SELF-GUIDED PRACTICE WORKBOOK [72]
CST Transformational Learning

WORKBOOK TITLE:

NURSING: NICU

Last update: February 6, 2018

CLINICAL + SYSTEMS TRANSFORMATION
Our path to smarter, seamless care

TRANSFORMATIONAL LEARNING

TABLE OF CONTENTS

SELF-GUIDED PRACTICE WORKBOOK

Before getting started	■ Sign the attendance roster (this will ensure you get paid to attend the session). ■ Put your cell phones on silent mode.
Session Expectations	■ This is a self-paced learning session. ■ A 15 min break time will be provided. You can take this break at any time during the session. ■ The workbook provides a compilation of different scenarios that are applicable to your work setting. ■ Each scenario will allow you to work through different learning activities at your own pace to ensure you are able to practice and consolidate the skills and competencies required throughout the session.
Key Learning Review	■ At the end of the session, you will be required to complete a Key Learning Review ■ This will involve completion of some specific activities that you have had an opportunity to practice through the scenarios.

PLEASE NOTE: Throughout this session, you may encounter a BMDI (Bedside Medical Device Integration) pop-up window asking you to associate your patient to a monitor; BMDI monitoring is not included in this classroom session, please close the window and continue through your workbook.

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 – Patient List

Learning Objectives

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

- Create a Location Patient List
- Create a Custom Patient List
- Find patients on your Location Patient List and move them onto your Custom Patient List

SCENARIO

Scenario: A 28-year-old, MRSA positive mother is admitted for C-section at 33 weeks for severe preeclampsia. The newborn is admitted to NICU for monitoring and will require phototherapy. Patient has arrived from LD OR; you have received handover, and are ready to assume care.

As an inpatient nurse you will complete the following activities:

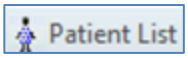
- Set-up a Location Patient List
- Create a Custom Patient List

Activity 1.1 – Set Up a Location Patient List

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

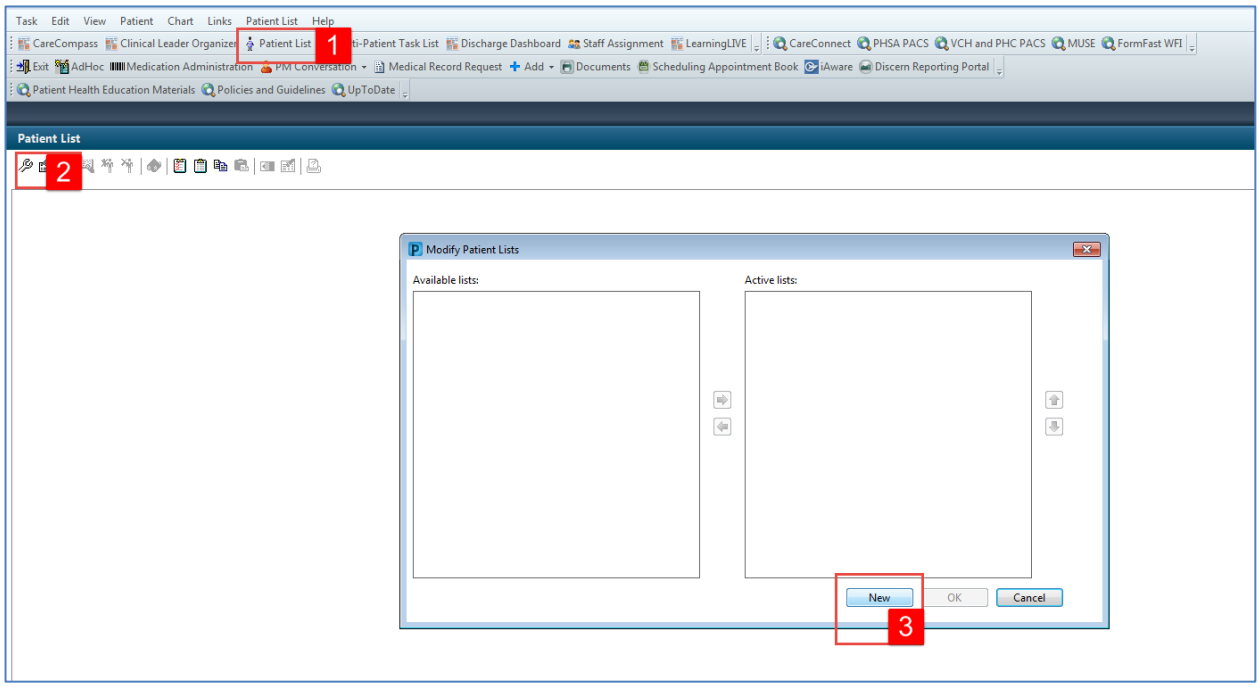
Note: if you are a Patient Care Coordinator or your primary role is as a Charge Nurse, your landing page will be the Clinical Leader Organizer (CLO).

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 patients assigned to your unit.

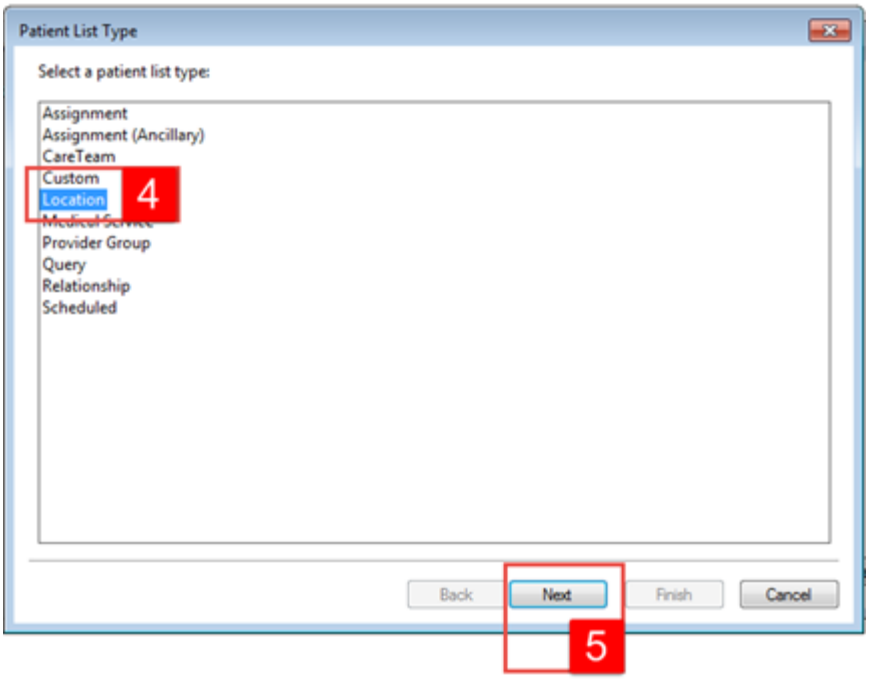
1. Select the **Patient List** icon 

from the **Toolbar** at the top of the screen.
2. The screen will be blank. To create a location list, click the **List Maintenance** icon  . When you hover over the wrench it will say **List Maintenance**.
3. Click the **New** button 

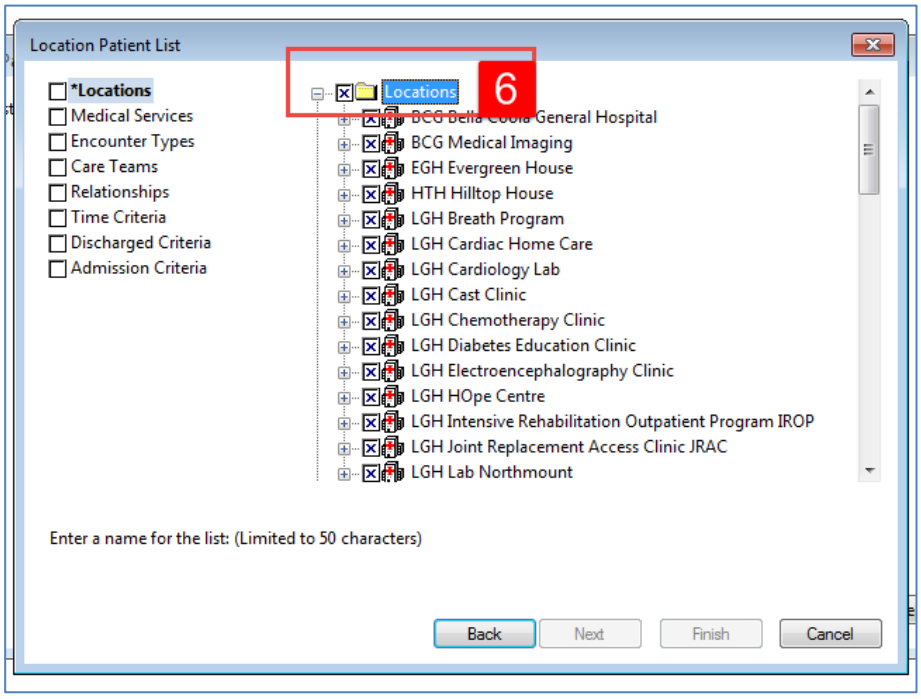
in the bottom right corner of the **Modify Patient Lists** window.



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



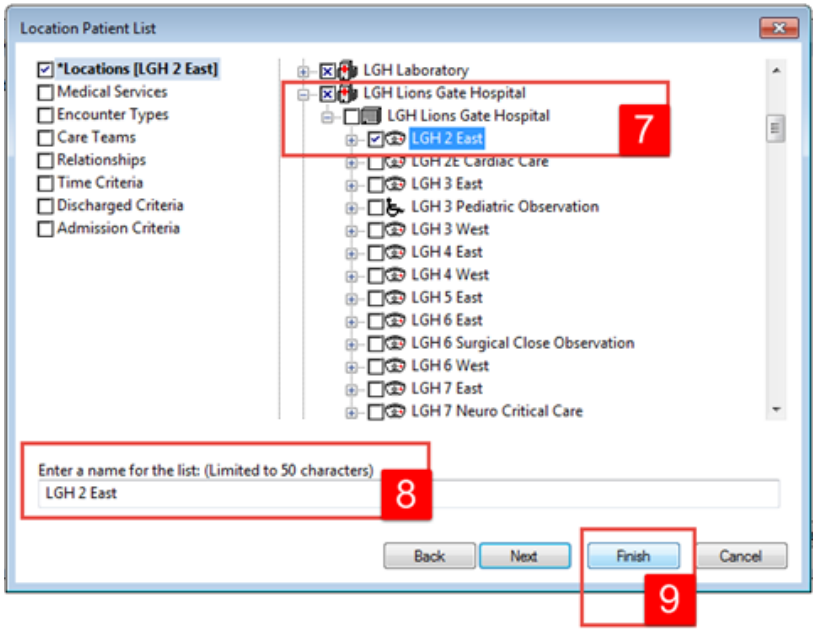
6. In the **Location Patient List** window a location tree will be on the right hand side. Expand the list by clicking on the **tiny plus** + sign next to **Locations**.



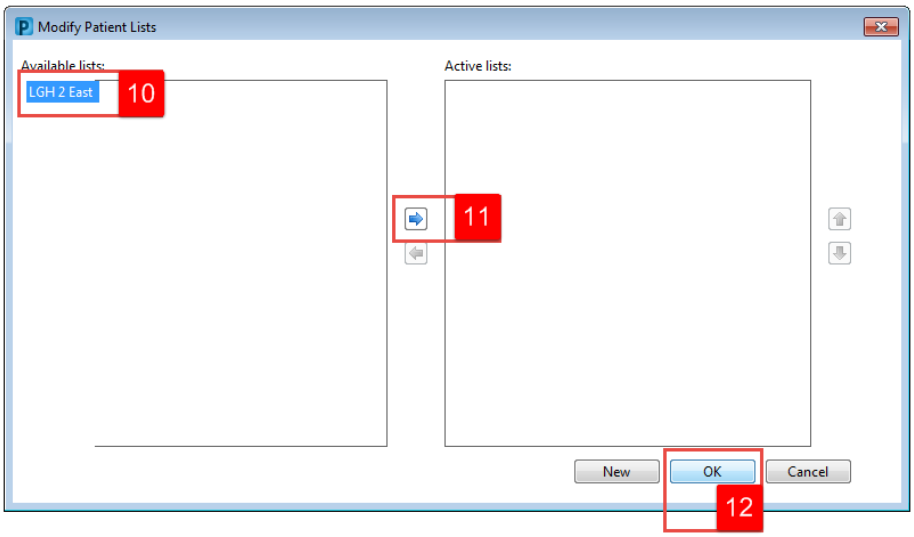
7. Scroll down until you find the location assigned to you. (You may need to further expand a facility to select your specific unit.) To select a unit, check the box next to the unit name.

8. Patient Lists need a name to help identify them. Location lists are automatically named for the location you select.

9. Click the **Finish**



10. In the **Modify Patient Lists** window select the **Location** list you've created.
11. Click the **blue arrow** icon  to move the **Location** to the right, under **Active Lists**.
12. Click **OK** to return to **Patient Lists**. Your Location list should now appear.



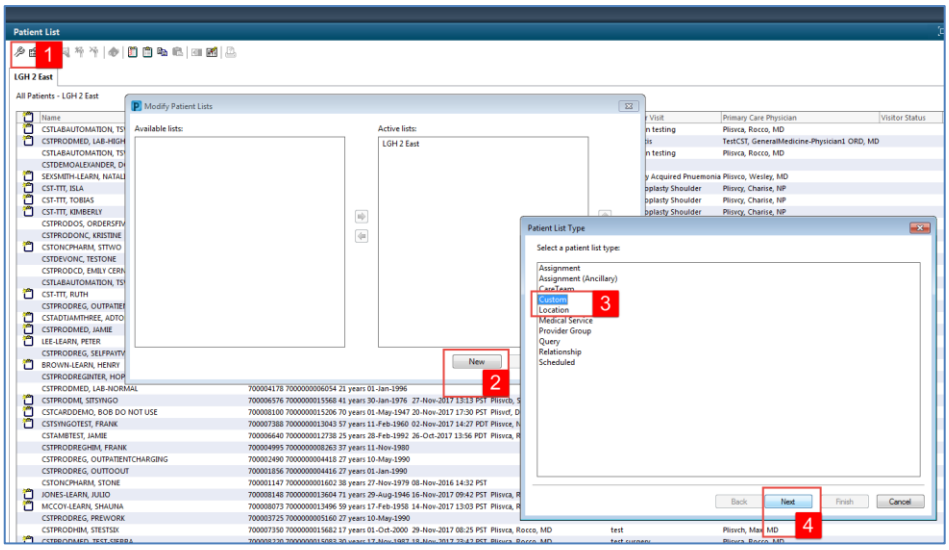
Key Learning Points

- 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

Activity 1.2 – Create a Custom Patient List

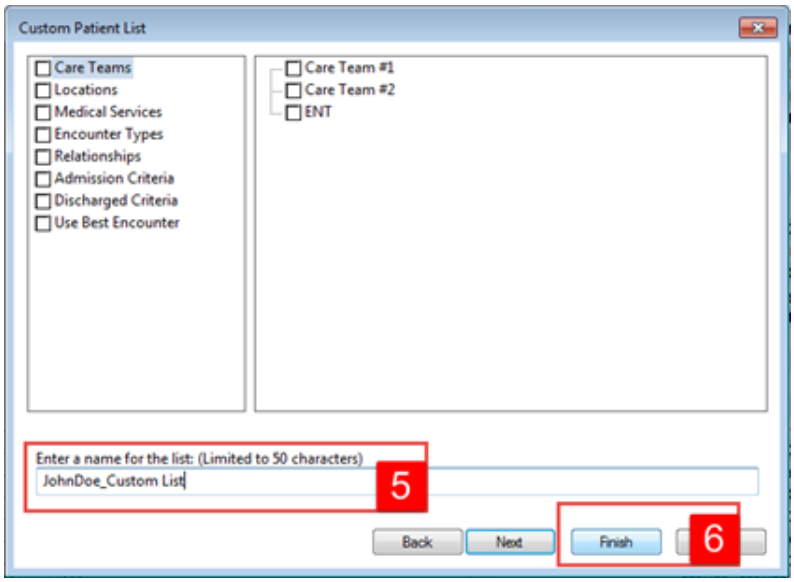
1 Next you need to create a **Custom List** that will contain only the patients under your care.

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

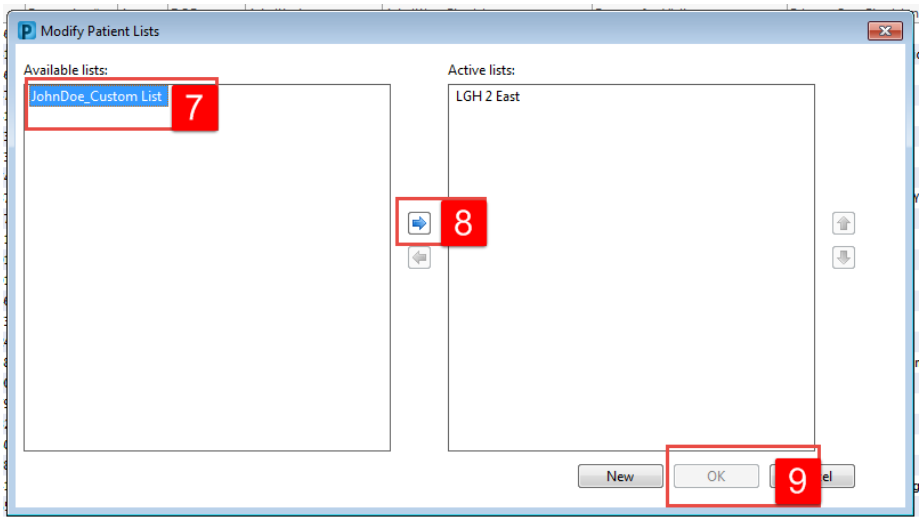


5. **The Custom Patient List** window opens. **Custom Lists** need a unique name. Type YourName_Custom (for example Sara_Custom).

6. Click **Finish**.

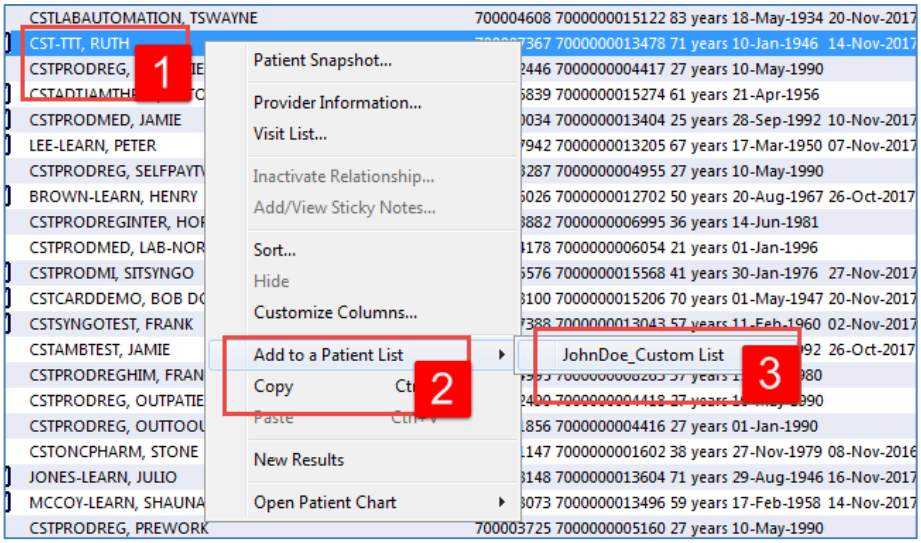


7. In the **Modify Patient Lists** window select **your Custom List**.
8. Click the **blue arrow** icon  to move your **Custom List** to the right, under **Active Lists**
9. Click **OK**

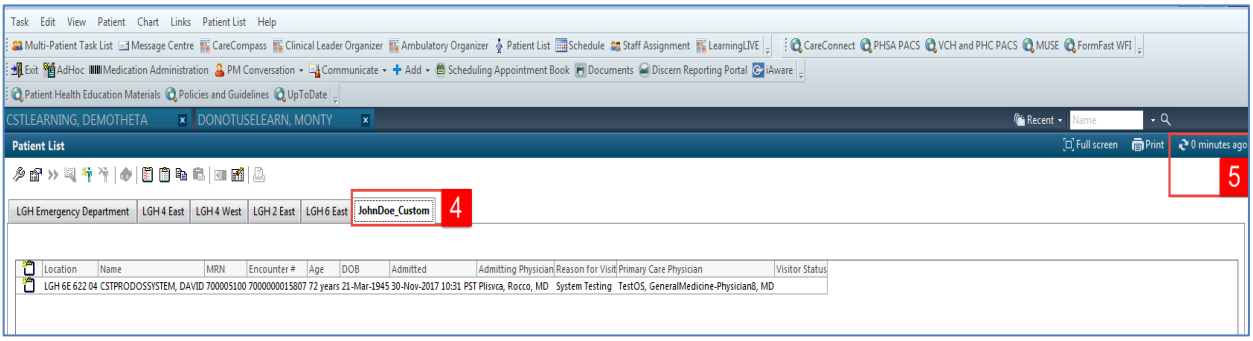


2 At the beginning of a shift or with any assignment changes you will need to add your patients from your location list to your custom list. To do this:

1. First find your patient on your **Location List**. Right-click on your **patient's name**.
2. Hover your cursor over **Add to a Patient List**.
3. Select **YourName_Custom List**.



4. Navigate to your custom list by clicking on **YourName_Custom** tab. The tab will be empty.



5. Click the **Refresh** icon  to refresh your screen. Now your patient will appear in your **Custom List**. Please ensure the patient you have just added to your custom list is the patient assigned to you today

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

Key Learning Point

You can create a Custom List that will consist of only patients that you are caring for on your shift

PATIENT SCENARIO 2 - CareCompass

Learning Objectives

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

- Navigate CareCompass
- Select the correct Patient List
- Review and complete tasked activities

SCENARIO

As an inpatient nurse you will complete the following activities:

- Review CareCompass
- Establish a relationship in the system with your patients and review patient information
- Review and complete tasks in CareCompass

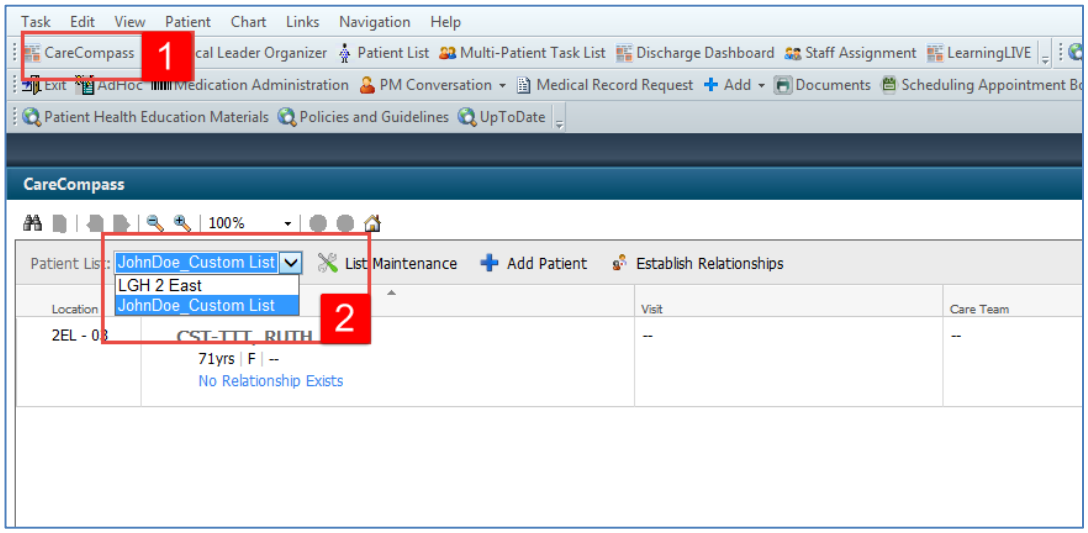
Activity 2.1 - Review CareCompass

CareCompass displays key information about your patients, including important details such as allergies, resuscitation status, reason for visit, and scheduled medications/tasks, orders, and results.

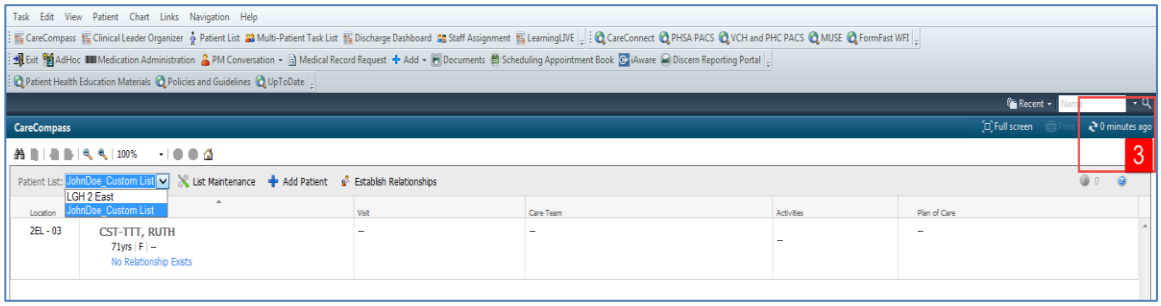
1

1. Navigate back to **CareCompass** by clicking on the **CareCompass** icon 

in the **toolbar**.
2. Select **YourName_Custom** from the **Patient List** drop-down.



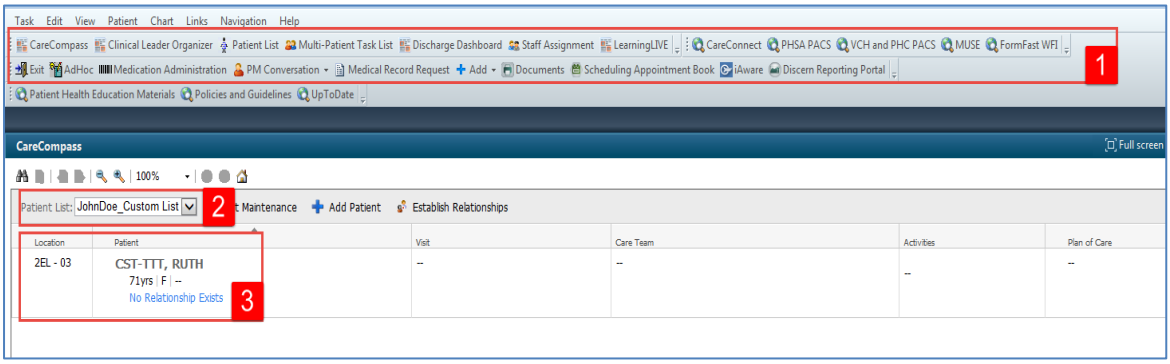
1. Click the **Refresh** icon  . Your selected patient is now visible on your custom list.



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** dropdown menu enables you to select the appropriate patient list 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. (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 their location, name and basic demographics

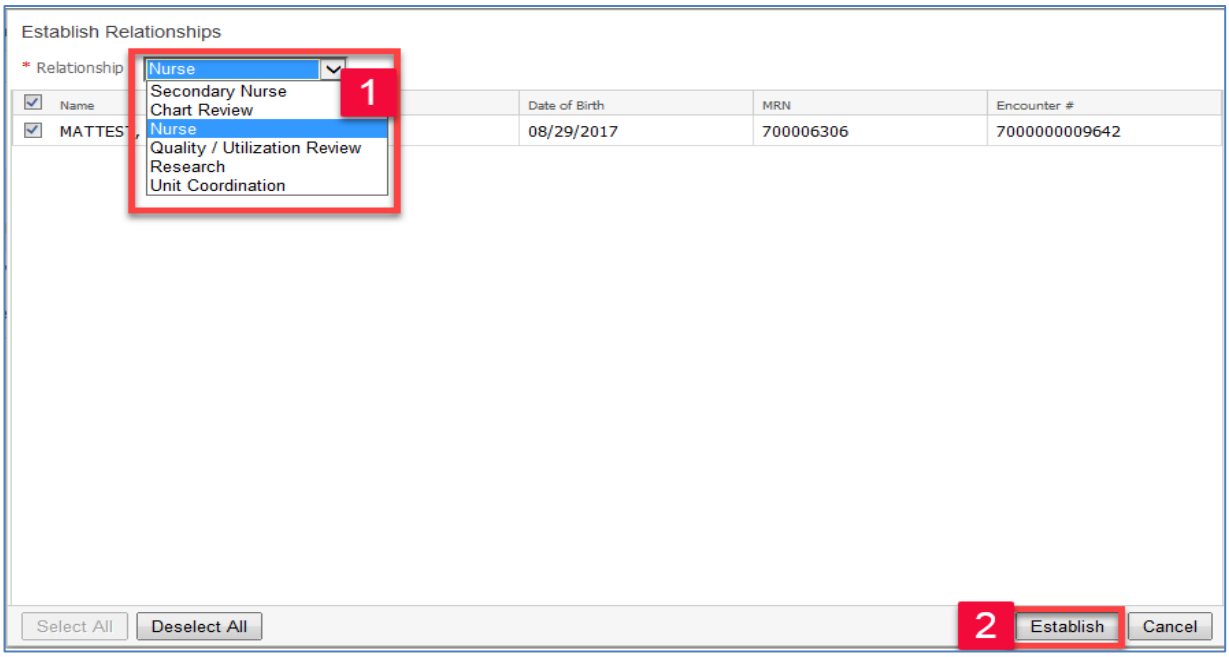
Activity 2.2 – Establish a Relationship and Review Patient Information in CareCompass

1 Now that you have created your custom list, you must establish a relationship with each of your patients in order to view more patient information or access patient charts

1. Click **Establish Relationships**

2

1. From the **Relationship** drop-down select **Nurse**
2. Click **Establish**



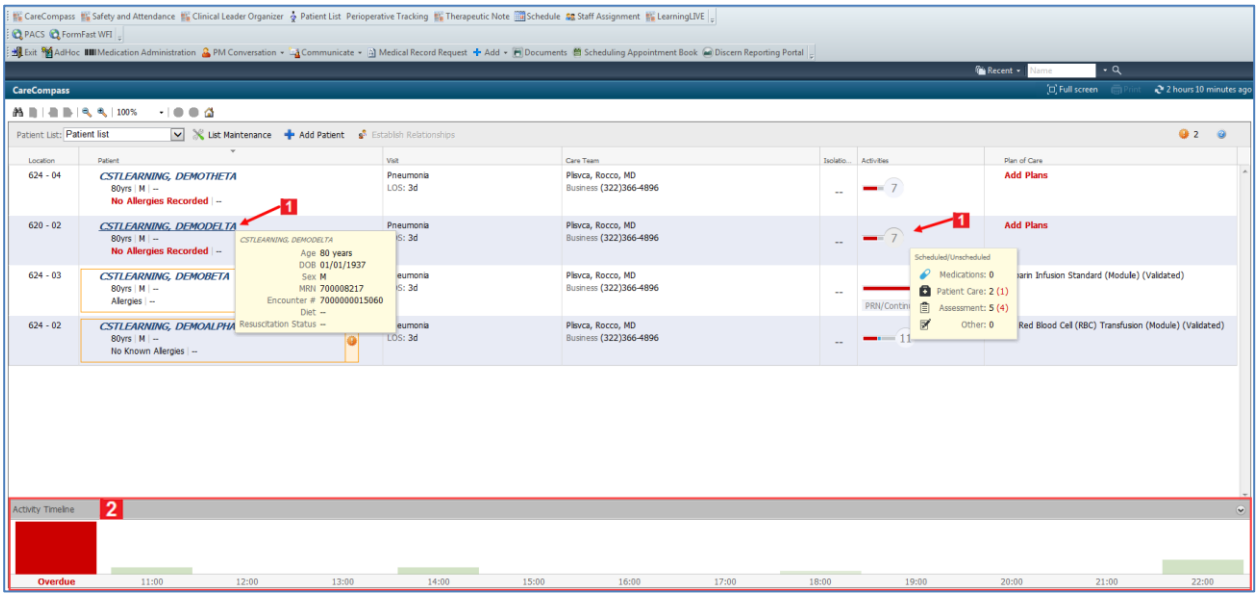
Once a relationship is established with your patients, additional information will appear on

CareCompass.

