SELF-GUIDED PRACTICE WORKBOOK [N16]
CST Transformational Learning

WORKBOOK TITLE:

Provider: Inpatient

TRANSFORMATIONAL
LEARNING

CLINICAL + SYSTEMS
TRANSFORMATION
Our path to smarter, seamless care

📄 TABLE OF CONTENTS

✚ SELF-GUIDED PRACTICE WORKBOOK

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

Using Train Domain

You will be using the Train domain to complete activities in this workbook. It has been designed to match the actual Clinical Information System (CIS) as closely as possible.

- Scenarios and their activities demonstrate the CIS functionality **not the actual workflow**

- Some clinical scenario **details have been simplified** for training purposes

- Some screenshots may not be identical to what is seen on your screen and should be used for reference purposes only

- **Follow all steps** to be able to complete activities

- If you have trouble to follow the steps, immediately **raise your hand for assistance** to use classroom time efficiently

📕 In This Workbook

Patient Scenario 1 – Accessing and Reviewing Patient's Chart

Patient Scenario 2 – Admitting the Patient

Patient Scenario 3 – Managing Your Patient during Rounding

Patient Scenario 4 – Discharging a Patient Home or External Site

Patient Scenario 5 – Transferring a Patient

Key Learning Review

🎬 PATIENT SCENARIO 1 – Accessing and Reviewing Patient's Chart

Learning Objectives
At the end of this scenario, you will be able to: 🟩 Open and work with a patient's chart 🟩 Locate and review patient information

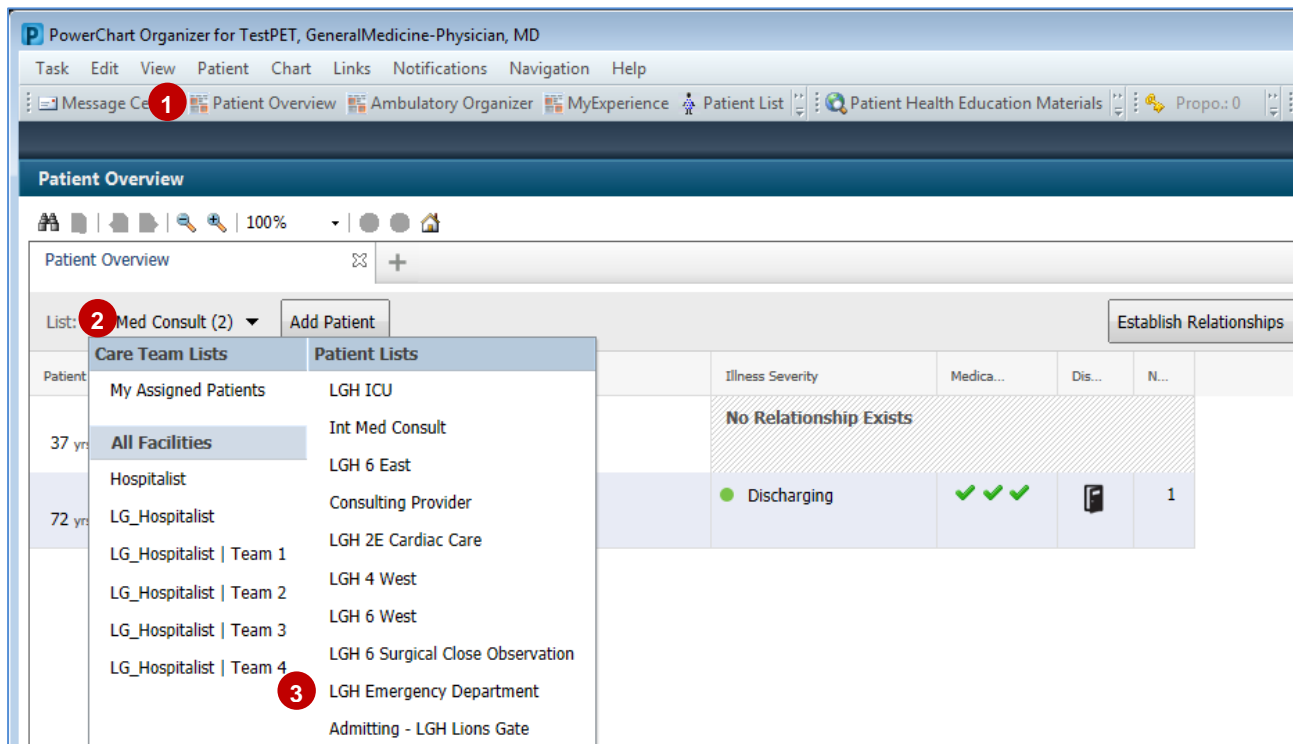| SCENARIO |
| --- |
| As the provider covering the Medicine Unit, you received a phone call from the Emergency Department provider, who requested a **new patient consult**. You access patient's chart and review information to make a **decision about the possible admission**.

You will complete the following activities:

🟩 Access a patient's chart

🟩 Navigate a patient's chart

🟩 Review and update patient history

🟩 Review and update patient allergies

🟩 Review documents, labs, and imaging |

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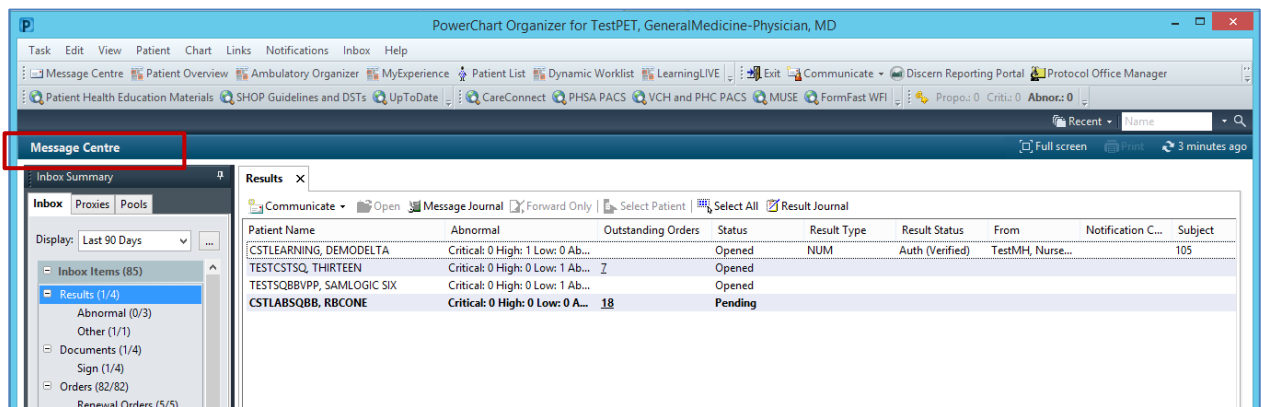
2 | In the real life, you will be able to find your patient on the existing ED patients list but in the Train Domain, Jane has been added to the **My Assigned Patients** list.

1. Select the **Patient Overview**.

2. Click the down arrow and select **My Assigned Patients** list.

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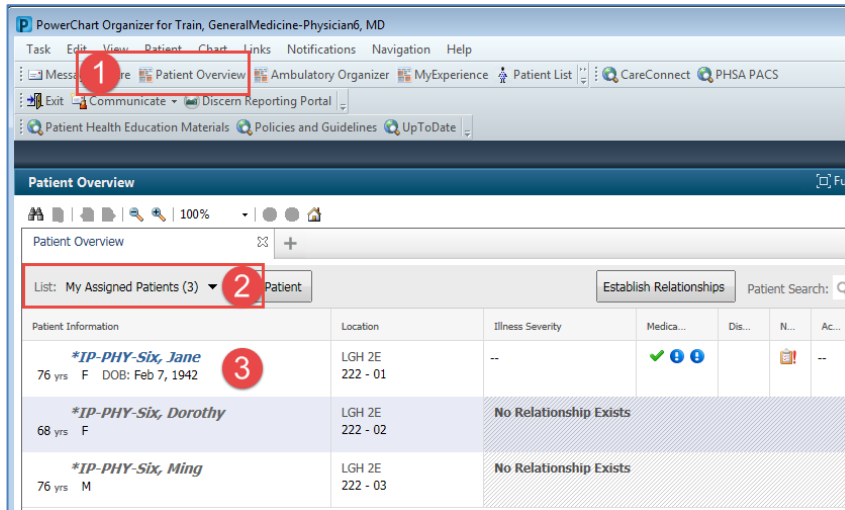
3 The patient's chart opens to the **Provider View** which is your current default screen. Now let's explore the screen a little further.

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).

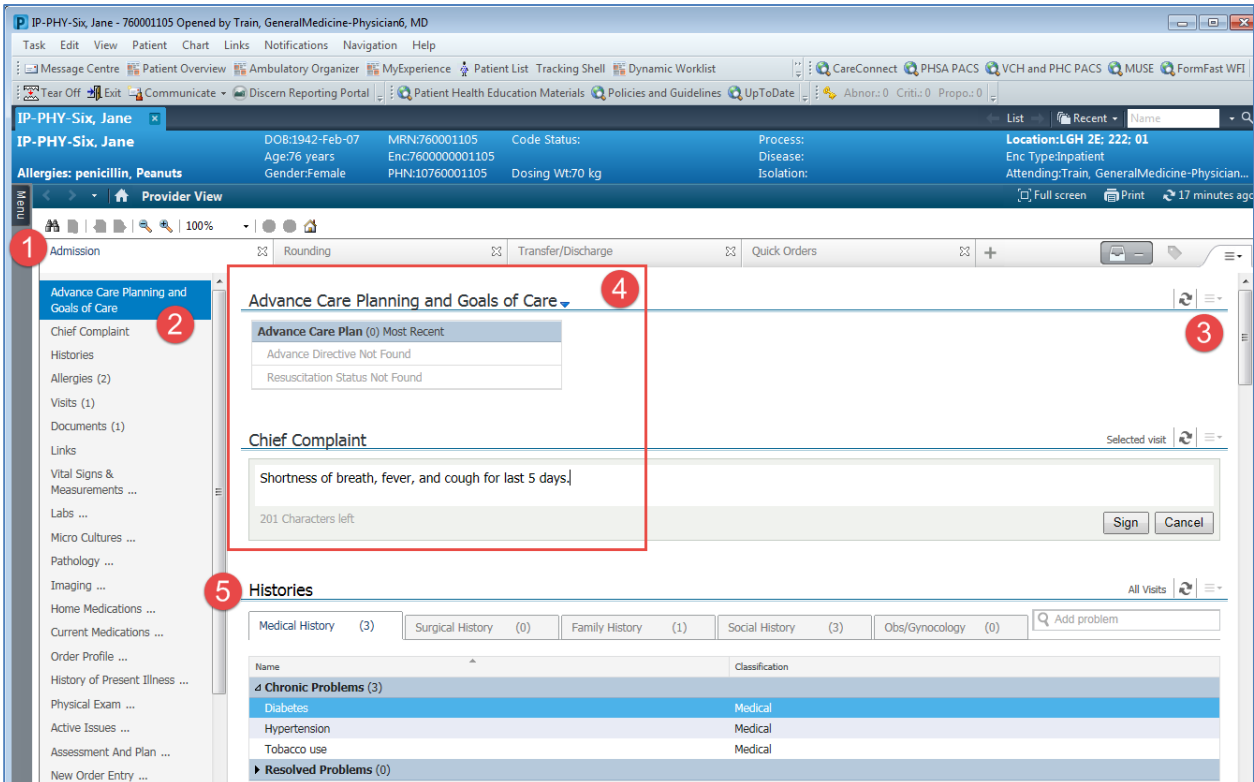8. At the bottom, you will see your login name. Ensure you always work under your own login.
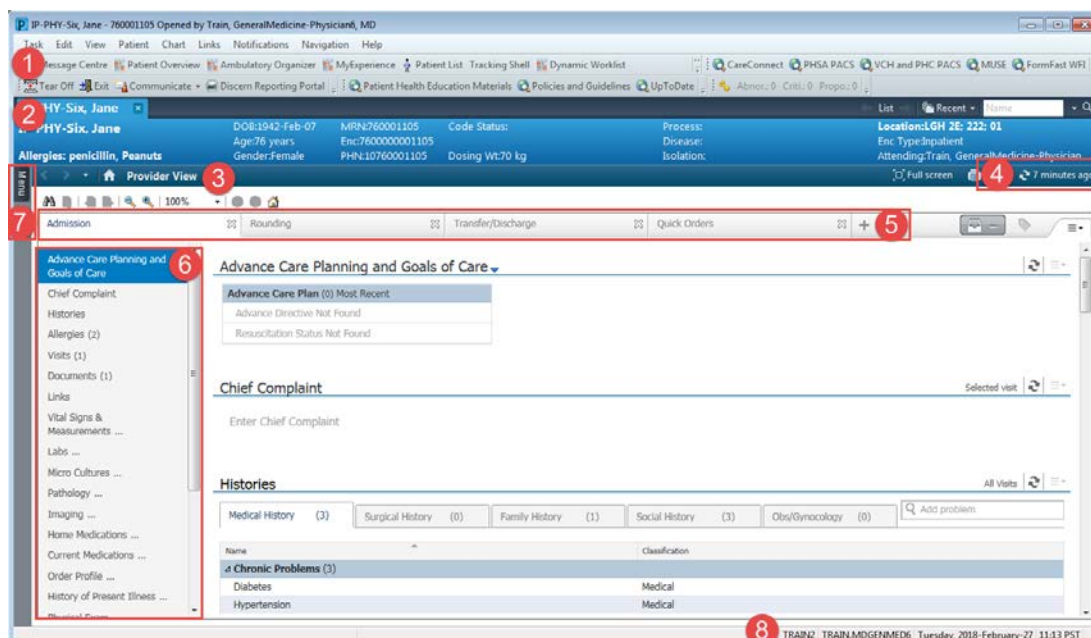
4

Now you will review Jane's chart to decide about her 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?

🔑 Key Learning Points

- Use the **Patient Overview** and specific patient lists to access patient charts

- Review **Banner Bar** information to ensure you have selected the right patient and the right encounter

- Remember to **refresh** your screen frequently to view the most up-to-date information

- The **Provider View** provides access to various workflow tabs

- Each workflow tab has a **list of components** specific to this workflow and to your specialty

- Click the **component heading** to open a more comprehensive window

🧩 Activity 1.2. – Review Histories

Jane just told you about a hip replacement she had last year and you want to enter this information.
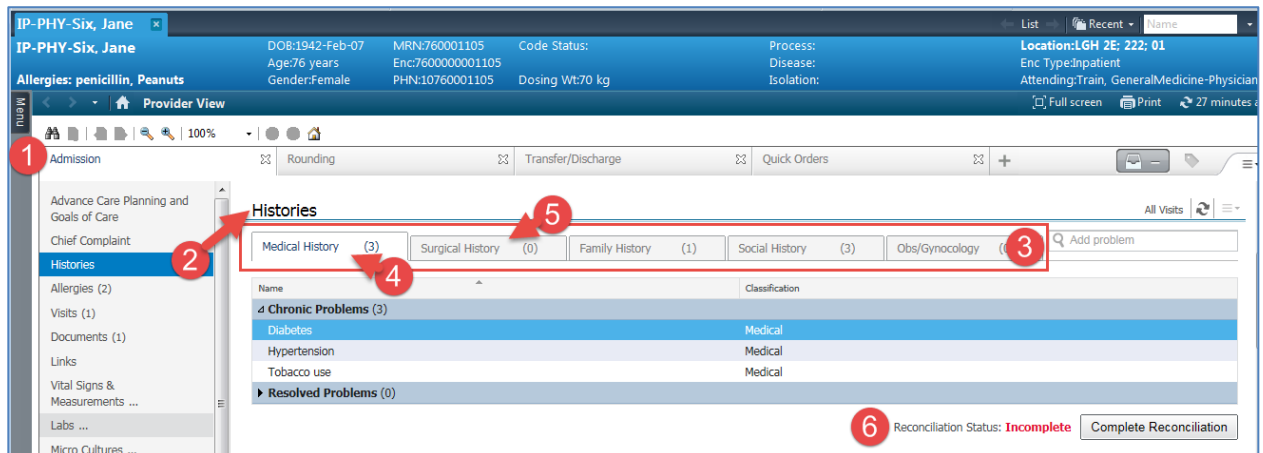
In this activity you will:
- Add a new procedure to patient's history

1

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

2. Click the **Histories** component from the list to display Jane's record.

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, Jane has 3 records for **Medical History** entered previously.

6. To add a hip replacement 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 *hip replacement.* A list of options will appear.

3. Select an appropriate option from the list below.

3 Take a look at Jane's record:

1. The selected procedure automatically populates Surgical History.

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 75* years – scroll down, if necessary.

