SELF-GUIDED PRACTICE WORKBOOK [N37] CST Transformational Learning

WORKBOOK TITLE: Nursing: Pre-Operative





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# **\$** SELF-GUIDED PRACTICE WORKBOOK

Duration	3 hours
Before getting started	<ul> <li>Sign the attendance roster (this will ensure you get paid to attend the session)</li> <li>Put your cell phones on silent mode</li> </ul>
Session Expectations	<ul> <li>This is a self-paced learning session.</li> <li>A 15-min break time will be provided. You can take this break at any time during the session</li> <li>The workbook provides a compilation of different scenarios that are applicable to your work setting</li> <li>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</li> </ul>
Key Learning Review	<ul> <li>At the end of the session, you will be required to complete a Key Learning Review</li> <li>This will involve completion of some specific activities that you have had an opportunity to practice through the scenarios</li> <li>Your instructor will review and assess these with you</li> </ul>



# 🖬 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)

1



## Activity 1.1 – Navigate Perioperative Tracking

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.

ask Edit View Patient Chart Links Case Actions Provider List Help										
Perioperative Tracking 1 suage Centre & Patient List. Dynamic Case Tracking 🖌 Pref Card Picklist 🖗 Case Selection 👫 Time-Critical Procedures 👫 Day of Surgery View 👫 Historical View 👫 Listorical View										
📲 Enit 🦉 AdHoc 🞟 Medication Administration 🔮 PM Conversation - 🎍 Communicate + 👜 Medical Record Request 💠 Add + 着 Scheduling Appointment Book 🔳 Documents 🎇 Staff Assign 🍘 Preference Card Maintenance 着 Report Builder 🚇 Discem Reporting Portal 🚇 Report Manager 💆 (Aware										
Q Patient Health Education Materials Q Policies and Guidelines Q UpToDate										
CSTSNWORKBOOK, REVIEW										
Perioperative Tracking (3) Full screen @Print. \$2 minutes ago										
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Status Sched. Start Start Stop Add Pt. Type CK Iso Alerts Allergy Patient Age Procedure Surgeon PreOp Nurse Scheduling Comments										
LGHOR GRV (1 case)										
07-Dec-2017 08:00 09:27 Day Surgery CSTPRODBCSN, ANESTHESIA 47 years "Right Hernia Inguinal" Hunter, J										
LGHOR KC (1 case)										
07-Dec.2017         14:00         15:00         Pre-Day Sun         CSTS/WVORKBOOK, RE/VIEW         54 years         "Repair Right Hermia Ingunal"         Plisscw, T         3										

- Any time you need to navigate back to Perioperative Tracking you can click
   Perioperative Tracking
   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

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and the test test sints user unto the test rep										
Perioperative Tracking 🖾 Message Centre 🎍 Patient List. Dynamic Case Tracking 脳 Pref Card Picklist 🖗 Case Selection 脳 Time-Critical Procedures 脳 Day of Surgery View 脳 Historical View 🐘 LearningLife 📋 🛱 CareConnect 🛱 PHSA PACS 🛱 VCH and PHC PACS 🛱 MMSE 🏘 FormFast WEI 🚦										
🖼 Enit 🎬 Adriloc 🗰 Medication Administration 🚊 PM Conversation + 🛁 Communicate + 📄 Medical Record Request 💠 Add + 👼 Scheduling Appointment Book 🛞 Documents 🎆 Staff Assign 🖗 Preference Card Maintenance 🛱 Report Builder 🛁 Discen Reporting Portal 🚇 Report Manager 💆 Alware :										
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LGHOR KC (1 case)										
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- 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.

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

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



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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.

Task Edit View Patient Chart Links Navigation Help											
Perioperative Tracking 🔄 Message Centre 🛓 Patient List. Dynamic Case Tracking 🎬 Peri Card Picklet. 🕲 Case Selection 🐒 Time-Critical Procedures 📓 Day of Surgery View 📓 Historical View 📓 Learning Life 🕴 Case Connect. 🕲 PHSA PACS. 🕲 VCH and PHC PACS. 🕲 MUSE. 🕲 FormFast WRI 🗧											
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		Age:54 years	Enc:700000016214			Disease:		Enc Type:Pre	e-Day Surgery		
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Results Review	Surgical Free Text:	Repair Rig	ht Hernia Inguinal		Selected Visit		Consents				÷
	Anesthesia Type(s):	Defer to A	nesthesia		No results found		ECG	4			÷
Form Browser	Surgeon:	Plisvcw, T	rler, MD				H&P				÷
Histories	Surgery Start:				Labs	≡·	ID Verification				÷
Allergies 🕂 Add	Surgery Stop:	-			Selected visit 🔻		Site Verification			,	÷ _
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Patient Information	No results round				Selected visit						
Reference	Problems			≡•⊗	△ Scheduled (1)		Perioperative Tracking			≡•	<u>ہ</u>
	All Visits			_	phenytoin 30 mg, PO, qHS		Anticipated Start Dt/Tm		7/12/17 14-00		
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							PRODEC	TEST PERIONI IRS	FTEAMIEAD Thurs	day 07-December-2017 1	0-53 PST

- 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 equivalent 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 Allergies (1) 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

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

CSTSNWORKBOOK, REVIEW ×										
Perioperative Tracking										
SGH Intraop SGH Phase I SGH Phase II LGH Endo PreOp LGH Endo PostOp LGH PAC	LGH ASC Phase II LGH ASC PreOp LGH Pref Card LGH Family	LGH MTR IntraOn LGH Case Communicat	ion LGH OB View SGH LGH Intraop LGH Phase I	OB View LGH ECT SGH						
Filter: LGH Preop Today 🔹 🕅 🔞 🛛 🚔 👄 🚺   Total Cases: 4										
Status Sched. Start Stop	Add Pt. Type CK Iso Alerts Allergy	/ Patient Age	Procedure	Surgeon PreOp Nurse						
LGHOR GRV (1 case) 07-Dec-2017 09:30 10:57 09:30:00 10:57	Day Surgery	CSTPRODBCSN, ANESTHESIA 47 years	"Right Hernia Inguinal"	Hunter, J						
LGHOR KC (1 case)	Pre-Day Suri	CSTSNWORKBOOK, REVIEW 54 years	"Repair Right Hernia Inguinal"	Plisvcw, T						
LGHOR SEY (1 Cas Scheduling Appointment Book Periop Document Manager Surgical Case Check-In	Pre-Day Sur	CSTPRODBCSN, BRITTANI 47 years	"Colposcopy"	Hunter, J						
Staff Assign Mass Checkout	Day Surgery	CSTEDHARDY, TOM 53 years	"repair hernia inguinal"	Plisvcd, M						
SurgiNet Rules Update Anticipated OR Open Patient Chart										

- 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.

Name:	CST	5NWORKBOOK R	Surg Start Tim	e: 14:	00 Nov Tulor MD		Anesth	esiologist:	Defer to Anosthosia	
Procedure:	Rep	air Hernia Inguinal	Case #:	LGF	IOR-2017-1702		Anes.	гуре.	Defer to Allestifesia	
PO Status	on PAC	Case CX Day of Surgery	Date 07-Dec-2	017	Time 11:48 11:51	Locked	lcon	Name Pt in V Pt in F	Vaiting Room PreOp	
PostOp F Show N	AC Locati	Delay								
olation <mark>atient/No</mark>	reOp P/	Block Ready								
Alerts Is sumped P	ntra0p P	Pt. in Block Room								
Case Cart	Phase II	Ready for Surgery								
-	Phase I/	Transport to OR								
			•						ОК	Cance

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



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

Perioperative Tracking												
SGH Intraop LGH Endo PreOp	SGH Phase I LGH Endo PostOp	SGH Phase I	GH PAC	LGH ASC Phase II LGH Pref Card	LGH ASC PreOp LGH Family		LGH MTR IntraOp	LGH LGH Emer	Case Communica gency List	ation LGH LGH Intraop	I OB View LGH Phase	SGH OB View LGH
Filter: LGH Preop Today	-   🖭 🔞   🝰 🔶	其   Total C	ases: 4									
Status	Sched. Start	Start	Stop	Add Pt. Type CK Iso	Alerts	Allergy	Patient		Age	Procedure		Surgeon
LGHOR GRV (1 ca	ase)											
	07-Dec-2017 09:30:00	09:30	10:57	Day Surgery		Q.	CSTPRODBCSN, A	ANESTHESIA	47 years	"Right Hernia Ing	uinal"	Hunter, J
LGHOR KC (1 cas	<u>e)</u>											
Pt. in PreOp	07-Dec-2017 14:00:00	14:00	15:00	Pre-Day Sur		$\bigcirc$	CSTSNWORKBOC	K, REVIEW	54 years	"Repair Right Her	nia Inguinal"	Plisvcw, T
LGHOR SEY (1 ca	ise)											
	07-Dec-2017 07:45:00	07:45	08:25	Pre-Day Sur		Ø	CSTPRODBCSN, E	BRITTANI	47 years	"Colposcopy"		Hunter, J
LGHOR WHS (1 c	ase)											
	07-Dec-2017 15:05:00	15:05	16:32	Day Surgery			CSTEDHARDY, TO	M	53 years	"repair hernia ing	uinal"	Plisvcd, M

- 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

#### Use PM Conversation to complete bed transfer details.

1

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.

Perio	perative Tracking  🛔 Patient l	List 🛯 Dase Selectio	n 🎬 Time-Critica	Procedures	👫 LearningLI	VE 📮	0	CareConnect 🜊 PH	HSA PAC	S 🜊 VCH and PHC I	PACS 🕄 MUSE 🧃
Ex	📲 Exit 🎬 AdHoc 🔒 PM Conversation 🔹 🕂 Add 👻 🗐 Documents 🭙 Discern Reporting Portal 📳 Report Builder 🚆 Scheduling Appointment Book 🕼 Report Manager 🎇 St										
🕄 😋 Pa	文 Patient Health Education Materials 🔍 Policies and Guidelines 🔍 UpToDate 🦕										
CSTS	CSTSNWORKBOOK, REVIEW										
Perio	Perioperative Tracking										
	SGH Pref Card	SGH Emergency Lis	t S	GH PreOp	sc	GH Intr	аор	SGH	OB View	SGH	Case Communicat
	LGH Case Communication	LGH	Pref Card	LGH	Emergency Lis	st		LGH PAC		LGH PreOp	LGH
Filte	er: LGH Preop Today	🔁 🔞   🔓 🔶	🛐   Total Cases: 4								
	Status	Sched. Start	Start Stop	Add	Pt. Type	CK	lso	Alerts	Allergy	Patient	
	LGHOR GRS (2 cases	s)									
		13-Dec-2017	10:15 11:3	0	Pre-Day Sur	!			Ő	CSTPRODBCSN,	JAMES

1. To open patient, Select Patient Tab

	the second se	the second se	
Task Edit View Patient C	hart Links Navigation He	lp	
Perioperative Tracking 🖃 Messa	ge Centre 🛔 Patient List Dyna	mic Case Tracking 🔡 Pref Card Pick	list 🐞 Case Selection 📲 Time-Cr
🗄 🔀 Tear Off 📲 Exit 🎬 AdHoc 🛽	🖩 Medication Administration	🔓 PM Conversation 👻 📲 Communic	ate 👻 🗎 Medical Record Request
2 Patient Health Education Mate	rials 🔇 Policies and Guidelin	Bed Transfer	
CSTSNWORKBOOK, REVI	EW 🗵	Cancel Discharge	
CSTSNIWORKBOOK REVI	EVA/	Cancel Pending Transfer	MRN:700008243
CSTSINWORKBOOK, REVI		Cancel Transfer	Enc:700000016214
Allergies: No Known Medicati	on Allergies	Discharge Encounter	PHN:9876429433
Menu P	< 🖂 🕣 🏦 Periop	Facility Transfer	
Perioperative Summary		Leave of Absence	
Perioperative Dec		Modify Discharge	
	Preop Summary	Pending Facility Transfer	🖾 Posto
Orders 🛉 Add		Pending Transfer	
MAR	Allergies (1)	Print Specimen Labels	=-
MAR Summary		Process Alert	
Interactive View and I&O	All Visits	Register Phone Message	
Results Review	No Known Medication All	Update Patient Information	
Form Browser	Diagnosos	View Encounter	=-
Histories	Diagnoses	View Person	
	Selected visit		_
Allergies 🕂 Add	No results found		

