SELF-GUIDED PRACTICE WORKBOOK [N37]
CST Transformational Learning

WORKBOOK TITLE:

Nursing: Pre-Operative

Last update: March 8, 2018 (v2)

CLINICAL + SYSTEMS TRANSFORMATION
Our path to smarter, seamless care

TRANSFORMATIONAL LEARNING

TABLE OF CONTENTS

SELF-GUIDED PRACTICE WORKBOOK

Duration	3 hours
Before getting started	■ Sign the attendance roster (this will ensure you get paid to attend the session) ■ Put your cell phones on silent mode
Session Expectations	■ This is a self-paced learning session. ■ A 15-min break time will be provided. You can take this break at any time during the session ■ The workbook provides a compilation of different scenarios that are applicable to your work setting ■ 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 Perioperative Tracking
- Display and navigate the Patient Chart
- Update the patient's status in Perioperative Tracking
- Complete the patient's bed transfer process
- Document on a PowerForm
- Set a Process Alert
- Initiate orders
- Document in iView
- Administer Medication Using the Medication Administration Wizard
- Navigate the Perioperative Summary

SCENARIO

Overall Scenario:

A 54-year-old male patient with an inguinal hernia met with a General Surgeon and is scheduled for an elective right inguinal hernia repair. The patient has a medical history including seizure disorder and a surgical history of an appendectomy. He has attended a PAC appointment with a Nurse and Anesthesia. He was assessed as fit for surgery and it is set for 3 weeks after the appointment. The patient arrives for his elective day surgery procedure.

Focus of this Scenario:

It is the day of the patient's surgical appointment, and he arrives for his elective day surgery procedure.

As a Pre-Op Nurse, you will complete the following 14 activities:

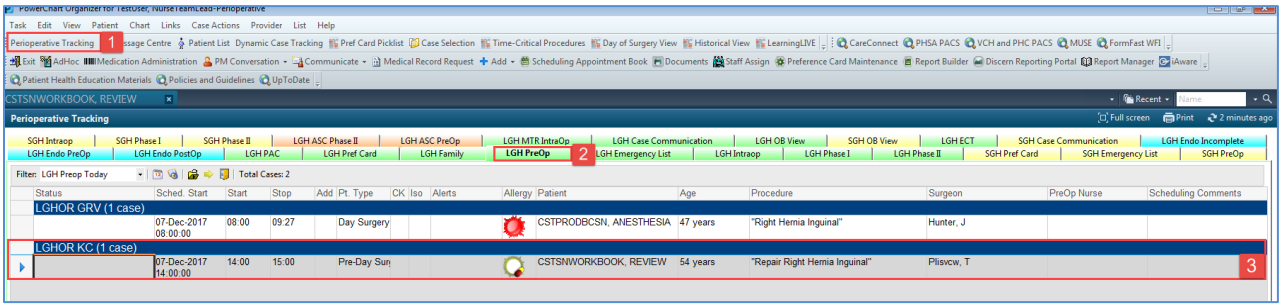
- Navigate the Tracking Board
- Display and Navigate the Patient Chart
- Update the Patient's Status within Perioperative Tracking by Setting an Event
- Use PM Conversation to complete the patient's Bed Transfer
- Locate and verify the Procedure Consent
- Complete the Surgical Assessment PowerForm
- Complete the Perioperative Preprocedure Checklist
- Set a Process Alert

- Initiate Orders
- Document in iView for Intravenous Insertion
- Complete the Steps to Administer Medications via Medication Administration Wizard (MAW)
- Setting an Event (Patient Ready for Surgery)
- Patient Handover
- Setting an Event (Transport to OR)

Activity 1.1 – Navigate Perioperative Tracking

1 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 Preop** view is recommended to access patient charts within the **LGH Preop** 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 

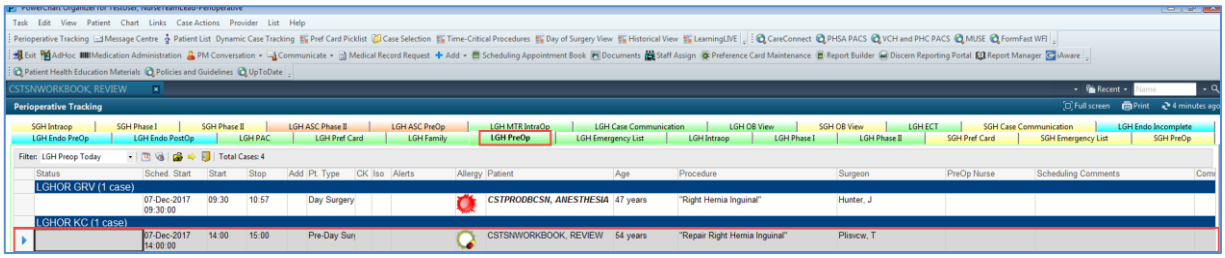
from the toolbar.
2. Preoperative patients will display in **LGH PreOp** tracking view.
3. Each row within this table represents a patient. They are typically arranged by room (e.g. OR).

Key Learning Points

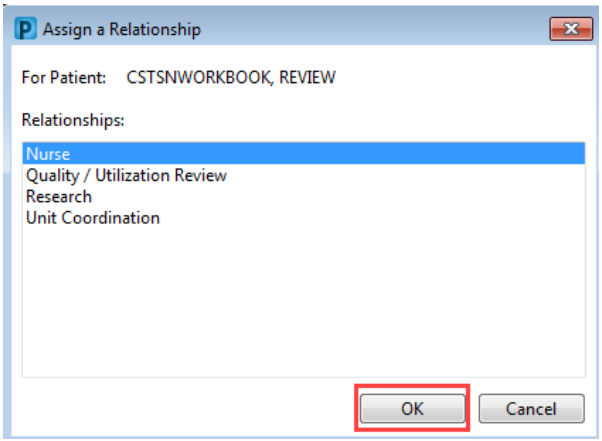
- You can use the Perioperative Tracking within the toolbar to return to LGH PreOp view from any other area of PowerChart

Activity 1.2 – Display and Navigate the Patient Chart

1 Opening the patient's chart in the Perioperative Tracking

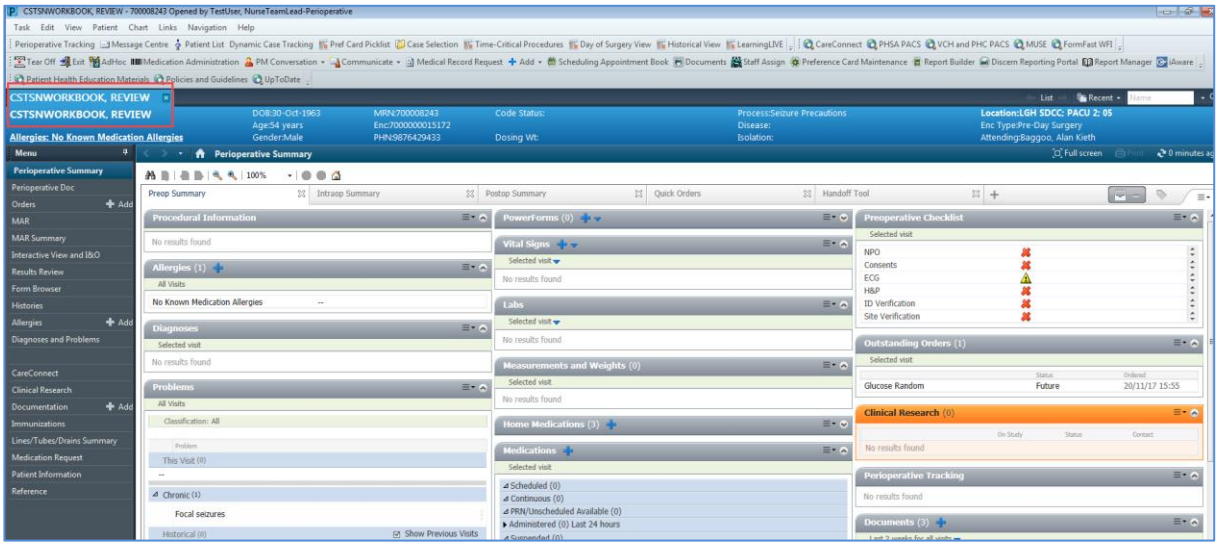


1. Select the **LGH PreOp** view.
2. Select the appropriate patient by Clicking on the row. Blue arrow will appear.
3. Double-click the Blue arrow next to the patient's chart to open their chart.



4. 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.

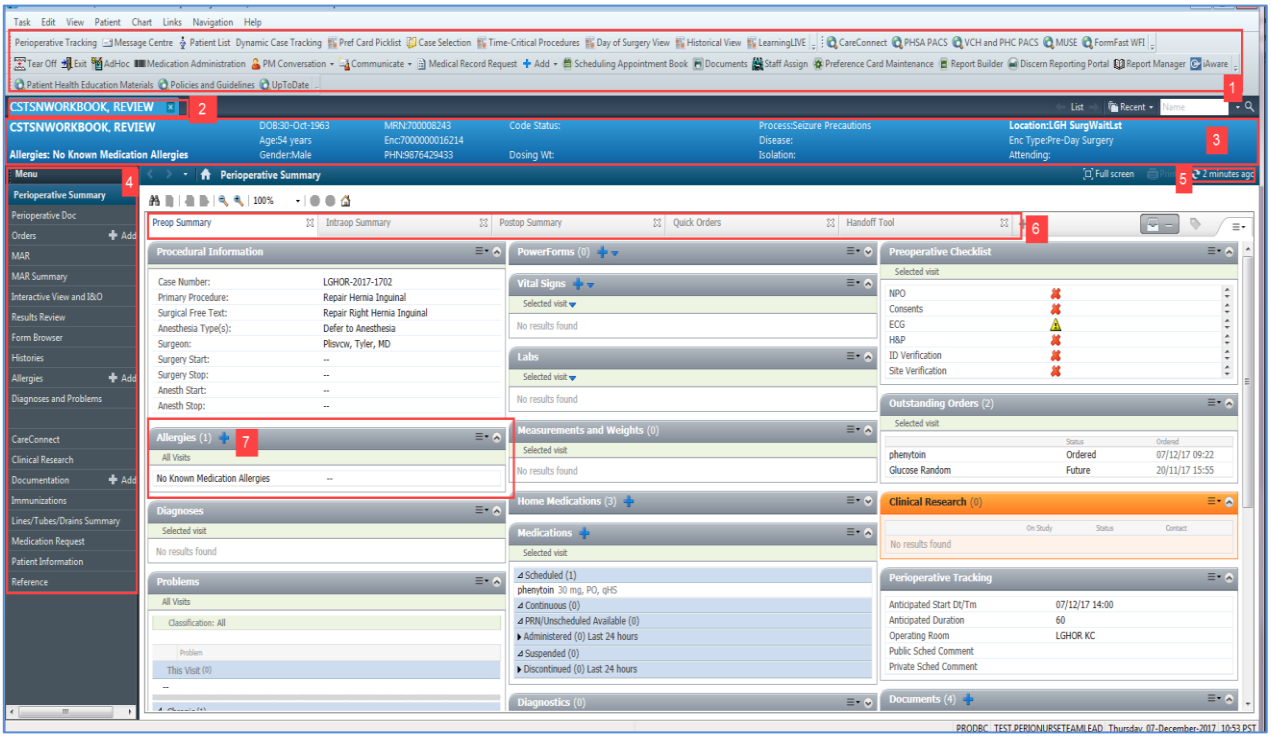
   Note: If this is the wrong patient, click the cancel button to return to Tracking View
5. Select **Nurse** to assign relationship.
6. Click **OK**



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

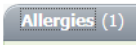
2 Navigate the Patient Chart

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



1. The **Toolbar** is located above the patient's chart and it contains buttons that allow you to access various tools within the Clinical Informatics 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 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 

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

Key Learning Points

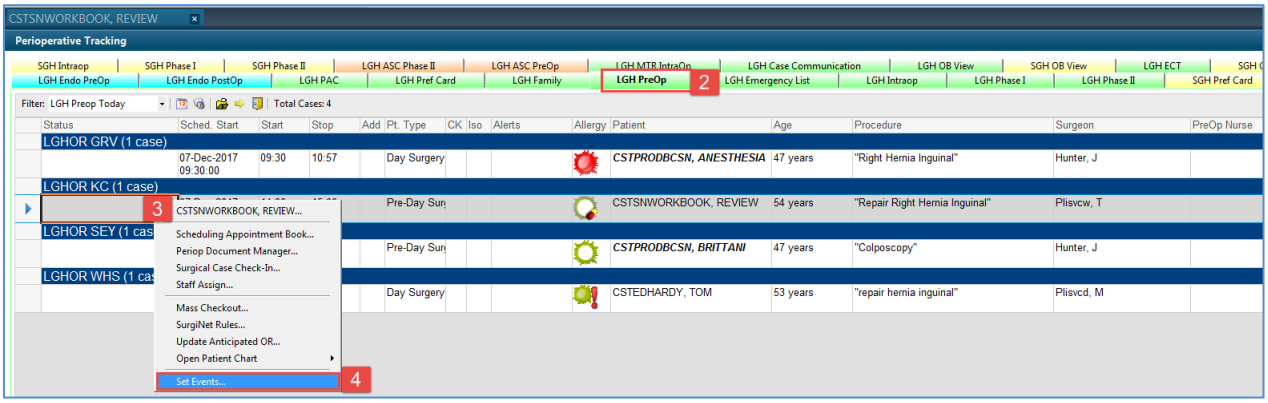
- The blue arrow indicates that you have selected a patient in the tracking view
- Users accessing a patient's information for the first time are prompted to assign the relationship with the patient e.g. Nurse
- Verify the correct patient's chart has opened
- The Perioperative Summary page provides an 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 – Update Patient's Status in Perioperative Tracking by Setting an Event

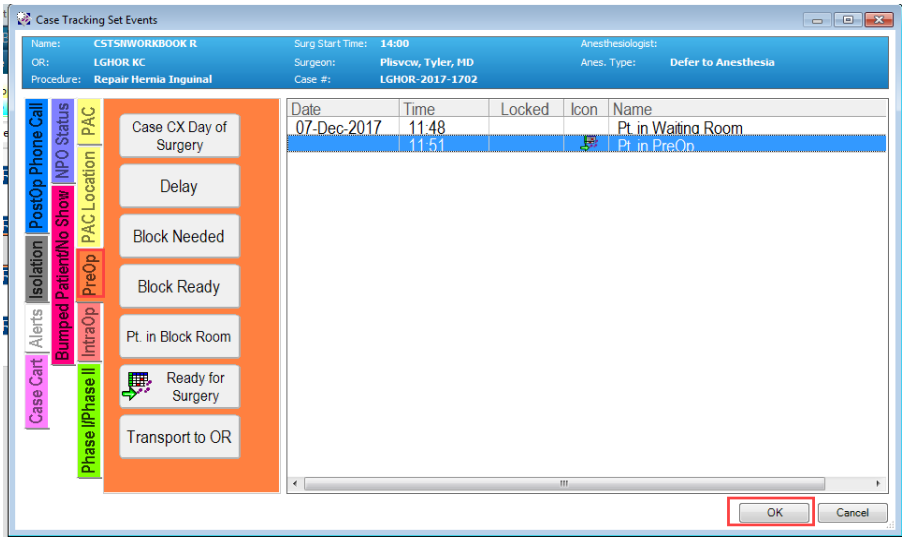
1 The advantage of Perioperative Tracking is that real time patient status can be immediately communicated as they occur. The functionality is referred to as **Setting an Event.**

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:

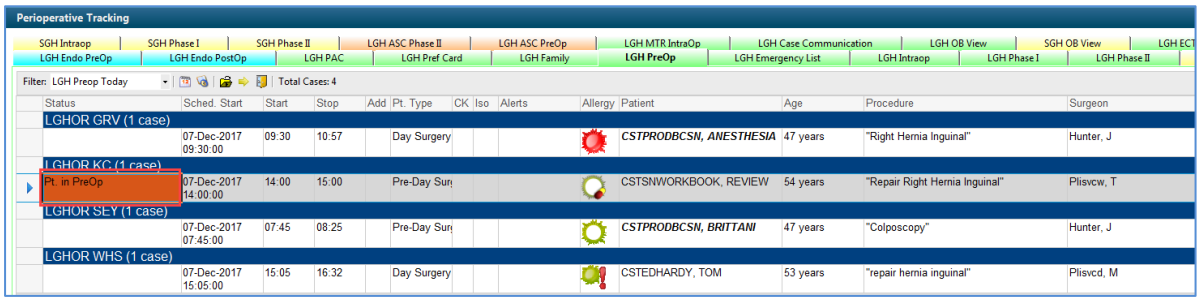


1. Do not close the patient chart from the previous activity. The chart can remain open even though you will accessing Perioperative Tracking
2. Select Perioperative Tracking
3. Select the **LGH PreOp** view
4. Right-click anywhere on the line with the relevant patient.
5. Select **Set Events…** from the drop-down list.
    - The Case Tracking Set Events window will display.



