SELF-GUIDED PRACTICE WORKBOOK [N34]

CST Transformational Learning

WORKBOOK TITLE:

Provider: Surgeon Inpatient (Workbook #2)

Last update: April 10, 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 – Discharge Patient Home

Learning Objectives

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

- Complete discharge steps, reconcile orders and medications.
- Update discharge diagnosis.
- Complete discharge documentation.

SCENARIO

It is post-op day 4 for your other patient. There were no complications in the post-operative period. You are ready to discharge your patient home. As part of the discharge process, the discharge medication reconciliation has to be done. Since the patient will be following up in your clinic you want to have some repeat blood work.

You will complete the following 4 activities:

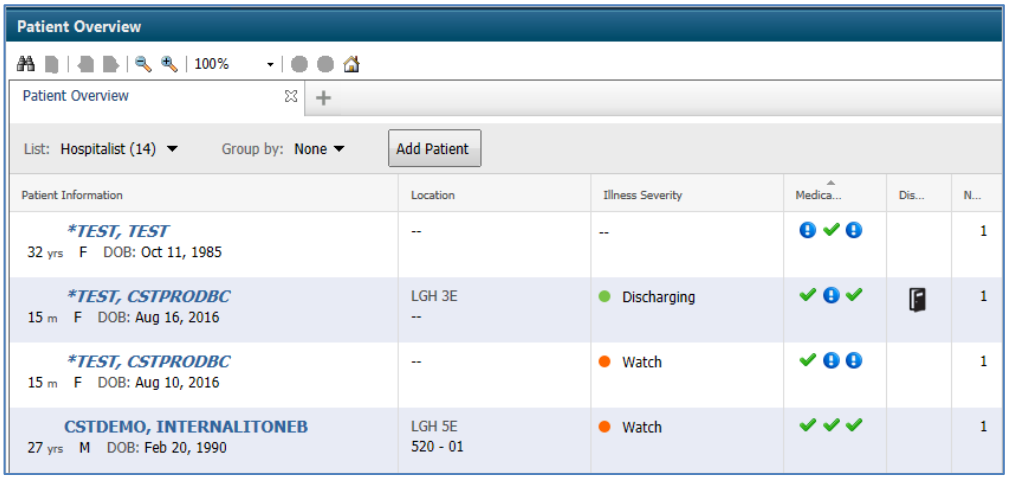
- Patient Overview
- Discharge Medication Reconciliation & Create Prescriptions
- Place a Discharge Order and Future Orders
- Complete Discharge Diagnosis & Discharge Documentation

Activity 1.1 – Patient Overview

You may use **Patient Overview** to communicate with other providers about the patient's status. Although it does not create any action items, it serves as a communication tool during patient handoff.

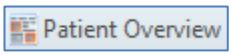
It provides a snapshot of patient's status and also helps you manage your patients:

- **Location** – indicates where the patient is located (e.g. unit / room / bed)
- **Illness Severity** – communicates the patient's illness severity and status
- **Medication Reconciliation status** - tracks medication reconciliation completion status
- **Other communication tools** – see discharge status, new lab results to be reviewed, and action items

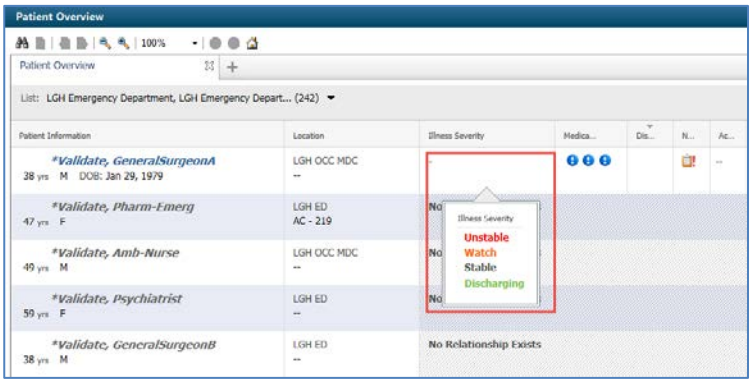


1 First you will be communicating your plans to discharge in patient in Patient Overview:

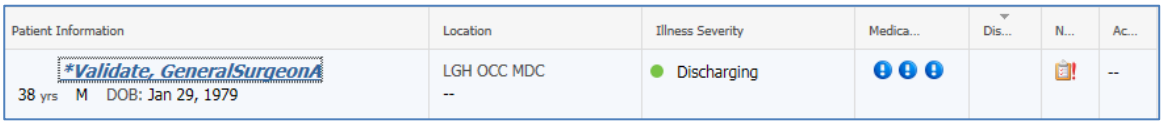
Select Patient Overview from the Toolbar and find the patient from the list.



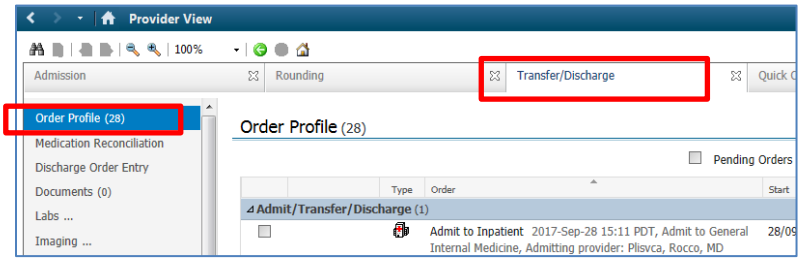
2 Click inside the column under **Illness Severity** and select **Discharging**



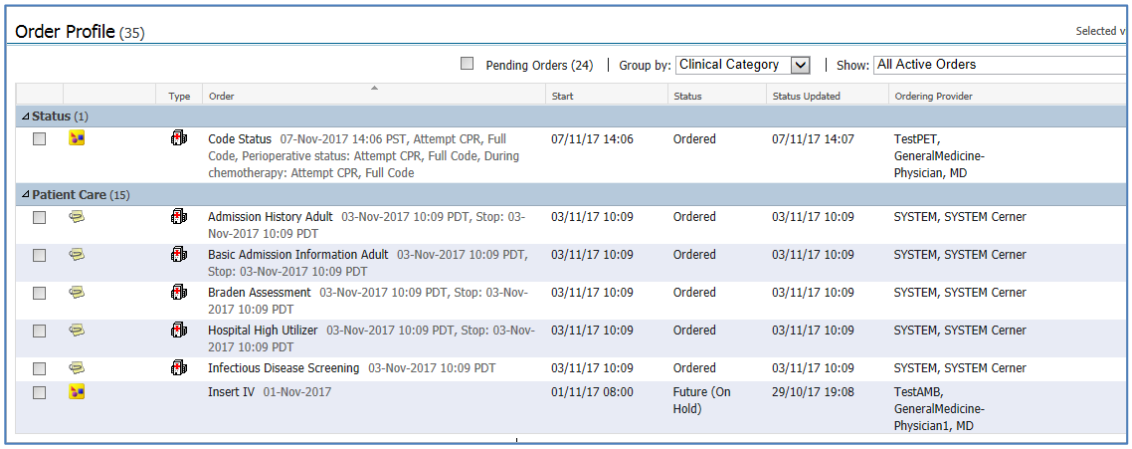
3 Click directly on the patient name to open their chart in Provider View.



4 Select the Transfer/Discharge tab and select **Order Profile.**



5 Review the patient's current orders under **Orders Profile**.



NOTE: No manual action is required to discontinue orders at discharge. When the patient's encounter is discharged from the system (the act of discharging an encounter is usually completed by the unit clerk or nurse) this will automatically discontinue any active orders. Any planned orders to be completed in the future (non-initiated) or orders with pending results placed prior to discharge will remain active.

Key Learning Points

- Outstanding orders are automatically closed after discharge except future orders and orders with pending results

Activity 1.2 – Discharge Medication Reconciliation & Create Prescriptions

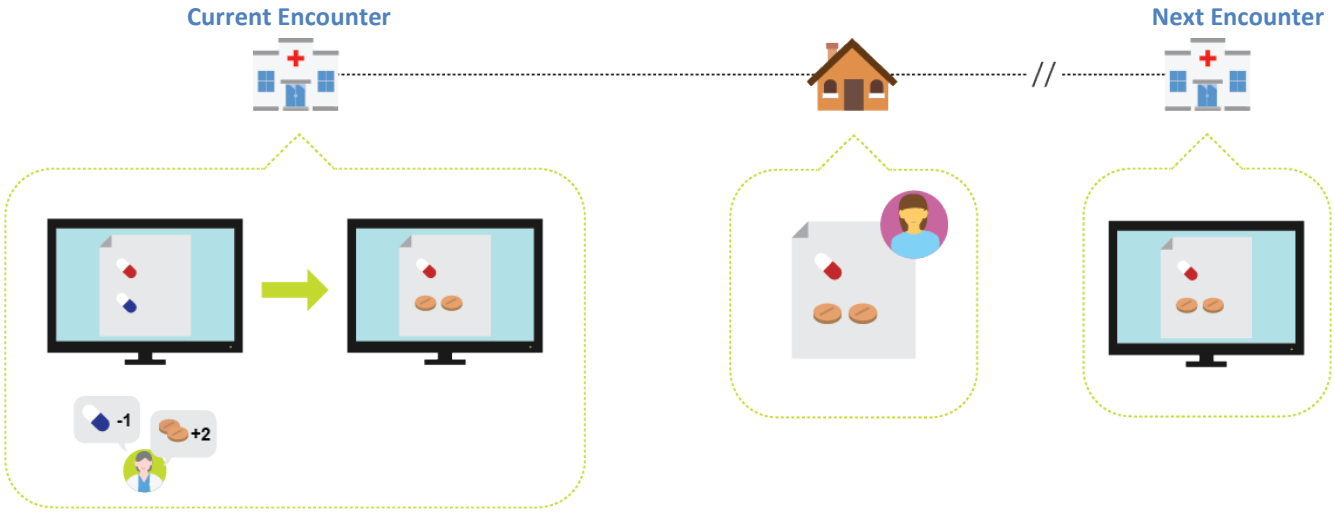
Now that you have reviewed current orders, you are ready to complete your discharge medication reconciliation. The list of **medications to reconcile during discharge** includes:

- **Home Medications** – medications that the patient was taking at home prior to admission. These medications were documented with BPMH but were **not continued during the hospital visit**
- **Continued Home Medications** – medications the patient was taking at home prior to admission and **continued during this admission**
- **Medications** – new medications that the patient started during this inpatient stay
- **Continuous Infusions** – inpatient fluids and medications that were given by continuous infusion

You will determine which medications your patient should continue after discharge.

Continued medications will be carried forward and available as documented home medications within the patient's medication history. You can also create a prescription for the existing or new medications directly in the reconciliation screen.

All medications marked to be continued at home will be viewable at the patient's next visit.



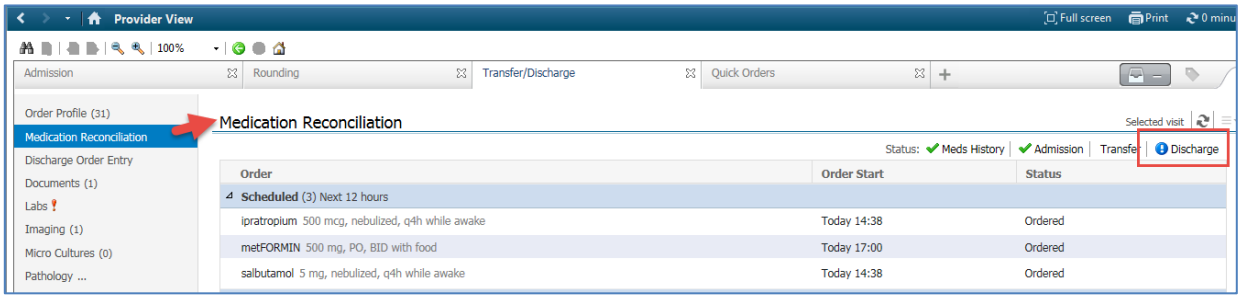
In this activity you will:

- Discontinue or return to home medications
- Discontinue inpatient medications
- Create a prescription for an inpatient medication and a new home medication

1

Ensure you are in the Transfer/Discharge tab.

Select the **Medication Reconciliation** component and click **Discharge**.



2 The Order Reconciliation Discharge window displays (your list might be in a different order).

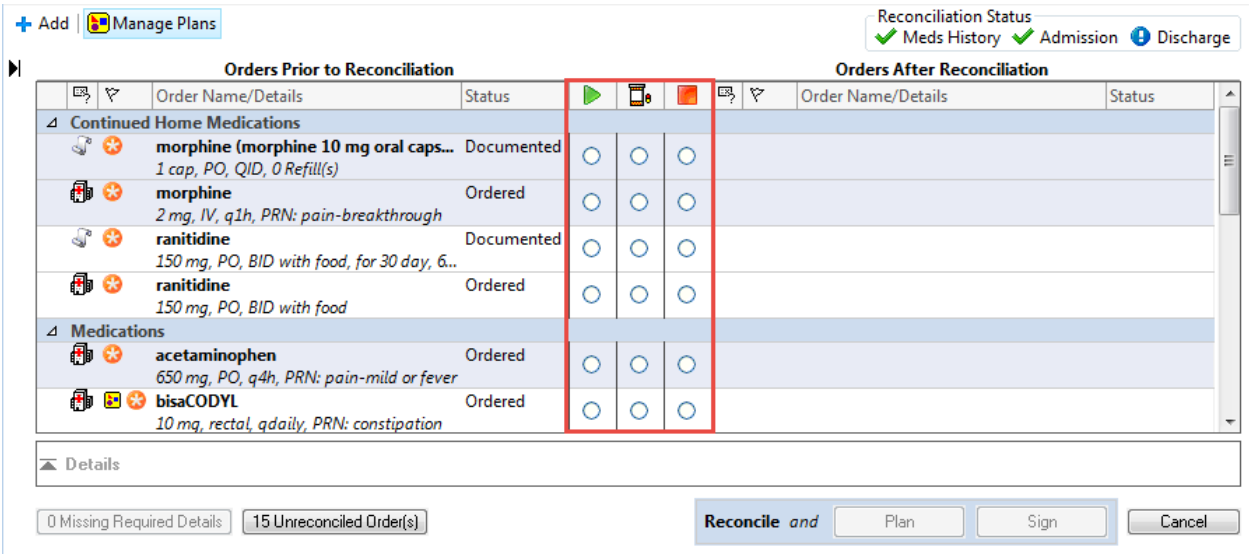
- Documented home medications marked by the icon
- Inpatient medications marked by the icon
- Home prescription medications marked by the icon

You will manage the patient's medications after discharge by selecting the corresponding button:

Continue after discharge

to create a **prescription** for your patient to take home

Do Not Continue After Discharge



NOTE: Some medications are listed twice: one is home medication and another is inpatient medication. If home medications are to be continued after discharge, select documented medication marked by rather than inpatient orders marked by the icon.

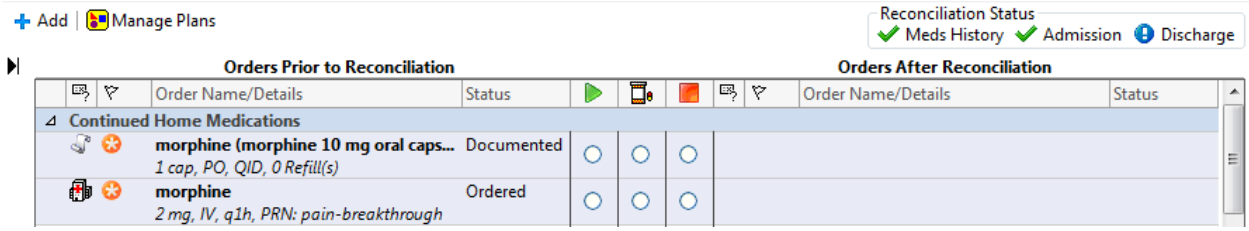
3 **Home Medications** section lists medications that were not ordered at admission.

The icon indicates medications awaiting your decision. Review each medication and make your selection.

Multivitamin Centrum is a documented home medication and was not continued at the hospital. You have the following options:

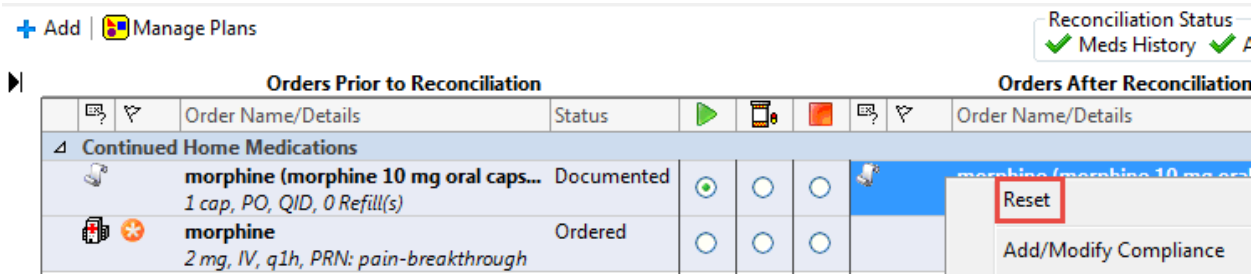
Select the continue button if you want the patient to return to taking it at home.
A prescription will not be provided but the patient will receive a Patient Discharge Summary listing multivitamin under section of “Home Medications – Continue Taking”.
It will be also viewable at the patient’s next visit under Medication History.

Select the discontinue button if you want the patient to stop taking it after her discharge.
The multivitamin will be listed under Stop Taking the Following Home Medications in the Patient Discharge Summary.
It will not be viewable at the patient’s next visit.



Go ahead and reconcile Morphine.