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

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

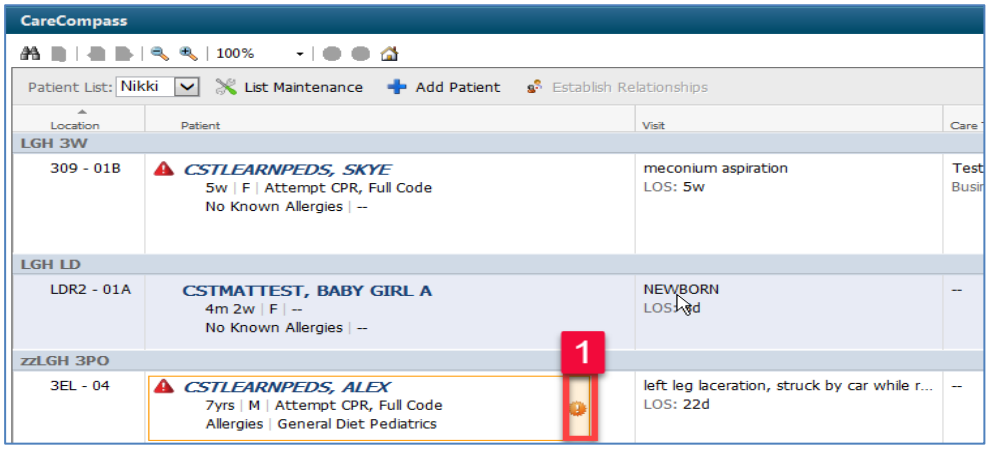
1. You can hover your cursor over icons, buttons, and patient information to discover additional details.
2. **Activity Timeline** appears at the bottom of CareCompass. It provides a visual representation of certain activities that are due for the patients on your list.



4 Notice the **orange exclamation** symbol next to your patient's name. This indicates that there are new orders and/or results for a patient requiring review. Note that there is also an exclamation mark on the top right of the CareCompass page, this is the sum of patients with new orders.

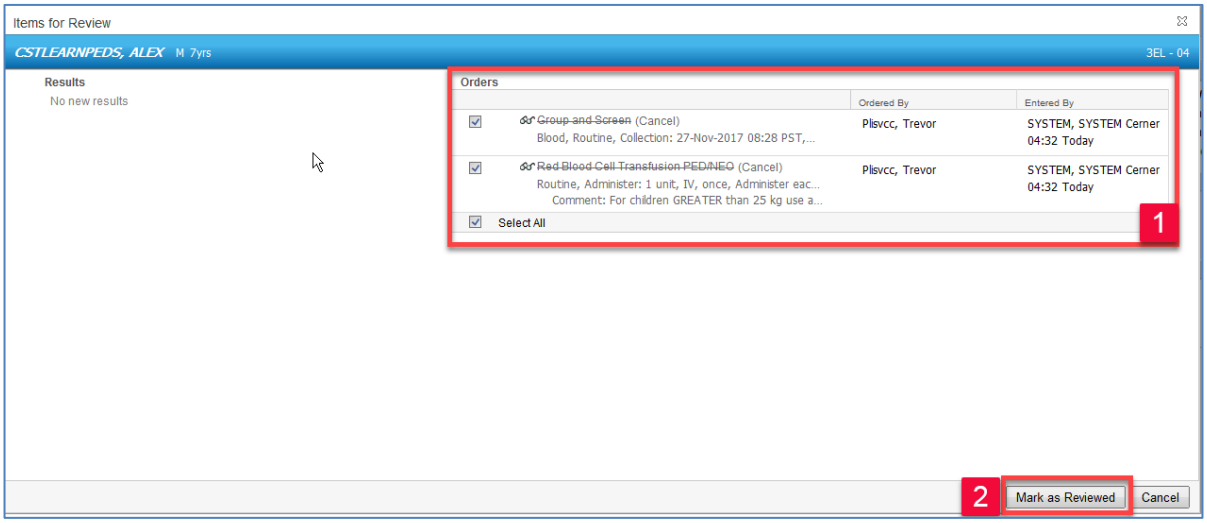
Note: Indicates new non-critical results or orders for a patient.
Indicates new critical results or STAT/NOW orders.

1. Click the **orange exclamation** symbol.



5

1. Review new orders and results in the **Items for Review** window
2. Click **Mark as Reviewed** when done



Once you have marked the orders as reviewed, you are taken back to CareCompass and the orange exclamation symbol will disappear.

Key Learning Points

- A relationship must be established with patients in order to access their patient chart
- Remember to select the correct role when establishing your 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

Indicates new critical results or STAT/NOW orders

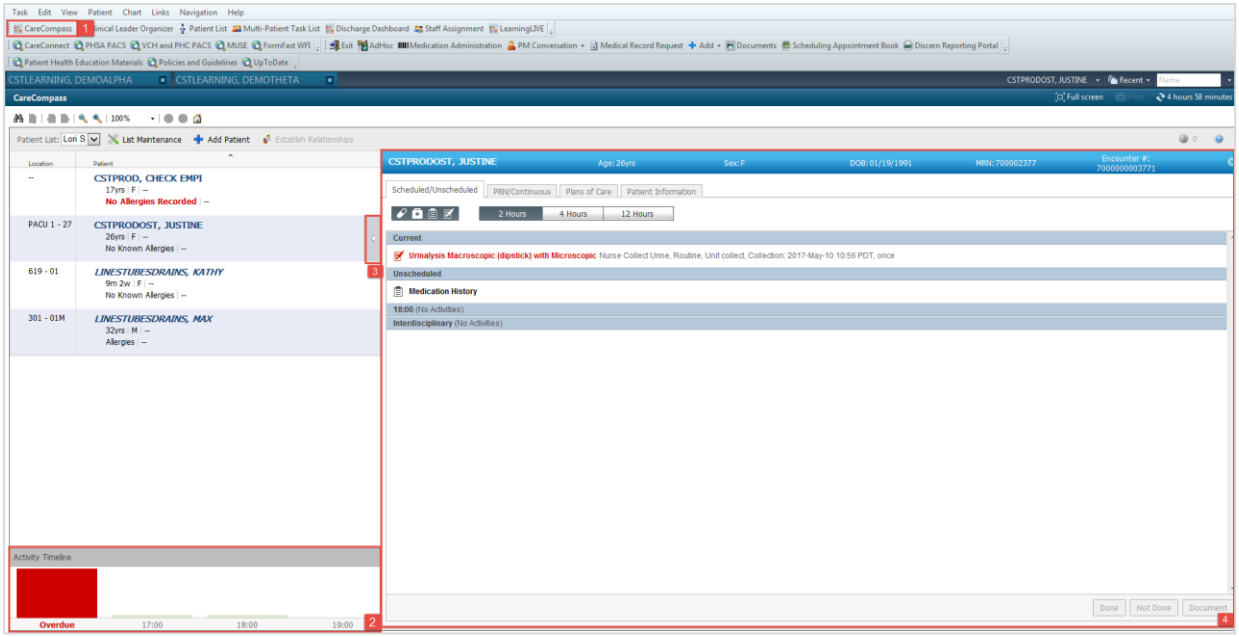
Activity 2.3 – Review and Complete Tasks in CareCompass

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 on your patient.

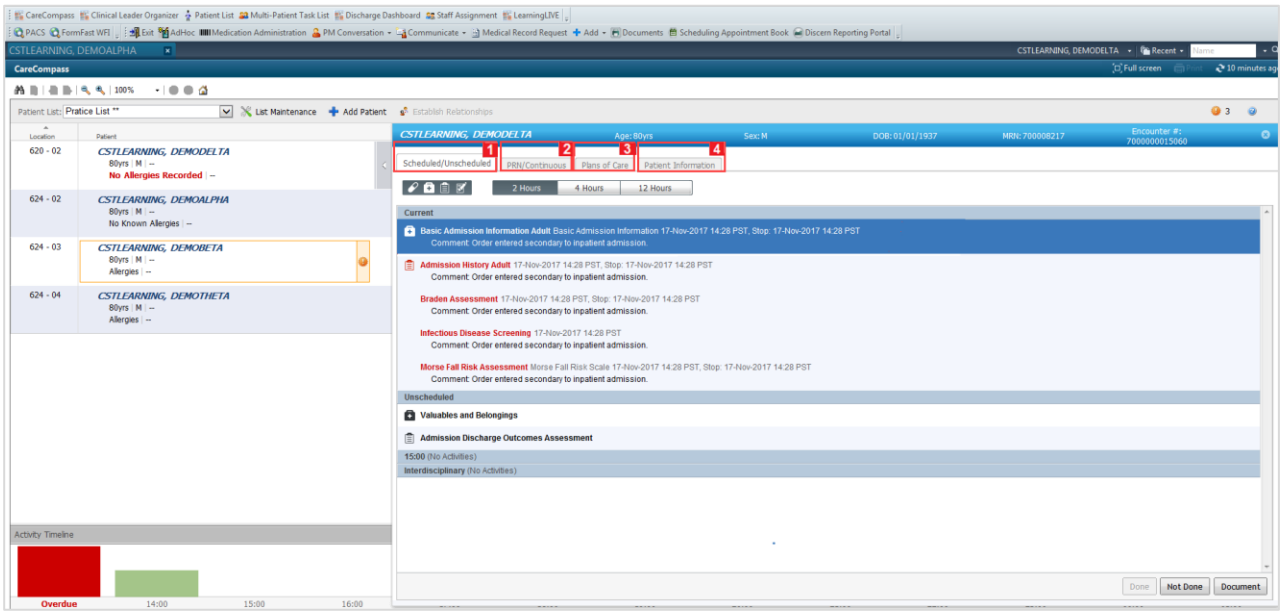
- Ensure you are viewing **CareCompass**
- Scheduled tasks for multiple patients are summarized in the **Activity Timeline.** (You can click on the red or light green shaded bars to view task details.)
- Click the grey forward arrow to the right of your patient's name to open the **Single Patient Task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



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

To see different information you can navigate to:

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. **Admission History NICU** is one of these tasks.

Complete the Newborn Admission Assessment task:

1. Select **Admission History NICU**
2. Click **Document**

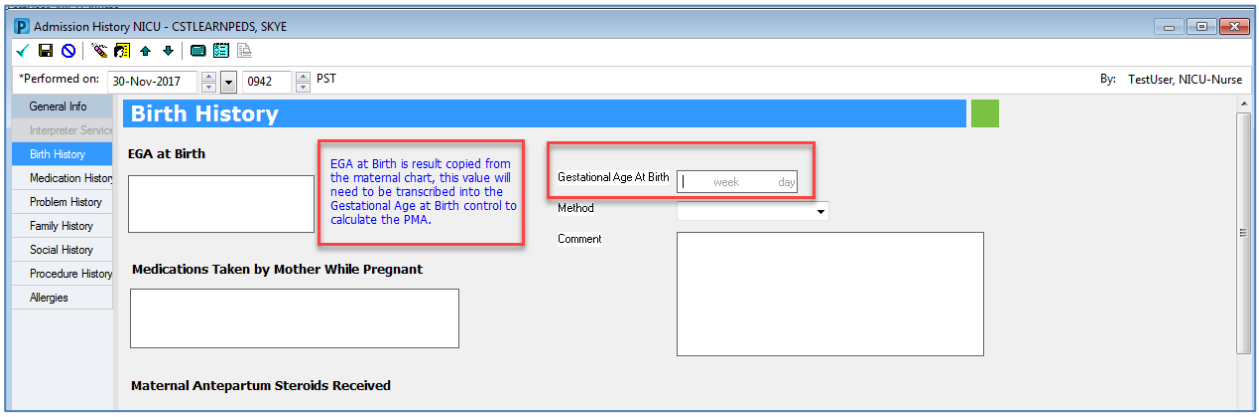
Note: If a task is associated to documentation, clicking **Document** takes you directly to the appropriate documentation within the patient's chart. Admission History NICU, is documented using a **PowerForm** (a standardized electronic documentation form).

3 Once you click Document, the **Admission History NICU** PowerForm opens. This form is where you

document the patient's measurements.

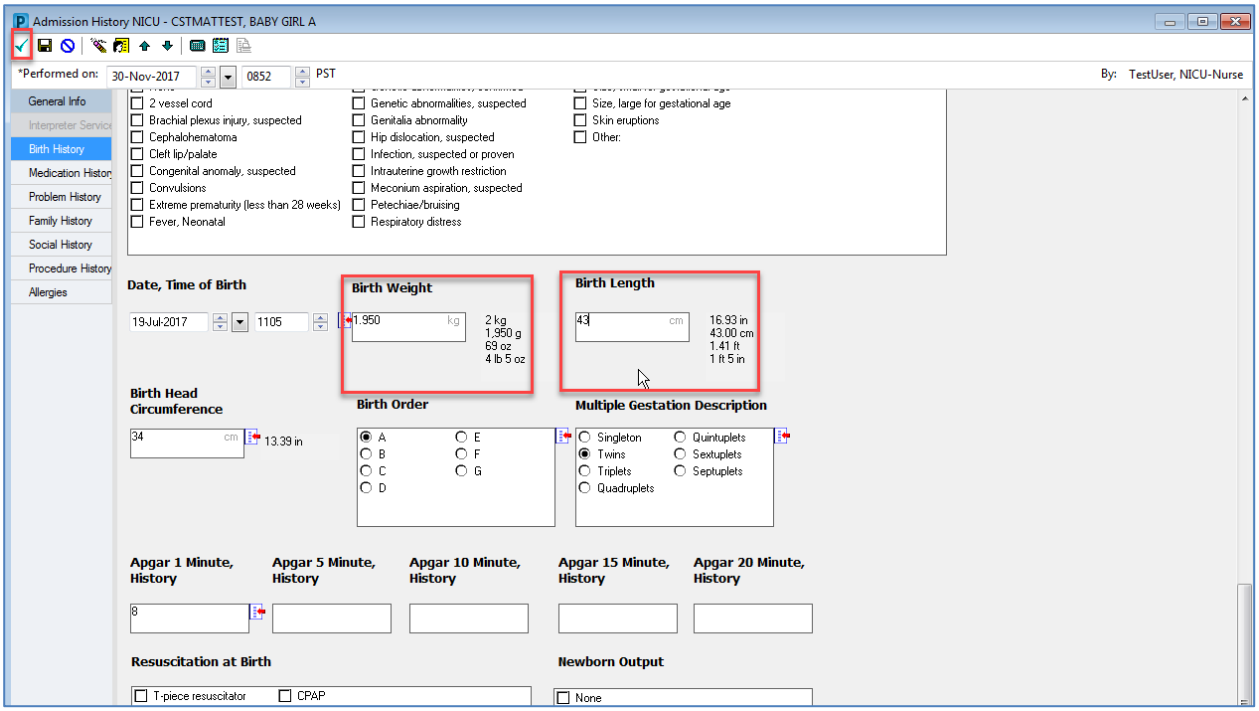
The blue text at the top next to the EGA at Birth field is a reminder that data from the mother's chart should be result copied to the baby's chart prior to baby's admission to the NICU. The **Gestational Age at Birth** must be manually entered by the nurse in order for the PMA to auto-populate.

Note: If the baby's chart has been properly result copied by the postpartum team, the fields on the Admission History NICU form should already be filled out. However, practice using a powerform by manually entering the following data.



Continue to complete this PowerForm:

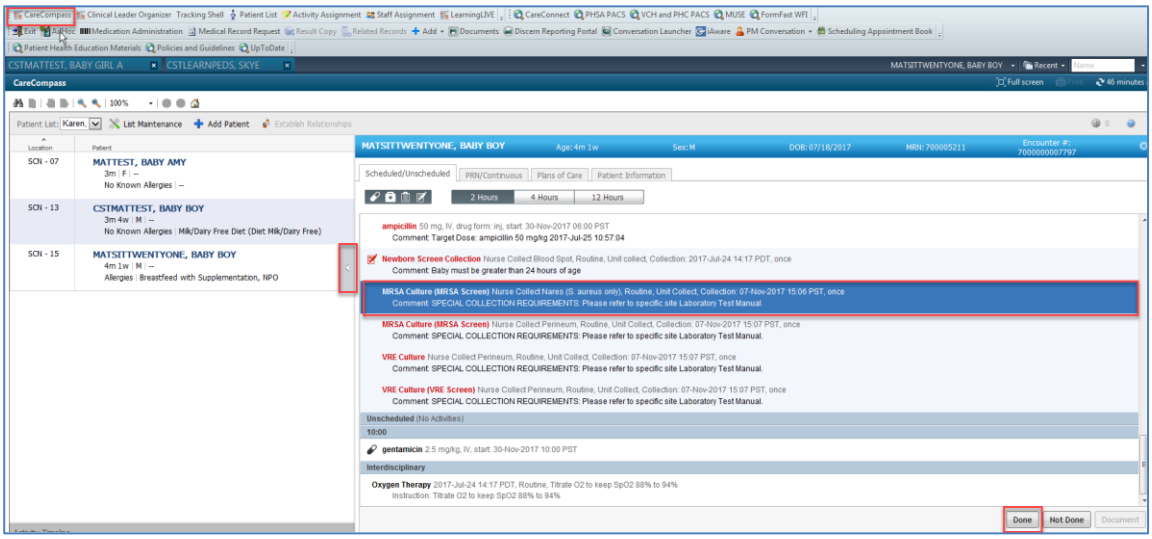
1. Enter a **Weight Measured** of 1.950 kg. Notice it automatically shows weight conversions.
2. Enter **Length Measured** as 43 cm.
3. Click the **Green Check Mark** ✓ to Sign.



8 Let's complete one final task. You have collected a MRSA Culture (Nares) from your patient.

1. Navigate back to **CareCompass** 

2. Open the task box
3. Select **MRSA Culture**
4. Click **Done**
5. A **Nurse Collect** box appears. Review the information and Click **OK**



Note: For the purpose of this workbook and activities, other orders present in the task box will be addressed later. The additional Admission tasks will not be addressed in this workbook but would be completed in your clinical setting. CareCompass should be reviewed throughout the shift to view new orders and results, 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 within CareCompass by clicking “Document” or “Done”.
- Completion of a task will remove the task from the patient task list.
- CareCompass should be reviewed throughout the shift.

PATIENT SCENARIO 3 – Accessing and Navigating 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

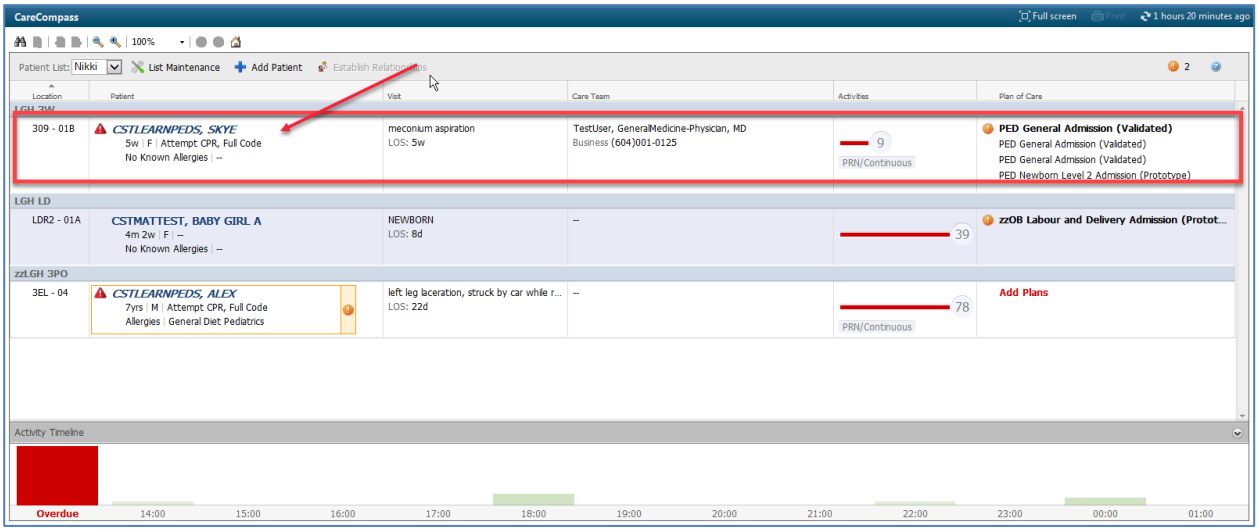
In this scenario, we will review how to access the patient's chart and navigate the different pages of the chart to learn more about the patient.

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

- Introduction to Banner Bar, Toolbar, and Menu
- Introduction to Neonate Overview

Activity 3.1 – Introduction to Banner Bar, Toolbar, and Menu

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

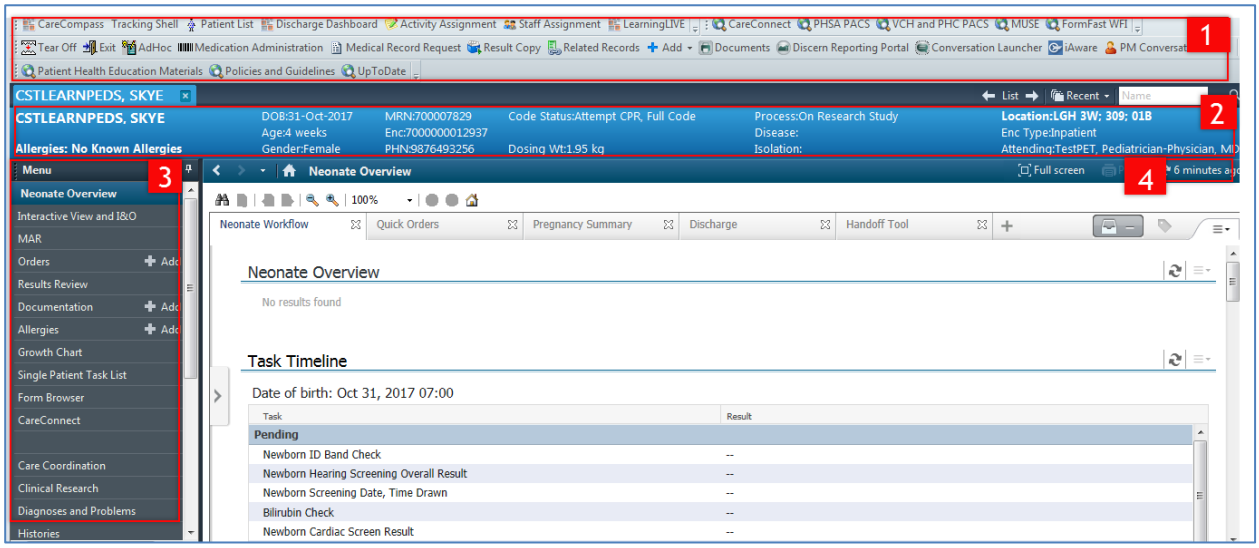


2 The patient's chart is now open, let's do an overview on this screen.

1. The **Toolbar** is located above the patient's chart and it contains buttons for you to navigate to other parts or functions of the Clinical Information System (CIS).
2. The **Banner Bar** displays patient demographics and important information that is visible to anyone accessing the patient's chart. Information displayed includes:
    1. Name
    2. Allergies
    3. Age, date of birth, etc.
    4. Encounter type and number
    5. Code status
    6. Weight
    7. Process, disease and isolation alerts
    8. Location of patient
3. The **Menu** on the left has pages similar to a paper-based patient chart which contain colored dividers. The Menu contains pages such as Orders, Medication Administration Record (MAR), and more.
4. The Refresh icon 

updates the patient chart when clicked. It is important to refresh the chart regularly especially as other clinicians may be accessing the chart simultaneously.

Note: The chart does not automatically refresh. When in doubt, refresh!



Key Learning Points

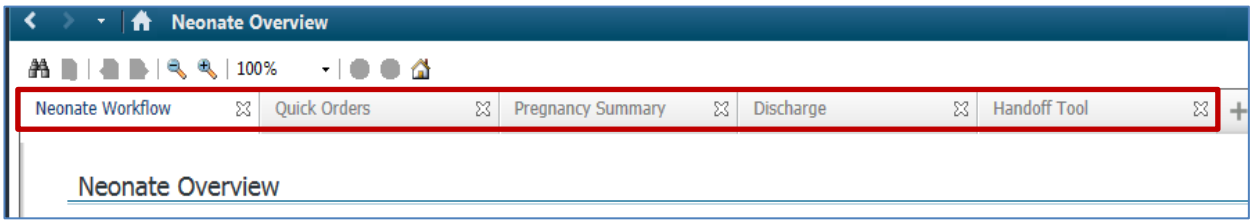
- The toolbar is used to navigate to other parts or functions of CIS
- The banner bar displays patient demographics and important information
- The Menu contains sections of the chart similar to your current paper chart
- The patient chart should be refreshed regularly to view the most up-to-date information

Activity 3.2 – Introduction to Neonate Overview and Task Timeline

1 Upon accessing the patient's chart you will see **the Neonate Overview** page open. The **Neonate Overview** will provide key clinical information about the patient.

There are different tabs such as **Neonate Workflow**, **Quick Orders**, **Pregnancy Summary**, **Discharge**, and **Handoff Tool** that you can review to learn more about the patient.

Click on the different tabs for an overview of the patient.



2 Click the Refresh icon 

to get the most updated information on the patient.

The icon will reset to 0 minutes 

.

3 Click the Neonate Workflow tab and select the Task Timeline section.

The Task Timeline provides the nurse a quick overview of all the tasks that needs to be completed for the baby prior to discharge. It is separated into Pending and Completed sections.

Other disciplinary members, such as a hearing screener, can document the hearing screen result and the data will reflect on the Task Timeline, it will be viewable by the assigned nurse and

provider.

Key Learning Points

- Neonate Overview will provide key information about the patient
- Click the Refresh icon to get the most updated information on the patient
- The Task Timeline provides a quick multi-disciplinary overview of what needs to be completed prior to discharge.

PATIENT SCENARIO 4 – PM Conversation

Learning Objectives

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

- Utilize PM Conversation

SCENARIO

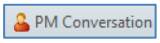
Unit clerks will often update the patient information in the system. In some situations, the nurse will need to update patient information such as process alerts (e.g. falls risk alert) in the chart. In this scenario, you will be reviewing PM Conversation and some of its functionalities. You will then learn how to add a process alert.

- PM Conversation

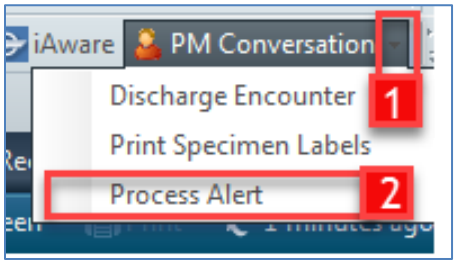
Activity 4.1 – PM Conversation

1 Patient Management Conversation (PM Conversation) provides access to manage alerts (such as violence risk, falls risk or isolation precautions), patient location, encounter information and demographics. Let's look at how alerts are managed.
Within the system, process alerts are flags that highlight specific concerns about a patient. These alerts display on the banner bar and can be activated by clinicians including nurses.

The patient's parents have requested visitor restrictions. To add a process alert for visitor restrictions:

1. Click drop-down arrow to right of **PM Conversation** 

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

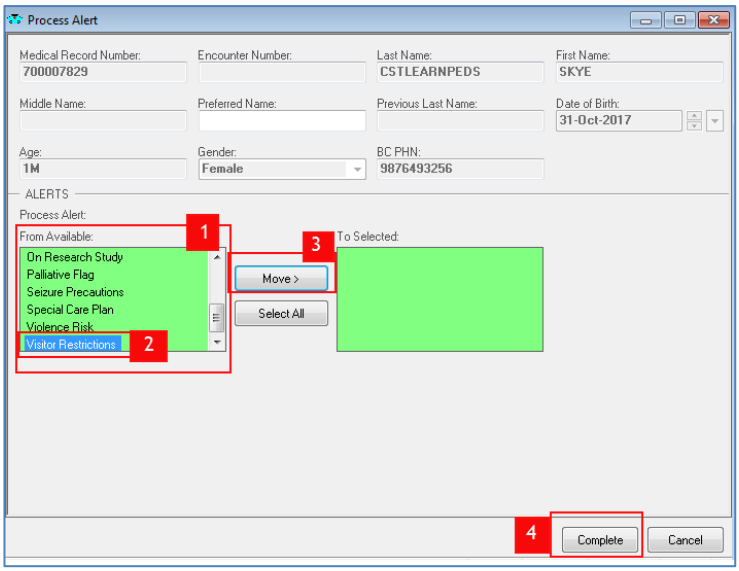


An organization window will display to select location.

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

2 The **Process Alert** window opens To activate the process alert:

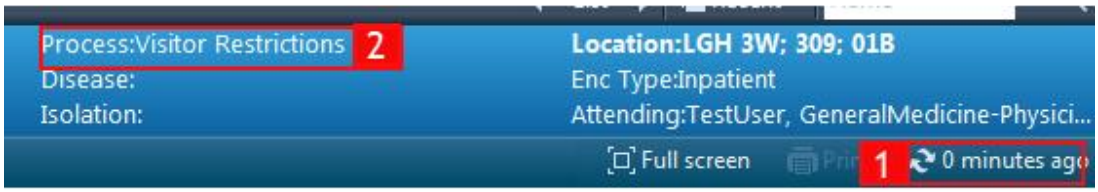
1. Click into the empty **Process Alert** box. A list of alerts that can be applied to the patient will display.
2. Select **Visitor Restrictions**
3. Click **Move** Move > The alert will now be within the **To Selected** box
4. Click **Complete**



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 flags and alerts.

3

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



Key Learning Points

- sing PM Conversation allows you to manage alerts, patient location, encounter information and demographicsU
- Updating Process Alerts in PM Conversation allow clinicians to see specific concerns related to the patient in the Banner Bar

PATIENT SCENARIO 5 - Orders

Learning Objectives

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

- Review Orders Page 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. To do so you will complete the following activities:

- Review the Orders Profile
- Place a No Cosignature Required Order
- Review Orders Statuses and Details
- Place a Verbal Order
- Complete an Order
- Review components of a PowerPlan

Activity 5.1 – Review Orders Profile

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

To navigate to the Orders Profile and review the orders:

1. Select **Orders** from the **Menu**
2. On the left side of the Orders Profile is the navigator (**View**) which includes several categories including:

1) **Plans**
2) **Categories of Orders**
3) **Medication History**
4) **Reconciliation History**

3. On the right side you can:

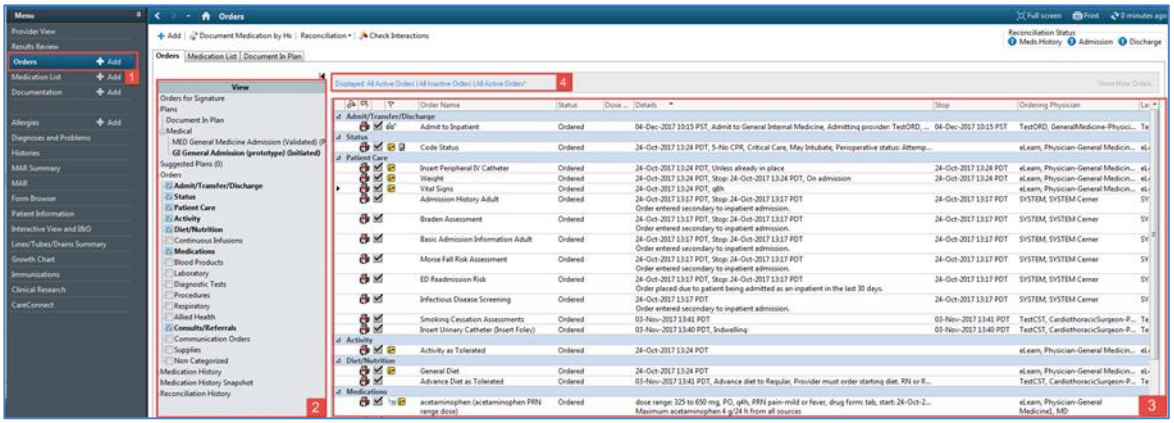
1. Review the list of **All Active Orders**

Moving the mouse over order icons allows you to **hover to discover** additional information.

