SELF- GUIDED PRACTICE WORKBOOK [N41]
CST Transformational Learning

WORKBOOK TITLE:

Nurse: Endoscopy

Last update: February 23, 2018 (v2)

CLINICAL + SYSTEMS TRANSFORMATION
Our path to smarter, seamless care

TRANSFORMATIONAL LEARNING

TABLE OF CONTENTS

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

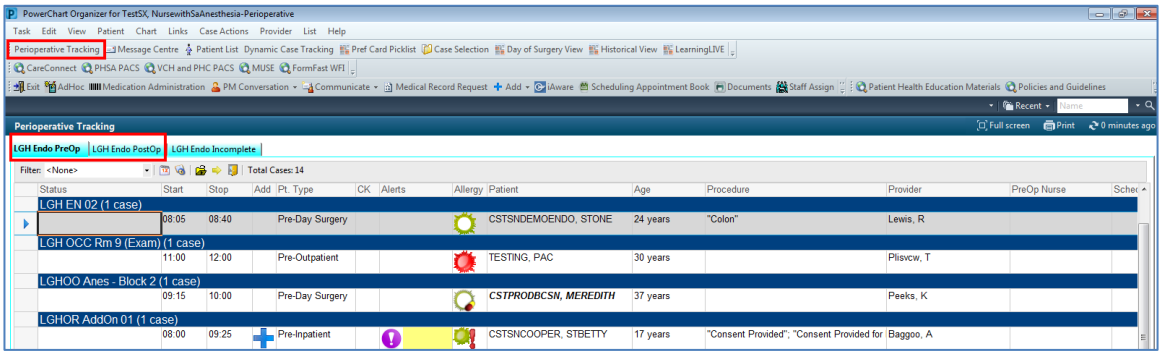
*The terms Intra-Op/Intra-Procedure & Procedure/Surgery will be used interchangeably in this workbook as some of the functionality is shared with other perioperative areas.

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.

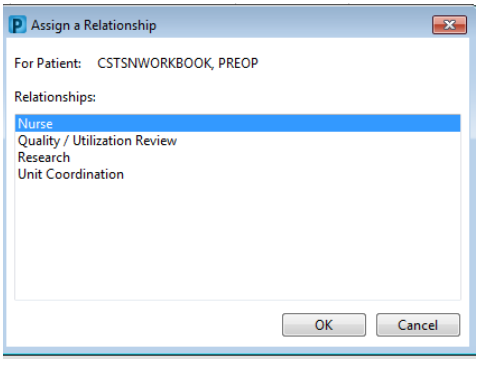


- To navigate back to Perioperative Tracking, Select Perioperative Tracking from the Toolbar
- Patients will reside in **LGH EndoPreOp** or **PostOp** Tracking View (or tab) depending on where they are in their patient journey
- Each row within Perioperative Tracking represents a patient. They are typically 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

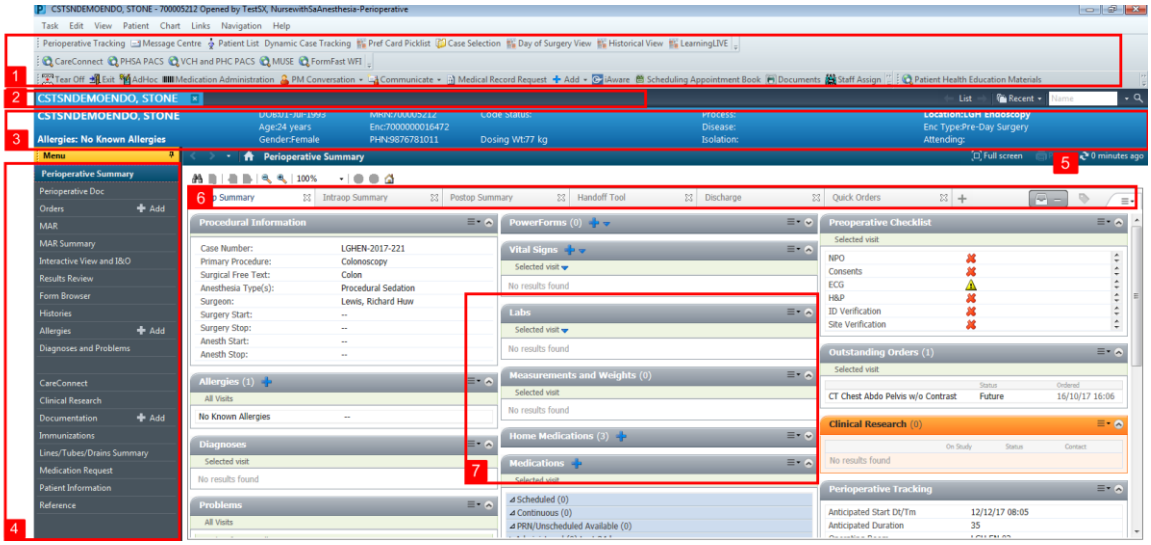


4. If this is the first-time logging in a patient's chart, the Assign a Relationship window will display, Verify this is the correct patient. Select Nurse to assign relationship.

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.



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  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  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 

vs. Refreshed 

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

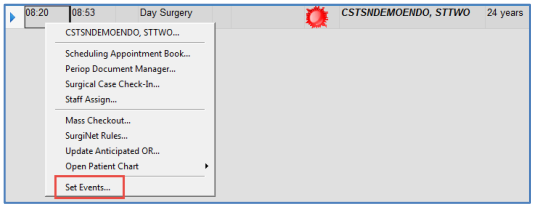
1

The advantage of Perioperative Tracking is that real time patient status can be immediately communicated as they occur. The functionality is referred to as **Setting an Event.** An Event can include an Alert (e.g., Violence Alert) or a patient's Status (e.g., Pt. in Waiting Room), and notifications (e.g., Seen by Nurse)

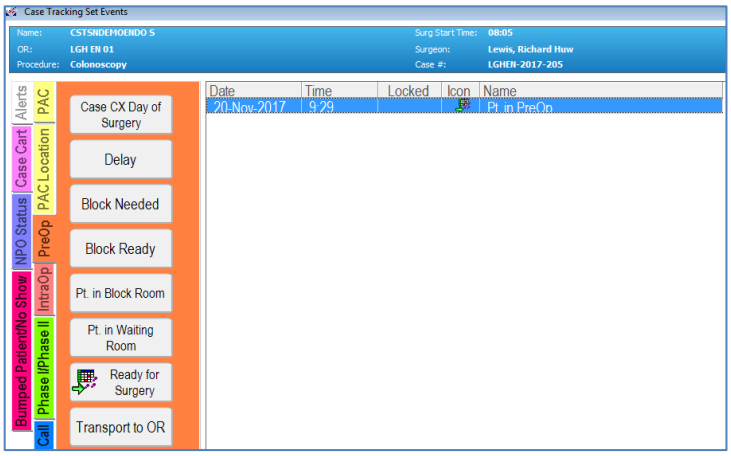
Do not close the patient chart from the previous activity. The chart can remain open even though you will access Perioperative Tracking.

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.

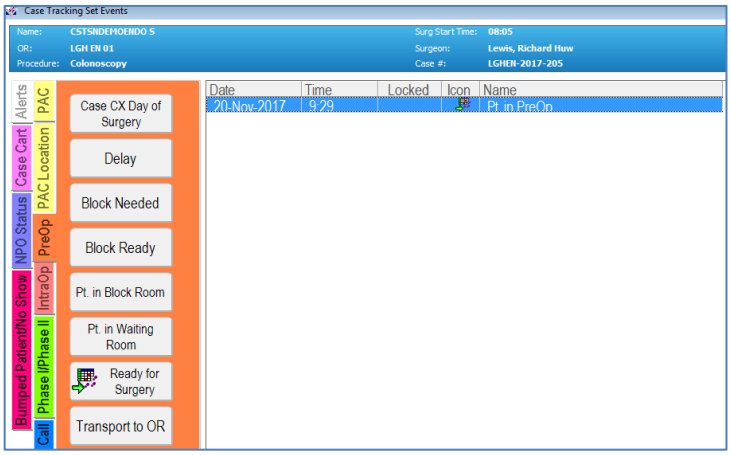


3. In the Case Tracking Set Events window, Select the orange PreOp **PreOp** tab

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

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

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

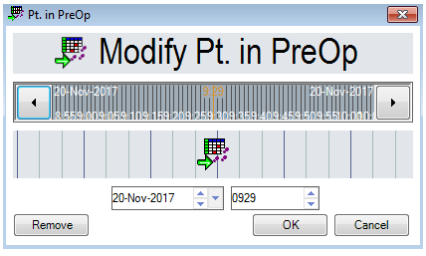


5. Click **OK**
6. Verify that the patient Status has been updated in Perioperative Tracking

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.

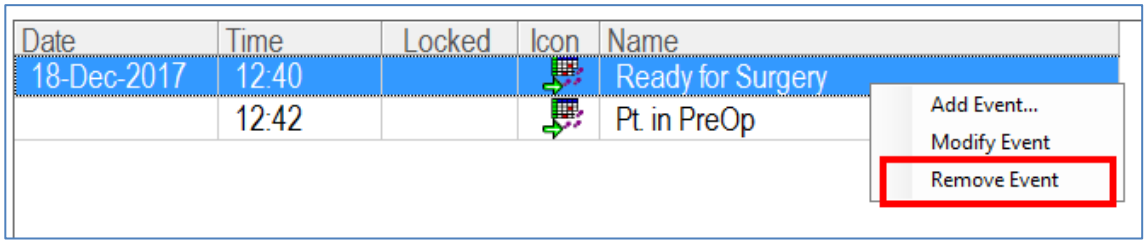
To modify an event:

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



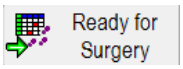
5. Click **OK**

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

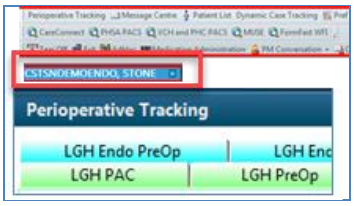


1. Right-Click **Set Events** from the LGH Endo PreOp view
    - Case Tracking Set Event window opens
2. Right Click on the Event to remove
3. Select **Remove Event**
4. Click **OK**

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

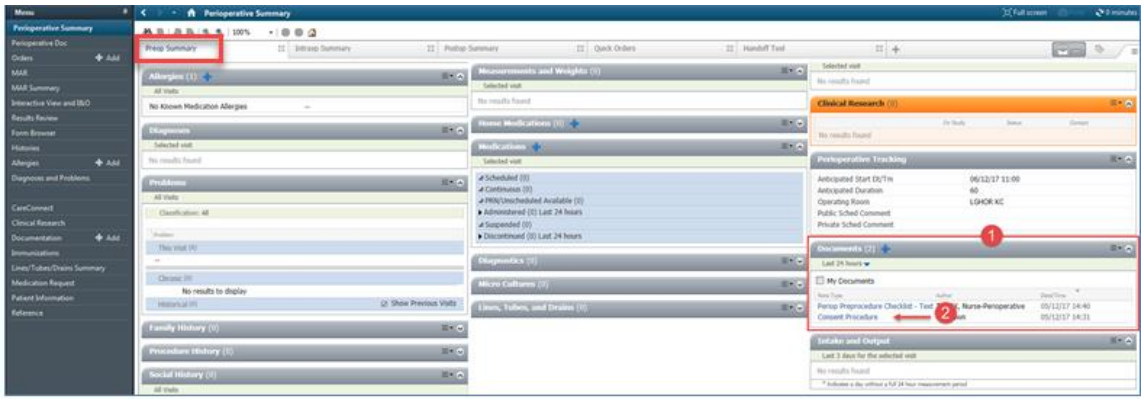


Key Learning Points

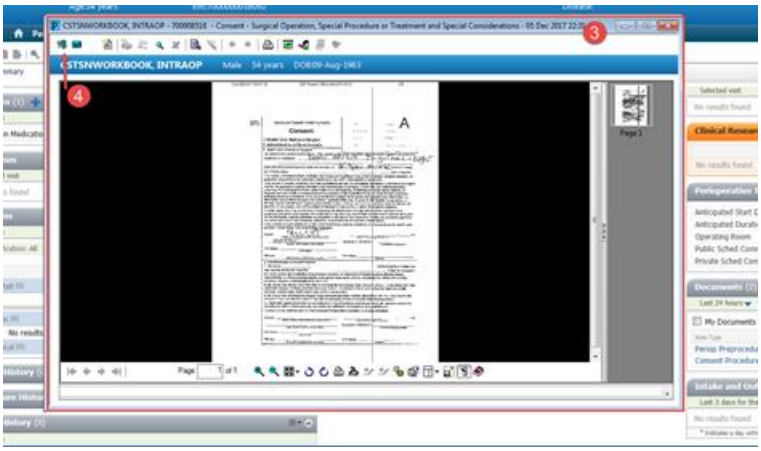
- Right Click anywhere on the line with the relevant patient to set event(s) too update a patient's Status in Perioperative Tracking.
- Events can be added, removed or modified.
- Date and time are the only fields that can be modified for an Event already set

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

1 To access the patient's Procedure Consent:



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** in the top left-hand corner

Key Learning Points

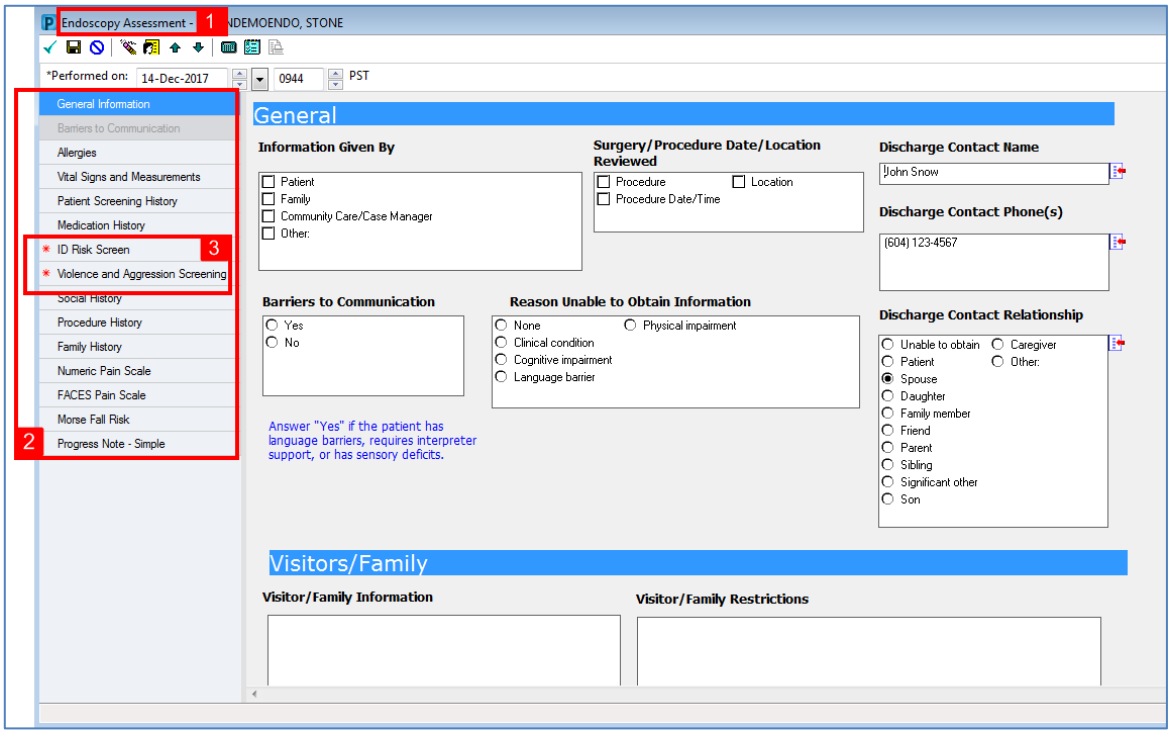
- Completed Procedure Consent can be found under Documents for review.
- Blank consents can be printed from FormFast.

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

1

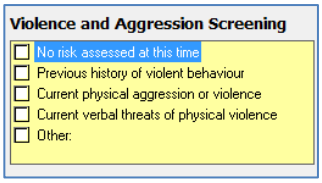
Overview of PowerForms

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.



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.

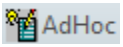
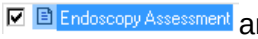


- Required field(s) within the PowerForm will be highlighted in Yellow. You will not be able to finalize a PowerForm unless all required fields are completed. For example,

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**  icon from the Toolbar
    - The Ad Hoc Charting window opens
2. Select the  folder from the left pane
3. Select the Endoscopy Assessment PowerForm  and Perioperative Preprocedure Checklist 
4. Click Chart
    - Endoscopy Assessment is the first form to open

3

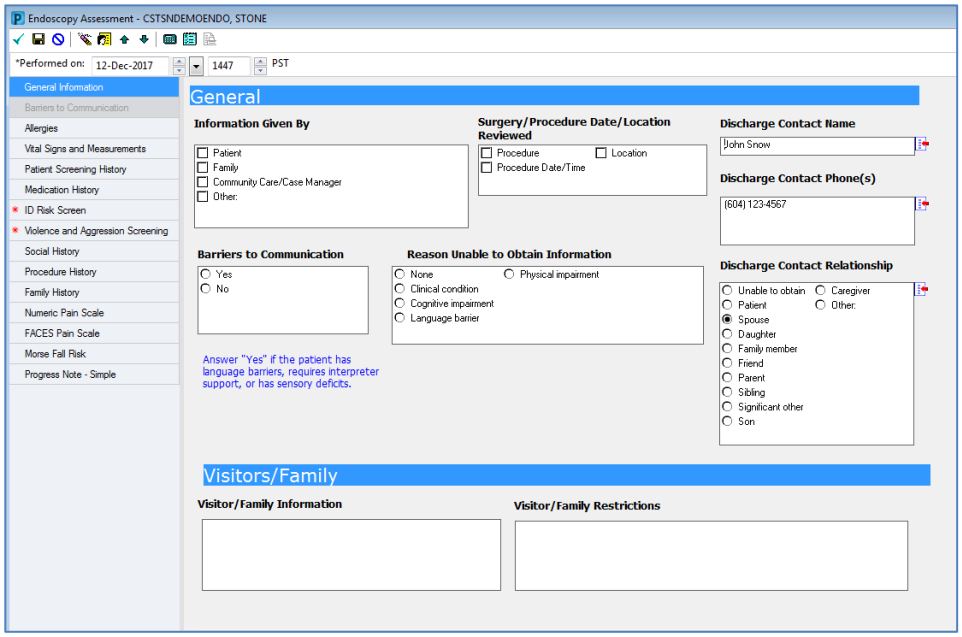
Documentation in the **Endoscopy Assessment PowerForm**

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:

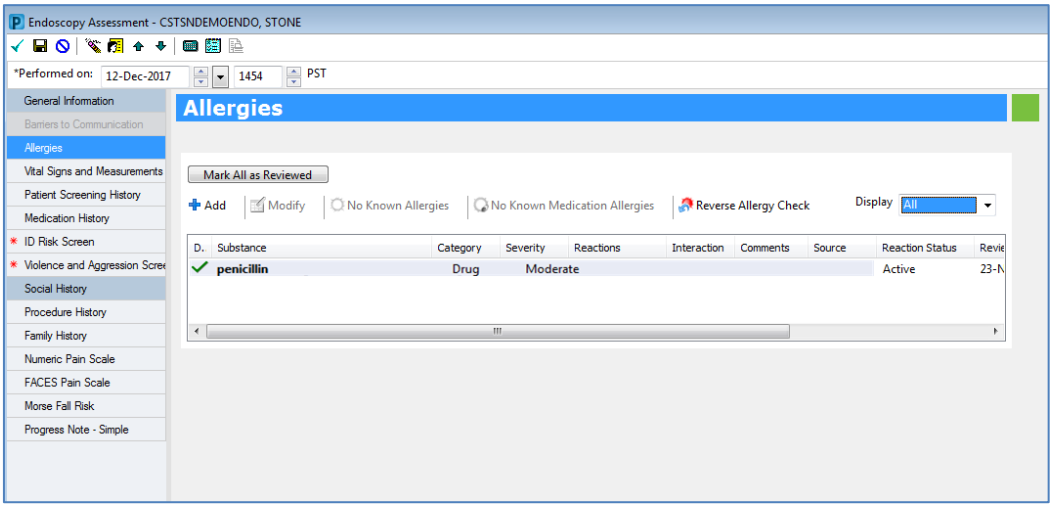


1. Click the **General Information** section.
2. Enter the following information to complete the General Information section:
   - Information Given By = *Patient*
   - Discharge Contact Name = *John*
   - Discharge Contact Phone(s) = *604-123-4567*
   - Discharge Contact Relationship = *Spouse*
   -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

Note:

- For fields that contain circle ○ (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

5 Complete the **Allergies** Section:

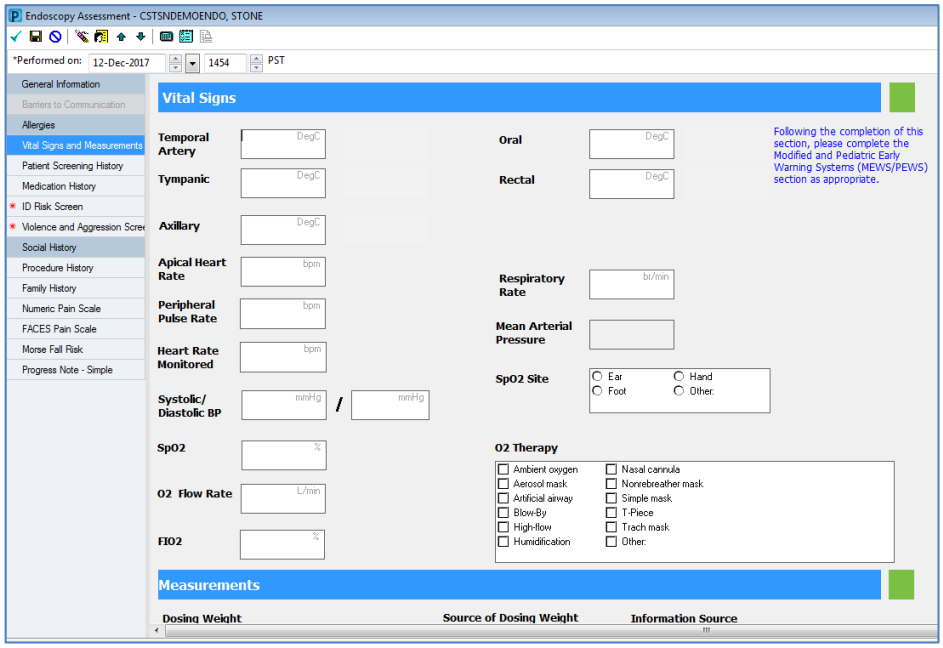


The patient currently has an allergy to penicillin recorded. To confirm this, Select **Mark All as Reviewed**. Allergy documentation **must** be completed to order and administer medications in PowerChart.

