SELF-GUIDED PRACTICE WORKBOOK [N70]
CST Transformational Learning

WORKBOOK TITLE:

Provider: OB Family Practice

Last update: February 11, 2018 (v2)

CLINICAL + SYSTEMS TRANSFORMATION
Our path to smarter, seamless care

TRANSFORMATIONAL LEARNING

TABLE OF CONTENTS

SELF-GUIDED PRACTICE WORKBOOK

Duration	4 hours
Before getting started	■ Sign the attendance roster (this will ensure you get paid to attend the session). ■ Put your cell phones on silent mode.
Session Expectations	■ This is a self-paced learning session. ■ A 15-min break time will be provided. You can take this break at any time during the session. ■ The workbook provides a compilation of different scenarios that are applicable to your work setting. ■ Work through different learning activities at your own pace
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.

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**
- 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

PATIENT SCENARIO 1 – Introduction to Tracking Shell and Reviewing Patient's Chart

Learning Objectives

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

- Locate and review the Tracking Shell
- Open patient chart
- Navigate within the Computer Information System (CIS) patient chart
- Customize your view of the patient chart
- Review patient history
- Review and add allergy

SCENARIO

As the OB Provider covering the Labour and Delivery Unit, you receive a phone call that a 30-year-old woman G1P0 at 38 weeks gestation, has presented to the LGH Labour and Delivery Department with contractions. She has Gestational Hypertension.

The **aim of this workbook** is to showcase the functionality of a fully loaded system. Therefore to illustrate the basic features of the Computer Information System (CIS), the patient scenario is more complex.

You will be completing the following activities:

- Review the Tracking Shell
- Access and navigate the patient's chart
- Locate and update patient history
- Navigate Workflow tab's (patient chart sections) component list and update Pregnancy Risk Factors
- Review and add Allergies

Activity 1.1 – Review Tracking Shell

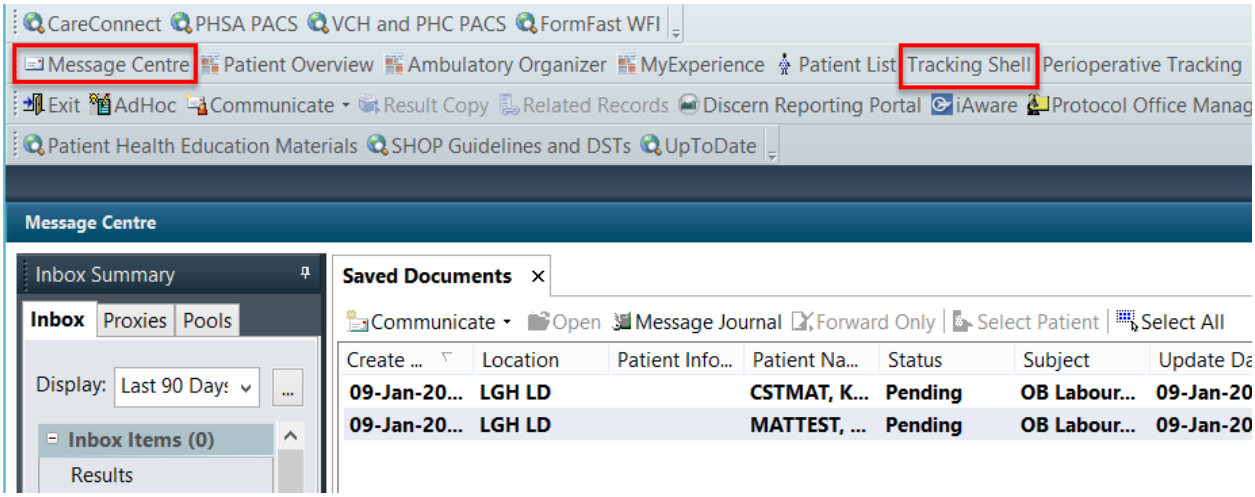
In this activity you will:

- Review the Tracking Shell.
- Practice navigating the patient's chart.

1 Ensure you are logged into PowerChart with the provided username and password.

2 The very first screen you see is **Message Centre**. It is similar to standard email software. It is integrated with patient records and internal to CIS users. You can learn more about Message Centre from the online eLearning module.

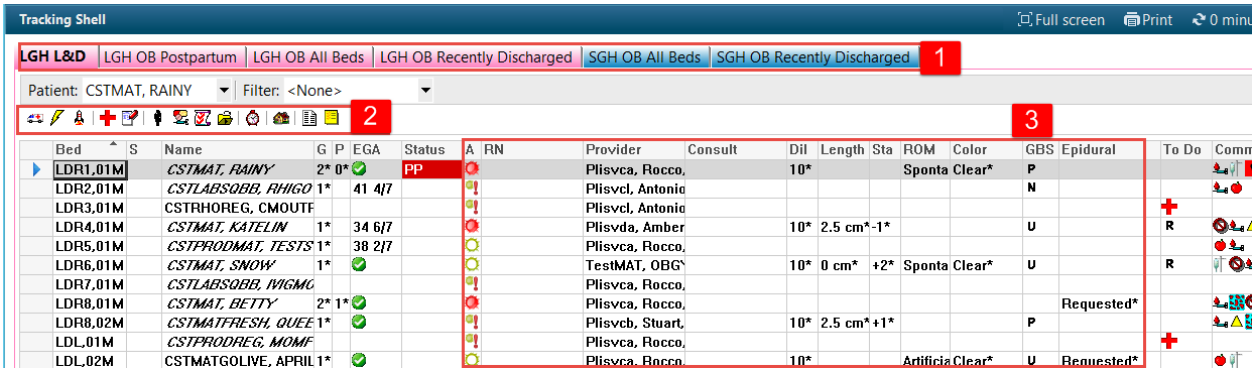
Click on **Tracking Shell** and the Tracking Shell page opens.



3 The **Tracking Shell** serves as the desktop for PowerChart Maternity, linking health care professionals to vital patient and department information.

The Tracking Shell is divided into sections:

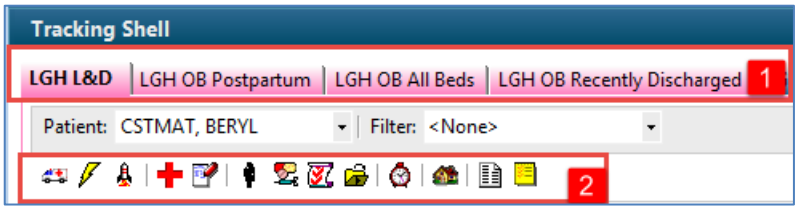
1. Tabs
2. Toolbar and Filters
3. Column Views



4 The **Tracking Shell** tabs display various locations such as LGH L&D, LGH OB Postpartum, and LGH OB All Beds, etc. These Location tabs allow you to move between different views.

1. The bolded tab indicates the view that is currently being displayed. Your default location tab is the **LGH L&D**.

2. The Icon toolbar displays various key buttons. Hover over each icon for more information. All care providers use the same view to access the icons.



For practice, hover over the icons below:

Conversations Launcher refers to Bed transfer or Documenting a Discharge

Interactive View and I&O: Providers use this icon to document from the OB Provider Band such as a cervical exam

Women's Health Overview: Providers use this icon to access the patient's chart

For your reference, providers also use these icons:

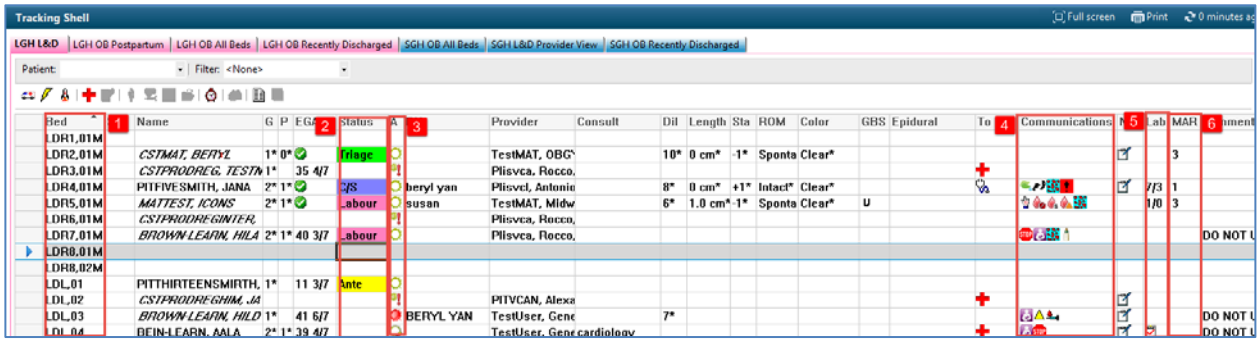
Open Chart

Add Order

Patient Summary Report

5 The Columns display the patients and specific patient details.

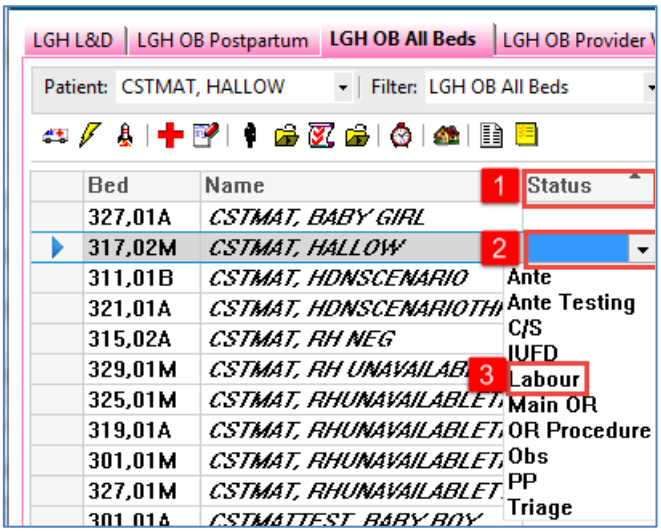
1. The **Bed** column displays the patient's bed location with **M = Mom**; and **A, B, C** representing sequential newborn beds.
2. The **Status** is updated through the patient's hospital visit. For example, **C/S for C-section**.
3. The **A** column displays allergies – hover over the Icon to see the exact allergy.
4. The **Communications** Column displays Alerts and Communications icons such as Isolation Alert and Rh Negative. Some icons can be added manually by right-clicking on the cell. Certain nursing and provider documentation pull data forward into these columns.
5. The **Lab** column shows the status of the lab orders.
6. The **MAR** displays the number and medication orders details.



For the remaining columns not mentioned above, hover to discover.

6 Navigate to the **LGH OB All Beds tab** and change the Tracking Shell status of your patient:

1. Locate the **Status** Column within the **LGH OB All Beds** tab.
2. Double click on the **Status cell** for your patient.
3. Select **Labour** from the drop-down menu.



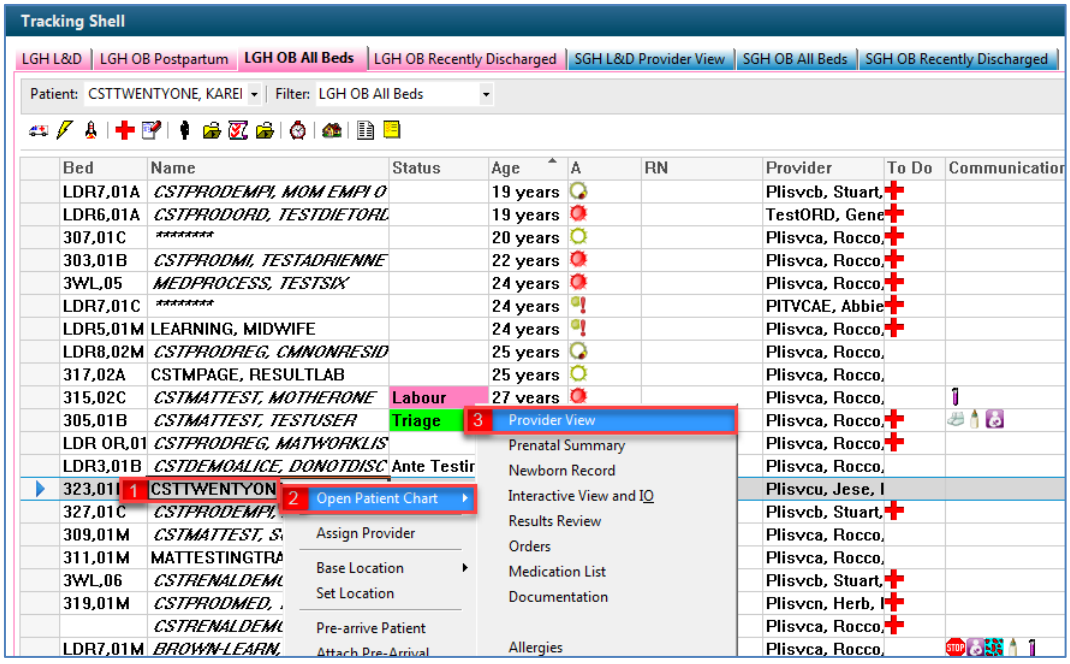
Key Learning Points

- The tracking shell provides a quick overview of all the patients in the specific department. (ie – LGH LDR, LGH OB All Beds, etc.)

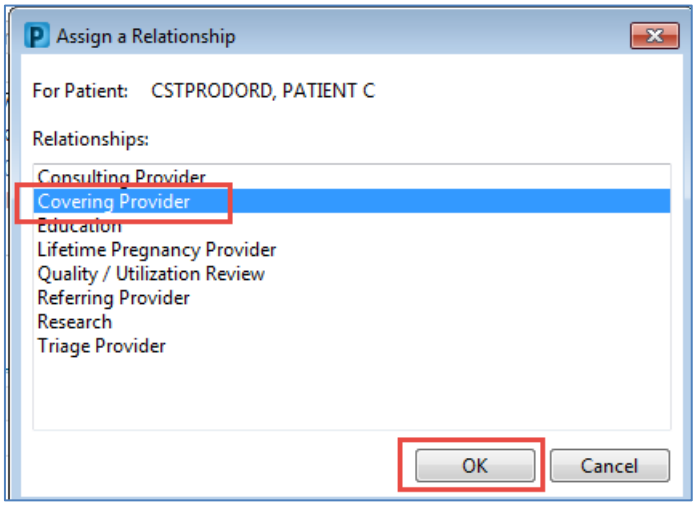
Activity 1.2 – Locate and Open the Patient's Chart

1 To open the patient's chart:

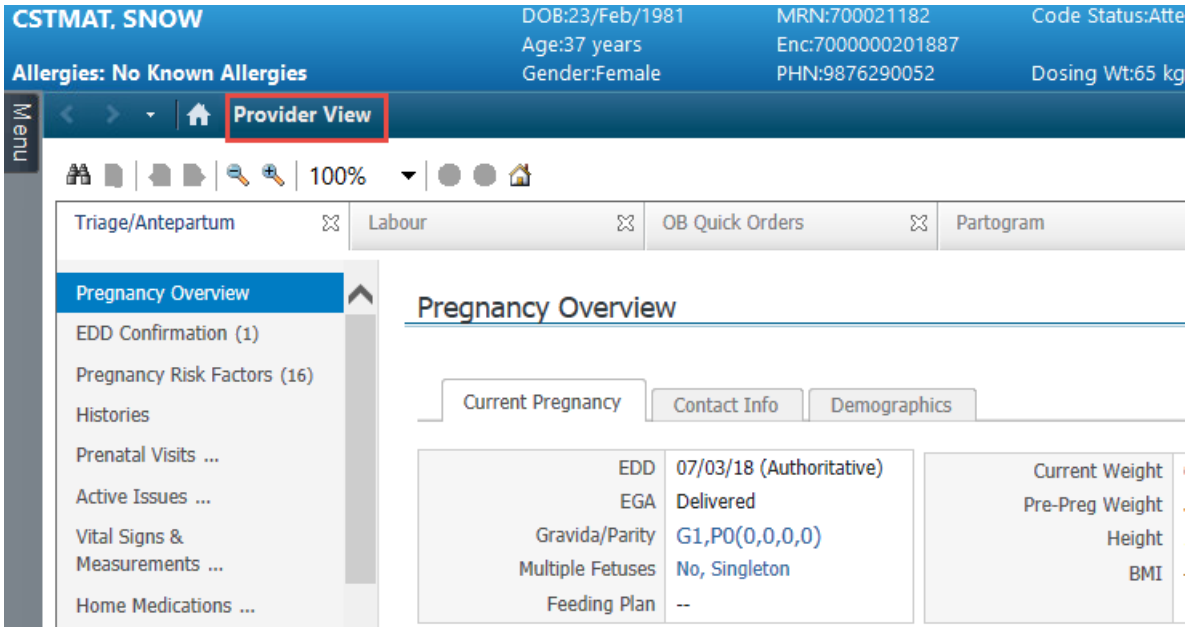
1. Right-click on **patient's name**.
2. Select **Open Patient Chart.**
3. Select **Provider View.**



If you have not established a relationship with your patient, you will be prompted with the **Assign a Relationship** pop-up screen. Select **Covering Provider** and then click **OK.**



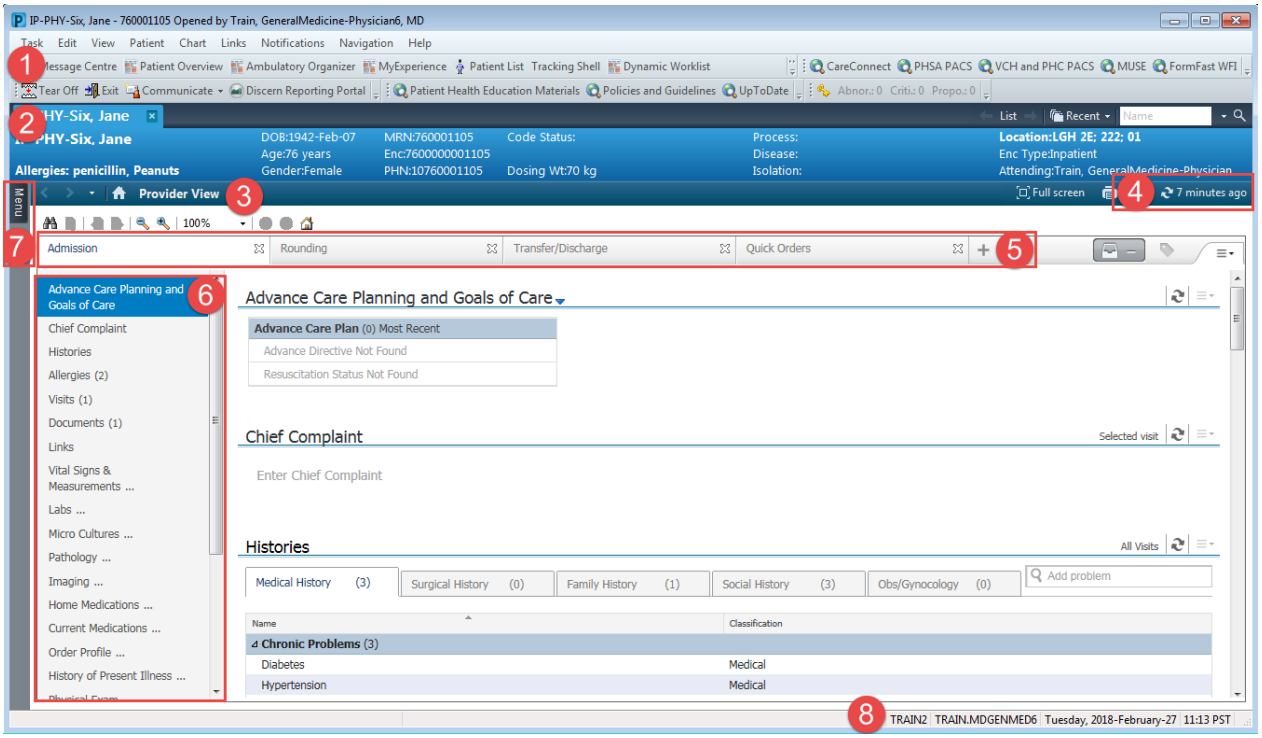
The patient's chart opens, and the **Provider View** will display as your default page.



Activity 1.3 – Review Patient Chart

1 Now let's explore the **Provider View** screen a little further.

1. The top **Toolbar** provides you with an alternate way to access PowerChart functions or to change the view.
2. The **Banner Bar** highlights important information about the patient's demographics, location, **encounter type**, **allergies**, alerts, and dosing weight. It is an easy way to ensure you are in the right patient's chart and right encounter. Many providers find it helpful to choose to check for each time patients name and age, encounter number, and encounter type.
3. Each window has its title. The current one is called **Provider View**. Note that you can use typical internet navigation buttons for moving one screen forward or back and going back to the **Home** view (your default screen) 
4. Click the **Refresh** icon  to ensure that your display is up-to-date. A timer shows how long ago the information on your screen was last updated. Refresh frequently.
5. The **Provider View** is organized into tabs. Each tab is designed to support a specific workflow. Click each tab to open a corresponding workflow view: Triage/Antepartum, Labour, OB Quick Orders, etc.
6. A **list of components** represents workflow steps specific to your specialty. To navigate patient's chart efficiently, **follow the component list:** Pregnancy Overview, EDD confirmation, Pregnancy Risk Factors, Histories, etc.
7. Use the **Menu** tab to view several pages that the Provider View doesn't list. You can use it to toggle between different chart views independently from the workflow. Most pages in the Menu can be accessed through the components in your Provider View; however, some infrequently used pages can be found within the Menu (ex. MAR Summary or Immunizations).
8. At the bottom, you will see your login name. Ensure you always work under your own login.



Key Learning Points

- You can access the patient's chart from the tracking shell.
- A relationship needs to be established to access the patient's chart.

Activity 1.4 – Customize Patient's Chart

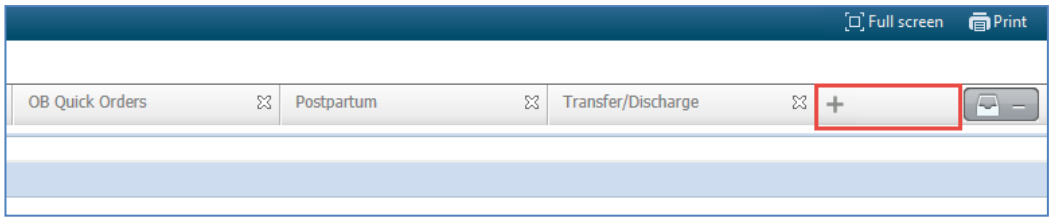
1

Workflow Tabs are available for your convenience. As a provider, they are similar to the sections of a paper chart. The added feature allows you to select only the Tabs you require, remove others and arrange them in a sequence that is useful to you.

Before navigating PowerChart, you'll select the Workflow tabs needed for this workbook.

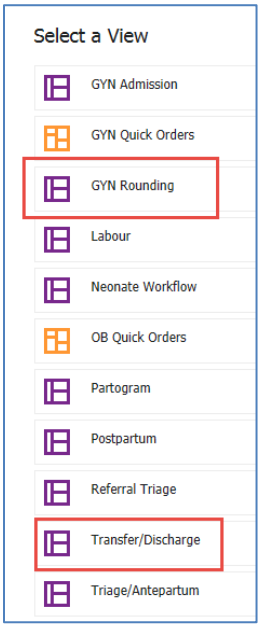
In this activity, you will Add or remove workflow tabs

If you cannot locate the Transfer/Discharge or GYN Rounding Workflow tab, click the add button + in the workflow tabs bar.



2

If you are missing workflow tabs you may select the tabs from the **Select a View** list. For example, click a missing tab: **GYN Rounding** or **Transfer/Discharge**. It is now added to your workflow tabs.

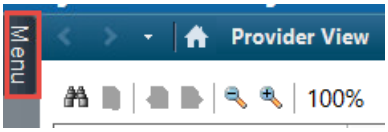


You may also remove a tab from the row by clicking the remove icon. To rearrange the

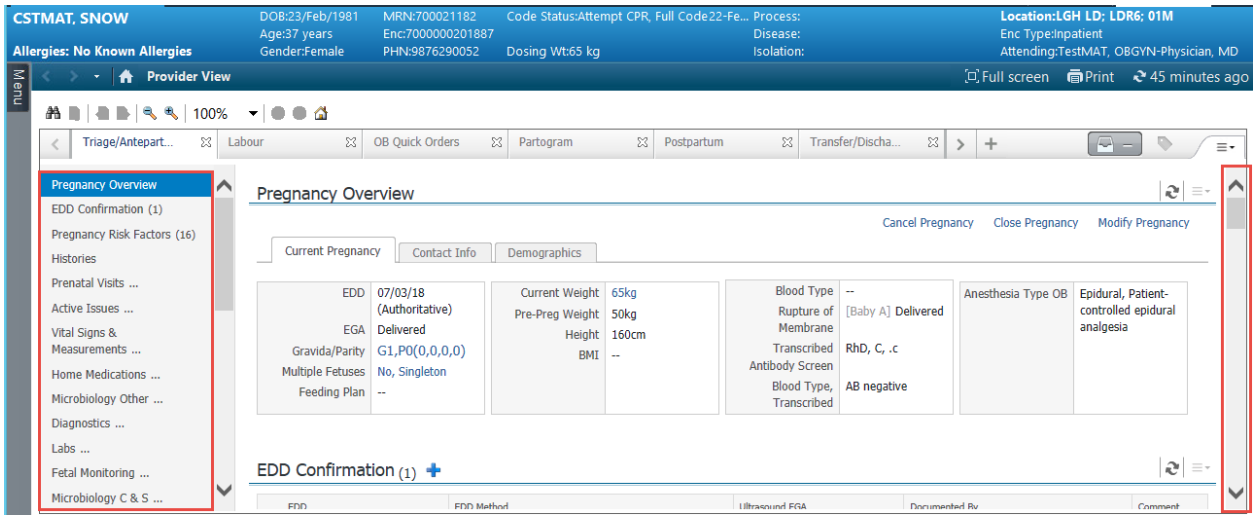
order of the tabs, slide **GYN Rounding** to the end of the row of tabs.

3 For increase viewing of the Workflow tabs, click on the **Auto hide** icon to the right of the **Menu** view.

NOTE: The table of contents Menu will be in the **hidden** view throughout this workbook. By clicking on the Menu button, the table of contents will re-appear again. This can be discussed further during your personalization sessions.



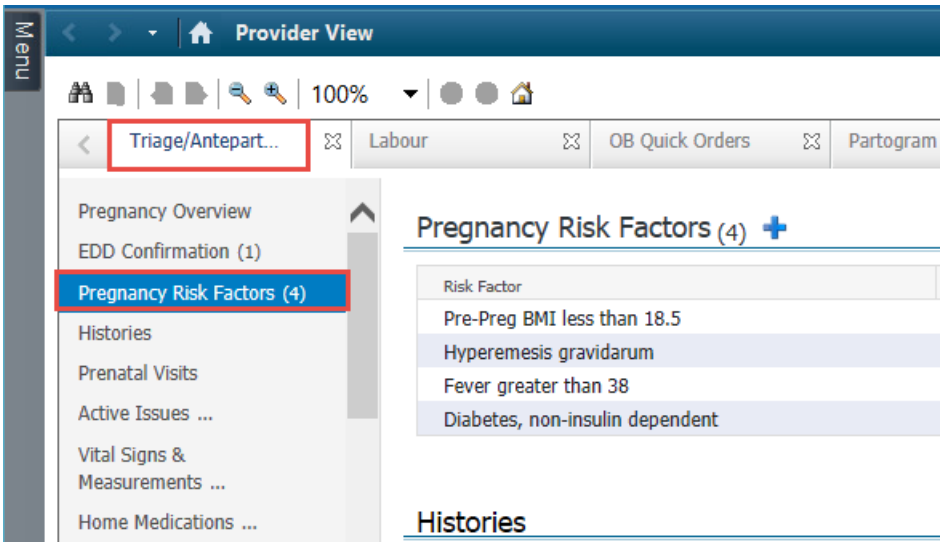
Locate on the left side of the screen, the **list of components** representing workflow steps specific to your specialty. Click the component or use the **scroll bar** to display the content of the patient's chart.


CSTMAT, SNOW
DOB:23/Feb/1981
Age:37 years
Gender:Female
MRN:700021182
Enc:7000000201887
PHN:9876290052
Code Status:Attempt CPR, Full Code22-Fe...
Dosing Wt:65 kg
Process:
Disease:
Isolation:
Location:LGH LD; LDR6; 01M
Enc Type:Inpatient
Attending:TestMAT, OBGYN-Physician, MD
Allergies: No Known Allergies
Menu
Provider View
Full screen
Print
45 minutes ago
100%
Triage/Antepart...
Labour
OB Quick Orders
Partogram
Postpartum
Transfer/Discha...
Pregnancy Overview
EDD Confirmation (1)
Pregnancy Risk Factors (16)
Histories
Prenatal Visits ...
Active Issues ...
Vital Signs & Measurements ...
Home Medications ...
Microbiology Other ...
Diagnostics ...
Labs ...
Fetal Monitoring ...
Microbiology C & S ...
Pregnancy Overview
Cancel Pregnancy
Close Pregnancy
Modify Pregnancy
Current Pregnancy
Contact Info
Demographics
EDD 07/03/18 (Authoritative)
EGA Delivered
Gravida/Parity G1,P0(0,0,0,0)
Multiple Fetuses No, Singleton
Feeding Plan --
Current Weight 65kg
Pre-Preg Weight 50kg
Height 160cm
BMI --
Blood Type --
Rupture of Membrane [Baby A] Delivered
Transcribed Antibody Screen RhD, C, .c
Blood Type, Transcribed AB negative
Anesthesia Type OB Epidural, Patient-controlled epidural analgesia
EDD Confirmation (1)
EDD
EDD Method
Ultrasound EGA
Documented By
Comment

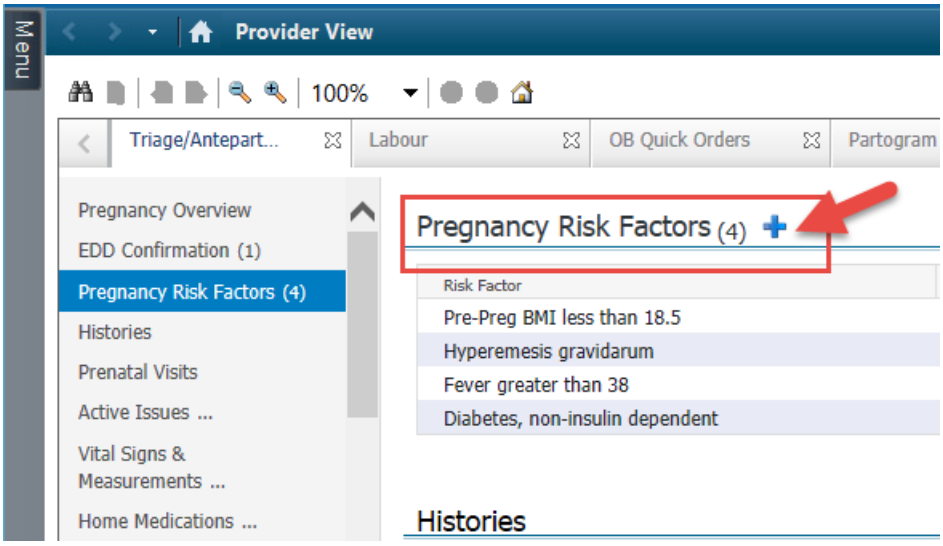
Activity 1.5 – Explore Component List and Update Risk Factors

1 Begin using the Component list and update your patient's Pregnancy Risk Factors.

1. Navigate to the **Triage/Antepartum** workflow Tab.
2. Click the **Pregnancy Risk Factors** component from the list.

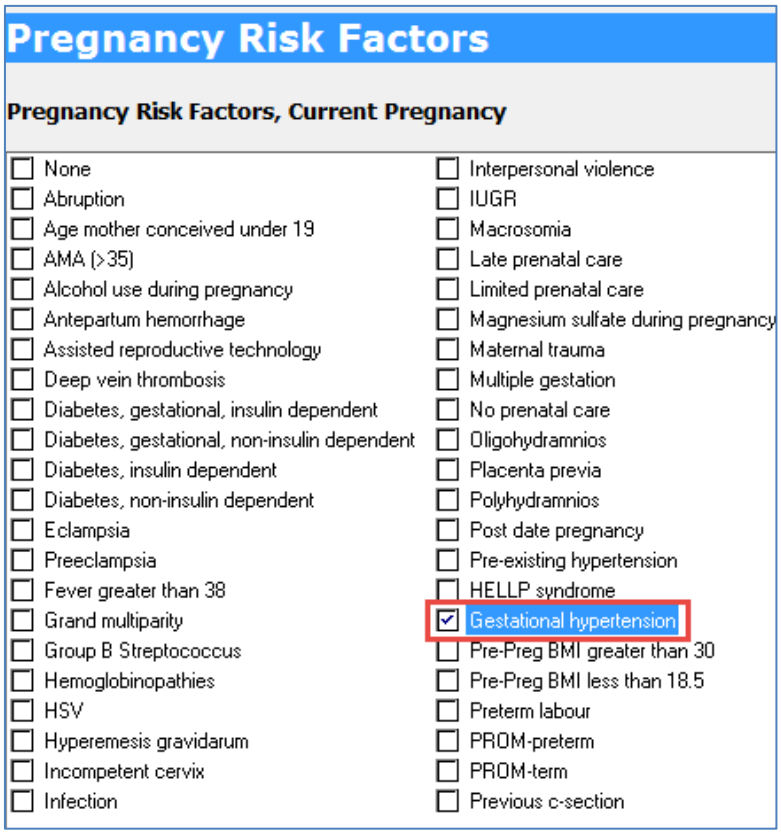


3. Click the Pregnancy Risk Factors **+ button** and the Pregnancy Risk Factors window opens.

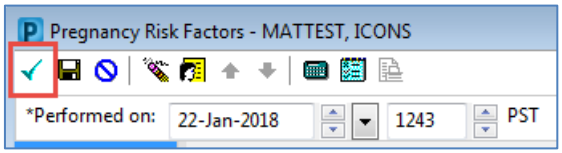


NOTE: Nurses may also complete the Pregnancy Risk Factors using the nursing PowerForms documentation and it will flow into the Workflow tab page. It will also flow into your clinic note.

4. Locate and check **Gestational hypertension** box.



5. Sign the form with the green checkmark at the top left of the screen.



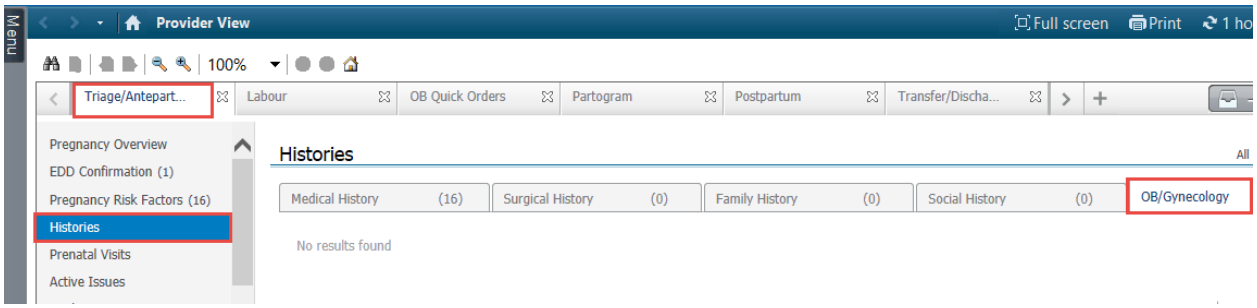
6. Refresh screen .

Activity 1.6 – Review Histories

Review your patient's **Obs/Gynecology History** information.

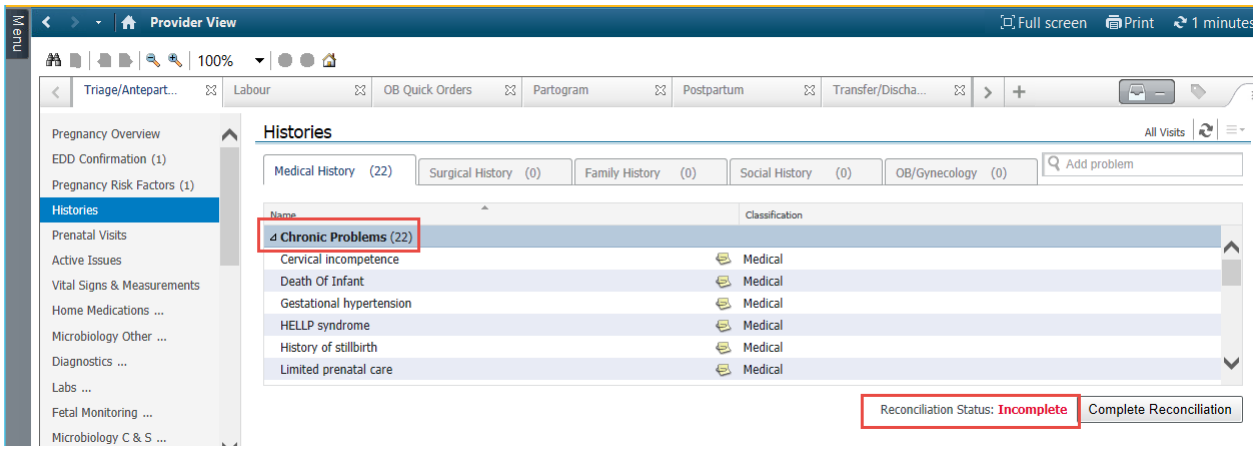
1

1. Select the **Triage/Antepartum** Workflow tab.
2. Click the **Histories** component from the list.
3. There is a tab for each history type: Medical, Surgical, Family, Social, and **Obs/Gynecology**.

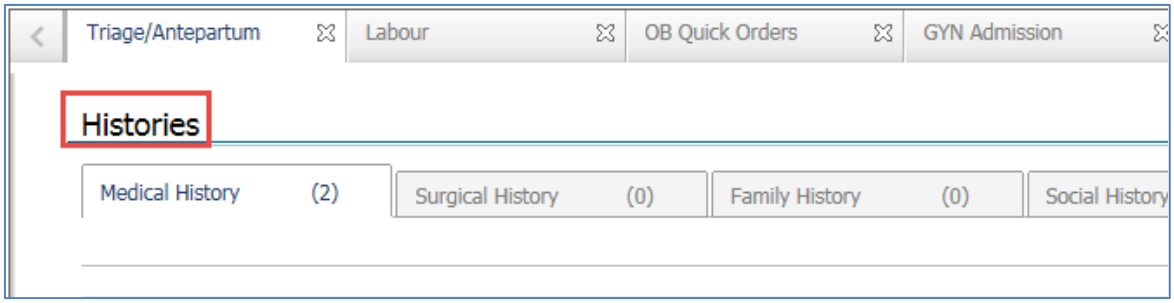


4. Review each tab to display its entries right underneath. The number in brackets indicates how many entries are in each tab.
5. For example, there are 22 records for **Medical History** entered previously.

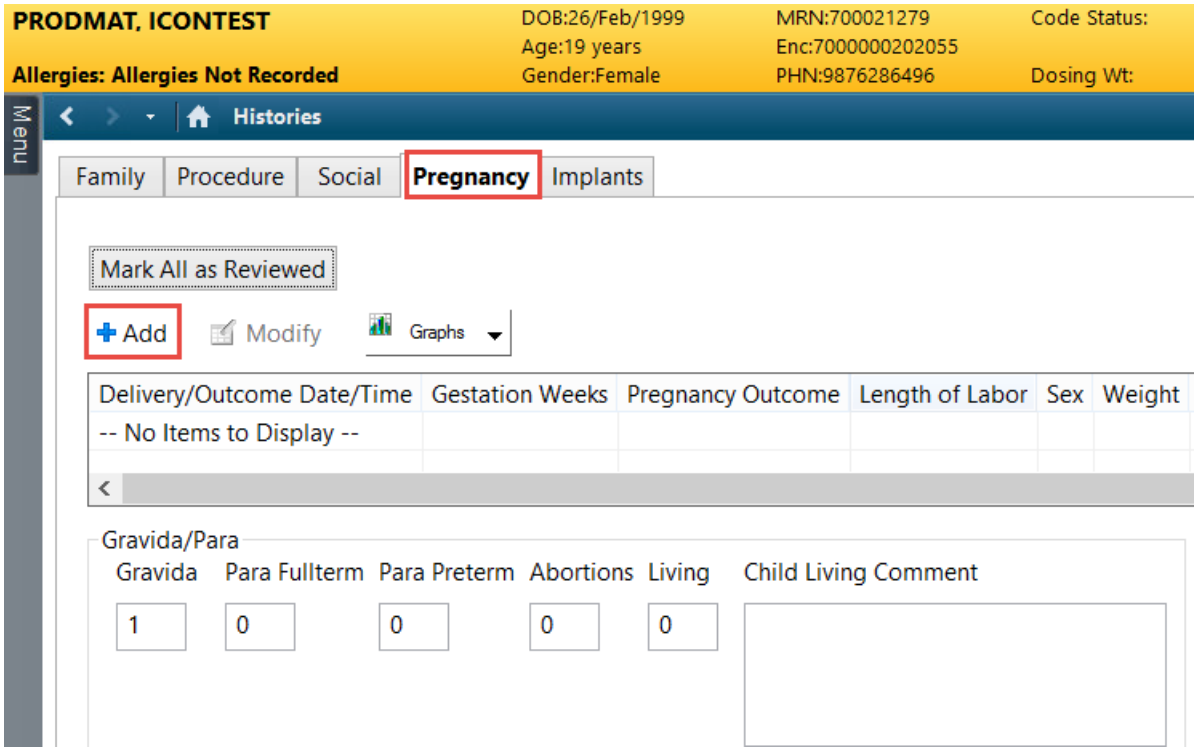
   Some components have a status line. When you access patient's chart for the first time during this visit, you might see the status of histories or allergies as **Incomplete.** Update the information if necessary or click **Complete Reconciliation** to document your review.



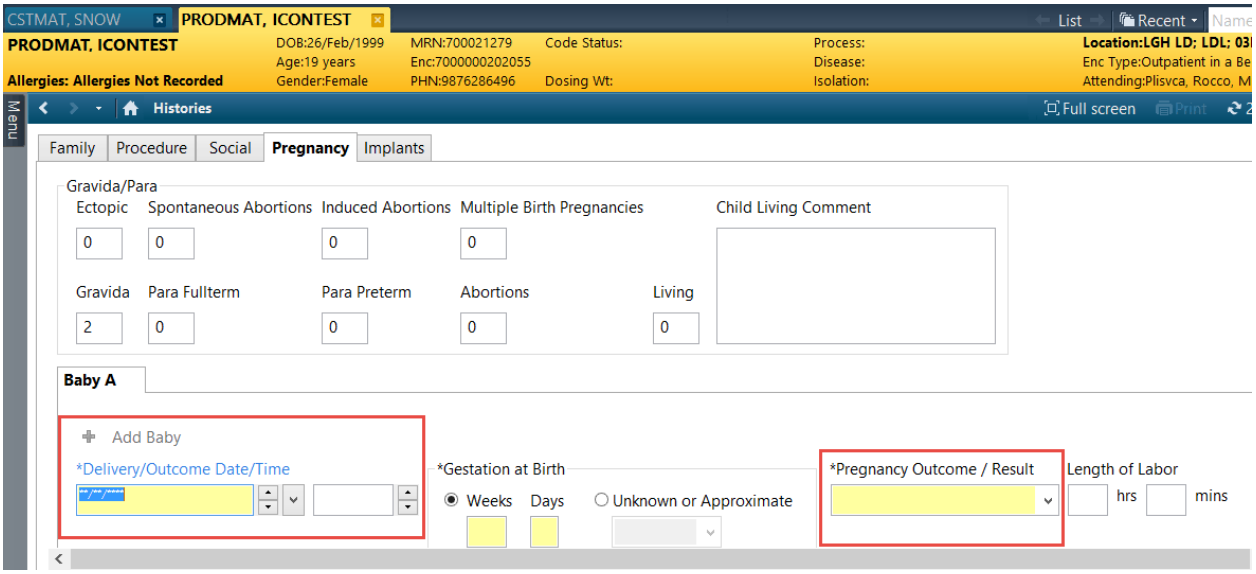
6. Click the **Histories** hyperlinked heading. Place the cursor over the heading. This icon means it is a link. Each component from the component list has a heading. Pregnancy History window opens.



7. Click the + **Add** button to update history and add comments as needed.



8. Completed the mandatory fields and sign **OK.**


CSTMAT, SNOW
PRODMAT, ICONTEST
List
Recent
PRODMAT, ICONTEST
DOB:26/Feb/1999
Age:19 years
Gender:Female
MRN:700021279
Enc:7000000202055
PHN:9876286496
Code Status:
Dosing Wt:
Process:
Disease:
Isolation:
Location:LGH LD; LDL; 03
Enc Type:Outpatient in a Be
Attending:Plisvca, Rocco, M
Allergies: Allergies Not Recorded
Menu
Histories
Full screen
Print
Family
Procedure
Social
Pregnancy
Implants
Gravida/Para
Ectopic
Spontaneous Abortions
Induced Abortions
Multiple Birth Pregnancies
Child Living Comment
0
0
0
0
Gravida
Para Fullterm
Para Preterm
Abortions
Living
2
0
0
0
0
Baby A
Add Baby
*Delivery/Outcome Date/Time
*Gestation at Birth
Weeks
Days
Unknown or Approximate
*Pregnancy Outcome / Result
Length of Labor
hrs
mins

5 **REMEMBER:** If you lose your way in the patient's chart, select the **Home** icon or use the **Arrow** icon below the banner bar.

takes you back one screen
takes you to your default view – the **Provider Overview**
displays a list of recently visited screens for an easy jump back

To open another patient's chart previously accessed in Clinical Information System (CIS), click the drop-down arrow icon in the **Recent** box located in the upper right corner.