6. Click the **PreOp** tab on the left.

7. Click on the **Pt. in PreOp** button.
8. Click **OK**



9. Verify that the preop location has been updated on Perioperative Tracking

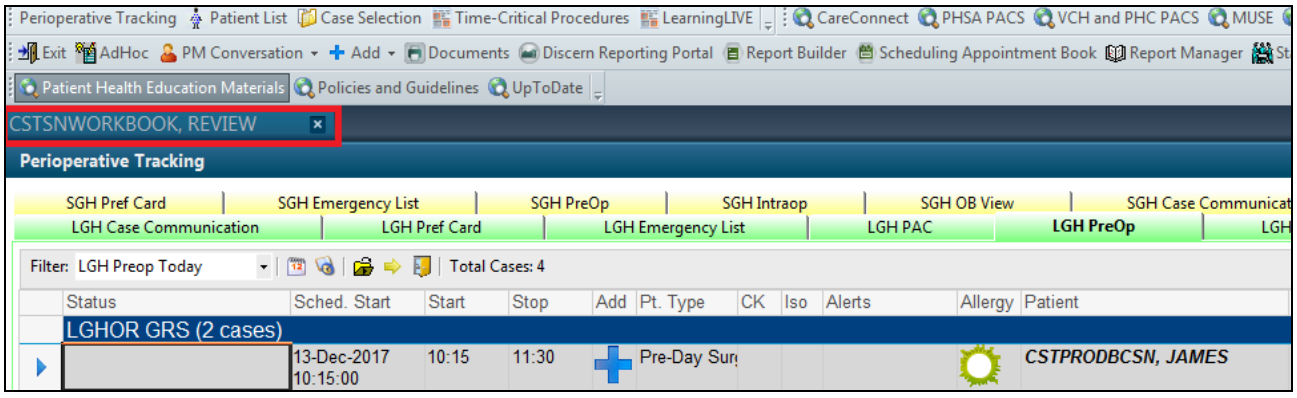
Key Learning Points

- Right-click anywhere on the line with the relevant patient to set the event(s)
- Perioperative Tracking will be updated to show the patient's status

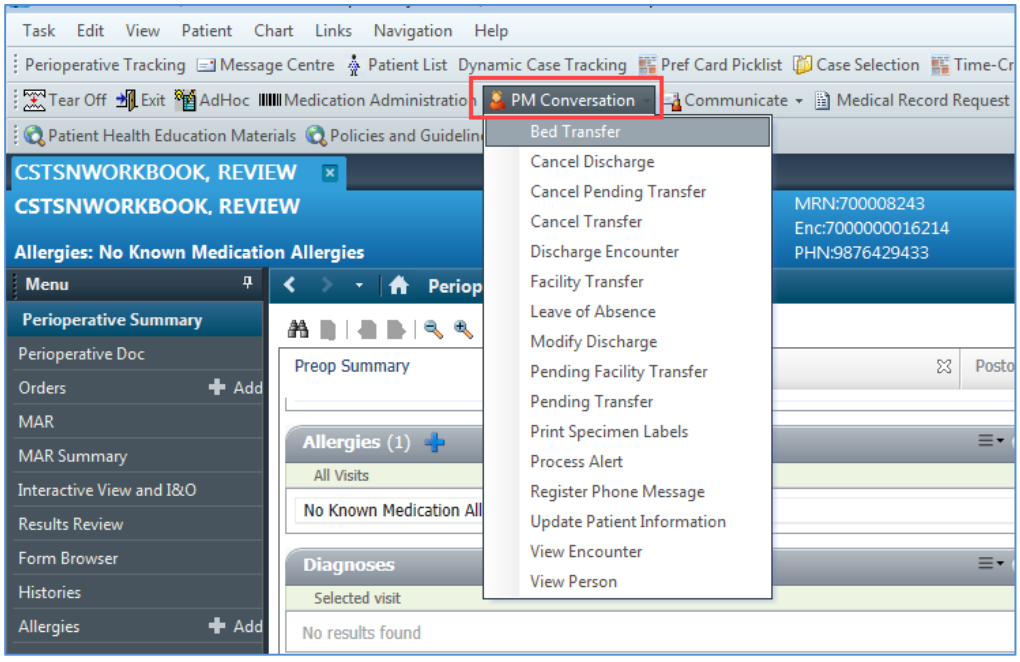
Activity 1.4 – Use PM Conversation to Complete the Patient's Bed Transfer

1 Use PM Conversation to complete bed transfer details.

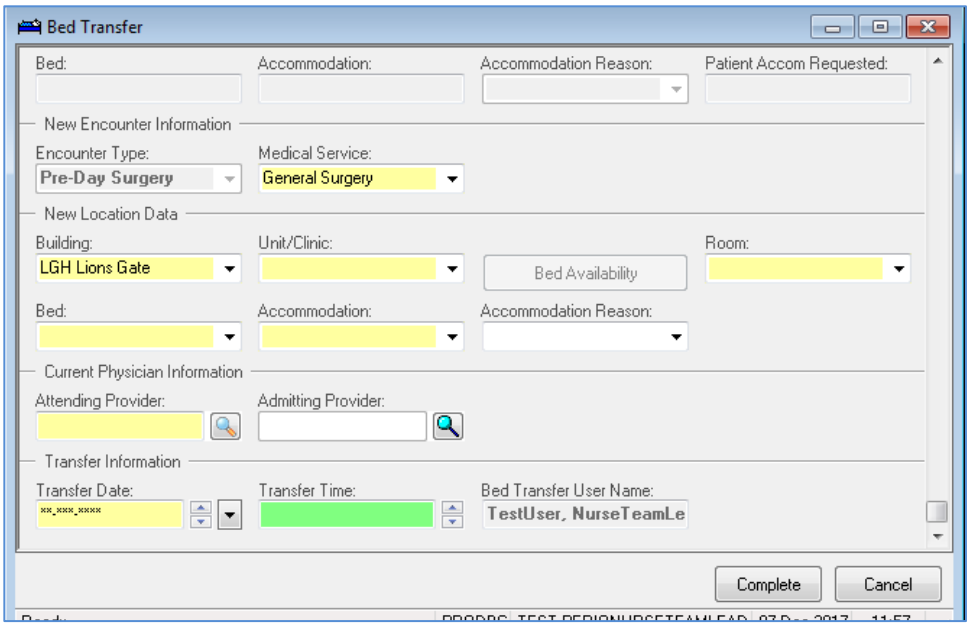
Patient Management Conversation (PM Conversation) provides access to manage alerts (such as violence risk, falls risk or isolation precautions), patient location, encounter information and demographics. Let's look at how to complete a bed transfer.



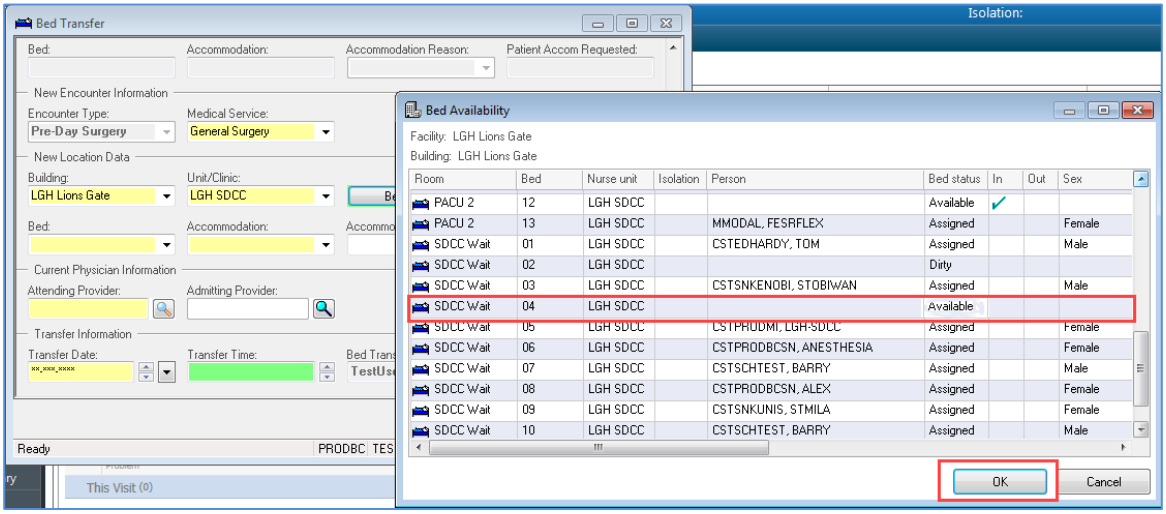
1. To open patient, Select Patient Tab



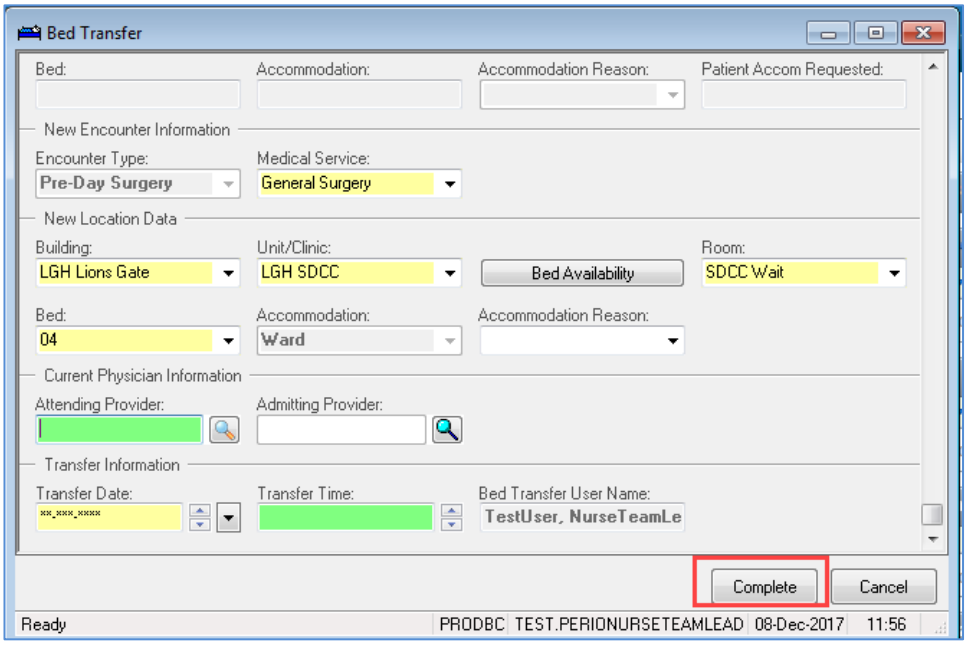
2. Click the arrow next to **PM Conversation** from the tool bar and Select **Bed Transfer.**
   - **Bed Transfer** window will open.



3. Click **Unit/Clinic** and select **LGH SDCC** from the list of options in the drop-down list
4. The fields highlighted in yellow are mandatory
5. Click **Bed Availability**
6. **Bed Availability** Window Opens



7. Click the appropriate **Preop** bed/chair/waiting room which has a status column as "Available"
8. Click **OK**
9. The **Room** and **Bed** fields will populate, **Accomodation** will autopopulate



10. Complete the remaining fields:

    Attending Provider= *<Surgeon's Name>*

    Transfer Date= < *Today's Date*>

    - Hint: Typing "T" will autopopulate the current Date

    Transfer Time= <*Current Time*>

    - Hint: Typing "N" will autopopulate the current Time

11. Click **Complete**

12. Click **Refresh** 

and verify the patient's bed location will now be displayed on Blue Banner Bar in the patient's chart.

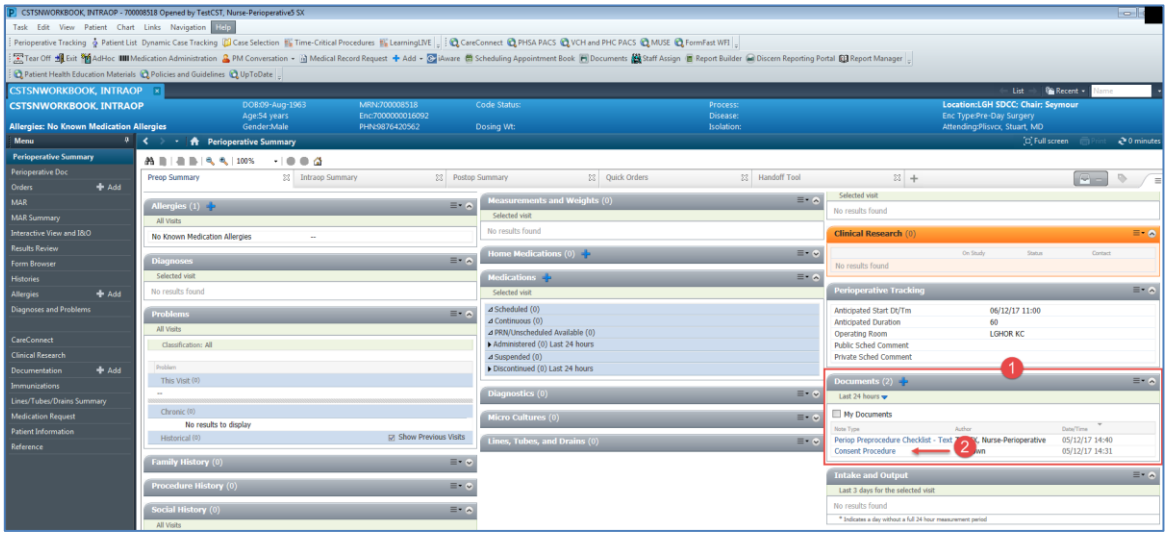
Key Learning Points

- PM Conversation is used to transfer patients to different locations
- The fields highlighted in Yellow indicate mandatory criteria that must be entered to proceed to the next step
- Remember to select beds that show the status column as 'Available'
- Click Refresh to verify updated patient location

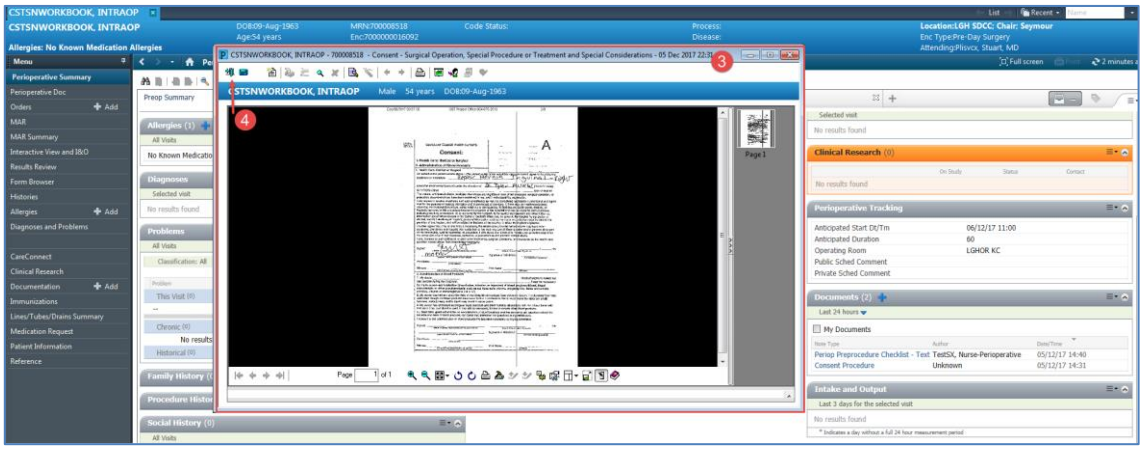
Activity 1.5 - Locating and Verifying Consent Procedure

1 Verification of the consent should be done prior to completing the Perioperative Preprocedure Checklist.

From the Perioperative Summary page on the Preop Summary tab:



1. Locate the **Documents**
2. Click on the **Consent Procedure** link.



3. The consent will **open.**
4. To close the consent, click on the **Exit** icon in the top left-hand corner.

Activity 1.6 - Documentation of Surgical Assessment PowerForm

1 Opening a Surgical Assessment & Perioperative Preprocedure Checklist PowerForm

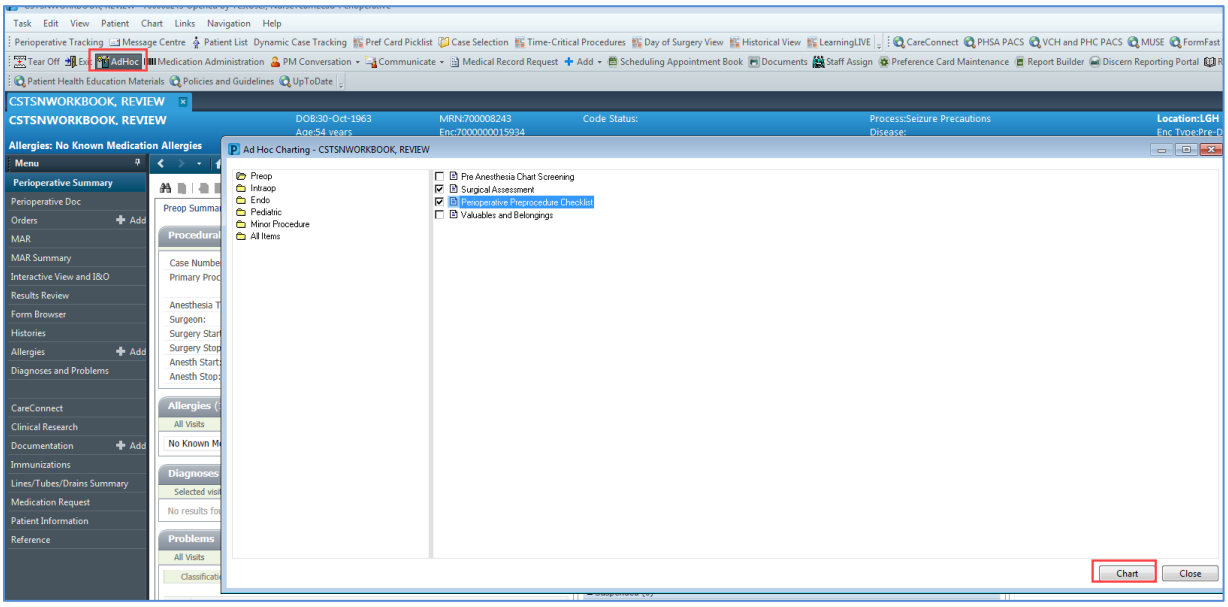
PowerForms are the electronic equivalent of paper forms currently used to document patient information.

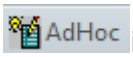
Data entered in **PowerForms** can flow between other parts of the chart including iView flowsheets, Clinical Notes, Allergy Profile, and Medication Profile, and PAC documentation will flow to PreOp documentation.

In this example we are going to document on the **Surgical Assessment PowerForm** and **Perioperative Preprocedure Checklist.**

Note: If the patient had a PAC visit then portions of the Surgical Assessment PowerForm will be populated and would only require verification or updating by the PreOp nurse; only the portions that remain constant i.e. vitals signs would not pull forward.

