Cerner Resource Guide

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CHI Saint Joseph Health

Nursing Standards of Documentation

Documentation Category	Standard	Location in Cerner
Patient Handoff	**Areas to Discuss:** • Diagnosis/Physician • History/Procedures • Presentation/Assessment • Telemetry Reading • Recent Vitals • Pain Score • MEWS Score • Code Status • High Risk/Precautions (Fall, Skin, Bleeding, Seizure ETC) • IV Details • Wounds/Incisions/Drains • Home Med History Complete? • Foley Catheter/I&Os • Review Medications Given • Patient Specific Details (Sheaths, Restraints, Blood Administration ETC) • Orders Pending Nursing Action • IPOC/Plan of Care	IView>QuickView>Communication >Report
Vital Signs **(Temp, BP, Full 1min count Respirations, Pulse Ox, End-Tidal CO2 if monitored)**	• Within **15 min** of admission • Per MD order • Any change in patient condition • **Q 4hr** (Routine) **(TIMES 0600-1000-1400-1800-2200-0200)** • Ensure Accurate when saving to EHR **Notes:** • *Preference is for 0700 & 1900 VS to be obtained by Nurse during Bedside Shift Report to Calculate MEWS)*	IView> Quickview band
Alarm Settings	• **Q Shift** during Bedside Report • Must Document the **ACTUAL** limits	IView>Systems Assessment>Alarms Settings

Patient Weights	**Clinical Dosing Weight:** • On Admission • With MD/Phar.D. Order **Routine/Daily Weight:** • Prior to Breakfast • After Voiding/Cath Bag Emptied	Admission History PowerForm If MD or Pharmacy order to update clinical dosing- Use task Order Routine Daily Weights- Use task list QuickView>Patient Height & Weight
Communication Board (White Board)	Items to Include on **Admission** and **Q Shift** & during **MD Rounds**: • Nurse's Name & Phone Number • PCA Name & Phone Number • Daily Patient Goals (pain goal, ADLs, physical therapy, advancing diet) • Continued on Next Page • Unit Manager Contact/Case Manager • Time of last PRN medication "Things to ask my doctor" or "Symptoms I have been having"	
Admission History PowerForm **1.) Reconcile Outside Records**	On Admission ensure that you Complete Reconciliation for the following: ○ Home Medications ○ Allergies ○ Problems	Access from the Admission/Discharge Workflow mPage Import Records>>Consent Granted>> Clinical Reconcilliation buttons for Home Meds, Allergies and Problems
2.) Advance Directives	On Admission **REASSESS** if unable to attain on admit ***IF patient has a paper copy on file from previous admission then print, review,***	Access Admission History Powerform from the TASK LIST

3.) **Columbia Suicide Risk Screening** 4.) **Sleep Apnea Risk Assessment** **5. Travel Screening**	***have pt. or DPA initial, & place on patient current chart*** On Admission **REASSESS** if unable to attain on admission ***Complete Full Screening*** On Admission **REASSESS** if unable to attain on admission (Notify MD if positive screen) ○ If Score >3 Inform MD & Monitor ETCO2 On Admission **REASSESS** if unable to attain on admission	
Patient Stated Goals	• Create on Admission • Review and Update at Discharge **Notes:** If unable to obtain on admission, document **ASAP!**	Admission Workflow mPage Discharge Workflow mPage
Patient Preferred Pharmacy	• On Admission ○ Reassess if unable to obtain ○ If already completed from previous visit- verify it is still correct- If it has changed UPDATE IT	Via PATIENT PHAMRCY Link on Tool Bar. Once complete- Document "done" via the task on the task list.
Planned Powerplans (Physician's Orders)	• On **Admission** (Initiate Admission PowerPlan and any other Powerplans needed based on patient specific needs. For Example: Glucose Control, CC or Tele Protocol, ETC)	Orders Profile section of the Patient's Chart Use Care Compass to utilize Nurse Review Feature **AND** Nurse Review Feature in the

	• **Throughout Shift** (Regularly check for new orders and initiate or discontinue as appropriate) • Evaluate during **Chart Checks** at 0500 & 1700 EVERYSHIFT At Patient **Handoff** (Shift, Unit to Unit, or Facility to Facility)	Orders Profile Section of the Patient's Chart
Initial Assessment	• Complete within **15 min of Admission** complete the following: ○ Admission Arrival Time ○ Admission Assessment Complete ○ Admission Assessment Comment ○ Focused Assessment • Documented within **8 hr. of Admission**	IView>System Assessment band Admission Arrival Time>>Admission System Assessment Section
Routine Assessment	• Tele/Med-Surg **Q Shift** • Critical Care Areas are **Q 4hr**	IView>Systems Assessment band
Comprehensive Pain Assessment	• On **Admission** • **Q 12 hr.** • Reassess **after Applicable Timeframe** of Intervention: ○ IV – **30** min ○ PO – **60-90** min ○ IM/SQ – **60** min ○ Non-Pharmacologic **60** min Document **Pain Goal**: ○ Pain Goal ○ Scale Used ○ Current Level ○ Location (if pt. has pain) ○ Quality (if pt. has pain) Even if patient has no pain: • Pain Goal • Scale Used Intensity=0	IView>QuickView> Primary Pain Assessment CPOT (Critical Care Pain Observation Tool) Pain Interventions **REASSESSMENT: USE MAR OR TASK LIST (this gives you the exact time that reassessment documentation needs to be completed.**

MEWS **(Pediatrics- Use PEWS)**	**Do Not** use VS > 1 hr. old to calculate • **On Arrival** to Unit • Calculate during **Hand Off of Care** • **Change in Patient Condition**	IView>Systems Assessment Band Pediatrics- Use the Pediatric Scales and Screens IVIEW band
ABC Fall Injury & Morse Fall	• On **Admission** • **Q Shift** • Change in **Level of Care** • Change in **Patient Condition** • **After a Fall** Complete Post Fall Huddle	Admission History PowerForm IView>Systems Assessment Band
SKIN Braden	• On **Admission within 8 hours** • **Q shift** • **Skin Breakdown Prevention Interventions**	IView>Systems Assessment IView>>QuickView>>Routine Rounding>>Skin Breakdown Prevention Interventions
Wound/Dressing Changes	• On **Admission** • **Discovery of Wound** • When Wound **Resolved** • Transfer • At **Discharge**	• IView>Wound Assessment band • Pressure Ulcers – document in the Pressure Ulcer Dynamic Group section • Wounds/Incisions – document in the Wounds/Incision Dynamic group section • Photo on admission-Place an IRIS report if found on admission
ECG Tele-Strips	• On **Admission** • **Q 3-5 hr. (PR, QRS, QT, & Interpretation)** • With A**ny Change** in Rhythm • Upon **return from a procedure**	Telemetry monitoring rhythm strips are placed in paper chart. Rhythm is documented in IView>Systems Assessment>Cardiac Rhythm Analysis section
IV Sites	Create a **Dynamic Group** for all sites: • On **Admission** • Any **New** IV Assess all sites: • **Q Shift** ***(Hourly*** if receiving a vesicant medication) • Patient **C/O Discomfort** • Medication Administration • After Removal	IView>Lines & Drains band