Now to return to your **Provider View**, simply click the Home icon.

Key Learning Points

- You can add or remove workflow tabs when necessary.
- Workflow tabs are like the sections of the chart eg: Quick Orders, Triage/Antelabour, Labour, etc.
- Components are listed in order of your day to day workflow: Pregnancy Overview, EDD confirmation, Pregnancy Risk Factors, etc
- Arrange the Component items to suit your workflow by dragging the items up or down the list.
- Refresh often to view the most up to date information.

Activity 1.7 – Review and Add Allergies

In this activity you will:

- Add a new allergy.
- Modify the existing allergy record.

In the Clinical Information System (CIS), patient allergies can be added and updated by providers and clinicians. In the inpatient setting, a patient's allergies are to be reviewed by a provider on admission and at every transition of care. Allergy information is carried forward from one patient visit to the next.

It will also track allergy-to-drug interactions.

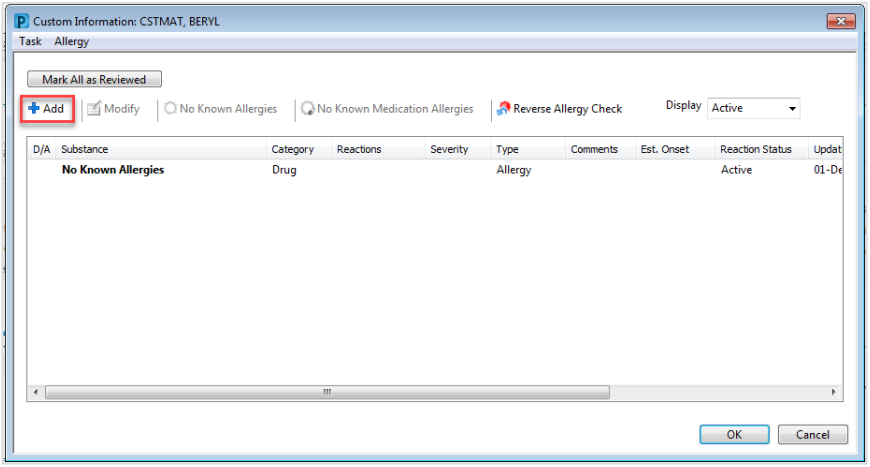
The CIS keeps **track of the allergy** status and will automatically prompt you when the information is not up-to-date. When placing an order with allergy contraindication, an alert will display.

.

1 You learn from the patient that they are allergic to Sulfa and you document this allergy.

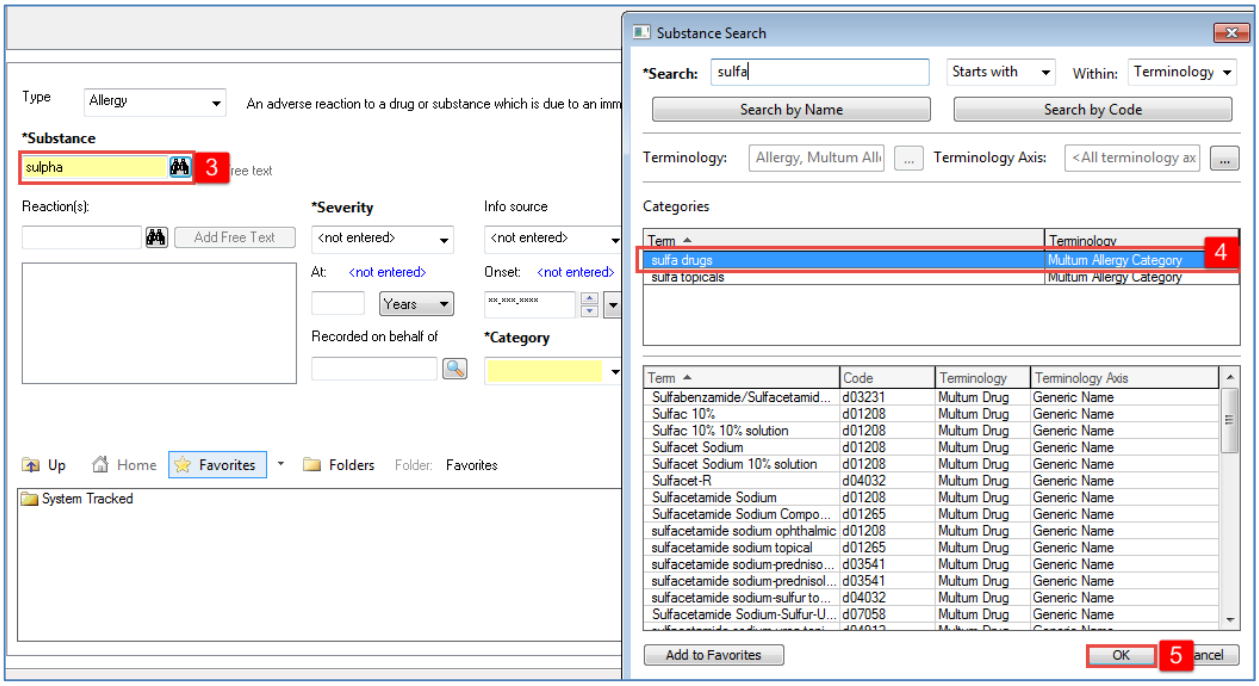
1. Navigate to the **Allergies** in the Banner Bar. Click on the hyperlink Allergies: No Known Allergies. The GYN workflow tabs include Allergies in their components list. The Add Allergy window opens.

2. Click the Add button. The **Add Allergy/Adverse Effect** window opens.



3. In the **Substance** field, type = *Sulfa* and click the **Search** icon.
4. Select **sulfa drugs** (Sulpha is not available as an alternative).
5. Click **OK.**

NOTE: Yellow highlighted and starred fields including substance and category are mandato fields that need to be completed.



8. Add appropriate options in the other two mandatory fields:

Mandatory

- Select *Severe* for the ***Severity** as it is

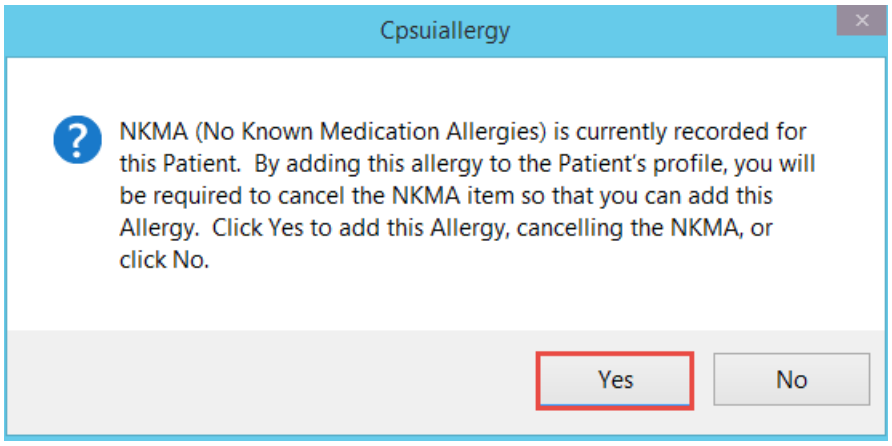
Non-mandatory

- Search for *Rash* in the

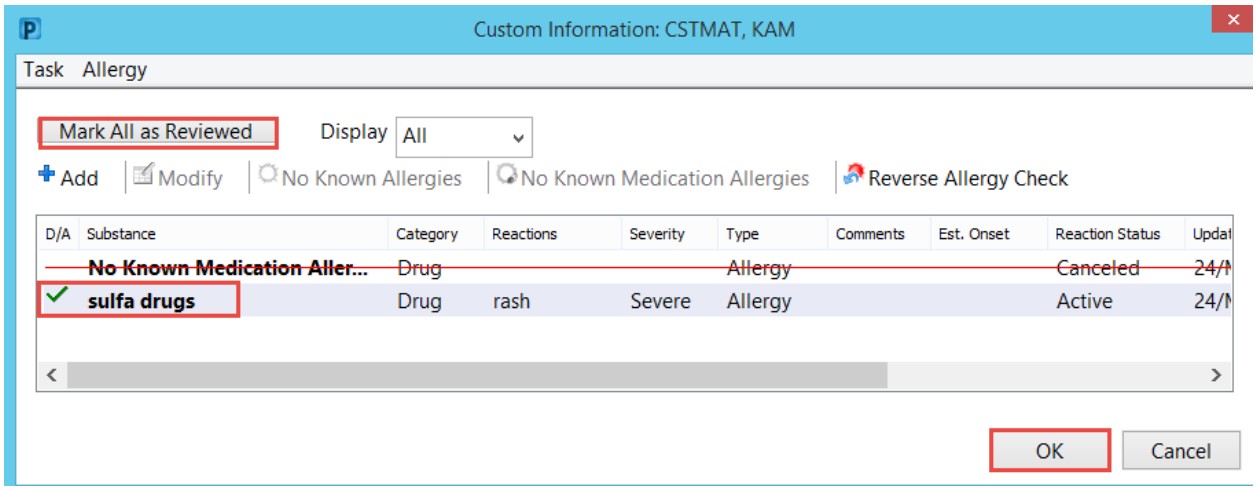
starred * **Reaction**(s) box (recommended)

- Select *Drug* for the **Category**

6. Click **OK** to save the information.
7. Click **Yes**, when you see a NKMA pop-up.



8. Click Mark All as reviewed.
9. Click **OK.**
10. Patient's allergy record is now updated.

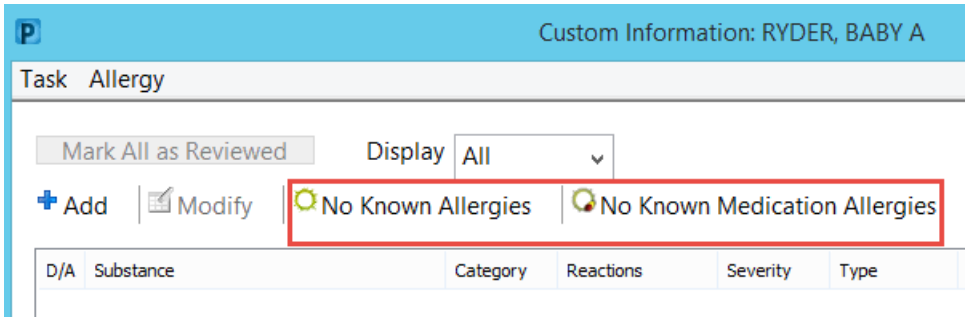


NOTE: For the pharmacy to dispense, they must see that the allergy record has been reviev by a provider.

- If a patient has no known allergies, click on **Allergies Not Recorded**

Select one of the following:

- No Known Allergies
- No Known Medication Allergies



Refresh your screen and Click the icon to return to the Provider View to view the added Allergy.

Key Learning Points

- Patient allergies and interactions are monitored by the CIS.
- Allergy record needs to be reviewed for each encounter on admission, at discharge, with a change in the level of care.
- Review of allergies is complete when Mark All as Reviewed is selected.

PATIENT SCENARIO 2 – Admit Patient

Learning Objectives

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

- Admit Patient
- Complete Admission Medication Reconciliation
- Update Active Issues (problems and diagnoses)
- Place an Admission PowerPlan (order set)
- Document in Interactive View and I&O (iView)
- Complete and sign an admission note

SCENARIO

In this scenario, you will go through the admission process. The patient also tells you that she forgot to mention she takes Labetalol 200 mg PO BID. The Admission PowerPlan will be initiated. You will also be documenting on your patient.

You will be completing the following activities:

- Enter Admit to Inpatient order
- Update Best Possible Medication History and complete an Admission Medication Reconciliation
- Update Active Issues for both this visit and chronic issues (problems and diagnoses)
- Place PowerPlan with added Orders and Module into the PowerPlan for patient admission
- Document Cervical Exam in Interactive View and I & O (iView) Flowsheets
- Create an OB Admission and H&P Note

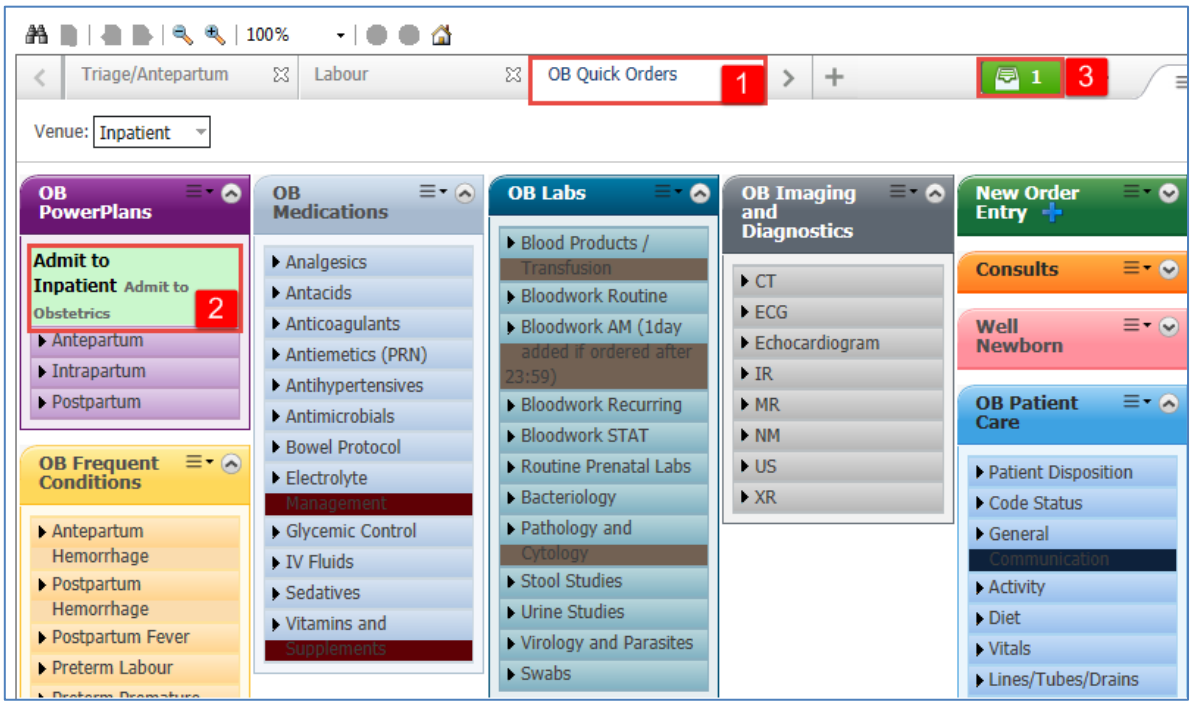
Activity 2.1 – Admit a Patient

Your next step after reviewing your patient is to admit the patient.

1

1. Click on the **OB Quick Orders** workflow tab.
2. Click **Admit to Inpatient** under the OB PowerPlans.
3. Click **Orders for Signature** icon  . The icon turns green and indicates you have 1 order in the queue. Click it once.

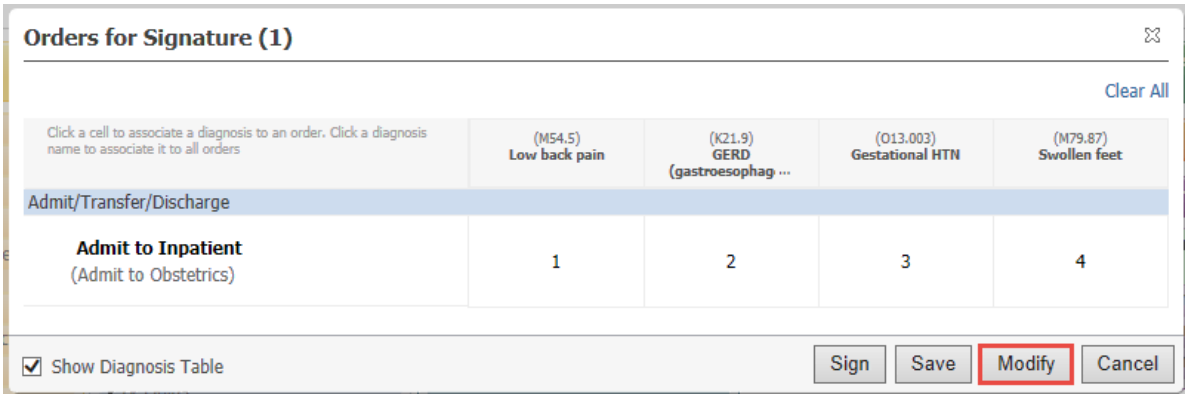
   The Orders for Signature (1) window opens.



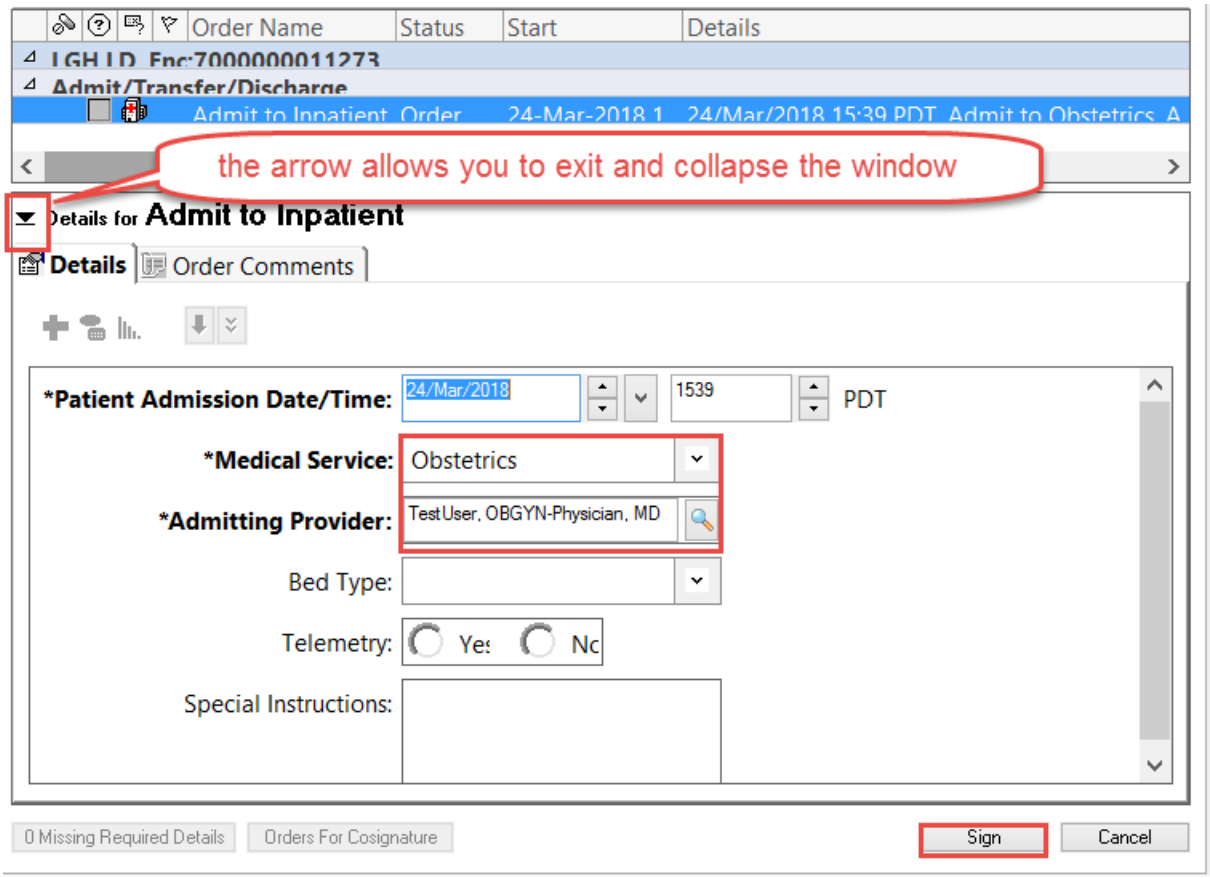
2

The **Orders for Signature** window lists all orders that you have selected. In our example, there is just one order.

1. Ensure the right order is listed.
2. If no order details are missing and you are familiar with the order, you would click **Sign**. However, the CIS will prompt you to enter the required details missing.
3. To learn what details are provided in the Admit to Inpatient order, click **Modify**. The Orders page opens.



4. Click on the order name Admit to Inpatient Order to open the order details.
5. Review the auto-populated fields **Medical Service** and **Admitting Provider**.
6. Note the **Details** panel displays. Click the ▼ icon to collapse the panel and exit the order.
7. Click **Sign**.



NOTE: Your patient is admitted to **Obstetrics** service. In the hospital setting, refresh your screen and the encounter flips from **Outpatient in a Bed** to **Inpatient** from if initial encounter type was outpatient.

Key Learning Points

- When admitting a patient, it is critical to place the Admit to Inpatient order prior to entering additional orders.
- Review the Banner Bar information to ensure you have selected the right patient and the right encounter.
- The Provider View provides access to various workflow tabs such as Quick Orders for frequently used orders.
- Remember to refresh your screen frequently to view the most up-to-date information.

Activity 2.2 – Review Patient's Best Possible Medication History (BPMH)

In this activity you will:

- Update BPMH – your patient forgot to mention her Labetalol while the nurse was entering the BPMH.
- Complete the admission medication reconciliation.

1

1. Click on the **Triage/Antepartum** Workflow Tab.
2. Click the **Home Medications** component to display the list of documented home medications.

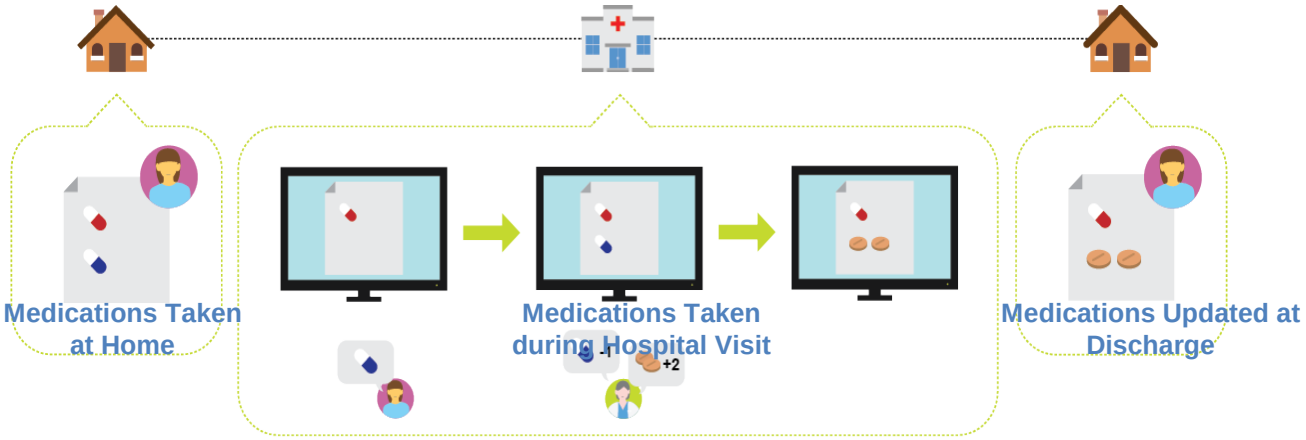
Read the following sections until you come to further steps:

The BPMH is generally documented by a pharmacy technician. When a pharmacy technician is not available, it can be completed by a pharmacist, nurse, medical student, resident, or by the patient's most responsible physician.

In the CIS there are two places to see a list of home medications. You can look in the **Home Medication** component of the **Triage/Antepartum** workflow. This will show you the medications that the patient was taking upon discharge from their last encounter.

You can also see the patient's PharmaNet Profile when documenting the BPMH. When you create the BPMH, these lists can be seen side-by-side. More details about how to view the PharmaNet profile and complete the BPMH will be shown in other training sessions.

2 Home medications are reconciled each time the medication reconciliation is done.



WARNING: In the CIS, the BPMH **must be completed before** proceeding with the admission medication reconciliation. The Admission Reconciliation will not be available until the Medication History is documented.

Within the Triage/Antepartum workflow tab, there are a few tools to help with this:

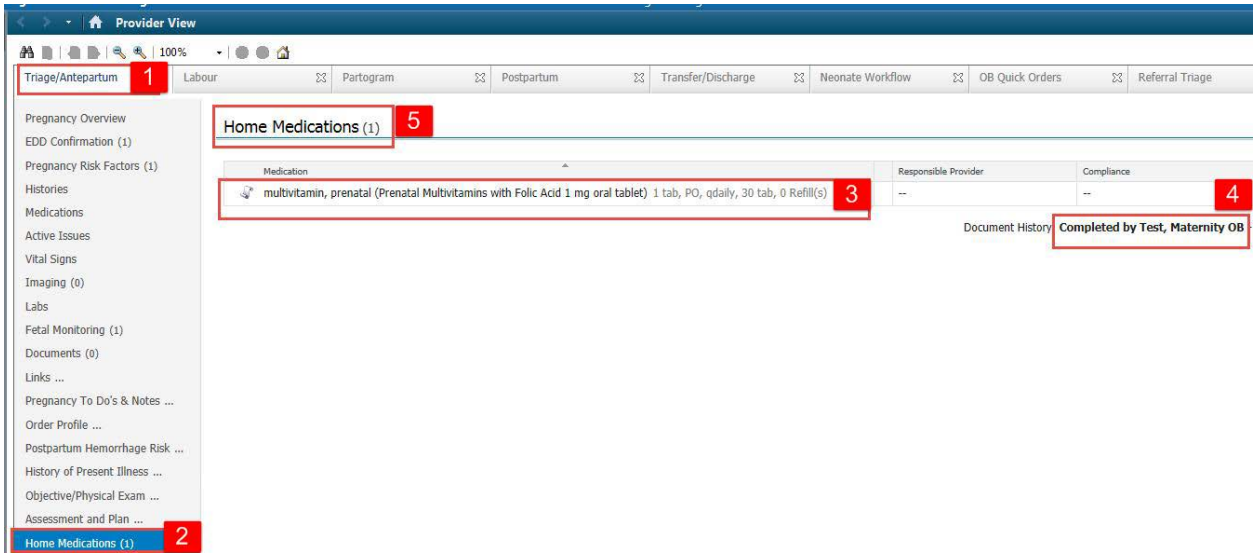
- **Home Medications** – this component lists home medications documented for this visit and carried over from previous encounters
- **Current Medications** – this component lists medications ordered during the current encounter
- **Medication Reconciliation Tool** – for admission, transfer, and discharge, it allows you to manage all home and ordered hospital medications through one convenient screen

Your patient has told you that she is taking Labetalol 200 mg twice a day at home and forgot to mention this to the Nurse who completed the BPMH. Complete the Admission Medication Reconciliation:

1. Continue on the **Triage/Antepartum** Workflow Tab.
2. Continue the **Home Medications** component to display the list of documented home medications.
3. Note the documented home medications are marked by the icon.
4. Note the status line **Document History** indicating who and when updated the medication

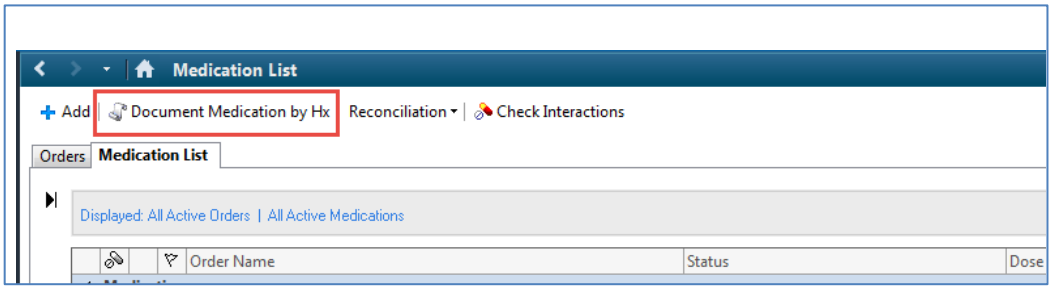
history.

5. Click the **Home Medications** hyperlinked heading. The Medication List window opens.

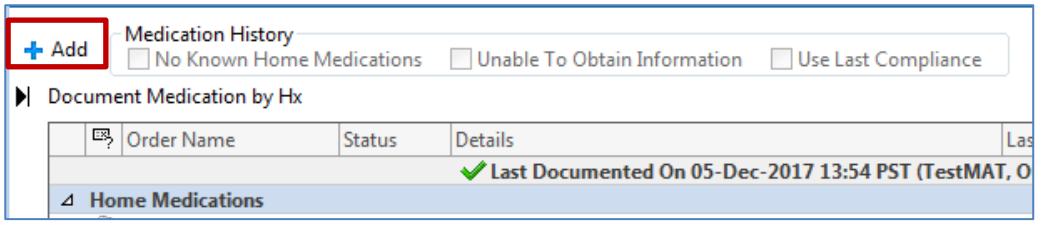


6. In the Medication List window, click **Document Medication by Hx.**

   Confirm the Dropdown list beside the Document Medication by Hx is **Reconciliation, not Inpatient**.



7. Click the **+ Add** button on the Medication History toolbar

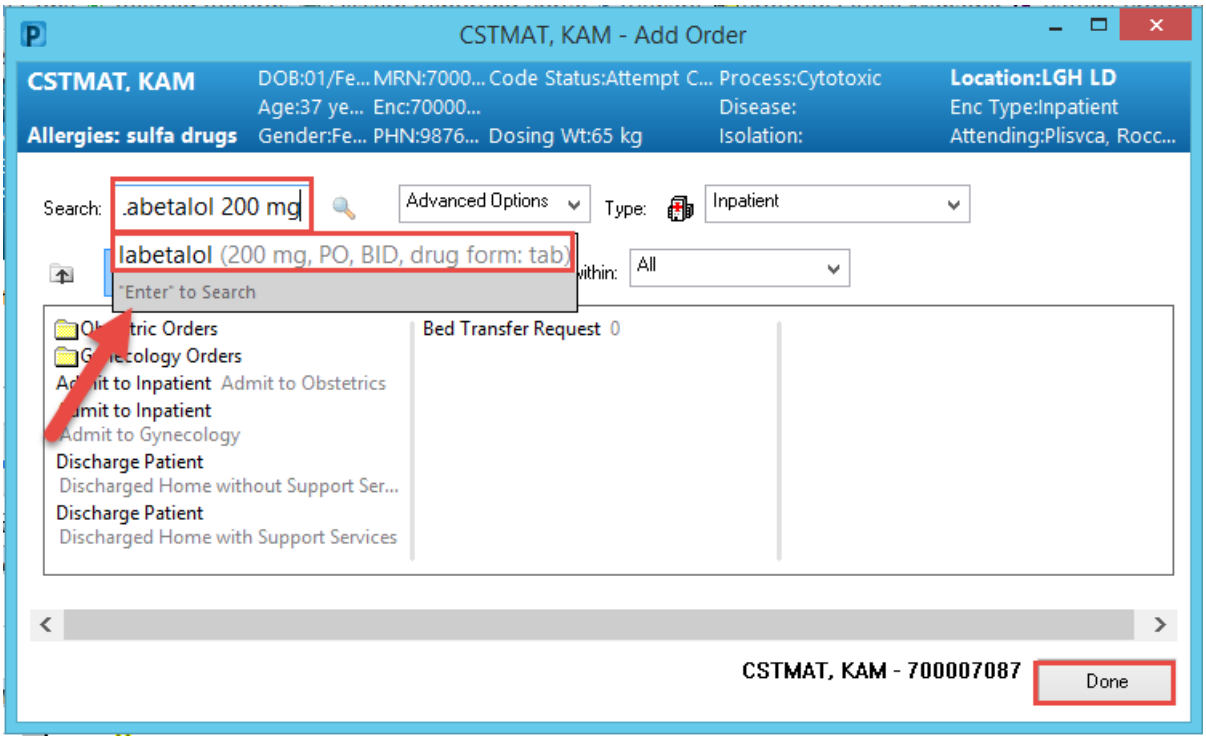


8. Enter in the **Search** box = ***Labetalol 200 mg***
9. Select **Labetalol 200 mg oral tablets (1 tab, PO, BID, drug form tab, dispense qty: 60**

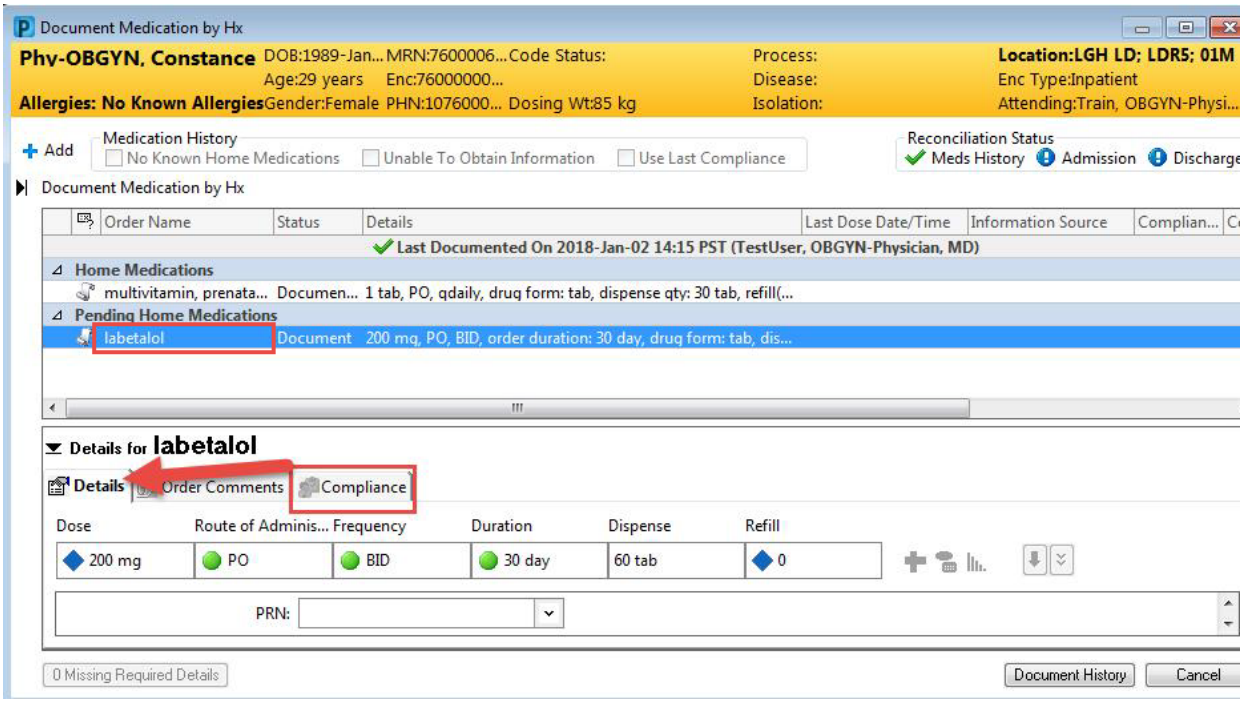
tabs)

FYI: If needed, click Enter to display more order sentences for this medication to review.

10. Click **Done.** The Order window opens.



11. Select the order to display its details. Right-Click on Order name and select Modify.
12. It is very important to know if the patient is compliant with the prescription. To add this information, click on the **Compliance** tab.

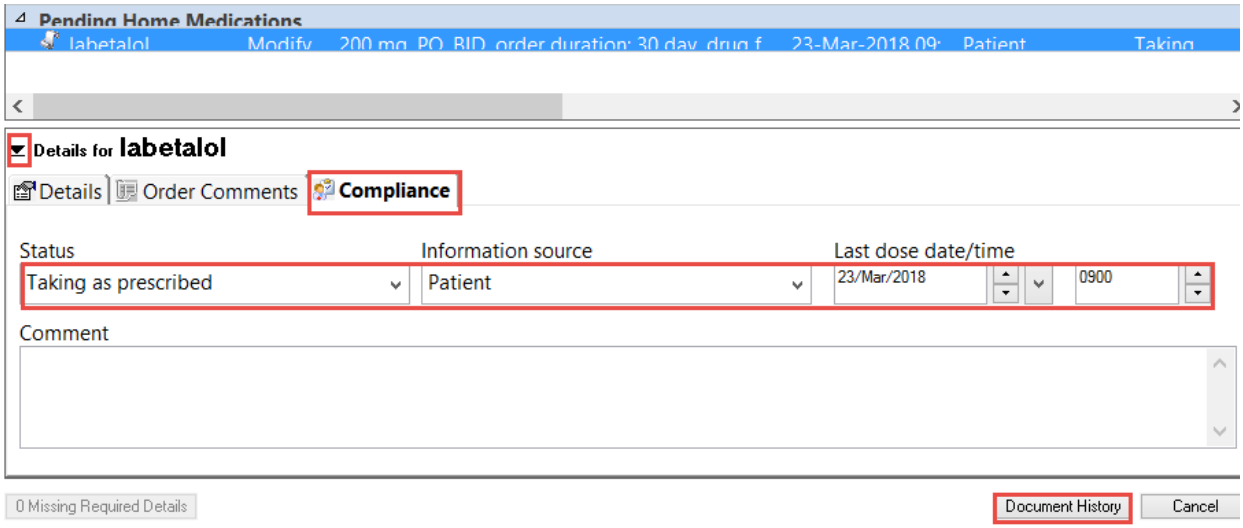


13. Document the following compliance information:

- **Status =** Taking as prescribed
- Information source = **Patient**
- Last dose date/time = *Yesterday at 0900*

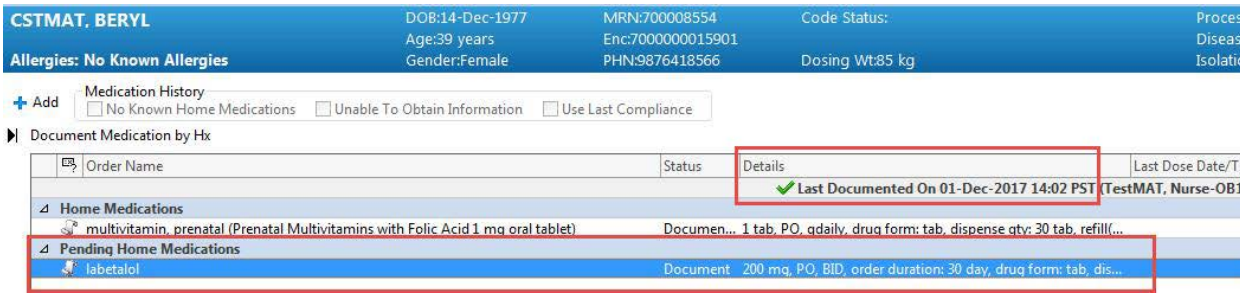
14. Click **Document History**

REMEMBER: Click Details to exit the order and collapse or expand details for a selected order.

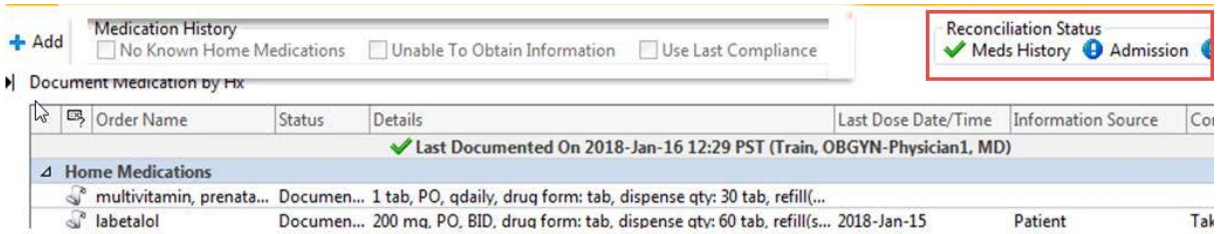


15. The updated list of current home medications for your patient is displayed.

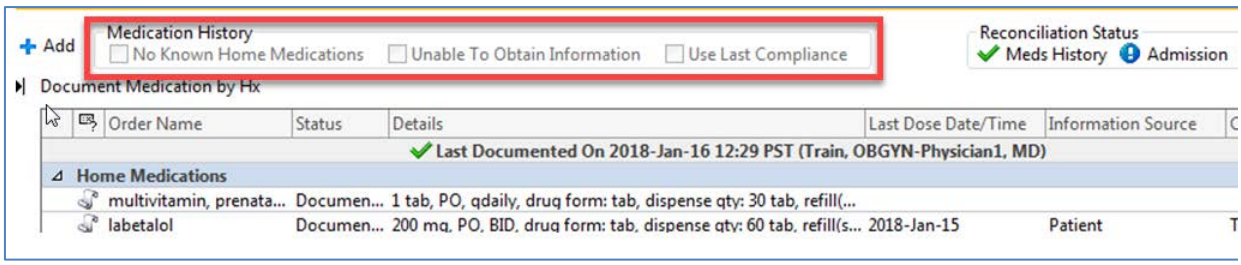
REMEMBER to refresh your screen.



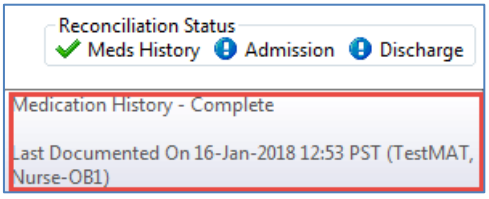
16. Locate the **Reconciliation Status** column and review the **Med History** ✔ is documented.



REMEMBER: Home medications can be updated at any time, even if the Meds History status states C**omplete.** In some cases, you may document that the patient has no home medications, or you are unable to obtain information respectively.



17. Hover over the **Meds History** Reconciliation Status line to display who and when the reconciliation was documented.

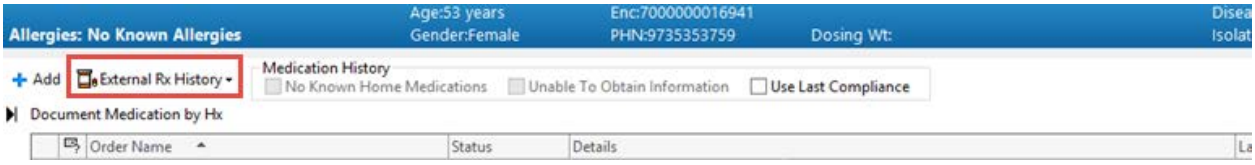


NOTE: The following information and screenshots are to illustrate the ability to see a patient's PharmaNet profile when completing BPMH.

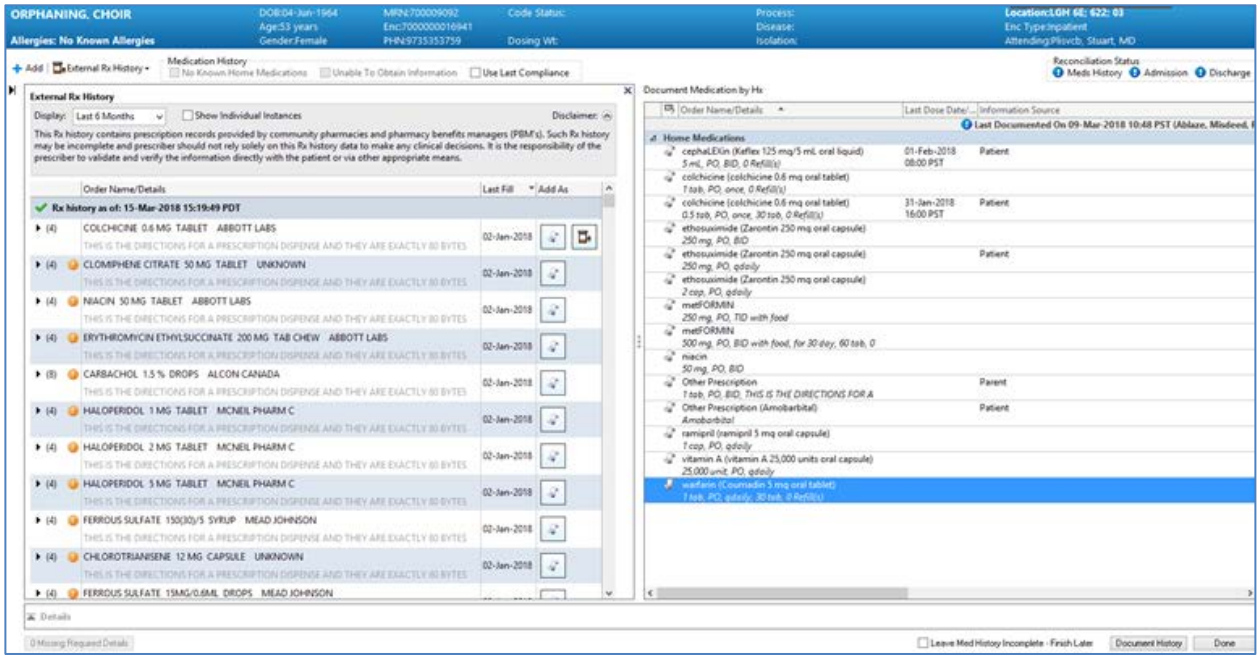
This is not available in the Train domain that you are currently learning in, but will be available when the CIS goes live. Resources to review this process will be available in future sessions prior to go-live.