Click **Save.**

Save	Cancel	⋙

Open treatment of spontaneous hip dislocation (developmental, including congenital or pathological), replacement of femoral head in acetabulum (including tenotomy, etc);

| At/On | ▾ | Age | ▾ | 75 | Years | ▾ |

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.
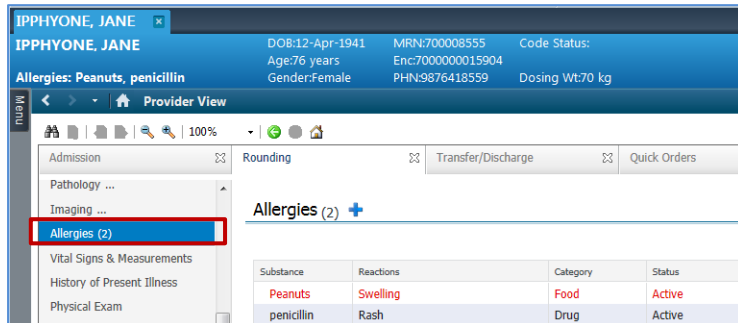
🔑 Key Learning Points

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

Activity 1.3 – Review Allergies
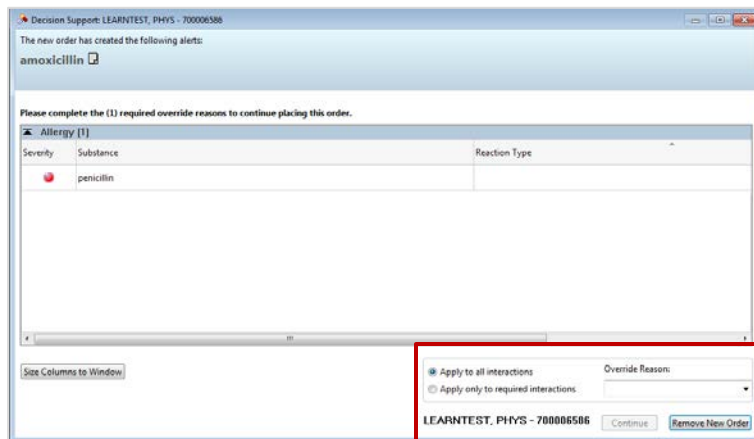
In the Clinical Information System (CIS), a patient's allergies are **to be reviewed** by a provider on admission and at every transition of care. Allergy information is carried forward from one patient visit to the next.

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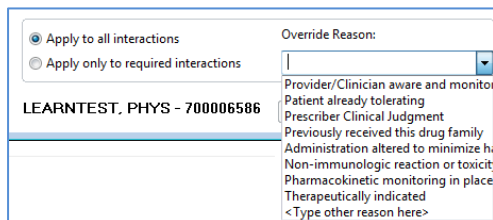
You can either remove the order and select another medication, or continue with the order by overriding the alert and documenting the reason:

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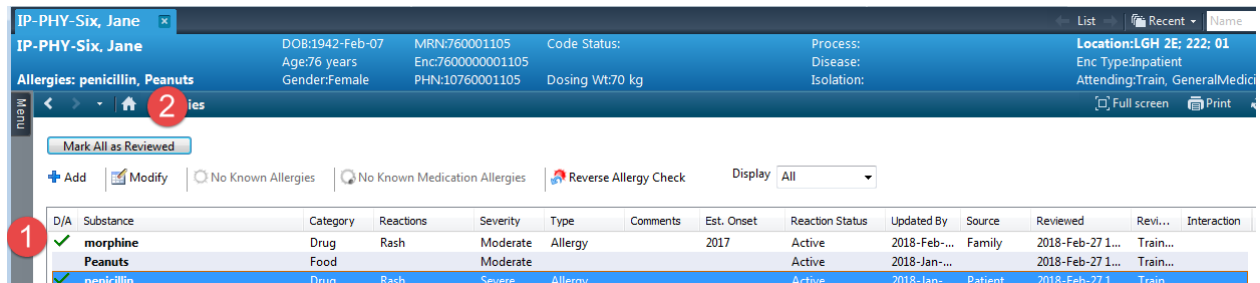
6 Check if morphine allergy is added to Jane's record.

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
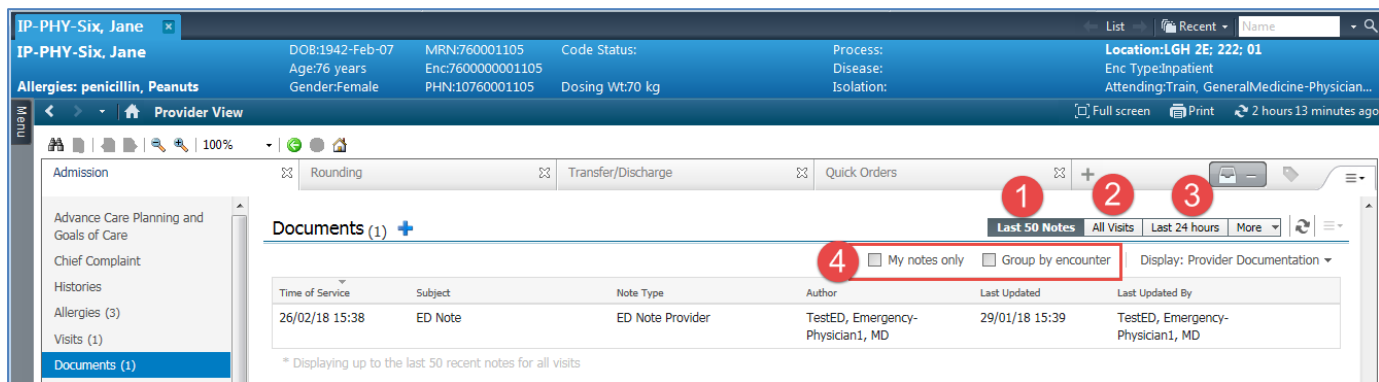
- Patient **allergies** and interactions are monitored by the CIS

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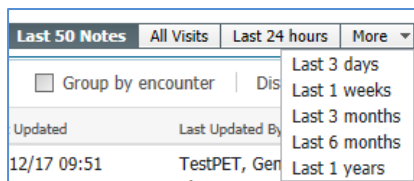
One good example of how to use filters is the **Documents** component:

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**.
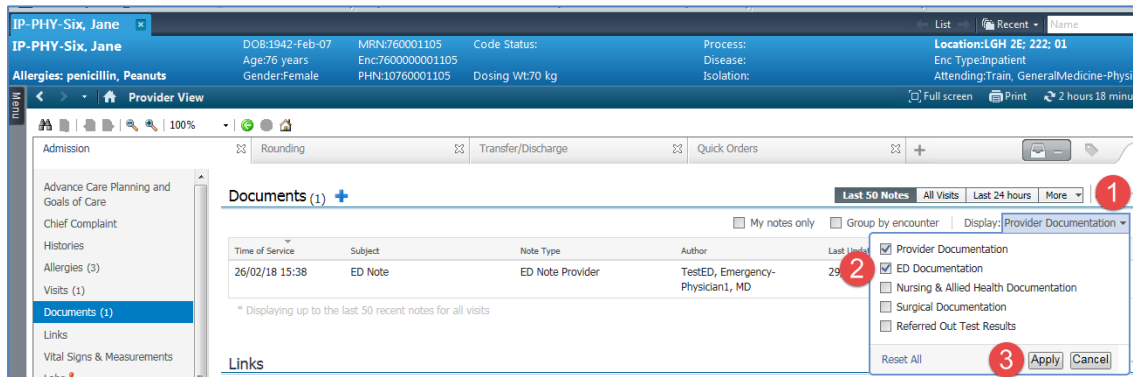
In this activity you will:

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

1 With Jane'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 **ED Note**. The note content displays for your review.

4. Click the tab highlighted below to close the split screen.
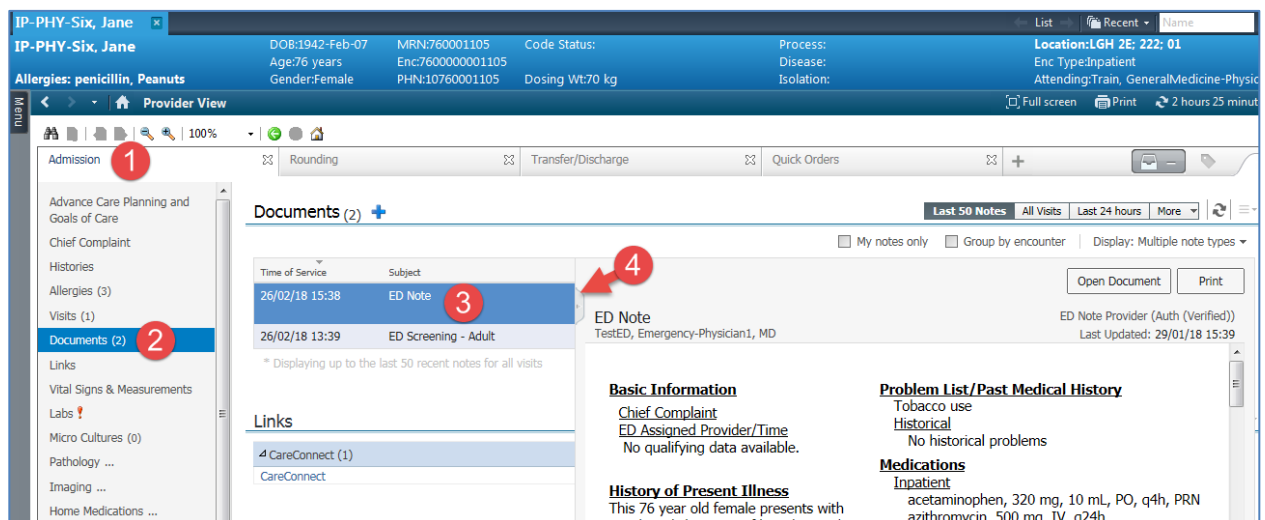
2

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 38.2.

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?
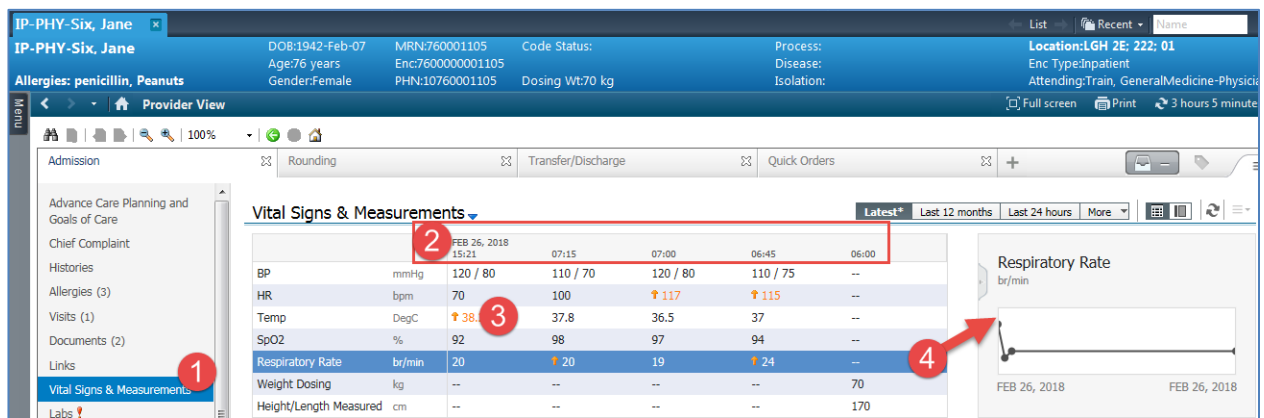
3   The **Labs** component is also a table organized by time. Only labs that have at least one result will display. In real life this list can be very extensive, so filtering will be important.

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 Jane?

If you are successful, you should display the following report. Click the X 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

PATIENT SCENARIO 2 – Admitting the Patient

Learning Objectives
At the end of this scenario, you will be able to: ■ Place and manage admission orders   ■ Review and manage medications on admission   ■ Complete patient's admission and document patient care

SCENARIO

Jane, a 76 year-old female, presented to the ED with fever, shortness of breath, and a productive cough. You examined Jane in the ED and decided to admit her for a course of antibiotics for presumed pneumonia.

The following steps are required for the patient's admission when using the Clinical Information System (CIS):

1. Placing an **Admit to Inpatient** order
2. Reviewing the patient's **Best Possible Medication History** and completing admission medication reconciliation
3. Placing admission orders
4. Creating an admission note

You will complete the following activities:

■ Locate and place the Admit to Inpatient order

■ Review home medications and complete admission medication reconciliation

■ Place orders through PowerPlans (order sets) for patient admission

■ Update problems and diagnoses and document your assessment findings

■ Complete and sign an admission note

Activity 2.1 – Place an Admit to Inpatient Order

Before you start next activities, consider the admission process from the workflow perspective. Typically, you would review the patient chart, assess the patient and you make a decision about the admission:

- If you decide **not to admit** the patient, you will create a consult note and close the chart

- If you **admit** the patient, the first step you need to take is to **place the Admit to Inpatient** order

In real life, either the ED provider or the admitting provider can place the Admit to Inpatient order. If the admitting provider places this order, details will be auto-populated. Placing this order allows the following important steps to happen automatically:

- 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.

In this activity you will:
- Locate and place the Admit to Inpatient order

1

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.
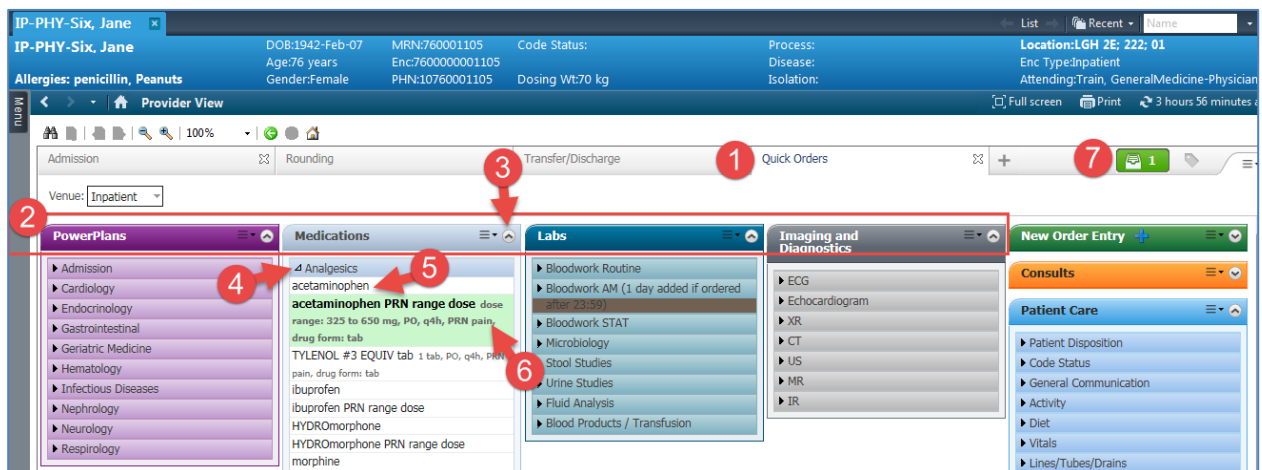
2

Learn how 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. In the **Patient Care** category, expand the **Patient Disposition** folder.

2. Click once the **Admit to Inpatient** order.

3. The **Orders for Signature** icon turns green and indicates you have 1 order in queue. Click it once only.

3
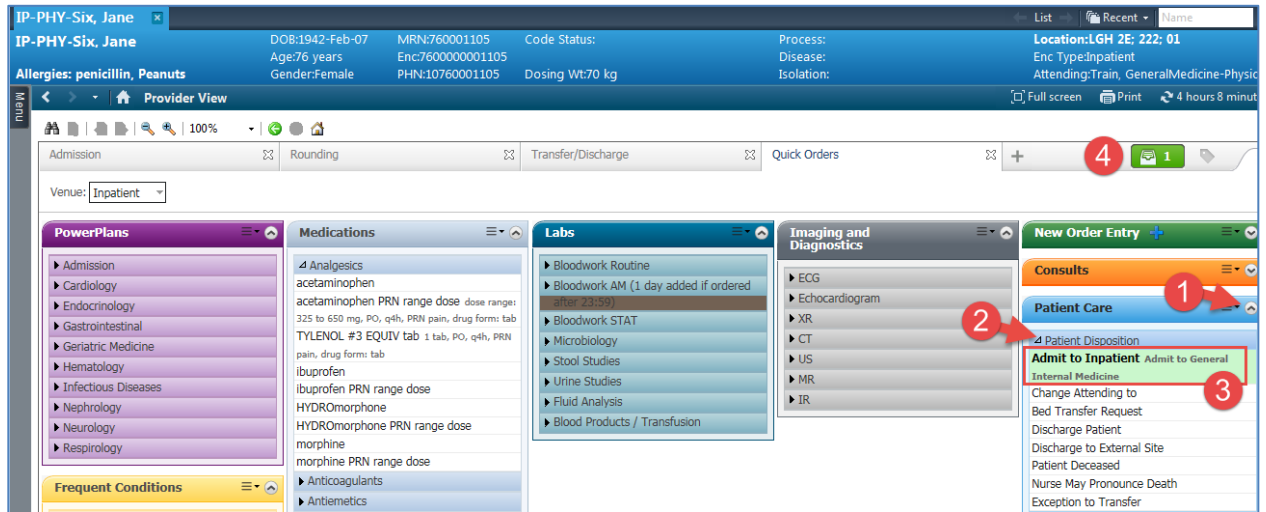
The **Orders for Signature** window opens and lists all orders that you have selected. In our example there is just one order.

1. Ensure the right order is listed.

2. If no order details are missing and you are familiar with the order, you would click Sign. However, the CIS will prompt you to enter the required details missing.

