

IP Registered Nurse

Inpatient



Table of Contents

Introduction	6
Overview	7
Study Checklist.....	9
Getting Started	11
Log in to Hyperspace	11
Log Out of Hyperspace	12
Understanding Workspaces	13
Managing Patients Under Your Care	14
Understanding the Patient Lists Activity	14
Patient List Directory.....	15
Patient List Display Pane	15
Report Display Pane	16
The Report Tool Bar.....	17
Customizing the Patient Summary Toolbar.....	17
Create a My List	18
Copying a Standard My List Column Layout	19
Populate your My List using the System List	20
Updating Treatment Team	21
Add a New Attending Provider	22
General Activities	23
Patient Summary	23
Chart Review	23
Results Review	25
Nurse to Nurse Handoff	27
Start of Shift	28
Patient Summary	29
Acknowledging Orders.....	30
Active Orders.....	30
FYI	31
Immunization Activity	33
Allergies.....	36

History	39
Medications Activity	40
Assessment.....	40
Vital Signs	40
Pain Assessment.....	41
Order Entry Activity.....	41
MAR.....	46
Doc Flowsheets.....	56
Restraints.....	63
Order Modes.....	64
Lab Orders.....	64
Blood Transfusion.....	68
LDAs	70
I/O - Drains	73
Notes.....	77
Arriving a Patient.....	81
Primary Focus.....	81
RN Arrival Navigator.....	82
Admitting a Patient	84
Admission Navigator	84
ED Encounter Summary	85
Belongings.....	85
Allergies.....	87
Patient’s Home Meds (PTA).....	89
Surescripts.....	92
Immunization HX	92
History within RN Admission Navigator	93
Admit Screens.....	93
Active LDAs.....	94
Plan of Care.....	94
Patient Education	94
FYI	95
Patient Education.....	96
Create a New Learning Assessment.....	97

Plan of Care	99
Documenting Plan of Care.....	99
Initiate a Plan of Care	100
Discharging a Patient.....	104
Review and Acknowledge Discharge Orders.....	105
Review the Discharge Order Report	106
Remove Lines, Drains, Airways.....	106
Belongings.....	106
Resolve Plan of Care	107
Resolve Patient Education	107
Unresolved Education.....	109
Discharge Note (AVS)	111
Review / Process Check.....	113
Appendix	115
Create a Note Using a SmartText	115
Practice Scenarios	Error! Bookmark not defined.

Introduction

Welcome to Epic training. This user support guide is designed to be utilized as your classroom workbook and your go-live support guide. This workbook describes the steps you need to complete your daily work, as well as advanced tips to help you optimize your use of the system.

Overview

Hyperspace makes your job easier by allowing you to focus less on paperwork and finding information, and more on helping the people who need you. This Hyperspace system manages all areas of hospital information electronically, giving you immediate access to the information you need.

With Hyperspace:

- Information that is gathered in one department is immediately visible to those who need to know in other departments.
- Interdepartmental communications are instantaneous and in many cases automatic.
- You can view the complete history of each patient in moments because there is only one patient record for inpatient and ambulatory care.
- Care providers, including Emergency Department physicians, never need to wait to see a patient's chart.
- At a glance, floor staff and physicians can see the status of any patient and know who is currently on staff.

Hyperspace gives you the tools to make faster and better-informed decisions, decrease your paperwork, maintain high standards, complete protocols, and reduce Costs for each department. That means you spend your time and energy doing your work, not writing about it.

Study Checklist

Ensure you can define the following key terms:

- Patient Workspace
- Patient Summary Activity
- Chart Review and Results Review
- Allergies
- Order Entry

Ensure you can perform the following tasks:

Patient Summary Activity

- List four Reports available in the Patient Summary Activity
- Customize order reports in Patient Summary Activity

Patient Workspace

- Identify two methods to open a Patient Workspace
- Define information available in the Patient Header
- Identify the anatomy of the Patient Workspace

Chart Review

- Identify function of Chart Review
- Know the tabs
- Sort information by categories and column headers

Results Review

- Two ways to access
- How to search for results
- View Reference Ranges
- Time Mark Results

Arriving a Patient

- Be able to navigate
- Know how to arrive a patient

Admitting a Patient

- Be able to use the admission navigator
- Know how to document belongings
- Know Surescripts

Patient Education

- must be able to create a new learning assessment

Discharge a Patient

- Be able to review and acknowledge discharge orders, reports
- Return belongings
- Resolve Plan of Care and Patient Education
- Print and Preview AVS

Ensure you fully understand and can explain the following concepts:

- Flowsheet Documentation
- Mar Administration and downtime
- ADT/Unit Census Functionality
- Documenting and reviewing notes
- Documenting Vitals, HX, Allergies and Immunizations.

Getting Started

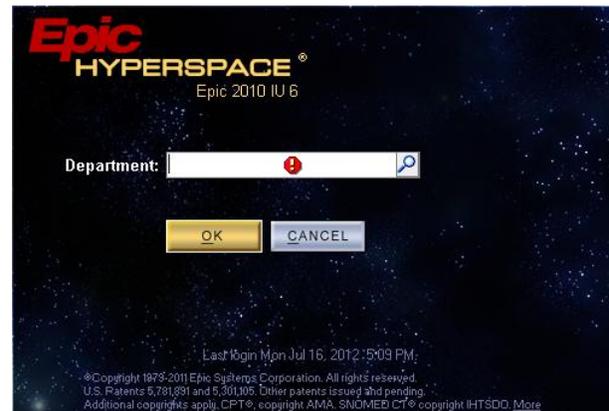
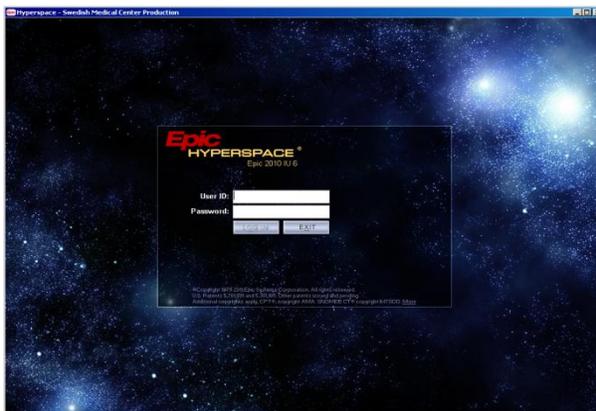
Included in this Chapter:

- Log In to Hyperspace
- Log Out of Hyperspace
- Understanding Workspaces and Activities

Log in to Hyperspace

To log in to Hyperspace, you need a user ID and a password. You also need to know the specific department where you want to log in. The way you access the login screen depends on your facility's setup. There might be a Hyperspace icon on your Windows desktop that you can double-click to open the login screen.

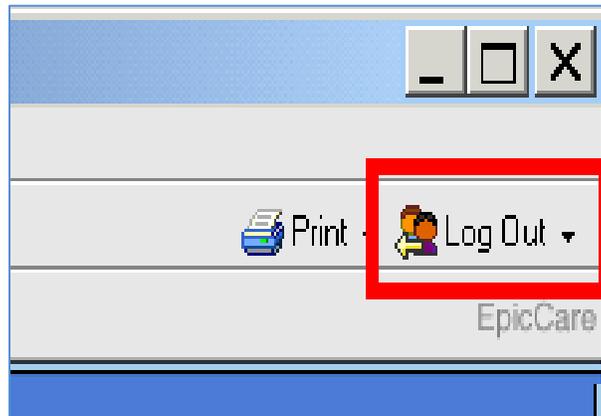
1. On your desktop, double-click the Hyperspace icon.
2. Enter your user ID in the User ID field.
3. Press TAB and enter your password.
4. Press ENTER. The Department field appears.
5. Enter your department.
6. Press ENTER to log in to Epic.



Log Out of Hyperspace

To maintain patient confidentiality, you should log out of Hyperspace when you are done working or need to leave the computer for any reason; the next time you log in you are taken to your home workspace.

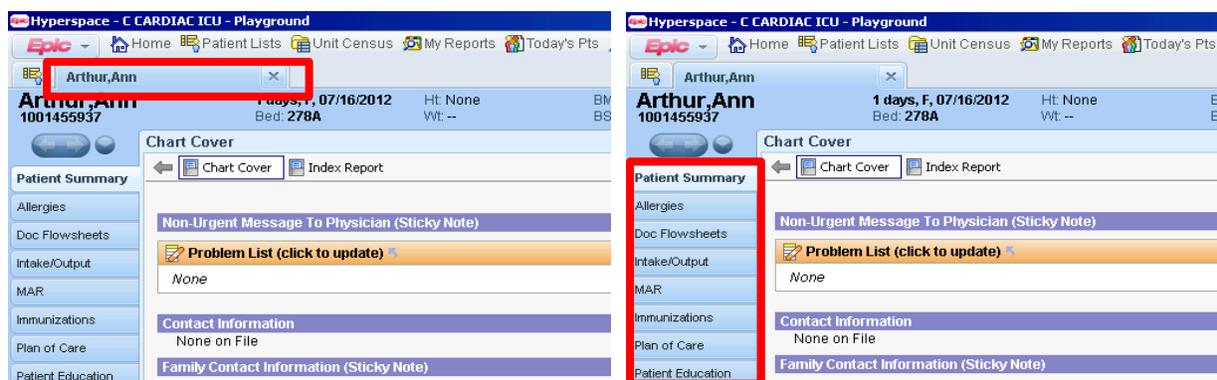
To log out, click  Log Out in the upper right corner of the screen.



Security Reminders: It is your responsibility to keep your login and password safe. Do not share your password with anyone. Your Epic ID and password can be equated to your signature. Anything you do while logged into Epic has your electronic signature attached, so if you let someone else document under your log in, you will be held accountable for their documentation. This also means that anytime you walk away from a computer you should log out of Epic.

Understanding Workspaces

A workspace is an area within Hyperspace where you perform tasks. Each patient's hospital chart opens in a separate workspace. When working in a hospital chart, the tasks that you perform within that workspace are specific to that patient. For patient safety reasons, your facility might choose to allow only one patient chart to be open at a given time. Allowing only one patient chart to be open at a given time helps to ensure that you do not accidentally document on the wrong patient.



An activity is a tool within Hyperspace that supports specific tasks, such as reviewing the patient's chart, documenting vitals, or documenting medication administrations. For example, you can document vitals in the Documentation Flow sheets activity, and you can document medication administrations in the MAR activity. You can access activities using the tabs on the left side of the screen in a patient's chart.



Tip: Navigate Easily Through Activities and Workspaces

Use the following keyboard shortcuts to navigate through activity and workspace tabs:

**Press and hold CTRL+UP
ARROW**

Cycles you up through the activity tabs in a patient's hospital chart. The selected activity opens when you release the CTRL key

**Press and hold
CTRL+DOWN ARROW**

Cycles you down through the activity tabs. The selected activity opens when you release the CTRL key

Press and hold CTRL+TAB

Cycles you through workspaces to the right. The selected workspace opens when you release the CTRL key

**Press and hold
CTRL+SHIFT+TAB**

Cycles you through workspaces to the left. The selected workspace opens when you release the CTRL key

Press CTRL+W

Closes the current workspace. This does not apply to the home workspace

Managing Patients Under Your Care

The Patient Lists activity is the most common home workspace, meaning it is often the first screen you see after logging in to Hyperspace. When you need to find a patient, see a basic report about her, or open her chart, use the Patient Lists.

Included In this Chapter:

- Understanding the Patient Lists Activity
- Patient List Directory
- Patient List Display Pane
- Report Display Pane
- Create a My List

Understanding the Patient Lists Activity

In Patient Lists you can:

- Create a custom list of just your patients
- View reports about patients without having to open their charts
- View all of your patients without searching through all patients in your facility
- Quickly see warning flags, such as flags for new test results and overdue medications

The Patient Lists activity is divided into three sections: the patient list directory, patient list display pane, and report display pane.

The screenshot displays the EpicCare Patient Lists interface. On the left is a navigation pane with folders for 'My Patient Lists', 'Shared Patient Lists', 'System Lists', 'Discharged Patients', 'Expected Inpatients', 'Hospital OP Visits', and 'Pre-admits Today & Tomorrow'. The main area shows a table titled 'My patients (3 Patients)' with columns: Room/Bed, Patient Name/Age/Sex, Admitting Provider, Unack Ord, Code St, Med Overdue, Signed/Held, Due Task, and Treatment Team. The table lists three patients: Arthur, A (1 days F); Gant, P (69 y.o. M); and Thayer, B (23 y.o. F). Below the table is a report display pane for the selected patient, Thayer, Bernice B #1001456297 (Acct: 3352074) (23 y.o. F) (Adm: 07/17/12 0932) Inpatient. The report includes fields for Allergies (No Known Allergies), Colonization (None), Code Status (FULL), Height (152.4 cm (5')), Current Wt (63.504 kg (140 lb)), Admission Wt (63.504 kg (140 lb)), Anticipated Dx (Pregnancy), BMI (27.34 kg/m²), and BSA (1.64 m²).

Room/Bed	Patient Name/Age/Sex	Admitting Provider	Unack Ord	Code St	Med Overdue	Signed/Held	Due Task	Treatment Team
278/278A	Arthur, A (1 days F)	Sweeney, Terrence J, MD						
305/305P	Gant, P (69 y.o. M)	Tuggy, Michael L, MD						
482/482P	Thayer, B (23 y.o. F)	Miller, J Heath, MD						

Thayer, Bernice B #1001456297 (Acct: 3352074) (23 y.o. F) (Adm: 07/17/12 0932) Inpatient F 4S 482P

Attending Provider: Michael L Tuggy, MD

Allergies: **No Known Allergies** Colonization: None Ht: 152.4 cm (5') Anticipated Dx: Pregnancy BMI: 27.34 kg/m²
Last verified: 07/17/12 Code Status: FULL Current Wt: 63.504 kg (140 lb) Admission Wt: 63.504 kg (140 lb) BSA: 1.64 m²

Patient List Directory

Along the left side of the screen is the patient list directory. This list contains folders of available patient lists at your facility, including lists by unit or specific statuses, such as recently discharged patients.



Patient list directory

At the top of the directory is the My Patient Lists folder. This is where you can create your My List and add patients under your care so you can directly access your patients without having to search for them in the system lists, which often contain hundreds of patients.

Patient List Display Pane

The patient list display pane in the upper right section contains additional information about each of the patients on your list.

My patients (3 Patients)								as of 0940
Room/Bed	Patient Name/Age/Sex	Admitting Provider	Unack Ord	Code St	Med Overdue	Signed/Held	Due Task	Treatment Team
482/482P	Thayer, B (23 y.o. F)	Miller, J Heath, MD						
305/305P	Gant, P (69 y.o. M)	Tuggy, Michael L, MD						
278/278A	Arthur, A (1 days F)	Sweeney, Terrence J, MD						

If the unit list contains a large number of patients, you might want to click on the reports display pane to hide the report and maximize the space for patient names. To view the reports pane again, click , which appears in the upper-right corner of the patient list display pane after the report display pane has been hidden.

Report Display Pane

The report display pane in the lower right section contains a report with information on the patient selected in your patient list.

Report: Nursing PL Report

Arthur, Ann #1001455937 (Acct: 3351582) (1 days F) (Adm: 07/16/12 0702) Inpatient F 2S-278A

Attending Provider: Terrence J Sweeney, MD

Allergies: No Known Allergies
Last verified: 07/16/12

Colonization: None
Code Status: FULL

Ht: --
Current Wt: --
Admission Wt: --

Anticipated Dx: Premature
BMI: --
BSA: --

FYI Information
No FYI flags for this patient

Staff Communication (Sticky Note) [Add/Edit comment]

Non-Urgent Message To Physician (Sticky Note) [Add/Edit comment]

Due Medications (Through this shift) [Open MAR]
Scheduled

1. You can view all available reports by clicking  next to the Report field and selecting the report you want.

Report: Nursing PL Report

Arthur, Ann #1001455937 (Acct: 3351582) (1 days F) (Adm: 07/16/12 0702) Inpatient F 2S-278A

Attending Provider: Terrence J Sweeney, MD

Allergies: No Known Allergies
Last verified: 07/16/12

FYI Information
No FYI flags for this patient

Staff Communication (Sticky Note) [Add/Edit comment]

Non-Urgent Message To Physician (Sticky Note) [Add/Edit comment]

Due Medications (Through this shift) [Open MAR]
Scheduled
None

Record Select

Search: []

Report Name	Report Display Name	ID
ACCORDION - ETOH	ETOH	95122146620
ACCORDION - RESTRAINT AUDIT	Restraint Audit	95126646620
CARE COOR REVIEW	Care Coor Review	951204360007
CARE COORDINATION - PLR	CARE COOR SNAPSHOT	349907
CDIP REPORT	CDIP Report	300789
DEFAULT - PLR	Patient List Report	349991
MEDICAL STAFF - PLR	Quick Round	349919
NEONATOLOGY PLR	Neonatology	309400
NURSING - PLR	Nursing PL Report	349921
NURSING UNIT SECRETARY - PLR	U Sec PL Report	349926
ONC SPRINGBOARD Chemo, Supportive, and ...	Chemo/Bio/Sup/Therap	95120277600
ONC TREATMENT PLAN CURRENT AND NEX...	TP Current/Planned	95120577600
ONC TREATMENT PLAN SPRINGBOARD	Springboard Report	95120177600
PEDS TX QUICK REPORT	Peds Tx Quick Report	95121846005
SCI REVIEW FLOWSHEET	Treatment Review	95120177200
SW_AMB_EPISODE-ENCOUNTER OB REPO...	OB HTML Report	95120354050

16 records total, all records loaded.

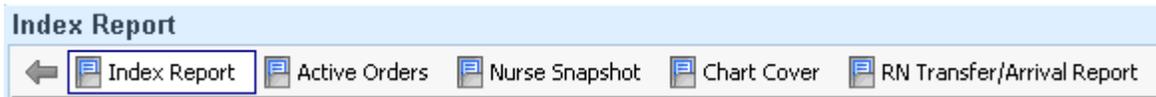
Accept Cancel

To return to the Patient List activity:

2. In the activity toolbar, click , or
3. In the Desktop menu, select Patient Lists

The Report Tool Bar

The Patient Summary Toolbar is configured with several reports, based upon your role. To switch reports, simply click the report button on the toolbar and that report will open.



There are other reports not visible on the toolbar. They can be found by clicking the selection button. You can add, remove and change the order of reports on the toolbar to meet your charting needs.



Customizing the Patient Summary Toolbar

1. Click the  in the right hand corner of the Patient Summary activity.
2. Click the  in the first open row.
3. Type 'Nurse Snapshot'.
4. Click 'Accept'.

This process can be used whenever you see the .

Add the following reports: Active Orders, RN Transfer Arrival, and Nurse Snapshot

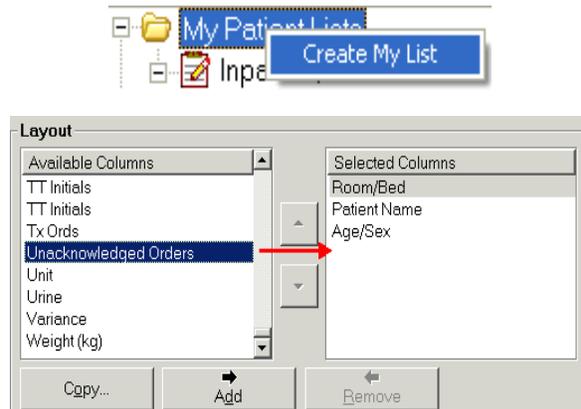
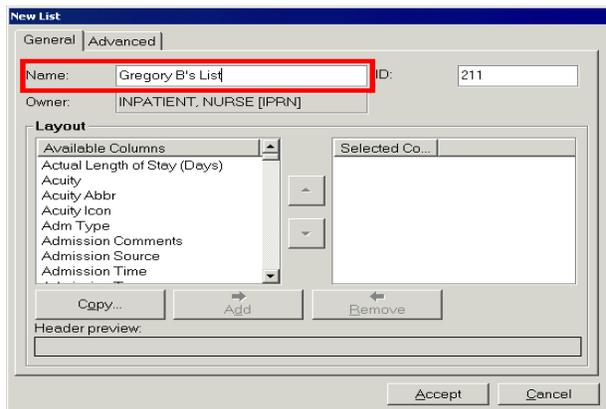
Put the reports in the order below:

1. Index Report
2. Active Orders
3. Nurse Snapshot
4. Chart Cover
5. RN Transfer/Arrival

Create a My List

A My List is a patient list specific to you – only you can see it. It appears every time you log in to Hyperspace and contains only the patients that you add to it.

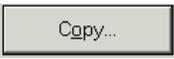
1. Right-click the My Patient Lists folder in the directory, and select Create My List from the menu.
2. In the New List window, enter a name for your list in the Name field. Enter a name that is easily identifiable to others as your list, such as your name. Consider that many other clinicians create My Lists and it's important to have a unique and identifiable title.
3. Select the columns you want to appear in your My List by selecting the column in the Available Columns list and click .
4. You can select multiple columns at the same time by pressing CTRL while clicking.
5. If you want to adjust the order in which the columns appear, select a column in your Selected Columns list and click  and  to move columns up and down. Click Accept to save your list.

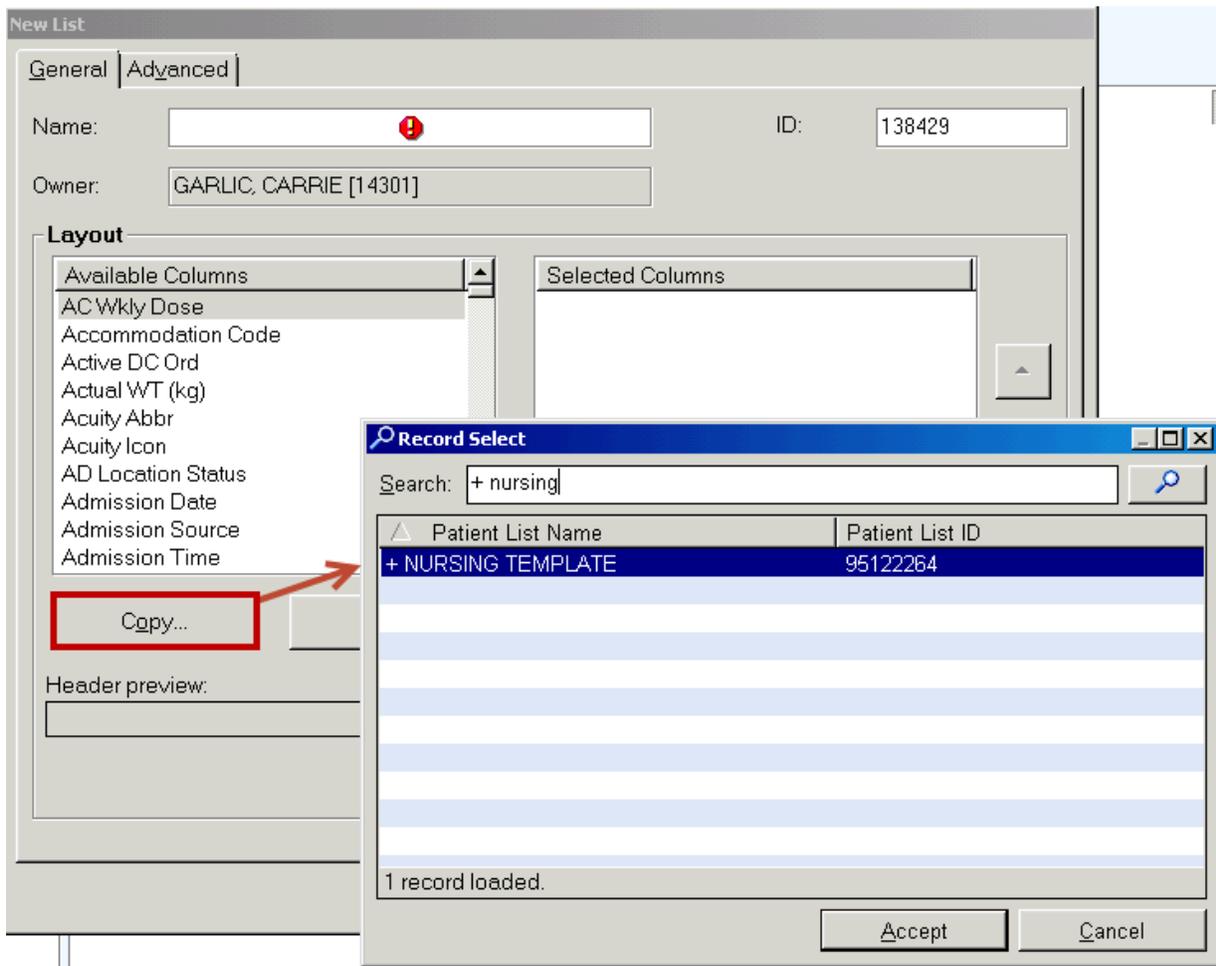


Copying a Standard My List Column Layout

You might want to set up your My List in the same way as another nurse on your unit. You can copy a previously formatted group of columns without having to individually select the same columns she has on her My List.

To copy a My List column layout already in use:

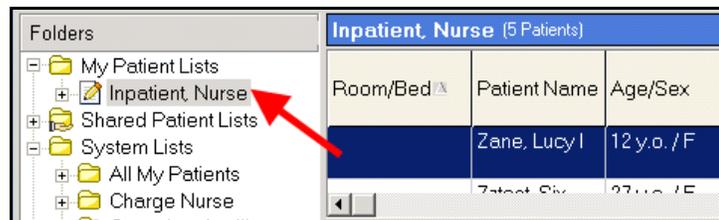
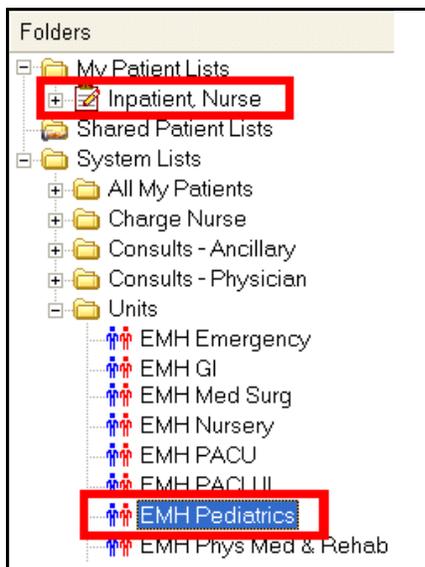
Click  and enter '+ nursing' to copy. This copies the columns designated for nursing, not the patients on it.



Populate your My List using the System List

System lists are lists of patients sorted by departments or units. As you can imagine, these lists can be quite extensive and finding a specific patient can be time consuming. However, when adding patients to your My List at the beginning of a shift, the system list is one of the first places you look. After you have identified the patients currently on your unit, you can easily add the patients to your My List.

1. With your department selected in the system list, scroll up in the directory until you see your My List.
2. Find the name of your patient in the patient list display pane.
3. Drag-and-drop the patient's name into your My List. To do this, click on the patient's name and then, with the mouse button held down, move the cursor over to the top of your My List folder and release the button after the folder is highlighted.



Updating Treatment Team

To update the Treatment Team and change the Attending Provider:

1. Select the Patient and Right click
2. Click on Treatment Team

Bed ^	Patient	Age/Sex	Private Encounter Flag	Allergies	Attend Prov	A
300P	Boot, Peter C	69 y.o. / M		Penicillins	TUGGY, M	E
301P	Emdall, Peter C	69 y.o. / M		Penicillins	TUGGY, M	E
302P	Parker, Peter C	69 y.o. / M		Penicillins	TUGGY, M	E
303P	Gomez, Peter C	69 y.o. / M			, M	E
304P	YaYa, Peter C	69 y.o. / M			, M	E
305P	Gant, Peter C	69 y.o. / M			, M	E
306P	Banzai, Peter C	69 y.o. / M			, M	E
307P	Wharfin, Peter C	69 y.o. / M			, M	E
308P	Priddy, Peter C	69 y.o. / M			, M	E
309D	Widmark,	69 y.o. / M			, M	E

Print List

Refresh List

View Legend

✓ View Report

Treatment Team

Assign Me

End My Assignments

Assign Others

End Others' Assignments

List Memberships

✓ Show Folders

Copy Patient

3. Click on the [Blue Hyperlink](#) for the Attending Provider

Attending Provider

 [Michael L Tuggy, MD](#)

4. Enter an End Date and Time and click Accept

Attending Provider

 **Michael L Tuggy, MD**

Start:

End:

ED Provider:

Add a New Attending Provider

1. To add a New Attending Provider click on the second Add plus **+** symbol

2. Enter the new Attending in the Provider box and click Accept

3. The Attending Provider is changed

Attending Provider

Doctor Test, MD

4. Review the Nursing Unit Secretary PL (Patient List)

302P	Parker, Peter C	69 y.o. / M		Penicillins	TEST, D	Esophageal Cancer			
303P	Gomez,	69 y.o. / M		Penicillins	TUGGY, M	Esophageal			

Patient List Report U Sec PL Report Report: U Sec PL Report

Parker, Peter C #1001456102 (Acct: 27) (69 y.o. M) (Adm: 10/12/11 1308) Inpatient F 3SW-30

Attending Provider: Doctor Test, MD

Allergies: Penicillins Last verified: 10/12/11	Colonization: None Code Status: FULL	Ht: 180 cm (5' 10.87") Current Wt: 99.8 kg (220 lb 0.3 oz) Admission Wt: 99.8 kg (220 lb 0.3 oz)	Anticipated Dx: Esophageal Cancer	BMI: 30.80 kg/m ² BSA: 2.23 m ²
--	---	--	--------------------------------------	--

FYI Information
 No FYI flags for this patient

ADT Active Orders
 None

General Activities

Patient Summary

When you open a patient chart, the default Activity is Patient Summary. Patient Summary is an activity that provides you with current patient specific reports that update in real time.