3 To view a patient's PharmaNet profile, you will access home medications in a similar manner as above, by selecting the **Document Medications by Hx** button. Document Medication by Hx

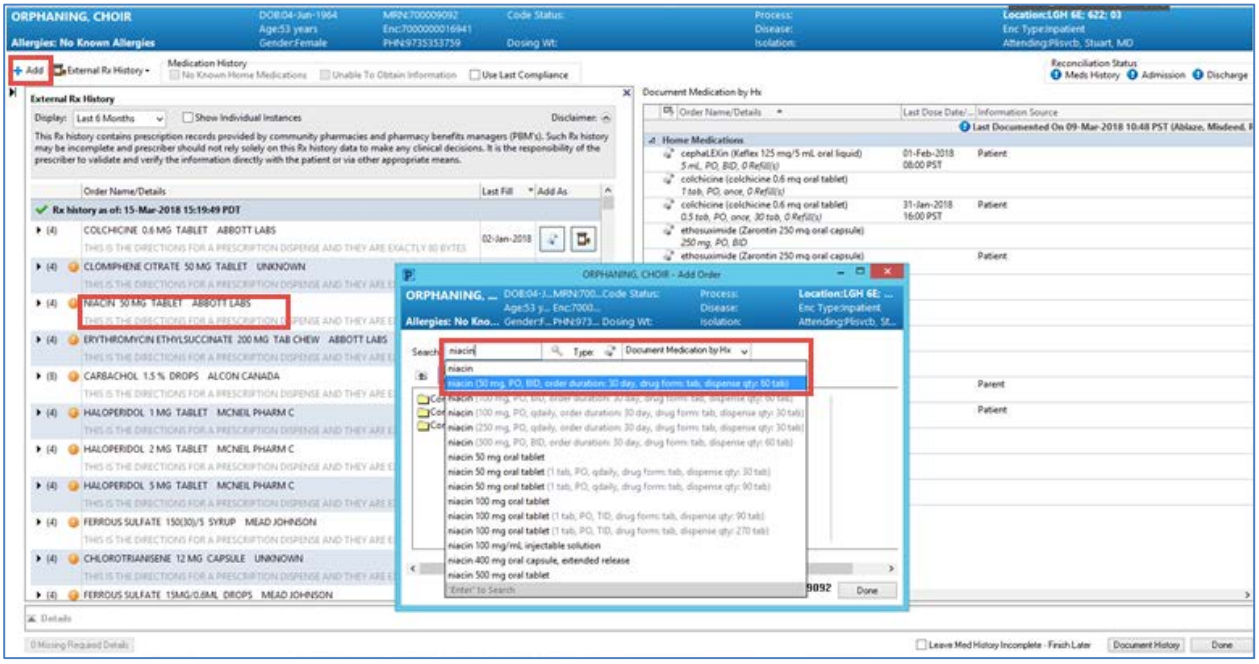
Within the Document Medications by Hx page, a new **External Rx History** button will be visible. External Rx History



Clicking this button will open up the PharmaNet External Rx History window in a side-by-side view with the Document Medication by Hx window.



From these windows, users can then review a patient's PharmaNet history and make informed decisions regarding which medications to add to the patient's BPMH.



Activity 2.3 – Complete Admission Medication Reconciliation

1 Now that you have updated the medication history and will complete the **Admission** Medication Reconciliation.

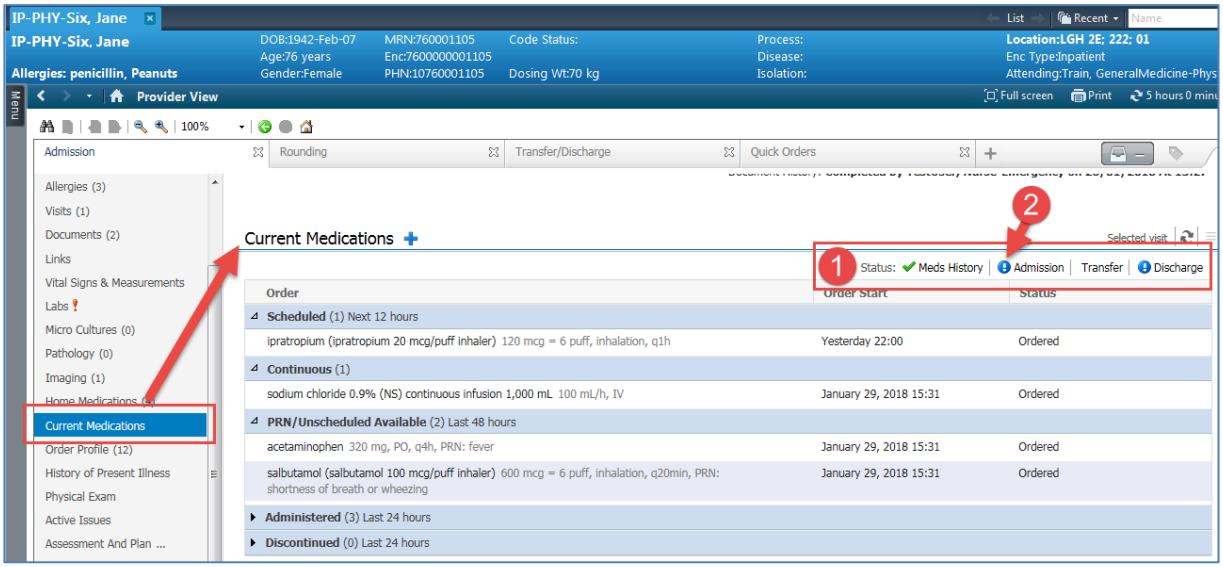
In this activity you will:

- Select home medications to be continued or discontinued
- Review current inpatient medications and decide a course of action
- Complete the admission medication reconciliation

Navigate to the home icon 

and the **Triage/Antepartum** Workflow tab.

1. Click to the **Current Medications** in the **component list**.
2. Click the **Admission** button in the upper right corner. The **Orders Prior to Reconciliation** window opens.



NOTE: The status of medication management in the top right corner.

- ✔ means complete
- ❗ means incomplete
- ◔ means partially complete

2

The admission reconciliation displays medications in a different order on your screen.

Take a very close look at this window. Reconciliation at any point of care – admission, transfer, or discharge works the same way.

Review the **Orders Prior to Reconciliation** on the left. Some icons you already know:

indicates a documented home medication from the BPMH
indicates an inpatient medication
indicates the medication is part of the order set called PowerPlan
indicates unreconciled medication

WARNING: ED medications that **are ordered as "once" will not be displayed** on the Admission Medication Reconciliation screen.

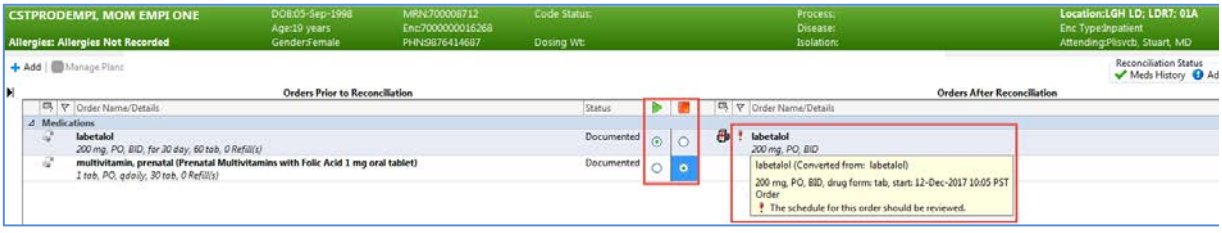
The following icons help you to manage the process:

allows for continuing a medication
allows for discontinuing a medication

3. Review the Medication Orders Prior to Reconciliation on the left.

   Order Reconciliation: Admission displays documented home medications for your patient.

   If there were previous orders entered on your patient, it would show here as well (i.e. current medications, etc.).



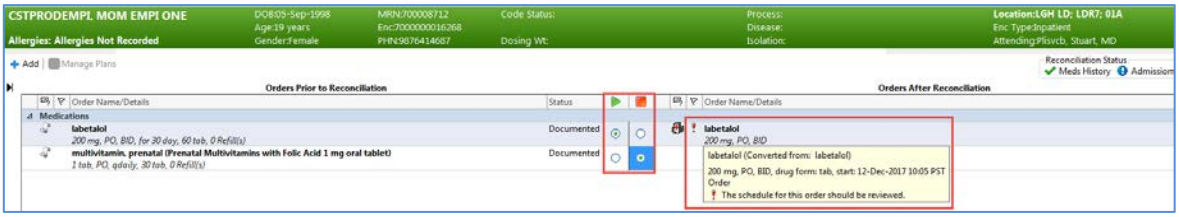
   Continue the following home medications :

4. Click the radio button to continue **Labetalol 200 mg PO BID**.

Discontinue the following home medications :

5. Click the radio button to discontinue the **Multivitamin.**

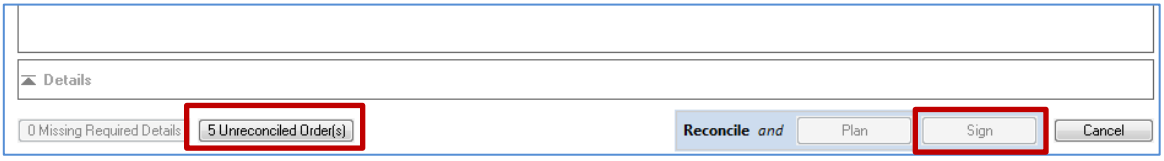
6. Review the list of **Orders After Reconciliation** on the right side of this window.



REMEMBER: The continued medication becomes an inpatient order marked by the icon.

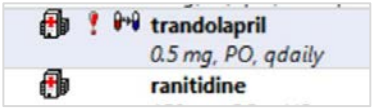
7. Click **Sign** to complete the process and have the medications orders to be continued as active.

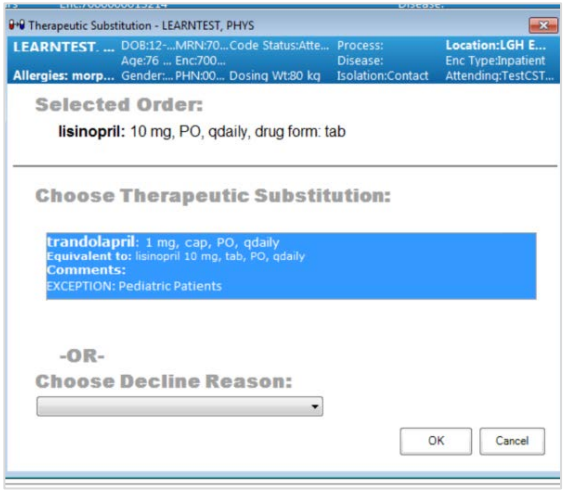
   You cannot sign off until you address all medications listed. The unreconciled orders button in the bottom left corner provides a count of the medications that still require reconciliation.



It is recommended to complete the admission medication reconciliation before placing new orders. If you complete this step after entering orders, they will also appear here. This makes it more difficult to read and asks you to continue or discontinue medications that you just ordered.

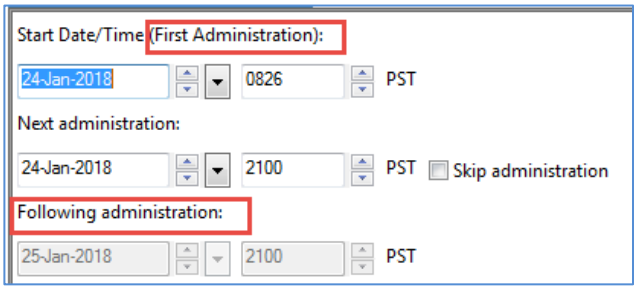
NOTE: If a home medication is not available, a medication substitution is indicated by icon. You can accept the suggested replacement or choose a reason to decline it and this will be communicated to the pharmacy.





NOTE: Some medications might be marked by ❗. The CIS will prompt you if the first dose administration time has passed and allows you to adjust the first dose time.

Review the line to display the Details window, and then click **!Review Schedule** to check if details are correct for drug administration. You will be able to adjust the first dose time if appropriate. See example below.

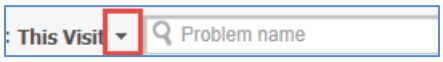


Key Learning Points

- The **Admission Medication Reconciliation** screen displays all current active medication orders
- You can choose to continue or discontinue any medications listed on the Admission Medication Reconciliation screen
- It is recommended to complete admission medication reconciliation **prior to** entering additional admission orders

Activity 2.4 – Update Active Issues

1 READ THIS SECTION: Your patient has several active issues for this visit. Before you see the patient, the nurse or unit clerk will have added a pregnancy to the PowerChart. Pregnancy will be an active issue that will show up across encounters. In PowerChart, every pregnant woman prompts the display to "add a pregnancy". This is unique to Obstetrics.

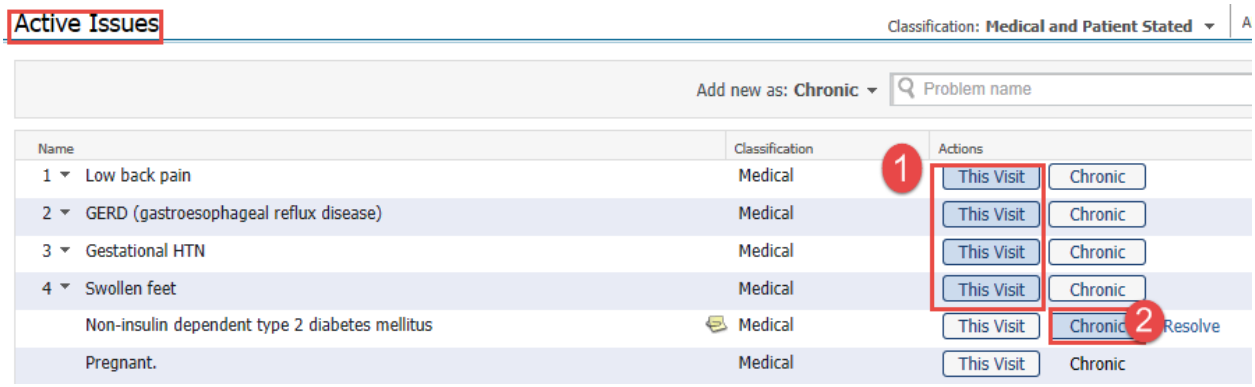
More commonly, each patient's problems and diagnoses are documented under the **Active Issues** component. When adding Issues, you can select the following descriptors by clicking the downward arrow: 

For each issue documented under the Active Issues component, you can select the following descriptor:

- **This Visit** (category 1) – the issue is a focus of the current encounter (e.g. presenting complaints). It is not shared between encounters and not carried over to the next encounter.
- **Chronic** (category 2) – the issue is ongoing and can be active or resolved. Chronic problems are shared across encounters and carried over to the next encounter. Chronic issues will appear under Medical History component.
- **This Visit and Chronic** (combination) –the issue is marked in both categories. When marked as a **Chronic** category, it is carried over to the next encounter

NOTE: The difference when adding Diagnosis versus Problems. Diagnoses are for the current encounter (reason for visit) and problems are chronic issues (i.e. medical, social, or others).

This Visit issues (1) will be automatically resolved when the patient is discharged. Chronic issues (2) are typically active but can also be resolved. Resolved issues become historical issues.



The diagnoses and problems recorded in the Active Issues component as chronic will carry over

from visit to visit, which builds a comprehensive summary of the patient's health record. Keeping a patient's problems and diagnosis up-to-date is important.

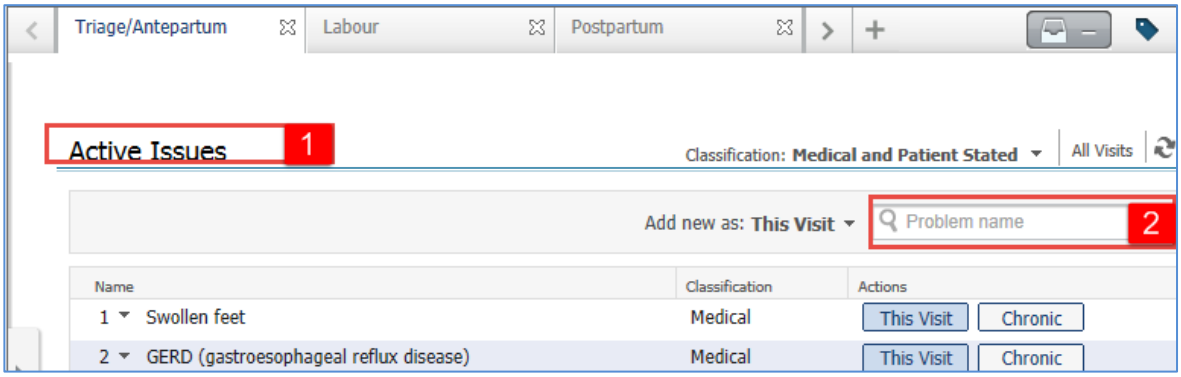
In this activity you will:

- Add This Visit and Chronic problem
- Practice how to resolve and modify existing problems

2 Gestational Hypertension is an active issue in this admission. **Add new as: This Visit**:

1. On the **Triage /Antepartum** Workflow Tab, select **Active Issues** from the workflow components list on the left.

2. Click in the search box and type or use front-end speech recognition (FESR) to enter = *Gestational HTN***.**

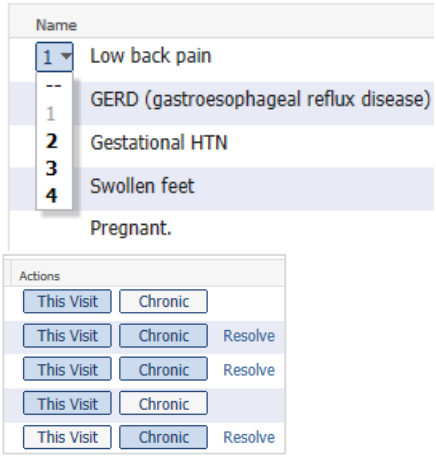


Note: FESR software captures your dictation directly into the Clinical Information System (CIS).

3. The Active Issues component will now display the newly added issue.

3

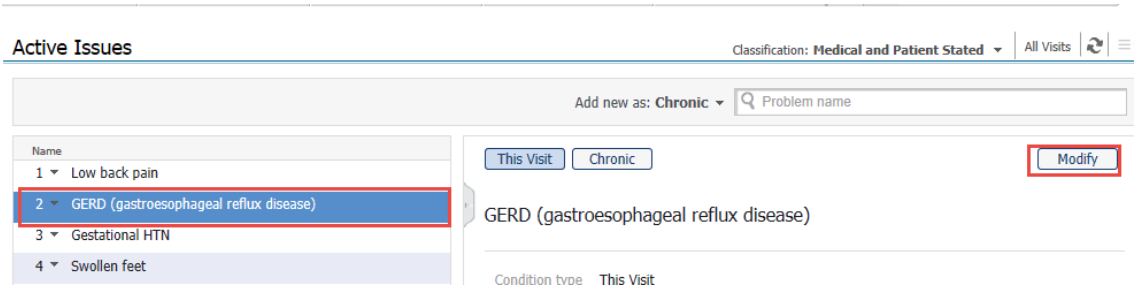
1. You can also update problems as displayed in the workflow view:



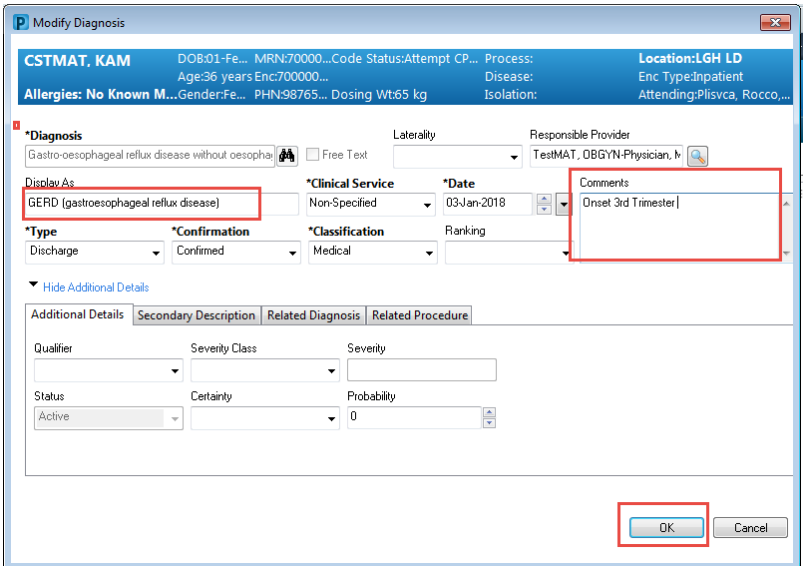
- These visit diagnoses are numbered as primary, secondary, tertiary, etc. You can easily rearrange this order by clicking the digit and selecting a different number.

- You can change an issue - **This Visit** or to a **Chronic** problem/diagnosis or both by clicking the appropriate buttons.
- You can also click **Resolve** to move a **Chronic** problem/diagnosis to the Historical section.
- The issues for **This Visit** This Visit can be canceled or made into a **Chronic** problem/diagnosis by **hovering** over This Visit and a click.

2. Click on the Name: **GERD (gastroesophageal reflux disease)** to display more details.
3. Click **Modify** this problem. The Modify Diagnosis window opens.

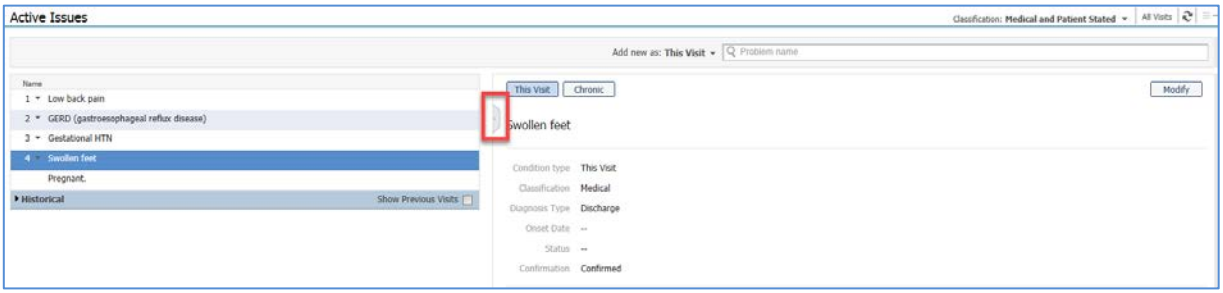


4. Locate **Comments** and enter = *onset in 3rd trimester* and click **OK**

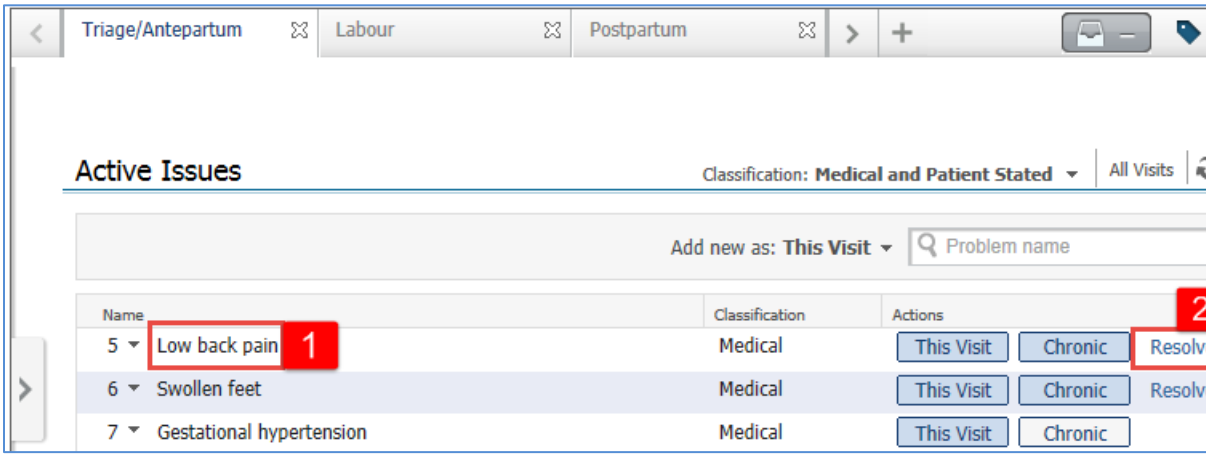


5. For your next practice, **cancel** the **swollen feet** active issue. Click on swollen feet. Hover over **This Visit** until a line is drawn through it: ~~This Visit~~ Chronic

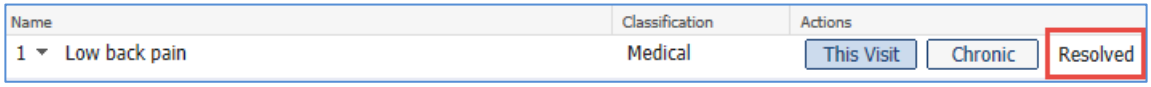
REMEMBER: To remove the split screen, click the tab to collapse



6. On admission, your patient reported Lower Back Pain as a current persistent chronic issue.
7. From the dropdown arrow, select **This Visit** This Visit **and Chronic** Chronic
8. Enter = ***Low back pain*** as an active issue Add new as: **This Visit** Problem name .
9. Selecting Chronic ensure it will remain on the chart across all encounters. Later, your patient reported her low back pain resolved.
    1. Click on **Lower back pain**.
    2. Select **Resolve (**not **Resolved)**

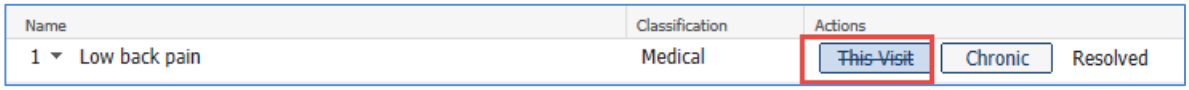


10. Your view is the Low back pain is still active on this visit and **Resolved (**not **Resolve)** displays for the Chronic issue



11. As your patient reports the low back pain is resolved also for this visit, you **cancel** this issue by **hovering** over

    This Visit and click**.**



Now **both** the current **This Visit** and **Chronic** have been resolved and you can locate Low back pain in the **Historical** location. What should you do if the Low back pain become active again? Click This Visit  and it will become an active issue again.

Active issues for This Visit will disappear unless they are moved to Chronic. Chronic can be resolved and it will go into Historical on this page.

Key Learning Points

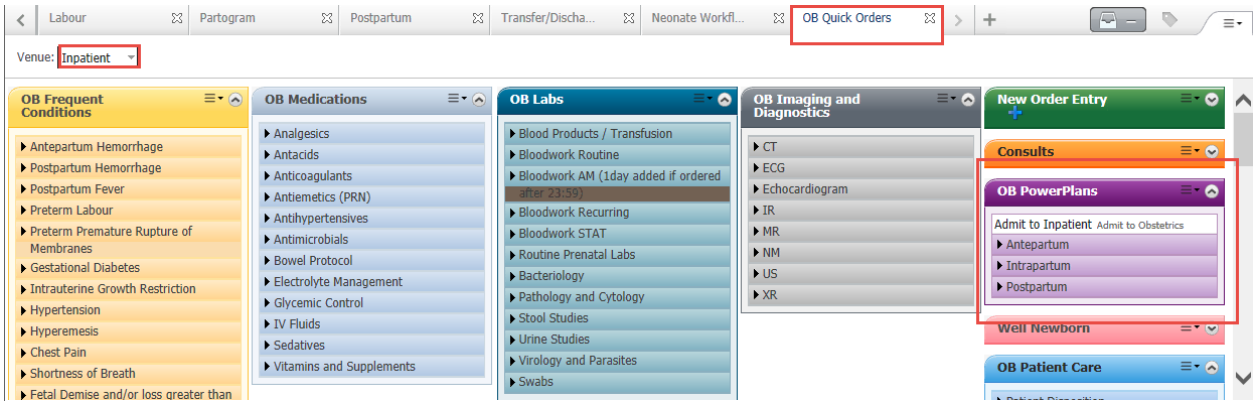
- Use **Active Issues** to manage problems and diagnosis for patient's current visit.
- **This Visit** refers to diagnosis or problems for this current hospitalization.
- **Chronic** refers to past medical history that may be active during this hospitalization or may have already resolved prior to admission.

Activity 2.4 – Place a PowerPlan (order set) for Labour and Delivery Admission

After completing Medication Reconciliation and Active Issues, you are ready to place orders for your patient. You will use a PowerPlan that is specifically designed for admitting patients to the General Medicine unit.

PowerPlans are similar to pre-printed orders (PPOs), allowing you to plan and coordinate care in the acute care environment by defining sets of orders that are often used together.

All PowerPlans for your specialty are grouped in the separate category in the **Quick Orders** tab on the Workflow tabs.



In this activity you will:

- Select the admission PowerPlan.
- Modify the admission PowerPlan to fit your needs.
- Complete the PowerPlan to make it active for other caregivers.

You will use a PowerPlan that is specifically designed for admitting patients to labour and delivery.

PowerPlans are similar to pre-printed orders (PPOs), allowing you to plan and coordinate care in the acute care environment by defining sets of orders that are often used together. You can adapt PowerPlans to fit your needs:

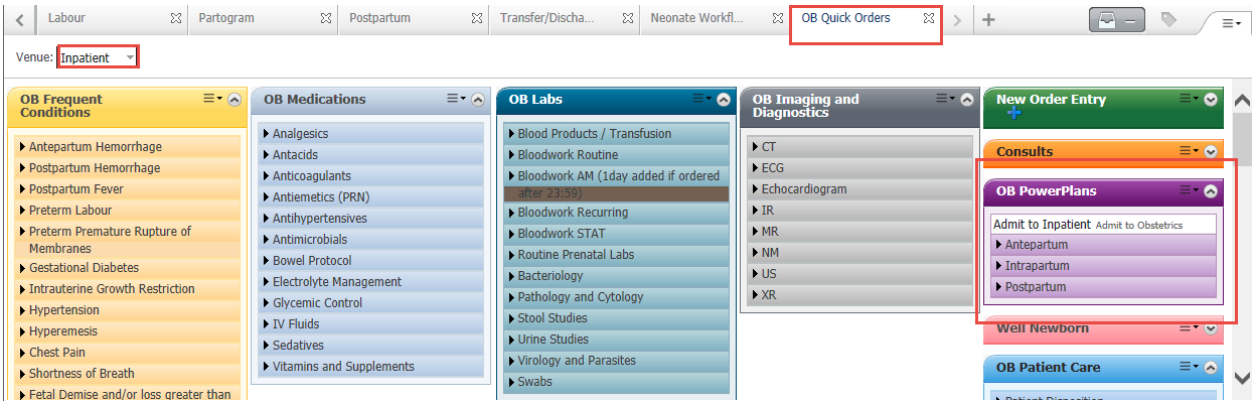
- You can select and deselect individual orders from the PowerPlan list
- You can add orders that are not listed on the PowerPlan
- You can add other modules (orders sets) that are listed in a PowerPlan

An **Initiated** PowerPlan becomes active immediately and its orders create respective tasks and actions for other care team members.

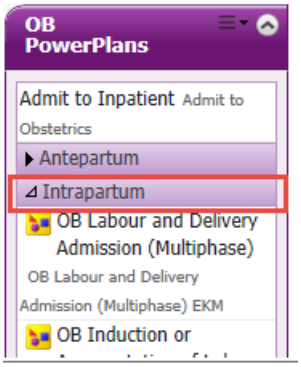
A **Signed** PowerPlan that is **not** initiated remains in a **planned** stage allowing to prepare orders for a future activation as needed.

1

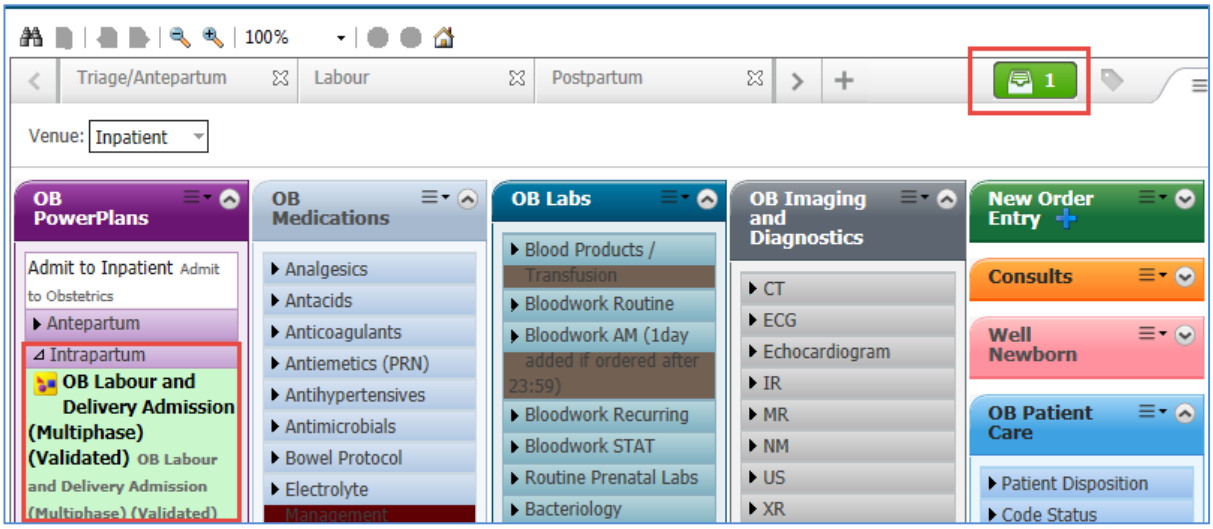
1. Click the **OB Quick Orders** workflow tab.
2. Locate the **OB PlanPlans**.



3. Categories and folders can be collapsed or **expanded** by clicking the expansion arrows and
4. Expand the **OB PowerPlans** folder.
5. Open **Intrapartum** folder. PowerPlans are marked by the icon.

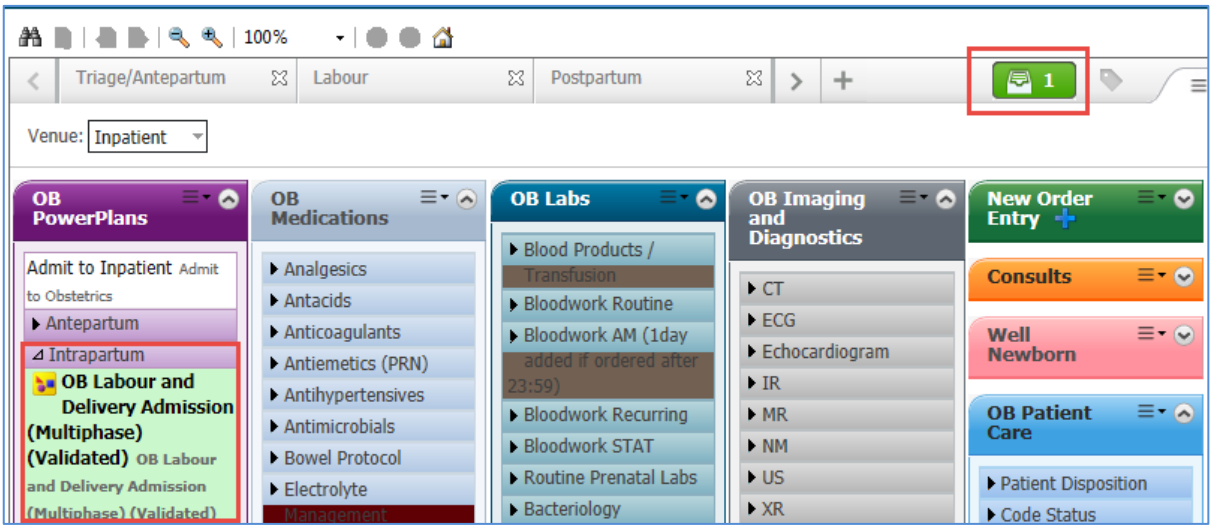


6. Click **OB Labour and Delivery Admission (Multiphase).**
7. **The Orders for Signature** icon 1 appears at the top right of the screen.

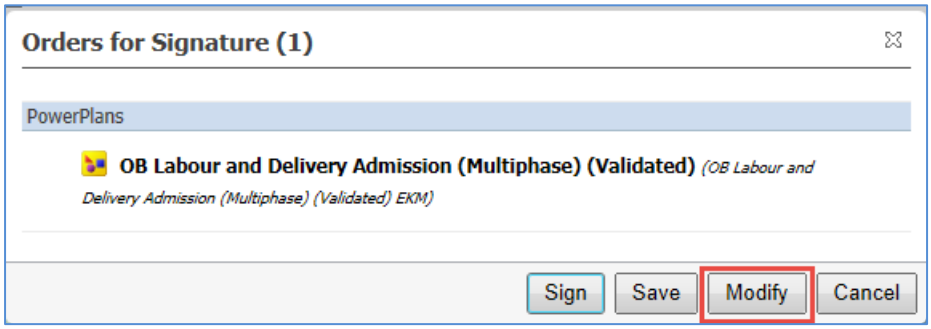


2

1. Click the **Orders for Signature** icon  at the top right of the page.



2. Click **Modify.** The Orders page opens.



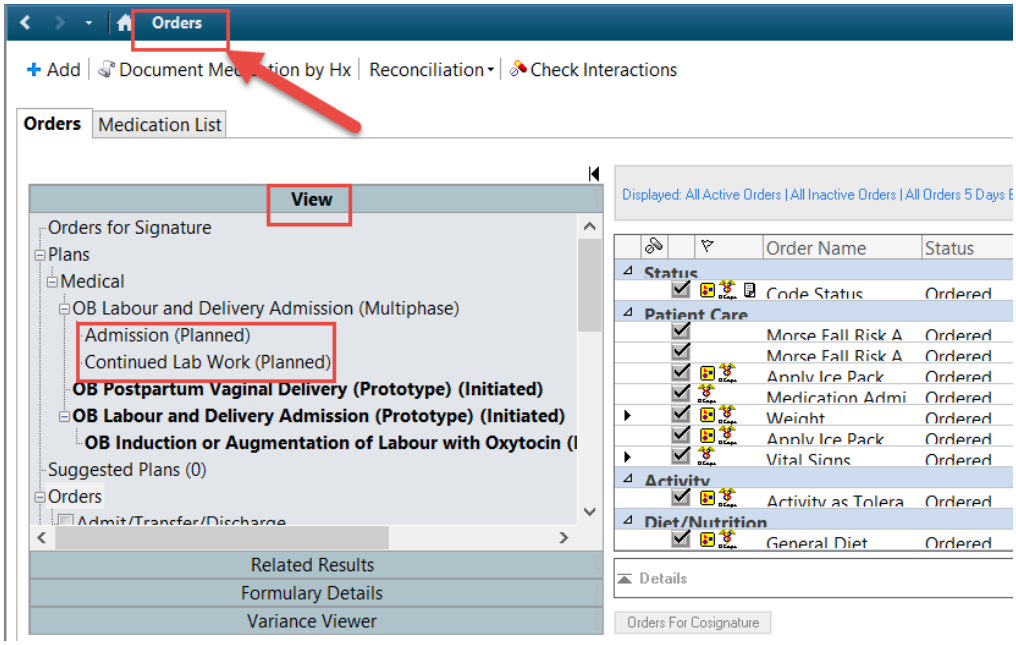
NOTE: The following Sections 3 and 4 below are an overview of PowerPlans.

3 PowerPlans open in the **Orders View** that works like a scratch pad to customize your plan.

Stay in the **Orders** window. It offers the most comprehensive summary of patient's orders grouped into categories in the View panel. It is a good practice to **frequently visit this window to monitor patient's orders**.

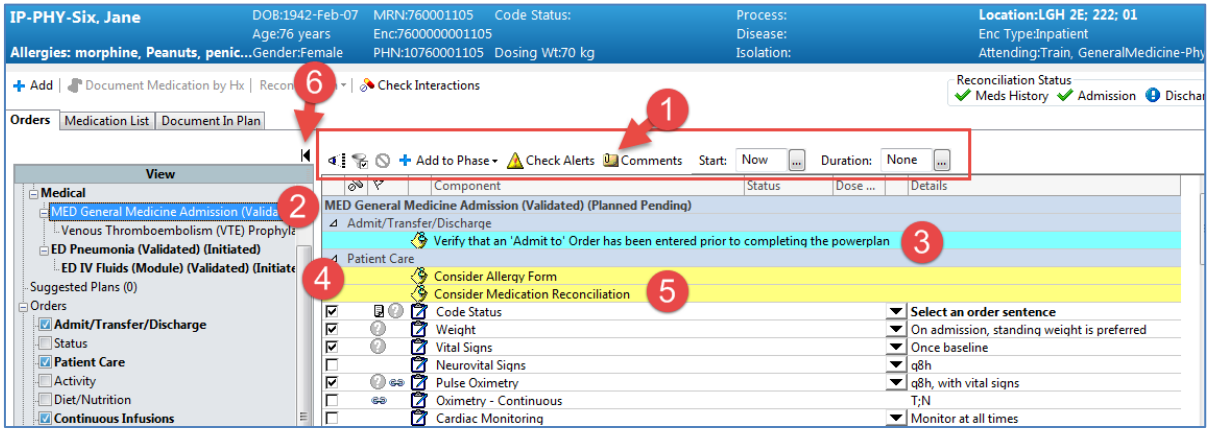
WARNING:

- Orders view is also one of the only ways to review and activate PowerPlans in **a planned status** – orders that have been signed but not initiated.
- There is also a component called **Planned PowerPlans** that will be available in your Provider view that will enable you to view PowerPlans in a planned status. This is not currently available in the Train Domain you are practicing on now.



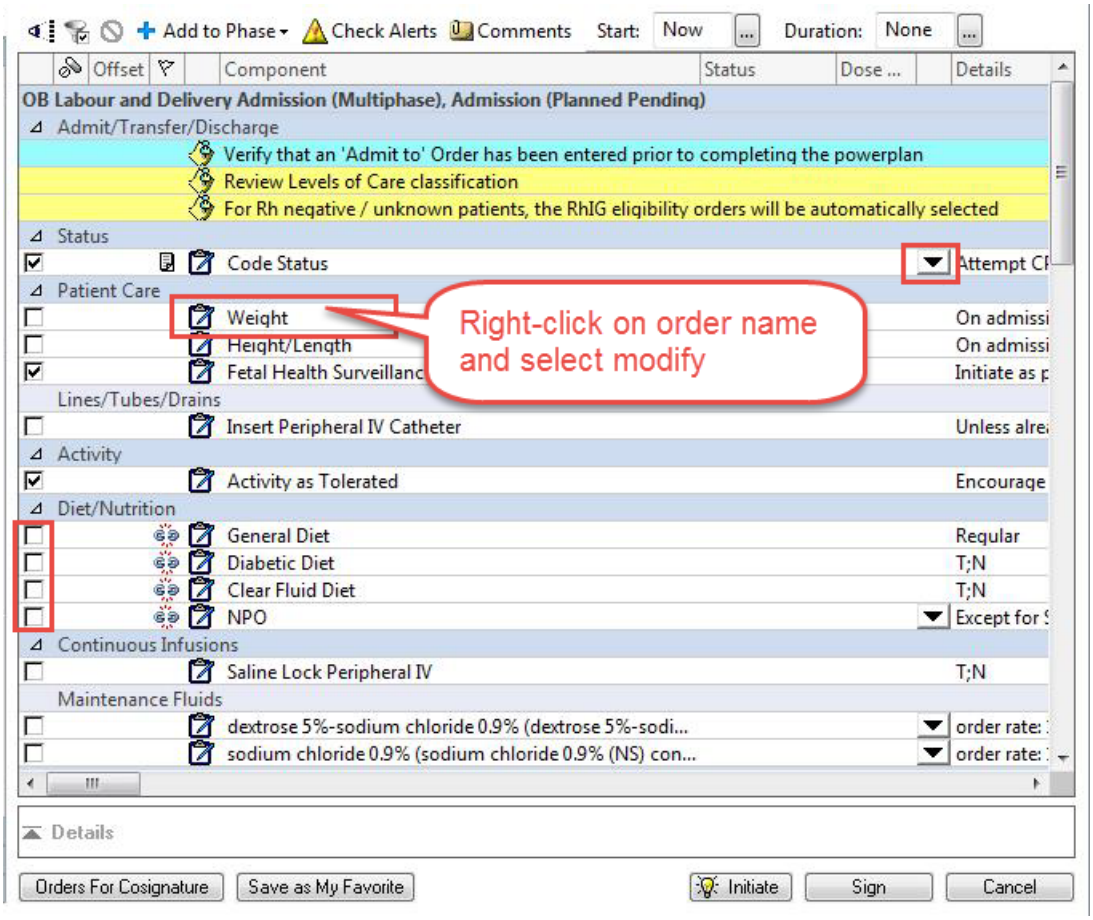
Scroll through to locate visual cues used to categorize orders:

1. The **toolbar** provides you with tools, for example clicking the Comments button opens a box for adding a comment to the selected order; a nurse assigned to this patient will be informed that you placed additional information.
2. At the top, you will see the PowerPlan name. Until you complete the process, its status is Planned Pending.
3. Bright blue highlighted text identifies **critical reminders** – for example, a reminder about the 'Admit to…' order.
4. Light blue-grey highlighted text separates **categories** of orders, for example, Patient Care.
5. Bright yellow highlighted text identifies **clinical decision support** information.
6. Collapse the View navigator to have more screen space.

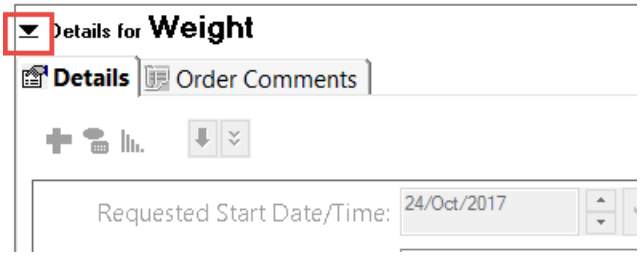


4 Here is an overview how to modify the orders in the plan:

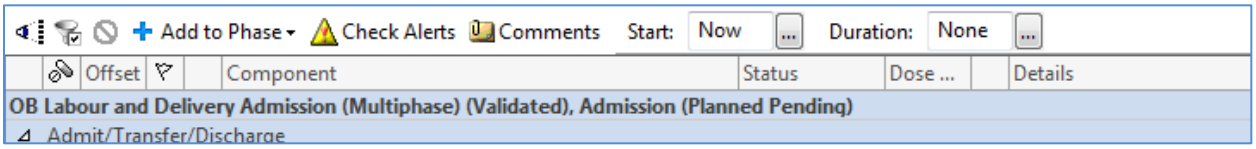
- **Checking and unchecking** order boxes
- Use the **drop downs** Modify the details of the orders
- **Right-click on the Weight order** and select **Modify**



- Click on the Details arrow to exit the order



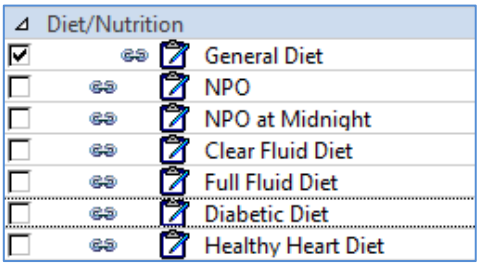
Hover Over the icons in the toolbar below.