4 If you make an error, right click the medication and select Reset.



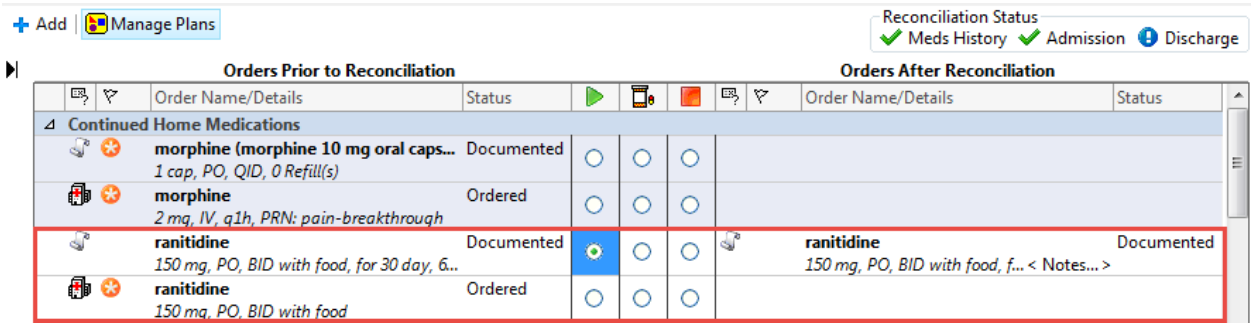
5 **Continued Home Medications** section lists medications that were ordered at admission.

Ranitidine is listed as a documented home medication and was continued as an inpatient medication.

NOTE: Select documented medication marked by rather than inpatient orders marked by icon, if home medications are to be continued after discharge.
If the inpatient medication is continued upon discharge rather than restarting the home medication, this may create confusing notations within the Discharge Summary.

You the following options:

Select if you want the patient to return to taking her home medication after discharge.
Select to discontinue the inpatient medication after discharge.
Select if the patient has run out of her prescription and you would like to create a refill.



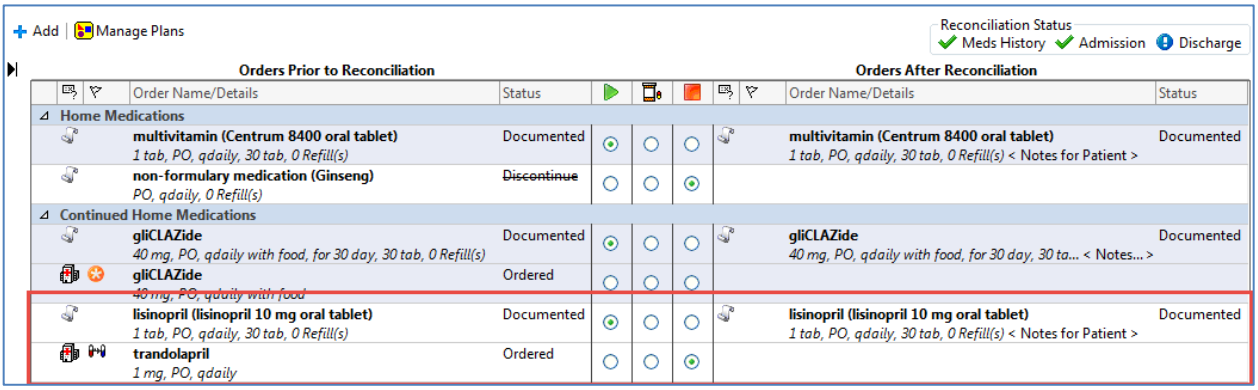
6 Lisinopril is also the patient's documented home medication that has been continued in the hospital but substituted to trandolapril .

WARNING: It is recommended to select a documented home medication and stop the substitution . If the substitution must be selected, **stop both** medications and create a new prescription order

Keeping the above note in mind, consider one of the following options:

Select if you want to discontinue inpatient trandolapril.
Select if you want the patient to return to taking lisinopril after discharge.
Select if the patient has run out of her prescription and you would like to print a new one.

Your decision will be reflected in the Patient Discharge Summary and example of this document will be provided when you complete the reconciliation.



7 Continue to review medications on the list and make your selections. Remember that it is recommended to return rather to home medication than to continue the inpatient one.

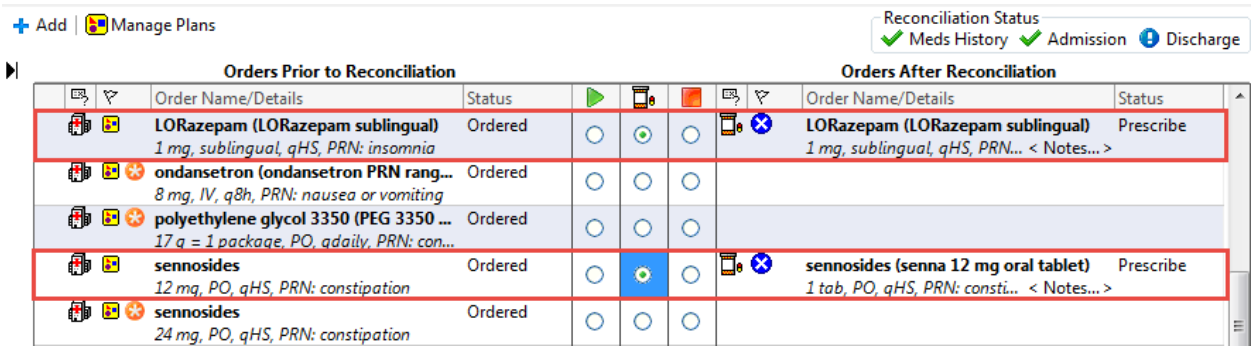
NOTE: **Continued medications will be captured** in the patient's Document Medication by Hx list (BPMH) and carried forward to the next visit.
Discontinued home medications will not be included in the Document Medication by Hx list (BPMH).

Create Prescriptions

1

You can **create a new prescription from any inpatient medication** order in the discharge reconciliation window.

To create a prescription for *Lorazepam and Sennosides 12 mg*.
click the column marked with the icon.

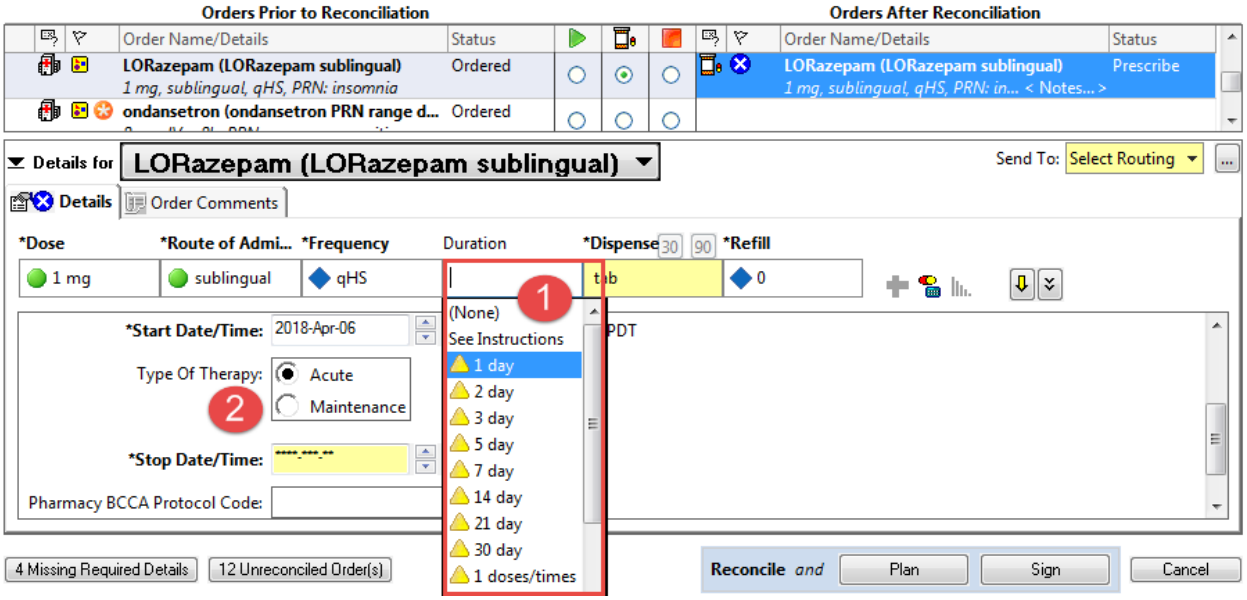


2 Click each order marked by the ⊗ icon and add required missing details. For example, select **prednisone**.

1. To auto-populate **Dispense** and **Stop Date/Time** boxes, select **Duration** from the drop-down. The CIS **will calculate** the Dispense amount and the Stop Date/Time.

   In this example, the Dose is **1 tab**. Select **7 day** for Duration – the Dispense and Stop Date/Time will be filled.

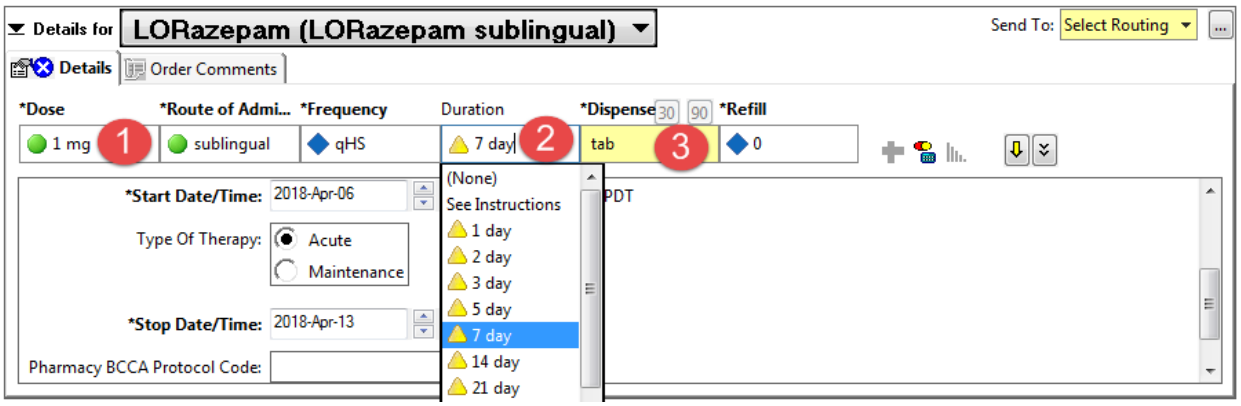
2. Ensure the **Type Of Therapy** selection is correct for the medication.



3

NOTE: For some home medications **dosed as strength** (for example mg, mcg, etc.), you may need to enter the **Dispense** amount in days equal to selected duration value.

1. In this example, the Dose is **1 mg**.
2. Select **7 day** for duration.
3. ***Dispense** = tab.

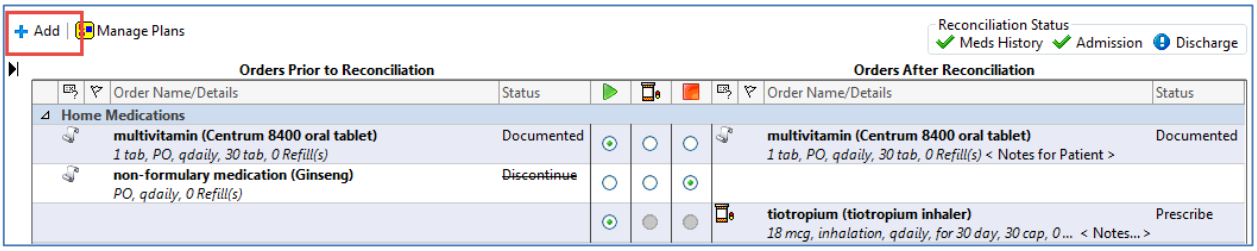


4

You can also **add additional prescriptions** for home medications that will be new to the patient. For your patient, you would like to add tiotropium.

Click the + Add icon.

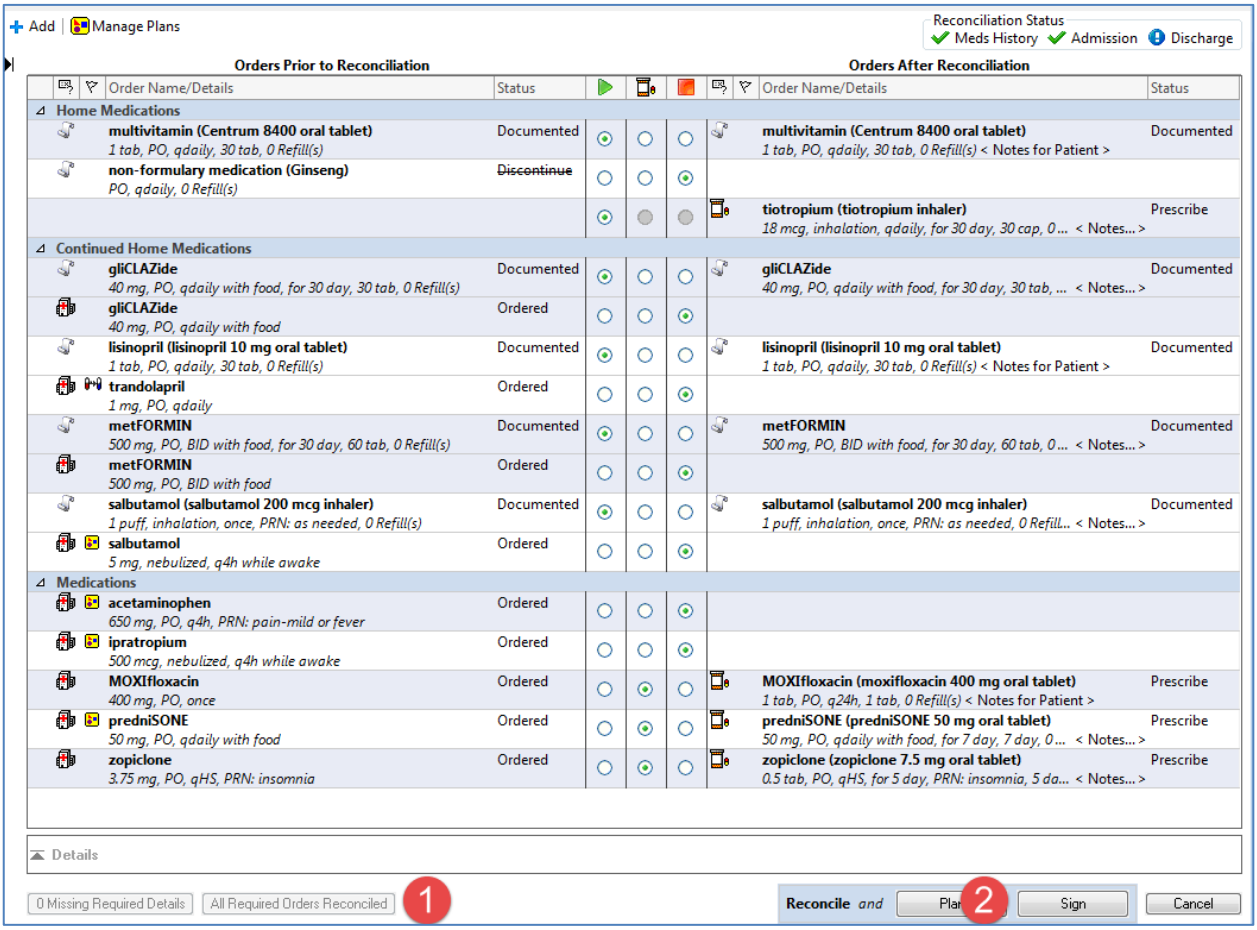
By now, you are familiar with the Search window and search techniques. Search for *tiotropium 18 mcg once daily.*



Complete Discharge Medication Reconciliation

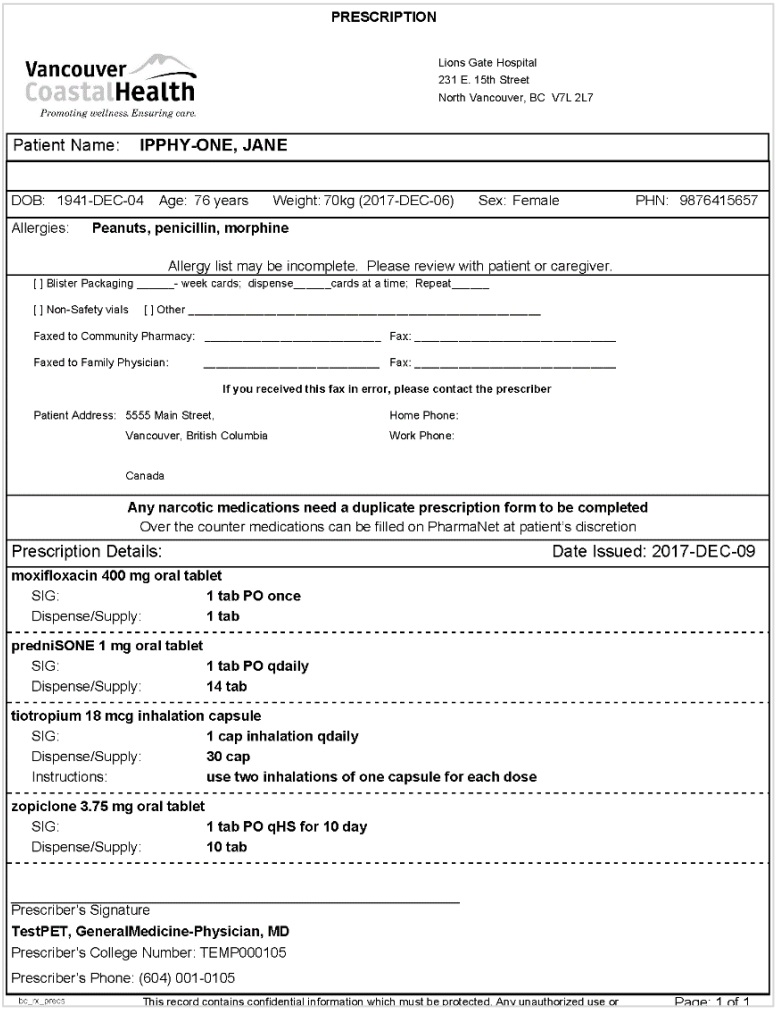
1 Continue to reconcile all medications to successfully complete the discharge medication reconciliation process.

