SELF-GUIDED PRACTICE WORKBOOK [N36] CST Transformational Learning

Nursing: PAC







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***** SELF-GUIDED PRACTICE WORKBOOK

Duration	2 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:

- Navigate the Perioperative Tracking Board PAC view
- Set Events
- Complete the Surgical Assessment PowerForm
- Set Event Alerts
- Set Process Alerts
- Update the Perioperative Tracking Board as required

SCENARIO

Overall Scenario:

A 54-year-old male with an inguinal hernia meets with a General Surgeon and is scheduled for an elective right inguinal hernia repair. The patient has a medical history of seizure disorder and a surgical history of appendectomy. Following his appendectomy he had a violent episode upon emergence, which was associated with the anesthetic drugs he received.

His chart is screened by the PAC nurse and he is booked for a Nurse and Anesthesia PAC Appointment. He attends his PAC appointment and is determined fit for surgery. Surgery is scheduled three weeks from the date of the PAC appointment.

Focus of this Scenario:

It is the day of the PAC appointment. This scenario is from the perspective of the PAC nurse. The Anesthesiologist portion of PAC will be reviewed in the Anesthesiologist workbook.

As a PAC Nurse, you will complete the following 6 activities:

- Navigate the Tracking Board
- Display and navigate the patient chart
- Set events to update the patient's status in Perioperative Tracking
- Document in the Surgical Assessment PowerForm including conducting the Best Possible Medication History (BPMH) and recording allergies & vital signs
- Set an event alert
- Set and review a Process Alert
- Flag the appointment as a PAC Complete



Activity 1.1 - Navigate the Tracking Board

When you login to PowerChart it will open to **Perioperative Tracking**.

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

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P PowerChart Organizer for TestUser, NurseTeamLead-Perioperative	2 💌
Task Edit View Patient Chart Links Case-Actions Provider List Help	
Perioperative Tracking 1 essage Centre & Petient List. Dynamic Case Tracking 🎬 Pref Card Picklist (2) Case Selection 👫 Time-Critical Procedures 🐩 Day of Surgery View 👫 Historical View 👫 LearningLIVE 🕴 🕄 CareConnect. 🖏 PHSA PACS 🕲 VCH and PHC PACS 🕲 MUSE 🕲 FormFast WFI 🖕	
📲 Eait 🐐 Advice 💷 Medication Administration 🔒 PM Conversation - 🍓 Communicate - 🗟 Medical Record Request 🔶 Add - 着 Scheduling Appointment Book 🛞 Documents 🎇 Staff Assign 🙊 Peterence Card Maintenance 🖀 Report Builder 📾 Discern Reporting Portal 🚇 Report Manager 📴 Aware .	
Q Patient Health Education Materials @ Policies and Guidelines @ UpToDate	
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Perioperative Tracking	utes ag
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Filter: LGH PAC Yesterday 🔹 🔟 🔞 👔 🖨 🔶 🚺 Total Cases: 2 Patient: CSTSNWORK800K, REV -	
Status PAC Time PAC Location Patient Age/Sex Alerts Allergy Anesthesiologist Old Chart Status Proc. Date Procedure Surgeon PAC Visit Type Seen	by Nur
LGH OCC Rm 10 (Exam) (1 case)	
07-0x-2017 CSTPRC0DECSN, 37 years / 08:00:00 MEREDITH Female CARANSENSIS Visit	
LGH OCC Rm 9 (Exam) (1 case)	
07-Dec-2017 CSTSW/VORKBOOK, 54 years / 10:00:00 REVIEW Male Pisocw, Tyler, MD PreAnsthesia and Nurse Visit	3

- Any time you need to navigate back to Perioperative Tracking you can click
 Perioperative Tracking from the toolbar
- 2. Patients will display in LGH PAC tracking view
- 3. Each row within this table represents a patient. They are typically arranged by room (e.g. OR and PAC).

Key Learning Points

You can use the Perioperative Tracking within the toolbar to return to this view from any other area of PowerChart



Activity 1.2 – Display and Navigate the Patient's chart

Opening the Patient's Chart in Perioperative Tracking

Task Edit View Patient Chart Links Case Actions Provider List H	lelp			
Perioperative Tracking 🖃 Message Centre 🛔 Patient List Dynamic Case Tracking	a 🎇 Pref Card Picklist 📁 Case Selection 👫 Time-Critical Procedu	res 🎬 Day of Surgery View 🎬 Historical View 🎇 LearningL	VE 🖕 🗄 😋 CareConnect 😋 PHSA PACS 😋 VCH	and PHC PACS 🜊 MUSE 🜊 FormFast WFI 💡
📲 Exit 🎬 AdHoc 💵 Medication Administration 🔒 PM Conversation 🔹 🕞 Com	municate 👻 🗟 Medical Record Request 💠 Add 👻 🏥 Scheduling	Appointment Book 📄 Documents 🕌 Staff Assign 👳 Prefe	rence Card Maintenance 🖀 Report Builder 🗃 Dis	scern Reporting Portal 🚇 Report Manager 📴 iAware 👃
😋 Patient Health Education Materials 🔞 Policies and Guidelines 🔇 UpToDate 💡				
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Perioperative Tracking				(미) Full screen 👼 Print 온 2 minutes ag
SGH Intraop SGH Phase I SGH Phase I LGH LGH Endo PreOp LGH Endo PostOp LGH PAC 1	Hase II LGH ASC PreOp LGH MTR IntraOp H Pref Card LGH Family LGH PreOp	LGH Case Communication LGH OB View LGH Emergency List LGH Intraop	SGH OB View LGH ECT LGH Phase I LGH Phase I SG	SGH Case Communication LGH Endo Incomplete H Pref Card SGH Emergency List SGH PreOp
Filter: LGH PAC Yesterday 🔹 💿 👒 🎼 😝 🚺 Total Cases: 2 Patient	CSTSNWORKBOOK, REV +			
Status PAC Time PAC Location	Patient Age/Sex Alerts	Allergy Anesthesiologist Old Chart S	tatus Proc. Date Procedure	Surgeon PAC Visit Type Seen by Nur
LGH OCC Rm 10 (Exam) (1 case)				
07-Dec-2017 08:00:00	CSTPRODBCSN, 37 years / MEREDITH Female	Q		Lo, NOLDAP, Charles PreAnesthesia Clinic Anesthesia Visit
CGH OCC Rm 9 (Exam) (1 case)				
▶ 2 07-Dec-2017 10:00:00 F	CSTSNWORKBOOK, 54 years / REVIEW Male	Q		Plisvcw, Tyler, MD PreAnesthesia Clinic Anesthesia and Nurse Visit

1. Select the LGH PAC view

1

- 2. Select the appropriate patient by Clicking on the row. Blue arrow 🕨 will appear
- 3. Double- click the Blue arrow Next to the patient's chart to open their chart

P Assign a Relationship
For Patient: CSTSNWORKBOOK, REVIEW
Relationships:
Nurse Quality / Utilization Review Research Unit Coordination
OK 5 ancel

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



CSTSNWORKBOOK, REVIEW - 70	0008243 Opened by TestUser, Nur	sellearnLead-Perioperativ	e							
Task Edit View Patient Ch	hart Links Navigation Help									
Perioperative Tracking	ge Centre 🛔 Patient List Dynami	c Case Tracking 脳 Pref (Card Picklist 🐌 Case Selection 🚦	Time-Critical Procedures	Day of Surgery View 🔛 Historical View	K LearningLIVE	ect 🗿 PHSA PACS 🔞 VCH ani	PHC PACS 🐧 MUSE 🐧	FormFast WFI 👳	
Tear Off 📲 Exit 🎬 AdHoc 🔳	Medication Administration 🔒	PM Conversation - 🔩 C	ommunicate + 🚊 Medical Recor	f Request 🕂 Add + 🛍 Sche	duling Appointment Book 📻 Document	s 🛗 Staff Assign 🧔 Preference Ca	rd Maintenance 💼 Report Build	er 🗃 Discern Reporting Pr	istal 🚺 Report Manag	er 💽 Aware 🚽
Patient Health Education Mater	rials 🕜 Policies and Guidelines 😮	UpToDate								
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MAR	Procedural Information		=	- PowerForms (0)	++	≡• ♥	Preoperative Checklist			=• *
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	Historical (0)		Show Previous Vit	Administered (0) L	ast 24 hours		Operating Room			
	Family History (0)		-	▲ Suspended (0)			Public Sched Comment			

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

2 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.