5 Modifying the PowerPlan

Your screen opens to the scratch pad where you can make changes to the PowerPlan.

REMEMBER: Only one type of Diet Order can be entered at a time for your patient. You will need to deselect General Diet before selecting a Diabetic Diet. Both orders are marked by the link icon. In this example, it prevents two contradicting orders to be placed at the same time. In other situations, orders might be linked so that they can automatically be placed together.



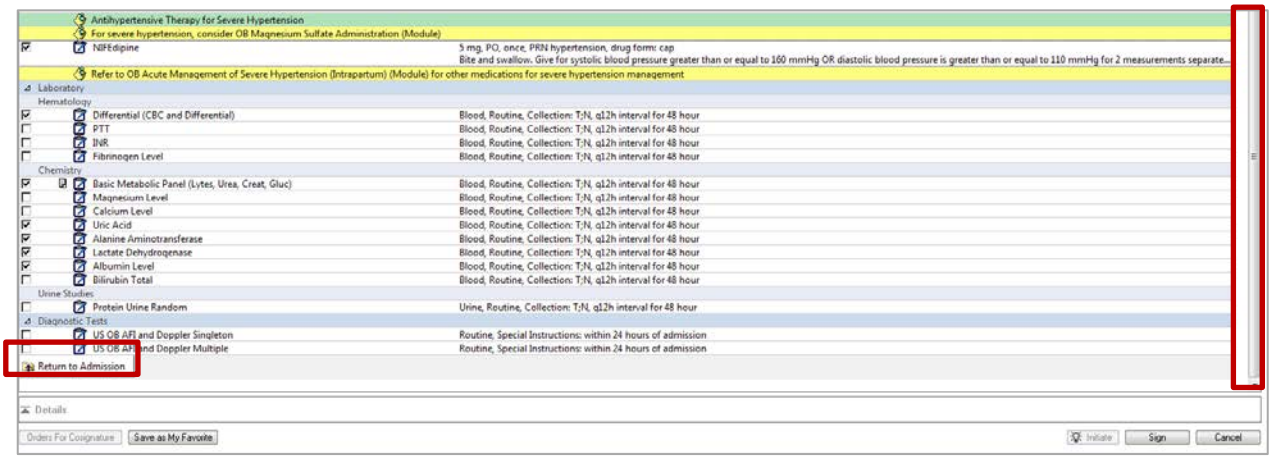
Check the following order tick-boxes:

- **Diet/ Nutrition**: General Diet
- **Continuous Infusion**: Saline Lock Peripheral IV
- **Obstetrics Modules**: OB Gestational Hypertension and Pre-Eclampsia Intrapartum

NOTE: After selecting the above module, you will be taken to another window for **OB Gestational Hypertension and Pre-Eclampsia Intrapartum (Module).**

Check the following order tick-boxes:

- **Nifedipine** under **Antihypertensive Therapy for Severe Hypertension**.
- **Do not Sign** the order yet, scroll down and click the **Return to Admission** button to continue with the OB Labour and Delivery Admission (Multiphase) PowerPlan.



The icon next to an order indicates missing details. This is a standard icon across the entire CIS.

WARNING: After you made your selections, **do not click sign yet**. You need to return to the main PowerPlan by selecting **Return to Admission** to sign off the entire PowerPlan.

Review the Toolbar icons to flex the display of the PowerPlan to facilitate easier review. For example:

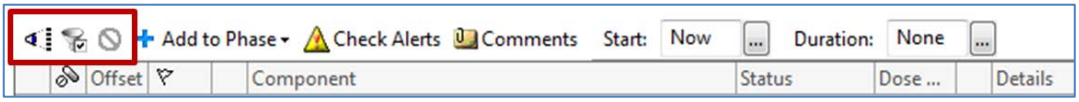
Collapses or expands the list of order categories on the left side of the screen. Collapsing the list creates more room for the PowerPlan Navigator

Details Remember to click the button to expand or collapse the order details view.

Details for Collapsing allows entry of multiple orders before signing all PowerPlan orders

Displays pre-selected defaulted orders only

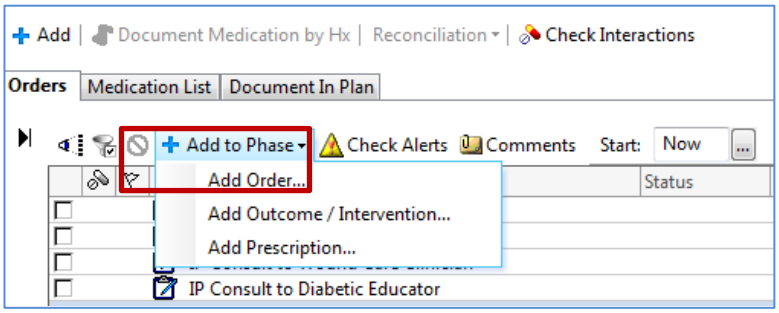
Merges your planned orders with existing orders to avoid duplicating an order.



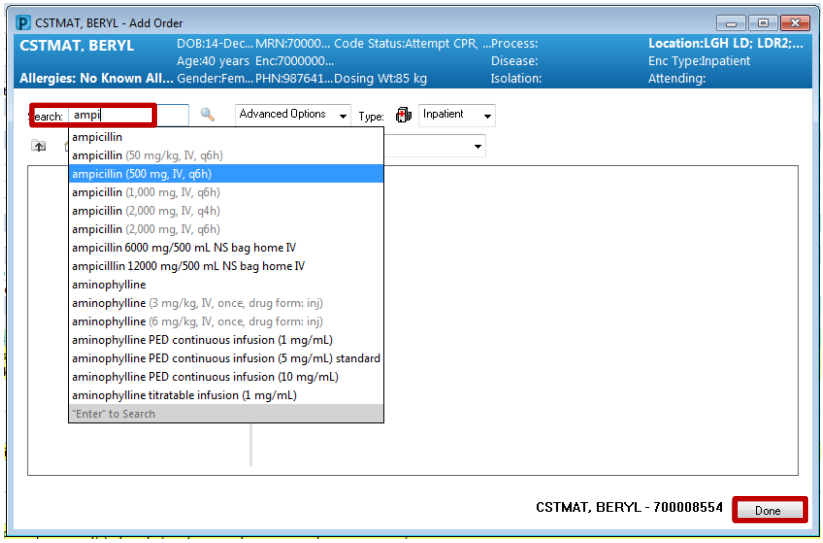
6 Adding to Phase while in PowerPlan

1. You want to add some **new orders** to the PowerPlan.

2. Click + **Add to Phase** button
3. Click **Add Order.** These orders will reside within the PowerPlan and will be removed when the PowerPlan is discontinued unless you select them to continue.

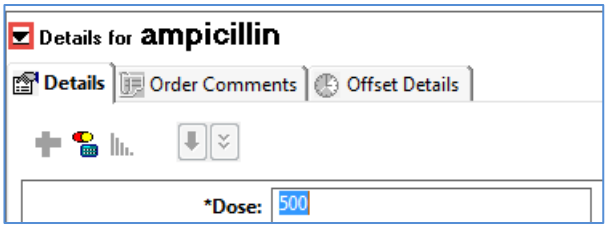


4. Enter on the order search catalogue:
   - *Ampicillin 500 mg, IV, Q6H* – click **Done**
   - Review the order and **don't sign**



5. Click the downward arrow to go to the next order 

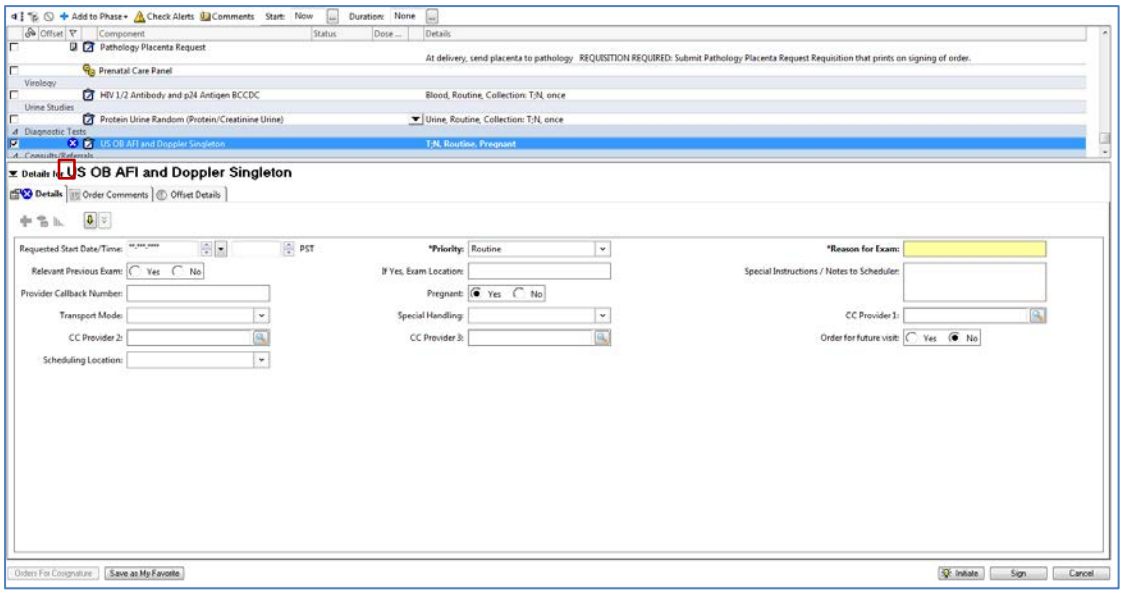
this permits you to add multiple orders.



6. Click **+ Add to Phase** button to enter more orders.
7. Click **Add Order**… and enter = *US OB AFI and Doppler Singleton*

8. When you have selected the orders above, click **Done** in the lower right corner.
9. The **Details for US OB AFI and Doppler Singleton** appears as it is the last order you entered in the catalogue search.
10. Enter the following information:

- **Requested Start Date/Time:** type = *t* (today for date field) and type = *n* (now for hour and minutes field). This will automatically enter today's date and current time
- **This is a mandatory field: Reason for Exam** enter = *severe hypertension*
- **Priority:** *Urgent*

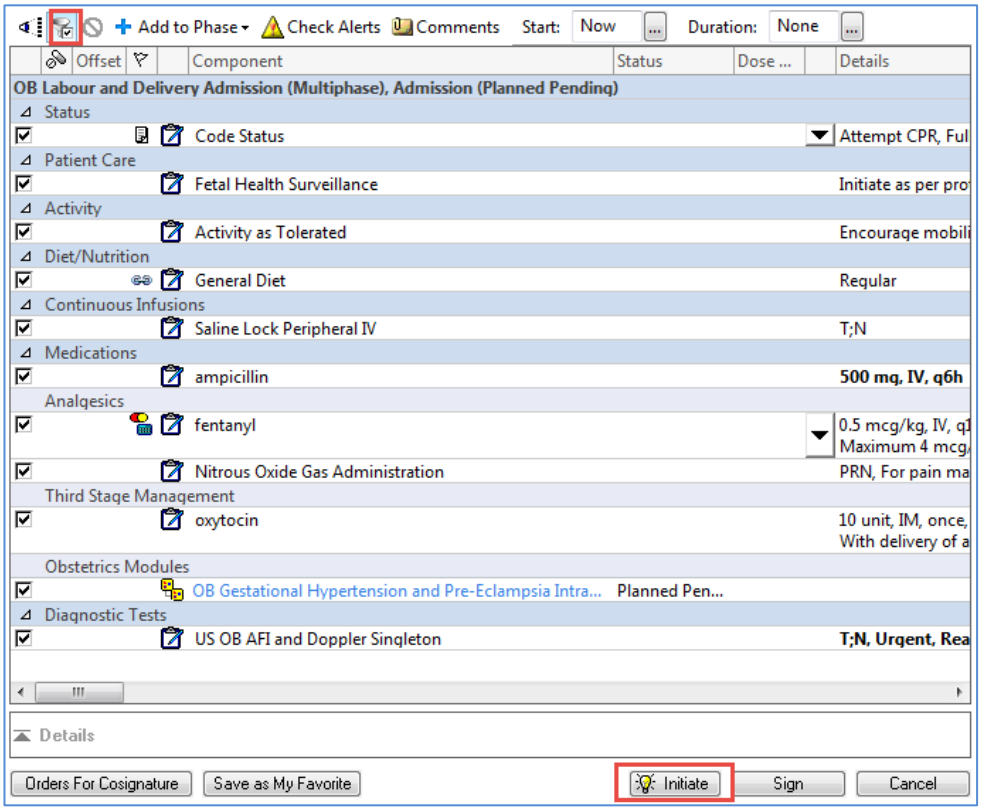


11. **Do not Sign here yet** if you sign now, the orders become signed before you can review them.
12. Click the **Details** icon to collapse the Details for **US OB AFI and Doppler Singleton**.

    Notice the **Details** is now collapsed at the bottom of your PowerPlan Order Screen.

13. Use the **Show only select items** only icon, to review all the selected PowerPlan orders.

NOTES: Once all the necessary fields are completed the mandatory icon next to US OB AFI and Doppler Singleton disappears and the PowerPlan is ready to initiate.



This multiphase PowerPlan has two phases. You will **Initiate** the **Admission Phase** and leave the Continued Lab Work phase in a **planned** state to be initiated later by nursing staff.

WARNING: The following is **important** and must be considered or followed:

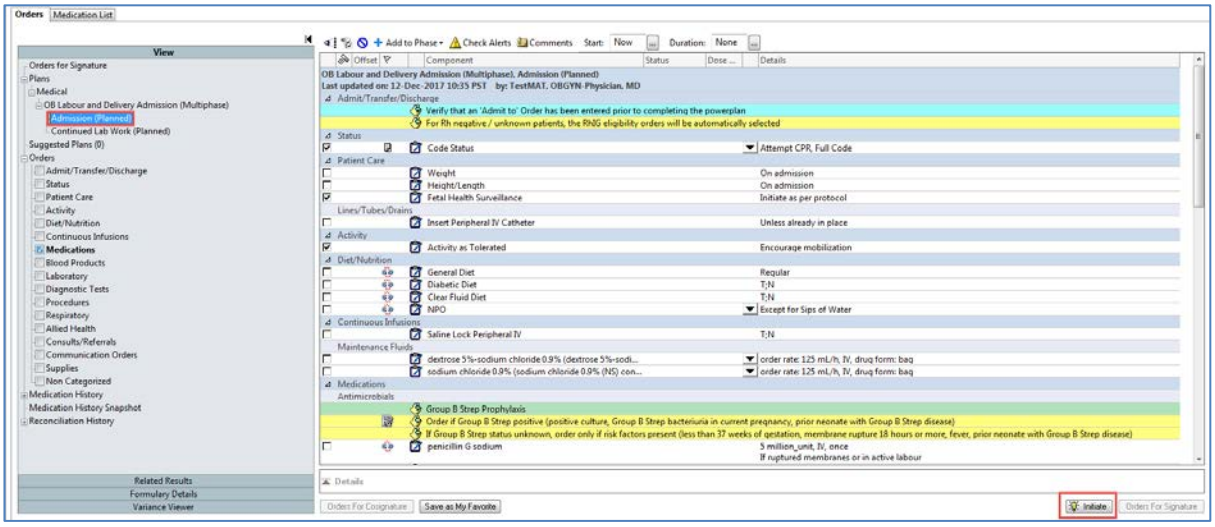
If you want the Phase of orders to be **active immediately** after ordering, use the **2 step process**:

Step one: Initiate
Initiated PowerPlans become active immediately and their orders create respective tasks and actions for other care team members.

Step two: Sign

If you want the phase of orders you place to be **activated later (planned),** use **the 1 step process**:

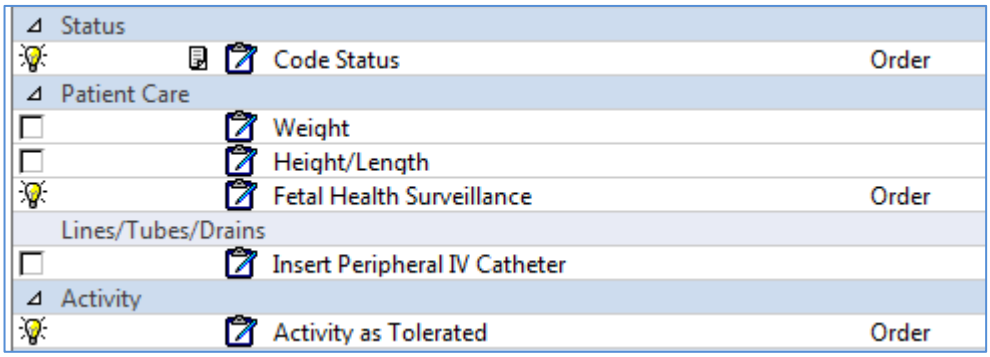
14. Select **Sign only**
    A PowerPlan that is **signed** only but **not initiated**, remains in a **planned** state allowing you to prepare orders for future activation as needed. This is useful for surgical scenarios and for future procedures.
15. In the View section, ensure the **Admission** phase is selected.
16. At the bottom right of the page click **Initiate** Initiate.



Note: Fentanyl has a dosage calculator and requires a patient weight to complete. Exit fentanyl pop-up if it occurs.

7 Initiating the PowerPlan:

1. Once **Initiate** is selected, a lightbulb icon is displayed beside each of the checked orders and allergy checking and drug-drug interaction checking occurs.
2. Click **Orders for Signature**.



3. Click **Orders for Signature.**
4. In the next window click **Sign** to complete the process.

REMEMBER:

- Click **Initiate** first to ensure that all selected orders are immediately active. If you **do not** Initiate the PowerPlan and click **Sign only**, the orders are **not** active.
- The PowerPlan remains in a planned state until it is activated later by a provider or a nurse assigned to this patient.
- For example, the provider created the PowerPlan in a planned state before the patient's admission. The receiving nurse will I**nitiate** the PowerPlan order upon

patient's arrival on the unit, and the orders will then become active

8 From the **Order Page View** section, select your PowerPlan and explore some of the further features in the PowerChart icons.
For example:

 indicates the Nurse has yet to marked she reviewed these orders

WARNING:

- PowerPlans that are in a planned status, signed but not initiated, are not listed under **Orders Profile** component.
- Click on the **Order Profile** component hyperlinked heading for a more detailed review on the **Orders Page View** section of orders including those in the planned state.

Key Learning Points

- PowerPlans are like pre-printed orders.
- You can select and add new orders not listed in the PowerPlan by using Add to Phase functionality.
- By signing one order, it signs all the orders, wait until you have reviewed all the orders before signing or initiating the orders.
- You can select from available order details using drop-down lists or modify order sentences manually where needed.
- Initiate means that PowerPlan orders are immediately active and as such, can be actioned right away by the appropriate individuals.
- To ensure orders within a PowerPlan are immediately active, click Initiate first and then Sign
- Sign will place orders into a planned state for future activation.

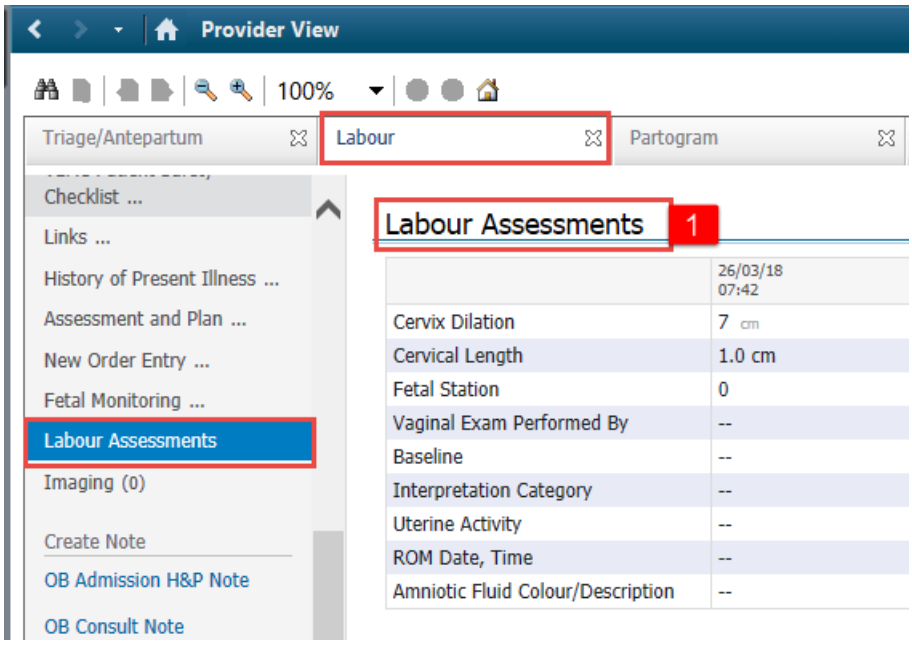
Activity 2.5 – Document Labour Assessment in Interactive View I&O (iView)

1

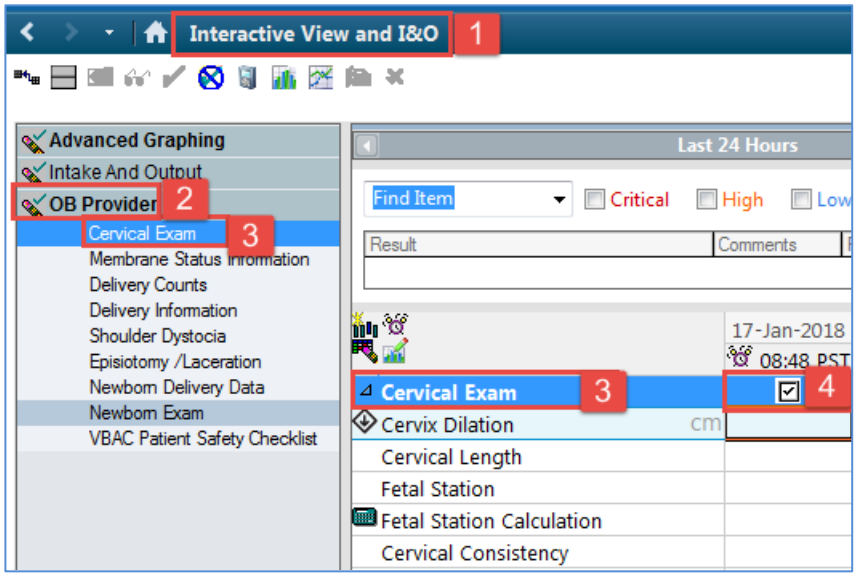
By documenting cervical exams in iView, the data will populate the partogram and pull into your notes. A single documentation goes to multiple places. Documenting only in the note will mean that someone else will have to read your note and complete iView to populate the partogram.

In the **Labour** workflow tab, click on the **Labour Assessments** in the component list to document your cervical exam findings.

1. Click on the **Labour Assessments** hyperlinked heading. The Interactive View and I&O (iView) window opens.



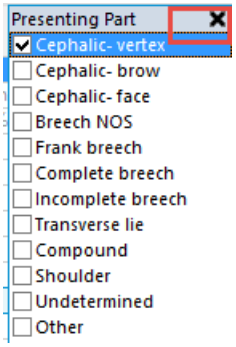
1. This link takes you to **iView**.
2. Locate and click the **OB Provider** band within the Interactive View and I&O page.
3. Click on the **Cervical Exam** section.
4. Double click on the blue cell to open the cells for documentation



Begin documentation by entering the following information. You may hit the tab button on your keyboard to advance

- **Cervical Dilation =** *7*
- **Cervical Length =** *1*
- **Fetal Station =** *0*
- **Fetal Station Calculation =** *0* (Auto-calculated)
- **Cervical Consistency =** *soft*
- **Cervical Position =** *anterior*
- **Bishop's Score =** *11* (Auto-calculated)
- **Presenting Part =** *Cephalic- Vertex*

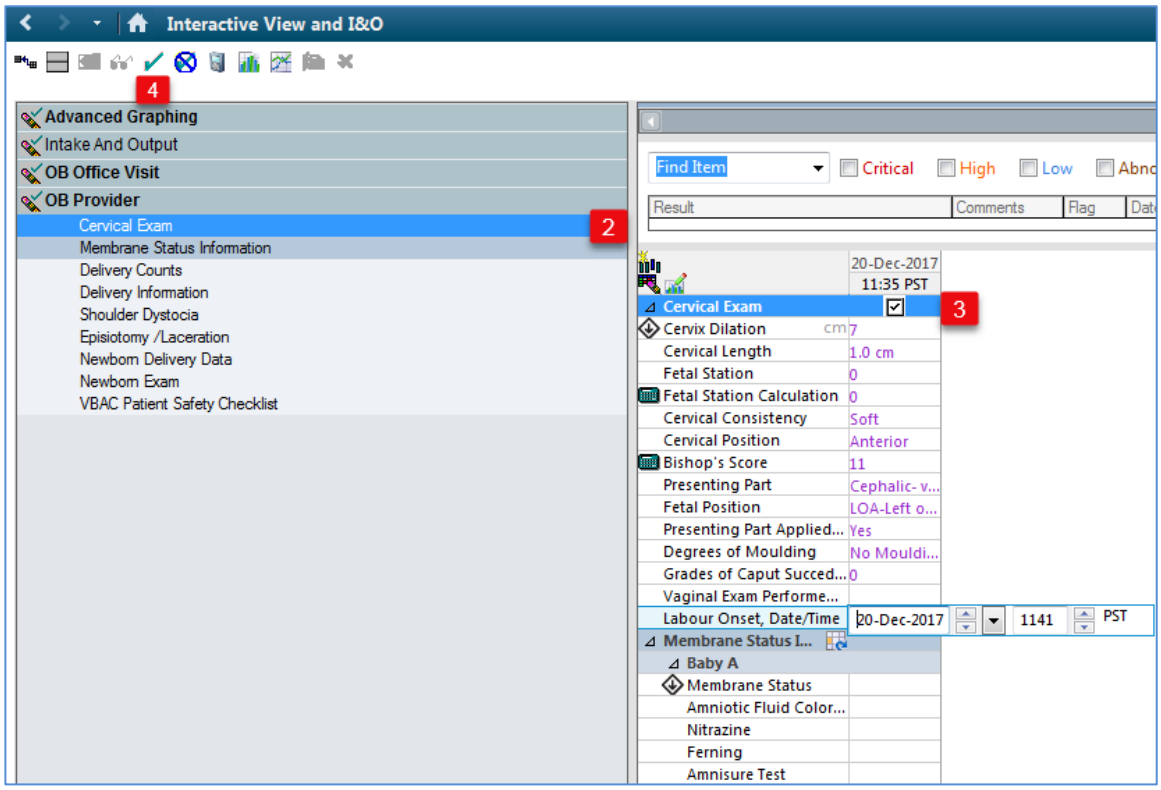
Note: click the x to escape window



- **Fetal position =** *Left occiput anterior*
- **Presenting part applied to cervix =** *yes*
- **Degrees of Moulding =** *No, Moulding*
- **Grades of Caput succedaneum =** *0*
- **Labour onset, date/time =** *T/N* (today and now)

NOTE: The Vaginal Exam Performance entry: if you are charting for someone – then enter their name.

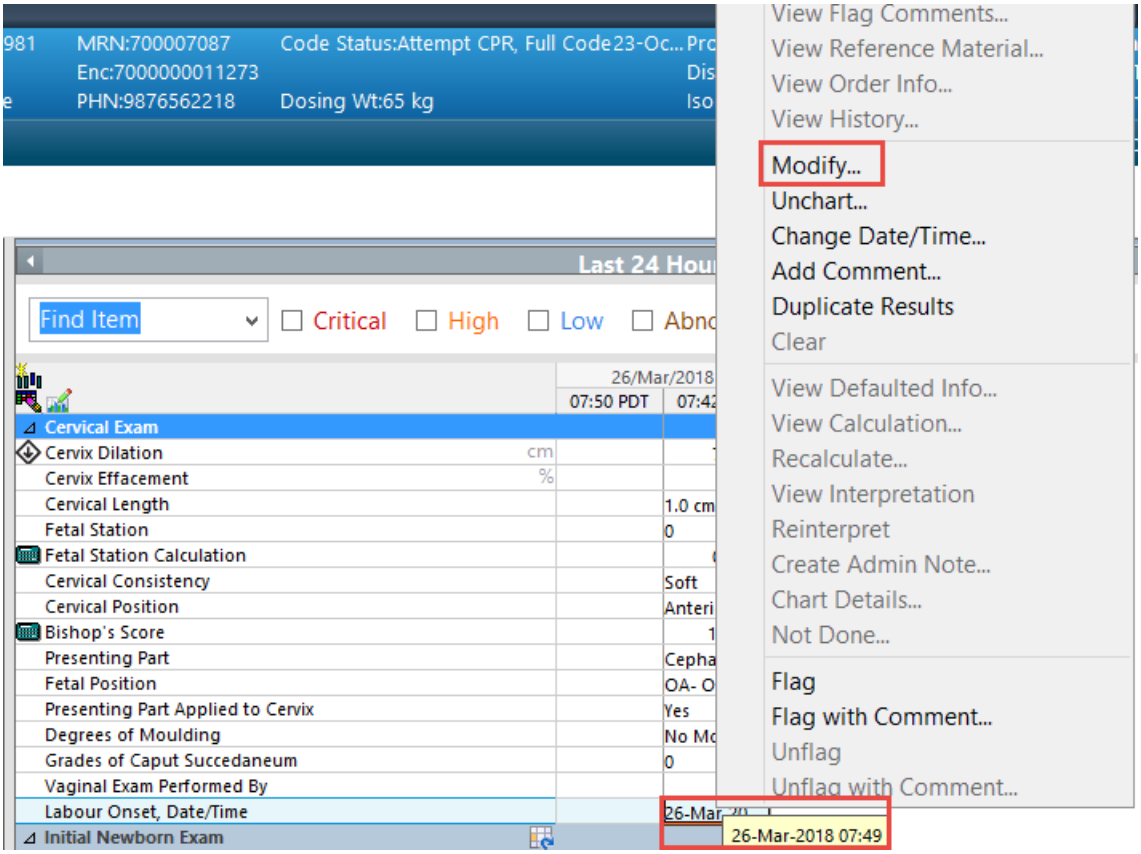
Click the **Sign** ✔ icon to complete and save your documentation.



Notice your font color changed from purple to black after signing with the green checkmark.

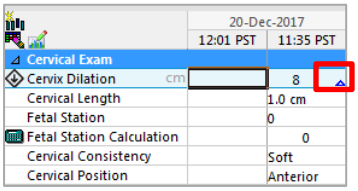
3 Right-clicking on a data cell such as **Labour Onset, Date/Time**, after you have documented to take you to a list of functions, including the following:

- Modify
- Unchart
- Change Date/Time
- Add comment
- Flag, etc.



For practice, modify **Cervix Dilation** from **7 to 8.**

1. Right-click on **Cervical Dilation** cell.
2. Select **Modify.**
3. Type **8.**
4. Click **Sign** ✔ icon to complete.



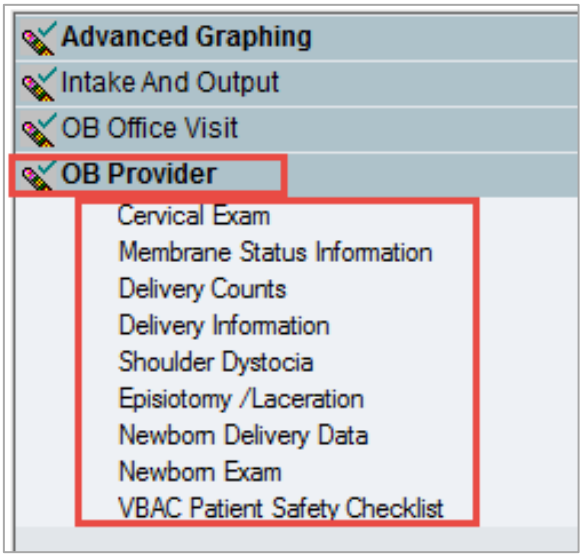
Notice the blue triangle in the right corner of the cell. This indicates that a change has been made.

Hover to discover in the Interactive View and I&O (iView):

This icon allows you to insert and change a new time and date in the iView flowsheet

If you see this cancel icon, it allows you to cancel the new time and date you inserted

4 Now that you have documented your assessment findings, review the rest of the listed documentation available to you under OB Provider Band in iView.



To return to the **Provider View**, click the icon.

Key Learning Points

- Information documented in iView will pull through to other forms and notes.
- iView allows you to chart, unchart, modify, and add comments to your documentation.

Activity 2.6 – Create an OB Admission and H&P Note

In this activity you will:

- Create an admission note from information that has already been entered.
- Edit and complete the admission note.

As the last step of admitting your patient, you create the admission note.

The Clinical Information System (CIS) uses Dynamic Documentation to pull all existing and relevant information into a comprehensive document using a standard template.

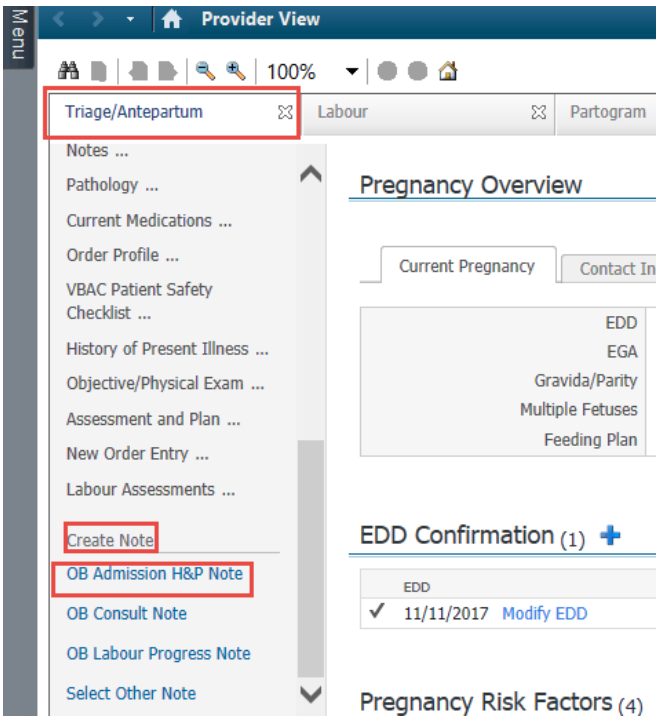
Dynamic Documentation can save you time by allowing you to populate your documentation with items you have reviewed and entered in the Admission workflow tab. This is why it is more efficient to create the note as the last step of the admission process. You can also add new information by typing or dictating.

Workflows such as Labour, Rounding, and Transfer/Discharge have the Create Note section displaying relevant note types represented by links. With one-click on the desired note type link, the CIS (Clinical Information System) generates a note.

1

1. Navigate to the **Create Note** section in the Triage/Antepartum workflow tab.

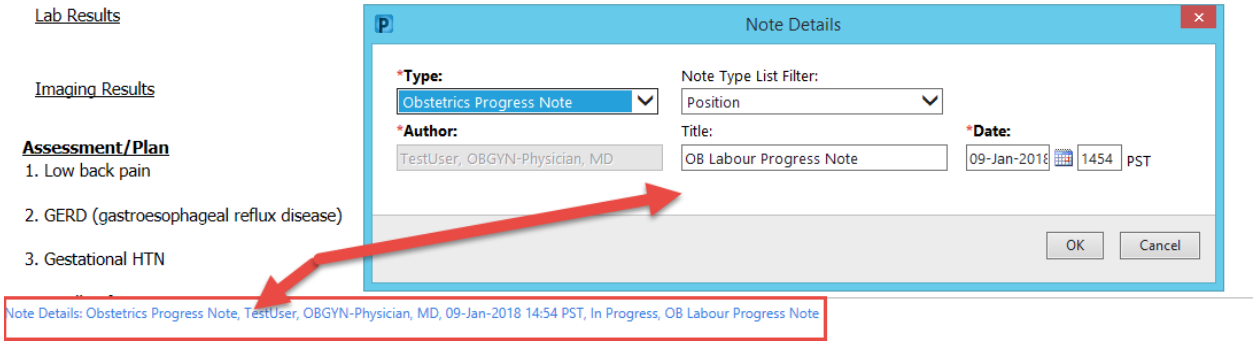
2. To document an admission, click **OB Admission H&P Note.**



2 Hover your cursor over the Chief Compliant heading to activate a small toolbar:

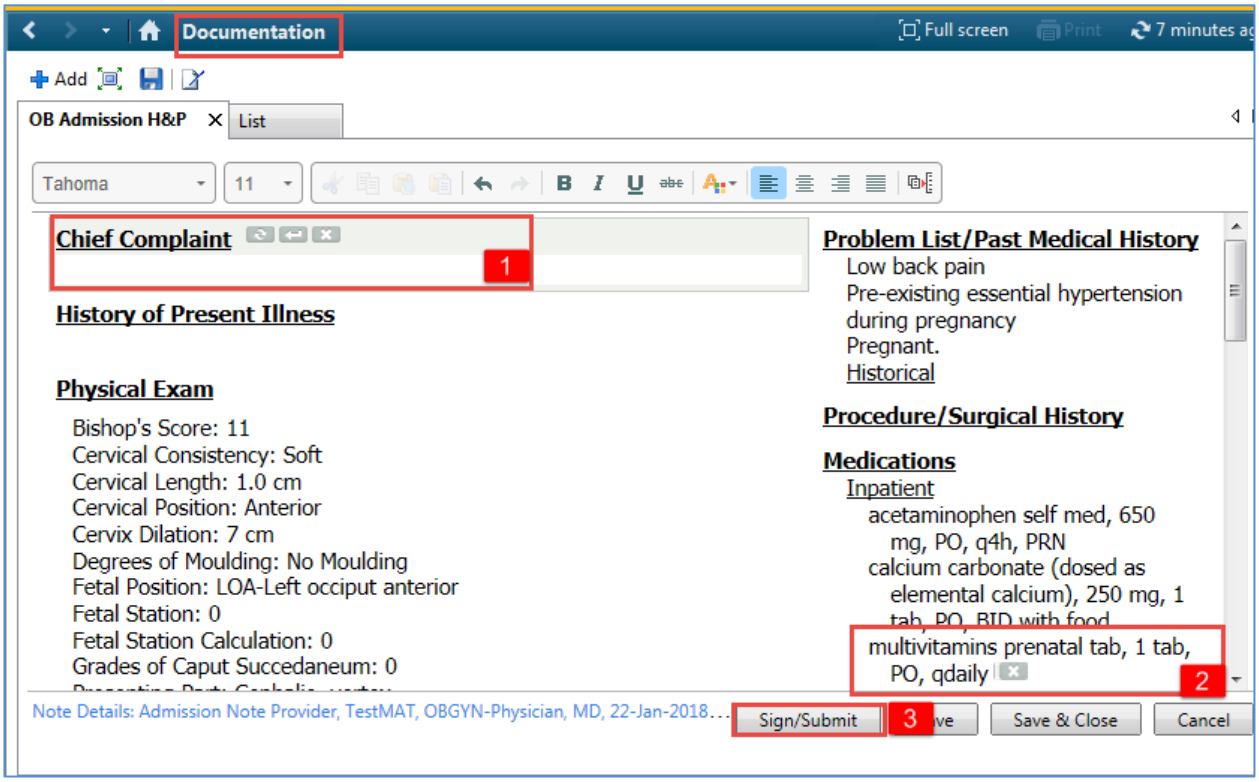
- refreshes the dynamic information in the box
- activates the box for edits or new entries
- removes the entire section or content of the box

NOTE: If a heading title in your note is not your preferred choice of heading titles, edit the heading title by clicking the note details.

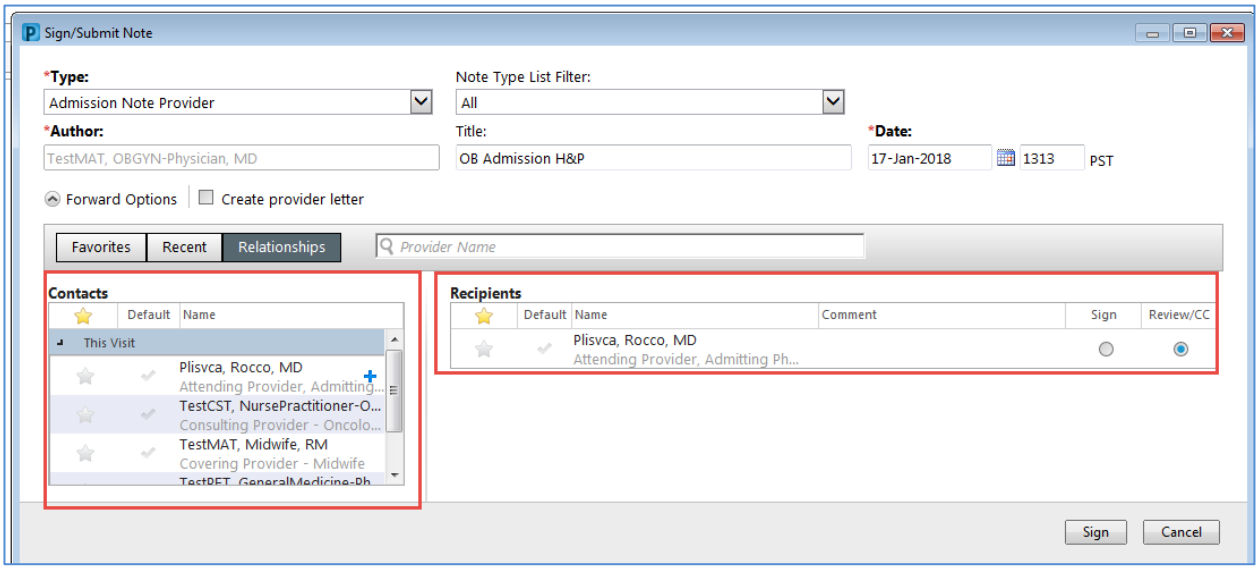


3 The draft note displays in edit mode populated with the information captured by you and other clinicians. Review different sections of this note.

1. Enter = *Contractions* under the Chief Compliant heading. You can type or dictate directly using FESR
2. Review the information on the right side of the note. It was pulled in automatically from the nursing and provider notes. You may delete information that is not pertinent to your note by hovering over the text and clicking the icon
3. **Sign/submit** your note.



NOTE: Once the Sign/Submit button has been clicked, the note you created may be forwarc to additional Providers for review or sign-off, as applicable by entering the receiving/intende provider's name in the box.



Key Learning Points

- Each workflow tab has its own list of notes: Triage/Antepartum, Labour etc.
- Use Dynamic Documentation to prepare notes which standardize the documentation practices.
- Only when a note is signed will it be visible to the care team.
- Saved notes remain in a draft format and are visible only to you.

PATIENT SCENARIO 3 – Ongoing Patient Documentation

Learning Objectives

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

- Review the Labour Workflow Tab
- Review Partogram
- Create an OB Labour Progress Note
- Review OB documentation and results

SCENARIO

Your patient is now in active labour. You have performed the patient's cervical exam and she remains stable during labour.

