SELF-GUIDED PRACTICE WORKBOOK [N33]
CST Transformational Learning

WORKBOOK TITLE:

Provider: Surgeon Inpatient (Workbook #1)

Last update: February 1, 2018 (v2)

CLINICAL + SYSTEMS TRANSFORMATION
Our path to smarter, seamless care

TRANSFORMATIONAL LEARNING

TABLE OF CONTENTS

SELF-GUIDED PRACTICE WORKBOOK

Duration	**3 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
- An attempt has been made to ensure scenarios are as clinically accurate as possible
- Some clinical scenario details have been simplified for training purposes
- Some screenshots may not be identical to what is seen on your screen and should be used for reference purposes only
- Follow all steps to be able to complete activities
- If you have trouble to follow the steps, immediately raise your hand for assistance to use classroom time efficiently
- Ask for assistance whenever needed

PATIENT SCENARIO 1 – Admission

Learning Objectives

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

- Access the Patient Chart through Patient Overview
- Understand the Banner Bar
- Understand Provider view

SCENARIO

A 39-year-old patient presents to the Emergency Department with a seven day history of abdominal pain and constipation. The patient has a history of chronic knee pain and has been on long term narcotic therapy. Patient reports that they are allergic to penicillin and adhesive tape both results in hives. Your patient was found to have a small bowel obstruction after being assessed in the emergency department.

You are called in as the Consulting Provider.

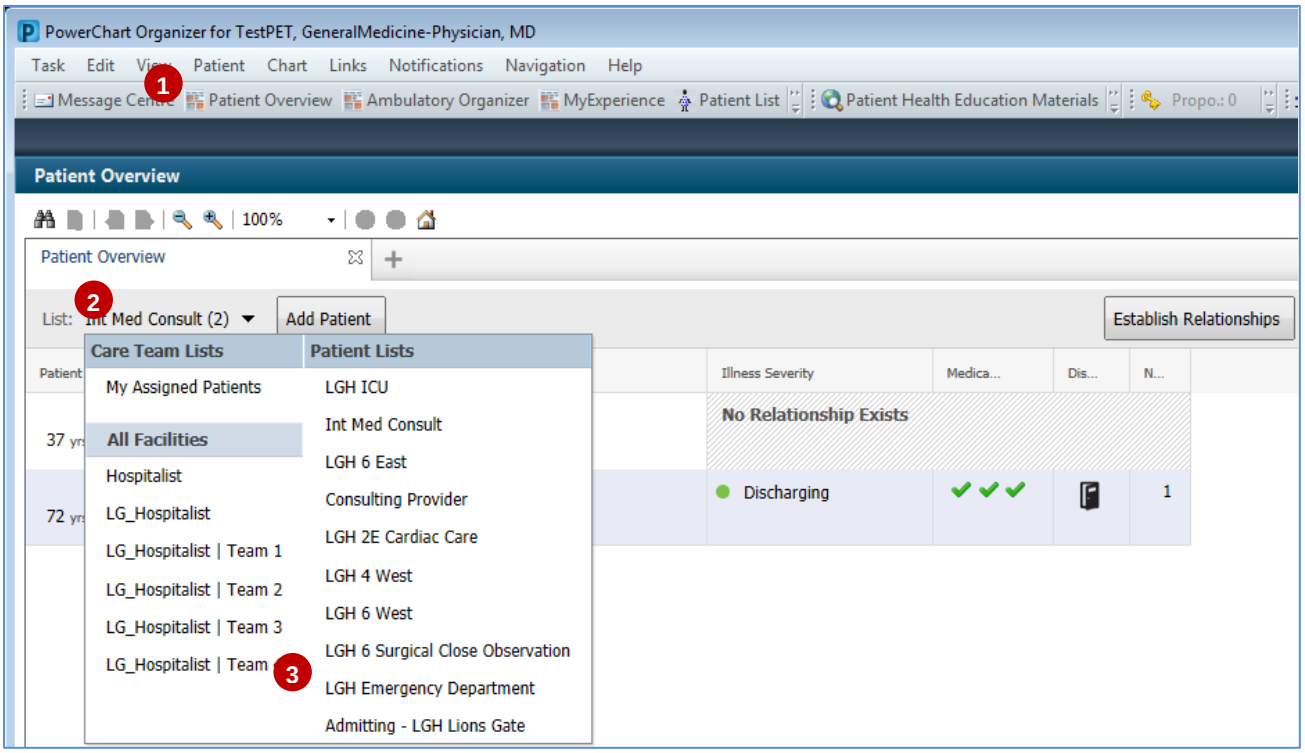
Activity 1.1 – Access Patient Chart

When using the Clinical Information System (CIS), you will have an immediate access to patient's chart using one of Cerner's applications – PowerChart. It is one of the many applications that together create a robust Clinical Information System (CIS) allowing all providers for improved patient care.

The CIS offers you many ways to complete one task. In this workbook you will use Train Domain to learn **a recommended practice** leaving additional more complex material to be covered by other learning resources.

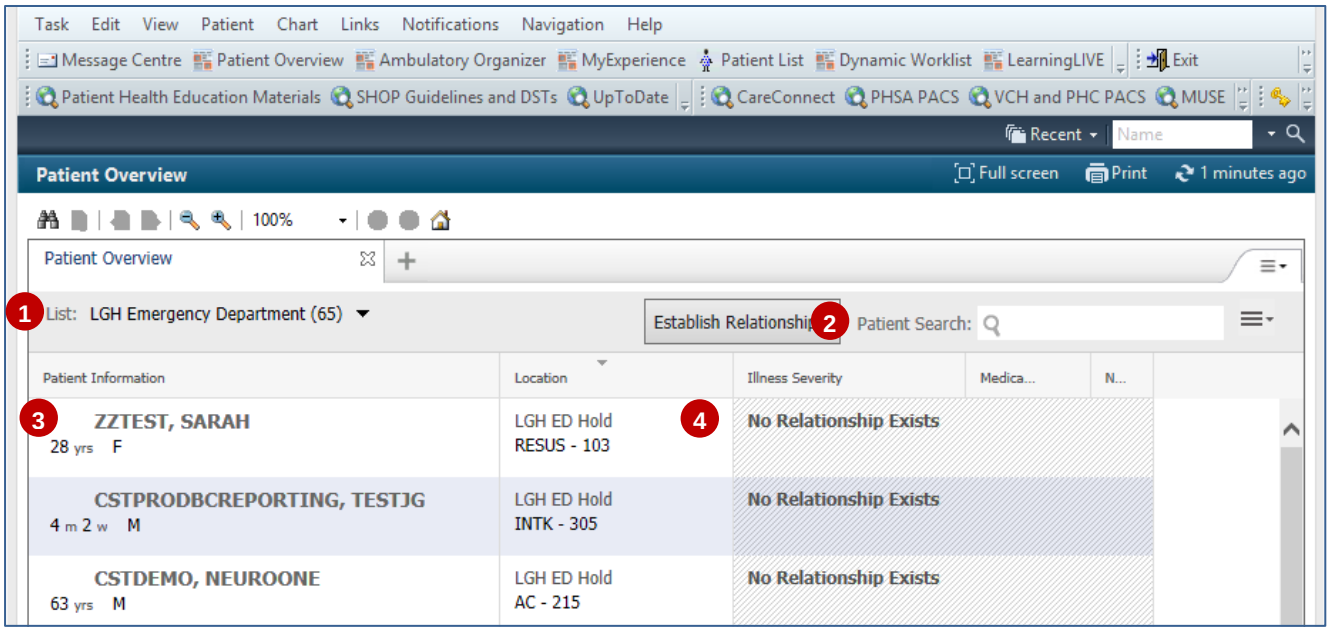
When using the CIS, you will open patient's chart from the **Patient Overview**. This is the best way to access the right patient and the right encounter.

1. The **Patient Overview** window can be opened from the main toolbar.
2. You can display all lists currently available to you by clicking the down arrow.
3. You will be able select the appropriate list, for example the **LGH Emergency Department.**

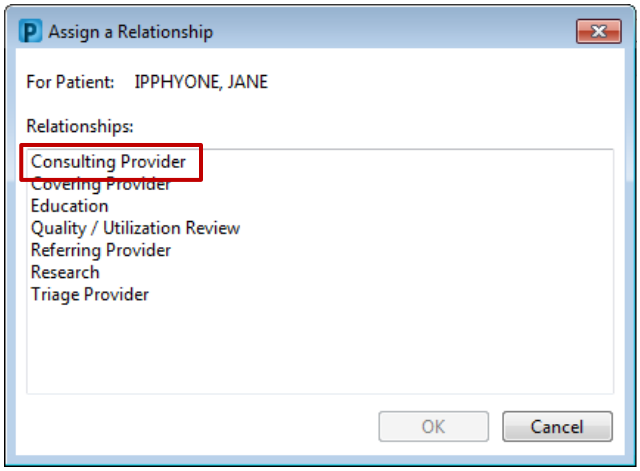


The **LGH Emergency Department** patient list will automatically gather all patients that are currently admitted to ED. Other lists may include patients from a specific location or patients where you are the attending provider. You can also share lists with your colleagues.

1. When contacted by the ED physician in real life, you will select the **Emergency Department** list. Lists can be extensive. Our example here contains 65 names as indicated by the number in brackets.
2. You can also type patient's name and search the currently displayed list.
3. Clicking the patient's name will open the chart. This is just an example.
4. If you have never accessed this patient's chart, the patient is marked by **No Relationship Exists.**



When opening the chart for the first time, a prompt to **Assign a Relationship** will display. As a consulting provider to the ED patient, you would select **Consulting Provider**.



In this activity, follow steps to:

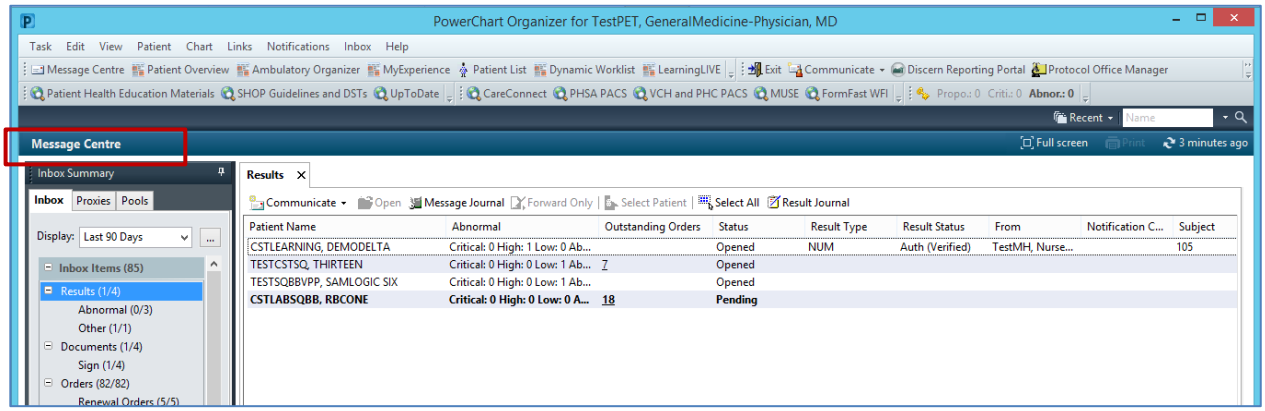
- Practice accessing and navigating patient's chart.

1

Log into the CIS with as a general medicine provider with the instruction provided.

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.

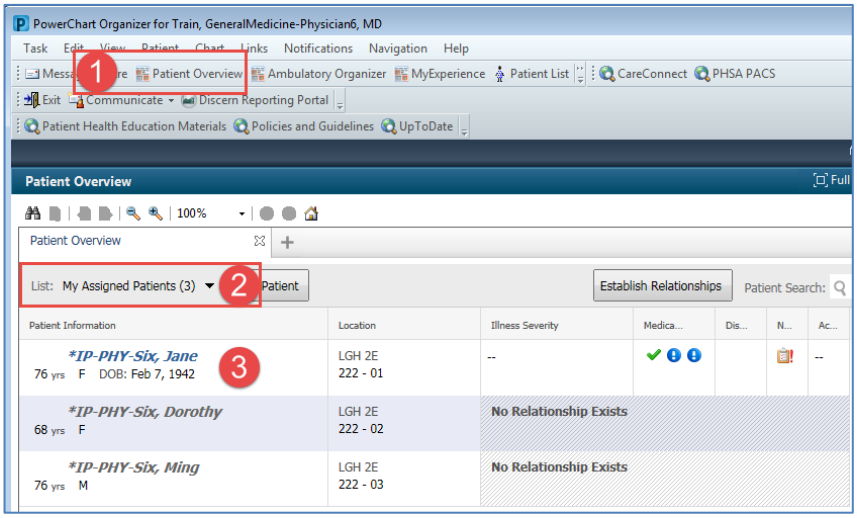
You can use toolbar to change your view.
Do you remember how to open the Patient Overview window?



2

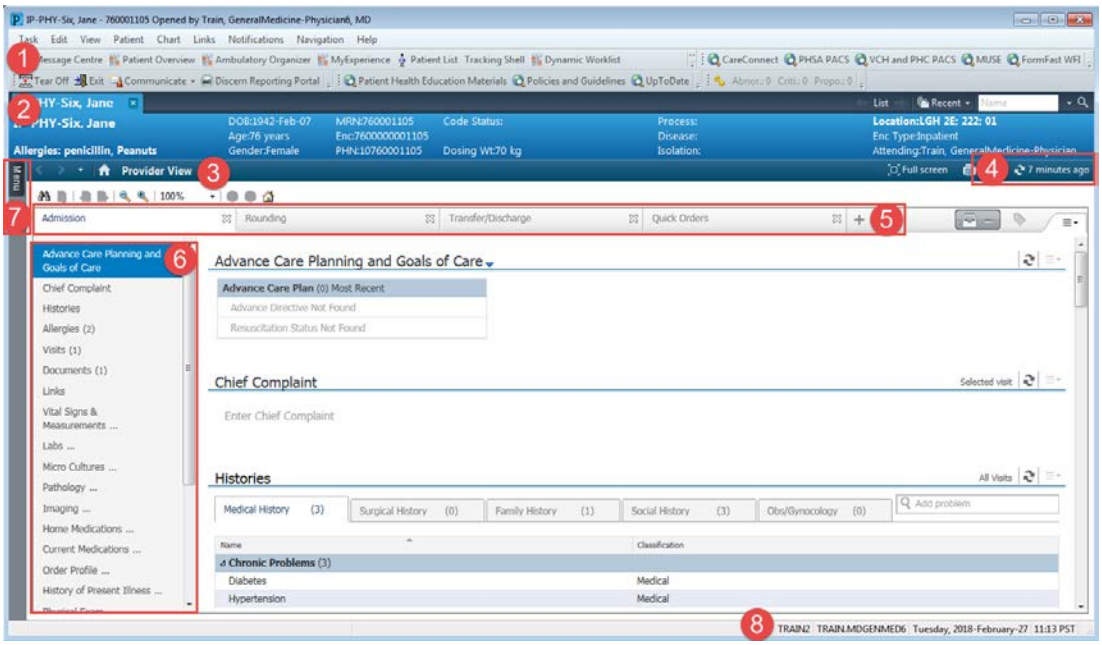
In the real life, you will be able to find your patient on the existing ED patients list but in the Train Domain, your patient has been added to the **My Assigned Patients** list.

1. Select the **Patient Overview**.
2. Click the down arrow and select **My Assigned Patients** list.
3. Click the patient's name to access the chart.



3 The patient's chart opens to the **Provider View** which is your current default screen. Now let's explore the screen a little further.

1. The top menu and toolbar provide 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.
6. A **list of components** represents workflow steps specific to your specialty. To navigate patient's chart efficiently, **follow the component list.**
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.

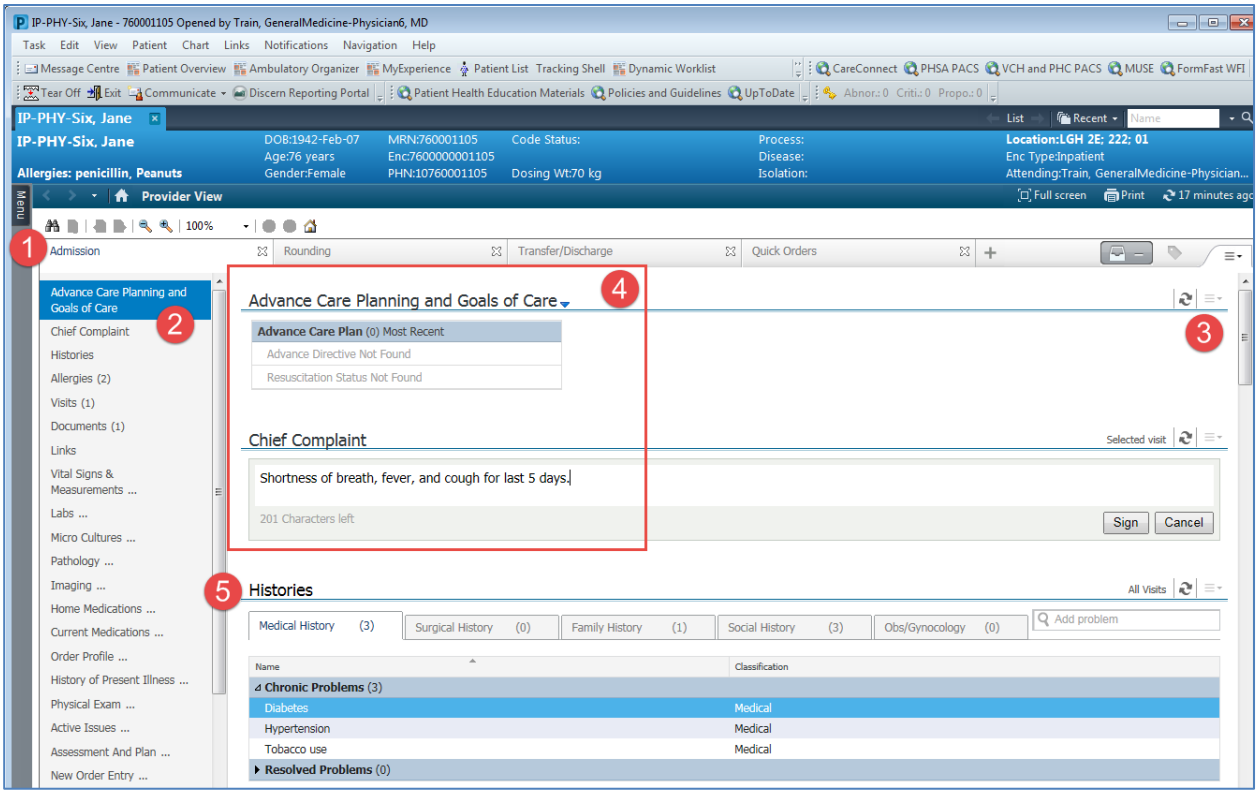


4 Now you will review the patient's chart to decide about a possible admission.

1. Select the **Admission** tab.
2. Click each component from the list to display its content.
3. Use scroll bar to move down the screen.
4. There are different types of components. For example:
   - The **Advance Care Planning and Goals of Care** will display information from other parts of a patient's chart once they are entered.
   - The **Chief Complaint** allows you to type or dictate text. Click the text box and type for example: *Shortness of breath, fever, and cough for last 5 days.*
     This information will be transferred to your chart note.
5. Each component has a **heading**. Place the cursor over the heading. This icon means the heading is an active link. Click the heading to open a comprehensive window with more options to review or enter patient's information.

   For example, click **Histories** and see another window open.

You can use navigation buttons similar to other internet applications. Do you remember how to return to your default view? What is your default view called?



Activity 1.2 – Placing the Admit to Inpatient Order

At the Emergency Department, you examine the patient and decide to admit them to the Surgery Unit. Now, you must place an **Admit to Inpatient** order to ensure that the following important steps happen:

- The status of the patient becomes inpatient and the **clock starts for the admission**
- There is a notification to Access Services to **locate a bed for the patient**
- The encounter type changes from Emergency to **Inpatient**
- Admission **tasks are sent to the inpatient nurse** assigned to this patient
- It is also important that the Admit to Inpatient Order is placed **before any other orders**. Pharmacy dispensing may be delayed if this order is not placed first.

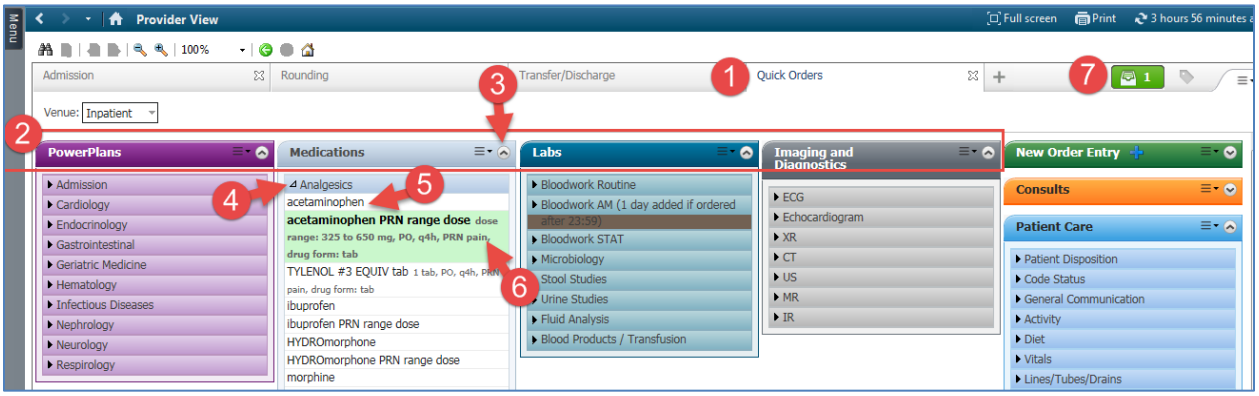
NOTE: The completion of the Admit to Inpatient order involves actions taken by other hospital departments. Such a process cannot be fully represented in the Train Domain and **patients in the Train Domain are already admitted** to the General Medicine Unit. You will place the Admit to Inpatient order for practice only.

It is important to place the **Admit to Inpatient Order** before any other orders as the routing of tasks to other clinicians is dependent on the encounter type.

1 Overview

The best option for placing orders is via the **Quick Orders** tab. This view is one-stop shop for **common orders and PowerPlans** that are **specialty specific**. It depends on your specialty, which orders you see and how orders are displayed.

