WORKPACKAGE
CST Transformational Learning

CURRICULUM TRACK:

Mental Health: Psychometrist

Within this work package you will find:

- Self-Guided Practice Workbook

Last update: February 1, 2018

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SELF-GUIDED PRACTICE WORKBOOK

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

Using Train Domain

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

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

PATIENT SCENARIO 1 – Introduction to Consults and Patient Chart

Learning Objectives

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

- Create Patient Lists
- Navigate Multi-Patient Task List
- View Consults
- Navigate the Patient Chart

SCENARIO

In this scenario, you begin your day by receiving a consult from your unit. To start, log into the Clinical Information System (CIS) with your provided username and password.

As a Psychologist, you will be completing the following activities:

- Create a Location List
- Customize the Departmental View
- Review consults from the Multi-Patient Task List
- Review the patient's electronic chart

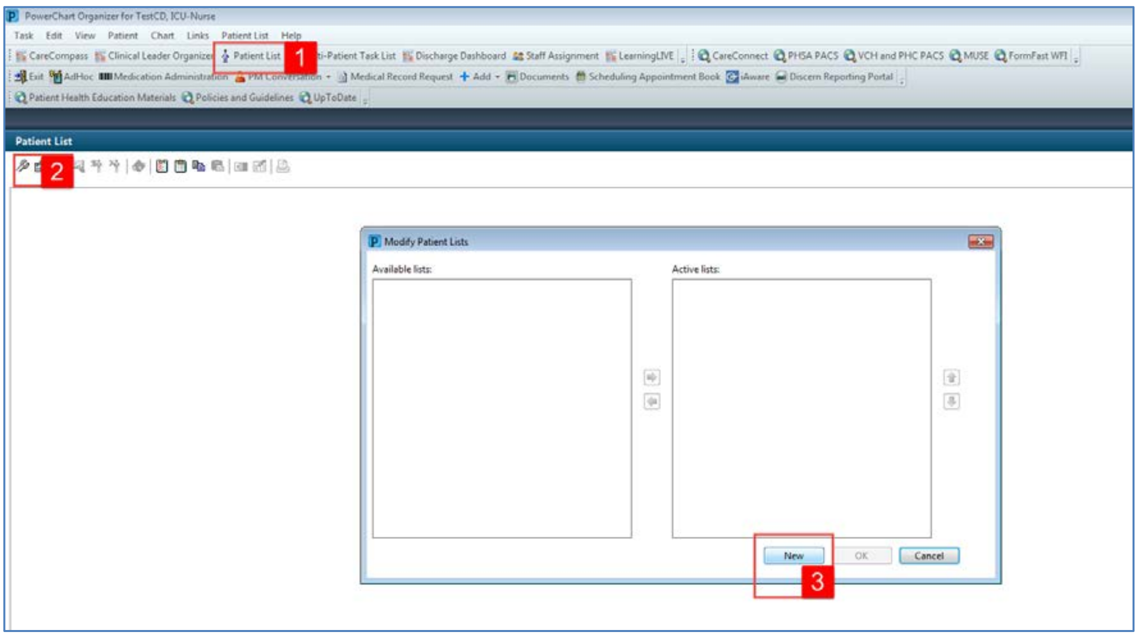
Activity 1.1 – Create a Location List

1 Upon logging in, you will land on **Message Centre**. We will be reviewing the functionality of Message Centre with an eLearning module. First, you may want to review any consults that have been sent to you.

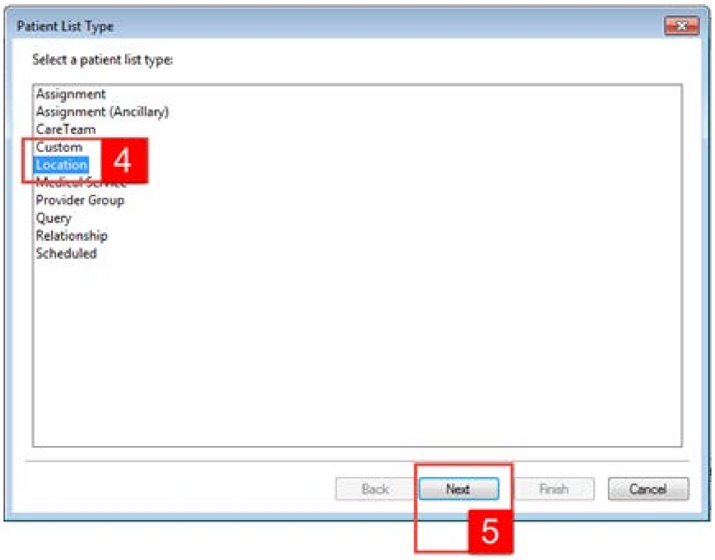
Before you can view consults, you will need to set up a **Patient List**. The **Patient List** is a view of all the patients that are on a specific unit.

1. Select the **Patient List** 

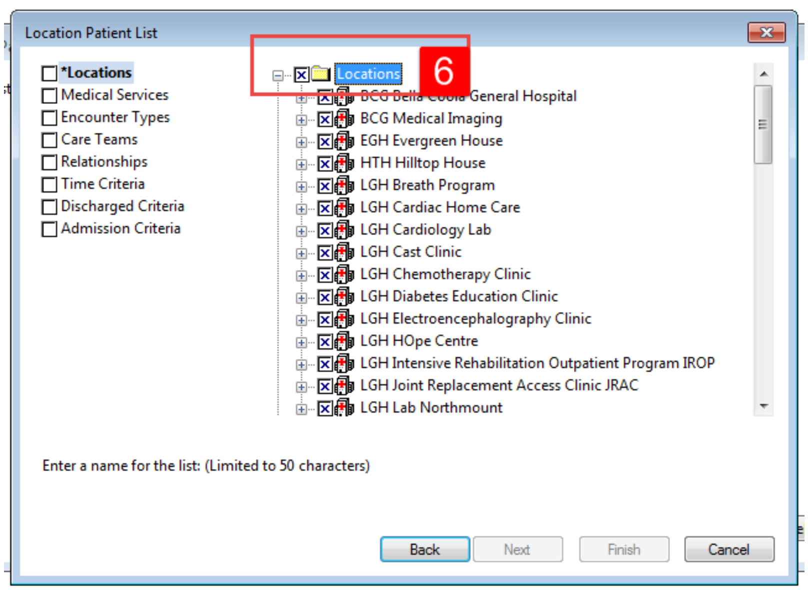
from the **Toolbar** at the top of the screen
2. The screen will be blank. To create a location list, click the **List Maintenance** icon  When you hover over the wrench it will say **List Maintenance**
3. Click the **New** button in the bottom right corner of the **Modify Patient Lists** window



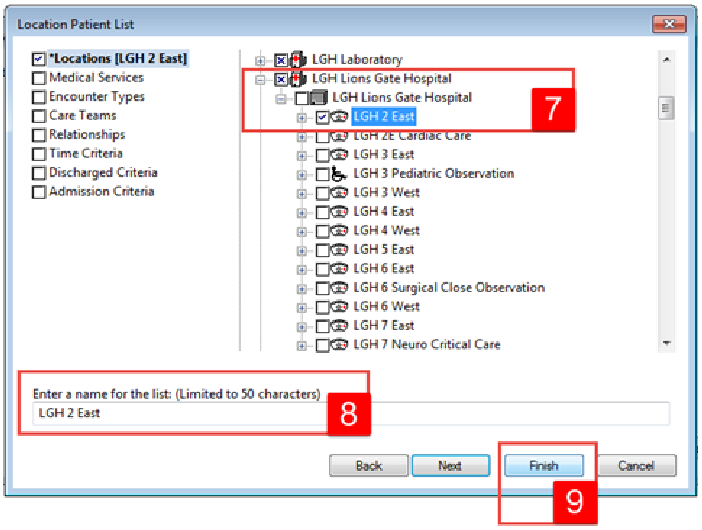
4. From the **Patient List Type** window select **Location**
5. Click the **Next** button in the bottom right corner



6. In the **Location Patient List** window a location tree will be on the right hand side. Expand the list by clicking on the **tiny plus** + sign next to the facility.



7. Scroll down until you find the location assigned to you. Expand the location and select your unit by checking the box next to it
8. Patient Lists need a name to differentiate them. Location lists are automatically named by the Location
9. Click the **Finish** button in the bottom right corner



10. In the **Modify Patient Lists** window select your **Location** list

11. Click the **blue arrow** icon  to move the **Location** to the right **Active List**

12. Click the **OK** button in the bottom right corner to return to **Patient Lists**. Your Location list should now appear

The Patient List is now set with patients that are on the specific unit that you selected. You can go back to Patient List any time to access a patient's chart on your selected unit by double-clicking on the patient's name.