3. To learn what details are provided in the Admit to Inpatient order, click **Modify**.
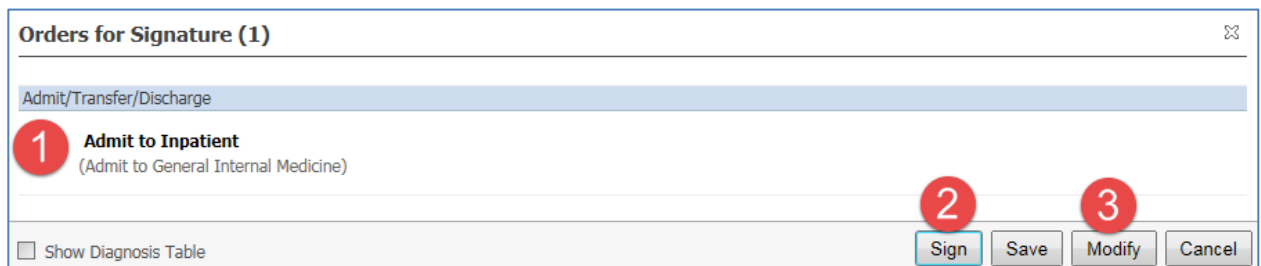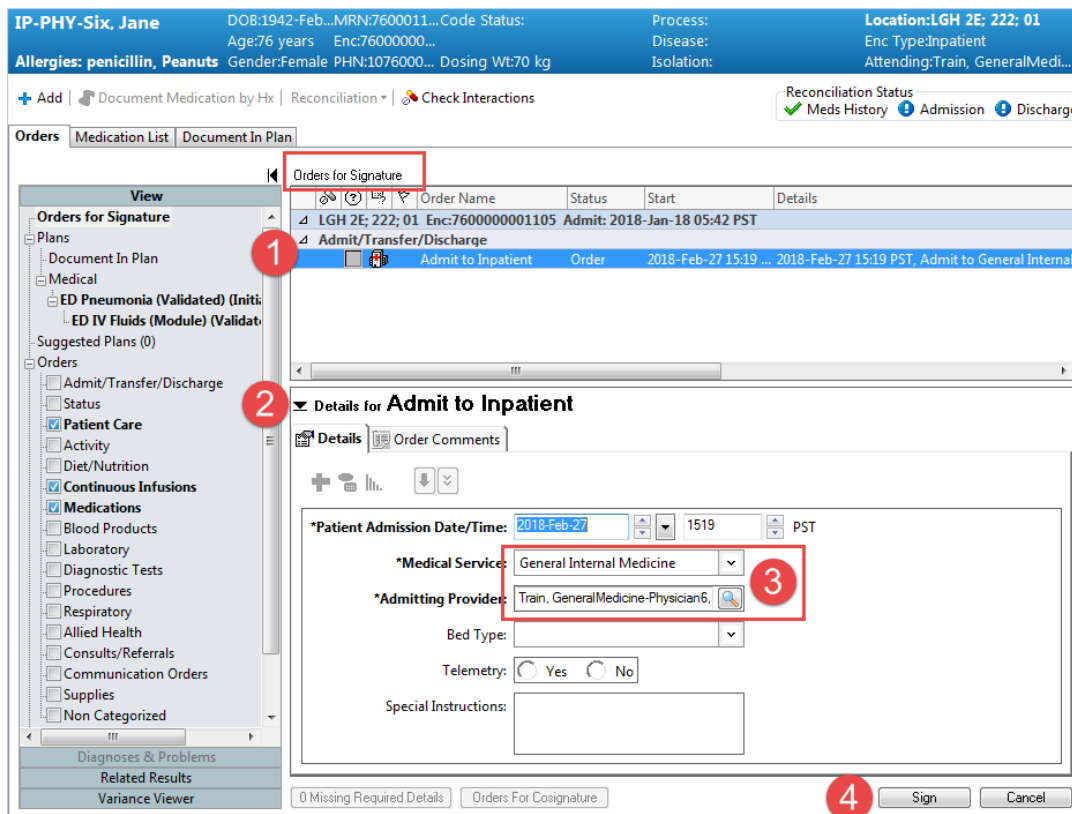
4 You are transferred to the **Orders for Signature** window:

1. See the **Admit to Inpatient** order listed. Click the order to display details.

2. **Details** panel displays. Click the ⬇ icon to collapse or expand the panel.

3. **Note**: If you (as the admitting provider) place the Admit to Inpatient order, order details such as Medical Service Admitting Provider are auto-populated.

4. Clicking **Sign** will complete the process. Once the **Admit to Inpatient** order is placed, your patient will be transferred there when a bed becomes available on a General Medicine unit and you will then become the attending provider.

   However, note that in the Train Domain Jane is already admitted with a bed assigned.

🔑 **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 2.2 – Review Best Possible Medication History (BPMH)

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

In the CIS there are two places to see a list of home medications. You can look in the Home Medication component of the **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.

Medications Taken at Home	Medications Taken during Hospital Visit	Medications Updated at Discharge
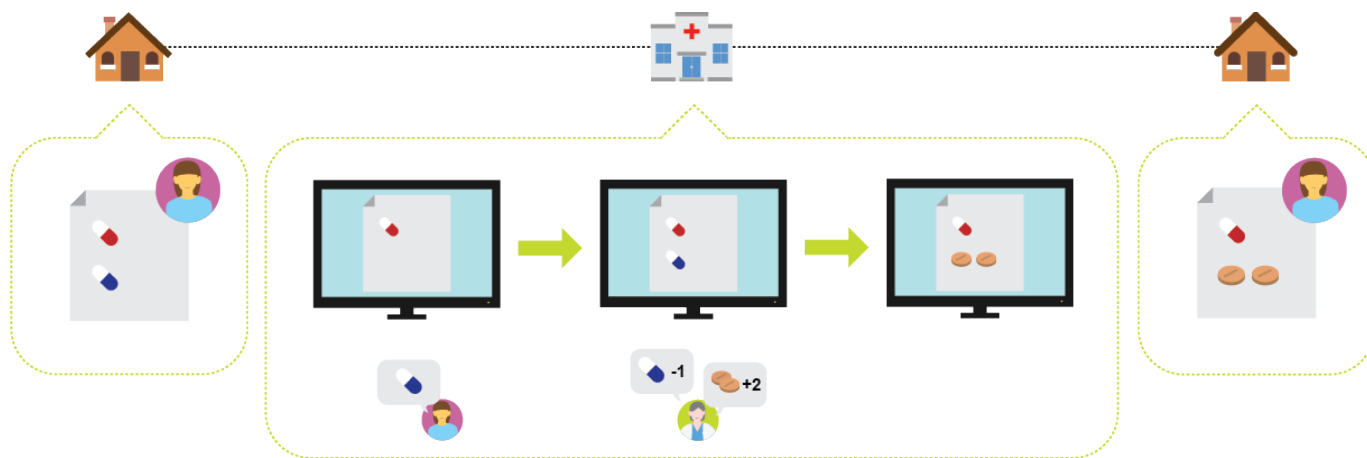
WARNING: In the CIS, the BPMH **must be completed before** proceeding with the admission medication reconciliation. The Admission Reconciliation will not be available until the Medication History is documented.

In our scenario, the pharmacy technician documented home medications. Jane's daughter brought Jane's *gliclazide* and *salbutamol inhaler* with her from home and you decided to document them to complete the admission reconciliation.
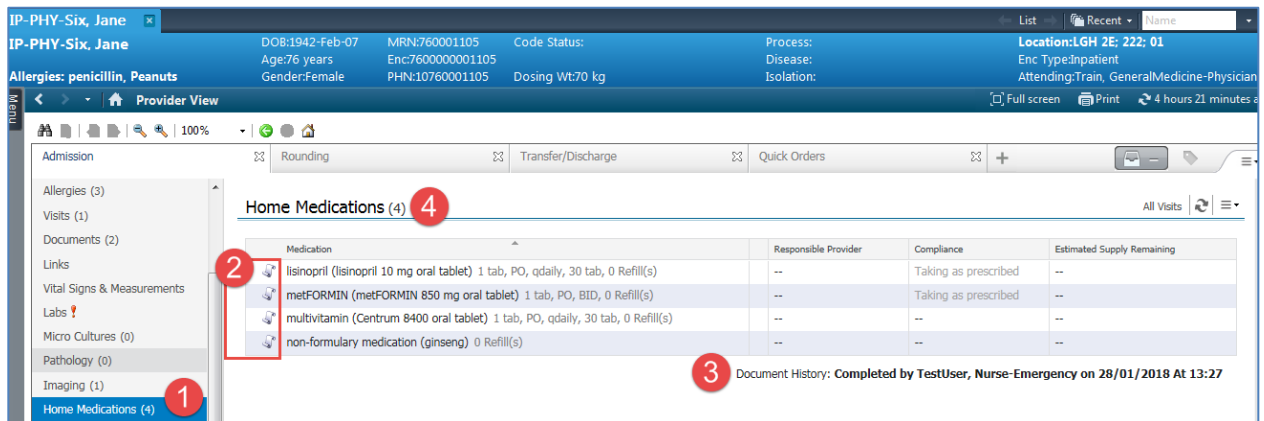
In this activity you will:
- Review and update the BPMH

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] 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 Jane.

Hover to discover to check what on-screen explanation is provided:
- [icon] indicates inpatient medication
- [icon] indicates medication is part of the order set; Hover to discover more information.
- [icon] 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 the most detailed and appropriate order sentence to avoid manual entries
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.
   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 Jane 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 will occasionally update the home medications because there will be Pharmacy Techs but this is very important for patient safety.
For your practice, add *gliclazide 40 mg PO qdaily*. 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.
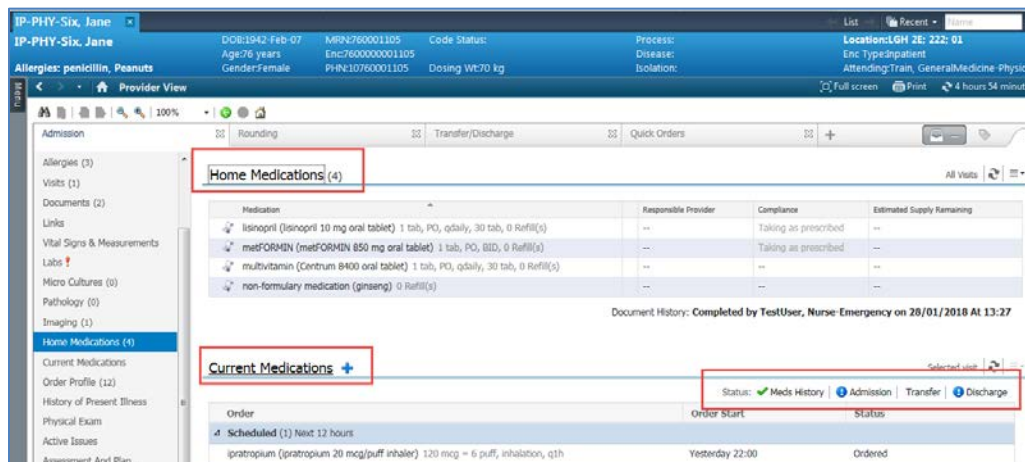

🔑 **Key Learning Points**

- **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 2.3 – 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 Jane. You will review her 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

   ❶ means incomplete

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

2 The admission reconciliation screen for Jane 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

IP-PHY-Six, Jane	DOB:1942-Feb... MRN:7600011... Code Status:		Process:	Location:LGH 2E; 222; 01
	Age:76 years Enc:76000000...		Disease:	Enc Type:Inpatient
Allergies: penicillin, Peanuts	Gender:Female PHN:1076000... Dosing Wt:70 kg		Isolation:	Attending:Train, GeneralMedi...

+ Add | ▣ Manage Plans

Reconciliation Status
✔ Meds History ❶ Admission ❶ Discharge

		Orders Prior to Reconciliation			▶	■			**Orders After Reconciliation**	
		Order Name/Details	Status						Order Name/Details	Status
◿ **Medications**										
	acetaminophen		Ordered		○	○				
	320 mg, PO, q4h, PRN: fever									
	azithromycin		Ordered		○	○				
	500 mg, IV, q24h									
	cefTRIAXone		Ordered		○	○				
	2,000 mg, IV, q24h									
	gliCLAZide		Documented		○	○				
	40 mg, PO, BID with food, for 30 day, 60 tab, 0...									
	ipratropium (ipratropium 20 mcg/puff inhal...		Ordered		○	○				
	120 mcg = 6 puff, inhalation, q1h									
	lisinopril (lisinopril 10 mg oral tablet)		Documented		○	○				
	1 tab, PO, qdaily, 30 tab, 0 Refill(s)									
	metFORMIN (metFORMIN 850 mg oral tabl...		Documented		○	○				
	1 tab, PO, BID, 0 Refill(s)									
	multivitamin (Centrum 8400 oral tablet)		Documented		○	○				
	1 tab, PO, qdaily, 30 tab, 0 Refill(s)									
	non-formulary medication (ginseng)		Documented		○	○				
	0 Refill(s)									
	salbutamol (salbutamol 100 mcg/puff inhaler)		Documented		○	○				
	1 puff, inhalation, once, PRN: as needed, 1 inh...									
	salbutamol (salbutamol 100 mcg/puff inhaler)		Ordered		○	○				
	600 mcg = 6 puff, inhalation, q20min, PRN: sh...									
◿ **Continuous Infusions**										
	sodium chloride 0.9% (NS) continuous infusi...		Ordered		○	○				
	100 mL/h, IV									

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 🏠 :

- centrum 1 tab PO QD
- ginseng
- salbutamol inhaler 1 puff QID PRN

Continue ▶ the following home medications 🏠 :

- gliclazide 30 mg PO BID
- metformin 500 mg PO BID

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
- azithromycin 500 mg IV q24h
- 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 Jane 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 Jane'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.

IP-PHY-Six, Jane	DOB:1942-Feb...MRN:7600011...Code Status:				Process:		Location:LGH 2E; 222; 01	
	Age:76 years Enc:76000000...				Disease:		Enc Type:Inpatient	
Allergies: penicillin, Peanuts	Gender:Female PHN:1076000... Dosing Wt:70 kg				Isolation:		Attending:Train, GeneralMedi...	

➕ Add | 🔲 Manage Plans

Reconciliation Status
✔ Meds History ❶ Admission ❶ Discharge

Orders Prior to Reconciliation				**Orders After Reconciliation**		
Order Name/Details	Status	▶	◼	Order Name/Details	Status	
⊿ **Medications**						
acetaminophen 320 mg, PO, q4h, PRN: fever	Ordered	◉	○	**acetaminophen** 320 mg, PO, q4h, PRN: fever	Ordered	
azithromycin 500 mg, IV, q24h	Ordered	◉	○	**azithromycin** 500 mg, IV, q24h	Ordered	
cefTRIAXone 2,000 mg, IV, q24h	~~Discontinue~~	○	◉			
gliCLAZide 40 mg, PO, BID with food, for 30 day, 60 tab, 0...	Documented	◉	○	**gliCLAZide** 40 mg, PO, BID with food	Order	
ipratropium (ipratropium 20 mcg/puff inhal... 120 mcg = 6 puff, inhalation, q1h	~~Discontinue~~	○	◉			
lisinopril (lisinopril 10 mg oral tablet) 1 tab, PO, qdaily, 30 tab, 0 Refill(s)	Documented	◉	○	**trandolapril** 1 mg, PO, qdaily	Order	
metFORMIN (metFORMIN 850 mg oral tabl... 1 tab, PO, BID, 0 Refill(s)	Documented	◉	○	**metFORMIN** 850 mg, PO, BID	Order	
multivitamin (Centrum 8400 oral tablet) 1 tab, PO, qdaily, 30 tab, 0 Refill(s)	Documented	○	◉			
non-formulary medication (ginseng) 0 Refill(s)	Documented	○	◉			
salbutamol (salbutamol 100 mcg/puff inhaler) 1 puff, inhalation, once, PRN: as needed, 1 inh...	Documented	○	◉			
salbutamol (salbutamol 100 mcg/puff inhaler) 600 mcg = 6 puff, inhalation, q20min, PRN: sh...	~~Discontinue~~	○	◉			
⊿ **Continuous Infusions**						
sodium chloride 0.9% (NS) continuous infusi... 100 mL/h, IV	Ordered	◉	○	**sodium chloride 0.9% (NS) continuous infusi...** 100 mL/h, IV	Ordered	

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.

IP-PHY-Six, Jane	DOB:1942-Feb...MRN:7600011...Code Status:		Process:	Location:LGH 2E; 222; 01
	Age:76 years Enc:76000000...		Disease:	Enc Type:Inpatient
Allergies: penicillin, Peanuts	Gender:Female PHN:1076000... Dosing Wt:70 kg		Isolation:	Attending:Train, GeneralMedi...