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



Ĕ	🖴 Bed Transfer				×
Γ	Bed:	Accommodation:	Accommodation Reason:	Patient Accom Requested:	*
	– New Encounter Information –		<b>•</b>		
	Encounter Type:	Medical Service:			
	Pre-Day Surgery	General Surgery 🔷 👻			
	- New Location Data				
	Building:	Unit/Clinic:		Room:	
	LGH Lions Gate 🗾 👻	-	Bed Availability	-	
	Bed:	Accommodation:	Accommodation Reason:		
	•	<b>•</b>	•		
	- Current Physician Information				
	Attending Provider:	Admitting Provider:			
		<u> </u>			
ŀ	- Transfer Information				
	Transfer Date:	Transfer Time:	Bed Transfer User Name:		
	**_***		TestUser, NurseTeamLe		
L					4
				Complete Cancel	
	No A.	- DDC	DDC TECT DEDIONUDCETEA	MUEAD 07 D 2017 11.57	

- 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

🚔 Bed Transfer							23		Isc	lation										
Bed:	Accommodation:		Accommod	lation Reason:	Patient Acc	om Requested:														
New Encounter Information     Encounter Type:	Medical Service:			🔒 Bed Availabilit	y							- 0	×							
Pre-Day Surgery - New Location Data	General Surgery	•		Facility: LGH Lions Building: LGH Lion	Gate s Gate															
Building:	Unit/Clinic:			Room	Bed	Nurse unit	Isolation	Person	Bed status	In	Out	Sex								
LGH Lions Gate	LGH SDCC	•	Be	PACU 2	12	LGH SDCC			Available	1										
Bed:	Accommodation:		Accommo	PACU 2	13	LGH SDCC		MMODAL, FESRFLEX	Assigned			Female								
•		•		🚔 SDCC Wait	01	LGH SDCC		CSTEDHARDY, TOM	Assigned			Male								
<ul> <li>Current Physician Information</li> </ul>				🚔 SDCC Wait	02	LGH SDCC			Dirty											
Attending Provider:	Admitting Provider:	ting Provider:	ting Provider:								🚔 SDCC Wait	03	LGH SDCC		CSTSNKENOBI, STOBIWAN	Assigned			Male	_
				🚔 SDCC Wait	04	LGH SDCC			Available											
Transfer Information				🚔 SDCC Wait	05	LGH SDCC		CSTPRUDMI, LGH-SDCC	Assigned			Female	_							
Transfer Date:	Transfer Time:		Bed Trans	🚔 SDCC Wait	06	LGH SDCC		CSTPRODBCSN, ANESTHESIA	Assigned			Female								
**_***			TestUs	🚔 SDCC Wait	07	LGH SDCC		CSTSCHTEST, BARRY	Assigned			Male	E							
				🚔 SDCC Wait	08	LGH SDCC		CSTPRODBCSN, ALEX	Assigned			Female								
				🚔 SDCC Wait	09	LGH SDCC		CSTSNKUNIS, STMILA	Assigned			Female								
				🚔 SDCC Wait	10	LGH SDCC		CSTSCHTEST, BARRY	Assigned			Male	-							
Ready		PRO	DBC TES	•		III							•							
y This Visit (0)										OK		Cance	el							

- 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





🚔 Bed Transfer				×
Bed:	Accommodation:	Accommodation Reason:	Patient Accom Requested:	*
- New Encounter Information -				-
Encounter Type:	Medical Service:			
Pre-Day Surgery	General Surgery 🗾 👻			
- New Location Data				_
Buildina:	Unit/Clinic:		Room:	
LGH Lions Gate 🗸 🗸	LGH SDCC 🚽	Bed Availability	SDCC Wait 🗸 👻	
	A 1.0			
Bed:	Accommodation:	Accommodation Heason:		
▼	ward	•		
Current Physician Information				-
Attending Provider:	Admitting Provider:			
— Transfer Information ———				-
Transfer Date:	Transfer Time:	Bed Transfer User Name:		
**_***		TestUser, NurseTeamLe		
				Ŧ
			Complete	
Ready	PRO	DBC TEST.PERIONURSETEA	MLEAD 08-Dec-2017 11:56	

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

Location:LGH SDCC; SDCC Wait; 04 Enc Type:Pre-Day Surgery Attending:Plisvcc, Trevor, MD

2 0 minutes ago

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

1



# Activity 1.5 - Locating and Verifying Consent Procedure

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

From the Perioperative Summary page on the Preop Summary tab:

CSTSNWORKBOOK	, INTRAOP - 700	008518 Opened by TestCST,	Nurse-Periope	erative5 \$7	ĸ											
Task Edit View	Patient Chart	Links Navigation Hill	ip .													
Perioperative Tracking	g 🎍 Patient List	Dynamic Case Tracking 🧯	📁 Case Selectio	on 🌇 Tir	me-Critical Pro	cedures 🌃 LearningLIVE	💡 İ 🕄 Care	eConnect 🔃 PHSA PACS	CCH and PHC PACS	🕄 MUSE 🕄 FormFa	st WFI u					
🗄 🎦 Tear Off 📲 Exit	🖬 AdHoc 🎟 M	edication Administration 🧯	PM Conversa	ation -	Medical Reci	ord Request 💠 Add - 🙆	iAware 🛱	Scheduling Appointmen	t Book 🔚 Documents 🕌	Staff Assign 🔳 Repo	ort Builder 🗃 Discern Reporting I	lortal 🚺 Report Manager 🧋				
🗄 😋 Patient Health Edu	cation Materials	Rolicies and Guidelines	🕄 UpToDate													
CSTSNWORKBO	ok, intrao	Ρ 🔳												List 🔿 📬	Recent + Name	•
CSTSNWORKBO	OK, INTRAC	P	DO8:09-	Aug-196		MRN:700008518					Process:		Location:LGH SD	CC; Chair; Sey	mour	
Allergies: No Known	n Medication A	llergies	Age:54 y Gender:1	rears Male		Enc:700000016092 PHN:9876420562		Dosing Wt:			Disease: Isolation:		Attending:Plisvex	Surgery ituart. MD		
Menu		< > • 🔒 Perio	perative Sur	mmary												0 minutes
Perioperative Summ	ary		Lanner													
Perioperative Doc			1 100/0	-			CO. Durton		M Autorit		M Handall Zool	24				n (
Orders	+ Add	Preop Summary		24	intraop Summa	ry	2.5 Poscop	Summary	2.5 Quick Orbi	615	2.5 Handoff Tool	* +				\> <
MAR		Allemies (1)					= 0	Measurements a	nd Weights (0)		≡• ⊗	Selected visit				
MAR Summary		All Visite					- •	Selected visit				No results found				
Interactive View and I8		No Known Medication A	Allernies					No results found				Clinical Research (0)				≡•⊗
Results Review			and great					Homo Medication	ar (0) 📥		=• 0		On Study	Salar	Cretert	_
Form Browser		Diagnoses					≡• ⊙	Thomas Predication	<b>B</b> (0) <b>T</b>			No results found				
Histories		Selected visit						Medications 🔶			≡• 6					
Allergies	+ Add	No results found						Selected visit				Perioperative Tracking				=• 📀
Diagnoses and Problem		Problems	_		_		=. 0	⊿ Scheduled (0)				Anticipated Start Dt/Tm	06/12	/17 11:00		
		All Visits		-				⊿ Continuous (0)				Anticipated Duration	60			
CareConnect		Classification: All						<ul> <li>Administered (0) L</li> </ul>	Available (U) ast 24 hours			Operating Room Public Sched Comment	LGHC	RKC		
Clinical Research								⊿ Suspended (0)				Private Sched Comment				
Documentation	🕂 Add	Problem						Discontinued (0) Li	ast 24 hours					1)		
Immunizations		This Visit (0)						Disconstice (0)				Documents (2) 🔶				=• o
Lines/Tubes/Drains Su								Diagnostics (0)			=•0	Last 24 hours 🖝				
Medication Request		Chronic (0)	diselas					Micro Cultures (0			<b>≡•</b> •	My Documents				
Patient Information		Mintorical (0)	uspay			IZI Show Previ	ous Visits				-	Note Type	Author	a da mara kha n	Date/Time	
Reference						87		Lines, Tubes, and	i Drains (0)		=• •	Consent Procedure	2 wn	erioperative	05/12/17 14:40	
		Family History (0)					≣• ≎					L				
		Procedure History	(0)				=- 0					Intake and Output				<b>≡</b> • ⊗
		Procedure history	(0)									Last 3 days for the selected vie	iit			
		Social History (0)					≡• ⊙					No results found				
		All Visits										* Indicates a day without a full 24 ho	ur measurement period			

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

CSTSNWORKBOOK, INTRAO	P 🖬							tint 🖙 🛍	Recent - Name	•
CSTSNWORKBOOK, INTRAC	P	D08:09-Aug-1963 Ane-S4 years	MRN:700008518 Enc:700000015097	Code Status:	Process			Location:LGH SDCC; Chair: Sey	mour	
Allergies: No Known Medication	Allergies	Age of Jeans	E18.700000010051		Disease.			Attending:Plisvcx, Stuart, MD		
Menu P	< > - 🕈 Pe	P CSTSNWORKBOOK, INTRAOP - 1	700008518 - Consent - Surgical C	Operation, Special Procedure or Trea	tment and Special Considerations - 05 Dec 2017 22:31			(D) Full se	teen 🗇 👘	2 2 minutes a
Perioperative Summary	ABIABIS	#■ 11 10 元 4 1	x 🖪 🔨 + + 🖻 1	<b>∃ 4</b> 8 ♥		-				
Perioperative Doc	Preop Summary	STSNWORKBOOK, INT	RAOP Male 54 years	DOB:09-Aug-1963			22 +			B (-
Orders 🕂 Add			Cerviticher* 20191 ik	old Proor Oke XXXXX 1					C. Ind	- A -
MAR	Allergies (3)	(4)				a45.4	2066LEGD ARE			
MAR Summary	Al Vota		1000	a dia man		100	Ne results found			
Interactive View and I&O	No Known Medicatio		1957 and	Consest:	A	Page1	Clinical Research (0)			<b>=•</b> 🔿
Results Review			Litter of a second s	te belara bajar da riburingan farre bagai				On Study Dates	Contract.	
Form Browser	Diagnoses		Indiana a	A Tas. Particular	-Kept-		No results found	in stand stand	CO NEL	
Histories	Selected visit		Sectors of president des	er en	en 9.0		DUCTORNAL			
Allergies 🕂 Add	No results found		And the second s				Perioperative Tracking			=• 🗢
Diagnoses and Problems CareConnect	Problems Al Vists Classification: Al		A second se	23412			Anticipated Start Dt/Tm Anticipated Duration Operating Room Public Sched Comment	06/12/17 11:00 60 LGHOR KC		
Clinical Research			Bus	All Decision for a fill and the second secon	and a second		Private Sched Comment			
Documentation + Add	This Visit (0)		ter andre Art Transmission andre andre	Ang ten regioner			Documents (2)			
Immunizations	-		Sectores applications applications applications applications of the sector of the sect	and and the second seco	-		Last 24 hours		_	
Lines/Tubes/Drains Summary	(Chennic (0)		Total a to				III the Decomposite			
Medication Request	No results		Suma -	Aparta Babar Babar Babar	-		E Hy Documents	12.4.2		_
Patient Information	Historical (0)			Dutshilly Add			Periop Preprocedure Checklist	- Text TestSX, Nurse-Perioperative	05/12/17 14:40	
Reference		Contraction of the second					Consent Procedure	Unknown	05/12/17 14:31	
	Family History (C	10 0 0 0 0		B-00000ッシック	©:□- <u>□</u> ]@@		denie w second y second y			
	Procedure Histor						Intake and Output			=- *
							Last 3 days ror the selected visi			
	Social History (0)			=- 📀			No results found			
	Alt Visits						shorares a only without a full 24 feb.	Contract Decision		'

- 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

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



- 1. 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
- 2. Select Surgical Assessment and Perioperative Preprocedure Checklist.
- 3. Click Chart



2	Documenting on the Surgical Assessment PowerForm & Perioperative Preprocedure
	Checklist

Performed on: 12/12/2017	1053 PST			
General Information General Information Barriers to Communication Allergies Valas/Measurements/MEWS/PEWS Advance Care Planning Past Medical History, Problems, Diagn Patient Screening History		S R [	urgery/Procedure Date/Location eviewed Procedure Location Procedure Date/Time	Discharge Contact Name
STOP BANG Assessment Medication History ID Risk Screen Violence and Aggression Screening Jal History ScAID Assessment Nicotine Dependence Assessment Procedure History Anesthesia/Sedation Family History	Barriers to Communication           Yes           No           Answer "Yes" if the patient has language barriers, requires interpreter support, or has sensory deficits.	Reason Unable	e to Obtain Information O Physical impairment nt	Discharge Contact Relationship Unable to obtain Caregiver Patient Other: Daughter Friend Friend Significant other Significant other
Pain Assessment Numeric Pain Scale FACES Pain Scale Transfusion Reaction Morse Fall Risk	Visitors/Family Visitor/Family Information		Visitor/Family Restrictions	
Discharge Needs Skin Assessment				

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.

