SELF- GUIDED PRACTICE WORKBOOK [N41] CST Transformational Learning

WORKBOOK TITLE: Nurse: Endoscopy





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TABLE OF CONTENTS

•	SELF-GUIDED PRACTICE WORKBOOK	3
•	USING TRAIN DOMAIN	2
•	PATIENT SCENARIO 1 – Pre-Procedure	3
	Activity 1.1 – Navigate Perioperative Tracking & Access Powerchart	4
	Activity 1.2 – Set an Event to Update Patient Status in Perioperative Tracking	7
	• Activity 1.3 – Review the Patient's Chart for Documentation (e.g., Consent Form)	10
	 Activity 1.4 – Document in the Endoscopy Assessment & Perioperative Preprocedure Checklist 	ə 12
	Activity 1.5 – Initiate PreOp Orders	26
	Activity 1.6 – Complete IView Documentation for a Peripheral IV Insertion	31
	Activity 1.7 – Utilize Barcode Scanning to Administer Medications	34
•	PATIENT SCENARIO 2 – Intra-Procedure	36
	Activity 2.1 – Review the Patient's PreOp Documentation	37
	Activity 2.2 – Complete the Surgical Case Check-In to Access Perioperative Documentation	40
	Activity 2.3 – Initiate GI Procedural Sedation Medication Orders	42
	Activity 2.4 – Create a Sedation Record	43
	Activity 2.5 – Document Times in the Sedation Record	50
	Activity 2.6 – Document Medication Administration in the Sedation Record	53
	Activity 2.7 – Document Patient Comfort Score (NAPCOMS)	57
	Activity 2.8 – Complete Perioperative Documentation	59
	Activity 2.9 – Enter a Pathology Surgical Request	72
	Activity 2.10 – Finalizing Perioperative Doc and the Sedation Record	74
•	PATIENT SCENARIO 3 – Post-Procedure	77
	Activity 3.1 – Access Patient's Chart from Perioperative Tracking (Review)	78
	Activity 3.2 – Review IntraProcedure Medications Administered	81
	Activity 3.3 – Discontinue PreOp Orders & Initiating Postop Orders	83
	Activity 3.4 – BMDI Association & Vital Signs Documentation in IView	86
	Activity 3.5 – Completing Documentation in Endoscopy Quick View (IView)	89
	Activity 3.6 – BMDI Dissociation	93
	Activity 3.7 – Complete the Nursing Discharge Checklist	95
	Activity 3.8 – Finalize PostOp Perioperative Documentation	97
	Activity 3.9 – Discharge the Patient Encounter	98
	End of Workbook	101

F SELF-GUIDED PRACTICE WORKBOOK

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

USING TRAIN DOMAIN

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

Please note:

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



PATIENT SCENARIO 1 – Pre-Procedure

Learning Objectives

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

Complete the pre-procedure process to prepare the patient for their endoscopy

SCENARIO

Scenario: Patient X was referred by his GP to have a Colonoscopy Biopsy with a GI Provider at Lion's Gate Hospital. They have arrived to the Endoscopy unit for their procedure.

As an endoscopy pre-op nurse you will perform your pre-procedure assessments, prep your patient for their procedure and document your interventions; you will be completing the following activities (in PowerChart):

- Navigate Perioperative Tracking & Access Powerchart
- Set an Event to Update Patient Status in Perioperative Tracking
- Review Patient's Chart for Documentation (e.g., Consent Form)
- Document the Endoscopy Assessment & Perioperative Preprocedure Checklist
- Initiate PreOp Orders
- Complete IView Documentation for a Peripheral IV Insertion
- Utilize Barcode Scanning to Administer Medications
- Update Patient's Status to 'Patient Ready for Surgery in Perioperative Tracking

*The terms Intra-Op/Intra-Procedure & Procedure/Surgery will be used interchangeably in this workbook as some of the functionality is shared with other perioperative areas.



Activity 1.1 – Navigate Perioperative Tracking & Access Powerchart

1

All perioperative and endoscopy nursing logins for PowerChart will open to Perioperative Tracking as the landing page.

Utilization of Perioperative Tracking **Endo PreOp and Endo PostOp** view (or tab) is recommended to access patient charts within the Endoscopy unit. Perioperative Tracking will display various views (or tabs) depending on your area.

P Po	werChart Organizer for TestSX, N	lursewithSa/	Anesthesia-Per	rioperative								- 0 ×
Task	Edit View Patient Chart	t Links (Case Actions	Provider List Help								
Perio	perative Tracking 🖃 Message (Centre 🛓 P	atient List Dy	namic Case Tracking iii Pr	ef Card Picklist 🐞	Case Selection	n 🎬 Day of Surgery View 📲 Histor	ical View 👫 Lear	ningLIVE 🖕			
i 🕄 ci	areConnect 🕄 PHSA PACS 🔇	VCH and PH	IC PACS 🔃	MUSE 🕄 FormFast WFI 🝦								
Ex	it 🎦 AdHoc IIIII Medication A	dministration	n 🔒 PM Con	versation 👻 🕞 Communic	ate 👻 🔝 Medical R	Record Request	: 🕂 Add 👻 💽 iAware 🖄 Scheduli	ing Appointment B	Book 🖲 Documents 🎇 Staff Assign 🍸 🕄 😋 Pati	ent Health Education Materia	ls 🔃 Policies and Gui	delines []
										•	Recent - Nam	• Q
Perie	operative Tracking									(D) F	ull screen 👩 Print	€ 0 minutes ago
LGH	Endo PreOp LGH Endo PostO	p LGH End	do Incomplete									
Filte	er: <none> •</none>	🔟 🔞 🖬	🖥 🔶 🚺 To	otal Cases: 14								
	Status	Start	Stop	Add Pt. Type	CK Alerts	Allergy	Patient	Age	Procedure	Provider	PreOp Nurse	Schet *
	LGH EN 02 (1 case)	_										
•		08:05	08:40	Pre-Day Surgery		0	CSTSNDEMOENDO, STONE	24 years	"Colon"	Lewis, R		
	LGH OCC Rm 9 (Exam) (1 case)									
		11:00	12:00	Pre-Outpatient		Ö	TESTING, PAC	30 years		Plisvcw, T		
	LGHOO Anes - Block 2	(1 case)				3.00						
		09:15	10:00	Pre-Day Surgery		Q	CSTPRODBCSN, MEREDITH	37 years		Peeks, K		
	LGHOR AddOn 01 (1 c	ase)										
		08:00	09:25	Pre-Inpatient	•		CSTSNCOOPER, STBETTY	17 years	"Consent Provided"; "Consent Provided for	Baggoo, A		E

- To navigate back to Perioperative Tracking, Select Perioperative Tracking from the Toolbar
- Patients will reside in LGH EndoPreOp or PostOp Tracking View (or tab) depending on where they are in their patient journey
- Each row within Perioperative Tracking represents a patient. They are typically arranged chronologically and by room (e.g. Procedure Room 1, 2, 3)

2 To open a patient's chart from Perioperative Tracking:

- 1. Ensure the LGH Endo PreOp view is selected (the tab title will be bold)
- 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 name to open their chart

P Assign a Relationship		
For Patient: CSTSNWORKBOOK, PREOP		
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. Select Nurse to assign relationship.



5. Click OK

3

Perioperative Summary is the landing page when you access a patient's chart; this is where you will find an overview of key clinical information on a patient's chart.

	CSTSNDEMOENDO, STONE - 70000	5212 Opened by TestSX, NursewithSaAnesthesia-Perioperative					ł	- 0 ×
	Task Edit View Patient Chart	Links Navigation Help						
	Perioperative Tracking 🖃 Message C	ientre 🎍 Patient List Dynamic Case Tracking 🎬 Pref Card Picklist 👹 C	ase Selectio	n 🎬 Day of Surgery View 🎬 Historical View 🎬 LearningLIVE 🧋				
	CareConnect 😋 PHSA PACS 😭	VCH and PHC PACS 🕄 MUSE 🐧 FormFast WFI 🐰						
1	Tear Off	ledication Administration 🔒 PM Conversation - 🕞 Communicate - 🗟	Medical R	ecord Request 🕂 Add 🖌 💽 iAware 😁 Scheduling Appointment Bo	ok 🗑 Document	ts 📇 Staff Assign 🎬 💽 Patient Health Edu	cation Materials	
2	CSTSNDEMOENDO, STONE					← List =	🗄 🍘 Recent 👻 Name	، م
	CSTSNDEMOENDO, STONE	DOR01-10-1883 WKW:100002515		Process:		Location:LGH	Endoscopy	
2	Allertics No Known Allertics	Age:24 years Enc:700000016472		Disease:		Enc Type:Pre-D		
3	Allergies: No Known Allergies	Gender:Female PHIN:9876781011		ing wt://kg Isolation:		Attending:	Full comes	3 0 minutes ano
-	menu	Perioperative Summary					5	C- o minutes ago
I 1	Perioperative Summary	👫 📗 🔍 🔍 100% 🔹 💭 🌑 🟠						
L	Perioperative Doc	6 p Summary 💱 Intraop Summary 💱 P	ostop Sumi	mary 💱 Handoff Tool 💱 Discharge	S	3 Quick Orders 🛛 🗧 🕂	V	
L	Orders 🕈 Add	Procedural Information	=. 0	PowerForms (0)	=. 0	Broopgrative Checklist		= 0 0
L	MAR	Procedural Information		Powertoring (o)	- 0	Cleated visit		
L	MAR Summary	Case Number: LGHEN-2017-221		Vital Signs 💠 🗸	≡•⊗	Selected Visit		
L	Interactive View and I&O	Primary Procedure: Colonoscopy		Selected visit -		NPO X		÷.
I 1	Results Review	Surgical Free Text: Colon		No coulte found		FCG A		
I 1	Form Browser	Anesthesia Type(s): Procedural Sedation	_	HO TESUICS TOUTO		1 H8P		¢ E
I 1	Histories	Surgery Start:		Labs	≡• ⊘	ID Verification		\$
L	Allergies + Add	Surgery Stop:		Selected visit -		Site Verification		¢
I 1	Diseases and Dashlams	Anesth Start:		No combo found				
L		Anesth Stop:		No results round		Outstanding Orders (1)		=• ~
L			== 0	Measurements and Weights (0)	≣• ⊗	Selected visit		
L	CareConnect	Allergies (1)	=- ~	Selected visit		CT Chart Abda Dabis w/a Castrart 5	Ratus Ordered	17.16-06
L	Clinical Research	All Visits	-	No results found		CT Chesc Abdo Pelvis W/o Condrasc P	Future 10/10/	17 10.00
L	Documentation 🕂 Add	No Known Allergies	_			Clinical Research (0)		≡•⊗
L	Immunizations	Diamagan	== 0	Home Medications (3) 💠	≡• ~			
L	Lines/Tubes/Drains Summary	Diagnoses	*		-	On Study No. consults found	Status Conta	
L	Medication Request	Selected visit	7	Medications 🗣	=• ~	No results round		
L	Patient Information	No results found		Selected visit		Perioperative Tracking		≣∙⊗
L	Reference	Problems	≣• ⊘	⊿ Scheduled (0)				
		All Visits		Continuous (0) CONULtracked data (unitable (0))		Anticipated Start Dt/Tm 12/	/12/17 08:05	
4				2 Prot/Unscriedured Available (0)		Anucpated Duration 35	0.00.00	*

- 1. **Toolbar** located above the patient's chart, allows you to access various functionalities within Powerchart.
- 2. **Patient Tab(s)** when more than one patient's chart is open, each tab displays the patients' names, clicking **x** will close the chart.
- 3. Banner Bar displays patient demographics and basic information.
- 4. **Menu** allows access to different sections of the patient chart similar to the coloured dividers within a paper-based patient chart.
 - Click ^{**P**} to pin the Menu
 - Click
 to unpin the Menu for a wider view
 - Click on the far left to access a collapsed Menu
- 5. **Refresh Icon** updates the patient's chart with the most up-to-date information. It is important refresh the chart frequently especially as other clinicians may be accessing and documenting in the patient chart simultaneously.

Hint: Always remember to REFRESH your screen any time you modify the patient's chart in order to see your changes, when in doubt or when something is not working, REFRESH your screen!

NOT Refreshed ^{21 hours 32 minutes ago}	vs. Ref	freshed	🍳 0 minutes ago
--	---------	---------	-----------------

6. **Workflow Tabs** – Depending on what stage the patient is in, Click to access more details about them under the relevant tab (e.g. Preop, Intraop, Postop, and Discharge)



7. **Summary Tabs** – Navigate/View different sections of the patient chart underneath each tab (e.g., tabs with 📑 enables you to shortcut to documentation)

🔦 Key Learning Points

- Select the appropriate view in Perioperative Tracking (e.g., LGH EndoPreOp)
- Users accessing a patient's information for the first time are prompted to Assign a Relationship with the patient.
- Perioperative Summary is the landing page when you open a patient's chart.
 - The Perioperative Summary page provides an overview of the patient information and allows for navigation elsewhere in the chart.



Activity 1.2 – Set an Event to Update Patient Status in Perioperative Tracking

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's Status (e.g., Pt. in Waiting Room), and notifications (e.g., Seen by Nurse)

Do not close the patient chart from the previous activity. The chart can remain open even though you will access Perioperative Tracking.

To Set an Event:

1. Return to Perioperative Tracking, ensure LGH EndoPreOp view is selected



2. Right Click anywhere on the line with the relevant patient, Select **Set Events** from the drop down list.



3. In the Case Tracking Set Events window, Select the orange **PreOp** tab

Note: You may need to resize your Case Tracking Set Events window if you cannot see the icons

4. Select **Pt. in PreOp** icon



• Notice the Pt. in PreOp button disappears from the PreOp tab and appears in the right details window.

Case Trac	king Set Events		
	CSTSNDEMOENDO S	Surg Start Time: 08	
	LGH EN 01	Surgeon: Le	wis, Richard Huw
rocedure:	Colonoscopy	Case ≆: LG	HEN-2017-205
n PAC	Case CX Day of Surgery	Date Time Locked Icon Na 20-Nov-2017 9-29 Pt	ime : in PreOn
Locatio	Delay		
PAC	Block Needed		
Preop	Block Ready		
Intra0p	Pt. in Block Room		
hase II	Pt. in Waiting Room		
hase l/P	Ready for Surgery		
	Transport to OR		

- 5. Click OK
- 6. Verify that the patient Status has been updated in Perioperative Tracking

CSTS	NDEMOENDO, STON	E ×									- 🛍 Rece	nt • Name	• • ٩
Peri	operative Tracking										[0] Full screen	Print	€ 0 minutes ago
LGH	Endo PreOp LGH Endo	PostOp LGH	H Endo Incomp	lete									
Filt	er: LGH EN Preop Today	- 🖻 🔞	i 🔒 🔶 🔋	Total Cases: 1									
	Status	Start	Stop	Add Pt. Type	СК	Alerts Allerg	y Patient	Age	Procedure	Provider	PreO	p Nurse	Scheduli
	LGH EN 02 (1 case	a)											ľ
►	Pt. in PreOp	08 05	08:40	Pre-Day Surgery		Ö	CSTSNDEMOENDO, STONE	24 years	"Colon"	Lewis, R			
		_											

2 Events may be modified if necessary. The date and time are set when you modify the event. The date and the time are the only fields that can be modified on an Event.

To modify an event:

- 1. Right Click the Event to modify
- 2. Select Modify Event to open the details window
- 3. Modify the time 10 minutes back
- 4. Click OK



5. Click OK



3

Events may be removed as necessary. To remove an Event:

Date 18-Dec-2017	Time 12:40	Locked	lcon	Name Ready for Surgery	
5	12:42		Ţ.	Pt. in PreOp	Add Event Modify Event Remove Event

- 1. Right-Click Set Events from the LGH Endo PreOp view
 - Case Tracking Set Event window opens
- 2. Right Click on the Event to remove
- 3. Select Remove Event
- 4. Click OK

4 Once all the pre-op activities have been completed you will set the patient's status to "Ready for Surgery" in Perioperative Tracking.



1. Return to the patient chart by clicking on the tab above Perioperative Tracking to reopen the patient chart



Key Learning Points

- Right Click anywhere on the line with the relevant patient to set event(s) too update a patient's Status in Perioperative Tracking.
- Events can be added, removed or modified.
- Date and time are the only fields that can be modified for an Event already set



Activity 1.3 – Review the Patient's Chart for Documentation (e.g., Consent Form)

1

To access the patient's Procedure Consent:

Menn	S Perioperative Summary		John Kinner Commentation
Preimperative Summary	A B (B B (S + 10 B G)		
Colors & Ald	Press Summary II Intrate Summary II Pedice I	Saramany II Quols Orders II Handoff Teel	1 + Em > / =
N/1	and a second	Measurements and Weights (0)	Solected net
MAR Summery		Selected visit	His Apoulta Roand
Interactive View and ISLO	No. Konan Mediciliyo Alertari	No results found	Clinical Research (II)
Repuits Faurew		and the second sec	And And And And
Form Browner	Degenera II* O		The results floared
Hatoree	Selected stat	Reduction . ET 9	
Alorges + Add	The results found	Selected visit	Perhaperative Tracking R* O
Diagnouss and Problems	Problems II* O	# Scheduled (I)	Anticipated Start DUTH 06/32/37 11:00
	Al toda	→ Continues (0) → PR0(Contracteduded Acadatite (0)	Antopared Duration 60 Courating Room LCHOR KC
CareConnel	Cambone: 4	 Administered (0) Last 24 Isaars 	Public Sched Comment
Cincil Reserch	New	# Supported (0)	Private Sched Comment
	This wait (W	Conservation for the states	(Determined (2) .
Line Dates (Davis Summary	Carto Santa Car	Elegendas (1)	Last 25 North -
Medication Request	Onine IV	Micro Calherra (2)	E My Ceamera
Patient Monmation	No results to display	Dependent (AM)	heading and and and a
Reference	HERRY IN STORE AND A DOMESTICS	Lines, Tubes, and Draim (1)	Percep Preprocedure Checklist - Test 201, Nurse-Perceperative 05/13/17 14:40
	Family History (0) II * 0	0	
			Sedake and Detput
	House Herey (1)		Last 3 days for the selected with
	Social History (I) E • 🔿		No resulta fixand
	Al Yola		- Hereiter eine hannen ber bereiter bereiter

- 1. On the Perioperative Summary page
- 2. Ensure the Preop Summary tab is selected
- 3. Locate Documents
- 4. Click on the **Consent Procedure** link



- 5. The patient's completed consent will be displayed.
 - Only COMPLETED consents will be associated to patient charts. If the patient does not have a signed consent, you will need to print a blank paper consent from FormFast
- 4. To close the consent, click Exit 4 in the top left-hand corner



Key Learning Points

Completed Procedure Consent can be found under Documents for review.

Blank consents can be printed from FormFast.



Activity 1.4 – Document in the Endoscopy Assessment & Perioperative Preprocedure Checklist

Overview of PowerForms

1

PowerForms are one way of documenting patient information/assessments in PowerChart. They are similar to paper forms but with more functionality. Certain details entered in PowerForms automatically flow elsewhere in PowerChart so there is no duplication and other clinicians can access the same information. In Endoscopy, information/assessments are documented in 2 PowerForms.

	DEMOENDO, STONE		Surgery/Procedure Date/Location Reviewed Procedure Location Procedure Date/Time	Discharge Contact Name John Snow Discharge Contact Phone(s) (604) 123 4567
Social History Procedure History Family History Numeric Pain Scale FACES Pain Scale Morse Fall Risk 2 Progress Note - Simple	Barriers to Communication	Reason Una None Clinical condit Cognitive impe Language ban	able to Obtain Information Physical impairment irrent	Discharge Contact Relationship
	Visitors/Family Visitor/Family Information		Visitor/Family Restrictions	

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. The red asterisk ★ indicates required field(s) to be completed within that section. The checkmark ✓ ID Risk Screen means that mandatory fields in that section are completed.

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

• Required field(s) within the PowerForm will be highlighted in Yellow. You will not be able to finalize a PowerForm unless all required fields are completed. For example,



ID Risk Screen and Violence and Aggression Screening are sections that contain mandatory fields to be completed in the Endoscopy Assessment PowerForm.