	Notes: *Ensure Documentation of **Number of Attempts*** ***Inactive** Dynamic Group when IV is Discontinued*	
Tubes & Drains **Includes but not limited to:** • **Central Lines/PICC** • **Chest Tubes** • **GI Tubes** • **Surgical Drain**	Create a **Dynamic Group** for all sites: • On **Admission** • Any **New** Insertions • Assess all sites: • **Q Shift** • With **Any changes** • Per MD order **Notes:** • *Ensure Documentation of **Removal** of Tube/Drain* • ***Inactive** Dynamic Group when Tube/Drain is Discontinued*	IView>Lines & Drains band
Foley	Create a **Dynamic Group**: • On **Admission** • Any **New** Insertions Assess: • **Q Shift** • With **Any Changes** • Per MD order **Notes:** • Document **Foley Bundle** & D/C Criteria **q Shift** • Ensure to Document **Removal** of Foley • ***Inactive** Dynamic Group when Foley is Discontinued* *Complete & Document **Peri-Care***	IView>Lines & Drains
Patient Education **Suggested Topics but not limited to:**	**Learning Assessment**: • On **Admission** (Admission Powerform)	IView>Adult Education **OR** Ad Hoc>Education Folder

• **Plan of Care** • **Fall Precaution** • **Disease Process** • **Surgical Procedure** • **Diet Instructions** • **Diabetes** • **New Medications** • **Sepsis** • **Restraints** • **Risk for Infection** • **Heart Failure** • **Isolation** • **Malnutrition**	• **Document each time education performed** ○ Who was taught ○ Barriers ○ Readiness ○ Method **Patient Teaching:** • **Q Shift** • At **Discharge** (Must include Diagnosis this Admission)	Some Education topics will be Tasked **(USE YOUR TASK LIST)**
IPOC **(Care Plans)**	• On **Admission** • **Q 24 hr.** • **GOALS Must be Completed by an RN** **INDIVIDUAL Plan of Care by adding a PATIENT SPECIFIC GOAL**	For a New IPOC: • Click Orders & Click Add (as you would for a new order) & Search IPOC • Initiate Suggested IPOC from the VIEW Section of the Orders Profile To Update Q 24 hr.: Enter the Orders Profile & Click on the Document in Plan Tab
Restraints	**Education Q Shift** **Plan of Care** **NON-VIOLENT Q2 hr:** ○ Circulation and Skin Integrity of Restrained Limb ○ Toileting, Food, & Fluids Offered ○ ROM & Rotate Sites if Possible ○ Position Changes ○ Vital Signs **VIOLENT Q 15 min:** ○ Circulation and Skin Integrity of Restrained Limb ○ Toileting, Food, & Fluids Offered ○ ROM & Rotate Sites if Possible ○ Position Changes ○ Vital Signs	**USE YOUR TASK LIST**

	○ Specific Behavior Requiring Restraint **DISCONTINUATION:** ○ Activate the section by double clicking in the Blue cell directly under the time column ○ Time of Discontinuation (this will remove the order from the patient chart and stop the task from firing to task list. ○ Discontinuation Criteria **Notes:** *These areas **MUST** be documented:* ○ *Pre-Restraint Alternatives **Prior to Restraint Initiation*** ○ *Reason for the Restraints* ○ *Type of Restraint Device* ○ *Criteria for Discontinuation* ○ *If **VIOLENT** Patient must be in **Continuous Observation** (can be through door or window)* ○ *Must **Renew Order Q 24 hr.*** ○ *Document all Patient Responses to less Restrictive Restraint Alternatives*	
I & O	• Should be **Documented in Real Time During** Hourly Rounding: ○ Diet Type **Q Shift** ○ Meal % **WITH EVERY MEAL** (even if it is 0%) ○ Oral Intake ○ Outputs Ensure you Validate accuracy at End of Shift	IView>Intake and Output band
Meal and Oral Supplements	**All meal activity must be documented:** 1. Diet Type 2. Nutritional Activity (fed patient, patient refused, wears dentures, etc) 3. Breakfast % 4. Lunch %	Iview>Quickview>Nutrition section

	5. Dinner % 6. If patient is NPO- document that in the meal type **Oral Supplements**- If ordered- must be administered and documented	
Sheath	**Document the following Assessments:** • Pulse Check • Sheath Site • Circulation of Extremity • B/P & Heart Rate • Site Assessment Frequency **While Sheath in Place:** • On Admission • Q 15min X 1 hr. • Q 30min until Sheath is Removed Frequency **Once Sheath Removed:** • Q 15 min X 1 hr. • Q 30 min X 2 hr. • Q 1 hr. X 4 hr. Q 4 hr. X 24 hr. & PRN	IView> Cath Lab Procedure
Pre-Procedure Checklist	**All documentation Fields** as appropriate for each surgery.	IView>Pre-Procedure Checklist
Blood Administration	**Initiating a Transfusion:** • Patient/Family Education • Consent • Nursing Witness • Pre-Transfusion Documentation & VS • Document Start Time • Stay with Patient for 1st 15min • Document VS at 15 min • VS Q 1 hr. for remainder of transfusion **Completion of Transfusion:**	IView>Blood Administration

	• Post-Transfusion VS • Date/Time Completed • Amount Transfused • Patient Response • Document Blood Intake and Saline Intake in I&O Band **Documenting a Transfusion Reaction:** • Type of Product • Amount Infused • Events surrounding Reaction • Actions Taken • Patient Response • Complete the Transfusion Reaction Report (MR-57) & Send to Blood Bank **Notes:** *Blood Transfusion must **begin with 30 min** after leaves Blood Bank and infusion must be **Complete within 4 hours.***	
Chart Check	Review completion of the following at **5am** and **5pm** daily: • New Orders Reviewed (Electronic and Paper) • Planned PowerPlans initiated when appropriate • Verify Nurse vs Lab Collect status is accurate in Lab orders • Discontinue Nursing Misc. orders that have been completed • Task List reviewed and ready for next shift • Assessment Documentation Complete • IPOC Goals and Interventions Update • Education Assessment and Topics Documented • Telemetry Rhythm Strips Interpreted per Policy	**USE YOUR TASK LIST**

	Discontinue Orders that have been completed and still remain as an Active Order (Nursing Misc., Communication Orders, Patient Care etc….)	
Medication Administration	Review MAR Scan EVERY medication	MAR Medication Administration via tool bar
Vaccine Administration **Vaccine Information Statements (VIS)**	Print and provide patient Vaccine Information Statement (VIS) Scan all vaccines via medication administration scanning workflow.	IntraNet>>Vaccine Administration>>CDC VIS site
IV Drip Titrations	Initiate Drip Per MD only Titrate per MD order only Document titration clinical data parameters with every titration Every titration change on the pump must be documented in Cerner	MAR>Continuous IV Fluids- Scan begin bag Titrations- IVIEW>>Quickview>>IV Drip Section
Sepsis Screening Alerts	System will monitor for SIRS and Sepsis criteria- If Discern Alert triggers to the nurse- The nurse is responsible for notifying the provider and following policy.	Task List>SIRS or Sepsis Alert task>>Links to provider notification documentation.
Specimen Collection	All specimens are to be scanned for Positive Patient Identification (PPID) Print specimen label prior to going into patient room- Scan patient armband and specimen at the	Print label from Task List>>Right Click on task>>Reprint Labels>>Select Printer Scan and document collection from SPECIMEN COLLECTION via toolbar.

