IP Registered Nurse

Inpatient

Table of Contents

NOTES

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.

NOTES

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

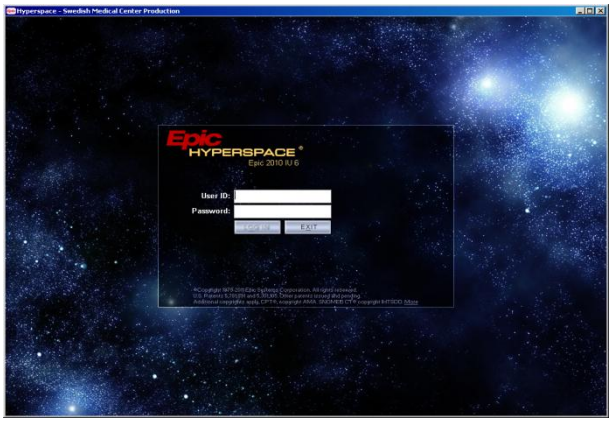
Included in this Chapter:

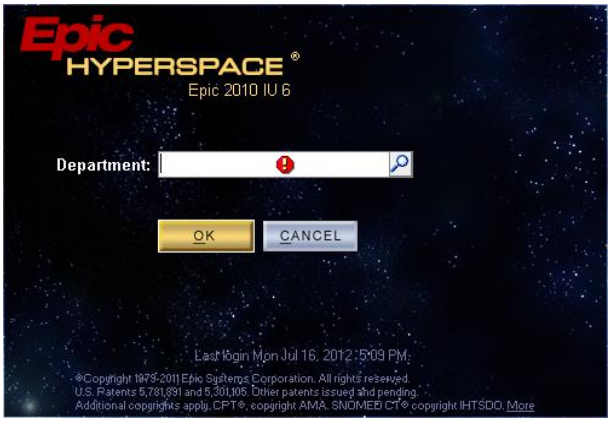
- Log In to Hyperspace
- Log Out of Hyperspace
- Understanding Workspaces and Activities

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.



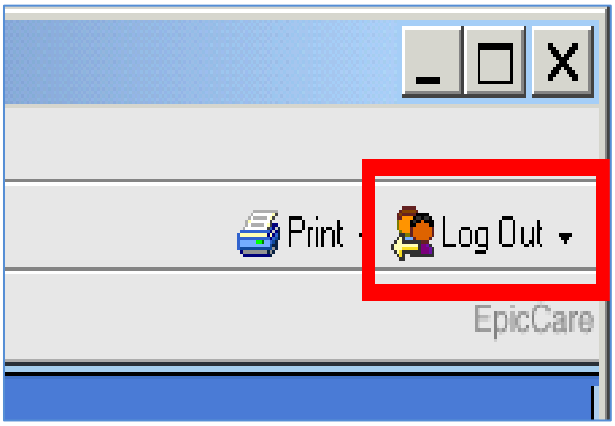


Log Out of Hyperspace

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 

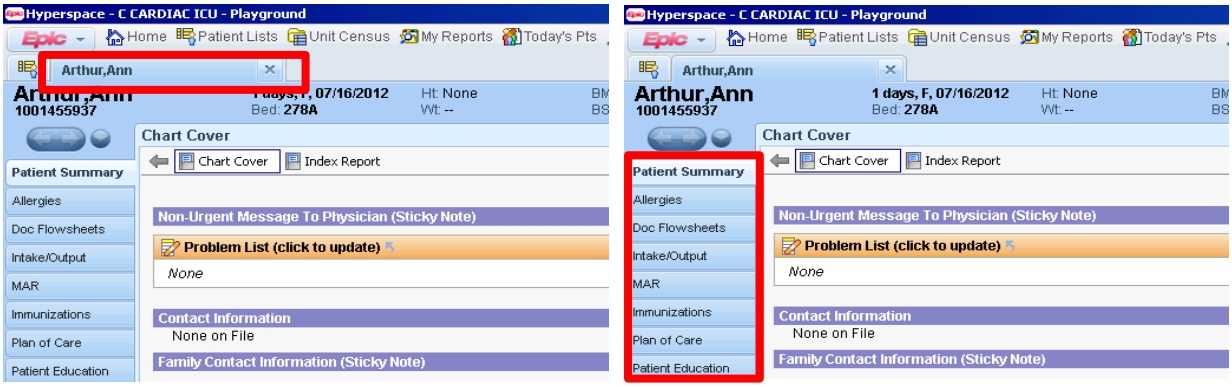
in the upper right corner of the screen.



!	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:

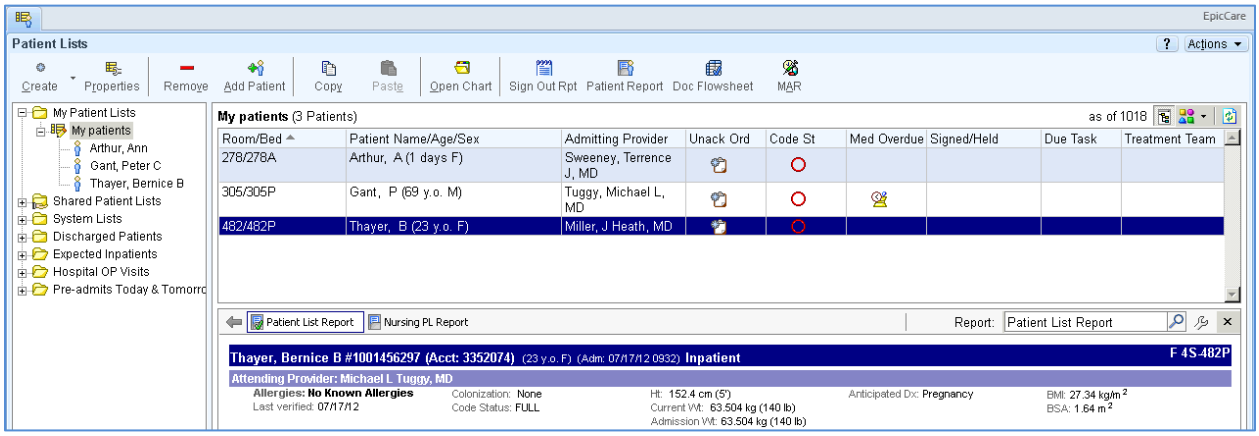
- Understanding the Patient Lists Activity
- Patient List Directory
- Patient List Display Pane
- Report Display Pane
- Create a My List

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.



Patient List Directory

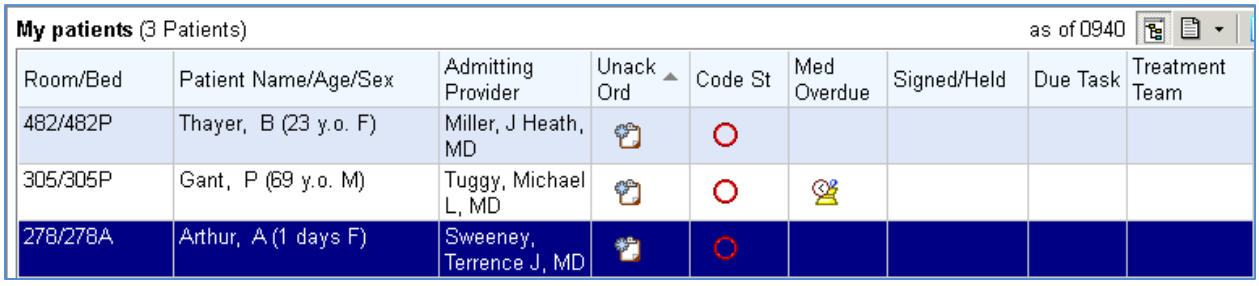
Along the left side of the screen is the patient list directory. This list contains folders of available patient lists at your facility, including lists by unit or specific statuses, such as recently discharged patients.

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

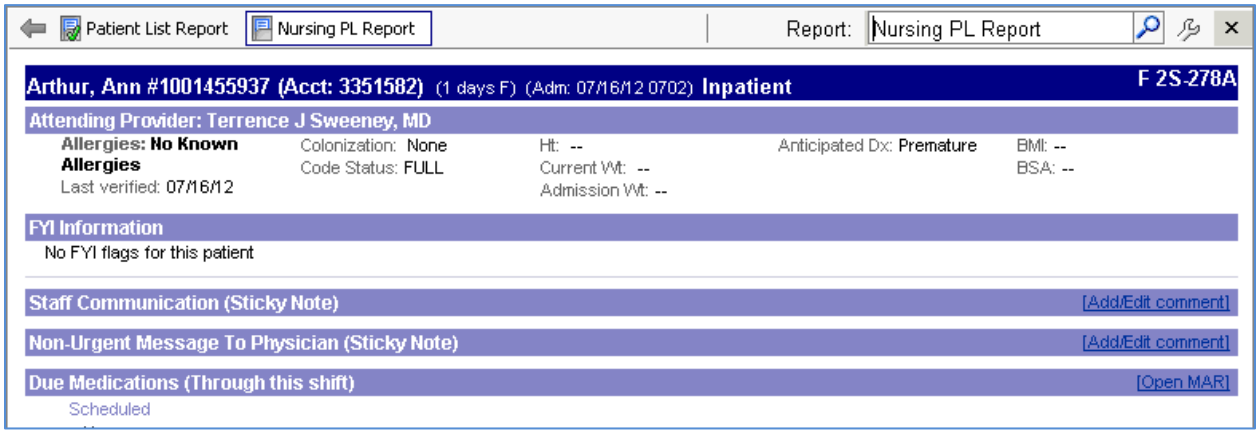
The patient list display pane in the upper right section contains additional information about each of the patients on your list.



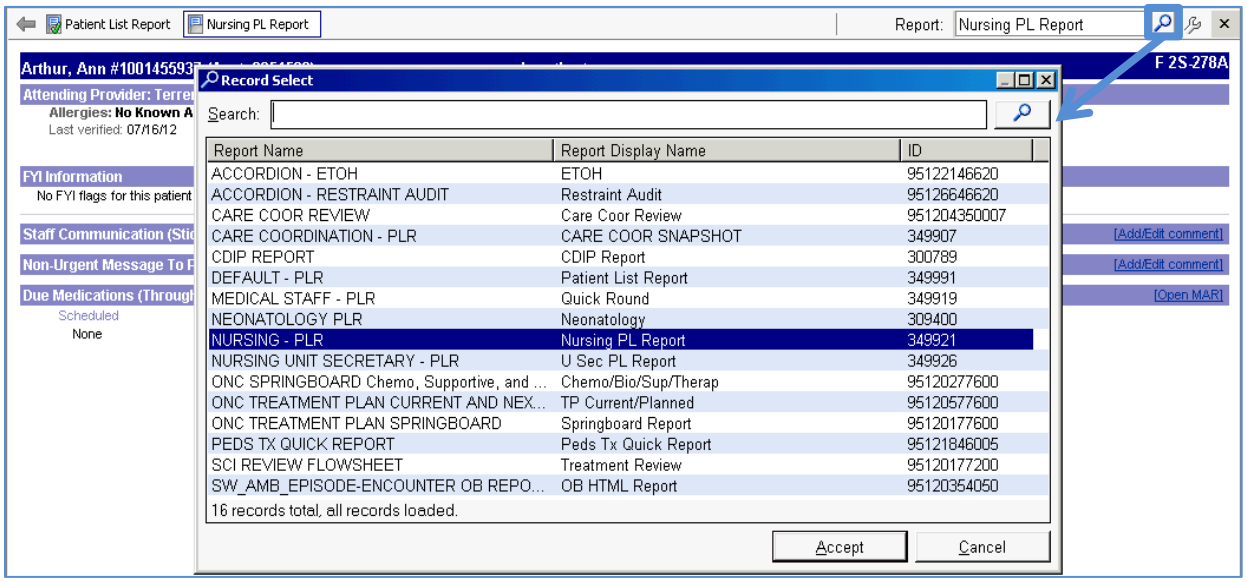
If the unit list contains a large number of patients, you might want to click ✕ on the reports display pane to hide the report and maximize the space for patient names. To view the reports pane again, click, which appears in the upper-right corner of the patient list display pane after the report display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

Report Display Pane

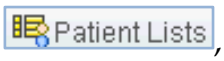
The report display pane in the lower right section contains a report with information on the patient selected in your patient list.



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



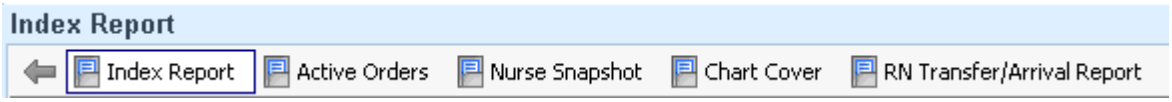
To return to the Patient List activity:

2. In the activity toolbar, click 

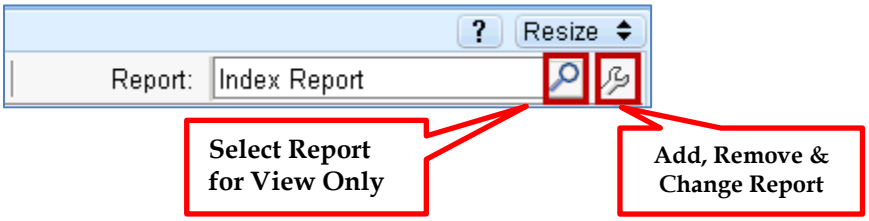
, or
3. In the Desktop menu, select Patient Lists

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:

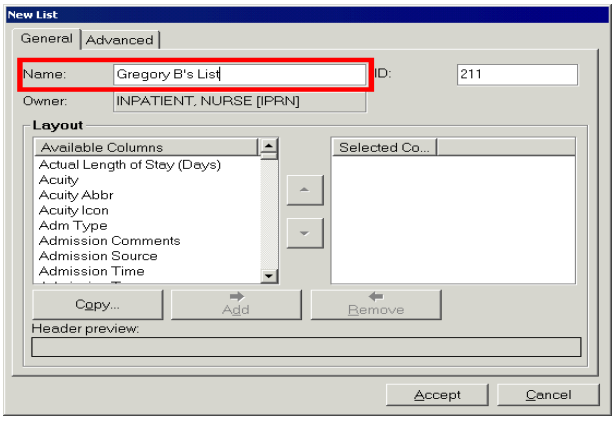
1. Index Report
2. Active Orders
3. Nurse Snapshot
4. Chart Cover
5. RN Transfer/Arrival

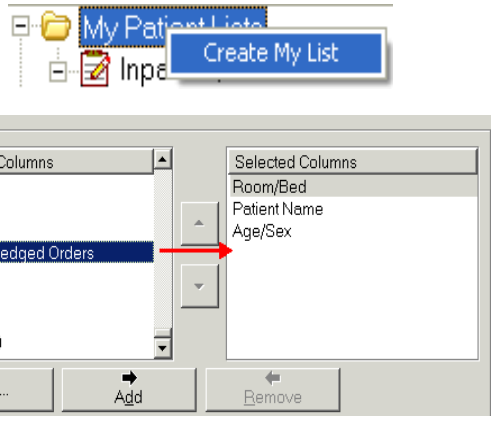
Create a My List

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.

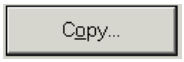




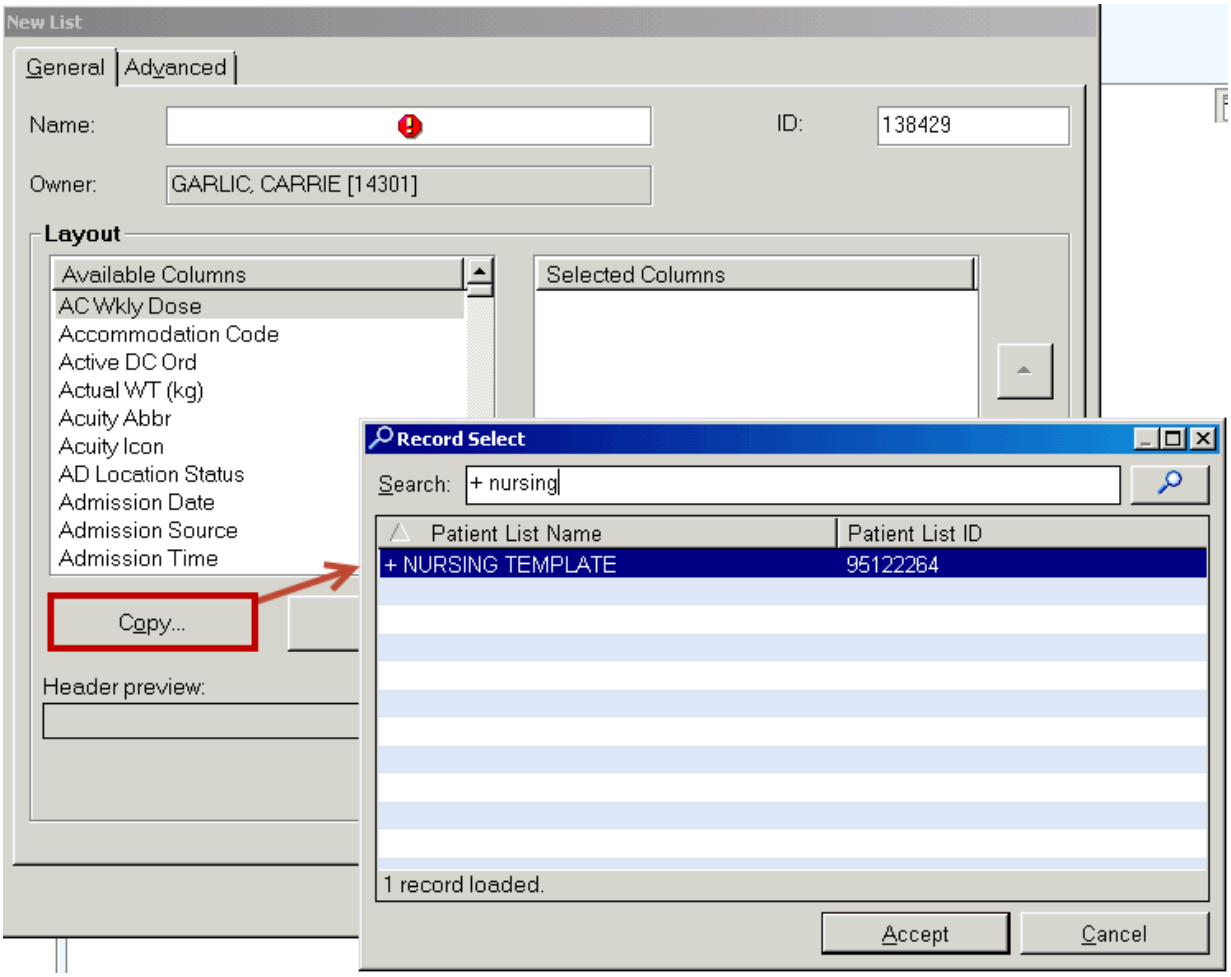
Copying a Standard My List Column Layout

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 

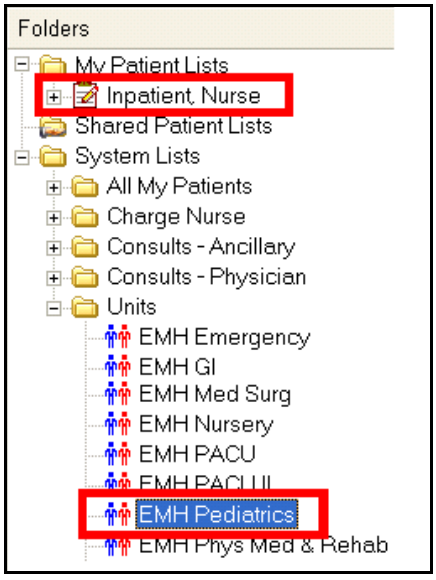
and enter '+ nursing' to copy. This copies the columns designated for nursing, not the patients on it.

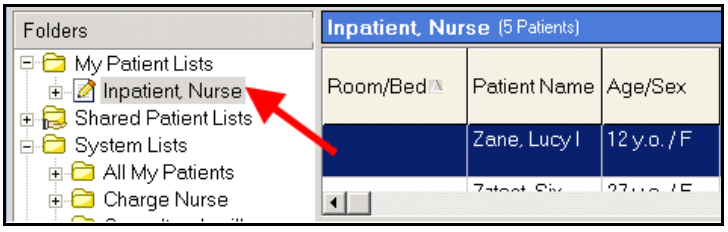


Populate your My List using the System List

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.

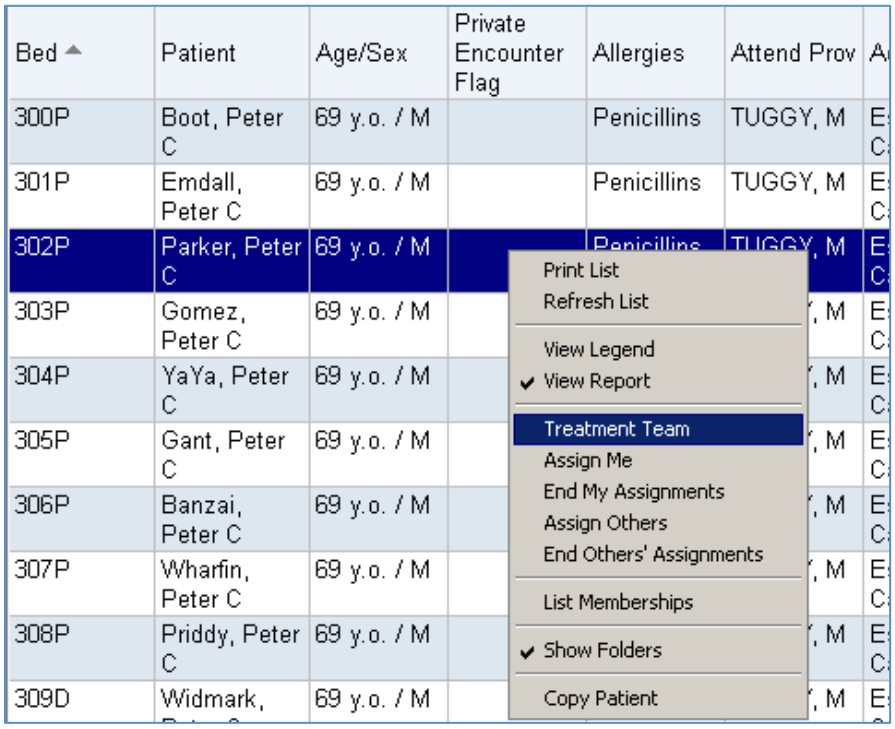




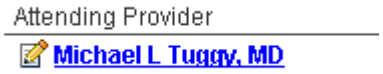
Updating Treatment Team

To update the Treatment Team and change the Attending Provider:

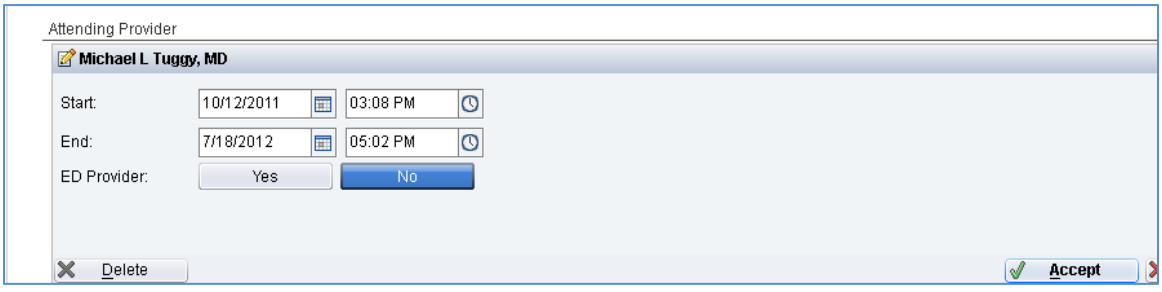
1. Select the Patient and Right click
2. Click on Treatment Team



3. Click on the Blue Hyperlink for the Attending Provider

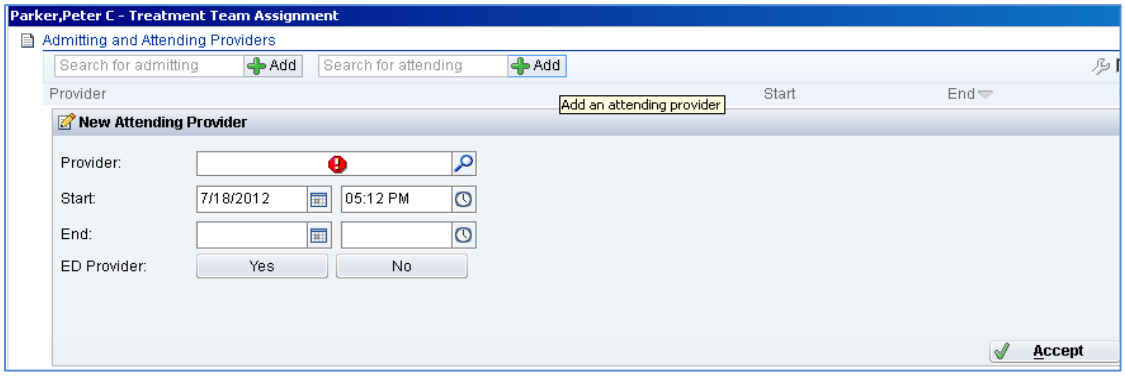


4. Enter an End Date and Time and click Accept

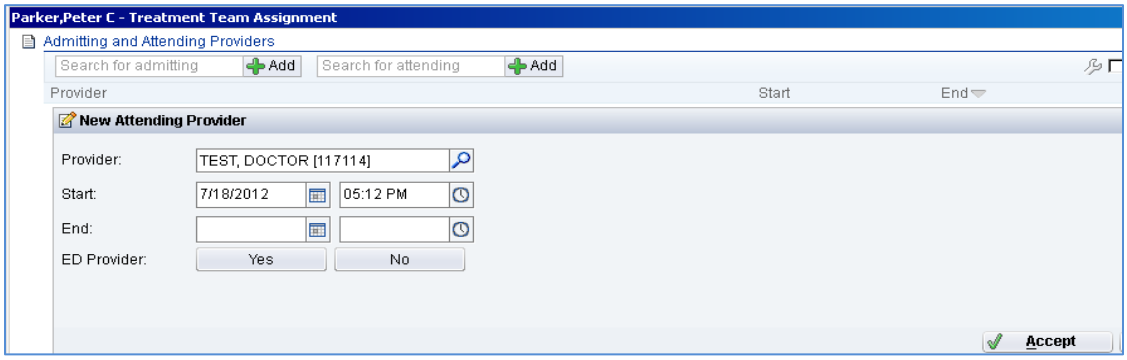


Add a New Attending Provider

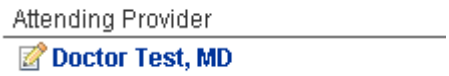
1. To add a New Attending Provider click on the second Add plus + symbol



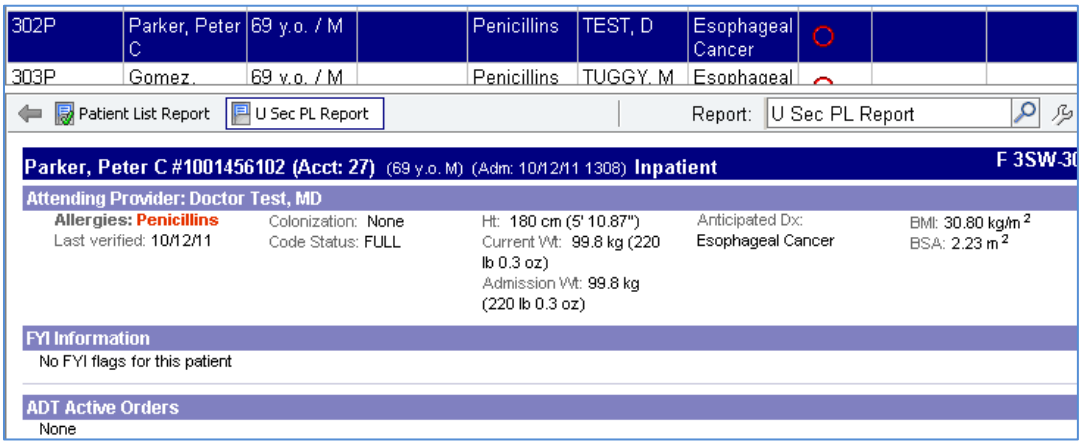
2. Enter the new Attending in the Provider box and click Accept



3. The Attending Provider is changed



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



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.

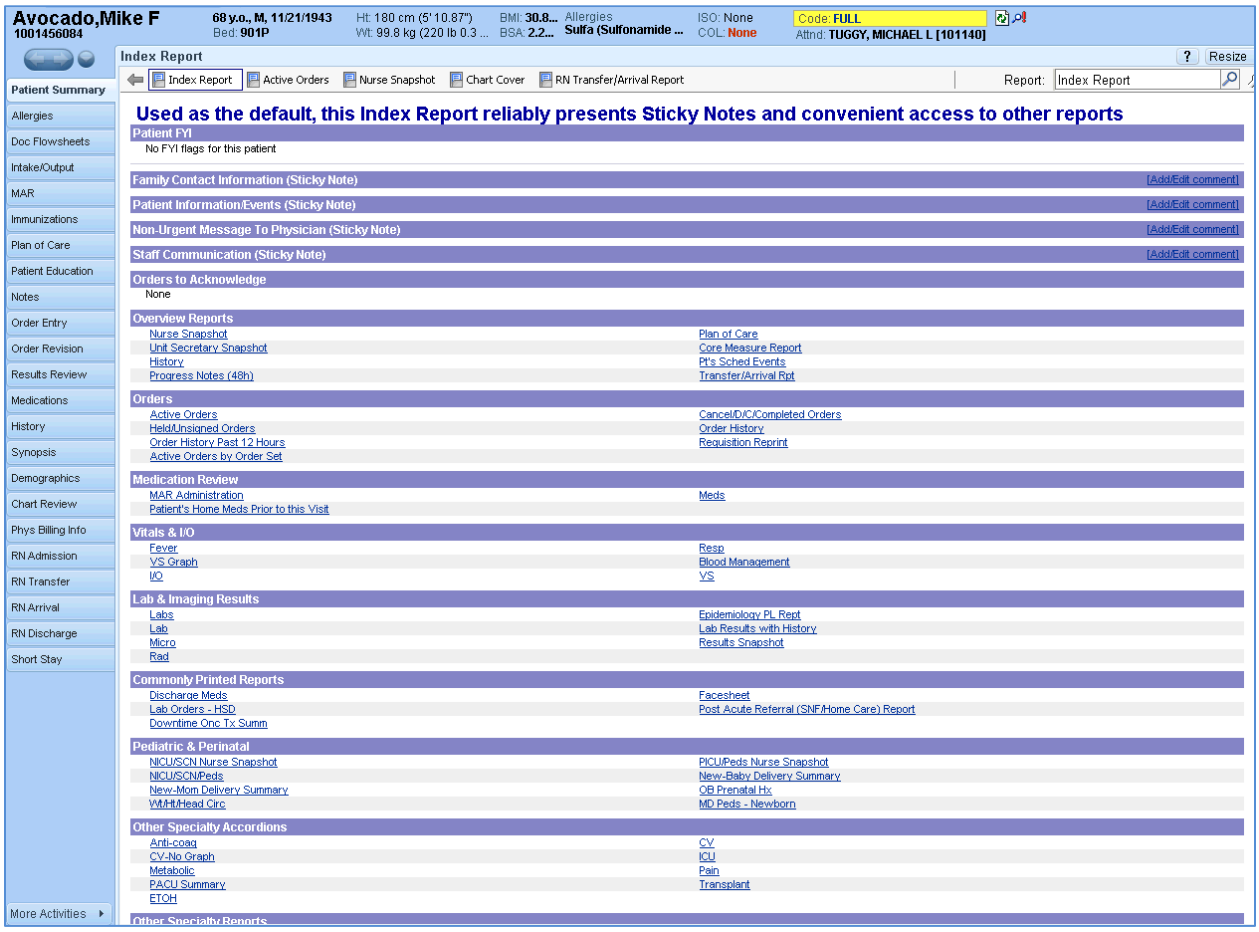


Chart Review

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.