- 2 To open both Endoscopy Assessment PowerForm and the Perioperative Preprocedure Checklist:
 - 1. Click the **AdHoc** ^{MAdHoc} icon from the Toolbar
 - The Ad Hoc Charting window opens
 - Select the Decide the Endo folder from the left pane
 - 3. Select the Endoscopy Assessment PowerForm 🔽 Endoscopy Assessment and Perioperative Preprocedure Checklist 🗹 E Perioperative Preprocedure Checklist
 - 4. Click Chart
 - Endoscopy Assessment is the first form to open

3 Documentation in the Endoscopy Assessment PowerForm

The following sections are available for documentation in the Endoscopy Assessment PowerForm:

- General Information
- Barriers to Communication
- Allergies
- Vital Signs and Measurements
- Past Medical History, Problems, Diagnosis
- Patient Screening History
- Medication History
- * ID (Infectious Disease) Risk Screen
- Violence and Aggression Screening
- Social History
- Procedure History
- Anesthesia Sedation
- Family History
- Pain Assessment (there are several Pain Scales)
- Morse Fall Risk
- Progress Note

4 Complete the **General Information** section:



General Information	General				
Allergies	Information Given By	Surgery/Pro	cedure Date/Location	Discharge Contact Name	
Vital Signs and Measurements	Patient			John Snow	Ŀ
Patient Screening History	E Family	Procedure D	ate/Time		
Medication History	Community Care/Case Manager			Discharge Contact Phone(s)	
ID Risk Screen				(604) 123-4567	
Violence and Aggression Screening					
Social History	Barriers to Communication	Reason Unable to Obtain 1	nformation		
Procedure History	O Yes	O None O Physica	l impairment	Discharge Contact Relationship	•
Family History	O No	C Clinical condition		O Unable to obtain O Caregiver	ŀ
Numeric Pain Scale		C Cognitive impairment		O Patient O Other:	
FACES Pain Scale		C cangaage banks		O Daughter	
Morse Fall Risk	Answer "Ver" if the patient bac			O Family member	
Progress Note - Simple	Anguage barriers, requires interpreter support, or has sensory deficits.			 hrend Parent Sibing Significant other Son 	
	Visitors/Family				
	Visitor/Family Information	Visitor	/Family Restrictions		

- 1. Click the General Information section.
- 2. Enter the following information to complete the General Information section:
 - Information Given By = Patient
 - Discharge Contact Name = John
 - Discharge Contact Phone(s) = 604-123-4567
 - Discharge Contact Relationship = Spouse
 - Barriers to Communication = *No*

Note:

- For fields that contain circle O (radio) buttons, only 1 selection can be made
- For fields that contain square □ checkboxes (e.g. Information Given By), multiple selections can be made
- · A blank box indicates a free text area where you may type any text





Complete the Allergies Section:

/ 🖬 💟 🗞 🌠 🕈 🚸							
Performed on: 12-Dec-2017	🔹 💌 1454 🌩 PST						
General Information	Allergies						
Barriers to Communication							
Allergies							
Vital Signs and Measurements	Mark All as Reviewed						
Patient Screening History	And Margaret Com		No Konsen Markins Allensies	D	Charab	Display All	_
	Add I SI Modify I UN	lo Known Allergies 🛛 🔍 🔊 I	No Known Medication Allergies	🚮 Keverse Alle	rgy Check '	All	
Medication History							
Medication History ID Risk Screen	D. Substance	Category	Severity Reactions	Interaction Con	nments Source	Reaction Status	Revie
Medication History ID Risk Screen Violence and Aggression Scree	D Substance	Category Drug	Severity Reactions Moderate	Interaction Con	nments Source	Reaction Status Active	Revie
Medication History ID Risk Screen Violence and Aggression Scree Social History	D. Substance	Category Drug	Severity Reactions Moderate	Interaction Con	nments Source	Reaction Status Active	Revie
Medication History ID Risk Screen Violence and Aggression Scree Social History Procedure History	D. Substance ✓ penicillin	Category Drug	Severity Reactions Moderate	Interaction Con	ments Source	Reaction Status Active	Revie
Medication History ID Risk Screen Violence and Aggression Scree Social History Procedure History Family History	D. Substance ✓ penicillin	Category Drug	Severity Reactions Moderate	Interaction Con	iments Source	Reaction Status Active	Revie
Medication History ID Risk Screen Violence and Aggression Scree Social History Procedure History Family History Numeric Pain Scale	D. Substance penicillin (Category Drug	Severity Reactions Moderate	Interaction Con	aments Source	Reaction Status Active	Revie
Medication History ID Risk Screen Violence and Aggression Scree Social History Procedure History Family History Numeric Pain Scale FACES Pain Scale	D. Substance penicillin (Category Drug	Severity Reactions Moderate	Interaction Con	mments Source	Reaction Status Active	Revi 23-N
Medication History ID Risk Screen Violence and Aggression Scree Social History Procedure History Family History Numeric Pain Scale FACES Pain Scale Morse Fall Risk	D. Substance penicillin (Category Drug	Severity Reactions Moderate	Interaction Con	mments Source	Reaction Status	Revii 23-N

The patient currently has an allergy to penicillin recorded. To confirm this, Select **Mark All as Reviewed**. Allergy documentation <u>must</u> be completed to order and administer medications in PowerChart.

The patient mentions they actually have an allergy to adhesive tape. To document the adhesives allergy:

- 1. Click the Allergies section
- 2. Click the Add ⁺ icon
 - The Add Allergy/Adverse Event window opens
- 3. Enter <adhesive> in the Substance field and Click Search
 - The substance search window opens
- 4. Select Adhesive Bandage
- 5. Click OK
- 6. Enter the following information to complete the Allergies section:
 - Severity = Mild
 - Info source = Patient
 - *Category = Other
- 7. Click OK



6

Complete the Vital Signs and Measurements section

P Endoscopy Assessment - C	STSNDEMOENDO, STONE			
*Performed on: 12-Dec-2017	1454 🌩 PST			
General Information				
Barriers to Communication	vital Signs			
Allergies	Terment		DeeC	Following the completion of this
Vital Signs and Measurements	Artery	Oral	Degc	section, please complete the Modified and Pediatric Early
Patient Screening History	- DeaC		DeeC	Warning Systems (MEWS/PEWS)
Medication History	Tympanic	Rectal	Dege	section as appropriate.
* ID Risk Screen				
★ Violence and Aggression Scree	Axillary DegC			
Social History				
Procedure History	Apical Heart bpm Rate	Possivatore (br/min	
Family History		Rate		
Numeric Pain Scale	Peripheral bpm			
FACES Pain Scale		Mean Arterial Processor		
Morse Fall Risk	Heart Rate bpm	Fressure		
Progress Note - Simple	Monitored	Sn02 Site	O Ear O Hand	7
	Systolic/ Diastolic BP	mmHg	O Foot O Other:	
	Sp02 %	02 Therapy		
	02 Flow Rate	 Ambient oxygen Aerosol mask Artificial airway Blow-By 	Nasal cannula Norrebreather mask Simple mask T-Piece	
	FI02 %	High-flow Humidification	Trach mask Other:	
	Measurements			
	Dosing Weight	Source of Dosing Weight	Information Source	
	•			

- 1. Click the Vital Signs and Measurements section
- 2. Enter the following information to complete the Vital Signs section:
 - Temperature Axillary = 36.5
 - Peripheral Pulse Rate = 75
 - Systolic/Diastolic BP = 115/80
 - SpO2 = 99
 - Respiratory Rate = 14
 - Dosing Weight = 65 kg
 - *Weight Measured = 65 kg
 - Source of Admit Weight = *Measured*
 - *Height/Length Measured = I
- Dosing Weight <u>must</u> be completed to order and administer medications in PowerChart.
- Body Mass Index Measured (BMI) is auto-calculated from entry of *Weight Measured and *Height/Length Measured.

7



P Endoscopy Assessment - C	STSINDEMOENDO, STOINE		
🗸 🖬 🔕 📉 🗗 🕈			
*Performed on: 12-Dec-2017	7 🚔 👻 1454 🚔 PST		
General Information	Infectious Discoses Dis		
Barriers to Communication	Infectious Disease Kis	sk Screening	
Allergies	ARO: Antibiotic-Resistant Organisms including M	IRSA or VRE MRSA: Methicillin Resis	tant Staphylococcus Aureus
Vital Signs and Measurements	CPO: Carbapenemase-Producing Organisms	VRE: Vancomycin Resi	stant Enterococcus
Patient Screening History	Do you have any risk factors for AROs?	•	
Medication History	None	Chemotherapy within the last year	Household contact with known CPO in the last year
ID Risk Screen	Healthcare in Lanada within the last year Healthcare outside Canada within the last year	Intravenous drug use in the last year Incarceration in the last year	Unable to obtain
* Violence and Aggression Scree	Dialysis within the last year	Homelessness or in shelter in the last year	
Social History			
Procedure History	Healthcare includes medical/surgical procedures	s, overnight stays, chemotherapy, dialysis, or	other care specified by organizational practices.
Family History	If any risk is identified for AROs, the patie quidelines to determine which tests need	ent may need ARO screening swabs to b to be completed.	e ordered and performed. Please refer to site-spec
Numeric Pain Scale	In what facility and (or country did this	healthcare rick factor accur? When di	d this take place?
	In what lacing and/or country the	The second	
FACES Pain Scale	, and, are a second y did did	incurrente risk factor occur? When u	•
FACES Pain Scale Morse Fall Risk		incurrence i pri laccor occur i Wilen u	·
FACES Pain Scale Morse Fall Risk Progress Note - Simple			
FACES Pain Scale Morse Fall Risk Progress Note - Simple	Have you or a household member trave outside of Canada within the last 30 day	led ys? Location of Rece	nt Travel
FACES Pain Scale Morse Fall Risk Progress Note - Simple	Have you or a household member trave outside of Canada within the last 30 day	led Location of Rece	nt Travel
FACES Pain Scale Morse Fall Risk Progress Note - Simple	Have you or a household member trave outside of Canada within the last 30 day O Yes, paint O Yes, household member	led ys? Location of Rece Africe Africe	nt Travel
FACES Pain Scale Morse Fall Risk Progress Note - Simple	Have you or a household member trave outside of Canada within the last 30 day O Yes; patient O Yes; patient and household member O No.	led ys? Location of Rece Africa Africa Central Africe South	nt Travel
FACES Pain Scale Morse Fall Risk Progress Note - Simple	Have you or a household member trave outside of Canada within the last 30 day O Yes, patient O Yes, household member O Yes, patient and household member O No O No O Unable to obtain	Location of Rece	nt Travel Caribbean Caribbean Contral America Contral America China Cutrica Eastern Europe India Other:
FACES Pain Scale Morse Fall Risk Progress Note - Simple	Have you or a household member trave outside of Canada within the last 30 day Ores, pouehold member Ores, patient and household member No Unable to obtain	Location of Rece Africa Africa South Africa-South Africa-South Africa-South Africa-South Africa-South Africa-South Africa-South Africa-South	nt Travel Caribbean Bussia Cariba America States Eastern Europe Western Europe India Office: Mexico
FACES Pain Scale Morse Fall Risk Progress Note - Simple	Have you or a household member trave outside of Canada within the last 30 day O Yes, patient O Yes, bouehold member O Yes, patient and household member O No O Unable to obtain	Location of Rece Africa Africa-Scatta Africa-Scattal Afric	nt Travel Caribbean Caribbean Cariba America Chrina Chrin
FACES Pain Scale Morse Fall Risk Progress Note - Simple	Have you or a household member trave outside of Canada within the last 30 day O Yes; patient O Yes; household member O Yes; patient and household member O No O Unable to obtain	led ys? Africa Africa Africa-Central Africa-Central Africa-South Arrica-Vest Australia/New Zeal illance	nt Travel Caribbean Caribbean Central America Contral America Chine Caribbean Chine Caribbean Contral America Contral
FACES Pain Scale Morse Fall Risk Progress Note - Simple	Have you or a household member trave outside of Canada within the last 30 day O Yes, patient O Yes, household member O Yes, bousehold member O No O Unable to obtain	Location of Rece ys? Location of Rece Africa Africa Africa Central Africa-Scatta Africa-Scatta Africa-Statta Africa-Statta Africa-Statta Africa-Statta Africa-Statta Africa-Statta Africa-Statta Africa-Statta Arrica-Stat	nt Travel Caribbean Caribbean Cariba America Caritral Am

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

Note: You may also Select Yes / No / Unable to Obtain for each **Risk Factors and Symptoms/ARO Surveillance** field



P Endoscopy Assessment - CS	STSNDEMOENDO, STONE	
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*Performed on: 12-Dec-2017	1454 PST	
General Information Barriers to Communication	Violence and Aggression Screening	
Allergies	Violence and Aggression Screening Additional Information	
Vital Signs and Measurements	No risk assessed at this time	
Patient Screening History	Previous history of violent behaviour	
Medication History		
✓ ID Risk Screen	Cher:	
Violence and Aggression Scree		
Social History	If national has a provinue history of or current indication of violence or addression, complete the remainder of the form as applicable	
Procedure History	In patient has a previous instory of or current indication of violence or aggression, complete the remainder of the form as applicable.	
Family History	Current Patient Presentation Current Presentation Additional Information	
Numeric Pain Scale	Attack on object	
FACES Pain Scale	Instrument of harm/weapon	
Morse Fall Risk	Physical harm (e.g. strikes, grabs) Physical threat	
Progress Note - Simple	Unwanted sexual touch	
	Vetbal aggression with another behaviour or history of violence Vetbal ar written threat of physical violence Other:	
	Perceived Staff Approach Stressors Perceived Staff Stressors Additional Information	
	Enflocing or authoritarive Denial or delay of request, action or item Rushed or fast pace Sudden or unankipiteled approach Task. focus Unwelcome touch Other:	

- 2. Enter the following information to complete the **Violence and Aggression Screening** section:
 - Violence and Aggression Screening = No risk assessed at this time





Complete the Family History section:

P Endoscopy Assessment - CS	ISNDEMOENDO, STONE				
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*Performed on: 12-Dec-2017	🚔 🔻 1454 🌲 PST				
General Information					
Barriers to Communication			Family Histor	y	
Allergies					
Vital Signs and Measurements					
Patient Screening History	Mark all as Heviewed				
Medication History	Family				
✓ ID Risk Screen	🕂 Add 🗹 Modify	Display: Family Member Vi	ew (Positive Only) 🗸 🗸	Negative Unknown U	Jnable to Obtain 🛛 📄 Patient A
 Violence and Aggression Scree 	Last Update: 30.Nov.2017 14:28 b	u TestSX Nurse-Perioperative			
Social History	Last opuale. 301407-2017 14:20 bj	7 resion, indiser elloperative			
Procedure History	Family Member Information	Age of Onset	Severity	Course	Life Cycle
Family History	Cancer.				
Numeric Pain Scale	Father:				
FACES Pain Scale	Cancer.				
Morse Fall Risk	Colori Calicei				
Progress Note - Simple					
Trogress Note - Simple					
	•				•

- 1. Click the Family History section
- 2. Click the Add 🕇 icon

Family History							
dd Family History							
ast Update: 30-Nov-2017 14:28 by Te	estSX, Nurse-Perioperativ	e 📄 Focus Mo	de			▼ Add Far	ily Memb
	Relationship	Father	Mother	randmother (Mirand	father (M§ran	dmother (PGrano	lfather (
	Name						
	Health Status	-	-	• •	-	-	•
🗄 QuickList	Q				_		
General Family History	Q						
Alcohol abuse.	-						
Alzheimer's disease.	-						
Breast cancer.	-						
Cancer.	-						
Colon cancer	-						
Dementia.	-						
Developmental delay.	-						
Diabetes	-						
Heart attack.	-						
Hypertension.	-						
Mental disability.	-						
Osteoporosis.	-						
	- 1						

- 3. Within the Colon cancer row, Click once within the shaded column under Father
 - + appears in the box



Family History						
odd Family History ast Lindate: 30-Nov-2017 14-28 bu Te	stSX Nurse-Perioperat	Focus Ma	nde	💌 àdd Familis Mer		
	Relationship	Father	Mother	randmother (Norandfather (Morandmother (PGrandfather		
	Name					
	Health Status	•		· · · ·		
QuickList	٩		_			
General Family History	Q					
Alcohol abuse.	-					
Alzheimer's disease.	-					
Breast cancer.	-					
Cancer.	-	11				
Colon cancer	-					
Dementia.	-					
Developmental delay.	-					
Diabetes	-					
Heart attack.	-					
Hypertension.	-					
Mental disability.	-					
Osteoporosis.	-					
	-					

- 4. Double Click + to open the Update Family Member window
- 5. Click box next to Deceased
- 6. Enter Age of Death = 65
- 7. Click OK
- 8. Click OK to close Add Family History window

9 Finalize the Endoscopy Assessment PowerForm

Information entered into the Endoscopy PowerForm is not officially complete until you Finalize



- 1. Click the green check mark ✓ on the top left corner of the PowerForm
 - The Endoscopy Assessment PowerForm form will close
 - The Perioperative Preprocedure Checklist will open to the **Patient Preparation** section





offormed on: 01-Nov-2017	▼ 1337 PDT					
Patient Preparation	Patient Prepa	aration				
Preop Preprocedure Checklist	Procedure Location	Can Last Fluid and Last	Last Fluid Intake Amount	Patient Extern	nal Warming Device	
Program Note - Simple	Troccure cocución	Food Intake be Obtained?		Applied		
riogram note - simple	O Operating room	O Yes	mL.	O Yes	O N/A	
	C Cardiac Cath Lab	O Unable to obtain	Last Oral Intake Type	Nasal Decolori	Nasal Decolonization	
	C Radiology C Emergency department	Lact Ehvid Intako	O Clear liquid	C Yes	O N/A	
O Bedside O Other:	O Bedside O Other:		 Full liquid (other than breast mik) Solid food 	Preop Carboh	ydrate Drink	
				C HS		
		Last Food Intake		C AM		
		11,111,000 A V		O N/A		
		Last Void	Pre Transfusion Testing Complet	ed		
		10,000,0000 A V	Prior to Current Hospital Admiss	sion		
		Last Bowel Movement	O Yes O No			
	Alcohol, Substance Abuse	11,112,000 A	If answering "Yes" to either questions	below, contact Tran	sfusion Medicine Service	
	or Tobacco on Social History above, document	Alcohol Last lies	patient has been transfused/pregnant	. Order a STAT Group	p and Screen.	
	date/time of last use.		Has the patient been pregnant	Has the patien	t been transfused w	
			in the past 90 days?	red cells or pla	telets in the past 90	
		Taba and Look Has	-	-		
		Tobacco Last Use	O Yes	O Yes		
			O Yes O No O N/A	O Yes O No O N/A		
		Recreational Drug Last Use	O Yes O No O N/A	O Yes O No O N/A		
		Recreational Drug Last Use	O Yes O No O N/A	O Yes O No O N/A		
	Is there a possibility t	Recreational Drug Last Use	O Yes O No O N/A Preop Site Prep	O Yes O No O N/A		
	Is there a possibility t patient is pregnant?	Recreational Drug Last Use	C Yes C No C N/A Preop Site Prep	AM HS	N/A	
	Is there a possibility t patient is pregnant? O Yes O No	Recreational Drug Last Use	Ves No N/A Preop Site Prep 2% Chlorhesidine Wipes	AM HS	N/A	
	Is there a possibility t patient is pregnant? O Yes O No	INDUCCO LAST USE INTERIMENT OF MERICAN Recreational Drug Last Use INTERIMENT OF MERICAN INTERIMENT OF MERICAN INTERIMENT	Ves No NA Preop Site Prep 22 Chlorhesidine Wipes Wash with Chlorhesidine Solution	O Yés O Na O N/A	N/A	
	Is there a possibility t patient is pregnant? Yes No Hair Removal	Recreational Drug Last Use	Vec No NA Proop Site Prop ZX Chlorhesidine Wipes Wash with Chlorhesidine Solution Wash With Soap	AM HS	N/A	
	Is there a possibility t patient is pregnant? O Yes O No Hair Removal	Recreational Drug Last Use Recreational Drug Last Use Recreational Drug Last Use Boweel Prep Completed	C Yes No No Preop Site Prep 22 Chlorhesidine Wiges Wash with Chlorhesidine Solution Wash With Soap	AM HS	N/A	
	Is there a possibility patient is pregnant? Ves No Hair Removal O Doper O ho internoval performe	Recreational Orug Last Use www.www.last Use www.www.last Use Bowel Prep Completed d C Yes	V Yes No No No No No No No No No No No No No	AM HS	N/A	
	Is there a possibility transmission of the pregnant?	reaccould use use increase of a line of a line reaccould be a line increase of a line increas	V Yes O Hos O Hos O Hos Preop Site Prep 22 Chlorhendine Wyes Wash with Chlorhendine Solution Wash With Scop	AM HS	N/A	
	Is there a possibility patient is pregnant? Yes Ne Hair Removal Coper No hair removal performe Other:	Concern as use Concern and the concern as the con	C Yes D to O N/A Preop Site Prep 22 Chorheadine Wyes Wash with Chorheadine Solution Wash With Soap	AM HS	N/A	
	Is there a possibility 1 patient is pregnant? Vis No Hair Removal Coper Other.	Recreational Orug Last Use w.str.um Recreational Orug Last Use w.str.um Recreational Orug Last Use Bowel Prep Completed d C Yes C No. NA	V Yes No No No No No No No No No No No No No	AM HS	N/A	
	Is there a possibility t patient is pregnant? O Yes O No Hair Removal O Coper O No hair renoval performe O Drac	Produced Last Use International Drug Last Use International Drug Last Use International Drug Completed Bowel Prep Completed C Yes Bowel Prep Completed A C Yes A C Ye	V Yes O Hos O Hos O Hos Preop Site Prep 22 Chlorheadone Vijes Wash with Chlorheadone Solation Wash With Scap	AM HS	N/A	
	Is there a possibility t patient is pregnant? Ves No Hair Removal Cipper Other: Reviewed by OR Nurse	Recreational Oreg Last Use Recreational Oreg Last Use Re	C Yes No O No Proop Site Prop 22 Charbonatine Wass Wash with Charbonatine Solution Wash With Soap	AM HS	N/A	
	Is there a possibility t patient is pregnant? Ves No Hair Removal Oper Ohair removal patrome Other Reviewed by OR Nurse	reactors in the reactors Recreational Drug Last Use intervent Recreational Drug Last Use i	V Yes O Ho O Ho O Ho N Preop Site Prep 22 Chlorheadone Vijes Wash with Chlorheadone Solation Wash With Scap	AM HS	N/A	
	Is there a possibility t patient is pregnant? Ves No Hair Renoval Other Other Reviewed by OR Nurse Ves	Hereard Last Use	C Yes D to O Huit Preop Site Prep 22 Obseheadine Viges Wash with Charbraidine Solution Wash With Soap	AM HS	N/A	

The following sections are available for documentation in the **Perioperative Preprocedure Checklist** PowerForm:

- * Patient Preparation
- Preop Preprocedure Checklist
- Values/Belongings
- Progress Note

The red asterisk ***** indicates a mandatory section with required fields highlighted in yellow.

If you answer Yes to "Can the Last Fluid and Last Food Intake be Obtained"

Can Last Fluid and Last Food Intake be Obtained?
O Yes O Unable to obtain

The following two sections will be also be highlighted for completion.