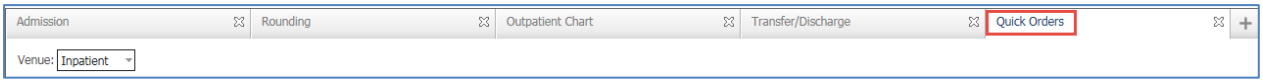
1. Select the **Quick Orders** tab.
2. Quick Orders are organized into different **categories** such as PowerPlans, Medications, Labs, etc.
3. Click the arrow to collapse the category, click again to expand it back.
4. Under each category, there are **folders**. Click the folder to collapse or expand its content. Folders list individual orders and you can select them with one click.
5. You can select **acetaminophen** and add additional details yourself regarding dose, frequency, route, etc.
6. You may see orders that have these details pre-determined for ease of ordering as an **order sentence**: For example, you can select **acetaminophen PRN range dose 325 to 650 mg, PO, q4h, PRN pain, drug form: tab.**
7. Once the order is selected, the **Orders for Signature** box will turn green and show the number of orders waiting for you to sign. Here one order has been selected.



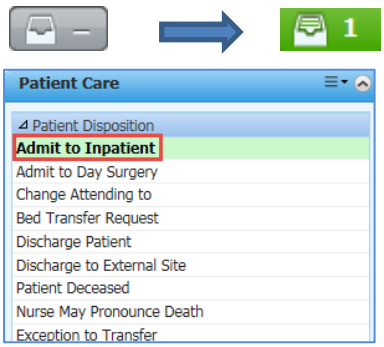
2 Follow the steps to locate and place the **Admit to Inpatient** order:

Remember, in the Train Domain your patients are already admitted but in real life, you will place the Admit to Inpatient order to start the admission process.

1. Select the **Quick Orders** tab from Provider View.

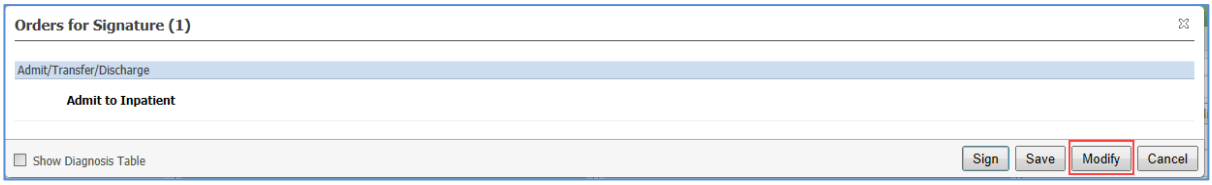


2. Under Patient Care, click **Patient Disposition** to expand the list and select **Admit to Inpatient**.
3. Once selected, the order will be highlighted green and the orders for signature box icon will show there's an order to sign.

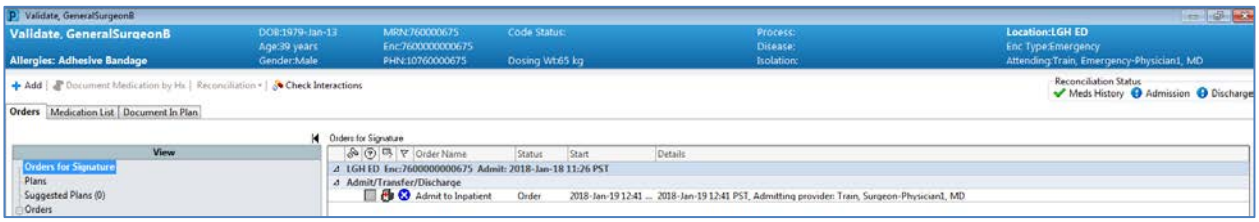


4. Click **Orders for Signature**  icon.
    - Orders for Signature window opens

3 Click **Modify**



The detailed orders page will open:

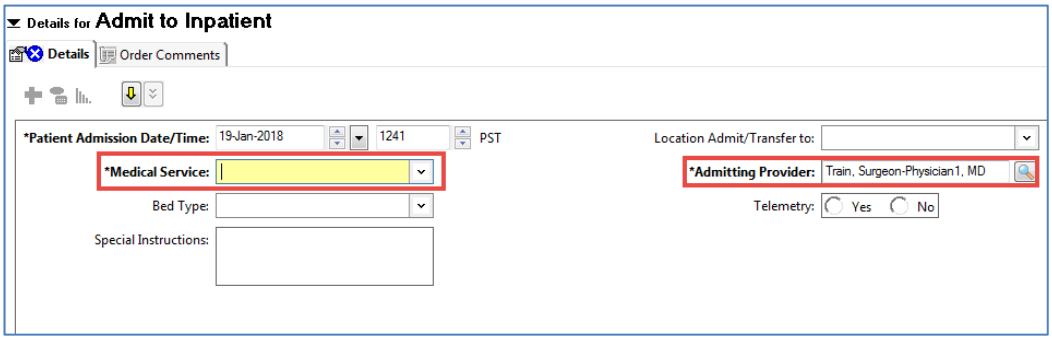


 indicates that details need to be entered to complete and sign the order, PowerChart will not let you sign the order until missing details are filled in.

4

1. Click to bring up the order details for **Admit to Inpatient**. The yellow highlighted and/or starred fields are mandatory.
2. Select **General Surgery** under **Medical Service.**
   - The Admitting Provider field should be auto-completed with your name when using your own login.

NOTE: If admitting for a colleague, ensure that their name is entered.

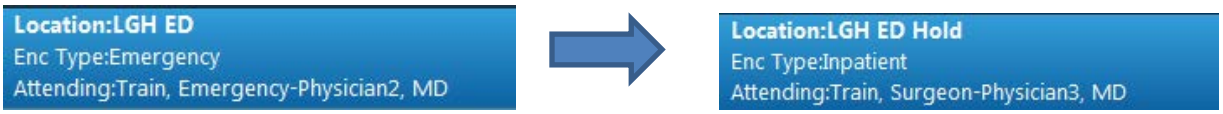


5

Click Sign then **Refresh**

6

Verify the **encounter type** in the Banner Bar has changed from Emergency to Inpatient



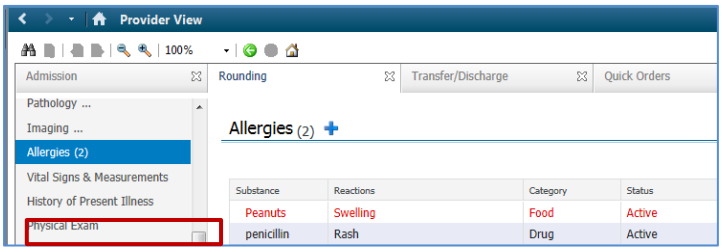
Key Learning Points

- When admitting a patient it is critical to place the **Admit to Inpatient** order
- Use **Quick Orders** tab for placing orders efficiently
- Place the **Admit to Inpatient** order prior to entering additional orders

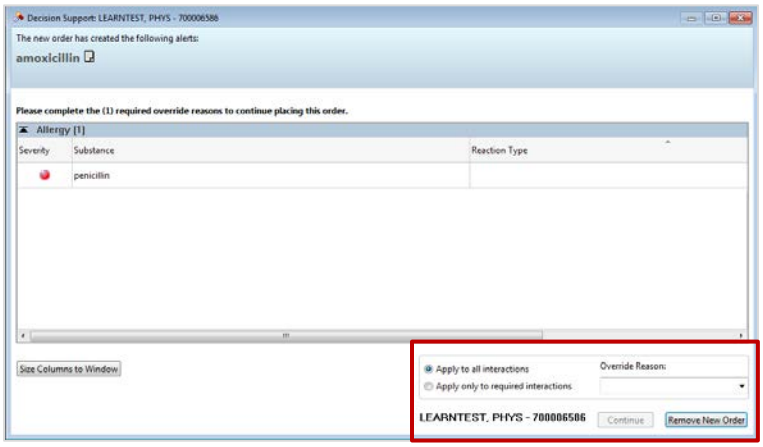
Activity 1.3 – Review Allergies

In the Clinical Information System (CIS), 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.

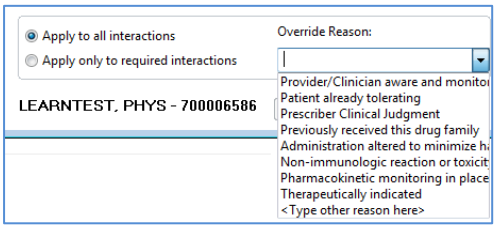
Patient allergies can be added and updated in the **Allergies** component.



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.



You can either remove the order and select another medication, or continue with the order by overriding the alert and documenting the reason:



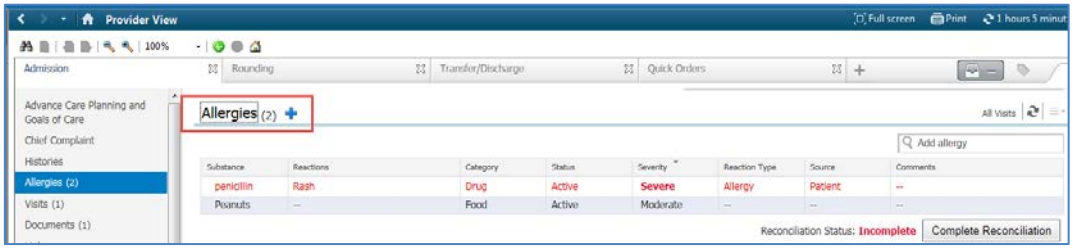
The CIS will also **track allergy-to-drug interactions**.

In this activity you will:

- Add a new allergy
- Modify the existing allergy record

1 In order for the pharmacy to dispense a medication, the allergy record must be reviewed for the

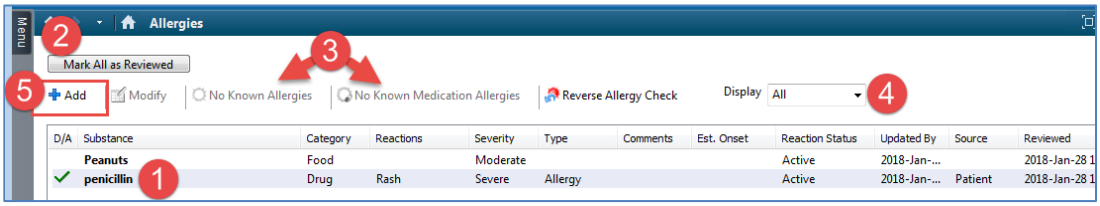
current encounter. Click the **Allergies** heading to add a new allergy.



2

The **Allergies** window displays a comprehensive table with patient allergies:

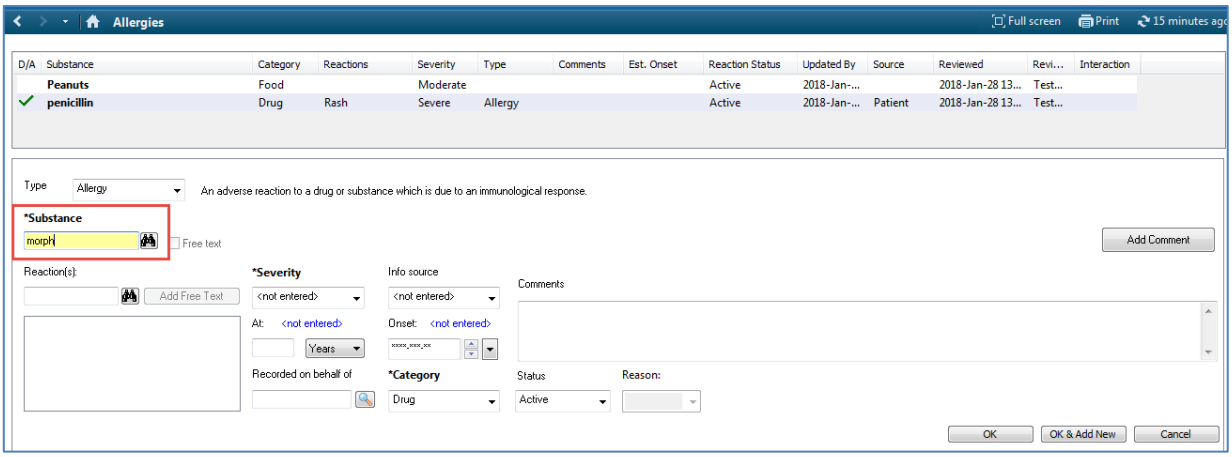
1. A green checkmark indicates a drug allergy.
2. If the record is complete and no changes required, click **Mark All as Reviewed** to complete the review.
3. When there is no information available, you can use other the toolbar options:
   - No Known Allergies
   - No Known Medication Allergies
4. Click the arrow to select viewing All records or filtering only Active or Inactive
5. To add a new allergy, click the Add icon on the toolbar.



3 You can enter new allergy below the allergies list.

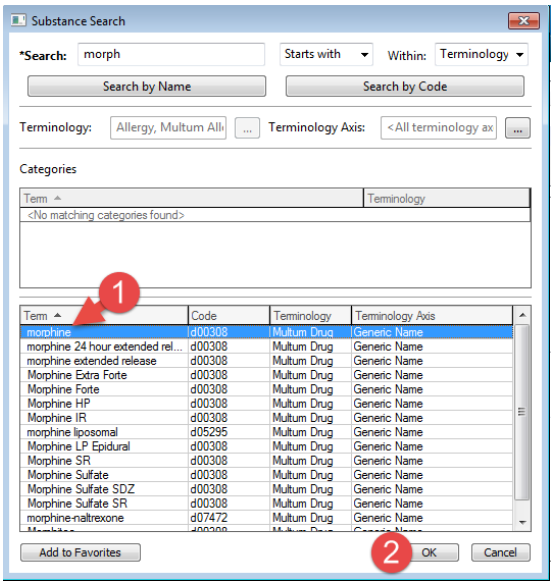
NOTE: All mandatory boxes have yellow background such as Substance and are marked with an asterisk. Yellow background disappears when a default entry populates the mandatory box, for example Category = Drug.

1. Type *morph* in the **Substance** box and click to execute the search.



4

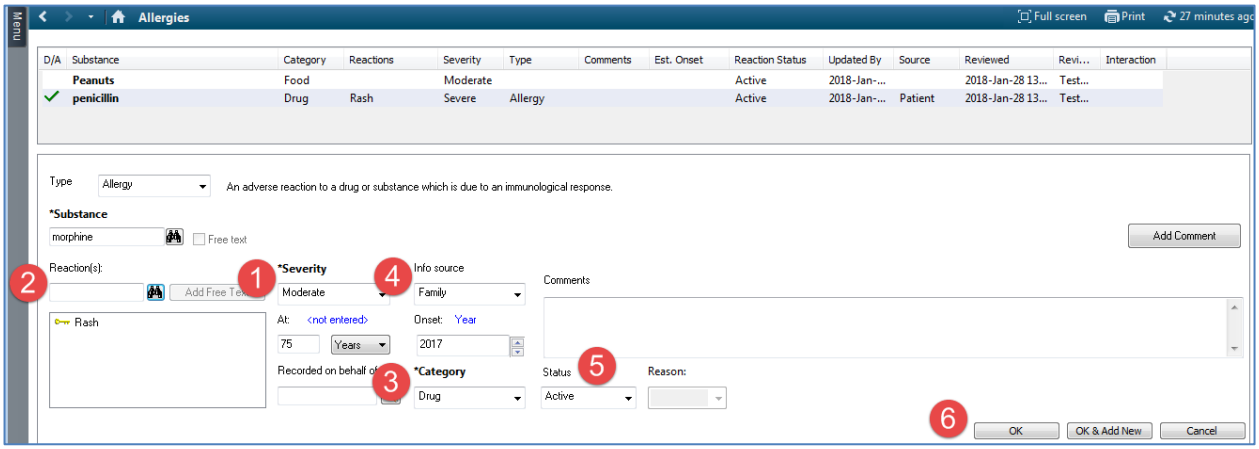
1. Select **morphine** from the list displayed.
   It is the best practice to keep the entry generic to ensure the system tracks all types of morphine medications.
2. Click **OK** to return to the Add Allergy/Adverse Effect window.



5 Fill the mandatory boxes and add other appropriate options:

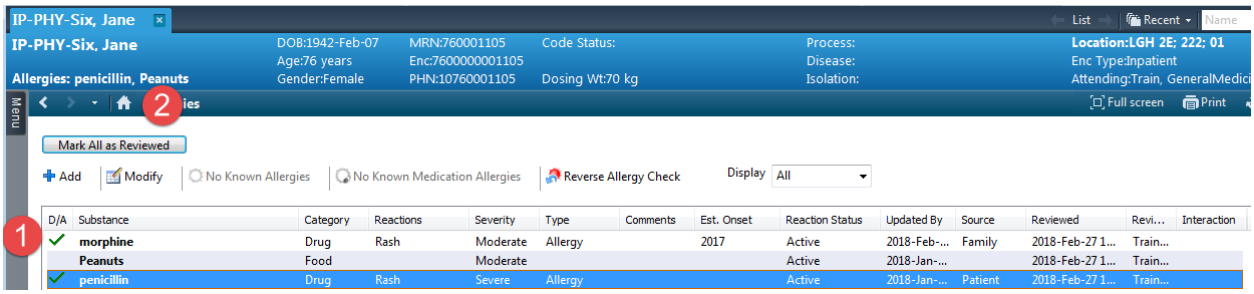
Do you remember how to spot mandatory boxes?

1. Select *Severe* for the **Severity.**
2. Type *rash* and click in the **Reaction**(s) box (recommended).
3. Select *Drug* for the **Category.**
4. Select *Family* for **Info Source.**
5. Note Status is **Active**. Use the drop-down to display more options.
6. Click **OK** to save the information. OK & Add New allows for multiple entries.



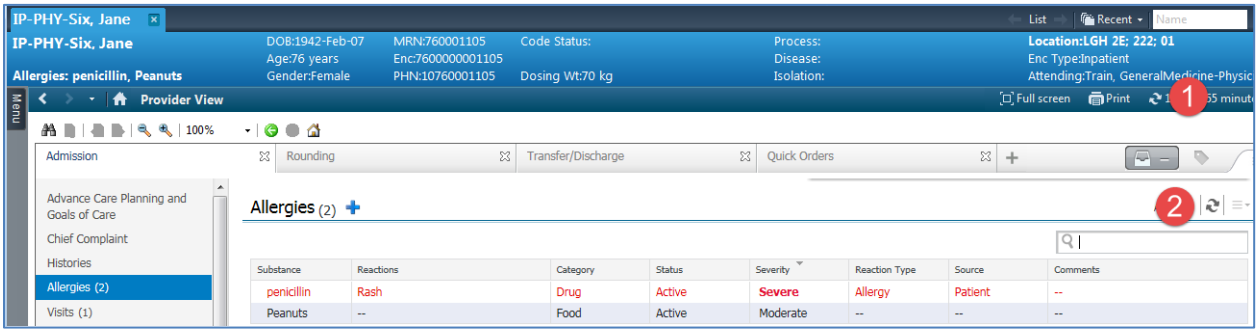
6 Check if morphine allergy is added to the patient's record.

1. The **green checkmark** indicates drug allergies.
2. Click the icon to return to the **Provider View.**



7 When you are back in the Provider View, you may notice that your display does not always display the most current information. Refresh your screen frequently:

1. Click the **Refresh button on the Banner Bar** to refresh all information in the current workflow tab
2. Click the **Refresh button for an individual component** to update this information only and stay with this component.



Key Learning Points

- Patient **allergies** and interactions are monitored by the CIS.
- Allergy record needs to be **reviewed for each encounter** on admission.
- A review of allergies is complete when Mark All as Reviewed is selected

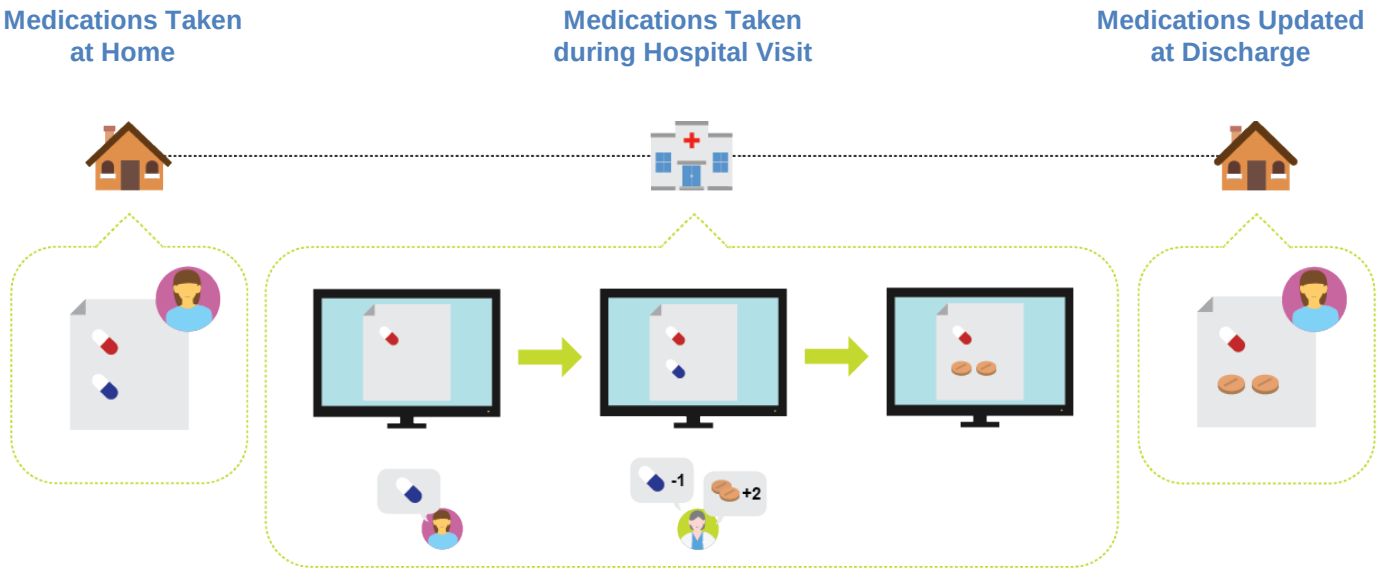
Activity 1.4 – Review Best Possible Medication History (BPMH)

The BPMH is generally documented by a pharmacy technician (ED only). 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 **Admission** 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.

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.

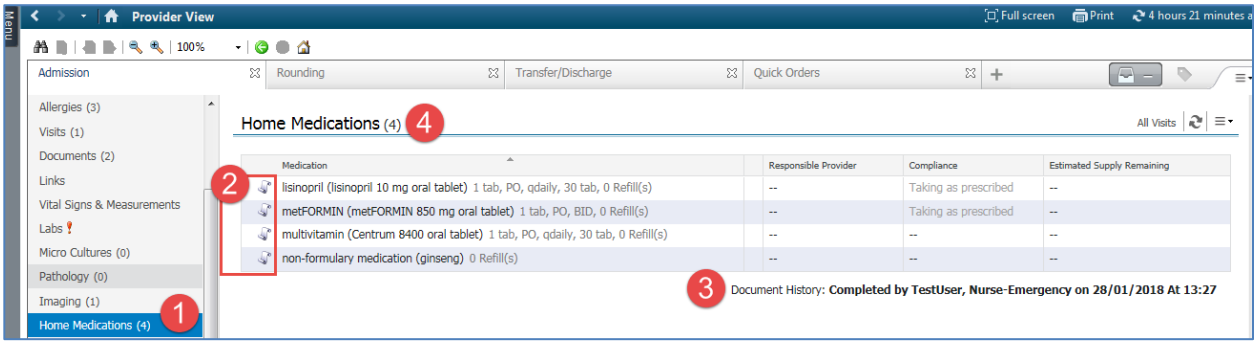
In our scenario, home medications are documented. The patient brought in their *gliclazide* and *salbutamol inhaler* from home, neither of which is documented. You decided to document them to complete the admission reconciliation.