You will complete the following activities:

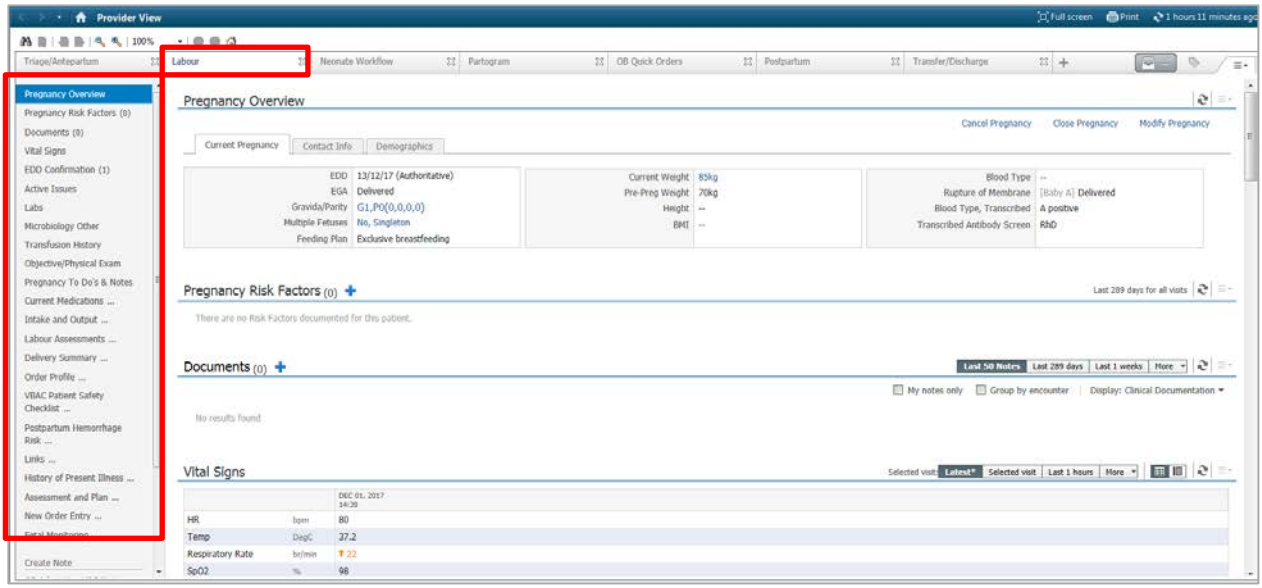
- Review the Labour workflow tab
- Review Partogram
- Create an OB Labour Progress Note with auto texting and tagging
- Review Documents, Labs, and Imaging

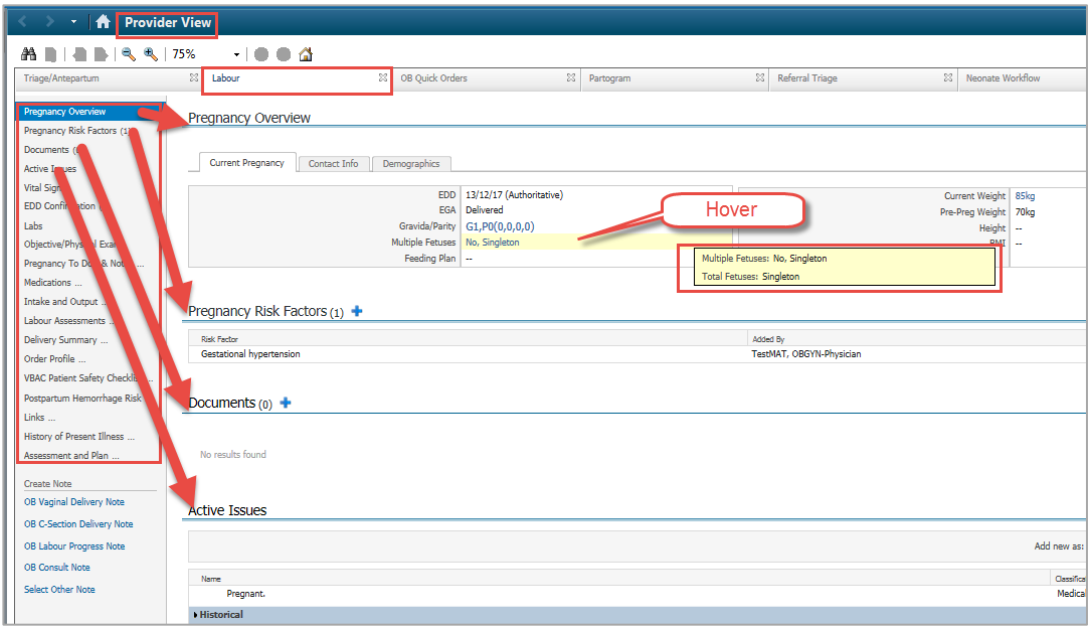
Activity 3.1 – Review the Labour workflow tab

1 The **Labour** workflow tab is where you can review the following information listed below.

Nursing Documentation flows into the workflow pages. For example, the OB triage and Assessment documentation flows into Documents. Nursing documentation in iView Vital Signs flows into the Vital Signs component and some nursing iView documentation flows into the partogram workflow page.

- Pregnancy Overview
- Pregnancy Risk Factors
- Documents
- Vital Signs
- EDD Confirmation
- Active Issues
- Labs
- Microbiology
- Transfusion History, etc.





Key Learning Points

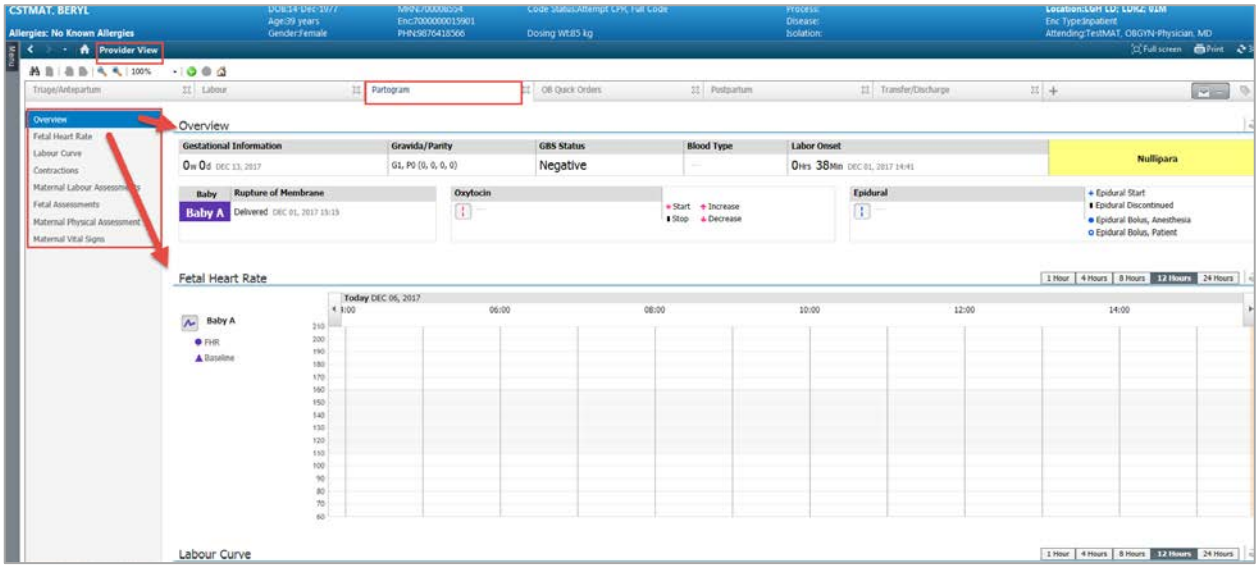
- The labour workflow tab allows you to access different components related to the patient's labour.

Activity 3.2 – Review the Partogram

1 Read the following sections 1 and 2:

The Partogram is a graphical display of data that has been charted on a labouring patient. It provides an overview of useful information such as the current Oxytocin rate and current epidural rate. You can also view a graphical display of fetal heart rates as well as the labour curve graph and the maternal vital signs graph.

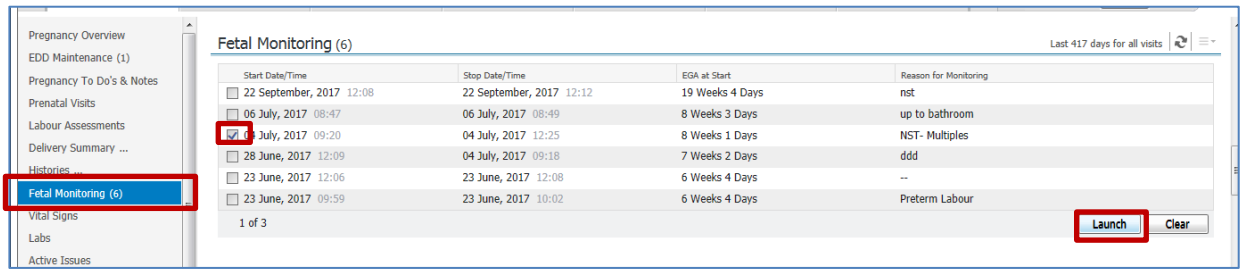
Note: A detailed Partogram is not viewable in the classroom.



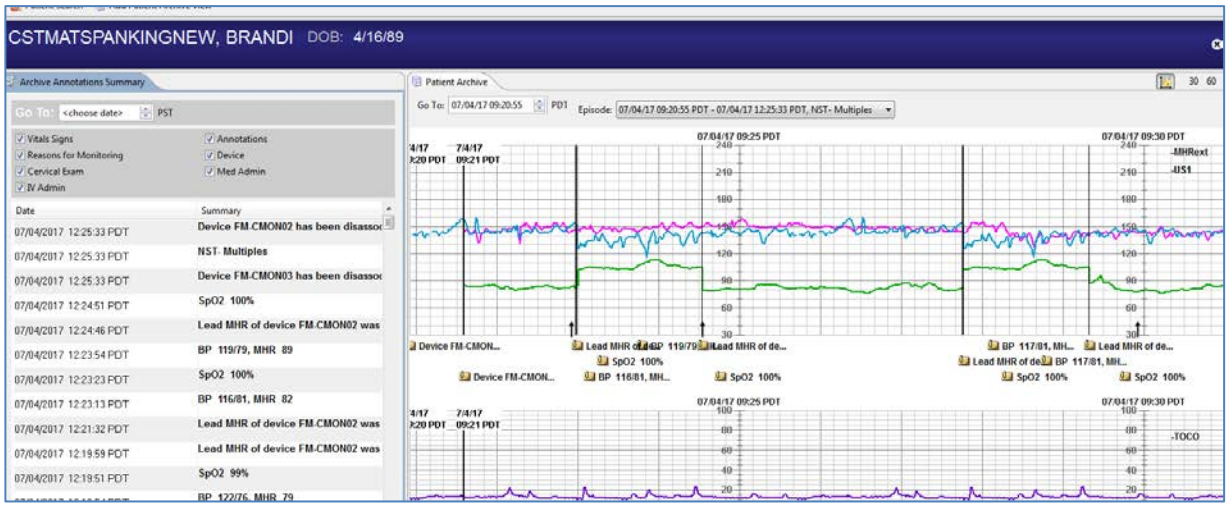
2 From the Partogram workflow tab, review the Fetal Monitoring component.

1. Select **Fetal monitoring** component.
2. Click the box for **Start Date/Time.**
3. Then click **Launch.**

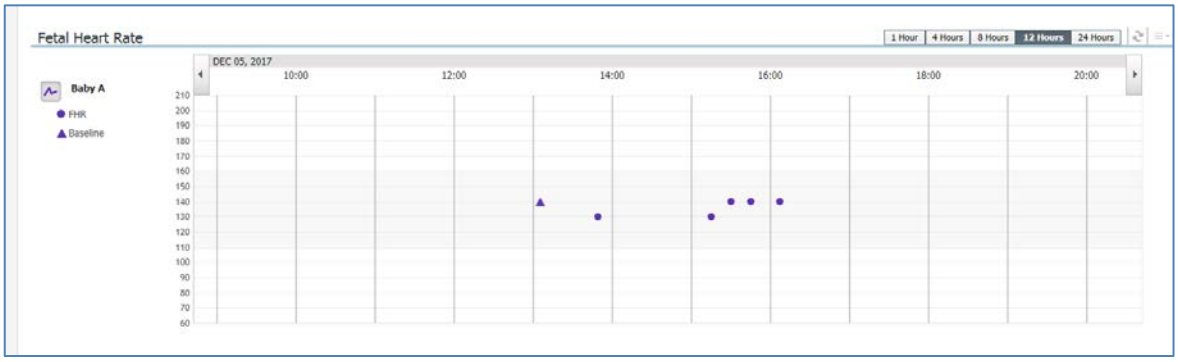
Note: The screenshot below is an example and may not be the same as your assigned patient.



Below is an example of what you will view in FetaLink.



NOTE: The Fetal Heart Rate shown below is derived from iView and is manually entered. I the Hospital, the FetaLink will display the Fetal Heart Rate.



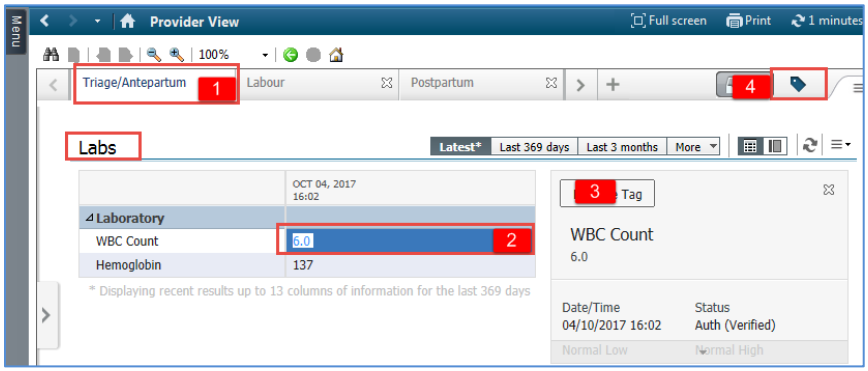
Key Learning Points

- The Partogram is a graphical display of data that has been charted on a labouring patient.
- It provides as much information as was documented on this patient and her labour progress.

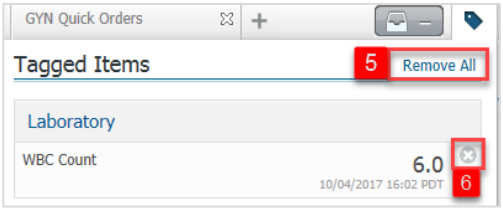
Activity 3.3 – Create an OB Labour Progress Note and Use Tagging

1 You already know how to remove sections or edit text. Now begin learning how to avoid transcribing or entering repetitive information by using tagging. This will be a very helpful feature in the hospital setting.

1. Navigate to the **Labs** component within the **Triage/Antepartum** workflow tab. (If not available in the classroom, use Results Review from the Menu)
2. Click the WBC Count lab result to highlight and open the Tag window
3. Click the **Tag** button in the details pane.
4. Then, click the **Tag** icon to view the item being tagged.

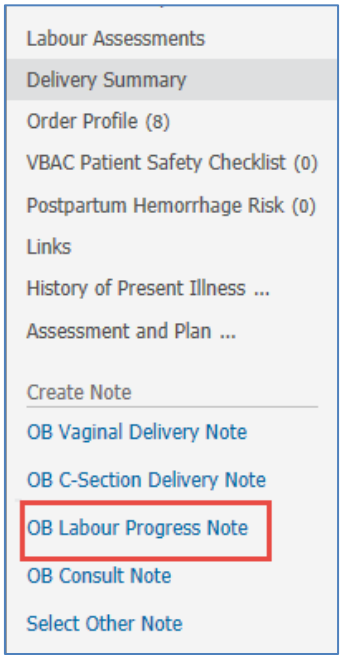


5. You can delete all tagged items by clicking the **Remove All** link.
6. You can also remove individually tagged items by clicking the icon next to the item.



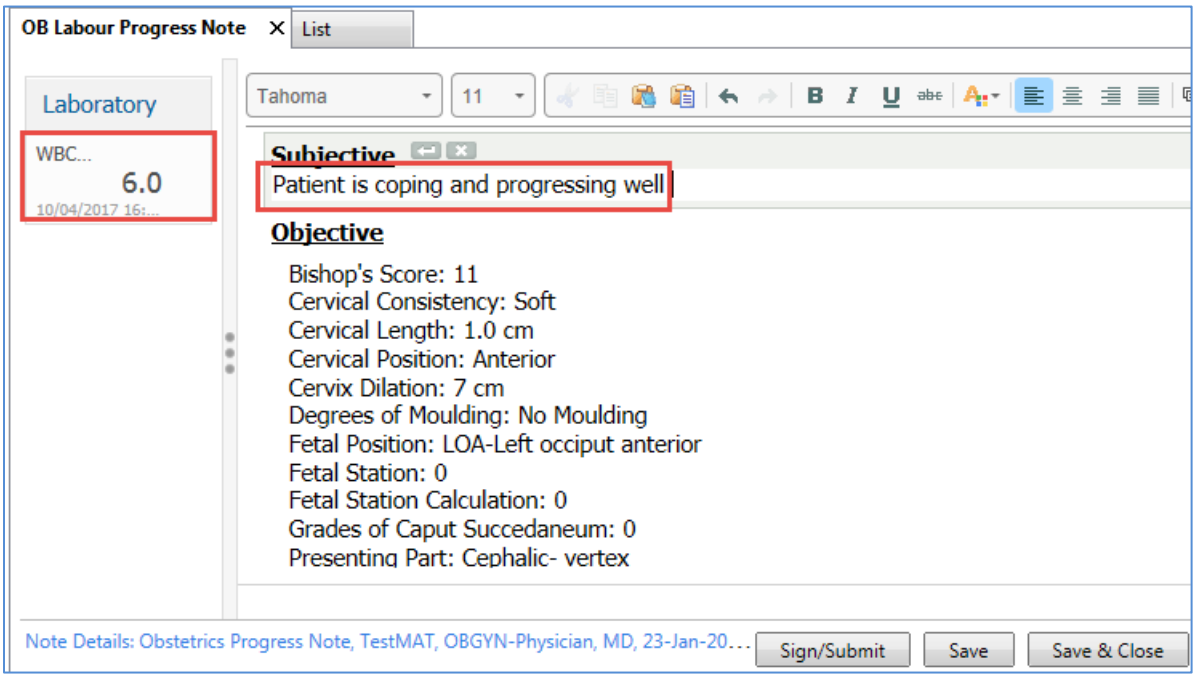
2 Next, go to the **Labour** workflow tab, locate and select a new OB **Labour Progress Note**. The newly tagged items can only be added to a new note, not to a saved or signed note.

Like the Triage/Antepartum workflow tab, the Labour workflow tab also provides one-click access to the most relevant note type.



3

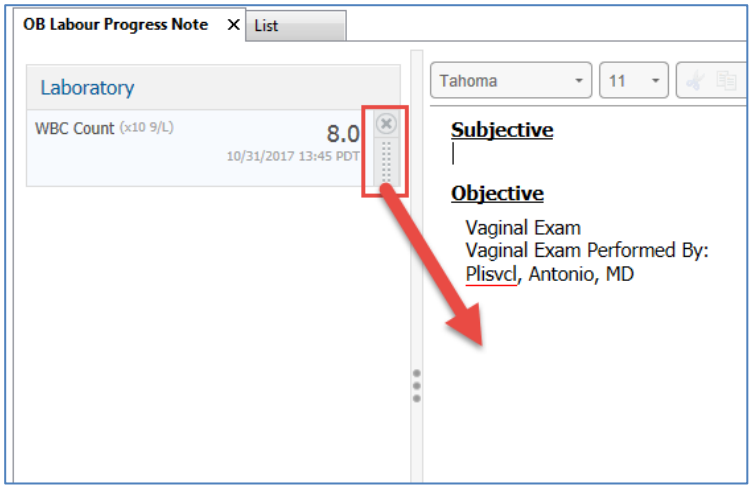
1. In the Subjective section: Enter the following text = *Patient is coping and progressing well.*
2. Review your Vaginal exam in the **Objection section**. The content can be edited if needed.
3. The **tagged WBC count result** is now waiting in your new note section.



Note: Your view may not be the same as the screenshots in the workbook.

4

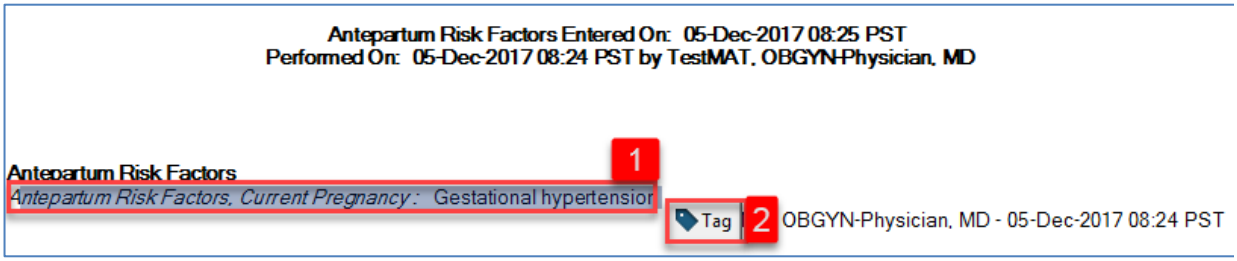
4. **Activate** the tag transfer action by clicking the section (the tag becomes blue indicating it is ready).
5. Drag the tagged WBC count into the Objective section.



5

Tagging Note: You can also tag text from other clinicians' documents or from radiology reports to include in your note.

1. Highlight the text you want to tag to be available in your note.
2. Click the tag icon when it appears.



Key Learning Points

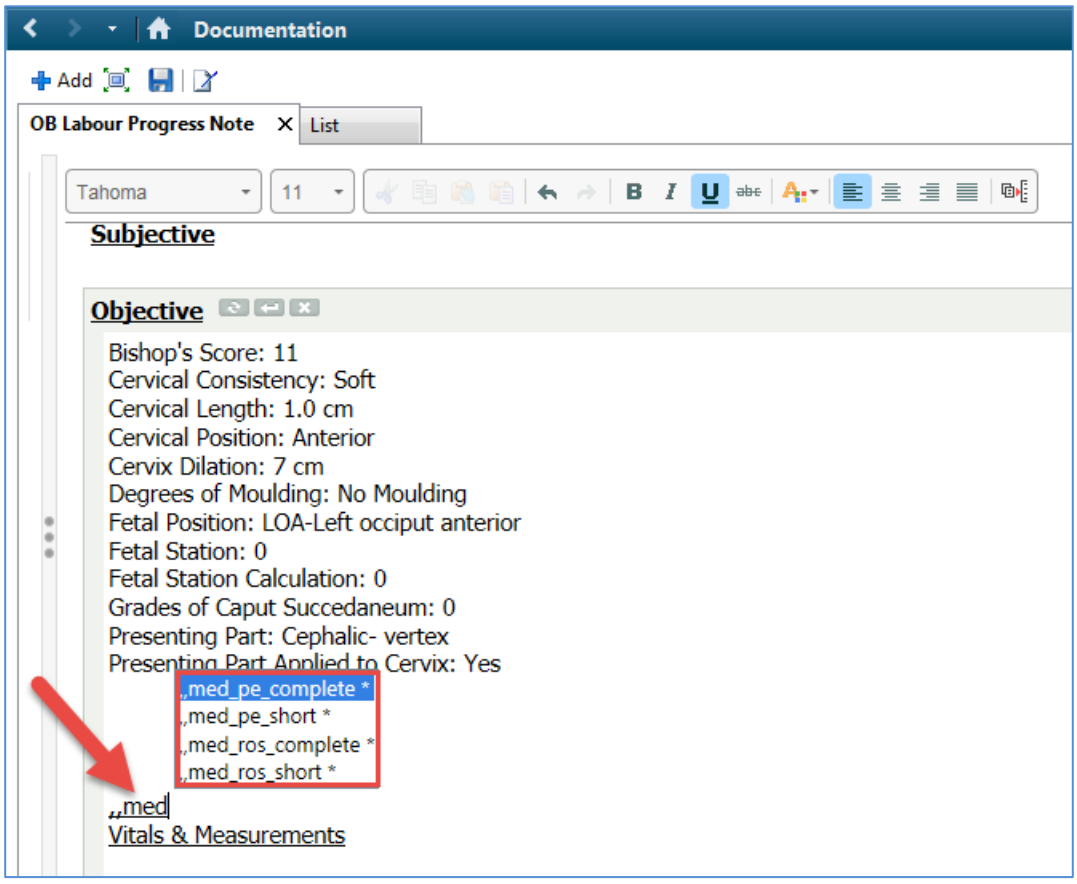
- Tagged data is not attached to previously saved or signed notes.

Activity 3.4 – Continue the OB Labour Progress Note and Use Auto Text Entry

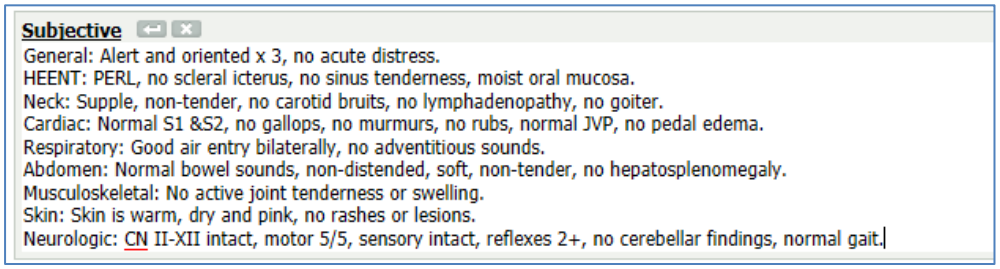
1 The auto text functionality may not be necessary when you document your progress note as an OB provider. However, for physicians who work in OB/GYN and other specialty areas, this tool may be useful.

Now let's learn how to avoid entering repetitive information by using the auto text feature.

1. From the list under Create Note, select **OB Labour Progress Note** which will pull existing relevant information.
2. To activate a free text box under the **Objective** heading, type ,,***med***. A list of auto text entries starting with "comma comma med" is displayed. Select: ***,,med_pe_complete****.



3. The programmed auto text entry populates in the box. Edit this text to complete your note.



Auto text entries are shared across the organization helping to adhere to agreed standards. You can also create your own auto text entries. You will learn how to create auto text entries at a more personalized learning session.

4. Then click **Sign/Submit** to finalize your OB Labour Progress Note.
5. On the next screen click **Sign.**

Key Learning Points

- Use auto text entries for commonly entered information.
- Auto text entries shared between all providers help to maintain standards when documenting patient's care.

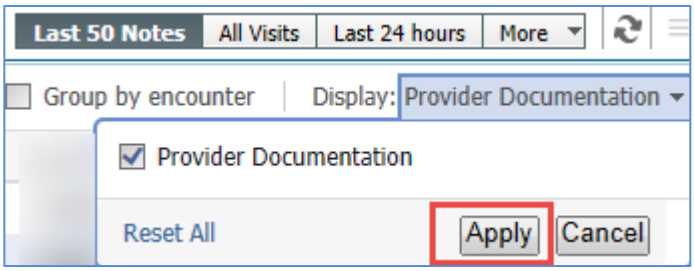
Activity 3.5 – Review Documents, Labs, and Imaging

In this activity you will:

- Navigate the chart to review patient's documents and labs.
- Filter documents for viewing.

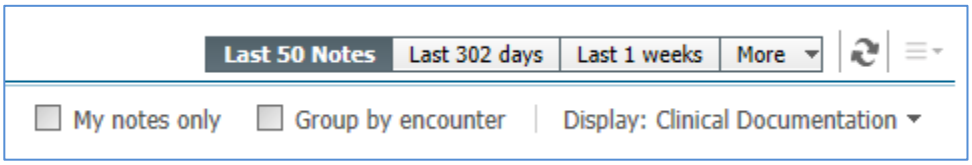
1 Continue reviewing the patient's chart by following the **Labour** workflow tab list of components.

In the **Documents** component, on the right if not active, select **Provider Documentation** and click **Apply**. (This feature is currently being built and may not be in view on your screen)

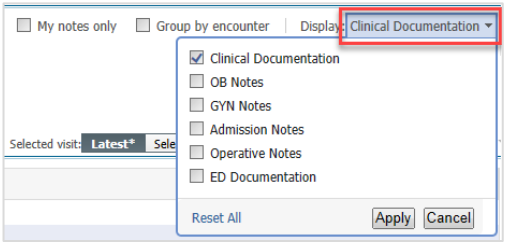


For many components, you can filter in many ways. For example, in the Documents component you can:

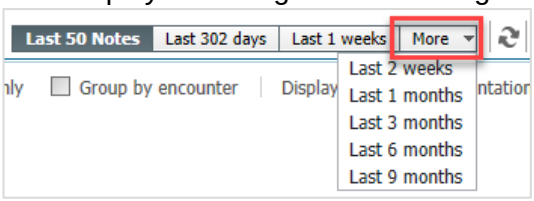
- Display notes from the **My notes only**
- Use **Group by encounter** to see notes for the current encounter only
- Limit documents to **Last 50 notes**
- Access notes for **All Visits**



Your Display is Facility defined view. You can also change the displayed note types by selecting **Provider Documentation**.

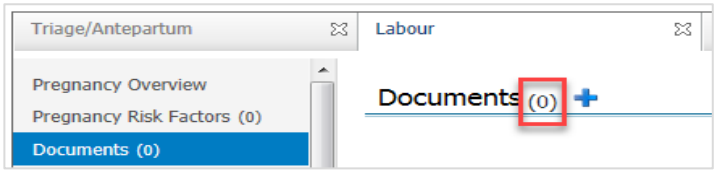


The display time range can be changed by expanding options under **More**



Remember that if you select a specific filter, the selection narrows and you might not display all relevant information. Ensure that the filter type corresponds to your current needs.

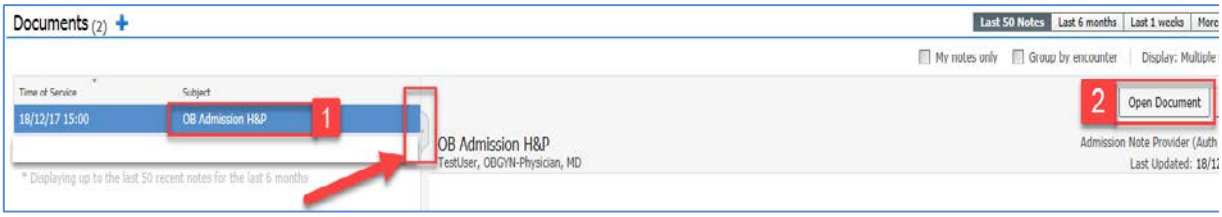
2 You recently entered an OB Admission and H&P note and an OB Labour Progress Note. Now you will see your note within the Documents component. The number in brackets beside the Documents heading link will show you how many documents are available.

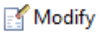


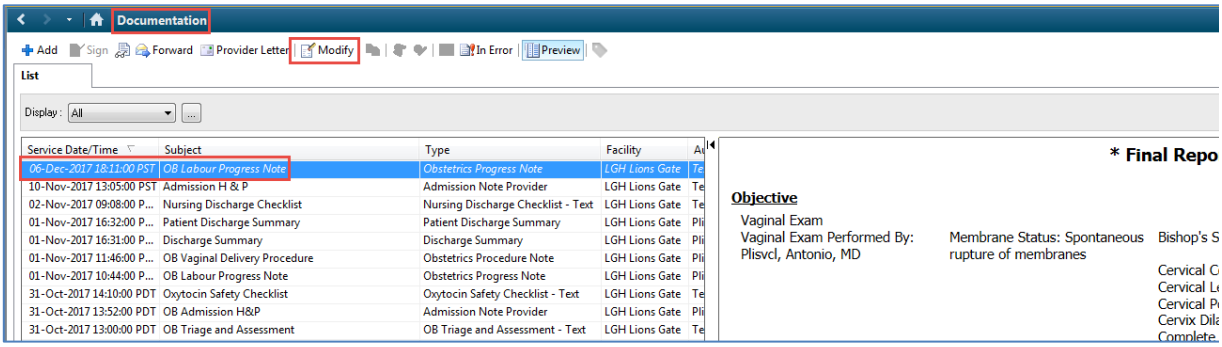
Let's practice.

1. Click the **OB Admission and H&P** note under the Documents heading. The document details will be displayed on the right panel without leaving the screen.
2. To view the document in full screen, click the **Open Document** button.
3. Once opened, click the  icon to close the document. This will take you back to the Documents component.

Note: You can also click the tab to close the split screen.



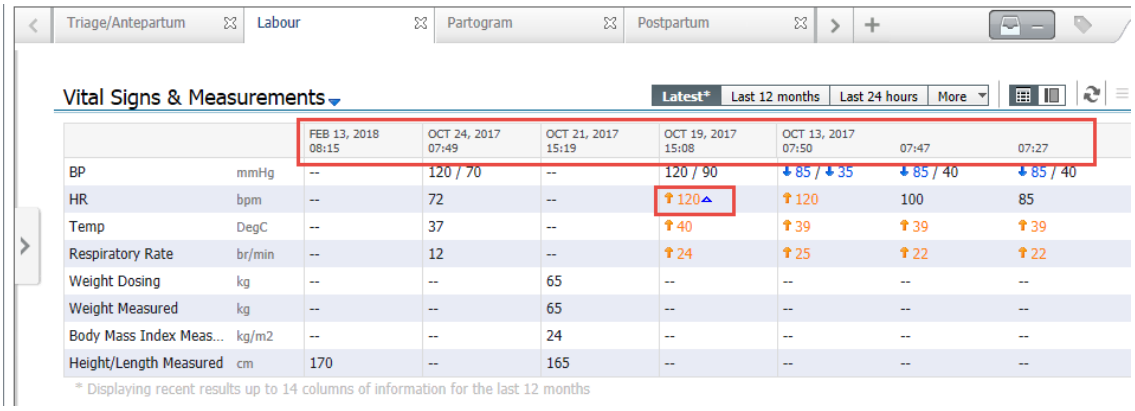
4. Locate your note in the **Documents** component in the Labour workflow tab.
5. Review the Modify function by selecting the Modify icon  . This function will add an addendum.



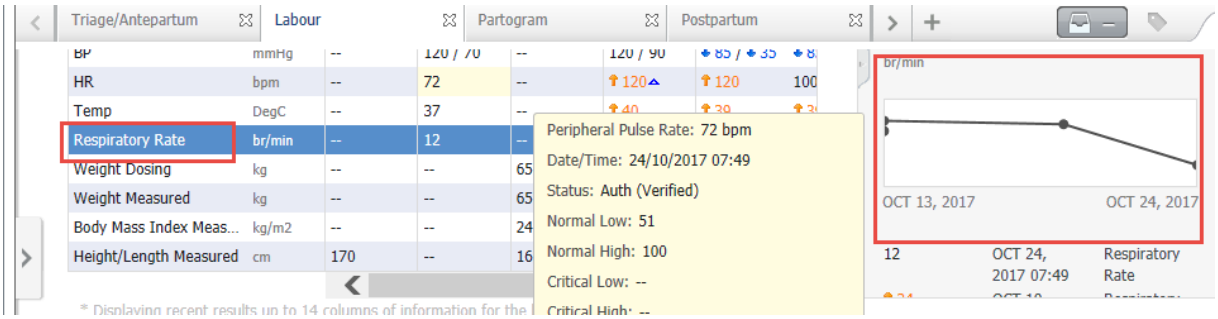
6. Use the navigation buttons  to return to the Provider View.

3 Locate the **Vital Signs and Measurements** from the Component List.

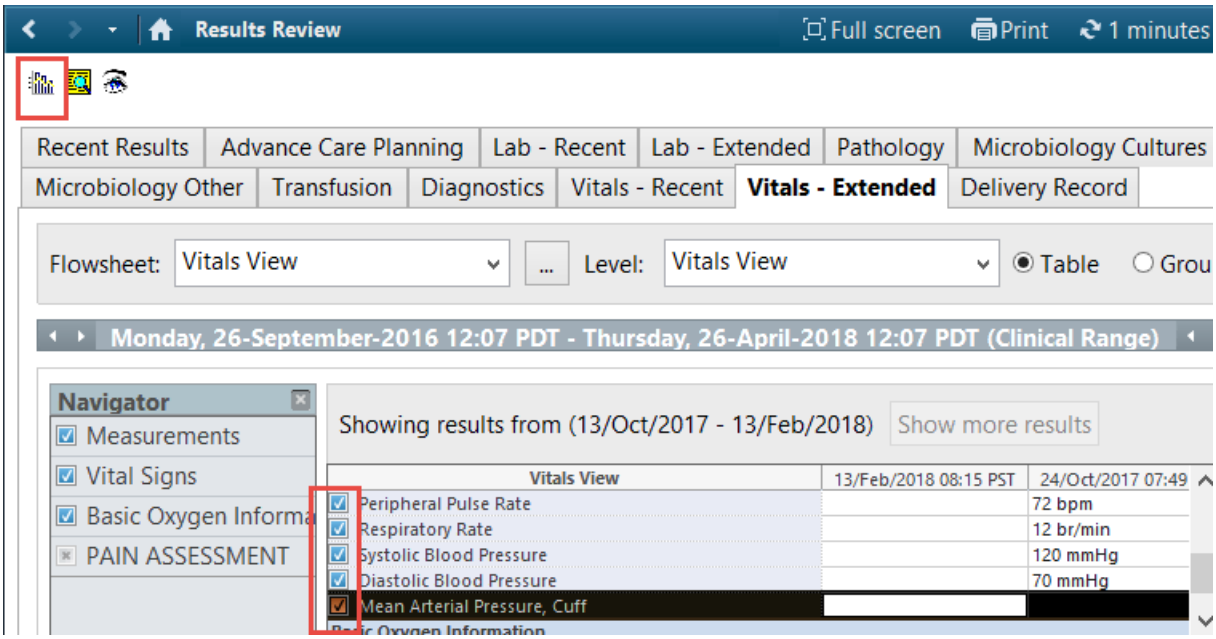
1. The **Vital Signs** component is organized as a table.
2. Table headings show the **time** the information was entered.
3. Vital signs have visual clues (colours and arrows) when they are out of range, for example, Heart Rate 120.



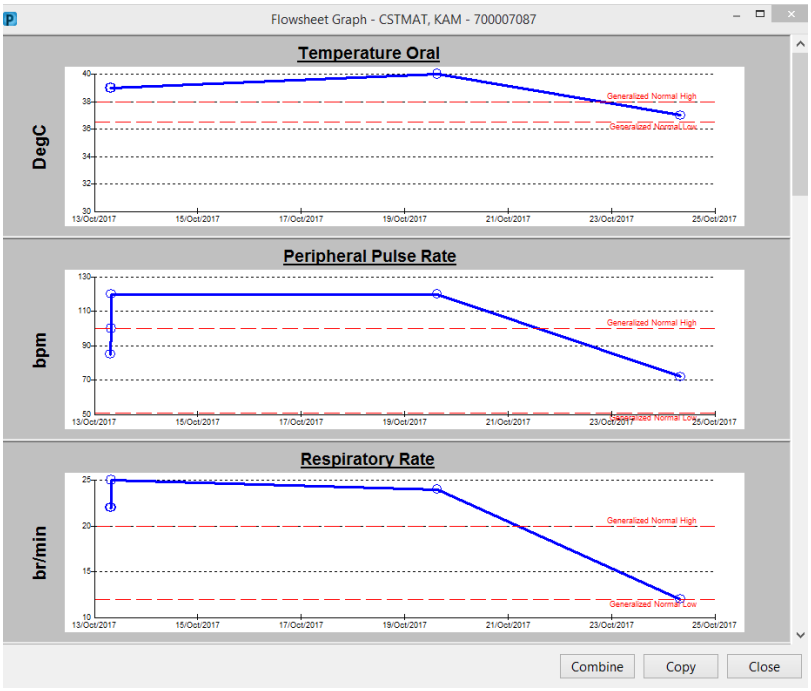
4. For a single measure graph, click on the name of measurement: **Respiratory Rate.**



5. To display a multi-item graph, click the **Vital Signs & Measurements** hyperlinked heading. The Results Review window opens.
6. **Check** the box values needed.
7. **Click** on the graph icon .



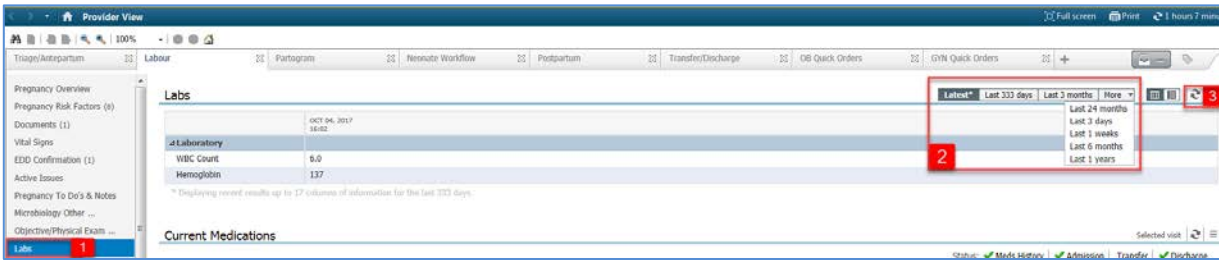
8. The Flowsheet Graph window opens.



Close and click Home icon.

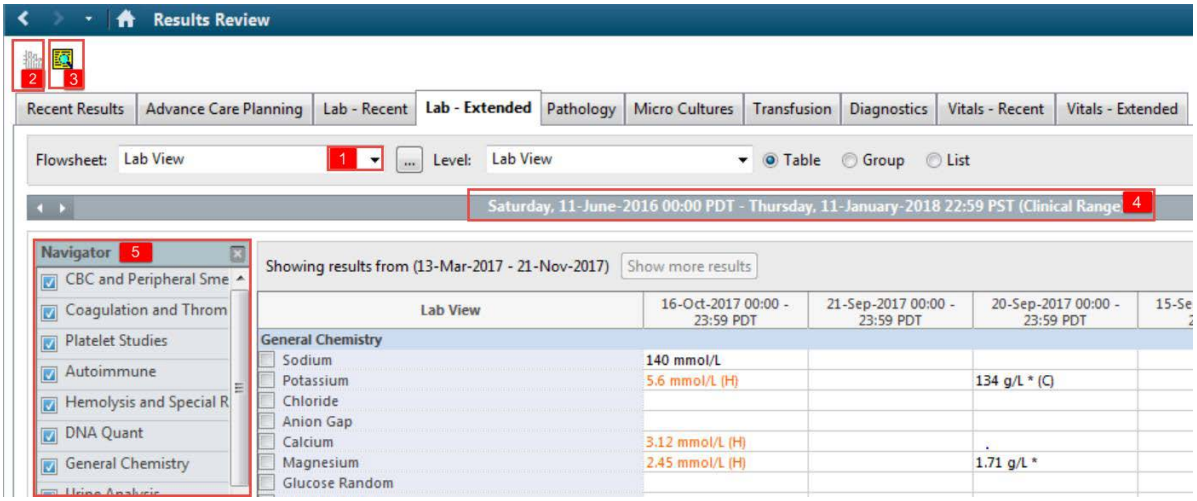
4 To review Labs:

1. Select the **Labs** component under the **Triage/ Antepartum** workflow tab.
2. Use filters to display results that are relevant to you.
3. Click the refresh icon to update the information just for this component.



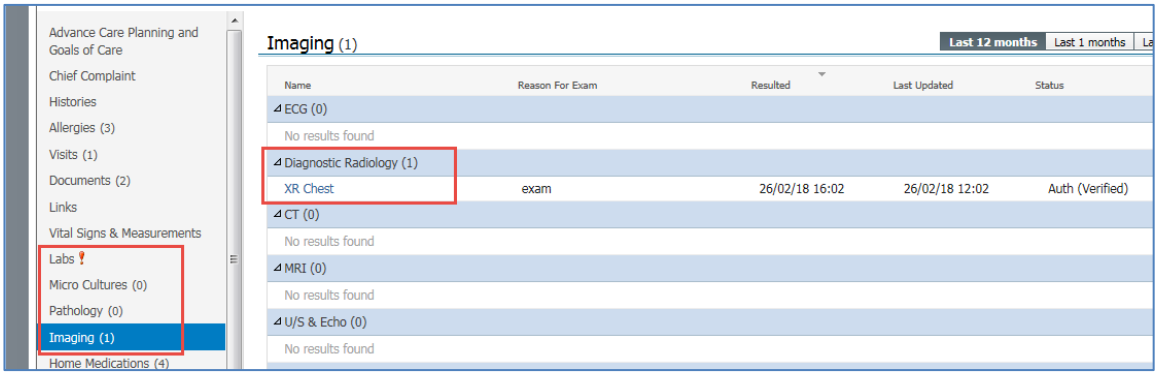
Click the **Labs** hyperlinked heading (the Results Review window opens) to display comprehensive summaries of patient's results grouped in separate tabs.

1. Click the down arrow to select a specific view from the drop-down, for example Anticoagulation View, Pain View, or Respiratory View.
2. Select the result and click the icon to create a graph.
3. For extensive and long lists, click the icon. It is a view seeker that brings focus to a specific place in the table.
4. Check the time range of the current display. This time range can be customized to fit your needs with a right-click.
5. Use the Navigator panel to display different types of results.



If you want to review pathology, microbiology, or diagnostic imaging only, you can select a

corresponding component from the component list. (XR Chest may not available on the OBGYN provider view in the classroom).



Key Learning Points

- Using filters will display only pertinent information. Remember to check what filter is currently selected to ensure that it fits your current needs.
- Once you sign and submit a note, further edits can be added but will appear as an addendum.

PATIENT SCENARIO 4 – Newborn: Care and Documentation

Learning Objectives

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

- Access newborn's chart using Patient Overview
- Review the Neonate Workflow Tab
- Document the Newborn Delivery Data
- Review Newborn BPMH
- Create Newborn admission note with auto-texting
- Locate Newborn Record Report
- Document Active Issues

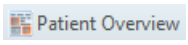
SCENARIO

As an OB Family Practice Provider, you will order and document on the newborn.

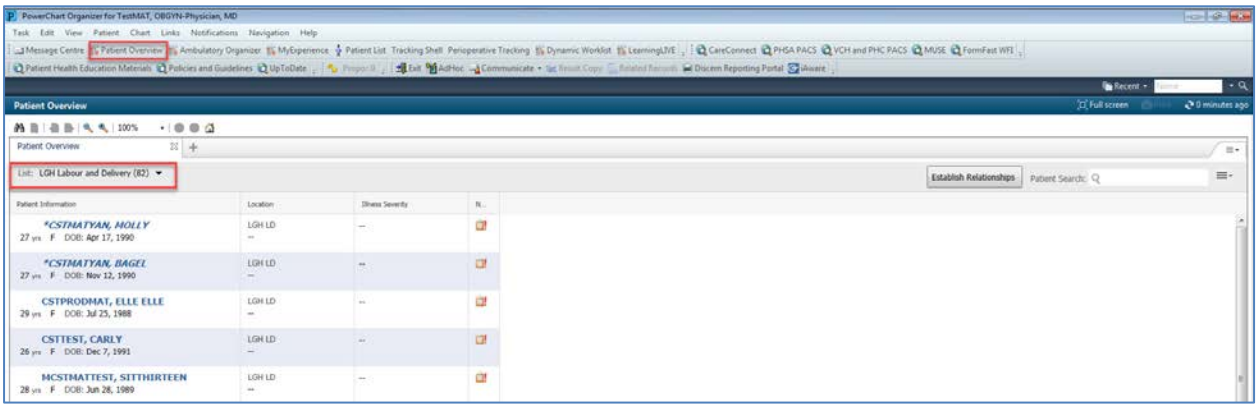
You will complete the following activities:

- Access newborn's chart using Patient overview
- Locate and review the Neonate Workflow Tab
- Document Newborn Delivery Data in iView
- Locate and Document the Newborn's BPMH
- Create a Newborn Admission Note with auto-texting
- Locate the Newborn Record Report
- Document Active Issues for the Newborn

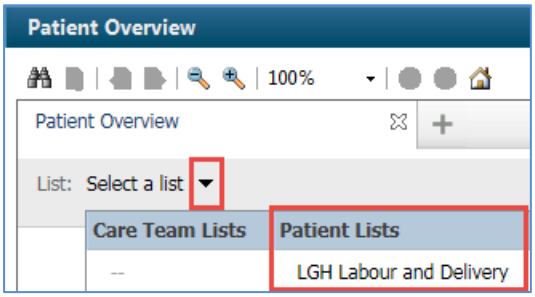
Activity 4.1 – Introduction to Patient Overview

You can access your patient lists by clicking **Patient Overview** in the toolbar 

. It is also used to communicate with other providers about the patient's status which will be discussed further on the next page.