Task Edit View Patient Ch	art Links Navigation He	• •											
Perioperative Tracking Messag	e Centre 🍐 Patient List Dyna	amic Case Tracking III Pref	Card Picklist 10 Case Selection	15 Time	e-Critical Procedures 📧 Day of	Surgery View K Historical View	E LearningLIVE	CareConne	ect 🔞 PHSA PACS 🙆 VCH and I	PHC PACS 🔂 MU	SE 🔂 FormFast	WFI _	
Tear Off 📲 Exit 🎁 AdHoc 💵	Medication Administration	PM Conversation -	Communicate + 🕅 Medical Rec	ord Requ	Jest 🕂 Add 👻 🛗 Scheduling /	Appointment Book PDocumen	its 🛗 Staff Assign 🐼 P	Preference Car	d Maintenance (Report Builde	r 📾 Discern Repo	rting Portal 1831 R	eport Manager 💽 iAware	
Patient Health Education Materi	ials 😭 Policies and Guideline	UnToDate	_										1
CSTSNWORKBOOK REVIE											List - Re Re	rent + Name	γa
CSTSNWORKBOOK REVIE	TW 2	DOB:30-Oct-1963	MRN:700008243	-	Code Status:		Process:Seizure P	recautions		Location:LGH	SurgWaitLst		
			Enc:7000000016214							Enc Type:Pre-D			
Allergies: No Known Medicatio	n Allergies	Gender:Male	PHN:9876429433		Dosing Wt:		Isolation:			Attending:			
Menu 4	< > • 👔 Periope	rative Summary									,D, Full scree	1 BPart 5 C 2 minut	tes ago
Perioperative Summary	AA 🐘 🖷 🐘 🔍 🔨	100% 🔹 🛛 🌑 🖓										_	
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Results Review	Surgical Free Text: Anesthesia Type(s):	Repair R Defer to	ight Hernia Inguinal Anesthesia		No results found				ECG	Ā		4	
Form Browser	Surgeon:	Plisvcw,	Tyler, MD						H&P	#		\$	1
Histories	Surgery Start:	-			Labs			≡• ⊘	ID Verification			\$	
Allergies 🕂 Add	Surgery Stop:				Selected visit 💙				Site Verification	*		Ç.	e
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Documentation 🛛 🕂 Add	No Known Medication Alle	rgies			No results found				Glucose Random	F	Future	20/11/17 15:55	
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	Classification: All				 Administered (0) Last 24 h 	lours			Operating Room	LGH	IOR KC		
	Problem				⊿ Suspended (0)				Public Sched Comment				
	This Visit (0)				Discontinued (0) Last 24 h	iours			Private Sched Comment				
									December (A)			=-/	
< >	A				Diagnostics (0)			≣• ⊗	Documents (4)			=• >	
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- 1. **Toolbar** 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. **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. **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 in updates the patient chart with the most up to date entries when clicked. It is important refresh the chart frequently especially as other clinicians may be accessing and documenting in the patient chart simultaneously.
- 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

Key Learning Points

- The blue arrow indicates that you have selected a patient in the tracking view
- Users accessing a patient's chart for the first time are prompted to assign the relationship with the patient e.g. Nurse
- Always 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



Activity 1.3 – Update Patient's Status in Perioperative Tracking by Setting an Event

The advantage of Perioperative Tracking is that real time patient status changes can be immediately communicated as they occur. The functionality is referred to as **Setting an Event**.

An Event can include an Alert (e.g. Violence Alert) or a patient Status (e.g. Pt. in Waiting Room), and notifications (e.g. Seen by Nurse). To Set an Event:



1. Select Perioperative Tracking

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- 2. Select the LGH PAC view
- 3. Right-click anywhere on the line with the relevant patient
- 4. Select **Set Events...** from the drop-down list. The **Case Tracking Set Events** window will display.

🥺 Case Tracking Set Even	nts								- • •
Name: CSTSHWO OR: CSTSHOOD Procedure 5 Anesth	RKBOOK R Rm 8 (Exam) hesia Clinic Anesthesia and Nurs	se Visit	Surg Start Time: Surgeon: Case #:	07:45 Plisvcd, Moham LGHPA-2017-31	med, MD .3		Anesthesiologist: Anes. Type:		
art Alerts Isolation PostOP Prione Call Bumped Pattentitio Show Intradop Preop PAC Location PAC	Chart Received Chart Requested EKG Lab Results Available PAC Phone Attempt 1.	Date 23-Nov-2017	Time 9:41	Locked	lcon	Name Pt in Waiting Room			
NPO Status Case C Phase Uphase	Attempt 2 PAC Phone Attempt 3. PAC Left Message PAC C In Revised	6						7 ок	Cancel

- 5. Click the PAC tab
- 6. Scroll down to Click **Pt. in Waiting Room** button
- 7. Click



Peri	ioperative Tracking										ĵ) Full screen 🛛 👼 Print
	SGH Intraop	SGH Phase I SGH Phase LGH Endo PostOp	II LGH AS	C Phase II LGH LGH Pref Card	LGH Family	LGH MTR IntraOp LGH Cas LGH PreOp LGH Emerger	e Communication	LGH OB View op LGH Pha	SGH OB View se I LGH I	LGH ECT	SGH Case Communica of Card SGH I	tion LGH Ende Emergency List
Filt	ter: LGH PAC Yesterday	-) 🖾 🔞 i 🚘 🔶 🚺 i Te	otal Cases: 2 Patien	CSTSNWORKBOOK, RE	۷ •							
	Status	PAC Time	PAC Location	Patient	Age/Sex Alerts	Allergy	Anesthesiologist	Old Chart Status	Proc. Date	Procedure	Surgeon	PAC Visit Type
	LGH OCC Rm 1	0 (Exam) (1 case)										
		07-Dec-2017 08:00:00		CSTPRODBCSN, MEREDITH	37 years / Female	\mathbf{Q}					Lo, NOLDAP, Charles	s PreAnesthesia Clinic Anesthesia Visit
	LGH OCC Rm 9	(Exam) (1 case)										
Þ		07-Dec-2017 10:00:00	Pt. in Waiting Ro	STSNWORKBOOK, REVIEW	54 years / Male	Q					Plisvcw, Tyler, MD	PreAnesthesia Clinic Anesthesia and Nurs Visit

8. Verify that the PAC location has been updated on Perioperative Tracking

2 Remove an Event

Surg Start Time Surgeon: Case #:	: 15:00 Plisvew, Tyler, HD LGH0R-2017-1357		Anesthesologist: Anes, Type:	Defer to Anesthesia
y of Delay	Date 13-Oct-2017	Time 15-20	Add Event	Name Pt in Waiting Room
led Block Ready		0	Modify Event Remove Event	3
oom 🥵 Pt. in PreOp				
for ry Transport to OR				
	1			
	y of Delay led Block Ready oom I Pt in PreOp for ry Transport to OR	y of Delay Block Ready oom PL in PreOp for ny Transport to OR	Surgent Plavex, Tyler, H0 Surgent Plavex, Tyler, H0 Case #: LGHOR.2017-1357	y of Delay Block Ready com PL in PreOp for my Transport to OR

- 1. Right- click **Set Events** from the **LGH PAC** view. Case Tracking Set Events window opens.
- 2. Right- click on the Pt. in Waiting Room event
- 3. Click Remove Event
- 4. Click OK

Key Learning Points

Right- click anywhere on the line with the relevant patient to set the event(s)

Perioperative Tracking will be updated to show the patient status

Events can be added or removed



Activity 1.4 - Documentation of Surgical Assessment PowerForm

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, and PAC documentation will flow to PreOp documentation.