Violence and Aggression Screening
<ul> <li>No risk assessed at this time</li> <li>Previous history of violent behaviour</li> <li>Current physical aggression or violence</li> <li>Current verbal threats of physical violence</li> <li>Other:</li> </ul>

- 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** 

General Informatic	General				
Barriers to Commu	Information Given By		Surgery/Procedure Date/Location	Discharge Contact Name	
Allergies	Information Given by		Reviewed		
Vitals/Measureme	Patient		Procedure Location		
Advance Care Pla	Family     Community Care/Case Manager		Procedure Date/Time	Discharge Contact Phone(s)	
Past Medical Hist	Other:				
Patient Screening					
STOP BANG Ass			1		
Medication Histor	Barriers to Communication	Reason Un	able to Obtain Information	plastana Gastat Balatianski	
ID Risk Screen	O Yes	O None	O Physical impairment	Discharge Contact Relationship	
Violence and Agg	C No	C Clinical condi	tion	O Unable to obtain O Caregiver	
Social History		O Language ba	mer	O Spouse	
CAGE-AID Assess				O Daughter	
Nicotine Depende	Answer "Yes" if the patient has			C Family member	
Procedure History	language barriers, requires interpreter			O Parent	
Anesthesia/Sedat	support, or has sensory denets.			O Sibling	
Family History				O Significant other	
Pain Assessment					
Numeric Pain Sca					
FACES Pain Scale	Visitors/Family				
Transfusion Reac	Visitor/Family Information		Vicitor (Family Postrictions		
Morse Fall Risk			VISION/Failing Rescrictions		
Discharge Needs					
Skin Assessment					
PreProcedure Inst					
Program Note - S					

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

*Performed on: 1	3-Dec-2017 🚔 🔻 1157 🚔 P	ST									
General Informatic	Allergies										
Barriers to Commu	Allergies										
Allergies 1											
Vitals/Measureme	Mark All as Reviewed	Mark All as Reviewed 2									
Vitals/Measureme Advance Care Pla	Mark All as Reviewed 2					A11 C1	, Die	splay Mating			
Vitals/Measureme Advance Care Pla Past Medical Histo	Mark All as Reviewed 2	nown Allergies	No Known M	ledication Allergies	🔗 Reverse	e Allergy Chec	:k Dis	splay Active	•		
Vitals/Measureme Advance Care Pla Past Medical Hist Patient Screening	Mark All as Reviewed 2 Add Modify No Ki 3 D. Substance	nown Allergies	No Known M Severity	ledication Allergies	Reverse	e Allergy Chec Comments	:k Dis Source	Reaction Status	- Rev		
Vitals/Measureme Advance Care Pla Past Medical Hist Patient Screening STOP BANG Ass	Mark All as Reviewed 2 Add Modify No Ka D. Substance V penicillin	nown Allergies Category Drug	No Known M Severity Mild	Reaction Allergies	Reverse Interaction	e Allergy Chec Comments	k Dis Source Patient	Reaction Status	▼ Rev 13-		
Vitals/Measureme Advance Care Pla Past Medical Histo Patient Screening STOP BANG Asso Medication Histor	Mark All as Reviewed 2 Add Modify O No Ki D. Substance V penicillin	Category Drug	No Known M Severity Mild	Reactions Reactions Rash	Reverse	e Allergy Chec Comments	k Dis Source Patient	Reaction Status Active	• Rev 13-		
Vitals/Measureme Advance Care Pla Past Medical Histo Patient Screening STOP BANG Asso Medication Histor ID Risk Screen	Mark All as Reviewed 2 Add Modify O No Ki D. Substance V penicillin	nown Allergies Category Drug	No Known M Severity Mild	Reaction Allergies Reactions Rash	Reverse	e Allergy Chec Comments	k Dis Source Patient	Reaction Status Active	Rev 13-		

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 I**. The Add Allergy/Adverse Event window displays.

Allerge • An adverse read	for to a fing or rule ( ) Substance Search	
elve A fan ind	"Search affenive Statis with + Walking Termine Search in Name Search in Crute	All Centert
nordd See	restly Tamendage: [Alway, M/Itam All] [1] Tamendage Aas	*
	contentente Categories	
Page	New - Develop	
	6	
	Terming Terming As	OK. OKAANse Course
food Merges	Advanta Sandore (1000000) News Many Con-	
Jamon Dug Alleges		
	Add to Parentee	Canot

- 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.



STSNIKORKBOOK, REVEW (MRN 7000	00243) - Add Allergy/Adverse	Dffect		
po Adenge • An ad- ubstance Resive Sandage 🙀 - Free Ind action(d)	erre reaction to a drug or radiots No aderge checking is and "Serverity	nce which is due to an immur able to non-Multure allergies Info source	digical response.	Add Comment
Add Free Text	ind arised:	ind entends	Connerts	
	At out entered	Droet oral entered		
	Recorded on behall of	Category 1	Status Reasons	
		one 💌	Adhe •	2
Ap 🖾 Home 😒 Favorites * ood Alergies reinomental Alergies person Duca Alergies	Folders Folder: Fol	5e1		

- 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.

Alle	ergies									
Ma	ark All as Reviewed									
	L # 1				1				-	
P Ao	d 🛛 🖾 Modify 🔹 📿 No Knov	wn Allergies 🛛 🖓 🕅	No Known Me	edication Allergies	Reverse 🖉	e Allergy Cheo	:k	Display	Active	-
P Ac	dd 🛛 🖾 Modify 💭 No Know	wn Allergies 🛛 🖓 🕅	No Known Me	edication Allergies	Reverse	e Allergy Cheo	:k	Display	Active	•
P Ac	dd Modify ONo Know	wn Allergies	No Known Me Severity	edication Allergies Reactions	Reverse	e Allergy Cheo Comments	Source	Display	Active action Status	▼ Revi∈
D.	dd Modify No Knor Substance Adhesive Bandage	Wn Allergies	No Known Me Severity	edication Allergies Reactions	Reverse	e Allergy Cheo Comments	Source	Display Rea Act	Active action Status tive	• Revie 14-D
D	dd Modify No Know Substance Adhesive Bandage penicillin	WIN Allergies Category Category Other Drug	No Known Me Severity Moderate	edication Allergies Reactions	Reverse	e Allergy Cheo Comments	Source	Display Rea Ac	Active action Status tive tive	▼ Revie 14-D 14-D
D	dd Modify O No Knor Substance Adhesive Bandage penicillin	Category Other Drug	No Known Me Severity Moderate	edication Allergies	A Reverse	e Allergy Cheo Comments	Source	Display Rea Ac Ac	Active action Status tive tive	Revie 14-D 14-D



5 Completing Vitals/ Measurements/MEWS/PEWS Section

🗸 🖬 🔕 🖹 🛃 🔶	📾 🔝 🔛			
*Performed on: 23-Nov-201	7 🕂 💌 1359 🐥 PST			
General Informatic				
Barriers to Comm. Vita	l Signs			
Allergies	Temporal Artery	Oral	Tympanic	
Vtals/Measureme	DedC	DeaC	DecC	Following the completion of this
<ul> <li>Advance Care Pla</li> </ul>				section, please complete the Modified and Pediatric Early
Past Medical Histo	ohaes -			Warning Systems (MEWS/PEW) section as according
Patient Screening	Rectal	Axillary		sector or appropriate.
STOP BANG Aste	DegC	DegC		
Medication History				
<ul> <li>ID Risk Screen</li> </ul>	_			
<ul> <li>Volence and Agg</li> </ul>	Apical Heart Bate	Heart Rate Monitored	Peripheral Pulse Bate	
Social History Heat	Rate bpm	bpm	bpm	
CAGE-AID Assess				
Notine Depende				
Procedure History	Respiratory Rate	Mean Arterial Pressure	Systolic/ Diastolic BP	
Anesthesia/Sedat	br/min		meHg .	mnHg
Family History			· · · · · ·	
Pain Assessment	SP02	SP02 Site	F102	
Numeric Pain Sca	2	O Ear O Other		
FACES Pain Scale		C Foot		
Transfusion Read	Visit	C Hand		
Morse Fall Risk				
Discharge Needs	02 Flow Rate	02 Therapy		
Skin Assessment	0.000	Ambient coggen Nasal can	rula the mark	
PreProcedure Inst		Atticial airway	stra main.	
Progress Note - S		Biow-By T-Piece		
		Highflow Trach has	ik.	
Mea	isurements			
Dosin	g Weight	Source of Dosing Weight	Information Source	
	ko			

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

117 0					
eral informatic	Past Medical History, Problems and Diagnoses				
8		-			
Measureme	Mark all as Reviewed				
e Care Pla	Diamosis (Problem) being Addressed this Visit				
edical Histe		Most Recent Hospitaliz	ation(s)	D	Comment
creening		Hospitalization #1	ale	neason	Comment
NG Ass	Priority Annotated Display Condition Name Date Code Clinical Dx	Hospitalization #2			
n Histor		Hospitalization #3			
creen		Hospitalization #4			
and Agg	( )	Hospitalization #5			
tory					
D Assest	Problems				
Depende	💠 Add 🖆 Modify 🍒 Convert 🚯 No Chronic Problems 🛛 Display: All 🛛 🗸 🛄 🔎 IMO	-			
e History	Annelated Display Condition Name Onset Date Code Name of Problem A Life Cycle 9: 🚇 Classification				
a/Sedat					
tory					
ssment					
ain Sca					
ain Scale					
on Reac					
Del.					

 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.

#### Completing the Medication History Section

7

neral Informatic	Medication History					
riers to Commu						
rgies						🚭 Print 🛷 0 minut
als/Measureme	+ Add Ocument Medication by Hx Recor	nciliation 🕶 🛛 🔈 Check Inte	ractions			Reconciliation Status
vance Care Pla						U Meds History U Admission U Outp
st Medical Hist	View	Displayed: All Active Medi	cations, All Inactive Medications	24 Hrs Back		Show More 0
ient Screening	·· Orders for Signature					
OP BANG Ass	Medication List	Order N	lame Status	Dose Details		
dication Histor	Admit/Transfer/Discharge		No	orders currently me	et the specified filter criteria	L
Risk Screen	Patient Care					
ence and Agg	- Activity					
cial History	- Diet/Nutrition					
GE-AID Assest	Continuous Infusions     Medications					
otine Depende	Blood Products					
cedure History	- Laboratory					
esthesia/Sedat	Diagnostic Tests     Procedures					
nily History	Respiratory					
n Assessment	- Allied Health					
meric Pain Sca	Consults/Referrals					
CES Pain Scale	- Supplies					
nsfusion Reac	Non Categorized					
rse Fall Risk	Medication History					
charge Needs	Reconciliation History					
n Assessment						
Procedure Inst						
gress Note - S						
	Diagnoses & Problems	The Details				
	Related Results		[			
	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)





Note: the Reconcilation status for Meds History shows as incomplete

3. Click Add . 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



10	O color Manage	Challens	Dataila			Last Dava Data (Tr	and Information Course	ComeSue	Campliana Cam
	-7 Order Name	Medicati	Details	at wat have down	nonted Blassa decumos	Last Dose Date/11	ine information source	e Compian.	. Compliance Con
4 H	Iomo Medications	• medicati	on nistory has no	or yet been docum	nenteu. Flease documen	the metacation list	ory for this patient en	ounter.	
	acety/salicy/ic acid (A	Documen	1 tab PO odail	k, drug form; tabu	chew dispense at 31 tak				
A P	Pending Home Medicatic	in procuments	. 1 00, 10, 400	in, and retricted to	circit, and crise desires an				
	acetaminophen	Document	650 ma 20 at	h PRN nain-mild	or fever, order duration: 3		Patient	Taking as	
. D	utaily for acetamir	ophen							
E D	etails for <b>acetamir</b> Details ) IIII Order Comm	10phen	pliance						
	etails for <b>aCetamir</b> Details ) 📆 Order Comm	1 <b>ophen</b> 1nts 👮 Com	pliance	Information rou			art dore data/time		
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E D Stat	etails for <b>acelamir</b> Details )  Order Comm tus king as prescribed	1 <b>ophen</b> ents 🚰 Com	pliance	Information sou Patient	irce		Last dose date/time	•	a a
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State Con	etails for <b>aCetamin</b> Details ) Use for the community (the segment of the segmen	10phen ents 🚰 Com	pliance	Information sou Patient	rce	•	Last dose date/time	•	

- 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

8



Note: the Reconciliation Status changes to a Green checkmark.