Some examples of icons are:

- Order for nurse to review
- Additional reference text available
- Order part of a PowerPlan
- Order waiting for Pharmacy verification

4. Notice the display filter default setting is set to display **All Active Orders**. This can be modified to display other order statuses by clicking on the blue hyperlink.



Key Learning Points

- The Order Page consists of the Orders View (Navigator) and the Order Profile.
- The Orders View displays the lists of PowerPlans and clinical categories of orders.
- The Order Profile page displays all of the orders for a patient.

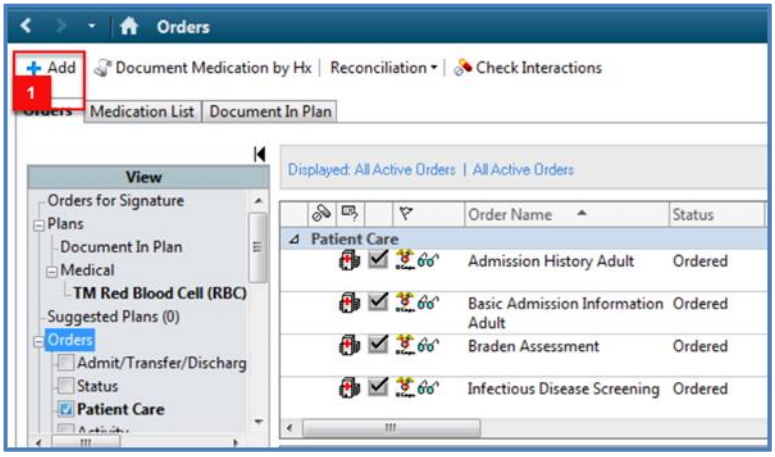
Activity 5.2 – Place an Order (No Cosignature Order)

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

1) Orders requiring a co-signature of the provider e.g. telephone and verbal orders
2) Orders that do not require a co-signature e.g. order within nursing scope, Nurse Initiated Activities (NIA)

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

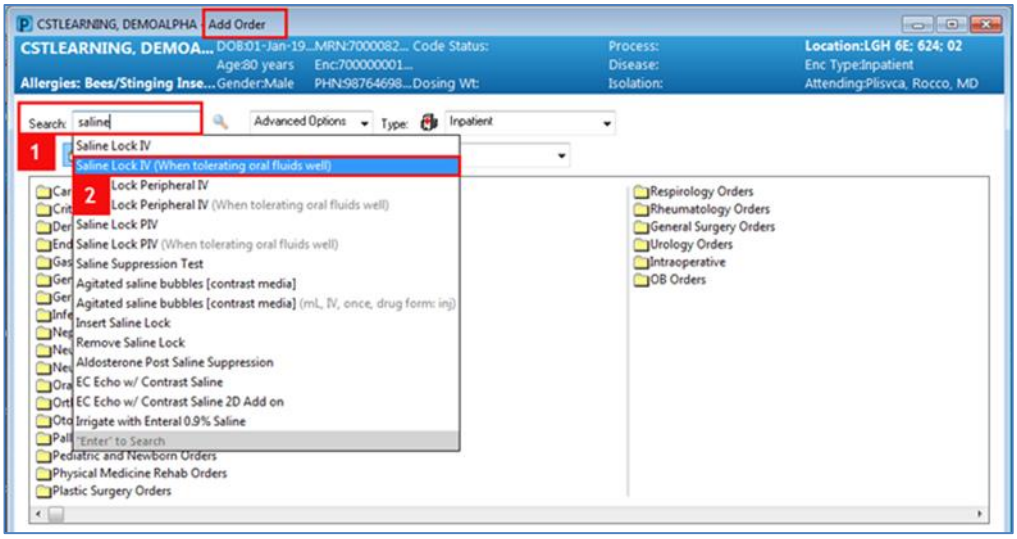
1. Click **Add** within the **Orders** page.



The **Add Order** window will open.

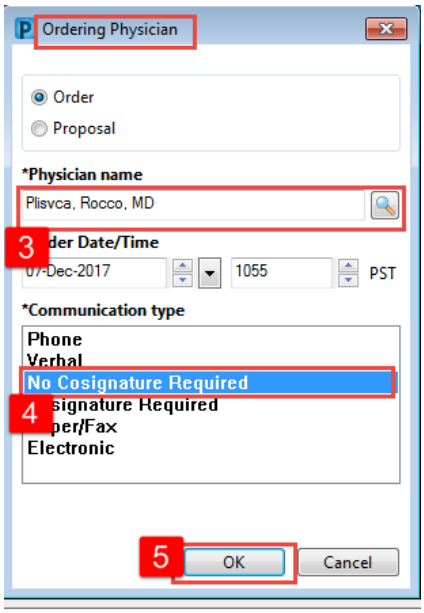
1. Type *saline lock* into the search window and a list of choices will display.
2. Select **Saline Lock Peripheral IV (when tolerating oral fluids well)**.

Note: In this example "(when tolerating oral fluids well)" is an order sentence. Order sentences help to pre-fill order details.

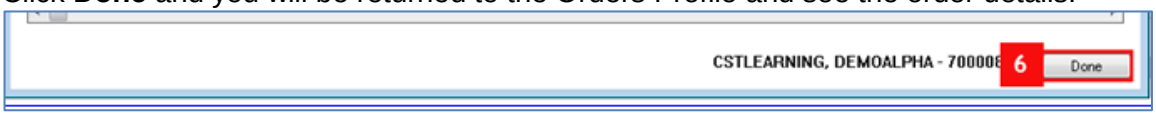


The **Ordering Physician** window opens.

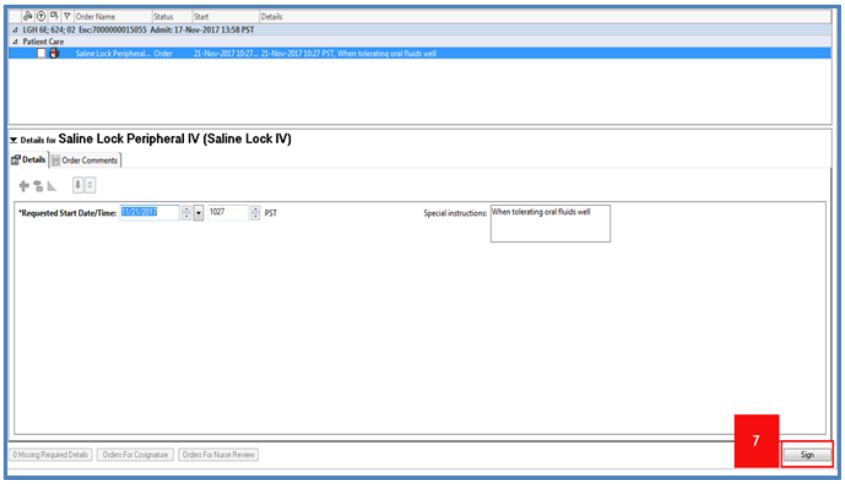
3. Type in the name of the patient's Attending Physician
4. Select **No Co-signature Required**
5. Click **OK**



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



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



8. Click **Refresh** 

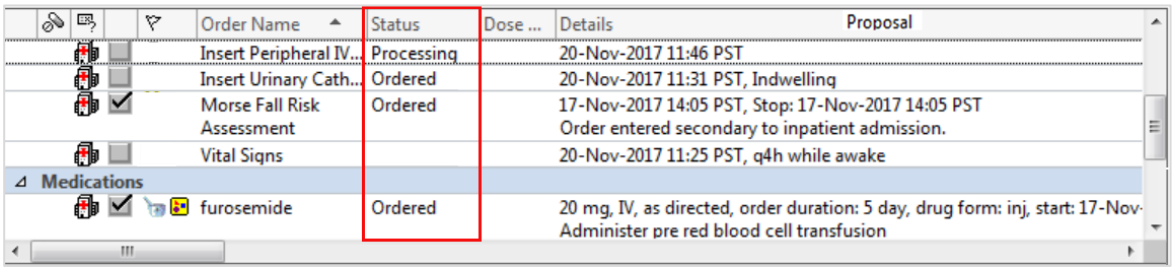
Key Learning Points

- Nurses can place Nurse Initiated orders as No Co-signature Required Orders
- Order sentences add additional information to an order

Activity 5.3 – Review Order Statuses and Details

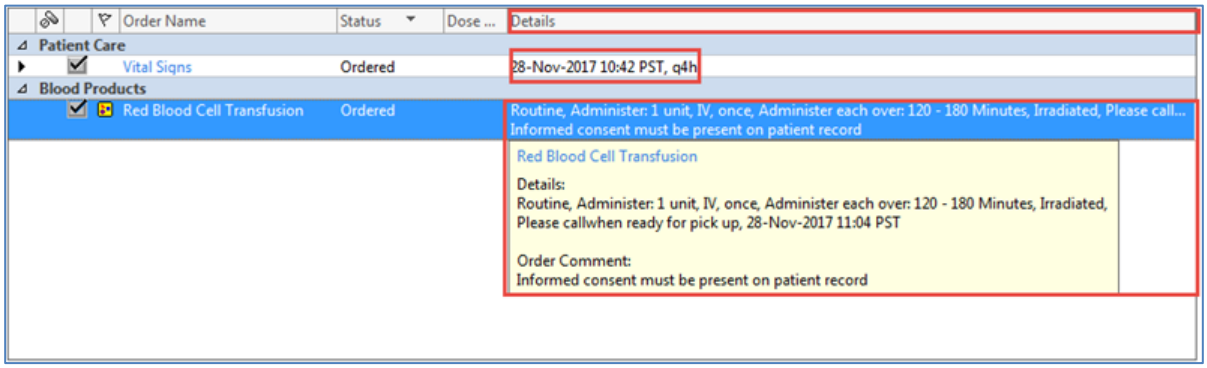
1 To see examples of different order statuses, review the image below:

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



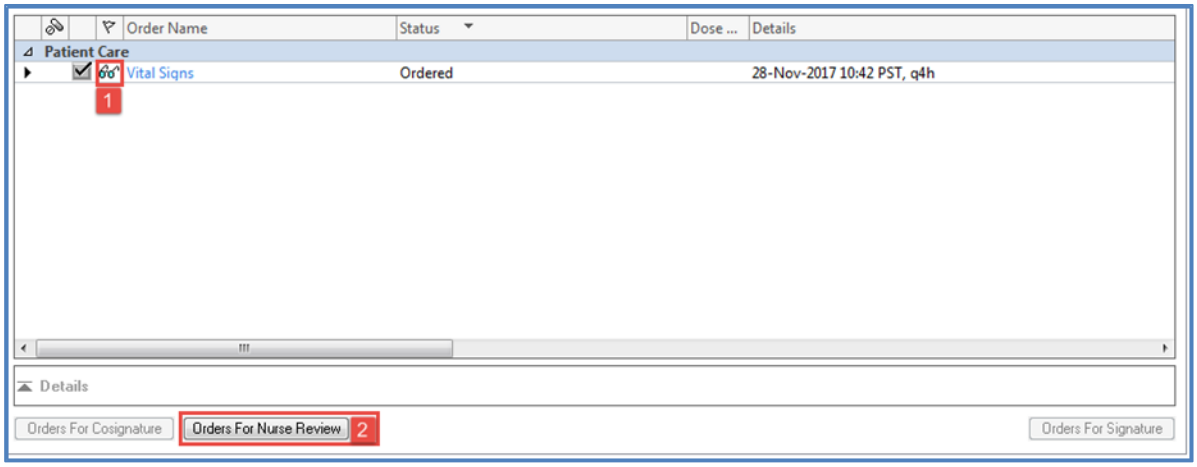
To see examples of order details review the image below:

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



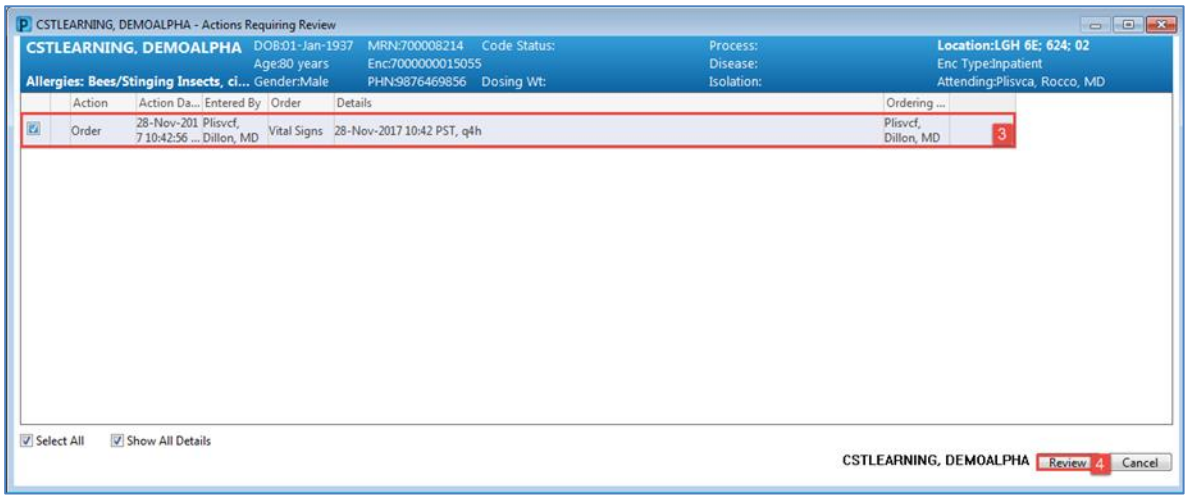
When new orders are placed in the chart, a nurse must review these new orders and document their review. Below we outline the steps for how this should be done. **Note:** Do not follow these steps in the system but instead refer to the screenshots to understand the process.

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. Click the **Orders for Nurse Review** button to open the review window.



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

- Review order details
- Click **Review**



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

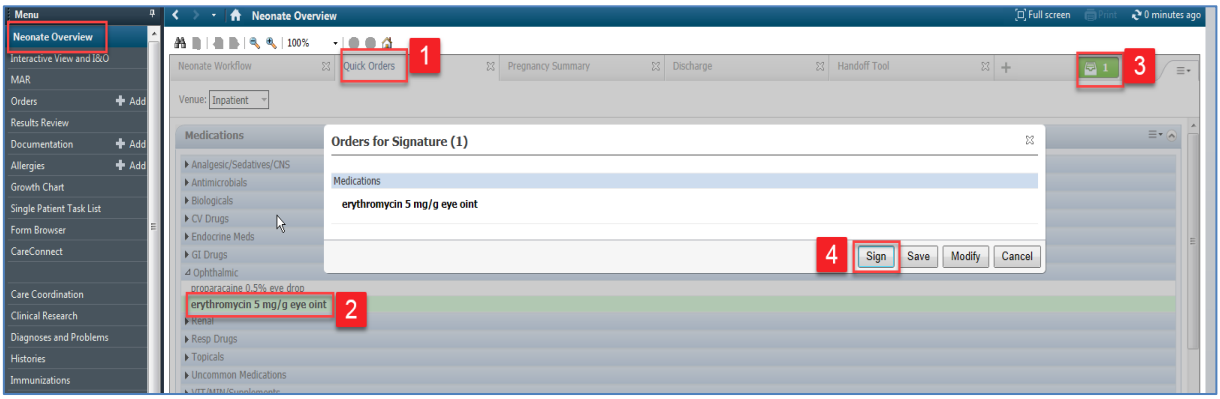
Activity 5.4 – Place a Verbal Order

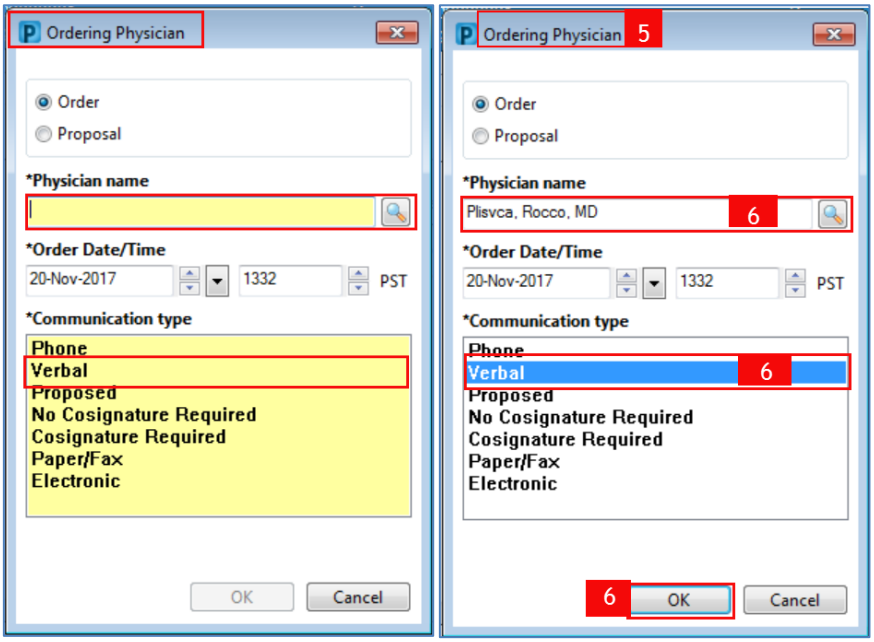
1 A **Verbal Order** is only accepted when there is no reasonable alternative. Nurses should enter the order as promptly as possible.

The pediatrician gives you a verbal order for the Erythromycin 5 mg/g eye ointment to be administered.

To place a verbal order:

1. Select **Quick Orders tab** from the **Neonate Overview** section.
2. Select the appropriate order from the Medications Section.
3. Click the **Orders for Signature**  icon at the top right corner.
4. Check to make sure the order selected is correct, click **Sign**.
5. The Ordering Physician window will pop up, fill in the appropriate information, physician name (last name, first name).
6. Select verbal as communication type. Click OK.





Key Learning Points

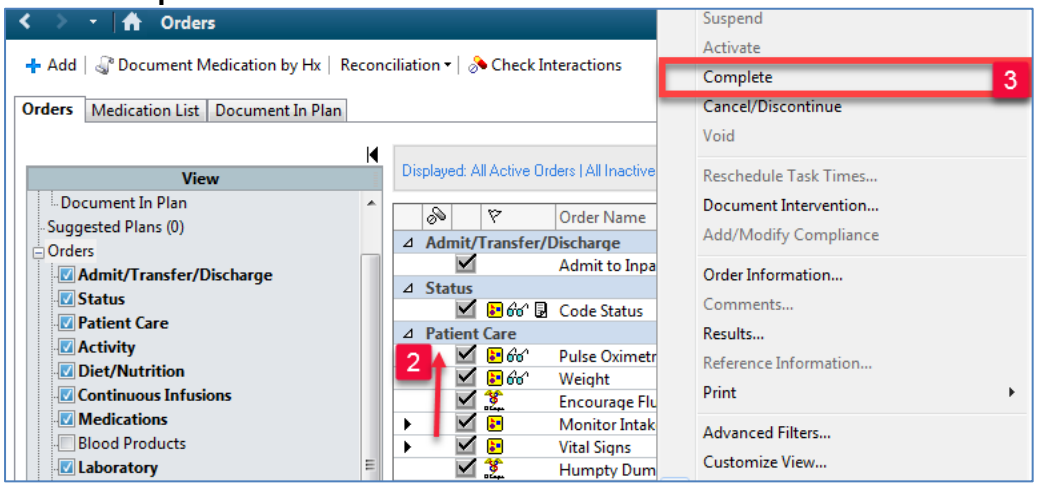
- Required fields are always yellow
- Verbal and telephone orders are limited to extenuating circumstances. For example, during a code situation.

Activity 5.5 – Complete or Cancel/Discontinue an Order

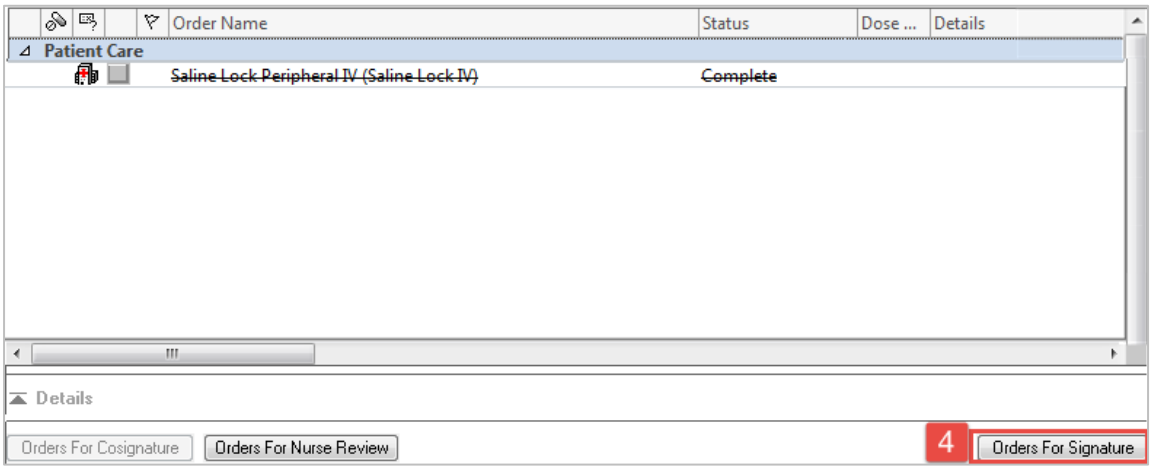
1 When a one-time order has been carried out, the order needs to be removed from the patient's order profile. This is done by completing the order.

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

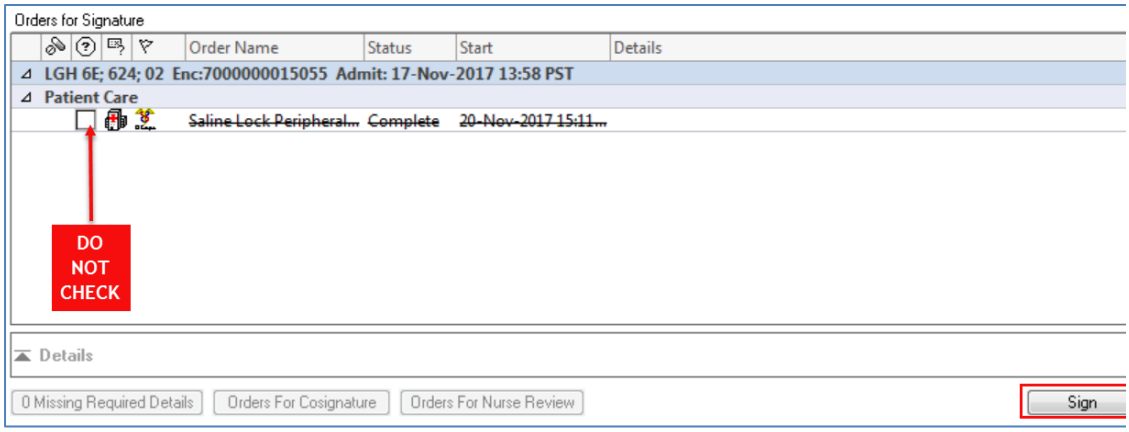
- Review the Orders Profile
- Right-click order to **Saline Lock Peripheral IV**
- Select **Complete**



- Click **Orders For Signature**



- Review Order for signature and click the **Sign** button. You will return to Orders Profile where the order will show as processing.



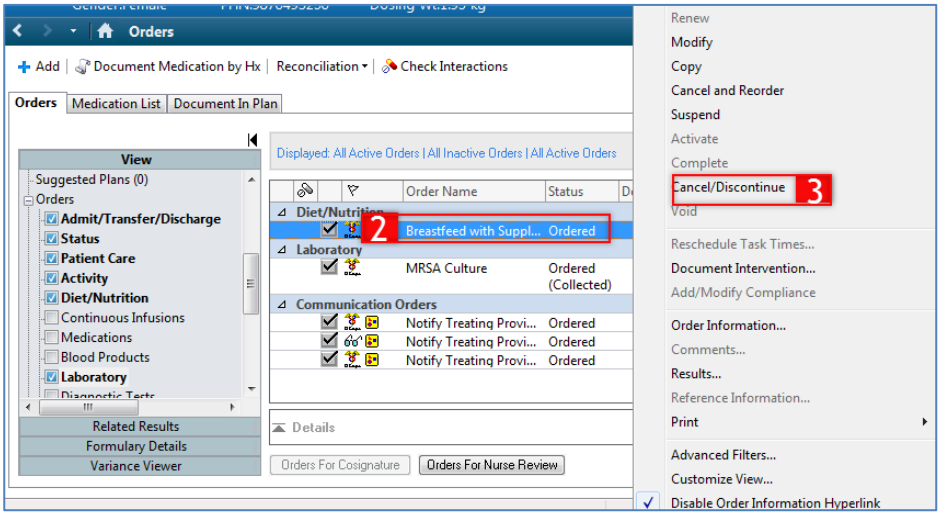
- **Refresh**  the screen and the order will no longer be visible on the Orders Profile.

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

a) Review the **Orders Profile**

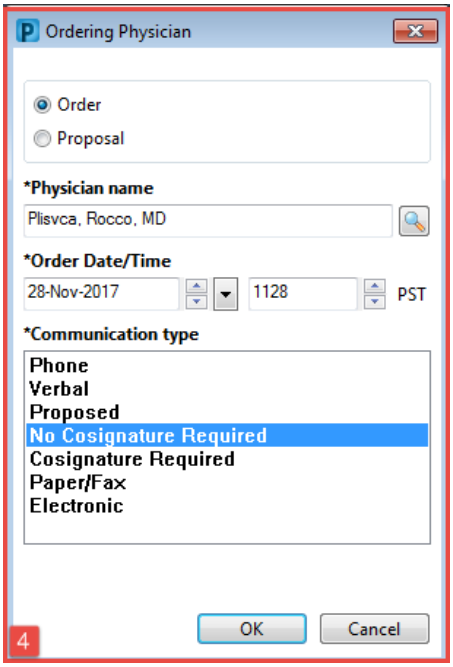
b) Right-click order **Breastfeed with Supplementation**

c) Select **Cancel/Discontinue**

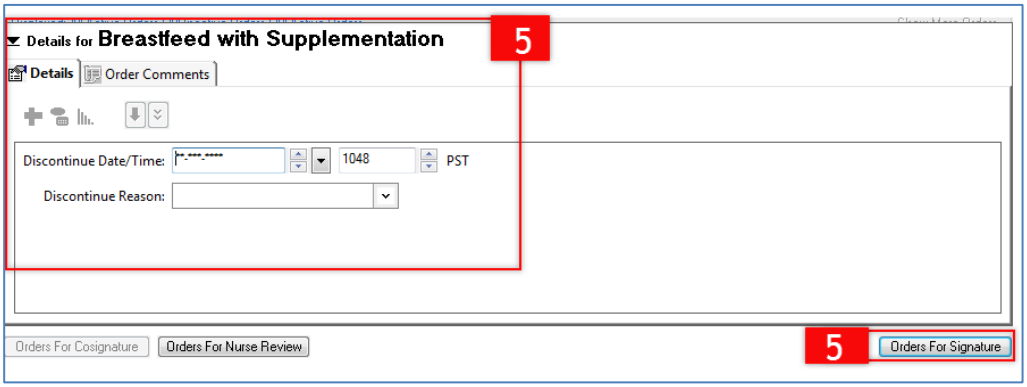


d) **Ordering Physician** window will appear. Fill out required fields (required fields are always yellow) and click **OK.**

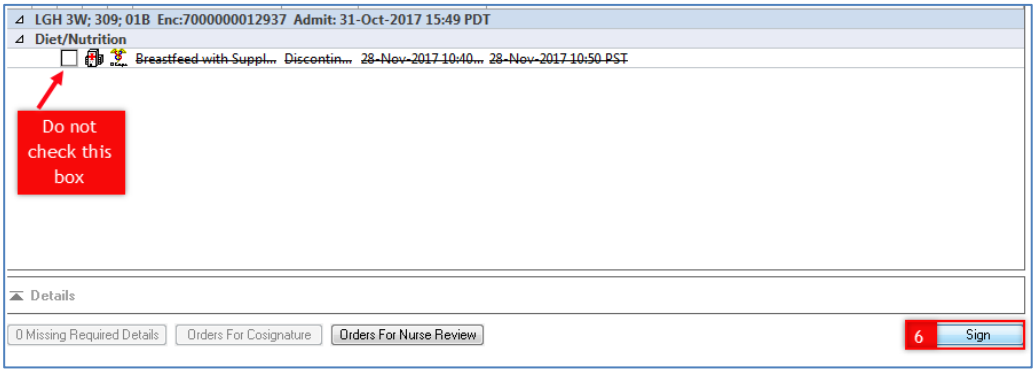
1. **Physician name** = *type name of Attending Physician (last name, first name)*
2. **Communication type** = *No Cosignature Required*



e) Review fields and click the **Orders For Signature** button



f) Review Order for signature and click **Sign**. You will return to Orders Page



g) **Refresh** the page. Order will no longer be visible on Order Profile.