- 1. Enter the following information to complete the **Patient Preparation** section:
 - Procedure Location = *Endoscopy*
 - Can Last Fluid and Last Food Intake be Obtained?= Yes
 - Last Fluid Intake = Today's Date, 06:00
 - Last Food Intake = Yesterday's Date, 11:30
 - Last Oral Intake Type = Clear liquid



- Bowel Prep Completed = Yes
- 2. To enter type of bowel prep used, Right Click anywhere on the **Bowel Prep Completed** box and Click **Comment**
- 3. Enter type of bowel prep used in the free text box and Click OK

		Comment
		Pt took picolax as instructed
Bowel Prep Co	mpleted Wash With Soap	
• Yes		
O No O N/A	Comment	
	Modifiers	
	Reference Text	
	View Result Details	
	Clear	OK Carel



Complete the Preop Preprocedure Checklist section

formed on: 01-Nov-2017						
tient Preparation	Broop Broprocoduro	Chockli	ot			
op Preprocedure Checklist	Preop Preprocedure	CHECKI	SL			
uables/Belongings	Preprocedure Patient Verification					
aress Note - Simple		Yes	No	N/A	Comment	
	ID Band on and Verified	~				
	Allergy Visual Cue Present	×				
	Site Verified by Patient/Family			×		
	Surgical Marking Verified by RN			×		
	Surgical Site/Side Marked by Surgeon			×		
	Patient Consents					
		Yes	No	N/A	Comment	
	Surgical Consent Complete			×		
	Blood/Blood Products Consent Complete			×		
	Blood/Blood Products Refusal Complete			×		
	Procedure Consent Complete	×				
	Video/Photography Consent Complete			×		
	Chart Review Current ECG in Medical Record	Yes	No	N/A ×	Comment	Capillary Blood Glucose Numeric
	Current H&P in Medical Record			×		Result
	Relevant Images in Medical Record	×				mmol/L
	Review of Labs	×				
	Capillary Blood Glucose Done			×		Capillary Blood
	Vital Signs, Height & Weight Documented	×				Glucose Non-
	Current Group & Screen Confirmed			×		indirence resourc
	Presence of Advance Care Plan/DNR Ord	ler		×		O Non-numeric High
	Current Medications Reviewed	×				C ASPHGINERIC LOW
	Preop Medications Adminstered	×				
	Prosthetics / Implants / Belongings					
		Ye	s No	•	Comment	
	Patient Has Implanted Device					
	Denture/Bridges/Orthodontic Devices Re	moved				If any Prosthetics /
	Glasses/Contacts/Hearing Aids Removed	×				Implants / Belongings
	Jewelry/Body Piercings Removed	×				Valuables / Belonging
						CECTION
	Nail Polish/Fake Nails/Makeup Removed					SECTION

- 1. Select Preop Preprocedure Checklist
- Enter the following information to complete the **Patient Preparation** section: Preprocedure Patient Verification
 - ID Band on and Verified = Yes
 - Allergy Visual Cue Present = Yes
 - Enter N/A for all other fields in this section

Patient Consents

• Procedure Consent Complete = Yes



- Enter N/A for the other fields in this section
- 3. Please also review the following content (not required for completion of this activity)
 - Chart Review
 - Prosthetics/Implants/Belongings

Hint: Clicking on the column header 'Yes', 'No', or 'N/A' will complete the whole section with that input



Perioperative Preprocedure Check	dist - CSTSNDEMOENDO, STONE			
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*Performed on: 01-Nov-2017	▼ 1337 🐥 PDT			
Patient Preparation Preparedure Checklist	Valuables/Belongin	ngs		
Valuables/Belongings	Does patient have any valuables/belongings with them?	Patient instructed to exception of persona	send all items home with the assistive devices?	Special circumstances including unconscious/incapacitated patients,
Progress Note - Simple	● Yes O No	 Yes; Items sent home wi Yes; Pt unwilling, or unal No; special circumstance 	h relative or friend sle to send items home with relative or friend s	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 Sent Home With Be	elongings Labeled	Does patient have any contrabands with them?	Contrabands Removed as per Policy
) <mark>Yes</mark>) Other:	O Yes O No	O Yes O Other:

- 1. Select the Valuables/Belongings
- 2. Enter the following information to complete the Values/Belongings section
 - Does patient have any valuables/belongings with them? = Yes
 - Belongings Labeled = Yes
- 3. Under Personal Devices, Double Click the cell next to Glasses

	Description	Number of Items
Assistive Devices		
Cane		
Contact Lenses		
Dentures, Lower		
Denture Partial Plate		
Dentures, Upper		
Glasses		
Hair Piece, ₩ig		
Hearing Aid, Left		
Hearing Aid, Right		

4. Enter <description and comment> as necessary



P Add Result Comment	×
Description	
reading glasses with red polka dot frame	
Comment	
1	
	OK Cancel

- 5. Click OK
- 6. Click the green checkmark \checkmark to finalize the **Perioperative Preprocedure Checklist**
 - The Endoscopy Assessment PowerForm form will close

13 If you need to modify documentation in any PowerForm after it's finalized, to re-open the PowerForm:

1. Select Form Browser Form Browser from the Menu

< 🖂 🕆 者 Form Browser	
< >	Monday, December 11, 2017 PST-
Sort by : Form 💌	
Dall Forms	
Findoscopy Assessment Image: The provide the provided and the	sthesia-Perioperative

- 2. Right click on the PowerForm to be modified
- 3. Modify information within the PowerForm, as necessary
- 4. Click the green check mark ✓ to finalize again

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



Key Learning Points

- In PowerForms, asterisked sections means there are required fields contained within. Required fields within sections are highlighted in yellow.
- All required fields must be completed in order finalize a PowerForm.
- All PowerForms are finalized only after clicking the green checkmark.
- Modifications to PowerForms can be made by accessing them through Form Browser.



Activity 1.5 – Initiate PreOp Orders

Orders Overview

1

Menu 9	< > • 🔒 Orders			(D) Full screen 🛛 👼 Print 🛛 🗞 18 minutes ag
Patient Summary	+ Add 2 Document Medication	by Hx Reconciliation - A Check Interactions		Reconciliation Status
Orders 🕂 Add				Meds History 4 Admission 4 Discharge
1 Patient Task List	Orders Medication List Documer	t In Plan		
MAR	K	Displayed All Active Orders 1 All Active Orders		Chour More Orders
Interactive View and I&O	View Orders for Signature	Displayed An Acare Crace An Acare Craces		UNIT THE DIDES.
Results Review	Plans	Se 🗟 🕫 Order Name 🍝	Status Dose	Details
Documentation + Add Medication Request	Document In Plan ⊟ Medical	⊿ Medications	Ordered	20 mg, IV, as directed, order duration: 5 day, drug form: inj, start: 17-Nov Administer pre red blood cell transfusion
Histories	- TM Red Blood Cell (RBC) - Suggested Plans (0)	△ Blood Products		
Allergies 🕂 Add		4 M 🕑 66° Red Blood Cell Transfusion	Ordered	Routine, Administer: 1 unit, IV, once, Administer each over: 120 - 180 Mi Informed consent must be present on patient record
Diagnoses and Problems	Admit/Transfer/Discharg Status Patient Care	△ Laboratory	Ordered	Blood, Routine, Collection: 17-Nov-2017 14:48 PST, once
	Asticity	I State of the second sec		·

To navigate the Order Profile and review the orders:

- 1. Select Orders from the Menu
- 2. On the left side of the Orders Page 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
 - Moving the mouse over order icons allows you 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
- 4. Orders are classified by status including:

	S	<u>₽</u> }	8	Order Name 🔺	Status	Dose	Details	*
		e 🖿 🖿	2	Insert Peripheral IV	Processing		20-Nov-2017 11:46 PST	
		🔁 🗆		Insert Urinary Cath	Proposal		20-Nov-2017 11:31 PST, Indwelling	
		🔁 🗹	1 🏂	Morse Fall Risk	Ordered		17-Nov-2017 14:05 PST, Stop: 17-Nov-2017 14:05 PST	
				Assessment			Order entered secondary to inpatient admission.	Ξ
		🔁 🗆		Vital Signs	Proposal		20-Nov-2017 11:25 PST, q4h while awake	
►		🔁 🗹	1 뚳 😧	Vital Signs	Ordered		17-Nov-2017 16:24 PST	
⊿	Mee	dicatio	ns					
		⊕ ⊵	1 🕞 🗈	furosemide	Ordered		20 mg, IV, as directed, order duration: 5 day, drug form: inj, start: 17-Nov- Administer pre red blood cell transfusion	Ŧ
٠.								

- Processing order has been placed but the page needs to be refreshed to view updated status
- Ordered active order that can be acted upon
- **Proposal** are proposed by non-providers. These are suggestions sent for provider review and should not be acted upon until signed by a provider. Once signed, these



will become active and status will change to Ordered as above

A PowerPlan in PowerChart is the equivalent of pre-printed orders in current state; they are multiphase order sets placed once for all phases in a patient's surgical/procedural journey.

2 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 endoscopy pre-op nurse will need to initiate the Pre-Procedure order.

	CSTSHIPEMOENDO STONE - 20005	112 Onenard In: TestSX: NorseTeamI earl, Perinnerative1			- 6	121 52
	Task Edit View Patient Chart	Links Options Current Add Help				LUIL ISS
	Perioperative Tracking (-1 Message Cer	ntre & Patient List Dynamic Case Tracking W Pref Card Picklist 20 Case Select	on W. Time-Critical Procedures W Discharge Dathboard W	Day of Surgery View IIC Historical View IIC Learning	ad IVE A PACS O FormFact WE	
SCHOLMWORNOUCSTONE CSTONEWARDNOUCSTONE CSTONEW	Tear Off M Exit MAdHoc IIIIMe	dication Administration 🔒 PM Conversation + 🔩 Communicate - 👔 Medical	Record Request 🔸 Add + 🔅 Preference Card Maintenance 🛔	Scheduling Appointment Book 🖷 Documents	😫 Staff Assign 🝵 Report Builder 🖨 Discern Reporting Portal 🛄 Report Manager 💽 Aware	
STANDARDON DON TONE Badge 24 A Cook Malage Badge 24 A Cook Malage 24 A Cook	CSTSNDEMOENDO, STONE				🗁 List 🛁 🌆 Recent + 🛛 Nime	• 9
April 2 years April 2 years Decomposition April 2 years April 2 years Decomposition April 2 years April 2 years April 2 years April 2 years April 2 years April 2 years </th <th>CSTSNDEMOENDO, STONE</th> <th>DOB:01-Jul-1993 MRN:700005</th> <th>212 Code Status:</th> <th>Process:</th> <th>Location:LGH Endoscopy: Pre Op; 03</th> <th></th>	CSTSNDEMOENDO, STONE	DOB:01-Jul-1993 MRN:700005	212 Code Status:	Process:	Location:LGH Endoscopy: Pre Op; 03	
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	Menu 0	Center, Fernale PHIV:5676783	UII Dusing WE77 kg	Isolation:	attending prisyca, Kotto, MD	
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Care Close		Suggested Plans (0)	M In tentanyl (fentanyl PRN range dose)	Ordered	dose range: 25 to 200 mcg, IV, as directed, PRN pain, drug form: inj, start: 31-Oct-2017 12:42 PDT	
Courd Breach Courd States Provide States Pr	CareConnect	Citizes	M The midazolam (midazolam PRN range dose)	Ordered	dose range: 1 to 10 mg, IV, as directed, PRN sedation, drug form: inj, start 31-Oct-2017 12:42 PDT	- II
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menolofisis livear Under Chenologia Subarrity Mada Jane Regest Mada Jane Regest Mada Jane Regest Subarrity Ethere is Ethere is Ether i	Documentation + Add	Z Patient Care				
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On the Orders profile:

1. Locate the Plans category to the left side of the screen under View



- 2. Under GI Endoscopy (Multiphase), Click the GI Endoscopy Pre Procedure (Planned)
- 3. Review order details within the PowerPlan
- 4. Click Initiate. The Ordering Physician box will display



🕂 Add 🎝 Document Medication by Hx Reconciliation 🗸 🚴 Check In	nteractions	Reconciliation Status
Orders Document In Plan		
	📕 🐗 😧 🕂 Add to Pha	Duration: None
View	P Ordering Physician	Dasa Dataile
E Plans	A CIT I Compose	Dose Decans
Document In Plan	Gi Endoscopy (Multiphase) *Physician name	
i Medical	Alerts last checked on 2011 Playex, Stuart, MD	
- GI Endoscopy Procedural Sedation (Module) (Validated) (Planned)	4 Admit/Transfer/Dischar	
GI Endoscopy (Multiphase) (Validated)	*Order Date/Time	
Pre Procedure (Planned)	⊿ Patient Care 23-Jan-2018 🚔 💌 1409 🚔 PST	
Post Procedure (Planned)	Vital Sig	once
- Suggested Plans (0)	△ Diet/Nutrition	
Orders	NPO for Phone	 Except medications with sips; after completion of bowel preparation
Admit/Transfer/Discharge	Clear Fi No Casimosturo Dequired	 Day before procedure
- Status	△ Continuous Infusions	
Patient Care	Paper/Fax	If no IV in place
Activity	Electronic	order rate: 50 mL/h, IV, drug form: bag
Diet/Nutrition	C dextrost	order rate: 50 mL/h, IV, drug form: bag
Continuous Infusions	4 Medications	
Medications	Bowel Preparation	
Blood Products	🤹 📝 polyeth	↓ 140 g, PO, once, drug form: powder
Laboratory	EQUIV 280 g/4000 mL oral liq)	140 g = 2000 mL, Give at on the day prior to procedure. Drink 250 mL every 10 min until 2000 mL solu
Diagnostic Tests	DUP/ 200 and and in a	140 g. PO, once, drug form: powder 140 g. 200 gt. C'arch. and drug formations Drink 250 gt. and a start 10 gt. 2000 gt. a start in sig
Procedures	EQUIV 280 graduer circuite crainiq)	1 and a 2000 million at on day of procedure. Drink 250 million and 2000 million at gr
Respiratory	EOUTV nowder)	I package, PO, once, drug form: powder Give aton the day prior to procedure. Mix each packet of PICO-S&LAX to 150 mL cold water. Stir for
Allied Health	codium picorulfate/Ma oxide/citric acid (PICO-SALAY	1 parkage PO end daug form: power and and parket of the object of the cold when shirts in
Consults/Referrals	EOUIV powder)	Give at on the day of procedure. Mix each packet of PICO-SALAX to 150 mL cold water. Following do
Communication Orders	D bisaCODYL	10 mg. PO, pre-procedure, drug form; tab
Supplies		Give in AM the day before procedure
Non Categorized	D bisaCODYL	10 mg, PO, pre-procedure, drug form: tab
Medication History		Give at HS the day before procedure
Medication History Snapshot	Antiemetics	
Reconciliation History	C ndansetron	4 mg, IV, once, PRN nausea, drug form: inj
Related Results	T Details	
Formulary Details		
Variance Viewer	Orders For Costanature Orders For Nurse Beview Save as My Favorite	30: Initiate
Contract Viewer		AR HINNEY

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



• Pre Procedure orders are now Initiated Pending, it is not initiated until Signed

🛧 Add 🖑 Document Medication by Hx Reconciliation = 🕭 Check Inte	eractions		Reconciliation Status Meds History 🔮 Admission	Discharg
Orders Document In Plan				
View	🔹 🔹 🖗 🛇 🕂 Add to Phase - 🛄 Comments Start:	2018-Jan-23 14:14 PST D	uration: None	
Plans	Second Component	Status	Dose Details	^
Document In Plan	GI Endoscopy (Multiphase) (Validated), Pre Procedure (I	Initiated Pending)		
Medical	Last updated on: 2018-Jan-04 11:40 PST by: Plisvcx, S	tuart, MD		
GI Endoscopy Procedural Sedation (Module) (Validated) (Planned)	Alerts last checked on 2018-Jan-04 11:40 PST by: Plisvo	ix, Stuart, MD		
GI Endoscopy (Multiphase) (Validated)	⊿ Admit/Transfer/Discharge			
St Pre Procedure (Initiated Pending)	Nurse to initiate Pre Procedure phase of t	his plan		
Post Procedure (Planned)	2 Patient Care	0.1.		
Supported Plans (II)	Ar Vital signs	Order	2018-Jan-23 14:14 PS1, once, Stop: 2018-Jan-23 14:14 PS1	
Order	2 Diet/Nutrition	Order	2018 Jun 22 1414 DCT. Except exclusion with size after exception of house exception.	
Admit/Transfer/Discharge	Clay Build Diet	order	Day lafers procedure Day lafers procedure	
- Online riverse backinge	4 Continuour lefuriner		- Day before proceedine	
Patient Care	Continuous Birustons Desert Peripheral IV Catheter	Order	2018-Jan-22 14:14 PST Mino IV in place	
Activity	sodium chloride 0.9% (sodium chloride 0	19% (NS) con-	▼ order rate: 50 m//h V drug form bag	
Dist/Mutition	destrose 5%-sodium chloride 0.9% (destr	rose 5%-sodi	order rate: 50 ml /h IV, drug form bag	- 1
Castingues Inferiore	⊿ Medications			
Continuous andstons	Bowel Preparation			
Pland Bradwate	polyethylene alycol 3350 with electrolyte	s (PEGLYTE	140 g. PO, once, drug form: powder	
Blood Products	EQUIV 280 g/4000 mL oral lig)		140 g = 2000 mL. Give at on the day prior to procedure. Drink 250 mL every 10 min until 2000 mL solution is given. I	. If pa
Laboratory	D State of the second secon	s (PEGLYTE	140 g, PO, once, drug form: powder	
Diagnostic Tests	EQUIV 280 g/4000 mL oral liq)		140 g = 2000 mL. Give at on day of procedure. Drink 250 mL every 10 min until 2000 mL solution is given. If patient	t bec
Procedures	sodium picosulfate/Mg oxide/citric acid	(PICO-SALAX	1 package, PO, once, drug form: powder	
Kespiratory	EQUIV powder)		Give at on the day prior to procedure. Mix each packet of PICO-SALAX to 150 mL cold water. Stir for 2 to 3 min unti	til co
- Allied Health	Sodium picosulfate/Mg oxide/citric acid	(PICO-SALAX	1 package, PO, once, drug form: powder	
Consults/Referrals	EQUIV powder)		Give at on the day of procedure. Mix each packet of PICO-SALAX to 150 mL cold water. Following dose, give 1500 t	to 20
Communication Orders	L DisaCODYL		10 mg, PO, pre-procedure, drug form: tab Give in AM the day before procedure	
Non Categorized	D DisaCODYL		10 mg. PO, pre-procedure, drug form: tab	u
Medication History			Give at HS the day before procedure	
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Reconciliation History	- ndansetron		4 mg. IV, once, PRN nausea, drug form: inj	
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variance viewer	Others For Note Heview	e eo my r er vine	A: man	r or signature

7. Click Orders for Signature



Add Tocument Medication by Hx Reconciliation * Check Inte Orders Document In Plan	ractions				Reconciliation Status Meds History 9 Admiss	ion Dischar
Mau	de (⑦ B) ♥ Order Name	Status	Start	Details		
Orders for Simplure	⊿ LGH Endoscopy; Endoscopy Wait; 45 E	Enc:76000	00000281 Admit: 201	3-Jan-18 11:25 PST		
	2 Patient Care	0.1	2010 1 21 00 10	2010 L - 31 00 10 P/T 01 3010 L - 31 00 10 P/T		
Desument In Disc	Vital Signs	Order	2018-Jan-24 09:19 .	2018-Jan-24 09(19 PST, once, stop: 2018-Jan-24 09(19 PST		
Medical	4 Dist/Nutrition	Order	2010-380-24 09:19 -	2010-Jan-24 09119 PST, if no tv in place		
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GE Endersony (Multichere) (Validated)		oraci	2020 3011 24 03:23 .	2020 Sun 24 0525 FST, Except medications with spy, and completion of bower preparation		
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Post Procedure (Planned)						
Suggested Plans (II)						
Orders						
Admit/Transfer/Discharge						
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Patient Care						
Activity						
Diet/Nutrition						
Continuous Infusions						
Medications						
Right Products						
Laboratory						
Diagnostic Tests						
Procedures						
Respiratory						
Allied Health						
Consults/Referrals						
Communication Orders						
Supplies						
Non Categorized						
Medication History						
Medication History Snapshot						
Reconciliation History						
Kelated Kesults	Details					
Formulary Details			0.1. T. N			C 0100
Variance Viewer	Unters For Cosp	gnature	Urders For Nutse Review			Sign

- 8. Click Sign
- 9. Click Refresh

3

Although providers are entering orders in PowerChart, there are times a nurse may order on behalf of a GI Provider. In this scenario, the GI Provider mentions that the patient should receive a dose of acetaminophen before their procedure.

This was not ordered before as part of the Pre Procedure orders, so we need to enter it as a verbal order, this type of 'one off' type order is also called an *Ad Hoc* order:

- 1. On the **Orders** page, Click + Add
 - a. Add Order window that opens
- 2. Enter <acetaminophen> in the search box and Click
- 3. Select 1000mg, PO once, drug form: tab

P Order Sentences	
Order sentences for: acetaminophen	V Filtered Order Sentences
650 mg, rectal, q6h, PRN pain-mild or fever, drug form: supp	Greater Than or Equal To 12 year 🔺
650 mg, rectal, QID, drug form: supp	Greater Than or Equal To 17 year
975 mg, PO, once, drug form: tab	Greater Than or Equal To 17 year
975 mg, PO, QID, drug form: tab	Greater Than or Equal To 17 year
975 mg, PO, QID, PRN pain-mild or fever, drug form: tab	Greater Than or Equal To 17 year
975 mg, PO, TID, drug form: tab	Greater Than or Equal To 17 year
975 mg, PO, TID, PRN pain-mild or fever, drug form: tab	Greater Than or Equal To 17 year
1,000 mg, PO, once, drug form: tab	Greater Than or Equal To 17 year
1,000 mg, PO, QID, drug form: tab	Greater Than or Equal To 17 year
1,000 mg, PO, QID, PRN fever, drug form: tab	Greater Than or Equal To 17 year
1,000 mg, PO, QID, PRN pain-mild, drug form: tab	Greater Than or Equal To 17 year
1,000 mg, PO, QID, PRN pain-mild or fever, drug form: tab	Greater Than or Equal To 12 year
1,000 mg, PO, TID, drug form: tab	Greater Than or Equal To 17 year
1,000 mg, PO, TID, PRN fever, drug form: tab	Greater Than or Equal To 17 year
1,000 mg, PO, TID, PRN pain-mild, drug form: tab	Greater Than or Equal To 17 year
1 000 mg PO_TID_PRN nain-mild or fever_drug form; tab	Greater Than or Equal To 17 year
Reset	OK Cancel

- 4. Click OK
- 5. Enter <GI Provider> in the Ordering Physician window and Select Verbal



Ordering Physician	
Order	
Proposal	
*Physician name	
*Order Date/Time	
06-Nov-2017 🔹 💌 1117 🗭 PST	
*Communication type	
Phone Verbal No Cosignature Required Cosignature Required Papet/Fax Electronic	
OK Cancel	

- 6. Click OK
- 7. Review/add any details necessary in the details pane, then Click Sign
- 8. Click Refresh

Key Learning Points

- The Order Page 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
- Remember to sign when initiating an order(s)
- Verify that the order is initiated by checking the View window under the Orders Tab.
- Ad Hoc orders may sometimes need to be placed by nurses



Activity 1.6 – Complete IView Documentation for a Peripheral IV Insertion

Interactive View and I&O (IView) is the electronic equivalent of current state paper flow sheets.