1. Click Advance Care Planning section

Data entry details for Advance Care Planning:

• Advance Care Plan = No





**Completing the ID Risk Screen Section** 

2017-Aug-02	▼ 1424 ▼ <sup>FD1</sup>			
General Information	Infoctious Disease Piel	/ Scroon	ing	
Barriers to Communication	Infectious Disease Kisi	k Screen	ing	
	APO: Antibiotic Resistant Organisms including MP	PSA or VPE	MPCA: Mothicilin Pociet	ant Stanbulacoccus Aurous
Allergies	CPO: Carbapenemase-Producing Organisms	GA OF VICE	VRE: Vancomycin Resis	stant Enterococcus
Vital Signs and Measurements	Do you have any rick factors for ADOr?			
Advance Care Planning	bo you have any risk factors for AROS?			
Past Medical History, Problems, Diagn	None     Healthcare in Canada within the last year	Chemotherapy	within the last year	Household contact with known CPO in the last year Unable to obtain
Patient Screening History	Healthcare outside Canada within the last year	Incarceration	n the last year	
STOP BANG Assessment	Dialysis within the last year	Homelessnes:	or in shelter in the last year	
Medication History				
ID Risk Screen	Healthcare includes medical/surgical procedures,	overnight stays, o	hemotherapy, dialysis, or	other care specified by organizational practices.
Violence and Appression Screening	If any risk is identified for AROs, the patien	nt may need AR	) screening swabs to be	e ordered and performed. Please refer to site-specif
Social History	guidelines to determine which tests heed t	o be completed.		
CACE AID Assessment	In what facility and/or country did this h	ealthcare risk f	actor occur? When die	d this take place?
CAGE-AID Assessment				
Nicotine Dependence Assessment				
Procedure History				
Anesthesia/Sedation	Have you as a household member travel			
Family History	outside of Canada within the last 30 days	s?	Location of Recei	nt Travel
Pain Assessment				Do . Diving .
Numeric/FACES Pain Scale Adult	Yes, patient     Yes, bousehold member		Africa-Central	Caribbean     Griphean     Griphean
Transfusion Reaction	C Yes, patient and household member		Africa-East	Central America South America
	No		Africa-South	🗖 China 🔲 United States
Morse Fall Risk	O Unable to obtain		Africa-West	Eastern Europe Western Europe
ADLs and DC Needs			🔲 Asia	🔲 India 📃 Other:
Skin Risk			Australia/New Zeala	and L Mexico
PreProcedure Instructions				
Progress Note - Simple	Risk Factors and Symptoms/ARO Surveil	ance		Unable to Obtain Current Visit Informatio
		Yes No	Unable to obtain	None Physical impairment
	*Fever	×		Clinical condition No parents
	*Diarrhea	×		Cognitive impairment
	*Headache	×		Language barrier
	*Photophobia	×		Patient's age
	*Illness With Generalized Rash	×		
	*New or Worsening Cough	×		
	*Recent Exposure to Communicable Disease			Communicable Disease Exposed To:
	*Recent Exposure to Communicable Disease *History of AROs	X		Communicable Disease Exposed To:
	*Recent Exposure to Communicable Disease *History of AROs *History of CPO	×		Communicable Disease Exposed To:

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

*Performed on: 2017-Aug-02	<ul> <li>▼ 1424</li> <li>PDT</li> </ul>	
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     Durrent verbal threats of physical violence	
Patient Screening History	0 Other:	
STOP BANG Assessment		
Medication History	If patient has a previous history of or su	ment indication of violence or someories, complete the remainder of the form or applicable
/ ID Risk Screen	If patient has a previous history of or cu	interior indication of violence or aggression, complete the remainder of the form as applicable.
Volence and Aggression Screening	Current Patient Presentation	Current Presentation Additional Information

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

#### **Completing the Perioperative Preprocedure Checklist**

1

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).

Perioperative Pr	eprocedure Checklist - CSTSNWC	RKBOOK, REVIEW					
🖌 🖬 🛇 🖹	5 🛧 🕈 📾 🖺 🗎						
*Performed on: 0	8-Dec-2017 🗦 💌 1212	PST *					
Patient Preparatio     Preop Preprocedu	Patient Prepa	ration					
Valuables/Belong	Procedure Location	Can Last Fluid and Last Food Intake be Obtained?	Last Fluid Intake Amount	Patien Applie	t External V d	Warming Devic	De
Progress Note - 5	O Operating room	O Yes	mL	O Yes	0	N/A	
	C Cardiac Cath Lab	O Unable to obtain	Last Oral Intake Type	Nasal I	Decolonizat	ion	
	C Radiology	La de Challanda da	O Clear liquid	O Yes	0	N/A	
	O Bedside O Other:		<ul> <li>Full liquid (other than breast milk)</li> <li>Solid food</li> </ul>	Preop	Carbohydra	ate Drink	
		Last Food Intake		O HS			
				O N/A			
			Dro Transfusion Tosting Comple	tod			
			Prior to Current Hospital Admis	sion			
			O Yes O No				
	If "Use" is "Current" for	Last Bowel Movement	16				
	or Tobacco on Social	H,R0,000	patient has been transfused/pregnan	t. Order a ST	AT Group and	d Screen.	nces
	date/time of last use.	Alcohol Last Use	Has the patient been pregnant	Has the	e patient be	en transfuse	d with
		1,11,111	in the past 90 days?	red cell	ls or platele	ts in the past	: 90 days?
		Tobacco Last Use	O Yes	O Yes			
		85,865,0008	O N/A	O No O N/A			
		Recreational Drug Last Use					
		H,00,000 A	Preon Site Pren				
	Is there a possibility the	e		AM	HS	N/A	
	D Yes O No		2% Chlorhexidine Wipes				
	Cites Cites		Wash with Chlorhexidine Solution				
	Hair Removal	Bowel Prep Completed	Wash With Soap				
	Clipper     No hair removal performed     Other:	O Yes O No O N/A					

1. Click the Patient Preparation section.

Data entry details for Patient Population:

- 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

Last Fluid	Intake	
**_***_***		-
Last Food	Intake	
**_***_***		-

**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



Preprocedure Patient Verification         Yes       No       N/A       Comment         Di Band on and Verified       X       I       I         Allergy Visual Cue Present       X       I       I         Allergy Visual Cue Present       X       I       I         Ster Verified by Patient/Family       X       I       I         Surgical Marking Verified by RN       I       I       I         Surgical Site/Side Marked by Surgeon       X       I       I         Surgical Consent Complete       I       I       I         Blood/Blood Products Consent Complete       I       I       I       I         Diod/Blood Products Refusal Complete       I       I       I       I       Comment         Blood/Plood Products Refusal Complete       I       I       I       Comment       Comment         Urited Products Refusal Record       Yes       No       N/A       Comment       Capilian         Current ECG in Medical Record       I       I       I       Comment       Capilian         Relevant Images in Medical Record       I       I       I       Capilian         Vital Signs, Height & Weight Documented       I       I <thi< th=""> <thi< th=""><th>Preop Preprocedure</th><th>Check</th><th>dist</th><th></th><th></th><th></th></thi<></thi<>	Preop Preprocedure	Check	dist			
YCL       No       N/A       Comment         ID Band on and Veified       X       ID Band on and Veified       X         ID Band on and Veified       X       ID Band on and Veified       X         Bitery Visual Cue Present       X       ID Band on and Veified by Patient/Family       X         Star Veified by Patient/Family       X       ID Band on and Veified by Patient/Family       X         Surgical Making Veified by BN       X       ID Band on and Veified by Patient/Family       X       ID Band on and Veified by Patient/Family         Patient Consents       Yes       No       N/A       Comment       ID Band on and Veified by Surgeon X         Patient Consents       Yes       No       N/A       Comment       ID Band Ondots Consent Complete         Blood/Blood Products Consent Complete       ID I	Preprocedure Patient Verification					
ID Band on and Verified       x         Allergy Visual Cue Present       x         Site Verified by Patient/Family       x         Surgical Marking Verified by RN       x         Surgical Marking Verified by RN       x         Surgical Star/Side Marked by Surgeon       x         Patient Consents       x         Surgical Consent Complete       x         Blood/Blood Products Consent Complete       x         Blood/Blood Products Consent Complete       x         Procedure Consent Complete       x         Video/Photography Consent Complete       x         Current ECG in Medical Record       x         Review       Yes       No         Current H&P in Medical Record       x         Review of Labs       x       x         Capillary       Xespith & Weight Documented       x         Vital Signz, Height & Weight Documented       x       x         Procedure of Advance Care Plan/DNR Order       x       x         Procendure of Advance Care Plan/DNR Order       x       x         Nore       X       x       x	s	Yes	No	N/A	Comment	
Allergy Visual Cue Present       X         Site Vonified by Patient/Family       X         Surgical Marking Verified by RN       X         Surgical Marking Verified by Surgeon       X         Surgical Site/Side Marked by Surgeon       X         Patient Consents       X         Surgical Consent Complete       X         Blood/Blood Products Consent Complete       X         Blood/Blood Products Refueal Complete       X         Video/Photography Consent Complete       X         Current ECG in Medical Record       X         Current HaP in Medical Record       X         Review of Labs       X         Capillargy Blood Blocose Done       X         Vital Sign, Height & Weight Documented       X         Current Group & Screen Confirmed       X         Precoy Medications Administreed       X	ID Band on and Verified	x				
Site Verified by Patient/Family     X       Surgical Marking Verified by RN     X       Surgical Site/Side Marked by Surgeon     X       Patient Consents       Patient Consents       Surgical Consent Complete     No       Blood/Blood Products Consent Complete     Image: Star Side Side Side Side Side Side Side Side	Allergy Visual Cue Present	×				
Surgical Marking Verified by RN       ×	Site Verified by Patient/Family	x				
Yes       No       N/A       Comment         Sugical Consents	Surgical Marking Verified by RN	×				
Patient Consents         Yes       No       N/A       Conment         Surgical Consent Complete       Image: Consent Complete       Image: Consent Complete       Image: Consent Complete         Blood/Blood Products Consent Complete       Image: Consent Complete       Image: Consent Complete       Image: Consent Complete         Procedure Consent Complete       Image: Consent Complete       Image: Consent Complete       Image: Consent Complete         Video/Photography Consent Complete       Image: Consent Complete       Image: Consent Complete       Image: Consent Complete         Current ECG in Medical Record       Image: Consent Complete       Image: Consent Consent: Consent: Consent Consent: Consent: Consent: Consent: Consent: Consent: Consent:	Surgical Site/Side Marked by Surgeon	×				
Yes       No       N/A       Comment         Surgical Consent Complete       Image: Comment       Image: Comment       Image: Comment         Blood/Blood Products Refusal Complete       Image: Comment       Image: Comment       Image: Comment         Blood/Blood Products Refusal Complete       Image: Comment       Image: Complete       Image: Comment       Image: Comment         Blood/Blood Products Refusal Complete       Image: Comment       Image: Comment       Image: Comment       Image: Comment       Capillary         Video/Photography Consent Complete       Image: Comment       Image: Comment       Capillary       Capillary         Current ECG in Medical Record       Image: Image	Patient Consents					
Surgical Consent Complete       Image: Consent Complete         Blood/Blood Products Consent Complete       Image: Consent Complete         Blood/Blood Products Refusal Complete       Image: Consent Complete         Video/Photography Consent Complete       Image: Consent Complete         Video/Photography Consent Complete       Image: Consent Complete         Video/Photography Consent Complete       Image: Consent Complete         Current ECG in Medical Record       Image: Consent Complete         Current H&P in Medical Record       Image: Consent Complete         Current H&P in Medical Record       Image: Consent Complete         Capillary       Image: Consent Complete         Vital Signs, Height & Weight Documented       Image: Consent Confirmed         Current Medications Administered       Image: Consent Confirmed         Presp Medications Administered       Image: Consent Confirmed		Yes	No	N/A	Comment	
Blood/Blood Products Consent Complete       Image: Complete State St	Surgical Consent Complete					
Blood/Blood Products Refusal Complete       Image: Complete       Complete       Image: Complete       Complete       Image: Complete       Complet	Blood/Blood Products Consent Complete					
Procedure Consent Complete       Video/Photography Consent Complete         Video/Photography Consent Complete       Video/Photography Consent Complete         Chart Review       Yez       No       N/A       Comment       Capillary Glucose         Current ECG in Medical Record       Yez       No       N/A       Comment       Capillary Glucose         Current H&P in Medical Record       Capillary       Capillary Glucose       Capillary Glucose       Capillary Glucose       Capillary Glucose       Capillary Glucose         Vital Signs, Height & Weight Documented         Capillary Glucose       Capillary Glucose       Capillary Glucose         Current Group & Screen Confismed          Norr Norr Norr       Norr         Presence of Advance Care Flan/DNR Order          Norr         Current Medications Administered         Norr       Norr	Blood/Blood Products Refusal Complete					
Yideo/Photography Consent Complete       Capillary         Chart Review       Yes       No       N/A       Comment       Capillary         Current ECG in Medical Record         Glucose	Procedure Consent Complete					
Chart Review  Current ECG in Medical Record Current HLP in Medical Record Current HLP in Medical Record Review of Labs Capillary Vital Signs, Height & Weight Documented Current Group & Screen Confirmed Presence of Advance Care Flan/DNB Order Current Medications Administreed	Video/Photography Consent Complete					
Yez         No         N/A         Conneed         Capillary Glucose           Current ECG in Medical Record           Glucose         Glucose         Glucose         Residential         Glucose	Chart Review					
Current ECG in Medical Record       Capiliary         Current H&P in Medical Record       Relevant Images in Medical Record         Relevant Images in Medical Record       Capiliary         Review of Labs       Capiliary         Capillary Bood Glucose Done       Capillary         Vital Signs, Height & Weight Documented       Capillary         Current Group & Scaren Confismed       Confismed         Presence of Advance Care Plan/DNR Order       Noner         Current Medications Administered       Noner		Yes	No	N/A	Comment	
Current H&P in Medical Record     Result       Relevant Images in Medical Record     Result       Review of Labs     Capillary       Capillary Blood Glacose Done     Capillary       Vital Signar, Height & Weight Documented     Glacose       Current Group & Screen Confirmed     O Norr       Presence of Advance Care Plan/DNR Order     O Norr       Current Medications Reviewed     O Norr	Current ECG in Medical Record					Glucose Nume
Relevant Images in Medical Record       Capital         Review of Labs       Capital         Capitary Blood Glucose Done       Capital         Vital Signs, Height & Weight Documented       Capitary         Current Group & Screen Confirmed       mumerix         Presence of Advance Care Plan/DNB Drder       None         Current Medications Administered       None	Current H&P in Medical Record					Result
Review of Labs     Capillary       Capillary Blood Glucose Done     Capillary       Vital Signs, Height & Weight Documented     Glucose       Current Group & Screen Confirmed     Image: Screen Confirmed       Presence of Advance Care Plan/DNR Drder     Image: Screen Confirmed       Current Medications Administered     Image: Screen Confirmed	Relevant Images in Medical Record					m
Capillary Blood Glucose Done     Capillary       Vital Signs, Height & Weight Documented     Glucose numeric       Current Group & Sciene Confirmed     Onor       Presence of Advance Care Plan/DNR Drder     O Norr       Current Medications Reviewed     Onor	Review of Labs					
Vital Signs, Height & Weight Documented Glucose numeric Current Group & Screen Confirmed Current Group & Screen Confirmed Control Cont	Capillary Blood Glucose Done					Capillary Bloo
Current Group & Screen Confirmed Presence of Advance Care Plan/DNB Order Current Medications Reviewed Preop Medications Administered	Vital Signs, Height & Weight Documented					Glucose Non-
Presence of Advance Care Plan/DNR Drder Current Medications Reviewed Preop Medications Administered	Current Group & Screen Confirmed					numeric Resu
Current Medications Reviewed O None Preop Medications Administered	Presence of Advance Care Plan/DNR Orde	r				O Non-numeric
Preop Medications Adminstered	Current Medications Reviewed					O Non-numeric
	Preop Medications Adminstered					

