

**SELF-GUIDED PRACTICE WORKBOOK [N63-B]**  
CST Transformational Learning

WORKBOOK TITLE:

**Nurse – Rural: OB Inpatient Add-On  
(Antepartum, L&D, Postpartum)**

---

*Last updated: Mar 2, 2018*



Last update: March 1, 2018

## TABLE OF CONTENTS

Nurse – Rural: OB Inpatient Add-On (Antepartum, L&D, Postpartum) .....	1
• Using Train Domain .....	4
• PATIENT SCENARIO 1 – Position Picker and Logging Into PowerChart .....	5
• Activity 1.1 – Log into Position Picker and Select the Appropriate Position .....	6
• Activity 1.2 – Log into PowerChart .....	9
• PATIENT SCENARIO 2 – Tracking Shell Overview.....	11
• Activity 2.1 – Tracking Shell Overview .....	12
• Activity 2.2 – Add a Communications Alert to Tracking Shell for Your Patient.....	17
• PATIENT SCENARIO 3 – OB Triage and Assessment PowerForm .....	21
• Activity 3.1 –Documenting on the OB Triage and Assessment PowerForm .....	22
• PATIENT SCENARIO 4 – Women’s Health Overview Summary Page and How to Add a Pregnancy.....	27
• Activity 4.1 – Navigate to the Women’s Health Overview Summary Page.....	28
• Activity 4.2 – Adding a Pregnancy .....	30
• Activity 4.3 – Review of the Women’s Health Overview Page .....	35
• PATIENT SCENARIO 5 – Documenting on OB patients in Interactive View and I&O .....	37
• Activity 5.1 – Documenting OB Assessments in Interactive View and I&O .....	38
• PATIENT SCENARIO 6 – Partogram .....	42
• Activity 6.1 – Viewing the Partogram.....	43
• PATIENT SCENARIO 7 – OB Quick Orders.....	46
• Activity 7.1 – Overview of the OB Quick Orders Page.....	47
• Activity 7.2 – Place an OB Quick Order .....	48
• Activity 7.3 – Place an Order via Add Order.....	51
• Activity 7.4 – Initiate a PowerPlan.....	54
• PATIENT SCENARIO 8 – Single Patient Task List.....	59
• Activity 8.1 – Review Single Patient Task List and Complete a Task .....	60
• PATIENT SCENARIO 9 - Scheduling an OB Anesthesia/Epidural Appointment.....	62
• Activity 9.1 – Scheduling an OB Anesthesia/Epidural Appointment.....	63
• PATIENT SCENARIO 10 – Delivery Documentation & Newborn Quick Registration .....	68
• Activity 10.1 – Document Delivery Information (iView) .....	69
• Activity 10.2 – Quick Registering the Newborn .....	72
• PATIENT SCENARIO 11 – Result Copy, Related Records, Transfer .....	78
• Activity 11.1 – Result Copy .....	79

---

- Activity 11.2 – Related Records ..... 82
- Activity 11.3 – Bed Transfer ..... 85
- PATIENT SCENARIO 12 – Create Patient Lists to Manage Post-Partum Patients and Newborns 87
  - Activity 12.1 – Set Up a Location Patient List..... 88
  - Activity 12.2 – Create a Custom Patient List ..... 91
- PATIENT SCENARIO 13 – Navigate to CareCompass to manage PostPartum Patients and Newborns ..... 94
  - Activity 13.1 – Navigate to CareCompass..... 95
  - Activity 13.2 – Completing Tasks from CareCompass ..... 97
- PATIENT SCENARIO 14 – Self Administered Medications (SAM) ..... 102
  - Activity 14.1 – SAM..... 103
- PATIENT SCENARIO 14 – Neonate Workflow ..... 107
  - Activity 14.1 – Neonate Workflow ..... 108
  - End Book One ..... 112

## ■ 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

**Note:** The Train Domain only has patients and locations for Lion's Gate Hospital. Therefore, you will be practicing using LGH locations and seeing LGH screen shots. In practice, you will use Squamish General Hospital Location lists and patient beds.

**Note:** In order to complete this particular workbook, you will be logging in as and OB-Nurse position. In practice, you will log in as the Nurse – Rural position, so some of the screen shots may not match exactly.

## PATIENT SCENARIO 1 – Position Picker and Logging Into PowerChart

### Learning Objectives

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

- Log into Position Picker to select Nurse – Rural in order to care for an Obstetrics/L&D patient
- Log into PowerChart

### SCENARIO

As a maternity nurse at Squamish General Hospital, you will complete the following activities:

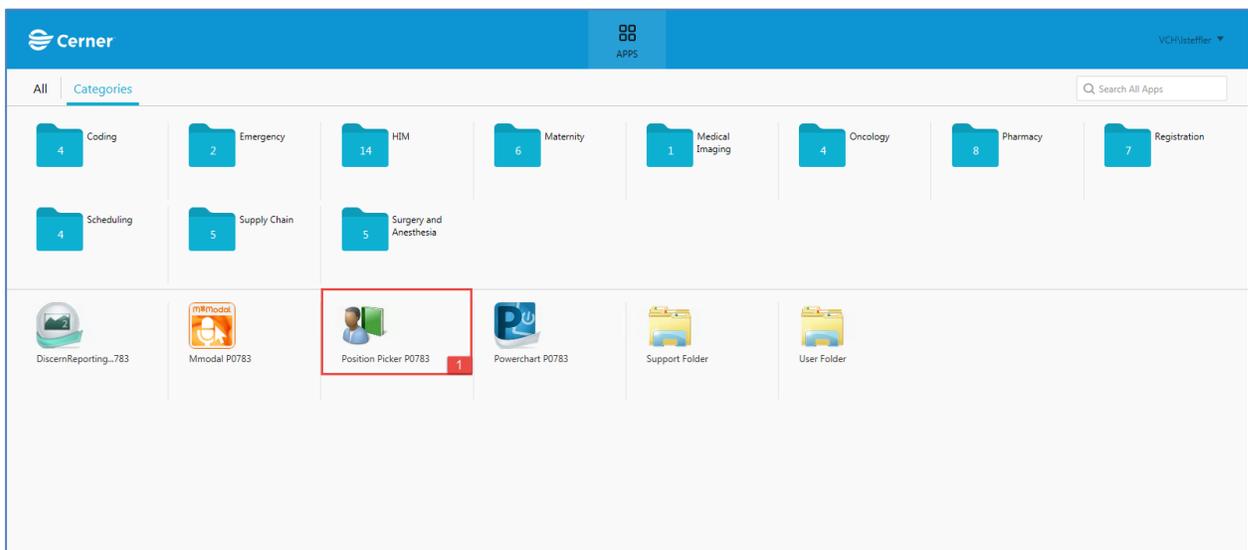
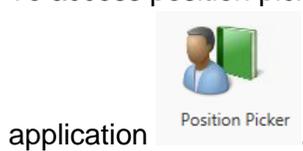
- Log into Position Picker to select Nurse –Rural in order to care for an Obstetrics/L&D patient
- Log onto PowerChart

## Activity 1.1 – Log into Position Picker and Select the Appropriate Position

- 1 When working as a Maternity Nurse at Squamish General Hospital, you will need to log into Position Picker and make sure you are in the position of **Nurse – Rural**.

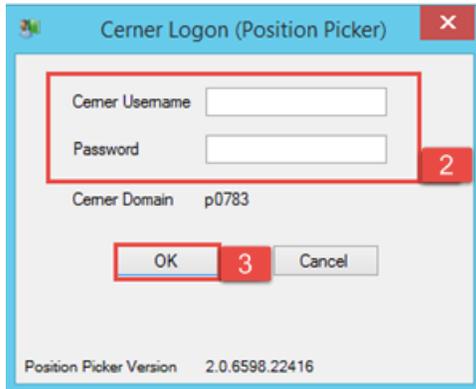
**NOTE:** Read the following steps for review only, do not attempt these steps in the system during this classroom experience:

1. To access position picker from Cerner Citrix Store Front, click on the **Position Picker**

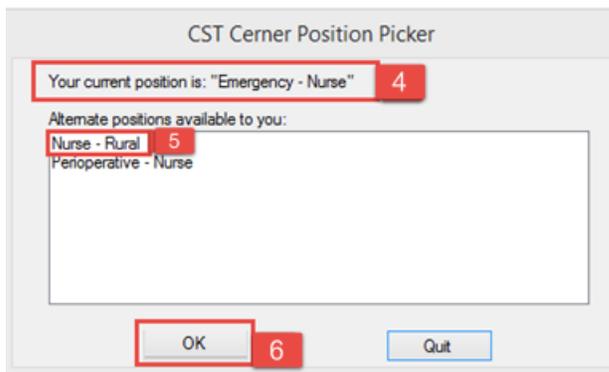


A Cerner Logon (Position Picker) window will open

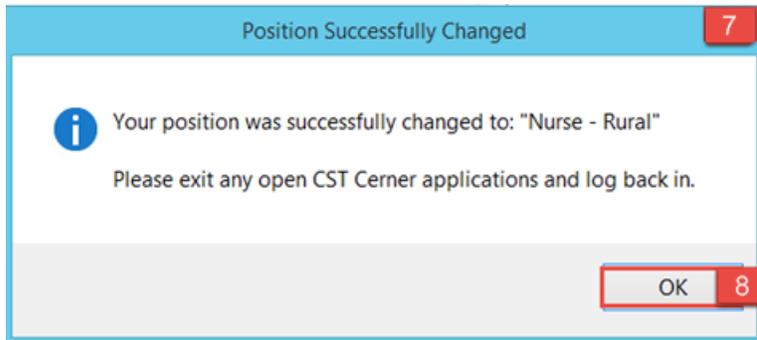
2. Type your assigned **username** and **password**
3. Click **OK**



4. A CST Cerner Position Picker window displays stating “*Your current position is: ‘Emergency – Nurse’*”
5. You want to switch your position because you are now working on an inpatient unit caring for a labour and delivery patient, so select ***Nurse – Rural***
6. Click **OK**



7. A window will display: “*Your position was successfully changed to: “Nurse – Rural” Please exit any open CST Cerner applications and log back in.*”
8. Click **OK**



You've switched your position from **Emergency – Nurse** to **Nurse – Rural** and are now ready to start your work as a maternity nurse.

**Note:** Always be sure you have logged out of any Cerner application including FirstNet or PowerChart when switching positions in Position Picker.

### Key Learning Points

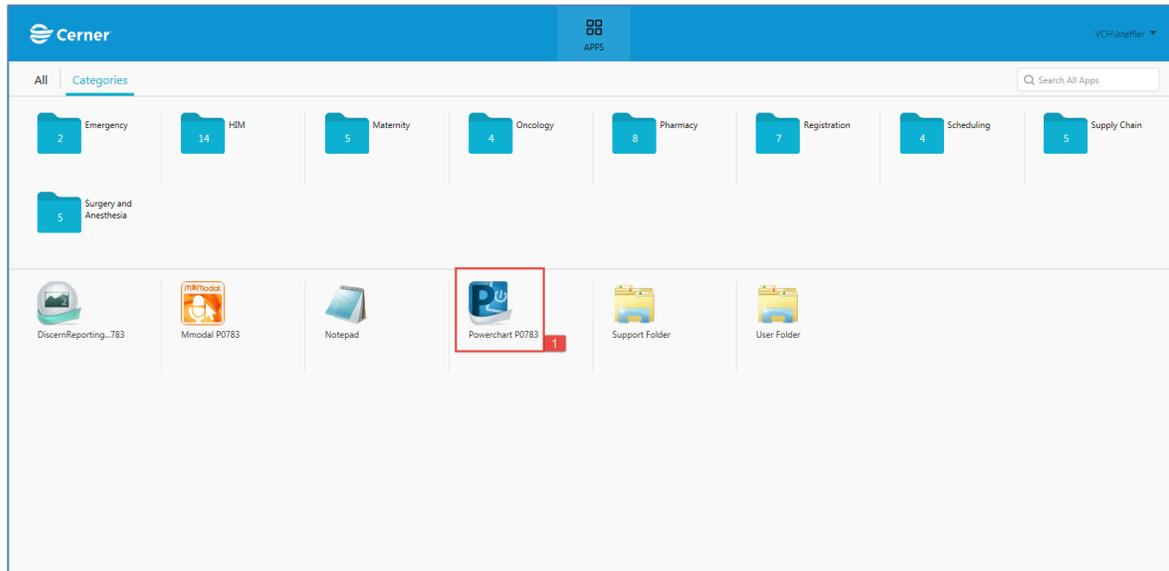
- Cerner Position Picker is the application you will use to switch positions within the CIS to reflect the change in your role throughout your shift
- Log out of any open CST Cerner application (FirstNet or PowerChart) when you switch to a different position using Cerner Position Picker
- At the start of every shift, first log into Cerner Position Picker and make sure you have selected the appropriate position
- Nurse – Rural is the position you need to be in when working as a maternity nurse

## Activity 1.2 – Log into PowerChart

- 1 Now that you have made sure you are in the correct position of Nurse – Rural, you can log into PowerChart to start caring for your patient in labour.

To log onto PowerChart, complete the following steps:

1. From the Cerner Citrix Store Front, double click on the PowerChart application.



2. A login window will open. Type in the assigned **username** and **password** and click **OK**

Cerner  
Cerner Millennium®

Username :

Password :

Domain :  
p0783

OK Cancel

PowerChart

© 2011 Cerner Corporation. All rights reserved.  
Access and use of this solution system (including components thereof) require, and are governed by, license(s) from Cerner Corporation.  
Unauthorized use, access, reproduction, display or distribution of any portion of this solution or the data contained therein may result in  
severe civil damages and criminal penalties. Further information may be found in Help About.

2

You are now logged onto **PowerChart** in the position of **Nurse – Rural** and you can start caring for your laboring patient.

### Key Learning Points

-  After making sure you are in the correct position for looking after a maternity patient (Nurse – Rural), you can access Power Chart from Cerner Citrix Store Front

## PATIENT SCENARIO 2 – Tracking Shell Overview

### Learning Objectives

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

- Understand the basic functionalities of the Tracking Shell

### SCENARIO

Your patient has just presented to the labour and delivery (L&D) unit. She has already been fully registered and has been placed in a bed on the L&D unit. Locate your patient on the Tracking Shell.

In this scenario, we will review the functionalities of the Tracking Shell.

As an inpatient nurse you will be completing the following activities:

- Access Tracking Shell from the tool bar
- Add a Communications alert to your patient on the Tracking Shell

## Activity 2.1 – Tracking Shell Overview

- 1 As a rural inpatient nurse, when you log into PowerChart the first page that opens will be CareCompass. CareCompass is a summary page for patients that are *not* Labour and Delivery (L&D) patients.

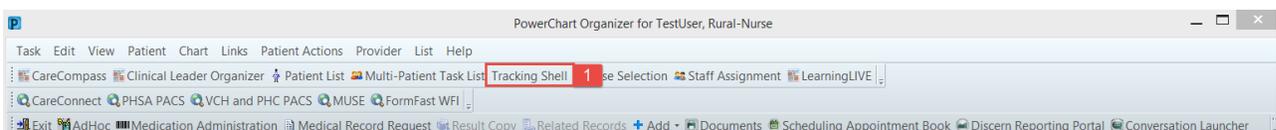
When managing L&D patients, you will instead use **Tracking Shell** to provide an overview of patient location, status and workflow. When a patient becomes postpartum, **CareCompass** will be used to manage patient care, but **Tracking Shell** will still be used as a reference.

### Tracking Shell:

- Will be used in place of CareCompass as a tool to organize the user’s workflow for labour and delivery (L&D) patients
- Will be used as a reference for postpartum patients
- Provides users with a ‘quick’ overview of the patient’s overall status
- Different views or tabs can be utilized – each provides unique information
- The columns of the tracking shell display and sort patient information and activities related to the patient

To navigate to **Tracking Shell**:

1. Click on  from the Tool Bar at the top of the page.



**Note:** When you work at Squamish, you will use the SGH location views/tabs. Due to the restrictions of the train domain, you will be using Lion’s Gate Hospital (LGH) locations to find your patients in this workbook.

2. **Tracking Shell** opens and will appear as below
3. Notice the different **tabs** across the top. These **tabs** provide different locations and views for tracking patients. At SGH these tabs will include views such as SGH L&D, SGH OB All Beds, SGH L&D Nurses, and SGH OB Recently Discharged etc.

Bed	S	Name	G P EGA	Status	A RN	Provider	Consult	Dil	Length Sta	ROM	Color	GBS Epidural	To Do	Communications	NR	Lab	MAR	Comment
LDL.01M		CSTPRODREG, WORK				Plisvca, Rocco,		10*		Sponta								
LDL.02M		CSTMATGOLIVE, APRIL 1*				Plisvca, Rocco,		10*				U					2	Please DO NOT
LDL.03M		CSTLABSOBB, RHIGM 1*				Plisvcl, Antonio										5/0		
LDL.04M		CSTPRODREGHIM, JA 2*				PITVCAD, Arche										3/0		
LDR1.01M		*****				Plisvcb, Stuart,												
LDR2.01M		CSTLABSOBB, RHIGO				Plisvcl, Antonio						N				7/2		DO NOT USE, I
LDR3.01M		CSTMATPROD, LABOU 2* 0*				Plisvca, Rocco, Berard, Vera		10* 1.5 cm*-1*		Sponta Clear*		P	R			3/0	8	Shared care
LDR4.01M		CSTONETHREE, INTE 1*	38 0/7			PLISVFC, Jarmi						P				4/0	3	
LDR5.01M		CSTMATPROVIDERS, 2* 0*				Plisvca, Rocco,		10* 0 cm* -1*		Sponta Clear*		P	Administered*			3/0	4	Please do not u
LDR6.01M		CSTMATTEST, SUSAN 1*				Plisvca, Rocco,						P				5/0	2	
LDR7.01M		CSTLABSOBB, IVIGMC				Plisvcl, Antonio										6/3		Do not discharg
LDR8.01M		CSTMAT, BETTY	1* 1*			Plisvca, Rocco,												DO NOT USE!!!
LDR8.02M		CSTLABSOBB, BABY				Plisvca, Rocco,												

- You are currently on the **LGH L&D** tab. All of the patients listed on this tab are L&D patients. Notice the **columns** listed in this view. These columns provide information specific to L&D patients.

Bed	S	Name	G P EGA	Status	A RN	Provider	Consult	Dil	Length Sta	ROM	Color	GBS Epidural	To Do	Communications	NR	Lab	MAR	Comment
LDL.01M		CSTPRODREG, WORK				Plisvca, Rocco,		10*		Sponta								
LDL.02M		CSTMATGOLIVE, APRIL 1*				Plisvca, Rocco,		10*				U					2	Please DO NOT
LDL.03M		CSTLABSOBB, RHIGM 1*				Plisvcl, Antonio										5/0		
LDL.04M		CSTPRODREGHIM, JA 2*				PITVCAD, Arche										3/0		
LDR1.01M		*****				Plisvcb, Stuart,												
LDR2.01M		CSTLABSOBB, RHIGO				Plisvcl, Antonio						N				7/2		DO NOT USE, I
LDR3.01M		CSTMATPROD, LABOU 2* 0*				Plisvca, Rocco, Berard, Vera		10* 1.5 cm*-1*		Sponta Clear*		P	R			3/0	8	Shared care
LDR4.01M		CSTONETHREE, INTE 1*	38 0/7			PLISVFC, Jarmi						P				4/0	3	
LDR5.01M		CSTMATPROVIDERS, 2* 0*				Plisvca, Rocco,		10* 0 cm* -1*		Sponta Clear*		P	Administered*			3/0	4	Please do not u
LDR6.01M		CSTMATTEST, SUSAN 1*				Plisvca, Rocco,						P				5/0	2	
LDR7.01M		CSTLABSOBB, IVIGMC				Plisvcl, Antonio										6/3		Do not discharg
LDR8.01M		CSTMAT, BETTY	1* 1*			Plisvca, Rocco,												DO NOT USE!!!
LDR8.02M		CSTLABSOBB, BABY				Plisvca, Rocco,												

- Now click on the **LGH OB All Beds** tab. This view provides a list of all patients that are in OB beds, including L&D patients, postpartum patients and newborn babies.
- Notice the columns across the top of this view are different compared to the L&D tab. These columns provide different information about the patients listed.

Tracking Shell

LGH L&D | LGH OB Postpartum | **LGH OB All Beds 5** | OB Recently Discharged | SGH L&D | SGH OB All Beds | SGH L&D Nurses | SGH OB Recently Discharged

Patient: RHOCARECONNEC Filter: LGH OB All Beds

Bed	Name	Status	Age	A	RN	Provider	To Do	Communications	NR	Lab	MAR	Comment
301,01M	RHOCARECONNECT, AUTHUR		28 years			Plisvcc, Trevor						
303,01A	CSTMAT, KAMTYO		28 years			Plisvcl, Antonio						DO NOT US
303,01B	CSTMAT, BABY GIRL		4 weeks			Plisvca, Rocco					1	
303,01M	CSTMATTEST, MOTHERONE	Labour	27 years			Plisvca, Rocco					5	COASTAL DEM
305,01B	CSTLABSQQB, BABY BOY		8 days			Plisvcl, Antonio					7/3	
305,01C	CSTPRODREGHIM, CINDY		21 years			PITVCAA, Branc					1/0	
307,01C	CSTPRODAC, TESTMEGANN		24 years			Plisvcl, Dillon					1/0	3
307,01M	CSTPRODPET, KEVIN		37 years			TestPET, Gene						
309,01A	CSTPRODREG, ALCDATETES7		27 years			Plisvcg, Joshu						
309,01B	CSTLABSQQB, BABY BOY		8 days			Plisvcl, Antonio						
309,01M	CSTLABAUTOMATION, MFOUR		39 years			Plisvca, Rocco						
311,01A	CSTPRODREG, BABY GIRL		3 months			Plisvcl, Dillon						
311,01B	CSTMAYTEST, TWELEVE MISS		41 years			Plisvcc, Trevor						
311,01C	CSTMATTEST, BABY GIRL A		3 months			Plisvca, Rocco					1/0	2
311,01M	CSTMAT, BLUE		32 years			Plisvca, Rocco						
315,01A	MEDPROCESS, TESTFIVE		36 years			Plisvca, Rocco						13
315,01B	CSTMATTEST, MOMNOPREG		37 years			Plisvca, Rocco						
315,01C	CSTMATTEST, BABY BOY		5 days			Plisvca, Rocco						
315,01M	CSTMATPROVIDERS, BABY G		2 weeks			Plisvcl, Antonio						
315,02A	CSTLGHDEMO, BABY GIRL		7 weeks			TestOS, Midwif						
315,02B	CSTMATTEST, TAFITI		40 years			Plisvcl, Antonio					2/0	seen by LN
315,02C	CSTPRODREG, BABY GIRL		4 weeks			Plisvcl, Mohan						
315,02M	DONOTUSE, DONOTUSE		19 years			Plisvcj, Linwoo						11 DO NOT USE
317,01A	FORD-LEARN, HARRY		7 years			Plisvca, Rocco						
317,01B	CSTPRODEICA, ERICA		47 years			TestCRD, Gene					7/0	12
317,01C	CSTPRODEMP, BABY BOY	Labour	3 months			Plisvcb, Stuart						
317,01M	CSTLGHDEMO, SARAH		28 years			TestUser, Midw					2/0	3

**Note:** In Tracking Shell, you can hover over icons, double click on cells, or right click on cells to see more information.

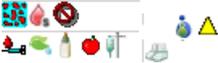
Let's learn more about what the **columns** mean in Tracking Shell:

7. Click on the **LGH L&D** **LGH L&D** tab and notice these columns:

Bed	S	Name	G	P	EGA	Status	A	RN	Provider	Consult	Dil	Length	Sta	ROM	Color
GBS	Epidural	To Do	Communications	NR	Lab	MAR	Comment								

The table below describes what the different columns in Tracking Shell represent:

Column	Description
<i>Bed</i>	Room and bed number: M= Mom bed A = Baby A bed B = Baby B bed (if there are twins) C = Baby C bed (if there are multiples)
<i>S</i>	Status of bed – ie) assigned, available, dirty etc.
<i>Name</i>	Patient name
<i>G</i>	Gravida
<i>P</i>	Parity
<i>EGA</i>	Estimated Gestational Age The green checkmark icon  in this column indicates the baby has been delivered. Hovering over this icon tells you the delivery date and time, as well as EGA at delivery.
<i>Status</i>	Reflects the patient’s status as she moves through different stages of care – ie.) Ante, Ante Testing, C/S, IUFD, Labour, Main OR, OR Procedure, Obs,PP, Triage etc.
<i>A</i>	Allergies - You can hover over the icons to tell you the exact allergy status.  You can double click on the patient’s allergy icon to update or modify the allergies directly from the Tracking Shell
<i>RN</i>	RN assigned to patient
<i>Provider</i>	Attending Provider
<i>Consult</i>	This is a freetext field where any consulting team can be listed
<i>Dil</i>	Dilation of cervix
<i>Length</i>	Length of cervix
<i>Sta</i>	Station of the baby
<i>ROM</i>	Rupture of Membranes – ie) intact, spontaneous artificial etc.
<i>Color</i>	Colour of amniotic fluid
<i>GBS</i>	Group B Strep status – P = positive, N = negative, U = unknown
<i>Epidural</i>	Status of patient having an epidural (pulls from iView <b>Labour and Delivery</b> )

	band from documenting in the <b>Anesthesia, OB</b> section)
<i>To Do</i>	<p>Hover to discover the icons in this column which act as alerts or reminders for nurses to follow up appropriately.</p> <p>For example, the Red Cross Icon  indicates the OB Triage and Assessment PowerForm (for moms) or the Newborn Admission History PowerForm (for newborns) needs to be completed. The R Icon  indicates the patient is Rubella Non-Immune.</p>
<i>Communications</i>	<p>Icons in this column act as an alert or reminder for nurses to follow up appropriately (e.g. Diabetes, Hepatitis B Positive, Isolation, and Rh Negative). In tracking shell, you can hover to discover what the icons represent. Here are examples:</p> 
<i>NR</i>	<p>Nurse Review – if there are new orders placed for the patient, a clipboard  icon will appear in this column. Double clicking on it will open new orders for nurse to review.</p>
<i>Lab</i>	<p>Lab orders and results are indicated here (including blood product orders) – for example: <b>3/1</b> means there are 3 lab orders placed and 1 lab result</p>
<i>MAR</i>	<p>Medication Administration Record – hover over the cells in this column to see a summary of ordered medications. Double click on the cells in this column to open up the patient’s MAR</p>
<i>Comment</i>	<p>This is a freetext cell. It can be used to type any informal communication that you need other team members to know about the patient.</p>

**Note:** Many of the columns in Tracking Shell will auto-populate from documentation (or orders) that are completed elsewhere in the patient’s chart, such as in iView or PowerForms. Therefore, the information visible in Tracking Shell is only as accurate as what users document within the patient’s chart.

## Activity 2.2 – Add a Communications Alert to Tracking Shell for Your Patient

- Remember that other clinicians can see the Tracking Shell, so any changes made are visible to anyone who views the Tracking Shell.

Adding a **Communications alert** for a patient allows all clinicians viewing Tracking Shell to see important patient information face-up.

