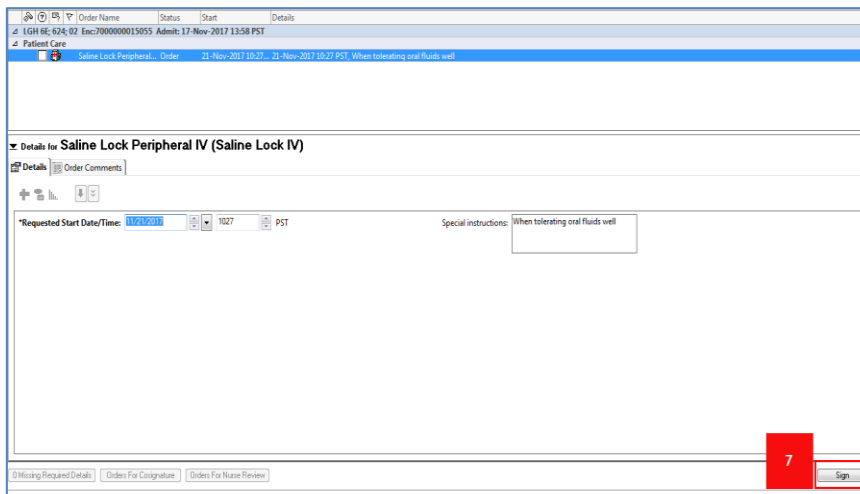
14 OK

15 Cancel

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





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



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

	Order Name	Status	Dose ...	Details	Proposal
	Insert Peripheral IV...	Processing		20-Nov-2017 11:46 PST	
	Insert Urinary Cath...	Ordered		20-Nov-2017 11:31 PST, Indwelling	
	Morse Fall Risk Assessment	Ordered		17-Nov-2017 14:05 PST, Stop: 17-Nov-2017 14:05 PST Order entered secondary to inpatient admission.	
	Vital Signs			20-Nov-2017 11:25 PST, q4h while awake	
Medications					
	furosemide	Ordered		20 mg, IV, as directed, order duration: 5 day, drug form: inj, start: 17-Nov-Administer pre red blood cell transfusion	


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

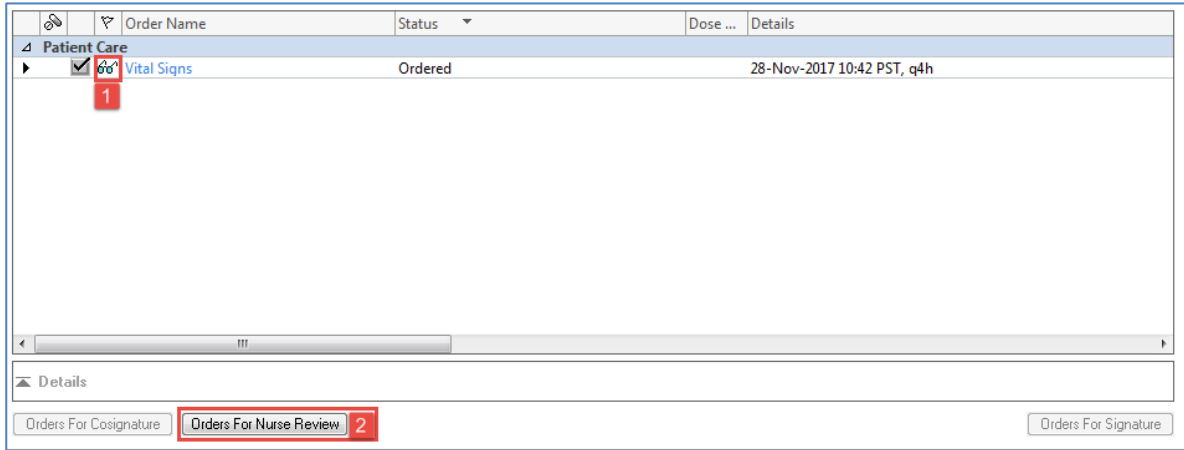
- Focus on the **Details** column of the **Orders Profile**
- Hover your cursor over certain order details to see complete order information
- Note the start date and that orders are organized by clinical category

	Order Name	Status	Dose ...	Details
Patient Care				
	Vital Signs	Ordered		28-Nov-2017 10:42 PST, q4h
Blood Products				
	Red Blood Cell Transfusion	Ordered		Routine, Administer: 1 unit, IV, once, Administer each over: 120 - 180 Minutes, Irradiated, Please call... Informed consent must be present on patient record Red Blood Cell Transfusion Details: Routine, Administer: 1 unit, IV, once, Administer each over: 120 - 180 Minutes, Irradiated, Please callwhen ready for pick up, 28-Nov-2017 11:04 PST Order Comment: Informed consent must be present on patient record

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

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

1. A **Nurse Review** icon  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.



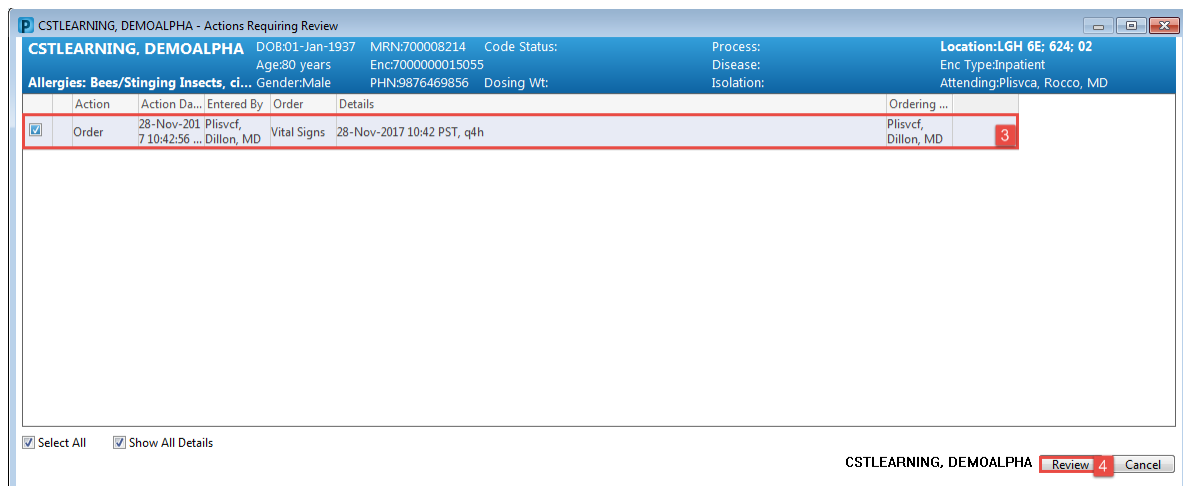
Order Name	Status	Dose ...	Details
<input checked="" type="checkbox"/> Vital Signs	Ordered		28-Nov-2017 10:42 PST, q4h

Details

Orders For Cosignature **Orders For Nurse Review** Orders For Signature

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

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



CSTLEARNING, DEMOALPHA - Actions Requiring Review

CSTLEARNING, DEMOALPHA DOB:01-Jan-1937 MRN:700008214 Code Status: Process: Location: LGH 6E: 624; 02
 Age: 80 years Enc: 70000000015055 Disease: Enc Type: Inpatient
 Allergies: Bees/Stinging Insects, cl... Gender: Male PHN: 9876469856 Dosing Wt: Isolation: Attending: Plisvca, Rocco, MD

Action	Action Da...	Entered By	Order	Details	Ordering ...
<input checked="" type="checkbox"/> Order	28-Nov-2017 10:42:56 ...	Plisvca, Dillon, MD	Vital Signs	28-Nov-2017 10:42 PST, q4h	Plisvca, Dillon, MD

☒ Select All ☒ Show All Details

CSTLEARNING, DEMOALPHA **Review** Cancel

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

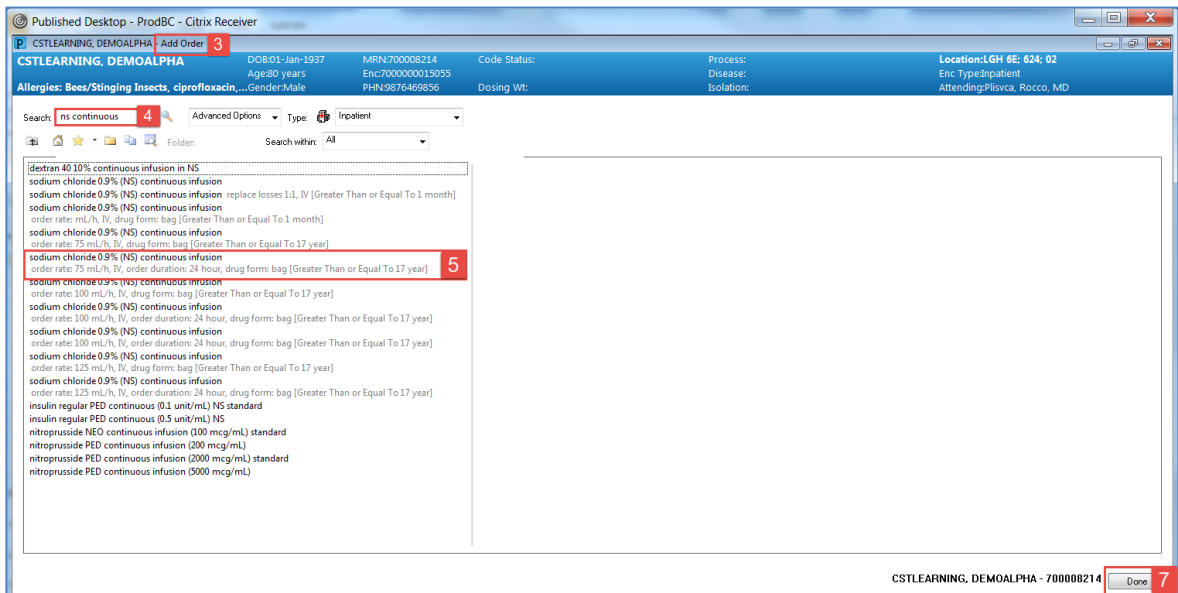
1

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]**



Published Desktop - ProdBC - Citrix Receiver

CSTLEARNING, DEMOALPHA Add Order 3

DOB: 01-Jan-1937 MRN: 700008214 Code Status: Process: Location: LGH 6E: 624; 02
Age: 80 years Enc: 7000000015055 Disease: Enc Type: Inpatient
Allergies: Bees/Stinging Insects, ciprofloxacin, ... Gender: Male PHN: 9876469856 Dosing Wt: Isolation: Attending: Piva, Rocco, MD

Search: ns continuous 4 Advanced Options Type: Inpatient

Folder: Search within: All

dextran 40 10% continuous infusion in NS
 sodium chloride 0.9% (NS) continuous infusion
 sodium chloride 0.9% (NS) continuous infusion replace losses 1:1, IV [Greater Than or Equal To 1 month]
 sodium chloride 0.9% (NS) continuous infusion
 order rate: mL/h, IV, drug form: bag [Greater Than or Equal To 1 month]
 sodium chloride 0.9% (NS) continuous infusion
 order rate: 75 mL/h, IV, drug form: bag [Greater Than or Equal To 17 year]
 sodium chloride 0.9% (NS) continuous infusion 5
 order rate: 75 mL/h, IV, order duration: 24 hour, drug form: bag [Greater Than or Equal To 17 year]
 sodium chloride 0.9% (NS) continuous infusion
 order rate: 100 mL/h, IV, drug form: bag [Greater Than or Equal To 17 year]
 sodium chloride 0.9% (NS) continuous infusion
 order rate: 100 mL/h, IV, order duration: 24 hour, drug form: bag [Greater Than or Equal To 17 year]
 sodium chloride 0.9% (NS) continuous infusion
 order rate: 100 mL/h, IV, order duration: 24 hour, drug form: bag [Greater Than or Equal To 17 year]
 sodium chloride 0.9% (NS) continuous infusion
 order rate: 125 mL/h, IV, drug form: bag [Greater Than or Equal To 17 year]
 sodium chloride 0.9% (NS) continuous infusion
 order rate: 125 mL/h, IV, order duration: 24 hour, drug form: bag [Greater Than or Equal To 17 year]
 insulin regular PED continuous (0.1 unit/mL) NS standard
 insulin regular PED continuous (0.5 unit/mL) NS
 nitroprusside NEO continuous infusion (100 mcg/mL) standard
 nitroprusside PED continuous infusion (200 mcg/mL)
 nitroprusside PED continuous infusion (2000 mcg/mL) standard
 nitroprusside PED continuous infusion (5000 mcg/mL)

CSTLEARNING, DEMOALPHA - 700008214 Done 7

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

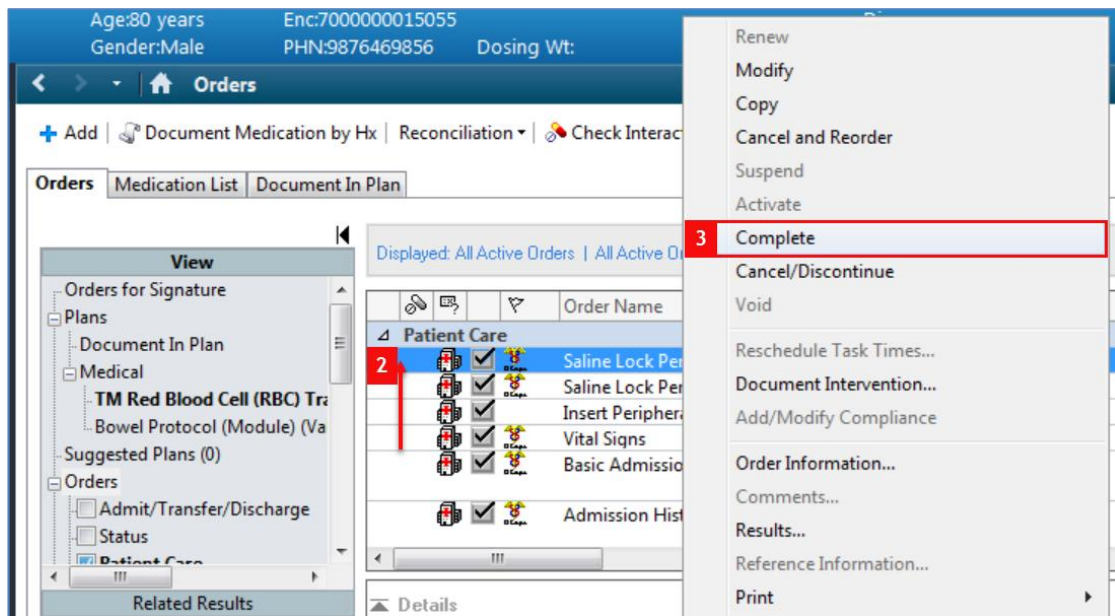
Activity 6.5 – Complete or Cancel/Discontinue an Order

1

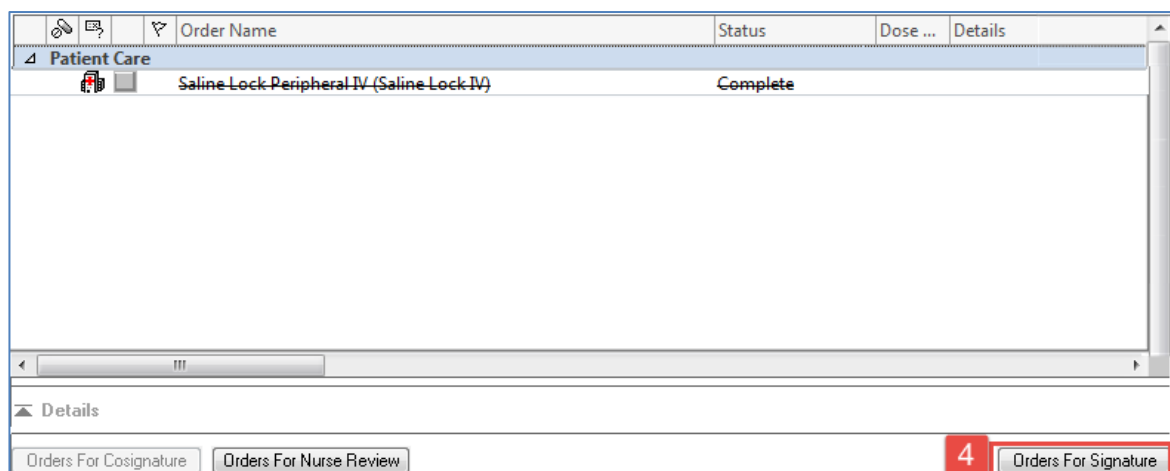
When a one-time order has been carried out, the order needs to be removed from the patient's order profile. This is done by completing the order.

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.



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

Orders for Signature

	Order Name	Status	Start	Details
<div> <div></div> <div></div> <div></div> <div></div> </div>	LGH 3W; 331; 01B Enc:7000000015869 Admit: 01-Dec-2017 00:24 PST			
Patient Care				
<input type="checkbox"/> <div></div>	Saline Lock Peripheral...	Complete	09-Dec-2017 14:16...	

Details


0 Missing Required Details

Orders For Cosignature

Orders For Nurse Review

5

Sign

- 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**

The screenshot shows the 'Orders' tab in a clinical system. On the left is a 'Menu' sidebar with options like Patient Summary, Orders, MAR, etc. The main area displays a list of orders. The 'Encourage Fluids' order is highlighted with a red box and a red '2'. A right-click context menu is open over this order, with 'Cancel/Discontinue' highlighted by a red box and a red '3'. Other menu options include Renew, Modify, Copy, etc. The background shows a list of various medical orders with columns for Order Name, Status, Dose, and Details.

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*

The 'Ordering Physician' window is shown. It has a title bar with a close button. Inside, there are radio buttons for 'Order' (selected) and 'Proposal'. Below are three fields with yellow highlights: '*Physician name' (containing 'Plesva, Rocco, MD'), '*Order Date/Time' (containing '28-Nov-2017' and '1128' with a 'PST' dropdown), and '*Communication type' (a list box with 'No Cosignature Required' selected). At the bottom are 'OK' and 'Cancel' buttons. A red box with a red '4' is in the bottom left corner.

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

Details for **Encourage Fluids**

Details | Order Comments

Discontinue Date/Time: 28-Nov-2017 11:39 PST

Discontinue Reason: [Dropdown]

Orders For Cosignature | Orders For Nurse Review | **5 Orders For Signature**

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

LGH 6E; 624; 02 Enc:7000000015055 Admit: 17-Nov-2017 13:58 PST

Patient Care

Order	Status	Discontinue Date/Time	Discontinue Reason
Encourage Fluids	Discontinued	28-Nov-2017 11:39 PST	

Details

0 Missing Required Details | Orders For Cosignature | Orders For Nurse Review | **Sign 6**

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

Key Learning Points

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

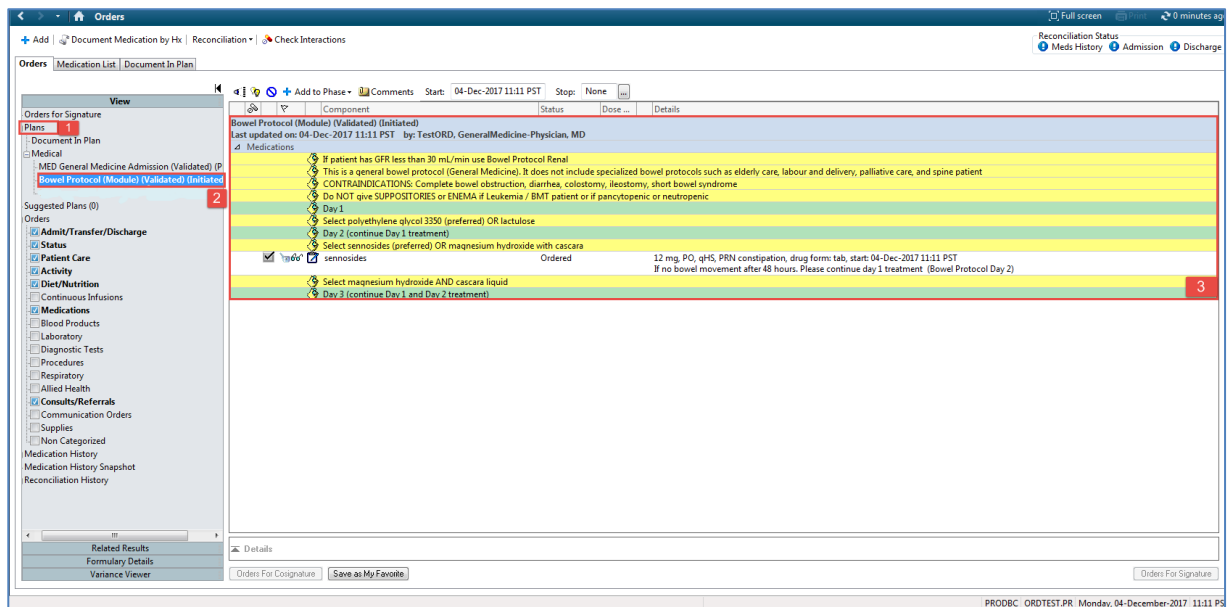
Activity 6.6 – Review Components of a PowerPlan

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

- 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*)



The screenshot shows the 'Orders' window in the CIS. The 'View' menu on the left has 'Plans' selected. The main area displays the 'Bowel Protocol (Module) (Validated) (Initiated)' PowerPlan. The plan details include a list of orders: 'Sennosides 12mg, PO, qHS, PRN constipation, drug form: tab, start: 04-Dec-2017 11:11 PST' and 'Magnesium hydroxide with cascara liquid'. The status of the plan is 'Initiated'.



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:

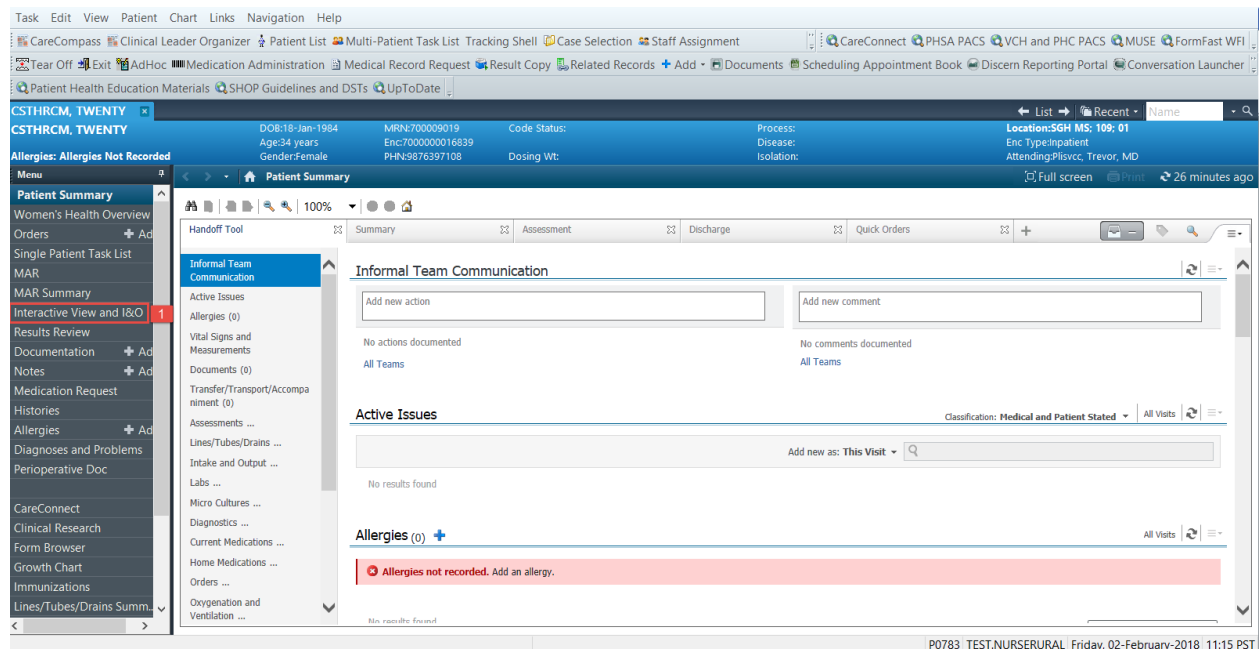
-  Navigate to Interactive View and I&O (iView)
-  Document in iView
-  Change the time of documentation
-  Document a dynamic group in iView
-  Modify, unchart or add a comment in iView

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.

The screenshot displays the CSTLEARNING DEMOTHETA patient interface. The top bar shows patient information: DOB 01-Jan-1937, Age 80 years, MRN 700008216, Enc 7000000015058, Gender Male, PHN 9876469824, Code Status, Process: Isolation, Disease: Isolation, Location: LGH 6E; 624; 04, Enc Type: Inpatient, Attending: Plisvca, Rocco, M. The left menu includes options like Patient Summary, Orders, Single Patient Task List, MAR, Interactive View and I&O, Results Review, Documentation, Medication Request, Histories, Allergies, Diagnoses and Problems, CareConnect, Clinical Research, Form Browser, Growth Chart, Immunizations, Lines/Tubes/Drains Summary, MAR Summary, Medication List, Patient Information, and Reference. The main area is titled 'Interactive View and I&O' and contains a list of 'Adult Quick View' items (1), a 'Vital Signs' table (3), and a 'MEWS Temperature Score' table (4). A red box (2) highlights the 'Adult Systems Assessment' section.