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

Data entry details for Preop PreProcedure Checklist:

- 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.



*Performed on: 2	4-Nov-2017	▼ 1443 🌻 PS	т			
Patient Preparatio	Valuab	les/Belon	gings			
Preop Preproced. Valuables/Belong	Does patient have any valuables/belongings with them?		Patient instructon Patient instructon Patient instructor	ed to send all items hom sonal assistive devices?	Special circumstances including unconscious/incapacitated patients,	
Progress Note - 5	O Yes O No		O Yes; Items sent h O Yes; Pt unwilling, O No; special circur	ame with relative or friend or unable to send items home with instance	patients coming for day surgery. If patient unwiling or unable to send items home with relative or friend, ensure that patient has signed a "waiver of responsibility for valuables" form.	
	Belongings Se	ent Home With	Belongings Labeled	Does patien contraband	t have any s with them?	Contrabands Removed as per Policy
			O Yes O Other:	O Yes O No		O Yes O Other:
	Contrabands					
		Description		Number of Items	Sent to	
	Contraband					
	Does the pat	ient have any	List any hospital equ the patient	ipment that has been loa	aned to	Has the hospital equipment been returned?
	home medica	uons with them?				
	home medica O Yes O No	dons with them?				O N/A O Yes O Other:
	home medical	tions				O N/A O Yes O Other:
	home medica	tions Medication N	lame/Route	Home	Medications Sen	N/A Ves Othe:
	home medica O Yes No Home Medica Medication #1	tions Medication N	lame/Route	Home	Medications Sen	N/A O Yes O Other:
	home medica O Yes No Home Medica Medication #1 Medication #2	tions Medication N	lame/Route	Home (Alpha (Alpha	Medications Sen	C N/A C Yes O Other:
	home medica C Yes O No Home Medica Medication #1 Medication #2 Medication #3	tions Medication N	łame/Route	H ame Alpha Alpha Alpha	Medications Sen D D	NAA C Yes O Other:
	home medica C Yes No Home Medica Medication #1 Medication #3 Medication #4	tions Medication N	lame/Route	Hom cAbh cAbh cAbh cAbh	Medications Sen D D D D D	NAA Yes Other:
	home medica C Yes No Home Medica Medication #1 Medication #3 Medication #4 Medication #4	tions Medication N	lame/Route	Hom CAbh CAbh CAbh CAbh CAbh	Medications Sen ຍ ຍ ຍ ຍ	N/A Yes Othe:
	home medica Yes No Home Medication #1 Medication #2 Medication #3 Medication #5 Medication #6	tions Medication N	lame/Route	Home CAbh CAbh CAbh CAbh CAbh CAbh	Medications Sen ย ย ย ย ย ย	C NA Yes O Other:

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

< 🖂 🛉 Perioperative Summary		🗇 Full screen 👘 Print 🕹 0 minutes
🗚 🐘   🗮 🐘   🔍 🔍   100% 🔹   🖝 🖓		
Preop Summary 🔯 Intraop Summary S	Postop Summary 22 Quick Orders 22 Hando	f Tool 🛛 🗧 + 💽 🗧 🕞 🦯 🗉
Procedural Information	PowerForms (0) 💠 🐱 🚍 🗸	Preoperative Checklist 🔤 🗸 🤇
	Vital Signs 🖕 🚽 🚍 🚍 👘	Selected visit
Allergies (0) 🌪 =	Selected visit	Consents 🚜 🗘
All VISITS	No results found	ECG
	Labs	ID Verification
Diagnoses	Selected visit	Site Verification 🖌 🗘
Enlosted visit		

- 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.

💮 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.

TProcess Alert			
Medical Record Number: 700008243	Encounter Number:	Last Name: CSTSNWORKBOOK	First Name: REVIEW
Middle Name:	Preferred Name:	Previous Last Name: CSTSNWORKBOOK	Date of Birth: 30-Oct-1963
Age: 54Y	Gender: Male	BC PHN: 9876429433	
— ALERTS — Process Alert: From Available:	Ta	o Selected:	
Gender Sensitivity No Ceiling Lift On Research Study Palliative Flag Seizure Precautions	Move >     Select All		
Special Care Plan	·		
			Complete
Ready	PR	DDBC TEST.PERIONURSETEA	MLEAD 08-Dec-2017 16:26

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



#### **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:

Menu 7	< - 🕈 Orders			🗇 Full screen 🛛 👼 Print 🛛 🗞 18 minutes ag
Patient Summary	+ Add   @ Document Medication b	y Hx   Reconciliation •   🚴 Check Interactions		Reconciliation Status
Orders + Add	Orders Mudication List Deserved	In Dian		Meds History Hadmission Discharge
1 Patient Task List	orders Medication List Document	in Pian		
MAR	K	Disalana di Ali Astrino Gadero I. Ali Astrino Gadero		Chana Maran Gadana
Interactive View and I&O	View Orders for Signature	Displayed, All Active Orders 1 All Active Orders		Show more bruers.
Results Review	Plans	l 🖓 📴 🦻 Order Name ▲	Status Dose	Details
Documentation + Add	Document In Plan 🗉	4 Medications		
Medication Request	Medical	Turosemide	Ordered	20 mg, IV, as directed, order duration: 5 day, drug form: inj, start: 1/-Nov Administer pre red blood cell transfusion
(Estate)	- IM Ked Blood Cell (KBC)	⊿ Blood Products		
Plistones	- Suggested Plans (0)	4 🗹 🖻 😚 🛛 Red Blood Cell Transfusion	Ordered	Routine, Administer: 1 unit, IV, once, Administer each over: 120 - 180 Mi
Allergies 🕂 Add	Admit/Transfer/Dircharg			Informed consent must be present on patient record
Diagnoses and Problems	Status	Laboratory	Ordered	Blood Routine Collection: 17-Nov-2017 14:48 PST once
	Patient Care	Con the letter of the broup and screen	Oldeled	biodd, Roddine, Collection: 17-1409-2017 14:46 P31, once *
	A set inter			· · · · · · · · · · · · · · · · · · ·

- 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:

- 66 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:

S	7	Order Name	▼	Status	 Dose	Details
Status						
		MEWS Alert		Processing		
	<b>&gt;</b>	Code Status		Ordered		30-Nov-2017 09:41 PST, Attempt CPR, Full Code, Perioperative status: Attempt CPR, Full Code, Du.
Patient	Care					
	<b>*</b>	Weight		Ordered		30-Nov-2017 09:41 PST, Stop: 30-Nov-2017 09:41 PST, On admission, standing weight is preferred
		Vital Signs		Ordered		06-Dec-2017 12:51 PST, q4h
		Pulse Oximetry	·	Ordered		30-Nov-2017 09:41 PST, q8h, with vital signs
	<b>*</b>	Negative Press	ure Wound Therapy	Ordered		30-Nov-2017 09:26 PST, 125 mmHq, Pressure interval: Continuous, Filler: Black Foam, Dressing ch.,
	2	Morse Fall Risk	Assessment	Ordered		17-Nov-2017 14:17 PST, Stop: 17-Nov-2017 14:17 PST
						Order entered secondary to inpatient admission.
		Intensive Care	Delirium Screening Checklist (ICDSC)	Ordered		05-Dec-2017 12:00 PST, BID, To be done at 0600 and 1600 and as needed.

- 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.

