SELF-GUIDED PRACTICE WORKBOOK [N31]
CST Transformational Learning

WORKBOOK TITLE:

Provider: Anesthesia (Workbook #1)

Last update: April 10, 2018 (v2)

CLINICAL + SYSTEMS TRANSFORMATION
Our path to smarter, seamless care

TRANSFORMATIONAL LEARNING

TABLE OF CONTENTS

SELF-GUIDED PRACTICE WORKBOOK

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

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 1 – Pre-Operative Patient (Pre-Op)

Learning Objectives

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

- Access a patient's chart and review patient care information
- Place and manage admission orders
- Complete patient admission and medication reconciliation
- Document patient care

SCENARIO

A 54 year old male patient has an inguinal hernia. He meets with a General Surgeon and is scheduled for an elective right inguinal hernia repair. He is booked for a Nurse and Anesthesia PAC Appointment. He attends his PAC appointment and is determined fit for surgery.

NOTE: This workbook will only address pre-operative and post-operative aspects of the chart. SA Anesthesia (Workbook #2) will address the intra-operative documentation for Anesthesiologists.

As an Anesthesiologist you will complete the following 7 activities:

- Perioperative Tracking and Review the Patient Chart
- Review Allergies
- Review Best Possible Medication History (BPMH)
- Place an Anesthesia pre-operative PowerPlan
- Update Anesthesiologist Workflow for problems, active issues and indications for procedures
- Completing an Anesthesia Consult Quick Chart
- Completing an Anesthesia Consult Note

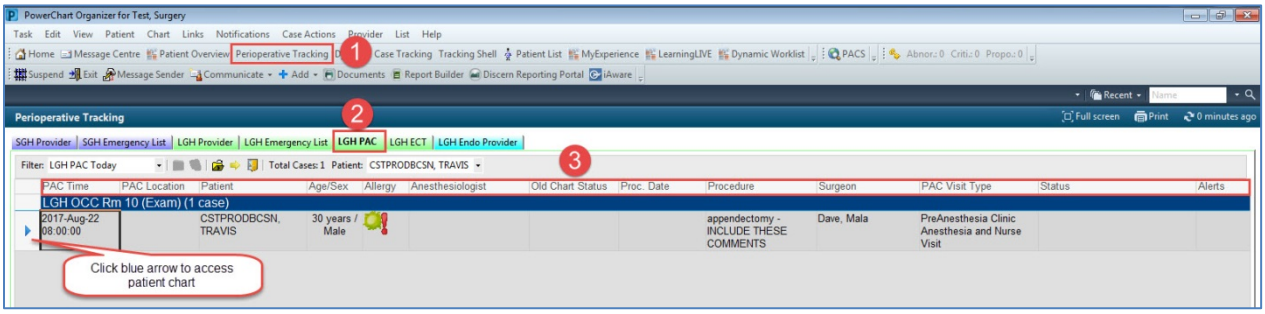
Activity 1.1 – Perioperative Tracking and Reviewing the Patient Chart

1 Access Patient Chart

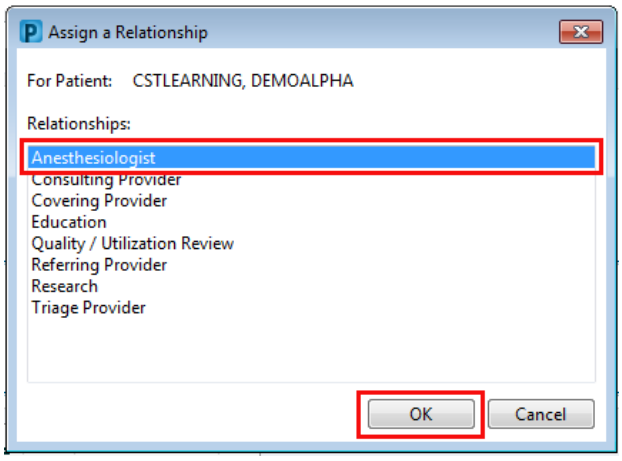
Accessing patient chart using the patient list through Perioperative Tracking tool is the recommended way to access patient charts. This ensures that the correct encounter is chosen for the patient. Perioperative Tracking is the equivalent of a slate with real-time updates on current status.

To access the Perioperative Tracking view:

1. Click on the **Perioperative Tracking** located in the toolbar.
2. Click on the **LGH PAC** view.
3. Click on the **blue arrow** beside Patient A to access the patient chart.



4. You will need to establish a relationship with your patient in order to view patient chart
   - Select **Anesthesiologist**
   - Click **OK**

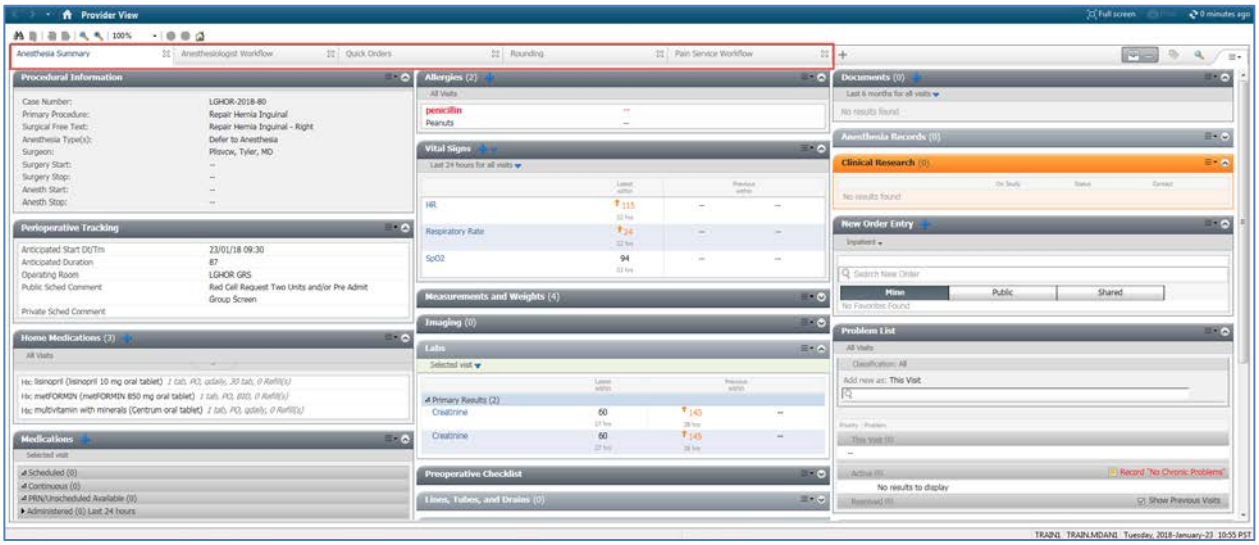


NOTE: If you established a relationship with your patient prior to this event, you will view patient chart directly and will not be asked to establish a relationship.

2 Review of Patient Chart

The patient's chart opens to the **Provider View** which is your current default screen when accessing a patient's chart. It is organized into several tabs. Each tab is designed to support a specific workflow.

Click each tab to open this view.

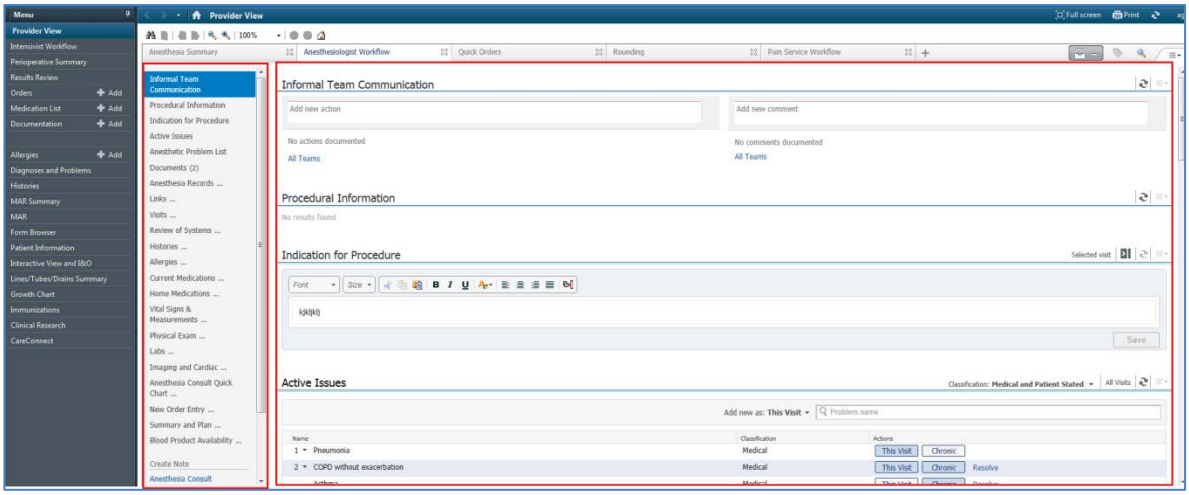


The **Banner Bar** located at the top of the screen displays demographic data, alerts, information about patient's location, and current encounter.

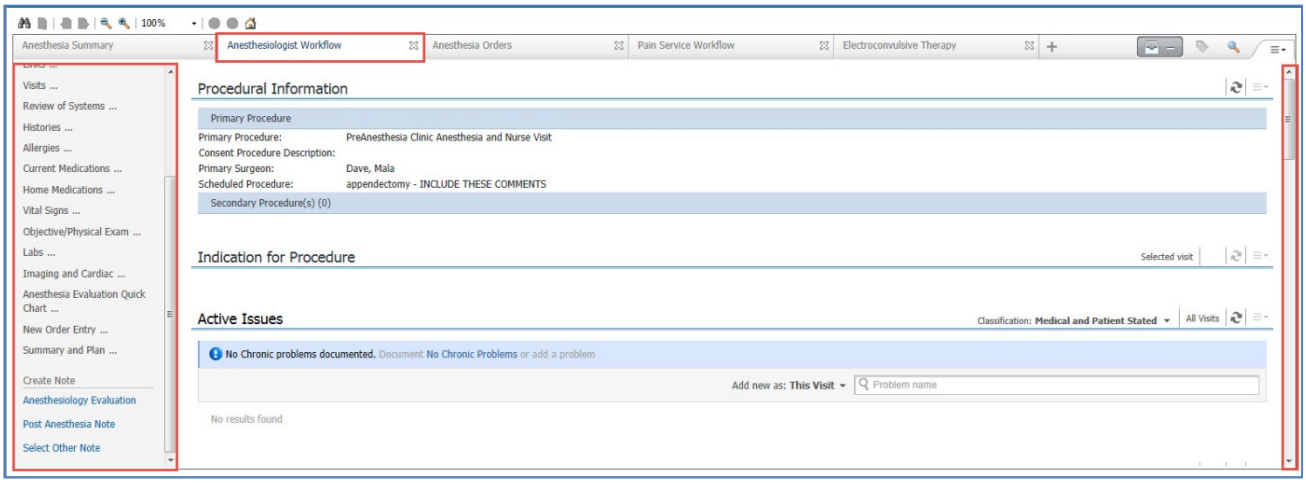
Click the **Refresh** icon to ensure that your display is up-to-date. A timer shows how long ago the information on your screen was last updated.

REMEMBER: Refresh frequently!

Open the **Anesthesiologist Workflow** tab to start.



On the left side of the screen there is a list of components representing workflow steps specific for your specialty. Click the component or use the scroll bar to display the content of patient's chart.



NOTE: Components listed in each view are designed to meet the needs of each workflow.

Each component has a heading. Place the cursor over the heading. This icon means it is a link. Click this heading to open a comprehensive window with more options.

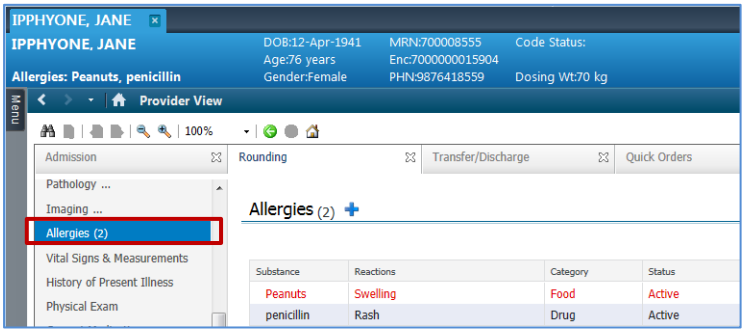
Key Learning Points

- Workflow views include specific components that are designed to meet the needs of each workflow
- Anesthesiologist Summary provides an overall review of the patient's chart
- Anesthesiologist workflow allows you to review and document in the patient chart
- **REMEMBER** to click the **Refresh** icon  often to ensure that your display is up-to-date.

Activity 1.2 Review Allergies

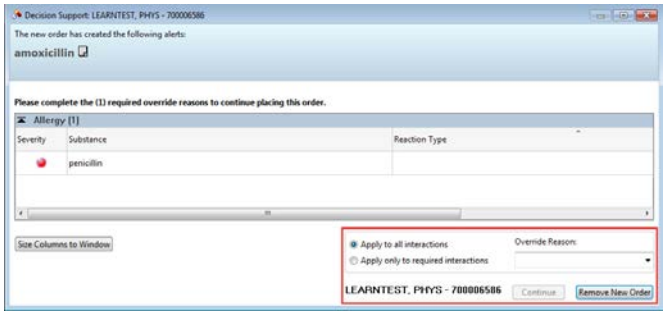
In the Clinical Information System (CIS), a patient's allergies are **to be reviewed** by a provider on admission and at every transition of care. Allergy information is carried forward from one patient visit to the next.

Patient allergies can be added and updated in the **Allergies** component.