Let's practice adding a **No Vaginal Exam** communications alert to the Tracking Shell for your patient:

- Locate the **Communications** column
- Right click on the **Communications** cell for your patient

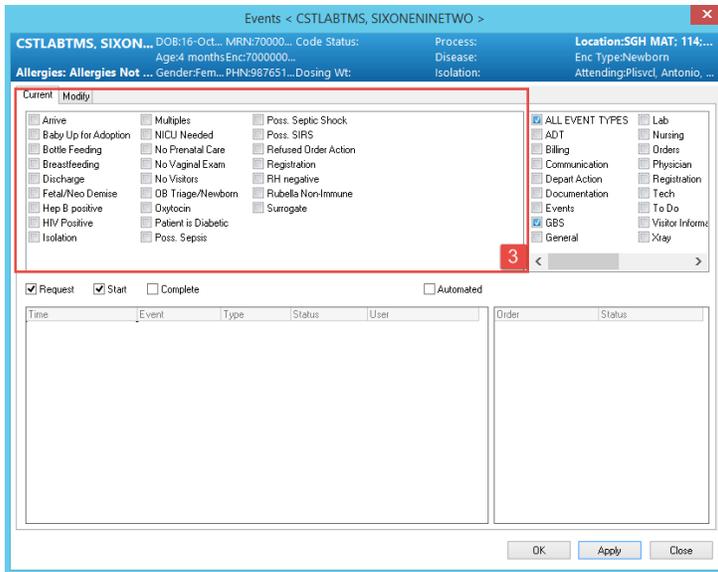
Tracking Shell

LGH L&D | LGH OB Postpartum | LGH OB All Beds | LGH OB Recently Discharged | SGH L&D | SGH OB All Beds | SGH L&D Nurses | SGH OB Recently Discharged

Patient: CSTLABSQBB, RHIC Filter: <None>

Bed	S	Name	G	P	EGA	Status	A	RN	Provider	Consult	Dil	Length	Sta	ROM	Color	GBS	Epidural	To Do	Communications	Lab	MAR	Comment		
LDL_01M		CSTPRODRÉG, WORK							Plisvca, Rocco,		10*			Sponta				+						
LDL_02M		CSTMATGOLIVE, APRIL 1*							Plisvca, Rocco,		10*							+			5/0	2	Please DO NOT	
LDL_03M		CSTLABSQBB, RHIGM 1*							Plisvcl, Antonio									+			5/0			
LDL_04M		CSTPRODRÉGHIM, JA 2*							PITVCAD, Arche									+			3/0			
LDR1_01M		*****	1*		33 2/7				TestMAT, OBG									+						
LDR2_01M		CSTLABSQBB, RHIGO							Plisvcl, Antonio									+			7/2		DO NOT USE, I	
LDR3_01M		CSTMATPROD, LABOU 2* 0*							Plisvca, Rocco, Berard, Vera		10*	1.5 cm*-1*		Sponta Clear*				3			3/0	8	Shared care	
LDR4_01M		CSTONETHREE, INTEL 1*							PLISVFC, Jarmi		10*	0 cm*-2*		Sponta Clear*				+						Please do not U
LDR5_01M		CSTMATPROVIDERS, 2* 0*							Plisvca, Rocco,		10*	0 cm*-1*		Sponta Clear*				+			3/0	4		
LDR6_01M		CSTMATTEST, SUSAN 1*							Plisvca, Rocco,									+			5/0	2		
LDR7_01M		CSTLABSQBB, WIGMG							Plisvcl, Antonio									+			6/3		Do not discharge DO NOT USE!!!!	
LDR8_01M		CSTMAT, BETTY	1* 1*						Plisvca, Rocco,									+						
LDR8_02M		CSTLABSQBB, BABY							Plisvca, Rocco,									+						

- The **Events** window will open. Notice all of the possible Communications Alerts that are listed here in the Current tab.

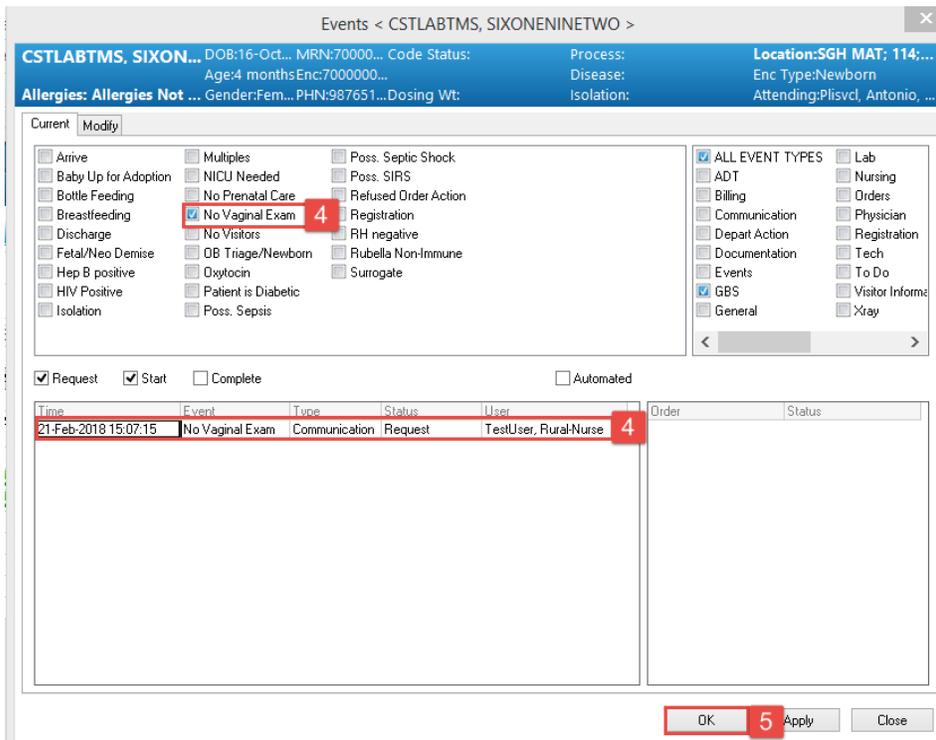


**Note:** Some of these communication alerts, such as RH negative or Hep B positive will auto-populate Tracking Shell from documentation on the **OB Triage and Assessment PowerForm** that has been previously completed for the patient. Other communication alerts, such as Oxytocin, will auto-populate Tracking Shell from an order.

4. Under the Current tab, Click **No Vaginal Exam**

- Selecting this makes the alert drop down to the lower field in this window

5. Click **OK**



The **No Vaginal Exam** icon is now visible in the Communications column for your patient. All clinicians viewing Tracking Shell will now be able to see that your patient should have no vaginal exams.

- Now anyone viewing Tracking Shell can hover over this icon and immediately know that this patient should have No Vaginal Exams.

Bed	S	Name	G	P	EGA	Status	A	RN	Provider	Consult	Dil	Length	Sta	ROM	Color	GBS	Epidural	To Do	Communications	NR	Lab	MAR		
112,01M																								
114,01M		CSTLABTMS, SIXONE	1*		41	1/7			Plisvcl, Antonio															
115,01M																								
115,02M		TEST, WH RULES	1*		40	1/7			Plisvca, Rocco								P		R				4	
116,01M		CSTPRODLAB, PAT	1*					RT	Test, Alex, RPh														3/1	3
116,02M		RYDER, RAPUNZEL	2*	1*					Plisvcl, Antonio		6*	1.0 cm*	-1*											2
117,01M		MATERNITY, DEMO	2*	1*					TestMAT, OBG		8*	0 cm*	-1*											1
118,01M																								
AC,06																								
AC,07																								
CR1,01M																								
CR2,01M																								

Let's say you accidentally added the wrong Communications alert. You can remove the icon by completing the following steps:

- Right click on the **Communications** column cell for your patient. The **Events** window will open.
- Under the **Status** field for the No Vaginal Exam event, click the drop down arrow and select **Cancel**
- Click **OK**

Events - CSTLABTMS, SIXONENINETWO

CSTLABTMS, SIXONE, DOB:16-Oct-... MRN:70000... Code Status: ... Process: ... Location:SGH MAT; 114...  
Age:4 months Enc:7000000... Disease: ... Enc Type:Newborn  
Allergies: Allergies Not ... Gender:Fem... PHN:987651... Dosing Wt: ... Isolation: ... Attending:Plisvcl, Antonio, ...

Current Modify

Arrive  Multiples  Poss. SIRS  ALL EVENT TYPES  Lab

Baby Up for Adoption  NICU Needed  Refused Order Action  ADT  Nursing

Bottle Feeding  No Prenatal Care  Registration  Billing  Orders

Breastfeeding  No Visitors  RH negative  Communication  Physician

Discharge  OB Triage/Newborn  Rubella Non-Immune  Depart Action  Registration

Fetal/Neo Demise  Dextrocin  Surrogate  Documentation  Tech

Hep B positive  Patient is Diabetic  Events  To Do

HIV Positive  Poss. Sepsis  GBS  Visitor Inform

Isolation  Poss. Septic Shock  General  Xray

Request  Start  Complete  Automated

Time	Event	Type	Status	User	Order	Status
21-Feb-2018 15:37:36	No Vaginal Exam	Communication	Cancel	TestUser, RuralNurse		

OK Apply Close

The **No Vaginal Exam** icon  has now been removed from the Communications column for your patient.

### Key Learning Points

- Tracking Shell provides an overview of L&D patients including; location, status and workflow
- Different location tabs on Tracking Shell provide different patient lists and different patient information
- The accuracy of the information seen in Tracking Shell is only as accurate as clinician's documentation in other parts of the patient's chart
- Information previously documented in the **OB Triage and Assessment** PowerForm will auto-populate some alert icons on the Tracking Shell
- Some Communication alerts can be added or removed directly from the Communications column in Tracking Shell

## PATIENT SCENARIO 3 – OB Triage and Assessment PowerForm

### Learning Objectives

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

- Document on the OB Triage and Assessment PowerForm from Tracking Shell

### SCENARIO

Your patient has arrived for a labour assessment. You need to document your assessment on your patient.

In this scenario, we will review PowerForm documentation.

As a rural inpatient OB nurse you will be completing the following activity:

- Opening and Documenting on the OB Triage and Assessment PowerForm from Tracking Shell

## Activity 3.1 – Documenting on the OB Triage and Assessment PowerForm

**1 PowerForms** are the electronic equivalent of paper forms currently used to chart patient information. The **OB Triage and Assessment** PowerForm is the electronic documentation in the CIS that will be replacing the BC Perinatal Triage and Assessment Record.

It is important to document and complete the **OB Triage and Assessment** PowerForm as accurately as possible. This is because a lot of this documentation will automatically flow to other areas of the patient’s chart including:

- Provider documentation
- Tracking Shell
- Pregnancy Overview component on the Women’s Health Summary page
- Neonate Overview component on the Women’s Health Summary page in the baby’s chart

Let’s practice documenting on the OB Triage and Assessment PowerForm:

1. Locate your patient on the Tracking Shell.
2. Hover over the **Red Cross** icon **+** under the **To Do** column of your patient’s name. (Hovering over this **+** icon displays an **OB Triage/Newborn** message. This means that for a mother, the **OB Triage and Assessment** PowerForm needs to be completed on your patient)

Tracking Shell

[LGH L&D](#) | [LGH OB Postpartum](#) | [LGH OB All Beds](#) | [LGH OB Recently Discharged](#) | [SGH L&D](#) | [SGH OB All Beds](#) | [SGH L&D Nurses](#) | [SGH OB Recently Discharged](#)

Patient: CSTLABSQBB, IVIGI Filter: <None>

Bed	S	Name	G	P	EGA	Status	A	RN	Provider	Consult	Dil	Length	Sta	ROM	Color	GBS	Epidural	To Do	Communications	NR	Lab	MAR	Comment
LDR7,01M		CSTLABSQBB, IVIGI							Plisvca, Rocco		10*			Sponta				+	OB Triage/Newborn				
LDR8,01M		CSTMAT, BETTY	1*	1*					Plisvca, Rocco									+					Do not discharge DO NOT USE!!!

**Note:** When looking after newborn patients, the **+** icon in the **To Do** column still says OB Triage/Newborn, indicating that the **Newborn Admission History** PowerForm needs to be completed. This PowerForm needs to be completed for all newborns once during the initial postpartum period.

Now you need to open and document on the **OB Triage and Assessment PowerForm**. To do this:

1. Click on your patient’s name on Tracking Shell to highlight your patient
2. Then click the Red Cross icon **+** in the **Icon Toolbar** (not in the To Do column)
3. Select **OB Triage and Assessment**

Bed	Newborn Admission History	Icon History	Status	A	RN	Provider	Consult	DH	Length	Sta	ROM	Color	GBS	Epidural	To Do	Communications	NR	Lab	MAR	Comment
LDL,0	OB Triage and Assessment	3				Plisvca, Rocco,		10*			Sponta		U		+					
LDL,02M	CSTMATGOLIVE, APRIL 1*					Plisvca, Rocco,		10*											2	Please DO NOT
LDL,03M	CSTLABSQBB, RHIGM 1*					Plisvcl, Antonio									+			5/0		
LDL,04M	CSTPRODREGHIM, JA 2*					PITVCAD, Arche												3/0		
LDR1,01M	*****	1*	33	2/7		TestMAT, OBG							N		+					
LDR2,01M	CSTLABSQBB, RHIGO					Plisvcl, Antonio							N					7/2		DO NOT USE, C
LDR3,01M	CSTMATPROD, LABOU 2* 0*					Plisvca, Rocco, Berard, Vera		10*	1.5 cm* -1*		Sponta Clear*		P		R			3/0	8	Shared care
LDR4,01M	CSTONETHREE, INTEL 1*					PLISVFC, Jarmi		10*	0 cm* -2*		Sponta Clear*		P	Administered*				8/5	5	
LDR5,01M	CSTMATPROVIDERS, 2* 0*					Plisvca, Rocco,		10*	0 cm* -1*		Sponta Clear*		P	Administered*				3/0	4	Please do not U
LDR6,01M	CSTMATTEST, SUSAN 1*					Plisvca, Rocco,							P					5/0	2	
LDR7,01M	CSTLABSQBB, IVIGMG					Plisvcl, Antonio												6/3		Do not discharg
LDR8,01M	CSTMAT, BETTY	1				Plisvca, Rocco,									+					
LDR8,02M	CSTLABSQBB, BABY					Plisvca, Rocco,														

**Note:** You may be asked to establish a relationship with your patient because this the first time you’ve entered their chart. Select **Nurse**.

Bed	S	Name	G	P	EGA	Status	A	RN	Provider	Consult	DH	Length	Sta	ROM	Color	GBS	Epidural	To Do	Commu	
LDL,01M		CSTPRODREG, WORK																		
LDL,02M		CSTMATGOLIVE, APRIL 1*															U		+	
LDL,03M		CSTLABSQBB, RHIGM 1*			34	2/7														
LDL,04M		CSTPRODREGHIM, JA 2*																		
LDR1,01M		CSTRHOMAT-MOVEEN 1*			38	4/7													+	
LDR2,01M		CSTLABSQBB, RHIGO																		
LDR3,01M		CSTMATPROD, LABOU 2* 0*																	R	
LDR4,01M		CSTMAT, KATELIN	1*		30	6/7														
LDR5,01M		CSTMATPROVIDERS, 2* 0*																		
LDR6,01M		CSTMAT, SNOW	1*																	
LDR7,01M		CSTLABSQBB, IVIGMG							Plisvcl, Antonio											
LDR8,01M		CSTMAT, BETTY	1*		1*				Plisvca, Rocco,										+	
LDR8,02M		CSTPRODREG, TEST	1*						Plisvca, Rocco,											

4. The **OB Triage and Assessment PowerForm** opens.

**Note:** Remember that in practice, this form needs to be completed as accurately and as detailed as possible.

For this scenario, you will only document the following sections:

1. **OB Subjective Data** section:

- **Reason for Visit** = *Labour check*
- **Labour Onset, Date/Time** = *Today/0600*

(**Note:** only fill this field in if patient is in *active labour* OR starting oxytocin induction)

\*The Labour Onset, Date/Time field documentation will activate the Partogram. This will be covered later in this workbook.

2. **\*ID Risk Screen** section (\* indicates mandatory field):

- Select **None** or **No** for all fields

3. **Pregnancy Risk Factors** section:

- Pregnancy Risk Factors, Current Pregnancy = *Group B Streptococcus*

*\*This flows to provider note, tracking shell and pregnancy overview.*

4. **Prenatal Investigations and Results** section:

- Blood Type = *A positive*
- Antibody Screen = *Negative*

*\*This flows to provider note, tracking shell and pregnancy overview. On the right hand side of the PowerForm, you will see any previously documented labs transcribed by the unit clerk from the **BC Antenatal Record Part 3, Section 13**. Review and update or modify the information as needed.*

5. **\*Violence and Aggression Screening** section (\* indicates mandatory field):

- Click- *No risk assessed at this time*

6. Click the green checkmark ✓ to sign your documentation

**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** icon .

**British Columbia Antenatal Record Part 2**

12. Intended place of birth: \_\_\_\_\_ Alternate place of birth (Hospital): \_\_\_\_\_

**13. Investigations/Result**

ABO group	Rh factor	Rubella titre	Prenatal Genetic Screening Type	Result
		<input type="checkbox"/> PP vaccination indicated		
Antibody titre (cc/nw/yyyy)	Results	S.T.S.	Gest. diabetes screen (24-28 wks)	Result
1		HIV test done	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2		HBsAg done	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Rhlg given (cc/nw/yyyy)		<input type="checkbox"/> Negative	GBS screen (35-37 wks)	Result
1		<input type="checkbox"/> Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2		<input type="checkbox"/> Partner/household contact	Edinburgh Postnatal Depression Scale (28-32 weeks)	Score
Hemoglobin		<input type="checkbox"/> Nil vaccination indicated	Follow-up	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fat	3rd	Other tests (e.g. Hep C, TSH, Varicella)		
Urine C & S result				

14. Age: \_\_\_\_\_ Pre-pregnant weight (kg): \_\_\_\_\_ Height (cm): \_\_\_\_\_ LMP (cc/nw/yyyy): \_\_\_\_\_ Confirmed EDD (cc/nw/yyyy): \_\_\_\_\_

15. Potential or Actual Concerns:

- Lifestyle
- Pregnancy
- Labour
- Breastfeeding
- Postpartum
- Newborn

16. Date: \_\_\_\_\_ S.P.: \_\_\_\_\_ Urine: \_\_\_\_\_ Wt. (kg): \_\_\_\_\_ Gest. wks.: \_\_\_\_\_ Fundus (cm): \_\_\_\_\_ FHR: \_\_\_\_\_ FM: \_\_\_\_\_ Pres. and Pos.: \_\_\_\_\_

Comments: \_\_\_\_\_ **7**

You will return to the Tracking Shell. Note that the Red Cross icon **+** under the To Do column in your patient’s row is no longer present, signaling that the OB Triage and Assessment PowerForm has been completed on your patient.

**Key Learning Points**

- PowerForms are the electronic equivalent of paper forms currently used to chart patient information.
- When the Red Cross icon **+** under the To Do column in your patient’s row is no longer present, it indicates that the OB Triage and Assessment PowerForm has been completed on your patient.

## **■ PATIENT SCENARIO 4 – Women’s Health Overview Summary Page and How to Add a Pregnancy**

### **Learning Objectives**

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

- Navigate to the Women’s Health Overview Summary Page in the patient’s chart
- Add a Pregnancy to the patient’s chart

### **SCENARIO**

As a rural inpatient OB nurse, you will be completing the following activities:

- Navigate to the Women’s Health Overview Summary Page
- Add a Pregnancy
- Review the different tabs and information on the Women’s Health Overview page

## Activity 4.1 – Navigate to the Women’s Health Overview Summary Page

### 1 You will now be entering your patient’s chart from Tracking Shell.

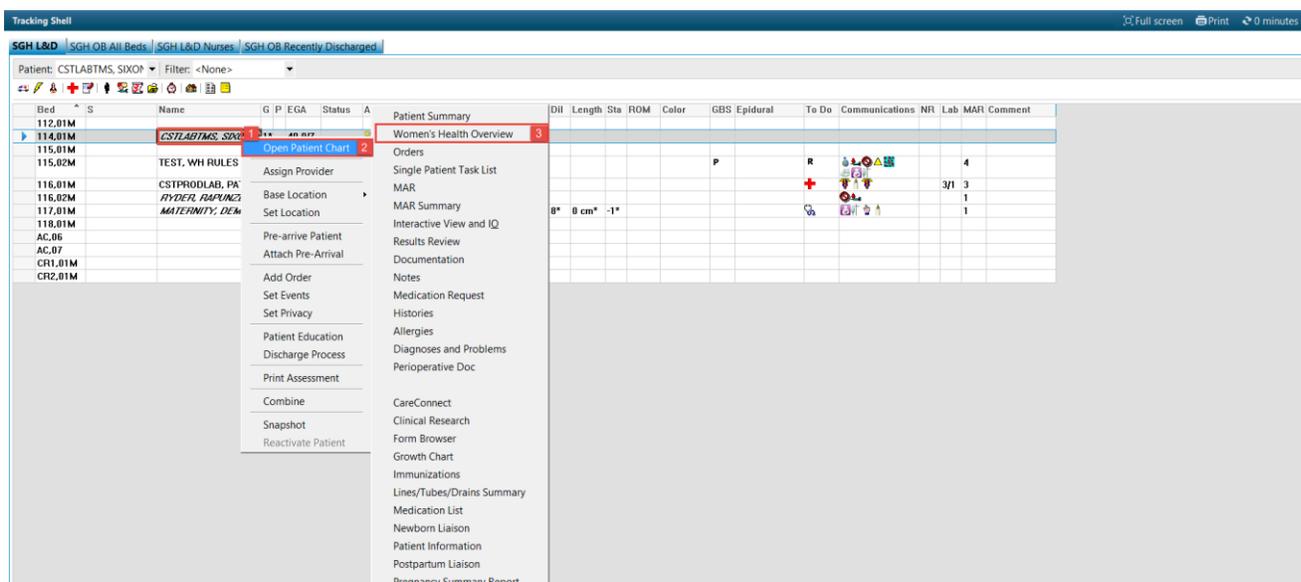
There are a couple of ways you can enter your patient’s chart:

- By double clicking on the blue forward arrow  in the far left column next to patient OR
- Right click on patient’s name and select *Open Patient’s Chart*.

You will open your patient’s chart from Tracking Shell by following these steps:

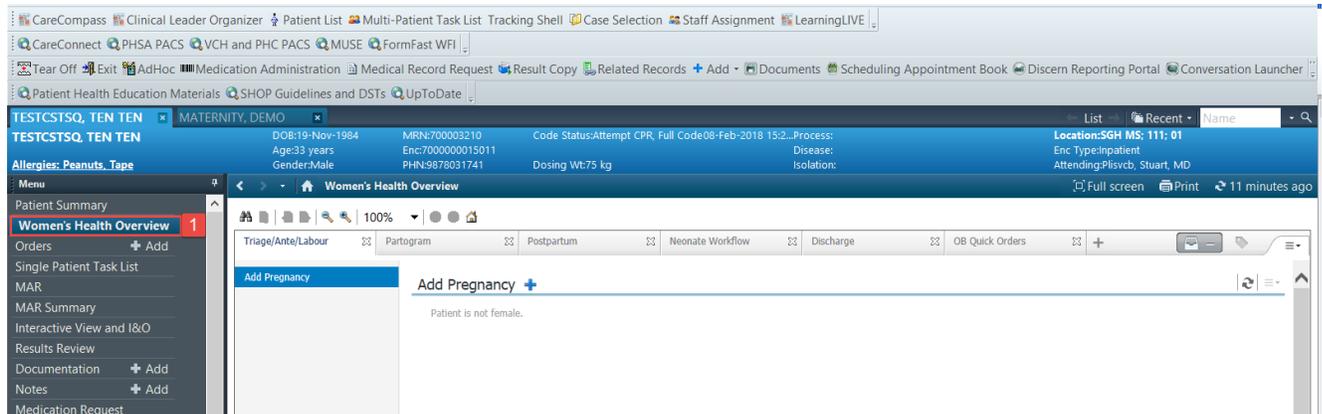
1. Right click on your patient’s name
2. Select **Open Patient Chart**
3. Select **Women’s Health Overview**

**Note:** Selecting any item listed from the Open Patient Chart list will navigate you directly to that page inside the patient’s chart.



The **Women’s Health Overview** summary page will open. This summary page is similar to the **Patient Summary** page that was covered in Activity 4.2 in the Rural Nurse workbook. The **Women’s Health Overview** page provides access and views of key clinical patient information specifically for **OB patients** or **Newborns**.

1. If you are ever lost and need to return to this page, click on **Women’s Health Overview** from the **Menu**.



### Key Learning Points

- The Women’s Health Overview is a summary page of key clinical patient information
- The Women’s Health Overview can be found in the Menu

## Activity 4.2 – Adding a Pregnancy

- 1 You notice that your patient’s chart does not yet have a pregnancy added so you will need to add a pregnancy.

**Note:** You need to add a pregnancy in order to activate and view components in the **Women’s Health Overview** page, as well as populate the Gravida, Parity, and Estimated Gestational Age columns in **Tracking Shell**.

1. From the **Triage/Ante/Labour** tab of the Women’s Health Overview page, click the Blue Cross icon  beside Add Pregnancy.



2. The **Add Pregnancy** window opens.
3. In the **Onset: Date** field, choose a date about 10 months ago.

**Note:** In real life, you would enter the LMP date from the BC Antenatal Record Part 1, Section 4.

4. In the **Onset Date** field, select “Use as LMP Date”
5. Ensure the **Number of Gestations = Number of Baby Labels** is correct

**Note:** This field is defaulted to 1 = Baby A for singletons; for multiples gestations, select the appropriate number of babies.

6. Click **OK**

The screenshot shows the 'Add Pregnancy' form with several fields highlighted by red boxes and numbered callouts:

- 2:** The 'Add Pregnancy' title bar.
- 3:** The 'Onset Date' field, currently set to 11-Dec-2017.
- 4:** The 'Onset Date' radio button options, with 'Use as LMP Date' selected.
- 5:** The 'Number of Gestations = Number of Baby Labels' dropdown menu, which is open and shows options from '1 = Baby A' to 'Unknown'.
- 6:** The 'OK' button at the bottom right of the form.

You will return to the Triage/Ante/Labour Page with the **Pregnancy Overview** populated.

The screenshot shows the 'Pregnancy Overview' page. The left sidebar contains a navigation menu with 'Pregnancy Overview' selected. The main content area displays the following information:

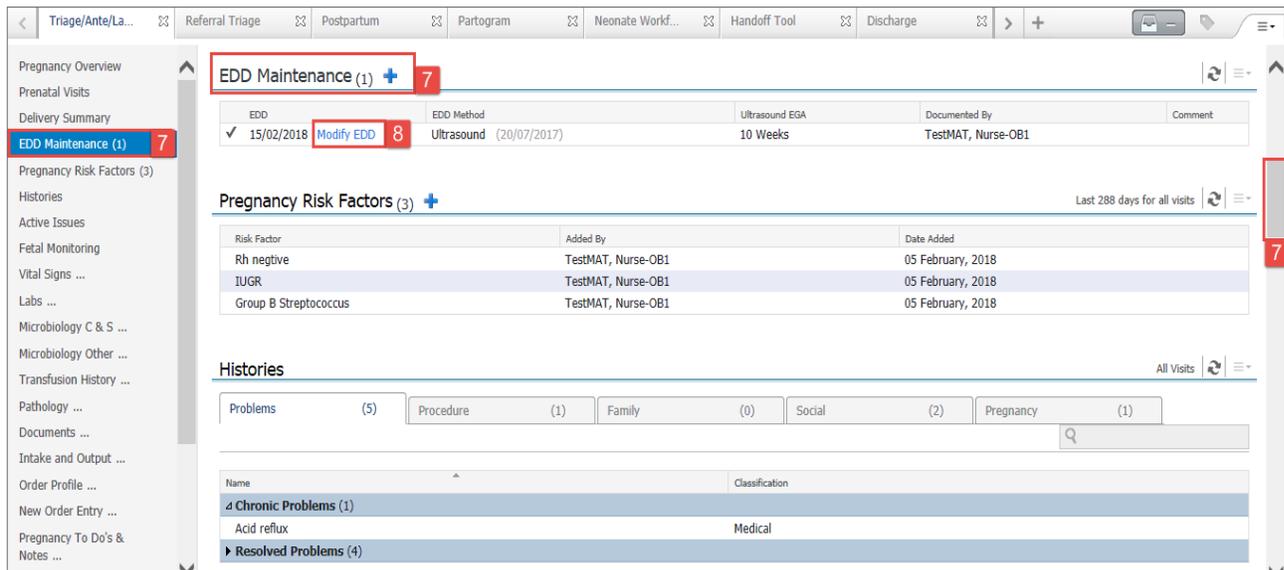
- Current Pregnancy:** EDD 15/02/18 (Authoritative), EGA Delivered, Gravida/Parity G2, P0(0,0,1,0), Multiple Fetuses No, Singleton, Feeding Plan Breastfeeding with supplementation.
- Current Weight:** 85kg, Pre-Preg Weight 65kg, Height --, BMI --.
- Blood Type:** --, Rupture of Membrane [Baby A] Delivered, Blood Type, Transcribed A negative, Transcribed Antibody Screen Negative.
- Epidural Administration Status:** Administered, Anesthesia Type OB Epidural.

Below this, there are sections for 'Prenatal Visits' (No results found) and 'Delivery Summary (1)'. The delivery summary table is as follows:

Baby	Delivery Date/Time	Delivery Type	Gender	EGA at Delivery	Neonate Outcome
Baby A	06/02/18 08:19	Vaginal	Female	38w 5d	Live birth

7. To modify the Expected Delivery Date (EDD), scroll or click to the **EDD Maintenance** component on the page

8. Click on **Modify EDD** (highlighted in blue).



9. The **EDD Maintenance** window will open.

10. In the **Method** section, select *Ultrasound* from the dropdown list.

**Note:** The Date of Method and EGA by Ultrasound fields will become mandatory fields (highlighted in yellow).

11. In the **Date of Method** field, select a date about 6 months ago.

**Note:** In practice, you would enter the 1st Ultra Sound date from the BC Antenatal Record (Section 4).

12. In the **EGA by Ultrasound** field, document *8 weeks*.

**Note:** In practice, you would enter the Gestational Age by Ultra Sound from the BC Antenatal Record (Section 4).

13. The **EDD** and **Current EGA** will auto-calculate. Adjust the EDD as needed in the EDD field.

14. Click **OK**

15. The Pregnancy Overview will now show the updated EDD and EGA.

Confirmation	Status	EDD	EGA on Method Date	Method	Date of Method	Description
<input checked="" type="checkbox"/>	Authoritative	17-Sep-2018 PDT	0 0/7 weeks	Last Menstrual Per...	11-Dec-2017 PST	

Modify EDD Maintenance

Method: Ultrasound (10)    Date of Method: 11-May-2017 (11)

Confirmation: Confirmed     Final     Initial

EDD: 21-Dec-2017 (13)    EGA by Ultrasound: 8 weeks (12)

Current EGA: 38 weeks 4 days (13)

Description: Crown rump length [ ] cm, Biparietal diameter [ ] cm, Head circumference [ ] cm

Comments: [ ]

Buttons: Delete, OK (14), Cancel

**Note:** You will only need to add a pregnancy once for a patient. For the majority of patients, this Add Pregnancy and EDD Maintenance step will already be completed as part of the pre-registration process by the unit clerk or registration clerk.