Avocado, Mike F 68 y.o., M, 11/21/1943 Bed: 901P
Ht: 180 cm (5'10.87") BSA: 2.2... Allergies Sulfa (Sulfonamide ...
Wt: 99.8 kg (220 lb 0.3 ... BMI: 30.8... ISO: None COL: None Code: FULL Attn: TUGGY, MICHAEL L [101140]

Index Report

Used as the default, this Index Report reliably presents Sticky Notes and convenient access to other reports

Patient FYI
No FYI flags for this patient

Family Contact Information (Sticky Note) [Add/Edit comment]

Patient Information/Events (Sticky Note) [Add/Edit comment]

Non-Urgent Message To Physician (Sticky Note) [Add/Edit comment]

Staff Communication (Sticky Note) [Add/Edit comment]

Orders to Acknowledge
None

Overview Reports
Nurse Snapshot Plan of Care
Unit Secretary Snapshot Core Measure Report
History Pts Sched Events
Progress Notes (48h) Transfer/Arrival Report

Orders
Active Orders Cancel/D/C/Completed Orders
Held/Unshipped Orders Order History
Order History Past 12 Hours Requisition Reprint
Active Orders by Order Set

Medication Review
MAR Administration Meds
Patient's Home Meds Prior to this Visit

Vitals & I/O
Fever Resp
VS Graph Blood Management
IO VS

Lab & Imaging Results
Labs Epidemiology PL Rpt
Lab Lab Results w/History
Micro Results Snapshot
Rad

Commonly Printed Reports
Discharge Meds Facesheet
Lab Orders - HSD Post Acute Referral (SNF/Home Care) Report
Downtime One Tx Summ

Pediatric & Perinatal
NICUSON Nurse Snapshot PICUPeds Nurse Snapshot
NICUSONPeds New-Baby Delivery Summary
New-Mom Delivery Summary OB Prenatal Hx
W/HT/Head Circ MD Peds - Newborn

Other Specialty Accordions
Anti-coag CV
CV No Graph ICU
Metabolic Pain
PACU Summary Transplant
ETOH

Other Specialty Reports

Chart Review

The Chart Review Activity stores current and historical patient information; both inpatient and ambulatory. It is divided into various category tabs that help distinguish the types of information you can review.

You will perform the following tasks with guidance:

- View present and historical data, both ambulatory and inpatient
- Sort information by categories and column headers
- View reports

Category Tabs

Chart Review is divided into categories. These categories act as filters to separate the patient information. This allows for convenience and the ability to quickly locate the information you want to review.

Tab	Definition
Encounters	Contains reports detailing the patient's office visits, ED visits, and hospital stays. An encounter is any clinical contact with the patient. The encounter reports show orders, notes, allergies, medications and other documentation pertaining to the specific visit.
Notes/Trans	Contains all notes written for the patient as well as all transcribed notes.
Scan Doc	Contains scanned documents (i.e. consent forms, etc.)
Labs	Contains all lab orders with their corresponding results. Use this tab to view the status of lab results or to see if the lab has drawn a specimen. (e.g., Final Result, Preliminary Result, In Process).
Microbiology	Contains cultures (i.e. blood, nasal swab)
Imaging	Contains imaging orders and their associated interpretations. It does not currently include a scan of the actual film.
Procedures	Contains reports of procedure orders such as ECG or PT/OT procedures.
Cardiology	Contains reports of all orders related to cardiology. Currently, it only includes narrative results.
Meds	Contains a record of all of the patient's medications, both historical and current.
Other Orders	Contains nursing orders and other order types not displayed on the other category tabs.
Episodes	Contains Episodes of Care for a patient. Episodes are collections of encounters grouped by some common theme, e.g., pregnancy or Workers' Compensation.
Letters	Contains all letters that have been created for the patient.
AdvDir	Contains Advance Directive
Misc. Reports	Contains non-encounter-specific reports, such as immunization, health maintenance, or financial summary reports.
Referrals	Contains all referral orders.

Results Review

The Results Review activity allows you to view both past and present lab and imaging results based on a date range you prefer. You can view reports, images and reference ranges.

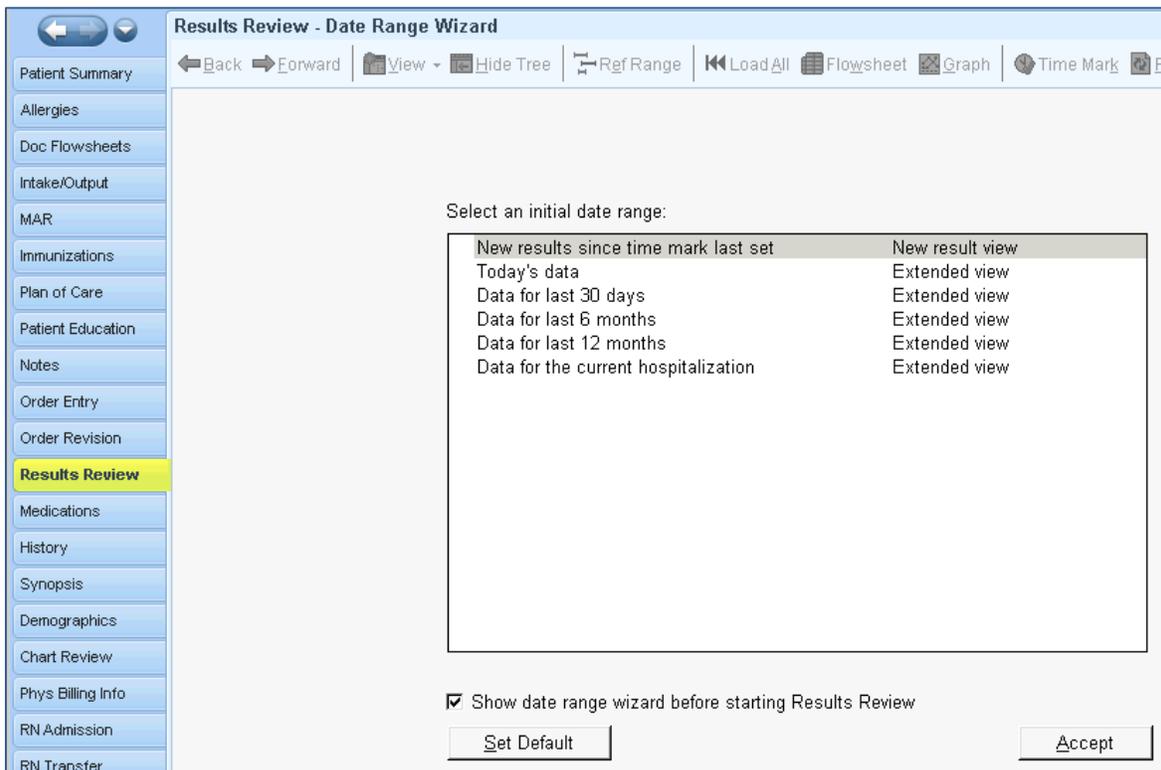
Two ways to access Results Review

You can access Results Review from within the patient's chart and your My List.

1. If an icon displays in the New Rslt Flag column for a patient on your My List, double click the icon to open Results Review in that patient's chart.



2. If a chart is open, click the Results Review activity tab.



3. Select Data for the current hospitalization and click Accept. The results display in a table format.

Two ways to Search for Results

1. You can type: To search for a particular result, type the name of the test in the Search field or expand the results tree to the left.
2. You can click: You can also expand a selection by clicking on the + sign. You can click on a single result or on a classification section.

	3 12/15/2011	2 1/22/2012	1 8/1/2012 1023	1 8/1/2012 1024
CBC				
wBC	6.9			16.8E
RBC				4.5E
HEMOGLOBIN	14.1			14.5
HEMATOCRIT	42.9			42
MCV	88.9			90
PLATELET CT				560
DIFFERENTIAL				
EOSINOPHILS, ABSOLUTE	0.1			
BANDS %				15E
LYMPHOCYTES %				8.0
MONOCYTES %				2
EOSINOPHILS %				1
BASOPHILS %				3
PLT	375			
MISC HEMATOLOGY				
NEUTROPHILS	5			
FLOW CYTOMETRY				
LYMPHOCYTES	1.1			
COMMON CHEMISTRIES				
SODIUM	136		141	
POTASSIUM	3.5		4.5	
CHLORIDE	101		102	

View Reference Ranges

To view the reference range for a particular result, either click **Ref Range** to see a column with the ranges next to each lab component or hover the mouse pointer over a result to display the reference ranges for that component in the status bar at the bottom of the panel.

View Image and Radiology Result Reports

To view the report for Radiology/Imaging results, **double-click** the  icon. The report will display.

Time Mark Results



Time marking distinguishes new results from those you have already reviewed. Any new results entered into a patient's chart will display in bold font. After you have reviewed those results, click **Time Mark**. The results will change from bold to regular font.

When new results are entered into the chart, an icon will display on your My List and the patient header. Once you time mark, the icon will disappear.

Nurse to Nurse Handoff

1. Get patient assignment
2. Meet with prior shift nurse to receive report.
3. Prior nurse will hand off patient to oncoming nurse.
4. While receiving report from the prior shift note, together both nurses;
 - a. Review patients and care
 - b. Review Nurse Snapshot
 - c. Review active order
 - d. Review orders to be acknowledged
 - e. Review MAR

Start of Shift

Patient Summary

When you open a patient chart, the default Activity is Patient Summary. Patient Summary is an activity that provides you with current patient specific reports that update in real time. These reports are similar to the reports found in Patients Lists and will vary based upon your role and department.

The screenshot displays the Patient Summary interface with several callouts pointing to specific sections:

- Orders to Acknowledge:** Points to the "Orders to Acknowledge" section, which includes a table of discontinued orders. One example is "BLOOD CULTURE" with start and end dates, a routine status, and a duplicate reason.
- History:** Points to the "Overview Reports" section, which includes links for Nurse Snapshot, Unit Secretary Snapshot, History, Progress Notes (Labs), Plan of Care, Care Measure Report, RN's Sched Events, and Transfer/Arrival Rpt.
- Active Orders:** Points to the "Orders" section, which includes links for Active Orders, Held/Assigned Orders, Order History (Past 12 Hours), Active Orders by Order Set, Cancel/CC Completed Orders, Order History, and Requisition Report.
- Held/Unsigned:** Points to the "Medication Review" section, which includes links for MAR Administration and Patient's Home Meds (Look for the List).
- MAR Admin:** Points to the "MAR Administration" link in the Medication Review section.
- Vitals & I/O:** Points to the "Vitals & IO" section, which includes links for Exam, VS Search, and VS.
- Requisition Reprint:** Points to the "Requisition Report" link in the Orders section.
- Meds:** Points to the "Meds" link in the Medication Review section.
- Labs & Rad:** Points to the "Lab & Imaging Results" section, which includes links for Labs, Lab, Micro, Rad, Epidemiology Pt. Rpt, Lab Results with History, and Results Snapshot.

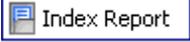
Important Reports:

1. Index
2. Active Orders
3. Nurse Snapshot
4. Chart Cover
5. RN Transfer/Arrival

Acknowledging Orders

Acknowledge Medication Orders

Medication orders populate the Index Report in the Patient Summary Activity and must be acknowledged. Once an order is entered into Epic by the practitioner, it populates the Index Report and Active Orders Report as **Orders to Acknowledge**. The nurse then reviews the new orders and acknowledges them. The acknowledgement signifies that the nurse has read and understood the orders and will complete the task.

1. Click the  report button. **Orders to Acknowledge** appears near the top of the report.
2. Click  when you've reviewed and understood the task.

View Orders To Be Acknowledged

You have entered several orders. It is a best practice to acknowledge orders after you enter them. Go to the **Index** report in Patient Summary and individually acknowledge your orders.

Nursing Communication orders

Nursing Communication Orders are physician orders indicating a course of action or those situations where patient specific information is communicated.

Active Orders

'Active orders' are located on the Index Report on the Patient Summary activity. An Active Orders report may also be wrenched in. Active orders is a task management tool to help you manage the daily care for your patients. The tasks that display are triggered by the orders transcribed Epic. You can view current, future and completed tasks.

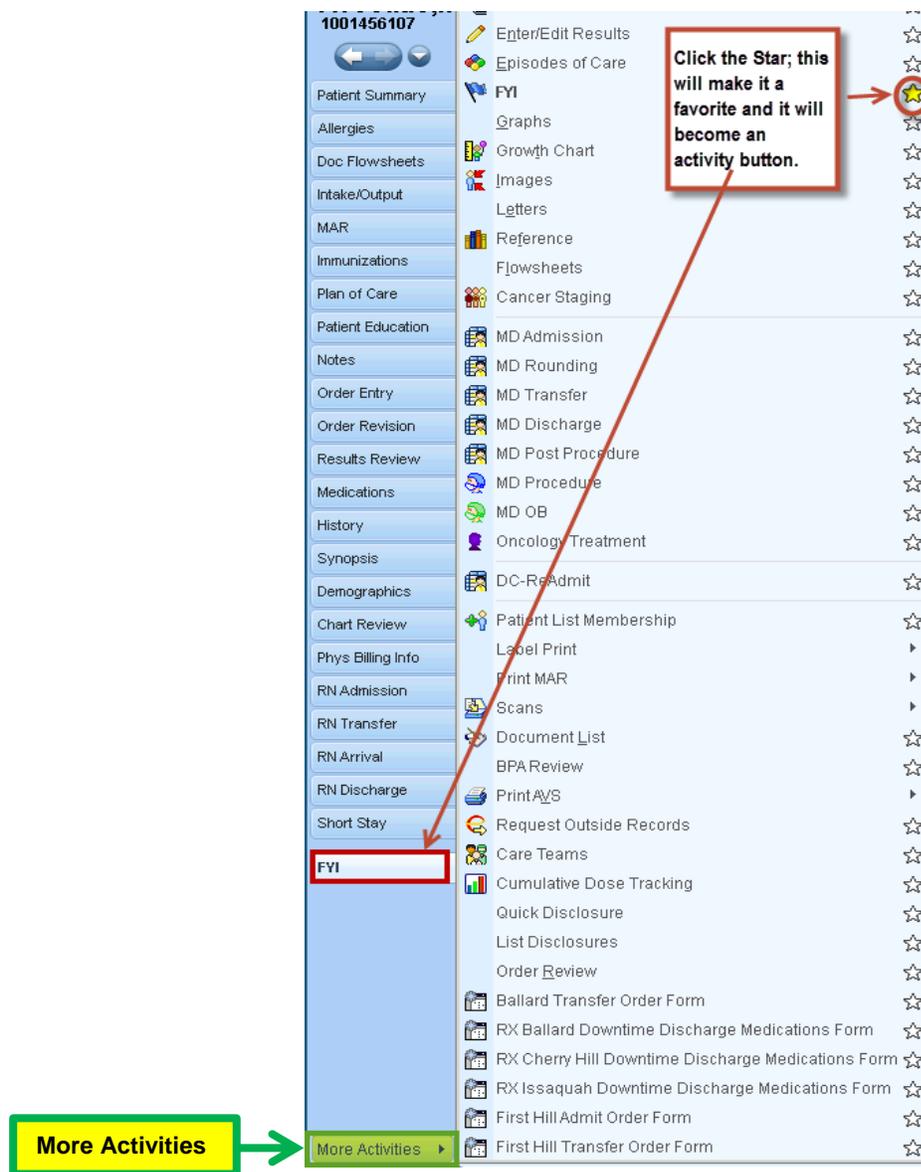
Active Orders Report is utilized throughout the shift, from start of report until the end of the shift. You can view, document and organize tasks for your patient.

FYI

An FYI flag is a way to communicate patient information to all health care providers and assigned treatment team members across facilities. FYI flags can be viewed from the Index Report and the Nurse Snapshot.

FYI is located under More Activities. By clicking the  located across from the FYI activity, will enable the FYI activity to become a permanent fixture under the activity tabs. FYIs may be edited and/or deactivated. All FYIs are permanent records in the patient's file, even if deactivated.

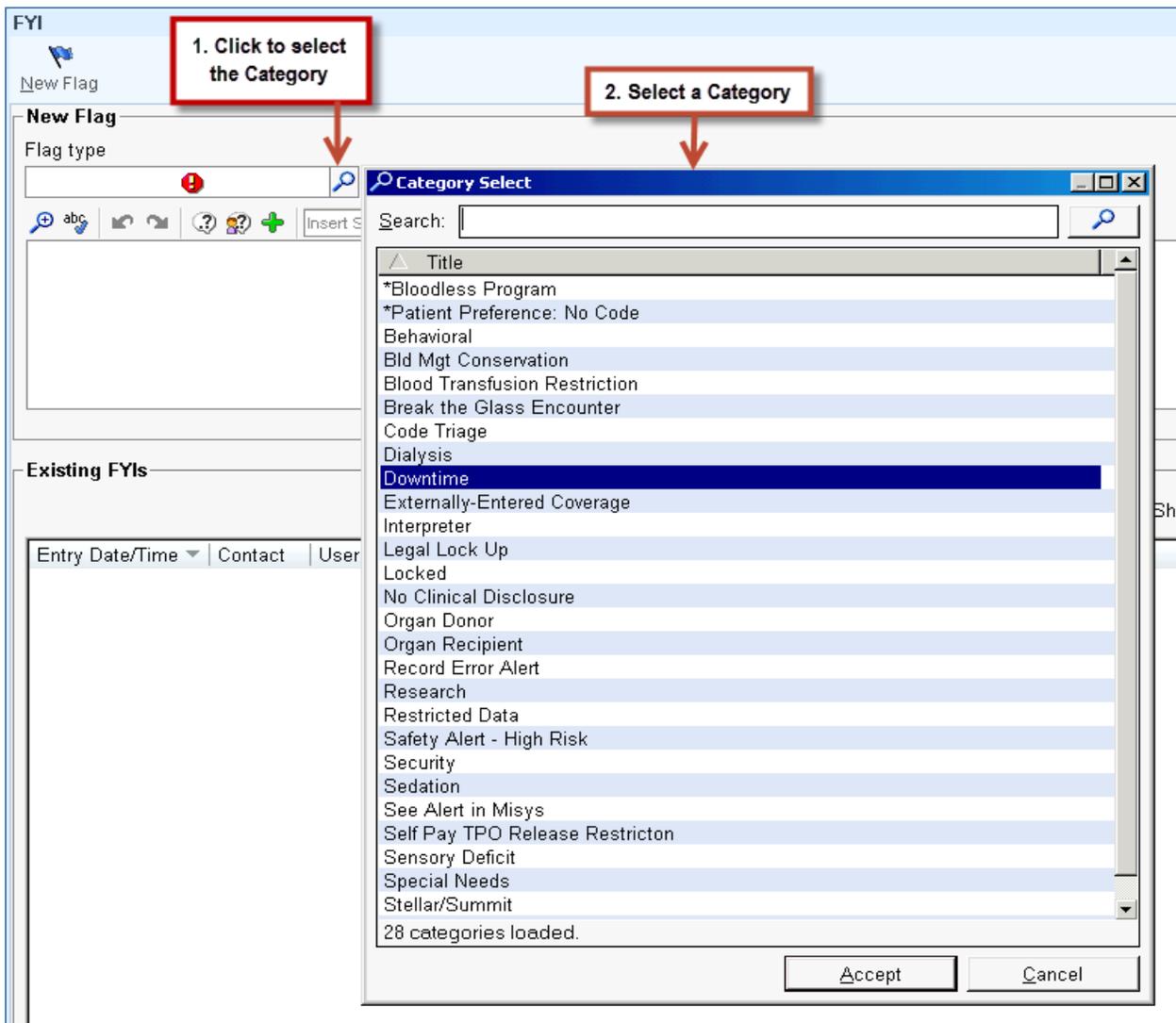
1. To create an FYI, click More Activities, located in the bottom left portion of the screen.



2. Click the star, across from FYI. This will make FYI a favorite on your activity buttons
3. FYI displays, click Flag.



4. Click , to view the categories

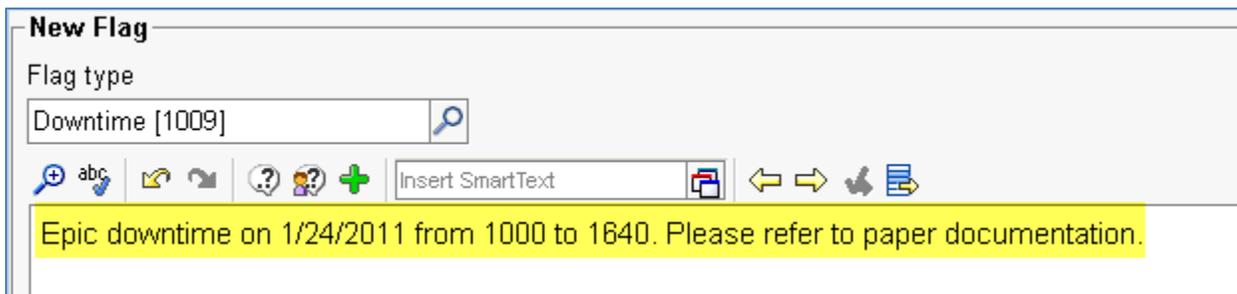


5. Type “.dt” which is the smartphrase for Downtime



6. Double click DT.

7. Message appears in FYI as:

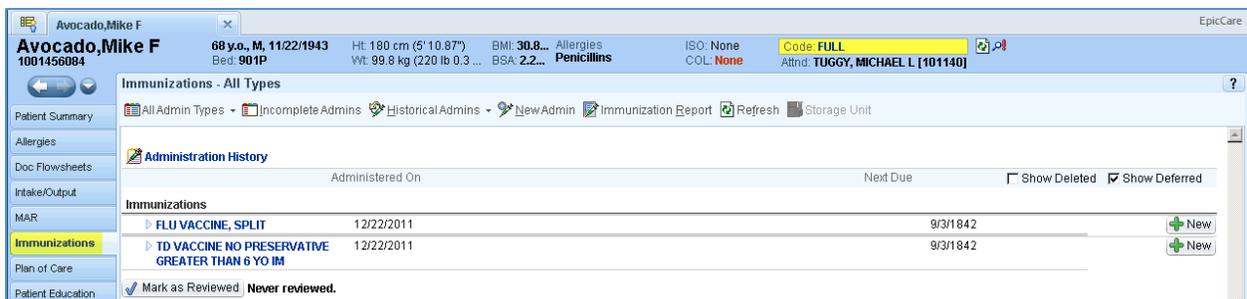


8. Click Accept

Immunization Activity

In addition to the screening of patients for required vaccinations, vaccination records should be reviewed upon the first 24 hours of admission and updated as necessary.

Immunization shows any immunizations on record.



Nurses are required to update Immunization history upon admission through the RN Admission.

1. Click Immunization activity button
2. Click Historical Administrations. Select Historical Admins.

The screenshot shows the 'Immunizations - All Types' interface. At the top, there are navigation buttons: 'All Admin Types', 'Incomplete Admins', 'Historical Admins' (highlighted with a red box), 'New Admin', 'Immunization Report', 'Refresh', and 'Storage Unit'. Below these, a dropdown menu is open, showing 'Historical Admins' (highlighted with a red box) and 'Single Historical Immunization'. The main area shows 'Administration History' with a table of immunizations:

Immunizations	Administered On	Next Du
FLU VACCINE, SPLIT	12/20/2011	
TD VACCINE NO PRESERVATIVE GREATER THAN 6 YO IM	12/20/2011	

At the bottom, there is a 'Mark as Reviewed' button and the text 'Never reviewed.'

3. Select Ped or Adult patient

The screenshot shows the 'Immunizations - All Types' interface. At the top, there are navigation buttons: 'All Admin Types', 'Incomplete Admins', 'Historical Admins', 'New Admin', 'Immunization Report', 'Refresh', and 'Storage Unit'. Below these, a dropdown menu is open, showing 'Historical Admins' and 'Single Historical Immunization'. The main area shows 'Historical Immunizations' with a 'Template to use:' dropdown menu. The dropdown menu is open, showing 'SW_AMB_PED_HISTORICAL_IMMUNIZA' (highlighted with a blue box) and 'SW_AMB_ADULT_HISTORICAL_IMMUNIZA' (highlighted with a blue box). Below the dropdown menu, there is a table with columns 'Immunizations' and 'Comment':

Immunizations	Comment
1 HEP B VACC, PED/ADOL, 3 DOSE IM [38	
2 HEP B VACC, PED/ADOL, 3 DOSE IM [38	

- Select Row with correct immunization. Example Swine Flu vaccine.

Historical Immunizations
 Template to use: SW_AMB_ADULT_HISTORICAL

Immunizations	Date
23 FLU VACCINE, SPLIT [9]	
24 FLU VACCINE, NASAL [104]	

Clicking the Calendar opens the Date Entry

Date Entry 8/9/2012

August 2012						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
29	30	31	1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	1
2	3	4	5	6	7	8

Today 

January	▲
February	2003
March	2004
April	2005
May	2006
June	2007
July	2008
August	2009
September	2010
October	2011
November	2012
December	▼

Accept Cancel

Historical Immunizations
 Template to use: SW_AMB_ADULT_HISTORICAL

Immunizations	Date	Confirmed	Comment
23 FLU VACCINE, SPLIT [9]			
24 FLU VACCINE, NASAL [104]	8/2/2012	PT RPT [1]	

Auto populates, otherwise enter 'Comments'

- Click accept.

Enter Patient Reported Vaccinations

Your patient has indicated that he received a H1N1 shot at his local CVS just last week.

In the Admission navigator, you can view the Immunization Summary Report, showing the recent Pneumovax administration and add any vaccination reported by the patient.

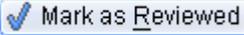
1. Click the downward arrow next to Historical Admins and select Historical Admins.
2. Select SW_AMB_ADULT_HISTORICAL_IMMUNIZA.
3. Find FLU VACCINE (H1N1 - Swine) [172].
4. Click the date column next to Flu Vaccine.
5. Type t-7, Enter.
6. The Confirmed column, defaults and PT RPT[1] defaults automatically.
7. Click Accept

Allergies

Knowledge of a patient's allergies and reactions is imperative to providing safe, effective patient care. The Allergy activity allows you to do the following:

- Review known allergies
- Unable to assess allergies
- No known allergies
- Add allergies
- Modify current allergies
- Delete allergies

Review

It is required that allergies be reviewed with the patient on each admission, transfer and whenever there is a change in allergy status.  requires speaking directly to the patient and reaffirming their allergies.

If a patient has never been seen to this facility, there will be no allergy information in his/her chart and you will enter all allergies for that patient. If your patient does have prior entries, you will review the allergy list with the patient to see if anything has changed and then modify the list accordingly.

If your patient has no information on file, you should see this:

Unable to Assess Allergies

Any time you are unable to assess the patient's allergies, you should follow the steps below. There are many reasons why you may be unable to assess the patient's allergies when they are first admitted: such as confusion, severe pain or unconsciousness. 'No known allergies' is to be documented.

No Known Allergies:

1. Click the 'No Known Allergies' box

2. The Allergies in the Patient Header will now say **No Known Allergies**

Adding an Allergy

1. In the Search field, type 'penicillins' then click the 'Add' button (or press Enter).

2. In the Agent Select window, select the allergen of 'penicillins' with the allergen type of Drug Class.
3. Click 'Accept'.
4. Click in the Reactions field

5. Click the 
6. Select 'Hives' and then click 'Accept'
7. Click on the row beneath 'Hives'.
8. Click on the 'Selection' button.
9. Select 'Itching' and then click 'Accept'. (You can add as many reactions as the patient reports. Each time you add a reaction, a new field becomes available.)
10. Click the 'Selection' button in the Severity field.

