SELF- GUIDED PRACTICE WORKBOOK [N45]
CST Transformational Learning

WORKBOOK TITLE:

Nursing: Minor Treatment Room

Last update: February 2, 2018 (v2)

CLINICAL + SYSTEMS TRANSFORMATION
Our path to smarter, seamless care

TRANSFORMATIONAL LEARNING

TABLE OF CONTENTS

SELF-GUIDED PRACTICE WORKBOOK

Duration	1 hour
Before getting started	■ Sign the attendance roster (this will ensure you get paid to attend the session) ■ Put your cell phones on silent mode
Session Expectations	■ This is a self-paced learning session ■ A 15 min break time will be provided. You can take this break at any time during the session ■ The workbook provides a compilation of different scenarios that are applicable to your work setting ■ Each scenario will allow you to work through different learning activities at your own pace to ensure you are able to practice and consolidate the skills and competencies required throughout the session
Key Learning Review	■ At the end of the session, you will be required to complete a Key Learning Review ■ This will involve completion of some specific activities that you have had an opportunity to practice through the scenarios ■ Your instructor will review and assess these with you

Using Train Domain

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

Please note:

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

PATIENT SCENARIO

Learning Objectives

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

- Access the Tracking Board to review the day's slate
- Check in the patient
- Open the patient's chart
- Review and Document the patient's allergies
- Document in the Minor Procedure PowerForm
- Place a Surgical Specimen Order
- Discharge the patient

GENERAL SCENARIO

There is a full slate of minor procedures in MTR. Prior to the first patient's arrival, you as the MTR nurse, reviews the slate and preps the procedure room.

Your first patient has arrived in the unit and will need to be checked in and prepped for the procedure. During the procedure, a biopsy specimen is collected and sent to the lab. The patient is then discharge home.

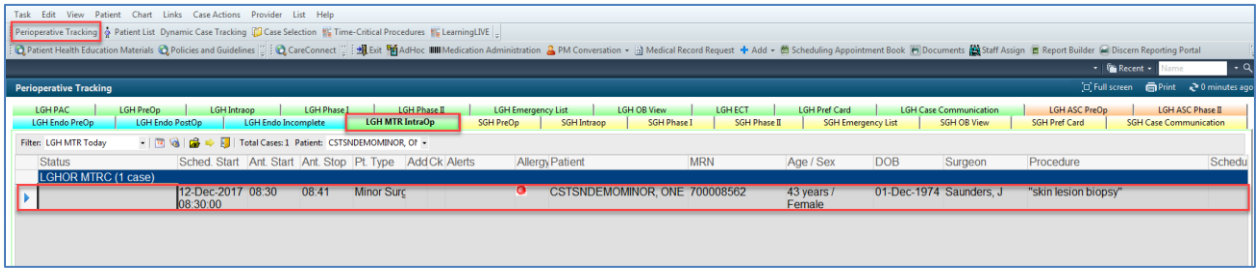
As the MTR nurse, you will be completing the following activities:

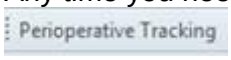
- Access Perioperative Tracking Board to review the day's slate
- Check in the patient in Perioperative Tracking
- Open the patient's chart
- Utilize the Patient Summary page to navigate the patient chart
- Review and document the patient's allergies
- Document, complete, and finalize the Minor Procedure PowerForm
- Place an Adhoc order for Surgical Specimen
- Discharge the patient encounter

Activity 1.1 - Reviewing the day's slate in Perioperative Tracking

1 All Nursing logins within PowerChart will open to **Perioperative Tracking**

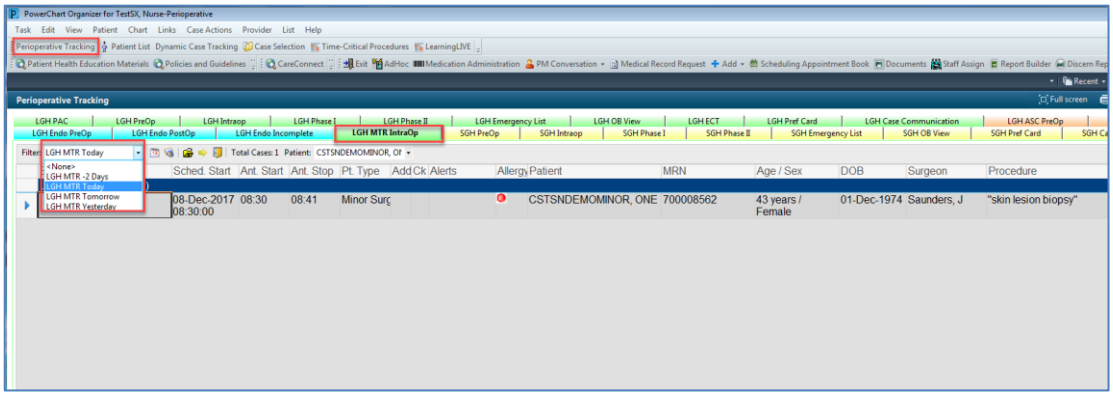
Perioperative Tracking will display various views (or tabs) depending on your area/login. Utilization of Perioperative Tracking **LGH MTR IntraOp** view is recommended to access patient charts within the **LGH MTR** unit. This view acts as a slate, a communication tool, and eliminates the need to search for patients individually.



1. Any time you need to navigate back to Perioperative Tracking you can click 

from the Toolbar.
2. Minor procedure patients will display in **LGH MTR IntraOp** tracking view.
3. Each row within this table represents a patient.

2 **Review the day's slate in Perioperative Tracking**



In **LGH MTR IntraOp** view

1. Select the **LGH MTR Today** from the dropdown box next to the time frame filter.
2. The day's patient list will be displayed.

Note: Views based on time frames can be filtered (e.g., LGH MTR Today). To see another view, select a different filter (e.g., LGH MTR Tomorrow).

Note: For urology procedures done in the Local Room select the **LGH ASC Preop** Tab

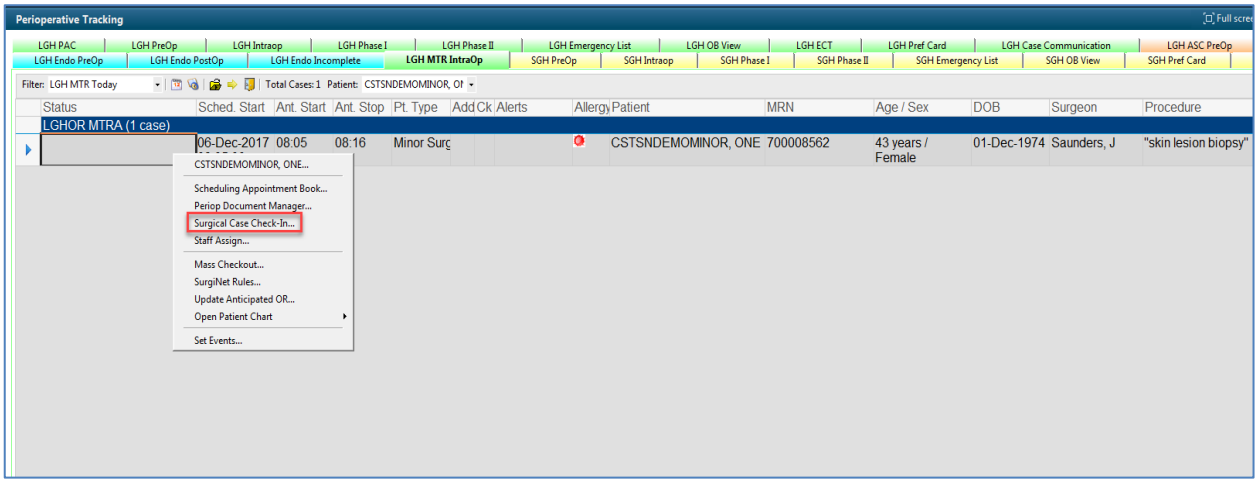
Key Learning Points

- The Perioperative Tracking Board is the equivalent of a paper slate with real time information.
- You can use the Perioperative Tracking within the toolbar to return to LGH MTR IntraOp view from any other area of PowerChart.