	bedside to mark specimen as collected Send specimen with specimen label to lab.	DO NOT send specimen to lab by just placing a specimen label on the specimen without scanning and marking the specimen as collected.
Problem List Update	**Update on Admission and Q shift:** The problem list should be updated with all problems throughout the shift. Resolved problems should be marked as resolved (ie. Patient came in previous visit with UTI and then is readmitted two years later- resolve the UTI if it is no longer an active problem) All problems throughout the visit should be added to the problem list- (ie, patient falls, +MDRO, cardiac arrest, any new diagnosis, pressure ulcer or skin problems, acute confusion, etc).	Admission Workflow mPage>>Problems/Procedures/Social History- Click on problems tab then the Problems/Procedures/Social History component header MENU>>Problems and Diagnosis

RESOURCES:

Policy Stat: Policy and Procedure Library

Nursing Standards of Documentation for Critical Care

Documentation Category	Standard	Location in Cerner
Cardiovascular Assessment	• VS Q 2 H or more frequently based on patient acuity	IView>ICU Systems Assessment>Cardiovascular
ECG Strip	• EKG strip Q4 H any changes (measurements PR, QRS, & QT Q4 H)	Telemetry monitoring strips placed in paper chart. Rhythm documented in IView>Systems Assessment>Cardiac Rhythm Analysis section
Swan-Ganz Reading	• SWAN/GANZ readings per pt acuity • Zero lines Q shift & any Δ's in positioning	IView>Adult Lines and Drains ○ Pulmonary Artery Line must be customized ○ A separate Line must also be created for the Introducer under the Central Line Section
Pacemaker Settings	• Pacemaker Settings & with any Δ's	IView>Adult Systems Assessment>Pacemaker
Impella	• Document you V/S, Device Assessment, Hemodynamics, Site Assessment, & Distal Pulses: ○ Upon arrival to unit ○ Q 15 min X 4 ○ Q 30min X 2 ○ then hourly • Document the following Q I Hour: 1. Performance Level, 2. Flow Liters/min, Placement 3. Signal, Motor Current, Pump 4. Position, Purge Pressure, 5. Infusion Rate, Power-AC or 6. Battery	IView>Adult Devices and Treatments>Impella Flowsheet
Ventilator	• Settings Q 4 H and with any Δ's • Oral Care Q 2 H • If no contraindications, HOB > 30° • Daily Wake up	IView>Respiratory Therapy>Mechanical Ventilation
IABP	• VS Q 15-30 minutes until Q 2 H or more frequent (include MAP) (documenting augmented pressure) • Document the following pressures Q 4 (UAEDP/AAEDP, USyst/Asyst, Aug Dia,) • Pedal & Radial Pulses, Temp, & Skin	IView>Adult Devices and Treatments>IABP

	• Color of extremity Q 1 H or more freq • LOC & UOP Q 2 H • Check timing Q I H & prn with any changes in HR and rhythm • Document EKG, AL & IABP waveforms on a rate of 1:2. • Neuro Checks Q 4 H and prn SAFETY CHECKS: • Q 8 H : Slow Gas Alarm - ON • IABP Fill - AUTO • Timing - AUTO • Helium Level Amount of PSI Q I H: • Insertion site, Clean / Dry • HOB < 30° • Trigger Source • Pumping Ratio • No Blood Noted in Ext. Tubing	
TOF	• Upon initiation Q 15min until Goal is met, then Q 4 H	IView>Adult Scales and Screens>Neuromuscular Blockade ○ Must Customize to pull into Documentation
BIS	• Titrate until the MD ordered BIS monitor goal is achieved then Q 4 & with drip changes	IView>ICU Systems Assessment>Neurological Monitoring>Bispectral Index Monitoring
Cam-ICU	• Completed with any acute change from mental status baseline or patient's mental status fluctuating during past 24 Hours.	IView>Adult Scales and Screens>Cam-ICU Assessment

Build a Custom List

Note: Only have to do this the first time.

1. Click on wrench icon. Click **New**.
2. Select **Assignment**.
3. Select "Include patients that have met the criteria in the last" and enter 1 hour.
4. Name the Assignment Type Patient List.
5. Select **Finish**.
6. Move from Available list to Active. Click **OK**.
7. Go to CareCompass and Refresh (to pull information over)

Shift Report

Review together:

- Use the Patient Handoff Report for each patient AND the following tools in Cerner during handoff report- shift to shift or unit to unit
    - MAR- look for overdue medicaqtions- if they were given- make sure the off going nurse documents the medications. If still needing to be given- oncoming nurse responsible for administration. DO NOT LEAVE MEDICATIONS OVERDUE.
    - Task List (click on task to complete or from CareCompass – right click on the task and select Done
    - Labs/Radiology
    - IPOC
    - Orders Profile

Clinician Communication

1. Document shift to shift, unit to unit, and receiving facility handoff.
2. Go to iView.
3. Select **Adult (ICU) Quick View** band.
4. Choose **Clinician Communication** section.

To Change Navigator Bands

1. Click **View** in toolbar then **Layout** then **Navigator Bands**.
2. Select appropriate band from box.
3. Move from Available box to Active box.
4. Close application (or chart) by clicking X by patient tab.
5. Select Recent then select patient to reopen chart.
6. Return to iView. Refresh.

Note: New band will appear at the bottom.

Note: Adding a **Navigator Band** will add it to ALL the patients under your log on.

7. Click **View** (in toolbar). Click **Layout.**
8. Close application (or chart) by clicking **X** by patient tab.
9. Select **Recent**. Select patient to reopen chart.
10. Return to iView . Refresh.

Resetting Navigator Bands (to change back to Defaulted Settings):

From **View** (in toolbar)

1. Select **Layout** then **Reset Navigator Bands**

Consult to Physician Workflow

1. MD places an order for “consult to physician” and enters the physician’s name.

2. “Notify Physician of Consult” tasks to Nursing/Unit Secretary positions.
3. Nursing/Unit Sec calls physician office to communicate consult.
4. If the physician who is accepting the consult is different than the physician entered the nurse/US will modify the physician’s name in the “Consult to Physician” order.
5. US/Nursing documents the consult phone call documentation from the “Notify Physician of Consult” task

Transferring a Patient

1. Select and Review the Patient Handoff screen.
2. Review any transfer orders
3. Go to iView.
4. Select **Adult (ICU) Quick View** band.
5. Choose **Clinician Communication** section
6. Document as needed

Using CareAdmin Quick Reference Guide

Administer Medications Using CareAdmin

1. Click the **Medication Administration** button in the toolbar. Medication Administration
2. Scan the patient’s wristband.
3. Scan the medication.
4. Enter additional information if the icon displays by double clicking in the results column.
5. Scan additional medication if the icon appears or Double-click the **results column** to edit the dose if the appears indicating a higher dose was scanned than what was ordered.
6. Click the **OK** button to save the details.
7. Administer the medication to the patient.
8. Click the **Sign** button to sign all of the orders at one time.