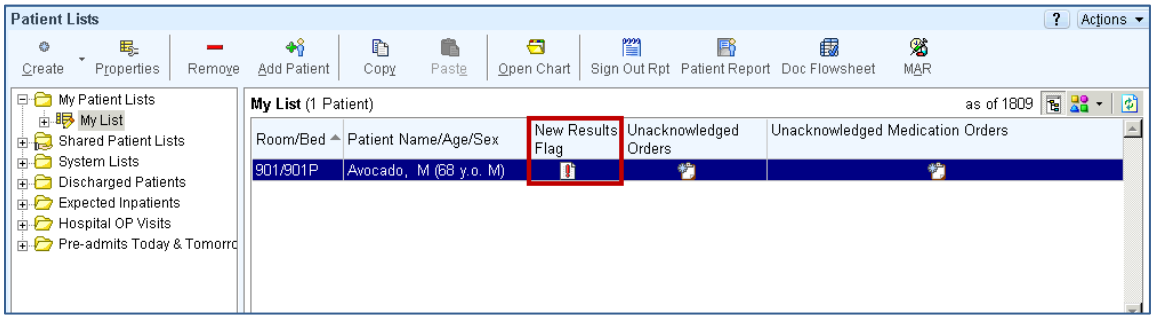
Results Review

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

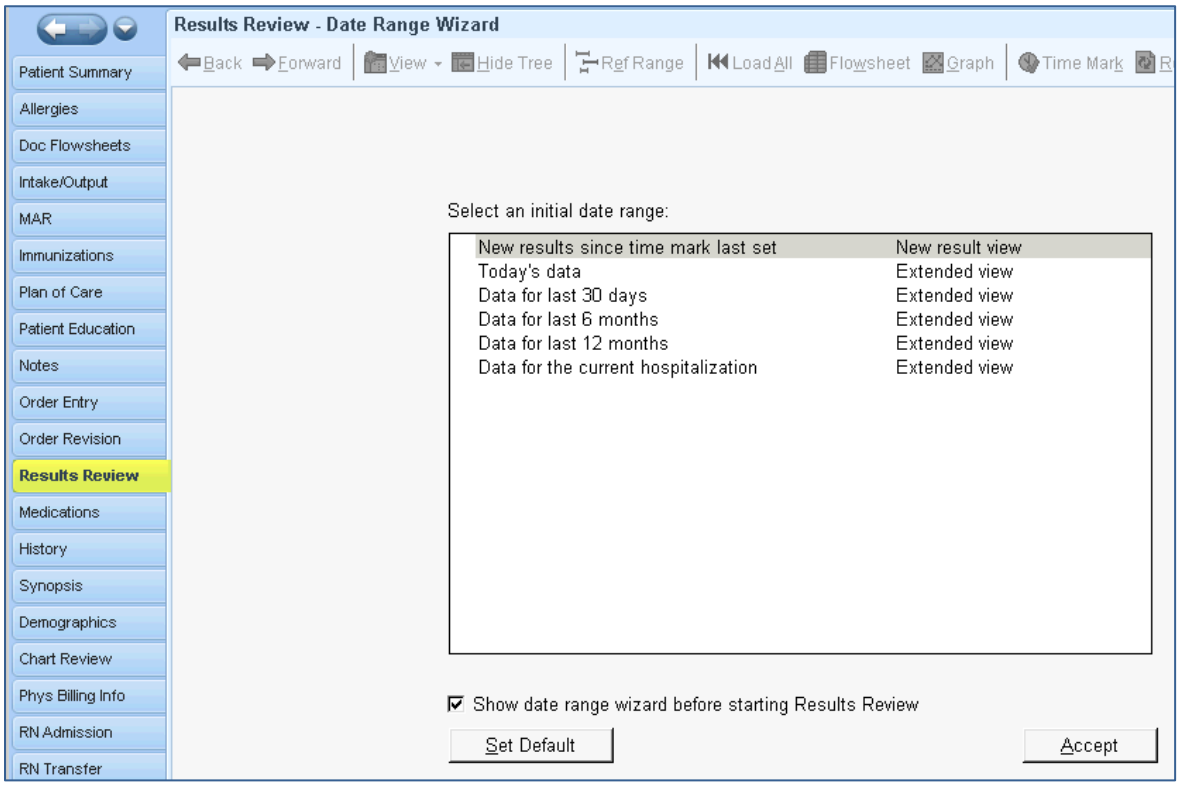
Two ways to access Results Review

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.

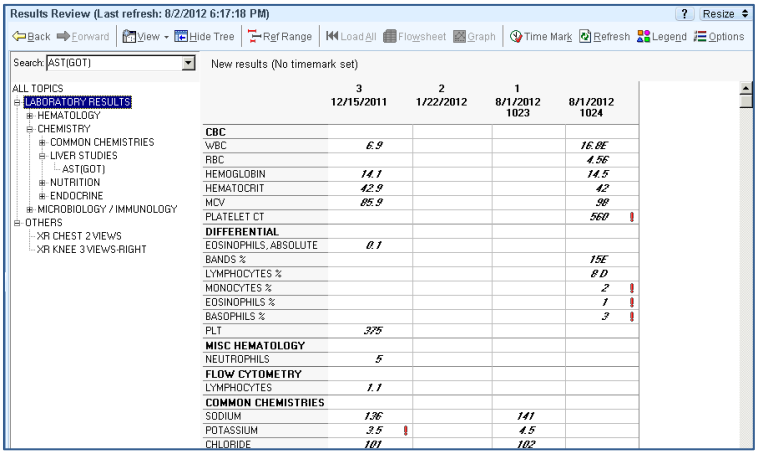


3. Select Data for the current hospitalization and click Accept. The results display in a table format.

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.



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

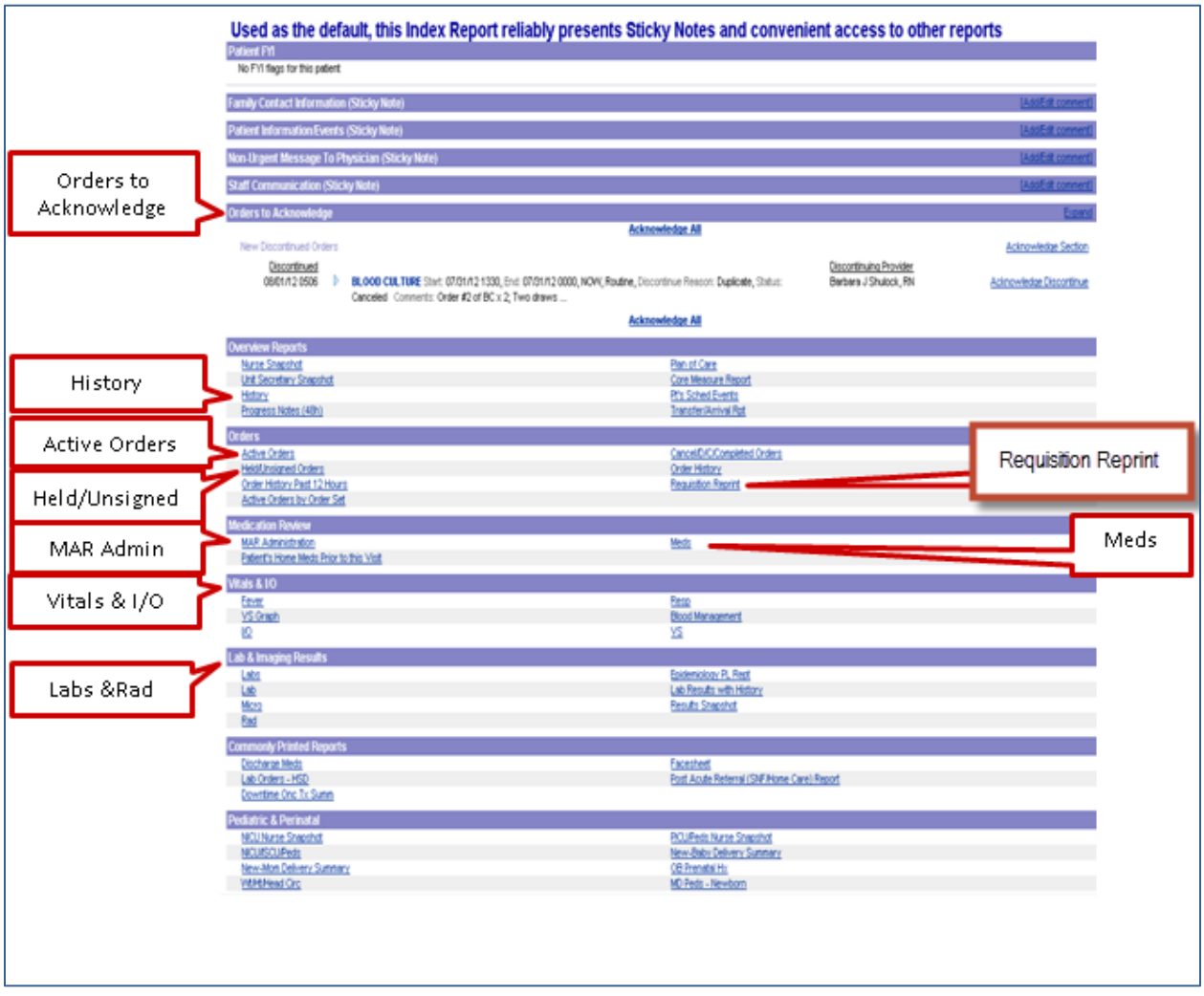
1. Get patient assignment
2. Meet with prior shift nurse to receive report.
3. Prior nurse will hand off patient to oncoming nurse.
4. While receiving report from the prior shift note, together both nurses;
    a. Review patients and care
    b. Review Nurse Snapshot
    c. Review active order
    d.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

NOTES

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.



Important Reports:

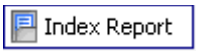
1. Index
2. Active Orders
3. Nurse Snapshot
4. Chart Cover
5. RN Transfer/Arrival

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 

. 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. 

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.

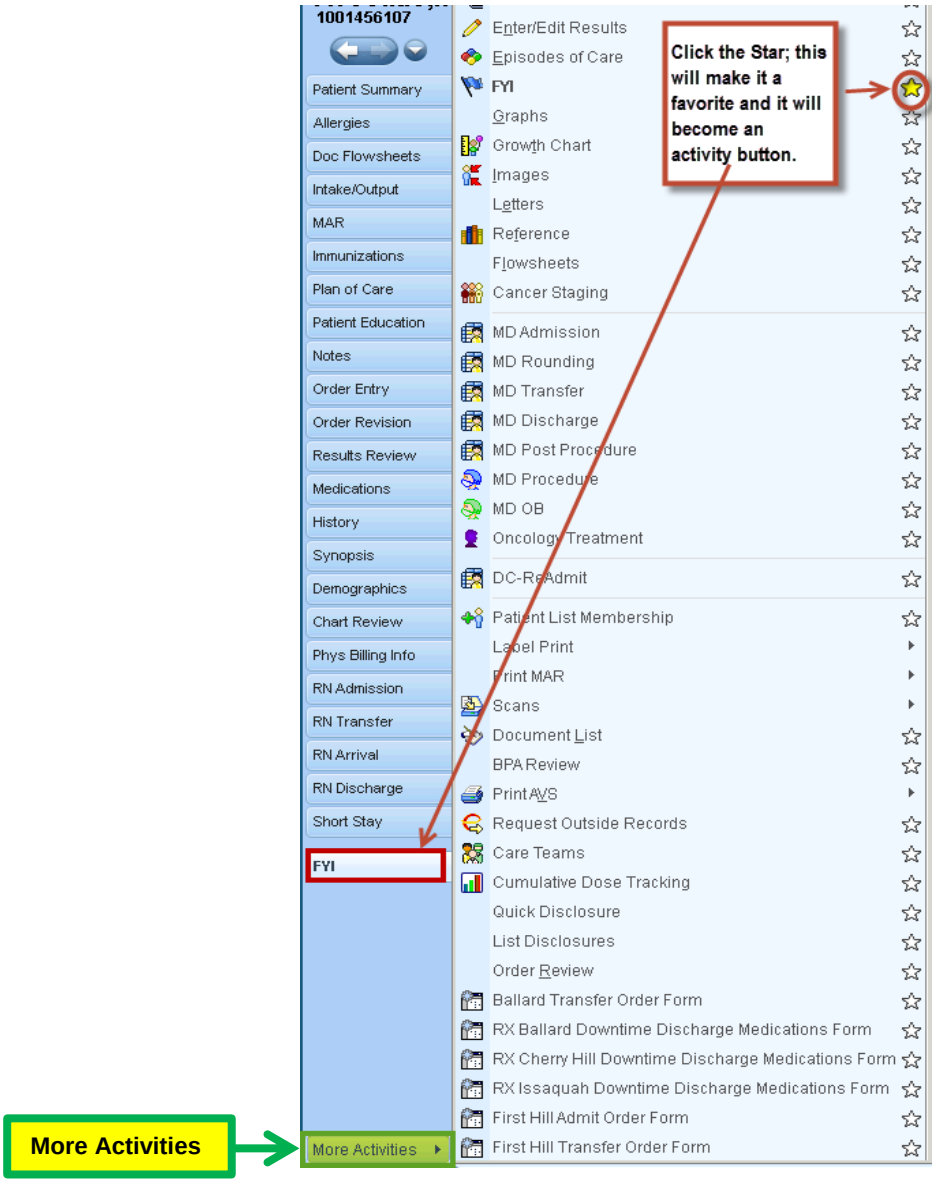
Active Orders Report is utilized throughout the shift, from start of report until the end of the shift. You can view, document and organize tasks for your patient.

FYI

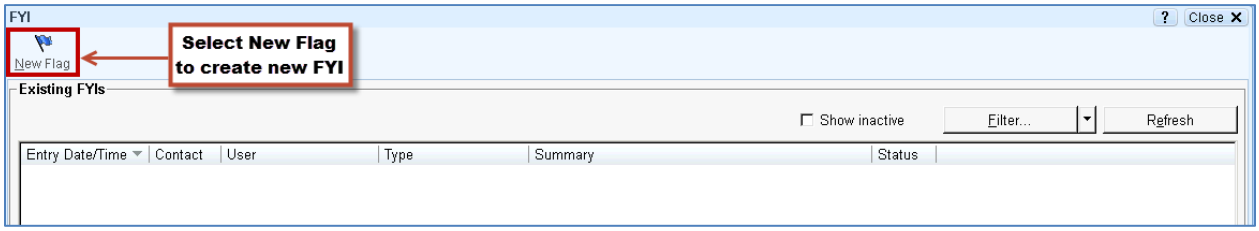
An FYI flag is a way to communicate patient information to all health care providers and assigned treatment team members across facilities. FYI flags can be viewed from the Index Report and the Nurse Snapshot.

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.

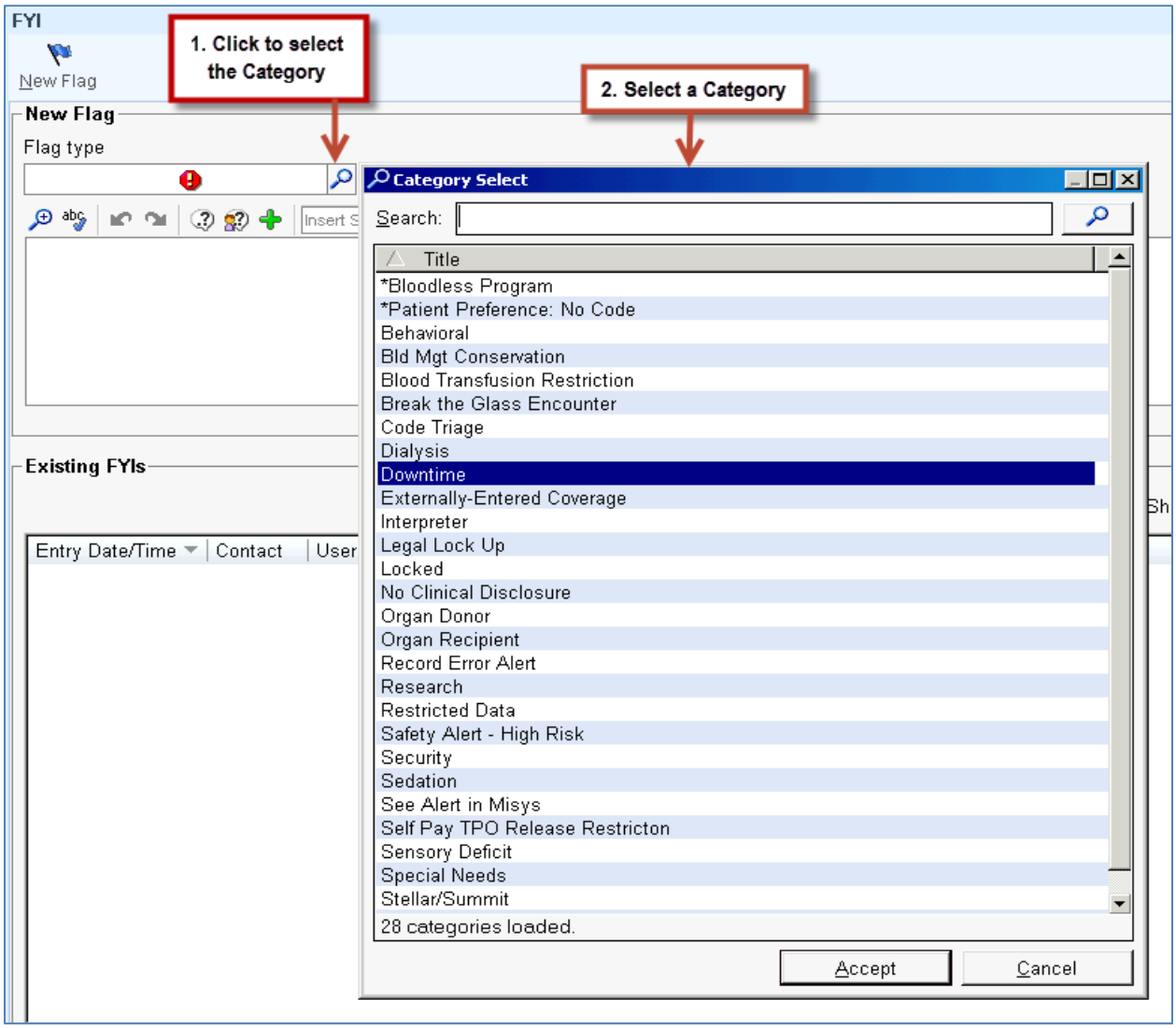
1. To create an FYI, click More Activities, located in the bottom left portion of the screen.



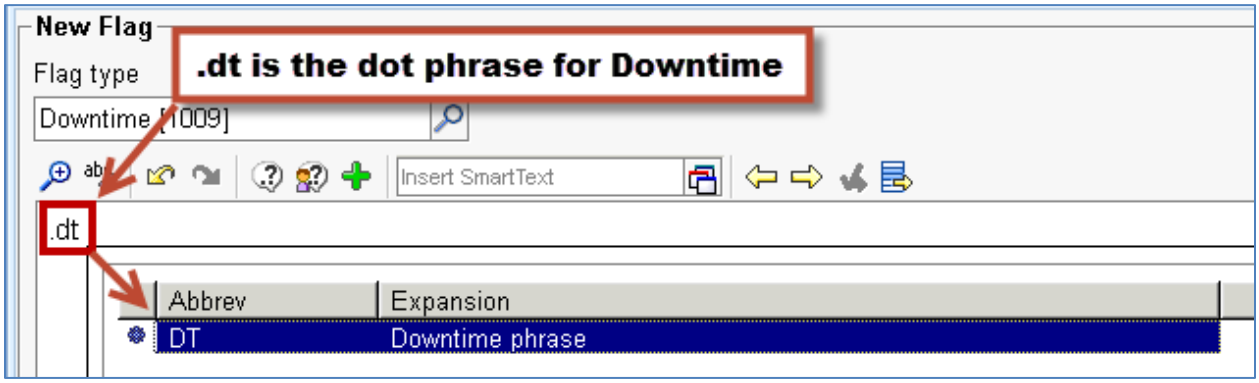
2. Click the star, across from FYI. This will make FYI a favorite on your activity buttons
3. FYI displays, click Flag.



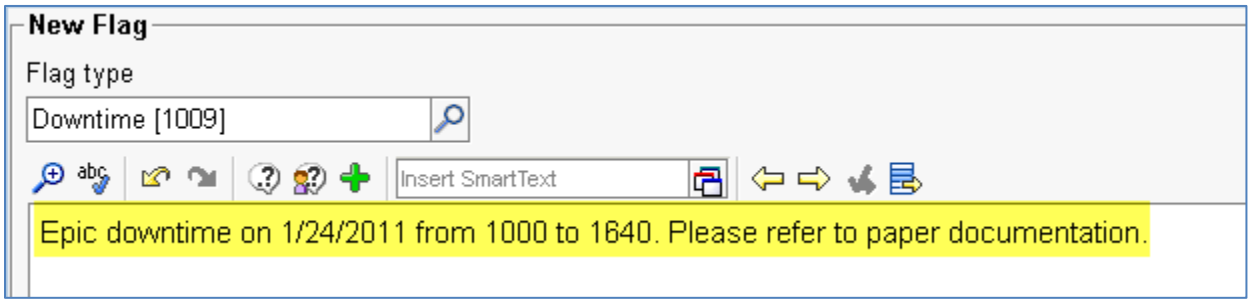
4. Click  , to view the categories



5. Type ".dt" which is the smartphrase for Downtime



6. Double click DT.
7. Message appears in FYI as:

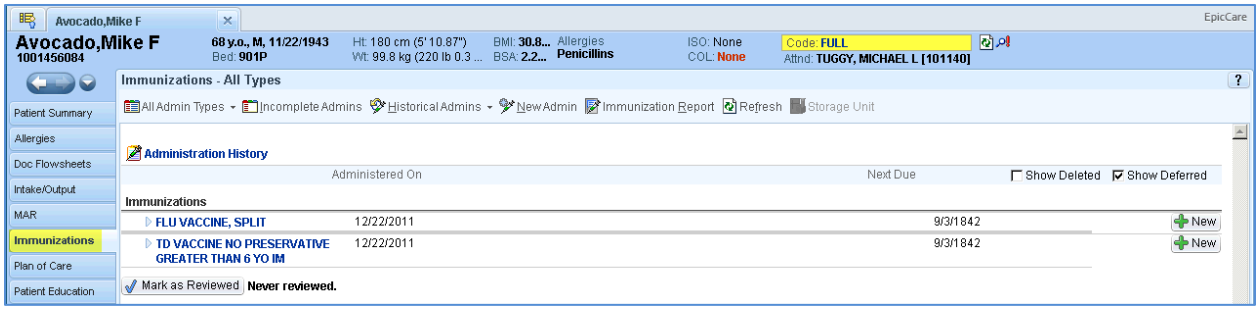


8. Click Accept

Immunization Activity

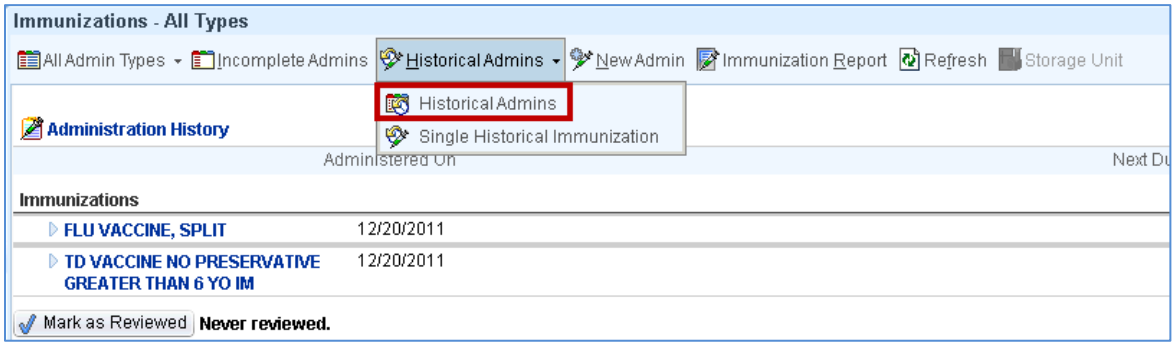
In addition to the screening of patients for required vaccinations, vaccination records should be reviewed upon the first 24 hours of admission and updated as necessary.

Immunization shows any immunizations on record.

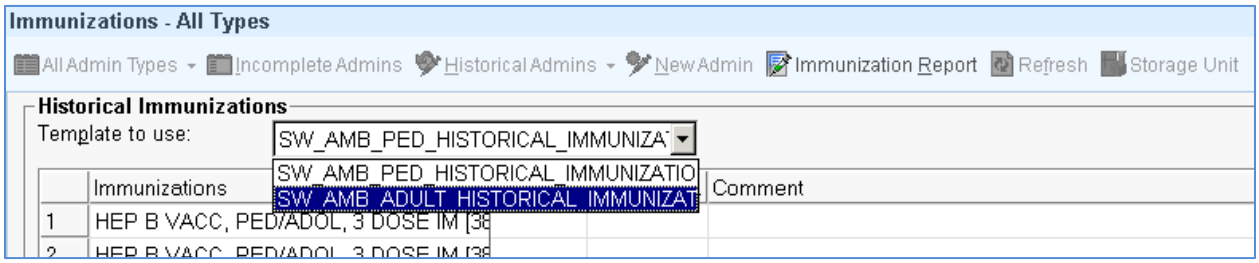


Nurses are required to update Immunization history upon admission through the RN Admission.

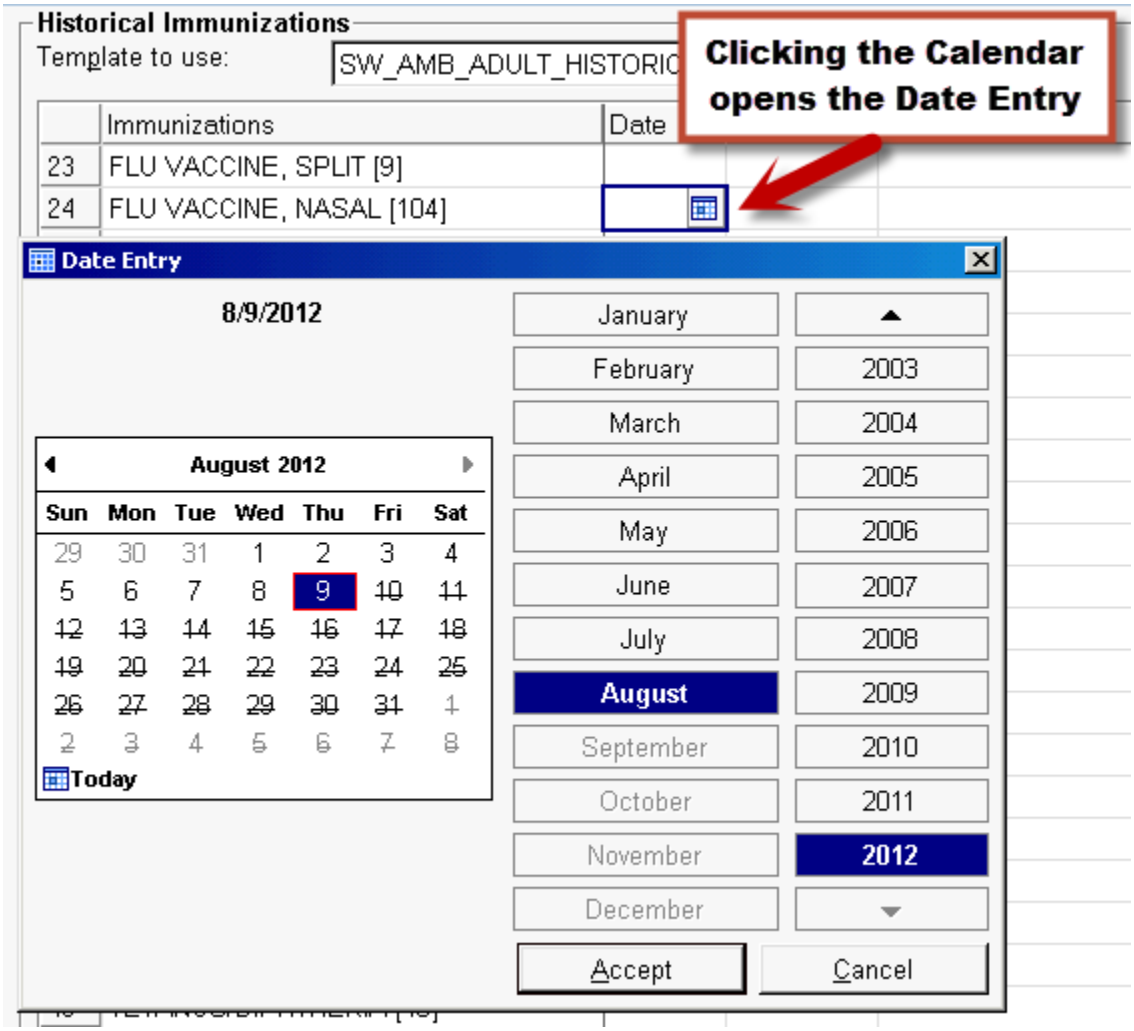
1. Click Immunization activity button
2. Click Historical Administrations. Select Historical Admins.

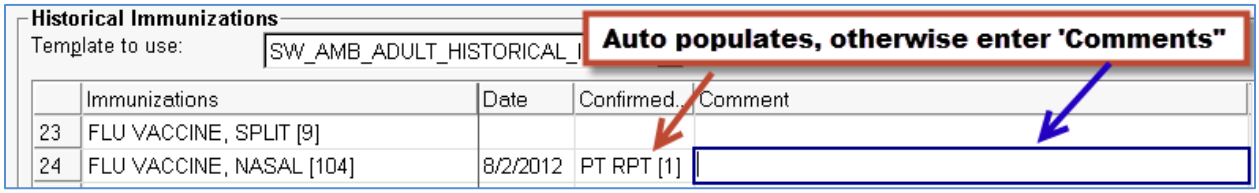


3. Select Ped or Adult patient



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





5. 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.

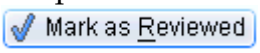
1. Click the downward arrow next to Historical Admins and select Historical Admins.
2. Select SW_AMB_ADULT_HISTORICAL_IMMUNIZA.
3. Find FLU VACCINE (H1N1 - Swine) [172].
4. Click the date column next to Flu Vaccine.
5. Type t-7, Enter.
6. The Confirmed column, defaults and PT RPT[1] defaults automatically.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

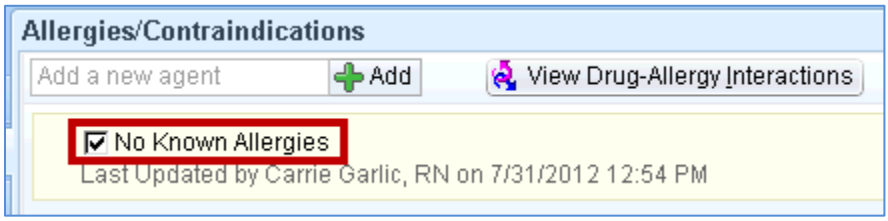
If a patient has never been seen to this facility, there will be no allergy information in his/her chart and you will enter all allergies for that patient. If your patient does have prior entries, you will review the allergy list with the patient to see if anything has changed and then modify the list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

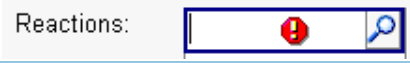


2. The Allergies in the Patient Header will now say **No Known Allergies**

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.