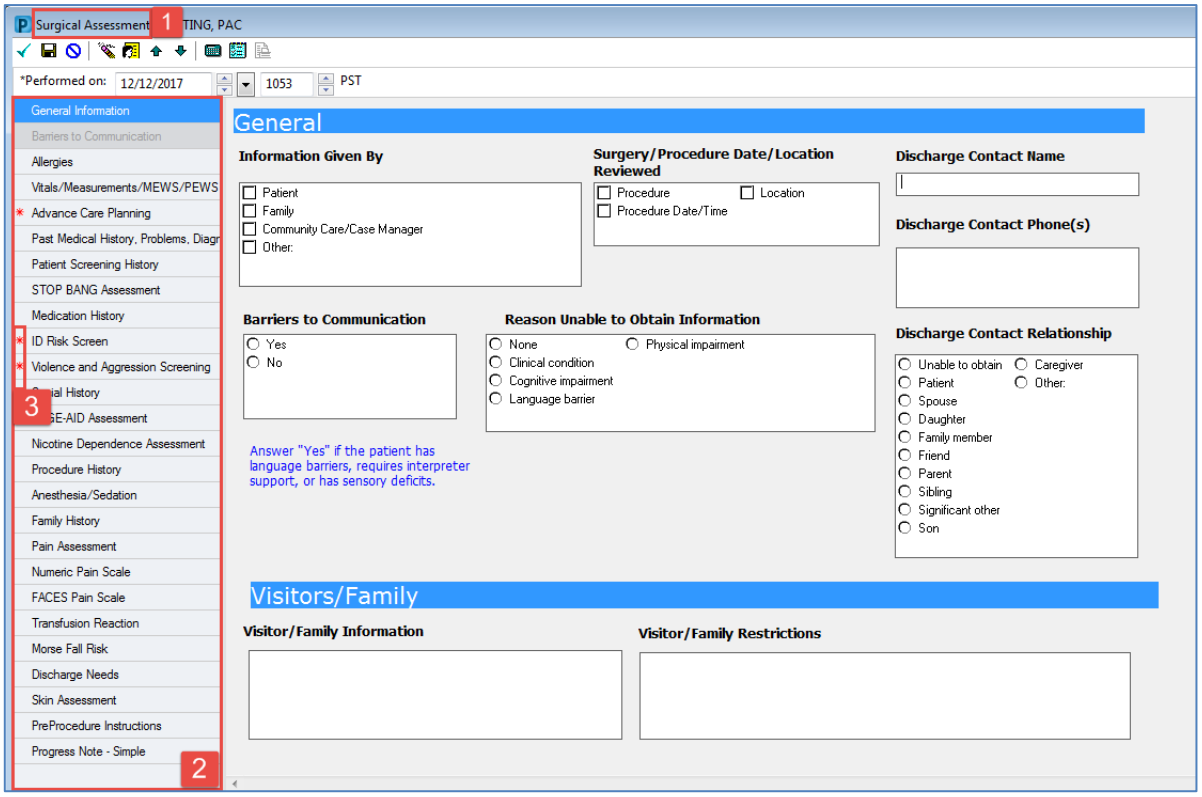
To open and document:



1. Click the 

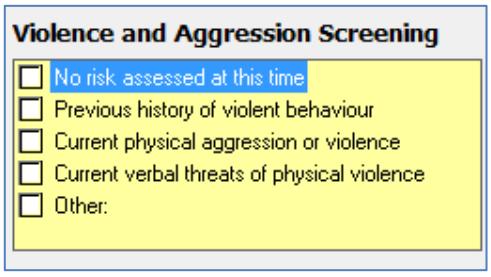
icon from the Toolbar
   - The **AdHoc** folder is an electronic filing cabinet that allows you to find any PowerForm on an as needed basis.
   - The Ad Hoc Charting Window Opens
   - The PreOp folder opens by default
2. Select Surgical Assessment and Perioperative Preprocedure Checklist.
3. Click **Chart**

2 Documenting on the Surgical Assessment PowerForm & Perioperative Preprocedure Checklist



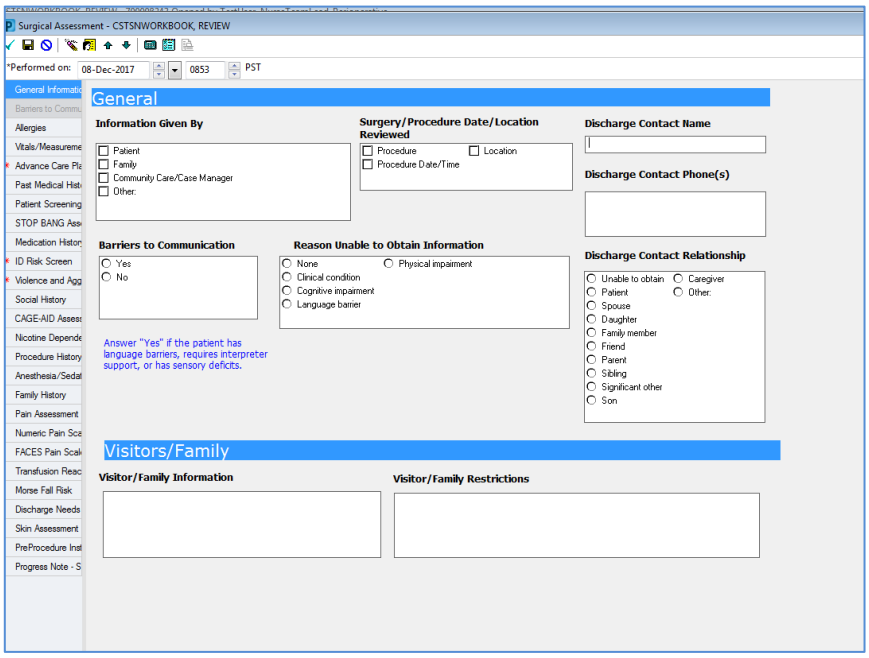
Review the screenshot above for a general overview of PowerForm features:

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.



5. You cannot finalize a PowerForm unless all mandatory fields within a section have been completed.
    - The checkmark ✓ ID Risk Screen means that mandatory fields in that section are completed.

3 Completing the General Information Section



1. Click the **General Information** section. Enter the required information within this section.

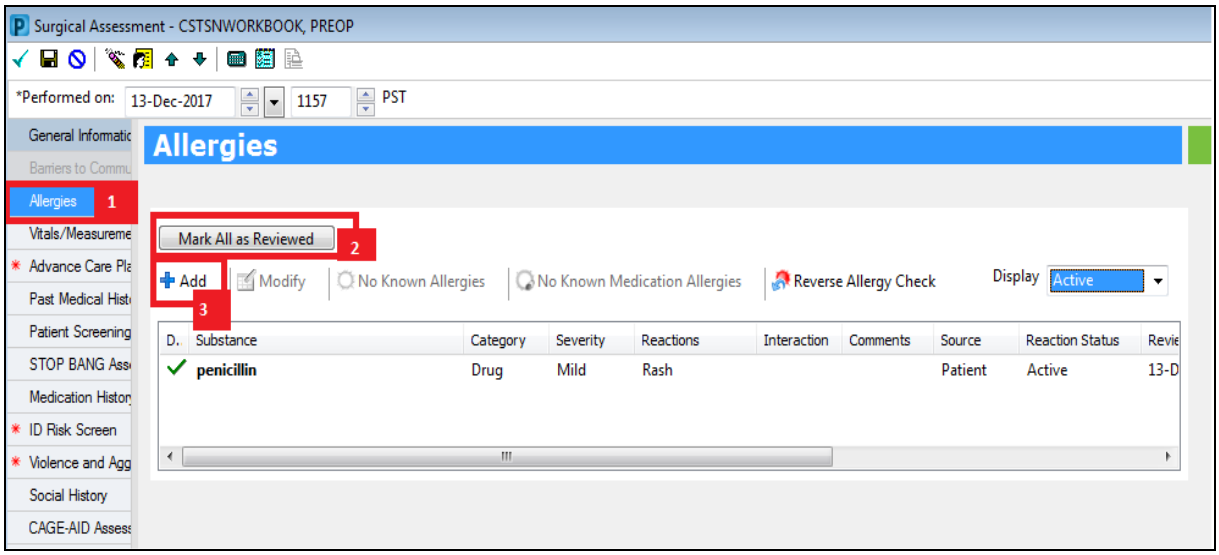
   Data entry details for General Information:

   - **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:

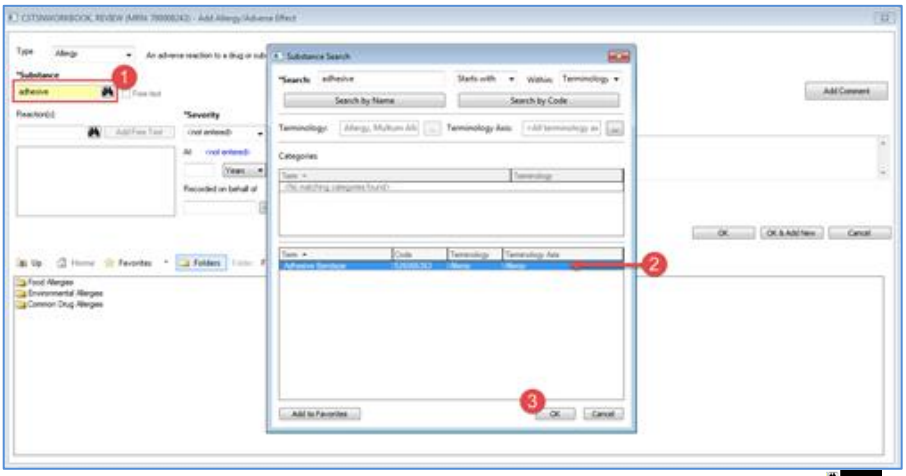
- For metrics that contain circle (radio) buttons to select an option, you may only select one of the options
- For metrics that contain square check boxes (e.g. Preferred Language), you may select one or more options
- If there is a blank box, it indicates a free text box where you may type any text

4 Completing the Allergies Section

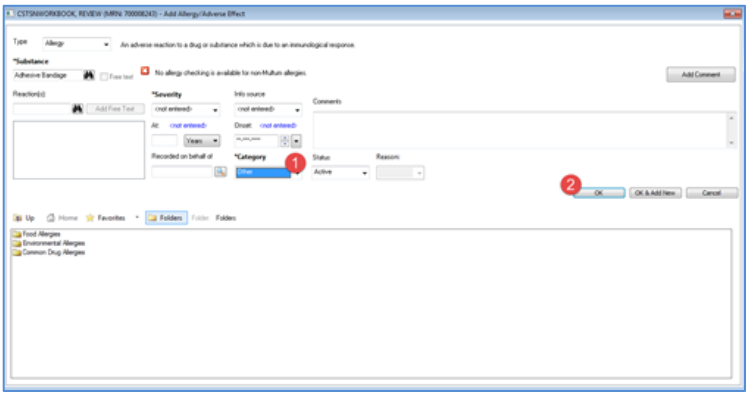


The patient currently has an allergy to Penicillin recorded. Review allergy with patient and update as necessary. The patient states they are also allergic to adhesive bandages.

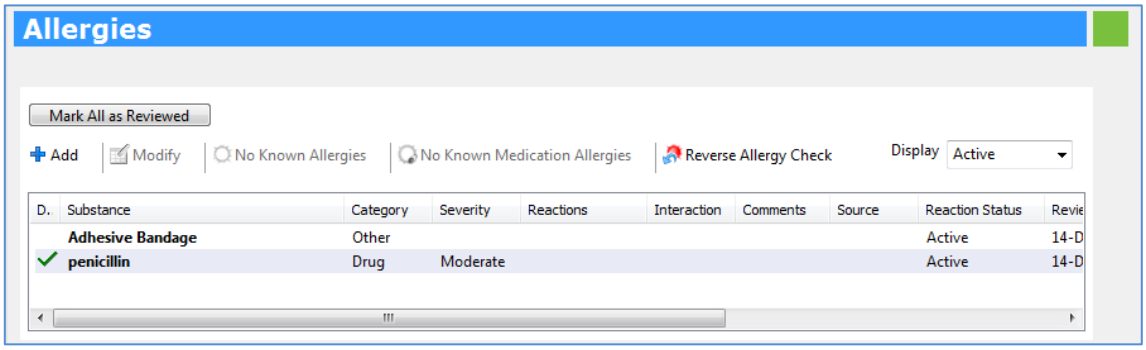
1. Click on **Allergies** section
2. Select **Mark All as Reviewed** to verify the Penicillin allergy.
3. To document the adhesive allergy, click the **Add**  . The Add Allergy/Adverse Event window displays.



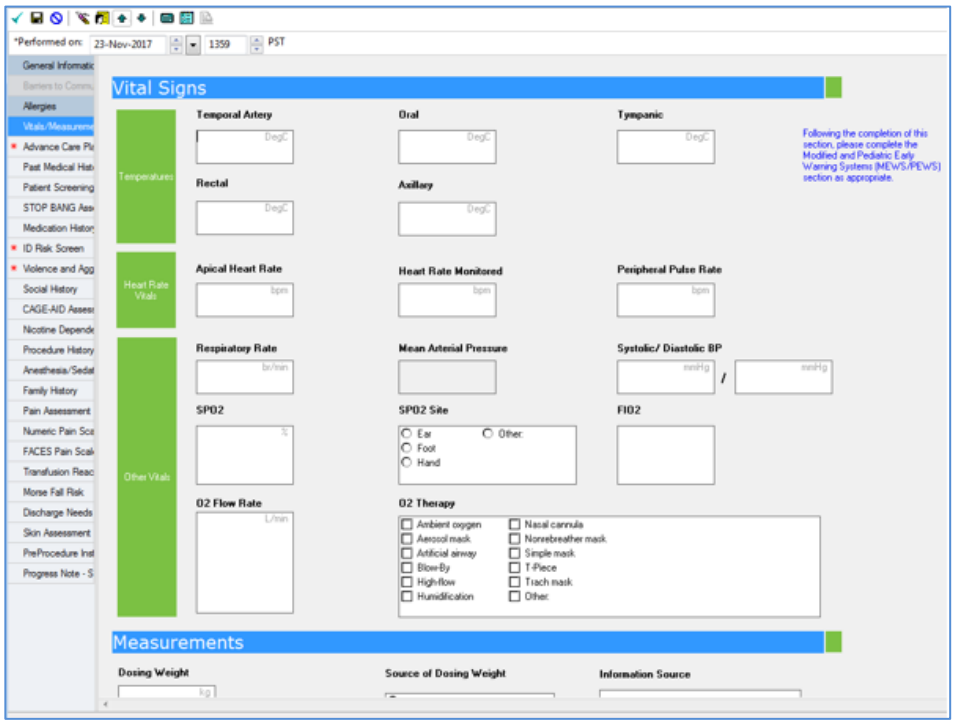
4. Enter **Adhesive** in the Substance field and click the **search**  icon.
5. The Substance Search window will appear. Select **Adhesive Bandage** from the result window.
6. Click **OK**
   - Add Allergy/Adverse Window is shown.



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.



5 Completing Vitals/ Measurements/MEWS/PEWS Section



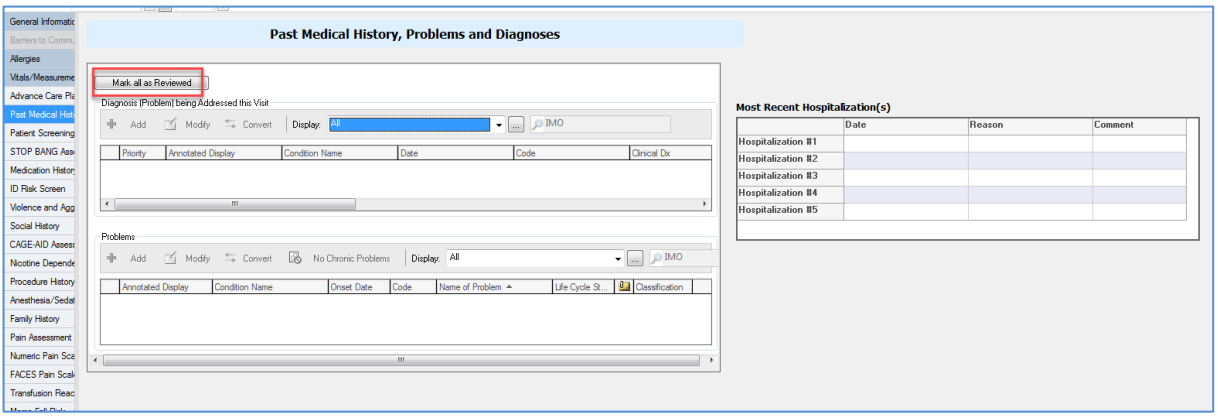
1. Click Vital/ Measurements/ MEWS/ PEWS

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** = *autopopulated by PAC visit*
- ***Weight Measured** = *autopopulated by PAC visit*
- **Source of Admit Weight** = *autopopulated by PAC visit*
- ***Height/Length Measured** = *autopopulated by PAC visit*
- 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

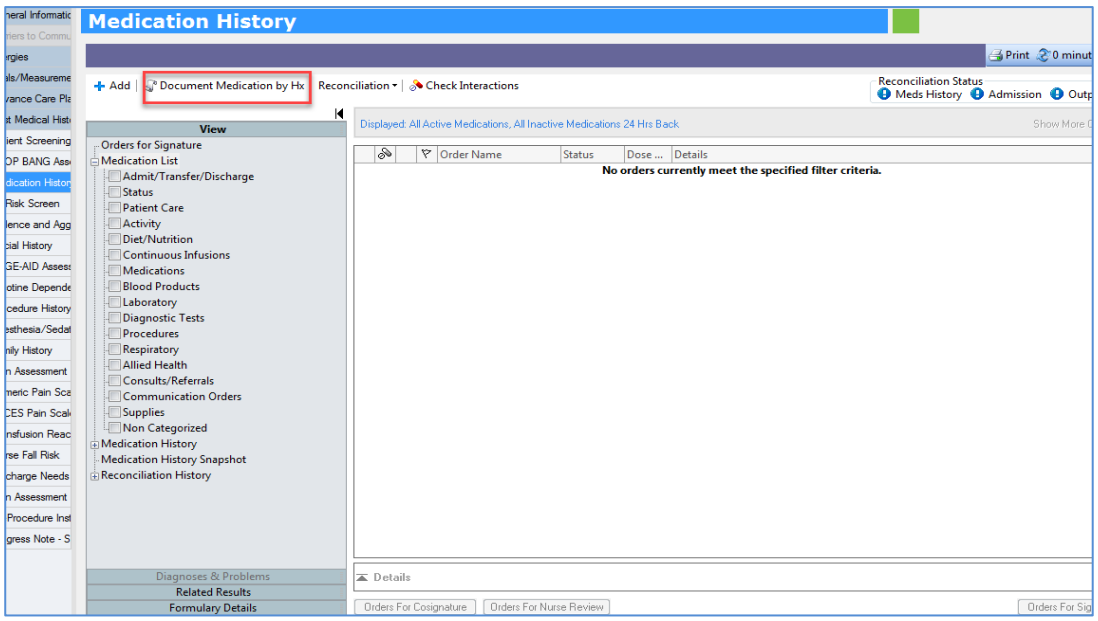
Note: As data collected here is not likley to remain constant by the time this patient arrives in SDCC on the day of the procedure, this data will not pull forward into other sections of the chart.