Endoscopy nurses in pre-op and post-op will be documenting in IView under the "Endoscopy Quick View" band:

Menu	4	< 🔹 者 Interactive View and I&C
Perioperative Summary		** 🖃 🕮 🐼 🖌 🚫 📓 📄 🗎 🗶
Perioperative Doc		
Orders	🕈 Add	Veriop Quick View
MAR		Periop Systems Assessment
Interactive View and 18	0	Periop Safety Departure
Interactive view and to		evileteke and Output
Results Review		Tintake And Output
Form Browser		Advanced Graphing
		X Adult Education
nistories		Contraction Pediatric Education
Allergies	+ Add	Endoscopy Quick View
Diagnoses and Problems		VITAL SIGNS
		Peripheral IV
		RESPIRATORY
		Sedation Scales
Clinian Damasak		PAIN ASSESSMENT
Clinical Research		Lines Catheter
Documentation	🕈 Add	Glucose Blood Point of Care
Immunizations		Restraint Information
		Provider Notification
Lines/Tubes/Drains Sumr	mary	

- 1. From the Menu, Select Interactive View & I&O
- 2. Select Endoscopy Quick View band

Overview of IView

1

2

Menu	< 🕞 👻 👬 Interactive View and I&O	
Perioperative Summary	🛰 🖃 🖽 🐼 🖌 😥 🕲 🐘 🖿 🍋 🗶	
Perioperative Doc		1
Orders 🕂 Ada	🗙 Periop Quick View	 Last 24 Hours
haan a	🗙 Periop Systems Assessment	
	X Periop Safety Departure	Find Item Critical High Low Abnormal Unauth Flag And Or
MAR Summary	Y Periop Lines-Devices	Danik Date Date Defended Di
Interactive View and I&O	🗙 Intake And Output	13.Dec.2017
Results Review	X Advanced Graphing	14:07 PST
	Adult Education	Heart Rate Monit bpm
Form Browser	Vediatric Education	SBP/DBP Cuff mmHc
Histories 1	C Endoscopy Quick View	Cutre Leave Annual Company
Allergies 📥 Add	VITAL SIGNS	Mean Arterial P mmHc
	Peripheral IV	Blood Pressure Method
Diagnoses and Problems	RESPIRATORY	Central Venous mmHg
	Sedation Scales	Intracranial Pre mmHc
CareConnect	DAIN ACCECCMENT	Cerebral Perfus mmHo
	GASTROINTESTINAL	∠ Oxygenation
Clinical Research	Urinary Catheter	Respiratory D//min
Documentation 🛛 🕂 Add	Glucose Blood Point of Care	Owners Articity
The second section of the second	Restraint Information	OxygenTherapy
Immunizations	2 Provider Notification	Oxygen Flow L/min
Lines/Tubes/Drains Summary		Humidificatio DegC
Medication Request		Tidal CO2 mmHg
		Sp02 %
Patient Information		Sp02 Site
Reference		A PAIN ASSESSMENT
		Pain Present
		Respiratory Rate br/min 3
		PROI

- 1. A band is the a heading with a collection of flowsheets organized beneath it. In the image above, Endoscopy Quick View band is expanded displaying the sections within it. A band is indicated by the pencil 📡 icon.
- 2. The set of bands below **Endoscopy Quick View** are collapsed. Bands can be expanded or collapsed by clicking on their name. A **section** is an individual flowsheet that contains related assessment and intervention documentation.
- 3. A **cell** is the individual field where data is documented.

Document an IV insertion in Endoscopy Quick View

1. Select IView from the Menu



- 2. Select Endoscopy Quick View
- 3. Select Peripheral IV

Periop System Assessment Periop State Departure Periop Lines-Devices Indiace And Output Advanced Graphing Adult Education Periop Lines VTAL SIGNIS Periop Lines VTAL SIGNIS Periop Lines Part ASSESSMENT Part ASSESSMENT Part ASSESSMENT Part ASSESSMENT GASTRONTESTINAL Unay Cather Glucose Blood Point of Core Part Astic Information Provider Natification Provider Natification	eriop Quick View	
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Intake And Output Intake And Output Advanced Graphing Qualit Education Pediatric Education Peripheral IV YTAL SIGNS Peripheral IV Path ASSESSMENT Peripheral IV Respiratory Rate Br/min Poset PAIN ASSESSMENT Provoking Painter Concore Location Location Location Provoking Provider Notification Provoking Pain Stes Provoking	Periop Lines-Devices	Result
Advanced Graphing Advanced Graphing Advanced Graphing Pediatric Education Endoscopy Quick View VTXL 595185 Respiratory Rate br/min Pain ASSESSMENT Pain ASSESSMENT Pain ASSESSMENT Pain ASSESSMENT Pain ASSESSMENT Pain ASSESSMENT Pain ASSESSMENT Concern GASTRONTESTINAL Unary Cathere GastrafontTeSTINAL Unary Cathere Respirate formation Provide Notification Provide Notification	ntake And Output	1 Works
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Kindoscopy Guick New VITAL SIGNS VITAL SIGNS Preventer VITAL SIGNS Preventer VITAL SIGNS Prevent Respiratory Rate Br/min Onset Provoking Privi ASSESSMENT Onset Provoking Privi ASSESSMENT Quality Location Location Country Restraint Information Provider Notification Provider Notification Provider Notification Secondary Pain Sites		Peripheral IV
VITAL SIGNS Pain Present Resthead IV Respiratory Rate bit/min Restriction Vitation Onset Sodation Scales Provoking PAIN ASSESSMENT Pailiating Quality Unary Clarter Glucose Blood Point of Care Laterality Restrict Homation Radiation Characteristics Provider Natification Secondary and site	ndoscopy Quick View	⊿ PAIN ASSESSMENT
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PAIN ASSESSMENT Palliating GASTROUTESTINAL Quaity Unary Catheter Location Glucose Blood Point of Care Laterality Restrait Homation Radiation Characteristics Provider Notification Pain Comment Secondary Pain Site	Sedation Scales	Provoking
GASTROINTESTINAL Uhany Clarker Ukany Clarker Glucose Blood Point of Care Restant Information Provider Notification Provider Notification Point Comment Secondary Pain Site	PAIN ASSESSMENT	Palliating
Ulnay/Catheter Location Glucose Blood Point of Care Restraint information Provider Notification Provider Notification Pain Comment Secondary Pain Site Additional Pain Sites	GASTROINTESTINAL	Quality
Glucose Blood Point of Care Laterality Restrait Homation Characteristics Provider Notification Characteristics Pain Comment Secondary Pain Site Additional Pain Sites	Urinary Catheter	Location
Restraint Information Radiation Characteristics Provider Notification Provider Notification Site Additional Pain Sites	Glucose Blood Point of Care	Laterality
Provider Notification Pain Comment Secondary Pain Site Additional Pain Sites	Restraint Information	Radiation Characteristics
Additional Pain Site	Provider Notification	Pain Comment
Additional Pain Sites		Secondary Pain Site
Additional Pairt Sites		Additional Dain Sites
Data Teal Used		Pain Teel Used
V Pain Tool Used		Pant tool Used

- 4. Click the dynamic group icon 🔣
 - The Dynamic Group window opens

eripheral Hand Left < Peripheral IV Catheter Size:>	A
Peripheral IV Catheter Type:	-
Peripheral	
Midline	
Peripheral IV Site:	
Antecubital	
Basilic vein	=
Cephalic vein	
Chest	
Digit	
External jugular	
Foot	
Forearm	
Frontal vein	
Great saphenous vein	
Hand	
Median cubital vein	
Posterior auricular vein	
Small saphenous vein	
Superficial temporal vein	
Upper arm	
Wrist	
Peripheral IV Laterality:	
✓ Left	
Right	
Medial	

- 5. Enter the following information to complete IV insertion documentation:
 - Peripheral IV Catheter Type = Peripheral
 - Peripheral IV Site = Hand
 - Peripheral IV Laterality = Left
 - Peripheral IV Catheter Size = 20 gauge
- 6. Click **OK**, a label will display under Peripheral IV heading



⊿ Peripheral IV	
⊿ <peripheral 18="" antecubital="" gauge="" left=""></peripheral>	
Activity	
Line Status	
Line Care	
Site Assessment	
Site Care	
Dressing Activity	
Dressing Condition	
Patient Response	

7. To enter further information for the IV insertion, Double Click on the cell next to Activity:

⊿ Peripheral IV			
⊿ <peripheral 18="" antecubital="" gauge="" left=""></peripheral>			
Activity	Activity 🗙		
Patient Identified	✓ Insert		
Total Number of Attempts	Assessment		
Unsuccessful Attempt Site	Blood drawn		
Line Insertion	Discontinued		
Line Status	Present on admission		
Line Care	Other		
Site Assessment			
Site Care			
Dressing Activity			
Dressing Condition			
Patient Response			

- Activity = Insert
- Total Number of Attempts = 1
- **Dressing Activity** = Applied

Hint: Instead of clicking to move to the next cell press the Enter

- 8. Click Sign button 🗸
 - The data will be automatically time-stamped for the current time and may be adjusted as necessary

Note: Documentation entered will remain purple and is not saved until Signed, finalized data shows in black. Once finalized, the documentation is available to all clinicians with access to the patient's chart.

🔦 Key Learning Points

- Endoscopy nurses in pre-op will be documenting in IView under the "Endoscopy Quick View" band.
- A dynamic group in IView allows detailed information about a nursing activity/assessment to be documented.
- Double Click the cell next to the section to activate it for charting.
- Click green checkmark to finalize IView documentation. Once finalized, IView documentation changes from purple to black.



Activity 1.7 – Utilize Barcode Scanning to Administer Medications

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.

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
- 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
- When the barcode scanner is not in use, wipe down the device and place it back in the charging station

In this activity, you will be using medication administration to give a dose of pre-op acetaminophen that was ordered previously:

- 1. Review medication information in the MAR. From the Toolbar, Click Medication Administration
 - The Medication Administration window opens prompting you to scan the patient's wristband



- 2. Scan the barcode on the patient's wristband
 - A list of ordered medications appear on the Medication Administration window
- 3. Scan the barcode for the acetaminophen to be given


				Nurse Review	Last Refresh at 11:3	9 PDT
CSTSN emale	DEMOENDO, STO	NE MRN: 700005212 FIN#: 700000012037	DOB: 01-Jul-1993 Age: 24 years		Loc: Pre "No Known /	Op; (
		02-Nov-2017 10:24	PDT - 02-Nov-2017 12:	54 PDT		
	Scheduled	Mnemonic	Details			Result
l)a	02-Nov-2017 12:00 PDT	acetaminophen	325 mg, PO, once, d Maximum acetamino	rug form: tab, start: 02-Nov-2017 ophen 4 g/24 h from all sources	12:00 PDT, stop: 02	
ि जि	PRN	fentanyl fentanyl (fentanyl PRN range dose)	dose range: 25 to 20	00 mcg, IV, as directed, PRN pain,	drug form: inj, start:	

4. Click Sign to complete your documentation

Note: You will still be able to document medication administration without barcode scanning, but you must provide a reason to override and move onto the next step.



Key Learning Points

First, verify that there was an order placed for the medication to be administered.

Medication Administration from the Toolbar utilizes barcode scanning to administer medication.



PATIENT SCENARIO 2 – Intra-Procedure

Learning Objectives

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

Complete intra-procedure documentation in both Powerchart (Perioperative Documentation) and SAAnesthesia (Sedation Record)

SCENARIO

As the endoscopy intra-op nurse, you have set up the procedure room for the patient's colonoscopy and ready to bring the patient into the room from the endoscopy pre-op area.

You will be switching between two applications: PowerChart & SAAnesthesia. As an endoscopy intra-op nurse you will be completing the following activities:

- Review Patient's PreOp Documentation
- Complete Patient Check-In to Access Perioperative Documentation
- Initiate Procedural Sedation Medication Orders
- Create a Sedation Record
- Document Times in the Sedation Record
- Document Medication Administration in the Sedation Record
- Document Patient Comfort Score (NAPCOMS)
- Enter a Pathology Surgical Request & Document a Specimen in Perioperative Documentation
- Finalize Perioperative Documentation & the Sedation Record

1



Activity 2.1 – Review the Patient's PreOp Documentation

As the intra-op endoscopy nurse, you see that the patient's status is set to 'Ready for Surgery' so you bring the patient to the procedure room for their colonoscopy:

LG	I Endo PreOp	Dp LGH E	ndo Incomple	te						
Fi	Iter: LGH EN Preop Today 🔹	1 🔯 🔞 1	🝰 🔶 🔳 (1	Total Cases: 2						
	Status	Start	Stop	Add Pt. Type	CK Alerts	Allergy	Patient	Age	Procedure	Provider
	LGH EN 01 (1 case)									
		13:00		Pre-Day Su	9	Q	CSTSNTOOK, STPEREGRIN	59 years	"Colonoscopy"	Plisvcx, S
	LGH EN 02 (1 case)									
	Ready for Surgery	07:50		Day Surgery	′ 🗸	Ö	CSTSNDEMOENDO, STONE	24 years	"Colon"	Lewis, R

To open the patient's chart (review of Activity 1.1):

- 1. Select the LGH EndoPreOp tab
- 2. Double Click the blue arrow Next to the patient's chart to open their chart

Perioperative Summary is the landing page when you open a patient's chart.

You can review the patient's pre-op documentation by accessing them via the Perioperative Summary page:

< 🔹 🔺 Perioperative Summary			[□] Full s	creen 🛛 👼 Print	ninutes ago 🌮
🗚 📄 📥 🔍 🔍 100% 🛛 + 🌰 🖬					
Preop Summary 🕅 Intraop Summary 🕅 Postop Sum	mary 🔀 Handoff Tool 🔀 Discharge	23 (uick Orders 🛛 🛠 🕂) 🗞 📃 🗐
Procedural Information =• 👁	PowerForms (0) 🕂 🗢	≣∙⊗	Preoperative Checklist		≡• ⊗ _
No results found	Vital Signs	=- 0	Selected visit		
		🔊	NPO 🗶		<u> </u>
	Selected visit 🔻		Consents #		<u>^</u>
	No results found		ECG		× E
All Visits	No results found		H&D W		× 1
No Known Allergies	Labs	≣• ⊘	ID Verification		÷
	Selected visit		Site Verification 🕌		÷
Diagnoses =• 📀	No. or other formed				
Selected visit	No results round		Outstanding Orders (3)		≡• ⊗
No results found	Measurements and Weights (0)	=- 0	Selected visit		
	Theast relience and theights (0)	- •	St	tatus	Ordered
Problems =• 🔿	Selected visit		Pathology Surgical Request O	rdered	14/12/17
All Vieite	No results found				11:16
All Value			Pathology Surgical Request O	Irdered	14/12/17
Classification: All	Home Medications (3) 🕂	≡• 📀			10:21
			CT Chest Abdo Pelvis w/o Contrast Fi	uture	16/10/17
Problem	Medications 🕂	≣• ⊘			16:06

2 Review the Endoscopy Assessment PowerForm and Preoperative PreProcedure Checklist completed by the PreOp nurse.

In Preop Summary Tab:

1. Under Documents, Select Endoscopy Assessment



🛔 📗 🖣 📄 🔍 🍕 100%	- 🕘 🖨 🟠				
Preop Summary	🔀 Intraop Summary	X	Postop Summary	X	Hando
Documents (6) 🕂				≡• (ð (F
Last 2 weeks for all visits 🔫					
My Documents					P
My Documents	Author		Date/Time		
My Documents Note Type Consent Procedure	Author Unknown		Date/Time 06/11/17 09:11		
My Documents Note Type Consent Procedure Endoscopy Assessment - Text	Author Unknown TestSX, NursewithSaAnest Perioperative	nesia-	Date/Time 06/11/17 09:11 03/11/17 10:43		
My Documents Note Type Consent Procedure Endoscopy Assessment - Text	Autor Unknown TestSX, NursewithSaAnest Perioperative TestSX, NursewithSaAnest Perioperative	nesia- nesia-	Date/Time 06/11/17 09:11 03/11/17 10:43 03/11/17 10:25		

2. Review the summarized Endoscopy Assessment PowerForm

CSTSNDEMOENDO, STO	NE Female 24 years DOB:01-Jul-1993	
Perform	Endoscopy Assessment Entered On: 03-Nov-2017 11:10 Pl ed On: 03-Nov-2017 10:43 PDT by TestSX, NursewithSaAnesthe	DT sia-Perioperative
Allergies <u>Allergies (Active)</u> No Known Allergies	Estimated Onset Date: Unspecified; Created By: TestSX, Nurse TeamLead-Perioperative1; Reaction Status: Active; Category: Drug; Substance: No Known Allergies; Type: Allergy: Updated By: TestSX, Nurse TeamLead-Perioperative1; Reviewed Date: 29-Sep-2017 14:33 PDT	(As Of: 03-Nov-201711:10:07 PDT)
Past Medical History, Probler Patient Screening History BLANK Neurological problems : No Stroke : No Seizures : No Severe i Headaches : No	ıs, Diagnoses	(As Of: 03-Nov-201711:10:07 PDT)
Glaucoma: No Cerebral Palsy: No	TestSX, NursewithSaAnesthesia-F	Perioperative - 03-Nov-2017 10:43 PDT

- 3. To close the window, Click 🕮
- 4. Under Documents, Select Periop Preprocedure Checklist
- 5. Review the summarized Periop Preprocedure Checklist

CSTSNDEMOENDO, STONE Female 24 years DOB:01	-Jul-1993
Perioperative Preprocedure Checklist Performed On: 01-Nov-2017 13:37 PDT I	Entered On: 01-Nov-2017 15:09 PDT by TestSX, Nurse TeamLead-Perioperative 1
Patient Preparation <i>SN - Unable to Obtain NPO</i> : Unable to obtain <i>Preop Bowel Prep Completed</i> : Yes (Comment Ptopk picolage as instructed ITedSX NurseTeamLead-F	TestSX, NurseTeamLead-Perioperative1 - 01-Nov-2017 15:22 PDT Perionerative1 - 01-Nov-2017 15:22 PDT1)
Preop Preprocedure Checklist Preprocedure Patient Verification ID Band on and Verified: Yes Allergy Visual Cue Present: Yes Site Verified by Patient/Family: NIA	TestSX, NurseTeamLead-Perioperative1 - 01-Nov-2017 13:37 PDT
Surgical Marking Verified by RN: NIA Surgical Site/Side Marked by Surgeon: NIA <u>BLANK</u> Surgical Consent Complete: NIA Blood/Blood Products Consent Complete: NIA	TestSX, Nurse TeamLead-Perioperative 1 - 01-Nov-2017 13:37 PDT
Bload/Bload Products Refusal Complete : NIA Procedure Consent Complete : Yes Videa/Photography Consent Complete : NIA DCP GENERIC CODE Current ECG in Medical Record : NIA	TestSX, NurseTeamLead-Perioperative1 - 01-Nov-2017 13:37 PDT
(Current H&P in Medical Record: N A Relevant Images in Medical Record: Yes Review of Labs: Yes Capillary Blood Glucose Done: N A Vital Signs, Height & Weight Documented: Yes Current Group & Screen Confirmed: N A Presence of Advance Care PlanD/NR Order: NIA	
Current Medications Reviewed: Yes Preop Medications Adminstered: Yes	



6. To close the window, Click #

To view the patient's Procedure Consent form:

1. Under Documents in the Perioperative Summary page, Select Consent Procedure

CSTSNDEMOEND	D, STONE Female 24 years	DOB:01-Jul-1993		
∲ ÷ ÷ ÷	Page 1	Vencouver Coastal Health Authority Consent: 1. Health Care: Medical or Surgical 2. Administration of Blood Products 1. Health Care: Medical or Surgical Charlen of Blood Products 1. Health Care: Medical or Surgical Charlen of the patient namina above, if we bailered of the above the patient namina above, if we bailered of MacDOBS/Other Charlen of the model medication of and the name inclinated effects, available atternatives and procedure ideorded above have been explained to re, last as gains to model or medication of and another the another bailered on solar metablesce 1. State signers to model or medication of another the 1. State signers to model or medication of another the solar 1. State signers to model or medication of another the solar 1. State signers to model or medication of another the solar 1. State signers to model or medication of another the solar 1. State signers to model or medication of another the solar the sol	A service A service and servic	
Result type Result date Result status Result status Encounter info	Consent Procedure Monday, 06-November-2017 09:1 Auth (Verified) Consent: Medical or Surgical, Ad 7000000013085, LGH Lions Gate	1 PST ministration of Blood Products , Day Surgery, 07-Nex-2017 -		

- 2. Review the procedure consent

Key Learning Points

Review the patient's pre-op documentation from the Perioperative Summary.