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

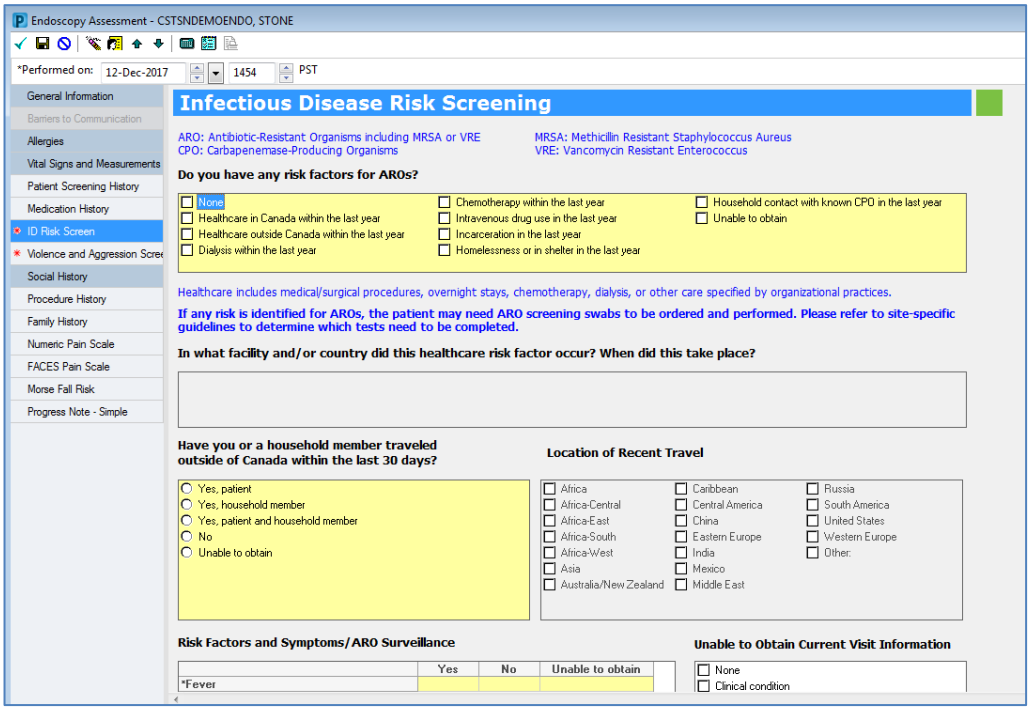


1. Click the Vital Signs and Measurements section
2. Enter the following information to complete the Vital Signs section:

- 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

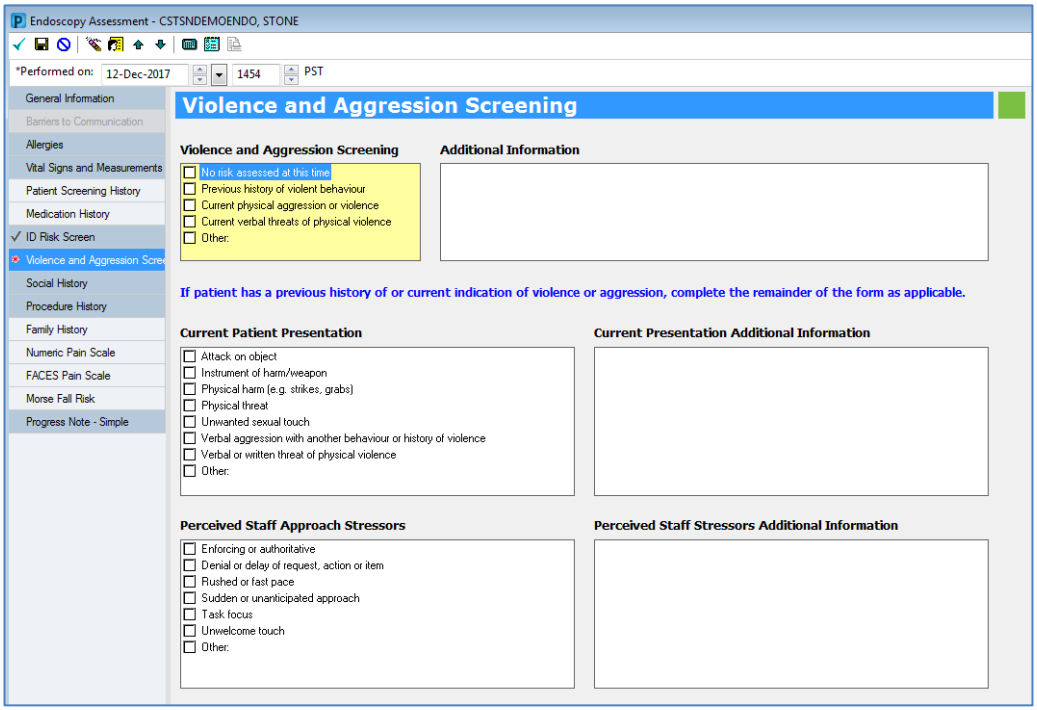
- Dosing Weight **must** be completed to order and administer medications in PowerChart.
- Body Mass Index Measured (BMI) is auto-calculated from entry of *Weight Measured and *Height/Length Measured.

7 Complete the **ID Risk Screen and Violence and Aggression** section



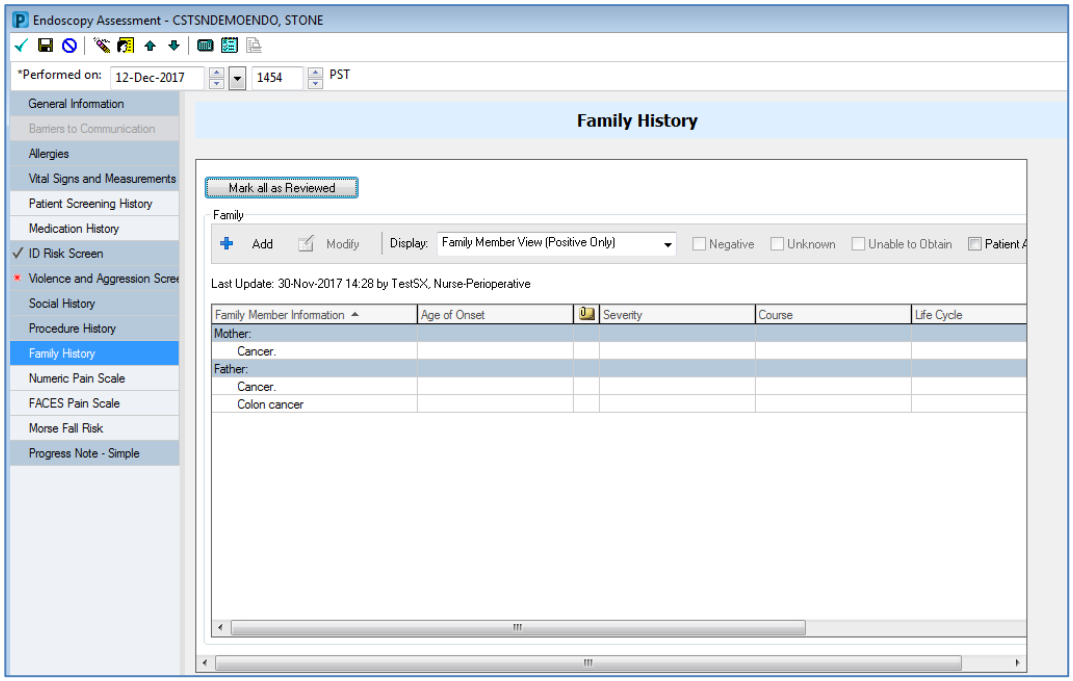
1. Enter the following information to complete the **ID Risk Screening** section:
   - Do you have any risk factors for AROs = *None*
   - Have you or a household member traveled outside Canada within the last 30 days? = *No*
   - Risk Factors and Symptoms = Click on the column header for *No* to mark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

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

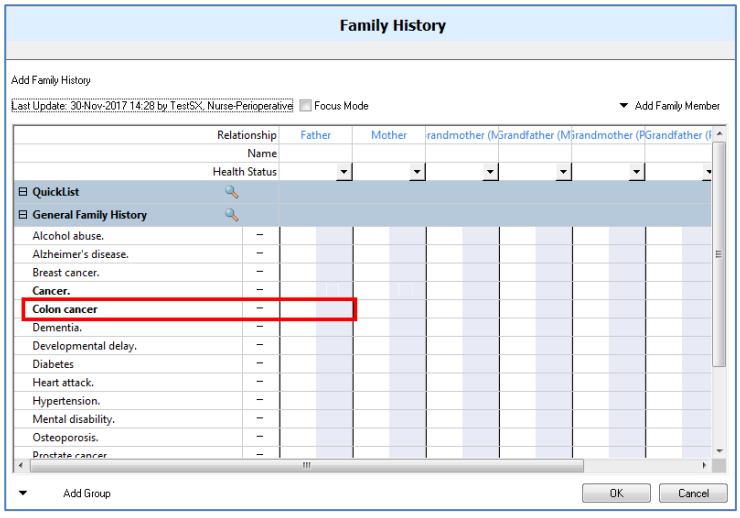


2. Enter the following information to complete the **Violence and Aggression Screening** section:
    - Violence and Aggression Screening = *No risk assessed at this time*

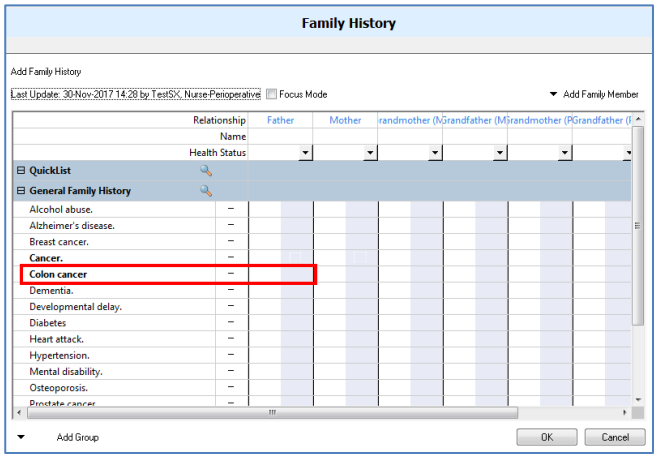
8 Complete the **Family History** section:



1. Click the **Family History** section
2. Click the Add ✚ icon



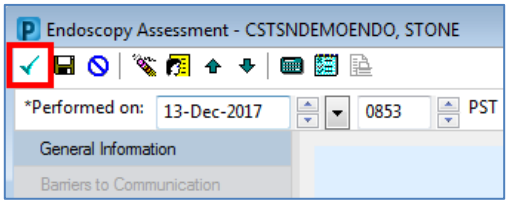
3. Within the Colon cancer row, Click once within the shaded column under Father
   - + appears in the box



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

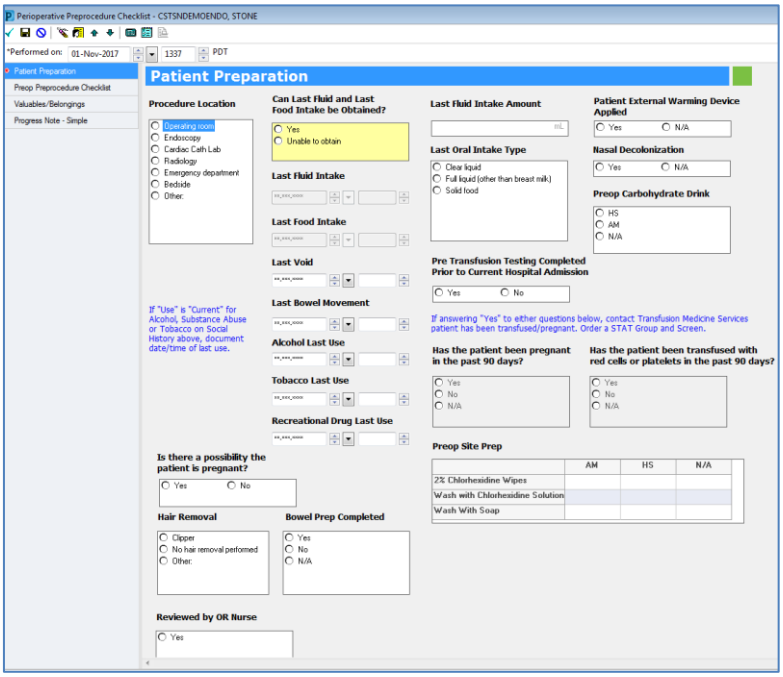
9 Finalize the **Endoscopy Assessment PowerForm**

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

10 Documentation in the **Perioperative Preprocedure Checklist**

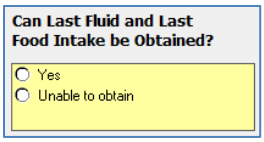


The following sections are available for documentation in the **Perioperative Preprocedure Checklist** PowerForm:

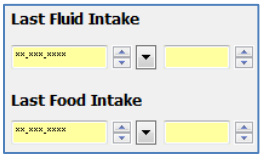
- Patient Preparation
- Preop Preprocedure Checklist
- Values/Belongings
- Progress Note

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”



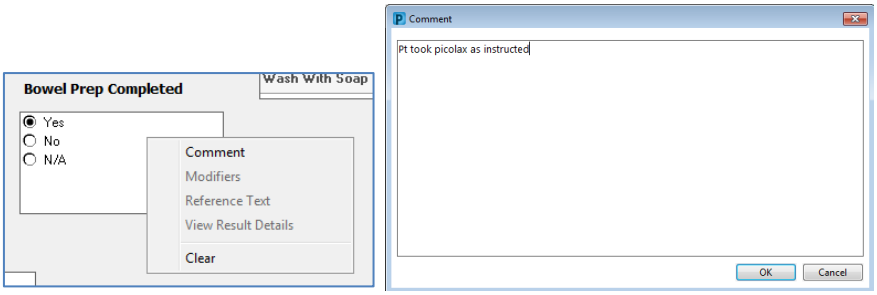
The following two sections will be also be highlighted for completion.



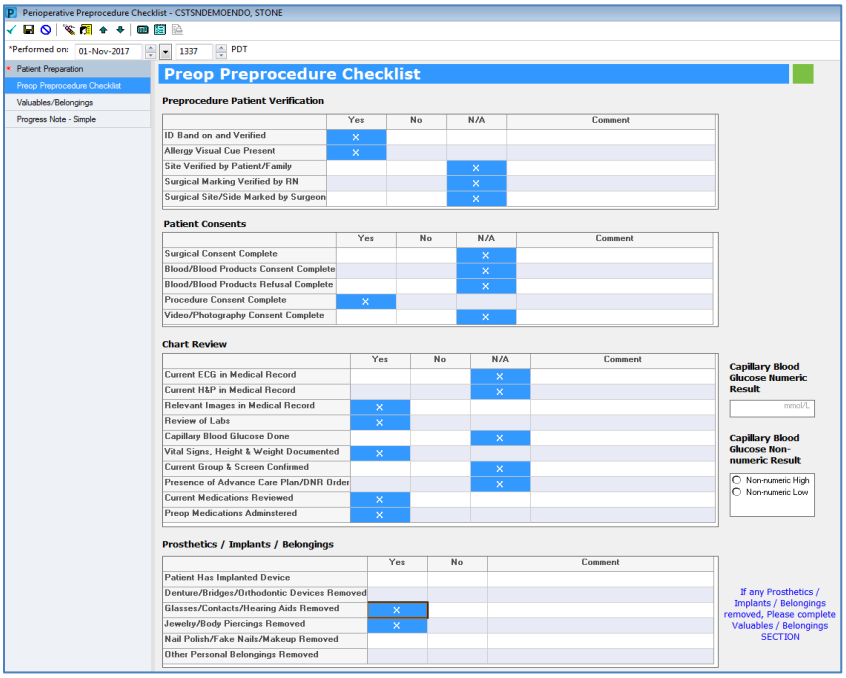
1. Enter the following information to complete the **Patient Preparation** section:
    - Procedure Location = *Endoscopy*
    - Can Last Fluid and Last Food Intake be Obtained?= *Yes*
    - Last Fluid Intake = *Today’s Date, 06:00*
    - Last Food Intake = *Yesterday’s Date, 11:30*
    - Last Oral Intake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



11 Complete the **Preop Preprocedure Checklist** section



1. Select **Preop Preprocedure Checklist**
2. 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

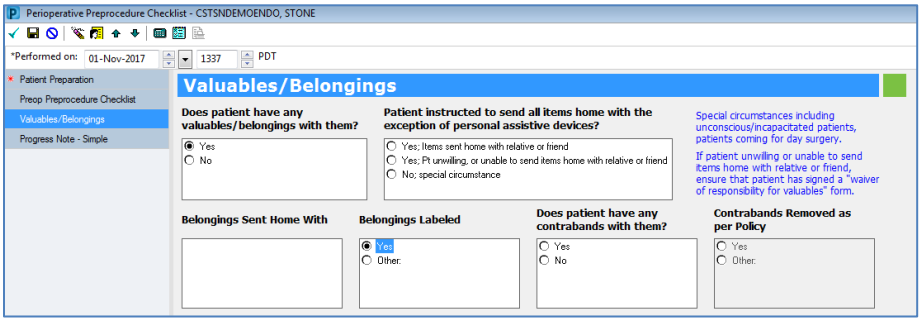
   - Procedure Consent Complete = *Yes*

- Enter N/A for the other fields in this section

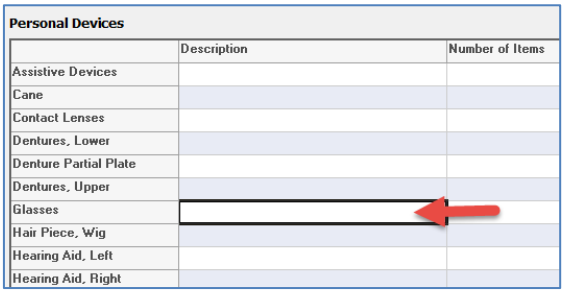
3. Please also review the following content (not required for completion of this activity)
   - Chart Review
   - Prosthetics/Implants/Belongings

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

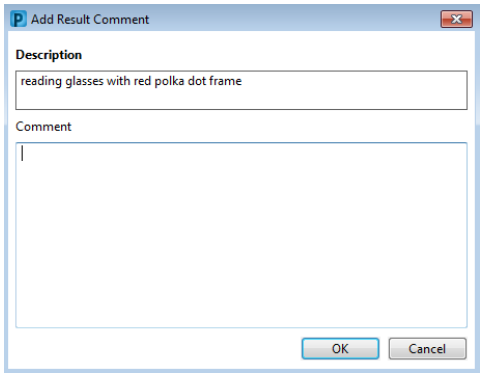
12 Complete **the Valuables/Belongings** section



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



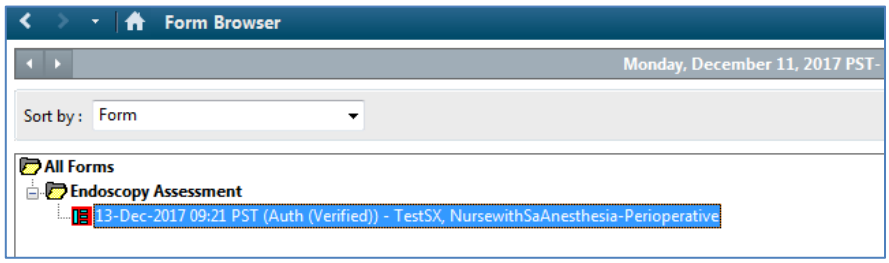
4. Enter <description and comment> as necessary



5. Click OK
6. Click the green 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



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 🖫 only saves the documentation for you. The finalize ✓ button will make the information visible to any clinician with access to the patient's chart.

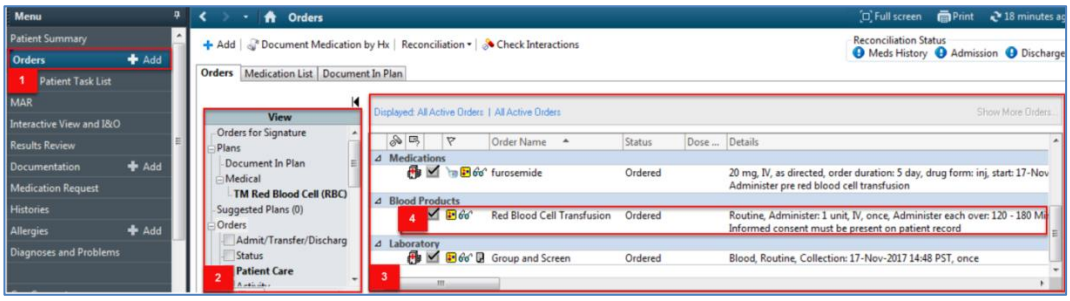
Key Learning Points

- 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

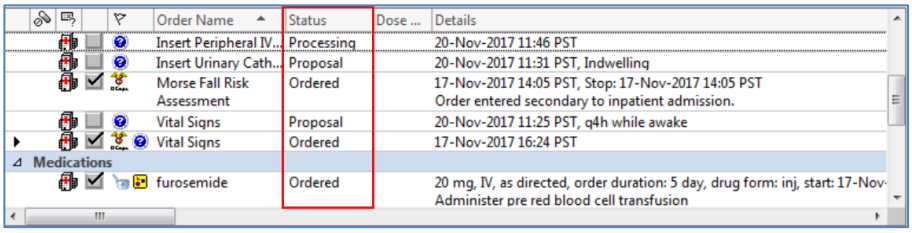
1

Orders Overview



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:
        - 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:



- **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

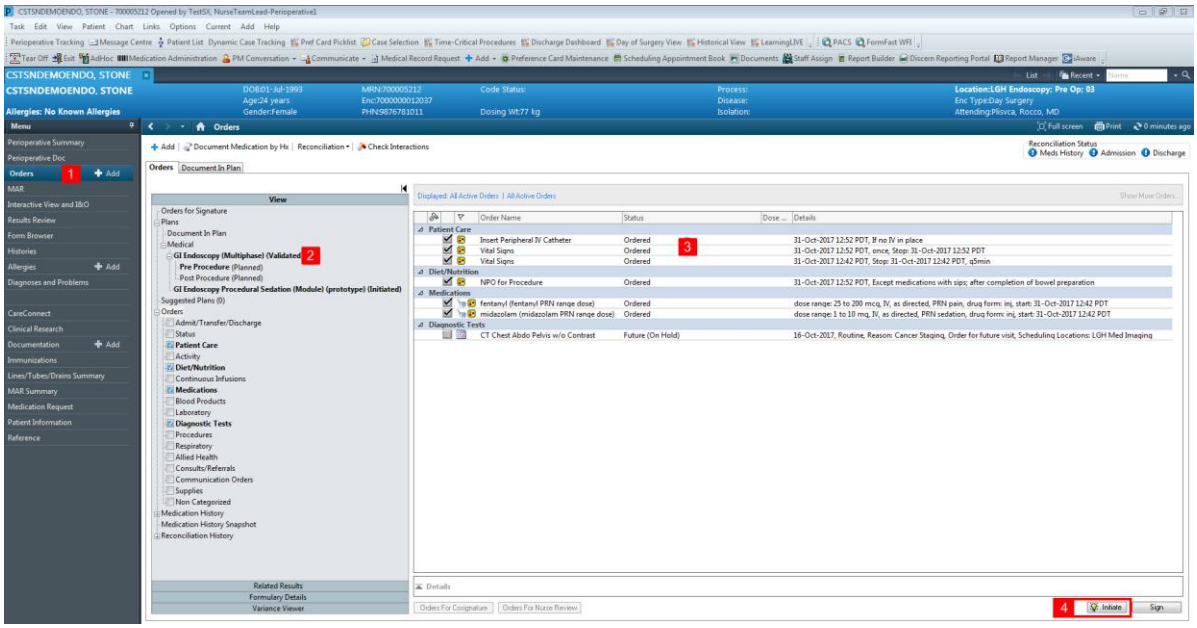
will become active and status will change to Ordered as above

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

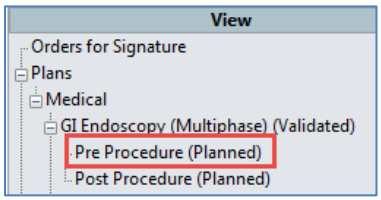
Planned orders (orders placed ahead of time) are only to be initiated in the appropriate phase when a nurse is about to carry them out.