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

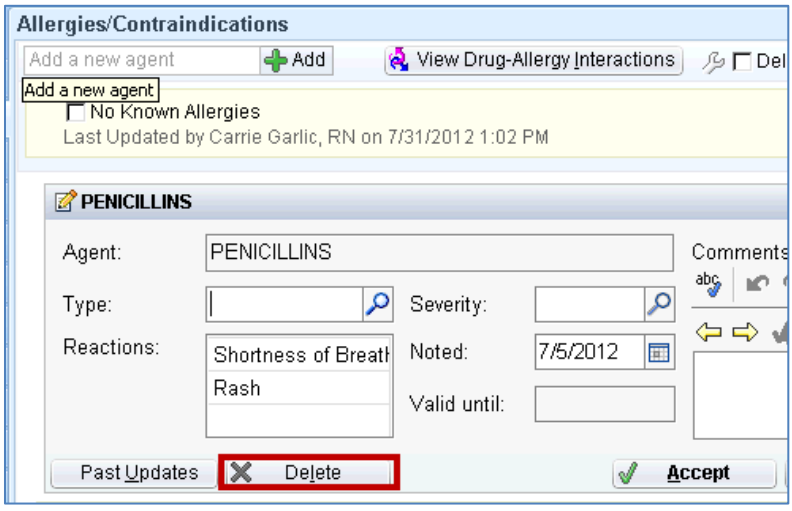
Modifying a Current Allergy

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

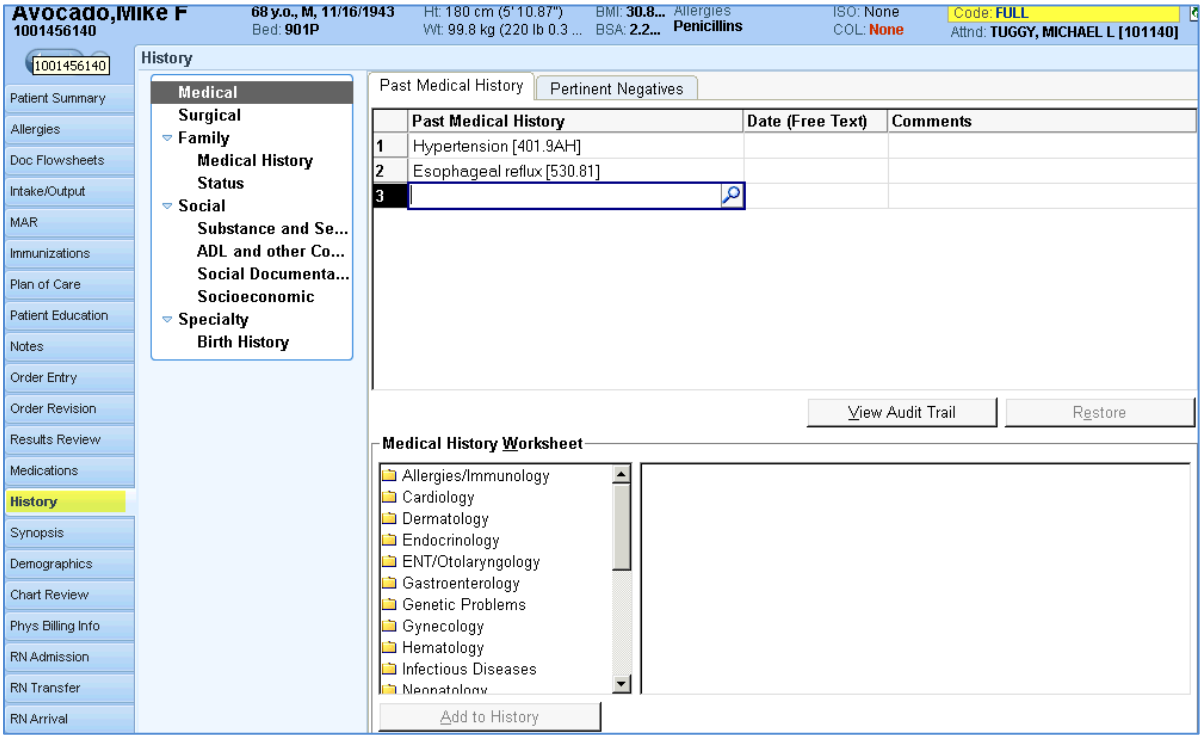
1. Click Penicillins
2. Click 'Delete'



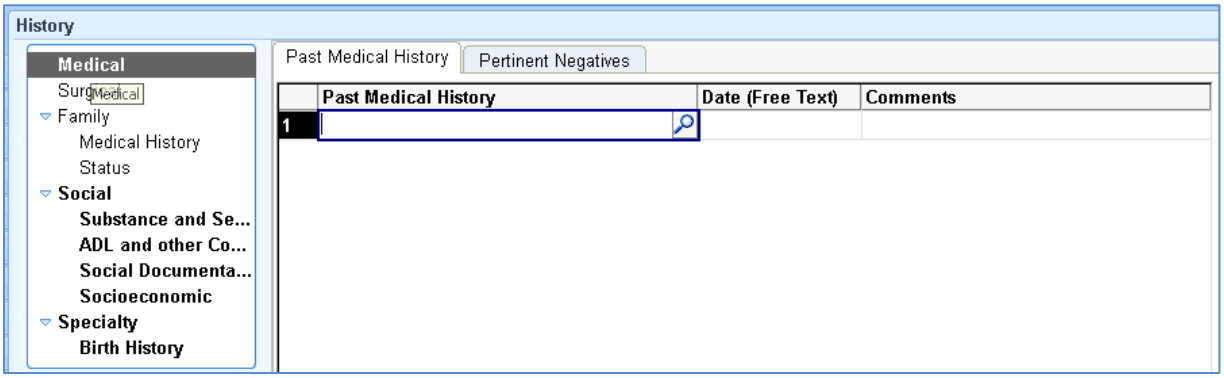
History

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



2. In the Medical Surgical section:



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

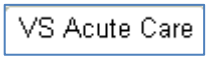
When you complete a Head to Toe assessment, you must document on each system. Epic requires you to determine if the assessment is WDL (Within Defined Limits) or if there is an Exception to WDL. A set of "normal values" has been determined for each body system and is displayed in the Details Window.

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 

activity.
2. Click the 

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

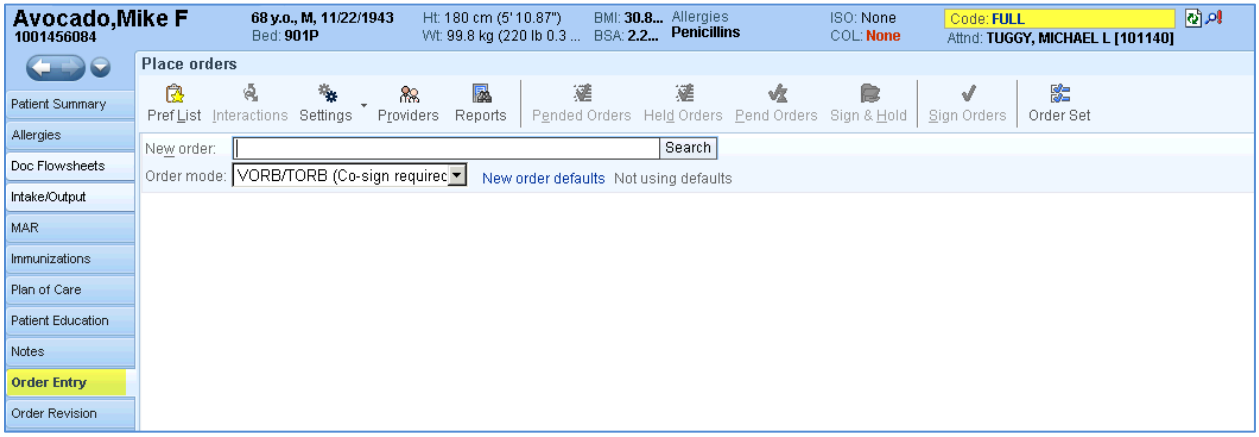
Pain Assessment, located directly beneath the **Pain Description**, asks whether **Add'l Pain** Documentation is needed. If **Yes** is selected , Pain Management is added to the flowsheet.

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.



Order Modes

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

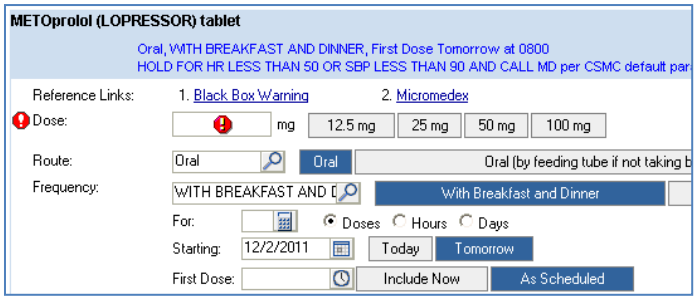
Order Mode	Definition	Physician Cosign Required	Example
VORB / TORB	Order(s) is being placed as a result of a verbal or telephone order from an LIP	Yes	Entering an order for a medication given as a result of a VORB during a procedure, orders taken as a result of a phone discussion related to a change 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.

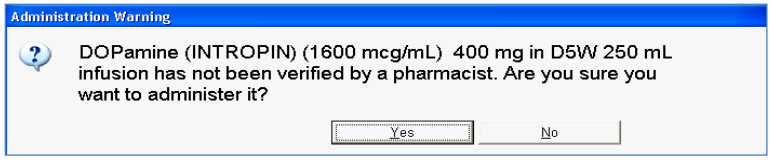


Sign the medication order

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.



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.

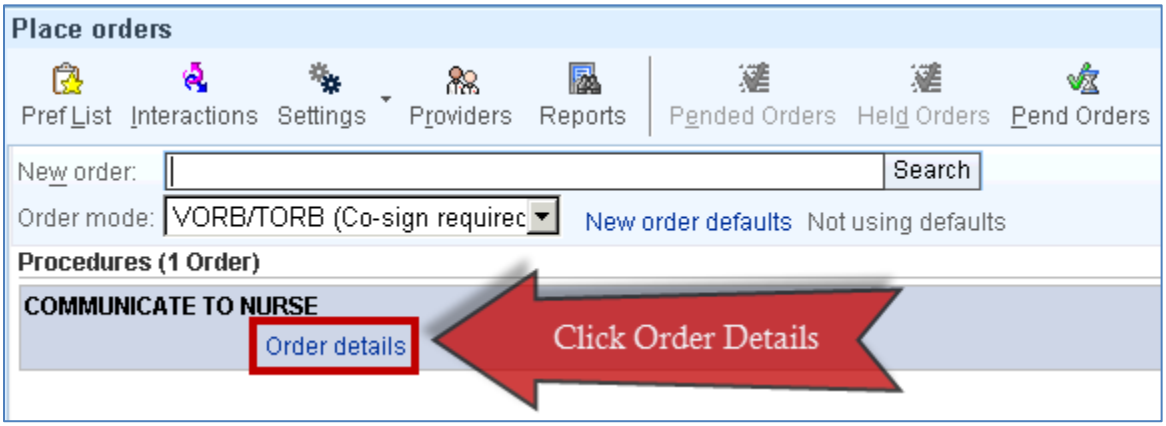
6. Select per guideline as the order mode.
7. Enter Dr. Michael Tuggy as the Ordering Provider.
8. Click Accept.

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

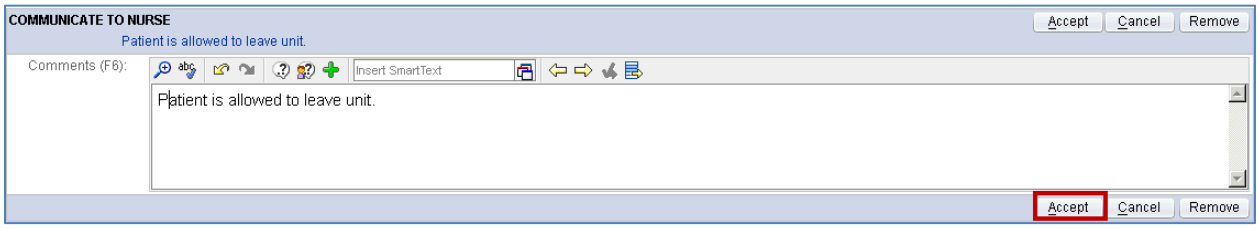
Generic Communication Order

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.



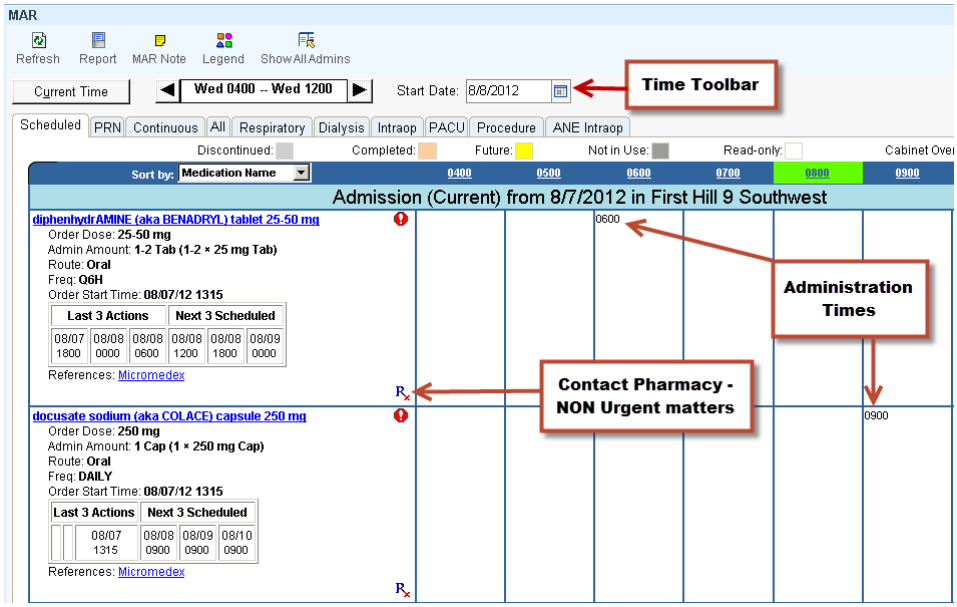
6. Communication appears as:

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.



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

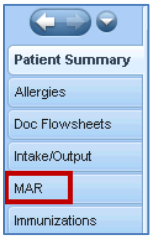
- Document TPN
- Document PCS

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

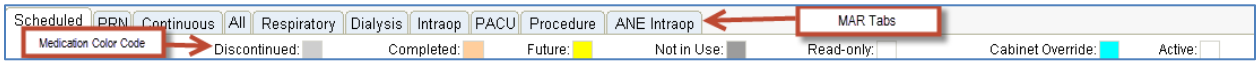
The MAR tabs filter medication based on certain criteria. Each tab represents a specific type of medication order. When you click on a tab, only medications of that type will display.

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

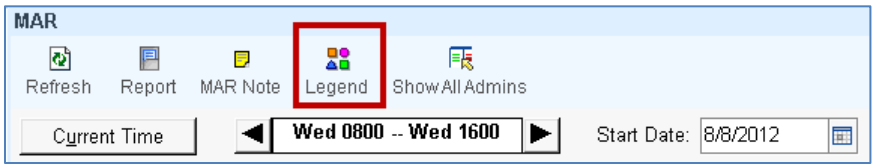
The MAR is color coded to help you easily recognize the status of medications. There are two legends. One helps define the medication status and the other defines the icons, administration types and links.



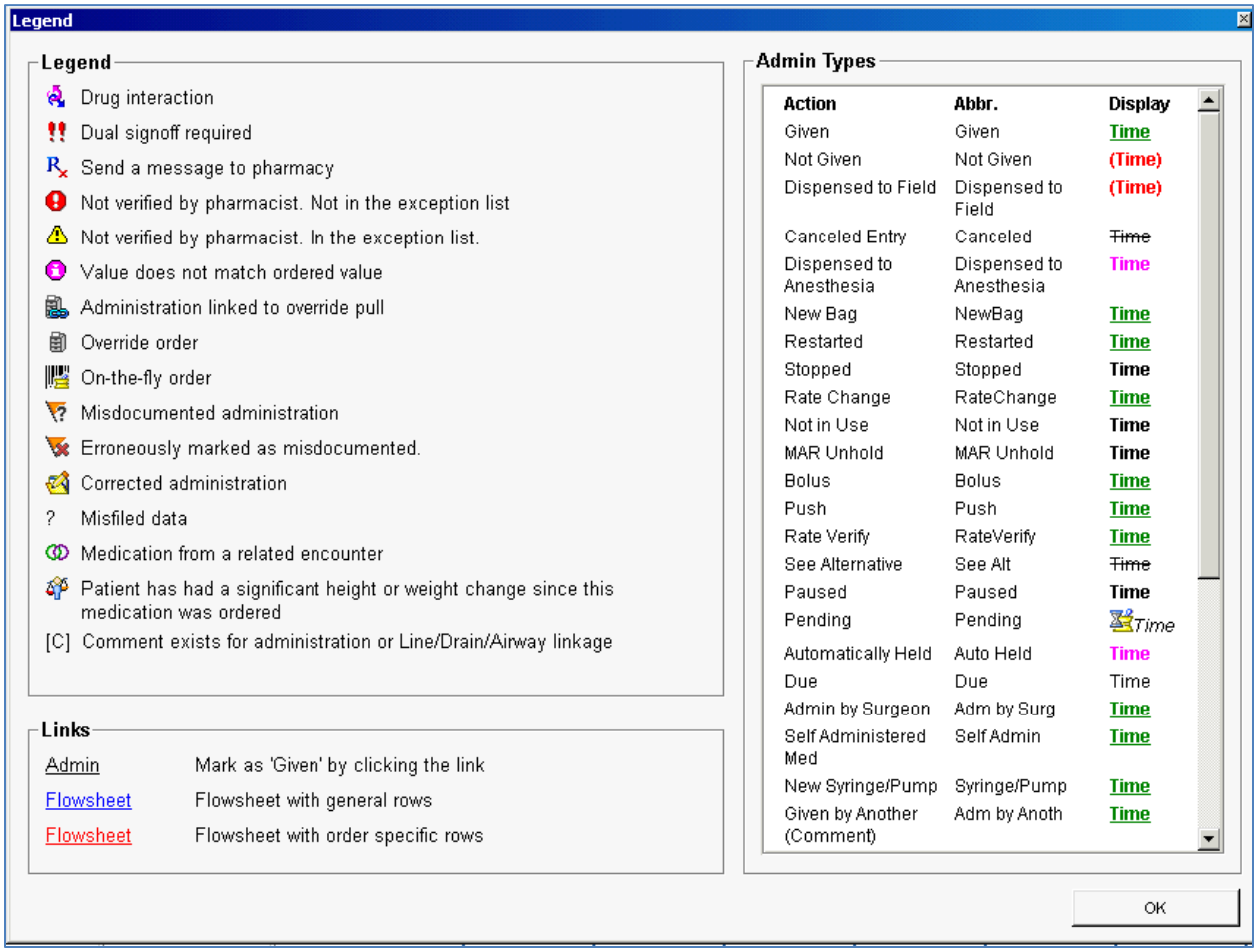
MAR Status Key

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

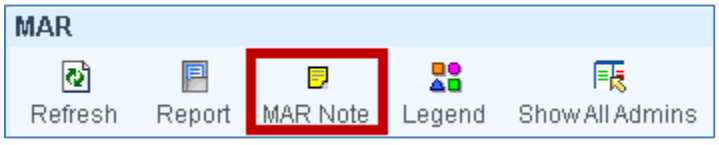


On the Activity Toolbar, there is a Legend button. Click Legend and you will find a definition for every icon and administration type that displays in the MAR table.



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. Mark as Reviewed requires speaking directly to the patient and reaffirming their allergies.

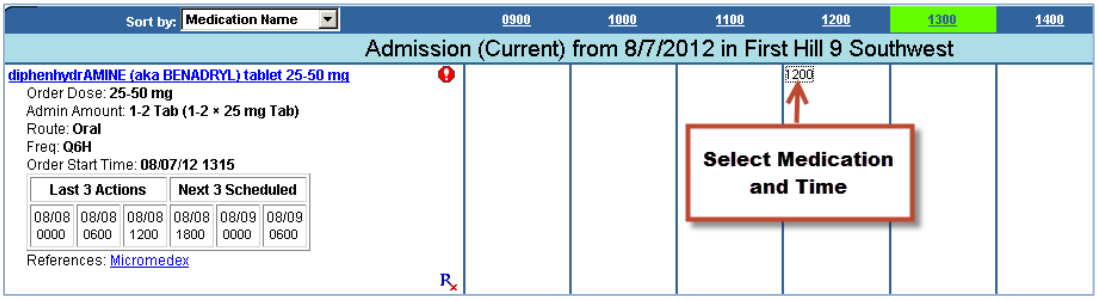
You can view the allergies on the patient header, but must go to the Allergy activity to I. Mark as Reviewed . If the patient has multiple allergies and they are not all visible on the patient header, hover your mouse over the allergies and they will all display.

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

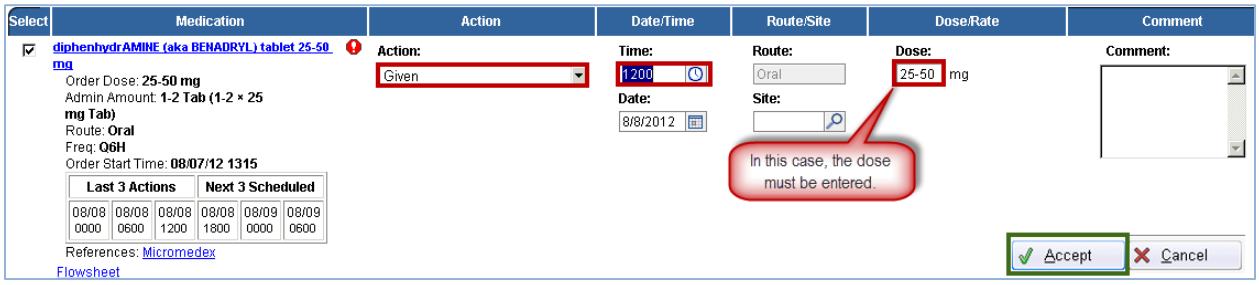
1. Click the Allergies activity
2. Select the checkbox for No Known Allergies.
3. Click Mark as Reviewed.

Document a Scheduled Medication

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



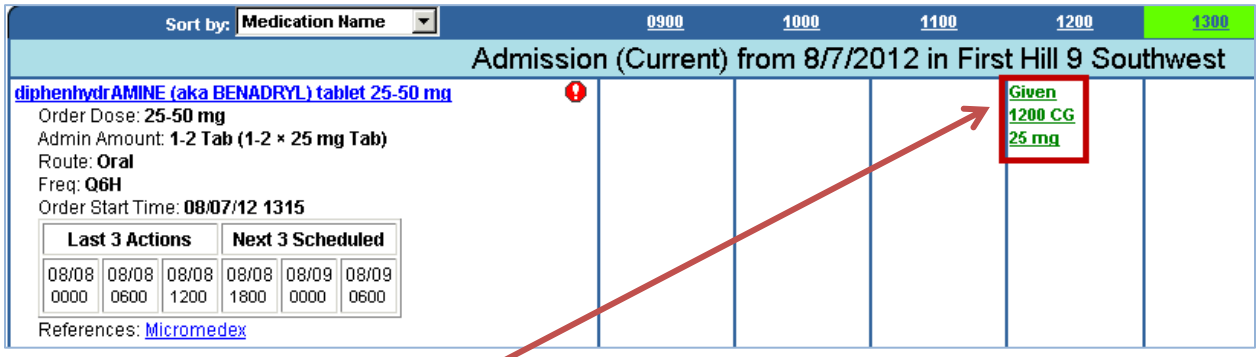
2. Medication box will appear.



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

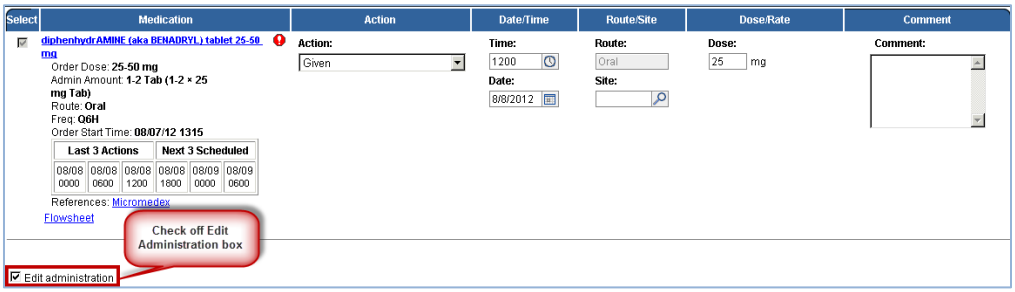
View Administration Action on the MAR Table

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.

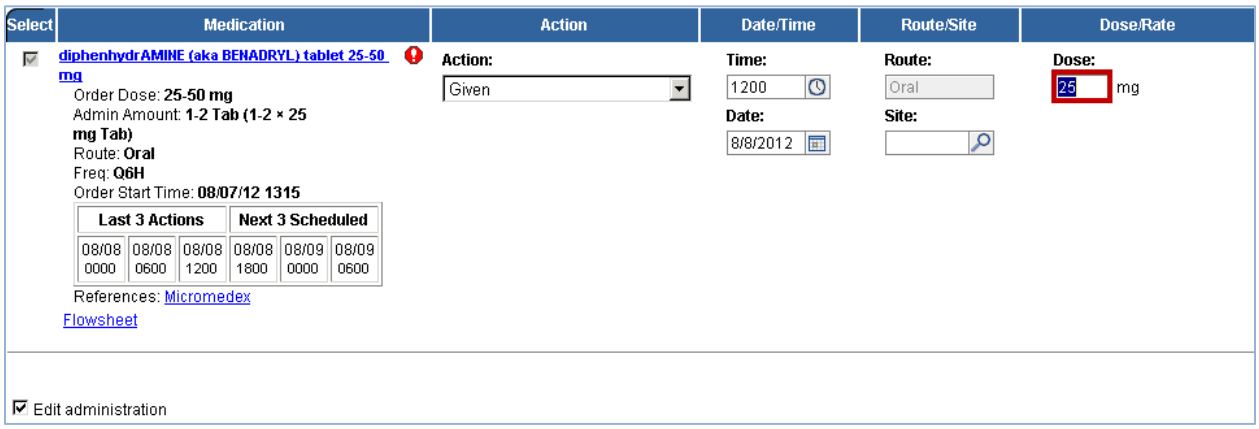


Edit Details of an Administered Medication

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



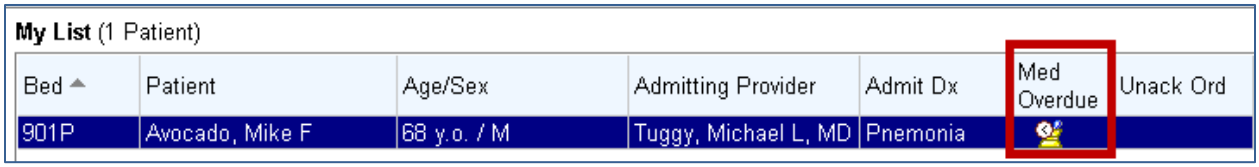
3. Change the dose to 30

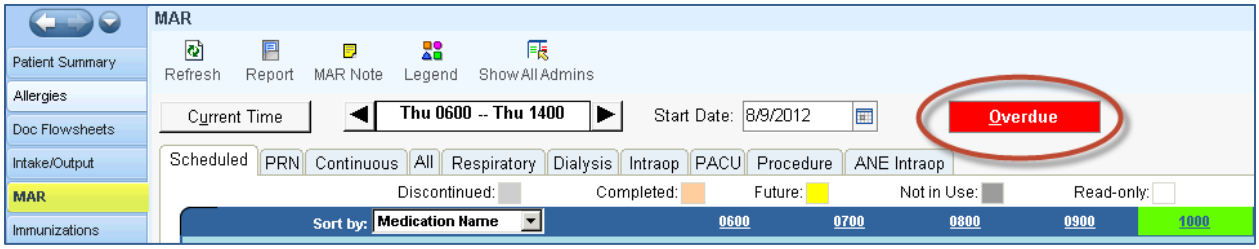


Document Overdue Medications

Identify Overdue Medications

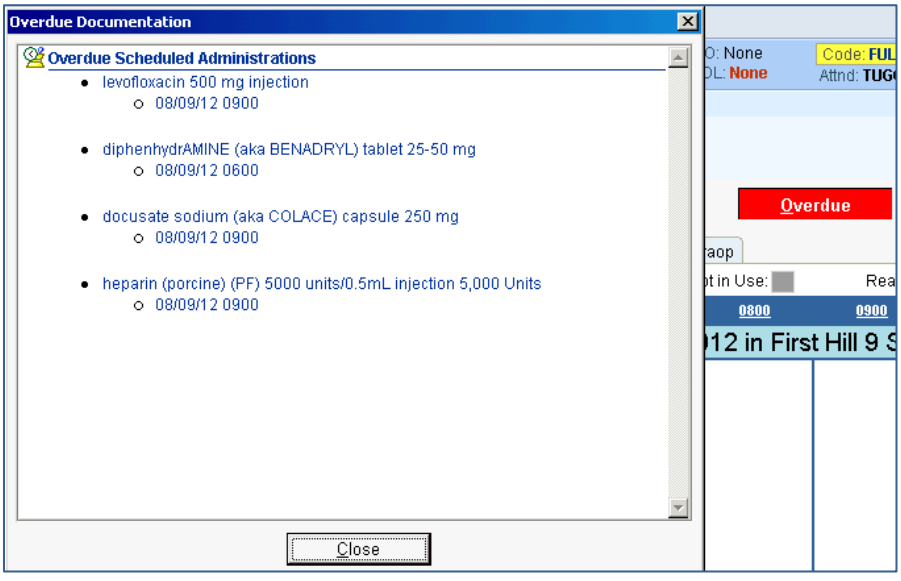
A scheduled medication not administered within an hour of the scheduled time is overdue. A number of tools exist to alert clinicians of overdue medications. From Patient List, a column on you My List shows an icon for patients with overdue medications and MAR activity will show a red flag for overdue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





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.