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.

- 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.

The screenshot shows the Cerner iView patient interface for Michael Testsqbb. The top header displays patient information: CSTRCM, TWENTY; DOB: 18-Jan-1984; Age: 34 years; Gender: Female; MRN: 700009019; Enc: 7000000016839; PHN: 9876397108; Code Status: ; Process: Disease: Isolation: ; Location: SGH MS; 109; 01; Enc Type: Inpatient; Attending: Plsvcc, Trevor, MD. The left sidebar shows a menu with options like Patient Summary, Women's Health Overview, Orders, Single Patient Task List, MAR, MAR Summary, Results Review, Documentation, Notes, Medication Request, Histories, Allergies, Diagnoses and Problems, Perioperative Doc, CareConnect, Clinical Research, Form Browser, Growth Chart, Immunizations, Lines/Tubes/Drains Summ..., and Medication List. The 'Interactive View and I&O' band is highlighted in the sidebar. The main window displays a 'Last 24 Hours' view of vital signs and other clinical data. The 'VITAL SIGNS' section is expanded, showing a list of vital signs with their respective units and values. The 'OB Systems Assessment' band is also visible in the sidebar.

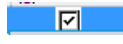
Note: Maternity documentation and functionality will be covered in the OB workbook.


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 

PATIENT SCENARIO 7 - Interactive View and I&O

CSLEARNING, DEMOTHETA - 700008216 Opened by TestUser, Nurse

Task Edit View Patient Chart Links Options Documentation Orders Help

CSLEARNING, DEMOTHETA DOB: 01-Jan-1937 MRN: 700008216 Code Status: Process/Falls Risk
Age: 80 years Enc: 7000000015058 Disease: Isolation:
Gender: Male PHN: 9876469824 Dosing Wt:

Allergies: penicillin, Tape

Menu: Patient Summary, Orders, Single Patient Task List, MAR, **Interactive View and I&O**, Results Review, Documentation, Medication Request, Histories, Allergies, Diagnoses and Problems, CareConnect, Clinical Research, Form Browser, Growth Chart, Immunizations, Lines/Tubes/Drains Summary, MAR Summary, Medication List, Patient Information, Reference.

Adult Quick View (1)

VITAL SIGNS

Modified Early Warning System

PAIN ASSESSMENT

Pain Modalities

IV Drops

Insulin Infusion

Heparin Infusion

Apnea/Bradycardia Episodes

Mental Status/Cognition

Sedation Scales

Provider Notification

Environmental Safety Management

Activities of Daily Living

Measurements

Glucose Blood Point of Care

Individual Observation Record

Comfort Measures

Transfer/Transport

Shift Report/Handoff

Adult Systems Assessment

Adult Lines - Devices

Adult Education

Blood Product Administration

VITAL SIGNS (2)

Find Item	Critical	High	Low	Abnormal	Unauth	Flag
Result						
Comments						
Flag						
Date						
Performed By						

Temperature Axillary Deg

Temperature Temporal Artery Deg

Temperature Oral Deg 36.9

Apical Heart Rate bpm 91

Peripheral Pulse Rate bpm 91

Heart Rate Monitored bpm 140/90

SBP/DBP Cuff mmHg 140/90

Cuff Location

Mean Arterial Pressure, Cuff mmHg 107

Blood Pressure Method

Cerebral Perfusion Pressure, Cuff mmHg

Oxygenation (3)

Respiratory Rate br/min 16

Measured O2% (FIO2)

Oxygen Activity

Oxygen Therapy Nasal cann...

Oxygen Flow Rate L/min

Skin/Nare Check

SpO2 99

SpO2 Site Hand

SpO2 Site Change

Modified Early Warning System

- 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.

CSLEARNING, DEMOTHETA - 700008216 Opened by TestUser, Nurse

Task Edit View Patient Chart Links Options Documentation Orders Help

CSLEARNING, DEMOTHETA DOB: 01-Jan-1937 MRN: 700008216 Code Status: Process/Falls Risk
Age: 80 years Enc: 7000000015058 Disease: Isolation: Location: LGH RE-634-04
Gender: Male PHN: 9876469824 Dosing Wt: Enc Type: Inpatient
Attending: Plevins, Micozzi, MD Full screen

Allergies: penicillin, Tape

Menu: Patient Summary, Orders, Single Patient Task List, MAR, **Interactive View and I&O**, Results Review, Documentation, Medication Request, Histories, Allergies, Diagnoses and Problems, CareConnect, Clinical Research, Form Browser, Growth Chart, Immunizations, Lines/Tubes/Drains Summary, MAR Summary, Medication List, Patient Information, Reference.

Adult Quick View

VITAL SIGNS

Modified Early Warning System

PAIN ASSESSMENT

Pain Modalities

IV Drops

Insulin Infusion

Heparin Infusion

Apnea/Bradycardia Episodes

Mental Status/Cognition

Sedation Scales

Provider Notification

Environmental Safety Management

Activities of Daily Living

Measurements

Glucose Blood Point of Care

Individual Observation Record

Comfort Measures

Transfer/Transport

Shift Report/Handoff

Adult Systems Assessment

Adult Lines - Devices

VITAL SIGNS (5)

Find Item	Critical	High	Low	Abnormal	Unauth	Flag
Result						
Comments						
Flag						
Date						
Performed By						

Temperature Axillary Deg

Temperature Temporal Artery Deg

Temperature Oral Deg 36.9

Apical Heart Rate bpm 91

Peripheral Pulse Rate bpm 91

Heart Rate Monitored bpm 140/90

SBP/DBP Cuff mmHg 140/90

Cuff Location

Mean Arterial Pressure, Cuff mmHg 107

Blood Pressure Method

Cerebral Perfusion Pressure, Cuff mmHg

Oxygenation

Respiratory Rate br/min 16

Measured O2% (FIO2)

Oxygen Activity

Oxygen Therapy Nasal cann...

Oxygen Flow Rate L/min

Skin/Nare Check

SpO2 99

SpO2 Site Hand


SpO2 Site Change

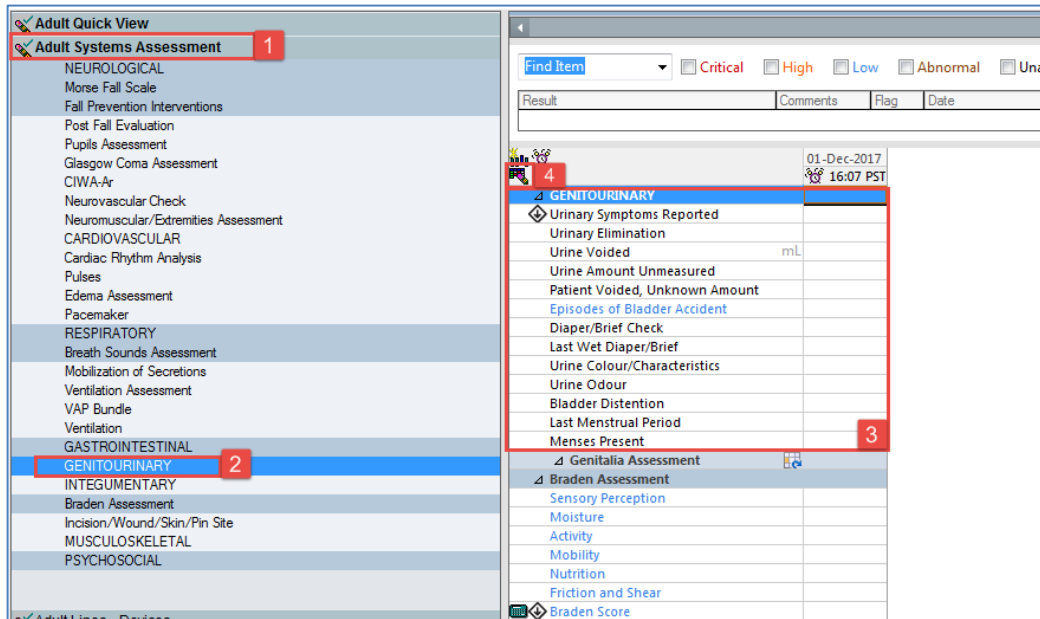
Modified Early Warning System

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

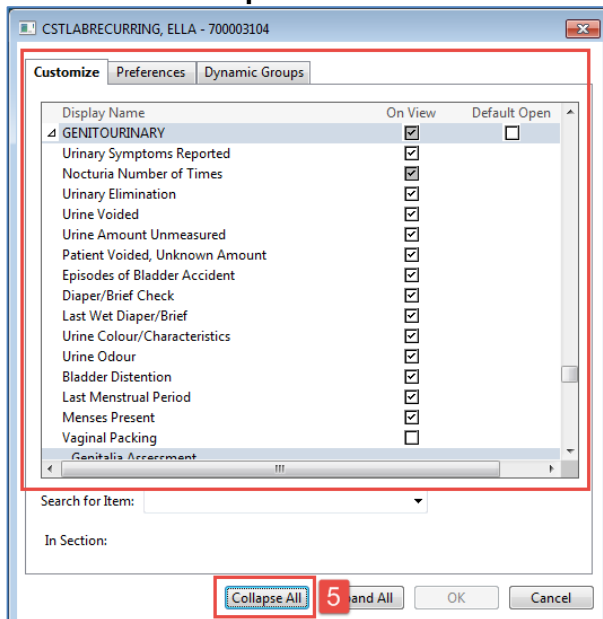
Let's pretend that you just did a bladder scan on your patient and now you want to document.

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



The screenshot shows the iView interface. On the left, the 'Adult Systems Assessment' band is selected (1). The 'Genitourinary' section is highlighted in blue (2). The 'Customize View' icon is visible (4). The right pane shows the 'Genitourinary' section with various items listed, including 'Urinary Symptoms Reported', 'Urinary Elimination', 'Urine Voided', 'Urine Amount Unmeasured', 'Patient Voided, Unknown Amount', 'Episodes of Bladder Accident', 'Diaper/Brief Check', 'Last Wet Diaper/Brief', 'Urine Colour/Characteristics', 'Urine Odour', 'Bladder Distention', 'Last Menstrual Period', and 'Menses Present' (3).

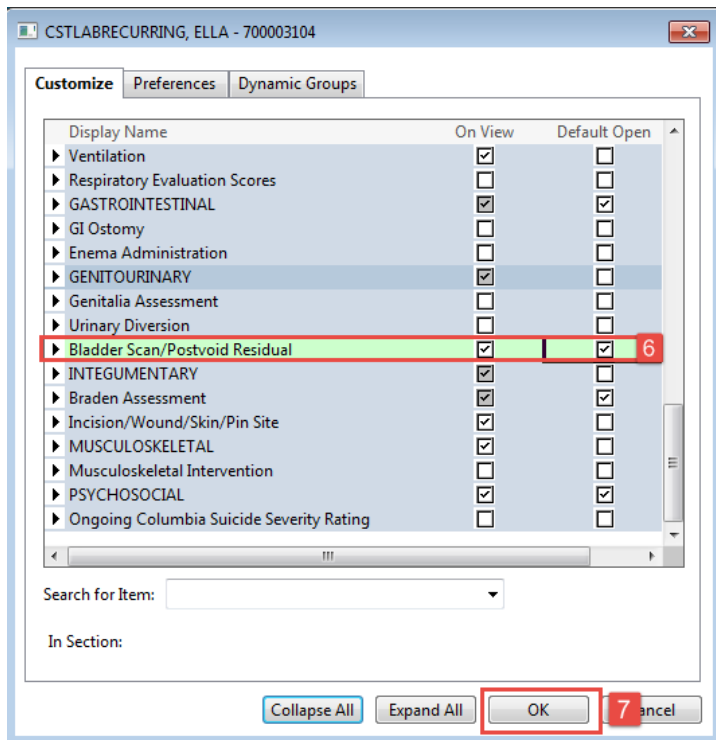
5. A **Customize** window opens displaying all the content within the Genitourinary section. Click the **Collapse All** button to see all of the section names at a glance.





The screenshot shows the 'Customize' window. The 'Genitourinary' section is expanded, showing a list of items with checkboxes for 'On View' and 'Default Open'. The 'Collapse All' button is highlighted (5).

Display Name	On View	Default Open
GENITOURINARY	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Urinary Symptoms Reported	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Nocturia Number of Times	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Urinary Elimination	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Urine Voided	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Urine Amount Unmeasured	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Patient Voided, Unknown Amount	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Episodes of Bladder Accident	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Diaper/Brief Check	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Last Wet Diaper/Brief	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Urine Colour/Characteristics	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Urine Odour	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Bladder Distention	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Last Menstrual Period	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Menses Present	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Vaginal Packing	<input type="checkbox"/>	<input type="checkbox"/>
Genitalia Assessment	<input type="checkbox"/>	<input type="checkbox"/>

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

Adult Systems Assessment

NEUROLOGICAL
Morse Fall Scale
Fall Prevention Interventions
Post Fall Evaluation
Pupils Assessment
Glasgow Coma Assessment
CIWA-Ar
Neurovascular Check
Neuromuscular/Extremities Assessment
CARDIOVASCULAR
Cardiac Rhythm Analysis
Pulses
Edema Assessment
Pacemaker
RESPIRATORY
Breath Sounds Assessment
Mobilization of Secretions
Ventilation Assessment
VAP Bundle
Ventilation
GASTROINTESTINAL
GENITOURINARY
Bladder Scan/Postvoid Residual 8
INTEGUMENTARY
Braden Assessment
Incision/Wound/Skin/Pin Site
MUSCULOSKELETAL
PSYCHOSOCIAL

Find Item ☐ Critical ☐ High ☐ Low

Result Comments Flag

01-Dec-2017 16:26 PST

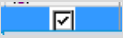

GENITOURINARY

Urinary Symptoms Reported
Urinary Elimination
Urine Voided mL
Urine Amount Unmeasured
Patient Voided, Unknown Amount
Episodes of Bladder Accident
Diaper/Brief Check
Last Wet Diaper/Brief
Urine Colour/Characteristics
Urine Odour
Bladder Distention
Last Menstrual Period
Menses Present
Genitalia Assessment

Bladder Scan/Postvoid Residual

9 Voided Within 15 Minutes Prior to Scan
Post Void Bladder Volume mL
Random Scan Bladder Volume mL 300 10
Was Patient Catheterized
Post Void Residual Catheterization ... mL

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

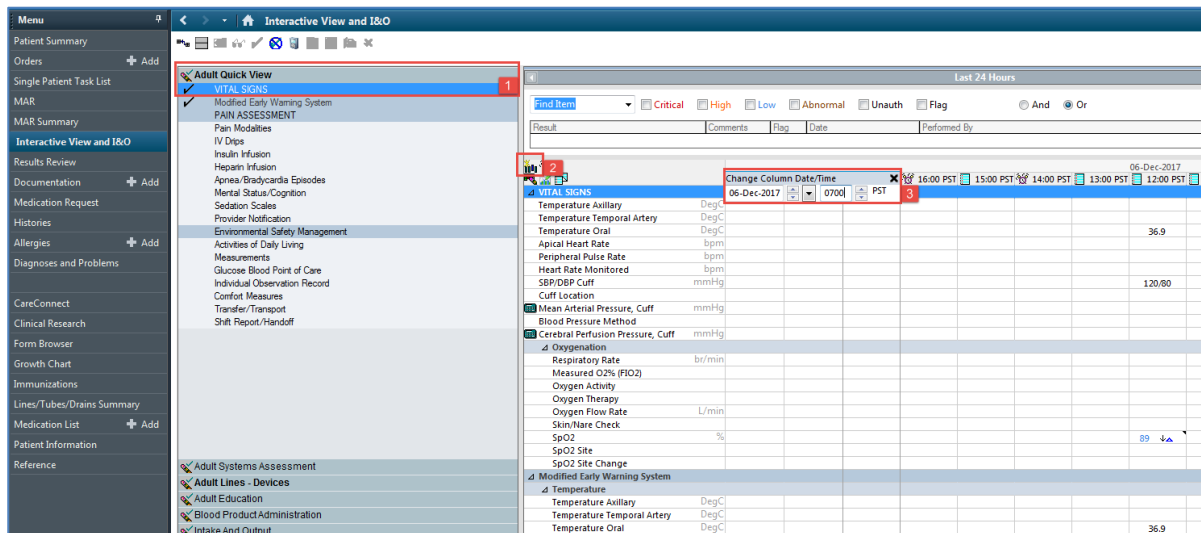
Activity 7.3 – Change the Time Column in iView

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



The screenshot shows the iView interface with the 'Adult Quick View' band selected. The 'Vital Signs' section is active. A 'Change Column Date/Time' window is open, showing the date '06-Dec-2017' and time '0700' selected. The background table shows vital signs for various times, with the '0700' column highlighted.

	06-Dec-2017	0700	16:00 PST	15:00 PST	14:00 PST	13:00 PST	12:00 PST
VITAL SIGNS							
Temperature Axillary							
Temperature Temporal Artery							
Temperature Oral							36.9
Apical Heart Rate							
Peripheral Pulse Rate							
Heart Rate Monitored							
SBP/DBP Cuff							120/80
Cuff Location							
Mean Arterial Pressure, Cuff							
Blood Pressure Method							
Cerebral Perfusion Pressure, Cuff							
Δ Oxygenation							
Respiratory Rate							
Measured O2% (FIO2)							
Oxygen Activity							
Oxygen Therapy							
Oxygen Flow Rate							
Skin/Nare Check							
SpO2							89
SpO2 Site							
SpO2 Site Change							
Δ Modified Early Warning System							
Temperature Axillary							
Temperature Temporal Artery							
Temperature Oral							36.9

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.

The screenshot displays the CSTLEARNING DEMOTHETA software interface. The top navigation bar includes options like Task, Edit, View, Patient, Chart, Links, Options, Documentation, Orders, and Help. Below this, a patient summary bar shows details for 'CSTLEARNING, DEMOTHETA' including DOB, MRN, Code Status, Process/Falls Risk, and Location. A left sidebar menu lists various functions such as Patient Summary, Orders, Single Patient Task List, MMR, Interactive View and I&O (highlighted), Results Review, Documentation Request, Medication Request, Histories, Allergies, Diagnoses and Problems, CareConnect, Clinical Research, and Form Browser. The main content area is titled 'Interactive View and I&O' and shows a table of vital signs and assessments for 'Wednesday, 22 November 2017 00:00 PST - Wednesday, 22 November 2017 23:59 PST'. The table includes columns for 'Find Item', 'Critical', 'High', 'Low', 'Abnormal', 'Unauth', 'Flag', and 'Performed By'. A red box highlights the 'Temperature Oral' row, showing a value of 36.9. A red '5' icon is visible in the bottom right corner of the interface.

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

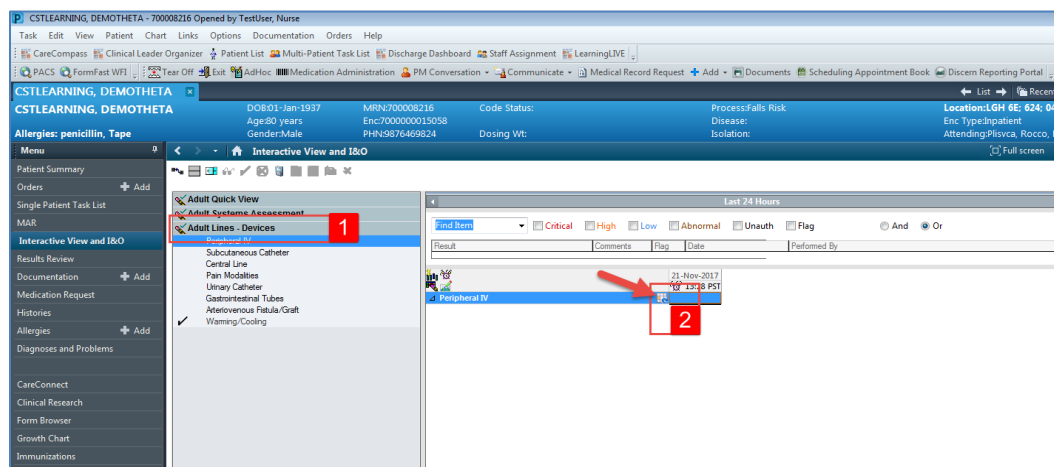
If you have completed Nursing Emergency workbook, you may skip over this activity

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.



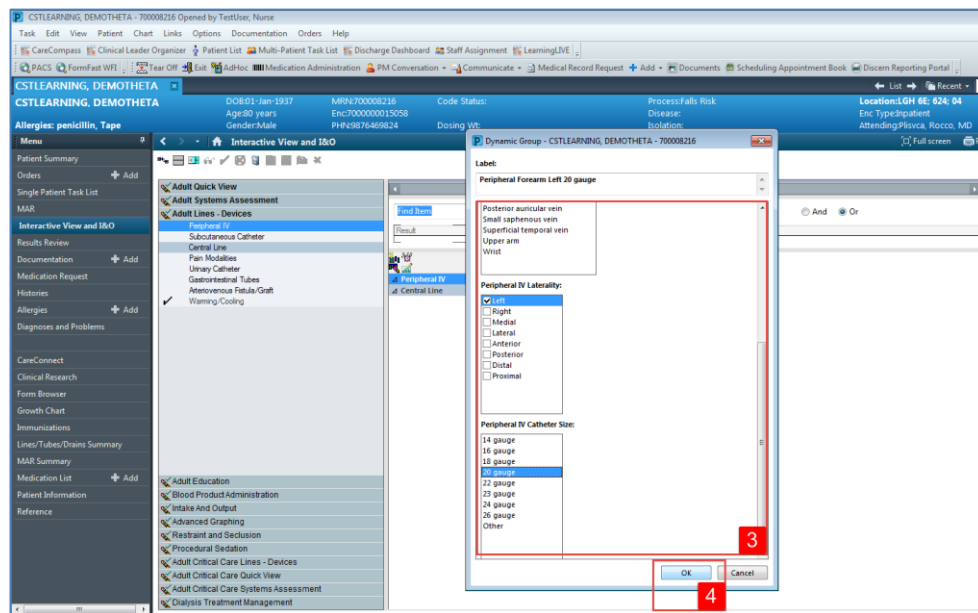
3. The **Dynamic Group** window appears. A dynamic group allows you to label a line, wound, or drain with unique identifying details.


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.

The screenshot shows the CSTLEARNING, DEMOTHETA - 700008216 interface. The top menu bar includes options like Task, Edit, View, Patient, Chart, Links, Options, Documentation, Orders, and Help. The patient information section displays DOB: 01-Jan-1937, Age: 80 years, Gender: Male, MRN: 700008216, Enc: 7000000015058, PHN: 9876469824, Code Status, and Process: Falls Risk. The left menu includes Patient Summary, Orders, Single Patient Task List, MAR, Interactive View and I&O (highlighted with a red box and number 1), Results Review, Documentation, Medication Request, Histories, Allergies, Diagnoses and Problems, CareConnect, Clinical Research, Form Browser, Growth Chart, Immunizations, Lines/Tubes/Drains Summary, MAR Summary, Medication List, Patient Information, and Reference. The central area shows the 'Interactive View and I&O' section with a list of 'Adult Lines - Devices' including Peripheral IV, Subcutaneous Catheter, Central Line, Pain Modalities, Urinary Catheter, Gastrointestinal Tubes, Arteriovenous Fistula/Graft, and Warming/Cooling. The right-hand section displays a table of documentation for the 'Peripheral IV' section, with a red box and number 2 highlighting the 'Peripheral Forearm Left 20 gauge' entry. The table includes columns for Result, Comments, Flag, Date, and Performed By. The 'Peripheral Forearm Left 20 gauge' entry shows a status of 'Insert' (highlighted with a red box and number 3) and a date of '24-Nov-2017 09:44 PST'. The 'Insert' button is highlighted with a red box and number 4. The 'Intact' status is highlighted with a red box and number 5. The 'Applied' status is highlighted with a red box and number 6.

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 'inserted' you will see it display in the **Lines/Tubes/Drains Summary** Page from the **Menu**.

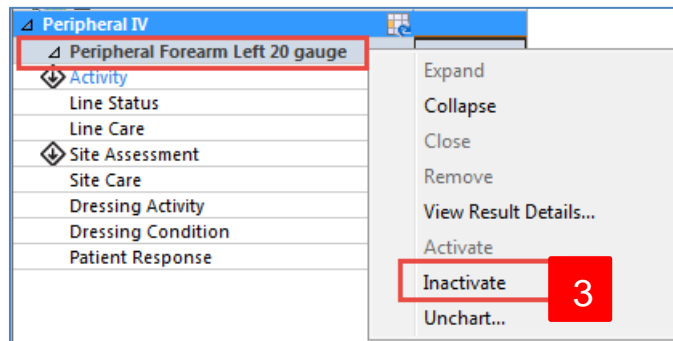
1. Click on **Lines/Tubes/Drains Summary** from the **menu**
2. Notice that the **Peripheral Forearm Left 20 gauge** IV is now listed here with the insertion date and time listed, as well as where the line was placed (Unit Origin).
3. Look at the screenshot below. Notice that the **Lines/Tubes/Drains 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**.