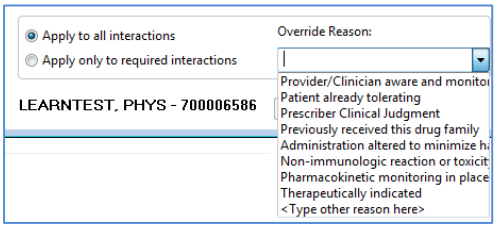


The CIS keeps **track of the allergy** status and will automatically prompt you when the information is not up-to-date. When placing an order with allergy contraindication, an alert will display as displayed below.

NOTE: If not contraindication is present, this screen will not appear.



You can either remove the order and select another medication, or continue with the order by overriding the alert and documenting the reason:

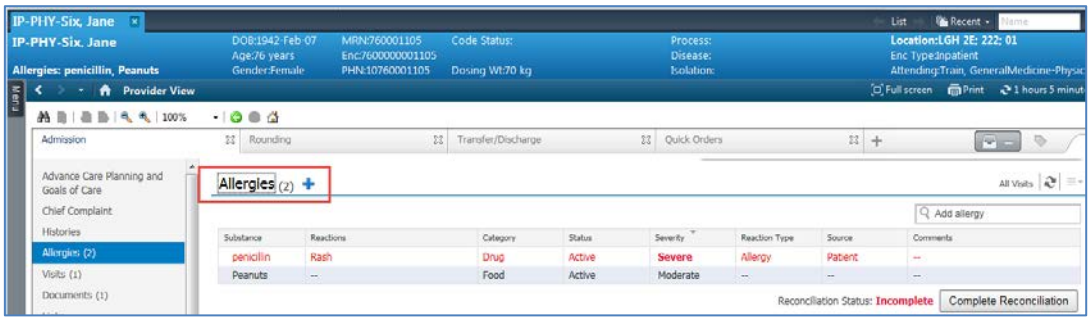


The CIS will also **track allergy-to-drug interactions**.

In this activity you will:

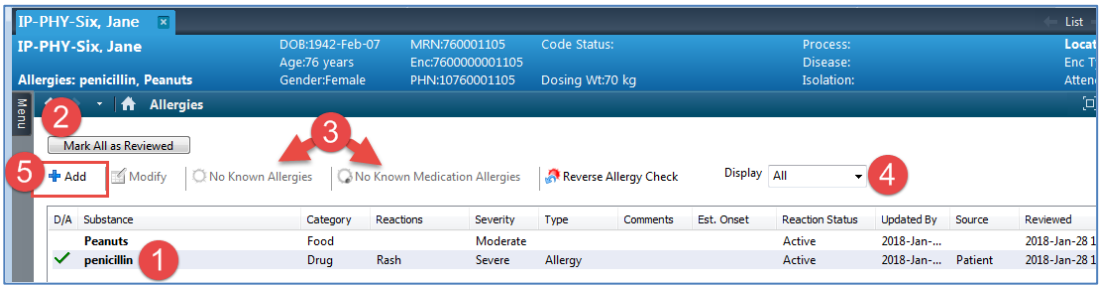
- Add a new allergy
- Modify the existing allergy record

1 In order for the pharmacy to dispense a medication, the allergy record must be reviewed for the current encounter. Click the **Allergies** heading to add a new allergy.



2 The **Allergies** window displays a comprehensive table with patient allergies:

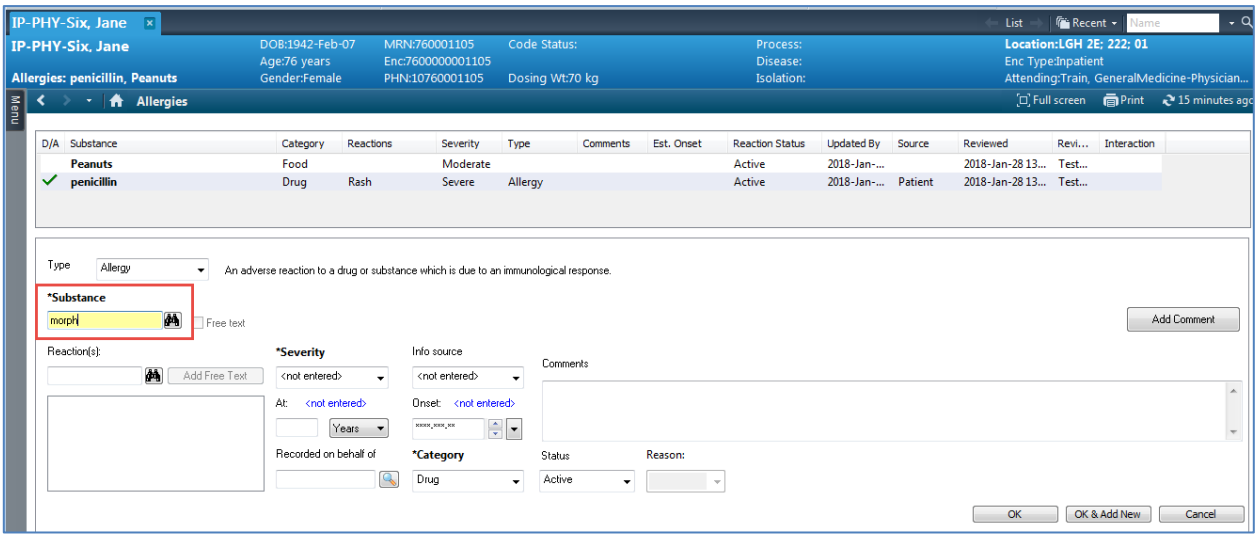
1. A green checkmark indicates a drug allergy.
2. If the record is complete and no changes required, click **Mark All as Reviewed** to complete the review.
3. When there is no information available, you can use other the toolbar options:
   - No Known Allergies
   - No Known Medication Allergies
4. Click the arrow to select viewing All records or filtering only Active or Inactive
5. To add a new allergy, click the Add icon on the toolbar.



3 You can enter new allergy below the allergies list.

NOTE: All mandatory boxes have yellow background such as Substance and are marked with an asterisk. Yellow background disappears when a default entry populates the mandatory box, for example Category = Drug.

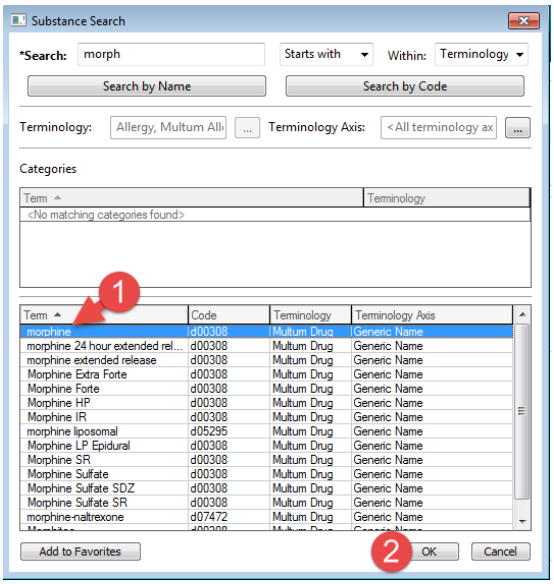
1. Type *morph* in the **Substance** box and click to execute the search.



NOTE: If a substance that the patient is allergic to can't be found in the substance search, a free-text allergy must be entered. Only pharmacists can enter free-text allergies. To request that a pharmacist document this free-text allergy, please submit a consult to pharmacy be ordering "IP Consult to Pharmacy – Determine Allergy History" in the details section indicate the substance that must be entered as free-text.

4

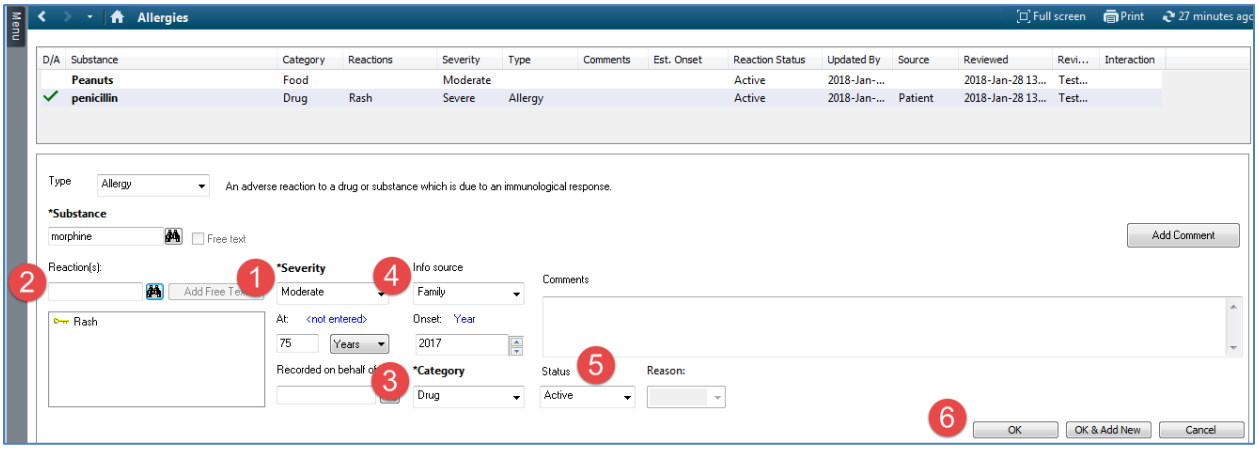
1. Select **morphine** from the list displayed.
   It is the best practice to keep the entry generic to ensure the system tracks all types of morphine medications.
2. Click **OK** to return to the Add Allergy/Adverse Effect window.



5 Fill the mandatory boxes and add other appropriate options:

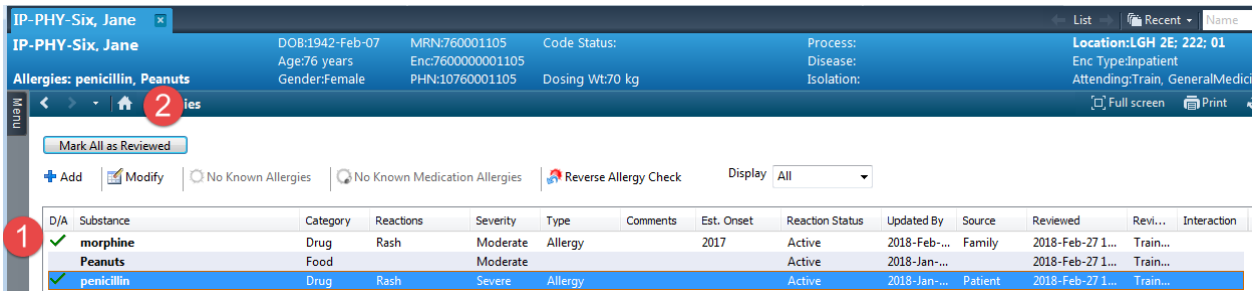
Do you remember how to spot mandatory boxes?

1. Select *Severe* for the **Severity.**
2. Type *rash* and click  in the **Reaction**(s) box (recommended).
3. Select the reaction.
4. Click **Done**.
5. Select *Drug* for the **Category.**
6. Select *Family* for **Info Source.**
7. Note Status is **Active**. Use the drop-down to display more options.
8. Click **OK** to save the information. OK & Add New allows for multiple entries.



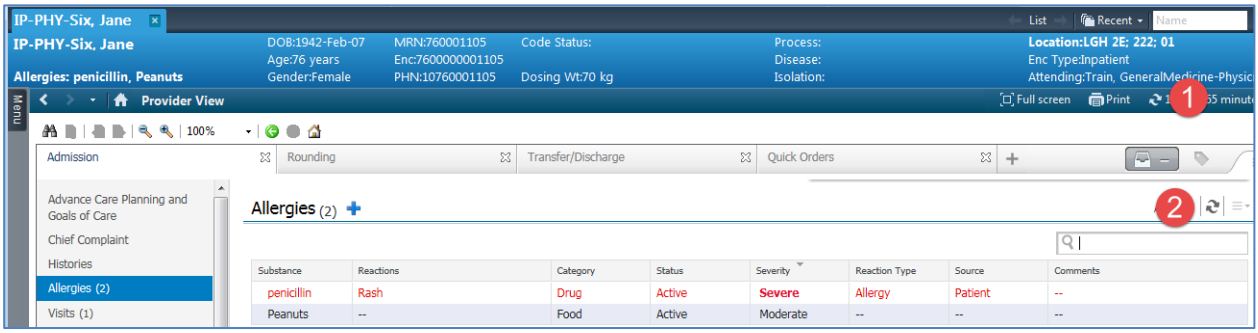
6 Check if morphine allergy is added to the patient's record.

1. The **green checkmark** indicates drug allergies.
2. Click the icon to return to the **Provider View.**



7 When you are back in the Provider View, you may notice that your display does not always display the most current information. Refresh your screen frequently:

1. Click the **Refresh button on the Banner Bar** to refresh all information in the current workflow tab
2. Click the **Refresh button for an individual component** to update this information only and stay with this component.