CCTCANNOR/POOK REVIEW DORRAD-Oct-1063 MRN/200008243 Code Status: Drorass:Seizura Process/Seizura Process/Seizura	
COTONWORKDOOK, REVIEW DODDO COLOD CO	
Age:54 years Enc:7000000026309 Disease: Enc Type#Pre-Day Surgery	
Allergies: Adhesive Bandage Gender:Male PHN:9876429433 Dosing Wt: Isolation: AttendingPlisvcc, Trevor, MD	
Menu ? < > - ↑ Orders (0) full screen (0) Phil	t 🛛 🍣 3 minutes ago
Perioperative Summary + Add   @ Document Medication by Hx   Reconciliation *   @ Check Interactions Reconciliation *	
Perioperative Doc	ission 😈 Discharge
Orders 1 + Add Orders Documentin Plan	
MAR	
MAR Summary View VIEW V Component Status Dose Details	*
Interactive View and J&O Plane A MIS Pre Operative (Day of Surgery) (Validated) (Planned)	
Document in Pan Last updated on 00-Dec: 2017 17:02 PST by: TestUser. Anesthesiologist-Physician. MD 3	
Form Browser Education Contraction and Carl and	
ANES Pre Operative (Day of Surgery) (Validate) (Planned) GERSING General, Box Comparis, Diversity (Validate) (Planned) General, Diversity (Validate) (Planned) GERSING General, Box Comparis, Diversity (Validate) (Planned) General, Box Comparis, Diversity (Validate) (Planned) General, Diversity (Val	
Celebon de deserrar e la constance de la	
Allegies Aug Antesthesia Care Unit (PACU) (prototype) (Planned) 4 Patient Care	
Diagnoses and Problems ANES Respiratory Depression (Module) (validated) (Planned) 🔽 💭 Insert Peripheral IV Catheter 🔽 20 qauge needle	
RESP Continuous Positive Airway Pressure (CPAP) and Positive A Communication Order Prepare Fluid warming cartridge in IV line	E
CareConnect Suggested Plans (0)	
Chaird Berearch	
Comment occurred Comment and Comme	
Documentation + Ad Patient Care / Continuous Infusions	
Immunications Solution Solutio	
Lines/Dubss/Drains Symmaxy Det/Nutrition order rate: 75 mL/h, IV, drug form: bag	
Continuous Infusions	
Medication Kequest	
Patient Information Clinical event of the month of the mo	ignt nepari
Reference Claboratory Claborat	
Diagnostic Tests Diagnostic Tests S00 mg, PO, 90 min pre-op, drug form: tab	
Procedures ISO mg, PO, 90 min pre-op, drug form: tab	
Respiratory II patient has taken, on day of surgery, a proton pump inhibitor or ranitidine, do not administer	
The second secon	
Balated Benults	
Forman Datik	
Variance Viewer Orders For Conjonature   Orders For Nutre Review   Save as My Eavorte   4 💱 Initiate	Diders For Signature

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.

Add	ctions		✓ Meds History ④ Admission ④
Orders Document In Plan			
H	4 1 % 🛇 🕂 Add to Pha	se . A Check Alerts A Comments Start: Now	Duration: None
View	9 17 Camera	D Ordering Physician	Date Date
Orders for Signature	Pre-Op	*Physician name	DOSE UPDAINS
Document In Plan	⊿ Patient Care	Pisvci, Brooks, MD	
ANTE De Orientine (Der of Committee) (Directo)	🗹 🚺 Insert P		✓ 20 gauge needle
ANES Pre Operative (Day of Surgery) (Validated) (Planned)	C Commi	*Order Date/Time	Prepare Fluid warming cartridge in IV line
GENSURG General - Pre Operative (Day of Surgery) (Validated) (Planned)	Provide	09-Jan-2018 👘 💌 1550 👘 PST	Apply to patient on admission
Suggested Plans (0)	🗖 🖸 POC GI		once, notify treating provider if blood glucose is LESS than 3.6 mmol/L or GREATER than 10 mmol/L
Orders	⊿ Diet/Nutrition	*Communication type	
Admit/Transfer/Discharge	P D NPO	Phone	Except for Medications
Status	4 Continuous Infusions	Verbal	
Patient Care	🗹 🚺 sodium	No Cosignature Required	order rate: 75 mL/h, IV, drug form: bag
- Activity	🗖 🚺 plasma	Cosignature Required	order rate: 75 mL/h, IV, drug form: bag
Diet/Nutrition	dextros	Paper/Fax	order rate: 75 mL/h, IV, drug form: bag
Continuous Infusions	⊿ Medications	Electronic	
Medications	F Dold M		Clinical event: On the morning of procedure, Medication(s) to be held: heparin or low molecular weight heparin, Instru
Blood Products	🗹 🚺 acetam	OK Cancel	<ul> <li>975 mg, PO, 90 min pre-op, drug form: tab</li> <li>Maximum acetaminophen 4a/24 h from all sources</li> </ul>
Laboratory		10	500 ma PO 90 min pre-on dua form tab
Diagnostic Tests	₽ 17 ranitidi	0e	150 ma PO 90 min pre-op dua form tab
Procedures			If patient has taken, on day of surgery, a proton pump inhibitor or ranitidine, do not adminster
Respiratory	metock	opramide	10 mg, PO, 90 min pre-op, drug form; tab
Allied Health	Salbuta	mol	2.5 mg, nebulized, 30 min pre-op, drug form; neb
Consults/Referrals	LORaze	pam (LORazepam sublingual PRN range dose)	dose range: 0.5 to 1 mg, sublingual, 30 min pre-op, PRN anxiety, drug form: tab May repeat dose x 1 if initial dose ineffective
Supplies	⊿ Laboratory		
Non Categorized	INR 🖸 INR		Blood, STAT, Collection: T;N, once
Medication History	Differer	itial (CBC and Differential)	Blood, STAT, Collection: T;N, once
- Medication History Snapshot	🗹 🖬 🚺 Basic M	letabolic Panel (Lytes, Urea, Creat, Gluc)	Blood, STAT, Collection: T;N, once
Reconciliation History	⊿ Diagnostic Tests		
	Electron	ardiogram 12 Lead STAT	Reason: Pre-operative evaluation
Related Results	T Details		
Formulary Details			
Variance Viewer	Orders For Cosignature	Inders For Nurse Review Save as My Favorite	Tinitate Ordens For

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

CSTSHWORKBOOK, REVIEW - 70000243 C	upened by Testuser, Wurse Learnicead-Penoperative								
ask Edit View Patient Chart Link	ks Options Current Add Help								
erioperative Tracking	🎍 Patient List Dynamic Case Tracking 🔛 Pref Card P	icklist 💹 Case	Selection #	Time-Critical Procedures	Day of Surgery View	Historical View	Learning	LIVE CareConnect Q PHSA PACS Q VI	CH and PHC PACS Q MUSE Q FormFast WFI
Tear Off a Exit WAdHoc III Medicat	tion Administration 🔒 PM Conversation 🔹 🗔 Commu	inicate = (1) M	edical Recon	d Request + Add - # Scheo	luling Appointment Bool	Document	Staff As	ssion 😺 Preference Card Maintenance 着 Report	rt Builder 🖨 Discern Reporting Portal 🛍 Report Manager 😋 Aware
2 Patient Health Education Materials 🔞 Po	olicies and Guidelines 🕲 UpToDate								
STSNWORKBOOK, REVIEW			-						- List - Marcent + Name - C
STSNWORKBOOK, REVIEW	DOB:30-Oct-1963	MRN:700008	248	Code Status:				Seizure Precautions	Location:LGH SDCC: SDCC Wait; 04
And the second second second second	Age:54 years	Enc:70000000	16309				Disease		Enc Type:Pre-Day Surgery
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teractive View and I&O	iers for signature	ń A	NES Pre Ope	trative (Day of Surgery) (Valid	lated) (Initiated Pendin	0			
De Deuiseur	ocument In Plan	L	ist updated	on: 08-Dec-2017 17:02 PST	by: TestUser, Anesthes	ologist-Physicia	n. MD		
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a a a a a a a a a a a a a a a a a a a	ANES Pre Operative (Day of Surgery) (Validated) (In	nitiated	6	Restricted to Department of	Anesthesiology				
istories	GENSURG General - Pre Operative (Day of Surgery) (Valid	dated) (P	\$	Pre-Op Nurse to discontinue	the PAC (Pre Anesthesia	Clinic) plan			
llergies 🕂 Add	ANES Post Ameritaria Care Unit (PACII) (notothing) (Pla	dated) (#	C. Commercia	Pre-Op Nurse to initiate the i	Pre Operative (Day of Su	gery) plan			
lagnoses and Problems	ANES Respiratory Depression (Module) (validated) (Pla	inned)	E Datient Ca	Insert Peripheral IV Catheter		Order		▼ 08-Dec-2017 17:09 PST. 20 gauge needle	
	RESP Continuous Positive Airway Pressure (CPAP) and P	ositive A	Č	Communication Order				Prepare Fluid warming cartridge in IV line	
Sug	gested Plans (0)	- C	1 6	Provide Forced Air Warmer				Apply to patient on admission	
© Orde	es	C	C (	POC Glucose Whole Blood				once, notify treating provider if blood glucos	se is LESS than 3.6 mmol/L or GREATER than 10 mmol/L
Inical Research	Admit/Transfer/Discharge	1	Diet/Nutri	tion NOO				Freedow Manhattana	
ocumentation 🕂 Add	Status		Continuo	a lafurings				Except for Medications	
amunizations.	Patient Care		C.	adium chloride 0.9% (sodiu	im chloride 0.9% (NS) co	n		order rate: 75 mL/h. IV. drug form: bag	
and has been been a	Dist/Netrition	C	1 C	plasmalyte (plasmalyte cont	inuous infusion)			order rate: 75 mL/h, IV, drug form: bag	
	Continuous Infusions		C (2	dextrose 5%-sodium chlorid	e 0.45% (deitrose 5%-so	l		order rate: 75 mL/h, IV, drug form: bag	
edication Request	Medications		Medicatio	NS		0.1.		00 D	and the second sec
itient Information	Blood Products	1		exateminophen		urder		075 ms PO 90 min pre-so dout form tab	e morning of procedure, medication(s) to be held: heparin of low
derence	Laboratory			, accommodation				<ul> <li>Maximum acetaminophen 4g/24 h from all s</li> </ul>	sources
	Diagnostic Tests	E	6	naproxen				500 mg, PO, 90 min pre-op, drug form: tab	
	Procedures	0	1 0	3 ranitidine				150 mg, PO, 90 min pre-op, drug form: tab	
	Mispiratory Allied Mealth			· materia and a second second				If patient has taken, on day of surgery, a prot	ton pump inhibitor or ranitidine, do not administer
			. ¥	metocograniide				10 mg, PO, 90 mm pre-op, drug form: tab	
	Related Results		Details						
	Formulary Details								
	Variance Viewer		Driders For Co	lignature   Orders For Nurse Re	Save as My Favo	ite .			Statiste Orders For Signature
			Douarth	ant Occasions for TextUres. Ann	etheriologist.				

7. Click Orders For Signature.

STSNWORKBOOK, REVIE	W 🛛								- List -> Mane - Q
STSNWORKBOOK, REVIE	W DO	8:30-Oct-1963 M	RN:70000	8243	Code Status:			Process:Seizure Precautions	Location:LGH SDCC; SDCC Wait; 04
lloraior: Adhorivo Bandago	Age	:54 years En	IC:700000	0016309	Doring W/t			Disease: Irolation:	Enc Type:Pre-Day Surgery Attending:Plicace Traver MD
Manu 3	A X A Ordere		114.507.04	29433	Dosing We			150180011	Bull crean Chint 27 minuter and
ning and a Community	N I H Olders								
enoperative summary	🕂 Add   🥼 Document Medicatio	n by Hx   Reconciliation •   🚴	Check Inte	eractions					Meds History     Admission     Discharge
erioperative Doc	Orders Document In Plan								- ,
Orders 🕂 Add									
IAR		12	M	2 0 B P	Order Name	Status	Start	Details	
AR Summary	Orders for Signature	view		⊿ LGH SDCC; SD	CC Wait; 04 Enc:70000	00016309			
teractive View and I&O	Plans		n.	2 ratient Care	Insert Perinheral IV Ca	Order	08-Dec-2017 17:09	08-Dec-2017 17:09 PST 20 gauge peedle	
esults Review	Document In Plan			⊿ Communicatio	n Orders			to bet tot this i bi, to quade neede	
				<del>()</del> 🕫	Hold Medication(s)	Order	08-Dec-2017 17:09	08-Dec-2017 17:09 PST, Clinical event: On the morn	ing of procedure, Medication(s) to be held: heparin or low molecular weight heparin, Instr
onn browser	ANES Pre Operative (D	y of Surgery) (Validated) (Initia	ited I						
istories	-GENSURG General - Pre Op	erative (Day of Surgery) (Validate	d) (P						
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ference	2 Laboratory								
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	Procedures								
	Respiratory								
	Allied Health								
	Rela	ed Results		▲ Details					
	Form	ulary Details	1						
	Varia	nce Viewer	1	0 Missing Required	Details Orders For Cosi	gnature 0	Irders For Nurse Review	]	Sign

- 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**.