Severity: 

11. Select 'Medium' and then click 'Accept'.
12. Write a comment, as needed, in the Comment box.
13. Click 

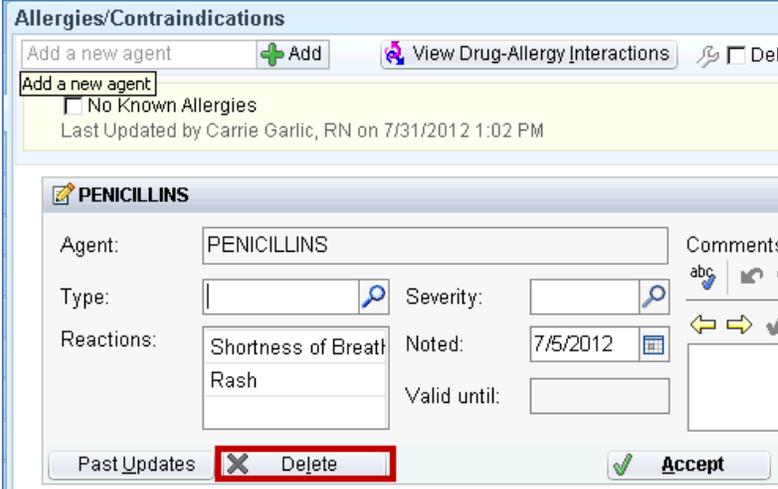
Modifying a Current Allergy

You patient remembered he also experienced shortness of breath when he received penicillin. You need to add this to the list of reactions for his allergy.

1. Click the 'Penicillin' allergy to edit the details of that entry.
2. Click the next blank Reaction field and type 'short'. Press 'Enter'
3. Click 'Accept'.

Deleting a Current Allergy

1. Click Penicillins
2. Click 'Delete'



The screenshot shows the 'Allergies/Contraindications' interface. At the top, there are buttons for 'Add a new agent', 'View Drug-Allergy Interactions', and 'Delete'. Below this is a section for 'PENICILLINS' with the following fields: Agent (PENICILLINS), Type (empty), Reactions (Shortness of Breath, Rash), Severity (empty), Noted (7/5/2012), and Valid until (empty). At the bottom, there are buttons for 'Past Updates', 'Delete' (highlighted with a red box), and 'Accept'.

History

The History section allows you to indicate past medical history, past surgeries, and important lifestyle habits, such as tobacco, alcohol, or drug use and sexual activity of a patient. This section is not encounter specific so information documented here will be available after discharge. History may be found on both the Activity and RN Admission Navigator. You can update the information directly in the Surgical History, Medical and Family History sections.

1. Open the History activity

The screenshot shows the History activity interface for patient Avocado, Mike F. The patient's information is displayed at the top: 68 y.o., M, 11/16/1943, Bed: 901P, HT: 180 cm (5'10.87"), WT: 99.8 kg (220 lb 0.3...), BMI: 30.8..., Allergies: Penicillins, ISO: None, COL: None, Code: FULL, Attn: TUGGY, MICHAEL L [101140].

The interface is divided into several sections:

- Left Sidebar:** A list of navigation options including Patient Summary, Allergies, Doc Flow sheets, Intake/Output, MAR, Immunizations, Plan of Care, Patient Education, Notes, Order Entry, Order Revision, Results Review, Medications, **History** (highlighted), Synopsis, Demographics, Chart Review, Phys Billing Info, RN Admission, RN Transfer, and RN Arrival.
- History Section:** A tree view under the heading "History" with categories: Medical (Surgical, Family, Medical History, Status), Social (Substance and Se..., ADL and other Co..., Social Documenta..., Socioeconomic), Specialty, and Birth History.
- Past Medical History Table:** A table with columns "Past Medical History", "Date (Free Text)", and "Comments". It contains three entries:

Past Medical History	Date (Free Text)	Comments
1 Hypertension [401.9AH]		
2 Esophageal reflux [530.81]		
3		
- Medical History Worksheet:** A section with a list of medical specialties (Allergies/Immunology, Cardiology, Dermatology, Endocrinology, ENT/Otolaryngology, Gastroenterology, Genetic Problems, Gynecology, Hematology, Infectious Diseases, Neonatology) and an "Add to History" button.
- Buttons:** "View Audit Trail" and "Restore" buttons are located below the table.

2. In the Medical Surgical section:

This screenshot shows a closer view of the Medical Surgical section within the History activity. The "Medical" category is expanded to show "Surgical" and "Family". The "Past Medical History" table is visible, showing the first entry:

Past Medical History	Date (Free Text)	Comments
1		

3. Click to indicate whether your patient has or has had surgeries listed.
4. Add comments by clicking 'Comment'. Free text your comment(s).
5. In the Family Medical History section, record the medical history and status (alive or deceased) of the patient's family members.
6. The Family Status section allows for a review all previously submitted information pertaining to family medical history.
7. Social section allows for sexual history and substance use.

Medications Activity

Medication is a major part of a nurse's job, and it is also one of the most vital aspects of patient care and safety. The electronic Medication Administration Record (MAR) displays medications and facilitates documentation of administrations.

Assessment

When you complete a Head to Toe assessment, you must document on each system. Epic requires you to determine if the assessment is WDL (Within Defined Limits) or if there is an Exception to WDL. A set of "normal values" has been determined for each body system and is displayed in the Details Window.

Vital Signs

Vital signs are documented in the Doc Flowsheets activity, under the VS flowsheet. This flowsheet will be used throughout your shift to document your patient's pain.

Your patient is now running a fever and has a headache. Let's document his vital signs.

1. Click the **Doc Flowsheets** activity.
2. Click the **VS Acute Care** tab.
3. Enter the following in the Vitals group:
 - a. Observation: Pt. awake
 - b. Temp: 100.2
 - c. Temp Source: Oral
 - d. Pulse Rate: 65
 - e. BP: 146 84 (be sure to include the space)
 - f. BP Cuff Location: Left arm
 - g. BP Method: Automatic
 - h. SpO2: 97

Pain Assessment

Your patient informs you he is experiencing mild lower back pain. You assess the level of pain using a verbal scale.

1. Click the Doc Flowsheets activity.
2. Locate Pain Description on the navigator.
3. Click the Pain Description. Note that the Pain Description is brought to the top of the flowsheet.
4. Add a column to document an assessment for the current time.

Use the following information to complete the pain assessment:

Field	Data
Pain Site	Back
Pain Orientation	Lower
Pain Quality	Aching
Pain Scale	6

Pain Assessment, located directly beneath the **Pain Description**, asks whether **Add'l Pain** Documentation is needed. If **Yes** is selected, Pain Management is added to the flowsheet.

Complete the rest of the assessment using your own values.

1. Enter the following in the Pain Description #1:
 - a. Pain site: Chest
 - b. Pain Orientation: Right; Left
 - c. Pain Quality: Aching
2. Enter the following in the Pain Assessment:
 - a. Pain Scale: 6
 - b. Sedation level: Awake and responding

Order Entry Activity

The Order Entry activity is a convenient workspace to search, customize and sign orders. After the medication orders to the pharmacy are entered, you will be able to enter the non-medication orders.

Avocado, Mike F 1001456084 68 y.o., M, 11/22/1943 Bed: 901P Ht: 180 cm (5'10.87") Bmi: 30.8... Allergies Penicillins ISO: None COL: None Code: FULL Attn: TUGGY, MICHAEL L [101140]

Place orders

Patient Summary Allergies Doc Flowsheets Intake/Output MAR Immunizations Plan of Care Patient Education Notes **Order Entry** Order Revision

Order mode: VORB/TORB (Co-sign required) New order defaults Not using defaults

Order Modes

Nursing and Pharmacy will utilize the following Order Modes to place orders:

Order Mode	Definition	Physician Cosign Required	Example
VORB / TORB	Order(s) is being placed as a result of a verbal or telephone order from an LIP	Yes	Entering an order for a medication given as a result of a VORB during a procedure, orders taken as a result of a phone discussion related to a change in the patient's condition.
Emergency	Unit Secretaries who enter non-medication orders during a true emergency	Yes	Code Blue
Standard	Order is within your scope of practice and it will not generate a message for a co-signature for the physician.	No	Specialty beds or other equipment the patient might need
Per Guideline	Order is being placed as a result of an LIP ordering a protocol.	No	Ordering SCDs after the "DVT Protocol" order has been paced or ordering an IV restart once the IV has been ordered. MRSA test of patients in the ICU, orders from the normal hospital newborn orderset.

Place Medication Orders

Your patient's blood pressure has consistently been recorded at 160/95 for the past 30 minutes. After calling the physician, he asked you to place an order for an oral dose of Metoprolol (Lopressor), 25 mg, PO, BID with meals.

Use the scenario above to place an order for Metoprolol.

1. Go to Order Entry.
2. Type "metop" in the order search field.
3. Select METOprolol (LOPRESSOR) tablet and click Accept. The Order Composer displays.
4. Click 25 mg.
5. Verify BID with meals.
6. Click Accept.

The screenshot shows the 'METOprolol (LOPRESSOR) tablet' order composer. At the top, it specifies 'Oral, WITH BREAKFAST AND DINNER, First Dose Tomorrow at 0800' and a warning: 'HOLD FOR HR LESS THAN 50 OR SBP LESS THAN 90 AND CALL MD per CSMC default par'. Below this, there are 'Reference Links' for 'Black Box Warning' and 'Micromedex'. The 'Dose' field is set to 25 mg, with other options at 12.5 mg, 50 mg, and 100 mg. The 'Route' is 'Oral'. The 'Frequency' is 'WITH BREAKFAST AND DINNER'. The 'For' field is set to 'Doses'. The 'Starting' date is '12/2/2011', with 'Today' and 'Tomorrow' buttons. The 'First Dose' is set to 'As Scheduled', with an 'Include Now' button.

Sign the medication order

1. Verify VORB/TORB as the Order Mode.
2. Sign Dr. Michael Tuggy as the ordering provider.
3. Click Accept.

Pharmacy Verification

Administration warnings will remind the nurse if a medication has not been verified by the Pharmacy, asking if the nurse still wants to administer the medication. Nurses can call the pharmacy to request that medications be verified.

The screenshot shows an 'Administration Warning' dialog box. It contains a question: 'DOPamine (INTROPIN) (1600 mcg/mL) 400 mg in D5W 250 mL infusion has not been verified by a pharmacist. Are you sure you want to administer it?'. Below the question are two buttons: 'Yes' and 'No'.

Acknowledge Medication Orders

Medication orders populate the Index Report in the Patient Summary Activity and must be acknowledged individually like all other orders .

Nursing Communication Orders

Nursing Communication Orders are physician orders indicating a course of action or those situations where patient-specific information is communicated.

Only orders appropriate to support scope of practice for a nurse will be available to physicians.

You will perform the following tasks with guidance:

- Advance Diet as Tolerated
- May leave unit

Advance Diet as Tolerated Order Process

This is a nurse communication order that directs the nurse to enter new diet orders based on the patient's progression in diet tolerance. An example of this can be to advance the diet from NPO to clear liquids, to full liquid, etc.

Enter a Clear Liquid Diet

1. Click Order Entry.
2. Type "clear liquid" in the order search field.
3. Select DIET CLEAR LIQUIDS and click Accept. You can click the Summary Sentence to add any additional details to the order.
4. Click Accept.
5. Click Sign.

The Providers window displays.

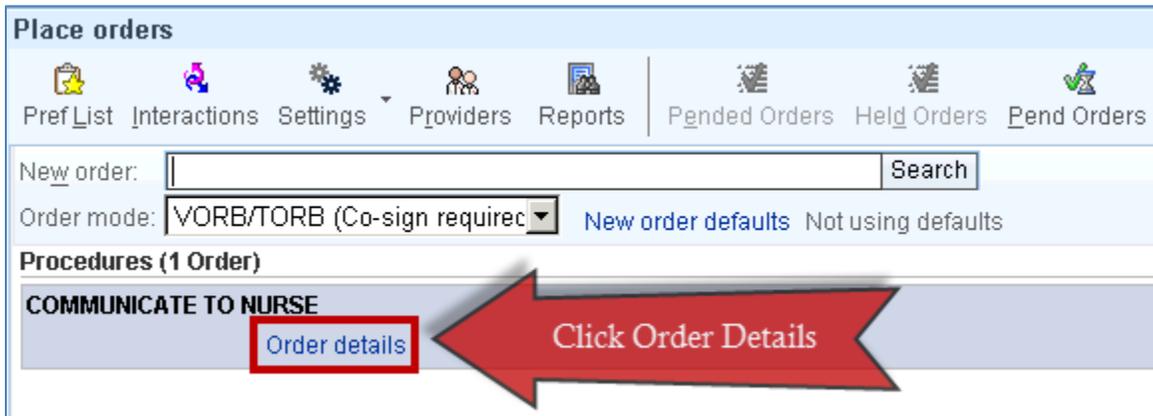
6. Select per guideline as the order mode.
7. Enter Dr. Michael Tuggy as the Ordering Provider.
8. Click Accept.

Once the order is signed, it will display as an order to be acknowledged in Patient Summary.

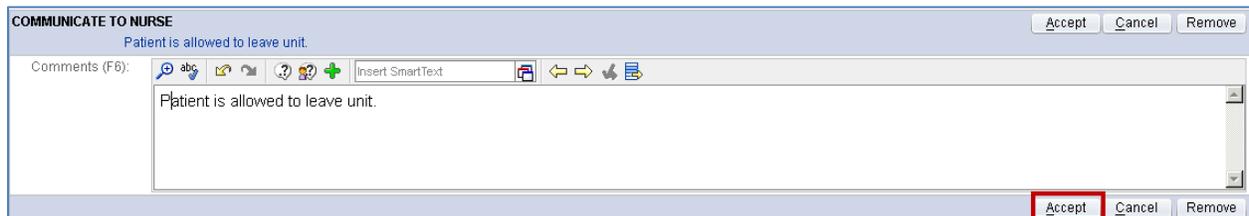
Generic Communication Order

A generic Nursing Communication order will be made available to physicians and should be utilized only when a discrete order is not otherwise available. For example, the patient is allowed to leave the unit.

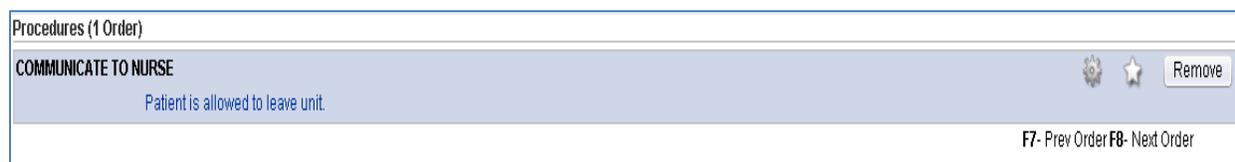
1. Click Order Entry activity.
2. Highlight Communicate to Nurse.
3. Click Accept.
4. Order is placed, click Order details.



5. Type, 'Patient may leave unit', click Accept.



6. Communication appears as:



MAR

Overview

The MAR is a very interactive workplace. The legends help you define the color schemes and notations that display throughout the MAR.

The electronic MAR is organized by rows and columns. Each row represents a different medication order. Each column represents a one-hour block of time. Scheduled administration times display as a due time at the intersection of a row and column.

The screenshot displays the MAR interface for a patient. The top section includes a 'Time Toolbar' with a play button and a date selector set to 8/8/2012. Below this are tabs for medication types: Scheduled, PRN, Continuous, All, Respiratory, Dialysis, Intraop, PACU, Procedure, ANE Intraop. A legend bar shows status indicators for Discontinued, Completed, Future, Not in Use, Read-only, and Cabinet Over. The main grid is titled 'Admission (Current) from 8/7/2012 in First Hill 9 Southwest' and is sorted by Medication Name. Two medication orders are visible:

- diphenhydramine (aka BENADRYL) tablet 25.50 mg**: Order Dose: 25.50 mg, Admin Amount: 1-2 Tab (1-2 x 25 mg Tab), Route: Oral, Freq: Q6H, Order Start Time: 08/07/12 1315. The 'Next 3 Scheduled' times are 08/08 0600, 08/08 1200, and 08/09 0000.
- docusate sodium (aka COLACE) capsule 250 mg**: Order Dose: 250 mg, Admin Amount: 1 Cap (1 x 250 mg Cap), Route: Oral, Freq: DAILY, Order Start Time: 08/07/12 1315. The 'Next 3 Scheduled' times are 08/08 0900, 08/09 0900, and 08/10 0900.

Red callout boxes highlight: 'Time Toolbar' (top right), 'Administration Times' (pointing to 0600), and 'Contact Pharmacy - NON Urgent matters' (pointing to a red Rx icon).

Unlike a paper MAR, the electronic MAR automatically rearranges itself as new orders are entered or existing orders are either completed or discontinued.

In the paper world, nurses use a paper version of the MAR that is fairly similar to the electronic version. The biggest difference is that medications listed on the paper MAR are either hand-written or based on labels that are printed out of the pharmacy system. Nurses then penciled in the times that meds are due or when a dose is given, held or missed. The electronic MAR handles these updates automatically based on orders placed by the physician and verified by the pharmacy.

You will perform the following tasks with guidance:

- Access and navigate the MAR activity
- Document medication administration actions
- Send messages to the pharmacy
- Verify medication orders
- Verify rates
- Document IV infusions

- Document TPN
- Document PCS

Access the MAR Activity

Two ways to access the MAR

1. From you're my List, select a patient's name and click the MAR button on the toolbar, [OR]



2. Open the patient's chart and click the MAR activity on the left hand side



The Time Toolbar

You can change the time block you are viewing by clicking the arrows on the either side of the time field. To change the date, click the **Calendar** icon in the **Start Date** field and select which day you would like to view. TO return to the current shift, click the **Current Time** button.

MAR Tabs

The MAR tabs filter medication based on certain criteria. Each tab represents a specific type of medication order. When you click on a tab, only medications of that type will display.

Scheduled	Medications are to be given at specific times
All	Lists all ordered medications
Continuous	Medications infused intravenously. Maintenance fluids and medication drips

PRN	Medications that are given as needed. These orders all have PRN frequencies. These orders do not have scheduled times on the MAR
Respiratory	Medications that are related to Respiratory
Dialysis	Medications that are related to Dialysis
Intraop	Used for Reference, to see what meds were given Intraop. Inpatient RN's do not document here.
PACU	Used for Reference, to see what meds were given in PACU. Inpatient RN's do not document here
Procedure	Used for Reference, to see what meds were given in the procedure suite. Inpatient RN's do not document here
ANE Intraop	Used for Reference, to see what Anesthesia meds were given Intraop. Inpatient RN's do not document here.

MAR Status Key/Legend

The MAR is color coded to help you easily recognize the status of medications. There are two legends. One helps define the medication status and the other defines the icons, administration types and links.



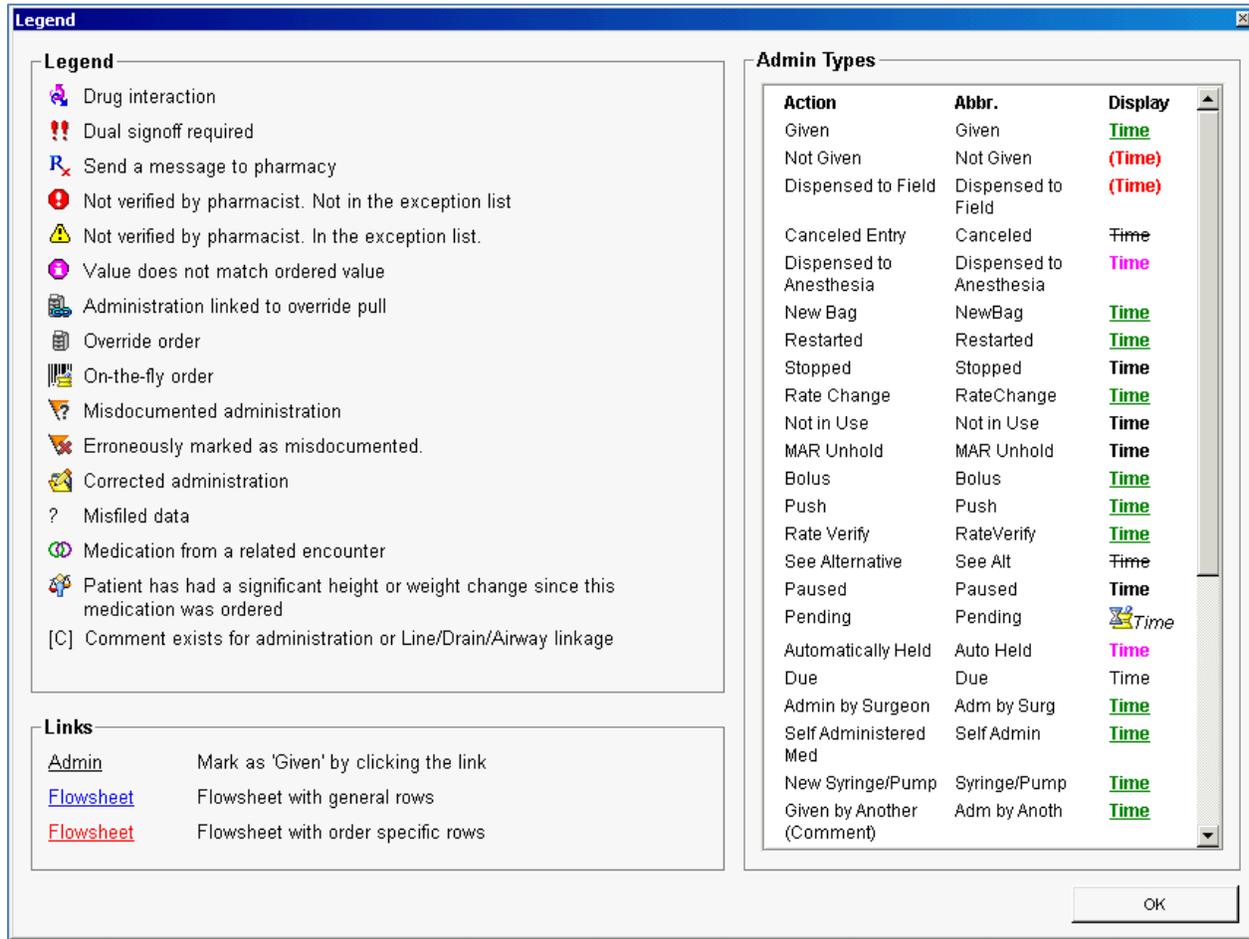
MAR Status Key

The medication statuses are color-coded and shade the medication row on the MAR table. The key to define these colors is located directly under the MAR tabs. Below is a quick reference list of some of the main color coding you might see on the MAR, and what each color means:

MAR Icons and Administration Types

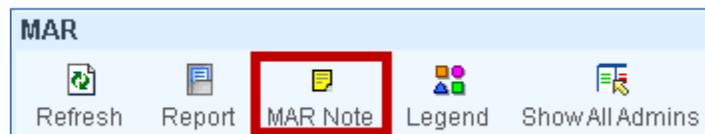


On the Activity Toolbar, there is a Legend button. Click Legend and you will find a definition for every icon and administration type that displays in the MAR table.

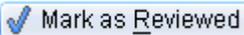


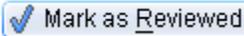
MAR Note

You can add general comments to the MAR by creating a MAR note. For example, you could add a note that, "The patient needs PO meds crushed in applesauce."



Review Allergies

It is required that allergies be reviewed with the patient on each admission, transfer and whenever there is a change in allergy status.  requires speaking directly to the patient and reaffirming their allergies.

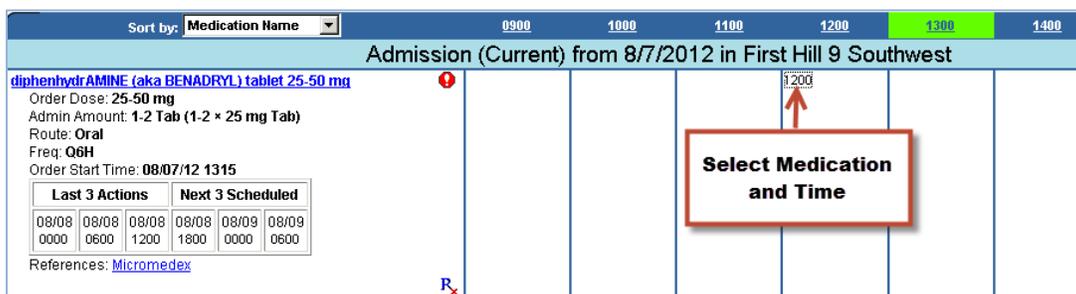
You can view the allergies on the patient header, but must go to the Allergy activity to I. . If the patient has multiple allergies and they are not all visible on the patient header, hover your mouse over the allergies and they will all display.

The patient has no known allergies. You need to review the patient's allergies and mark them as reviewed

1. Click the Allergies activity
2. Select the checkbox for No Known Allergies.
3. Click Mark as Reviewed.

Document a Scheduled Medication

1. Select the patient's medication and administration time.



Sort by: Medication Name

0900 1000 1100 1200 1300 1400

Admission (Current) from 8/7/2012 in First Hill 9 Southwest

diphenhydramine (aka BENADRYL) tablet 25-50 mg

Order Dose: 25-50 mg
Admin Amount: 1-2 Tab (1-2 x 25 mg Tab)
Route: Oral
Freq: Q6H
Order Start Time: 08/07/12 1315

Last 3 Actions			Next 3 Scheduled		
08/08 0000	08/08 0600	08/08 1200	08/08 1800	08/09 0000	08/09 0600

References: [Micromedex](#)

Rx

Select Medication and Time

2. Medication box will appear.



Select	Medication	Action	Date/Time	Route/Site	Dose/Rate	Comment												
<input checked="" type="checkbox"/>	diphenhydramine (aka BENADRYL) tablet 25-50 mg Order Dose: 25-50 mg Admin Amount: 1-2 Tab (1-2 x 25 mg Tab) Route: Oral Freq: Q6H Order Start Time: 08/07/12 1315 <table border="1"><thead><tr><th colspan="3">Last 3 Actions</th><th colspan="3">Next 3 Scheduled</th></tr></thead><tbody><tr><td>08/08 0000</td><td>08/08 0600</td><td>08/08 1200</td><td>08/08 1800</td><td>08/09 0000</td><td>08/09 0600</td></tr></tbody></table> References: Micromedex Flowsheet	Last 3 Actions			Next 3 Scheduled			08/08 0000	08/08 0600	08/08 1200	08/08 1800	08/09 0000	08/09 0600	Action: Given	Time: 1200 Date: 8/8/2012	Route: Oral Site: 	Dose: 25-50 mg	Comment:
Last 3 Actions			Next 3 Scheduled															
08/08 0000	08/08 0600	08/08 1200	08/08 1800	08/09 0000	08/09 0600													

In this case, the dose must be entered.

Accept Cancel

3. Review the administration details.
4. Click Accept.

View Administration Action on the MAR Table

Locate the medication on your MAR. It will be listed on either the All or Scheduled tab. The administration action displays in green with your initials and the time of the administration.

Sort by: Medication Name		0900	1000	1100	1200	1300												
Admission (Current) from 8/7/2012 in First Hill 9 Southwest																		
diphenhydramine (aka BENADRYL) tablet 25-50 mg						Given 1200 CG 25 mg												
Order Dose: 25-50 mg Admin Amount: 1-2 Tab (1-2 x 25 mg Tab) Route: Oral Freq: Q6H Order Start Time: 08/07/12 1315																		
<table border="1"> <thead> <tr> <th colspan="3">Last 3 Actions</th> <th colspan="3">Next 3 Scheduled</th> </tr> </thead> <tbody> <tr> <td>08/08 0000</td> <td>08/08 0600</td> <td>08/08 1200</td> <td>08/08 1800</td> <td>08/09 0000</td> <td>08/09 0600</td> </tr> </tbody> </table>		Last 3 Actions			Next 3 Scheduled			08/08 0000	08/08 0600	08/08 1200	08/08 1800	08/09 0000	08/09 0600					
Last 3 Actions			Next 3 Scheduled															
08/08 0000	08/08 0600	08/08 1200	08/08 1800	08/09 0000	08/09 0600													
References: Micromedex																		

Edit Details of an Administered Medication

1. Click the Given documentation in the cell for Benadryl.
2. Select the Edit administration check box to enable editing. The fields become active.