Key Learning Points

- Patient List can be accessed by clicking on the Patient List icon in the Toolbar
- You can set up a patient list based on location

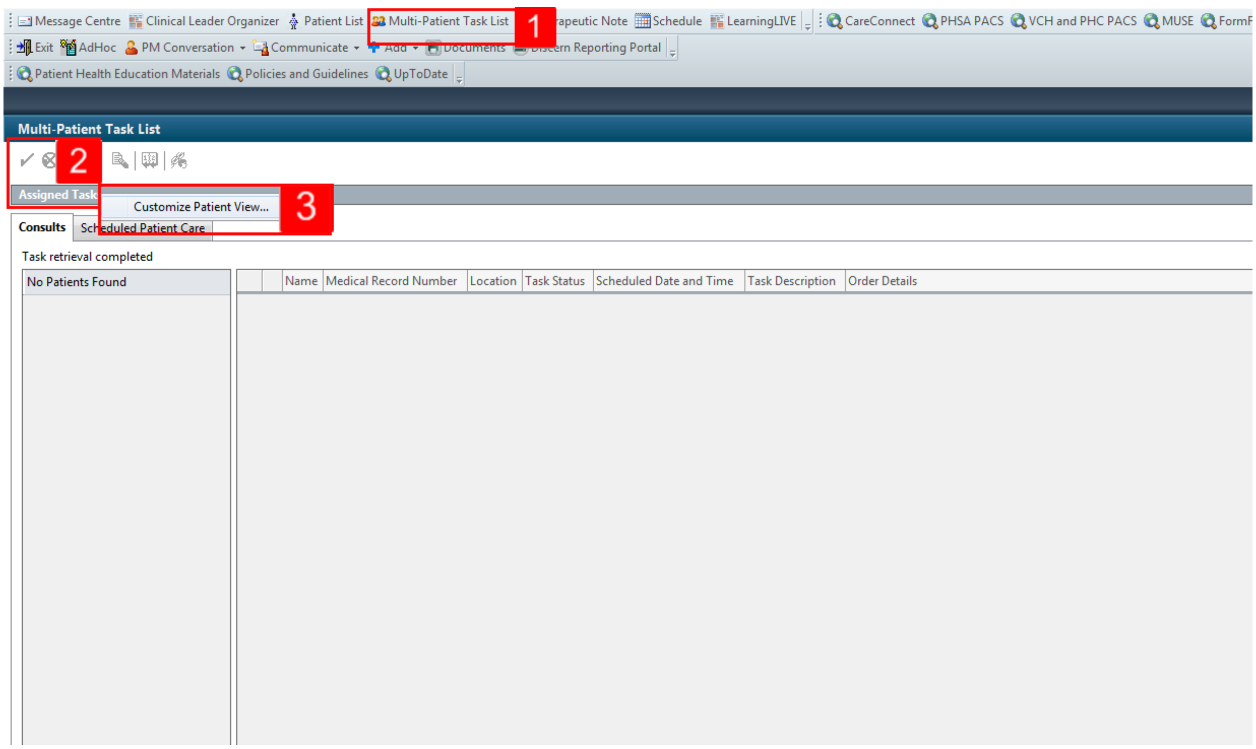
Activity 1.2 – Customize the Multi-Patient Task List

1 The **Multi-Patient Task List (MPTL)** provides a list of the patients and consults from your department.

The first time you log in, you will need to set up the **MPTL** to view consults from your unit. To do this you will select the appropriate **Patient List** and **Time Frame** to display. Let's do this now.

1. Click on **Multi-Patient Task List**  in the Organizer Toolbar

2. Right-click on the words **"Assigned Tasks"** in the grey information bar
3. Select **Customize Patient View**

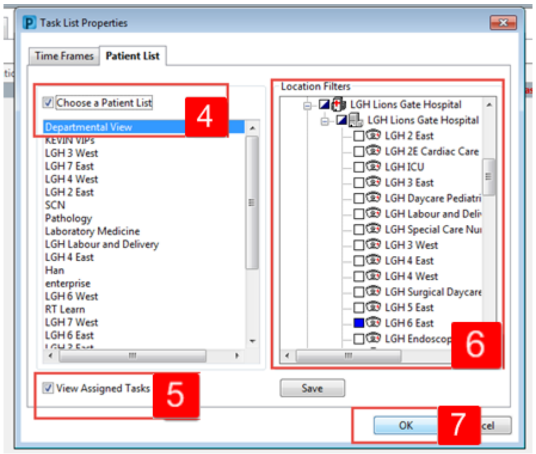


Within the **Task List Properties** window:

4. In the Patient List tab, select **Choose a Patient List** and select **Departmental View** in the list below
5. Select the appropriate location using the location filter
   - Double-click the **All Locations** folder
   - Double-click **LGH HOpe Centre**
   - Double-click **LGH HOpe Centre sub-category**
   - Click on the checkbox beside the unit you are assigned to in this class

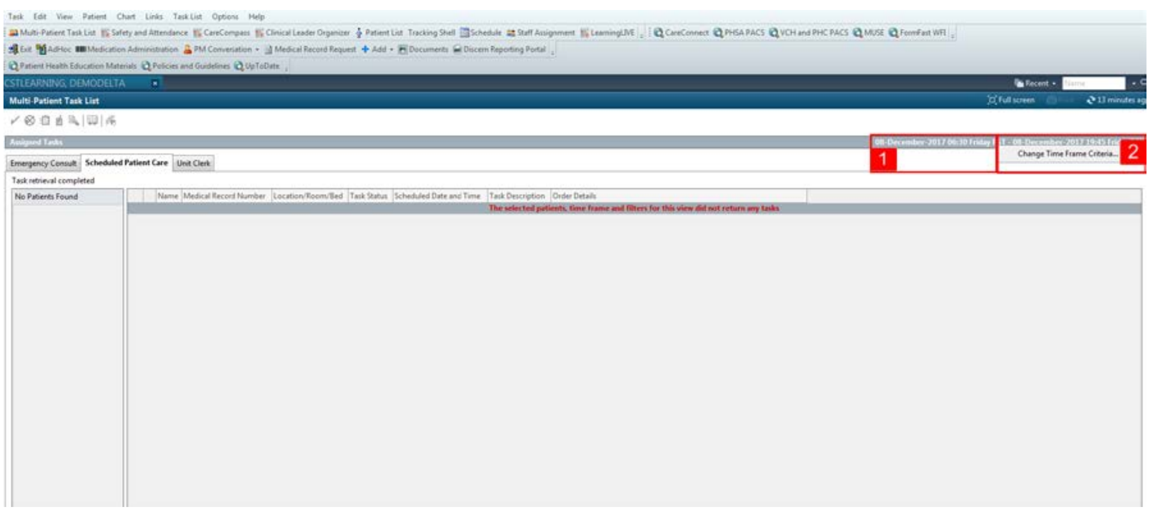
Note: Only choose locations for the department you are working on. If you choose an entire hospital or too many locations, the system might not be able process all the tasks in the MPTL.

6. Ensure **View Assigned Tasks** is checked as this will ensure tasks display on your **MPTL**
7. Click the **OK** button



2 After selecting the appropriate Patient List you need to set up the **Defined Time Frame**.

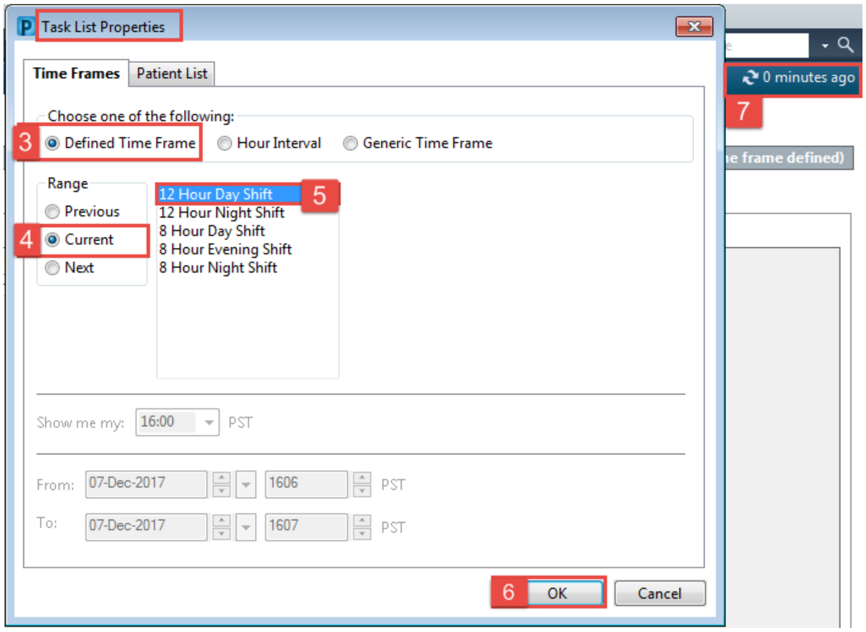
1. Right-click the words **"(no time frame defined)"** in the information bar
2. Select **Change Time Frame Criteria**



The **Task List Properties** window opens.

3. In the **Time Frames** tab select the **Defined Time Frame** option
4. Select **Current**
5. Select the time from the list = *12 hour day shift*
6. Click the **OK** button
7. Click on the **Refresh** button near the top right corner of the window to ensure you can

see the most current orders and tasks



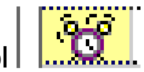
The **MPTL** is now set to view consults for your unit.

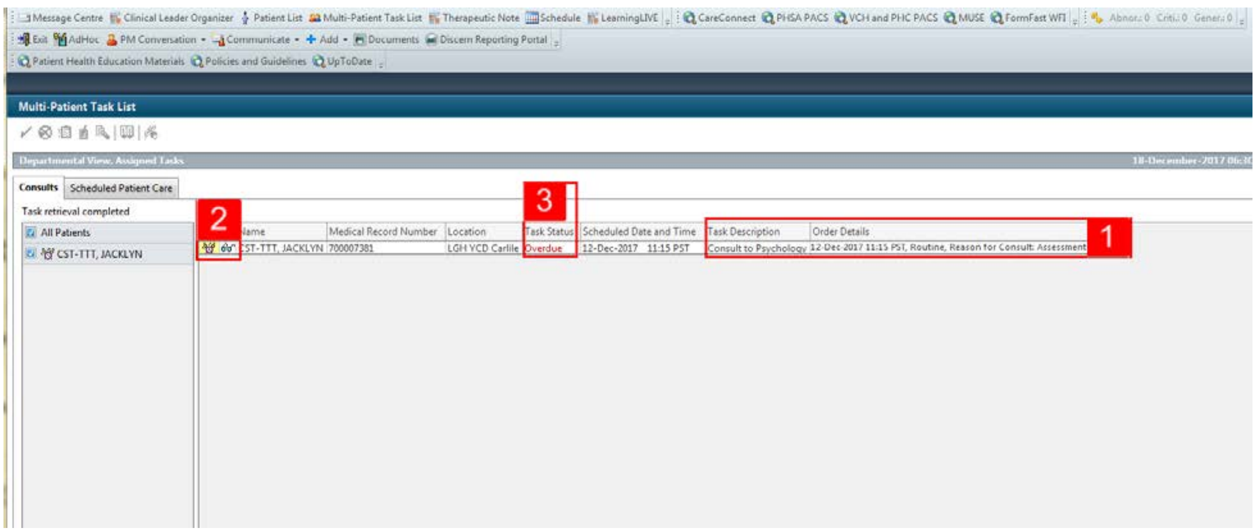
Key Learning Points

- You must select the appropriate time frame in order to see assigned tasks for your patients
- Ensure you set up the correct view for each tab in the MPTL so you can see all of your tasks
- Click refresh to ensure you can see the most current tasks

Activity 1.3 – Access and Navigate the Multi-Patient Task List

1 You can find consults listed in your MPTL. Electronic consults are sent to the psychologist to give basic information about the patient and will replace any paper consult forms.