Note: A PRN response section appears on patient’s MAR. Double-click the blue response square and complete documentation within one hour of administration.

Note: If medication requires a co-signature, double- click the results column and enter the witnessing nurse in the documentation details

Note: Wasting narcotics will continue to be witnessed in the Accudose.

Reschedule a Medication

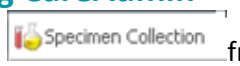
From the patient’s MAR:

1. Right-click the appropriate medication.
2. Select **Reschedule dose**.
3. Document the appropriate details.

Un-Chart a Scanned Medication

If you scan a medication in error you can un-chart your documentation by unchecking the box in the Medication Administration window.

Collect a Specimen Using CareAdmin

1. Select **Specimen Collection** 

from the toolbar to launch the specimen collection window.

   Note: Specimen Collection can also be launched by selecting **Chart** in the toolbar and then **Specimen Collection** from the menu items.
2. Scan the patient's wristband to populate the due specimen collect tasks in the window.
3. Select the specimen for collection and click the **drop down arrow** on the right hand side of the Specimen Collect window. 
4. Select **Print,** then **Print Label.**

   Note: The selected printer can be set as the default by selecting the **Set as Default Label Printer** box.
5. Select **Print.**
6. Collect the specimen from the patient.
7. Place the labels on the specimen containers.
8. Time and initial specimen labels.
9. Scan the specimen label(s).
10. Transport the specimen to the lab.

Using Filters for Specimen Collection

1. Select the filter icon 
2. Select **both** lab collect and nurse collect options.

Note: These selections will display all specimens to be collected.

3. Select the **Show Nurse Collect Indicator** box to identify which specimens are nurse collect tasks.

Note: These options can be saved as a default by selecting the default box.

4. Select **Apply**.

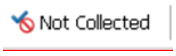
Reschedule a Collection

1. Select the **Reschedule** icon 

2. Select the reason for reschedule and the reschedule date and time.
3. Select the collections to be rescheduled.
4. Click **Apply.**
5. Click **Sign.**

Mark a Collection as Not Done

Only for collections that have been cancelled.

1. Select the **Not Collected** icon 

2. Choose a reason that the specimen will not be collected.
3. Select which specimens will not be collected.

4. Click **Apply.**
5. Click **Sign.**

Order Entry & Task List Quick Reference Guide

Order Entry

Place a New or Continuous Order From PowerChart:

1. Select **Orders** from the Menu.
2. Click the **Add** button.
3. Search for the order in the Find field.
4. Select the order from the list below.
5. Enter the ordering physician's name.

Note: You can search for the ordering physician by typing in the first few letters of his/her name and then clicking the Binoculars icon.

6. Select the communication type.
7. Click the **OK** button.
8. Select an order sentence if applicable.
9. Click the **OK** button.
10. Click the **Done** button.
11. Complete any necessary details on each order.
12. Click the **Sign** button.

Modify Orders

From PowerChart:

1. Select Orders from the Menu.
2. Right-click the order you want to modify. Select Modify.
3. Modify the order as necessary.
4. Click the Orders for Signature button.
5. Click the Sign button.

Note: Clicking the Refresh button updates the order status.

Due to interdepartmental communication needs, not all orders can be modified. If an order cannot be modified, the modified selection will be grayed out. If you need to change something on an order that you cannot modify, you should cancel/reorder.

Review Orders in PowerOrders

From PowerChart:

1. Select Orders from the Menu.
2. Click the Orders for Nurse Review button.
3. Select the order to review.

4. After reviewing all orders and associated details, click the Review button.

Note: If there are any orders that you do not wish to review at this time, you can uncheck those individual orders.

Address Order Alerts

If an allergy, drug interaction, or duplicate therapy alert displays, enter an override reason or remove the new order.

If a duplicate order alert displays, continue such the duplicate order is placed anyway, cancel the new order, or modify the new order.

1. Click the **Remove or Remove New Order** button.
2. Either leave the order as is or continue by placing a new order.

Cancel/Discontinue an Order

From PowerChart:

1. Select Orders from the Menu.
2. Right-click the order you wish to cancel and/or discontinue.
3. Select Cancel/DC.
4. Select the ordering physician.
5. Select the communication type.
6. Click the OK button.
7. Enter the discontinue reason if applicable.
8. Click the Orders for Signature button.
9. Click the Sign button.

Note: Clicking the Refresh button will update the order status.

Order Entry Details

Order Entry Details is documented in order to auto populate specific orders that have order detail fields that are included in the Order Entry Details Power Form. When the nurse updates the Order Entry Details Power Form with the appropriate information, the order details will automatically be filled out within the order.

Details that will need to be documented:

1. Transportation Mode
2. Isolation Precautions
3. Pregnancy Status
4. IV
5. Oxygen
6. Nurse Collects Blood Specimens
7. Lift/Transfer

8. Central Line
9. Room Service
10. Order Entry Details will be completed on Admission in the Admission History Power Form.

Every day at 0200 nursing will be tasked to complete the Order Entry Details.

If there is a change in status that affects the Order Entry Details, or if the patient has been transferred from one unit to another, the nurse will need to Ad hoc the Order Entry Details Power Form to complete.

The Nurse should not wait until 0200 for the next task to appear.

Note: This is a nursing function for the inpatient population.

Task List

Tasks are generated by orders placed by providers and clinicians. The order and task descriptions include a target time for completion and task details. When a task is overdue, it is flagged, and when a task is complete, it drops off the task list automatically. The Task List only shows tasks to be completed during your shift. There may be tasks that you know need to be completed that are not listed or that need to be completed outside the listed timeframe. Use your experience and knowledge to perform the right tasks at the correct times.

Chart a Task with an Associated Form

From PowerChart:

1. Select Task List from the Menu.
2. Click the appropriate tab.

Note: You view a list of tasks in each tab. Only some of the tasks have associated forms that you can open and document within. For those that do not have associated forms, you can only chart as done or not done. The actual documentation is done elsewhere.

3. Double-click the appropriate task.
4. Complete the appropriate documentation.
5. Click the Sign  icon to sign your documentation.

Note: A green check mark displays next to the task, and the task status is complete.

Chart a Task Done

From the Task List:

Note: This option is available only for tasks that do not have an associated form.

1. Right-click the appropriate task.
2. Select Chart Done.
3. Modify the Date/Time, if necessary.
4. Click the OK button.

Note: A green check mark displays next to the task, and its status is complete.

5. Click the Refresh 

button.

Note: The task is removed from theTask List.

Chart a Task Not Done

From the Task List:

Note: This option is available only for tasks that do not have an associated form.

1. Right click the appropriate task.Select Chart Not Done.
2. Select a reason from the Reason Not Done drop-down menu.
3. Enter a comment in the Comment field, if necessary.
4. Click the Sign  icon.

