SELF-GUIDED PRACTICE WORKBOOK [72] CST Transformational Learning

WORKBOOK TITLE: NURSING: NICU







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***** 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 Article Patient List from the **Toolbar** at the top of the screen.
- 2. The screen will be blank. To create a location list, click the List Maintenance icon 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.

Modify Patient Lists Active lists: Available lists: Active lists: Image: Comparison of the second	Task Edit View Patient Chart Links Patient List Help Image: CareCompass IIII Clinical Leader Organize Patient List 1 1 Image: Disk IIII Clinical Leader Organize Patient List 1 1 Image: Disk IIII Clinical Leader Organize Patient List 1 1 Image: Disk IIII Clinical Leader Organize Patient List 1 1 Image: Disk IIII Clinical Leader Organize Patient Clinical Leader Organize Patient Clinical List Image: Disk IIII Clinical List 2 1 1 1 Image: Disk IIII Clinical List 2 1 1 1 Image: Disk IIII Clinical List 2 1 1 1 1 Image: Disk IIII Clinical List 2 1 1 1 1 1	nt Task List 🎬 Discharge Dashboard 🏔 Staff A Medical Record Request 🕈 Add 👻 🖲 Documi te 🥊	ssignment 🌃 LearningLIVE 🗐 🕄 🕄 CareConnect 🎕 PHSA P	ACS 🔃 VCH and PHC PACS 🔃 MUSE 🔃 FormFast WFI 🖕
		Modify Patient Lists	Activa liste	
		Available lists:	Active lists:	(a) (b)

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



Patient List Type			.
Select a patient list type:			
Assignment Assignment (Ancillary) CareTeam Custom Location Provider Group Query Relationship Scheduled			
Back	Next	Finish	Cancel
	5		

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**.

it	Location Patient List	Image: Continue of the construction	
	Enter a name for the list: (Limited		•
-		Back Next Finish Can	:el

- 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.

CLINICAL + SYSTEMS TRANSFORMATION Our path to smartee seamless care

9. Click the Finish

Location Patient List		- X-
	GH Laboratory GH Lions Gate Hospital GH Lions Gate Hospital GH Lions Gate Hospital GH Z East GH	• W
Enter a name for the list: (Limited to LGH 2 East	50 characters) Back Next Finish Ca	incel

- 10. In the **Modify Patient Lists** window select the **Location** list you've created.
- 11. Click the **blue arrow** icon 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.

P Modify Patient Lists					—
Available lists: IGH 2 East 10	•	Active lists:			(i) (i)
			New	ОК	Cancel
				12	



Key Learning Points

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1

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

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 ² 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.



Custom Patient List
Care Teams Locations Medical Services Encounter Types Admission Criteria Discharged Criteria Use Best Encounter
Enter a name for the list: (Limited to 50 characters) JohnDoe_Custom List Back Next Finish 6

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

P Modify Patient Lists		—
Available lists:	Active lists:	
JohnDoe_Custom List 7	LGH 2 East	
	8	Image: A = 0Image: A = 0Image: A = 0
	New OK [9	el

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.



Γ	CSTLABAUTOMATION, TSWAYN	IE	70000)46	08 700000015122	83 years	18-May-1934	20-Nov-2017
)	CST-TTT, RUTH		70000	73	67 700000013478	71 years	10-Jan-1946	14-Nov-2017
)	CSTPRODREG, 1	Patient Snapshot		24	46 7000000004417	27 years	10-May-1990	
	CSTADTIAMTH	Provider Information		58	39 7000000015274	61 years	21-Apr-1956	
	CSTPRODMED, JAMIE	Visit List		00	34 7000000013404	25 years	28-Sep-1992	10-Nov-2017
	LEE-LEARN, PETER	VISIT LIST		79	42 700000013205	67 years	17-Mar-1950	07-Nov-2017
	CSTPRODREG, SELFPAYT	Inactivate Relationship		32	87 7000000004955	27 years	10-May-1990	
)	BROWN-LEARN, HENRY	Add/View Stichy Notes		50	26 7000000012702	50 years	20-Aug-1967	26-Oct-2017
	CSTPRODREGINTER, HOP	Add/ view blicky ivotes		8	82 700000006995	36 years	14-Jun-1981	
	CSTPRODMED, LAB-NOR	Sort		11	78 700000006054	21 years	01-Jan-1996	
)	CSTPRODMI, SITSYNGO	Hide		i5	76 700000015568	41 years	30-Jan-1976	27-Nov-2017
þ	CSTCARDDEMO, BOB DO	Customizo Columns		81	00 7000000015206	70 years	01-May-1947	20-Nov-2017
)	CSTSYNGOTEST, FRANK	Customize Columns		73	88 700000001 3043	57 years	11-Eeb-1960	02-Nov-2017
	CSTAMBTEST, JAMIE	Add to a Patient List	•	\square	JohnDoe_Cust	tom List	92	26-Oct-2017
	CSTPRODREGHIM, FRAN	Conv Ct 2			70000000000203	or years	I <mark>3</mark> 980	
	CSTPRODREG, OUTPATIE			24	0 7000000004418	27 years	1	
	CSTPRODREG, OUTTOOL	Paste Ctil+v		.8	56 700000004416	27 years	01-Jan-1990	
)	CSTONCPHARM, STONE	New Results		1	47 7000000001602	38 years	27-Nov-1979	08-Nov-2016
	JONES-LEARN, JULIO			31	48 700000013604	71 years	29-Aug-1946	16-Nov-2017
	MCCOY-LEARN, SHAUNA	Open Patient Chart	•	80	73 700000013496	59 years	17-Feb-1958	14-Nov-2017
L	CSTPRODREG, PREWORK		70000	37	25 700000005160	27 years	10-May-1990	

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

Task Edit View Patient Chart Links PatientList Help			
📾 Multi-Patient Task List 🖃 Message Centre 🕌 CareCompass 🎬 Clinical Leader Organizer 🎬 Ambulatory Organizer 🛓 Patient List 🗐 Schedule 📾 Staff Assignment 🐂 LearningLIVE 🔶 🕄 CareConnect 🛱 PHSA PACS 🛱 VCH and PHC PAC	.S 🔃 MUSE 🕄 FormFast WI	FI 🖕	
🗐 Exit 🎁 Adhoc 💷 Medication Administration 🔒 PM Conversation + 🔓 Communicate + 💠 Add + 📇 Scheduling Appointment Book, 📆 Documents 🔒 Discen Reporting Portal 💇 Hware 🖕			
🗘 Patient Health Education Materials 🐧 Policies and Guidelines 🐧 UpToDate 💡			
CSTLEARNING, DEMOTHETA 🔳 DONOTUSELEARN, MONTY 🔳	Recent - Name	- Q	
Patient List	[🗆] Full screen	Print	€ 0 minutes ago
▶☆ ☆ >> 및 ** ** ● 20 = 10 = 10			5
LGH Emergency Department LGH 4 East LGH 2 East LGH 5 East JohnDoe Custom 4			
C Location Name MRN Encounter # Age DOB Admitted Admitting Physician Reason for Visit Primary Care Physician Visitor Status			
GH 6E 622 04 CSTPRODOSSYSTEM, DAVID 700005100 7000000015807 72 years 21-Mar-1945 30-Nov-2017 10:31 PST Plisvca, Rocco, MD System Testing TestOS, GeneralMedicine-Physician8, MD			

5. Click the **Refresh** icon is 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 $\stackrel{\text{T}}{\longrightarrow}$.

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

1



in

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.

- Navigate back to CareCompass by clicking on the CareCompass icon the toolbar.
 - 2. Select YourName_Custom from the Patient List drop-down.

Task Edit View Patient Chart Links Navigation Help				
🗄 🎬 CareCompass 🧧 🚺 cal Leader Organizer 🗍 Patient List 🔉 Multi-Patient Task List 🎬 Discharge Dashboard 🎎 Staff Assignment 🎬 LearningLIVE 🚽 🔅 😋				
🗄 📆 Exit 📷 AdHoc 🗤 Medication Administration 🔒 PM Conversation 👻 🗎 Medical Rec	ord Request 🚦 Add 👻 🕞 Documents 🕮 Sche	duling Appointment Bo		
🕴 🔃 Patient Health Education Materials 🔞 Policies and Guidelines 🔞 UpToDate 🖕				
CareCompass				
Patient Lis: JohnDoe_Custom List V 💥 List Maintenance 🕂 Add Patient	Stablish Relationships			
Location JohnDoe_Custom List	Visit	Care Team		
2EL - 03 CST-TTT_RITH	-	-		
71yrs F				
No Relationship Exists				

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

Task Edit View Patient Chart Links Navigation Help							
🙀 CareCompass 🙀 Clinical Leader Organizer 🎍 Patient List 😩 Multi-Patient Task List 🙀 Discharge Dashboard 🎕 Staff Assignment 🎇 LearningLive 🚽 🕲 CareComnet 🔞 PHSA PACS 🐧 VCH and PHC PACS 🆓 MUSE 🐧 FormFast WFI 🖕							
🗄 📲 Exit 🎬 AdHoc 💷 Medication Administration 🔒 PM Conversation 👻	📄 Medical Record Request 🚦 Add 👻 📻 D	ocuments 📋 Scheduling Appointment Book 💽 iAware 🗃 I	Discern Reporting Portal				
💐 Patient Health Education Materials 🐧 Policies and Guidelines 🐧 UpTo	Date 🖕						
					👫 Recent 👻 Name		
CareCompass					Full screen 🔅 Print ෫ O minute		
🏔 🗋 🚔 🔍 100% 🔹 🔿 🖬 🖆	A 1 3 4 4 1005 - 10 0 G						
Patient List: JohnDoe_Custom List 🗸 List Maintenance 🕂 A	idd Patient 🔹 😵 Establish Relationships				0 0		
LGH 2 East Location JohnDoe_Custom List	Visit	Care Team	Activities	Plan of Care			
2EL - 03 CST-TTT, RUTH 71yrs F No Relationship Exists	-	-	-	-			

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.)

Task Edit View Patient Chart Links Navigation Help						
👫 CareCompass 👫 Clinical Leader Organizer 🎍 Patient List 😂 Multi-Patient Task List 🕌 Discharge Dashboard 📾 Staff Assignment 🕌 LearningLIVE 🚽 🕄 CareConnect 🔃 PHSA PACS 🕲 VCH and PHC PACS 🕲 MUSE 🕲 formFast WFI 🚽						
💐 Exit 🦉 AdHoc 🎟 Medication Administration 🆀 PM Conversation 👻 👔 Medical Reco	rd Request 🔸 Add 👻 🕞 Documents 🛗 Scher	duling Appointment Book 💽 iAware 🎯 Discern Reporting Portal		1		
🕄 🕄 Patient Health Education Materials 🔍 Policies and Guidelines 🔍 UpToDate 🖕						
CareCompass				(🗆) Full screen		
😤 🗋 🖶 🔍 🌯 100% 🛛 + 🗨 🚭 🚰						
Patient List: JohnDoe_Custom List 🔽 🙎 t Maintenance 💠 Add Patient 💰	Establish Relationships					
Location Patient	Visit	Care Team	Activities	Plan of Care		
2EL - 03 CST-TTT, RUTH	-	-	-	-		

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

CareCompass						
	🗚 📄 📲 🖿 🔍 🔍 100% 🛛 + 🌑 🜑 🟠					
Patient List: Karen, 🔽 💥 List Maintenance 🕂 Add Patient 😵 Establish Relationships 1						
▲ Location	Patient	Visit	Care Team			
SCN - 07	MATTEST, BABY AMY 3m F No Relationship Exists	-				
SCN - 13	CSTMATTEST, BABY BOY 4m M No Known Allergies Milk/Dairy Free Diet (Diet Milk/D	NEWBORN LOS: 4m	Plisvca, Rocco, MD Business (322)366-4896			
SCN - 15	MATSITTWENTYONE, BABY BOY 4m 2w M Allergies Breastfeed with Supplementation, NPO	NEWBORN LOS: 4m 2w	Plisvch, Max, MD Business (501)241-1078			

2

1. From the Relationship drop-down select Nurse

2. Click Establish

Establish Relationships			
* Relationship			
Name Chart Review	Date of Birth	MRN	Encounter #
MATTES, Nurse	08/29/2017	700006306	700000009642
Research Unit Coordination			
Select All Deselect All			2 Establish Cancel

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.

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.

reCompass						(D) Full screen 👘 Print 💸 2 hours 10 minutes a
	🔍 🔍 100% → 🌑 🜑 🏠					
atient List: Pa	tient list 💌 💥 List Maintenance 💠 Add Patient	💰 Establish Relationships				🤪 2 🛛 🥹
Location	v Patient	Vst	Care Team	Isolatio	Activities	Plan of Care
624 - 04	CSTLEARNING, DEMOTHETA 80yrs M No Allergies Recorded	Pneumonia LOS: 3d	Plavca, Rocco, MD Business (322)366-4896		- 7	Add Plans
620 - 02	CSTLEARNING, DEMODELTA 80yrs N Age 80 yes No Allergies Recorded Age 80 yes Deve 81 (AL)	Pneumonia IS: 3d	Plisvca, Rocco, MD Business (322)366-4896			Add Plans
624 - 03	CSTLEARNING, DEMOBETA 80yrs M Allergies MRN 70000 Encounter # 70000 Dist	eumonia 8217 IS: 3d 00015060	Plavca, Rocco, MD Business (322)366-4896		PRN/Contin Assessmen	s: 0 parin Infusion Standard (Module) (Valdated) e: 2 (1) t: 5 (4)
624 - 02	CSTLEARNING, DEMOALPHA 80yrs M No Known Allergies	eumonia LOS: 3d	Plavca, Rocco, MD Business (322)366-4896			r: 0 Red Blood Cell (RBC) Transfusion (Module) (Validated)
	0					

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.



CareCompass							
	👬 🗋 🛋 🖿 🔍 🖏 100% 🛛 + 🜑 🜑 🖾						
Patient List: Nik	iki 💌 💥 List Maintenance 🚦 Add Patient	🕏 Establish I	Relationships				
Location Patient Visit Care							
LGH 3W							
309 - 01B	CSTLEARNPEDS, SKYE Sw F Attempt CPR, Full Code No Known Allergies		meconium aspiration LOS: 5w	Test Busir			
LGH LD							
LDR2 - 01A	CSTMATTEST, BABY GIRL A 4m 2w F No Known Allergies		NEWBORN LOSI				
ZZLGH 3PO							
3EL - 04	CSTLEARNPEDS, ALEX 7yrs M Attempt CPR, Full Code Allergies General Diet Pediatrics	9	left leg laceration, struck by car while r LOS: 22d				

1. Review new orders and results in the Items for Review window

2. Click Mark as Reviewed when done

Items for Review				×
CSTLEARNPEDS, ALEX M 7yrs				3EL - 04
Results		Orders		
No new results		Croup and Scroop (Concel)	Ordered By	Entered By
	N	Blood, Routine, Collection: 27-Nov-2017 08:28 PST,	Plisvcc, Trevor	04:32 Today
	4	Red Blood Cell Transfusion PED/NEO (Cancel) Routine, Administer: 1 unit, IV, once, Administer eac Comment: For children GREATER than 25 kg use a	Plisvcc, Trevor	SYSTEM, SYSTEM Cerner 04:32 Today
		Select All		1
			2	Mark as Reviewed Cancel

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

٩	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

Task Edit View	Task Edit View Patient Chart Links Navigation Help								
🔣 CareCompass	🕵 CareCongass 1 nical Leader Organizer 🛓 Patient List 🏨 Multi-Patient Task List 🎇 Discharge Disabloard 😂 Staff Assignment 🎇 LearningLINE 💡								
CareConnect	😰 CareConnect 🔞 PHSA PACS 🕲 VCH and PHC PACS 🕲 MUSE 🕲 TormFact WFI 🚦 🏨 Leit 👹 Addrec 🞟 Medication Administration 🔒 PMC Conversation + 🗋 Medical Record Reputet 💠 Add + 🛞 Documents 🏙 Scheduling Appointment Book 🔬 Discent Reporting Portal 🖕								
E Q Patient Health E	ducation Materials 🔞 Policies and Guidelines 😋 UpToDate 💡								
CSTLEARNING, D	DEMOALPHA × CSTLEARNING, DEMOTHETA	×					CSTPRODOST, JU	STINE 🔹 👫 Recent 🔹	Name
CareCompass							,O,	Full screen 🔅 Print 🤞	4 hours 58 minutes
ABIBB	م م 100% - ا 🔿 🌑 🟠								
Patient List: Lori	S 💌 💥 List Maintenance 💠 Add Patient 💰 Establish Relat	onships							@ · · @
Location	Patient		CSTPRODOST, JUSTINE	Age: 26yrs	Sex: F	DOB: 01/19/1991	MRN: 700002377	Encounter #: 7000000003771	c
-	CSTPROD, CHECK EMPI 17yrs F -		Scheduled/Unscheduled PRN/Continuo	us Plans of Care Patient Information				700000000771	
PACU 1 - 27	No Allergies Recorded		🖌 🖸 🖹 📝 🛛 2 Hours	4 Hours 12 Hours					
	26yrs F	<	Current						-
	Ivo known Allergies		🖉 Urinalysis Macroscopic (dipstick) wit	th Microscopic Nurse Collect Urine, Routine	, Unit collect, Collection: 20	17-May-10 10:56 PDT, once			
619 - 01	LINESTUBESDRAINS, KATHY	3	Unscheduled						
	No Known Allergies		Medication History						
301 - 01M	LINESTUBESDRAINS, MAX		18:00 (No Activities)						
	32yrs M		Interdisciplinary (No Activities)						
	Allergies								
Activity Timeline									
		2						Done Not Do	ine Document
Overdue	17:00 18:00	19:00 2							