In this example we are going to document on the Surgical Assessment PowerForm.

To open and document on a new PowerForm:

1



Opening the Surgical Assessment PowerForm

1. To open the patient's chart, double click on next to the patient's name. Alternatively, if the chart is still open, click on the patient chart tab.



- 2. Click the ^{MAdHoc} icon from the Toolbar
 - The **AdHoc** folder is an electronic filing cabinet that allows you to find any PowerForm on an as needed basis
 - The Ad Hoc Charting Window opens
 - The PreOp folder opens by default
- 3. Select the Surgical Assessment PowerForm
- 4. Click Chart



*Performed on: 12/12/2017	▼ 1053 ● PST			
General Information Barriers to Communication	General			
Allergies	Information Given By	5	Surgery/Procedure Date/Location	Discharge Contact Name
Vitals/Measurements/MEWS/PEWS	Patient	r	Procedure Location	
 Advance Care Planning 	Family		Procedure Date/Time	
Past Medical History, Problems, Diagr	Community Care/Case Manager			Discharge Contact Phone(s)
Patient Screening History				
STOP BANG Assessment				
Medication History	Barriers to Communication	Reason Unabl	e to Obtain Information	
* ID Risk Screen	O Yes	O None	O Physical impairment	Discharge Contact Relationshi
 Violence and Aggression Screening 	O No	O Clinical condition		O Unable to obtain O Caregiver
al History		C Lognitive impairme C Language barrier	ent	O Patient O Other:
3 E-AID Assessment				O Daughter
Nicotine Dependence Assessment	Answer "Yes" if the patient has			Family member Friend
Procedure History	language barriers, requires interpreter			O Parent
Anesthesia/Sedation	support, or has sensory dencits.			O Sibling
Family History				O Son
Pain Assessment				
Numeric Pain Scale				
FACES Pain Scale	Visitors/Family			
Transfusion Reaction	Visitor/Family Information		Visitor/Family Restrictions	
Morse Fall Risk	· · · · · · · · · · · · · · · · · · ·			
Discharge Needs				
Skin Assessment				
Pro Procedure Instructions				

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 asterix denotes sections that have required field(s)
- 4. Required field(s) within the PowerForm will be highlighted in yellow. You will be unable to sign a PowerForm unless all required fields are completed. An example of a required field can be found in Violence and Aggression Screening.



Note: You cannot finalize a PowerForm unless all mandatory fields within a section have been completed.



Completing the General Information Section

verformed on: 0	8-Dec-2017 🔹 💌 0853 🐳 PST		
General Informatic	General		
Allergies	Information Given By	Surgery/Procedure Date/Location	Discharge Contact Name
Vitals/Measureme	Patient	Procedure Location	_ L
dvance Care Pla	Family	Procedure Date/Time	Discharge Contact Phone(s)
Past Medical Hist	Community Lare/Lase Manager Other:		booldinge contact Phone(3)
Patient Screening			
STOP BANG Ass			
Medication Histor	Barriers to Communication	Reason Unable to Obtain Information	
ID Risk Screen	O Yes	None O Physical impairment	Discharge contact Relationship
Violence and Agg	O No	Cinical condition Conditive impairment	O Unable to obtain O Caregiver
Social History		C Language barrier	O Spouse
CAGE-AID Assess			O Daughter
Nicotine Depende	Answer "Yes" if the patient has		C Friend
Procedure History	language barriers, requires interpreter support, or has sensory deficits.		O Parent
Anesthesia/Sedat			 Significant other
Family History			O Son
Pain Assessment			
Numeric Pain Sca			
FACES Pain Scale	Visitors/Family		
Transfusion Reac	Visitor/Family Information	Visitor/Family Restrictions	
Morse Fall Risk			
Discharge Needs			
Skin Assessment			
PreProcedure Inst			
ALL C			

Within the **General Information** section, enter the required information within this section:

- Information Given By = Family
- Surgery/Procedure Date/Location Reviewed = Procedure, Procedure Date/Time, Location
- **Discharge Contact Name** = Mary
- Discharge Contact Phone(s) = 604-123-4567
- Barriers to Communication = No
- Discharge Contact Relationship = Parent

Note:

- For metrics that contain circle (radio) buttons to select an option, you may only select one of the options
- For metrics that contain square check boxes (e.g. Preferred Language), you may select one or more options
- If there is a blank box, it indicates a free text box where you may type any text



Completing the Allergies Section

Surgical Assessment - CSTSNWORKBOOK, PREOP								
🗸 🖬 🛇 🖏 🌠 🋧 🔸 📾 🔠 🗟								
*Performed on: 13-Dec-2017 🔹 💌 1157 🔺 PST								
General Informatic Allergies								
Barriers to Commu								
Allergies 1								
Vitals/Measureme Mark All as Reviewed								
* Advance Care Pla	. 10.							
			12 AT A11 T	A a		. Du		
Past Medical Hist	gies	No Known M	edication Allergies	💦 Reverse	e Allergy Chec	k Di	splay Active	•
Past Medical Hist Patient Screening D. Substance	Category	No Known M Severity	edication Allergies Reactions	Interaction	e Allergy Chec Comments	source	Reaction Status	▼ Revi€
Past Medical Hist Patient Screening STOP BANG Ass STOP BANG Ass	Category Drug	No Known M Severity Mild	edication Allergies Reactions Rash	Reverse	e Allergy Chec Comments	k Dis Source Patient	Reaction Status	▼ Revi¢ 13-D
Past Medical Hist Patient Screening STOP BANG Ass Medication Histor	Category Drug	Severity Mild	edication Allergies Reactions Rash	Reverse	e Allergy Chec Comments	k Di Source Patient	Active Reaction Status Active	Revie 13-D
Past Medical Hist Patient Screening STOP BANG Ass Medication Histor * ID Risk Screen	Category Drug	No Known M Severity Mild	edication Allergies Reactions Rash	Interaction	e Allergy Chec Comments	k Di: Source Patient	Reaction Status Active	▼ Revie 13-D
Past Medical Hist Modify No Known Aller Patient Screening D. Substance STOP BANG Ass Penicillin Medication Histor * ID Risk Screen Volence and Agg	Category Drug	Severity Mild	edication Allergies Reactions Rash	Reverse Interaction	e Allergy Chec	k Di Source Patient	Reaction Status Active	▼ Revie 13-D
Past Medical Histor Patient Screening STOP BANG Ass Medication Histor * ID Risk Screen * Violence and Agg Social History	Category Drug	Severity Mild	Reactions Reactions Rash	Reverse Interaction	e Allergy Chec	k Di Source Patient	Active Reaction Status Active	▼ Revie 13-D

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.
- 3. To document the adhesive allergy, click the **Add 1**. The Add Allergy/Adverse Event window displays.