Key Learning Points

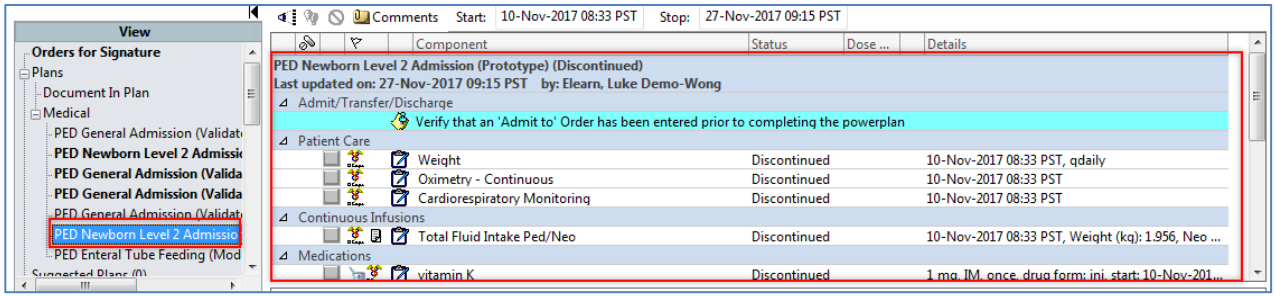
- Right-click to mark an order as completed or discontinued
- Both of these actions will remove orders from patient's Order Profile

Activity 5.6 – Review Components of a PowerPlan

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. Locate the **PED Newborn Level 2 Admission**
3. Review the orders within the PowerPlan



Key Learning Points

- The Orders page 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 6 - Interactive View and I&O

Learning Objectives

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

- Review the Layout of Interactive iView
- Document and Modify your Documentation in iView

SCENARIO

In this scenario, you will be charting on your patient. You will need to complete the following activities:

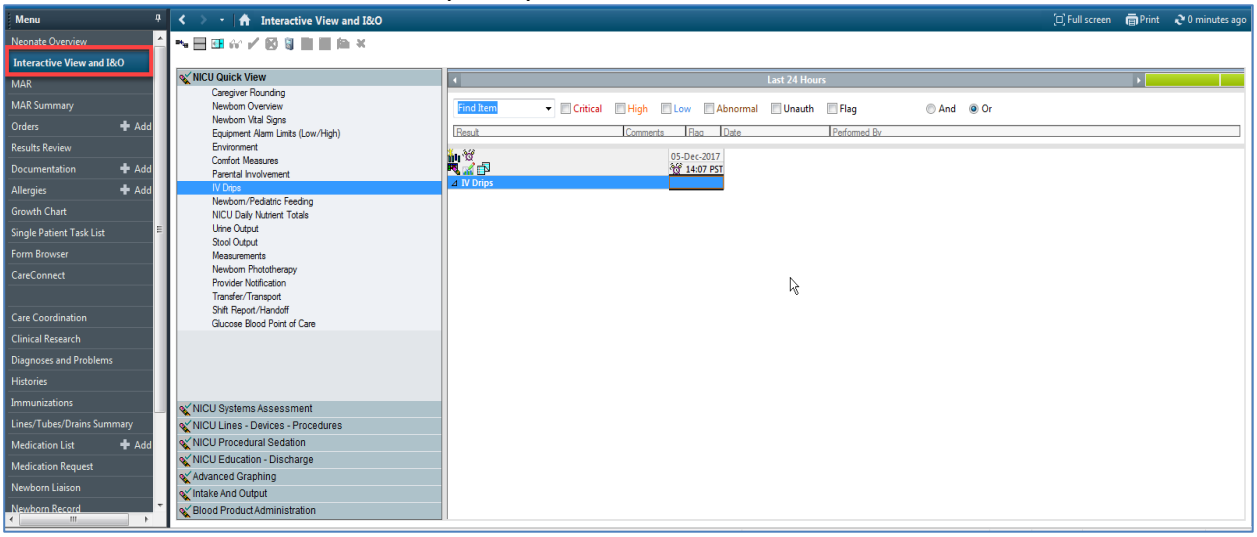
As an inpatient nurse you will be completing the following activities:

- 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 Interactive View

Activity 6.1 – Navigate to Interactive View and I&O

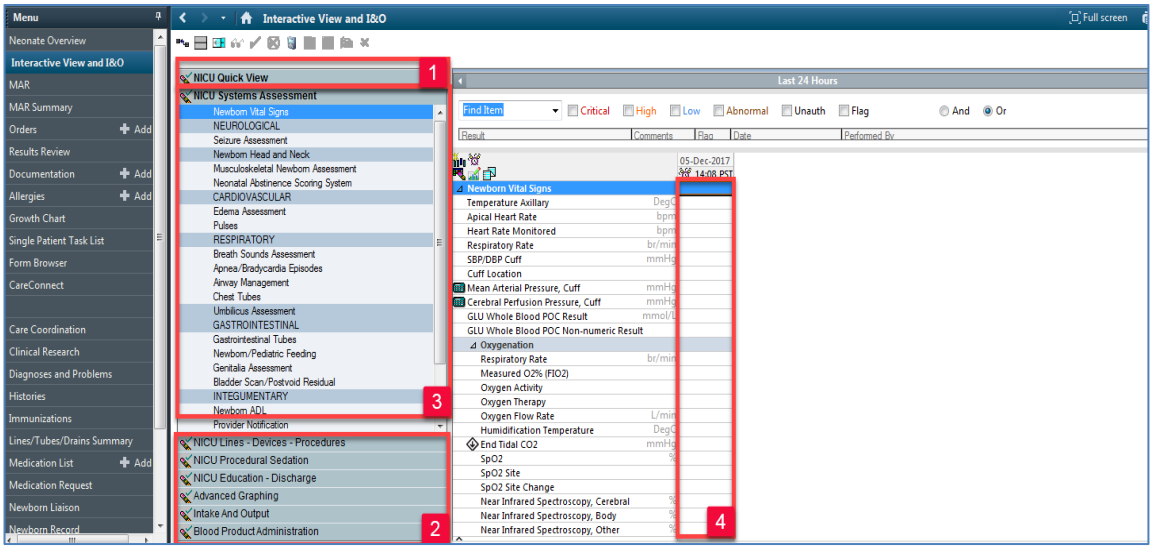
1 Nurses will complete most of their documentation in **Interactive View and I&O (iView)**. iView is the electronic equivalent of current state paper flow sheets. For example, vital signs and pain assessment will be charted in iView.

Select **Interactive View and I&O** (**iView**) within the **Menu**.



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

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



Key Learning Points

- Nurse will complete most of their documentation in iView
- iView contains flowsheet type charting

Activity 6.2 – Documenting in Interactive View and I&O

1 With the **NICU Quick View** band expanded you will see the **Newborn Vital Signs** section. If the patient is on monitoring, results will be automatically fed from the device into the chart using **BMDI**. You will learn more about BMDI in a hands-on practice at the bedside. Follow the steps below for times you may need to manually enter vital signs.

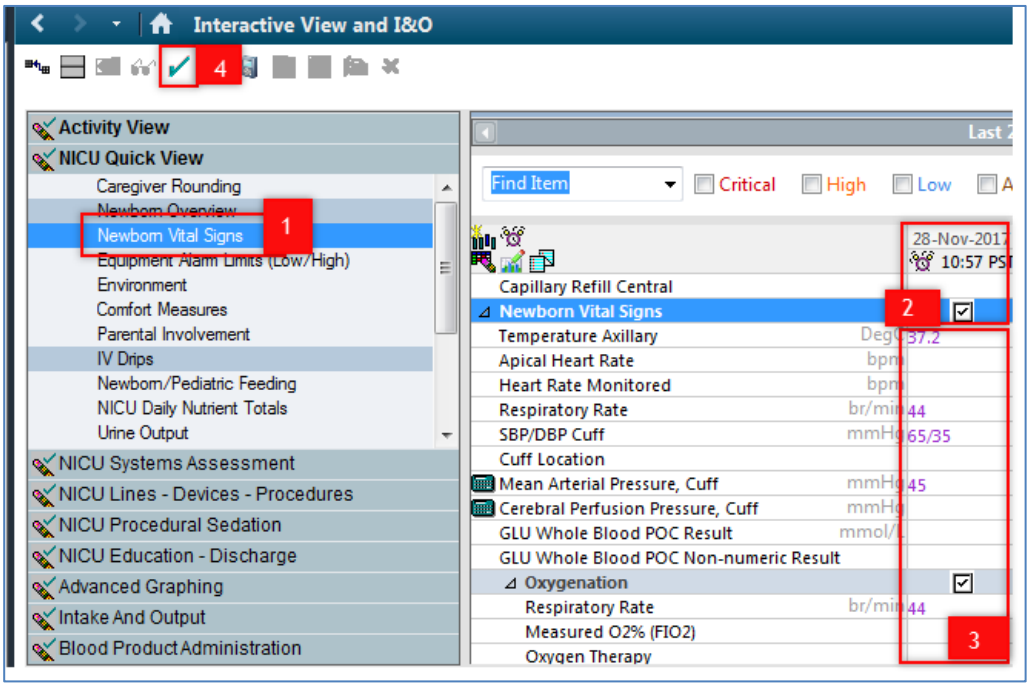
- Select the **Newborn Vital Signs** component under **NICU Quick View**
- Double-click the **blue box** next to the name of the section to document in several cells. You can move through the cells by pressing the **Enter** key.
- Document the following data:
  - **Temperature Axillary** = *37.2*
  - **Apical Pulse Rate** = *160*
  - **SBP/DBP Cuff** = *65/35*
  - **Mean Arterial Pressure, Cuff** = (double-click the empty cell for automated 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** = *44*
  - **SpO2**= *97*
  - **SpO2 Site**= *Foot*

Notice that the text is purple. This means that the documentation has not been signed and is not part of the chart yet. Once the documentation is signed in iView, it is completed in the chart and is available to others accessing the patient's chart.

- To sign your documentation, click the **Green Checkmark** icon



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

Note: **NICU Quick View** is for frequently accessed charting while **NICU Systems Assessment** is the head to toe documentation area. 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.

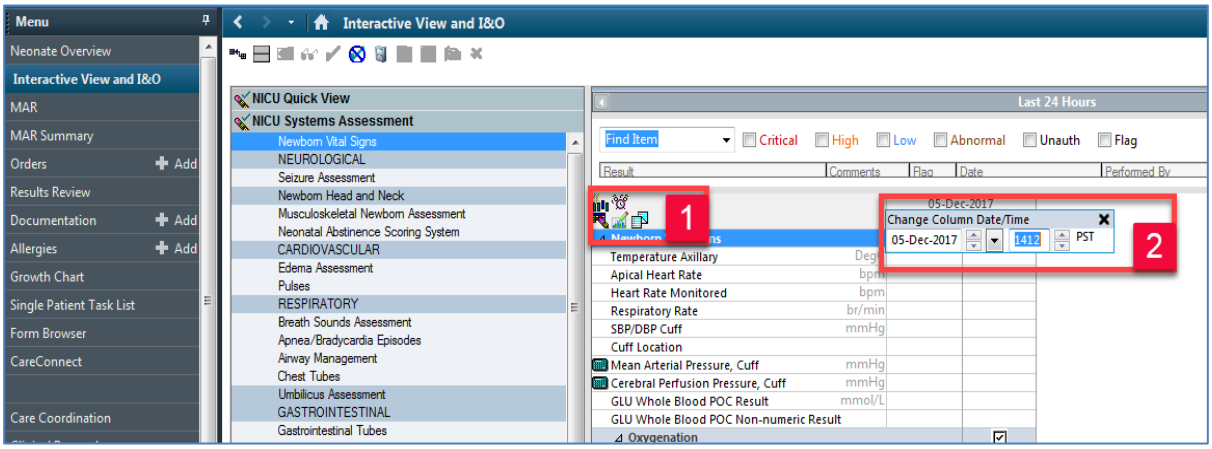
Key Learning Points

- Documentation will appear in purple until signed. Once signed, the documentation will become black
- The newest documentation is to the left
- 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

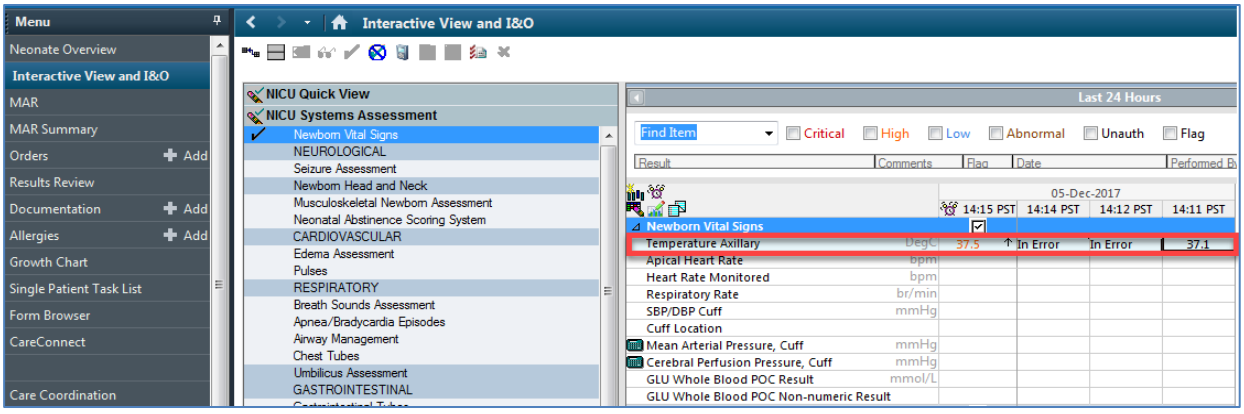
Activity 6.3 – Change the Time Column in iView

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 10:00 am temperature.

1. Click the **Insert Date/Time** icon .
2. A new column and Change Column Date/Time window appears. Choose the appropriate date and time you wish to document under. In this example, the date will be today's date and time of *1000*.
3. Click the **Enter** key.



4. In the new column, enter Temperature Axillary = 37.1 and click the **Green Checkmark** icon ✔ to sign



Key Learning Points

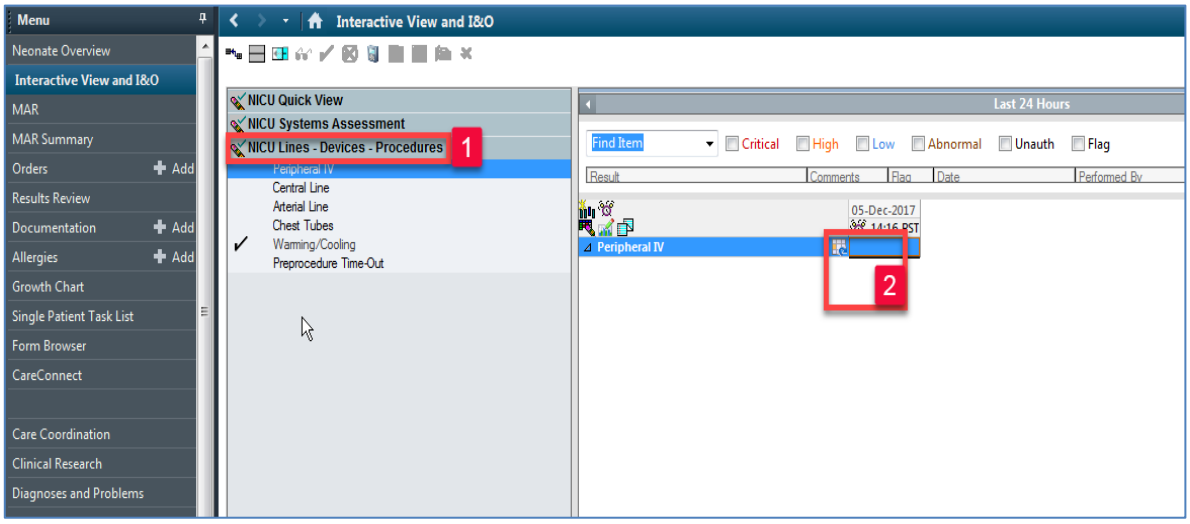
- If required, you can create a new time column and document under a specific time

Activity 6.4 – Document a Dynamic Group in iView

1 Dynamic groups allow documented data to be the documentation and display of multiple instances of the same grouping of data elements. Examples of dynamic groups include wound assessments, IV Sites, chest tubes and more.

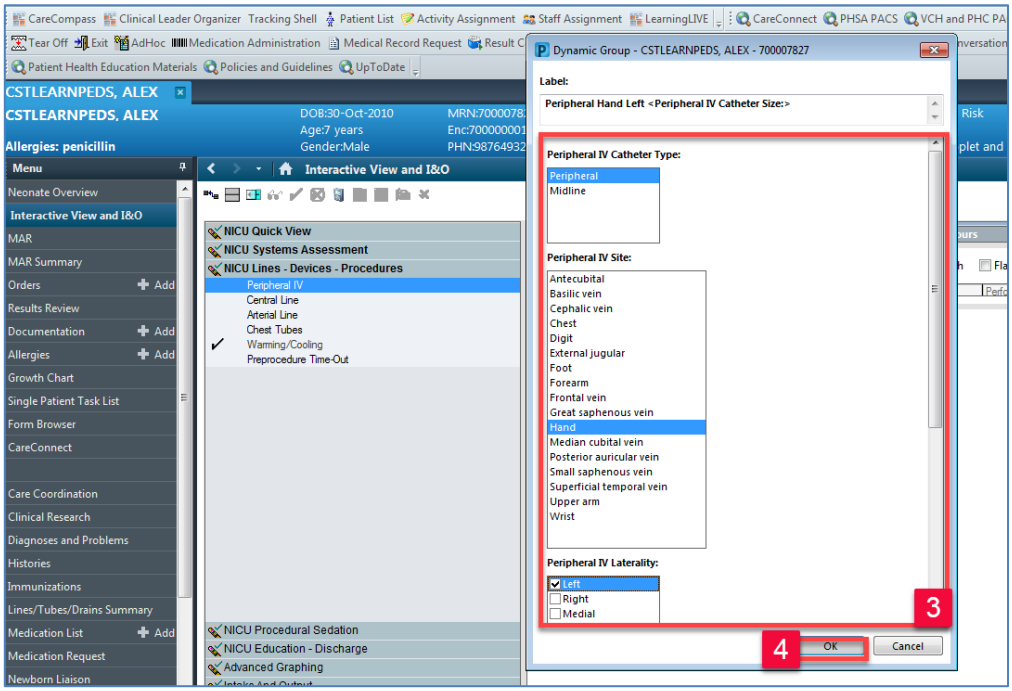
For the purposes of this scenario, assume that your patient requires a peripheral IV (PIV) to be inserted. After inserting the IV successfully, you are now ready to document the details of the IV insertion.

1. Click on the **NICU Lines – Devices –Procedures** band.
2. Now that the band is expanded, click on the **Dynamic Group** icon to the right of the Peripheral IV (PIV) heading in the flowsheet.



3. The Dynamic Group window appears, a dynamic group allows you to label a line, wound, or other patient care with specific details. 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 to create a label:
   a) Peripheral IV Catheter Type: **Peripheral**
   b) Peripheral IV Site: **Hand**
   c) Peripheral IV Laterality: **Left**
   d) Peripheral IV Catheter Size: **26 gauge**
4. Click **OK**

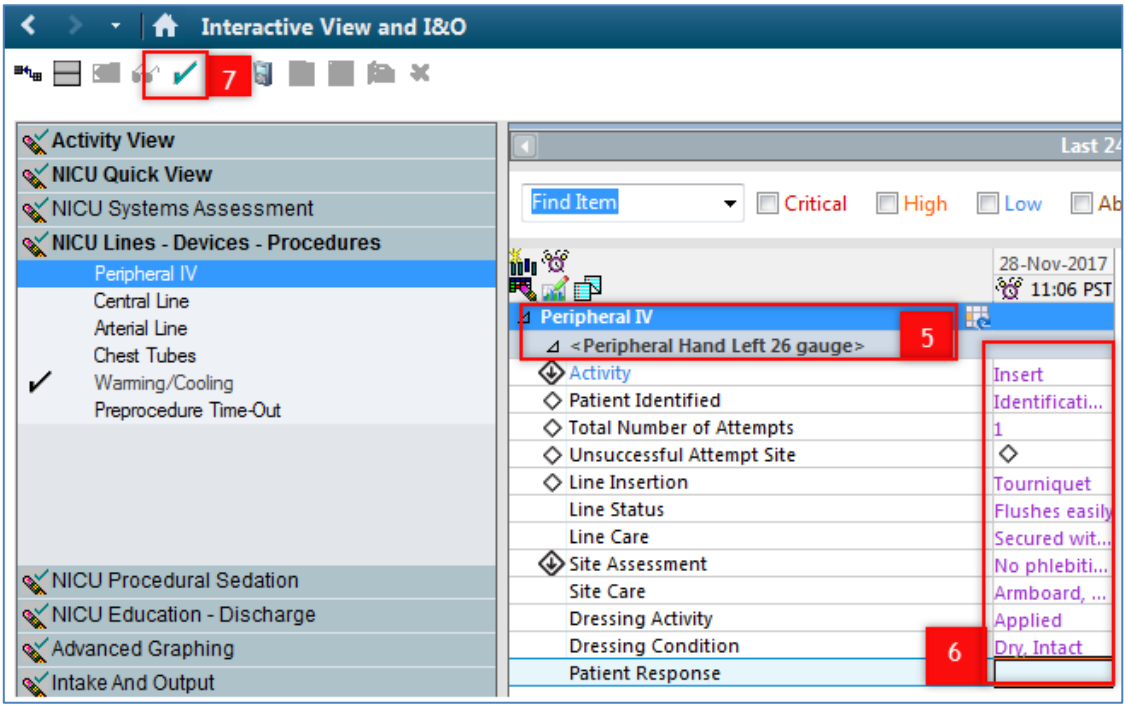


5. The label created will display at the top, under the Peripheral IV section heading.
6. Double-click the **blue box** next to the name of the section to document in several cells. You can move through the cells by pressing the **Enter** key.

Now document the activities related to this PIV:

- **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*
- **Site Care** = *Armboard*
- **Dressing Activity** = *Applied*
- **Dressing Condition** = *Intact*

7. Click the Green Checkmark icon ✔ to sign. Once signed the label will be accessible for other clinicians to complete further documentation within the same dynamic group. The label does not need to be re-created.

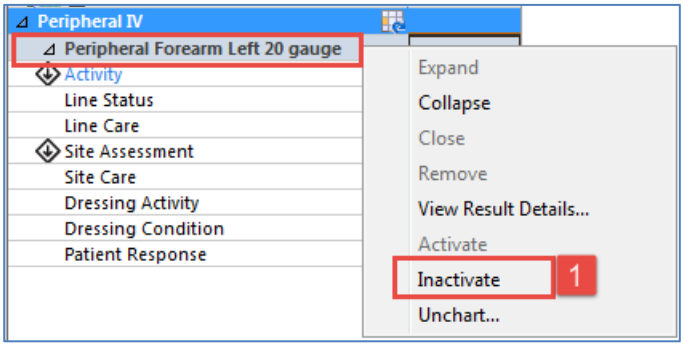


Note: A trigger icon can be seen in some cells, such as Activity, indicating that there is additional documentation to be completed if certain responses are selected. The diamond icon indicates the additional documentation cells that appear as a result of these responses being selected. These cells are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

2 You can inactivate a dynamic group when it is no longer in use. For example, when an IV, drain or tube is removed.

To inactivate your PIV dynamic group section:

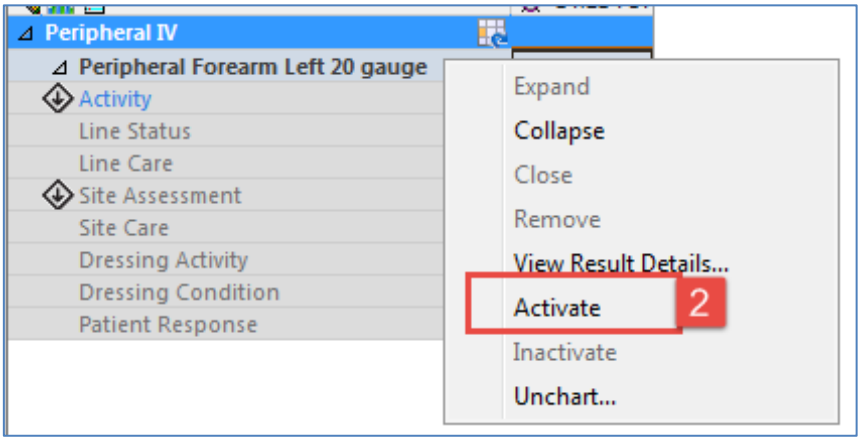
- Right-click the dynamic group label for the **Peripheral Forearm Left 20 gauge,** and select **Inactivate**.



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.

If you accidently 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 documentation.

Key Learning Points

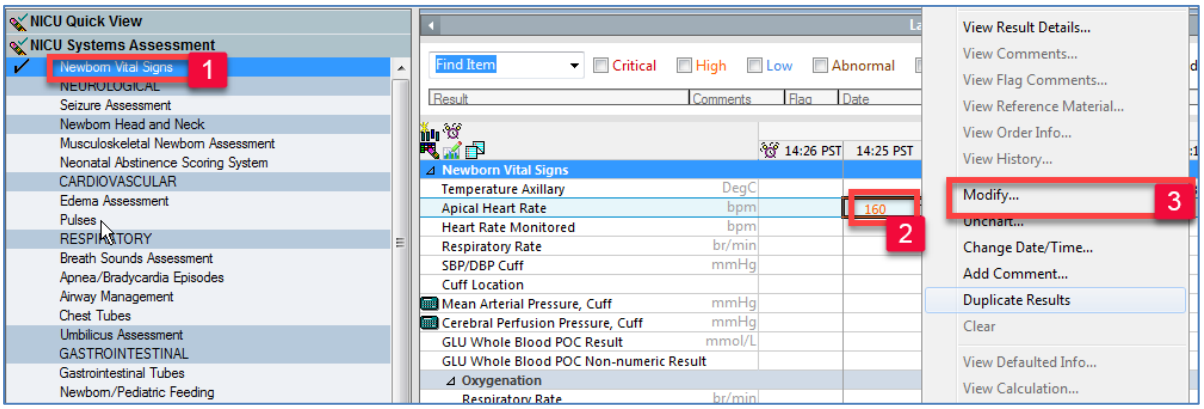
- Examples of dynamic groups include wound assessments, IV sites, chest tubes, and other lines or drains
- Once documentation within a dynamic group is signed the label will be accessible for other clinicians to complete further documentation within the same dynamic group
- When a dynamic group is no longer in use, such as when an IV, drain or tube is removed, you can inactivate it

Activity 6.5 – Modify, Unchart or Add a Comment in Interactive View

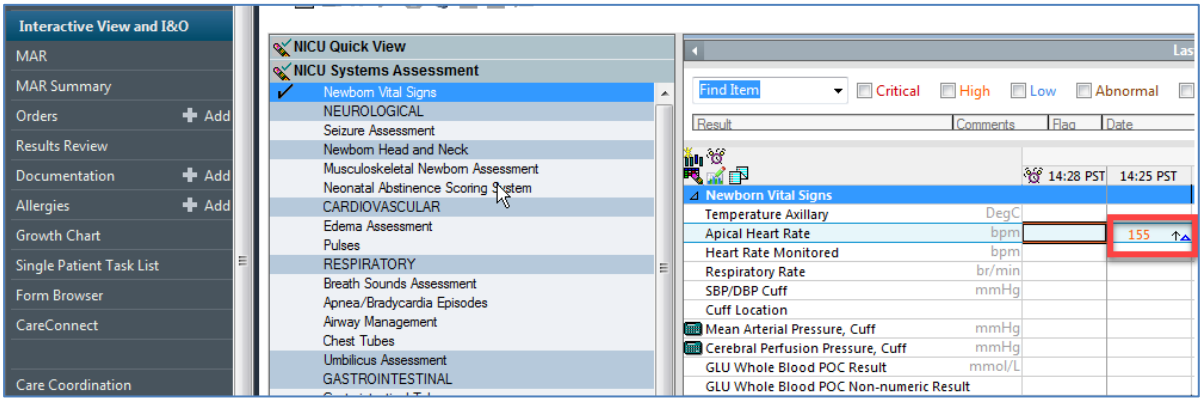
1 Modify

You realize upon reviewing your earlier charting that you wrote the incorrect Peripheral Pulse Rate value. Let's modify the Peripheral Pulse Rate originally documented in Activity 5.2.

1. Click on the **Newborn Vital Signs** section heading in the NICU Quick View band.
2. Right click on the **Peripheral Pulse Rate** (160) cell.
3. Select **Modify…**.



4. Enter in new Apical Pulse Rate = *155* and click the **Green Checkmark** icon ✔ to sign.
5. 155 now appears in the cell and the Corrected icon will automatically appear on bottom right corner to denote modification has been made.

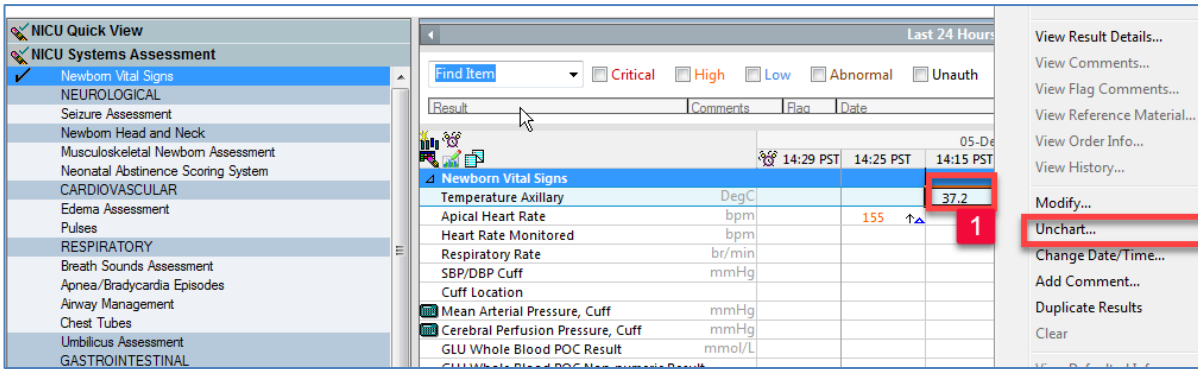


2 Unchart

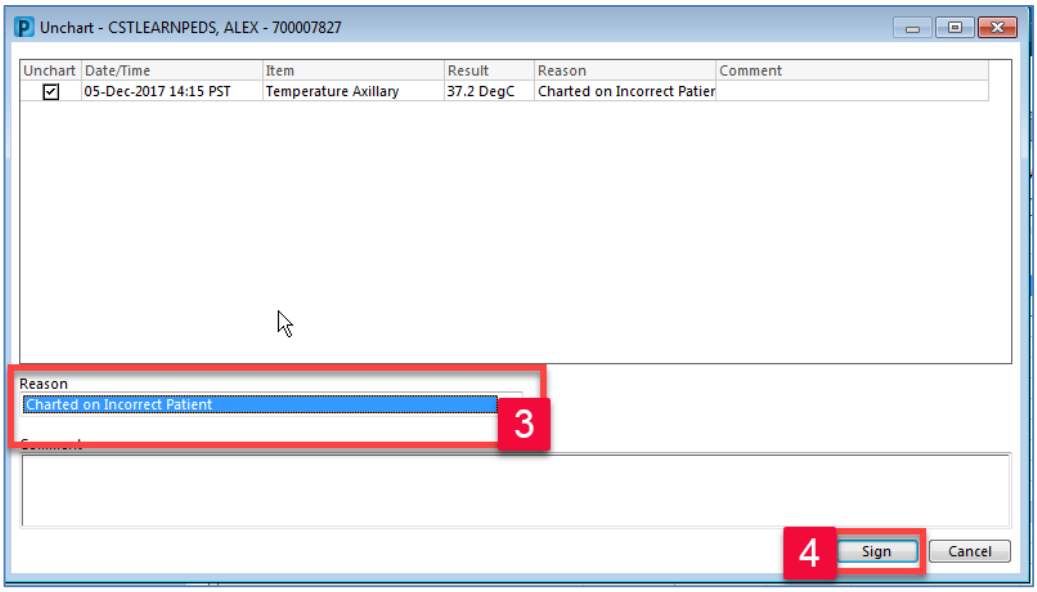
The unchart function will be used when information has been charted in error and needs to be removed. For example, a set of vital signs is charted in the wrong patient's chart.