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

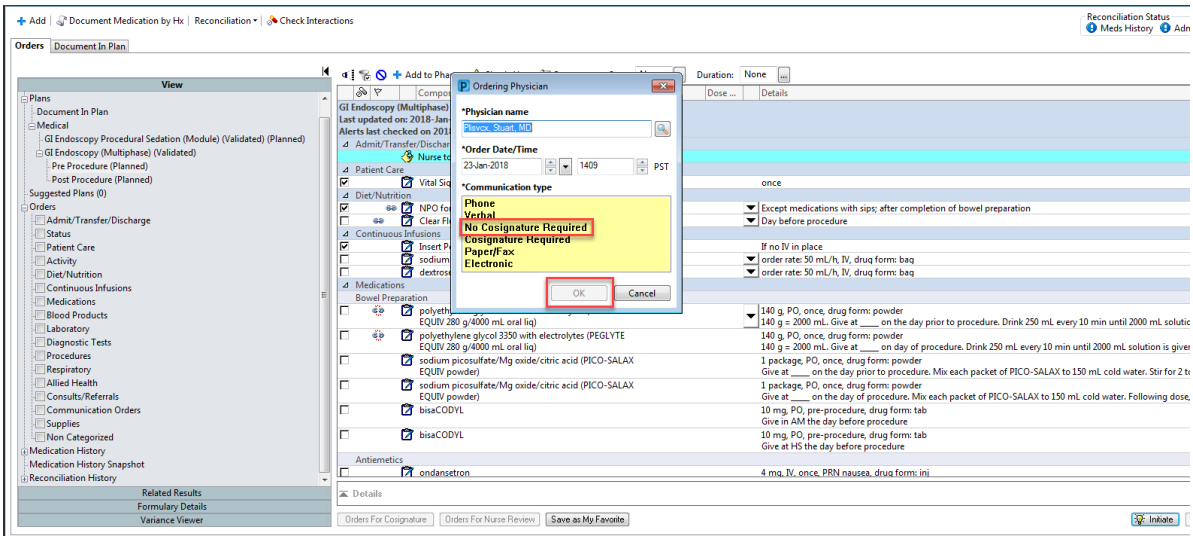


On the **Orders** profile:

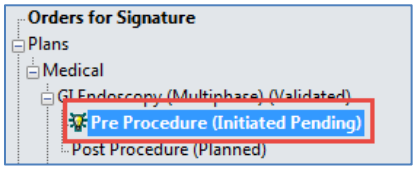
1. Locate the **Plans** category to the left side of the screen under **View**



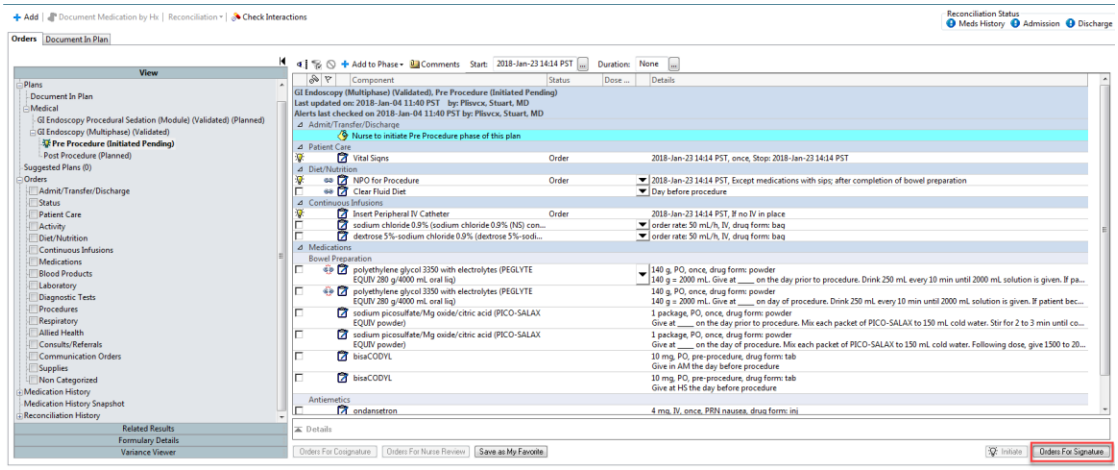
2. Under GI Endoscopy (Multiphase), Click the GI Endoscopy Pre Procedure (Planned)
3. Review order details within the PowerPlan
4. Click **Initiate.** The Ordering Physician box will display



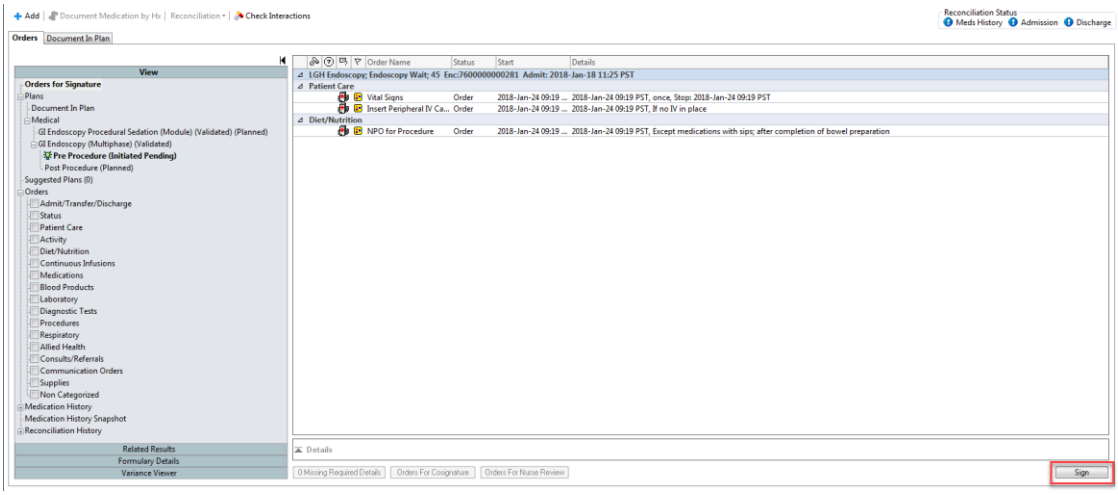
5. The Physician will autopopulate. Select **No Cosignature Required**
6. Click **OK**



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



7. Click **Orders for Signature**



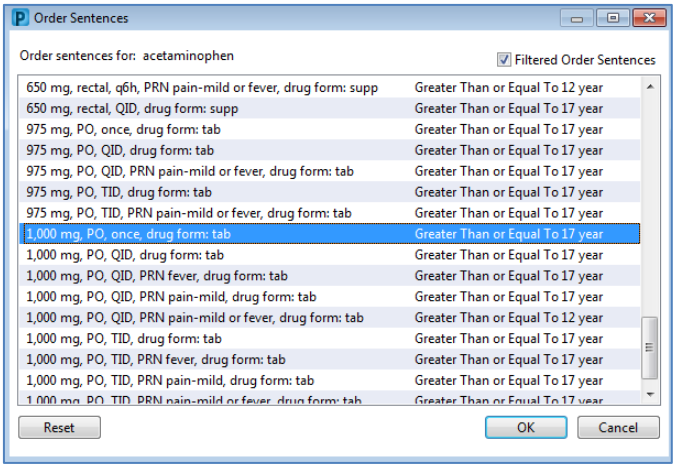
8. Click **Sign**
9. Click **Refresh**

3

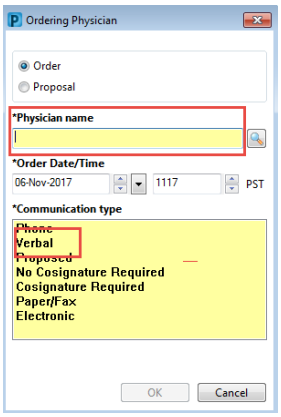
Although providers are entering orders in PowerChart, there are times a nurse may order on behalf of a GI Provider. In this scenario, the GI Provider mentions that the patient should receive a dose of acetaminophen before their procedure.

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*



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



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

Key Learning Points

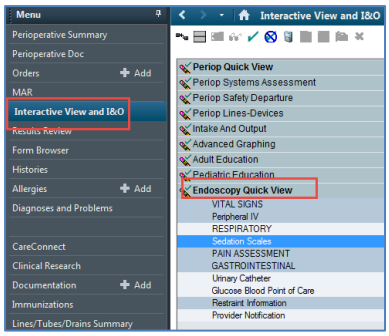
- The Order Page consists of the orders view and the order profile
- The Orders View (Navigator) displays all order for the patient, including PowerPlans and clinical categories of orders
- The Order Profile page displays all the orders for a patient
- Remember to sign when initiating an order(s)
- Verify 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

1

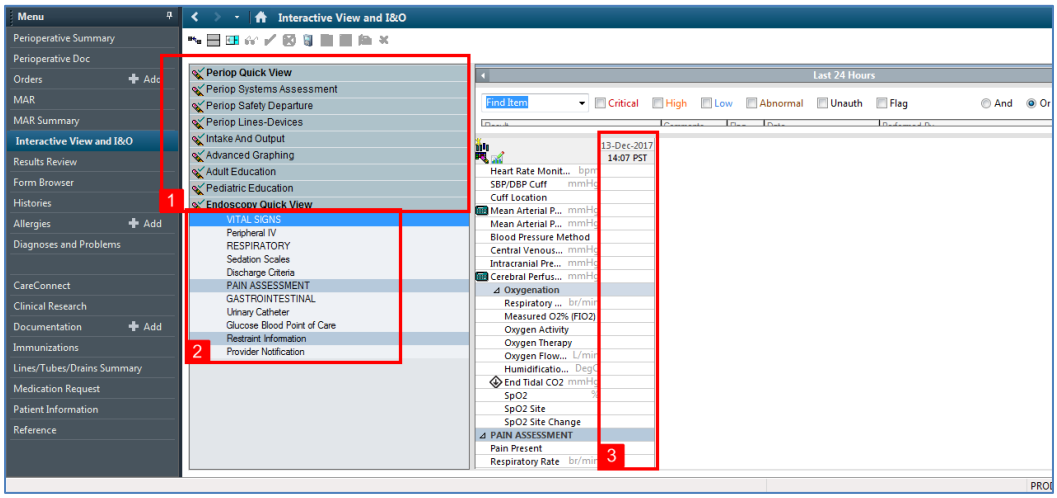
Interactive View and I&O (IView) is the electronic equivalent of current state paper flow sheets.

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



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

Overview of IView



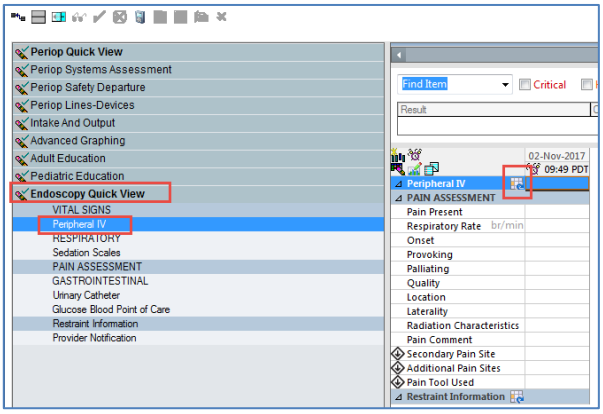
1. **A band** is the a heading with a collection of flowsheets organized beneath it. In the image above, **Endoscopy Quick View** band is expanded displaying the sections within it. A band is indicated by the pencil icon.
2. The set of bands below **Endoscopy Quick View** are collapsed. Bands can be 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.

2

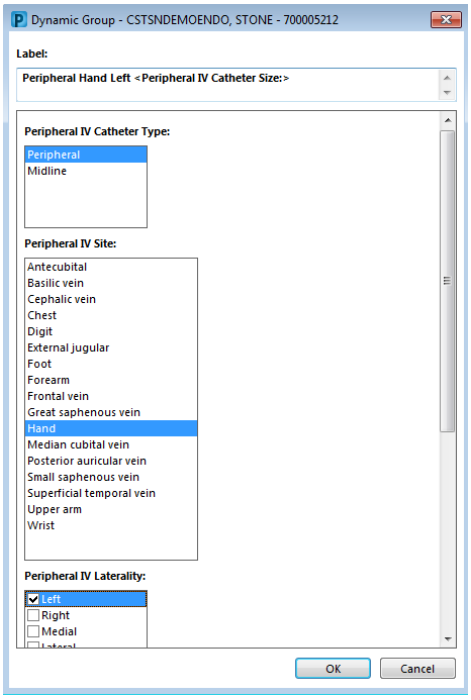
Document an IV insertion in **Endoscopy Quick View**

1. Select **IView** from the Menu

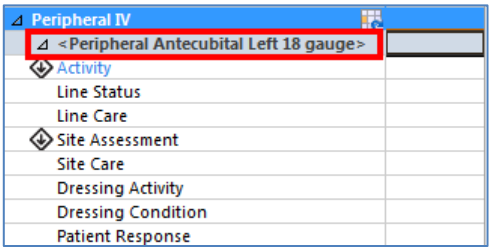
2. Select **Endoscopy Quick View**
3. Select Peripheral IV



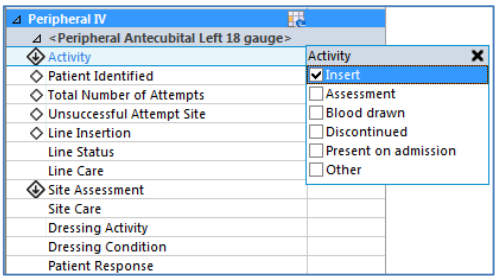
4. Click the dynamic group icon
    - The Dynamic Group window opens



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



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



   - **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

1

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

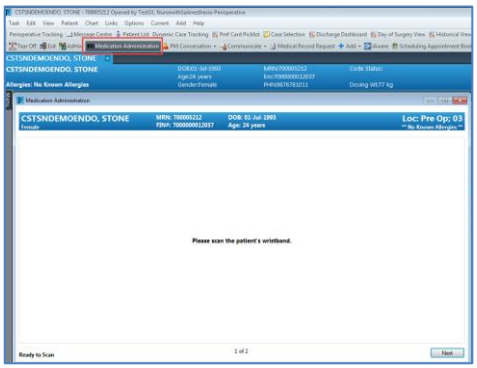
Note: IV medication volumes will flow from the MAR directly into the **Intake and Output** section of IView.

Tips for using the barcode scanner:

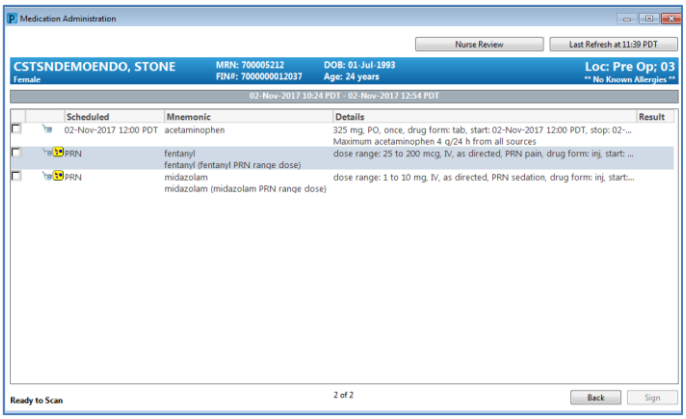
- Point the barcode scanner toward the barcode on the patient's wristband and/or the medication (Automated Unit Dose- AUD) package and pull the trigger button located on the barcode scanner handle
- To determine if the scan is successful, there will be a vibration in the handle of the barcode scanner 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

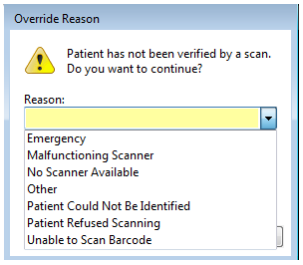


2. Scan the barcode on the patient's wristband
    - A list of ordered medications appear on the Medication Administration window
3. Scan the barcode for the acetaminophen to be given



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.

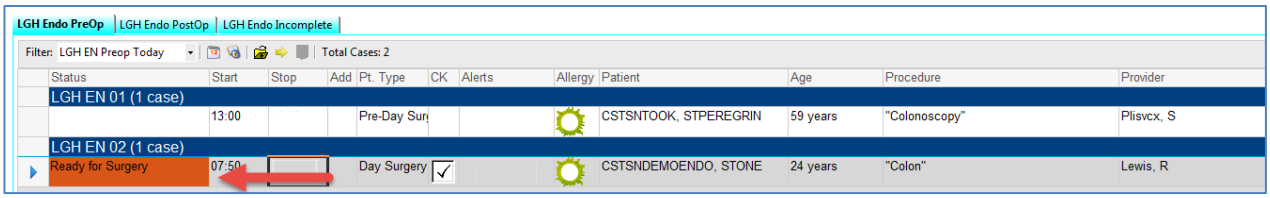
You will be switching between two applications: PowerChart & SAAnesthesia. As an endoscopy intra-op nurse you will be completing the following activities:

- 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

Activity 2.1 – Review the Patient's PreOp Documentation

1

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:

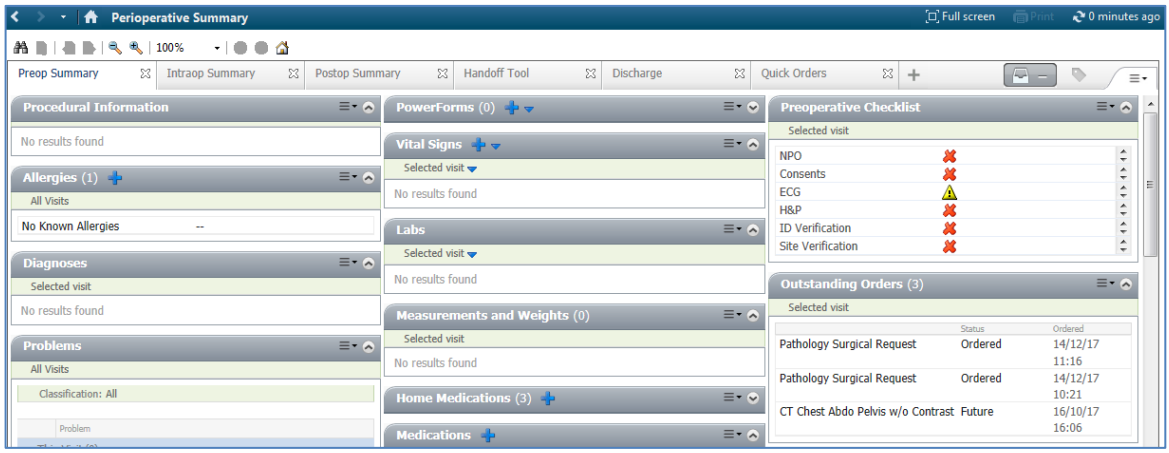


To open the patient's chart (review of Activity 1.1):

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:

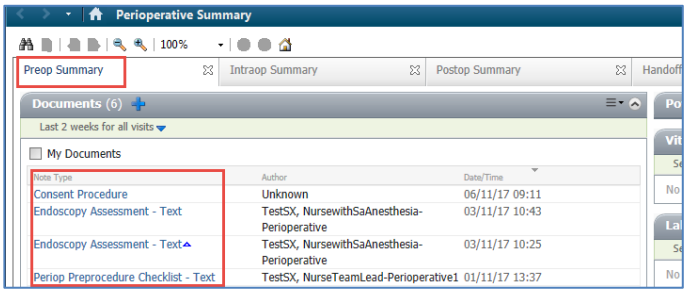


2

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

In Preop Summary Tab:

1. Under **Documents**, Select Endoscopy Assessment

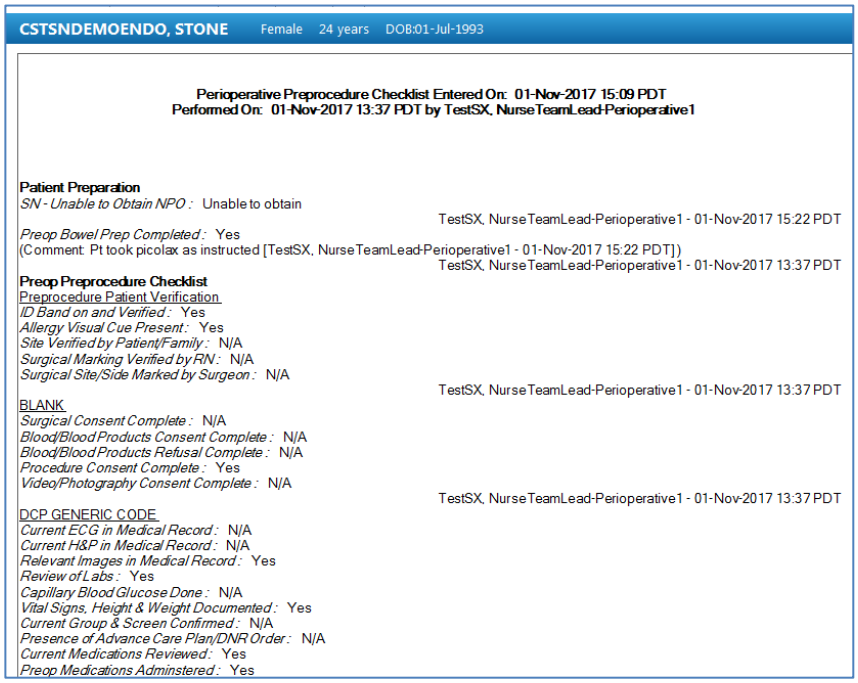


2. Review the summarized Endoscopy Assessment PowerForm

3. To close the window, Click

4. Under Documents, Select Periop Preprocedure Checklist

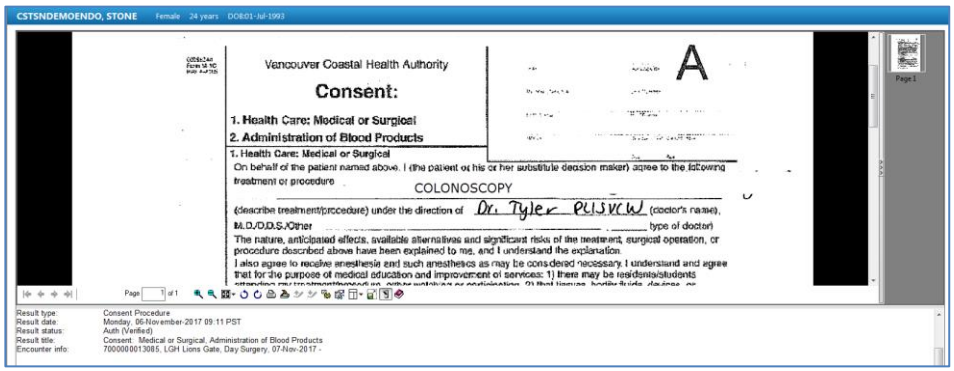
5. Review the summarized Periop Preprocedure Checklist