Always and a shore teacher	to + thep of reds 4 - Sudorbance Search	600 (
Marce 4	"Search: adhesive	Martswith + Walking Terminology +	AMComment
and Real	Search by Name	Search by Code	
A Addres fait over a	web Tarminology Mergy, Mykum All	Terminology Rails (All Terminutegy av and	
	creation Categories		
	Year -	Investing	9
Patiet	Contraction of Contra		
	The second se	have been a large	OK OKANINE CAN
ip 🗇 Hime 🕆 Facordae 🔹 🗔 Sold	Afreis ferten filten	12 Mars Mars	5
ood Aleegee novermental Aleegee			
Inneron Drug Allergee			
	1	0	
	Add to Pavorites	Carcel Carcel	

- 4. Enter **Adhesive** in the Substance field and click the **search** icon
- 5. The Substance Search window opens. Select **Adhesive Bandage**
- 6. Click OK. Add Allergy/Adverse Window is shown.



STSNIJORKBOOK, REVEW (MRN 7000	6243) - Add Allergy/Adverse	Offect		6
pe Allegy • An adv obstance desire Bandage 🙀 🛛 Free text	erse reaction its a drug or substa	nce which is due to an immu lable for non-Multure allergie	ndigical response.	Add Connect
naction(c)	"Severity	His source	Connerts	
Add Free Text	indefeed +	(not entered) •		
	At out entered	Drost ond entered		
	Faceshel on helped of	Yatara T	and there	
		(there	the v	8 OK OK & Add New Cancel
Up 🙆 Home 👷 Favorites - Food Alergies Diversimental Alergies Common Drug Alergies	Tolden Folder Fold	ies .		

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



Completing Vitals/Measurements/MEWS/PEWS Section

🗸 🖬 🔕 🔌 🕯	• • •			
*Performed on: 2	-Nov-2017	▼ 1359 🌰 PST		
General Informatic				
Barriers to Comm.	Vital Sid	ins		
Allergies		Temporal Artem	Red	Impanic
Vtals/Measurem		Temporal survey	Der	Following the completion of this
 Advance Care Pla 		L DOZL	U egc	section, please complete the Modified and Pediatic Early
Past Medical Hist-	Temperatures			Warning Systems (MEWS/PEWS) section as a constraints
Patient Screening		Rectal	Axillary	and the suppression.
STOP BANG Ass		DegC	DegC	
Medication Histor				
 ID Risk Screen 				
 Volence and Agg 	Hand Date	Apical Heart Rate	Heart Rate Monitored	Peripheral Pulse Rate
Social History	Vitals	bpm	bpm	bpm
CAGE-AID Assess				
Record on Materia		Reminators Bate	Mean Asterial Pressure	Santolin / Diantolin BP
Anotheria (Sadat		br/nin		nnHo nnHo
Family History				/
Pain Assessment		SP02	SP02 Site	FID2
Numeric Pain Sca		2	O Ex O Oter	
FACES Pain Scale			O Foot	
Transfusion Reac	Officer Visiola		C Hand	
Morse Fall Risk				
Discharge Needs		02 Flow Rate	02 Therapy	
Skin Assessment			Ambent coygen Nacal cannula	nark
PreProcedure Inst			Attificial airway	
Progress Note - S			Biow-By Trece	
			Humidification Other	
	Measure	ements		
	Dosing Weig	ht	Source of Dosing Weight	Information Source
		kg	-	
	<			

Click Vital/ Measurements/ MEWS/ PEWS

Data entry details for Vital/ Measurements/ Signs and Measurements:

- **Temperature Axillary** = 36.5
- Peripheral Pulse Rate = 75
- Systolic/Diastolic BP = 120/80
- **SpO2** = 100
- **Respiratory Rate** = 20
- **Dosing Weight** = 65kg
- *Weight Measured = 65kg



- Source of Admit Weight = Measured
- *Height/Length Measured = 170 cm
- Body Mass Index Measured (BMI) is autocalculated from entry of *Weight Measured and *Height/Length Measured
- AVPU = Alert and responsive
- MEWS Total Score is autocalculated = 2
- **Situational Awareness Factors** = click on the Column Header for No to mark all as No

*As data collected here is not likley to remain constant by the time this patient arrives in SDCC on the day of the procedure, this data will not pull forward into other sections of the chart.

6 Completing the Past Medical History, Problems, Diagnosis Section

Mark all as Reviewed

General Informatic					
Barriers to Commu	Past Medical History, Problems and Diagnoses				
Allergies					
Vitals/Measureme	Mark all as Reviewed 2				
Advance Care Pla	Diagnosis (Problem) being Addressed this Visit		Most Pocont Hospi	Most Recent Hespitalization(s)	Most Pocont Hospitalization(s)
Past Medical Hist	1 🖶 Add 🖆 Modify 🌣 Convert Display: 🕅		Mose Recent hospi	Date	Date Reason
Patient Screening			Hospitalization #1	Hospitalization #1	Hospitalization #1
STOP BANG Ass	Priority Annotated Display Condition Name Date Code Clinical Dx	ī	Hospitalization #2	Hospitalization #2	Hospitalization #2
Medication Histor			lospitalization #3	Hospitalization #3	Hospitalization #3
ID Risk Screen			Hospitalization #4	Hospitalization #4	Hospitalization #4
Violence and Agg	< •		Hospitalization #5	Hospitalization #5	Hospitalization #5
ocial History	- Problems				
CAGE-AID Assess	alle Add To Madia 🌐 Casand Elle Na Disadar Alle - 🗌 🛛 MO			-	
Vicotine Depende					
Procedure History	Annotated Display Condition Name Onset Date Code Name of Problem 🔺 Life Cycle St 💷 Classification				
Anesthesia/Sedat					
Family History					
Pain Assessment					
Numeric Pain Sca	۲				
FACES Pain Scale					
Transfusion Reac					

1. Click the **Past Medical History, Problems, Diagnosis** section to review existing information from previous visits. If a Problem or Diagnosis has been entered previously by a Provider this section will already be populated.

In this case Select

icon.



Completing the Medication History Section

heral Informatic	Medication History			
ners to Commu rgies				📑 Print ಿ 0 minut
als/Measureme	+ Add Document Medication by Hx 2 n	iliation 🕶 🔗 Check Interactions		Reconciliation Status
vance Care Pla				Wieds History 😈 Admission 😈 Outp
t Medical Hist	View	Displayed: All Active Medications, All In	active Medications 24 Hrs Back	Show More C
ient Screening	Orders for Signature			
DP BANG Ass	Medication List	0 V Order Name	Status Dose Details	mosified filter stitutio
lication Histor Risk Screen	Admit/Transfer/Discharge Status Patient Care		no orders carrently incertaics	
ence and Agg	- Activity			
sal History	Diet/Nutrition Continuous Infusions			
GE-AID Assess	Medications			
otine Depende	Blood Products			
cedure History	- Laboratory			
esthesia/Sedat	Procedures			
nily History	Respiratory			
n Assessment	Allied Health			
meric Pain Sca	Communication Orders			
CES Pain Scale	Supplies			
nsfusion Reac	Hedication History			
rse Fall Risk	Medication History Snapshot			
charge Needs	Reconciliation History			
n Assessment				
Procedure Inst				
gress Note - S				
	Diagnoses & Problems	▲ Details		
	Related Results	- Dorono		
	Formulary Details	Orders For Cosignature Orders For	Nurse Review	Orders For Sig

- 1. Click Medication History section
- 2. Click from the tool bar (this step is equivalent to doing the Best Possible Medication History BPMH)

A	llergies: Adhes	ive Bandage, No Know.	Age:17 years Gender:Male	Enc:/000000015411 PHN:9876429433	Dosing Wt:		Disease: Isolation:		Enc Type:Pre-Outpatient Attending:	
-	Add Medica	ation History Known Home Medications	🔲 Unable To Obtain	Information 🔲 Use I	ast Compliance				Reconciliation Status Meds History Admission Uutpatien	nt
M	Document Med	lication by Hx								-
	Crder	Name Status	Details			Last Dose Date/Time	Information Source	Complian Compliance	Comments	П
			Medica	tion history has not yet	been documente	ed. Please document th	e medication history f	or this patient encounter		
L										

Note: the Reconcilation status for Meds History shows as incomplete

- 3. Click + Add.
 - The Add Order window will display.