In this activity you will:

Review and update the BPMH

1 Ensure you are in the **Admission** tab:

1. Click the **Home Medications** component to display the list of documented home medications.
2. Documented home medications are marked by the  icon.
3. Note the status line indicating who and when updated the medication history.
4. Click the **Home Medications** heading.

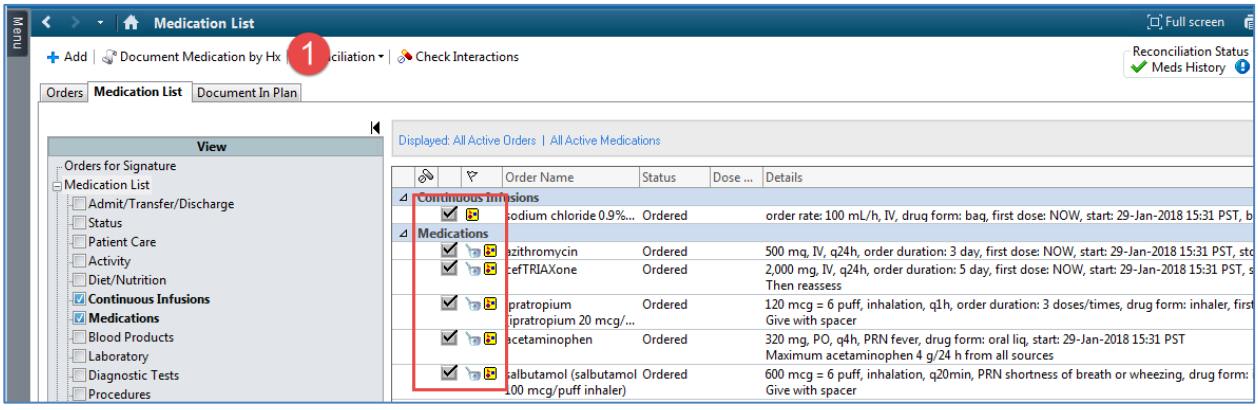


2 The **Medication List** window displays and you can check details for **all current** medications for your patient.

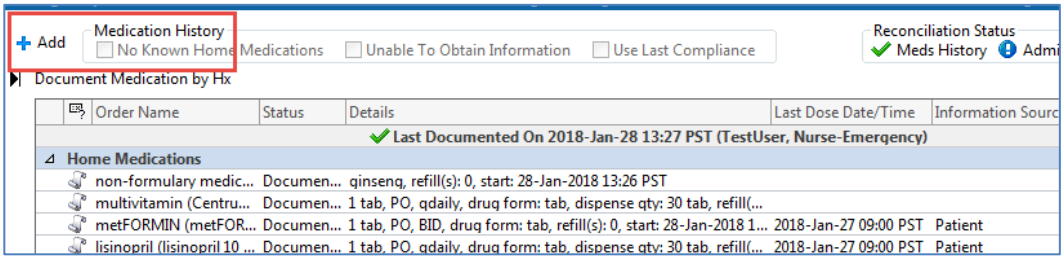
Hover to discover to check what on-screen explanation is provided:

- indicates inpatient medication
- indicates medication is part of the order set; Hover to discover more information.
- indicates that pharmacy must verify the medication

1. Click **Document Medication by Hx**.

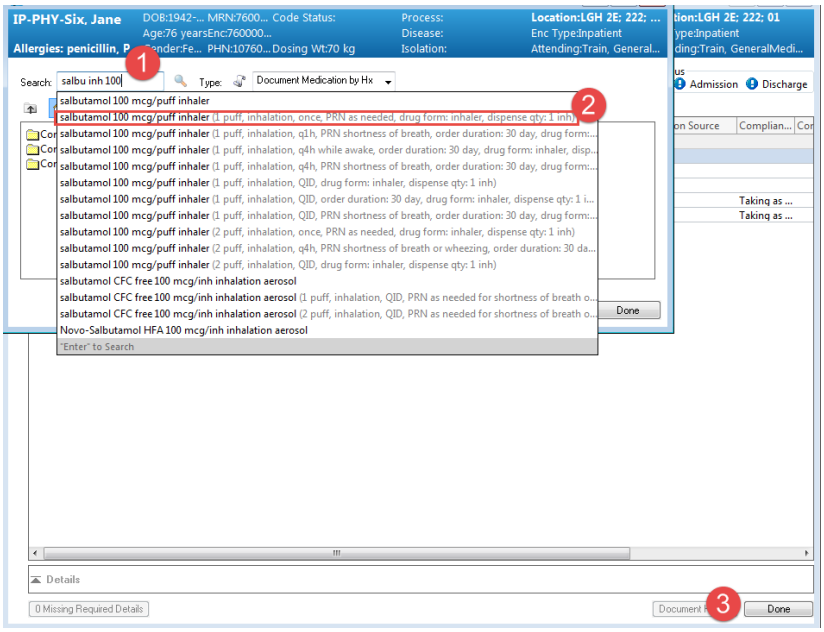


3 Ensure you are in the Medication History window. Click the + Add button on the **Medication History** toolbar.



4 In the **Search** window you can search the entire catalogue.

1. You may need some practice to be able to use the search efficiently. Here are few tips:
   - Type few first characters.
   - Add more details to truncate the list of possible options.
   - For this example, type ***salbu inh 100.***
2. Select salbutamol 100 mcg/puff inhaler (1 puff, inhalation, q1h, PRN shortness of breath or wheezing, drug form: inhaler).
3. Once you select the medication and associated details (order sentence), the medication order is placed and waiting for your signature. You can continue searching and adding more medication orders if needed.
4. For this activity, you want to add just this one. Click **Done**.



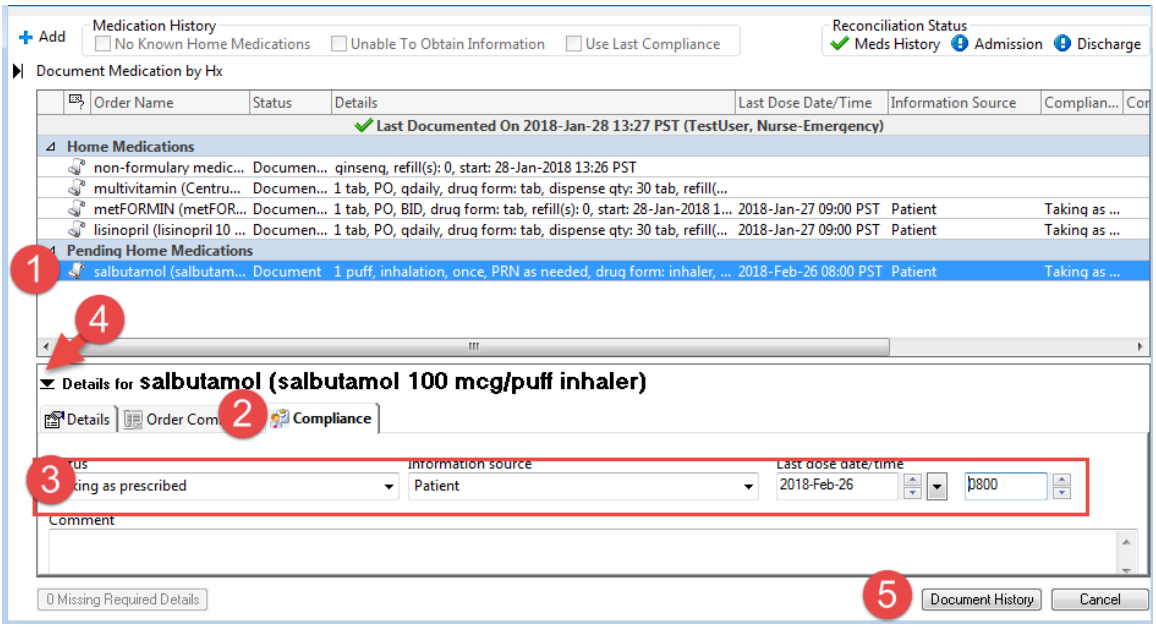
5

1. Select the order to display its details.
2. It is very important to know if the patient is compliant with prescription. To add this information, click on the **Compliance** tab.
3. Document the following in the **Compliance** tab:

   Status = Taking as prescribed

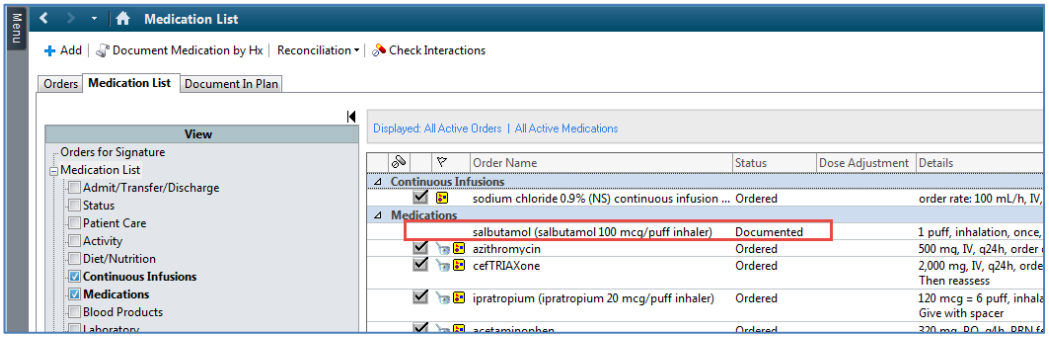
   Information source = *Patient*

   Last dose date/time= *Yesterday at 0900,* use calendar to enter date in a proper format
4. Click Details to collapse or expand details for the selected order.
5. Click **Document History** to complete the process.



6

The updated list of current home medications for your patient displays.



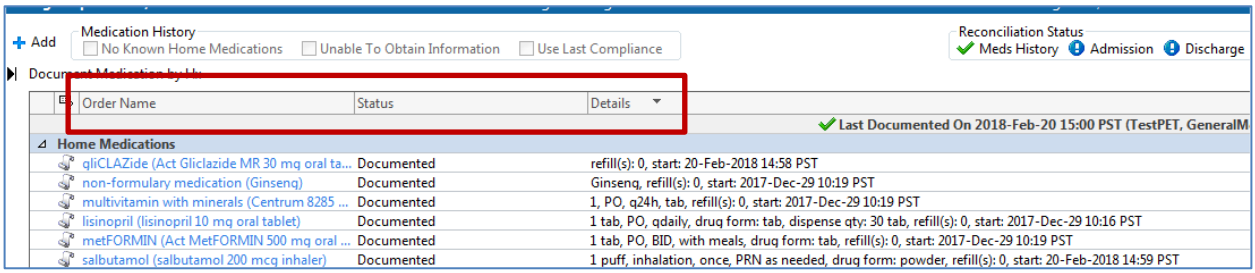
7 In some cases, you may need to document that the patient has no home medications or you are unable to obtain information. Select Document Medication by Hx

When needed, you can select one of the following options:

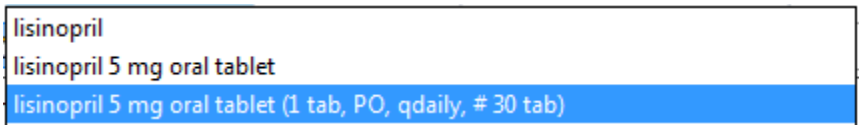
No Known Home Medications

Unable to Obtain Information

You can also select the medication and click **Use Last Compliance** – this will copy the past medication record as a current entry



8 Providers can update the home medications as this is very important for patient safety. For your practice, add ***lisenopril*** *5mg oral tablet (1tab, PO, Qdaily #30 tab)*. Ensure that you add this medication using **Document Medication by Hx** type of entry.

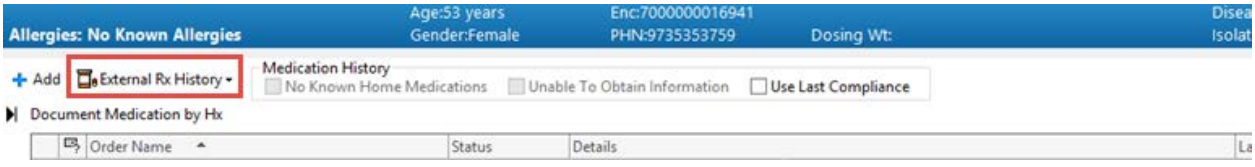


NOTE: The following information and screenshots are to illustrate the ability to see a patient's PharmaNet profile when completing BPMH.

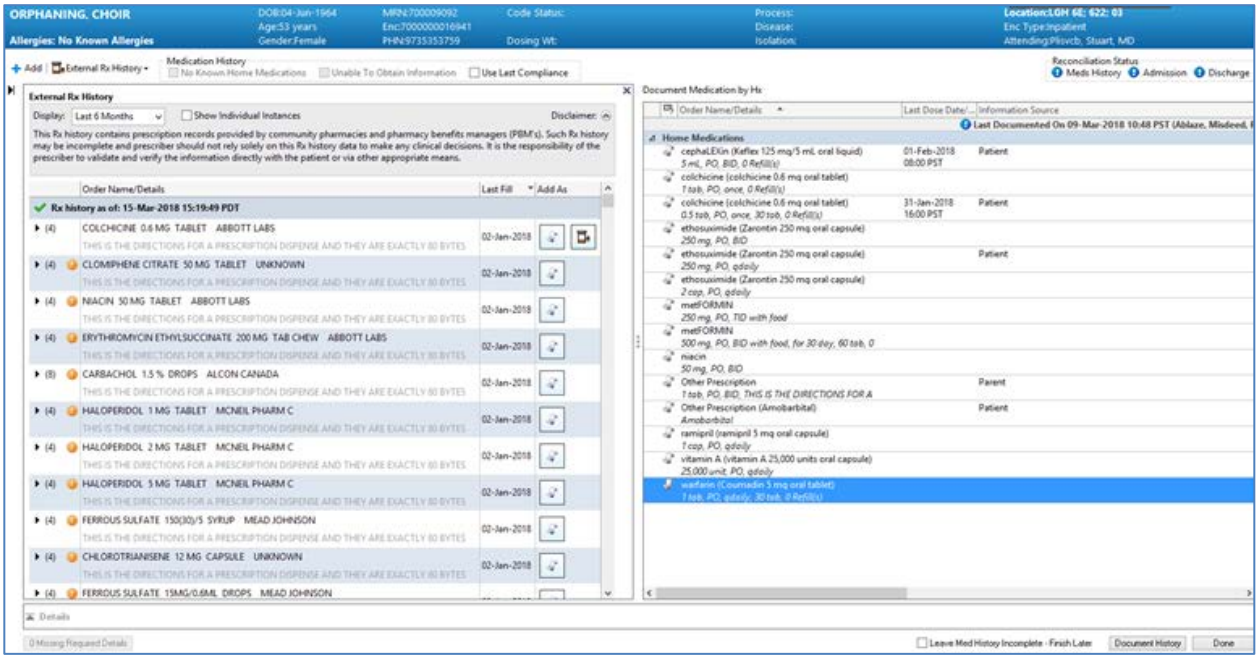
This is not available in the Train domain that you are currently learning in, but will be available when the CIS goes live. Resources to review this process will be available in future sessions prior to go-live.

9 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

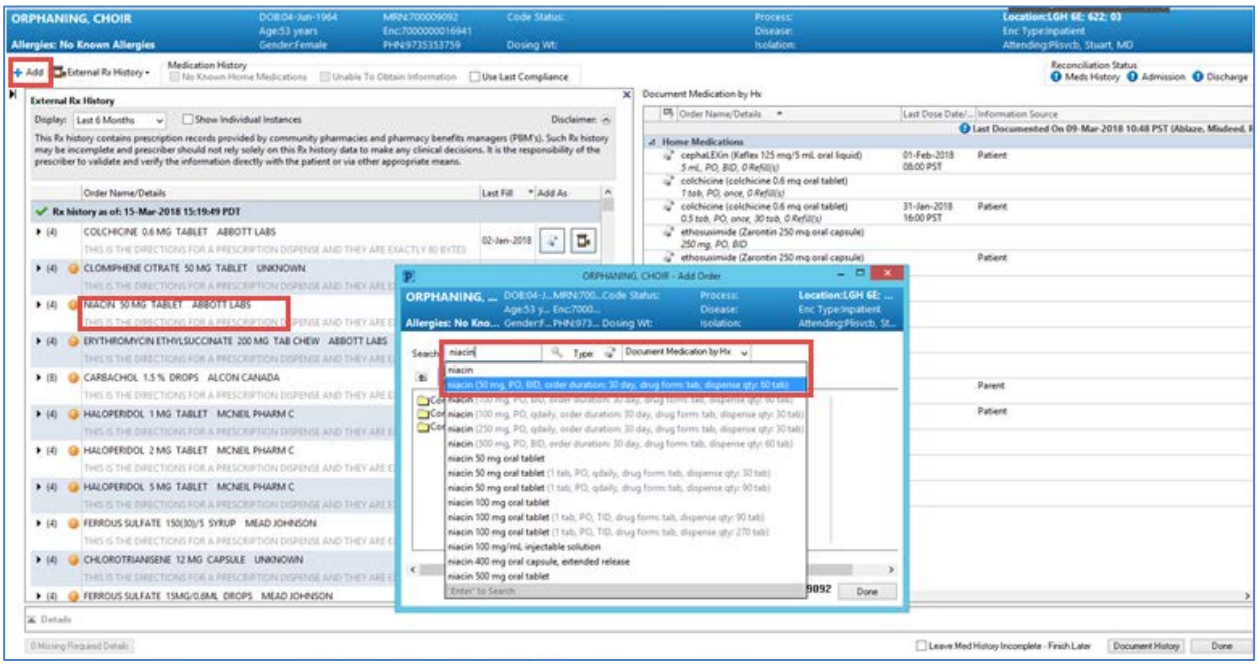
Within the Document Medications by Hx page, a new **External Rx History** button will be visible. External Rx History



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.



Key Learning Points

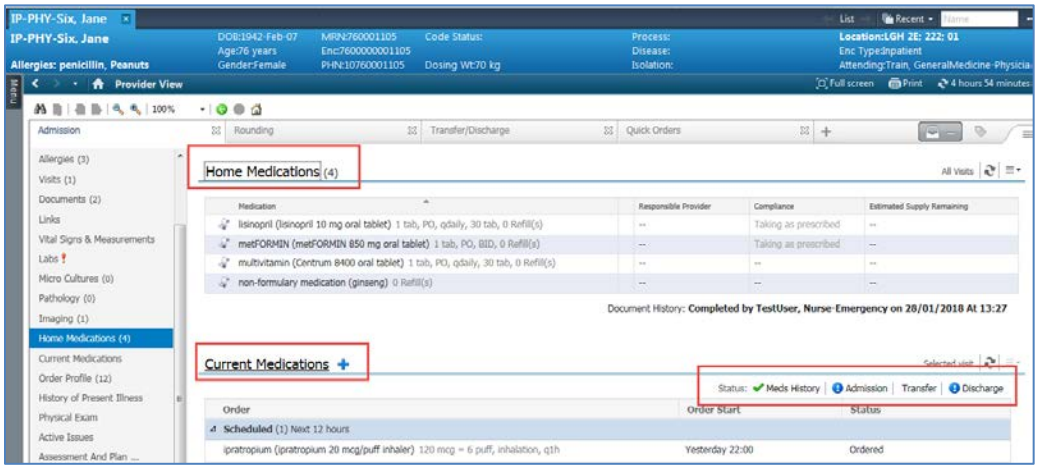
- **BPMH** must be completed **before** admission medication reconciliation can occur
- Home medications, once documented, can be updated at any time
- Documented home medications can be continued during the hospital visit
- Documented home medications can be continued or stopped when patient is discharged

Activity 1.5 – Complete Admission Medication Reconciliation

Admission reconciliation gives you the opportunity to review and make decisions about current home medications and prescriptions as well as medications the patient has received so far during this visit.

Within the **Admission** tab of the patient's chart, you have a few tools to help with the medication management process:

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



With the BPMH completed, you can **start admission medication reconciliation** for your patient. You will review the home medications and **stop ginseng and Centrum**. You also want to **modify medications placed by the ED provider**.

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

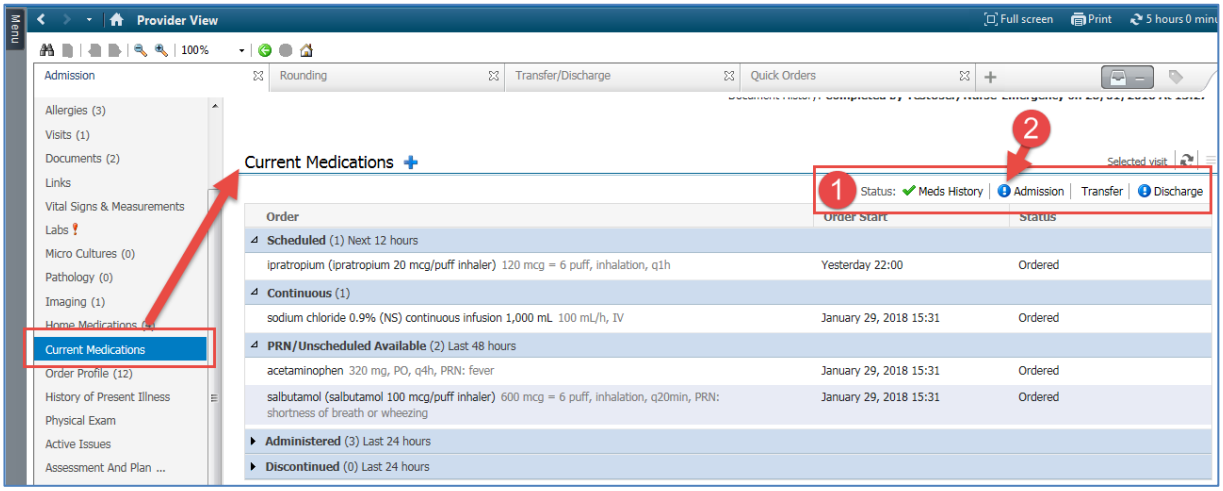
1 Select the next component – **Current Medications**.

1. Note the status of medication management in the top right corner.

   ✔ means complete

   ❗ means incomplete

2. To complete admission medication reconciliation, click the **Admission** button.



2

The admission reconciliation screen for your patient displays. You may see 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.