Now that a pregnancy has been added, you will be able to view all the different pages and components from the **Women’s Health Overview**. Continue to the next activity to explore and review the Women’s Health Overview.

**Note:** Most patients will already be pre-registered in the system. The pre-registration process includes:

1. Pre-registering a patient and creating a “Pre-Outpatient in a Bed” encounter (completed by main registration clerk when he/she receives patient's registration forms).
2. Attaching the BC Antenatal Record Part 1 and 2 forms to the system (completed by unit clerk)
3. Adding a pregnancy and modifying the EDD (completed by unit clerk)
4. Transcribing information from the BC Antenatal Record Part 1 and 2 to the Antenatal Record

PowerForm (completed by unit clerk)

- a. Obstetrical History (Section 3)
- b. Prenatal Investigations and Results (Section 13)
- c. Weight History (Pre-pregnant Weight and Height) (Section 14)

**Note:** This "Pre-Outpatient in a Bed" encounter is to be used when the patient presents in labour. If this "Pre-Outpatient in a Bed" encounter is used and the patient is discharged home (for example, in early labour), then another "Pre-Outpatient in a Bed" encounter will need to be created for use when the patient returns for subsequent labour assessments.

### Key Learning Points

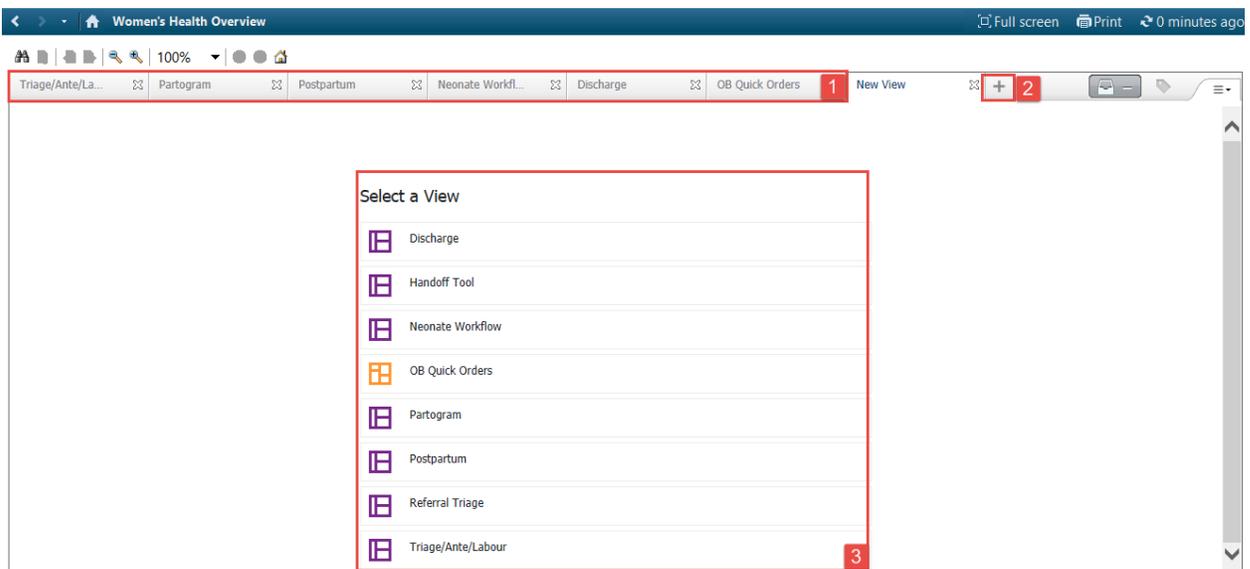
-  A pregnancy needs to be added to activate and view the different components of the Women's Health Overview page.
-  When a pregnancy has been added, some of this information will populate columns on the Tracking Shell
-  Most labour and delivery patients will already be pre-registered in the CIS with a pre-outpatient in a bed encounter type.
-  EDD and EGA can be modified from the EDD Maintenance component in the Women's Health Overview page

## Activity 4.3 – Review of the Women’s Health Overview Page

1 Now that you have added a pregnancy to the patient’s chart, you will be able to see a summary of key clinical patient information on the **Women’s Health Overview** summary page.

1. There are different tabs across the top of the page including **Triage/Ante/Labour, Partogram, Postpartum, Neonate Workflow, Discharge and OB Quick Orders** etc.
2. There are more views that can be accessed by clicking on the  to the right of the tabs
3. You will be able to select any view from this list as well.

**Note:** OB quick orders, Handoff Tool and Discharge views can be found here



- **Click** on the different tabs
  - Review the information/components that can be found on each tab
4. Each tab has different components of information. You can use the scroll bar on the right hand side to look at all the components on each tab/page.
  5. A list of the components can be seen on the left hand side. You can click on any item in this list and it will bring you to that component instead of using the scroll bar.
  6. The **OB Quick Orders** tab can be used to place orders for the patient. This feature will be covered later on in the workbook.

The screenshot shows the 'Women's Health Overview' interface. At the top, there are navigation tabs: Triage/Ante/La..., Partogram, Postpartum, Neonate Workfl..., Discharge, OB Quick Orders (highlighted with a red box and the number 6), and Handoff Tool. A red box with the number 4 highlights the right-hand side of the main content area. A red box with the number 5 highlights the left-hand navigation menu. The main content area is titled 'Pregnancy Overview' and includes sections for 'Current Pregnancy', 'Prenatal Visits', and 'Delivery Summary (3)'. The 'Current Pregnancy' section contains a table with the following data:

EDD	18/03/17 (Authoritative)	Current Weight	--	Blood Type	--
EGA	88 Weeks, 4 Days	Pre-Preg Weight	60kg	Rupture of Membrane	[Baby A] Delivered
Gravida/Parity	G2,P1(1,0,0,1)	Height	--	Blood Type, Transcribed	A negative
Multiple Fetuses	Yes, Triplets	BMI	--	Transcribed Antibody Screen	RhD
Feeding Plan	--				

The 'Delivery Summary (3)' section contains a table with the following data:

Baby	Delivery Date/Time	Delivery Type	Gender	EGA at Delivery	Neonate Outcome
Baby A	17/02/17 15:20	Vaginal	Female	36w 4d	Live birth

**Note:** Remember that as an Inpatient Rural Nurse, you will also have a Patient Summary page. You will use this summary page when looking after a non-maternity patients.

### Key Learning Points

- The Women’s Health Overview page is a summary page for key patient clinical information
- The Women’s Health Overview page is used for OB patients and Newborns
- Clicking on the different tabs across the top allows the user to see different views of information
- You may have to customize what views you can see by clicking on the 
- Orders for the patient can be entered from the OB Quick Orders tab

## **■ PATIENT SCENARIO 5 – Documenting on OB patients in Interactive View and I&O**

### **Learning Objectives**

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

- Navigate to iView and I&O
- Document in OB specific bands in iView

### **SCENARIO**

In this scenario, you will be charting on your L&D patient.

As a rural inpatient OB nurse you will be completing the following activities:

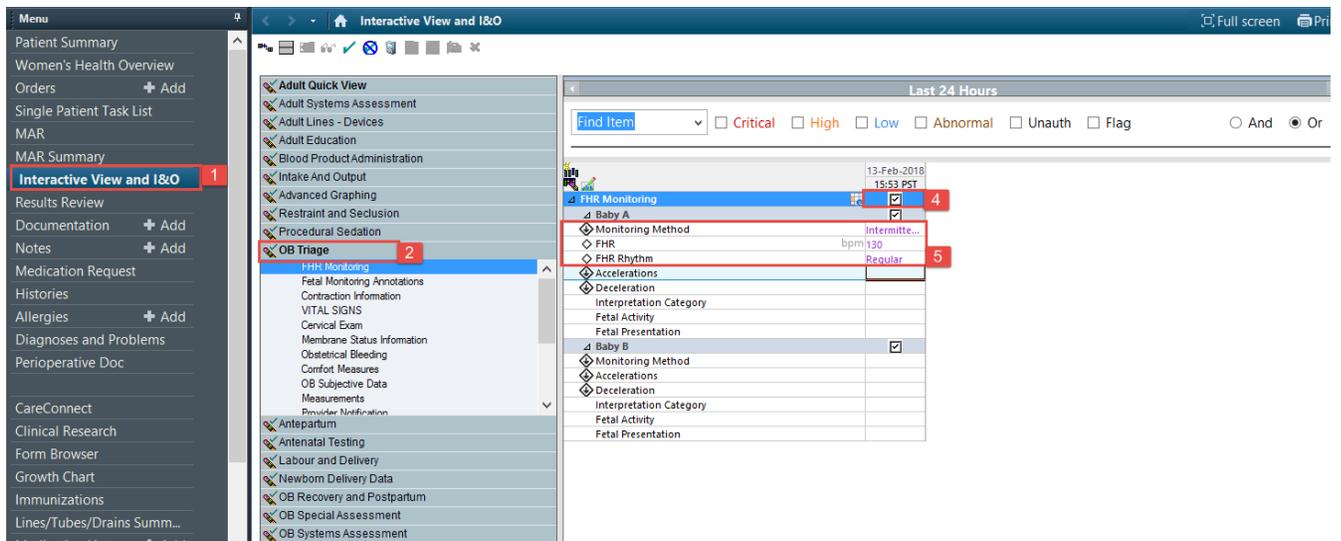
- Navigate to Interactive View and I&O (iView)
- Document OB specific assessments in iView

## Activity 5.1 – Documenting OB Assessments in Interactive View and I&O

1 As you learned in Scenario 8 in the Nurse – Rural workbook, iView is where nurses complete most of their documentation including vital signs and head to toe assessments. You've previously learned how to document on non-maternity patients in iView.

In this activity you will learn how to document OB assessments, specifically your FHR Monitoring and Cervical Exam assessments.

1. Navigate to iView by clicking on **Interactive View and I&O** from the menu
2. Click on the **OB Triage** band and the FHR Monitoring section is automatically available for documentation
3. Click Refresh  to ensure that previously documented data pulls through so that you are viewing the most up to date information.
4. Double-click the **blue box** next to the name of the section to document in several cells. You can move through the cells by pressing the **Enter** key.
5. Document the following data in the **FHR Monitoring** Section:
  - **Monitoring Method** = Intermittent Auscultation
  - **FHR** = 130
  - **FHR Rhythm** = Regular



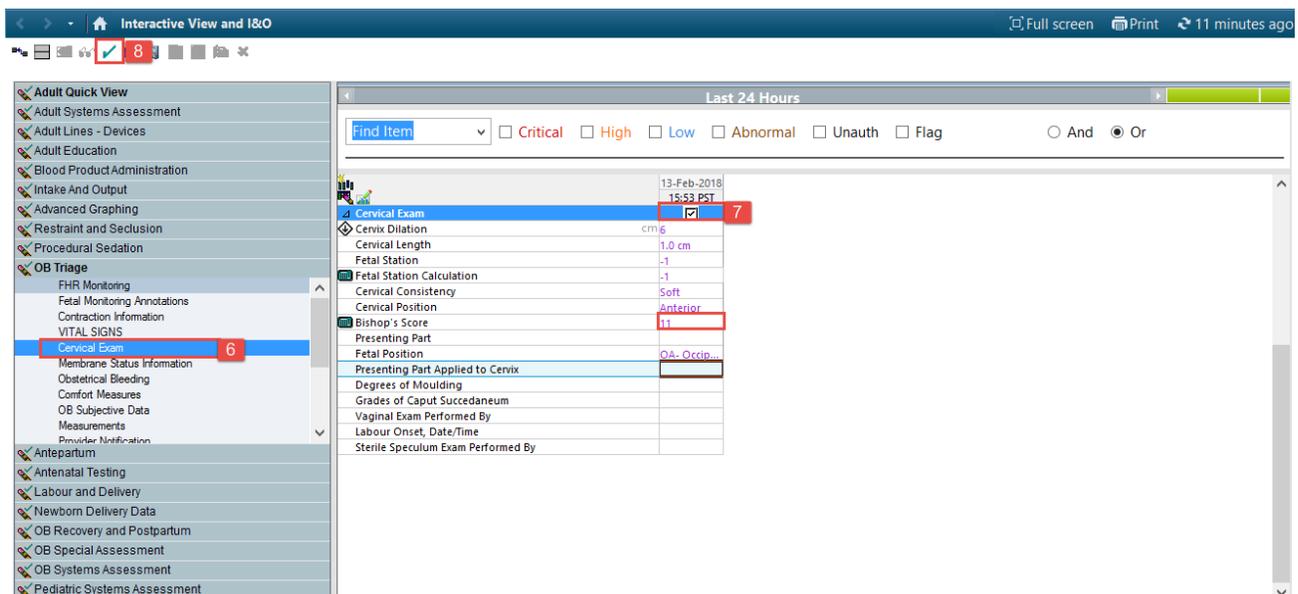
The screenshot displays the iView software interface. On the left is a navigation menu with 'Interactive View and I&O' highlighted. The main window shows a list of assessment categories, with 'OB Triage' selected. A sub-menu for 'FHR Monitoring' is open, showing a table for data entry. The table has columns for 'Monitoring Method', 'FHR', and 'FHR Rhythm'. The 'Monitoring Method' is set to 'Intermittent Auscultation', 'FHR' is '130', and 'FHR Rhythm' is 'Regular'. Red boxes and numbers 4 and 5 highlight these specific entries in the table.

6. Now click on the **Cervical Exam** Section in the same **OB Triage** Band
7. Double-click the **blue box**  next to the name of the section to document in several cells. Again, use the **Enter** key on the keyboard to move through the cells. Document the following:

- **Cervix Dilatation = 6cm**
- **Cervical Length = 1.0 cm**
- **Fetal Station = -1**
- **Cervical Consistency = Soft**
- **Cervical Position = Anterior**
- **Fetal Position = OA- Occiput Anterior**

The Calculator icon  is an auto-calculation based on data entered. Note that the **Bishop's Score** auto-calculates = 11.

8. **Sign**  your documentation.



The screenshot shows the 'Interactive View and I&O' software interface. The left sidebar lists various clinical sections, with 'OB Triage' expanded to show 'Cervical Exam' selected. The main window displays a table of data for the 'Cervical Exam' section, dated 13-Feb-2018 at 15:53 PST. The table includes fields for Cervix Dilatation (6 cm), Cervical Length (1.0 cm), Fetal Station (-1), Cervical Consistency (Soft), Cervical Position (Anterior), and Bishop's Score (11). A red box highlights the Bishop's Score field. The interface also shows a 'Find Item' search bar and various filter options (Critical, High, Low, Abnormal, Unauth, Flag) and logical operators (And, Or).

Field	Value
Cervix Dilatation	6 cm
Cervical Length	1.0 cm
Fetal Station	-1
Fetal Station Calculation	-1
Cervical Consistency	Soft
Cervical Position	Anterior
Bishop's Score	11
Presenting Part	
Fetal Position	OA- Occip...
Presenting Part Applied to Cervix	
Degrees of Moulding	
Grades of Caput Succedaneum	
Vaginal Exam Performed By	
Labour Onset, Date/Time	
Sterile Speculum Exam Performed By	

**Note:** The Labor Onset Date/Time that you previously entered in the OB Triage and Assessment PowerForm auto-populates here. Documentation of Labour Onset Date/Time will activate the **Partogram** (more about the Partogram later).

	13-Feb-2018
	16:07 PST
▲ Cervical Exam	
◆ Cervix Dilatation	cm
Cervical Length	
Fetal Station	
■ Fetal Station Calculation	
Cervical Consistency	
Cervical Position	
■ Bishop's Score	
Presenting Part	
Fetal Position	
Presenting Part Applied to Cervix	
Degrees of Moulding	
Grades of Caput Succedaneum	
Vaginal Exam Performed By	
Labour Onset, Date/Time	13-Feb-20...
Sterile Speculum Exam Performed By	

You have successfully documented the FHR Monitoring and Cervical Exam for your patient!

**Note:** FetaLink is a fetal and maternal monitoring system that interacts with PowerChart. When a FetaLink compatible machine is used, **Vital Signs** and **Fetal Annotations** (comments you make to the electronic fetal heart tracing in FetaLink) can auto-populate sections in iView. You will learn more about FetaLink functionality in another workshop.

- Now is a good opportunity to click through the rest of the OB bands in iView to familiarize yourself with where you will be documenting the rest of your OB assessments.

Notice these other bands as well:

- Antepartum
- Antenatal
- Labour and Delivery
- Newborn Delivery Data

The screenshot shows the iView software interface. On the left, a navigation pane lists various clinical bands. A red box highlights the 'OB Bands' section, which includes 'FHR Monitoring', 'Fetal Monitoring Annotations', 'Contraction Information', 'VITAL SIGNS', 'Cervical Exam', 'Membrane Status Information', 'Obstetrical Bleeding', 'Comfort Measures', 'OB Subjective Data', 'Measurements', 'Provider Notification', and 'PAIN ASSESSMENT'. Below this, other OB bands like 'Antepartum', 'Antenatal Testing', 'Labour and Delivery', 'Newborn Delivery Data', 'OB Recovery and Postpartum', 'OB Special Assessment', and 'OB Systems Assessment' are listed. A red arrow points to the 'OB Bands' label. The main window displays the 'FHR Monitoring' band for 'Baby A' and 'Baby B'. The data table for 'Baby A' is as follows:

		13-Feb-2018
		16:16 PST   15:53 PST
Monitoring Method		Intermitte...
FHR	bpm	130
FHR Rhythm		Regular
Accelerations		
Deceleration		
Interpretation Category		
Fetal Activity		
Fetal Presentation		

The data table for 'Baby B' is currently empty.

**Note:** You may see a few areas in iView where you could document the same information. For example, you can document VITAL SIGNS under the OB Triage band or under the Adult Quick View band. When caring for an OB patient, it is preferable to use the maternity-specific sections but should vital signs happen to be documented under Adult Quick View, the data will carry over to the OB sections.

The first set of vital signs must always be documented in OB Triage before documenting in the Antepartum, Labour and Delivery, etc sections.

### Key Learning Points

- When looking after OB patients and Newborns you will document your assessments in the specific OB bands in iView
- Clicking into each band will allow you to learn which assessments are documented where.
- Always sign  your documentation so that it becomes a part of the patient's legal chart.
- If there are duplicate sections in iView, the documented information will flow to all duplicated sections.

## PATIENT SCENARIO 6 – Partogram

### Learning Objectives

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

- Access the partogram to view necessary labour information.

### SCENARIO

In this scenario, we will access the Partogram from the Women’s Health Overview.

As an inpatient nurse you will be completing the following activities:

- Locate the Partogram Overview
- Locate the Partogram FHR
- Locate the Partogram Labour Graph

## Activity 6.1 – Viewing the Partogram

- 1 The **Partogram** is a graphical, view-only display of data that has been charted on a labouring patient. It provides an overview of useful information such as the current oxytocin rate and/or the current epidural rate. You can also view a graphical display of fetal heart rates as well as the labour curve graph.

The **Partogram** can be accessed from the Partogram tab in the **Women’s Health Overview** page.

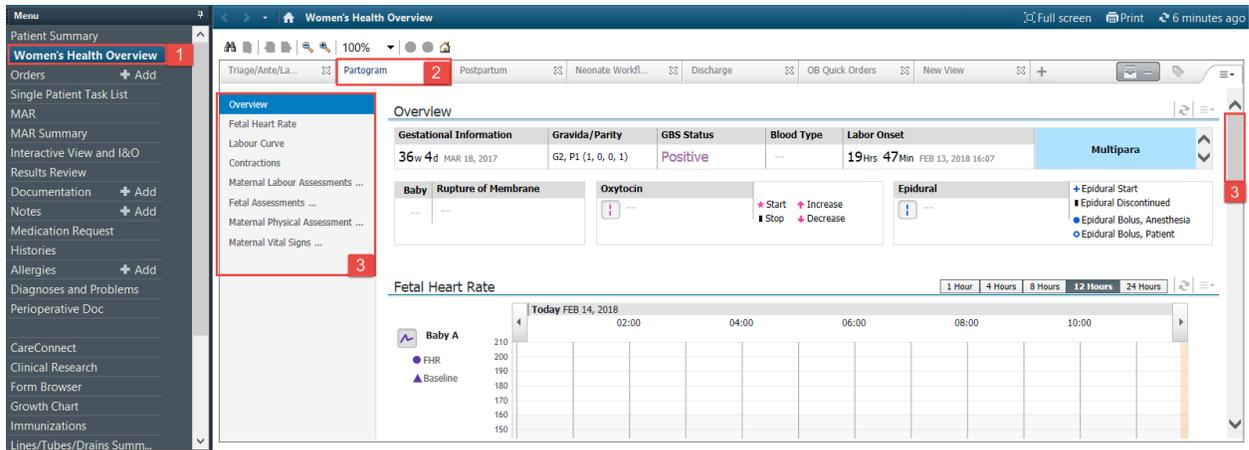
**Note:** If not already done, you will be prompted to document the labour onset date and time (the first stage of labour) before you can view the Partogram. If you are commencing oxytocin and the patient has not yet entered the first stage of labour, document the oxytocin start date and time in the Labour Onset, Date/Time field to populate the Partogram. You will need to update the Labor Onset, Date/Time field once you can confirm the date/time of the patient’s first stage of labour since this is used for the **Stages of Labour** auto calculation.

Explore the Partogram:

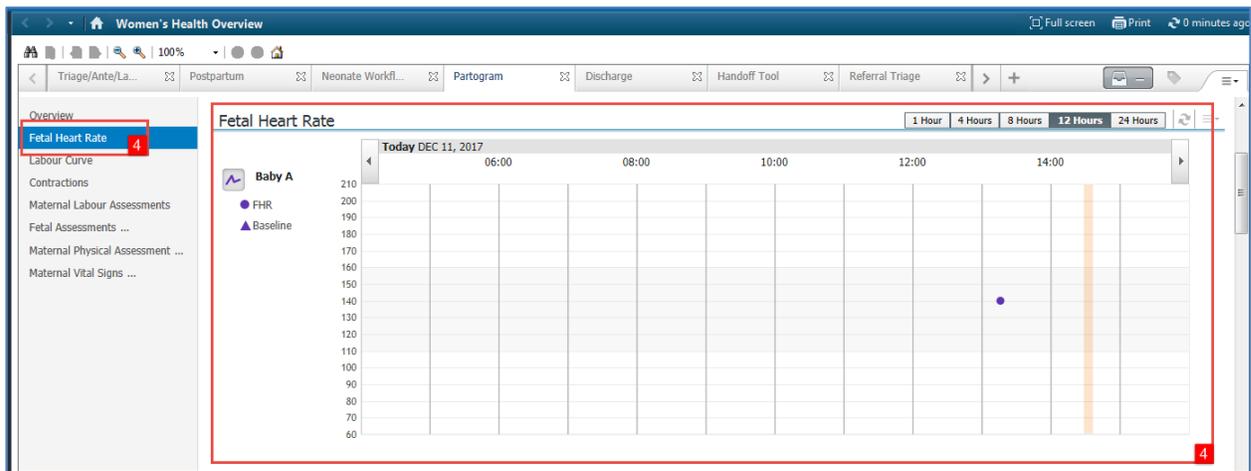
1. Navigate to the **Women’s Health Overview** from the **Menu**
2. Click on the **Partogram** tab.

**Note:** If the Partogram tab is not in view, click on the  sign. A list of Views will populate. Select Partogram.

3. The Partogram page opens. Various components of the Partogram are listed to the left, including Overview, Fetal Heart Rate, Labour Curve, Contractions, and Maternal Labour Assessments etc.

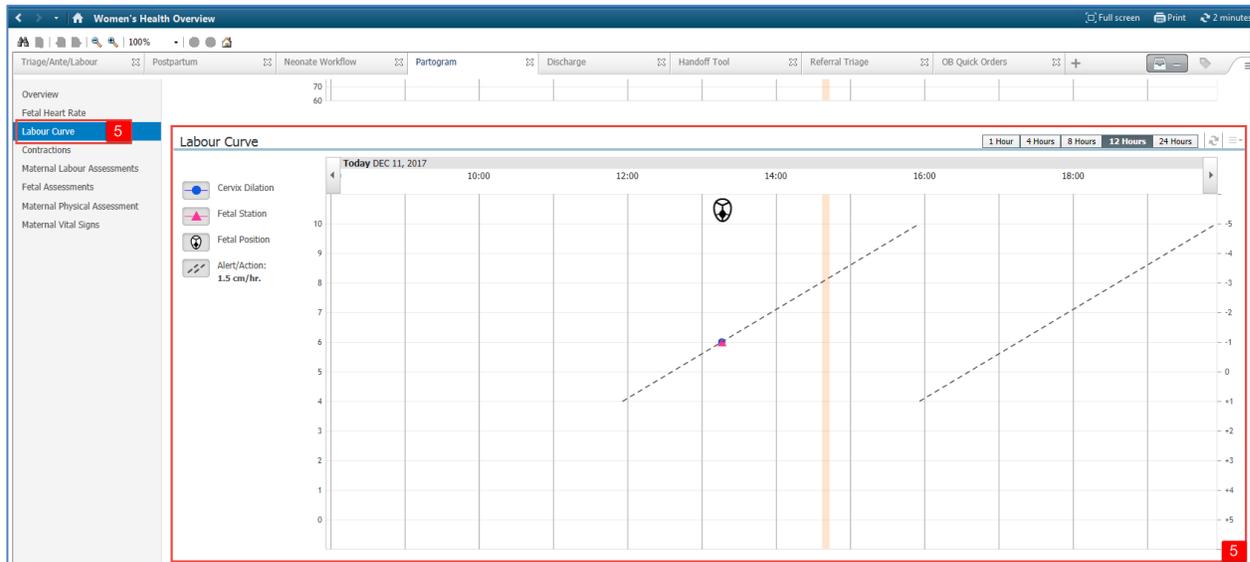


- Click on the Fetal Heart Rate component. Note that the FHR you documented in iView populates here. When multiple FHRs are documented in iView, the results will display here in a graphical format. If updated information is not appearing as expected, click refresh ↻ 19 minutes ago in the upper right corner of the screen to populate the information.



**Note:** The Partogram only displays iView documented FHRs; it is not a display of real time electronic fetal heart rate tracings. To view real time FHR tracings, you will need to access the **FetaLink** application. This will be covered in another learning session.

- Now click on the Labour Curve component. The cervical exam you documented in iView populates here.



**Note:** You cannot chart directly on the Partogram; it is view only. The more information you document in iView, the more data will populate on the Partogram.

### Key Learning Points

- The Partogram is accessible from the Women's Health Overview page.
- It provides a summary of pertinent clinical information such as the FHR and the labour curve graph.

## PATIENT SCENARIO 7 – OB Quick Orders

### Learning Objectives

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

- Navigate to OB quick orders
- Place an order from OB quick orders
- Initiate an order

### SCENARIO

As a rural nurse caring for OB patients, you will need to place OB specific orders on your patient in certain situations. To do so you will complete the following activities:

- Navigate to OB Quick Orders
- Place an order from OB Quick Orders
- Initiate an Order

## Activity 7.1 – Overview of the OB Quick Orders Page

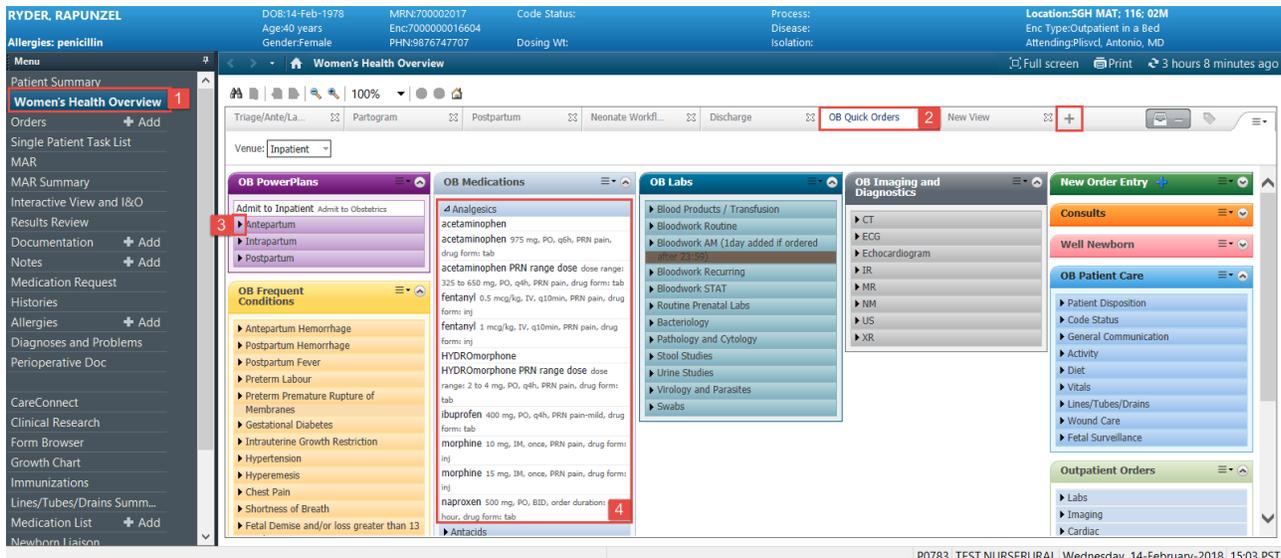
- The **OB Quick Orders** page features the most commonly used orders in obstetrics. You can order **Powerplans** (the equivalent to preprinted orders) as well as stand-alone orders (for example, vital signs q4h). Orders are categorized into different colour-coded sections, for example, **OB PowerPlans**, **OB Medications**, **OB Labs** and **OB Patient Care** etc.