Select	Medication	Action	Date/Time	Route/Site	Dose/Rate	Comment												
<input checked="" type="checkbox"/>	diphenhydramine (aka BENADRYL) tablet 25-50 mg Order Dose: 25-50 mg Admin Amount: 1-2 Tab (1-2 x 25 mg Tab) Route: Oral Freq: Q6H Order Start Time: 08/07/12 1315	Action: <input type="text" value="Given"/>	Time: <input type="text" value="1200"/>	Route: <input type="text" value="Oral"/> Site: <input type="text"/>	Dose: <input type="text" value="25"/> mg	Comment: <input type="text"/>												
<table border="1"> <thead> <tr> <th colspan="3">Last 3 Actions</th> <th colspan="3">Next 3 Scheduled</th> </tr> </thead> <tbody> <tr> <td>08/08 0000</td> <td>08/08 0600</td> <td>08/08 1200</td> <td>08/08 1800</td> <td>08/09 0000</td> <td>08/09 0600</td> </tr> </tbody> </table>		Last 3 Actions			Next 3 Scheduled			08/08 0000	08/08 0600	08/08 1200	08/08 1800	08/09 0000	08/09 0600					
Last 3 Actions			Next 3 Scheduled															
08/08 0000	08/08 0600	08/08 1200	08/08 1800	08/09 0000	08/09 0600													
References: Micromedex Flowsheet																		
<input checked="" type="checkbox"/> Edit administration																		

3. Change the dose to 30

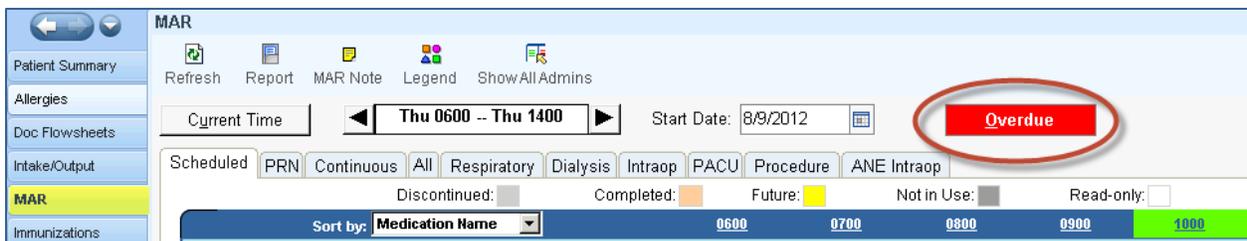
Select	Medication	Action	Date/Time	Route/Site	Dose/Rate												
<input checked="" type="checkbox"/>	diphenhydramine (aka BENADRYL) tablet 25-50 mg Order Dose: 25-50 mg Admin Amount: 1-2 Tab (1-2 x 25 mg Tab) Route: Oral Freq: Q6H Order Start Time: 08/07/12 1315	Action: <input type="text" value="Given"/>	Time: <input type="text" value="1200"/>	Route: <input type="text" value="Oral"/> Site: <input type="text"/>	Dose: <input type="text" value="25"/> mg												
<table border="1"> <thead> <tr> <th colspan="3">Last 3 Actions</th> <th colspan="3">Next 3 Scheduled</th> </tr> </thead> <tbody> <tr> <td>08/08 0000</td> <td>08/08 0600</td> <td>08/08 1200</td> <td>08/08 1800</td> <td>08/09 0000</td> <td>08/09 0600</td> </tr> </tbody> </table>		Last 3 Actions			Next 3 Scheduled			08/08 0000	08/08 0600	08/08 1200	08/08 1800	08/09 0000	08/09 0600				
Last 3 Actions			Next 3 Scheduled														
08/08 0000	08/08 0600	08/08 1200	08/08 1800	08/09 0000	08/09 0600												
References: Micromedex Flowsheet																	
<input checked="" type="checkbox"/> Edit administration																	

Document Overdue Medications

Identify Overdue Medications

A scheduled medication not administered within an hour of the scheduled time is overdue. A number of tools exist to alert clinicians of overdue medications. From Patient List, a column on you My List shows an icon for patients with overdue medications and MAR activity will show a red flag for overdue medications.

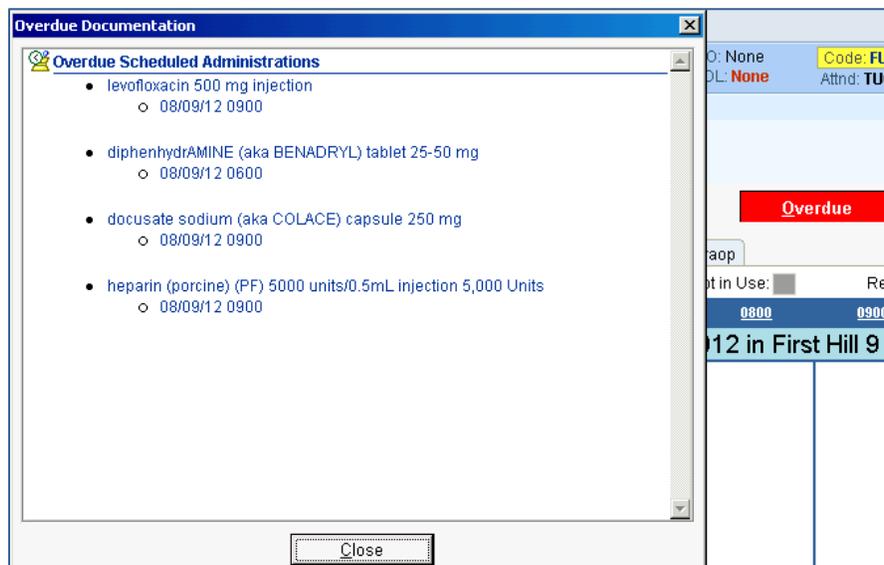
Bed ^	Patient	Age/Sex	Admitting Provider	Admit Dx	Med Overdue	Unack Ord
901P	Avocado, Mike F	68 y.o. / M	Tuggy, Michael L, MD	Pneumonia		



The screenshot shows the MAR interface for a patient. The 'Overdue' button is highlighted with a red circle. The interface includes a navigation pane on the left with options like Patient Summary, Allergies, Doc Flowsheets, Intake/Output, MAR (selected), and Immunizations. The main area shows the current time as 'Thu 0600 -- Thu 1400' and a start date of '8/9/2012'. There are filters for medication types (Scheduled, PRN, Continuous, All, Respiratory, Dialysis, Intraop, PACU, Procedure, ANE Intraop) and status (Discontinued, Completed, Future, Not in Use, Read-only). A timeline at the bottom shows time slots from 0600 to 1000.

Review Overdue Medications

1. Open your patient's chart.
2. Click the MAR activity.
3. Click the Overdue button. A list of all overdue medications displays.



The screenshot shows the 'Overdue Documentation' window. The window title is 'Overdue Documentation'. The main content area is titled 'Overdue Scheduled Administrations' and lists the following medications and their scheduled times:

- levofloxacin 500 mg injection
 - 08/09/12 0900
- diphenhydrAMINE (aka BENADRYL) tablet 25-50 mg
 - 08/09/12 0600
- docusate sodium (aka COLACE) capsule 250 mg
 - 08/09/12 0900
- heparin (porcine) (PF) 5000 units/0.5mL injection 5,000 Units
 - 08/09/12 0900

The window also shows a 'Close' button at the bottom. The background shows the MAR interface with the 'Overdue' button highlighted.

4. Click close after reviewing overdue medications.

Document an Overdue Medication

You saw that the docusate sodium (Colace) is overdue. The medication was unavailable at the time it was due.

1. Go to MAR activity.
2. Click on the **Overdue** button.
3. Locate docusate sodium (Colace).

The screenshot shows a software window titled "Overdue Documentation". On the left side, there is a sidebar with a red "Overdue" button. The main area displays a list of "Overdue Scheduled Administrations":

- levofloxacin 500 mg injection
 - 08/09/12 0900
- diphenhydramine (aka BENADRYL) tablet 25-50 mg
 - 08/09/12 0600
- docusate sodium (aka COLACE) capsule 250 mg
 - 08/09/12 0900
- heparin (porcine) (Document administration for this scheduled time)
 - 08/09/12 0900

A red box highlights the blue underlined date "08/09/12 0900" under the docusate sodium entry, with an arrow pointing to it. A text box below the arrow contains the instruction: "The blue underline is the hyperlink. Click the hyperlink". A "Close" button is located at the bottom right of the window.

4. The Medication displays.
5. Medication box appears.

Select	Medication	Action	Date/Time	Route/Site	Dose/Rate	Comment
<input checked="" type="checkbox"/>	docusate sodium (aka COLACE) capsule 250 mg Order Dose: 250 mg Admin Amount: 1 Cap (1 x 250 mg Cap) Route: Oral Freq: DAILY Order Start Time: 08/08/12 1315 Last 3 Actions: 08/08 1315, 08/09 0900 Next 3 Scheduled: 08/10 0900, 08/11 0900, 08/12 0900 References: Micromedex Flowsheet	Action: Given Due Given Admin by Surgeon Self Administered Med Given by Another (Comment) Downtime Documentation Device Fill/Refill Admin by Physician Start Patch Applied Not Given Dispensed to Field Dispensed to Anesthesia Canceled Entry Bolus Push Removed Infusion Stopped Infusion Restarted Completed Chemo Dose Check	Time: 0900 Date: 8/9/2012	Route: Oral Site:	Dose: 250 mg	Comment:

Click the drop down window and select 'Not Given'

By selecting 'Not Given' a Reason window will populate

Select	Medication	Action	Date/Time	Route/Site	Dose/Rate	Comment
<input checked="" type="checkbox"/>	docusate sodium (aka COLACE) capsule 250 mg Order Dose: 250 mg Admin Amount: 1 Cap (1 x 250 mg Cap) Route: Oral Freq: DAILY Order Start Time: 08/08/12 1315 Last 3 Actions: 08/08 1315, 08/09 0900 Next 3 Scheduled: 08/10 0900, 08/11 0900, 08/12 0900 References: Micromedex Flowsheet	Action: Not Given Reason: Med has not arrived	Time: 0900 Date: 8/9/2012	Route: Oral Site:	Dose: 250 mg	Comment: spoke to Jon Doe, pharmacist, is aware of urgency.

By selecting 'Not Given' a Reason window will populate

Additional comments, if necessary

Select	Medication	Action	Date/Time	Route/Site	Dose/Rate	Comment
<input checked="" type="checkbox"/>	docusate sodium (aka COLACE) capsule 250 mg Order Dose: 250 mg Admin Amount: 1 Cap (1 x 250 mg Cap) Route: Oral Freq: DAILY Order Start Time: 08/08/12 1315 Last 3 Actions: 08/08 1315, 08/09 0900 Next 3 Scheduled: 08/10 0900, 08/11 0900, 08/12 0900 References: Micromedex Flowsheet	Action: Not Given Reason: Med has not arrived	Time: 0900 Date: 8/9/2012	Route: Oral Site:	Dose: 250 mg	Comment: spoke to Jon Doe, pharmacist, is aware of urgency.

Click Accept

Accept Cancel

Upon returning to the MAR, the medication is noted with:

Sort by: Medication Name	0700	0800	0900
1800 0000 0600 1200 1800 0000 References: Micromedex			
docusate sodium (aka COLACE) capsule 250 mg Order Dose: 250 mg Admin Amount: 1 Cap (1 x 250 mg Cap) Route: Oral Freq: DAILY Order Start Time: 08/08/12 1315 Last 3 Actions: 08/08 1315, 08/09 0900 Next 3 Scheduled: 08/10 0900, 08/11 0900, 08/12 0900 References: Micromedex	Rx		Not Given (0900) CG [C]

[C] denotes the comment

Send a Message to Pharmacy

Pharmacy messages may be sent through Epic, however these messages are for non-urgent matters.

The screenshot shows the Epic 'Send Message to Pharmacy' window. The patient is 'Avocado, Mike F' and the subject is 'docusate sodium (aka COLACE) capsule 250 mg'. The reason is 'Missing medication'. The message field is empty, with a red box and arrow pointing to it labeled '4. Insert message here'. A 'Category Select' dialog box is open, showing a list of reasons with 'Missing medication' selected. A red box and arrow point to this selection with the label '3. Indicate reason for message'. In the background, the Medication Administration Record (MAR) is visible, with a red box and arrow pointing to the 'R_x' icon for the 'docusate sodium' medication, labeled '1. Message to Pharmacy selected. This is for NON-urgent matters.' Another red box and arrow point to the 'R_x' icon for the 'heparin (porcine) (PF) 5000 units/0.5mL injection 5.000 Units' medication, labeled '2. Message appears'.

Document a PRN Medication

Even though PRN medication do not have scheduled times, there are limitations to how often they can be administered. Before giving a dose of a PRN medication, you should verify the time of the last dose.

You can check for an action on the MAR activity and select PRN tab. The last date and time will display allowing you to calculate when the next dose is appropriate.

A nurse can document giving a PRN medication much like any other administration. Start by selecting the medication and clicking in the time you are going to administer. The administration window displays. The dose shows a range. Enter the dose being given. In the Comment box, type Pain Score 6/10, then Accept.

The screenshot shows the administration window for 'acetaminophen (aka TYLENOL) tablet 325-650 mg'. The order dose is '325-650 mg' and the admin amount is '1-2 Tab (1-2 x 325 mg Tab)'. The route is 'Oral' and the frequency is 'Q6H PRN'. The PRN reasons are 'Pain or Fever'. The admin instruction is 'Do not exceed the following amount of acetaminophen from all sources in 24 hours: Under 45kgs - 90mg/kg/day, 45kgs and over - 4 grams/day'. The order start time is '08/08/12 1300'. The 'References: Micromedex' link is highlighted with a red box and arrow, with a red box and arrow pointing to it labeled 'Micromedex is a resource used for dosing.'

Document a Medication Infusion

1. From the MAR activity, select the Continuous tab.
2. Select a time, 1300 column was the time selected.

Scheduled PRN **Continuous** All Respiratory Dialysis Intraop PACU Procedure ANE Intraop

Discontinued: Completed: Future: Not in Use: Read-only:

Sort by: Medication Name 0900 1000 1100 1200 **1300**

Admission (Current) from 8/8/2012 in First Hill 9 Southwest

D5-1/2NS (D5-0.45% NaCl) + KCl 20meq/L IV solution 1,000 mL ⚠

Order Dose: 1,000 mL
Route: Intravenous
Freq: CONTINUOUS
Ordered Infusion Rate: 100 mL/hr
Dispensed Volume: 1,000 mL
Order Start Time: 08/08/12 1300

Last 3 Actions Next 3 Scheduled

	08/08			
	1315			

References: [Micromedex](#)

Rx

3. The Administration window displays.
4. New Bag is the default Action

Select	Medication	Action	Date/Time	Route/Site	Dose/Rate	Comment
<input checked="" type="checkbox"/>	D5-1/2NS (D5-0.45% NaCl) + KCl 20meq/L IV solution 1,000 mL Order Dose: 1,000 mL Route: Intravenous Freq: CONTINUOUS Ordered Infusion Rate: 100 mL/hr Dispensed Volume: 1,000 mL Order Start Time: 08/08/12 1300	Action: New Bag	Time: 1333	Route: Intravenous	Dose: 1,000 mL	Comment:
			Date: 8/9/2012	Site:	Rate: 100 mL/hr	
					Order Concentration: 1 mL/mL	

Last 3 Actions Next 3 Scheduled

	08/08			
	1315			

References: [Micromedex](#)

[Flowsheet](#)

5. Verify the 5 rights.
6. Click Accept.

Doc Flowsheets

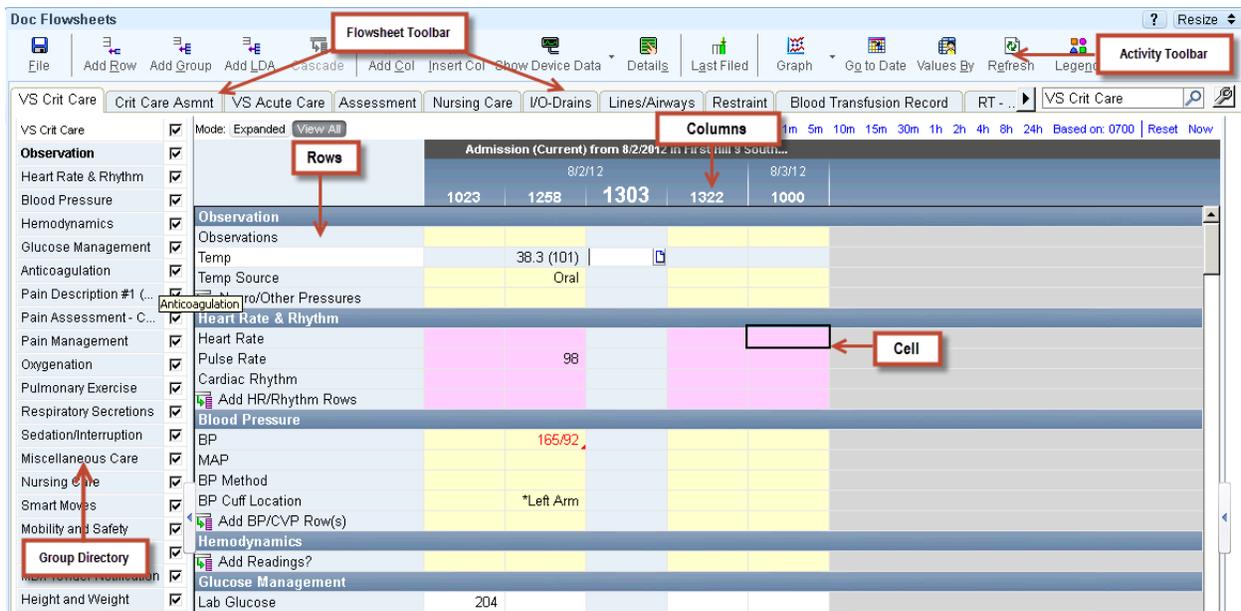
Doc Flowsheets Basics

You will use flowsheets to document many aspects of patient care including assessments and interventions. Flowsheets contain discrete data which can be used for research, core measure and occurrence reporting as well as other management reports.

Some flowsheets will be available through navigators, while others are only available in the Doc Flowsheets Activity because of length.

1. Click the **Doc Flowsheets** activity tab.
2. The flowsheet that opens by default is the VS flowsheet.

- To access other department specific flowsheets you can click the name of the flowsheet on the toolbar.



Finding Flowsheets Not on the Toolbar

The Flowsheet toolbar row can only hold so many buttons. Sometimes nurses may need to use flowsheets that do not readily appear on the button bar. There are 2 different ways to find hidden flowsheets. Additional flowsheets may be found by clicking the  or the , to the right of the flowsheets.

- Click on the  button at the end of the Flowsheet row. This will move the hidden flowsheets into view.
- Select any of the Flowsheets that appear. It will open automatically after selecting it.
- Click on  in the Flowsheet window.
- Scroll through the list and view the available flowsheets.
- The user may also search or scroll through the list and view the available flowsheets.
- Select any flowsheet on the list
- Click 'Accept'.

Adding a Column: For Current Assessment

Before documenting in the flowsheets on a patient's chart, it is crucial that you first add or insert a column to designate the time the assessment was performed. To enter data for the current time, use the 'Add Column' button.



1. Click .
2. A new column appears with current date and time. This is the column in which the user will document data for actions or assessments that they have just performed.
3. Click the 'Temp' cell in the time column that we just added and type '99.3F' (must insert 'F'; 'C' is optional).
4. Click in the next cell below for the 'Temp Source,' then click on  and select 'Oral'.
5. Click 'Accept'.
6. Your patient has abnormal values for 'Heart Rate' and 'BP'. Fill in your own abnormal values.

Inserting a Column: For Past Assessments

Occasionally, it is necessary to document actions that were performed in the past, because the nurse could not document directly after performing an assessment.



1. Click .

In the calendar window, enter the time the assessment was done (e.g., one hour ago) and then click 'Accept'. This inserts a column on the flowsheet for the appropriate time.

2. The nurse can now document in the column with the correct time.

3 Ways to Enter Flowsheet Data

Selection button (Selection Tool)

If you click in a cell and a **Selection button** icon displays on the right side of the cell, this indicates that there is a pre-built list of options to use when documenting in this particular cell.

1. Click the Temp Source cell. A selection button displays to the right of the cell.
2. Click the selection button.
3. Click Oral to select, your selection will display in the field.

Use Details to Document a Shift Assessment

An alternative method to document in a flowsheet is the Details Window. This function displays all choices of a cell in a single box and allows you to enter data with minimal checks.

The Details Window provides the following information:

- The row of the flowsheet that is currently in use.
- The responses available for selection in the current row.
- Value descriptions and definitions.
- Last filed value information.

1. Click the Heart Rate field
2. Click the Details button on the activity toolbar.

The Details window displays. The Details Window is a fixed window on the right side of your screen.

Free Text (Typing)

When no selection button is in a field, you must type data into that cell because there are no options for you to choose. The majority of free text fields are fields where numerical values are to be entered.



is the selection button, which requires a certain criteria to be selected.

You cannot free text in a field with a selection button . By typing a few letters in your search area , matching options may populate the field.

Enter/Edit Flowsheet Data

If you document in a flowsheet and edit unsaved entries that display in blue font before clicking file, there will be no tracking of your edit. However, if the information is filed displaying in black font, an audit trail will track those edits.

Enter Vitals at Current Time

1. Click the Temp cell and type '99.3F'.



2. Click .
3. Return to the Temp cell and delete 99.3F and enter '104.3F' and press Enter.
4. There is now a dark red triangle in the upper right corner of the cell indicating the cell has been edited. 

Add Flowsheet Comments

You can add comments to any cell in a Doc Flowsheet. Comments are a way for you to further explain a single piece of data or indicate specific information that may not be listed as a choice in the field. Adding comments is one of the preferred methods for nurses to document in a chart.

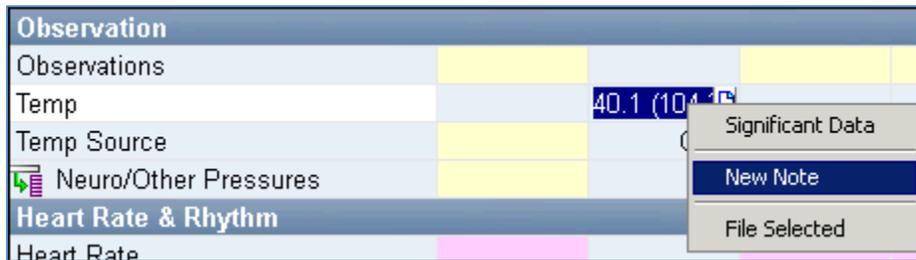
1. While in the 'Temp' cell, click on the .
2. In the Comment box, enter 'patient complained of chills' then click 'Accept.' The comment icon has changed to indicate a comment was written.

Create Flowsheet Notes

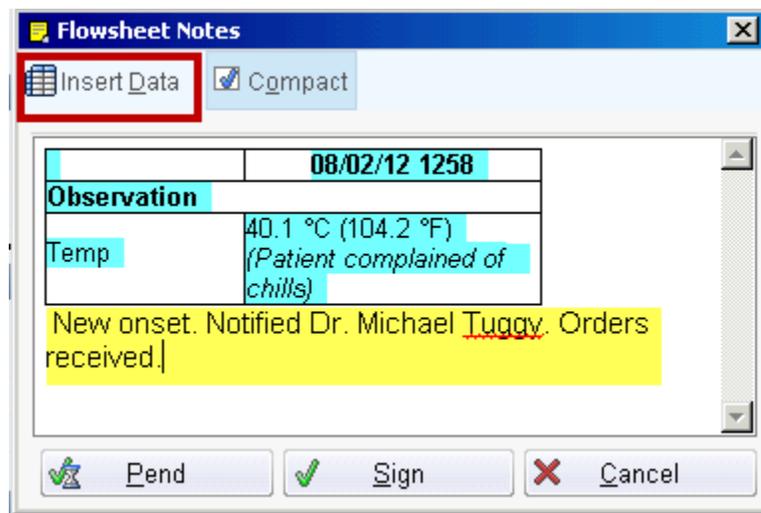
Besides adding a comment for a single piece of data, you can also create an entire note for either a single piece of data or for multiple entries that merit further explanation. Flowsheet notes display in the notes Activity as a Progress Note for all other clinicians to view.

The patient has an elevated temperature of 104.3. You want to indicate that you contacted Dr. Michael Tuggy.

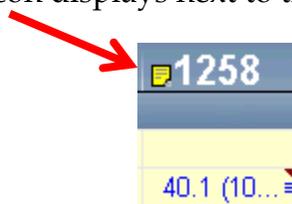
1. Click the Temp cell. The data highlights in blue.
2. Right click in the cell and select New Note. The flowsheet Notes window displays.



3. Click Insert Data. The data that you highlighted will display in the new not.
4. Scroll down under the data table and type a note stating: New onset. Notified Dr. Michael Tuggy. Orders received.



5. Click Accept. A yellow icon displays next to the time for that column

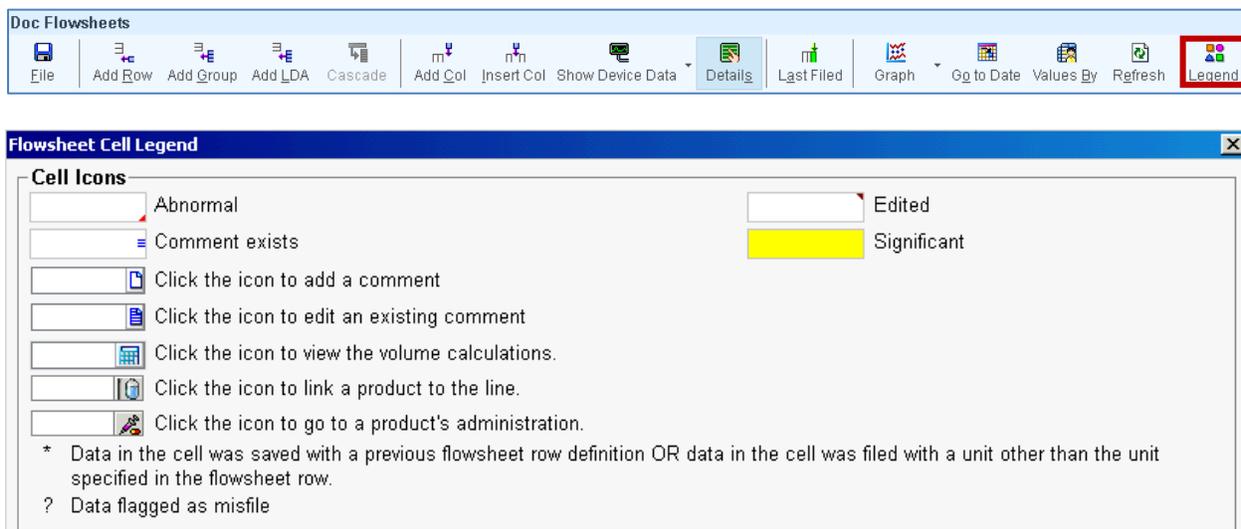


View Flowsheet Comment

1. Double-click the yellow icon and the note will display [OR]
2. Right click any cell that has the  icon and click View Notes. The note will display.

View Flowsheet Legend

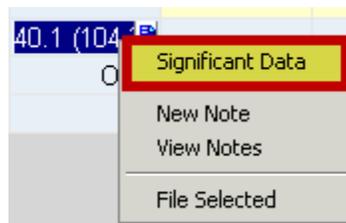
To obtain additional information regarding the data entered in the flowsheet, the **Legend** is accessible through the **Toolbar**.



Indicate Significant Data

Marking data significant creates a yellow highlight to call attention to the information.

1. Right click in the Temp cell.
2. Select Significant Data.
3. Click in any other cell.



The entire cell is highlighted in yellow. When reviewing patient reports, data marked significant displays highlighted in yellow for all users.

Document a Pain Assessment

This flowsheet will be used throughout your shift to document your patient's pain.

1. Click the Doc Flowsheets activity.
2. Click the VS Flowsheet.
3. Locate Pain Description in the group directory.
4. Click Details in the activity toolbar.
5. Add a column to document an assessment for the current time.

Restraints

During the rounding process, the provider can manage existing restraints orders by modifying, re-ordering (expected every 24 hours), or discontinuing orders as appropriate.

After a certain period of time, restraints orders are built to automatically expire based on the specific order (adult, pediatric, violent, and non-violent).

Face -to-face evaluations are to be completed by Physicians every 24 hrs. to maintain restraints.

- Medical restraints are evaluated with 12 hrs. of admission
- Violent restraints are evaluated within 1 hr. of admission

Order Medical Restraints

Your patient is confused and has been pulling at his IV lines since returning from surgery. You call the physician to recommend the patient be placed under non-violent restraints for his safety. The physician agrees and asks you to place the orders in Epic.

1. Click Order Entry activity
2. Type 'restraints in the New order search field. Press Enter.
3. Select 'Restraints Non-Violent'. Click Accept.

The Summary Sentence displays:

4. Click the Summary Sentence. The Order Composer displays.

Order Modes

Nursing and Pharmacy will utilize the following Order Modes to place orders:

Order Mode	Definition	Physician Cosign Required	Example
VORB / TORB	Order(s) is being placed as a result of a verbal or telephone order from an LIP	Yes	Entering an order for a medication given as a result of a VORB during a procedure, orders taken as a result of a phone discussion related to a change in the patient's condition.
Emergency	HUCs who enter non-medication orders during a true emergency	Yes	Code Blue
Standard	Order is within your scope of practice and it will not generate a message for a co-signature for the physician.	No	Specialty beds or other equipment the patient might need
Per Guideline	Order is being placed as a result of an LIP ordering a protocol.	No	Ordering SCDs after the "DVT Protocol" order has been paced or ordering an IV restart once the IV has been ordered. MRSA test of patients in the ICU, orders from the normal hospital newborn orderset.

