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

WORKBOOK TITLE:

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

Last update: March 1, 2018

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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

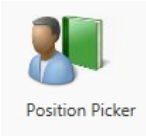
As a maternity nurse at Squamish General Hospital, you will complete the following activities:

- 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** application 

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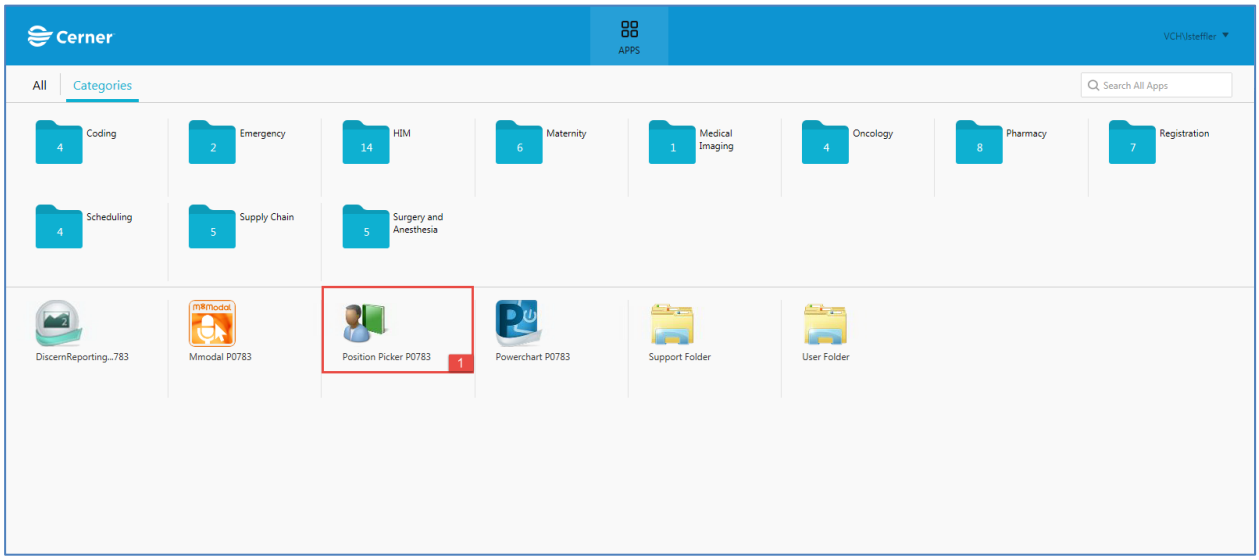
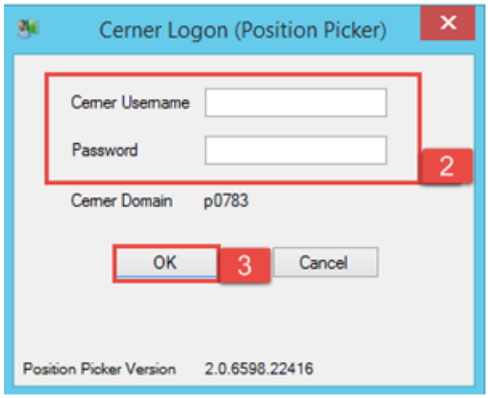
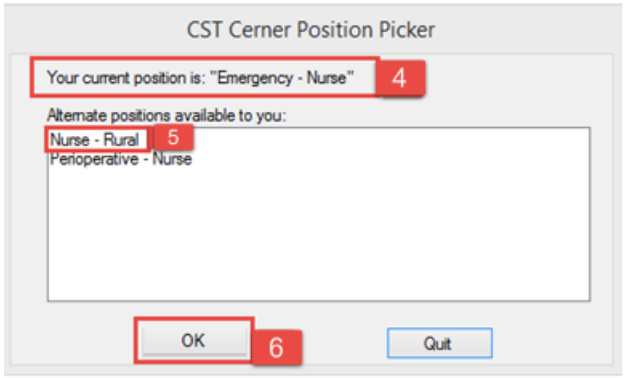


A Cerner Logon (Position Picker) window will open

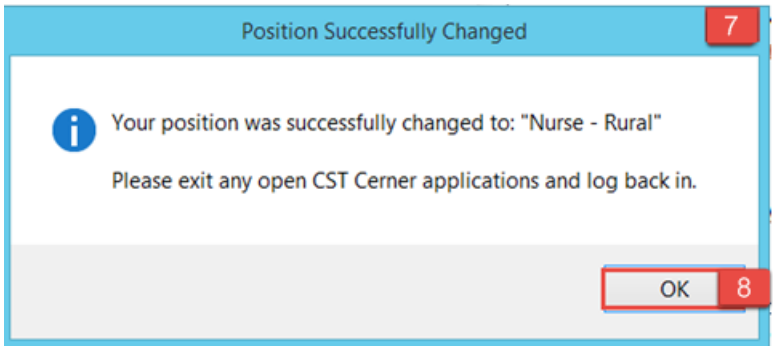
2. Type your assigned **username** and **password**
3. Click **OK**



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

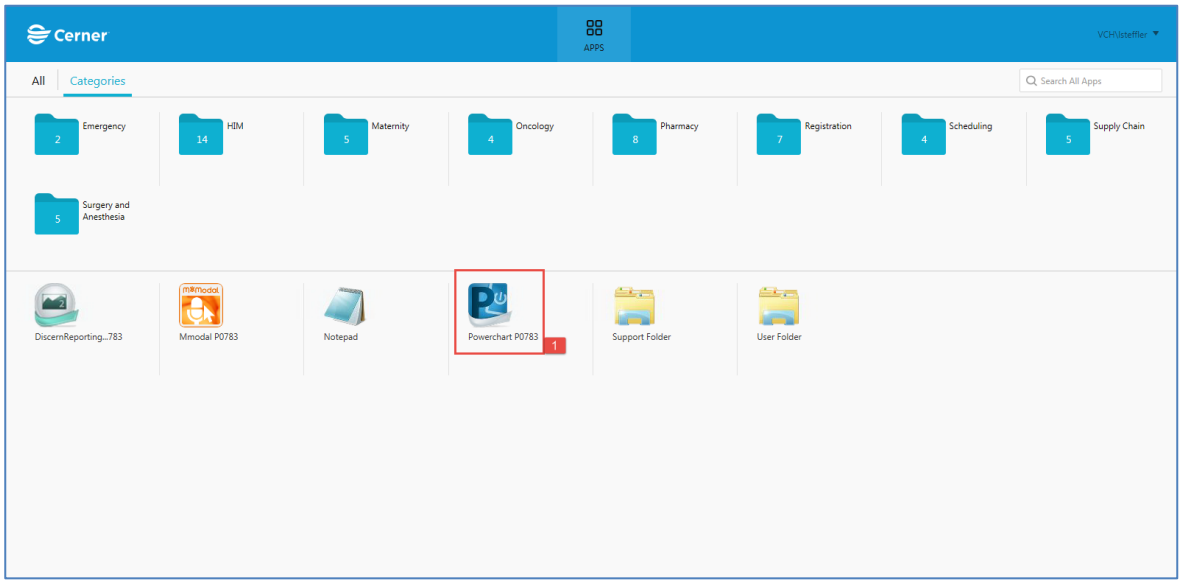
- Cerner Position Picker is the application you will use to switch positions within the CIS to reflect the change in your role throughout your shift
- Log out of any open CST Cerner application (FirstNet or PowerChart) when you switch to a different position using Cerner Position Picker
- At the start 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

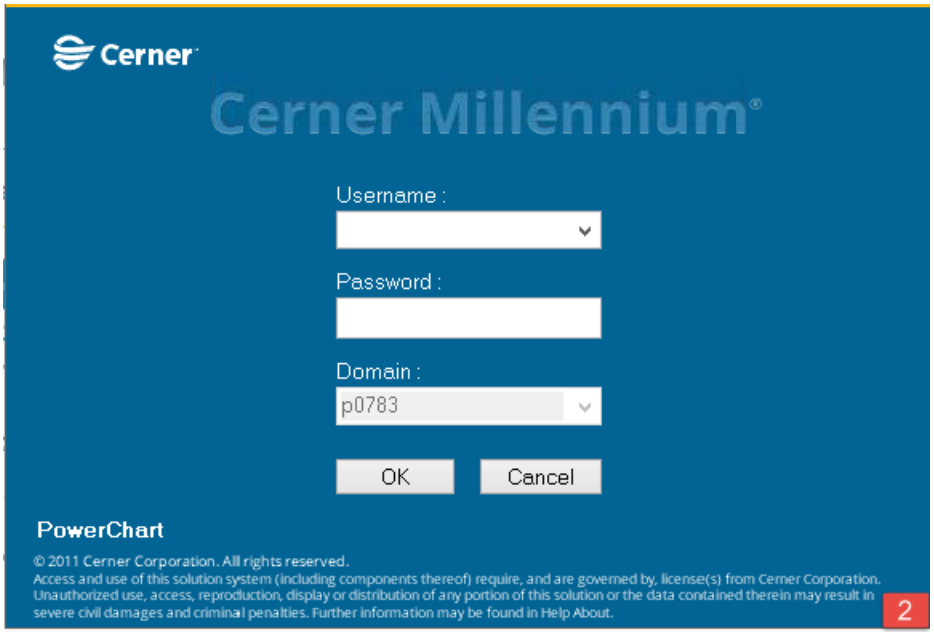
1 Now that you have made sure you are in the correct position of Nurse – Rural, you can log into PowerChart to start caring for your patient in labour.

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**



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.

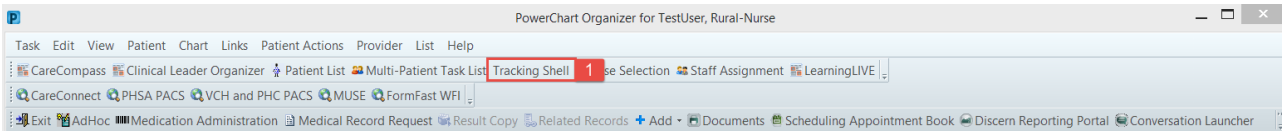
When managing L&D patients, you will instead use **Tracking Shell** to provide an overview of patient location, status and workflow. When a patient becomes postpartum, **CareCompass** will be used to manage patient care, but **Tracking Shell** will still be used as a reference.

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**:

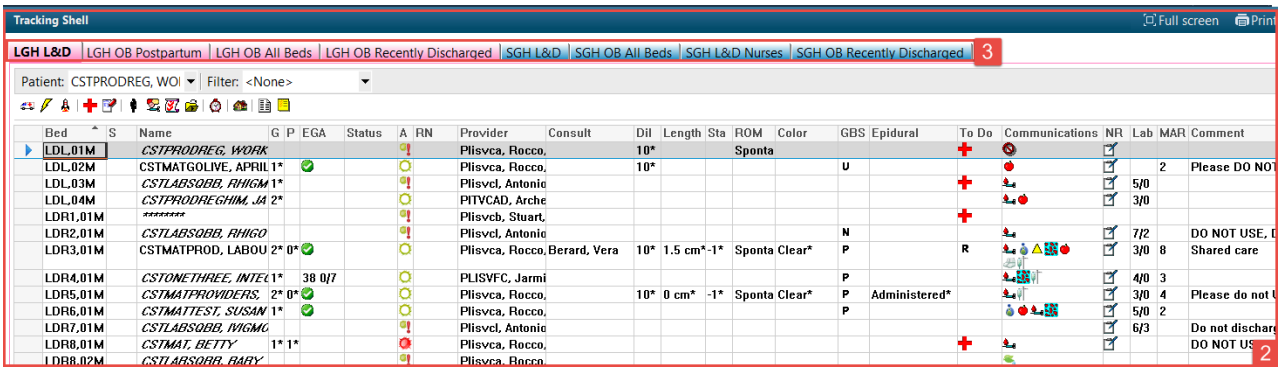
1. Click on Tracking Shell from the Tool Bar at the top of the page.



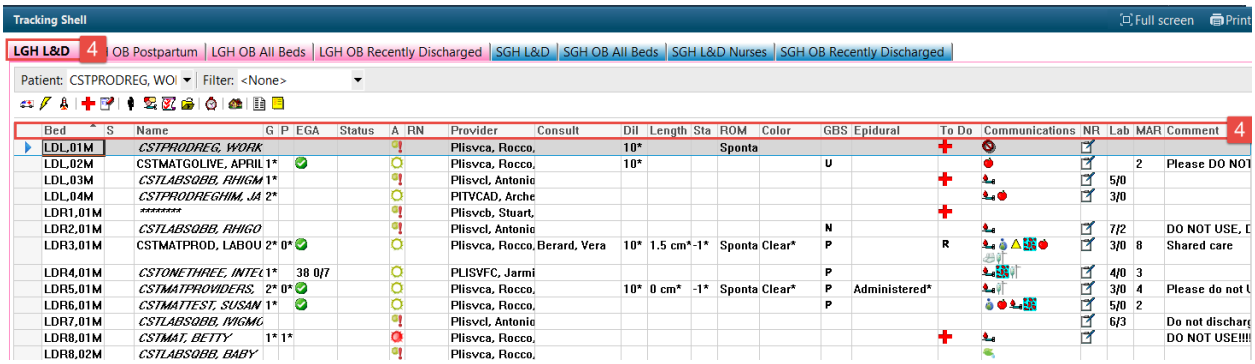
Note: When you work at Squamish, you will use the SGH location views/tabs. Due to the restrictions of the train domain, you will be using Lion's Gate Hospital (LGH) locations to find your patients in this workbook.

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.

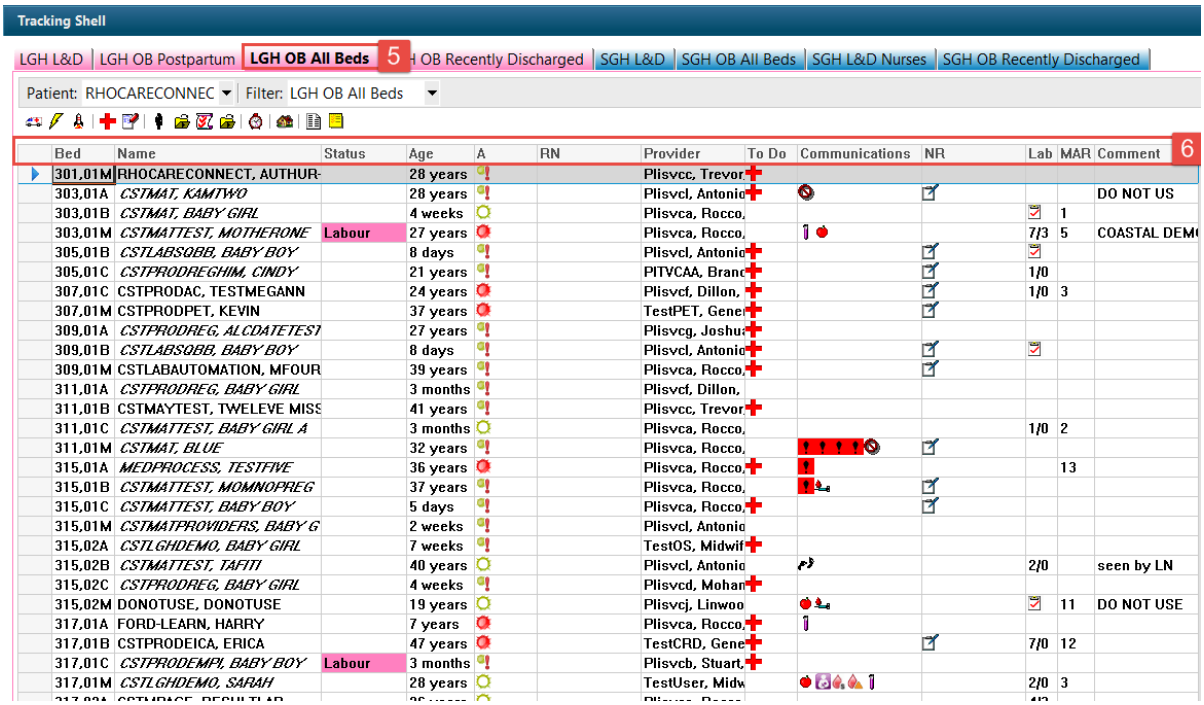


4. You are currently on the **LGH L&D** tab. All of the patients listed on this tab are L&D patients. Notice the **columns** listed in this view. These columns provide information specific to L&D patients.



5. 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.

6. 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.



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:

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

Column	Description
Bed	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)
S	Status of bed – ie) assigned, available, dirty etc.
Name	Patient name
G	Gravida
P	Parity
EGA	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.
Status	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.
A	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
RN	RN assigned to patient
Provider	Attending Provider
Consult	This is a freetext field where any consulting team can be listed
Dil	Dilation of cervix
Length	Length of cervix
Sta	Station of the baby
ROM	Rupture of Membranes – ie) intact, spontaneous artificial etc.
Color	Colour of amniotic fluid
GBS	Group B Strep status – P = positive, N = negative, U = unknown
Epidural	Status of patient having an epidural (pulls from iView **Labour and Delivery**

	band from documenting in the **Anesthesia, OB** section)
To Do	Hover to discover the icons in this column which act as alerts or reminders for nurses to follow up appropriately. 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.
Communications	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: 
NR	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.
Lab	Lab orders and results are indicated here (including blood product orders) – for example: **3/1** means there are 3 lab orders placed and 1 lab result
MAR	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
Comment	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.

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.

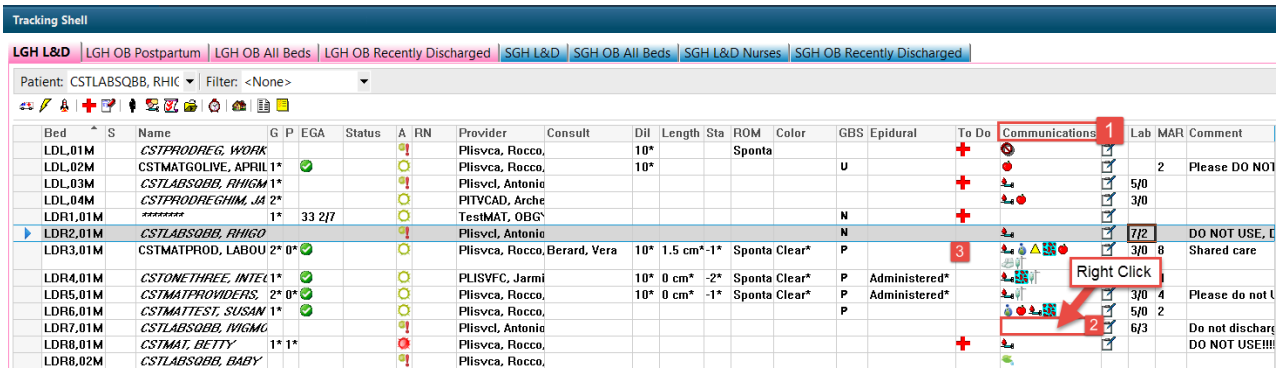
Activity 2.2 – Add a Communications Alert to Tracking Shell for Your Patient

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

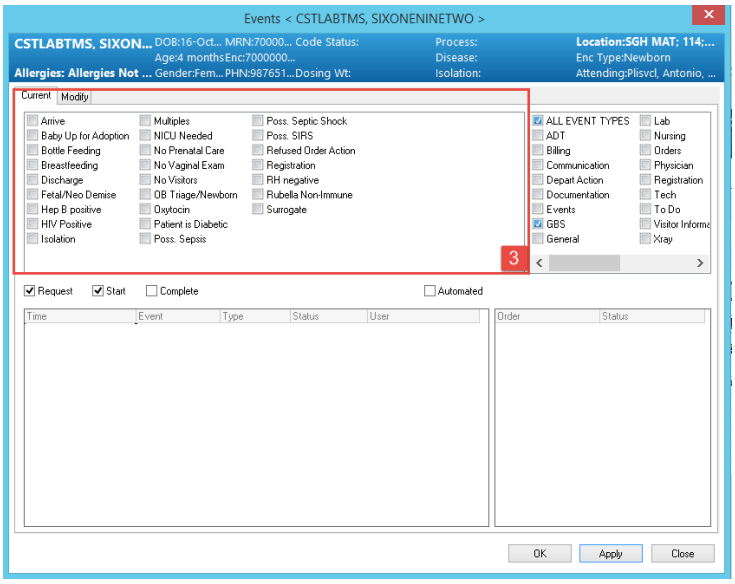
Adding a **Communications alert** for a patient allows all clinicians viewing Tracking Shell to see important patient information face-up.

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

1. Locate the **Communications** column
2. Right click on the **Communications** cell for your patient

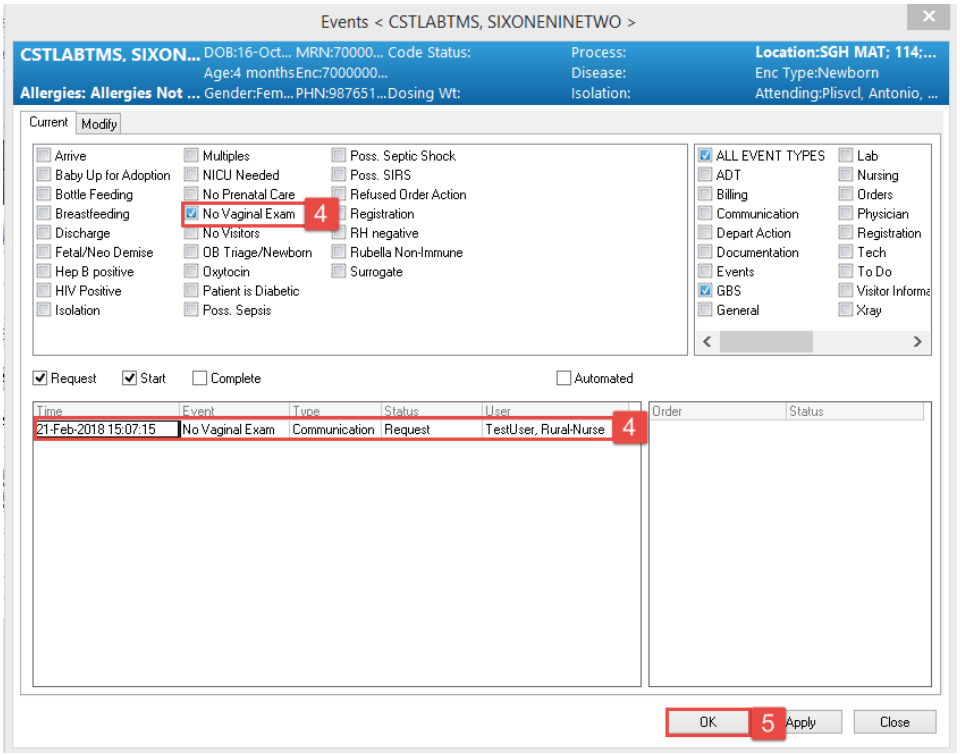


3. The **Events** window will open. Notice all of the possible Communications Alerts that are listed here in the Current tab.



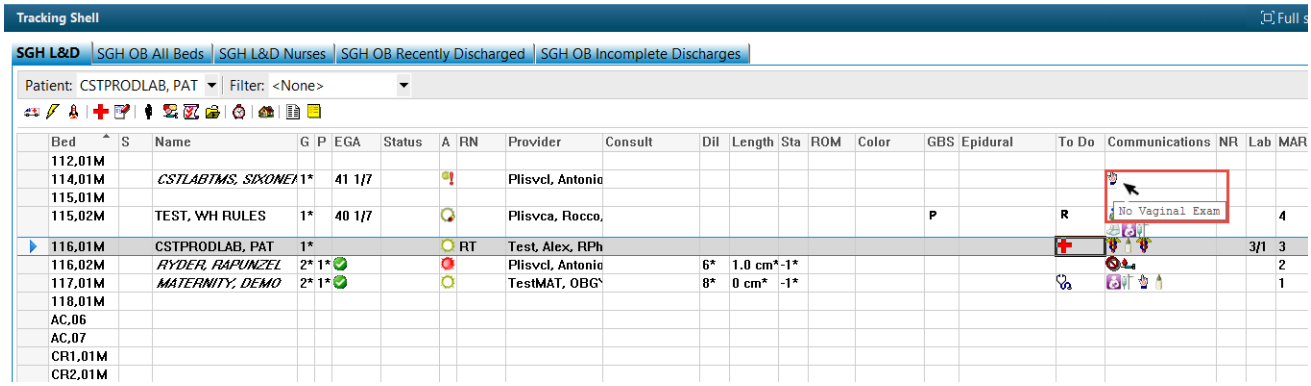
Note: Some of these communication alerts, such as RH negative or Hep B positive will auto-populate Tracking Shell from documentation on the **OB Triage and Assessment** PowerForm that has been previously completed for the patient. Other communication alerts, such as Oxytocin, will auto-populate Tracking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



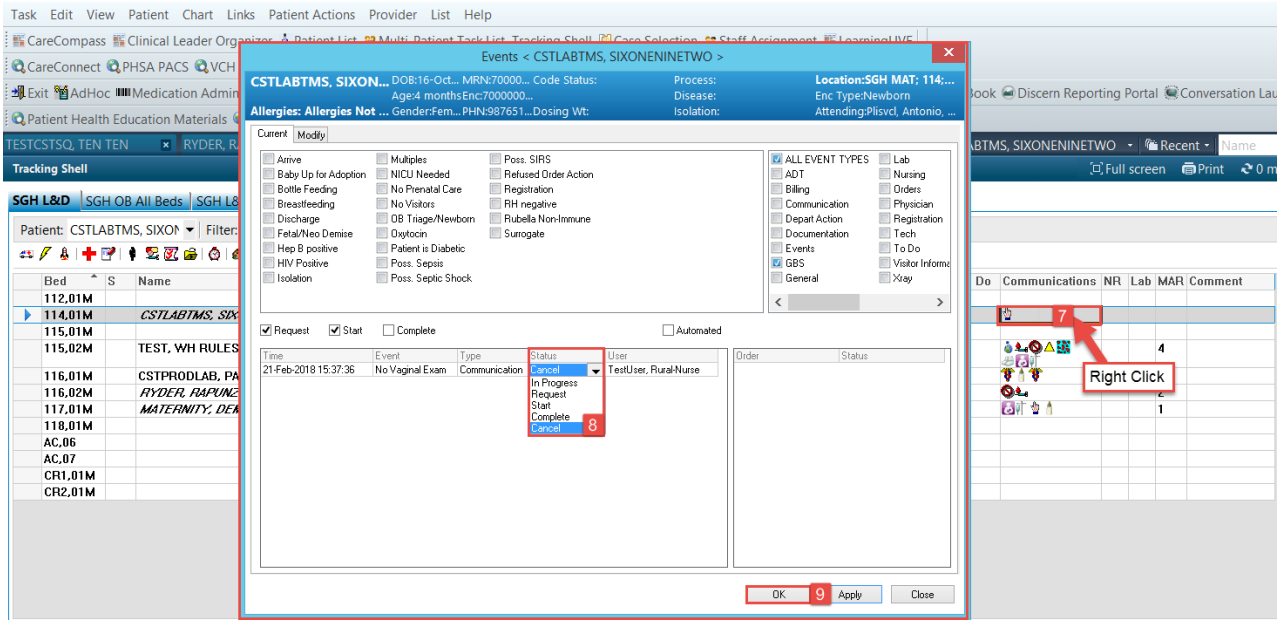
The **No Vaginal Exam** icon is now visible in the Communications column for your patient. All clinicians viewing Tracking Shell will now be able to see that your patient should have no vaginal exams.

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



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

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



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

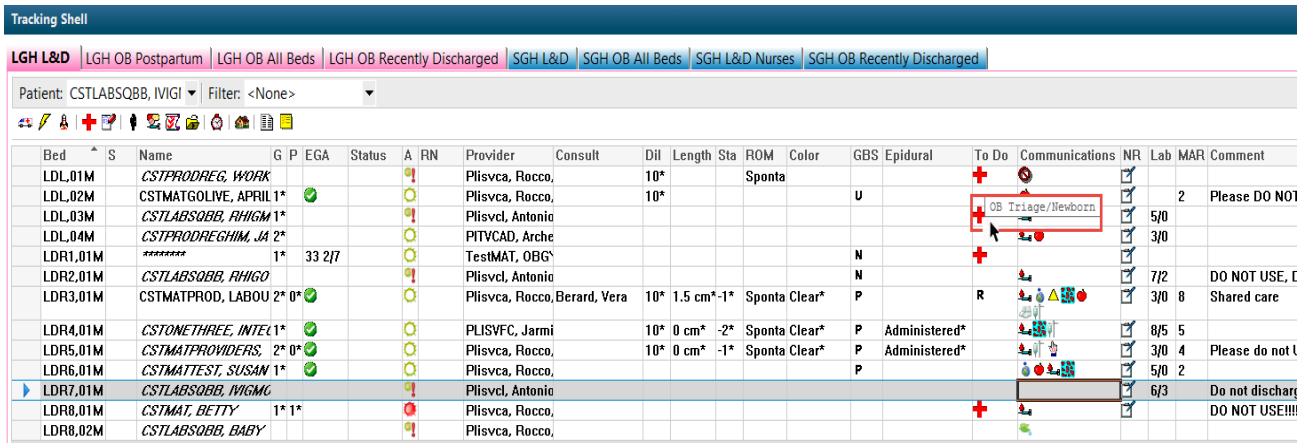
1 **PowerForms** are the electronic equivalent of paper forms currently used to chart patient information. The **OB Triage and Assessment** PowerForm is the electronic documentation in the CIS that will be replacing the BC Perinatal Triage and Assessment Record.