Activity 2.2 – Complete the Surgical Case Check-In to Access Perioperative Documentation

Perioperative Documentation (Perioperative Doc or Periop Doc) is used for documenting procedure-related information. It is the electronic equivalent of an intraoperative/intraprocedure record.

The first time you access Perioperative Doc, you must complete the **Surgical Case Check-In**. The Surgical Case Check-In is not equivalent to the patient check-in process completed in PreOp with the Preprocedure Checklist. The Surgical Case Check-in process is necessary to obtain access to Perioperative Documentation, but it should not occur until the patient is in the procedure room.

To complete the Surgical Case Check-In:

- 1. Select Perioperative Doc Perioperative Doc from the Menu
 - Document Selection window opens

Document Selection
Select the type of document you want to open.
日本
OK Cancel

- 2. Select LGH IntraOp Record EN
- 3. Click OK
 - Check In window will opens

					Age	24 Years		S	ex: Female	
CSTSNDEMOENDO, STC	General Summary Deta	ils Orders	Guidelines N	lotification	Conversation	Summaries	Itineraries	Locks	Eligibility	Booking Note
Surgery Endoscopy	Date:				Time					
	07-Nov-2017				1122					
	T		*							w.
	Tracking location:									
	<none></none>									
	Comments:									
	Person Name	Enc Type								
	Person Name CSTSNDEMOENDO, STON	Enc Type E Day Surgery								
	Person Name CSTSNDEMOENDO, STON	Enc Type E Day Surgery	Guar Pret	Ene		View	Modify		Sat Enc	Charme
	Person Name CSTSNDEMOENDO, STON	Enc Type E Day Surgery	Guar Prit	Enc	ht .	View	Modify		Set Enc	Charge
	Person Name CSTSNDEMOENDO, STON Request Information	Enc Type E Day Surgery No	Guar Prit	Enc	ht .	View	Modify		Set Enc	Charge

- 4. Verify the patient's information in the Check-In window, as necessary
 - Note: The Check-In window displays scheduling and encounter information
 pertaining to the patient. It is not necessary to review the information contained in
 the tabs at this point, however, you may choose to explore what is contained under



each tab in this activity.

5. Click OK

The patient will now appear as Checked-In on Perioperative Tracking indicated by a check mark under the 'CK' Column

LGH	Endo PreOp LGH Endo PostOp LG	H Endo Inco	omplete							
Filte	r: LGH EN PostOp Today 🔹 🛙 🔞) 🚔 🔶	📕 Total (Cases: 2		1				
	Status	Start	Stop	Add PT Type	CK	Alerts	Allergy	Patient	Age / Sex	Provider
	LGH EN 01 (2 cases)									
	Surgery Start	08:15	08:49	Day Surgery	$\overline{\checkmark}$		Ô	CSTSNDEMOENDO, S	24 years / Female	Lewis, R



- Perioperative Documentation is used for documenting procedure-related information.
- The first time you access Perioperative Doc, the system requires a process the Surgical Case Check-In.
- The Surgical Case Check-In is not equivalent to the patient check-in process completed in PreOp with the Preprocedure Checklist.
 - The Surgical Case Check-in process should not occur until the patient is in the procedure room



Activity 2.3 – Initiate GI Procedural Sedation Medication Orders

1

In order to document the procedural sedation medication you may be administering in endoscopy, you first need to make sure that an order for these medications were placed and initiated. This follows the same steps as Activity 1.4, but you will be initiating the procedural sedation medication orders.

On the Orders profile (access from Menu):

- 1. Locate the Plans category to the left side of the screen under View
- 2. Click the GI Endoscopy Procedural Sedation (Planned)

View
··· Orders for Signature
Plans
-Document In Plan
🖻 Medical
- GI Endoscopy Procedural Sedation (Module) (prototype) (Planned)

- 3. Review order details within the PowerPlan
- 4. Click Initiate. The Ordering Physician box will display
- 5. The Physician will autopopulate. Select No Cosignature Required
- 6. Click OK
- 7. Click Orders for Signature
- 8. Click Sign
- 9. Click Refresh

Key Learning Points

- In order to document the procedural sedation medication you may be administering in endoscopy, you first need to make sure that an order for these medications were placed and initiated.
- In order to complete the initiation of the GI Procedural Sedation order, you must Click Orders for Signature and Sign.



Activity 2.4 – Create a Sedation Record

Application: SAAnesthesia

1

2

So far, you have become familiarized with PowerChart. You will now be introduced to a different module that you will use in conjunction with PowerChart in order to make the endoscopy procedural sedation process more streamline.

SA Anesthesia is a specific module within the Clinical Information System designed to replace the current state paper charts Anesthesiologists use. This module is mostly used by Anesthesiologists with the exception of specific nurses in some perioperative areas. As an endoscopy intra-op nurse, you will be using SA Anesthesia to document patient's vital signs, procedural sedation medications, and other select data.

The patient's procedural sedation document you create using SA Anesthesia is called the 'Sedation Record'

Creating the Sedation Record involves:

- · Selecting the right patient to associate to the record
- Associating BMDI
- Pulling in Procedural Sedation medications
- Assigning yourself as an Attendee
- Assigning the GI Provider as Supervisor
- Executing a sedation macro

H 4 11-Dec-201 8:45 9:45 To Do List eted To Do 6 + 02 Flow -EKG - An × × 88 ß + + 1 >> × ٠O .

Overview of the Sedation Record

- 1. Toolbar Each icon allows access to specific actions.
- 2. Banner Bar Shows patient demographics like in Powerchart.

3



- 3. Workflow Pane Contains the To-Do List (list of actions to complete during the case).
- 4. **Monitors** Displays the vital signs and NAPCOMS documentation.
- 5. Medication Pane Displays medication administration
- 6. **Current Time** The Sedation Record is dynamic in that it will automatically scroll as time passes. The vertical line always represents the current time.
- 7. Vital Signs Graphing Displays the graphical component of BMDI.
- 8. **Event Pane** Displays actions completed from the To-Do List (ie. staff presence in the room, procedure start/stop time etc.).
- 9. **Views Buttons** The icons allow you to toggle between the To Do List, Documentation, and Reminder views to display in the Workflow Pane.
- To access SA Anesthesia from PowerChart and Create a Sedation Record:
 - 1. Click the SA Anesthesia SaAnesthesia icon from the toolbar in Powerchart.
 - Select Case window opens
 - 2. Select the patient under the Cases window and Double Click
 - **Note**: If you cannot find your patient in Select case, ensure that the Surgical Area field is set to LGH Endoscopy. You can also search a patient by name or MRN.



3. Verify the patient information is correct in the Verify Case window and Click the green checkmark.

CST	SND	EMOENDO,	STONE
MRN: 70000 Allergies: No Knowr	15212 Allergies	DOB: 01-Jul-1993	AGE: 24 years
Operating Room: Surgeon: Anesthesiologist(s): Surgery Date/Time:	LGH EN 01 Lewis, Richard I <none> 08-Nov-2017 8:1</none>	Huw 05	
Procedure	Procedure Colonoscopy	Surgeon Lewis, Richard Huw	
Case Number:	LGHEN-2017-1	93	

• Select Device window opens



BMDI (Bedside Medical Device Integration) automatically records data from bedside monitors into SA Anesthesia. Once the monitors are attached to the patient and BMDI is associated, the patient's vital signs will be automatically charted to the Sedation Record. It is important to associate the correct device to your patient. It is crucial so you are not documenting the wrong patient's vital signs.

To associate the BMDI device:

1. Select the LGH Endo tab

Select Device		-			٤
LGH Main OR	LGH Endo	LGH Out of O	R	Selected D	levices
LGHEN Monitors		-		Device	
LGH_ENDO_PF B650 MODEL 1	ROC1 LGH	LENDO_PROC2 B650 MODEL 1	LGH_END B MOD	0_PROC3 650 0EL 1	
	14-11		-		1
			9	<	•

2. Click LGH ENMonitors icon

Select Device	Endo LGH Out of O	R Selected Device	s
LGHEN Monitors		Device	
LGH_ENDO_PROC1 B650 MODEL1	LGH_ENDO_PROC2 B650 MODEL 1	LGH_ENDO_PROC3 B650 MODEL 1	
		< _ m	•
Other		OK Ca	ncel

- 3. Select the BMDI device for the correct procedure room
- 4. Click OK



5. Start User window opens next

😂 Start User - SXTEST.NSA	•••					
Do you wish to start your time?						
Activity Type:	Start Time:					
	Yes No					

In the Start User window, the endoscopy intra-op nurse is the Attendee. Start Time refers to when the monitors will start its documentation. These are defaulted entries and you do not need to change this.

6. Click Yes to continue

You'll recall that you initiated the GI Procedural Sedation orders, you will need to 'pull in' these meds to SA Anesthesia in order to document its administration:

7. Check the boxes next to the 3 procedural sedation medications to be pulled into the Sedation Record: *Fentanyl, Midazolam, and Naloxone*

📱 Continuing Orders 💿 💿 💌											
				Infu	sions						
Name	Details	Details			Ordered By		Last B	Bag Start	Volume Remaining	Continue?	
			F								
8				Medio	cations						
Name	Details	Status	Ordered	By	Last Doos	Last	Admin n	Frequency	Stop DtTm	Volume Remaining	Continue? ^
fentanyl (fentanyl PRN range dose)	dose range: 25 to 200 mcg, IV, as directed, PRN pain, drug form: inj, start 08-Nov-2017 09:57	Ordered	TestSX, Surgeon n, MD	-Physicia				as directed	15-Nov-2017 9:56	4 mL	
midazolam (midazolam PRN range dose)	dose range: 1 to 10 mg, IV, as directed, PRN sedation, drug form: inj, start: 08-Nov-2017 09:57	Ordered	TestSX, Surgeon n, MD	-Physicia				as directed		0	
naloxone	0.2 mg, IV, q3min, PRN other (see comment), order duration: 24 hour, drug form: inj, start.	Ordered	TestSX, Surgeon n, MD	-Physicia				q3min	09-Nov-2017 9:56	0.5 mL	
											•
+			Othe	r Sche	duled Or	der	S				
										ОК	Cancel

8. Click OK, the 3 medications will be populated to the To Do List in the Sedation Record

	To Do List							
Completed To Do	Event fentanyl midazolam naloxone	Details 200 mcg, IV 10 mg, IV 0.2 mg, IV						

Note: All initiated medication orders will show up on the Continuing Orders window, you should only pull in the medications related to the intra-op phase.



- 5 You will need to assign the GI Provider as a Supervisor in the Sedation Record. Upon finalization of the sedation record, any medications administered without an order entered will route for co-signature to the GI Provider.
 - 1. From the Toolbar, Select the Personnel resonance icon
 - Modify Personnel window opens
 - 2. Select Add



- Select Personnel window opens
- 3. Select the Procedural Provider tab

Select Personnel					×			
An esthesiologist	Anesthesiologist - As It i Medical Student	sisting Anesthesia	Fellow Anesthesia	Resident Other Re	sident			
Abedi, Nasim	Aslani, Nava	Aslani, Nava	ATT, Physician - Surgeon ATT, Physician - Surgeon	Baggoo, Alan Kieth				
Bessie, Jake	Brooks-Hill, Alexandra Louise	Brown, David Ross	Buonassisi, Thomas Joseph	Bush, Kevin Leslie				
Chang, Albert	Chang, George	Chew, Roderick	Chow, Victor Ding	Clark, Sarah Jane	E			
Crofts, Paul Gray	Cudmore, Richard Hugh	Dave, Mala	David, Eytan Abraham	Diamond, Ronald Christopher				
Donnelly, Carolyn Patricia	eLearn, MDSURG, MD	El-Sheikh, Rhonda	Evaschesen, Chad John	Fine, David Edgar				
Fry, Nicholas John	Gawley, William Finan	Godinho, Derek Vivek	Goldberg, Aron	Goojha, Ciaran Akash				
Gosnell, Shawn	Guilfoyle, Francis John	Hahn, Michael Eric	Haniak, William Angelo	Harriman, Maureen Margaret				
Ho, Jin Kee	Hoag, Christopher Campbell	Hoyer, Emelie Mary	Hunter, James McPhalen	Isbister, Carolyn Marie				
Jando, Victor Tibor	Janicki, Ryan Richard	Johner, Amanda Marie	Kang, Erh-Tung	Kaye, Stephen Howard				
Other Multi-Select								

- 4. Select <GI Provider>
 - The provider selected will be added as a Supervisor to the list view in the Modify Personnel box with the current time
- 5. Double Click the GI Provider's Start Time

•	🏘 Modify Personnel			- • •				
l	Personnel for LGHEN-2017-222							
	Name Lewis, Richard Huw TestSX, NursewithSaAnesthesia-Perioperative	Start Date Start Time End Date 14-Dec-2017 1552 2 14-Dec-2017 15.49	End Time Activity Type Supervisor Attendee	•				
	Add Remove		[OK Cancel				



- 6. Enter the time to match your Start Time
- 7. Click OK, the Sedation Record is now open

Note: Notice the two personnel icons appear in the Events pane; these represent you and the GI Provider.

C	TestSX, Nurse	ewithSaAn	esthesia-P	erioperativ	/e
<u> </u>	Lewis, Richard	d Huw			
100 M					

6 When a **Macro** is executed, the system runs a pre-defined number of events and actions in the Sedation Record automatically so you do not have to populate them individually (i.e. adding medications to the To Do List and routine vital signs documentation).

The macro you select will depend on whether or not medications were pulled in from the procedural sedation orders:

		Select Macro		
edation				
Endo Sedation (no orders)	Endo Sedation (with orders)	No Sedation	Sedation (no orders)	Sedation (with orders)

Endo Sedation (no orders): Select this if the provider has NOT placed Procedural Sedation Orders

Endo Sedation (with orders): Select this if the provider has placed Procedural Sedation Orders

No Sedation: Select this when there is no sedation for the procedure

To execute an Endo sedation macro:



- 1. Select the Macros disconfrom the Toolbar
- 2. Select Endo Sedation (with orders)
- 3. Review the contents in the Macros window, as necessary



🛙 Macros										
Sedation (with orders)										
Execute	To Do	Allergy Interaction	Event	Туре	Details	Date Time	Edit			
			EKG- Anes	Monitors	Monitor Off	14-Dec-2015:59				
			NIBP Diastolic-	Monitors	Monitor On	14-Dec-20 15:59				
			NIBP Mean- Ar	Monitors	Monitor On	14-Dec-20 15:59	1			
			NIBP Systolic- /	A Monitors	Monitor On	14-Dec-2015:59	1			
			Fi O2- Anes	Monitors	Monitor On	14-Dec-20 15:59	100			
			O2 Flow- Anes	Monitors	Monitor On	14-Dec-2015:59	1			
			Heart Rate- An	e Monitors	Monitor On	14-Dec-20 15:59	1			
			SPO2- Anes	Monitors	Monitor On	14-Dec-20 15:59	1	1		
			Pain Intensity-	I Monitors	Monitor Off	14-Dec-20 15:59	1	1		
			Pain Frequency	Monitors	Monitor Off	14-Dec-20 15:59	1	4		
			Pain Duration-	I Monitors	Monitor Off	14-Dec-2015:59	1			
			Level of Consci	c Monitors	Monitor Off	14-Dec-20 15:59		<u> </u>		
			Tolerability- NA	Monitors	Monitor Off	14-Dec-2015:59	1			
			NAPCOMS Tota	a Monitors	Monitor Off	14-Dec-20 15:59				
			Patient In Roor	r Actions		14-Dec-20 15:59				
			Surgery Start	Actions		14-Dec-20 15:59				
			Briefing/Time (Actions	Yes, Surgery, Nursing	g 14-Dec-2015:59	N			
Mainta	in Macro	0				Set All Times to Current	Execute	Cancel		

4. Click Execute

Key Learning Points

- The patient's procedural sedation documentation in SA Anesthesia is called the 'Sedation Record'
- SA Anesthesia is a different application than Powerchart with a different layout and functionalities
- Creating the Sedation Record involves:
 - Selecting the right patient to associate to the record
 - Associating BMDI
 - Pulling in Procedural Sedation medications
 - Assigning yourself as an Attendee
 - Assigning the GI Provider as Supervisor
 - Executing the sedation macro



Activity 2.5 – Document Times in the Sedation Record

1

Document/Modify Patient in Room time:

- 1. Double Click Patient in Room 된 Patient In Room from the To Do List
 - The **Patient in Room** € icon will populate the current time and appear in the Event pane.

SurgiNet: Anesthesia - [LGHEN-2017-194]			
Z Task View Document Window He	р		
Select Case Views Finalize Case Signatures	Suspend Case	Change User	E Macros (
Name: CSTSNDEMOENDO, STONE DOB: 01-Jul-1993 Age: 24 years MRN: 700005212	Case #: Procedure: Surg. Date: Anesthesiologis	LGHEN-20 Colonosco 09-Nov-20 t: Lewis, Ric	17-194 py 17 8:00 hard Huw
	10:15		-
EKG - Anes ben SPO2 - Anes ben SPO2 - Anes ben Pain Intensity - NAPCOMS Score Pain Duration - NAPCOMS Score Level of Consciousness - NAPCOMS S Tolerability - NAPCOMS Score NAPCOMS Score NAPCOMS Total Score	⇒< 59 • ⇒< 99 •	60 • 100 •	60 • • • • •
Y	ŤŤ		
)
Patient In Room 9: Comment: Note	47		

2. To verify the time documented, Hover over the **Patient in Room** icon in the Event pane to view details

To modify the time documented, in the Event pane

- 3. Double Click the Patient in Room 1 icon
- 4. Enter **Time** = current time less 10 minutes



5. Click OK, the time will be adjusted

Document Briefing/Time Out:

2

1. Double Click Briefing/Time O Yes, Surgery, Nursing from the To Do List



- The **Briefing/Time Out** icon will populate the current time and appear in the Event pane
- 2. To verify time documented, Hover over the **Briefing/Time Out** icon in the Event pane to view details

💋 SurgiNet: Anesthesia - [LGHE	N-2017-194]				
🖉 Task View Document	Window He	lp			
Select Case Views Finalize	Case Signatures	Susp	end Case	Shange User	E Macros Co
Name: CSTSNDEMOENDO, S	TONE	Ca	se #:	LGHEN-20	17-194
DOB: 01-Jul-1993		Pro c	ocedure:	Colonoscoj	py 17.9-00
MRN: 700005212		An	esthesiologi	st: Lewis, Rich	hard Huw
			10.16		
			10.15		
O2 Flow - Anes L/min					
EKG - Anes					
Heart Rate - Anes bpr	n		•< 59 •	60	60 • 🗆 🛥 📼
SPO2 - Anes bpm			•< 99 •	100 • 1	100 • 🗆 🖛 📼
Pain Intensity - NAPCO	OMS Score				
Pain Frequency - NAPO	JOINS Score				
≥ Pain Duration • NAP CC Level of Consciousnes	s - NAPCOMS S	core			
Tolerability - NAPCOM	S Score				
 NAPCOMS Total Score 	Э				
	Ý	\vee			
8			Ý		
		23	23		
28					
	~	$^{\diamond}$	~		
		+			
					_
L			_		
T					

To modify the Briefing/Time Out, in the Event pane:

- 6. Double Click the Briefing/Time Out Briefing/Time O Yes, Surgery, Nursing icon
 - The Action Details window opens





- 7. Modify **Time** = current time less 10 minutes
- 8. Click OK, the time will be adjusted

3 Documenting Surgery Start time

Once the GI Provider starts the procedure, you will document the procedure start time:

- 1. Double Click the Surgery Start / Surgery Start icon from the To Do List
- 2. The Surgery Start 🖉 icon will populate the current time and appear in the Event pane

Key Learning Points

Document the following times from the To Do List in the Sedation Record

- Patient in Room Time
- Briefing/Time Out
- · Surgery Start Time from the To Do List
- Any time-related actions will document to the Event Pane in the Sedation Record.



Activity 2.6 – Document Medication Administration in the Sedation Record

To document medications:

1

To Do List					
°.		Event	Details		
		fentanyl preserv free 100 n	n 100 mcg, IV		
Ĕ		midazolam 5 mg/5 mL inj	5 mg, IV		
Completed		naloxone 0.4 mg/mL inj	0.2 mg, IV		

- 1. Double Click midazolam from the To Do List
- 2. Double Click fentanyl
 - Once you Double Click the medication, they will disappear from the To Do List and appear in the Completed tab. Each medication dose will be populated to the current time in the Medications pane

Me	*	midazolam 5 mg/5 mL inj i∨ 5 mg 5 mg fentanyl preserv free 100 mcg/2 mL 100 mcg 100 mcg 0	
S	*	Fi O2 - Anes %	
ß	Ŧ	O2 Flow - Anes L/min	
	*	EKG - Anes	
		SPO2 - Anes %	
٤		Pain Intensity - NAPCOMS Score	
Ē		Pain Frequency - NAPCOMS Score	
Aon		Pain Duration - NAPCOMS Score	
2		Level of Consciousness - NAPCOMS Score	
		Tolerability - NAPCOMS Score	
	-	NAPCOMS Total Score	

You will need to note that the doses were administered by the provider instead of yourself, in the Medication pane:

- 3. Click directly on the midazolam dose $\frac{5 \text{ mg}}{9}$
 - Modify Medication Administration window opens
- 4. Modify the **Dose amount** = 2 mg
- 5. Enter **Comment** = administered by GI Provider in the comment box



🐣 Add Medication Administration 🛛 💦 🕰				
Nen	fentanyl preservative free			
	100 mcg/ 2 mc			
Bolus	Concentration		Heigh	nt: 0
Infusion	Product: 100 mcg / 2 mL	_	Weig	ht: 0 kg
	Diluent: (None)	mL		
	Final: 100 mcg / 2 mL			
12 H 4	2018-Jan-25 13:00 13:15 13:30 13:45	13:50 }-J	lan-25 14:00	• H
		0		
Bolus				
Admin time:	13:50	7	8	9
Dose amou	Int: 100 mcg	4	5	6
Volume:	2 mL	1	2	2
Weight base	ed dose: Weight required		2	3
			0	«
Route: IV	Site: (None)	e)		•
🗖 S	how all routes	ow all si	ites	
Comment:				
administered	by Dr. Deck			Î
		OK		Cancel

- 6. Click OK
- 7. Repeat the same steps for the fentanyl dose 100 mcg o
- 2 You documented 2 mg midazolam, but the GI Provider clarified they gave 4 mg of midazolam. To modify the medication administration.
 - 1. Locate the dose of midazolam you just documented in the Medication pane



- 2. Click directly on the midazolam dose 2 mg you intend to modify
 - In the Modify Medication Administration window opens



😁 Modify Medication Administration			×	
midazolam				
dose range: 1 to 10 mg, IV, as directed, PRN sedation, drug for	orm: inj	, start: (08	
Bolus Concentration Product: 2 mg / 2 mL Diluent: (None) * Final: 2 mg / 2 mL	nL	Height: Weight:	160 cm 77 kg	
12 Nov-2017 12:00 12:15 12:30 12	2 46 HNc :45	w-2017	H	
Bolus				
Admin time:	7	8	9	
Dose amount: 4 mg Volume: 4 mL	4	5	6	
Weight based dose: 0.0519 mg/kg	1	2	3	
	•	0	«	
Route: IV Site: (None)			•	
Show all routes Sho	w all site	s		
Comment:				
			^ 	
Remove Admin	ОК		Cancel	

- 3. Modify **Dose amount** = 4 mg
- 4. Click OK

3 If the GI Provider asked you to administer another 100 mcg of fentanyl during the procedure. To document an additional (new) dose of fentanyl.