Lab Orders

Specimen Collection Workflow: Lab Collect vs. Unit Collect

The system recognizes whether the nurses on your unit collect specimens or not. If you are a Unit Collect, once the order is entered into Epic, a task will display on the Active Orders report with hyperlink. If not, the requisition will print in the Lab or Blood Bank for collection.

The default order class can be changed by the nurse for all lab orders in the Order Revision activity.

1. Go to the Patient Summary Activity.
2. Locate Lab Orders.
3. Locate Urinalysis with Culture if Indicated.

Lab Orders			
Lab Active Orders Needing Specimen Collection		** None **	
Lab Active Orders Expand			
Start			Ordered
08/07/12 0700	▶ CBC AM DRAW 0700, Routine		08/06/12 1311
08/07/12 0000	▶ URINALYSIS WITH CULTURE IF INDICATED ONCE, Routine	Collect	08/06/12 1311

4. Click Collect.
5. Collect initiates lab slip needed to submit the specimen.
6. Retrieve the lab slip and take it with you to the room to collect the specimen.

Reprint Lab Labels

1. Go to Patient Summary activity.
2. Click Index Report
3. Locate Orders.
4. Click Requisition Reprint

Orders	REQUISITION REPRINT	Cancel/D/C/Completed Orders
Active Orders Held/Unsigned Orders Order History Past 12 Hours Active Orders by Order Set		Order History Requisition Reprint

Pathology and Cytology Orders

Pathology & Cytology orders are entered into Epic.

Pathology and Cytology orders will appear on the Active Orders report as a task to be completed, if on a Unit Collect. The nurse will print the requisition, which accompanies the specimen to the lab, the labels, and document the collection.

Results for both Cytology and Pathology will appear in Results Review under the Pathology/Cytology/Histology section.

Specimen Source Documentation

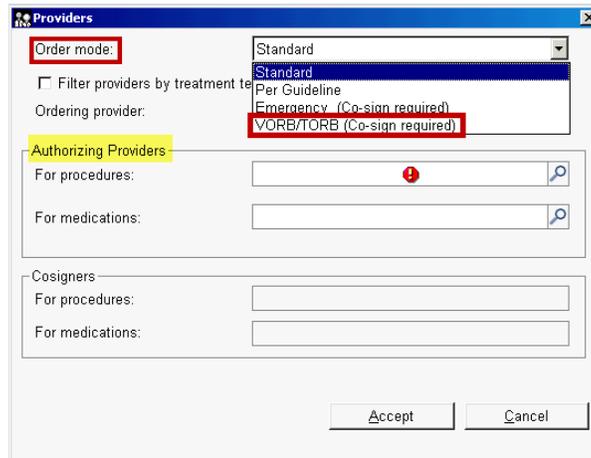
In some instances a Physician may place an order using VORB/TORB indicating the specimen source in the Order Composer. When this happens and the lab order is unit collect, you will be required to indicate the specimen source when printing.

Assign the Authorizing Provider

1. Click Sign Orders. The Providers window displays.



2. Verify the Order Mode is Standard, Per Guideline, Emergency or VORB/TORB.



3. Type 'Tuggy, Michael' in the Ordering Provider field. Dr. Tuggy's name will auto populate the remaining Authorizing Providers fields.
4. Click Accept.

Add-on Lab Orders

Dr. Michael Tuggy wants to place an additional lab order for a Serum Magnesium.

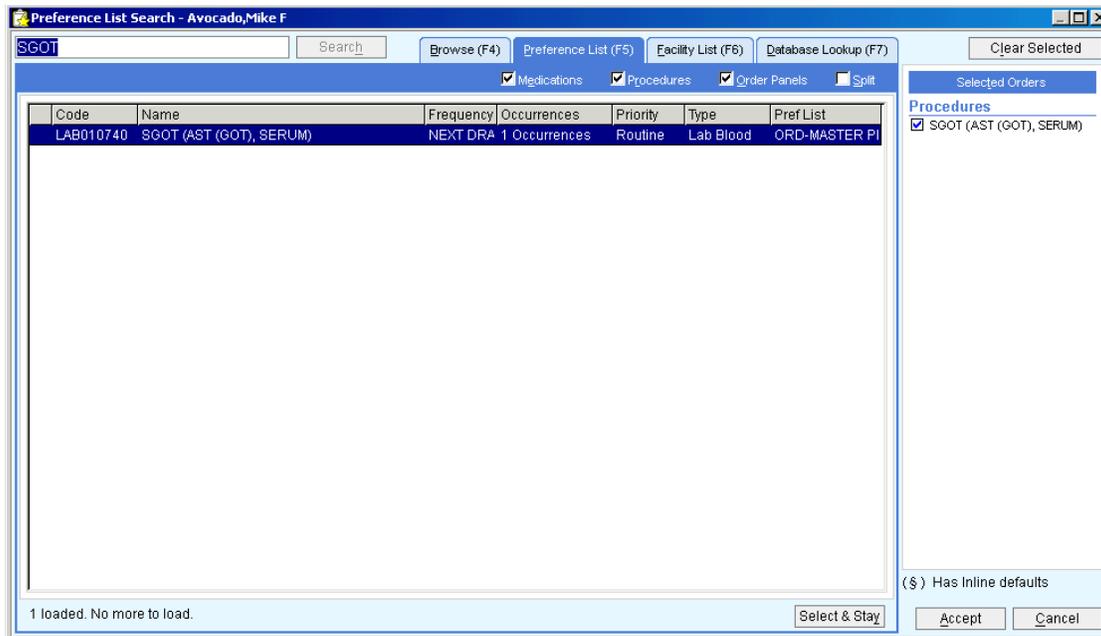
1. Type "mag" in the New Order field, and press Enter.
2. Select Serum Magnesium and click Accept.
3. Click the Summary Sentence. The Order Composer displays.
4. Click the selection button in the Priority field and select Add-On.

Assign the Authorizing Provider

1. Click Sign Orders.
2. Verify that the Order Mode is VORB/TORB.
3. Type "Tuggy, Michael" in the Ordering Provider field.
4. Click Accept.

Enter Multiple Orders

You can enter multiple orders and sign them all at once. After searching for the first order, click **Select & Stay** in the Preference List Search window. It will create a shopping cart of orders in the Selected Orders pane, to the right. Once you have completed entering all orders, click **Accept**. You can then set parameters for each order selected. When all orders are as the physician has requested on the telephone, sign all the orders as you would for a single order.



Blood Transfusion

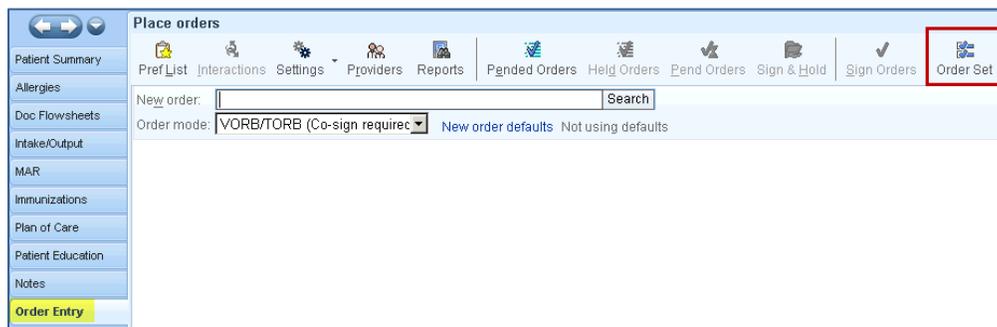
Blood Transfusion Order

The patient's hemoglobin is low. You call Dr. Tuggy and he has given you a telephone order for 1 unit of packs of RBCs. You work on a unit collect floor. After calling the lab, you determine the specimen drawn earlier is insufficient for further testing.

There are two orders placed when ordering a transfusion. **Type and Crossmatch** (blood bank lab order) and **Transfuse** order (nursing order). Both orders will display on the Index and Active Orders reports to be acknowledged.

If a Transfuse RBC order is placed and a Crossmatch is needed, an alert will appear that allows the Crossmatch to be ordered. Both Type and Screen and Crossmatch are prerequisites for Transfusion.

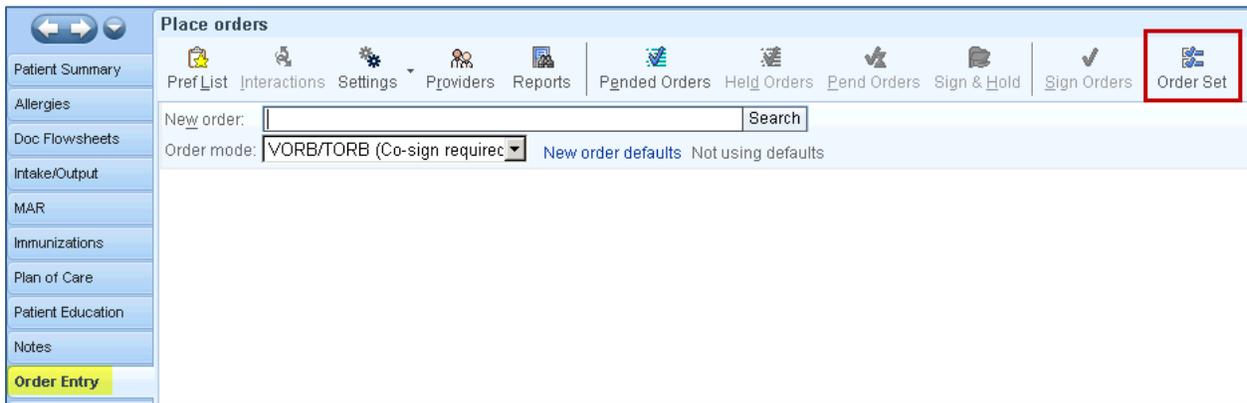
1. Click Order Entry



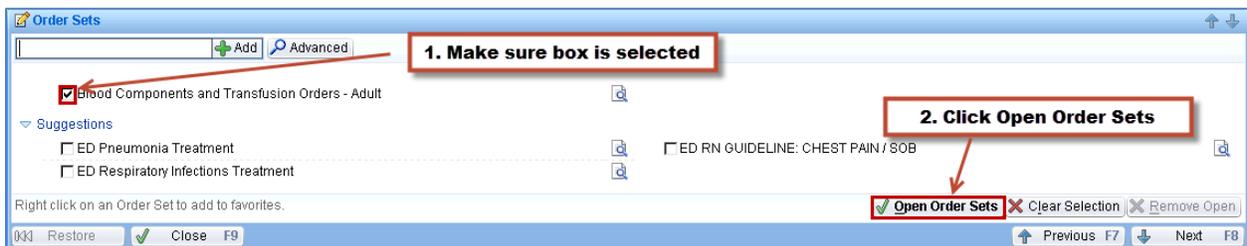
2. Click Order Sets and type 'Gen Blood Comp'



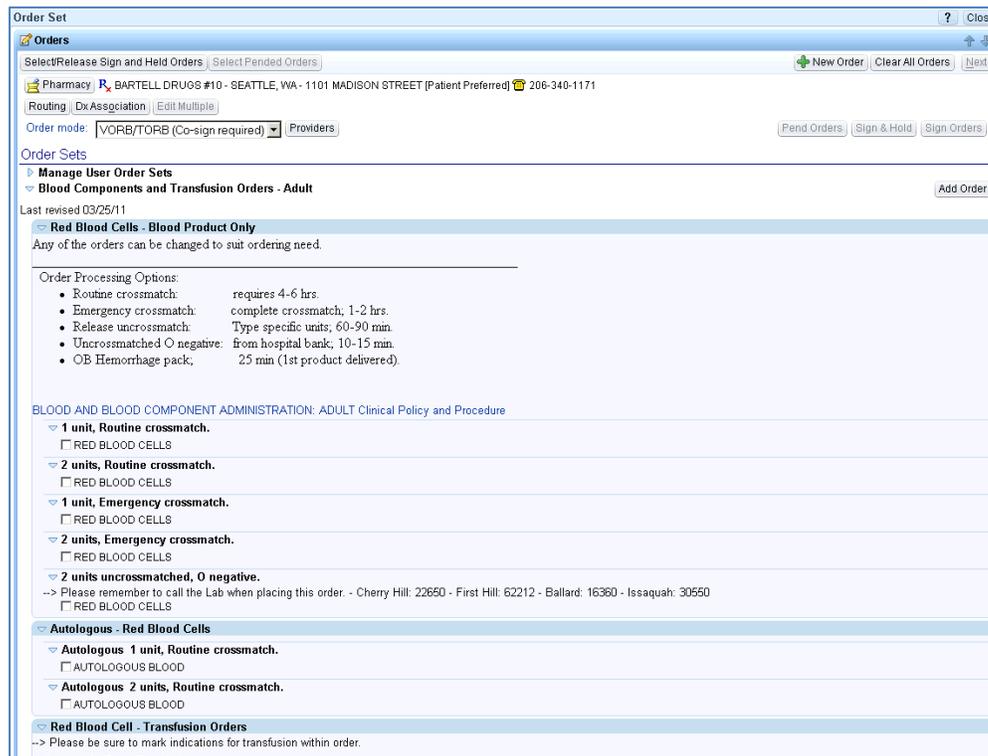
3. Type 'Gen Blood Comp'



4. Make sure the check mark is on Blood Components and Transfusion Orders – Adult and click Open Order Sets.



5. Order set opens and physician will provide specifics for order.

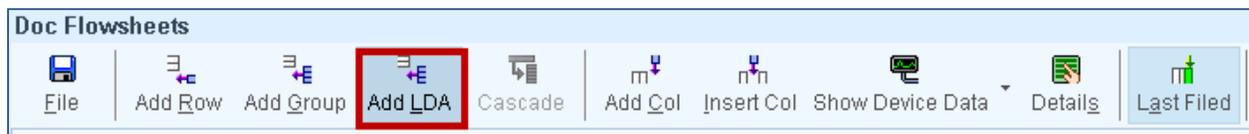


LDAs

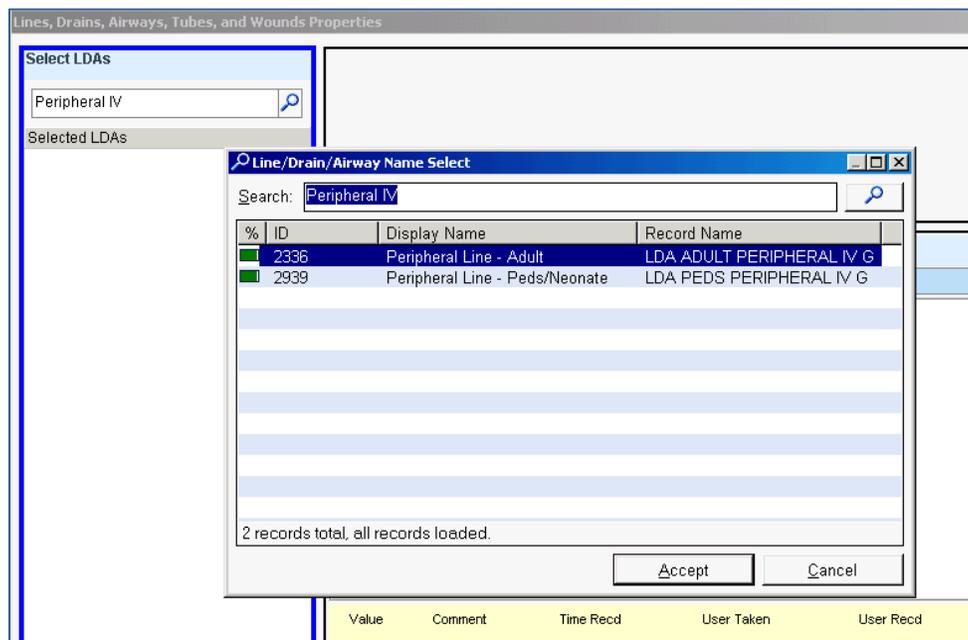
Document an IV Line Insertion

You have just placed a 20 gauge IV in the right forearm of your patient on the first attempt.

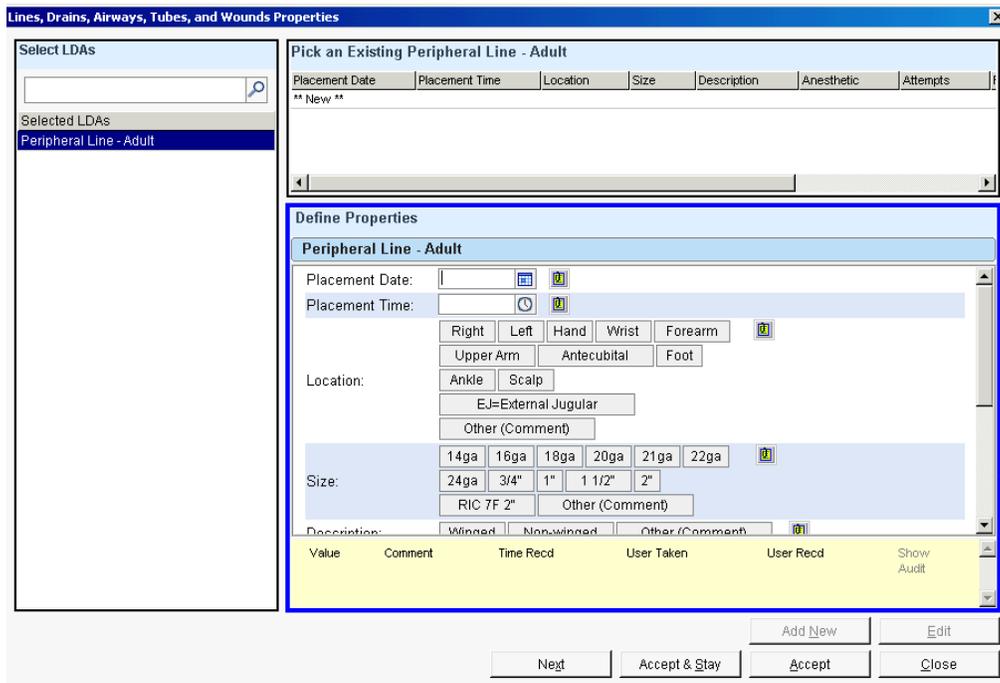
1. Click the Doc Flowsheets activity.
2. Click the Lines/Airways Flowsheet.
3. Add a column to document an assessment for the current time.
4. In the Activity Toolbar, click Add LDA selection button icon.



5. Type Peripheral IV. The Properties window displays. Highlight and Accept.



6. Fill out information accordingly and Accept.



When you accept the LDA properties, a Peripheral IV Group is added to the Lines/ Airways flowsheet. Next you will document your site assessment using the rows in the new Peripheral IV group.

Document the Assessment

Based on what you have just learned about flowsheets, document the assessment finding for the line you just started.

1. Add a column to document an assessment for the current time.
2. Place your cursor in the Site Assessment row in the new column.
3. Click Details.

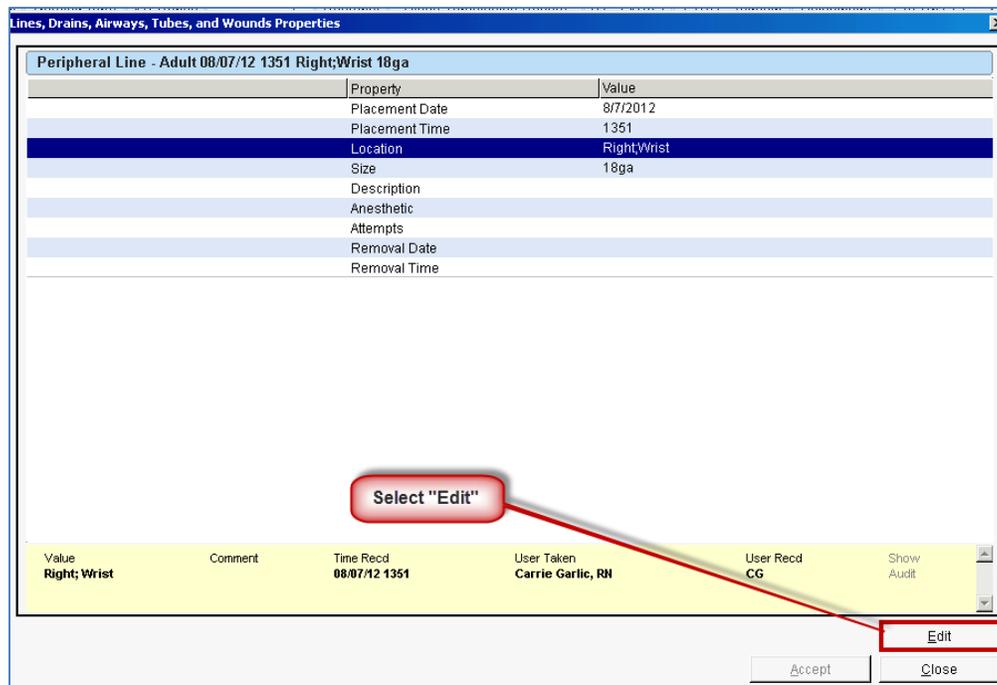
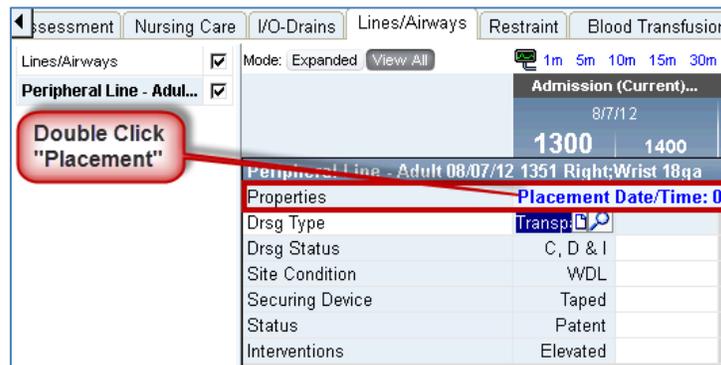
Use the following information to complete the site assessment:

Field	Data
Drsg Status	C, D & I
Site Condition	WDL
Securing Device	Taped
Status	Patent
Interventions	Elevated

Discontinue an Active Line

If the flowsheet indicates a LDA that is not currently present upon your assessment of the patient, it is the responsibility of the Nurse on duty to discontinue the line and update the flowsheet accordingly. The Nurse can do this even if they were the not the clinician who discontinued the LDA.

Lines are not automatically discontinued at the time of discharge. If a nurse does not document the removal of the line at discharge, it will show as active in Patient Summary reports the next time the patient is admitted to the hospital.



Lines, Drains, Airways, Tubes, and Wounds Properties

Peripheral Line - Adult 08/07/12 1351 Right;Wrist 18ga

Placement Date: 8/7/2012
 Placement Time: 1351

Location: Right Left Hand Wrist Forearm Upper Arm Antecubital
 Foot Ankle Scalp EJ=External Jugular Other (Comment)

Size: 14ga 16ga 18ga 20ga 21ga 22ga 24ga 3/4" 1" 1 1/2" 2"
 RIC 7F 2" Other (Comment)

Description: Winged Non-winged Other (Comment)

Anesthetic: Buffered Lidocaine 1% Lidocaine 1% None Other (Comment)

Attempts: x1 x2 x3 x4 x5 x6 Unsuccessful attempt
 2nd Inserter called Ultrasound guided
 Other (Comment)

Removal Date:
 Removal Time:

Indicate removal date & time;
 t = today; n = now

If date & time of removal is unknown, use current date & time.
 Include 'comment' here (i.e. LDA not removed in Epic but removed previously from patient).

Value	Comment	Time Recd	User Taken	User Recd	Show Audit
8/7/2012		08/07/12 1351	Carrie Garlic, RN	CG	

Upon completion, click "Accept"

Accept Close

I/O - Drains

Intake and output values are documented on their own Doc Flowsheet, utilizing the flowsheet functionality. When a drain or catheter is added to the I/O - Drains Flowsheet, rows are automatically added to allow for documentation of the drain.

Doc Flowsheets

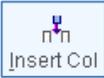
VS Crit Care Crit Care Asmnt Nursing Care I/O-Drains Lines/Airways Restraint Blood Transfusion Record RT - ADULT Triage Start

Mode: Expanded View All

	Admission (Current) from 7/31/12 to 8/1/12		
	7/31/12	1900	0400
Oral			1100
Oral Intake	100	200	250
Diet Intake		Ate 33%	Ate 50%
IV			250
Piggyback/Other			
DS 1/2 NS w/KCl 20mEq Volume			
IV Fluids - Misc			
Misc IV Fluid			
Miscellaneous IV Fluid			
Other Intake			
Other Intake			
Urine			
Additional Urine Rows?			
Voided Amount	125		125
Color	Yellow...		
Appearance	Clear		
Unmeasurable Output			
Emesis			
Emesis Description		100	
Stool			
Stool			
Mixed Urine/Stool Volume			
Stool Volume			
Date of Last BM			
Other Output			
Other Output			
Other Output			
OR Intake & Output			
Show More Rows?			
OR Crystalloid			
OR Red Blood Cells			
OR Urine Output			
OR Estimated Blood Loss			

Document I/O

It is the end of the shift, you are collecting your final I/O for the shift. Your patient has 600 ml of oral intake throughout the shift today. In addition, there is a 500 ml of clear, yellow urine in the Foley bag. Document these end of shift totals.

1. Open the patient's chart.
2. Click on 'Doc Flowsheets' activity
3. Select the 'I/O-Drain' flowsheet
4. Click . The Date/Time Entry window appears.
5. In the Time field, enter 1000 to reflect this occurrence.
6. In Oral Intake row, enter 600
7. Under Urine, enter 500 for the Voided Amount
8. Enter the color and appearance.

Document Tubes and Drains

Documenting the insertion of tubes and drains is done in the I/O - Drains flowsheet. Enter the properties and then complete an assessment. Output from tubes and drains is documented on the I/O - Drains, as well as ongoing assessments (site conditions, status, etc.) and removal documentation.

Document NG Tube Properties

Once a NG Tube has been added in the I/O - Drains, NG Tube volumes and residual rows display and can be recorded on the I/O - Drains flowsheet.

Use the following information to complete the nutrition assessment:

Field	Data
Type of Feeding Tube	NG Tube
Taped at (cm)	30
Interventions	Flushed
Suction	N/A
Residual	10 ml

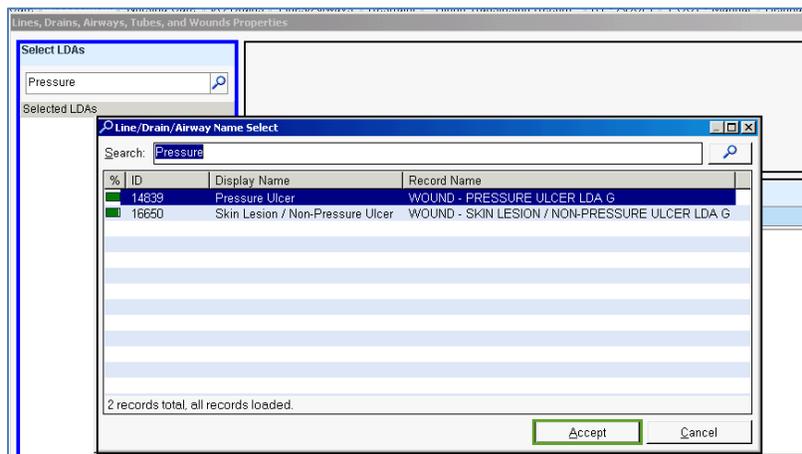
Skin/Wound/PU Flowsheet

Skin, wound, and pressure ulcers are documented in the **Assessment** flowsheet. Like LDAs, you will first document the properties and then complete an assessment.

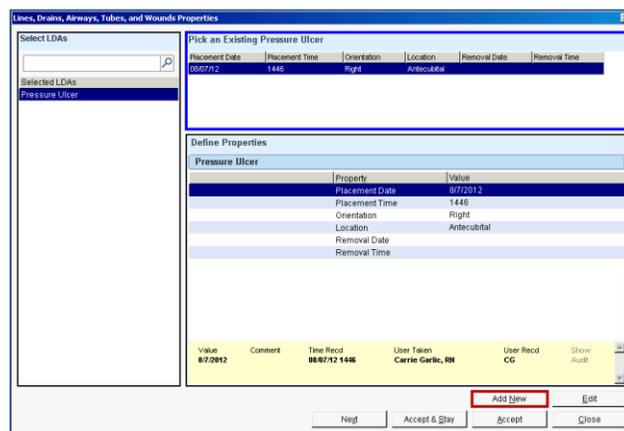
Document a Pressure Ulcer



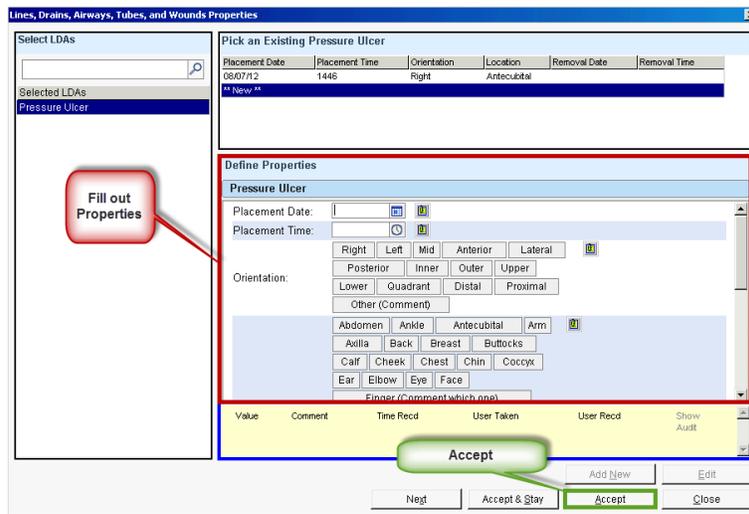
1. Select
2. Type 'Pressure' and Enter, select highlighted 'Pressure Ulcer' and click Accept.