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



2. Review the procedure consent
3. To close the window, Click .

Key Learning Points

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

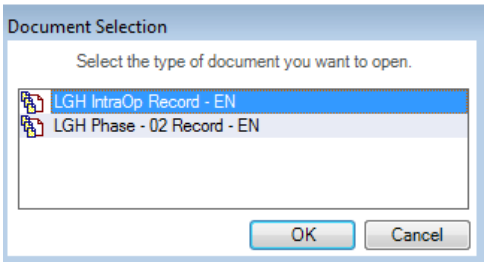
Activity 2.2 – Complete the Surgical Case Check-In to Access Perioperative Documentation

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

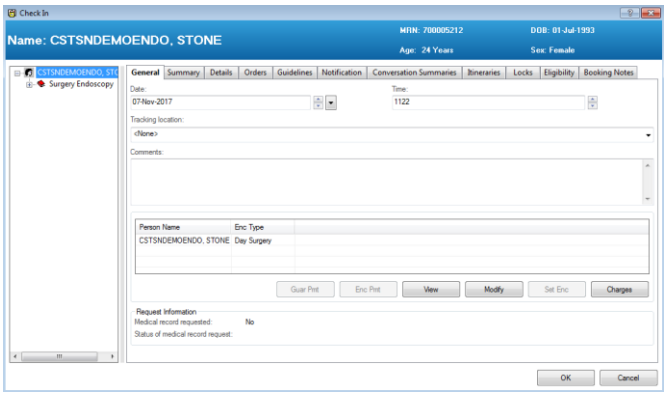
The first time you access Perioperative Doc, you must complete the **Surgical Case Check-In**. The Surgical Case Check-In is not equivalent to the patient check-in process completed in PreOp with the Preprocedure Checklist. The Surgical Case Check-in process is necessary to obtain access to Perioperative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



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

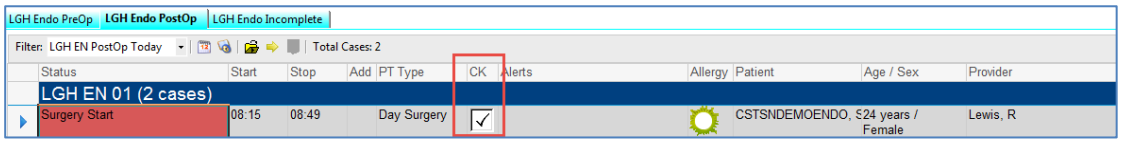


4. Verify the patient's information in the Check-In window, as necessary
   - Note: The Check-In window displays scheduling and encounter information pertaining to the patient. It is not necessary to review the information contained in the tabs at this point, however, you may choose to explore what is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



Key Learning Points

- 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

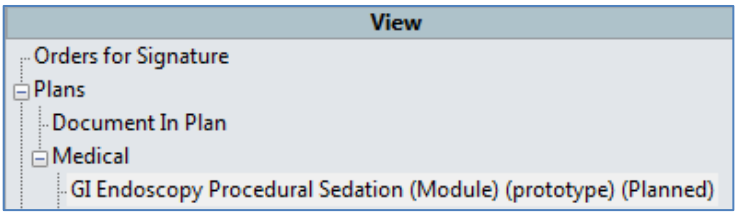
Activity 2.3 – Initiate GI Procedural Sedation Medication Orders

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)



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

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.

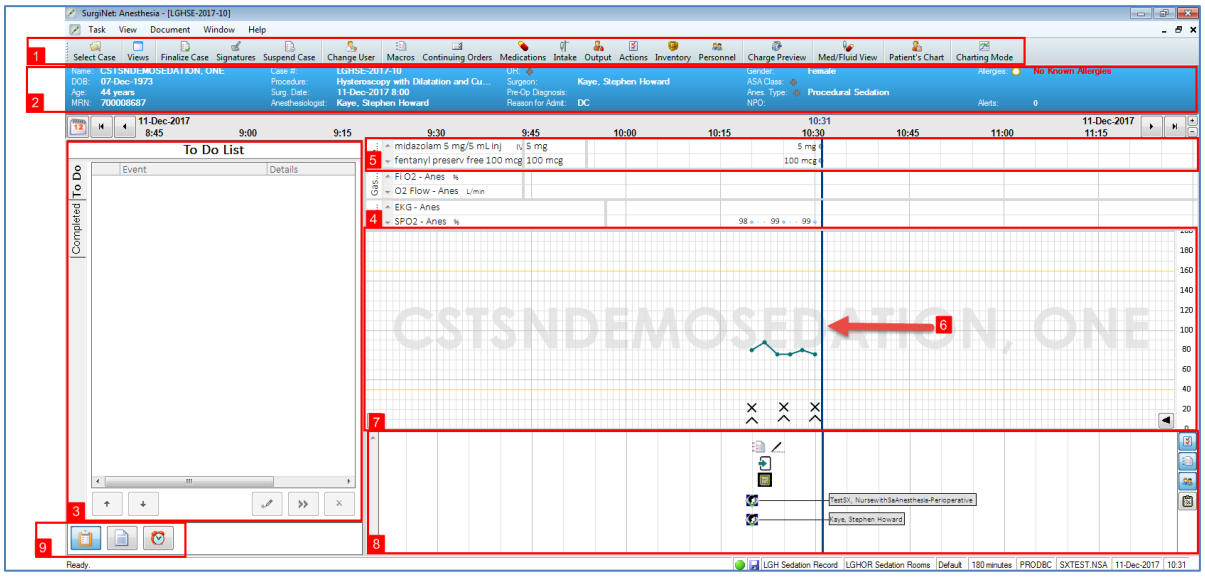
The patient's procedural sedation document you create using SA Anesthesia is called the 'Sedation Record'

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

2

Overview of the Sedation Record

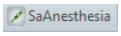


1. **Toolbar** – Each icon allows access to specific actions.
2. **Banner Bar** – Shows patient demographics like in Powerchart.

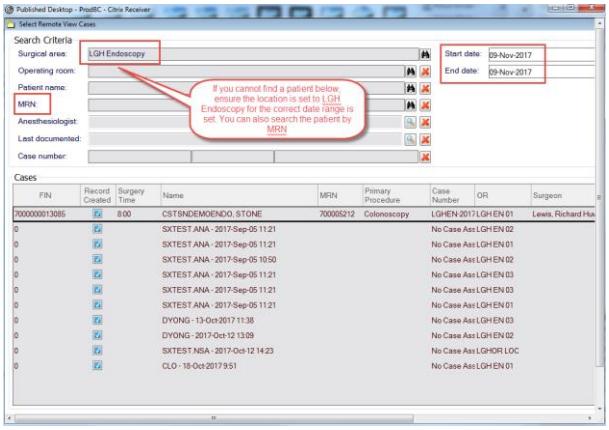
3. **Workflow Pane** – Contains the To-Do List (list of actions to complete during the case).
4. **Monitors** – Displays the vital signs and NAPCOMS documentation.
5. **Medication Pane** – Displays medication administration
6. **Current Time** - The Sedation Record is dynamic in that it will automatically 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.

3

To access SA Anesthesia from PowerChart and Create a Sedation Record:

1. Click the SA Anesthesia 

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.

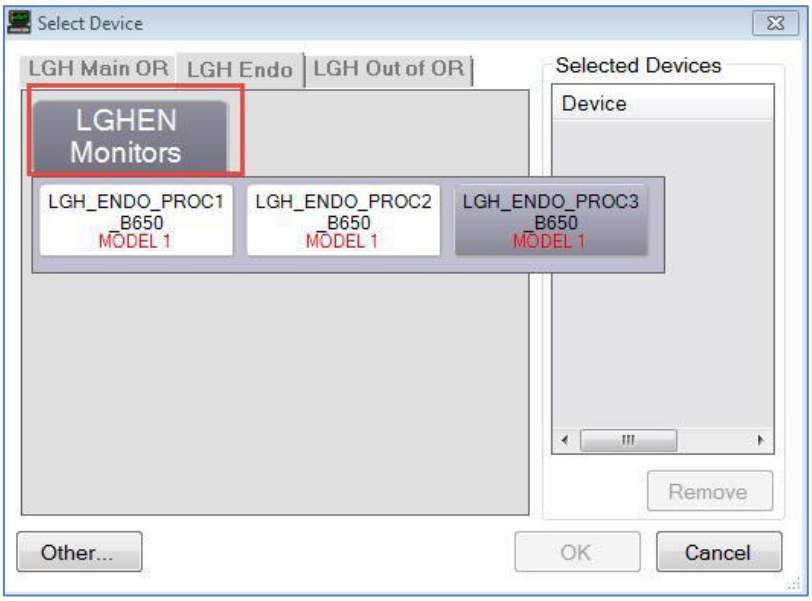
   - Select Device window opens

4 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

2. Click **LGH ENMonitors** icon



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

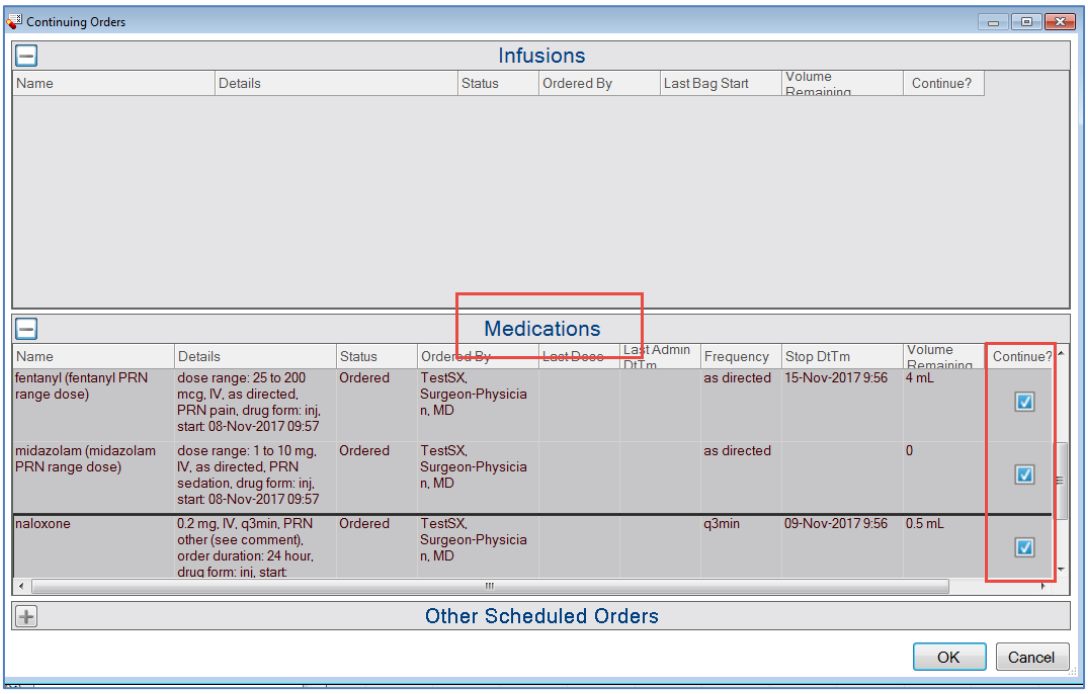
5. Start User window opens next

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.

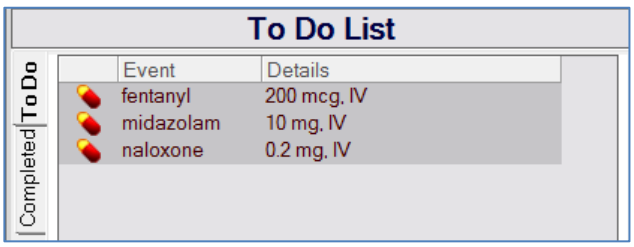
6. Click **Yes** to continue

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*



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

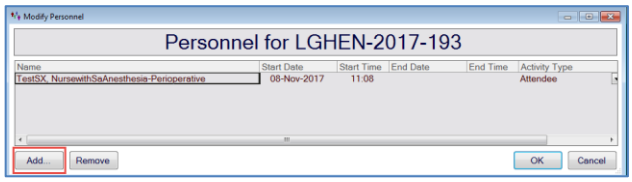


Note: All initiated medication orders will show up on the Continuing Orders window, you should only pull in the medications related to the intra-op phase.

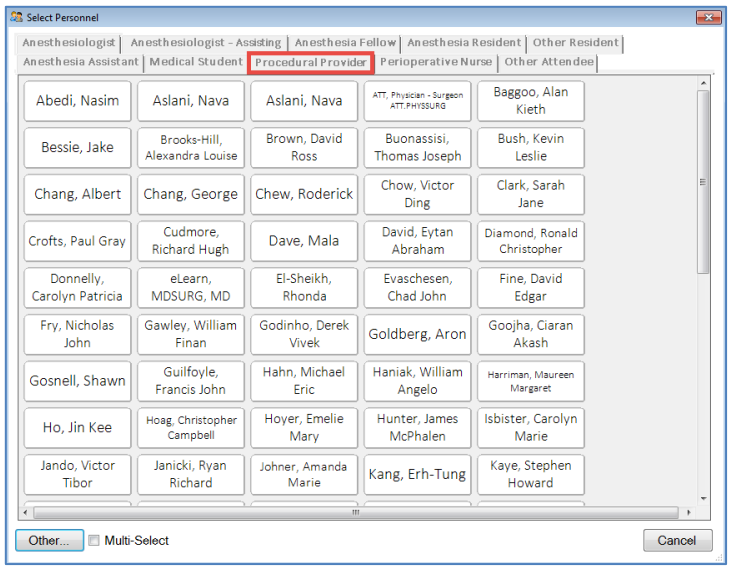
5 You will need to assign the GI Provider as a Supervisor in the Sedation Record. Upon finalization of the sedation record, any medications administered without an order entered will route for co-signature to the GI Provider.

1. From the Toolbar, Select the Personnel 

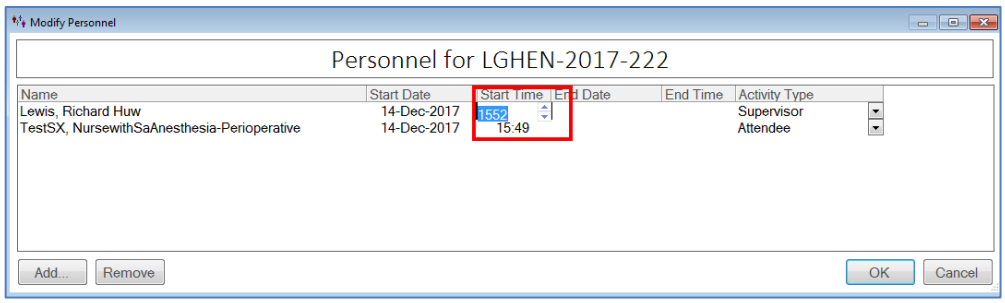
 icon
    - Modify Personnel window opens
2. Select Add



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

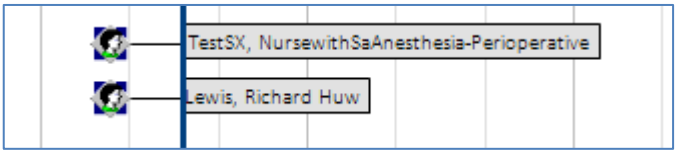


4. Select <GI Provider>
    - The provider selected will be added as a Supervisor to the list view in the Modify Personnel box with the current time
5. Double Click the GI Provider's Start Time



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.



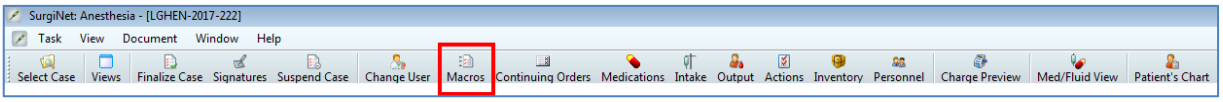
6

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:

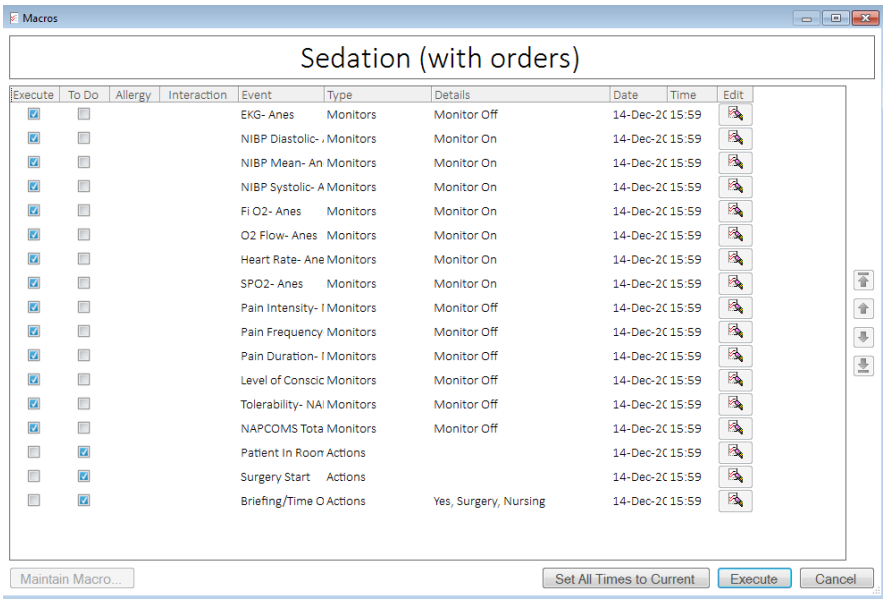
Endo Sedation (no orders): Select this if the provider has NOT placed Procedural Sedation Orders
Endo Sedation (with orders): Select this if the provider has placed Procedural Sedation Orders
No Sedation: Select this when there is no sedation for the procedure

To execute an Endo sedation macro:



1. Select the Macros 

icon from the Toolbar
2. Select **Endo Sedation (with orders)**
3. Review the contents in the Macros window, as necessary



4. Click **Execute**

Key Learning Points

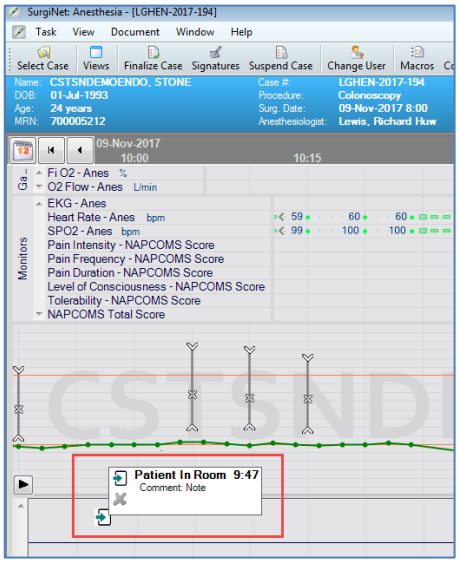
- The patient's procedural sedation documentation in SA Anesthesia is called the 'Sedation Record'
- SA Anesthesia is a different application than Powerchart with a different layout and functionalities
- Creating the Sedation Record involves:
  - Selecting the right patient to associate to the record
  - 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:

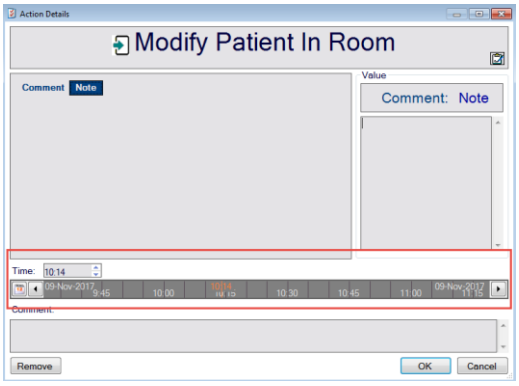
1. Double Click **Patient in Room** Patient In Room from the **To Do List**
   - The **Patient in Room** icon will populate the current time and appear in the Event pane.