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

🐒 CareCompass 🐒 Clinical Leader Organizer 🚽 Patient List. 😫 Multi-Patient Task List. 🎇 Discharge Dashboard 😂 Self Assignment. 🖏 LearningLNE 🔒							
CETLEADNING	Fast WFI 🔮 🕄 Exit 🏫 AdHoc 🛲 Medical	tion Administration 🎽 PM Conversation 👻	- 🔓 Communicate - 🔄 Medical Record Request 🅈 Add - 🖪 Documents 🗃 Scheduling Appointment Book 🖬 Discern Reporting Portal 💡	Barret - Norse			
CareCompass				reen Print 210 minutes age			
ADIADI	🔍 🌯 100% - 🖌 🖨 🖓						
Patient List: Prat	tice List **	💥 List Maintenance 🛛 💠 Add Patient	Establish Relationships	9 3 9			
				ounter #:			
620 - 02	Source Stream St	¢	Schedulard Underdulung Participation and Care	000015060			
624 - 02	CSTLEARNING, DEMOALPHA 80yrs M No Known Alergies		2 Hours 4	^			
624 - 03	CSTLEARNING, DEMOBETA 80yrs M Allergies	•	Commet: Oxfer entered secondary to tradetert admission Admission Historia entered secondary to tradetert admission Commet: Oxfer entered secondary to tradetert admission Commet: Oxfer entered secondary to tradetert admission				
624 - 04	CSTLEARNING, DEMOTHETA 80yrs M Allergies		Braden Assessment 17-169-2017 14:28 PST, Step: 17-809-2017 14:28 PST Comment: Order entered secondary to inpatient admission.				
			Infectious Disease Screening 17:40x-2017 14:28 PGT Communit Orien retend scoracity in bigateria division. Morse Fail Risk Assessment Morse Fail Risk Scale 17:40x-2017 14:28 PGT, Stop: 17:40x-2017 14:28 PGT				
			Comment: Order entered secondary to inpatient admission.				
			Unscreeues A Valuable and Relondings				
			Admission Discharge Outcomes Assessment				
			15:00 (No Activities)				
			Interdisciplinary (No Activities)				
Activity Timeline							
				Not Done Document			
Overdue	14:00	15:00 16:00					

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.

P Admission Histo	ory NICU - CSTLEARNPEDS, SKYE			
🖌 🖬 🛇 🖄 🖡	38 🛧 🔸 🔲 🖼 🗎			
*Performed on: 3	80-Nov-2017 📮 🔽 0942 🚔	PST		By: TestUser, NICU-Nurse
General Info	Birth History			^
Interpreter Service	Direit motory			-
Birth History	EGA at Birth	EGA at Birth is result copied from		
Medication Histor		the maternal chart, this value will	Gestational Age At Birth week day	
Problem History		Gestational Age at Birth control to	Method	
Family History		calculate the PMA.	Common (=
Social History			Commern	
Procedure History	Medications Taken by Mothe	er While Pregnant		
Allergies				
	National Astronomy Character	de Deserburd		
	Maternal Antepartum Stero	ias keceivea		

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 \checkmark to Sign.



P Admission Histo	ory NICU - CSTMATTEST, BABY GIRL A			
🗸 🖬 🛇 🔌	74 🔸 💷 🖾 🗎			
*Performed on:	30-Nov-2017 📮 💌 0852 📮 PST			By: TestUser, NICU-Nurse
General Info Interpreter Service Birth History Medication History Problem History Family History Social History	2 vessel cord Brachial plexus injury, suspected Cephalohematoma Cleft lip/palate Congenital anomaly, suspected Convulsions Extreme prematurity (less than 28 weeks Fever, Neonatal	Genetic abnormalities, suspected Genetic abnormality Hip dislocation, suspected Infection, suspected or proven Infacture growth restriction Meconium aspiration, suspected Petechiae/bruising Respiratory distress	Size, large for gestational age Skin eruptions Uther:	
Procedure History			Dist. Longth	
Allergies	Date, Time of Birth	Birth Weight	Birth Length	
	19Jul-2017 🗘 🗙 🗙 1105 🗘	41.950 kg 2 kg 1.950 g 69 oz 4 lb 5 oz	43 cm 15.93 in 4300 cm 1.41 ft 1.15 in 1.55 in	
	Birth Head Circumference	Birth Order	Multiple Gestation Description	
	34 cm 📴 13.39 in		Image: Singleton Quintuplets Image: Twins Sextuplets Triplets Septuplets Quadruplets Septuplets	
	Apgar 1 Minute, Apgar 5 M History History	inute, Apgar 10 Minute, History	Apgar 15 Minute, Apgar 20 Minute, History History	
	8			
	Resuscitation at Birth		Newborn Output	
	T-piece resuscitator CPAP		None None	=

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



200	and we have a second of the second								
CareCompass	Clinical Leader Organizer Tracking Shell & Patient List & Activity Assign	ment 🗱 Staff Assignment 🐘 LearningLive 🖕 : 📮 Careconnect 😋 PHSA PACS 😋 VCH and PHC PACS 😋 MUSE 😋 Formfast WH 🔓							
Patient Health	Education Materials (2) Policies and Guidelines (2) UnToDate	an reactor records 🕈 Ada * 🕐 bocuments 🖷 officer reporting Portal 🖉 conversation cauricite 🥁 Aware 🎽 Privice versation * 🖬 screeding Appendiment abox (-							
CSTMATTEST, B	ABY GIRLA CSTLEARNPEDS. SKYE	MATSITTWENTYONE	BABY BOY - Recent - Name						
CareCompass			🖸 Full screen 💿 Print 🔊 46 minute						
	8 8 J 100Y - J 8 8 4								
									
Patient List: Ka	ren, 🔟 📉 List Maintenance 🛉 Add Patient 💣 Establish Relationshi		U						
Location	Patient	MATSITTWENTYONE, BABY BOY Age: 4m 1w Sex: M DOB: 07/18/2017 MRN: 700005211	Encounter #: 7000000007797						
SCN - 07	MATTEST, BABY AMY 3m F No Known Alergies	Scheduled/Unscheduled PRI/Continuous Plans of Care Patient Information							
SCN - 13	CSTMATTEST, BABY BOY	Chill C 2 Hours 4 Hours 12 Hours							
	3m 4W M No Known Allergies Mik/Dairy Free Diet (Diet Mik/Dairy Free)	ampicilin 50 mg, IV, drug form: inj, start: 30-44e+2017 06:00 PST Comment: Target Dose: ampicillin 50 mg/kg 2017-Jul-25 10:57:04							
SCN - 15	SCI - 15 MATSITTWENTYONE, BABY BOY MITWI NI - More Beaver and the second water of the second secon								
		MRSA Culture (MRSA Screen) Nurse Collect Nares (5. aureus only). Routine, Unit Collect, Collection. 07-Nov-2017 15:06 PST, once Comment: SPECIAL COLLECTION REGUREMENTS: Please refer to specific site Laboratory Test Manual							
	IBSA Cuttine IBSAS Screed Nans Cluted Parasam Rodon, Unit Add. Catal-data 0241500 71507 0761 door Comment DPECIAL COLLECTION RECOVERENCE Press network to specific bala balantaria for Manual								
		VRE Culture Nurse Collect Perineum, Routine, Unit Collecti, Collection: 07-Nov-2017 15:07 PST, once Comment: SPECIAL COLLECTION REGUREMENTS: Please refer to specific site Laboratory Test Manual.							
		VRE Culture (VRE Screen) Nurse Collect Perineum, Routine, Unit Collect, Collection 07-Nov-2017 15:07 PST, once Comment SPECIAL COLLECTION REGUREMENTS: Please refer to specific site Laboratory Test Manual.							
		Unscheduled (No Adlvities)							
		10:00							
		gentamicin 2.5 mg/kg, IV, start. 30-Nov-2017 10:00 PST							
		Interdisciplinary							
		Oxygen Therapy 2017-Jul-24 14.17 PDT, Routine, Titrate O2 to keep SpO2 88% to 94% Instruction: Titrate O2 to keep SpO2 88% to 94%							
			Done Not Done Document						

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

areCompass								(0) Full screen 👘 P	int 🔹 🥭 1 hours 20 mi
	🔍 🍕 100% 🛛 🔹 🌑 🌑 🏠								
atient List: Nik	iki 🔽 💥 List Maintenance 🛛 🕂 Add Pati	nt 🥵 Establish	Relationships						9 2
Location SHL 3W	Patient	/	Visit	G	are Team	Activities		Plan of Care	
309 - 01B	CSTLEARNPEDS, SKYE Sw F Attempt CPR, Full Code No Known Allergies		meconium aspiration LOS: 5w	T	estUser, GeneralMedicine-Physician, MD usiness (604)001-0125	9 PRN/Contin	uous	PED General Admission PED General Admission (Va PED General Admission (Va PED Newborn Level 2 Adm	(Validated) Iidated) Iidated) Iission (Prototype)
GH LD									
LDR2 - 01A	CSTMATTEST, BABY GIRL A 4m 2w F No Known Allergies		NEWBORN LOS: 8d				39	🥹 zzOB Labour and Delive	ery Admission (Prot
LGH 3PO									
3EL - 04	CSTLEARNPEDS, ALEX 7yrs M Attempt CPR, Full Code Allergies General Diet Pediatrics	•	left leg laceration, struck by LOS: 22d	car while r		PRN/Contir		Add Plans	
tivity Timeline									

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
- 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 ^{20 minutes ago} 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!



🕴 🎫 CareCompass Tracking Shell 🎄 Patier	nt List 🕮 Discharge Dashboarg	Activity Assignment	: 🚜 Staff Assignment 🕮 LearningLIV	: StareConnect	PHSA PACS 😭 VCH and	PHC PACS C MUSE C Fo	mFast WFI
Tear Off 📲 Exit 🌇 AdHoc 📖 Medica	ation Administration 🖷 Medic	al Record Request 🙀 Re	sult Copy 🛄 Related Records 🕂 Add		ern Reporting Portal 🕥 C	Conversation Launcher 💽 iA	ware & PM Conversat
Relient Health Education Materials	Policies and Guidelines 🔞 Up	FoDate _	10 00		1 5 600	_	
CSTLEARNPEDS, SKYE		¥				← List → 🌾 Re	ecent - Name
CSTLEARNPEDS, SKYE	DOB:31-Oct-2017 Age:4 weeks	MRN:700007829 Enc:7000000012937	Code Status:Attempt CPR, Full Co	de Process:On Disease:	Research Study	Location:LGH Enc Type:Inpa	3W; 309; 01B 2
Allergies: No Known Allergies	Gender:Female	PHN:9876493256	Dosing Wt:1.95 kg	Isolation:		Attending:Test	PET, Pediatrician-Physician, M
Menu 🤈 🕂 🗸	> 👻 者 Neonate Ov	erview				[I] Full scree	en 🗇 P 🦯 🖁 6 minutes a
Neonate Overview 🦰 🚔 🏨							4
Interactive View and I&O	eonate Workflow	Ouick Orders	M Pregnancy Summary S?	Discharge	S? Handoff Tool	57 L	
MAR		Quick orders	Da Fregnancy bannary Da	biblinge		~ T	
Orders 🕂 Adc	Neenste Overview						a =-
Results Review 😑	Neonate Overviev	V					
Documentation 🕂 Add	No results found						
Allergies 🕂 Add							
Growth Chart	Tack Timeline						$ \alpha = $
Single Patient Task List							~ -
Form Browser	Date of birth: Oct 31	, 2017 07:00					
CareConnect	Task			Result			
	Pending						^
Care Coordination	Newborn ID Band Chec	k					
Clinical Research	Newborn Hearing Screet	ening Overall Result					
Diagnoses and Problems	Biliruhin Check	te, Time DiaWit					E
Histories	Newborn Cardiac Scree	n Result					

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

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.

Neonate Overview

Neonate Workflow

Quick Orders

Pregnancy Summary

Discharge

Handoff Tool

+

Neonate Overview

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

1



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.

Menu P	< 🔹 🕂 🔒 Neonate Overview	🗇 Full screen 🗇 Print 🌏			
Neonate Overview 🔶	AA	1003			
Interactive View and I&O	Neonate Workflow	Durk Orders 12 Dremanny 12 Discharme 12 Handoff Tool 12 L			
MAR					
Orders 🕂 Add	Neonate Overview	Date of birth: Jul 19, 2017 06:05			
Results Review	Task Timeline	Task Result			
Documentation 🕂 Add	Infant Feeding (0)	Pending 2			
Allergies 🕂 Add	Documents (0)	Newborn TD Band check			
Growth Chart	Veral Sinne Newborn Hearing Screening Overall Result				
Single Patient Task List	Labo	Newoon Screening Date, Inne Drawn			
Form Browser	New Order Entry	Newborn Cardiac Screen Result			
CareConnect		Newborn Car Seat Check			
cureconnect	Micro Cultures	Newborn Hepatitis B Vaccine			
	Pathology	Newborn Head Ultrasound			
Care Coordination	Imaging	Maternal Drug Exposure Test			
Clinical Research	Order Profile	Retinopathy of Prematurity (ROP)			
Diagnoses and Problems	Billirubin Nomogram 35	Weight Discharge			
Histories	Weeks and Greater	Completed 2			
Immunizations	Histories	No results found			

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

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



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

💮 Organization
Please select the facility where you want to view person aliases.
Facility Name Facility Alias
LGH Lions Gate 1
LGH Lions Gate Hospital 2
Facility:
LGH Lions Gate Hospital
3 OK Cancel



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** The alert will now be within the **To Selected** box
- 4. Click **Complete**

Process Alert			
Medical Record Number: 700007829	Encounter Number:	Last Name: CSTLEARNPEDS	First Name: SKYE
Middle Name:	Preferred Name:	Previous Last Name:	Date of Birth: 31-Oct-2017
Age: 1M	Gender: Female	BC PHN:	
From Available: On Research Study Palliative Flag Seizure Precoutions Special Care Plan Wolence Risk Visikor Restrictions 2	1 Move> Select All	To Selected:	
			4 Complete Cancel

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.

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

3

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:

- 66 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.