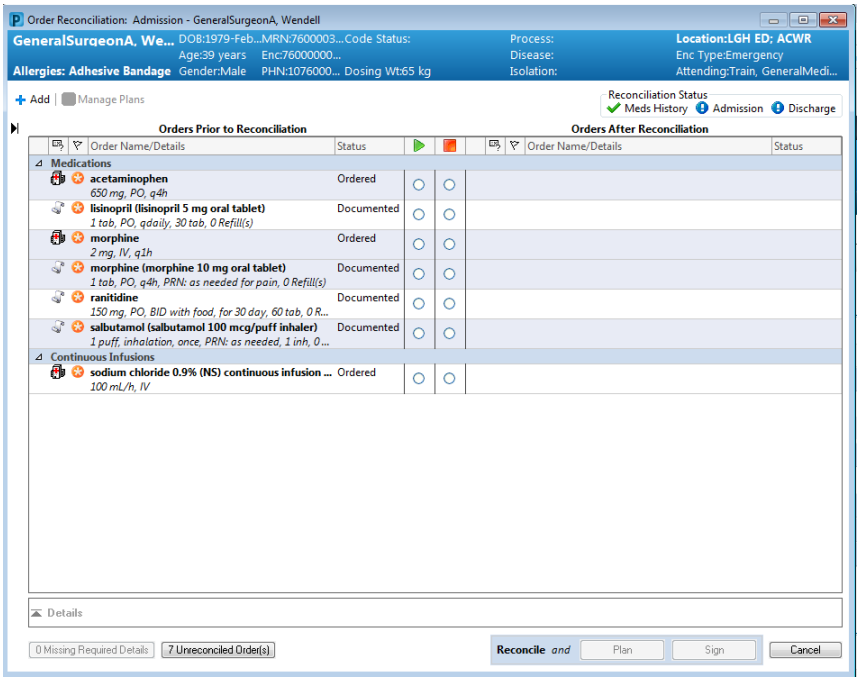
Review the **Orders Prior to Reconciliation** on the left. Some icons you already know:

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

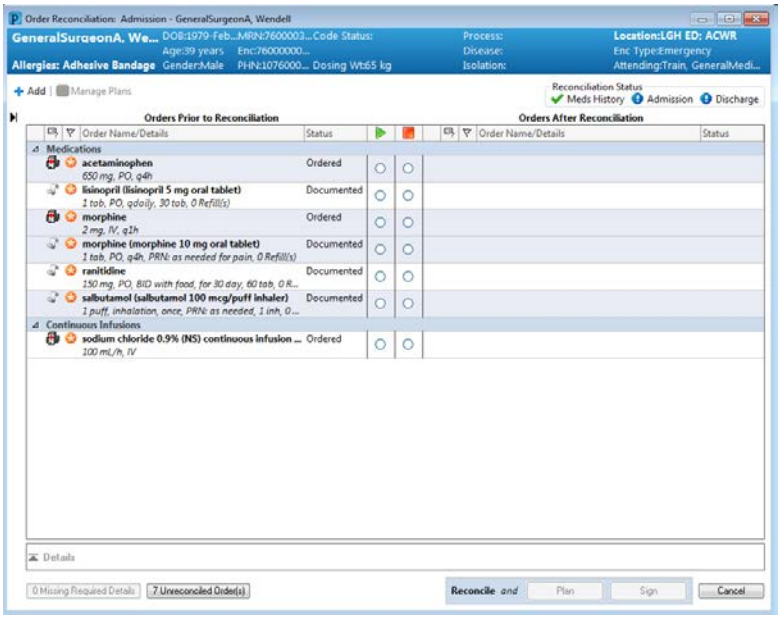


Reconcile Home Medications

1

Click the corresponding button to continue and or to discontinue for each home medication.

Do you remember what icon marks a documented home medication?



Discontinue the following home medications :

- morphine po
- salbutamol inhaler 1 puff QID PRN

Continue the following home medications :

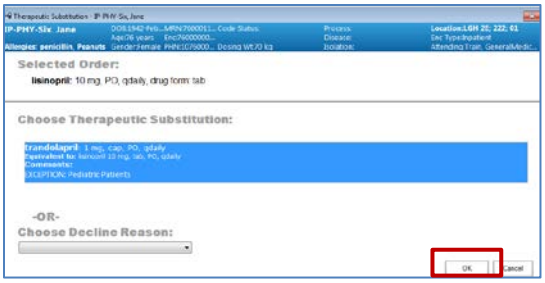
- ranitidine

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

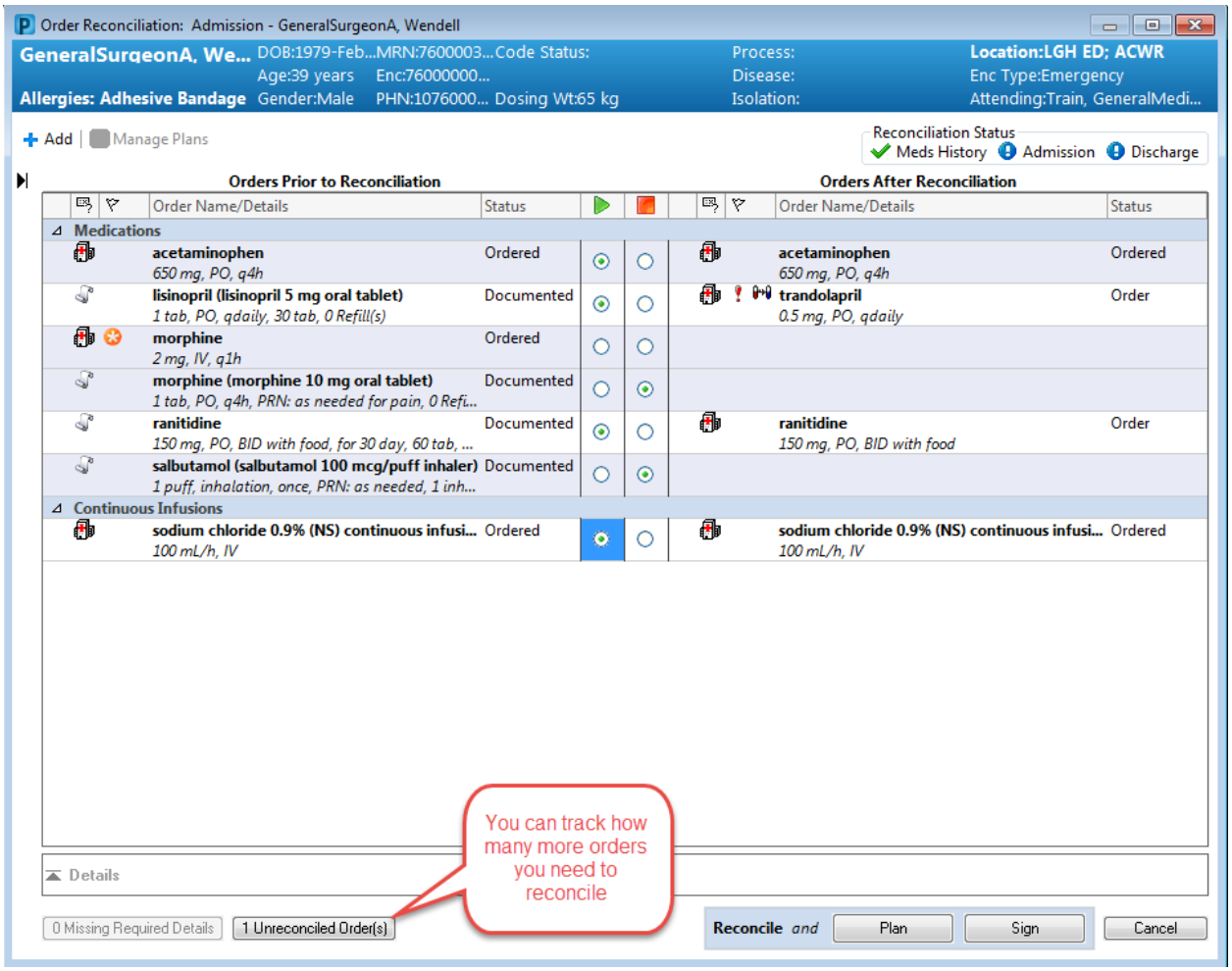
- **Continue** lisinopril 10 mg PO daily

NOTE: You will be notified that lisinopril will be **substituted** with trandolapril.
You can accept the suggested replacement or choose a reason to decline it and this will be communicated to the pharmacy. Medication substitution is indicated by icon.

Click **OK** to accept.



2 Ensure you have the following selections for home medications.



Reconcile ED Medications

1

Orders placed in the ED are marked by the icon and also part of the PowerPlan (order set). If they **do not require any changes**, you can select to continue them.

WARNING: If the **ED provider wrote the order and you decide to continue as an inpatient, they will remain the originator** of these ongoing orders. If it is important that you be the originator of these order, you can **discontinue the ED orders and place new orders**

Continue the following inpatient medications:

- acetaminophen 320 mg PO q4h
- morphine 3 mg iv q1h
- sodium chloride 0.9% NS 1000 mL

2

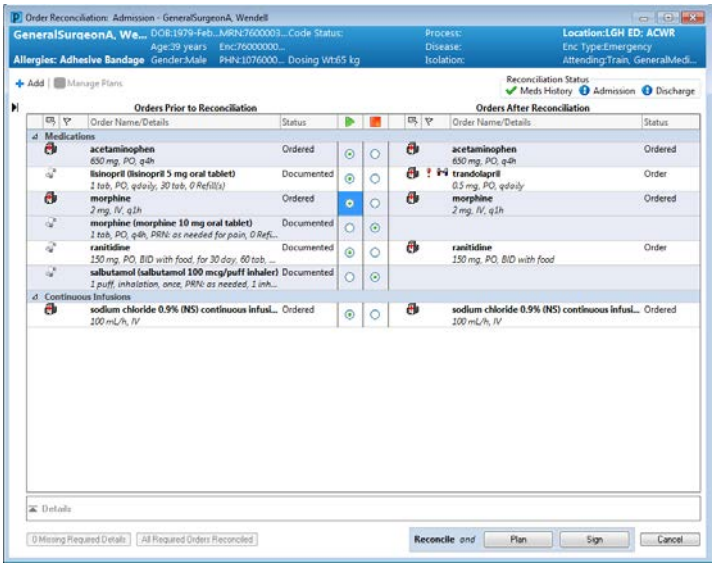
You may want to **modify medication orders** that have been placed by the ED provider. Your plan for the patient is to:

- **Change the route** for salbutamol and ipratropium placed in ED to nebulizers
- **Change the medication** from ceftriaxone to moxifloxacin.

NOTE: It is possible to modify orders placed by the ED provider directly within the reconciliation window.

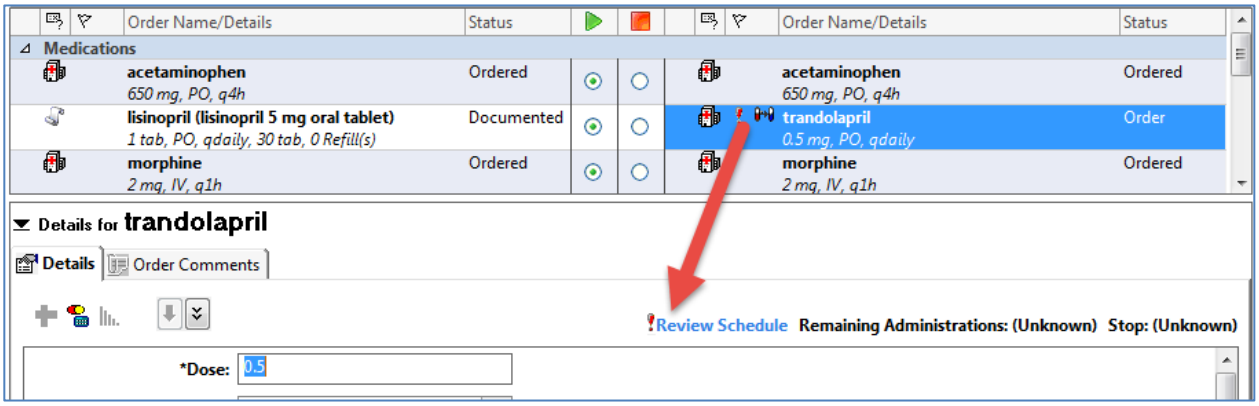
3

Check the list of the patient's medications after reconciliation. Compare with your display and ensure you were able to follow instructions. All medications should be reconciled before you sign the reconciliation.

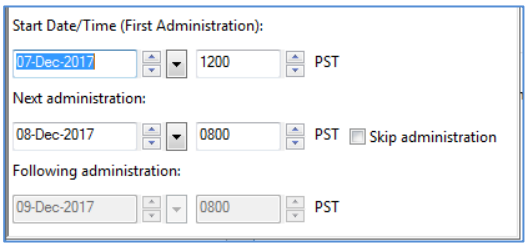


4

You may be prompted by the icon for some medications. It means that the first dose default administration time has passed and you may need to adjust the first dose administration time. Click on the medication line to display the details window and then select **Review Schedule**.



Review if times for drug administration are correct and you may adjust if needed.

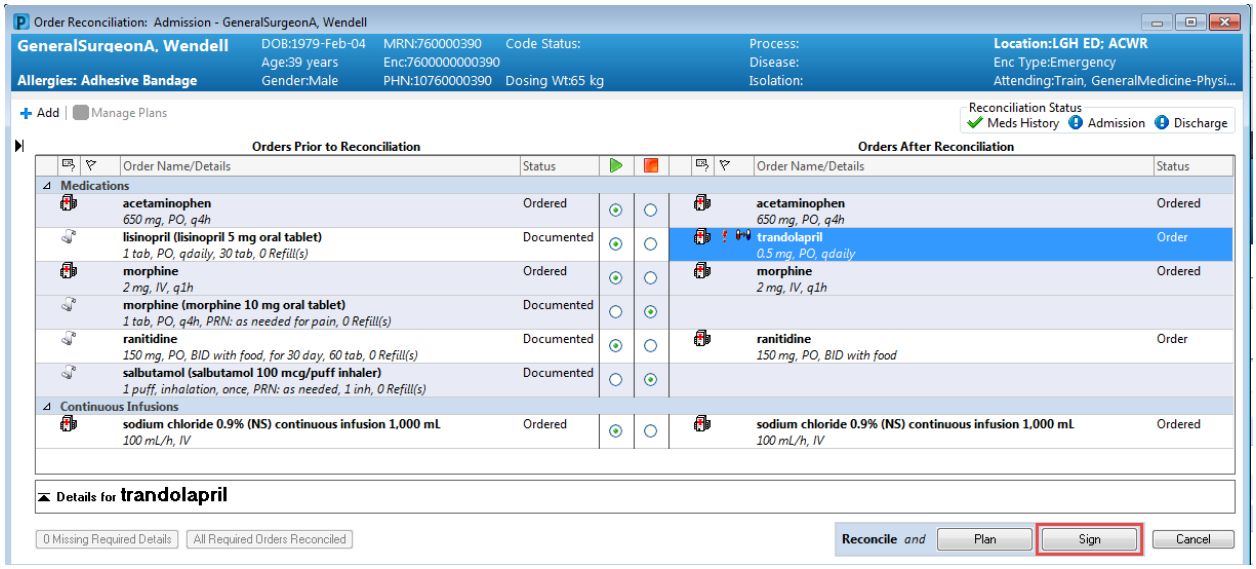


Complete the Admission Reconciliation

1 The admission medication reconciliation cannot be completed unless all orders are addressed. Each medication is either continued or discontinued.

> Do you remember how to collapse the Details panel?
> Do you remember how to ensure that all medication orders have been reconciled?

2 Review the list of **Orders After Reconciliation** on the right side of this window. Click **Sign** to complete the process.



Key Learning Points

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

Activity 1.6 – Review Histories

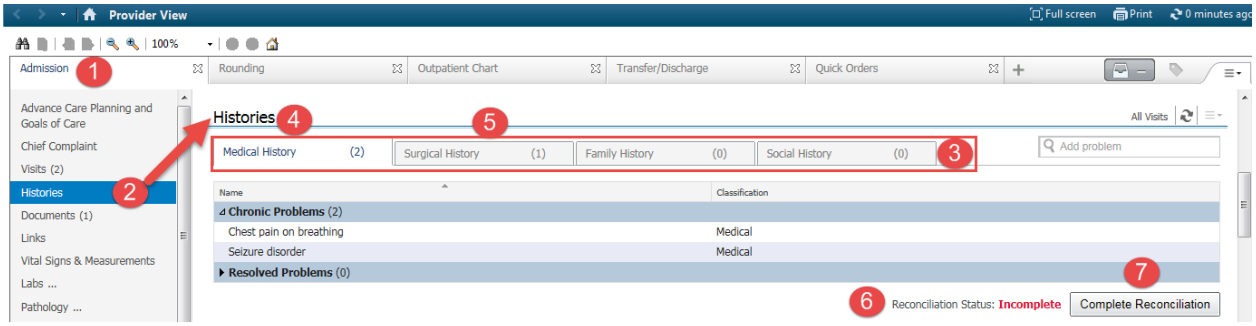
The patient just told you about a knee arthroplasty that last year and you want to enter this information.

In this activity you will:

- Add a new procedure to patient's history

1

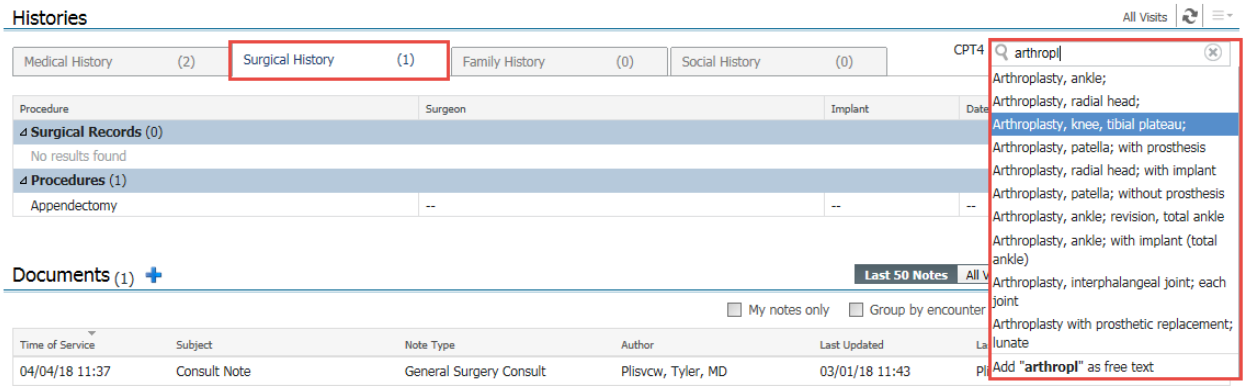
1. Ensure you are in the **Admission** tab.
2. Click the **Histories** component from the list.
3. In this component, there is a separate tab for each history type: Medical, Surgical, Family, Social, and Obs/Gynecology.
4. Select each tab to display its entries right underneath. The number in brackets indicates how many entries are in each tab.
5. For example, the patient's screenshot has 3 records for **Medical History** entered previously.
6. To add a knee arthroplasty procedure, select the **Surgical History** tab.
7. Notice that 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.



2 If a patient had a surgical procedure in the past that has been documented in the CIS, this record will display automatically under the Surgical History.

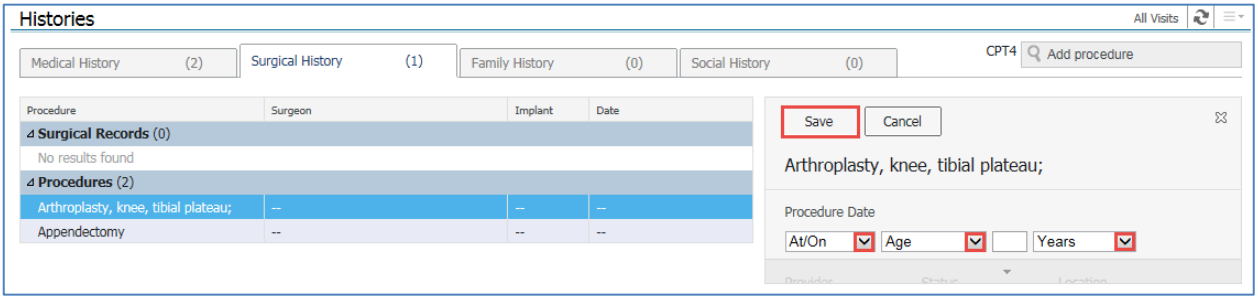
Information about past procedures or procedures performed at sites with no CIS must be added manually:

1. Select the **Surgical History** tab.
2. Click the search box and type *arthroplasty.* A list of options will appear.
3. Select an **Arthroplasty, knee, tibial plateau**.



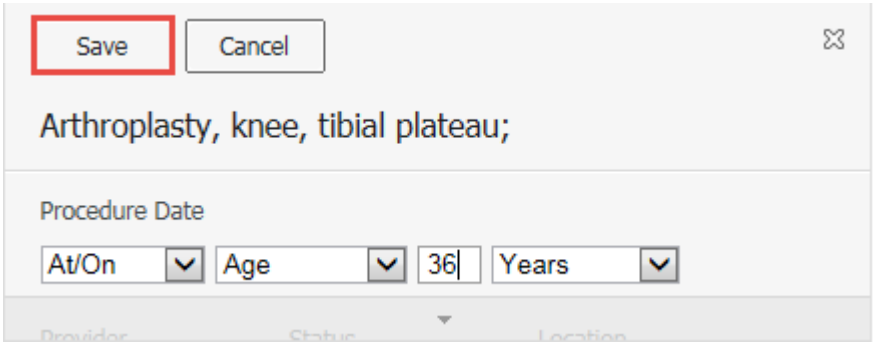
3 Take a look at the patient's record:

1. The selected procedure automatically populates within the Surgical History tab.
2. You can click **Save**, or
3. You can click one of the arrows here to add more details.