Explore the **OB Quick Orders** Page:

- Navigate to the **Women’s Health Overview** from the Menu
- Click on the **OB Quick Orders** tab.

**Note:** If the OB Quick Orders tab is not in view, click on the  sign. A list of Views will populate. Select OB Quick Orders.

- The OB Quick Orders Page opens. Different orders are categorized into different sections. You can click on the arrow  to the left of any order type to expand a list of related orders.
- Click on the arrow beside **Analgesics** in the OB Medications section. A list of the most commonly used OB analgesics will open.



The screenshot displays the OB Quick Orders interface for patient RYDER, RAPUNZEL. The top navigation bar includes patient demographics and a menu. The main content area is divided into several color-coded sections: OB PowerPlans (purple), OB Medications (blue), OB Labs (teal), OB Imaging and Diagnostics (grey), and New Order Entry (green). The OB Medications section is expanded to show a list of analgesics, with 'Analgesics' highlighted. The OB Labs section is also expanded to show various lab tests. The interface includes a search bar, a patient summary sidebar, and a bottom status bar.

Now is a good opportunity to review the different order categories, expand the order types and see the related orders that are available on the OB Quick Orders page. These orders are pre-populated with the most common order sentences for OB patients.

## Activity 7.2 – Place an OB Quick Order

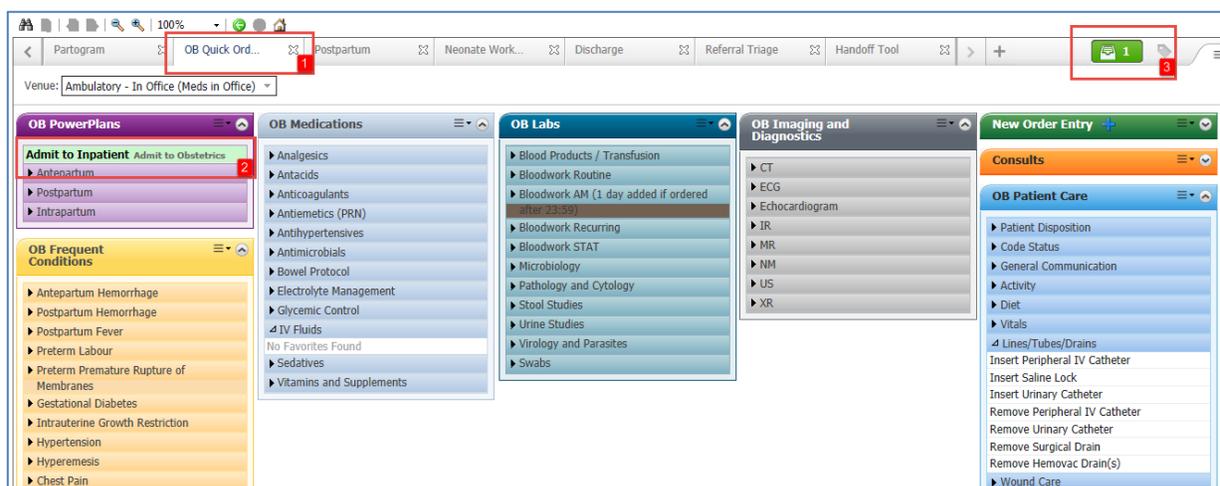
- 1 Your patient is in active labour. You have called the OB Provider and the decision has been made to admit the patient. Your patient’s current encounter type is Outpatient in a Bed; this encounter type is used for all OB patient assessments (Note that for scheduled outpatient activities such as NSTs or Iron Sucrose Infusions, the encounter type will be Outpatient OB).

You will need to place an order to admit her as an Inpatient. Let’s practice placing an order from the **OB Quick Orders** Page.

**Note:** Verbal and phone orders that nurses enter in the CIS will be automatically routed to the ordering provider for co-signature

1. If not already done, open the **OB Quick Orders** Page from the **Women’s Health Overview**.
2. Click on the **Admit to Inpatient** order under the **OB PowerPlans** section.
3. Click the **Orders for Signature** icon (Green Orders Tray) . This tray acts like an orders “shopping cart” and is updated when you select different orders from the OB Quick Orders Page.

**Note:** You can place more than one quick order at a time. Let’s say you place 4 orders, you will see this number reflected in the green orders tray .



4. The **Orders for Signature** window will open. It will list all the orders you have placed in your “shopping cart”. Click Sign.

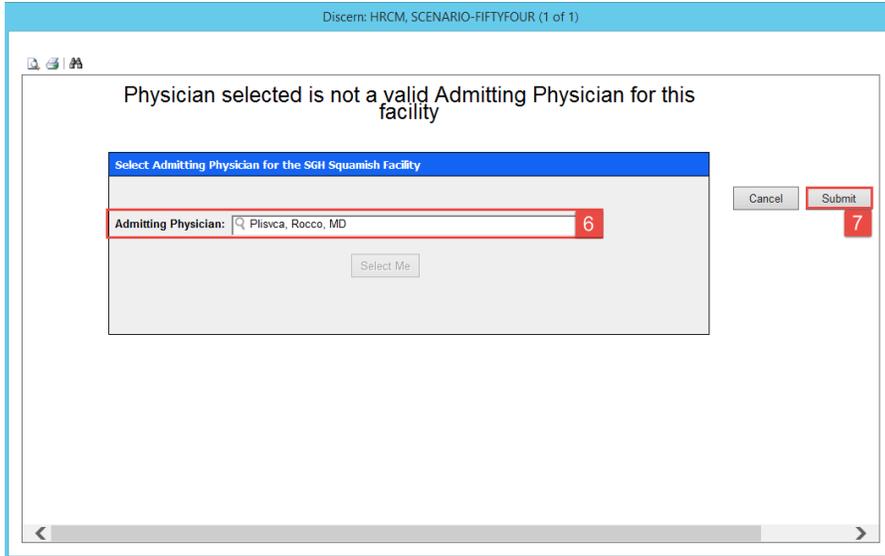
5. The Ordering Physician window will open. Document:

- Physician Name = xxx (Plisvca, Rocco)
- Communication Type = Phone
- Click **OK**

Remember that fields highlighted in yellow are mandatory.

A Discern window will appear asking to select a valid Admitting Physician (in practice please type in the correct obstetrics provider).

6. In the **Admitting Physician** field enter *Plisvca, Rocco*
7. Click **Submit**



You will return to the **OB Quick Orders** Page.

**Refresh**  your screen. Your patient's Encounter will now be updated **from Outpatient in a Bed to Inpatient** in the Banner Bar.

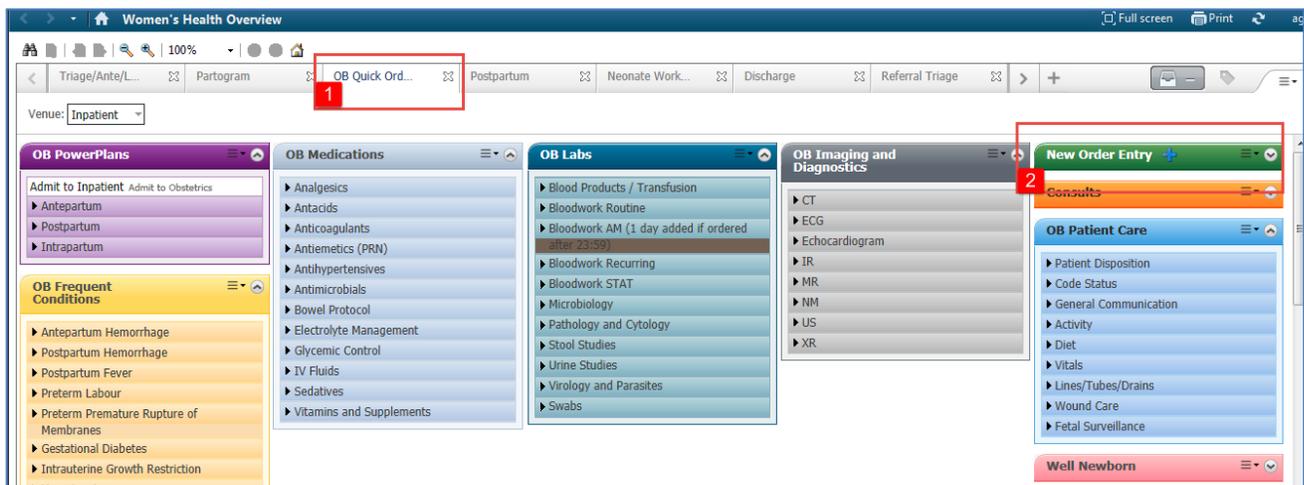


## Activity 7.3 – Place an Order via Add Order

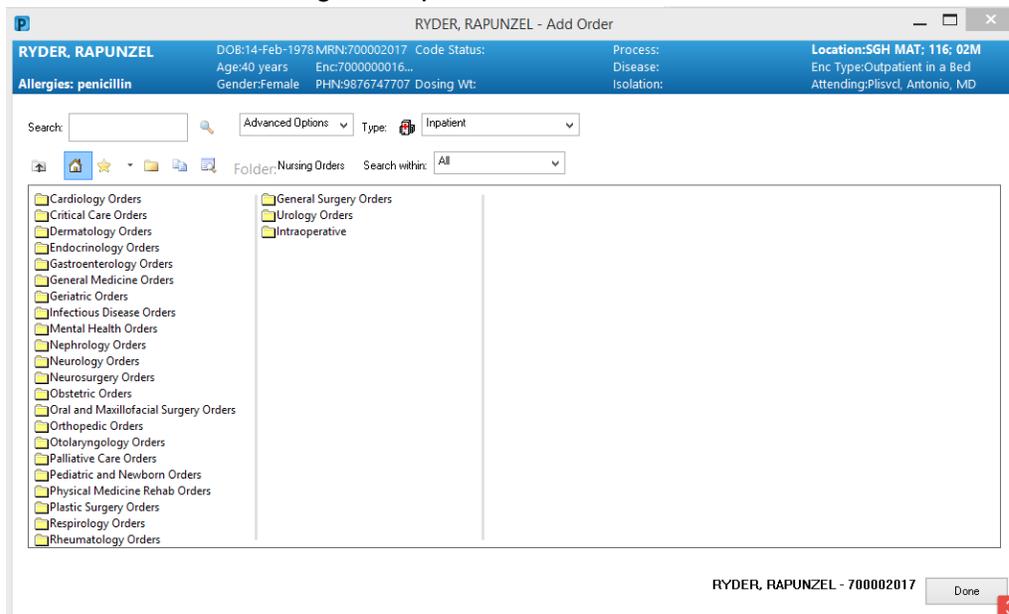
1 Some orders do not require a cosignature by physician. Let's practice placing an order that does not need to be routed to a physician for cosignature.

1. Navigate back to the **OB Quick Orders** page.

2. Click the **blue plus sign** of the **New Order Entry** button  at the top right hand corner. (The text is also clickable but takes you to the list of current orders.)

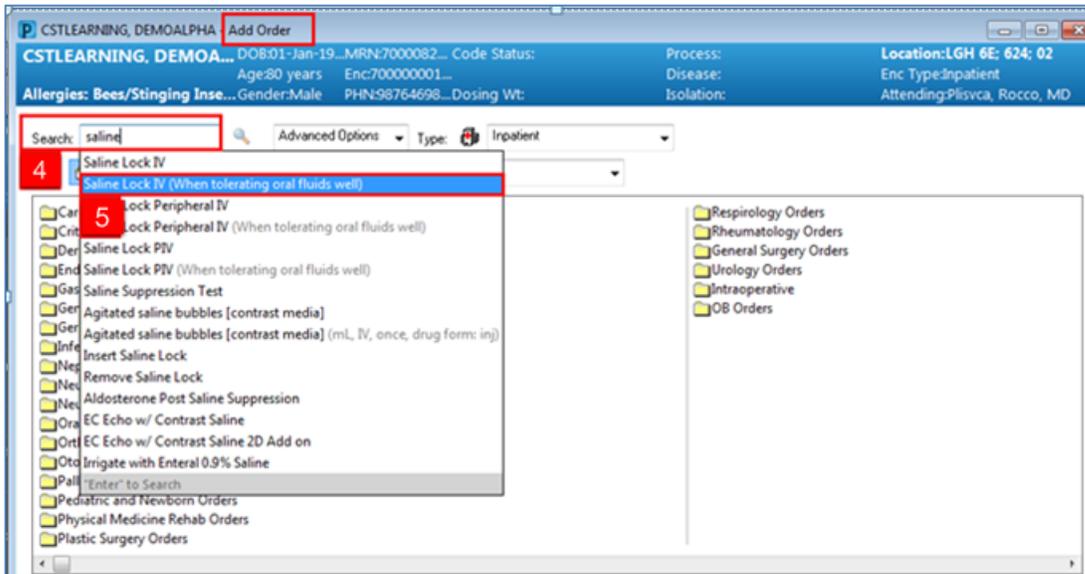


3. The **Add Orders** Page will open.

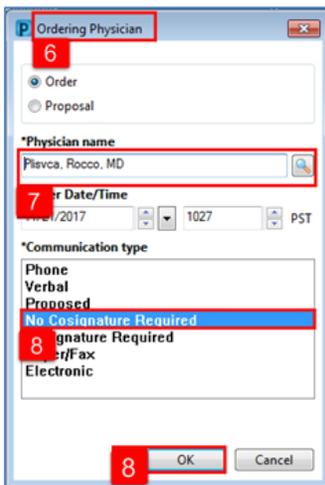


4. Type *saline lock* into the search window and a list of choices will display.

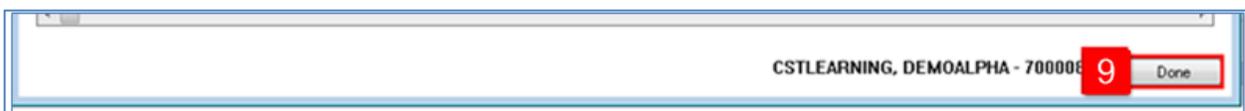
5. Select **Saline Lock Peripheral IV** with order sentence of (*when tolerating oral fluids well*).  
Order sentences help to pre-fill order details.



6. The **Ordering Physician** window opens.
7. Type in the name of the patient's Attending Physician
8. Select **No Cosignature Required** and click **OK**.



9. Click **Done** and you will be returned to the **Orders Page** and see the order details in the Orders Profile.



10. The order is now ready for your review and signature. Notice that the **Special instructions** box is pre-filled with **When tolerating oral fluids well**. Click **Sign**.

The screenshot shows a web-based medical order entry system. At the top, there are tabs for 'Order Name', 'Status', 'Start', and 'Details'. Below this, a patient care summary is visible, including 'LGH 6E; 624; 02 Enc:7000000015055 Admit: 17-Nov-2017 13:58 PST'. The main section is titled 'Details for Saline Lock Peripheral IV (Saline Lock IV)'. It includes a 'Details' tab and an 'Order Comments' section. A 'Requested Start Date/Time' field is set to '11/21/2017 10:27 PST'. A red box highlights the 'Special instructions' field, which contains the text 'When tolerating oral fluids well'. At the bottom right, a red box with the number '10' is placed over the 'Sign' button. Other buttons at the bottom include 'Missing Required Details', 'Orders For Co-signature', and 'Orders For Nurse Review'.

11. Click **Refresh** 

The order has been placed and you will be brought back to the OB Quick Orders page.

## Activity 7.4 – Initiate a PowerPlan

- 1 A **PowerPlan** in the Clinical Information System is the equivalent to preprinted orders (PPOs) in current state. An example of a **PowerPlan** is the **OB Labour and Delivery Admission (Multi-phase) Powerplan**.

Powerplans can be in different statuses:

- **Planned** – Orders that have been signed but not initiated. This means that the orders cannot yet be carried out but they are prepared in advance for future activation
- **Initiated** – Orders that have been activated and signed. This means that the orders can now be carried out
- **Discontinued** – Orders that have been discontinued and can no longer be carried out

A **Multi-phase PowerPlan** is one that has multiple phases to it. For example when a patient moves from pre-op to intra-op to post-op. Or, in this scenario when a woman is in labour and needs to be admitted, delivers the baby and then becomes a postpartum patient.

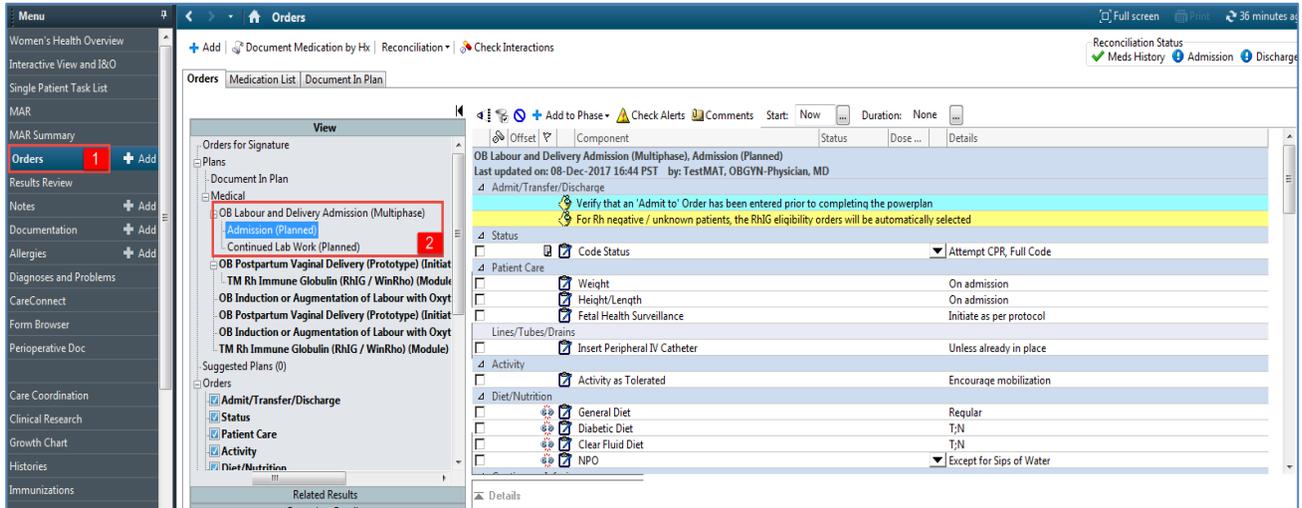
Let's say that the OB Provider has placed the **OB Labour and Delivery Admission (Multi-phase) PowerPlan** in a **planned** state.

You will need to **initiate** the PowerPlan in order to act on the (planned) orders. Because this is a Multi-phase PowerPlan, you will need to initiate (as well as discontinue) the different phases separately.

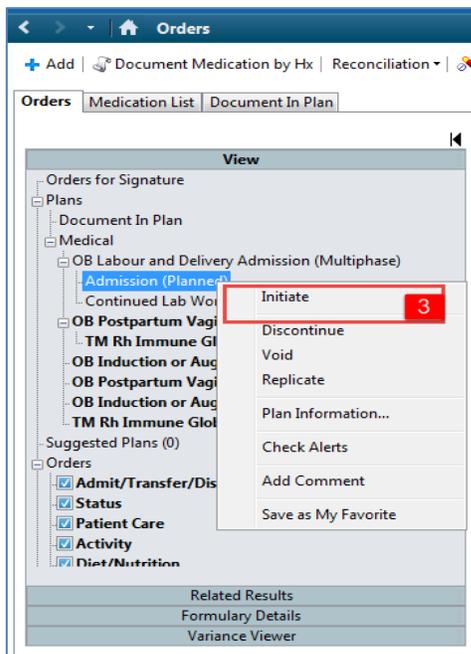
1. Click on the **Orders** band from the Menu.
2. Locate the **OB Labour and Delivery Admission (Multiphase) PowerPlan** in the Navigator (View). The Admission phase and Continued Lab Work phase are both in planned statuses.

**Note:** A **Postpartum PowerPlan** in a planned state can be placed by the provider for after the baby is delivered. Post-delivery, as the patient becomes a postpartum patient, the nurse will **discontinue** the **Admission phase** of the **OB Labour and Delivery Admission PowerPlan**, and **initiate** the **PostPartum PowerPlan**.

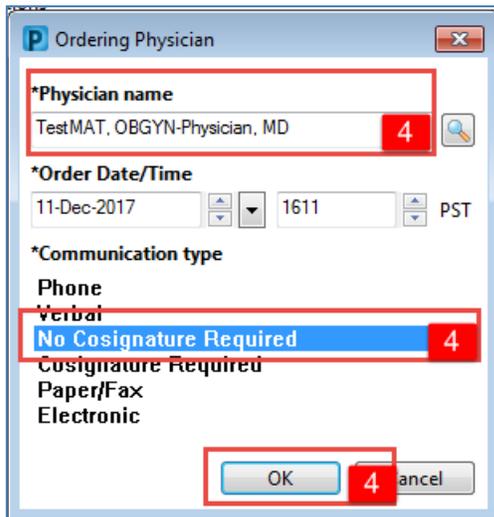
**Note:** The **Continued Lab Work** phase of the **OB Labour and Delivery Admission PowerPlan** does not get discontinued during the postpartum phase, as this bloodwork needs to continue throughout the patient's journey.



3. Right click on the **Admission (Planned)** phase and select Initiate from the drop down list.

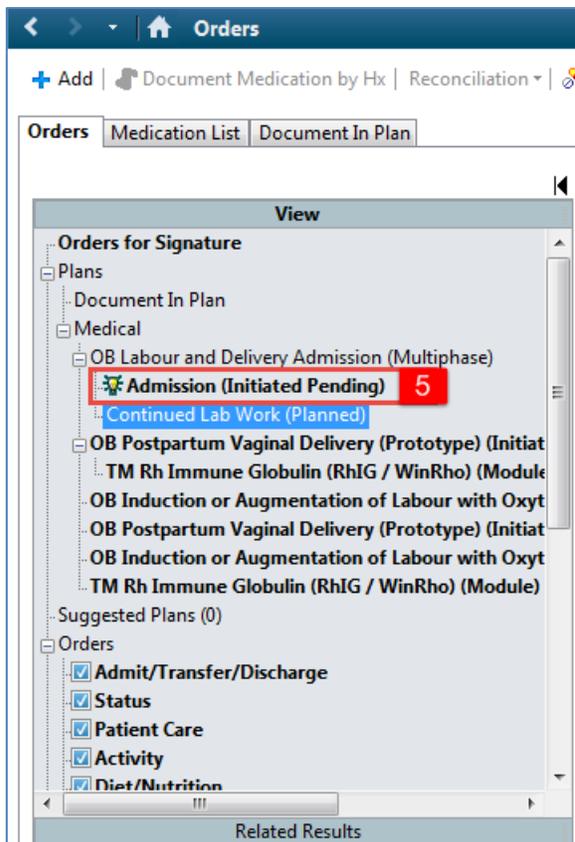


- The **Ordering Physician Window** opens with the provider name automatically prepopulated. Select No Cosignature required and click OK.



**Note:** A planned PowerPlan has already been signed by the provider and therefore 'No Cosignature Required' can be selected when initiating it.

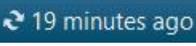
- The Admission phase will now be updated with the status as Initiated Pending.



6. Click **Orders for Signature** from the Orders Profile.

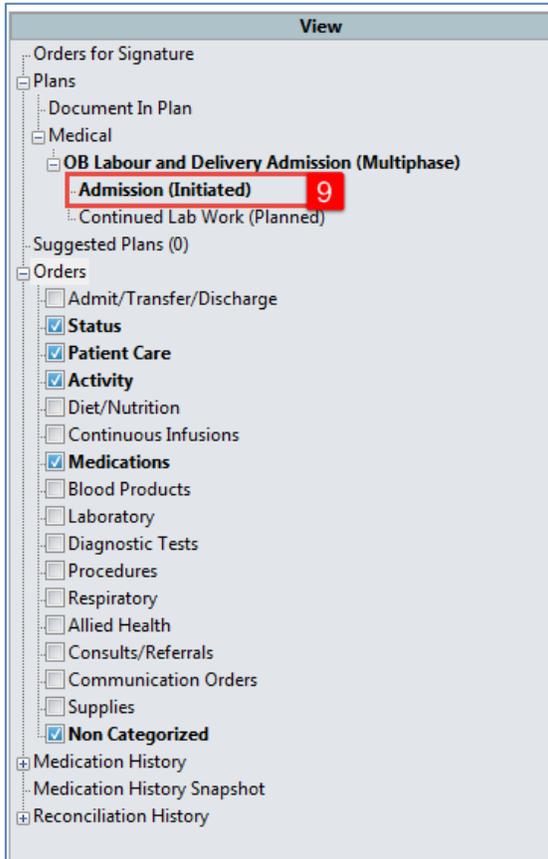
The screenshot shows the 'Orders' section of a clinical system. On the left, a navigation pane has 'Orders for Signature' selected. The main pane displays a list of orders under the heading 'OB Labour and Delivery Admission (Multiphase)'. The orders include Patient Care (Weight, Height/Length, Fetal Health Surveillance), Lines/Tubes/Drains (Insert Peripheral IV Catheter), Activity (Activity as Tolerated), Diet/Nutrition (General Diet, Diabetic Diet, Clear Fluid Diet, NPO), Continuous Infusions (Saline Lock Peripheral IV), Maintenance Fluids (dextrose 5%-sodium chloride 0.9%, sodium chloride 0.9% (sodium chloride 0.9% (NS) con...)), and Medications (Antimicrobials: Group B Streptococcal, penicillin G sodium, cefAZolin; For severe penicillin or cephalosporin allergy; clindamycin; vancomycin). At the bottom right, a red box highlights the 'Orders for Signature' button.

7. The Orders Profile will update and display only the selected orders.

8. Click **Sign** and then click refresh  19 minutes ago

The screenshot shows the 'Orders' section after the 'Sign' action. The left navigation pane remains the same. The main pane now displays a filtered list of orders. A red box highlights the 'Sign' button at the bottom right. The orders shown are: 'LGH LD; LDR7; 01M Enc:7000000012814 Admit: 27-Oct-2017 14:33 PDT', 'Nitrous Oxide Gas Ad...' (Activity), 'fentanyl' (Medications), 'oxytocin' (Medications), and 'Fetal Health Surveillance...' (Non Categorized).

9. The Admission phase status will be updated to Initiated.



Repeat Steps 3 - 9 to initiate the Continued Lab Work (Planned) phase.

**Note:** When the OB Admission phase is completed, it will need to be discontinued and an OB Postpartum PowerPlan will need to be initiated. The Continued Lab Work phase should not be discontinued as it applies to the patient even in the postpartum period.

### Key Learning Points

- Although the OB Quick Orders Page contains the majority of orders you will need for an obstetrical patient, you can also search for an add an order using the Add Order function.
- Orders in a PowerPlan that is in a planned state cannot be carried out
- A PowerPlan needs to be initiated in order to act on the orders
- Multi-phase PowerPlans that are in a planned state will need the different phases to be initiated (as well as discontinued) at the appropriate times.

## PATIENT SCENARIO 8 – Single Patient Task List

### Learning Objectives

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

- Access the Single Patient Task List

### SCENARIO

In this scenario, we will review the Single Patient Task List.