3. Add New



4. Fill out 'Properties' and Accept.



The **Pressure Ulcer** group will display with the properties identifying the date, location, orientation, and location.

5. Chart the pressure ulcer assessment.

Doc Flowsheets

File | Add Row | Add Group | Add LDA | Cascade | Add Col | Insert Col | Show Device Data | Details | Last Filed | Graph | Go to Date

Acute Care | Assessment | Nursing Care | I/O-Drains | Lines/Airways | Restraint | Blood Transfusion Record | RT - ADULT | POCT - M:

Assessment Mode: Expanded View All 1m 5m 10m 15m 30

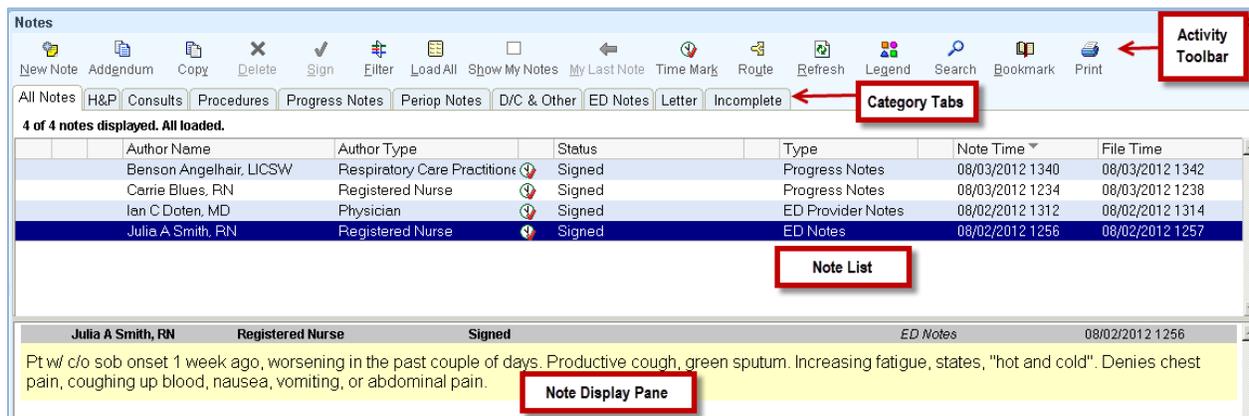
	Admission (Current)...	
	8/6/12	8/7/12
	1303	1300
Pressure Ulcer 08/07/12 1456 Right Elbow		
Properties	Placement Date/Time: 08/07/12 1456 Orientation: Right Location: Elbow	
Ulcer Size (Approximate)(cm)		
Staging (done by CWON Only)		
Site Assessment		
Drainage Character		
Ulcer Covering		
Dressing Status		
Interventions		
Dressing Change		

Your patient has a pressure ulcer with a small amount of serosanguineous drainage on his right elbow that was present on admission. You need to document the initial assessment. It is currently covered with a gauze dressing.

Notes

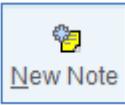
The Notes activity stores all notes related to the current encounter only. The activity is divided into tabs to help find a specific note type quickly. RNs will use the Notes activity to document patient information. Notes entered in the Notes Activity are a permanent part of the patient's record.

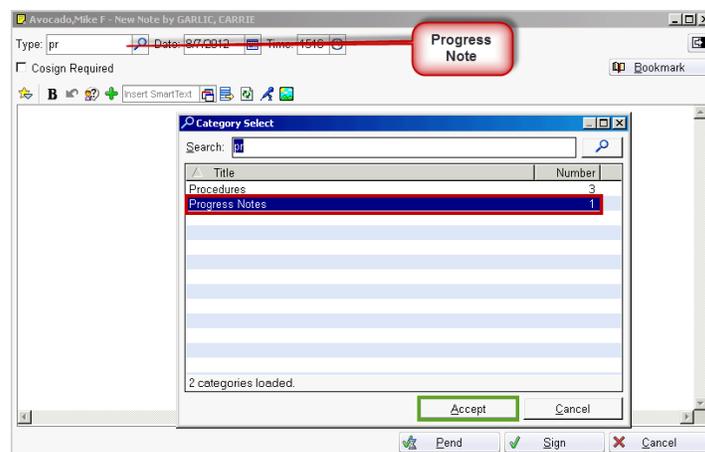
RN's have the ability to enter a progress note to document.



Document a Note

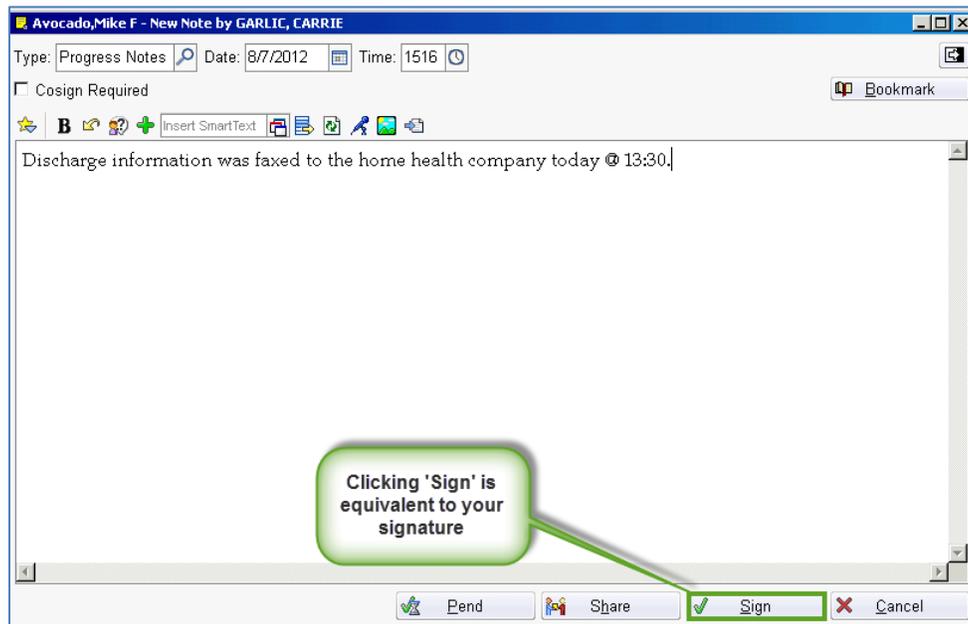
Document that the discharge information was faxed to the home health company.

1. You should still be in your Patients chart.
2. Select  in the activity list and the Notes activity opens.
3. Click  the Note window opens to with current date and time.
4. Type of Note: Progress Note



5. Click Accept.

Document your note.



6. Sign your note

View Existing Notes

When you select an entry in the upper pane, the note will display for your review in the lower pane.

1. Click Notes activity.
2. Select a note written by a registered nurse. The note displays in the lower pane for your review.

Author Name	Author Type	Status	Type	Note Time	File Time
Ian C Doten, MD	Physician	Signed	ED Provider N	08/01/2012 1312	08/01/2012 1314
Julia A Smith, RN	Registered Nurse	Signed	ED Notes	08/01/2012 1256	08/01/2012 1257

Julia A Smith, RN	Registered Nurse	Signed	<i>ED Notes</i>	08/01/2012 1256
--------------------------	-------------------------	---------------	-----------------	-----------------

Pt w/ c/o sob onset 1 week ago, worsening in the past couple of days. Productive cough, green sputum. Increasing fatigue, states, "hot and cold". Denies chest pain, coughing up blood, nausea, vomiting, or abdominal pain.

3. Select a note written by a physician. The note displays in the lower pane for your review.

Note Category Tabs

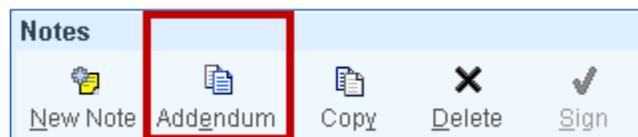
You can sort notes by category. The default category is **All Notes**. When you want to view a different type of note, click the corresponding category tab and only those types of notes display.

Addend a Note

You can create an addendum for any note that has been saved. The addendum will become the new note of record. However, the original note will be linked to the addendum and remain a permanent part of the patient record.

You accepted the occurrence note but became aware there was an additional witness. You need to add Olive Oil, RN to the list of witnesses in the note.

1. Select the note you just wrote.
2. Click Addendum.



The original note will display in the top pane and remains a permanent part of the patient record. The same note displays in the lower pane but it is editable.

Notes

New Note Addendum Copy Delete Sign Filter Load All Show My Notes My Last Note Time Mark Route Refresh Legend Search Bookmark Print

All Notes H&P Consults Procedures Progress Notes Periop Notes D/C & Other ED Notes Letter Incomplete

1 of 1 note displayed. All loaded.

Author Name	Author Type	Status	Type	Note Time	File Time
Carrie Garlic, RN	Registered Nurse	Addendum	Progress Notes	08/07/2012 1516	08/07/2012 1531

Carrie Garlic, RN Registered Nurse Addendum Progress Notes 08/07/2012

Discharge information was faxed to the home health company today @ 13:30.

Spoke to Balsamic Vinegar at home health company and he states that their fax is not working.

▶ Revision History...

The new note is linked to the original note using the **Revision History**.

Delete a Note

1. Highlight note to be deleted.
2. Select 'Delete' button on the Toolbar.

Notes

New Note Addendum Copy Delete Sign Filter Load All Show My Notes My Last Note Time Mark Route Refresh Legend Search Bookmark Print

All Notes H&P Consults Procedures Progress Notes Periop Notes D/C & Other ED Notes Letter Incomplete

1 of 1 note displayed. All loaded.

Author Name	Author Type	Status	Type	Note Time	File Time
Carrie Garlic, RN	Registered Nurse	Addendum	Progress Notes	08/07/2012 1516	08/07/2012 1531

Admission (Current) from 8/6/2012 in First Hill 9 Southwest

3. Box appears requiring reason for deletion.

Arriving a Patient

The Transfer navigator streamlines the review and documentation for a patient being sent out of a unit and a patient arriving to a unit. It is a single navigator with two templates: one for transfer out and the other for arrival in. Both the sending and receiving nurse will use the same navigator, but will complete their documentation on the appropriate template. Once you select the activity, the Transfer template displays by default. If you are the receiving nurse completing the patient's arrival, you need to click the Arrival template.

Avocado, Mike F
1001456140

68 y.o., M, 11/16/1943
Bed: 901P

Ht: 180 cm (5'10.87")
Wt: 99.8 kg (220 lb 0.3 ...)

BMI: 30.8...
Allergies: Penicillins

ISO: None
C.OL: None

Code: FULL
Attn: TUGGY, MICHAEL L [101140]

Transfer

- Transfer
- Nurse Snapshot
- Active Orders Rpt
- Plan of Care
- Progress Notes
- Belongings

My Progress Notes (last 24 hours)

Author	Service	Author Type	Cosign	Status	File Time	Note Time
Carrie Blues, RN		Registered Nurse		Signed	08/03/2012 1238	08/03/2012 123

Carrie Blues, RN Registered Nurse Signed 08/03/2012 1238

Addend Delete

Observation

Temp	08/02/12 1258
40.1 °C (104.2 °F)	(Patient complained of chills)

New onset. Notified Dr. Michael Tuggy. Orders received.

Belongings

New Reading | Go to Doc Flowsheets

No data found.

Primary Focus

1. Plan of Care
 - a. This should be reviewed prior to transfer
 - b. Updated as needed
2. Progress Notes
 - a. A note should be documented to explain the reason for transfer
 - b. Enter as a Progress note.
3. Belongings
 - a. Verify belongings
 - b. Make sure belongings are transferred with patient.

The Transfer activity allows these navigators to be easily accessible during a transfer.

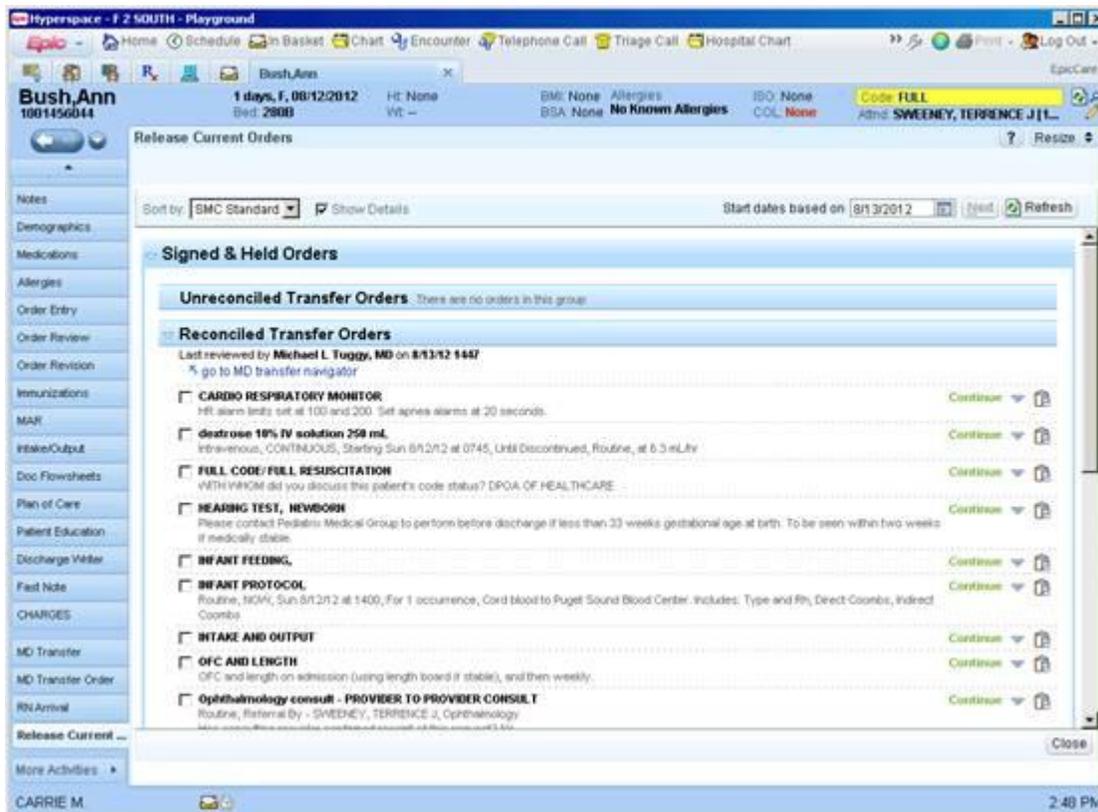
RN Arrival Navigator

Prior to the transfer of a patient to a new unit, the physician places the transfer order. The physician then “signs and holds” the transfer order.

1. Go to RN Arrival Navigator.
2. On the right portion of the screen, under Orders, click the hyperlink:

[\[Click HERE to launch Order Release Navigator \]](#)

3. Review the Reconciled Transfer order that were signed and held by the physician.



4. Scroll down and click ‘Select all reconciled transfer orders’



5. Click Release.

Admitting a Patient

Admission Navigator

The Admission Navigator streamlines the review and documentation for an admission. Whether the patient is admitted from the ED or a Direct Admit, you only use this navigator once during the entire hospital stay.

Access the Admission Navigator

1. Open your patient's chart.
2. Click the RN Admission activity. The Admission Navigator displays.

The screenshot shows the Admission Navigator interface for patient Avocado, Mike F. The patient's information is displayed at the top: 68 y.o., M, 11/15/1943, Bed: 901P, Ht: 180 cm (5'10.87"), Wt: 99.8 kg (220 lb 0.3...), BMI: 30.8..., Allergies: Penicillins, ISO: None, COL: None, Code: FULL, Attn: TUGGY, MICHAEL L [101140].

The interface is divided into several sections:

- Admission Summary:** Includes ED Encounter Summary, Belongings, Allergies, Home Medications, SureScripts Payer Disclaimer, Verify National Pharmacy Database, Reconcile Medication Dispendes, Pharm Preference, and Immunization History.
- Allergies:** A table showing a rash reaction to Penicillins on 7/7/2012.
- Home Medications:** A table listing active medications: diltiazem (AKA CARDIZEM) 240 mg Oral SR 24Hr Cap, famotidine (PEPCID) 20 mg Oral Tab, and levothyroxine (AKA SYNTHROID) 100 mcg Oral Tab.
- Immunization History:** A table showing previous immunizations: FLU VACCINE, SPLIT (12/15/2011, Next Due 8/27/1842) and TD VACCINE NO PRESERVATIVE GREATER THAN 6 YO IM (12/15/2011, Next Due 8/27/1842).

ED Encounter Summary

ED Encounter Summary

Frog, Nesbit N #1001456171 (Acct: 3351389) (68 y.o. M) PCP: TUGGY, M (206-386-6111)

Attending Provider: Michael L Tuggy, MD

Allergies: **Penicillins** Colonization: None Ht: 180 cm (5' 10.87") Anticipated Dx: Pneumonia BMI: 30.80 kg/m²
 Last verified: 08/09/12 Code Status: FULL Current Wt: 99.8 kg (220 lb 0.3 oz) Admission Wt: 99.8 kg (220 lb 0.3 oz) BSA: 2.23 m²

PATIENT IS HIGH FALL RISK

ED Disposition

Admit What is the ED IMPRESSION for this patient's admission?: pneumonia
 Patient Class: Inpatient [1]
 Hospital Area: FIRST HILL [120]
 Transfer Date: 4/26/2010

ED Arrival Information

Expected	Arrival	Acuity Level	Means of Arrival	Escorted By	Service	Admission Type	Arrival Complaint
-	8/9/2012 12:54	Level 3	Car	Daughter	Medical	Emergency	-

FYI Information
No FYI flags for this patient

Research Study Enrollments
No research study enrollments for this encounter.

CHIEF COMPLAINT
RESPIRATORY DISTRESS

Diagnosis
None

ED Notes from 8/9/12 12:53 to 8/9/12 15:10:24

Julia A Smith, RN 8/9/2012 12:57
 Pt w/ c/o SOB onset 1 week ago, worsening in the past couple of days. Productive cough, green sputum. Increasing fatigue, states, "hot and cold". Denies chest pain, coughing up blood, nausea, vomiting, or abdominal pain.

Allergies as of 8/9/2012

Belongings

Itemization of patient belongings are done in the RN Admission activity. The Belongings navigator allows for an itemization of all the patient's belongings. In the event additional belongings are not listed in the template, a row may be added.

Belongings - Belongings

Time Taken: []
 Date: 8/10/2012 [] Show Last Filed Value
 Time: 1240 [] Show Row Info
 Add Group Add Row Add LDA
 Values By Create Note

To flag data as significant, right click on the row name

Essentials

Dentures? [None] [Upper] [Lower] [Partial] [] []
 Last Filed Value:
 Upper/Lower taken at 08/09/12 1727 by Barbara J Shulock, RN
 Observed in mouth [] In denture cup [] With family [] At home [] In secured area [] With Security []
 Dentures Location [] Patient's Room [] Other (Comment) [] [] []

Hearing Aids? [None] [R Ear] [L Ear] [] []
 Last Filed Value:
 None taken at 08/09/12 1727 by Barbara J Shulock, RN

Vision Assist? [None] [Glasses] [Contacts] [] []
 Last Filed Value:
 Glasses taken at 08/09/12 1727 by Barbara J Shulock, RN
 Vision Assist Location [] With patient [] In the safe [] In the Secured Area [] Home with family [] With Security [] Patient's Room []

Other Items With Patient? [No] [Yes] [] []
 Last Filed Value:
 No taken at 08/09/12 1727 by Barbara J Shulock, RN

Valuables

Add Group Add Row Add LDA
 Values By Create Note

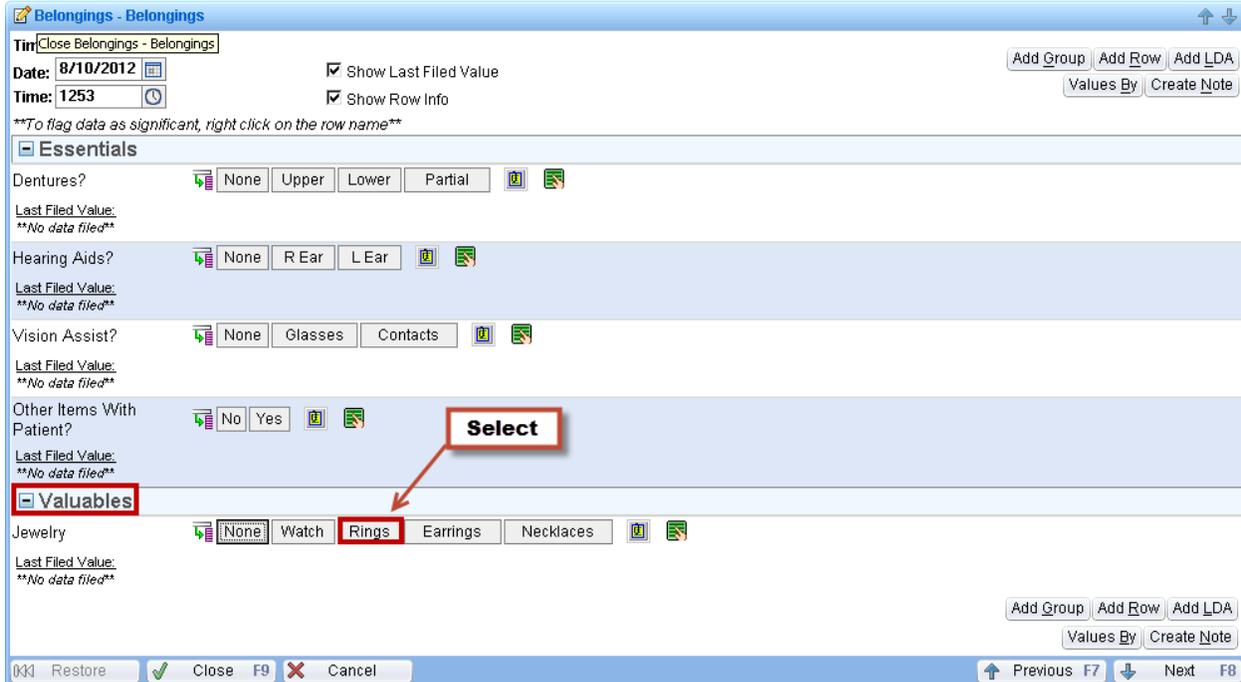
Close F9 Cancel Previous F7 Next F8

Select Flowsheet Row

Row: Jewel []
 Display name: []
 Accept Cancel

The patient has a 5 ct. diamond ring that will need to be added.

1. Select the Add Row.
2. Select Flowsheet Row displays.
3. In Row, type 'Jewel'
4. The Row Name Select display appears. Select Jewelry, click Accept.
5. Valuables is now listed at the bottom of the Belongings display



6. Clicking 'Ring', displays the location of the jewelry.



7. Select the location, click Close.

Allergies

Knowledge of a patient's allergies and reactions is imperative to providing safe, effective patient care. The Allergy activity allows you to do the following:



Review

It is required that allergies be reviewed with the patient on each admission, transfer and whenever there is a change in allergy status. **Mark as Reviewed** requires speaking directly to the patient and reaffirming their allergies.

If a patient has never been seen to this facility, there will be no allergy information in his/her chart and you will enter all allergies for that patient. If your patient does have prior entries, you will review the allergy list with the patient to see if anything has changed and then modify the list accordingly.

If your patient has no information on file, you should see this:

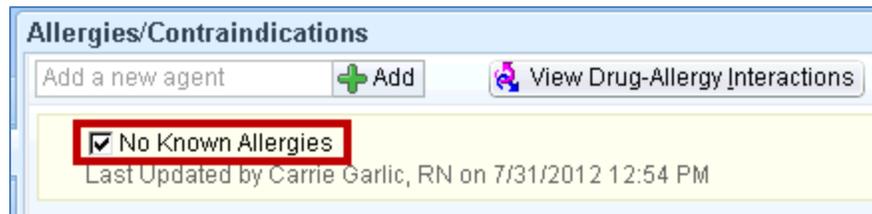


Unable to Assess Allergies

Any time you are unable to assess the patient's allergies, you should follow the steps below. There are many reasons why you may be unable to assess the patient's allergies when they are first admitted: such as confusion, severe pain or unconsciousness. 'No known allergies' is to be documented.

No Known Allergies:

1. Click the 'No Known Allergies' box



Allergies/Contraindications
Add a new agent
 No Known Allergies
Last Updated by Carrie Garlic, RN on 7/31/2012 12:54 PM

2. The Allergies in the Patient Header will now say **No Known Allergies**

Adding an Allergy

1. In the Search field, type 'penicillins' then click the 'Add' button (or press 'Enter').

2.

3. In the Agent Select window, select the allergen of 'penicillins' with the allergen type of Drug Class.
4. Click 'Accept'.
5. Click in the Reactions field

6.

7. Click the

8. Select 'Hives' and then click 'Accept'
9. Click on the row beneath 'Hives'.
10. Click on the 'Selection' button.
11. Select 'Itching' and then click 'Accept'. (You can add as many reactions as the patient reports. Each time you add a reaction, a new field becomes available.)
12. Click the 'Selection' button in the Severity field.

13.

14. Select 'Medium' and then click 'Accept'.
15. Write a comment, as needed, in the Comment box.
16. Click

Modifying a Current Allergy

You patient remembered he also experienced shortness of breath when he received penicillin. You need to add this to the list of reactions for his allergy.

1. Click the 'Penicillin' allergy to edit the details of that entry.
2. Click the next blank Reaction field and type 'short'. Press 'Enter'
3. Click 'Accept'.

Deleting a Current Allergy

1. Click Penicillins
2. Click 'Delete'

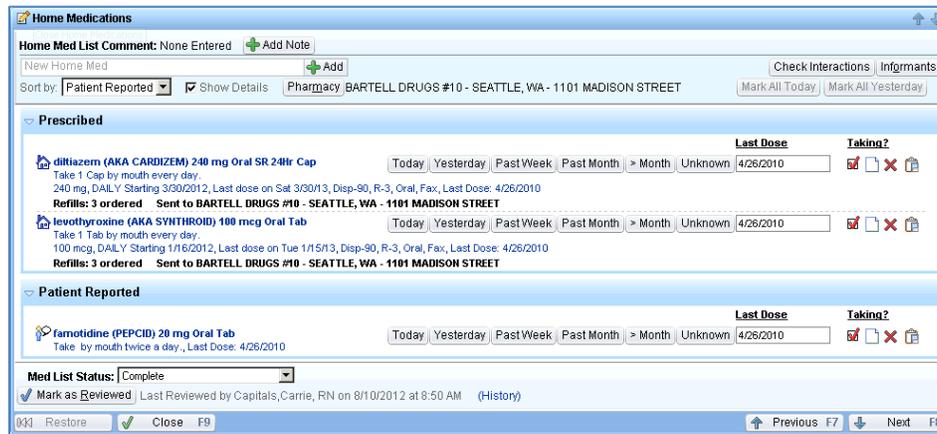
The screenshot shows the 'Allergies/Contraindications' interface. At the top, there is a search bar with 'Add a new agent' and a green '+ Add' button. Below this is a table with columns for 'Reaction' and 'Severity'. The 'Allergies' section is expanded to show details for 'PENICILLINS'. The 'Agent' field contains 'PENICILLINS'. The 'Type' field is empty with a search icon. The 'Severity' field is empty with a search icon. The 'Reactions' field contains 'Rash'. The 'Noted' field contains '7/20/2012' with a calendar icon. The 'Valid until' field is empty. At the bottom, there are two buttons: 'Past Updates' and 'Delete'. The 'Delete' button is highlighted with a red box.

Patient's Home Meds (PTA)

The first step in prior to admission medication review, during admission or otherwise, is to work with the patient or the patient's representative to review the prior to admission medications. This involves the review of any PTA medications already on record in the patient chart, verifying the name, dosage, route, frequency, and last dose (if taking); then adding any additional medications. Prior to Admission Medications can be updated and documented during the admission process. While a physician has the ability to update PTA Meds, this is a responsibility carried out primarily by the nurse.