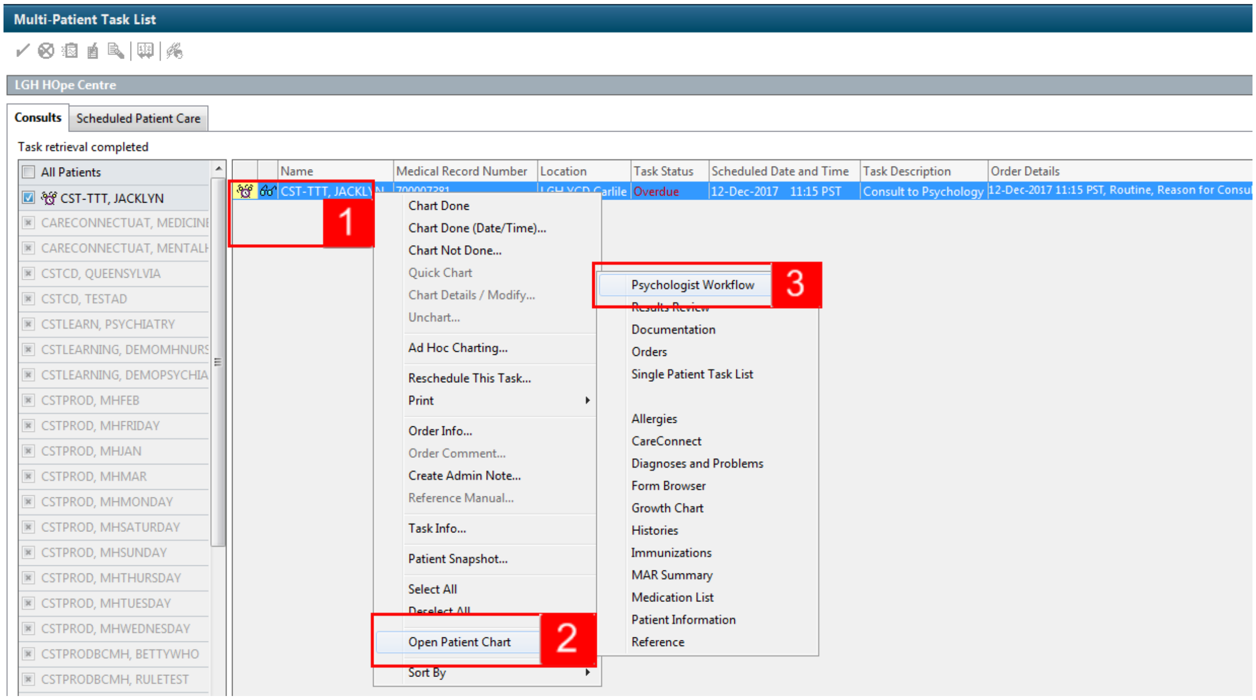
1. Locate the new Consult Order and notice the various information located within a consult
2. The glasses symbol  indicates that the consult has not been reviewed
3. A consult becomes overdue 24 hours after it is entered. The alarm clock symbol  indicates a task is overdue, or that the psychologist has not marked the task as complete



Note: At times, you may see a Following Order rather than a Consult Order. This indicates that the psychologist has completed their initial consult and will continue to consult on the patient on an ongoing basis. With the following order, the patient will stay on the Multi-Patient Task List as long as the order is active and will never have a status of overdue.

You can enter the patient's chart through the consult or following order by right clicking on it. Let's practice entering the chart.

1. Right click on the consult to open the right click menu
2. Hover over **Open Patient Chart** near the bottom of the right-click menu. Another menu appears with various chart components which you can navigate to directly.
3. Select **Psychologist Workflow**



Note: You must establish a relationship with a patient in order to access the patient chart. A relationship will last for 16 hours, after which the nurse will need to re-establish the relationship. Select **Psychometrist** as your relationship from the drop-down menu.

You are brought directly the Psychologist Workflow Page within the patient's chart.

Key Learning Points

- Consults are located in the Multi-Patient Task List
- Consults contain information including status of consult
- You can access the chart from the Multi-Patient Task List through the right-click menu

Activity 1.4 – Access and Navigate the Patient Chart

1 The patient's chart is now open. Let's review the key parts of this screen:

1. The **Toolbar** is located above the patient's chart and it contains buttons that allow you to access various tools within the Clinical Information System.
2. The **Banner Bar** displays patient demographics and important information that is visible to anyone accessing the patient's chart. Information displayed includes:

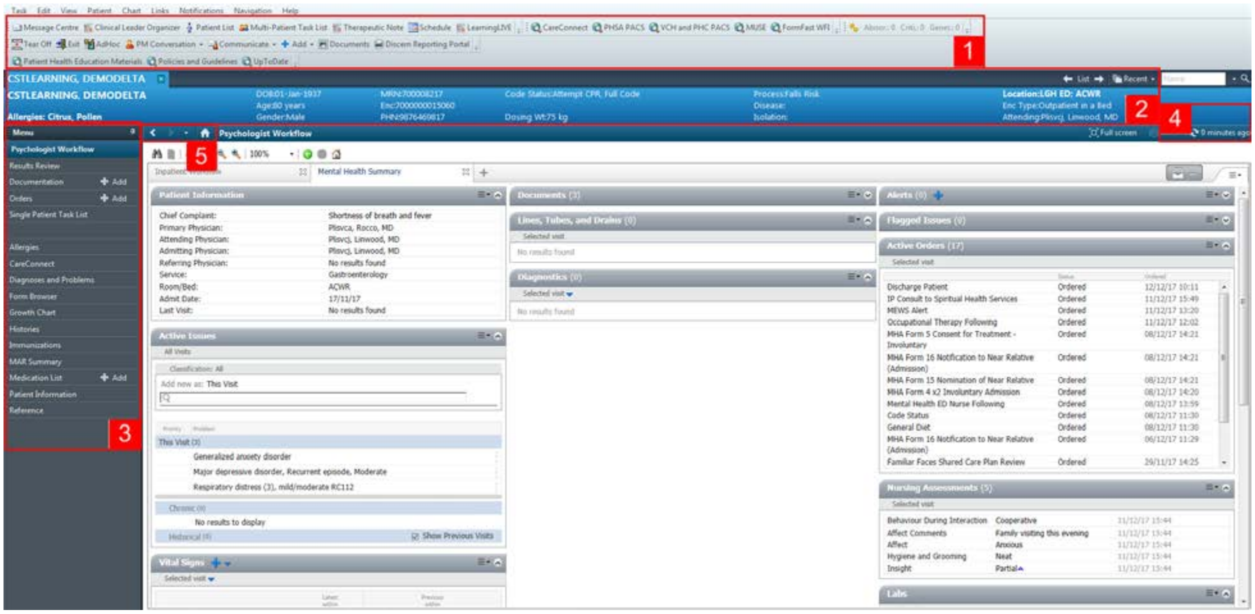
- Name
- Allergies
- Age, date of birth, gender
- Encounter type and number
- Code status
- Weight
- Process, disease and isolation alerts
- Location of patient
- Attending Physician