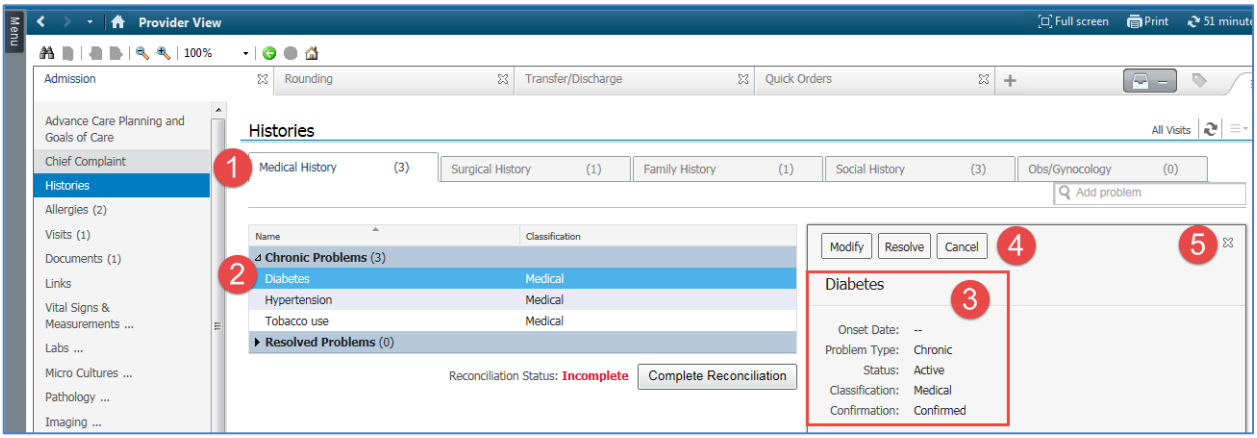
4 Enter procedure date information of *Age 36* years – scroll down, if necessary.

Click **Save.**



5 In the CIS, you can often display more information without leaving the current view.

1. Select the tab for the history you would like to review, for example **Medical History.**
2. Click the item from the list to split the screen, for example **Diabetes**.
3. You will see more information about this entry displayed.
4. You can make changes to this record.
5. To return to the full screen, click the icon.



Key Learning Points

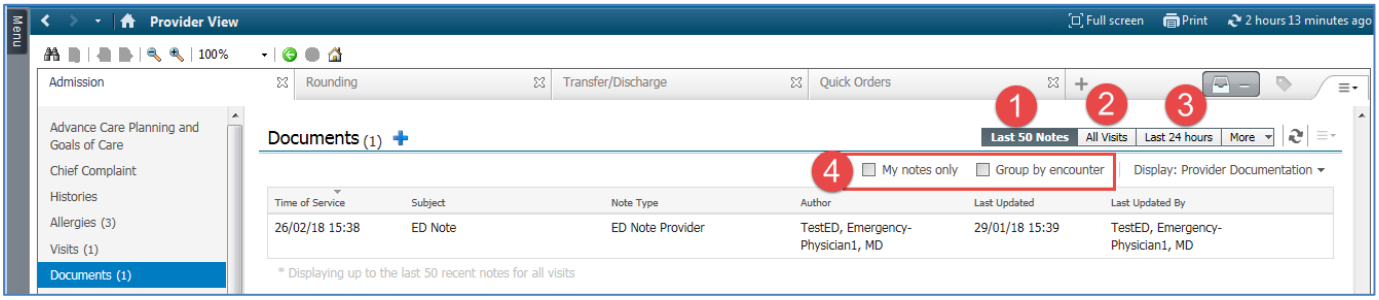
- Histories information including surgical procedures can be added when taking a patient's history.

Activity 1.7 – Review Documents, Labs, and Imaging

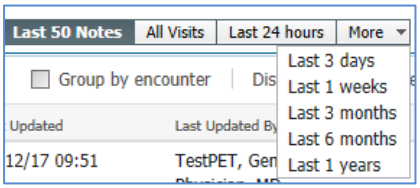
When using the Clinical Information System (CIS), you might be faced with a large amount of **information that you can filter** in many ways. You will learn more about customizing your view later when you become familiar with standard functions. There is not enough information in the Train Domain to demostrate filtering to its potential. The following activity will walk you through some standard steps.

One good example of how to use filters is the **Documents** component:

1. Limit documents to **Last 50 notes**
2. Access notes for **All Visits**
3. Display notes from the **Last 24 hours**
4. Use **My notes only** or **Group by encounter** to see notes for the current encounter only

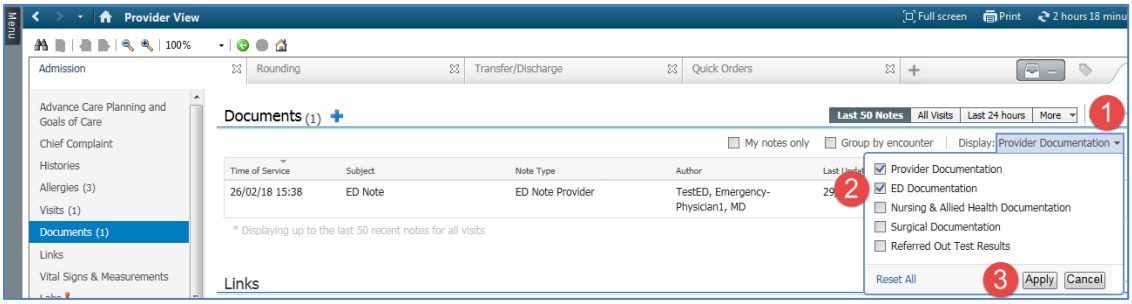


You can also select a custom time range by expanding options under **More**.



You can display notes by a specialty. For example:

1. Expand the **Provider Documentation** list.
2. Check the box to display **ED Documentation** only.
3. Select **Apply**.



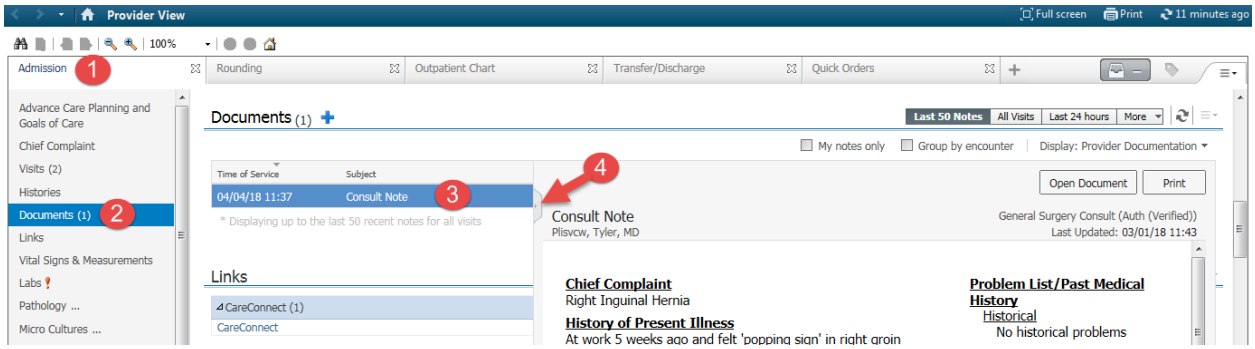
In this activity you will:

- Navigate the chart to review patient's documents and labs

1

With the patient's chart open:

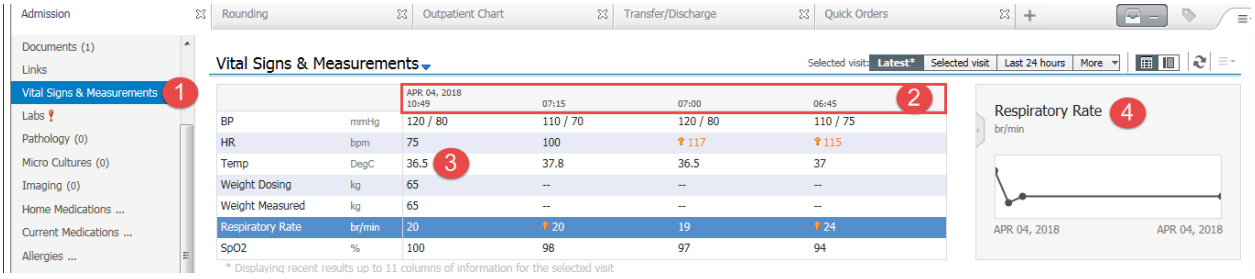
1. Ensure you are in the **Admission** tab.
2. Click **Documents** component on the list to display a list of documents.
3. Select the **Consult Note**. The note content displays for your review.
4. Click the tab highlighted below to close the split screen.



2

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 Temperature 36.5.
4. When you select an item, you can display a graph.

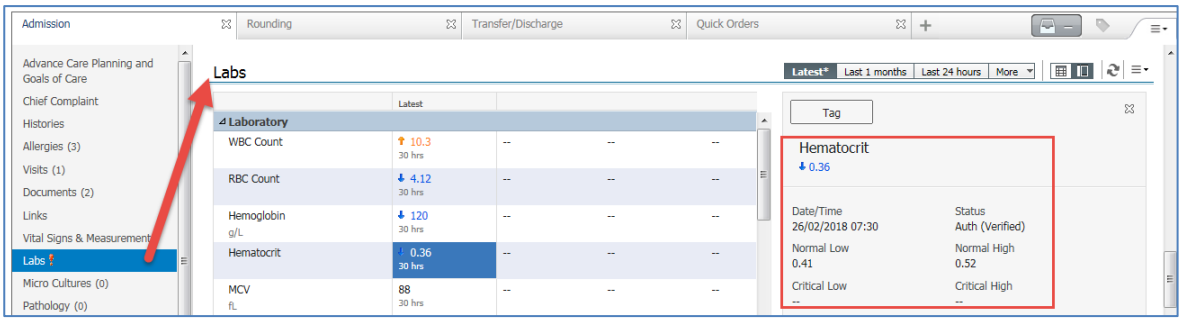
Do you remember how to:
Close the graph window?
Change the view to display results for Last 24 hours?
Refresh this component to include the most recent information?



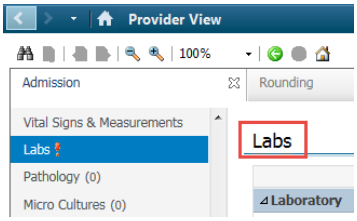
3

The **Labs** component is also a table organized by time. Only labs that have at least one result will display. In real life this list can be very extensive, so filtering will be important.
Remember that filters limit the information and always ensure the selected filter displays what you need to review.

How you can display individual result information it without leaving the current view?
How you can access a more comprehensive window of all results?

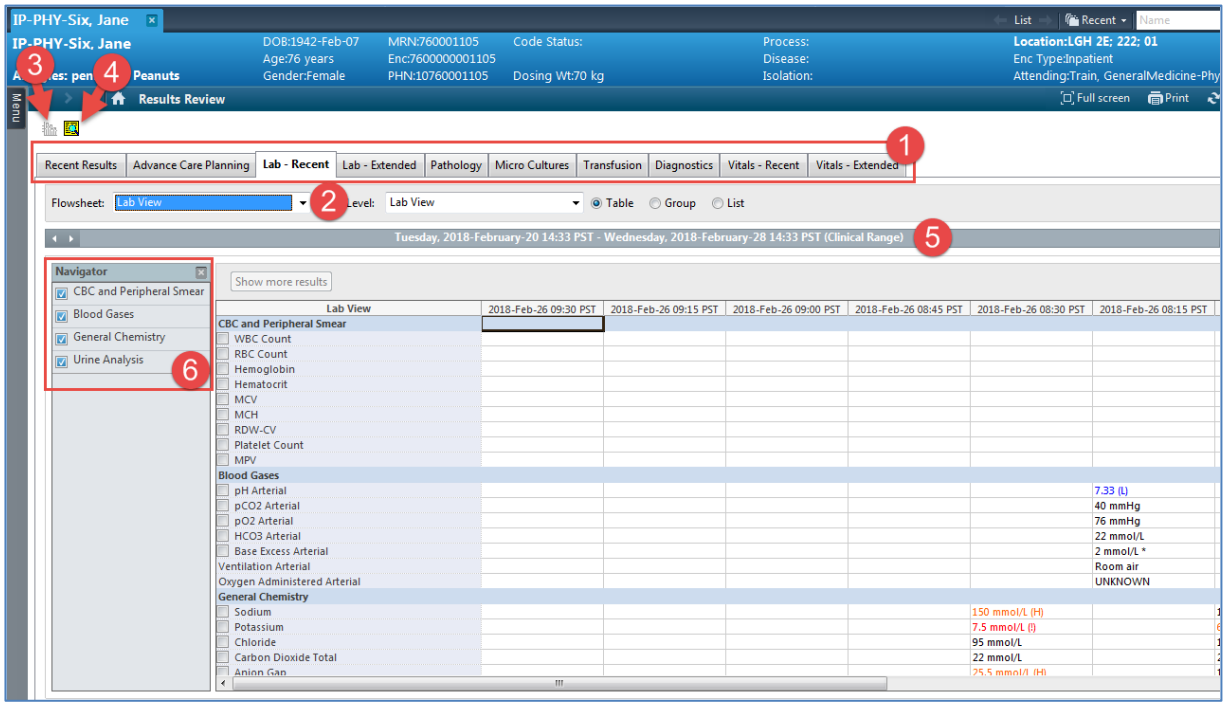


4 When you click the Labs heading, the **Results Review** window displays.



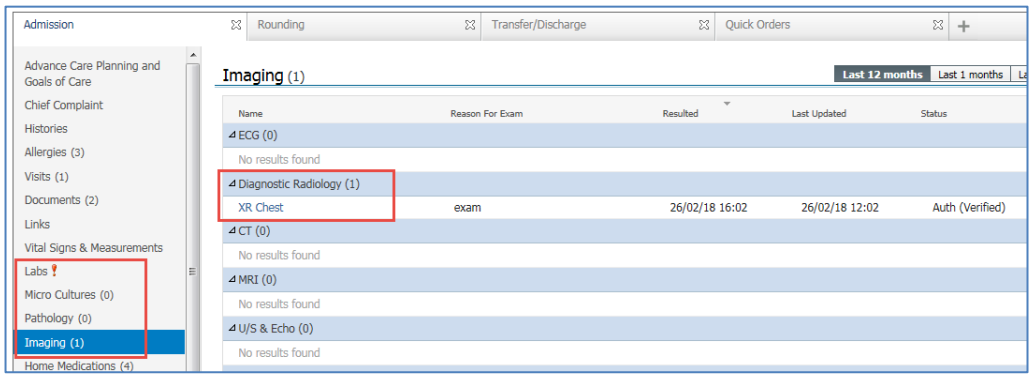
1. Click each tab in the Results Review for comprehensive summaries of patient's results by category.
2. Click the down arrow to select a specific view from the drop-down, for example Anticoagulation View, Pain View, or Respiratory View.
3. Select the result and click the icon to create a graph.
4. For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

How do you ensure that you are reviewing results for the right patient? How do you return to the Provider View?

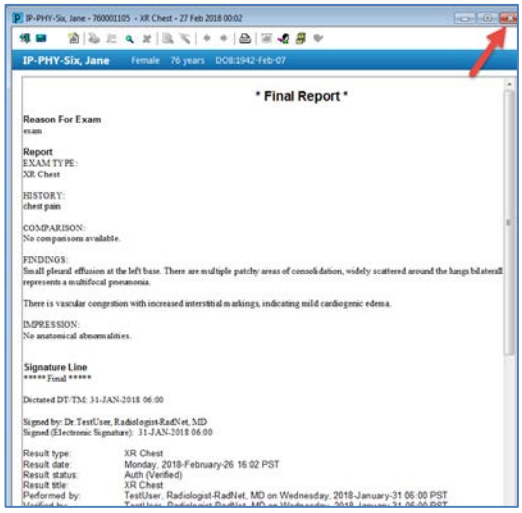


5 If you want to review pathology, microbiology, or diagnostic imaging only, you can select a corresponding component.

Can you display the Imaging component?
Do you remember how to display more information about the XR Chest result listed for the patient?



If you are successful, you should display the following report. Click the ✕ to close this window.



Key Learning Points

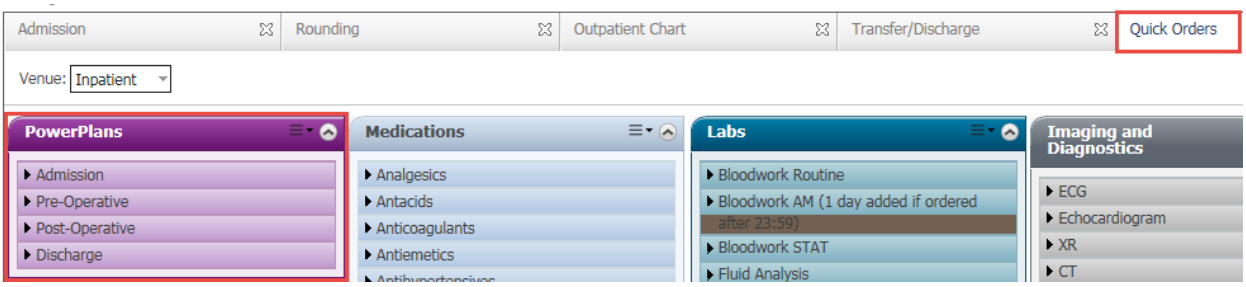
- Using **filters** will display only pertinent information
- Remember to check what filter is selected to ensure that it fits your current needs

Activity 1.8 – Place Admission Orders

After completing medication reconcilation, you are ready to place orders for your patient. You will use a PowerPlan that is specifically designed for admitting patients to the General Surgery 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.

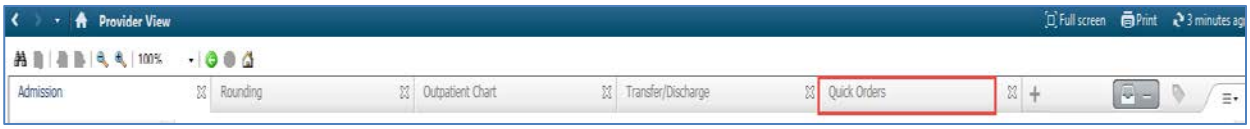


In this activity you will:

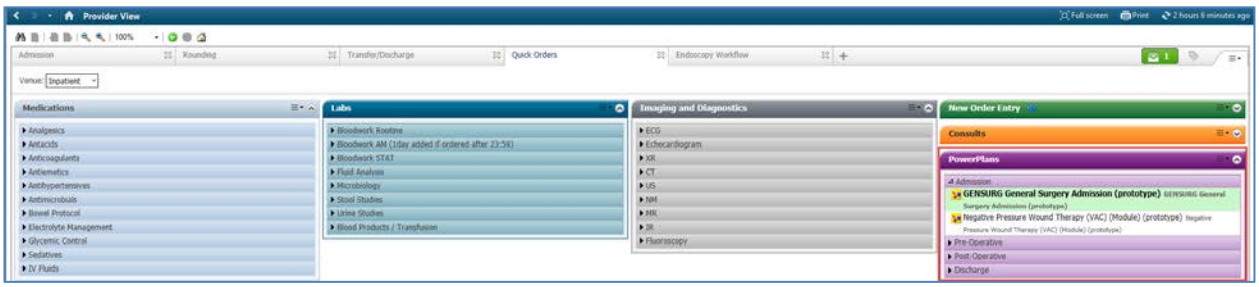
- Select the admission PowerPlan
- Modify the admission PowerPlan

Placing a PowerPlan

1 Navigate to the **Quick Orders** tab and click on it.



2 While you are in Quick Orders tab, let's also include a PowerPlan. Select **GENSURG General Surgery Admission** marked by the icon.



3 Click the Orders for Signature icon 

. When you place the order, it turns green and indicates the number of selected orders waiting for your signature.

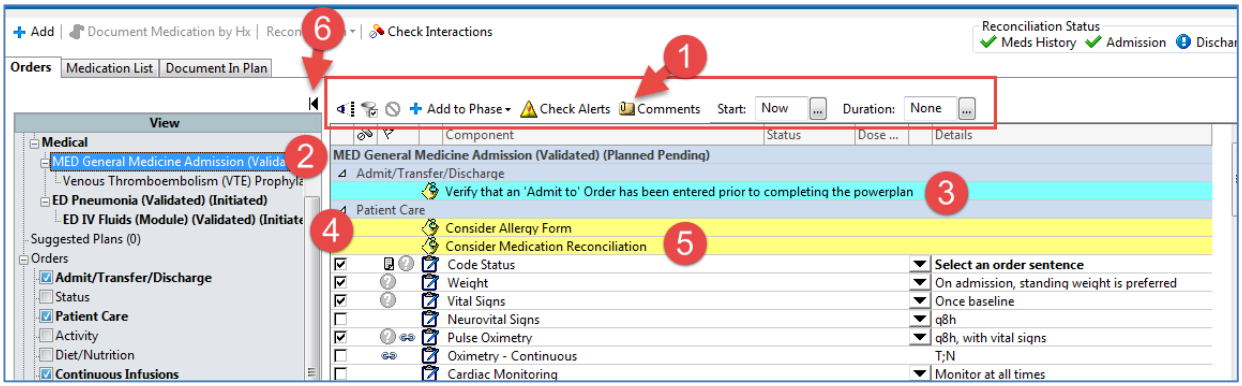
4 Click **Modify**

5 PowerPlans open in the **Orders View** that works like a scratch pad to customize your plan. Scroll through to locate visual cues used to categorize orders:

1. The **toolbar** provides you with tools, for example

   clicking the 

   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.



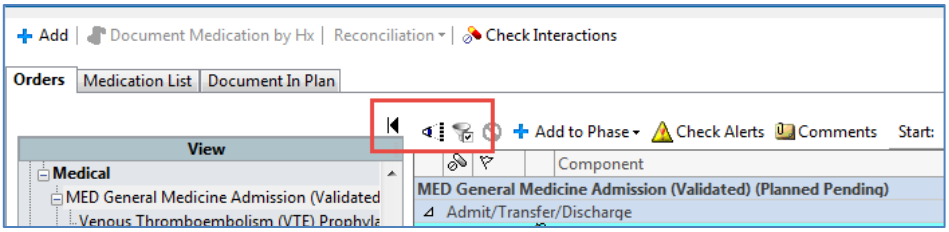
6 Toolbar icons flex the display of the PowerPlan to facilitate easier review. For example:

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

Merges your planned orders with existing orders to avoid duplicating an order. However, the CIS will warn you about order duplications for specific types of orders.

Displays selected orders only.

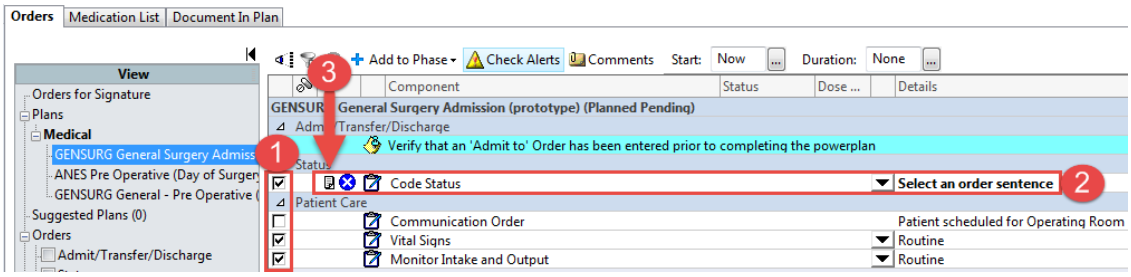
Click the button to review what orders have been selected by default in this PowerPlan. Click again to return to the full list.