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:

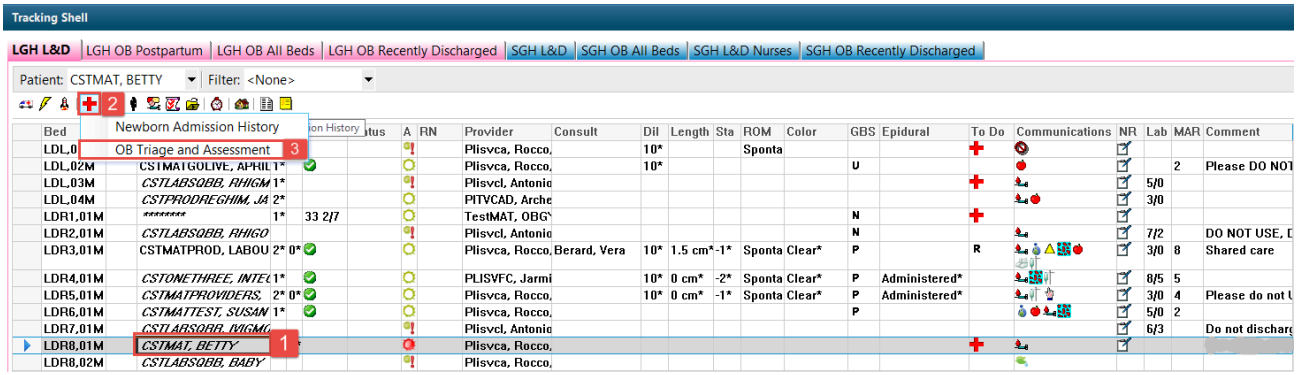
1. Locate your patient on the Tracking Shell.
2. Hover over the **Red Cross** icon ✚ under the **To Do** column of your patient's name. (Hovering over this ✚ icon displays an **OB Triage/Newborn** message. This means that for a mother, the **OB Triage and Assessment** PowerForm needs to be completed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



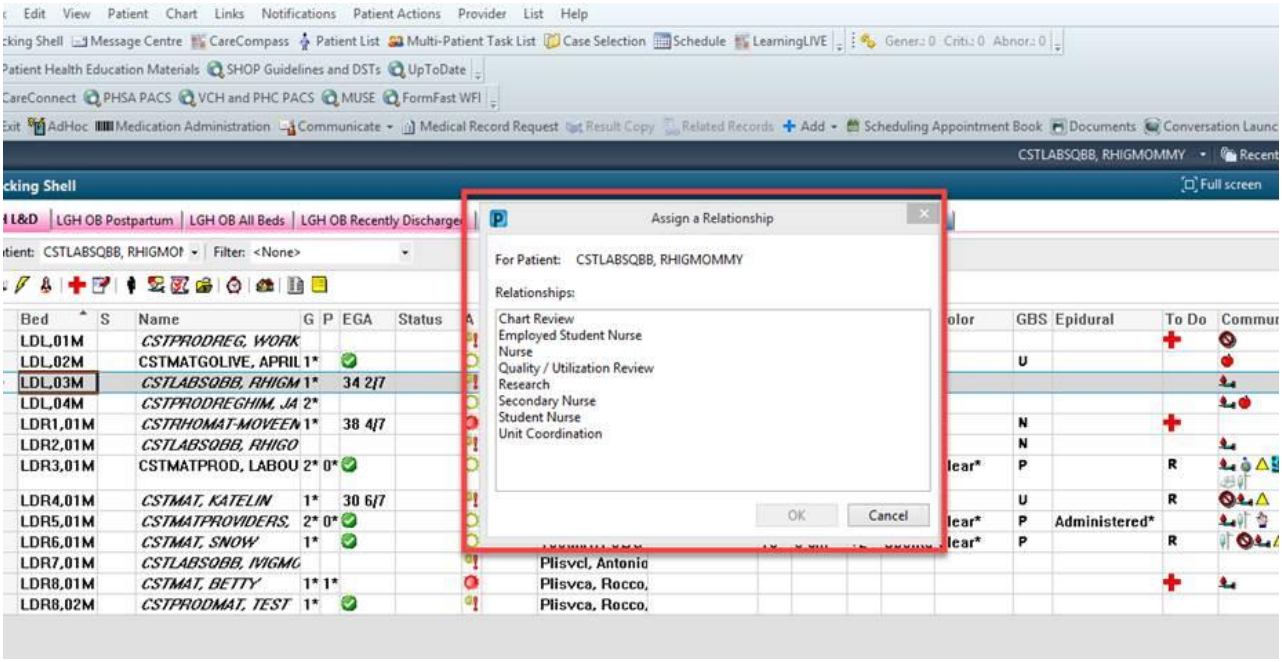
Note: When looking after newborn patients, the ✚ icon in the **To Do** column still says OB Triage/Newborn, indicating that the **Newborn Admission History** PowerForm needs to be completed. This PowerForm needs to be completed for all newborns once during the initial postpartum period.

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

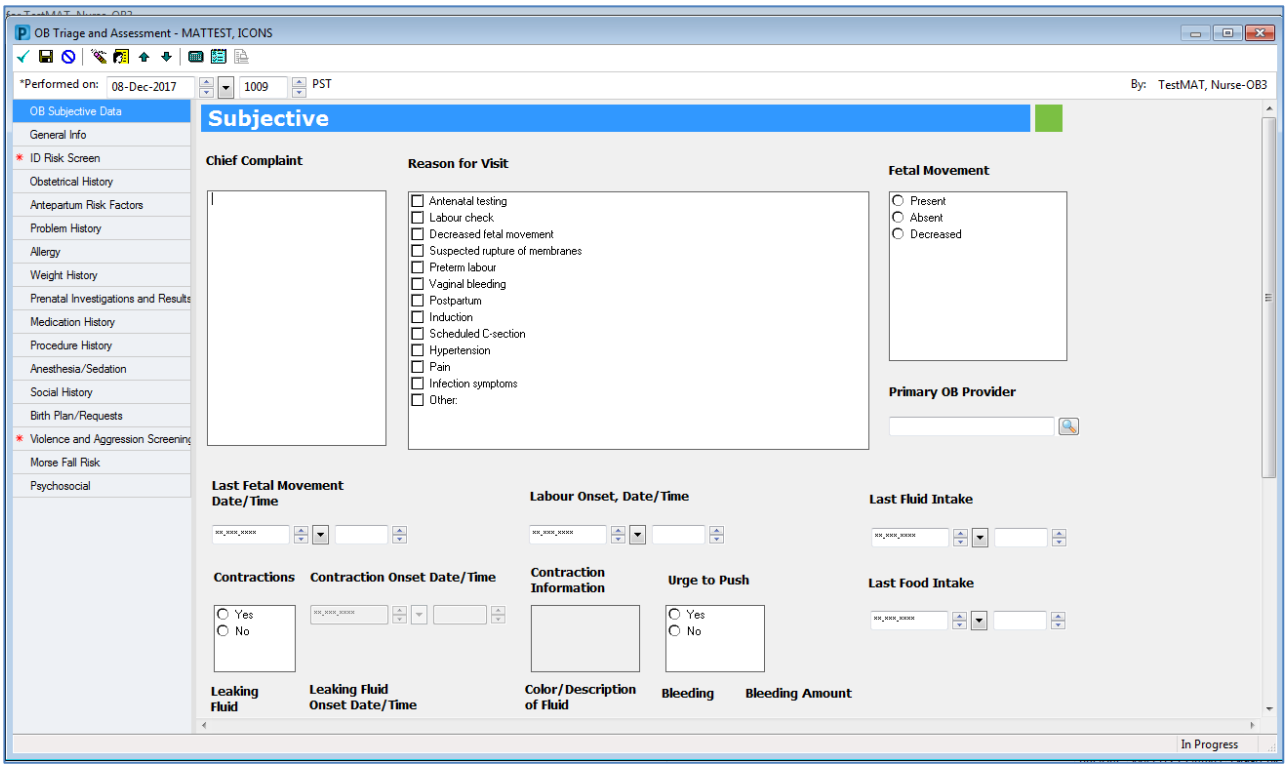
1. Click on your patient's name on Tracking Shell to highlight your patient
2. Then click the Red Cross icon ✚ in the **Icon Toolbar** (not in the To Do column)
3. Select **OB Triage and Assessment**



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



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*

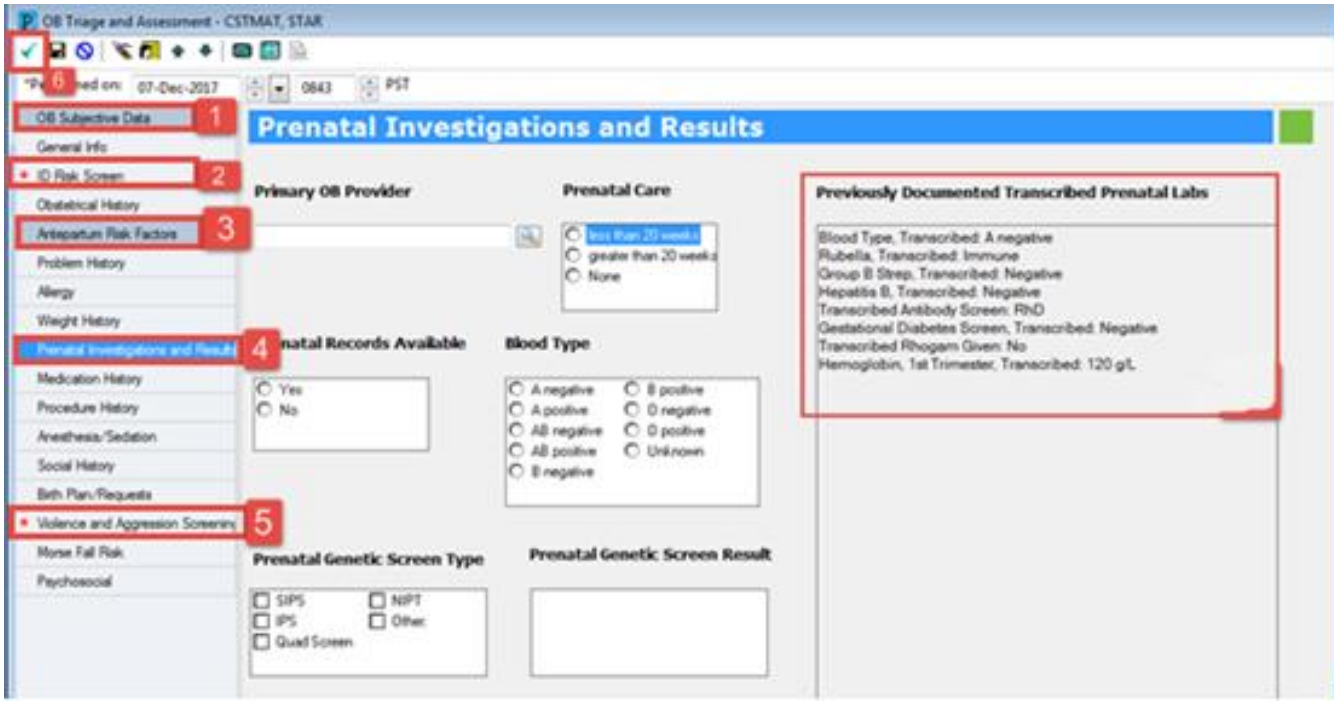
**This flows to provider note, tracking shell and pregnancy overview.*

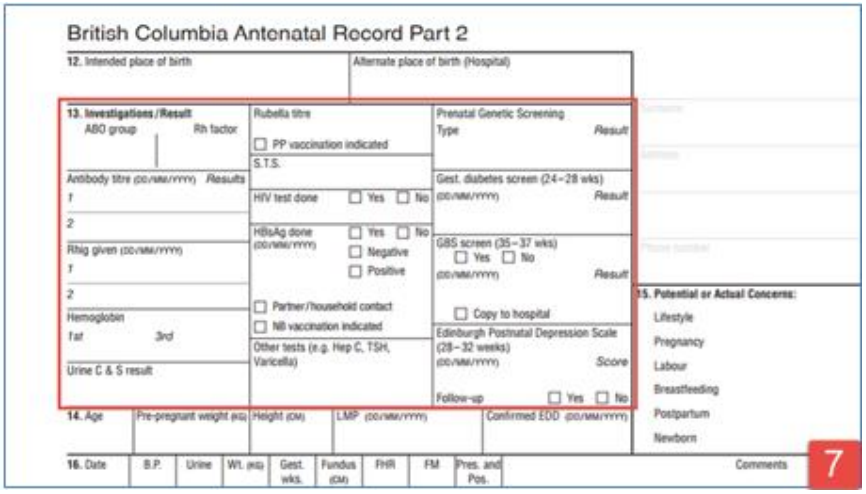
4. **Prenatal Investigations and Results** section:
    - Blood Type = *A positive*
    - Antibody Screen = *Negative*

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 ✔.





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

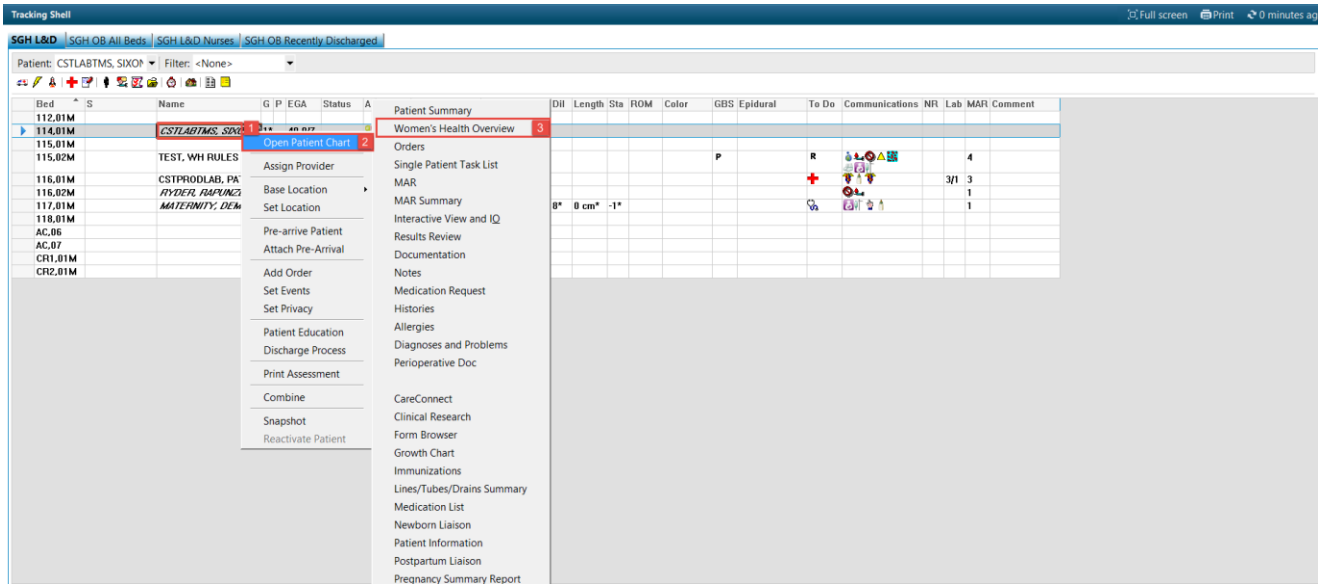
OR

- 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:

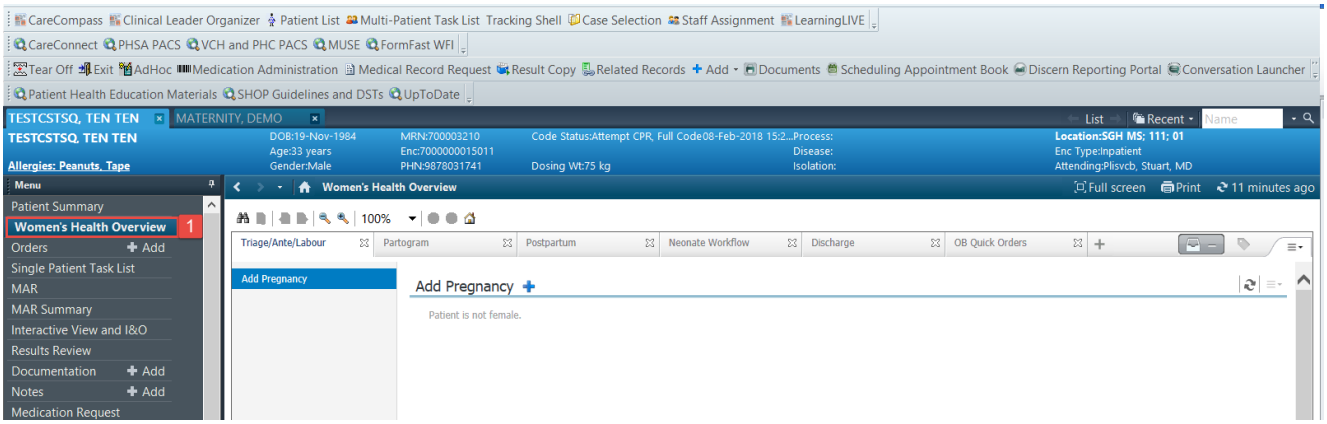
1. Right click on your patient's name
2. Select **Open Patient Chart**
3. Select **Women's Health Overview**

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.

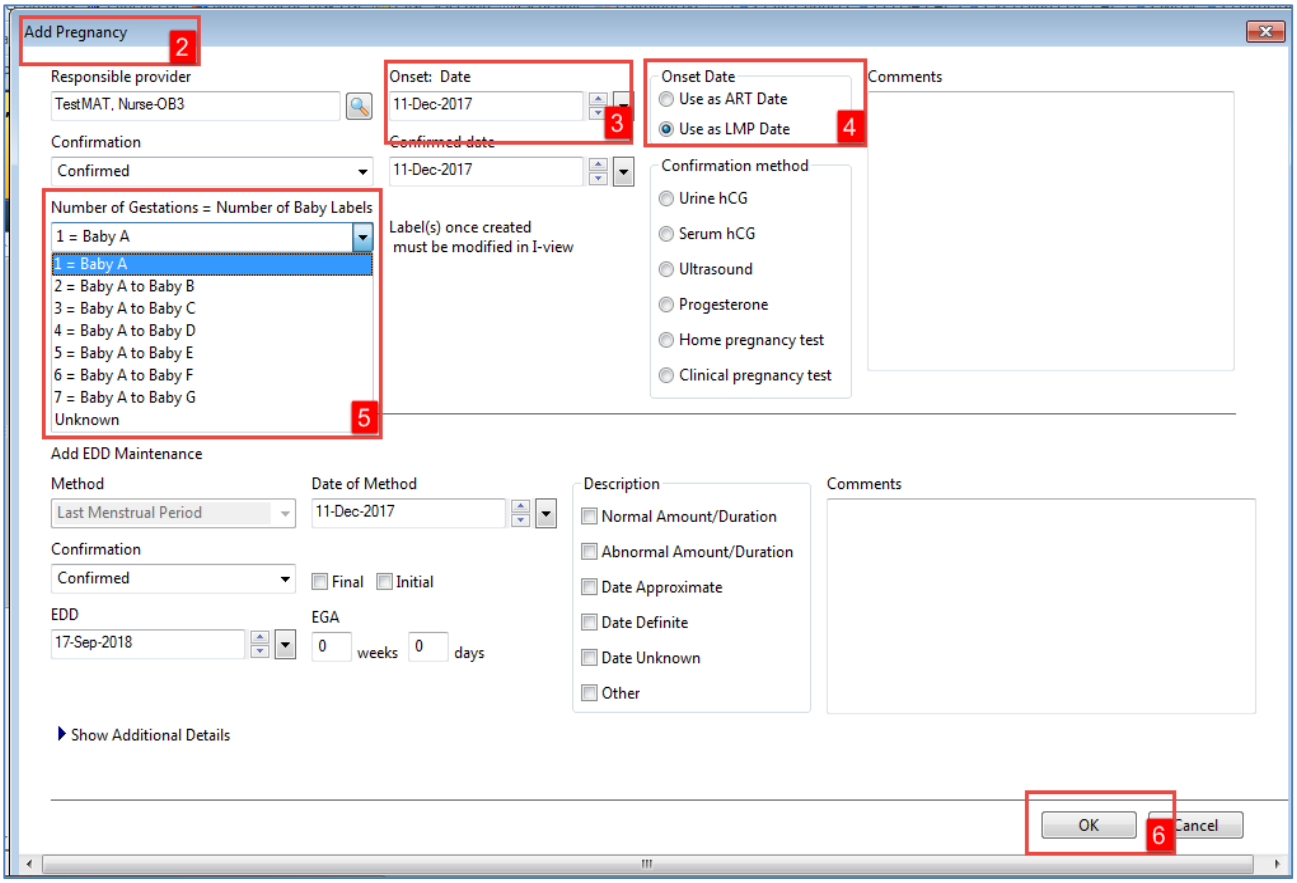
2. The **Add Pregnancy** window opens.
3. In the **Onset: Date** field, choose a date about 10 months ago.

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

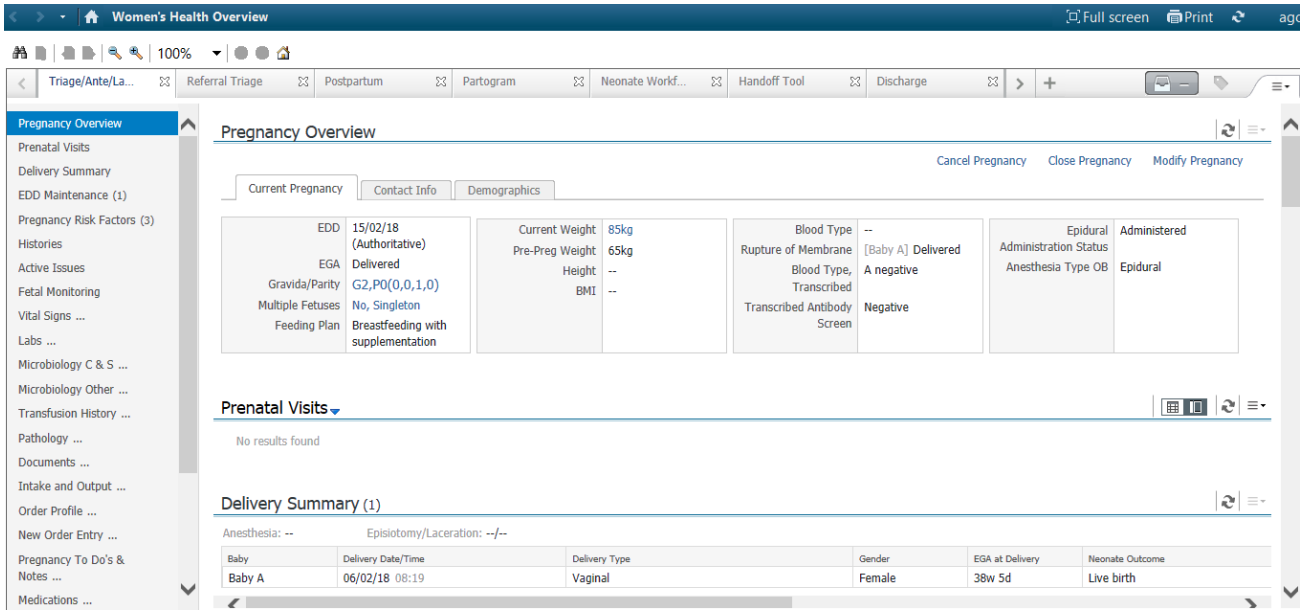
4. In the **Onset Date** field, select "Use as LMP Date"
5. Ensure the **Number of Gestations = Number of Baby Labels** is correct

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

6. Click **OK**

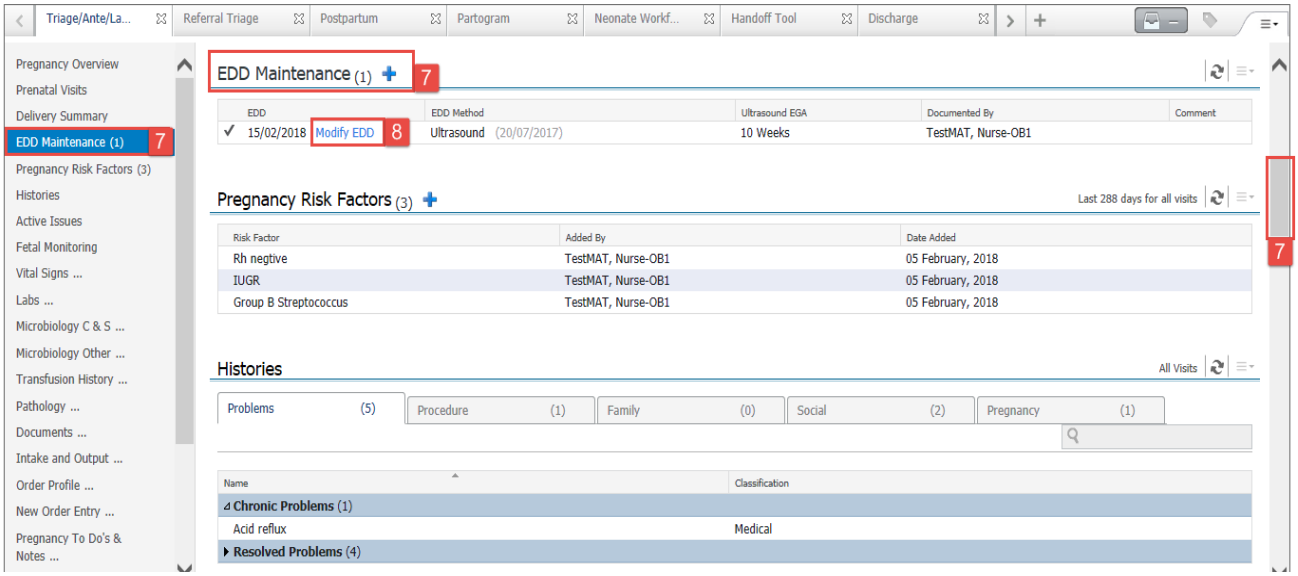


You will return to the Triage/Ante/Labour Page with the **Pregnancy Overview** populated.



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).

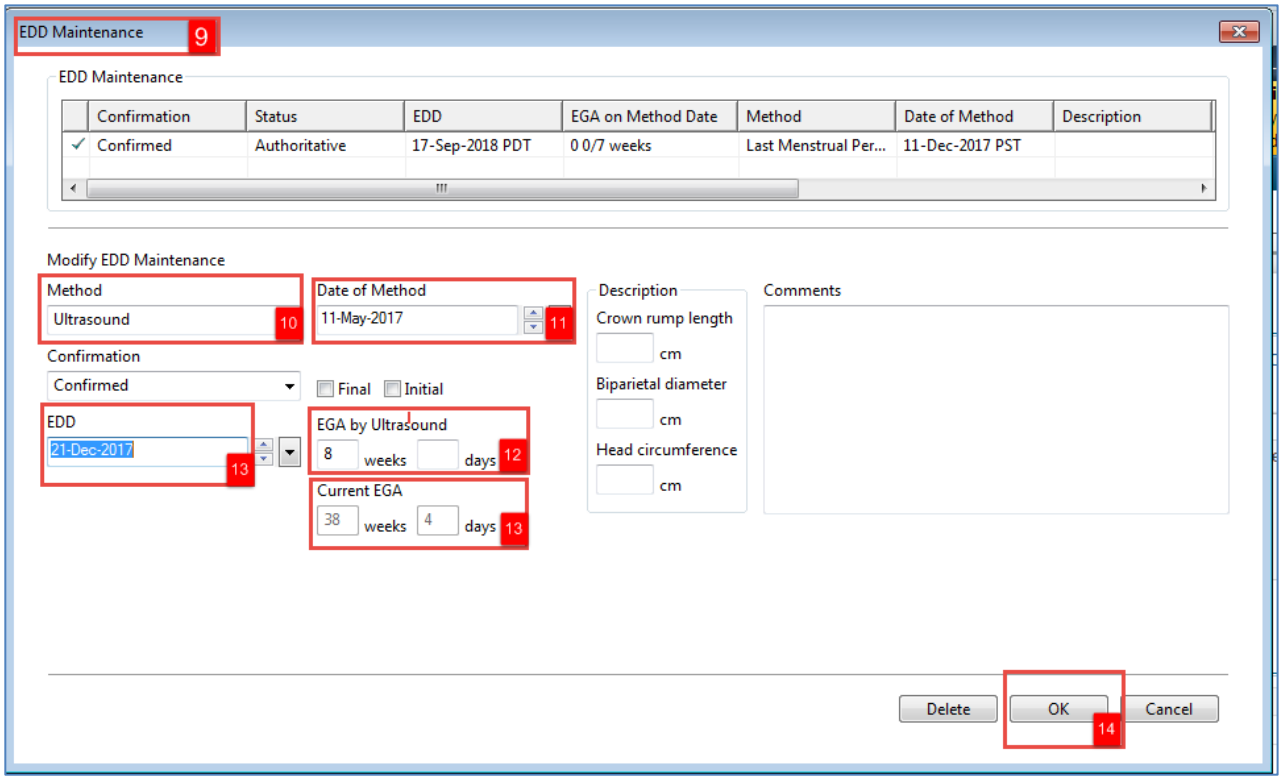
11. In the **Date of Method** field, select a date about 6 months ago.

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.