3. The **Menu** on the left allows access to different sections of the patient chart. This is similar to the coloured dividers within a paper-based patient chart. Examples of sections included are Orders, Medication Administration Record (MAR) and more.
4. The **Refresh** icon updates the patient chart with the most up to date entries when clicked. The time displayed in this icon is the time since you last refreshed your screen. It is important to click the **Refresh** icon frequently especially as other clinicians may be accessing and documenting in the patient chart simultaneously.
5. Use the navigation buttons to return to the previous view

takes you back one screen

takes you to your default view – the **Inpatient Workflow**

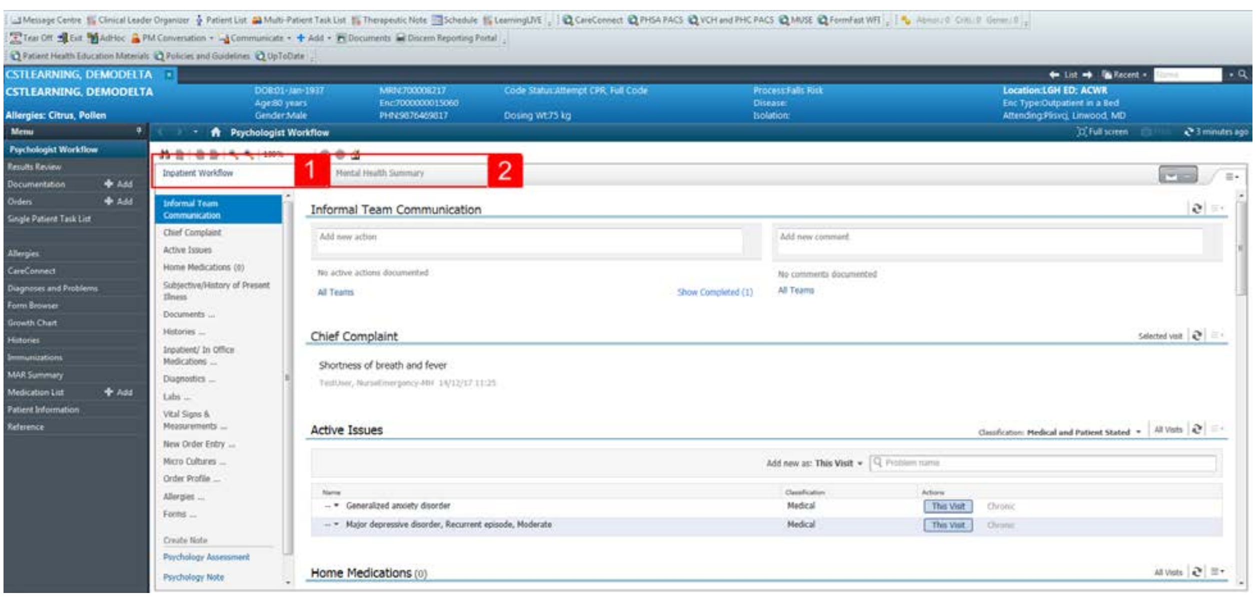
displays a list of recently visited screens for an easy jump back



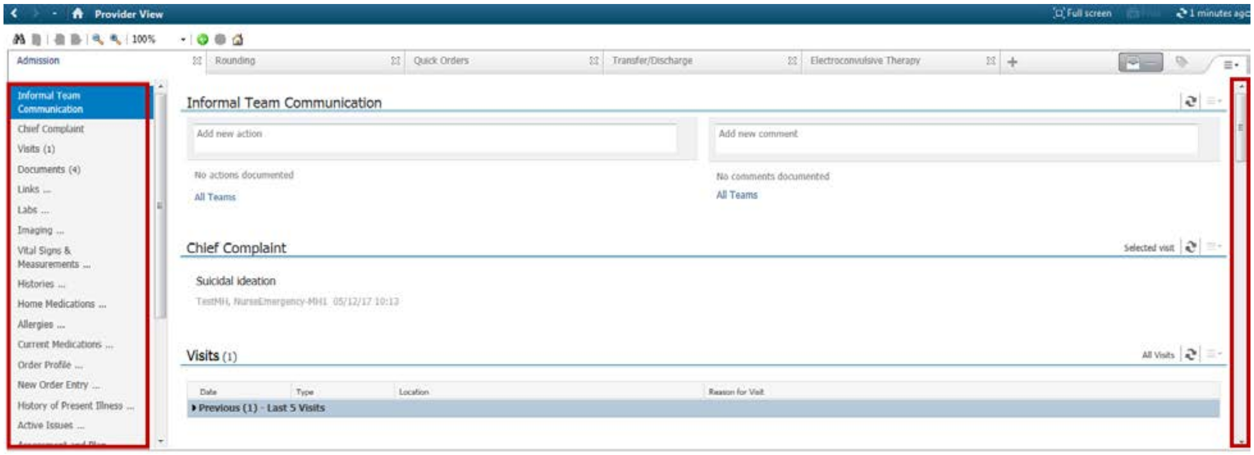
Note: The chart does not automatically refresh! When in doubt, click Refresh

2 The patient's chart opens to the **Psychologist Workflow** which is your default screen when accessing the patient's electronic chart. It is organized into two tabs.

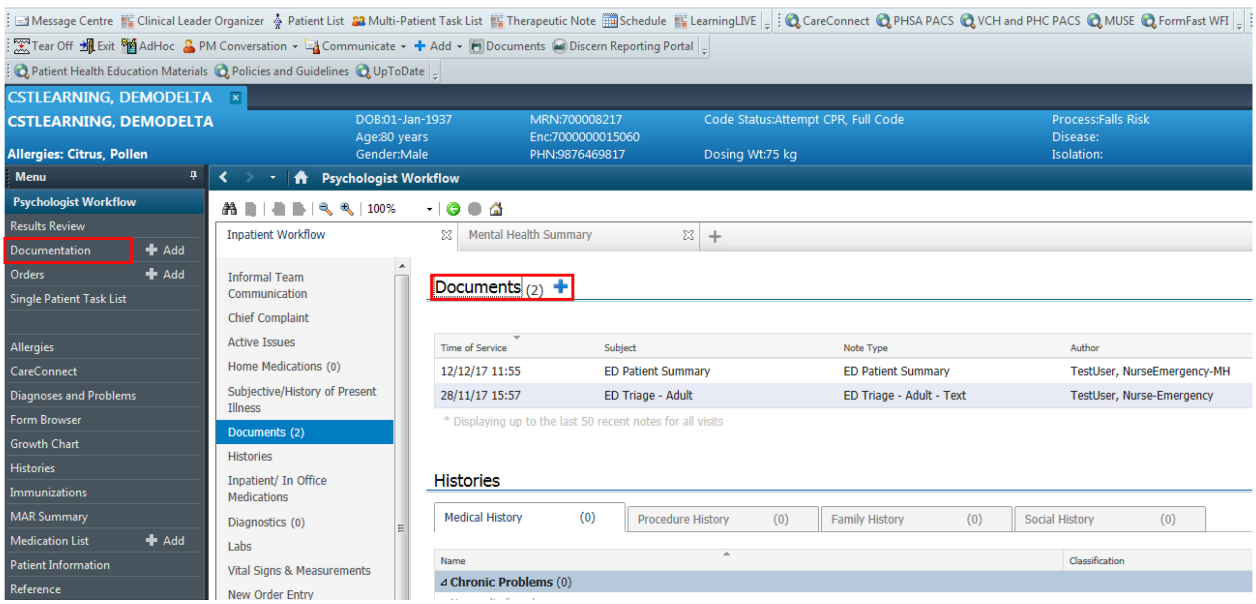
1. **Inpatient Workflow** = used for daily chart review and information input
2. **Mental Health Summary** = used for an overview pertinent patient information



3 On the left side of the screen there is a **list of components** representing workflow steps specific for your specialty. Click the component or use the scroll bar to display the content of the patient's chart.



Each component has a heading. Place the cursor over the heading. This icon means it is a link. This acts as a quick link to the respective Menu component. For example, the Documents link outlined below will take you to the Documents component in the Menu. We will discuss the Documents Menu component later on in this workbook.

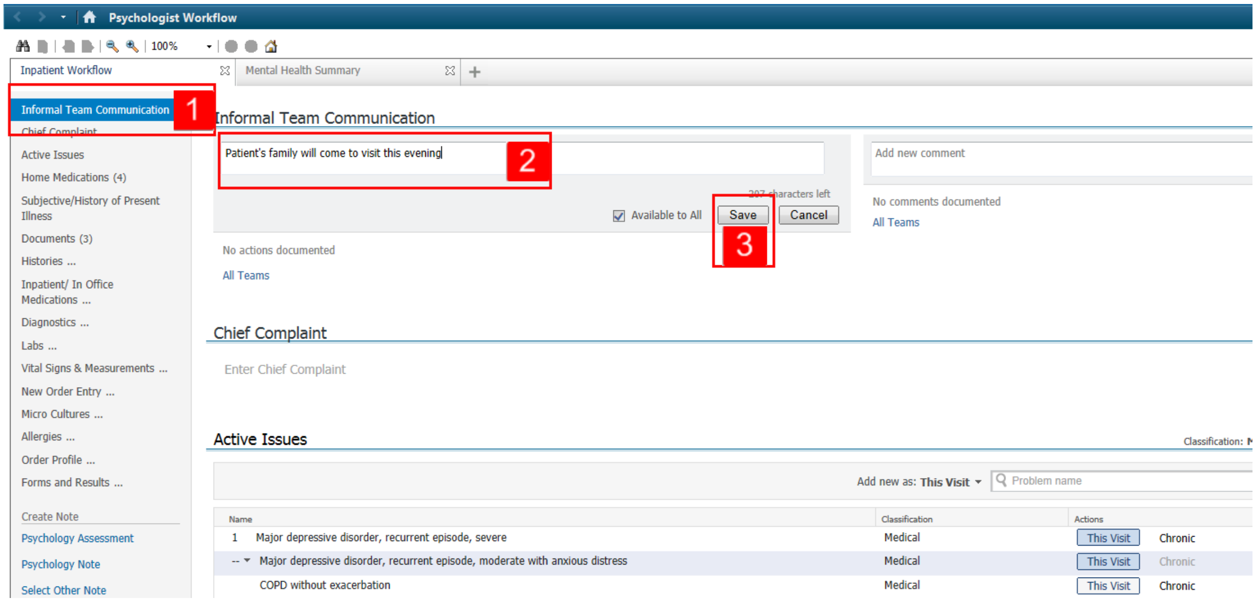


4 The **Informal Team Communication** Tool can be used to add actions or comments to handover to your colleagues, similar to leaving a note in the chart.

Note: The **Informal Team Communication** is NOT part of the patient's legal chart. This is not to be used for legal documentation purposes.

1. Navigate to the **Informal Team Communication** component
2. Type the following = *Patient's family will come to visit this evening*

3. Click **Save**



You may complete or delete these informal team communications when they no longer apply.