In the Medication pane:

1. Click fentanyl 100 mcg/2mL inj

🕗 SurgiNet: Anesthesia - [LGHEN-2017-194]	
🖉 Task View Document Window	Help
Select Case Views Finalize Case Signatur	es Suspend Case Change User Macros
Name: CSTSNDEMOENDO, STONE DOB: 01-Jul-1993 Age: 24 years MRN: 700005212	Case #: LGHEN-2017-194 Procedure: Colonoscopy Surg. Date: 09-Nov-2017 8:00 Anesthesiologist: Lewis, Richard Huw
09-Nov-2017 12:45	13:00
midazolam 2 mg/2 mL inj IV 10 m ≤ fentanyl 100 mcg/2 mL inj IV 200 n	ig < mcg <
; ▲ FiO2-Anes % ੴ ▼ O2 Flow - Anes ⊥/min	

- The Add Medication Administration window opens
- 2. Enter **Dose Amount** = 100 mcg



Add Medicat	on Administration			×
19en	fentanyl 100 mcg/2 mL			
 Bolus Infusion 	Concentration Product: 100 mcg / 2 mL Dituent: (None) Final: 100 mcg / 2 mL	mL	Height: Weight:	160 cm 77 kg
11 H	(09-Nov-2017 15 13:30 13:45 14:00	14 10 HN 14: 0	ov-2017 15	• H
Bolus Admin time:	14:10	7	8	9
Dose amou Volume:	nt: 200 mcg	4	5	6
Weight base	ad dose: 2.5974 mcg/kg	1	2	3
		•	0	«
Route: IV	Site: [Non Site:] Sh	e) ow all site	es	•
		ОК		

• Since you are administering an additional dose, 'New' displays next to the drug name on the top banner.



3. Click OK, the new dose of fentanyl will be documented

Key Learning Points

- Any medication-related actions will appear in the Medications pane
- Double click medications from the To Do List to document their administration.
- Medication documentation may be modified in the Modify Medication Administration window.
- When documenting an additional dose of medication, ensure 'New' displays next to the drug name on the top banner of the Add Medication Administration window.



Activity 2.7 – Document Patient Comfort Score (NAPCOMS)

4

To document the patient's NAPCOMS score:



In the Monitors pane:

1. Select Pain Intensity - NAPCOMS Score

E Add Monitor Value				E	<
Add Pain Intensity - NAP	CON	AS So	core		
*Value:		Keypad			
0 - None or Minimal	•	7	8	9	
1 - Mild 2 - Moderate 3 - Severe		4	5	6	
		1	2	3	
			0	«	
*Value time: 09:17					
09-Nov-2017 9 7 9:15 9:30		ç	09-Nov-:):45	2017 🕞	
Comment: Minutes ag	o: 3	0 15	10	5 Nov	v
					*
		ОК		Cancel	

- 2. Select Value = 1- Mild
- 3. Click OK
- 4. Select Pain Frequency- NAPCOMS Score
- 5. Select Value = 1-Few (1-2 Episodes)
- 6. Click OK
- 7. Select Pain Duration- NAPCOMS Score
- 8. Select Value = 1-Short (Episode<30s)
- 9. Click OK
- 10. Select Level of Consciousness NAPCOMS Score



- 11. Select Value = 1-Sleepy but initiates
- 12. Click **OK**
- 13. Select Tolerability NAPCOMS Score
- 14. Select Value = 1-Reasonably well toler
- 15. Click OK

Once all 5 assessed NAPCOMS values are entered, Calculate the Total Score

- 16. Select NAPCOMS Total Score
- 17. Select Value = 5
- 18. Click OK



Key Learning Points

The NAPCOMS patient comfort score does not automatically calculate and must be calculated and inputted manually.



Activity 2.8 – Complete Perioperative Documentation

1

SA Anesthesia will remain open as you monitor the patient's vitals, patient comfort score, and document additional medications as necessary. At the same time, you will be completing procedure charting in Perioperative Documentation (or Perioperative Doc).

To return to PowerChart from SA Anesthesia:

1. Click Patient's Chart Patient's Chart icon

Overview of Perioperative Doc

C > A Perioperative Doc	(II) Full screen	👼 Print 🛛 🍣 1 minutes ago
LIGH Hrstop Record EN Case Attendee Role Perf Time In Time Out Procedure Vendor Rep Case Attendee Role Perf Time In Time Out Procedure Vendor Rep Case Attendee Role Perf Time In Time Out Procedure Vendor Rep Part Concernation Concernatio Concernation Concernation Concernation C	Vendor Company	
2 Enced Late Enced Attract 2 Enced Attract Enced Attract		
Add Modiy Remove Dear Connents B X III III III 1 3 7 III IIII IIII	6	<< Prev Next>>

- 1. **Icon Bar** Icons for quick access of certain Perioperative Doc functions.
- Documentation Contains a list of segments for documentation. Segments are listed alphabetically.
- 3. Pages The number of pages within the current segment.
- Multi-Entry Box enables multiple entries of certain fields to be documented in Perioperative Doc. Where relevant procedure data already documented in other applications (e.g., SA Anesthesia), an entry in the Multi-Entry Box will be pre-populated.
 - When default data is appears in the **Multi-Entry Box**, clicking the item in the **Multi-Entry Box** will auto-populate the segment data
 - To add a new entry in the **Multi-Entry Box**, complete the fields first then Click
 - To modify an existing entry in the **Multi-Entry Box**, select the entry in you are modifying in the **Multi-Entry Box**, document the modifications then Click Modify
 - To remove an entry from the Multi-Entry Box Click Remove
 - Note: Fill in all fields within a segment prior to clicking Add, otherwise details will display on separate lines in the Multi-Entry box.
- 5. Add / Modify / Remove / Clear Buttons used add/change entries in the Multi-Entry Box.



- <<Prev and Next >> Buttons to navigate to the next segment or the next page of a multipage segment.
- Comments This is a free text box area where additional notes can be typed while on any segment.

Note: Depending on the orientation of your computer screen and its resolution, the layout of each segment's fields will vary and the number of **Pages** displayed will differ. Most Perioperative Doc segments, are optimally displayed when the screen is oriented vertically.

2 Perioperative Doc Segments Explained



Perioperative Doc segments are grouped to resemble different sections of an intra-procedure record. The exclamation marks **!** next to the first 4 segments are mandatory segments that must be completed in order to finalize.

Once a segment's mandatory fields are completed, a green checkmark ✓ will replace the exclamation to indicate there are no documentation deficits in that segment.



Which segments appear by default is dependent on the procedure scheduled; you may add additional segments if your documentation requirements change during a case.

There are also required fields *within* each segment which have light gray highlighting of the field. A checkmark in the gray box \vec{s} will appear once the required field is completed. These fields also need to be completed in order to finalize Perioperative Doc at the end of the case.



Colonoscopy Completion Details	Insertion of Endoscope Time:
	Field Withdrawal Time:

Note: You may navigate each Perioperative Doc segment by selecting each segment from the Documentation pane; however, you can also choose to Click the Next button within the segment. The sequence of the segments is predetermined based on a specific endoscopy workflow. If the sequence does not match how you work, you may Click into each segment from the list.

Documenting Case Attendees

3

- 1. Select Case Attendees
- 2. Select the GI Provider from the Multi-Entry Box
 - Notice that the GI Provider's Time In is already populated in the Multi-Entry Box, as you recall this was entered in SA Anesthesia. SA Anesthesia feeds data into Powerchart every 5 minutes, if you do not see the Time In here, you can return later. If there are discrepancies between SA Anesthesia and Powerchart, you will be asked to fix them before finalizing.
- 3. The Case Attendee, Role Performed, and Time In will be populated from your Multi- Entry Box selection.

Note: You do not need to add yourself as a Case Attendee.

Case Attendee	Role Perf	Time In	Time Out	Procedure	Vendor Rep	Vendor Company
Lewis, Richard Huw	Surgeon - Primary	10-Nov-2017 11:50		Colonoscopy		
•						•
Case Attendee: Lewis, Richard Huw			Surgeon	erformed: - Primary	T	
Time In: 1150 📮 10-Nov-2017	▲ ▼		Time Time			
Procedure:			<u>V</u> endor R	ep:		
Vendor Company:						

At this point in the scenario, the patient is still undergoing their procedure; therefore you will not have a Time Out for the GI Provider so you will be returning to this later.

4. Click Next to move to the next segment

4 Document General Case Data

61



Case Information	
d <u>0</u> R:	d <u>⊂</u> ase Level:
LGH EN 01 -	None
✓ Wound Class:	d Specially:
2-Clean-Contaminated -	Gastroenterology (SN) -
ASA Class:	
Preop Diagnosis:	
	A

Notice the fields are already completed; these fields are populated from the scheduled procedure.

- 1. Click the segment in order to get the green checkmark ✓ to complete it
- 2. Click Next to move to the next segment



5
J

6

Document Endoscopic Procedures

Procedure	Modifiers	Addtnl Detail	Primary
📲 Colonoscopy Biops	ÿ	Colonoscopy Biopsy	Yes
•			۰.
Procedure:			
			•
Modifiers:	- >>		
	· · · · · · · · · · · · · · · · · · ·		
Additional Procedure De	tail:		
		*	
		~	
Primary Procedure:		<u> </u>	
C Yes C No			
□ Start:		T Stop:	
× × × × × × × × × × × × × × × × × × ×	× •	× ××_×××	
Anest <u>h</u> esia Type:		Surgical Service:	_
		▼	•

- 1. Select Colonoscopy Biopsy from the Multi-Entry Box
 - Procedure field, Primary Procedure, Endoscopist, Start Time, Anesthesia type, and Surgical Service will auto-populate
- 2. Click Next to move to next segment

Document Patient Care Devices

This segment is where scope ID numbers are documented

- Equipment is a required field.
- 1. Select to open the master inventory

Equipment:			
	-	~	

To search for the scope in use in the Find: All Items window:

2. Enter Equipment = colonoscope



Item number Description Clinical description Mfr catalog number Other: Includes Colonoscope Help Location: Include sublocations Class: Equipment Include subclassifications Vendor: Manufacture:	ieneral Item Typ	e Advanced	
Location: Include sublocations Include sublocations Browse Include subclassifications Include subclassifications Vendor: (*) Manufacturer: (*)	 ✓ Item number ✓ Clinical description Search For: 	Description Short description Mfr catalog number Other: Includes Colonoscope	Find Nov New Sear Get Mor Help
Class: Loupment Frowse Include subclassifications Vendor: Manufacturer: K K K K K K K K K K K K K K K K K K K	Location:	Include sublocations	
Vendor: « Manufacturer: «	V Ulass:	Include subclassifications	
Manufacturer:	Vendor:	×	
	Manufacturer:	*	

3. Click Find Now

Note: If your search does not return any entries, ensure **Description** is checked, and change the **Search For:** to *Includes*

📝 Item number	Description	Short description
Clinical description	Mfr catalog number	Other:
Search For:	Includes 🛛 🗸 colonos	соре

4. Select LGH COLONOSCOPE STANDARD from the list



General Item Type	Advanced		
			Find Nov
Item number	Description	Short description	New Sear
Clinical description	Mfr catalog number	Other:	- Cot Mar
Search For:	Includes		
Location:			-
Class:	Include sublocations		Browse
	Include subclassifications		
Vendor:			«
🔘 Manufacturer:			«
em Number	Description	Short Description	Clinical Description
GH00003004	LGH COLONOSCOPE DUAL CHANN	LGH COLONOSCOPE DUAL CHANN	Generic Equipment Item
GH00003005	LGH COLONOSCOPE RETROVIEW	LGH COLONOSCOPE RETROVIEW	Generic Equipment Item
GH00003006	LGH COLONOSCOPE SLIM	LGH COLONOSCOPE SLIM	Generic Equipment Item
GH00003007	LGH COLONOSCOPE STANDARD	LGH COLONOSCOPE STANDARD	Generic Equipment Item
GH00003014	LGH VIDEO COLONOSCOPE	LGH VIDEO COLONOSCOPE	Generic Equipment Item
GH1514248	LGH COLONOSCOPE ULTRA SLIM (LGH COLONOSCOPE ULTRA SLIM (PENTAX EC-2990LI
GH1514255	LGH COLONOSCOPE RETROVIEW	LGH COLONOSCOPE RETROVIEW	PENTAX EC-3490TLI
GH1514259	LGH COLONOSCOPE RETROVIEW	LGH COLONOSCOPE RETROVIEW	PENTAX EC-3490TLI
CU1E1/001	LGH COLONOSCOPE SLIM (A110374)	LGH COLONOSCOPE SLIM (A110374)	PENTAX EC34-110L
UN1014201			DENTAX ECONISOL
GH1514263	LGH COLONOSCOPE SLIM (A110394)	LGH CULUNUSCOPE SLIM (ATTU394)	PENTAX EC34-HUL

- 5. Click OK
- 6. Enter the scope's Identification Number = *Type 1234567*
- 7. Click Add, the scope information will appear in the Multi-Entry Box
- 8. Click Next to move to next segment

7

Document Additional Lower Endoscopy Detail

This segment is where cecal intubation times and hemorrhoid treatment details are documented:

Colonoscopy Completion Details	
Cecum Reached:	Insertion of Endoscope Time:
Cecum Reached:	Withdrawal Time:
⊢ Hemorrhoid Treatment Details	
Hemorrhoid Banding:	Number of Bands Used:
C Yes C No	

In the Cecum Reached field:

- 1. Select **Cecum Reached** = Yes from the dropdown
 - Enter the specific times per site policy as necessary (Insertion of Endoscope Time, Cecum Reached, Withdrawal Time)
- 2. Select Next to move to next segment





9

Document Case Times

Stat Time:	Stoo Time:
Polient Ø∫in Room Time: 1150 ★ 10-Nov-2017 ★ ▼	
Sugey/Procedure	

The patient's In Room Time and Start Time auto-populates from the Sedation Record in SA Anesthesia. You will be asked to correct discrepancies if any Case Times/ Attendees Times do not match with Perioperative Doc. You will not be able to Finalize the Sedation Record (SA Anesthesia) until there are no discrepancies with Time fields.

1. Click Next to move to next segment

Document Insufflation

Insufflation	Insufflation Unit ID	
🗖 Car <u>b</u> on Dioxide Ins	ufflation?:	
C Yes C No		
Insufflation Unit Identi	fication Number:	

- 1. Enter the following:
 - Carbon Dioxide Insufflation = Yes
 - Insufflation Unit Identification Number = Type 12345
- 2. Click Add
- 3. Click Next to move to next segment

10 Document Cautery/Argon Plasma Coagulator



2.01-			-,
•			Þ
Cautery Type:		<mark>⊫</mark> Electrosurgical Unit Identifica	ition Number:
Grounding Pad Detail(s)			
Grounding Pad Site:]	Grounding Pad Applied By:	
Grounding Pad Site Satisfactory:	-		
C Yes C No			
Setting(s)			
Cut Setting:		Coagulation Setting:	
Bipolar Setting:			
Other Detail(s)			
Argon Identification Number:		<u>E</u> ndocut:	
		O Yes O No	

- 1. Enter the following:
 - **Cautery Type** = Monopolar
 - Electrosurgical Unit Identification Number = < Type 1234567>
 - Grounding Pad Site = Leg Upper, left
 - **Grounding Pad Applied By** = Select GI Provider
- 2. Click Add
- 3. Click Next to move to next segment

11 Complete Hemostasis

Location	No. Endo C	lips Used	Number of Bands Used	
_				
Endoscopic Anat	omical Location:	N <u>u</u> mbe	er of Endo Clips Used:	
	•			
Number of Esophag	eal Bands Used:			



- 10. Select Endoscopic Anatomical Location = Sigmoid colon
- 11. Click Add
- 12. Click Next to move to next segment

12 Document Specimens

	Specimens Order	ed	Specimen Type	Quantity
•				4
Note: Only document the Spe Surgical Request Order:	cimen Type and Qua	ntity when I	NOT documenting in the	e Pathology
Specimens Ordered:		Sp <u>e</u> cimen	Туре:	1
O Yes O No O N/A	۱		•	J.
<u>Q</u> uantity:				
Disposition of Tissue removed	:			
Discarded at Surgeon's Red O Yes	quest?:			
Commonte:				
			*	

- 1. Enter the following:
 - **Specimen Type** = *Pathology from the drop down*
 - **Quantity =** <*Type 1*>
- 2. Click Add
 - Data entered will appear in the Multi-Entry Box
- 3. Click Next to move to next segment

Perioperative Doc will now take you back to the Lower Endoscopy Detail segment assuming you will be completing your Cecal Intubation Times. You may click into segments that require further completion or Click **Next** to move through as necessary.



13 Complete Outstanding Segment Documentation per Workflow

Notice at this point some segments are marked with a green checkmark and others remain an exclamation, you will not be able to Finalize this intraoperative record in Periop Doc till the required field are completed and all the segments have green checkmarks.

Docu	umentation
🗟 ເ	GH IntraOp Segment Group - EN
A 1	Case Attendees
A 1	t Case Times
A 1	✓ General Case Data
A 1	Endoscopic Procedure(s)
A 🔁	 Additional Lower Endoscopy Detail
A 🔁	✓ Insufflation
A 🔁	 Patient Care Devices
A 🔁	 Safety Checklist - 3) Debriefing
	Observe Completed Colonoscopy>

In the scenario, the GI Provider is finishing the procedure; you will go back and complete outstanding fields in some segments. You may:

- · Click Next to move through the segment list or
- Select the specific segment that requires completion as indicated by ¹

In Case Times:

- 1. Click Stop Time:
- 2. Click Out Room Time:
 - Once the Out Room Time is entered it will populate all Attendee Out Times
- 3. Select <GI Provider> from the Multi-Entry box

In Endoscopic Procedures:

- 2. Select Colonoscopy Biopsy from the Multi-Entry Box
 - Since the Out Room Time was already entered, this will populate an Stop time for the Procedure

In Case Attendees:

- 1. Select <GI Provider> from the Multi-Entry Box
 - Since the Out Room Time was already entered, this will populate an **Time Out** for the GI provider



14

Document Safety Checklist - Debriefing

You will recall that you entered the Briefing/Time Out information in the Sedation Record. Since you are finishing the case in Perioperative Doc, you will enter your Debriefing information here.

<u>D</u> ebriefing Completed:	
C Yes C No	
Reason Debriefing Not Completed:	
	*
Debriefing Participants: Surgery Anesthesiology Nursing Other Time Completed:	

1. Enter the following:

Debriefing Completed= Yes

Time Completed = *Enter current time*

- Once you navigate away from Safety Checklist 3) Debriefing in the Segment List, you will notice the green checkmark ✓ Safety Checklist 3) Debriefing indicating that this segment is complete
- 3. Click Next to move to next segment


15 Once you click away from the last segment you complete, each segment on the list should have green checkmarks beside them. This means all Perioperative Documentation is complete and ready to be Finalized.



Since there are other topics to cover still, the Finalize activity for Perioperative Doc will be covered later.

- In practice, you will still have SA Anesthesia open on one computer screen as you monitor the patient's vitals, comfort score, and administer additional meds (if necessary). At the same time, on another computer screen you will be completing the procedure charting in Perioperative Doc.
- In Perioperative Doc, which segments appear by default is dependent on the procedure that was scheduled.
- Segments with an exclamation mark are required segments.
- Segments indicated by a green checkmark means it is completed.
- Within each Segment, gray highlighting indicates a required field.
- In this Activity you learned how to document the all the Segments for a Colonoscopy Biopsy in Perioperative Doc



Activity 2.9 – Enter a Pathology Surgical Request

1

Pathology specimens are treated like an Order in Powerchart. As an endoscopy intra-op nurse, if a specimen was removed to be sent for pathology, you will be placing an Order so that it cues the lab to expect a specimen to arrive for this particular patient. The pathology surgical request is considered an **Ad Hoc** order.