- Click on [Discontinue](#) and the system will take you back to the iView section for further documentation.

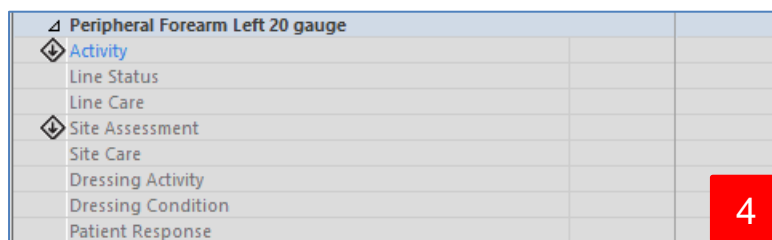
Let's say your PIV has been discontinued. To **inactivate** your Peripheral Line dynamic group complete the following steps:

-
- The screenshot shows the Epic EMR interface. On the left is a navigation menu with options like 'Patient Summary', 'Orders', 'Single Patient Task List', 'MAR', 'MAR Summary', 'Interactive View and I&O' (highlighted in blue), 'Results Review', 'Documentation', 'Medication Request', 'Histories', and 'Allergies'. The main area is titled 'Interactive View and I&O'. It contains a toolbar with icons for various views and a list of 'Adult Lines - Devices'. The 'Peripheral IV' item is selected and highlighted with a red box and a red '2'. Below it, a list of IVs is shown, including 'Subcutaneous Catheter', 'Central Line', 'Pain Modalities', 'Urinary Catheter', 'Gastrointestinal Tubes', 'Arteriovenous Fistula/Graft', and 'Warming/Cooling'. The 'Peripheral IV' section is expanded, showing a list of IVs. The 'Peripheral IV' section is highlighted with a red box and a red '1'.

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



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



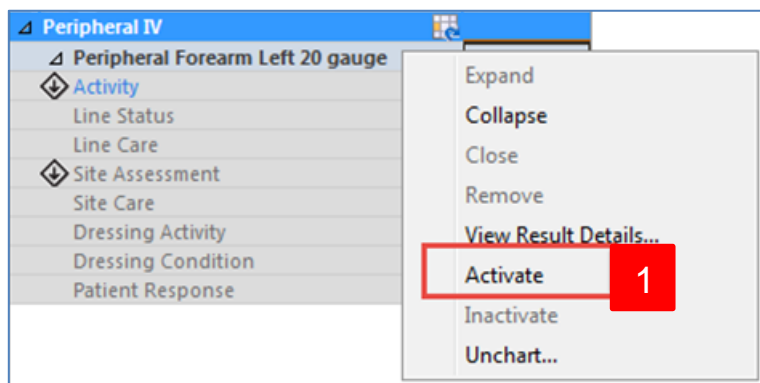
Note: The inactivated dynamic group remains in the view, but is unavailable, meaning clinicians cannot document on it. If there are no results for the time frame displayed, the inactive dynamic group is automatically removed from the display.

4

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

To do this:

- 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 inactive dynamic group if necessary.

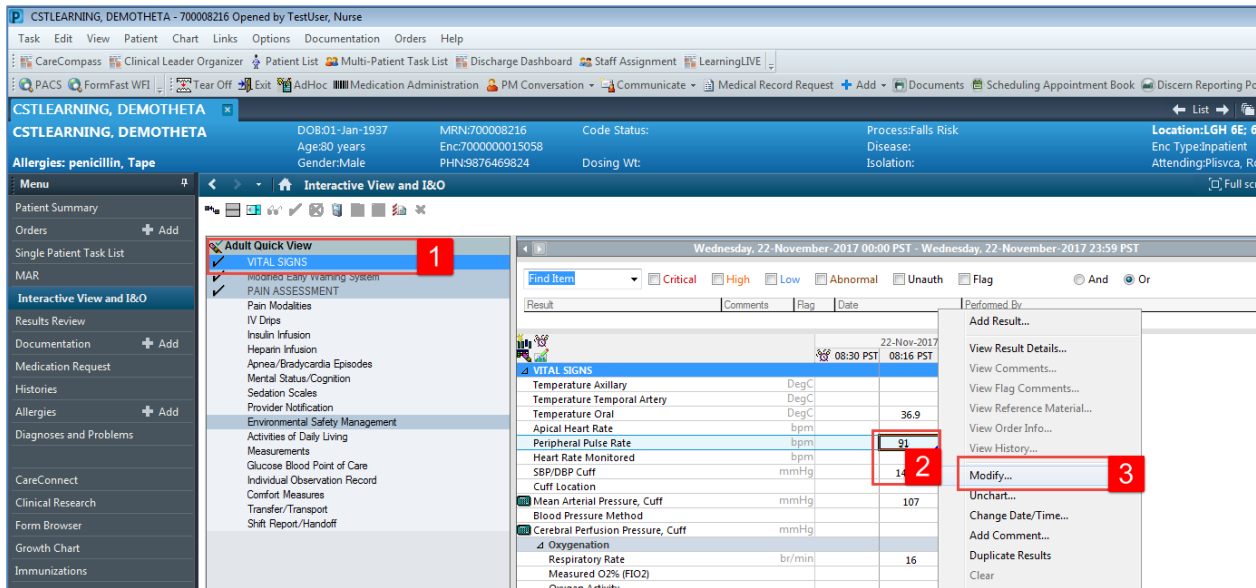
Key Learning Points

- 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

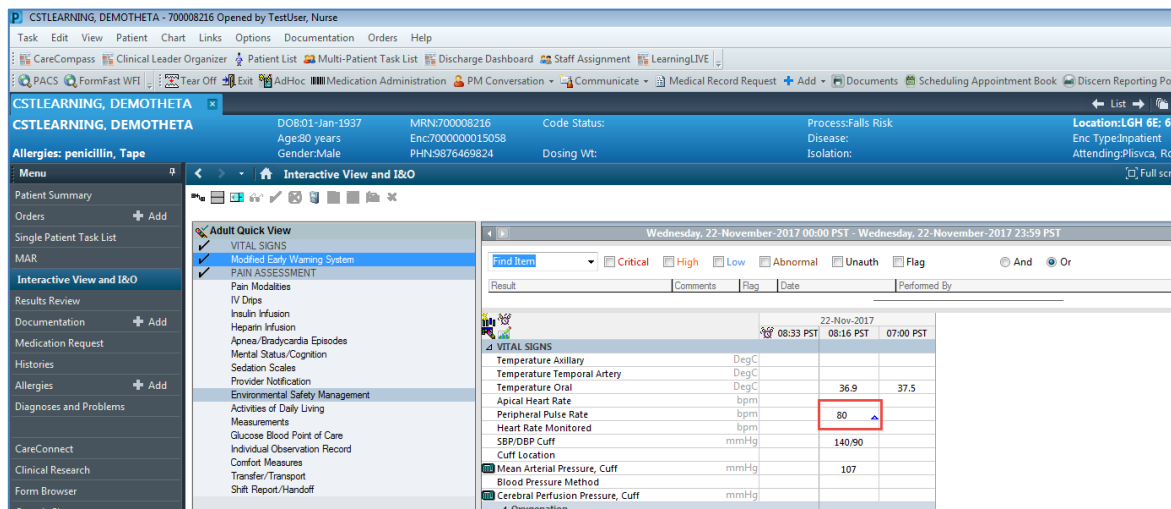
1 You realize upon reviewing your earlier charting that you wrote the incorrect Peripheral Pulse Rate value. Let's modify the Peripheral Pulse Rate.

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...**



The screenshot shows the CSTLEARNING, DEMOTHETA patient chart. The 'Interactive View and I&O' section is active. The 'Vital Signs' section is expanded, and the 'Peripheral Pulse Rate' is highlighted. A right-click context menu is open, showing the 'Modify...' option. The current value is 91, and the new value to be entered is 80.

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.



The screenshot shows the CSTLEARNING, DEMOTHETA patient chart. The 'Interactive View and I&O' section is active. The 'Vital Signs' section is expanded, and the 'Peripheral Pulse Rate' is highlighted. The new value 80 is entered, and a blue triangle icon is visible in the bottom right corner of the cell.

- 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.

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

The screenshot shows the CSTLEARNING, DEMOTHETA patient chart. The 'Interactive View and I&O' section is active. A table of vital signs is displayed, including Temperature Oral, which has a value of 37.5. A right-click context menu is open over the 37.5 value, showing options such as 'Add Result...', 'View Result Details...', 'Unchart...', and 'Duplicate Results'. A red box highlights the 'Unchart...' option, and another red box highlights the '37.5' value.

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

The screenshot shows the CSTLEARNING, DEMOTHETA patient record interface. The 'Interactive View and I&O' menu is selected. An 'Unchart' dialog box is open, showing a table with columns: Unchart, Date/Time, Item, Result, Reason, and Comment. The 'Reason' dropdown menu is highlighted with a red box and labeled '3'. The 'Sign' button is highlighted with a red box and labeled '4'.

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

The screenshot shows the CSTLEARNING, DEMOTHETA patient record interface. The 'Interactive View and I&O' menu is selected. A table of vital signs is displayed, showing columns for Result, Comments, Flag, Date, and Performed By. The 'In Error' text is highlighted in the 'Comments' column with a red box and labeled '4'.

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.

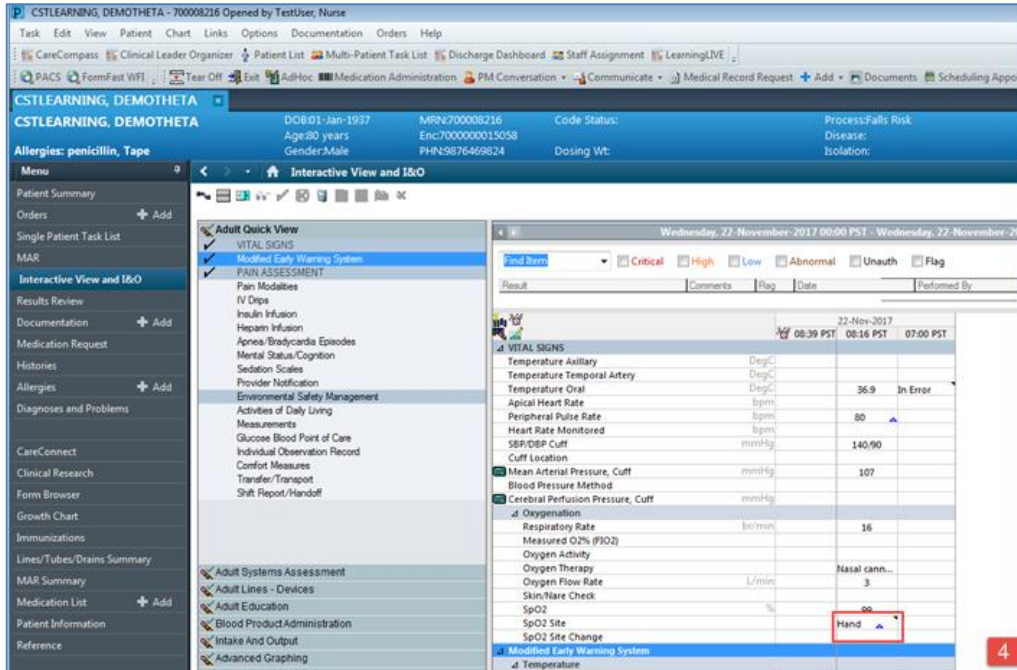
1. Right click on the documented value for SPO2 site, **hand**
2. Select **Add Comment**

The screenshot shows the CSTLEARNING, DEMOTHETA patient record. The 'Interactive View and I&O' tab is selected. A right-click context menu is open over the 'SpO2 Site' value 'Hand'. The menu includes options like 'Add Result...', 'View Result Details...', 'Add Comment...', and 'Flag with Comment...'. The 'Add Comment...' option is highlighted with a red box and a red '2'. The 'SpO2 Site' value 'Hand' is also highlighted with a red box and a red '1'.

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

The screenshot shows the 'Comment - CSTLEARNING, DEMOBETA - 700008215' dialog box. The 'SpO2 Site:' field is set to 'Hand'. The 'Comment' text area contains the text 'Right hand'. The 'OK' button is highlighted with a red box and a red '3'.

- An icon indicating the documentation has been modified  will display and another icon  will display in the cell. Right-click on the cell and select **View Comments...** to view a comment.



The screenshot shows the CSTLEARNING, DEMOTHEA patient interface. The top bar displays patient information: DOB: 01-Jan-1937, Age: 80 years, Gender: Male, MRN: 700008216, Enc: 7000000015058, PHN: 9876469824, Code Status, Process: Falls Risk, Disease: Isolation. The left menu includes options like Patient Summary, Orders, MAR, Results Review, Documentation, Medication Request, Histories, Allergies, Diagnoses and Problems, CareConnect, Clinical Research, Form Browser, Growth Chart, Immunizations, Lines/Tubes/Drains Summary, MAR Summary, Medication List, Patient Information, and Reference. The main area is titled 'Interactive View and I&O' and shows a table of vital signs and other clinical data. A red box highlights a cell in the table with a comment icon and a blue triangle icon.

Unit Item	Critical	High	Low	Abnormal	Unauth	Flag
VITAL SIGNS						
Temperature Axillary						
Temperature Temporal Artery						
Temperature Oral						
Apical Heart Rate						
Peripheral Pulse Rate						
Heart Rate Monitored						
SBP/DBP Cuff						
Cuff Location						
Mean Arterial Pressure, Cuff						
Blood Pressure Method						
Cerebral Perfusion Pressure, Cuff						
Oxygenation						
Respiratory Rate						
Measured O2% (FIO2)						
Oxygen Activity						
Oxygen Therapy						
Oxygen Flow Rate						
Skin/Name Check						
SpO2						
SpO2 Site						
SpO2 Site Change						
Modified Early Warning System						
Temperature						



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

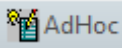
SCENARIO

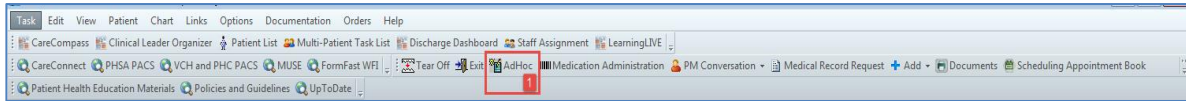
In this scenario, we will review another method of documentation.

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

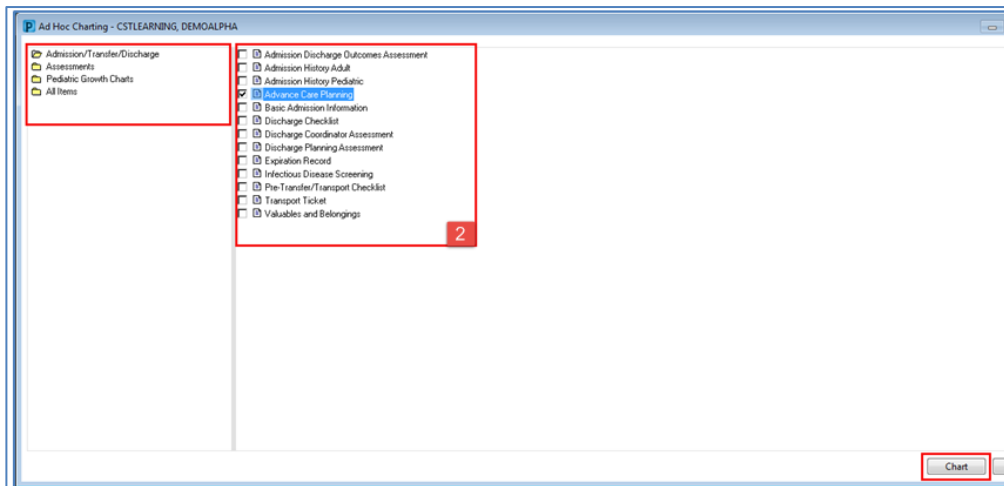
To open and document on a new PowerForm:

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  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

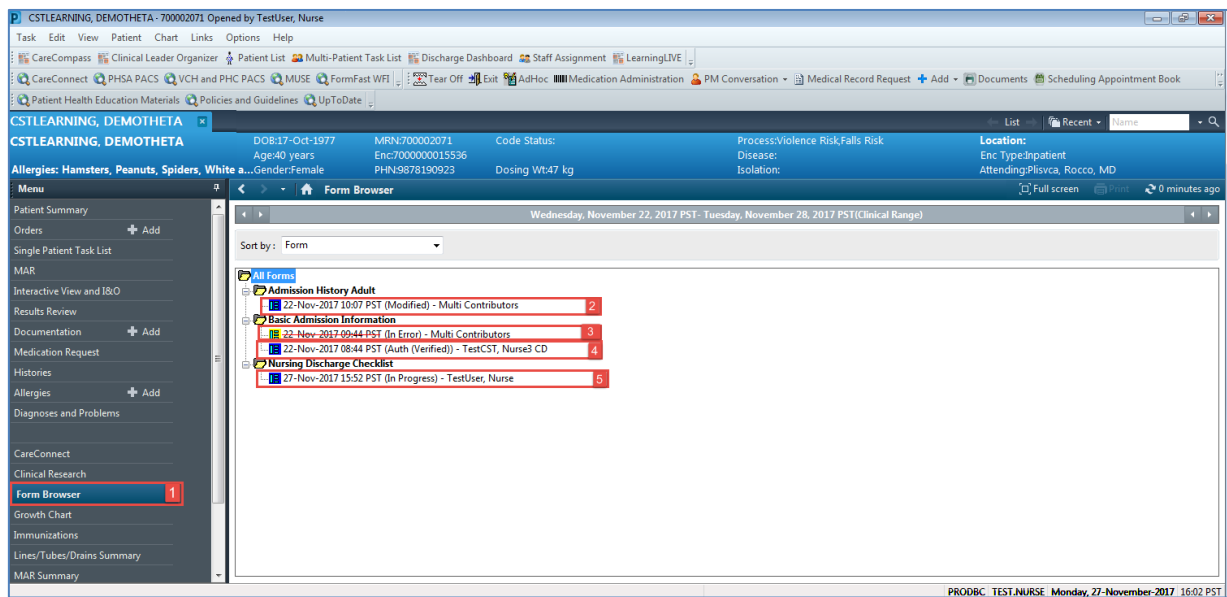
Activity 8.2 – Viewing an existing PowerForm

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

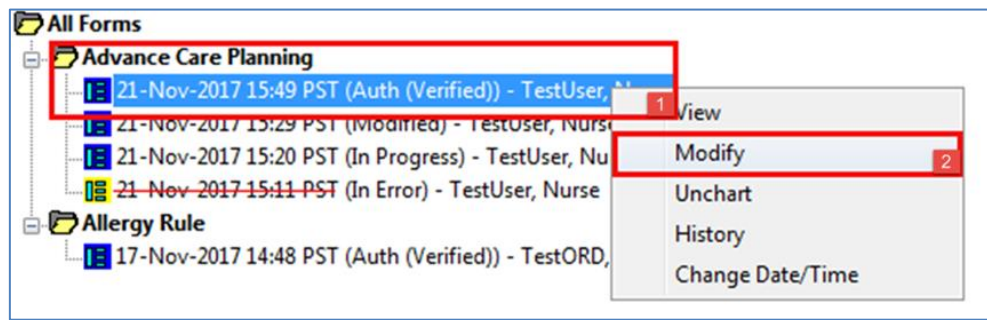
It may be necessary to modify PowerForms if information was entered incorrectly.

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**

- 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

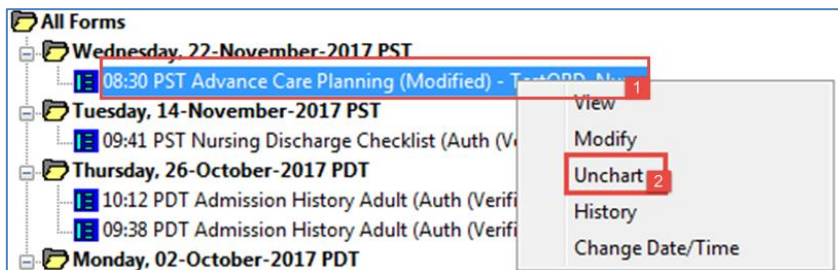
Activity 8.4 – Uncharting an existing PowerForm

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.

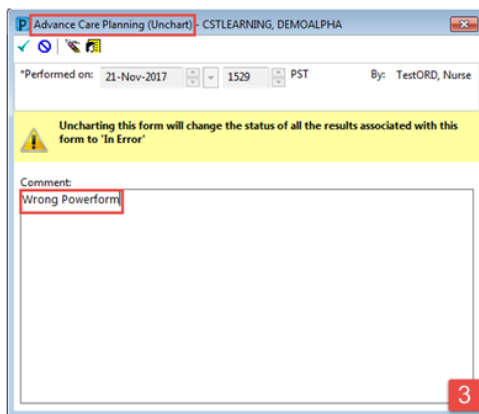
To unchart the PowerForm, within Form Browser:

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



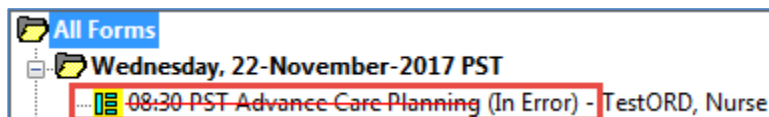
3. The Unchart window opens.

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: <ul style="list-style-type: none">  Document Allergies

SCENARIO

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

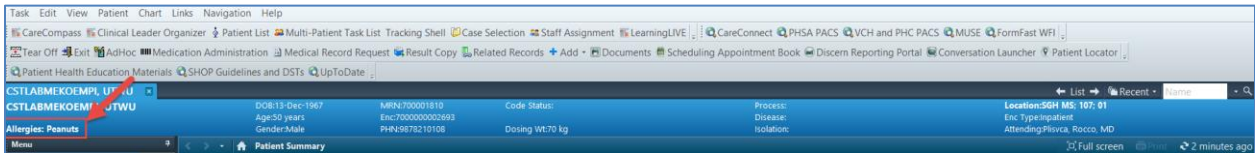
As an inpatient rural nurse you will complete the following activity:

-  Review allergies
-  Add an allergy

Activity 9.1 – Review Allergies

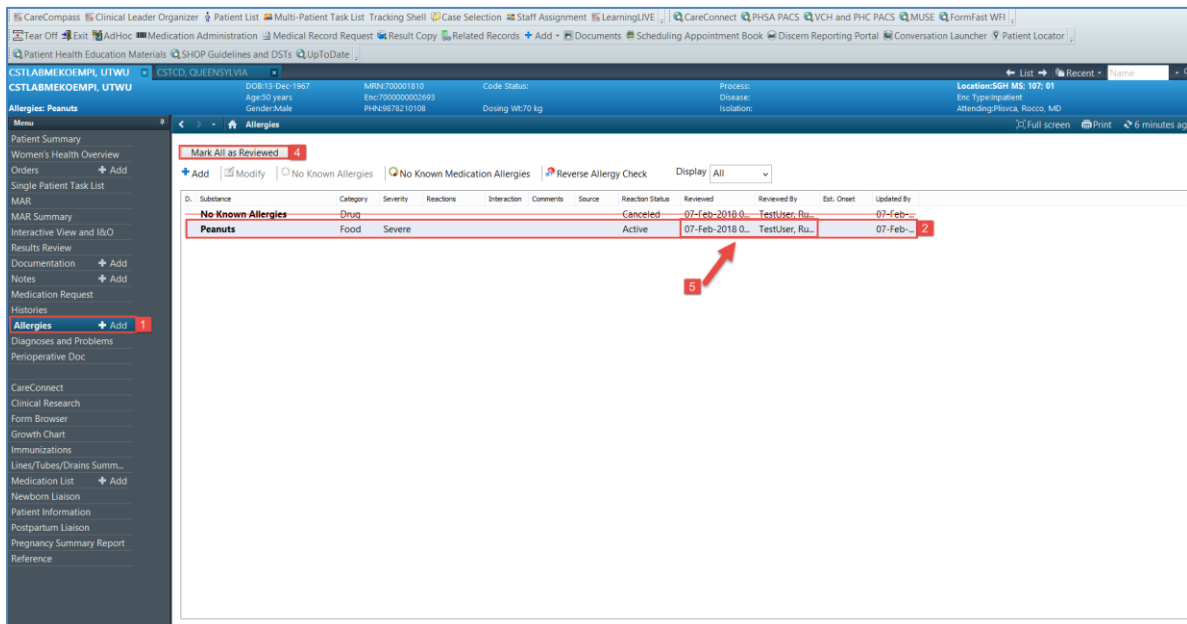
- 1 When your patient is admitted, you need to review his allergies. **Allergies** in the CIS carry forward from previous encounters.