Key Learning Points

- Patient **allergies** and interactions are monitored by the CIS
- Allergy record needs to be **reviewed for each encounter** on admission
- A review of allergies is complete when Mark All as Reviewed is selected

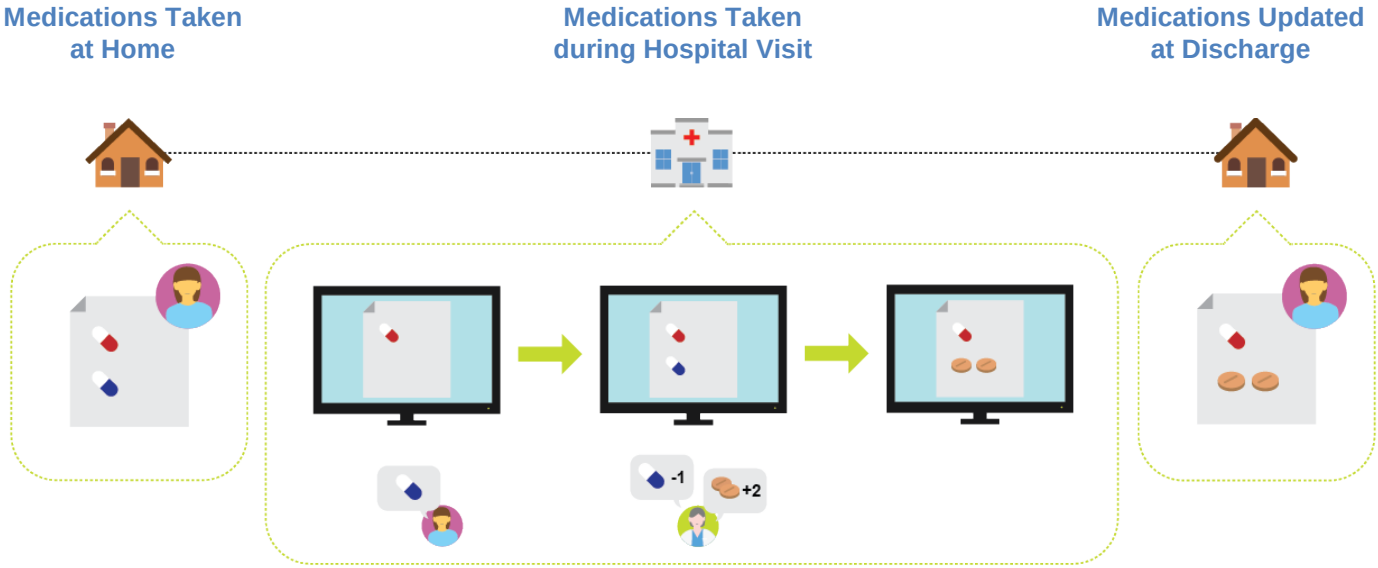
Activity 1.3 – Review Best Possible Medication History (BPMH)

The BPMH is generally documented by a pharmacy technician (only in ED). When a pharmacy technician is not available, it can be completed by a pharmacist, nurse, medical student, resident, or by the patient's most responsible physician.

In the CIS there are two places to see a list of home medications. You can look in the Home Medication component of the **Admission** workflow. This will show you the medications that the patient was taking upon discharge from their last encounter.

You can also see the patient's PharmaNet Profile when documenting the BPMH. When you create the BPMH, these lists can be seen side-by-side. More details about how to view the PharmaNet profile and complete the BPMH will be shown in other training sessions.

Home medications are reconciled each time the medication reconciliation is done.



WARNING: In the CIS, the BPMH **must be completed before** proceeding with the admission medication reconciliation. The Admission Reconciliation will not be available until the Medication History is documented.

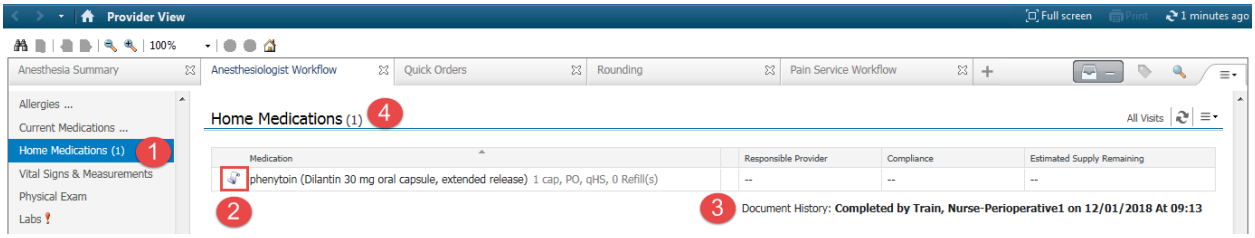
In this scenario, the PAC Nurse has already documented the patient's home medications. You learn from the patient that she forgot to mention her Gliclazide and Salbutamol inhaler and will update the information.

In this activity you will:

Review and update the BPMH

1 Ensure you are in the **Anesthesiologist Workflow** tab:

1. Click the **Home Medications** component to display the list of documented home medications.
2. Documented home medications are marked by the  icon.
3. Note the status line indicating who and when updated the medication history.
4. Click the **Home Medications** heading.



2 The **Medication List** window displays and you can check details for **all current** medications for the patient.

Hover to discover to check what on-screen explanation is provided:

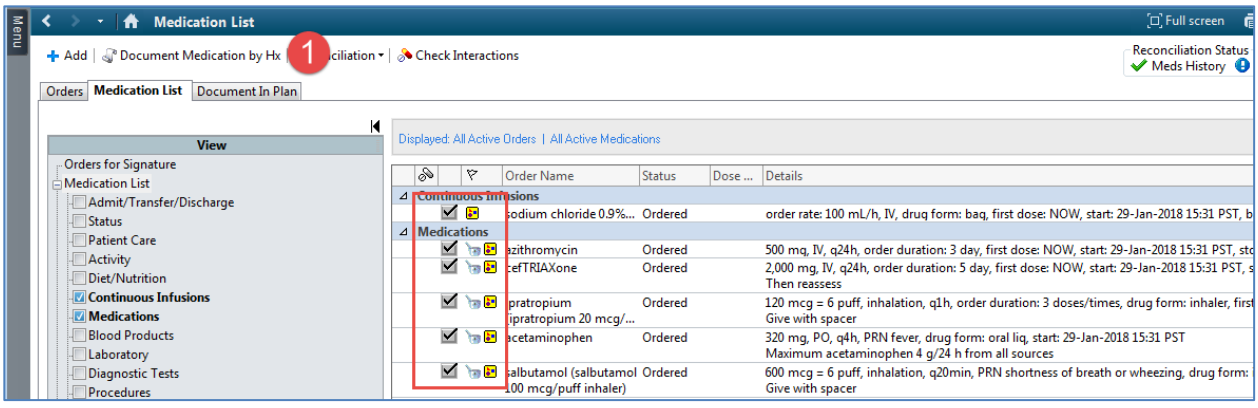
 indicates inpatient medication

 indicates medication is part of the order set; Hover to discover more information.

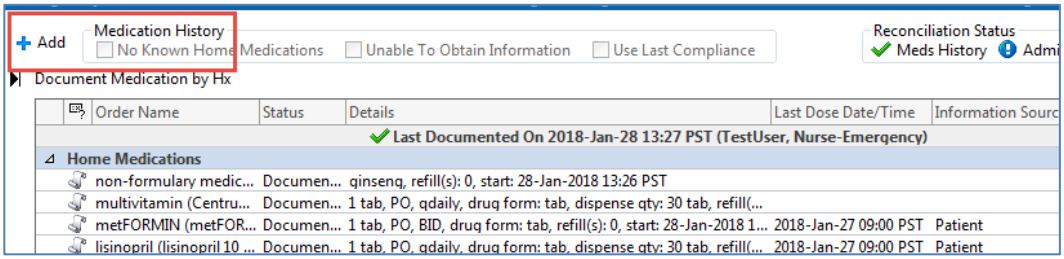
 indicates that pharmacy must verify the medication

1. Click **Document Medication by Hx**.

NOTE: Do not click +Add when adding a home medication. Remember to use **Document Medication by Hx**.

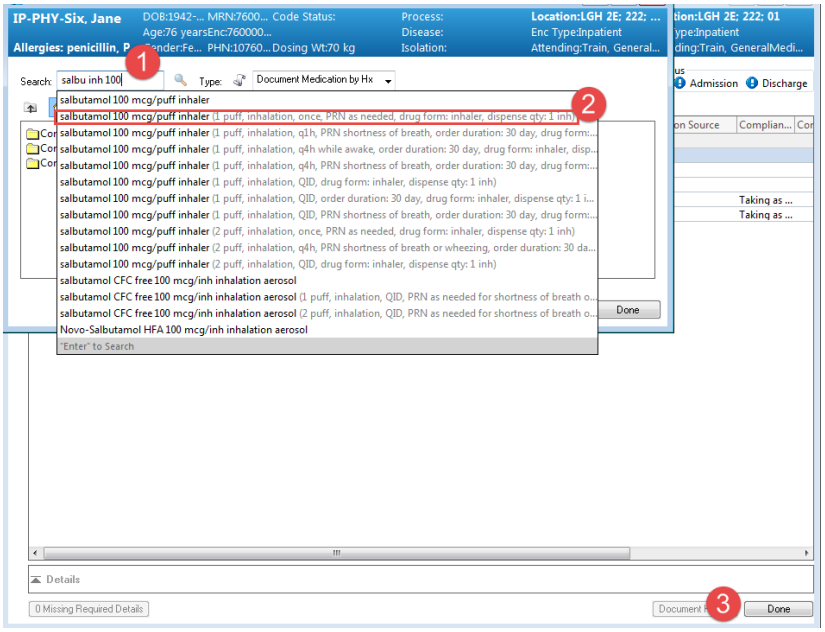


3 Ensure you are in the Medication History window. Click the + Add button on the **Medication History** toolbar.



4 In the **Search** window you can search the entire catalogue.

1. You may need some practice to be able to use the search efficiently. Here are few tips:
   - Type few first characters.
   - Add more details to truncate the list of possible options.
   - For this example, type ***salbu inh 100.***
2. Select salbutamol 100 mcg/puff inhaler (1 puff, inhalation, q1h, PRN shortness of breath or wheezing, drug form: inhaler).
3. Once you select the medication and associated details (order sentence), the medication order is placed and waiting for your signature. You can continue searching and adding more medication orders if needed
4. For this activity, you want to add just this one. Click **Done**.



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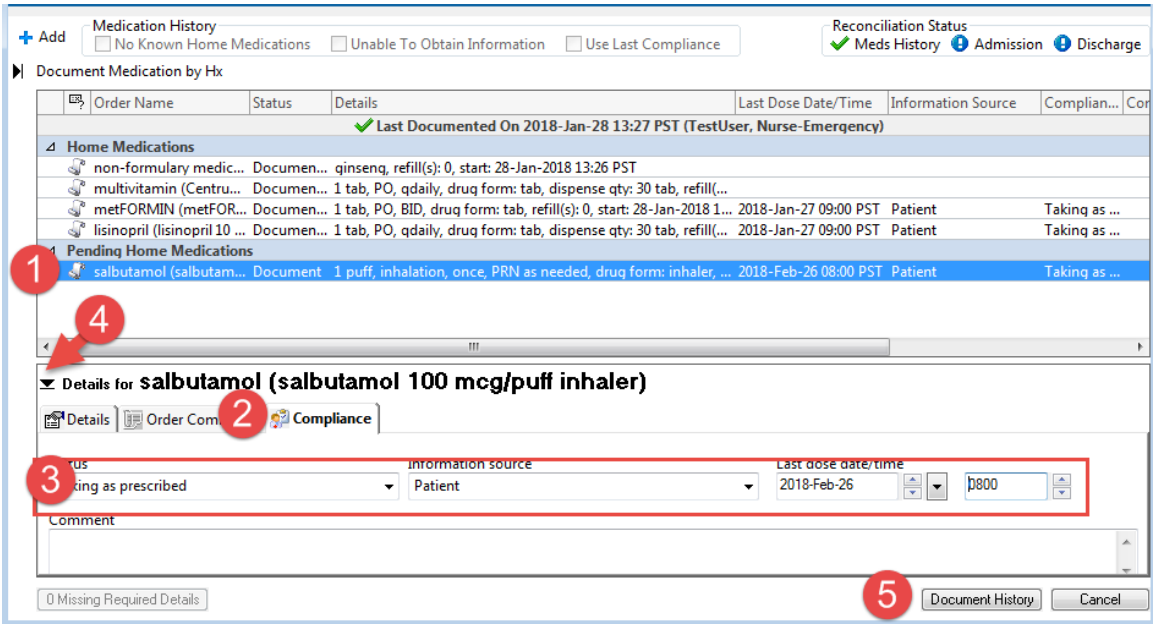
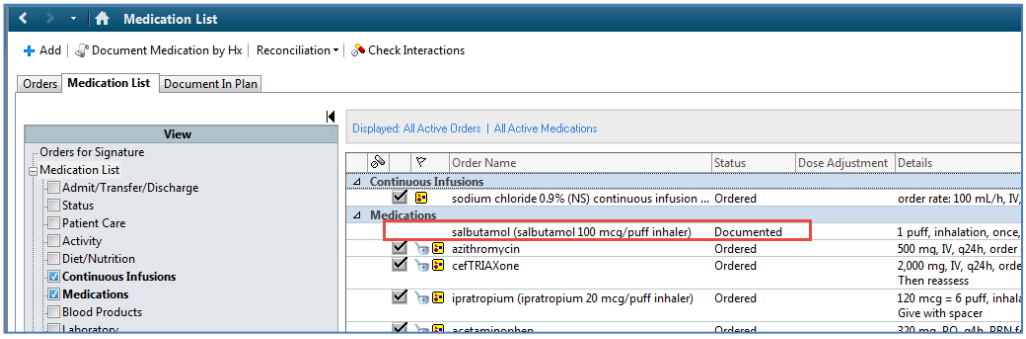
1. Select the order to display its details.
2. It is very important to know if the patient is compliant with prescription. To add this information, click on the **Compliance** tab.
3. Document the following in the **Compliance** tab:
   - **Status** = Taking as prescribed
   - **Information source** = *Patient*
   - **Last dose date/time**= *Yesterday at 0900,* use calendar to enter date in a proper format
4. Click Details to collapse or expand details for the selected order.
5. Click **Document History** to complete the process.