1. Only when **all medications are reconciled** as indicated at the bottom of this window, the Sign button becomes active.
2. Click **Sign**.



2 The following will happen

- The **Document Medication by Hx** list (BPMH) will be populated by medications that you selected to continue. Prescriptions will be added to this list.
- Home medications that are not continued in current discharge reconciliation, will be dropped and removed from the list.
- The prescription will print automatically.



PRESCRIPTION

Vancouver Coastal Health
Promoting wellness. Ensuring care.

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

Patient Name: **IPPHY-ONE, JANE**

DOB: 1941-DEC-04 Age: 76 years Weight: 70kg (2017-DEC-06) Sex: Female PHN: 9876415657

Allergies: **Peanuts, penicillin, morphine**

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: 5555 Main Street, Vancouver, British Columbia Canada

Home Phone:
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: 2017-DEC-09

moxifloxacin 400 mg oral tablet
SIG: **1 tab PO once**
Dispense/Supply: **1 tab**

predniSONE 1 mg oral tablet
SIG: **1 tab PO qdaily**
Dispense/Supply: **14 tab**

tiotropium 18 mcg inhalation capsule
SIG: **1 cap inhalation qdaily**
Dispense/Supply: **30 cap**
Instructions: **use two inhalations of one capsule for each dose**

zopiclone 3.75 mg oral tablet
SIG: **1 tab PO qHS for 10 day**
Dispense/Supply: **10 tab**

_____
Prescriber's Signature
TestPET, GeneralMedicine-Physician, MD
Prescriber's College Number: TEMP000105
Prescriber's Phone: (604) 001-0105

bc_rx_prescr This record contains confidential information which must be protected. Any unauthorized use or Page: 1 of 1

3 A medication summary will be included in the **Patient Discharge Summary** as well as in the **Discharge Summary**.

Medications

New Medications to Start Taking

Medication	How Much	How	When	Reason	Next Dose	Additional Instructions
MOXIfloxacin (moxifloxacin 400 mg oral tablet)	1 tablet	by mouth	every 24 hours			
predniSONE (predniSONE 50 mg oral tablet)	50 milligram	by mouth	daily with food			Stop Date: 07-MAR-2018
tiotropium (tiotropium inhaler)	18 microgram	by inhalation	daily			
zopiclone (zopiclone 7.5 mg oral tablet)	0.5 tablet	by mouth	daily at bedtime as needed	insomnia		Stop Date: 05-MAR-2018

Home Medications - Continue Taking

Medication	How Much	How	When	Reason	Next Dose	Additional Instructions
gliCLAZide	40 milligram	by mouth	daily with food			
lisinopril (lisinopril 10 mg oral tablet)	1 tablet	by mouth	daily			
metFORMIN	500 milligram	by mouth	twice a day with food			
multivitamin (Centrum 8400 oral tablet)	1 tablet	by mouth	daily			
salbutamol (salbutamol 200 mcg inhaler)	1 puff	by inhalation	one time as needed	as needed		

Stop Taking the Following Home Medications

Medication	Reason to Stop Taking
non-formulary medication (Ginseng)	

Key Learning Points

- Both home and inpatient medications can be converted into prescriptions during the discharge reconciliation process
- **Continued medications will be captured** in the patient's Document Medication by Hx list (BPMH) and carried forward to the next visit
- **Discontinued home medications will not be included** in the Document Medication by Hx list (BPMH)
- Discharge **medication information is included in the discharge summary** forwarded to patient's family doctor and in the **patient discharge summary** given to the patient

Activity 1.3 – Place a Discharge Order and Future Orders

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** such as:

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

When the electronic order is placed, a testing facility that is part of your CIS will see that request to be added to their electronic queue.

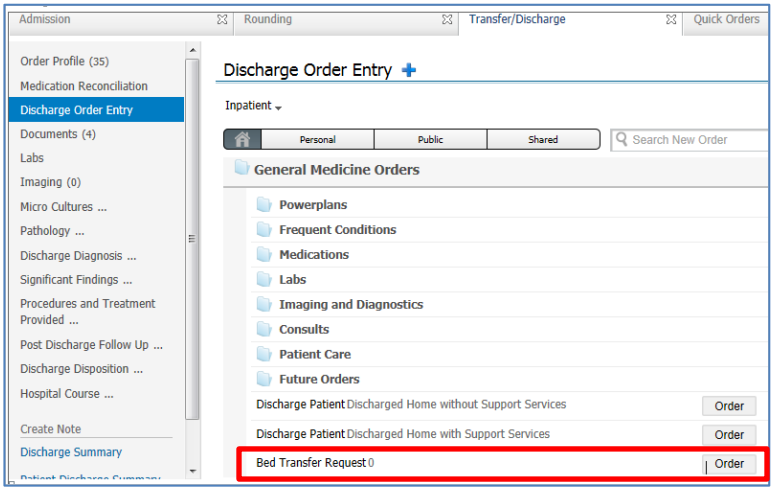
When the order is going to be completed at the external site that does not have CIS or a specimen is expected to be collected at home, a printed requisition will be given to the patient for post-discharge orders. The electronic order is placed for the record only.

For your patient, you decide to place future orders for an abdominal CT with contrast. You also want to provide them with a referral to the Ostomy Clinic.

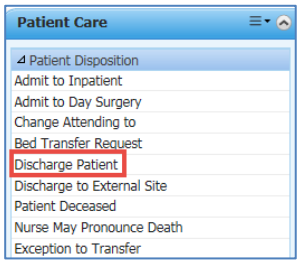
1 Navigate to the **Transfer/Discharge** tab in Provider View.

Select or scroll to **Discharge Order Entry**

Under **Future Orders** folder, find **Discharge Patient (Discharged without Support Services)** and select **Order**

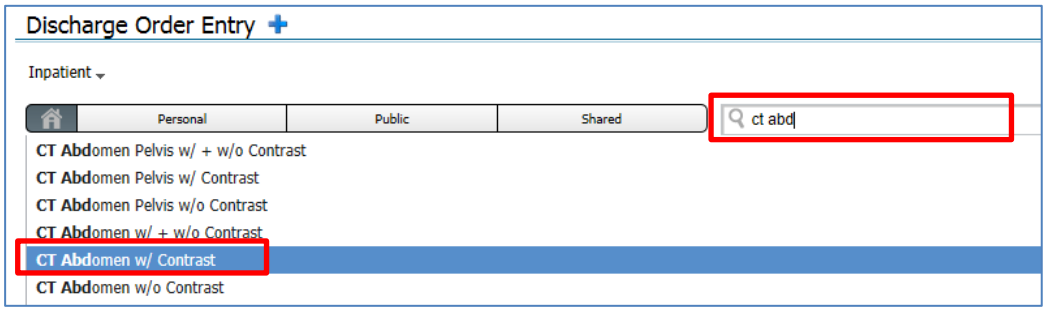


NOTE: You may also use Quick Orders and select Discharge Patient under Patient Care.



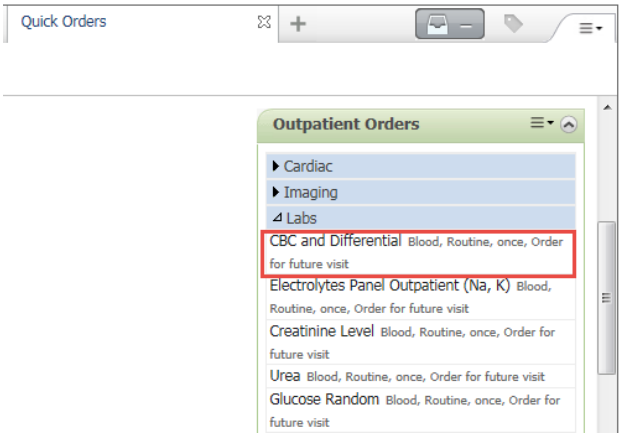
2 To add a **CT abdomen scan with contrast** as a future order, search the catalogue directly from Discharge Order Entry.

Search *ct abd*
Select **CT Abdomen w/contrast** from the drop-down list.



3 Repeat the same steps to add the **Referral to Ostomy-Colostomy** search the catalogue directly from Discharge Order Entry

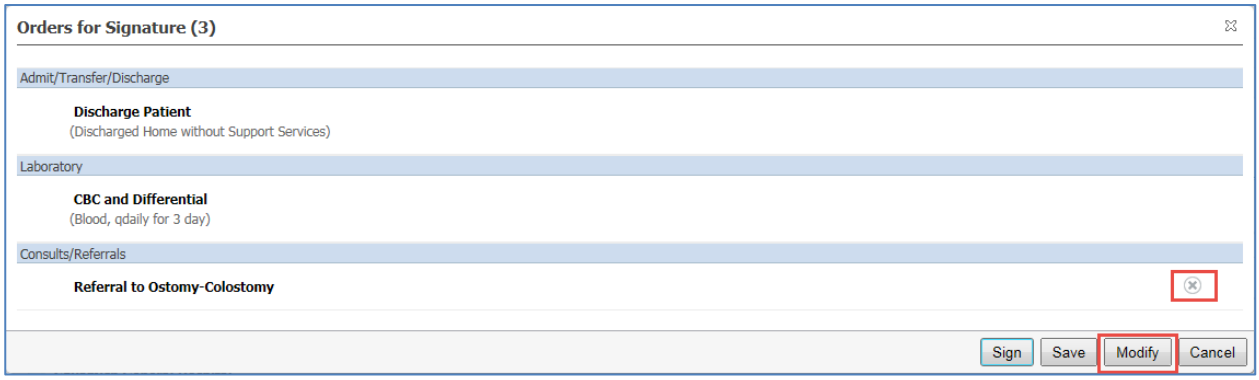
4 To add a CBC and Differential go to the Quick Orders tab and select the order sentence from the outpatient Orders Folder.



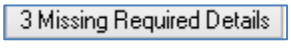
5 Click **Orders for Signature** 

, then click **Modify**.

- This will enable you to add more details to the orders

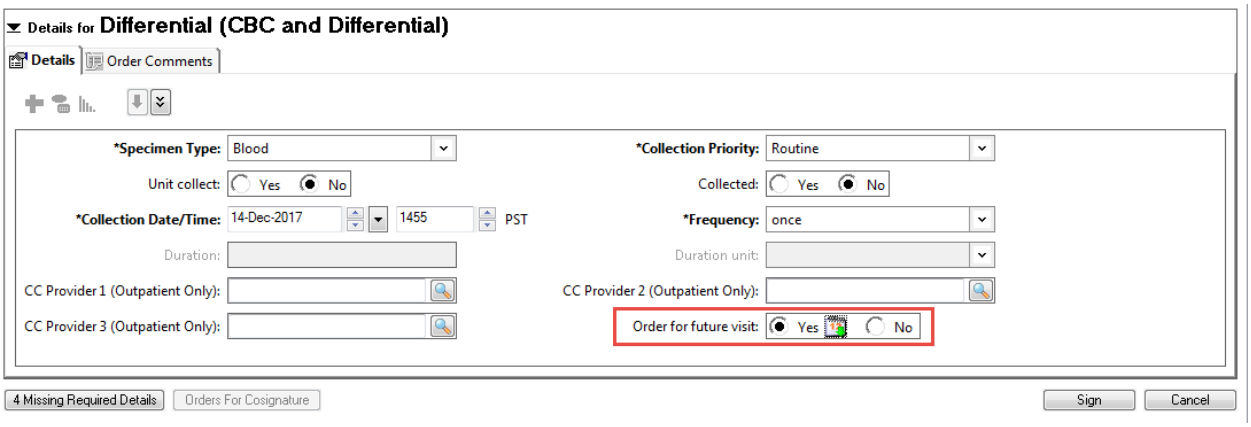


NOTE: You can remove the order placed in error by placing the cursor over the individual order in the Orders for Signature window, and clicking the **x**.

6 Complete the order details indicated by  and 

at the bottom.

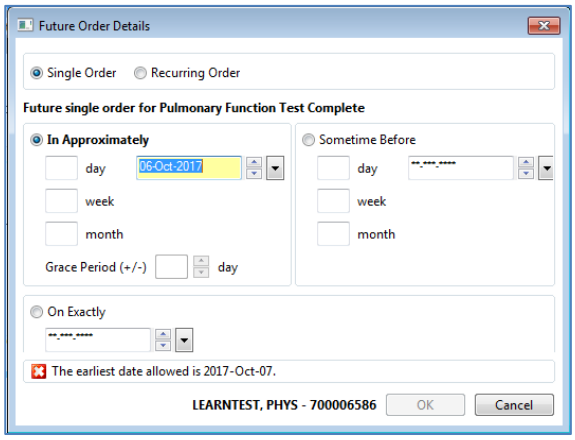
7 For the **CBC and Differential**, by the **Order for future visit** and click the calendar icon 

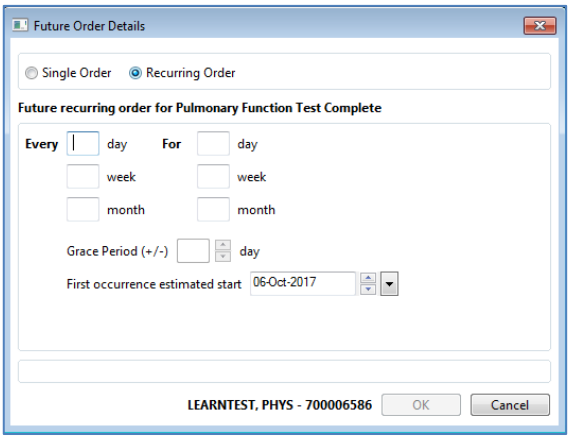


8 You have an option to select different details recommending when the test should be completed or if it has to be repeated. Select one of the options:

- One-time test (single order) or recurring
- An approximate time from now
- An approximate time before a specific date
- Time range in days for a grace period
- Exact date

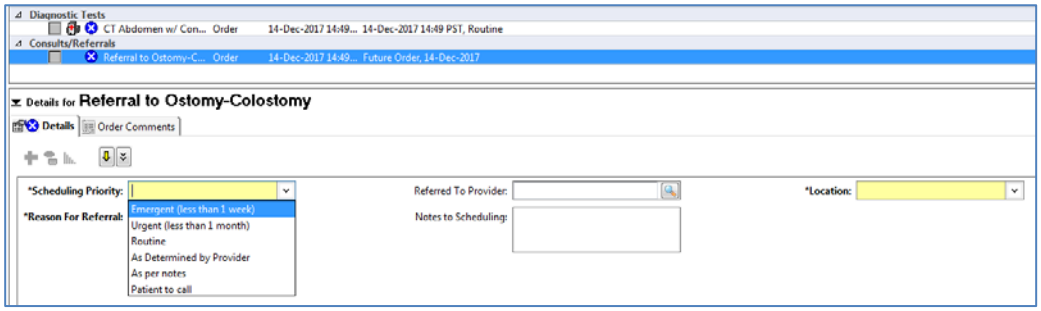
NOTE: These details are to guide appropriate booking not to book the actual test.





9 For the **Referral to Ostomy-Colostomy**, complete the following details:

- **Location**: *LGH Wound Ostomy*
- **Scheduling Priority:** *Emergent (less than 1 week)*
- **Reason for Referral:** Type “follow-up for further education”
- **Location:** *Paper referral*



NOTE: For locations that are not part of PowerChart, the **Paper Referral** should be selected. Although the process remains on paper, placing this order in PowerChart informs care providers for this patient that the specific referral has been placed.

10 Click **Sign**

Key Learning Points

- A **Discharge Patient Order** documents the decision to discharge a patient (required by the Hospital Act Regulation) and informs patient registration and the nurse
- **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
- You can easily place **recurring future orders** using appropriate options
- Selecting a specific location will prompt staff at the location that the order has been placed
- 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

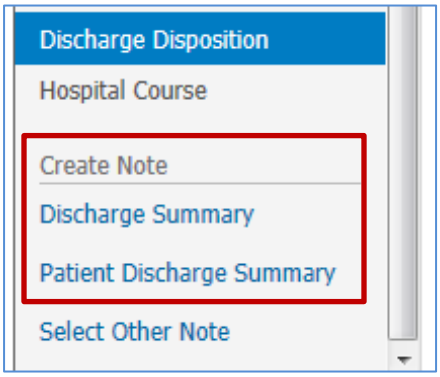
Activity 1.4 – Complete Discharge Diagnosis & Discharge Documentation

By now you are familiar with using **Dynamic Documentation**. It pulls the data such as:

- Test results, vital signs, or medications
- Your private notes typed or dictated in the Transfer/Discharge tab like **Significant Findings**

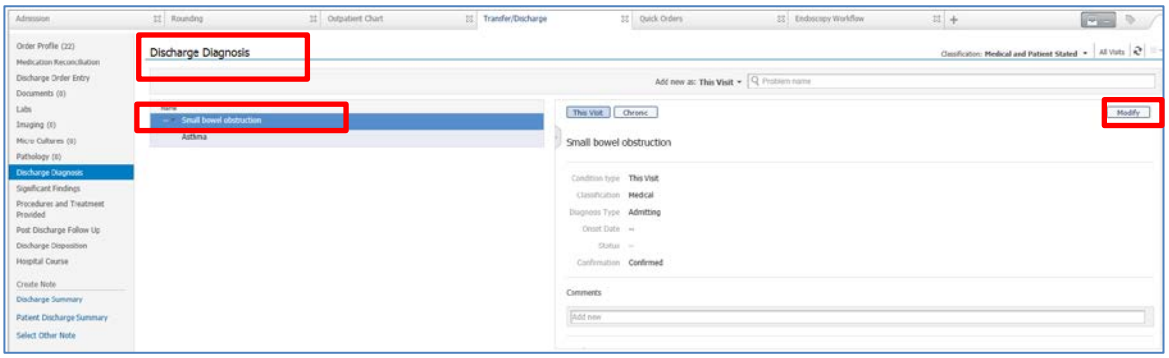
The CIS provides links to two discharge document types:

- **Discharge Summary** – to be distributed through Excelleris to the list of automatically included providers. You can also select other providers who should receive a copy.
- **Patient Discharge Summary –** to be printed by a nurse and handed to the patient.