You can click on the drop-down icon from the **List** and select the appropriate patient list. In your case, LGH Labour and Delivery is your default patient list.



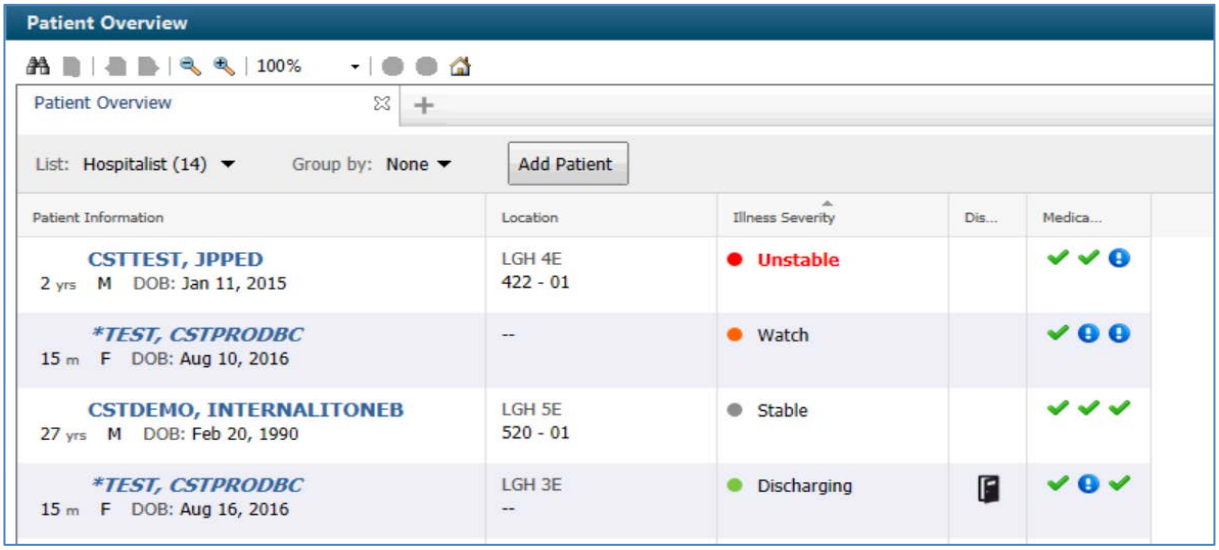
Note: Once the newborn has been registered in the CIS, you will be able to access the baby's chart in the Patient Overview.

1 Patient Overview serves as a communication tool during patient handoff. It provides a snapshot of

the patient's status and helps you manage your work:

- You can track new results that you have not yet reviewed indicated by icon
- You can see where the patient is located: unit / room / and bed number
- You can make a note of patient's illness severity
- You can see the discharge status indicated by the icon
- You can track medication reconciliation completion

Below is an example of the Patient Overview. This may not be your current view.



You can click a column heading such as Location to display all patients in the same unit together. Clicking Patient Information will place names in alphabetical order.

Patient Overview also displays a snapshot of patient status under the **Illness Severity** column. You can easily add or change your patient status by clicking the corresponding space under this column and selecting one of the options from the list. You can click the column heading to sort all patients.

2 Let's practice locating the newborn:

1. Locate the newborn from the **Patient Information** list.
2. Click on the patient's name to open the chart.

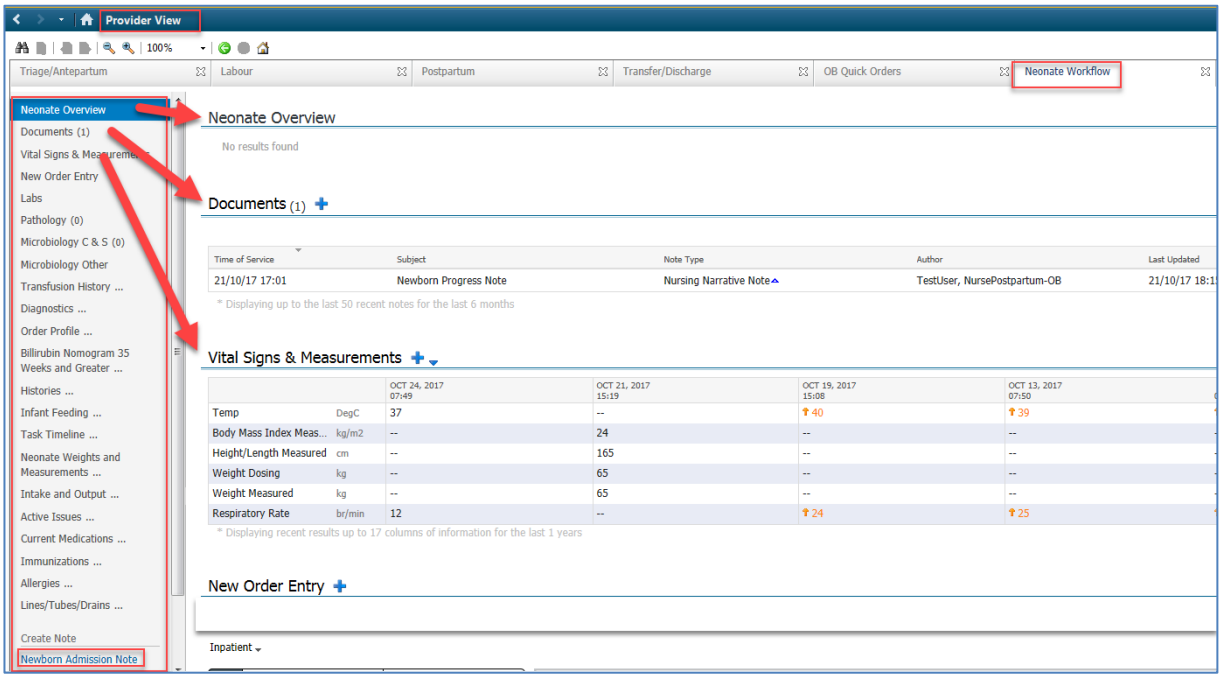
Note: Notice that the banner bar shows two opened charts: one for the mother and the newborn. The newborn's chart is currently open and is highlighted in blue. The banner bar displays the newborn information. You may leave the charts open so that you can toggle between the charts for documentation purposes.

Key Learning Points

- Patient Overview is another way of accessing your patient's chart.

Activity 4.2 – Locate and Review the Neonate Workflow Tab

1 Locate the **Neonate Workflow** tab, review the components. Vital Signs are pulled in from the nursing documentation in iView. Notice that the Newborn Admission Note is found at the end of the component list.

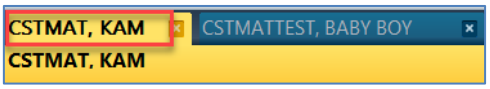


Key Learning Points

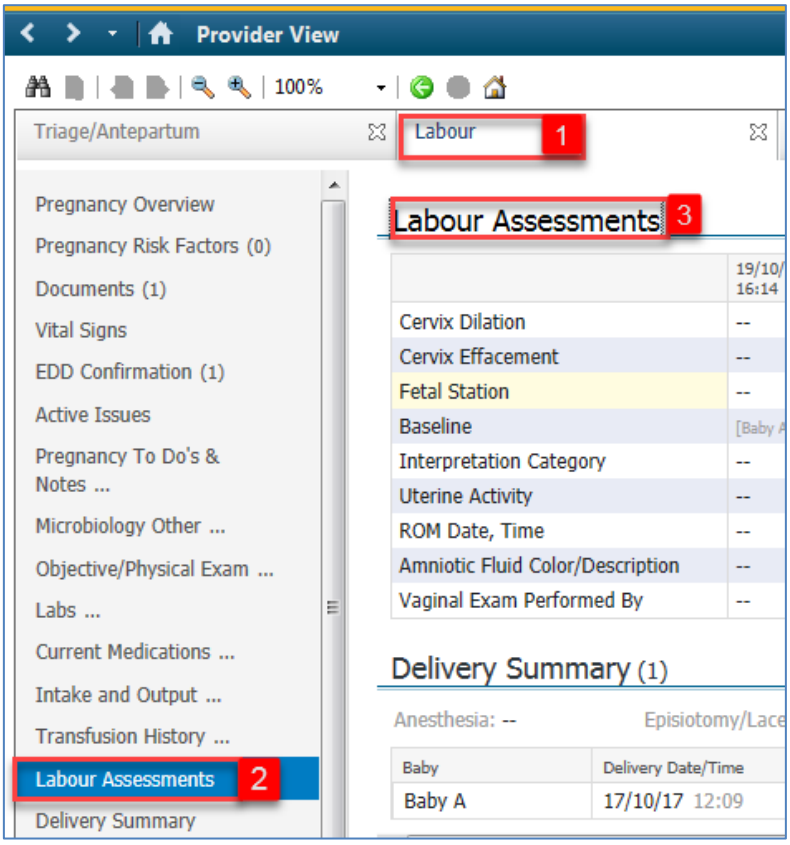
- The Neonate Workflow tab displays newborn specific iView information such as neonate overview, vital signs and measurements, documents, labs, etc.

Activity 4.3 – Document the Newborn Delivery Data in iView within Labour Workflow

1 Document the Newborn Delivery Data in the mother's chart. Remember to toggle to the mother's chart and do not close the newborn's chart for use later this activity.

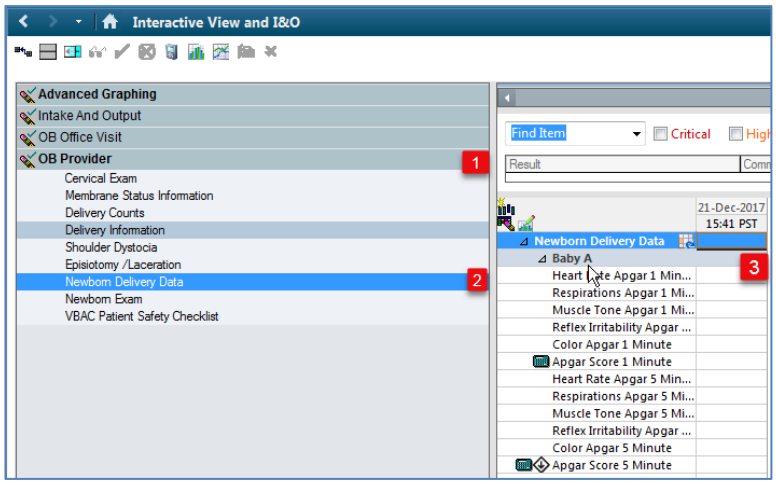


1. From **Provider View** in the Menu select the **Labour** tab
2. Click on the **Labour Assessments** component
3. Click on the **Labour Assessments** heading



2 To begin your documentation, select the appropriate Band and Section:

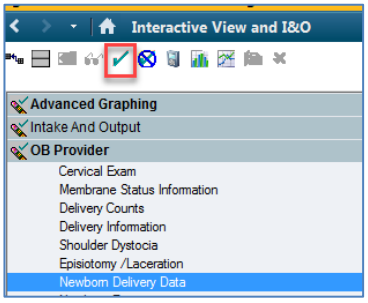
1. Click on **OB Provider** band .
2. Click on **Newborn Delivery Data** section.
3. Double click on blue **Newborn Delivery Data** line to open the cells for one-click documentation. Use the tab key to advance your documentation.



3 Enter the following data into the Newborn Delivery flowsheet:

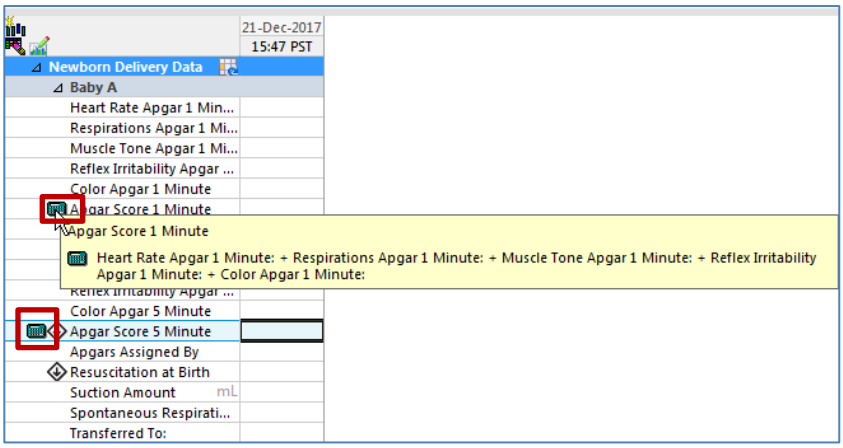
- **Heart rate Apgar 1 minute** = greater *than 100 beats per minute*
- **Respirations Apgar 1 minute** = *good, strong cry*
- **Muscle Tone Apgar 1 minute** = *active motion*
- **Reflex irritability Apgar 1 minute** = *cry or active withdrawal*
- **Color Apgar 1 minute** = *body pink, extremities blue*
- **Apgar score 1 minute** = *9*
- **Heart rate Apgar 5 minute** = *greater than 100 beats per minute*
- **Respirations Apgar 5 minute** = *good, strong cry*
- **Muscle Tone Apgar 5 minute** = *active motion*
- **Reflex irritability Apgar 5 minute** = *cry or active withdrawal*
- **Color Apgar 5 minute** = *body pink, extremities blue*
- **Apgar score 5 minute** = *9*

To document, click **Sign** icon.

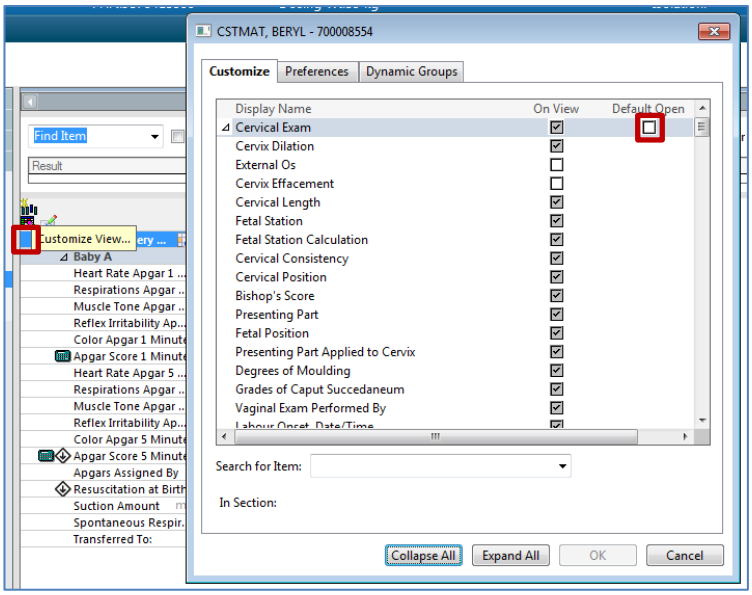


4 Review iView icons.

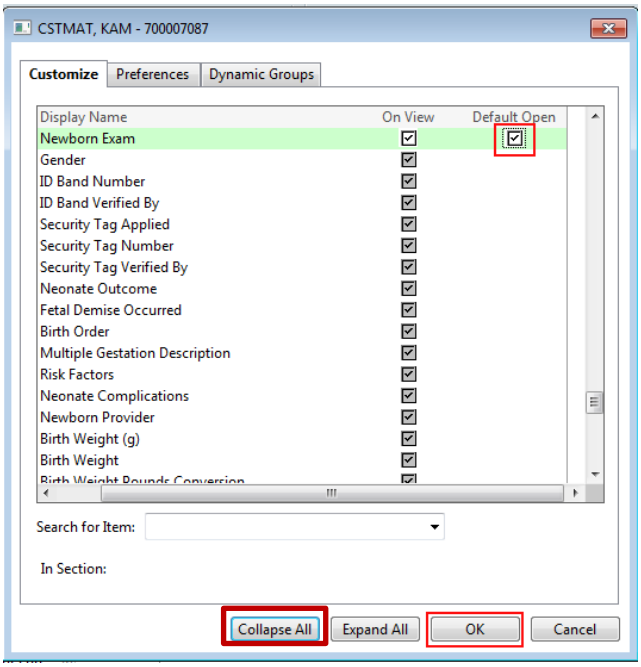
The Calculation icon denotes that the cell will populate a result based on a calculation associated with it. Hover over the calculation icon to view the cells required for calculation.



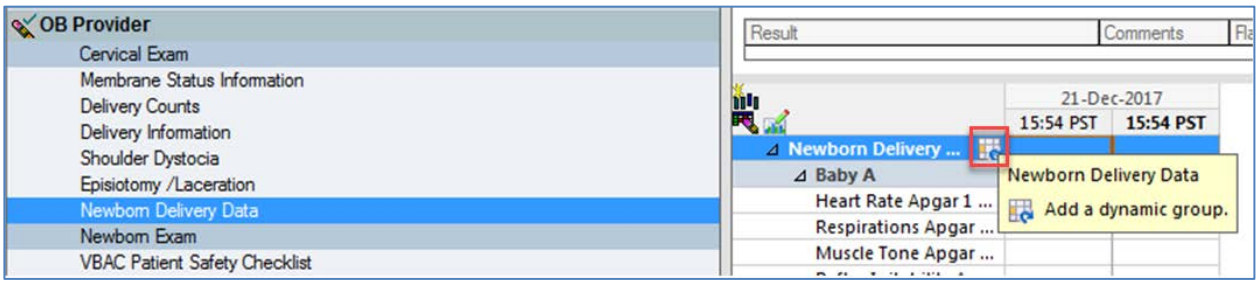
Click the **Customize View** icon  to search for a section not displayed.



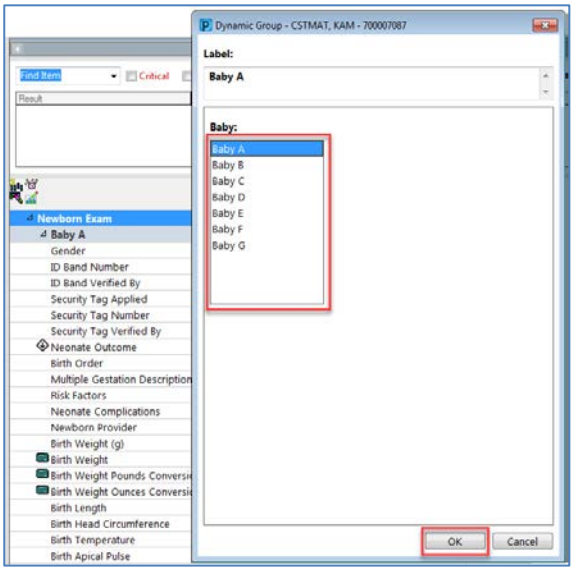
For practice, in the **Newborn Exam** section, ensure the checkbox is ticked under **Default Open** and then click **OK** to close this window. This flowsheet will now appear as one of your default screens when you return to Interactive View and I&O.



Click on the **Dynamic Group** icon to the right of the cell.

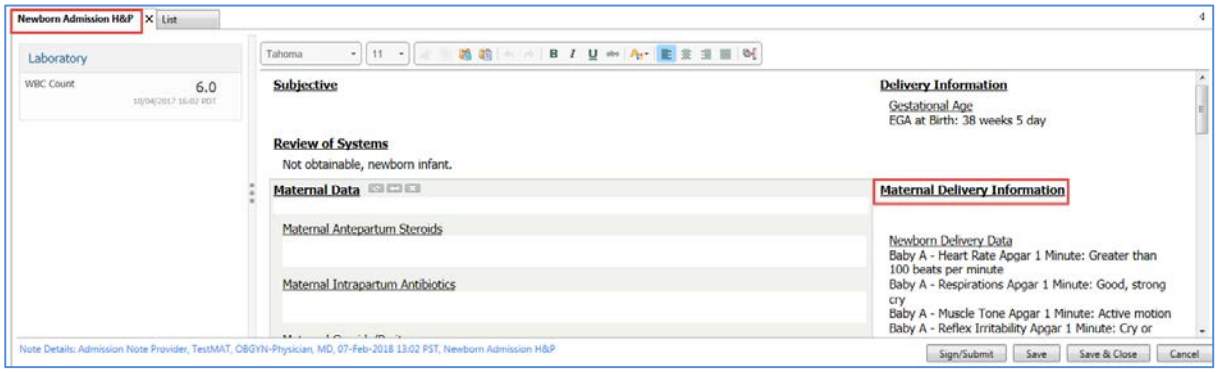


A dynamic group permits you to label newborn twins A and B in iView. These groups should appear because the patient has been flagged as having multiples when their antenatal information is entered, but it is good to know how to add the section in case it does not appear. You can now click Cancel or icon since we already have Baby A on record.



Remember: the Newborn Delivery documentation is entered into iView and will flow into your Newborn Admission Note.

This Newborn Delivery documentation is entered on the Labour workflow tab and the Labour Assessment component.



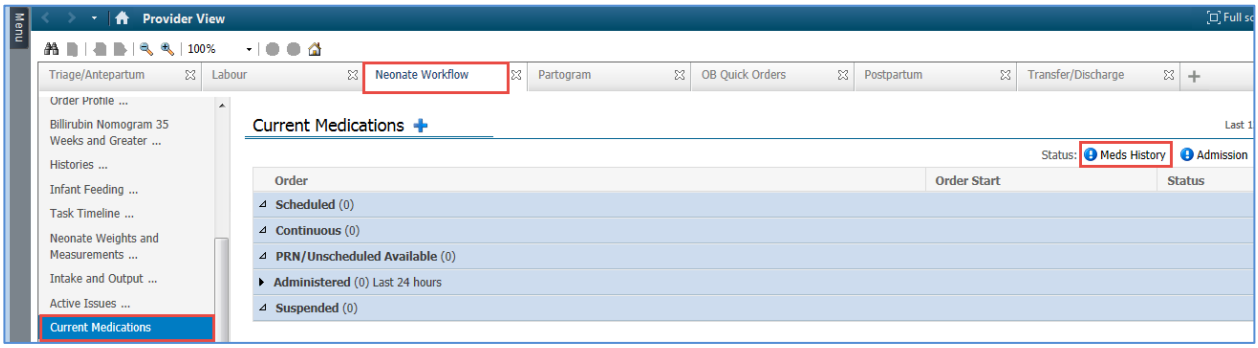
Key Learning Points

- You can toggle between the patient (mother) and the newborn's charts for easy accessibility.
- Add a workflow tab by clicking on the add button located at the end of the tabs.
- Use the mother's chart to document the Newborn Delivery Data.
- A dynamic group permits you to label multiple newborns from Baby A to G in iView.

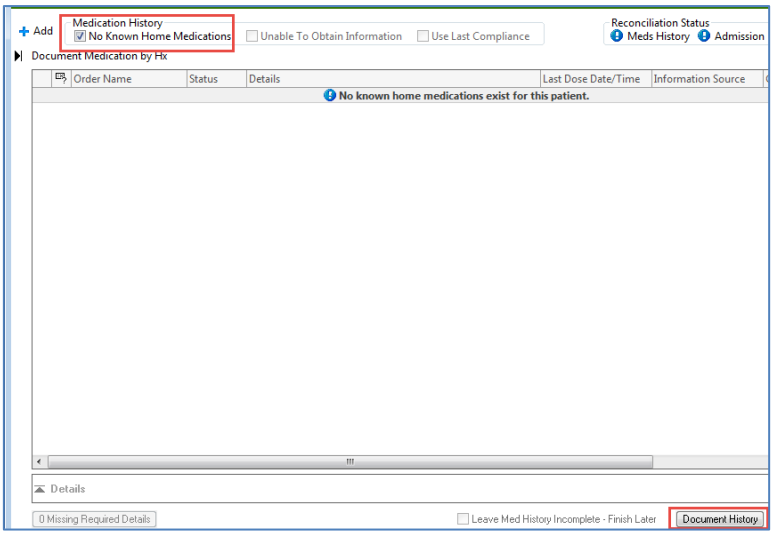
Activity 4.4 – Review and Document the Newborn BPMH

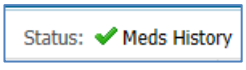
You still have the newborn's chart open. Toggle to the newborn's chart for further documentation.

1 Locate the **Neonate Workflow** tab under Provider View and select the **Current Medications** component. Click on the **Meds History** from the Status line.



2 In the Medication History check box, click **No Known Home Medications.** Then select **Document History.**



Refresh your screen . Now the BPMH is competes. 

Key Learning Points

- Use the Current Medications component and select the Meds History to complete the newborn's BPMH

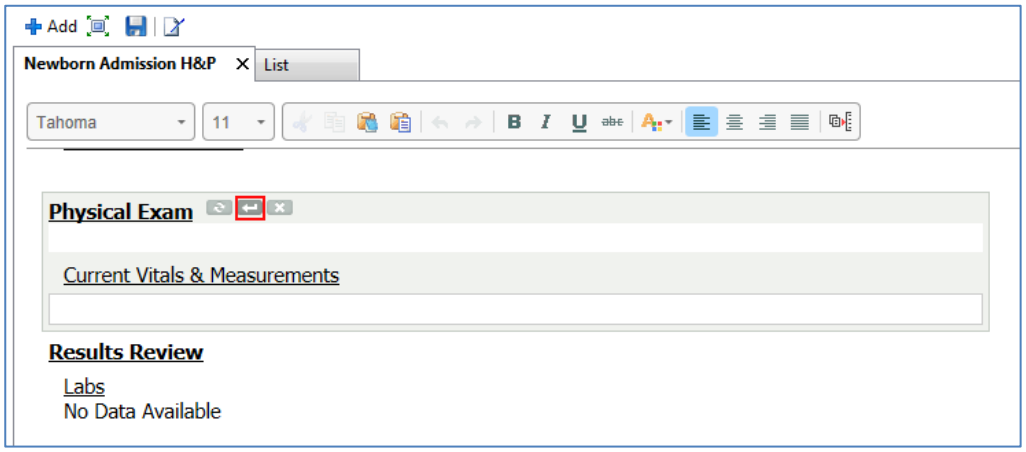
Activity 4.5 – Create a Newborn Admission Note with auto-texting

1

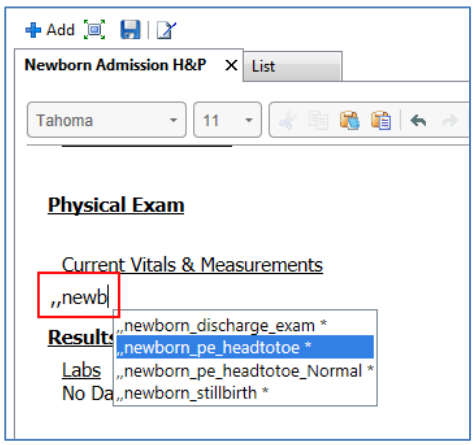
The auto text functionality may not be necessary when you document your progress note as an OB Family Practice provider. However, this tool may be useful.

Now let's learn how to avoid entering repetitive information by using the auto text feature. Continuing in the Neonate Workflow tab, locate **Create a Note** at the end of the workflow component's list and select **Newborn Admission Note**.

Scroll down to the **Physical Exam** section**,** and click on the **Insert free text** icon to add another line.



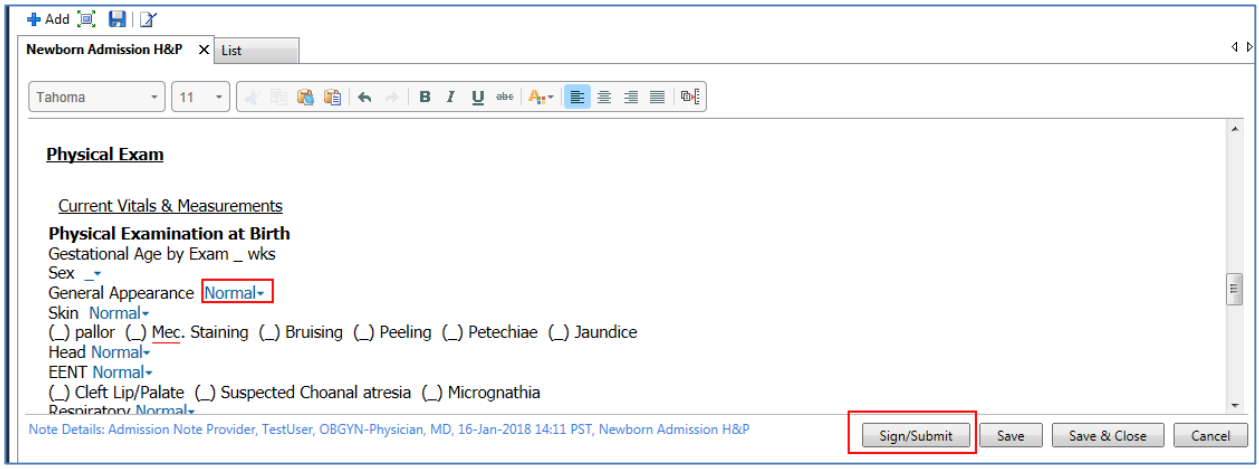
Then, enter = ***,,newb*** in the free text box and select **,,newborn_pe_heattotoe*** by double clicking.



`2

The programmed auto text entry populates in the box. Modify the content as appropriate. Click on

Normal to select **Normal** or **Abnormal**.



Once documentation is complete, click **Sign/Submit** button to finalize your note.

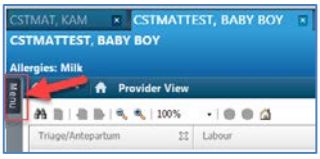
Auto text entries are shared across the organization helping to adhere to agreed standards. You can also create your own auto text entries. You will learn how to create auto text entries at a more personalized learning session.

Key Learning Points

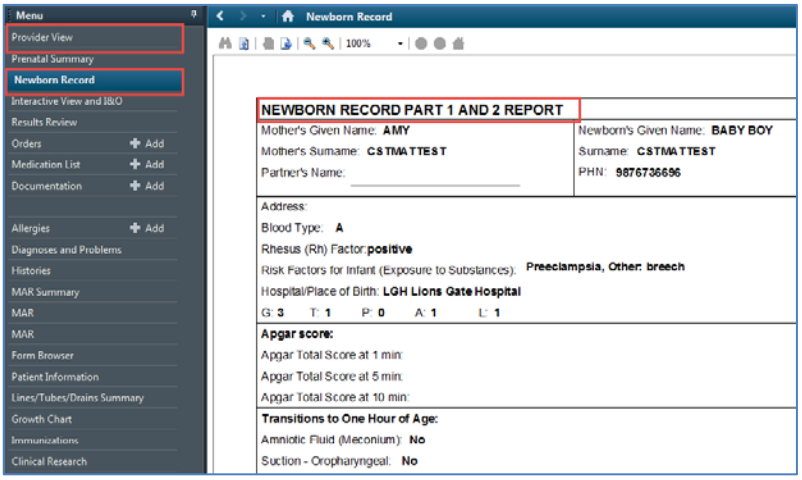
- Auto text entries shared between all providers help to maintain standards when documenting patient's care.
- Use auto text entries for commonly entered information.

Activity 4.6 – Locate the Newborn Record Report

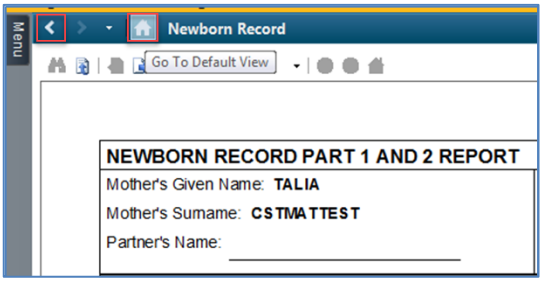
1 You can locate reports such as the **Newborn Record** in the **Menu** list. To open, simply click on the **Menu.**



The information is pulled from documentation areas such as iView.



After reviewing the newborn's record, click the **Go To Default View** icon or the **Back** icon to return to your previous page.



Key Learning Points

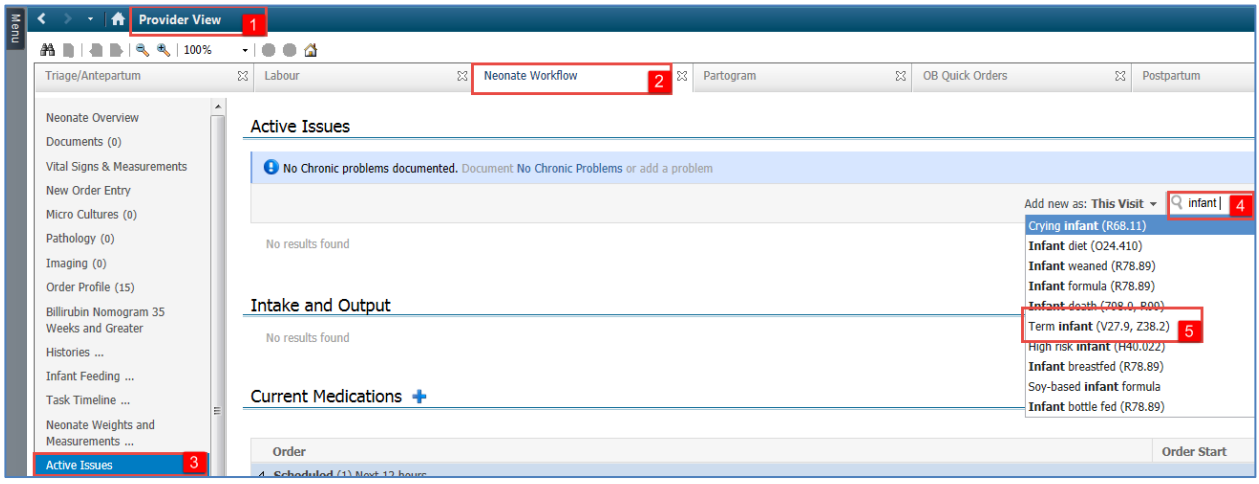
- Newborn Reports are in the Menu page list.

Activity 4.7 – Active Issues for the Newborn

1 The newborn needs a diagnosis recorded as a base for future visits.

It will be identical steps for the newborn as it was with the mother and you will be documenting it in the newborn's chart.

1. Navigate to the **Provider View**
2. Click on **Neonate Workflow** tab
3. Click on **Active issues** component
4. In the **Add new as: This Visit** search box, enter = ***Infant***
5. Select **Term Infant**



Key Learning Points

- Entering diagnosis or active issues is the same for mother and newborn.

Key Learning Points

- Result copy allows you to copy documented information from mom's chart over to the newborn's chart.
- Result copy is necessary at minimum during the follow 3 situations:
    1. When the newborn has been quick registered
    2. When mom and baby are being transferred from labour to postpartum
    3. When mom and baby are being discharged from the hospital

PATIENT SCENARIO 5 – Postpartum

Learning Objectives

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

- Discontinue a PowerPlan
- Place a PowerPlan in Planned State
- Initiate the Planned State PowerPlan

SCENARIO

Your patient has delivered a healthy newborn. The OB Admission PowerPlan needs to be discontinued. This may be done by the nurse or the provider. In this case, you will discontinue the OB Labour and Delivery Admission PowerPlan. You will also place the OB Postpartum Vaginal Delivery in a planned state for the nurse to activate at the appropriate time.

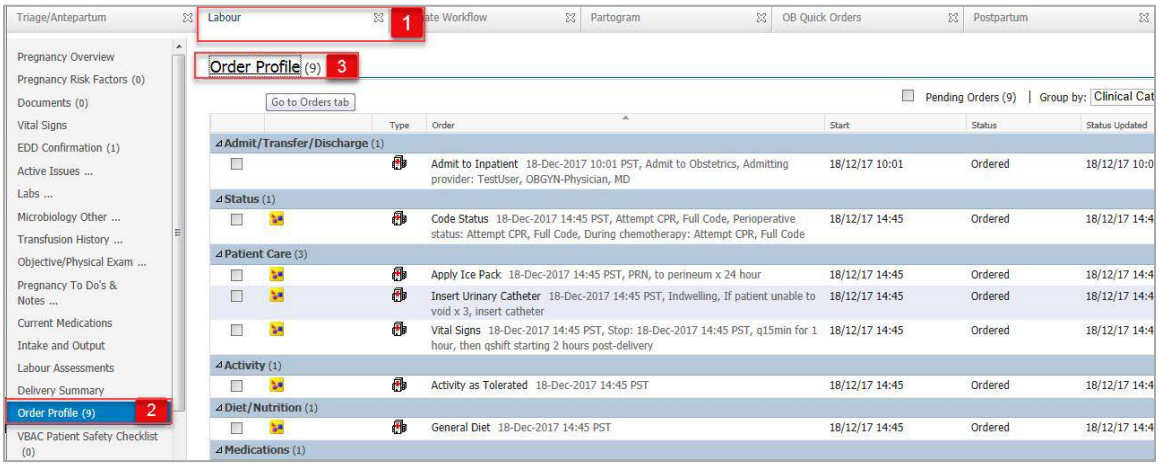
Note: If the newborn is born with health complications, the newborn must immediately be quick registered by the nurse for the newborn provider to enter transfer orders to NICU and NICU can then enter orders. This avoids the newborn arriving at NICU and orders cannot be placed.

- Discontinue the OB Admission PowerPlan
- Place the OB PostPartum Vaginal Delivery PowerPlan in Planned State
- Initiate the OB Postpartum Vaginal Delivery Planned State PowerPlan

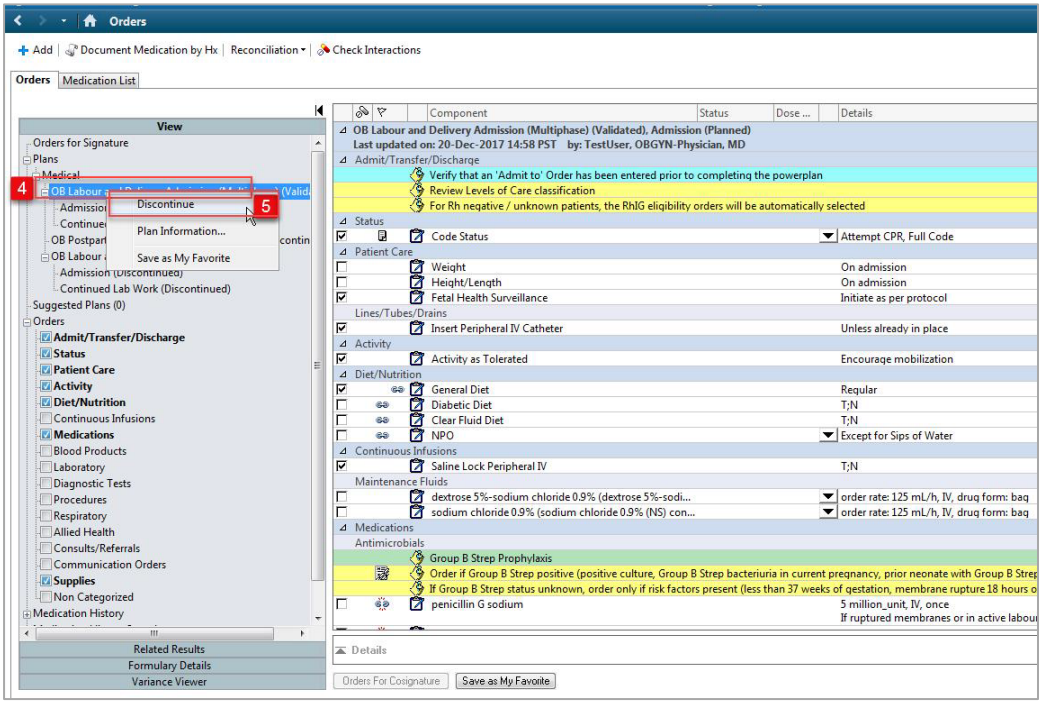
Activity 5.1 – Discontinue an OB Labour and Delivery Admission PowerPlan

1

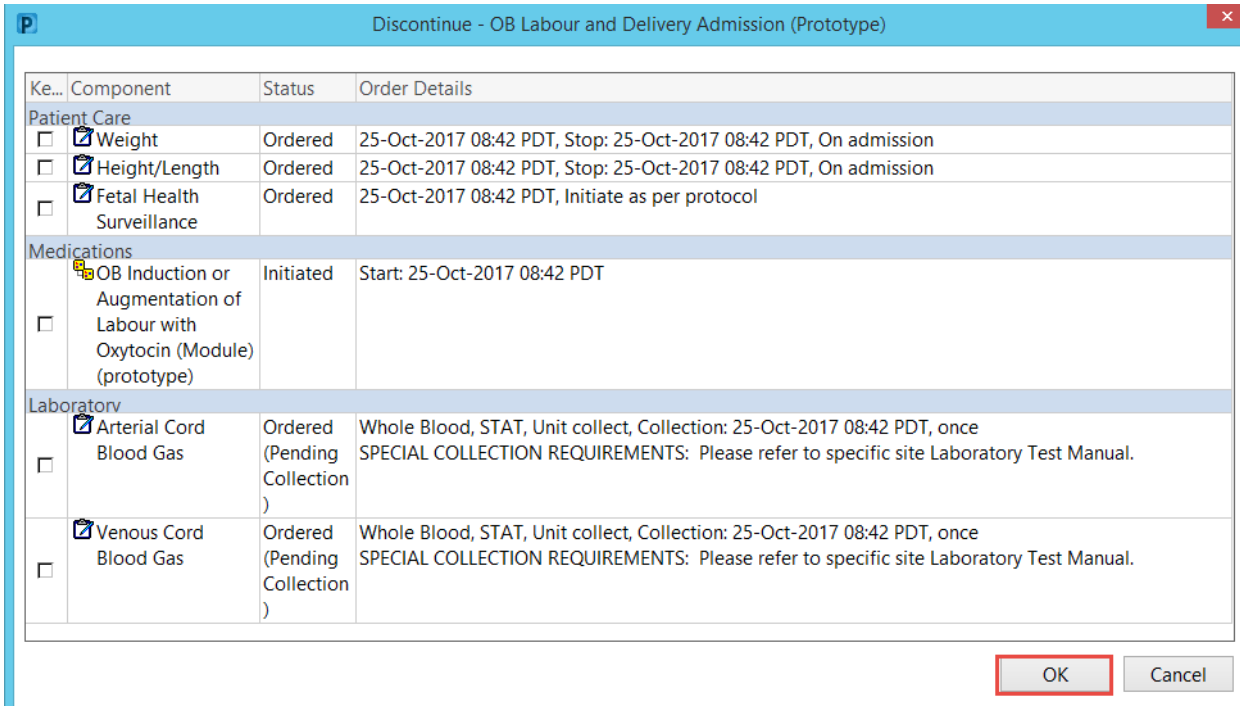
1. Click the **Labour** workflow tab.
2. Select the **Order Profile** component.
3. Click the **Order Profile** link.



4. Locate and select the OB Labour and Delivery Admission (Multiphase) in the View menu.
5. Then, right-click to **Discontinue** the PowerPlan.