Mens		K - A Orders							Dall screen @Print 20	minutes ar
Provider View		+ Add 2 Document Medication by Hs Reconci	liation • A Check Interac	tions				- 1) e	econciliation Status	
Results Review									Meds History O Admission O	Discharge
Orders	+ 444	Orders Medication List Document In Plan								
Medication List	+ Add 1		PROPERTY OF REAL PROPERTY.	CONTRACTOR OF A DESCRIPTION OF A DESCRIP	4					
Documentation		View	And a second second second second	The marine point the scheduler.						
		Orders for signature.	30 CJ P	Order Name	Status	Dose_ 0	Details *	Rop	Ordening Physician	La +
400.000		Document in Flam	d Admit/Transfer/Dis	charge						(100 B)
Alleget		Medical	🔂 🗹 áo'	Admit to Inpatient	Ordered		N-Dec-2017 10:15 PST, Admit to General Internal Medicine, Admitting provider: TestORD,	04-Dec-2017 10:15 PST	TestORD, General/Medicine-Physic	d Te
Diagnoses and Proble		MED General Medicine Admission (Validated) (P	d Status							
Histories		GI General Admission (prototype) (Initiated)	Q X 85	Code Status	Ordered	11	NI-Dct-2017 13-24 PDT, 5-No CPR, Critical Care, May Intubate, Perioperative status: Attemp.		el.eam, Physician-General Medicir	s_ etc
and the second s		Suggested Plans (0)	A Patient Care		Contract					
Mask Summary		Orden	803	insett vergineral to catheter	Ordered		N-Oct-2017 13:24 PD1, Unless aready in place	24-001-2017 15:24 PD1	eLearn, Physician-General Medicin	L etc
MAR		Z Admit/Transfer/Discharge		Vital Cons	Ordered		M-Oct 2017 13-34 PDT, Map 24-OCT 2017 13:24 PDT, OR ADMISSION	58-00-2011 13-24 PUT	al ann. Physician General Madicia	the state
Form Browser		Status Reflect Care	88	Admission History Adult	Ordered		4-Oct-2017 1317 POT, Stop: 24-Oct-2017 1317 POT	24-0ct-2017 13:17 PDT	SYSTEM, SYSTEM Cerner	SY
Patient Information		Z Activity	0⊻	Braden Assessment	Ordered	- 8	24-Oct-2017 13:17 PDT, Stop: 24-Oct-2017 13:17 PDT	24-Oct-2017 13:17 PDT	SYSTEM, SYSTEM Cerner	SV.
Lines/Tubes/Drains Se	ionu ionumary	Continuous Infusions	8⊻	Basic Admission Information Adult	Ordered		24-Oct-2017 1317 POT, Stop: 24-Oct-2017 1317 POT	24-Oct-2017 13:17 POT	SYSTEM, SYSTEM Cerner	5Y I
Growth Chart		Blood Products		Morse Fall Risk Assessment	Ordered		Nort entered secondary to inpatient admission. N-Oct-2017 1317 POT, Stopi 24-Oct-2017 1317 POT	24-Oct-2017 13:17 PDT	SYSTEM, SYSTEM Cerner	51
Immunications		Deproving Tests	6⊻	ED Readmission Risk	Ordered		Arder entered secondary to inpatient admission. 24-Oct-2017 13:17 POT, Stop: 24-Oct-2017 13:17 POT	24-Oct-2017 13:17 PDT	SYSTEM, SYSTEM Cerner	SY
CareConnect		Procedures Respiratory	6⊻	Infectious Disease Screening	Ordered		Vide places due to patient being administration in ingestern in the tast of barys. 24-Oct-2017 13:17 POT Order anterest excendence to insultant administration.	24-Oct-2017 13:17 POT	SYSTEM, SYSTEM Cerner	SY.
		Alled Health	8M	Smoking Cestation Assessments	Ordered		03-Nov-2007 13-41 PDT	03-Nov-2017 13-41 PDT	TestCST, CardiothoracicSurgeon-4	P. Te
16		Consults/Referrals	àM	Inset Urinary Catheter (Inset Foley)	Ordered		03-Nov-2007 13:40 PDT, Indwelling	03-Nov-2017 13-40 PDT	TestCST, CardiothoracicSurgeon-B	P., Te
		Communication Orders	d Activity							
		Supplies	0 1 8	Activity as Tolerated	Ordered		N-Oct-2017 13/24 PDT		eLearn, Physician-General Medicin	n eli
		Non Categorized	d Diet/Nutrition							
		Medication History	0 10	General Diet	Ordered		N-Oct-2017 13:24 PDT		eLearn, Physician-General Medicin	A. els
12		Medication History Snapshot	. C9 ⊻	Advance Diet as Tolerated	Ordered	3	33-Nov-2017 13:41 PDT, Advance diet to Regular, Provider must order starting diet. RN or R.		TestCST, CardiothoracicSurgeon-I	P. Te
2		Reconciliation History	A Medication	acetaminophen (acetaminophen PRN range dose)	Ordered	1	dose range: 325 to 650 mg, PO, q4h, PPN pain-mild or fever, drug form: tab, start: 24-Oct-2. Maximum acetaminophen 4 g/24 h from all sources		eLearn, Physician-General Medicine1, MD	3



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:

< > - 🔒 Orders						
Add Document Medication	n by Ho ent In F	Reco Reco	oncili	ation •	≫ Check Interactions	
View	Dis	played: A	All Act	ive Order:	s All Active Orders	
Orders for Signature		8 B		8	Order Name 🔺	Status
Document In Plan	۵	Patient	Care	2 260	Admission History Adult	Ordered
TM Red Blood Cell (RBC) Suggested Plans (0)		0		2.60	Basic Admission Information Adult	Ordered
Orders Admit/Transfer/Discharg		0	~	2 66	Braden Assessment	Ordered
- Status		0		2.60	Infectious Disease Screening	Ordered
	1	į.	"	(

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

P Ordering Physician
 Order Proposal
*Physician name
Plisvca, Rocco, MD
3 der Date/Time 07-Dec-2017 ↓ 1055 ↓ PST
*Communication type Phone Verhal
No Cosignature Required Signature Hequired per/Fax
Electronic
5 OK Cancel

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

6 Done

CSTLEARNING, DEMOALPHA - 700008


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

P 🖓 🖓 🖓 Order Name	Status Start	Details			
GH 6E; 624; 02 Enc:700000001505	5 Admit: 17-Nov-2017 13:58 P	ST			
Patient Care	0.4	22. N. LL., MIXING MIR MIT 115	al sendo se a send de la de sende		
Saine Lock verphera		27	olerating oral fluids well		
Salina Laak Da	rinharal N/ (Calina	Look BA			
etais for Saline Lock Pe	ipneral iv (Saline	LOCKIVJ			
Details 🔢 Order Comments					
• Ta ⊾ 🛛 🕙					
		1	1	televales and their call	
equested Start Date/Time:		- P31	Special instructions: With	en tolerating oral fluids wei	
					7
coing Required Details Orders For Co	ignature Orders For Nurse Rev	iew.			s

8. Click Refresh



Nurses can place Nurse Initiated orders as No Co-signature Required Orders

Order sentences add additional information to an order

1



Activity 5.3 – Review Order Statuses and Details

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

🔊 🖗 🦻 🕅 Order Na	me 🔺 Stati	us Dose	e Details	Proposal	*
Insert Per	ipheral IV Proc	cessing	20-Nov-201	7 11:46 PST	
📑 🛄 🛛 Insert Uri	nary Cath Ord	ered	20-Nov-201	7 11:31 PST, Indwelling	
Morse Fa Assessme	I Risk Orde nt	ered	17-Nov-201 Order enter	7 14:05 PST, Stop: 17-Nov-2017 14:05 PST ed secondary to inpatient admission.	
👘 🛄 🛛 Vital Sign	s		20-Nov-201	7 11:25 PST, q4h while awake	
⊿ Medications					
👘 🗹 🍗 🗈 furosemi	de Orde	ered	20 mg, IV, a Administer	s directed, order duration: 5 day, drug form: inj, start: 17-Nov pre red blood cell transfusion	•
•				4	

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

	S	1	9	Order Name	Status	Ŧ		Dose	Details	
⊿ Patient Care										
)		\checkmark		Vital Signs	Ordere	ed			28-Nov-2017 10:42 PST, q4h	
4	Blo	od Pr	odu	icts						
			•	Red Blood Cell Transfusion	Ordere	٤d			Routine, Administer: 1 unit, IV, once, Administer each over: 120 - 180 Minutes, Irradiated, Ple Informed consent must be present on patient record	ase call
									Red Blood Cell Transfusion	
									Details: Routine, Administer: 1 unit, IV, once, Administer each over: 120 - 180 Minutes, Irradiated, Please callwhen ready for pick up, 28-Nov-2017 11:04 PST	
									Order Comment: Informed consent must be present on patient record	

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

- 1. A **Nurse Review** icon *deternormal* 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.



	S	🕅 Order Name	Status 👻	Dose Details
⊿	Patien	nt Care		
►	\checkmark	🚺 😚 Vital Signs	Ordered	28-Nov-2017 10:42 PST, q4h
		1		
		-		
۲		m		•
	Details	\$		
	Irders For	r Cosignature Orders For Nurse Review 2		Orders For Signature
_				

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

- Review order details
- Click **Review**

P cs	TLEARNING,	DEMOALPHA - Actions R	lequiring Review					
CST Alle	LEARNIN	NG, DEMOALPHA	DOB:01-Jan-19 Age:80 years Gender:Male	37 MRN:700008214 Code Enc:7000000015055 PHN:9876469856 Dosi	le Status: ing Wt:	Process: Disease: Isolation:	Location:LGH 6E; 62 Enc Type:Inpatient Attending:Plisvca, Ro	1 4: 02 cco, MD
	Action	Action Da Entered	By Order E	letails			Ordering	
	Order	28-Nov-201 Plisvcf, 7 10:42:56 Dillon, M	D Vital Signs 2	3-Nov-2017 10:42 PST, q4h			Plisvcf, Dillon, MD 3	
Sel	ect All	Show All Details					CSTLEARNING, DEMOALPHA	eview 4 Cancel

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





Activity 5.4 – Place a Verbal Order

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

- 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.

Menu	ą	< 🔸 🕘 🚹 Neonate Overvi	iew (D) Full screen	🛛 🗇 Print 🛛 🎝 O minutes ago
Neonate Overview	<u>^</u>	AA		
Interactive View and I&O		Neonate Workflow	72 Deick Orders 12 Prennancy Stimmary 12 Discharge 12 Handoff Tool 12 L	3
MAR			And a second and a second a se	
Orders	Add	Venue: Inpatient 👻		
Results Review				
Documentation	Add	Medications	Orders for Signature (1)	=• (>
Allergies	Add	Analgesic/Sedatives/CNS		
Growth Chart		► Antimicrobials	Medications	
Single Patient Task List		▶ Biologicals	erythromycin 5 mg/g eye oint	
Form Browser	E	CV Drugs Fondecrine Mede		
CareConnect		GI Drugs	A Sign Save Modify Cancel	
Care Coordination		proparacaine 0.5% eve drop		
Clinical Research		erythromycin 5 mg/g eye oint	2	
Diagnoses and Problems		▶ Resp Drugs	-	
Histories		▶ Topicals		
Immunizations		Uncommon Medications		
		► WIT/MIN/Cupplements		



P Ordering Physician	P Ordering Physician 5
● Order● Proposal	 Order Proposal
*Physician name	*Physician name Plisvca, Rocco, MD 6
*Order Date/Time 20-Nov-2017 1332 PST	*Order Date/Time 20-Nov-2017 🔹 💌 1332 🔷 PST
*Communication type	*Communication type
Phone Verbal Proposed No Cosignature Required	Phone Verbal 6 Proposed No Cosignature Required
Cosignature Required Paper/Fax Electronic	Cosignature Required Paper/Fax Electronic
OK Cancel	6 OK Cancel

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

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

< > 🔹 🏦 Orders			Suspend					
	Activate							
🕂 Add 🍕 Document Medication by Hx	+ Add 🎝 Document Medication by Hx Reconciliation - 🔊 Check Interactions							
Orders Medication List Document In Plan	n		Cancel/Discontinue					
			Void					
View	P	Displayed: All Active Orders All Inactive	Reschedule Task Times					
- Document In Plan								
Suggested Plans (0)		🔊 🕅 Order Name	bocument intervention					
Orders		⊿ Admit/Transfer/Discharge	Add/Modify Compliance					
Admit/Transfer/Discharge		Admit to Inpa	Order Information					
		⊿ Status						
Patient Care		🗹 🗈 😚 🗟 Code Status	Comments					
		⊿ Patient Care	Results					
		2 🛦 🗹 🗈 😚 🔹 Pulse Oximetr	Reference Information					
		📕 🗹 🗈 😚 🛛 Weight	Drint					
Continuous Infusions		🗹 🤶 🛛 Encourage Flu	Print					
Medications		Monitor Intak	Advanced Filters					
Blood Products		Vital Signs						
- Z Laboratory	E	🗹 🌋 🛛 Humpty Dum	Customize View					

• Click Orders For Signature

	ø	• 🖏	1	2	Order Name	Status	Dose	Details
⊿	Pa	tient	Care					
		Ð		-	Saline Lock Peripheral IV (Saline Lock IV)	Complete		
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	n .							
	Del	tails						
	rders	s For C	osigna	ature	Orders For Nurse Review			4 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.



Ord	lers for Si	gnature							
	2	1 🖻 🖗	Order Name	Status	Start	Details			
⊿	LGH 6	E; 624; 02 I	Enc:700000015055 Ad	mit: 17-Nov	-2017 13:58 PST				
⊿	Patient	t Care							
		🖶 🌋	Saline Lock Peripheral	- Complete	20-Nov-2017 15:11				
	DO NO CHE	D DT CK							
	▲ Details								
	0 Missing Required Details Orders For Cosignature Orders For Nurse Review Sign								
		2							

- **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*



P Ordering Physician
Order
Proposal
*Physician name
Plisvca, Rocco, MD
*Order Date/Time
28-Nov-2017 🔺 💌 1128 🔺 PST
*Communication type
Phone
Proposed
No Cosignature Required
Cosignature Required
Electronic
4 OK Cancel

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

l line lenne di UU U elune l'Indenni UU Une elune l'Indenni UU U elune l'Indenni.	Cham Mara Galan
Details for Breastfeed with Supplementation	5
Details III Order Comments	
+ 2 lh. IV	
Discontinue Date/Time: +	
Discontinue Reason:	
Orders For Cosignature Orders For Nurse Review	5 Orders For Signature

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

△ LGH 3W; 309; 01B Enc:700000012937 Admit: 31-Oct-2017 15:49 PDT	
△ Diet/Nutrition	
🗌 🤀 🧏 Breastfeed with Suppl Discontin 28-Nov-2017 10:40 28-Nov-2017 10:50 PST	
Do not check this box	
► Details	
O Missing Required Details Orders For Cosignature Orders For Nurse Review 6 Sign	

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





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

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

K	ৰ 👔 🐚 🚫 🛄 Comments Start: 10-Nov-2017 08:33 PST Stop: 27-No	ov-2017 09:15 PST
View		Chatura Dana Dataila
Orders for Signature	Component	Status Dose Details
Plans	PED Newborn Level 2 Admission (Prototype) (Discontinued)	
Desument In Dian	Last updated on: 27-Nov-2017 09:15 PST by: Elearn, Luke Demo-Wong	
= Document in Plan	⊿ Admit/Transfer/Discharge	
Medical	Verify that an 'Admit to' Order has been entered prior to	o completing the powerplan
 PED General Admission (Validate 	A Patient Care	
PED Newborn Level 2 Admissic	Weight	Discontinued 10-Nov-2017 08:33 PST adaily
PED General Admission (Valida	🗍 🌮 🕅 Oximetry - Continuous	Discontinued 10-Nov-2017 08:33 PST
PED General Admission (Valida	Cardiorespiratory Monitoring	Discontinued 10-Nov-2017 08:33 PST
PED General Admission (Validate	∠ Continuous Infusions	
PED Newborn Level 2 Admissio	🔲 🏂 🖟 🍞 Total Fluid Intake Ped/Neo	Discontinued 10-Nov-2017 08:33 PST, Weight (kg): 1.956, Neo
PED Enteral Tube Feeding (Mod	⊿ Medications	
Suggested Dians (0)	🔲 🥫 🕅 vitamin K	Discontinued 1 ma. IM. once. drug form: ini. start: 10-Nov-201

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. nteractive View and I&C 📾 Print 🕹 0 minu ヽ 🗄 💷 🗤 🖌 😒 🛢 🗮 🛤 VICU Quick View Caregiver Rounding Newborn Overview Newborn Vital Signs Equipment Alarm Limits (Low/High) Environment Confront Measures Parental Involvement V Dros Find Item Critical High Low Abnormal Unauth Flag And Or + A Result Comments Elag Date Perfor ₩¥ **2**10 05-Dec-2017 Newborn/Pediatric Feeding NICU Daily Nutrient Totals Urine Output tool Output R der Notification sfer/Transport Report/Handoff /Handon and Point of Care VICU Systems Assessment VICU Lines - Devices - Procedures VICU Procedural Sedation VICU Education - Discharge X Advanced Graphing Intake And Output Slood Product Administration

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.