+ Add | **Manage Plans**

Reconciliation Status
✔ Meds History ● Admission ● Discharge

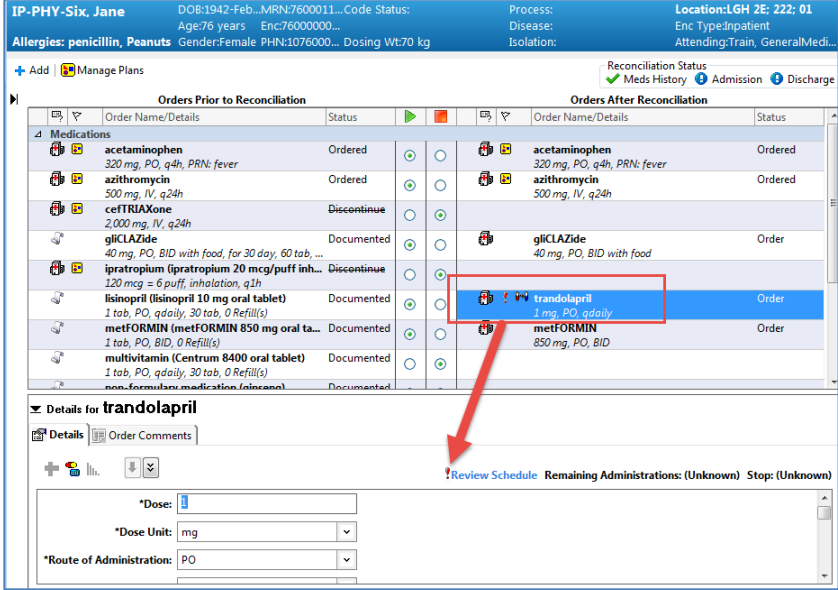|	**Orders Prior to Reconciliation**		▶	■			**Orders After Reconciliation**	
	Order Name/Details	Status					Order Name/Details	Status
⊿ **Medications**								
	acetaminophen 320 mg, PO, q4h, PRN: fever	Ordered	⊙	○			**acetaminophen** 320 mg, PO, q4h, PRN: fever	Ordered
	azithromycin 500 mg, IV, q24h	Ordered	⊙	○			**azithromycin** 500 mg, IV, q24h	Ordered
	cefTRIAXone 2,000 mg, IV, q24h	~~Discontinue~~	○	⊙				
	gliCLAZide 40 mg, PO, BID with food, for 30 day, 60 tab, 0...	Documented	⊙	○			**gliCLAZide** 40 mg, PO, BID with food	Order
	ipratropium (ipratropium 20 mcg/puff inhal... 120 mcg = 6 puff, inhalation, q1h	~~Discontinue~~	○	⊙				
	lisinopril (lisinopril 10 mg oral tablet) 1 tab, PO, qdaily, 30 tab, 0 Refill(s)	Documented	⊙	○			**trandolapril** 1 mg, PO, qdaily	Order
	metFORMIN (metFORMIN 850 mg oral tabl... 1 tab, PO, BID, 0 Refill(s)	Documented	⊙	○			**metFORMIN** 850 mg, PO, BID	Order
	multivitamin (Centrum 8400 oral tablet) 1 tab, PO, qdaily, 30 tab, 0 Refill(s)	Documented	○	⊙				
	non-formulary medication (ginseng) 0 Refill(s)	Documented	○	⊙				
	salbutamol (salbutamol 100 mcg/puff inhaler) 1 puff, inhalation, once, PRN: as needed, 1 inh...	Documented	○	⊙				
	salbutamol (salbutamol 100 mcg/puff inhaler) 600 mcg = 6 puff, inhalation, q20min, PRN: sh...	~~Discontinue~~	○	⊙				
⊿ **Continuous Infusions**								
	sodium chloride 0.9% (NS) continuous infusi... 100 mL/h, IV	Ordered	⊙	○			**sodium chloride 0.9% (NS) continuous infusi...** 100 mL/h, IV	Ordered

⊼ Details for trandolapril

[0 Missing Required Details]   [All Required Orders Reconciled]   **Reconcile** *and* [Plan] [**Sign**] [Cancel]
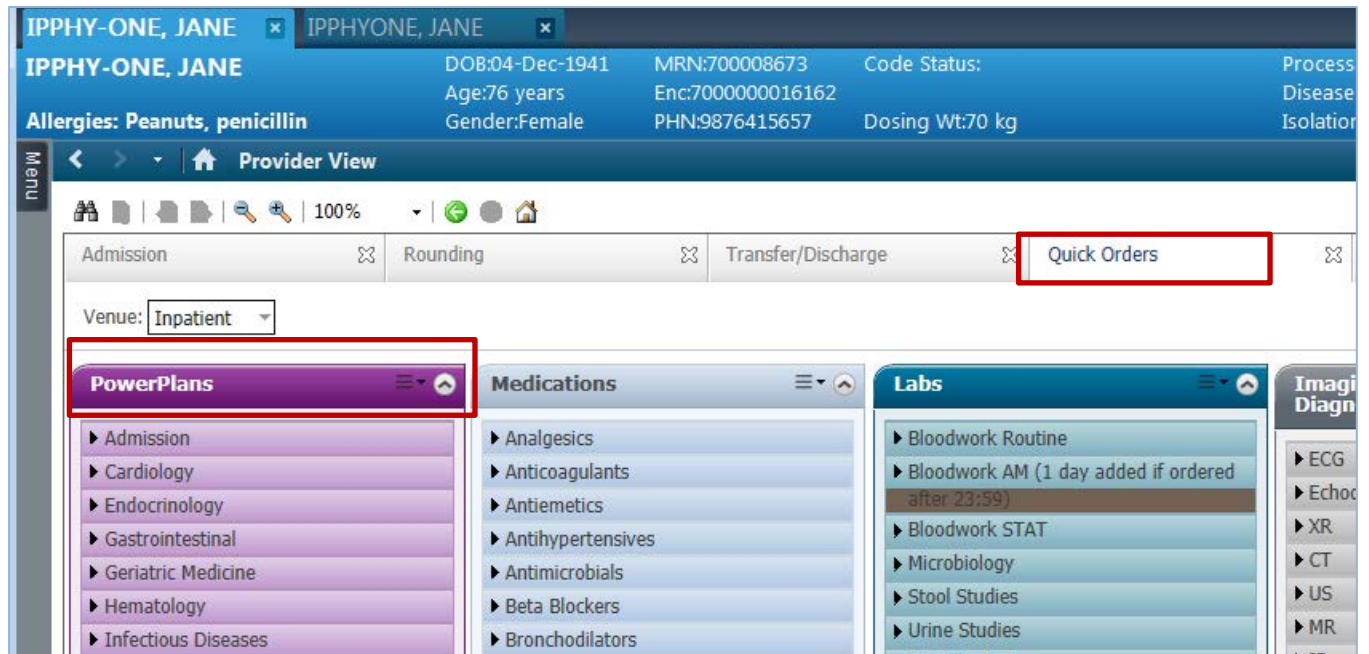

🔑 **Key Learning Points**

■ 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 2.4 – Place The Admission PowerPlan

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 Medicine unit.

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

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

In this activity you will:
- Select the admission PowerPlan
- Modify the admission PowerPlan to fit your needs
- Complete the PowerPlan to make it active for other caregivers

Placing the PowerPlan

**1**   In the **Quick Orders** tab, expand the **Admission** folder.

> Do you remember what icon is used to represent PowerPlans?

1. Select MED General Medicine Admission.

2. Click the **Orders for Signature** icon 🗒 1 . When you place the order, it turns green and indicates the number of selected orders waiting for your signature.
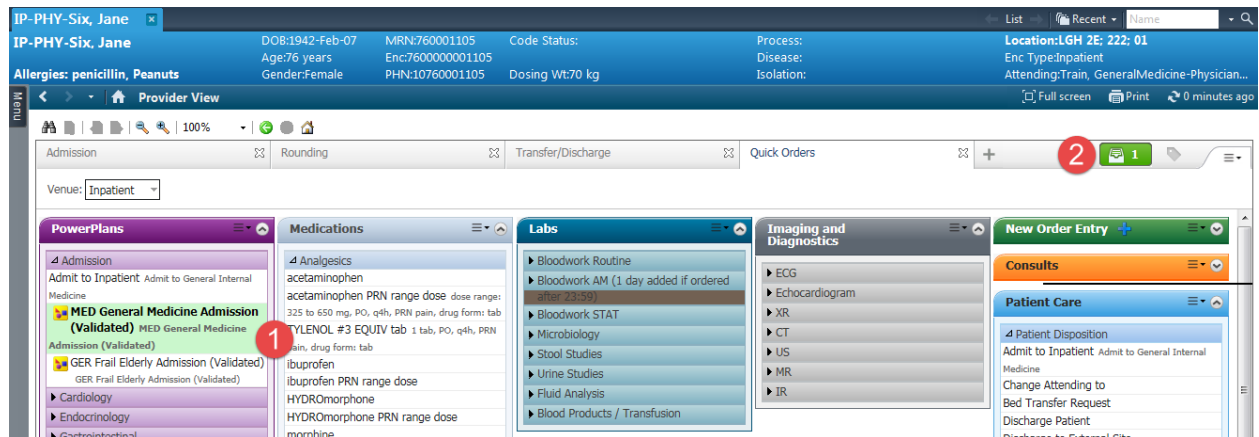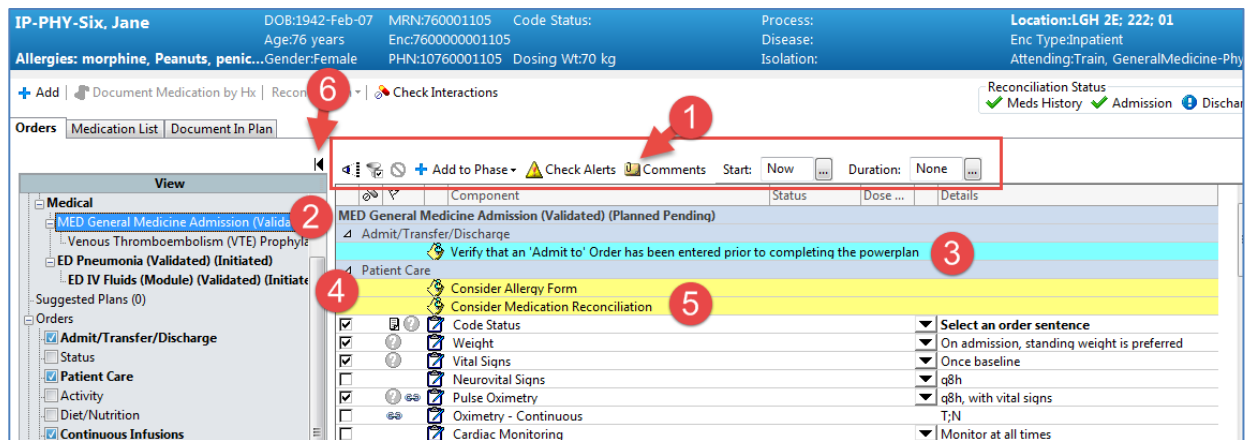

2   The selected PowerPlan is listed in the **Orders for Signature** window.
PowerPlans are complex and provide options that need your decision. Click **Modify** to make all necessary selections.
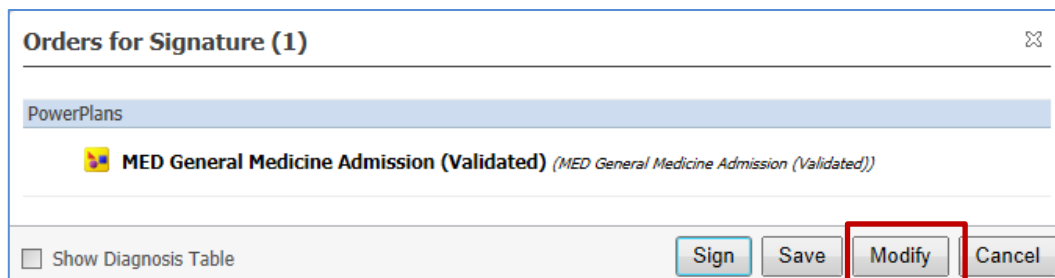
3 PowerPlans open in the **Orders View** that works like a scratch pad to customize your plan. Scroll through to locate visual cues used to categorize orders:

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

   clicking the **Comments** button opens a box for adding a comment to the selected order; a nurse assigned to this patient will be informed that you placed additional information.

2. At the top you will see the PowerPlan name. Until you complete the process, its status is Planned Pending.

3. Bright blue highlighted text identifies **critical reminders** – for example a reminder about the 'Admit to…' order.

4. Light blue-grey highlighted text separates **categories** of orders, for example Patient Care.

5. Bright yellow highlighted text identifies **clinical decision support** information.

6. Collapse the View navigator to have more screen space.

4 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.
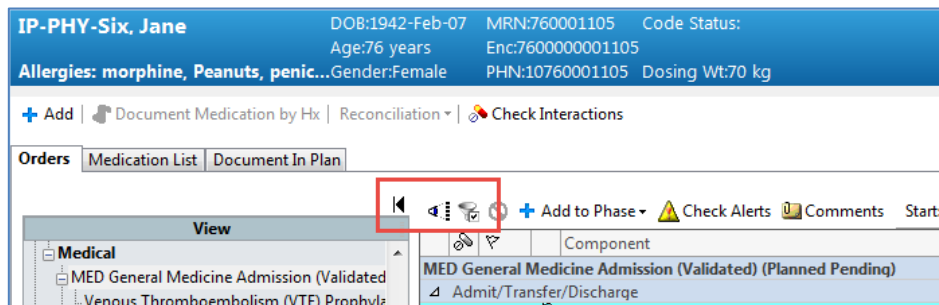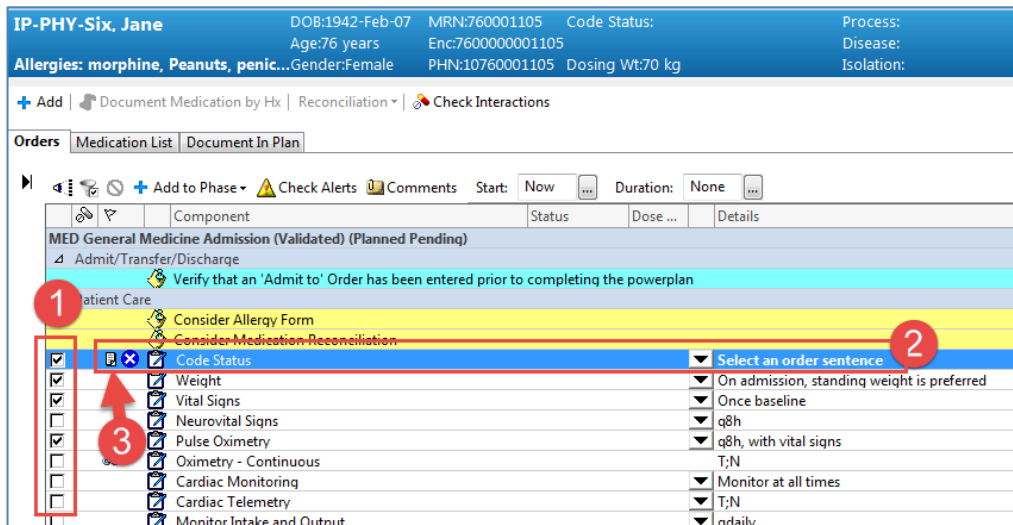
Modifying the PowerPlan

<div>1</div>

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.

2 Scroll down the PowerPlan orders and continue adding the following orders to the PowerPlan. At the minimum, select the following:

- **Monitor Intake and Output**
- **Diabetic Diet**

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

- **Sodium Chloride 0.9% NS continuous infusion 100 mL/h**
- **D-Dimer**
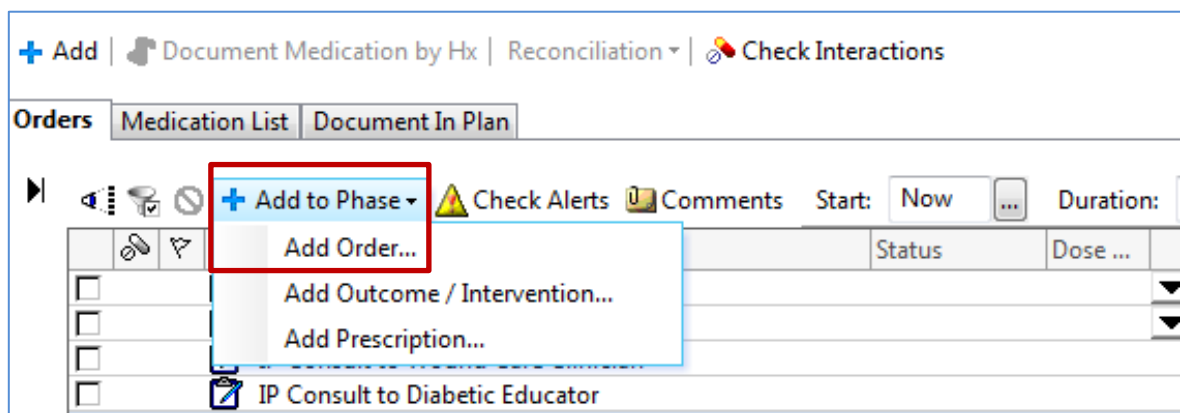- **Melatonin 3 mg PO qHS**
- **Alanine Aminotransferase**

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

3 You can also **add individual orders** that are not part of the PowerPlan. For Jane, you want to add an additional test.

Click **+ Add to Phase** button on the toolbar and select **Add Order**.

4	The **Search** window displays. You have used this window before.

Search the order catalogue for *Aspartate Aminotransferase*,
then click **Done**.

NOTE: There are lab synonyms and you can also enter *AST* and get to the same lab test.

5	Once you complete the above step, you will see the order added under the appropriate order categories, in this case, **Laboratory**.

Selecting Additional Modules

1	You can also add other modules (orders sets) that are listed within a PowerPlan.

Scroll down to locate General Medicine Modules to add the **RESP Exacerbation of COPD (Module).**

2   The list of this module orders displays. Select the following:

- **moxifloxacin 400 mg IV, q24h, order duration 7 days**
- **prednisone 50mg PO qdaily with food, duration 5 days**
- **salbutamol 5 mg, nebulized q4h while awake**
- **ipratropium 500 mg nebulized, q4h while awake**

> PowerPlans have often long lists of orders.
> Do you remember how to display only selected orders and hide the rest of the list?

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

3

The VTE module is another example of a defaulted selection.

1. This module is **pre-selected.**

2. None of the orders for this plan are selected. You will be not able to place the PowerPlan without addressing missing details.