6 Completing the Past Medical History, Problems, Diagnosis Section

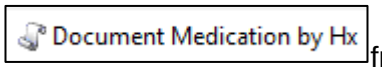


1. Click the **Past Medical History, Problems, Diagnosis** section to review existing information from previous visits. If a Problem or Diagnosis has been entered previously by a Provider this section will already be populated – in this case Click **Mark all as Reviewed**.

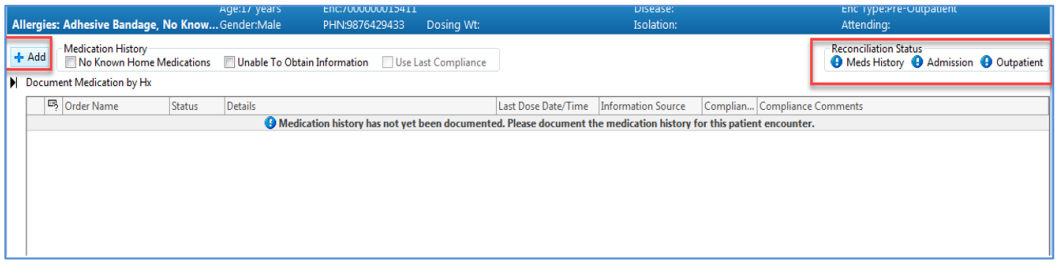
7 Completing the Medication History Section



1. Click **Medication History** section

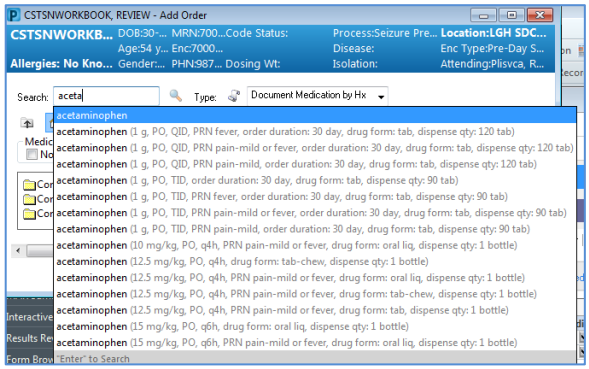
2. Click 

from the tool bar (this step is equivalent to doing the Best Possible Medication History – BPMH)

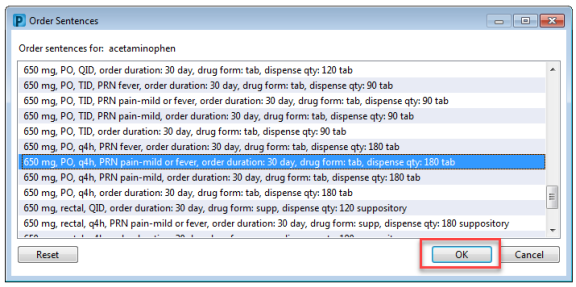


Note: the Reconcilation status for **Meds History** shows as incomplete

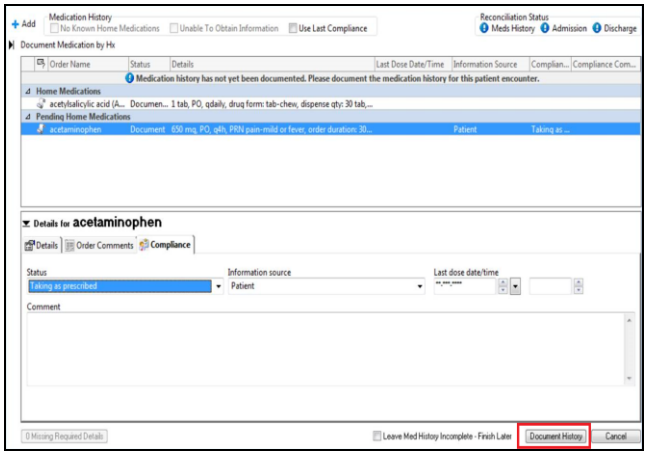
3. Click  . The Add Order window will display.



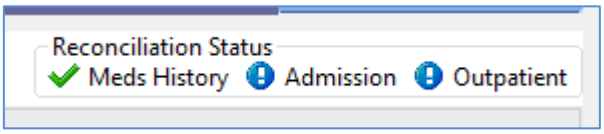
4. Type in acetaminophen and search. Select: **acetaminophen**. The Order Sentences window will display.



5. Select **acetaminophen 650mg, PO, q4h**.
6. Click **OK**

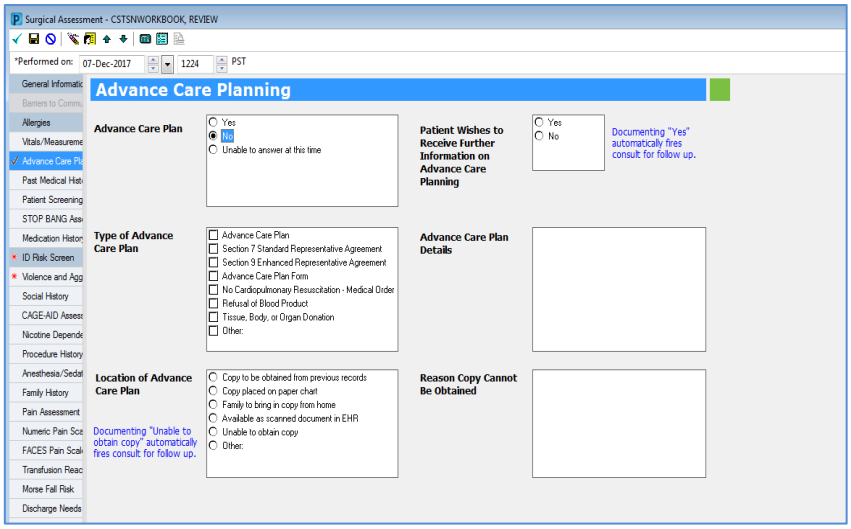


7. Review details for the documented medication.
8. Click the **Compliance** tab within the Medication details.
9. Update Status, Information Source, and Document Last Dose Date/Time.
10. Click **Document History**



Note: the Reconciliation Status changes to a Green checkmark.

8 Completing the Advance Care Planning Section

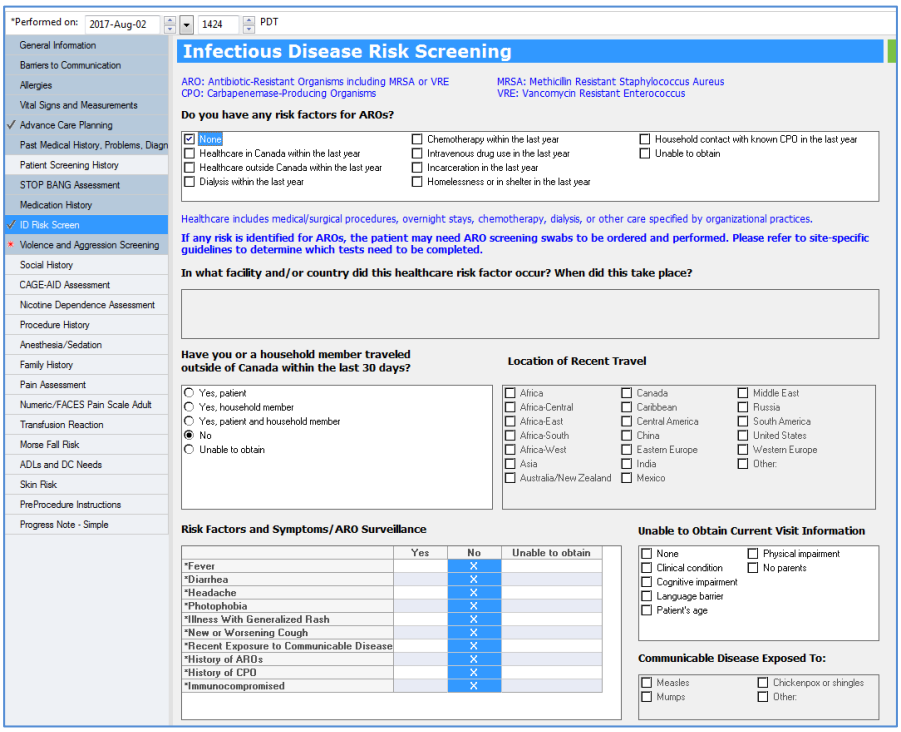


1. Click **Advance Care Planning** section

   <u>Data entry details for Advance Care Planning</u>:

   - **Advance Care Plan** = *No*

9 Completing the ID Risk Screen Section



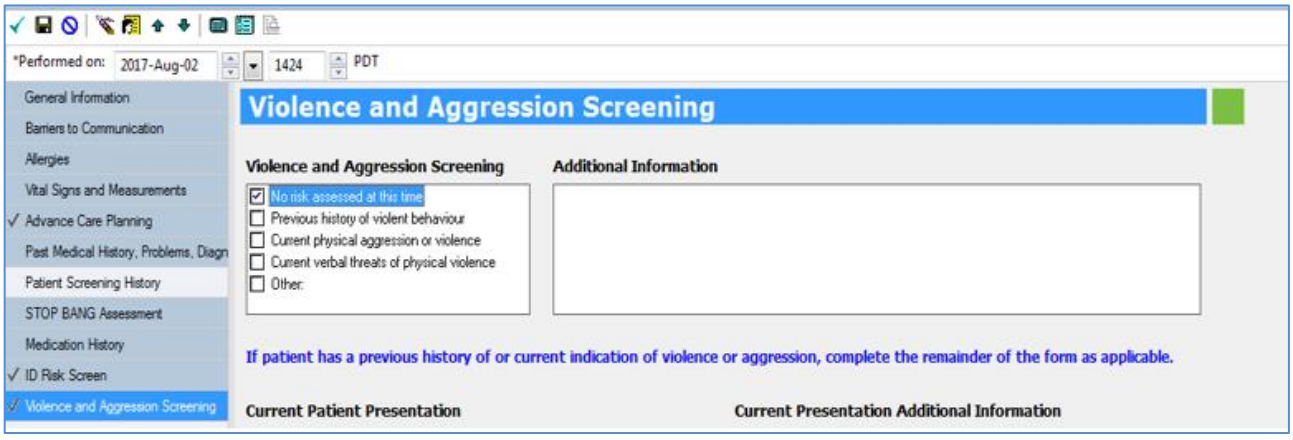
1. Click on **ID Risk Screen**

Data entry details for ID Risk Screen:

- **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** or **No** for each of the risk factors.

10 Completing the Violence and Aggression Screening Section

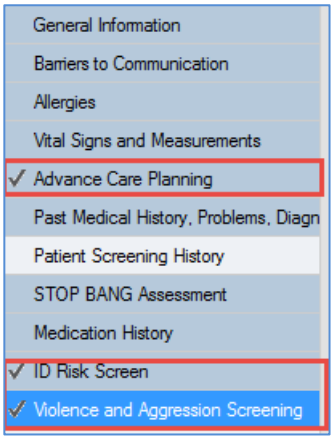


1. Click **on Violence and Aggresion Screening** section:

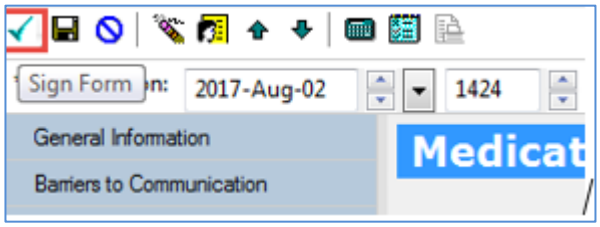
Data entry details for Violence and Aggression Screening:

- **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 Finalize the Surgical Assessment PowerForm



1. Click the ☑ in the top left corner of the Surgical Assessment PowerForm.
   - The PowerForm is now Finalized.
   - The Perioperative Preprocedure Checklist will display.

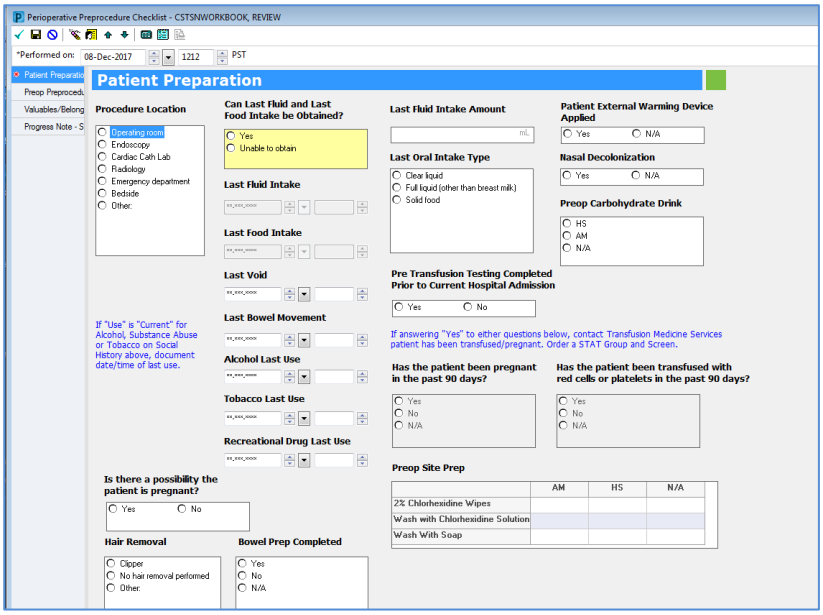
Key Learning Points

- 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
- 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 1.7 – Complete the Perioperative Preprocedure Checklist

1 Completing the Perioperative Preprocedure Checklist

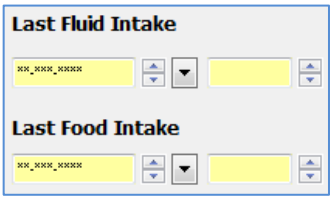
The Perioperative Preprocedure Checklist will display once the Surgical Assessment PowerFrom is finalized. If both forms were not selected, return to AdHoc forms and chose the Perioperative Preprocedure Checklist from the Preop folder).



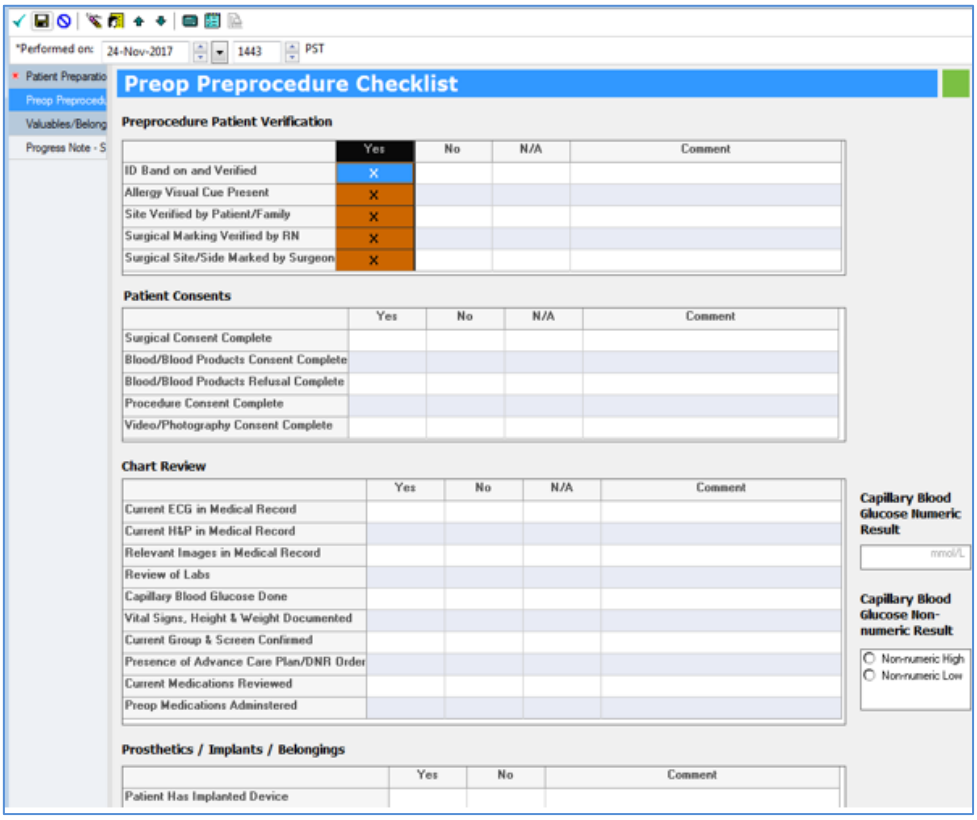
1. Click the **Patient Preparation** section.