CSTSN	WORKBOOK, F	REVIEW - A	dd Orde	r					
CSTSN	WORKB	DOB:30	MRN:	00Co	de Status:	Proces	s:Se	izure Pre Location:LGH SDC	
	Age:54 y		00	Diseas	e:	Enc Type:Pre-Day S	on 🚦		
Allergie	s: No Kno)	Gender:	PHN:9	87 Dos	sing Wt:	Isolatio	on:	Attending:Plisvca, R	lecor
Search:	aceta		🔍 Ту	pe: 🎝	Document	Medication by Hx	Ŧ		
	acetaminophe	en							
	acetaminophe	en (1 g, PO,	QID, PF	N fever,	order durat	ion: 30 day, drug	j forr	m: tab, dispense qty: 120 tab)	
Medic	acetaminophe	en (1 g, PO,	QID, PF	N pain-r	mild or feve	r, order duration	: 30 c	day, drug form: tab, dispense qty: 120 t	tab)
	acetaminophe	en (1 g, PO,	QID, PF	N pain-r	mild, order (duration: 30 day,	drug	g form: tab, dispense qty: 120 tab)	
Cor	acetaminophe	en (1 g, PO,	TID, or	der durat	ion: 30 day,	drug form: tab,	disp	ense qty: 90 tab)	
Cor	acetaminophe	en (1 g, PO,	TID, PR	N fever,	order durati	on: 30 day, drug	form	n: tab, dispense qty: 90 tab)	
Cor	acetaminophe	en (1 g, PO,	TID, PR	N pain-n	nild or fever	, order duration	30 d	lay, drug form: tab, dispense qty: 90 ta	b)
	acetaminophe	en (1 g, PO,	TID, PR	N pain-n	nild, order d	luration: 30 day,	drug	j form: tab, dispense qty: 90 tab)	
•	acetaminophe	en (10 mg/l	kg, PO, i	q4h, PRN	pain-mild	or fever, drug fo	rm: c	oral liq, dispense qty: 1 bottle)	1
	acetaminophe	n (12.5 mg	ı/kg, PO	, q4h, dru	ug form: tal	o-chew, dispense	e qty	: 1 bottle)	- 1
	acetaminophe	en (12.5 mg	ı/kg, PO	, q4h, PR	N pain-mile	d or fever, drug f	orm	: oral liq, dispense qty: 1 bottle)	
	acetaminophe	n (12.5 mg	ı/kg, PO	, q4h, PR	N pain-mile	d or fever, drug f	orm:	tab-chew, dispense qty: 1 bottle)	- H
Interactive	acetaminophe	en (12.5 mg	ı/kg, PO	, q4h, PR	N pain-mile	d or fever, drug f	orm:	: tab, dispense qty: 1 bottle)	
	acetaminophe	n (15 mg/l	kg, PO, i	qбh, drug	g form: oral	liq, dispense qty	:1 b	ottle)	di
Results Re	acetaminophe	en (15 mg/l	kg, PO, i	q6h, PRN	pain-mild	or fever, drug fo	rm: c	oral liq, dispense qty: 1 bottle)	
Form Brow	"Enter" to Sear	ch							



- 4. Type in acetaminophen and hit Enter on your keyboard to search. Select acetaminophen.
 - The Order Sentences window will dipslay.



- 5. Select acetopminophen 650mg, PO, q4h
- 6. Click OK
- 7. Click Done

	No Known Home N	Medications	Unable To Ob	stain Information	Use Last Compliance		Keconcili Meds	History I Adn	mission 🔒 Discha
locu	ument Medication by Hx								
	Order Name	Status	Details			Last Dose Date/Tir	me Information Sour	ce Complian.	Compliance Cor
		Medicati	on history has no	t yet been docur	mented. Please document	the medication hist	ory for this patient en	counter.	
4	Home Medications								
	acetylsalicylic acid (A.	Documen.	. 1 tab, PO, qdaih	, drug form: tab-	-chew, dispense qty: 30 tab,-				
4	Pending Home Medicatio	INS							
	acetaminophen	Document	650 mg, PO, q41	h, PRN pain-mild	or fever, order duration: 30.	_	Patient	Taking as	_
: [ophen							
sta	Details for acetamin Details) <u>III</u> Order Comme Itus	nophen ents 🚰 Com	pliance	Information sou	urce		Last dose date/time		
sta	Details for acetamin Details) <u>I</u> Order Comme atus aking as prescribed	nophen ents 😤 Com	pliance]	Information sou Patient	urce		Last dose date/time	•	*
Sta Co	Details for acetamin Details)	nophen ents 🕺 Com	pliance	Information sou Patient	urce	•	Last dose date/time	•	A
Sta Co	Details for aCetamin Details) U Order Comme tus Along as prescribed mmment	nophen ents 🐒 Com	pliance	Information sou Patient	urce	·	Last dose date/time		A.

- 8. Review details for the documented medication
- 9. Click the **Compliance** tab within the Medication details
- 10. Update **Status**, **Information Source**, and **Document Last Dose Date/Time** as required
- 11. Click Document History

-Reconciliation Sta	tus	
Meds History	Admission	🕒 Outpatient

Note: the Reconciliation Status changes to a Green checkmark.



Completing the Advance Care Planning Section

-					
P Surgical Assessn	nent - CSTSNWORKBOOK, REV	/IEW			
- 🖌 🖸 🖉	🏂 🛧 🗣 🛄 🔛 🔛				
*Performed on: 0	07-Dec-2017 🚔 💌 1224	PST			
General Informatic	Advance Car	e Planning			
Barriers to Commu	Advance cur	e i lanning			
Allergies	Advance Care Plan	O Yes	Patient Wishes to	O Yes	
Vitals/Measureme		Inable to answer at this time	Receive Further	O No automatically fires	
🗸 Advance Care Pla			Information on Advance Care	consult for follow up.	
Past Medical Hist			Planning		
Patient Screening					
STOP BANG Ass					_
Medication Histor	Type of Advance	Advance Care Plan	Advance Care Plan		
* ID Risk Screen	Care Plan	Section 7 Standard Representative Agreement	Details		
 Violence and Agg 		Advance Care Plan Form			
Social History		No Cardiopulmonary Resuscitation - Medical Urder Befusal of Blood Product			
CAGE-AID Assess		Tissue, Body, or Organ Donation			
Nicotine Depende		Other:			
Procedure History					
Anesthesia/Sedat	Location of Advance	C Copy to be obtained from previous records	Reason Copy Cannot		7
Family History	Care Plan	O Copy placed on paper chart	Be Obtained		
Pain Assessment		Available as scanned document in EHR			
Numeric Pain Sca	Documenting "Unable to	O Unable to obtain copy			
FACES Pain Scale	fires consult for follow up.	O Other:			
Transfusion Reac					
Morse Fall Risk					
Discharge Needs					