> Do you remember how to open the module?
> Make at least one selection.
> Remember to click **Return to MED General Medicine Admission** to continue working on your PowerPlan.
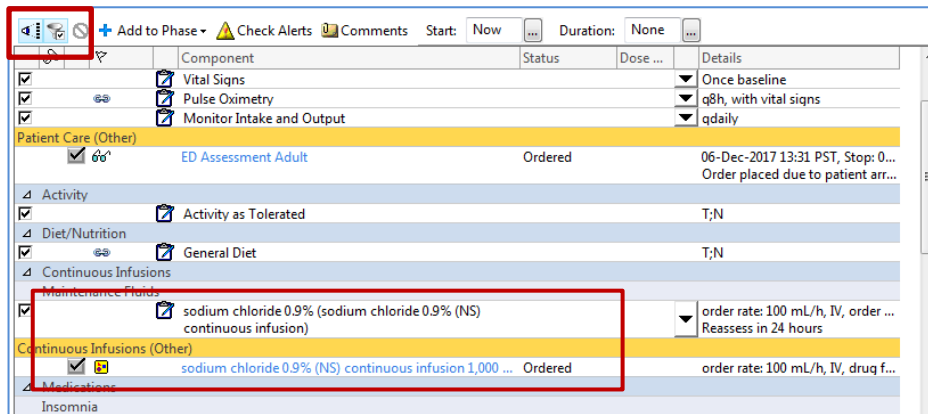
Completing the PowerPlan

1

Once you have finished selecting all your orders, you are getting ready to sign off.
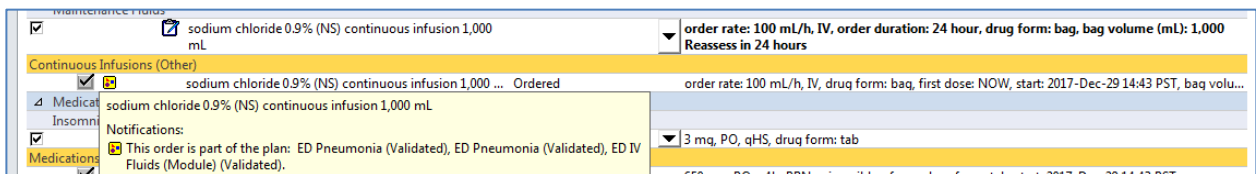
Click the ![icon] icon to see what has been selected so far and ![icon] to merge your plan with other current orders. This will help to identify any **duplications**.
You will notice that fluid infusion was already placed in ED.

2

Hover the cursor over duplicate orders to check which one was ordered in ED and then **deselect** the ED order.

3 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 patient Jane, **Initiate** the plan to ensure the orders are **active immediately**.

> **!** **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 MED General Medicine Admission PowerPlan in a planned state when the patient was still in ED. The receiving nurse will initiate the PowerPlan order upon patient's arrival on the General Medicine Unit. Only then will the orders become active.

4 Once Initiate is selected, the Orders View displays the 💡 icon next to your initiated orders. Click **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.

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

6   Now, all orders for Jane will display. Click **Done** to close this window.
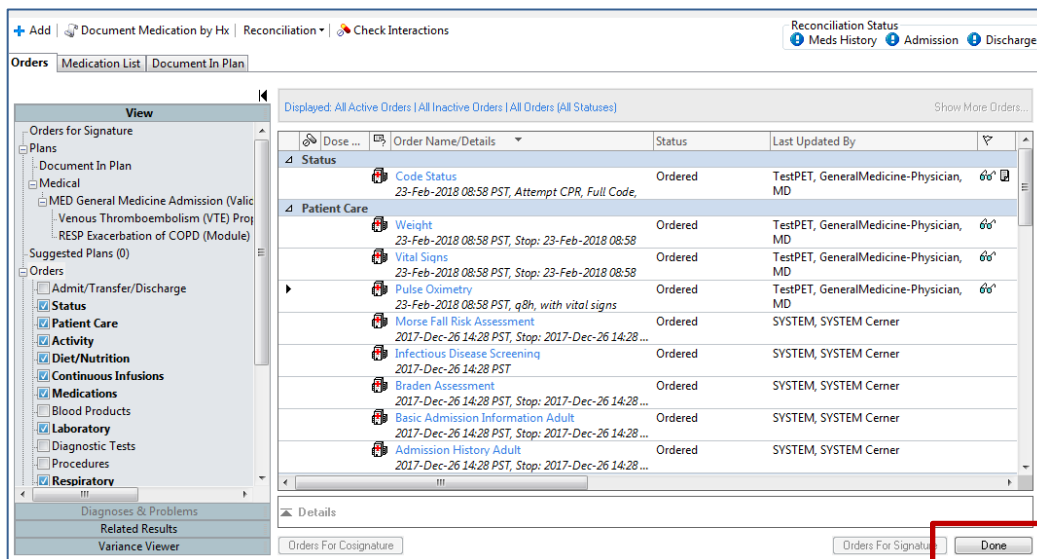
7   Ensure you are in the **Admission** tab.

1. Click the **Order Profile** component to display all currently active orders for Jane for your review.

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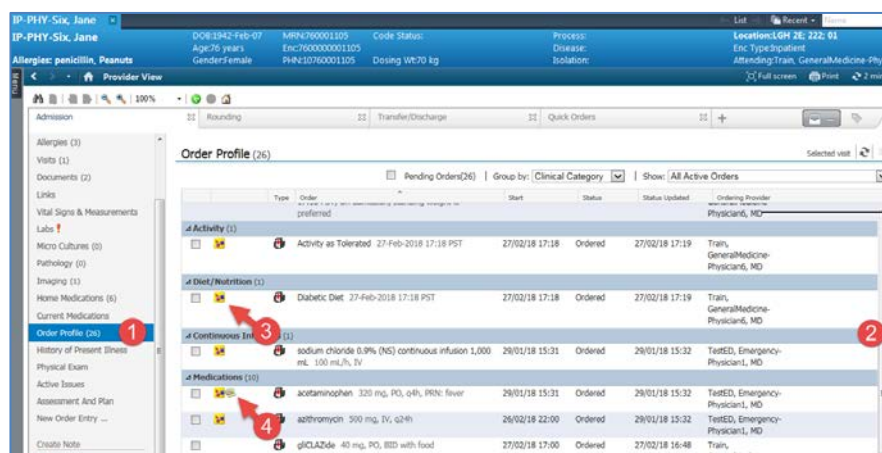
> **!** **WARNING**: PowerPlans that are in a planned status, signed but not initiated, are not listed under Orders Profile. Click on the Order Profile heading for a more detailed review of orders including those in the planned state.

🔑 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 2.5 – Document Findings and Add Admission Diagnosis

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

- **History of Present Illness**
- **Physical Exam**
- **Assessment and Plan**

The above components are **free text** components where you can type or dictate. Front end speech recognition (FESR) software captures your dictation directly into the CIS.

Another type of data entry, known as discrete data entry, requires selecting information from lists or catalogues **pre-defined** in the CIS. This type of data entry improves data quality and can be used to generate reports. An example of this type of entry is the **Active Issues** component.

In this activity you will:
- Enter your observations and assessment as free text
- Enter admission diagnosis as active issue

1

1. In the Admission tab, select the **History of Present Illness** component.

2. Click the blank space under the heading to activate the free text box and type or dictate some text.
   For example,

3. Continue adding your notes in the **Physical Exam** component.
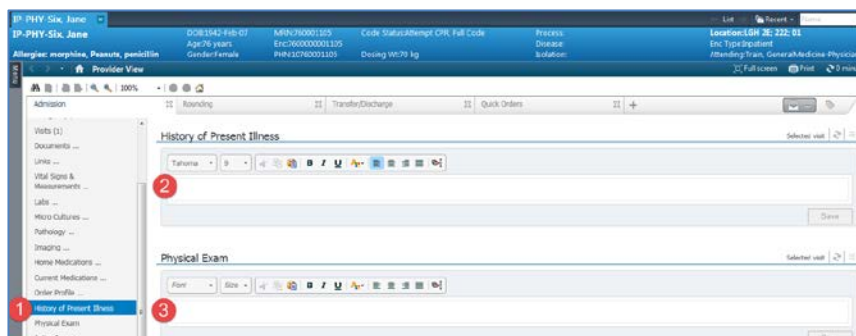
NOTE: These components serve as a **temporary note pad** for your notes right in the Admission tab. Information entered here is saved until you are ready to create a formal Admission note. With one click, this information will be transferred into the note. Until then, any information captured will only be visible to you.

2 Select **Active Issues** from the components list to add **pneumonia as an admitting diagnosis** for Jane.

Search for *pneumonia* and select it from the list.
(The system uses medical coding languages such as ICD-10-CA and Intelligent Medical Objects (IMO) to capture problems and diagnoses.)

3 Ensure that pneumonia is listed as an issue for **This Visit**. You will learn how to manage patient problems later.

4 View the **Assessment and Plan** component. The pneumonia diagnosis is already listed.

For our example, leave this free text box as it is. You will have an opportunity to add this information directly to the admission note you will be creating.

🔑 Key Learning Points

- Your findings and observations can be added directly into appropriate **free text** components within the Admission workflow tab

- Text entered in the free text components is **not visible** to other care team members until you create and sign your document

- Use the **Active Issues** to capture both presenting issues (**This Visit**) and chronic issues (**Chronic**)

✦ Activity 2.6 – Complete an Admission Note

As the last step of admitting Jane, 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.
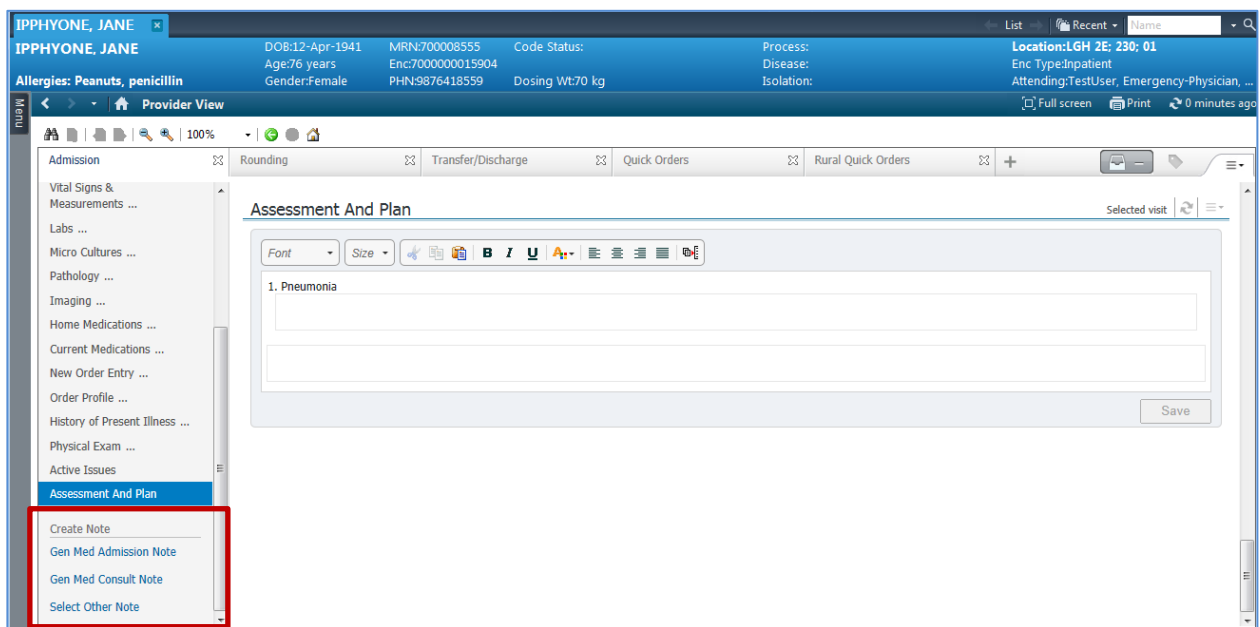
In this activity you will:

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

| 1 | In the Admission tab, scroll down to the **Create Note** section under components and click **Gen Med Admission Note**. |

2   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.

3   You can **remove a section** that is not required or is currently blank. For example, place the cursor over the heading and click ☒ on the toolbar to remove the entire section.

4   You can **remove the contents of a section**. Click the ☒ in the text box next to the content.
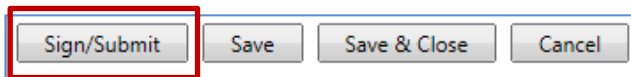
5 You can also **edit existing text**. Place the cursor over the heading to activate the text box. If the box is not active, click the ⏎ icon. Select the text to add or delete as needed.

History of Present Illness
One week history of shortness of breath progressively worsening. Mid-sternal chest pain that is worse with coughing and deep breathing. Green tinged sputum has been present for the last 36 hours.
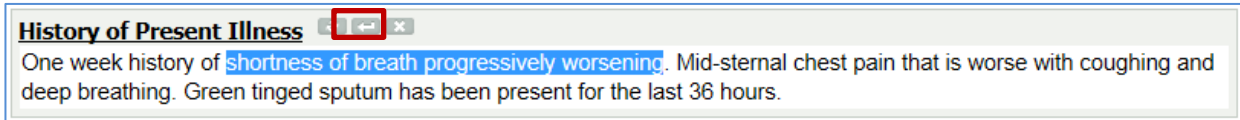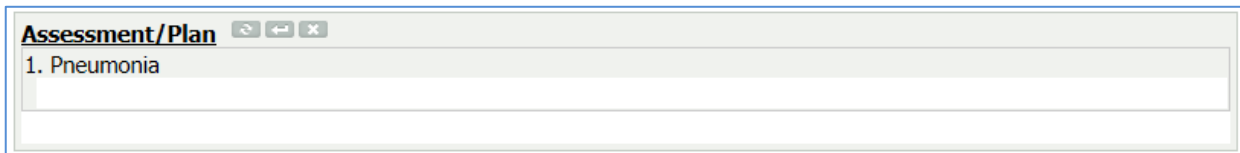
6 You can **enter new text**. For practice, add new text to the Assessment/Plan section.

Assessment/Plan
1. Pneumonia

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

Sign/Submit | Save | Save & Close | Cancel

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.

8

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 - Pneumonia*.

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.

9

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.
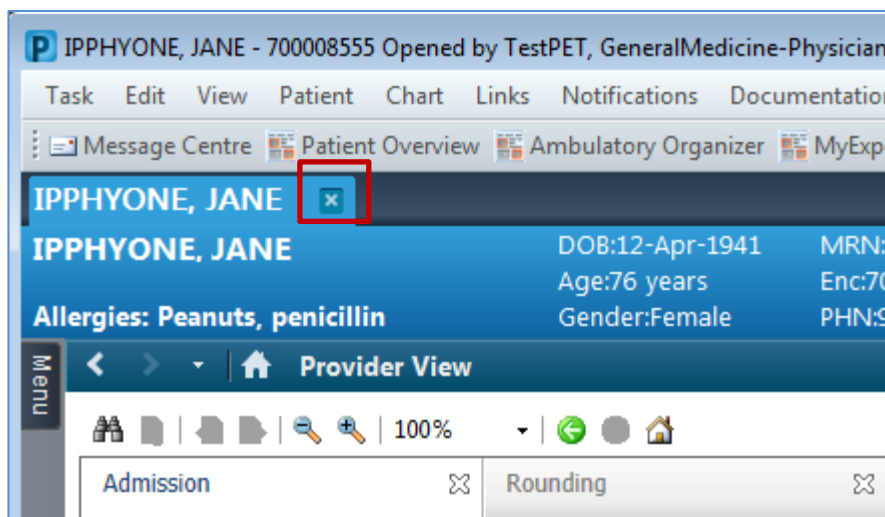> Do you know why you might not see your document listed there?

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

10 To close this patient's chart, click the ⊠ 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 3 – Managing Your Patient during Rounding

Learning Objectives
At the end of this scenario, you will be able to: 🟩 Update patient information 🟩 Modify current orders 🟩 Review documents and create a progress note

SCENARIO

While rounding on your patients today, you examined Jane admitted for pneumonia a few days ago and now want to document in her chart.

Initially, her shortness of breath progressively worsened. She had rigors and chills two nights ago but today she is afebrile. Her chest sounds remain decreased to the bases but her cough is now stronger and is productive with green-tinged sputum.

You want to reduce the continuous IV infusion due to increased oral intake and place orders for an electrolyte panel, sputum culture, and chest x-ray. You also learned that Jane, who is a heavy smoker, has suffered from gradually worsening shortness of breath and cough since last winter.

You will complete the following activities:

🟩 Manage orders – add, modify, and cancel

🟩 Update Active Issues

🟩 Complete a progress note

Activity 3.1 – Manage Orders: Add, Modify, and Cancel

When you do your rounds, you will use the **Rounding** tab and follow its list of components.
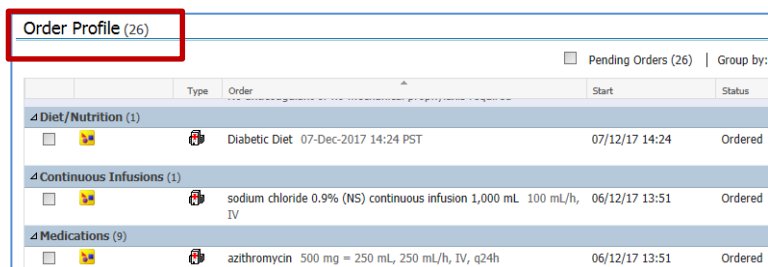
Your next step is to review the patient's current medications and orders and make necessary modifications. When using Clinical Information System (CIS), there are recommended practices for adjusting medications and monitoring orders.

When replacing a medication order with another or altering medication dosages, you should stop (Cancel/Discontinue) the current order and place a new order. There are few exceptions when you can modify the existing order:

- Adjusting the rate of a continuous infusion

- Adding a new comment to the order

- Modifying an existing comment

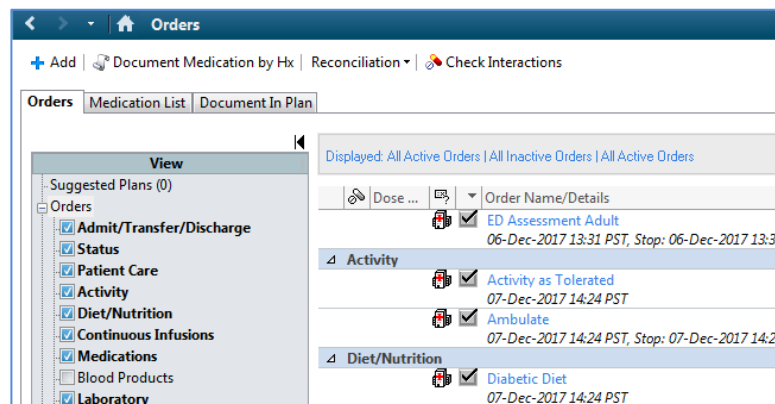The CIS provides a few tools to manage orders:

Order Profile component – this view displays directly in the workflow tab. It lists individual current orders.