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** icon
4. Enter **Time** = *current time less 10 minutes*



5. Click OK, the time will be adjusted

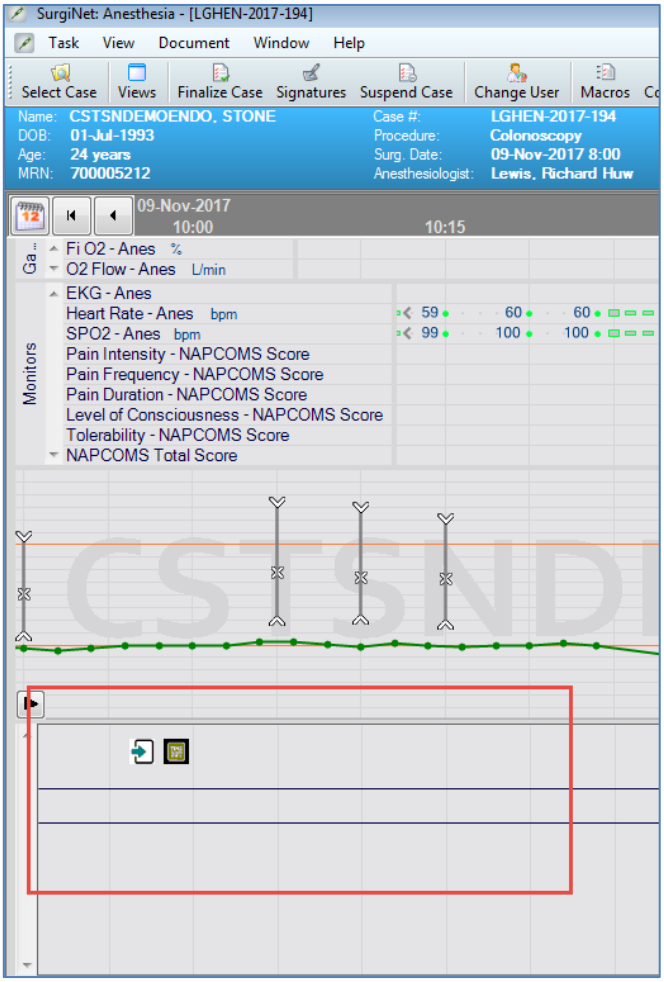
2

Document Briefing/Time Out:

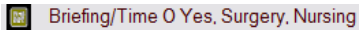
1. Double Click Briefing/Time O Yes, Surgery, Nursing from the **To Do List**

- The **Briefing/Time Out** icon will populate the current time and appear in the Event pane

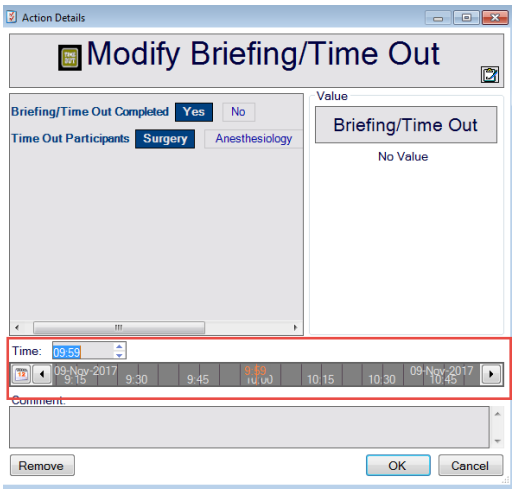
2. To verify time documented, Hover over the **Briefing/Time Out** icon in the Event pane to view details



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

6. Double Click the Briefing/Time Out  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:

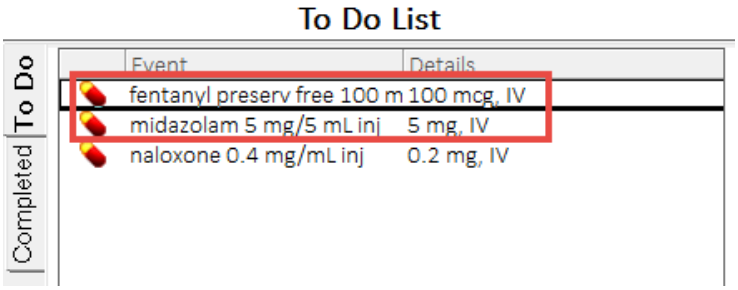
1. Double Click the **Surgery Start** Surgery Start icon from the **To Do List**
2. The **Surgery Start** icon will populate the current time and appear in the Event pane

Key Learning Points

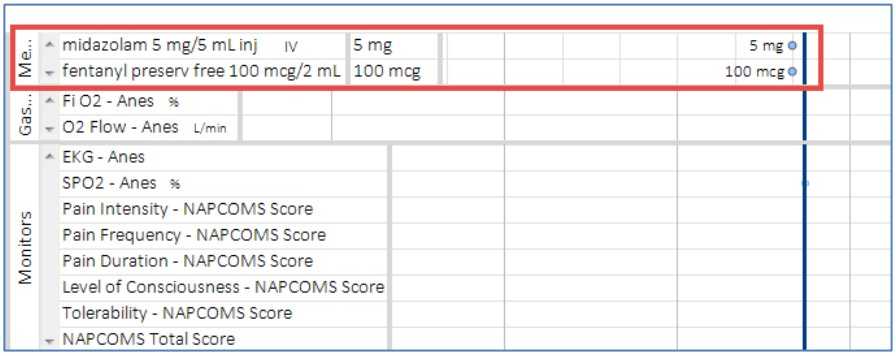
- Document the following times from the To Do List in the Sedation Record
  - Patient in Room Time
  - Briefing/Time Out
  - Surgery Start Time from the To Do List
- Any time-related actions will document to the Event Pane in the Sedation Record.

Activity 2.6 – Document Medication Administration in the Sedation Record

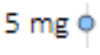
1 To document medications:



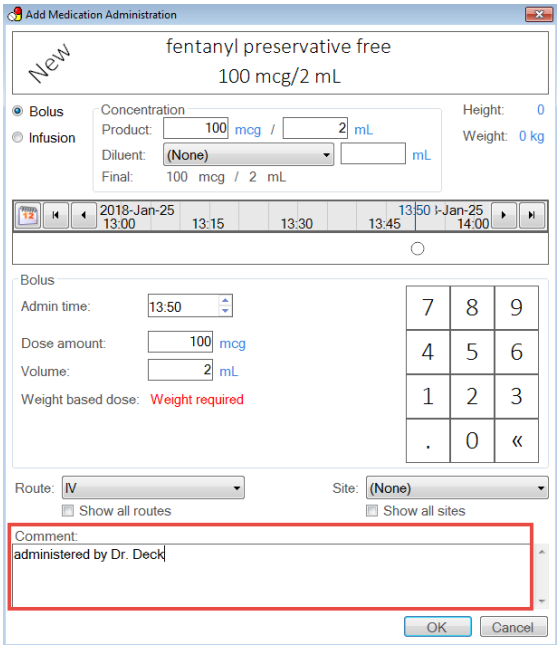
1. Double Click **midazolam** from the To Do List
2. Double Click **fentanyl**
   - Once you Double Click the medication, they will disappear from the To Do List and appear in the Completed tab. Each medication dose will be populated to the current time in the Medications pane



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 

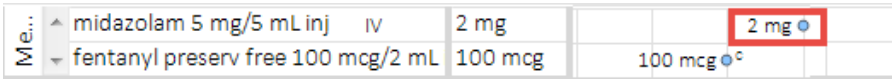
   - Modify Medication Administration window opens
4. Modify the **Dose amount** = *2 mg*
5. Enter **Comment** = *administered by GI Provider* in the comment box



6. Click **OK**
7. Repeat the same steps for the fentanyl dose 100 mcg

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

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

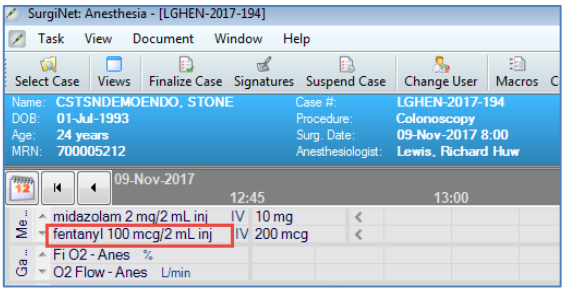
3

If the GI Provider asked you to administer another 100 mcg of fentanyl during the procedure.

To document an additional (new) dose of fentanyl.

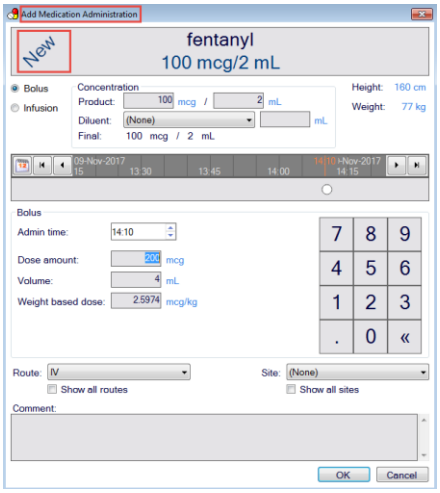
In the Medication pane:

1. Click fentanyl 100 mcg/2mL inj



- The Add Medication Administration window opens

2. Enter **Dose Amount** = *100 mcg*



- 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

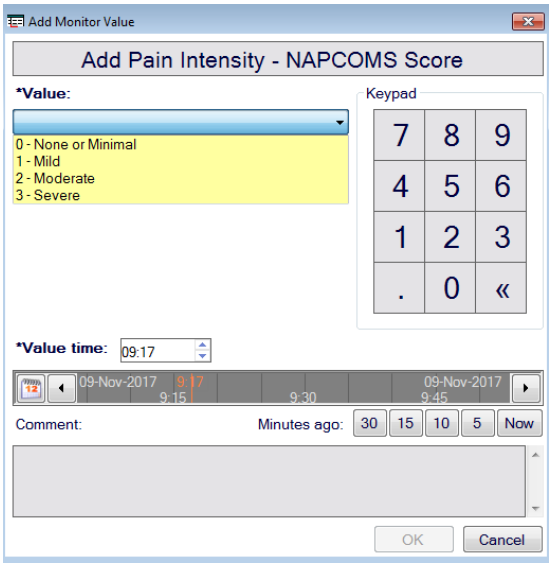
- Any medication-related actions will appear in the Medications pane
- Double click medications from the To Do List to document their administration.
- Medication documentation may be modified in the Modify Medication Administration window.
- When documenting an additional dose of medication, ensure ‘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

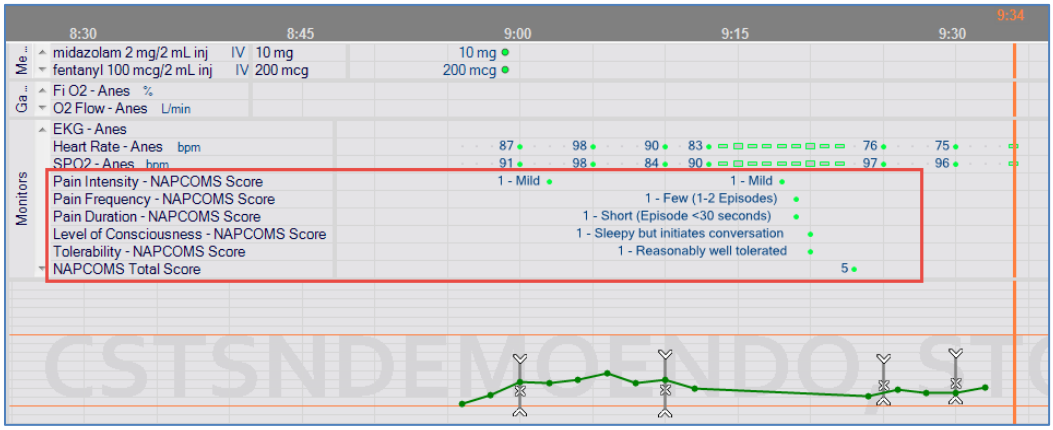


2. Select **Value** = *1- Mild*
3. Click OK
4. Select **Pain Frequency– NAPCOMS Score**
5. Select **Value** = *1-Few (1-2 Episodes)*
6. Click **OK**
7. Select **Pain Duration– NAPCOMS Score**
8. Select **Value** = 1-Short (Episode<30s)
9. Click **OK**
10. Select **Level of Consciousness – NAPCOMS Score**

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

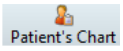
- The NAPCOMS patient comfort score does not automatically calculate and must be calculated and inputted manually.

Activity 2.8 – Complete Perioperative Documentation

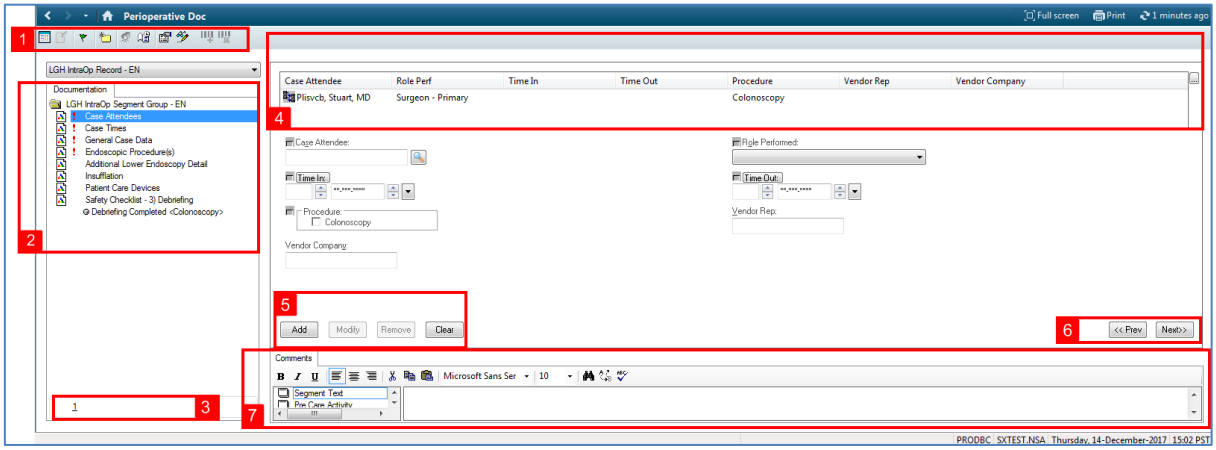
1

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  icon

Overview of Perioperative Doc



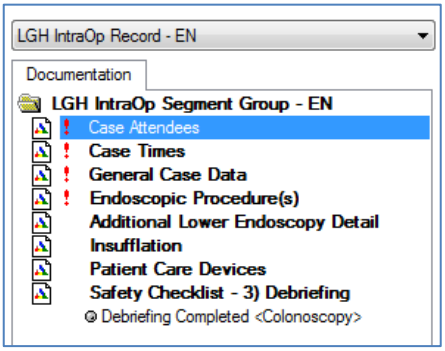
1. **Icon Bar** – Icons for quick access of certain Perioperative Doc functions.
2. **Documentation** – Contains a list of segments for documentation. Segments are listed alphabetically.
3. **Pages** – The number of pages within the current segment.
4. **Multi-Entry Box** – enables multiple entries of 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 
    - To remove an entry from the **Multi-Entry Box** Click 
    - 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.

6. **<<Prev and Next >> Buttons** – to navigate to the next segment or the next page of a multi-page segment.
7. **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.

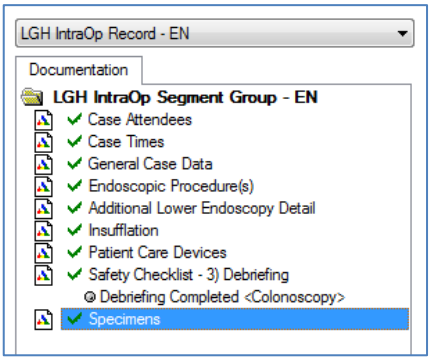
2

Perioperative Doc Segments Explained



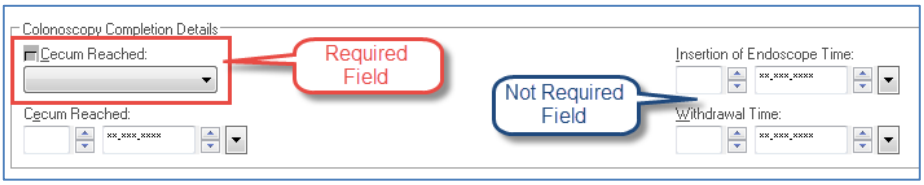
Perioperative Doc segments are grouped to resemble different sections of an intra-procedure record. The exclamation marks ! next to the first 4 segments are mandatory segments that must be completed in order to finalize.

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 ☑ 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.



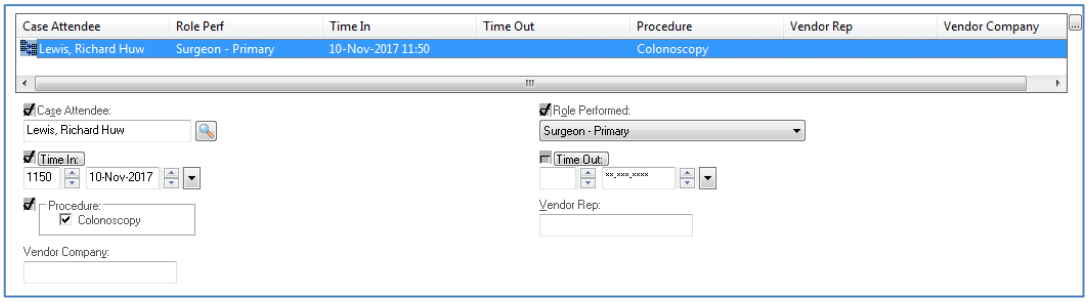
Note: You may navigate each Perioperative Doc segment by selecting each segment from the Documentation pane; however, you can also choose to Click the Next Next>> button within the segment. The sequence of the segments is predetermined based on a specific endoscopy workflow. If the sequence does not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

3 Documenting Case Attendees

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.

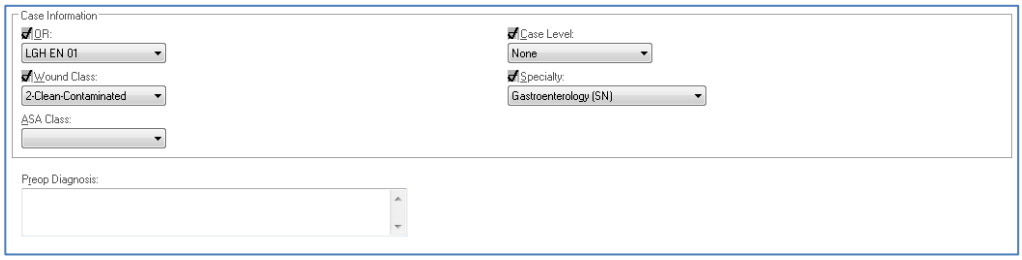
    Note: You do not need to add yourself as a Case Attendee.



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

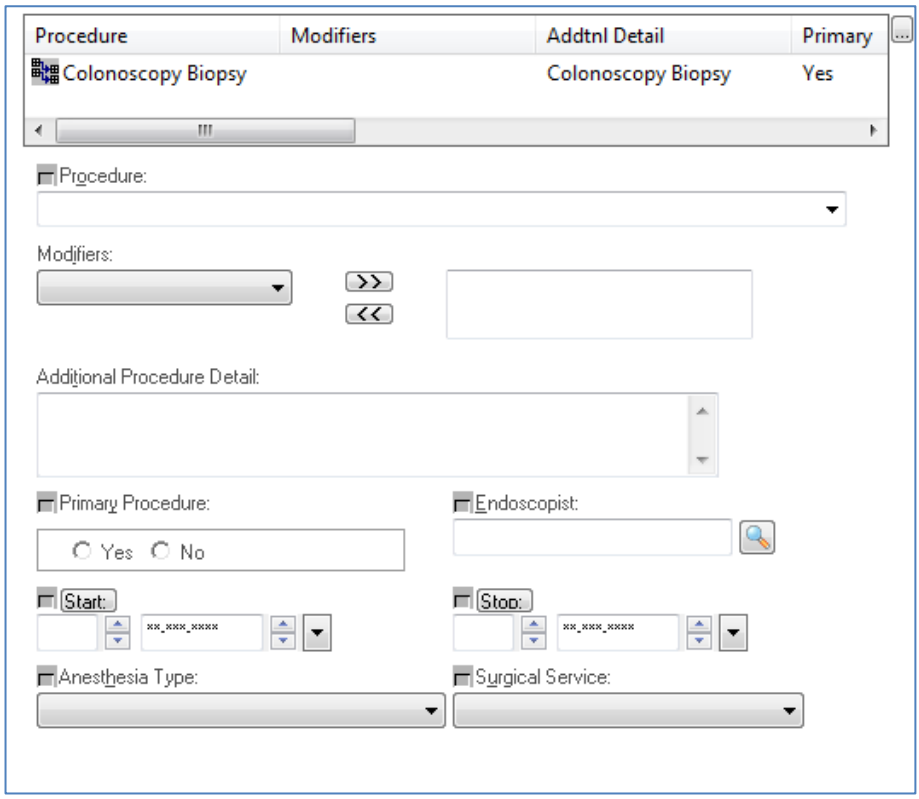
4 Document General Case Data



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 Document Endoscopic Procedures



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

6 Document Patient Care Devices

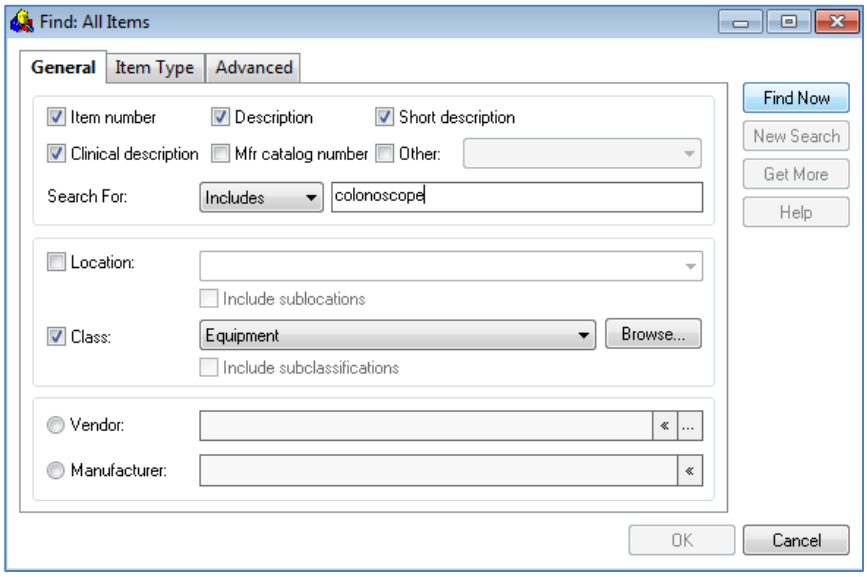
This segment is where scope ID numbers are documented

- Equipment is a required field.