Click Advance Care Planning section. Enter details:

• Advance Care Plan = No

9 Completing the ID Risk Screen section

*Performed on: 2017-Aug-02	▼ 1424 ● PDT										
General Information											
	Infectious Disease Ris	k Scr	eenir	ıg							
Barriers to Communication											
Allergies	ARO: Antibiotic-Resistant Organisms including Mi CPO: Carbanenemase-Producing Organisms	RSA or VRI	E	MRSA: Methicilin Resista VRE: Vancomycin Resista	nt Staphylococcus Aureus ant Enterococcus						
Vital Signs and Measurements				,							
✓ Advance Care Planning	Do you have any risk factors for ARUS?										
Past Medical History, Problems, Diagn	V None Healthcare in Canada within the last year	Cher	motherapy wi	thin the last year	Household contac	t with known CPO in the last year					
Patient Screening History	Healthcare outside Canada within the last year		rceration in t	ne last year							
STOP BANG Assessment	Dialysis within the last year	Horr	elessness or	in shelter in the last year							
Medication History											
✓ ID Risk Screen	Healthcare includes medical/surgical procedures,	overnight	stays, che	motherapy, dialysis, or ot	her care specified by organ	nizational practices.					
* Violence and Aggression Screening	If any risk is identified for AROs, the patie	nt may n	ed ARO s	creening swabs to be	ordered and performed.	Please refer to site-specific					
Social History	guidelines to determine which tests need	to be con	ipieted.								
CACE AID Assessment	In what facility and/or country did this l	nealthcar	re risk fac	tor occur? When did	this take place?						
CHOE-HID Assessment											
Nicotine Dependence Assessment											
Procedure History											
Anesthesia/Sedation	Have you or a household member travel	ho									
Family History	outside of Canada within the last 30 day	s?		Location of Recent	Travel						
Pain Assessment	O Ves estimat			Africa	Canada .	Middle Fast					
Numeric/FACES Pain Scale Adult	O Yes, household member			Africa-Central	Caribbean	Russia					
Transfusion Reaction	O Yes, patient and household member			Africa-East	Central America	South America					
Morse Fall Risk	No Unable to obtain			Africa-South	China	United States					
ADLs and DC Needs				Asia	India	Other:					
Skin Risk				Australia/New Zealan	d 🔲 Mexico	_					
Pre-Pre-sedure Instructions											
Deserves Nata Circula											
Progress Note - Simple	Risk Factors and Symptoms/ARO Surveil	lance			Unable to Obtain	Current Visit Information					
		Yes	No	Unable to obtain	None	Physical impairment					
	*Fever		×		Clinical condition	No parents					
	*Diamhea		X		Cognitive impairme	ent					
	*Headache		X		Language barrier						
	*Photophobia		X		Patient's age						
	Alliness With Generalized Rash		X								
	New or Worsening Lough		X								
	"Hecent Exposure to Communicable Disease		X		Communicable Di	soace Expected Tex					
	THISTORY OF ARIUS		×		communicable bi	sease Exposed 10:					
	*Immunocompromised		Ŷ		Measles	Chickenpox or shingles					
	minurocompromised		~		Mumps	Dther:					



Click on ID Risk Screen section. Enter details:

- Do you have any risk factors for AROs= None
- Have you or a household member traveled outside of Canada within the last 30 days? = *No*
- **Risk Factors and Symptoms**: Click on the **column header** for **No** to mark all as *No*.

Note: You can individually select Yes / No for each of the risk factors.

10 Completing the Violence and Aggression Screening section

*Performed on: 2017-Aug-02	▼ 1424 🌦 PDT	
General Information Barriers to Communication	Violence and Aggress	sion Screening
Allergies	Violence and Aggression Screening	Additional Information
Vital Signs and Measurements	No risk assessed at this time	
/ Advance Care Planning	Previous history of violent behaviour	
Past Medical History, Problems, Diagn	Current physical aggression or violence	
Patient Screening History	0 Other:	
STOP BANG Assessment		
Medication History	Market has a second second second	and infinition of side and a second in the second day of the form as and while
/ ID Risk Screen	If patient has a previous history of or cu	irrent indication of violence or aggression, complete the remainder of the form as applicable.
Volence and Aggression Screening	Current Patient Presentation	Current Presentation Additional Information

Click on Violence and Aggresion Screening section. Enter details:

• Violence and Aggression Screening = No risk assessed at this time

Note: As you complete the mandatory areas, you will see that the Yellow field turn White, to indicate their completion.





11 Finalizing the Surgical Assessment PowerForm



- 1. Click the 🗹 in the top left corner of the Surgical Assessment PowerForm.
 - The PowerForm is now finalized.

1	renoperative samma	ر.						······ ·	- - 9 -
Perioperative Summary	A 100% -								
Perioperative Doc	Preop Summary 23 Int	itraop Summary S3 Postop Summar	y 🔯 Quick Orders	13 Handoff Tool		23 New View	23 +		
MAR	No results found		Measurements and Weights (0)		≣• ⊗	Selected visit			_ ^
MAR Summary	Problems	≡• ⊗	Selected visit			Glucose Random	Future	Ordered 20/11/17 15:55	
Interactive View and I&O Results Review	All Visits		No results found			Clinical Research (0)		≡• (0
Form Browser	Classification: All		Home Medications (3) 🌩		≣• ⊙		On Study Status	Contact	3
Histories	This Visit (0)	CSTSNWORKBOOK, REVIEW - 700008243 - Surgi	ical Assessment - 06 Dec 2017 17:29		≣• ⊗	No results found			<u>_</u>
Diagnoses and Problems	- A Chemin (1)	CSTSNWORKBOOK, REVIEW M	ale 54 years DOB:30-Oct-1963			Perioperative Tracking		≡• (2
CareConnect	Focal seizures					No results found		=.	
Clinical Research	Historical (0)	Surgi Performed C	ical Assessment Entered On: 06-Dec-2017 112 On: 06-Dec-2017 09:29 PST by TestSX, Nurse	20 PST		Last 2 weeks for all visits			~
Documentation + Add Immunizations	Family History (0)					My Documents		· · · · ·	_
Lines/Tubes/Drains Summary	Procedure History (1)	Advance Care Planning			≣• ≎	Surgical Assessment - Text	TestSX, Nurse-Perioperative	07/12/17 09:20	
Medication Request Patient Information	Social History (0)	Advance Care Plan : No	TestSX, N	lurse-Perioperativ	≡• ⊙				
Reference	All Visits	Past Medical History, Problems, Diagnoser Patient Screening History	5	(As Of:	≡• ≎	Intake and Output		≡• (~
	No results round	BLANK		-		Last 3 days for the selected visit			
			**		-	* Indicates a day without a full 24 hour me	asurement period		
					1	Plan of Care (2)		≡• (~

- 2. The document can be viewed clicking on the **Surgical Assessment Text** link in the Documents component of the Perioperative Summary.
- 3. Click Exit to close

Key Learning Points

The red asterisk next to Advance Care Planning, ID Risk Screen and Violence and Aggression Screening indicates that there are mandatory components in these forms that are required to be completed. These sections are highlighted in yellow.

PowerForms may be broken up into several sections. Section headings are displayed to the left side of PowerForm.

The system will not allow the record to be finalized until mandatory fields are completed.

Always Sign the PowerForm using green checkmark ✓ to finalize the Surgical Assessment chart and make it available to other users to see it in the chart.



Activity 1.5 - Setting Alerts within Perioperative Tracking

1 The advantage of Perioperative Tracking is that real time patient Alerts can be immediately communicated as they occur. The functionality is referred to as **Setting an Event**. Alerts are a type of Event – refer to Activity 1.3 for a review.