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

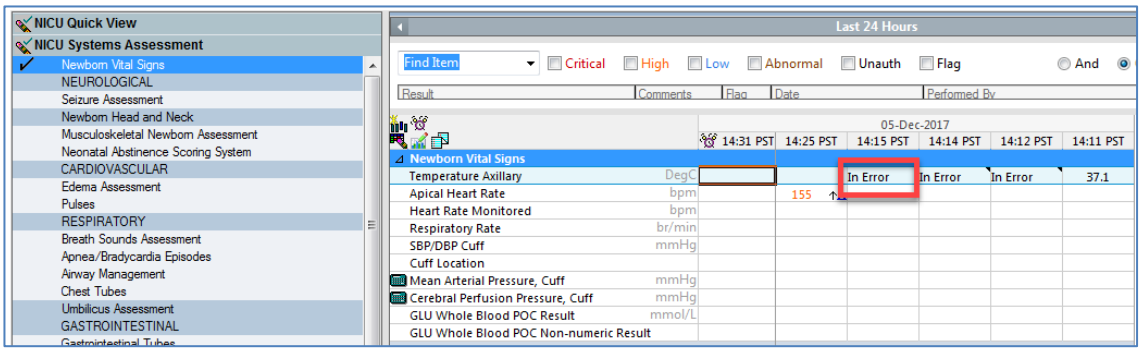
- Right click on the **Temperature Oral** (37.2) cell.
- Select **Unchart…**



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



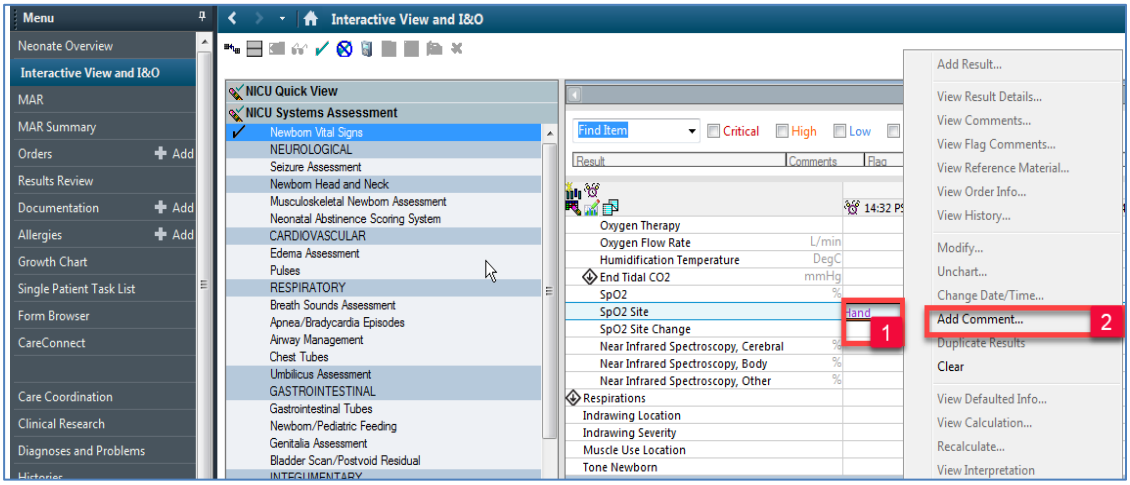
- You will see **In Error** displayed in the uncharted cell. The Result Comment or Annotation icon  will also appear in the cell.



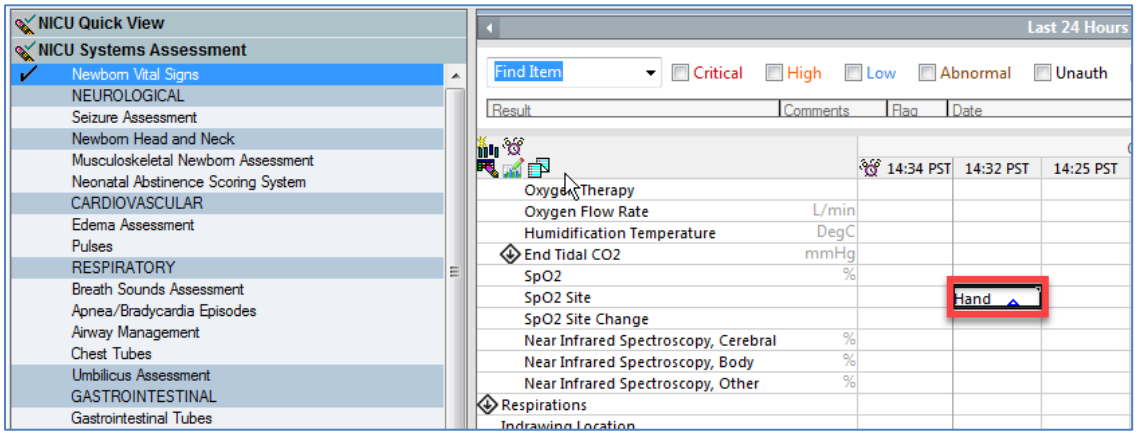
3 Add a Comment

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 foot.

1. Right-click on the SPO2 Site (Foot) cell.
2. Select **Add Comment.**



3. The Comment window opens, enter Comment = *Right foot* and click the **OK** button.
4. An icon indicating the documentation has been modified will display and another icon indicating comments can be found will display in the cell. (Right-click on the cell and select **View Comments…** to view a comment.)



Key Learning Points

- Dynamic groups are created within specific sections of Interactive View and I&O
- Dynamic groups allow for the documentation and display of grouped data elements such as multiple IV or wound sites
- Results can be modified and uncharted within Interactive View and I&O
- A comment can be added to any cell

PATIENT SCENARIO 7 - PowerForm

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 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
- Modify an existing PowerForm
- Unchart an existing PowerForm

Activity 7.1 – Opening and Documenting on PowerForms

1 Throughout your shift, you will document on your patient.

PowerForms are the electronic equivalent of paper forms currently used to document patient information.

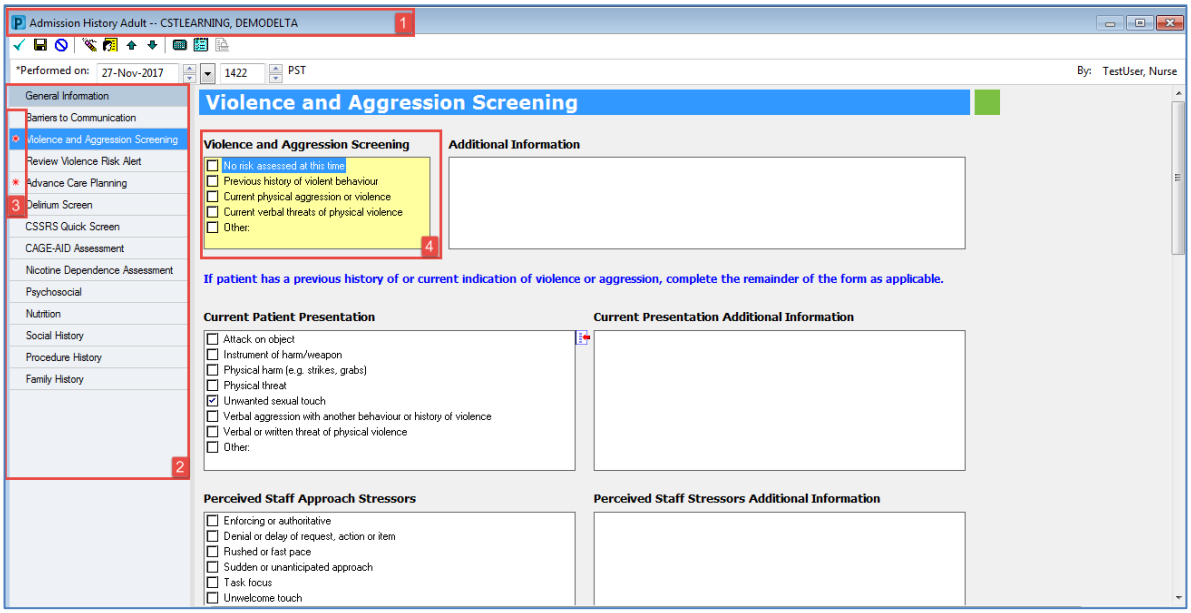
Data entered in **PowerForms** can flow between other parts of the chart including iView flowsheets, Clinical Notes, Allergy Profile, and Medication Profile.

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

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

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

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



In this example we are going to document on the **Admission History NICU** PowerForm.

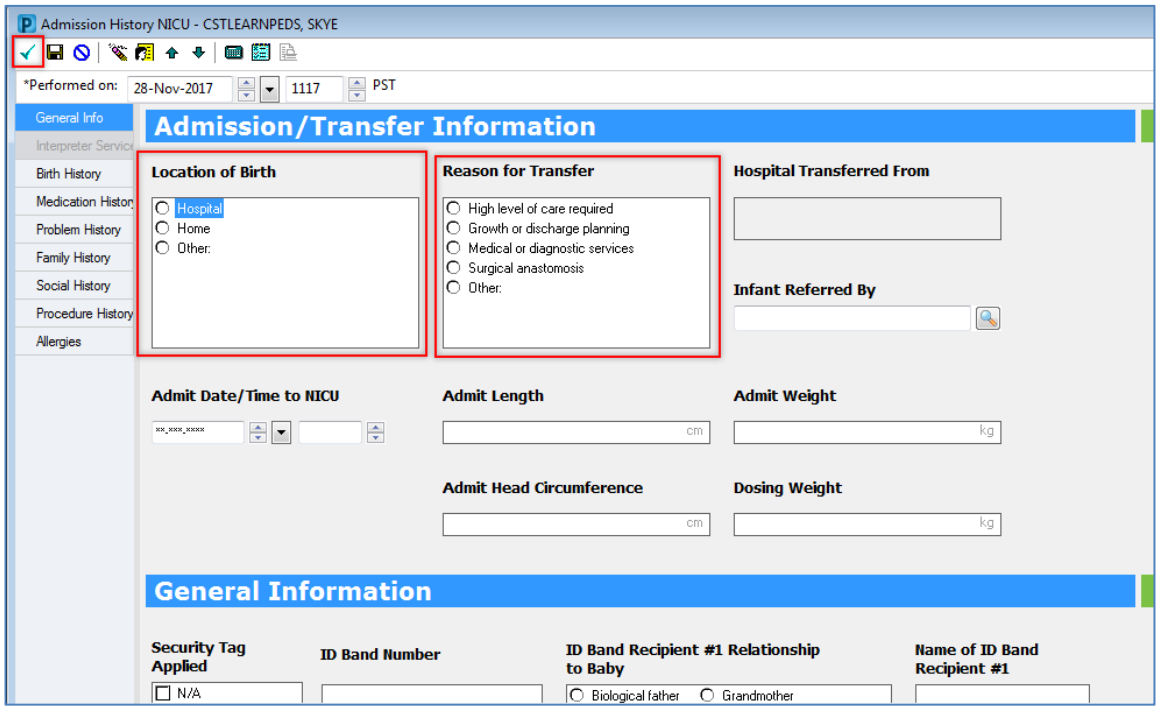
To **open** and **document** on a new PowerForm:

1. Click **AdHoc**  on the **Toolbar**

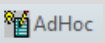
Note: The Ad Hoc window contains two panes. The left side displays folders that group similar forms together. The right side displays a list of PowerForms within the selected folder.

2. Select the **Admission History NICU** PowerForm by selecting the title. Then click **Chart.**
3. In the **Admission History NICU** fill in the following:
    - **Location of Birth**: Home
    - **Reason for Transfer**: High level of care required
4. To complete PowerForm, click the **green checkmark** to sign  and then click the **Refresh** screen 

Note: The Admission History NICU PowerForm pulls data from the result copy information from within the same facility. Also, using the **Save Form** icon is discouraged because no other users will be able to view your saved documentation until it is signed. To sign use the green checkmark icon .



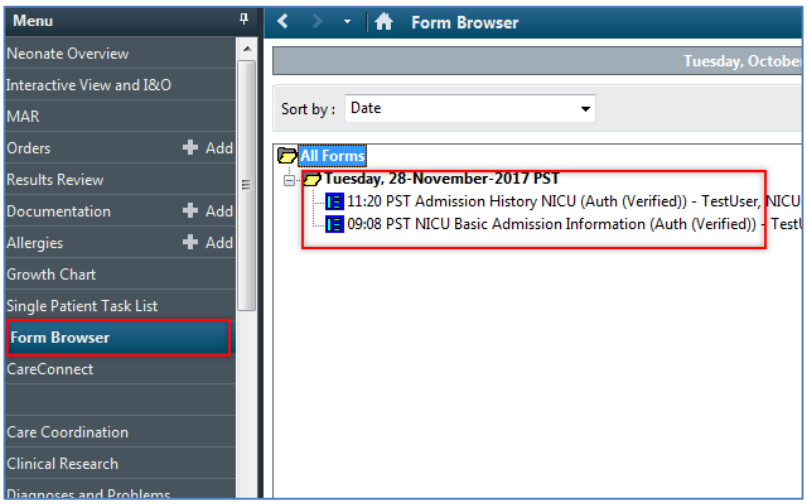
Key Learning Points

- 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 7.2 – Viewing an existing PowerForm

1 Throughout your shift, you may need to view previously documented PowerForms.
To **view** a **PowerForm**:

1. Select **Form Browser** in 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 the Form Browser
- A form can have different statuses (e.g. In Progress, Auth Verified, Modified, and In Error)

Activity 7.3 – Modify an existing PowerForm

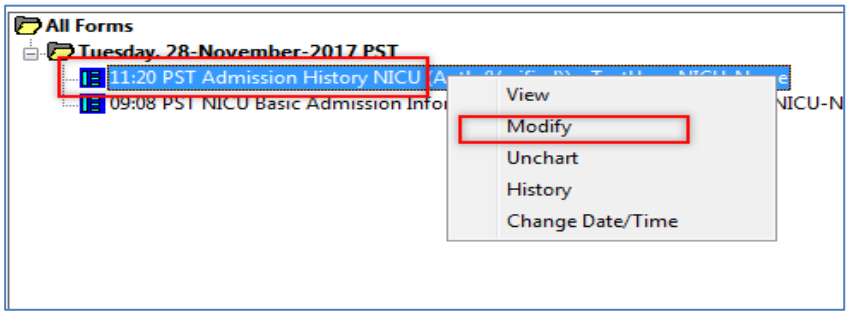
1 It may be necessary to modify PowerForms if information was entered incorrectly.

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.

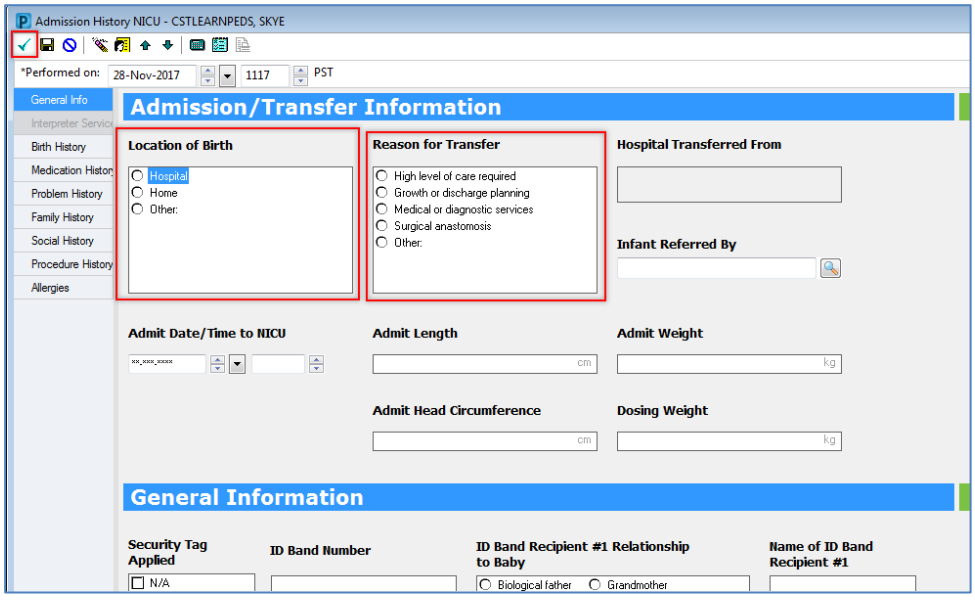
Let's modify the **Admission History NICU** form.

To **modify** a **PowerForm** select it from within **Form Browser**.

1. Right-click on **Admission History NICU** form in **Form Browser**
2. Select **Modify**



3. **Admission History NICU** form opens. Change the charting for **Location of Birth** to *Hospital.*



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

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

Key Learning Points

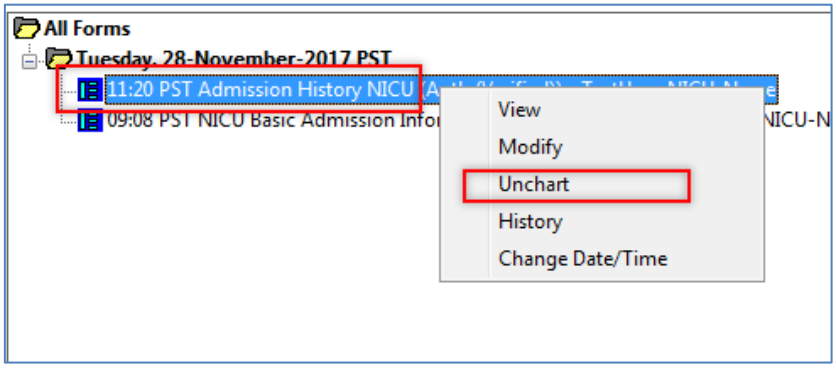
- A document can be modified if needed.
- A modified document will show up as Modified in the Form Browser

Activity 7.4 – Unchart an existing PowerForm

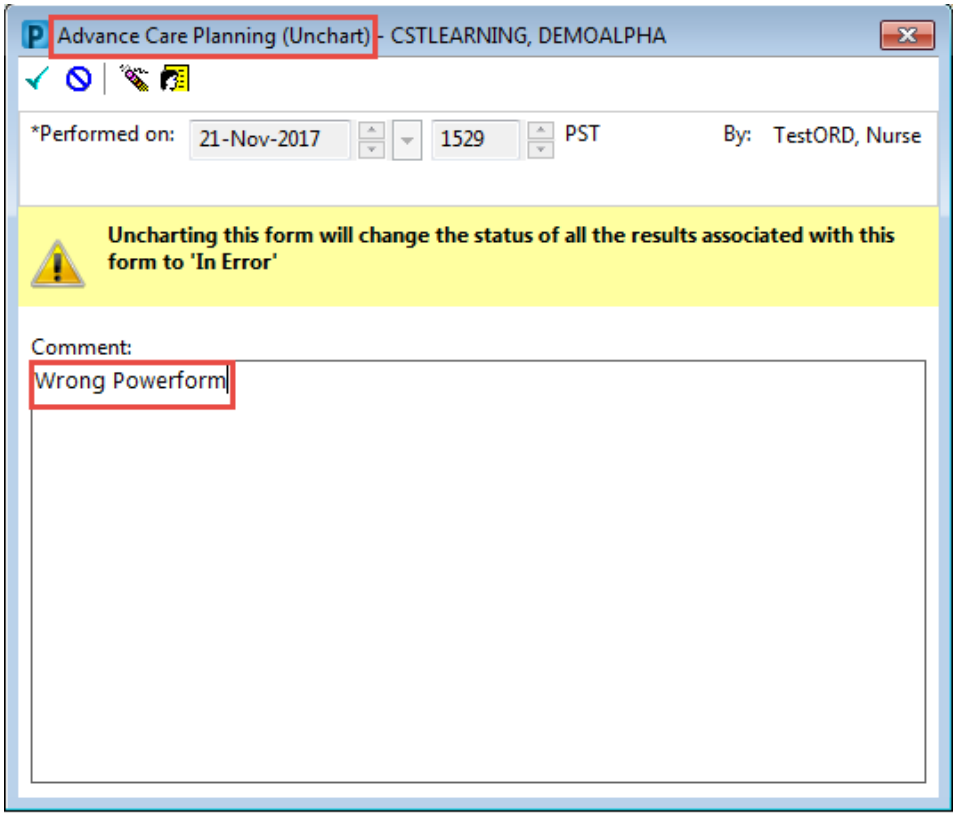
1 It may be necessary to unchart an existing PowerForm if, for example, the PowerForm was completed on the wrong patient or it was the wrong PowerForm.

To unchart a PowerForm within **Form Browser**:

1. Right-click on **Admission History NICU**
2. Select **Unchart**

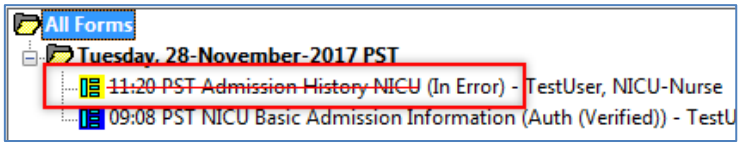


3. The Unchart window opens. Enter the reason for uncharting in the **Comment** box as *Wrong PowerForm*



4. Click the green **Check Mark** button  to sign the documentation. Refresh your screen  and you return to the previous window.

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 8 - Document an Allergy

Learning Objectives

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

- Review and Document Allergies

SCENARIO

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

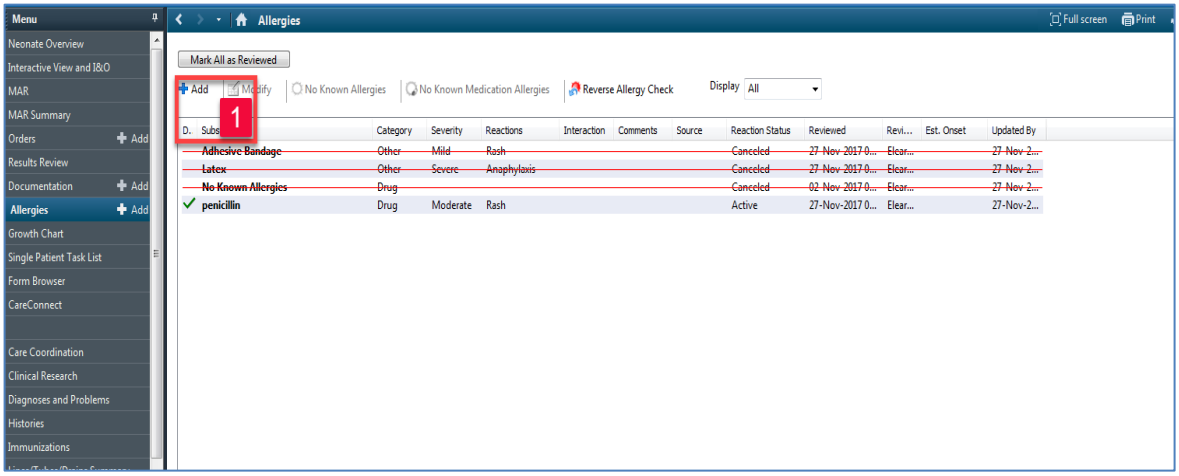
As an inpatient nurse you will be complete the following activity:

- Add an allergy

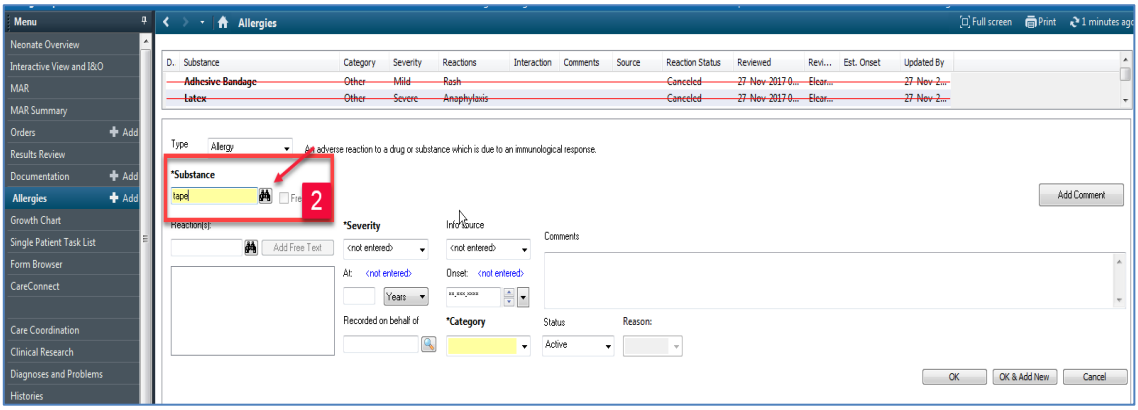
Activity 8.1 – Add an Allergy

1 About an hour after securing the patient's IV with tape, you notice mild redness to the patient's skin under the tape. The patient's mom states a similar thing happened when he had a bandage applied following an immunization.

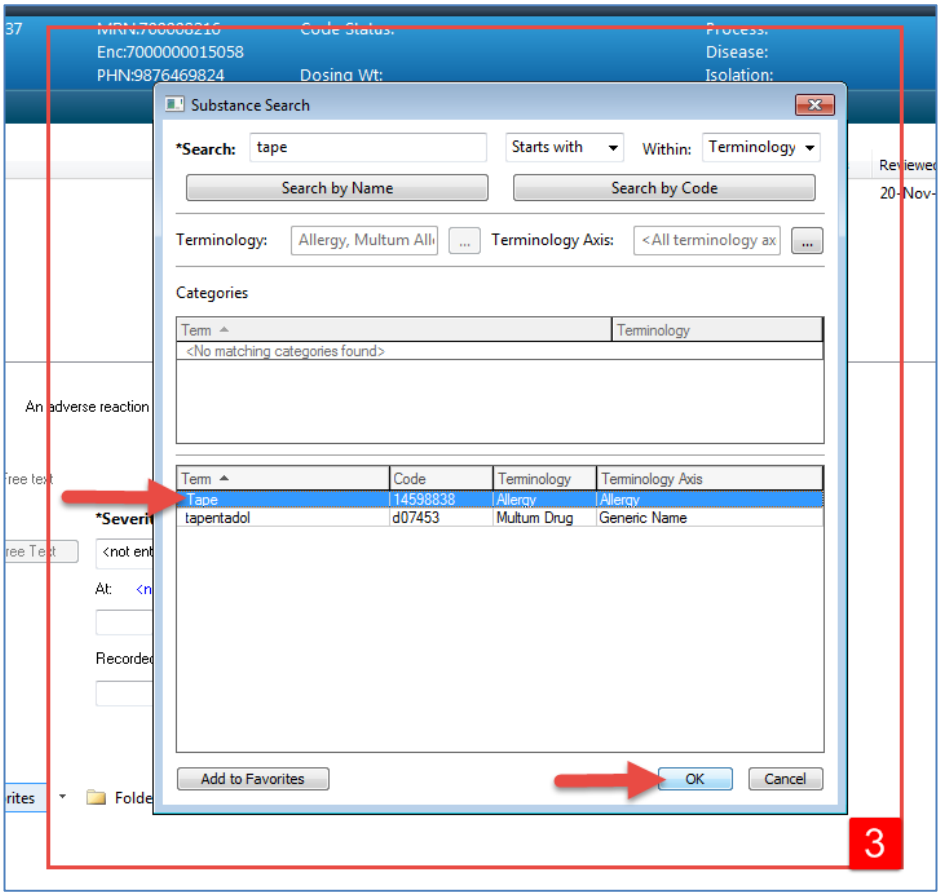
1. Navigate to the Allergies section of the Menu and click **Add**.



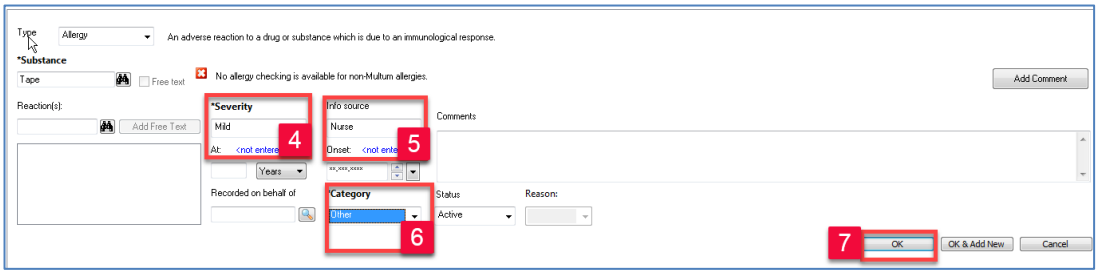
2. Enter in the **Substance** field = *Tape* and click the **Search** icon . Please note **Yellow fields** (**Substance** and **Category**) are mandatory fields that need to be completed.



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

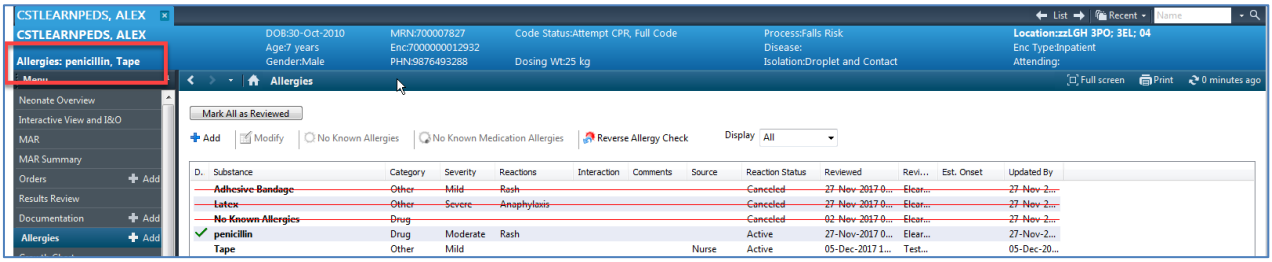


4. Select **Mild** in the **Severity** dropdown
5. Select **Patient** in the **Info source** dropdown
6. Select **Other** in the **Category** dropdown
7. Click **OK**



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

Note: Allergies in the banner bar are sorted by severity (most to least). 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 first
- Yellow fields are mandatory fields that need to be completed

PATIENT SCENARIO 9 - Review Medication Administration Record (MAR)

Learning Objectives

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

- Review and Learn the Layout of MAR
- Request a Medication

SCENARIO

In this scenario, you will be reviewing the scheduled and PRN medications for your patient today.

Note: Pediatric nurses are still required to calculate safe dosages per policy. On the WOW, nurses can click the Windows button  in the lower left corner of the screen to access the Windows calculator.

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

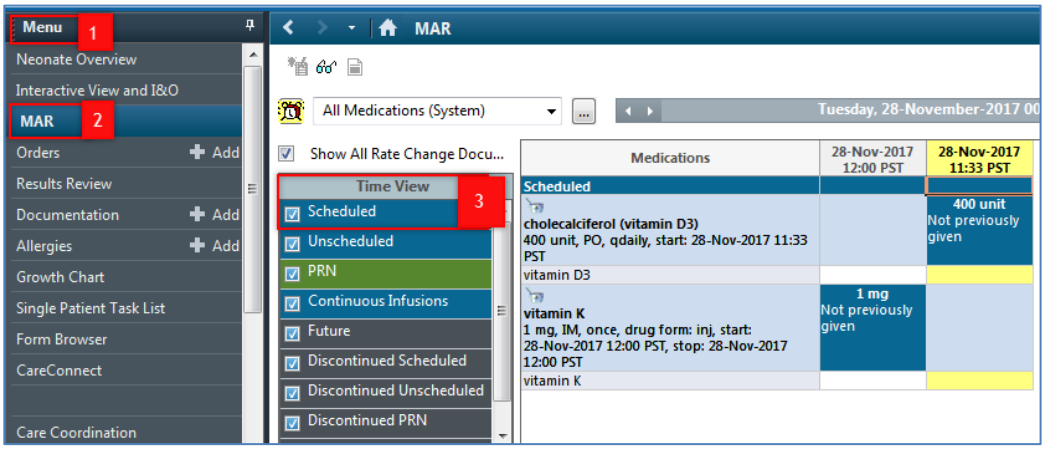
- Review and learn the layout of the MAR
- Request a medication in the MAR

Activity 9.1 – Review the MAR: Time view and reverse chronological order

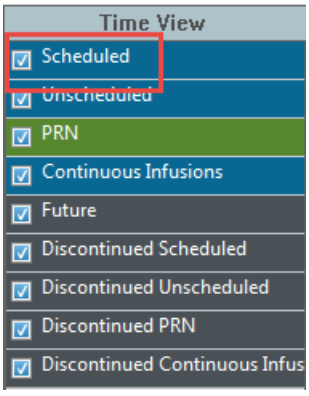
1 The MAR is a record of medications administered to the patient by clinicians. The MAR displays medication orders, tasks, and documented administrations for the selected time frame.