Activity 1.2 - Performing the Surgical Case Check-In and Opening the Patient's chart

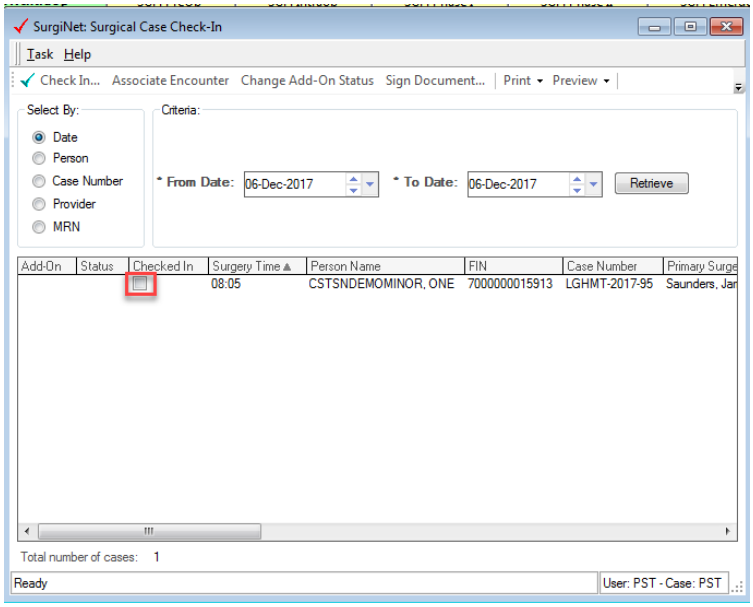
1

Surgical Case Check-In

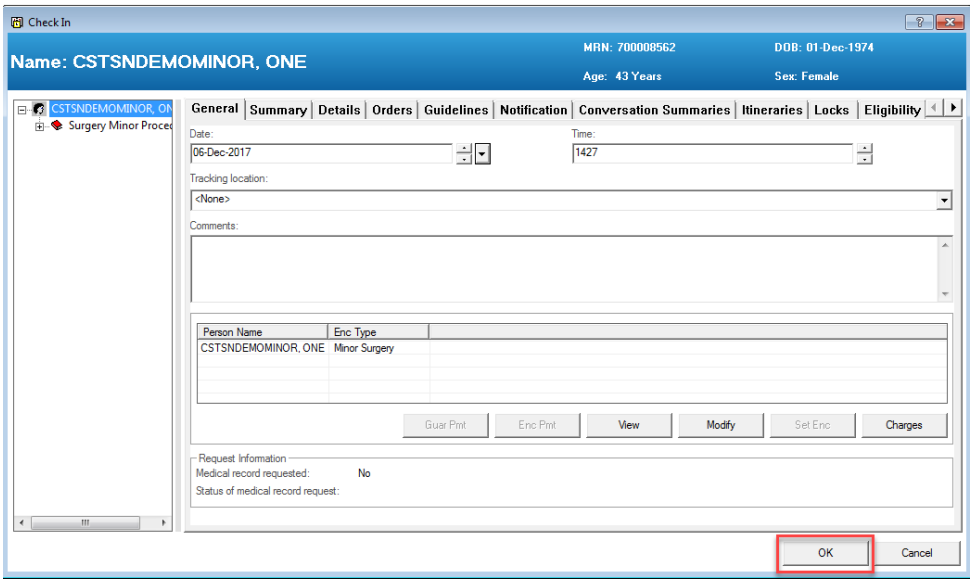


To check in a patient in Perioperative Tracking:

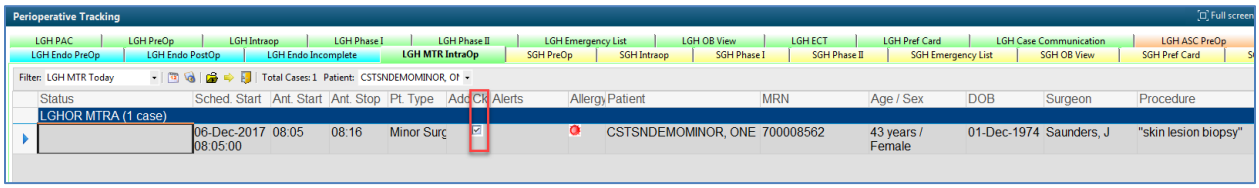
1. Right click on the row of the appropriate patient.
2. Select **Surgical Case Check-In**.
    - The SurgiNet: Surgical Case Check-In window displays.



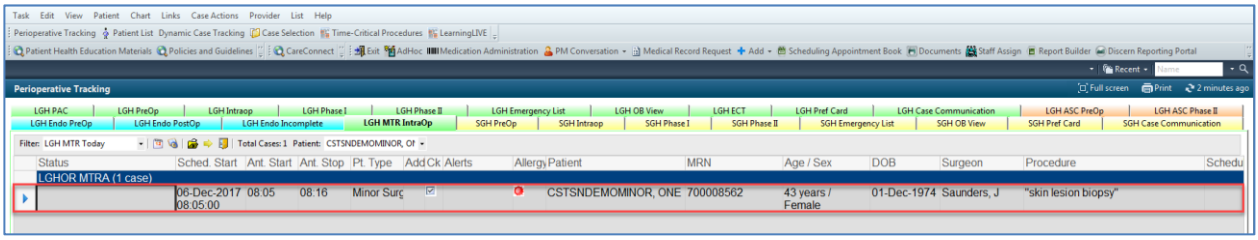
3. Click the Multi Select Box within the **Checked In** column.
    - The Check In window displays.



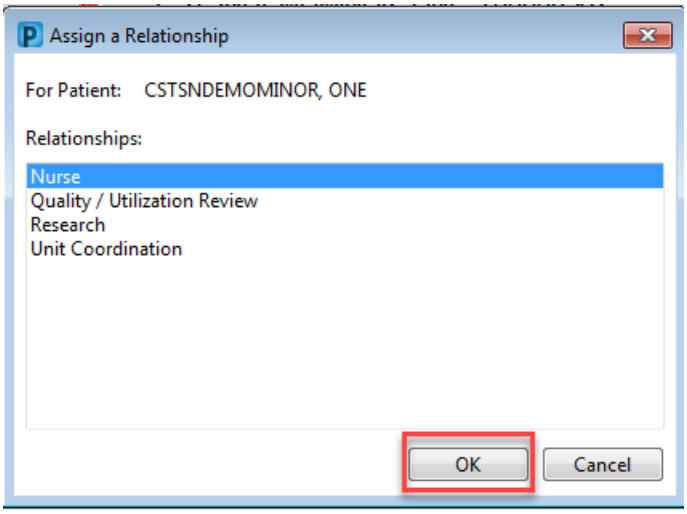
4. Click OK.
5. Click  to close the **Surginet: Surgical Check-In** window and return to Perioperative Tracking.
6. Click Refresh  in the top right hand of the screen.
    - Notice the checkmark  under the **Ck** column in Perioperative Tracking. You have now completed the patient's Check-In.