6

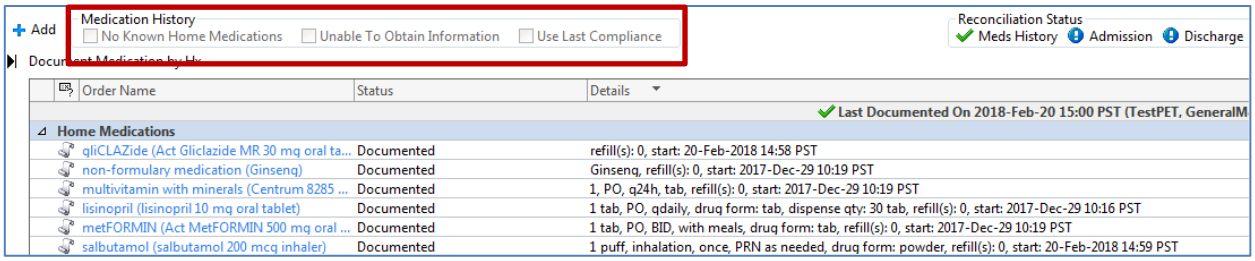
The updated list of current home medications for the patient displays.



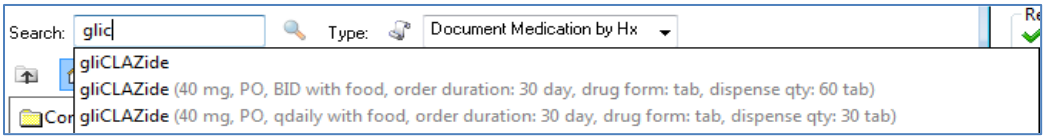
7 In some cases, you may need to document that the patient has no home medications or you are unable to obtain information. Select Document Medication by Hx

When needed, you can select one of the following options:

- **No Known Home Medications**
- **Unable to Obtain Information**
- You can also select the medication and click **Use Last Compliance** – this will copy the past medication record as a current entry



8 Providers will occasionally update the home medications because there will be Pharmacy Techs but this is very important for patient safety.
For your practice, add ***gliclazide 40 mg PO qdaily***. Ensure that you add this medication using **Document Medication by Hx** type of entry.

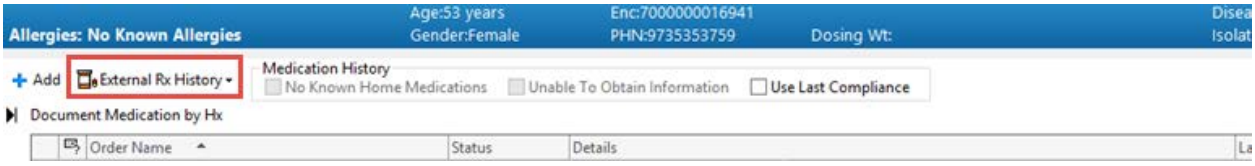


NOTE: The following information and screenshots are to illustrate the ability to see a patient's PharmaNet profile when completing BPMH.

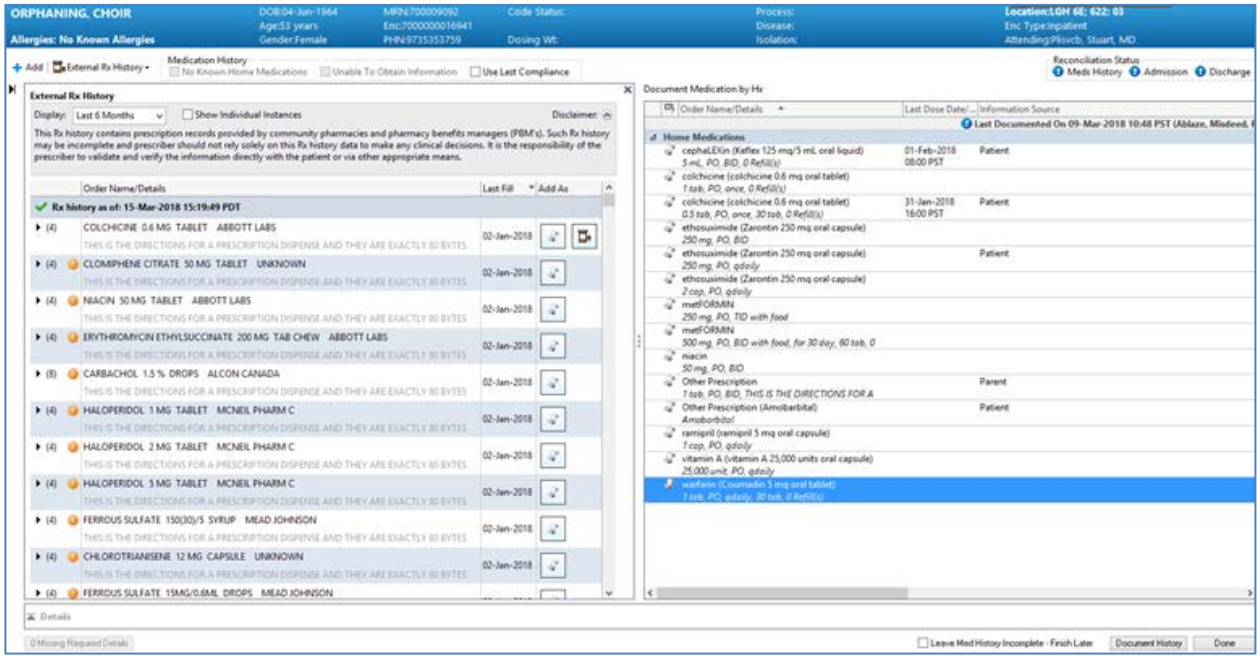
This is not available in the Train domain that you are currently learning in, but will be available when the CIS goes live. Resources to review this process will be available in future sessions prior to go-live.

9 To view a patient's PharmaNet profile, you will access home medications in a similar manner as above, by selecting the **Document Medications by Hx** button. Document Medication by Hx

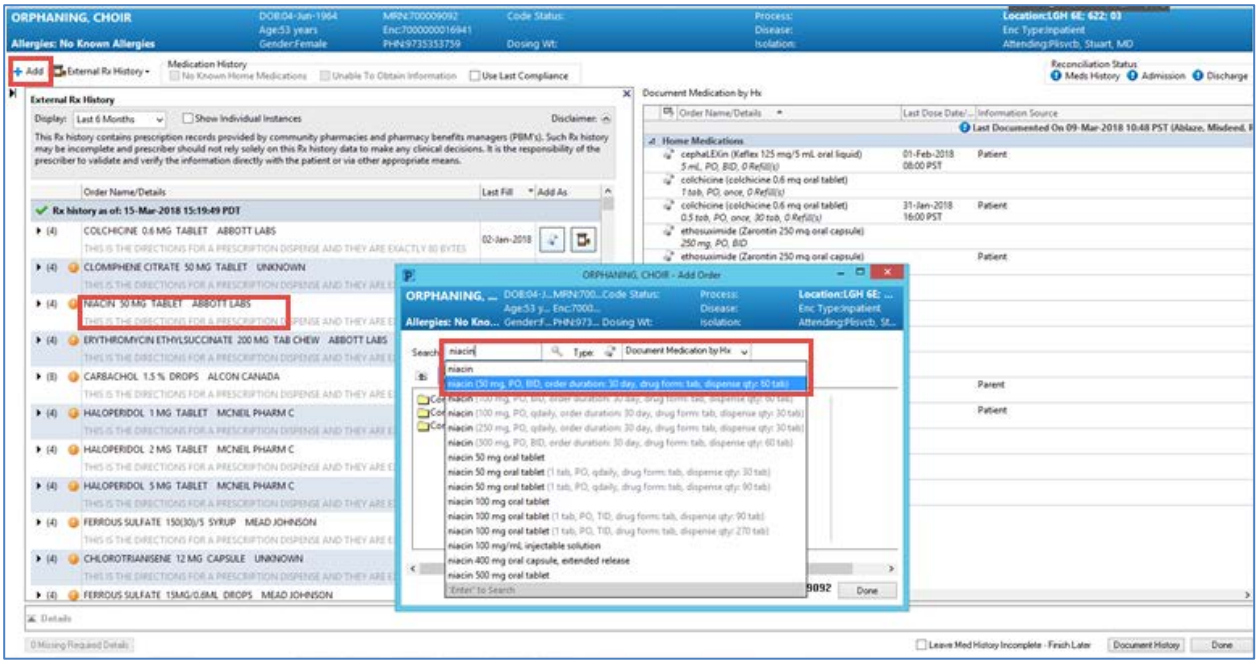
Within the Document Medications by Hx page, a new **External Rx History** button will be visible. External Rx History



Clicking this button will open up the PharmaNet External Rx History window in a side-by-side view with the Document Medication by Hx window.



From these windows, users can then review a patient's PharmaNet history and make informed decisions regarding which medications to add to the patient's BPMH.



Key Learning Points

- **BPMH** must be completed **before** admission medication reconciliation can occur
- Home medications, once documented, can be updated at any time
- Documented home medications can be continued during the hospital visit
- Documented home medications can be continued or stopped when patient is discharged

Activity 1.4 – Placing an Anesthesia pre-operative PowerPlan

1 PowerPlans are similar to pre-printed orders (PPOs), allowing you to plan and coordinate care in the acute care environment by defining sets of orders that are often used together. You can adapt PowerPlans to fit your needs:

- You can select and deselect individual orders from the PowerPlan list
- You can add orders that are not listed in the PowerPlan
- You can add other modules (orders sets) that are a listed in a PowerPlan

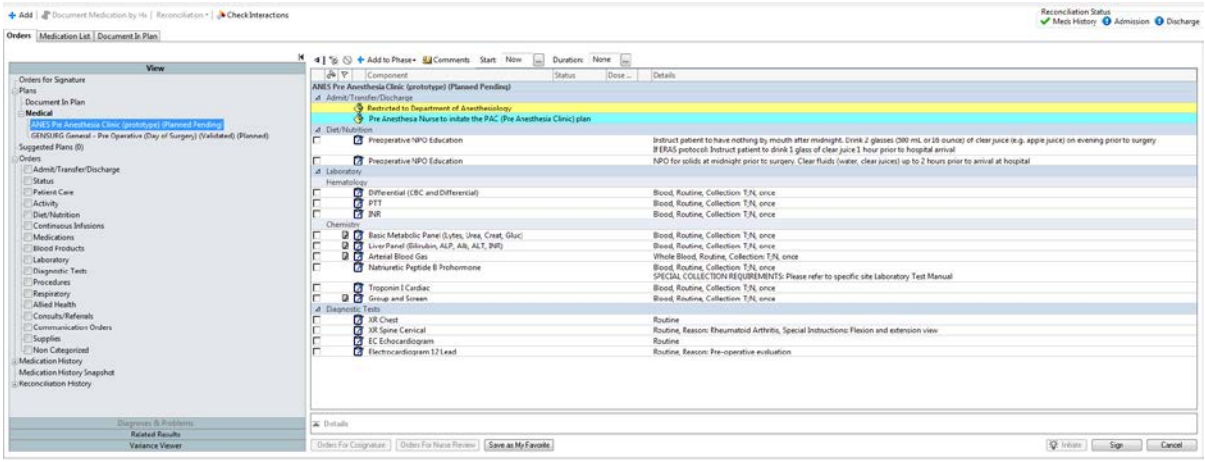
WARNING: A PowerPlan that is **Initiated** becomes active immediately and its orders create respective tasks and actions for other care team members. A PowerPlan that is **not** initiated remains in a planned stage allowing to prepare orders for a future activation as needed. This is useful for surgical scenarios and for future prodedures. If you want some thing to happen now, **Initiate and sign it (2 step process)**. If you want an order to happen later, **Sign**.

The best option for placing PowerPlans and orders is via the Quick Orders tab. This view is a one-stop shop for common orders and PowerPlans organized in separate categories.

- Under each category, there are folders. For example, under the medication category is the analgesics folder which contains individual orders for analgesic medications such as acetaminophen. Orders may allow you to add additional details regarding dose, frequency, route, etc., or may have these details pre-determined for ease of ordering as an order sentence. Categories and folders can be collapsed or expanded by clicking the expansion arrows and

The name of the PowerPlan is listed on the left with the phases of the plan directly under. On the right side of the window is the name of the phase of the plan curretly displaying with the details of the phase listed underneath.

This is an example of how what a PowerPlan looks like.

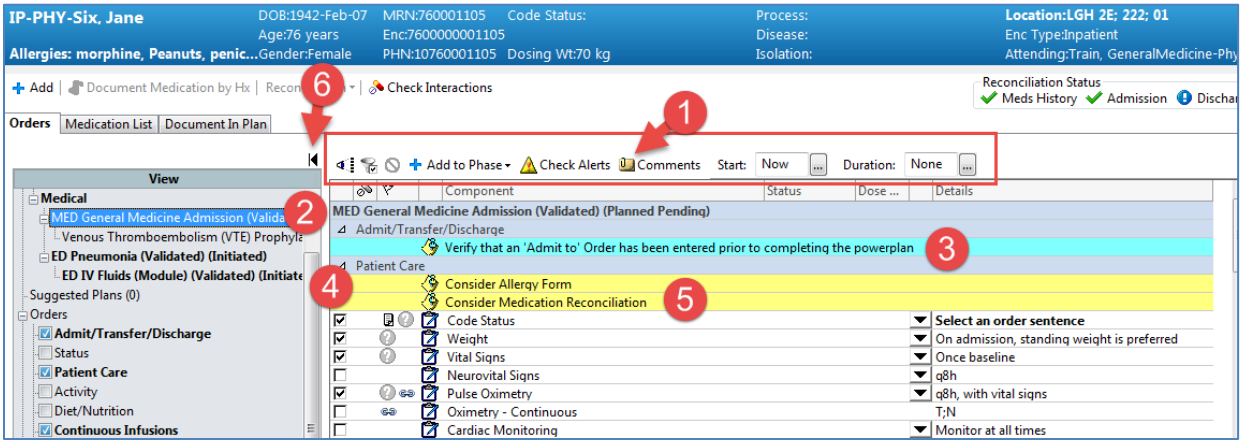


2

PowerPlans open in the **Orders View** that works like a scratch pad to customize your plan. Scroll through to locate visual cues used to categorize orders:

1. The **toolbar** provides you with tools, for example:

   Clicking the Comments button opens a box for adding a comment to the selected order; a nurse assigned to this patient will be informed that you placed additional information.
2. At the top you will see the PowerPlan name. Until you complete the process, its status is Planned Pending.
3. Bright blue highlighted text identifies **critical reminders** – for example a reminder about the 'Admit to…' order.
4. Light blue-grey highlighted text separates **categories** of orders, for example Patient Care.
5. Bright yellow highlighted text identifies **clinical decision support** information.
6. Collapse the View navigator to have more screen space.