1. Select ··· to open the master inventory

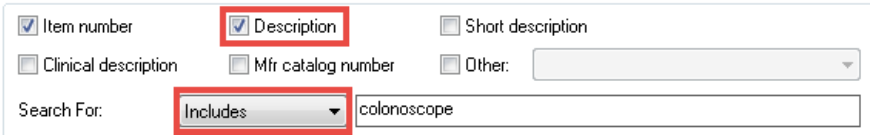
To search for the scope in use in the **Find: All Items** window:

2. Enter Equipment = *colonoscope*

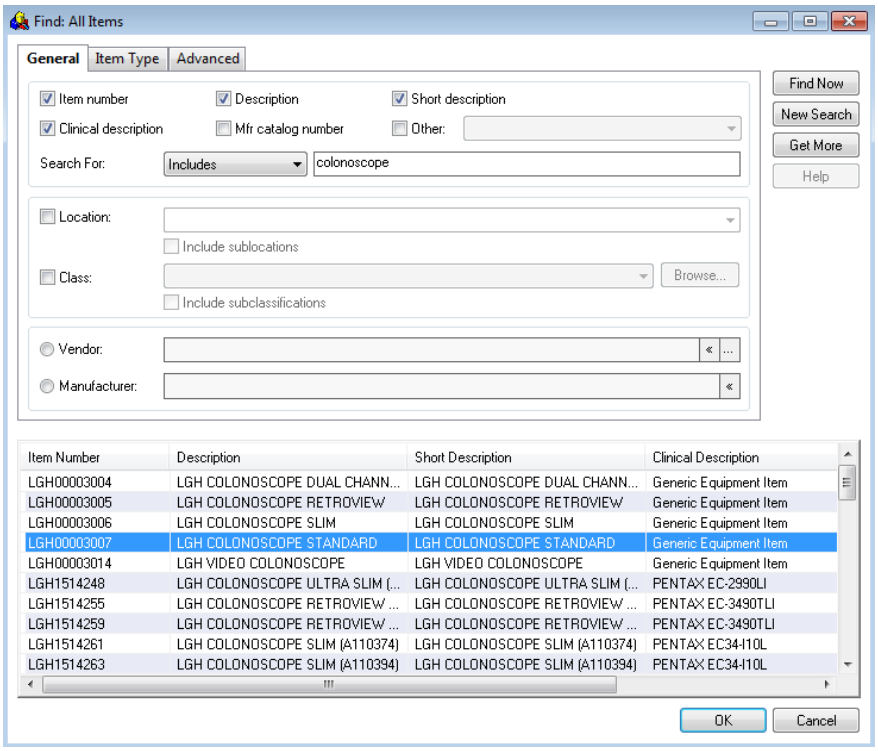


3. Click Find Now

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



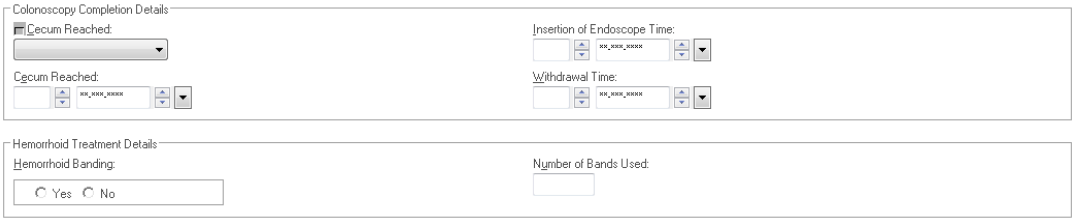
4. Select **LGH COLONOSCOPE STANDARD** from the list



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

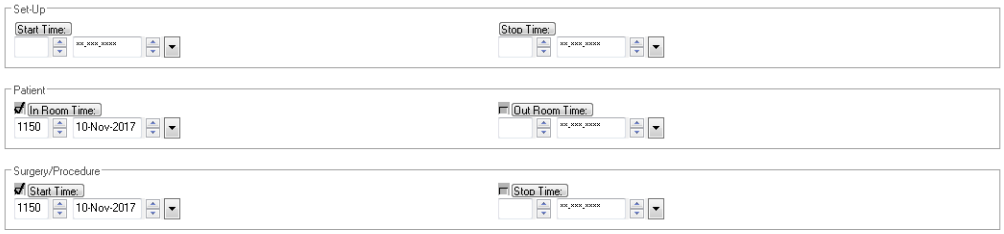
This segment is where cecal intubation times and hemorrhoid treatment details are documented:



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

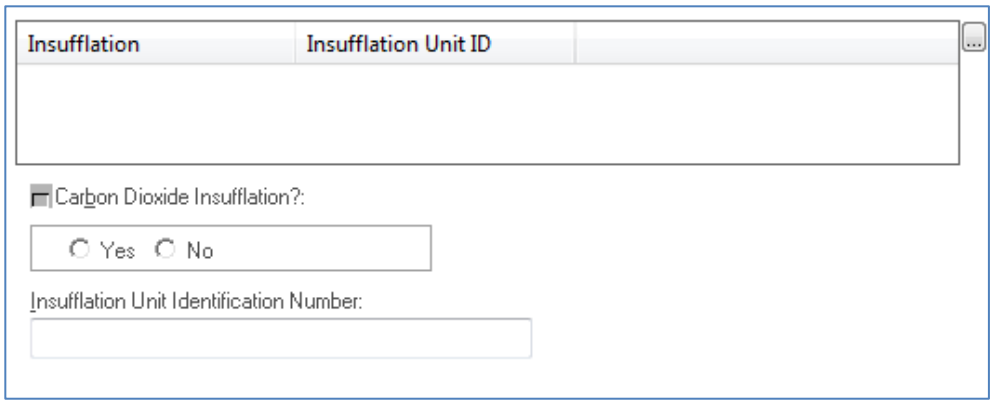
8 Document Case Times



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.

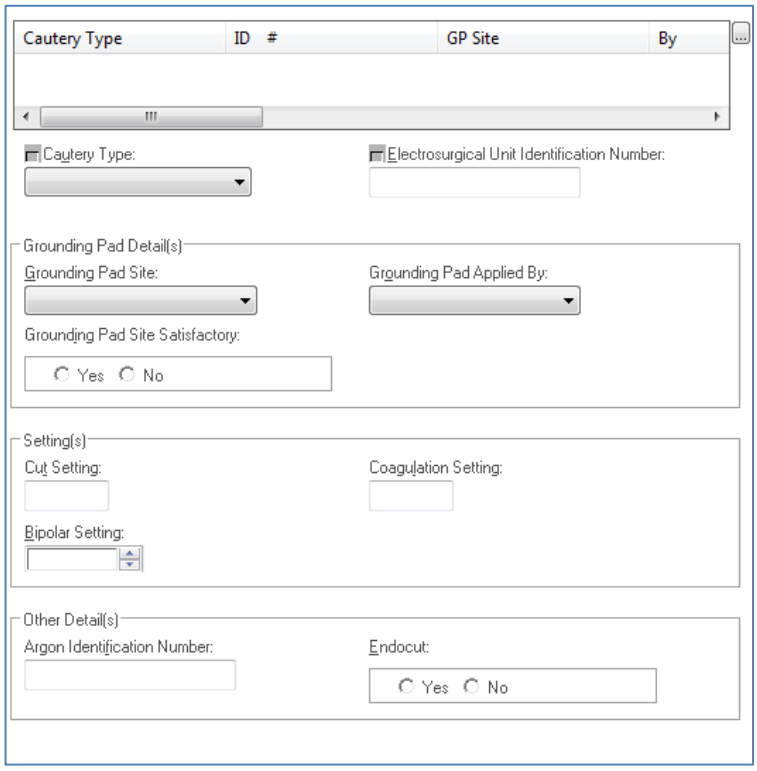
1. Click **Next** to move to next segment

9 Document Insufflation



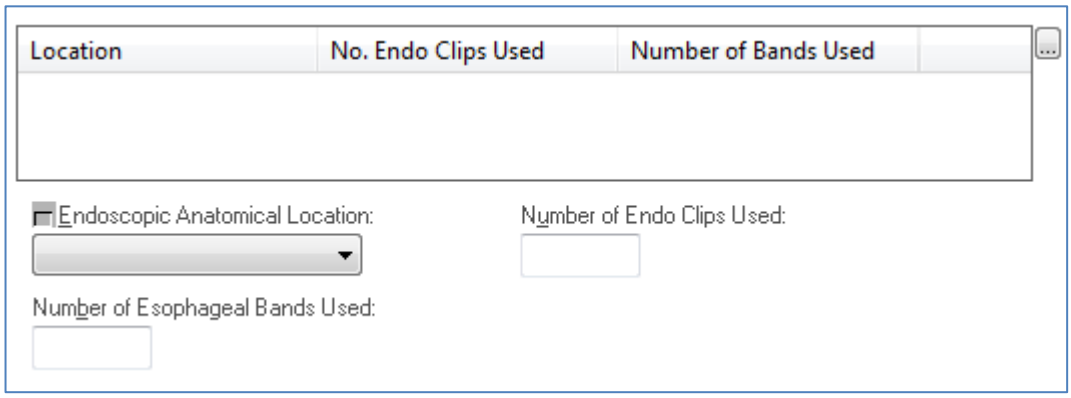
1. Enter the following:
   - **Carbon Dioxide Insufflation** = *Yes*
   - **Insufflation Unit Identification Number** = Type 12345
2. Click **Add**
3. Click **Next** to move to next segment

10 Document Cautery/Argon Plasma Coagulator



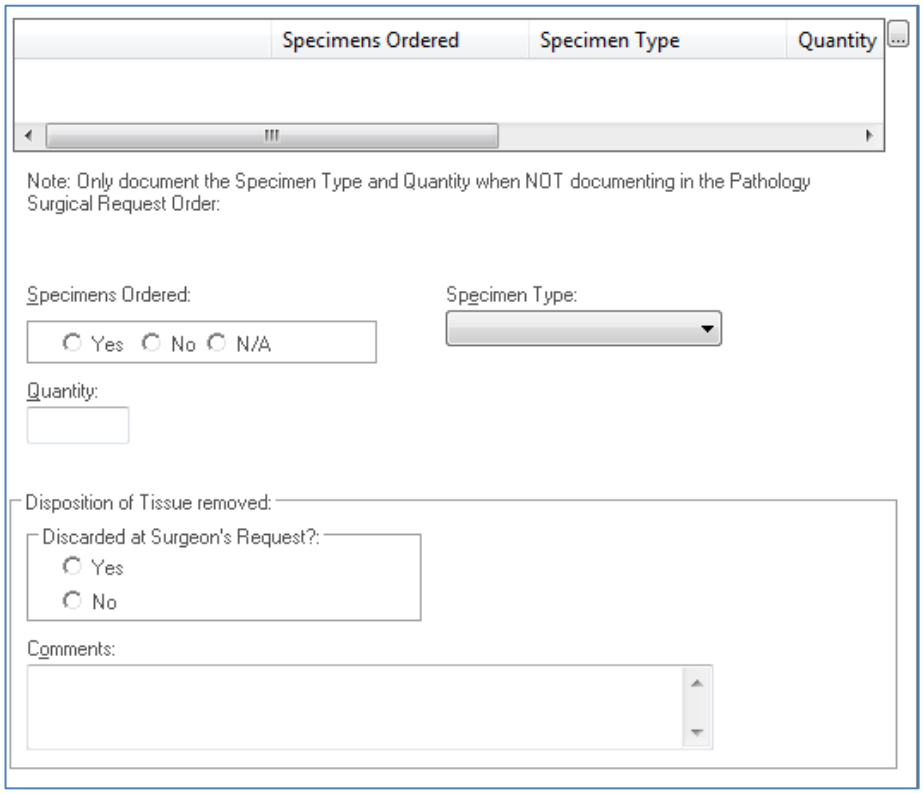
1. Enter the following:
    - **Cautery Type** = *Monopolar*
    - **Electrosurgical Unit Identification Number** = *<Type 1234567>*
    - **Grounding Pad Site** = *Leg – Upper, left*
    - **Grounding Pad Applied By** = *Select GI Provider*
2. Click **Add**
3. Click **Next** to move to next segment

11 Complete Hemostasis



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

12 Document Specimens

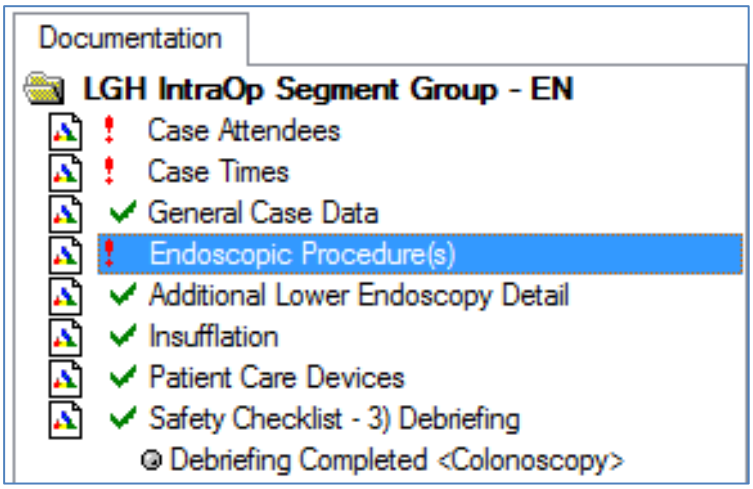


1. Enter the following:
    - **Specimen Type** = *Pathology from the drop down*
    - **Quantity =** <*Type 1*>
2. Click **Add**
    - Data entered will appear in the **Multi-Entry Box**
3. Click **Next** to move to next segment

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.



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 !

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

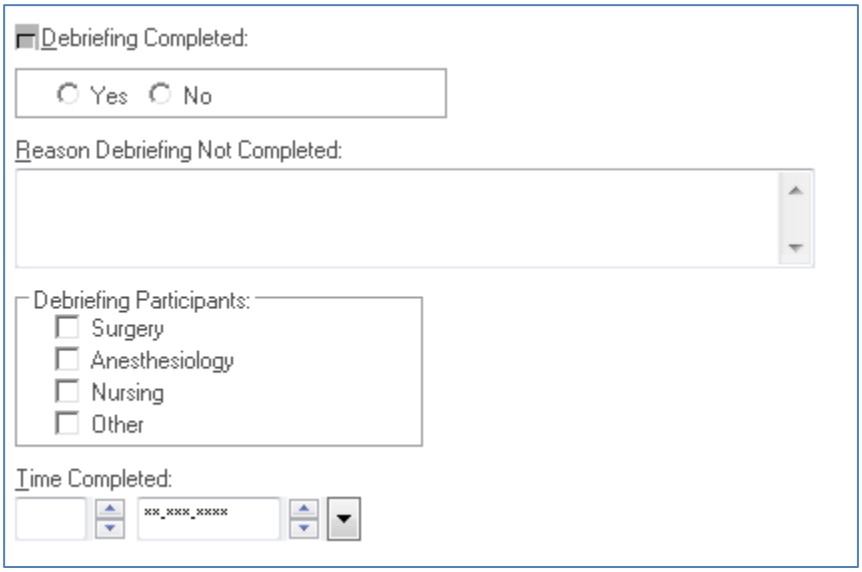
In Case Attendees:

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.



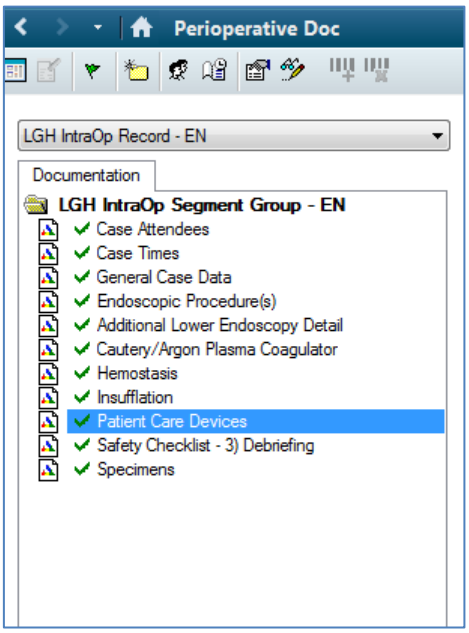
1. Enter the following:

   Debriefing Completed= *Yes*

   Time Completed = *Enter current time*

2. 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.

Key Learning Points

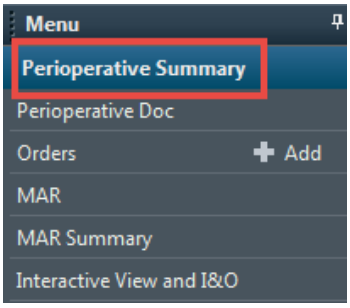
- In practice, you will still have SA Anesthesia open on one computer screen as you monitor the patient's vitals, comfort score, and administer additional meds (if necessary). At the same time, on another computer screen you will be completing the procedure charting in Perioperative Doc.
- In Perioperative 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

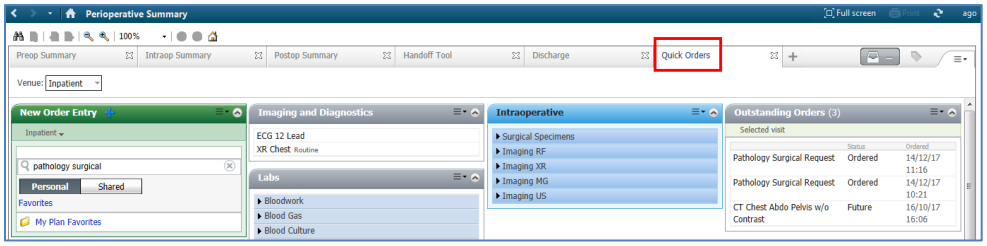
1 Pathology specimens are treated like an Order in Powerchart. As an endoscopy intra-op nurse, if a specimen was removed to be sent for pathology, you will be placing an Order so that it cues the lab to expect a specimen to arrive for this particular patient. The pathology surgical request is considered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

To place a Pathology Surgical Request:

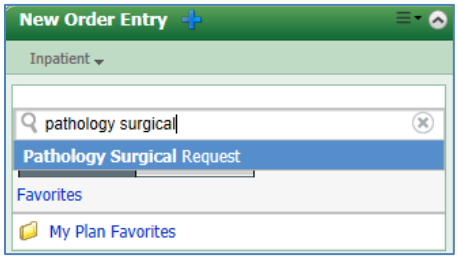
1. Select **Perioperative Summary** from the Menu



2. Select **Quick Orders** tab



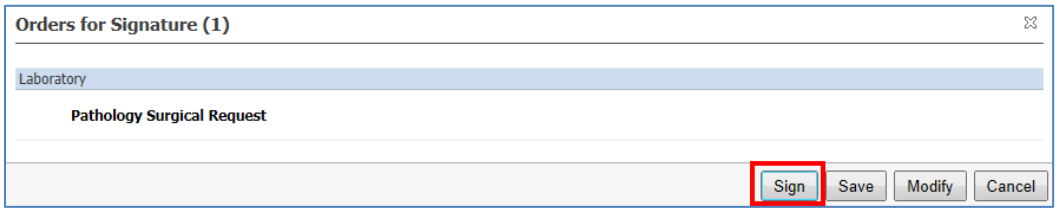
3. Enter = *Pathology Surgical* in the Search box



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

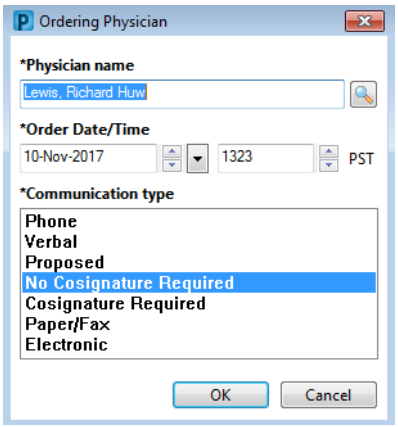
5. Click Orders for Signature icon 

6. Click **Sign**



- Ordering Physician window opens

7. Enter *<GI Provider>*
8. Select **Communication Type** = *No Cosignature Required*



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

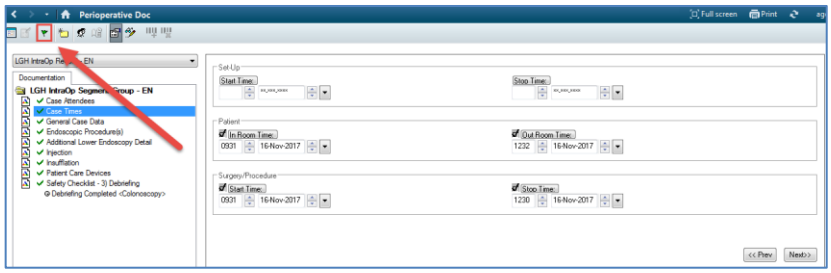
- A Pathology Surgical Request must be placed to notify the lab to expect a specimen to arrive.
- Once completed, a paper form will automatically print to be completed and signed by the GI Provider
- The completed/signed copy of the Pathology Specimens Request will accompany the specimen to the lab

Activity 2.10 – Finalizing Perioperative Doc and the Sedation Record

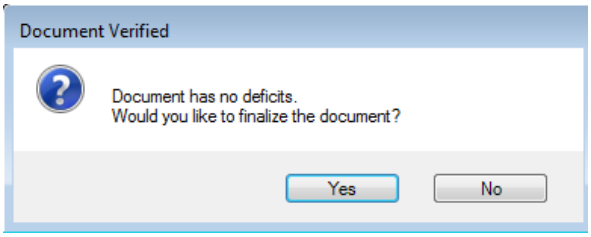
Application: Perioperative Doc (Powerchart) & SA Anesthesia (Sedation Record)

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

1. Click green flag icon



- Document Verified window opens



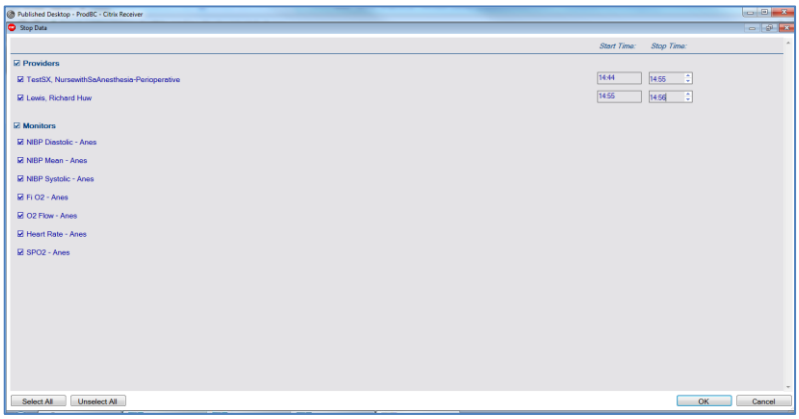
2. Click **Yes** to complete

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.