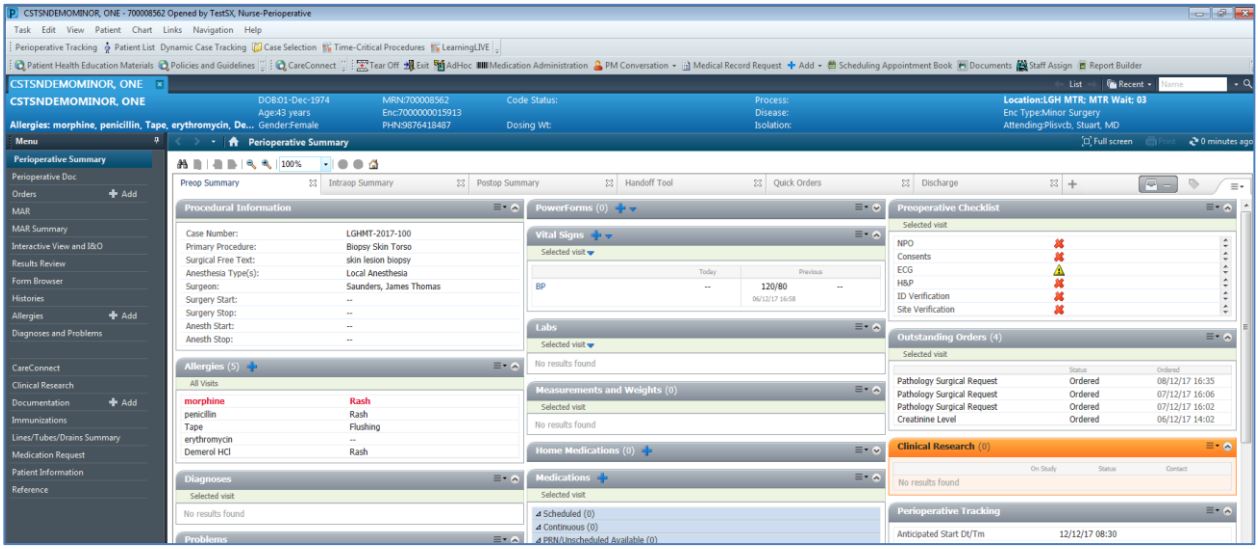
2 Open the patient's chart in the Perioperative Tracking



1. Select the appropriate patient by Clicking on the row. A Blue arrow will appear.
2. Double Click on the Blue arrow to open the patient's chart.



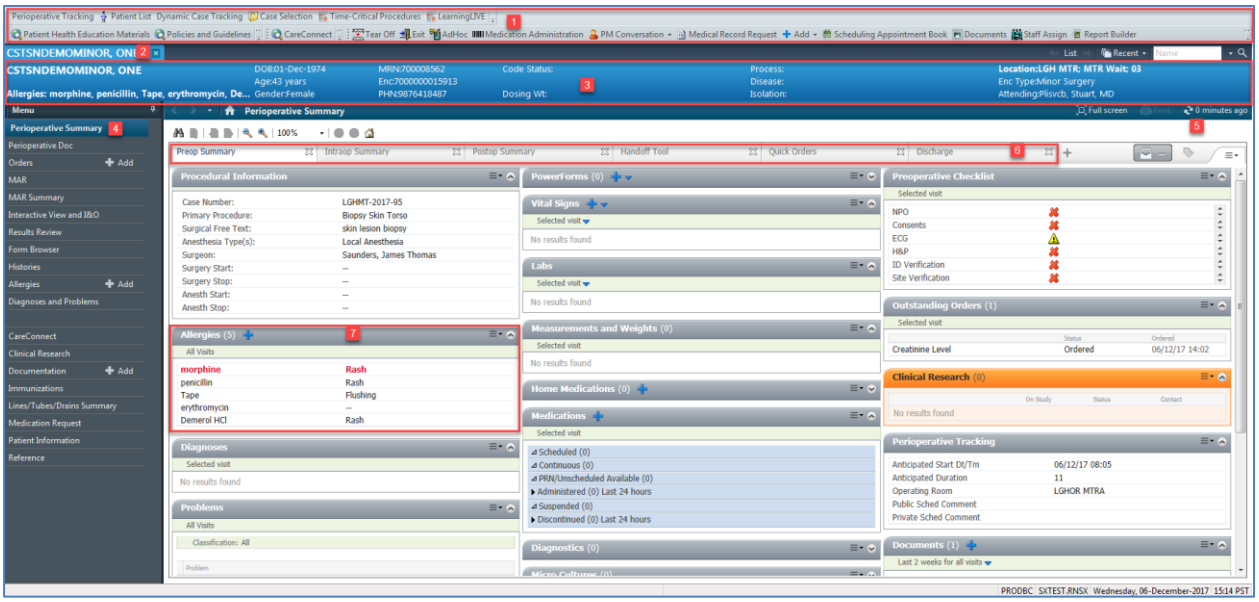
3. If this is your first time logging in a patient's chart, the Assign a Relationship window will display. Verify this is the correct patient.
   Note: If this is the wrong patient, click the cancel button to return to Perioperative Tracking view.
4. Select **Nurse** to assign relationship.
5. Click **OK**.



6. Perioperative Summary displays when you access a patient's chart. Verify this is the correct patient's chart that has opened.

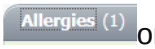
3 Navigate the patient chart

Upon accessing the patient's chart, you will see the **Perioperative Summary** page open. The summary will provide views of key clinical patient information.



1. The **Toolbar** is located above the patient's chart and it contains buttons that allow you to access various tools within the Clinical Information System.
2. Patient tab – displays patient's name and clicking on  will close the chart.
3. The **Banner Bar** displays patient demographics and important information that is visible to anyone accessing the patient's chart. Information displayed includes:
    - Name
    - Allergies
    - Age, date of birth, etc.
    - Encounter type and number
    - Code status
    - Weight
    - Process, disease and isolation alerts
    - Location of patient
    - Attending Physician
4. The **Menu** on the left allows access to different sections of the patient chart. This is similar to the coloured dividers within a paper-based patient chart. Examples of sections included are Orders, Medication Administration Record (MAR) and more.
5. The **Refresh** icon  updates the patient chart with the most up to date entries when clicked. It is important to refresh the chart frequently especially as other clinicians may be accessing and documenting in the patient chart simultaneously.