Modifying a PowerPlan

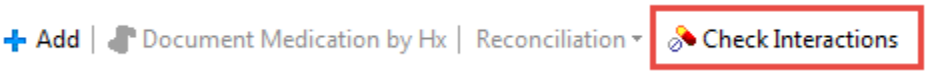
1 You can adapt PowerPlans to fit your needs.

1. Click the corresponding box **to select or deselect individual orders** from the PowerPlan. Some orders are already pre-selected for efficiency but you can click the box to deselect, if necessary.
2. **Code Status** order is pre-selected but you need to select the order sentence.
   This is why the icon is next to this order. This is a standard icon indicating missing details.
   Click to select one of the options.
3. Clicking this icon opens a window with additional clinical decision support information.

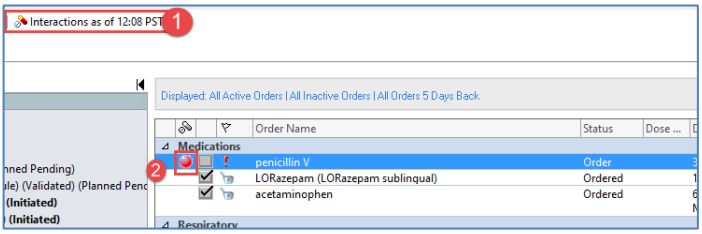


NOTE: If you are ordering a Diet, only one type of Diet Order can be entered at a time for your patient. The system prevents two contradicting orders to be placed at the same time. In other situations, orders might be linked so that they can automatically be placed together.

2 PowerChart also allows you to check all drug-to-drug interactions when ordering medications by clicking the **Check Interactions** button within the Medication List.



For example the patient is allergic to penicillin, however an order for penicillin V was ordered. After Clicking on the interactions you see the following



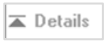
1. The time that the interactions was checked
2. The item that is in conflict.

3 Code Status order is pre-selected but the order sentence for the appropriate option needs to be chosen. Click  to select one of the options.

NOTE: The  icon next to the order indicates missing details. This is a standard icon across the entire PowerChart.

4 Adding the following orders to the PowerPlan:

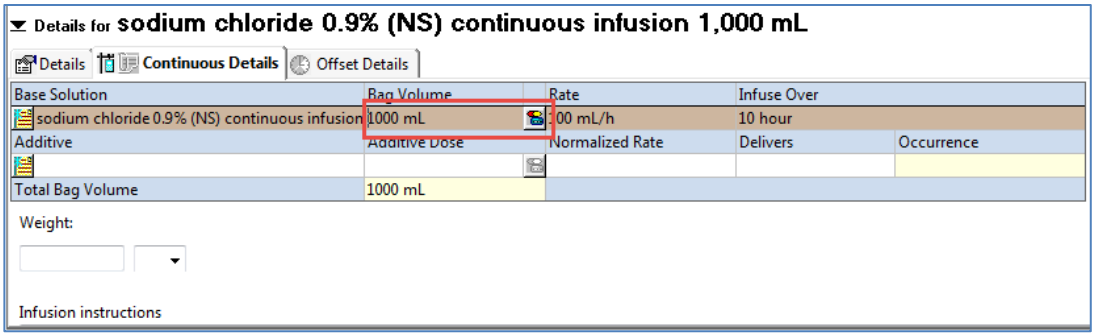
- Venous Thromboembolism Prophylaxis
- NPO
- Ringers Lactate IV at 100cc/h
- CBC and Diff in am
- Lorazepam 1 mg SL QHS PRN

Remember to click the 

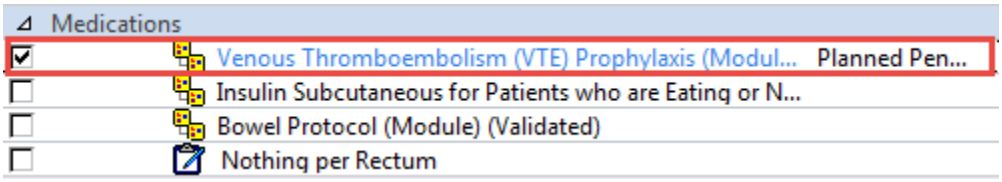
button to expand or collapse the order details view.

NOTE: You can select details provided by the order sentence or change details manually in the Details view.

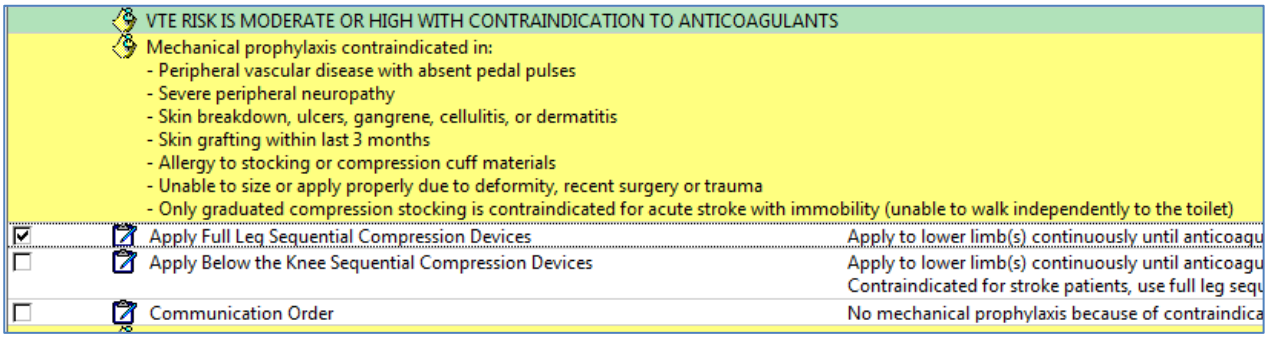
For any IV infusion PowerChart requires the Bag Volume be entered:



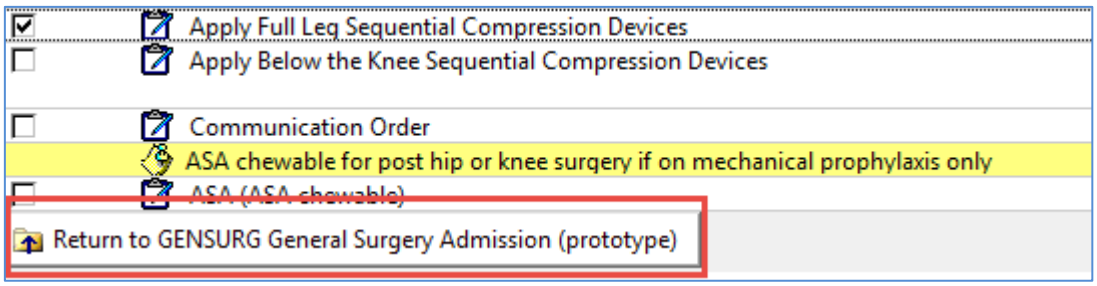
5 When Venous Thromboembolism (VTE) Prophylaxis module is selected, a module opens.



6 The submodule is now open. Scroll down and select **Apply Full Leg Sequential Compression Devices**

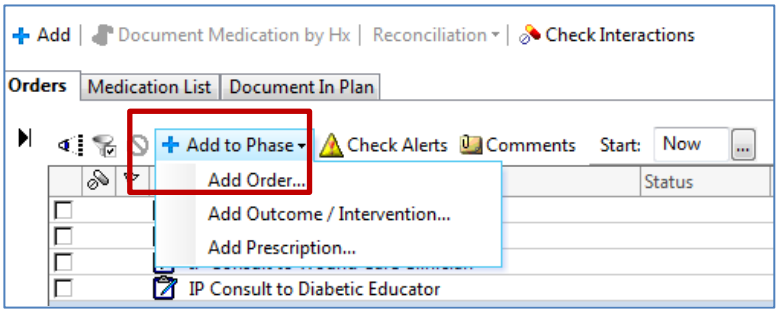


7 At top or bottom of the window click the **Return to GENSURG General Surgery Admission (prototype)** to return the PowerPlan.



8 **Adding to Phase while in PowerPlan**

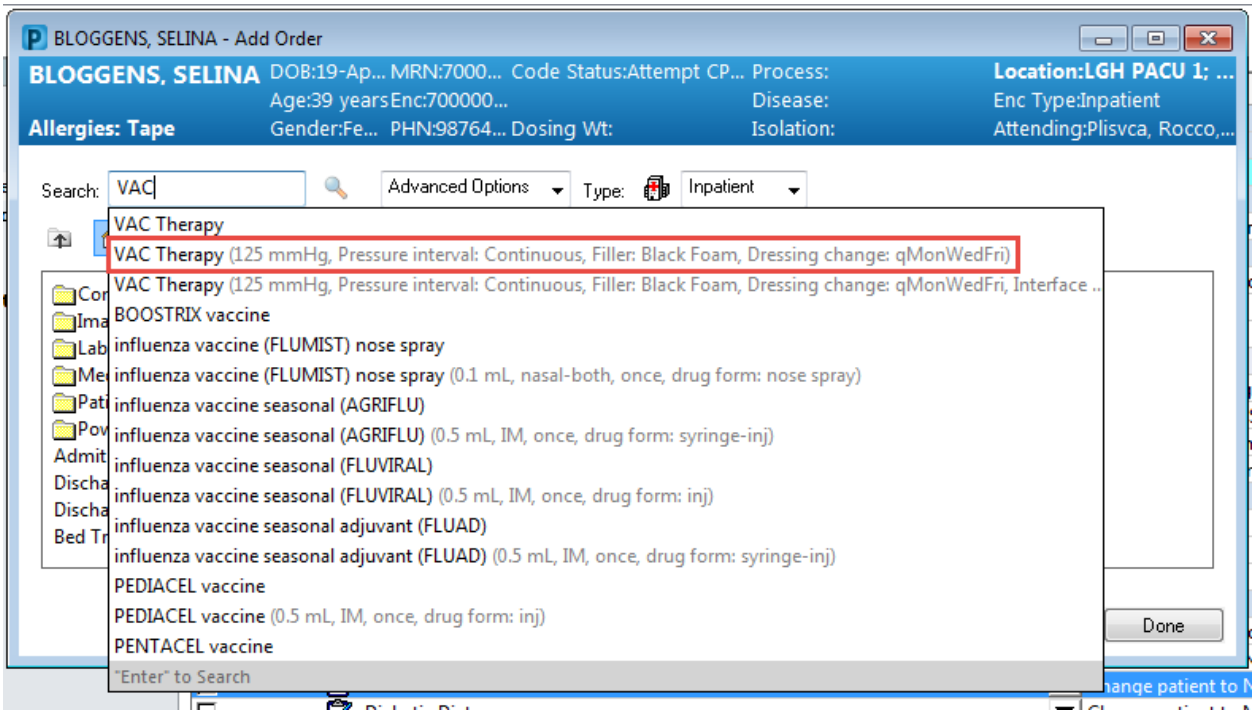
You want to add some orders that are not part of the PowerPlan. Click + **Add to Phase** button.



9 Select **Add Order**

10 Search the order catalogue for:

- VAC Therapy (125mmHg, Pressure interval: Continuous, Filler: Black Foam, Dressing change: qMonWedFri)



11 Click **Done**

12 After making needed adjustments to the PowerPlan, finish the process.

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

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

If you want orders you place to be **activated later,** use **the1 step process**:

1. 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.

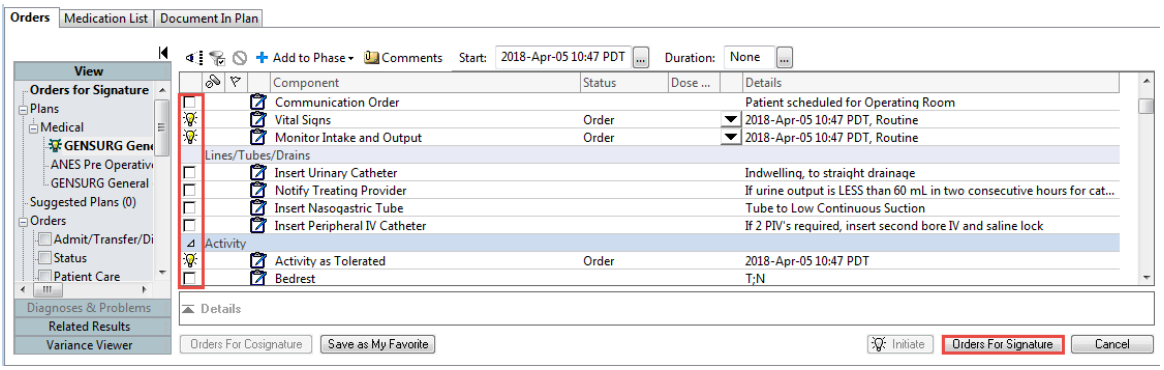
For your current patient, you are done with the power plan and would like to initiate immediately. Click **Initiate** 

.

NOTE: Initiated PowerPlans and phases are **bolded**.

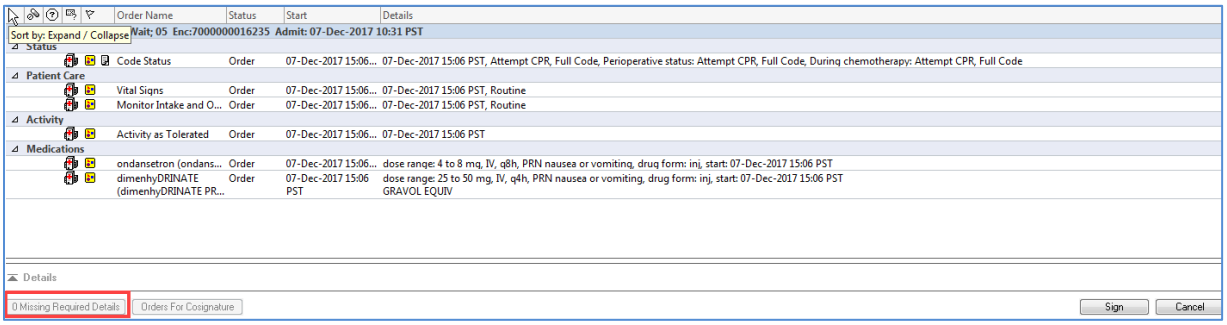
WARNING: **Click Initiate first to ensure that all selected orders are immediately active.** If you **do not** Initiate the PowerPlan and click **Sign only**, the orders are **not active**. The PowerPlan remains in planned state until it is activated later by a provider or a nurse assigned to this patient. For example, you could place the GENSURG General Surgery Admission PowerPlan in a planned state when the patient was still in ED. The surgical daycare nurse will initiate the PowerPlan order upon patient's arrival on the Unit. Only then will the orders become active.

13 Once Initiate is selected, the Orders View displays the icon next to your initiated orders. Click **Orders For Signature** Orders For Signature. Only selected and initiated orders will display. Review all the orders for the last time.



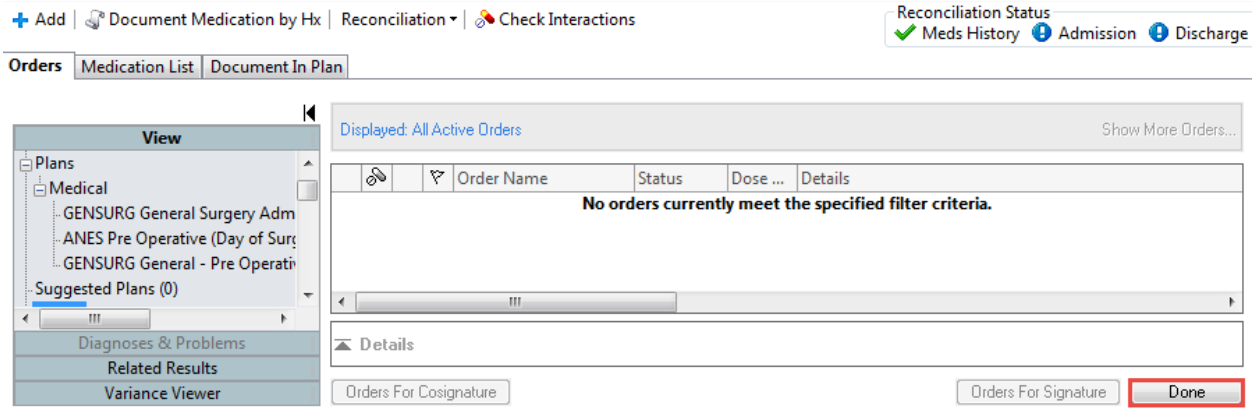
NOTE: If you click **Cancel** at this point, **no orders** will be placed or actioned.

14 With only selected orders displayed, you can review your PowePlan. Click **Sign**.



NOTE: If there are any missing details the **Missing Required Detail** button will be illuminated with the number of missing details.

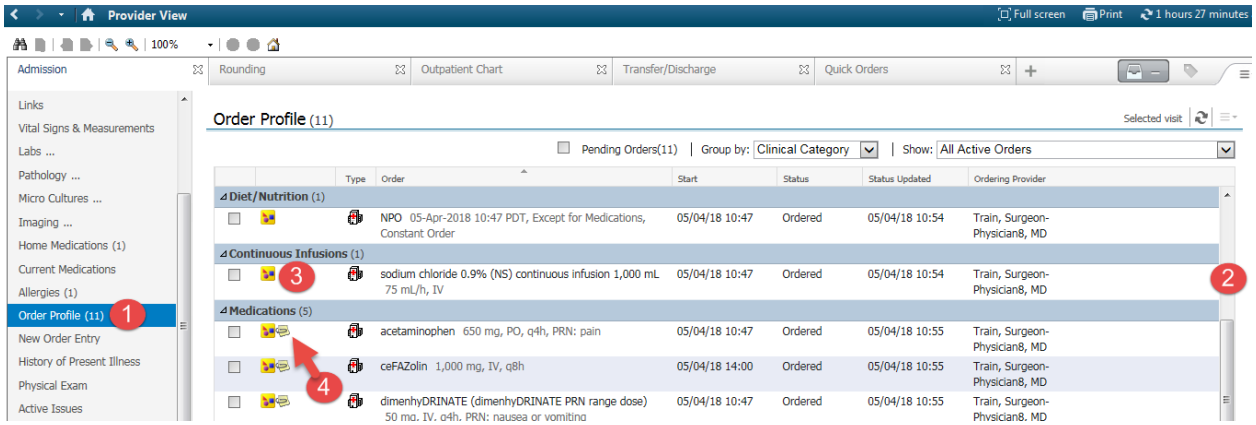
Now, all orders for the patient will display. Click **Done** to close this window.



To view all active orders

Ensure you are in the **Admission** tab.

1. Click the **Order Profile** component to display all currently active orders for the patient.
2. Scroll down to display medications.
3. The icon indicates that the order is part of the PowerPlan.
4. Use hover to discover to see what information the icon provides.



WARNING: PowerPlans that are in a planned status, signed but not initiated, are not listed under Orders Profile. Click on the Order Profile heading for a more detailed review of orders including those in the planned state.

Key Learning Points

- **PowerPlans** are similar to pre-printed orders
- You can select and add new orders not listed in the PowerPlan by using Add to Phase functionality
- You can select from available **order sentences** using drop-down lists or modify details manually where needed
- **Initiate and Sign** (2 step process) means that PowerPlan orders are immediately active and as such, can be actioned right away by the appropriate individuals
- Sign will place orders into a **planned** state for future activation

Activity 1.9 – Complete your Documentation on HPI, Physical Exam, and Active Issues

Now that you have entered your admission orders, you are ready to continue updating the chart. The next components are:

- History of Present Illness
- Physical Exam
- Active Issues

The above are called free text components. You can type or dictate directly into them. There is no limitation on length. Front end speech recognition (FESR) software captures your dictation directly into PowerChart. Note that FESR will not be part of this activity.

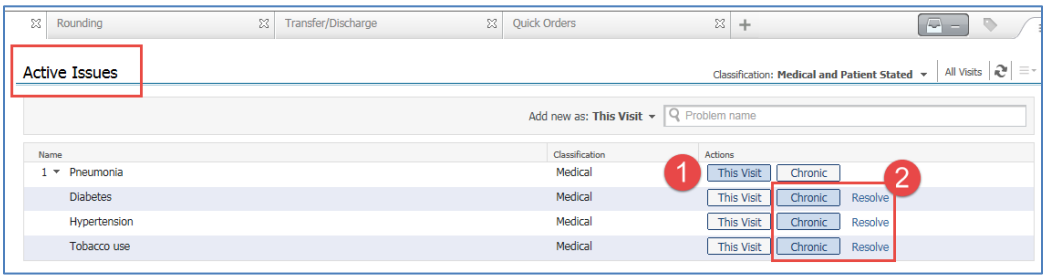
When you reach the **Active Issues** component, you will notice it is identical to the component we used to add an admitting diagnosis.

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 **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 (e.g. 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.

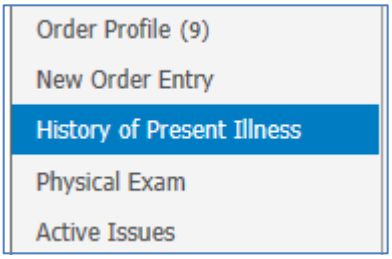


The diagnoses and problems recorded in the Active Issues component as chronic will carry over from

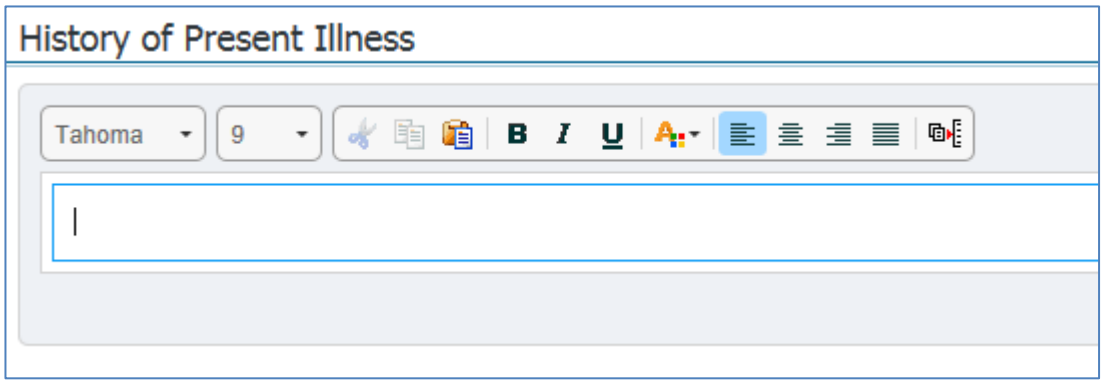
visit to visit, which builds a comprehensive summary of the patient's health record. Keeping a patient's problems and diagnosis up-to-date is important.

NOTE: Any documentation in the Assessment and Plan component under the Admission tab will only auto-populate the Assessment and Plan section within the Gen Surg Admission Note template as an example of dynamic documentation. Make sure to click the Refresh button after creating your Assessment and Plan content to have it appear in the Gen Surg Admission Note.