   <u>Data entry details for Patient Population:</u>

   - **Procedure Location:** *Operating room*
   - **Can Last Fluid and Last Food Intake be Obtained?:** *Yes*
   - **Last Fluid Intake:** *<Enter T for current date, then adjust by clicking arrows to yesterday' date>. Enter N for current time, then adjust by clicking arrows to 2 hours previous to current time>*
   - **Last Food Intake:** *Enter T for current date, then adjust by clicking arrows to yesterday' date>. Enter for time: 2200.*
   - **Last Oral Intake Type:** *Clear liquid*



Note: As denoted by the red asterisk , Patient Preparation includes mandatory data fields highlighted in Yellow. If you answer Yes to "Can the Last Fluid and Last Food Intake be Obtained", these sections will be highlighted as well for completion

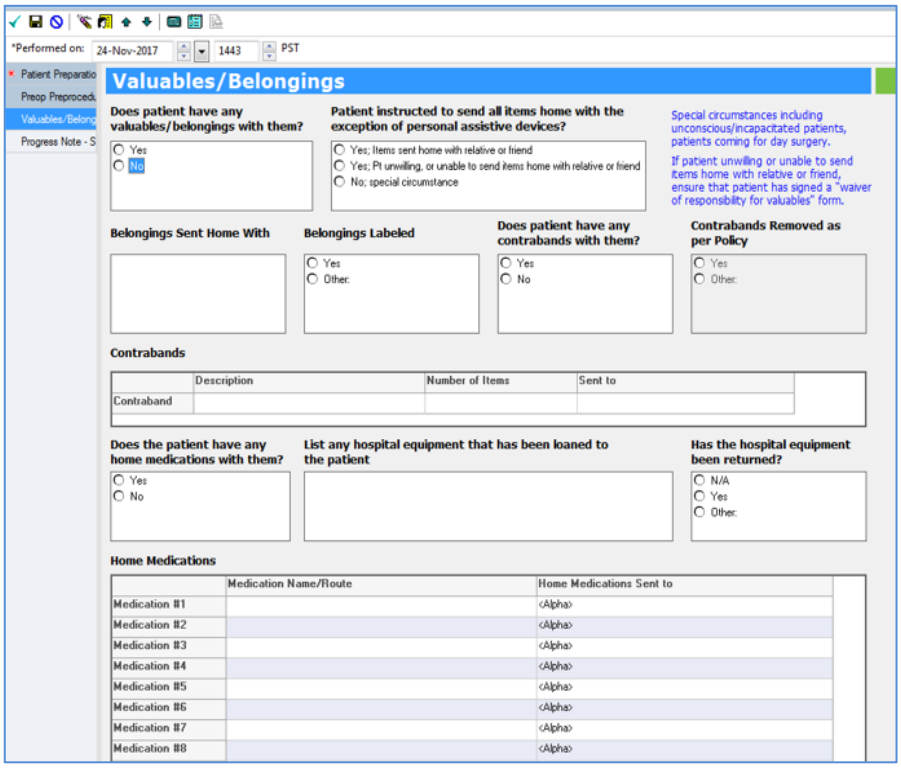


2. Click the **Preop Preprocedure Checklist** section

<u>Data entry details for Preop PreProcedure Checklist:</u>

- **Preprocedure Patient Verification:** Click ***Yes*** to select all
- **Patient Consents:**
    - **Surgical Consent Complete:** *Yes*
    - **Blood/blood products consent complete:** *N/A*
    - **Blood/blood products refusal complete:** *N/A*
    - **Procedure Consent Complete:** *N/A*
    - **Video/photography consent complete**: *N/A*
- **Chart Review**
    - **Current H&P in Medical Record**: Yes

Hint: By clicking on the column header 'Yes', it will auto select Yes for each of the items under the Preprocedure Patient Verification section. Click any one field to change it.

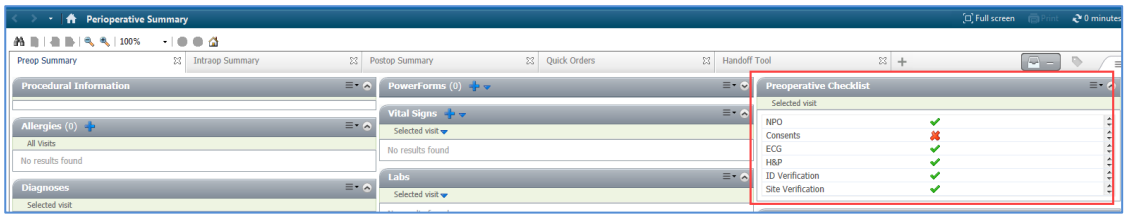


3. Click the **Valuables/Belongings** section.

   Data entry details for Valuable/Belongings:

   - **Does patient have any valuables/belongings with them?:** *No*

4. Finalize the Perioperative Preprocedure Checklist. Click the  on the top left corner to finalize the PowerForm



5. The Perioperative Summary page will be shown.

   - Review the Perioperative Checklist component to ensure it is correct. Green checkmarks means all documentation requirements are met. Hover over the any of the icons to review documented information.

Note: Hover over a red X to view documented information, the information may be complete for the patient situation (e.g. surgical consent may be present but blood consent may not be required per site policy and so it is showing as incomplete).

Key Learning Points

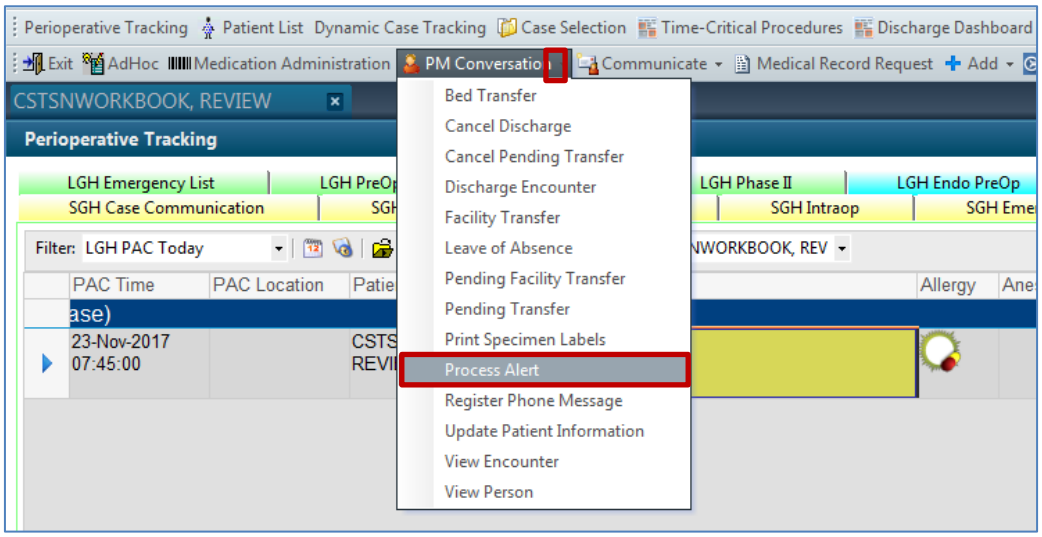
- Remember to complete the mandatory Yellow fields in the Patient Preparation section.
- Verify the Preoperative checklist component within the Perioperative Summary to ensure that all items are accurately recorded as complete or incomplete.

Activity 1.8 – Setting Process Alerts from PM Conversation

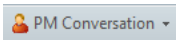
Patient Management Conversation (PM Conversation) provides access to manage alerts, patient location, encounter information and demographics.

1 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.

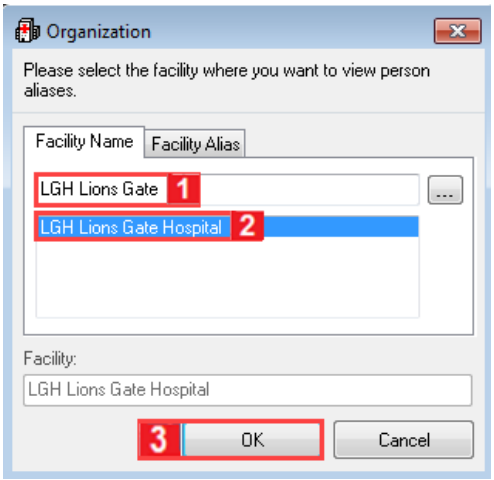
Since the patient has a history of seizures, a Process Alert should be added to the patient's chart.



To add the Alert:

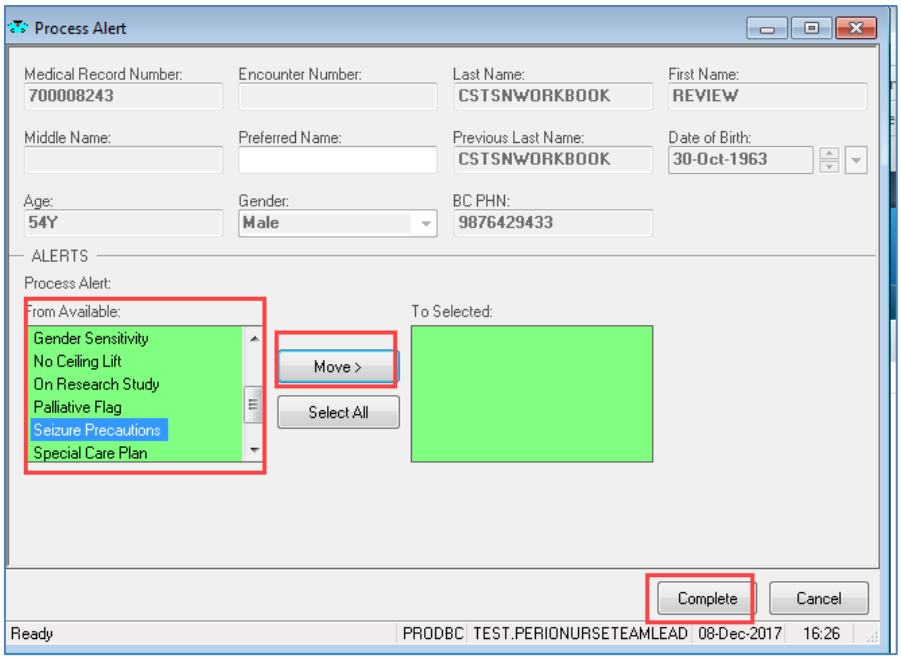
1. Click the drop-down arrow to right of **PM Conversation**  in the toolbar.
2. Select **Process Alert** from the drop-down menu.

The Organization window will display.



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.



To activate the Seizure Precautions Process Alert on the patient's chart

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 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.

Key Learning Points

- 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

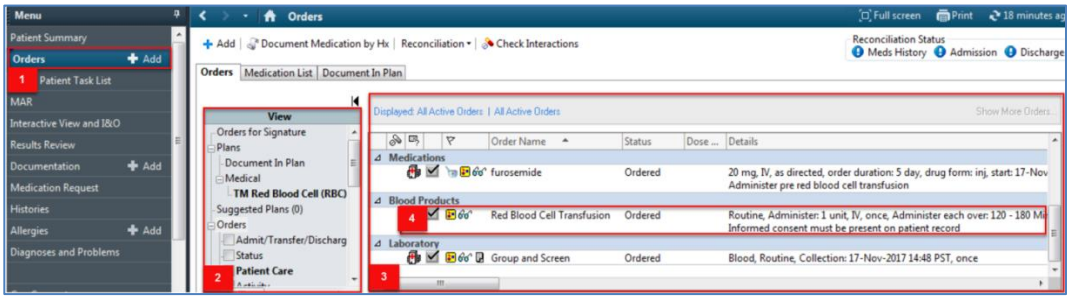
Activity 1.9 – Orders and PowerPlans

1

Orders Overview

The **Orders Profile** is where you will access a full list of the patient's orders.

To navigate the **Orders Profile** and review the orders:

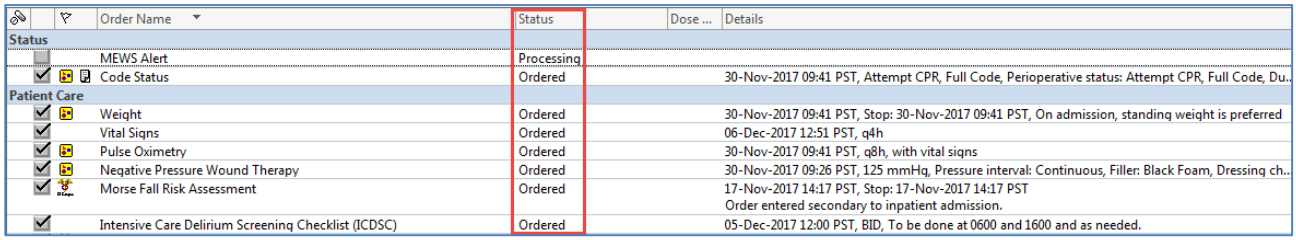


1. Select **Orders** from the **Menu**
2. On the left side of the Orders Profile is the Navigator (**View**) which includes several categories including:
   - **Plans**
   - **Categories of Orders**
   - **Medication History**
   - **Reconciliation History**
3. On the right side is the **Order Profile** where you can:
   Review the list of orders
4. Moving the mouse over order icons allows you to **hover to discover** additional information.

   Some examples of icons are:

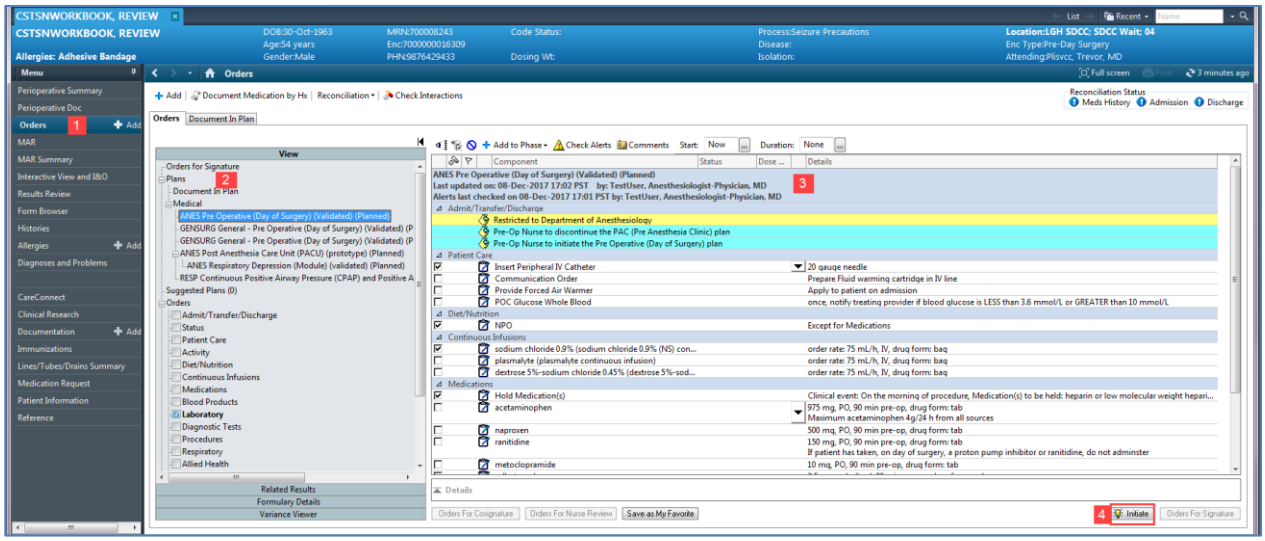
   - Order for nurse to review
   - Additional reference text available
   - Order part of a PowerPlan
   - Order waiting for Pharmacy verification

   Orders are classified by status including:



5. **Processing** - order has been placed but the page needs to be refreshed to view updated status
6. **Ordered** - active order that can be acted upon

A PowerPlan in the Clinical Information System is the equivalent of preprinted orders in current state and is often referred to as an order set.

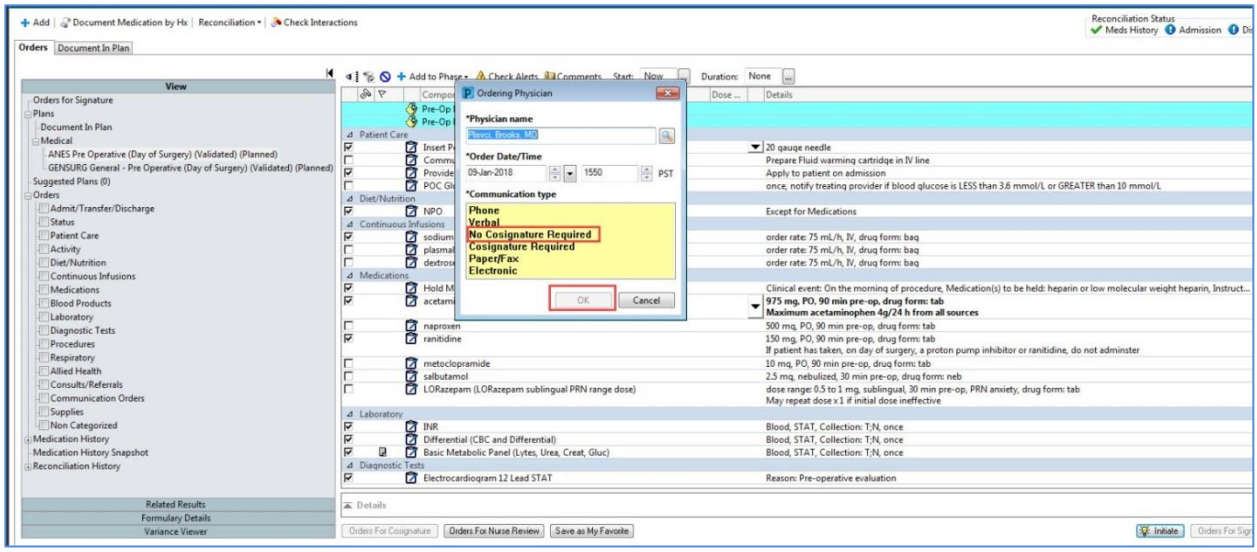


Planned orders (orders placed ahead of time) are only to be initiated in the appropriate phase when a nurse is about to carry them out.

In order to act on planned orders placed by a provider, the nurse will need to initiate the Pre-Procedure order.

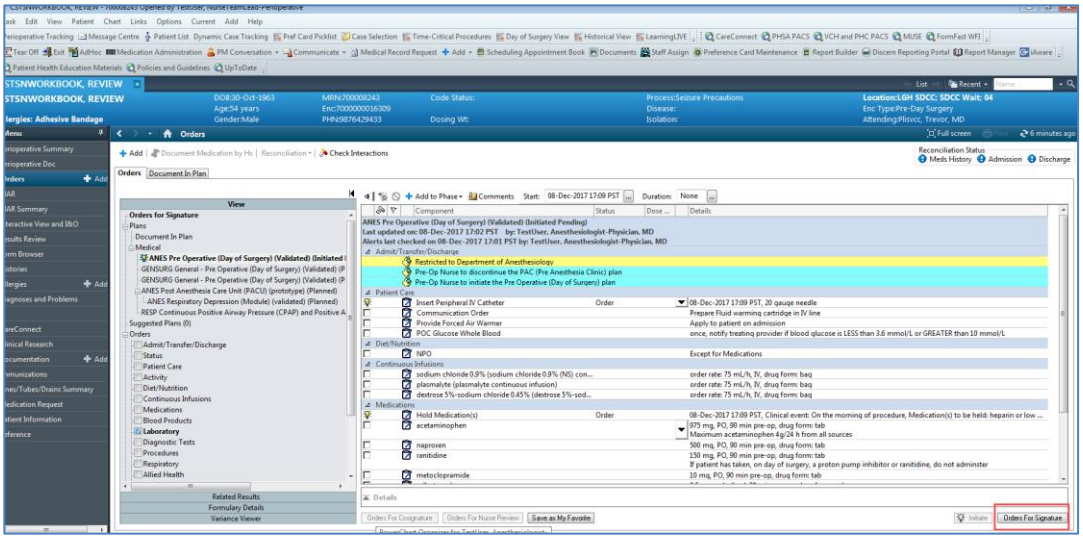
While on the **Orders Profile**:

1. Locate the **Plans** category to the left side of the screen under **View**.
2. Click the **ANES Pre Operative (Day of Surgery) (Planned)** PowerPlan**.**
3. Review the orders within the PowerPlan.
4. Click **Initiate**. The Ordering Physician box will display.