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

6. There are different tabs (e.g. Preop Summary, Intraop Summary, Postop Summary, Quick Orders, Handoff Tool, and Discharge) that can be used to learn more about the patient. Click on the different tabs to see a quick overview of the patient.
7. Each tab has different components. You can navigate to different sections of the chart by clicking on the component link(s) e.g. clicking on the Allergies link 

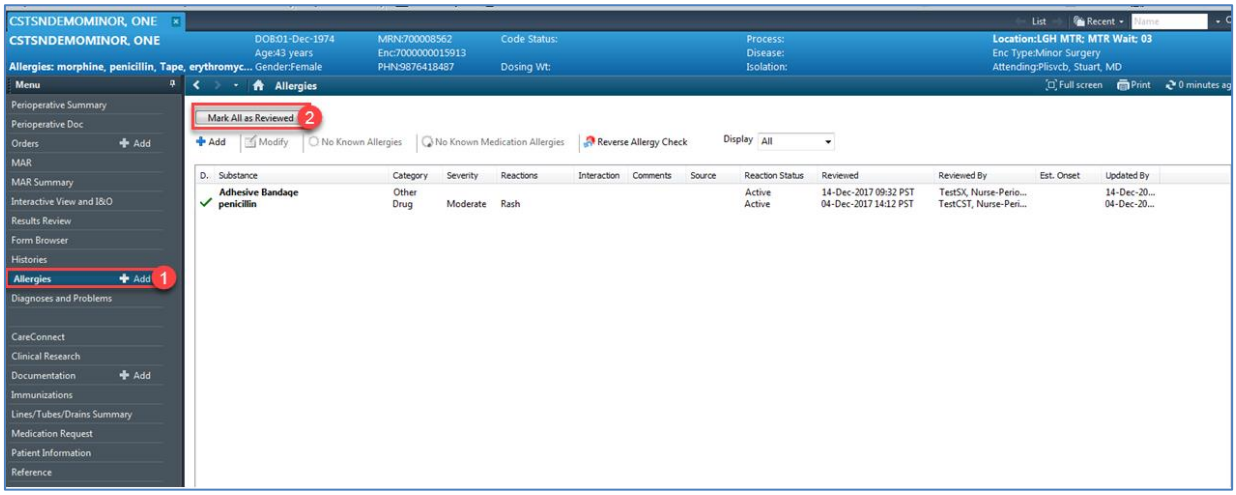
or Add  is the same as clicking on the Allergies band in the Menu.

Key Learning Points

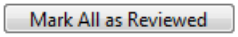
- The Blue arrow indicates that you have selected a patient in the tracking view.
- Users accessing a patient's information for the first time are prompted to assign a relationship with the patient (e.g., Nurse).
- Verify the correct patient's chart has opened.
- The Perioperative Summary page provides an overview of the patient information and allows for navigation elsewhere in the chart.
- The patient chart should be refreshed regularly to view the most up-to-date information.

Activity 1.3 - Reviewing and Documenting Patient's Allergies

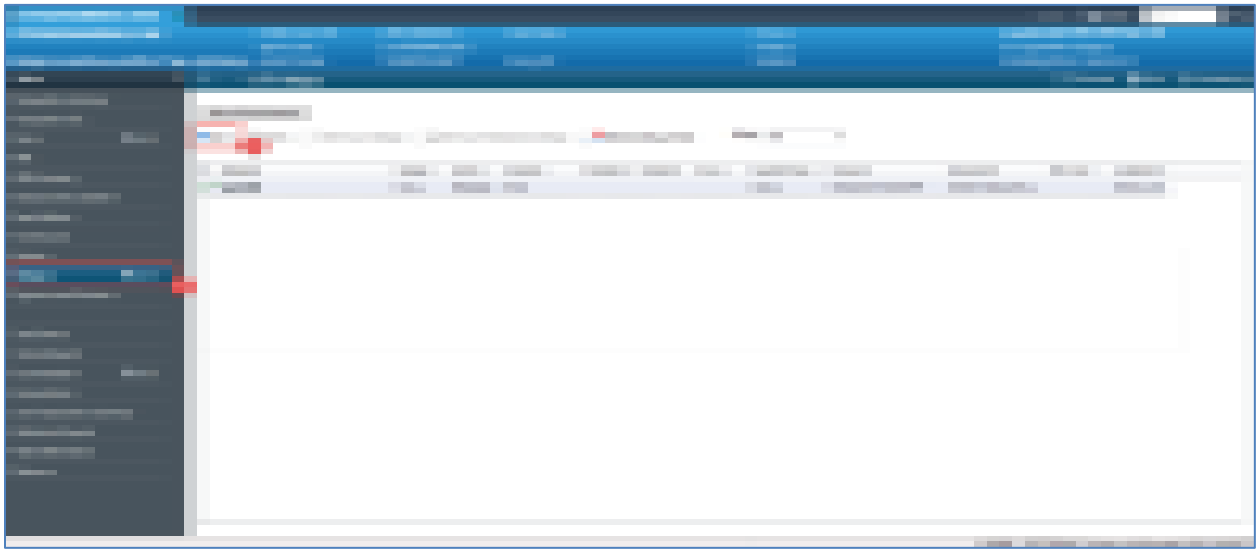
1 Review the patient's allergies



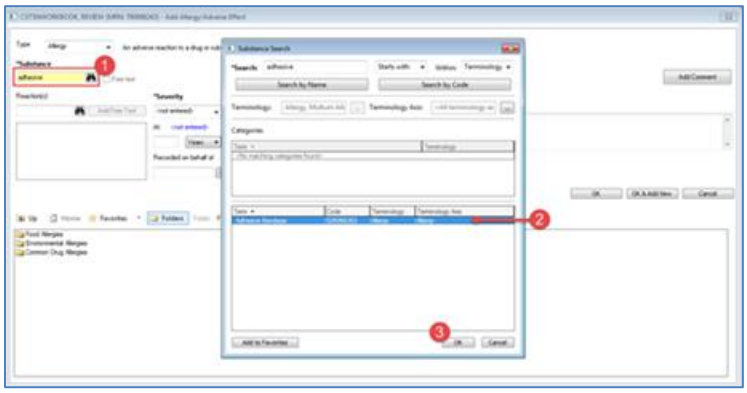
The patient currently has an allergy to Penicillin recorded. Review allergy with patient and update as necessary. The patient states they are also allergic to adhesive bandages.

1. Click on **Allergies** section
2. Select **Mark All as Reviewed**  to verify the Penicillin allergy.

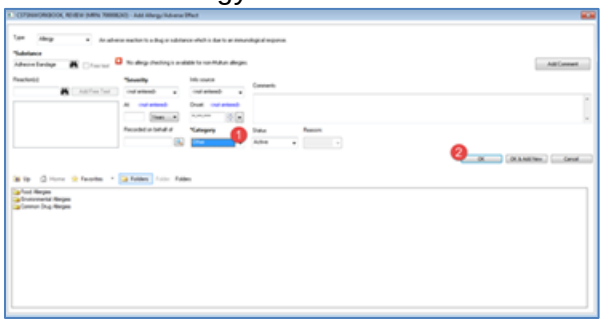
2 Document an allergy



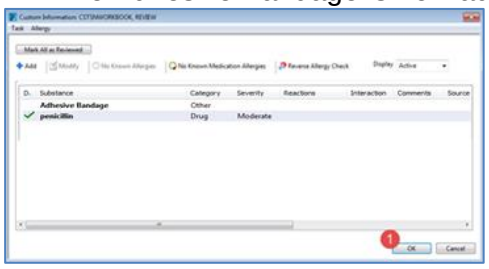
To document the adhesive allergy, click the + Add . The Add Allergy/Adverse Event window displays.



1. Enter **Adhesive** in the Substance field and click the **search** icon.
2. The Substance Search window will appear. Select **Adhesive Bandage** from the result window.
3. Click **OK**.
    - Add Allergy/Adverse Window is shown.



4. Select **Other** in the **Category** drop-down
5. Click **OK.**
    - The Allergy window will reappear.
    - The Adhesive Bandage is now added as an allergy.