Orders – this window displays when you click on the Order Profile heading (see screenshot above). It is the most comprehensive display of orders that includes discontinued orders, PowerPlans in planned status, future orders, as well as cancelled orders.

In this activity you will:
- Stop melatonin and replace it with zopiclone
- Stop IV moxifloxacin and replace it with PO moxifloxacin
- Add orders for electrolyte panel, sputum culture, and chest x-ray
- Reduce the infusion of NaCl 0.9% IV from 100 mL/h to 75 mL/h

1 Now you want to **change the route for moxifloxacin and replace melatonin**.
First, you will **discontinue** these medications.

> Do you remember how to open Jane's chart?

Ensure you are in the **Rounding** tab and select **Order Profile** component. Locate **moxifloxacin** and **melatonin** on the list.

1. Select the check boxes next to these medications

2. Click **Cancel/DC**.

Icons are visual cue and provide additional information. Remember to use hover to discover to find out what icons mean:

indicates there are comments added to the order, hover the cursor to display the text

indicates inpatient medication

indicates medication requires pharmacy verification

indicates a nurse review is pending

indicates that the order comes from a PowerPlan

2 The second step is to place new orders from the **Quick Orders** tab.

1. You already placed two cancellations in the Orders for Signature basket.

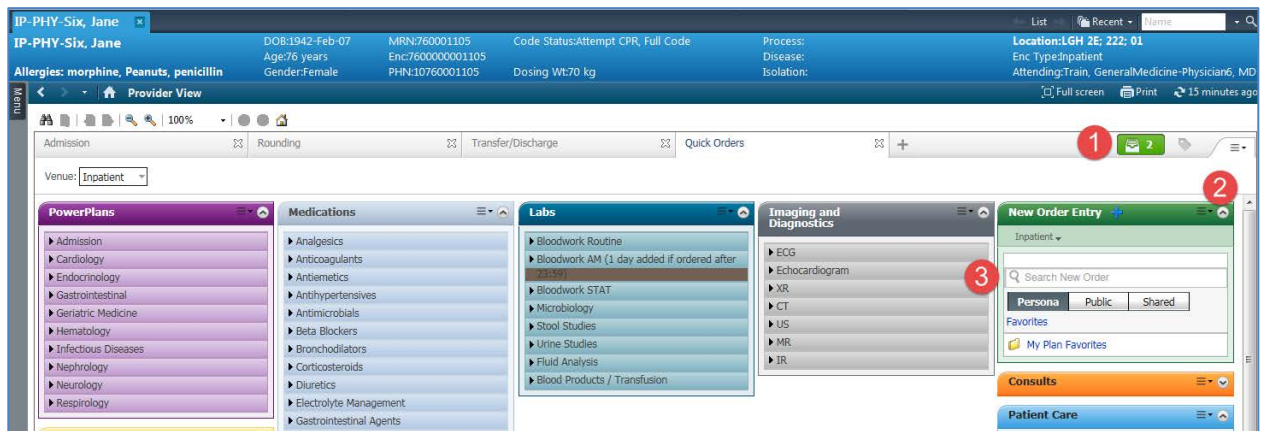> Do you remember how to select the following orders?
> *Zopiclone* under the Sedatives folder
> *Electrolytes Panel* under Labs > Bloodwork Routine
> *Sputum Culture* under Labs > Microbiology
> *XR Chest* under Imaging and Diagnostics > XR

2. When you cannot locate the necessary orders under your folders, expand the **New Order Entry** component.

3. Search for *moxifloxacin*.

3 Type the first few characters to display a list of options. Adding the dosage will truncate the list further and make the selection easier. Select the order sentence for oral route.
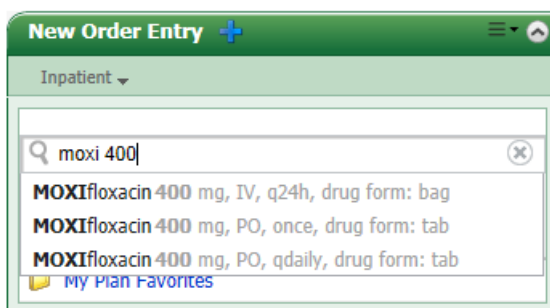
4 Once all the orders are selected, click **Orders for Signature** 📧 7 which includes cancelled and new orders.

5 In the **Orders for Signature** window, scroll down to see discontinued orders.

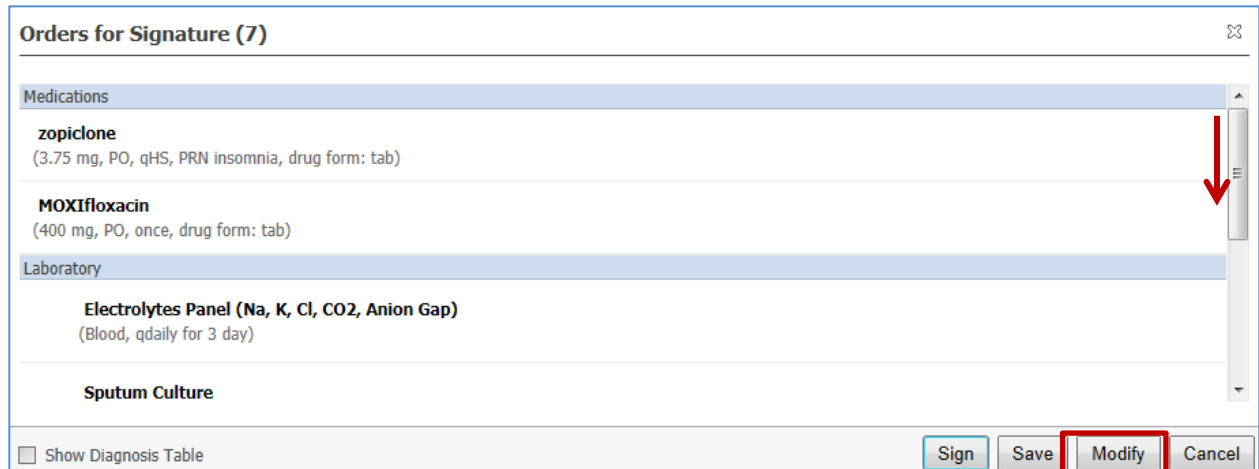Click **Modify**. Select this option if you want to review or edit order details. If you click Sign, the CIS will prompt you to enter the missing details.
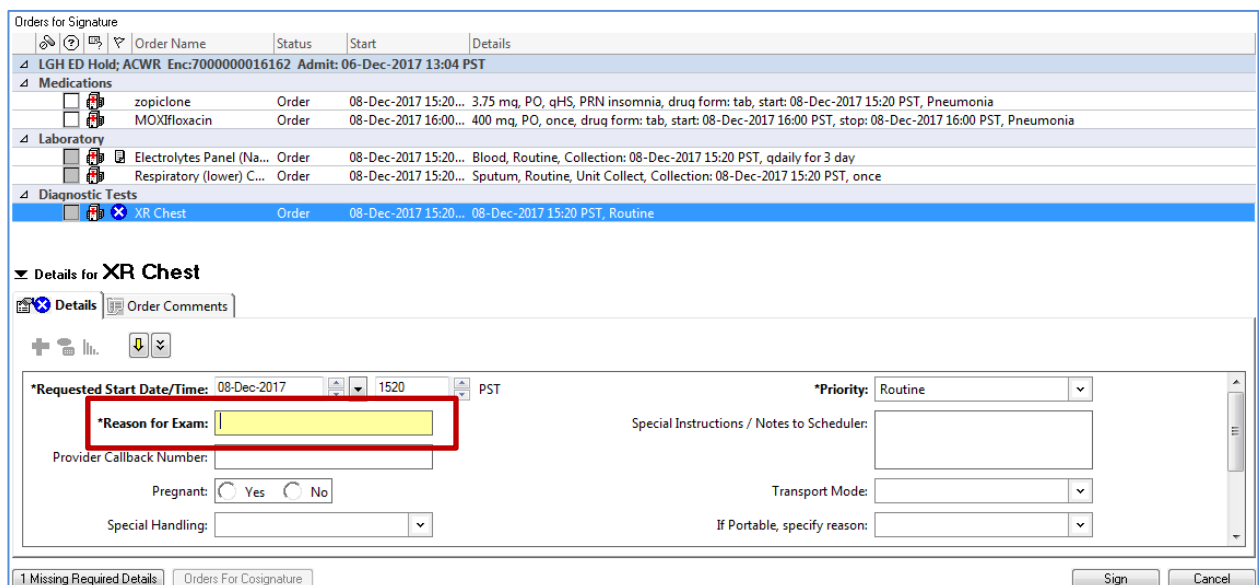

6 The **Orders for Signature** window lists the orders that you have just selected.

> When you select the order sentence, many details are already in place but some required details might be missing:
> How can you identify which order requires more details?
> How are mandatory fields marked?

Add required details to **XR Chest** order.

! **WARNING**: Ensure the checkboxes for medications **are NOT selected**. Only medications have these checkboxes enabled. If you check this box, the order becomes a proposed (not active) order even after you sign it.

7   Next, select the **sputum culture** test to display details.

Note that the **Unit Collect**, **Yes** is pre-selected. This means that the unit collects the specimen and is responsible for printing the label and delivering the specimen to the lab. There is also an option to indicate if the specimen has already been collected.

8   Click **Sign** to place selected orders.

9   You want to **modify** the rate of NaCl 0.9% (NS) IV from 100 mL/h to 75 mL/h.

The **continuous infusion rate can be modified** without the need to stop the order.
It must be done from the **Orders** window.

> When reading the introduction to this activity, you have learned about the two order management views.
> Do you remember which component displays all current orders?
> Which component heading you should click to display the Orders window?

10 In the **Orders** window, locate **Continuous Infusions** to display all infusion orders. In our example there is only one. Right-click the order and select **Modify.**

11 Details for the sodium chloride infusion display:

1. Select the rate **100 mL/h** and type *75*.

2. The **Infuse Over** refers to the duration of the bag and will be automatically calculated by the CIS.

3. Click [Orders For Signature] to display only orders that you need to sign.

12 The order to be signed displays. However, your cursor over the icons to see more information. Icons provide visual cue about the order.

Click **Sign** to complete the process.

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

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

14 You can manage orders from the Orders window. Right-click on a selected PowerPlan or an individual order. Depending on the order type, you will see different options. A drop-down will allow you to select the appropriate action:

- When you right-click a PowerPlan, you select **Discontinue**.
  You will be able to stop the entire PowerPlan or individual orders from this PowerPlan.
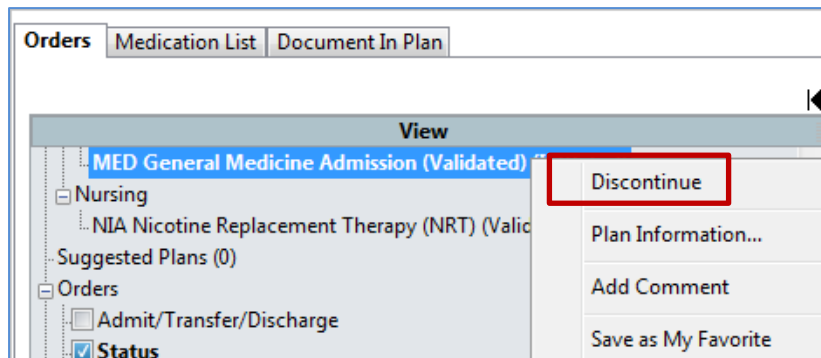
- When you right-click the PowerPlan in a Planned status, you can Initiate the planned PowerPlan you prepared earlier. The orders of this PowerPlan become active.
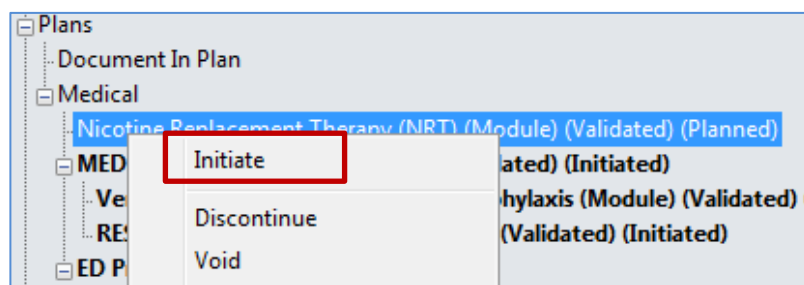
When you right-click individual order, you will have the following options:

- Cancel and Reorder will stop the current order and make a duplicate allowing for a quick change.
- Cancel/Discontinue will stop the order.
- Convert to Prescription will print a prescription from the existing order.
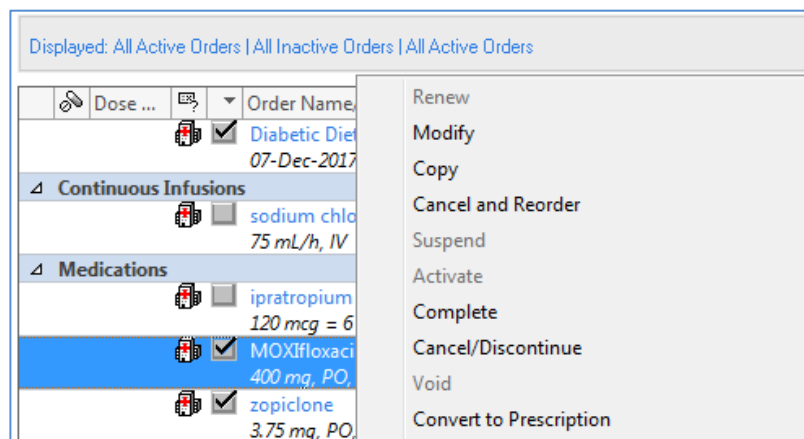
For your practice, select the sodium chloride continuous infusion and right-click to Cancel/Discontinue this order.
Select one or the other method to cancel and discontinue azithromycin IV.

15 Return to **Provider View** window.
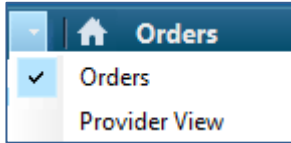
🔑 **Key Learning Points**

There are many ways to place a new order. Use the method that is the most convenient for your situation

To replace a medication, start by discontinuing the existing order and then place a new one

Existing orders can be modified only for adjusting the infusion rate or adding / modifying order comments

🧩 Activity 3.2 – Update Active Issues

Active Issues is the next component on the Rounding tab. 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
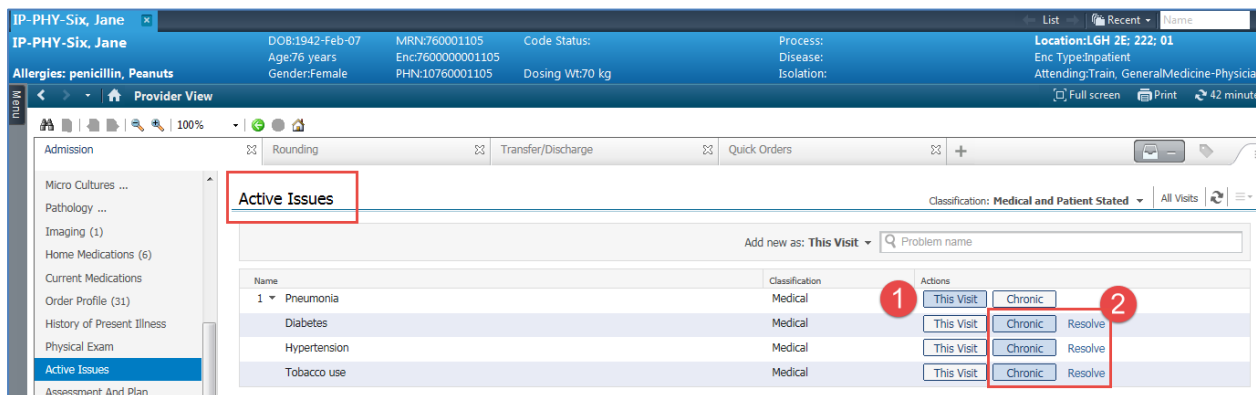
Note the difference when adding diagnosis versus problems. Diagnoses are for the current encounter (reason for visit) and problems are chronic issues (e.g. medical, social, or others).

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.

In this activity you will:
- Add This Visit and Chronic problem
- Practice how to resolve and modify existing problems

1 Click down arrow and select **This Visit and Chronic** descriptor.
Search for COPD in the **Problem name** box and select one of the entries.

COPD as a chronic problem will carry over from this visit to the next.

2 You can also update problems right in this workflow view:

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

- You can change 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.