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

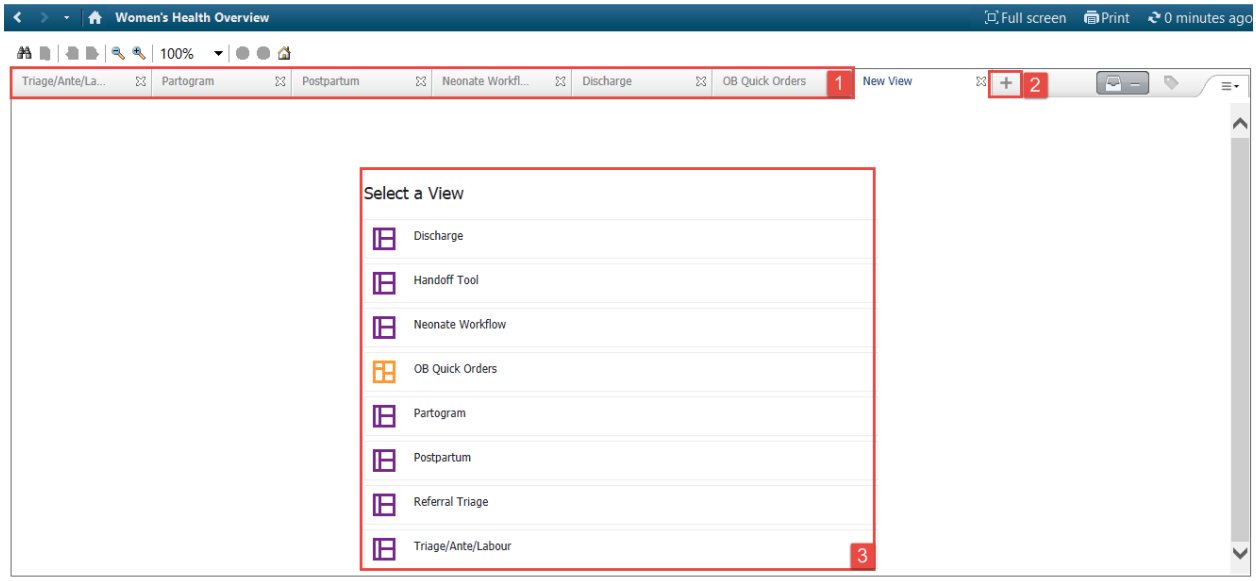
- A pregnancy needs to be added to activate and view the different components of the Women's Health Overview page.
- When a pregnancy has been added, some of this information will populate columns on the Tracking Shell
- Most labour and delivery patients will already be pre-registered in the CIS with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

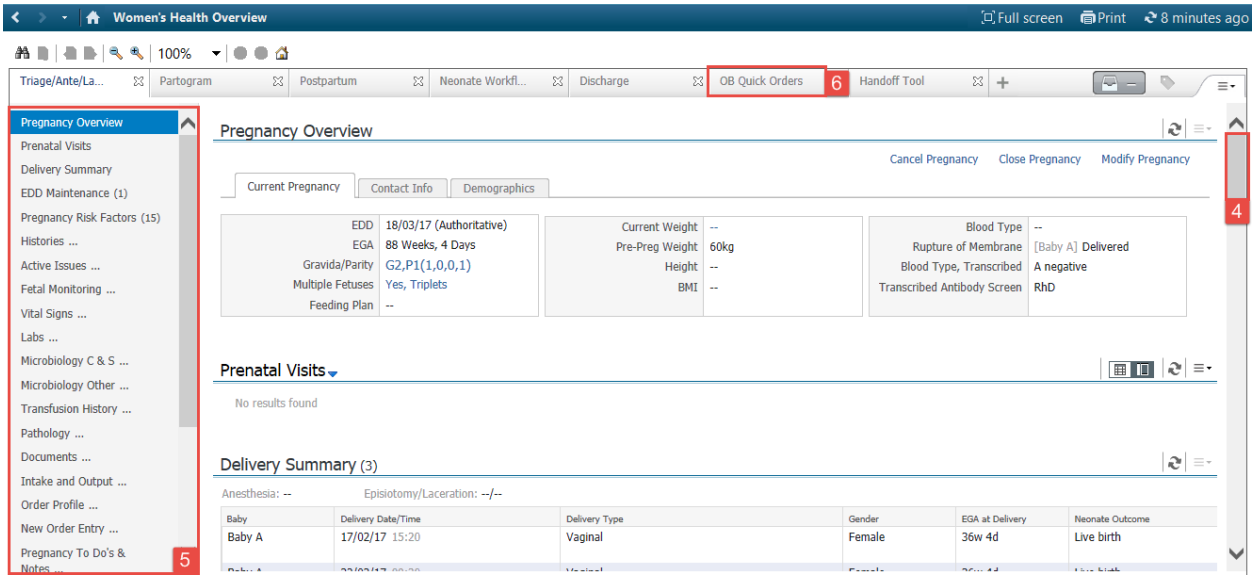
1. There are different tabs across the top of the page including **Triage/Ante/Labour, Partogram, Postpartum, Neonate Workflow, Discharge and OB Quick Orders** etc.
2. There are more views that can be accessed by clicking on the + to the right of the tabs
3. You will be able to select any view from this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



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:

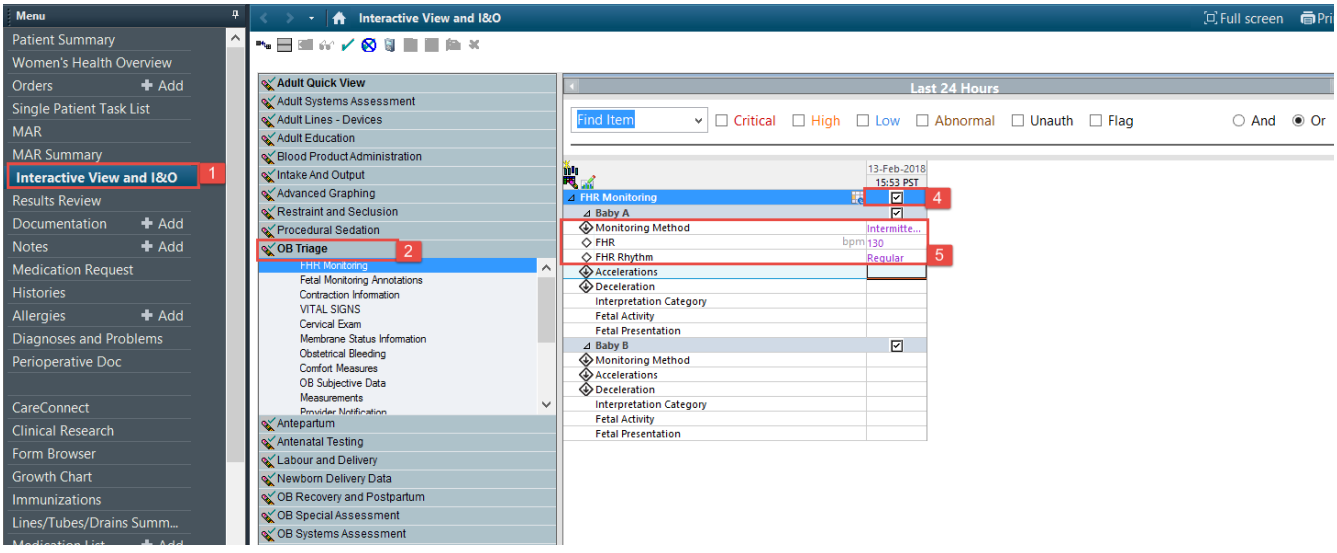
- Navigate to Interactive View and I&O (iView)
- Document OB specific assessments in iView

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.

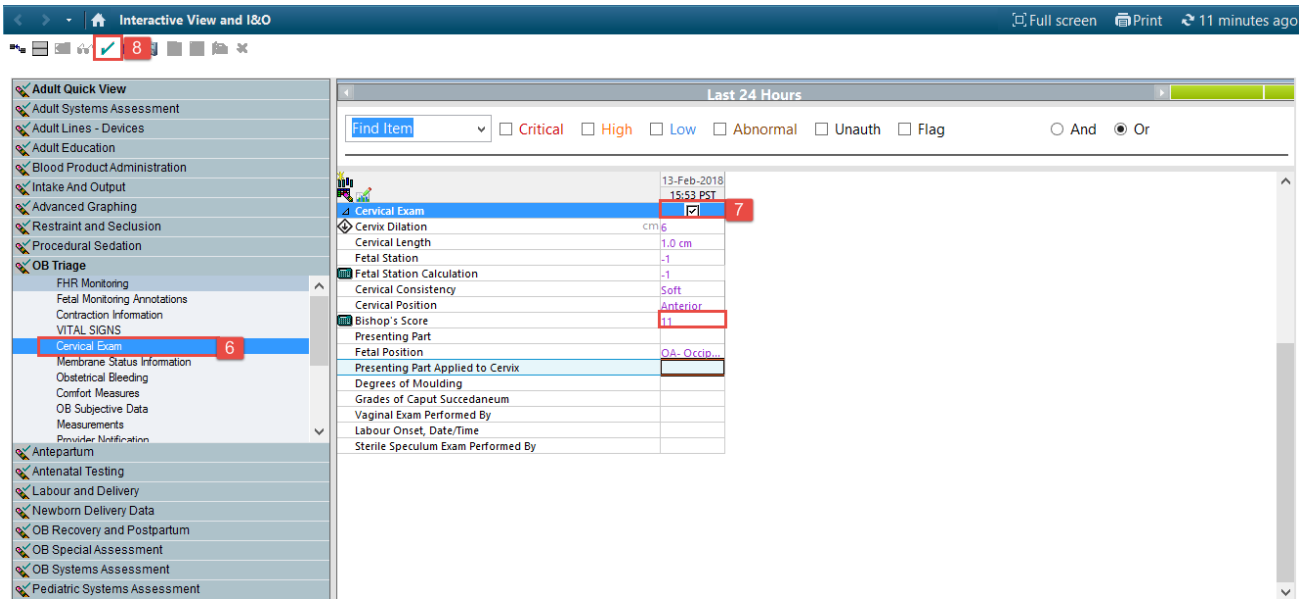
1. Navigate to iView by clicking on **Interactive View and I&O** from the menu
2. Click on the **OB Triage** band and the FHR Monitoring section is automatically available for documentation
3. Click Refresh  to ensure that previously documented data pulls through so that you are viewing the most up to 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



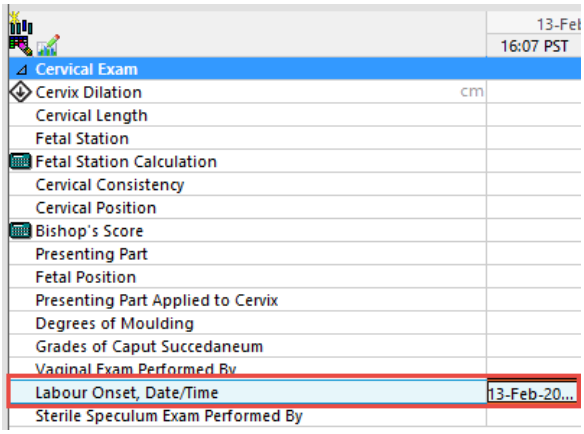
6. Now click on the **Cervical Exam** Section in the same **OB Triage** Band
7. Double-click the **blue box** next to the name of the section to document in several cells. Again, use the **Enter** key on the keyboard to move through the cells. Document the following:
    - **Cervix Dilation** = *6cm*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



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).



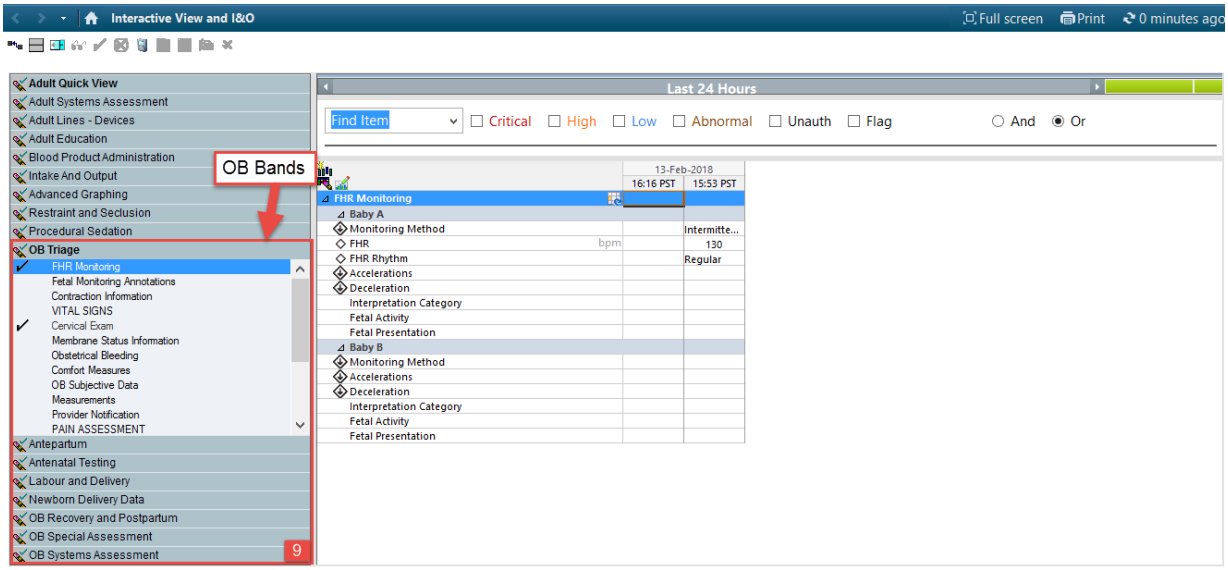
You have successfully documented the FHR Monitoring and Cervical Exam for your patient!

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.

9. 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



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.

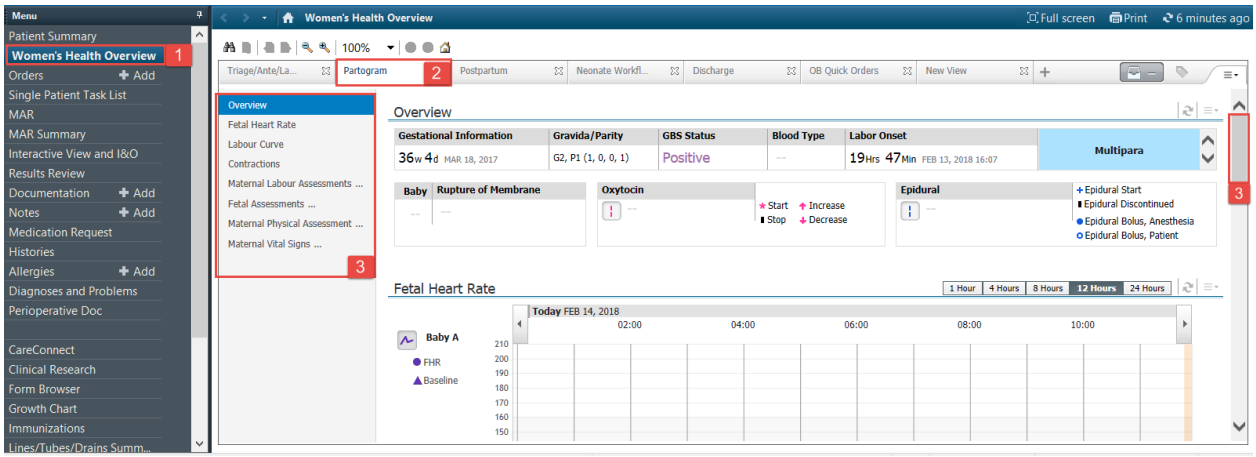
Note: If not already done, you will be prompted to document the labour onset date and time (the first stage of labour) before you can view the Partogram. If you are commencing oxytocin and the patient has not yet entered the first stage of labour, document the oxytocin start date and time in the Labour 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:

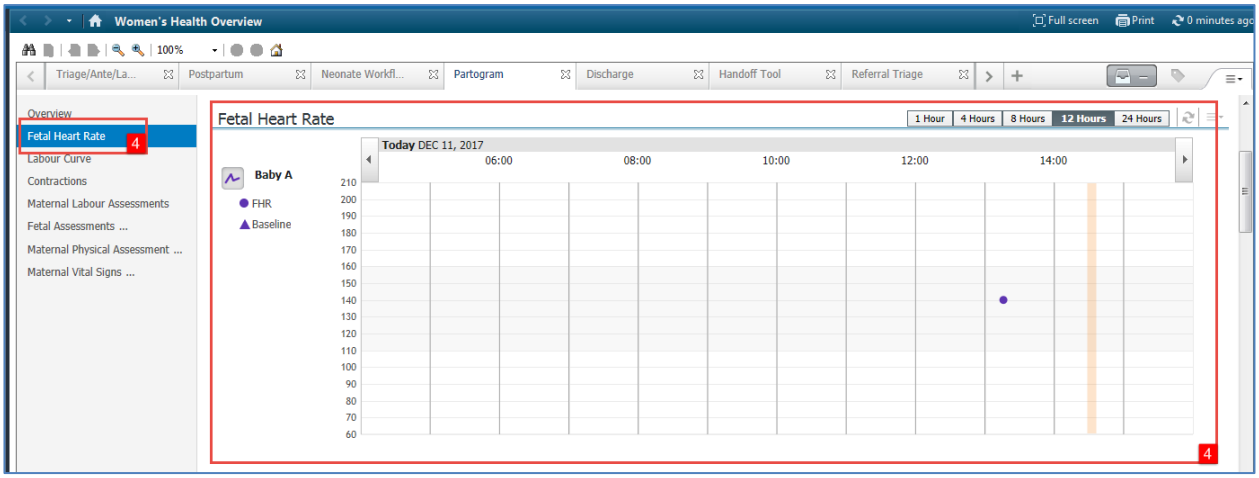
1. Navigate to the **Women's Health Overview** from the **Menu**
2. Click on the **Partogram** tab.

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.

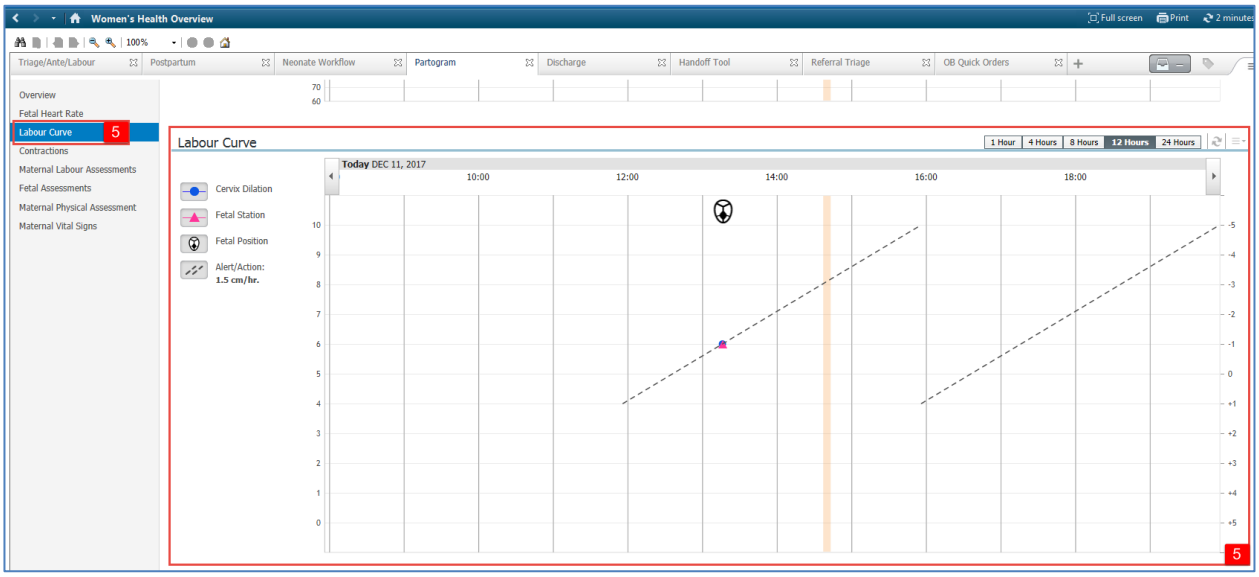


4. Click on the Fetal Heart Rate component. Note that the FHR you documented in iView populates here. When multiple FHRs are documented in iView, the results will display here in a graphical format. If updated information is not appearing as expected, click refresh  in the upper right corner of the screen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

5. 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 as 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

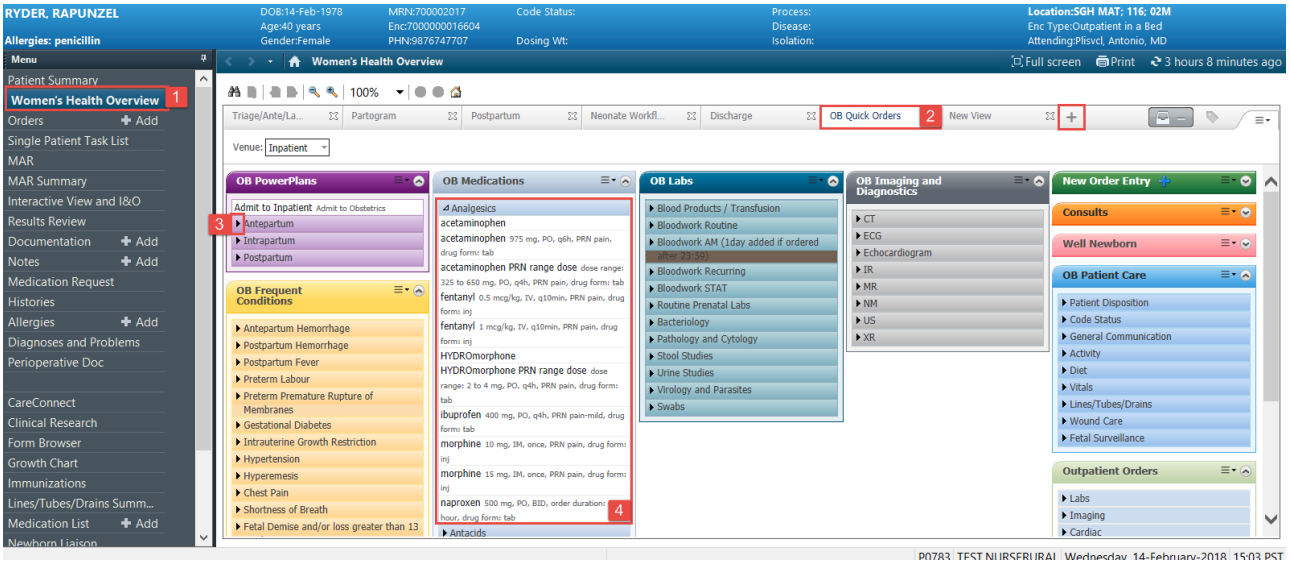
1 The **OB Quick Orders** page features the most commonly used orders in obstetrics. You can order **Powerplans** (the equivalent to preprinted orders) as well as stand-alone orders (for example, vital signs q4h). Orders are categorized into different colour-coded sections, for example, **OB PowerPlans,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

Explore the **OB Quick Orders** Page:

1. Navigate to the **Women's Health Overview** from the Menu
2. 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.

3. 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.
4. Click on the arrow beside **Analgesics** in the OB Medications section. A list of the most commonly used OB analgesics will open.



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

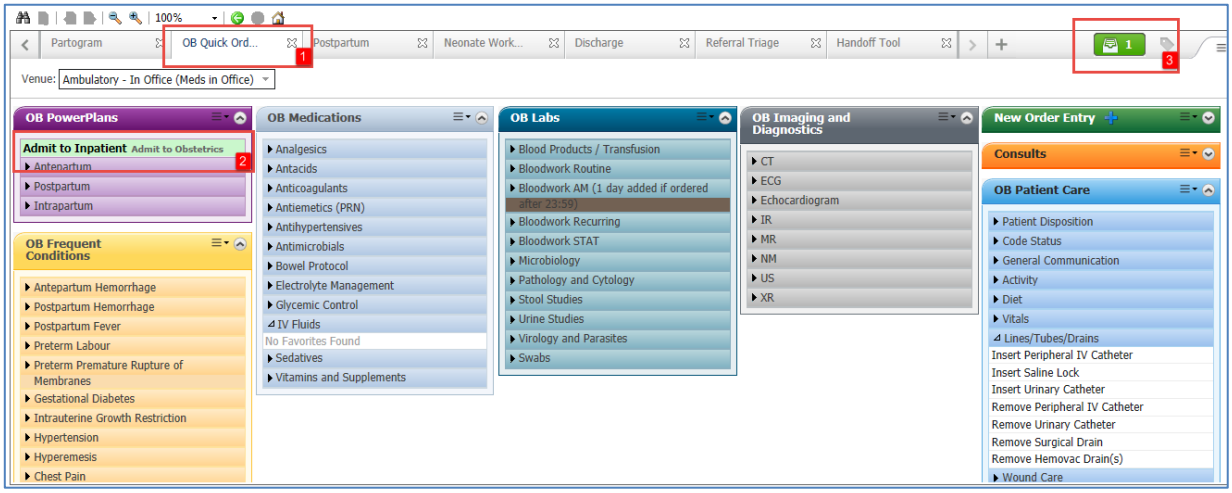
Your patient is in active labour. You have called the OB Provider and the decision has been made to admit the patient. Your patient's current encounter type is Outpatient in a Bed; this encounter type is used for all OB patient assessments (Note that for scheduled outpatient activities such as NSTs or 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.

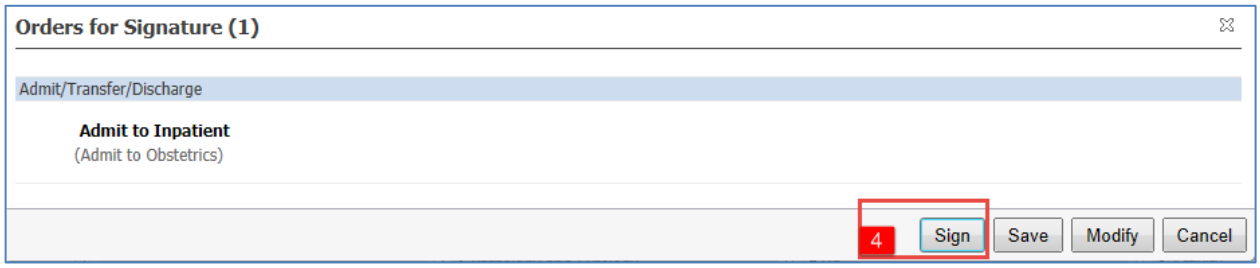
Note: Verbal and phone orders that nurses enter in the CIS will be automatically routed to the ordering provider for co-signature

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 s**ection.
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  .

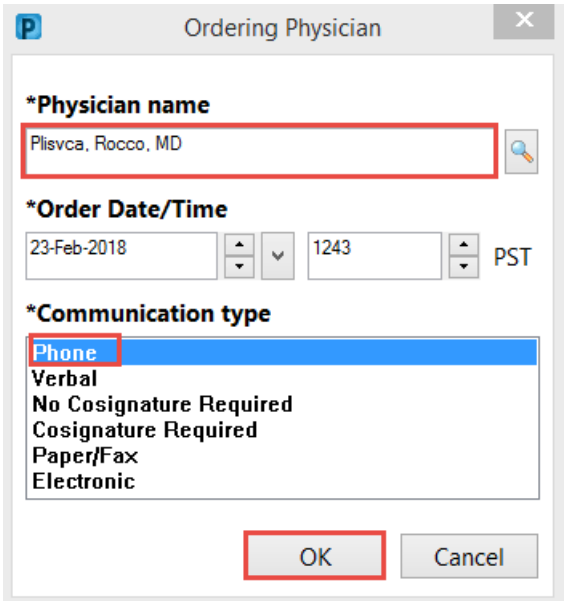


4. The **Orders for Signature** window will open. It will list all the orders you have placed in your "shopping cart". Click Sign.



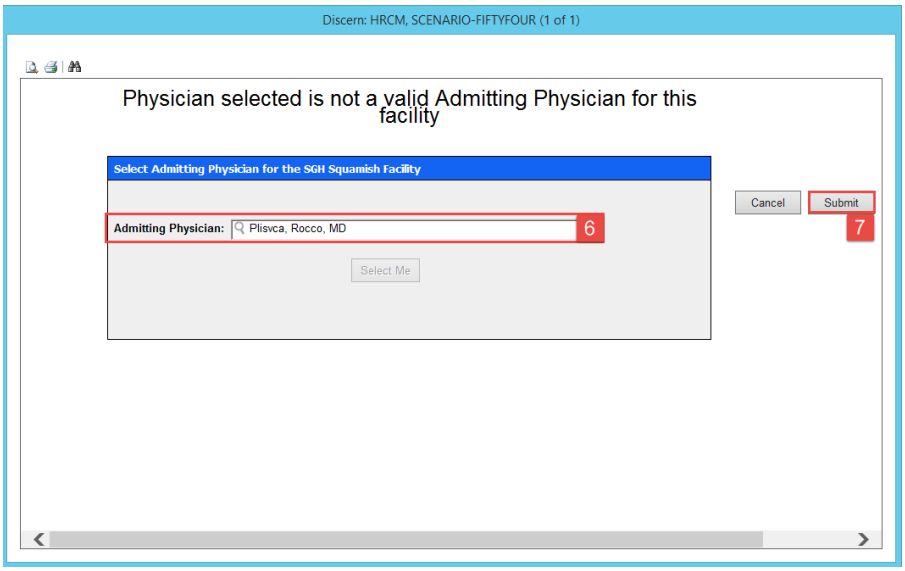
5. The Ordering Physician window will open. Document:
    - Physician Name = xxx (Plisvca, Rocco)
    - Communication Type = Phone
    - Click **OK**

Remember that fields highlighted in yellow are mandatory.



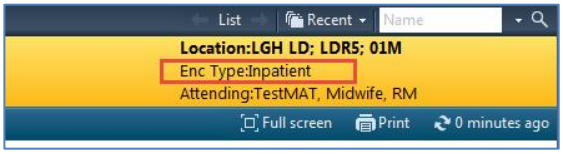
A Discern window will appear asking to select a valid Admitting Physician (in practice please type in the correct obstetrics provider).

6. In the **Admitting Physician** field enter *Pliscva, 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.

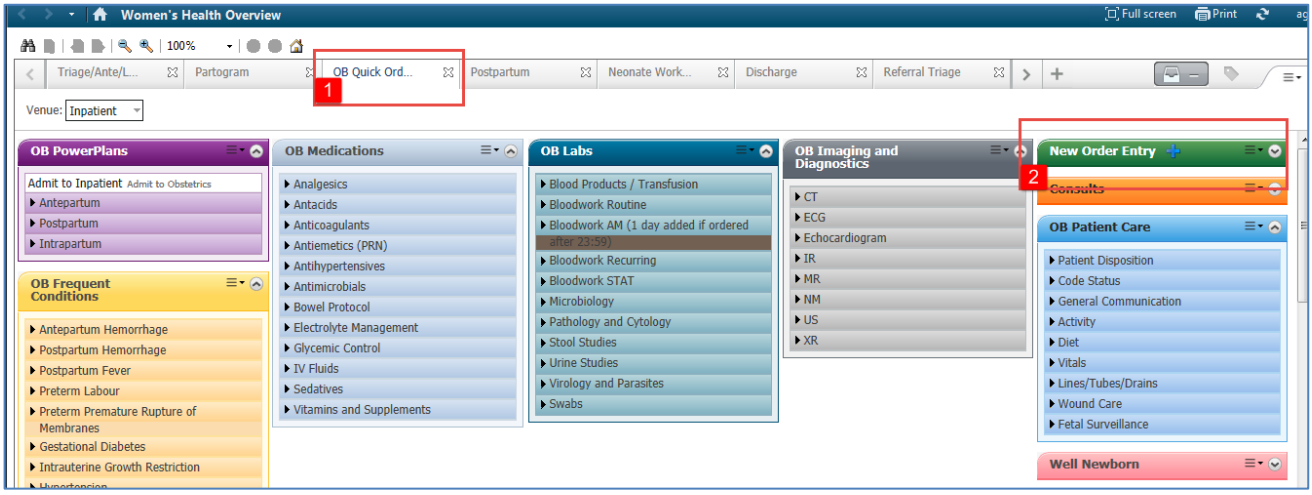


Activity 7.3 – Place an Order via Add Order

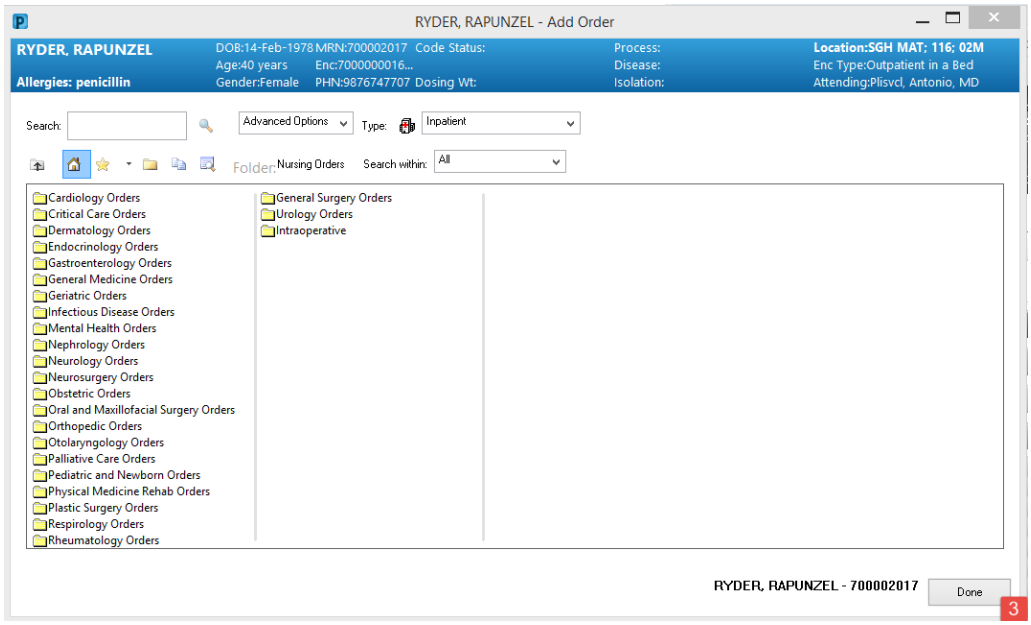
1 Some orders do not require a cosignature by physician. Let's practice placing an order that does not need to be routed to a physician for cosignature.