As an Rural inpatient OB nurse you will be completing the following activities:

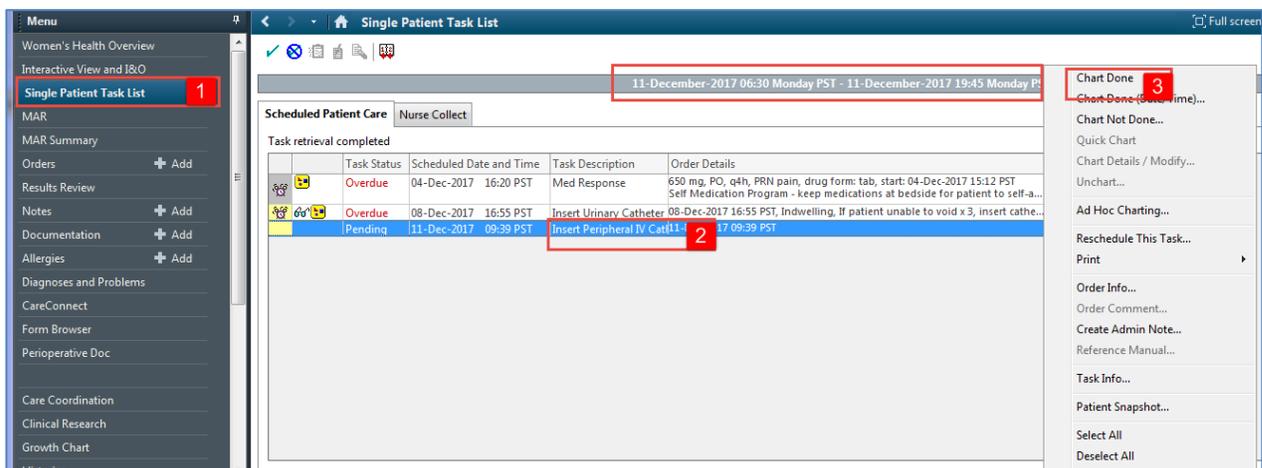
- Review the Single Patient Task List
- Complete a Task

## Activity 8.1 – Review Single Patient Task List and Complete a Task

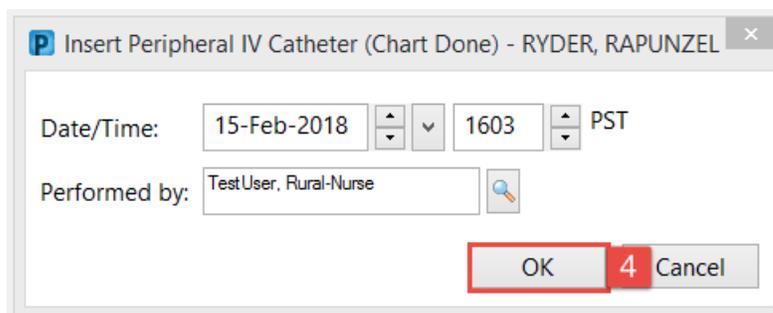
1 The **Single Patient Task List** displays the list of tasks associated to the patient from within the patient’s chart. You can access the Single Patient Task List from the Menu (within each patient’s chart) throughout your shift to view pending tasks and mark them as completed when done.

Let’s say you just inserted a peripheral IV for your patient. Now you need to complete the **Insert Peripheral IV Catheter** task from the Single Patient Task List.

1. Select **Single Patient Task List** from the **Menu**
2. Right click **Insert Peripheral IV Catheter** task
3. Select **Chart Done**



4. Confirm the date/time that the task was completed and Click the **OK** button in the pop-window that displays (make sure this time is aligned with when the IV was inserted and when you documented this insertion in iView).



5. The task will now be marked as complete. When the page is refreshed the task will no longer appear on the task list.

The screenshot shows a web browser window titled "Single Patient Task List". The browser's address bar and toolbar are visible at the top. Below the browser, there is a navigation bar with tabs for "Scheduled Patient Care", "Nurse Collect", "Respiratory Therapy", and "Unit Clerk". The "Scheduled Patient Care" tab is active. Below the tabs, the text "Task retrieval completed" is displayed. A table with the following columns is shown: "Task Status", "Scheduled Date and Time", "Task Description", and "Order Details". The table contains one row with the following data: "Complete", "15-Feb-2018 16:02 PST", "Insert Peripheral IV Catheter", and "15-Feb-2018 16:02 PST". A red box highlights the "Complete" status and the "Scheduled Date and Time" column. A red "5" is visible in the bottom right corner of the table area.

Task Status	Scheduled Date and Time	Task Description	Order Details
Complete	15-Feb-2018 16:02 PST	Insert Peripheral IV Catheter	15-Feb-2018 16:02 PST

Congratulations you have just completed a task on the Single Patient Task List!

### Key Learning Points

-  The Single Patient Task List displays the list of tasks associated to the patient from within the patient's chart.

## **■ PATIENT SCENARIO 9 - Scheduling an OB Anesthesia/Epidural Appointment**

### **Learning Objectives**

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

- Schedule an OB Anesthesia /Epidural appointment.

In this scenario, we will use the scheduling appointment book to schedule an OB Anesthesia/Epidural appointment.

As an inpatient nurse you will be completing the following activities:

- Use the scheduling appointment book to schedule an OB Anesthesia/ Epidural appointment

## Activity 9.1 – Scheduling an OB Anesthesia/Epidural Appointment

- 1 All admitted patients in labour will need to be scheduled for an OB Anesthesia/Epidural appointment, regardless if they need one or not. This is to notify the OR and Anesthesia that there is a woman in labour who may possibly need surgical services.

Scheduling the patient for an anesthesia/epidural appointment allows Anesthesia to find the patient on their patient list.

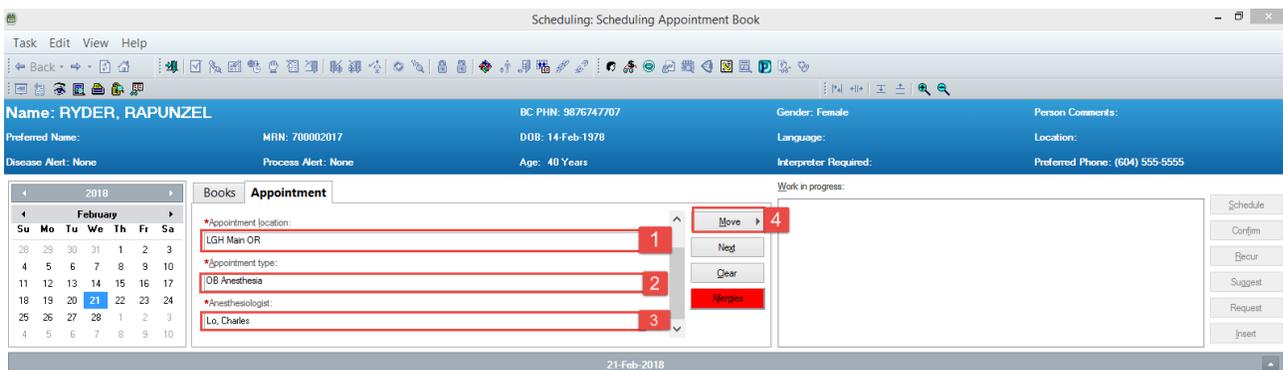
Let's practice how to schedule an OB Anesthesia/Epidural appointment:

Once in the patient's chart, select the **Scheduling Appointment Book** button from the Toolbar.

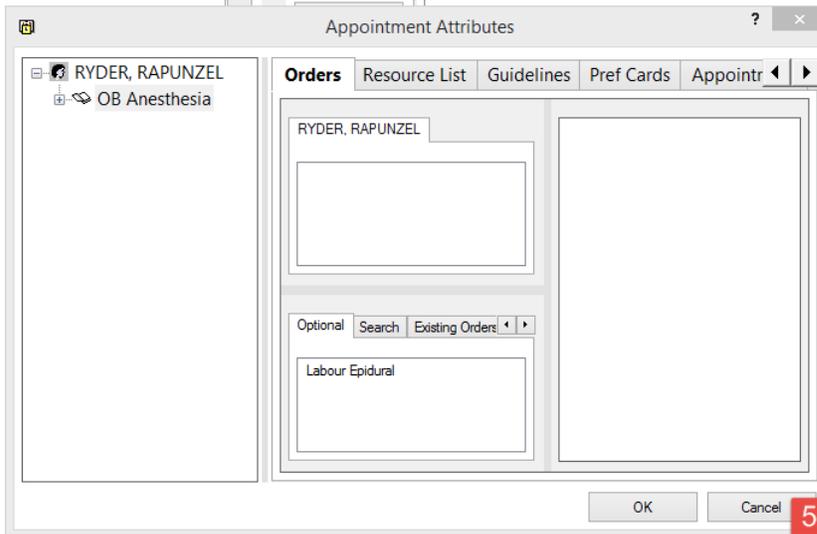


The Scheduling Appointment Book (also called SchAppt Book) launches and opens to the main page. Your patient's name auto-populates in the **Person name** field in the **Appointment** tab. Complete required fields:

1. Appointment location = *LGH Main OR*.
2. Appointment type = *OB Anesthesia*
3. Anesthesiologist = *xxx [Lo, Charles]*
4. Click on the **Move** button.

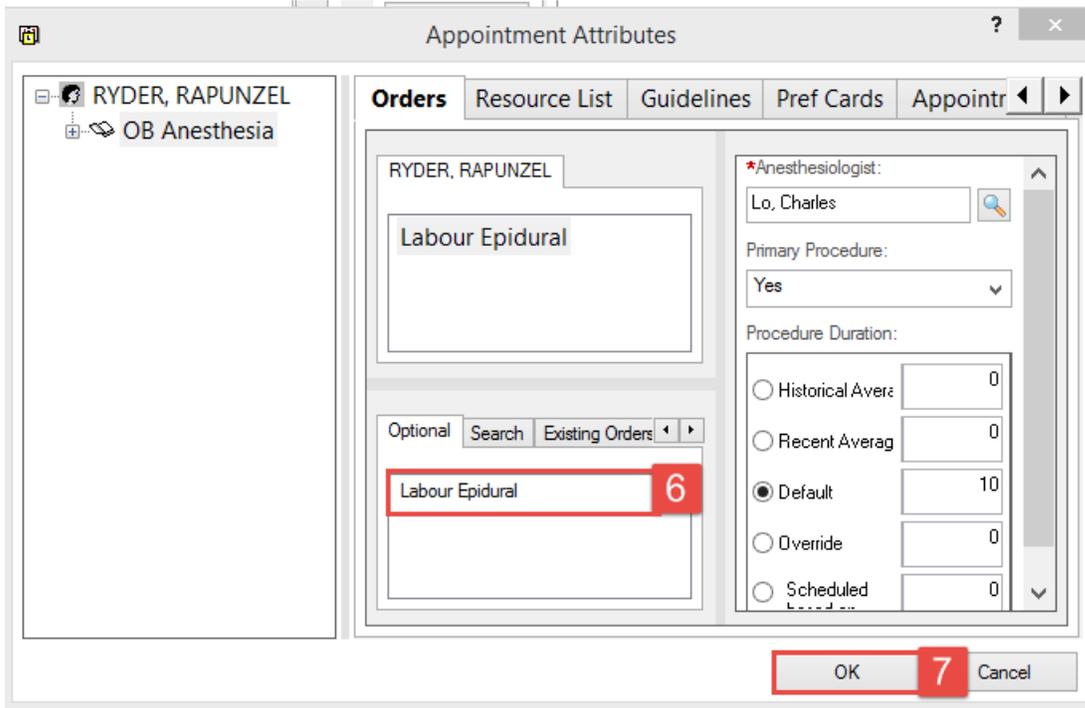


5. The **Appointment Attributes** window opens.

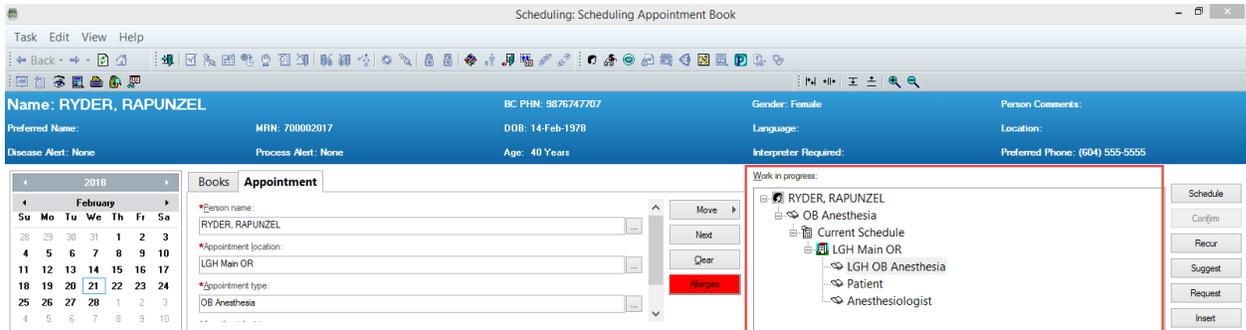


6. Double click on **Labour Epidural** in Optional tab (the blank field on the right will now be populated).

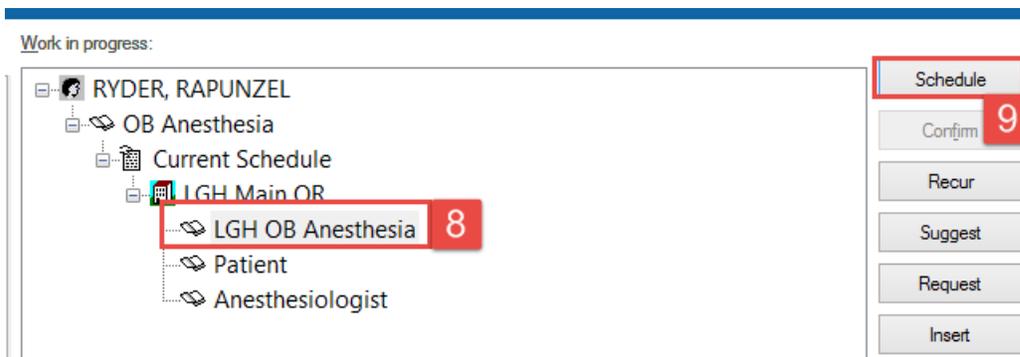
7. Click **OK**.



The scheduling item now appears in the Work in Progress box (located beside the "Move" button).



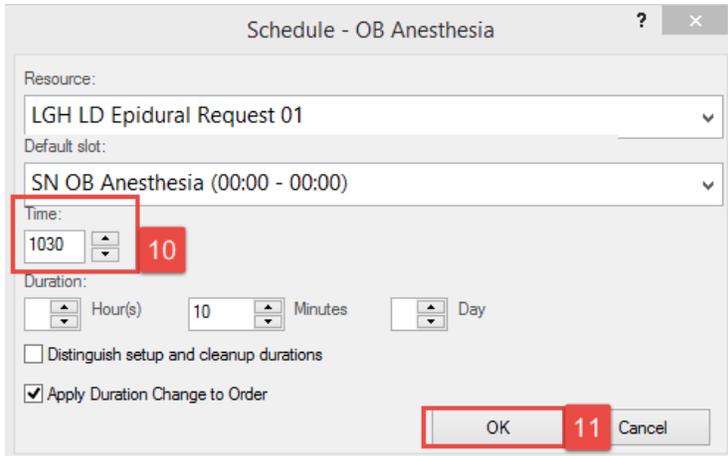
8. Click to highlight the **LGH OB Anesthesia** in the Work in progress box
9. Then click on the **Schedule** button



The **Schedule – OB Anesthesia** window opens:

10. In the **Time** field, select a time 30 minutes from now. Be sure the correct time period is selected from the **Default Slot** drop-down menu.
11. Click **OK**

**Note:** It does not matter what time you choose; you are only placing the patient on the list so that if the patient does need to go to the OR, anesthesia will be aware.

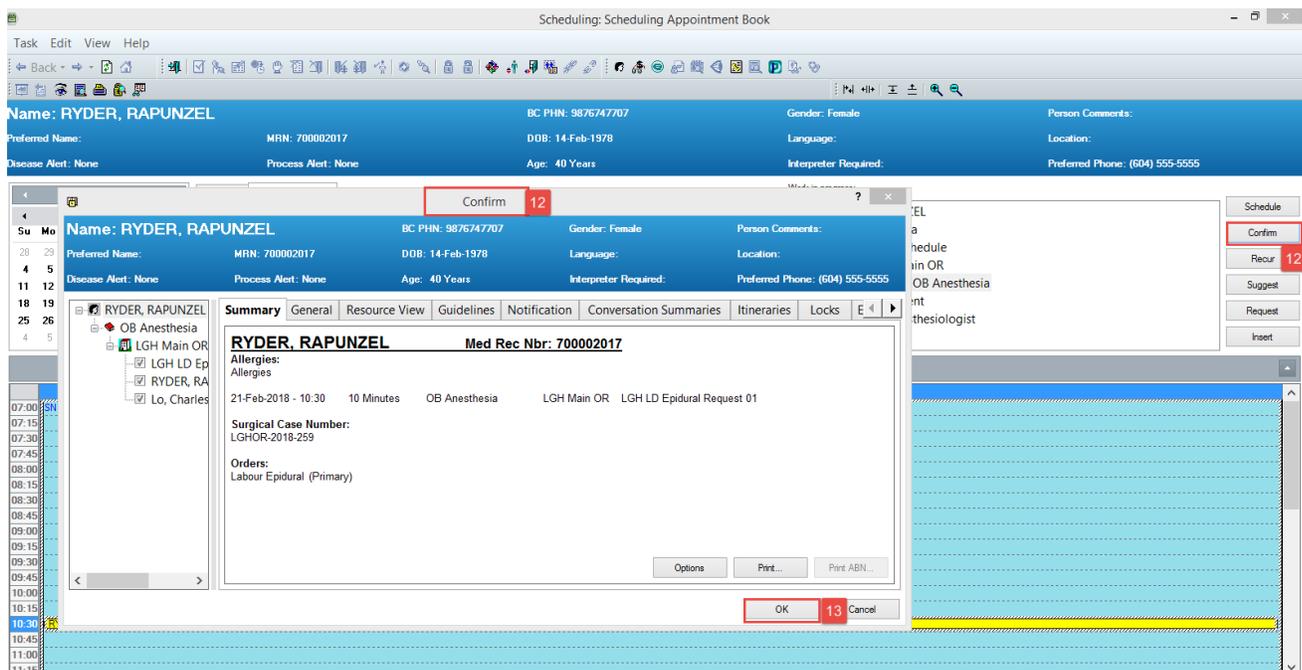


The **Schedule – OB Anesthesia** window closes and **Scheduling Appointment Book** is now displayed.

12. Click **Confirm**. The Confirm window opens with a summary of the appointment details.

13. Click **OK**.

**Note:** Bright yellow highlighted appointments mean the appointment is booked.



The Confirmation window closes and returns to a blank **Scheduling Appointment Book**.

14. Click on the exit (door) icon  to close out of the **Scheduling Appointment Book**. The patients chart will now be displayed again.

The patient has now been tentatively scheduled for an anesthesia/epidural appointment.

Anesthesia will now be able to see the patient on their patient list, notifying them that their services might be needed.

**Note:** If you click back on the  Scheduling Appointment Book button, a confirmation window will open stating that a future OB Anesthesia appointment at LGH Main OR has been booked.

Request Action	Appointment Type	Earliest Request Date	Latest Request Date	Created By	Date Created

Current State	Appointment Type	Location	Begin Date/Time	End Date/Time	Created By
Confirmed	OB Anesthesia	LGH Main OR	23-Feb-2018 - 15:30	23-Feb-2018 - 15:40	TestMAT, Nurse-OB1

Select Unselect OK Cancel

### Key Learning Points

- Every admitted woman in labour will get a scheduled OB Anesthesia/ Epidural appointment, just in case they need it.
- The OB Anesthesia / Epidural appointment is scheduled through the **Scheduling Appointment Book**.

## **■ PATIENT SCENARIO 10 – Delivery Documentation & Newborn Quick Registration**

### **Learning Objectives**

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

- Document delivery data in iView.
- Quick register a newborn to create a chart and populate the patient on the Tracking Shell.

### **SCENARIO**

In this scenario, you will use the WH Quick Registration to Quick Register a patient.

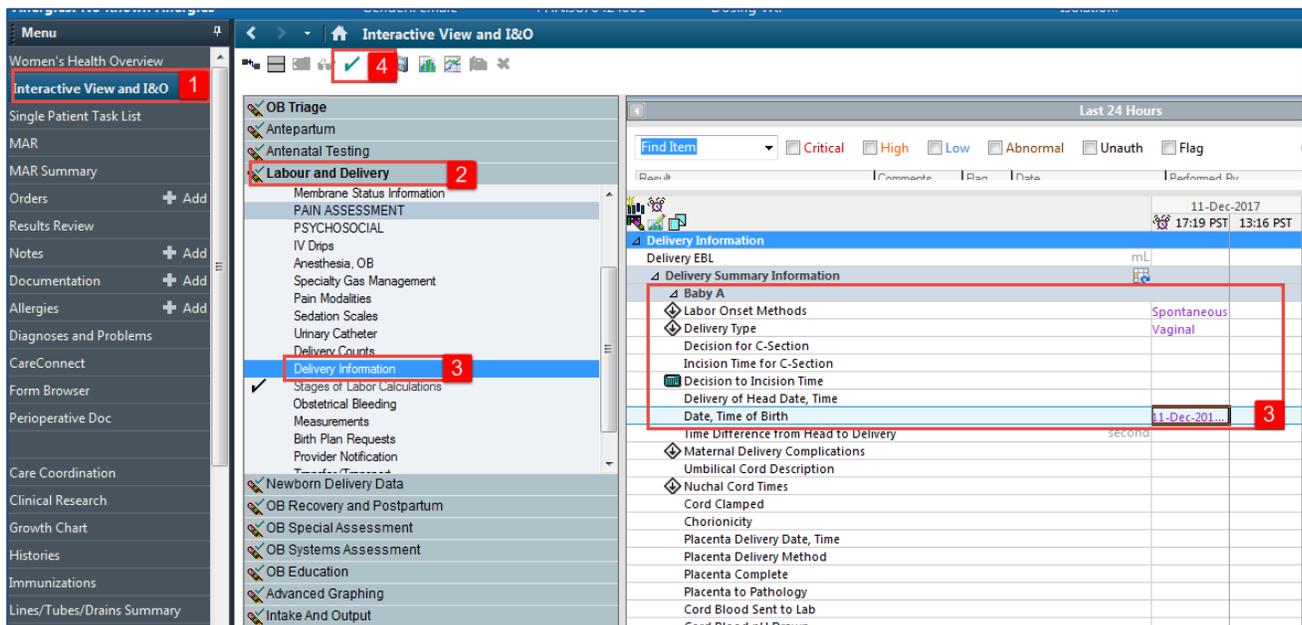
As an inpatient nurse you will be completing the following activities:

- Document delivery data in iView.
- Quick Register a newborn

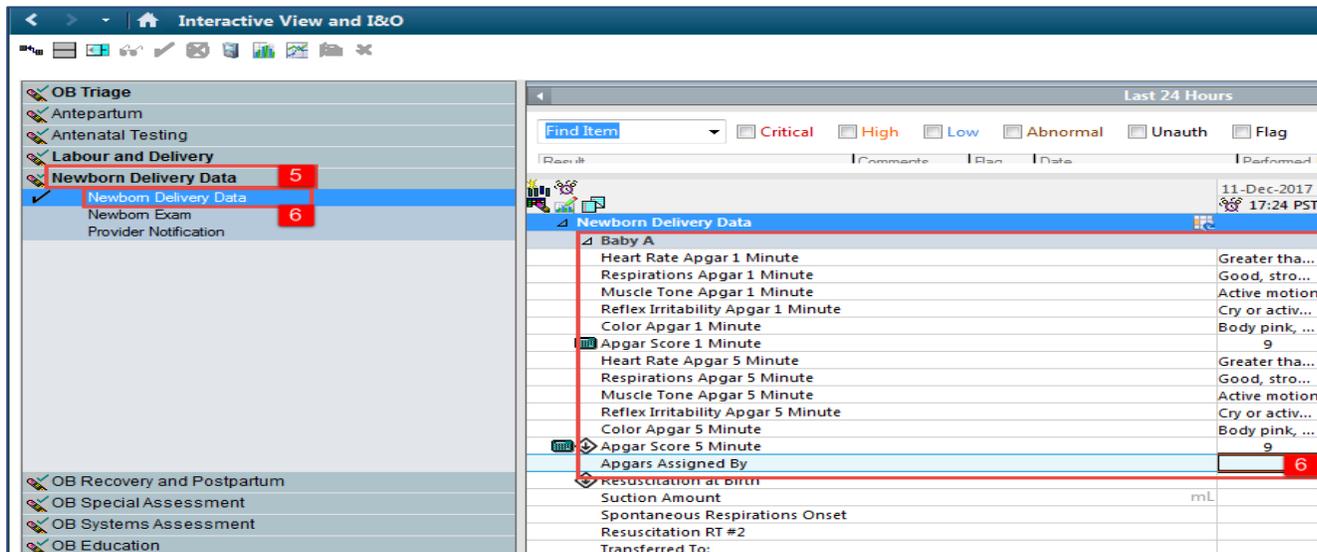
## Activity 10.1 – Document Delivery Information (iView)

1 For the purposes of this classroom exercise, you will only be documenting in a few fields in iView. In real practice, it is important to make documentation as complete as possible since iView documentation flows to the Provider’s Documentation as well as to the Labour and Birth Summary Record, the Newborn Record and Tracking Shell.

1. Navigate to **Interactive View and I&O** from the menu.
2. Click on the **Labour and Delivery** iView band.
3. Scroll down to and click on the **Delivery Information** section. This is where you will document your delivery data. Document the following for Baby A:
  - Labour Onset Methods = *Spontaneous*
  - Delivery Type = *Vaginal*
  - Date, Time of birth: *Today/0800*
4. Click the green check mark to sign your documentation.



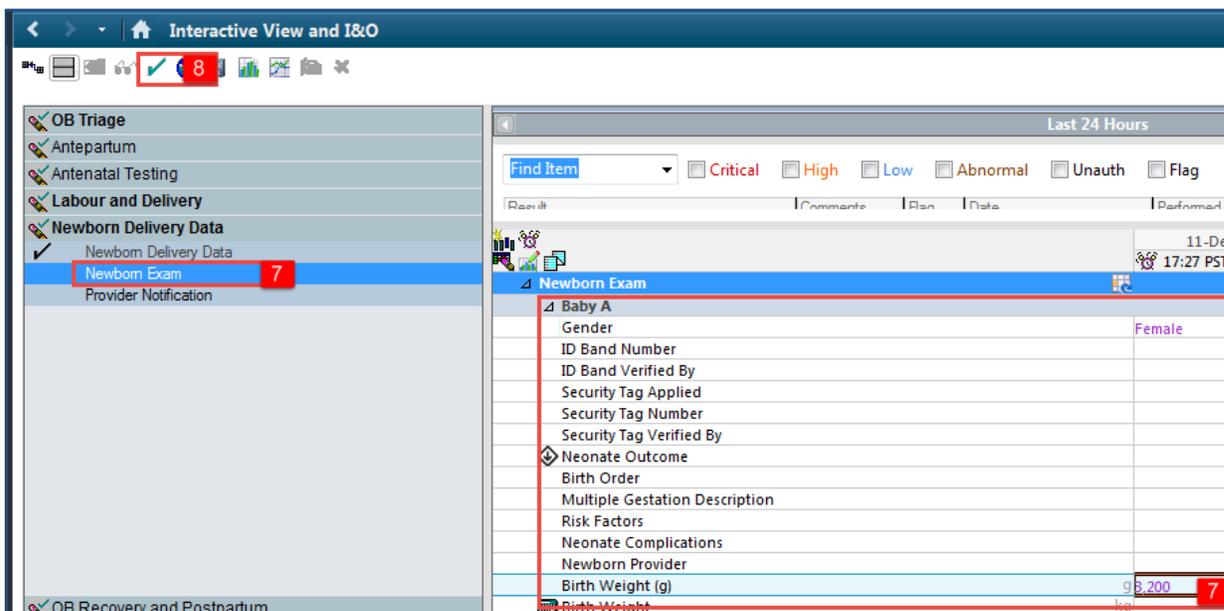
5. Now navigate to the **Newborn Delivery Data** iView band.
6. Click on the **Newborn Delivery Data** section and document the following for Baby A:
  - Heart Rate Apgar 1 Minute = *Greater than 100 beats per minute*
  - Respirations Apgar 1 Minute = *Good, strong cry*
  - Muscle Tone Apgar 1 Minute = *Active motion*
  - Reflex Irritability Apgar 1 Minute = *Cry or active withdrawal*
  - Color Apgar 1 Minute = *Body pink, extremities blue*
  - Apgar score 1 Minute (autocalculation) = 9



7. Now click on the **Initial Newborn Exam** section and document the following:

- Gender = *Female*
- Birth Weight (g) = 3200

8. Click the Green Check Mark to sign your documentation.



Your patient has delivered a baby girl vaginally with APGARs of 9 and weight= 3200g!

**Note:** The Delivery Information/Newborn Delivery Data/Initial Newborn Exam sections are shared iView sections with OB Providers. Some fields will be completed by nurses and some fields will be completed by providers.

**Note:** The newborn delivery documentation including gender, APGARs, weight, length, and head circumference are documented in the *mom's* chart and then result copied into the newborn's chart (you will learn more about Result Copy later).

**Note:** For a multiples birth, you will need to document delivery information and newborn delivery data for Baby A and Baby B (etc.) separately.