Note: A Not Done icon displays next to the task, and the task status is complete.

5. Click the Refresh 

button.

Note: The task is removed from the Task List.

PowerPlans & PowerForms Quick Reference Guide

PowerPlans are aggregated sets of orders that allow you to place several orders for a single patient simultaneously.

Add a PowerPlan

From PowerChart:

1. Select Orders from the Menu.
2. Click the Add 

button.

Note: You can choose the PowerPlan from the Home or My Favorites folders, or search for it in the Find box.

3. Enter the PowerPlan you want to add in the Find field.
4. Select a PowerPlan from the search results.
5. Click the Done button.

Note: Pay close attention to comments attached to orders as you place orders because they provide important information and warnings about drug interactions. Some orders are selected by default in the

6. Select Orders from the list as appropriate.
7. Click the icon to complete all missing details for each order.

Note: Required fields are yellow and an asterisk precedes the field name.

8. Click the Initiate button to add all the selected orders to the PowerPlan.

Note: When you initiate a PowerPlan, nursing and other ancillary departments are notified to start delivering care.
You can also sign the orders without initiating them, which puts them in a Planned status. Orders in a Planned status are not communicated to the different departments for execution. While in a Planned status, users can continually modify the PowerPlan prior to submitting the orders to the appropriate departments. This can be done by right-clicking the order, selecting Modify from the options, and then editing the details as needed.

9. Click the Orders for Signature button.
10. Click the Sign button**.**

Note: After you sign the orders, they display as Processing. This means that the orders were placed successfully.

11. Click the Refresh button to view the PowerPlan in the View panel with an Initiated status.

Add an Order to a Phase

From PowerChart:

1. Select Orders from the Menu.
2. Select the appropriate PowerPlan from the View panel
3. Click the Add to Phase button.
4. Select Add Order.
5. Enter the order in the Find field or select desired order from the appropriate folder.
6. Select the appropriate order from the search results.
7. Click the Done button.
8. Enter any applicable order details.

Note: Yellow fields with an asterisk are required fields.

9. Continue addressing other orders in the PowerPlan as outlined above.
10. Click the Initiate button if you are initiating the PowerPlan at this time.
11. Click the Orders for Signature button.
12. Click the Sign button.
13. Click the Refresh button to view the signed order in the list

Create a Favorite

1. Select **Orders** from the Menu.
2. Right-click the PowerPlan or order within the PowerPlan.
3. Select **Save as my Favorite**.
4. Enter a name for the favorite.
5. Click the **OK** button.

Manage PowerPlans

From a PowerPlan on the Orders screen:

1. Right-click the order you want to cancel.
2. Select Cancel/DC to discontinue an order or Cancel/Reorder to reorder the same order after cancelling the current one.
3. Select the Discontinue reason and complete other details as necessary.

Note: You can manage multiple orders before signing. Click the Collapse icon in the upper left corner of the Details window to view other orders. When you are done managing orders, complete steps 4-6.

4. Click the Orders for Signature button.
5. Click the Sign button.
6. Click the Refresh button to view the updated statuses.

Discontinue a PowerPlan

From the Orders screen:

1. Right-click the PowerPlan in the View panel.
2. Select Discontinue.
3. Select any orders you want to keep in the Discontinue window.
4. Select a Discontinue Reason from the drop-down menu if applicable.
5. Click the OK button.
6. Click the Orders for Signature button.
7. Click the Sign button.
8. Click the Refresh button.

Note: The PowerPlan is now in a Discontinued status.

PowerForms

Some patient documentation is completed using PowerForms. PowerForms are assigned in the Task List

Document a PowerForm from a Task

From PowerChart:

1. Select Task List from the Menu.
2. Double-click the appropriate PowerForm task.
3. Select the appropriate section from the Navigator on the left.

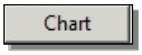
Note: Best practice is to document on all sections. Sections with required fields are identified with a red asterisk.

4. Click a radio button to make a single selection.
5. Click check boxes to make multiple selections.
6. Click a date field to type the date; click the Up or Down arrow to move the date up or down by one day; or click the drop-down arrow to select the date from a calendar.
7. Click the appropriate cell in a discrete grid to document the appropriate response.
8. Click and type in a cell in a PowerGrid.
9. Continue documenting the form.
10. Click the Sign icon.

Document an AdHoc PowerForm

From PowerChart:

1. Click the AdHoc 

button.
2. Click the appropriate folder on the left side of the Ad Hoc Charting window.
3. Click the check box next to the appropriate PowerForm.
4. Click the Chart 

button.
5. Complete all sections of the PowerForm.
6. Click the Sign  icon.

View a PowerForm

From PowerChart:

1. Select Form Browser from the Menu.

Note: You can use the Sort by drop-down menu to change the order of the forms displayed.

2. Double-click the appropriate PowerForm to open and view it.
3. Click the X Close button when you are finished viewing the PowerForm.

Orders Management on Admission

ED Holding PowerPlans

ED Holding PowerPlans should be initiated once the patient is admitted to the Inpatient Unit. The Patient Status Order within the ED Holding PowerPlan needs to be activated.

- In the event that the Admitting Physician has entered Admitting Orders prior to the nurse initiating the Planned ED Holding PowerPlan, the nurse should do the following:
    1. **DO NOT** "discontinue" or "void" the Planned ED Holding PowerPlan.
       Why? - The Patient Status Order originally entered by the ED Physician is included in this PowerPlan.
    2. Review the ED Holding PowerPlan and deselect any orders that are not applicable to the admission if already ordered in the Admitting Physician's orders.
    3. Ensure that the Patient Status Order is selected
    4. Initiate the PowerPlan (Even if every other order has been deselected)

  Note: For orders in the ED Holding PowerPlan that the Admitting Physician did not address, the nurse should communicate with the Admitting Physician to clarify if these orders should be initiated or removed.

Taking Telephone Orders for Admission Orders and Home Medications

In the event that a physician is giving the Nurse a telephone order for Admission PowerPlans, the Nurse should:

- Ensure that the communication type for the Admission PowerPlan is **Telephone Read Back for Co Sign.**
- DO NOT select **Add to Phase** and enter the patient's home medication.
- To enter home medications, if given as a telephone order, should be ordered outside of the PowerPlan
    - **Reasoning:** If the Physician discontinues the PowerPlan at a later time, then the home medications get discontinued along with the entire PowerPlan.