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

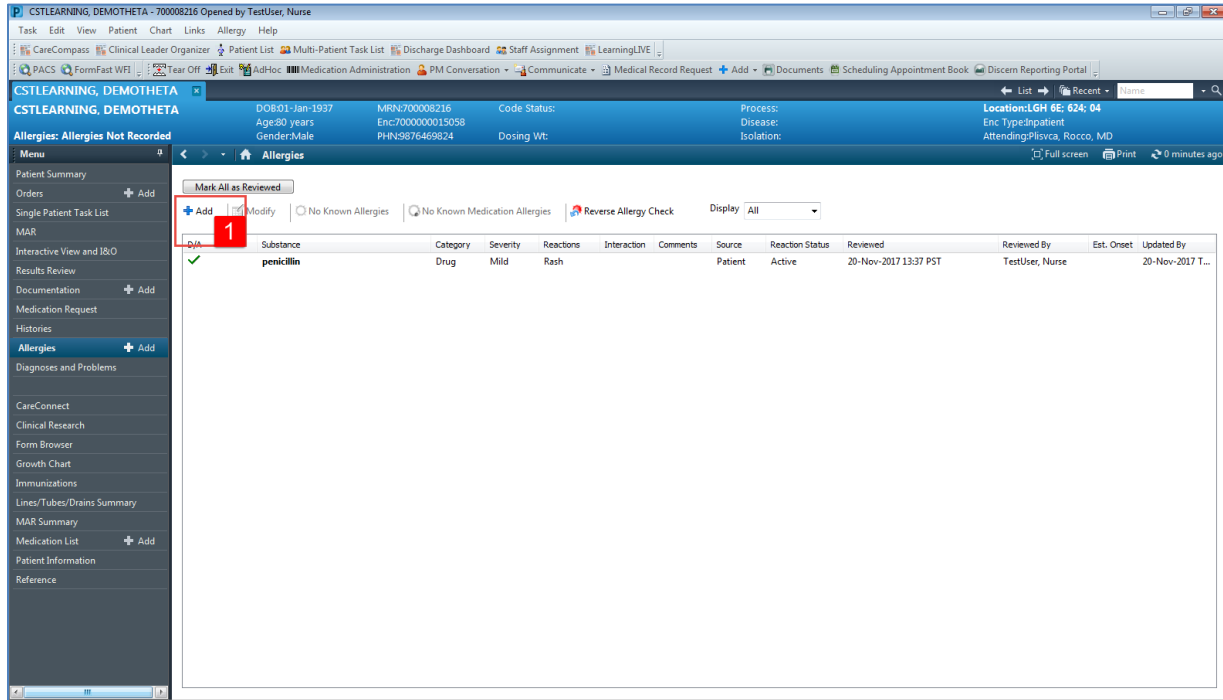
Key Learning Points

- 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 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**



The screenshot shows the EHR interface for a patient named CSTLEARNING, DEMOTHEA. The 'Allergies' section is selected in the left-hand menu. The main area displays a table of allergies. The first row shows an allergy to 'penicillin' with a severity of 'Mild' and a reaction of 'Rash'. The '+ Add' button is highlighted with a red box and a red '1'.

Substance	Category	Severity	Reactions	Interaction	Comments	Source	Reaction Status	Reviewed	Reviewed By	Est. Onset	Updated By
penicillin	Drug	Mild	Rash			Patient	Active	20-Nov-2017 13:37 PST	TestUser, Nurse	20-Nov-2017 T...	

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.

The screenshot shows the CSTLEARNING, DEMOTHEA interface. The top navigation bar includes links like Task, Edit, View, Patient, Chart, Links, Allergy, and Help. The main header displays patient information: DOB: 01-Jan-1937, Age: 80 years, Gender: Male, MRN: 700000015058, PHN: 9876469824, Code Status: Dosing Wt: Isolation: Location: LGH 6E: 624: 04. The left sidebar contains a menu with options like Patient Summary, Orders, Single Patient Task List, MAR, Interactive View and I&O, Results Review, Documentation, Medication Request, Histories, Allergies, Diagnoses and Problems, CareConnect, Clinical Research, Form Browser, Growth Chart, Immunizations, Lines/Tubes/Drains Summary, MAR Summary, Medication List, Patient Information, and Reference. The main content area shows the 'Allergies' section with a table of existing allergies. Below this, there is a form to add a new allergy. The 'Substance' field is highlighted with a red box and a red arrow, and the value 'tape' is entered. A red circle with the number '2' is also present. The 'Severity' field is set to 'Mild', and the 'Category' is set to 'Drug'. The 'Status' is 'Active'. The 'Reason' field is empty. The 'Add Comment' button is visible. The 'OK', 'OK & Add New', and 'Cancel' buttons are at the bottom right.

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

The screenshot shows the 'Substance Search' window. The search criteria are: *Search: tape, Starts with: Within: Terminology. The search results are displayed in a table with columns: Term, Code, Terminology, and Terminology Axis. The first row is 'Tape' with Code '14598838' and Terminology 'Allergy'. The second row is 'tapentadol' with Code 'd07453' and Terminology 'Multum Drug'. A red box highlights the 'Term' column with the value 'Tape' and a red arrow pointing to it. A red circle with the number '3' is also present. The 'Add to Favorites' button is at the bottom left, and the 'OK' and 'Cancel' buttons are at the bottom right.

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**

The screenshot shows the 'Allergies' form in the CSTLEARNING DEMOTHETA system. The form is titled 'Allergies: Allergies Not Recorded'. It contains a table with columns: D/A, Substance, Category, Severity, Reactions, Interaction, Comments, Source, Reaction Status, Reviewed, Reviewed By, Est. Onset, and Updated By. The first row shows 'penicillin' as the substance, 'Drug' as the category, 'Mild' as the severity, and 'Patient' as the info source. The 'OK' button is highlighted with a red box and a red arrow, indicating step 7.

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

The screenshot shows the 'Allergies' form in the CSTLEARNING DEMOTHETA system, updated with the 'Tape' allergy. The table shows the following data:

D. Substance	Category	Severity	Reactions	Interaction	Comments	Source	Reaction Status	Reviewed	Reviewed By	Est. Onset	Updated By
No Known Allergies	Drug						Canceled	07-Feb-2018 0...	TestUser, Ru...	07-Feb...	
Peanuts	Food	Severe					Active	07-Feb-2018 0...	TestUser, Ru...	07-Feb...	
Tape	Other	Mild					Active	07-Feb-2018 0...	TestUser, Ru...	07-Feb...	

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

Key Learning Points

- Documented allergies are displayed in the Banner Bar for all who access the patient's chart
- Allergies will display with the most severe allergy listed first

PATIENT SCENARIO 10 - Review Medication Administration Record (MAR)

Duration	Learning Objectives
10 minutes	<p>At the end of this Scenario, you will be able to:</p> <ul style="list-style-type: none">■ 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

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

The screenshot shows the 'All Active Medications (System)' window. On the left, the 'Time View' sidebar has 'Scheduled', 'Unscheduled', 'PRN', and 'Continuous Infusions' checked. A red box labeled '3' highlights the 'Continuous Infusions' option. The main table lists medications: acetaminophen 650 mg PO q4h, ceftriaxone 1,000 mg IV q12h, and hydromorphone 3 mg NG-tube q4h. A red box labeled '4' highlights the acetaminophen row. A right-click context menu is open over the acetaminophen row, with a red box labeled '5' highlighting the 'Reference Manual...' option.

- 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

The screenshot shows the 'MAR' (Medication Administration Record) window. The top bar indicates the date range: Monday, 2018-Jan-15 09:13 PST - Wednesday, 2018-Jan-17 09:13 PST (Clinical Ra). The left sidebar shows the 'Time View' with 'Scheduled', 'Unscheduled', 'PRN', and 'Continuous Infusions' checked. The main table displays medication administration times for various medications. Red boxes labeled '6' highlight specific medication rows: ranitidine, sodium chloride 0.9% (NS) bolus, thiamine, and vancomycin. The table shows administration status for each medication across different dates and times, with some cells indicating 'Not previously given' or '500 mg', '200 mg', '1,000 mg'.

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

- 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).
- The dates/times are displayed in **reverse chronological order**. (this differs from current state paper MARs)
- The current time and date column will always be highlighted in yellow.

Tuesday, 28-November-2017 12:21 PST - Thursday, 30-November-2017 12:21 PST (Clinical Range)											
	30-Nov-2017 10:00 PST	30-Nov-2017 06:00 PST	30-Nov-2017 02:00 PST	29-Nov-2017 22:00 PST	29-Nov-2017 18:00 PST	29-Nov-2017 14:00 PST	29-Nov-2017 12:26 PST	29-Nov-2017 12:22 PST	29-Nov-2017 10:00 PST	28-Nov-2017 22:00 PST	
Medications											
Scheduled											
acetaminophen (TYLENOL)	640 mg Last given: 22-Nov-2017 12:41 PST	640 mg Last given: 22-Nov-2017 12:41 PST	640 mg Last given: 22-Nov-2017 12:41 PST	640 mg Last given: 22-Nov-2017 12:41 PST	640 mg Last given: 22-Nov-2017 12:41 PST	640 mg Last given: 22-Nov-2017 12:41 PST	640 mg Last given: 22-Nov-2017 12:41 PST				
640 mg, PO, q4h, drug form: oral liq, start: 29-Nov-2017 14:00 PST											
PRN											
Maximum acetaminophen 4 g/24 h from all sources											
acetaminophen											
Continuous Infusions											
Temperature Axillary											
Temperature Oral											
Future											
Numeric Pain Score (0-10)											
Discontinued Scheduled											
vancomycin	1,000 mg Last given: 22-Nov-2017 10:00 PST			1,000 mg Last given: 22-Nov-2017 10:00 PST				1,000 mg Last given: 22-Nov-2017 10:00 PST			
1,000 mg, IV, q12h, start: 29-Nov-2017 12:22 PST											
Discontinued Unscheduled											
vancomycin											
Discontinued PRN											
Discontinued Continuous Infusions											
PRN											
HYDROMORPHONE (DILAUDID PRN range dose)							1 mg Not previously given				
dose range: 0.5 to 1 mg, PO, q1h, PRN pain, drug form: oral liq, start: 29-Nov-2017 12:24 PST											
HYDROMORPHONE											
Respiratory Rate											
Continuous Infusions											
sodium chloride 0.9% (NS) continuous infusion 1,000 mL order rate: 75 mL/h, IV, drug form: bag, start: 29-Nov-2017 12:23 PST, bag volume (mL): 1,000							Pending Not previously given				
Administration Information											
sodium chloride 0.9%											

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...**

The screenshot shows the MAR interface. On the left, the 'MAR' menu item is highlighted in the sidebar. The main window displays a list of medications. A right-click context menu is open over the 'vancomycin 1,000 mg, IV, q12h' entry. The 'Med Request...' option is selected in the context menu. Red boxes and numbers 1 and 2 highlight the medication entry and the 'Med Request...' option respectively.

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

The screenshot shows the 'Medication Request' dialog box. The patient information is 'CSTLEARNING, DE...' with age '81 years' and DOB '01-Jan-1937'. The medication is 'ceFAZolin 1,000 mg, IV, q8h, start: 08-Feb-2018 14:00 PST'. The 'Reason' dropdown is set to 'Cannot locate' (highlighted with a red box and number 3). The 'Priority' radio buttons are set to 'Low' (highlighted with a red box and number 4). The 'Submit' button is highlighted with a red box and number 5.

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...**

The screenshot shows the MAR interface. On the left, the 'MAR' menu item is highlighted in the sidebar. The main area shows a list of medications. A red box highlights the 'vancomycin 1,000 mg, IV, q12h' entry. A right-click context menu is open over this entry, with 'Med Request...' highlighted by a red box and a red circle with the number 2.

3. Click on the View History blue text [View History](#).

The screenshot shows the Medication Request form. The form displays patient information (TESTCSTSQ, TEN TEN, 33 years, M, DOB: 19-Nov-1984) and medication details (vancomycin 1,000 mg, IV, q12h, start: 07-Feb-2018 11:49 PST). The status is 'Pending (1) - 17 min ago'. A red box highlights the 'View History' link, with a red circle and the number 3 next to it.

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

Status	Reason	Priority/Doses	Event Time
Pending	Requested by TestUser, Rural-Nurse please change administration times to 0500 and 1700	Change in scheduled ti... High	07-Feb-2018 13:02 PST

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.

Medication	Reason	Priority	Comment
acetaminophen, 650 mg, PO, q4h, drug form: tab, start: 07-Feb-2018 11:48 PST, Maximum acetaminophen 4 g/24 h from all sources			
vancomycin, 1,000 mg, IV, q12h, start: 07-Feb-2018 11:49 PST			
DILAUDID PRN range dose, dose range: 0.5 to 1 mg, PO, q4h, PRN pain, drug form: tab, start: 07-Feb-2018 11:47 PST			

Submit



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

- 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:

- Right click on the blue medication task for **vancomycin 1,000mg, IV, q12h**
- Select **Reschedule This Dose...**

1,000 mg
Not given
within 7 days.

The screenshot shows the MAR interface for patient TESTCSTQ, TEN TEN. The top header displays patient information: DOB 19-Nov-1984, Age 33 years, Gender Male, MRN 700000015011, Enc 7000000015011, PHN 987831741, Code Status: Isolation, Process: Isolation, Location: 5GH MS 111: 01, and Attending: Pilsbry, Stuart, MD. The left sidebar contains a menu with options like Patient Summary, MAR, and Medication Request. The main area shows a grid of medication administration tasks. A context menu is open over a Vancomycin task, with the option 'Reschedule This Dose...' highlighted. The menu also includes 'Order Info...', 'Task Info...', 'Chart Details...', 'Quick Chart...', 'Chart Dose...', 'Chart Not Done...', and 'Unchart...'.

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

The dialog box is titled 'Reschedule dose only' and contains a warning icon. The text inside reads: 'Rescheduling this dose will only affect the selected dose and will not affect other future scheduled doses for this order. Would you like to continue?'. At the bottom, there are two buttons: 'Yes' and 'No'. The 'Yes' button is highlighted with a red box and a red number 3.

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

Reschedule vancomycin for TESTCSTSQ, T...

Currently scheduled date and time
07-Feb-2018 11:49

Rescheduled date and time
07-Feb-2018 1300 PST

Rescheduling reason
Patient Unavailable

OK Cancel

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

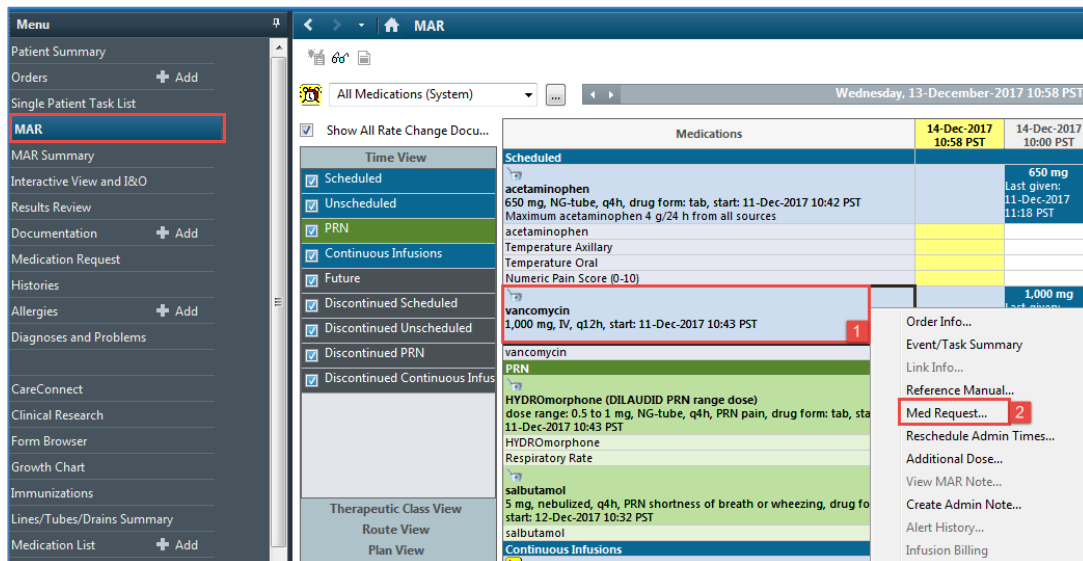
Key Learning Points

- Right clicking on the medication task on the MAR provides options such as Reschedule This Dose...
- Using this function will only reschedule one dose and not all future doses

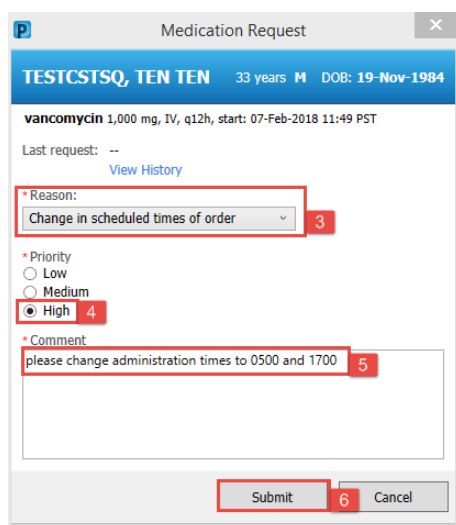
Activity 10.4 –Reschedule All Future Doses of a Medication

1 In some cases, all administration times of a medication may have to be completely adjusted. If this is the case, you can either call pharmacy, or notify pharmacy through the CIS by following these steps:

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



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.

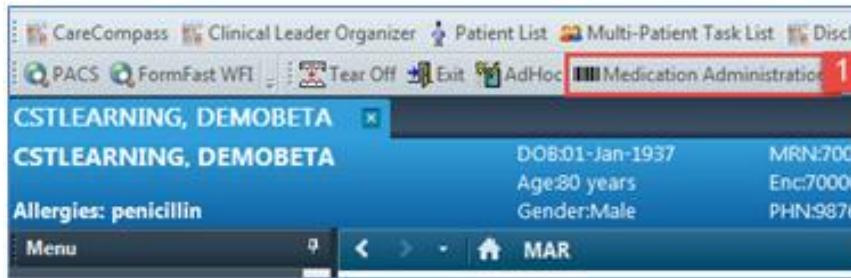
- PO medication: **acetaminophen 650 mg PO**, the drug form is tablet (acetaminophen 325 mg x 2 tabs)
- Range dose medication: **hydromorphone 0.5 mg PO**, PRN for pain, using hydromorphone 1 mg tab product barcode
- IV medication: **vancomycin 1 g, IV**, premixed bag

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.

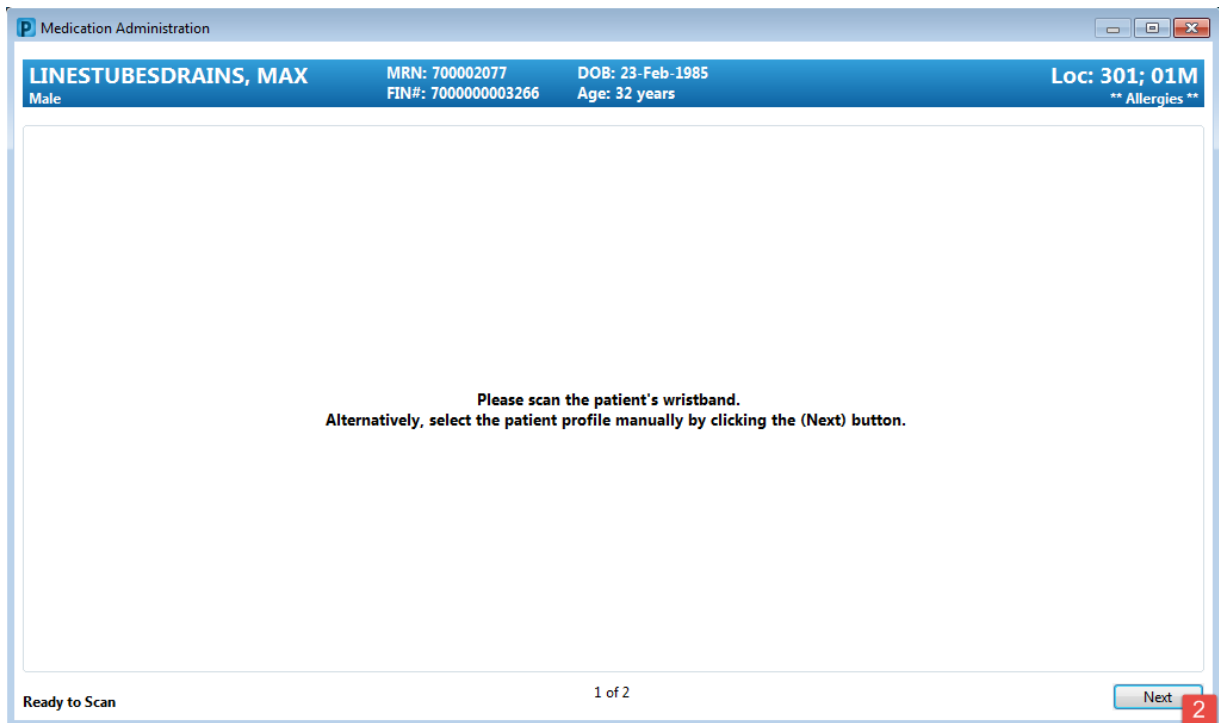
Let's begin the medication administration following the steps below:

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.

Medication Administration

Nurse Review Last Refresh at 11:02 PST

CTSLearning, DEMOTHEA MRN: 700008216 DOB: 01-Jan-1937 Loc: 406; 01
Male FIN#: 7000000015058 Age: 80 years ** Allergies **

11-Dec-2017 09:47 PST - 11-Dec-2017 12:17 PST

	Scheduled	Mnemonic	Details	Result
<input type="checkbox"/>	11-Dec-2017 10:42 PST	acetaminophen	650 mg, NG-tube, drug form: tab, start: 11-Dec-2017 10:42 PST Maximum acetaminophen 4 g/24 h from all sources	
<input type="checkbox"/>	11-Dec-2017 10:43 PST	vancomycin	1,000 mg, IV, start: 11-Dec-2017 10:43 PST	
<input type="checkbox"/>	PRN	hydromorphone HYDROMORPHONE (DILAUDID PRN range dose)	dose range: 0.5 to 1 mg, NG-tube, q4h, PRN pain, drug form: tab, start: 11-...	
<input type="checkbox"/>	Continuous	insulin regular	titrate, IV, 1 unit/h starting rate, 0 unit/h minimum rate, 20 unit/h maximum r...	
<input type="checkbox"/>	Continuous	insulin regular (human) additive 100 unit + sodium chloride 0.9...	Protocol for Patient NOT currently receiving insulin infusion Blood glucos...	
<input type="checkbox"/>	Continuous	norepinephrine norepinephrine additive 8 mq + dextrose 5% (D5W) titratable i...	titrate, IV, 0 mcg/min minimum rate, 20 mcg/min maximum rate, titrate instr...	
<input type="checkbox"/>	Continuous	Sodium Chloride 0.9%	order rate: 125 mL/h, IV, drug form: bag, start: 10-Dec-2017 15:52 PST, bag...	
<input type="checkbox"/>	Continuous	sodium chloride 0.9% (NS) continuous infusion 1,000 mL	order rate: 75 mL/h, IV, drug form: bag, start: 11-Dec-2017 10:43 PST, bag ...	
<input type="checkbox"/>	Continuous	sodium chloride 0.9% (NS) continuous infusion 1,000 mL		

Ready to Scan 2 of 2 Back Sign

- 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.

Filtered Tasks

IP-CriticalCareNurse, Terry MRN: 760000277 DOB: 1977-Jan-13 Loc: 710; 04
Male FIN#: 7600000000277 Age: 41 years ** No Known Medication Allergies **

Scanned:

Medication	Strength	Volume
acetaminophen	325 mg	1 tab

Qualified Tasks:

Scheduled	Mnemonic	Details	Qualifications
2018-Jan-17 02:00 PST	acetaminophen	650 mg, NG-tube, drug form: tab, start: 2018-Jan-17 02:00 PST Maximum acetaminophen 4 g/24 h from all sources	Underdose
2018-Jan-17 06:00 PST	acetaminophen	650 mg, NG-tube, drug form: tab, start: 2018-Jan-17 06:00 PST Maximum acetaminophen 4 g/24 h from all sources	Underdose
2018-Jan-17 10:00 PST	acetaminophen	650 mg, NG-tube, drug form: tab, start: 2018-Jan-17 10:00 PST Maximum acetaminophen 4 g/24 h from all sources	Underdose

Scan additional ingredients or choose a task to continue. OK Cancel

- 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.
- Select the one that is close to the current time you administering acetaminophen. In this Activity, let's select 06:00.
- Click **OK**

Filtered Tasks

IP-CriticalCareNurse, Terry MRN: 760000277 DOB: 1977-Jan-13 Loc: 710; 04
Male FIN#: 7600000000277 Age: 41 years ** No Known Medication Allergies **

Scanned:

Medication	Strength	Volume
acetaminophen	650 mg	2 tab

Qualified Tasks:

Scheduled	Mnemonic	Details	Qualifications
2018-Jan-17 02:00 PST	acetaminophen	650 mg, NG-tube, drug form: tab, start: 2018-Jan-1...	Exact match
		Maximum acetaminophen 4 g/24 h from all sources	
2018-Jan-17 06:00 PST	acetaminophen	650 mg, NG-tube, drug form: tab, start: 2018-Jan-1...	Exact match
		Maximum acetaminophen 4 g/24 h from all sources	
2018-Jan-17 10:00 PST	acetaminophen	650 mg, NG-tube, drug form: tab, start: 2018-Jan-1...	Exact match
		Maximum acetaminophen 4 g/24 h from all sources	

Scan additional ingredients or choose a task to continue.