### Key Learning Points

- Newborn delivery data can be documented in iView by providers and nurses
- Newborn delivery data is documented in the mom's chart and then result copied into the newborn's chart

## Activity 10.2 – Quick Registering the Newborn

- 1 Once a baby is born, it is necessary to register the baby into the CIS. The first step is to Quick Register the Newborn, which is what you will do as a nurse. The registration clerk will be responsible for doing Full Registration in the CIS (this can be done after Quick Registration).

Completing **Newborn Quick Reg** (Registration) will create an electronic chart for the baby. Orders cannot be placed for the newborn (since the chart does not exist yet) if the newborn quick registration has not been completed.

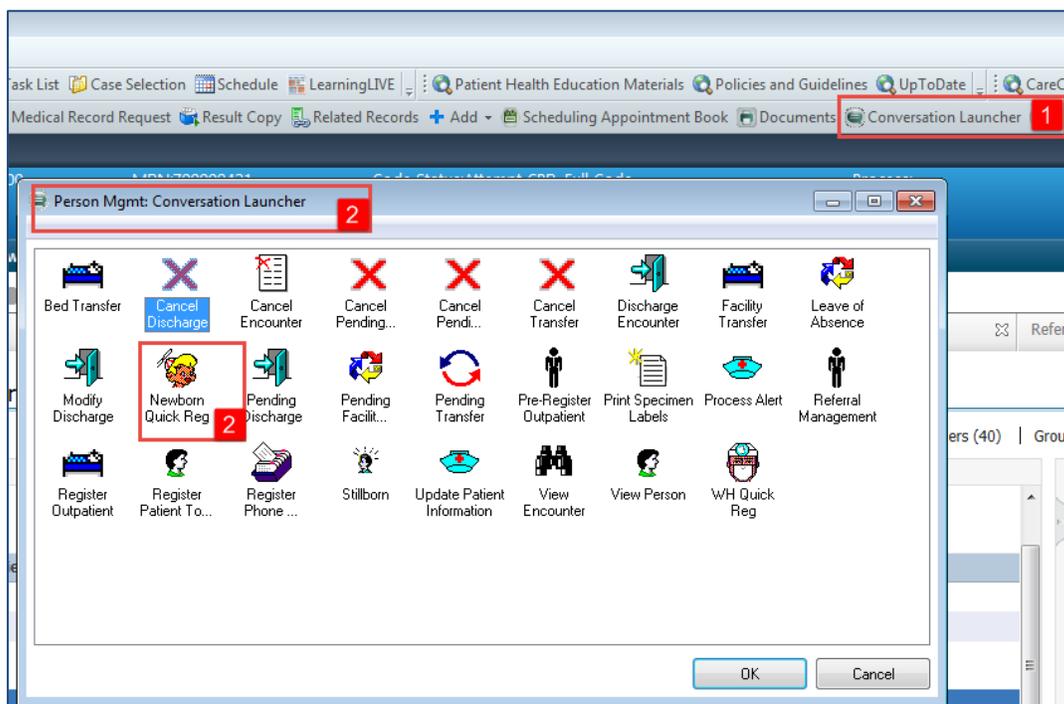
The newborn must be quick registered prior to transferring mom and baby to the postpartum unit.

Let's practice completing the **Newborn Quick Registration**:

1. Click on the **Conversation Launcher**  on the Toolbar.

**Note:** If unable to see this on your tool bar, click the down arrow  on the far right of the toolbar to see more options.

2. The **Person Mgmt: Conversation Launcher** window opens. Double click on the **Newborn Quick Reg** icon



3. The **Encounter Search** window opens. Type in the patient's (mother's) Encounter number (located in the Banner bar) in the "Encounter #" field. Note: You can also search using three patient identifiers; first name, last name and DOB.

4. Click on the Search button.
5. Your patient's name will populate on the right. Verify the details to ensure you have the correct patient.
6. Click on the correct Inpatient Encounter type
7. Click on the **OK** button

27-Nov-2000      MRN:700008431      Code Status:Attempt CPR, Full Code      Process:  
17 years      Enc:7000000015645      3      Disease:  
der:Female      PHN:9876424061      Dosing Wt:      Isolation:

**Encounter Search** 3

VIP	Deceased	Alerts	BC PHN	MRN	Name	DOB	Age	Gender	Address	A
2			9876424061	700008431	MATTEST, ICONS	27-Nov-2000	17 Years	Female	509 8th st W	5

Facility	Encounter #	Visit #	Enc Type	Med Service	Unit/Clinic	Room	Bed	Est Arrival Date
LGH Lions Gate	7000000015645	7000000015645	Inpatient	Obstetrics	LGH LD	LDR5	01M	6

Encounter #: 7000000015645 3

Visit #:

Historical MRN:

Search 4

OK 7 Cancel Preview...

8. The External MPI (EMPI) window opens with a **Newborn Request PHN**. Enter the following information:
  - Sex = *Female*
  - Baby last name = *autopopulates with the mother's last name*
  - Baby first name = *autopopulates with Baby Girl (based on selection from Sex field)*
  - Date of birth = *Today's Date*
  - Birth time = *0800*

9. Click **Submit**

**Note:** For multiple births, you must check off the Multiple births box and select a letter corresponding to the Baby's birth order. This field must be left blank for singletons.

A **Newborn Quick Reg: Newborn 1 of 1** window will pop up. Fill in all the following fields:

10. **First Name:** *for the purposes of this classroom workbook, re-name Baby Girl to a unique first name*
11. **Multiple Birth:** *No*
12. **Unit/Clinic:** *LGH Labour and Delivery*
13. Click **Bed Availability**

The screenshot shows a 'Newborn Quick Reg: Newborn 1 of 1' window. At the top, a message says 'The PHN Request was successful'. The form is divided into several sections:
 

- Patient Information:** Medical Record Number (700020913), Encounter Number, Gender (Female), Last Name (RYDER), First Name (BABY GIRL), Middle Name, Date of Birth (16-Feb-2018), Birth Time (13:22), Age (0H), BC PHN (9876296196).
- Multiple Birth?:** No (with a red '11' next to it).
- Mother's Information:** Medical Record Number (700020917), Last Name (RYDER), First Name (RAPUNZEL), Middle Name, Date of Birth (14-Feb-1978).
- Newborn Encounter Info:** Encounter Type (Newborn), Medical Service, Reason for Visit (NEWBORN).
- Location:** Building (SGH Squamish), Unit/Clinic (SGH MAT), Room (116), Bed (02B). A red box highlights 'SGH MAT' and a tooltip for 'Bed Availability' is shown.
- Care Providers:** Admitting Provider (Plevca, Rocco, MD), Attending Provider (Plevca, Rocco, MD), Primary Care Provider (PCP) (Plevcl, Antonio, MD).
- Account Data:** Registration Date (16-Feb-2018), Registration Time (13:22), Patient Admit Date (16-Feb-2018), Patient Admit Time (13:22), Newborn Quick Reg User Name (TestUser, Rural-Nurse).
- Comment:** A large empty text area for notes.

 At the bottom right, there are 'OK' and 'Cancel' buttons. The status bar at the bottom shows 'Ready' and 'P0783: TEST.NURSE.RURAL: 16-Feb-2018: 13:59'.

A **Bed Availability** window will open.

14. Search for the room that the mother is admitted into. She will be in a **M** bed.
15. Select an available baby bed (not assigned or dirty) that corresponds with the mother's room number. For a singleton this should be **A** bed.

**Note:** Choose Bed A for Baby A. (If there are multiples, you would choose Bed B for Baby B and Bed C for baby C). For example is Mother is in Room 116 Bed02**M**, choose room 116 Bed02**A** for Baby A.

The screenshot shows a 'Bed Availability' window with a table of rooms and beds. The table has columns for Room, Bed, Nurse Unit, Isolation, Person, Bed Status, In, Out, Gender, MRN, and En. Red boxes and arrows highlight specific rows:
 

- A red box labeled 'Baby A' with a red '15' points to the row for Room 117, Bed 01A, SGH MAT, which is marked as 'Dirty'.
- A red box labeled 'Mom' with a red '14' points to the row for Room 116, Bed 02B, SGH MAT, which is marked as 'Assigned' and occupied by 'RYDER, RAPUNZEL'.
- Another red box labeled 'Mom' with a red '14' points to the row for Room 116, Bed 02M, SGH MAT, which is marked as 'Assigned' and occupied by 'MATERNITY, DEMO'.
- The 'OK' button at the bottom right is highlighted with a red box and labeled '16'.

Room	Bed	Nurse Unit	Isolation	Person	Bed Status	In	Out	Gender	MRN	En
116	02B	SGH MAT			Available					
116	02C	SGH MAT			Available					
116	02M	SGH MAT		RYDER, RAPUNZEL	Assigned			Female	700002017	70
117	01A	SGH MAT			Dirty					
117	01B	SGH MAT			Available					
117	01C	SGH MAT			Assigned					70
117	01M	SGH MAT		MATERNITY, DEMO	Available			Female	700009081	70
118	01A	SGH MAT			Available					
118	01B	SGH MAT			Available					
118	01C	SGH MAT			Available					
118	01M	SGH MAT			Available					
CR1	01A	SGH MAT			Assigned					

- 16. Click **OK**
- 17. **Admitting Provider:** *Plisvca, Rocco.*
- 18. **Attending Provider:** *Plisvca, Rocco.*
- 19. Click **OK**

The screenshot shows a web-based form titled "Newborn Quick Reg: Newborn 1 of 1". The form is divided into several sections: "Medical Record Number" (700020913), "Encounter Number", "Gender" (Female), "Last Name" (RYDER), "First Name" (BABY GIRL), "Date of Birth" (16-Feb-2018), "Birth Time" (13:22), "Age" (0H), and "BC PHN" (9876296196). Below these are fields for "Multiple Birth?", "Birth Order", and "Adoption/Surrogacy?". The "Mother's Information" section includes "Medical Record Number" (700002017), "Last Name" (RYDER), "First Name" (RAPUNZEL), and "Date of Birth" (14-Feb-1978). The "Newborn Encounter Info" section has "Encounter Type" (Newborn), "Medical Service" (Newborn), and "Reason for Visit" (NEWBORN). The "Location" section includes "Building" (SGH Squamish), "Unit/Clinic" (SGH MAT), "Room" (116), and "Bed" (02B). The "Care Providers" section has "Admitting Provider" (Plisvca, Rocco, MD), "Attending Provider" (Plisvca, Rocco, MD), and "Primary Care Provider (PCP)" (Plisvl, Antonio, MD). The "Account Data" section includes "Registration Date" (16-Feb-2018), "Registration Time" (13:22), "Patient Admit Date" (16-Feb-2018), "Patient Admit Time" (13:22), and "Newborn Quick Reg User Name" (TestUser, Rural-Nurse). A "Comment" field is at the bottom. At the bottom right, there are "OK" and "Cancel" buttons. A status bar at the bottom left says "Ready" and the bottom right says "P0783 TEST NURSERURAL 16-Feb-2018 13:59".

20. The Document Selection window opens. This window provides options to print Armband labels, Lab Blood Specimen Labels, and Lab Non-Blood Specimen Label. In practice, you would click OK to print the documents. However in class, because you are not synced with a printer, please select **Do not print documents** and click **OK**.

The screenshot shows a "Document Selection" window. It contains a table with the following data:

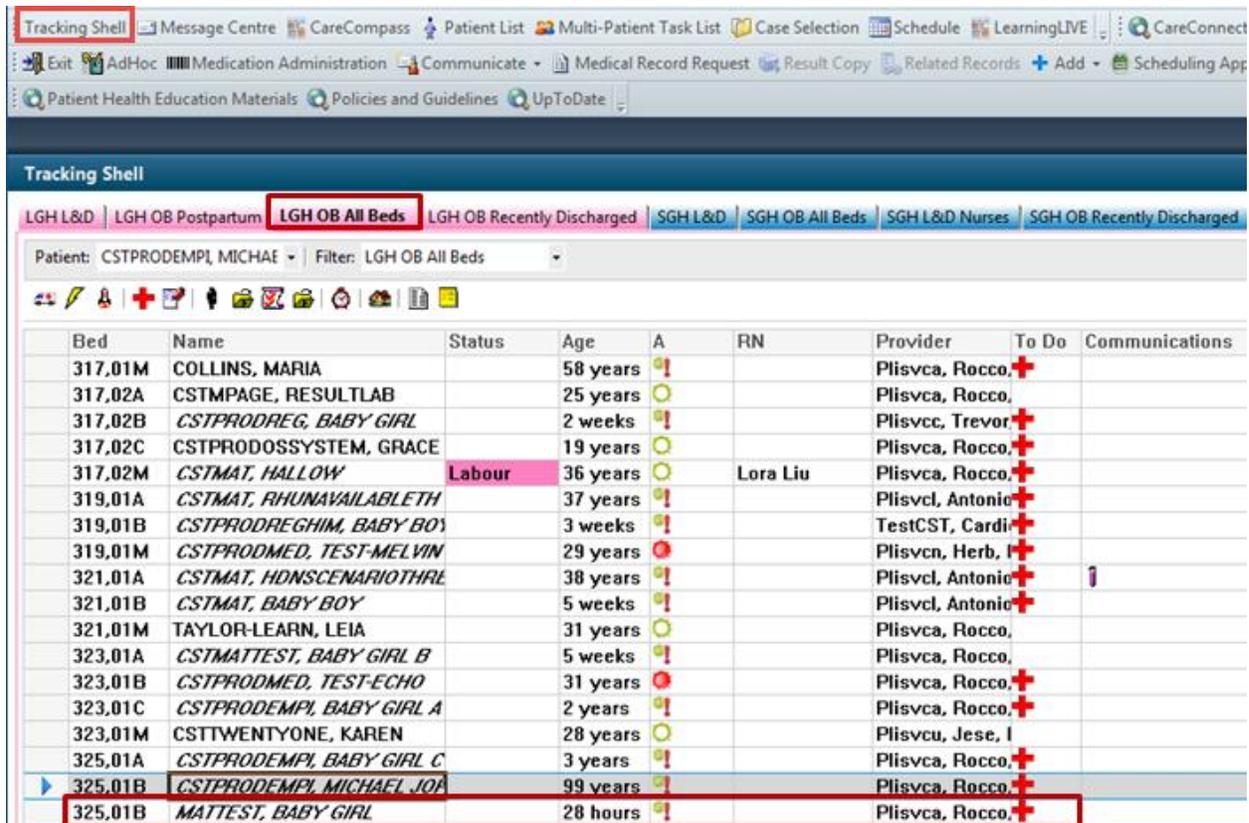
Document	Printer	Copies
<input checked="" type="checkbox"/> Newborn Armband Label	590_1stfl_t9	1

At the bottom of the window, there is a checkbox labeled "Do not print documents" which is checked. To its right is a red box with the number "20". Further right is an "Edit" button, and to its right is an "OK" button with a red box and the number "20".

The baby has now been quick registered!

To see the baby on the **Tracking Shell**, click on the Tracking Shell button on the Toolbar. Select the **LGH OB All Beds** location tab (remember that only the OB All Beds tab shows baby beds).

**Refresh**  the screen. Your baby should appear on the Tracking Shell in the bed that you placed them in.



Bed	Name	Status	Age	A	RN	Provider	To Do	Communications
317,01M	COLLINS, MARIA		58 years	!		Plisvca, Rocco	+	
317,02A	CSTMPAGE, RESULTLAB		25 years	!		Plisvca, Rocco		
317,02B	CSTPRODREG, BABY GIRL		2 weeks	!		Plisvcc, Trevor	+	
317,02C	CSTPRODOSSYSTEM, GRACE		19 years	!		Plisvca, Rocco	+	
317,02M	CSTMAT, HALLOW	Labour	36 years	!	Lora Liu	Plisvca, Rocco	+	
319,01A	CSTMAT, RHUNAVAILABLETH		37 years	!		Plisvcl, Antonio	+	
319,01B	CSTPRODREGHIM, BABY BOY		3 weeks	!		TestCST, Cardi	+	
319,01M	CSTPRODMED, TEST-MELVIN		29 years	!		Plisvca, Herb	+	
321,01A	CSTMAT, HDNSCENARIOOTHR		38 years	!		Plisvcl, Antonio	+	
321,01B	CSTMAT, BABY BOY		5 weeks	!		Plisvcl, Antonio	+	
321,01M	TAYLOR-LEARN, LEIA		31 years	!		Plisvca, Rocco		
323,01A	CSTMATTEST, BABY GIRL B		5 weeks	!		Plisvca, Rocco		
323,01B	CSTPRODMED, TEST-ECHO		31 years	!		Plisvca, Rocco	+	
323,01C	CSTPRODEMPI, BABY GIRL A		2 years	!		Plisvca, Rocco	+	
323,01M	CSTTWENTYONE, KAREN		28 years	!		Plisvca, Jese, I		
325,01A	CSTPRODEMPI, BABY GIRL C		3 years	!		Plisvca, Rocco	+	
325,01B	CSTPRODEMPI, MICHAEL JOE		99 years	!		Plisvca, Rocco	+	
325,01B	MATTEST, BABY GIRL		28 hours	!		Plisvca, Rocco	+	

**Note:** After a baby has been quick registered, the OB unit clerk or Registration Clerk needs to be notified to perform a full registration on the baby.

### Key Learning Points

-  Newborns need to be Quick Registered in order to create an electronic chart for the baby (separate to the mother's chart)
-  Newborn Quick Registration can be completed through the Conversation Launcher.
-  Mothers are placed in beds with the letter M. Baby A should be placed in the corresponding room as the mother in a bed with the letter A. Baby B will be placed in a bed with the letter B and so on.
-  Newborn Quick Registration is required prior to the baby being transferred to a different unit.

## PATIENT SCENARIO 11 – Result Copy, Related Records, Transfer

### Learning Objectives

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

-  Result Copy from the mother's chart to the baby's chart.
-  Access related records
-  Transfer mother and baby from Labour & Delivery to Postpartum

### SCENARIO

In this scenario, we will learn how to result copy from the mother's chart to the baby's chart. We will learn of when to use the result copy function.

As a rural inpatient OB nurse you will be completing the following activities:

-  Result copy from the mother's chart to the newborn's chart, prior to transfer.
-  Access related records
-  Result copy from the mom's chart to the newborn's chart must be done at the following times (at minimum):
  1. After the baby has been quick registered
  2. When the mom and baby is being transferred from labour to postpartum
  3. Prior to the mom and baby being discharged from the hospital.

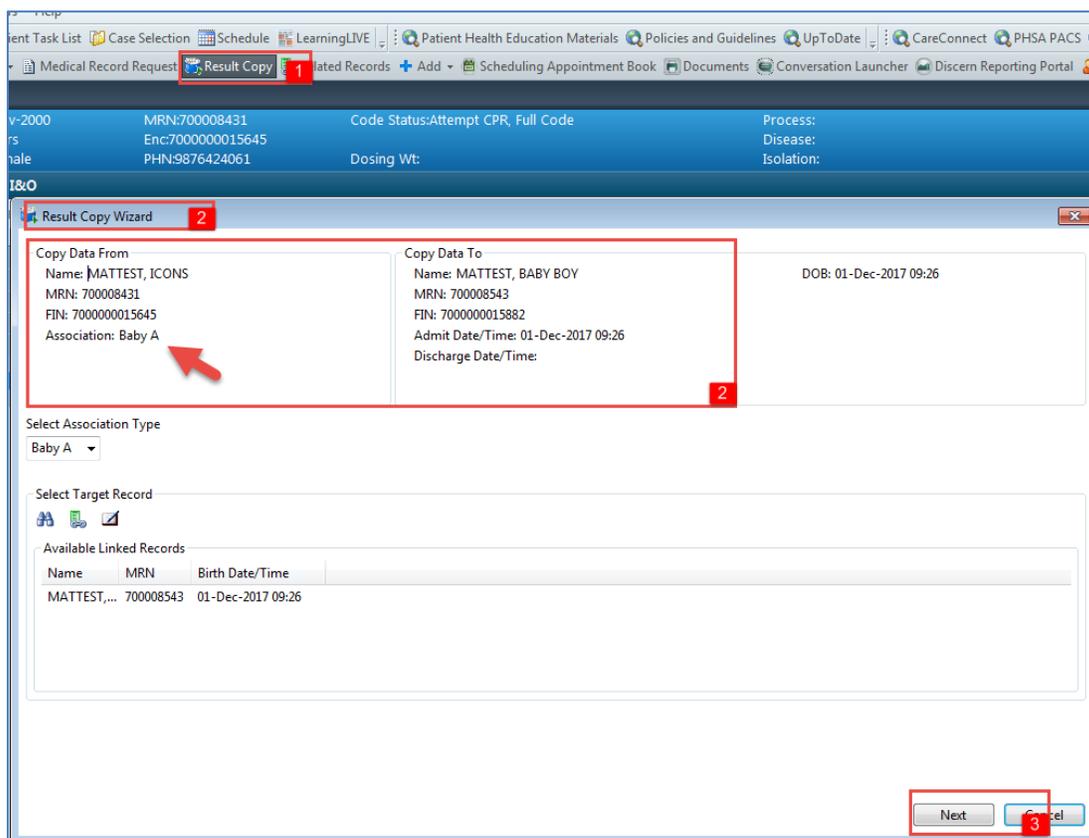
## Activity 11.1 – Result Copy

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

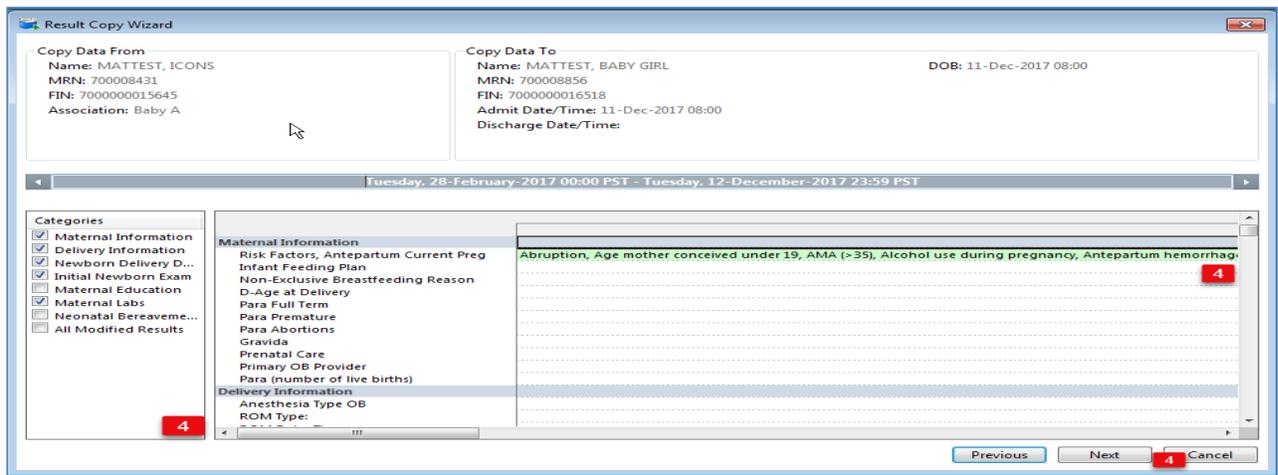
1. From the mom's chart, click the **Result Copy**  in the Toolbar.
2. The **Result Copy Wizard** window opens. Check to ensure the demographic information is correct for both the mom (in the Copy Data From box) and her newly quick registered newborn (in the Copy Data To box).

**Note:** for multiples, ensure the **Association Type** field under the Copy Data From box is referring to the correct Baby.

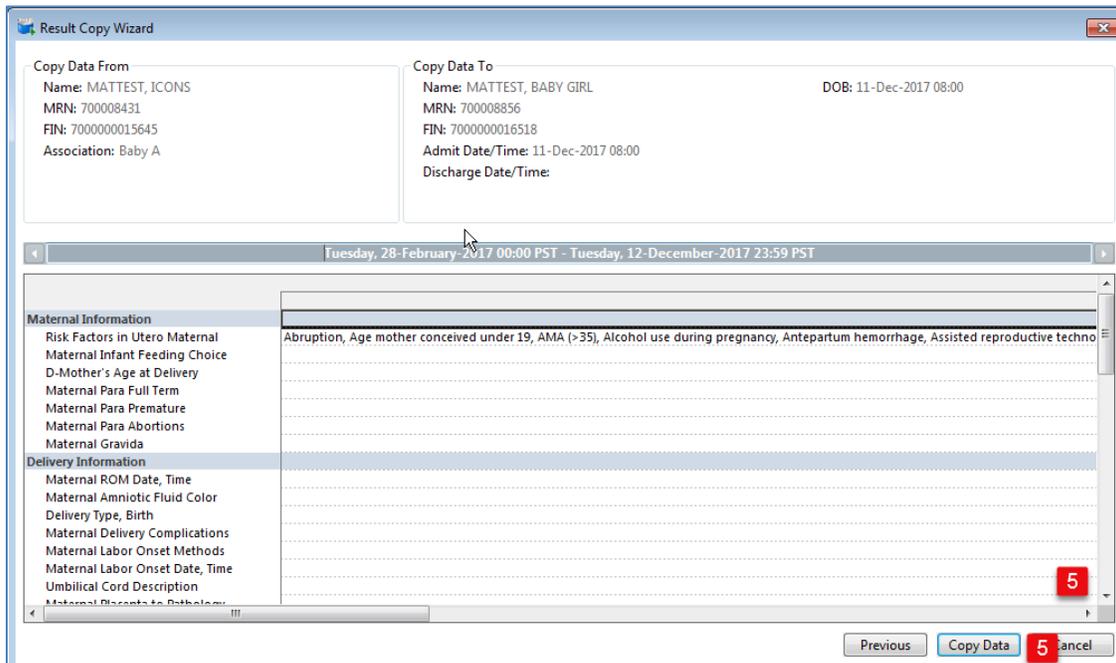
3. Select **Next**.



4. Any information that is highlighted green is newly documented information that will be copied over to the baby's chart. Select **Next**.



5. Information that will be copied over will show up once more; verify it is accurate and click **Copy Data**



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

**Note:** Result Copy can be done at any time during nursing documentation, however, at a minimum, it should **always** be done at the following times in order for appropriate information to be viewable in the newborn chart (and therefore facilitate appropriate care):

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

Now that you have created an electronic chart for the baby (via Newborn Quick Reg) and you have performed result copy to copy pertinent delivery information from the mom's chart to the baby's chart, you can document on the baby.

**Note:** Shortly after a baby is born, the nurse needs to complete the Newborn Admission History PowerForm.

### Key Learning Points

- Result copy allows you to copy documented information from mom's chart over to the newborn's chart.
- Result copy must be performed at the follow 3 times (at minimum):
  1. When the newborn has been quick registered
  2. When mom and baby are being transferred from labour to postpartum
  3. When mom and baby are being discharged from the hospital

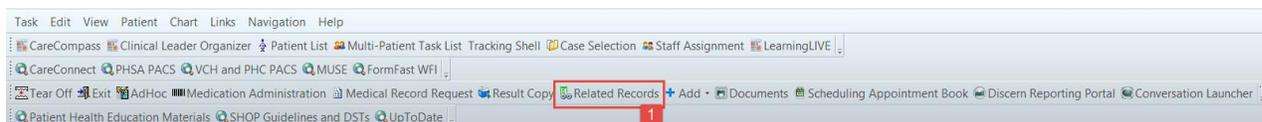
## Activity 11.2 – Related Records

- 1 The **Related Records** function acts as a link and can be used to find and open a chart of a related patient. For example, if you are in a mom's chart and you wish to quickly find and open her baby's chart, you can use the Related Records function.

Let's practice using **Related Records** to open a baby's chart:

1. From the mom's chart, click on the **Related Records**  from the Toolbar.

**Note:** If unable to see this on your tool bar, click the down arrow  on the far right of the toolbar to see more options.



2. If this is your first time accessing the newborns chart, you will first be prompted to establish a relationship to the baby. Select Nurse. Click **OK**



3. The Encounter Selection window will open. Select the correct encounter (note that because the newborn only has one encounter, it will already be selected). Click on the X icon  to close the window.

Encounter Type	Location	Admit Date	Discharge Date	Encounter #
Newborn	LGH LD LDR5 01A	01-Dec-2017 09:26 PST		7000000015882

4. The baby’s chart will open to the **Patient Summary** page.

**Patient Summary**

**RYDER, BABY A** | DOB: 22-Feb-2017 | MRN: 700002103 | Code Status: | Process: | Location: LGH LD: LDR4: 01A  
 Age: 11 months | Enc: 7000000003305 | Disease: | Enc Type: Newborn  
 Gender: Female | PHN: | Dosing Wt: | Isolation: | Attending:

**Allergies: Allergies Not Recorded**

**Informal Team Communication**

Active Issues: No actions documented

**Allergies (0)**

Allergies not recorded. Add an allergy.

5. Click on the **Women’s Health Overview** from the menu and the **Neonate Overview** tab will be defaulted open.



## Activity 11.3 – Bed Transfer

- The mother and the baby will need to be transferred from Labour & Delivery (L&D) bed to a Postpartum bed within the system. This can be done by a nurse or unit clerk.