Manage the Blood Administration Process

Transfusion Workflow

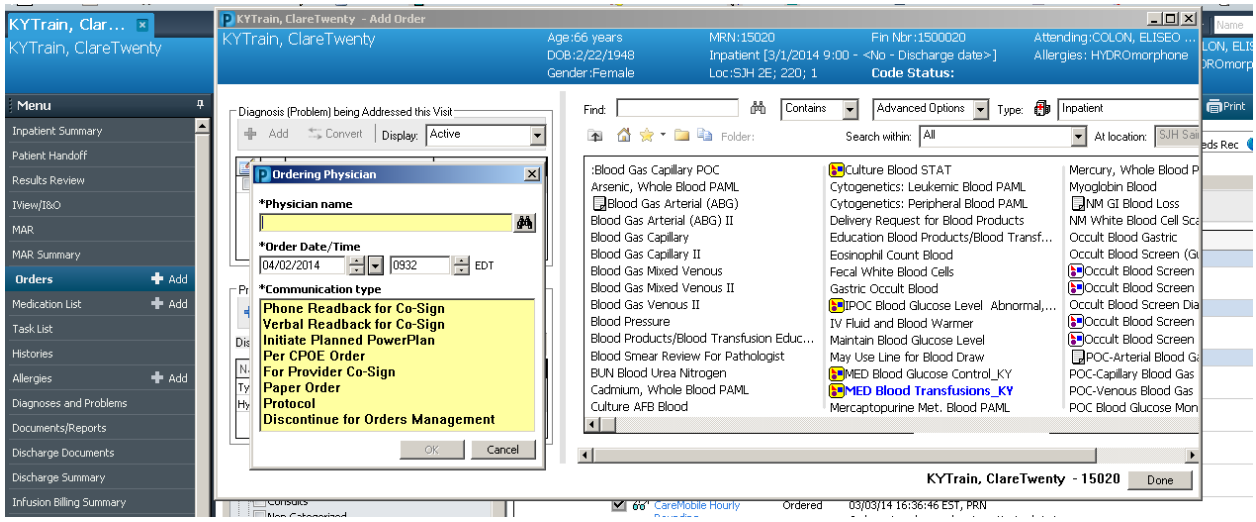
The process for administering blood transfusions has not changed. The forms that were previously completed on paper can now be completed in Cerner.
The process for reviewing patient information, documenting vitals, and other blood administration policies will continue to follow the current process.

Order a Blood Product

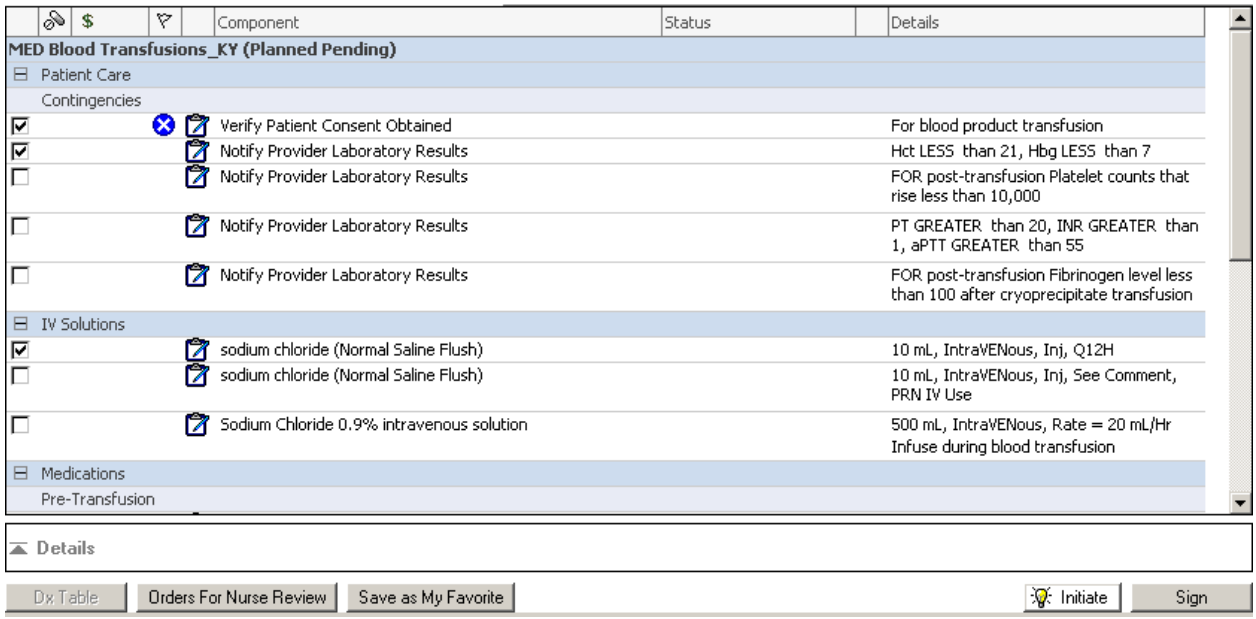
From your patient's open chart:

1. Select **Orders** from the menu**.**

2. Click on **Add Orders** icon.
3. Type "**blood**" in Find Field. Make sure your filter is set to "contains".
4. Select **MED Blood Transfusions_KY** PowerPlan.
5. Enter the ordering physician's name and communication type. Click **OK.**
6. Click **Done.**



7. Select the appropriate orders as indicated by the physician.
8. Complete order details as necessary where indicated by a blue and white ⊗ by double clicking in the "Details" column.

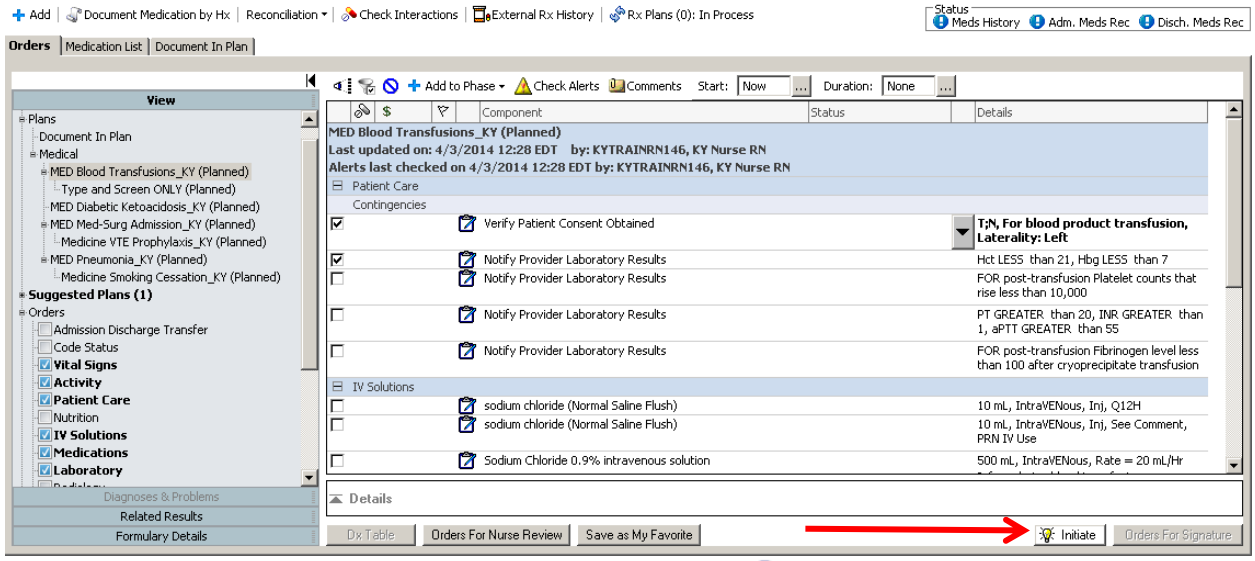


9. Click **Sign.**
10. Click **Refresh.** The PowerPlan is now in a planned state.

To initiate the Blood Transfusion PowerPlan:

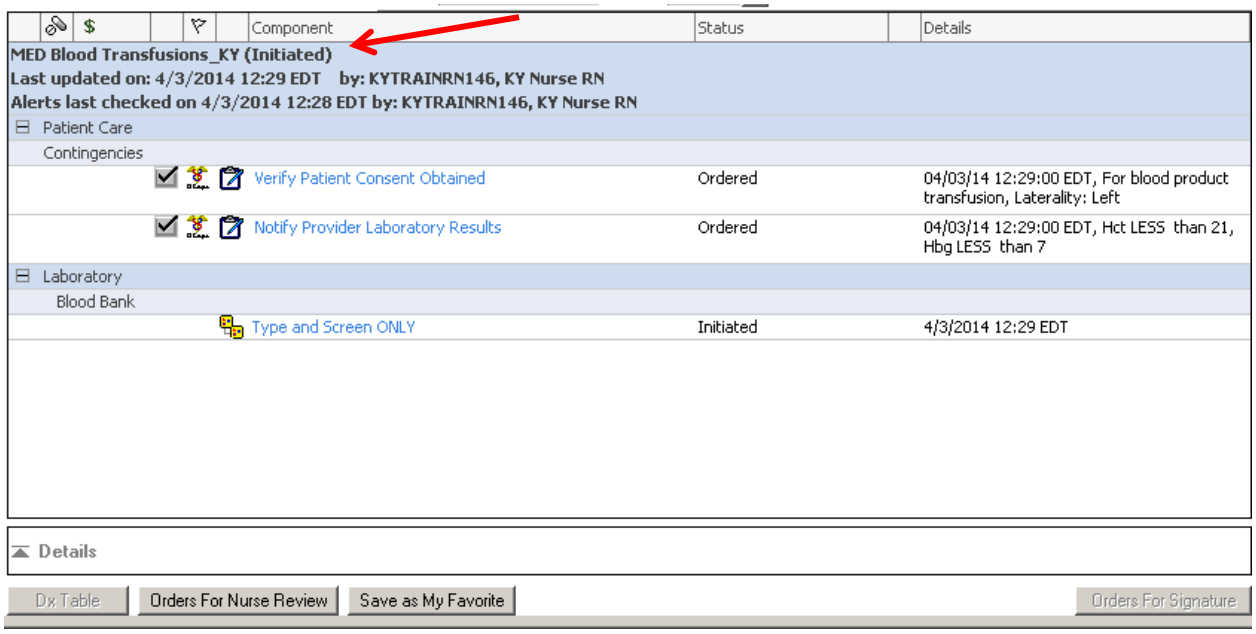
11. In the View area of the Orders menu, select the **MED Blood Transfusions_KY** plan.

12. Click **Initiate.**



13. Complete any additional order details necessary (indicated by) by clicking the "Component" column of the pending PowerPlan and then clicking in the "Details" column.
14. Click **Orders for Signature.**
15. Click **Sign.**
16. Click **Refresh.** The PowerPlan is now in an initiated state.

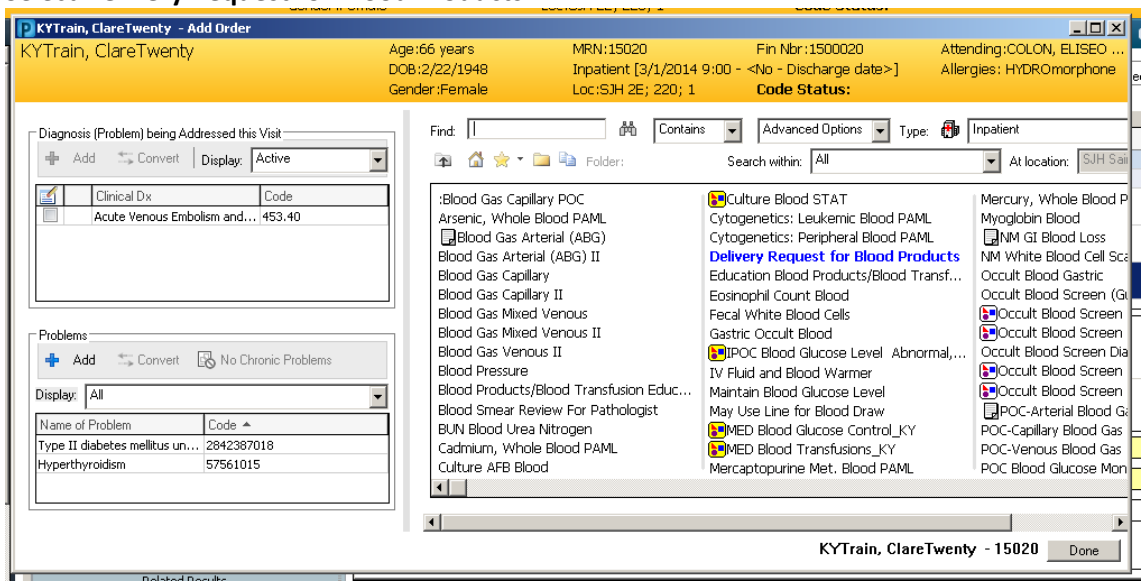
Note: If blood products are ordered to be held for patient, and at a later point the patient condition warrants transfusion, the PowerPlan will need to be updated and signed with the transfusion order. An order to transfuse the previously ordered blood product does not exist outside the Blood Administration PowerPlan.



Before you administer the blood product:

1. Confirm that the product is ready. The blood bank will place an order and task "Blood Product Ready" to notify the nurse that the product is ready to be delivered.

2. Place an order for a blood product delivery/pickup request.
3. Select **Orders** from the Menu.
4. Click on **Add Orders** icon.
5. Type "**blood**" in Find Field. Make sure your filter is set to "contains".
6. Select **Delivery Request for Blood Products**



1. Receive the blood product.
   Note: Blood will need to be picked up at Blood Bank when blood is available, and should appear on the Nurse's Task List.
2. Take the blood product and a witness into the patient's room.
   - Please refer to your facility's exact procedures for these processes.