6. Click **OK** to exit back to the chart.

Key Learning Points

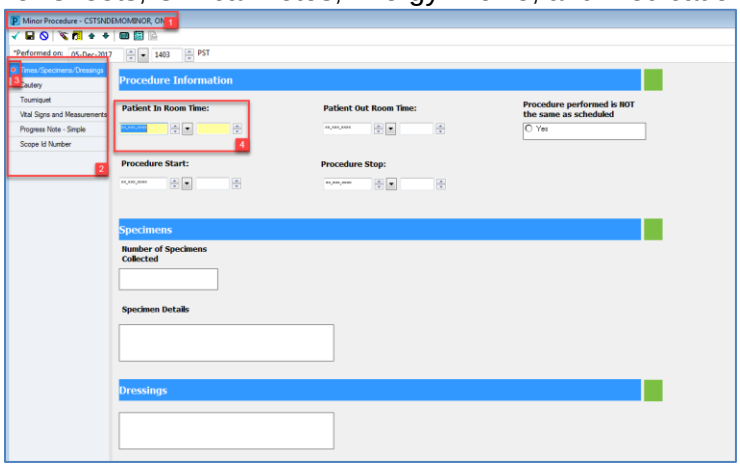
- Documented allergies are displayed in the Banner Bar for all who access the patient's chart.
- Allergies will display with the most severe allergy listed first.

Activity 1.4 - Documenting in the Minor Procedure PowerForm

1 Overview of PowerForms

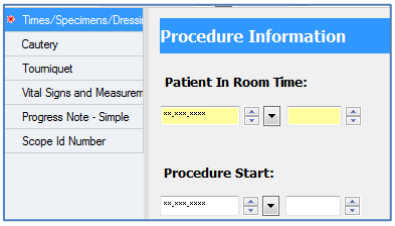
PowerForms are the electronic equivalent of paper forms currently used to document patient information.

Data entered in **PowerForms** can flow between other parts of the chart including iView flowsheets, Clinical Notes, Allergy Profile, and Medication Profile.



Review the screenshot above for a general overview of PowerForm features:

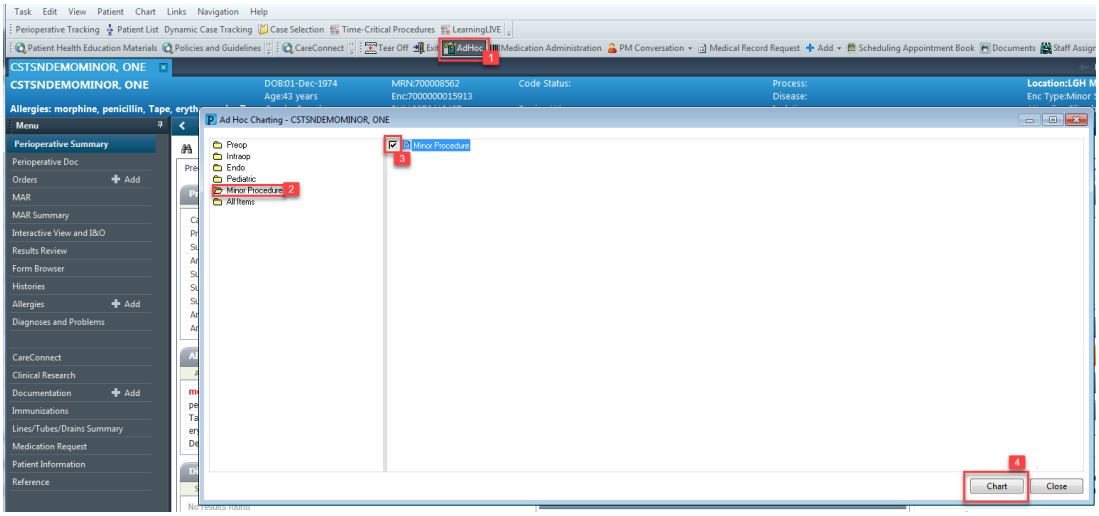
1. Title of the current PowerForm you are documenting on
2. List of **sections** within the PowerForm for documentation
3. A red asterisk denotes section(s) that have required field(s)
4. Required field(s) within the PowerForm will be highlighted in yellow.

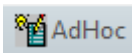
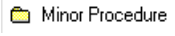


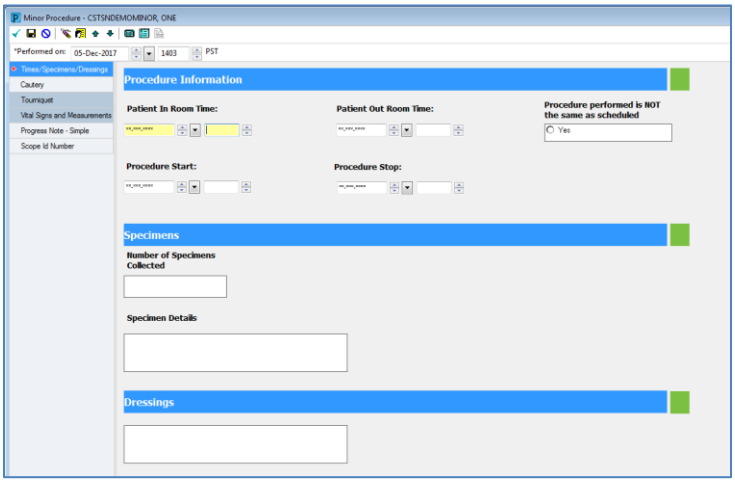
5. You cannot finalize a PowerForm until all mandatory fields in that section have been completed.
    - The checkmark 

means that mandatory fields in this section are completed.

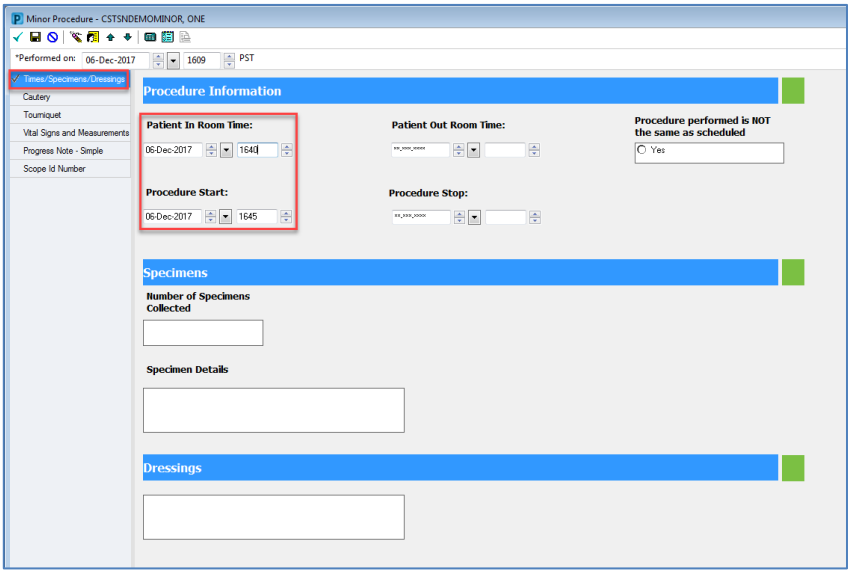
2 Open the Minor Procedure PowerForm



1. Click the **AdHoc** icon  from the toolbar.
    - The **AdHoc** folder is an electronic filing cabinet that allows you to find any PowerForm
    - The Ad Hoc Charting window opens.
    - The PreOp folder opens by default.
2. Select the **Minor Procedure** folder  from the left pane.
3. Select the **Minor Procedure** PowerForm.
4. Click **Chart.**
    - The Minor Procedure Powerform opens.