3 Click the item 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

4 For your practice, add

- *acid reflux* as chronic problem and resolve it
- *lower back pain* as this visit problem and change it to a chronic problem

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 3.3 – Create a Progress Note and Use Auto Text Entry

Similar to the Admission tab, the Rounding tab also provides one click access to the most relevant note type. You have already learned how to remove sections or edit text within your note. Now let's learn how to **avoid entering repetitive information by using the auto text feature.**

In this activity you will:
- Create a **progress note** for Jane
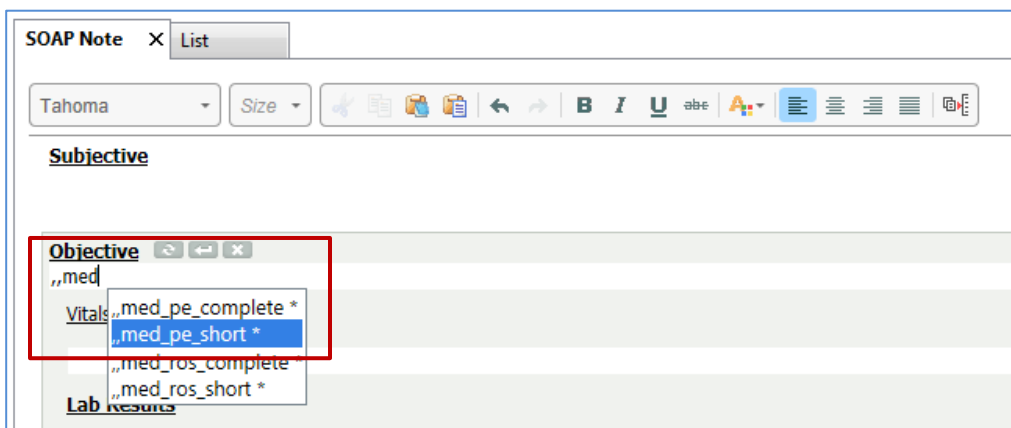- Practice how to use an auto text

1	From the list under **Create Note**, select **Progress Note** which will pull existing information into relevant sections (in the Train domain, this information is limited).

2	With the note displayed, use an **auto text** entry. 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 more personalized learning session.

1. Activate a free text box under the **Objective** heading

2. Type **,,med**

3. A list of auto text entries is displayed. Double-click on **,,med_pe_short***

3 The programmed auto text entry populates the box. This text can be edited or left as is, if appropriate.

> **Objective**
> General: Alert and oriented x 3, no acute distress.
> Cardiac: Normal S1 &S2, no gallops, no murmurs, no rubs, normal JVP, no pedal edema.
> Respiratory: Good air entry bilaterally, no adventitious sounds.
> Abdomen: Normal bowel sounds, non-distended, soft, non-tender, no hepatosplenomegaly.

4 Once you finish edits, click **Sign/Submit** to complete the progress note.

5 Click **Sign**.

> Do you remember what component lists your completed notes?
> You might not see the newly completed document, what you need to do?

🔑 **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

▇ PATIENT SCENARIO 4 – Discharging a Patient

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

Your patient Jane has been improving and is ready to be discharged. You want to complete the necessary steps required to discharge the patient when using the Clinical Information System (CIS):

1. Completion of discharge medication reconciliation including prescriptions.
2. Placing a **Patient Discharge** order for nursing and Registration.
3. Entering discharge diagnoses and any future investigation orders and referrals.
4. Creating a **Discharge Summary**.
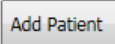
You will complete the following activities:

■ Review orders

■ Reconcile medications at discharge and create prescriptions

■ Place orders when discharging a patient

■ Update discharge diagnoses

■ Complete discharge documentation

Activity 4.1 – Review Patient Status

You have used the **Patient Overview** a few times to access patient's chart. You can also use it to connect with other providers about the patient's status. Although it does not create any action items**, it serves as a communication tool for patient handover**. It provides a snapshot of patient's status and helps you manage your work:

1. You can see where the patient is located: unit / room / bed

2. You can make a note of patient's illness severity by selecting an option from the drop-down

3. You can track medication reconciliation completion ✔✔ⓘ

4. Once the patient is discharged, the 🚪 icon appears under the Discharge column

5. You can track new results that you have not yet reviewed 📋!

6. The last column will list any action items related to this patient.

In this activity you will:
- Use Patient Overview to communicate patient's status
- Review orders before discharging your patient

1

The Patient Overview displays a snapshot of patient condition under the **Illness Severity** column. You can easily add or change your patient status by clicking the corresponding space under this column and selecting one of the options from the list.

> Hover to discover displays more information.
> In this example, discover truncated column headings.

1. Ensure you are in the **My Assigned Patients** list

2. Locate Jane's name in the **Patient Overview**

3. Click in the **Illness Severity** column

4. Select **Discharging** to document your decision.

2

Your list in the Train Domain has only three names but the real life lists will be much longer.

Within a patient list, click the column heading such as **Location** to display all patients in the same unit together. Clicking **Patient Information** will place names in alphabetical order.

1. You can click **Illness Severity** heading to group all patients ready for discharge.

2. You can also search for a patient in the currently displayed list.

3 Ensure that you are in the **Discharge/Transfer** tab of Jane's chart. Select the **Order Profile** which is the very first component on the list.
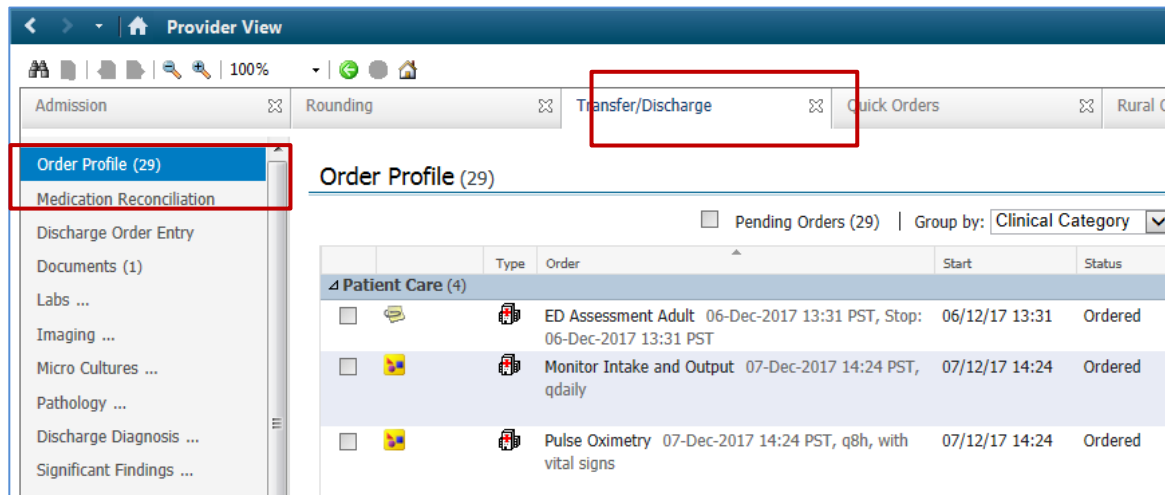
4 Review patient's orders to be aware of any outstanding lab or imaging orders. Visual cues provide additional information:

Hover to discover can always help you to find out what the icons mean directly on your screen.

🗨 indicates comments

🟡 order is part of the PowerPlan

🏥 inpatient medication

NOTE: No manual action is required to stop orders at discharge. When a patient physically leaves the unit and is discharged from the system by the unit clerk or nurse, their encounter becomes closed. This will automatically discontinue their orders. Any orders to be completed in the future or orders with pending results that you have placed prior to discharge will remain active.

For your practice, **Cancel/Discontinue sodium chloride 0.9% continuous infusion** from the Order Profile.

🔑 Key Learning Points

Outstanding orders are automatically closed after discharge except for future orders (completed after discharge) and orders with pending results

## Activity 4.2 – Reconcile Medications and 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.

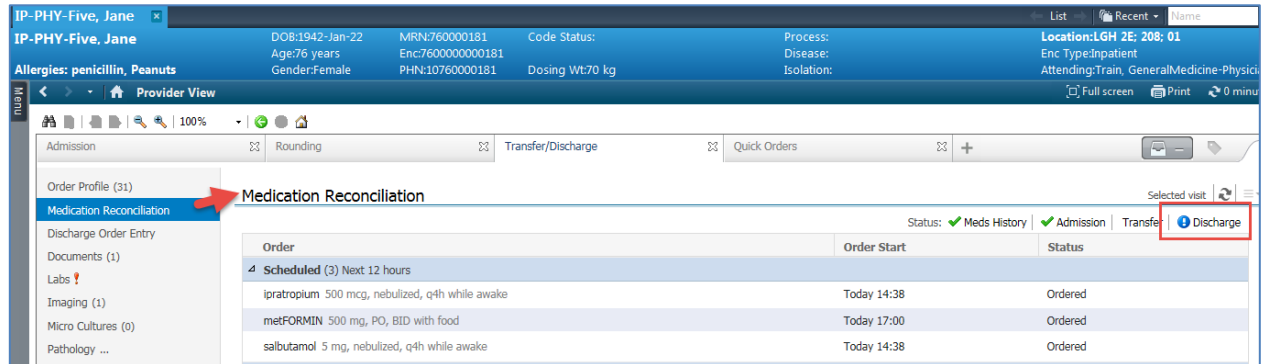All medications marked to be continued at home will be viewable at the patient's next visit.
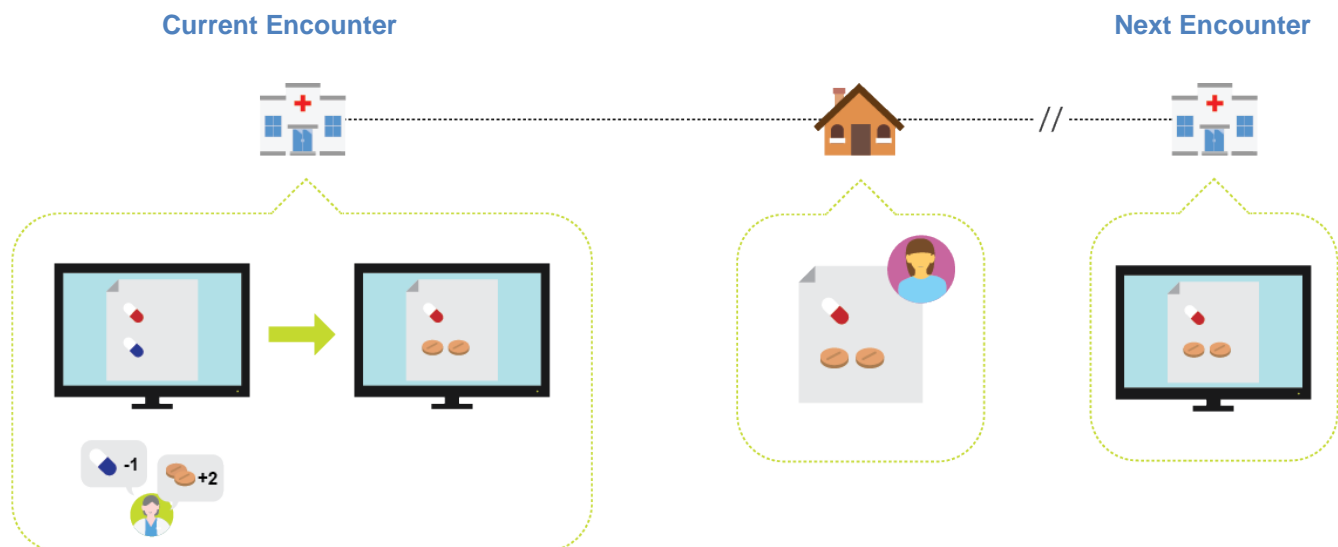
In this activity you will:
- Discontinue or return to home medications
- Discontinue inpatient medications
- Create a prescription for an inpatient medication and a new home medication

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 Jane'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 Jane to return to taking it at home.
A prescription will not be provided but Jane 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 Jane 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 non-formulary ginseng.

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.

Gliclazide 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 Jane to return to taking her home medication after discharge.
Select 🟥 to not continue the inpatient medication after discharge.
Select 💊 if Jane has run out of her prescription and you would like to create a refill.

6 Lisinopril is also Jane'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 Jane to return to taking lisinopril after discharge.
Select if Jane 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 *moxifloxacin, prednisone, and zopiclone*,

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 **50 mg**.

2. Select **7 day** for duration.

3. If you see Dispense amount not calculated, **type** *7 day*.

4

You can also **add additional prescriptions** for home medications that will be new to the patient. For Jane, 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,   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-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_presc   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)	

102

🔑 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 4.3 – Place Orders when Discharging a Patient

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.

In this activity you will:
- Place a Discharge Patient order
- Place a future order for a Pulmonary Function Test
- Create a referral to a Respirologist

1 You have used the Quick Orders tab to place orders as the most efficient method. Orders can be also placed directly from the workflow tab.

1. In the **Transfer/Discharge** tab, select **Discharge Order Entry**

2. Click **Order** to select *Discharge Patient without Support Services.*

> The Orders for Signature button shows one order waiting for you to sign.
> Can you locate the Orders for Signature button on the workflow tab?
> Can you complete placing this order based on what you have learned?
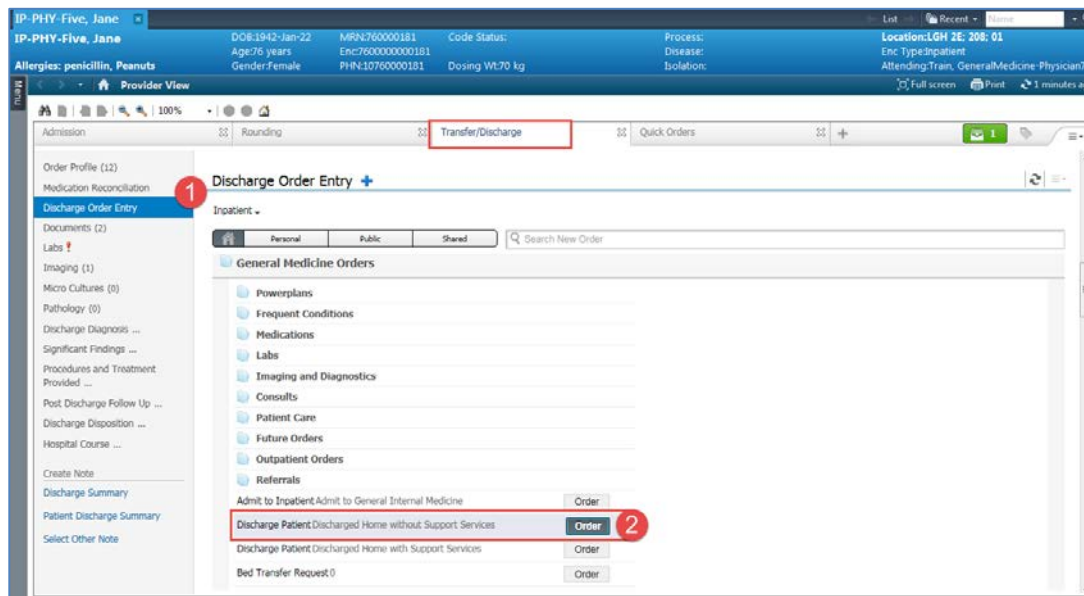
2

Now you will learn how to place an order by searching the catalogue directly from the workflow tab:

1. Use the **Discharge Order Entry** component

2. Search for a **Pulmonary Function Test** and select the order from the drop-down.

3. Click the **Orders for Signature** icon

3

You would like to add more details. Click **Modify**.
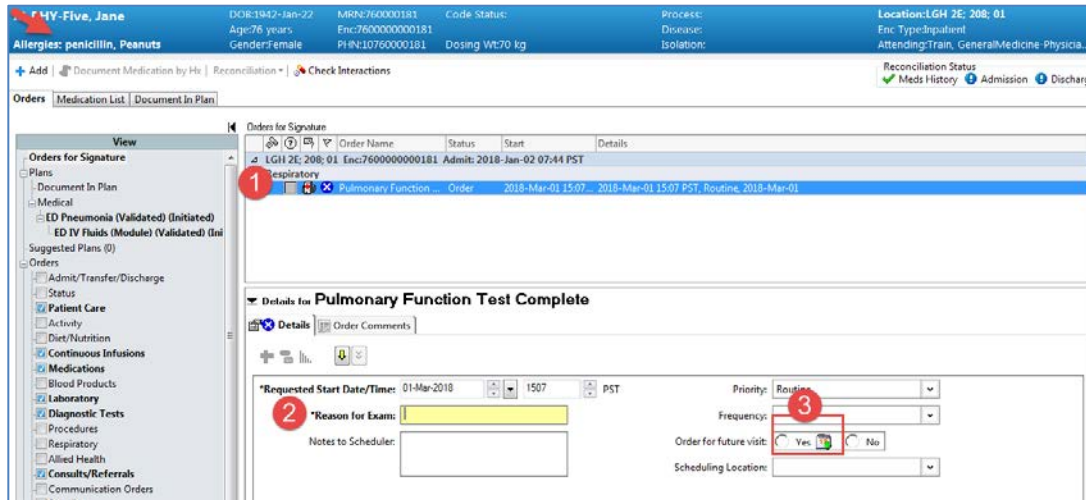
NOTE: You can remove the order placed in error by placing the cursor over the individual order in the Orders for Signature window, and clicking the **x**.

4

1. Click the order to display **Details**

2. Add missing required details.

3. Check **Yes** for **Order for future visit** and click the calendar icon 📅 .

5

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.

6

The **Scheduling Location** drop-down will list any location that is part of your CIS.

For our example, select LGH PF Lab. In real life, the lab selected will be prompted to proceed with the order.

WARNING: For locations that are not part of the CIS, the **Paper Referral** option is to be selected. Although the process remains on paper, entering and signing this order in the CIS informs care providers for this patient that the specific referral has been placed.

7

For your practice, search and add the **Referral to Respirology**. For best results, use combination *referral resp*

8 Note, that your **Quick Orders** tab will list the most common orders for outpatient future visits.

1. **Outpatient Orders** are grouped by the order type.

2. **Referrals** are grouped by the location.

9 Note the order sentence – the option **Order for future visit** is already preselected. This will speed up placing future orders.