3

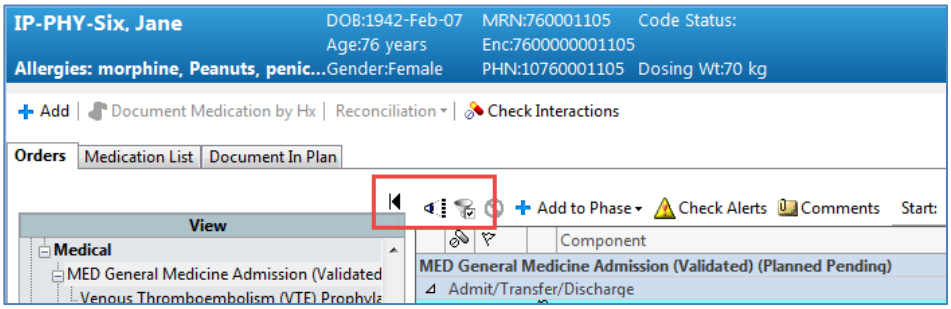
Toolbar icons flex the display of the PowerPlan to facilitate easier review. For example:

Collapses or expands the list of order categories on the left side of the screen. Collapsing the list creates more room for the PowerPlan orders list.

Merges your planned orders with existing orders to avoid duplicating an order. However, the CIS will warn you about order duplications for specific types of orders.

Displays selected orders only.

Click the button to review what orders have been selected by default in this PowerPlan. Click again to return to the full list.

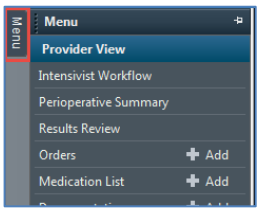


4 There may be surgical orders already placed by the Surgeon. You may review their orders prior to placing Anesthesia orders.

Pre-Operative PowerPlans placed at the time of the PAC will be initiated by nursing staff when appropriate.

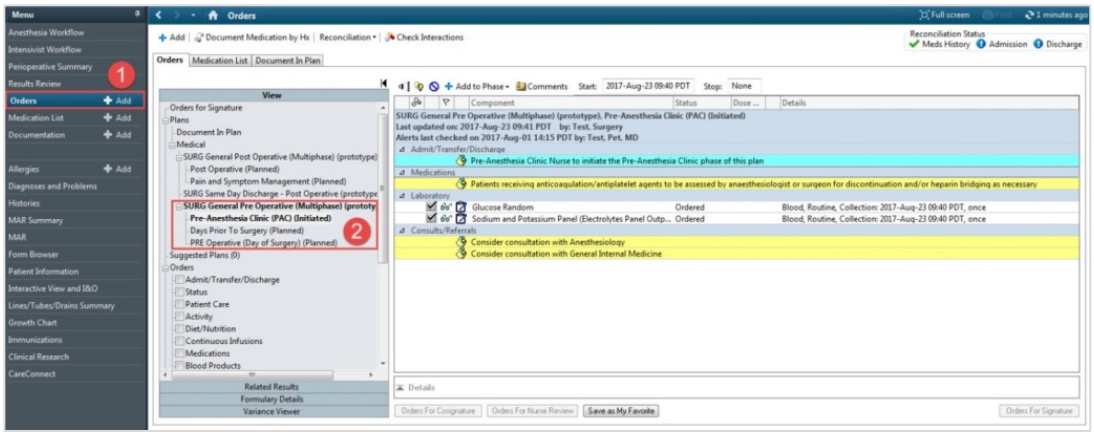
To review surgical orders:

1. Open the **Menu** on the left side of the screen



2. Click on **Orders**.

   The orders profile will open and displays all active and planned PowerPlans.



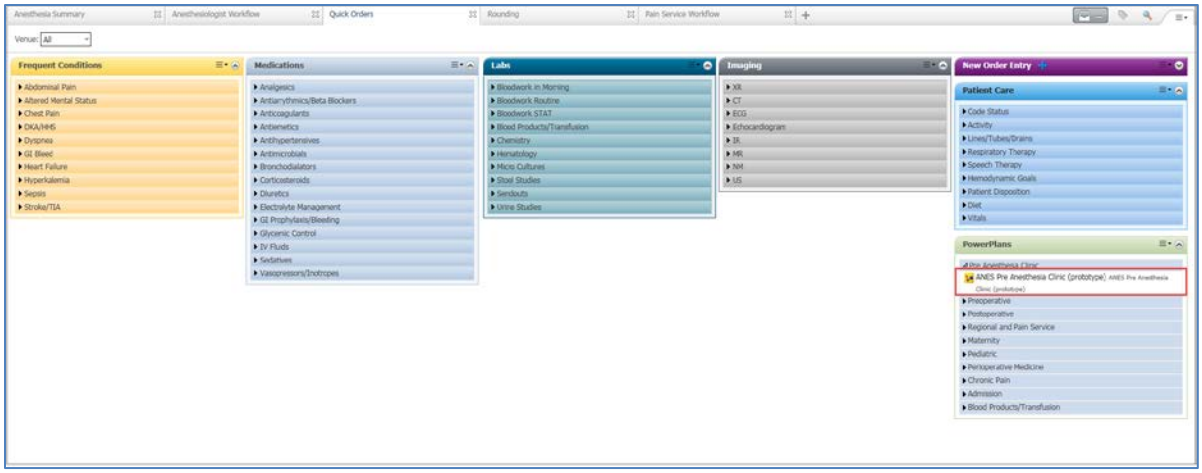
5 You are now ready to place and initiate the PAC PowerPlan. Then place the pre-operative orders in a planned state for the patient.

Navigate to the **Quick Orders** view.

Place the following PAC and pre-operative PowerPlans:

1. Click on  to go home
2. Click on **Quick Orders** and locate the **PowerPlan** section

3. Click on **ANES Pre Anesthesia Clinic**



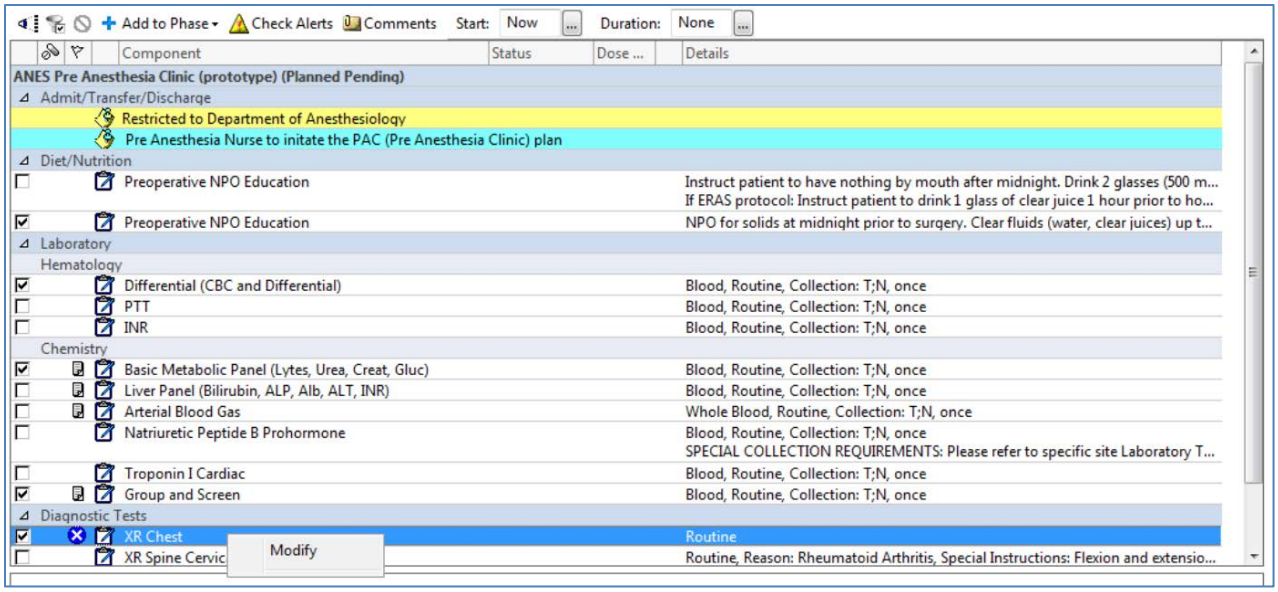
4. Click the **Orders for Signature** icon  to review selected order and click **Modify.**

6

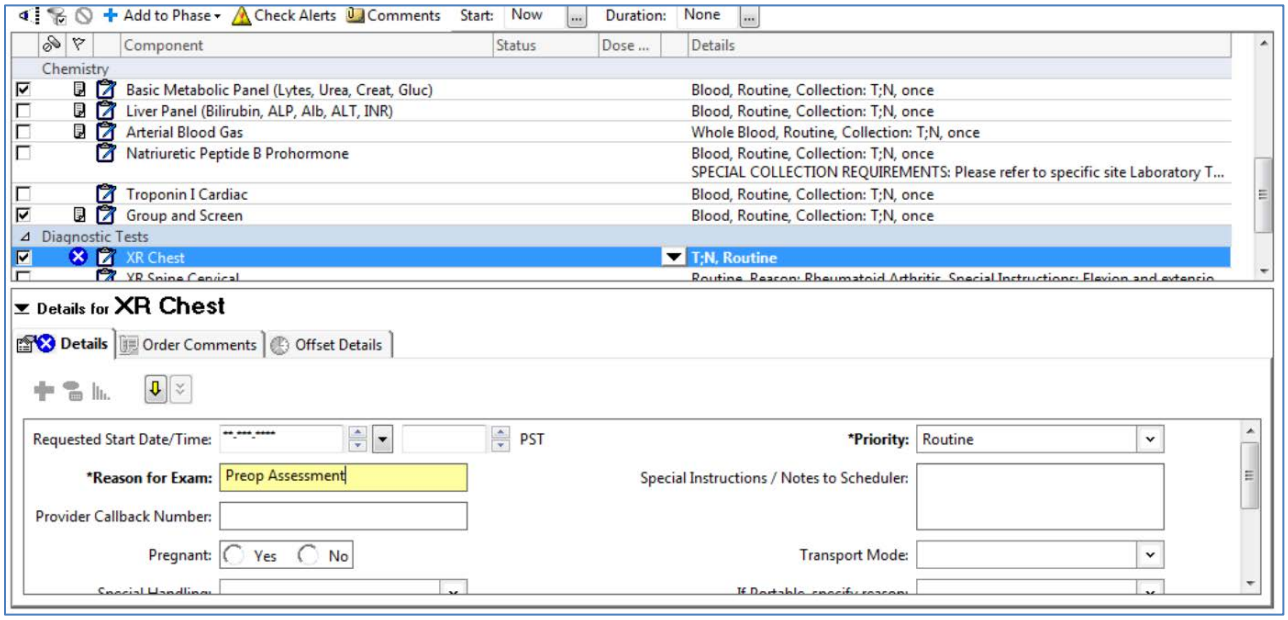
Select the following orders using the checkboxes beside each individual order

- Preop NPO Education (NPO for solids at midnight prior to surgery)
- Differential (CBC and differential)
- Basic metabolic panel
- Group and Screen
- XR Chest
- Electrocardiogram 12 lead

1. XR Chest order will have a  indicating there are missing required details
2. Right click on the order and click the Modify button



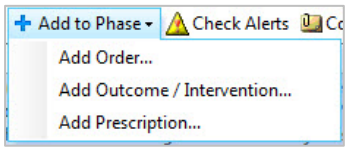
3. Complete missing required details indicated by a bold title or yellow field.
4. Complete the missing reason for exam
    - Preoperative Assessment



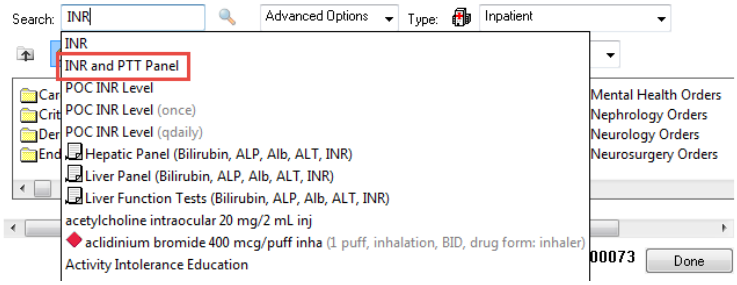
7 For this scenario you want to add an INR and PTT order.

To add ad hoc medications:

1. Click **Add to Phase** and click **Add Order**



2. Type the name of test: INR



3. Click on “INR and PTT Panel”
4. Click **Done**
5. Ensure the order particulars are correct. In this case there is nothing to add.
6. Once all appropriate orders have been entered click 

   - Typically, the PAC nurse will initiate the PowerPlan. This is workflow dependent.
7. Click **Orders for Signature**
8. Click **Sign**
9. Click **Done**

WARNING: Signing a PowerPlan places the orders in a planned state (not active). Orders will not be active until they are initiated. This is the equivalent of writing orders in the patient chart ahead of time and having them executed at the appropriate time.