Menu	ņ	< 🔹 🛉 Interactive View and I&O		(II) Full screen 🛛 🙀
Neonate Overview	<u>^</u>	•• 🖶 🖽 ŵ 🖌 🐼 🖏 🖿 🖬 🏔 ×		
Interactive View and I8	kO	1		
MAR		🔨 NICU Quick View	Last 24 Hours	
		VICU Systems Assessment		
MAR Summary		Newborn Vital Signs	Find Item	
Orders	+ Add	NEUROLOGICAL		
		Seizure Assessment	Liesuit IComments I Hao I Date I Performed By	
Results Review		Newborn Head and Neck	05-Dec-2017	
Documentation	🕂 Add	Musculoskeletal Newborn Assessment	14-08 PST	
		Neonatal Abstinence Scoring System	A Newborn Vital Signs	
Allergies	Add	CARDIOVASCULAR	Temperature Axillary DegO	
Growth Chart		Edema Assessment	Apical Heart Rate bpm	
	-	Pulses	Heart Rate Monitored bpm	
Single Patient Task List	-	RESPIRATORY	Respiratory Rate br/min	
Form Browser		Breath Sounds Assessment	SBP/DBP Cuff mmHg	
		Apnea/Bradycardia Episodes	Cuff Location	
CareConnect		Anway Management	Mean Arterial Pressure, Cuff mmHg	
		Chest lubes	Cerebral Perfusion Pressure, Cuff mmHg	
		CASTDOINTESTINAL	GLU Whole Blood POC Result mmol/L	
Care Coordination		GASTRONYTESTINAL	GLU Whole Blood POC Non-numeric Result	
Clinical Research		Vastrointestinai Tubes	△ Oxygenation	
Chined Research		Castala Assessment	Respiratory Rate br/min	
Diagnoses and Problems		Diaddor Socio / Destuaid Desidual	Measured O2% (FIO2)	
Listarias		INTEGUMENTARY	Oxygen Activity	
HISTORIES	_	Newborn ADI	Oxygen Therapy	
Immunizations		Provider Natification	Oxygen Flow Rate L/min	
Lines (Turkey (During Course			Humidification Temperature DegO	
Lines/Tubes/Drains Sum	mary	VICU Lines - Devices - Procedures	Send Tidal CO2 mmHg	
Medication List	Add	VICU Procedural Sedation	Sp02 %	
Madiantian Demonst		VICU Education - Discharge	Sp02 Site	
Medication Request		Advanced Graphing	SpO2 Site Change	
Newborn Liaison		a Vintaka And Output	Near intrared Spectroscopy, Cerebral	
		A make And Output	Near Intrared Spectroscopy, Body 74	
INEWDOINT RECOID		Blood Product Administration	wear infrared Spectroscopy, Other /	

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
 - \circ **SBP/DBP Cuff** = 65/35
 - Mean Arterial Pressure, Cuff = (double-click the empty cell for automated result)

Note: The **Calculation** icon local 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 🖌



< 🔹 🔹 👫 Interactive View and I&	0			
**• 🖿 💷 🛠 🖌 🧧 🖬 🖿 🎘 🛪				
X Activity View		•		Last 2
VICU Quick View				
Caregiver Rounding		Find Item 👻 🔲 Critical	🔳 High 🛛	Low A
Newborn Overview				
Newborn Vital Signs		1 m m		28-Nov-2017
Equipment Alarm Limits (Low/High)	Ξ			0 10:57 PS
Environment		Capillary Refill Central	_	
Comfort Measures		⊿ Newborn Vital Signs	Deed	∠ ⊻
V Drine		I emperature Axillary	Degu	37.2
Newhom /Pediatric Feeding		Apical Heart Rate	bpn	
NICLI Daily Nutrient Totals		Perpiraton/Pate	br/mir	
Urine Output	-	SBP/DBP Cuff	mmHe	65/35
NICLI Systems Assessment		Cuff Location		05,55
		📾 Mean Arterial Pressure, Cuff	mmHe	45
NICO Lilles - Devices - Procedules		Cerebral Perfusion Pressure, Cuff	mmHg	
NICU Procedural Sedation		GLU Whole Blood POC Result	mmol/	
VICU Education - Discharge		GLU Whole Blood POC Non-numeric	Result	
🗙 Advanced Graphing		⊿ Oxygenation		
🗙 Intake And Output		Respiratory Rate	br/mir	44
S Blood Product Administration		Measured O2% (FIO2)		3
Nordan Houddon Ianimiou autom		Oxygen Therapy		

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.



- 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 im.
- 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.

Menu	ą	< 🔹 🗧 🔒 Interactive View and I&O		
Neonate Overview	<u>^</u>	🏎 🚍 💷 🎶 🖌 🚫 🦉 🛄 📰 🎘 🛪		
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MAR		VICU Quick View		Last 24 Hours
		XICU Systems Assessment		
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		Edema Assessment	Temperature Axillary Deg	
Growth Chart		Pulses	Apical Heart Rate bpm	
Single Patient Task List	E	RESPIRATORY	Realt Rate Monitored bpm	
		Breath Sounds Assessment	SBP/DBP Cuff mmHa	
Form Browser		Apnea/Bradycardia Episodes	Cuff Location	
CareConnect		Airway Management	Mean Arterial Pressure, Cuff mmHg	
		Chest Tubes	Cerebral Perfusion Pressure, Cuff mmHg	
		Umbilicus Assessment	GLU Whole Blood POC Result mmol/L	
Care Coordination		GASTRUINTESTINAL Gastraistastinal Tubas	GLU Whole Blood POC Non-numeric Result	
		Gastrointestinal Tubes	△ Oxygenation	

In the new column, enter Temperature Axillary = 37.1 and click the Green Checkmark icon
 ✓ to sign

Menu	ť		< 🔹 🛉 Interactive View and I&O								
Neonate Overview	-	1	™ 🚍 💷 @ 🖌 🔗 📓 📰 📰 🌆 😣 ×								
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Orders	🕂 Add		NEUROLOGICAL					10.1			0 (10
	_		Seizure Assessment	_	Result	Comments		a Da	te		Performed by
Results Review			Newborn Head and Neck		5. 88				05-De	c-2017	
Documentation	🕂 Add		Musculoskeletal Newborn Assessment		🗮 🗟 🗗		8 14	15 PST 1	4:14 PST	14:12 PST	14:11 PST
			Neonatal Abstinence Scoring System	_	⊿ Newborn Vital Signs		F	7			
Allergies	Add	11.8	CARDIOVASCULAR		Temperature Axillary	Deg	37.5	↑ In	Error	In Error	37.1
Growth Chart			Edema Assessment		Apical Heart Rate	bpr	n				
			Fulses	_	Heart Rate Monitored	bpr	n				
Single Patient Task List			RESPIRATORY	Ξ	Respiratory Rate	br/mi	n				
Form Browser			Breath Sounds Assessment		SBP/DBP Cuff	mmH	g				
			Aprica / Bradycardia Episodes		Cuff Location						
CareConnect			Airway Managemeni. Chost Tubos		Mean Arterial Pressure, Cuff	mmH	g				
			Limbilious Assassment		Cerebral Perfusion Pressure,	Cuff mmH	g				
			GASTROINTESTINAI		GLU Whole Blood POC Resul	lt mmol/	L				
Care Coordination			Control Tolar		GLU Whole Blood POC Non-	numeric Result					

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

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.

Menu P	< 🔹 🔹 🛉 Interactive View and I&O	
Neonate Overview	•• 🖃 💷 ŵ 🖌 🕺 🦉 📑 🖿 🎘 ×	
Interactive View and I&O		
MAR	WICU Quick View	Last 24 Hours
MAR Summary	NICU Systems Assessment	Find Item Critical High Low Abnormal Unauth Flag
Orders 🕂 Add	Peripheral IV	Result Comments Rag Date Performed By
Results Review	Arterial Line	05 Dec 2017
Documentation 🛛 🕂 Add	Chest Tubes	
Allergies 🕂 Add	V Warming/Cooling Preprocedure Time-Out	⊿ Peripheral IV
Growth Chart		2
Single Patient Task List	N	
Form Browser	100	
CareConnect		
Care Coordination		
Clinical Research		
Diagnoses and Problems		

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



📲 CareCompass 📲 Clinical Leader (Organizer Tracking Shell 🛔 Patient List 🦻 Acti	ivity Assignment 🛔	🕻 Staff Assignment 📲 LearningLIVE 📮 🗄 😋 CareConnect 😋 PHSA PACS 😋 VCH	and PHC PA
🖾 Tear Off 📲 Exit 🎽 AdHoc 🎟 🕅	Addication Administration 📋 Medical Record Rec	quest 🖏 Result C	Dynamic Group - CSTI FARNPEDS ALEX - 700007827	nversation
🔇 Patient Health Education Materials	s 🔇 Policies and Guidelines 🔇 UpToDate 🝦			
CSTLEARNPEDS, ALEX 🛛 🛛			Label:	
CSTLEARNPEDS, ALEX	DOB:30-Oct-2010	MRN:7000078:	Peripheral Hand Left < Peripheral IV Catheter Size:>	Risk
Allergies: penicillin	Age:7 years Gender:Male	Enc:700000001 PHN:98764932	Peripheral IV Catheter Type:	plet and
Menu 🗜	< 🔹 🔹 者 Interactive View and I8	kO	Peripheral	
Neonate Overview 🔶	*** 🔜 🕶 🐼 🖌 🐼 🍇 🖿 🖬 🍋 🗶		Midline	
Interactive View and I&O				
MAR	VICU QUICK View			ours
MAR Summary	VICU Lines - Devices - Procedures		Peripheral IV Site:	h 📃 Fla
Orders 🕂 Add	Peripheral IV		Antecubital Basilic vein	Perfo
Results Review	Central Line Arterial Line		Cephalic vein	
Documentation 🕂 Add	Chest Tubes		Chest Digit	
Allergies 🕂 Add	Warming/Cooling Preprocedure Time-Out		External jugular	
Growth Chart			Foot Forearm	
Single Patient Task List 🗧			Frontal vein	
Form Browser			Hand	
CareConnect			Median cubital vein Botterior auricular vein	
			Small saphenous vein	
Care Coordination			Superficial temporal vein	
Clinical Research			Wrist	
Diagnoses and Problems				
Histories			Peripheral IV Laterality:	
Immunizations			Left	
Lines/Tubes/Drains Summary				
Medication List 🛛 🕂 Add	VICU Procedural Sedation			1
Medication Request	VICU Education - Discharge			
Newborn Liaison	Auvariced Graphing			

- 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.



< 🔹 📩 🛉 Interactive View and I&O		
*** 🖃 🖬 🗤 🖌 🖊 7 🖏 🖿 🖬 🎘 🛪		
Activity View NICU Quick View NICU Systems Assessment NICU Linea Decise Decedures	Find Item - Critical High	Last 24
Perpheral IV Central Line Arterial Line Chest Tubes Warming/Cooling Preprocedure Time-Out	 ✓ Peripheral IV ✓ Peripheral Hand Left 26 gauge> ✓ Activity ◇ Patient Identified ◇ Total Number of Attempts ◇ Unsuccessful Attempt Site ◇ Line Insertion Line Status Line Care 	28-Nov-2017 11:06 PST Insert Identificati 1 ◇ Tourniquet Flushes easily Secured wit
VICU Procedural Sedation	Site Care	Armboard,
Advanced Graphing	Dressing Condition 6 Patient Response	Dry, Intact

Note: A trigger icon \bigotimes 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 \bigotimes 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**.

⊿ Peripheral IV	
⊿ Peripheral Forearm Left 20 gauge	
Activity	Expand
Line Status	Collapse
Line Care	Close
Site Assessment	Close
Site Care	Remove
Dressing Activity	View Result Details
Dressing Condition	A still ust a
Patient Response	Activate
	Inactivate 1
	Unchart

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

Modify

1

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....

VICU Quick View VICU Systems Assessment Viewborn Vial Signs NEUROLOGICAL Seizure Assessment	Find Item Critical High Low Abnormal Result Comments Flag Date	View Result Details View Comments View Flag Comments View Reference Material
Newborn Head and Neck Musculoskeletal Newborn Assessment Neonatal Abstinence Scoring System	भिर्भे दिवित कि	View Order Info View History
Edema Assessment Pulses RESPINITORY	Temperature Axillary DegC Apical Heart Rate bpm 160 Heart Rate Monitored bpm 2	Modify 3 Uncnart
Breath Sounds Assessment Apnea/Bradycardia Episodes Airway Management	SBP/DBP Cuff mmHg Cuff Location Mean Arterial Pressure, Cuff mmHg	Add Comment Duplicate Results
Crest Tubes Umbilicus Assessment GASTROINTESTINAL	Cerebral Perfusion Pressure, Cuff mmHg GLU Whole Blood POC Result mmol/L GLU Whole Blood POC Non-numeric Result	Clear View Defaulted Info
Gastrointestinal Lubes Newbom/Pediatric Feeding		View Calculation

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

Interactive View and I&O					
MAR	🗙 NICU Quick View				Las
MAR Summary	VICU Systems Assessment		Find Item	High Lov	Abnormal
Orders 🕂 Add	NEUROLOGICAL Seizure Assessment		Result	Comments	Flag Date
Results Review	Newborn Head and Neck		M IL 33		
Documentation + Add	Musculoskeletal Newborn Assessment Neonatal Abstinence Scoring System		A Newborn Vital Signs	'ଶି :	14:28 PST 14:25 PST
Allergies 🕂 Add	CARDIOVASCULAR		Temperature Axillary	DegC	
Growth Chart	Edema Assessment Pulses		Apical Heart Rate	bpm	155 🛧
Single Patient Task List 🗧	RESPIRATORY	E	Respiratory Rate	bpm br/min	
Form Browser	Breath Sounds Assessment Apnea/Bradycardia Episodes		SBP/DBP Cuff	mmHg	
CareConnect	Airway Management Chest Tubes		Mean Arterial Pressure, Cuff	mmHg mmHg	
Care Coordination	Umbilicus Assessment GASTROINTESTINAL		GLU Whole Blood POC Result GLU Whole Blood POC Non-numeri	mmol/L ic Result	

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...

🗙 NICU Quick View	Last 24 Hour	View Result Details
VICU Systems Assessment		View Comments
Newborn Vital Signs	Find Item Critical High Low Abnormal Unauth	
NEUROLOGICAL		View Flag Comments
Seizure Assessment	Result Comments Had Date	View Reference Material
Newborn Head and Neck	5-D	View Order Info
Musculoskeletal Newborn Assessment	📆 📸 👘 14:29 PST 14:25 PST 14:15 PST	
Neonatal Abstinence Scoring System	△ Newborn Vital Signs	View History
CARDIOVASCULAR	Temperature Axillary DegC 37.2	Mardife
Edema Assessment	Apical Heart Rate bpm 155 A	Wodiry
Pulses	Heart Rate Monitored bpm	Unchart
RESPIRATORY	E Respiratory Rate br/min	Change Date/Time
Breath Sounds Assessment	SBP/DBP Cuff mmHg	Add Commont
Apnea/Bradycardia Episodes	Cuff Location	Add Comment
Airway Management	Mean Arterial Pressure, Cuff mmHg	Duplicate Results
	Cerebral Perfusion Pressure, Cuff mmHg	Clear
	GLU Whole Blood POC Result mmol/L	
GASTROINTESTINAL	CIULAR- La Diac d'OCC Mare aumania Danult	VC D.C. H. LT.C.

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

P Uncha	art - CSTLEARNPEDS, ALE>	(- 700007827				
Unchart	Date/Time	Item	Result	Reason	Comment	
$\overline{\mathbf{A}}$	05-Dec-2017 14:15 PST	Temperature Axillary	37.2 DegC	Charted on Incorrect Patier		
		\mathbb{R}				
Reason						
Charted	on Incorrect Patient		3			
					4 Sig	n Cancel

• You will see In Error displayed in the uncharted cell. The Result Comment or

Annotation icon will also appear in the cell.

VICU Quick View					La	ast 24 Hours	5		
VICU Systems Assessment									
 Newborn Vital Signs 	•	. Find Item 👻 🔲 Critical	🔲 High 🛛 🔳	Low 🔲 Ab	normal	Unauth	📃 Flag		🔘 And 🛛 🔘
NEUROLOGICAL									
Seizure Assessment		LResult	Comments	Flag L	late		Performed	V.	
Newborn Head and Neck		X. 98				05-De	c-2017		
Musculoskeletal Newborn Assessment		🗮 Ž ҧ	36	8 14:31 PST	14:25 PST	14:15 PST	14:14 PST	14:12 PST	14:11 PST
Neonatal Abstinence Scoring System		A Newborn Vital Signs	~						
CARDIOVASCULAR		Temperature Axillary	DegC			In Error	In Error	In Error	37.1
Edema Assessment		Apical Heart Bate	bpm		155	in choi	in circl		5712
Pulses		Heart Bate Monitored	bpm		133 14		-		
RESPIRATORY	Ξ	Respiratory Rate	br/min						
Breath Sounds Assessment		SBP/DBP Cuff	mmHa						
Apnea/Bradycardia Episodes		Cuff Location							
Airway Management		Mean Arterial Pressure, Cuff	mmHa						
Chest Tubes		Cerebral Perfusion Pressure, Cuff	mmHg						
Umbilicus Assessment		GLU Whole Blood POC Result	mmol/L						
GASTROINTESTINAL		GLU Whole Blood POC Non-numeric	Result						
Gastrointestinal Tubes						1	1		



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.