OK Cancel

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

Early/Late Reason

acetaminophen
650 mg, NG-tube, drug form: tab, start:
2018-Jan-17 06:00 PST
Maximum acetaminophen 4 g/24 h from all sou...

Scheduled date/time : 2018-Jan-17 06:00:00 PST
Performed date/time : 2018-Jan-17 09:06:00 PST

Please specify a reason why the medication is being documented late:

First dose given

Comment :

OK Cancel

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

Medication Administration

Nurse Review Last Refresh at 11:21 PST

IP-CriticalCareNurse, Juan MRN: 760000270 DOB: 1977-Jan-13 Loc: 706; 01
Male FIN#: 760000000270 Age: 41 years ** No Known Allergies **

2018-Jan-17 10:06 PST - 2018-Jan-17 12:36 PST

	Scheduled	Mnemonic	Details	Result
<input checked="" type="checkbox"/>	2018-Jan-17 06:00 PST	acetaminophen	650 mg, NG-tube, drug form: tab, star... Maximum acetaminophen 4 g/24 h fr...	acetaminophen 650 mg, NG-tube...
<input checked="" type="checkbox"/>	2018-Jan-17 10:00 PST	acetaminophen	650 mg, NG-tube, drug form: tab; start: ... Maximum acetaminophen 4 q/24 h from ...	
<input type="checkbox"/>	2018-Jan-17 10:00 PST	vancomycin	1,000 mg, IV, administer over: 60 minute...	
<input type="checkbox"/>	PRN	Dextrose 50% in Water	12.5 g, IV, q15min, PRN hypoglycemia, a...	
<input type="checkbox"/>	PRN	hydromorphone	dose range: 0.5 to 1 mg, NG-tube, q4h, ...	
<input type="checkbox"/>	PRN	HYDROMORPHONE (HYD...	DILAUDID EQUIV	
<input type="checkbox"/>	PRN	magnesium sulfate	5 g, IV, once, PRN hypomagnesemia, ad...	
<input type="checkbox"/>	PRN	potassium chloride	Dose as per ICU Electrolyte Replacement...	
<input type="checkbox"/>	PRN	potassium chloride	20 mmol, IV, q30min, PRN hypokalemia, ...	
<input type="checkbox"/>	PRN	potassium chloride	40 mmol, NG-tube, TID, PRN hypokalemi...	
<input type="checkbox"/>	PRN	sodium phosphate	15 mmol, IV, q4h interval, PRN hypophos...	
<input type="checkbox"/>	Continuous	SODIUM phosphate	Dose as per ICU Electrolyte Replacement...	
<input type="checkbox"/>	Continuous	insulin regular	titrate, IV, 1 unit/h starting rate, 0 unit/h ...	
<input type="checkbox"/>	Continuous	insulin regular (human) ...	Protocol for Patient NOT currently receivi...	
<input type="checkbox"/>	Continuous	norepinephrine	titrate, IV, 0 mcg/min minimum rate, 20 ...	
<input type="checkbox"/>	Continuous	norepinephrine additive...		
<input type="checkbox"/>	Continuous	vasopressin	titrate, IV, 0 unit/min minimum rate, 0.04 ...	

Ready to Scan 2 of 2 Back Sign

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.

Discern: CSTLEARNING, DEMODELTA (1 of 1)


Cerner

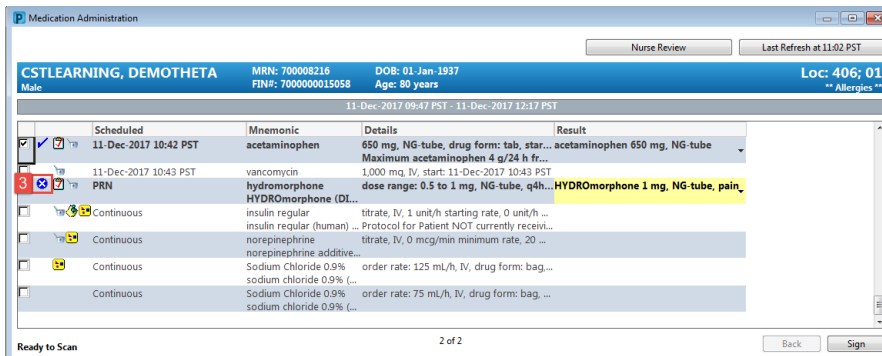
Range Dose Warning

You are administering a Range Dose order for HYDROMORPHONE. The range is from 0.5 mg to 1 mg.

Please verify you are administering the correct dose.

OK

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



Medication Administration

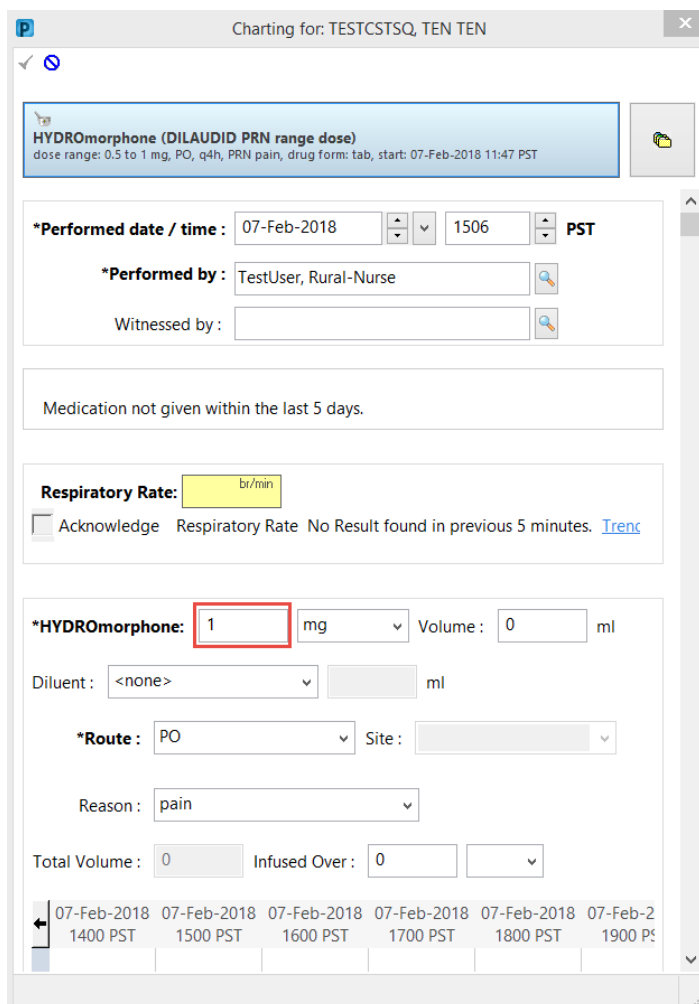
CSTLEARNING, DEMOTHEA MRN: 700008216 DOB: 01-Jan-1937 Loc: 406; 01
Male FIN#: 7000000015058 Age: 80 years **Allergies**

11-Dec-2017 09:47 PST - 11-Dec-2017 12:17 PST

Scheduled	Mnemonic	Details	Result
11-Dec-2017 10:42 PST	acetaminophen	650 mg, NG-tube, drug form: tab, star...	Maximum acetaminophen 650 mg, NG-tube
11-Dec-2017 10:43 PST	vancomycin	1,000 mg, IV, start: 11-Dec-2017 10:43 PST	
PRN	hydromorphone (DL...	dose range: 0.5 to 1 mg, NG-tube, q4h...	HYDROMORPHONE 1 mg, NG-tube, pain
Continuous	insulin regular	titrate, IV, 1 unit/h starting rate, 0 unit/h ...	
Continuous	insulin regular (human) ...	Protocol for Patient NOT currently receiv...	
Continuous	norepinephrine	titrate, IV, 0 mcg/min minimum rate, 20 ...	
Continuous	norepinephrine additive...		
Continuous	Sodium Chloride 0.9% (...)	order rate: 125 mL/h, IV, drug form: bag...	
Continuous	Sodium Chloride 0.9% (...)	order rate: 75 mL/h, IV, drug form: bag, ...	

Ready to Scan 2 of 2 Back Sign

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



Charting for: TESTCSTSQ, TEN TEN

HYDROMORPHONE (DILAUDID PRN range dose)
dose range: 0.5 to 1 mg, PO, q4h, PRN pain, drug form: tab, start: 07-Feb-2018 11:47 PST

*Performed date / time : 07-Feb-2018 1506 PST

*Performed by : TestUser, Rural-Nurse

Witnessed by :

Medication not given within the last 5 days.

Respiratory Rate:

☐ Acknowledge Respiratory Rate No Result found in previous 5 minutes. [Trend](#)

*HYDROMORPHONE: mg Volume : ml

Diluent : ml

*Route : Site :

Reason :

Total Volume : Infused Over :

07-Feb-2018 1400 PST 07-Feb-2018 1500 PST 07-Feb-2018 1600 PST 07-Feb-2018 1700 PST 07-Feb-2018 1800 PST 07-Feb-2018 1900 PST

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.

Charting for: TESTCSTSQ, TEN TEN

HYDROMORPHONE (DILAUDID PRN range dose)
dose range: 0.5 to 1 mg, PO, q4h, PRN pain, drug form: tab, start: 07-Feb-2018 11:47 PST

*Performed date / time : 07-Feb-2018 1521 PST

*Performed by : TestUser, Rural-Nurse

Witnessed by :

Medication not given within the last 5 days.

Respiratory Rate: 20 br/min

☐ Acknowledge Respiratory Rate No Result found in previous 5 minutes. [Trend](#)

***HYDROMORPHONE:** 0.5 mg Volume : 0 ml

Diluent : <none> ml

*Route : PO Site :

Reason : pain

Total Volume : 0 Infused Over : 0 minut

07-Feb-2018 1400 PST 07-Feb-2018 1500 PST 07-Feb-2018 1600 PST 07-Feb-2018 1700 PST 07-Feb-2018 1800 PST 07-Feb-2018 1900 PST

OK Cancel

Let's scan your last medication.

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

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

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.

131 | 186

Charting for: Validate, IP-CriticalCareNurse

vancomycin
1,000 mg, IV, administer over: 60 minute, drug form: bag, start: 2018-Jan-16 02:00 PST, bag volume (ml): 250

*Performed date / time : 16-Jan-2018 1039 PST

*Performed by : TestUser, ICU-Nurse

Witnessed by :

*vancomycin: 1,000 mg Volume : 250 ml

Diluent : <none> ml

*Route : IV Site :

Total Volume : 250 Infused Over : 60 minute

2018-Jan-16 0900 PST	2018-Jan-16 1000 PST	2018-Jan-16 1100 PST	2018-Jan-16 1200 PST	2018-Jan-16 1300 PST	2018-Jan-16 1400 PST
87.5	162.5				

☐ Not Given

Reason :

Comment...

OK Cancel

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.

Charting for: Validate, IP-CriticalCareNurse

vancomycin
1,000 mg, IV, drug form: inj, start: 2018-Jan-16 10:24 PST

*Performed date / time : 16-Jan-2018 1025 PST

*Performed by : TestUser, ICU-Nurse

Witnessed by :

*vancomycin: 1,000 mg Volume : 0 ml

Diluent : dextrose 5% ml

*Route : IV Site :

Total Volume : 0 Infused Over : 0 minute


2018-Jan-16 0900 PST 2018-Jan-16 1000 PST 2018-Jan-16 1100 PST 2018-Jan-16 1200 PST 2018-Jan-16 1300 PST 2018-Jan-16 1400 PST

☐ Not Given

Reason :

Comment...

OK Cancel

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

Medication Administration

Nurse Review Last Refresh at 11:02 PST

CSTLEARNING, DEMOTHEA MRN: 700008216 DOB: 01-Jan-1937 Loc: 406; 01
Male FIN#: 7000000015058 Age: 80 years ** Allergies **

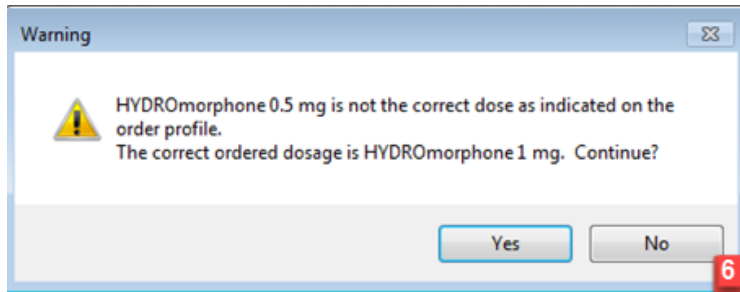
11-Dec-2017 09:47 PST - 11-Dec-2017 12:17 PST

	Scheduled	Mnemonic	Details	Result
<input checked="" type="checkbox"/>	11-Dec-2017 10:42 PST	acetaminophen	650 mg, NG-tube, drug form: tab, star... Maximum acetaminophen 4 g/24 h fr...	acetaminophen 650 mg, NG-tube
<input checked="" type="checkbox"/>	11-Dec-2017 10:43 PST	vancomycin	1,000 mg, IV, start: 11-Dec-2017 10:43 ...	vancomycin 1,000 mg, IV
<input checked="" type="checkbox"/>	PRN	hydromorphone	dose range: 0.5 to 1 mg, NG-tube, q4h...	HYDROmorphone 0.5 mg, NG-tube, pain, Respiratory Rate : 12 br/min
<input type="checkbox"/>	Continuous	insulin regular	titrate, IV, 1 unit/h starting rate, 0 unit/h ...	
<input type="checkbox"/>	Continuous	insulin regular (human) ...	Protocol for Patient NOT currently receiv...	
<input type="checkbox"/>	Continuous	norepinephrine	titrate, IV, 0 mcg/min minimum rate, 20 ...	
<input type="checkbox"/>	Continuous	norepinephrine additive...		
<input type="checkbox"/>	Continuous	Sodium Chloride 0.9%	order rate: 125 mL/h, IV, drug form: bag...	
<input type="checkbox"/>	Continuous	sodium chloride 0.9% (...)		
<input type="checkbox"/>	Continuous	Sodium Chloride 0.9%	order rate: 75 mL/h, IV, drug form: bag ...	
<input type="checkbox"/>	Continuous	sodium chloride 0.9% (...)		

Ready to Scan 2 of 2

Back **5** Sign


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



Congratulations, you have successfully administered three medications!

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

Medications	21-Nov-2017 14:00 PST	21-Nov-2017 12:54 PST	21-Nov-2017 11:57 PST	21-Nov-2017 11:54 PST	21-Nov-2017 11:11 PST	21-Nov-2017 11:09 PST
Scheduled						
acetaminophen 650 mg, PO, q4h, drug form: tab, start: 21-Nov-2017 11:11 PST Maximum acetaminophen 4 g/24 h from acetaminophen	650 mg Not previously given				✓ Complete	
Temperature Axillary						
Temperature Oral						
Numeric Pain Score (0-10)						
PRN						
vancomycin 1,000 mg, IV, q12h, start: 21-Nov-2017 11:09 PST						✓ Complete
vancomycin						
HYDROMORPHONE (HYDROMORPHONE P... dose range: 0.5 to 1 mg, PO, q4h, PRN pain, drug form: tab, start: 21-Nov-2017 11:09 PST ORLAUDID EQUIV HYDROMORPHONE Respiratory Rate		Med Response	1 mg Not previously given	✓ Complete		

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

All Active Medications (System)		Medications	21-Nov-2017 14:00 PST	21-Nov-2017 12:54 PST	21-Nov-2017 12:02 PST	21-Nov-2017 11:54 PST
<input checked="" type="checkbox"/> Show All Rate Change Docu...						
Time View						
<input checked="" type="checkbox"/> Scheduled		Scheduled				
<input checked="" type="checkbox"/> Unscheduled		acetaminophen 650 mg, PO, q4h, drug form: tab, start: 21-Nov-2017 11:11 PST Maximum acetaminophen 4 g/24 h from acetaminophen	650 mg Last given: 21-Nov-2017 11:54 PST			650 mg Auth (Vr
<input checked="" type="checkbox"/> PRN		Temperature Axillary				
<input checked="" type="checkbox"/> Continuous Infusions		Temperature Oral				
<input checked="" type="checkbox"/> Future		Numeric Pain Score (0-10)				
<input checked="" type="checkbox"/> Discontinued Scheduled		vancomycin 1,000 mg, IV, q12h, start: 21-Nov-2017 11:09 PST				1,000 mg Auth (Vr
<input checked="" type="checkbox"/> Discontinued Unscheduled		vancomycin				
<input checked="" type="checkbox"/> Discontinued PRN		PRN				
<input checked="" type="checkbox"/> Discontinued Continuous Infus		HYDROMORPHONE (HYDROMORPHONE P... dose range: 0.5 to 1 mg, PO, q4h, PRN pain, drug form: tab, start: 21-Nov-2017 11:09 PST ORLAUDID EQUIV HYDROMORPHONE Respiratory Rate	Med Response	1 mg Last given: 21-Nov-2017 11:54 PST		* 0.5 mg Auth (Vr 12 Auth (Verifies

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.

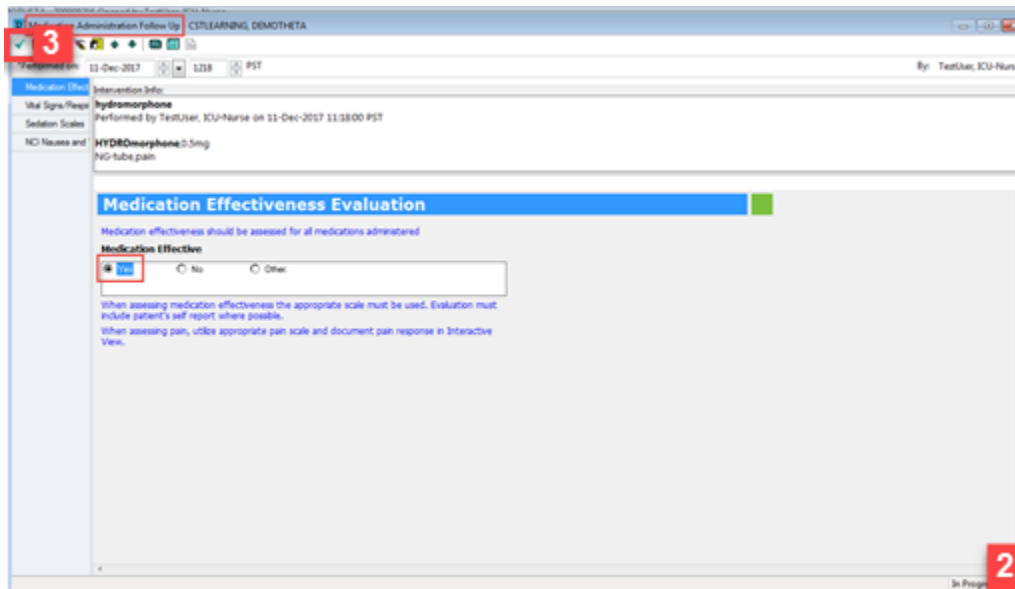
Activity 11.2 – Documenting Patient Response to Medication (Medication Response)

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.

Medications	11-Dec-2017 18:00 PST	11-Dec-2017 14:00 PST	11-Dec-2017 12:18 PST	11-Dec-2017 11:19 PST	11-Dec-2017 11:18 PST	11-Dec-2017 08:00 PST
Scheduled						
acetaminophen 650 mg, NG-tube, q4h, drug form: tab, start: 11-Dec-2017 10:42 PST Maximum acetaminophen 4 g/24 h from all sources	650 mg last given: 11-Dec-2017 11:18 PST	650 mg last given: 11-Dec-2017 11:18 PST				
acetaminophen Temperature Axillary Temperature Oral Numeric Pain Score (0-10)					650 mg Auth (V)	
vancomycin 1,000 mg, IV, q12h, start: 11-Dec-2017 10:43 PST						
vancomycin					1,000 mg Auth (V)	
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				Med Response 1 mg last given: 11-Dec-2017 11:18 PST		
HYDROMORPHONE Respiratory Rate					* 0.5 mg Auth (V) 12 Auth (Verific)	

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.



3

Medication Administration Follow Up

11-Dec-2017 12:18 PST

By: TestUser, ICU-Nurse

Medication Effectiveness Evaluation

Medication effectiveness should be assessed for all medications administered


Medication Effective




☒ Yes ☐ No ☐ Other

When assessing medication effectiveness the appropriate scale must be used. Evaluation must include patient's self report where possible.

When assessing pain, utilize appropriate pain scale and document pain response in Interactive View.

2

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-Dec-2017 11:18 PST
Scheduled						
 acetaminophen 650 mg, NG-tube, q4h, drug form: tab, start: 11-Dec-2017 10:42 PST Maximum acetaminophen 4 g/24 h from all sources	650 mg Last given: 11-Dec-2017 11:18 PST	650 mg Last given: 11-Dec-2017 11:18 PST	650 mg Last given: 11-Dec-2017 11:18 PST			
acetaminophen					650 mg Auth (V)	
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 (V)	
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 (Verified)	

Key Learnings Points

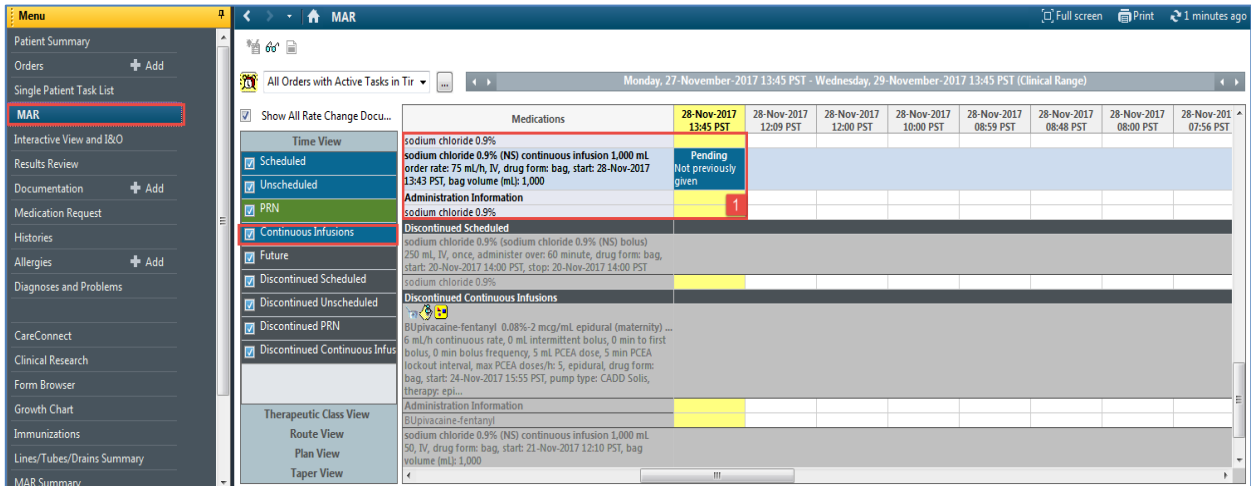
- Some PRN medications require further documentation on how the patient responds to the drugs. This can be done under Med Response from the MAR.

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

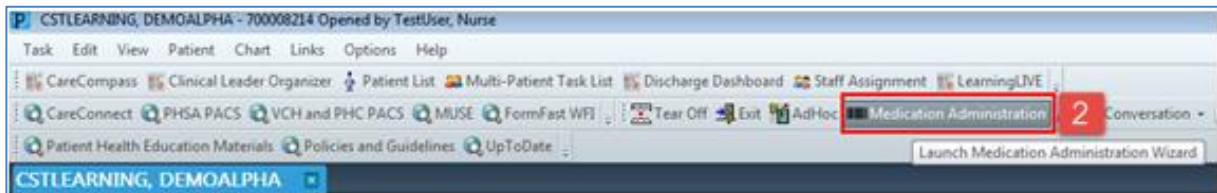
1 To administer normal saline continuous IV infusion, complete the following steps:

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.




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

Medication Administration

LINESTUBESDRAINS, MAX MRN: 700002077 DOB: 23-Feb-1985 Loc: 301; 01M
Male FIN#: 7000000003266 Age: 32 years ** Allergies **

Please scan the patient's wristband.
Alternatively, select the patient profile manually by clicking the (Next) button.