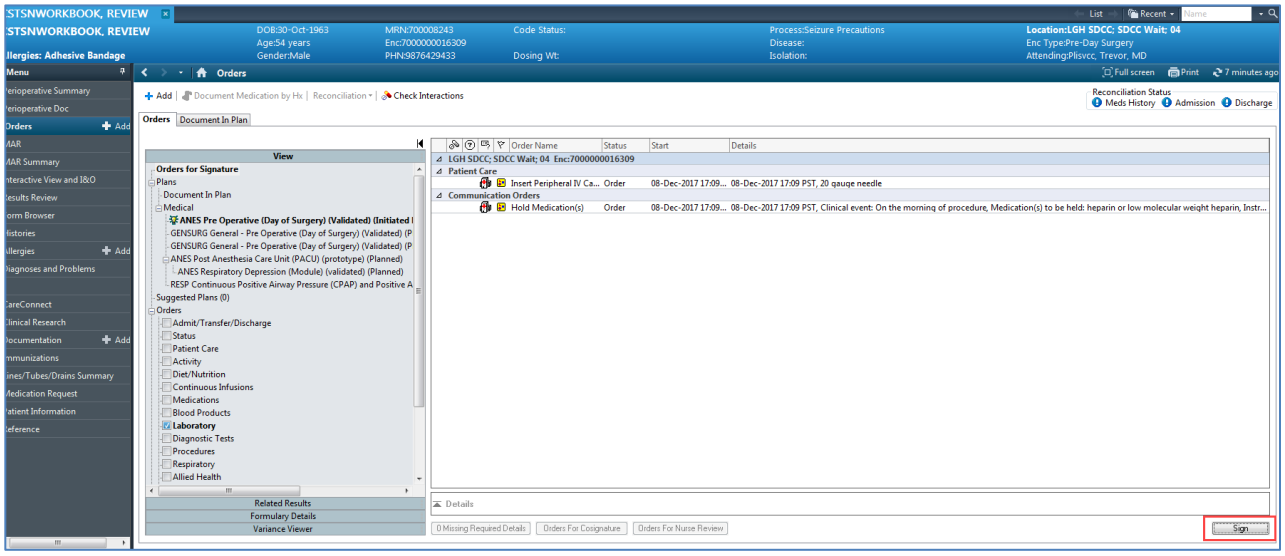


Since the nurse is acting upon planned orders, it requires a method of communication to be chosen to record the time of the initiation, which enables the orders to become active.

5. The Physician will autopopulate. Select **No Cosignature Required**
6. Click **OK**

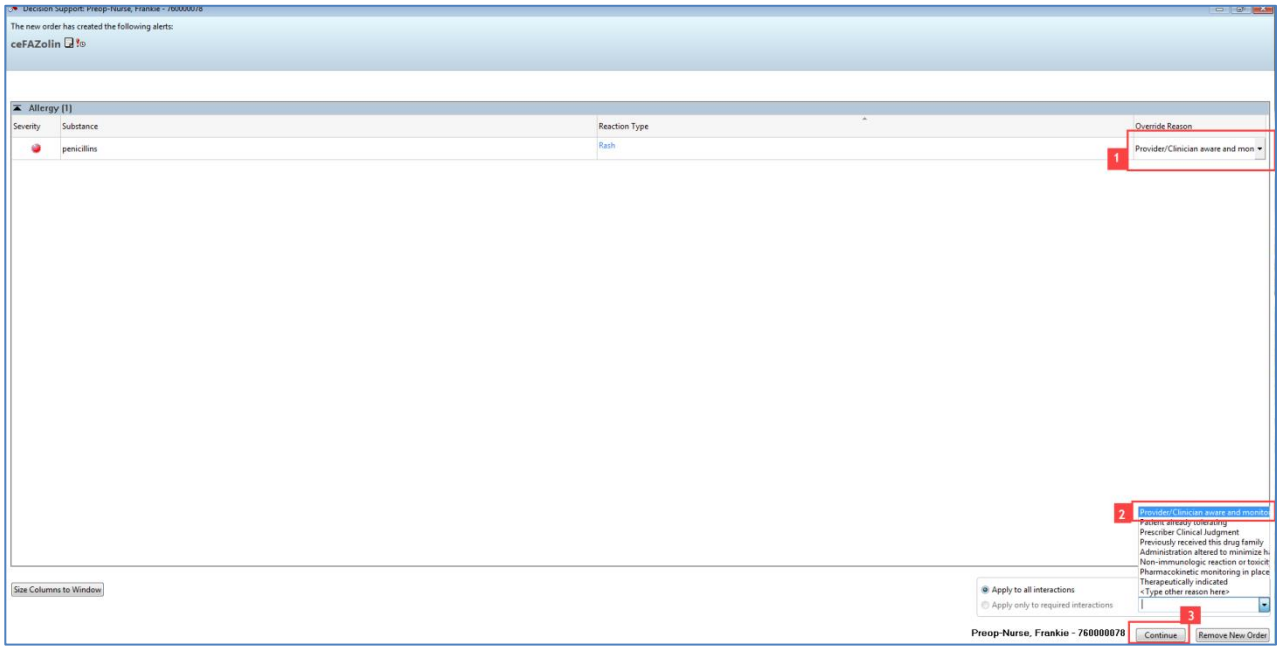


7. Click **Orders For Signature**.



8. Click **Sign**
9. Click **Refresh**.
10. Repeat steps 2-7 for the **GENSURG General Pre Operative (Day of Surgery) (Planned)** PowerPlan.

Note: Your patient has a penicllin allergy. If there is a medication allergy or drug interaction conflict the Decision Support window will appear upon clicking **Initiate**.



1. Review the Provider Override Reason.
2. If in agreement, choose the same Override Reason from drop down options.
3. Click **Continue**
    - Continue with steps 7

The Plan will now change from Planned to Initiated and the orders can be acted upon.

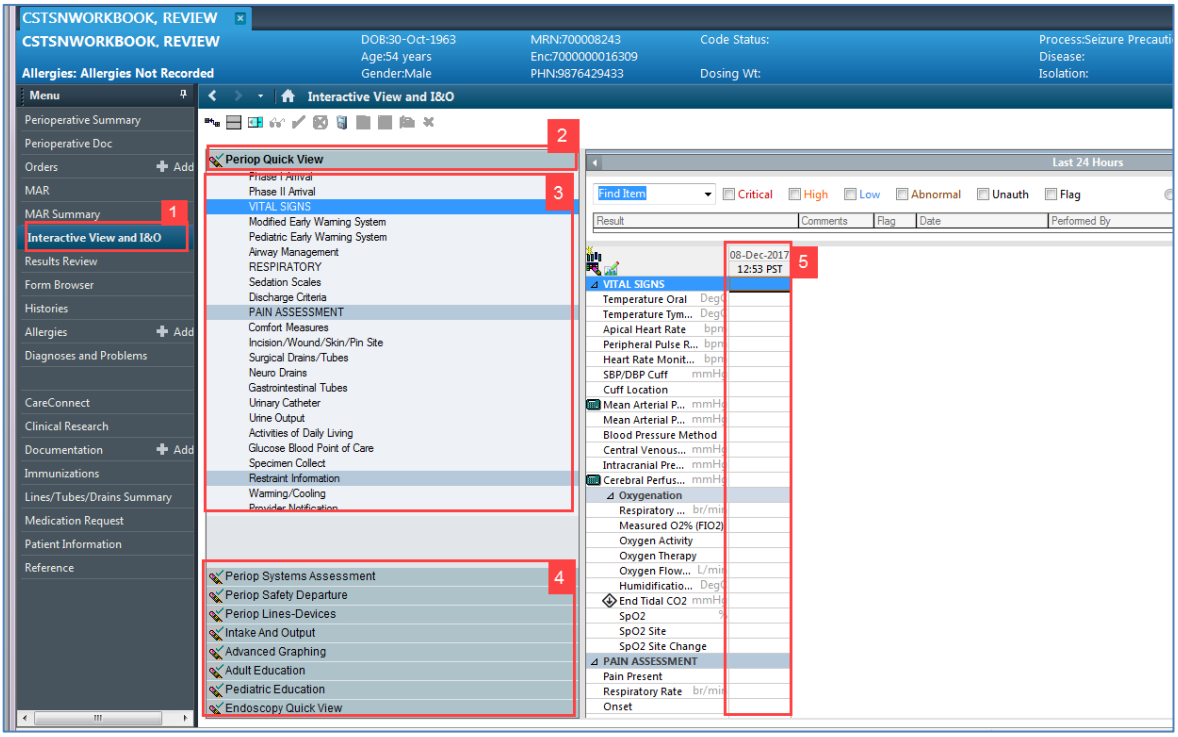
Key Learning Points

- The Order Profiles consists of the orders view and the order profile
- The Orders View (Navigator) displays all order for the patient, including PowerPlans and clinical categories of orders
- The Order Profile page displays all the orders for a patient
- Nurses should always verify the status of orders

Activity 1.10 – Documentation in iView (for intravenous insertion only)

1 Review the iView layout:

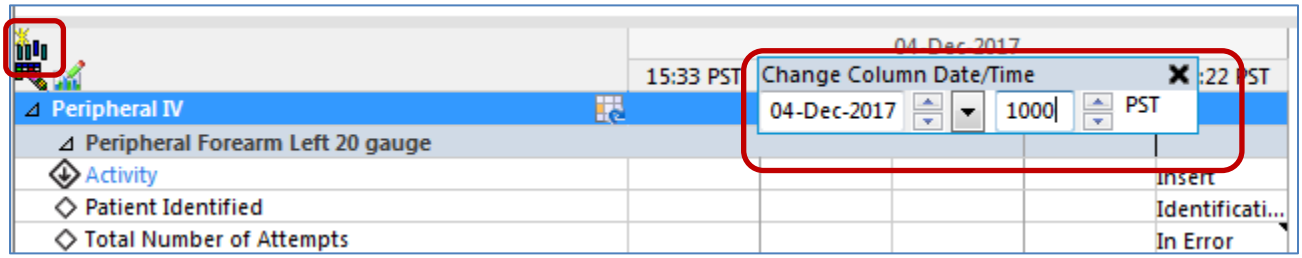
Nurses will complete most of their documentation in **Interactive View and I&O (iView)**. iView is the electronic equivalent of current state paper flow sheets. For example, vital signs and pain assessment will be charted in iView.



1. Select **Interactive View and I&O** within the **Menu**. Now that the iView page is displayed, let's view the layout.
2. A **band** is a heading that has a collection of flowsheets (**sections**) organized beneath it. In the image below, the **Periop Quick View** band is expanded displaying the sections within it.
3. A **section** is an individual flowsheet that contains related assessment and intervention documentation.
4. The set of bands below **Periop Quick View** are collapsed. Bands can be expanded or collapsed by clicking on their name.
5. **Cells** are fields where data is documented.

2 Change the time in Interactive View

We will make an assumption that you were unable to complete IV insertion documentation at the time it was performed. You can create a new time column and document under a specific time. For example, the IV was inserted 30 minutes ago and you need to document it.

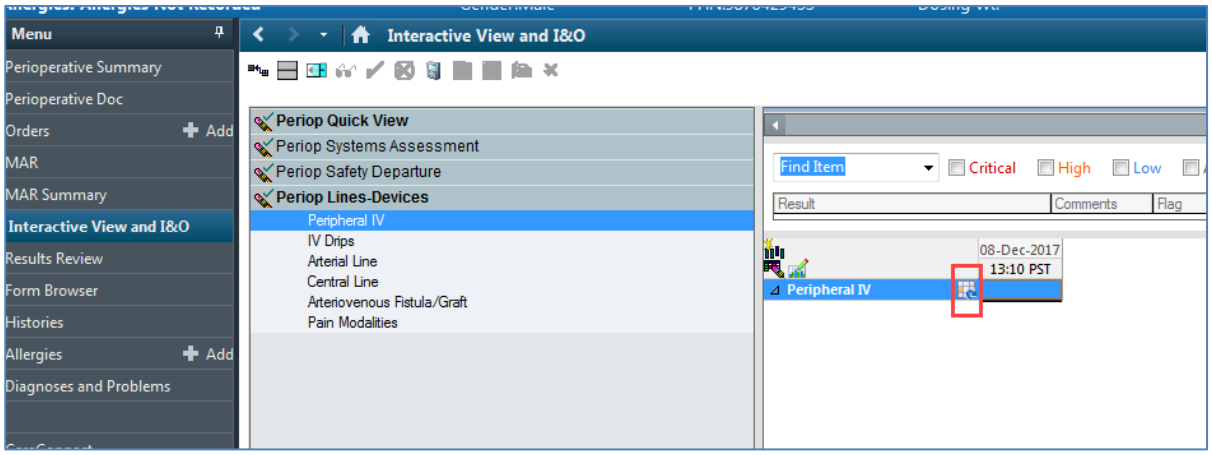


1. The time column will be the current time. Click the **Insert Date/Time** icon .
2. A new column and Change Column Date/Time window appears.
3. Choose the appropriate date and time you wish to document. In this example, use: Today's date and 30 minutes previous.
4. Click the **Enter** key

3 Document a Dynamic Group

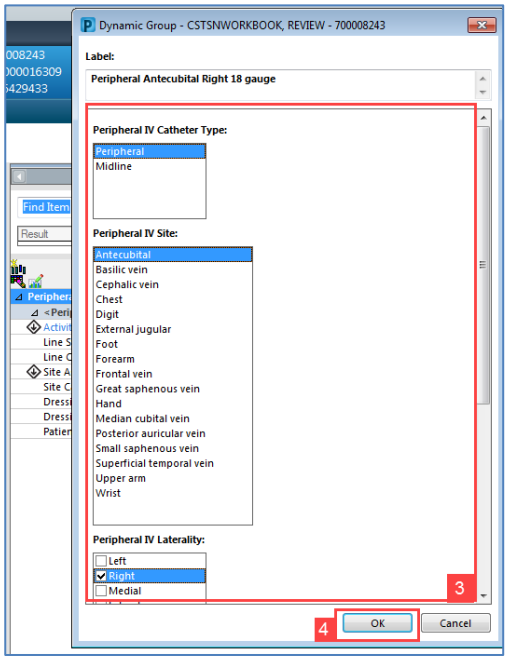
Dynamic Groups allow the documentation and display of multiple instances of the same grouping of data elements. Examples of Dynamic Groups include Wound Assessments, IV Sites, and more. They are identified by the symbol

For the purposes of this scenario, assume that your patient requires a peripheral IV (PIV) to be inserted. After inserting the IV successfully, you are now ready to document the details of the IV insertion.

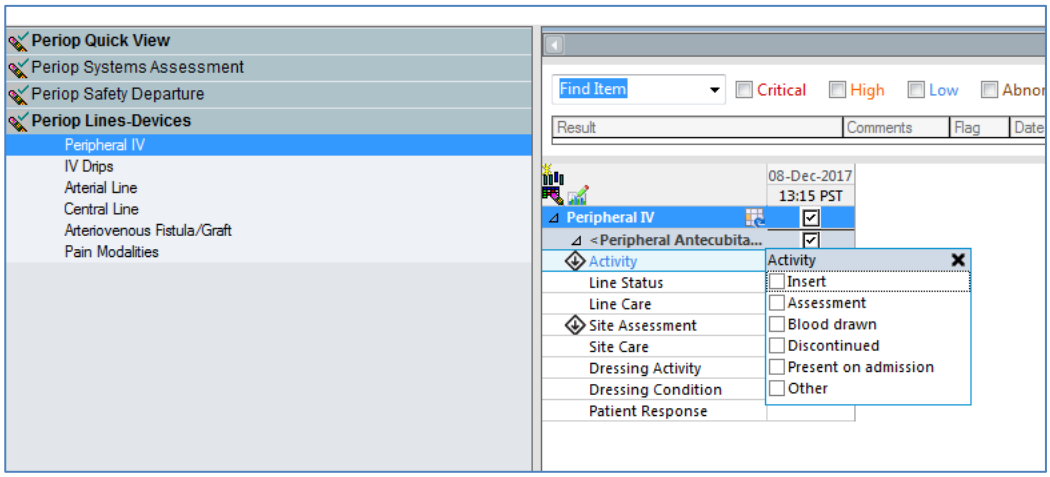


1. Click on the **Periop Lines – Devices** band
2. Now that the band is expanded, click on the **Dynamic Group** icon to the right of the Peripheral IV heading in the flowsheet.

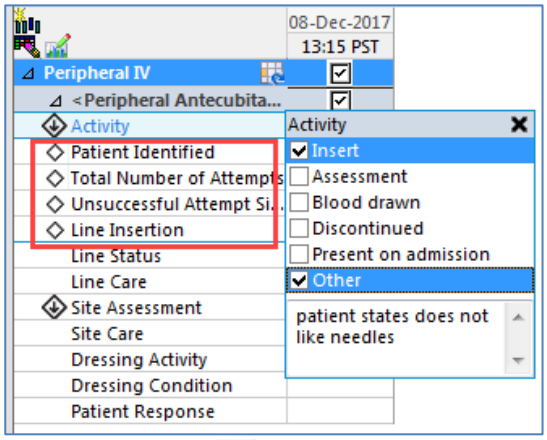
The Dynamic Group window appears. A dynamic group allows you to label a line, wound, or other patient care with specific details. You can add as many dynamic groups as you need for your patient. For example, if a patient has two peripheral IVs, you can add a dynamic group for each IV.



1. Select the following to create a label:
    - **Peripheral IV Catheter Type** = *Peripheral*
    - **Peripheral IV Site** = *Forearm*
    - **Peripheral IV Laterality** = *Left* (remember to use the scroll bar to see the remaining fields)
    - **Peripheral IV Catheter Size** = *20 gauge*
2. Click **OK**



3. The label created will display at the top, under the Peripheral IV section heading.
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. Now document the activities related to this Peripheral IV:
    - **Activity** = *Insert*



Note: A trigger icon can be seen in some cells, such as Activity, indicating that there is additional documentation to be completed if certain responses are selected. The diamond icon indicates the additional documentation cells that appear as a result of these responses being selected. These cells are not mandatory.