Key Learning Points

- PowerPlans are similar to pre-printed orders
- You can select and add new orders not listed in the PowerPlan by using Add to Phase functionality
- You can select from available order details using drop-down lists or modify order sentences manually where needed
- Initiate and sign (2 step process) means that PowerPlan orders are immediately active and as such, can be actioned right away by the appropriate individuals
- Sign will place orders into a planned state for future activation

Activity 1.5 – Update Anesthesiologist Workflow for problems, active issues and indications for procedures

1

Certain components such as Indications for Procedure are called free text components.You can type or dictate directly into them. Front end speech recognition (FESR) software captures your dictation directly into PowerChart.

They serve as a temporary note pad where you may enter your notes without leaving the Anesthesia Workflow. Information entered here is saved until you are ready to create a formal Admission note. With one click, this information will be transferred into the note. Until then, any information captured will only be visible to you.

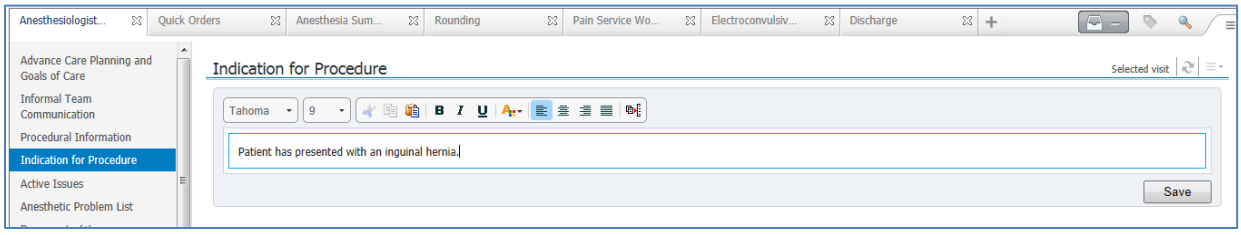
Indications for Procedure

Additional sections to be noted which are completed in the same way:

- Review of systems
- Physical exam
- Summary and plan

To complete **Indications for Procedure**, simply type in the free text box or utilize Front End Speech Recognition (FESR).

1. Select **Provider View** and Click on **Anesthesiologist Workflow**
2. Click on **Indications for Procedure** and type within the free text box
3. Type, “Patient has presented with an inguinal hernia.”
4. Click **Save**



Active Issues is the next component on the tab. It is identical to the component we used to add an admitting diagnosis.

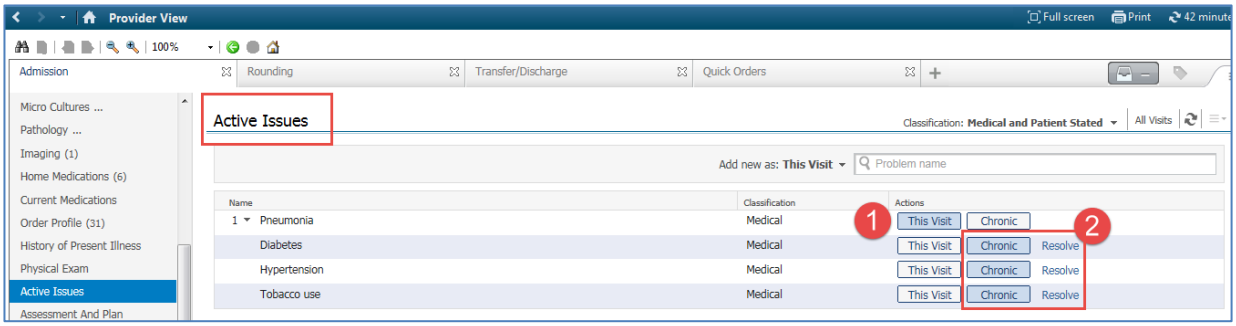
For each issue documented under the Active Issues component, you can select the following descriptor:

- **This Visit** (category 1) – the issue is a focus of the current encounter (e.g. presenting complaints). It is not shared between encounters and not carried over to the next encounter.
- **Chronic** (category 2) – the issue is ongoing and can be active or resolved. Chronic problems are shared across encounters and carried over to the next encounter. Chronic issues will appear under Medical History component.

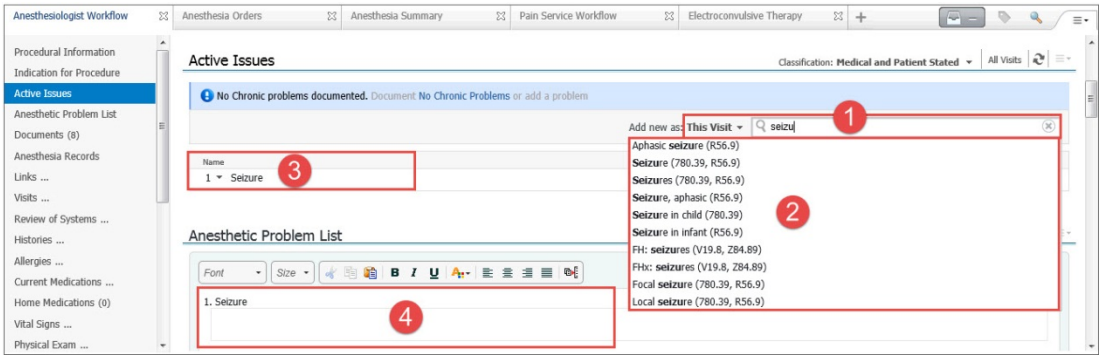
- **This Visit and Chronic** (combination) –the issue is marked in both categories. When marked as **Chronic** category, it is carried over to the next encounter.

Note the difference when adding diagnosis versus problems. Diagnoses are for the current encounter (reason for visit) and problems are chronic issues (e.g. medical, social, or others).

This Visit issues (1) will be automatically resolved when the patient is discharged. Chronic issues (2) are typically active but can also be resolved. Resolved issues become historical issues.



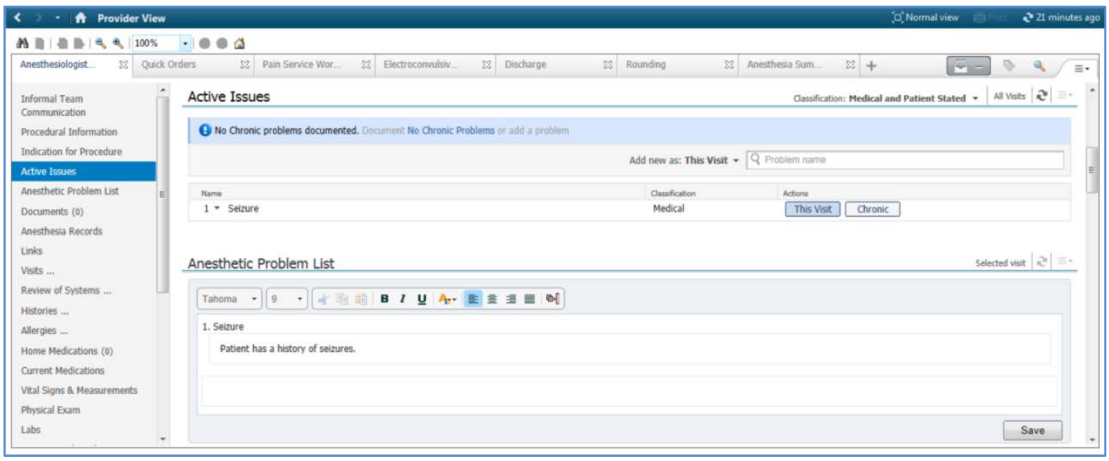
The diagnoses and problems recorded in the Active Issues component as chronic will carry over from visit to visit, which builds a comprehensive summary of the patient's health record. Keeping a patient's problems and diagnosis up-to-date is important.



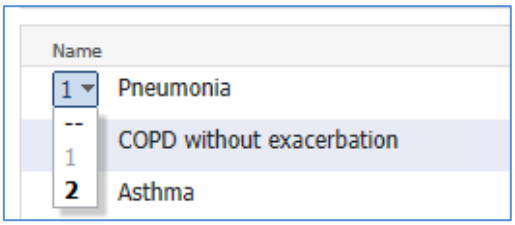
To update the **Anesthesia Problem List**:

1. Ensure the new Active Issue will be added as "This Visit and Chronic". If it is not, click the downward arrow beside the word and select **This Visit and Chronic**.
    - Type "seizure" in the box beside.
2. A window will appear displaying the closest matches available within the system. Along with the name of the issue, the ICD-9 and ICD-10 codes are also displayed.
    - Select **Seizure (780.39, R56.9)**.
3. Once you have selected an active issue within the Active Issues Control for "This Visit and Chronic", notice it will automatically appear in the Active Issues box.

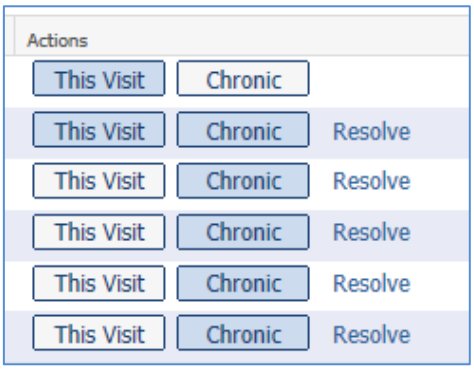
4. If the Active Issue for “This Visit and Chronic” appears in the Active Issues box, it will simultaneously appear in the Anesthetic Problem List box as well.
    - Click within the box below the issue and type: Patient has a history of seizures.
    - Click **Save.** This is required for dynamic documentation.
        i. Clicking Save is optional as there is a delayed auto-save that occurs 30 seconds later



You can also update problems right in this workflow view:



- These visit diagnoses are numbered as primary, secondary, tertiary, etc. You can easily rearrange this order by clicking the digit and selecting a different number.



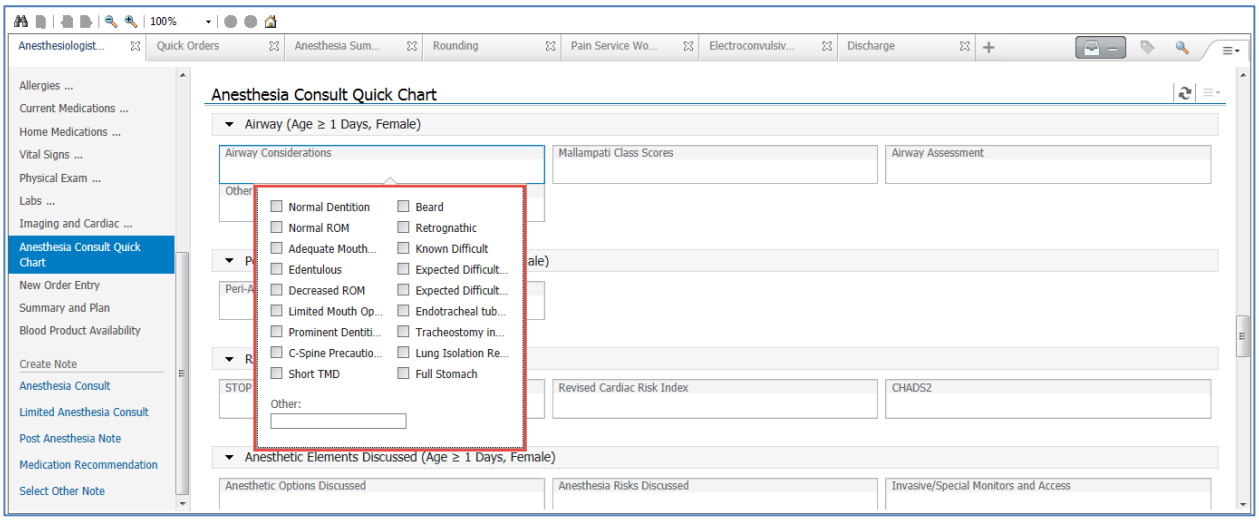
- You can change any This Visit diagnosis to a Chronic problem or both by clicking the appropriate buttons.
- You can also click **Resolve** to move a problem to the historical section.

Key Learning Points

- The Active Issues identified under “This Visit and Chronic” will automatically feed into the Anesthetic Problem List.
- Indications for Procedures is completed by free text.
- Remember to save each component after documenting.

Activity 1.6 – Completing an Anesthesia Consult Quick Chart

1 The **Anesthesia Consult Quick Chart** is a quick way to document some of the elements of the assessment and plan and is found within Anesthesiologist Workflow.



NOTE: Sections with a ☐, e.g. Airway Considerations, indicate ability to multi-select. Sections with a ○, e.g. Mallampati Class Score, indicate you can only select one answer.