10 Your **Quick Orders** tab will list referral orders organized by location. Select and sign the order from the list.

NOTE: For sites that do not use the CIS, paper referrals will be created. Still you will place the electronic order and select Paper Referral that will print a paper requisition.
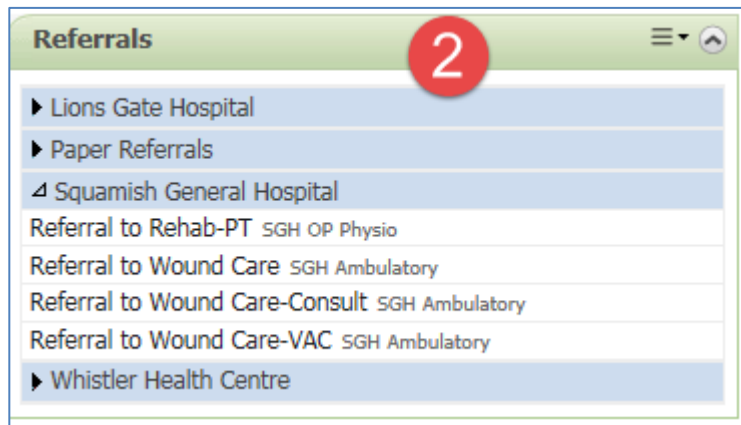
11 Note that the Discharge Order Entry component reflects your Quick Orders window. You can select Outpatient orders and Referrals directly from there.
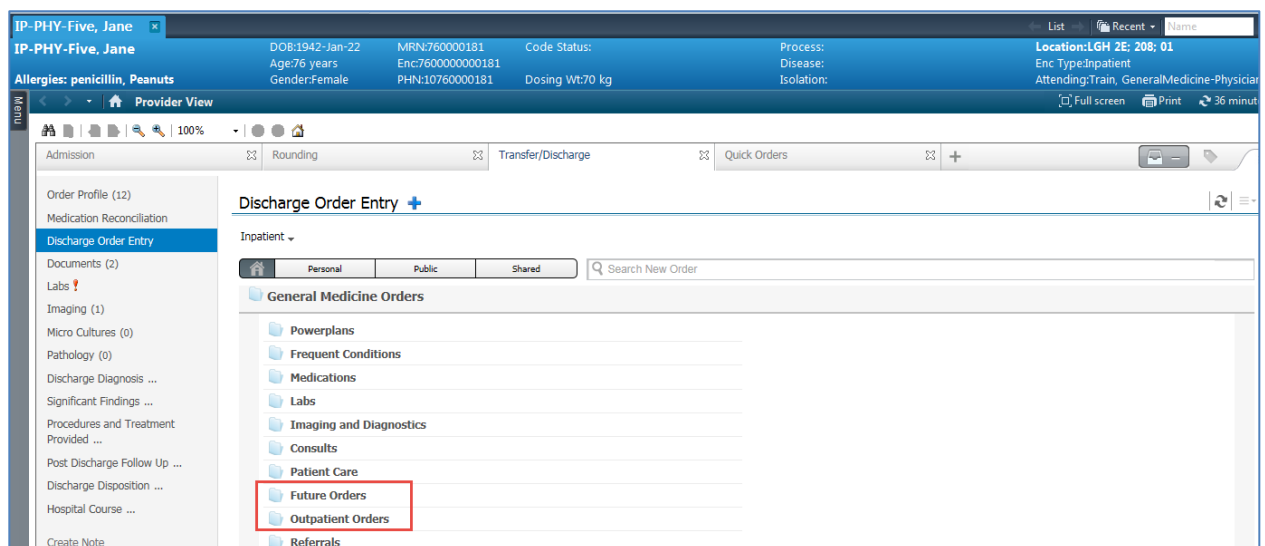
🔑 **Key Learning Point**

■ 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 4.4 – Complete Discharge Diagnosis and 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.
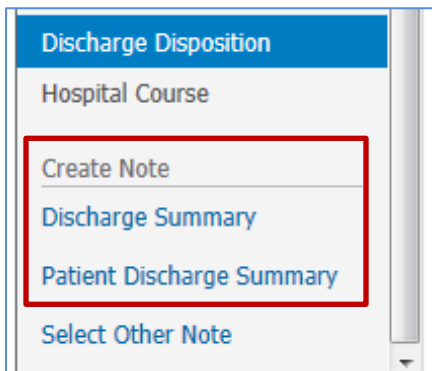
In this activity you will:
- Add a discharge diagnosis
- Create Discharge Summary and Patient Discharge Summary notes

1 In the **Discharge/Transfer** tab of Jane's chart, select **Discharge Diagnosis**.

Ensure that COPD without exacerbation applies to both **This Visit** and **Chronic** and the **Diagnosis Type** is *Discharge*.

2 Confirm problems and diagnoses status at discharge:

1. Select Pneumonia to display additional information.

2. Ensure it states that this is a discharge diagnosis.

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

> Do you remember how to remove the split screen?

3 Start documenting patient's discharge by typing information under:

1. **Significant Findings**

2. **Procedures and Treatment Provided**

3. **Post Discharge Follow up**
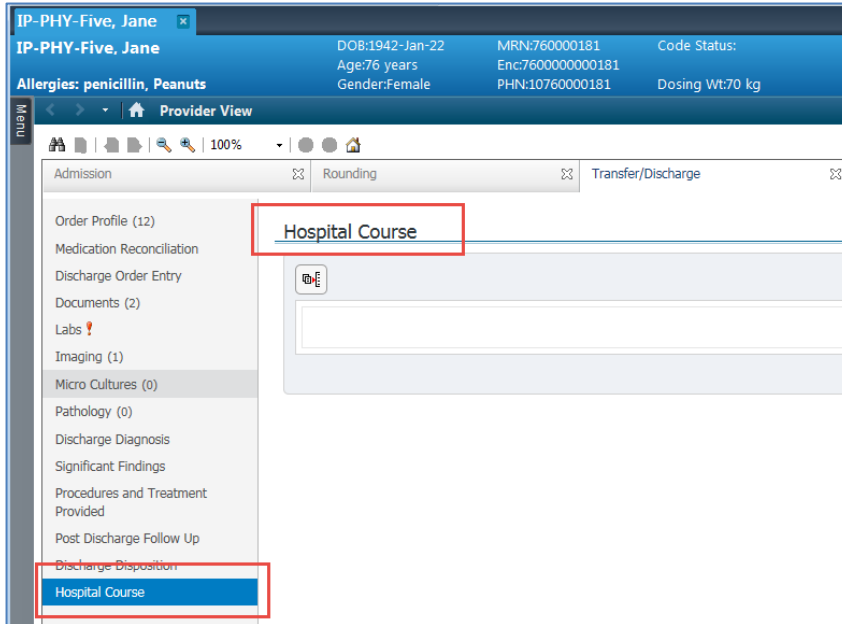
Entries made in these fields will auto-populate into your discharge summary.

> Remember that you can use auto text entry to speed up the process.
> Do you remember how to display them on your screen?
> If not, review Activity 3.3 Create a Progress Note.

You will learn how to personalize auto text entries from other resources.

4

In the **Hospital Course** component, many providers will document on the patient.

Unlike other free text components such as **Illness History** where you enter your own temporary notes, the Hospital Course is visible to other providers to enable collaborative input. Multiple providers will add their notes. All these entries are stored until the Discharge Summary note is created.

You will pull these collaborative comments into a Discharge Summary note once you choose to create one.

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

- **Discharge Summary** (to be distributed to other providers)
- **Patient Discharge Summary** (to be provided to the patient)

Click **Discharge Summary**.

6 With your note open, notice that you can finish your documents later. If you are interrupted, you have a choice to select:

- **Save** – it will save the information and documents remains open so you can continue working.

- **Save & Close** – it will save the information and close the document. It will be saved as a draft under the Documents component and sent to your Message Centre.
Draft documents are only visible to you.

Select **Save & Close**.

7 Back in the Transfer/Discharge tab:

1. Review the **Documents** component.

2. Ensure that this component is refreshed.

3. Note that your saved (not completed) note is listed as "**In Progress**". This document is not visible to other care team members.

9 Select your note in progress and click **Open Document** to continue working on the note.

10 Make edits, add more text and select **Sign/Submit** to complete the note.

11 A completed discharge note can be forwarded to other providers grouped in convenient folders:

1. **Favourites** folder is where you add frequently CC'd providers. You will learn how to manage Favourites during a more personalized learning session.

2. **Recent** folder lists all providers who recently accessed patient's chart.

3. **Relationships** folder contains care team members that are part of the patient's record and include care providers. They are grouped into **This Visit** and those that have **Lifetime** relationships. Currently, this is only the patient's Family Doctor. Lifetime relationship providers will be automatically cc'd.

4. **Search** box allows you for searching for any provider registered with the College of Physicians and Surgeons that also have registered with Excelleris.

5. In this scenario, you can select a provider from the **Relationships** list and double-click to add the name under Recipients.

6. Ensure that the appropriate action is checked off: either **Sign** or **Review/CC** to indicate the action required. Select **Review**.

7. Click **Sign**.

NOTE: If you wish to have a copy sent to yourself or your office, you will need to add yourself as a recipient. If you plan on doing this action frequently, you may want to add yourself as a Favourites contact.

🔑 Key Learning Points

- You can fully manage discharge diagnoses right in the **Transfer/Discharge** tab

- A **Patient Discharge Summary** is generated for the patient to take home. It is printed at the time of discharge by the nurse

- 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

- **Sign/Submit** completes the document

- **Saved document** can be completed later

■ PATIENT SCENARIO 5 – Transferring a Patient

Learning Objectives
At the end of this Scenario, you will be able to:
■ Complete patient transfer related tasks in the Clinical Information System

SCENARIO

Transfer scenarios are difficult to recreate in training. Both internal and external transfers involve many healthcare professionals. Keeping this limitation in mind, this scenario will address two typical situations from a perspective of the general medicine provider:
 	
Your patient Dorothy is progressively worsening and being transferred to the ICU:
 	
1. Both providers discuss the patient and make decision
2. A Bed Transfer Request order is placed
3. Transfer order reconciliation is completed
4. Documentation is completed
 	
Your current site cannot provide the necessary level of care for Dorothy so she requires transfer to another site:
 	
1. The patient must be discharged from the current site
2. The current encounter is closed
3. A patient is accepted and admitted to the receiving site
   • If the receiving site uses the CIS, the receiving provider has electronic access to patient information
   • If patient is moving to or coming from a site that has not implemented the CIS, paper-based documentation process is continued
 	
You will complete the following 3 activities:
 	
■ Initiate a transfer from Inpatient to ICU and place a **Bed Transfer Request** order
■ Reconcile medication and non-medication orders at transfer of care
■ Place a **Discharge to External Site** order

🧩 Activity 5.1 – Complete an Internal Transfer

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.
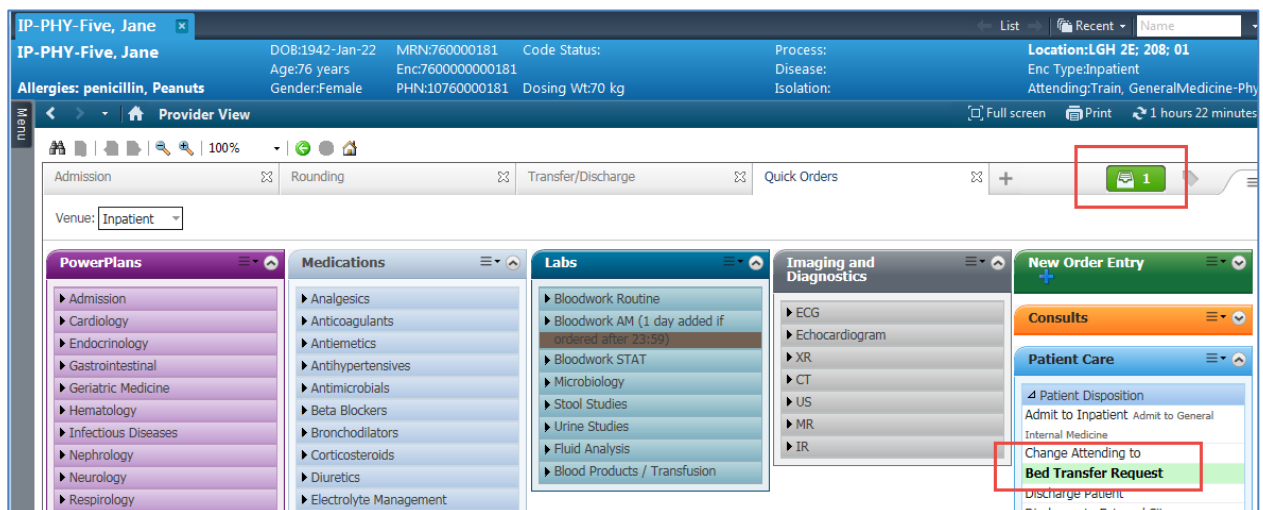
In this activity you will:
- Place the Patient Disposition order – Bed Transfer Request

| 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 5.2 –Reconcile Transfer Medications and Orders

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.

When Dorothy 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.
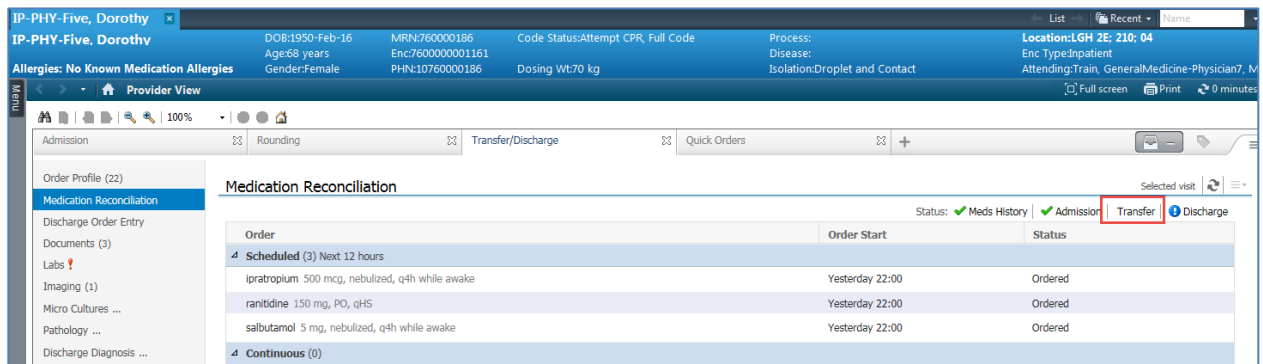
In this activity you will:
- Complete transfer medication reconciliation

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.

You can 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.

Medication Reconciliation		Selected visit ⟳ ≡
	Status: ✔ Meds History ✔ Admission 🔄 Transfer ❶ Discharge	
Order	**Order Start**	**Status**
⊿ **Scheduled** (3) Next 12 hours		
ipratropium 500 mcg, nebulized, q4h while awake	Yesterday 22:00	Ordered
ranitidine 150 mg, PO, qHS	Yesterday 22:00	Ordered
salbutamol 5 mg, nebulized, q4h while awake	Yesterday 22:00	Ordered
⊿ **Continuous** (0)		
⊿ **PRN/Unscheduled Available** (1)		
acetaminophen 650 mg, PO, q4h, PRN: pain-mild or fever	January 31, 2018 10:37	Ordered
⊿ **Suspended** (0)		
▶ **Discontinued** (0) Last 24 hours		

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 5.3 – Complete Patient Transfer to an External Site

Dorothy requires transfer to another 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 Dorothy.

In this activity you will:
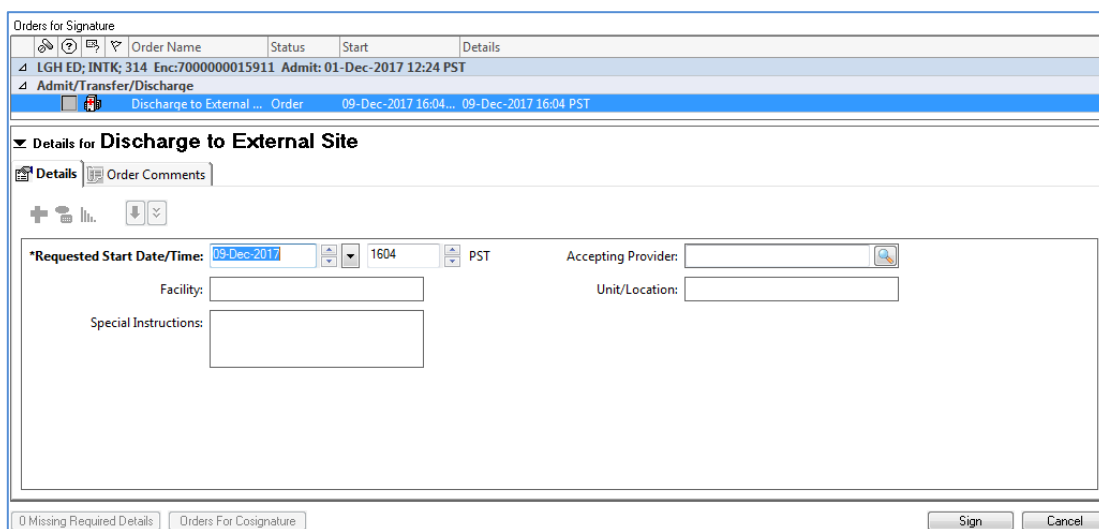
- Practice activities related to patient discharge necessary for patient transfer to the external site

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

2	Enter discharge diagnosis and add at least one chronic problem. Refer to activities 2.5, 3.2, and 4.4 if you would like to refresh your memory.

| 3 | Complete discharge medication reconciliation.
 Refer to activity 4.2 to review the process. |

| 4 | Complete discharge notes.
 This information is covered by activity 4.4 but you can find more information in activities 2.6 and 3.3 |

🔑 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

🧩 End of the Workbook

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