1 Click on the **History of Present Illness** component from the component list.

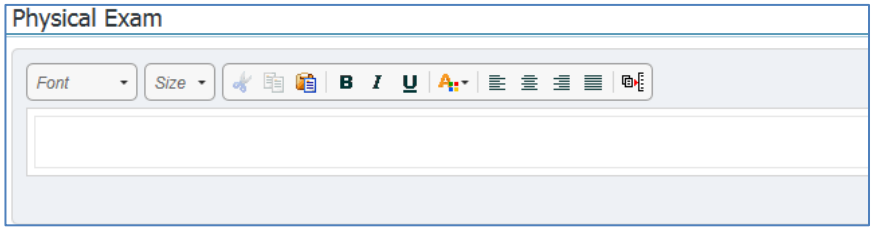


2 Click the blank space under **History of Present Illness** to activate the free text box and type some text. For example: "One week history of constipation and progressively worsening abdominal pain."



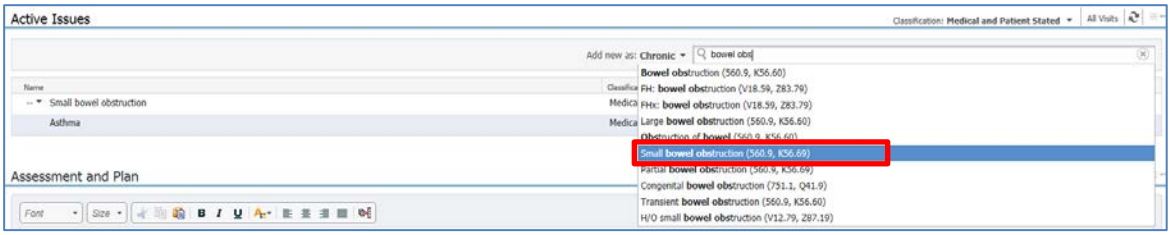
When done click on **Save**.

3 Continue adding your notes in the **Physical Exam** component.

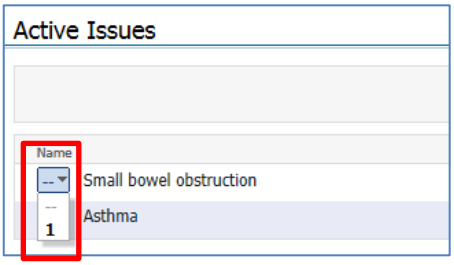


When done click on **Save**.

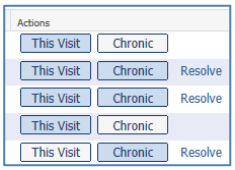
4 Next, select **Active Issues** component**.** To add bowel obstruction to patient's issues, select **This Visit** and begin typing *bowel obs.*



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



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

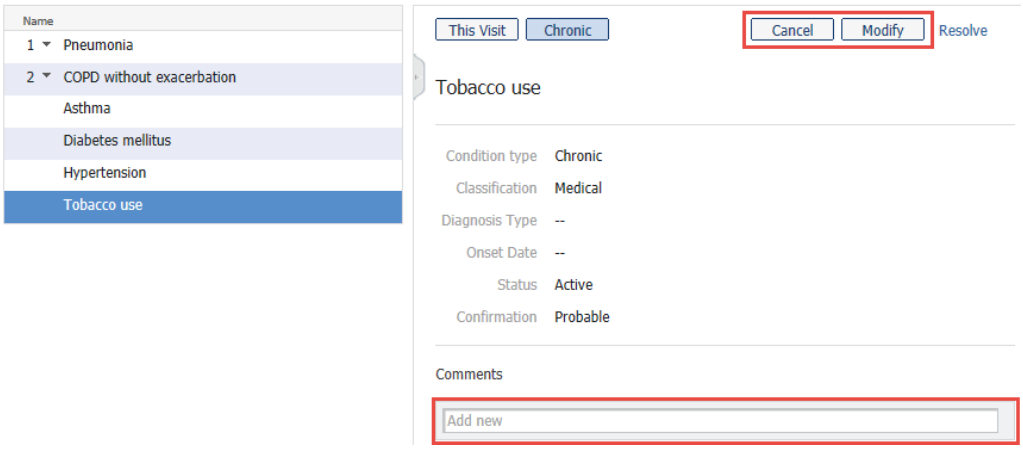


- You can change any This Visit diagnosis to a Chronic problem or both by clicking the appropriate buttons.

- You can also click **Resolve** to move a problem to the Historical section.

6 Click the active issue to display more details. Without leaving this view, you can:

- **Cancel** this problem
- **Modify** to update, for example, the **Status**
- Type **Comments**, especially if making any changes



7 For you practice:

- Add *obesity* as a chronic problem and resolve it.

Remember to click the tab in the middle to collapse and remove the split screen.

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. If patient improves over the course of hospitalization
- **Chronic** refers to past medical history that may be active during this hospitalization or may have already resolved prior to admission

Activity 1.10 – Complete Admission Note

As the last step of admitting the patient to the General Surgery Unit, 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.

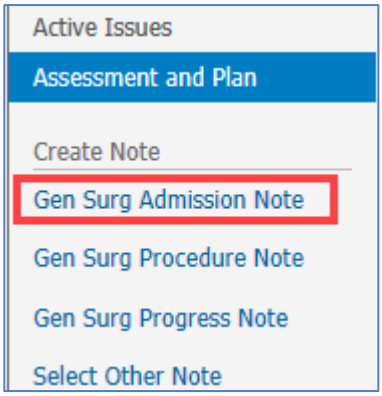
Dynamic Documentation can save you time by populating a note with items you have reviewed and entered in the workflow tab, in this case, in the Admission tab. This is why **it is more efficient to create the note as the last step** of the admission process. You can also add new information directly into the note by typing or dictating using front end speech recognition (FESR) software.

Workflow pages such as Admission, Rounding, and Transfer/Discharge have a **Create Note** section. Different note templates can be found here and each note type is listed as a link. With one click on the desired link, the CIS generates the selected charting note.

In this activity you will:

- Create an admission note from already entered information
- Edit and complete the admission note

1 Navigate to the **Create Note** section.

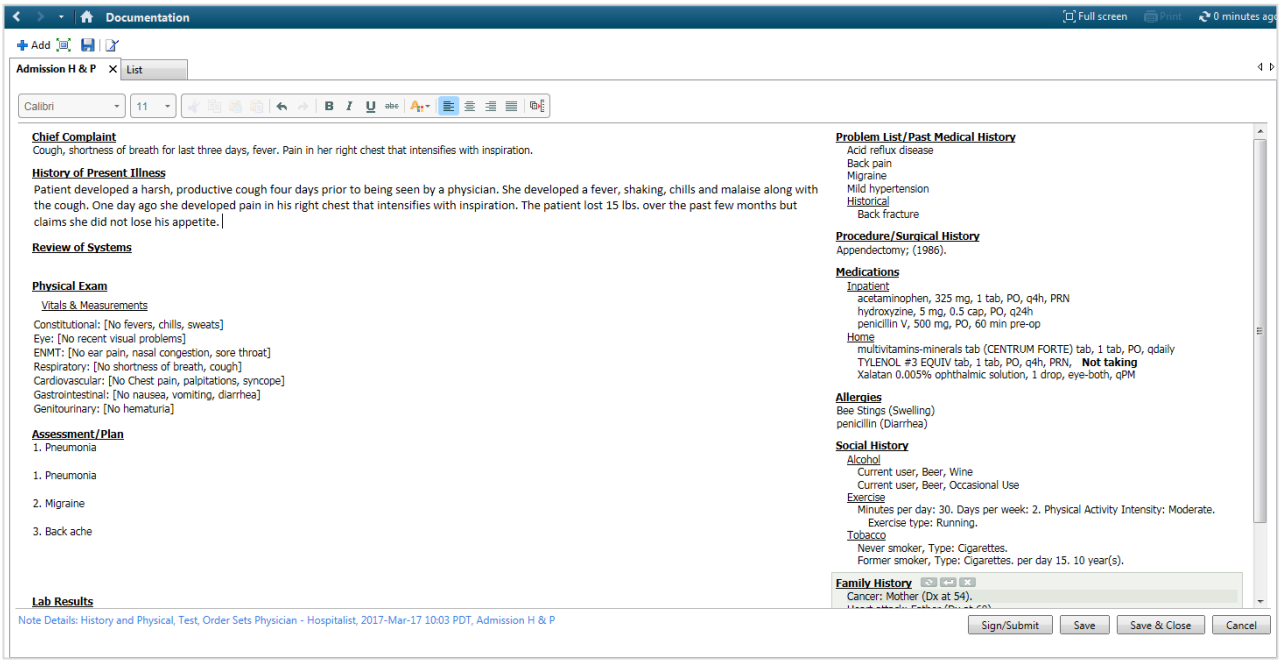


2 To document an admission, click **Gen Surg Admission Note**.

3 The draft note displays in edit mode.

It is **pre-populated with specific information** captured by you and other clinicians saving you time.

Scroll to review different sections of this note in both columns.

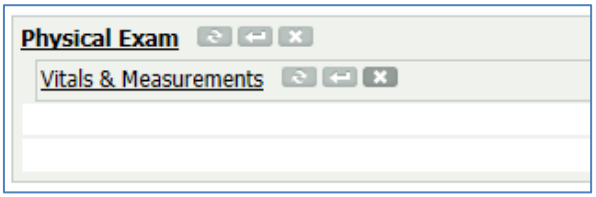


4 Position your cursor over the heading of any section to activate a small toolbar:

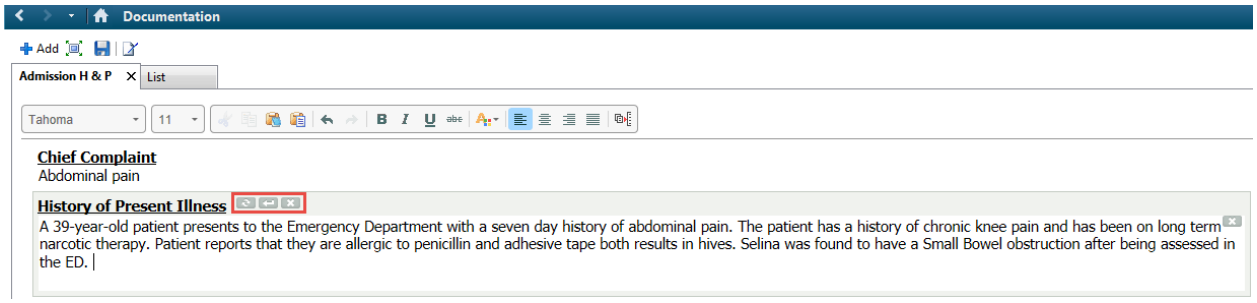
refreshes the dynamic information in the box

activates the box for edits or new entries

removes the entire section or content of the box

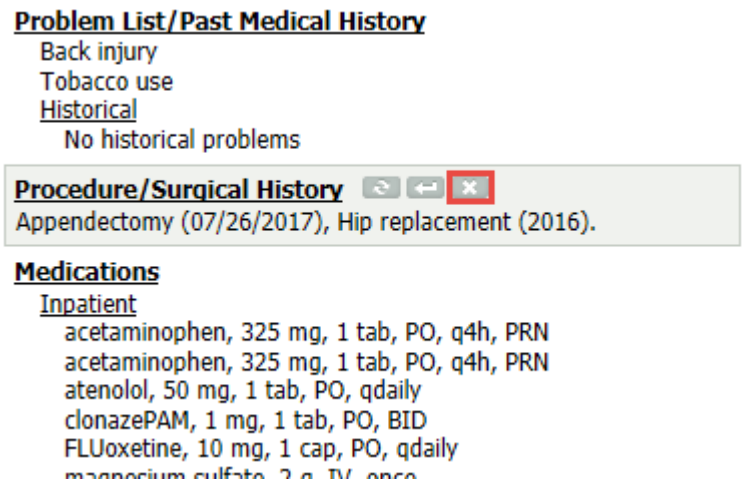


5 For editing the existing text, click into the box, for example **History of Present Illness**. It becomes active and you can select the text to add or delete as needed.

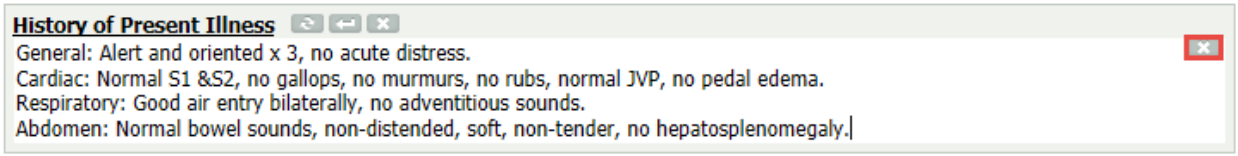


NOTE: PowerChart offers **Auto-Text** phrases that can be used within Provider documentation to quickly and easily insert note templates, and pull in patient data with smart templates. This will be discussed further in Activity 3.2.

6 You can remove section(s) that are not required or are currently blank. For example, place the cursor over the heading and click to remove the entire section.

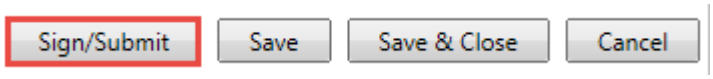


7 You can remove the entire content of a section, by activating the text box and click . For example, you can remove the content in the History of Present Illness and type a new text.



8 Review the **Assessment/Plan** section. It is populated with the diagnosis you have entered. Enter "*Plan is to take patient to surgery as a less than 8. Will make the patient NPO.*"

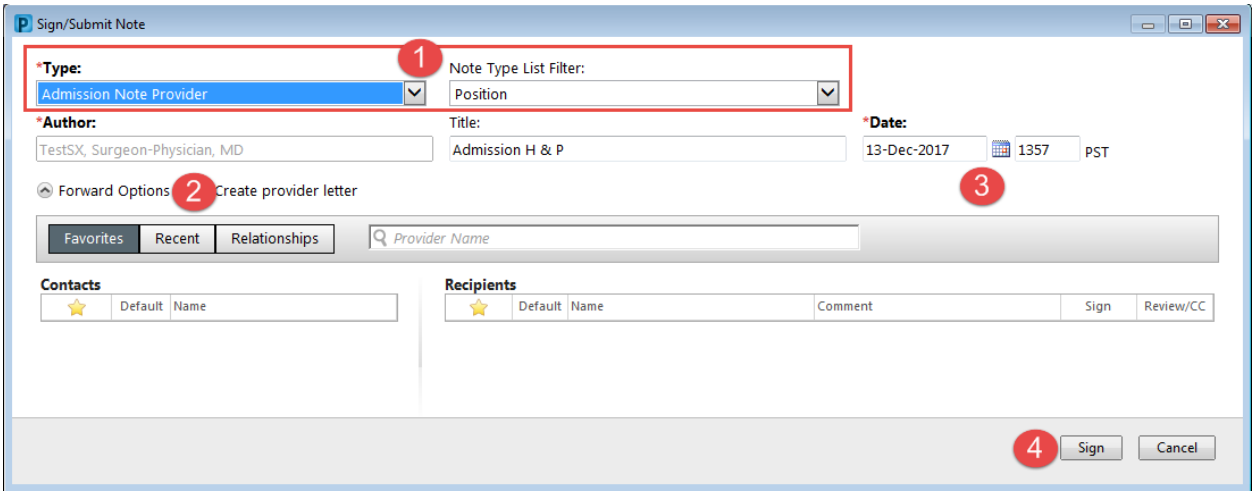
9 To complete your note, click **Sign/Submit.**



NOTE: You can click **Save** or **Save & Close** to continue to work on this document later. Saved documents are **not visible** to other care team members and must be signed to become visible.

10 In the **Sign/Submit window**, typically no changes are required if you use a link from Create Note section.

1. Note **Type** and **Title** are already populated but you can edit the **Title** to potentially make future searching easier. For example, you could name the title of the admission note: *Admission H & P*.
2. You will learn later how to use the **Forward** option to send copies of the admission note to other providers.
3. The **Date** box auto-populates with the current date. Ensure that it indicates the date of patient's admission, not the date the note is created.
4. Click **Sign** to complete the process.



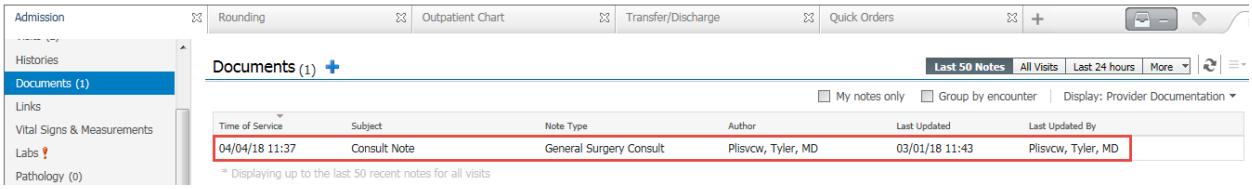
NOTE: Patients primary provider will be sent a copy of all reports.

11 Once you sign the note, its contents **cannot be directly edited;** however, changes can be made to the note in the form of an addendum. You can learn how to add an addendum from eLearning modules.

After signing the note, you are transferred back to the Admission tab.

> Do you remember how to display the **Documents** component.
> Do you know why you might not see your document listed there?

The admission note is now listed and is visible to the entire care team.



12 If you want to close this patient chart, click the **X** icon on the Banner Bar.

Key Learning Points

- Using **Dynamic Documentation** to prepare notes standardizes documentation practices
- Use note links listed under the **Create Note** sections to produce documents efficiently
- Only when a note is **signed and submitted** will it be visible to the rest of the care team
- Saved notes remain in a **draft** format and are visible only to you
- Once you sign and submit a note, further edits can be added but will appear as **addenda**

PATIENT SCENARIO 2 – Rounds

Learning Objectives

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

- Place Single Orders
- Place as PowerPlan in a planned State

SCENARIO

On PAD 1 you are doing your rounds on the floor for Patient. You need to review the vitals from overnight and nursing documentation. The patient states that they are having a minor flare up of their asthma but state that they do not require any medication at this time. As you round, you find out that the OR has found time for your patient's surgery. You need to order pre-op antibiotics. As it is a busy OR day you also want to place the post orders to save time.

You will complete the following activities:

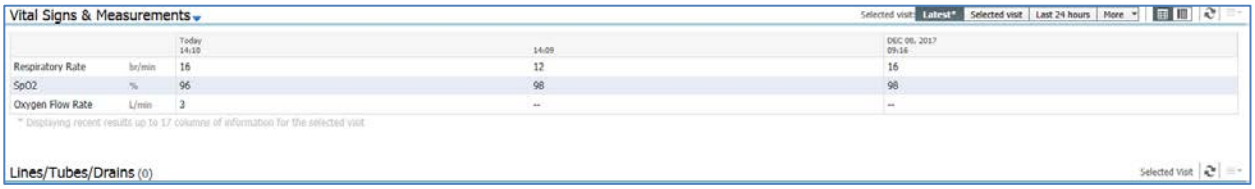
- Place a single/Ad Hoc order
- Placing a PowerPlan in a planned state

Activity 2.1 – Review Vital Signs

The next morning you are doing your rounds and you are wondering how your patient did overnight.

In PowerChart all vital signs that are charted in this encounter, regardless of source, all flow into the same table.

1 Ensure you have opened the correct patient chart. From the Rounding Tab workflow view, Select the Vitals Signs & Measurements component on the left or scroll down on the right to land on Vital Signs & Measurements.



The time frame for the displayed data is defaulted to the Latest results. This can be with the boxes and/or the dropdown menu.

2 From Vital Signs & Measurements click the name of the results you want to graph.

Key Learning Points

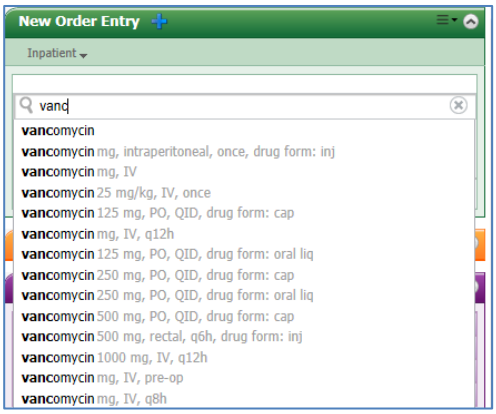
- Vital Signs view aggregates vital signs from across the patient chart.
- Views based on time frames can be filtered.
- Vital Signs can be graphed for Trends.

Activity 2.2 - Placing a single order (Ad Hoc)

As you are rounding you notice that your patient is missing their pre-op antibiotic. You decide to order it as part of your rounds.

Typically, your selection of multiphase PowerPlans should capture all the orders you will require. However, there will be instances where you would like to add additional ad hoc orders or revise orders.

1 Click on Quick Order tab on the work flow view

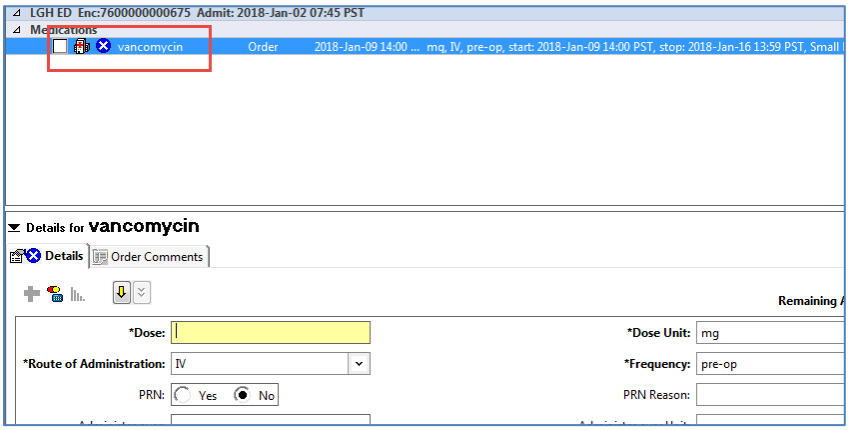


2 Start entering text of the order in the search box. As you type PowerChart will populate a results box with orders that match the search string. In this case you want to place an order for Vancomycin, since the patient has a penicillin allergy. Type in “Vanc”. Select the order sentence **“vancomycin (mg, iv, pre-op)**.