You will be locating and reviewing your patient's schedule, unscheduled and PRN medications.

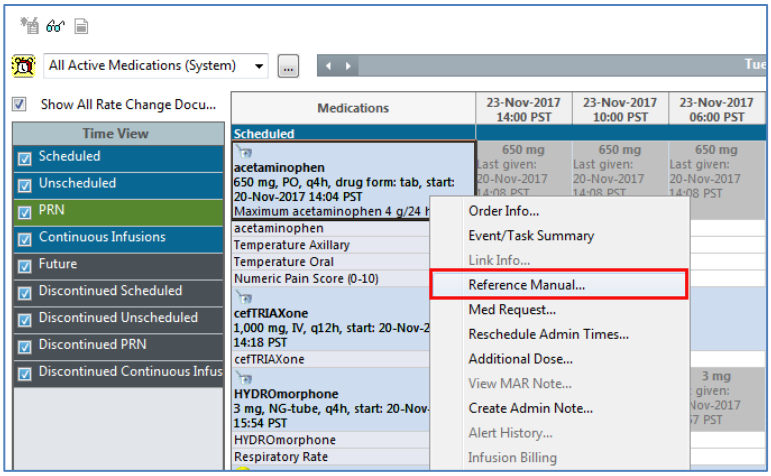
1. Go to **Menu**
2. Click **MAR**
3. Locate **Time View** and **Scheduled**



4. Click **Scheduled,** to ensure all your scheduled medications display at the top of the MAR list.
5. Next, select in order, **Unscheduled**, **PRN** and **Continuous Infusions**, bringing each section to the top of the list for your review



6. Review the MAR Medications. Be sure to review all medication information. If you wish to review the Reference Manual right-click on the medication name and review the Reference Manual



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

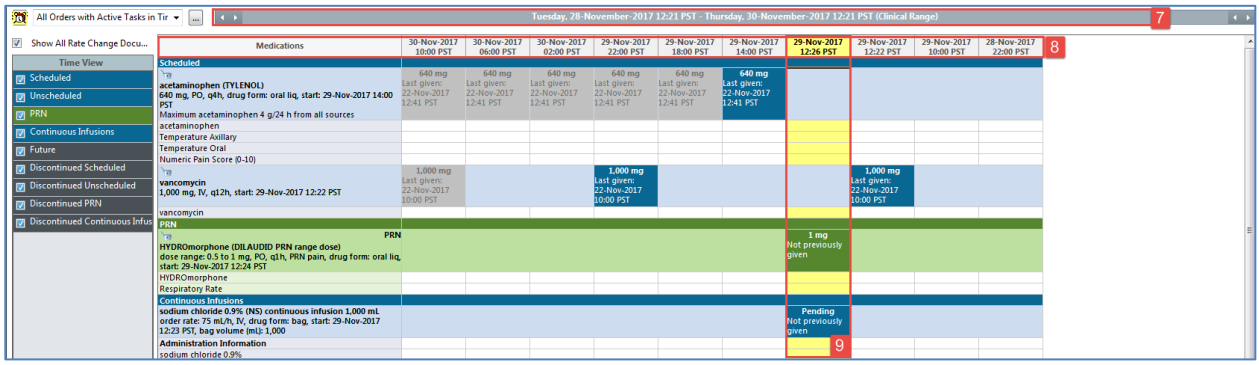
– The medication order has not been verified by pharmacy

– indicates that nurse review of the order is required

– Indicates the medication is part of a PowerPlan

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

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



Note that different sections of the MAR and statuses of medication administration are identified using colour coding**:**

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

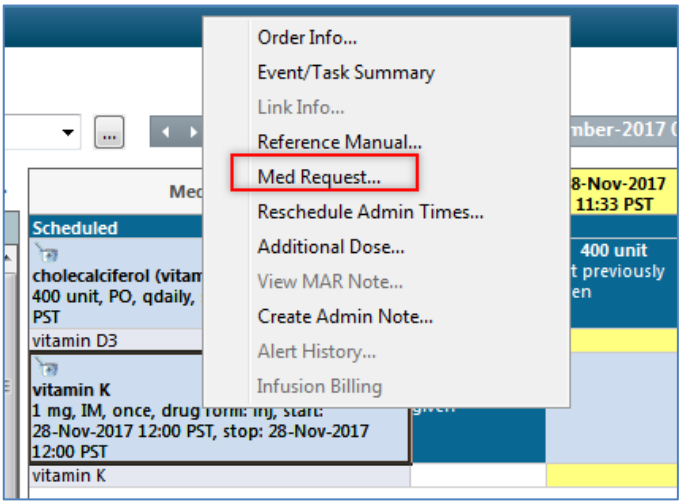
Key Learning Points

- The MAR is a record of the medications administered to the patient by clinicians.
- The MAR lists medication in reverse chronological order
- The MAR displays all medications, medication orders, tasks, and documented administrations for the selected time frame.

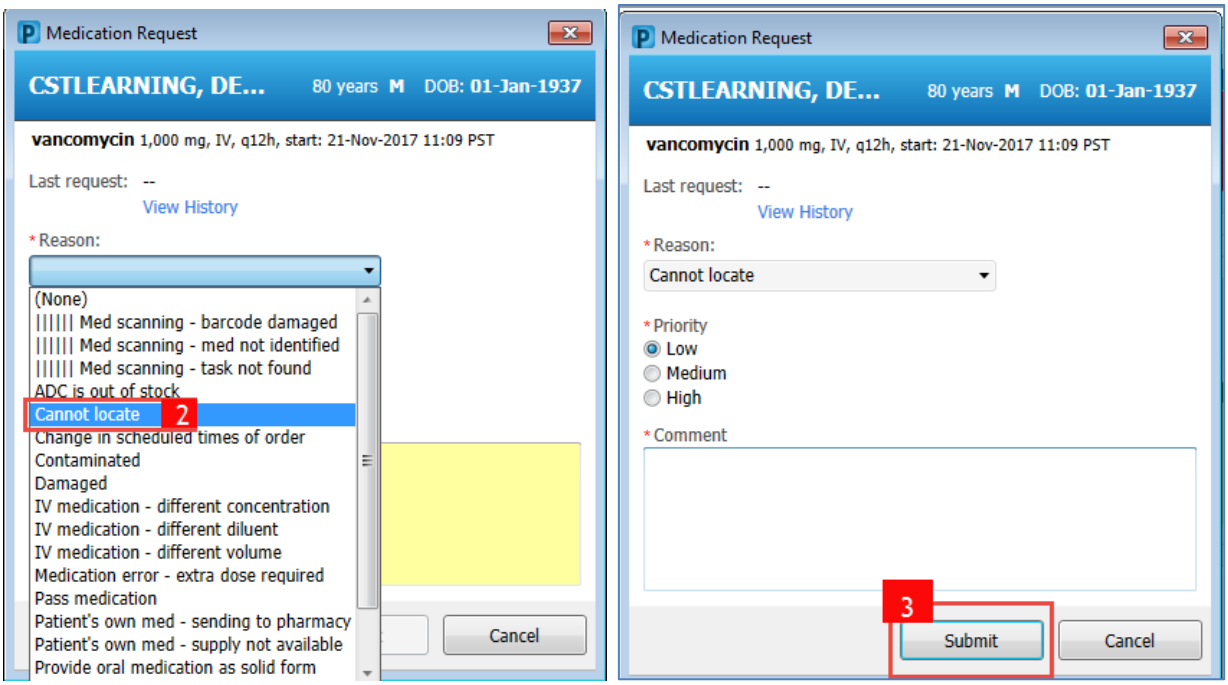
Activity 9.2 – Request a Medication

1 You can't find the Vitamin K injection for your patient so you need to submit a **Med Request** to Pharmacy.

1. Right- click on the medication order name
2. Select **Med Request…**



3. Select **Cannot Locate** under reason
4. Click **Submit**



Key Learning Points

- Right-clicking on medication order provides options such as Med Request
- Med Request sends a message to pharmacy to send the medication

PATIENT SCENARIO 10 - Medication Administration

Learning Objectives

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

- Administer Medication Using the Medication Administration Wizard
- Document Administration of Different Types of Medication

SCENARIO

In this scenario, you will be administering IV and PO medications. You will be using a Barcode Scanner to administer medication. The scanner scans both your patient's wristband and medication barcodes to correctly populate the MAR. The medications to be administered are: Cholecalciferol (Vitamin D3) 400 units once daily, Gentamicin IV, and Vitamin K injection.

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

- Administration Medication using the Medication Administration Wizard (MAW) and the Barcode Scanner
- Documenting administration of different types of medication

Activity 10.1 – Administration Medication using the Medication Administration Wizard (MAW) and the Barcode Scanner

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 helps to ensure 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**.

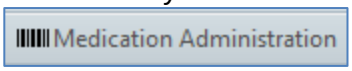
1 Tips for using the barcode scanner:

- Point the barcode scanner toward the barcode on the patient wristband and/or the medication (AUD - Automated Unit Dosage) 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

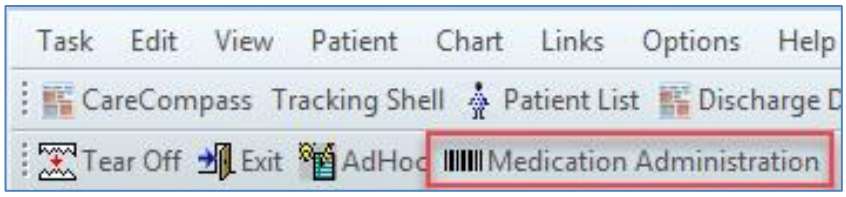
2 It is time to administer the following medications to your patient. You will scan both medications sequentially.

- PO medication: **Cholecalciferol PO**, using liquid Vitamin D3 drops
- IV medication: **Gentamicin IV**

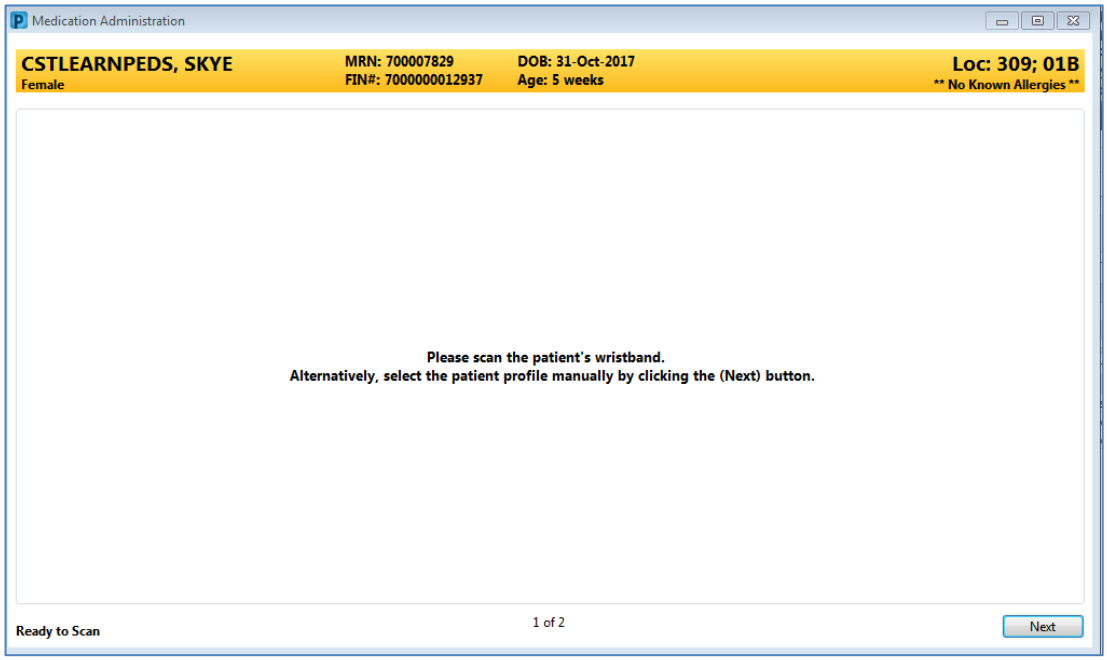
Let's begin the medication administration following the steps below.

1. Review medication information in the MAR and identify medications that are due. Click Medication Administration Wizard (MAW) 

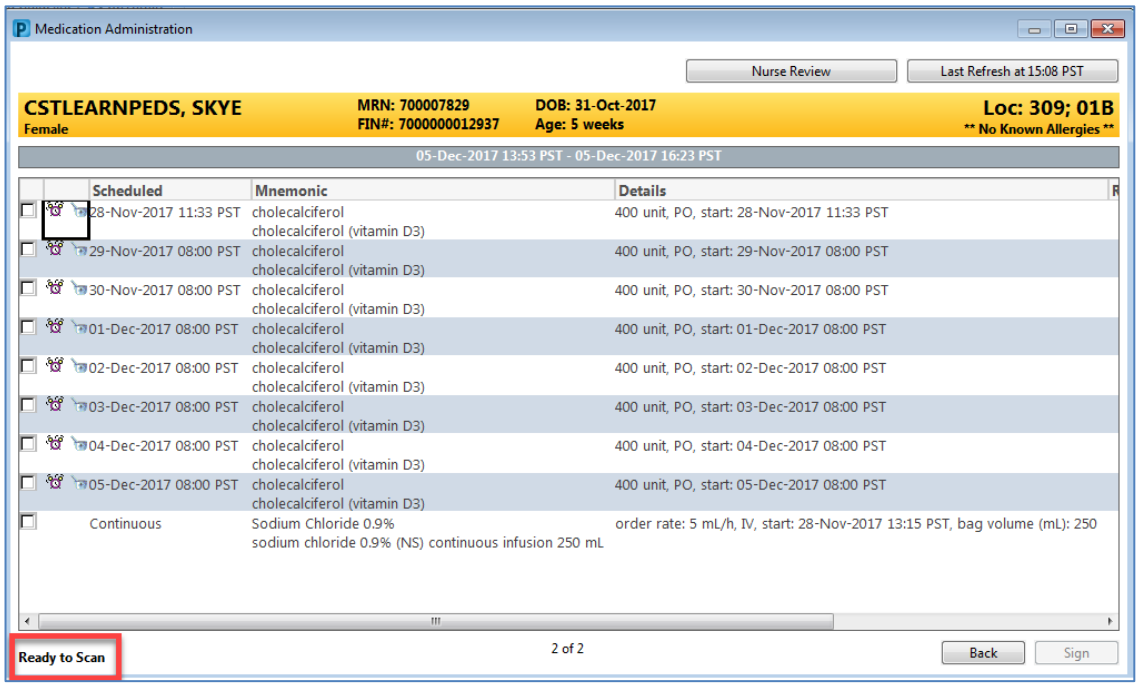
in the toolbar.



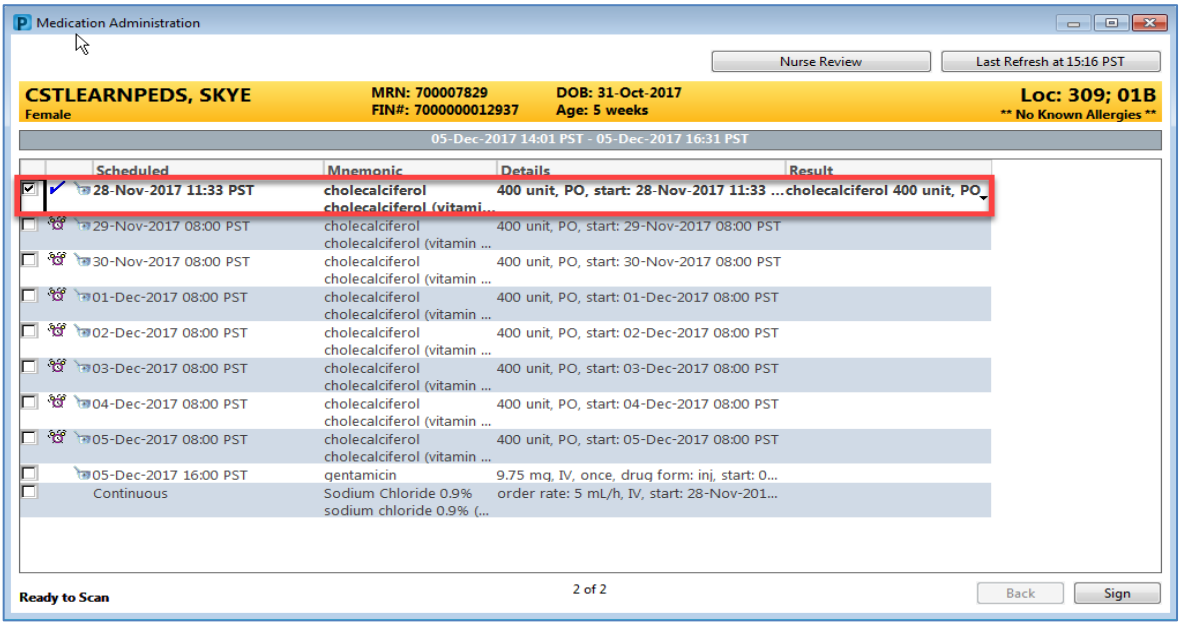
2. **Medication Administration** window will open.



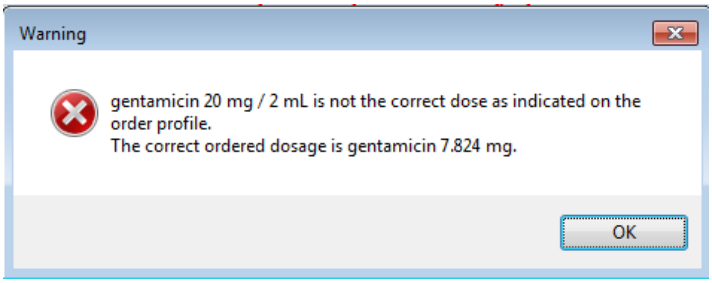
3. Scan the patient's wristband, the system displays all the medications that you can administer.



4. Scan the medication barcode for **Cholecalciferol** liquid. After the scan, the system finds a match for the prescribed dose. Choose the appropriate administration time.

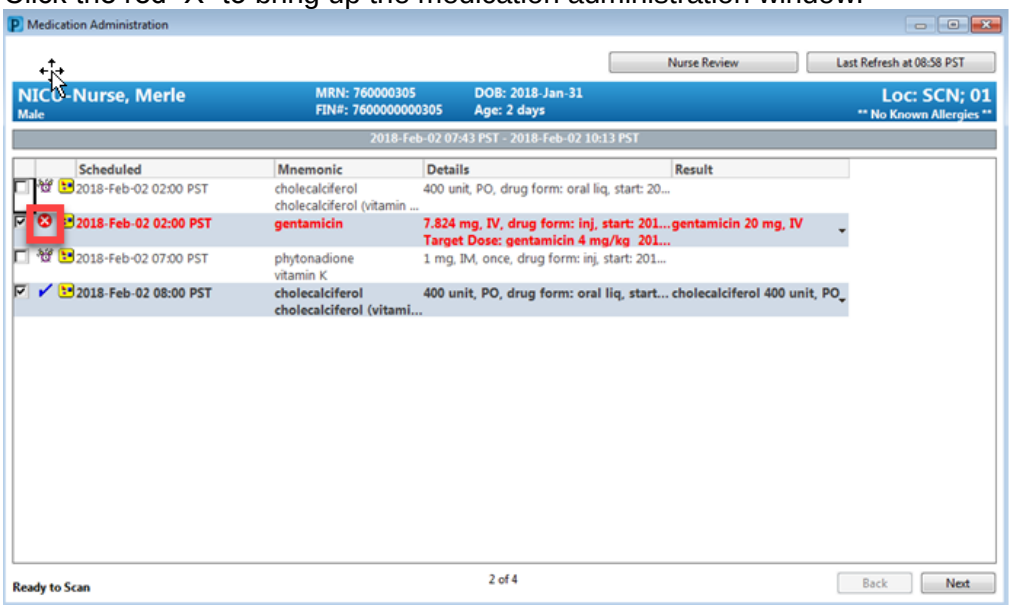


5. Scan your second medication barcode for **Gentamicin IV**. The system finds a match of the IV medication. The following warning box appears, click “OK”.

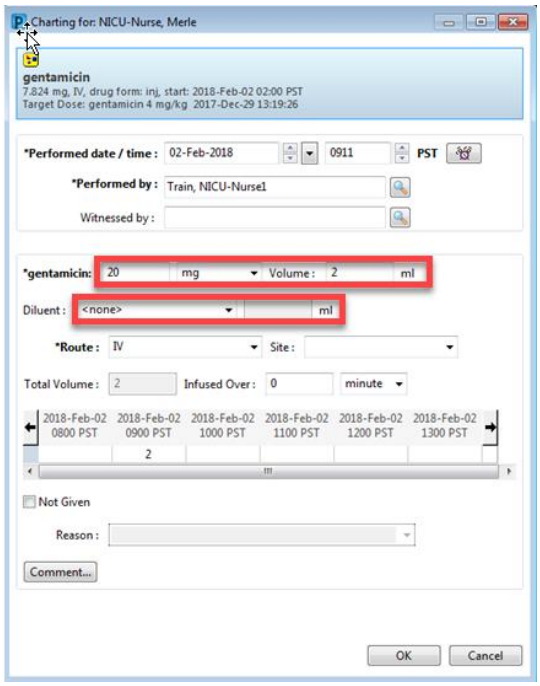


Note: This window appears because the barcode for medications needing reconstitution is for the entire contents of the vial, not the ordered dose.

6. Click the red “X” to bring up the medication administration window.

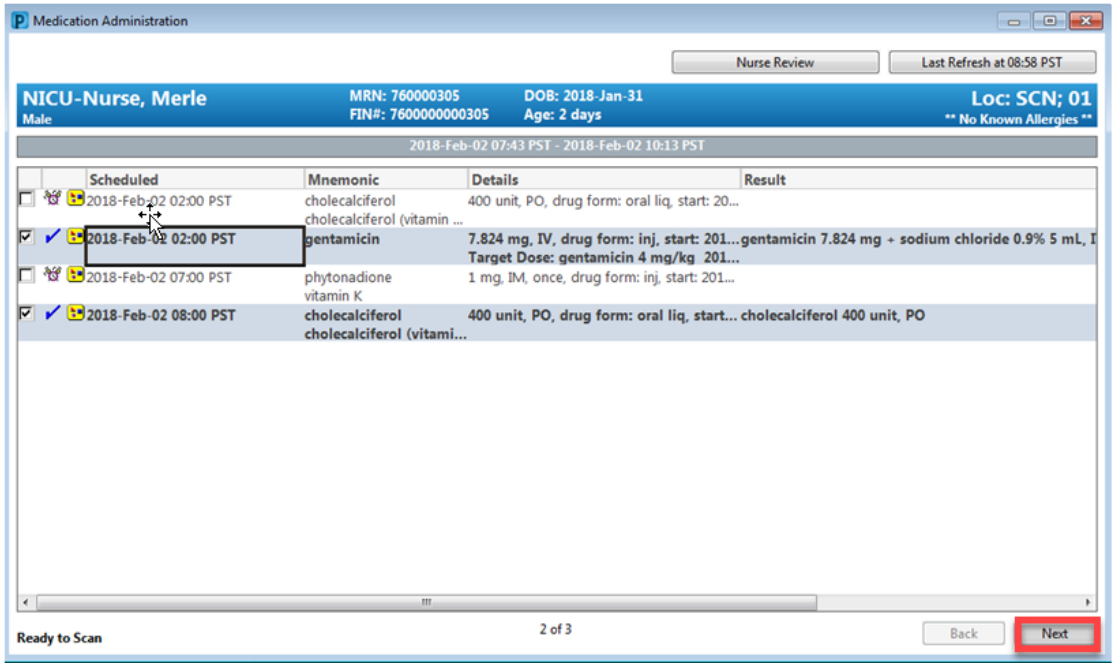


7. Complete the necessary information:
   Gentamicin: **7.824 mg**
   Volume: **0.5 mL**
   Diluent: **sodium chloride 0.9% in 5 ml**
   Click “OK”

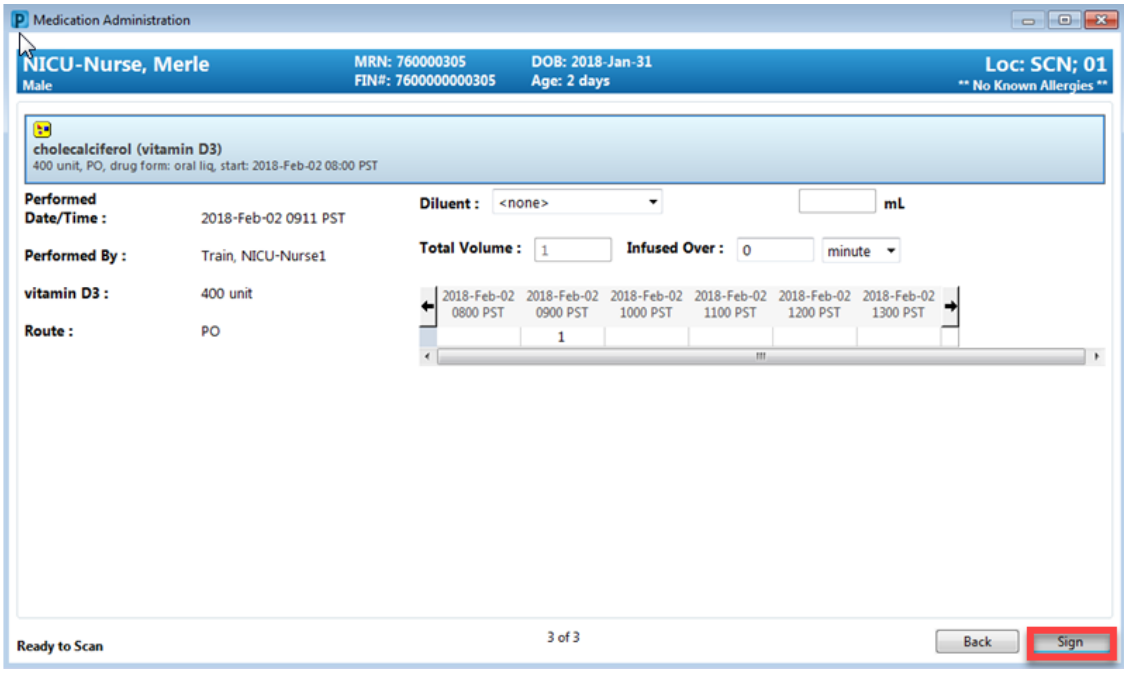


Note: Powdered medications require this extra step in order to administer **partial doses**. This is because the medication barcode on the vial will be for the *entire contents* of the vial. You will *always* need to update the window to the actual dose administered and the diluent amount for accurate ins and outs.

8. You have scanned both medications. Review the information and then click next.

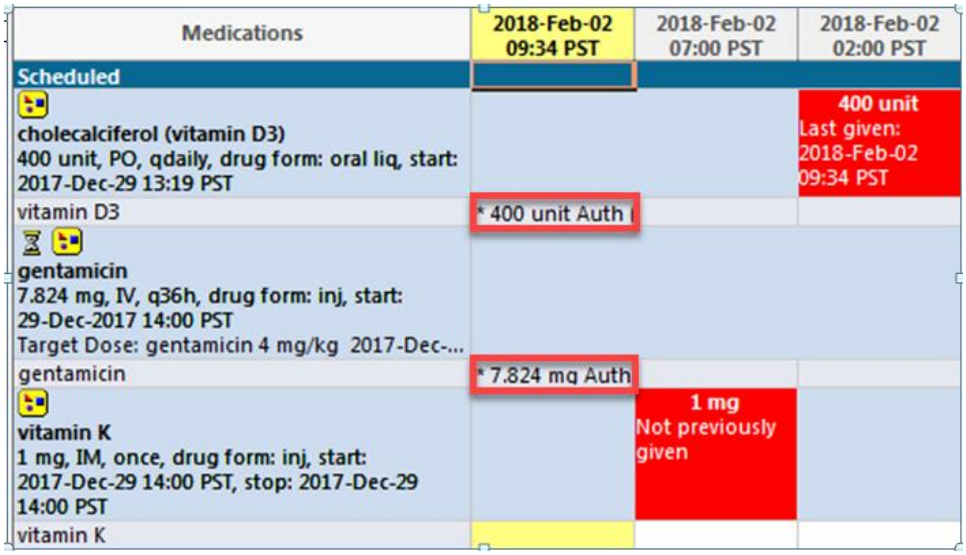


9. Review and click Sign.



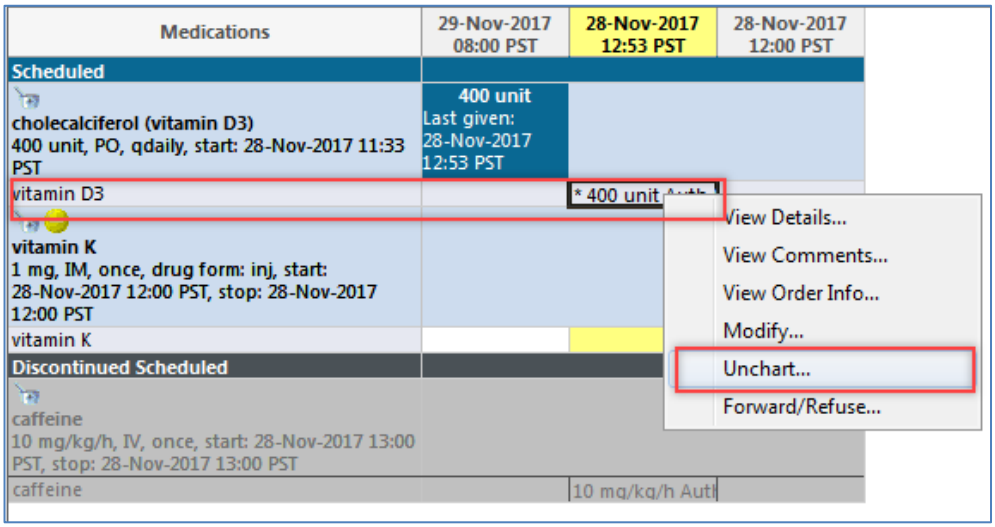
You have now successfully administered the two medications. You can go back to MAR to review the results.

10. Click on the “Refresh” button, you will be able to see more details**.**

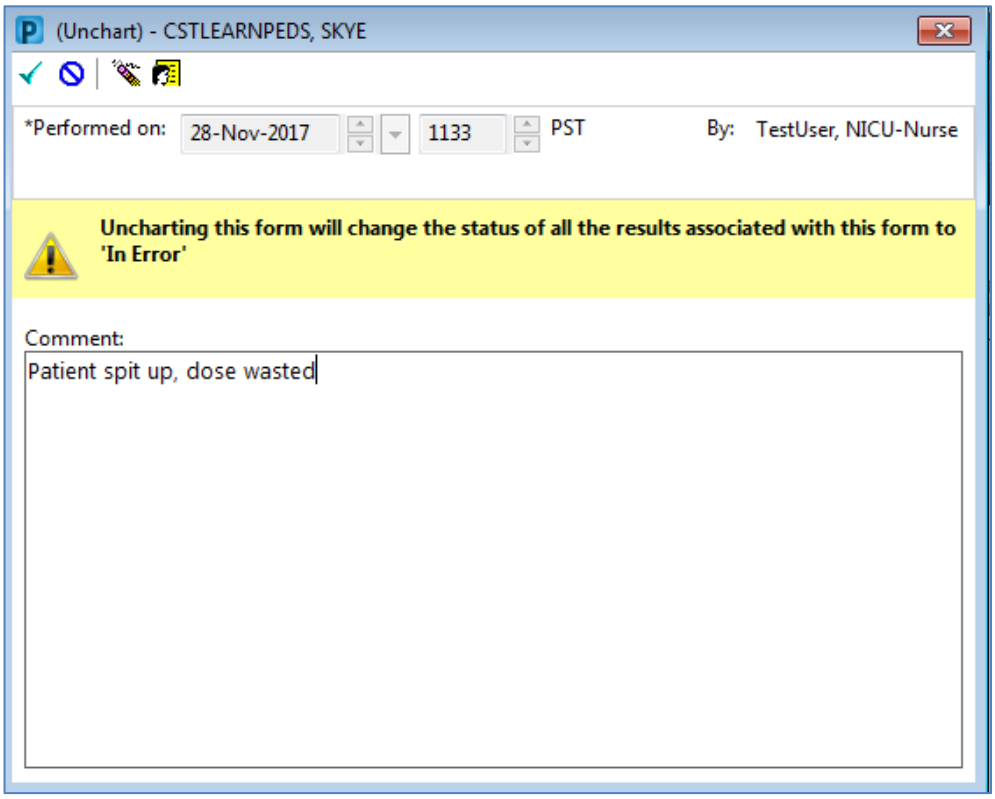


NOTE: In the event of administering a PRN medication, the system will ask you to complete a **Medication Response** assessment. The data entry box appears beside the dose. Ensure to click the green check mark to sign for this documentation. Refresh screen.