Ready to Scan 1 of 2 Next 3

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

Medication Administration

CSTLEARNING, DEMOALPHA MRN: 700008214 DOB: 01-Jan-1937 Loc: 624; 02
Male FIN#: 7000000015055 Age: 80 years ** Allergies **

28-Nov-2017 12:38 PST - 28-Nov-2017 15:08 PST

Scheduled	Mnemonic	Details	Result
<input type="checkbox"/> 28-Nov-2017 10:00 PST	ciprofloxacin	200 mg, IV, administer over: 60 minute, d...	
<input type="checkbox"/> 28-Nov-2017 10:00 PST	hydromorphone HYDRomorphone	3 mg, NG-tube, start: 28-Nov-2017 10:00...	
<input type="checkbox"/> 28-Nov-2017 10:00 PST	vancomycin	1,000 mg, IV, start: 28-Nov-2017 10:00 PST	
<input type="checkbox"/> 28-Nov-2017 12:00 PST	piperacillin-tazobactam	3.375 q, IV, start: 28-Nov-2017 12:00 PST	
<input type="checkbox"/> 28-Nov-2017 14:00 PST	acetaminophen	650 mg, PO, drug form: tab, start: 28-No... Maximum acetaminophen 4 q/24 h from ...	
<input type="checkbox"/> 28-Nov-2017 14:00 PST	hydromorphone HYDRomorphone	3 mg, NG-tube, start: 28-Nov-2017 14:00...	
<input type="checkbox"/> 28-Nov-2017 15:00 PST	moxifloxacin MOXIloxacin	400 mg, IV, administer over: 60 minute, d...	
<input type="checkbox"/> PRN	fentanyl	dose range: 25 to 50 mcg, IV, q5min, PR...	
<input type="checkbox"/> Continuous	norepinephrine norepinephrine additive...	titrate, IV, 0 mcg/min minimum rate, 20 ...	
<input type="checkbox"/> Continuous	Sodium Chloride 0.9% sodium chloride 0.9% (order rate: 50 mL/h, IV, drug form: bag, ...	
<input checked="" type="checkbox"/>  Continuous	Sodium Chloride 0.9% sodium chloride 0.9% ...	order rate: 75 mL/h, IV, drug form: ba... 1,000 mL, IV, 75 mL/h, <Site>	

4 5

6. Fill in the following information, in this case:

- **Performed time** = 0600
- **Site** = Arm, Lower - Left

7. Click **OK**

Charting for: CSTLEARNING, DEMOTHEA

sodium chloride 0.9% (NS) continuous infusion 1,000 mL
order rate: 75 mL/h, IV, drug form: bag, start: 11-Dec-2017 10:43 PST, bag volume (mL): 1,000

☒ Yes ☐ No sodium chloride 0.9% (NS) continuous infusion 1,000 mL Change

*Performed date / time : 11-Dec-2017 0600 6 PST Comment...

*Performed by : TestUser, ICU-Nurse

Witnessed by :

*Bag # : 1

*Site : Antecubital Fossa - Left

*Volume (mL) : <Show All>

*Rate (mL/h) : Arm, Lower - Left 6

Begin Bag OK 7 Cancel

8. Click the **Sign** button

Medication Administration

Nurse Review Last Refresh at 11:24 PST

CSTDEMO, ZEUS MRN: 700004780 DOB: 01-Feb-1979 Loc: IC06; 01
Male FIN#: 7000000013571 Age: 38 years ** Allergies **

02-Dec-2017 10:09 PST - 02-Dec-2017 12:39 PST

	Scheduled	Mnemonic	Details	Result
<input checked="" type="checkbox"/>	02-Dec-2017 08:00 PST	thiamine	200 mg, PO, drug form: tab, start: 02-Dec...	
<input checked="" type="checkbox"/>	02-Dec-2017 12:00 PST	piperacillin-tazobactam	3.375 g, IV, start: 02-Dec-2017 12:00 PST	
<input checked="" type="checkbox"/>	PRN	Dextrose 50% in Water	12.5 g, IV, q15min, PRN hypoglycemia, dr...	
<input checked="" type="checkbox"/>	PRN	dextrose 50% (dextrose...	For blood glucose 4 mmol/L or LESS; ad...	
<input checked="" type="checkbox"/>	PRN	fentanyl	25 mcg, IV, q5min, PRN pain-breakthrou...	
<input checked="" type="checkbox"/>	PRN	fentanyl	dose range: 25 to 50 mcg, IV, q5min, PR...	
<input checked="" type="checkbox"/>	PRN	fentanyl (fentanyl PRN r...		
<input checked="" type="checkbox"/>	PRN	hydromorphone	dose range: 0.5 to 1 mg, IV, q1h, PRN pa...	
<input checked="" type="checkbox"/>	PRN	HYDROMORPHONE (HYD...	DILAUDID EQUIV	
<input checked="" type="checkbox"/>	PRN	salbutamol	100 mcg = 1 puff, inhalation, q1h, PRN s...	
<input checked="" type="checkbox"/>	PRN	salbutamol (salbutamol ...		
<input checked="" type="checkbox"/>	PRN	sodium citrate	3 mL, instillation, q4h interval, PRN other ...	
<input checked="" type="checkbox"/>	Continuous	sodium citrate (sodium ...	PRN Reason: For capping of dialysis cath...	
<input checked="" type="checkbox"/>	Continuous	insulin regular	titrated, IV, 1 unit/h starting rate, 0 unit/h ...	
<input checked="" type="checkbox"/>	Continuous	insulin regular (human) ...	Protocol for Patient NOT currently receiv...	
<input checked="" type="checkbox"/>	Continuous	norepinephrine	titrated, IV, 0 mcg/min minimum rate, 20 ...	
<input checked="" type="checkbox"/>	Continuous	norepinephrine additive...		
<input checked="" type="checkbox"/>	Continuous	Sodium Chloride 0.9%	order rate: 25 mL/h, IV, drug form: ba... 1,000 mL, IV, 25 mL/h, Jugular, Internal - Rig	
<input checked="" type="checkbox"/>	Continuous	sodium chloride 0.9% ...		

Ready to Scan 2 of 2 8 Sign

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

Medications	02-Dec-2017 12:00 PST	02-Dec-2017 11:24 PST	02-Dec-2017 11:16 PST	02-Dec-2017 11:15 PST	02-Dec-2017 11:10 PST
norepinephrine additive 8 mg dextrose 5% (D5W) titratable infusion 250 mL titrate, IV, 0 mcg/min minimum rate, 20 mcg/min maximum rate, titrate instructions: titrate to maintain MAP goal, start: 15-Nov-2017 15:18 PST, bag volume (mL): 250			Pending Last bag started: 15-Nov-2017 16:04 PST		
Administration Information NORepinephrine dextrose 5%					
sodium chloride 0.9% (NS) continuous infusion 1,000 mL order rate: 25 mL/h, IV, drug form: bag, start: 15-Nov-2017 15:18 PST, bag volume (mL): 1,000		1,000 mL Last bag started: 02-Dec-2017 11:15 PST	9	Complete Begin Bag 1,000	
Administration Information sodium chloride 0.9%					
Discontinued Scheduled					

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

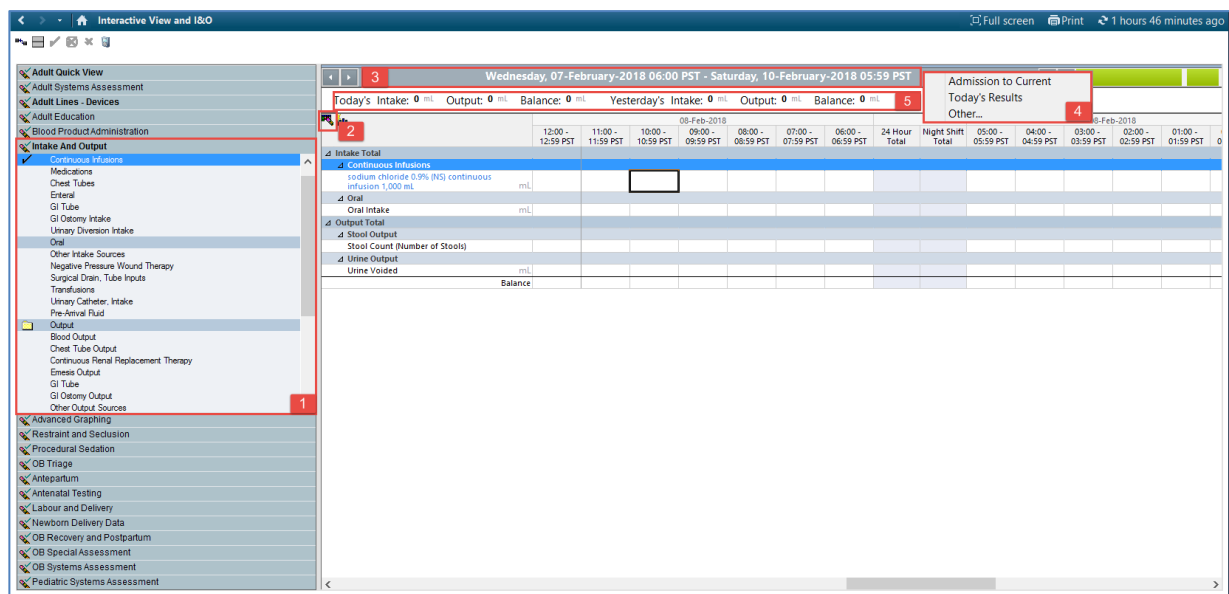
The screenshot shows the iView patient interface. The top header bar contains patient information: TESTCSTQ, TEN TEN, DOB: 19-Nov-1984, MRN: 700003210, Code Status: Process: Disease Isolation, Location: 5GH MS, 111: 01. The left sidebar menu is open, and 'Interactive View and I&O' is selected. The main area displays the 'Intake and Output' flowsheet for the period Wednesday, 07-February-2018 06:00 PST to Saturday, 10-February-2018 05:59 PST. The table shows fluid balance data with columns for time ranges and rows for various intake and output categories.

		Wednesday, 07-February-2018 06:00 PST - Saturday, 10-February-2018 05:59 PST													
		Today's Intake: 250 ml	Output: 0 ml	Balance: 250 ml	Yesterday's Intake: 0 ml	Output: 0 ml	Balance: 0 ml								
		15:00 - 15:59 PST	14:00 - 14:59 PST	13:00 - 13:59 PST	12:00 - 11:59 PST	11:00 - 10:59 PST	10:00 - 09:59 PST	09:00 - 08:59 PST	08:00 - 07:59 PST	07:00 - 06:59 PST	06:00 - 05:59 PST	24 Hour Total	Night Shift Total	05:00 - 04:59 PST	04:00 - 03:59 PST
Intake Total		250													
Continuous Intake		250													
Intravenous (IV) fluids		250													
Intravenous (IV) fluids - Dextrose 5%		250													
Medications		250													
Oral		250													
Oral Intake		250													
Output Total		0													
Stool Output		0													
Urine Output		0													
Urine Voided		0													
Balance		250													

- 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

Wednesday, 07-February-2018 06:00 PST - Saturday, 10-February-2018 05:59 PST																
Today's Intake: 250 mL Output: 0 mL Balance: 250 mL			Yesterday's Intake: 0 mL Output: 0 mL Balance: 0 mL													
			08-Feb-2018													
			15:00 - 15:59 PST	14:00 - 14:59 PST	13:00 - 13:59 PST	12:00 - 12:59 PST	11:00 - 11:59 PST	10:00 - 10:59 PST	09:00 - 09:59 PST	08:00 - 08:59 PST	07:00 - 07:59 PST	06:00 - 06:59 PST	24 Hour Total	Night Shift Total	05:00 - 05:59 PST	04:00 - 04:59 PST
Intake Total			250													
Continuous Infusions																
sodium chloride 0.9% (NS) continuous infusion 1,000 mL							75	75	75	75	75					
Medications			250													
vancomycin + dextrose 5%			250													
Oral																
Oral Intake																
Output Total																
Stool Output																
Stool Count (Number of Stools)																
Urine Output																
Urine Voided																
Balance			250 mL													

Once you double click in the blank cells, the hourly volume of the continuous infusion will populate

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

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

PATIENT SCENARIO 12 – Document Intake and Output

Wednesday, 07-February-2018 06:00 PST - Saturday, 10-February-2018 05:59 PST

Today's Intake: 250 mL Output: 0 mL Balance: 250 mL Yesterday's Intake: 0 mL Output: 0 mL Balance: 0 mL

	15:00 - 15:59 PST	14:00 - 14:59 PST	13:00 - 13:59 PST	12:00 - 12:59 PST	11:00 - 11:59 PST	10:00 - 10:59 PST	09:00 - 09:59 PST	08:00 - 08:59 PST	07:00 - 07:59 PST	06:00 - 06:59 PST	24 Hour Total	Night Shift Total	05:00 - 05:59 PST	04:00 - 04:59 PST	03-Feb-2018
Intake Total	250														
Continuous Infusions															
sodium chloride 0.9% (NS) continuous infusion 1,000 mL															
Medications	250														
vancomycin + dextrose 5%															
Oral Intake	2														
Output Total	0														
Stool Output															
Stool Count (Number of Stools)															
Urine Output	4														
Urine Voided	4														
Balance	250														

Now you can see fluid balances for your patient:

- 12 hour Day/Night Shift Total
- Hourly Total

Tuesday, 21-November-2017 06:00 PST - Friday, 24-November-2017 05:59 PST

Today's Intake: 1366 mL Output: 375 mL Balance: 991 mL Yesterday's Intake: 0 mL Output: 0 mL Balance: 0 mL

	Day Shift Total	17:00 - 17:59 PST	16:00 - 16:59 PST	15:00 - 15:59 PST	14:00 - 14:59 PST	13:00 - 13:59 PST	12:00 - 12:59 PST	11:00 - 11:59 PST	10:00 - 10:59 PST	09:00 - 09:59 PST
Intake Total	1366									
Continuous Infusions	466									
heparin additive 25000 unit + dextrose 5% premix 500 mL										
sodium chloride 0.9% (NS) continuous infusion 1,000 mL	166									
Medications	300									
vancomycin + dextrose 5%	500									
GI Tube	350									
Gastrostomy (G) tube Left upper quadrant 12 French										
Intake	300									
Flush	50									
Irrigant In										
Oral	50									
Oral Intake	50									
Other Intake Sources	20									
Surgical Drain, Tube Inputs										
Output Total	375									
Emesis Output										
GI Tube	375									
Gastrostomy (G) tube Left upper quadrant 12 French										
Output										
Irrigant Out										
Residual Discarded										
Other Output Sources										
Stool Output										
Stool Count (Number of Stools)										
Urine Output	375									
Urine Voided	375									
Urine Output mL/kg/hr	375									
Balance	991									




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

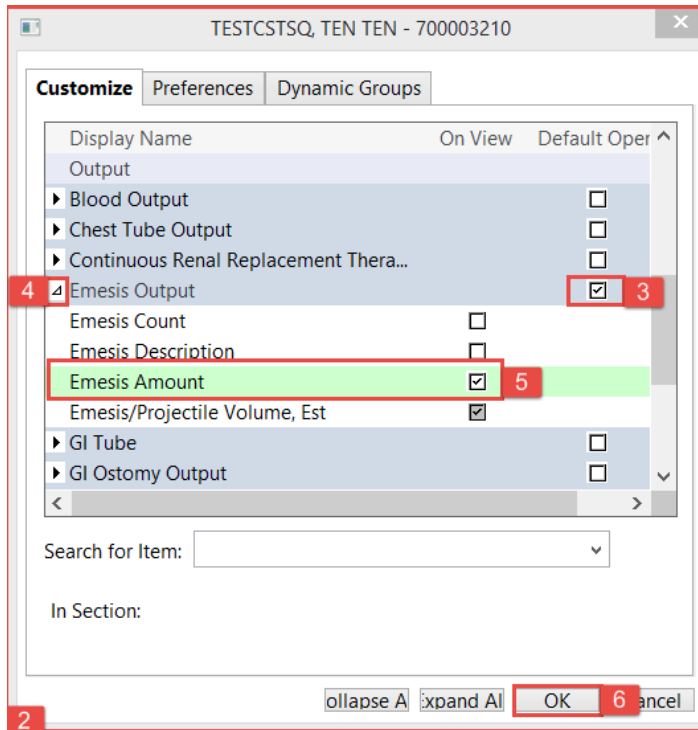
You can also unchart, modify or add a comment to any result.

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

The screenshot shows the CSTLEARNING DEMOTHETA software interface. The top navigation bar includes options like 'Task', 'Edit', 'View', 'Patient', 'Chart', 'Links', 'Options', 'Documentation', 'Orders', and 'Help'. The patient information section displays 'CSTLEARNING DEMOTHETA', 'DOB: 01-Jan-1917', 'Age: 90 years', 'Gender: Male', 'MIDN: 700000216', 'ENC: 7000000015058', 'Code Status: Do Not Resuscitate', 'Process/All Risk: Isolation', and 'Allergies: penicillin, Tape'. The left sidebar contains various menu items such as 'Patient Summary', 'Orders', 'Single Patient Task List', 'MAR', 'Interactive View and I&O', 'Results Review', 'Documentation', 'Medication Request', 'Histories', 'Allergies', 'Diagnoses and Problems', 'CareConnect', 'Clinical Research', 'Form Browser', 'Growth Chart', 'Immunizations', 'Lines/Tubes/Drains Summary', 'MAR Summary', 'Medication List', 'Patient Information', and 'Reference'. The main window displays the 'Interactive View and I&O' band for the date 'Tuesday, 21-November-2017 06:00 PST' to 'Friday, 24-November-2017 05:59 PST'. The band shows various intake and output categories with a table of values. A right-click context menu is open over the 'Gastrostomy (G) tube Left upper quadrant 12 French' intake entry, displaying options like 'Add Result...', 'View Result Details...', 'View Defaulted Info...', 'View Comments...', 'Unchart...', 'Change Date/Time...', 'Modify...', 'Confirm', 'Add Comment...', 'Clear', 'Not Done...', 'View Interpretation', and 'Reinterpret'.



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.

Wednesday, 07-February-2018 06:00 PST - Saturday, 10-February-2018 05:59 PST													
Today's Intake: 300 mL		Output: 525 mL		Balance: -225 mL		Yesterday's Intake: 0 mL		Output: 0 mL		Balance: 0 mL			
	15:00 - 15:59 PST	14:00 - 14:59 PST	13:00 - 13:59 PST	12:00 - 12:59 PST	11:00 - 11:59 PST	10:00 - 10:59 PST	09:00 - 09:59 PST	08:00 - 08:59 PST	07:00 - 07:59 PST	06:00 - 06:59 PST	24 Hour Total	Night Shift Total	05:00 - 05:59 PST
Intake Total	300												
Continuous Infusions													
sodium chloride 0.9% (NS) continuous infusion 1,000 mL													
Medications													
vancomycin + dextrose 5%	250												
Oral													
Oral Intake	50												
Output Total	525												
Emesis/Output	150												
Emesis/Projectile Volume, Est	Moderate												
Stool Output	375												
Stool Count (Number of Stools)													
Urine Output	375												
Urine Voided													
Balance	-225 mL												




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.

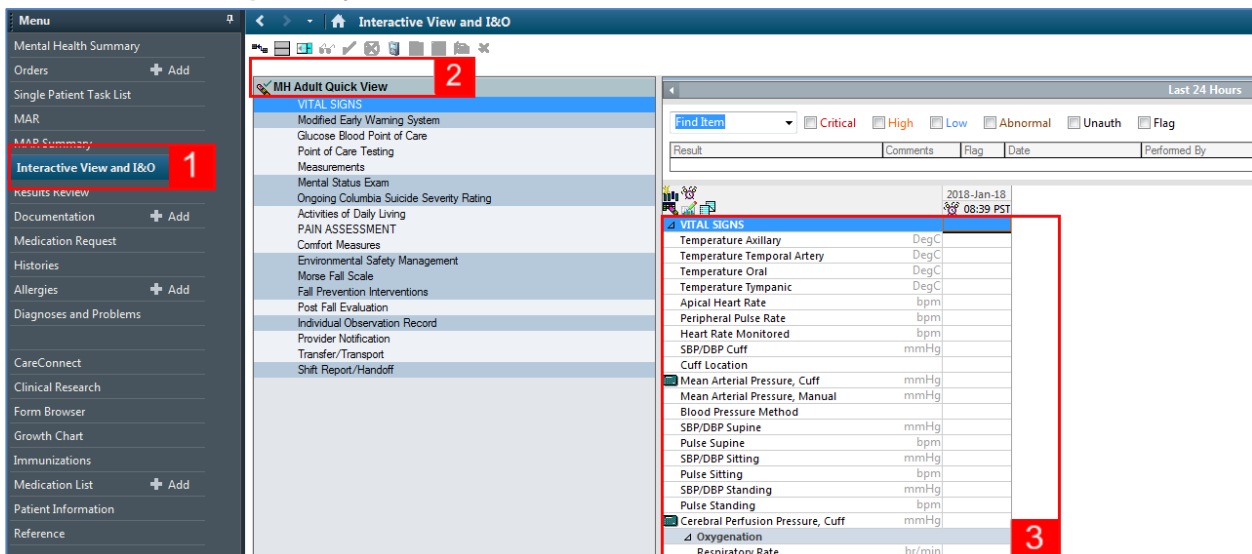
Note:

- 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.

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

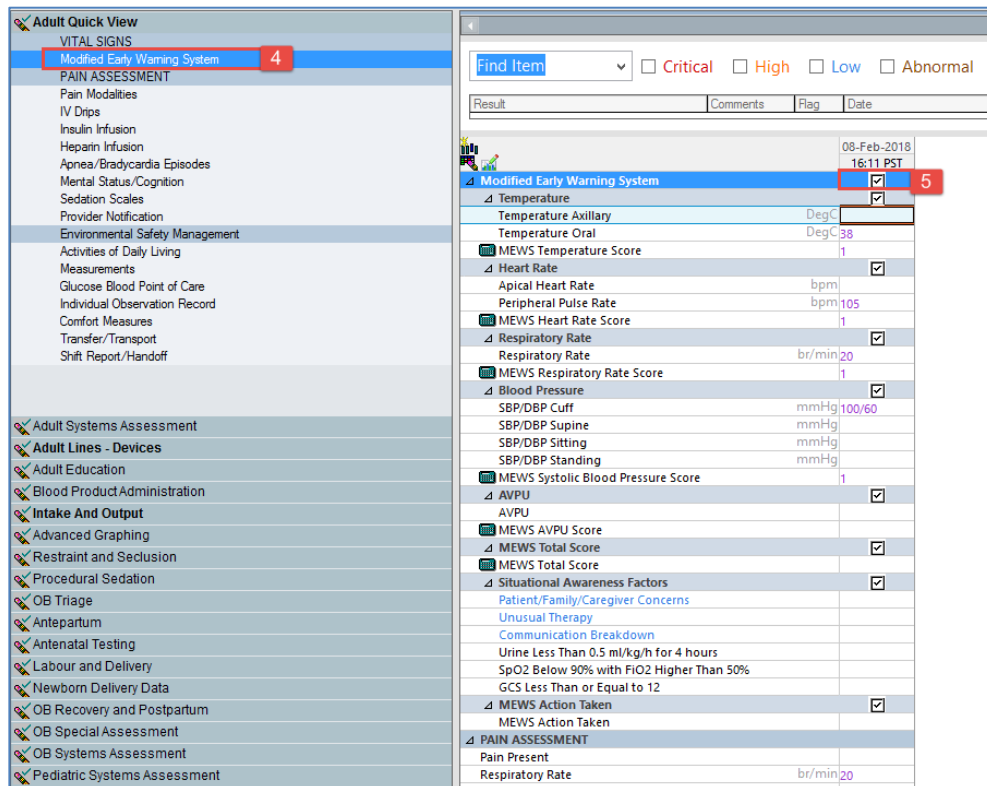


The screenshot displays the iView patient interface. On the left, a sidebar menu contains various options, with 'Interactive View and I&O' highlighted by a red box and the number 1. The central area shows the 'MH Adult Quick View' band, also highlighted by a red box and the number 2. The right panel, titled 'Last 24 Hours', contains a table of vital signs. The 'VITAL SIGNS' section is highlighted by a red box and the number 3. The table lists various vital signs and their units, including Temperature Axillary, Temperature Temporal Artery, Temperature Oral, Temperature Tympanic, Apical Heart Rate, Peripheral Pulse Rate, Heart Rate Monitored, SBP/DBP Cuff, Cuff Location, Mean Arterial Pressure, Cuff, Mean Arterial Pressure, Manual, Blood Pressure Method, SBP/DBP Supine, Pulse Supine, SBP/DBP Sitting, Pulse Sitting, SBP/DBP Standing, Pulse Standing, Cerebral Perfusion Pressure, Cuff, Oxygenation, and Respiratory Rate.