3 Click on orders for signature 

4 Click **Modify**

5 Click on the medication with the to bring up the details pane.



Orders requiring details before being completed are marked by

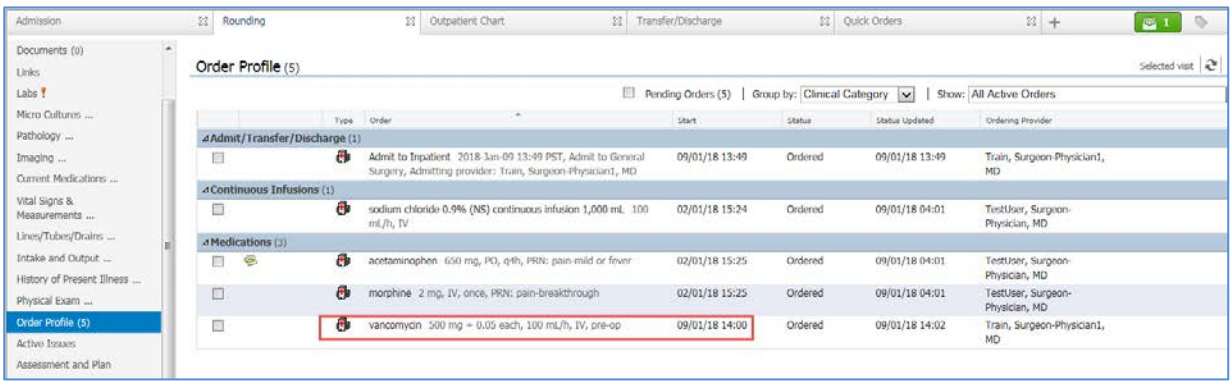
6 Fill in *500* in the dose field (yellow box).

Yellow boxes are order entry fields that required to be filled out.

7 Click **Sign**

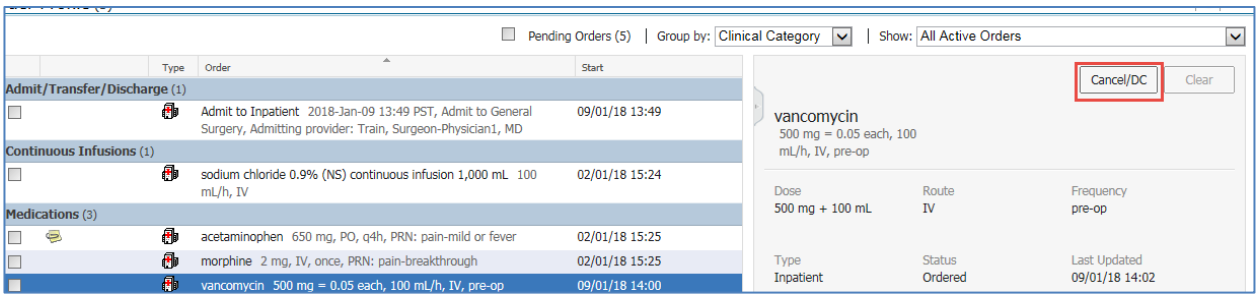
8 After placing the order for vancomycin, you realize that the dose should have been 1000mg not 500mg. As long as an order has not been signed you can modify it in the Order Entry Field. Once the order has been signed the order you want to modify has to be cancelled. This has to be done since the barcode generated for the medication is unique.

Go to the **Rounding Tab** and then Order profile.



Click on the vancomycin order.

9



Click on **Cancel/DC.**

10

Then the Order for Signature icon 

.

11

Finally click **Sign** button.

12

Enter an order for Vancomycin 1000 mg IV pre-op using the steps above.

Key Learning Points

- The recommended practice to access orders from the Quick Orders tab or from the workflow view.
- Ad hoc/Single Order that have been signed and require changes should be cancelled and new order should be made.

Activity 2.3 – Placing a PowerPlan in a Planned State

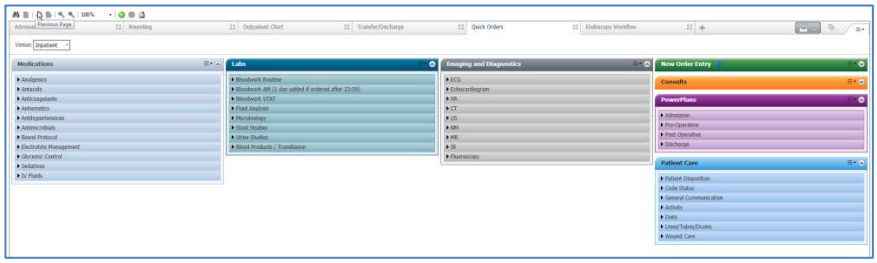
During rounds, you want to place your Patient's post-op orders in a planned state since it is a busy day. This is done by ordering the "Gensurg General – Post operative (Multiphase)" and placing it in the planned state.

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

When you **Sign** a PowerPlan that is **not** initiated, it remains in a planned stage, allowing to prepare orders for a future activation as needed by authorized individuals e.g. RN's.

Another use of PowerPlans that are not intitiated are Pre-op orders that are placed in your office or clinic, that will be intitiated by a RN in the admission process.

1 As with the admission PowerPlan, the best option for placing PowerPlans and orders is via the Quick Orders tab. This view is a one-stop shop for common orders and PowerPlans organized in separate categories.

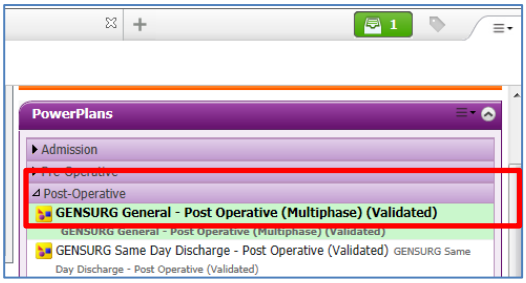


Categories and folders can be collapsed or expanded by clicking the expansion arrows and

NOTE: Order availability and lay out on the quick order page are based on the user's position and/or specialty.

2 Placing a PowerPlan

1. In the **Quick Orders** tab, expand the Post-Operative folder.
2. Select the **Gensurg General – Post operative (Multiphase)**. PowerPlans are marked by the icon.



3. Click on the **Orders for Signature** icon 1.
4. Click **Modify:**
5. The PowerPlan window will display.

PowerPlans open in the Plan Navigator. Scroll through to locate visual cues organizing orders:

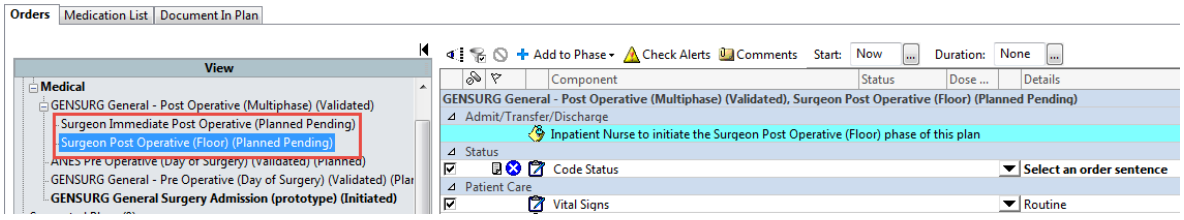
- Bright blue highlighted text for critical reminders
- Bright yellow highlights for clinical decision support information
- Light blue highlights that separate categories of orders.

3 Modifying A PowerPlan

1. Click the corresponding box to select or deselect individual orders from the PowerPlan. Some orders are already pre-selected for efficiency but you can click the box to deselect, if necessary.

   Click toolbar icons to flex the display of the PowerPlan to facilitate easier review.

   As this is a **Multiphase PowerPlan**, first click on **Surgeon Post Operative (Floor)** to locate the Code Status.



NOTE: All phases of Multiphase PowerPlans open by default; therefore, all orders from all phases are immediately visible. You can toggle between phases to easily locate your orders based on phases. You can view a single phase by clicking on the navigator pane (view) as per the screenshot above.

Code Status order is pre-selected but the order sentence for the appropriate option needs to be chosen.

Click to select one of the options.

NOTE: The icon next to the order indicates missing details. This is a standard icon across the entire PowerChart.

2. Continue adding the following orders to the Power Plan:

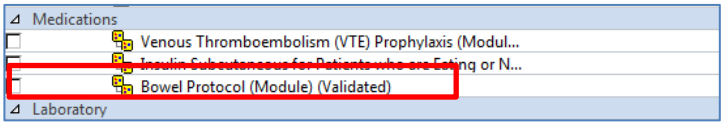
   Remember to click the Details button to expand or collapse the order details view.

   - In and Out Catheterization
   - Remove Staples
   - Sodium chloride 0.9% at 100ml/h
   - Ciprofloxacin 400 mg iv
   - General Diet

NOTE: You can select details provided by the order sentence or change details manually in the details view.

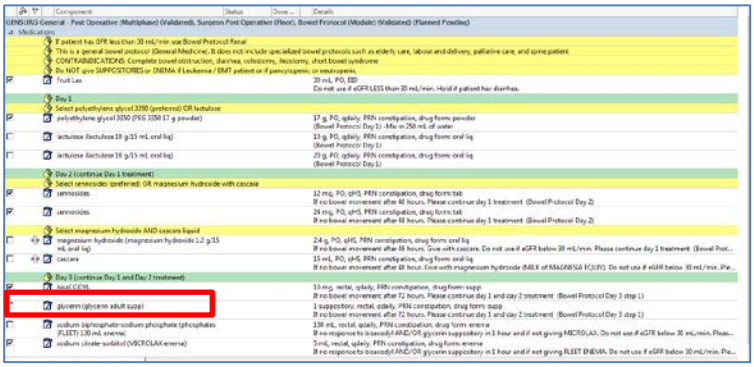
4 Adding Additional Module(s)

1. Scroll down to locate Gen Surg Modules to add the Bowel Protocol (Module)



Select the following:

- Glycerin

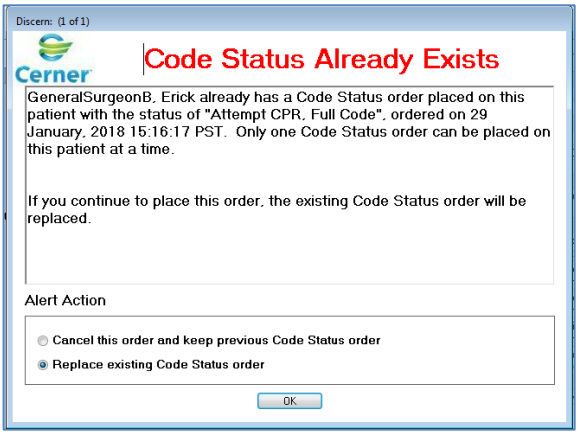


2. Once you have made your selections for this module, do not sign yet. You need to return to the main PowerPlan by selecting Return Gensurg General – Post operative (Multiphase) to sign off the entire PowerPlan.

3. Now, all your orders are selected and you are ready to sign off. Remember to use to see what has been selected so far and to merge your plan with other current orders. This will help to identify any duplication.

4. There is the option of Initiate, Sign or Cancel
   - Initiate: Activates the orders for example pharmacy would receive the order to dispense the ordered medications. For planned stated orders the provider would not click this.
   - Sign: Same as your signature on paper orders. Needed regardless if planned or not
   - Cancel: no orders will be placed and actioned
5. Click **Sign.** The orders are now in a planned state

5 After clicking Sign there will be a discern alerts that will appear.



Click: **Replace existing Code Status order.**

Note: Discern Alerts alert the user that the order they are attempting conflicts with an order or policy within the system.

Key Learning Points

- PowerPlans are similar to pre-printed orders
- You can select and add new orders not listed in the PowerPlan by using Add to Phase functionality
- You can select from available order details using drop-down lists or modify order sentences manually where needed
- Sign will place orders into a planned state for future activation
- Orders in Planned state are not active until they are initiated
- All phases of Multiphase PowerPlans open by default; therefore, all orders from all phases are immediately visible
- Toggle between phases to easily locate your orders based on phases. You can view a single phase by clicking on the navigator pane (view)

PATIENT SCENARIO 3 – Post Operative

Learning Objectives

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

- Initiate Planned Orders
- Document with Auto Text

SCENARIO

Your patient has just had their operation. There were no Intra-op complications and you are expecting a normal, uneventful recovery. You are in the PACU with the patient.

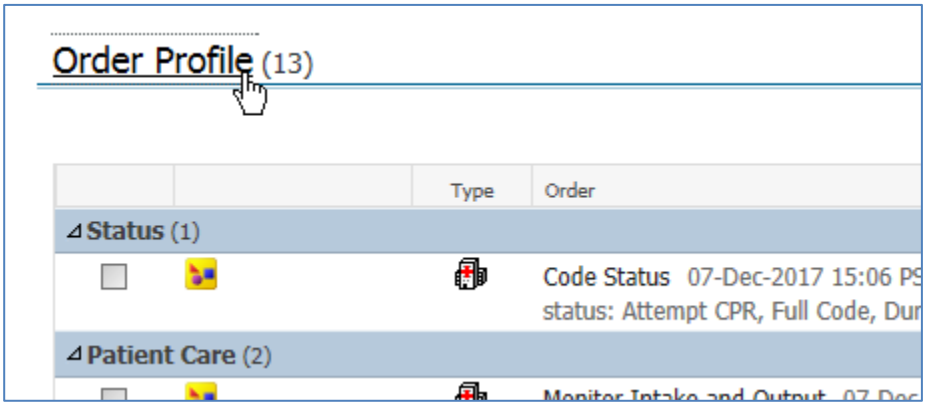
You will complete the following activities:

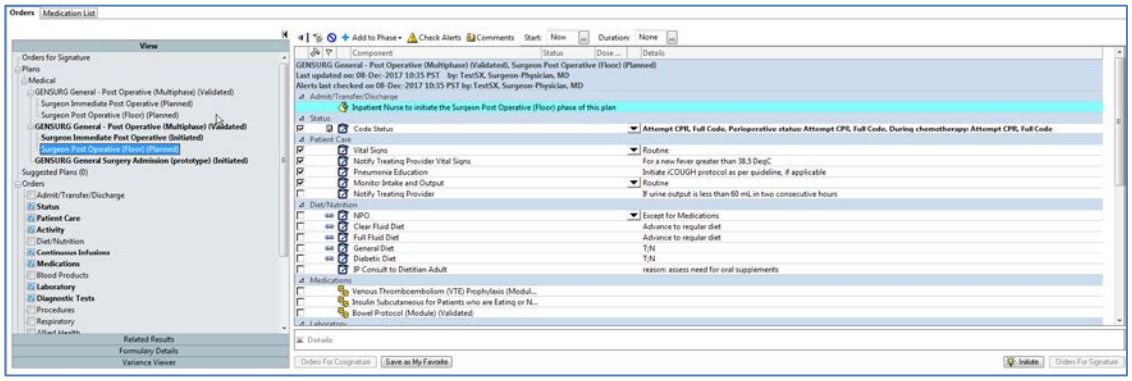
- Initiating Orders from a Planned State
- Complete an Operative Report with Auto Text

Activity 3.1 – Initiate Orders from a Planned State

As stated in the previous scenario, any PowerPlans that are in a planned state cannot be actioned by the system or other healthcare providers. For example, pharmacy would not dispense a medication until the PowerPlan is initiated. Initiating the PowerPlan allows the order to flow downstream to appropriate departments and staff. In this example the provider will initiate the PowerPlan, however this would typically be done by the PACU RN. For purposes of training we will initiate the PowerPlan.

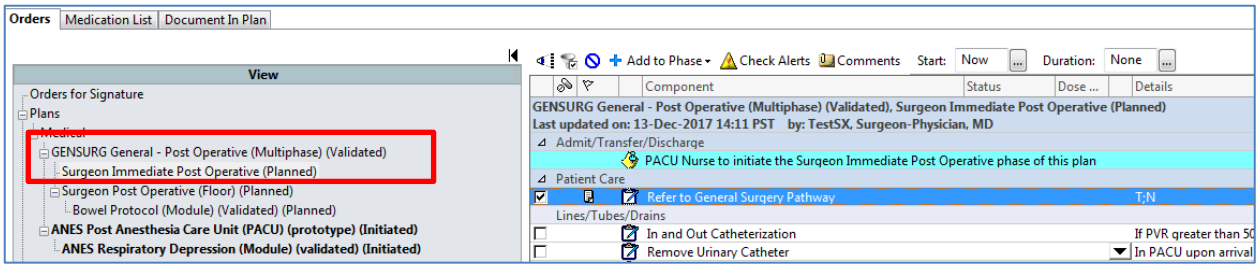
1 From the **Rounding** page scroll down to the order Profile and click the Header **Order Profile**. Alternatively, you can click on the **Order Profile** on the left-hand side menu. Then click on the **Order Profile** header.



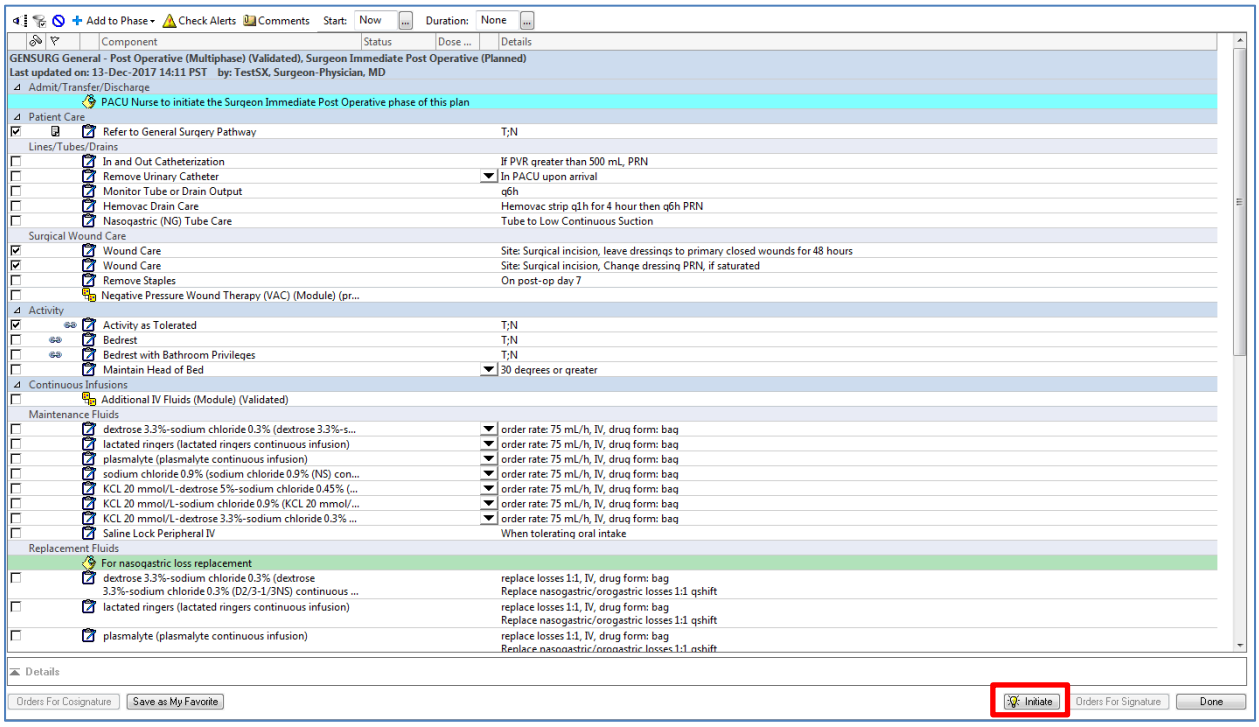


2 An individual order within a planned PowerPlan can be modified easily at any time before clicking the **Initiate** button. After a PowerPlan is initiated and a change to an order is required, the incorrect order must be canceled and the correct order placed anew.

3 For patient, select the **Surgeon Immediate Post-Operative (Planned)** in the view pane.



4 Click the **Initiate** Initiate button then the **Orders for Signature** Orders For Signature.



The view pane will show that the PowerPlan is now initiated.

Note: This PowerPlan contains two phases in one order set. The order that was just initiated is for the PACU portion.

5 Click Sign, then click **Refresh** 0 minutes ago.

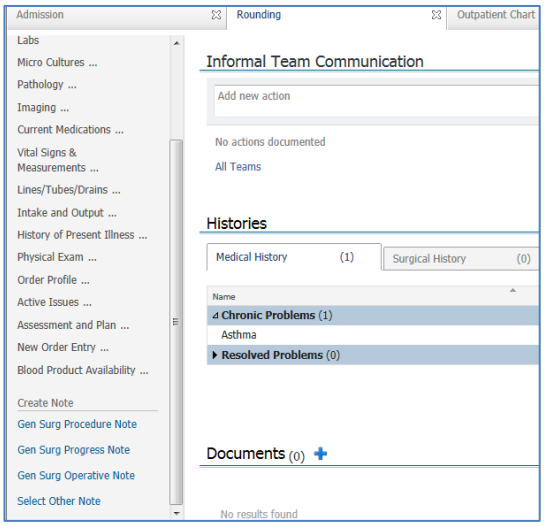
Key Learning Points

- Orders can be modified easily before they are initiated
- Only Active Orders are shown in the Order Profile

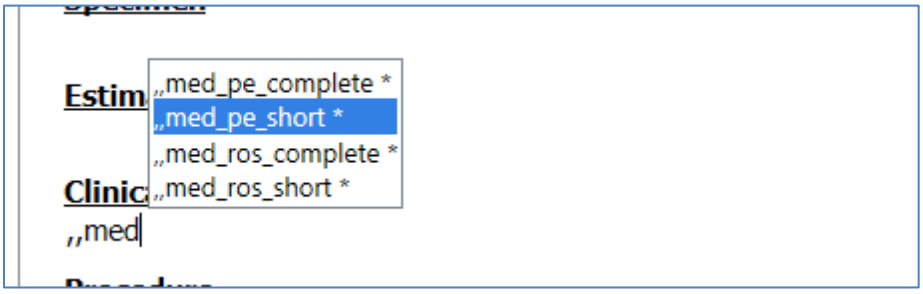
Activity 3.2 – Complete a Gen Surg Operative Note with Autotext

Similar to the Admission tab, the Rounding tab also provides one click access to the most relevant note type. You already know how to remove sections or edit text. Now let's learn how to avoid entering repetitive information by using the auto text feature, which is available to all notes.

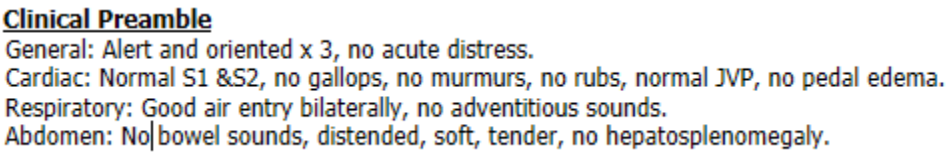
1 From the list under **Create Note**, select **Gen Surg Operative Note** which will pull existing relevant information from the patient's chart.



2 To activate a free text box under the **Clinical Preamble** heading, then click on the text box and type **,,med**. A list of auto text entries starting with "comma comma med" will be displayed. Double-click on **,,med_pe_short***. (It is recognized that that this would not be what would be charted, this is done here to teach functionality not workflow.)



3 The programmed auto text entry populates in the box. You can edit this text if necessary.



Built in 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 in a personalized learning session at a future date.

4 Click **Sign/Submit**

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

End Book One

You have reached the end of book one.