To complete this documentation click on the boxes to reveal a drop down list and select the appropriate data to capture:

1. Airway Considerations= Normal Dentition, Normal ROM
2. Mallampati Class Scores= Class I
3. Airway Assessment= Reassuring
4. Click **Sign**

After completion of the Anesthesia Consult Quick Chart and after it has been signed. The data will also be published into the **Pre Anesthesia Evaluation** band within **Interactive View and I & O (iView).**

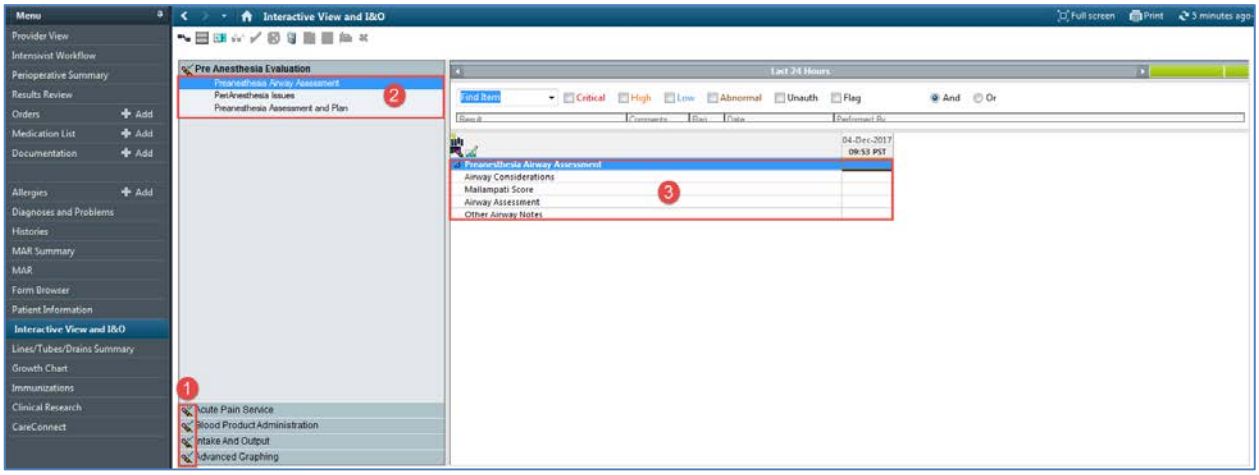
After data has been documented within the Anesthesia Consult Quick Chart, if changes are required, updates should be completed within iView.

2 Introduction to Interactive View and I & O (iView)

Interactive View (iView) is located under the Menu. This is the equivalent of the paper flowsheets that is used in your department. iView is organized in to Bands and Sections. Bands consists of the overall sections (i.e. Band – Pre Anesthesia Evaluation, Sections – Preanesthesia Airway Assessment, PeriAnesthesia Issues and Preanesthesia Assessment and Plan).

Not all bands are front facing. The typical bands required for each area of practice will appear. In the event a siatuation arises where additional bands are required, it can be added at any time. Please refer to the Quick Reference Guide on how to add bands.

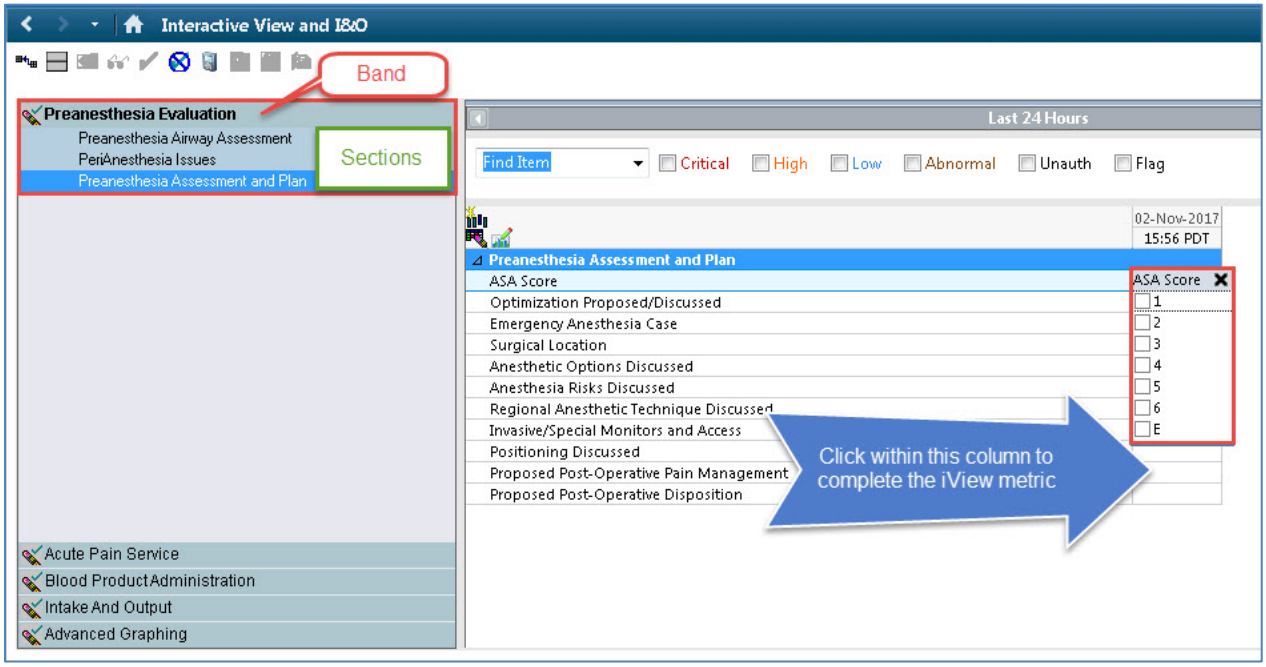
1.  icon indicates this is a band.
2. When a band is opened, the sections within the band will appear.
3. When a section is opened, the details within the section will appear in this window on the right.



3 The Preanesthesia Evaluation iView Band contains 3 Sections:

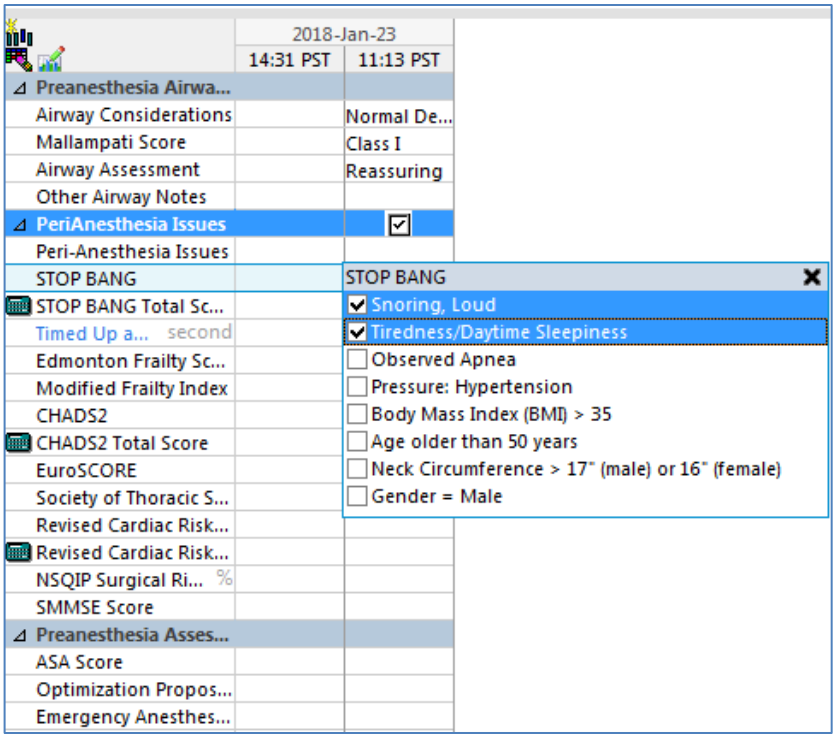
- Preanesthesia Airway Assessment
- PeriAnesthesia Issues
- Preanesthesia Assessment and Plan

Please take some time to review the metrics available from these 3 sections.



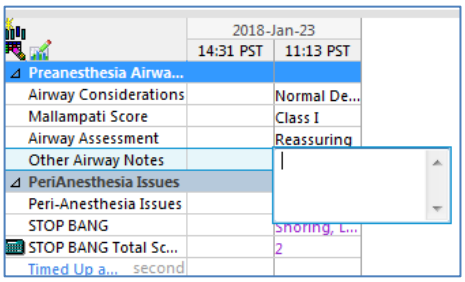
Basic ways to complete iView documentation:

- Click on the sections to populate the screen on the right.
- Double click the cell under the appropriate time and header column to open up all documentation for that section. Above screenshot shows an example would be the cell to the right of Preanesthesia Assessment and Plan and directly under the current time.
- Free text numbers (as displayed below)



Under STOP BANG select **Snoring, Loud** and **Tiredness/Daytime Sleepiness**

Under Other Airway Notes Free text box (as displayed below), enter *Poor Dentition*



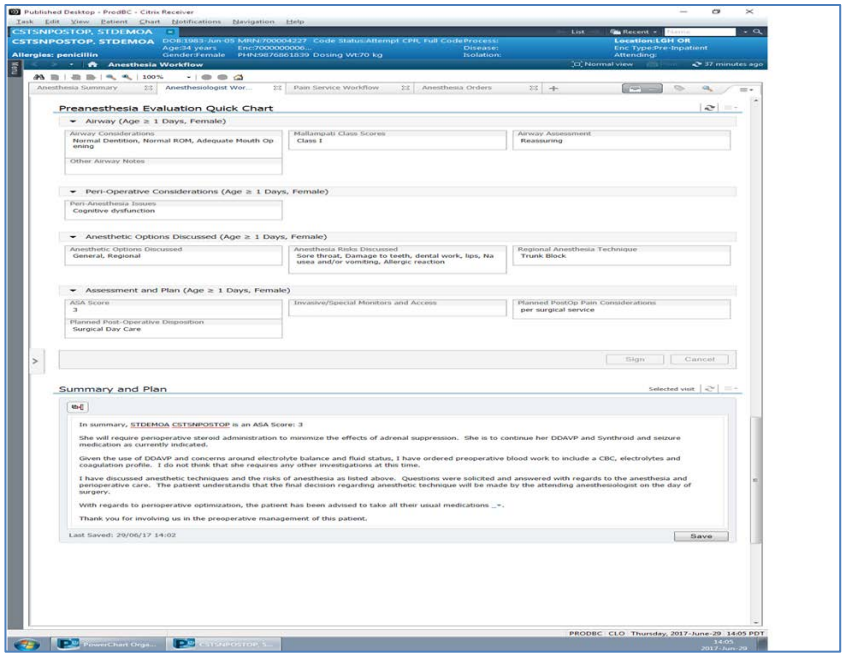
When done click the sign icon 

4

The **Summary and Plan** component allows for free text documentation of the Anesthesiologist's assessment and plan.

To complete a Summary and Plan:

1. Navigate from iView back to the Anesthesiologist Workflow. Click the home icon.
2. Click within the free text box.
    - Type "The patient has been advised to stop all medications the night before."
3. Click **Save**



Above is an example of a completed form.

Key Learning Points

- Anesthesia Consult Quick Chart data will also be pulled into the Pre Anesthesia Evaluation band within iView. Any edits required after saving in the Anesthesia Consult Quick Chart will need to be completed in iView.
- The Summary and Plan component can be completed from the free text box.

Activity 1.7 – Completing an Anesthesia Consult Note

1

PowerChart uses **Dynamic Documentation** to pull all existing and relevant information into a comprehensive document, using a standard template.

Dynamic Documentation can save you time by allowing you to populate your documentation with items you have reviewed and entered in the Anesthesiologist Workflow tab. This is why it is more efficient to create the note as the last step of the assessment. You can also add new information by typing or dictating.

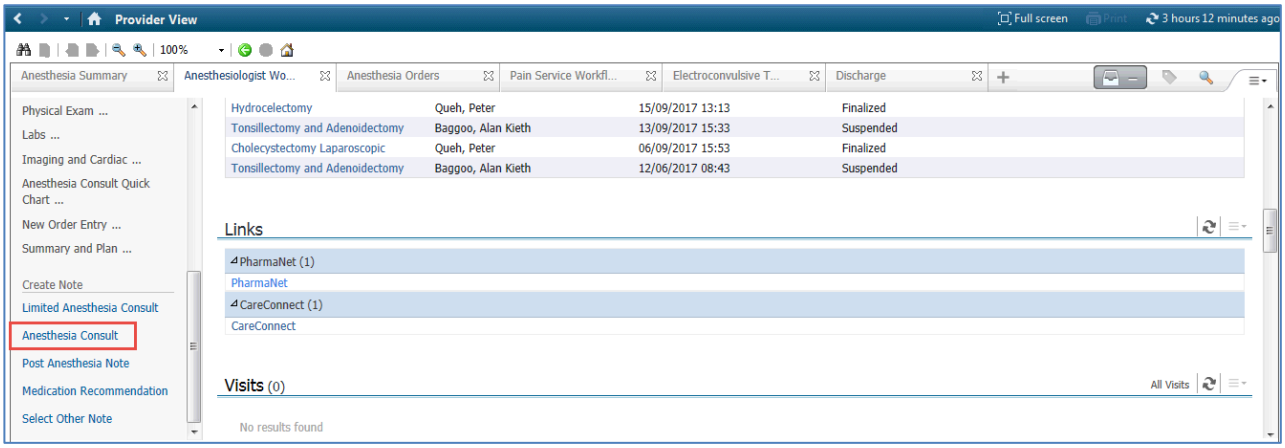
Other workflows such as Pain Service, Rounding, and Discharge have the Create Note section. Clicking on these items displays the relevant note types represented by links to make documentation easier. With one click on the desired note type link, PowerChart generates a charting note.

You would like to complete a consult note after seeing the patient in PAC.

In the event the patient is not seen in PAC, this note can also be used in Preop as well.

To access the Anesthesia Consult Note template: Ensure you are on the Anesthesiologist Workflow tab and scroll to the bottom of the list of components.

1. Click Anesthesia Consult.



There are 4 means of data entry into a note template:

1. Dictate as current state with Front End Speech Recognition (FESR).
2. Pulls from documentation within the Anesthesiologist Workflow. This should significantly reduce any additional manual typing.
3. Create/utilize Auto Text.
    - The programmed auto text entry populates in the box which can be modified by editing the text or left as is if appropriate. Auto text entries are shared across the organization helping to adhere to agreed standards. You can also create your own auto text entries. You will learn how to create auto text entries in a more personalized learning session.
4. Manual typing.

For all templates, generally the left side contains headings to the metrics that are required to be completed. Whereas the right side are the metrics that will auto-populate based on other documents within the system (i.e. labs).