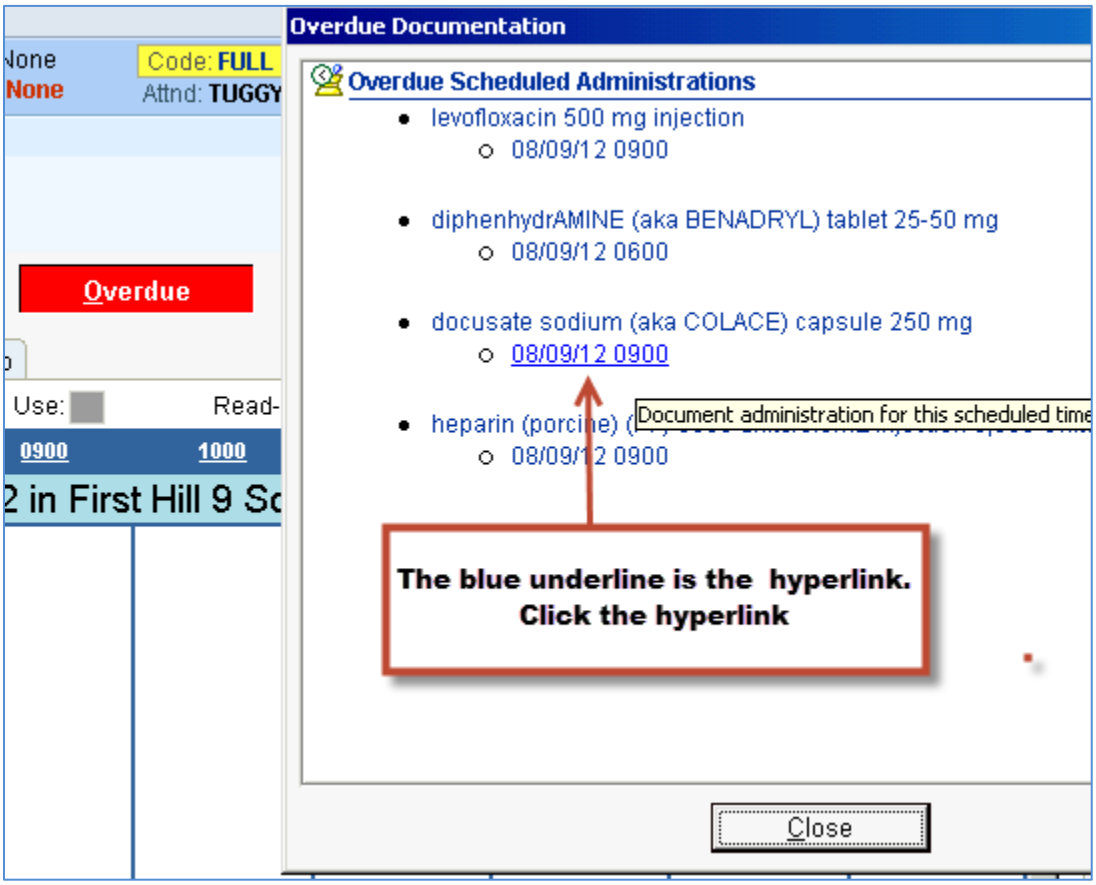


4. Click close after reviewing overdue medications.

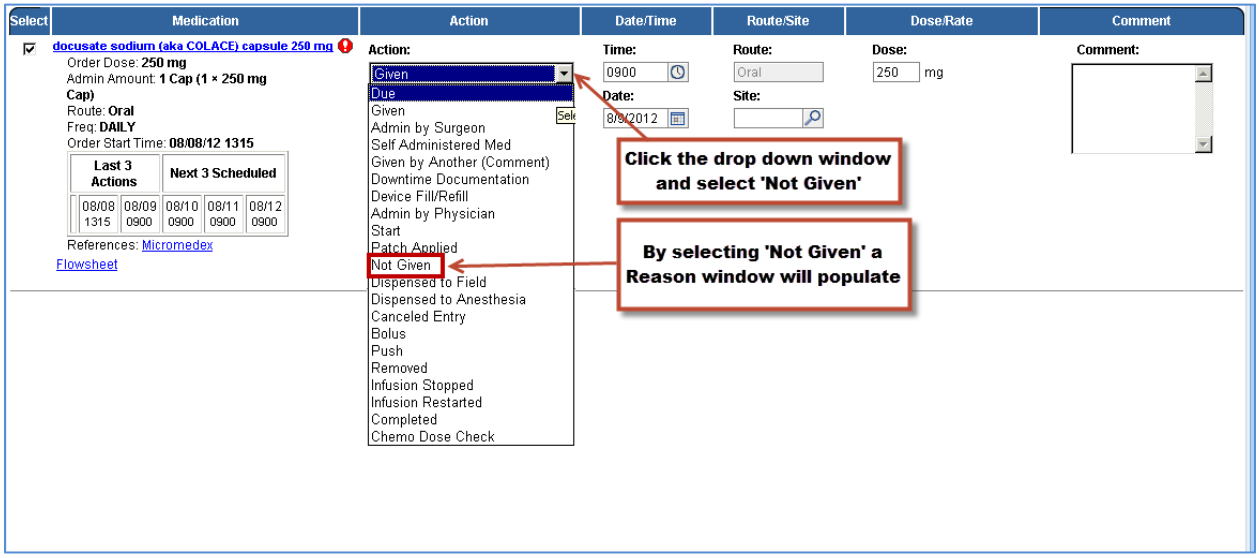
Document an Overdue Medication

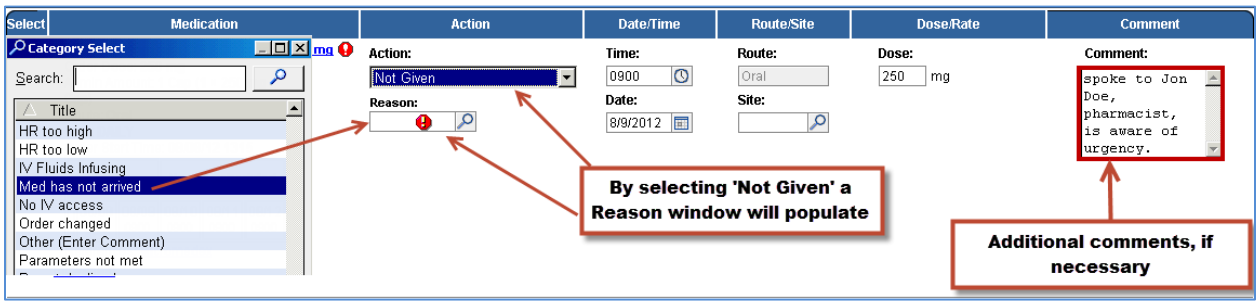
You saw that the docusate sodium (Colace) is overdue. The medication was unavailable at the time it was due.

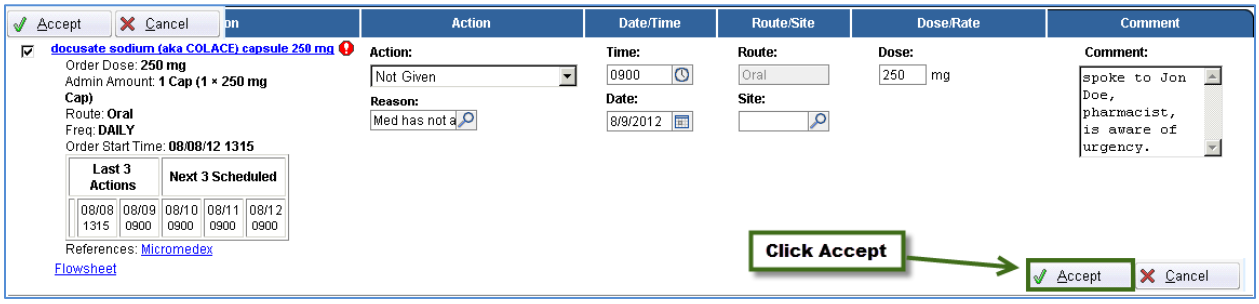
1. Go to MAR activity.
2. Click on the **Overdue** button.
3. Locate docusate sodium (Colace).



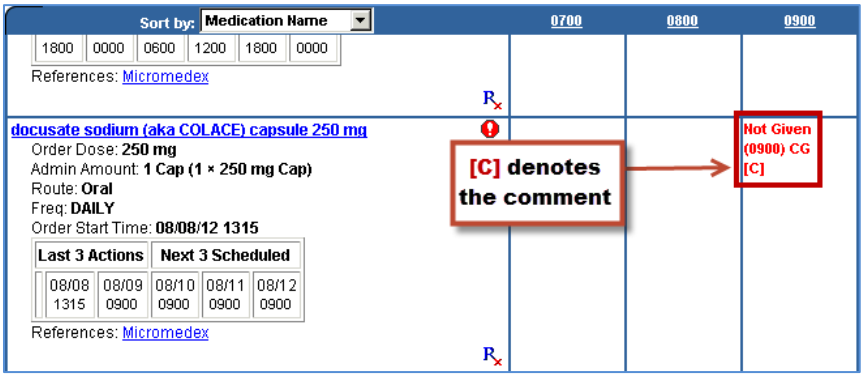
4. The Medication displays.
5. Medication box appears.





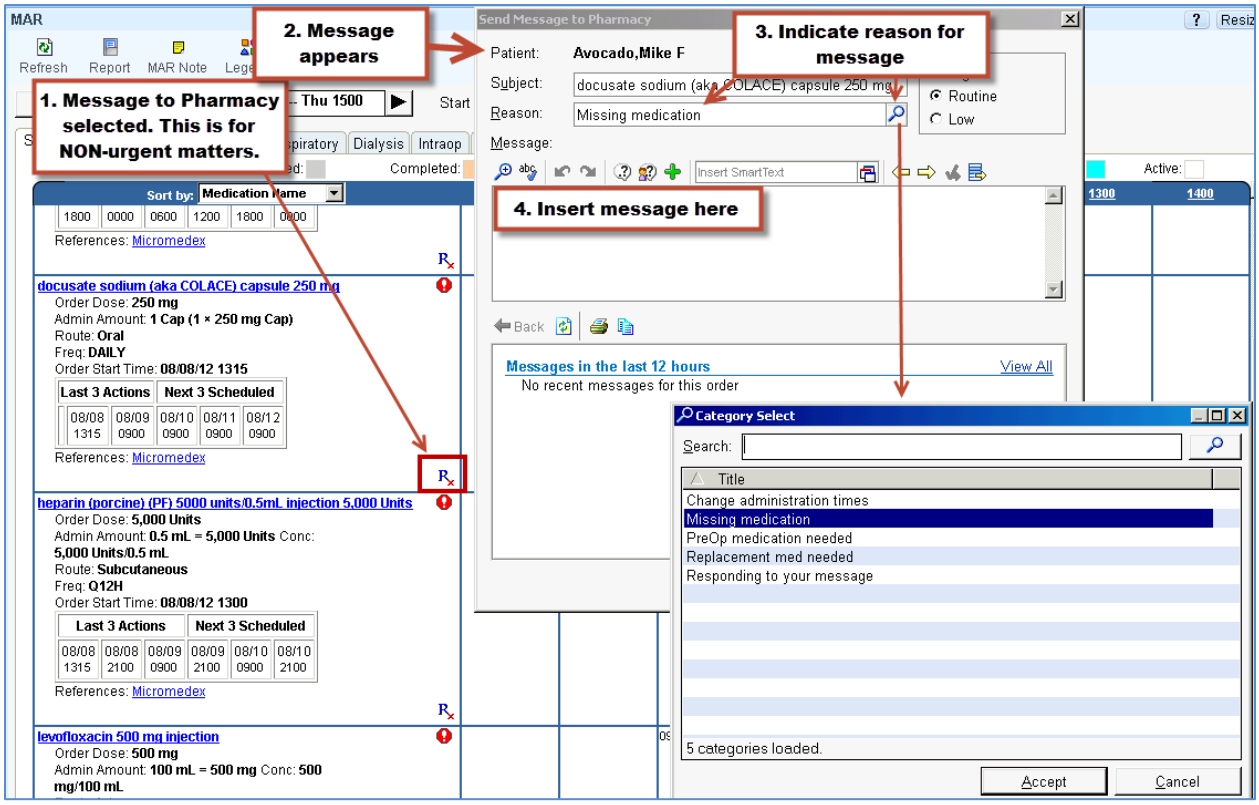


Upon returning to the MAR, the medication is noted with:



Send a Message to Pharmacy

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

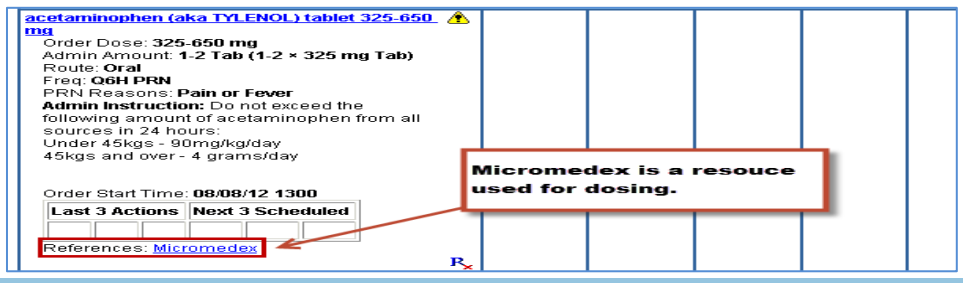


Document a PRN Medication

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.

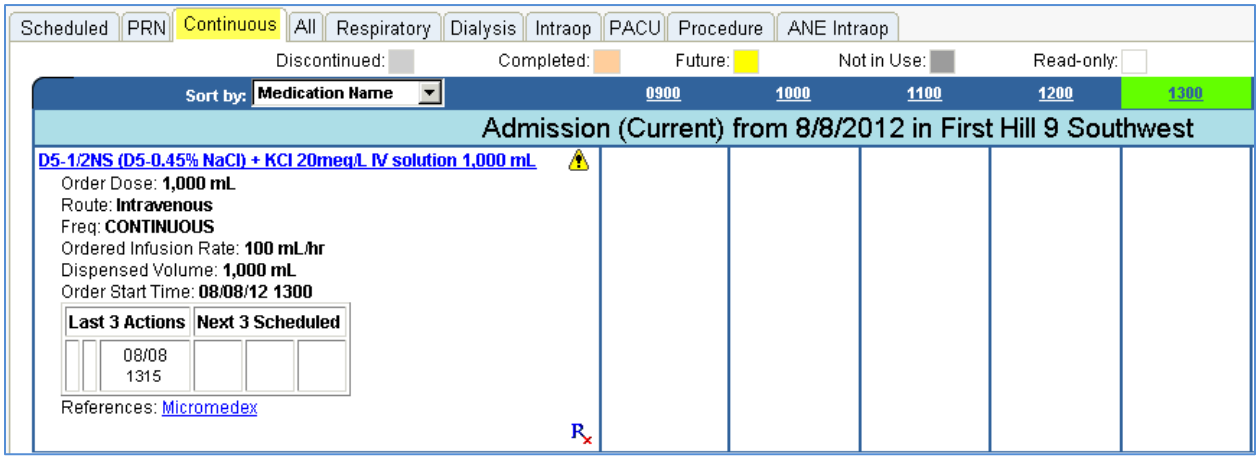
You can check for an action on the MAR activity and select PRN tab. The last date and time will display allowing you to calculate when the next dose is appropriate.

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.

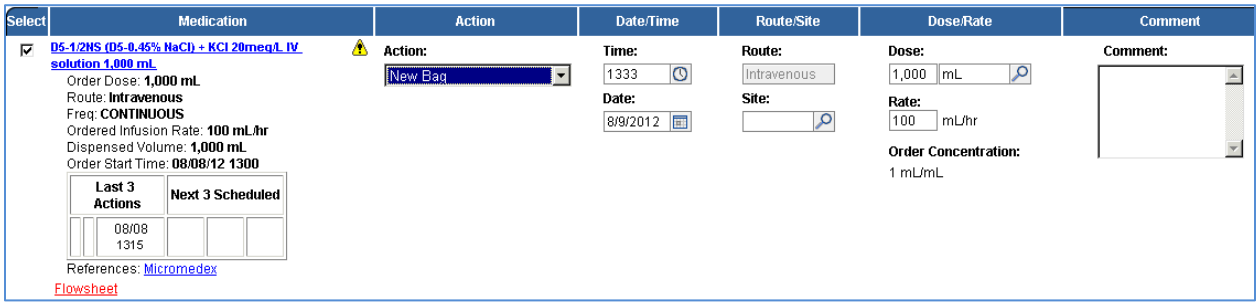


Document a Medication Infusion

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



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



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

Doc Flowsheets

Doc Flowsheets Basics

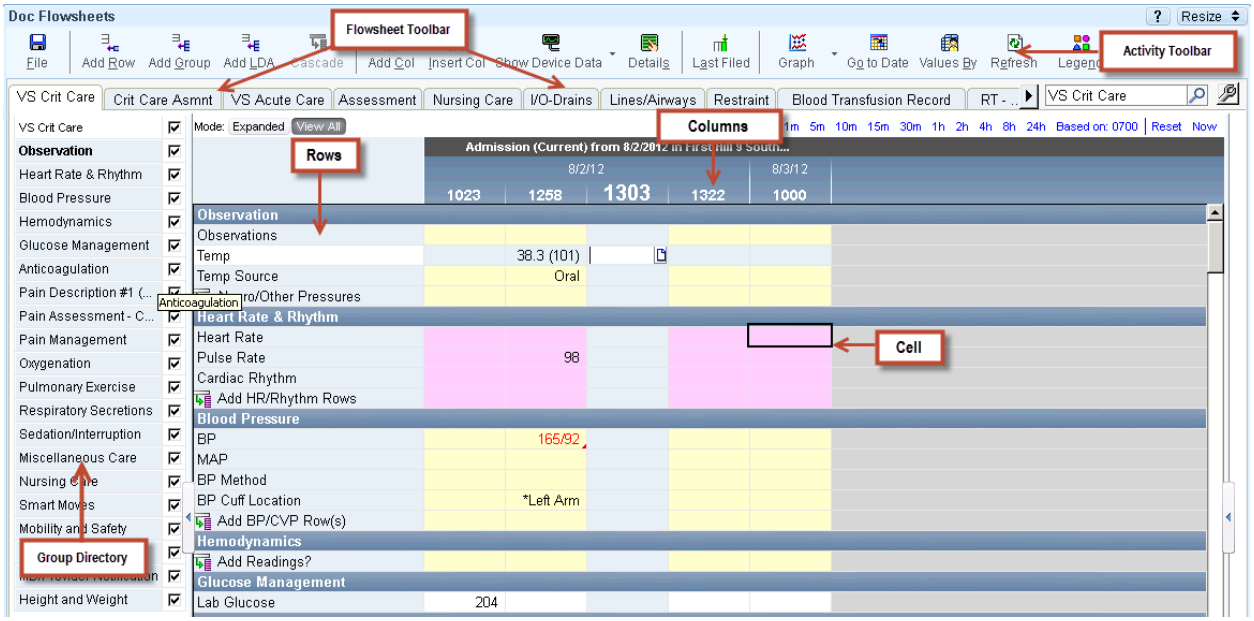
You will use flowsheets to document many aspects of patient care including assessments and interventions. Flowsheets contain discrete data which can be used for research, core measure and occurrence reporting as well as other management reports.

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

1. Click the 

activity tab.
2. The flowsheet that opens by default is the VS flowsheet.

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



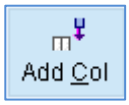
Finding Flowsheets Not on the Toolbar

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.

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

Adding a Column: For Current Assessment

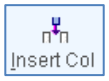
Before documenting in the flowsheets on a patient's chart, it is crucial that you first add or insert a column to designate the time the assessment was performed. To enter data for the current time, use the 'Add Column' button.

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.

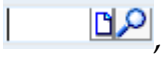
1. Click the Heart Rate field
2. Click the Details button on the activity toolbar.

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.

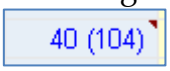
You cannot free text in a field with a selection button  . By typing a few letters in your search area  , matching options may populate the field.

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  .

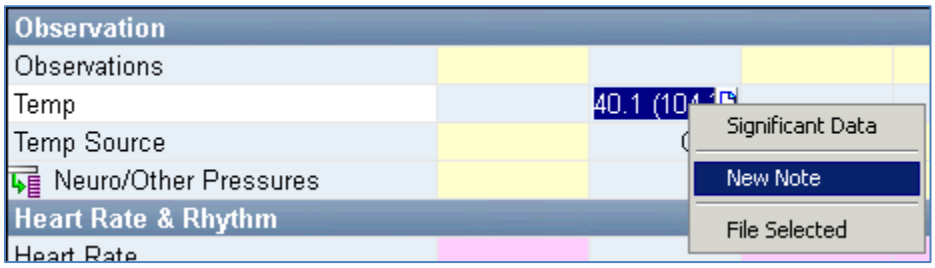
2. In the Comment box, enter 'patient complained of chills' then click 'Accept.' The comment icon has changed to indicate a comment was written.

Create Flowsheet Notes

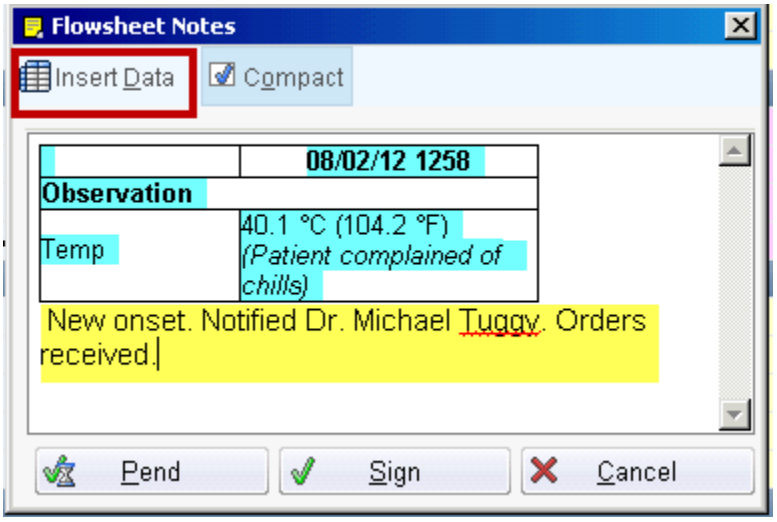
Besides adding a comment for a single piece of data, you can also create an entire note for either a single piece of data or for multiple entries that merit further explanation. Flowsheet notes display in the notes Activity as a Progress Note for all other clinicians to view.

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

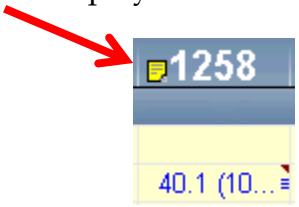
1. Click the Temp cell. The data highlights in blue.
2. Right click in the cell and select New Note. The flowsheet Notes window displays.



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

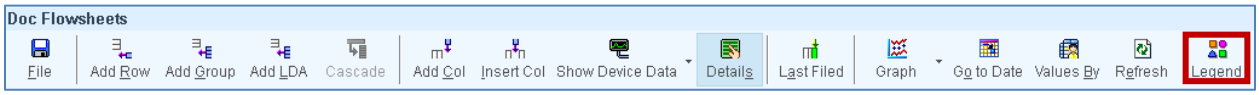


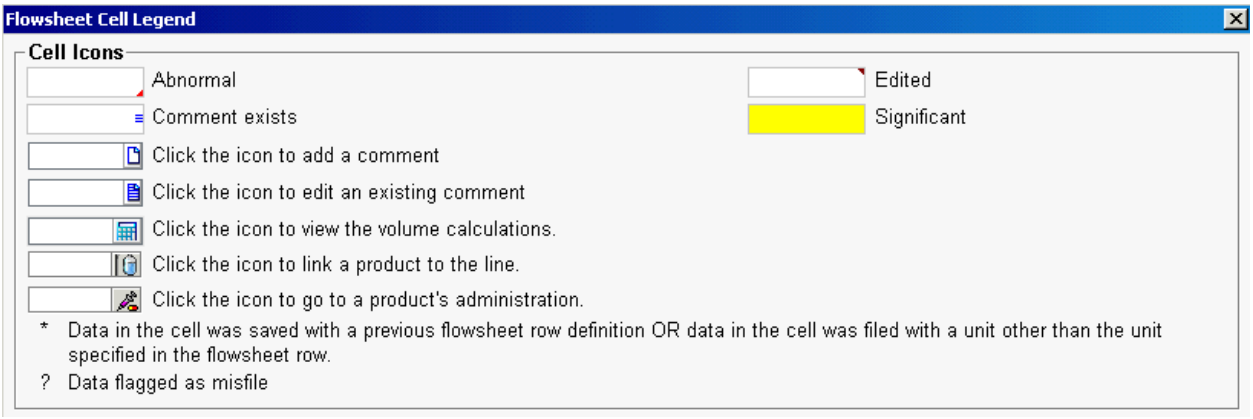
View Flowsheet Comment

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**.

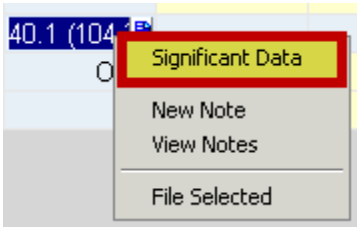




Indicate Significant Data

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.

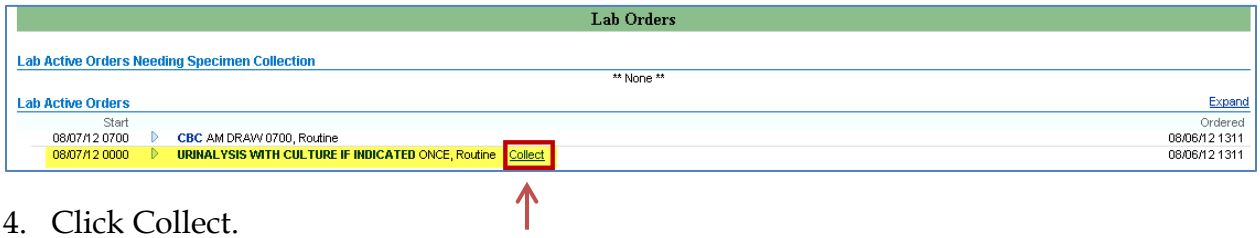
Lab Orders

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.

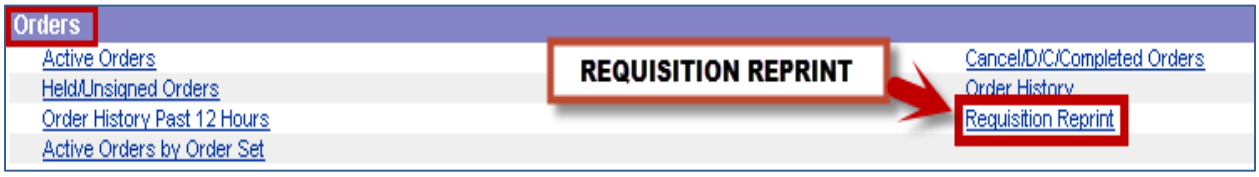
1. Go to the Patient Summary Activity.
2. Locate Lab Orders.
3. Locate Urinalysis with Culture if Indicated.



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



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.

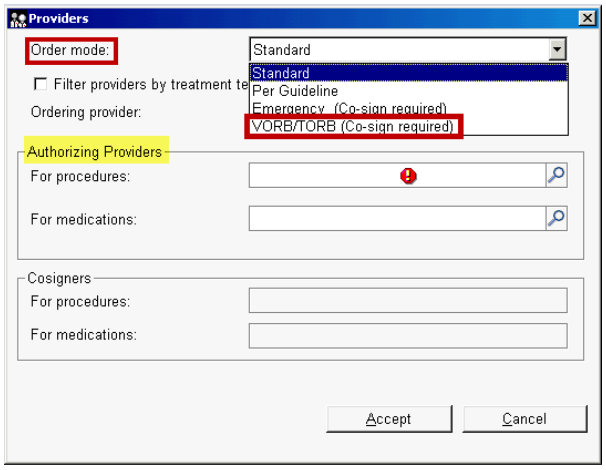
Specimen Source Documentation

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.

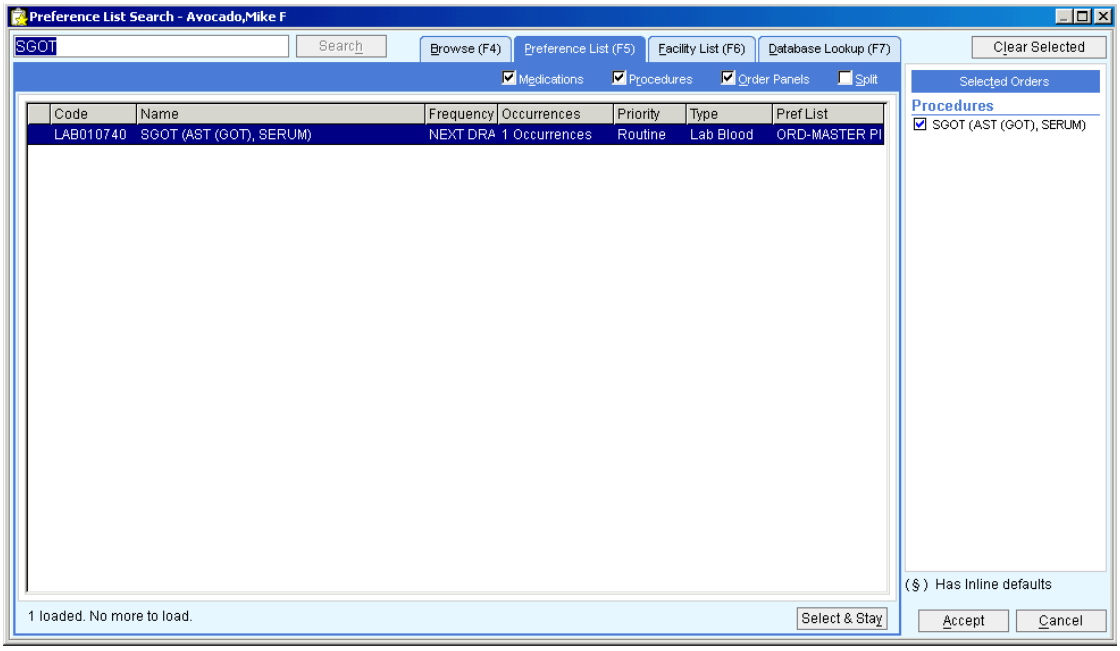
1. Type "mag" in the New Order field, and press Enter.
2. Select Serum Magnesium and click Accept.
3. Click the Summary Sentence. The Order Composer displays.
4. Click the selection button in the Priority field and select Add-On.

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

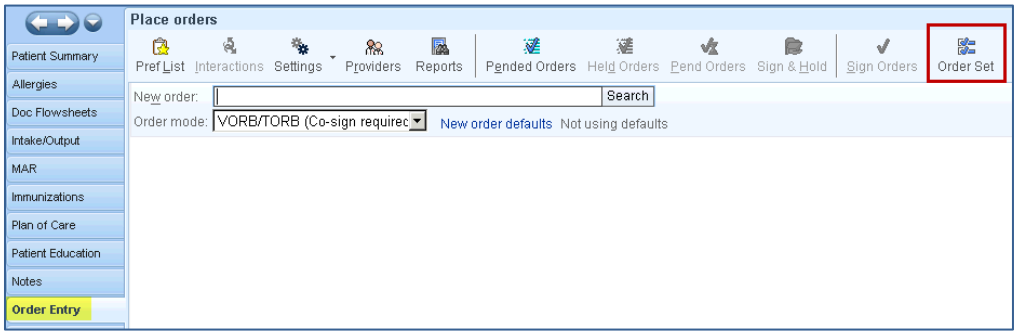
Blood Transfusion Order

> 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.

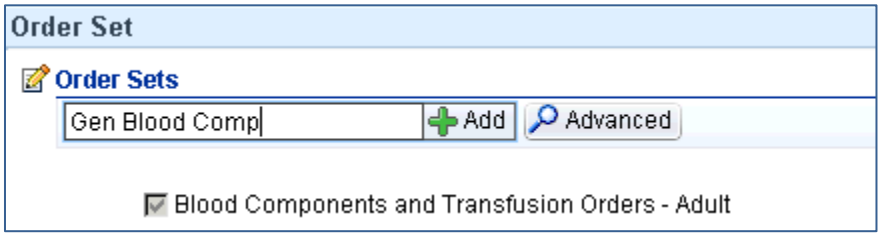
There are two orders placed when ordering a transfusion. **Type and Crossmatch** (blood bank lab order) and **Transfuse** order (nursing order). Both orders will display on the Index and Active Orders reports to be acknowledged.