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



Find Item	Critical	High	Low	Abnormal
Result	Comments	Flag	Date	
08-Feb-2018 16:11 PST				
Modified Early Warning System	<input checked="" type="checkbox"/>			
Temperature				
Temperature Axillary				
Temperature Oral				
MEWS Temperature Score				
Heart Rate				
Apical Heart Rate				
Peripheral Pulse Rate				
MEWS Heart Rate Score				
Respiratory Rate				
MEWS Respiratory Rate Score				
Blood Pressure				
SBP/DBP Cuff				
SBP/DBP Supine				
SBP/DBP Sitting				
SBP/DBP Standing				
MEWS Systolic Blood Pressure Score				
AVPU				
MEWS AVPU Score				
MEWS Total Score				
Situational Awareness Factors				
Patient/Family/Caregiver Concerns				
Unusual Therapy				
Communication Breakdown				
Urine Less Than 0.5 ml/kg/h for 4 hours				
SpO2 Below 90% with FiO2 Higher Than 50%				
GCS Less Than or Equal to 12				
MEWS Action Taken				
PAIN ASSESSMENT				
Pain Present				
Respiratory Rate				

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.

The screenshot displays the MEWS interface with a left-hand navigation menu and a main data table. The navigation menu includes sections like 'Adult Quick View', 'VITAL SIGNS', 'PAIN ASSESSMENT', 'Adult Systems Assessment', 'Adult Lines - Devices', 'Adult Education', 'Intake And Output', 'Advanced Graphing', 'Restraint and Seclusion', 'Procedural Sedation', 'OB Triage', 'Antepartum', 'Antenatal Testing', 'Labour and Delivery', and 'Newborn Delivery Data'. The main table lists various vital signs and scores, with a red box highlighting the 'MEWS Total Score' of 4 and the 'Situational Awareness Factors' section.

Find Item	Result	Comments	Flag	Date
Modified Early Warning System				08-Feb-2018 16:11 PST
Temperature				
Temperature Axillary	DegC			
Temperature Oral	DegC	38		
MEWS Temperature Score		1		
Heart Rate				
Apical Heart Rate	bpm			
Peripheral Pulse Rate	bpm	105		
MEWS Heart Rate Score		1		
Respiratory Rate				
Respiratory Rate	br/min	20		
MEWS Respiratory Rate Score		1		
Blood Pressure				
SBP/DBP Cuff	mmHg	100/60		
SBP/DBP Supine	mmHg			
SBP/DBP Sitting	mmHg			
SBP/DBP Standing	mmHg			
MEWS Systolic Blood Pressure Score		1		
AVPU		6	Alert and r...	
MEWS AVPU Score		0		
MEWS Total Score		4		
MEWS Total Score		4		
Situational Awareness Factors				
Patient/Family/Caregiver Concerns		No		
Unusual Therapy		No		
Communication Breakdown		No		
Urine Less Than 0.5 ml/kg/h for 4 hours		No		
SpO2 Below 90% with FIO2 Higher Than 50%		No		
GCS Less Than or Equal to 12		No		

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**.

Discern Notification (TEST.NURSERURAL)

Task Edit View Help

Subject: Rapid Response Early Warning - MEWS Event Date/Time: 08-Feb-2018 4:20:35 ...

100%

DISCERN ALERT

NAME: TESTCSTSQ, TEN TEN
DATE: 08 February, 2018 16:20:35 PST
MRN: 700003210
BIRTH DATE: 19 November, 1984
AGE: 33 Years
LOCATION: SGH Squamish; SGH MS; 111

MEWS Score (4)

- 1) Ensure accuracy of findings; Compare with patient's baseline
- 2) Review findings with nursing leader (CNL/PCC) or delegate; Discuss assignment change as needed
- 3) Notify Responsible Care Provider
- 4) Activate Rapid Response Team/ Clinical Resource Team
- 4) Reassess and rescore every 2 hours. If no improvement after 2 hours, notify Responsible Care Provider

MEWS Criteria

Ready P0783 TEST.NURSERURAL TEST.NURSERURAL Thursday, February 08, 2018 04:23 P 9

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

Key Learning Points

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

Activity 13.2 – Review the MEWS Alert

1

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

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

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

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

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

Discern Notification (TEST.NURSEICU)

Task Edit View Help

Subject: Rapid Response Early Warning - MEWS Event Date/Time: 28-Nov-2017 14:17:24

DISCERN ALERT

NAME: CSTLEARNING, DEMOALPHA
 DATE: 28 November, 2017 14:17:24 PST
 MRN: 700008214
 BIRTH DATE: 01 January, 1937
 AGE: 80 Years
 LOCATION: LGH Lions Gate; LGH 6E; 624

MEWS Score (4)


1) Ensure accuracy of findings; Compare with patient's baseline
 2) Review findings with nursing leader (CNL/PCC) or delegate; Discuss assignment change as needed
 3) Notify Responsible Care Provider
 4) Activate Rapid Response Team/ Clinical Resource Team
 4) Reassess and rescore every 2 hours. If no improvement after 2 hours, notify Responsible Care Provider

MEWS Criteria

Temperature Oral : 38 bpm - 1 point(s)
 Peripheral Pulse Rate : 105 bpm - 1 point(s)
 Respiratory Rate: 20 br/min - 1 point(s)
 Systolic Blood Pressure : 100 bpm - 1 point(s)

Ready PRODBC TEST.NURSEICU TEST.NURSEICU Tuesday, November 28, 2017 02:18 PM

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

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

Key Learning Points

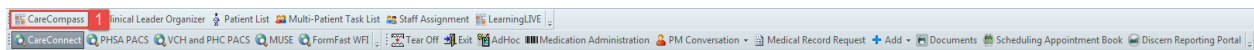
- MEWS alerts display patient information, MEWS score, and score criteria
- All nurses who have established a relationship with the patient in the CIS will receive the MEWS alert
- The clinical decision making support in the MEWS alert helps guide nurses in taking the appropriate next steps in caring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

Activity 13.3 – Document Provider Notification

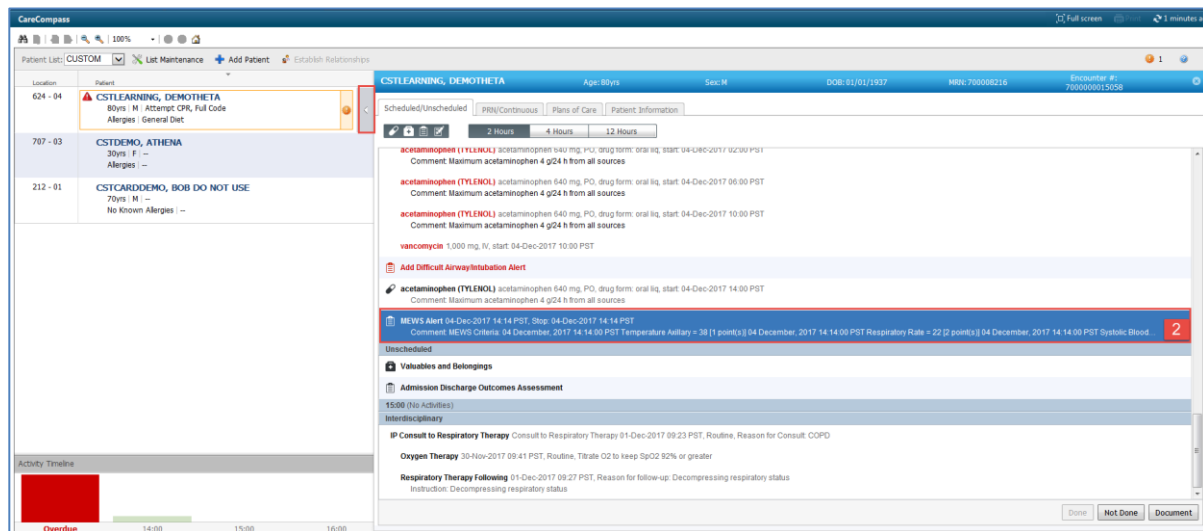
Once you receive a MEWS alert, you assess the patient and decide on further actions to take. In this scenario, we will contact the most responsible provider to let them know about the MEWS alert. After you notify the provider, you need to document that you have done so.

- 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.

The screenshot shows the CareCompass interface for a patient named CSTLEARNING, DEMOTHEA. The patient is 80 years old, Male, and has a full code status. The interface displays a list of tasks on the left, including 'CSTLEARNING, DEMOTHEA' and 'CSTCARDDEMO, BOB DO NOT USE'. The main area shows a list of orders and alerts. A red box highlights a 'MEWS Alert' task, which is a 'MEWS Alert 04-Dec-2017 14:14 PST, Stop: 04-Dec-2017 14:14 PST'. The alert comment states: 'MEWS Criteria: 04 December, 2017 14:14:00 PST Temperature Atrial = 38 [1 point(s)] 04 December, 2017 14:14:00 PST Respiratory Rate = 22 [2 point(s)] 04 December, 2017 14:14:00 PST Systolic Blood Pressure = 100 [1 point(s)]'. A red box with the number '3' is next to the 'Document' button at the bottom right of the alert.

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

The screenshot shows the CareCompass interface for a patient named CSTLEARNING, DEMOTHEA. The patient is 80 years old, Male, and has a full code status. The interface displays a list of tasks on the left, including 'CSTLEARNING, DEMOTHEA' and 'CSTCARDDEMO, BOB DO NOT USE'. The main area shows a list of orders and alerts. A red box highlights a 'MEWS Alert' task, which is a 'MEWS Alert 26-Nov-2017 17:49 PST, Stop: 26-Nov-2017 17:49 PST'. The alert comment states: 'MEWS Criteria: 26 November, 2017 17:41:00 PST Temperature Oral = 38 [1 point(s)] 26 November, 2017 17:41:00 PST Peripheral Pulse Rate = 110 [1 p...'. A red box with the number '4' is next to the 'Document' button at the bottom right of the alert.

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	<p>At the end of this Scenario, you will be able to:</p> <ul style="list-style-type: none">■ 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

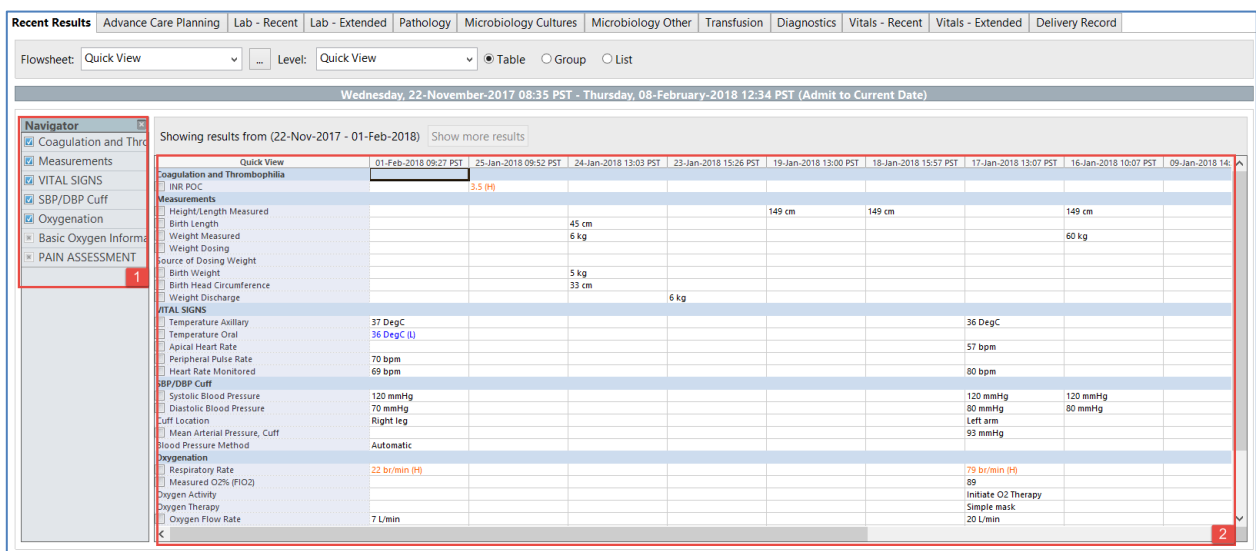
Activity 14.1 – Review Results Using Results Review

- 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**.



The screenshot shows the 'Recent Results' page with various tabs at the top: Recent Results, Advance Care Planning, Lab - Recent, Lab - Extended, Pathology, Microbiology Cultures, Microbiology Other, Transfusion, Diagnostics, Vitals - Recent, Vitals - Extended, and Delivery Record. The 'Flowsheet: Quick View' dropdown is set to 'Quick View'. The date range is 'Wednesday, 22-November-2017 08:35 PST - Thursday, 08-February-2018 12:34 PST (Admit to Current Date)'. The 'Navigator' on the left has a red box around the 'PAIN ASSESSMENT' category, with a red '1' next to it. The 'Results Display' grid shows data for various categories including Coagulation and Thrombophilia, Measurements, VITAL SIGNS, and Oxygenation. The grid has columns for different dates and times. A red '2' is in the bottom right corner of the grid.

Category	01-Feb-2018 09:27 PST	25-Jan-2018 09:52 PST	24-Jan-2018 13:03 PST	23-Jan-2018 15:26 PST	19-Jan-2018 13:00 PST	18-Jan-2018 15:57 PST	17-Jan-2018 13:07 PST	16-Jan-2018 10:07 PST	09-Jan-2018 14:00 PST
Coagulation and Thrombophilia	INR POC	3.5 (H)							
Measurements	Height/Length Measured		45 cm		149 cm	149 cm		149 cm	
	Birth Length		6 kg					60 kg	
	Weight Measured								
	Weight Dosing								
	Source of Dosing Weight		5 kg						
	Birth Weight		33 cm						
	Birth Head Circumference			6 kg					
	Weight Discharge								
VITAL SIGNS	Temperature Axillary	37 DegC					36 DegC		
	Temperature Oral	36 DegC (L)							
	Apical Heart Rate						57 bpm		
	Peripheral Pulse Rate	70 bpm							
	Heart Rate Monitored	69 bpm					80 bpm		
SBP/DBP Cuff	Systolic Blood Pressure	120 mmHg					120 mmHg	120 mmHg	
	Diastolic Blood Pressure	70 mmHg					80 mmHg	80 mmHg	
	Cuff Location	Right leg					Left arm		
	Mean Arterial Pressure, Cuff	Automatic					93 mmHg		
Oxygenation	Respiratory Rate	22 br/min (H)					79 br/min (H)		
	Measured O2% (FIO2)						89		
Oxygen Activity	Oxygen Therapy						Initiate O2 Therapy		
	Oxygen Flow Rate	7 L/min					Simple mask		
							20 L/min		

3. Notice the different category tabs across the top of the result 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.

PATIENT SCENARIO 14 - Results Review

Recent Results | Advance Care Planning | Lab - Recent | Lab - Extended | Pathology | Microbiology Cultures | Microbiology Other | Transfusion | Diagnostics | Vitals - Recent | Vitals - Extended | Delivery Record

FlowSheet: Quick View | Level: Quick View | Table | Group | List

Wednesday, 22-November-2017 08:35 PST - Thursday, 08-February-2018 12:27 PST (Admit to Current Date)

from (22-Nov-2017 - 01-Feb-2018) Show more results

Quick View	01-Feb-2018 09:27 PST	25-Jan-2018 09:52 PST	24-Jan-2018 13:03 PST	23-Jan-2018 15:26 PST	19-Jan-2018 13:00 PST	18-Jan-2018 15:57 PST	17-Jan-2018 13:07 PST	16-Jan-2018 10:07 PST	09-Jan-2018 14:00 PST
embophilia	3.5 (H)								
Height	149 cm	149 cm	149 cm	149 cm	149 cm	149 cm	149 cm	149 cm	149 cm
Weight	6 kg	6 kg	6 kg	6 kg	6 kg	6 kg	6 kg	6 kg	6 kg
Temperature	37 DegC	36 DegC (L)					36 DegC		
Heart Rate	70 bpm	69 bpm					57 bpm		
Blood Pressure	120 mmHg	70 mmHg					80 bpm		
Oxygen Saturation	93 mmHg	93 mmHg					120 mmHg	120 mmHg	120 mmHg
Respiratory Rate	22 br/min (H)						79 br/min (H)	89	89
Oxygen Therapy	7 L/min						Initiate O2 Therapy	Simple mask	20 L/min

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

Menu | Patient Summary | Women's Health Overview | Orders | Single Patient Task List | MAR | MAR Summary | Interactive View and I&O | **Results Review** | Documentation | Notes | Medication Request | Histories | Allergies | Diagnoses and Problems | Perioperative Doc | CareConnect | Clinical Research | Form Browser | Growth Chart | Immunizations | Lines/Tubes/Drains Summary | Medication List | Newborn Liaison | Patient Information | Postpartum Liaison | Pregnancy Summary Report | Reference

Results Review | Lab - Recent | Lab - Extended | Pathology | Microbiology Cultures | Microbiology Other | Transfusion | Diagnostics | Vitals - Recent | Vitals - Extended | Delivery Record

FlowSheet: Quick View | Level: Quick View | Table | Group | List

Wednesday, 22-November-2017 08:35 PST - Thursday, 08-February-2018 12:34 PST (Admit to Current Date)

Showing results from (22-Nov-2017 - 01-Feb-2018) Show more results

Quick View	01-Feb-2018 09:27 PST	25-Jan-2018 09:52 PST	24-Jan-2018 13:03 PST	23-Jan-2018 15:26 PST	19-Jan-2018 13:00 PST	18-Jan-2018 15:57 PST	17-Jan-2018 13:07 PST	16-Jan-2018 10:07 PST	09-Jan-2018 14:00 PST
Coagulation and Thrombophilia	3.5 (H)								
Height/Length Measured	149 cm	149 cm	149 cm	149 cm	149 cm	149 cm	149 cm	149 cm	149 cm
Weight Measured	6 kg	6 kg	6 kg	6 kg	6 kg	6 kg	6 kg	6 kg	6 kg
Temperature	37 DegC	36 DegC (L)					36 DegC		
Heart Rate	70 bpm	69 bpm					57 bpm		
Blood Pressure	120 mmHg	70 mmHg					80 bpm		
Oxygen Saturation	93 mmHg	93 mmHg					120 mmHg	120 mmHg	120 mmHg
Respiratory Rate	22 br/min (H)						79 br/min (H)	89	89
Oxygen Therapy	7 L/min						Initiate O2 Therapy	Simple mask	20 L/min

4. Review your patient's recent lab results.

CBC and Peripheral Smear	
WBC Count	1.5 x10 ⁹ /L (L)
RBC Count	2.00 x10 ¹² /L (L)
Hemoglobin	70 g/L (L)
Hematocrit	0.15 (L)
MCV	98 fL
MCH	28 pg
RDW-CV	15.3 % (H)
Platelet Count	10 x10 ⁹ /L (L)
NRBC Absolute	5.0 x10 ⁹ /L (H)
Neutrophils	0.04 x10 ⁹ /L (L)
Lymphocytes	0.15 x10 ⁹ /L (L)
Monocytes	0.23 x10 ⁹ /L
Eosinophils	0.01 x10 ⁹ /L
Basophils	0.01 x10 ⁹ /L
Metamyelocytes	0.73 x10 ⁹ /L (H)
Myelocytes	0.23 x10 ⁹ /L (H)
Promyelocytes	0.08 x10 ⁹ /L (H)
Blast Cells	0.02 x10 ⁹ /L (H)
Blood Film Comment	Platelet Estimate 4

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

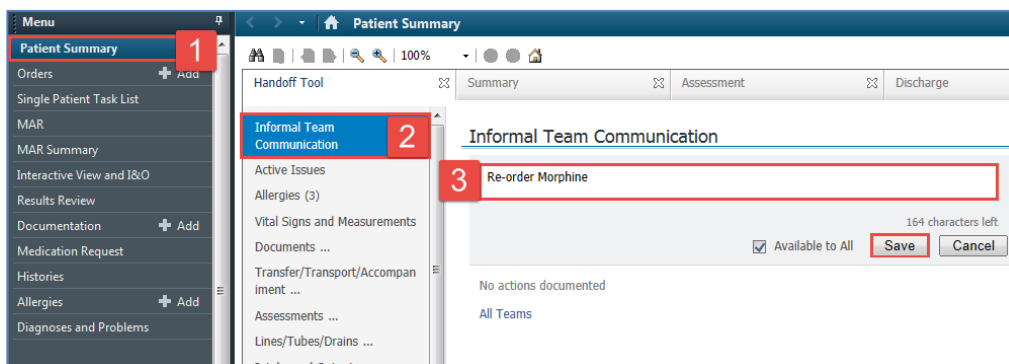
Activity 15.1 – Documenting Informal Team Communication

- 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.

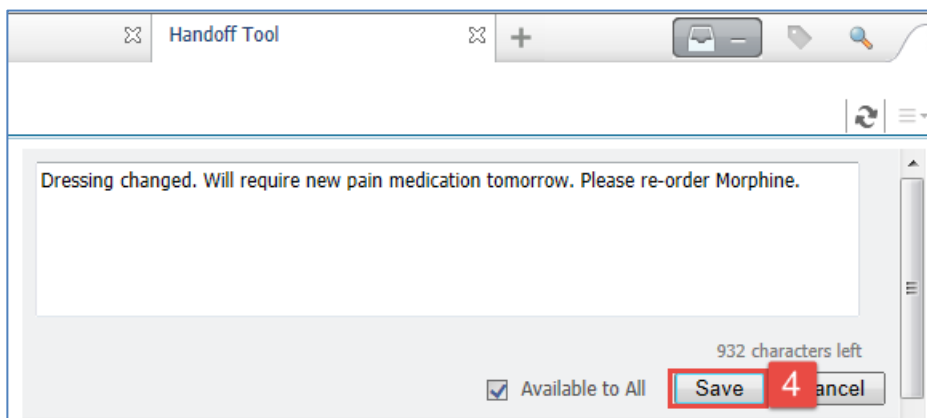
Note: Items documented within the Informal Team Communication component are **NOT** part of the patient's legal chart.

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**.



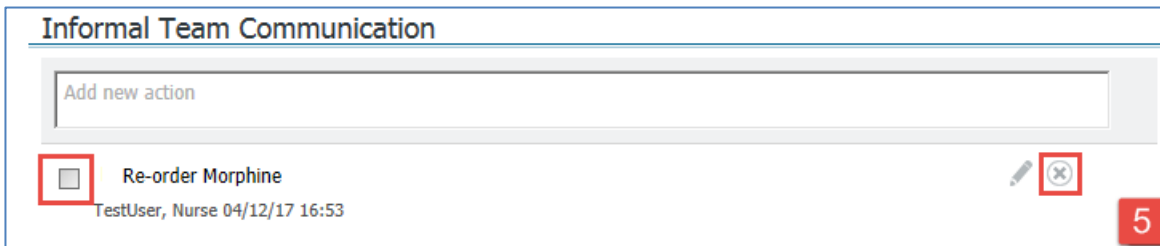
4. Under **Add new comment** type *Dressing changed. Will require new pain medication order tomorrow. Please re-order Morphine*. Click **Save**



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

The screenshot shows the 'Handoff Tool' interface. On the left is a sidebar with a list of categories: Informal Team Communication, Active Issues, Allergies (3), Vital Signs and Measurements, Documents (1), Transfer/Transport/Accompaniment (0), Assessments, Lines/Tubes/Drains, Intake and Output, Labs, Imaging, Medications, Home Medications, Orders, Oxygenation and Ventilation, Pathology, Histories, Create Note, Interdisciplinary Care Plan, Interdisciplinary Rounding Summary Note, **Nursing Shift Summary** (highlighted with a red box and a '2' in a circle), and Select Other Note. The main content area is titled 'Informal Team Communication' and has sections for 'Add new action', 'Add new comment', 'No actions documented', 'No comments documented', 'All Teams', 'Active Issues', and 'Allergies (3)'. The 'Active Issues' section contains a table with columns: Name, Classification, Actions, and Chronic. The table lists: Pneumonia (Medical, This Visit, Chronic), Diabetes (Medical, This Visit, Chronic), and Peripheral vascular disease (Medical, This Visit, Chronic). The 'Allergies (3)' section contains a table with columns: Substance, Reactions, Category, Status, Severity, Reaction Type, Source, and Comments. The table lists: Bees/Stinging Insects (Allergy, Active, Severe, Allergy, --, --), ciprofloxacin (Allergy, Active, Severe, Allergy, --, --), and diphenhydramine (Allergy, Active, Severe, Allergy, --, --). At the bottom right, there is a 'Reconciliation Status: Incomplete' and a 'Complete Reconciliation' button. A red box with a '1' in a circle highlights the 'Nursing Shift Summary' link in the sidebar.

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.