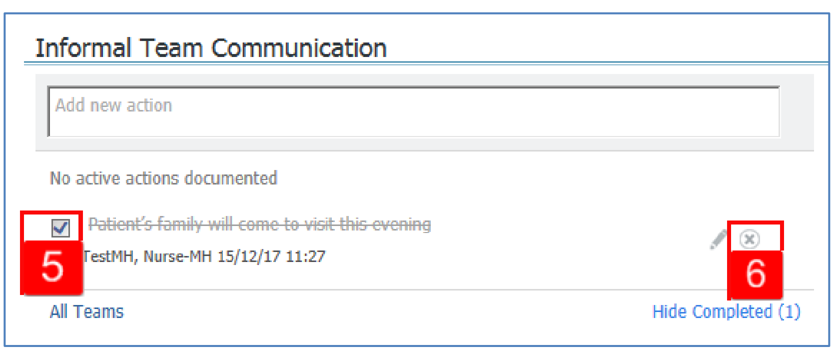
To complete a task in Informal Team Communication:

4. Click the checkbox to the left of the note. The task will appear as completed, and is still viewable.

To delete a task in Informal Team Communication:

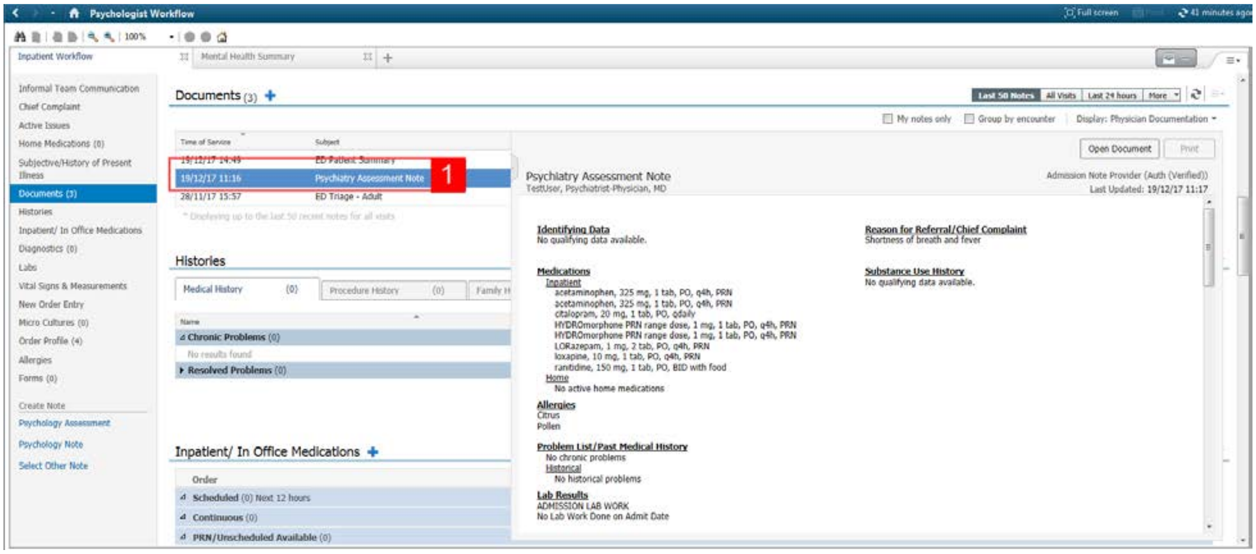
5. Click the small circle with the x to the right of the note

Note: It is important to remove/delete these informal team communications when they no longer apply.



5 Scroll down to the **Documents** component on the Inpatient Workflow page. You can view certain documents directly on your Inpatient Workflow tab. Review the latest document by the Psychiatrist for your patient.

1. Locate and click on **Psychiatry Assessment Note**



Key Learning Points

- The Toolbar is used to access various tools within the Clinical Information System
- The Banner Bar displays patient demographics and important information
- The Menu contains sections of the chart similar to your current paper chart
- The Psychologist Workflow view provides access to various workflow tabs
- The Informal Team Communication component is a way to leave a message for another clinician, but is NOT part of the patient's legal chart
- Remember to refresh your screen frequently to view the most up-to-date information

PATIENT SCENARIO 2 - PowerForm

Learning Objectives
At the end of this Scenario, you will be able to: - Document in PowerForms through AdHoc Charting - View and Modify Existing PowerForms

SCENARIO

In this scenario, we will review another method of documentation.

As a psychometrist, you will be completing the following activities:

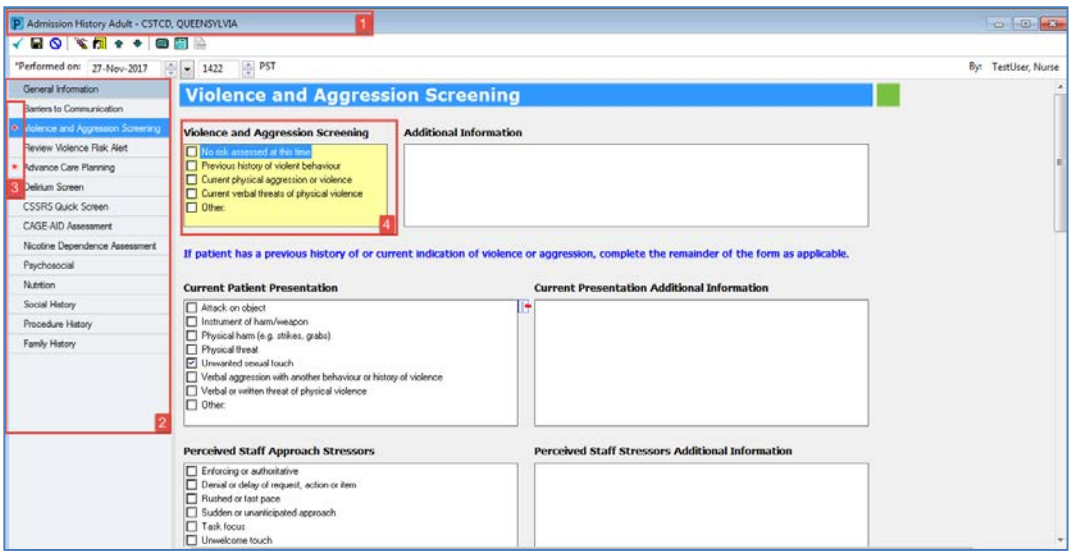
- Opening and documenting on PowerForms
- Viewing a completed PowerForm
- Modifying an existing PowerForm
- Uncharting an existing PowerForm

Activity 2.1 – Open and Document on PowerForms

1 PowerForms are the electronic equivalent of standardized documentation forms. Data entered in PowerForms can flow between the histories components, allergy profile, and medication profile. The AdHoc folder is an electronic filing cabinet that holds any PowerForms you may need to document.

Let's explore the different components of a PowerForm:

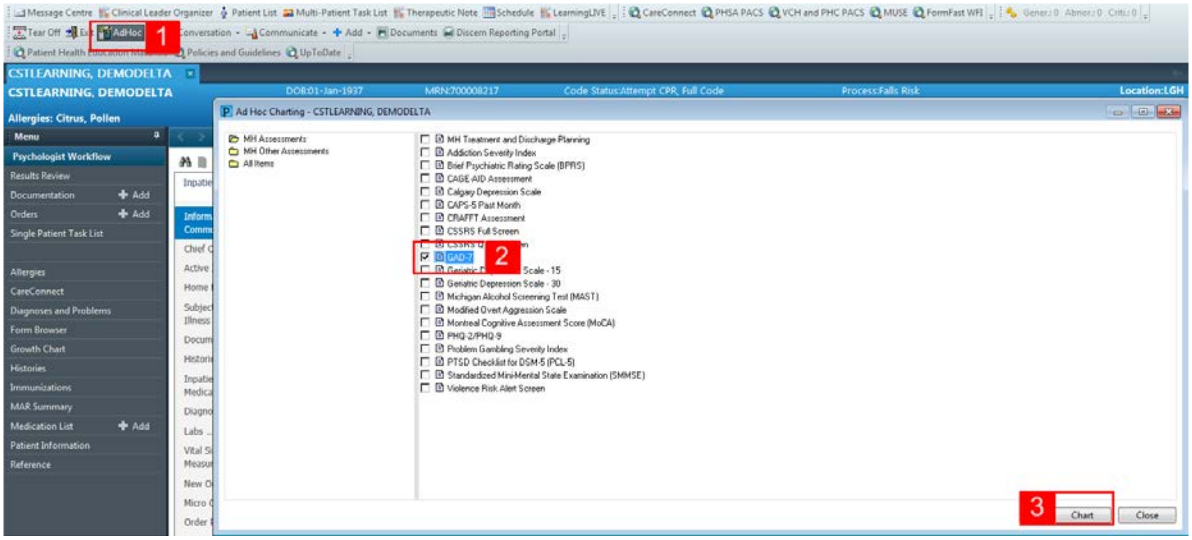
1. The title of the PowerForm and the patient you are documenting on is located in the top grey bar
2. A list of **sections** that can be documented is located on the left-hand side of the PowerForm
3. Sections that have a red asterisk contain required field(s) that are mandatory
4. The mandatory field(s) within the PowerForm will be highlighted in yellow. In some cases, you will be unable to sign a PowerForm unless all required fields are completed



2 In this example we are going to document on the **GAD 7** PowerForm.

To **open** and **document** on a new PowerForm:

1. Click the **AdHoc** button  from the **toolbar**
2. Select the **GAD 7** PowerForm by selecting the title
3. Click **Chart**