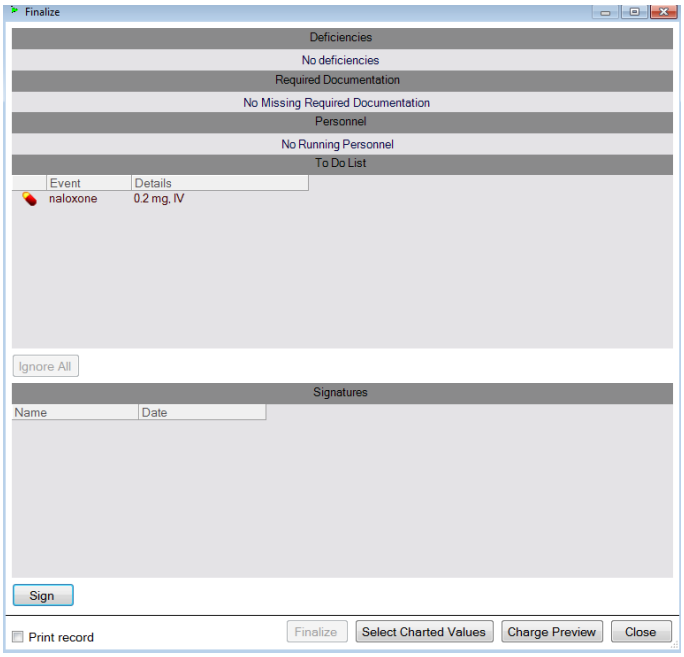
3 Finalize the Sedation Record

To finalize the Sedation Record, navigate back to **SAAnesthesia**:

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



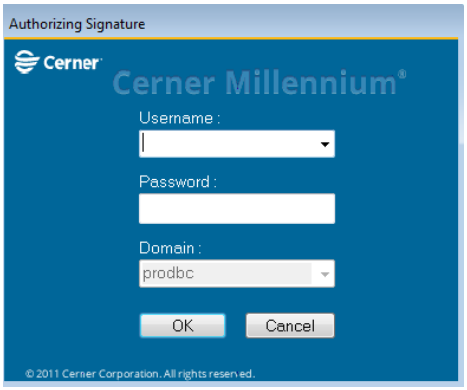
2. Click OK to verify you are stopping all documentation
    - Finalize window opens
3. Click **Ignore All** (under To Do List) to ignore the administration of naloxone



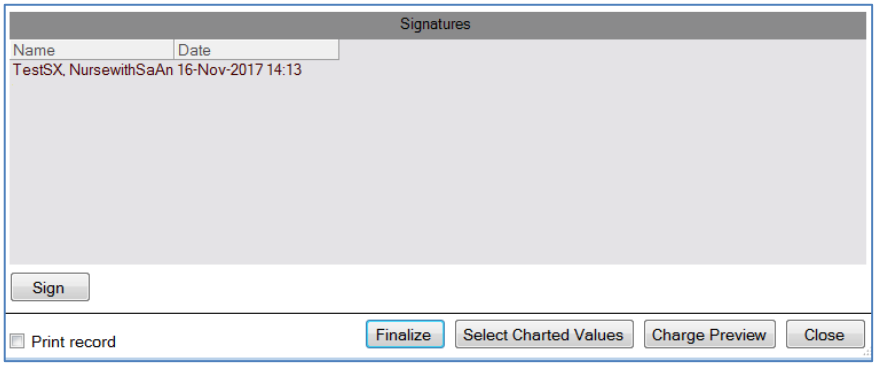
Note: SA Anesthesia will not finalize the Sedation Record until all items on the To Do List are completed. Nalaxone was populated the To Do List as a precaution.

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



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.
- BMDI 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):

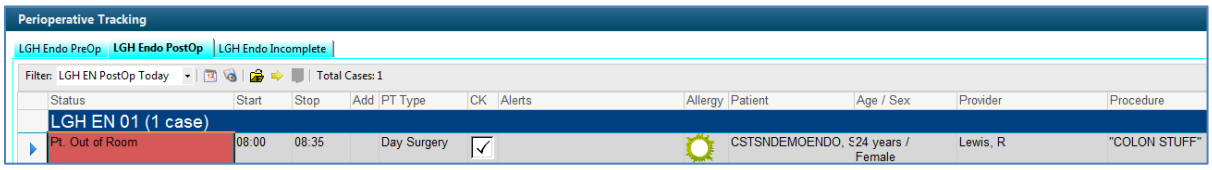
- Access Patient's Chart from Perioperative Tracking (Review)
- Review MAR for IntraOp Medications Administered (Review)
- Complete PostOp Perioperative Documentation
- Discontinue PreOp Orders & Initiating the PostOp Orders
- BMDI Association & Vitals Documentation in IView
- IView Documentation in 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.

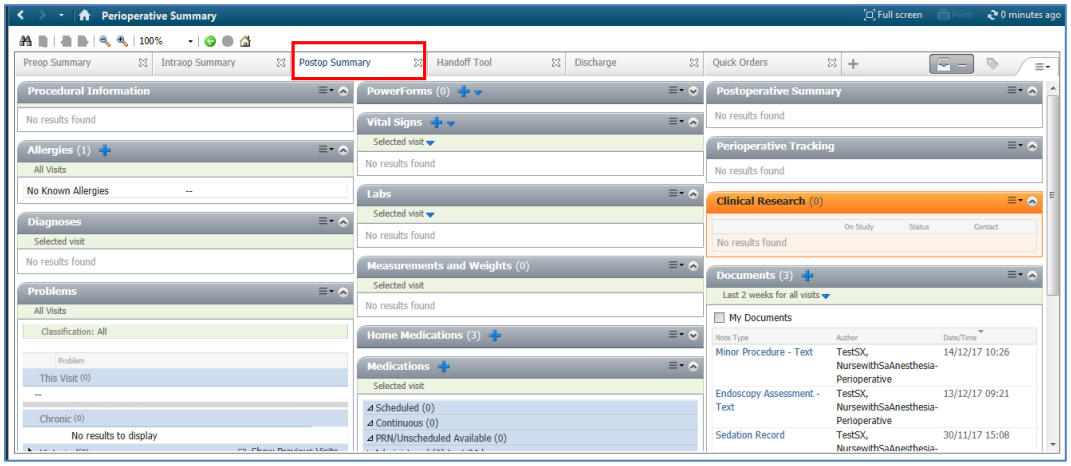
The patient's Status is already changed based on the Pt. Out of Room time in Perioperative Tracking.

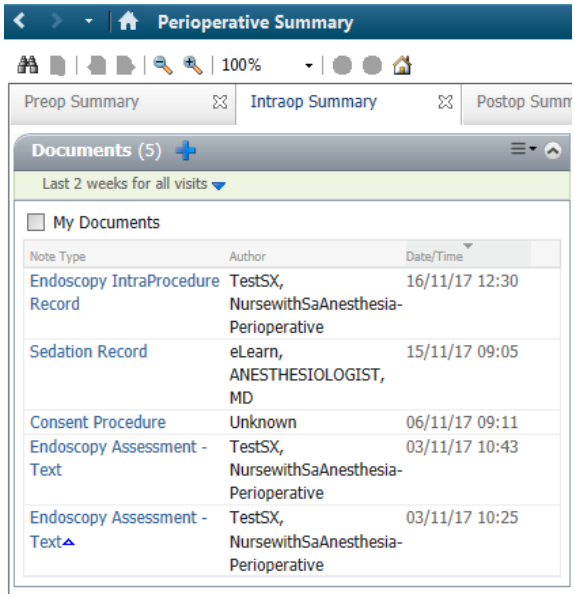


To open the patient's chart (skip this step if your chart is already open):

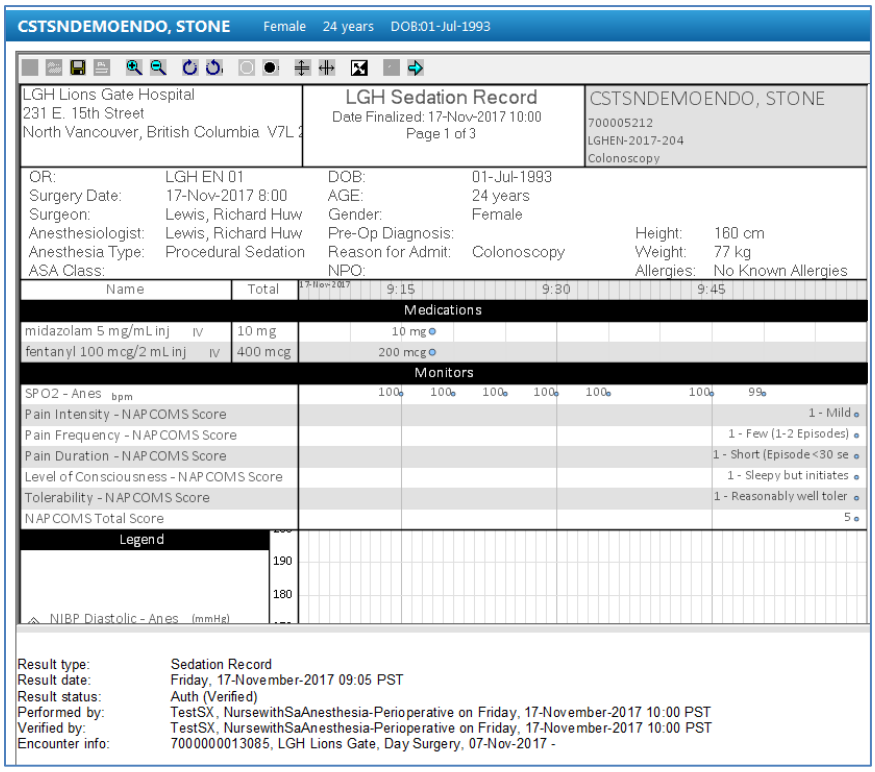
1. Double Click the blue arrow next to the patient's name
2. If this is your first time opening this patient's chart or a certain time limit has been exceeded, the Assign a Relationship window will display
3. Select **Nurse**

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





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



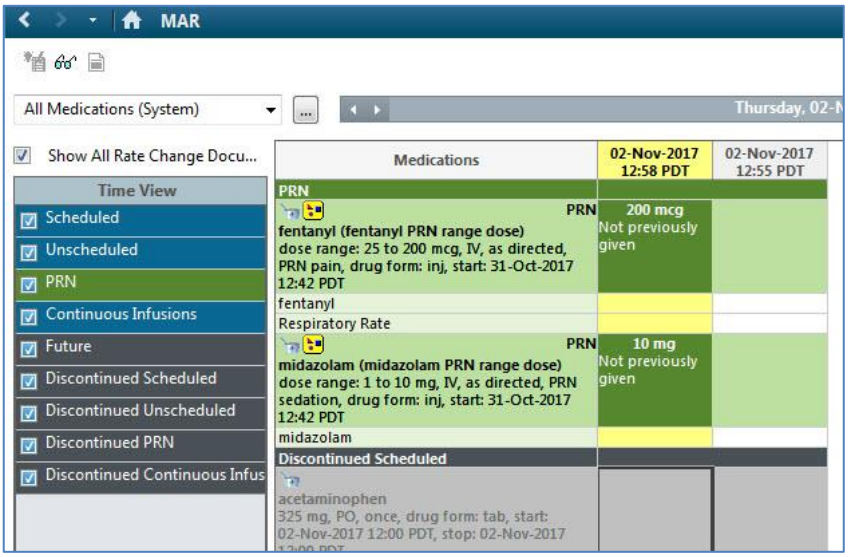
Key Learning Points

- 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

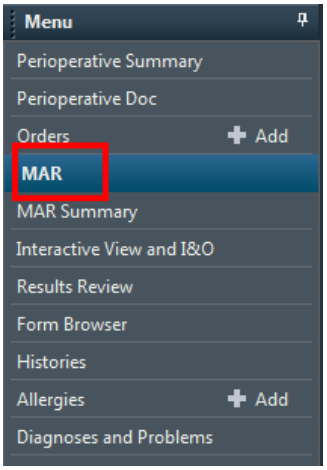
The Medication Administration Record (MAR) is a record of medications administered to the patient by clinician. The MAR displays medication orders, tasks, and documented administrations for the selected time frame.



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).

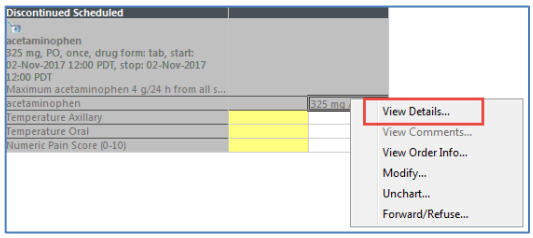
To review the patient's MAR:

From Menu:

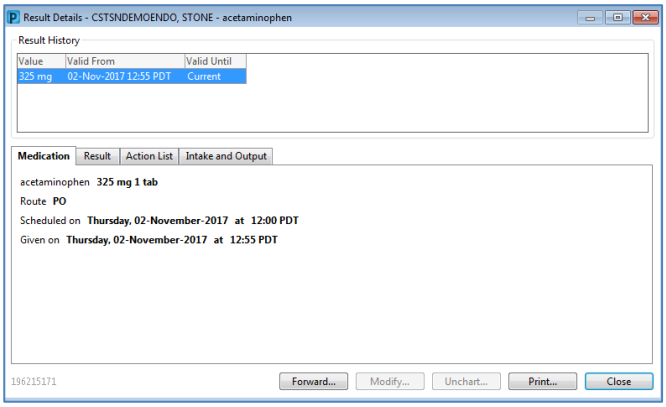


1. Select **MAR**
2. Verify the medications flowed through from SA Anesthesia

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



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



5. Click **Close** to complete

Key Learning Points

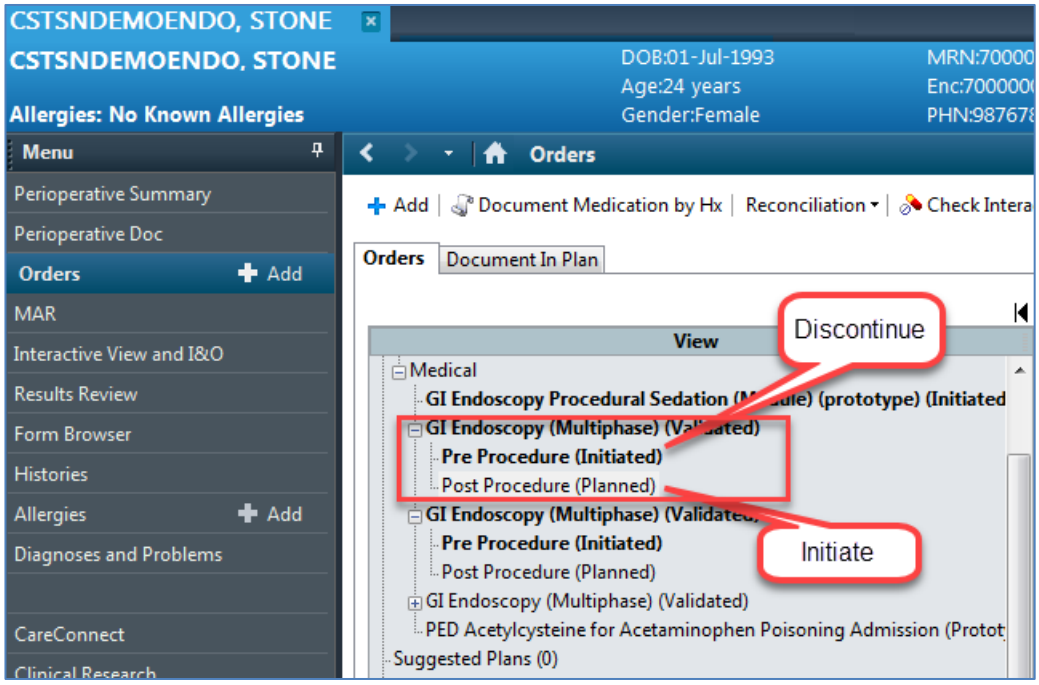
- Medications administered during the procedure were charted by the intra-op nurse on the Sedation Record, these medications will automatically be charted in the patients MAR (Medication Administration Record) in Powerchart.
- As a post-op nurse, you will verify that the medications given intra-op flowed 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

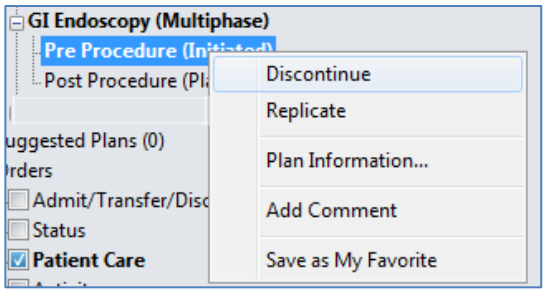
Recall that the GI Endoscopy Pre Procedure orders were initiated by the pre-op nurse, now as the post-op nurse you will need to discontinue the Pre Procedure phase orders so you can initiate the post procedure orders.

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.

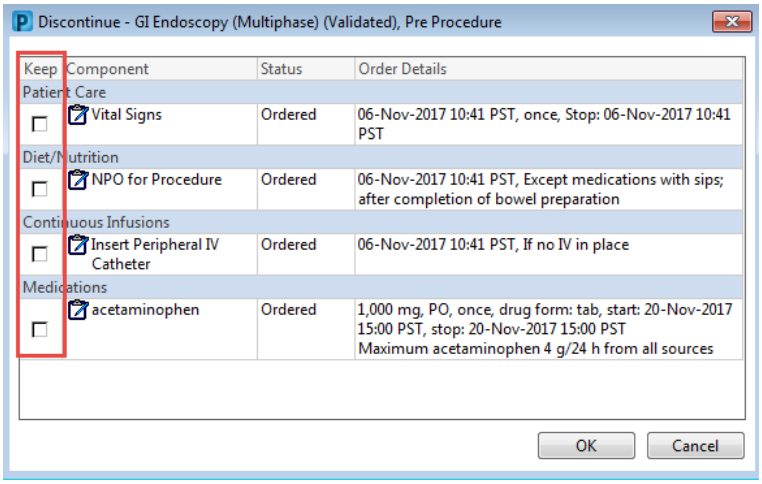


To discontinue the Pre Procedure phase orders:

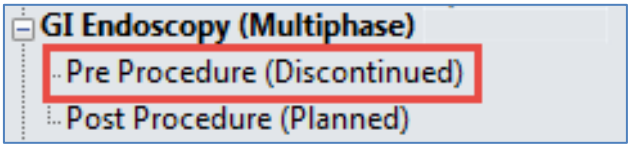
1. Click **Order** from the Menu
2. Under GI Endoscopy (Multiphase), Right Click **Pre Procedure (Initiated)**
3. Select **Discontinue**



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.

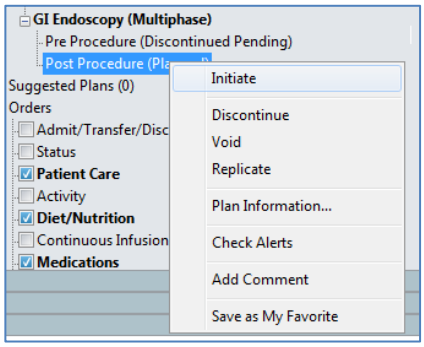


4. Click **OK**
    - Ordering Physician window opens
5. Enter **Physician Name** = <GI Provider> and Communication Type = *No Cosignature Required*
    - The Pre Procedure order will appear in the View Pane as 'Discontinued Pending' Pre Procedure (Discontinued Pending) until you sign
6. Click **Orders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



- The Post Procedure order will appear in the View pane as 'Initiated Pending' Post Procedure (Initiated Pending) 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.

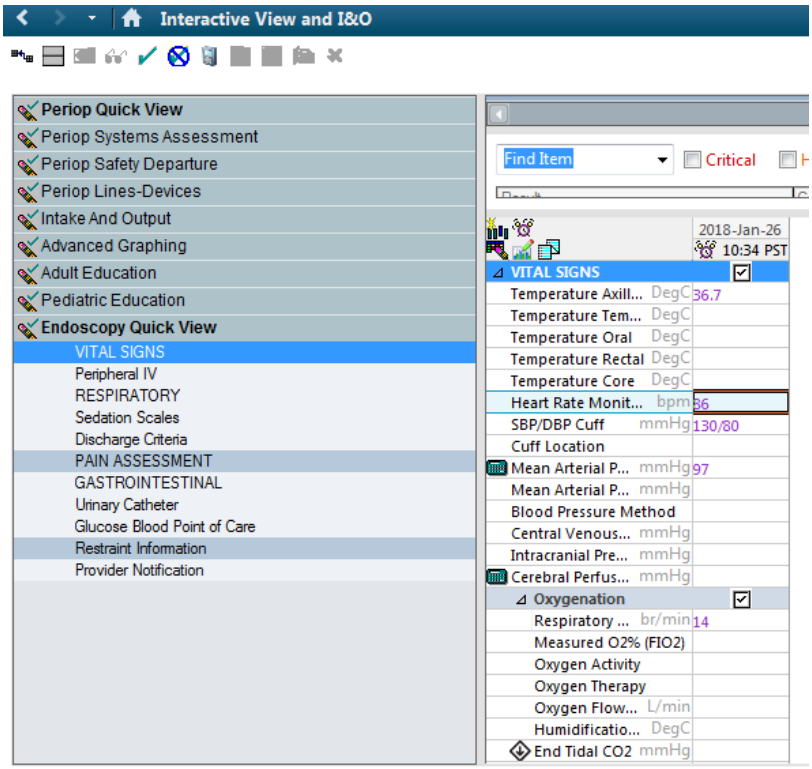
Key Learning Points

- 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.

Activity 3.4 – BMDI Association & Vital Signs Documentation in IView

1

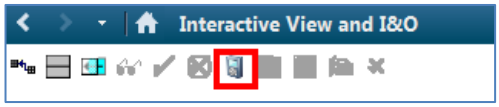
Just like in the procedure room, the patient's vitals can be tracked via BMDI in endoscopy post-op. As you recall, BMDI enabled the intra-op nurse to document the patient's vital signs automatically in SA Anesthesia. In post-op, you will also be using BMDI but through Powerchart in Interactive View (IView).



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.

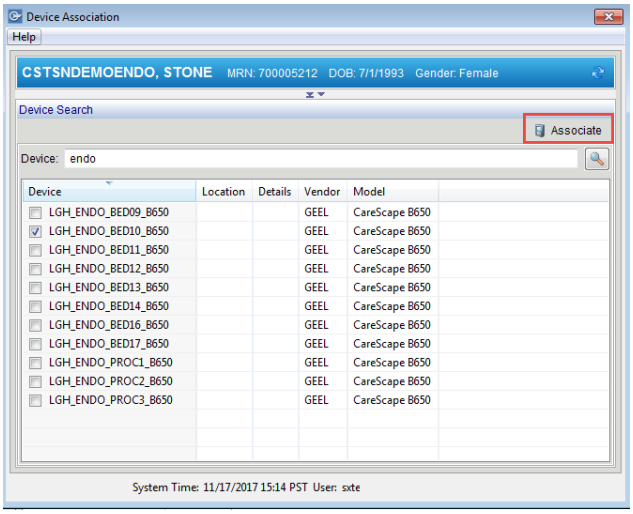
The first step to start BMDI is you must associate your patient to the right device.