3 Document the Patient In Room Time



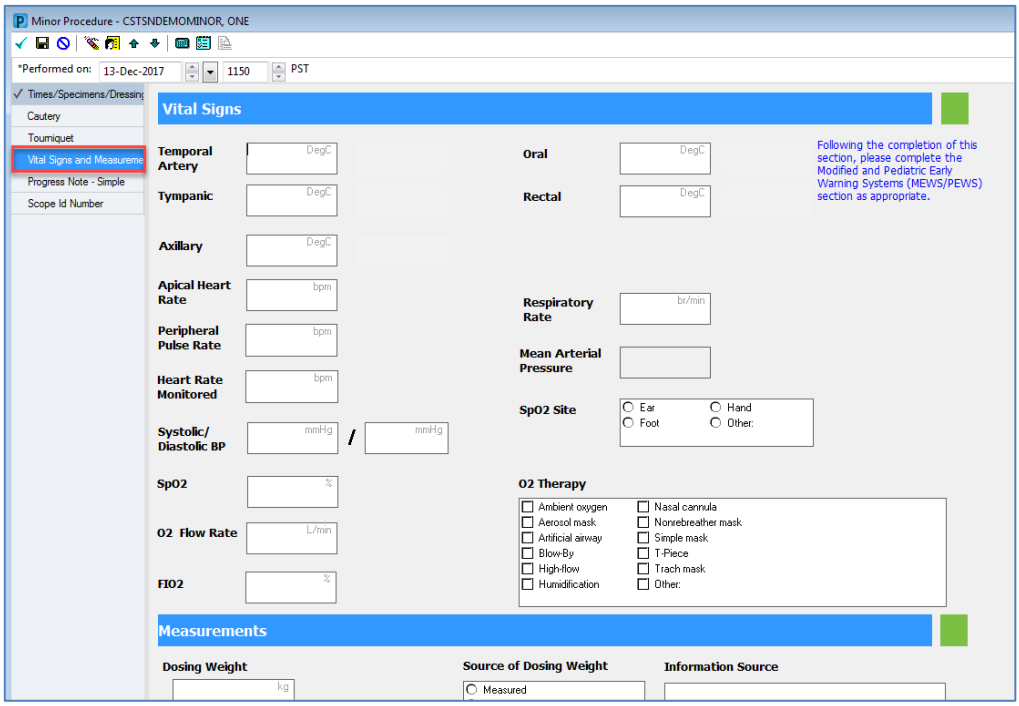
Within the **Times/Specimens/Dressings** segment, fill in the following data:

- **Patient In Room Time** = *today's date* and *5 minutes in the past*
- **Procedure Start** = *today's date* and *current time*

  Type ***T*** to autopopulate the current date

  Type ***N*** to autopopulate the current time

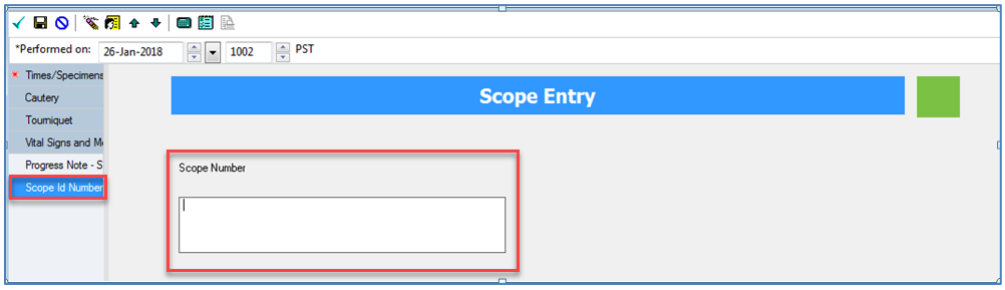
4 Document the Patient's Vital Signs



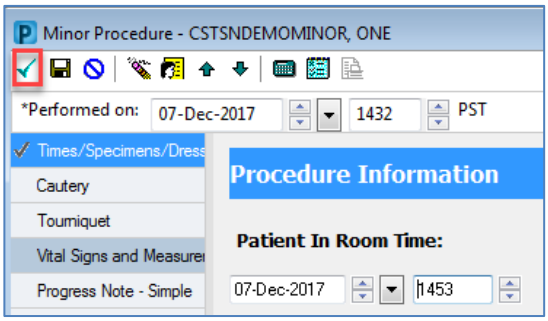
Select **Vital Signs and Measurements** and enter the following data:

- **Temperature Axillary** = *36.5*
- **Peripheral Pulse Rate** = *75*
- **Systolic/Diastolic BP** = *120/80*
- **SpO2** = *100*
- **Respiratory Rate** = *20*

Note: *For urology procedures done in the Local Room enter the Scope ID number



5 Save and sign the Minor Procedure PowerForm



1. To sign the Minor Procedure PowerForm, click the **green checkmark** icon ✓ in the top left corner of the PowerForm.

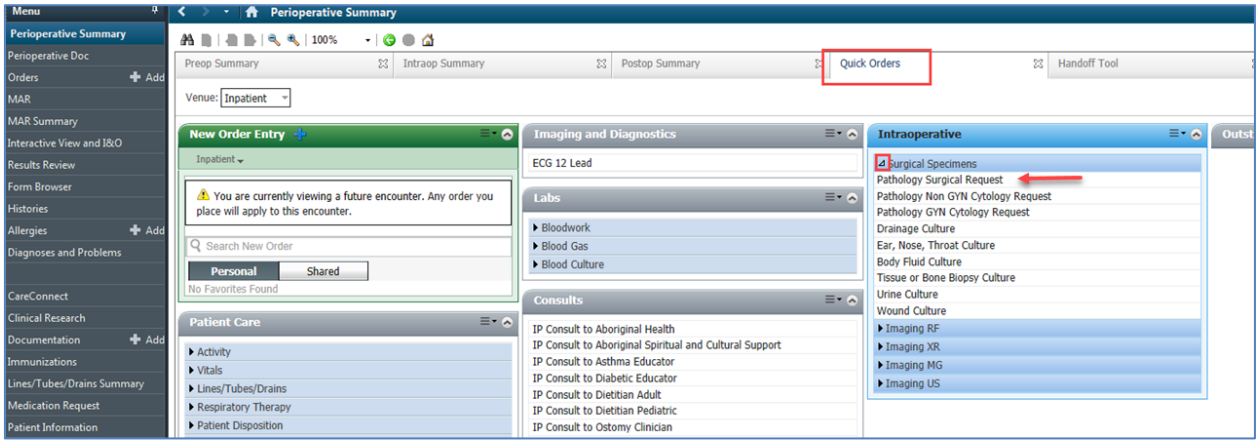
2. Click the **Refresh** icon .

Key Learning Points

- PowerForms are electronic forms used to chart patient information.
- The AdHoc button AdHoc in the toolbar allows you to locate a new PowerForm.
- PowerForms may be broken up into several sections. Section headings are displayed to the left side of PowerForm (e.g., Times/Specimens/Dressings)
- The red asterisk next to Times/Specimens/Dressings indicates that there are mandatory fields that are required to be completed. The Patient In Room Time is the only mandatory field.
- The system will not allow the record to be finalized until the mandatory fields are completed
- Always Sign the PowerForm using the green checkmark ✓ so that other users can see it in the chart.