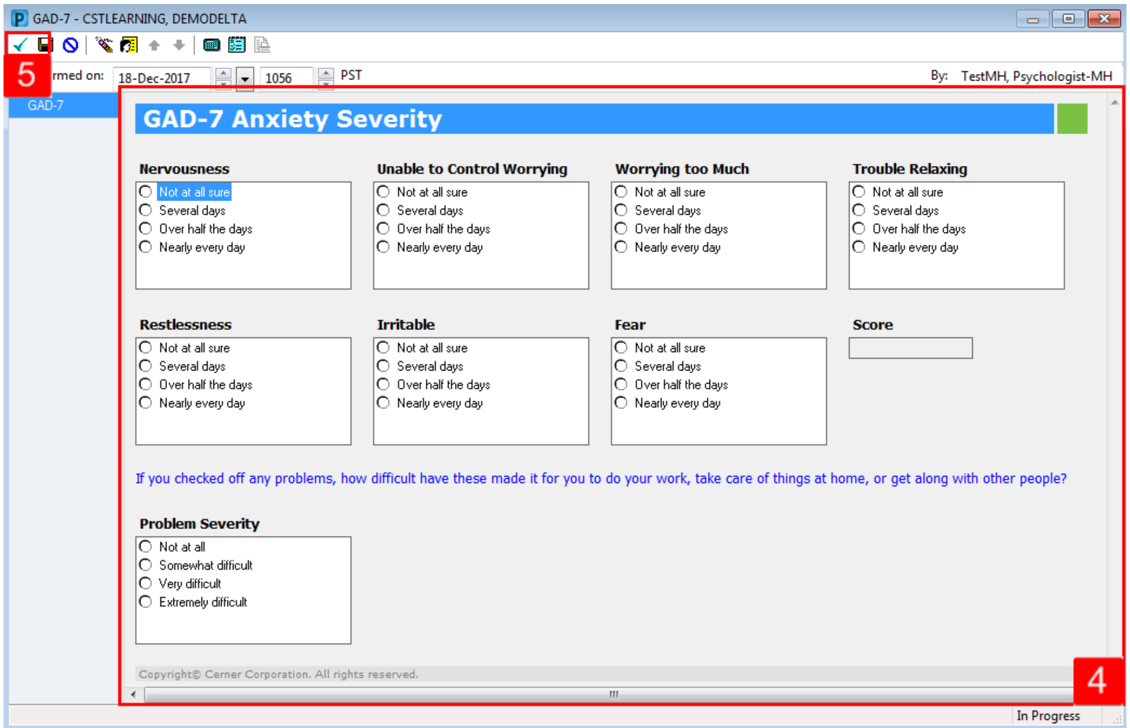


Note: The Ad Hoc window contains two panes. The left side displays folders that group similar forms together. The right side displays a list of forms within the selected folder.

4. Fill in the following fields:
   - **1. Feeling nervous, anxious, or on edge** = *Over half the days*
   - **3. Worry too much about different things** = *Over half the days*
   - **5. Being so restless that it's hard to sit still** = *Over half the days*
   - **Problem Severity** = *Somewhat difficult*
   - **For all other fields** = *Not at all*

Note: Some PowerForms contain auto calculated score boxes that score based on values completed in the form. The score will only calculate once all of the values have been entered.

5. To complete PowerForm, click the **green checkmark** to sign and then refresh the screen



Note: using the Save Form icon is discouraged because no other user will be able to view your documentation until it is signed using the Sign Form icon.

Key Learning Points

- PowerForms are the electronic equivalent of standardized documentation forms
- The AdHoc button in the toolbar is one way to locate a new Powerform
- PowerForms may be broken up into several sections. Section headings are displayed to the left side of PowerForm
- Documents that are saved will not be viewable to anyone except the author. Using the Save Form icon is discouraged for this reason

Activity 2.2 – Modify an existing PowerForm

1 Existing PowerForms can be found in **Form Browser**. Here, you can view, modify or unchart PowerForms. It may be necessary to modify PowerForms if information was entered incorrectly.

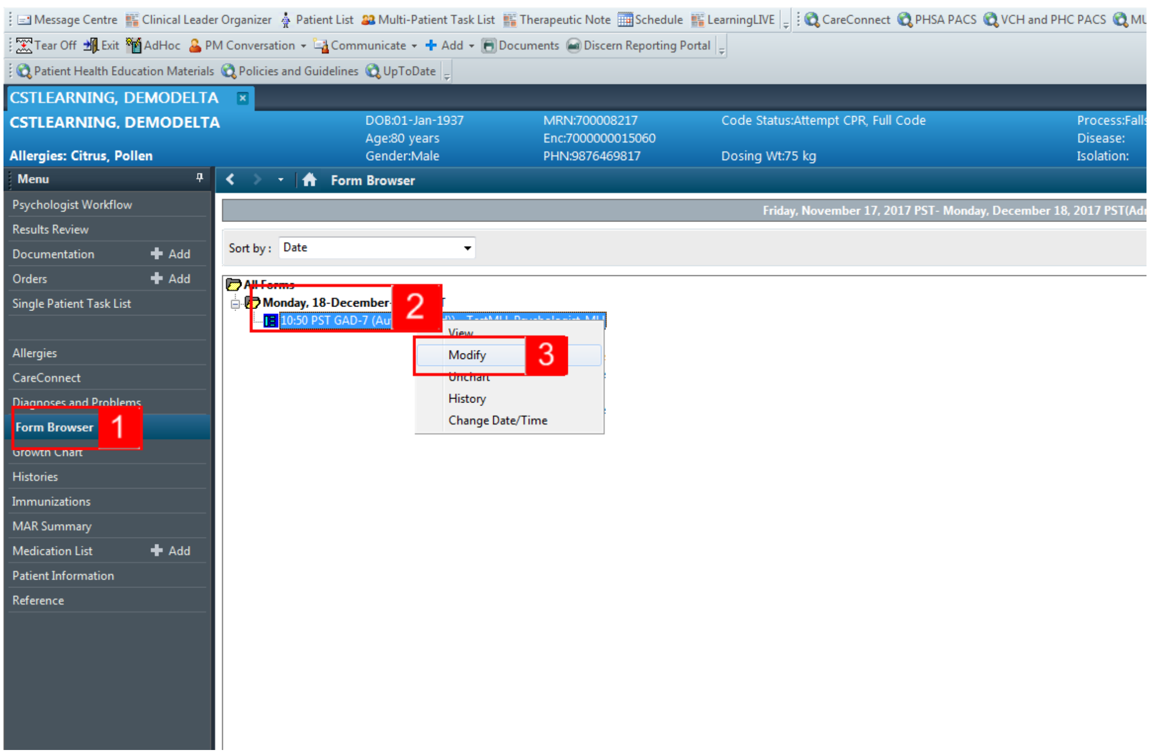
Note: to document or update information, it is recommended to start a new PowerForm and not to modify an already existing PowerForm

Let's modify the **GAD 7** form:

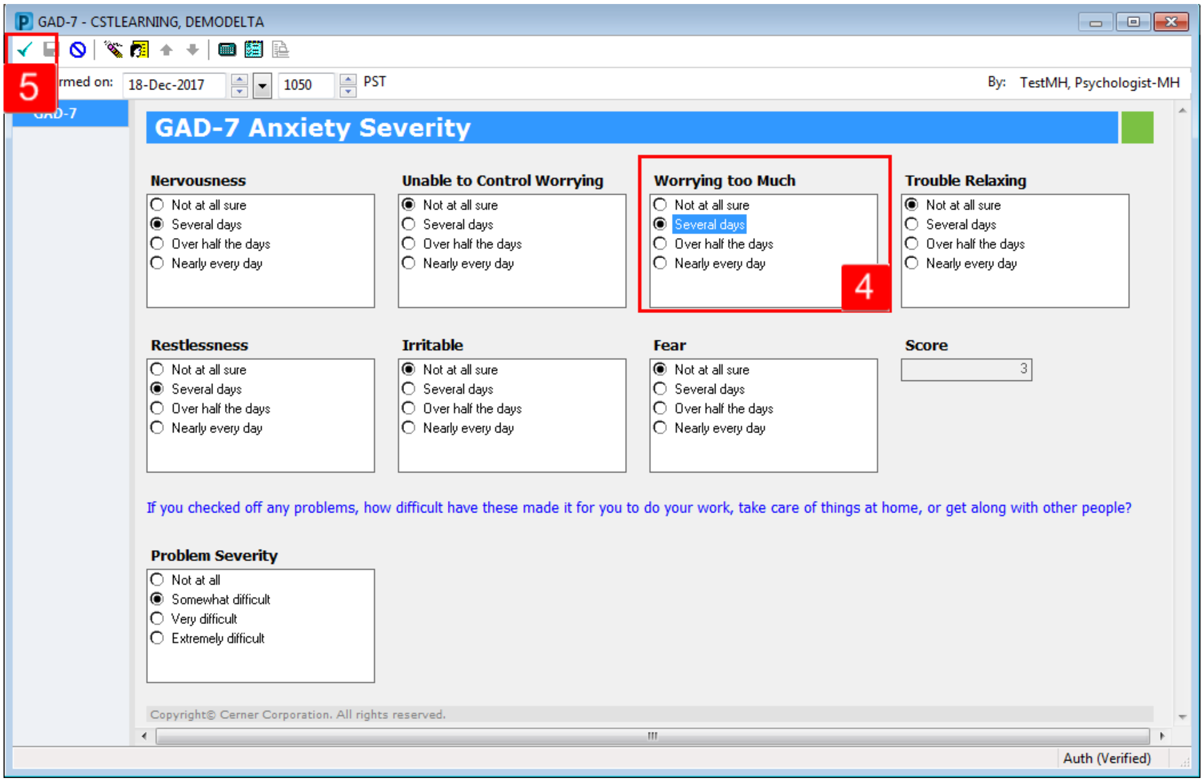
1. Navigate to Form Browser from the Menu

Note: For a PowerForm that has been completed and signed ✓ (Auth (Verified)) appears next to the title of the document. A saved PowerForm that has not been signed will display (In Progress) will appear next to the title.