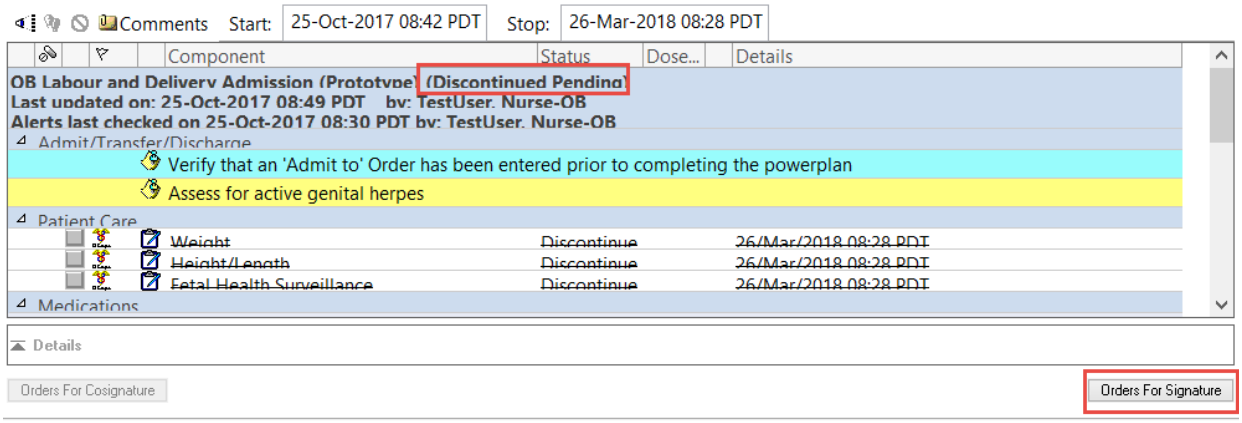


6. Click **OK**



NOTE: When you discontinue a PowerPlan and need to **keep** some orders, click the checkmark beside those orders before clicking **OK.**

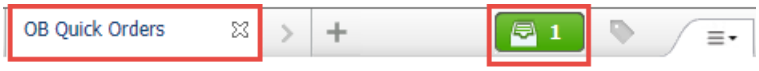
7. Review plan and click **Orders for Signature**

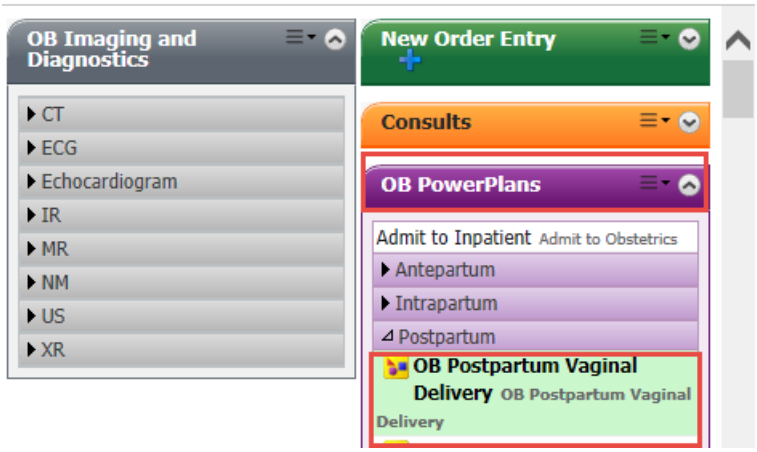


Activity 5.2 – Place an OB Postpartum Vaginal Delivery PowerPlan in Planned State

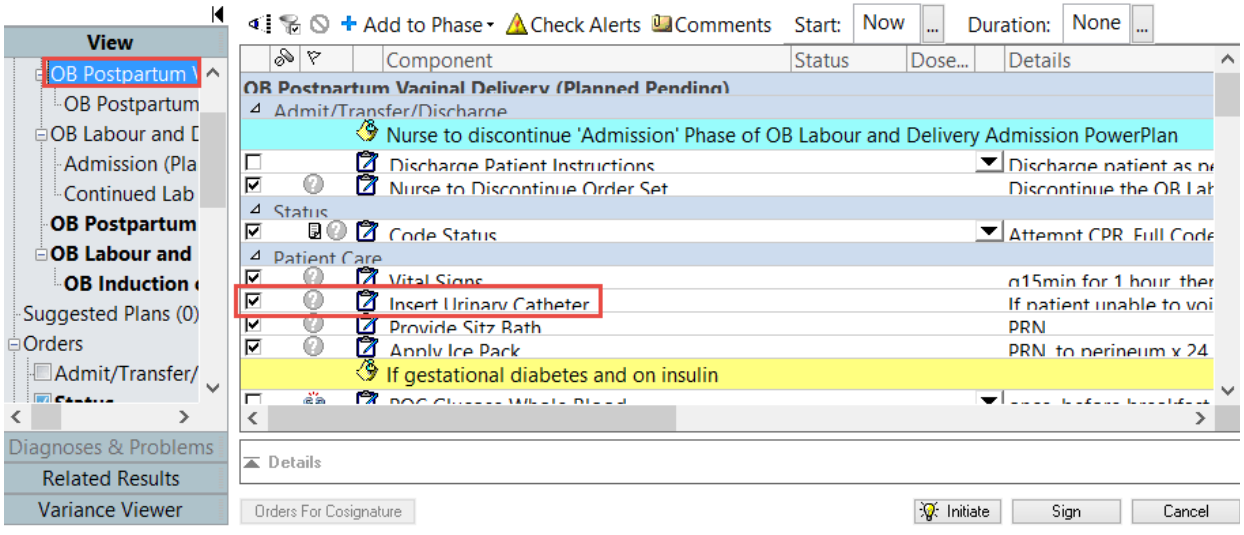
1

1. Click the **OB Quick Orders** tab.
2. Expand **Postpartum PowerPlans**.
3. Select the **OB Postpartum Vaginal Delivery PowerPlan**.
4. Click the Orders for Signature icon  .





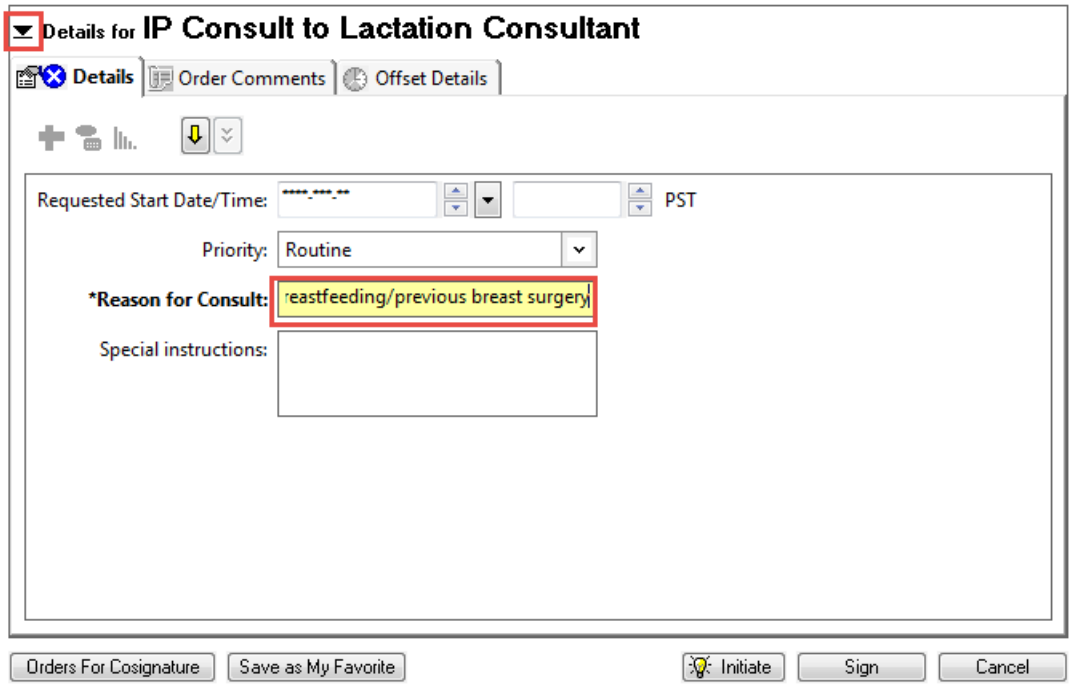
5. Select **Modify.**
6. **Deselect** *Insert Urinary Catheter* by unchecking the box next to the order.



7. Scroll down and **Select** *IP Consult to Lactation Consultant* by checking the box next to the order.

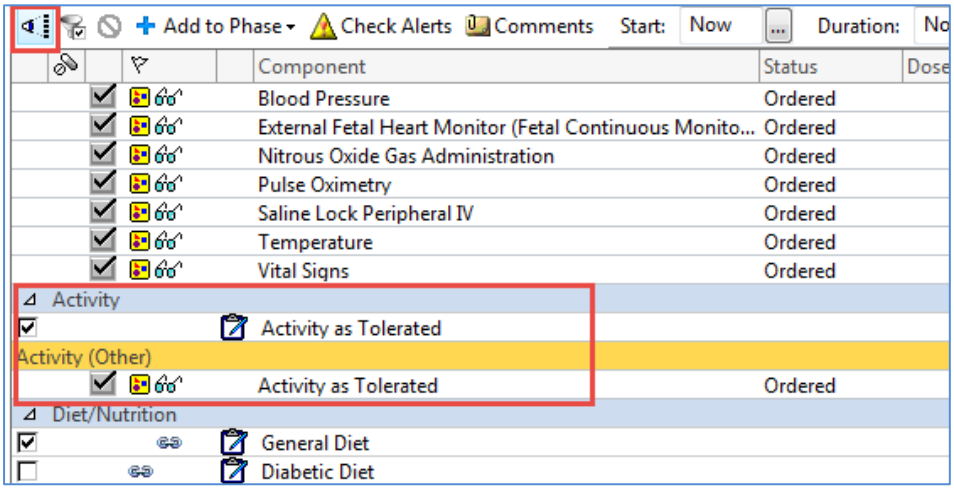
The icon indicates mandatory information, right click on the order to select Modify.

For practice, complete the **Details for IP Consult to Lactation Consultant** by entering the required **Reason for Consult =** *Breastfeeding/previous breast surgery.*

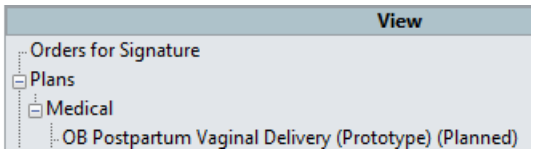


REMEMBER: not to sign yet as you still need to review all the orders in the PowerPlan. Simply click on the collapse icon.

8. As your patient's hospital visit progresses, remember to use the **Merge** icon to merge your plan with other current orders. This will help to identify duplication. Uncheck one of the two duplication orders.



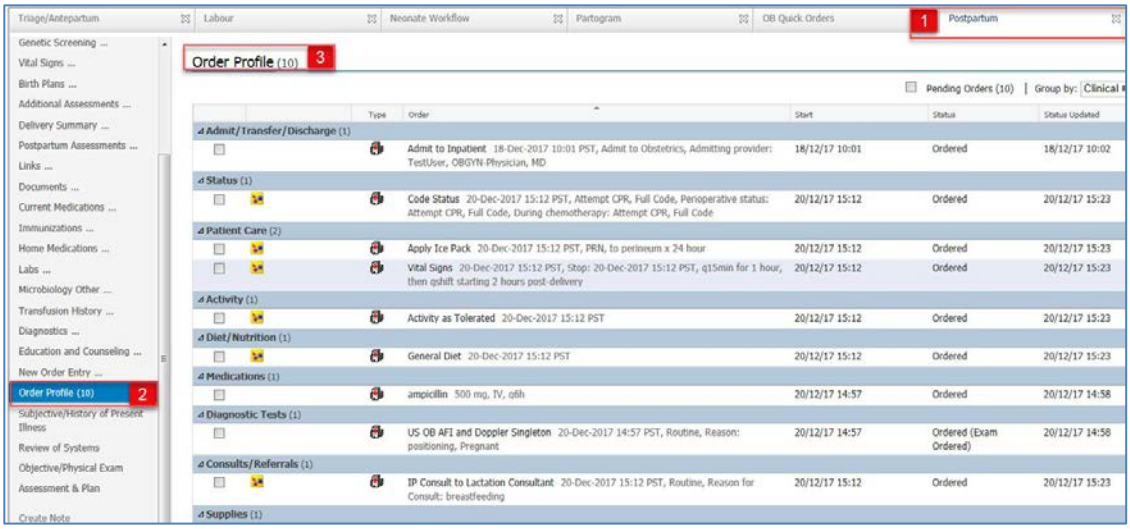
9. Reviewed all the orders in the PowerPlan.
10. Click **Sign and Done.** Your PowerPlan order is now in Planned State.



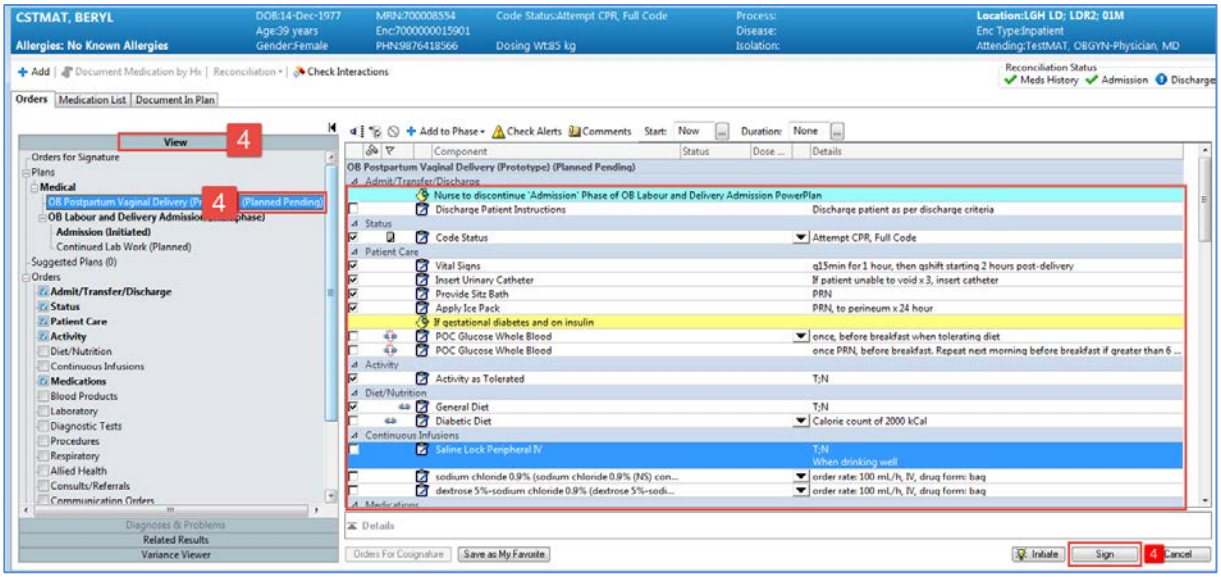
Activity 5.3 – Initiate the Planned State PowerPlan

1 The nurse is currently busy with the patient. Since you are on the unit, you decided to **Initiate** the **OB Postpartum Vaginal Delivery (Prototype) (Planned Pending)** PowerPlan.

1. Select the **Postpartum** tab.
2. Click on the **Order Profile** component.
3. Click on the **Order Profile** link.

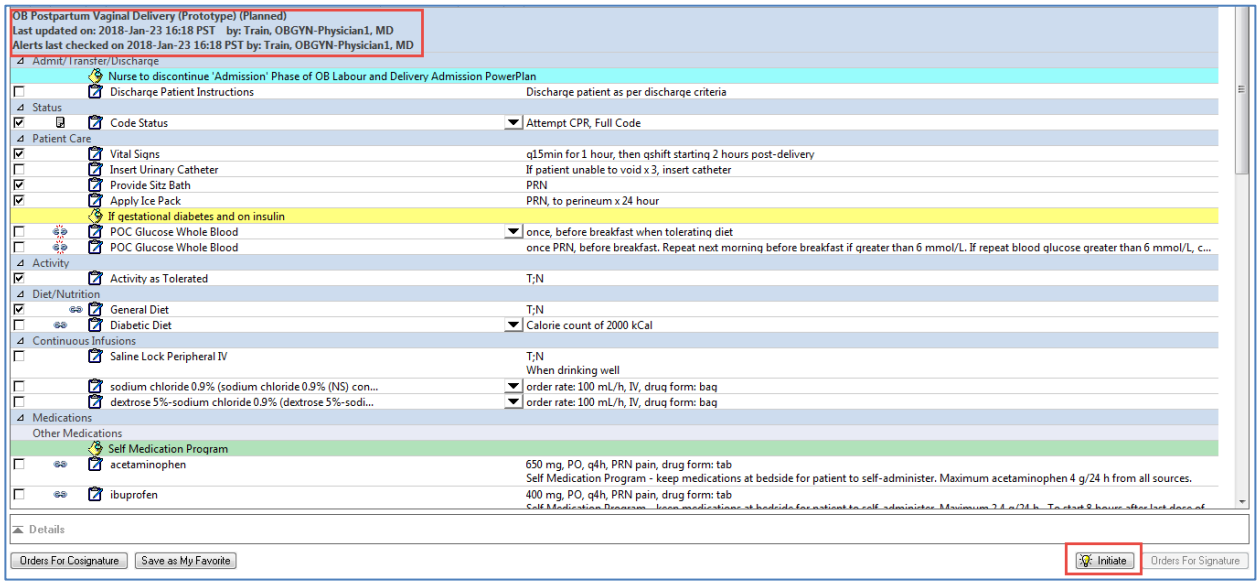


4. Locate and select the **OB Postpartum Vaginal Delivery (Prototype) (Planned)** in the **View** navigator.



5. When you have reviewed the orders for the **OB Postpartum Vaginal Delivery (Prototype) (Planned)**

6. Click **Initiate.**

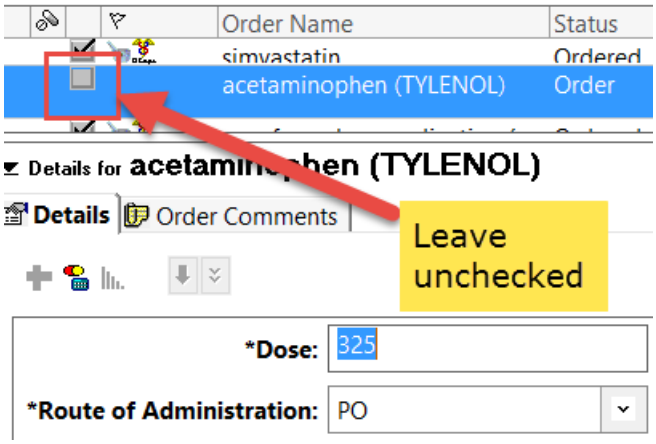


7. Click **Orders for Signature**.

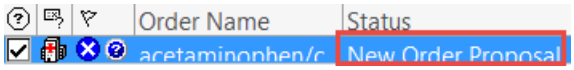
8. Next, review your PowerPlan orders and **Sign.**

WARNING: One more important consideration when you are ordering a single **Medication** order **OUTSIDE** the PowerPlan.

Ensure the checkbox for medications **are NOT selected**.



If you check this box, the order becomes a **New Order Proposal** - proposed (not active) order even after you sign it.



NOTE: **Do not close Mom's chart**

Key Learning Points

- Nurses, following clear communication from the provider, may Initiate a planned PowerPlan or Module.
- Nurses or Providers may discontinue or initiate a PowerPlan by right-clicking on the PowerPlan in the View navigator of the Orders page.
- Signed medication and lab orders cannot be modified, rather they are discontinued and reordered.

PATIENT SCENARIO 6 – Discharge Process

Learning Objectives

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

- Introduction to Patient Overview
- Review Orders
- Discharge Diagnosis and Reconcile Active Issues
- Complete the Discharge Medication Reconciliation and create a Prescription
- Place a Discharge Order and a Future Order
- Complete a Discharge Summary

SCENARIO

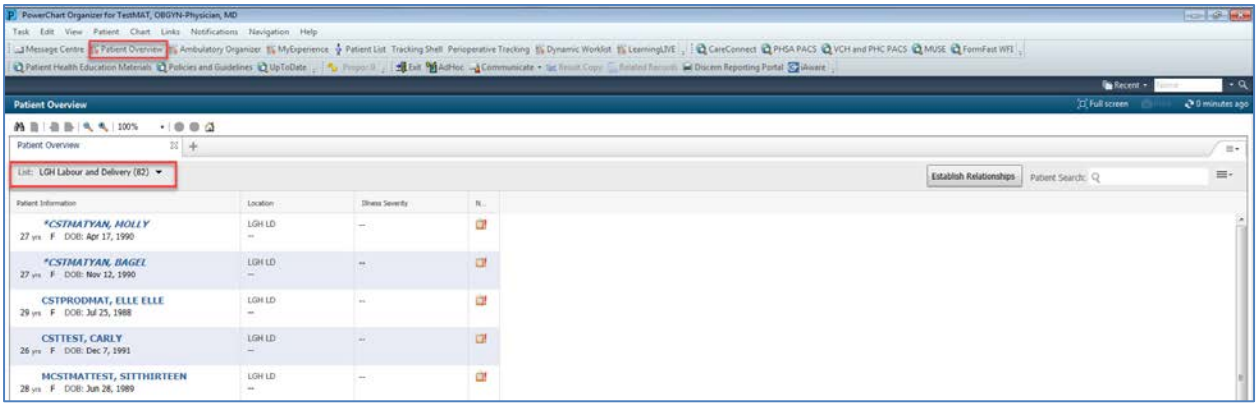
As the OB Provider, your patient is now ready to be discharged home.

You will complete the following activities:

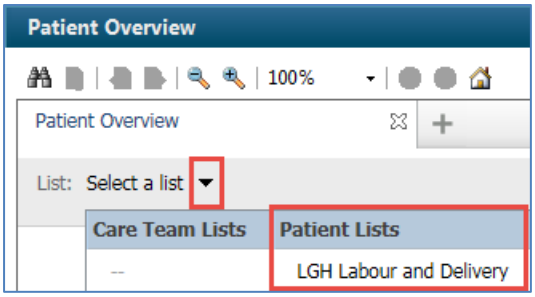
- Introduction to Patient Overview
- Update date your patient's status to Discharging
- Review orders prior to discharge
- Update Discharge Diagnosis and Reconcile Active Issues
- Complete the Discharge Medication Reconciliation and create a prescription
- Place a Discharge Order and a Future Order
- Complete a Discharge Summary

Activity 6.1 – Introduction to Patient Overview

You can access your patient list by clicking the **Patient Overview** in the toolbar**.** It is also used to communicate with other providers about the patient's status which will be discussed further on the next page.



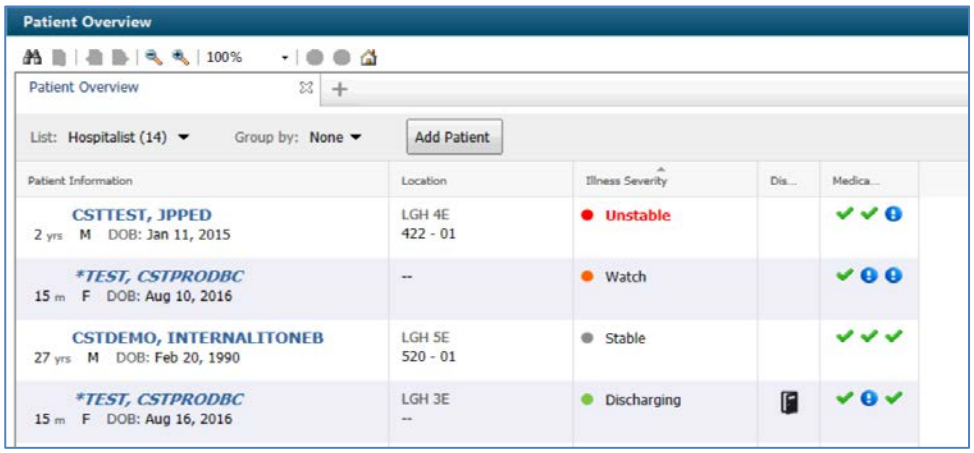
You can also click on the drop-down icon from the **List** and select the appropriate patient list. In your case, **LGH Labour and Delivery** is your default patient list.



1 Patient Overview serves as a communication tool during patient handoff. It provides a snapshot of patient's status and helps you manage your work:

- You can track new results that you have not yet reviewed indicated by icon.
- You can see where the patient is located: unit / room / and bed number.
- You can make a note of patient's illness severity.
- You can see the discharge status indicated by the icon.
- You can track medication reconciliation completion .

Below is an example of the Patient Overview. This may not be the same as your current view.



You can click a column heading such as Location to display all patients in the same unit together. Clicking Patient Information will place names in alphabetical order.

Patient Overview also displays a snapshot of patient status under the **Illness Severity** column. You can easily add or change your patient status by clicking the corresponding space under this column and selecting one of the options from the list. You can click the column heading to sort all patients.

Key Learning Points

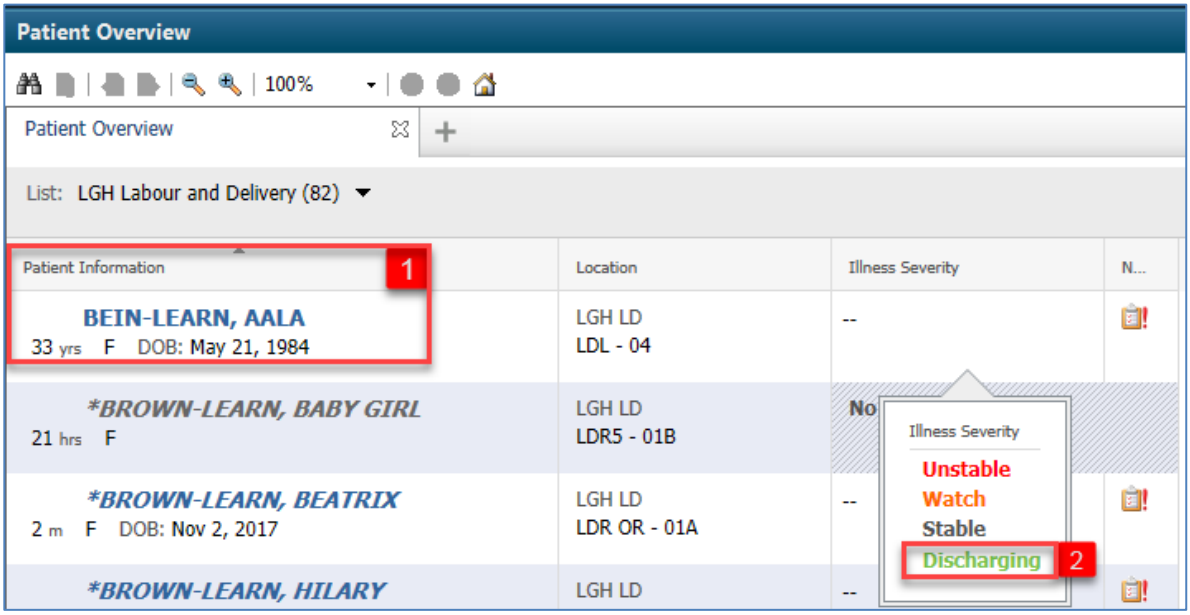
- Patient View is another way of accessing your patient's chart.

Activity 6.2 – Review Orders

1 Review and update your patient's status. Click on the **Patient Overview** Patient Overview button in the Toolbar. Patient Overview is also used at the beginning of your patient review process.

1. Locate the patient from **Patient Information** list.
2. Mark the Illness Severity as **Discharging** by clicking on the cell.

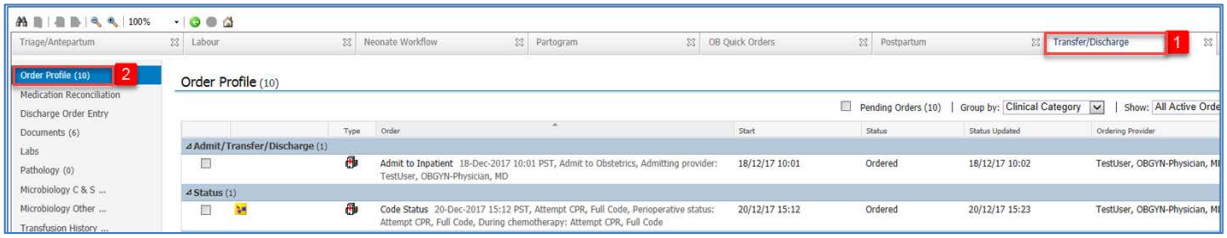
The discharge workflow occurs on the Transfer/Discharge workflow tab.



3. Click on the **patient's name** to open the chart.

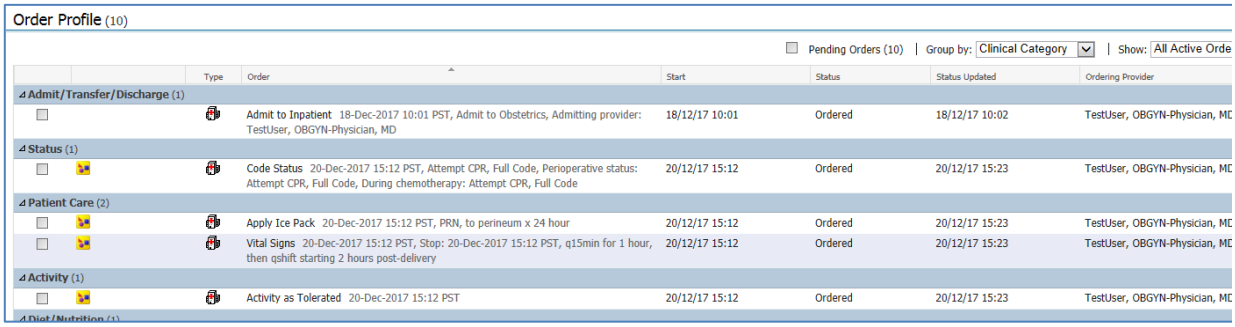
2 To review the orders:

4. Navigate to the **Transfer/Discharge** workflow tab
5. Click on the **Order Profile** component



6. Review patient's orders to be aware of outstanding lab or imaging orders. Hover over the

icons for order details.



NOTE:

- No manual action is required to stop orders at discharge.
- When a patient physically leaves the unit and is discharged from the system by the closed - this will automatically discontinue their orders.
- Orders placed purposefully, such as Imaging orders, and not just because they we orders with the pending results that you have placed prior to discharge will remain

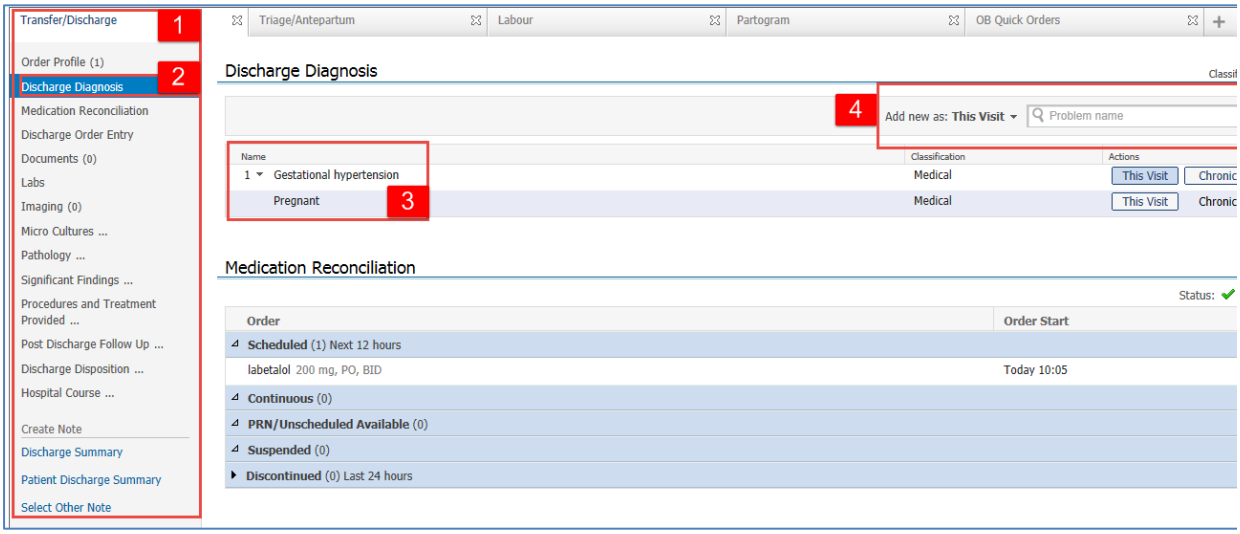
Key Learning Points

- Outstanding orders are automatically discontinued after discharge except for future orders and orders with pending results.

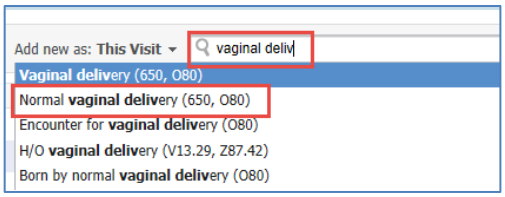
Activity 6.3 – Discharge Diagnosis and Reconcile Active Issues

1 The Transfer/Discharge workflow tab is standardized across all departments.

1. Navigate to the **Transfer/Discharge** workflow tab.
2. Locate and click the **Discharge Diagnosis** component.
3. Review the diagnosis and problems under Discharge Diagnosis
4. Locate Add new as: This visit



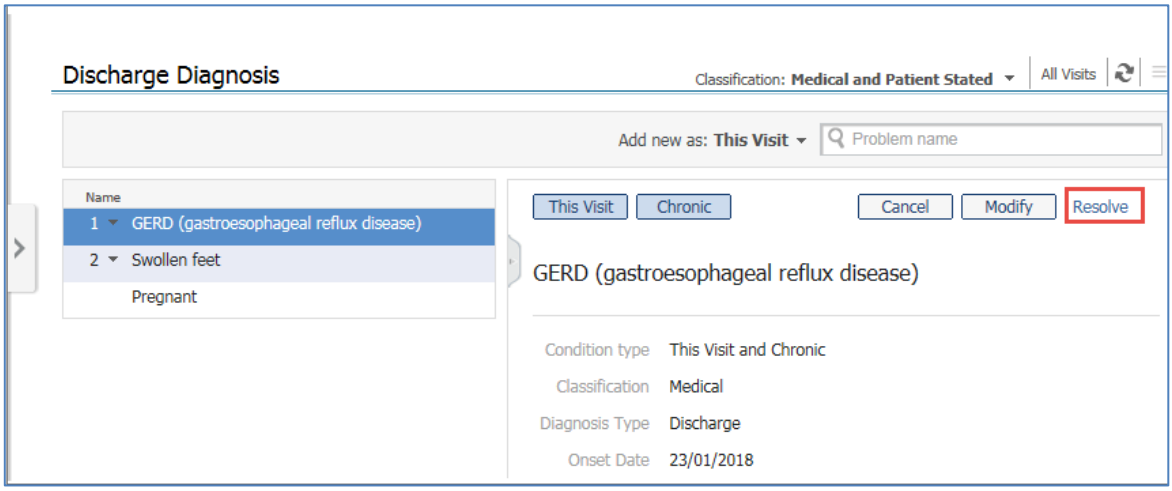
5. In the **This Visit** search box **enter the text =** *vaginal delivery*.
6. Select normal vaginal delivery.



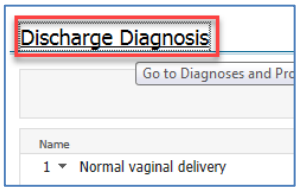
2 While you are on the Discharge Diagnosis component, reconcile the active issues GERD (gastro esophageal reflux disease) as resolved.

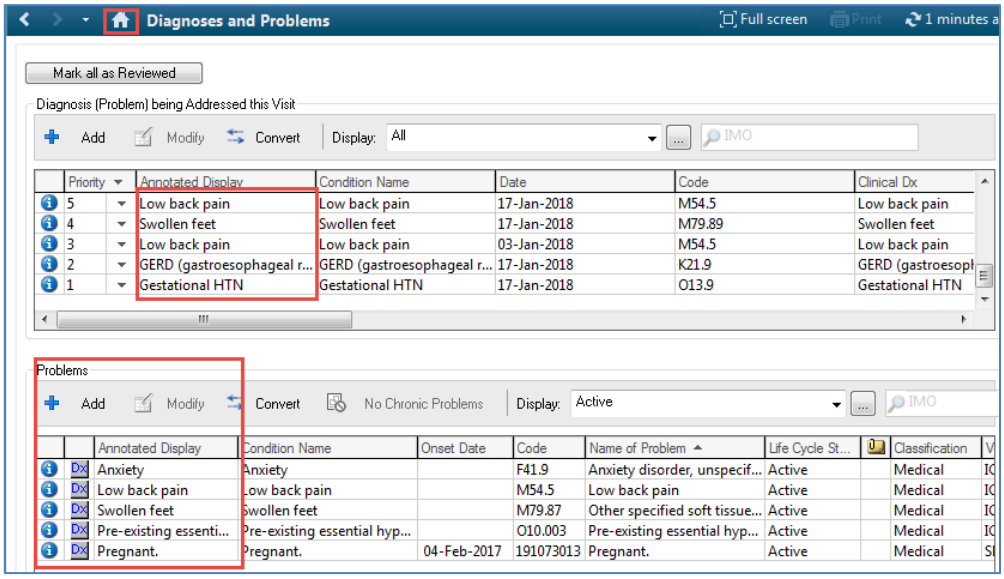
To reconcile active issues:

7. Click on **GERD (gastroesophageal reflux disease).**
8. Click on the **Chronic** button.
9. Click **Resolve**.



10. Click on the **Discharge Diagnosis** link, it will take you to another screen that shows a list of diagnosis (problem) addressed this visit.



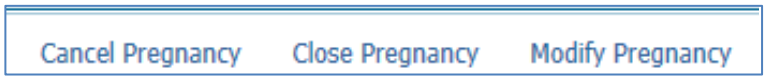


11. To return to your previous page, simply click the icon.

NOTE:

- A Pregnancy may remain active over several encounters before delivery.
- The Unit Clerk or RN usually will Close the Pregnancy. However, the Provider also may Close the Pregnancy from the Pregnancy Overview

component in the workflow tabs.

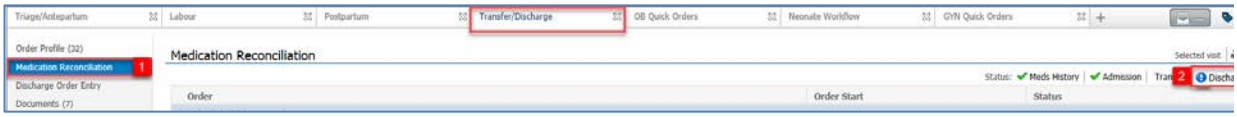


Activity 6.4 – Discharge Medication Reconciliation and Create a Prescription

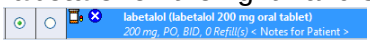
1 In the Status line, you completed the Meds History (✔) and Admission (✔) previously. Now, you will complete the Discharge Medication Reconciliation ( )

While you are in the **Transfer/Discharge** workflow tab:

1. Select the **Medication Reconciliation** component.
2. Click **Discharge** from the Status line.



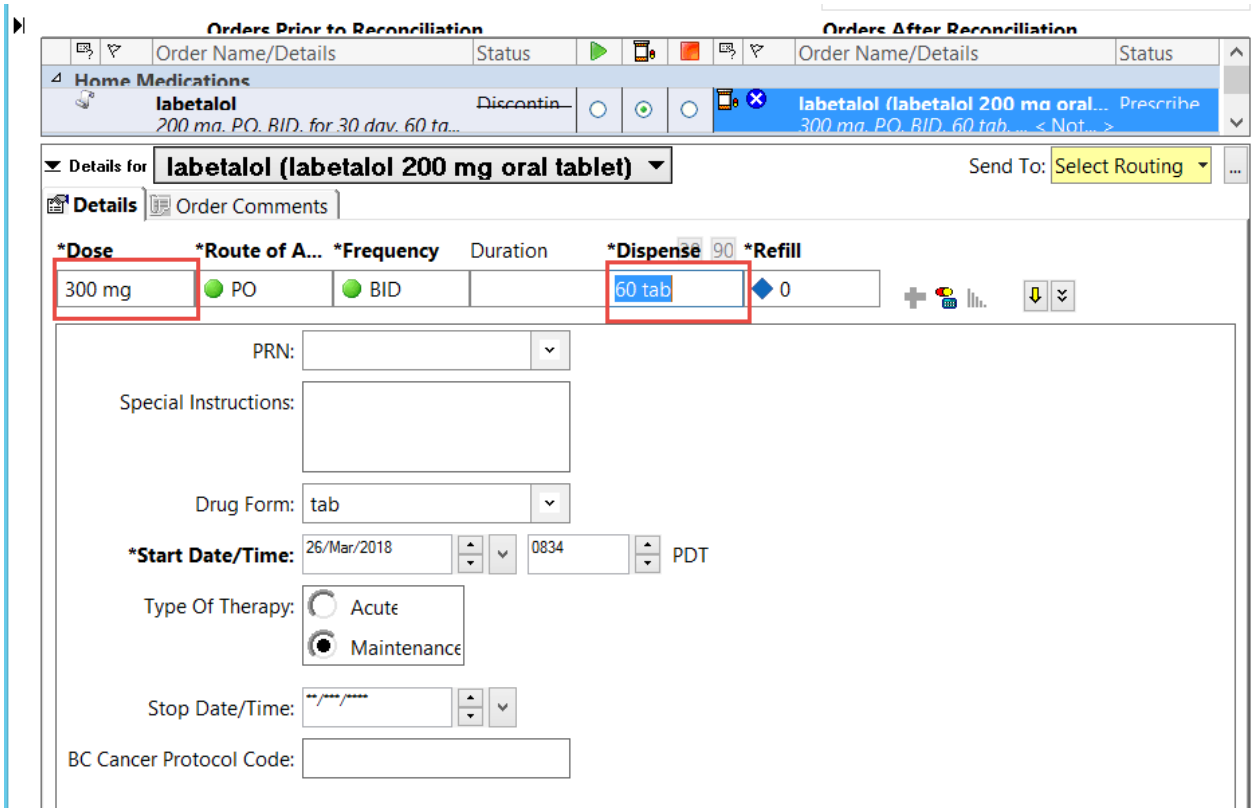
2 The documented Home Medications, continued Home Medications, and Medication orders will display on the medication reconciliation profile. **All the medications will be discontinued or stopped except the Labetalol**, which will be a prescription.

1. Select the radio button in the prescription column for **labetalol**. The labetalol has missing order details
2. Stop all Home Med such as the prenatal multivitamins and all Inpatient Med except labetalol.
3. Click on the **labetalol** on the right-hand side of the **Orders After Reconciliation** screen with the icon 

to complete the mandatory field.

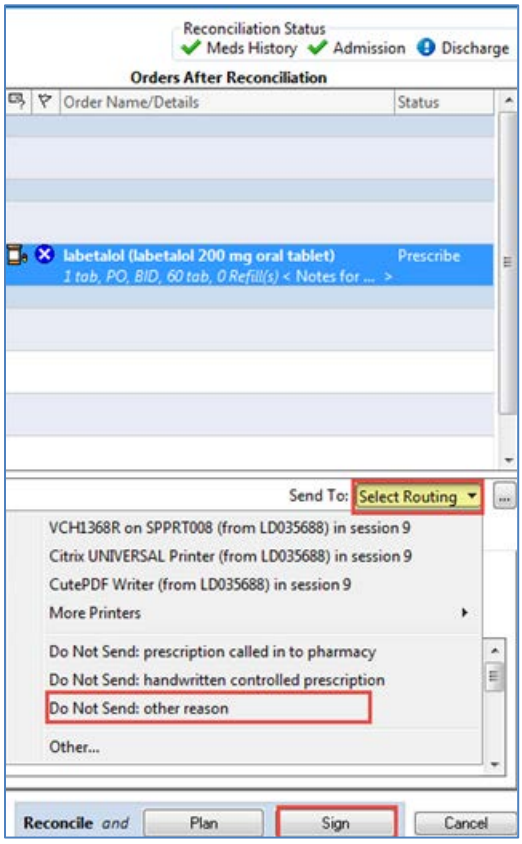
3 Review the Prescription and complete the missing mandatory fields

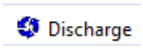
1. Change dose = *300* **mg.**
2. Dispense = *60* **tab.**



3. In the **Send to: Select Routing,** you would normally see your computer's default printer populated. This can be changed to any other network printer. For our training purposes, select **Do Not Send: other reason.**

4. Click **Sign.**



REMEMBER: If you see this icon 

beside the **Discharge** button on the **Medication Reconciliation** component you may have missed a medication. Go back to **Discharge** and ensure you made a choice for each medication.

At any time during the patient's hospital stay, you may put the discharge medication into a planned state by clicking the Plan button. You can then come back and complete the Reconciliation and sign it when appropriate for discharge. You may also change the Reconciliation after you have signed the Medication Reconciliation by clicking on the links. 

4 Prescription: review the Prescription Details, Prescriber's Signature Line and College Number.

Review the example prescription that will be available in the Hospital setting. It is not available in the classroom.

PRESCRIPTION

Lions Gate Hospital
231 E. 15th Street
North Vancouver, BC V7L 2L7

Patient Name: **Validate, Phy-OBGYN**

DOB: 1989-JAN-10 Age: 29 years Weight: Sex: Female PHN: 10760000733

Allergies: **sulfa drugs**

Allergy list may be incomplete. Please review with patient or caregiver.

[ ] Blister Packaging _____- week cards; dispense_____cards at a time; Repeat_____

[ ] Non-Safety vials [ ] Other _____

Faxed to Community Pharmacy: _____ Fax: _____

Faxed to Family Physician: _____ Fax: _____

If you received this fax in error, please contact the prescriber

Patient Address: 734 West Broadway,
Vancouver, British Columbia
V6R2L3
Canada

Home Phone: (4)1) 23--0734
Work Phone:

Any narcotic medications need a duplicate prescription form to be completed
Over the counter medications can be filled on PharmaNet at patient's discretion

Prescription Details: Date Issued: 2018-JAN-22

abetalol 300 mg **oral tablet**
SIG: **1 tab PO BID**
Dispense/Supply: **60 tab**

_____
Prescriber's Signature
Train, OBGYN-Physician1, MD
Prescriber's College Number: T0015
Prescriber's Phone: (604) 843-2110

bc_rx_precs

This record contains confidential information which must be protected. Any unauthorized use or disclosure is strictly prohibited.

Page: 1 of 1

NOTE: Narcotics requiring triplicate documentation will still remain in paper format.