Menu [‡]	< 👻 🝷 🚔 Interactive View and I&O	
Neonate Overview	•• = = = ↔ ✓ ⊗ 🔅 🖿 = fa ×	A del Darrolle
Interactive View and I&O		Add Result
MAR	🔨 NICU Quick View	View Result Details
	VICU Systems Assessment	View Comments
MAR Summary	Newborn Vital Signs Find Item Critical High Low	view comments
Orders 🕂 Add	NEUROLOGICAL	View Flag Comments
	Seizure Assessment	View Reference Material
Results Review	Newborn Head and Neck	View Order Info
Documentation 🛛 🕂 Add	Musculoskeletal Newborn Assessment 🕅 🙀 🚮 🗗	View History
Allergies 📥 Add	CARDIOVASCIII AR Oxygen Therapy	incorringing and a second seco
	Edma Assessment Oxygen Flow Rate	Modify
Growth Chart	Pulses	Unchart
Single Patient Task List	RESPIRATORY E Sn02	Change Date/Time
E	Breath Sounds Assessment Sp02 Site Band	change bate/ nine
Form browser	Apnea/Bradycardia Episodes SpO2 Site Change	Add Comment 2
CareConnect	Anway Management Near Infrared Spectroscopy, Cerebral %	Duplicate Results
	Unest Tubes Near Infrared Spectroscopy, Body %	Clear
	GASTROINESTINAI	
Care Coordination	Gastrointestinal Tubes	View Defaulted Info
Clinical Research	Newbom/Pediatric Feeding	View Calculation
Diagnoses and Problems	Genitalia Assessment Muscle Lise Location	Recalculate
	Bladder Scan/Postvoid Residual Tone Newborn	View Interpretation
Histories	INTEGLIMENTARY	viewinterpretation

- 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.)

🗙 NICU Quick View	∢ Last 24 Hour
🗙 NICU Systems Assessment	
🖌 Newborn Vital Signs 🔺	Find Item Critical High Low Abnormal Unauth
NEUROLOGICAL	
Seizure Assessment	Result Comments Hag Date
Newborn Head and Neck	X 969
Musculoskeletal Newborn Assessment	14:32 PST 14:32 PST 14:25 PST
Neonatal Abstinence Scoring System	Oxygen Therapy
CARDIOVASCULAR	Oxygen Flow Rate L/min
Edema Assessment	Humidification Temperature DegC
Pulses	End Tidal CO2 mmHg
RESPIRATORY	SpO2 %
Breath Sounds Assessment	SpO2 Site Hand
Apnea/Bradycardia Episodes	SpO2 Site Change
Airway Management	Near Infrared Spectroscopy, Cerebral %
Chest Tubes	Near Infrared Spectroscopy, Body %
	Near Infrared Spectroscopy, Other %
GASTRUINTESTINAL	
Gastrointestinal Tubes	Indrawing Location

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.

P Admission History Adult CSTLE	ARNING, DEMODELTA				- • ×
🗸 🖬 🚫 🧏 🗖 🕈 🔶 💷					
*Performed on: 27-Nov-2017	▼ 1422 ● PST				By: TestUser, Nurse
General Information	Violonco and Aggrossi	on Scrooning			*
Barriers to Communication	violence and Aggressi	on screening			
Nolence and Aggression Screening	Violence and Aggression Screening	Additional Information			
Review Violence Risk Alert	No risk assessed at this time				
* Advance Care Planning	Previous history of violent behaviour				E
3 Delirium Screen	Current physical aggression or violence Current verbal threats of physical violence				
CSSRS Quick Screen	Other:				
CAGE-AID Assessment	4	L			
Nicotine Dependence Assessment	If patient has a previous history of or curr	ent indication of violence	or aggression, complete the remainder of the	form as applicable.	
Psychosocial					
Nutrition	Current Patient Presentation		Current Presentation Additional Informat	ion	
Social History	Attack on object				
Procedure History	Instrument of harm/weapon				
Family History	Physical threat				
	Unwanted sexual touch				
	Verbal aggression with another behaviour or history Verbal or written threat of physical violence	of violence			
	Dther:				
2					
	Perceived Staff Approach Stressors		Perceived Staff Stressors Additional Info	rmation	
	Enforcing or authoritative				
	Denial or delay of request, action or item				
	Rushed or fast pace				
	Sudden or unanticipated approach Task focus				
	Unwelcome touch				-

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	AdHoc 🕈	on the Toolbar		
The inspectory	unande de Regner				

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 \checkmark 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** \blacksquare 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 \checkmark .

P Admission Histo	ory NICU - CSTLEARNPEDS, SKYE		
🖌 🖬 🛇 🕱 I	🌠 🛧 🔸 📾 🖼 🖹		
*Performed on: 2	28-Nov-2017 🚔 💌 1117 🚔 PST		
General Info	Admission/Transfer	Information	
Interpreter Service		1	1
Birth History	Location of Birth	Reason for Transfer	Hospital Transferred From
Medication Histor	O Hospital	O High level of care required	
Problem History	O Home	O Growth or discharge planning	
Family History	O Uther:	Medical or diagnostic services Surgical anastomosis	
Social History		O Other:	Infant Referred By
Procedure History			
Allergies			
	Admit Date/Time to NICU	Admit Length	Admit Weight
	XX_XXX_XXXX	cm	kg
		Admit Head Circumference	Dosing Weight
		cm	kg
	General Information	1 <u> </u>	
	Security Tag ID Band Numb	er ID Band Recipient #. to Baby	1 Relationship Name of ID Band Recipient #1
	□ N/A	O Biological father O	Grandmother







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 I 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)

1



Activity 7.3 – Modify an existing PowerForm

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

P All Forms		
Tuesday. 28-November-2017 PST		
	View NICU	-N
	Modify	
	Unchart	
	History	
	Change Date/Time	

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

All Forms	View Modify Unchart History Change Date/Time	e NICU-N

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

P Advance Care Planning (Unchart) - CSTLEARNING, DEMOALPHA
*Performed on: 21-Nov-2017 T IS29 PST By: TestORD, Nurse
Uncharting this form will change the status of all the results associated with this form to 'In Error'
Comment: 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

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**.

Menu	ņ		< 🔹 🕇 Allergies												[0] Full screen	Print
Neonate Overview	-															
Interactive View and I&O		Ι.	Mark All as Reviewed													
MAR			🕈 Add 🔄 Modify 📿 No Known Allerg	ies 🛛 🖓 N	o Known Me	dication Allergies	🔗 Reverse	Allergy Check	k Disp	play All	•					
MAR Summary			1													
Orders	+ Add	Ш	D. Subs	Category	Severity	Reactions	Interaction	Comments	Source	Reaction Status	Reviewed	Revi	Est. Onset	Updated By		
Parulte Paviau		Ľ	Adhesive Bandage	Other	Mild	Rash				Canceled	27 Nov 2017 0	Elear		27 Nov 2		
Nesults Neview		L	Latex	Other	Severe	Anaphylaxis				Canceled	27 Nov 2017 0	Elear		27 Nov 2		
Documentation	+ Add	L	No Known Allergies	Drug						Canceled	02 Nov 2017 0	Elear		27 Nov 2		
Allergies	🕂 Add	L	✓ penicillin	Drug	Moderate	Rash				Active	27-Nov-2017 0	Elear		27-Nov-2		
Growth Chart		L														
Single Patient Task List	E	L														
Form Browser																
CareConnect		l														
Care Coordination		L														
Clinical Research		L														
Diagnoses and Problems																
Histories																
Immunizations																
1:																

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.

Menu P	< >										[0] Full screen	🖨 Print	€1 minutes ago
Neonate Overview 🔶													
Interactive View and I&O	D. Substance	Category Severity	Reactions Inte	raction Comments	Source Re	eaction Status	Reviewed	Revi	Est. Onset	Updated By			^
MAR		Other Mild	Rash		6	anceled	27 Nov 2017 0	Elear		27 Nov 2			
MAR Summary	latex	Other Severe	Anaphylaxis		c	anceled	27 Nov 2017 0	Elear		27 Nov 2			Ŧ
Orders 🕂 Add	Terr												
Results Review	Type Allergy	e reaction to a drug or subst	ance which is due to an imm	unological response.									
Documentation 🕂 Add	*Substance												
Allergies 🕂 Add	tape 🛤 🛛 Fre 🙎											A	dd Comment
Growth Chart	Heaction(s):	*Severity	Infolia										
Single Patient Task List 🗧	Add Free Text	<not entered=""></not>	<not entered=""></not>	Comments									
Form Browser		At: <not entered=""></not>	Onset: <not entered=""></not>										~
CareConnect		Years 🔻	H . ROG . ROOM										÷
Care Coordination		Recorded on behalf of	*Category	Status	Reason:								
Clinical Research		<u>_</u>		Active	•	*							
Diagnoses and Problems										0	K OK &	Add New	Cancel
Histories													

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



37	MRN.70	0008216	Code Status.		Process.	
	Enc:7000	000015058			Disease:	
	PHN:987	6469824	Dosina Wt:		Isolation:	
		Substance Set	earch			×
		*Search: tag	e	Starts with	▼ Within: Terminology	
		Search.	-		VII.1111.	Review
			Search by Name		Search by Code	20-No
		Terminology:	Allergy, Multum Alle	Terminology A	Axis: <a>All terminology ax	
		Categories				
		Term 🔺			Terminology	
_		<no matching<="" td=""><td>categories found></td><td></td><td></td><td>-1</td></no>	categories found>			-1
An	adverse reaction					
ree tev		Tem A	Code	Terminology	Terminology Avis	
00 (0/		Таре	14598838	Allergy	Alleray	
	*Severit	tapentadol	d07453	Multum Drug	Generic Name	
ee Te	t <not ent<="" td=""><td></td><td></td><td></td><td></td><td></td></not>					
	∆t <n< td=""><td></td><td></td><td></td><td></td><td></td></n<>					
	Recorded					
		Add to Favo	rites	_	OK Cance	
	🔹 🚞 Folde			_		
ites						
ites						

- 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

Type Allergy An adverse reaction to a drug or substance which is due to an immunological response. "Substance Tape Image: Tape Image:								
Reaction(s): Add Free Test	Mid At <not entere<br="">Years •</not>	Info source Nurse Onset: <not ente<br="">source source so</not>	Comments			A 		
	Recorded on behalf of	Category Other 6	Status Active 🗸	Reson:	7 OK & Add	New Cancel		

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.



CSTLEARNPEDS, ALEX 🛛 🛛					← List → 🌾 Recent + Name 🛛 → 🔍
CSTLEARNPEDS, ALEX					Location:zzLGH 3PO; 3EL; 04
Allergies: penicillin, Tape	Age:7 years Gender:Male	Enc:700000012932 PHN:9876493288 Dos	osing Wt:25 kg	Disease: Isolation:Droplet and Contact	Enc Type:Inpatient Attending:
Manu	< 🖂 🔹 🛧 Allergies	N			🖽 Full screen 🛛 📾 Print 🛛 🎝 0 minutes ago
Neonate Overview		~			
Interactive View and I&O	Mark All as Reviewed				
MAR	🛉 Add 🛛 Modify 💭 No Known Allerg	gies 🛛 🖓 No Known Medication A	Allergies Reverse Allergy Check Displa	ay All 👻	
MAR Summary					
Orders 🕂 Add	D. Substance	Category Severity Reaction	ons Interaction Comments Source	Reaction Status Reviewed Revi Est. Onset	Updated By
Desults Destinut	Adhesive Bandage	Other Mild Rash		Canceled 27 Nov 2017 0 Elear	
Results Review	Latex	Other Severe Anaphy	rylaxis	Canceled 27 Nov 2017 0 Elear	- 27 Nov 2
Documentation 📫 Add		Drug		Canceled 02 Nov 2017 0 Elear	27 Nov 2
Allergies 🕂 Add	✓ penicillin	Drug Moderate Rash		Active 27-Nov-2017 0 Elear	27-Nov-2
Comp Charl	Tape	Other Mild	Nurse	Active 05-Dec-2017 1 Test	05-Dec-20

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

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

1

- 2. Click MAR
- 3. Locate Time View and Scheduled

Menu 1	≺ > - A MAR	
Neonate Overview 🔶	*********	
Interactive View and I&O		
MAR 2	All Medications (System)	1ber-2017 00
Orders 🕂 Add	☑ Show All Rate Change Docu Medications 28-Nov-2017 28 12:00 PST 1	-Nov-2017 11:33 PST
Results Review 😑	Time View Scheduled	
Documentation 🕂 Add	Scheduled	400 unit previously
Allergies 🕂 Add	Unscheduled 400 unit, PO, qdaily, start: 28-Nov-2017 11:33 give	in
Growth Chart	✓ PRN vitamin D3	
Single Patient Task List	Continuous Infusions E Vitamin K 1 mg Vitamin K	
Form Browser	Future Ing, IM, once, drug form: inj, start: given 28-Nov-2017 12:00 PST, stop: 28-Nov-2017	
CareConnect	Discontinued Scheduled	
	Discontinued Unscheduled	
Care Coordination	Discontinued PRN	

- 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



 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



*i 60° 🗎				
All Active Medications (System	n) 🔻 🛄 🔹 🕨			Tue
Show All Rate Change Docu	Medications	23-Nov-2017 14:00 PST	23-Nov-2017 10:00 PST	23-Nov-2017 06:00 PST
Time View	Scheduled			
Scheduled	acetaminophen 650 mg PO, g4b, drug form: tab, start:	650 mg Last given: 20-Nov-2017	650 mg Last given: 20-Nov-2017	650 mg Last given: 20-Nov-2017
PRN	20-Nov-2017 14:04 PST Maximum acetaminophen 4 g/24 r	0rder Info	14-08 PST	14:08 PST
Continuous Infusions	acetaminophen Temperature Axillary	Event/Task Summ	nary	
🔽 Future	Temperature Oral	Link Info		
Discontinued Scheduled	Numeric Pain Score (0-10)	Reference Manua	al	
Discontinued Unscheduled	cefTRIAXone	Med Request		
Discontinued PRN	1,000 mg, IV, q12h, start: 20-Nov-2 14:18 PST	Reschedule Adm	in Times	
	cefTRIAXone	Additional Dose		
Discontinued Continuous Infus	HYDROmorphone	View MAR Note		3 mg : given:
	3 mg, NG-tube, q4h, start: 20-Nov- 15:54 PST	Create Admin No	ote	Nov-2017 7 PST
	HYDROmorphone	Alert History		
	Respiratory Rate	Infusion Billing		_

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

- Image: Image:
- 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.

All Orders with Active Tasks in	Tir 🔻 📖 < 🔸			Tuesday, 28-N	ovember-2017	12:21 PST - Thu	rsday, 30-Nover	nber-2017 12:2	1 PST (Clinical F	lange)			7	7
Show All Rate Change Docu	Medications	30-Nov-2017 10:00 PST	30-Nov-2017 06:00 PST	30-Nov-2017 02:00 PST	29-Nov-2017 22:00 PST	29-Nov-2017 18:00 PST	29-Nov-2017 14:00 PST	29-Nov-2017 12:26 PST	29-Nov-2017 12:22 PST	29-Nov-2017 10:00 PST	28-Nov-2017 22:00 PST	8		
Time View	Scheduled											_		
Scheduled	acetaminophen (TYLENOL)	640 mg Last given:												
Unscheduled	640 mg, PO, q4h, drug form: oral liq, start: 29-Nov-2017 14:00 PST	22-Nov-2017 12:41 PST												
PRN PRN	Maximum acetaminophen 4 g/24 h from all sources													
Continuous Infusions	acetaminophen Temperature Axillary													
V Future	Temperature Oral													
Discontinued Scheduled	Numeric Pain Score (0-10)	4.000			1.000				1.000					
Discontinued Unscheduled	vancomycin	Last given:			Last given:				Last given:					
Discontinued PRN	1,000 mg, IV, q12h, start: 29-Nov-2017 12:22 PST	10:00 PST			10:00 PST				10:00 PST					
e obcontantaca r tat	vancomycin													
Discontinued Continuous Infus	PRN													
	PRM HYDROmorphone (DILAUDID PRN range dose) dose range: 0.5 to 1 mg, PO, q1h, PRN pain, drug form: oral lig start: 29-Nov-2017 12:24 PST	e L						1 mg Not previously given						
	HYDROmorphone													
	Respiratory Rate		1											
	Continuous Infusions							D 47						
	order rate: 75 mL/h, IV, drug form: bag, start: 29-Nov-2017 12:23 PST bag volume (mL: 1.000							Not previously given						
	Administration Information							0						
	sodium chloride 0.9%							9						

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...

		C	Order Info Event/Task Summary Link Info Reference Manual Med Request Reschedule Admin Times Additional Dose View MAR Note Create Admin Note	nber-2017 (8-Nov-2017 11:33 PST 400 unit t previously en
Ξ	PST vitamin D3 vitamin K		Create Admin Note Alert History Infusion Billing	
	1 mg, 1M, once, drug 28-Nov-2017 12:00 PS 12:00 PST vitamin K	Torm: T, sto	p: 28-Nov-2017	

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



P Medication Request	P Medication Request
CSTLEARNING, DE 80 years M DOB: 01-Jan-1937	CSTLEARNING, DE 80 years M DOB: 01-Jan-1937
vancomycin 1,000 mg, IV, q12h, start: 21-Nov-2017 11:09 PST	vancomycin 1,000 mg, IV, q12h, start: 21-Nov-2017 11:09 PST
Last request: View History *Reason: (None) (None) (IIIII Med scanning - barcode damaged IIIIII Med scanning - med not identified IIIIII Med scanning - task not found ADC is out of stock Cannot locate 2 Change in scheduled times of order Contaminated Damaged IV medication - different concentration IV medication - different tolluent IV medication - different volume Medication extra dose required Pass medication	Last request: View History * Reason: Cannot locate * Priority @ Low @ Medium @ High *Comment
Patient's own med - sending to pharmacy Patient's own med - supply not available Provide oral medication as solid form	Submit Cancel

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**.