- Click in **Other**. A free text box appears and type = *patient states does not like needles*

Fill in remaining data:

- **Patient Identified** = *Identification band*
- **Total Number of Attempts** = *1*
  Note: text appears purple until signed; once signed the text will become black.
- **Line Insertion** = *Tourniquet*
- **Line Status** = *Flushes easily*
- **Line Care** = *Secured with tape*
- **Dressing Activity** = *Applied*
- **Dressing Condition** = *Intact*

6. Click sign when complete. Note: once documentation is signed the entries turn black. Once signed the label will be accessible for other clinicians to complete further documentation within the same dynamic group. The label does not need to be re-created.

Key Learning Points

- iView contains flowsheet type charting.
- Documentation will appear in purple until signed. Once signed, the documentation will become black.
- The newest documentation displays in the left most column.
- Double-click the Blue box next to the name of the section to document in several cells; the section will then be activated for charting.
- Examples of Dynamic Groups include wound assessments, IV sites, chest tubes, etc.
- Once documentation within a dynamic group is signed the label will be accessible for other clinicians to complete further documentation within the same dynamic group.
- Dynamic groups are created within specific sections of iView.
- Dynamic groups allow for the documentation and display of grouped data elements such as multiple IV or wound sites.
- Results can be modified within iView.
- A comment can be added to any cell.
- If required, you can create a new time column and document under a specific time.
- Always sign your documentation once completed.

Activity 1.11 - Administering Medication using Medication Administration Wizard (MAW) and the Barcode Scanner

1 Medications will be administered and recorded electronically by scanning the patient's wristband and the medication barcode. Scanning of the patient's wrist band helps to ensure the correct patient is identified. Scanning the medication helps to ensure the correct medication is being administered. Once a medication is scanned, applicable allergy and drug interaction alerts may be triggered, further enhancing your patient's safety. This process is known as **closed loop medication administration**.

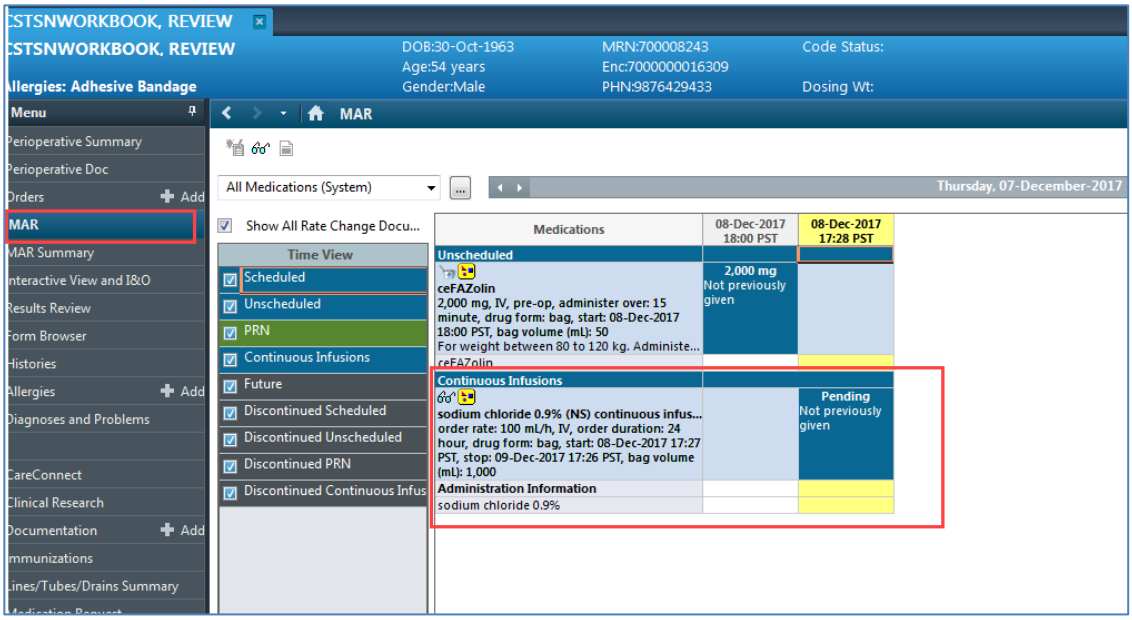
Note: IV medication volumes will flow from the MAR directly into the intake and output section of iView.

Barcode Scanner
Tips for using the barcode scanner:

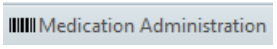
1. Point the barcode scanner toward the barcode on the patient's wristband and/or the medication (Automated Unit Dose- AUD) package and pull the trigger button located on the barcode scanner handle
2. To determine if the scan is successful, there will be a vibration in the handle of the barcode scanner and/or, simultaneously, a beep sound
3. When the barcode scanner is not in use, wipe down the device and place it back in the charging station

2 Administer IV Normal Saline

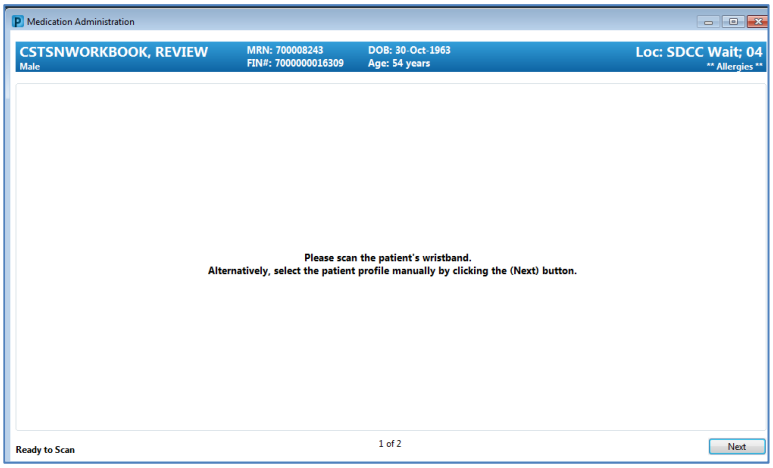
IV normal saline does not have a barcode to be scanned as it is a Stores Item. Stores items are documented on the MAR differently. Let's begin the medication administration following the steps below.



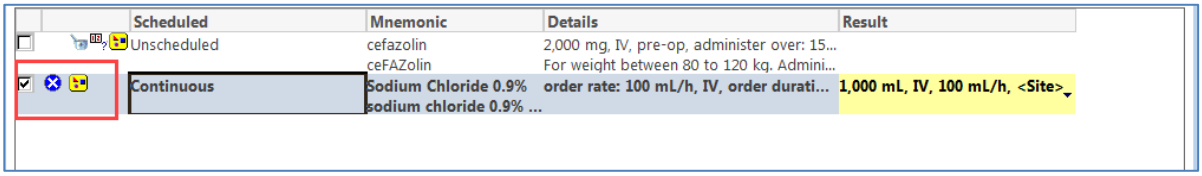
1. From the **MAR**, review the order details for the **sodium chloride 0.9% continuous infusion**. Note the status is **Pending** meaning it has not been administered yet.

2. To administer the infusion, click on the 

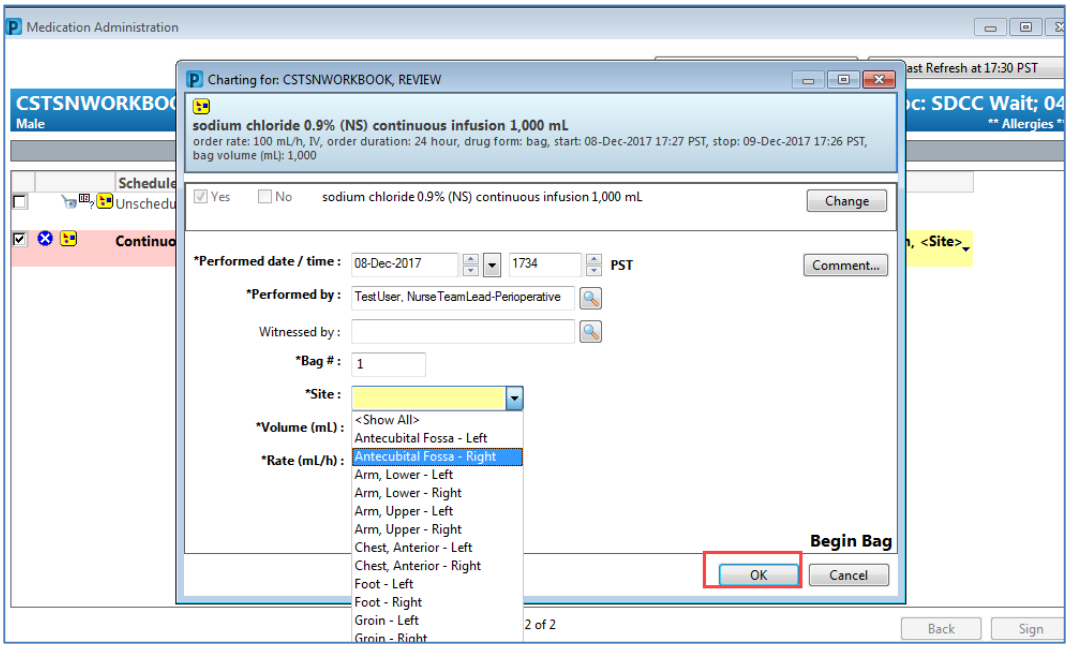
button from the tool bar at the top of the page.



3. The Medication Administration window pops up prompting you to scan the patient's wristband. Scan the barcode on the patient's wristband.

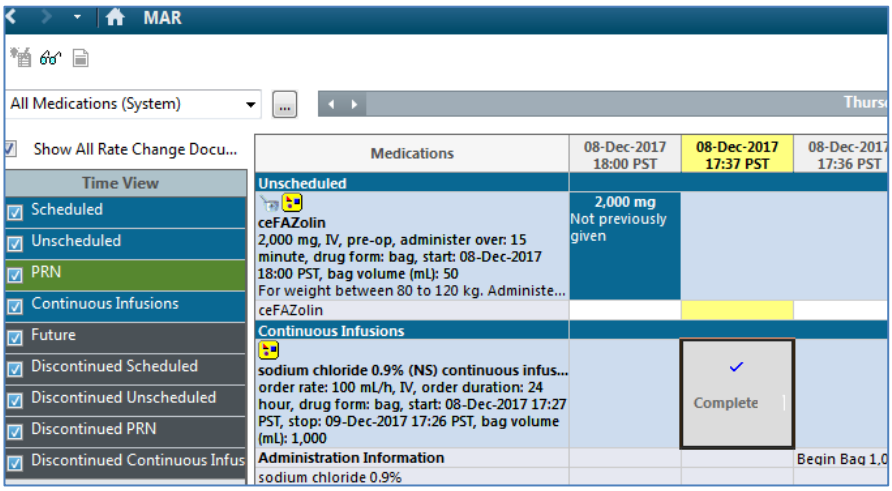


4. A list of ordered medications that can be administered appears in the Medication Administration window. The next step would be to scan the barcode on the medication, but with items that do not have a barcode, such as Normal Saline, we cannot do this. Instead, scroll down to manually select the small box on the left beside the order for the **Sodium Chloride 0.9% (NS) continuous infusion 1,000mL, order rate: 100ml/hr., IV**.
5. Click on the Task Incomplete icon and another charting window will open for the sodium chloride 0.9% (NS) continuous infusion 1,000mL



6. Fill in the mandatory information
   - Site = Arm, Lower-Left and
7. Click **OK**

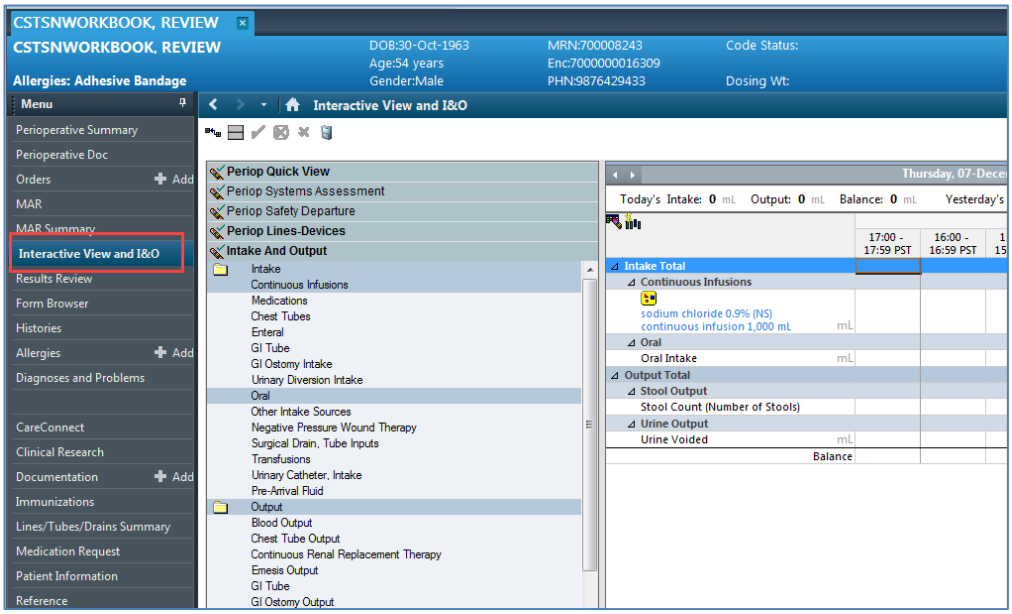
   *For this scenario, please fill in the Performed time = *0600*



8. Click on **Sign** and you will be brought back to the MAR where the sodium chloride 0.9% continuous infusion at 75mLh is now shown as **complete** and the time the bag was started

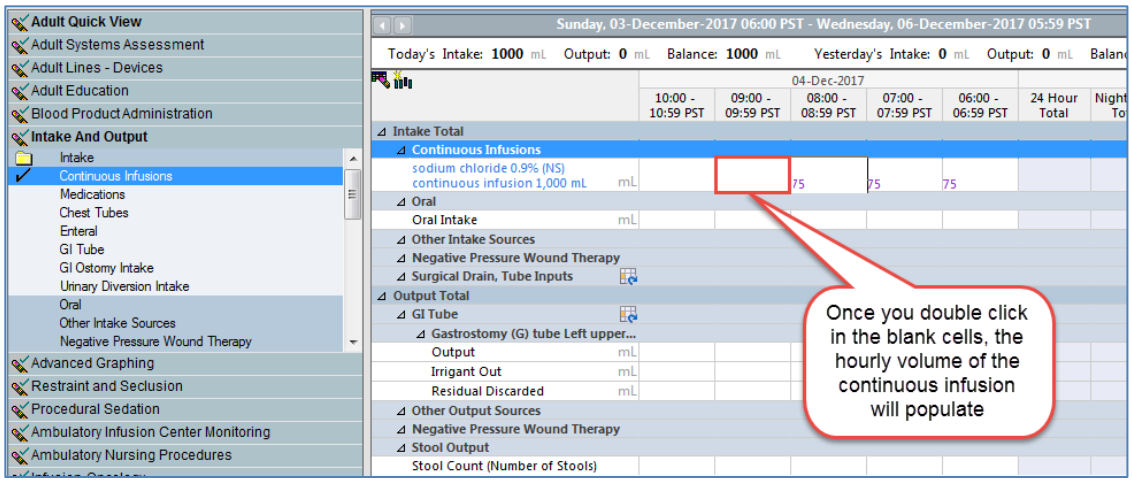
will be documented.

Note: As you have administerd the first bag of this continuous infusion it will show as completed. Once the page is refreshed, it will revert back to pending as the order is for continuous infusion; therefore this will continue to show as further bags are administered.



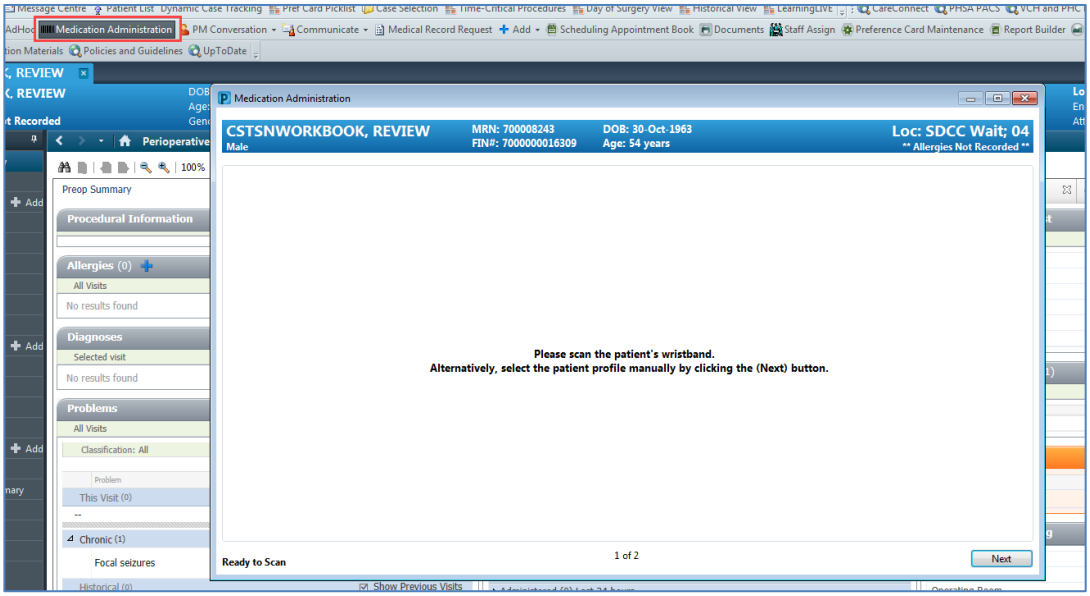
All fluids administered through MAR and MAW will be visible in **Intake and Output** where you will be able to see your patient's fluid balance.

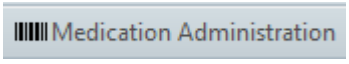
1. From the Menu, click on **Interactive View and I&O**
2. Click on the **Intake and Output** band
3. **Refresh** the page.
4. Click on Continuous Infusions. The Sodium Chloride infusion will be listed.