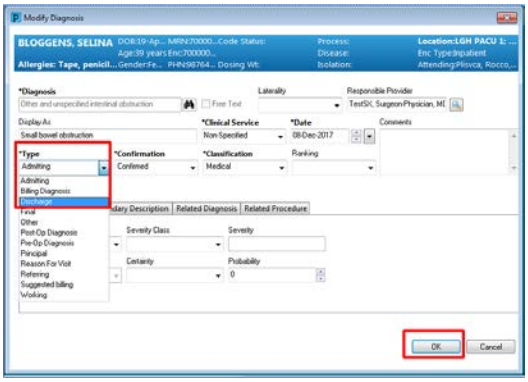


1 Confirm problems and diagnoses status at discharge:

Click on **Small Bowel Obstruction** to expand details. Ensure it states that this is a discharge diagnosis and note the status. Then, select **Modify.**



Ensure the diagnosis type reflects *discharge.*



NOTE: You can add comments for better communication with other care team members.

2 Click the **Discharge Summary** under **Create Note** component.

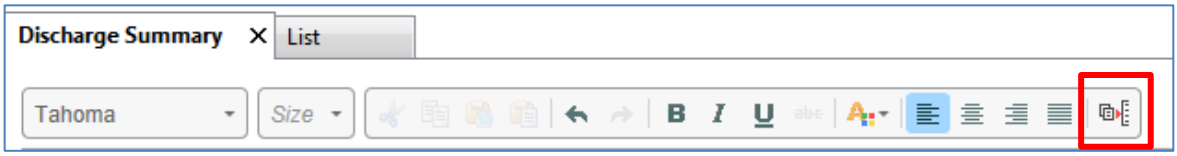
3

Start documenting patient's discharge by typing information under:

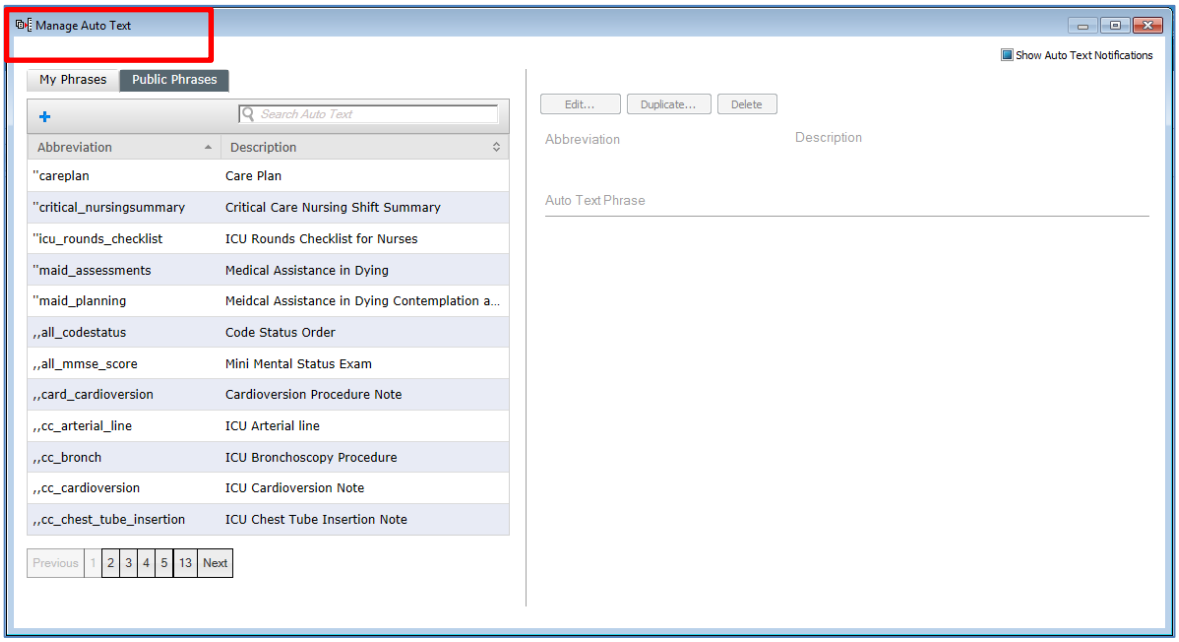
- Significant Findings
- Procedures and Treatment Provided
- Hospital Course

Entries made in these fields will auto-populate into your Discharge Summary.

Remember that you can use auto text entry to speed up the process. The Hospital Course component offers direct access to your saved autotext.



The **Manage Auto Text** window will appear.



4 Once you are ready to create discharge notes, click the note links provided under **Create Note**. There are two note links available:

- **Discharge Summary**
  - Create the note but Instead of **Sign/Submit**, clicking **Save & Close** will allow you to finish the note later in the Message Centre
- **Patient Discharge Summary**
  - Use this note template, if necessary

NOTE: PowerChart will automatically send a saved document to your Message Centre. The document will be saved as a draft and will only be visible to you.

Key Learning Points

- You can fully manage 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 any other providers selected by you
- Patient Discharge Summary is printed for the patient at discharge by nursing

PATIENT SCENARIO 2 – Transfers

Learning Objectives

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

- Inpatient Transfer
- Transfer Medication Reconciliation
- Discharge to an External Site

SCENARIO

Your other patient was admitted two days ago with a community acquired pneumonia. Her symptoms have been worsening despite antibiotic treatment. The patient was found to be septic.

You will complete the following 3 activities:

- Transfer to ICU
- Medication Reconciliation on Transfer
- Discharge to an External Site

Activity 2.1 – Transfer to ICU

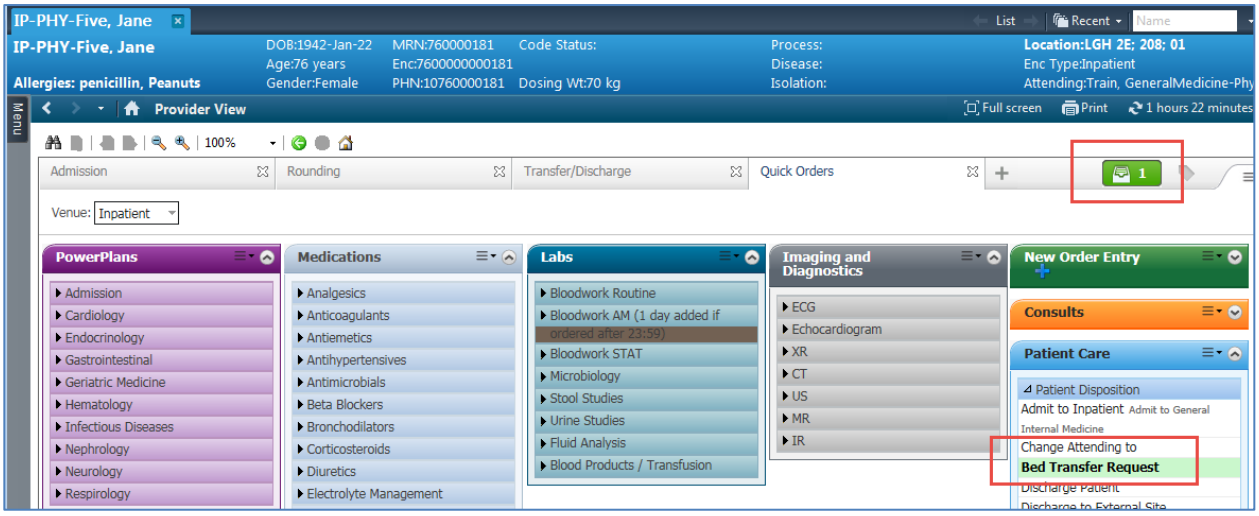
Once the decision to transfer a patient is made by the provider, physician to physician communication takes place outside of the Clinical Information System (CIS) to ensure proper transfer of responsibilities. It is important that the sending physician still discusses all aspects of care and shares any concerns with the receiving physician.

To initiate the transfer and locate an appropriate bed for the patient, a **Bed Transfer Request** order is placed. This order is typically placed by the Charge Nurse of the sending unit; however, a provider may also enter this order.

In this activity you will:

- Place the Patient Disposition order – Bed Transfer Request

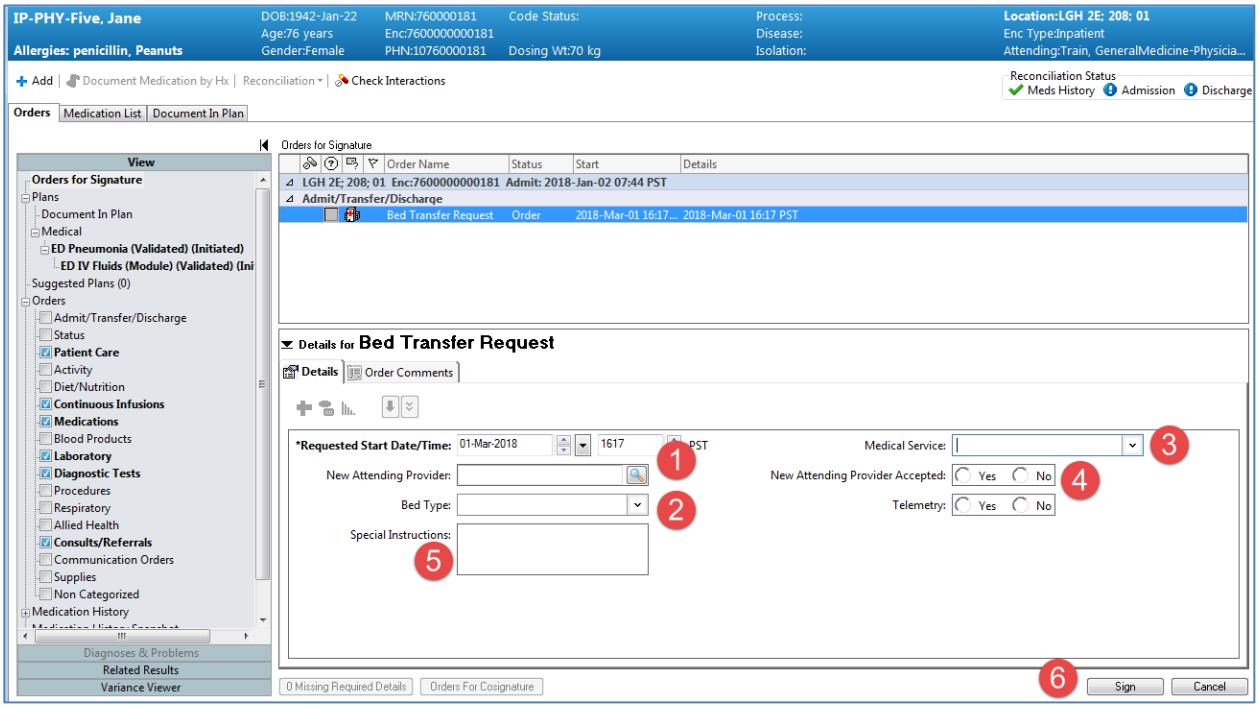
1 Place the Bed Transfer Order from the **Quick Orders tab > Patient Disposition** folder.



2 Click the **Orders for Signature** icon, then click **Modify.**

3 Review what details are included in this order. Note that some entries cannot be made in the Train Domain so you will leave them blank.

1. Name of the new attending provider = leave blank
2. Bed type = leave blank
3. Medical Service – use drop-down
4. If patient has been accepted by the new provider = yes
5. Special Instructions = type or dictate
6. Click **Sign** to complete the process.



Key Learning Points

- The **Bed Transfer Request** order initiates the process of searching for a bed. It also allows for identifying new medical service and transferring responsibility of care
- Verbal communication between units and physicians is critical

Activity 2.2– Medication Reconciliation on Transfer

When transferring a patient to a different level of care, all current medications and orders must be reconciled.

The transfer medication reconciliation is similar to the admission reconciliation; however, it also includes **non-medication orders**. In the Clinical Information System (CIS), this task may be performed as **many times** as necessary, whenever a patient is transferred. The transfer reconciliation window is a convenient tool to review all of the patient's medications and orders in one step.

The receiving provider is generally the one responsible for completing transfer medication reconciliation with the exception of Critical Care providers.

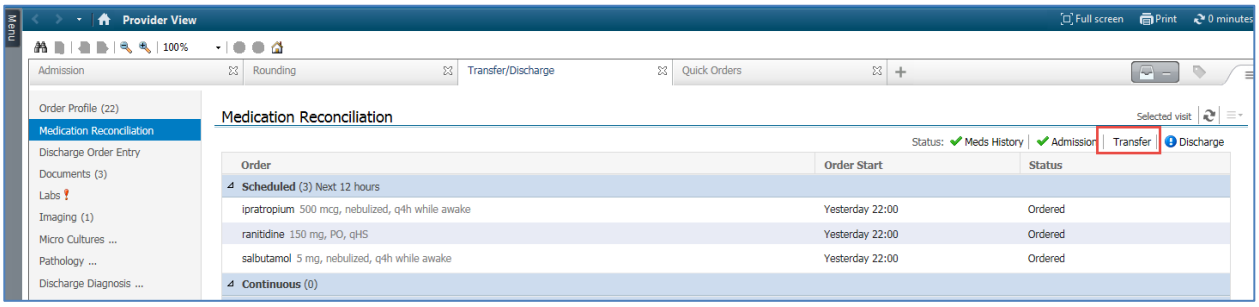
The Critical Care provider will be the one responsible for completing the reconciliation when accepting **and** when sending the patient. When the Critical Care provider transfers the patient out of the Critical Care unit, he or she will **plan** transfer medication reconciliation and the receiving provider will review and sign it to initiate orders once the patient has arrived at their new unit/patient care area.

For example, when a patient is being transferred back to the Medicine Unit, the Critical Care provider plans transfer reconciliation and you as the receiving provider will review the orders, make adjustments if necessary, and sign.

In this activity you will:

- Complete transfer medication reconciliation

1 In the **Transfer/Discharge** tab, display **Discharge Medication Reconciliation** component. Click **Transfer**.

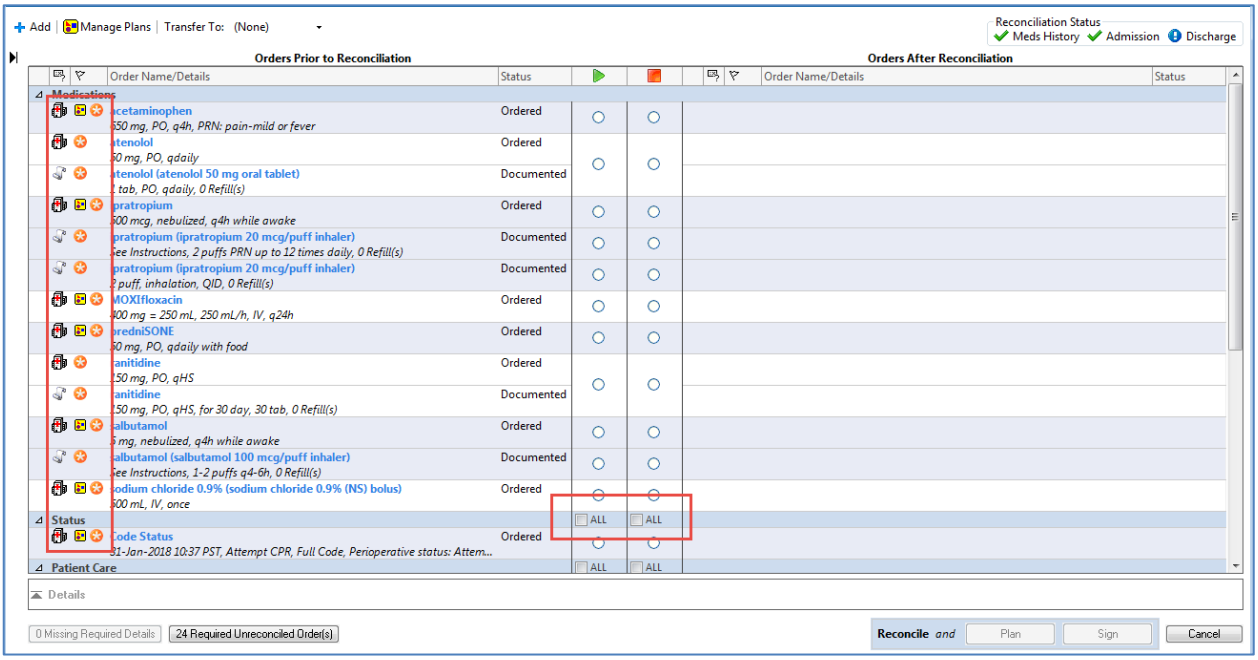


2 The **Transfer Reconciliation** screen displays.

You are now familiar with all icons. Use hover to discover to review this information.

NOTE: The transfer reconciliation displays medication and non-medication orders. On transfer within the hospital, you can continue orders that are already in place. This allows for a safe and effective transfer of care.

Click **All** to select all non-medication orders you would like to stop or continue, with one click.



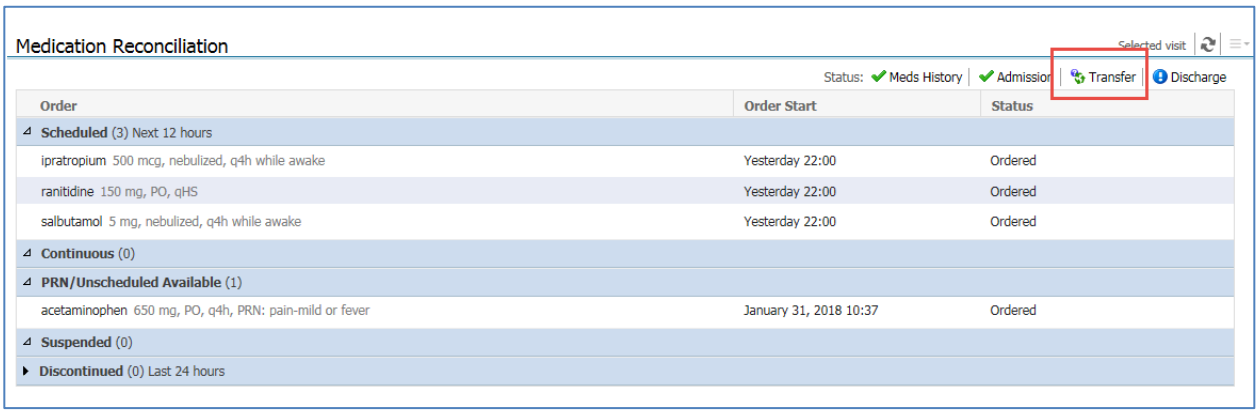
3 For your practice, make the appropriate selections. Once you reconcile all orders, you can choose one of the following two options:

- **Sign** – to complete the process, and activate orders immediately
- **Plan** – to save your selections to be activated at a later time.