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.)

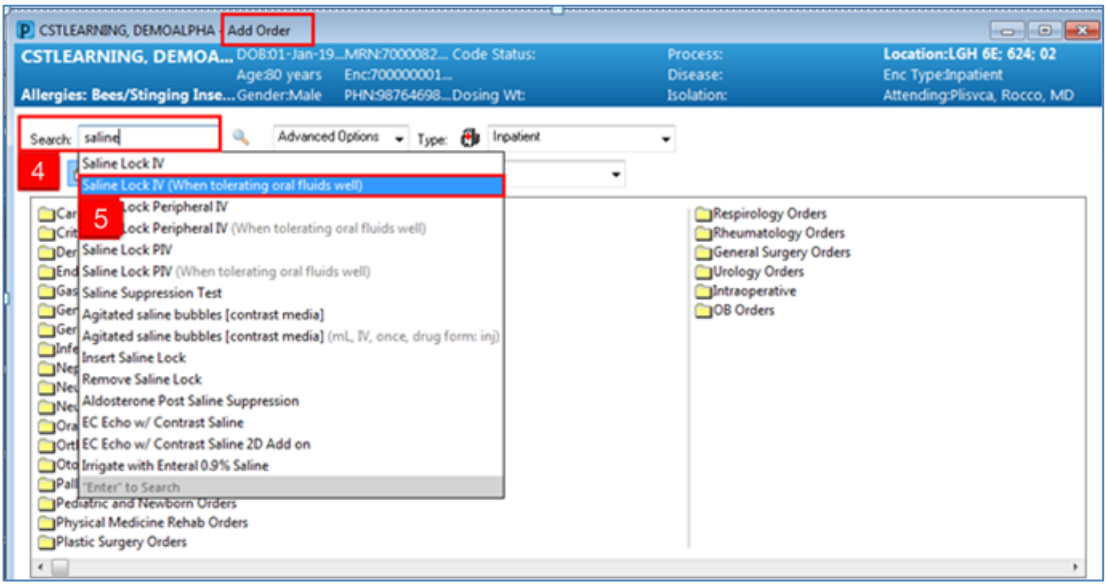


3. The **Add Orders** Page will open.

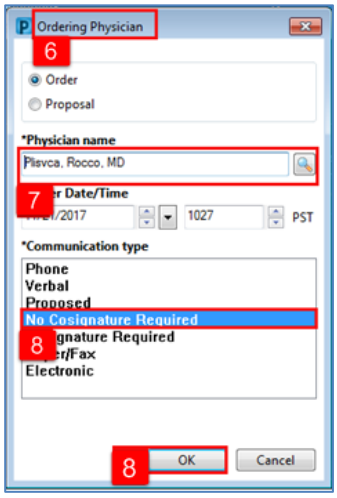


4. Type *saline lock* into the search window and a list of choices will display.

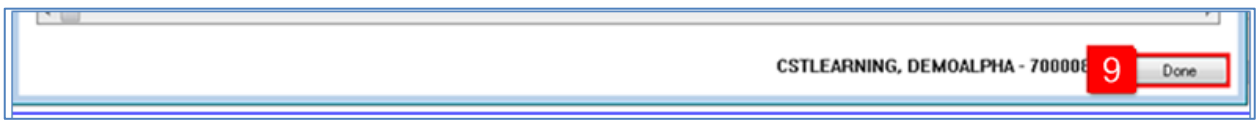
5. Select **Saline Lock Peripheral IV** with order sentence of (*when tolerating oral fluids well*). Order sentences help to pre-fill order details.



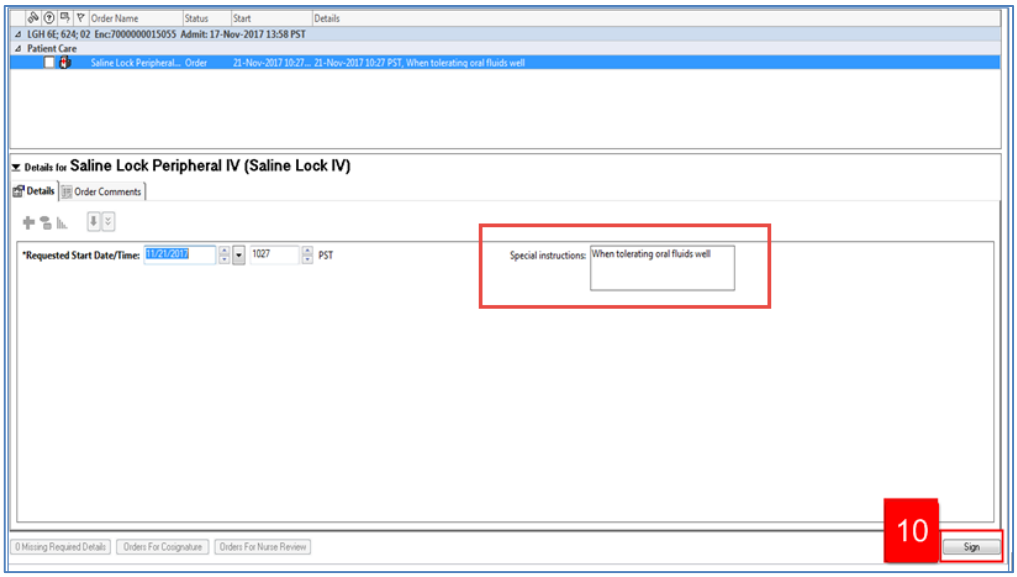
6. The **Ordering Physician** window opens.
7. Type in the name of the patient's Attending Physician
8. Select **No Cosignature Required** and click **OK.**



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.**



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.

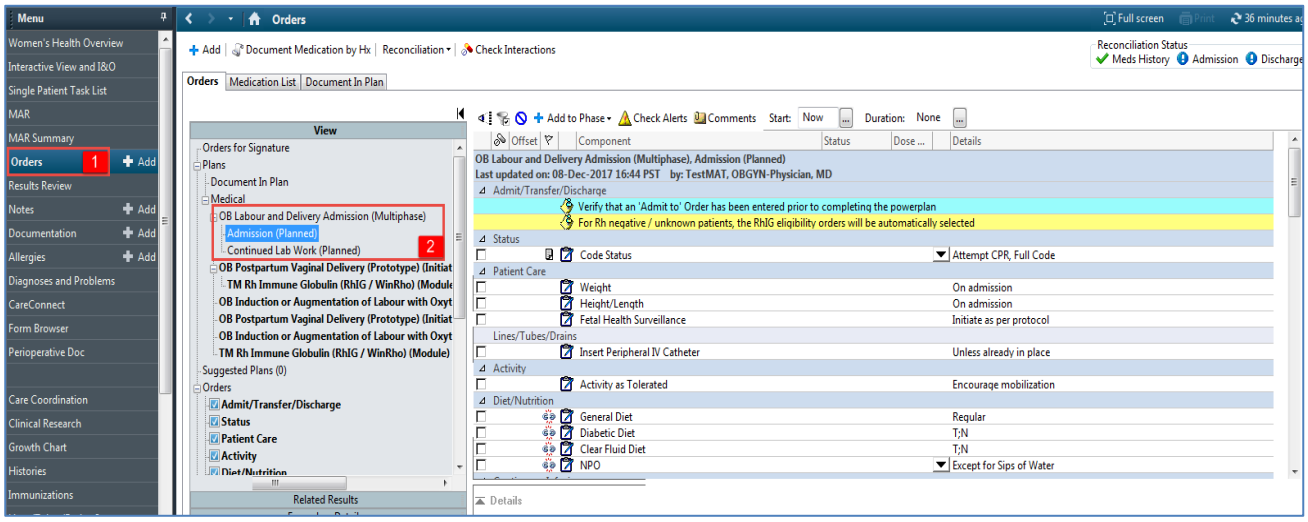
Let's say that the OB Provider has placed the **OB Labour and Delivery Admission (Multi-phase) PowerPlan** in a **planned** state.

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.

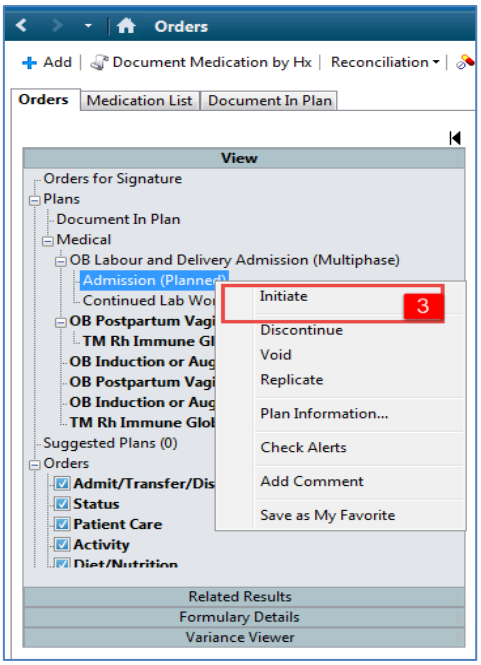
1. Click on the **Orders** band from the Menu.
2. Locate the **OB Labour and Delivery Admission (Multiphase) PowerPlan** in the Navigator (View). The Admission phase and Continued Lab Work phase are both in planned statuses.

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.**

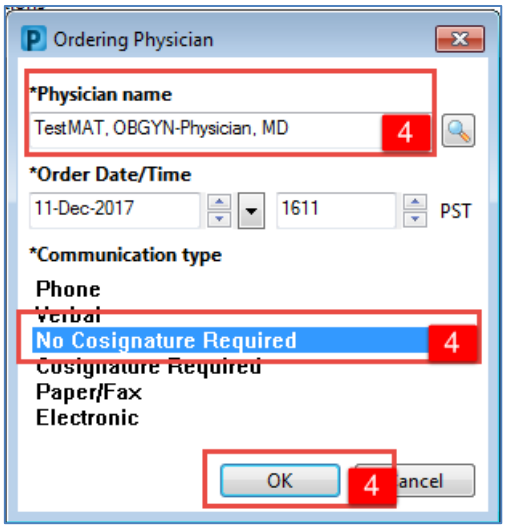
Note: The **Continued Lab Work** phase of the **OB Labour and Delivery Admission PowerPlan** does not get discontinued during the postpartum phase, as this bloodwork needs to continue throughout the patient's journey.



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

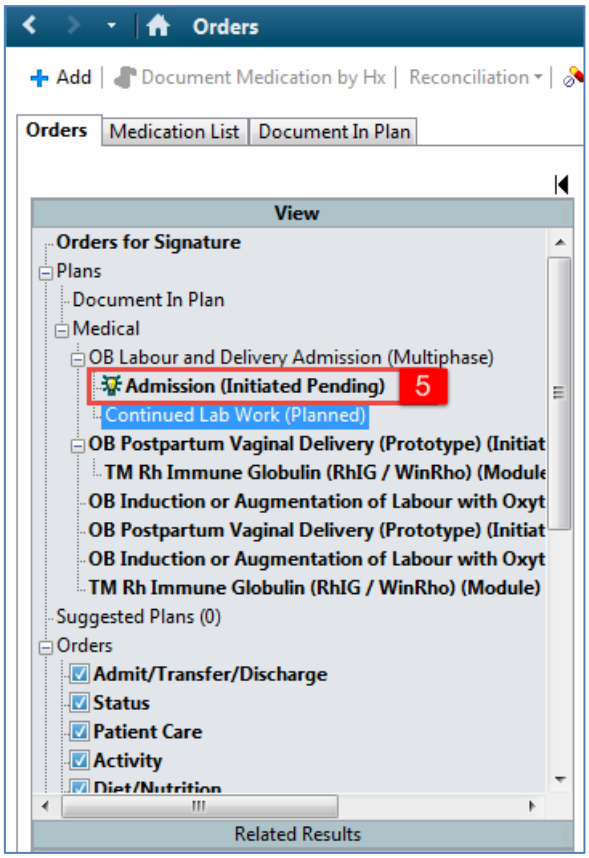


4. The **Ordering Physician Window** opens with the provider name automatically prepopulated. Select No Cosignature required and click OK.

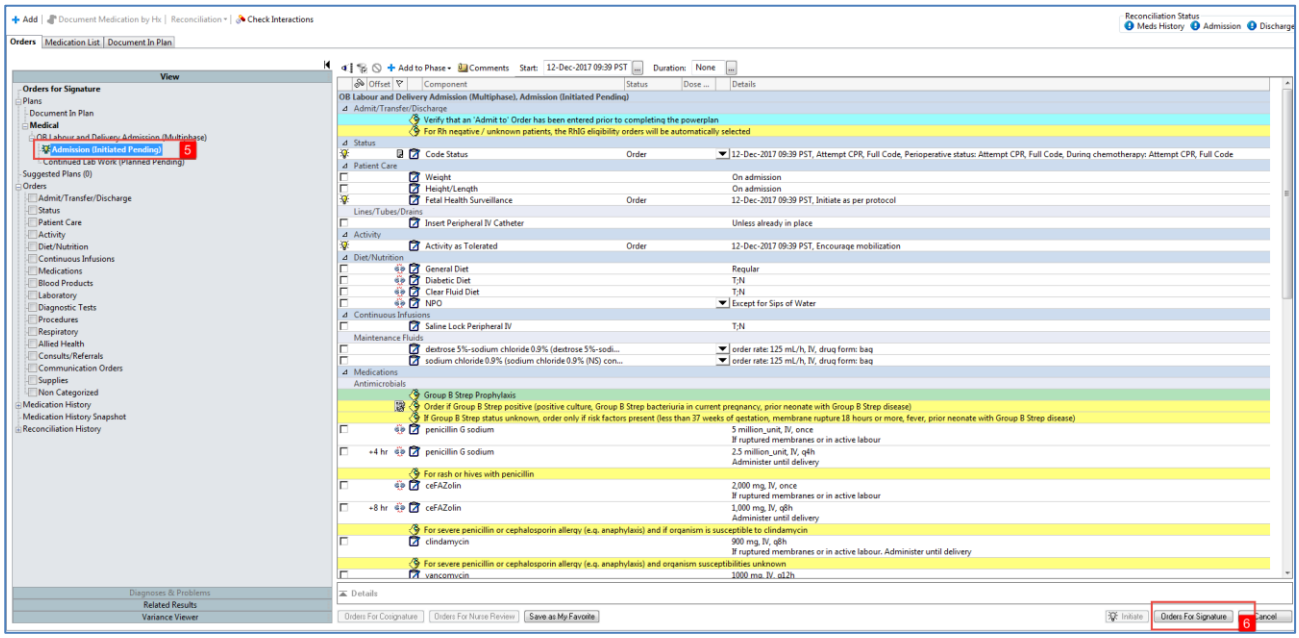


Note: A planned PowerPlan has already been signed by the provider and therefore 'No Cosignature Required' can be selected when initiating it.

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

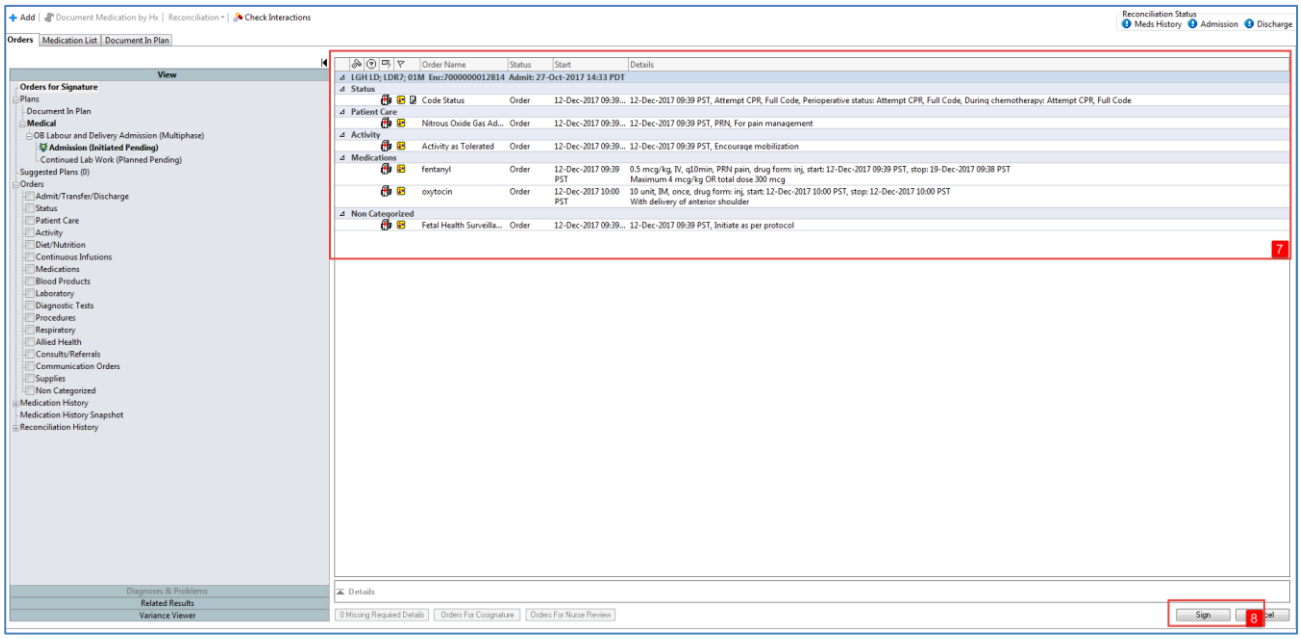


6. Click **Orders for Signature** from the Orders Profile.

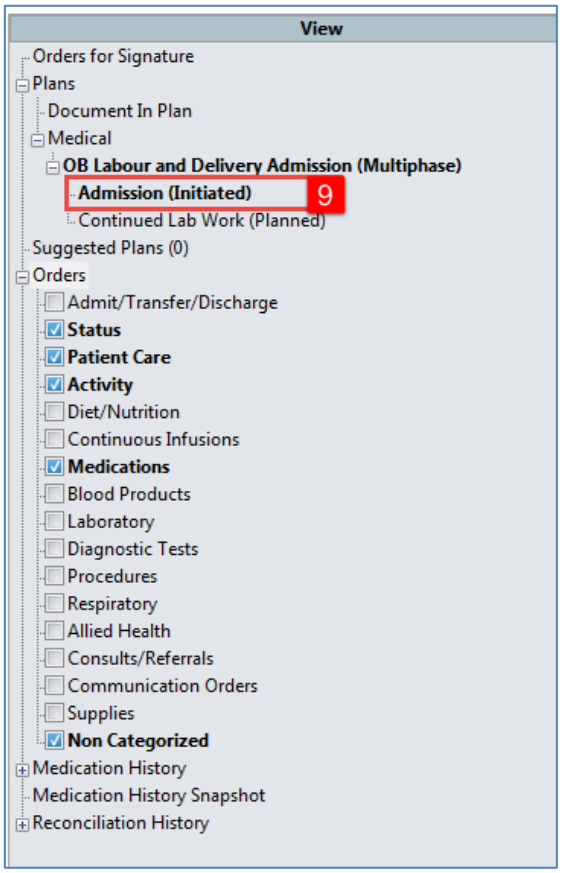


7. The Orders Profile will update and display only the selected orders.

8. Click **Sign** and then click refresh 



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:

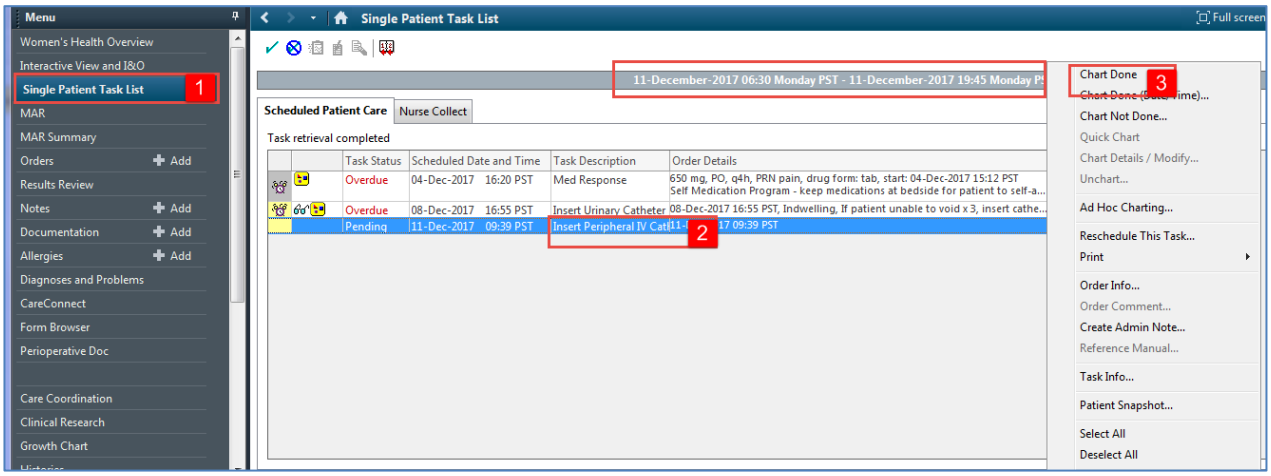
- Review the Single Patient Task List
- Complete a Task

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

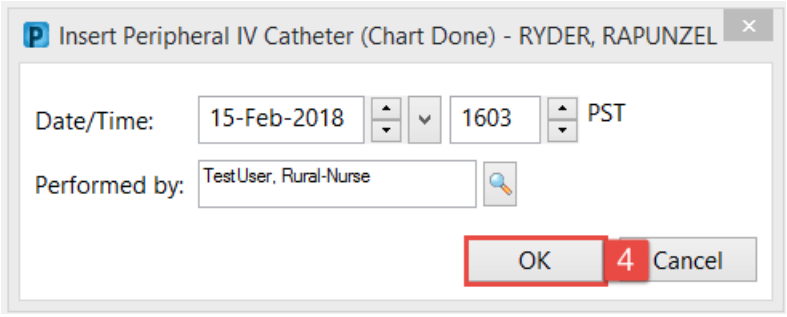
1 The **Single Patient Task List** displays the list of tasks associated to the patient from within the patient's chart. You can access the Single Patient Task List from the Menu (within each patient's chart) throughout your shift to view pending tasks and mark them as completed when done.

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

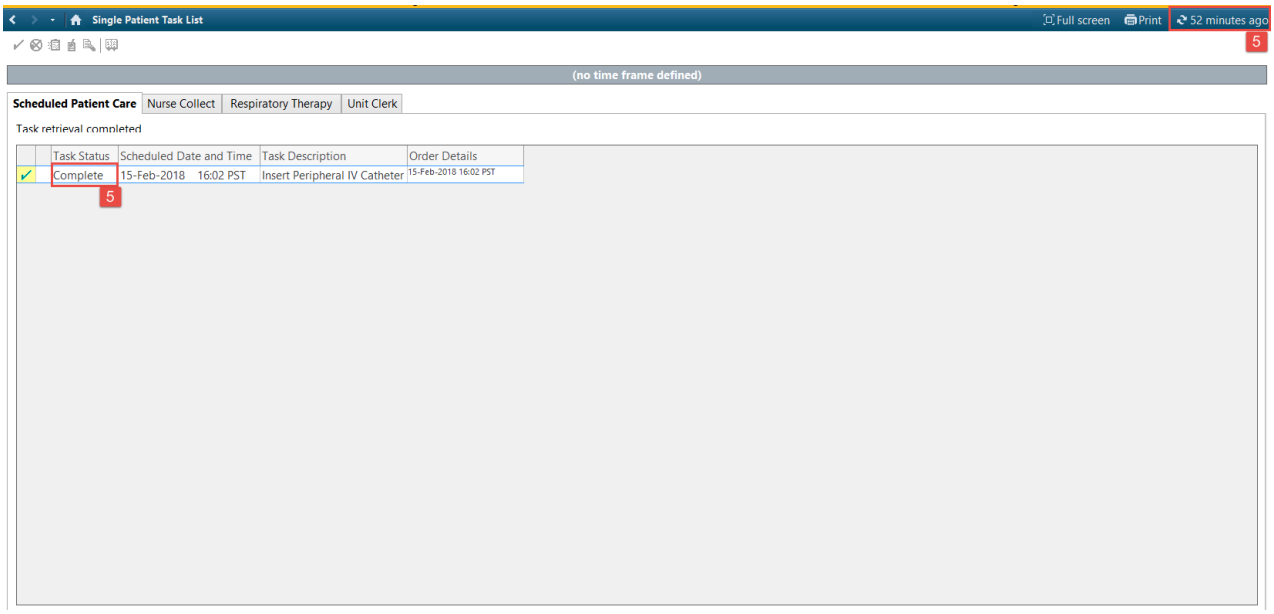
1. Select **Single Patient Task List** from the **Menu**
2. Right click **Insert Peripheral IV Catheter** task
3. Select **Chart Done**



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.



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

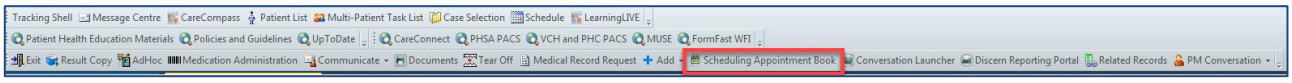
Activity 9.1 – Scheduling an OB Anesthesia/Epidural Appointment

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.

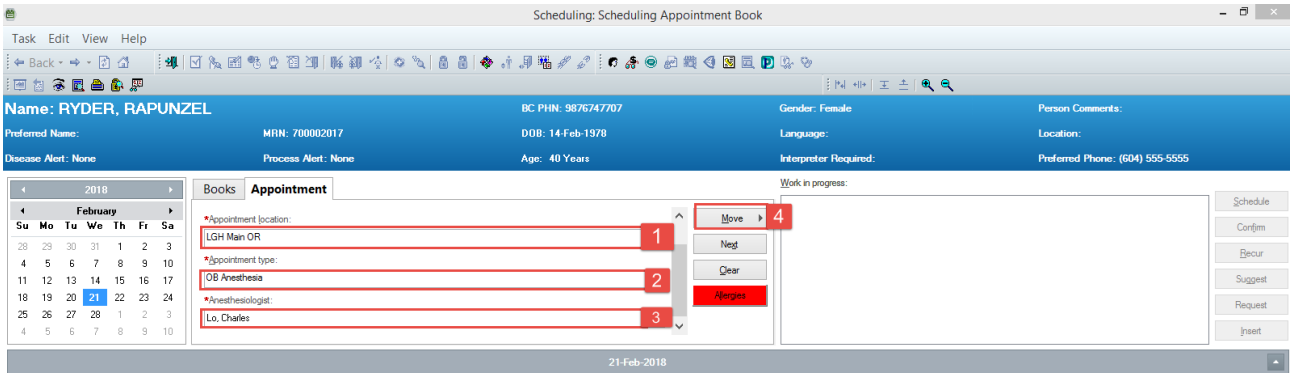
Let's practice how to schedule an OB Anesthesia/Epidural appointment:

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

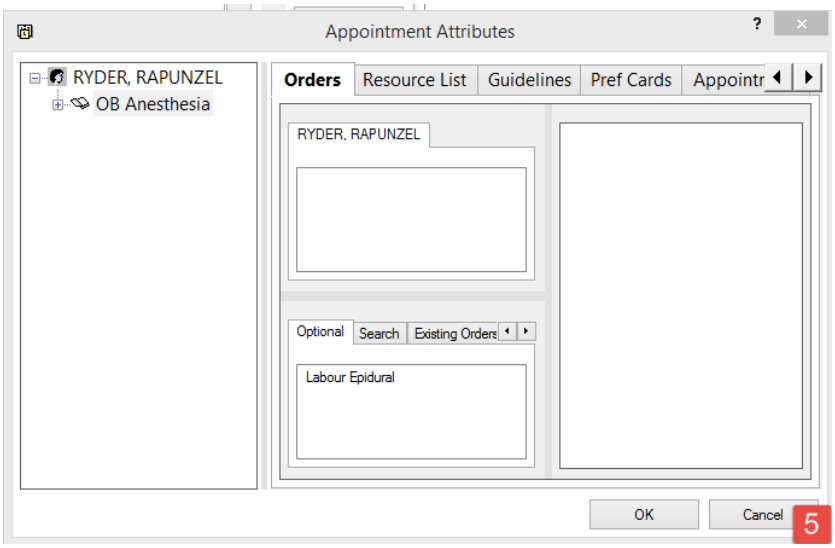


The Scheduling Appointment Book (also called SchAppt Book) launches and opens to the main page. Your patient's name auto-populates in the **Person name** field in the **Appointment** tab. Complete required fields:

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

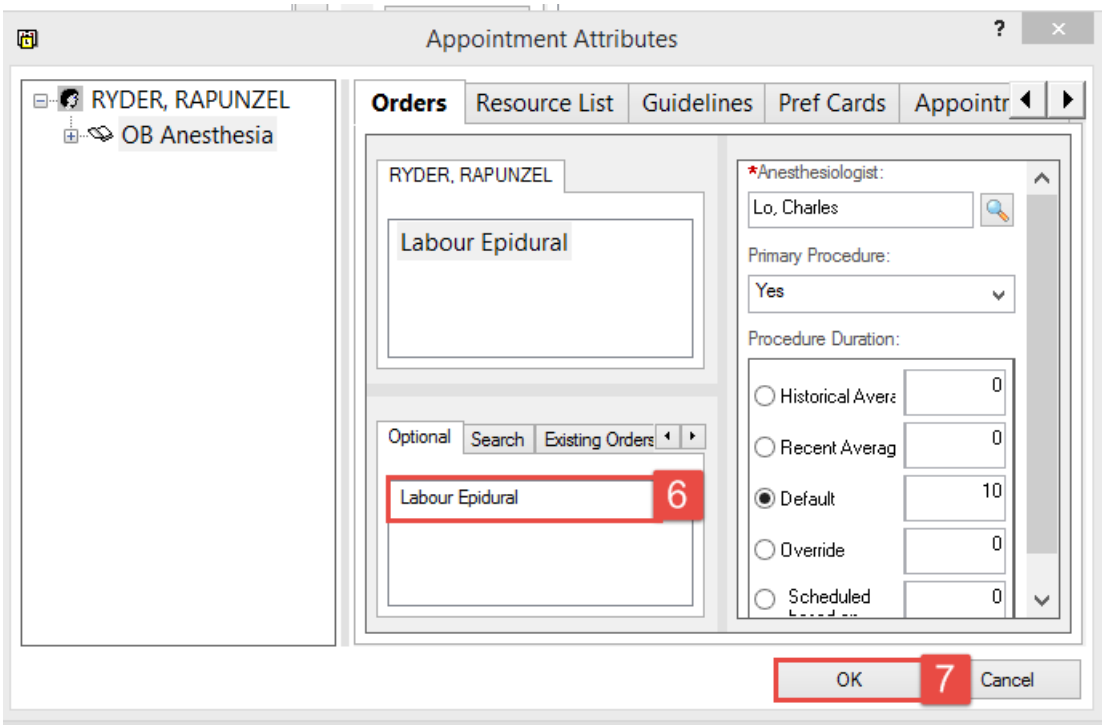


5. **The Appointment Attributes** window opens.