To perform a bed transfer:

- Navigate to the **Tracking Shell** from the toolbar, and click the **LGH L&D** tab
- Click to highlight your patient to be transferred
- Click on the **Conversation Launcher** (rocketship) icon in tracking shell and select **Bed Transfer**

The screenshot shows the 'Tracking Shell' interface. The 'LGH L&D' tab is selected. A patient is highlighted in blue, and the 'Bed Transfer' button (rocketship icon) is highlighted with a red box and the number '3'. The patient list table is as follows:

Bed	Encounter	YORK	G	P	EGA	Status	A	RN	Provider	Consult	Dil	Length	Sta	ROM	Color	GBS	Epidural	To Do	Communications	NR	Lab	MAR
LDL02M	Discharge Encounter	YORK							Plisvca, Rocco,		10*			Sponta		U		+				2
LDL03M	CSTIMAI GOLIVE, APRIL 1*								Plisvcl, Antonio									+				5/0
LDL04M	CSTLABSOBB, RHIGM 1*								PITVCAD, Arche													3/0
LDR1_01M	*****		1*		33 2/7				TestMAT, OBGYN							N		+				7/2
LDR2_01M	CSTLABSOBB, RHIGO								Plisvcl, Antonio							N						3/0
LDR3_01M	CSTMATPROD, LABOU		1*						Plisvca, Rocco, Berard, Vera		10*	1.5 cm*-1*		Sponta Clear*		P		R				3/0 8
LDR4_01M																						
LDR5_01M	CSTMATPROVIDERS, 2* 0*								Plisvca, Rocco,		10*	0 cm* -1*		Sponta Clear*		P	Administered*					3/0 4
LDR6_01M	CSTMATTEST, SUSAN 1*								Plisvca, Rocco,													5/0 2
LDR7_01M	CSTLABSOBB, WIGMG								Plisvcl, Antonio													6/3
LDR8_01M	CSTMAT, BETTY		1* 1*						Plisvca, Rocco,									+				
LDR8_02M	CSTLABSOBB, BABY								Plisvca, Rocco,													

The Bed Transfer Window will open:

- Complete all the yellow required field:
  - Unit/Clinic = *LGH 3W*
  - Accommodation = *Not Applicable*
  - Transfer Date = *T* (for today)
  - Transfer Time = *N* (for now)
- Click on the **Bed Availability** button
  - All available beds will show as empty. Ensure you select an available “M” bed for the mother (and a corresponding available “A” bed for Baby A as you will have to perform bed transfer on the newborn after).

6. After you have completed all the yellow required fields, click on the **Complete** button.

7. Refresh  19 minutes ago the screen. Your patient should now appear in the new bed on the Tracking Shell.

**Note:** Ensure you are in the appropriate tab on the Tracking Shell to see your patient.

8. Repeat Steps 1 to 6 to transfer the newborn. Note: Be sure to transfer newborn into the same room as the mother, in a “A” bed.

The mother and newborn are now transferred!

### Key Learning Points

-  Mother and baby charts must be transferred from Labour & Delivery to Postpartum unit
-  Steps must be repeated for both mom and baby charts
-  Ensure baby is transferred to the same room as the mother

## **■ PATIENT SCENARIO 12 – Create Patient Lists to Manage Post-Partum Patients and Newborns**

### **Learning Objectives**

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

- Set up a location patient list
- Create a custom patient list

### **SCENARIO**

Now that your patient has delivered, mom and baby will be transferred to the postpartum unit. You will now use CareCompass to manage your workflow and tasks for these patients in the CIS (rather than Tracking Shell), but first you need to set up your patient lists.

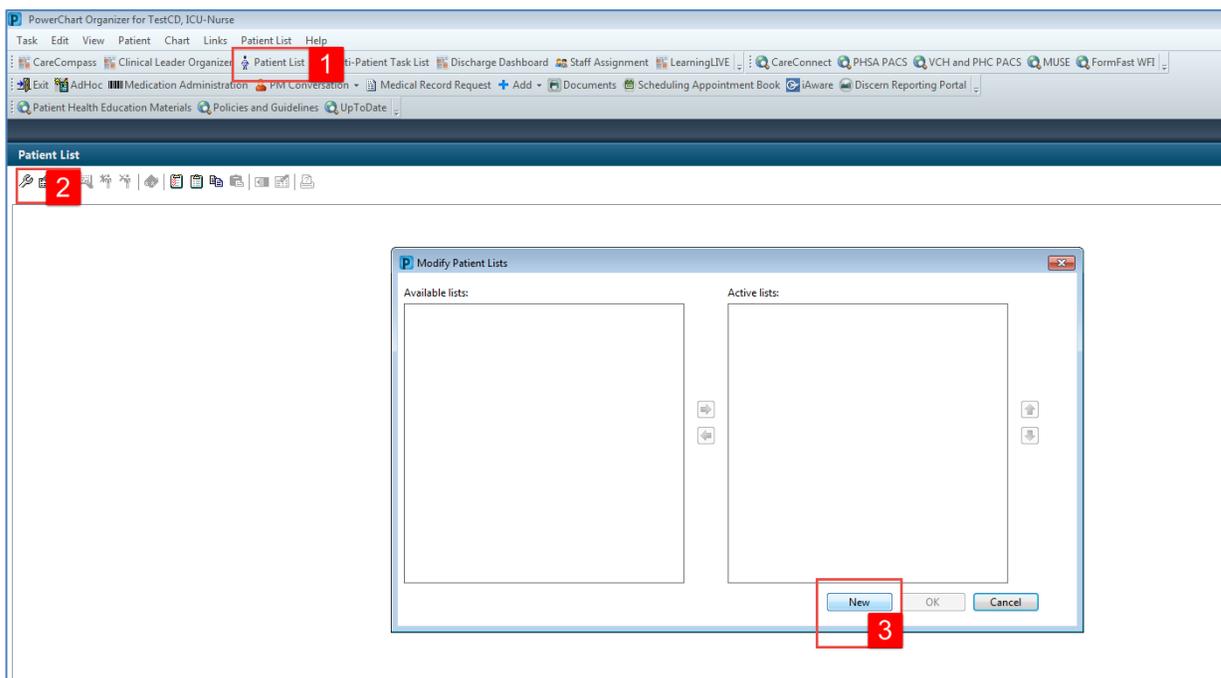
As a rural inpatient nurse looking after postpartum patients, you will be completing the following activities:

- Set up a location patient list
- Create a custom patient list

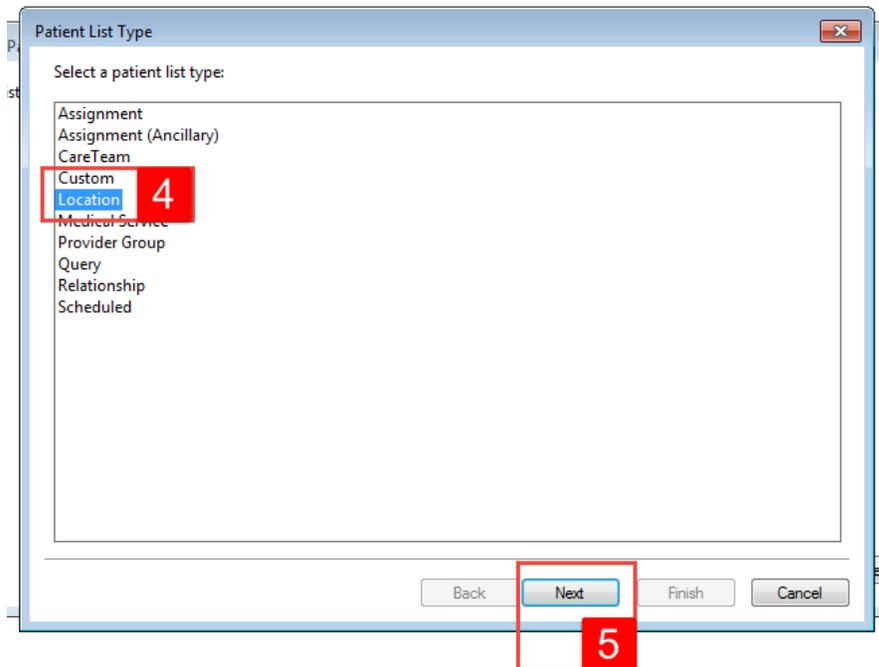
## Activity 12.1 – Set Up a Location Patient List

1 Once mom and baby are transferred to the postpartum unit, you will create a **Location List** that will consist of all the patients assigned to that unit. Once you have created your list in the system, it will remain on your account without the need to recreate it each shift.

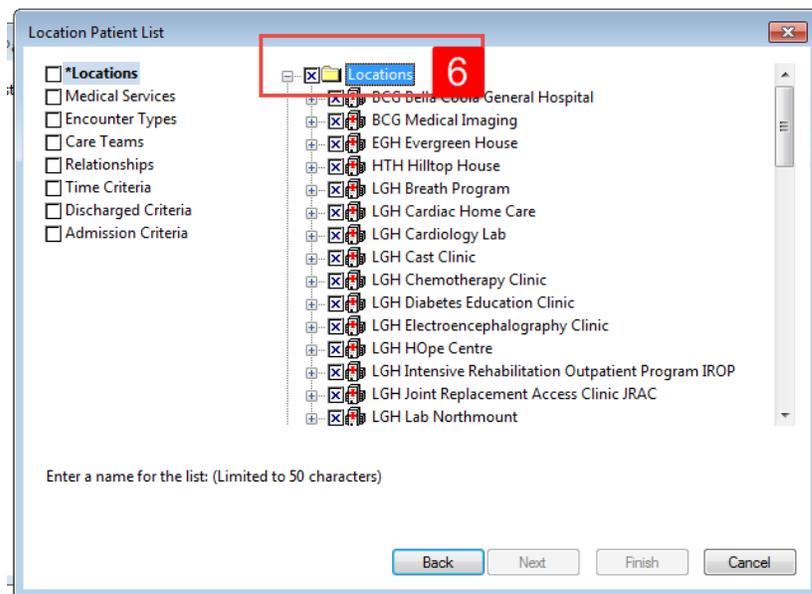
1. Select the **Patient List** icon  **Patient List** from the **Toolbar** at the top of the screen.
2. The screen may be blank. To create a location list, click the **List Maintenance** icon  .
3. Click the **New** button in the bottom right corner of the **Modify Patient Lists** window.



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



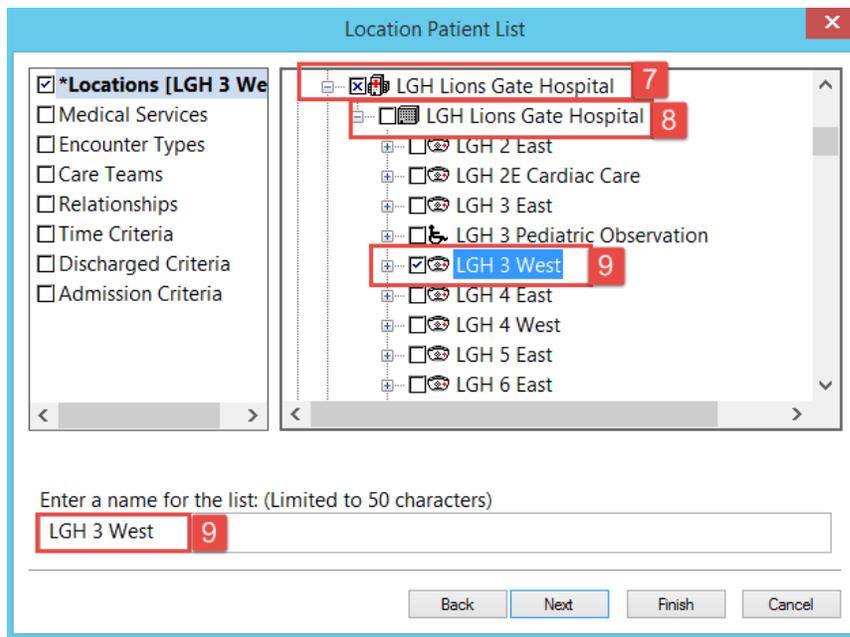
6. In the **Location Patient List** window, open the **Locations** folder by clicking the **Plus Sign**   **Locations** . A location tree will be displayed.



7. In this activity, use LGH Lions Gate Hospital as a selected location. Expand the location by clicking the **Plus Sign**:   **LGH Lions Gate Hospital**
8. Then, click the next **Plus Sign**:   **LGH Lions Gate Hospital**
9. For your practice, select **LGH 3 West** by checking the box next to the unit   **LGH 3 West** .

**Note:** Patient Lists need a name to differentiate them. Location lists are automatically named by the Location.

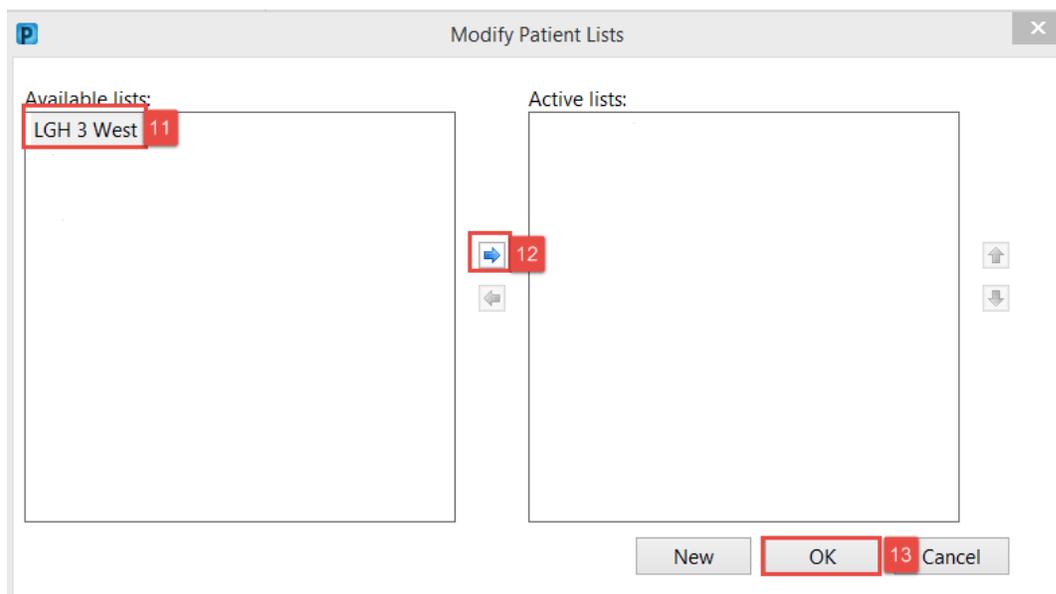
10. Click the **Finish** button  in the bottom right corner.



11. In the **Modify Patient Lists** window select a location or a unit.

12. Click the **Blue Arrow** icon  to move the selected location or unit to the **Active List** on the right side.

13. Click the **OK** button  in the bottom right corner to return to **Patient List** page. Your Location list should now appear.

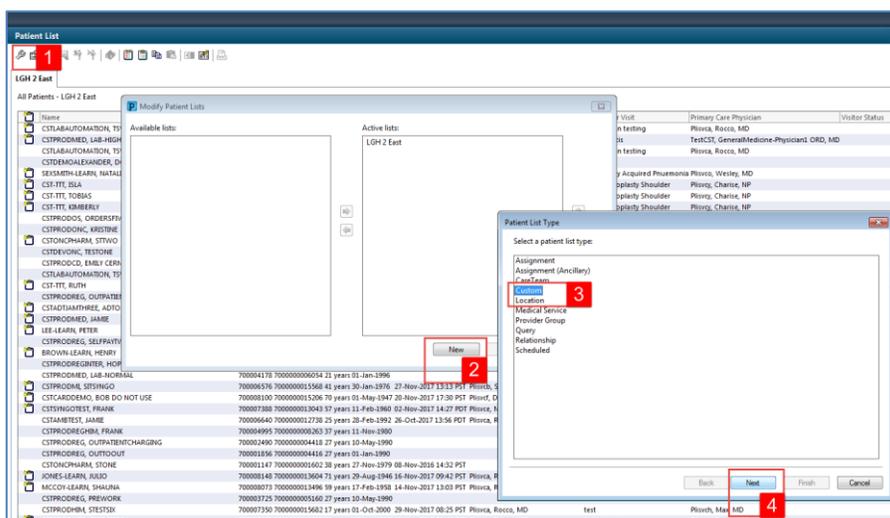


## Activity 12.2 – Create a Custom Patient List

- Next, create a **Custom List** that will contain only the patients that you are caring for, in this case your mother and baby patients.

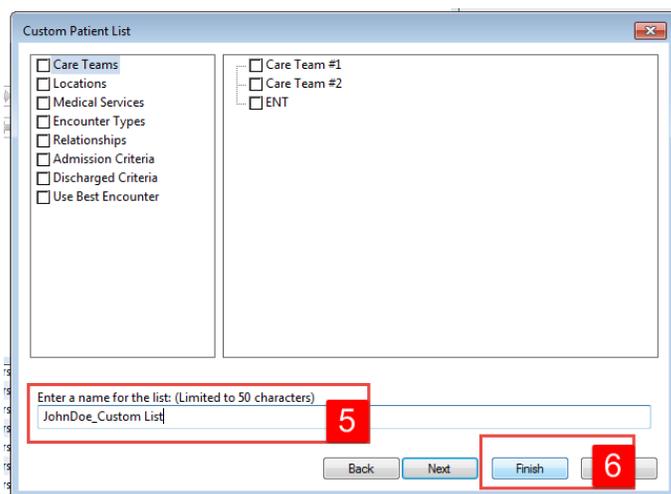
**Note:** you can also add patients that you will be covering for during your partner's break.

- To create a **Custom List**, click the **List Maintenance** icon 
- Click the **New** button in the bottom right corner of the **Modify Patient Lists** window
- Select **Custom** from the **Patient List Type** window
- Click the **Next** button

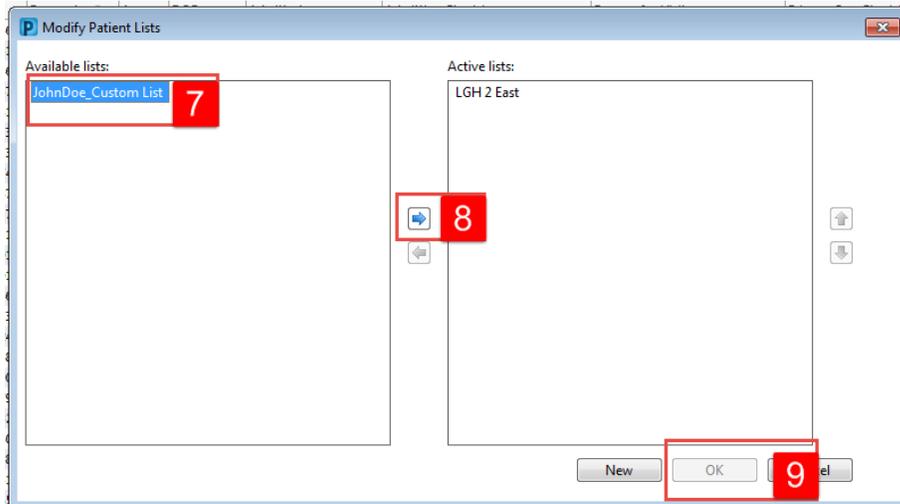


- The **Custom Patient List** window opens. In the **Enter a name for the list:** Type *YourName\_Custom* (i.e. John\_Custom)

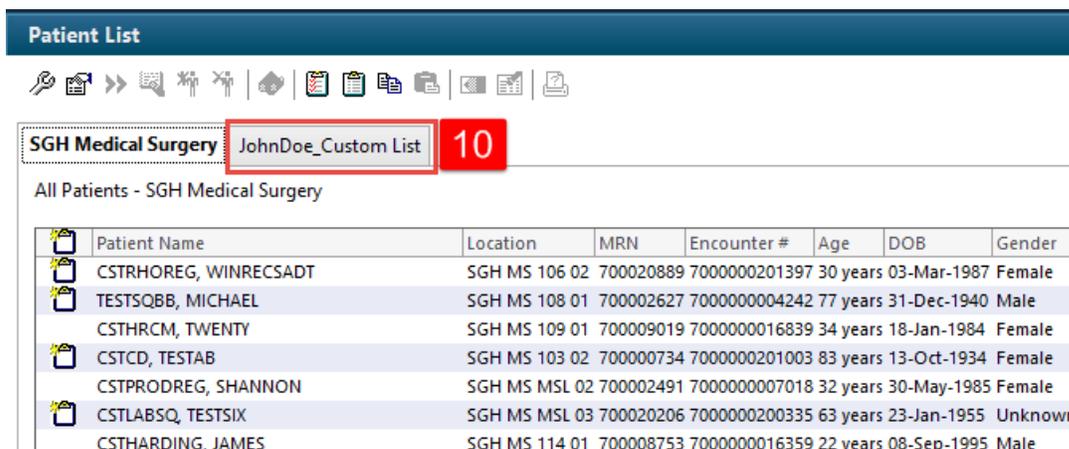
- Click the **Finish** button



7. In the **Modify Patient Lists** window select your Custom List (i.e. *YourName\_Custom*)
8. Click the **Blue Arrow** icon  to move your **Custom List** to the **Active List** on the right side
9. Click the **OK** button

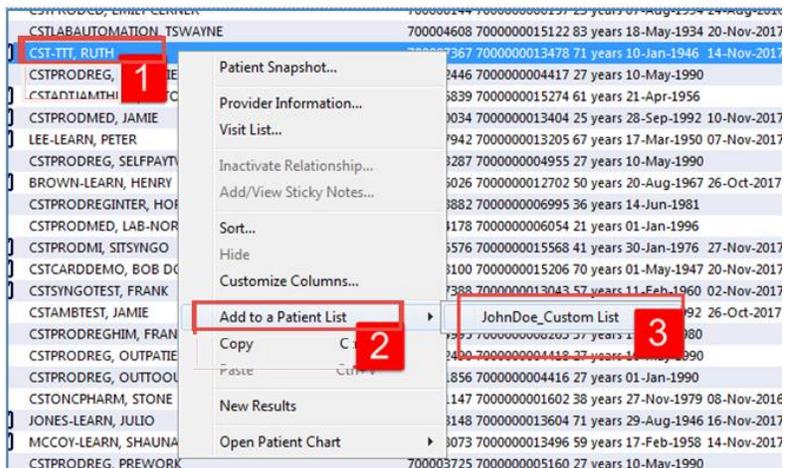


10. You will now see a tab for your Custom List



**Note:** Your custom list will be empty as you have not yet added any patients.

- 2 At the beginning of each shift or assignment change (or when your L&D patient becomes postpartum), you will need to add your patients to your custom list from your location list.
  1. From the **Patient List** window, make sure your location list tab is displayed (i.e. LGH 3 West). Find your assigned patient's name in the location list.
  2. Right click on your assigned patient's name (mother) and select **Add to a Patient List**
  3. Select **YourName\_Custom List**



**Note:** Repeat steps 1-3 for your newborn patient as well.

4. Return to **Patient List** window. Select **YourName\_Custom** tab.
5. Click the **Refresh** icon  to update the **Patient List** window.
6. Now your patient will appear in your Custom List.



**Note:** You can remove a patient from your custom list by highlighting the patient and clicking the **Remove Patient** icon  .

### Key Learning Points

- You can create a Custom List that will consist of only patients that you are caring for on your shift
- Add patients to your Custom List from a Location List – this helps to ensure you have the correct patient and the correct patient encounter
- When you are no longer caring for a patient on your custom list, you can remove the patient using the **Remove Patient** icon .

## **■ PATIENT SCENARIO 13 – Navigate to CareCompass to manage PostPartum Patients and Newborns**

### **Learning Objectives**

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

- Navigate to Care Compass
- Review tasks and complete tasks from CareCompass

### **SCENARIO**

Now that your patient has delivered, and mom and baby have been transferred to the postpartum unit, you will use CareCompass to manage your workflow and tasks for these patients in the CIS (rather than Tracking Shell),

As a rural inpatient nurse looking after postpartum patients, you will be completing the following activities:

- Navigate to CareCompass
- Review and complete tasks from CareCompass

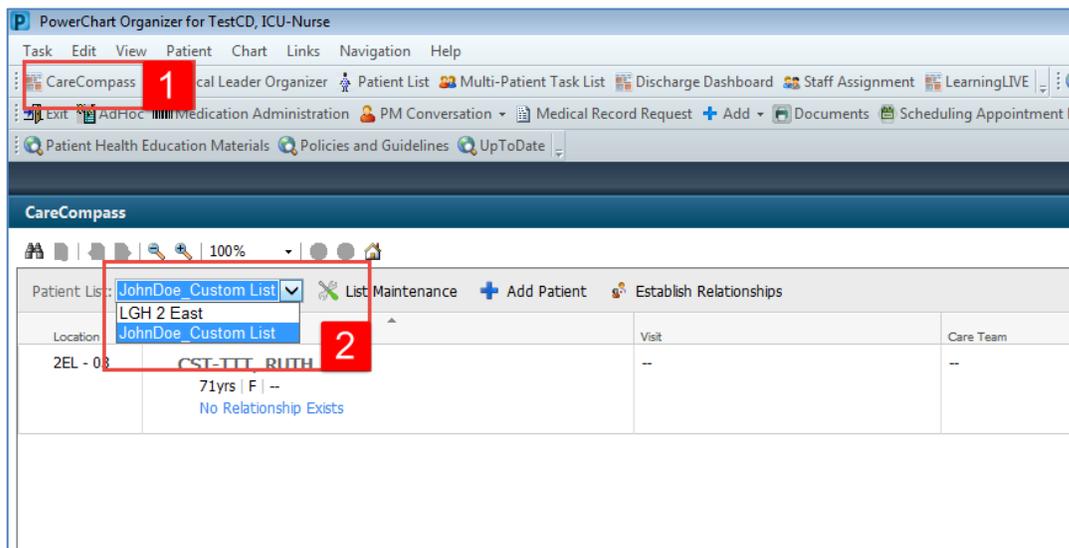
## Activity 13.1 – Navigate to CareCompass

- 1 As you learned in the Nurse- Rural Workbook, the page you land on when you log into PowerChart in the Nurse– Rural position is **CareCompass**. **CareCompass** is an interdisciplinary summary workflow that guides you, as a clinician, to organize, plan and prioritize care for your patients. CareCompass displays important details such as allergies, planned physician order sets, plans of care, resuscitation status, reason for visit, and more.

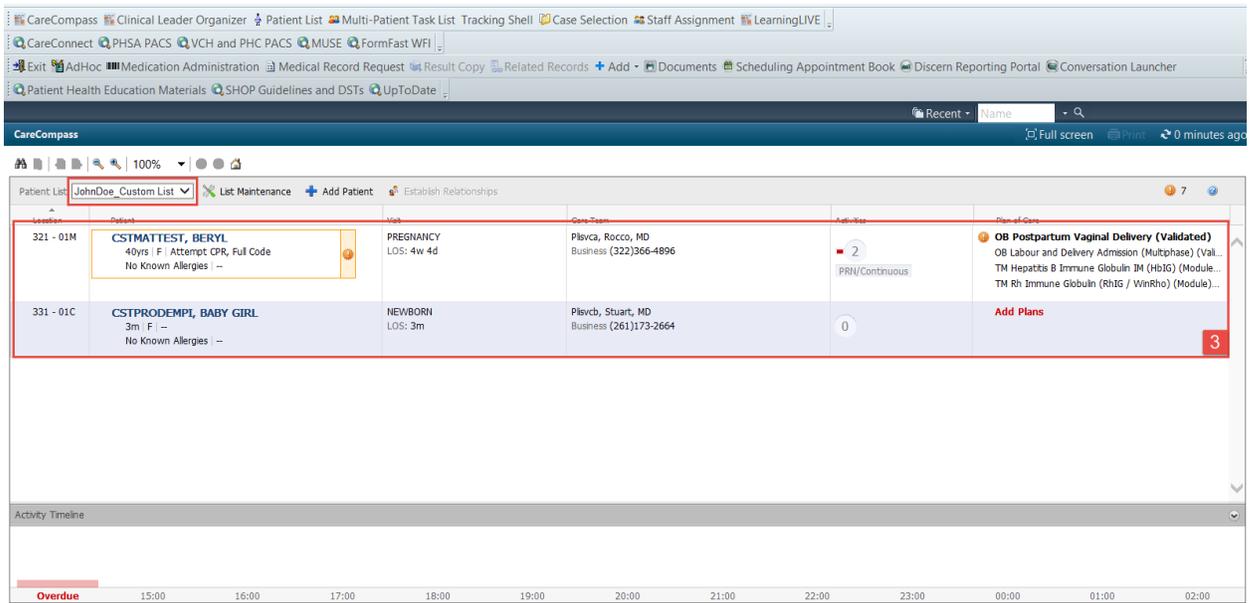
When you have multiple patients assigned to you (including postpartum moms and newborns), you will use **CareCompass** to support your workflow and orders, labs and tasks for your patients.