Jecisio	1 Support: Preop-Nurse, Frankie - 70000078				- 0 <b></b>
The new or	der has created the following alerts:				
ceFAZo	in 🖬 🕫				
Aller	IY (1)	An an ann			
Severity	Substance	Reaction Type	T	Override Reason	
۲	penicilins	Rash	1	Provider/Clinici	an aware and mon 👻
			_		
				Denvider/Clini	cian aware and monito
			2	Patient airead	tolerating
				Previously rec	erved this drug family
				Administration Non-immuno	n altered to minimize h- logic reaction or toxicit
				Pharmacokine Therapeutical	tic monitoring in place
Size Colum	nns to Window		Apply to all interactions	<type n<="" other="" td=""><td>tason here&gt;</td></type>	tason here>
			Apply only to required interactions		3
			Preop-Nurse, Frankie - 760000078	Continue	Remove New Order

- 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)

#### Review the iView layout:

1

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.



<b>K</b> ii		04-Dec-2017	
	15:33 PST	Change Column Date/Time	X :22 IST
⊿ Peripheral IV		04-Dec-2017 🊔 🔻 100	DOI 🍦 PST
⊿ Peripheral Forearm Left 20 gauge			
Activity Activity			Insert
Patient Identified			Identificati
Total Number of Attempts			In Error

- 1. The time column will be the current time. Click the **Insert Date/Time** icon **bu**.
- 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.

mergreen mitergreen meterse	oendermale	11110000420400	booning the
Menu P	< 🔹 📩 🦍 Interactive View and I&O		
Perioperative Summary	🖦 🔜 🖽 🎶 🖌 🗭 🍯 🔛 📰 🎘 🗙		
Perioperative Doc			
Orders 🗕 🕂 Add	Veriop Quick View	•	
	🗙 Periop Systems Assessment		
MAR	🗙 Periop Safety Departure	Find Item	
MAR Summary	Veriop Lines-Devices	Result	Comments Flag
Interactive View and I&O	Peripheral IV		
Results Review	IV Drips Arterial Line		08-Dec-2017 13:10 PST
Form Browser	Central Line	⊿ Peripheral IV	
Histories	Pain Modalities		
Allergies 🕂 Add			
Diagnoses and Problems			

- 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.



(	P Dynamic Group - CSTSNWORKBOOK, REVIEW - 700008243
008243 000016309 5429433	Label: Peripheral Antecubital Right 18 gauge
Find Item Result A Active A Active C ⊕ Site A Dress Dress Dress Patier	Peripheral IV Catheter Type: Peripheral IV Site: Peripheral IV Site: Peripheral IV Site: Peripheral IV Site: Peripheral IV Site: Digit External Jugular Foot Forearm Frontal vein Great saphenous vein Head Median cubital vein Posterior auricular vein Superificial temporal vein Upper am Wrist Peripheral IV Laterality:  Median 4 OK Cancel

- 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

🗙 Periop Quick View			
🗙 Periop Systems Assessment			
🗙 Periop Safety Departure	Find Item 🔻 [	🗖 Critical 🔲 High 🔲 Low 🔲 Al	bno
🗙 Periop Lines-Devices	Result	Comments Flag	Date
Peripheral IV			
IV Drips Arterial Line Central Line Arteriovenous Fistula/Graft Pain Modalities	<ul> <li>✓ Peripheral IV</li> <li>✓ Peripheral Antecubit</li> <li>✓ Activity</li> <li>Line Status</li> <li>Line Care</li> <li>✓ Site Assessment</li> <li>Site Care</li> <li>Dressing Activity</li> <li>Dressing Condition</li> <li>Patient Response</li> </ul>	08-Dec-2017         13:15 PST         Image: Second	

- 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  $\bigotimes$  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

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

1

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.



STSNWORKBOOK, REVI	W 🛛					
STSNWORKBOOK, REVI	EW	DOB:30-Oct-1963 Age:54 years	MRN:700008243 Enc:7000000016	309	Code Status:	
llergies: Adhesive Bandage	(	Gender:Male	PHN:987642943	3	Dosing Wt:	
Menu <sup>‡</sup>	< > 🕣 者 MAR					
Perioperative Summary	*16 66' 📄					
Perioperative Doc						71 1 071
Drders 🕂 Add	All Medications (System)	▼				Thursday, 07-
MAR	Show All Rate Change Doce	J Medication	15	08-Dec-2017	08-Dec-2017	
MAR Summary	Time View	Unscheduled		18:00 P31	17:26 P31	
nteractive View and I&O	Scheduled	ceFAZolin		2,000 mg Not previously		
Results Review	Unscheduled	2,000 mg, IV, pre-op, admin minute drug form; bag, sta	ister over: 15 rt: 08-Dec-2017	given		
<sup>2</sup> orm Browser	PRN	18:00 PST, bag volume (mL): For weight between 80 to 1	50 20 kg Administe			
Histories	Continuous Infusions	ceFAZolin	zo kg. Administer		_	_
Allergies 🕂 Add	🗹 Future	Continuous Infusions			Pending	
Diagnoses and Problems	Discontinued Scheduled	sodium chloride 0.9% (NS)	continuous infus		Not previously	
	Discontinued Unscheduled	hour, drug form: bag, start:	08-Dec-2017 17:27			
CareConnect	Discontinued PRN	(mL): 1,000	o PSI, dag Volume			
Clinical Research	Discontinued Continuous Ir	nfus Administration Information sodium chloride 0.9%				
Documentation 🛛 🕂 Add						
mmunizations						
.ines/Tubes/Drains Summary						

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 **Medication** Administration button from the tool bar at the top of the page.

CSTSNIMADEBOAR DEVIEW	MRN- 700008243	DOB: 30.0ct 1963	Loc: SDCC Wait: 0
Male	FIN#: 700000016309	Age: 54 years	Allergies
Aite	Please scar rnatively, select the patient	the patient's wristband. profile manually by clicking the (Next) button.	

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

		Scheduled	Mnemonic	Details	Result
	<del>ک</del> ب <sup>11</sup> س	Unscheduled	cefazolin	2,000 mg, IV, pre-op, administer over: 15	
			ceFAZolin	For weight between 80 to 120 kg. Admini	
~	😣 📴 📲	Continuous	Sodium Chloride 0.9%	order rate: 100 mL/h, IV, order durati	1,000 mL, IV, 100 mL/h, <site>_</site>
			sodium chloride 0.9%		· · · · · · · · · · · · · · · · · · ·



- 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 <sup>3</sup> icon and another charting window will open for the sodium chloride 0.9% (NS) continuous infusion 1,000mL

Medication Administration					
ĺ	P Charting for: CSTSNWOR	KBOOK, REVIEW			ast Refresh at 17:30 PST
CSTSNWORKBOO Male	sodium chloride 0.9% (N order rate: 100 mL/h, IV, orde bag volume (mL): 1,000	<b>VS) continuous infusion 1,</b> r duration: 24 hour, drug form	<b>000 mL</b> bag, start: 08-Dec-2017 17:27 F	ST, stop: 09-Dec-2017 17:26 PST,	oc: SDCC Wait; 04 ** Allergies *
Schedule ि ेत्र छि? 🔁 Unschedu	Ves No sodiu	ım chloride 0.9% (NS) continu	ous infusion 1,000 mL	Change	
🗹 😒 📴 Continuo	*Performed date / time :	08-Dec-2017	734 PST	Comment	1, <site></site>
	*Performed by :	TestUser, NurseTeamLead-Perio	perative 🔍		
	Witnessed by :				
	*Bag # :	1			
	*Site :				
	*Volume (mL) :	<show all=""> Antecubital Fossa - Left</show>			
	*Rate (mL/h) :	Antecubital Fossa - Right Arm, Lower - Left			
		Arm, Lower - Right			
		Arm, Upper - Left Arm, Upper - Right			
		Chest, Anterior - Left		Begin Bag	
		Chest, Anterior - Right Foot - Left		OK Cancel	
		Foot - Right			
		Groin - Left	2 of 2		Back Sign
		Arm, Upper - Right Chest, Anterior - Left Chest, Anterior - Right Foot - Left Foot - Right Groin - Left Groin - Left	2 of 2	Begin Bag	Back Sign

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

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

< > - 者 MAR				
**** 🖻				
All Medications (System)	▼			Thurse
Show All Rate Change Docu	Medications	08-Dec-2017 18:00 PST	08-Dec-2017 17:37 PST	08-Dec-2017 17:36 PST
Time View	Unscheduled			
🗹 Scheduled	ेन्न 🔚 ceFAZolin	2,000 mg Not previously		
Unscheduled	2,000 mg, IV, pre-op, administer over: 15 minute, drug form: bag, start: 08-Dec-2017	given		
PRN	18:00 PST, bag volume (mL): 50 For weight between 80 to 120 kg. Administe			
Continuous Infusions	ceFAZolin			
👿 Future	Continuous Infusions			1
Discontinued Scheduled	sodium chloride 0.9% (NS) continuous infus		×	
Discontinued Unscheduled	hour, drug form: bag, start: 08-Dec-2017 17:27		Complete	
Discontinued PRN	(mL): 1,000			
👿 Discontinued Continuous Infus	Administration Information			Begin Bag 1,0
	sodium chloride 0.9%			

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.

CSTSNWORKBOOK, REVIE	EW 🗵							
CSTSNWORKBOOK, REVI	EW	DOB:30-Oct-1963	MRN:700	008243	Code Status:			
		Age:54 years	Enc:7000	000016309				
Allergies: Adhesive Bandage		Gender:Male	PHN:9876	5429433	Dosing Wt:			
Menu <sup>‡</sup>	< > 🝷 者 Inte	eractive View and I&O						
Perioperative Summary	** 🖃 🖌 😢 🗶 🧃							
Perioperative Doc								
Orders 🕂 Add	Veriop Quick View			<ul> <li>▲</li> </ul>		Thu	ırsday, 07-C	Dece
MAR	Periop Systems Ass	essment		Today's Intake	e 0 mL Output: 0 mL B	alance: 0 mL	Yestero	lay's
MAR Summan/	Periop Salety Depair     A Periop Lines Devis			<b>PR</b> 1011				
Interactive View and I&O	V Intake And Output	5				17:00 - 17:59 PST	16:00 - 16:59 PST	1 15
Interactive view and iceo	Intake			⊿ Intake Total				
Results Review	Continuous Infusio	ons		⊿ Continuous	s Infusions			
Form Browser	Medications			<b>1</b>				
Histories	Chest Tubes			continuous	oride 0.9% (NS) infusion 1.000 mL m	ıL		
-	Enteral GLTubo			⊿ Oral				
Allergies 🛨 Add	GLOstomy Intake			Oral Intake	m	۱L		
Diagnoses and Problems	Urinary Diversion	Intake		⊿ Output Total				
	Oral			⊿ Stool Output	ut			
	Other Intake Sour	ces		Stool Coun	t (Number of Stools)			
CareConnect	Negative Pressure	e Wound Therapy	=	⊿ Urine Outp	ut			
Clinical Research	Surgical Drain, Tu	ibe Inputs		Urine Voide	ed m	nL		_
	Transfusions				Baland	e		_
Documentation 🛛 🕂 Add	Urinary Catheter,	Intake						
Immunizations	Pre-Arrival Fluid							
Lines/Tubes/Drains Summary	Blood Output							
	Chest Tube Output	.t						
Medication Request	Continuous Rena	Replacement Therapy						
Patient Information	Emesis Output GLTube							
Reference	GI Ostomy Output							

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.