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



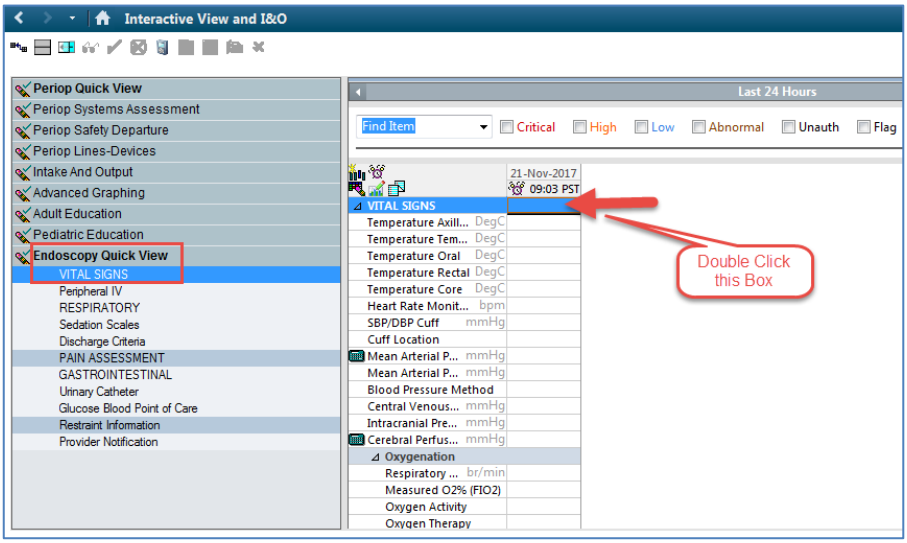
   - The Device Association window opens
3. Enter = <*endo*> in the Device search box

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

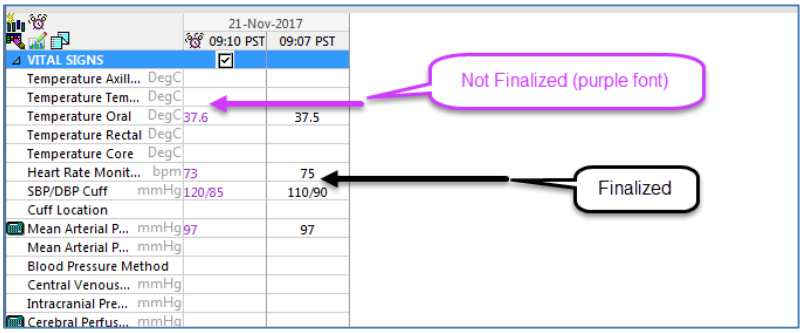


6. Click **Associate**
7. Click **X** to close the Device Association window.

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



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



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.

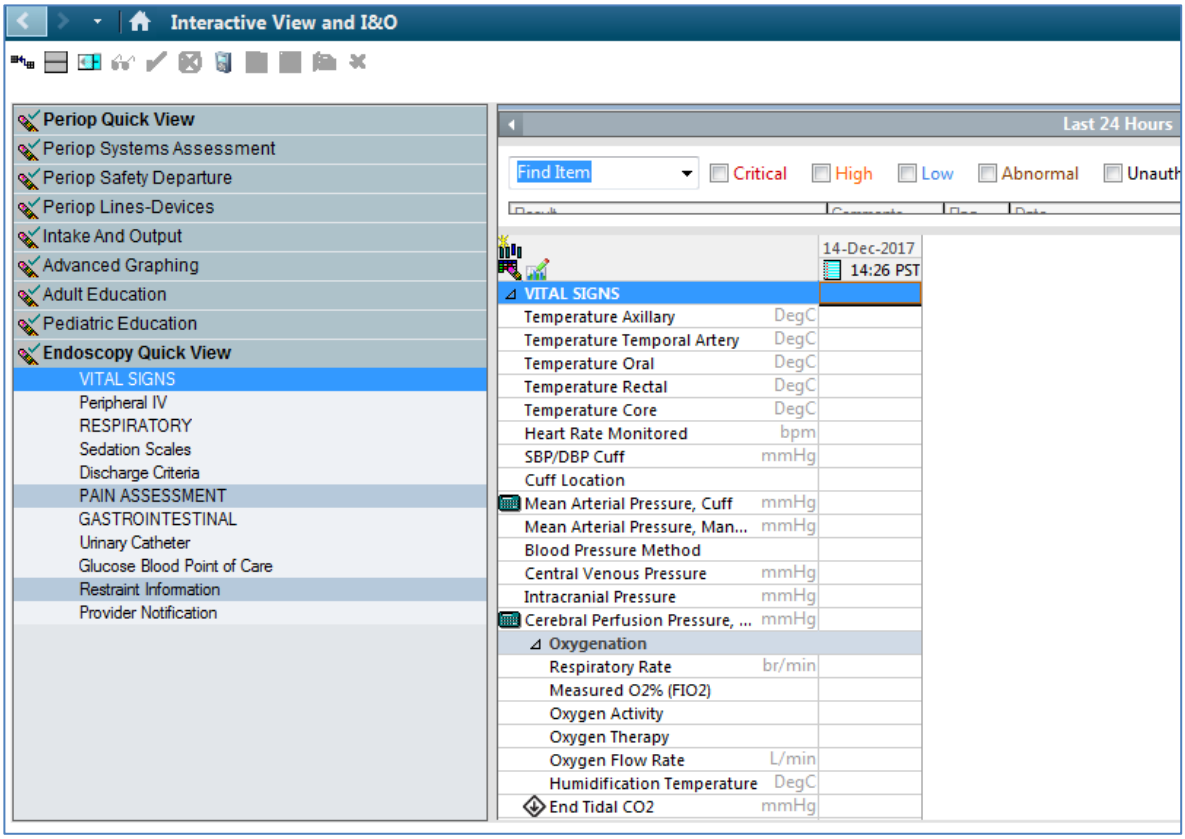
Key Learning Points

- 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).

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

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

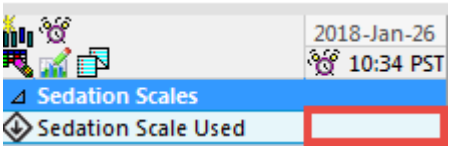
Review Activity 1.3 to re-familiarize yourself with the **Endoscopy Quick View** as necessary.



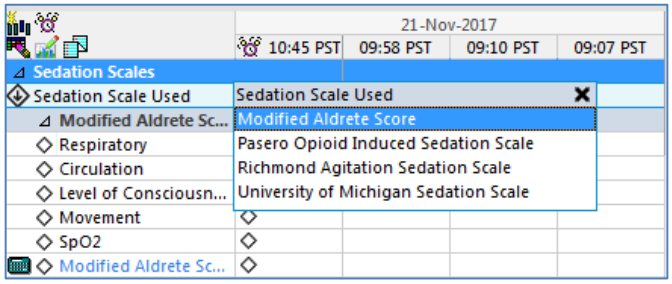
2 Document Sedation Scales

Under the **Endoscopy Quick View** band:

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



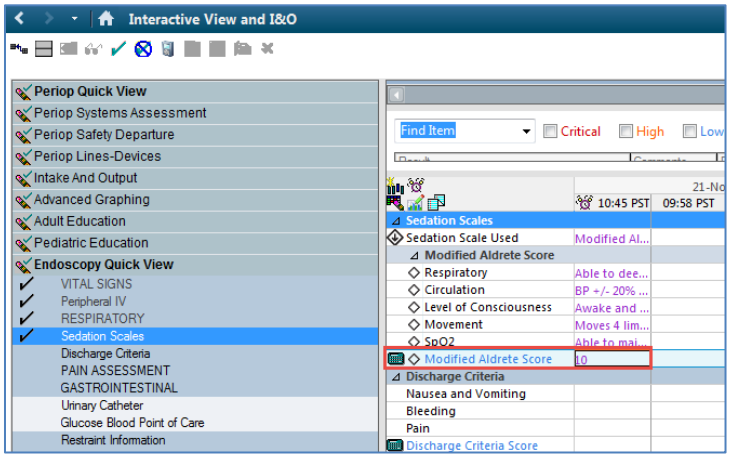
3. Select **Modified Aldrete**



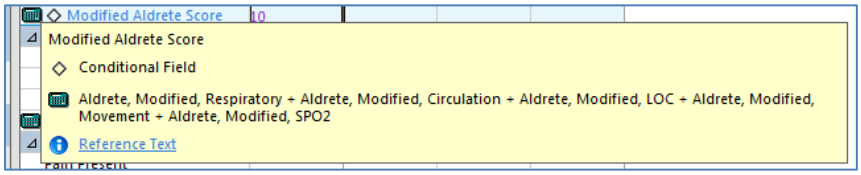
4. Document the following:
   - **Respiratory** = *Able to deep breathe and cough freely*
   - **Circulation** = *BP +/- 20% of pre-op value*
   - **Level of Consciousness** = *Awake and oriented*
   - **Movement** = *Moves 4 limbs on own*
   - **SPO2** = *Able to maintain O2 saturation greater than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

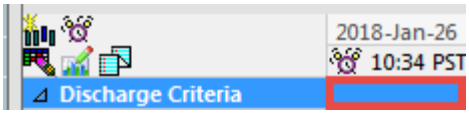


For additional reference information, Click next to the Modified Aldrete Score



Document Discharge Criteria:

1. Double Click inside the box next to **Discharge Criteria**

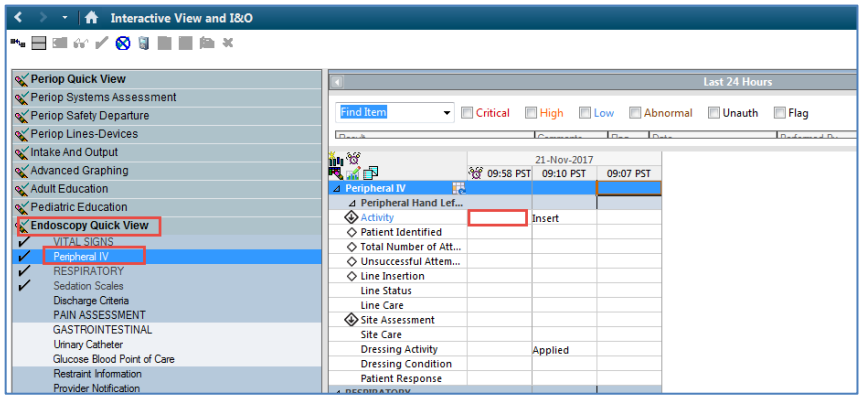


2. Document the following:
   - **Nausea and Vomiting** = *Controlled nausea/vomiting*
   - **Bleeding** = *Dressing site dry and clean*
   - **Pain** = *Controlled pain*
3. Click Sign ✓ to finalize

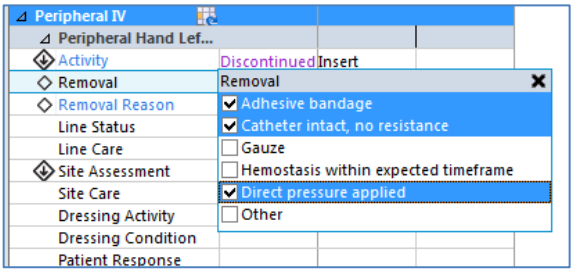
3 Recall that the endoscopy pre-op nurse inserted and documented a peripheral IV in IView, as the post-op nurse will document its removal:

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



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



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.

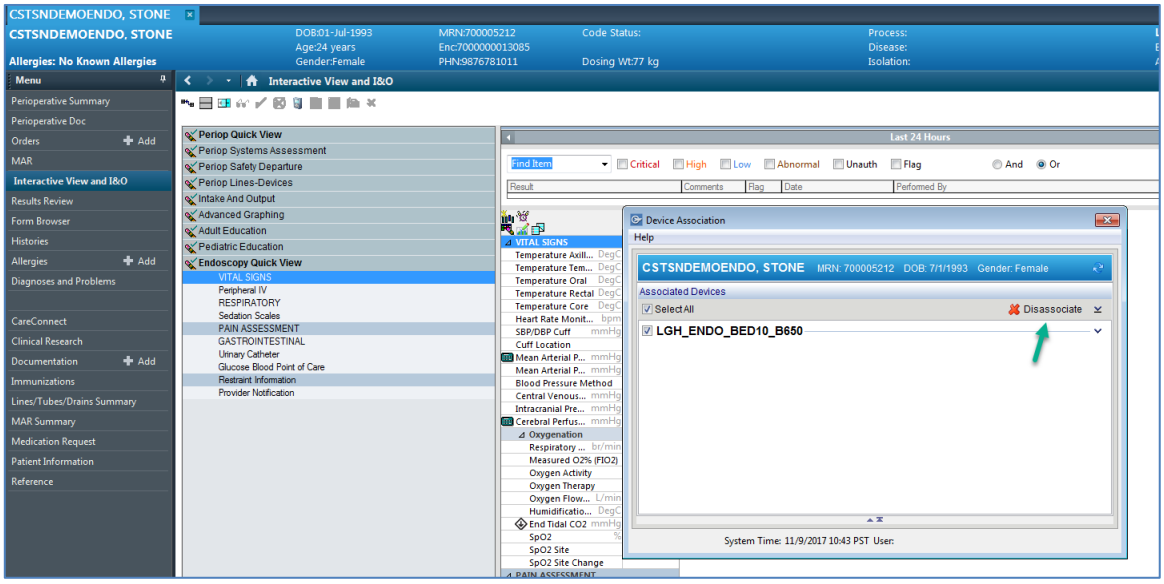
Key Learning Points

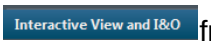
- As a post-op nurse, you will be documenting your post-op assessments and other interventions as necessary in the Endoscopy Quick View band.
- Modified Aldrete Sedation Scale and Discharge Criteria documentation was covered to familiarize you with one clinically relevant assessment you may be completing 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  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

Key Learning Points

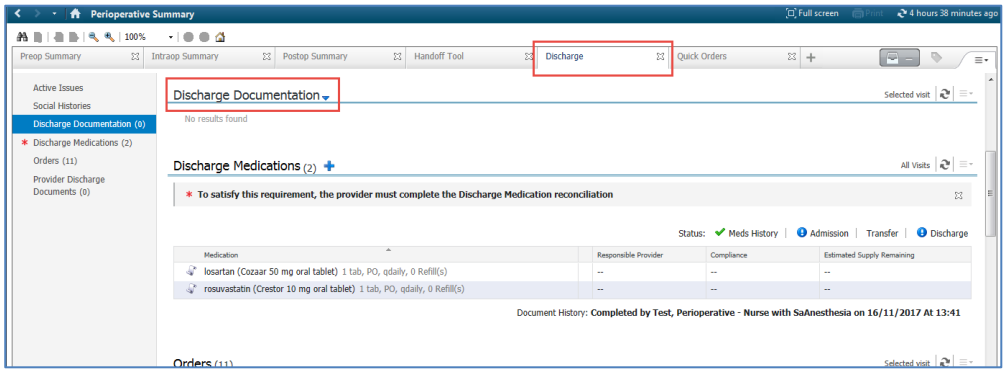
- When utilizing BMDI with IView, the patient will not automatically be dissociated when you disconnect them from the monitors.
- When you disconnect the patient from the monitors, you must also dissociate the patient from BMDI.
- Dissociating BMDI is important also important if you accidentally associate 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

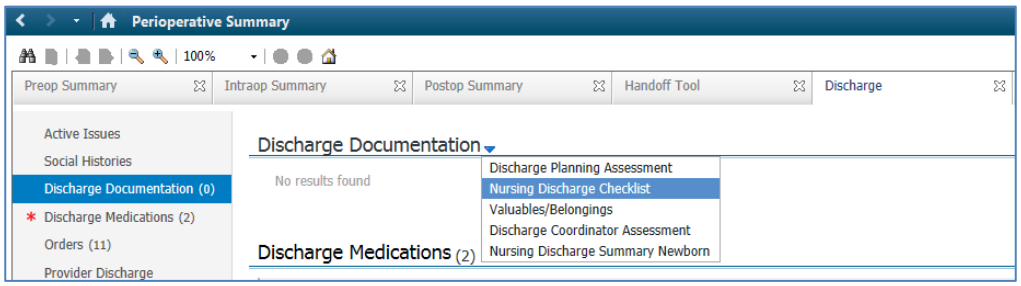
1

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

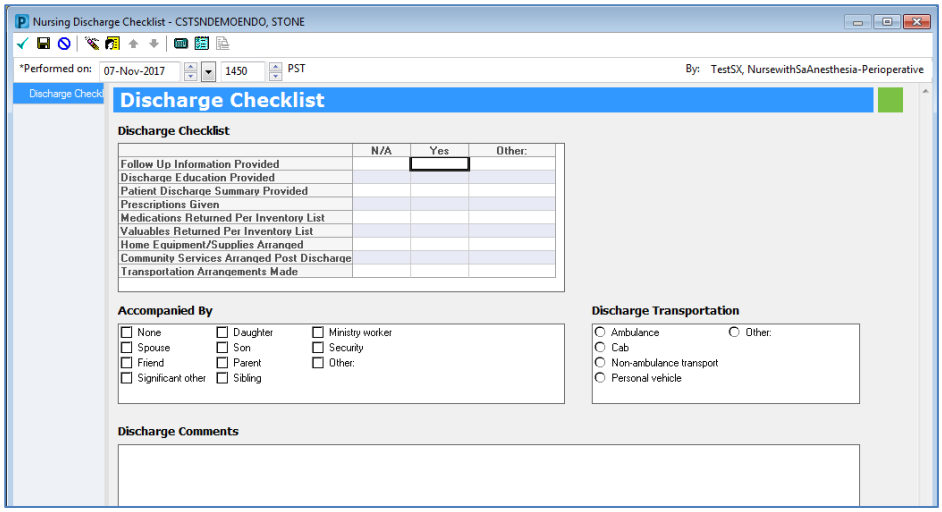
1. Select **Perioperative Summary** from the Menu
2. Select the **Discharge** tab



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



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



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

Key Learning Points

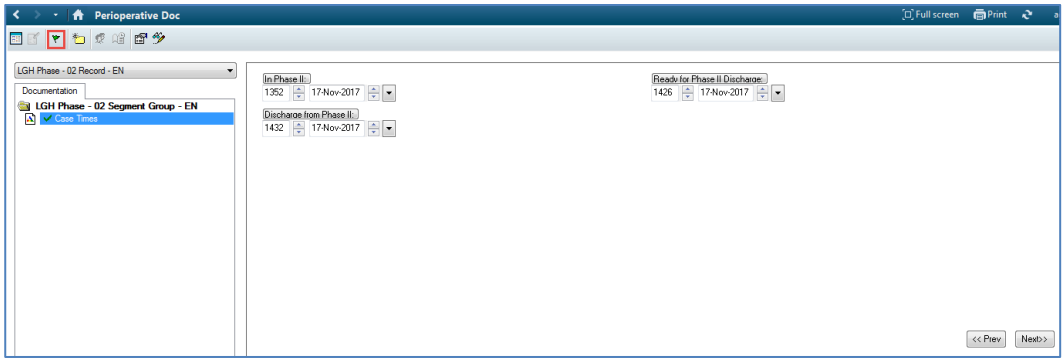
- Access the Nursing Discharge Checklist under the Discharge tab in Perioperative Summary.
- Just like with any other PowerForm, remember to finalize the document by clicking ✔
- The completed Nursing Discharge Checklist will appear in Documentation.

Activity 3.8 – Finalize PostOp Perioperative Documentation

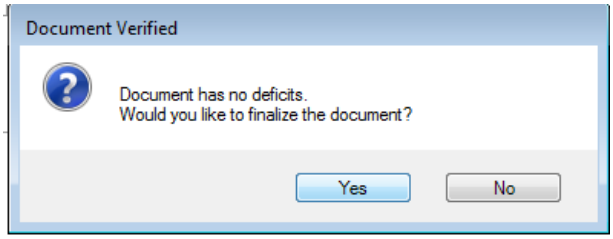
1

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 [Next>>] and the green checkmark will appear next to Case Times
2. Click the Finalize icon
   - The Document Verified window opens



3. Click **Yes** on the Document Verified window



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.

Key Learning Points

- 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

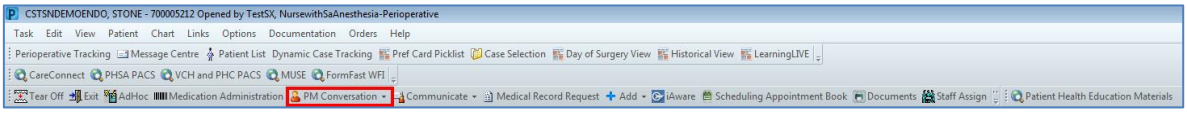
1

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

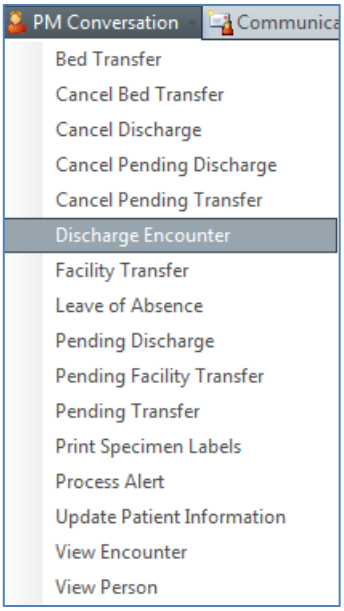
- Any outstanding initiated orders from your current encounter will automatically discontinue.
- You and other clinicians will still be able to document in the patient's chart
- The patient will stay on Perioperative Tracking as discharged for a certain time and then drop off.

To discharge the patient's encounter:

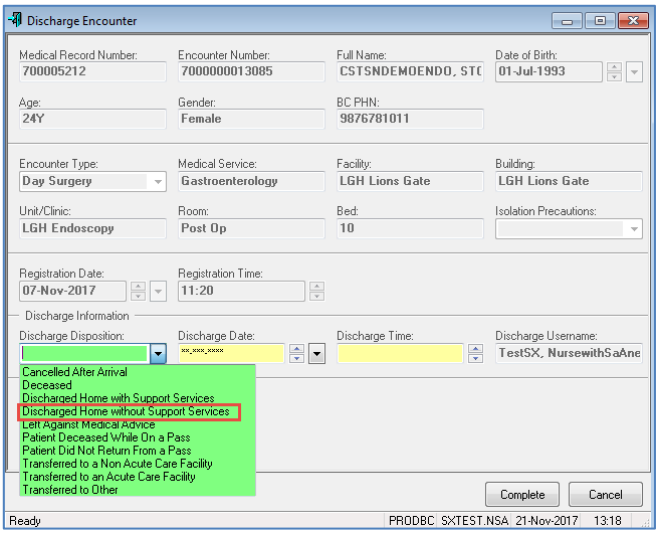


1. Click the arrow next to PM Conversation  on the Toolbar

2. Select **Discharge Encounter**



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

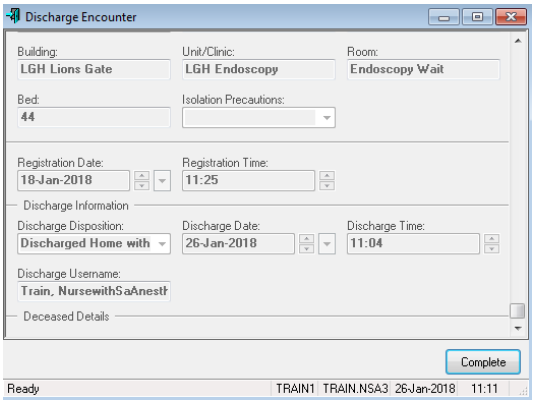


- **Discharge Date** = *<Enter Current Date>*
- **Discharge Time** = *<Enter Current Time>*

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



Key Learning Points

- 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

End of Workbook

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