**Note:** It is recommended that you still refer back to Tracking Shell at least once a shift for these postpartum and newborn patients to see icons related to their care.

- 2
  1. Navigate back to **CareCompass** by clicking on the **CareCompass**  in the Toolbar.
  2. Select **YourName\_Custom** from the **Patient List** dropdown.



3. Click the **Refresh** icon . Your selected patients (mom and newborn) are now visible on your custom list.



The patients that you have moved onto your Custom List are displayed in **CareCompass**.

### Key Learning Points

- You will use **CareCompass** to support your workflow and orders, labs and tasks for your patients.
- It is recommended that you still refer back to Tracking Shell at least once a shift for these postpartum and newborn patients to see icons related to their care.

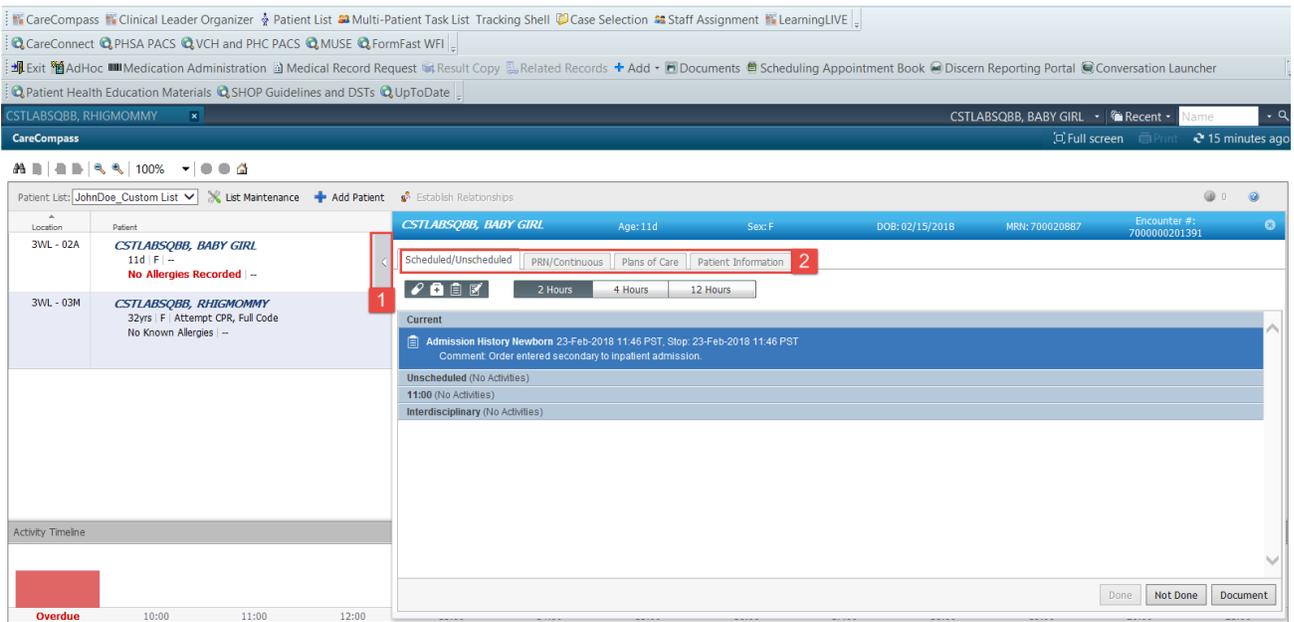
## Activity 13.2 – Completing Tasks from CareCompass

- 1 An overview of CareCompass was covered in the Rural Nurse workbook. Here, we will review how to see information about your mother and newborn patients on CareCompass, and how to complete tasks.

The task that needs to be complete for the newborn is the **Newborn Admission History** PowerForm.

Open the task list for your baby patient by completing the following steps:

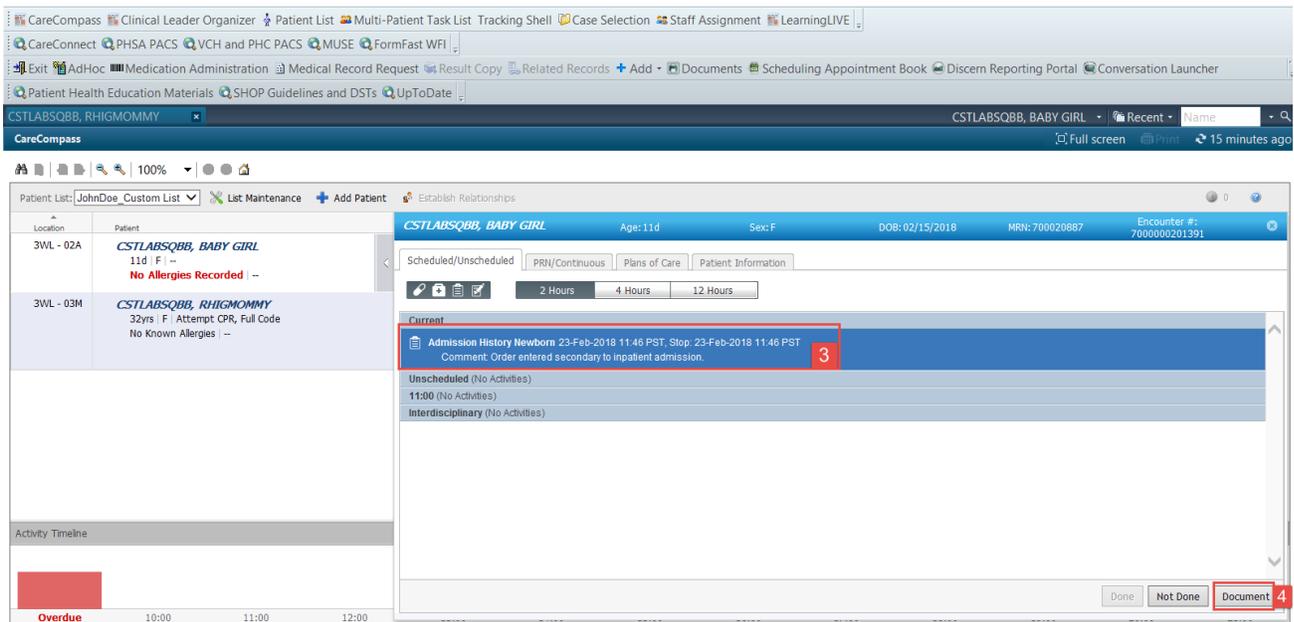
1. Click the grey forward arrow  to the right of your baby patient's name to open the single patient task list
2. Notice the different task type tabs including: Scheduled/Unscheduled, PRN/Continuous, Plans of Care, Patient Information



The screenshot displays the CareCompass interface. At the top, there is a navigation bar with various tools like 'CareConnect', 'PHSA PACS', 'VCH and PHC PACS', 'MUSE', and 'FormFast WFI'. Below this is a patient list table with columns for 'Location' and 'Patient'. The patient list includes 'CSTLABSQBB, BABY GIRL' (Age: 11d, Sex: F, DOB: 02/15/2018, MRN: 700020887, Encounter #: 7000000201391) and 'CSTLABSQBB, RHIGMOMMY' (32yrs F, Attempt CPR, Full Code, No Known Allergies). A red box labeled '1' highlights the grey forward arrow next to the baby girl's name. To the right, a detailed view of the 'CSTLABSQBB, BABY GIRL' patient is shown. This view includes tabs for 'Scheduled/Unscheduled', 'PRN/Continuous', 'Plans of Care', and 'Patient Information'. A red box labeled '2' highlights the 'Admission History Newborn' task under the 'Scheduled/Unscheduled' tab. Below the task list, there is an 'Activity Timeline' section showing a red bar labeled 'Overdue' between 10:00 and 11:00. At the bottom right of the task list, there are buttons for 'Done', 'Not Done', and 'Document'.

3. In the Scheduled/Unscheduled tab, click to highlight the **Admission History Newborn** task
4. Click **Document**

# PATIENT SCENARIO 13 – Navigate to CareCompass to manage PostPartum Patients and Newborns



The patient’s chart will open directly to the appropriate documentation section, in this case, the **Newborn Admission History** PowerForm.

**Note:** In practice, this form needs to be completed as detailed and thoroughly as possible. For the purposes of this classroom, you will only complete a small portion of the form.

Document using the following data:

5. In the General Info tab/section:
  - Location of Birth = *Hospital*
  - Accompanied By = *Mother*

Newborn Admission History - CSTLABSQBB, BABY GIRL

\*Performed on: 26-Feb-2018 1215 PST

**General Information**

**Location of Birth**

Hospital  
 Home  
 Other: 5

**Reason for Transfer**

High level of care required  
 Growth or discharge planning  
 Medical or diagnostic services  
 Surgical anastomosis  
 Other:

**Mode of Arrival on Unit**

Bassinet  
 Carried  
 Crib  
 Isolette  
 Wagon  
 Other:

**Day of Life on Transfer**

Day:

**Mode of Transfer**

Air ambulance  
 Ground ambulance  
 Private vehicle  
 Special Needs Transport  
 Other:

**Accompanied By**

None  
 Mother  
 Father  
 Foster mother  
 Foster father  
 Friend  
 Grandfather  
 Grandmother  
 Ministry worker  
 Sibling  
 Spouse  
 Steplather  
 Stepmother  
 Step sibling  
 Security  
 Other: 5

**Security Tag Applied**

N/A  
 Yes  
 No  
 Other:

**ID Band Number**

**ID Band Recipient #1 Relationship to Baby**

Biological father  
 Biological mother  
 Adoptive father  
 Adoptive mother  
 Co-Parent  
 Friend  
 Grandfather  
 Grandmother  
 Legal guardian  
 Sibling  
 Surrogate father  
 Surrogate mother  
 Other:

**Name of ID Band Recipient #1**

**ID Band Recipient #2 Relationship to Baby**

Biological father  
 Biological mother  
 Adoptive father  
 Adoptive mother  
 Co-Parent  
 Friend  
 Grandfather  
 Grandmother  
 Legal guardian  
 Sibling  
 Surrogate father  
 Surrogate mother  
 Other:

**Name of ID Band Recipient #2**

**ID Band Destroyed**

#1  
 #2

6. In the Birth History tab/section:

- EGA at Birth = autopopulates from mothers chart
- Gestational Age At Birth = *need to manually transcribe based on EGA field*

Scroll down and enter:

- Delivery Type = *Vaginal*

7. Click the **green checkmark** ✓ to sign your documentation.

# PATIENT SCENARIO 13 – Navigate to CareCompass to manage PostPartum Patients and Newborns



Newborn Admission History - CSTLABSQBB, BABY GIRL

\*Performed on: 26-Feb-2018 1215 PST

**Birth History**

EGA at Birth: 34W 2D  
EGA at Birth is result copied from the maternal chart, this value will need to be transcribed into the Gestational Age at Birth control to calculate the PMA.

Gestational Age At Birth: 34 week 2 day

Method: 6

**Auto-populates from mom's chart**

**Need to manually input**

**Medications Taken by Mother While Pregnant**

**Maternal Antepartum Steroids Received**

None  Dexamethasone, partial dose

Betamethasone, complete dose  
 Betamethasone, partial dose  
 Dexamethasone, complete dose

Partial dose = delivery less than 24 hours after 1st dose, or 7 days after last dose.  
 Complete dose = delivery greater than 24 hours and less than 7 days after final dose of steroid.

**Maternal Intrapartum Antibiotics Given**

None before delivery  
 Prior to delivery, less than 4 hours  
 Prior to delivery, greater than 4 hours, 1 dose  
 Prior to delivery, greater than 4 hours, 2 doses or more

**Mother/Baby Communicable Disease Exposure ( Prior to Delivery)**

	Yes	No	Comment
Chickenpox			
Hepatitis A			
Hepatitis B			
Hepatitis C			
HIV			
Measles			
Mumps			
Tuberculosis			
Other			

**Maternal Pregnancy Risk Factors**

None  Interpersonal violence  Previous infant death

You will be returned to CareCompass. Notice that the Admission History Newborn task has been completed and no longer appears on the baby's task list.

CareCompass Clinical Leader Organizer Patient List Multi-Patient Task List Tracking Shell Case Selection Staff Assignment LearningLIVE

CareConnect PHSA PACS VCH and PHC PACS MUSE FormFast WFI

Exit AdHoc Medication Administration Medical Record Request Result Copy Related Records Add Documents Scheduling Appointment Book Discern Reporting Portal Conversation Launcher

Patient Health Education Materials SHOP Guidelines and DSTs UpToDate

CSTLABSQBB, RHIGMOMMY CSTLABSQBB, BABY GIRL Recent Name

CareCompass Full screen Print 1 hours 48 minutes ago

Patient List: JohnDoe\_Custom List List Maintenance Add Patient Establish Relationships

Location Patient

3WL - 02A	<b>CSTLABSQBB, BABY GIRL</b> 11d F -- No Allergies Recorded --
3WL - 03M	<b>CSTLABSQBB, RHIGMOMMY</b> 32yrs F Attempt CPR, Full Code No Known Allergies --

Activity Timeline

**Overdue** 12:00 13:00 14:00

**CSTLABSQBB, BABY GIRL** Age: 11d Sex: F DOB: 02/15/2018 MRN: 700020887 Encounter #: 700000201391

Scheduled/Unscheduled PRN/Continuous Plans of Care Patient Information

2 Hours 4 Hours 12 Hours

Current (No Activities)  
 Unscheduled (No Activities)  
 13:00 (No Activities)  
 Interdisciplinary (No Activities)

Done Not Done Document

### Key Learning Points

- CareCompass provides a quick overview of patient information
- Tasks for postpartum patients and newborns will be found on CareCompass task lists. They can be completed through CareCompass.
- It is encouraged to check task lists frequently throughout your shift.

## **PATIENT SCENARIO 14 – Self Administered Medications (SAM)**

### **Learning Objectives**

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

- Access the Maternity Self- Medication Record from FormFast.

### **SCENARIO**

In this scenario, you will print the Maternity Self-Medication Record form for the mother to document when she is self-administering any medications.

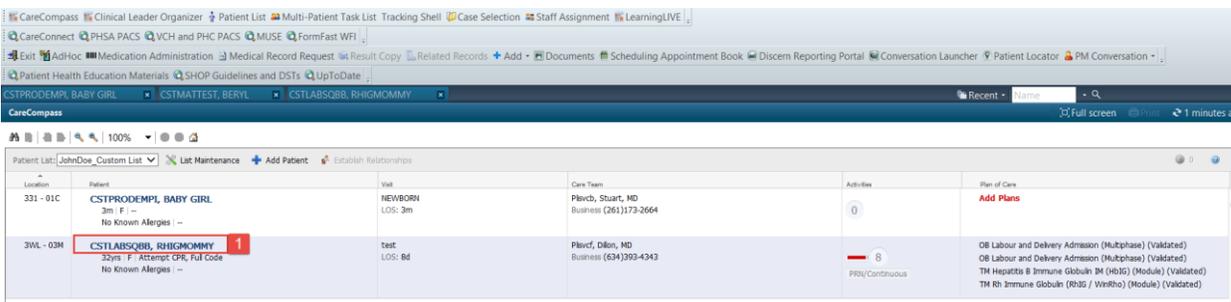
As an inpatient nurse you will be completing the following activities:

- Access the Maternity Self – Medication Record from FormFast.

## Activity 14.1 – SAM

1 The underlying concept of self-administered medications (SAMs) remains the same – you will provide a physical form for the mother to document when she is taking her medications.

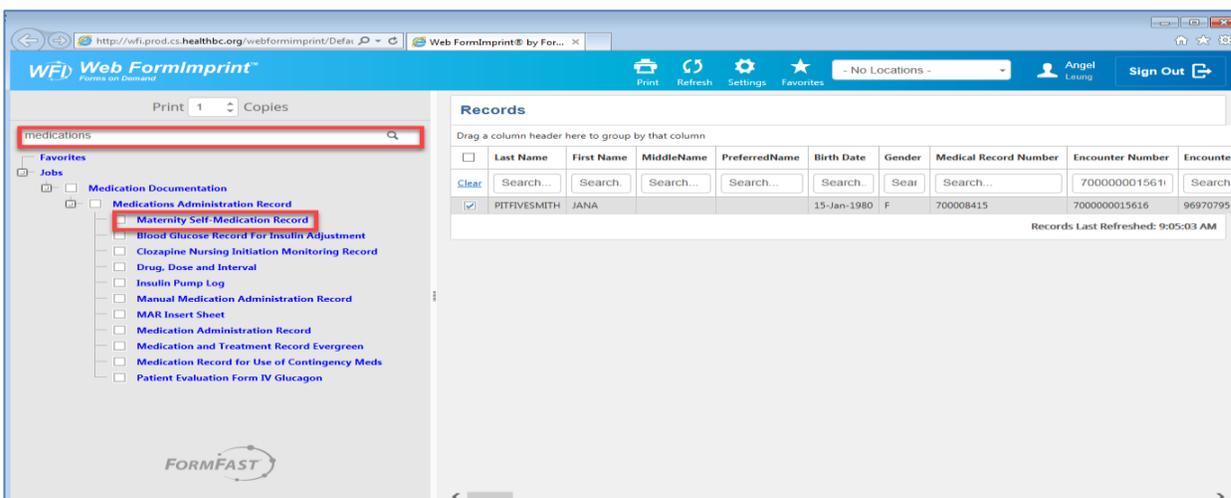
1. From CareCompass, open the mom’s chart by clicking on the patient’s name



To access the SAM form, you need to click on the FormFast button on the tool bar.



Type in “Medications” in the search bar on the top left corner. Select “Maternity Self- Medication Record”.



Review the name to ensure it is the right patient and click Print.

**Vancouver Coastal Health**  
Promoting wellness. Ensuring care.  
LGH Lions Gate Hospital

Place Patient Label Here  
**PITFIVESMITH, JANA**  
Inpatient  
BCPHN: 9876424814    DOB: 15-Jan-1980    F  
MRN: 700008415    Encounter#: 700000015616

**MATERNITY SELF-MEDICATION RECORD**  
1406

MEDICATIONS ADMINISTRATION RECORD

Nursing to cross out medications that are not ordered.  
 Patient received Maternity Self-Medicaton Program pamphlet and instructions involving self-administered medications and tracking record?

| MEDICATIONS AND DIRECTIONS | Date: |      |
|----------------------------|-------|------|-------|------|-------|------|-------|------|-------|------|
|                            | Time  | Dose |

At the end of every shift, best practice is to back enter the medications that your patient has taken during your shift.

1. Select MAR section from Menu column and scroll to PRN medications.
2. Click on the cell with Not previously given beside ibuprofen (ensure it is the **ibuprofen self med program**) 400 mg, PO q4h, PRN pain.

Menu

- Women's Health Overview
- Interactive View and I&O
- Single Patient Task List
- MAR** 1
- MAR Summary
- Orders + Add
- Results Review
- Notes + Add
- Documentation + Add
- Allergies + Add
- Diagnoses and Problems
- CareConnect
- Form Browser
- Perioperative Doc
- Care Coordination
- Clinical Research
- Growth Chart
- Histories
- Immunizations
- Lines/Tubes/Drains Summary
- Medication List + Add

MAR

All Medications (System)

Sunday, 10

Medications	11-Dec-2017 21:00 PST	11-Dec-2017 16:59 PST	10-Dec-2017 21:00 PST
<b>Scheduled</b>			
<input checked="" type="checkbox"/> Scheduled			
<input checked="" type="checkbox"/> docusate (docusate self med) 200 mg, PO, qHS, drug form: cap, start: 31-Oct-2017 21:00 PDT	Not previously given		200 mg Not previously given
<input checked="" type="checkbox"/> PRN 1			
<input checked="" type="checkbox"/> Self Medication Program - ke... docusate			
<input checked="" type="checkbox"/> Continuous Infusions			
<input checked="" type="checkbox"/> Future			
<input checked="" type="checkbox"/> PRN			
<input checked="" type="checkbox"/> acetaminophen (acetaminop... 650 mg, PO, q4h, PRN pain, drug form: tab, start: 31-Oct-2017 10:34 PDT		650 mg Not previously given	
<input checked="" type="checkbox"/> Self Medication Program - ke... acetaminophen			
<input checked="" type="checkbox"/> Temperature Axillary			
<input checked="" type="checkbox"/> Temperature Oral			
<input checked="" type="checkbox"/> Numeric Pain Score (0-10)			
<input checked="" type="checkbox"/> PRN			
<input checked="" type="checkbox"/> ibuprofen (ibuprofen self m... 400 mg, PO, q4h, PRN pain, drug form: tab, start: 31-Oct-2017 10:34 PDT		400 mg Not previously given	
<input checked="" type="checkbox"/> Self Medication Program - ke... ibuprofen			
<input checked="" type="checkbox"/> Temperature Axillary			
<input checked="" type="checkbox"/> Temperature Oral			

3. A **Charting for: Your Patient's Name** window will open with the medication name

(ibuprofen) listed at the top. In the Performed Date/Time: field, back enter the patient’s first dose taken on your shift. Enter = T/0500

4. In the Performed by: field, type = *Self* and the field will autopopulate with **Self-Administered, Self-Administered**.
5. Click **Sign** ✓.

6. The **Medication Administration Follow Up** PowerForm will open. Select **Yes** in the **Medication Effectiveness** field. **Sign** ✓.

Medication Administration Follow Up - MATTEST, ICONS

\*Performed on: 11-Dec-2017 1100 PST

Medication Effectiveness Evaluation

Medication effectiveness should be assessed for all medications administered

**Medication Effective**

Yes  No  Other:

When assessing medication effectiveness the appropriate scale must be used. Evaluation must include patient's self report where possible.  
When assessing pain, utilize appropriate pain scale and document pain response in Interactive View.

7. Medication will display on MAR.
8. Repeat for subsequent self-administered medications.

**Note:** once the mom has completed the form/ has been discharged, you need to place the form into the patient's chartlet so the unit clerk can scan the document into the patient's chart in PowerChart.

### Key Learning Points

- The Maternity Self Medication Record needs to be printed from FormFast to be given to the mother to document her medications.
- Best practice indicates nurses should back enter the information on the form into PowerChart at the end of each shift.

## PATIENT SCENARIO 14 – Neonate Workflow

### Learning Objectives

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

- Navigate to and understand functionality for the Neonate Workflow
- Access and document on the Newborn Discharge Checklist

### SCENARIO

In this scenario, you will be accessing the Neonate Workflow

As a rural inpatient OB nurse you will be completing the following activities:

- Navigate to the Task Timeline in the Neonate Workflow tab of Women’s Health Overview
- Document the car seat check being completed in the Newborn Discharge Checklist

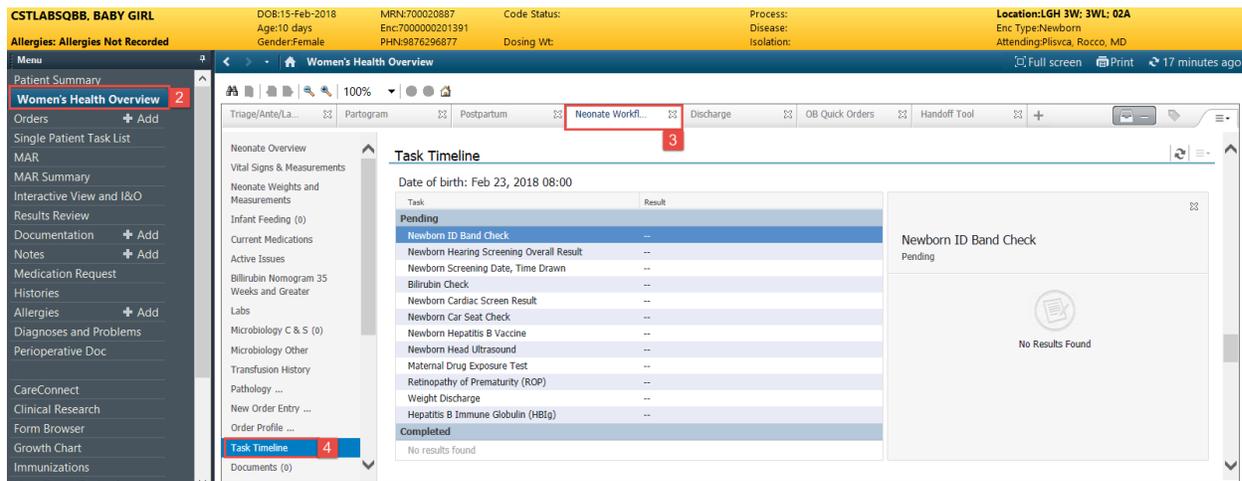
## Activity 14.1 – Neonate Workflow

- 1 The Neonate Workflow can be found by accessing the Women’s Health Overview summary page from the Menu. The Neonate Workflow provides a summary of the newborn baby including vital signs, weights and measurements, infant feeding, current medications, and lab results etc. This summary page pulls information in from other parts of the chart including iView and PowerForm documentation and results review.

The Neonate Workflow also helps support nurses in caring for the newborn. The Task Timeline component outlines a list of tasks that need to be completed for the newborn prior to discharge.

To Navigate to the Neonate Workflow:

1. Open the baby’s chart
2. Click on **Women’s Health Overview** summary page from the Menu
3. Click on the **Neonate Workflow** tab
4. From the list of components on the left, click to highlight the **Task Timeline** component (or you can use the scroll bar on the right to scroll down the page)



The screenshot displays the EHR interface for a patient named CSTLABSQBB, BABY GIRL, born on Feb 23, 2018. The interface is divided into several sections:

- Header:** Patient information including DOB, MRN, Code Status, Process, Location, and Enc Type.
- Menu:** A vertical list of navigation options on the left, with 'Women's Health Overview' highlighted (marked with a red '2').
- Workflow Tabs:** A horizontal row of tabs at the top of the main content area, including 'Triage/Ante...', 'Partogram', 'Postpartum', 'Neonate Workfl...' (highlighted with a red '3'), and 'Discharge'.
- Task Timeline:** A central panel showing a list of tasks for the newborn. The tasks are categorized into 'Pending' and 'Completed'. The 'Pending' section lists tasks such as 'Newborn ID Band Check', 'Newborn Hearing Screening Overall Result', 'Newborn Screening Date, Time Drawn', 'Bilirubin Check', 'Newborn Cardiac Screen Result', 'Newborn Car Seat Check', 'Newborn Hepatitis B Vaccine', 'Newborn Head Ultrasound', 'Maternal Drug Exposure Test', 'Rethopathy of Prematurity (ROP)', 'Weight Discharge', and 'Hepatitis B Immune Globulin (HBtG)'. The 'Completed' section is currently empty.
- Task Detail View:** A large panel on the right side of the Task Timeline, currently showing 'Newborn ID Band Check' with a status of 'Pending' and 'No Results Found'.

Notice the list of **Pending** tasks under the **Task Timeline**. Before the newborn is discharged, all of these tasks should be under the **Completed** section:

Task Timeline	
Date of birth: Feb 23, 2018 08:00	
Task	Result
<b>Pending</b>	
Newborn ID Band Check	--
Newborn Hearing Screening Overall Result	--
Newborn Screening Date, Time Drawn	--
Bilirubin Check	--
Newborn Cardiac Screen Result	--
Newborn Car Seat Check	--
Newborn Hepatitis B Vaccine	--
Newborn Head Ultrasound	--
Maternal Drug Exposure Test	--
Retinopathy of Prematurity (ROP)	--
Weight Discharge	--
Hepatitis B Immune Globulin (HBIG)	--
<b>Completed</b>	
No results found	

Documentation in iView and PowerForms will move these tasks automatically from the pending section to the completed section.

Let's try it!

2 The next steps will show you how to document the **Car Seat Check** in the **Newborn Discharge Checklist** section in **iView**. Documenting in this in iView will move the task from **Pending** to **Completed** on the **Neonate Workflow** page.

1. Select **Interactive View and I&O** from the **Menu**.

**Note:** Since you are in a Newborn's chart, you will see different iView bands than you would see for an adult patient.

2. Click on the **Newborn – Neonate Education** band
3. Select the **Newborn Discharge Checklist** section.
4. Double click on the cell next to **Car Seat Check** under the appropriate time column, and select **Done**.
5. Click the green check mark  to sign the documentation.

Now you go back to the Neonate Workflow:

6. Click on **Women’s Health Overview** from the Menu and make sure you are on the **Neonate Workflow** tab/page
7. Click refresh 3 minutes ago
8. Scroll down to the **Task Timeline** component
9. Notice the **Newborn Car Seat Check** is now **Completed**

You will know that you have completed all of the necessary discharge documentation on your newborn patient when all of the tasks display under the Completed section in the Task Timeline component.

**Note:** Even if a nurse documents “**N/A**” for these items, it will move the task to **Completed**.

### Key Learning Points

- The Neonate Workflow page in the Women’s Health Overview provides a summary of key patient information, as well as supports the nurse in the care of the newborn
- The Task Timeline lists Pending Tasks that need to be completed for the newborn prior to discharge
- Documenting in the appropriate sections in iView and PowerForms will move tasks to the Completed section of the Task Timeline component.

## End Book One

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