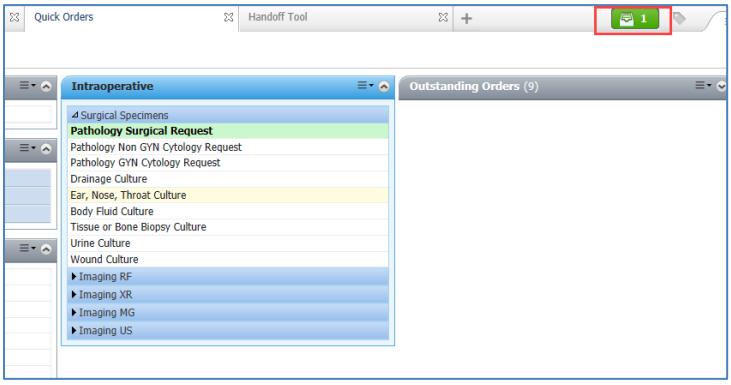
Activity 1.5 - Placing a Specimen Order

1 Specimens sent to pathology require an order. If an order for specimen collection was not placed pre-procedure or is requested during the procedure, an **AdHoc order** is required. This will generate the required paper requisition and labels that will be sent with the specimen to Pathology.

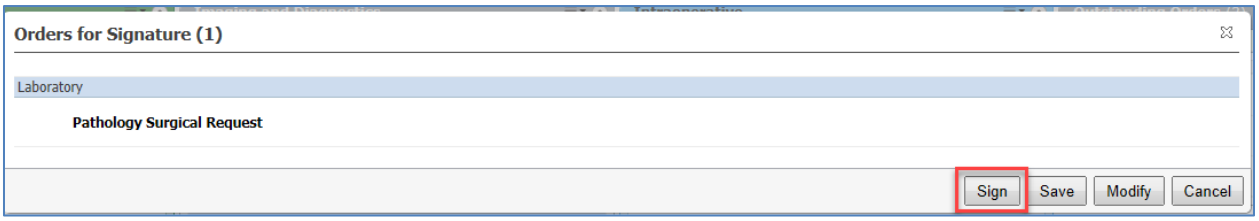


Go to the **Perioperative Summary - Quick Orders** tab

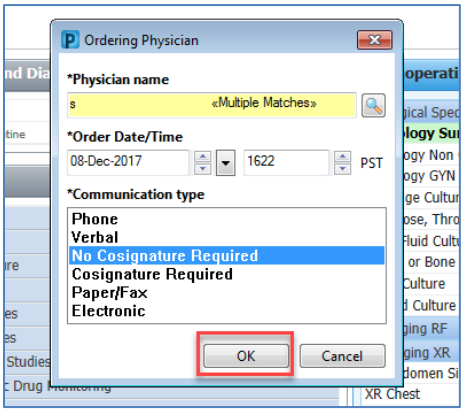
1. Locate the **Intraoperative** component.
2. Click the ▶ next to Surgical Specimens to open the list.
3. Select **Pathology Surgical Request**



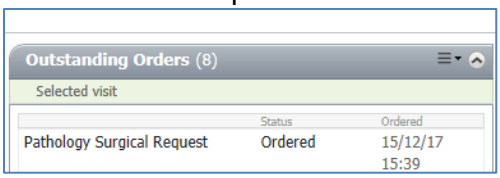
4. The order will be placed in the Inbox. Click on the **Inbox**  .
   - The Orders for Signature window will open.



5. Click **Sign**. The Ordering Physician window will open.



6. Type **Physician name** = <Provider name>
7. Select **No Cosignature Required**
8. Click **OK**. The specimen order is now complete.



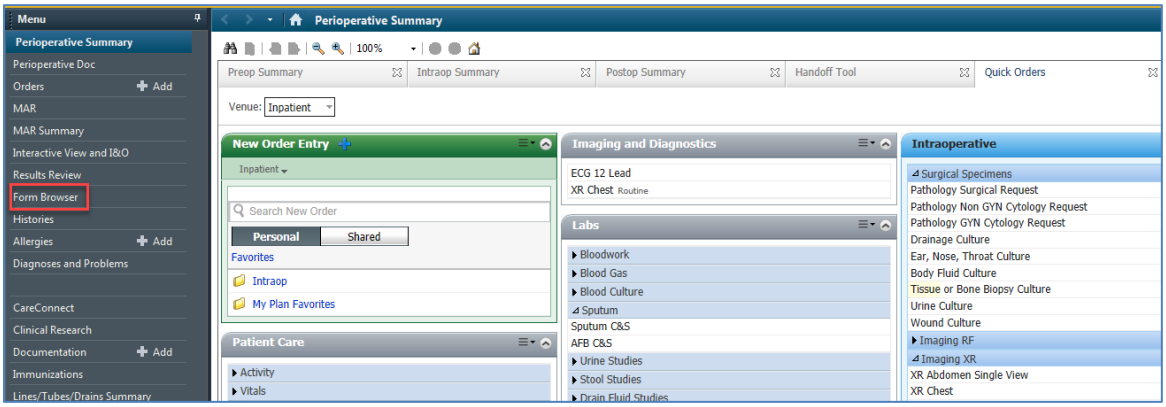
- The Pathology Surgical Request paper form and labels will print.
- Confirm that the information on the label is correct.

Key Learning Points

- The Pathology Surgical Request paper form and labels will print after clicking the Sign button.
- When the Details for Pathology Surgical Request window opens, data in the Requested Date/Time fields will autopopulate.

Activity 1.6 - Documenting Specimen Collection and Finalizing the Minor Procedure PowerForm

1 Modify the finalized Minor Procedure PowerForm

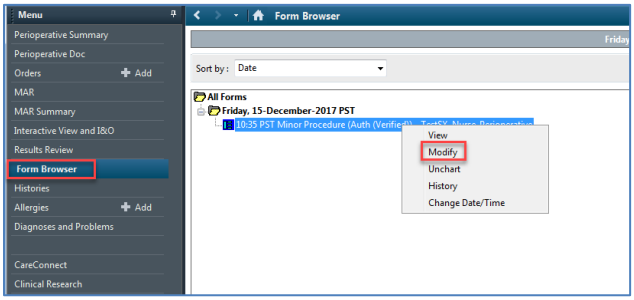


You can modify documentation in any PowerForm after it has been finalized. To re-open and modify a PowerForm:

1. Select Form Browser Form Browser from the Menu.
2. Right click on the PowerForm to be modified**.**
3. Select **Modify.**
4. Modify information within the PowerForm, as necessary.
5. Click the green check mark to finalize again.

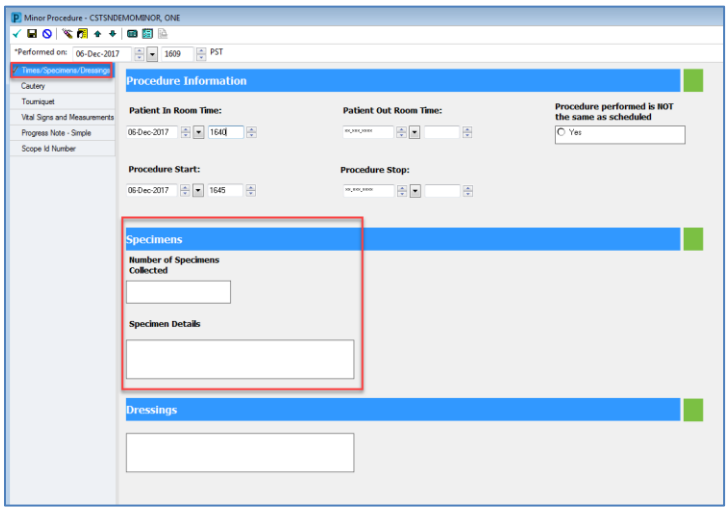
Note: The save button only saves the documentation for you. The finalize button will make the information visible to any clinician with access to the patient's chart.