Activity 6.5 – The Mother: Place a Discharge Order and a Future Order

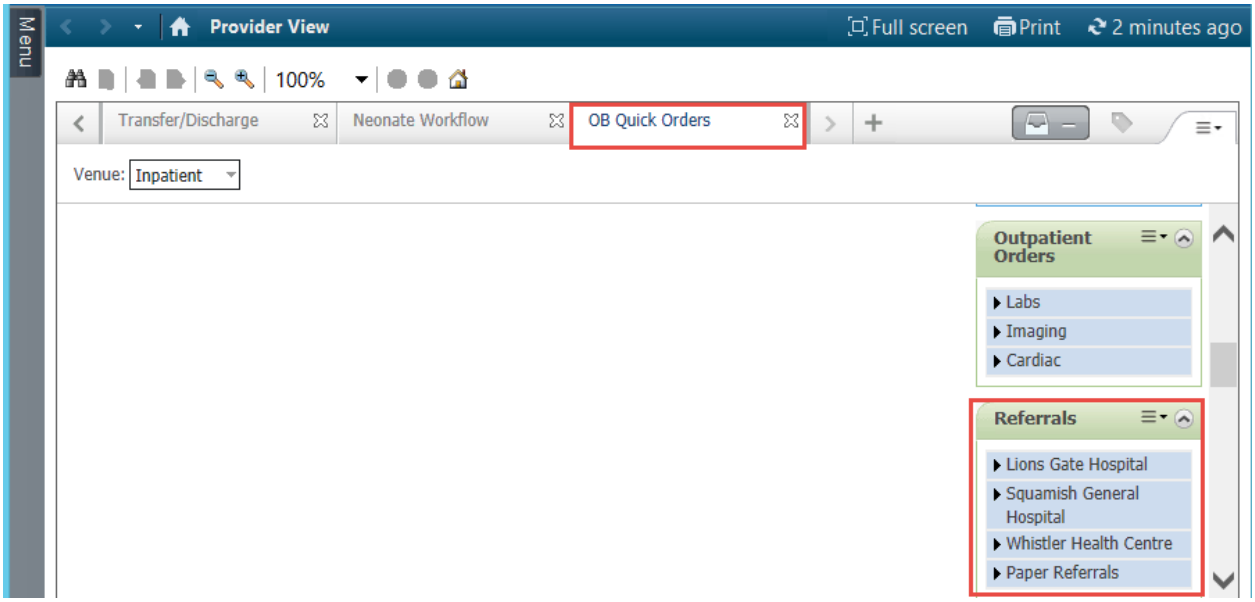
1 The **Discharge Patient** order creates tasks informing the team that the patient is ready to be discharged. The order is also required by Hospital Act Regulation. After the patient physically leaves the hospital, the encounter can be closed.

In the Clinical Information System (CIS), you also can create orders to be completed after the patient has been discharged. This applies to orders to be done post-discharge:

- Referrals
- Investigations such as labs/imaging are also called **future orders**

If a specimen is expected to be collected either at home or at an external facility, a printed requisition will be given to the patient.

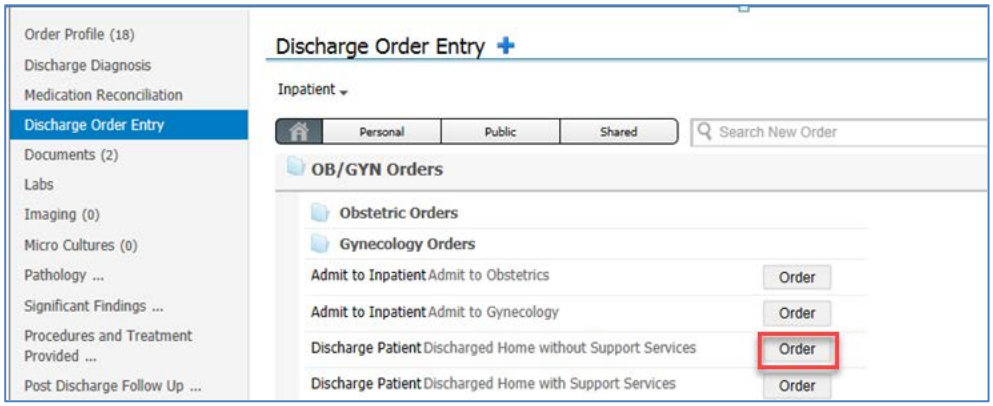
Referrals are located on the Quick Orders Workflow tab



In this activity, you will enter two orders: a **discharge order** and a **future order** (i.e. CBC).

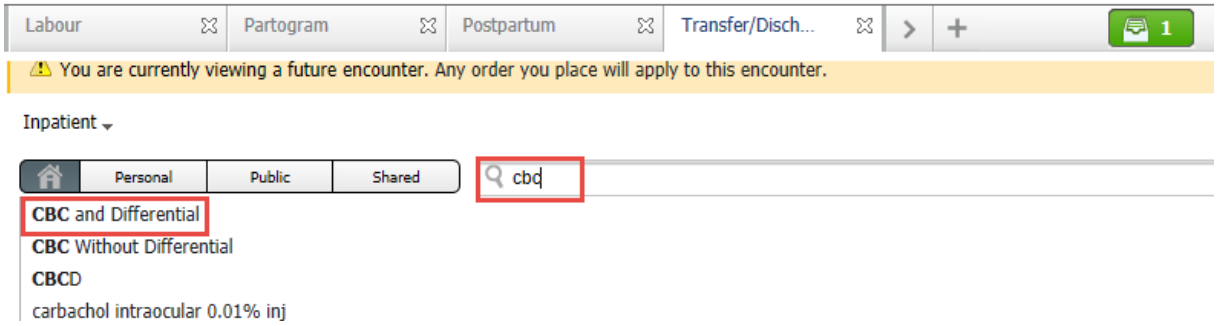
To place a **discharge order** for the patient:

1. Select the **Transfer/Discharge** workflow tab.
2. Click the **Discharge Order Entry** component.
3. Click **Order** to select **Discharge Patient: Discharge Home without Support Services.**



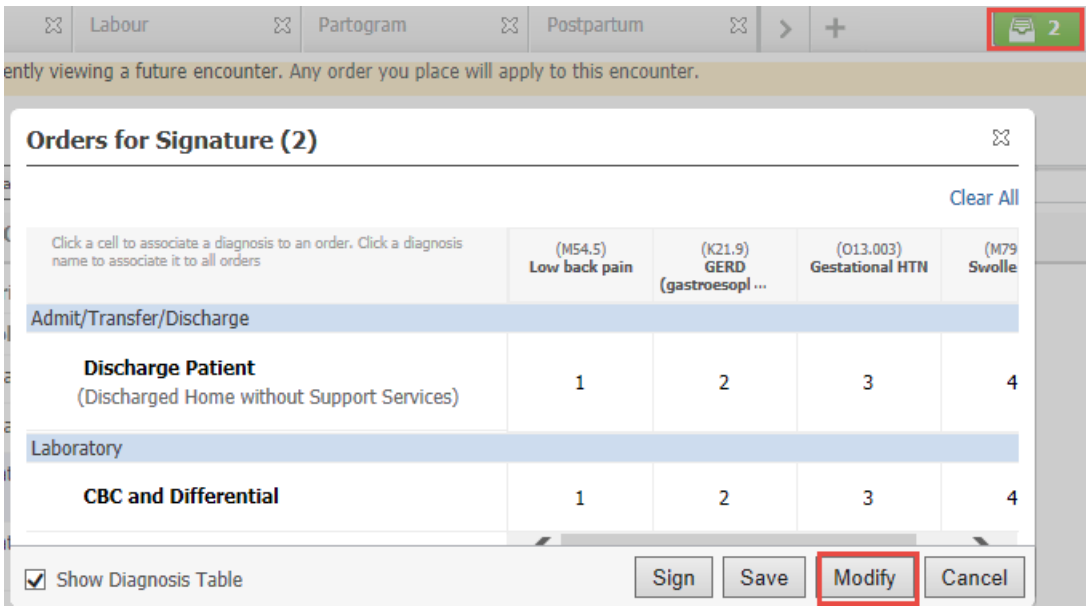
4. To add **CBC** 

as a **future order**, search the catalogue directly from the current component.
5. Select the appropriate order: **CBC and Differential**.



6. Click the **Orders for Signature** 

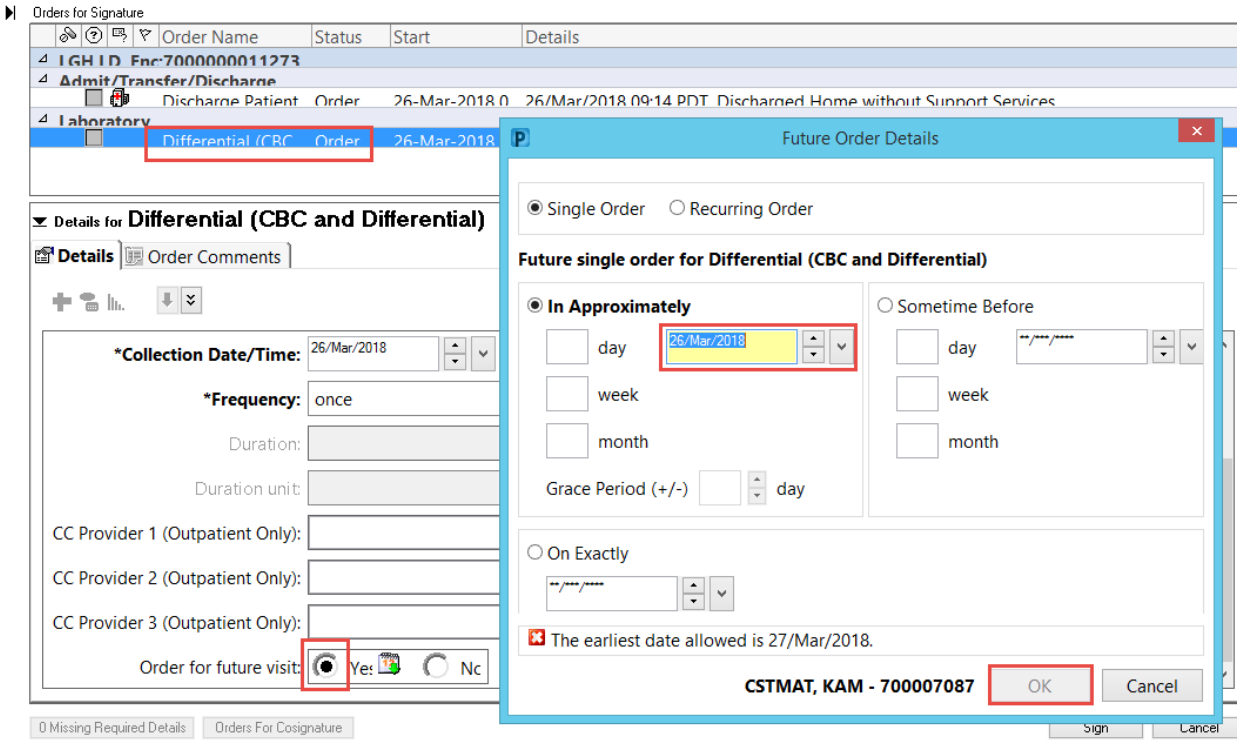
icon.
7. Click **Modify.** The Order Page window opens.



8. Click on the Differential (CBC and Differential) order.
9. Click radio button **Yes** on the **Order for future visit**: 

. The Future Order Details window opens.
10. Complete the yellow **Mandatory Field** and click **OK**.

    Note: Arranging the Recurring Orders is also available in this window.



11. **Please do not Sign** the discharge order as you will use this same patient for your **Key Learning Review.**

Key Learning Points

- Discharge medication reconciliation needs to be completed prior to the patient's discharge
- A **Discharge Patient Order** documents the decision to discharge a patient (required by the Hospital Act Regulation) and informs patient registration and the nurse
- Referrals and future orders are for referrals, tests, and investigations that will be carried out after discharge. They can remain active for up to 2 years after discharge
- Medication Reconciliation on discharge includes both home and hospital medications
- Both home and inpatient medications can be converted into prescriptions during the discharge reconciliation process
- Discontinued medications become historically documented on the chart
- Selecting **Paper Referral** indicates that the process remains manual as the facility/provider may be practicing outside of the CIS while the order is still captured in the patient's electronic chart

Activity 6.6 – Discharge Summary Notes

The last step in the discharge process is to complete the mother's Discharge Summary note.

1 To place a discharge order and a future order for the newborn:

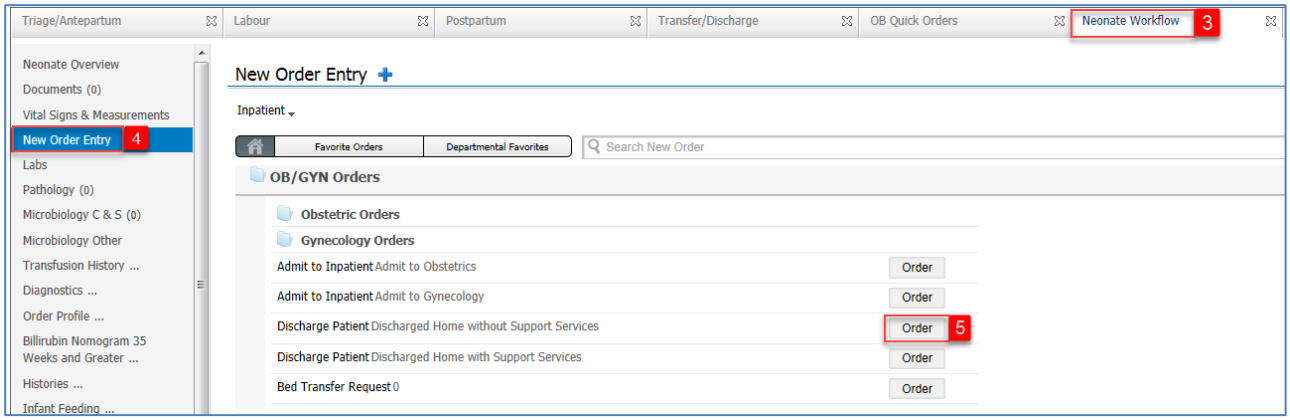
1. Navigate to the **Patient Overview** toolbar and locate the newborn from your patient list.

   Newborn's name: (refer to today's handout sheet)

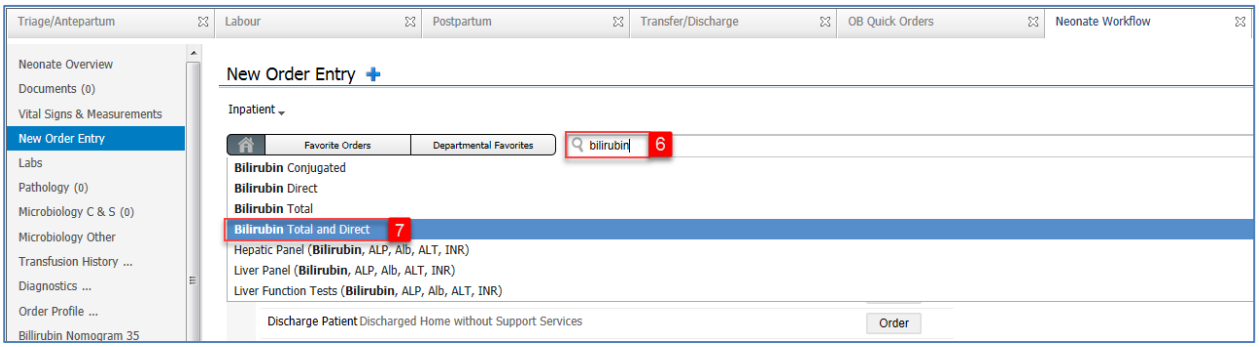
2. Click on the newborn name to open the patient's chart

Note: Notice that you now have two patient charts open in the banner bar. You can toggle between charts. Please ensure that you are working with the correct patient.

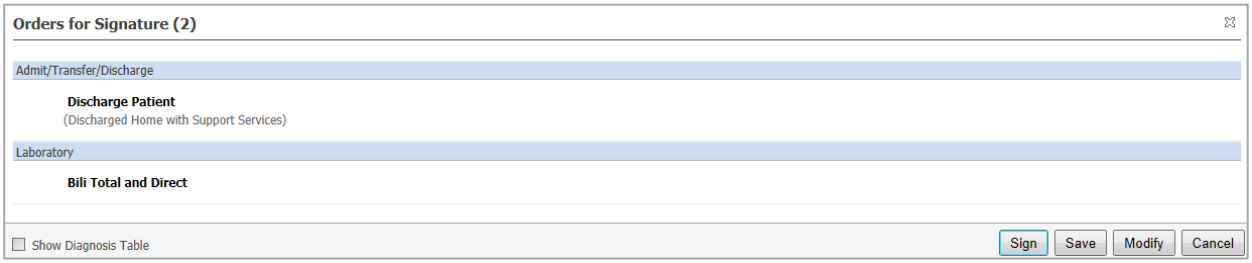
3. Select the **Neonate Workflow** tab.
4. Select the **New Order Entry** component.
5. Click **Order** to select **Discharge Patient: Discharge Home without Support Services.**



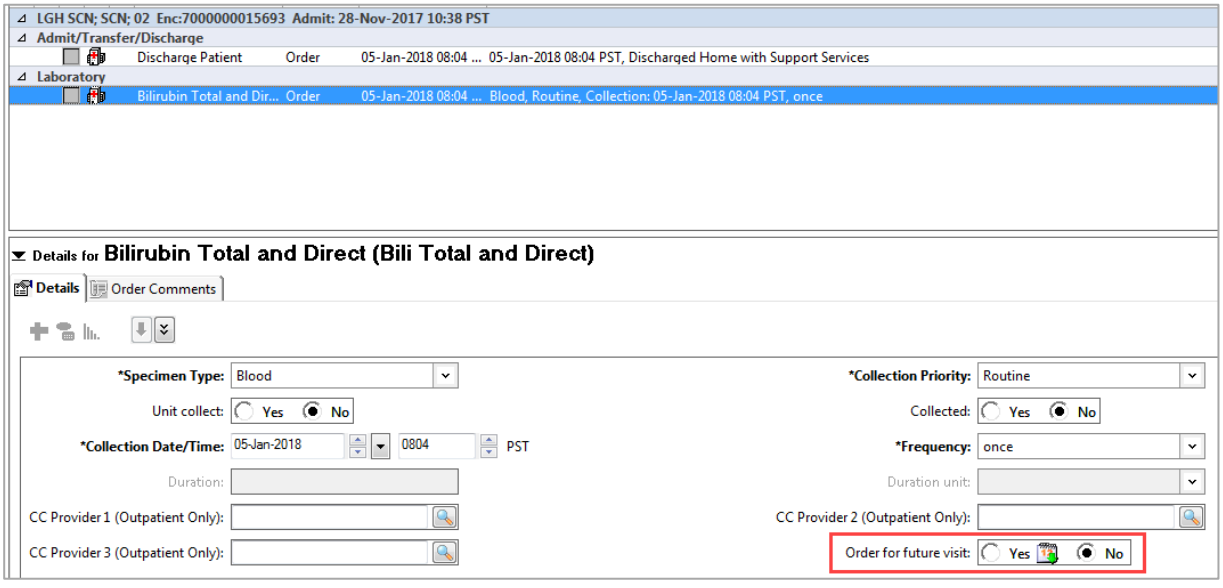
6. To add a **Bilirubin Total and Direct** test for the newborn as a future order, search the catalogue directly from the current component.
7. Select the appropriate order.



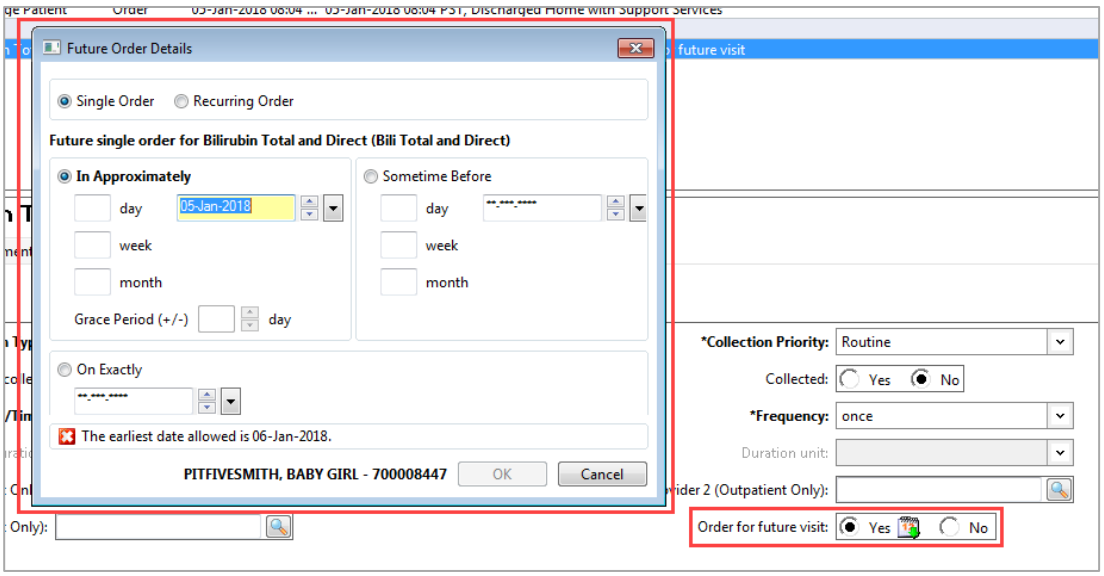
8. Click the **Orders for Signature**  icon.
9. Then, click **Modify.**



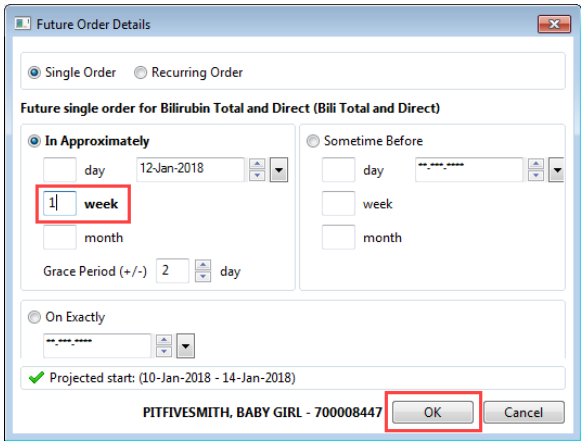
10. You will now be taken to the order profile. Click on the **Bilirubin Total and Direct** order to see the order details pane.



11. Click on the **Yes** radio button beside the **Order for future visit:** to show the Future Order Details window. Only select orders have the Order for future visit option.



12. Select an appropriate time frame, in this case under the **In Approximately** column, enter **1** in the **week** box.



13. Click the **Sign** button.

Note: the requisition automatically get printed to the printer.

In reality, you would complete the newborn documentation first prior to discharging the patient. For the purpose of this activity, the mother and newborn documentation will be completed in the next step.

Activity 6.6 – Discharge Summary Notes

The last step in the discharge process is to complete the Discharge Summary note.

1 Locate the Transfer/Discharge workflow tab and locate this tab's workflow components

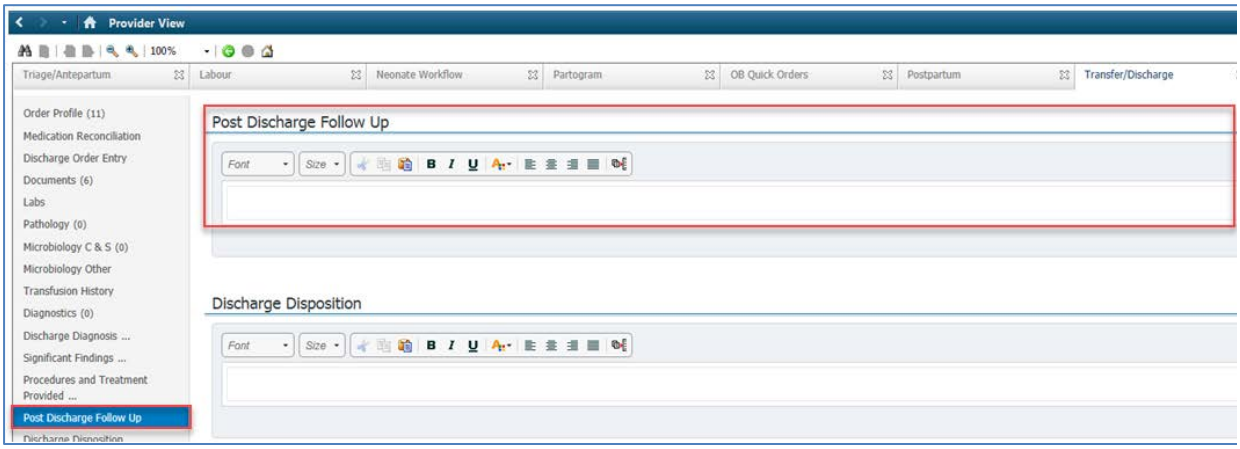
If time permits, start documenting the patient's discharge summary by typing information under:

- Hospital Course
- Significant Findings
- Procedures and Treatment Provided
- Discharge Disposition
- Post Discharge Follow Up

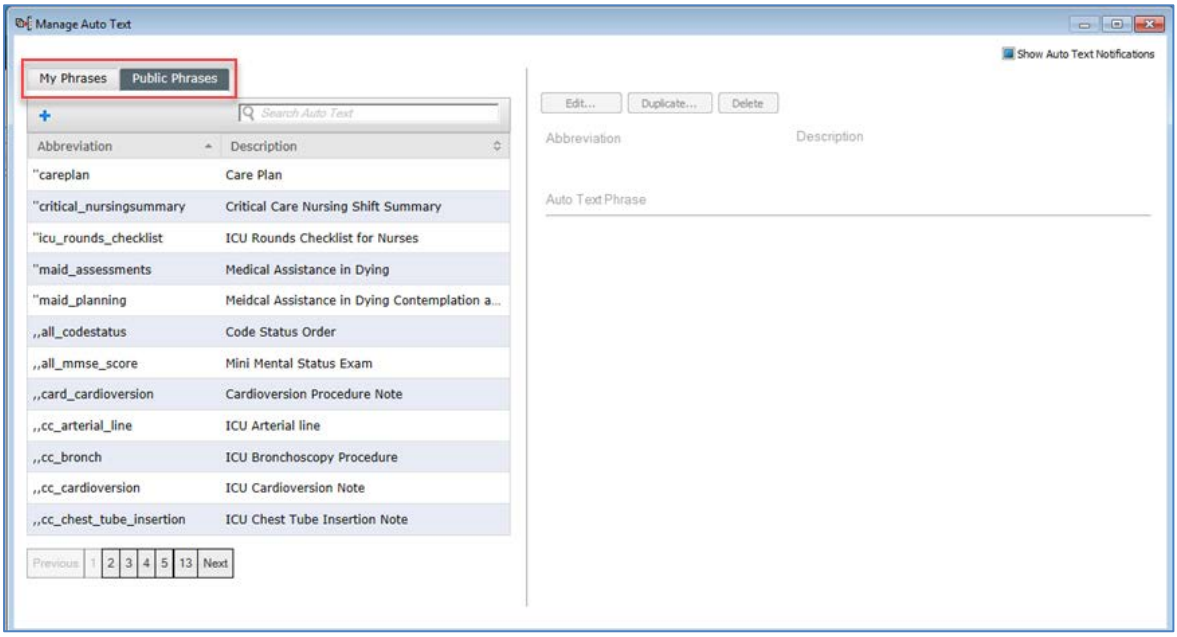
Entries made in these components will auto-populate the appropriate sections in your Discharge Summary note.

REMEMBER: You can type, use auto-text or FESR to complete documentation in these components.

1. Click on the **Transfer/Discharge** Workflow tab.
2. Click on the **Post Discharge** from the component list.
3. In the **Post Discharge Follow Up** text box, **enter =** *Follow up with GP in 2 weeks.*



4. Click the Manage Auto Text window. A list of Public Phrases window opens.
5. Review the Public Phrases.

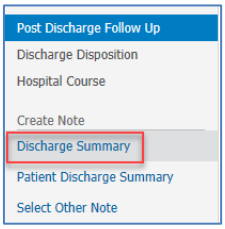


2 When you are ready to create discharge notes, there are two note links available there: Discharge Summary and Patient Discharge Summary

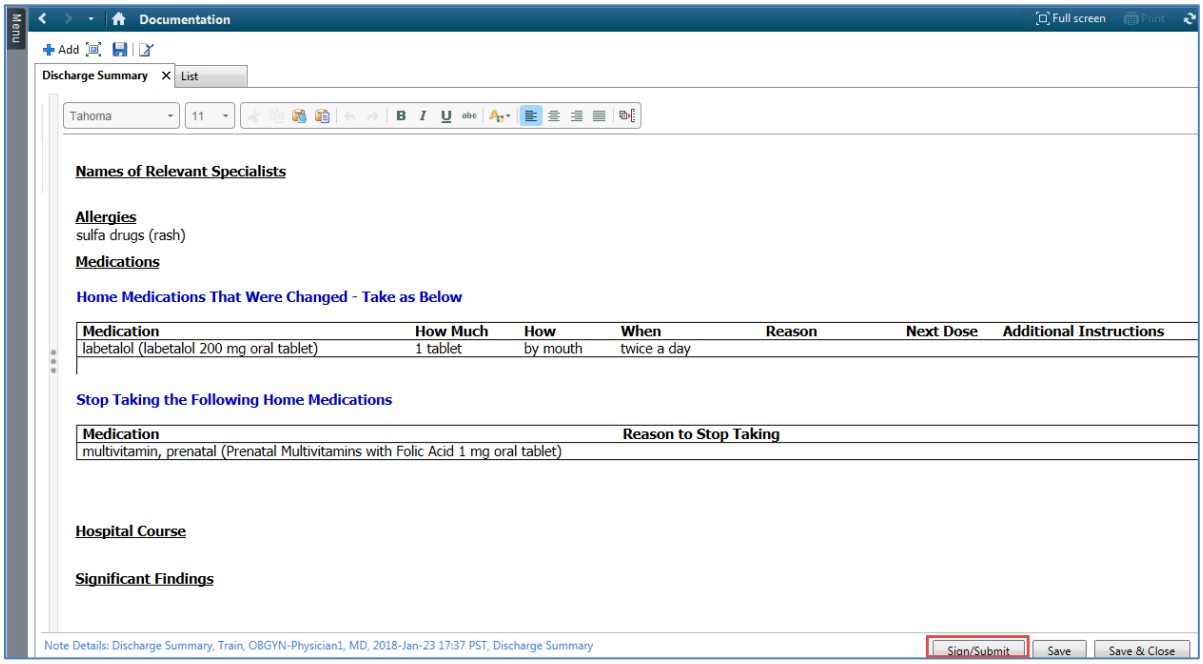
The **Discharge summary** is a summary of the patient's stay and is distributed to referring providers and consultants. The **Patient Discharge Summary** is a copy that is printed for the patient to take home. It includes space for specific patient instructions.

From the **Transfer/Discharge** workflow Tab:

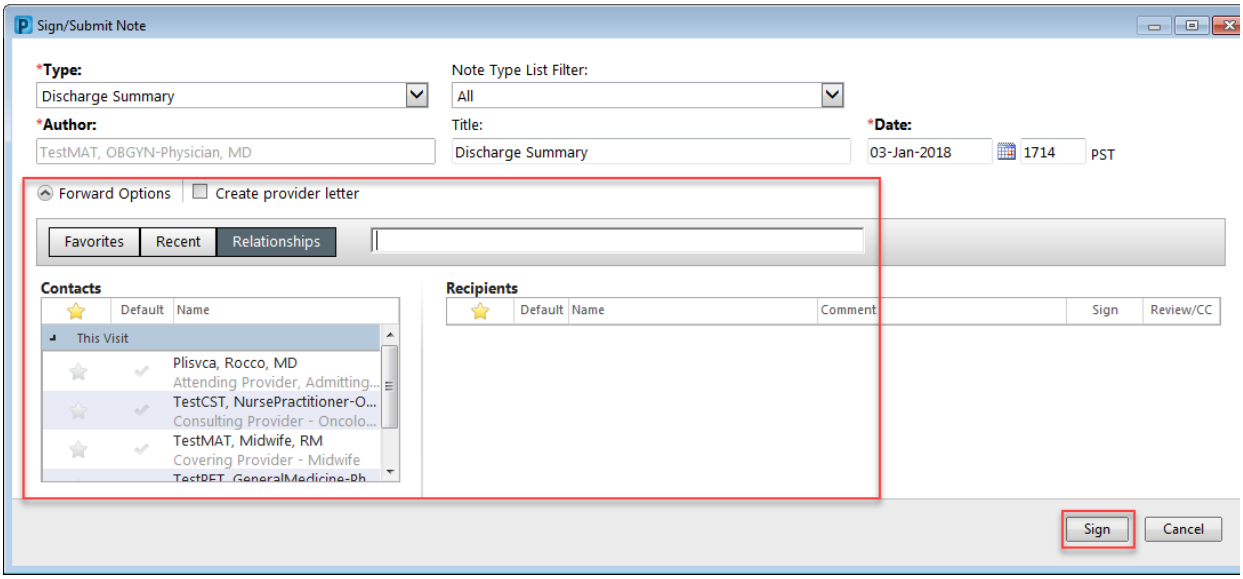
1. Locate **Create notes** at the bottom of your component list.
2. Click on **Discharge Summary**. The Discharge Summary note opens.



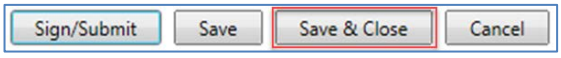
3. Review the note and make required modifications/updates.

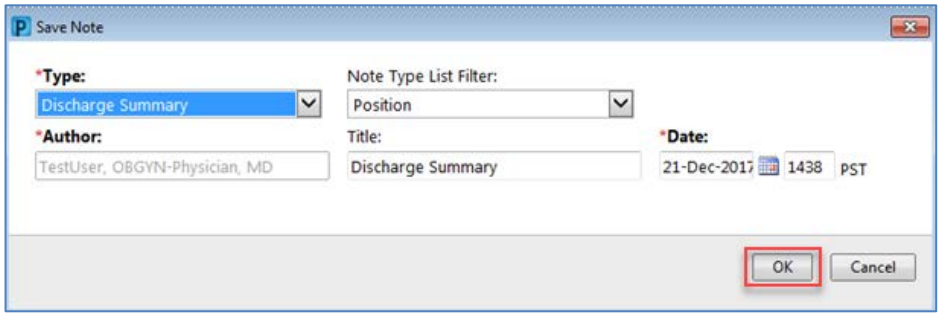


4. For this activity, select **Sign/Submit**. The Sign/Submit Note window opens.
5. **Sign/Submit note** screen that allows you to forward your note to other providers.



NOTE: A saved note will not be viewable by others until signed by you.





Key Learning Points

- You can fully manage the discharge diagnosis right in the Transfer/Discharge tab.
- A Discharge Summary will be distributed to the providers who have documented lifetime relationships on the patient's record and to other providers selected by you.
- Patient Discharge Summary is printed for the patient at discharge by nursing.
- Outstanding orders are automatically discontinued after discharge except for future orders and orders with pending results.

ADDENDUM – Newborn Result Copy and Related Records

Learning Objectives

IN THE CLASSROOM SETTING, THIS IS A READ-ONLY ADDENDUM

- Result Copy from the mother's chart to the baby's chart.
- Access related records

SCENARIO

Result Copy and Related Records are specific to Maternity settings and are activities involving both the mother's chart and the newborn's.

The following activities are added as an addendum because Result Copy will most often be done by *the nurse or a unit clerk* shortly after the newborn's birth. However, providers do have this functionality should they wish to use it. Because it is usually part of the nurse or unit clerk's workflow, it is advisable to alert them should you wish to Result Copy yourself.

Note that this addendum serves as an information addendum and the functionality may not be available in the classroom environment.

To complete the Result Copy, the following activities are required:

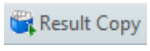
- Result Copy from the mother's chart to the newborn's chart
- Access related records

There are 3 minimal times when result copy is necessary:

1. After the baby has been quick registered.
2. When the mom and baby is being transferred from labour to postpartum.
3. Prior to the mom and baby being discharged from the hospital.

Result Copy

1 After the nurse has quick registered a baby, it is important to **Result Copy** from the mom's chart to the baby's chart. Performing Result Copy ensures that pertinent delivery and newborn information documented in the mom's chart is copied over to the baby's chart.

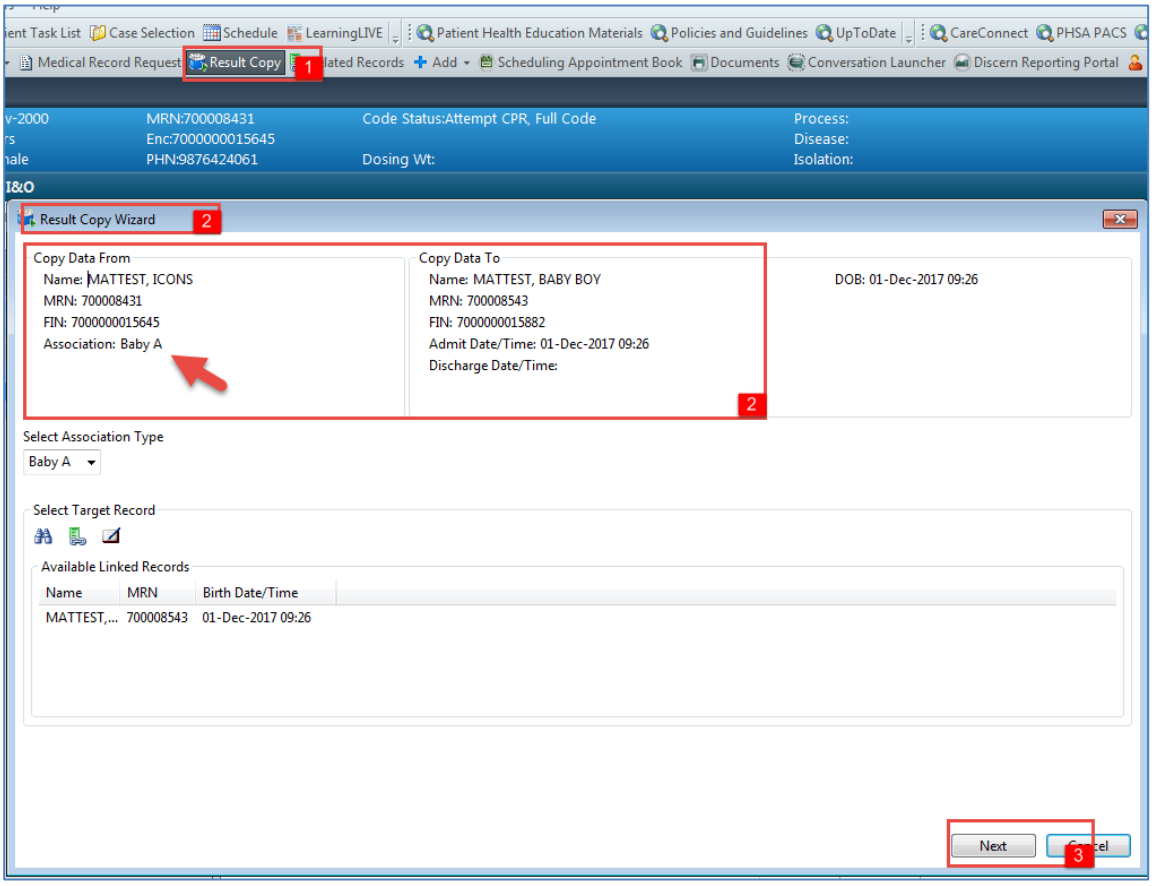
1. From the mom's chart, click the **Result Copy** 

in the Toolbar.
2. The **Result Copy** Wizard window opens. Check to ensure the demographic information is correct for both the mom (in the Copy Data From box) and her newly quick registered newborn (in the Copy Data To box).

Note: for multiples, ensure the Association field in the Copy Data From box is referring to the

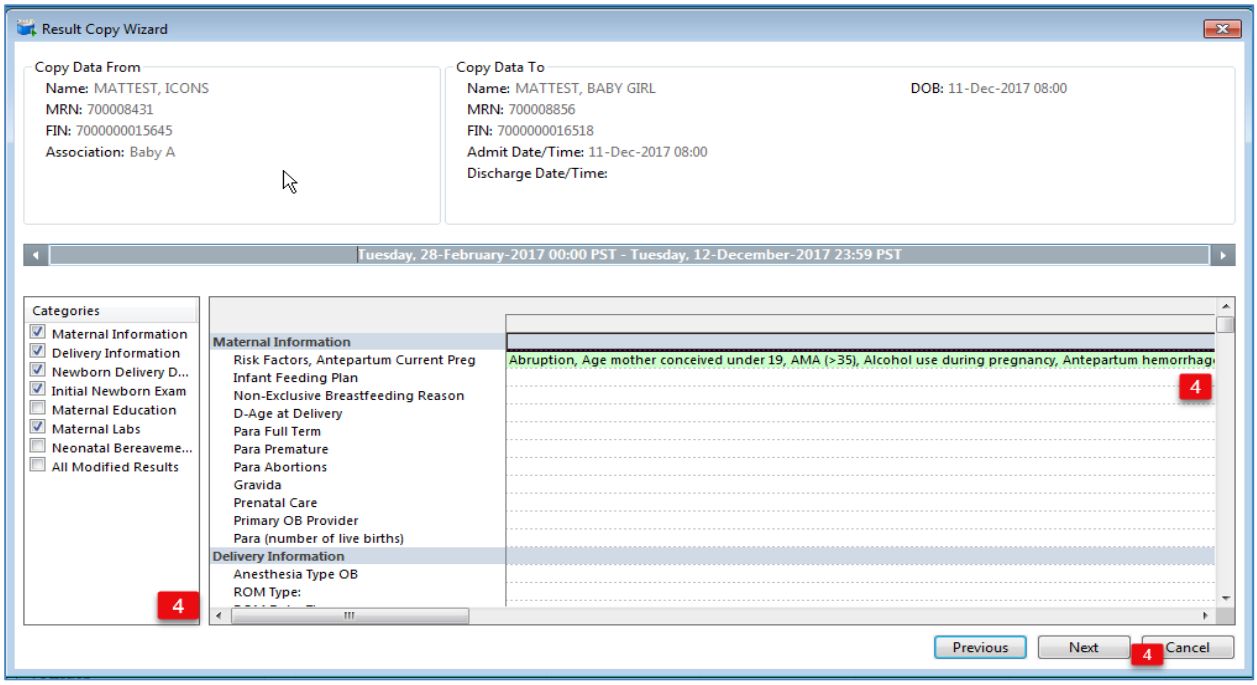
correct Baby.

3. Select **Next**.

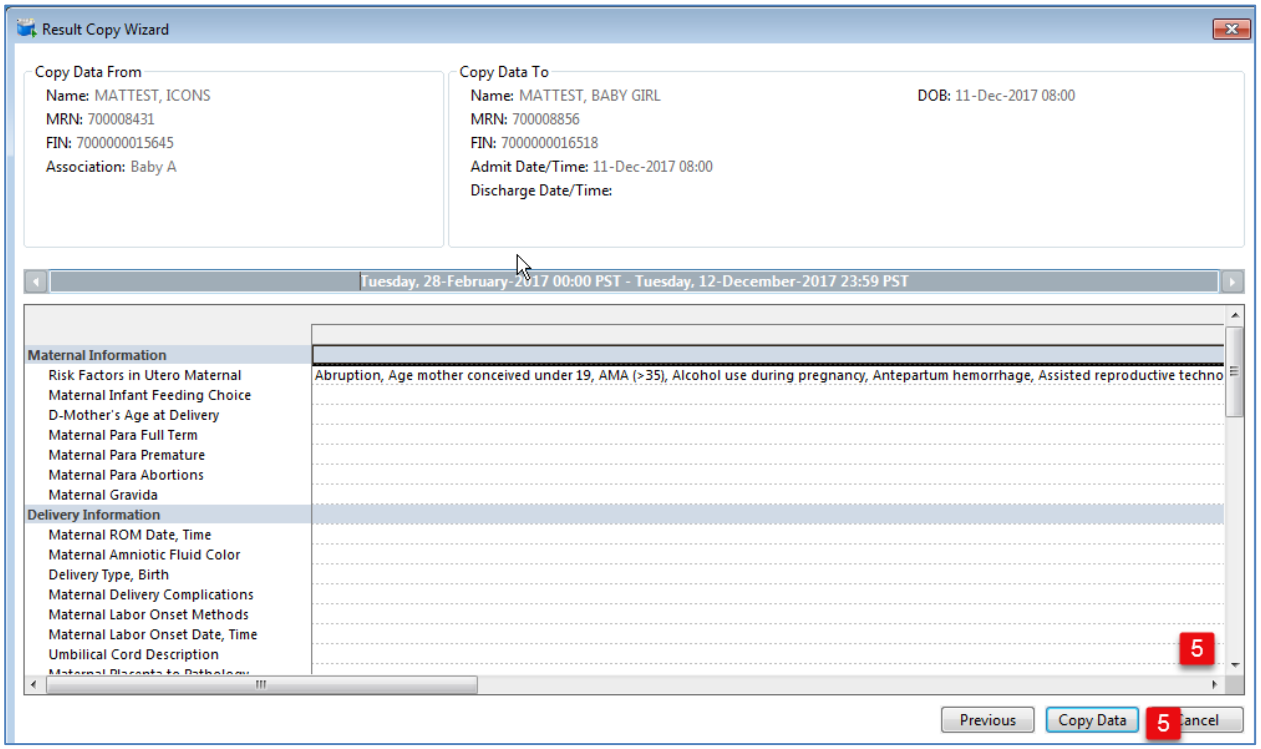


4. Information that will be copied over will show up once more; verify it is accurate. Any information that is highlighted green is newly documented information that will be copied over to the baby's chart. You can select or unselect any categories on the left.

   Select Next.



5. Click **Copy Data**



The Result Copy Wizard window will close and you will be taken back to your patient's (mom's) chart.

Note: Result Copy can be done at any time during nursing documentation, however, at a minimum, it should **always** be done at the following times in order for appropriate information to

be viewable in the newborn chart (and therefore facilitate appropriate care):

1. After Quick Registration of a newborn (Labour and Delivery Nurse to do Result Copy)
2. When mother's status is switched from Labour to Postpartum (Labour and Delivery Nurse to do Result Copy)
3. Before mother/baby is discharged from hospital (Postpartum Nurse to do Result Copy)

Now that you have created an electronic chart for the baby (via Newborn Quick Reg) and you have performed result copy to copy pertinent delivery information from the mom's chart to the baby's chart, you can document on the baby. After a baby is born, the nurse needs to complete the Newborn Admission History PowerForm.

Key Learning Points

- Result copy allows you to copy documented information from mom's chart over to the newborn's chart.
- Result copy is necessary at minimum during the follow 3 situations:
    4. When the newborn has been quick registered
    5. When mom and baby are being transferred from labour to postpartum
    6. When mom and baby are being discharged from the hospital

End Book One

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