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

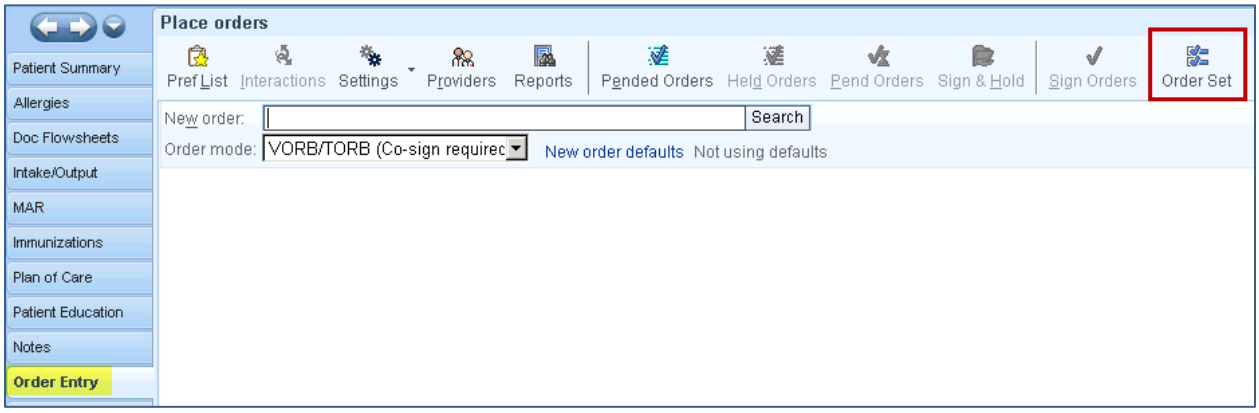
1. Click Order Entry



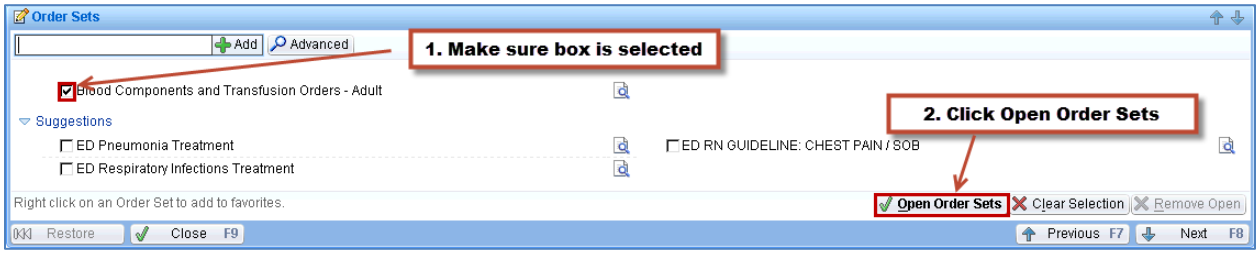
2. Click Order Sets and type 'Gen Blood Comp'



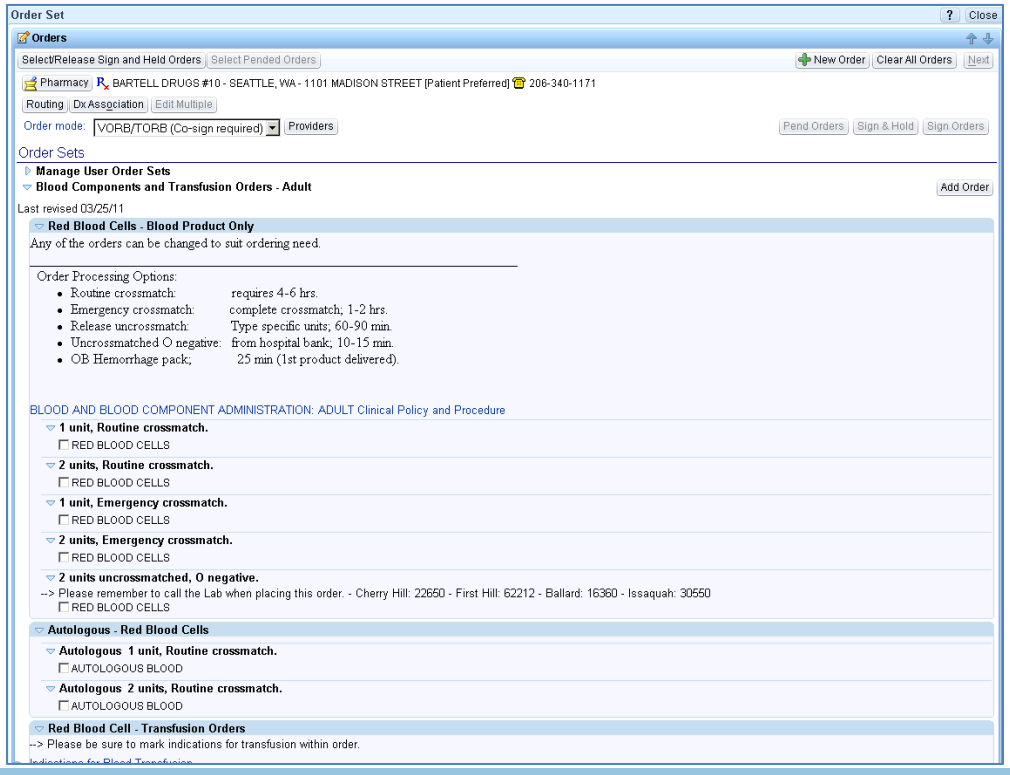
3. Type 'Gen Blood Comp'



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.

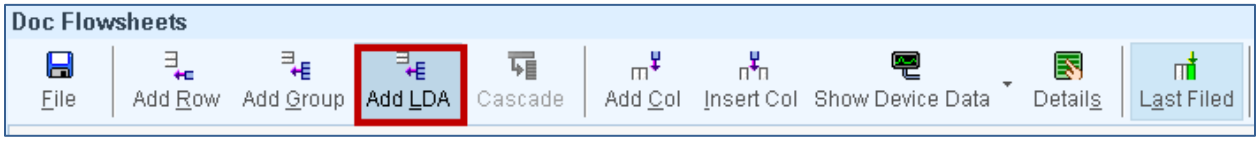


LDAs

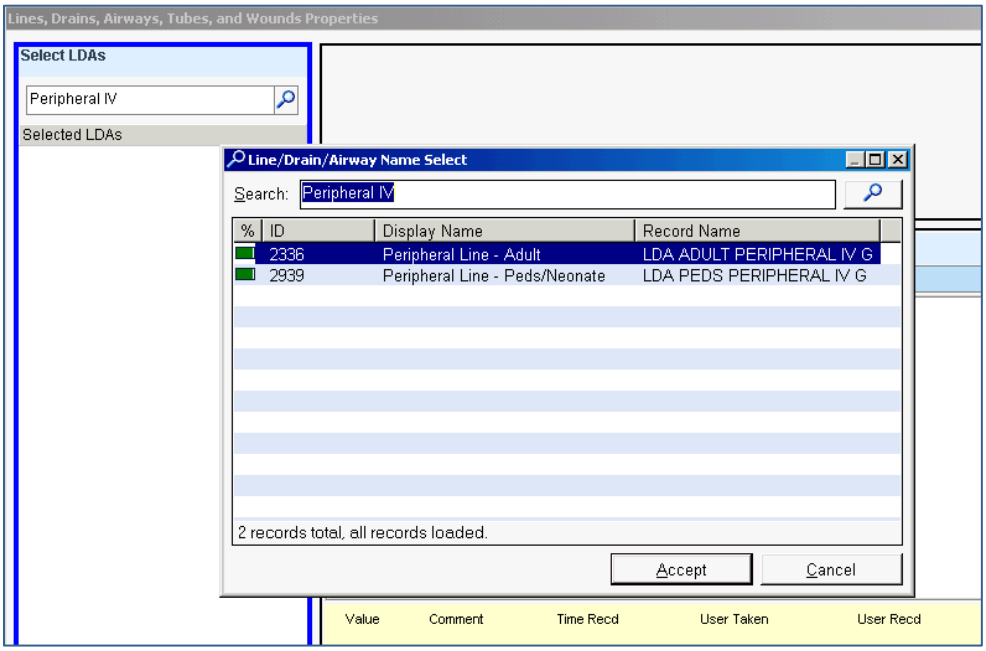
Document an IV Line Insertion

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

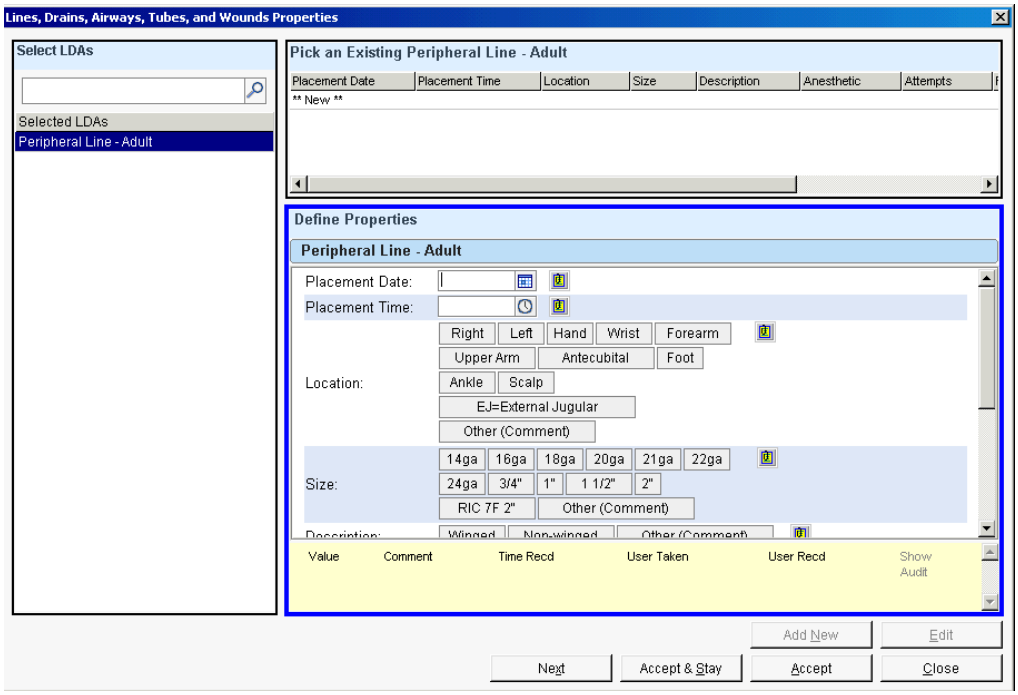
1. Click the Doc Flowsheets activity.
2. Click the Lines/Airways Flowsheet.
3. Add a column to document an assessment for the current time.
4. In the Activity Toolbar, click Add LDA selection button icon.



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.

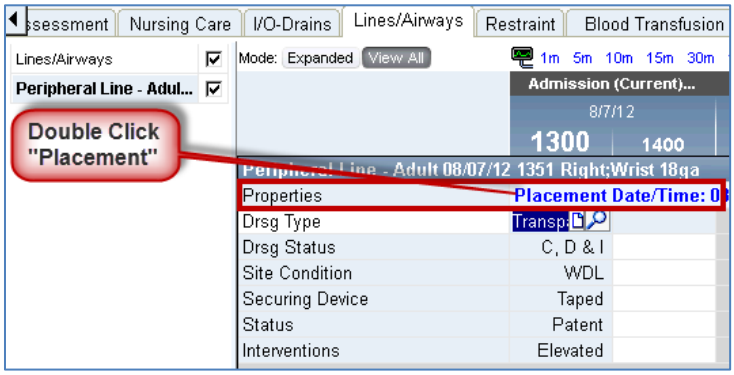
Use the following information to complete the site assessment:

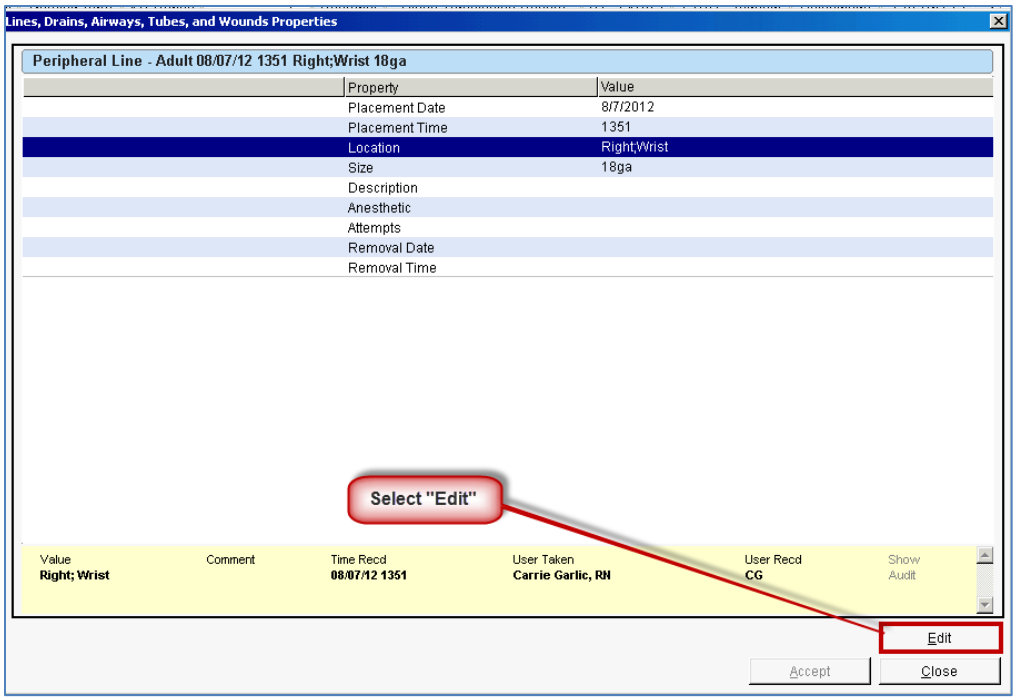
Field	Data
Drsg Status	C, D & I
Site Condition	WDL
Securing Device	Taped
Status	Patent
Interventions	Elevated

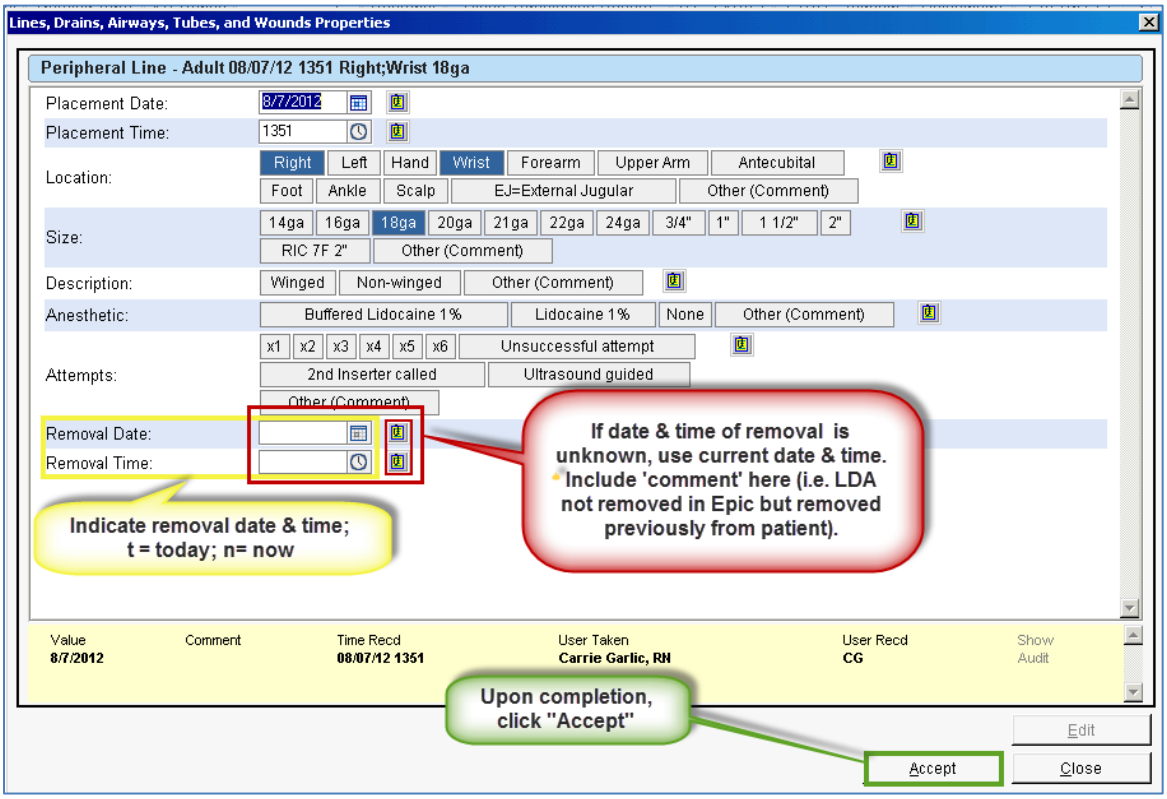
Discontinue an Active Line

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.

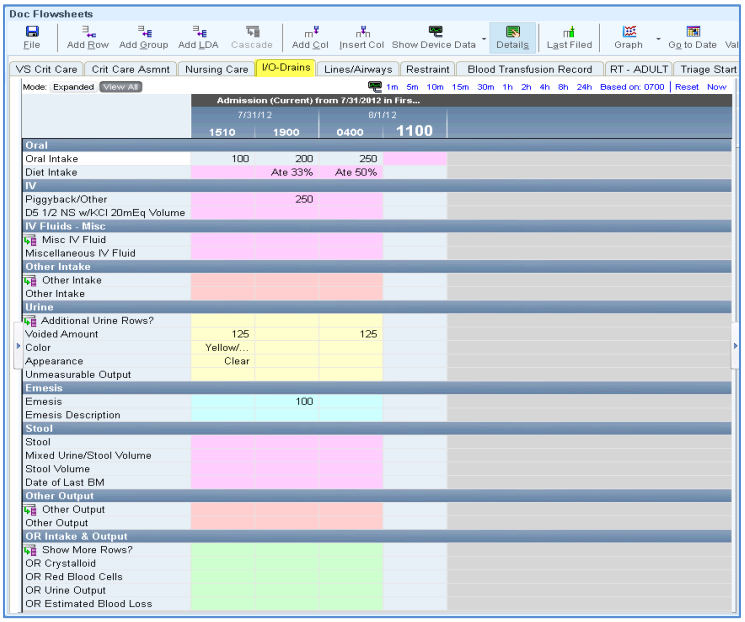






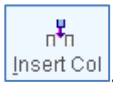
I/O - Drains

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.



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 or 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.

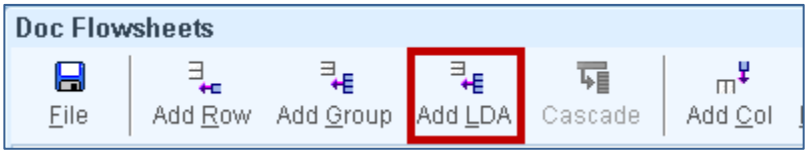
Use the following information to complete the nutrition assessment:

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

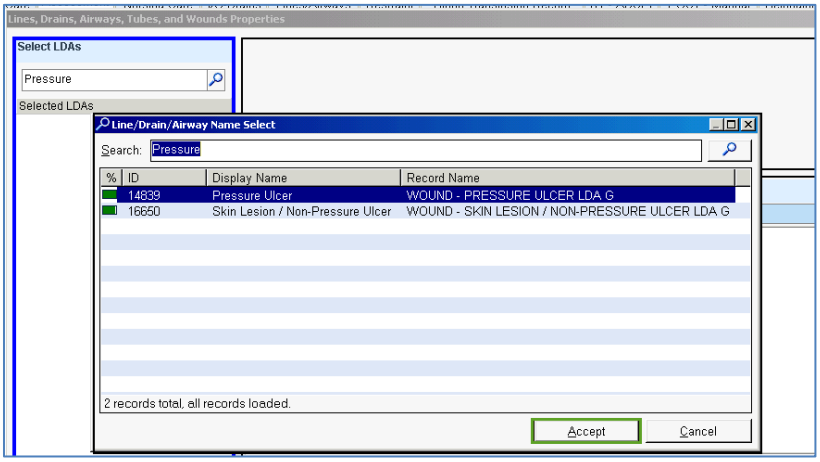
Skin/Wound/PU Flowsheet

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

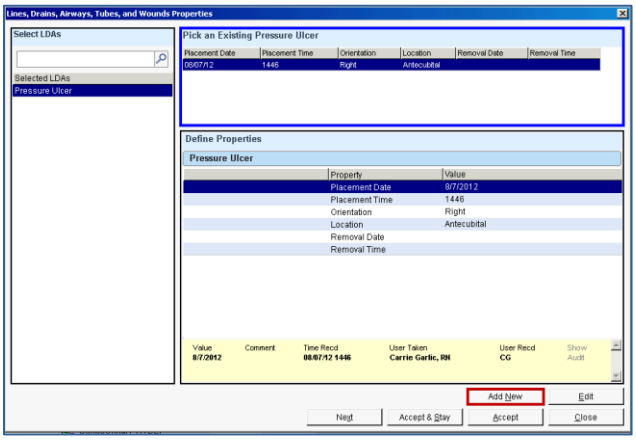
Document a Pressure Ulcer

1. Select 

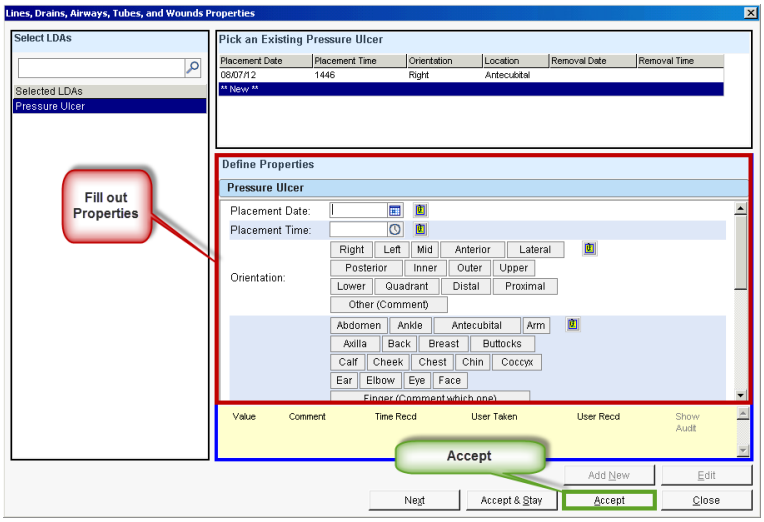
2. Type 'Pressure' and Enter, select highlighted 'Pressure Ulcer' and click Accept.



3. Add New

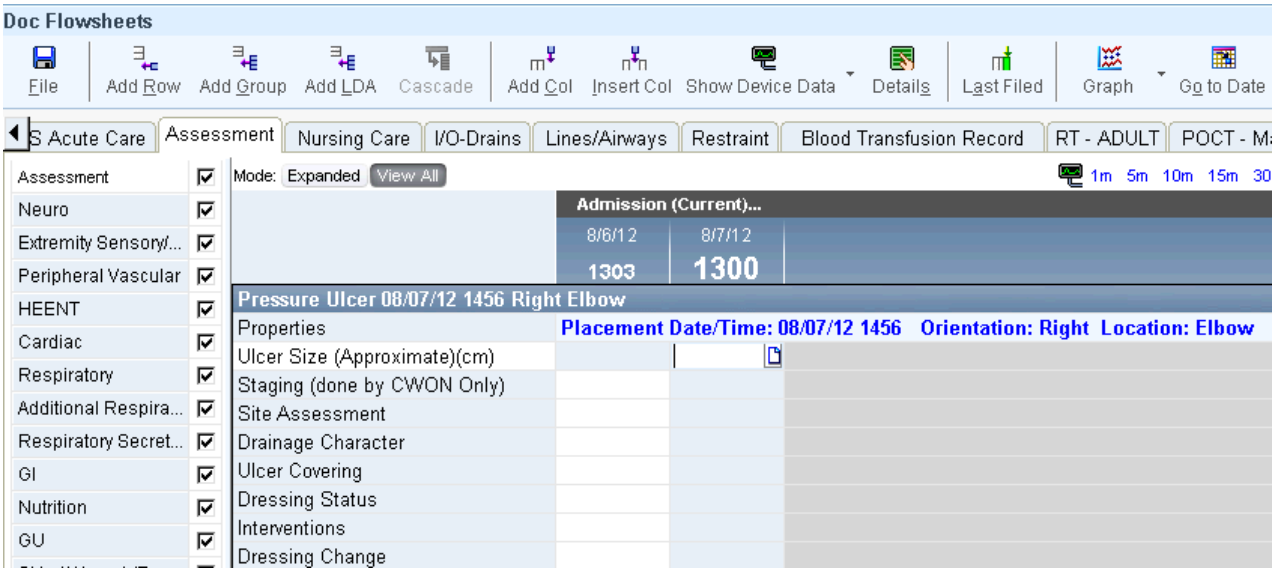


4. Fill out 'Properties' and Accept.



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

5. Chart the pressure ulcer assessment.

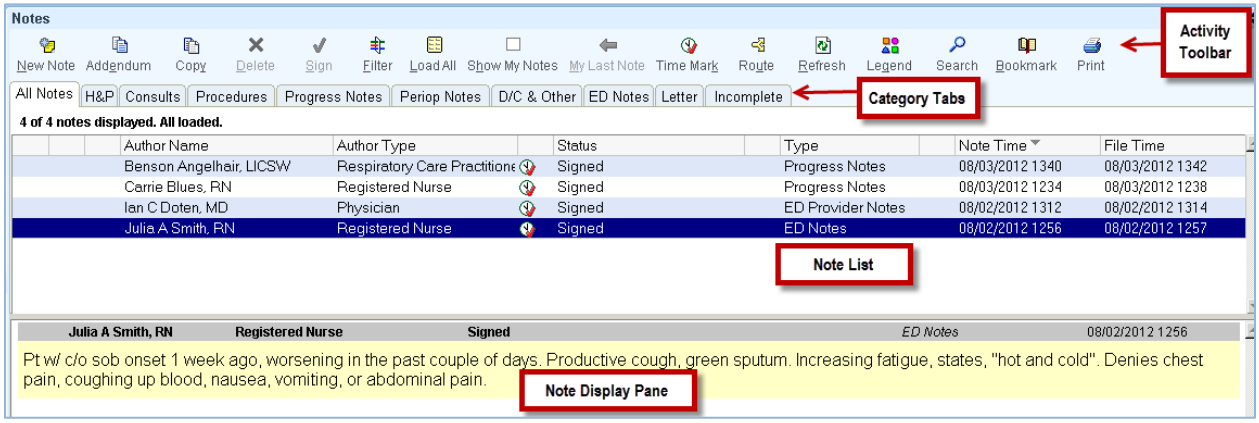


Your patient has a pressure ulcer with a small amount of serosanguineous drainage on his right elbow that was present on admission. You need to document the initial assessment. It is currently covered with a gauze dressing.

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.

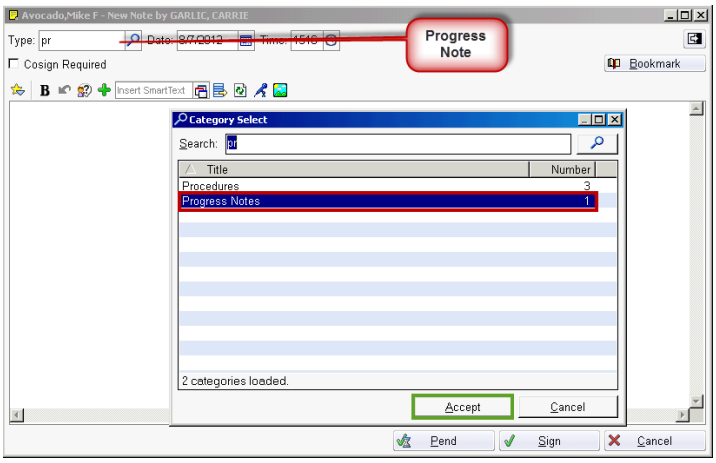
RN's have the ability to enter a progress note to document.



Document a Note

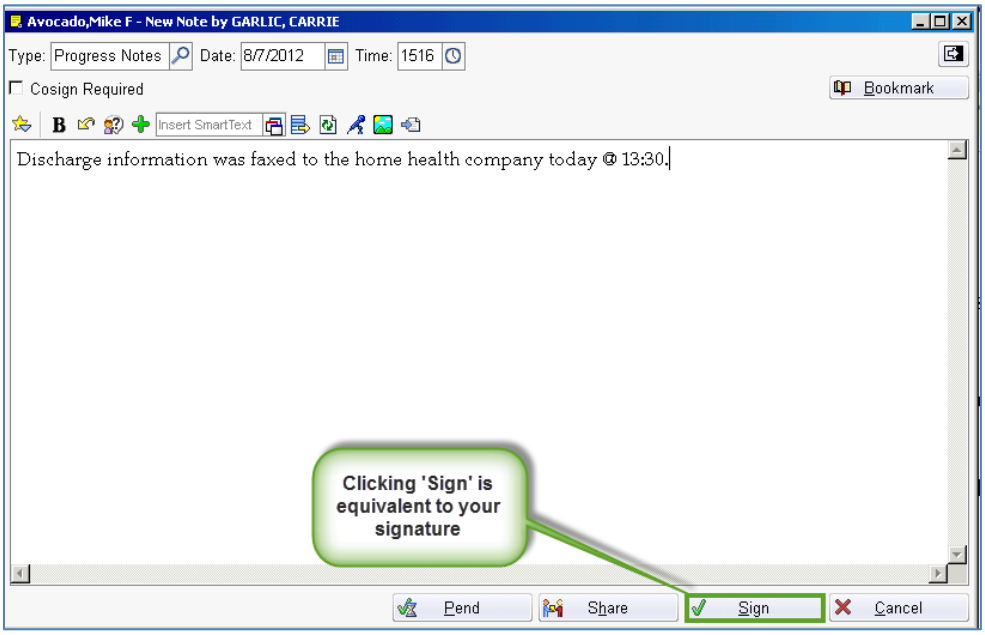
Document that the discharge information was faxed to the home health company.

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



5. Click Accept.

Document your note.

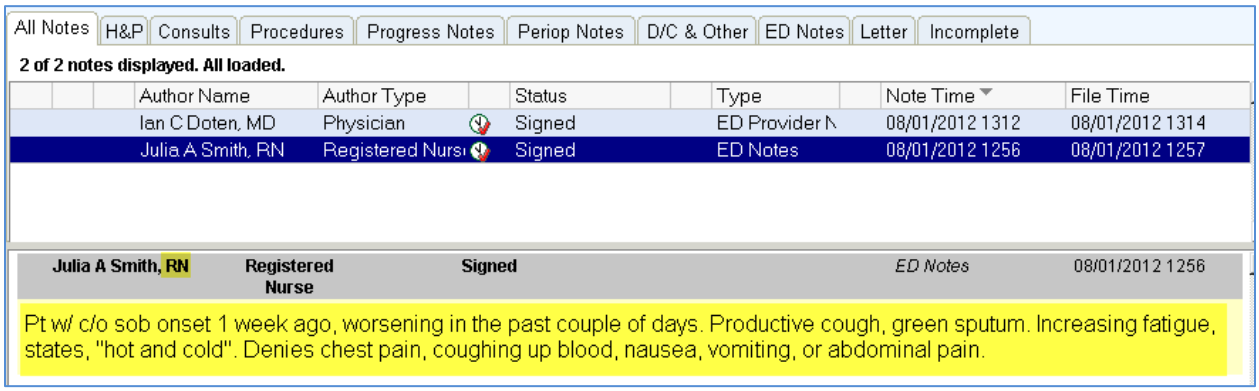


6. Sign your note

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.



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

Note Category Tabs

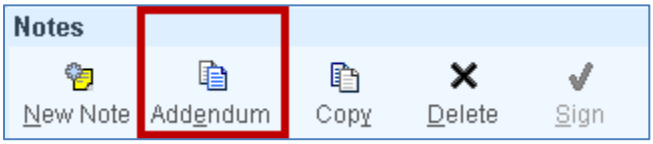
You can sort notes by category. The default category is **All Notes**. When you want to view a different type of note, click the corresponding category tab and only those types of notes display.

Addend a Note

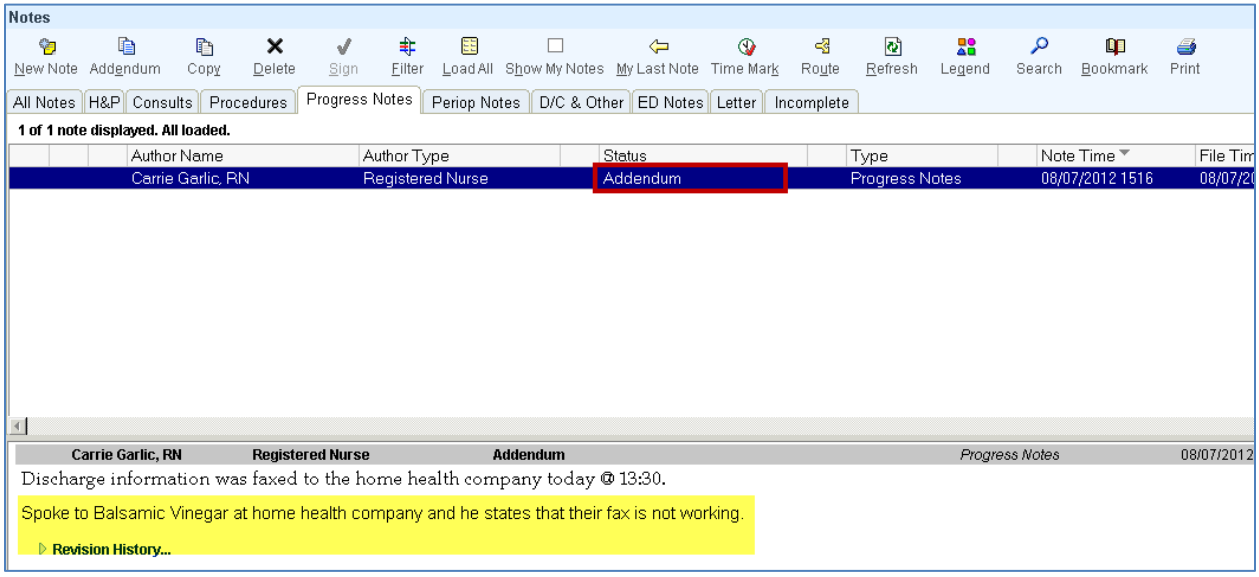
You can create an addendum for any note that has been saved. The addendum will become the new note of record. However, the original note will be linked to the addendum and remain a permanent part of the patient record.