Tips for using the barcode scanner:

1

- 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.

P Medication Administration			
CSTLEARNPEDS, SKYE Female	MRN: 700007829 FIN#: 700000012937	DOB: 31-Oct-2017 Age: 5 weeks	Loc: 309; 01B ** No Known Allergies **
	Please scan Alternatively, select the patient	the patient's wristband. profile manually by clicking the (Next) button.	
Ready to Scan		1 of 2	Next

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

P Medication Administration			
		Nurse Review	Last Refresh at 15:08 PST
CSTLEARNPEDS, SKYE	MRN: 700007829 DOB: 31- FIN#: 700000012937 Age: 5 w	·Oct-2017 eeks	Loc: 309; 01B ** No Known Allergies **
	05-Dec-2017 13:53 PST - 05-	Dec-2017 16:23 PST	
Scheduled	Mnemonic	Details	R
🗖 🛱 🗃 28-Nov-2017 11:33 PST	cholecalciferol cholecalciferol (vitamin D3)	400 unit, PO, start: 28-Nov-2017 11:33 PST	
🗖 📆 🗑 29-Nov-2017 08:00 PST	cholecalciferol cholecalciferol (vitamin D3)	400 unit, PO, start: 29-Nov-2017 08:00 PST	
🗖 🛍 🗑 30-Nov-2017 08:00 PST	cholecalciferol cholecalciferol (vitamin D3)	400 unit, PO, start: 30-Nov-2017 08:00 PST	
🗖 🐮 🗑 01-Dec-2017 08:00 PST	cholecalciferol cholecalciferol (vitamin D3)	400 unit, PO, start: 01-Dec-2017 08:00 PST	
🗖 🐮 🗑 02-Dec-2017 08:00 PST	cholecalciferol cholecalciferol (vitamin D3)	400 unit, PO, start: 02-Dec-2017 08:00 PST	
🗖 🐮 🗑 03-Dec-2017 08:00 PST	cholecalciferol cholecalciferol (vitamin D3)	400 unit, PO, start: 03-Dec-2017 08:00 PST	
🔲 🐮 🗑 04-Dec-2017 08:00 PST	cholecalciferol cholecalciferol (vitamin D3)	400 unit, PO, start: 04-Dec-2017 08:00 PST	
🗖 🛱 🗃 05-Dec-2017 08:00 PST	cholecalciferol cholecalciferol (vitamin D3)	400 unit, PO, start: 05-Dec-2017 08:00 PST	
Continuous	Sodium Chloride 0.9% sodium chloride 0.9% (NS) continuous infusion 250 m	order rate: 5 mL/h, IV, start: 28-Nov-2017 13 N	3:15 PST, bag volume (mL): 250
•	III		Þ
Ready to Scan	2 of 2		Back Sign



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.

P Medication Administration				
Real Provide American Science (Science Provide American Science Provide			Nurse Review	Last Refresh at 15:16 PST
CSTLEARNPEDS, SKYE	MRN: 700007829 FIN#: 70000001293	DOB: 31-Oct-2017 37 Age: 5 weeks		Loc: 309; 01B ** No Known Allergies **
	05-Dec-201	17 14:01 PST - 05-Dec-2017 16:	31 PST	
Scheduled	Mnemonic	Details	Result	
🗹 🖌 🗑 28-Nov-2017 11:33 PST	cholecalciferol 4 cholecalciferol (vitami	00 unit, PO, start: 28-Nov-20	17 11:33 cholecalciferol 400 un	it, PO
🔲 🛱 🗃 29-Nov-2017 08:00 PST	cholecalciferol 4 cholecalciferol (vitamin	00 unit, PO, start: 29-Nov-2017	08:00 PST	
🗖 🛍 词 30-Nov-2017 08:00 PST	cholecalciferol 4 cholecalciferol (vitamin	00 unit, PO, start: 30-Nov-2017	08:00 PST	
🗖 🛱 词 01-Dec-2017 08:00 PST	cholecalciferol 4 cholecalciferol (vitamin	00 unit, PO, start: 01-Dec-2017	08:00 PST	
🔲 🛍 词 02-Dec-2017 08:00 PST	cholecalciferol 4 cholecalciferol (vitamin	00 unit, PO, start: 02-Dec-2017	08:00 PST	
🔲 🐮 🐄 03-Dec-2017 08:00 PST	cholecalciferol 4 cholecalciferol (vitamin	00 unit, PO, start: 03-Dec-2017	08:00 PST	
🔲 🛍 词 04-Dec-2017 08:00 PST	cholecalciferol 4 cholecalciferol (vitamin	00 unit, PO, start: 04-Dec-2017	08:00 PST	
🔲 🛱 🗑 05-Dec-2017 08:00 PST	cholecalciferol 4 cholecalciferol (vitamin	00 unit, PO, start: 05-Dec-2017	08:00 PST	
16:00 PST	gentamicin 9	.75 mg, IV, once, drug form: in	j, start: 0	
Continuous	Sodium Chloride 0.9% o sodium chloride 0.9% (rder rate: 5 mL/h, IV, start: 28-	Nov-201	
Ready to Scan		2 of 2		Back Sign

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.

Medication Administration						
+				Nurse Review	Last	Refresh at 08:58 PST
ICO-Nurse, Merle	MRN: 760000305 FIN#: 76000000	0305	DOB: 2018-Jan-31 Age: 2 days			Loc: SCN; C
	2018-Fe	:b-02 07:43	3 PST - 2018-Feb-02 10:	13 PST		
Scheduled	Mnemonic	Details		Result		
헬 📴 2018-Feb-02 02:00 PST	cholecalciferol cholecalciferol (vitamin	400 unit,	PO, drug form: oral li	q, start: 20		
2018-Feb-02 02:00 PST	gentamicin	7.824 mg Target D	g, IV, drug form: inj, Dose: gentamicin 4 m	start: 201gentamicin 20 mg, IV g/kg 201	-	
🛱 본 2018-Feb-02 07:00 PST	phytonadione vitamin K	1 mg, IM	1, once, drug form: inj,	start: 201		
2018-Feb-02 08:00 PST	cholecalciferol cholecalciferol (vitami.	400 unit	, PO, drug form: oral	liq, start cholecalciferol 400 un	it, PO	
			2-64		_	
ly to Scan			2 01 4			Back Next

 Complete the necessary information: Gentamicin: 7.824 mg Volume: 0.5 mL Diluent: sodium chloride 0.9% in 5 ml Click "OK"

	ey unie.	02-Feb-2018	÷ • (0911	PST 📆
*Perfor	med by: T	rain, NICU-Nurse	1	9)
Witne	ssed by :			9	
					-
gentamicin:	20	mg 👻	Volume :	2 n	nl
Diluent : <non< td=""><td>e></td><td>•</td><td>ml</td><td></td><td></td></non<>	e>	•	ml		
*Route :	IV	-	Site :		•
Total Volume :	2	Infused Over :	0	minute 👻	
2018-Feb-02 0800 PST	2018-Feb-0 0900 PST	2 2018-Feb-02 1000 PST	2018-Feb-02 1100 PST	2018-Feb-02 1200 PST	2018-Feb-02 1300 PST +
	2				
•			-1072		
Not Given					
					-



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.

Medication Administration					
				Nurse Review	Last Refresh at 08:58 PST
NICU-Nurse, Merle	MRN: 760000305 FIN#: 760000000	DC 0305 Ag	98: 2018-Jan-31 e: 2 days		Loc: SCN; 01 ** No Known Allergies **
	2018-Fel	b-02 07:43 PS	T - 2018-Feb-02 10:1	3 PST	
Scheduled	Mnemonic	Details		Result	
C 🕅 🔁 2018-Feb-02 02:00 PST	cholecalciferol cholecalciferol (vitamin	400 unit, PO	, drug form: oral liq	, start: 20	
2018-Feb-02 02:00 PST	gentamicin	7.824 mg, I Target Dos	V, drug form: inj, s e: gentamicin 4 mg	tart: 201gentamicin 7.824 mg //kg 201	+ sodium chloride 0.9% 5 mL, I
🗖 📽 😬 2018-Feb-02 07:00 PST	phytonadione vitamin K	1 mg, IM, or	nce, drug form: inj, s	tart: 201	
🔽 🖌 📴 2018-Feb-02 08:00 PST	cholecalciferol cholecalciferol (vitami	400 unit, P0	O, drug form: oral I	liq, start cholecalciferol 400 ur	nit, PO
•					+
Ready to Scan		1	2 of 3		Back Next

9. Review and click Sign.

Medication Administr	ration					
NICU-Nurse, M Male	Merle	MRN: 760000305 FIN#: 760000000305	DOB: 2018-Jan-31 Age: 2 days			Loc: SCN; 01
cholecalciferol (vit. 400 unit, PO, drug forr	amin D3) m: oral liq, start: 2018-Feb-02 08:0	10 PST				
Performed Date/Time :	2018-Feb-02 0911 PST	Diluent : <n< th=""><th>one> 🔻</th><th></th><th>mL</th><th></th></n<>	one> 🔻		mL	
Performed By :	Train, NICU-Nurse1	Total Volume	1 Infused	Over: 0	minute 💌	
vitamin D3 :	400 unit	← 2018-Feb-02 0800 PST	2018-Feb-02 2018-Feb-02 0900 PST 1000 PST	2018-Feb-02 2018- 1100 PST 120	Feb-02 2018-Feb-02	
Route :	PO		1			
eady to Scan			3 of 3			Back 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.

-	Medications	2018-Feb-02 09:34 PST	2018-Feb-02 07:00 PST	2018-Feb-02 02:00 PST
	Scheduled	(
	cholecalciferol (vitamin D3) 400 unit, PO, qdaily, drug form: oral liq, start: 2017-Dec-29 13:19 PST			400 unit Last given: 2018-Feb-02 09:34 PST
	vitamin D3	* 400 unit Auth		
	gentamicin 7.824 mg, IV, q36h, drug form: inj, start: 29-Dec-2017 14:00 PST Target Dose: gentamicin 4 mg/kg 2017-Dec			c
	gentamicin	* 7.824 mg Auth		
	vitamin K 1 mg, IM, once, drug form: inj, start: 2017-Dec-29 14:00 PST, stop: 2017-Dec-29 14:00 PST		1 mg Not previously given	
	vitamin K			

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...**

Medications	29-Nov-2017 08:00 PST	28-Nov-2017 12:53 PST	28-Nov-2017 12:00 PST	
Scheduled				
cholecalciferol (vitamin D3) 400 unit, PO, qdaily, start: 28-Nov-2017 11:33 PST	400 unit Last given: 28-Nov-2017 12:53 PST			
vitamin D3		* 400 unit		
			View Details	
vitamin K			View Comments	
1 mg, IM, once, drug form: inj, start:				
28-NOV-2017 12:00 PSI, stop: 28-NOV-2017			View Order Info	
vitamin K			Modify	
Discontinued Scheduled			Unchart	
10		L	Econyard/Petuse	
caffeine			Forward/Keruse	
10 mg/kg/h, IV, once, start: 28-Nov-2017 13:00 PST, stop: 28-Nov-2017 13:00 PST				
caffeine		10 mg/kg/h Au	tl	



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

Medications	29-Nov-2017 08:00 PST	28-Nov-2017 12:53 PST	28-Nov-2017 12:00 PST	28-Nov-2017 11:33 PST
Scheduled				
cholecalciferol (vitamin D3) 400 unit, PO, qdaily, start: 28-Nov-2017 11:33 PST	400 unit Not previously given			400 unit Not previously given
vitamin D3		* In Error		

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

1



Activity 11.1 – Results Review

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

		Table © Group ©	List
	Saturda	ep. 78 May 2016 00:001	(b) - Thursday, 28 Dece
er C Showing results from (23-Oct-2017 - 25-Oct-20 and Peripheral Smare	17) [Show more results]		
ral Chemistry Lab View	25-0-0-2057-00-00 - 23-59-807	24-041-2017 00:00 - 29-56 (001	23-041-2017 00:00 - 23-59-807
sends Drug Moniton CBC and Peripheral Sever	Concentration of the second	- KONTON	and the second
W9C Count	7.0 410 9.5	7.0+109.5	7.0 400 9.1 . 8.0 400 9.1
Icrobiology RBC Court	8.45 x10 12/5	4.50 (10.12.5	4.55 x10 12.6 UT
Control/Security Hemoglobin	140 m/s	140 e.1	145 at 121
Hematpoit	0.40	0.41	0.43 +0.45 (2)
e Blood Point of Car	92 %	95.11	195 ft 98 ft. [2]
E MOR	31 pg	30 pig	12 00 (2)
RDW-CV	120%	120%	12.0 % [2]
Platetet Count	400 x00 9/1	350 x00 9.1	250 x20 9.1 - 300 x50 9.1
1 MPV			9.911
Neutrophis	4.90 x10 9/5	4.90 x10 9.5	4.90 x10 9.1 - 5.60 x10 9
Umphostes .	1.40 x30 9.5	1.40 x10 9.1	1.40 x10 9.1 - 1.60 x10 9
Monorates	0.35 x10 9.%	0.35 x10 9.4.	0.40 x10 9.1 + 0.63 x10 9
Ecunophila	0.25 x10 9.1	0.28 x10 9.5	0.07 x10 9.4 - 0.32 x10 9
Basephils	0.07 x30 9.5	0.07 x10 9.5	0.08 ×10 9.4
General Chemistry			
Sodun	142 mmol/L	145 mmol/L	140 mmol/L + 145 mmol
Potacsium	3.5 mnol/L	3.9 mmol/L	4.5 mmol/L - 5.0 mmol/L
Chlande	100 mmol/1	100 mmol/L	100 mmol/L - 105 mmolt
Carbon Dioxide Total	25 mmol/L	26 mmol/L	Jonn II Jinnoit
Anion Gap	20.8 mmath (H)	22.9 minuts #6	13.5 mmol/1 - 15.0 mmo
Glocose Random			6.0 minot/L
Unea		2.0 mmol/5.	2.0 mmol1
Creatinina		75 umail:	100 umol 1
Glomerular Fidvation Rate Estimated		82 mL/min	SE INCIDIO
[] Trapponin I			+0.03 ug t *; +0.07 ug t
Lab Add on Time		CRE and BUN added to	ŧ.
Therapeutic Drug Monitoring / Tasicology			
Vancottycin Trough Level	15.0 mg/L		
Vancomycin Date Lait Dose	201710.24		
Vanconycin Time Last Dose	2200		

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



Menu 7 🗸	🔷 🔹 者 🛛 Results Review	N					
Patient Summary	8. 🗖						
Orders 🛨 Add							
Single Patient Task List	ecent Results Advance Care Pla	inning Lab - Recent Lab - Ex	tended Pathology Micr	o Cultures Transfusion	Diagnostics Vit	tals - Recent Vitals - Extended 3	
MAR	2	4					
Interactive View and I&O	Flowsheet. Quick View	- Level:	Quick View	 Table 	○ Group ○ List	t	
Results Review 1	< >			Monday, 27-1	November-2017 1	5:43 PST - Friday, 01-December-2017 15	5:43 PST (
Documentation + Add							
 Medication Request	VITAL SIGNS	Show more results					
Histories	SBP/DBP Cuff	Quick View	28-Nov-2017 18:17 PST	28-Nov-2017 18:13 PST			
Allergies 📥 Add		VITAL SIGNS	20.0++6	20.04-0			
		Peripheral Pulse Rate	105 bpm (H)	105 bpm (H)			
Diagnoses and Problems	PAIN ASSESSMENT	SBP/DBP Cuff					
		Systolic Blood Pressure	100 mmHg	100 mmHg			
CareConnect		Diastolic Blood Pressure	60 mmHg	60 mmHg			
Clinical Descent		Oxygenation Despiratory Date	22 bs/min (b)	22 bs/min (b)			
			22 01/11111 (FI)	22 DI/IIIII (H)			
Form Browser							
Growth Chart							
Immunizations							
Lines/Tubes/Drains Summary							
MAR Summary							
Medication List 🕂 Add							
Patient Information							
Reference							

5. Review your patient's recent lab results:

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

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

1

Menu 🖓	< 🔹 🛉 Interactive View and I&O							(¤) Full sc
Neonate Overview	*• ✓ ⊗ × 3							
Interactive View and I&O								
MAR	🗙 NICU Quick View	↔ Monday, 27-November	r-2017 06:00) PST - Thur	day, 30-Nov	ember-2017	7 05:59 PST	
Ordorr Add	🗙 NICU Systems Assessment	Today's Intake: 0 mL Output: 0 mL Bal	lance: 0 mL	Yesterd	ay's Intake: (0 mL Outp	ut:0 mL I	Balance: 0
	VICU Lines - Devices - Procedures	調 ※				29. No.	2017	
Results Review	XICU Procedural Sedation	1 1 1 1	13:00 -	12:00 -	11:00 -	10:00 -	09:00 -	08:00 -
Documentation 🛛 🕂 Add	🗙 NICU Education - Discharge		13:59 PST	12:59 PST	11:59 PST	10:59 PST	09:59 PST	08:59 PST
	X Advanced Graphing	⊿ Intake Total						
	Vintake And Output	⊿ Oral						
Growth Chart	Intake	Oral Intake mL						
Single Patient Task List	Continuous Infusions	A Stool Output						-
	Medications E	Stool Count (Number of Stools)						
Form Browser	Chest Tubes	⊿ Urine Output						
CareConnect	Enteral	Urine Voided mL						
	GI Ostomy Intake	⊿ Urine Output mL/kg/hr						
	Urinary Diversion Intake	Balance						
Care Coordination	Oral							
Clinical Research	Other Intake Sources							
Diagnoses and Problems	Negative Pressure Wound Therapy Surgical Drain, Tube Inputs							
Histories 🔻	K Blood Product Administration	4						

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.