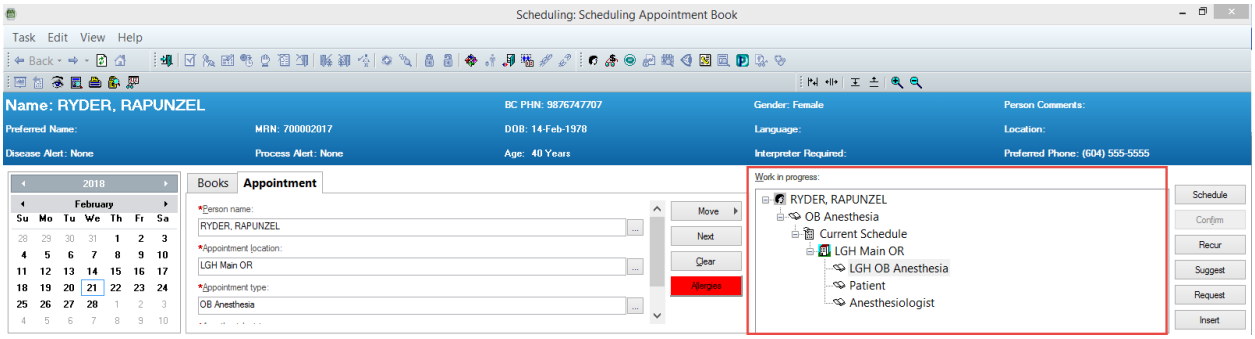


6. Double click on **Labour Epidural** in Optional tab (the blank field on the right will now be populated).

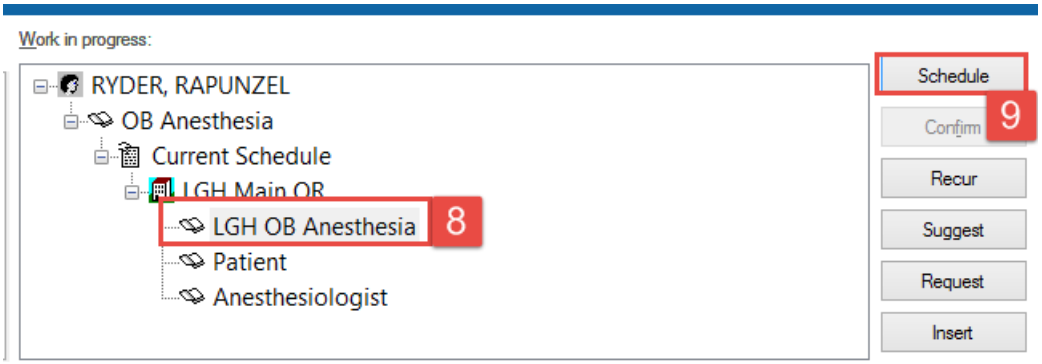
7. Click **OK**.



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



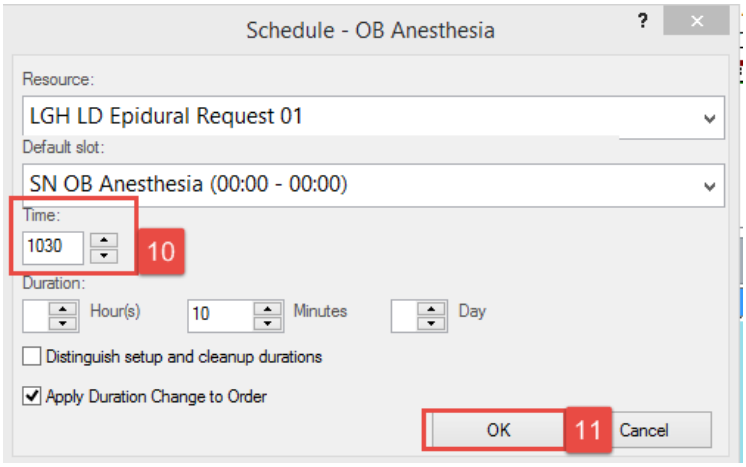
8. Click to highlight the **LGH OB Anesthesia** in the Work in progress box
9. Then click on the **Schedule** button



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**

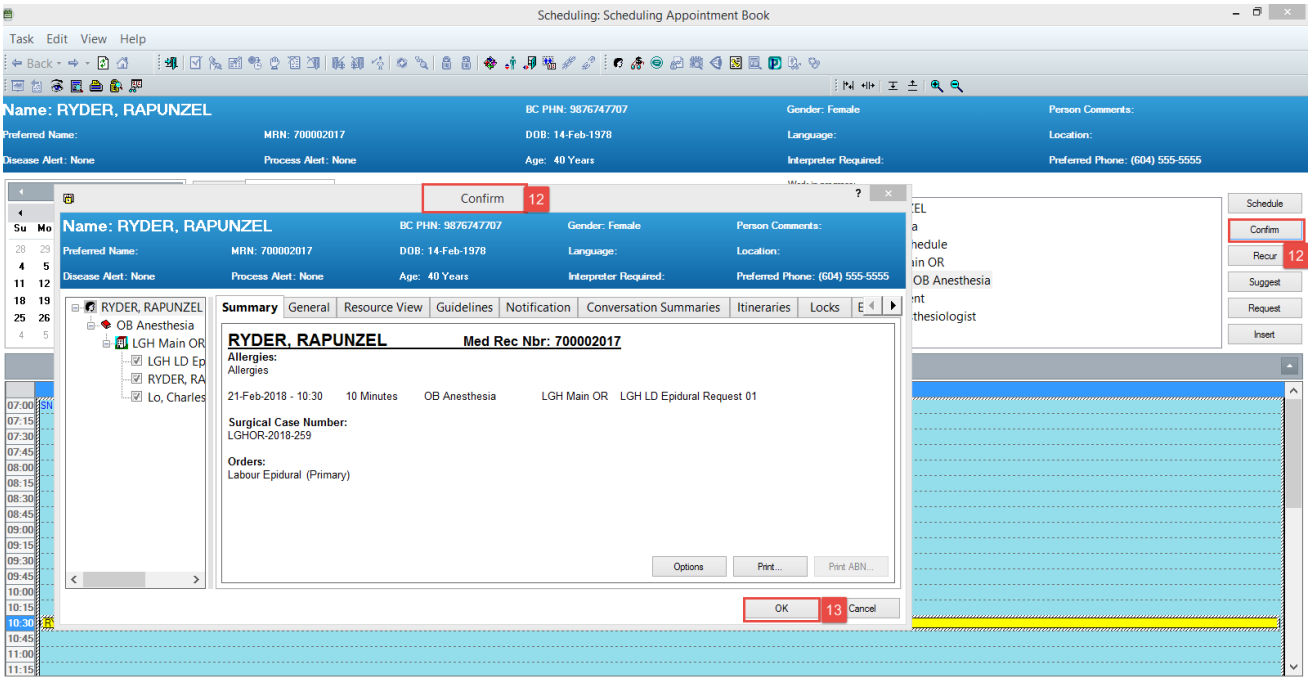
Note: It does not matter what time you choose; you are only placing the patient on the list so that if the patient does need to go to the OR, anesthesia will be aware.



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.



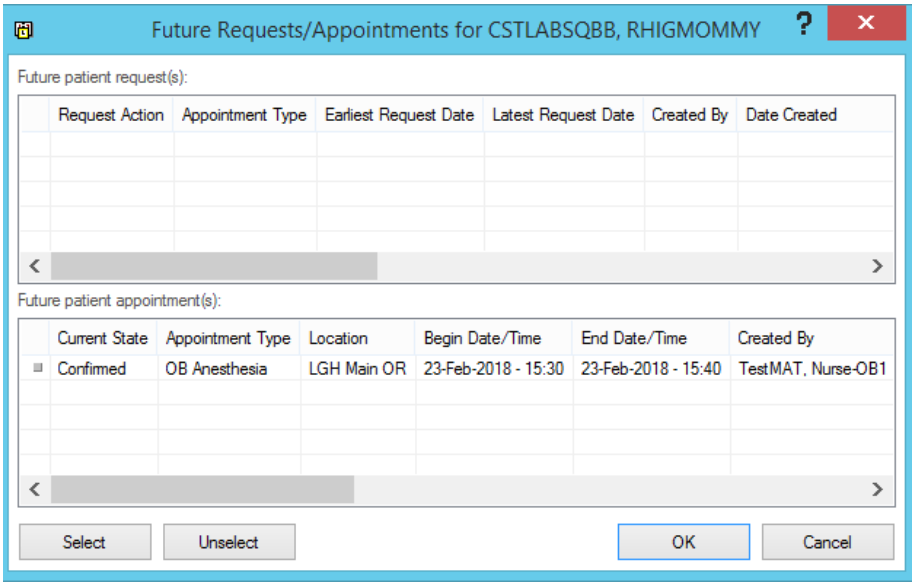
The Confirmation window closes and returns to a blank **Scheduling Appointment Book**.

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.



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.

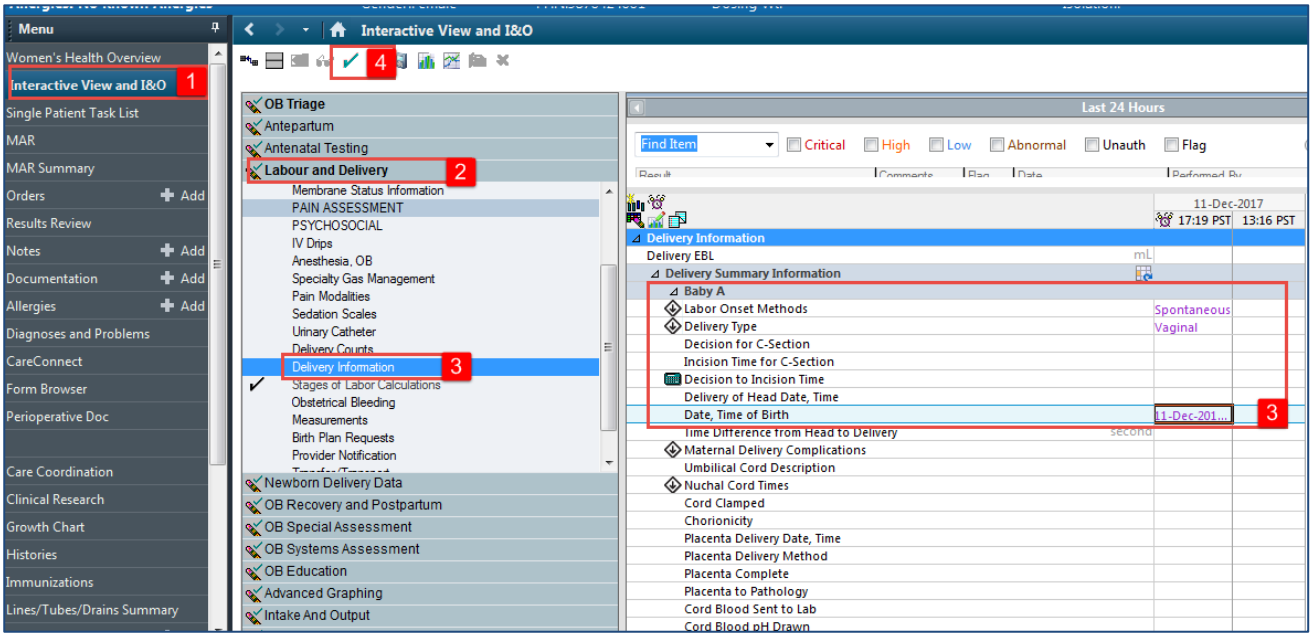
As an inpatient nurse you will be completing the following activities:

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

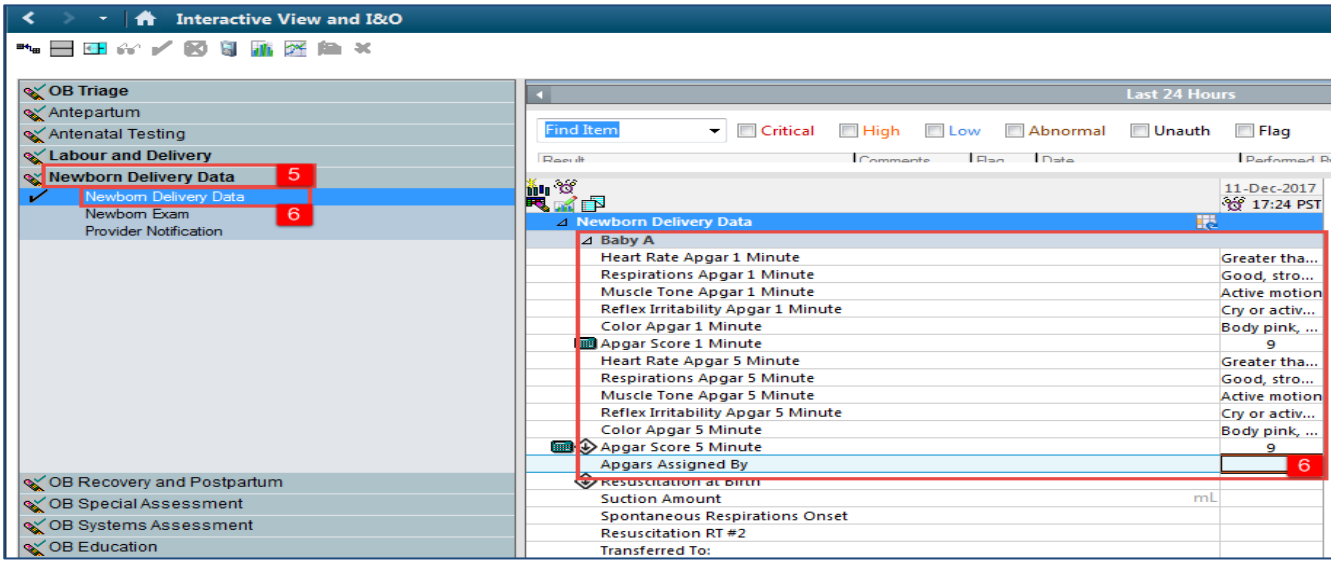
Activity 10.1 – Document Delivery Information (iView)

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.

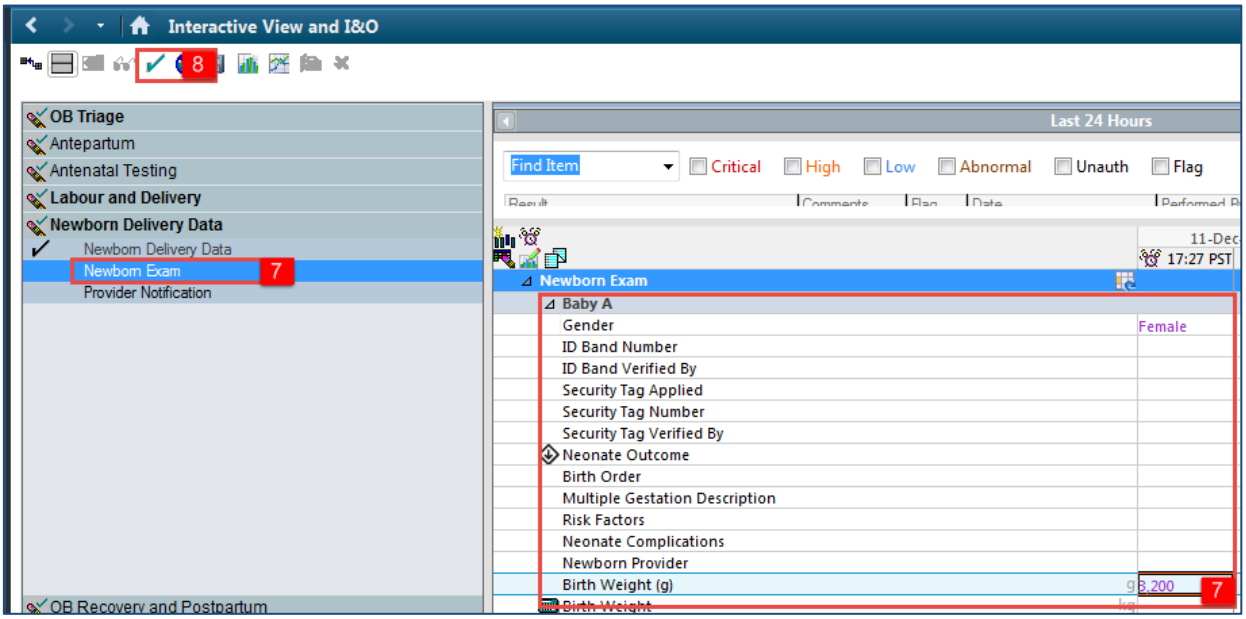


5. Now navigate to the **Newborn Delivery Data** iView band.
6. Click on the **Newborn Delivery Data** section and document the following for Baby A:
    - Heart Rate Apgar 1 Minute = *Greater than 100 beats per minute*
    - Respirations Apgar 1 Minute = *Good, strong cry*
    - Muscle Tone Apgar 1 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

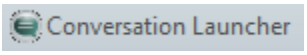
Activity 10.2 – Quick Registering the Newborn

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.

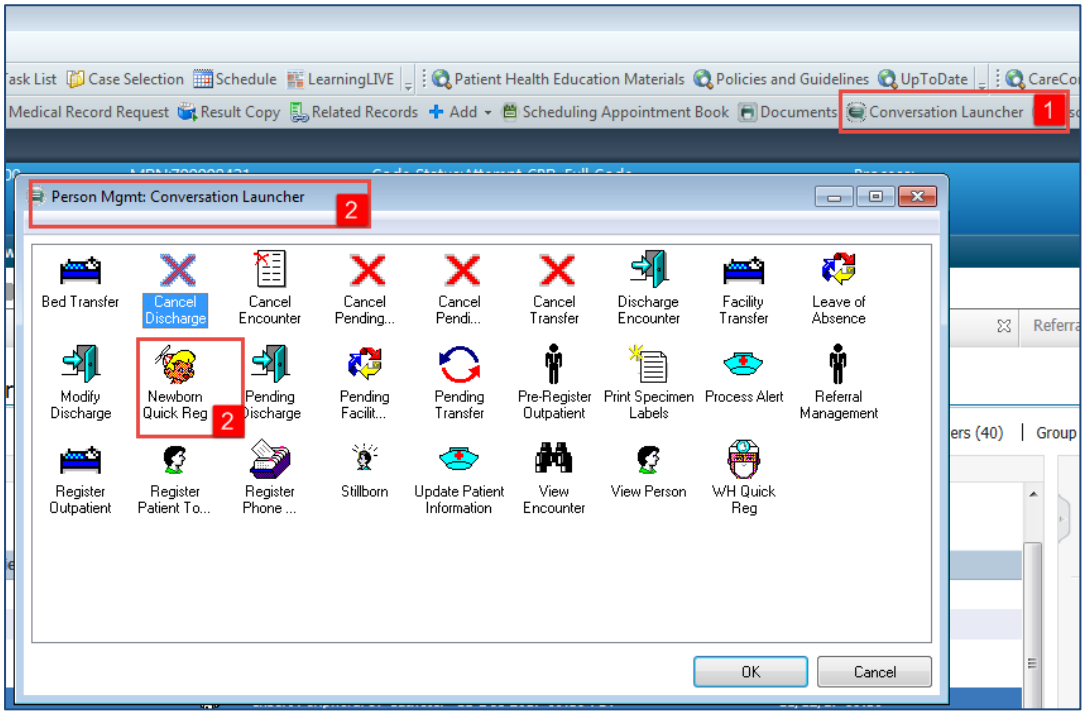
Let's practice completing the **Newborn Quick Registration**:

1. Click on the **Conversation Launcher** 

on the Toolbar.

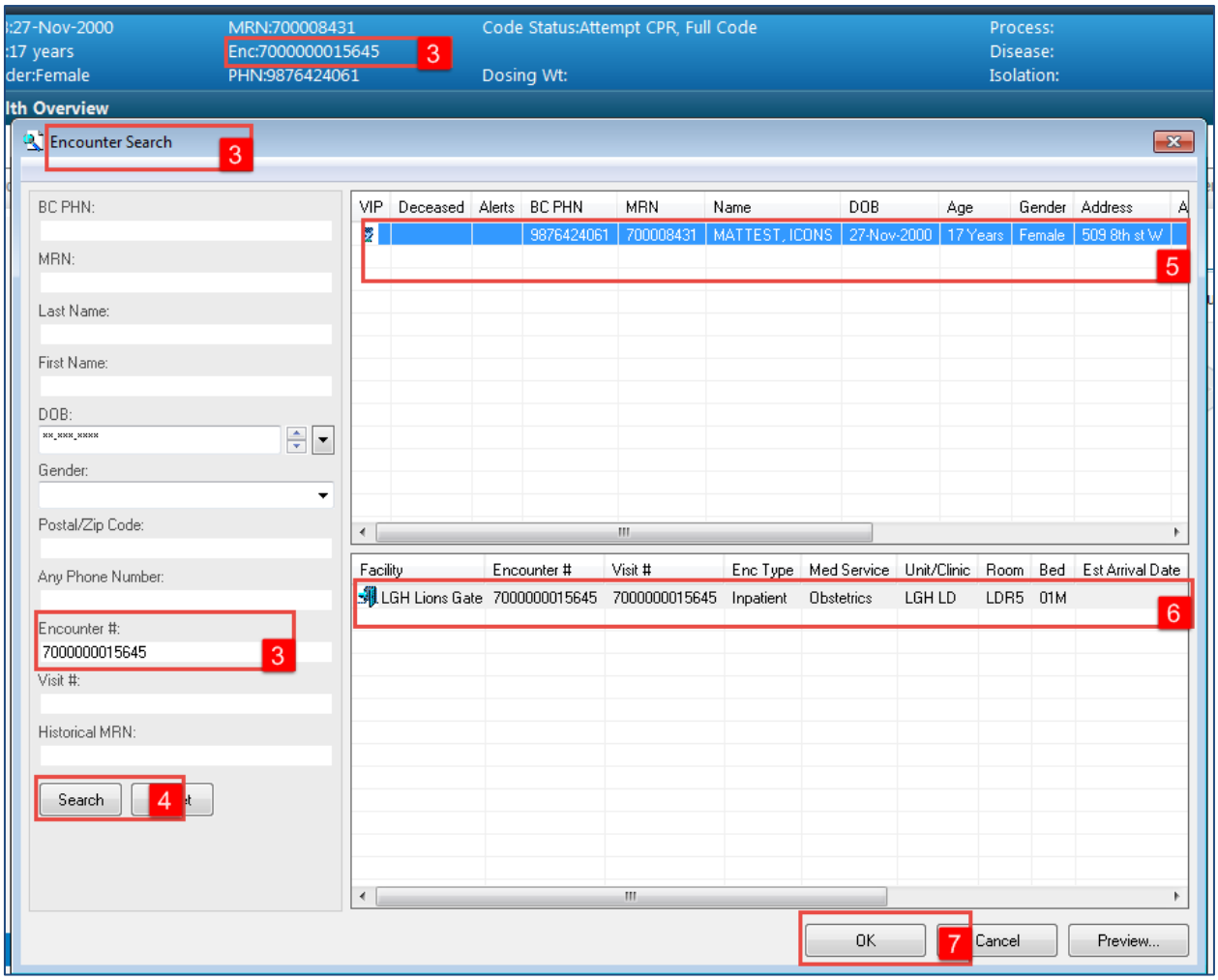
Note: If unable to see this on your tool bar, click the down arrow  on the far right of the toolbar to see more options.

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

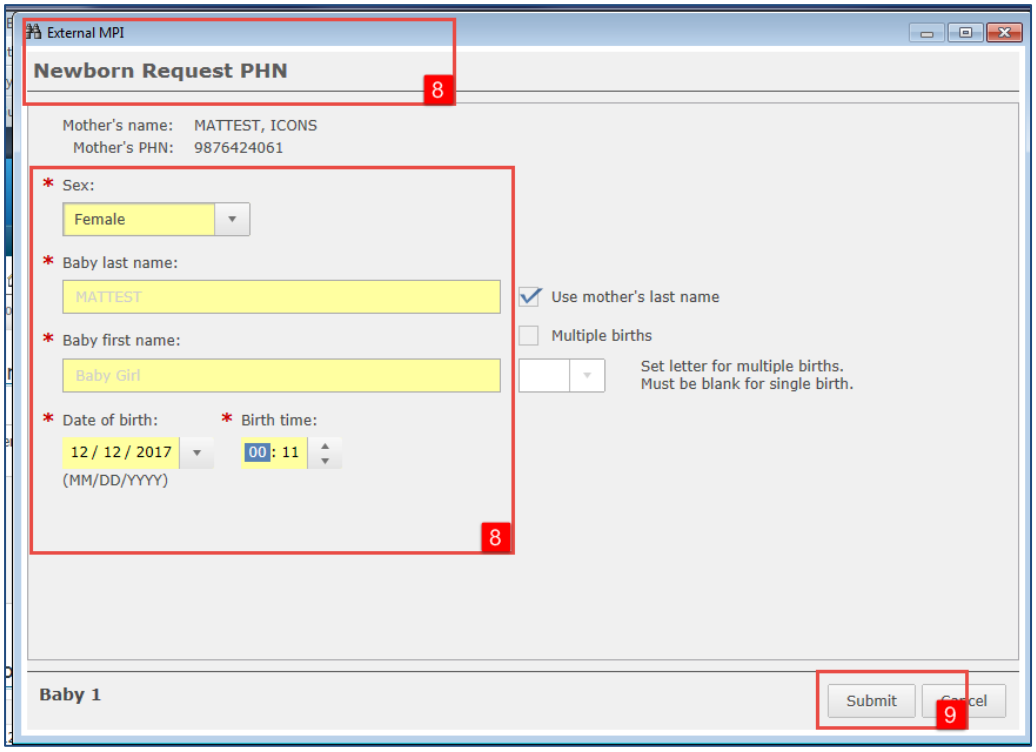


3. The **Encounter Search** window opens. Type in the patient's (mother's) Encounter number (located in the Banner bar) in the "Encounter #" field. Note: You can also search using three patient identifiers; first name, last name and DOB.

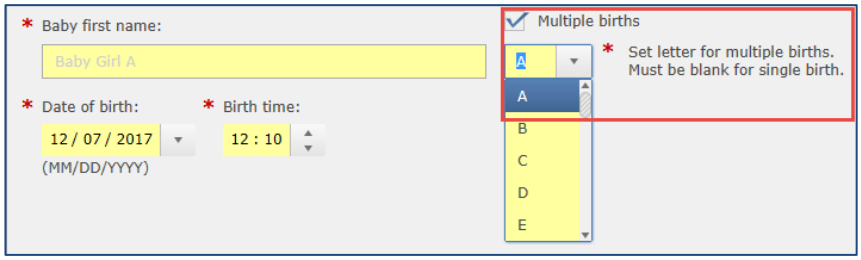
4. Click on the Search button.
5. Your patient's name will populate on the right. Verify the details to ensure you have the correct patient.
6. Click on the correct Inpatient Encounter type
7. Click on the **OK** button



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**

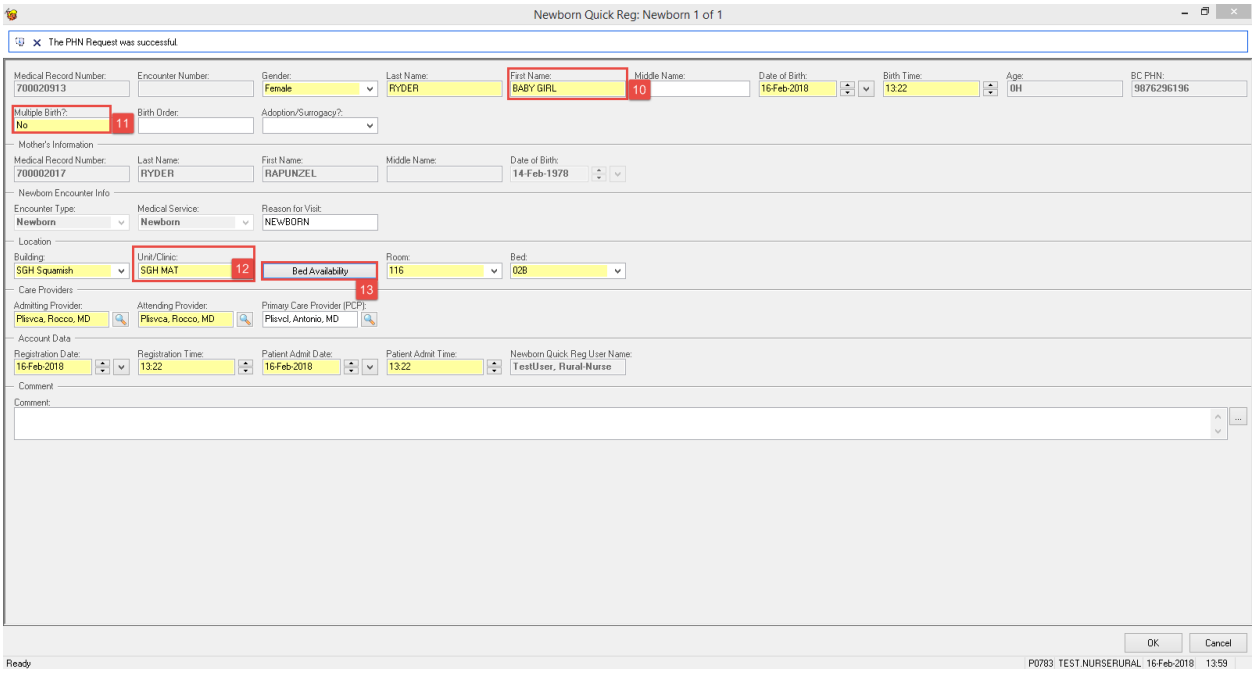


Note: For multiple births, you must check off the Multiple births box and select a letter corresponding to the Baby's birth order. This field must be left blank for singletons.