2. Right-click on the most recently completed GAD 7 form
3. Select Modify



4. Change the value for **3. Worrying too much about different things** = *Several days*
5. Click **green checkmark** icon ✓ to sign and complete the documentation and then refresh the screen.



Note: A form that has been modified will display (Modified) next to the title of the document in Form Browser

Key Learning Points

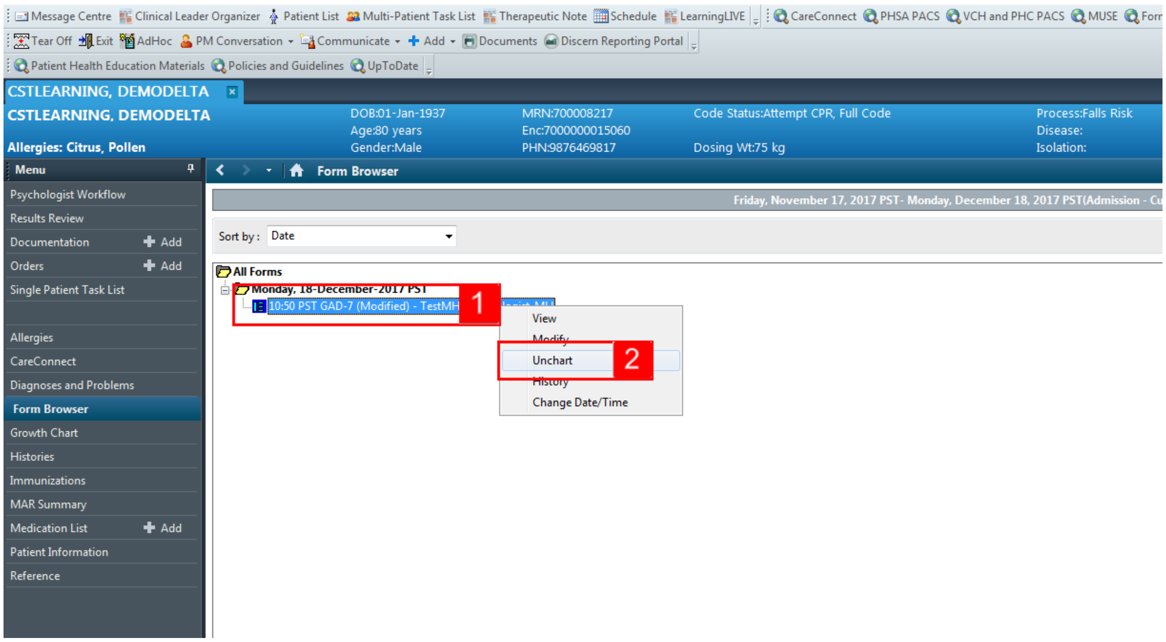
- Existing PowerForms can be accessed through the Form Browser
- A document can be modified if needed
- A modified document will show up as (Modified) in the Form Browser

Activity 2.3 – Unchart an Existing PowerForm

1 It may be necessary to **Unchart** an existing PowerForm, for example, if the PowerForm was completed on the wrong patient or it was the wrong PowerForm. Let's say the **GAD 7** PowerForm was documented in error.

To unchart the PowerForm:

1. Right-click on **GAD 7** in Form Browser
2. Select **Unchart**



3. The Unchart window opens. Enter a reason for uncharting in the **Comment** box = *Wrong PowerForm*
4. Click sign ✓ and then refresh your screen

Note: Uncharting the form will change the status of all the results associated with the form to (In Error). A red strike-through will also show up across the title of the PowerForm.

Key Learning Points

- A document can be uncharted if necessary
- An uncharted document will show up as In Error in the Form Browser

PATIENT SCENARIO 3 – Dynamic Documentation

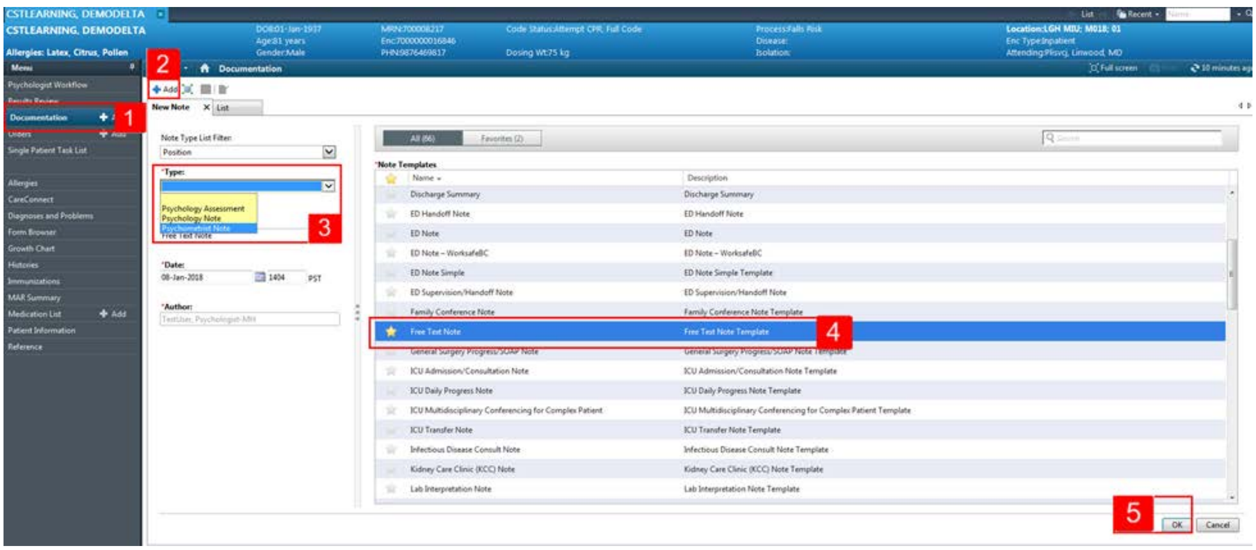
Learning Objectives
At the end of this Scenario, you will be able to: - Create a Dynamic Document - Modify a Dynamic Document

SCENARIO
In this scenario, you will be creating a progress note for your patient. As a psychometrist, you will be completing the following activities: - Create a new document - Access Documentation from the Menu - Modify your document

Activity 3.1 - Dynamic Documentation

1 Dynamic Documentation is similar to written progress notes. In a dynamic document, you have the ability to enter free text to document narrative information such as one-to-one sessions or family meetings.

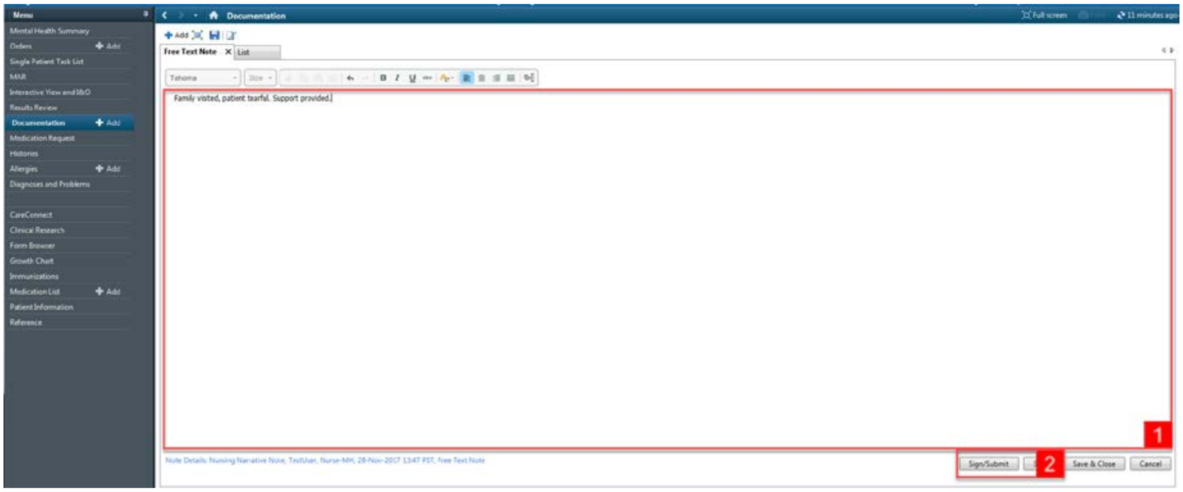
1. Select **Documentation** from the Menu. This is another way to view certain documents by the interdisciplinary team including both Dynamic Documents and PowerForms
2. Click **Add** Add near the top of the Documentation page
3. Select **Psychometrist Note** from the **Type** drop-down list
4. Select **Free Text Note** from **Note Templates** list
5. Click **OK**



2

1. Click in the top left of the text field to activate the text input. Type = *Assessment requested for concerns of anxiety.*
2. Click **Sign/Submit**

Note: You have also an option to click Save or Save & Close to continue to work on this document later. Saved documents are not visible to other care team members. For this reason, saving documentation is discouraged.