WARNING: When transfer reconciliation is in a **planned** status, provider's decisions remain saved but orders and order changes will not be active. Patient care is continued per current state orders until the transfer reconciliation is signed.

When a patient is transferred out of the ICU, the Critical Care provider makes decisions about current orders and chooses **Plan** so the orders continue until the receiving provider signs off.

The status of planned transfer reconciliation is partial pending indicated by icon.



In this situation, the receiving provider clicks the Transfer button to display pending Transfer Reconciliation window. The receiving provider reviews orders and makes decisions to continue, discontinue, or add orders. Sometimes it might be appropriate to stop all current orders and place new ones.

Key Learning Points

- The receiving provider is responsible for the review and signature of the transfer medication and non-medication reconciliation upon receipt of the patient
- When the Critical Care provider is transferring patients out of the Critical Care unit, they will leave the reconciliation in **planned** status (select Plan) and current orders continue until the receiving provider signs off

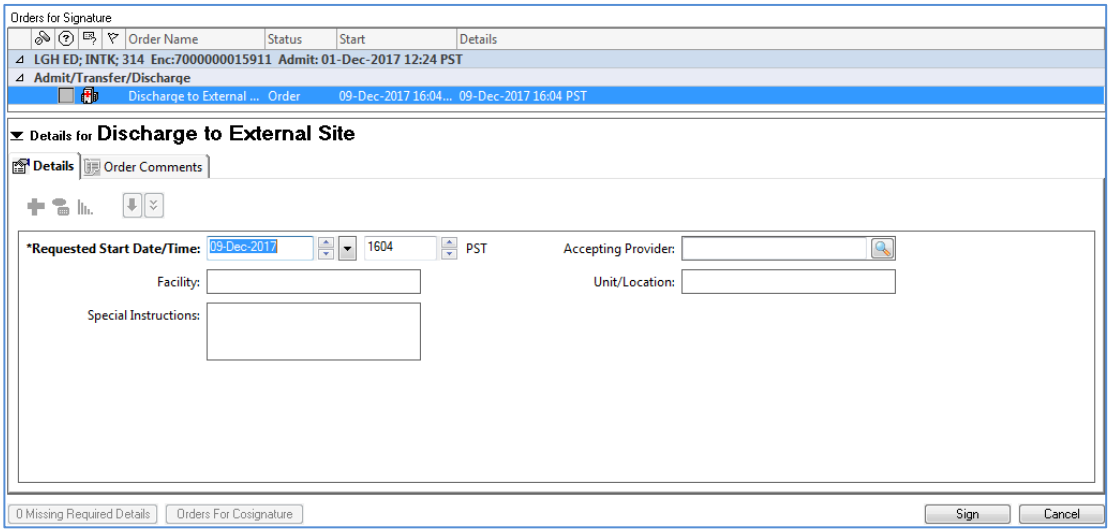
Activity 2.3 – Discharge to an External Site

When you transfer your patient to an external site, the patient must be discharged from the current site. The current encounter is closed. The receiving provider accepts the patient and completes steps for admission at the receiving site.

You contact Patient Transfer Network (PTN) to identify the receiving provider and arrange for a provider to provider communication. This action takes place outside of the Clinical Information System (CIS). In this example, a receiving provider has been identified and has accepted the patient. You complete handover and the patient is now ready to be moved.

To proceed with transfer to the external site, you will **discharge the patient from your site**. Follow the discharge process from our previous activities and discharge the patient.

1 Use one of the techniques you have learned before and place a **Discharge to External Site** order.



Key Learning Points

- When transferring your patient to an external site, you **discharge** the patient from the current site – this includes discharge medication reconciliation and a discharge summary
- **Discharge to External Site** order initiates the process of moving your patient to another site
- If the external site uses the CIS, the patient chart is available for the receiving team to view electronically. If the receiving site is not using the CIS, there will be a printout of the discharge summary as per organizational procedures

PATIENT SCENARIO 3 – Ambulatory Organizer

Learning Objectives

At the end of this Scenario, you will be able to do the following in Ambulatory Organizer:

- Access the Patient Chart through Ambulatory Organizer
- Document a patient visit

SCENARIO

In this scenario, you are seeing the patient in the outpatient clinic for a follow-up several weeks after surgery.

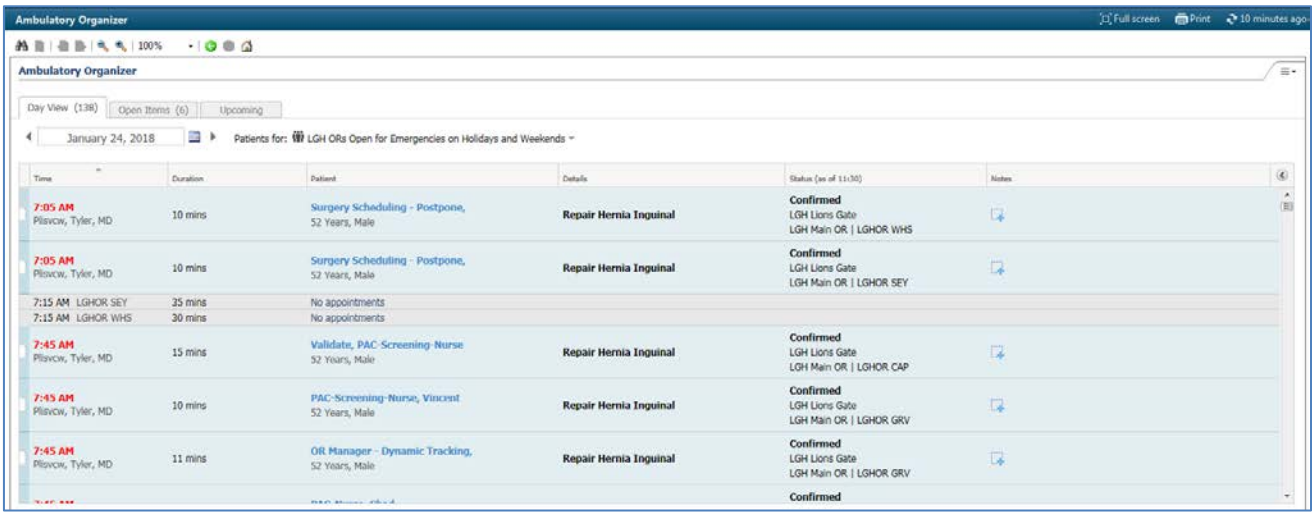
You will complete the following 3 activities in Ambulatory Organizer:

- Navigating Ambulatory Organizer
- Create Outpatient Prescriptions
- Complete a Visit Note

Activity 3.1 –Navigating Ambulatory Organizer

Ambulatory Organizer helps organize your day and see your schedule. The name Ambulatory Organizer is a misnomer as its functionalities are useful in more than just the ambulatory/outpatient setting. As a surgeon, whether or not you run a clinic in the hospital, you can use Ambulatory Organizer to view any scheduled appointment (i.e. surgical slate).

Since you have been accessing patients via Patient Overview thus far; **Ambulatory Organizer** is essentially another big picture way to view your patients and organize your workflow.

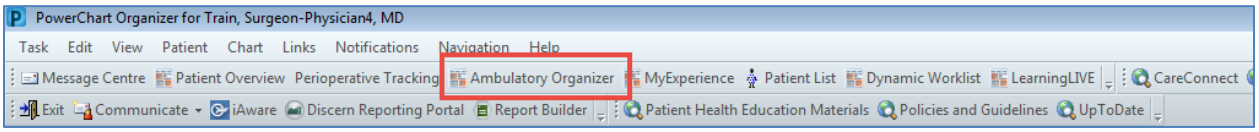


The **Ambulatory Organizer** provides a simple and comprehensive view of the clinic's schedule and displays a snapshot of the day's appointments. The view is organized by appointment times. It also includes additional pertinent information such as:

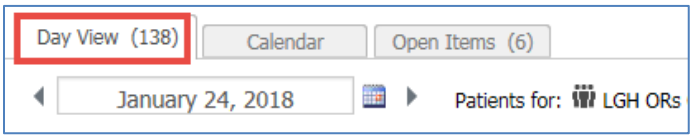
- Appointment times and details
- Patient information and status
- Outstanding items to be completed for each visit
- Patient care related reminders

Remember to click **Refresh** in **Ambulatory Organizer** to ensure that your display is up-to-date.

1 Select Ambulatory Organizer from the Toolbar.



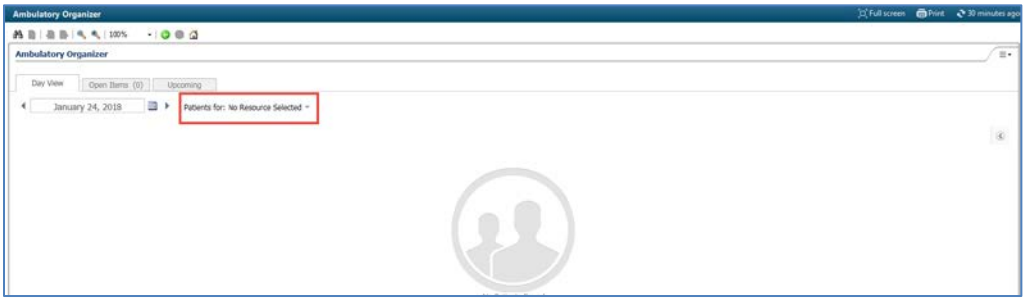
2 Once Ambulatory Organizer opens it is defaulted to **Day View** on today's date.



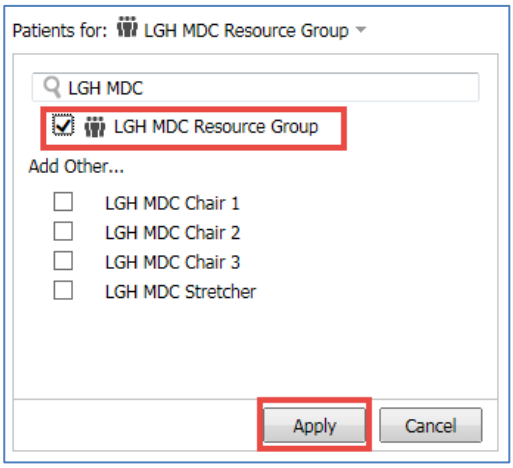
If this is your first time logging in you will need to set up what you want to see.

Click **No Resource Selected** to bring up the search box

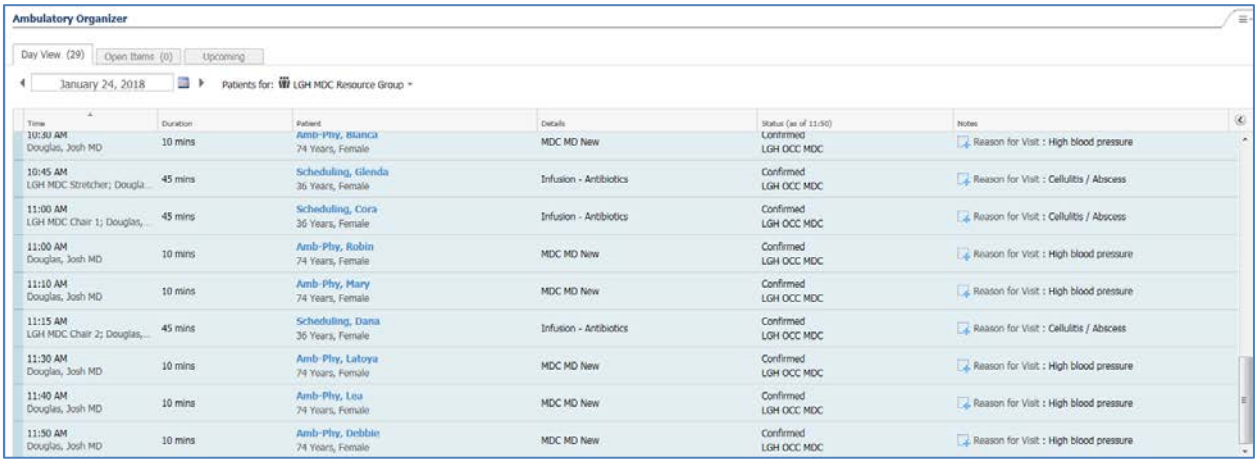
Type *LGH MDC* to display patients for this particular location



3 Select the **LGH MDC** Resource Group and click **Apply.**



4 All the patients in this clinic is now displayed in **Day View**:

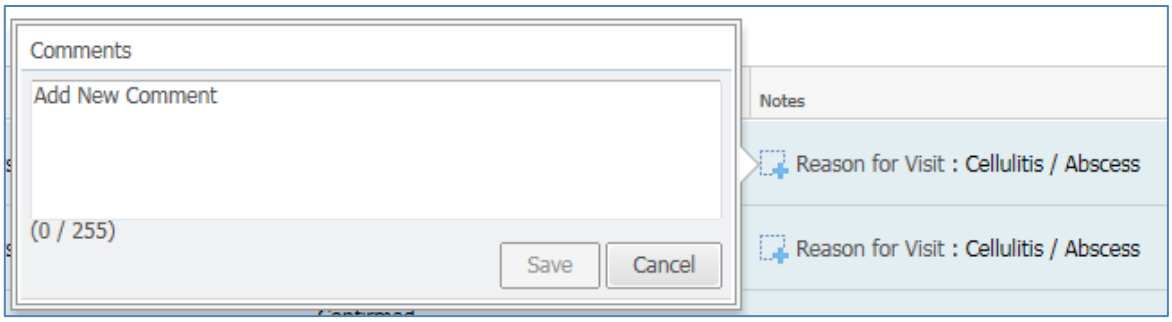


To help find your patient, you may sort the appointment list by selecting any of the following column headings:

5 You may add an informal comment to an appointment to share information with other providers and clinicians.

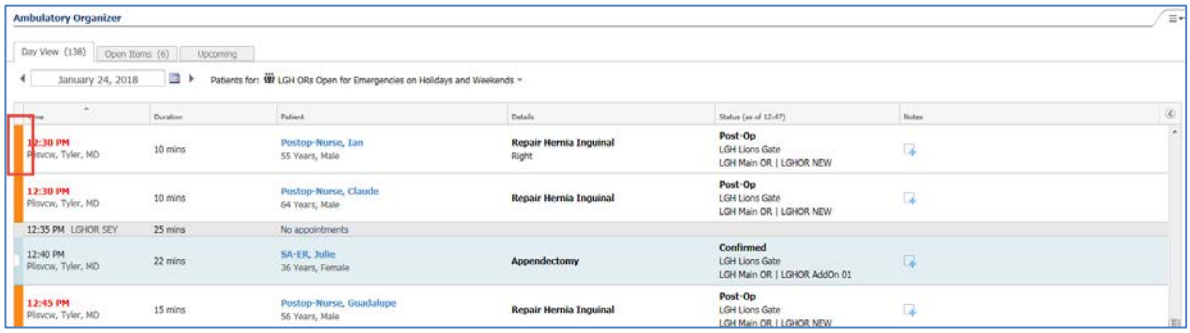
Click to open the Comments box

Type *testing* then click **Save.**



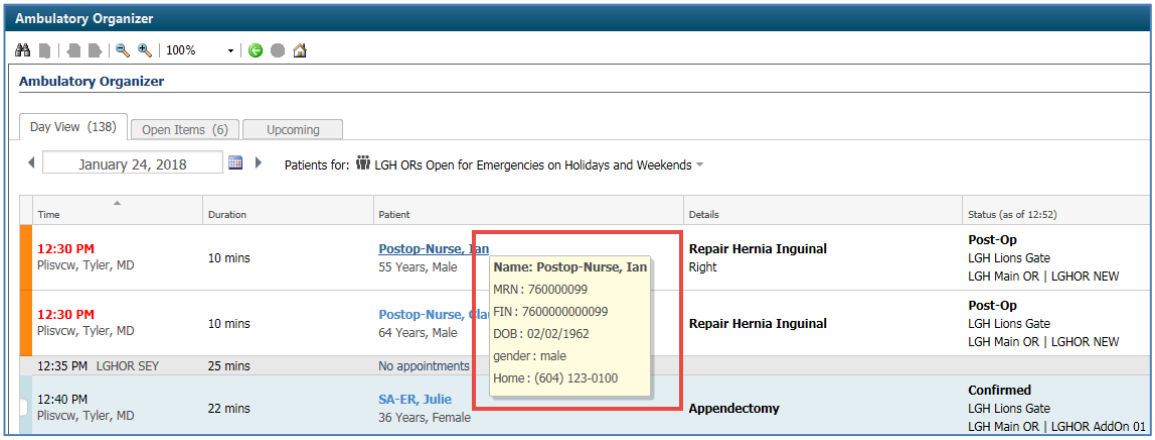
6 The color status on the left side of the booked appointment slot assists you to understand the flow of the clinic. The status of a patient will update based on documentation completed by other clinicians.

For example, an O.R. slate is displayed below to show a patient's status:



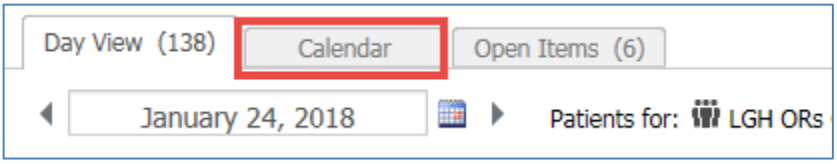
Color Status	Definition
	Light blue indicates a confirmed appointment.
	Medium blue indicates a checked in appointment.
	Green indicates a seen by nurse, medical student, Tech, Allied Health or custom status has taken place.
	Orange indicates a seen by physician, mid-level provider, resident, or custom status has taken place.
	Dark grey indicates the appointment has been checked out.
	White indicates a no show, hold, or canceled appointment (these appointment types are displayed if the system administrator has configured them to display).