> 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.



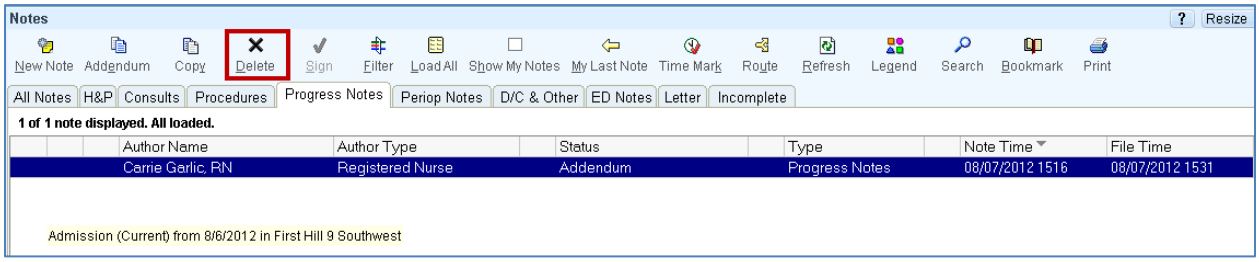
The original note will display in the top pane and remains a permanent part of the patient record. The same note displays in the lower pane but it is editable.



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

Delete a Note

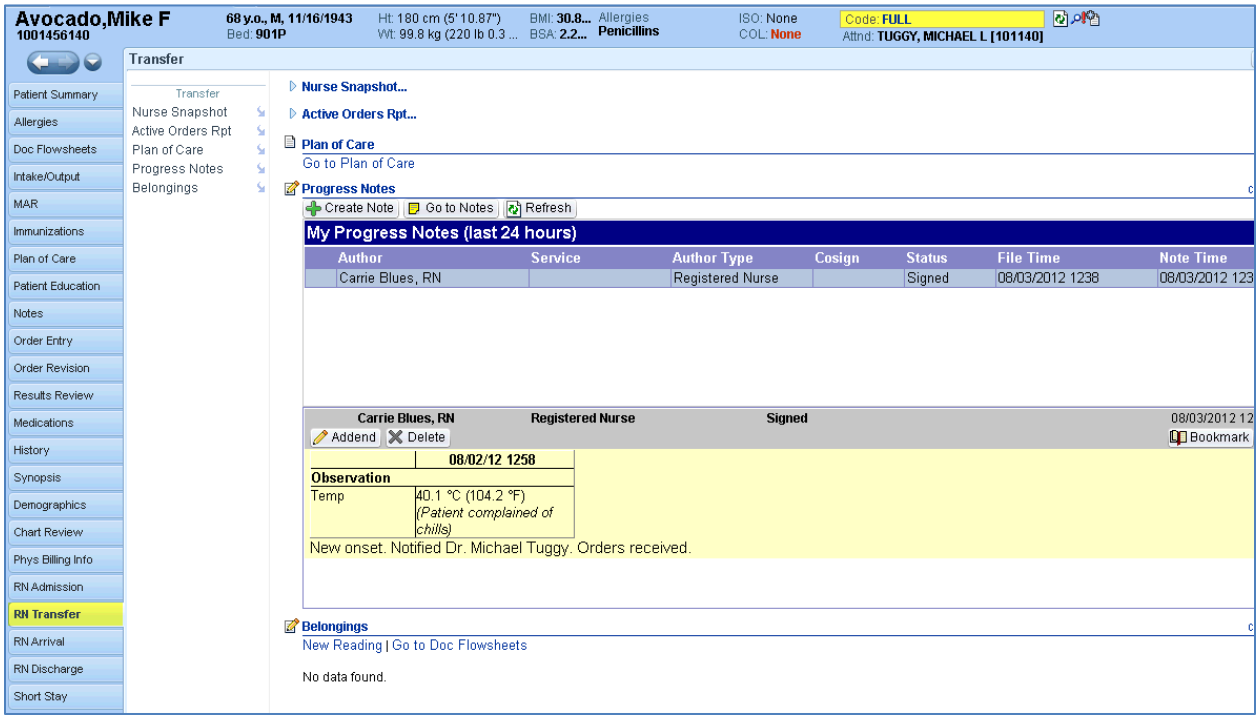
1. Highlight note to be deleted.
2. Select 'Delete' button on the Toolbar.



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.



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.

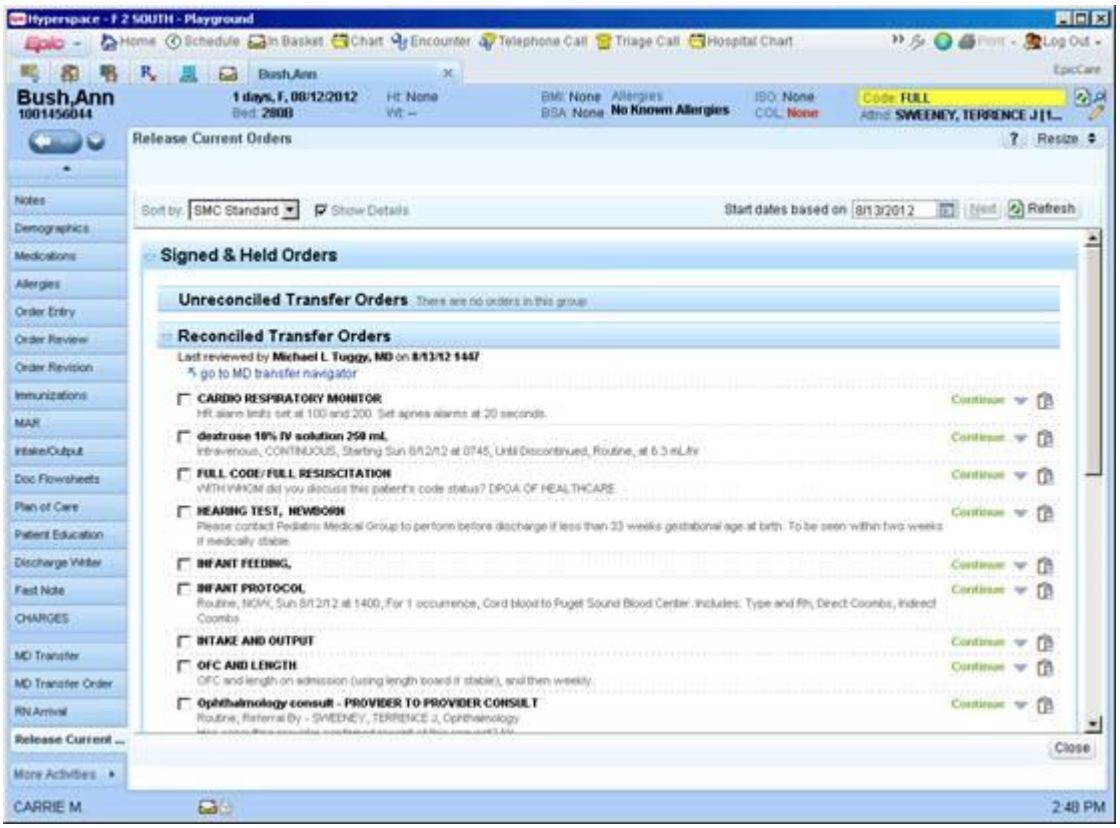
RN Arrival Navigator

Prior to the transfer of a patient to a new unit, the physician places the transfer order. Tthe 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 }

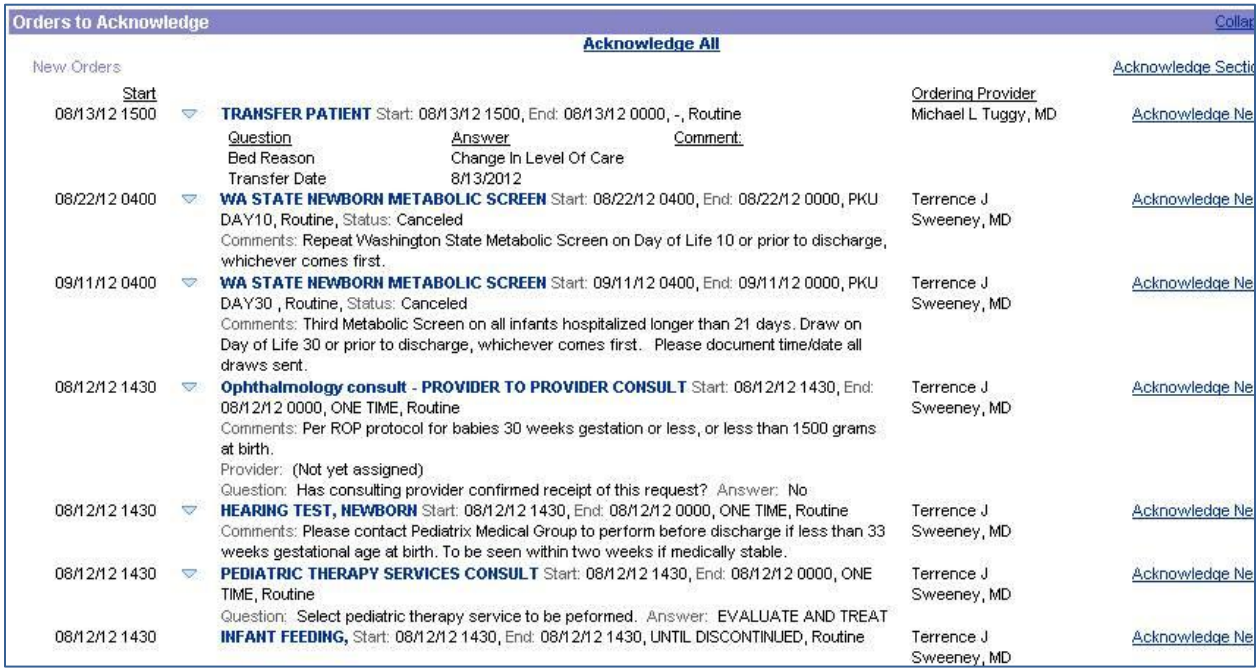
3. Review the Reconciled Transfer order that were signed and held by the physician.



4. Scroll down and click 'Select all reconciled transfer orders'

5. Click Release.

6. Go to Patient Summary, Index Report [or] Active Order Report.



Orders to Acknowledge Collap

Acknowledge All

New Orders Acknowledge Sectio

Start		Ordering Provider	
08/13/12 1500	**TRANSFER PATIENT** Start: 08/13/12 1500, End: 08/13/12 0000, -, Routine Question: Bed Reason — Answer: Change In Level Of Care Question: Transfer Date — Answer: 8/13/2012	Michael L Tuggy, MD	Acknowledge Ne
08/22/12 0400	**WA STATE NEWBORN METABOLIC SCREEN** Start: 08/22/12 0400, End: 08/22/12 0000, PKU DAY10, Routine, Status: Canceled Comments: Repeat Washington State Metabolic Screen on Day of Life 10 or prior to discharge, whichever comes first.	Terrence J Sweeney, MD	Acknowledge Ne
09/11/12 0400	**WA STATE NEWBORN METABOLIC SCREEN** Start: 09/11/12 0400, End: 09/11/12 0000, PKU DAY30 , Routine, Status: Canceled Comments: Third Metabolic Screen on all infants hospitalized longer than 21 days. Draw on Day of Life 30 or prior to discharge, whichever comes first. Please document time/date all draws sent.	Terrence J Sweeney, MD	Acknowledge Ne
08/12/12 1430	**Ophthalmology consult - PROVIDER TO PROVIDER CONSULT** Start: 08/12/12 1430, End: 08/12/12 0000, ONE TIME, Routine Comments: Per ROP protocol for babies 30 weeks gestation or less, or less than 1500 grams at birth. Provider: (Not yet assigned) Question: Has consulting provider confirmed receipt of this request? Answer: No	Terrence J Sweeney, MD	Acknowledge Ne
08/12/12 1430	**HEARING TEST, NEWBORN** Start: 08/12/12 1430, End: 08/12/12 0000, ONE TIME, Routine Comments: Please contact Pediatrix Medical Group to perform before discharge if less than 33 weeks gestational age at birth. To be seen within two weeks if medically stable.	Terrence J Sweeney, MD	Acknowledge Ne
08/12/12 1430	**PEDIATRIC THERAPY SERVICES CONSULT** Start: 08/12/12 1430, End: 08/12/12 0000, ONE TIME, Routine Question: Select pediatric therapy service to be peformed. Answer: EVALUATE AND TREAT	Terrence J Sweeney, MD	Acknowledge Ne
08/12/12 1430	**INFANT FEEDING,** Start: 08/12/12 1430, End: 08/12/12 1430, UNTIL DISCONTINUED, Routine	Terrence J Sweeney, MD	Acknowledge Ne

7. Acknowledge Transfer orders.

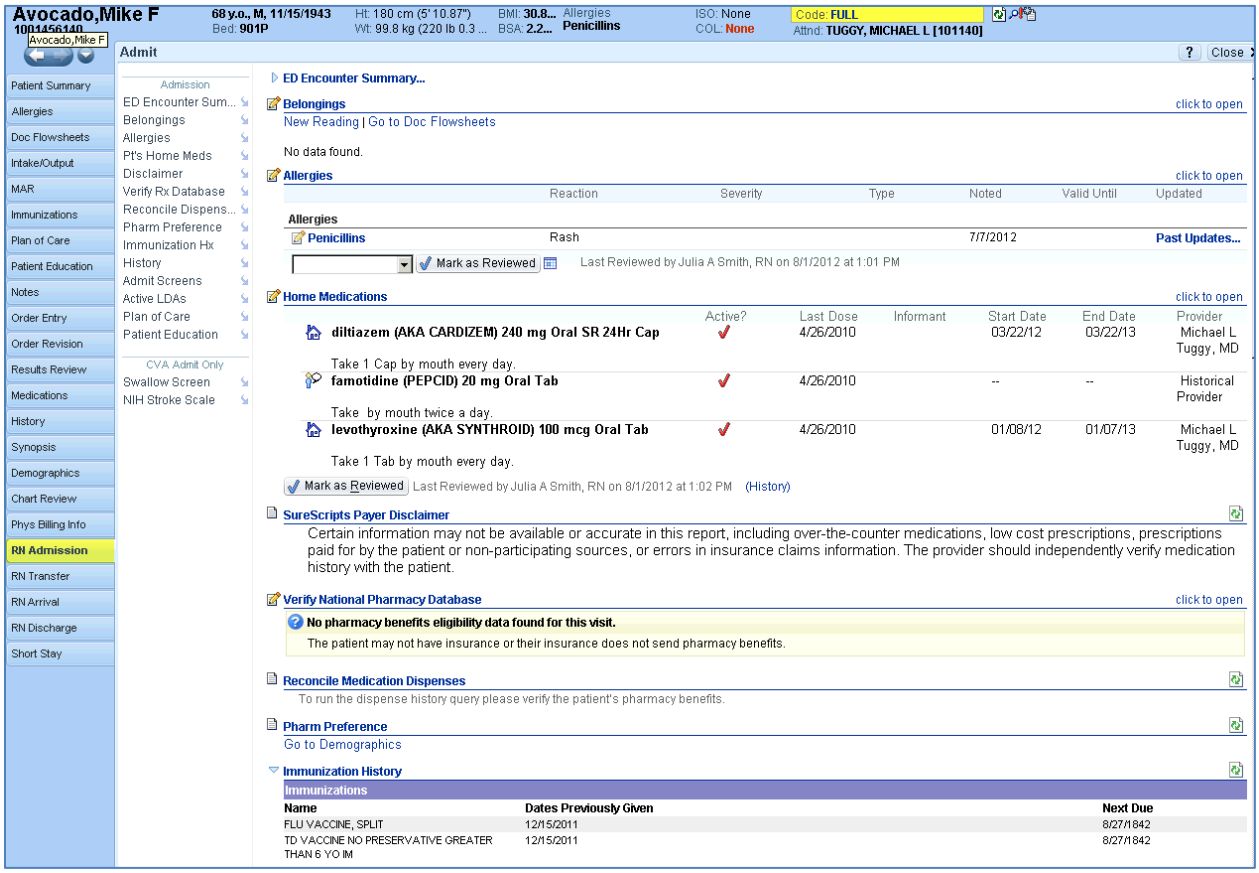
Admitting a Patient

Admission Navigator

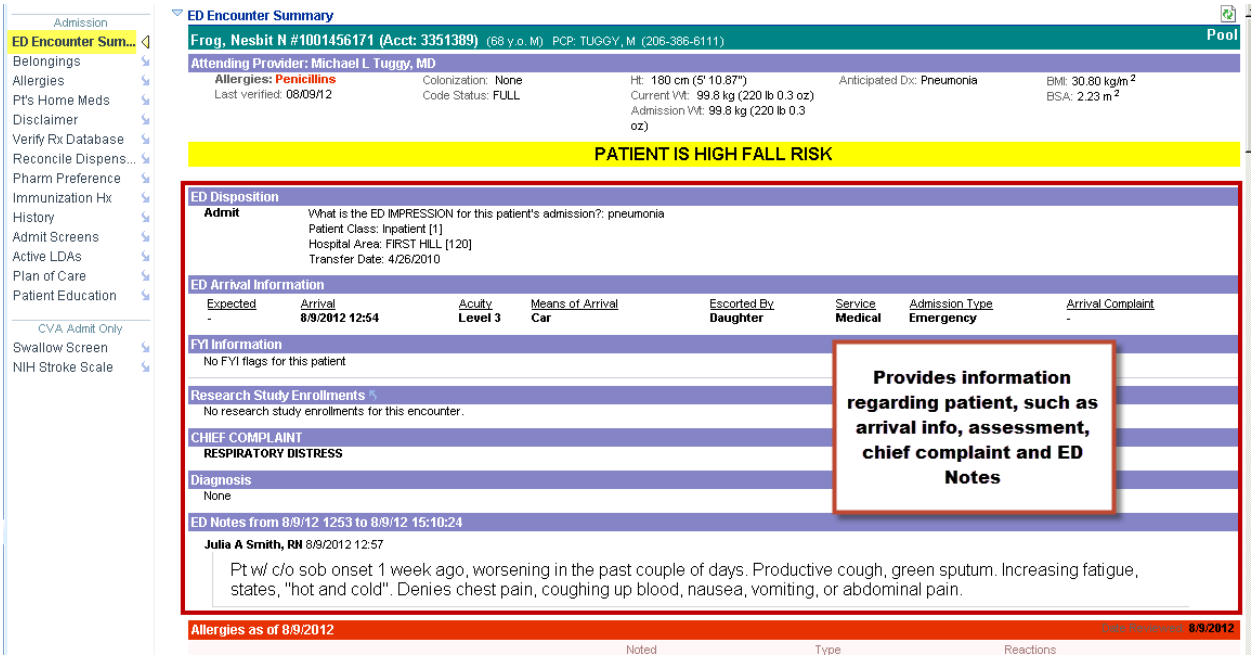
The Admission Navigator streamlines the review and documentation for an admission. Whether the patient is admitted from the ED or a Direct Admit, you only use this navigator once during the entire hospital stay.

Access the Admission Navigator

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

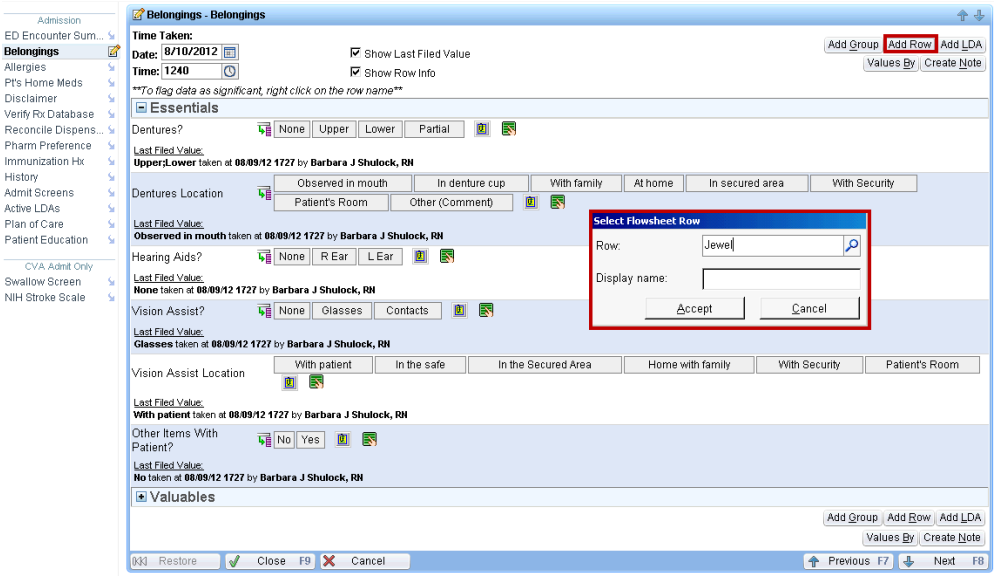


ED Encounter Summary



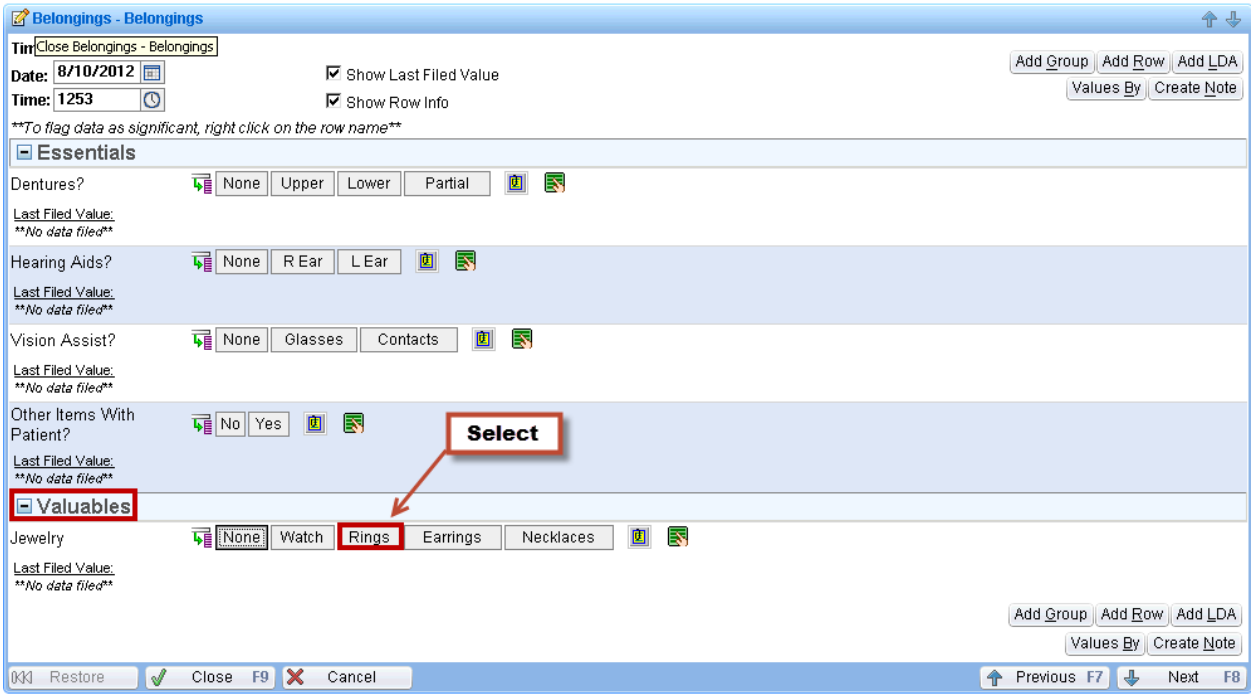
Belongings

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.

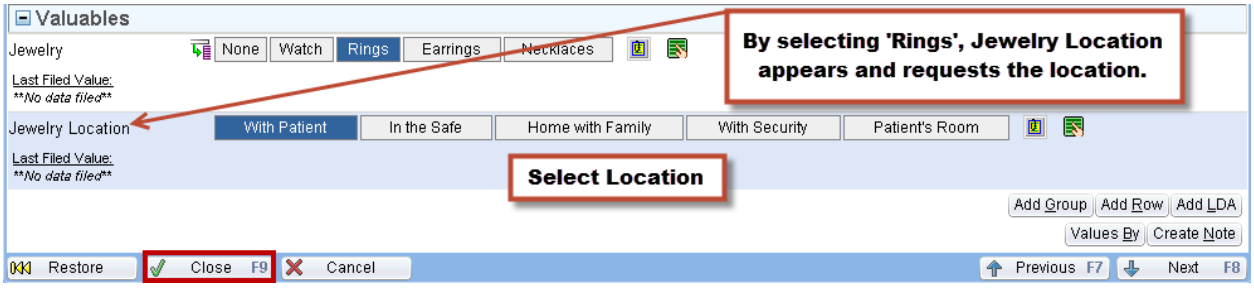


The patient has a 5 ct. diamond ring that will need to be added.

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.

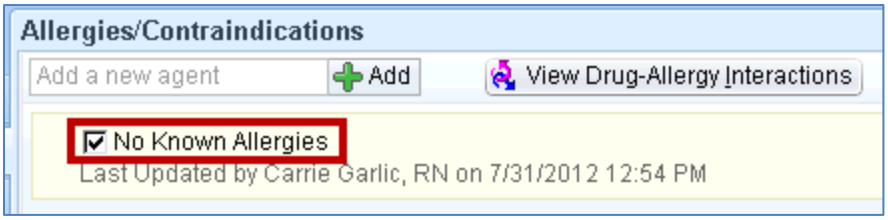
If your patient has no information on file, you should see this:

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



2. The Allergies in the Patient Header will now say 

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 

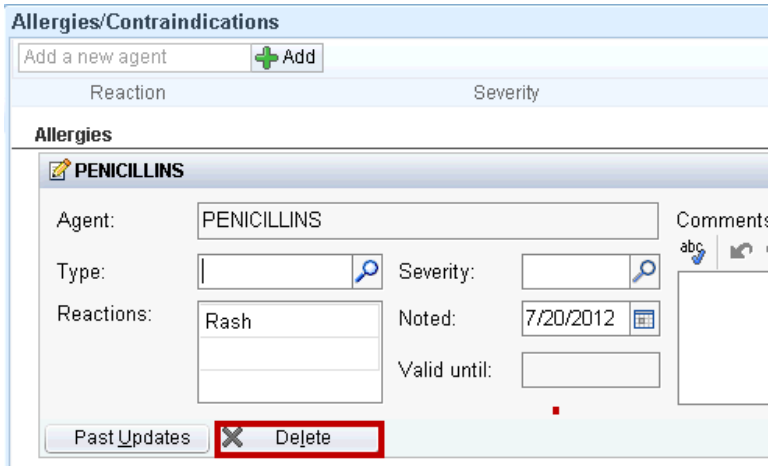
Modifying a Current Allergy

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'

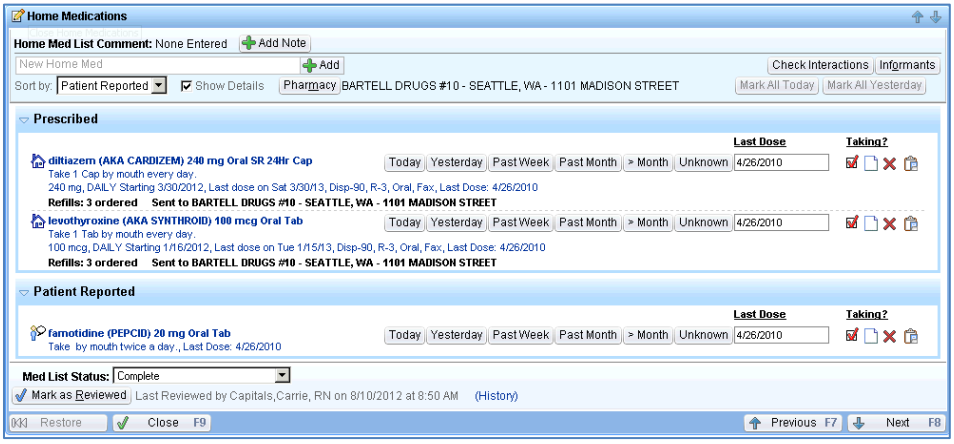


Patient's Home Meds (PTA)

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.

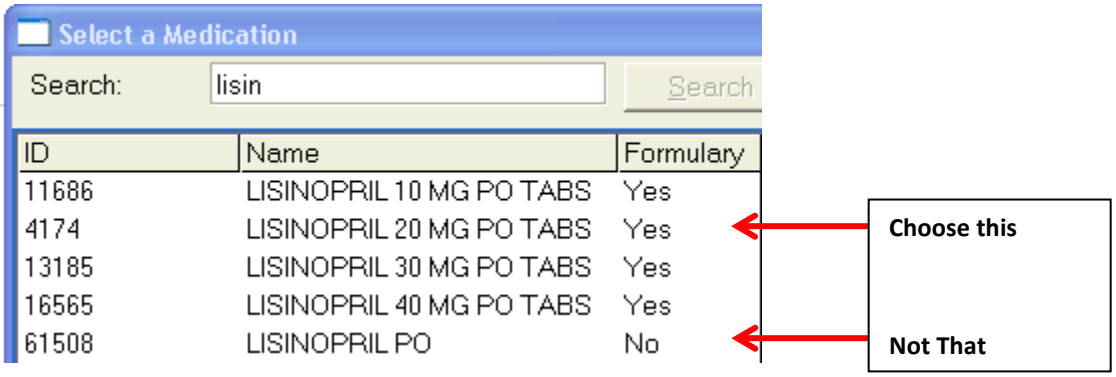
Use the scenario above to complete the PTA Meds section.

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.