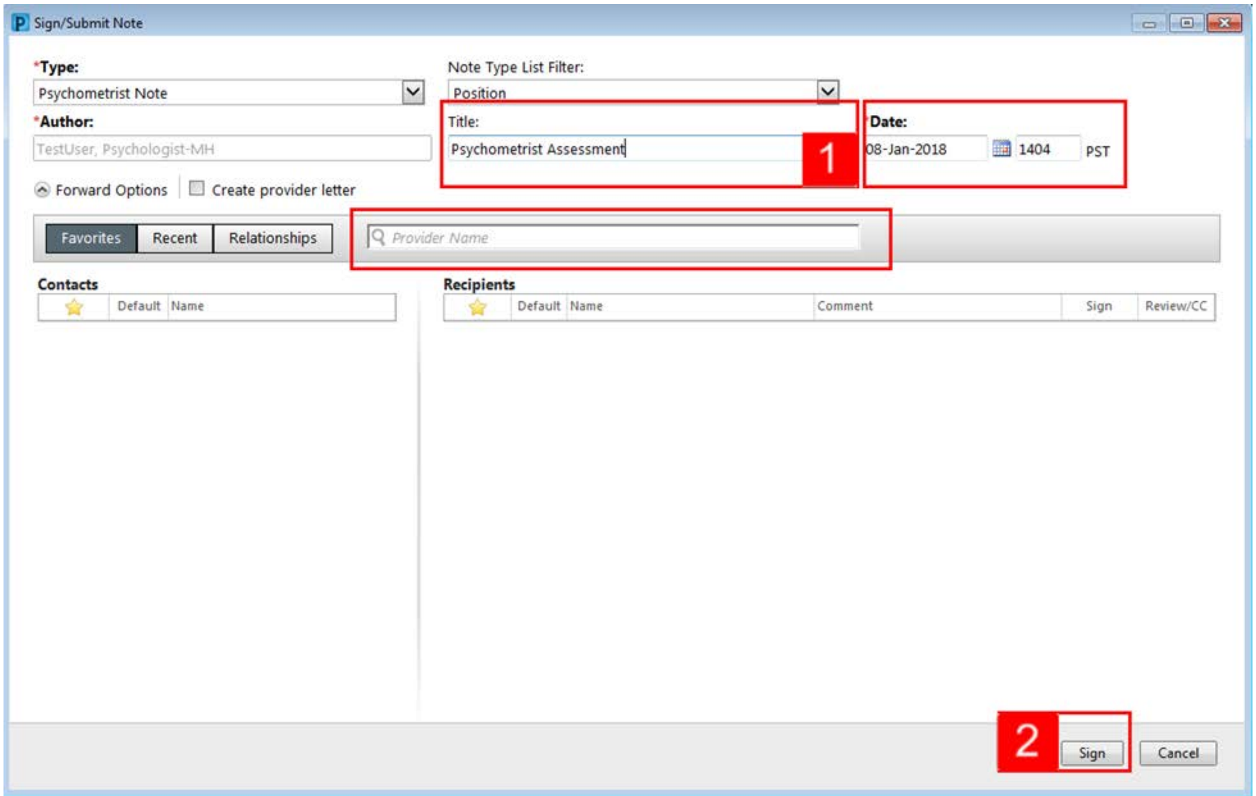


3

In the **Sign/Submit window**, the note type is already populated. The Date box auto-populates with the current date. Always ensure this information is the correct time and date of the assessment.

Note: You can forward dynamic documents to select users by entering the user's name into the **Provider Name** text box

1. Title the note = Psychometrist Assessment
2. Click **Sign** to complete the process



After signing the note, you are transferred back to the Psychologist Workflow view. Remember to click the **Refresh** button to be able to see your document under the Documents component. The Psychometrist Assessment Note is now listed and is visible to the entire care team.

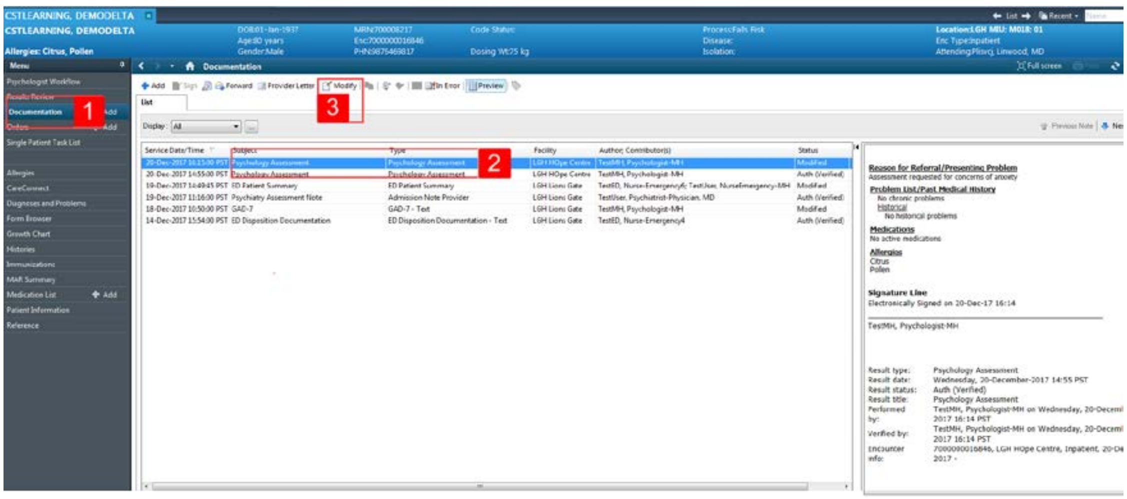
Key Learning Points

- Dynamic Documentation is similar to written progress notes
- You can send notes to other users when you have completed your note
- If necessary, you can save your note for completion at a later time. Saved notes are only visible to the author of the note

Activity 3.2 – Add An Addendum to a Completed Note

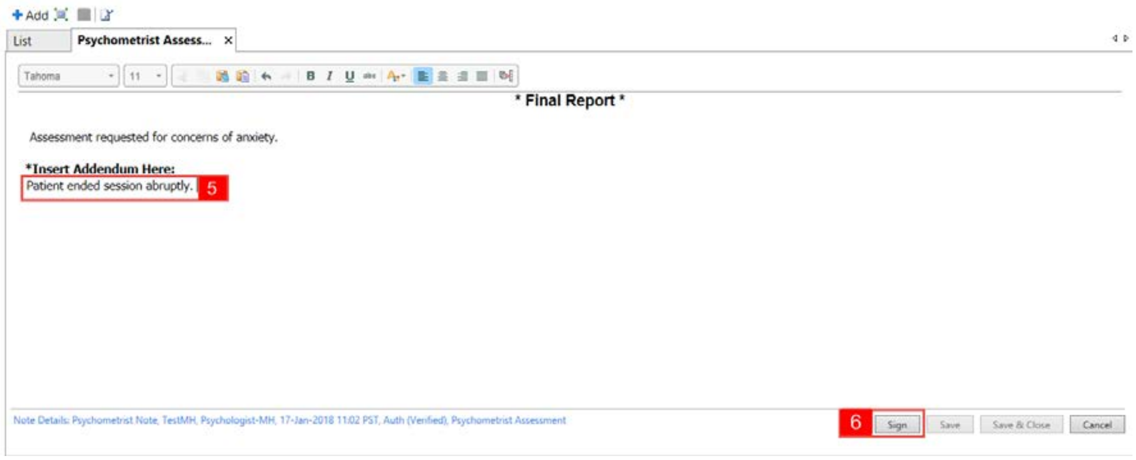
1 Once a note is signed, you cannot edit the existing text of a final report directly. You can, however, add an addendum. Let's make add an addendum to your Psychometrist Assessment note (the saved note, not the signed note).

1. Navigate to the Documentation component in the Menu
2. Select Psychometrist Assessment from the list
3. Click the **Modify** icon Modify in the toolbar

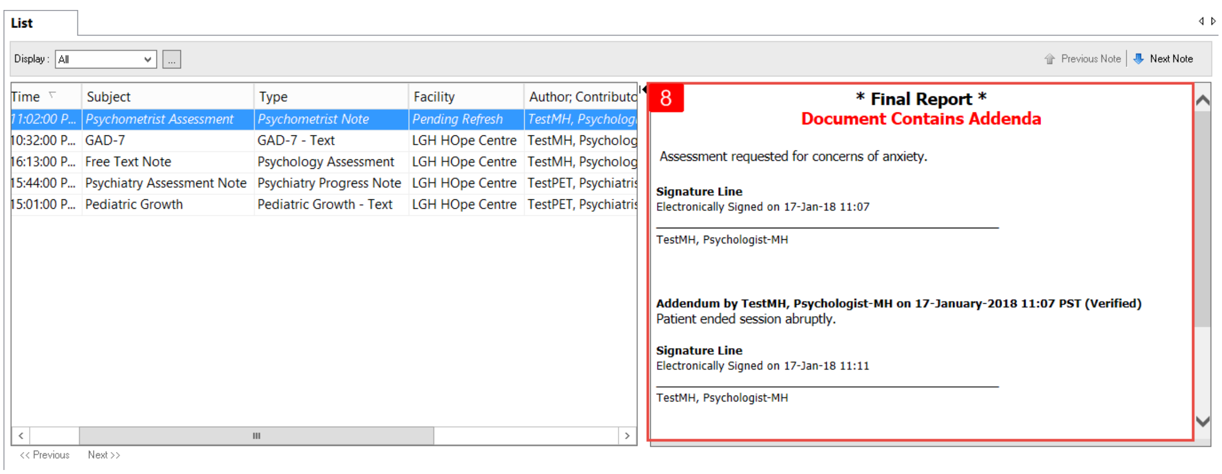


You are brought back to the original note. Notice that the headings are not modifiable, but there is a section at the bottom of the note for an appendix.

4. Click the area directly below ***Insert Addendum Here.** It becomes active and you can select the text to add or delete as needed
5. Enter freetext = *Patient ended session abruptly.*
6. Click Sign. You are brought back to the Documents component in the Menu



7. Refresh your screen
8. View your note in the preview window on the right-hand side of the screen. The addendum is stamped by the electronic signature and the document is marked with **Document Contains Addenda**



Key Learning Points

- Documents that are signed cannot be directly edited but can be updated by adding an addendum
- Notes with addenda are clearly marked and include the electronic signature with the author name, date, and time

End of Self Paced Workbook

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