To place a Pathology Surgical Request:

1. Select Perioperative Summary from the Menu



2. Select Quick Orders tab

< 🔹 📩 🏦 Perioperative Summary					[0] F	ull screen 🛛 着) Print 🍣 ag
🗚 🗋 🖶 🔍 🔍 100% 🔹 🌑 🖬							
Preop Summary 23 Intraop Summary	23 Postop Summary	E3 Handoff Tool	23 Discharge	23 Quick Orders	23 +	- 🗠	N (≡•)
Venue: Inpatient v							
New Order Entry 🕂 😑 👁	Imaging and Diagnostics	≡• ∾	Intraoperative	≡∙⊗	Outstanding Orders (3)		≡• ⊘
Inpatient 🗸	ECG 12 Lead		Surgical Specimens		Selected visit		
	XR Chest Routine		Imaging RF		Dathalamy Curainal Desurat	Status	Ordered
Q pathology surgical 🛞			Imaging XR		Patriology Surgical Request	Ordered	11:16
Personal Shared	Labs	=• •	Imaging MG		Pathology Surgical Request	Ordered	14/12/17
Favorites	Bloodwork		Imaging US		CT Chect Abde Debuic w/o	Eutore	10:21
My Plan Eavorites	Blood Gas				Contrast	Future	16:06
	Blood Culture						

3. Enter = Pathology Surgical in the Search box



4. Select Pathology Surgical Request, the order is now added to Orders for Signature



- 5. Click Orders for Signature icon 🖉 1
- 6. Click Sign



Orders for Signature (1)	X
Laboratory	
Pathology Surgical Request	
	Sign Save Modify Cancel

- Ordering Physician window opens
- 7. Enter <*GI Provider*>
- 8. Select **Communication Type** = No Cosignature Required

P Ordering Physician
*Physician name
Lewis, Richard Huw
*Order Date/Time
10-Nov-2017 💌 🔽 1323 🔺 PST
*Communication type
Phone
Verbal
Proposed
No Cosignature Required
Cosignature Required
Paper/Fax
Electronic
OK Cancel

9. Click OK to complete

Once entered, a paper Pathology Surgical Request form will automatically print. The specimen should be processed and labeled per site policy. The paper form will be completed and signed by the GI Provider to be sent with the specimen to be processed.

🔦 Key Learning Points

- A Pathology Surgical Request must be placed to notify the lab to expect a specimen to arrive.
- Once completed, a paper form will automatically print to be completed and signed by the GI Provider

The completed/signed copy of the Pathology Specimens Request will accompany the specimen to the lab



Activity 2.10 – Finalizing Perioperative Doc and the Sedation Record

Application: Perioperative Doc (Powerchart) & SA Anesthesia (Sedation Record)



To finalize Perioperative Documentation, first ensure all that all segments display green checkmarks in the segment list:

1. Click green flag 💌 icon

< > - 者 Perioperative Doc			(D) Full screen	💼 Print	e	ag
3 S 💽 🕤 🧟 📽 🔄 🌮 🔍 🖤						
LGH IntraOp Report EN	Set Up Stat Time:	500 Int. (2) 0,00,000 (2) 1				
A ✓ General Case Data ✓ Endescopic Procedure(s) △ Additional Lower Endoscopy Detail △ Injection ↓ Injection	Palient fin Room Time. 0531 16Nov-2017	2 Out Room Time: 1232 1 10 100 - 2017 1 •				
	Surgey/Piocedure d [Stat Time] 0831 1 16 Nov-2017 1	Ø <u>Stor Time.</u> 1220 € 16Nov-2017 € •				
				<< Prev	Next	•

• Document Verified window opens

Documen	t Verified	
?	Document has no deficits. Would you like to finalize the document?	
	Yes	No

2. Click **Yes** to complete

Note: The Document Deficits window will show if you try to Finalize Perioperative Doc with incomplete segments, you will be asked to fix any deficits before you can attempt to finalize again.





Finalize the Sedation Record

To finalize the Sedation Record, navigate back to SAAnesthesia:

- 1. Select the Finalize Case icon
 - Stop Data window opens

Published Desktop - ProdBC - Citrix Receiver	
Stop Data	- Ø
	Start Time: Stop Time:
Providers	
TestSX, NursewithSaAnesthesia-Perioperative	14:44 14:55 0
E Lewis, Richard Huw	14.56
2 Monitors	
R NBP Diestolic - Anes	
R NBP Mean - Anes	
NIBP Systolic - Anes	
8 Fi O2 - Anes	
2 O2 Flow - Anes	
2 Heart Rate - Anes	
2 SPO2 - Anes	
Select All Unselect All	OK Cancel

- 2. Click OK to verify you are stopping all documentation
 - Finalize window opens
- 3. Click Ignore All (under To Do List) to ignore the administration of naloxone

Deficiencies No deficiencies Required Documentation Personnel No Running Personnel To Do List Event Details naloxone 0.2 mg, IV	 Finalize 				-				
No deficiencies Required Documentation No Missing Required Documentation Personnel No Running Personnel To Do List Event Details naloxone 0.2 mg, N			Deficie	ncies					
Required Documentation No Missing Required Documentation Personnel To Do List Event Details naloxone 0.2 mg, IV Ignore All Signatures Name Date Print record Finalize Select Charted Values Charge Preview Close			No defic	encies					
No Missing Required Documentation Personnel No Running Personnel To Do List Event Details naloxone 0.2 mg, N			Required Doc	umentation					
Personnel No Running Personnel To Do List Event Details naloxone 0.2 mg. N Ignore All Signatures Name Date Sign Finalize Print record Finalize		No Missing Required Documentation							
No Running Personnel To Do List Print record Ignore All Signatures Signatures Signatures Print record Finalize Finalize Select Charted Values Charge Preview Close			Perso	nnel					
To Do List Event Details analoxone 0.2 mg, IV Ignore All Signatures Name Date Sign Print record Finalize Select Charted Values Charge Preview Close			No Running	Personnel					
Event Details Ignore All Signatures Name Date Sign Finalize Select Charted Values Charge Preview Close ,			To Do	List					
naloxone 0.2 mg, IV Ignore All Signatures Name Date Sign Print record Finalize Select Charted Values Charge Preview Close ,	Event	Details							
Ignore All Signatures Name Date Sign Print record Finalize Select Charted Values Charge Preview Close	💊 naloxone	0.2 mg, IV							
Ignore All Signatures Name Date Sign Print record Finalize Select Charted Values Charge Preview Close									
Ignore All Signatures Name Date Sign Print record Finalize Select Charted Values Charge Preview Close									
Ignore All Signatures Name Date Sign Print record Finalize Select Charted Values Charge Preview Close ,									
Ignore All Signatures Name Date Sign Print record Finalize Select Charted Values Charge Preview Close									
Ignore All Signatures Name Date Sign Print record Finalize Select Charted Values Charge Preview Close									
Ignore All Signatures Name Date Sign Print record Finalize Select Charted Values Charge Preview Close									
Ignore All Signatures Name Date Sign Print record Finalize Select Charted Values Charge Preview Close ,									
Signatures Name Date Sign Print record Finalize Select Charted Values Charge Preview Close	Ignore All								
Name Date Sign Print record Finalize Select Charted Values Charge Preview Close			Signat	ures					
Sign Print record Finalize Select Charted Values Charge Preview Close	Name	Date							
Sign Print record Finalize Select Charted Values Charge Preview Close									
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Sign Print record Finalize Select Charted Values Charge Preview Close									
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Sign Print record Finalize Select Charted Values Charge Preview Close									
Sign Print record Finalize Select Charted Values Charge Preview Close									
Sign Print record Finalize Select Charted Values Charge Preview Close									
Sign Print record Finalize Select Charted Values Charge Preview Close									
Print record Finalize Select Charted Values Charge Preview Close	Sign								
	Print record		Finalize	Select Charted Values	Charge Preview	Close			

Note: SA Anesthesia will not finalize the Sedation Record until all items on the To Do List are completed. Nalaxone was populated the To Do List as a precaution.

- 4. Click Sign
 - Authorizing Signature window opens



5. Enter **Username** = <username> and **Password** = <password>



- 6. Click OK
 - Your signature will appear under the Signatures Section

		Signatu	ires		
Name	Date				
TestSX, NursewithSaAn	16-Nov-2017 14:13				
Sign					
Print record		Finalize	Select Charted Values	Charge Preview	Close

- 7. Click Finalize
 - Sedation Record will close and bring you back to the main SA Anesthesia screen
 - Click the Select Case to open your next case

Note: BMDI will automatically dissociate once the Sedation Record is finalized.

Documentation in and need to access SAAnesthesia is complete.

Key Learning Points
Ensure all the Periop Doc segments display a green flag in the Segment List before attempting to Finalize.
The Document Deficits window will show if you try to Finalize Periop Doc with incomplete segments, you will be asked to fix any deficits before you can finalize again.
You will also need to switch back to SA Anesthesia to Finalize the Sedation Record.
BMDL will automatically dissociate once the Sedation Record is finalized



PATIENT SCENARIO 3 – Post-Procedure

Learning Objectives

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

Complete endoscopy post-procedure documentation utilizing IView, Perioperative Doc, BMDI, and Nursing Discharge Checklist

SCENARIO

The procedure has been completed and the patient has been transferred to the Endoscopy Post-Op area.

As the endoscopy post-op nurse, you will be assessing the patient and completing the documentation prior to discharging the patient home. You will be completing the following activities (in PowerChart):

- Access Patient's Chart from Perioperative Tracking (Review)
- Review MAR for IntraOp Medications Administered (Review)
- Complete PostOp Perioperative Documentation
- Discontinue PreOp Orders & Initiating the PostOp Orders
- BMDI Association & Vitals Documentation in IView
- IView Documentation in Endoscopy Quick View
- BMDI Dissociation
- Complete the Nursing Discharge Checklist
- Finalize Perioperative Doc
- Discharge the Patient Encounter



Activity 3.1 – Access Patient's Chart from Perioperative Tracking (Review)

1

Access to the patient's chart for the post-op endoscopy nurse is via Perioperative Tracking under the Endo PostOp ^{LGH Endo PostOp} view.

The patient's Status is already changed based on the Pt. Out of Room time in Perioperative Tracking.

Per	ioperative Tracking										
LG	LGH Endo PreOp LGH Endo PostOp LGH Endo Incomplete										
Fi	ter: LGH EN PostOp Today 🔹 🛙 🕅	à i 🝰 📫	📕 Total	Cases: 1							
	Status	Start	Stop	Add PT Type	CK	Alerts	Allergy	Patient	Age / Sex	Provider	Procedure
	LGH EN 01 (1 case)										
	Pt. Out of Room	08:00	08:35	Day Surgery	$\overline{\checkmark}$		Q	CSTSNDEMOENDO, S	24 years / Female	Lewis, R	"COLON STUFF"

To open the patient's chart (skip this step if your chart is already open):

- 1. Double Click the blue arrow 🕨 next to the patient's name
- 2. If this is your first time opening this patient's chart or a certain time limit has been exceeded, the Assign a Relationship window will display
- 3. Select Nurse

Your patient's chart will open to the Perioperative Summary; navigate to the **Postop Summary** tab.

< 🔹 🕂 🏦 Perioperative Summary		🗇 Full screen 🛛 👘 Print 🛛 🎝 0 minutes ag
🗚 🐘 🖶 🐘 🔍 🔍 100% 🔷 😋 🌑 🟠		
Preop Summary 🕅 Intraop Summary 🕅 Postop	iummary 🛛 Handoff Tool 🖓 Discharge 🕅	Quick Orders 🛛 + 🕞 - 🖻 🗐 =-
Procedural Information =	PowerForms (0)	Postoperative Summary = • 🕤
No results found	Vital Signs 💠 🗸 🔲 🗐	No results found
Allergies (1) 🕂 🗮	Selected visit 🗸	Perioperative Tracking =• 🗞
All Visits	No results found	No results found
No Known Allergies	Labs =- o	Clinical Research (0) =• 💿
Diagnoses	Selected visit	On Study Status Contact
Selected visit	No results found	No results found
No results found	Measurements and Weights (0)	Documents (3) 💠 📃 🖛
Problems =	Selected visit No results found	Last 2 weeks for all visits 🗸
All VISITS Classification: All		My Documents
	Home Medications (3) 🜩 = 🗸 🗸	Note Type Author Date/Time Minor Procedure - Text TestSX, 14/12/17 10:26
Problem This Visit (0)	Medications 💠 📃 🖛 🔿	NursewithSaAnesthesia- Perionerative
	Selected visit	Endoscopy Assessment - TestSX, 13/12/17 09:21
Chronic (0)	∠ Scheduled (0) ∠ Continuous (0)	Perioperative
No results to display	△ PRN/Unscheduled Available (0)	Sedation Record TestSX, 30/11/17 15:08 NursewithSaAnesthesia-



🕻 🖒 🔹 🛉 Periope	rative Summary		
#	100% - 🔵 🖨 🕻	5	
Preop Summary	Intraop Summary	X	Postop Sumr
Documents (5) 🕂			≣∙⊘
Last 2 weeks for all visits 🔻			
My Documents			
Note Type	Author	Date/Time	*
Endoscopy IntraProcedure Record	TestSX, NursewithSaAnesthesia- Perioperative	16/11/17	12:30
Sedation Record	eLearn, ANESTHESIOLOGIST, MD	15/11/17	09:05
Consent Procedure	Unknown	06/11/17	09:11
Endoscopy Assessment - Text	TestSX, NursewithSaAnesthesia- Perioperative	03/11/17	10:43
Endoscopy Assessment - Text	TestSX, NursewithSaAnesthesia- Perioperative	03/11/17	10:25

Review the patient's pre and intra-op documents as necessary under the **Documents** section (e.g. finalized Sedation Record)

CSTSNDEMOENDO, STONE Female	24 years DOB:01-Jul-1993	
	🕂 🔀 🖆 🕏	
LGH Lions Gate Hospital 231 E. 15th Street North Vancouver, British Columbia V7L :	LGH Sedation Record CSTSNDEMOENI Date Finalized: 17-Nov-2017 10:00 Page 1 of 3 LGHEN-2017-204 Colonoscopy	DO, STONE
OR: LGH EN 01 Surgery Date: 17-Nov-2017 8:00 Surgeon: Lewis, Richard Huw Anesthesiologist: Lewis, Richard Huw Anesthesia Type: Procedural Sedation ASA Class: Lord Page	DOB: 01-Jul-1993 AGE: 24 years Gender: Female Pre-Op Diagnosis: Height: 16 Reason for Admit: Colonoscopy Weight: 77 NPO: Allergies: Net	0 cm kg 5 Known Allergies
Name Iotal	9.15 9.30 9.45 Medications	
midazolam 5 mg/mLinj IV 10 mg fentanyl 100 mcg/2 mLinj IV 400 mcg	10 mg • 200 mcg •	
	Monitors	
SPO2 - Anes bpm Pain Intensity - NAP COMS Score Pain Prequency - NAP COMS Score Pain Duration - NAP COMS Score Level of Consciousness - NAP COMS Score Tolerability - NAP COMS Score NAP COMS Total Score		99₀ 1 - Mild ₀ 1 - Few (1-2 Episodes) ₀ Short (Episode <30 se ₀ 1 - Sleepy but initiates ₀ Reasonably well toler ₀ 5 ₀
Legenc 190		
Result type: Sedation Record Result date: Friday, 17-November-20 Result status: Auth (Verified) Performed by: TestSX, NursewithSaAn Verified by: TestSX, InvrsewithSaAn Forcounter info: 700000013085, LGH L	1017 09:05 PST nesthesia-Perioperative on Friday, 17-November-2017 10:00 PST nesthesia-Perioperative on Friday, 17-November-2017 10:00 PST Lions Gate, Day Surgery, 07-Nov-2017 -	



- As the endoscopy post-op nurse, you will find your post-op patient in Perioperative Tracking Endo PostOp view.
- Setting an Event in Perioperative Tracking is not necessary as the patient's status is automatically populated from Perioperative Documentation.
- View your patient's summary under the Postop Summary tab.



Activity 3.2 – Review IntraProcedure Medications Administered

1

The Medication Administration Record (MAR) is a record of medications administered to the patient by clinician. The MAR displays medication orders, tasks, and documented administrations for the selected time frame.

< > 👻 👫 MAR			
*** 🗃			
All Medications (System)	▼ < >		Thursday, 02
Show All Rate Change Docu	Medications	02-Nov-2017 12:58 PDT	02-Nov-2017 12:55 PDT
Time View	PRN		10 A
Scheduled	Fentanyi (fentanyi PRN range dose)	200 mcg Not previously	
Unscheduled	dose range: 25 to 200 mcg, IV, as directed,	given	
PRN PRN	12:42 PDT		
Continuour Infusions	fentanyl		
Continuous Infusions	Respiratory Rate		
👿 Future	PRN PRN	10 mg	
Discontinued Scheduled	midazolam (midazolam PRN range dose) dose range: 1 to 10 mg, IV, as directed, PRN codation, drug formulai, statk 21, Oct 2017	given	
👿 Discontinued Unscheduled	12:42 PDT		
Discontinued PRN	midazolam	1	
	Discontinued Scheduled		
Discontinued Continuous Infus	167		
	acetaminophen		
	325 mg, PO, once, drug form: tab, start: 02-Nov-2017 12:00 PDT_stop: 02-Nov-2017		
	10:00 007		

Medications administered during the procedure were charted by the intra-op nurse on the Sedation Record, these medications will automatically be charted to the patients MAR (it may take up to 5 minutes for data from SA Anesthesia to flow to Powerchart).

To review the patient's MAR:

From Menu:

Menu		Ф	
Perioperative Summary			
Perioperative Doc			
Orders		🖶 Add	
MAR			
MAR Summary			
Interactive View and I&O			
Results Review			
Form Browser			
Histories			
Allergies		🕈 Add	
Diagnoses	and Problems		

- 1. Select MAR
- 2. Verify the medications flowed through from SA Anesthesia



3. Review medications administered prior/during the patient's procedure



- 4. To view additional details, Right Click View Details
 - Result details window opens

Result Detai	ils - CSTSNDEMOENDC	, STONE - acetamino	phen		
Result Histor	У				
/alue Va	alid From	Valid Until		 	
325 mg 0.	2-Nov-2017 12:55 PDT	Current			
Medication	Result Action List	Intake and Output			
acetaminopl	hen 325 mg 1 tab				
Route PO					
Scheduled o	n Thursday, 02-Nove	mber-2017 at 12:	JO PDT		
Given on T	hursday, 02-Novembe	r-2017 at 12:55 Pl	т		

5. Click Close to complete

- Medications administered during the procedure were charted by the intra-op nurse on the Sedation Record, these medications will automatically be charted in the patients MAR (Medication Administration Record) in Powerchart.
- As a post-op nurse, you will verify that the medications given intra-op flowed to the MAR
- It may take up to 5 minutes for data from SA Anesthesia to flow to Powerchart
- You may also review the medications given in the MAR.



Activity 3.3 – Discontinue PreOp Orders & Initiating Postop Orders

1

Recall that the GI Endoscopy Pre Procedure orders were initiated by the pre-op nurse, now as the post-op nurse you will need to discontinue the Pre Procedure phase orders so you can initiate the post procedure orders.

The need to discontinue previous phase orders is *only* for Multiphase Orders (or PowerPlans). The Procedural Sedation order from the intra-op phase was a Single Phase order so it did not need to be discontinued.



To discontinue the Pre Procedure phase orders:

- 1. Click **Order** from the Menu
- 2. Under GI Endoscopy (Multiphase), Right Click Pre Procedure (Initiated)
- 3. Select Discontinue

GI Endoscopy (Multiphase)		
Pre Procedure (Init	istad)	
Post Procedure (Pla	Discontinue	
1	Replicate	
uggested Plans (0) Irders	Plan Information	
Admit/Transfer/Disc 💭 Status	Add Comment	
Patient Care	Save as My Favorite	



Note: In the Discontinue window that opens, you will have the opportunity to Select any orders you would like to continue in the post-op phase, in our scenario you will discontinue all the pre procedure orders, do not check any boxes.

14		C	
Кеер	Component	Status	Order Details
Patier	t Care		
	🎢 Vital Signs	Ordered	06-Nov-2017 10:41 PST, once, Stop: 06-Nov-2017 10:41 PST
)iet/I	utrition		
	🖄 NPO for Procedure	Ordered	06-Nov-2017 10:41 PST, Except medications with sips; after completion of bowel preparation
Conti	nuous Infusions		
	Insert Peripheral IV Catheter	Ordered	06-Nov-2017 10:41 PST, If no IV in place
Medi	ations		
	🔭 acetaminophen	Ordered	1,000 mg, PO, once, drug form: tab, start: 20-Nov-2017 15:00 PST, stop: 20-Nov-2017 15:00 PST Maximum acetaminophen 4 g/24 h from all sources

- 4. Click OK
 - Ordering Physician window opens
- 5. Enter **Physician Name** = <GI Provider> and Communication Type = *No Cosignature Required*
 - The Pre Procedure order will appear in the View Pane as 'Discontinued Pending' Pre Procedure (Discontinued Pending) until you sign
- 6. Click Orders for Signature
- 7. Click Sign
- 8. Click Refresh 🖻
 - The Pre Procedure orders will now appear in the View Pane as discontinued



To initiate Post Procedure phase orders:

- 1. Right Click Post Procedure (Planned)
- 2. Select Initiate



GI Endoscopy (Multiphase) - Pre Procedure (Discontinued Pending)			
Suggested Plans (0)	Initiate		
Orders Admit/Transfer/Disc Status Patient Care Activity Diet/Nutrition Continuous Infusion Medications	Discontinue Void Replicate Plan Information Check Alerts Add Comment		
	Save as My Favorite		

- The Post Procedure order will appear in the View pane as 'Initiated Pending' <u>Post Procedure (Initiated Pending)</u> until you sign it
- 3. Click Orders for Signature
- 4. Click Sign
- 5. Click Refresh 🜊
 - The Post Procedure Orders will now appear in the View pane as Initiated.

- Previous phase orders need to be discontinued only if they are a part of a Multiphase order set (or PowerPlan).
- You must discontinue the previous phase order (pre-op) in order to initiate the post-op orders in the GI Endoscopy Multiphase order set.
- You may select certain orders to continue to the next phase (ie. IV infusion), if necessary.
 - Remember to Refresh to see changes made.