The **LGH Case Communication** view displays all patient charts that have a confirmed surgical appointment that is between tomorrow and 30 days. To ensure the alert is seen on the patient's upcoming day of surgery the alert must be entered on the patient's surgical appointment directly. The patient's upcoming surgical appointments only appear in the **LGH Case Communication** view as opposed to the **LGH PAC** view.

To set an alert:

Per	Perioperative Tracking								
	LGH Endo PreOp SGH Intraop	LGH Endo PostOp SGH Phase I SGH P	LGH PAC LGH Pref Ca hase II LGH ASC Phase II	rd L	LGH Family LGH PreC	p LGH Emergen ntraOp LGH Case	cv List LGH Intraop LGH	Phase I LGH PI SGH OB View	
Filt	Filter: LGH Case Communicatic 🗸 🔯 🔞 🝰 🌳 🚼 Total Cases: 9 Patient: CSTSNWORKBOOK, REV 🗸								
	Surgery Date	[↑] OR	Patient	Allergy	Procedure	Anesthesiologist	Surgeon Iso Alerts		
	11-Dec-2017	LGHOR LON	CSTSNWORKBOOK, REVIEW	0	"Repair Hernia Inguinal"		CSTSNWORKBOOK, REVIEW		
	12-Dec-2017	LGHOR AddOn 01	CSTSNCOOPER, STBETTY	01	"Consent Provided"; "Consent Provided for Emergency"		Scheduling Appointment Book		
	12-Dec-2017	LGHOR GRV	CSTSNKELLER, STKEVIN	Q	"Consent Given"		Periop Document Manager Surgical Case Check-In	ert	
	12-Dec-2017	LGHOR GRS	CSTSNMCCOY, STJOSIE		"Consent Provided"; "Consent Given"		Staff Assign		
	19-Dec-2017	LGHOR GRV	CSTSNANDREWS, STARCHIE		"Consent Provided"	Queh, Peter	Mass Checkout		
	25-Dec-2017	LGHOR SEY	CSTSNBARR, STDANTE	Ó	"Consent Provided"		Update Anticipated OR		
	25-Dec-2017	LGHOR KC	CSTSNPACDEMO, STPACELEVEN		"T & A"		Open Patient Chart		
-							Set Events		

- 1. Select Perioperative Tracking
- 2. Select the LGH Case Communication view. Review any Alerts that are present.
- 3. Select **Set Events** from the drop- down list. (The Case Tracking Set Events window will display.)



- 4. Click the white Alerts tab
- 5. Scroll down to click Violence Alert
- 6. Click OK

Perio	operative Tracking										,C, Full s
	GH Endo PreOp	LGH Endo PostOp SGH Phase I SGH P	LGH PAC LGH Pref Car hase II LGH ASC Phase II	d L	LGH Family LGH Pr GH ASC PreOp LGH MTI	eOp LGH Emergency R IntraOp LGH Case C	List LGH Intra Communication	LGH (LGH Phase I LGH DB View SGH OB View	Phase II SGH Pref Card	SGH Emerge Communication
Filter LGH Case Communicate V 🕐 🍓 👺 🍕 🕽 Total Cases 9 Patient: CSTSNVORKBOOK, REV -											
	Surgery Date	OR	Patient	Allergy	Procedure	Anesthesiologist	Surgeon	lso	Alerts	Alert Icons	Comments
►	11-Dec-2017	LGHOR LON	CSTSNWORKBOOK, REVIEW	0	"Repair Hernia Inguinal"		Plisvcw, Tyler, MD]	Violence Alert	•	
				-							

- 7. Verify that the patient's Alert has been updated on Perioperative Tracking.
- 8. As our patient does not need this Alert, remove the alert see Activity 1.3 step 2.

Key Learning Points

The **LGH Case Communication** view displays all patient charts that have a confirmed surgical appointment that is between tomorrow and 30 days

- Right-click anywhere on the line with the relevant patient to set the event(s)
- Perioperative Tracking will be modified to show the Alert entered



Activity 1.6 – Setting Process Alerts from PM Conversation

Patient Management Conversation (PM Conversation) provides access to manage alerts, patient location, encounter information and demographics.

Within the system, process alerts highlight specific concerns about a patient. These alerts display on the banner bar and can be activated by any clinician including nurses.

Since the patient has a history of seizures, a process alert should be added to the patient's chart.

🗄 Perioperative Tracking 🛔 Patient List Dynamic Ca	se Tracking 🎁 Case Selection 🎬 Tir	ne-Critical Procedures 📲 Discharge Dashboard
🗄 🎢 Exit 🎬 AdHoc 🎟 Medication Administration	🚨 PM Conversation 🚽 1 mmunic	ate 👻 🖹 Medical Record Request 🚦 Add 👻 🤆
CSTSNWORKBOOK, REVIEW	Bed Transfer	
Perioperative Tracking	Cancel Discharge	
LGH Emergency List LGH PreOp SGH Case Communication SGH	Cancel Pending Transfer Discharge Encounter Facility Transfer	LGH Phase II LGH Endo PreOp SGH Intraop SGH Eme
Filter: LGH PAC Today 🔹 🛅 🔞 🚘	Leave of Absence	NWORKBOOK, REV 👻
PAC Time PAC Location Patie	Pending Facility Transfer	Allergy Ane
ase)	Pending Transfer	
23-Nov-2017 CSTS	Print Specimen Labels	
▶ 07:45:00 REVI	Process Alert	2
	Register Phone Message	
	Update Patient Information	
	View Encounter	
	View Person	
-		-

- 1. Click the drop-down arrow to right of **PM Conversation** in the toolbar.
- 2. Select Process Alert from the drop-down menu. The Organization window will display.

🚯 Organization
Please select the facility where you want to view person aliases.
Facility Name Facility Alias
LGH Lions Gate 1
LGH Lions Gate Hospital 2
Facility:
LGH Lions Gate Hospital
3 OK Cancel

- 1. In the Facility Name field, type = LGH Lions Gate and press Enter on your keyboard
- 2. Select LGH Lions Gate Hospital
- 3. Click **OK.** The Process Alert window displays.



2 To activate the seizure precautions process alert on the patient's chart:

REVIEW	
Previous Last Name:	Date of Birth: Age: 10-0ct-2000 17Y
Gender: Male	BC PHN: 9876429433
ALERTS Process Alert:	1
From & vailable:	La Valastadi
Gender Sensitivity No Ceiling Lift On Research Study	Selected. Selected. Selected. Selected.
Gender Sensitivity No Ceiling Lift On Research Study Palliative Flag Seizure Precautions Violence Risk	3 Move > Select All

- 1. Click into the empty **Process Alert** box. A list of alerts that can be applied to the patient will display. (This box will be empty until you click into it).
- 2. Select Seizure Precautions
- 3. Click **Move** The alert will now display within the **To Selected** box
- 4. Click Complete

Note: Multiple alerts can be activated at once. Alerts can be removed using the same process. Site policies and practices should be followed with regards to adding and removing flags and alerts.

- 1. Click Refresh 💽 to update the chart
 - 2. Once complete, the process alert will appear within the banner bar of the chart where it is visible to all those who access the patient's chart.