The screenshot shows the 'Free Text Note' interface. At the top, there is a header bar with patient information: DOB: 01-Jan-1937, Age: 80 years, Gender: Male, Code Status: Dying Wt, Process: Disease: Isolation, Location: LGH 06: 624: 02, Enc Type: Inpatient, Attending: Plavica, Rocco, MD. Below the header is a 'Menu' on the left with options: Patient Summary, Orders, Single Patient Task List, MAR, Interactive View and I/O, Results Review, **Documentation** (highlighted with a red box and a '2' in a circle), Medication Request, Histories, Allergies, Diagnoses and Problems, CareConnect, Clinical Research, Form Browser, Growth Chart, Immunizations, Lines/Tubes/Drains Summary, MAR Summary, Medication List, Patient Information, and Reference. The main content area is titled 'Free Text Note' and has a text input field with the text: 'Dressing changed. Will require new pain medication order tomorrow. Please re-order Morphine.' At the bottom right, there is a 'Sign/Submit' button (highlighted with a red box and a '4' in a circle), a 'Save' button, a 'Save & Close' button, and a 'Cancel' button. A red box with a '3' in a circle highlights the 'Sign/Submit' button.

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

The screenshot displays the EHR Documentation interface. On the left is a 'Menu' with various options like Patient Summary, Orders, and Documentation. The main area is titled 'Documentation' and shows a list of notes. A 'Nursing Shift Summary' note is selected, displaying its details in a 'Final Report' format. The report includes the result type, date, status, title, performer, and encounter information. The note content describes a patient visit and support provided.

Menu

- Patient Summary
- Orders
- Single Patient Task List
- MAH Summary
- Interactive View and I/O
- Results Review
- Documentation**
- Medication Request
- Histories
- Allergies
- Diagnoses and Problems
- CareConnect
- Clinical Research
- Form Browser
- Growth Chart
- Immunizations
- Lines/Tubes/Drains Summary
- Medication List
- Patient Information
- Reference

Documentation

Display: All Physician Notes

Arranged By: Date Newest At Top

Nursing Shift Summary 04-Dec-2017 17:09:00 PST
Free Text Note

*** Final Report ***

Wife visited, very teary. Provided support; will follow up tomorrow

Result type: Nursing Shift Summary
Result date: Monday, 04-December-2017 17:09 PST
Result status: Auth (Verified)
Result title: Free Text Note
Performed by: TestUser, Nurse on Monday, 04-December-2017 17:10 PST
Verified by: TestUser, Nurse on Monday, 04-December-2017 17:10 PST
Encounter info: 7000000015058, LGH Lions Gate, Inpatient, 17-Nov-2017 -

Key Learning Points

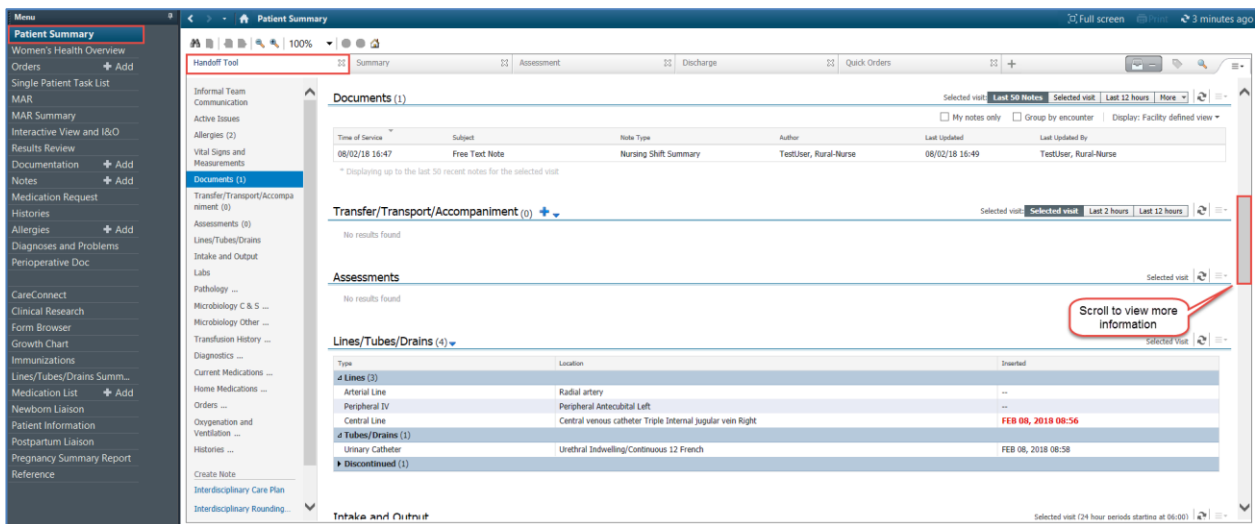
- A Nursing Shift Summary note is used to write a narrative note about what happened in a given shift for oncoming nurses
- The note must be signed in order for it to be recorded to the patient chart and viewable by other team members
- Nurses and other team members can view signed notes from the Documentation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



The screenshot shows the 'Patient Summary' page with the 'Handoff Tool' tab selected. The left sidebar contains a menu with 'Patient Summary' highlighted. The main content area displays several sections: 'Documents (1)' with a table of notes, 'Transfer/Transport/Accompaniment (0)', 'Assessments', 'Lines/Tubes/Drains (4)', and 'Intake and Output'. A red box highlights the 'Handoff Tool' tab in the top navigation bar. Another red box highlights the 'Lines/Tubes/Drains' section, with a callout bubble indicating 'Scroll to view more information'.

Time of Service	Subject	Note Type	Author	Last Updated	Last Updated By
08/02/18 16:47	Free Text Note	Nursing Shift Summary	TestUser, Rural-Nurse	08/02/18 16:49	TestUser, Rural-Nurse

Type	Location	Inserted
Arterial Line	Radial artery	--
Peripheral IV	Peripheral Antecubital Left	--
Central Line	Central venous catheter Triple Internal Jugular vein Right	FEB 08, 2018 08:56
Urinary Catheter	Urethral Indwelling/Continuous 12 French	FEB 08, 2018 08:58

Key Learning Point

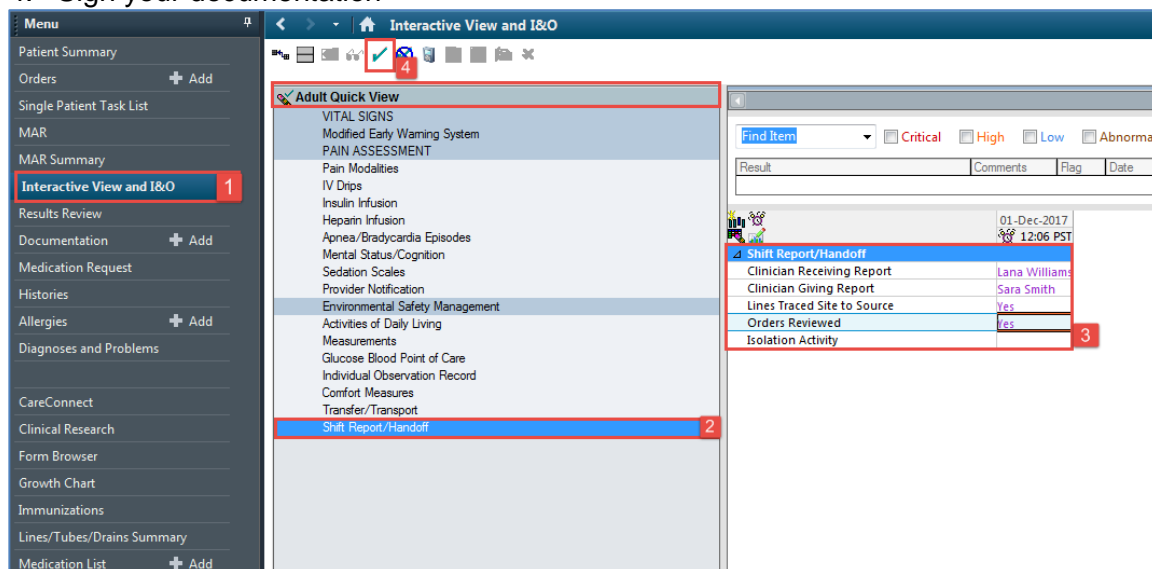
- Use the Handoff Tool (within the Patient Summary page) to review detailed patient information when giving handover to another nurse

Activity 15.4 – Documenting Handoff in iView

1

As an inpatient rural nurse, you can document that you have given report 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



The screenshot shows the iView software interface. On the left is a 'Menu' with various options. In the center is the 'Adult Quick View' section, which contains a list of categories like VITAL SIGNS, PAIN ASSESSMENT, etc. The 'Shift Report/Handoff' option is highlighted. On the right is the 'Shift Report/Handoff' form, which is populated with the following data:

Find Item	Critical	High	Low	Abnormal
Result				
Comments				
Flag				
Date				
01-Dec-2017 12:06 PST				
Shift Report/Handoff				
Clinician Receiving Report	Lana Williams			
Clinician Giving Report	Sara Smith			
Lines Traced Site to Source	Yes			
Orders Reviewed	Yes			
Isolation Activity				


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:

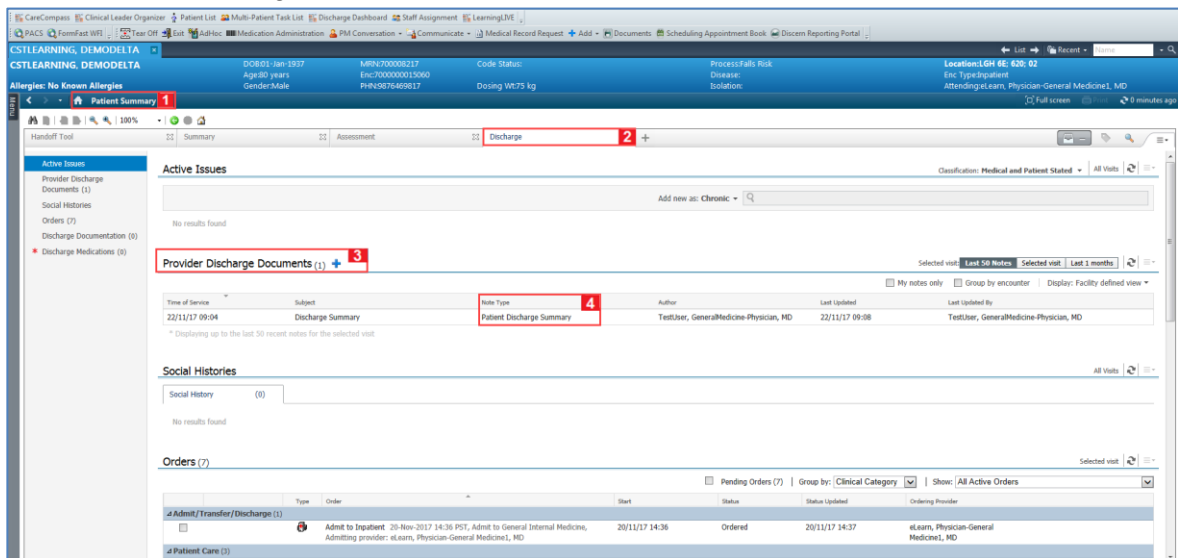
-  Printing a patient discharge summary

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.




The screenshot shows the 'Patient Summary' workflow page. The 'Discharge' tab is selected. Under 'Provider Discharge Documents (1)', the 'Patient Discharge Summary' document is highlighted. Below this, the 'Orders (7)' section is visible, showing a list of orders including 'Admit to Inpatient' and 'Admit to Outpatient'.

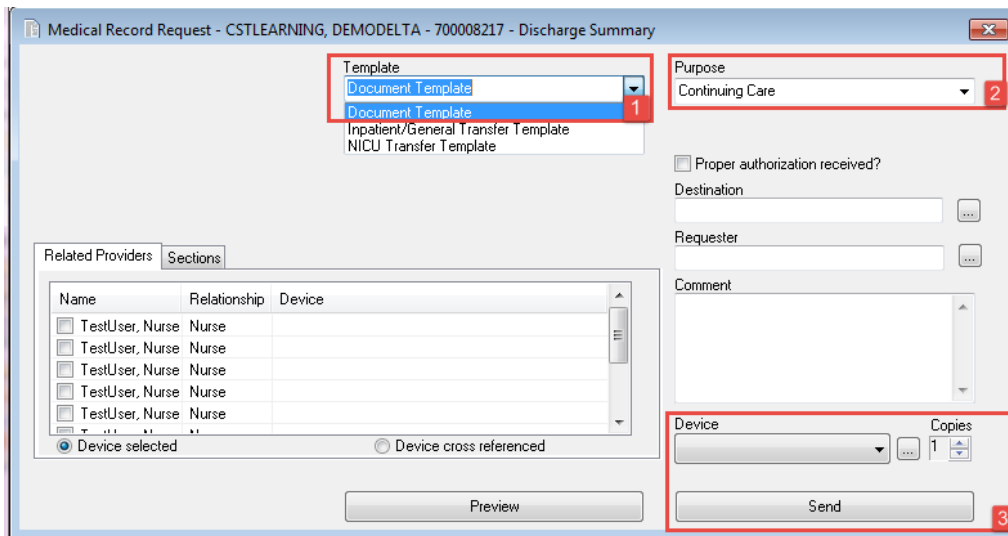
2

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

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

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

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



Medical Record Request - CSTLEARNING, DEMODELTA - 700008217 - Discharge Summary

Template: Document Template (1)

Purpose: Continuing Care (2)

Related Providers: Sections

Name	Relationship	Device
TestUser, Nurse	Nurse	
TestUser, Nurse	Nurse	
TestUser, Nurse	Nurse	
TestUser, Nurse	Nurse	
TestUser, Nurse	Nurse	
TestUser, Nurse	Nurse	

Device selected: Device cross referenced

Device: (3)

Copies: 1

Send (3)

Key Learning Points

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

SELF-GUIDED PRACTICE WORKBOOK [N54]

CST Transformational Learning

WORKBOOK TITLE:

Nursing: Supervisor

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

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

PATIENT SCENARIO 17 – Clinical Leader Organizer (CLO)

Learning Objectives

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

-  Review the Clinical Leader Organizer

SCENARIO

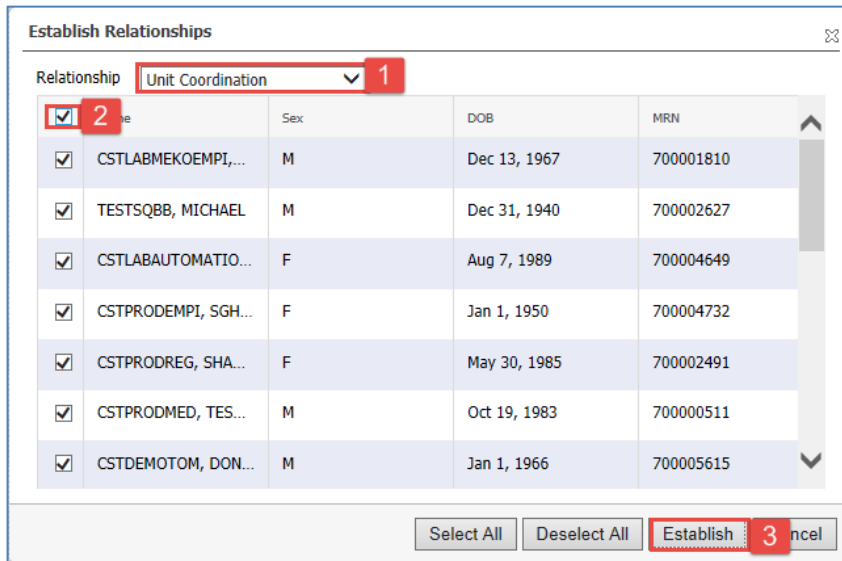
As an inpatient charge nurse, you will be completing the following activities in order to review your patients for the day:

-  Review the Clinical Leader Organizer (CLO)

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**



<input checked="" type="checkbox"/>	Name	Sex	DOB	MRN
<input checked="" type="checkbox"/>	CSTLABMEKOEMPI,...	M	Dec 13, 1967	700001810
<input checked="" type="checkbox"/>	TESTSQBB, MICHAEL	M	Dec 31, 1940	700002627
<input checked="" type="checkbox"/>	CSTLABAUTOMATIO...	F	Aug 7, 1989	700004649
<input checked="" type="checkbox"/>	CSTPRODEMPI, SGH...	F	Jan 1, 1950	700004732
<input checked="" type="checkbox"/>	CSTPRODREG, SHA...	F	May 30, 1985	700002491
<input checked="" type="checkbox"/>	CSTPRODREG, TES...	M	Oct 19, 1983	700000511
<input checked="" type="checkbox"/>	CSTDDEMOTOM, DON...	M	Jan 1, 1966	700005615

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.

Activity 17.1 – Review Clinical Leader Organizer (CLO)

Patient	Location	Dis...	HI...	Care Team	Air...	Fall	Iso...	Tel...	Central...	Ox...	Ski...	Ve...	Visit	Viewable
*CSTPRODPET, RAV...	34 yrs F	LGH 7E 718 - 01		--		75							Length of Stay: 2 months	Patient 48 ✓ Location ✓ Discharge 1 ✓ High Risk 1 ✓ Care Team ✓ Airway 0 ✓ Fall ✓ Suicide 0 ✓ Isolation 1 ✓ Telemetry 0 ✓ Central Line 1 ✓ Oxygen Therapy 0 ✓ Skin Integrity ✓ Ventilator 1 ✓ Visit ✓ Catheter 0 ✓ Restraints 0 ✓ Elopement 0 ✓
*CSTPRODREG, HLS...	27 yrs F	--		--		60							Length of Stay: --	Not in View
CSTPRODROW, SNT...	104 yrs M	LGH 7E --		--									Length of Stay: --	
CSTSCHHARVEY, ST...	26 yrs M	LGH 7E --		--									Length of Stay: --	
*TESTSQBBVPP, SA...	37 yrs M	LGH 7E --				70							Length of Stay: 6 months 2 weeks	
*TESTSQBBVPP, SA...	89 yrs M	LGH 7E --				55							Length of Stay: 6 months 2 weeks	
*TESTSQBBVPP, SA...	66 yrs M	LGH 7E --											Length of Stay: 6 months 2 weeks	
*TESTSQBBVPP, SA...	45 yrs M	LGH 7E --											Length of Stay: 6 months 2 weeks	
TESTCSTSQ, SIX LAU...	17 yrs F	LGH 7E --											Length of Stay: 6 months 2 weeks	
CSTLABADDON, DEM...	33 yrs F	LGH 7E 722 - 03		--		25							Length of Stay: 5 months 1 week	
CSTPRODOSLAB, DE...	53 yrs M	LGH 7E 724 - 01		--									Length of Stay: 5 months	
*WINRECS, INPATIE...	67 yrs F	LGH 7E 708 - 01		--									Length of Stay: 5 months	
*CSTLABAUTOMATI...	41 yrs M	LGH 7E --											Length of Stay: 5 months	

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

Patient	Location	Dis...	HI...	Care Team	Air...	Fall	Iso...	Tel...	Central...	Ox...	Ski...	Ve...	Visit	Ca...	Re...	Elo...	Pe...	Diet
*CSTPRODPET, RAV...	34 yrs F	LGH 7E 718 - 01		--		75							Length of Stay: 2 months					
*CSTPRODREG, HLS...	27 yrs F	--		--									Length of Stay: --					
CSTPRODROW, SNT...	104 yrs M	LGH 7E --		--									Length of Stay: --					
CSTSCHHARVEY, ST...	26 yrs M	LGH 7E --		--									Length of Stay: --					
*TESTSQBBVPP, SA...	37 yrs M	LGH 7E --											Length of Stay: 6 months 2 weeks					
*TESTSQBBVPP, SA...	89 yrs M	LGH 7E --				55							Length of Stay: 6 months 2 weeks					
*TESTSQBBVPP, SA...	66 yrs M	LGH 7E --											Length of Stay: 6 months 2 weeks					
*TESTSQBBVPP, SA...	45 yrs M	LGH 7E --											Length of Stay: 6 months 2 weeks					
TESTCSTSQ, SIX LAU...	17 yrs F	LGH 7E --											Length of Stay: 6 months 2 weeks					
CSTLABADDON, DEM...	33 yrs F	LGH 7E 722 - 03		--		25							Length of Stay: 5 months 1 week					
CSTPRODOSLAB, DE...	53 yrs M	LGH 7E 724 - 01		--									Length of Stay: 5 months					
*WINRECS, INPATIE...	67 yrs F	LGH 7E 708 - 01		--									Length of Stay: 5 months					

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

Key Learning Points

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

PATIENT SCENARIO 18 – Reports

Learning Objectives

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

- Run a report in the CIS

SCENARIO

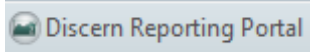
As an inpatient charge nurse or nurse manager, you will be completing the following activities:

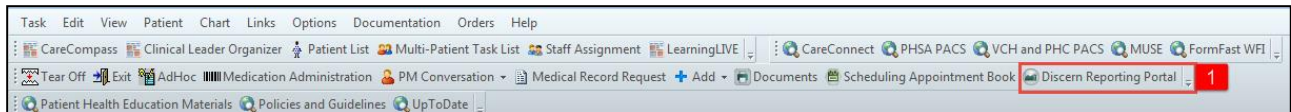
- Run a report for your unit/organization in the CIS

Activity 18.1 – Running Reports for your Unit/Organization

- 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  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**

Activity 18.1 – Running Reports for your Unit/Organization

The screenshot shows the 'Reporting Portal' interface. On the left, there are 'Filters' for 'Source' and 'Categories', and a 'Recent Reports' list. The main area displays the 'Patient Census by Location' report configuration. A red box labeled '3' highlights the report name. Another red box labeled '4' highlights the 'Run Report' button. The configuration includes fields for 'Report Name', 'Source', 'Categories', 'Description', 'Suggested Report Users', 'Suggested Report Frequency', 'Support Reference Number', 'Reporting Application', and 'Alternate Name'.

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**

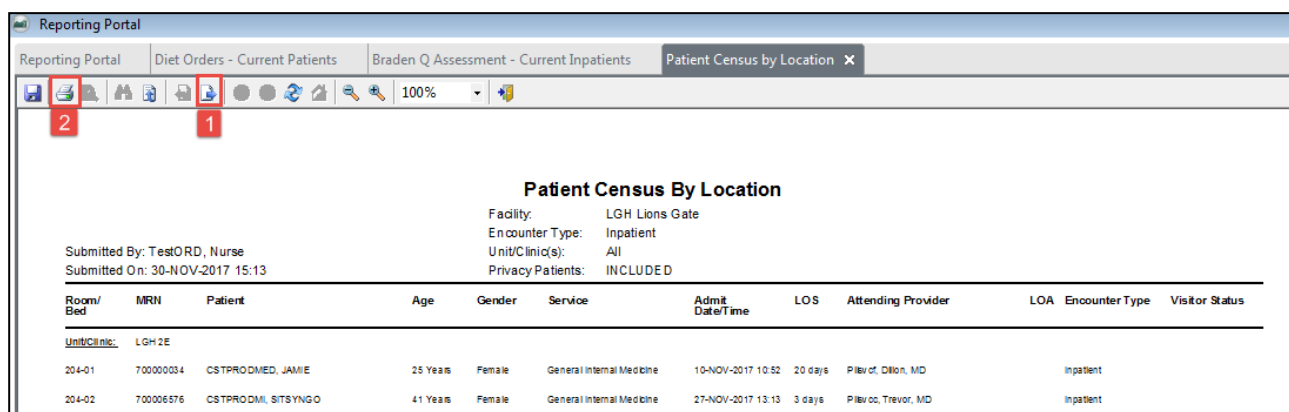
The screenshot shows the 'Discern Prompt: BC_ALL_PM_CENSUS_LOCN_LYT:DBA' window. It contains several configuration options: 'Output to File/Printer/MIME' (MIME), 'Output Type' (Printable(PDF)), 'Encounter Type(s)' (Inpatient), 'Health Organization' (Vancouver Coastal Health Authority), 'Site' (Squamish General Hospital), 'Facility' (SGH Squamish General Hospital), 'Unit/Clinic(s)' (All Nurse Units), 'Include VIP Patients?' (Yes), 'Page break on Unit?' (No), and 'Execute' button. Red boxes and numbers 1 through 5 highlight the selection steps for Encounter Type, Site, Facility, Unit/Clinic(s), and the Execute button respectively.

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

Activity 18.1 – Running Reports for your Unit/Organization

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.



Reporting Portal


Reporting Portal | Diet Orders - Current Patients | Braden Q Assessment - Current Inpatients | **Patient Census by Location** x

Submitted By: TestORD, Nurse
Submitted On: 30-NOV-2017 15:13

Facility: LGH Lions Gate
Encounter Type: Inpatient
Unit/Clinic(s): All
Privacy Patients: INCLUDED

Room/ Bed	MRN	Patient	Age	Gender	Service	Admit Date/Time	LOS	Attending Provider	LOA	Encounter Type	Visitor Status
<u>Unit/Clinic:</u> LGH 2E											
204-01	700000034	CSTPRODMD, JAMIE	25 Years	Female	General Internal Medicine	10-NOV-2017 10:52	20 days	Pilevicius, Dillon, MD		Inpatient	
204-02	700006576	CSTPRODMD, SITSYNGO	41 Years	Female	General Internal Medicine	27-NOV-2017 13:13	3 days	Pilevicius, Trevor, MD		Inpatient	

Key Learning Points

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

End of Workbook

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