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

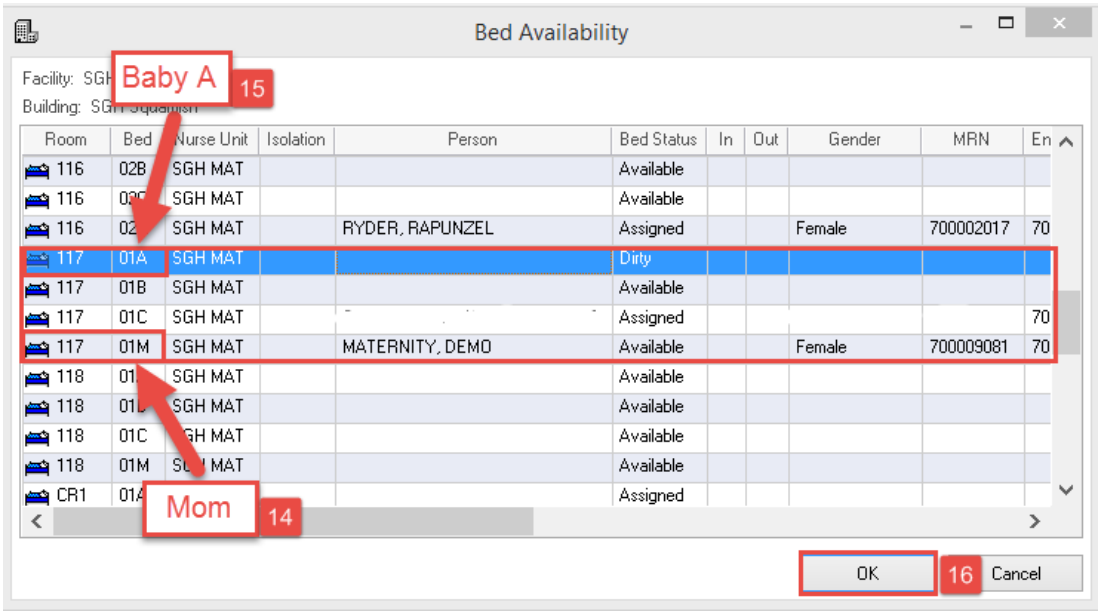
10. **First Name**: *for the purposes of this classroom workbook, re-name Baby Girl to a unique first name*
11. **Multiple Birth**: *No*
12. **Unit/Clinic:** *LGH Labour and Delivery*
13. Click **Bed Availability**



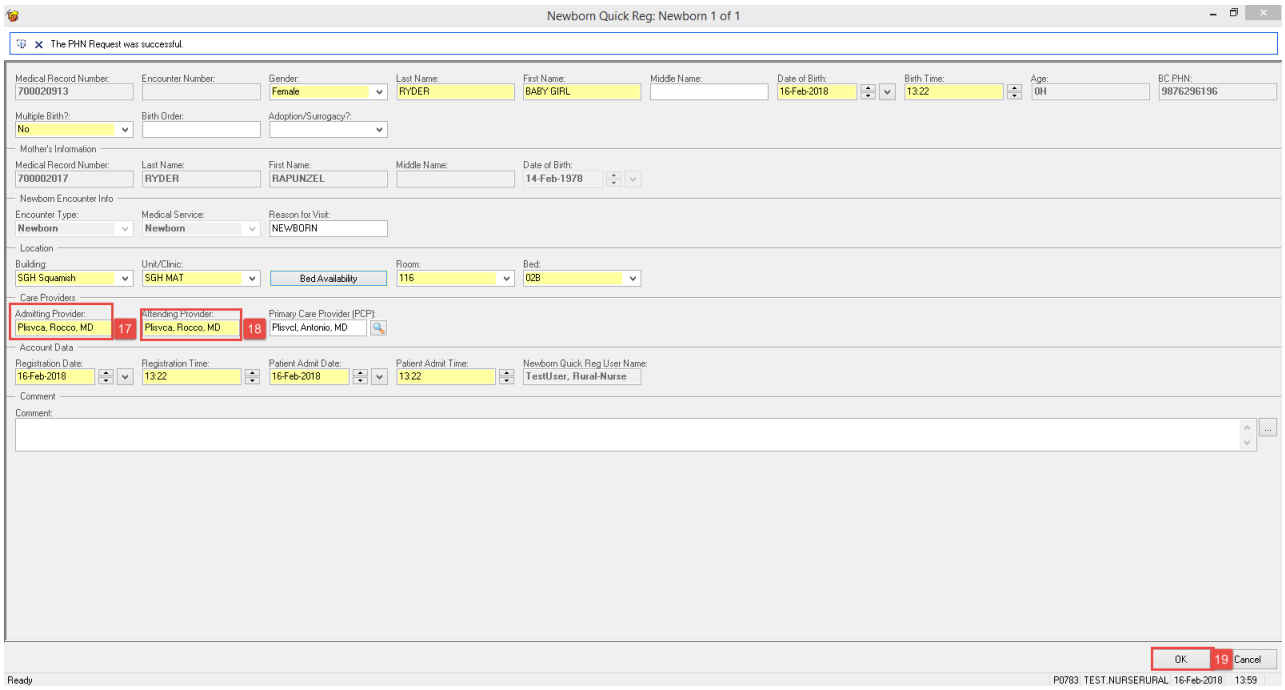
A **Bed Availability** window will open.

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.

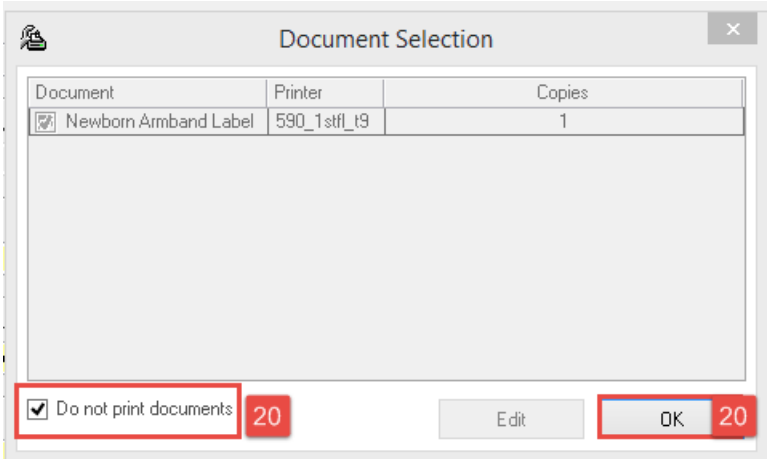
Note: Choose Bed A for Baby A. (If there are multiples, you would choose Bed B for Baby B and Bed C for baby C). For example is Mother is in Room 116 Bed02**M**, choose room 116 Bed02**A** for Baby A.



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



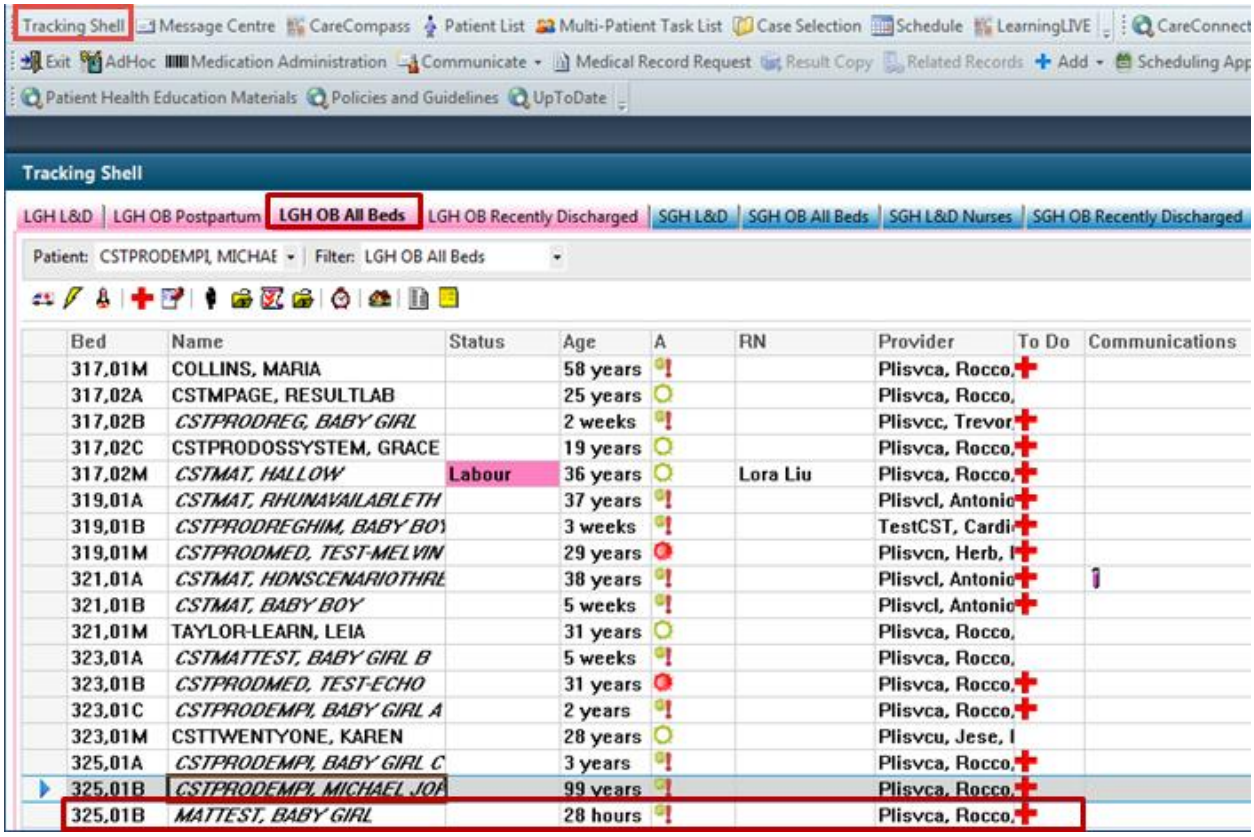
20. The Document Selection window opens. This window provides options to print Armband labels, Lab Blood Specimen Labels, and Lab Non-Blood Specimen Label. In practice, you would click OK to print the documents. However in class, because you are not synced with a printer, please select **Do not print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



The 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.



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 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

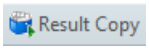
In this scenario, we will learn how to result copy from the mother's chart to the baby's chart. We will learn of when to use the result copy function.

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.

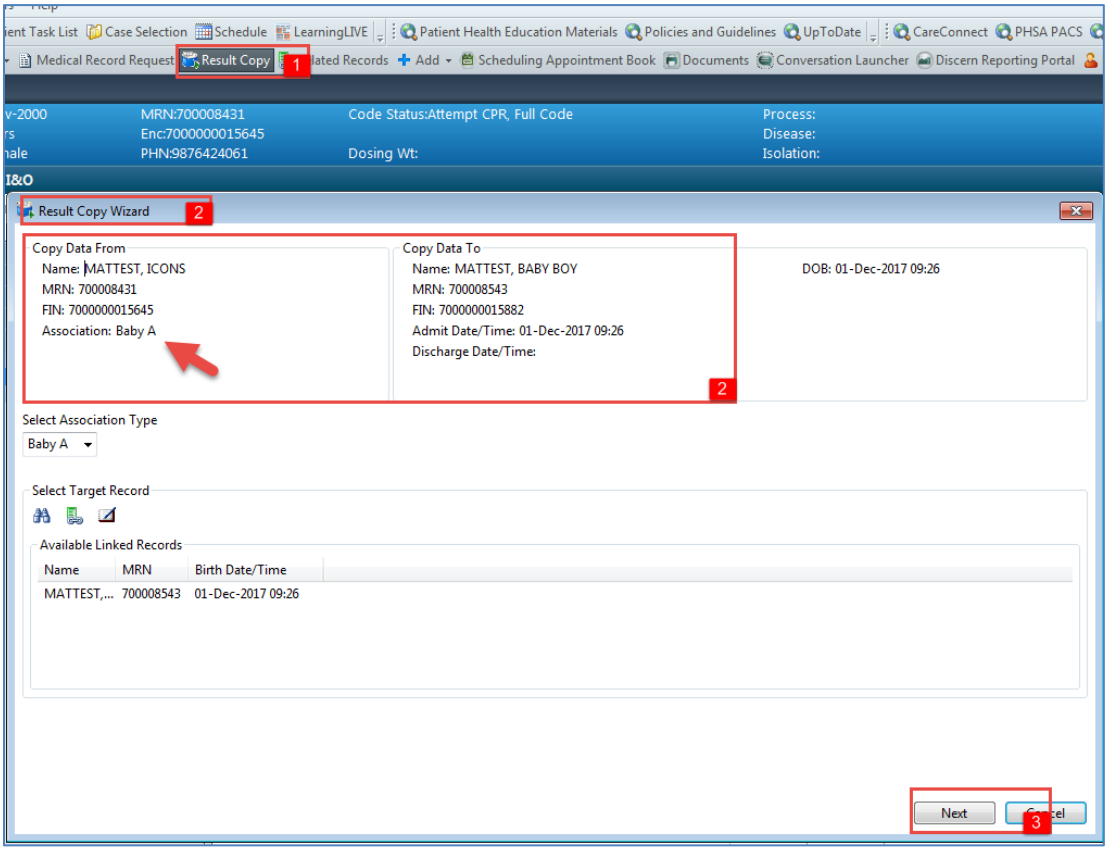
Activity 11.1 – Result Copy

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.

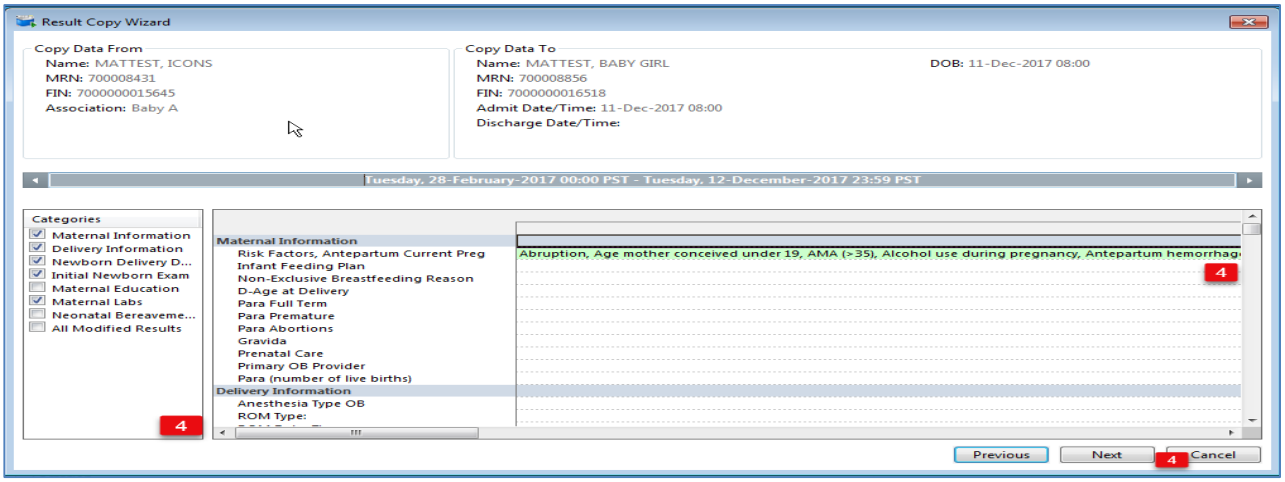
1. From the mom's chart, click the **Result Copy**  in the Toolbar.
2. The **Result Copy** Wizard window opens. Check to ensure the demographic information is correct for both the mom (in the Copy Data From box) and her newly quick registered newborn (in the Copy Data To box).

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

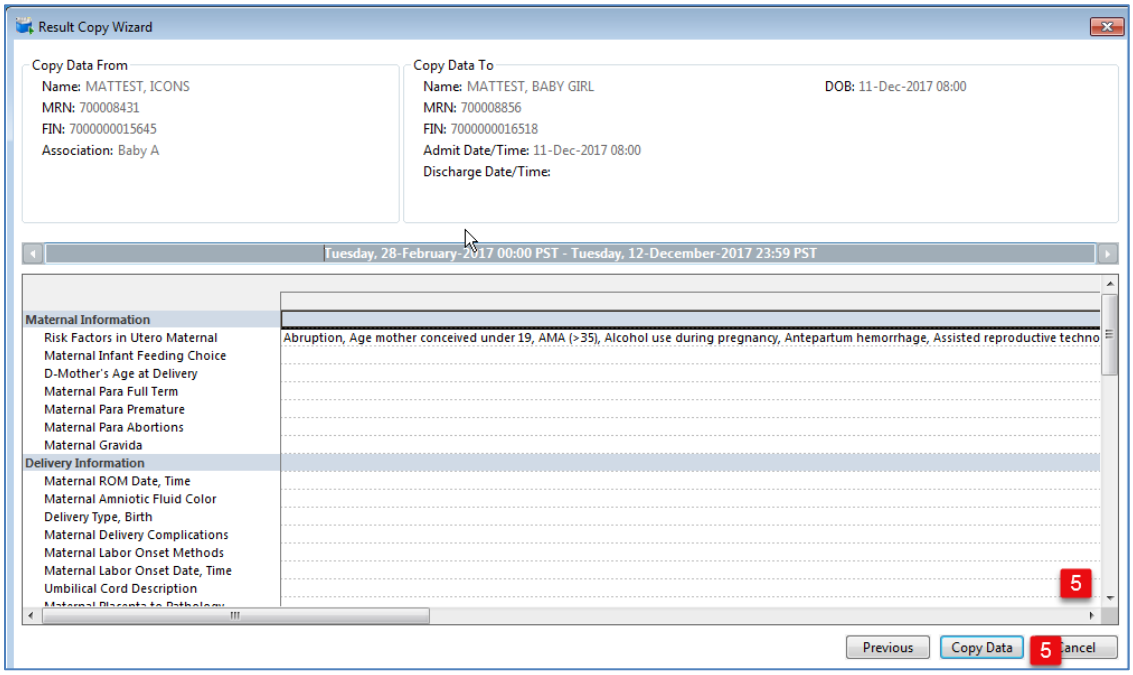
3. Select **Next**.



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.

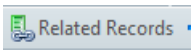
Key Learning Points

- 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

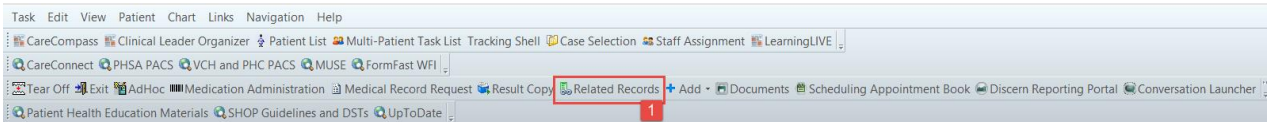
1 The **Related Records** function acts as a link and can be used to find and open a chart of a related patient. For example, if you are in a mom's chart and you wish to quickly find and open her baby's chart, you can use the Related Records function.

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

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

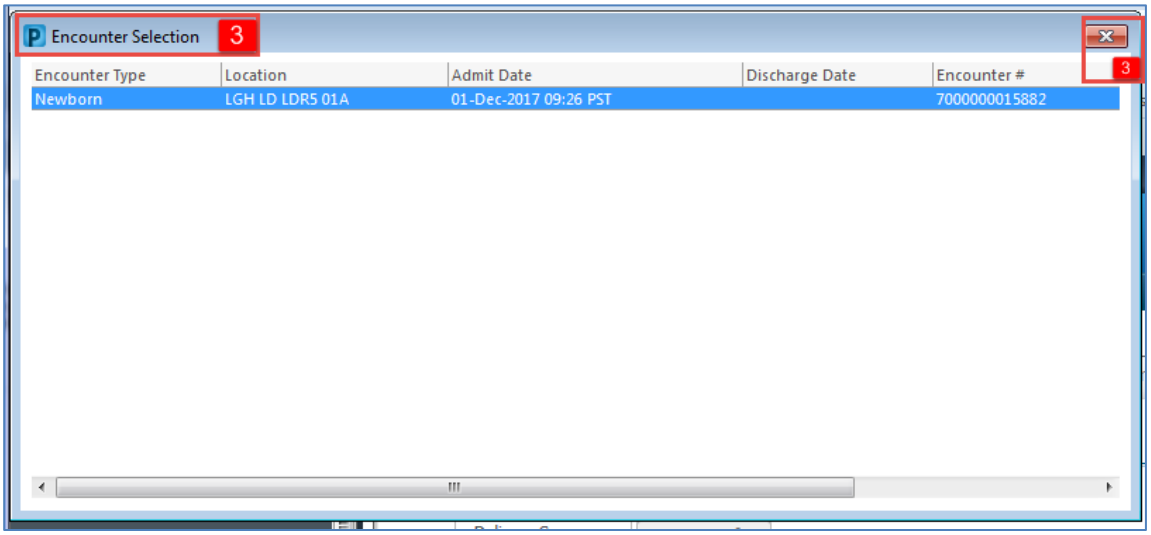
from the Toolbar.

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.

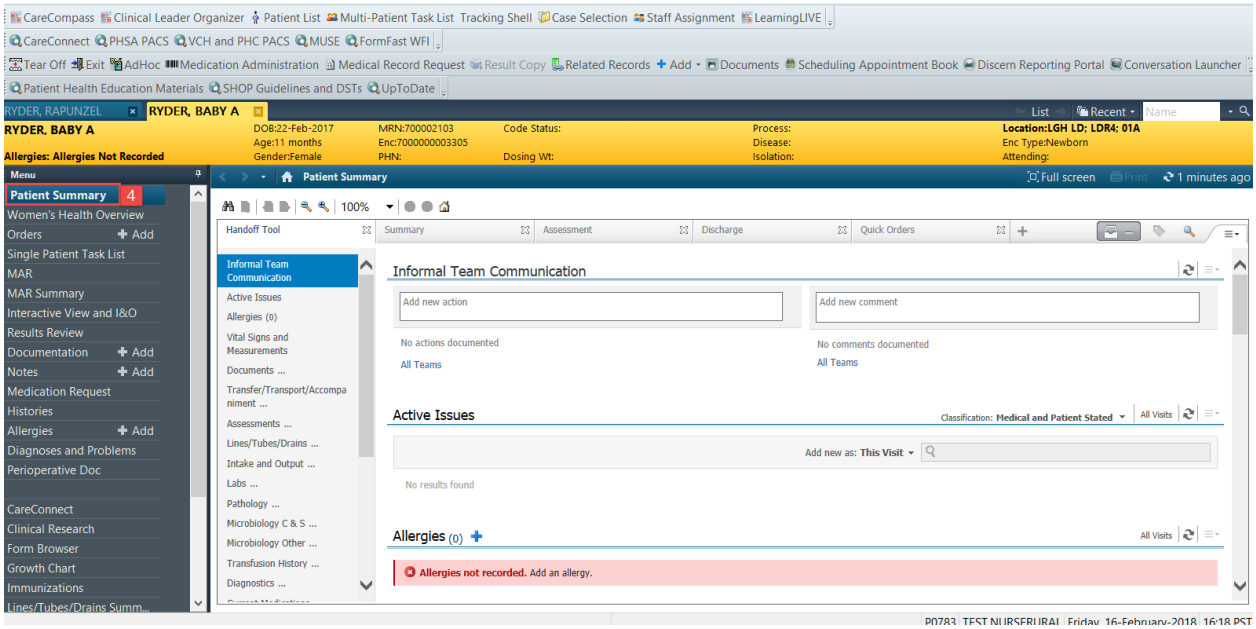


2. If this is your first time accessing the newborns chart, you will first be prompted to establish a relationship to the baby. Select Nurse. Click **OK**

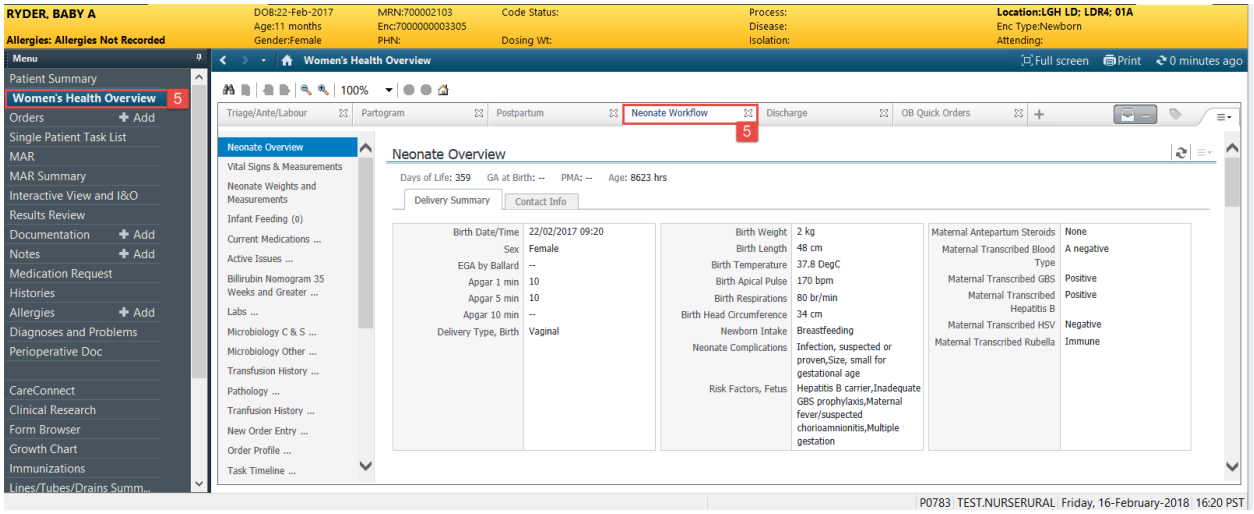
3. The Encounter Selection window will open. Select the correct encounter (note that because the newborn only has one encounter, it will already be selected). Click on the X icon  to close the window.



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



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



Key Learning Points

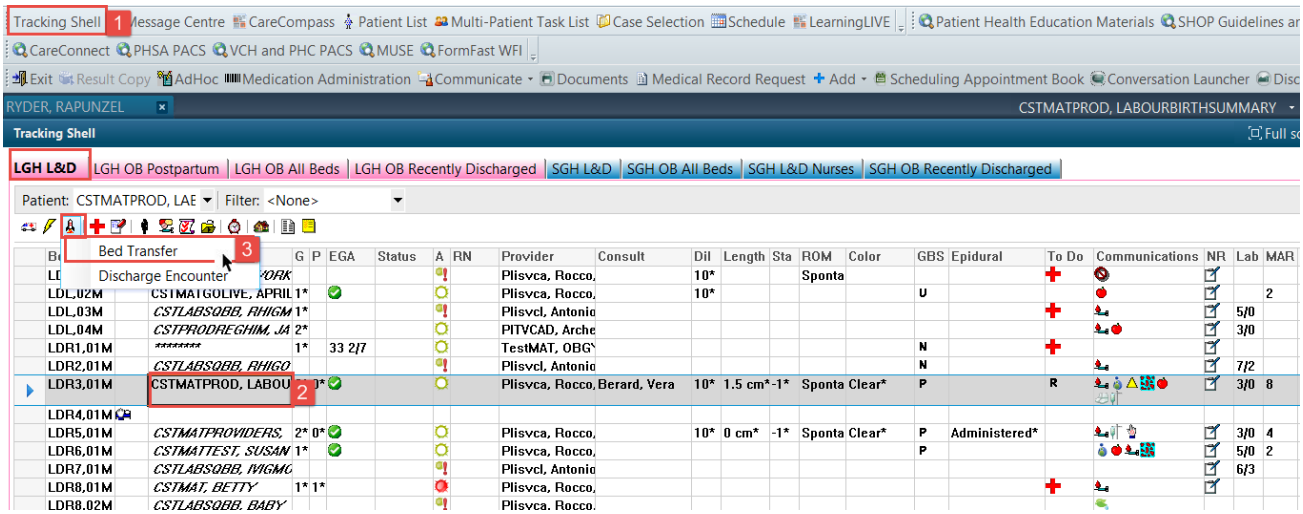
- The Related Records function can be used to find and open a chart of a related patient (ie. Use related records to open baby's chart from mom's chart).