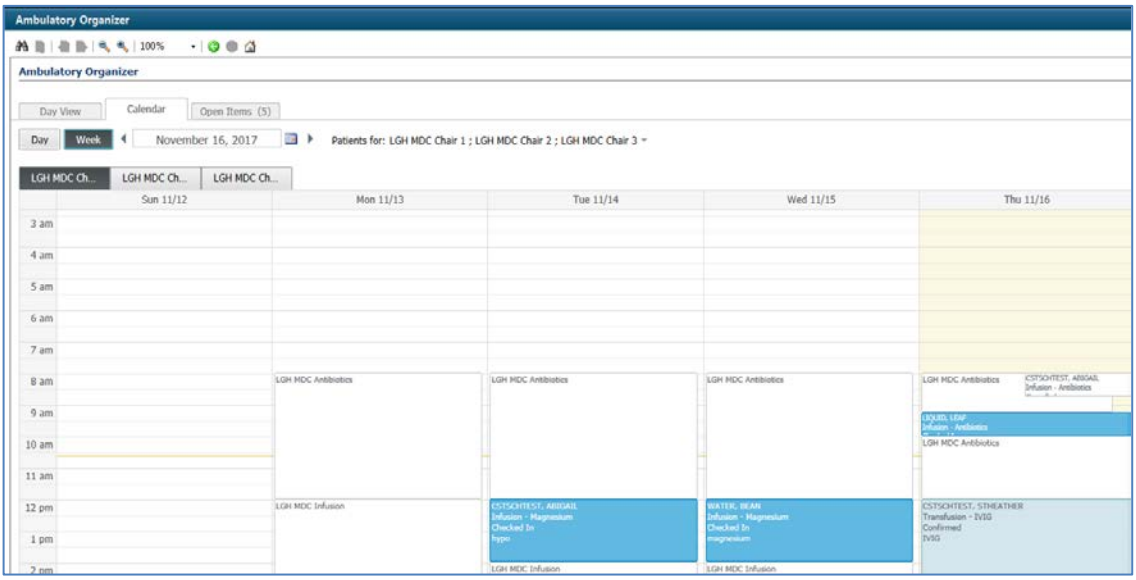
7 Hover the cursor over a patient's name to display patient demographic information in Day View.



8 Calendar View is also another way to view patients, select **Calendar View.**

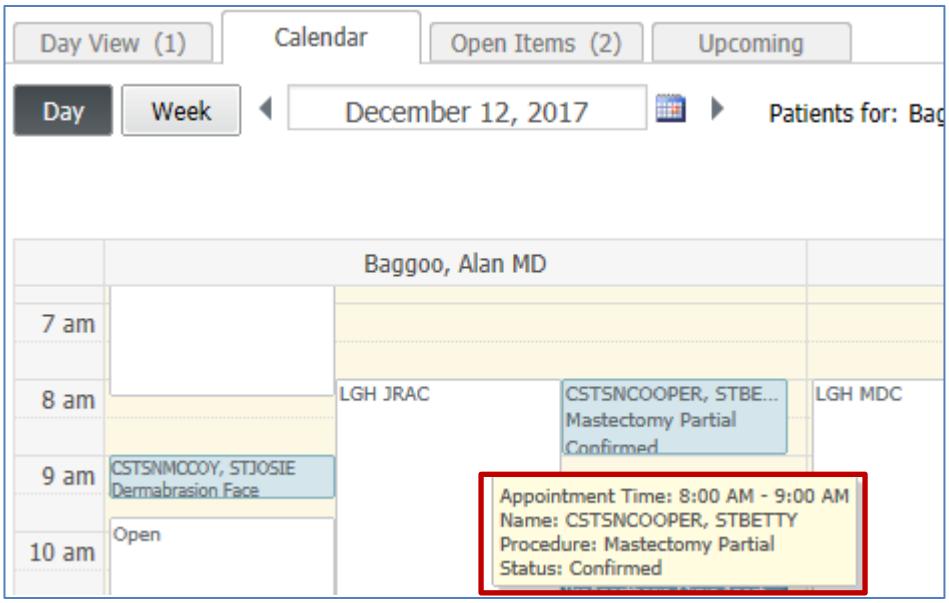
NOTE: Rescheduled, cancelled, hold, or no-show appointments are not displayed in Calendar View.



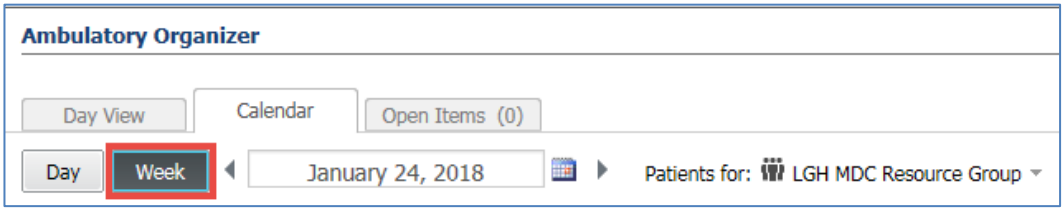


* Due to the limitations of the training environment, Calendar View is not currently configured

9 In Calendar View, you may also hover over patients to view demographic details.



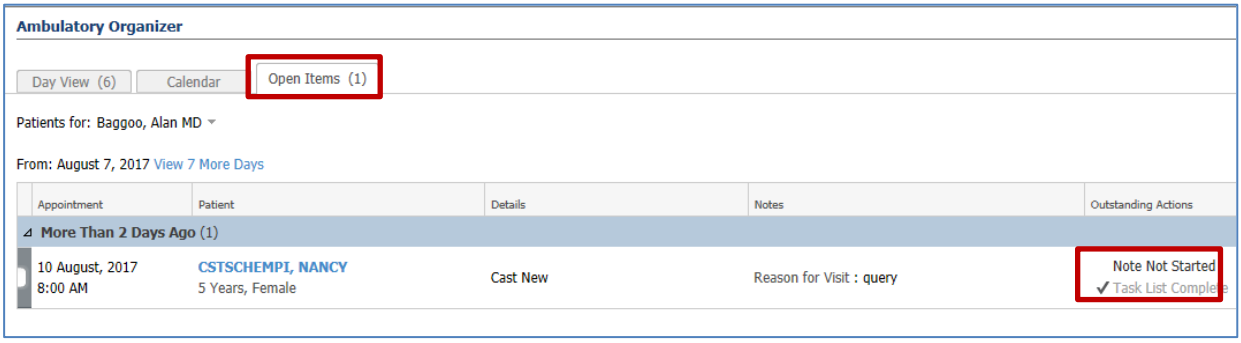
10 In Calendar View, you can also view your whole week, select **Week.**



11 **Open Items** displays a list of appointments that have outstanding actions to be completed (e.g. a missing consult note.)

Select the **Open Items** tab to view this.

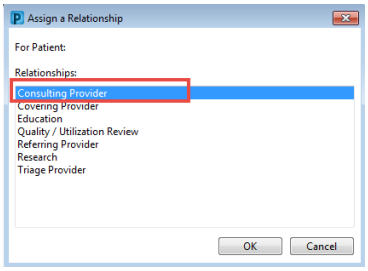
NOTE: The Task List feature used by the nursing is not available for providers.



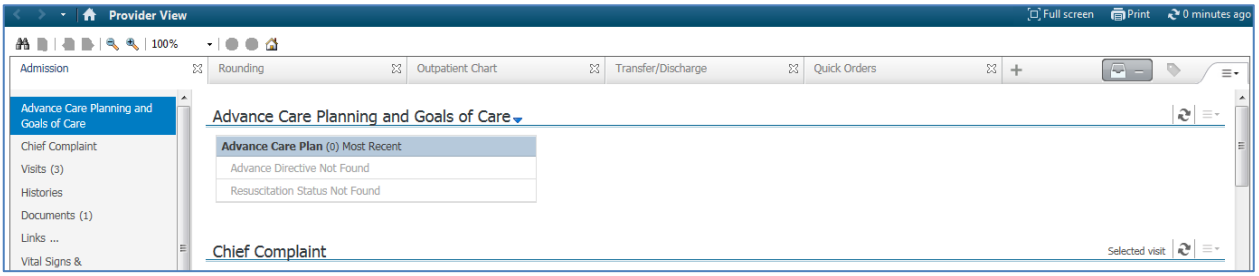
12 Now that you are familiar with Ambulatory Organizer, let's open the patient's chart from Day View.

Select **Day View** and find your patient and Click directly on the patient's name to open their chart.

13 You will be prompted to **Assign a Relationship** with the patient, select **Consulting Provider** and click **OK**



14 The patient's chart will open to Provider View.



Key Learning Points

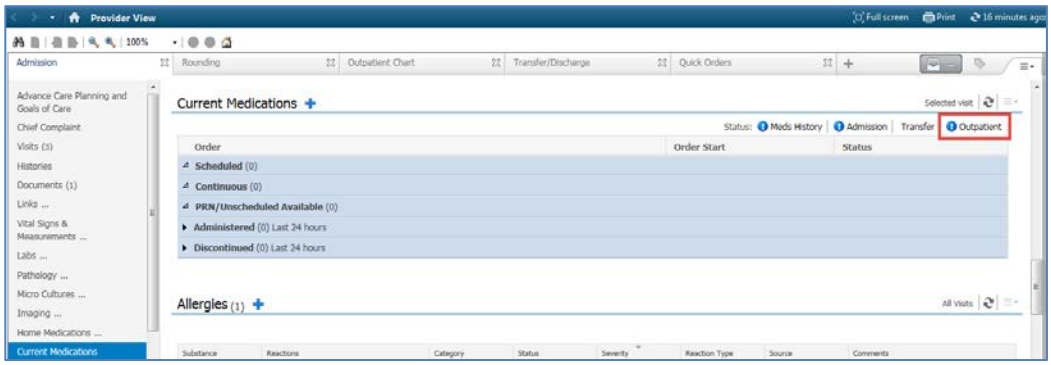
- **Ambulatory Organizer** allows you to see your scheduled appointments and offers three different displays to help you prioritize your day:
- **Day View** lists your appointments scheduled for a selected date and facility and informs about appointment status and details.
- **Calendar** tab displays your appointments for a selected day or week.
- **Open Items** tab display unfinished tasks for a single provider. You can open patient's chart in specific location directly from that view

Activity 3.2 – Create Outpatient Prescriptions

In the outpatient setting, you may need to create prescriptions for your patient.

1 If you decide to perform an Outpatient Medication Reconciliation, the process is similar to the inpatient process.

To access the Outpatient Reconciliation tab, Select or Scroll to Current Medications in Provider View.

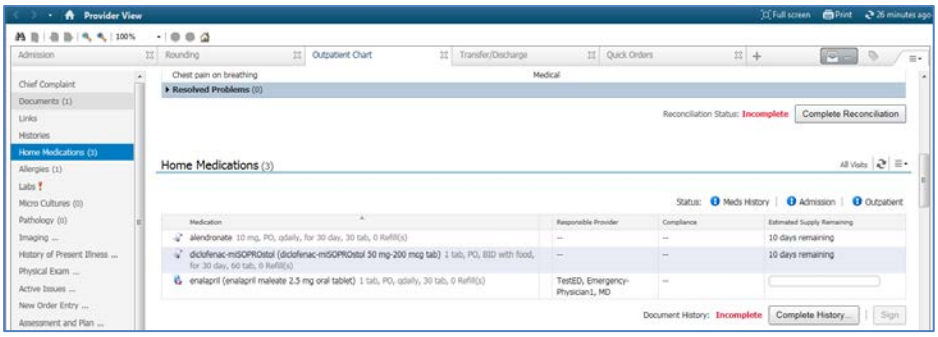


NOTE: Outpatient Reconciliation is only be available if the patient has an outpatient encounter.

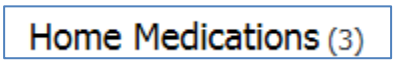
2 If you decide not to perform medication reconciliation, you may still create a prescription **from the existing medication list** for your patient.

To create a prescription, ensure you are on the **Outpatient** tab.

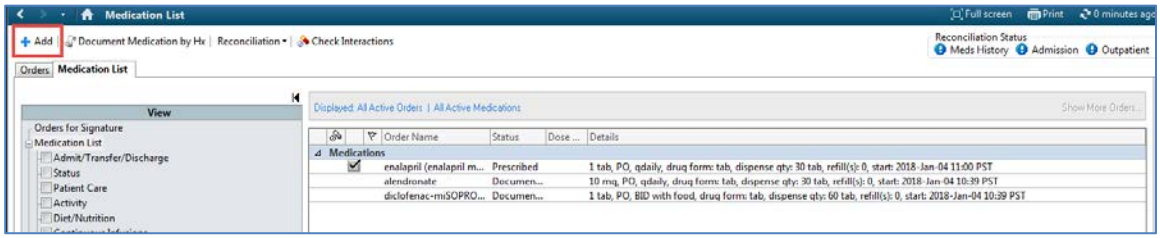
Select or scroll to **Home Medications.**



3 Click directly on the **Home Medications** heading.

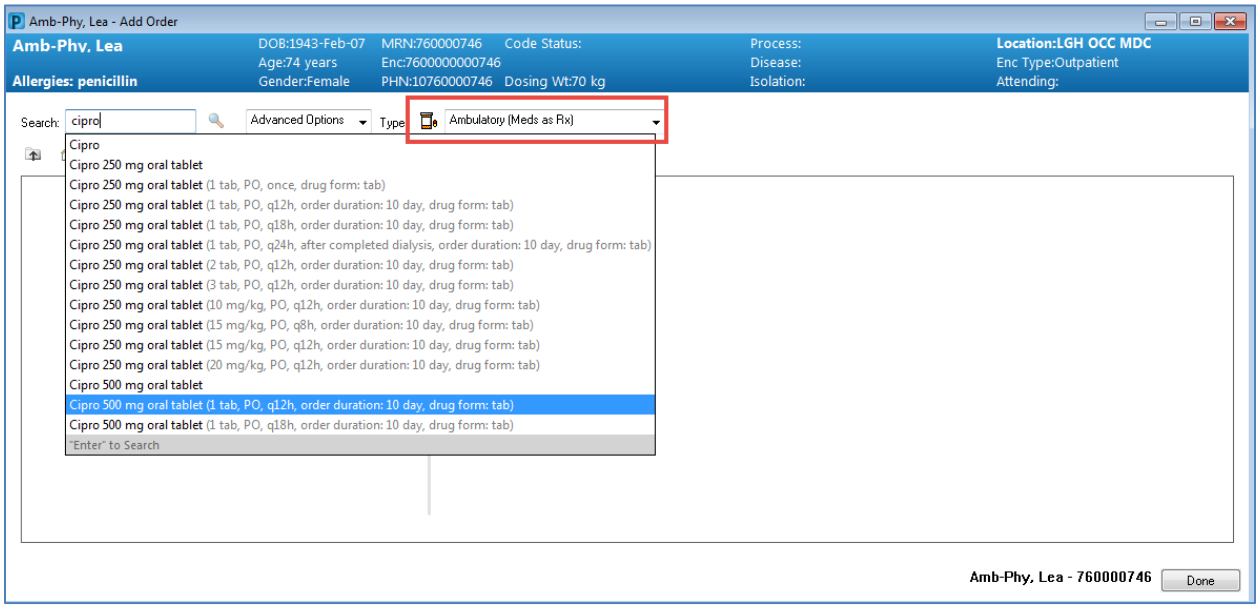


4 In the Medication List, Click **+Add**



5 In the Add Order window, search *cipro.*

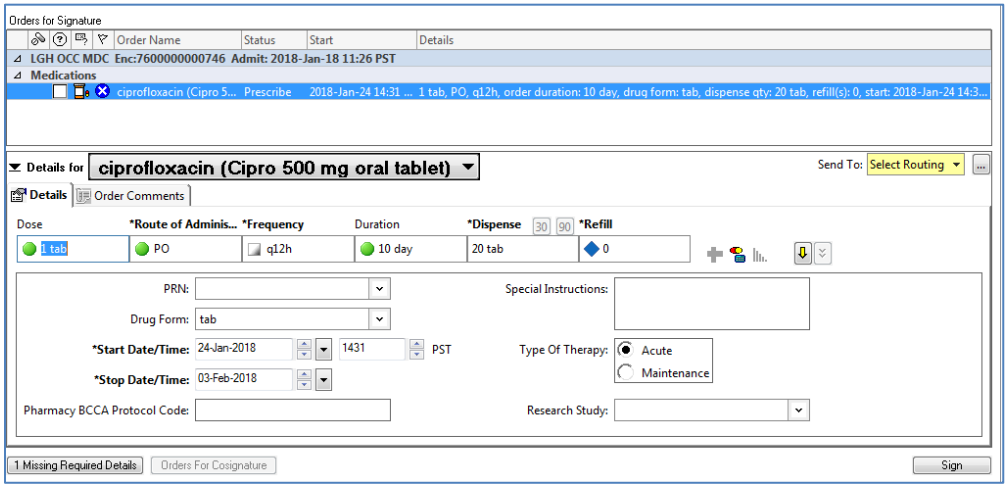
Ensure the *Ambulatory (Meds as Rx)* is selected for order **Type.**



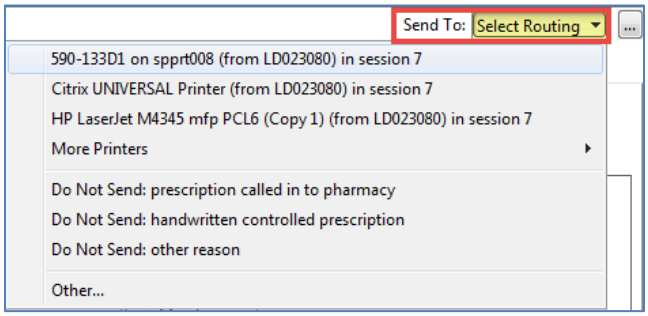
6 Select Cipro 500 mg oral tablet (1 tab, PO, q12h, order duration: 10 day, drug form: tab)

Click **Done**

7 Review and complete any missing details as necessary.



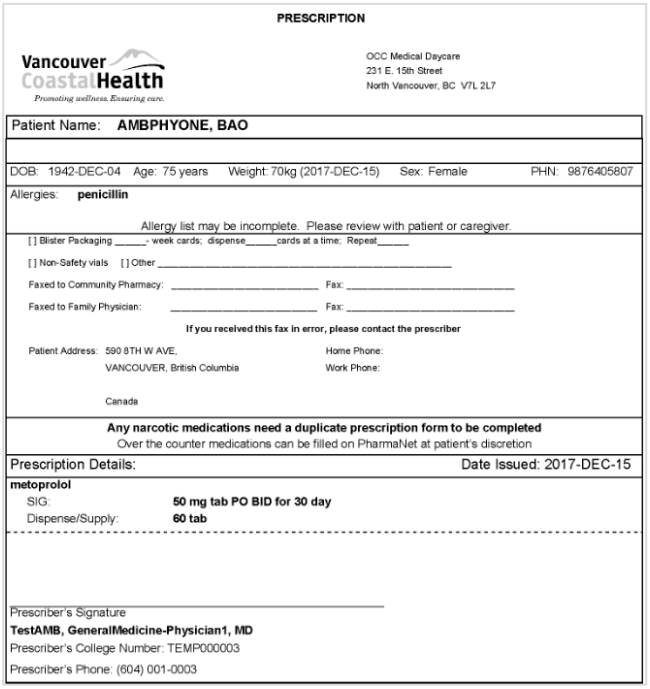
Select a printer, in **Send To:** select **Do Not Send: other reason** (for the purpose of training)



Click **Sign** when complete

Once you click **Sign** the following happens automatically:

- The medication is added to the patient's Medication List in their chart.
- The prescription will be automatically created and printed for your signature.