· · · ·					10/1	
CSTSNWORKBOOK, REVIEW						
CSTSNWORKBOOK, REVIEW	DOB:10-Oct-2000	MRN:700008243	Code Status:		Process:Seizure Precautions	
	Age:17 years	Enc:7000000015411				
Allergies: No Known Medication Allergies	Gender:Male	PHN:9876429433	Dosing Wt:		Isolation:	- CL

Key Learning Points

3

Process Alerts are important in alerting staff members to specific concerns related to the patient
 Use refresh after adding an alert to confirm it has been added to the patient's banner bar



Activity 1.7 – Flag the appointment as a PAC Complete

1. Select Perioperative Tracking and locate your patient.

Perioperative Tracking 🚺 ent list Dynamic Case Tracking 🖗 Case Selection 🎬 Time-Critical Procedures 🎆 LearningLWE :								
🗘 Patient Health Education Materials 🛱 SHOP Guidelines and DSTs 🛱 UpToDate								
CareConnect: 🛱 PHSA PACS 🛱 VCH and PHC PACS 🛱 MUSE 🛱 FormFast WFI								
📲 Eait 👹 AdHoc 🎟 Medication Administration 🔒 PM Conversation + 🔄 Medical Record Request 💠 Add + 着 Scheduling Appointment Book 🖷 Documents 🎇 Staff Assign 🖀 Report Builder 🖨 Discem Reporting Portal 😱 Report Manager 🛜 Hairet Locator								
CSTSNREACHER, STJACK 🖉								
Perioperative Tracking								
LGH Endo PreOp LGH Endo PostOp LGH Endo Incomplete LGH MTR IntraOp SGH PreOp SGH Intraop SGH Phase I SGH Phase II SGH Phase II SGH Emergency List SGH OB View LGH PreC and LGH Phase II LGH Phase II LGH Emergency List LGH OB View LGH ECT LGH PreC and LGH Case Communication	SG							
LGH Endo PreOp LGH Endo Incomplete LGH MR IntraOp SGH PreOp SGH Phase II LGH Phase III LGH Phase III LGH	SG							

2. Right click **Set Events** and the Case Tracking Set Events window will display.

🕴 Perioperative Tracking 🛓 Patient List Dynamic Case Tracking	Case Selection 👫 Time-Critical Procedure	Periopeantive Tracking 🛊 Perioret List Dynamic Case Tracking 📁 Case Selection 🐒 Time-Critical Procedures 🌇 LearningUNE									
🕄 🔃 Patient Health Education Materials 🕄 SHOP Guidelines and	🔃 Patient Health Education Materials 🖏 SHOP Guidelines and DSTs 🕲 UpToOte:										
C Cancionnes C PHSA PACS C VCH and PHC PACS C MAISE C Forméras WR											
🗐 Ein 🖥 Achice 💷 Medication Administration 🔓 PM Conversation + 🚽 Medica Record Request 💠 Add + 着 Scheduling Appointment Book 🔚 Documents 🌉 Staff Assign 🖥 Report Builder 🚔 Discem Reporting Portal 💷 Report Manager 💆 Assare 💎 Patient Locator											
								- 1	Recent - Name	- 0	
Perioperative Tracking									screen 👼 Print	2 0 minutes a	
LGH Endo PreOp LGH Endo PostOp LGH PAC LGH PreOp LGH	LGH Endo Incomplete LGH MT Intraop LGH Phase I	IR IntraOp LGH Phase II	SGH PreOp SGH Intrao LGH Emergency List	SGH Phase I LGH OB View	SGH Phase LGH ECT	II SGH Emergency List LGH Pref Card	SGH OB View	SGH Pref Card LGH ASC PreOp	SGH Case Comm	unication C Phase II	
Filter: LGH PAC Today 🔹 🗟 😪 😝 🚺 🗆	otal Cases: 1 Patient: CSTSNWORKBOOK, REV	•									
Status PAC Time	PAC Location Patient A	ge/Sex Alerts	Allergy	Anesthesiologist	Old Chart Status	Proc. Date Procedure	Surgeon	PAC Visit Type	Seen by Nurse	Seen by Ane	
LGH OCC Rm 8 (Exam) (1 case)	007000000000000000000000000000000000000						DI	0.1.1.1.01.1			
25-Jan-2018 14:00:00	REVIEW	Male	CSTSNWORKBOOK, REVIEW				Plisvcw, Tyler, MD	Anesthesia and Nurse			
			Scheduling Appointment Book Periop Document Manager Surgical Case Check-In SurgiCal Case Check-In Mass Checkout SurgiNet Rules Update Anticipated OR Open Patient Chart Set Events	-				visit			

3. Click the **PAC** tab if not already selected





- 4. Scroll down to Click **PAC Complete** button.
- 5. Verify that PAC Complete event is now displayed on the right



Name: OR: Procedu	CSTSHWORKDOOK R LGH OCC Rm 8 (Exam) e: PreAnesthesia Clinic Anesthesia and Nurse Yisit	Surg Start Time: 14:00 Surgeon: Plisvow, Tyler, MD Case #: LGHPA-2018-19	Arest-Ingel: Arest-Type:
No Show	Chart 25-Jan-2018 10.05	Name PAC Complete	3
Patient	Chart Requested		
I PAC	EKG		
Pre0p	Lab Results Available		
Intra0	PAC Phone Attempt 1.		
hase II	PAC Phone Attempt 2.		
hase I/P	PAC Phone Attempt 3.		
Call	PAC Left Message		
Phone	PACPt Request Cal Back		
PostOp	Seen by Anesthesia		
olation	Seen by Nurse		
erts Is	Seen by Other		
art Al	Pt. in Waiting Room		
Case (
Status			_
NPO			6
			OK Cancel

- 6. Click OK
- 7. Verify that the PAC location has been updated on Perioperative Tracking.

Pe	ioperative Tracking									(O) Full sci
	LGH Endo PreOp LGH PAC	LGH Endo PostOp LGH PreOp LG	LGH Endo Incomplete iH Intraop LGH Pha	LGH MTR IntraOp e I LGH Phase II	SGH PreOp SGH Intraop LGH Emergency List	SGH Phase I LGH OB View	SGH Phase II LGH ECT	SGH Emergency List LGH Pref Card	SGH OB View LGH Case Communication	SGH Pref Card LGH ASC PreOp
Filter: «None> - 🕐 🔞 🝰 🔶 7 Total Cases 5 Patient: CSTSNWORKBOOK, REV -										
	Status	PAC Time	PAC Location Patient	Age/Sex Ale	erts Allergy	Anesthesiologist	Old Chart Status	Proc. Date Procedure	Surgeon	PAC Visit Type
	LGH OCC Rm 8	(Exam) (1 case)								
•	PAC Complete	25-Jan-2018 14:00:00	CSTSNWO REVIEW	RKBOOK, 54 years / Male	•				Plisvcw, Tyler, MD	PreAnesthesia Clinic Anesthesia and Nurse Visit
	LGHOR AddOn (01 (1 case)								
-		25-Jan-2018 11:00:00	CSTSNAB REGHAAJ	DI, 21 years / Female	q				Plisvcd, Mohammed, MD	"APPENDICITIS"
LGHOR GRV (1 case)										
		25-Jan-2018 13:00:00	CSTSNMU	IMI, STHBB 29 years / Female	qi				Plisvcw, Tyler, MD	"right inguinal hernia repair"
LGHOR KC (2 cases)										
		25-Jan-2018 09:45:00	CSTSNMU	IMI, STHBB 29 years / Female	q				Plisvca, Rocco, MD	"repair hemia inguinal"
		25-Jan-2018 12:45:00	CSTSNMU	IMI, STHBB 29 years / Female	q				Lo, NOLDAP, Patrina	"repair hernia inguinal"

Key Learning Points

Right- click anywhere on the line with the relevant patient to set the event(s)

Perioperative Tracking will be updated to show the patient status as PAC Complete



End of Workbook

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