The listings in the PTA Meds section will fall under two types:

- (1) Prescribed
- (2)  Patient Reported



The steps should be taken:

1. Verify list is accurate.
2. Add note if uncertain about specific meds.
3. Document medication list status and make a selection.
4. Mark as Reviewed.

UPDATE PTA MEDICATIONS

The patient reported to the ED nurse 6 medications and confirmed an active prescription for Tylenol #3. The last dose for all medications was today at 0600 except Zocor was taken yesterday at 2000 and Nitrostat was taken sometime last month. The patient reports that they are also taking Lisinopril 20 mg daily.

Use the scenario above to complete the PTA Meds section.

Review the Medications

1. Review the medications with the patient or representative.
2. Verify the listed medication names (if any), dosage, route, frequency, and the date and time of last dose taken.
3. Medication list status update.
4. Once you have finished reviewing the medications with the patient, you can mark the list as reviewed by selecting the Mark as Reviewed function at the lower left of the PTA Meds section. Your name, along with the date and time you reviewed the meds list will appear.
5. Click Mark as Reviewed.

Add a New PTA Med

The patient tells you they are taking Lisinopril, 20 mg tablet. Their last dose was today at 08:00.

Select a Medication

Search:

ID	Name	Formulary
11686	LISINOPRIL 10 MG PO TABS	Yes
4174	LISINOPRIL 20 MG PO TABS	Yes
13185	LISINOPRIL 30 MG PO TABS	Yes
16565	LISINOPRIL 40 MG PO TABS	Yes
61508	LISINOPRIL PO	No

Choose this

Not That

Delete a Medication Entered in Error

Any medication listed in the PTA Med List which has been entered in error may be deleted immediately with the  button at the end of the row, if the list has not been

Pharmacy Preference

This is completed by the Pharmacy button in the home medications sections.

Admit

No Known Allergies

ED Encounter Sum...
Belongings
Allergies
PT's Home Meds
Disclaimer
Verify Rx Database
Reconcile Dispens...
Pharm Preference
Immunization Hx
History
Admit Screens
Active LDAs
Plan of Care
Patient Education

Home Medications

Home Med List Comment: None Entered
New Home Med

Sort by: Patient Reported

Fill prescriptions at:

Med Suggested

Med	E-Rx?	Name	Type	Phone
<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>			

Pharm Preference

1:44 PM

Surescripts

Disclaimer

SureScripts Payer Disclaimer

Certain information may not be available or accurate in this report, including over-the-counter medications, low cost prescriptions, prescriptions paid for by the patient or non-participating sources, or errors in insurance claims information. The provider should independently verify medication history with the patient.

Verify RX Database

Verify National Pharmacy Database

No pharmacy benefits eligibility data found for this visit.

[Check Again](#)

Restore Close F9 Previous F7 Next F8

Reconcile Medication Dispenses

Reconcile Medication Dispenses

To run the dispense history query please verify the patient's pharmacy benefits.

Immunization HX

In the Immunization History Section, you can view a patient's previous immunization record or you can update the history by clicking the hyperlink:

- [Enter Previous Pneumovax Immunizations within the last 5 years](#)
- [Enter Previous Flu Immunizations within the last year](#)

Immunization History

Name	Dates Previously Given	Next Due
FLU VACCINE, SPLIT	12/23/2011	9/4/1842
TD VACCINE NO PRESERVATIVE GREATER THAN 6 YO IM	12/23/2011	9/4/1842

[Enter Previous Pneumovax Immunizations within the last 5 years](#)

[Enter Previous Flu Immunizations within the last year](#)

History within RN Admission Navigator

Avocado, Mike F 68 y.o., M, 11/16/1943 Bed: 901P HT: 180 cm (5'10.87") BMI: 30.8... Allergies: Penicillins ISO: None COL: None Code: FULL Admtd: TUGGY, MICHAEL L [101140]

Admit

History

Medical History

Medical History: Add Pertinent Negative

No Known Problems	Yes	No	Stroke	Yes	No
Kidney Disease	Yes	No	Mental Health Condition	Yes	No
Arthritis	Yes	No	Heart Disease	Yes	No
Cancer	Yes	No	Heart failure	Yes	No
Diabetes	Yes	No	High Blood Pressure	Yes	No
Thyroid Disease	Yes	No	Asthma	Yes	No
COPD	Yes	No	Anesthesia Reaction	Yes	No
Liver Dysfunction?	Yes	No	Methicillin Resistant Staph Aureus(MRSA)	Yes	No

Other Medical History: Hypertension; Esophageal reflux

Surgical History

Surgical History: Add Pertinent Negative

Negative Surgical History	Yes	No	Brain Surgery	Yes	No
Appendectomy	Yes	No	Back Surgery	Yes	No
Colon Surgery	Yes	No	Eye Surgery	Yes	No
Hernia Repair	Yes	No	Tonsillectomy	Yes	No
Hysterectomy	Yes	No	Breast Surgery	Yes	No
Kidney Transplant	Yes	No	Thoracic Surgery	Yes	No
Artificial Joints	Yes	No	Heart Surgery	Yes	No
Broken bones/fractures	Yes	No	Vascular Surgery	Yes	No
Cosmetic Surgery	Yes	No	Abdominal Surgery	Yes	No
Skin Biopsy	Yes	No			

Other Surgical History: --- No other history on file ---

Social History

Tobacco Use? Former Smoker [X] Tobacco type? Cigarettes Cigars Pipe
 Packs/day? 0.25 0.5 1 1.5 2 1.00 Years? 1 5 10 15 20 25 30 40 50 50.0
 Quit Date? 12/5/2011
 Smokeless Tobacco: Unknown Types: Snuff Chew
 Ready to Quit: Yes No Counseling Given: Yes No
 Comment:
 Alcohol Use? Yes No Comment:

Admit Screens

The documentation needed are:

- Spiritual/ Cultural background screen
- Abuse screen
- Smoking Cessation screen
- Pressure Ulcer screen

Admit Screens - Admit Screens

Time Taken: Date: 8/10/2012 Time: 1414

Reason for Hospital Stay

Information Source? Patient Partner Spouse Sibling Parent Child GrandParent Guardian

Discharge Preparedness

Concerns/Worries About Hosp Stay/Self Care After Discharge? Yes No

Any Referral(s) Needed? No Financial Counselor Spiritual Care Social Services (Care Coordination) Other (Comment)

Who will help you at home? Child Parent Partner Sibling Spouse Grandparent Guardian Custodial parent Other (Comment)

Name of Escort (if Required)

Communication Screen

Hearing Impairment: None Minimal Moderate but no ... Wears Hearing Aids Affects Communic ...

Vision Impairment: None Corrects with OI ... Limited w/Glasse ... Requires Aids to ...

Spiritual/Cultural Background

Active LDAs

Clicking Doc Flowsheets takes you directly to the flowsheet

Category	8/9/12	8/10/12
VS Crit Care	1023	1258
Observation		
Heart Rate & Rhythm		
Blood Pressure		
Hemodynamics		
Glucose Management		
Anticoagulation		
Pain Description #1 (...)		
Pain Assessment - C...		
Pain Management		
Oxygenation		
Pulmonary Exercise		
Respiratory Secretions		
Sedation/Interruption		
Miscellaneous Care		
Nursing Care		
Smart Moves		
Mobility and Safety		
DVT Prophylaxis		
MD/Provider Notification		
Height and Weight		

Plan of Care

Allows you to begin the Plan of Care.

Problem	Codes	Priority	Class	Noted
Hypertension	401.9			Unknown
Esophageal reflux	530.81			Unknown
Tobacco use disorder	305.1			12/23/2011
Hypothyroidism	244.9			1/30/2012

Patient Education

Allows you to begin Patient Education.

Assessments

No Assessments

FYI

An FYI flag is a way to communicate patient information to all health care providers and assigned treatment team members across facilities. FYI flags can be viewed from the Index Report and the Nurse Snapshot.

1. To create an FYI, click More Activities, located in the bottom left portion of the screen.



2. Click FYI.

Patient Education

Patient Education is used to document teaching done for patients and/or their family members/caregivers. When you apply a Plan of Care template, an associated title is added to Patient Education. Each title has one or more topics and teaching points associated with it. When education is complete, the learner's progress is documented and the topics are resolved.

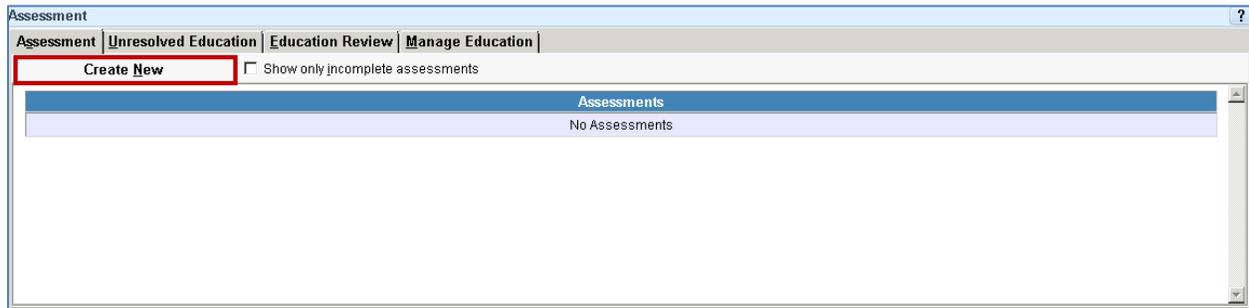
The screenshot displays the Epic EMR interface for a patient named Asparagus, Mike F. The patient's information includes: 68 y.o., M, 11/10/1943, Bed: 900P, Height: 180 cm (5' 10.87"), Weight: 99.8 kg (220 lb 0.3...), BMI: 30.8..., Allergies: Penicillins, ISO: None, COL: None, Code: FULL, and Attn: TUGGY, MICHAEL L [101140]. The interface shows the 'Assessment' section with tabs for 'Assessment', 'Unresolved Education', 'Education Review', and 'Manage Education'. The 'Assessments' table is currently empty, displaying 'No Assessments'. The left sidebar contains various navigation options, including 'Patient Education' and 'View and edit patient education information'. The bottom of the screen shows the user 'CARRIE G.' and the time '5:23 PM'.

Create a New Learning Assessment

The Learning Assessment should be documented upon admission. Whenever there is a change in the patient's ability to learn. A new assessment should be documented and filed in the chart.

1. Click Patient Education activity.

2. Click Create New.



3. Learning Assessment display appears.

A screenshot of a 'LEARNING ASSESSMENT' form. The form is divided into several sections: 'LEARNER', 'LANGUAGE', and 'LEARNING ASSESSMENT'. Each section contains various fields and checkboxes. Several fields are highlighted with red boxes: 'Learner?', 'Primary language for educational purposes?', 'Interpreter needed?', 'Reading ability?', 'Preferred learning method?', and 'Barriers to learning?'. The 'LEARNER' section includes checkboxes for 'Patient', 'Family', 'Caregiver', 'Mother', 'Father', 'Friend', 'Other (Comment)', 'Primary Learner', and 'Secondary Learner'. The 'LANGUAGE' section includes checkboxes for various languages like 'English', 'Spanish', 'Vietnamese', 'Cantonese', 'Somali', 'Mandarin', 'Russian', 'Korean', 'Cambodian/Khmer', 'Sign Language', and 'Other (Comment)'. The 'LEARNING ASSESSMENT' section includes checkboxes for 'Written', 'Verbal', 'Demonstration', 'Hands on', 'Video', 'Read lips', 'Medical Play', and 'Other (Comment)'. There are also text input fields for 'Learner Comment', 'Primary language comment', 'Reading ability comment', 'Who would you include?', and 'Barriers to learning comment'. At the bottom, there is an 'Assessment Comment' field.

4. The selected areas must be answered:
 - a. Learner?
 - b. Primary Language for educational purposes?
 - c. Interpreter needed?
 - d. Reading Ability?
 - e. Preferred learning method?
 - f. Barriers to Learning?
5. Upon completion, click File, bottom right side.

Plan of Care

The Plan of Care is a guide for nurses and other caregivers in addressing issues that stem from or contribute to a patient's illness.

Plan of Care is structured around patient care requirements. Each problem has a list of one or more goals that must be measurable. There are interventions associated with each Plan of Care. However, the documentation of interventions takes place in Notes activity as a Progress Note.

The screenshot displays the Epic EMR interface for a patient named Asparagus, Mike F. The patient's information includes age (68 y.o.), sex (M), date of birth (11/10/1943), height (180 cm), weight (99.8 kg), BMI (30.8), and allergies (Penicillins). The patient is currently an inpatient in room 900. The Plan of Care section is active, showing a table of non-hospital problems and a section for active multi-disciplinary problems.

Non-Hospital Problem List	Codes	Priority	Class	Noted	Never Reviewed
Hypertension	401.9			Unknown	
Esophageal reflux	530.81			Unknown	
Tobacco use disorder	305.1			12/10/2011	
Hypothyroidism	244.9			1/17/2012	

Multi-Disciplinary Problems (Active)
There are no active problems.

Documenting Plan of Care

Documenting the progression of Plan of Care Activity is a responsibility shared by all clinicians. You are responsible for documenting the patient's progression throughout their length of stay in the hospital. Plan of Care is multi-disciplinary and used by clinicians as well as dietary and therapies.

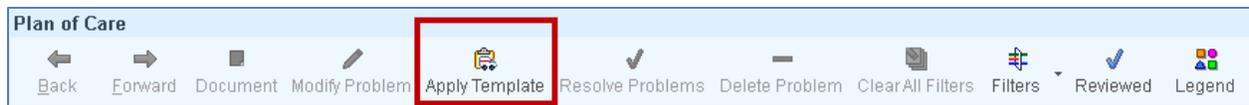
- Plan of Care is to be initiated within 24 hours of admission

- During the first 24 hrs: The nurse will apply templates of current patient problems.
- Plan of Care should be reviewed every shift.
- The nurse must document against each goal every 24 hours to indicate if the patient is progressing. If the patient is not progressing, a variance should be documented. An explanation should be entered in a Progress Note.
- The Plan of Care activity helps to reduce redundancy in communication and services.

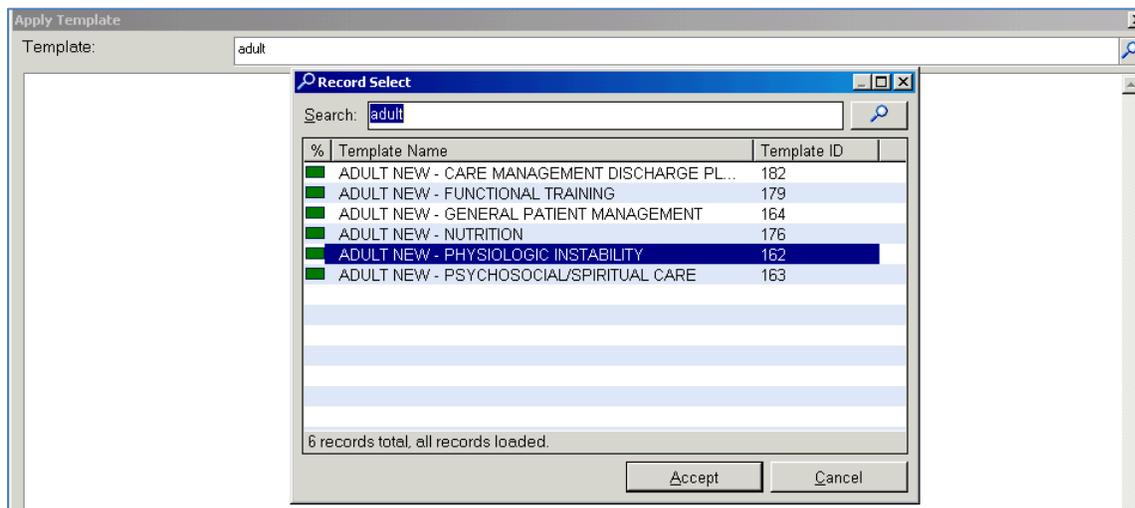
Initiate a Plan of Care

Olive Oil, RN is creating a plan of care for a 39-year old Adult pneumonia patient with poor dietary intake.

1. Click Plan of Care Activity.
2. Click Apply Template.



3. We are applying a template to an Adult patient.



4. Type 'Adult' in the template field and press Enter.
5. Select Adult New - Physiological Instability, click Accept.

6. Check off the boxes that pertain to patient's individualized Plan of Care.

Apply Template

Template: ADULT NEW - PHYSIOLOGIC INSTABILITY [162]

Select check boxes to apply to care plan

- NEUROSENSORY - ADULT**
 - Achieves stable or improved neurological status
 - Absence of seizures
 - Remains free of injury related to seizures activity
 - Achieves maximal functionality and self care
- CARDIOVASCULAR - ADULT**
 - Maintains optimal cardiac output and hemodynamic stability
 - Absence of cardiac dysrhythmias or at baseline
- RESPIRATORY - ADULT**
 - Achieves optimal ventilation and oxygenation
- GASTROINTESTINAL - ADULT**
 - Minimal or absence of nausea and vomiting
 - Maintains or returns to baseline bowel function
 - Maintains adequate nutritional intake
 - Establish and maintain optimal ostomy function
- GENITOURINARY - ADULT**
 - Absence of urinary retention
 - Urinary catheter remains patent
- METABOLIC/FLUID AND ELECTROLYTES - ADULT**
 - Electrolytes maintained within normal limits
 - Hemodynamic stability and optimal renal function maintained
 - Glucose maintained within prescribed range
- SKIN/TISSUE INTEGRITY - ADULT**
 - Skin integrity remains intact
 - Incision(s), wounds(s) or drain site(s) healing without S/S of infection
 - Oral mucous membranes remain intact
- HEMATOLOGIC - ADULT**

Clear All Accept Cancel

7. Click Accept.

Plan of Care	
<ul style="list-style-type: none"> Overview Plan of Care Progress Note Event Log ADULT - PHYSIOLOGIC INST <ul style="list-style-type: none"> RESPIRATORY - ADULT <ul style="list-style-type: none"> Achieves optimal ventilat GASTROINTESTINAL - ADL <ul style="list-style-type: none"> Maintains adequate nutri 	<p>Display: <input checked="" type="checkbox"/> Description</p> <p>ADULT - PHYSIOLOGIC INSTABILITY</p> <p>RESPIRATORY - ADULT</p> <p>Goal: Achieves optimal ventilation and oxygenation</p> <p>INTERVENTIONS:</p> <ol style="list-style-type: none"> 1. Assess for changes in respiratory status 2. Assess for changes in mentation and behavior 3. Position to facilitate oxygenation and minimize respiratory effort 4. Oxygen supplementation based on oxygen saturation or ABGs 5. Initiate Smoking cessation Protocol as indicated 6. Encourage broncho-pulmonary hygiene including cough, deep breathe, Incentive Spirometry 7. Assess the need for suctioning and aspirate as needed 8. Assess and instruct to report SOB or any respiratory difficulty 9. Respiratory Therapy support as indicated <p>GASTROINTESTINAL - ADULT</p> <p>Goal: Maintains adequate nutritional intake</p> <p>INTERVENTIONS:</p> <ol style="list-style-type: none"> 1. Monitor percentage of each meal consumed 2. Identify factors contributing to decreased intake, treat as appropriate 3. Assist with meals as needed 4. Monitor I&O, WT and lab values 5. Obtain nutritional consult as needed <p style="text-align: right;">Previous Template</p>

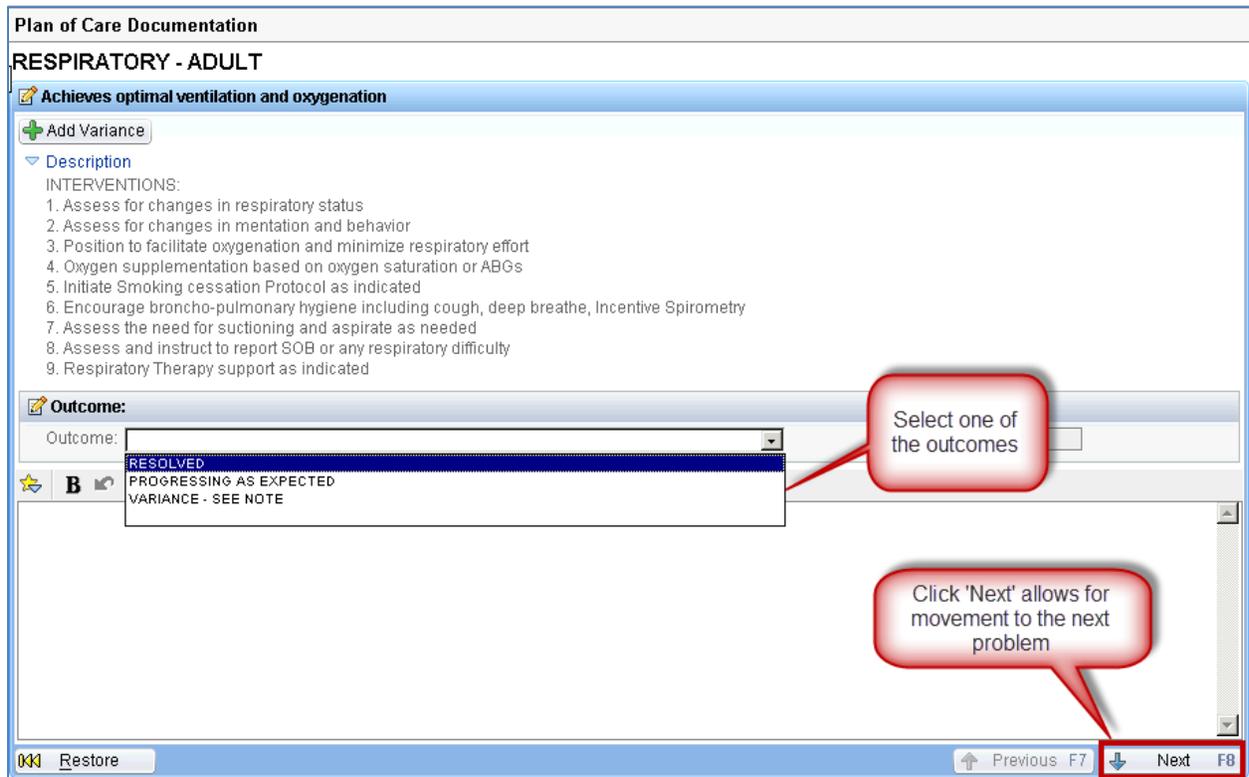
Plan of Care <ul style="list-style-type: none"> Overview Plan of Care Progress Note Event Log ADULT - PHYSIOLOGIC INST <ul style="list-style-type: none"> RESPIRATORY - ADULT <ul style="list-style-type: none"> Achieves optimal ventilat GASTROINTESTINAL - ADL <ul style="list-style-type: none"> Maintains adequate nutri 	Display: <input checked="" type="checkbox"/> Description
	ADULT - PHYSIOLOGIC INSTABILITY Problems
	RESPIRATORY - ADULT Goal Goal: Achieves optimal ventilation and oxygenation INTERVENTIONS: 1. Assess for changes in respiratory status 2. Assess for changes in mentation and behavior 3. Position to facilitate oxygenation and minimize respiratory effort 4. Oxygen supplementation based on oxygen saturation or ABGs 5. Initiate Smoking cessation Protocol as indicated 6. Encourage broncho-pulmonary hygiene including cough, deep breathe, Incentive Spirometry 7. Assess the need for suctioning and aspirate as needed 8. Assess and instruct to report SOB or any respiratory difficulty 9. Respiratory Therapy support as indicated
GASTROINTESTINAL - ADULT Goal Goal: Maintains adequate nutritional intake INTERVENTIONS: 1. Monitor percentage of each meal consumed 2. Identify factors contributing to decreased intake, treat as appropriate 3. Assist with meals as needed 4. Monitor I&O, WT and lab values 5. Obtain nutritional consult as needed	
	Previous Template

8. Click Accept.

Plan of Care <ul style="list-style-type: none"> Overview Plan of Care Progress Note Event Log ADULT - PHYSIOLOGIC INST <ul style="list-style-type: none"> RESPIRATORY - ADULT <ul style="list-style-type: none"> ● Achieves optimal ventilat GASTROINTESTINAL - ADL <ul style="list-style-type: none"> ● Maintains adequate nutr 	Display: <input checked="" type="checkbox"/> Description <input checked="" type="checkbox"/> Web Links <input type="checkbox"/> Detail <input type="checkbox"/> Outcomes
	Maintains adequate nutritional intake PROGRESSING AS EXPECTED INTERVENTIONS: 1. Monitor percentage of each meal consumed 2. Identify factors contributing to decreased intake, treat as appropriate 3. Assist with meals as needed 4. Monitor I&O, WT and lab values 5. Obtain nutritional consult as needed
	📄 Document ✎ Edit Goal
	Web Links Total Parenteral Nutrition-Adult Enteral Feeding-Adult Enteral Feeding Procedures-Adult Gavage Feeding Total Parenteral Nutrition & Lipids-Pediatric

9. Select goal to document (green button)

10. Select Document for Interventions



Document Care of Plan Goal Outcomes

During the first 24hrs of admission, the nurse will mark the Plan of Care as reviewed. After this, the nurse must review the Plan of Care during each shift.

Resolve Care Plan Goals

Whenever a goal is achieved, you should resolve it at that time.

1. Click Plan of Care.
2. Select the 'Resolved' outcome.
3. Click Accept.

Resolved goals are noted with a green check mark and displays grayed out. The interventions are also grayed out.



Discharging a Patient

The Discharge Navigator streamlines the review and documentation for a patient being discharged from the hospital. It displays reports and reminds you to discontinue LDAs, reconcile patient belongings, and resolve care plans and patient education. You will access this navigator at the end of a patient stay once there is an order for discharge.

The screenshot displays the EpicCare interface for patient Asparagus, Mike F. The patient summary at the top includes demographic information (68 y.o., M, 11/10/1943), vital signs (HT: 180 cm, WT: 99.8 kg), and clinical data (Allergies: Penicillins, Code: FULL, Altnr: TUGGY, MICHAEL L [1011140]). The Discharge Navigator is active, showing a list of discharge orders needing review. The orders table is as follows:

Order	Details	Provider	Order Origin
diltiazem (AKA CARDIZEM) 240 mg Oral SR 24Hr Cap	Take 1 Cap by mouth every day.	Michael L Tuggy, MD	Prior to Admission
levothyroxine (AKA SYNTHROID) 100 mcg Oral Tab	Take 1 Tab by mouth every day.	Michael L Tuggy, MD	Prior to Admission
famotidine (PEPCID) 20 mg Oral Tab	Take by mouth twice a day.	Historical Provider	Prior to Admission
D5-1/2NS (D5-0.45% NaCl) + KCl 20meq/L IV solution 1,000 mL	1,000 mL, at 100 mL/hr, Intravenous, CONTINUOUS, Starting Fri 7/27/12 at 1315, Until Discontinued	Curtis F Veal Jr., MD	Inpatient
metoclopramide (aka REGLAN) injection 5-10 mg	5-10 mg, Intravenous, Q6H PRN, Starting Fri 7/27/12 at 1258, Until Discontinued, Nausea or Vomiting, Routine	Curtis F Veal Jr., MD	Inpatient
ondansetron (PF) (aka ZOFRAN) injection 4-8 mg	4-8 mg, Intravenous, Q8H PRN, Starting Fri 7/27/12 at 1259, Until Discontinued, Other, If not controlled by Dopamine Receptor Antagonist medication	Curtis F Veal Jr., MD	Inpatient
heparin (porcine) (PF) 5000 units/0.5mL injection 5,000 Units	5,000 Units, Subcutaneous, Q12H, First dose on Fri 7/27/12 at 1315, Until Discontinued	Curtis F Veal Jr., MD	Inpatient
acetaminophen (aka TYLENOL) tablet 325-650 mg	325-650 mg, Oral, Q6H PRN, Starting Fri 7/27/12 at 1300, Until Discontinued, Pain or Fever	Curtis F Veal Jr., MD	Inpatient
docusate sodium (aka COLACE) capsule 250 mg	250 mg, Oral, DAILY, First dose on Fri 7/27/12 at 1315, Until Discontinued	Curtis F Veal Jr., MD	Inpatient
diphenhydramine (aka BENADRYL) tablet 25-50 mg	25-50 mg, Oral, Q6H, First dose on Fri 7/27/12 at 1315, Until Discontinued	Curtis F Veal Jr., MD	Inpatient
levofloxacin 500 mg injection	500 mg, Intravenous, DAILY, First dose on Fri 7/27/12 at 1315, Until Discontinued	Curtis F Veal Jr., MD	Inpatient

Below the table, there are sections for Reviewed Discharge Orders (but not yet released), Released Discharge Orders, ADT Active Orders, and Referral Active Orders, all showing 'None'.