PRESCRIPTION

Vancouver Coastal Health
Promoting wellness. Ensuring care.

OCC Medical Daycare
231 E. 15th Street
North Vancouver, BC V7L 2L7

Patient Name: **AMBPHYONE, BAO**

DOB: 1942-DEC-04 Age: 75 years Weight: 70kg (2017-DEC-15) Sex: Female PHN: 9876405807

Allergies: **penicillin**

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: 590 8TH W AVE, Home Phone:
VANCOUVER, British Columbia Work Phone:
Canada

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: 2017-DEC-15

metoprolol
SIG: **50 mg tab PO BID for 30 day**
Dispense/Supply: **60 tab**

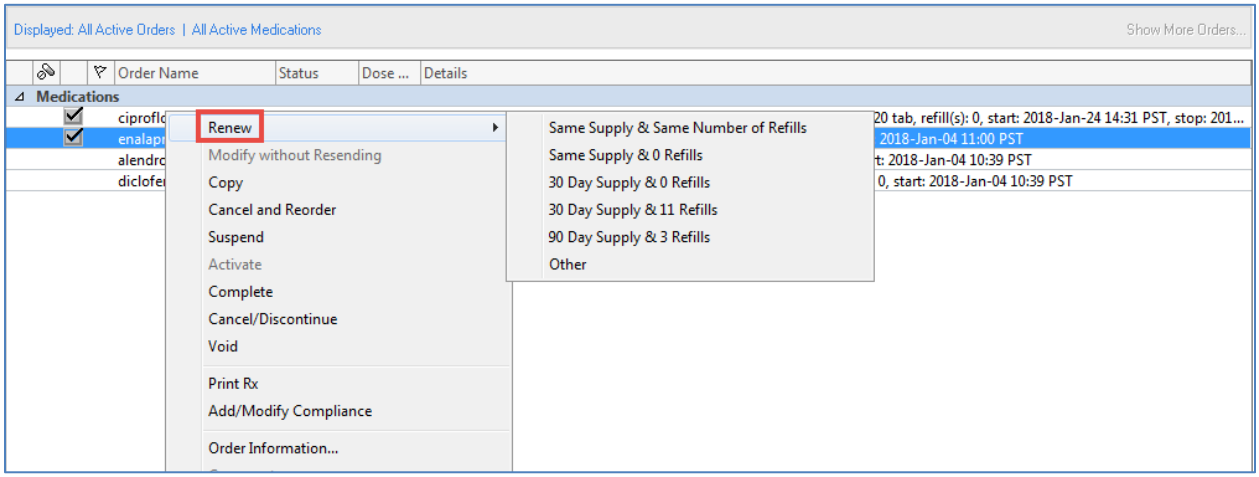
Prescriber's Signature
TestAMB, GeneralMedicine-Physician1, MD
Prescriber's College Number: TEMP000003
Prescriber's Phone: (604) 001-0003

8 To renew an existing prescription:

In the patient's **Medication List** locate the medication you wish to renew (e.g. *enalapril*).

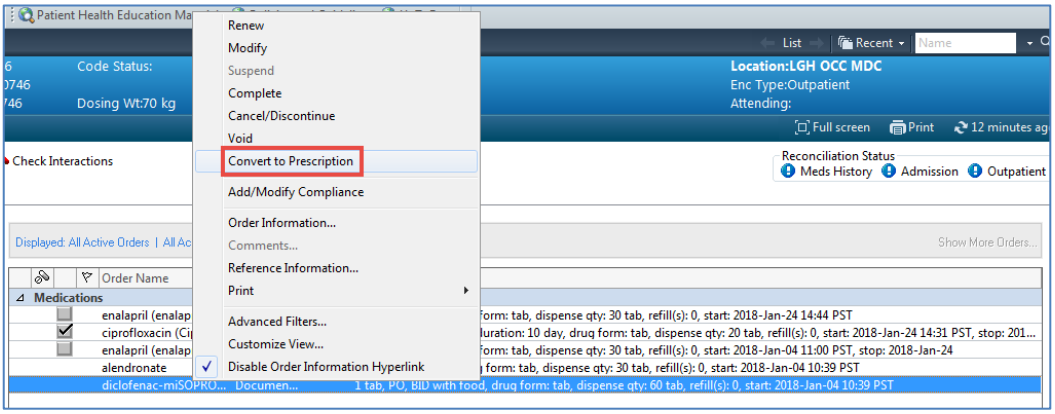
Right- click then select **Renew** and select any of the choices listed.

Complete any information as necessary to print and click **Orders for Signature** and **Sign.**



9 You may also create a prescription from any medication listed in the patient's **Medication List**. Right- click the medication and select **Convert to Prescription.**

Complete any information as necessary to print and click **Orders for Signature** and **Sign.**



Key Learning Points

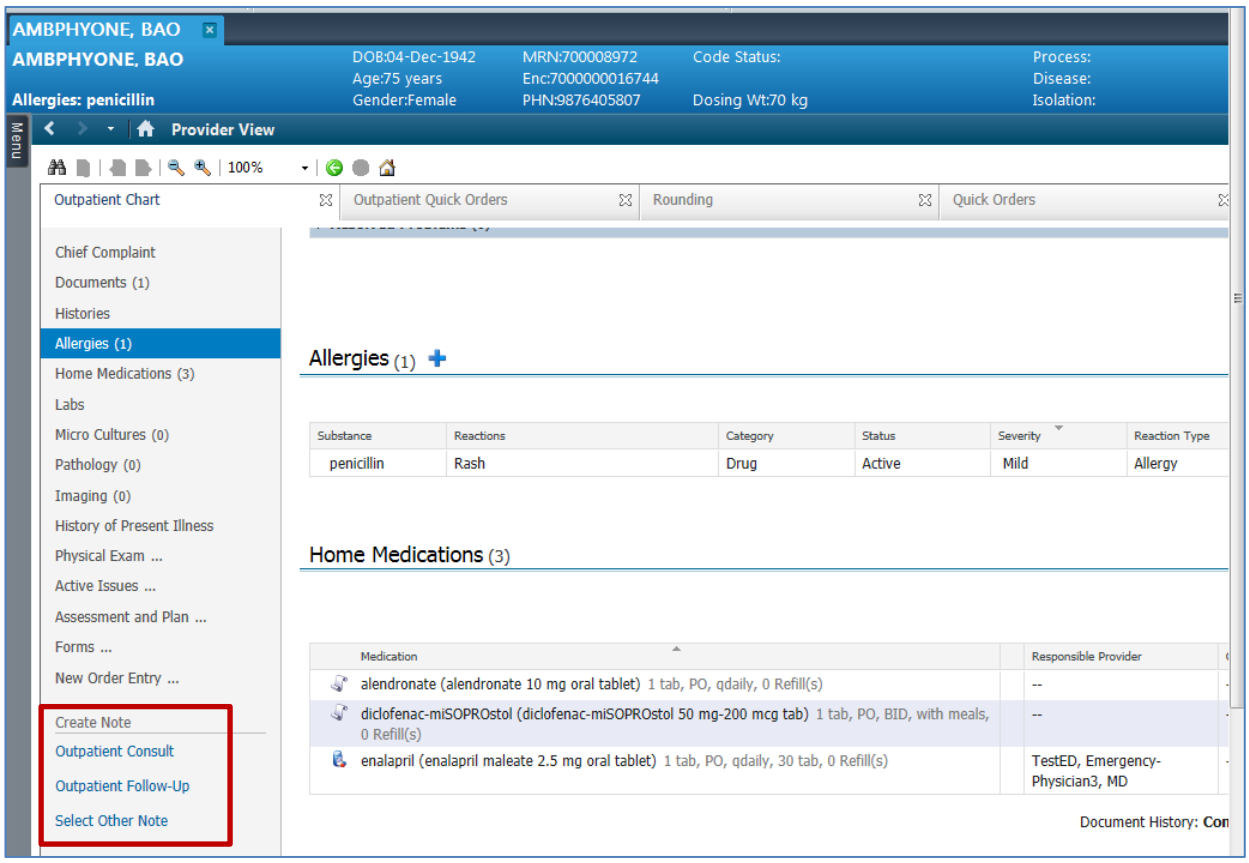
- You can add **a new prescription** or renew the existing one from the Medication List.
- The CIS will print the prescription automatically when you sign the electronic prescription.

Activity 3.3 – Complete a Visit Note

In the Outpatient Chart tab, you may generate an outpatient visit note using **Dynamic Documentation**

1 Navigate to the **Create Note** section (depending on you specialty, you may see links to different note types).

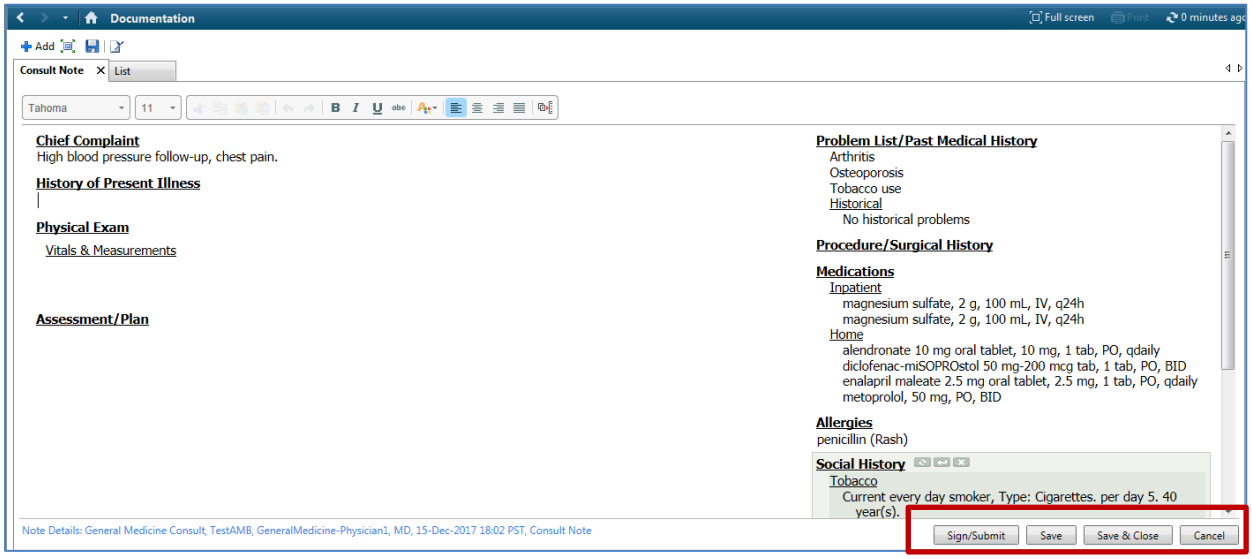
For this scenario, select **Outpatient Consult** note.



2 The note displays and pulls the information you have entered thus far for the outpatient visit.

Edit and complete the note as necessary.

Click **Sign/Submit** when done.



Key Learning Points

- Use note type links under the **Create Note** section to create a typical consult note.

PATIENT SCENARIO 4 – Managing Referrals

Learning Objectives

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

- Review and triage referrals

SCENARIO

As provider working in the outpatient setting, you may receive referrals. If a facility is not using Clinical Information System (CIS), the process will remain on paper. If a facility is using the CIS, referrals can be accepted, rejected, and scheduled electronically. In this scenario, you will practice managing referral orders, reviewing your referral queue, and accepting/rejecting a referral.

You will be completing the following 2 activities:

- Manage Referral Orders
- Access and Navigate the List of Referred Patients

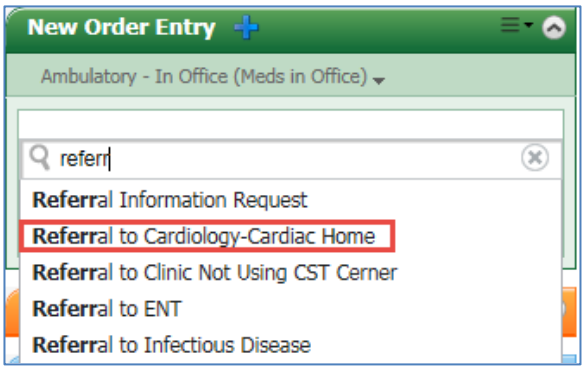
Activity 4.1 – Managing Referral Orders

How to Order a Referral

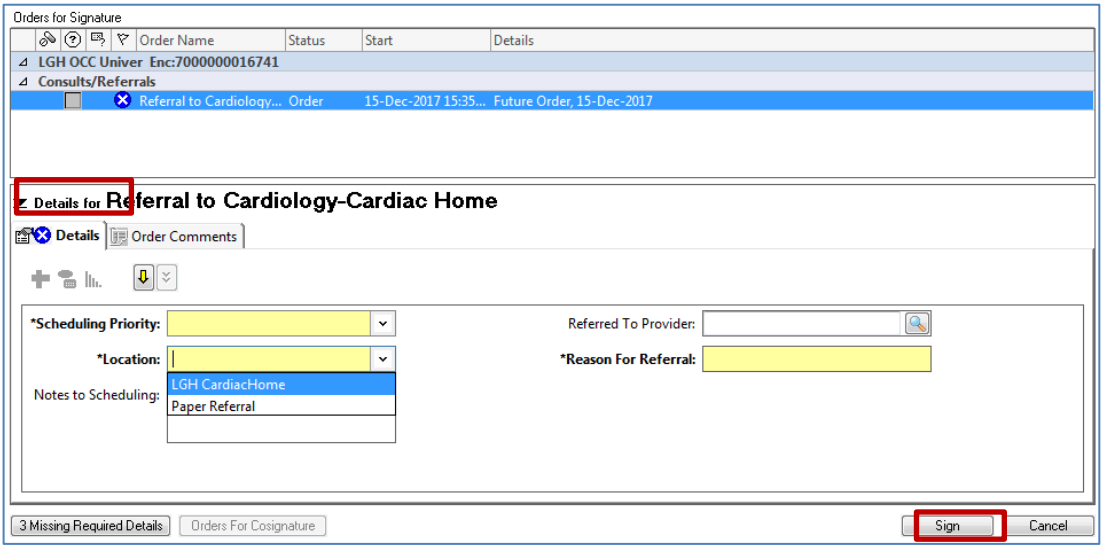
1 In the **Quick Orders** tab, expand **New Order Entry** folder.

Type *Referral*

Select **Referral to Cardiology-Cardiac Home**



2 Display **Details**, and add missing information to mandatory boxes, then click **Sign**.



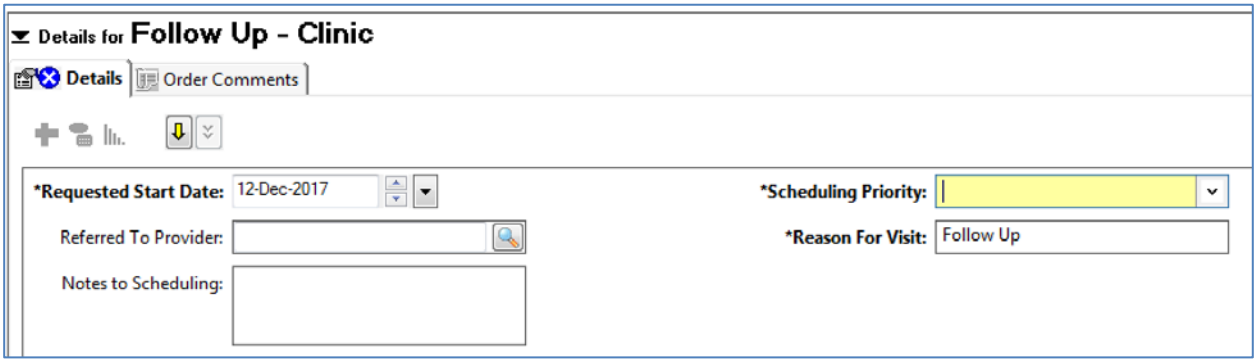
NOTE: Referral orders to different specialties have unique appointment types associated with the specific reason or the length of the visit.