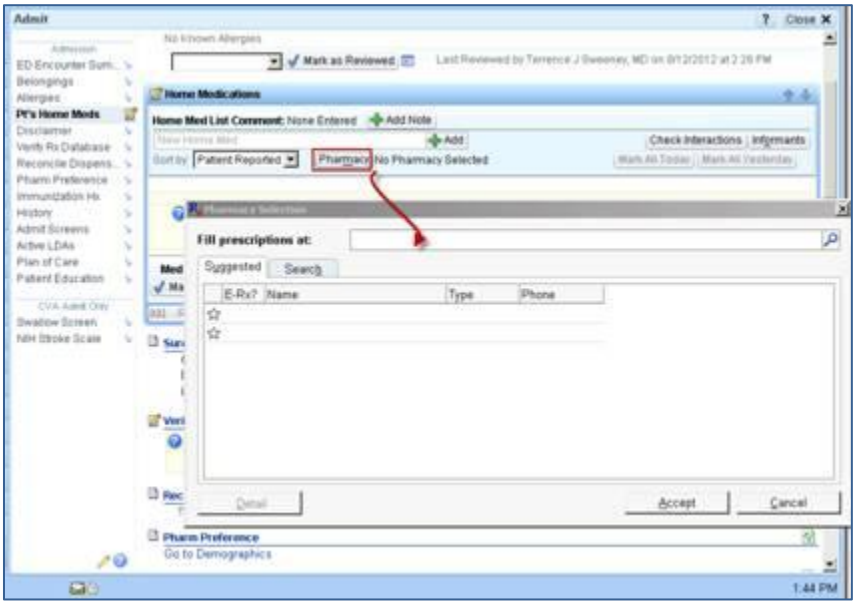


Delete a Medication Entered in Error

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

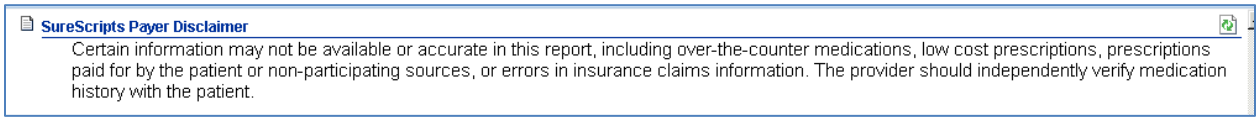
Pharmacy Preference

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

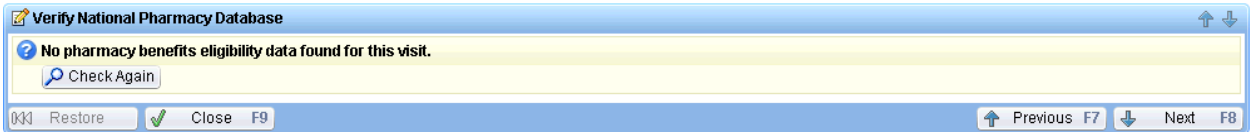


Surescripts

Disclaimer



Verify RX Database

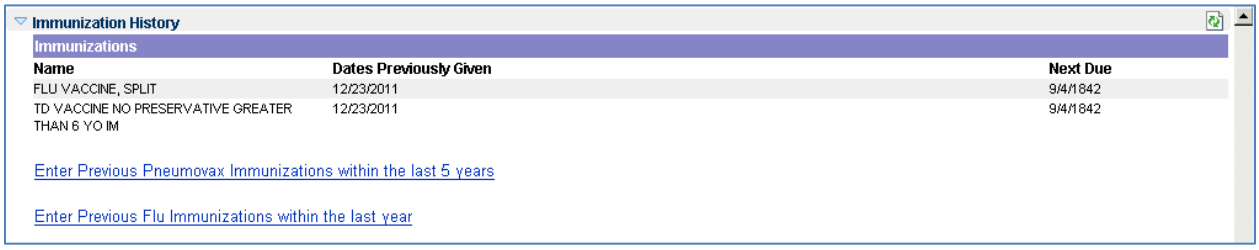


Reconcile Medication Dispenses

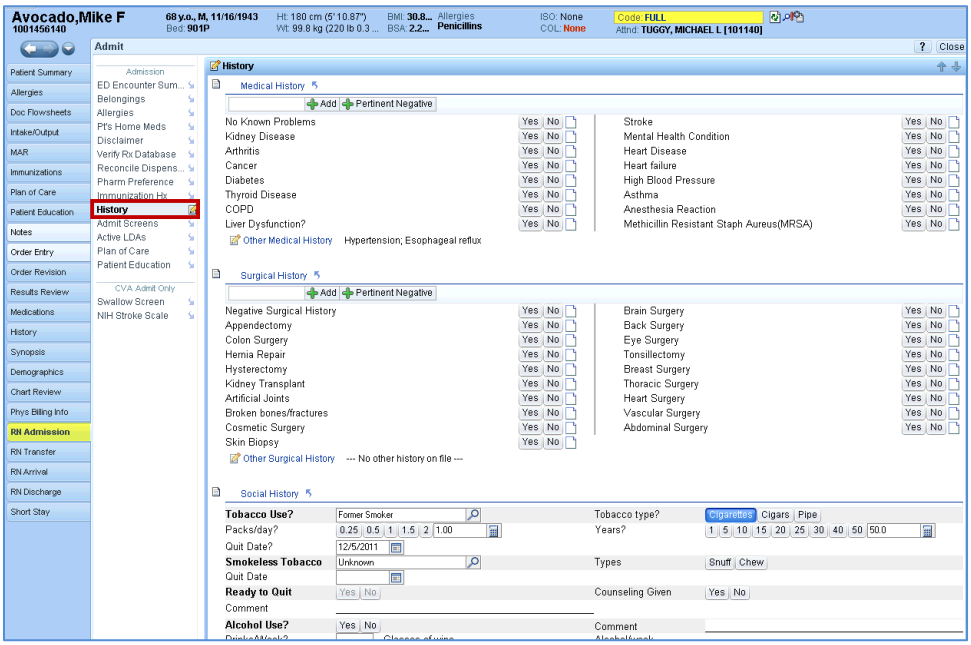
Immunization HX

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



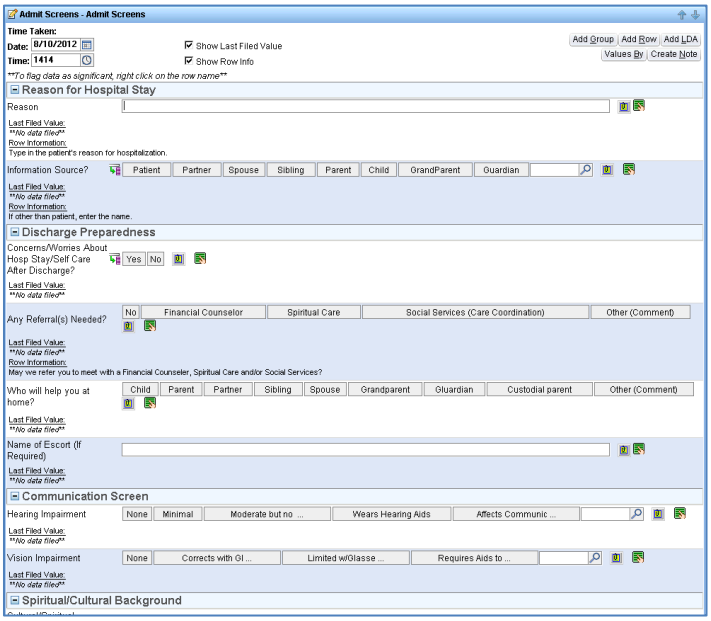
History within RN Admission Navigator



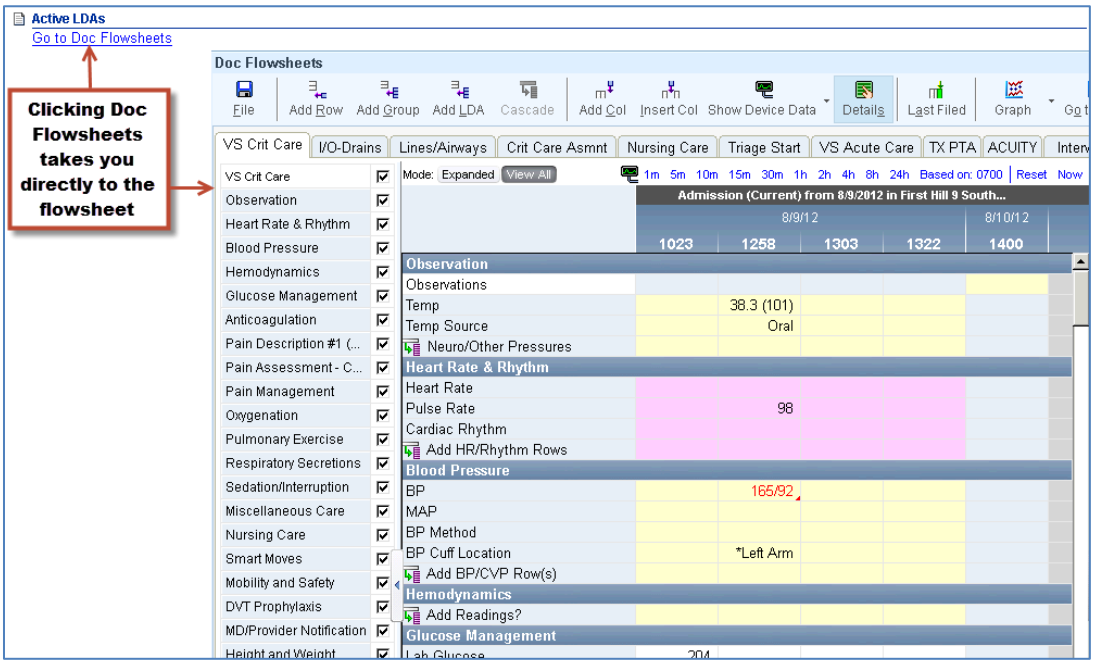
Admit Screens

The documentation needed are:

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

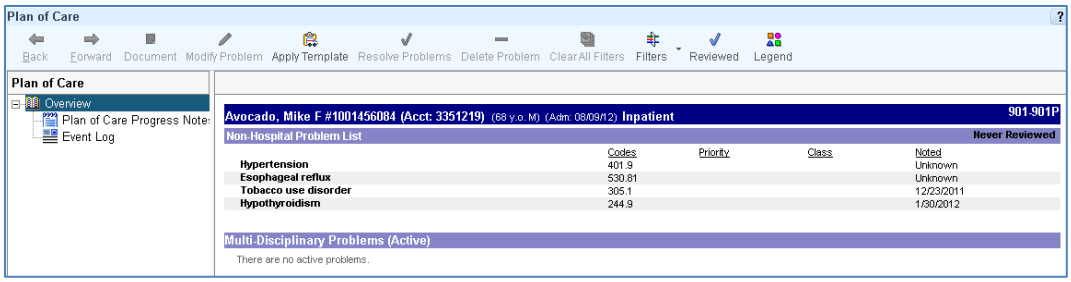


Active LDAs



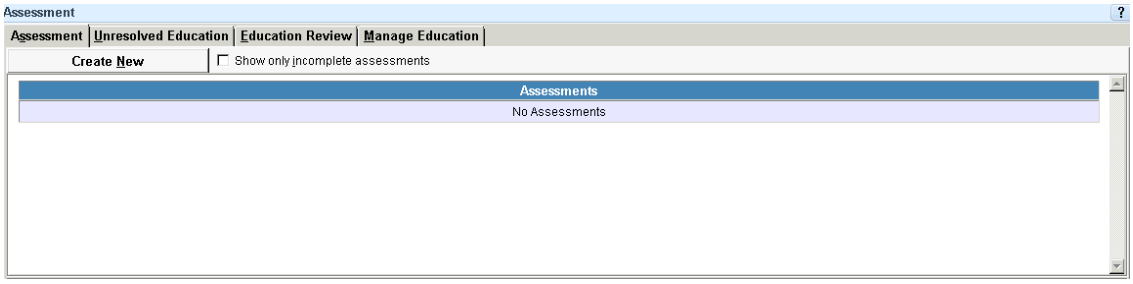
Plan of Care

Allows you to begin the Plan of Care.



Patient Education

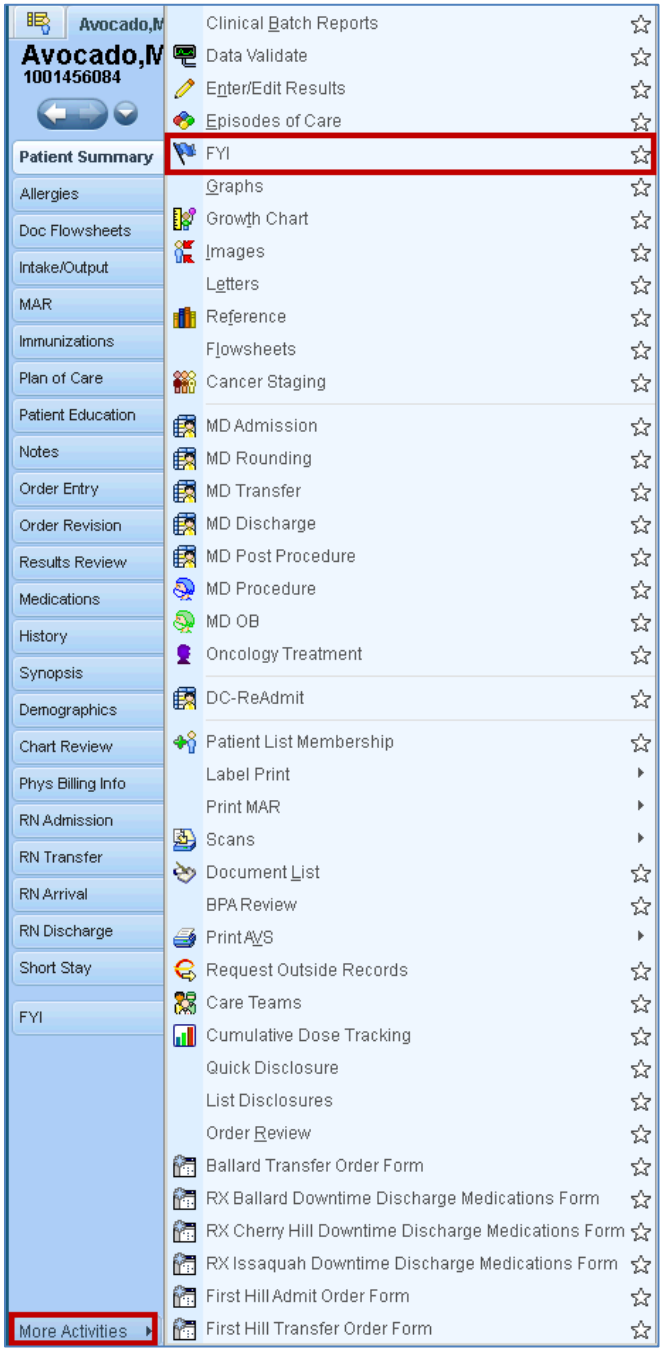
Allows you to begin Patient Education.



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.

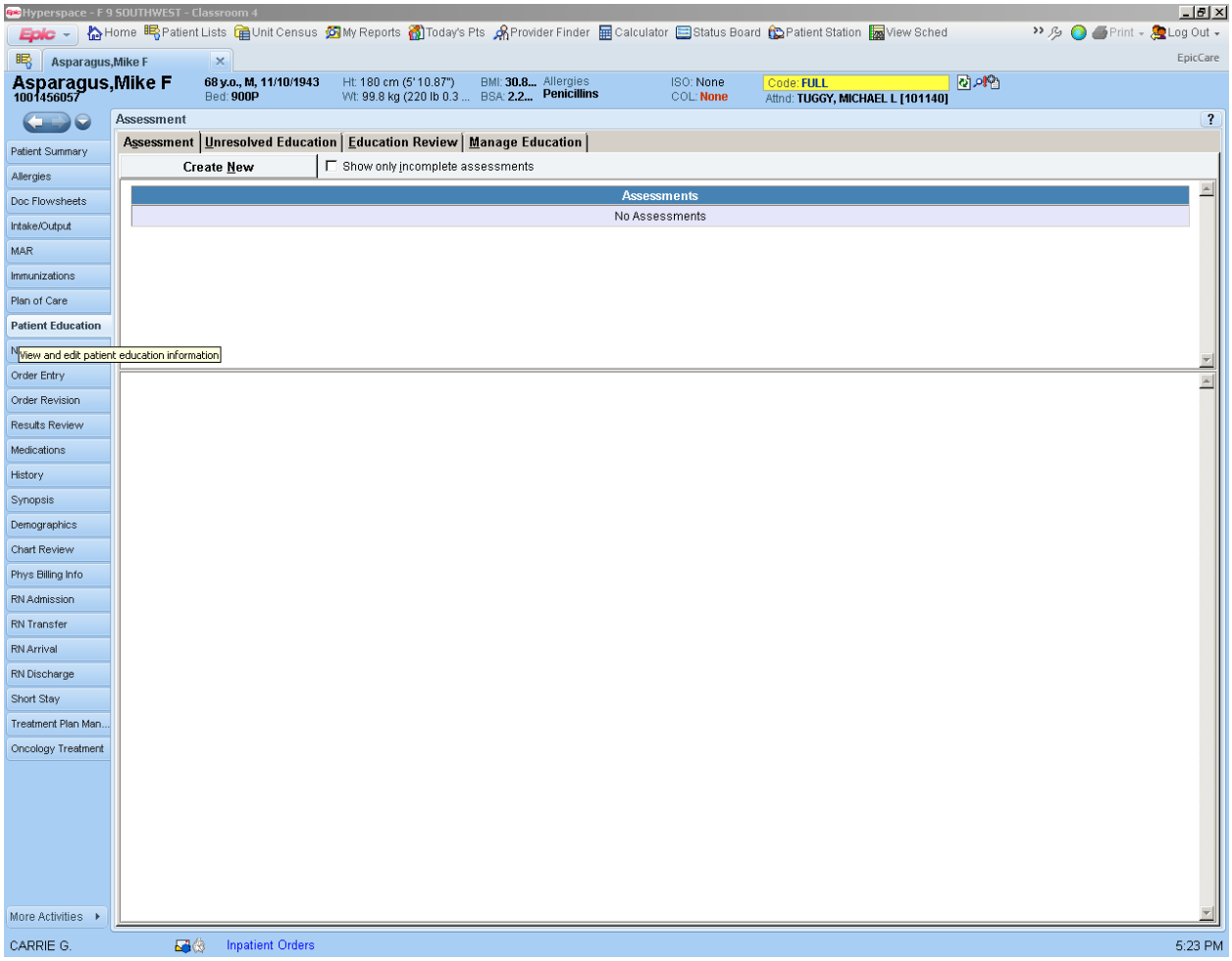


2. Click FYI.

NOTES

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.

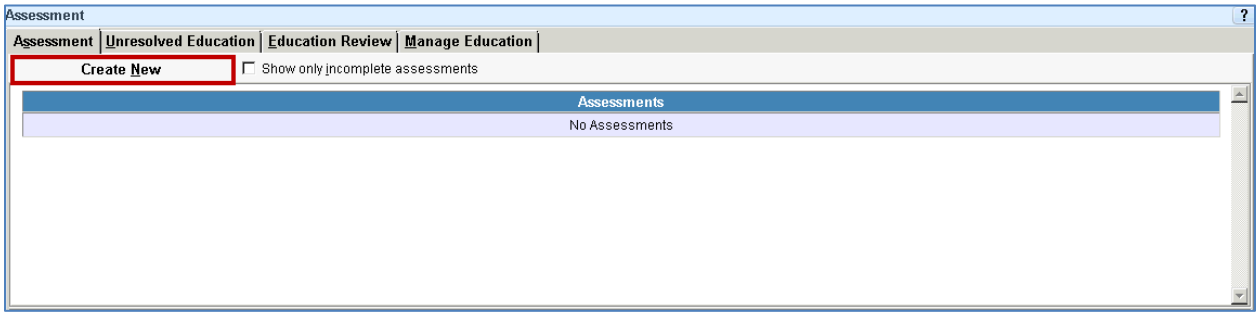


Create a New Learning Assessment

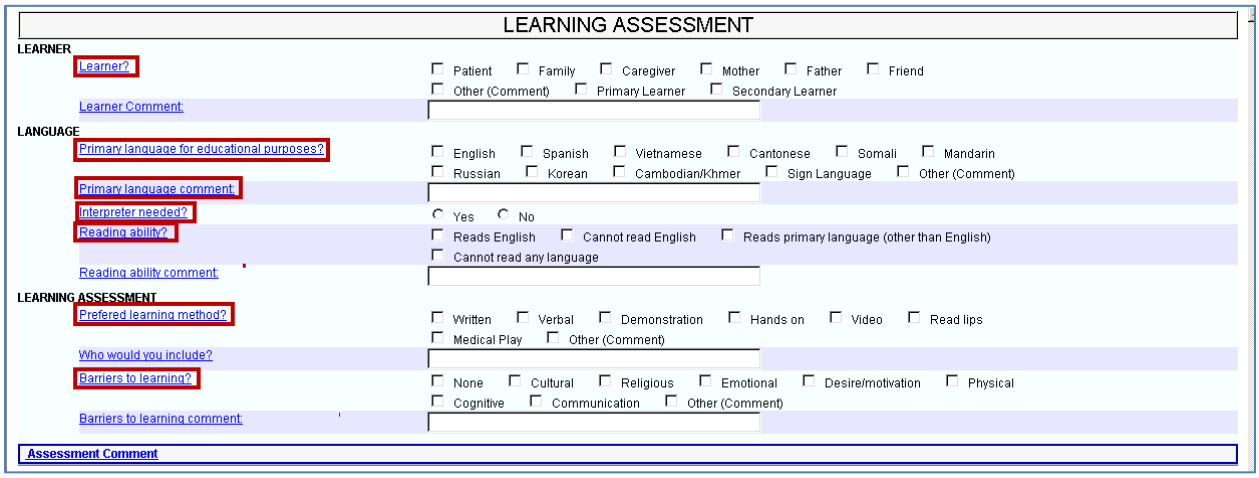
The Learning Assessment should be documented upon admission. Whenever there is a change in the patient's ability to learn. A new assessment should be documented and filed in the chart.

1. Click Patient Education activity.

2. Click Create New.



3. Learning Assessment display appears.

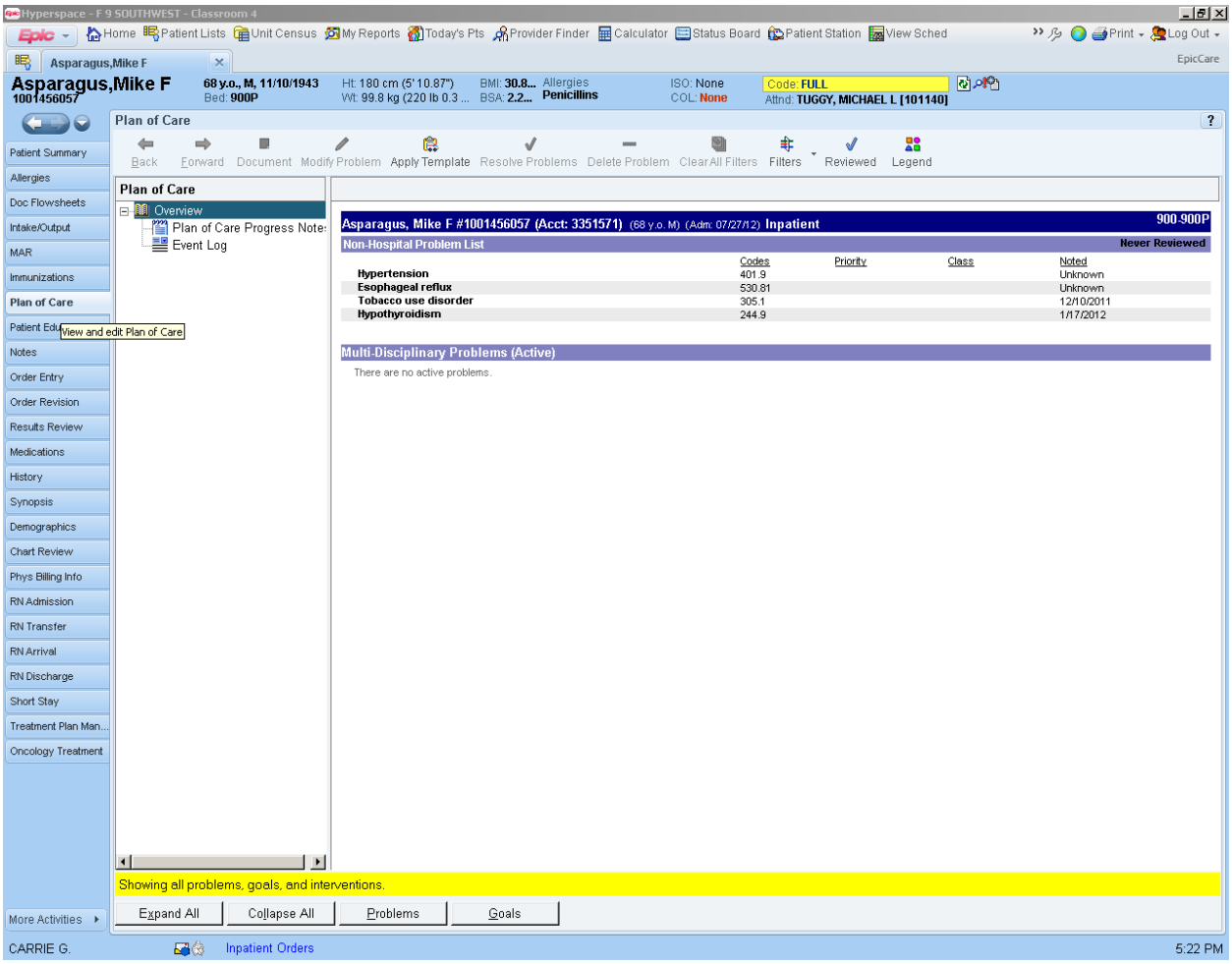


4. The selected areas must be answered:
    a. Learner?
    b. Primary Language for educational purposes?
    c. Interpreter needed?
    d. Reading Ability?
    e. Preferred learning method?
    f. Barriers to Learning?
5. Upon completion, click File, bottom right side.

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 measureable. There are interventions associated with each Plan of Care. However, the documentation of interventions takes place in Notes activity as a Progress Note.



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.

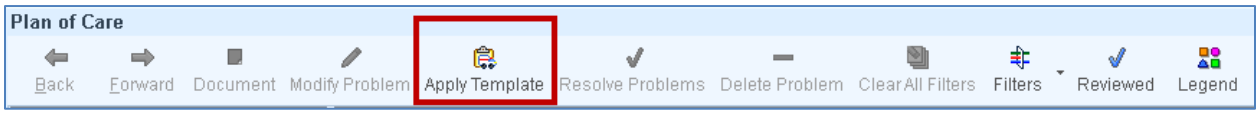
- Plan of Care is to be initiated within 24 hours of admission

- 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.

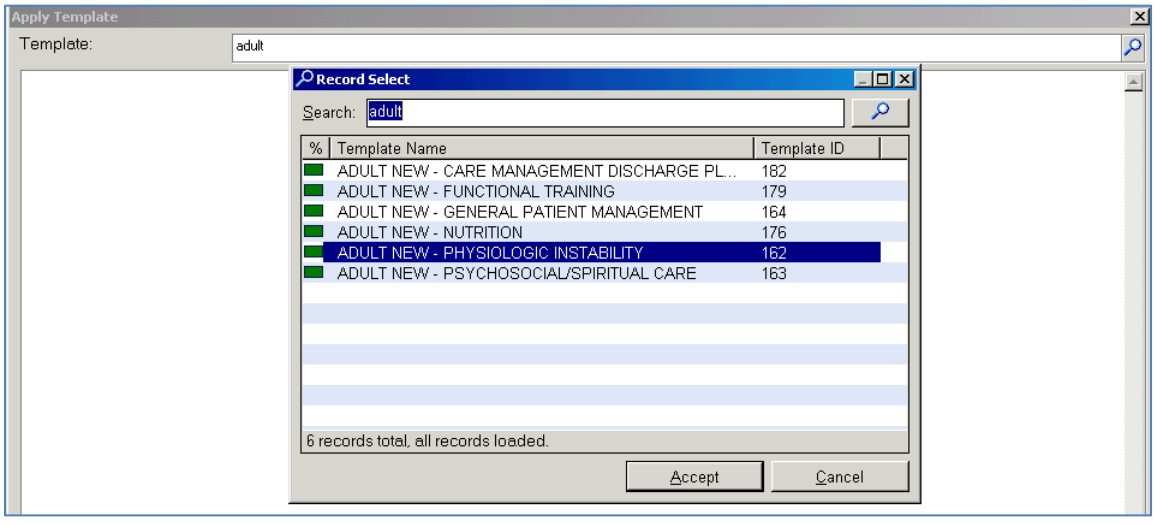
Initiate a Plan of Care

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.

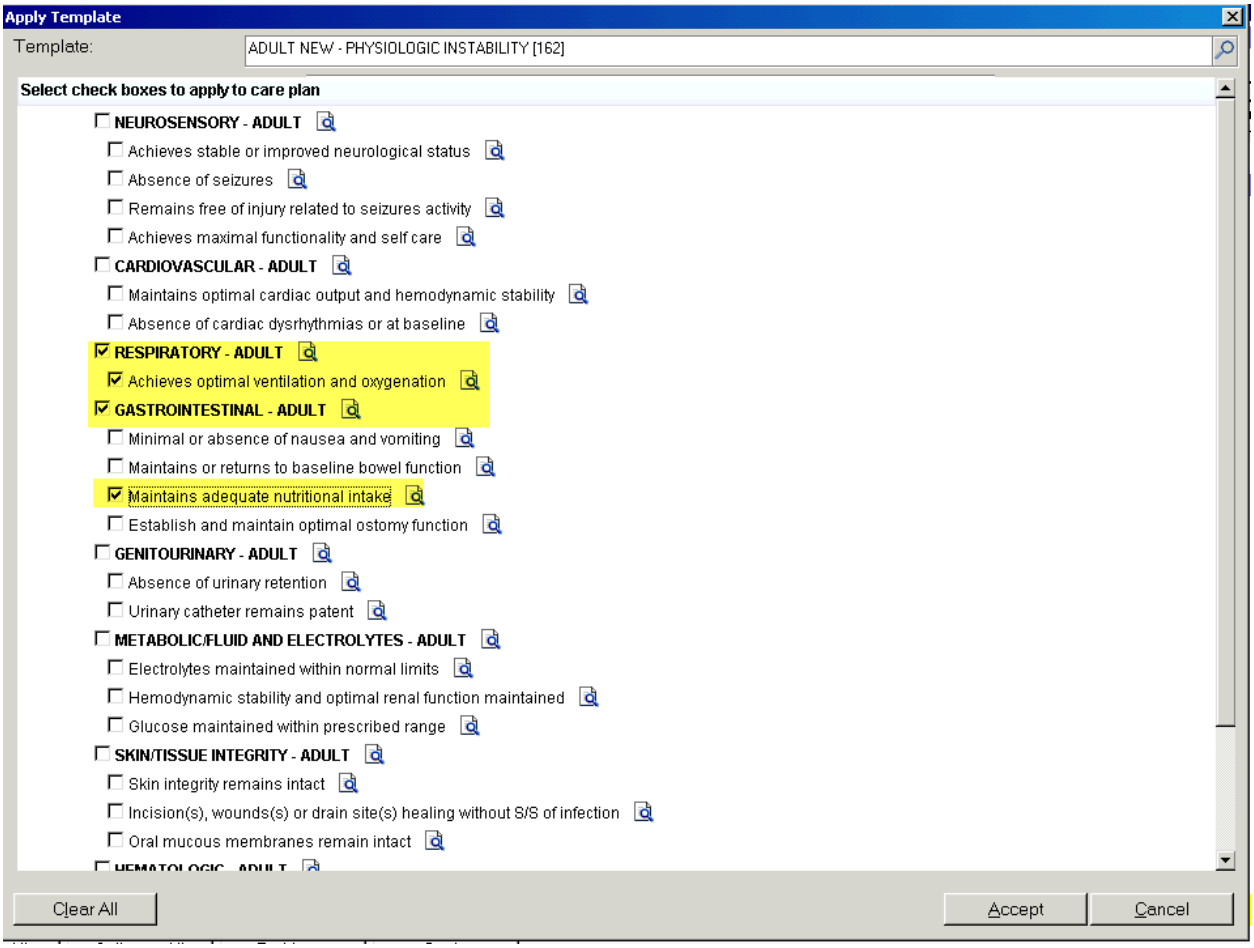


3. We are applying a template to an Adult patient.

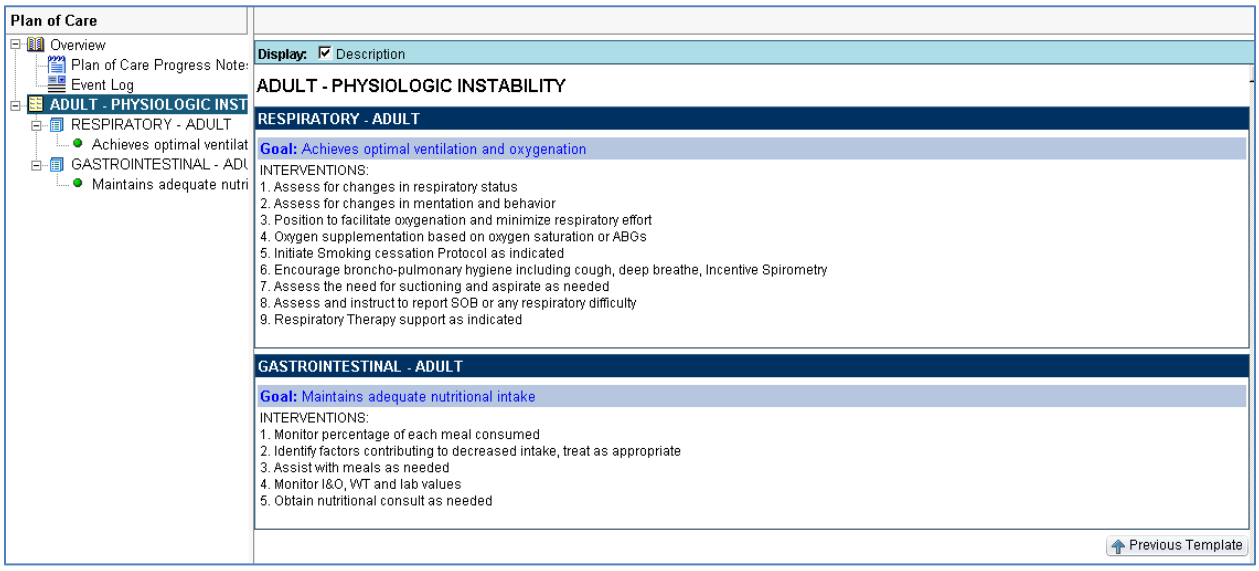


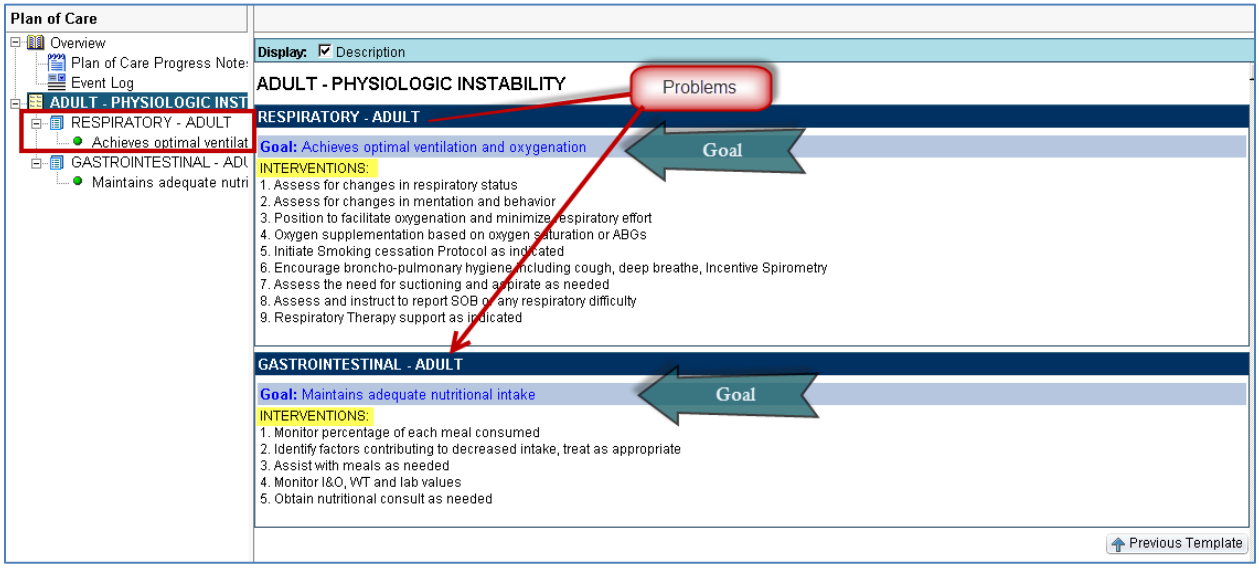
4. Type 'Adult' in the template field and press Enter.
5. Select Adult New – Physiological Instability, click Accept.