2 Document Specimen collection details



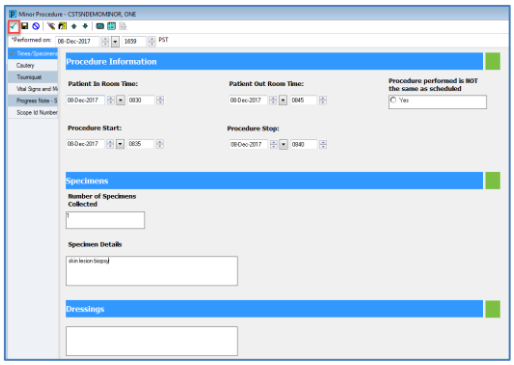
To document the specimen collection details of the biopsy specimen obtained during the procedure:

1. Select **Form Browser** from the Menu.
2. Right click **Minor Procedure.**
3. Select **Modify.**
    - The Minor Procedure PowerForm opens.



4. Select **Times/Specimens/Dressings** section.
5. Under **Specimens,** fill in the following details:
    - **Number of Specimens Collected** = *1*
    - **Specimen Details =** *skin lesion biopsy*

3 Complete and finalize the PowerForm



1. Click the green checkmark in the top left corner to finalize the PowerForm.
2. Click the Refresh icon
3. The PowerForm is now Finalized.

Key Learning Points

- Document the specimen details in the Times/Specimens/Dressings section of the PowerForm.
- Modifications to PowerForms can be made by accessing them through Form Browser.
- Clicking the green checkmark finalizes the PowerForm.

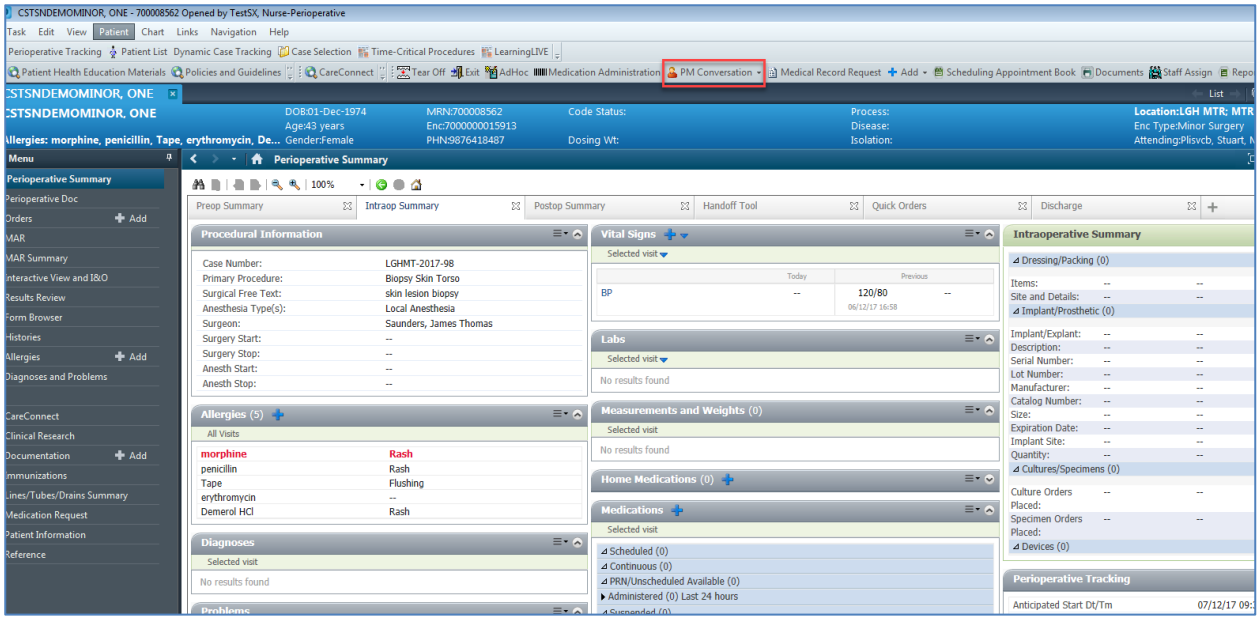
Activity 1.7 - Discharging a Patient

1

Discharge the Patient Encounter

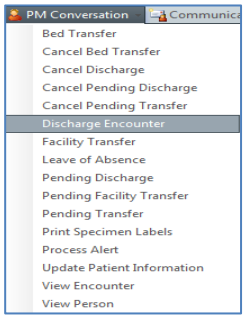
Once you discharge a patient:

- Any outstanding initiated orders from the current patient encounter will be discontinued automatically.
- You and other clinicians will still be able to document on the patient chart.
- The patient appears as discharged (crossed off) in Perioperative Tracking.

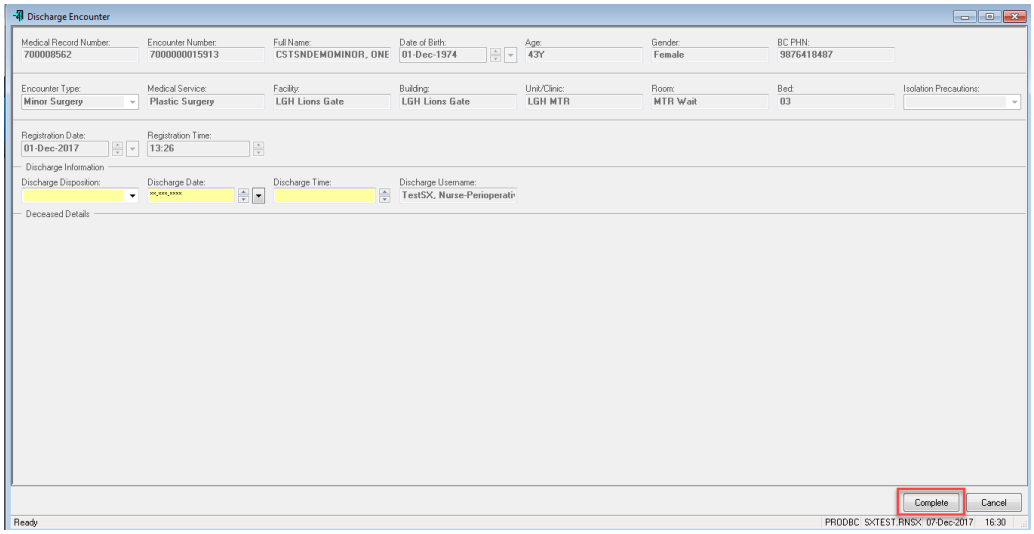


To discharge the patient using PM Conversation:

1. Click the arrow next to PM Conversation
2. Select **Discharge Encounter**



3. Within the Discharge Encounter window, complete the following required fields (highlighted in Yellow):



- **Discharge Disposition** = Select *Discharge Home without Support Services* from the drop down list
- **Discharge Date** = < *Discharge Date* >

  Type ***T*** to autopopulate the current date
- **Discharge Time** = < *Discharge Time* >

  Type ***N*** to autopopulate the current time

4. Click **Complete**.

Key Learning Points

- PM Conversation is used to discharge patients.
- The fields highlighted in Yellow indicate mandatory criteria that must be entered to proceed to the next step.

End of Workbook

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