Orders for Follow-up Appointments

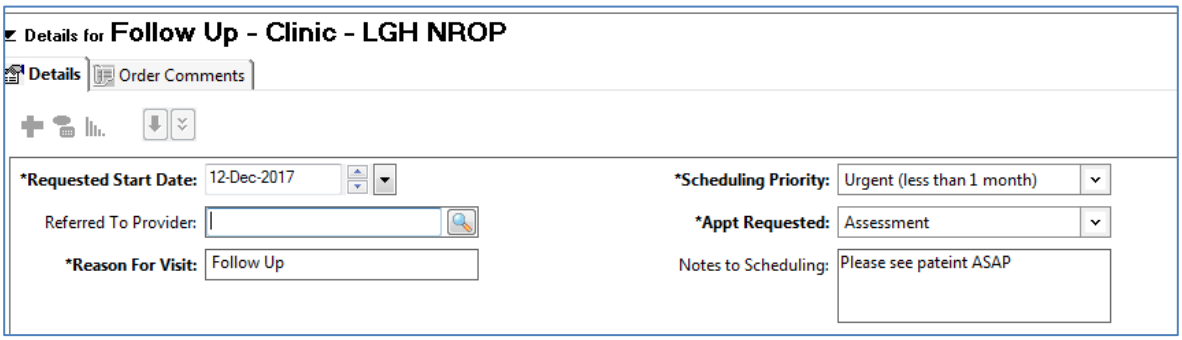
1 In the Quick Orders tab, locate the **Follow-up Clinic** order by using the New Order Entry search.

NOTE: Orders for follow-up visits are clinic specific and some clinics might have various types of appointments.

If your clinic has just one type of the follow-up appointment, you will see will see the generic "Follow up – Clinic" order:



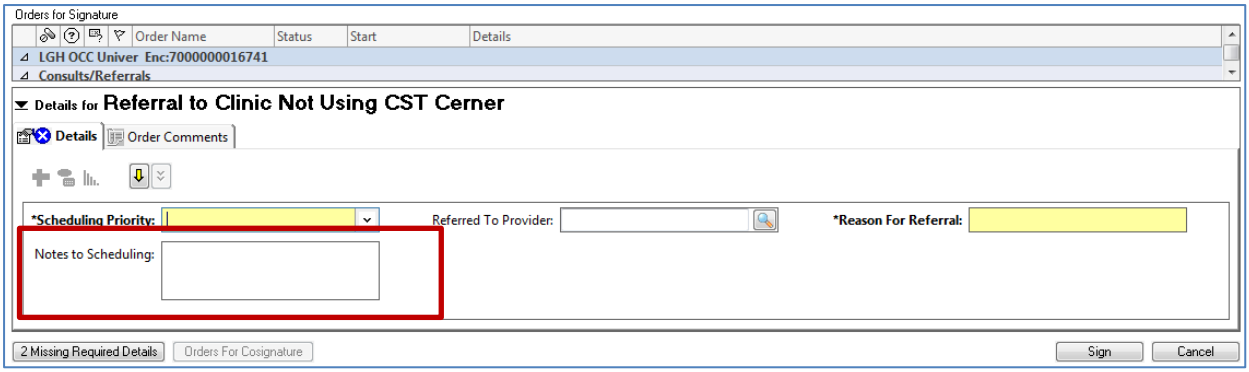
2 If the clinic has multiple follow-up appointments, the order name will specify the clinic name and you need to select a specific appointment type from the drop-down:



NOTE: You can save the repetitive orders with selections to favorites to optimize placing these orders in the future.

3 When referring your patient to a clinic that is not using the CIS, place a **Referral to Clinic Not Using CST Cerner**.

A paper referral requisition will print. The referring location should be indicated in the notes to scheduling.

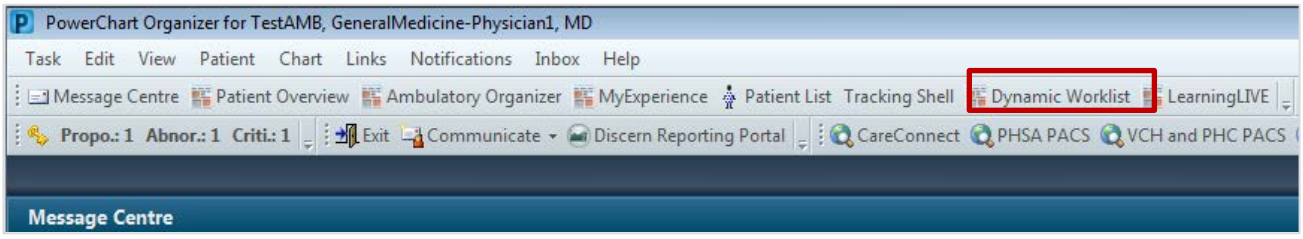


Key Learning Points

- Many outpatient orders are **future orders** as indicated by the order sentence
- When placing an order for the external facility, ensure to select a **Scheduling Location**
- When Scheduling Location is not available, select **Print to Paper**
- For clinics with multiple follow-up appointment types, the clinic name is part of the order name and appointment type can be selected

Activity 4.2 – Access and Navigate the List of Referred Patients

The CIS provides a list of referred patients using the **Dynamic Worklist** functionality that can be accessed from the main toolbar:



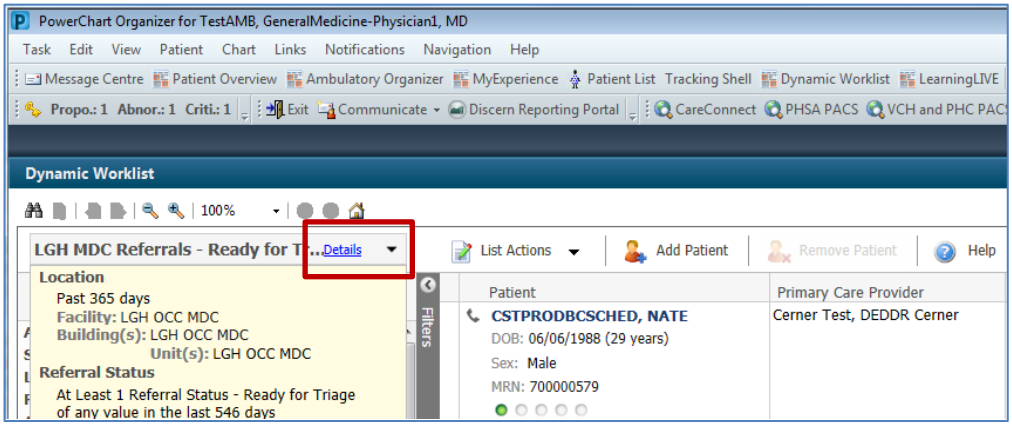
Dynamic Worklist allows users to create a subset of patients based on many different criteria, for example:

- Health conditions
- Results
- Orders
- Appointment types
- Demographics like age or sex

Below you see an example of criteria set for *Referrals coming to the LGH Neuro ROP Clinic* with a referral status of *Ready for Triage* in the last 546 days.

The Dynamic Worklist is vital for tracking and triaging patient referrals as they relate to your clinic. For example, one worklist can track patients that are **Ready for Triage** while other called **Booked** will group patients that already have an appointment.

It is important to name worklists properly to clearly reflect the selection criteria. Each list is set up once and then continuously used to monitor referrals. Hovering over the specific worklist **Details** will display its criteria to ensure that the right selection of patients is displayed.



Patient's chart can be open directly from the worklist assisting in making a decision to:

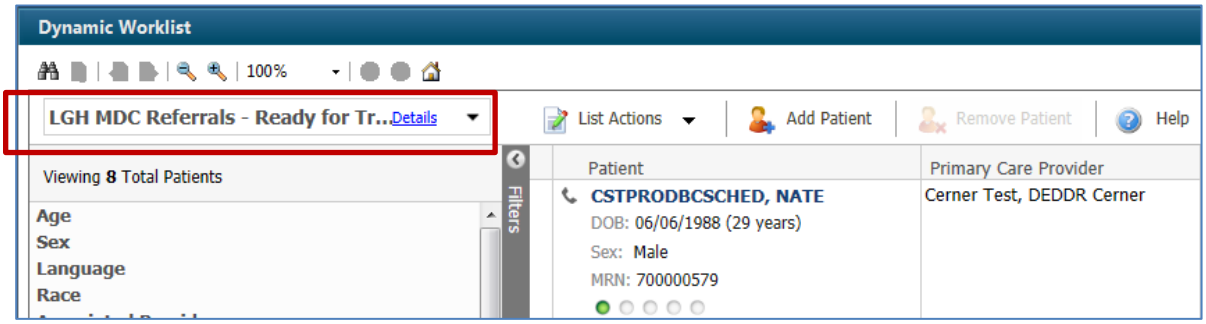
- Accept the referral
- Reject the referral
- Request more information

With patient's chart open, an order is placed that updates clinic's worklists:

- Placing the **Accept Referral** order will automatically update the referral status to A*ccepted.* Patient will drop from the *Ready for Triage* worklist and Scheduling will receive the order to book an appointment.
- Placing the **Reject Referral** order will automatically update the referral status to *Rejected*. Patient will drop from the worklist.
- Placing the **Referral Information Request** order will temporarily drop the patient from *Ready for Triage* worklist. The clerical staff receives the task to obtain information requested by a provider. Once the information is received, the nurse will change the referral status back to *Ready for Triage* and the provider will either accept or reject the referral.

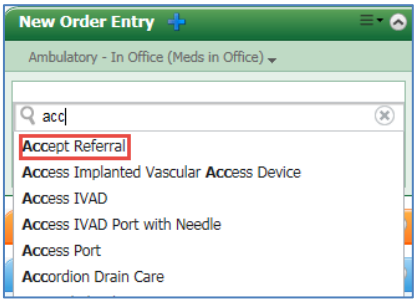
To Accept a Referral

1 Click the Dynamic Worklist button on the toolbar to display worklists. Ensure the **LGH MDC Referrals - Ready for Triage** list is displayed.



2 Click patient's name to open and review the chart.

1. To accept the referral, under New Order entry
2. Type *acc*

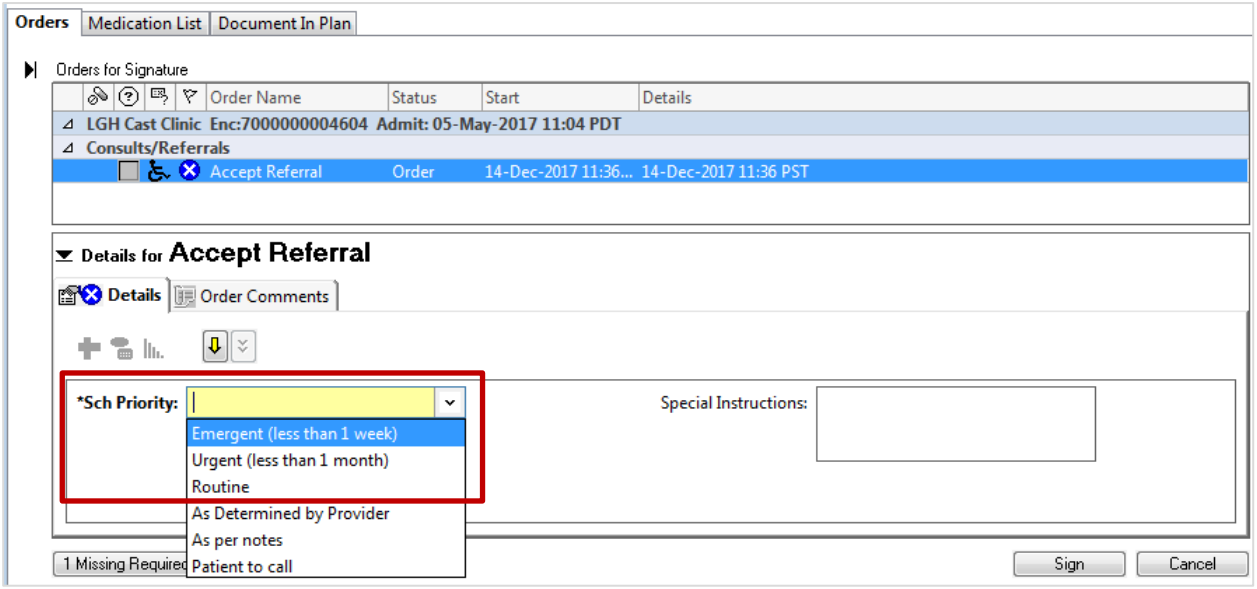


3 Select **Accept Referral** and click Orders for Signature  icon.

4 Click Modify to add required details and click the order to display **Details**.

Select one of the options for the **Sch Priority** for the Scheduling clerks. Special instructions are optional but might be helpful.

Click **Sign**. The referral is removed from the clinics Ready for Triage worklist.



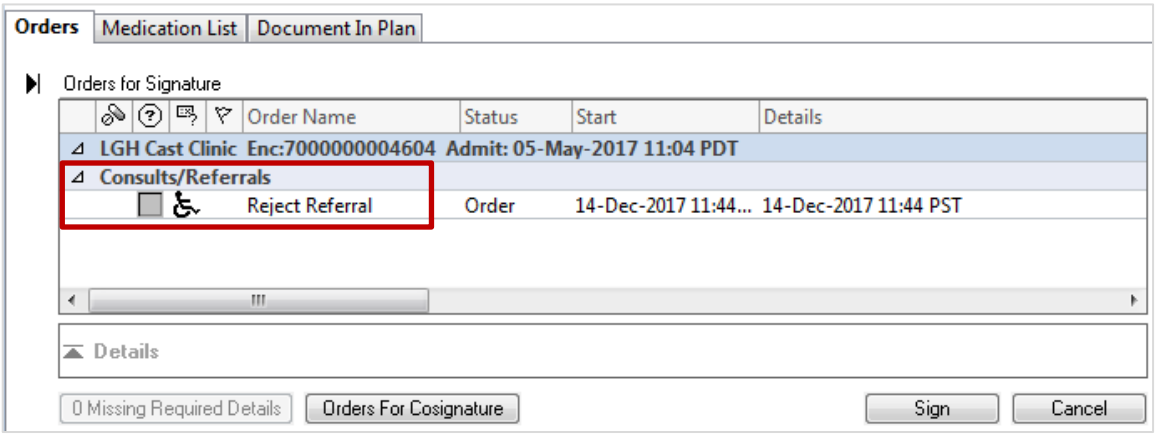
To Reject a Referral

1

1. Return to the Dynamic Worklist screen to display the **LGH MDC Referrals - Ready for Triage** worklist.

2. Select the patient, and locate the **Reject Referral** order under Outpatient Quick Orders > Referrals/Consults > Special Requests.

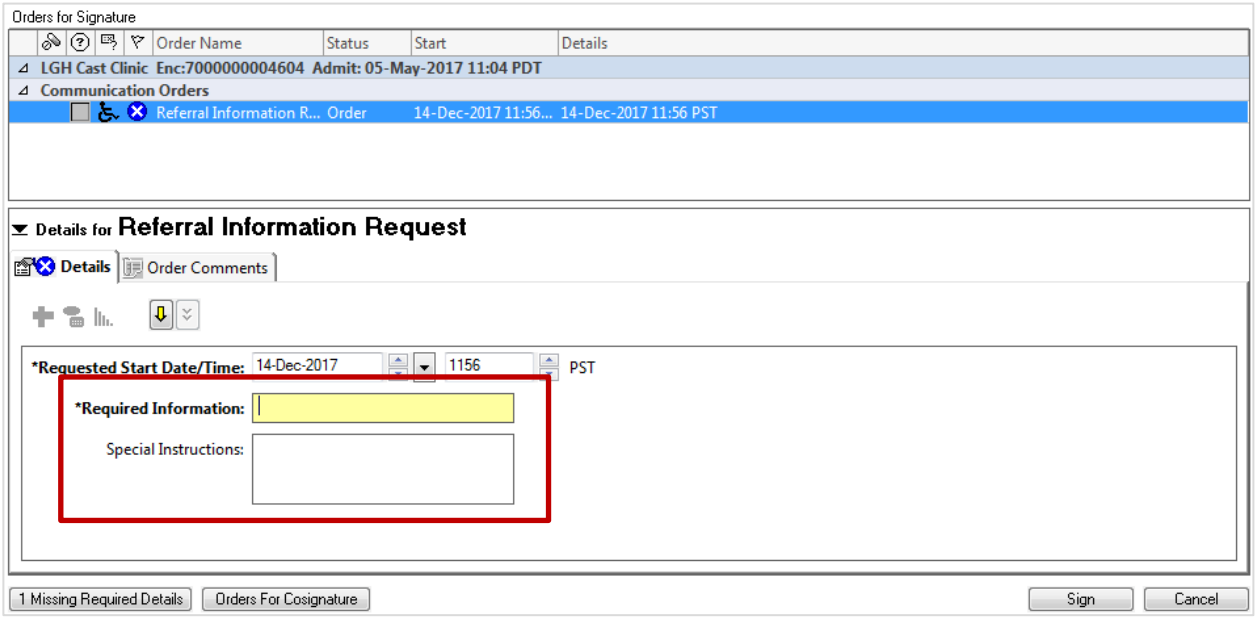
3. Place the order and **Sign**. The referral is removed from the clinics Ready for Triage worklist.



To Request More Information

1

1. Return to the Dynamic Worklist screen to display the **LGH MDC Referrals - Ready for Triage** worklist.
2. Select the patient, and locate the **Request More Information** order under Outpatient Quick Orders > Referrals/Consults > Special Requests.
3. Place the order and click Modify.
4. Click the order to display **Details** and type what information is required under **Required Information**.
5. Add Special Instructions if necessary.
6. Place the order and **Sign**. The referral is temporarily removed from the clinics Ready for Triage worklist until request is completed.



Key Learning Points

- Use **Dynamic Worklists** to triage and manage referrals
- Placing a **Special Request** order will document your decision to:
  - **Accept Referral**
  - **Reject Referral**
  - Place a **Referral Information Request**
- Special Request orders will update the appropriate Dynamic Worklist and trigger actions for designated team members

End Book Two

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