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

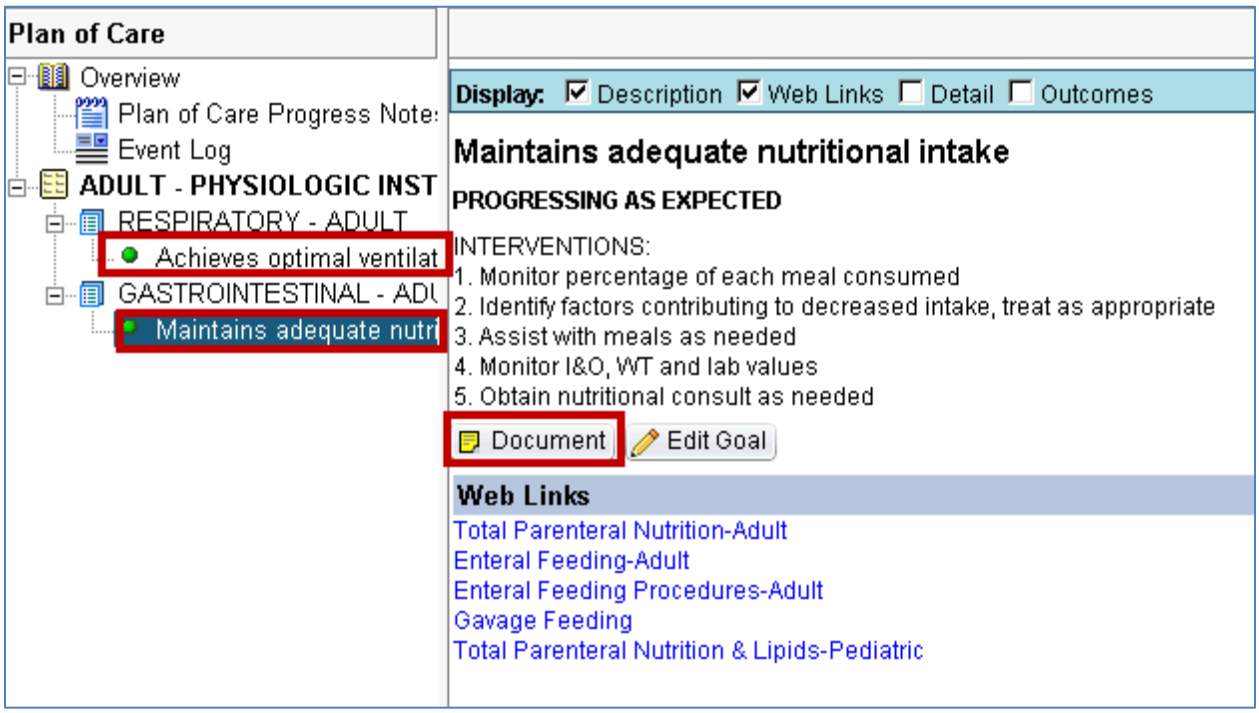


7. Click Accept.

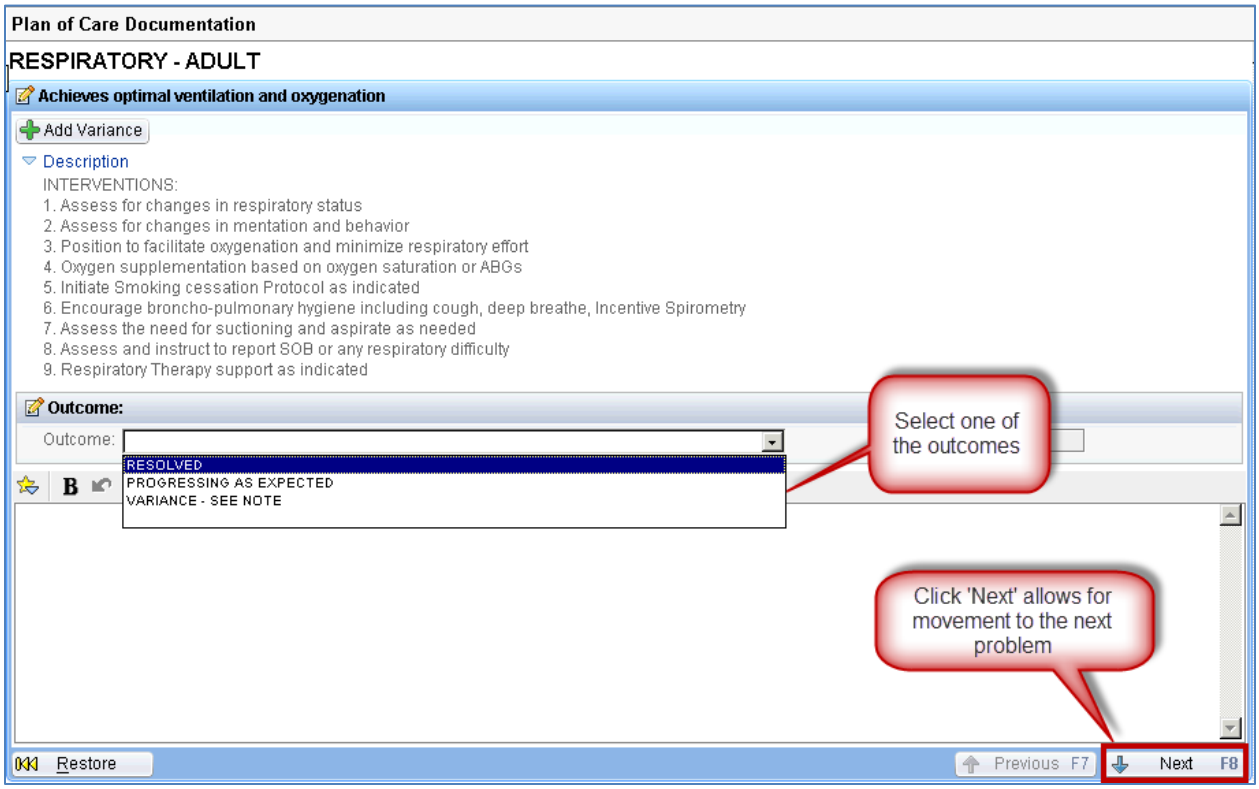




8. Click Accept.



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.

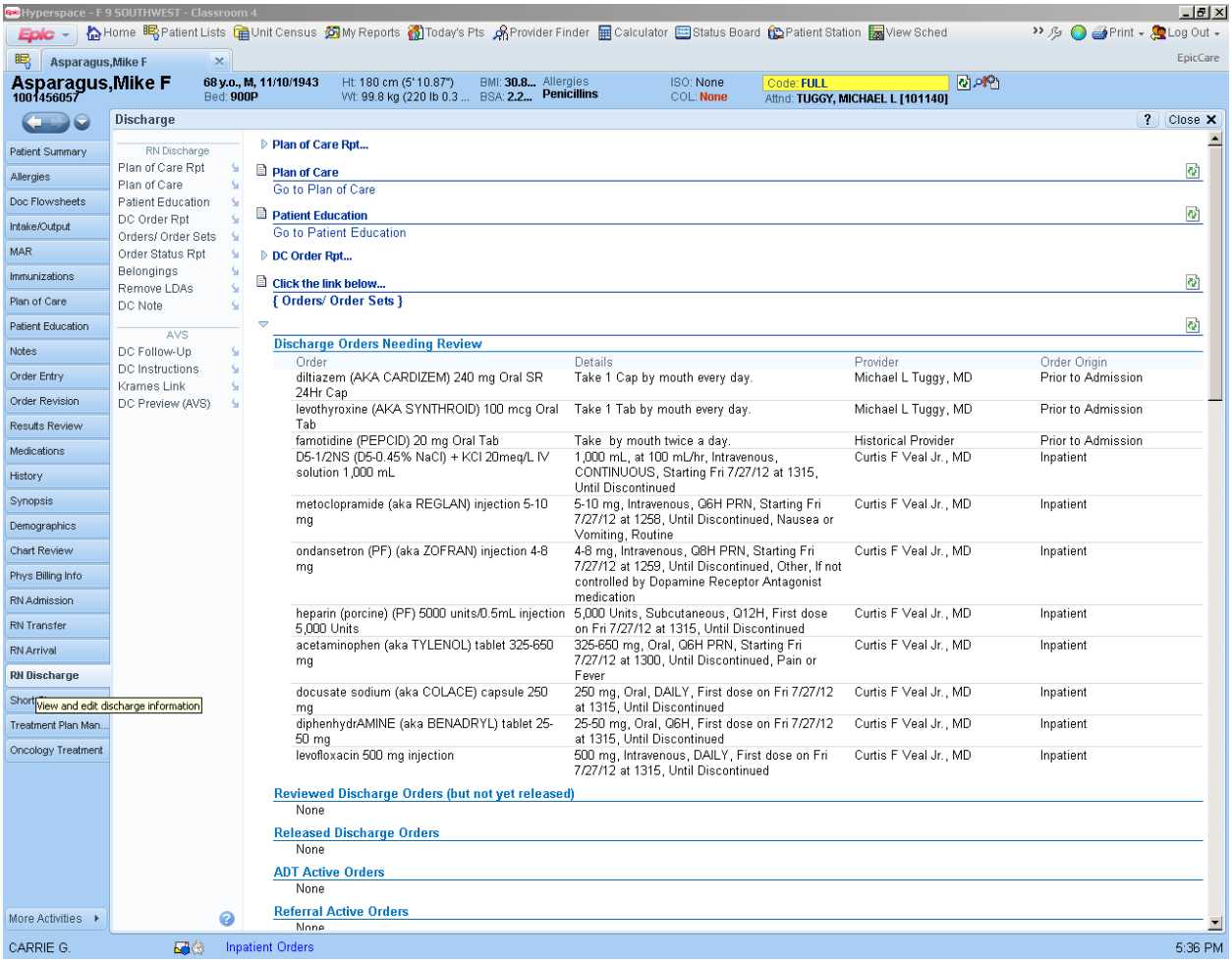
1. Click Plan of Care.
2. Select the 'Resolved' outcome.
3. Click Accept.

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

NOTES

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.



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, Q8H 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.

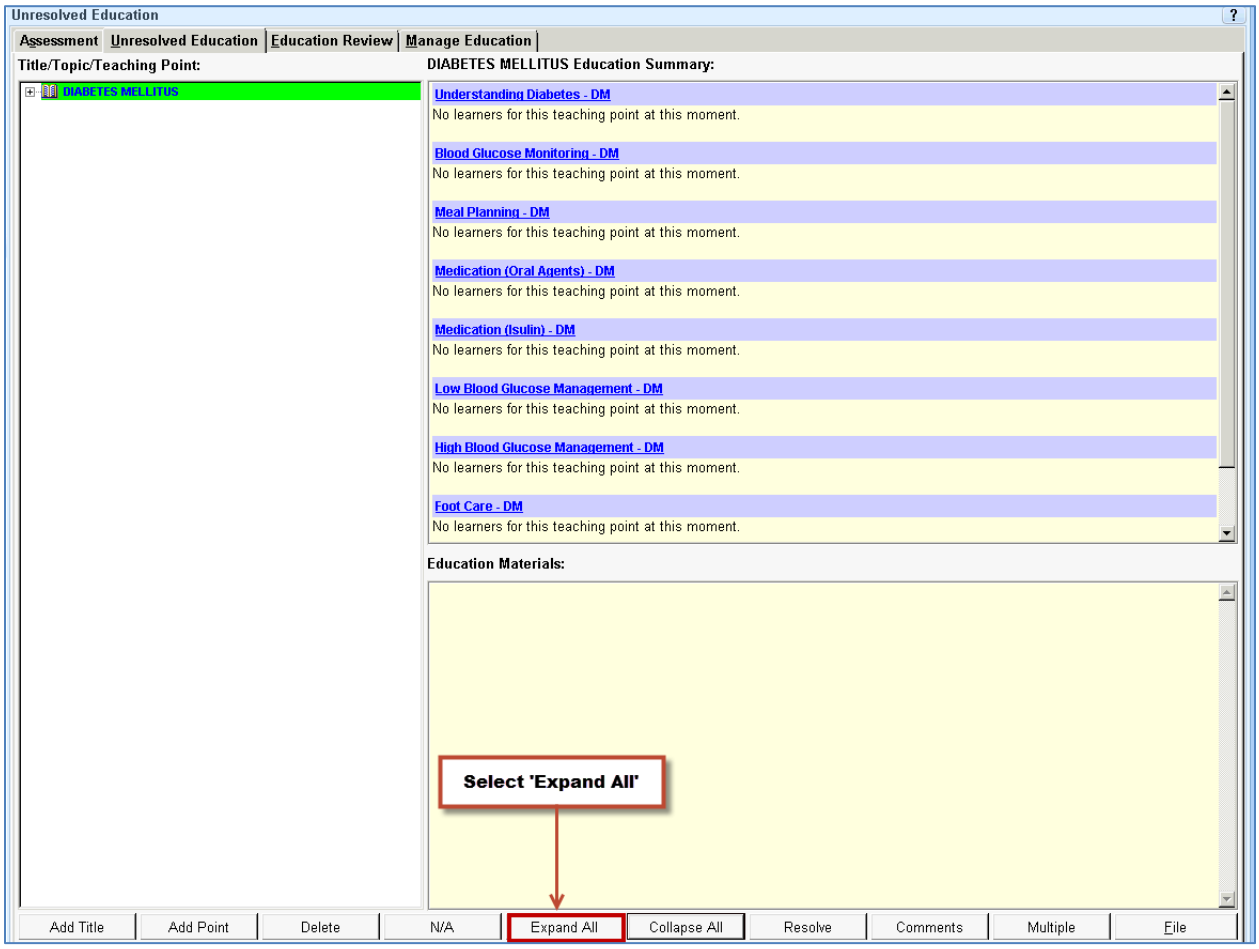
Resolve Plan of Care

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

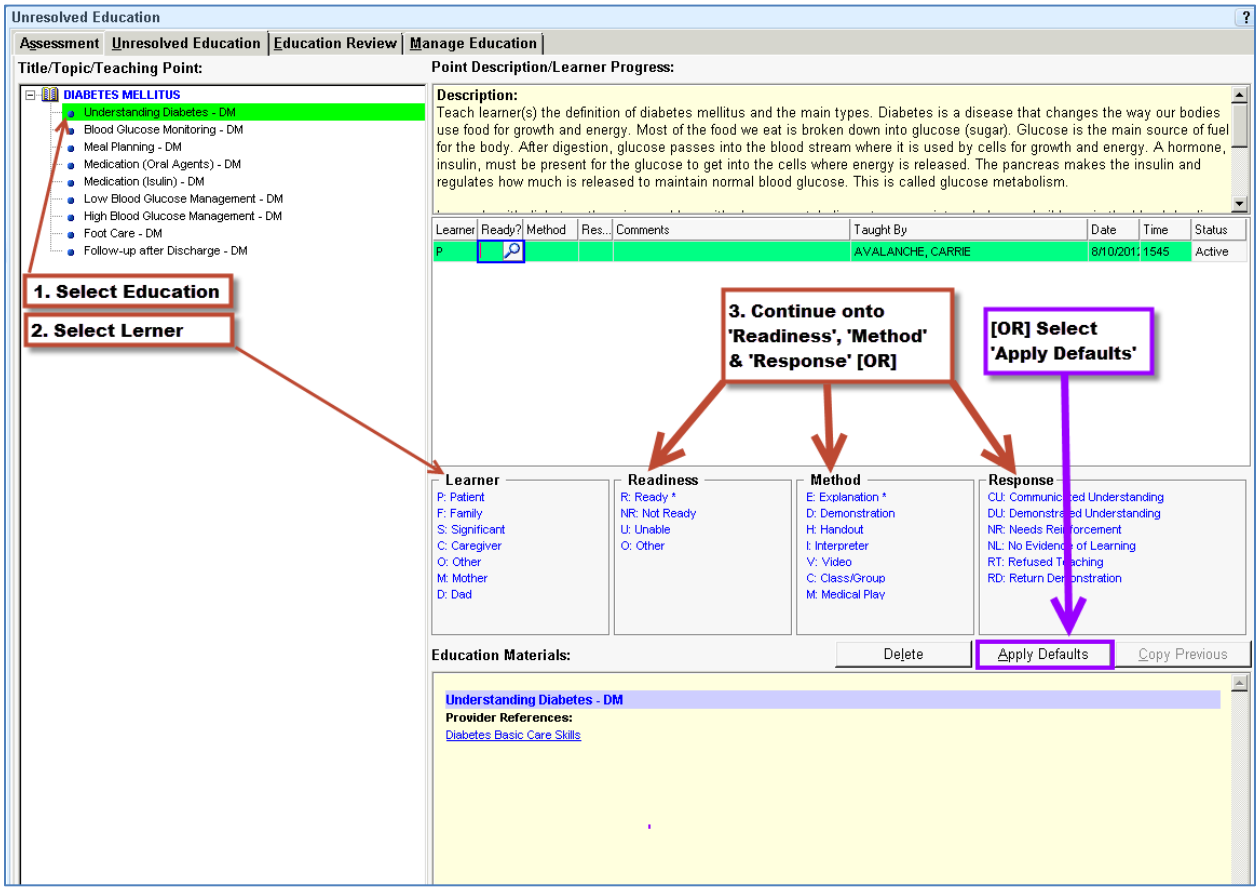
1. Click Plan of Care.
2. Click the green buttoned items
3. Select Document.
4. Go to Outcome, select , this will provide a drop down menu
5. Select Resolved.
6. Click Next F8 to move on to next item to resolve.
7. Once all has been resolved, click Accept and File.

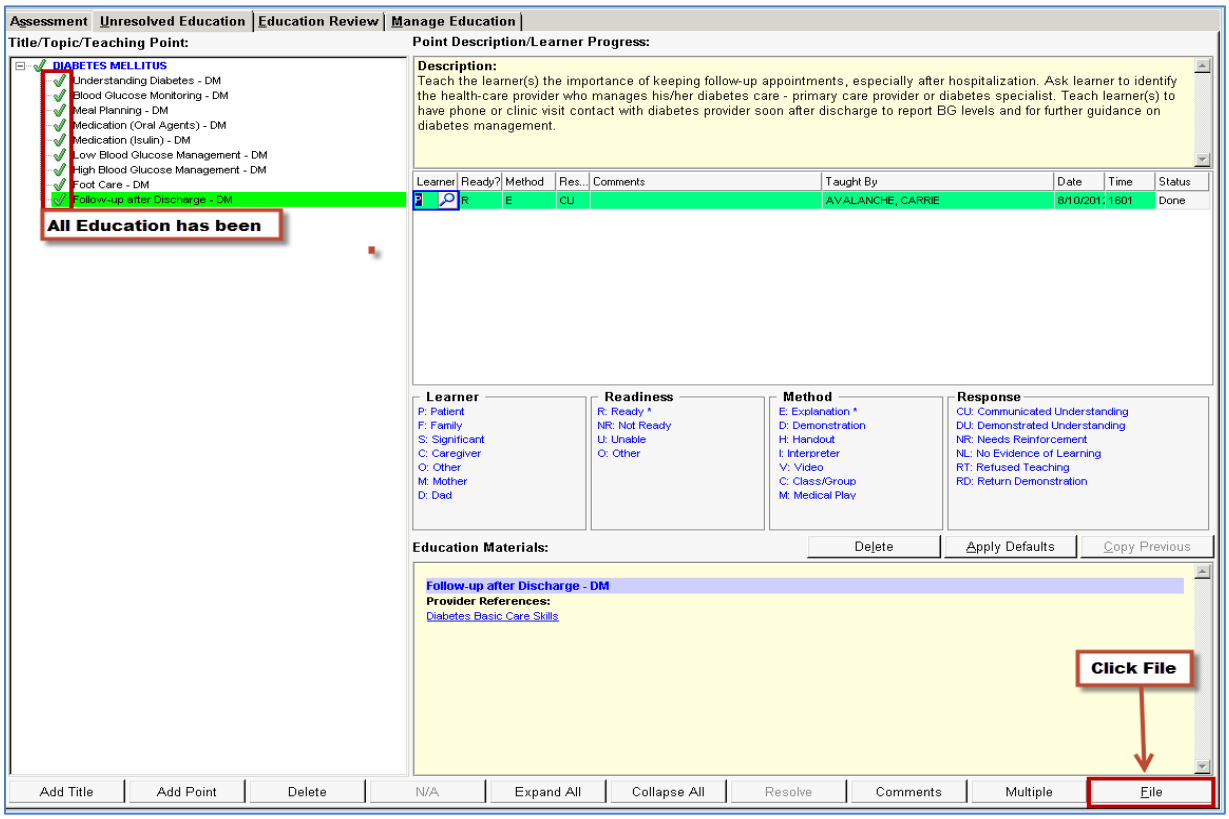
Resolve Patient Education

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



Discharging a Patient





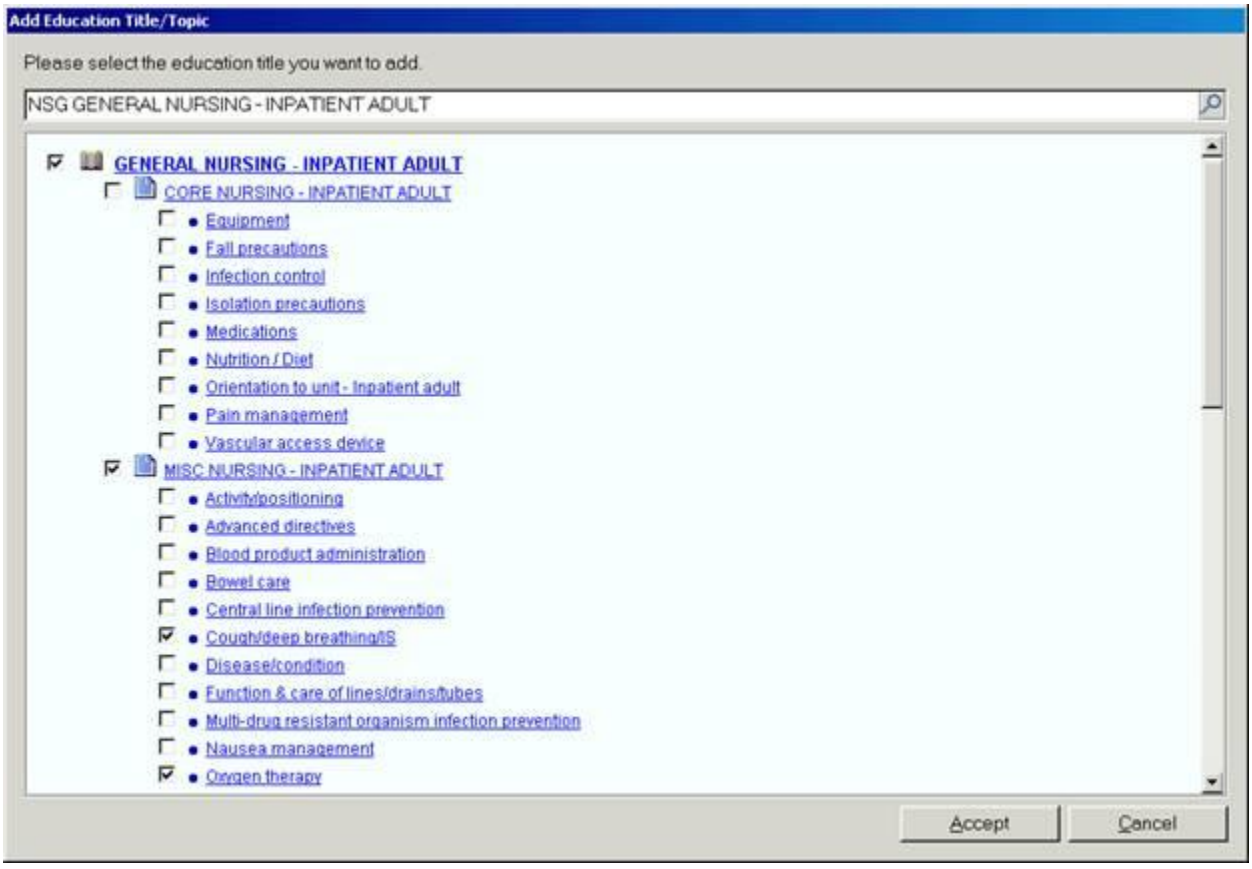
Discharging a Patient

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

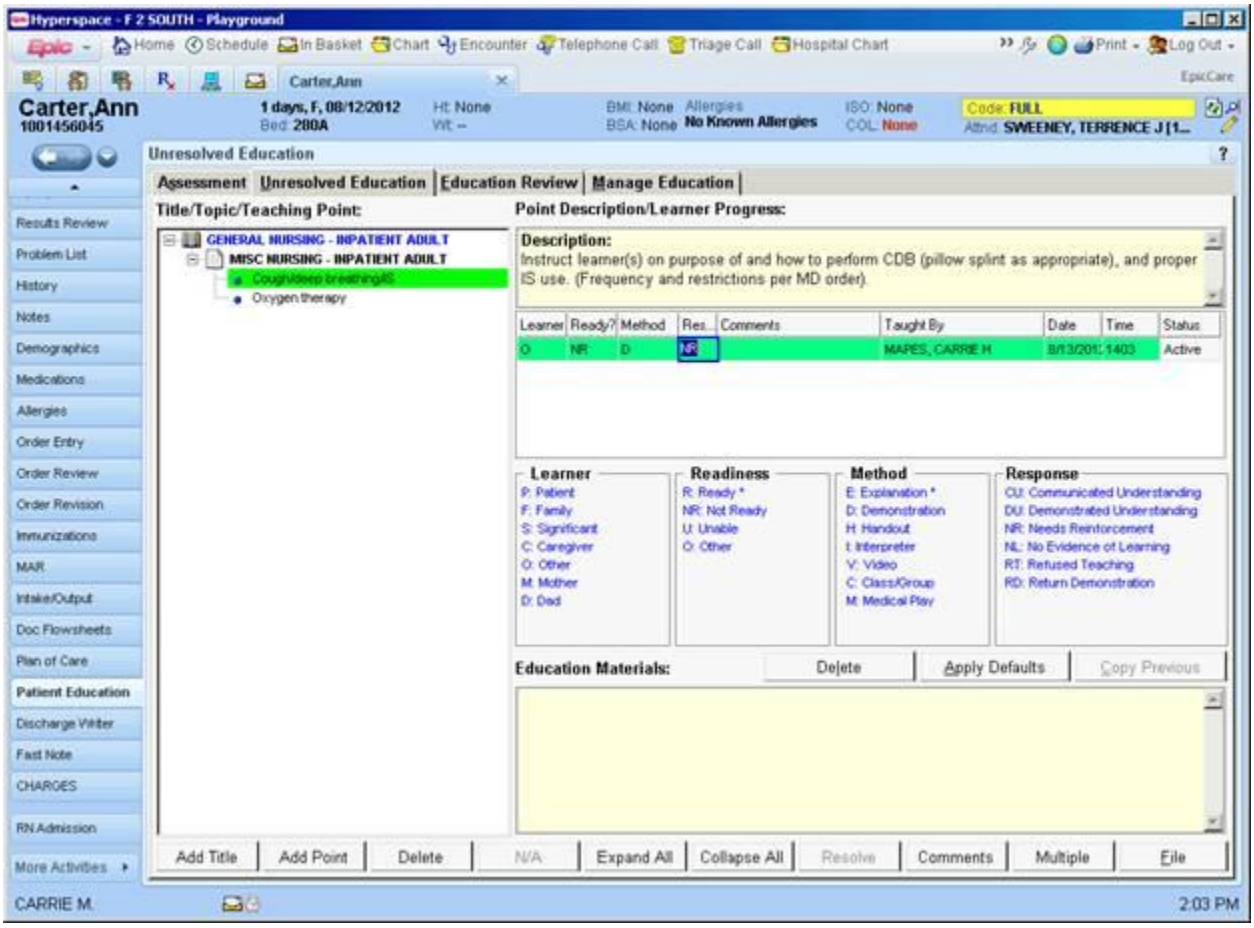
Discharging a Patient

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



Discharging a Patient

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.

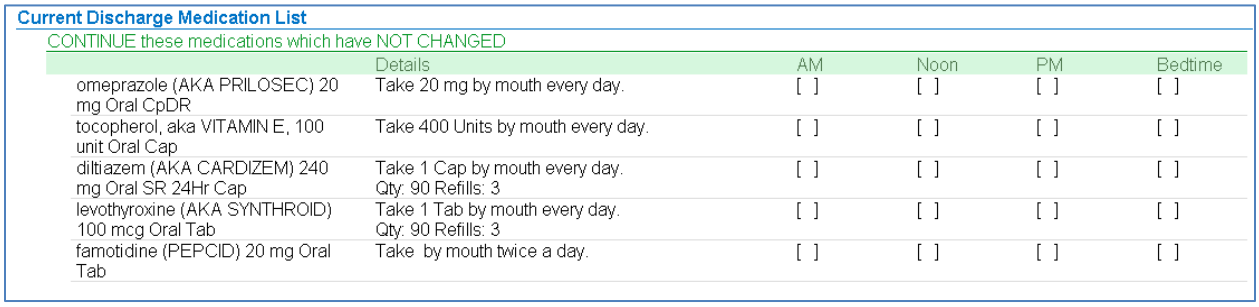
Preview and Print the After Visit Summary

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

CONTINUE these medications which have NOT CHANGED

	Details	AM	Noon	PM	Bedtime
omeprazole (AKA PRILOSEC) 20 mg Oral CpDR	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

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.

Discharging a Patient

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 specifiy 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 plaed by a provider, it is withing his/her scope to release these orders.
   a. True b. False

11. What can you use (instead of the slash key) to quicky 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 updated.
   a. True b. Fasle

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.

NOTES