🗙 Adult Quick View	Sunday, 03-December-2017 06:00 PST - Wednesday, 06-December-20	17 05:59 PST
🗙 Adult Systems Assessment	Today's Intake: 1000 mL Output: 0 mL Balance: 1000 mL Yesterday's Intake: 0 mL Out	tput: 0 mL Baland
X Adult Lines - Devices	04 Dec 2017	
X Adult Education	10:00 - 09:00 - 08:00 - 07:00 - 06:00 -	24 Hour Night
Second Product Administration	10:59 PST 09:59 PST 08:59 PST 07:59 PST 06:59 PST	Total To
🗙 Intake And Output	⊿ Intake Total	
📋 Intake 🔺	△ Continuous Infusions	
Continuous Infusions	sodium chloride 0.9% (NS) continuous infusion 1.000 ml mL 75 75 75	
Medications	⊿ Oral	
Chest Tubes	Oral Intake mL	
Enteral	△ Other Intake Sources	
Glube	△ Negative Pressure Wound Therapy	
Gi Ostomy Intake	⊿ Surgical Drain, Tube Inputs	
	⊿ Output Total	
Other Intaka Seurean	⊿ GI Tube 💀 🛛 🖉 🖉 🖉 🖉	ck
Negative Pressure Wound Therapy	⊿ Gastrostomy (G) tube Left upper	1e
Advanced Cranbing	Output mL bourdy volume of th	
Auvanceu Graphing	Irrigant Out mL nourly volume of the	
Restraint and Seclusion	Residual Discarded mL CONTINUOUS INTUSIO	n
Verocedural Sedation	⊿ Other Output Sources Will populate	
Ambulatory Infusion Center Monitoring	△ Negative Pressure Wound Therapy	
Ambulatory Nursing Procedures	⊿ Stool Output	
	Stool Count (Number of Stools)	

- 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

al Messag	e Centre 🤵 Patient List Dynamic Ca Il Medication Administration 🔓 PM (	ise Tracking 📷 Pref Card Picklist 📦 Case Selection 🕴 Conversation + 🚘 Communicate + 🗟 Medical Reco	n Inne-Critical Procedures 👫 D rd Request 🕂 Add 🗸 🖻 Schedu	ay of Surgery View 💼 Historical View 📸 LearningLIVE ing Appointment Book 👅 Documents 📸 Staff Assign	: 🛫 : 😨 CareConnect 😨 PHSA PACS 😨 VCH n 🛞 Preference Card Maintenance 🖀 Report Bi	and PHC I uilder 📾
tion Mater	ials 🔞 Policies and Guidelines 🔇 U	pToDate 🛫				
ς, revie	W 🗵					
(, REVI	EW DOB	P Medication Administration			- • •	Lo
t Record	ed Gen	CETENIMORYPOOK DEVIEW	MRN- 700008243	DOB: 30-Oct.1963	Loc: SDCC Wait: 04	Att
4	< 🔹 🖌 者 Perioperative	Male	FIN#: 700000016309	Age: 54 years	** Allergies Not Recorded **	
·	A 100%					
<b></b>	Preop Summary					×
T Add	Procedural Information					t
	Allergies (0) 🔶					
	All Visits					
	No results found					
	Diagnoses					
- Add	Selected visit		Please scan	the patient's wristband.		
	No results found	Alt	matively, select the patient	profile manually by clicking the (Next) button.		1)
	Problems					
	All Visits					
🕂 Add	Classification: All					
	Problem					
nary	This Visit (0)					
						a
	△ Chronic (1)			1 of 2	Next	-
	Focal seizures	Ready to Scan			Next	
	Historical (0)	IShow Previous Vi	sits Administered (0) Lost	54 kausa	Operating Room	

1. Review medication information in the MAR and identify medications that are due. Click

Medication Administration Wizard (MAW)

- 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.



Medication Administra	tion			
CSTSNWORKB	OOK, REVIEW	MRN: 700008243 FIN#: 700000016	DOB: 30-Oct-1963 LOC: SDCC 3309 Age: 54 years	Wait; 0
ceFAZolin 2,000 mg, IV, pre-op, ad For weight between 80	minister over: 15 minute, dru to 120 kg. Administer in pre-	g form: bag, start: 08-De op area / operating roon	c-2017 18:00 PST, bag volume (mL): 50 1	
erformed ate/Time :	08-Dec-2017 1741 F	ST	Diluent: <pre> mL</pre>	
erformed By :	TestUser, NurseTea	mLead-Perioperative	Total Volume : 50 Infused Over : 15 minute -	
FAZolin :	2,000 mg		◆ 08-Dec-2017 08-	
oute :	IV		<ul> <li>50</li> <li>↓</li> <li>↓</li> <li>↓</li> </ul>	
adv to Scan			3 of 3 Back	Sign

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

Medications (System)	· ·			Thursday
Show All Rate Change Docu	Medications	08-Dec-2017 17:44 PST	08-Dec-2017 17:37 PST	08-Dec-2017 17:36 PST
Time View	Unscheduled			
Scheduled	ceFAZolin	~		
Unscheduled	2,000 mg, IV, pre-op, administer over: 15 minute, drug form: bag, start: 08-Dec-2017	Complete		
PRN	18:00 PST, bag volume (mL): 50 For weight between 80 to 120 kg. Administe			
Continuous Infusions	ceFAZolin			
Future	Continuous Infusions			
Discontinued Scheduled	sodium chloride 0.9% (NS) continuous infus		×	
Discontinued Unscheduled	hour, drug form: bag, start: 08-Dec-2017 17:27		Complete	
Discontinued PRN	PST, stop: 09-Dec-2017 17:26 PST, bag volume (mL): 1,000			
Discontinued Continuous Infus	Administration Information			Begin Bag 1,000
	sodium chloride 0.9%			

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

Medications 🕂	≡• 🤞
Selected visit	
⊿ Scheduled (0)	
∠ Continuous (1)	
sodium chloride 0.9% (NS) continuous infusion 1,000 mL 100 mL/h, IV, Stop: 09 17:26 PST	-Dec-2017
⊿ PRN/Unscheduled Available (0)	
⊿ Administered (2) Last 24 hours	
ceFAZolin	
sodium chloride 0.9% (NS) continuous infusion 1,000 mL	
⊿ Suspended (0)	
Discontinued (0) Last 24 hours	



## 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

CSTSNWORKBOOK, REVI	EW ×				
Perioperative Tracking					
SGH Intraop LGH Endo PreOp	SGH Phase I SGH Phase II SGH Ph	LGH ASC Phase II LGH ASC PreOp LGH Pref Card LGH Family	LGH MTR IntraOn LGH	Case Communication LGH OB View gency List LGH Intraop LGH Phase I	SGH OB View LGH ECT SGH C LGH Phase II SGH Pref Card
Filter: LGH Preop Today	🔹   🔯 🍓   🚘 🌼 🚺   Total Cases: 4				
Status	Sched. Start Start Stop	Add Pt. Type CK Iso Alerts	Allergy Patient	Age Procedure	Surgeon PreOp Nurse
LGHOR GRV (1 c	ase) 07-Dec-2017 09:30 10:57 09:30:00 10:57	Day Surgery	CSTPRODBCSN, ANESTHESIA	47 years "Right Hernia Inguinal"	Hunter, J
LGHOR KC (1 cas	CSTSNWORKBOOK, REVIEW	Pre-Day Suri		54 years "Repair Right Hernia Inguinal"	Plisvow, T
LGHOR SEY (1 ca	Scheduling Appointment Book Periop Document Manager Surgical Case Check-In	Pre-Day Sur	CSTPRODBCSN, BRITTANI	47 years "Colposcopy"	Hunter, J
LGHOR WHS (1 o	Staff Assign Mass Checkout	Day Surgery	CSTEDHARDY, TOM	53 years "repair hemia inguinal"	Plisvcd, M
	SurgiNet Rules Update Anticipated OR Open Patient Chart				

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.

🛞 c	ase Tra	acking	Set Events						
Name:         CSTSNWORKBOOK R           OR:         LGHOR LON           Procedure:         Repair Hernia Inguinal			STSNWORKBOOK R HOR LON epair Hernia Inguinal	Surg Start Time: Surgeon: Case #:	08:20 Plisvcw, Tyler, MD LGHOR-2017-1708		Anesthesiologist: Anes. Type:	Defer to Anesthesia	
Status Case Cart Alerts Isolation PostOb Phone Call 3	Bumped Patient/No Show	Phase IPhase II IntraOp PreOp PAC Location PAC	Case CX Day of Surgery Delay Block Needed Block Ready Pt. in Block Room Image: Ready for Surgery Transport to OR	Case #:	IGHOR 2017-1708	Locked Icon	Name Pt. in Wait Pt in Pre(	ina Room In	
NPC								ОК	Cancel

- 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.

Menu 🖗	< > 🔸 🏦 Perioperative Summary	🗇 Full screen 🛛 Print 🛛 🗞 20 minutes ago
Perioperative Summary		
Perioperative Doc	Prono Summary 52 Intraon Summary 52 Poston Summary 52 Handoff Tool 53 Ouick Orders 52 Discharge	
Orders 🕂 Add		
MAR	Informal Team	<b>⊅</b>   <b>∩</b>
MAR Summary	Communication	
Interactive View and 18:0	Add new action Add new comment	
Results Review	Allergies (0)	E
Form Browser	Vital Signs and Measurements No actions documented No comments documented	
Histories	Documents (3) All Teams All Teams	
A.U	Transfer/Transport/Accompan	

- 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.

Preop Summary S	I 12	Intraop Summary 🛛	3	Postop Summary	23	Handoff Tool	X
Informal Team Communication	1	Informal Team Communi	ica	ation			
Active Issues		Patient requesting preop sedative.		1			
Allergies (0)							
Vital Signs and Measurements							221 characters left
Documents (3)				E	🖌 Avai	lable to All Sav	re Cancel

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

Preop Summary S	23	Intraop Summary 🛛	3 Postop Summary	23	Handoff Tool	23	Qu	uick Orders	Discharge	- 23		•	$\square$
Informal Team Communication		Informal Team Communi	lication									æ	=-
Active Issues		Add new action						Patient likes to be called Ren					
Allergies (0)													
Vital Signs and Measurements		Patient requesting preop sedal	ative										
Documents (3)		TestSX, Nurse-Perioperative 11/12	2/17 11:56										
Transfer/Transport/Accompan iment (0)		All Teams									970 chara	cters left	
Assessments										Available to All	Save	Cancel	

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.



Add new action		
1		
Dationt requesting proop code	tivo	

## 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)

#### Set Event Transport to OR

1

CSTSNWORKBOOK, REVIEW	N ×				
Perioperative Tracking					
SGH Intraop SGH LGH Endo PreOp	GH Phase I SGH Phase II SGH Phase I GH Endo PostOp LGH EAO	LGH ASC Phase II LGH ASC PreOp LGH Pref Card LGH Family	LGH MTR IntraOn LGH C	Case Communication LGH OB View SG ency List LGH Intraop LGH Phase I	H OB View LGH ECT SGH C
Filter: LGH Preop Today	🔹   🔯 🔞   🝰 🄶 🚺   Total Cases: 4				
Status	Sched. Start Start Stop	Add Pt. Type CK Iso Alerts	Allergy Patient	Age Procedure	Surgeon PreOp Nurse
LGHOR GRV (1 cas	Se) 07-Dec-2017 09:30 10:57 09:30:00 10:57	Day Surgery	CSTPRODBCSN, ANESTHESIA	47 years "Right Hernia Inguinal"	Hunter, J
LGHOR KC (1 case	CSTSNWORKBOOK, REVIEW	Pre-Day Suri	CSTSNWORKBOOK, REVIEW	54 years "Repair Right Hernia Inguinal"	Plisvcw, T
LGHOR SEY (1 cas	Scheduling Appointment Book Periop Document Manager Surgical Case Checks In	Pre-Day Sur	CSTPRODBCSN, BRITTANI	47 years "Colposcopy"	Hunter, J
LGHOR WHS (1 ca	Staff Assign Mass Checkout	Day Surgery	CSTEDHARDY, TOM	53 years "repair hemia inguinal"	Plisvcd, M
	SurgiNet Rules Update Anticipated OR Open Patient Chart +				
	Set Events				

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.



# **b** End of Workbook

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