1



Activity 3.4 – BMDI Association & Vital Signs Documentation in IView

Just like in the procedure room, the patient's vitals can be tracked via BMDI in endoscopy postop. As you recall, BMDI enabled the intra-op nurse to document the patient's vital signs automatically in SA Anesthesia. In post-op, you will also be using BMDI but through Powerchart in Interactive View (IView).

‰ 🚍 ﷺ ŵ 🖌 🚫 🦉 🖿 🖿 🍋 ×	
🗙 Periop Quick View	
🗙 Periop Systems Assessment	
🗙 Periop Safety Departure	Find Item - Critical
Periop Lines-Devices	Danuk Ic
Vintake And Output	W 9/2
Advanced Granhing	2018-Jan-26
Adult Education	
Padiatric Education	Temperature Axill DegC36.7
Fedraulic Education	Temperature Tem DegC
Endoscopy Quick View	Temperature Oral DegC
Perinhard IV	Temperature Rectal DegC
	Temperature Core DegC
Sedation Scales	Heart Rate Monit bpm 86
Discharge Criteria	SBP/DBP Cuff mmHg130/80
PAIN ASSESSMENT	Cuff Location
GASTROINTESTINAL	Mean Arterial P mmHg97
Urinary Catheter	Mean Arterial P mmHg
Glucose Blood Point of Care	Blood Pressure Method
Restraint Information	Central venous mmHg
Provider Notification	Garabaal Barfus mmHg
	4 Orargenation
	Respiratory br/min14
	Measured Q2% (FIQ2)
	Oxygen Activity
	Oxygen Therapy
	Oxygen Flow L/min
	Humidificatio DegC
	End Tidal CO2 mmHg

Unlike the Sedation Record (SA Anesthesia), in IView you must manually cue the system to document a patient's vitals at a given point in time and sign to finalize them. For example, If you are to monitor the patient's vitals q5mins, you need to click in IView every 5 minutes.

The first step to start BMDI is you must associate your patient to the right device.

- 1. Click Interactive View and I&O Interactive View and I&O from the Menu
- 2. Click Associate Device 📓 icon

Interactive View and I&O
 Image: Image:

- The Device Association window opens
- 3. Enter = <endo> in the Device search box



- 4. Click 🙈
- 5. Select the BMDI Device corresponding your patient's location

			ΞŦ		
evice Search					B 100000
					Associate
evice: endo					
Device	Location	Details	Vendor	Model	
LGH_ENDO_BED09_B650			GEEL	CareScape B650	
LGH_ENDO_BED10_B650			GEEL	CareScape B650	
LGH_ENDO_BED11_B650			GEEL	CareScape B650	
LGH_ENDO_BED12_B650			GEEL	CareScape B650	
LGH_ENDO_BED13_B650			GEEL	CareScape B650	
LGH_ENDO_BED14_B650			GEEL	CareScape B650	
LGH_ENDO_BED16_B650			GEEL	CareScape B650	
LGH_ENDO_BED17_B650			GEEL	CareScape B650	
LGH_ENDO_PROC1_B650			GEEL	CareScape B650	
LGH_ENDO_PROC2_B650			GEEL	CareScape B650	
LGH_ENDO_PROC3_B650			GEEL	CareScape B650	

- 6. Click Associate
- 7. Click X to close the Device Association window.

To populate the first set of post-op vital signs, ensure you are in the **Endoscopy Quick View** band:

< 🔹 🗧 🛔 Interactive View and I&O					
™ 🗄 🖽 🐼 🖌 🗭 🍇 📑 🖬 🍋 ×					
🗙 Periop Quick View	4		Last 24	4 Hours	
💊 Periop Systems Assessment					
Veriop Safety Departure	Find Item 🔹 🔲 Critical 📗	High 🔲 Low	Abnormal	🔲 Unauth	🔲 Flag
Periop Lines-Devices					
Vintake And Output	21-Nov-2017				
Advanced Graphing	💐 🚮 🗗 🕺 📆 🕅				
Adult Education	⊿ VITAL SIGNS				
Pediatric Education	Temperature Axill DegC				
Sector Street St	Temperature Oral DegC		Dente OF		
VITAL SIGNS	Temperature Rectal DegC		Double Cli	СК	
Peripheral IV	Temperature Core DegC	L L	INIS BOX		
RESPIRATORY	Heart Rate Monit bpm				
Sedation Scales	SBP/DBP Cuff mmHg				
Discharge Criteria	Cuff Location				
PAIN ASSESSMENT	Mean Arterial P mmHg				
GASTROINTESTINAL	Mean Arterial P mmHg				
Urinary Catheter	Blood Pressure Method				
Glucose Blood Point of Care	Central Venous mmHg				
Restraint Information	Intracranial Pre mmHg				
Provider Notification	Cerebral Perfus mmHg				
	⊿ Oxygenation				
	Respiratory br/min				
	Measured O2% (FIO2)				
	Oxygen Activity				
	Oxygen Therapy				

- 1. Select VITAL SIGNS
- 2. Double Click on the cell beside VITAL SIGNS
 - The patient's Vital Signs will now populate to IView



21-N	ov-2017	
40 00:10 bz	1 09:07 PS1	
⊿ VITAL SIGNS		
Temperature Axill DegC		Not Finalized (purple font)
Temperature Tem DegC		
Temperature Oral DegC 37.6	37.5	
Temperature Rectal DegC		
Temperature Core DegC		
Heart Rate Monit bpm 73	75 📥	
SBP/DBP Cuff mmHg 120/85	110/90	Finalized
Cuff Location		
Mean Arterial P mmHg97	97	
Mean Arterial P mmHg		
Blood Pressure Method		
Central Venous mmHg		
Intracranial Pre mmHg		
Cerebral Perfus mmHg		

3. Review the set of Vitals Signs and Click the green checkmark 🖌 to finalize (sign)

Note: The documentation is not officially inputted until it is finalized. If you navigate elsewhere before signing, you may lose your set of vitals.

Key Learning Points

BMDI captures vital signs data but must be manually cued to documents them to IView.

- Unlike SA Anesthesia, you must manually capture the patient's vital signs.
- IView documentation is not officially inputted in the system until it is finalized (signed).

1



Activity 3.5 – Completing Documentation in Endoscopy Quick View (IView)

As the endoscopy post-op nurse, you will be documenting your post-op assessments and other interventions in **Endoscopy Quick View** band in IView.

Review Activity 1.3 to re-familiarize yourself with the **Endoscopy Quick View** as necessary.

< 🔹 📩 Interactive View and I&O	
🖦 🔜 🖽 🞶 🖌 😥 🧃 📰 📾 🛪	
🗙 Periop Quick View	▲ Last 24 Hours
Yeriop Systems Assessment	
Yeriop Safety Departure	Find Item - Critical High Low Abnormal Unauth
Periop Lines-Devices	Danut Commente Des Dete
VIntake And Output	
Advanced Graphing	14-Dec-2017
Adult Education	
Addit Education	Temperature Axillary DegC
Cada a serve Quiale Missee	Temperature Temporal Artery DegC
	Temperature Oral DegC
VITAL SIGNS Botishard IV	Temperature Rectal DegC
RESPIRATORY	Temperature Core DegC
Sedation Scales	Heart Rate Monitored bpm
Discharge Criteria	SBP/DBP Cuff mmHg
PAIN ASSESSMENT	Cuff Location
GASTROINTESTINAL	Mean Arterial Pressure, Cuff mmHg
Urinary Catheter	Mean Arterial Pressure, Man mmHg
Glucose Blood Point of Care	Blood Pressure Method
Restraint Information	Intracronial Processore mmHg
Provider Notification	Carebral Perfusion Pressure mmHg
	4 Oxygenation
	Respiratory Rate br/min
	Measured O2% (FIO2)
	Oxygen Activity
	Oxygen Therapy
	Oxygen Flow Rate L/min
	Humidification Temperature DegC
	End Tidal CO2 mmHg



2 Document Sedation Scales

Under the Endoscopy Quick View band:

- 1. Select Sedation Scales
- 2. Double Click inside the box next to Sedation Scale Used

₩₩ ₩ ₩	2018-Jan-26
⊿ Sedation Scales	
Sedation Scale Used	

3. Select Modified Aldrete

1 11 W	21-Nov-2017				
R 🖬 🗗	👸 10:45 PST	09:58 PST	09:10 PST	09:07 PST	
⊿ Sedation Scales					
🐼 Sedation Scale Used	Sedation Scale	e Used		×	
⊿ Modified Aldrete Sc	Modified Aldrete Score				
Respiratory	Pasero Opioio	l Induced Sed	ation Scale		
Circulation	Richmond Agi	itation Sedati	on Scale		
Level of Consciousn	University of N	Michigan Seda	ation Scale		
Movement	\diamond				
♦ SpO2	\diamond				
🔜 🔷 Modified Aldrete Sc	\diamond				

- 4. Document the following:
 - **Respiratory** = Able to deep breathe and cough freely
 - **Circulation** = *BP* +/- 20% of pre-op value
 - Level of Consciousness = Awake and oriented
 - Movement = Moves 4 limbs on own
 - **SPO2** = Able to maintain O2 saturation greater than 92% room air

Hint: Instead of clicking to move to the next cell press Enter

Once each field is completed, the Modified Aldrete Score will automatically calculate

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Yeriop Quick View			
Yeriop Systems Assessment			
Periop Safety Departure	Find Item 👻 🔲 🕻	Critical 🛛 🔳 Hig	h 🔳 Low
Periop Lines-Devices	Death	Com	an a star a la
VIntake And Output	¥. 50		
Advanced Graphing		ିଖି 10:45 PST	21-No 09:58 PST
Adult Education	⊿ Sedation Scales	~	
Pediatric Education	Sedation Scale Used	Modified Al	
Sendoscopy Quick View	⊿ Modified Aldrete Score		
	Respiratory	Able to dee	
VITAL SIGNS	Circulation	BP +/- 20%	
Penpheral IV	Level of Consciousness	Awake and	
RESPIRATORY	Movement	Moves 4 lim	
Sedation Scales	♦ SpO2	Able to mai	
Discharge Criteria	Modified Aldrete Score	10	
PAIN ASSESSMENT	⊿ Discharge Criteria		
GASTROINTESTINAL	Nausea and Vomiting		
Urinary Catheter	Bleeding		
Glucose Blood Point of Care	Pain		
Restraint Information	Discharge Criteria Score		

For additional reference information, Click menext to the Modified Aldrete Score





Document Discharge Criteria:

1. Double Click inside the box next to Discharge Criteria

	2018-Jan-26
⊿ Discharge Criteria	

- 2. Document the following:
 - **Nausea and Vomiting** = Controlled nausea/vomiting
 - **Bleeding** = Dressing site dry and clean
 - **Pain** = Controlled pain
- 3. Click Sign ✓ to finalize
- 3 Recall that the endoscopy pre-op nurse inserted and documented a peripheral IV in IView, as the post-op nurse will document its removal:

Under the Endoscopy Quick View band

- 1. Select Peripheral IV
- 2. Locate the IV insertion documented by the pre-op nurse
- 3. Double Click inside the box next to Peripheral Hand Left to open documentation for the IV removal

< 🔹 🕂 🤺 Interactive View and I&O		
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Veriop Quick View		Last 24 Hours
Periop Systems Assessment		
Periop Safety Departure	Find Item Critical High Low Abnorr	nal 📃 Unauth 📄 Flag
Periop Lines-Devices	Danie Communia I Data	Defensed D.
Vintake And Output	× 340	
Advanced Graphing	21-Nov-201/	
Adult Education	∠ Peripheral IV	
Pediatric Education	△ Peripheral Hand Lef	
Endoscopy Quick View	Activity Insert	
A LINUSCOPY QUICK VIEW	Patient Identified	
VITAL SIGNS	Total Number of Att	
Penpheral IV	Unsuccessful Attem	
RESPIRATORY	♦ Line Insertion	
 Sedation Scales 	Line Status	
Discharge Criteria	Line Care	
PAIN ASSESSMENT	Site Assessment	
GASTROINTESTINAL	Site Care	
Urinary Catheter	Dressing Activity Applied	
Glucose Blood Point of Care	Dressing Condition	
Restraint Information	Patient Perpone	
Provider Notification	Facient Response	

- 4. Document the following:
 - **Activity** = *discontinue*
 - Removal = Adhesive bandage, Catheter intact, no resistance, Direct pressure applied



⊿ Peripheral IV	
⊿ Peripheral Hand Lef	
Activity	Discontinued Insert
Removal	Removal 🗙
🛇 Removal Reason	Adhesive bandage
Line Status	Catheter intact, no resistance
Line Care	Gauze
Site Assessment	Hemostasis within expected timeframe
Site Care	✓ Direct pressure applied
Dressing Activity	Other
Dressing Condition	
Patient Response	

5. Click Sign ✓ to finalize

As necessary, please take the time to familiarize yourself with the content of the Endoscopy Quick View band that was not covered in this activity.

- As a post-op nurse, you will be documenting your post-op assessments and other interventions as necessary in the Endoscopy Quick View band.
- Modified Aldrete Sedation Scale and Discharge Criteria documentation was covered to familiarize you with one clinically relevant assessment you may be completing in Endoscopy Quick View.
- Documenting the IV removal was covered to familiarize you with discontinuing an action completed by a previous clinician.
- Remember to sign in order to finalize your IView documentation.



Activity 3.6 – BMDI Dissociation

4

When utilizing BMDI with IView, the patient will not automatically be dissociated when you disconnect them from the monitors. Therefore, when you disconnect the patient from the monitors, you must also dissociate the patient from BMDI.

Dissociating BMDI is important, for example, when you accidentally associate your patient to the wrong device, you will need to dissociate and re-associate them to the correct one to ensure the right vitals are coming through from the right patient.



- 1. Click IView and I&O Interactive View and I&O from the Menu
- 2. Click Associate Device 🔋 icon



- 3. Click the checkbox next to the appropriate BMDI Device
- 4. Click Disassociate
- 5. Verify that the disassociated device has been removed from list
- 6. Click X to close the Device Association window



- When utilizing BMDI with IView, the patient will not automatically be dissociated when you disconnect them from the monitors.
- When you disconnect the patient from the monitors, you must also dissociate the patient from BMDI.
- Dissociating BMDI is important also important if you accidentally associate your patient to the wrong device, you will need to dissociate and re-associate them to the correct one to ensure the right vitals are coming through from the right patient.



Activity 3.7 – Complete the Nursing Discharge Checklist



In the scenario the patient is now ready to go home. You will be completing the Nursing Discharge Checklist.

- 1. Select Perioperative Summary from the Menu
- 2. Select the Discharge tab

< 🖂 🔹 者 Perioperative St	🕑 🖬 Perioperative Summary 🔅 🗇 thours 38 minutes ago								
A 10%	A] A] A] A] A] A] A] A] A] A]								
Preop Summary 🕅 In	raop Summary 🔯 Postop Summary 🛱 Handoff Tool 😂 🛙	Discharge 🔯 Quick	Orders 🛛 🕇	🖃 = 🕅 🖉 =•					
Active Issues Social Histories Discharge Documentation (0)	Discharge Documentation No results found			Selected visit ੴ ≡ -					
 Discharge Medications (2) Orders (11) Provider Discharge Documents (0) 	Discharge Medications (2) + * To satisfy this requirement, the provider must complete the Discharge Medication	n reconciliation		All Visits ∂ =- ⊠ E					
		Status	: ✔ Meds History 🙂 Adm	ission Transfer 9 Discharge					
	Medication	Responsible Provider	Compliance E	Estimated Supply Remaining					
	Iosartan (Cozaar 50 mg oral tablet) 1 tab, PO, qdaily, 0 Refill(s)	-							
	rosuvastatin (Crestor 10 mg oral tablet) 1 tab, PO, qdaily, 0 Refill(s)	-		-					
	Docume	nt History: Completed by Test, Periop	perative - Nurse with SaAnes	thesia on 16/11/2017 At 13:41					
1	Orders (11)			Selected visit 🍋 🔤					

3. Under the Discharge Documentation section, Click the small down arrow 🗷

< 🖂 - 者 Perioperative	< 🔹 🕆 🛉 Perioperative Summary							
👫 📄 📥 📄 🔍 🔍 100%								
Preop Summary 🛛	Intraop Summary 🛛 🕅	Postop Su	immary 🛛 🕅	Handoff Tool	×	Discharge	X	
Active Issues Social Histories	Discharge Docum	entation		coccment	1			
Discharge Documentation (0)	No results found		Nursing Discharge Ch	recklist				
* Discharge Medications (2)			Valuables/Belongings					
Orders (11)	Discharge Medicat	tions (2)	Discharge Coordinato Nursing Discharge Su	or Assessment Immary Newborn				
Provider Discharge								

- 4. Select Nursing Discharge Checklist
 - The Nursing Discharge Checklist PowerForm opens

Nursing Dischar	e Checklict - CSTSNDEMOENDO STONE								
*Performed on: 0	7-Nov-2017 🚔 💌 1450 🚔 PST				By: TestSX, NursewithSaAnesthesia-Pe	rioperative			
Dischame Check									
biocharge chock	Discharge Checklist								
	Discharge Checklist								
	N	/A 1	'es	Other:					
	Follow Up Information Provided								
	Discharge Education Provided								
	Patient Discharge Summary Provided								
	Prescriptions Liven								
	Valuables Returned Per Inventory List								
	Home Equipment/Supplies Arranged								
	Community Services Arranged Post Discharge								
	Transportation Arrangements Made								
	Accompanied By				Discharge Transportation				
	None Daughter Ministry work	ker			O Ambulance O Other:				
	Spouse Son Security				O Cab				
	□ Friend □ Parent □ Other:				O Non-ambulance transport				
	Significant other Sibling				O Personal vehicle				
	Discharge Comments								



5. Enter the following to complete the Nursing Discharge Checklist:

Follow Up Information Provided = Yes Discharge Education Provided = Yes Accompanied By = Spouse Discharge Transportation = Personal Vehicle

6. Click 🖌 to finalize the Nursing Discharge Checklist

- Access the Nursing Discharge Checklist under the Discharge tab in Perioperative Summary.
- Just like with any other PowerForm, remember to finalize the document by clicking
- The completed Nursing Discharge Checklist will appear in Documentation.



Activity 3.8 – Finalize PostOp Perioperative Documentation

1

Just like in the IntraOp Record, you will need to Finalize the Phase II record.

- 1. Once the Discharge from Phase II time is entered, Click Next № and the green checkmark ✓ will appear next to Case Times
- 2. Click the Finalize 🖹 icon
 - The Document Verified window opens

< 🖂 - 者 Perioperative Doc		[0] Full screen	🗊 Print	æ o
🖬 🖌 🕐 🏷 🧐 🔐 🗳				
LGH Phase - 02 Record - EN Cocumentation Guide H Phase - 02 Segment Group - EN Cose Trees	In Phase III In Phase III I			
			<< Prev	Next>>

3. Click Yes on the Document Verified window

Document Verified							
-	?	Document has no deficits. Would you like to finalize the document?					
		Yes No					

The Phase II Record will now be available for review in the Perioperative Summary, under the Postop Summary tab in Documents or via Documentation Documentation from the Menu.

- Once you complete all the documentation in the Case Times segment with no deficits, finalize by clicking the green flag icon.
- The finalized Phase II record can be found in Documentation or Perioperative Summary.



Activity 3.9 – Discharge the Patient Encounter

1

Once the patient has departed the Endoscopy unit, the last thing you need to do is discharge the patient's encounter from the Clinical Information System.

Once you discharge a patient

- Any outstanding initiated orders from your current encounter will automatically discontinue.
- You and other clinicians will still be able to document in the patient's chart
- The patient will stay on Perioperative Tracking as discharged for a certain time and then drop off.

To discharge the patient's encounter:



1. Click the arrow next to PM Conversation PM Conversation on the Toolbar

2. Select Discharge Encounter



- The Discharge Encounter window opens
- 3. Select Discharge Disposition = Discharge without Support Services



- Discharge Encounter			
Medical Record Number: 700005212	Encounter Number: 7000000013085	Full Name: CSTSNDEMOENDO, STC	Date of Birth: 01-Jul-1993
Age: 24Y	Gender: Female	BC PHN: 9876781011	
Encounter Type: Day Surgery	Medical Service: Gastroenterology	Facility: LGH Lions Gate	Building: LGH Lions Gate
Unit/Clinic: LGH Endoscopy	Room: Post Op	Bed: 10	Isolation Precautions:
Registration Date:	Registration Time:		
Discharge Disposition:	Discharge Date:	Discharge Time:	Discharge Username: TestSX, NursewithSaAne
Lancelled Atter Arrival Deceased Discharged Home with Support Discharged Home without Supp Left Against Medical Advice Patient Deceased While On a F Patient Deceased While On a F Transferred to a Non Acute Car Transferred to an Acute Care F	Services port Services Pass Pass e Facility acility		
Transferred to Other		PBODBC SXTEST	Complete Cancel

- **Discharge Date** = <*Enter Current Date*>
- **Discharge Time** = <*Enter Current Time*>
- 4. Click Complete

To confirm a patient's encounter has been discharged:

- 5. Select Discharge Encounter again from PM Conversation
 - Discharge Encounter opens, the date and time of discharge will display grayed out

- Discharge Encounter		
Building: LGH Lions Gate	Unit/Clinic: LGH Endoscopy	Room: A Contract Cont
Bed: 44	Isolation Precautions:	
Registration Date: 18-Jan-2018	Registration Time:	
Discharge Disposition: Discharged Home with 👻	Discharge Date: 26-Jan-2018	Discharge Time: 11:04
Discharge Username: Train, NursewithSaAnesth Deceased Details		
		Complete
Ready	TRAIN1 TR	AIN.NSA3 26-Jan-2018 11:11



- PM Conversation is used to discharge a patient's encounter.
- Clinicians will still be able document in the patient's chart after the encounter is discharged.
- Once discharged, the patient shows as crossed off on Perioperative Tracking for a time period and will automatically drop off
- The fields highlighted in Yellow indicate mandatory criteria that must be entered to proceed to the next step





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