Activity 11.3 – Bed Transfer

1 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:

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

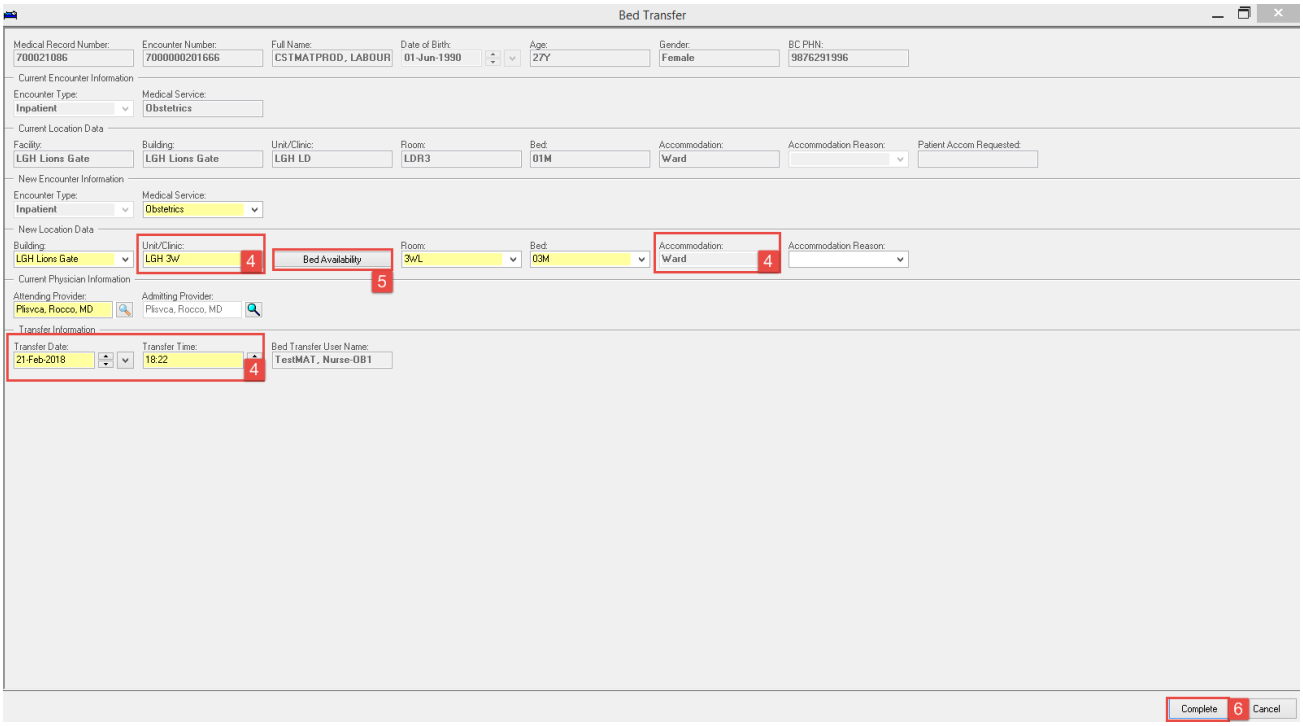


The Bed Transfer Window will open:

4. Complete all the yellow required field:
    - Unit/Clinic = *LGH 3W*
    - Accomodation = *Not Applicable*
    - Transfer Date = *T (*for *today)*
    - Transfer Time = *N (for now)*

5. 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 

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

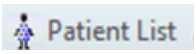
Now that your patient has delivered, mom and baby will be transferred to the postpartum unit. You will now use CareCompass to manage your workflow and tasks for these patients in the CIS (rather than Tracking Shell), but first you need to set up your patient lists.

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

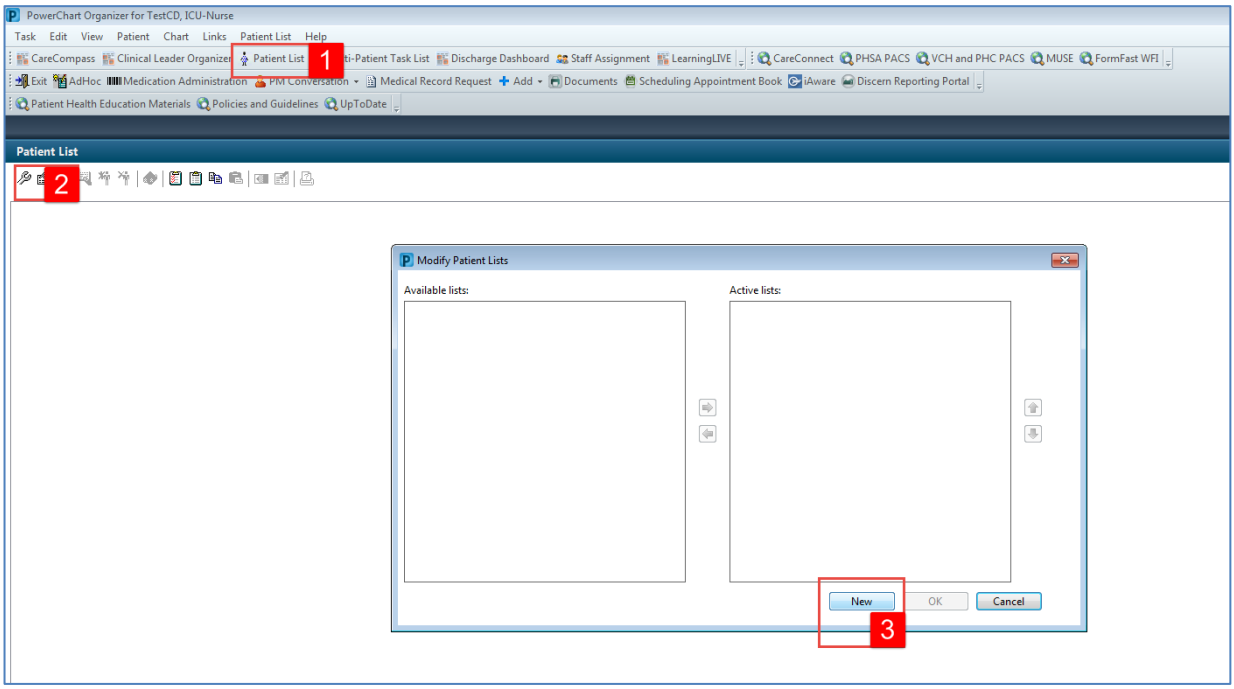
- Set up a location patient list
- Create a custom patient list

Activity 12.1 – Set Up a Location Patient List

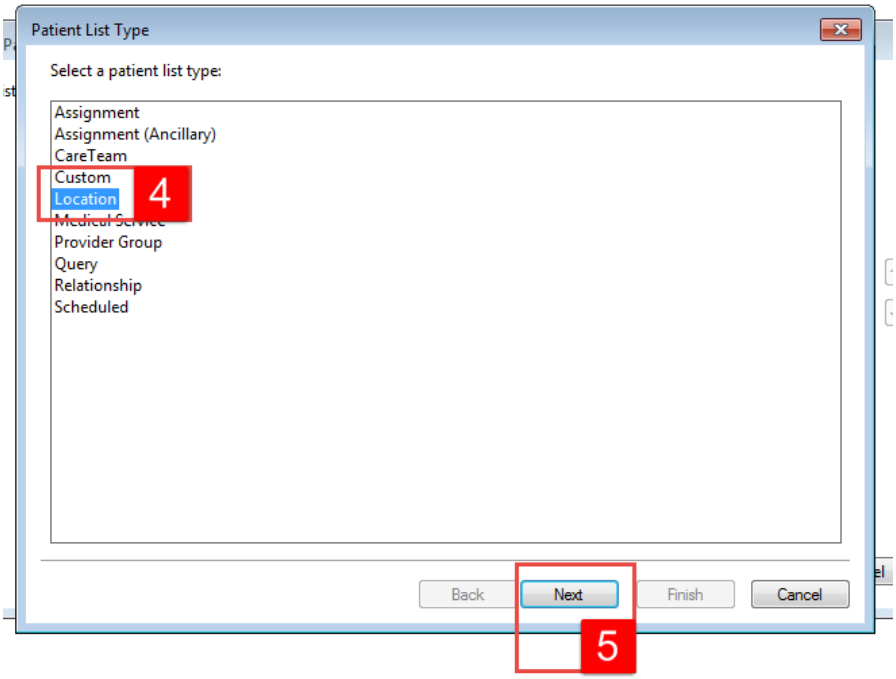
1 Once mom and baby are transferred to the postpartum unit, you will create a **Location List** that will consist of all the patients assigned to that unit. Once you have created your list in the system, it will remain on your account without the need to recreate it each shift.

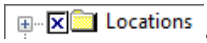
1. Select the **Patient List** icon 

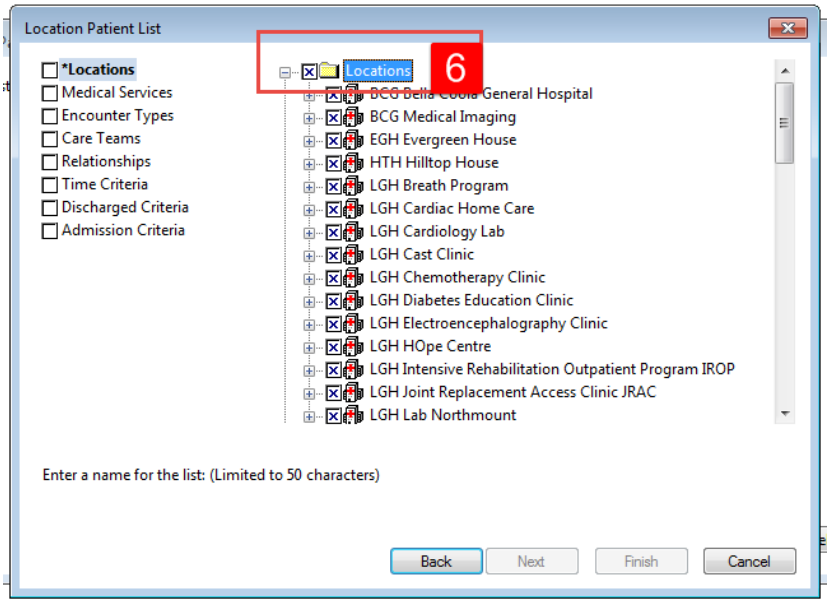
from the **Toolbar** at the top of the screen.
2. The screen may be blank. To create a location list, click the **List Maintenance** icon  .
3. Click the **New** button in the bottom right corner of the **Modify Patient Lists** window.



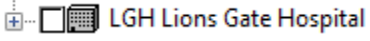
4. From the **Patient List Type** window select **Location**
5. Click the **Next** button in the bottom right corner.

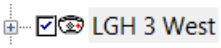


6. In the **Location Patient List** window, open the **Locations** folder by clicking the **Plus Sign**  . A location tree will be displayed.



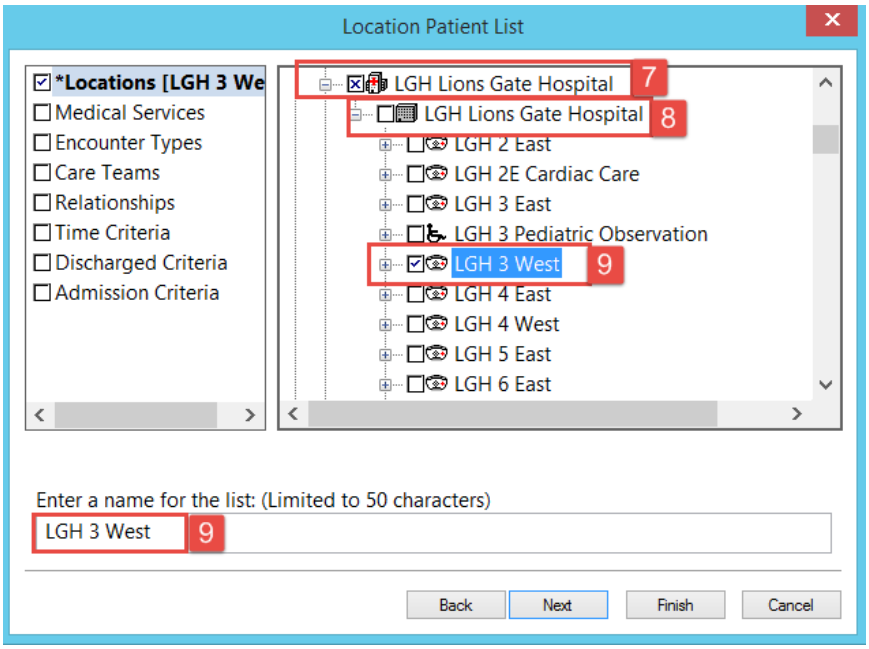
7. In this activity, use LGH Lions Gate Hospital as a selected location. Expand the location by clicking the **Plus Sign:** 

8. Then, click the next **Plus Sign:** 

9. For your practice, select **LGH 3 West** by checking the box next to the unit  .

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

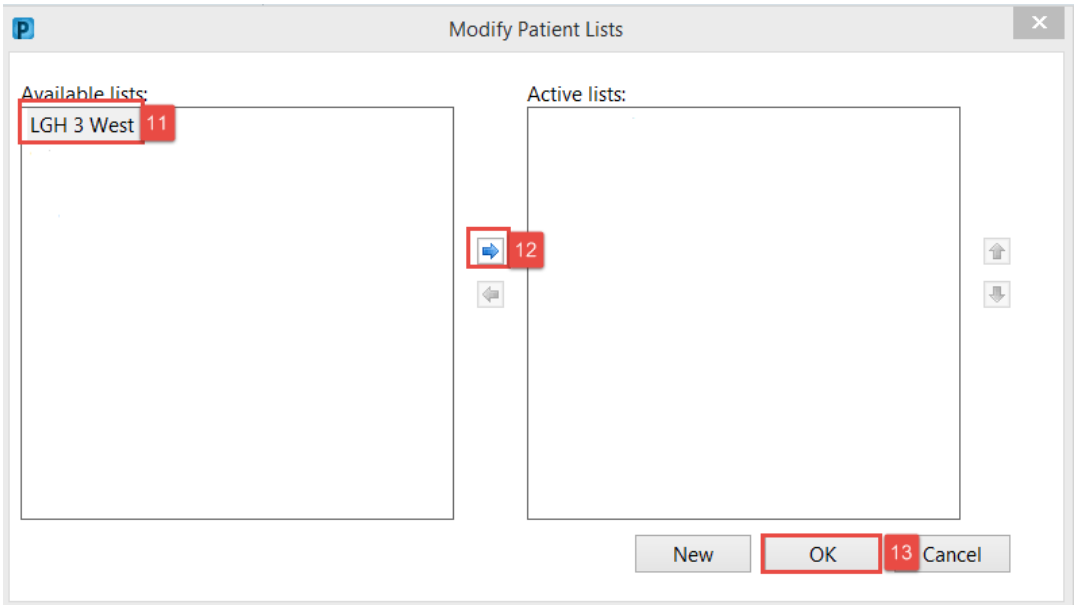
10. Click the **Finish** button Finish in the bottom right corner.



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

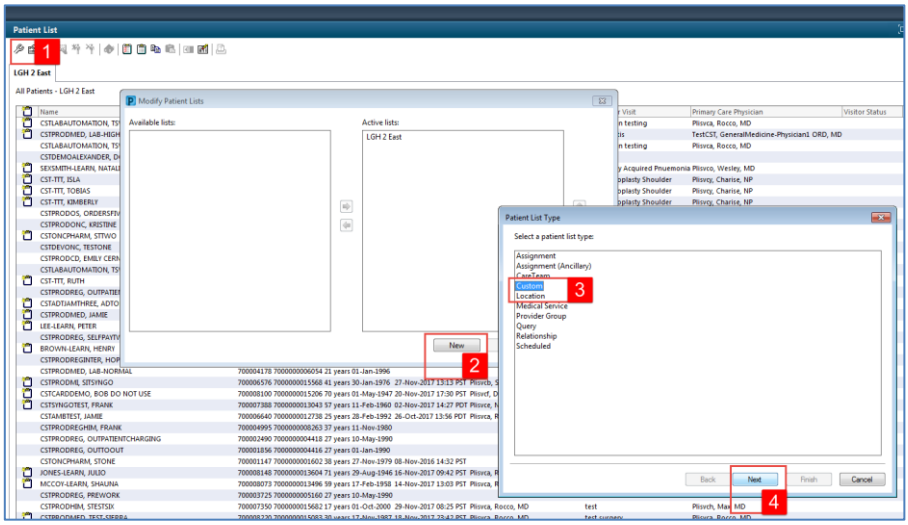


Activity 12.2 – Create a Custom Patient List

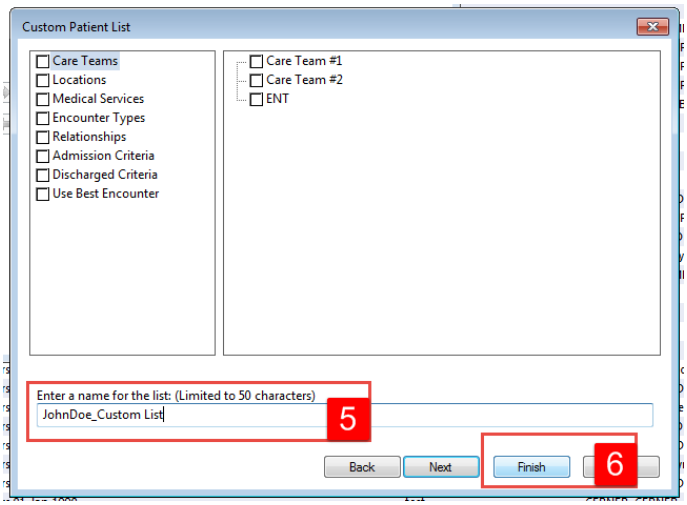
1 Next, create a **Custom List** that will contain only the patients that you are caring for, in this case your mother and baby patients.

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

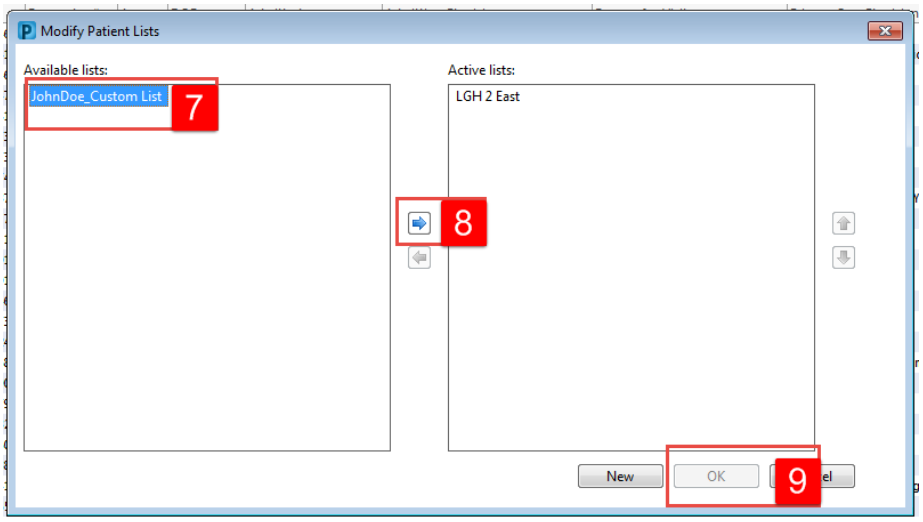
1. To create a **Custom List**, click the **List Maintenance** icon
2. Click the **New** button in the bottom right corner of the **Modify Patient Lists** window
3. Select **Custom** from the **Patient List Type** window
4. Click the **Next** button



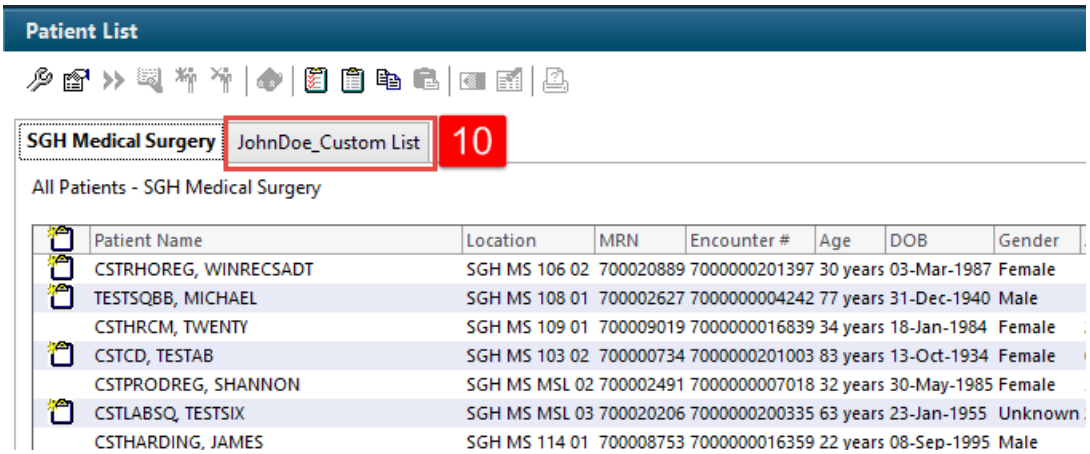
5. **The Custom Patient List** window opens. In the **Enter a name for the list:** Type *YourName_Custom* (i.e. John_Custom)
6. Click the **Finish** button



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



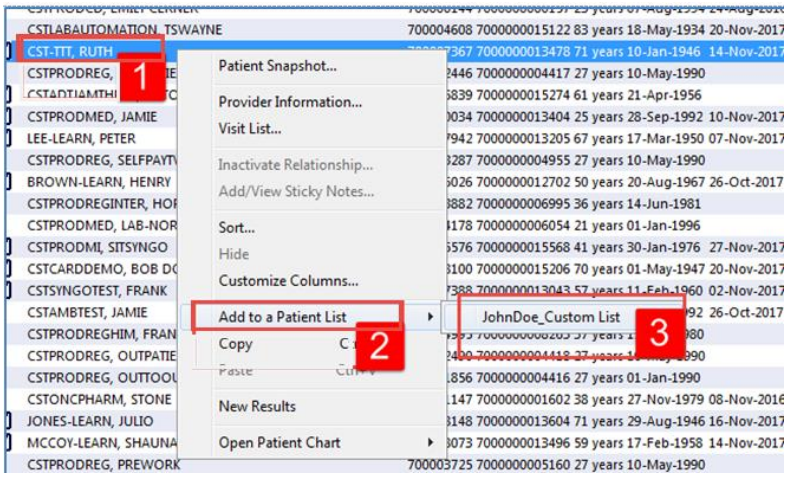
10. You will now see a tab for your Custom List



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

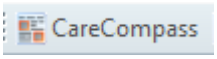
1

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.

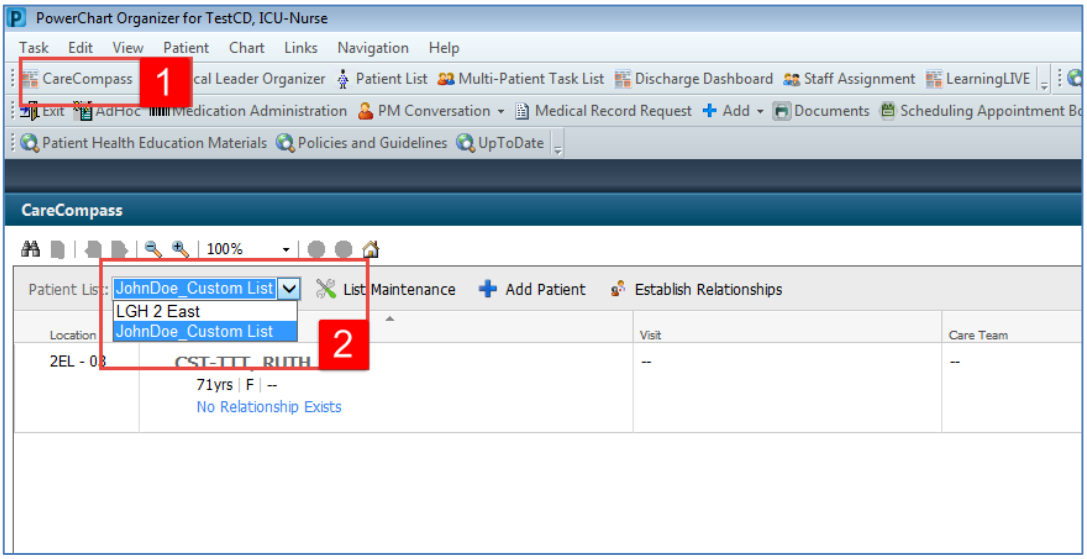
When you have multiple patients assigned to you (including postpartum moms and newborns), you will use **CareCompass** to support your workflow and orders, labs and tasks for your patients.

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.

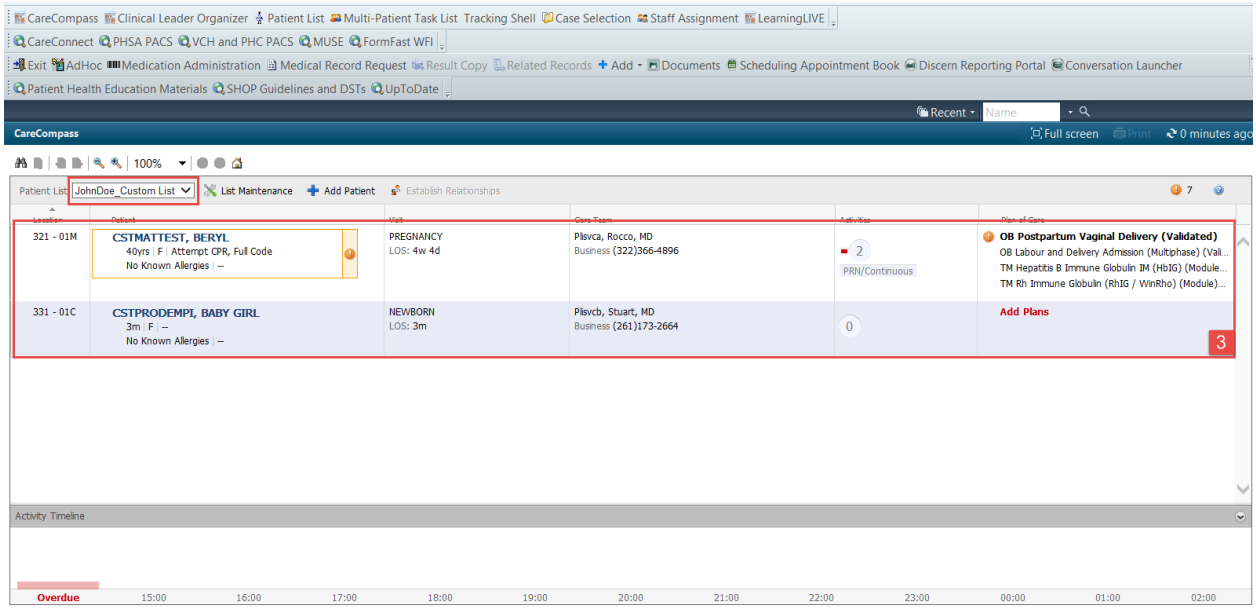
2

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.

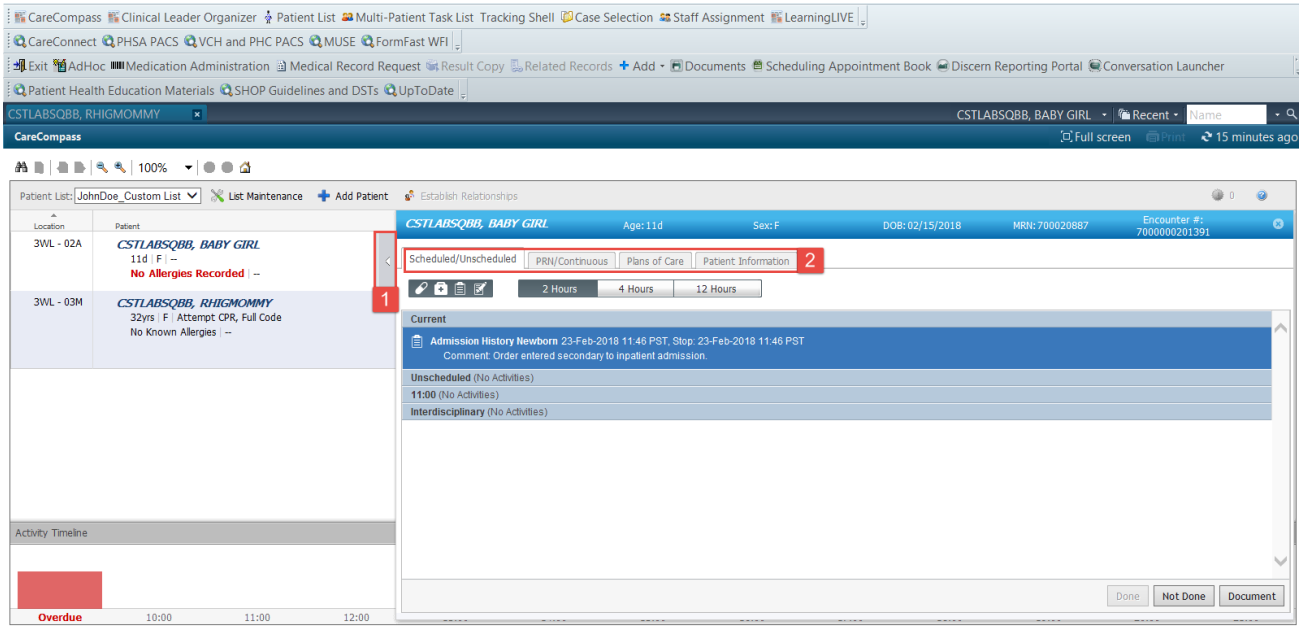
Activity 13.2 – Completing Tasks from CareCompass

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.