Image: Second	< 🔹 🛉 Interactive View and I&u	0						[0]	Full screen	Print	æ0
NICU Quick View 2 Tuesday, 28-November-2017 06:00 PST - Wednesday, 29-November-2017 05:59 PST I NICU Systems Assessment NICU Lines - Devices - Procedures Today's Intake: 43.6667 mL Output: 30 mL Balance: 13.6667 mL 3 NICU Education - Discharge 13:00 - 12:00 - 11:00 - 10:00 - 09:00 - 08:00 - 07:00 - 00:00 - 00:00	** 🖿 🖌 🔯 🛪 関										
NICU Procedural Sedation 28-Nov-2017 NICU Education - Discharge 13:00 - 11:00 - 11:00 - 10:00 - 09:00 - 08:00 - 07:00 - 00:05:9 PST 07:59 PST 07:50 PST 07:50 PST 07:50 PST 07:59 PST 07:59 PST 07:59 PST 07:50 PST	XICU Quick View XICU Systems Assessment XICU Lines - Devices - Procedures		Tuesday, 28-November-2017 Today's Intake: 43.6667 mL Output: 30 mL	06:00 PST - Balance: 13 .	Wednesday, .6667 mL	29-Novemb	er-2017 05:	59 PST			
▲ Intake Total 5 25 5 3.6667 ▲ Intake And Output 5 5 5 3.6667 Enteral △ A Medications 5 5 5 3.6667 GI Tube GI Ostomy Intake ✓ ✓ ✓ ✓ ✓ ✓ Unnary Diversion Intake ✓	NICU Procedural Sedation		10 Juli	13:00 - 13:59 PST	12:00 - 12:59 PST	11:00 - 11:59 PST	28-No 10:00 - 10:59 PST	v-2017 09:00 - 09:59 PST	08:00 - 08:59 PST	07:00 - 07:59 PST	06:0
Enteral sodium chloride 0.9% (NS) continuous mL 5 5 5 3.6667 GI Tube GI Tube ////////////////////////////////////	Advanced Graphing		 ⊿ Intake Total ⊿ Continuous Infusions 	5 5	25 5	5 5	3.6667 3.6667				
GI Ostomy Intake △ Enteral Urinary Diversion Intake △ Oral Oral 20 Oral Intake 20 Other Intake Sources △ Output Total 20 Negative Pressure Wound Therapy Surgical Drain, Tube Inputs △ Lotto Output Transfusions Urine Coutput 20 Urinary Catheter, Intake Urine Voided 20 Urine Voided 20 10	Enteral GI Tube	•	infusion 250 mL ml	5	5	5	3.6667				
Oral Intake Oral Intake mL 20 Other Intake Sources △ Output Total 20 10 Negative Pressure Wound Therapy Surgical Drain, Tube Inputs △ Stool Output 20 Transfusions △ Urine Output 20 Urinary Catheter, Intake Urine Voided 20 Pre-arrival Fluid Urine Voided 20	GI Ostomy Intake Urinary Diversion Intake		⊿ Enteral ⊿ Oral		20						
Surgical Drain, Tube Inputs Stool Count (Number of Stools) Transfusions ⊿ Urine Output Unary Catheter, Intake Urine Voided Pre-arrival Fluid 20	Otal Other Intake Sources Negative Pressure Wound Therapy	ł	Oral Intake mL ⊿ Output Total ⊿ Stool Output	20	20 10		•				
Pre-Antival Fluid	Surgical Drain, Tube Inputs Transfusions Urinary Catheter, Intake		Stool Count (Number of Stools) Urine Output Urine Vielded	20	10						
□ Output 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Pre-Arrival Fluid	1	Urine Output mL/kg/hr Balance Balance	-15 mL	10 15 mL	5 mL	3.6667 mL				

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

1



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

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.

< 🔹 🔹 🛉 Interactive View and I&O						[0]	Full screen	Print	æ∂ 0 minutes
™u 🗄 🖌 🖾 × 🖏									
VICU Quick View	▲ Tuesday, 28-November-2017	06:00 PST - 1	Wednesday,	29-Novemb	er-2017 05:	59 PST		•	
VICU Systems Assessment	Today's Intake: 43 6667 ml Output: 30 ml	Ralance: 13	6667 ml						
VICU Lines - Devices - Procedures		bulance 15.	0007 1112		20.11-				
VICU Procedural Sedation		13:00 -	12:00 -	11:00 -	28-INO 10:00 -	09:00 -	08:00 -	07:00 -	06:00 -
VICU Education - Discharge		13:59 PST	12:59 PST	11:59 PST	10:59 PST	09:59 PST	08:59 PST	07:59 PST	06:59 PST
Advanced Graphing	⊿ Intake Total	5	25	5	3.6667				
Vintake And Output	⊿ Continuous Infusions	5	5	5	3,6667				
Enteral	sodium chloride 0.9% (NS) continuous	5	5	5	3/ 1				
GI Tube	2 Medications								
GI Ostomy Intake	∠ Enteral								
Urinary Diversion Intake	_ ⊿ Oral		20						
V Oral	Oral Intake m		20						
Uther Intake Sources	⊿ Output Total	20	10						
Surgical Drain, Tubo Inputa	⊿ Stool Output								
Transfusions	Stool Count (Number of Stools)	20	10						
Urinary Catheter, Intake	Line Voided	20	10						
Pre-Arrival Fluid	4 Urine Output ml /kg/br	20	10						1
Output	* Balance	-15 mL	15 mL	5 mL	3.6667mL				
				-			1		

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).



		-						
Today's Intake: 43.6667 mL Output: 30 mL Balance: 13.6667 mL								
民 in	28-Nov-2017	7				28-Nov-2017		
	18:00 - 18:59 PST	Day Shift Total	17:00 - 17:59 PST	16:00 - 16:59 PST	15:00 - 15:59 PST	14:00 - 14:59 PST	13:00 - 13:59 PST	12:00 - 12:59 PST
⊿ Intake Total		43.6667				5	5	25
⊿ Continuous Infusions		23.6667				5	5	5
sodium chloride 0.9% (NS) continuous infusion 250 mL ml	L	23.6667				5	5	5
⊿ Medications								
⊿ Enteral								
⊿ Oral		20						20
Oral Intake mi	L	20						20
⊿ Output Total		30					20	10
⊿ Stool Output								
Stool Count (Number of Stools)								
⊿ Urine Output		30					20	10
Urine Voided m		30					20	10
⊿ Urine Output mL/kg/hr		1				4		
Balance	2	13.6667 mL				5 mL	-15 mL	15 mL

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

Menu 7	< 🔹 🔹 👘 Interactive View and I&O		
Neonate Overview 🔶	*• ⊟ ≠ ⊗ × ≋		
Interactive View and I&O			
MAR	VICU Quick View	Monday, 04-Dece	mber-2017 06:00 PST - Thursday, 07-December-2017 05:59 PST
MAR Summary	VICU Systems Assessment	Today's Intake: 0.98 mL Output: 0 mL Balance: 0	0.98 mL Yesterday's Intake: 0 mL Output: 0 mL Balance: 0 m
Orders 🕂 Add	VICU Procedural Sedation	PR in	05-Dec-2017
Results Review	NICU Education - Discharge	15	500 - 14.00 - 15.00 - 12.00 - 11.00 - 10.00 - 59 PST 14:59 PST 13:59 PST 12:59 PST 11:59 PST 10:59 PST
Documentation 🕂 Add	X Advanced Graphing		0.98
Allergies 🕂 Add	Vintake And Output	sodium chloride 0.9% (NS) continuous	
Growth Chart	Continuous Infusions	△ Medications	
Single Patient Task List 🗧	Medications Chest Tubes	gentamicin mL	0.98 View Result Details
Form Browser	Enteral	△ Nasogastric (NG) tube Nare, left 5 French	View Defaulted Info
CareConnect	GI Tube GI Ostomv Intake	Intake mL	View Comments
	Urinary Diversion Intake	Irrigant In mL	Unchart
Care Coordination	Other Intake Sources	⊿ Oral	Change Date/Time
Clinical Research	Negative Pressure Wound Therapy	⊿ Transfusions	Modify
Diagnoses and Problems	Transfusions	△ Output Total	Confirm
Histories	Urinary Catheter, Intake	Stool Count (Number of Stools)	Add Comment
Immunizations	Cutput	⊿ Urine Output	Clear Not Date
Lines/Tubes/Drains Summary	Blood Output Chest Tube Output	△ Urine Output mL/kg/hr	View Interpretation
Medication List 🕂 Add	Continuous Renal Replacement Therapy	Balance 0.	98 m Reinterpret
Medication Request	Emesis Output GI Tube		
Newborn Liaison	GI Ostomy Output		
Newborn Record	Other Output Sources Viter Output Sources Viter Output Administration		

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. 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**.

1

6. Click the green check mark to Sign.

VICU Quick View		•	
VICU Systems Assessment			
k Newborn Vital Signs		Find Item Critical High Low	А
NEUROLOGICAL			-
Seizure Assessment		Result Comments Hag	Т
Newborn Head and Neck			
Musculoskeletal Newborn Assessment		28-Nov-201	7
Neonatal Abstinence Scoring System		📉 🍕 🚮 👘 🕅	ST
CARDIOVASCULAR		△ Newborn ADL	
Edema Assessment		Newborn Location	
Pulses		Neonatal Daily Classification	1
RESPIRATORY		Suction Device	
Breath Sounds Assessment		Suction Pressure mmHg	_
Apnea/Bradycardia Episodes		Resuscitation Device at Bedside	_
Airway Management	=	Oral Care	_
Ventilation	_	Bath Newborn	_
Chest Tubes		Skin Care	_
Umbilicus Assessment		Umbilical Cord Care	_
GASTROINTESTINAL		Crib Wheels Locked	_
Gastrointestinal Tubes		ID Band Check	_
Newbom/Pediatric Feeding		ID Band Number	_
Genitalia Assessment		IV Tubing Labeled	_
Bladder Scan/Postvoid Residual			
INTEGUMENTARY			
Newborn ADL			
Provider Notification			
Transfer/Transport			

- 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 1 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**.



Reporting Portal						- • •
Reporting Portal	_	_				
😂 Cerner					Welcome: TestUser, NICU-	Nurse Settings Help
Reporting Port	al <mark>2</mark>			Q Search for Repo	ort Title	
Filters		All Repor	ts (10) My Favorite	s (0)		1 0
		Report N	ame 🔻	Categories	🗢 Source 🗧	Favorite 🗢 🔶
Source		Baby Bor	n in 24hrs	Maternity – Miscellaneous	Public	
Categories		Birth Log	Book	Maternity – Miscellaneous	Public	
Recent Reports		Delivery S	Summary Report	Maternity – Miscellaneous	Public	
Baby Born in 24hrs 3		Extractab	ole Birth Log Book Report	Maternity – Miscellaneous	Public	
Birth Log Book Neonatal Daily Classfica		FotoLMol	-Being Endorsement	Maternity – Miscellaneous	Public	☆ 『
	Run Report	Run Report 4 Run Report in Background ctivity Li View Previous Run Daily Class	ctivity Log	Maternity – Miscellaneous	Public	
	View Previous Ru		Daily Classfication	NICU-RN	Public	
		OB ACTIVI	cy Report	Maternity – Miscellaneous	Public	
		OB Arriva	l by Hour	Maternity – Miscellaneous	Public	*

- 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.



Discern Prompt: BC_ALL	_MAT_NICU_CLASS_LYT:DBA	
*SIte	Lions Gate Hospital 💌	Î.
*Facility	 EGH Evergreen House LGH HOpe Centre IGH Lions Gate Hospital LGH North Shore Hospice 	
*Nurse Unit	LGH OR LGH Operating Room LGH PACIL1 LGH PACIL1 LGH SCN LGH Special Care Nursery LGH SCU LGH SUCU LGH Surgical Close Observation LGH SDCC LGH Surgical Davcare Centre III III	* E
*Start Date	27-Nov-2017	
*End Date	28-Nov-2017	
•		•
Return to prompts on close	Execute Cancel of output	
Ready		

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

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

Menu 9	< 🔹 - 者 Neonate Overvi	iew					🔲 Full screen 🛛 🗎	rint 🎝 ago
Neonate Overview	A 100%	4						
Interactive View and 1&O	Neonate Workflow	23 Quick Orders	😂 Pregnancy Sumr	nary 🔀 Discharge	🔀 Hando		× + 🖂 1	b (=.
MAR	LIDES/ LIDES/ URAIDS			-				
Orders 🕂 Add	Labe							
Results Review	Transfer/Transport/Accompan	Informal Team C	ommunication					∂ =
Documentation 🕂 Add	iment							
Allergies 🕂 Add	Imaging	Add new action			Add new comment			
Growth Chart	Medications							
Single Patient Task List	Home Medications (0)	tolerating feeds we	ell. mom received vit D administra	tion teaching.	test Tastiliser, NICH Nurse 20/3	11/17 10:17		=
Form Browser	Orders	TestUser, NICU-Nurse	14/11/17 10:55		restoser, nico-nuise 30/1	11/1/ 10.1/		
CareConnect	Micro Cultures	All Teams			All Teams			
	Oxygenation and	1				\sim		
Care Coordination	Ventilation	1						
Clinical Research	Allergies	Documents (2)			Sele	ected visit: Last 50 Notes	Selected visit Last 12 hours More V	<u>]</u>
Diagnoses and Problems	Pathology	1			- N	Ay notes only 🛛 🔲 Group by	y encounter Display: Facility defin	ied view 🔻
Histories	Histories	Time of Service	Subject	Note Type	Author	Last Updated	Last Updated By	
Immunizations	Create Note	14/11/17 11:17	Discharge Summary	Interdisciplinary Care Plan	TestUser, NICU-Nurse	14/11/17 11:18	TestUser, NICU-Nurse	
Lines/Tubes/Drains Summary	Interdisciplinany Care Plan	14/11/17 11:15	Discharge Summary	Interdisciplinary Care Plan	TestUser, NICU-Nurse	14/11/17 11:16	TestUser, NICU-Nurse	
MAR Summary	Interdisciplinary care rian	* Displaying up to the la	ast 50 recent notes for the selecte	d visit				
Medication List 🔹 🕂 Add	Interdisciplinary Rounding Su mmary Note							
Medication Request	Nursing Shift Summary							3
Newborn Liaison	a local and a second se	Assessments					Selected visi	rt and
Newborn Record	Select Other Note	No results found						

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

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

2



Neonate Overview 1 🗠	A	 ۵ 	
Interactive View and I&O	Neonate Workflow 😂 Ouid	k Orders 🛛 Pregnancy Summary 🖄 Discharge	🛛 Handoff Tool 🛛 🖧 🕂 🕞 1 🕒 🦳 –
MAR	LIDES/ LIDES/ URAIDS		
Orders 🕂 Add	Labs		
Results Review	Transfer/Transport/Accompany Info	ormal Team Communication 2	2 =-
Documentation 🕂 Add	iment		
Allergies 🕂 Add	Imaging Add	d new action Add ne	ew comment
Growth Chart	Medications		
Single Patient Task List	Home Medications (0)	Need to thaw more EBM for the next shift Mother	will be staying overnight.
Form Browser	Orders	TestUser, NICU-Nurse 30/11/17 11:41	n, nco-nuise 30/11/7 11-11
CareConnect	Micro Cultures All T	Feams All Tear	ms
	Oxygenation and		

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

Handoff Tool	Summary	23 Assessmer	t 23 Di	charge						
Informal Team Communication	Active Issues						Cla	ssification: Medical and Patie	nt Stated 👻 🛛 All Visits 🛛 🤁	=- +
Active Issues						0				
Allergies (2)					Add new as: This Visit	• 9				
Vital Signs and Measurements	Name				Classification	Actions				
Documents (1)	Pneumonia				Medical	This \	isit Chronic			
Transfer/Transport/Accompanim	Diabetes				Medical	This	isit Chronic			
ent (0)	Peripheral vascula	ir disease			Medical	This \	isit Chronic			- t
Assessments (0)										_ [
Lines/Tubes/Drains										-
Intake and Output	Allergies (2)								All Visits 😴	
Laos									Scroll to v	riew
Imaging (0)	Substance	Reactions	Category	Status	Severity	Reaction Type	Source	Comments	more	
Medications	Bees/Stinging Insects		Environment	Active		Allergy				
Orders (10)	diphenhydrAMINE	**	Drug	Active		Allergy				
Organization and Ventilation (0)							Reco	nciliation Status: Incomplet	Complete Reconciliation	m
Pathology (0)							_			
Histories	Vital Signs and Me	asurements 🕂					Selected visit:	Latest ^a Selected visit Las	t 12 hours 🔠 🔟 🤊	=-
		NOV 20, 2017								
Create Note	Respiratory Rate	br/min \$22▲								
Interdisciplinary Care Plan	* Displaying recent result	s up to 16 columns of information for	the selected visit							_
Interdisciplinary Rounding Summ ary Note										
Nursing Shift Summary	Documents (1)						elected visit: Las	t 50 Notes Selected visit	Last 12 hours More 🔻 🖓	=-
Select Other Note							My notes only	Group by encounter	Display: Multiple note type	s *
	Time of Service	Subject	Note Type		Author	Last Update	ł	Last Updated By		
	20/11/17 16:37	Free Text Note	Nursing Shift Sur	nmary	TestORD, Nurse	20/11/17	16:38	TestORD, Nurse		

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.