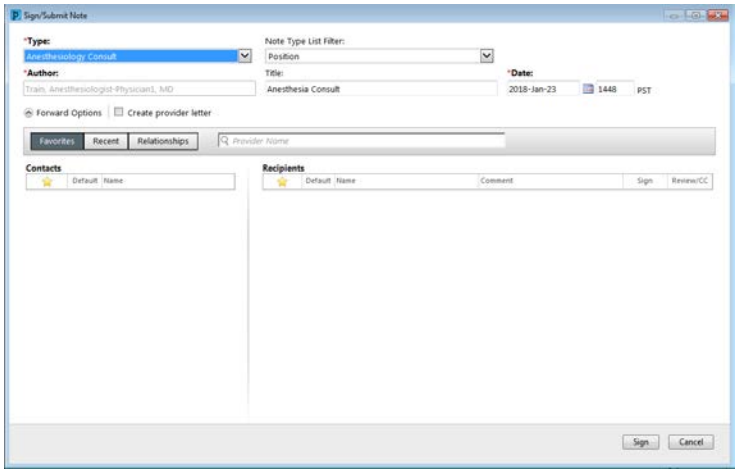
To complete the Consult note:

1. Type in the free text box to complete the Review of Systems.
    - ,,AnesRos and double click on the selection: The auto text will appear
2. Update the auto text to capture the seizure history
    - Click by CNS
    - Update to “Previous seizures”.
3. Once you have completed the Consult note, click **Sign/Submit**.

When completing your documentation, the options available to you are:

- **Sign/Submit:** This option indicates that you have completed your documentation and are ready to have this posted and viewable within the patient chart. If you require an addendum, it is still possible.
- **Save:** This option denotes that you have not completed your charting, yet do not want to lose the work you have completed to this point. The note cannot be viewed by others when it has been saved but not signed.
- **Save and Close:** This option is similar to the previous one of “Save”. The difference is that it will also close the window and you have to re-open it to continue developing the note. Your note is saved as a “Preliminary Report”. In this draft format, it is visible to other care team members and information is already shared however might not be enough to support decisions sufficiently.
- **Cancel:** Nothing will be saved or be retrievable.

WARNING: Ensure that the date indicates a date of service, not the date the note is created. This is to maintain correct dates for reporting purposes.



Here you can send copies of the report to other health care providers.

This will be covered at a later date.

For now click **Sign**

Key Learning Points

- There are 4 options on how to complete the documentation within a Note: FESR, auto-populating from the Anesthesiologist Workflow, Auto text or manual typing.
- Ensure that the date indicates a date of service, not the date the note is created.
    - This is to maintain correct dates for reporting purposes.
- Saved documents cannot be viewed by other professionals
- Signing a document published it to the patient's chart

PATIENT SCENARIO 2 – Elective Post-Op Patient (Post-Op)

Learning Objectives

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

- Update patient information
- Modify current orders
- Manage documents and create a progress note

SCENARIO

A 54 year old male patient has a inguinal hernia. He meets with a General Surgeon and is scheduled for an elective right inguinal hernia repair. He has finished his surgery and is now in the Post-operative phase.

NOTE: This workbook will only address Pre-Operative and Post-Operative aspects of the chart. SA Anesthesia (Package 2) will address the Intra-Operative documentation for Anesthesiologists.

As an Anesthesiologist you will complete the following 2 activities:

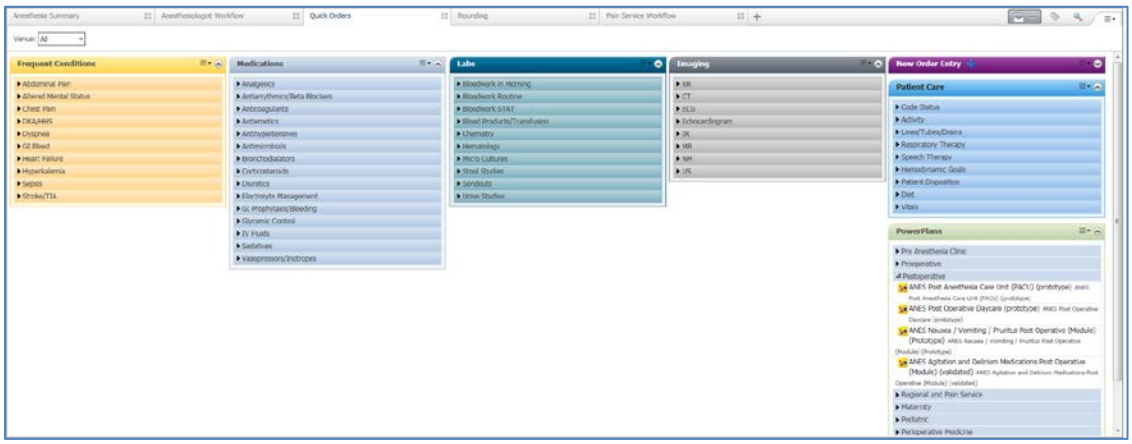
- Place and review post-operative PowerPlan
- Inclusion of an addendum

Activity 2.1 – Place and Review Post-Operative Powerplans

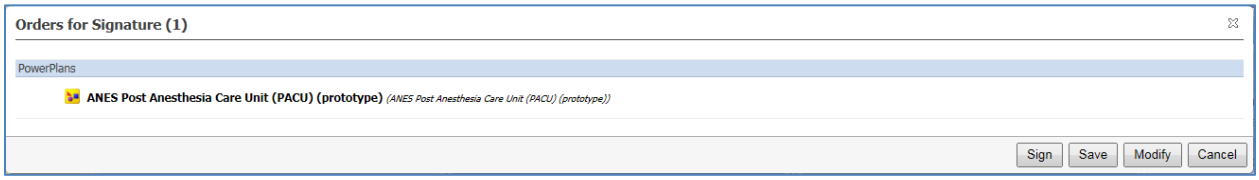
1 As the steps for placing a Post-Operative PowerPlan is similar to Scenario 1, Activity 5, this activity will consist of a review of the Post-Operative PowerPlans.

Place the following Post-Operative PowerPlans:

1. Click on  to go home (if not already there)
2. Click on **Quick Orders** and locate the **PowerPlan** section
3. Click on **ANES Post Anesthesia Care Unit (PACU)**

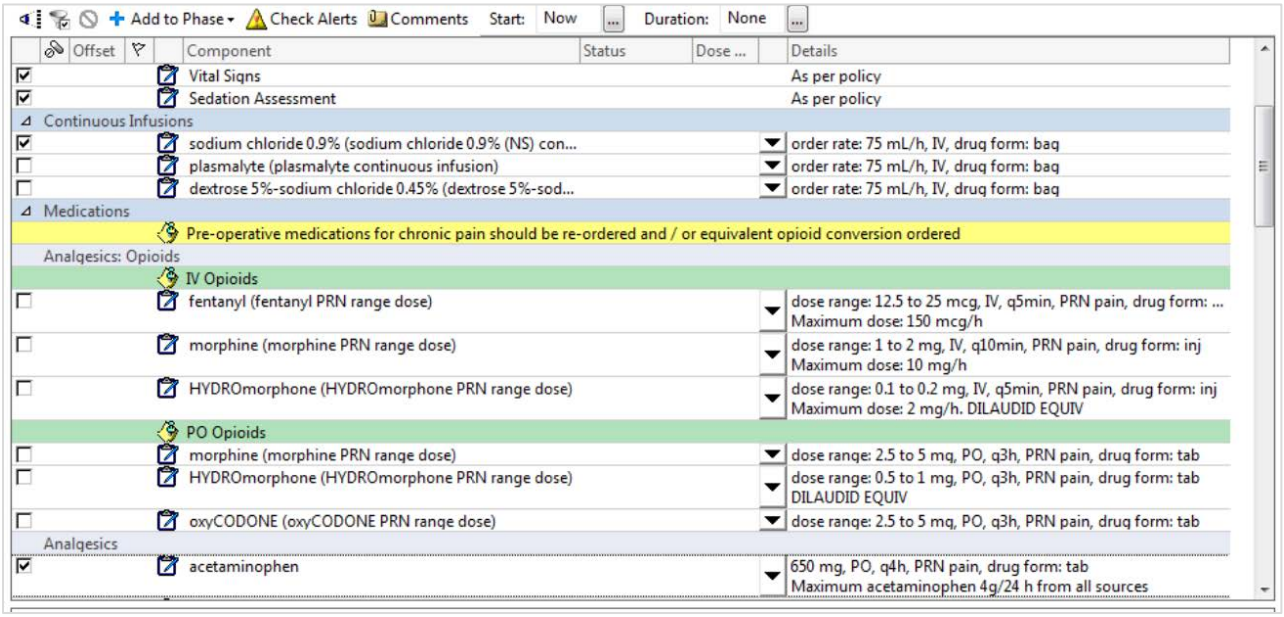


4. Click the **Orders for Signature** icon  to review selected order
5. Click **Modify**.



2

1. Select the following orders using the checkboxes beside each individual order
    - Vitals Signs (defaulted)
    - Sedation Assessment (defaulted)
    - Sodium Chloride 0.9% (75mL/h)
    - Acetaminophen 650 mg, PO, q4h, PRN
2. Deselect the following order
    - ANES Respiratory Despression (Module)



NOTE: Modules will be reviewed within another resource.

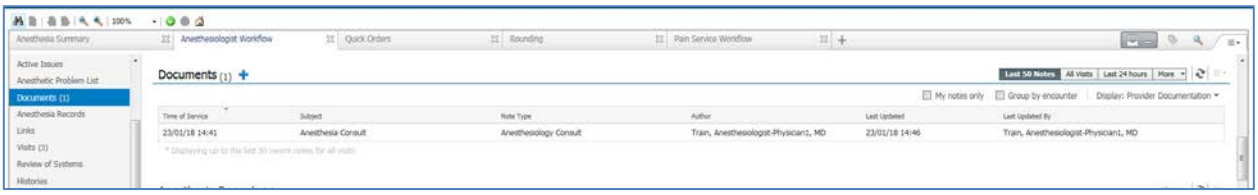
3. Click **Sign**
4. Click **Done**

Key Learning Points

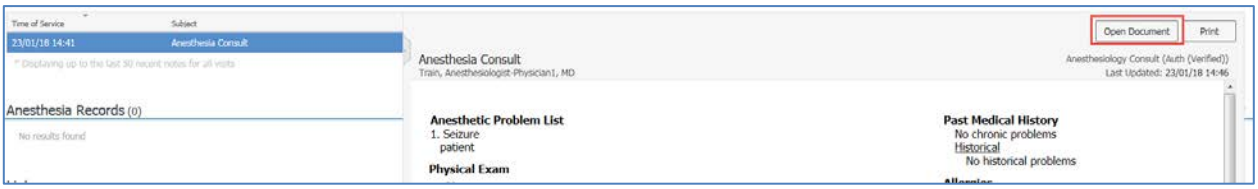
- PowerPlans can be accessed from Quick Orders with in Provider View
- Multiple PowerPlans can be placed at the same time.

Activity 2.2 – Inclusion of an Addendum

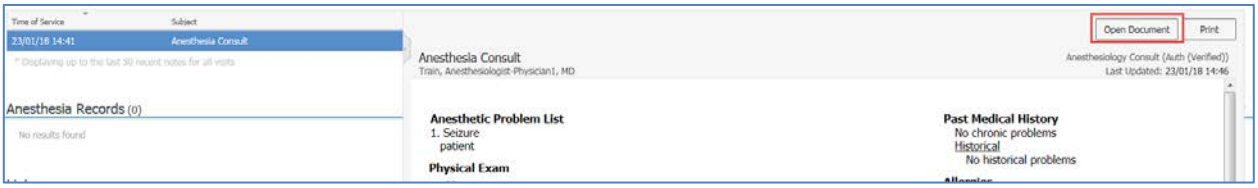
1 When reviewing the patient's documentation, you noticed that the admission note created by your resident requires a correction.



1. Select the note from the Documents component



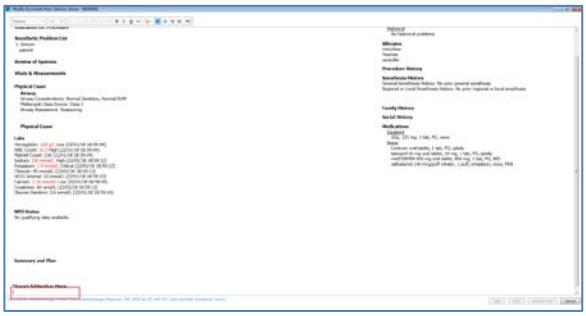
2. Click **Open Document**



3. Click  Modify icon on the toolbar.

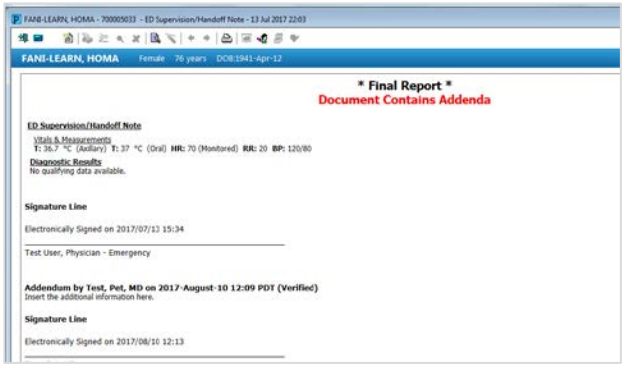
The document opens with the **Insert Addendum Here** field activated.

Type "Patient had a seizure last week."



Click **Sign**

The altered document will display with the red annotation at the top indicating it includes an addendum. The addendum includes an electronic signature.



Key Learning Points

- Once documents are signed, revisions can only be done by adding addendum.

End Book One

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