Access the RN Discharge activity

Review and Acknowledge Discharge Orders

Once the attending physician places discharge orders, you will have an icon in the Unacknowledged Orders column on your my List.

1. Double-click the icon in the Unacknowledged Orders column. The patient chart opens to the Patient Summary Index report.
2. Acknowledge each discharge order.

Discharge Orders Needing Review			
Order	Details	Provider	Order Origin
omeprazole (AKA PRILOSEC) 20 mg Oral CpDR	Take 20 mg by mouth every day.	Michael L Tuggy, MD	Prior to Admission
tocopherol, aka VITAMIN E, 100 unit Oral Cap	Take 400 Units by mouth every day.	Michael L Tuggy, MD	Prior to Admission
diltiazem (AKA CARDIZEM) 240 mg Oral SR 24Hr Cap	Take 1 Cap by mouth every day.	Michael L Tuggy, MD	Prior to Admission
levothyroxine (AKA SYNTHROID) 100 mcg Oral Tab	Take 1 Tab by mouth every day.	Michael L Tuggy, MD	Prior to Admission
famotidine (PEPCID) 20 mg Oral Tab	Take by mouth twice a day.	Historical Provider	Prior to Admission
D5-1/2NS (D5-0.45% NaCl) + KCl 20meq/L IV solution 1,000 mL	1,000 mL, at 100 mL/hr, Intravenous, CONTINUOUS, Starting Thu 8/9/12 at 1315, Until Discontinued	Curtis F Veal Jr., MD	Inpatient
metoclopramide (aka REGLAN) injection 5-10 mg	5-10 mg, Intravenous, Q6H PRN, Starting Thu 8/9/12 at 1258, Until Discontinued, Nausea or Vomiting, Routine	Curtis F Veal Jr., MD	Inpatient
ondansetron (PF) (aka ZOFRAN) injection 4-8 mg	4-8 mg, Intravenous, Q6H PRN, Starting Thu 8/9/12 at 1259, Until Discontinued, Other, If not controlled by Dopamine Receptor Antagonist medication	Curtis F Veal Jr., MD	Inpatient
heparin (porcine) (PF) 5000 units/0.5mL injection 5,000 Units	5,000 Units, Subcutaneous, Q12H, First dose on Thu 8/9/12 at 1315, Until Discontinued	Curtis F Veal Jr., MD	Inpatient
acetaminophen (aka TYLENOL) tablet 325-650 mg	325-650 mg, Oral, Q6H PRN, Starting Thu 8/9/12 at 1300, Until Discontinued, Pain or Fever	Curtis F Veal Jr., MD	Inpatient
docusate sodium (aka COLACE) capsule 250 mg	250 mg, Oral, DAILY, First dose on Thu 8/9/12 at 1315, Until Discontinued	Curtis F Veal Jr., MD	Inpatient
diphenhydramine (aka BENADRYL) tablet 25-50 mg	25-50 mg, Oral, Q6H, First dose on Thu 8/9/12 at 1315, Until Discontinued	Curtis F Veal Jr., MD	Inpatient
levofloxacin 500 mg injection	500 mg, Intravenous, DAILY, First dose on Thu 8/9/12 at 1315, Until Discontinued	Curtis F Veal Jr., MD	Inpatient
Reviewed Discharge Orders (but not yet released)			
None			
Released Discharge Orders			
None			

Review the Discharge Order Report

The purpose of the Discharge report is to provide a review of the following:

- Outstanding documentation items
- Discontinued orders
- Unresulted Labs
- Due Medications

Remove Lines, Drains, Airways

The Line, Drain, Airway section lists all active LDAs. It serves as a reminder to you to document the removal of LDAs that will not be discharged with the patient.

Belongings

Use the Belongings section to help reconcile the belongings of a patient at discharge. Before the patient leaves the unit, complete a new reading for the items indicating who has possession of the items when the patient leaves the hospital.

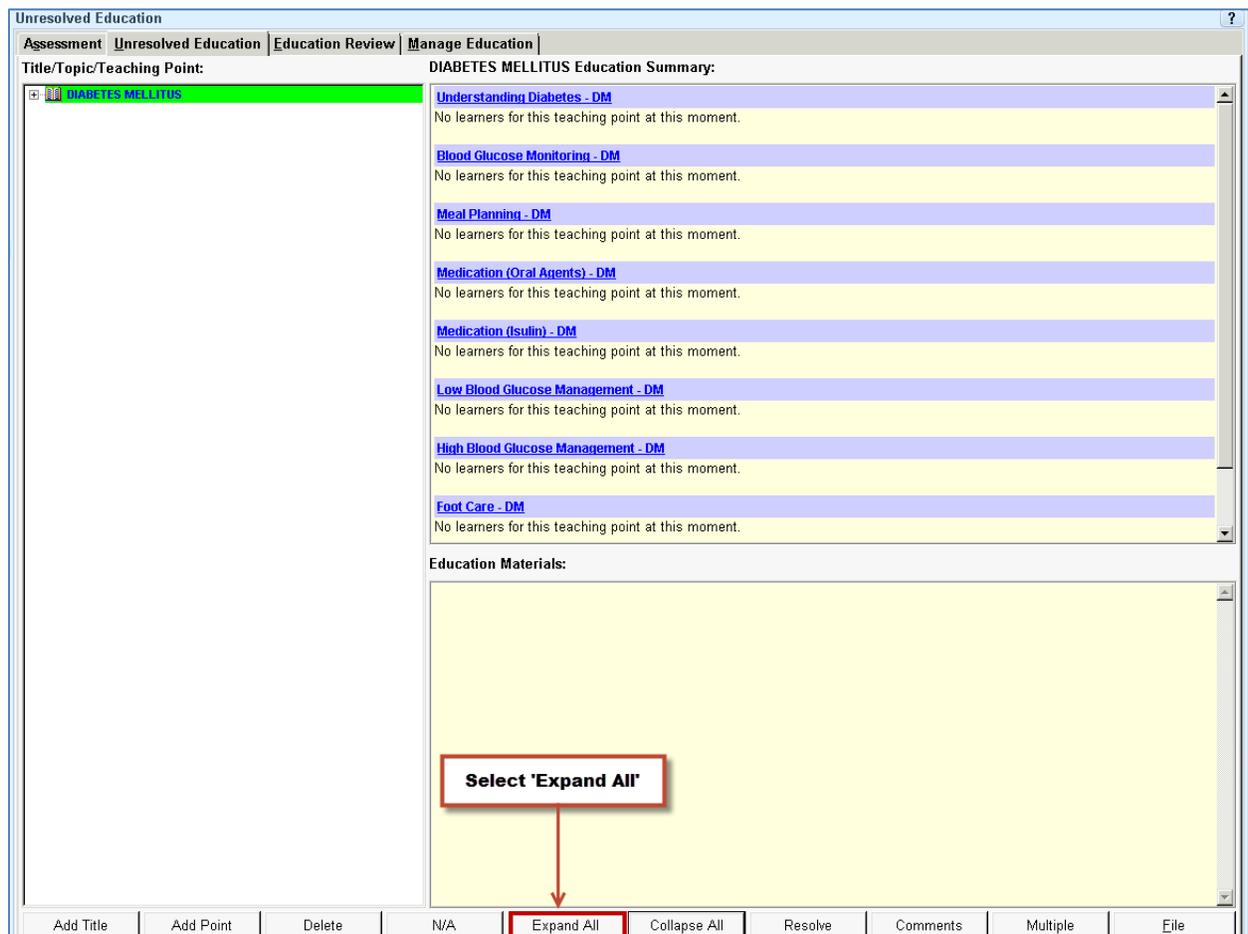
Resolve Plan of Care

All Care Plans should be resolved at or before the patient is discharged. To resolve:

1. Click Plan of Care.
2. Click the green buttoned items 
3. Select Document.
4. Go to Outcome, select , this will provide a drop down menu
5. Select Resolved.
6. Click  to move on to next item to resolve.
7. Once all has been resolved, click Accept and File.

Resolve Patient Education

All Patient Education should be resolved at or before the patient is discharged.



Unresolved Education

Assessment | Unresolved Education | Education Review | Manage Education

Title/Topic/Teaching Point:

DIABETES MELLITUS

DIABETES MELLITUS Education Summary:

- Understanding Diabetes - DM
No learners for this teaching point at this moment.
- Blood Glucose Monitoring - DM
No learners for this teaching point at this moment.
- Meal Planning - DM
No learners for this teaching point at this moment.
- Medication (Oral Agents) - DM
No learners for this teaching point at this moment.
- Medication (Insulin) - DM
No learners for this teaching point at this moment.
- Low Blood Glucose Management - DM
No learners for this teaching point at this moment.
- High Blood Glucose Management - DM
No learners for this teaching point at this moment.
- Foot Care - DM
No learners for this teaching point at this moment.

Education Materials:

Select 'Expand All'

Add Title | Add Point | Delete | N/A | Expand All | Collapse All | Resolve | Comments | Multiple | File

Unresolved Education

Assessment | Unresolved Education | Education Review | Manage Education

Title/Topic/Teaching Point: **DIABETES MELLITUS**

- Understanding Diabetes - DM
- Blood Glucose Monitoring - DM
- Meal Planning - DM
- Medication (Oral Agents) - DM
- Medication (Insulin) - DM
- Low Blood Glucose Management - DM
- High Blood Glucose Management - DM
- Foot Care - DM
- Follow-up after Discharge - DM

1. Select Education

2. Select Lerner

Point Description/Lerner Progress:

Description: Teach learner(s) the definition of diabetes mellitus and the main types. Diabetes is a disease that changes the way our bodies use food for growth and energy. Most of the food we eat is broken down into glucose (sugar). Glucose is the main source of fuel for the body. After digestion, glucose passes into the blood stream where it is used by cells for growth and energy. A hormone, insulin, must be present for the glucose to get into the cells where energy is released. The pancreas makes the insulin and regulates how much is released to maintain normal blood glucose. This is called glucose metabolism.

Learner	Ready?	Method	Res.	Comments	Taught By	Date	Time	Status
P					AVALANCHE, CARRE	8/10/2011	1545	Active

3. Continue onto 'Readiness', 'Method' & 'Response' [OR]

[OR] Select 'Apply Defaults'

Learner
 P: Patient
 F: Family
 S: Significant
 C: Caregiver
 O: Other
 M: Mother
 D: Dad

Readiness
 R: Ready *
 NR: Not Ready
 U: Unable
 O: Other

Method
 E: Explanation *
 D: Demonstration
 H: Handout
 I: Interpreter
 V: Video
 C: Class/Group
 M: Medical Play

Response
 CU: Communicated Understanding
 DU: Demonstrated Understanding
 NR: Needs Reinforcement
 NL: No Evidence of Learning
 RT: Refused Teaching
 RD: Return Demonstration

Education Materials: Delete Apply Defaults Copy Previous

Understanding Diabetes - DM
 Provider References:
[Diabetes Basic Care Skills](#)

Assessment | Unresolved Education | Education Review | Manage Education

Title/Topic/Teaching Point: **DIABETES MELLITUS**

- Understanding Diabetes - DM
- Blood Glucose Monitoring - DM
- Meal Planning - DM
- Medication (Oral Agents) - DM
- Medication (Insulin) - DM
- Low Blood Glucose Management - DM
- High Blood Glucose Management - DM
- Foot Care - DM
- Follow-up after Discharge - DM

All Education has been

Point Description/Lerner Progress:

Description: Teach the learner(s) the importance of keeping follow-up appointments, especially after hospitalization. Ask learner to identify the health-care provider who manages his/her diabetes care - primary care provider or diabetes specialist. Teach learner(s) to have phone or clinic visit contact with diabetes provider soon after discharge to report BG levels and for further guidance on diabetes management.

Learner	Ready?	Method	Res.	Comments	Taught By	Date	Time	Status
P	R	E	CU		AVALANCHE, CARRE	8/10/2011	1601	Done

Learner
 P: Patient
 F: Family
 S: Significant
 C: Caregiver
 O: Other
 M: Mother
 D: Dad

Readiness
 R: Ready *
 NR: Not Ready
 U: Unable
 O: Other

Method
 E: Explanation *
 D: Demonstration
 H: Handout
 I: Interpreter
 V: Video
 C: Class/Group
 M: Medical Play

Response
 CU: Communicated Understanding
 DU: Demonstrated Understanding
 NR: Needs Reinforcement
 NL: No Evidence of Learning
 RT: Refused Teaching
 RD: Return Demonstration

Education Materials: Delete Apply Defaults Copy Previous

Follow-up after Discharge - DM
 Provider References:
[Diabetes Basic Care Skills](#)

Click File

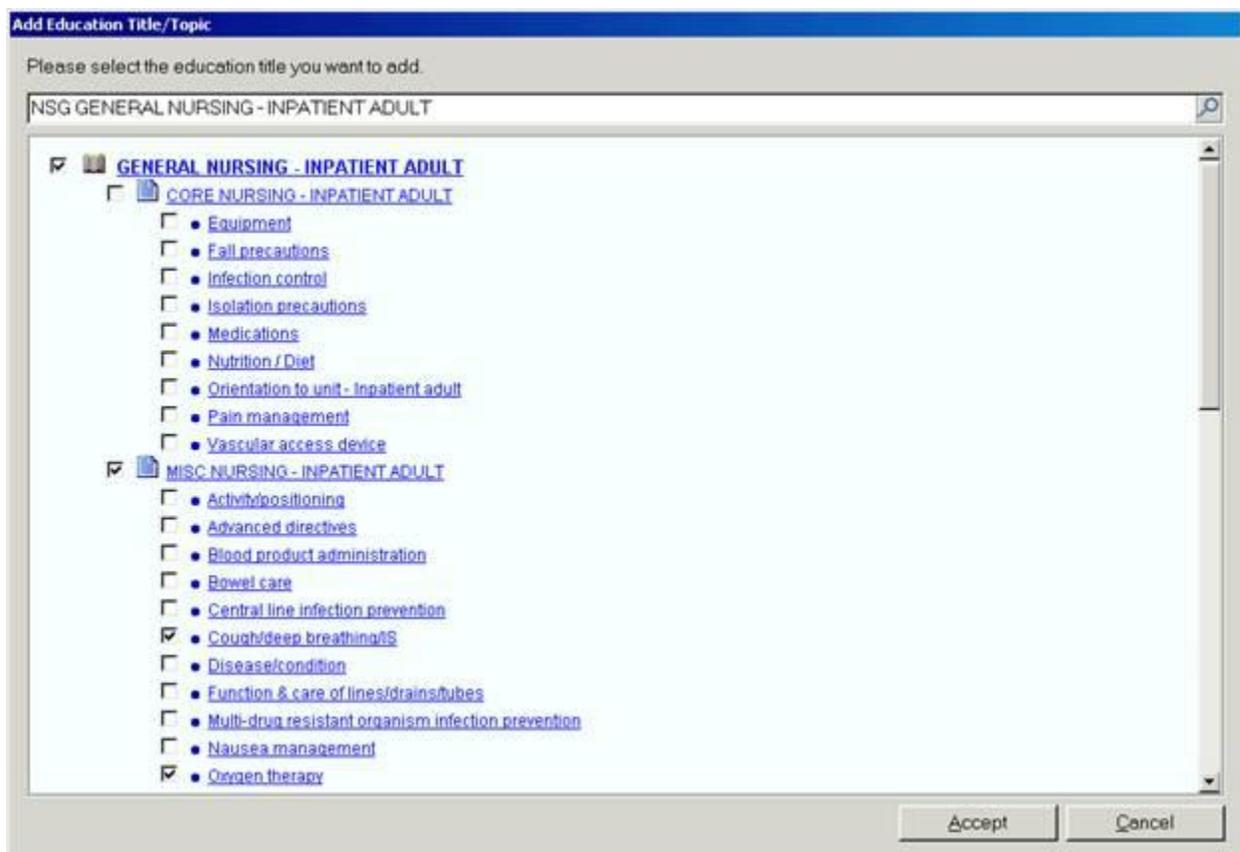
Add Title Add Point Delete N/A Expand All Collapse All Resolve Comments Multiple **File**

Unresolved Education

Pneumonia patient who is having difficulty breathing and is on oxygen therapy, and is requiring education on deep breathing and oxygen therapy use.

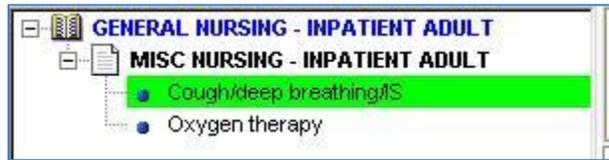
Under “Unresolved Education” Tab

1. Add Title >
2. Type “Adult” >
3. Highlight NSG General Nursing Inpatient Adult >
4. Accept
5. Select cough/deep breath and oxygen therapy as seen below:



6. Accept

7. Select the plus signs to the left of the teaching points to expand:



8. To document:

Go through Learner, Readiness, Method, and Response for each point you teach.

9. Select file

Unresolved Education

Assessment | **Unresolved Education** | Education Review | Manage Education

Title/Topic/Teaching Point:

- GENERAL NURSING - INPATIENT ADULT
 - MISC NURSING - INPATIENT ADULT
 - Cough/deep breathing/AS
 - Oxygen therapy

Point Description/Learner Progress:

Description:
Instruct learner(s) on purpose of and how to perform CDB (pillow splint as appropriate), and proper IS use. (Frequency and restrictions per MD order).

Learner	Ready?	Method	Res.	Comments	Taught By	Date	Time	Status
O	NR	D	NR		MAPES, CARRIE H	BR/3/2012	1403	Active

Learner
P: Patient
F: Family
S: Significant
C: Caregiver
O: Other
M: Mother
D: Dad

Readiness
R: Ready *
NR: Not Ready
U: Unable
O: Other

Method
E: Explanation *
D: Demonstration
H: Handout
I: Interpreter
V: Video
C: Class/Group
M: Medical Play

Response
CU: Communicated Understanding
DU: Demonstrated Understanding
NR: Needs Reinforcement
NL: No Evidence of Learning
RT: Refused Teaching
RD: Return Demonstration

Education Materials: [Delete] [Apply Defaults] [Copy Previous]

Buttons: Add Title | Add Point | Delete | N/A | Expand All | Collapse All | Resolve | Comments | Multiple | File

CARRIE M. 2:03 PM

Discharge Note (AVS)

Discharge instructions are comprised of the organization-approved discharge instruction SmartText note. These instructions are discussed with the patient or caregiver and include the necessary information for follow-up care. Upon reviewing this information with the patient, the After Visit Summary is printed and provided to the patient or caregiver.

Discharge instructions are a collaboration between Physicians and Nurses.

Preview and Print the After Visit Summary

The After Visit Summary (AVS) is a summary of the visit and includes the discharge instructions. SMC requires all patients to receive an AVS at the time of discharge.

1. Click the Discharge activity.
2. Click Preview AVS.

The After Visit Summary Displays.

The AVS will display the medications listed in sections to inform the patient what to do with the medication:

Current Discharge Medication List		AM	Noon	PM	Bedtime
CONTINUE these medications which have NOT CHANGED					
omeprazole (AKA PRILOSEC) 20 mg Oral CpDR	Details Take 20 mg by mouth every day.	[]	[]	[]	[]
tocopherol, aka VITAMIN E, 100 unit Oral Cap	Take 400 Units by mouth every day.	[]	[]	[]	[]
diltiazem (AKA CARDIZEM) 240 mg Oral SR 24Hr Cap	Take 1 Cap by mouth every day. Qty: 90 Refills: 3	[]	[]	[]	[]
levothyroxine (AKA SYNTHROID) 100 mcg Oral Tab	Take 1 Tab by mouth every day. Qty: 90 Refills: 3	[]	[]	[]	[]
famotidine (PEPCID) 20 mg Oral Tab	Take by mouth twice a day.	[]	[]	[]	[]

- **NEW RX - new prescription**
- **RESUME these medications have NOT CHANGED**
- **STOP TAKING these medications**

1. Scroll through the document to review the contents.
2. Select Print within the AVS summary when ready.

Discharge Medication Orders

Discharge medication orders placed by physicians will become prescriptions . Physicians are still required to sign the printed prescription.

Physicians will enter discharge prescriptions using their designated discharge navigator. Prescriptions (except Narcotics) should be processed to maintain the

Discharging a Patient

accuracy of the medication list and ensure the after visit summary (AVS) given to the patient is complete.

Prescriptions non-controlled substances, 3 per page will print. For controlled substance prescriptions, 1 prescription per page will print. Each page must be signed by the ordering physician.

Review / Process Check

1. Which of the following statements about acknowledging orders is true?
 - a. Acknowledging new orders means tht the user is taking responsibility for carrying them out
 - b. An order needs to be acknowledged before it becomes active
 - c. An order needs to be acknowledged before the lab can collect it
 - d. Acknowledging new orders means the order has been carried out

2. To add a patient to your My List, find the patient on a unit system list, then drag up to the My List folder.
 - a. True
 - b. False

3. What does it mean to mark as reviewed?
 - a. I have looked at this information.
 - b. I have verbally verified this information with the patient.
 - c. I understand this information.
 - d. I have reviewed the information that is pertinent to me.

4. When a patient is discharged from the hospital, they will automatically be removed from the My List:
 - a. True
 - b. False

5. In which of the following ways could you see all of the overdue medications for a particular patient?
 - a. Go to the Overdue tab on the MAR
 - b. Look at the Due Meds report from Patient Lists
 - c. Open the history activity
 - d. None of the above

6. You can search for specific results in the Results Review activity:
 - a. True
 - b. False

7. Which activity should you use to document collecting a lab specimen from a patient?
 - a. Care Plan
 - b. Order Entry
 - c. Order Revision
 - d. Active Order

8. When documenting an allergy you can specify details such as agent, type, reaction and severity:
 - a. True
 - b. False

9. The physician has just ordered a new morphine PCA for your patient. Where should you go first to document starting the infusion?
 - a. Doc Flowsheets
 - b. MAR
 - c. Order Revision
 - d. Patient Summary

10. In the Arrival Navigator, if the nurse sees Signed and Held orders placed by a provider, it is within his/her scope to release these orders.
 - a. True
 - b. False

11. What can you use (instead of the slash key) to quickly document blood pressure?
 - a. Tab key
 - b. Apostrophe
 - c. Space bar
 - d. Hyphen

12. Which button will display all of the items added to a patient's Care Plan or Education record?
 - a. Expand all
 - b. Show all
 - c. Show Details
 - d. Filters

13. If you document teaching a point in Patient Education, the Care Plan automatically updates.
 - a. True
 - b. False

Appendix

Create a Note Using a SmartText

A SmartText template is a pre-written form containing fields used to enter pertinent information.

Select a SmartText

1. Click the Notes activity.
2. Click New Note.
3. Click the selection button in the Type field and select Progress Notes-Nursing. Click Accept
4. Type 'occur' for occurrence in the Insert Smart Text field and press Enter.
5. Select Occurrence Note and click Accept. The Occurrence Entry note displays in the note field.

SmartText Required Fields

The following defines the SmartText required fields:

Icon	Symbol
Wildcard	*** must be selected and replaced with data
SmartList	{dropdown list within brackets} an option from the list must be selected.
Turquoise	A multiple select SmartList
Yellow	A single select SmartList

Complete a SmartText

Use the following information to complete the SmartText:

Field	Entry
Date	Today's date
Time	10:00 a.m.
Occurrence	Fall
Objective/Factual Description of Occurrence	The patient accidentally tripped over his wife's foot and fell. The patient continued to the restroom and contacted me after returning to the bed.
What	Patient tripped and fell over his wife's foot.
When	9:45 a.m. this morning
Where	In the patient room 502
Witnesses	Marilyn Smith, wife
Physician Notification	Paged Dr. Michael Tuggy
Patient/Family Notification	Marilyn Smith, wife
Action Taken	Documented a Pain Assessment. Patient reported no pain due to fall.

6. After you complete the note, click Accept.

Tent Card Patient Scenario: Mike Patient

Department: F 9 Southwest

PATIENT SCENARIO:

Mike is a 68 year old male who was brought into the First Hill Emergency Room for shortness of breath following a fall off of a 7 foot ladder. A chest x-ray confirmed a right sided hemothorax, and the ER physician inserted a single atrium with an initial output of 100cc of bloody drainage. He is transferred your unit where the surgical thoracic resident initiates orders.

1. Log into Epic using your assigned username and password.
2. Select F 9 Southwest as your department (remember to put a space between F and 9 and between 9 and Southwest).
3. This is the first time you're logging into Epic so you must set up you're my List. Create My Practice List.
4. Add your patients from your assigned tent card to My Practice List.
5. From the Patient Lists tree on the left side of the screen, click the plus sign next to the System Lists.
6. Click the plus next to System Lists, click the plus next to Nursing Units First Hill, click on F - 9 Southwest. The list of patients currently admitted to F - 9 Southwest appears in the window on the upper right.
7. Open your Mike patient chart by double-clicking his row in Patient Lists.
8. Your Patient Summary, Chart Cover is the report that opens.
9. Click the Index Report
10. On the Index Report, locate Active Orders
11. From the Index Report, add the Active Orders report.
12. Now go to the RN Admission activity. In the RN Admission, you will document:
 - a. Belongings. He has a wallet
 - b. Allergies: The patient is allergic to penicillin and the reaction is rash; Mike has recently discovered that he's allergic to pineapple with a reaction of vomiting. Upon completion, "Mark as Reviewed".
 - c. Review the patient's home meds and add the following medications:
 - i. Ibuprofen 600 mg, oral daily
 - ii. Lipitor, 20mg, daily
 - iii. Both medications were taken yesterday
 - d. History: Hypertension, Esophageal Reflux, High Cholesterol and had a tonsillectomy in 2002 with Anesthesia and no reaction. Document all that was not previously listed in History.
 - e. Social History: The patient quit smoking last year, which has already been documented. Document that they also drink on an average of 2 glasses of wine per week.
 - f. Admit Screens: work through the admit screens and answer all questions

- g. Plan of Care and Patient Education: you are not ready to begin this section. Move to the next section.
 - h. The Admit is now complete.
13. From the Patient Summary, the Active Orders report shows tasks that need to be done and documented shortly after the patient's arrival.
 14. Go the Doc Flowsheets, locate the I/O-Drains flowsheet. The patient had a chest tube placed prior to coming to the floor, but it still needs to be added to the chart. Document the addition of the LDA (Chest Tube to 20mmhg continuous suction). Document the assessment of the chest tube and document an output of 100mL upon insertion.
 15. Go to the VS Acute Care flowsheet to document vitals. Document:
 - a. Temp: 98.9F
 - b. Pulse: 96
 - c. Resp rate: 20
 - d. BP: 110/65 taken on right arm, while sitting
 - e. SP02: 96%
 - f. Room Air
 - g. Pain Description: Head, Aching
 - h. Pain Scale: 6
 - i. Safety Measures: Standard safety measures
 - j. Height: 6'2" (F=feet; I=inches)
 - k. Weight 210lb
 16. Go to the Assessment flowsheets and document:
 - a. Patient has a hacking cough with copious yellow secretions
 - b. Patient is not at an elevated risk for fall
 - c. Elevated risk for infection
 17. After the assessment, you notice that a UA has been ordered . You realize that the urine collection from earlier is enough for the UA. You have collected the specimen and need to print the requisition to send with the specimen to the lab.
 18. Write a Progress Note and accept it.
 19. Go to the MAR activity. After the patient rated their headache at a 6 on the pain scale, you offer them acetaminophen which they agree to take.
 - a. Document that you gave 650mg of acetaminophen
 - b. 25mg of Benadryl has been scheduled for every 6 hours; the patient has declined it, because it makes them sleepy.
 20. Go to the Plan of Care activity. Apply the Adult Physiological Instability template. Apply the applicable goals (goals should address the issues that are keeping the patient in the hospital). Document on the Plan of Care as appropriate.
 21. Go to the Patient Education activity. Create the Learning Assessment.
 - a. Go to the Assessment tab and click Create New
 - b. Document learner, readiness, method, and response for all points and click file
 - c. Go to the Unresolved Education tab.
 - d. Click Add Title
 - e. Type NSG General Inpatient Nursing Inpatient Adult

- f. Select the appropriate teaching topics from the template, click Accept
22. 30 minutes have gone by since you gave the patient acetaminophen. Reassess the pain and document it on the Doc Flowsheet. The patient's pain is now a 7/10.
23. The patient's pain scale is high and the acetaminophen is not assisting the patient, you have decided to call the provider to get a stronger pain medication. You speak to the provider and they ask you to place a verbal order for Oxycodone 5 mg Q4 hours PRN Pain.
24. Go to the Doc Flowsheets activity and select the VS Acute Care flowsheet.
25. Document the VORB/TORB located under the MD/Provider Notification section.
26. Go to the Order Entry activity to place the order for Oxycodone 5 mg Q4 hours PRN.
 - a. In the New Order area, type Oxycod
 - b. Select the appropriate medication, click Accept
 - c. Click on the medication's hyperlink
 - d. Review and click Accept.
 - e. Click Sign Orders.
27. Close the Patient's chart and log out.