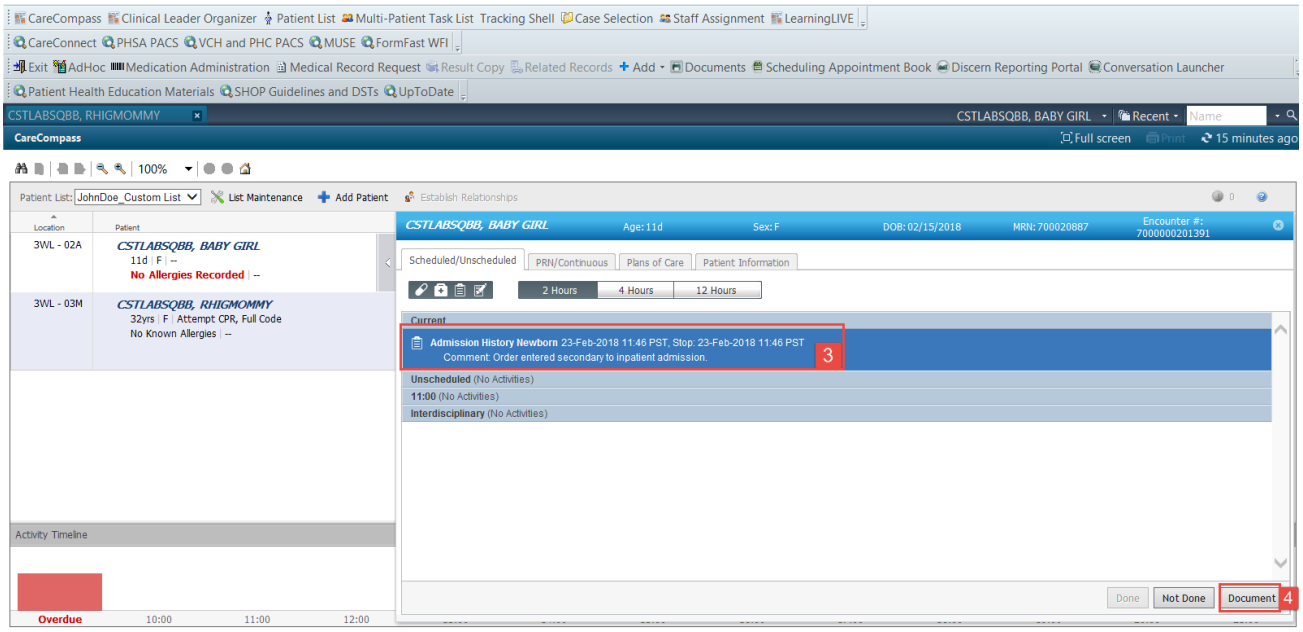
The task that needs to be complete for the newborn is the **Newborn Admission History** PowerForm.

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



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

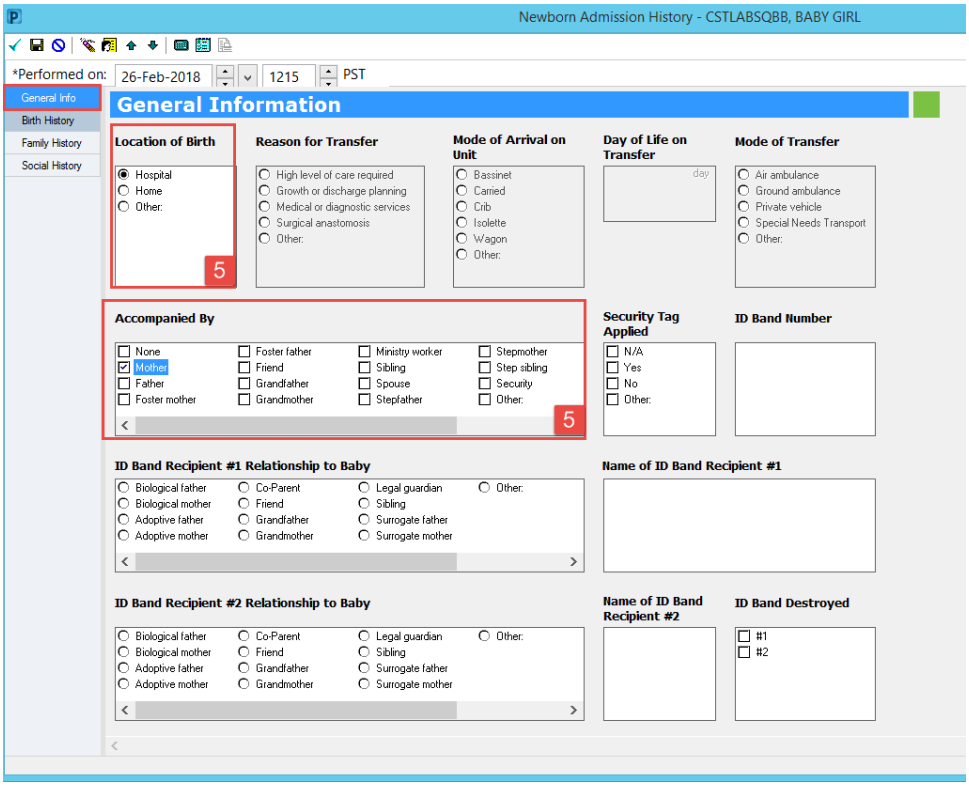


The patient's chart will open directly to the appropriate documentation section, in this case, the **Newborn Admission History** PowerForm.

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:

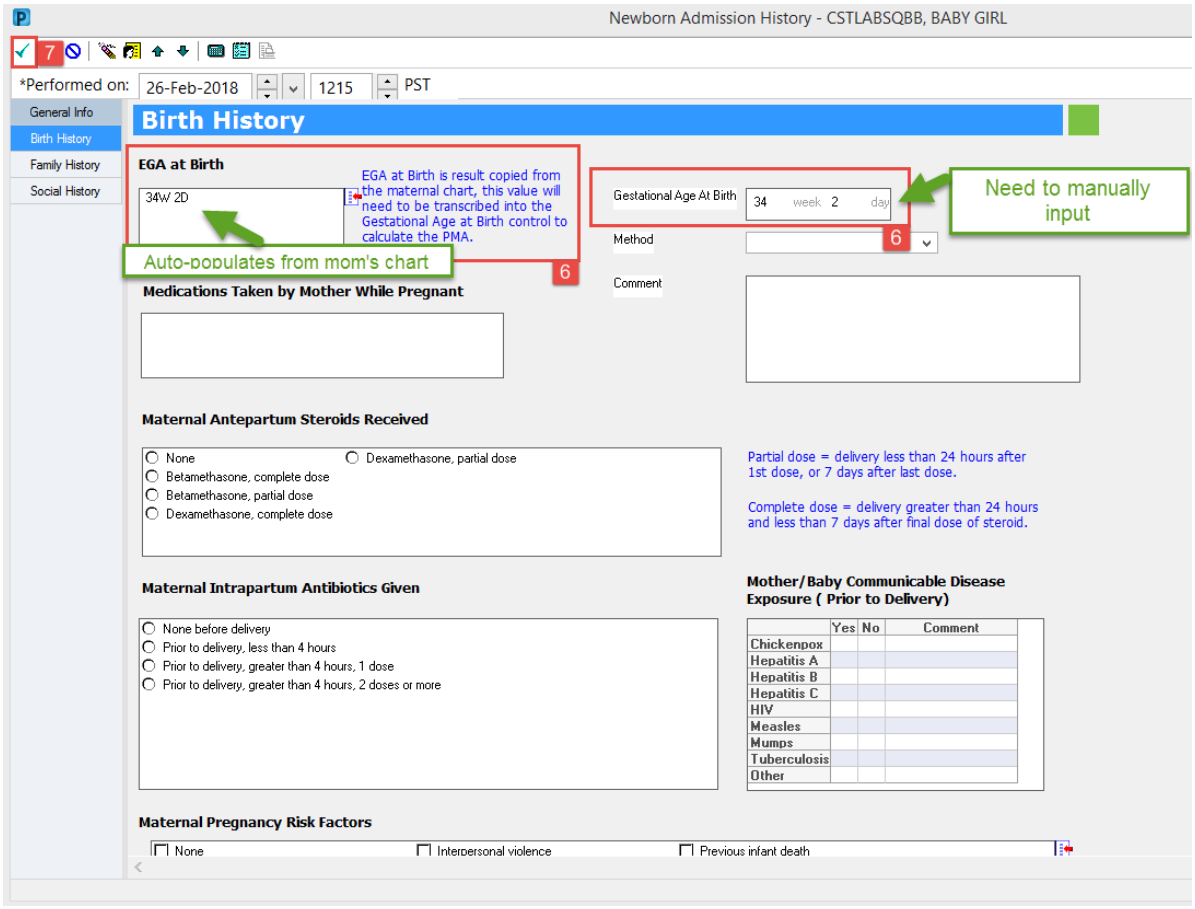
5. In the General Info tab/section:
    - Location of Birth = *Hospital*
    - Accompanied By = *Mother*



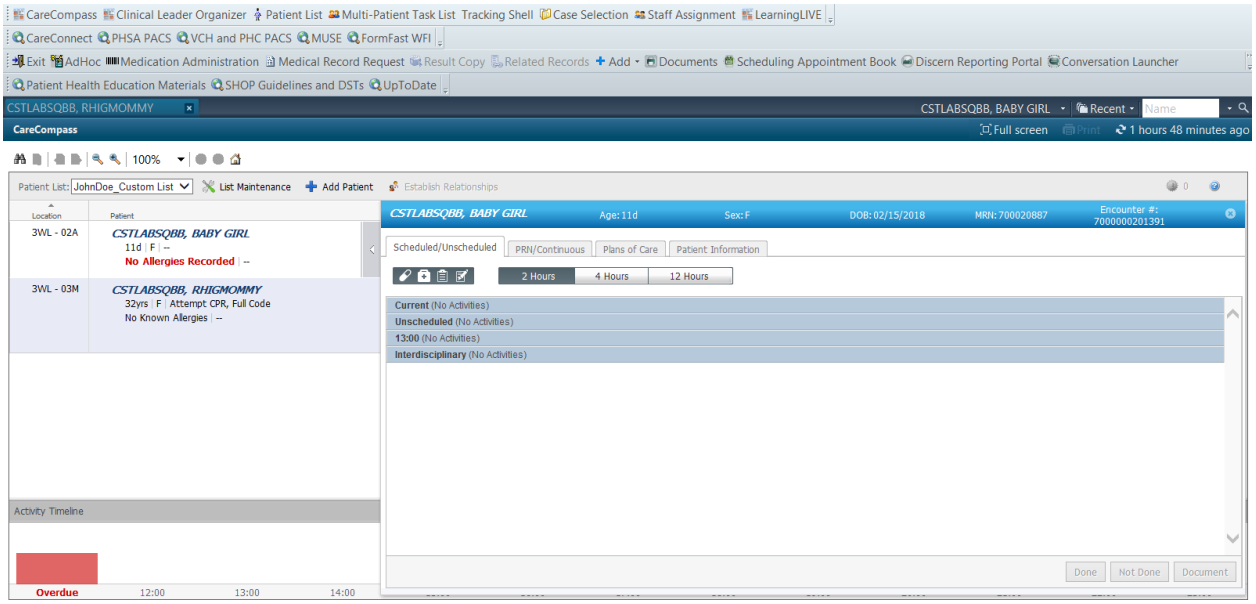
6. In the Birth History tab/section:
    - EGA at Birth = autopopulates from mothers chart
    - Gestational Age At Birth = *need to manually transcribe based on EGA field*

    Scroll down and enter:
    - Delivery Type = *Vaginal*

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



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.



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.

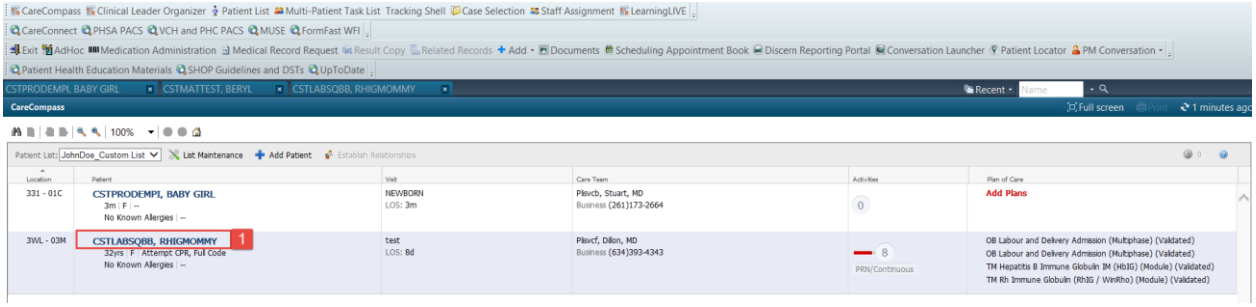
As an inpatient nurse you will be completing the following activities:

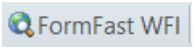
- Access the Maternity Self – Medication Record from FormFast.

Activity 14.1 – SAM

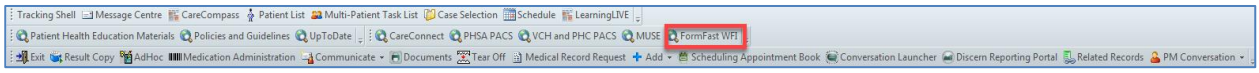
1 The underlying concept of self-administered medications (SAMs) remains the same – you will provide a physical form for the mother to document when she is taking her medications.

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

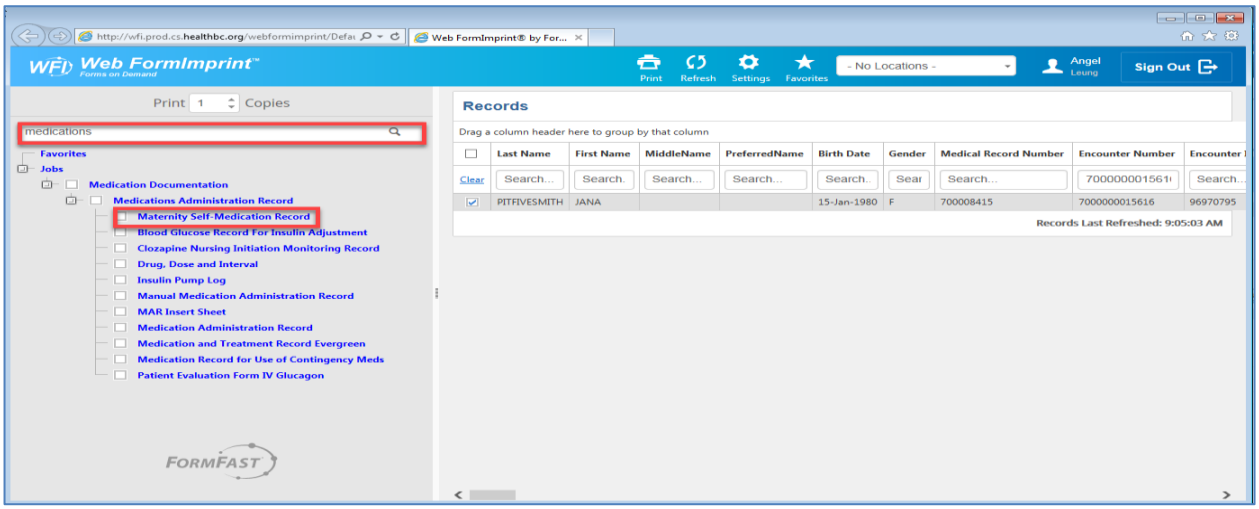


To access the SAM form, you need to click on the FormFast 

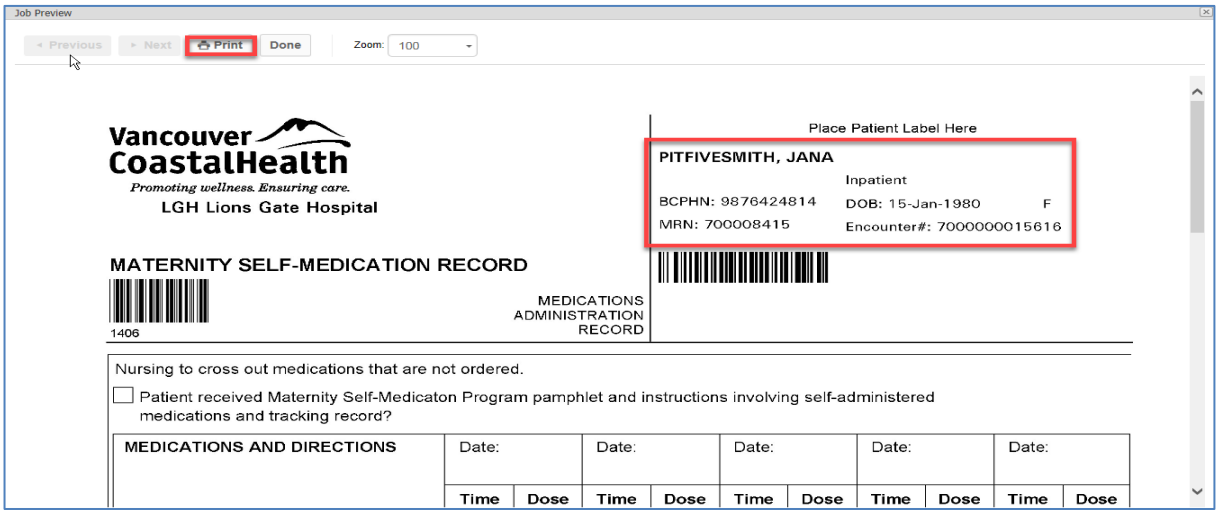
button on the tool bar.



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

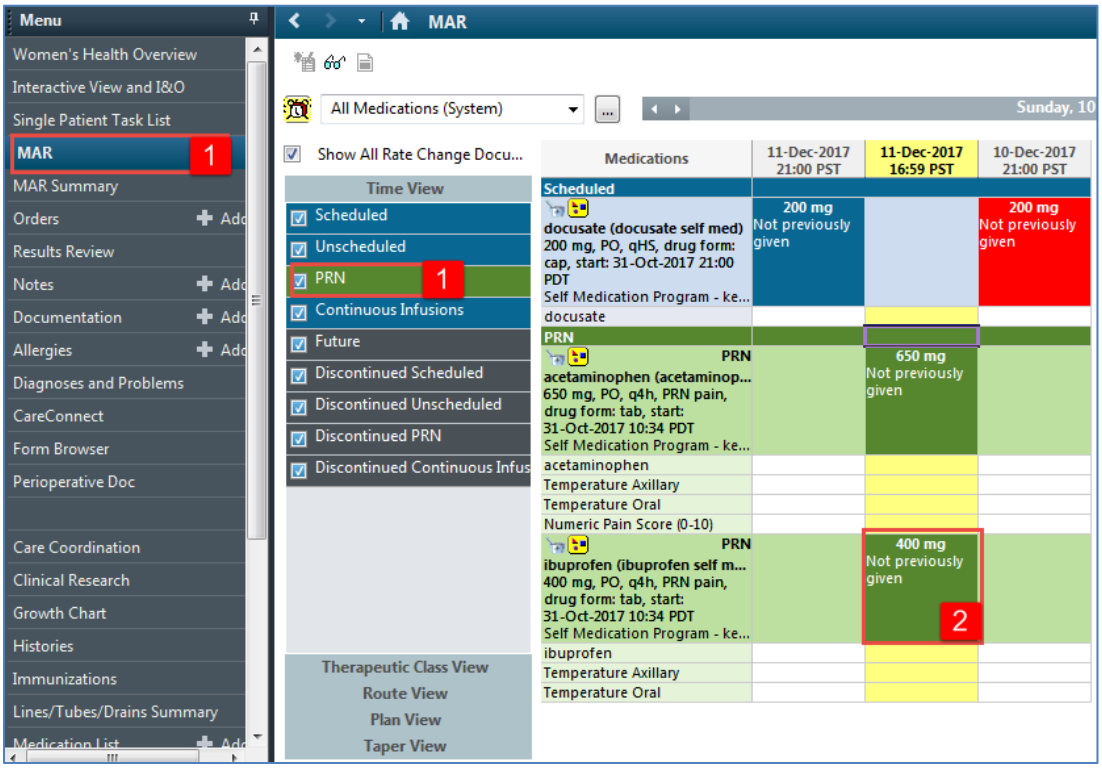


Review the name to ensure it is the right patient and click Print.



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.

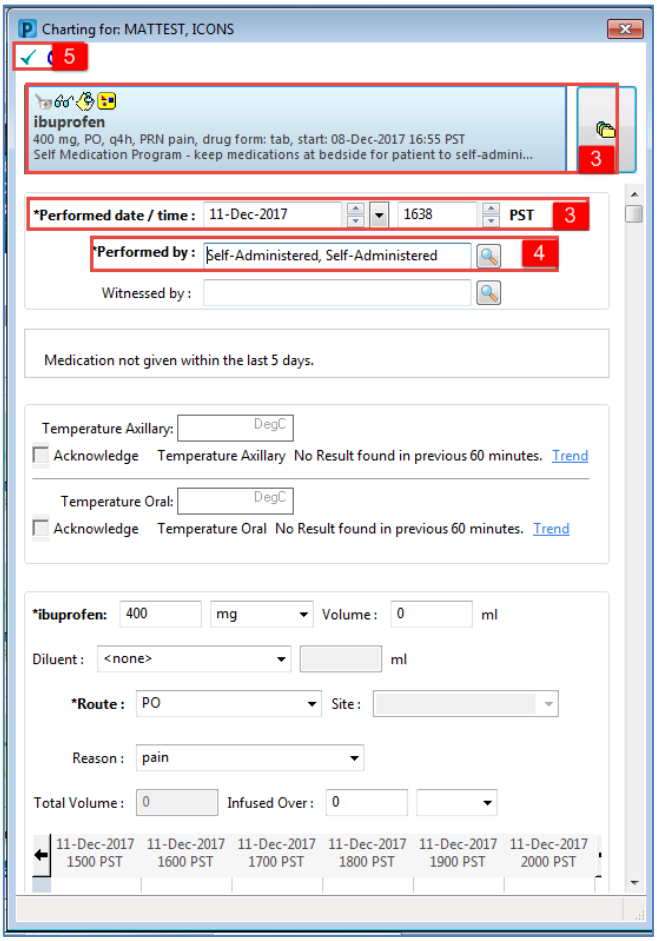


3. A **Charting for: Your Patient's Name** window will open with the medication name

(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** ✔ .

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

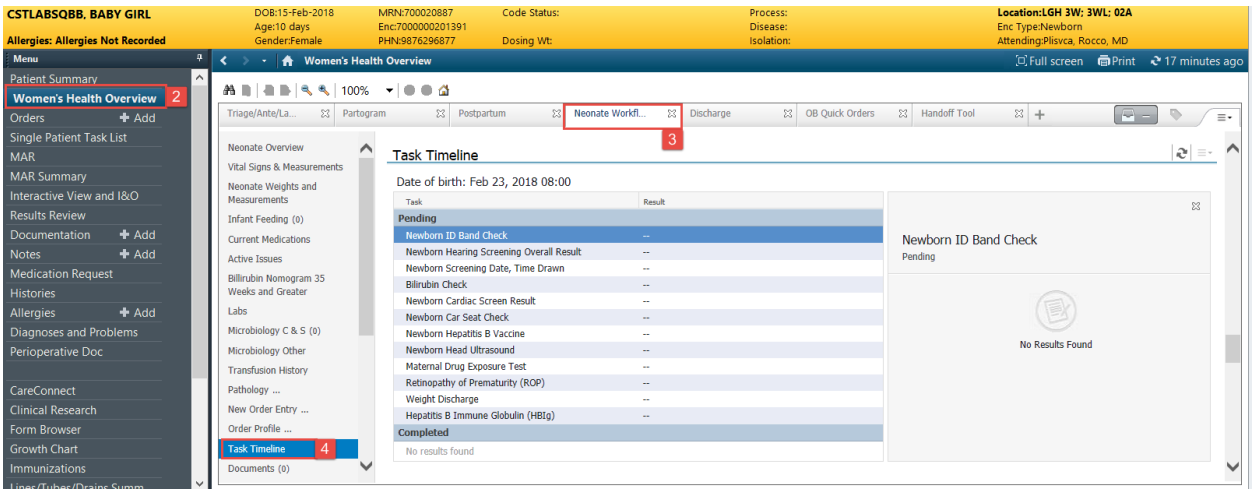
1

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.

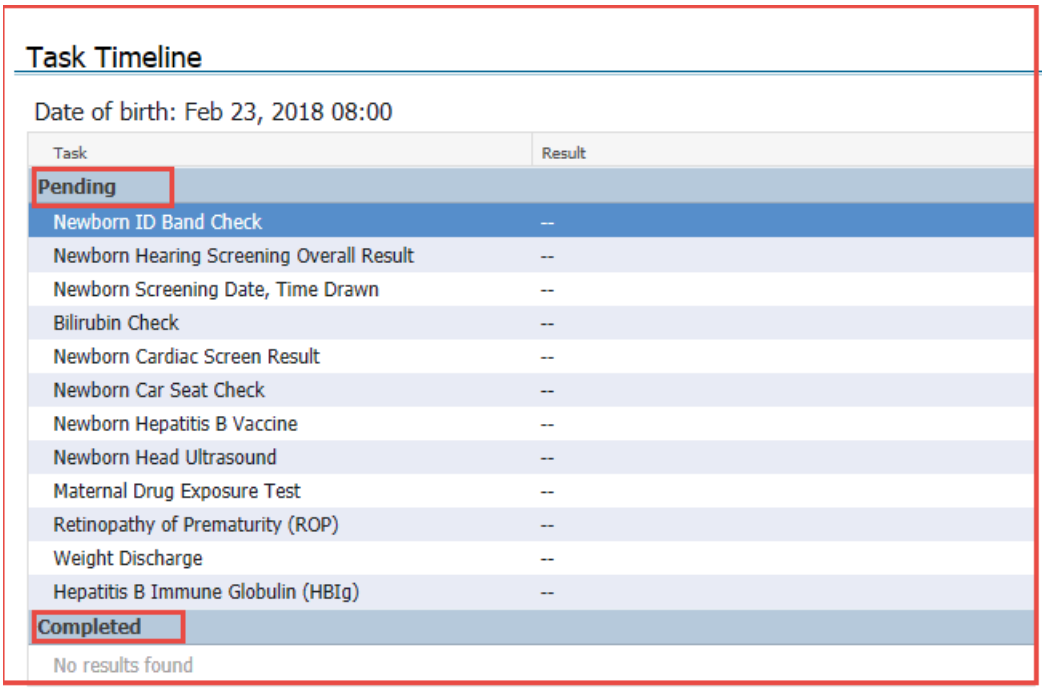
The Neonate Workflow also helps support nurses in caring for the newborn. The Task Timeline component outlines a list of tasks that need to be completed for the newborn prior to discharge.

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)



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:



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

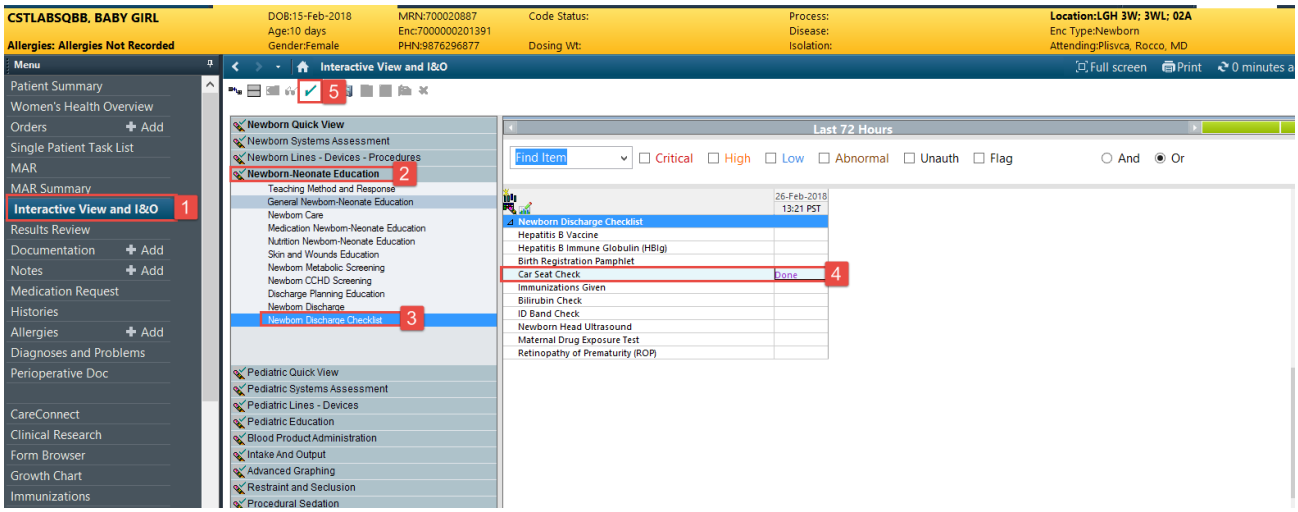
Let's try it!

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.

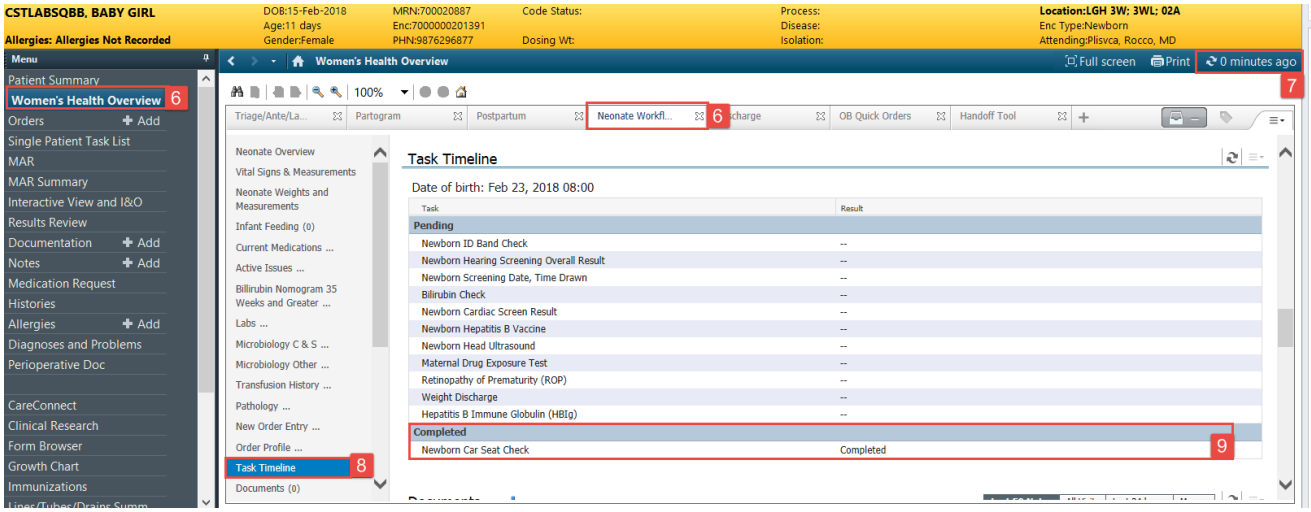
2. Click on the **Newborn – Neonate Education** band
3. Select the **Newborn Discharge Checklist** section.
4. Double click on the cell next to **Car Seat Check** under the appropriate time column, and select **Done**.
5. Click the green check mark ✔ to sign the documentation.



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 

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