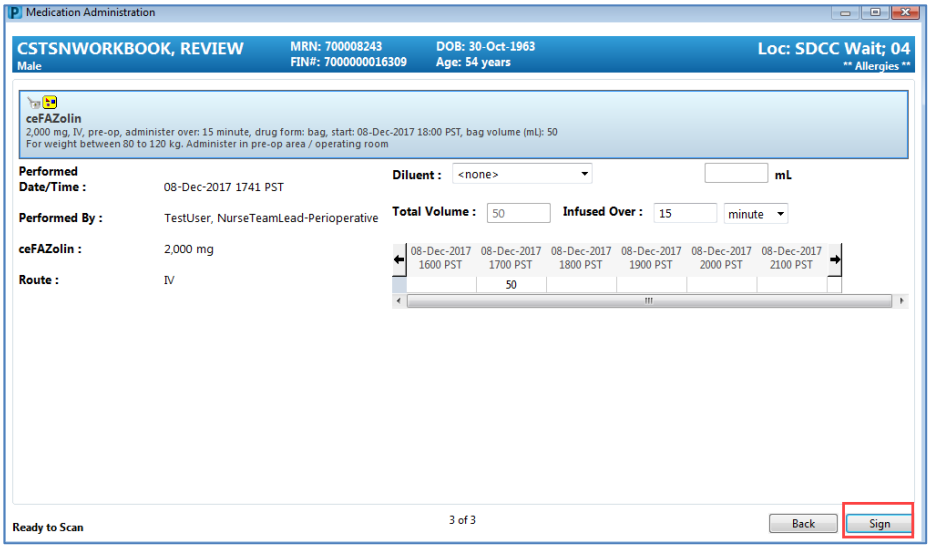
5. Double click in the time cell in the current hour (left hand side) for the continuous infusion. The cell will update with the prorated hourly volume.
6. Click **Sign**.

3 Administer a medication using the MAW

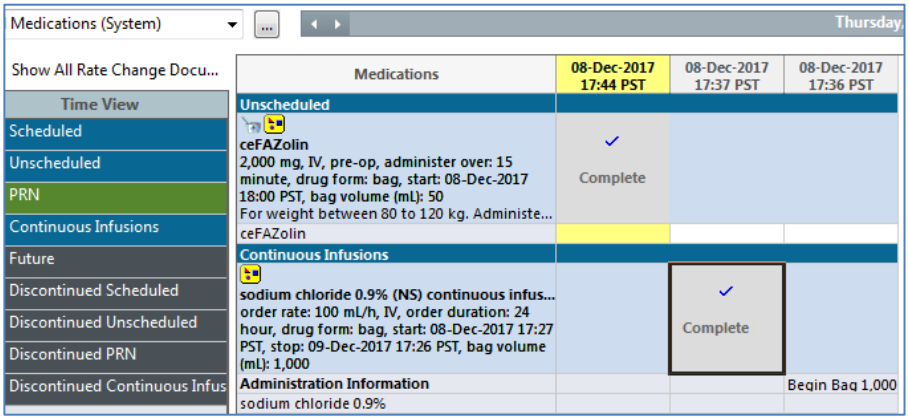


1. Review medication information in the MAR and identify medications that are due. Click Medication Administration Wizard (MAW)  in the toolbar.

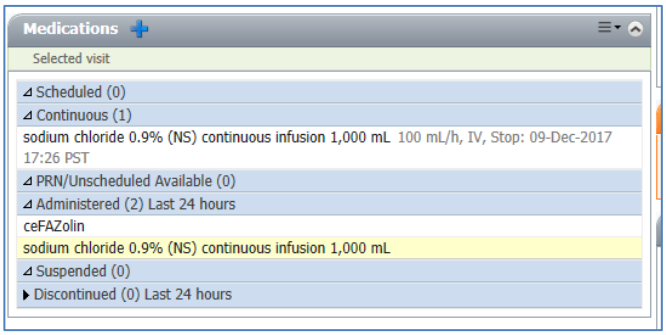
2. The **Medication Administration** window will appear.
3. Scan the patient's wristband, a window will pop up displaying the medications that you can administer. (Note: this list populates with medications that are scheduled for 1 hour ahead of the current time and any overdue meds up to 7 days in the past).
4. Scan the barcode for **Cefazolin 2,000 mg IV**. The system finds an exact match of the IV medication.
5. Click **Cefazolin 2,000 mg IV** in the Results column and Click **Sign.**
6. Now that you have scanned the patient and scanned the medication. You would complete your medication checks and administer the medication. Assuming this is complete, now you can sign for the medications administered.



7. Click **Sign** for the medications administered.
8. Medications show as administered on the MAR



9. Medications also show as administered on Perioperative Summary - PreOp Summary tab (in the Medications component).

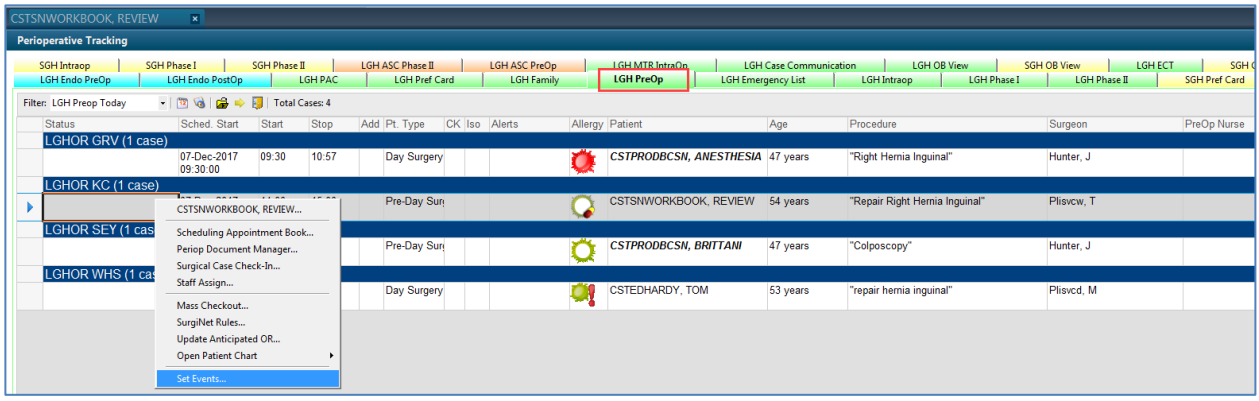


Key Learning Points

- Use barcode scanner to document medications
- Always use the barcode scanner to scan the patient's wristband regardless of whether the medication has a barcode. For example, non-barcoded IV fluids
- All continuous infusion documentation will flow from the MAR into the Intake and Output section of iView

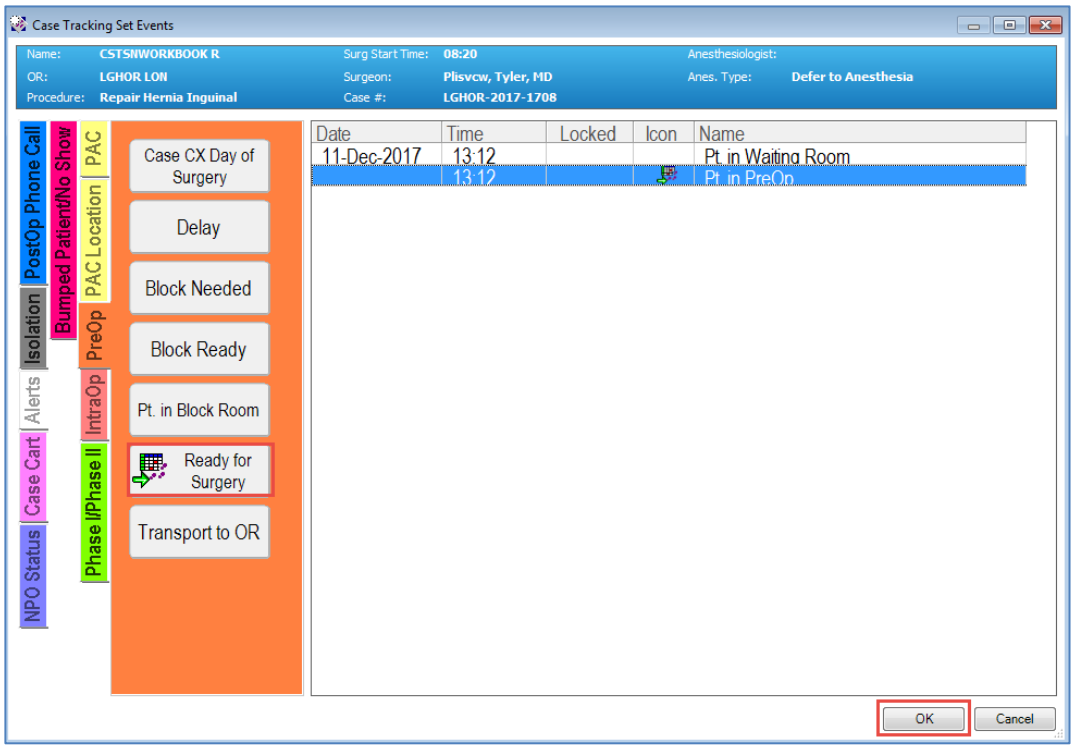
Activity 1.12 – Setting an Event (Patient Ready for Surgery)

1 Set Event **Patient Ready for Surgery**



This Event update is to notify the operating room nurse that patient is ready for surgery.

1. Select the **LGH Preop** view
2. Right click anywhere on the line with the relevant patient and Select **Set Events** from the drop down list. **The Case Tracking Set Events window will display.**
3. **Click the PreOp tab on the left.**



4. Click on the **Ready for Surgery** button.
5. Click **OK**

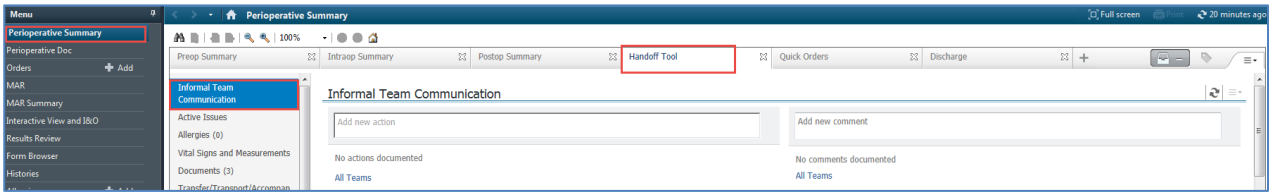
Key Learning Points

- 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.

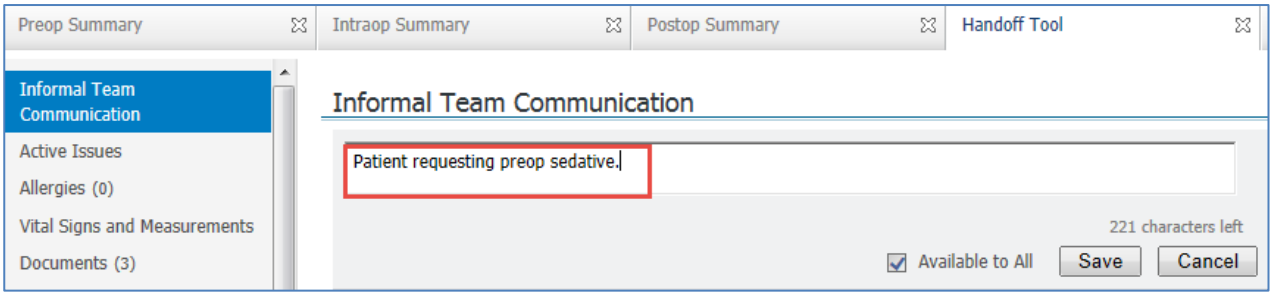
Activity 1.13 – Patient Handover

1 Within the **Handoff Tool** in the Perioperative Summary page there is an **Informal Team Communication** component that can be used for documentation of informal communication between all interdisciplinary care team members. Use the **Add new action** section to create a list of To Do action items. Use the **Add new comment** section to leave a comment for the oncoming nurse or other team members.

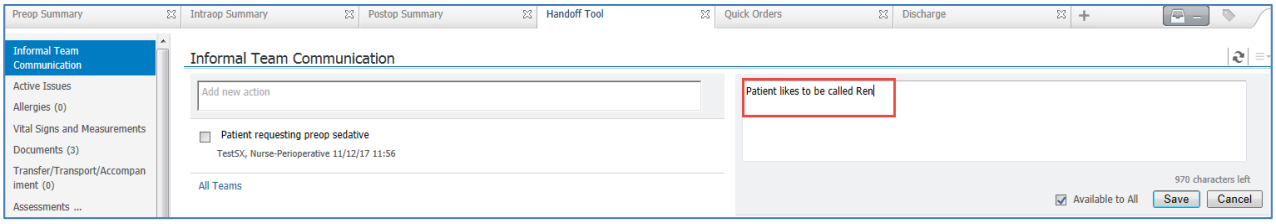
Note: Items documented within the Informal Team Communicaton component are **NOT** part of the patient's legal chart.



1. From the Menu, select **Perioperative Summary**
2. Select the **Handoff Tool** tab
3. Select the Informal Team Communication component
4. Under **Add new action**, type: Patient requesting preop sedative.



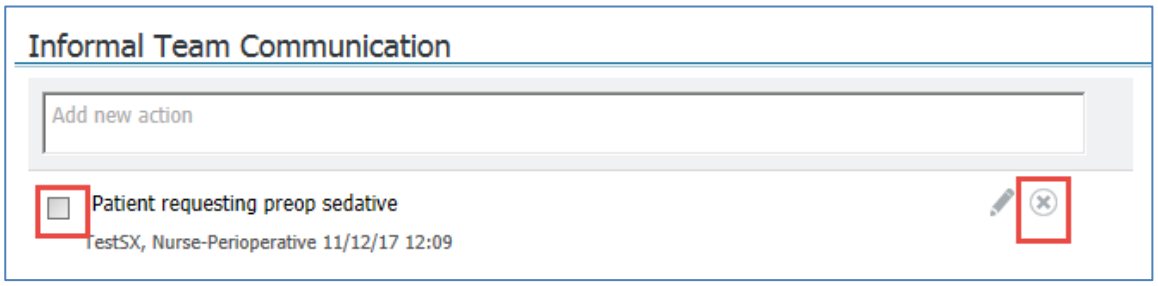
1. Click **Save**
2. Under Add new comment, type: Patient likes to be called Ren.



3. Click **Save**

Actions: It is important to mark completed the actions or delete these actions when they no longer apply.

- Clicking the small box to the left of the action will mark this action as completed.
- By clicking the x on the right, you are deleting the action.

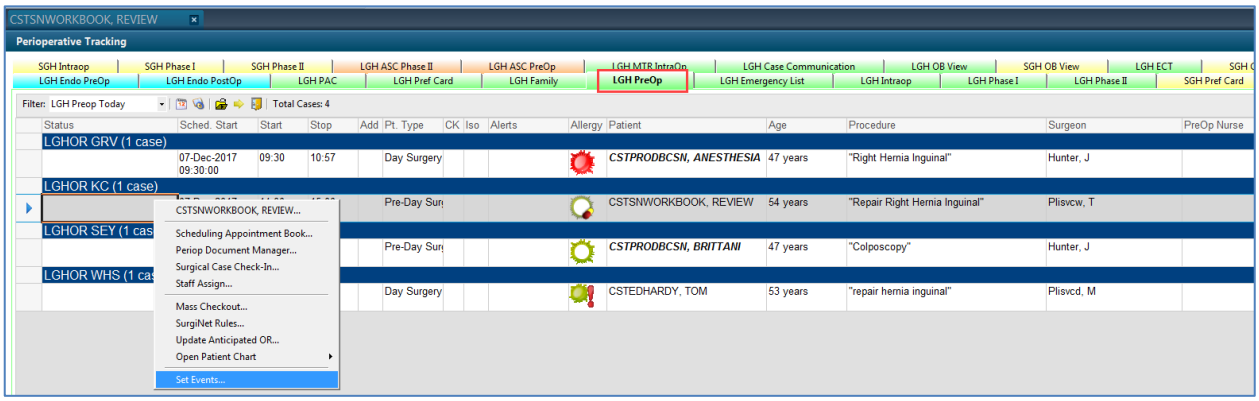


Key Learning Points

- The Informal Team Communication component is a way to leave an informal message for another clinician
- You can leave an action item or a comment
- Any Informal Team Communication message will NOT be considered part of the patient's legal chart

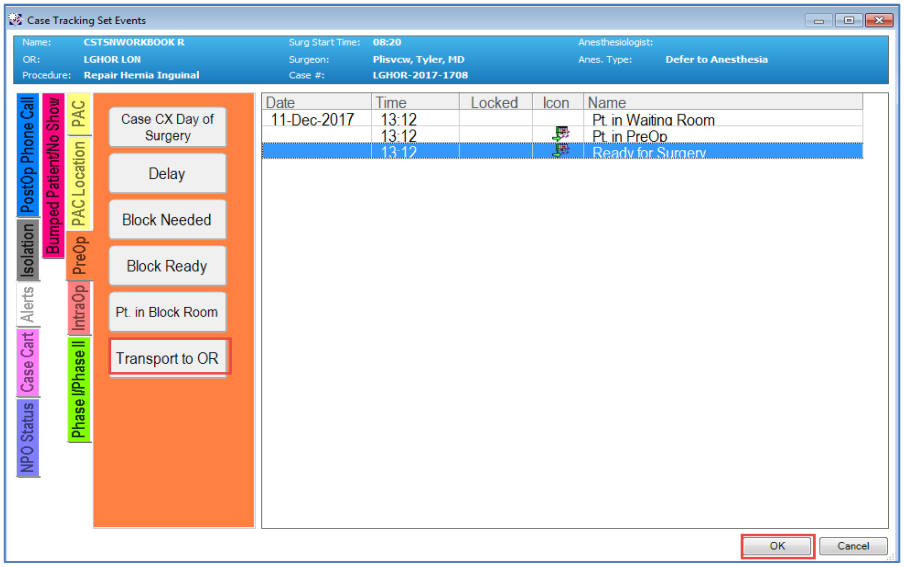
Activity 1.14 – Setting an Event (Transport to OR)

1 Set Event Transport to OR



Once handover report is given to the operating room nurse, the final Event should be set to track the patient's status before the patient is taken from the preoperative area (SDCC) to the operating room.

1. Select the **LGH Preop** view
2. Right click anywhere on the line with the relevant patient and Select **Set Events** from the drop down list. The Case Tracking Set Events window will display.
3. Click the **PreOp** tab on the left.



4. Click on the **Transport to OR** button.
5. 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.

End of Workbook

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