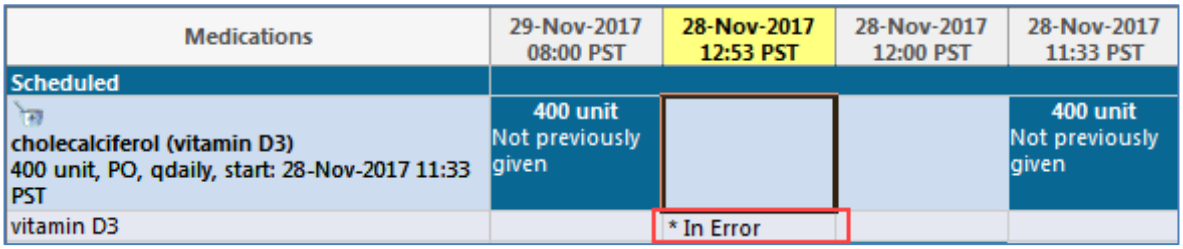
11. To cancel your documentation on administered medications, right-click on the medication, select **Unchart…**



12. Provide a reason for uncharting the medication in the Unchart window.



13. Click on green check mark  to sign. **"In Error"** appears in your MAR



Key Learning Points

- Use barcode scanner to administer medications
- Often times, additional information will be required upon administration
- Medication volumes will flow from the MAR to Intake and Output

PATIENT SCENARIO 11 - Results Review

Learning Objectives

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

- Review Patient Results
- Identify any Abnormal Results

SCENARIO

In this scenario, you will review your patient's results. One way to do this is result review.

You will complete the following activity:

- Review results using Result Review

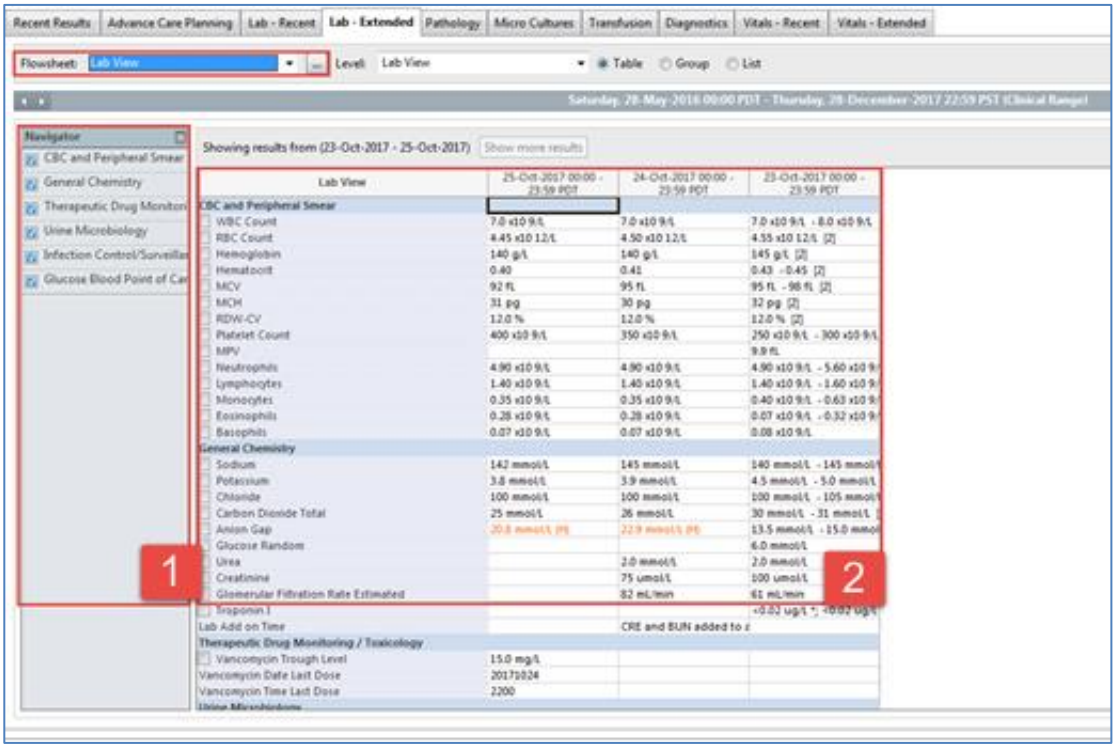
Activity 11.1 – Results Review

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

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

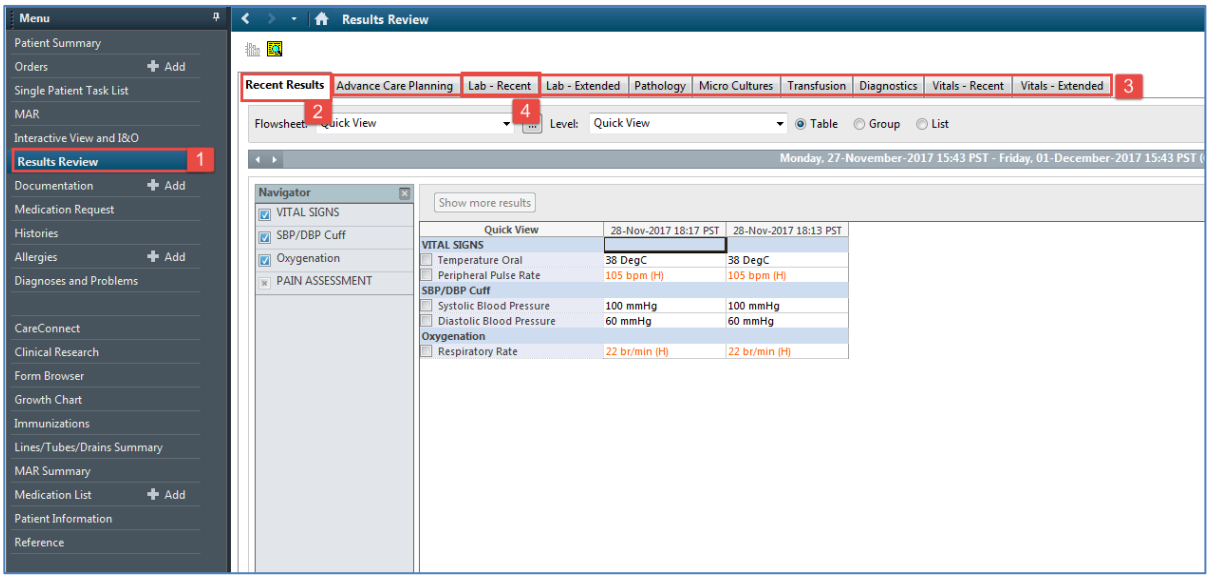
Flowsheets are divided into **two major sections.**

1. The left section is the Navigator. By selecting a category, you can zoom immediately to its contents, which are displayed as values in the grid on the right. T
2. The grid to the right is known as Results Display.

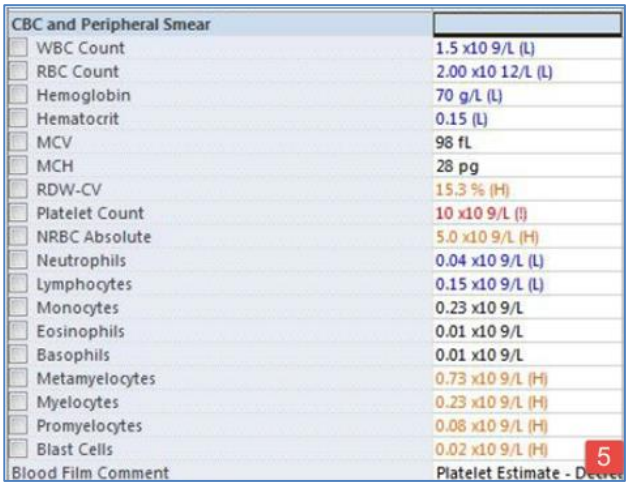


Review the most recent results for your patient:

1. Navigate to **Results Review** from the **Menu**
2. Review the **Recent Results** tab
3. Review each individual section within to see related results
4. Select **Lab - Recent**



5. Review your patient's recent lab results:



Note the colours of specific lab results and what they indicate:

- **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, cultures, transfusions, medical imaging, and vital signs

- The Navigator allows you to filter certain results in the Results Display
- Bloodwork is colour coded to represent low, normal, high and critical values
- View additional details of a result by double-clicking the value

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 be completing the following activities:

- Navigating to intake and output flowsheets within iView
- Reviewing and documenting in the intake and output record

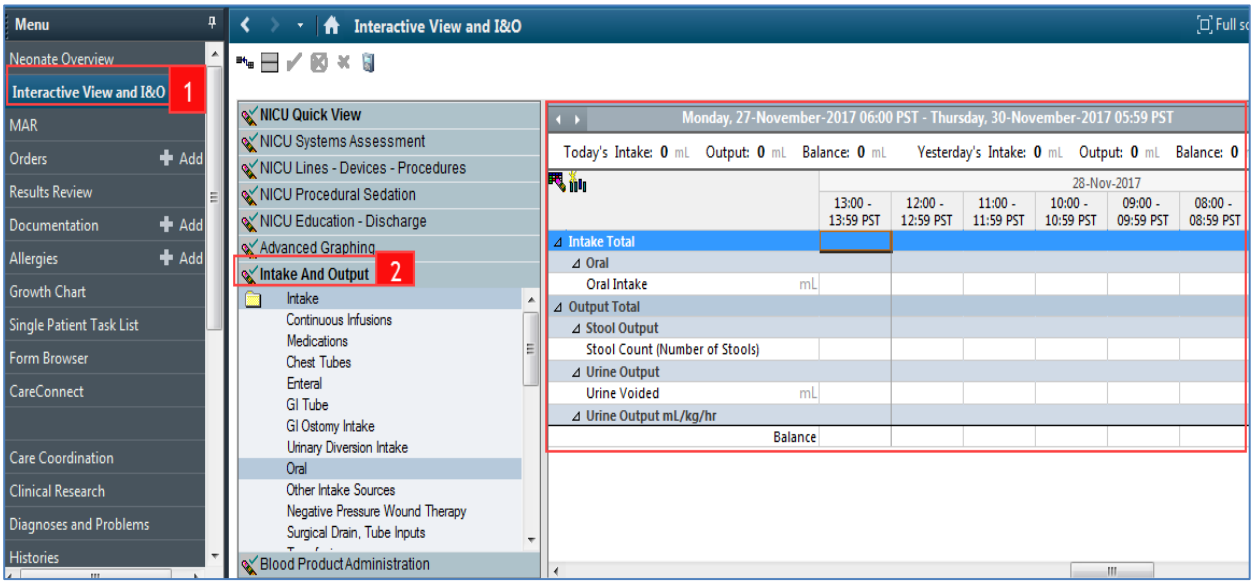
Activity 12.1 – Navigate to Intake and Output Flowsheets Within iView

Intake and Output (I&O) is found as a band within Interactive View and I&O (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 shift totals and daily (24 hour) totals.

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 time ranges. The left portion of the display lists the categories of input and output sections. Notice that the time columns in I&O are set to hourly ranges. You will need to document under the correct hourly range column.

1

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



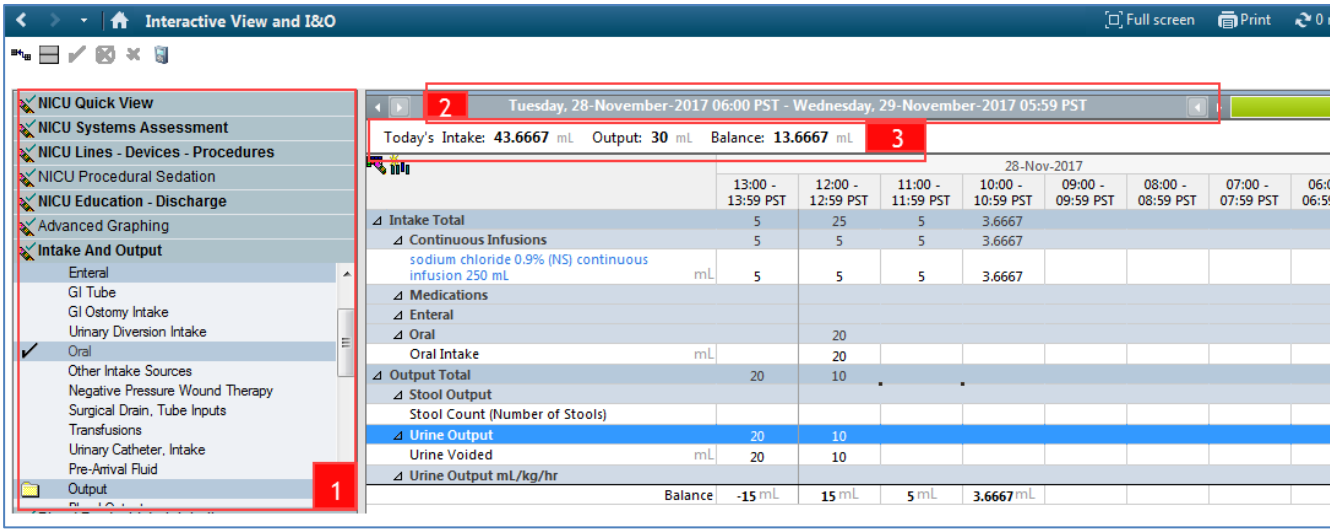
2 The **Intake and Output** band expands displaying the sections within it, and the I&O window on the right. Let's review the layout of the page:

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 populated in the flowsheet. To add others, click on the sections in the I &O navigator

2. The information bar displays the selected time range and indicates the type of data view displayed. Change the range by right-clicking on the grey bar and selecting:
   - Admission to Current
   - Today's Results
   - Other (Selecting appropriate Clinical Range).

3. 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

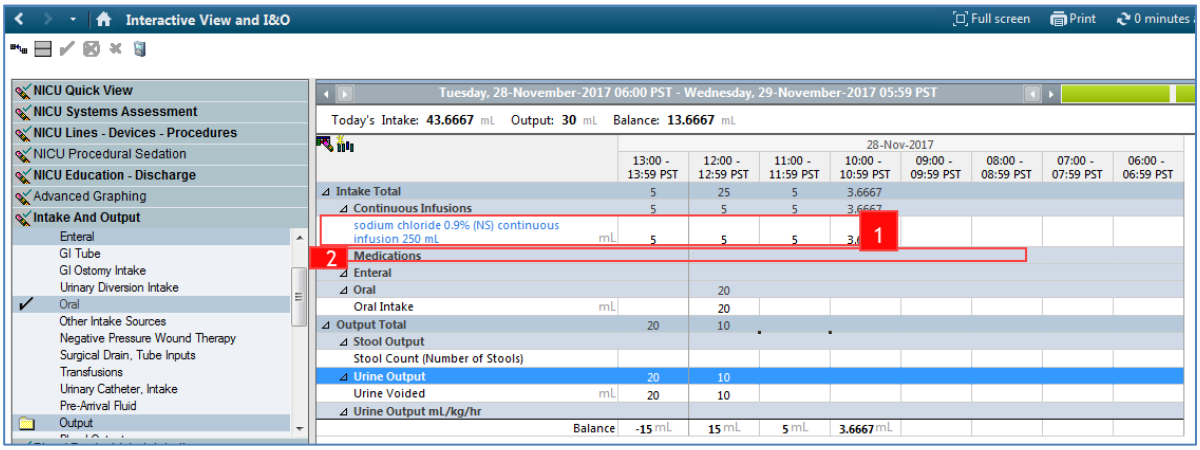
- Intake and Output (I&O) is found as a band within iView and is where a patient's intake and output will be documented

Activity 12.2 – Reviewing and Documenting in the Intake and Output Record

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

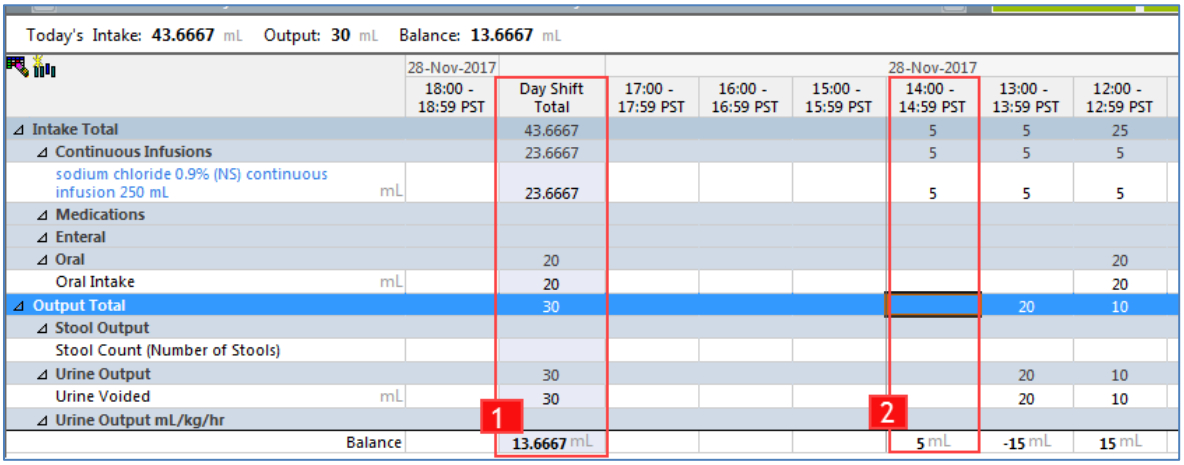
Review that appropriate values are displayed in I&O record.

1. **Continuous Infusions: Sodium Chloride 0.9%**
   - Values are displayed in each hourly time column since initiation.
   - Values will pull from Medication Administration Wizard (MAW) documentation.
2. Medications: Values will pull from Medication Administration Wizard (MAW) documentation.

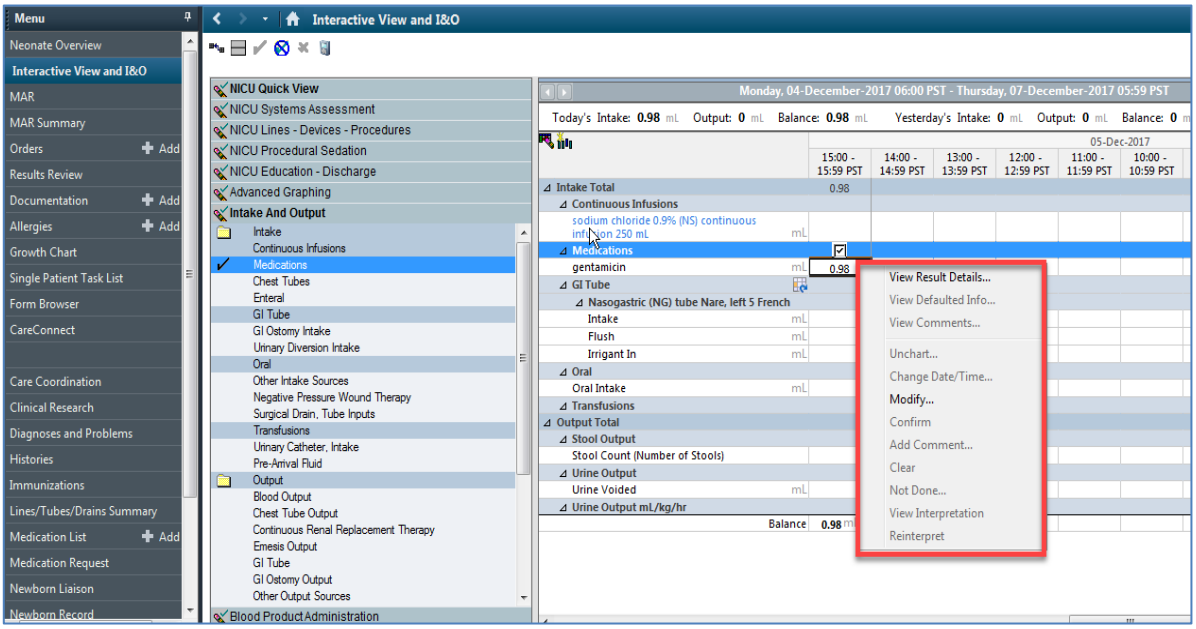


For this example, your patient drank 20 mL and voided 10 mL. Let's document these values.

1. Locate **Oral** section in the I&O navigator.
2. In the flowsheet on the right, document the following by clicking the cell.
   1. Oral Intake (mL)= *20*
   2. Urine Voided (mL)=*10*
3. Click the **Green Checkmark** icon ✔ to sign.
4. A separate column exists for your shift total and balance (1). The balance for the hour is displayed at the bottom of the hourly time column (2).



5. Additional functions and fields can be viewed by right clicking the cell.



Key Learning Points

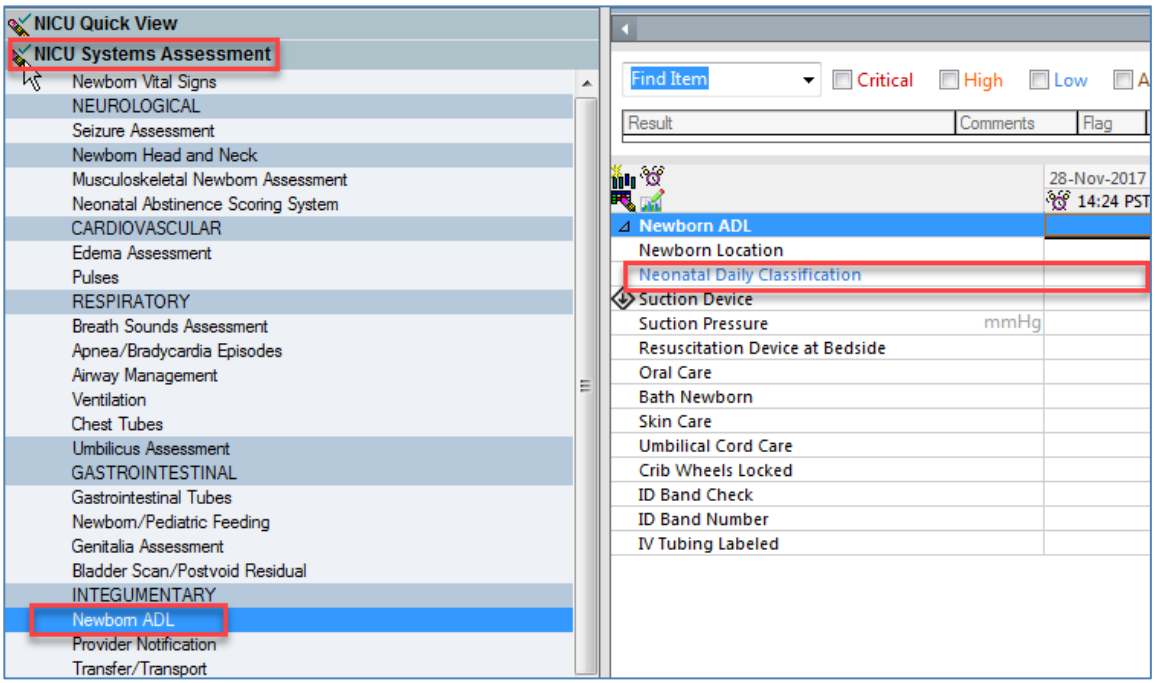
- Continuous Infusion, Medication, and Dynamic Group documentation will pull values into Intake and Output
- Some values will require direct charting in the Intake and Output band. For example, Oral Intake
- Time columns are organized into hourly intervals
- In the I&O navigator, the dark grey highlighted sections are active and are automatically populated in the flowsheet.
- Values can be modified and uncharted within Interactive View and I&O
- A comment can be added to any cell by right clicking

PATIENT SCENARIO 13 – Neonatal Daily Classification

A patient's Neonatal Daily Classification should be documented and current prior to the daily discharge coordinator call with BC Women's NICU (usually done at 1130.)

1

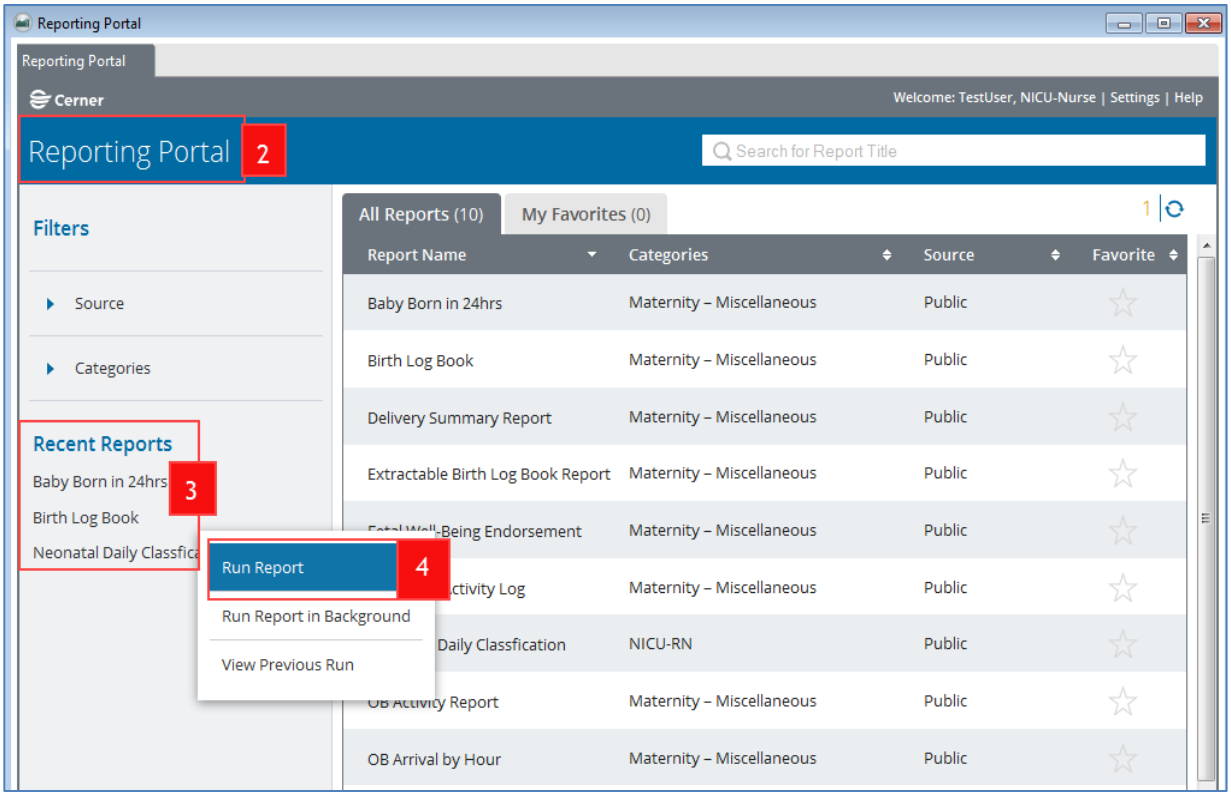
1. From the Menu, go to **Interactive View and I&O**
2. Select **NICU Systems Assessment**
3. Locate and click **Newborn ADL** from the NICU Systems Assessment menu
4. If needed, click on the text **Neonatal Daily Classification** to open the reference text for scoring the patient.
5. Enter a classification of **1b**.
6. Click the green check mark to **Sign**.



7. If needed, click on the text **Neonatal Daily Classification** to open the reference text for scoring the patient.
8. Enter a classification of **1b**.
9. Click the Green Check Mark ✔ to **save**.

To generate/print the Neonatal Daily Classification report:

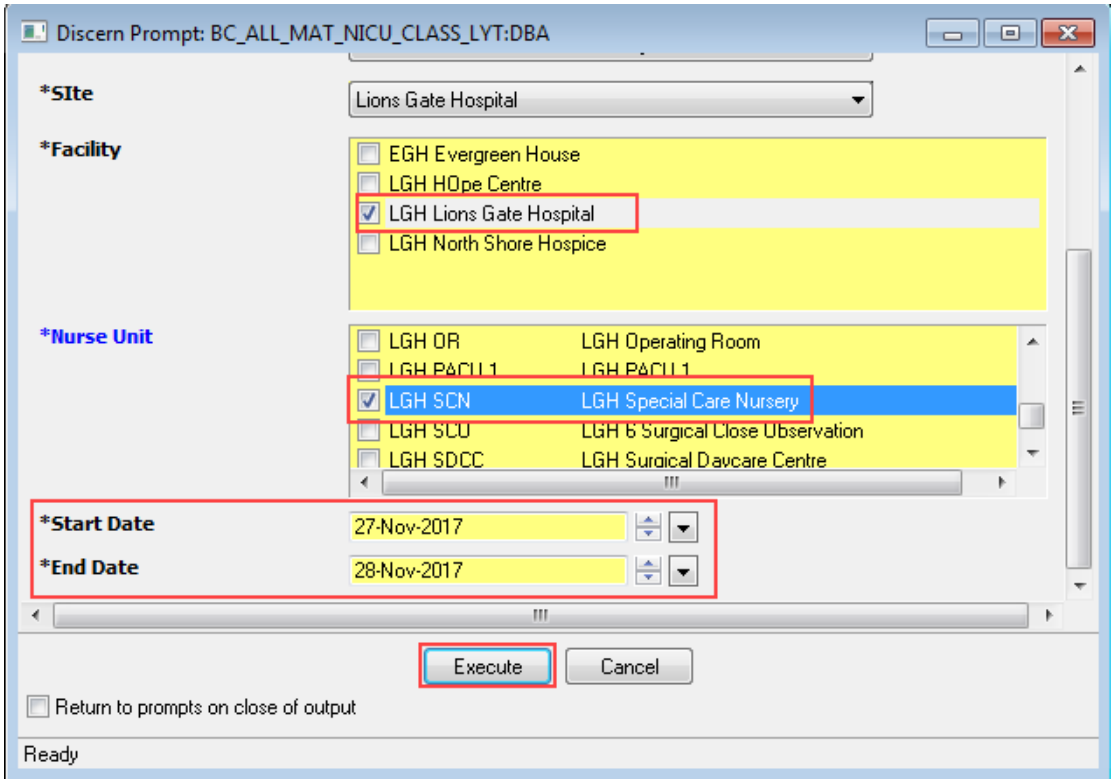
1. Click on the **Discern Reporting Portal** button on the top banner.
2. **A Reporting Portal** window will pop up.
3. Click on the **Neonatal Daily Classification** section on the left hand side and select **Run Report**.