Menu P	< 🔹 🔹 Interactive View and I&O	
Neonate Overview	🏎 🔜 📾 🎣 🖌 🔕 🗑 📰 🖿 🍋 🗶	
Interactive View and I&O		
MAR	VICU Quick View	L L
MAR Summary	Caregiver Rounding Newbom Overview	Find Item
Orders 🕂 Add	Newbom Vital Signs Equipment Alarm Limits (Low/High)	Result Comments Flag Date
Results Review	Environment	¥ 355
Documentation 🔹 Add	Comfort Measures Parental Involvement	105-Dec-2017 戦 215:32 PST
Allergies 🕂 Add	IV Drips	△ IV Drips
Growth Chart	Newbom/Pediatric Feeding NICU Daily Nutrient Totals	Clinician Receiving Report CST Nurse1
Single Patient Task List	Urine Output	Clinician Giving Report CST Nurse 2
	Stool Output	Lines Traced Site to Source Yes
Form Browser	Measurements	Isolation Activity
CareConnect	Provider Notification	
	Trade/Transf	
Care Coordination	Shift Report/Handoff Quecese Blood Point of Care	
Clinical Research		T
Diagnoses and Problems		
Histories		
· · · · ·		

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

Menu	🕈 < 🔺 🛉 Patient Summ	ary				
Patient Summary	A	- 0 0 4				
Orders 🛨 Ac	Handoff Tool	Summary	52 Assessment	22 Discharge	2 22	+
Single Patient Task List		Cu Durinitary		o bound ge	2	т
MAR	Active Issues	Discharge Desumentat	4			
Interactive View and I&O	Provider Discharge	Discharge Documentat	Discharge Planning Assessment			
Results Review	Documents (3)	No results found	Nursing Discharge Checklist 5			
Documentation 🕂 Ac	Social Histories		Valuables/Belongings			
Medication Request	Orders (9)	Discharge Medications	Discharge Coordinator Assessment			
Histories	Discharge Documentation (0)	3 Discharge Medications	(5) 🕶			
Allergies 🕂 Ac	* Discharge Medications (5)	* To satisfy this requireme	ent, the provider must complete the Discharg	e Medication reconciliation		
Diagnoses and Problems						
						Status: 0
CareConnect		Madiration	*		Remonstible Dravider	Compliance
Clinical Research		atonyastatin (atonyastatin	10 mg gral tablet) 1 tab PO gHS 0 Refill(c)		Testiliser GeneralMedicine.	compliance
Form Browser		4 80014830800 (00014830800	to my oral cabledy 1 cab, PO, GHD, 0 realings,		Physician, MD	-
Growth Chart		bisOPROLOL (bisoprolol 5	mg oral tablet) 1 tab, PO, qdaily, 0 Refill(s)		TestUser, GeneralMedicine-	
Immunizations		a formus fumarato (formus	fumarate 200 mg eral tablet) 1 tab DO, edaily, 0.6	2ofill/c)	Physician, MD Torti kor, GonoralMedicine	
Lines/Tubes/Drains Summary			runarate 500 mg oral tablety 1 tab, PO, quality, 0 h	(cim(s)	Physician, MD	
MAR Summary		🦨 furosemide 40 mg, PO, qu	daily, for 30 day, 30 tab, 0 Refill(s)		-	
Medication List 🕂 Ac		Ilidocaine topical (lidocaine	2% jelly) 10 mL, topical, as directed, PRN: consti	pation, 0 Refill(s)	TestPET, GeneralMedicine- Physician, MD	
Patient Information						

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 Z
- 4. Select Nursing Discharge Summary Newborn document.

< 🔹 🕇 Neonate Overview	1					j
🎢 📄 🗬 📄 🔍 🔍 100% 🛛 🗸 1	• • 4					
Neonate Workflow 🛛 Quick Orde	rs 🛛 🕅 Pregnancy Summary	23	Discharge	2	Handoff Tool	:
Social Histories						
Social History (0)	Pregnancy (0)					
No results found						
> Discharge Documentation	3					
No results found	Discharge Planning Assessment Nursing Discharge Checklist					
	Valuables/Belongings					
	Discharge Coordinator Assessment					
Discharge Medications (0)	Nursing Discharge Summary Newborn	4				
 To satisfy this requirement, 	the provider must complete the Disch	arge Me	edication reconciliation			

5. Open the document and enter data as appropriate.



P Nursing Dischar	ge Summary Newborn - CSTLEARNPEDS, SKYE	
🖌 🖬 🚫 📉		
*Performed on:	28-Nov-2017 🔍 💌 1450 🔍 PST	By: TestUser, NICU-Nurs
DC Information	Arrangements	
Education Newbo	Indicates date and time after discharge order when patient has received all discharge instructions and necessary discharge arrangements have been made	
	Clinical Discharge Date and Time Discharge Weight	
	28-Nov-2017 🔿 🔽 1450 🚖	
	Mode of Discharge Discharge Transportation	
	O Ambulatory O Wheelchair Image: Carried O Other: O Stretcher O Non-ambulance transport	
	Accompanied By Infant Feeding at Discharge	
	None Foster father Ministry worker Stepmother Ø Mother Friend Sibling Step sibling Ø Father Grandfather Spouse Security Foster mother Grandmother Step father Other: Image: Constant and the step in th	
	Discharge Comment	
	Segoe UI • 9 • <10 % 點 18 18 12 / 5 画 重 国	
	4 M	
	- S [

6. Use the Green Check Mark ^r 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



FATIENT 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

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

Handoff Tool	🖾 Summary	23 Assessment	23 Discharge	× +	
Active Issues Provider Discharge	Provider Discha	arge Documents (3) 🕇		Last 50 Notes Last 2	years Last 1 months 2 =-
Documents (3)				My notes only Group by encounter	Display: Facility defined view -
Social Histories	Time of Service	Subject			Onen Decum 4
Orders (9)	05/10/17 18:25	Discharge Summary			Phil
Discharge Documentation (1)			Patient Discharge Summary	Patient Discha	rge Summary (Auth (Verified))
* Discharge Medications (5)	12/07/17 14:52	2 Patient Discharge Summary	TestUser, GeneralMedicine-Physician, MD		Last Updated: 12/07/17 14:54
	12/07/17 14:51	Discharge Summany			n i i
	12/0//1/ 14.51	Discharge Summary	Most Responsible Provider		
	* Displaying up to th	e last 50 recent notes for the last 2 years	3 Primary Health Care Provider Dr. Eric Grafstein		
	Social Histories	i	Primary Health Care Provider was notified in (X) Yes () No	the first 24 hours post admission	E
	Social History	(1)	Date of Admission June 30, 2017		
	Category	Details	Other consulting providers involved in patie TEST MDNEPH	nt's hospital care	
	Alcohol	Use: Past user Type: Be	er. W		
			Copy of this form provided to: (X) Patient (X) Primary Health Care Provider / Family Physicia	n	
	Orders (9)		Problem List/Past Medical History		
			Diabetes type 2, controlled Hyperlipidemia		
			Hypertension		
	4 Patient Care (6)	Type Order	No historical problems		
	a ruticité dale (0)		Allergies		



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

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

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

Menu	4	< >	🝸 📫 Newborn Liais	on											
Neonate Overview		A 🗎	- 100%												
Interactive View and I	8.0														
MAR															
MAR Summary			Lisison Percent NEWRORN												
Orders	🕂 Add		Surname: CSTLEARN	PEDS	Sev: Female	MRN: 70000	7829 P	PHN: 9876493256							
Results Review			Given Name(s): SKYE		Hospita	Place of Birth: 1	GH Lions Gate Ho	spital							
Documentation	🕂 Add		Age at discharge:		Correct	Corrected Gestational Age at Discharge:									
Allergies	🕂 Add		Primary Contact:			Contact 2									
Growth Chart			Address:	Relationship:		Address:	Relatio	inship:							
Single Patient Task Li	st														
Form Browser			Phone:	Cell Phone:		Phone:	Cell Pr	none:							
CareConnect			Temporary Address:	Phone:	L.	Emergency Cont Address:	Relatio	onship:							
Care Coordination			Begin Date:	End Date:		Phone:	Cell Pr	none:							
Clinical Research			PROVIDERS												
Diagnoses and Proble			Attending Provider (M	RP): TestUser, (GeneralMedicine-F	Admitting Prov	vider: TestUser, (GeneralMedicine-Physici							
Histories			Primary Care Provide	Smith, Jenni		Hospital Consu	ultant/Referral: Te	stUser, GeneralMedicine							
mmunizations			BIRTH SUMMARY												
ines/Tubes/Drains S	ummary		Birth Date: 31-OCT-201	7 Birth Time:	Type of Bir	th:	Gestation	al Age:							
Medication List	🕂 Add		Birthweight: 1.950 kg	Discharge w	eight: 3.7 kg	Apgar Score 1m	nin: 5 mins	: 10min:							
Medication Request			Head circumference:	Length: Passed m	econium: No	Newborn Rh:	ABO:								
Newborn Liaison			Risk Factors, Fetus:	i asseu in	Contain. NO										
Newborn Record			Neonatal Complications												
Patient Information			NEONATAL RESUSCI	TATION											
ostpartum Liaison			Resuscitation at Birth:	N	0										
regnancy Summary	Report		Spontaneous Respiration	ons Onset: s respirations:											
Reference			Intubated: IP	PV: (CPAP:	Oxygen:	Chest Com	pressions:							
			Gord Gas Results. ART	ename pri.	1002	- C2 C		DAGE.							

To print this document, click on the Print

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** © conversation Launcher in the toolbar. The window will open. Examine the icons to explore available functions.



2. Click the Bed Transfer icon

e p	erson Mgi	mt: Conversat	ion Launcher															- 6
Bed { En	Transfer 2 View counter	Cancel Discharge	Cancel Encounter	Cancel Pending	Cancel Pendi	Cancel Transfer	Discharge Encounter	Facility Transfer	Leave of Absence	Modify Discharge	Pending Discharge	Pending Facilit	Pending Transfer	Print Specimer Labels	Process Alert	Register Outpatient	Register Phone	Update Patient Information

3. The **Encounter Search** window will open. Search for your correct Encounter, and click OK.

C PHN:	VIP	Deceased	Alerts	BC PHN	MBN	Name	D	ОB	Age
	2			10760000305	760000305	NICU-Nurse	, Merle 21)18-Jan-29.11:	25 1 D ay
BN:	2			10760000306	760000306	NICU-Nurse	Herman 21)18-Jan-29 11:	25 1 Day
	2			10760000307	760000307	NICU-Nurse	Harvey 21)18-Jan-29 11:	25 1 Day
ast Name:	1 2			10760000308	760000308	NICU-Nurse	, Louis 21)18-Jan-29.11:	25 1 Day
icu	- <u>6</u>	3	В	10760000309	760000309	NICU-Nurse	Jimmy 21	J18-Jan-29 11:	25 1 Day
ut blasses	Ø			10760000310	760000310	NICU-Nurse	, Stanley 21)18-Jan-29 11:	25 1 Day
rst Name:	2			10760000311	760000311	NICU-Nurse	, Shannon 21	J18-Jan-29 11:	25 1 Day
3A	2			10760000312	760000312	NICU-Nurse	Abel 21)18-Jan-29 11:	25 1 D ay
OB:	2			10760000313	760000313	NICU-Nurse	, Joseph 21	J18-Jan-29 11:	25 1 Day
CHNNINNH	· 12			10760000314	760000314	NICU-Nurse	, Brent 21	J18-Jan-29 11:	25 1 D ay
ender:	Ø			10760000315	760000315	NICU-Nurse	, Elbert 21	J18-Jan-29 11:	25 1 D ay
•	2			10760000316	760000316	NICU-Nurse	, Stuart 21	J18-Jan-29 11:	25 1 Day
	0			10760000317	760000317	NICU-Nurse	, Neal 21	J18-Jan-29 11:	25 1 D ay
ostal/Zip Code:	•			111					Þ
ny Phone Number:	Faci	ity	Enci	ounter # 🛛 🗸	isit #	Enc Type	Med Service	Unit/Clinic	Room Be
		GH Lions Ga	te 7600	000000309 7		8 Newborn	Neonatology	LGH SCN	SCN 05
ncounter #:									
sit #:									
istorical MRN:									
Search Reset									
	•			III					



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.

🚔 Bed Transfer							X			I X	3) (Ö
Current Encounter Information Encounter Type:	Medical Service:							0			HC	PACS 🕄 MUSI	E 🔇 FormFast W	FI 📮	
Newborn	Neonatology		🔒 Bed Av	ailabil	ity								-		x
Current Location Data			Eacility: Lf	i H L io	ns Giate		_	_							_
Facility:	Building:	Unit/Clinic:	Building: L	GH Lie	ons Gate			3							
Luti Lions date	Luti Lions date	Lun Joh	Room	Bed	Nurse unit	Isolation	Person	Bed status	In	Out	Sex	Medical rec nbr	Financial nbr	Duplica	atı 🔺
Bed:	Accommodation:	Accommodation Reason:	🛥 SCN	01	LGH SCN		NICU-Nurse, Merle	Assigned			Male	760000305	760000000305	False	
05	Ward		SCN	02	LGH SCN		NICU-Nurse, Herman	Assigned			Male	760000306	760000000306	False	
 New Encounter Information 			SCN	03	LGH SCN		NICU-Nurse, Harvey	Assigned			Male	760000307	760000000307	False	=
Encounter Type:	Medical Service:		SCN	04	LGH SCN		NICU-Nurse, Louis	Assigned			Male	760000308	760000000308	False	
Newborn	Neonatology -		SCN	05	LGH SCN		NICU-Nurse, Jimmy	Assigned			Male	760000309	760000000309	False	-
— New Location Data			SCN	06	LGH SCN		NICU-Nurse, Stanley	Assigned			Male	760000310	760000000310	False	-Ш
Building: 1	Unit/Clinic:	2	🚔 SCN	07	LGH SCN		NICU-Nurse, Shannon	Assigned			Male	760000311	760000000311	False	
LGH Lions Gate	LGH SCN 👻	Bed Availability	📥 SCN	08	LGH SCN		NICU-Nurse, Abel	Assigned			Male	760000312	760000000312	False	
Bed:	Accommodation:	Accommodation Reason:	🚔 SCN	09	LGH SCN		NICU-Nurse, Joseph	Assigned			Male	760000313	760000000313	False	-
	-		🚔 SCN	10	LGH SCN		NICU-Nurse, Brent	Assigned			Male	760000314	760000000314	False	_
Current Physician Information	4		🚔 SCN	11	LGH SCN		NICU-Nurse, Elbert	Assigned			Male	760000315	760000000315	False	-
Attending Provider	Admitting Provider:		🚔 SCN	12	LGH SCN		NICU-Nurse, Stuart	Assigned			Male	760000316	760000000316	False	-
Train, Pediatrician-Physician2	Train, Pediatrician-Physician2		•												
Transfer Information															
Transfer Date:	Transfer Time:	Bed Transfer User Name:											OK	Cancel	
		Train, NICU-Nurse2													_
							-								
			6	Con	nplete	Cancel									
Ready		TRA	IN1 TRAIN.N	ICU2	31-Jan-2018	10:30									

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.



b End Book One

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