4. A window will pop up and prompt you for appropriate info regard the report being run. Enter the following data:

   - **Site**: *Lions Gate Hospital*
   - **Facility**: *LGH Lions Gate Hospital*
   - **Nurse Unit**: *LGH SCN Special Care Nursery*
   - **Start Date**: *yesterday*
   - **End Date**: *today*

5. Click **Execute** to run the report.



Note: The report pulls data from what has been documented in the patient's chart. It is important for the bedside nurse to keep the classification score updated on the Daily Neonatal Classification in order for this report to relevant.

Key Learning Points

- The Daily Newborn Classification should be updated prior to the daily discharge coordinator call.
- The report generates data based on what is entered; therefore information should be kept accurate.

PATIENT SCENARIO 14 - 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 be reviewing how to access and preview discharge documents in the patient's chart. You will then practice printing a discharge summary.

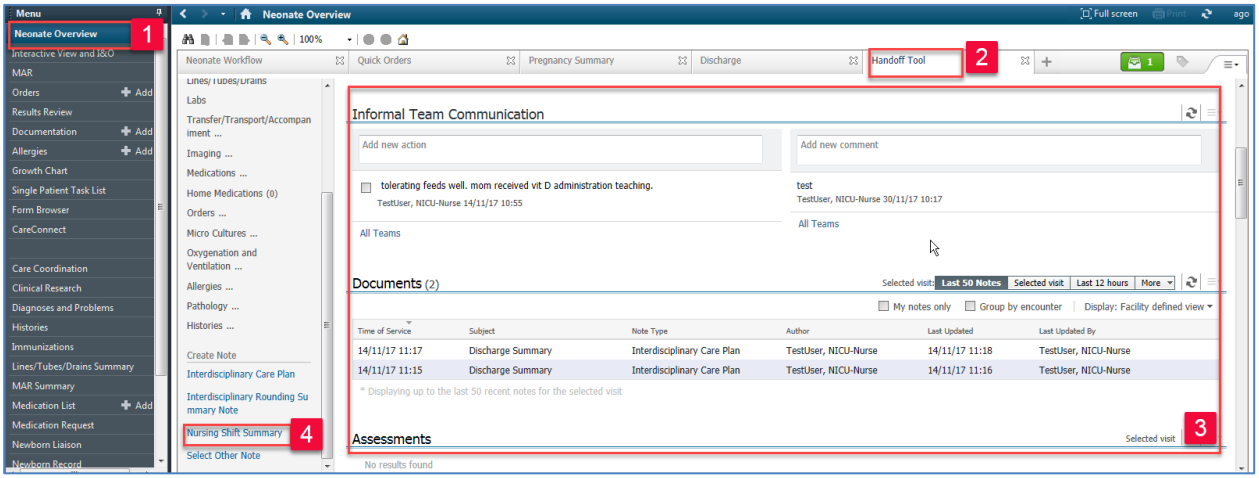
As a nurse, you will be completing the following activities:

- Completing a Nursing Shift Summary Note
- Complete Discharge Documentation

Activity 14.1 – Documenting Nursing Shift Summary

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. From the **Menu**, select **Neonate Overview**
2. Click **Handoff Tool** tab
3. Review information in Handoff Tool
4. Click on the **Nursing Shift Summary** blue link
5. Enter required data. *Feeding well, mom visited by lactation consultant*
6. Click **Sign/Submit**
    - Click Sign in the Sign/Submit note window
7. Click **Refresh** icon 

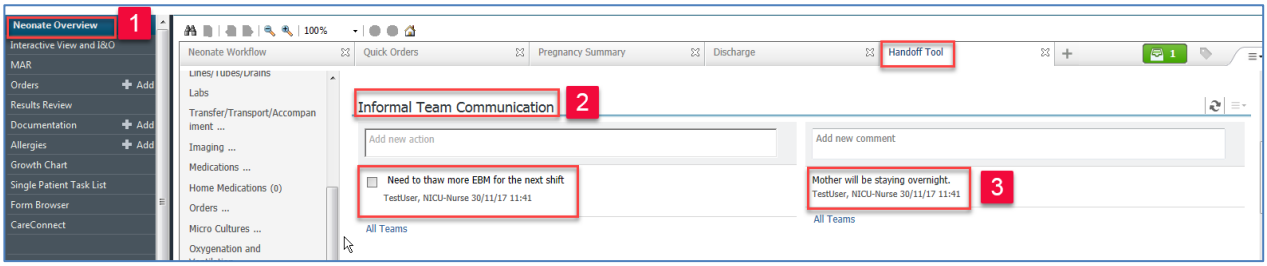


Note: The Nursing Shift Summary is a formal legal document.

2 **Informal Team Communication** can be used to communicate with other staff.

Leave a comment for the oncoming nurse.

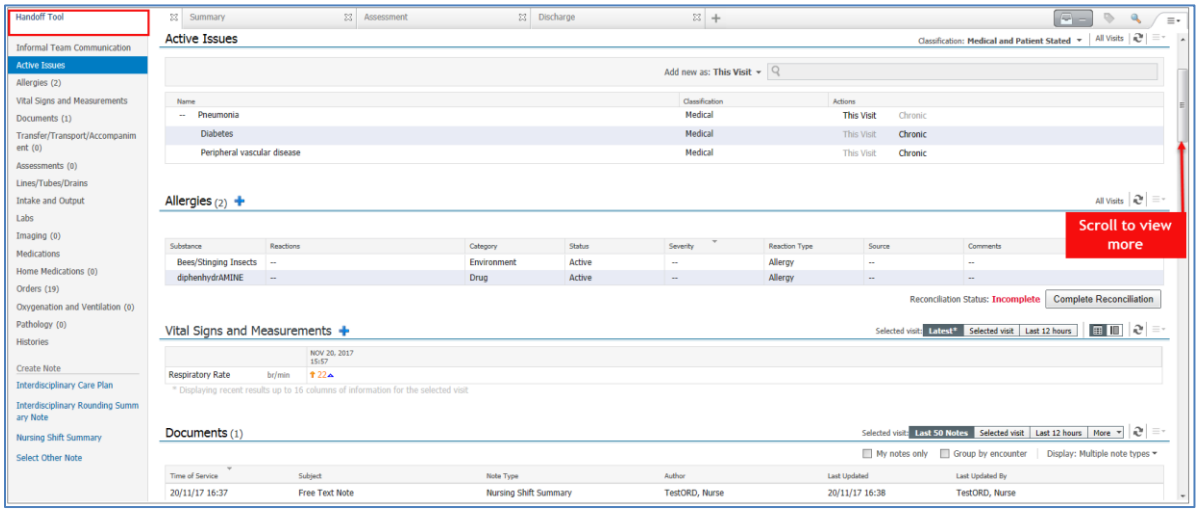
1. Select the **Handoff Tool** tab from the **Neonate Overview page**
2. Select the **Informal Team Communication** component
3. Enter the following data. *Mother will be staying the night.*
4. Click **Save**



Note: The Informal Team Communication has two text boxes, one for actions and one for comments. These are both informal documentation and are meant for informal staff communication. The text input into the actions box will generate a checklist while the text input into the comment box will display as a comment.

3 Use Handoff Tool to Review Patient

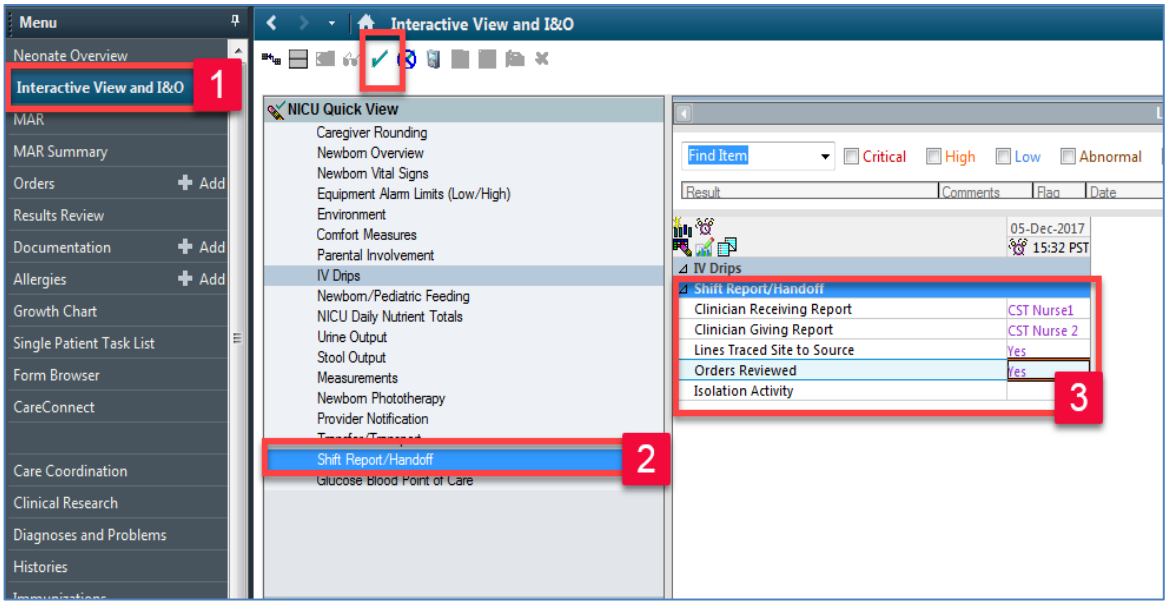
1. Select **Neonate Overview** from the **Menu**
2. Select the **Handoff Tool** tab
3. Scroll down the page or access each component by clicking within the Handoff Menu
4. Add missing information if required



4 Document Shift Report/Handoff

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

Click **Green Checkmark** icon ✔ to sign your documentation.



Key Learning Points

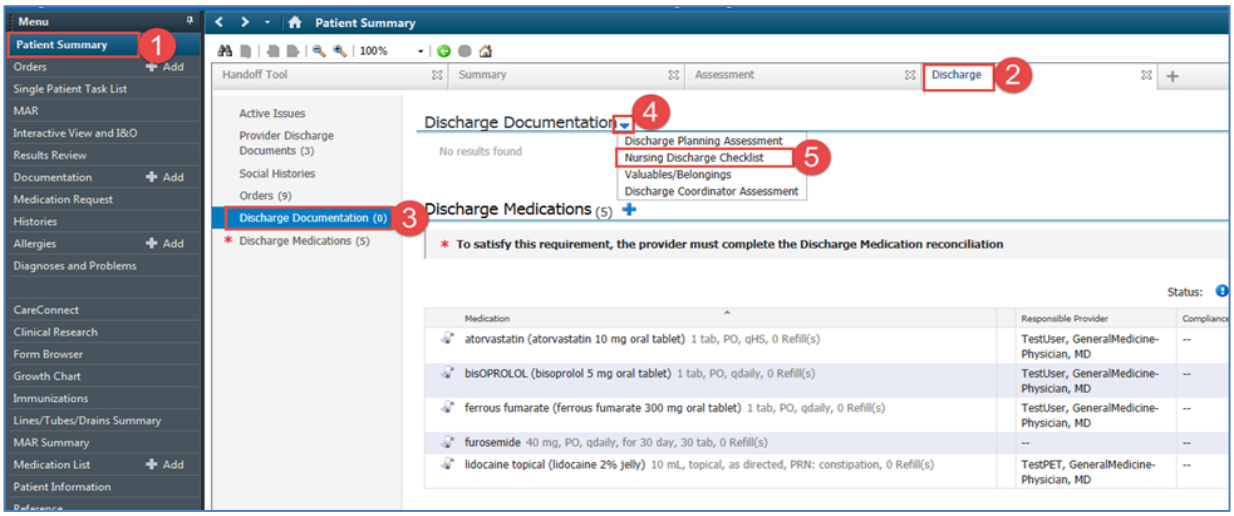
- Nursing Shift Summary is a permanent part of the chart
- Informal Team Communication is an informal note and not a permanent part of the chart
- Headings within Handoff Tool page can be clicked to access the corresponding part of the chart

Activity 14.2 – Complete Nursing Discharge Checklist

1 The patient remains in NICU receiving routine care for five weeks. The pediatrician then visits the patient and is satisfied the patient has stabilized and is safe to be discharged home.

Complete the Nursing Discharge Checklist and review and print the Discharge Summary to give to the parents.

1. Select **Neonate Overview** from the **Menu**
2. Navigate to the **Discharge** tab
3. Select **Discharge Documentation** component
4. Click on the blue downward arrow
5. Select **Nursing Discharge Checklist**



Complete the **Nursing Discharge Checklist**.

6. Document using the following data:
   - **Follow Up Information Provided**= *Yes*
   - **Discharge Education Provided**= *Yes*
   - **Patient Discharge Summary Provided**= *Yes*
   - **Prescriptions Given=** *Yes*
   - **Medications Returned Per Inventory List**=*N/A*
   - **Home Equipment/Supplies Arranged=** *N/A*
   - **Community Services Arranged Post Discharge**= *Yes*
   - **Transportation Arrangements Made=** *Yes*
   - **Accompanied By**= *Mother, Father*
   - **Discharge Transportation**= *Personal vehicle*
7. Click **Green Checkmark** ✔ to sign your documentation.

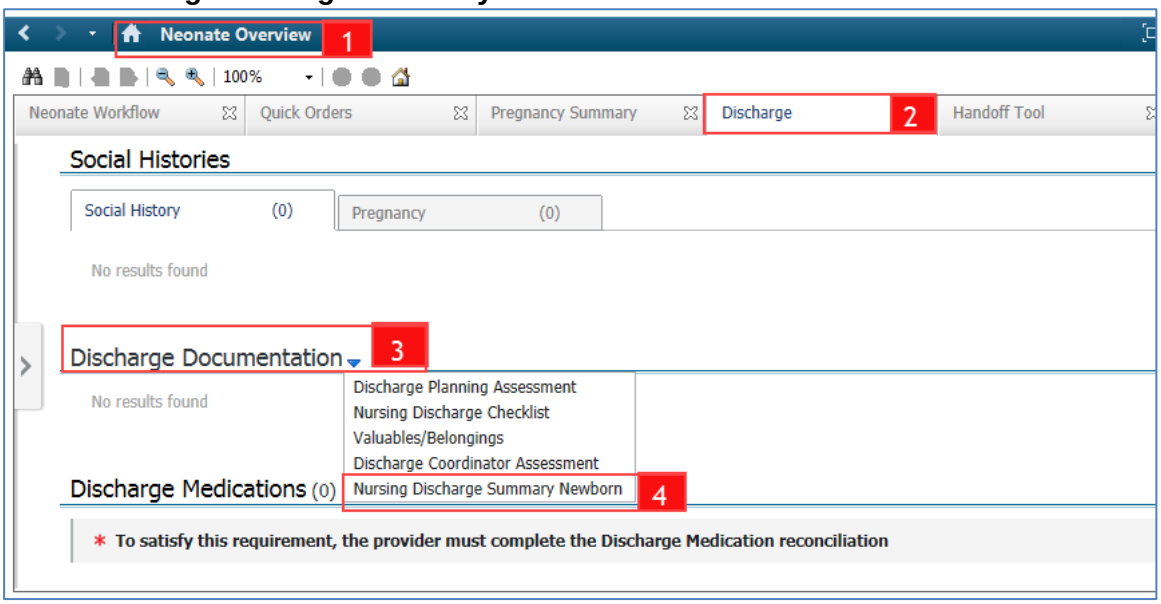
Key Learning Points

- The Nursing Discharge Checklist needs to be completed for patients being discharged and can be found under the discharge tab

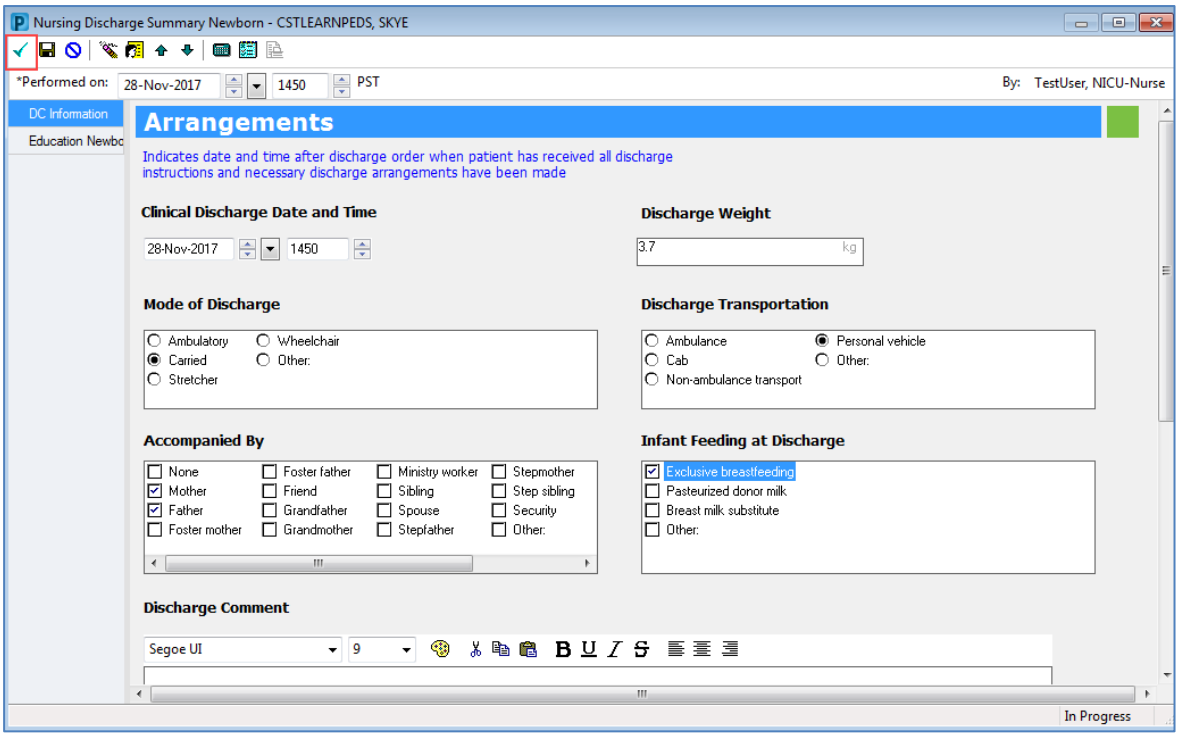
Activity 14.3 – Completing the Nursing Discharge Summary Newborn

1 To complete the Nursing Discharge Summary for the Newborn:

1. Navigate to the **Neonate Overview**
2. Select the **Discharge** tab
3. Scroll to find the **Discharge Documentation** and click the blue arrow
4. Select **Nursing Discharge Summary Newborn** document.



5. Open the document and enter data as appropriate.



6. Use the Green Check Mark ✔ to Sign when complete

Key Learning Points

- The Nursing Discharge Summary Newborn needs to be completed for newborns being discharged and can be found under the discharge tab

PATIENT SCENARIO 15 - Printing a Document

Learning Objectives

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

- Print a Document

SCENARIO

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

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

- Printing a Patient a Discharge Summary
- Printing the Newborn Record, Newborn Liaison, and the Birth & Labour Record

Activity 15.1 – Printing a Patient Discharge Summary

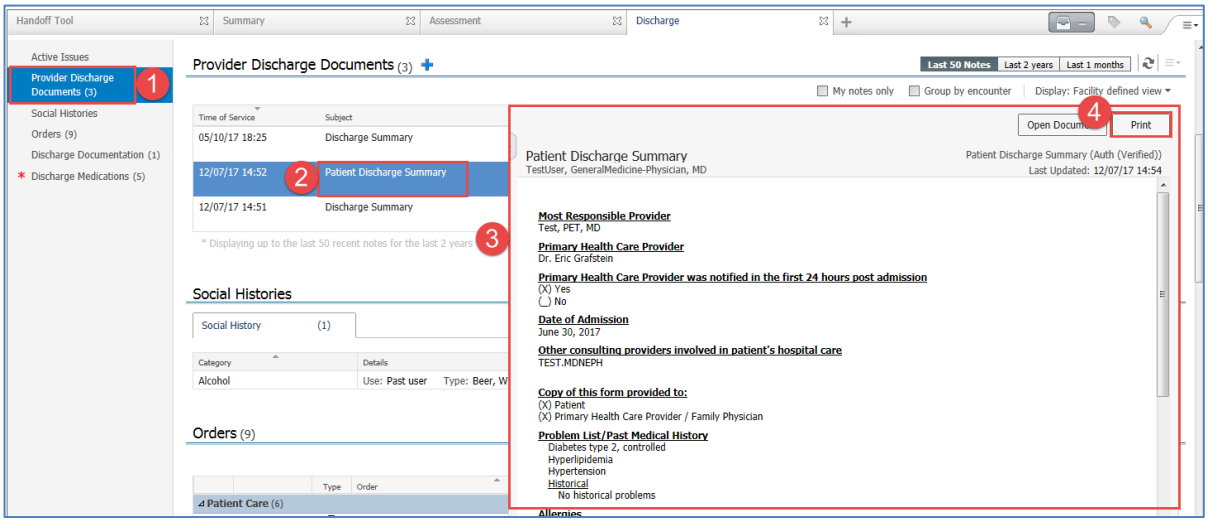
1 The Patient Discharge Summary is completed by the physician and needs to be printed and handed to the patient upon discharge.

To print the **Patient Discharge Summary**.

Note: This summary will be handed to the patient upon discharge.

1. From Neonate Overview, scroll down to **Provider Discharge Documents**.
2. Select **Patient Discharge Summary**
3. Review the **Patient Discharge Summary**
4. Click the **Print** button*

*Close out of the following screen as we will not be printing within this activity



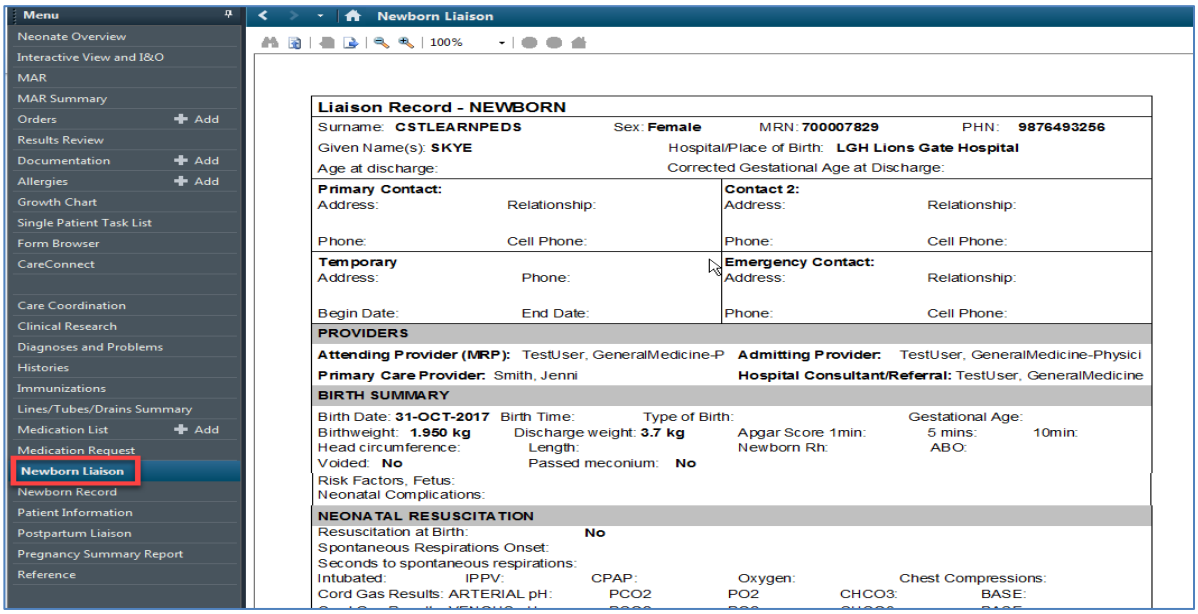
Key Learning Points

- The Patient Discharge Summary is completed by Physicians and must be printed for patients upon discharge
- The Patient Discharge Summary can be accessed within the discharge tab

Activity 15.2 – Printing the Newborn Record, Newborn Liaison, and Labour & Birth Summary

1 Certain documents will need to be printed prior to transfer or discharge; the most common ones are the **Newborn Record**, the **Newborn Liaison**, and the **Labour & Birth Summary**.

1. Select the **Newborn Liaison** from the Menu.



To print this document, click on the Print 

icon at the top right corner. We will not be printing documents but to do so you would check to make sure the correct printer is selected and click **OK.**

Note: The Newborn Record, the Newborn Liaison, and the Labour & Birth Summary are located on the Menu. These records reflect the documented data on the patient; the more thorough the documentation is the more complete and relevant these records will be.

Key Learning Points

- You can preview documents by clicking on it in the respective workflow page component.
- You may print documents from the same preview window.

PATIENT SCENARIO 16 –Conversation Launcher

Learning Objectives

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

- Utilize Conversation Launcher

SCENARIO

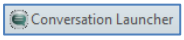
Conversation Launcher opens many different functions, but you will frequently use it for transfers. This could be transfers within the hospital or transfers to external facilities (which would still require provider orders per policy.)

You may notice that Conversation Launcher also has links to Process Alerts and Specimen Labels; however, **PM Conversation** has been configured as the preferred shortcut for these two functions because it skips the need to search for the patient's name. You learned about PM Conversation in Scenario 4.

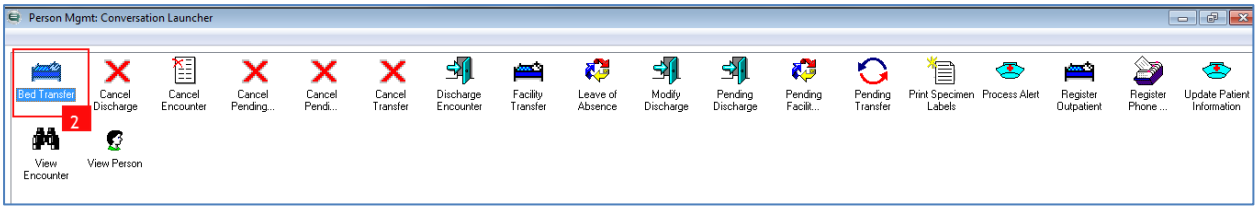
- Conversation Launcher

Activity 16.1 –Conversation Launcher

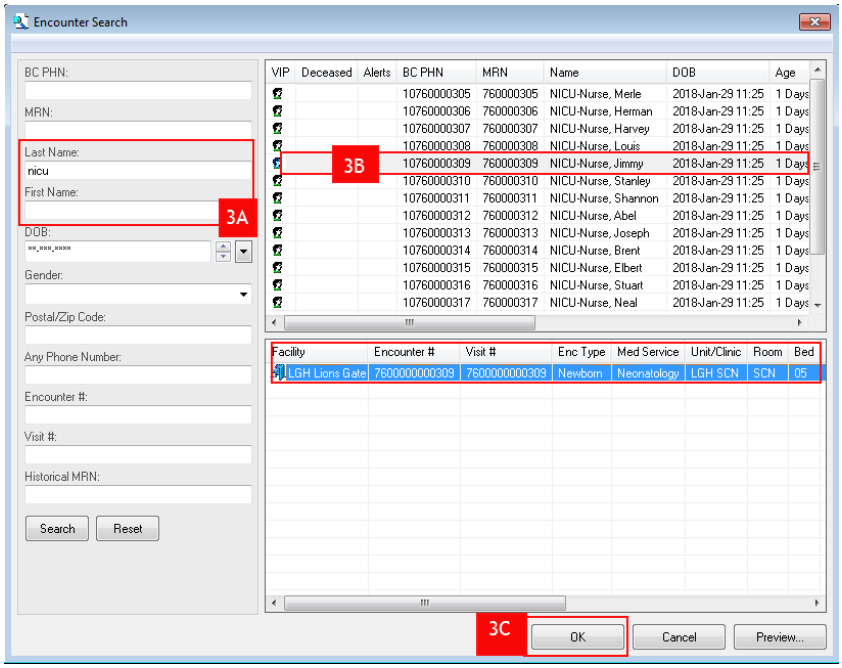
Conversation Launcher allows the nurse to process transfers and discharges. Let's practice a transfer.

1. Click **Conversation Launcher**  in the toolbar. The window will open. Examine the icons to explore available functions.

2. Click the **Bed Transfer** icon

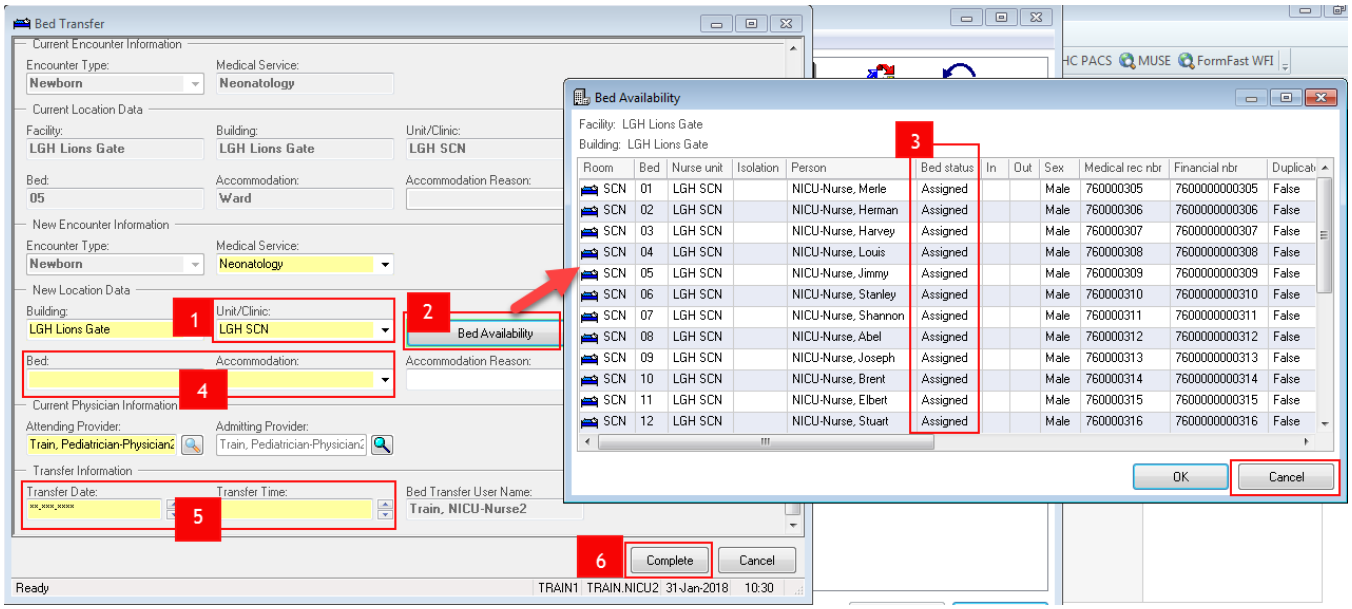


3. The **Encounter Search** window will open. Search for your <patient's name>, select the correct Encounter, and click **OK**.



The **Bed Transfer** window will open. Yellow fields are mandatory.

1. In the **Unit/Clinic** field, select **LGH SCN**.
2. Click the **Bed Availability** button.
3. The **Bed Availability** window opens and any available or dirty room can be selected under the **Bed Status** column. Unfortunately in this training environment every bed is filled with training patients, so click **Cancel** to close the Bed Availability window.
4. If you had been able to select an available bed, the **Bed** and **Accommodation** mandatory fields would be automatically filled in.
5. If you were completing the transfer, under **Transfer Date**, type 'T' (today). And under **Transfer Time**, type 'N' (now.)
6. Once all mandatory fields were filled out, you would then click **Complete** to complete the transfer.



Key Learning Points

- Conversation Launcher is a multifunctional component that manages patient location, alerts, encounter information and demographics.
- Conversation Launcher facilitates bed management between room, units and facilities.

End Book One

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