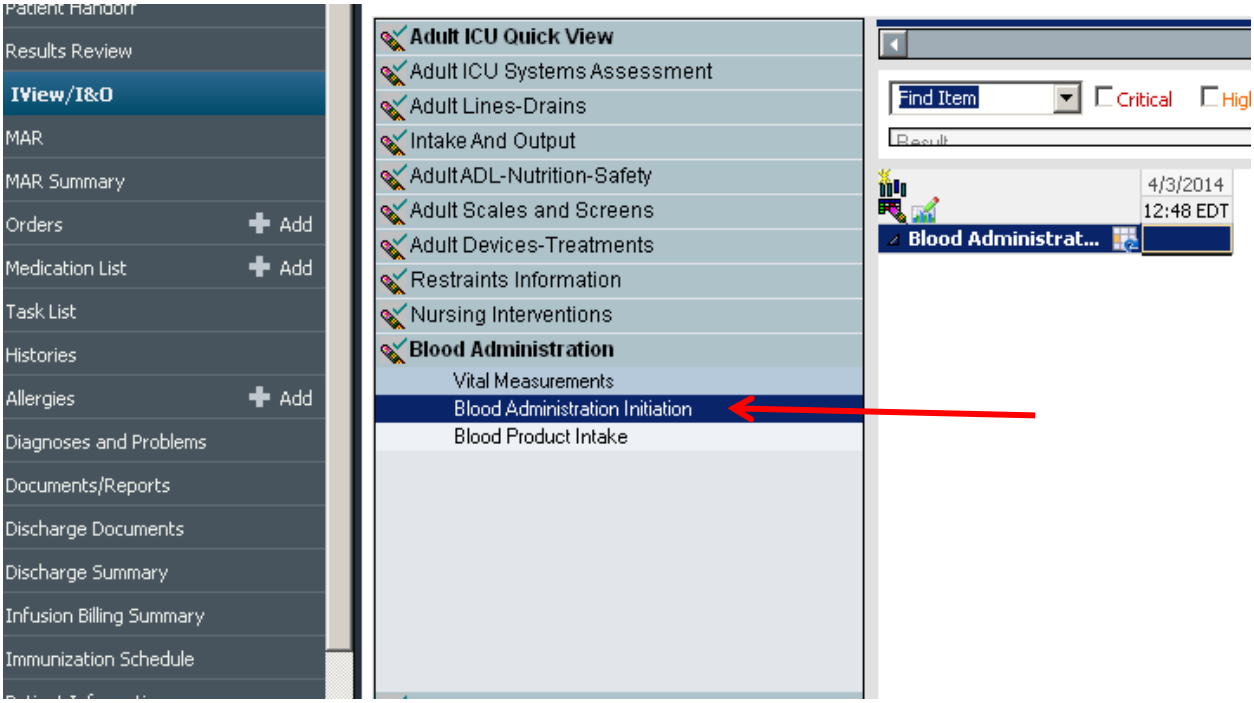
Facilitator Note: If witness is not obtained, then the blood will not drop a charge.

The blood product is ready for your patient. You have confirmed the proper patient identifiers for your patient, have had a witnessing nurse verify the blood product and patient information, and you need to document the administration of the packed red blood cells. Finally, you and the witness need to sign the Blood Administration form.

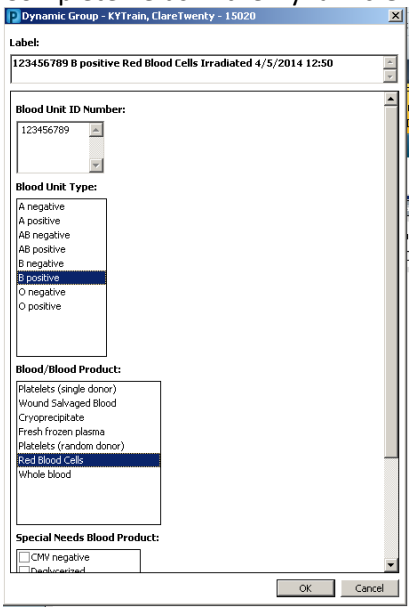
Document Blood Administration

From **PowerChart**: (Document from the Task List When the Blood is Ready)

1. Confirm proper patient and product identifiers.
2. Select **IView** from the Menu.
3. Click the **Blood Administration** band in iView.
4. Click the **Blood Administration Initiation** section.



5. Click the **Add a Dynamic Group** icon.
6. Complete fields in the Dynamic Group box and then click **OK.**

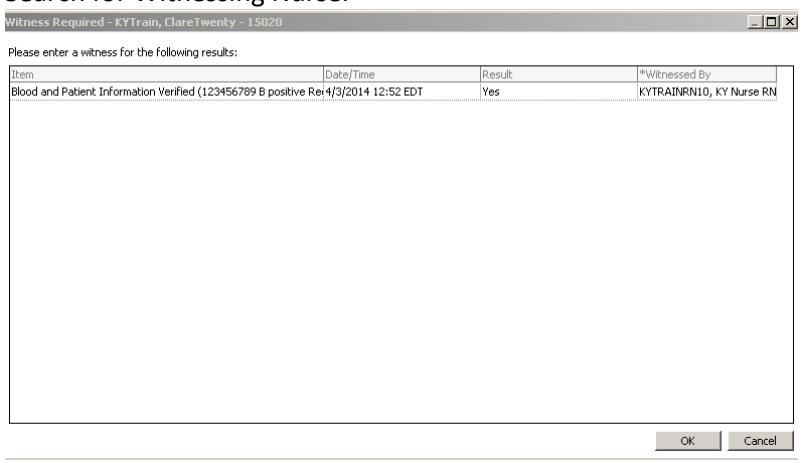


7. Double-click the **Blood Administration Initiation** cell in the appropriate time column.

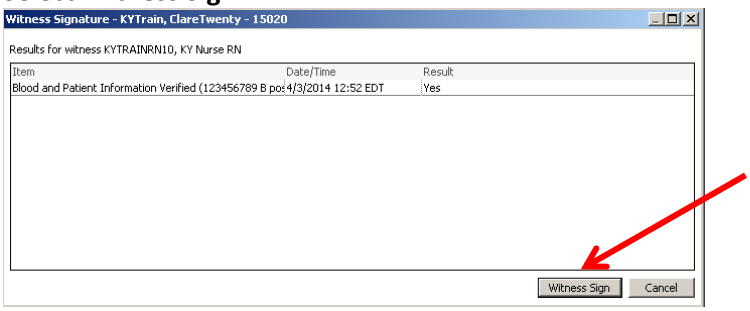
8. All documentation will be manual entry.
9. Have your witness verify the blood product and patient information.

- Click the **Blood and Patient Information Verify** cell

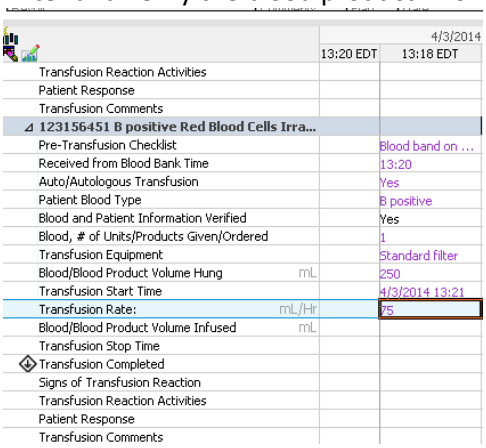
10. Click the **Sign** ✔ icon.
11. Search for Witnessing Nurse.



12. Select **OK.**
13. Select **Witness Sign.**



14. The witness will enter their username and password information.
15. Click the **OK** button.
16. Document the **Pre-Transfusion** checklist.
17. Enter and verify the blood product information.



18. Administer the blood product.
19. Click the **Sign** ✔ icon.
20. Click the **Refresh** button.

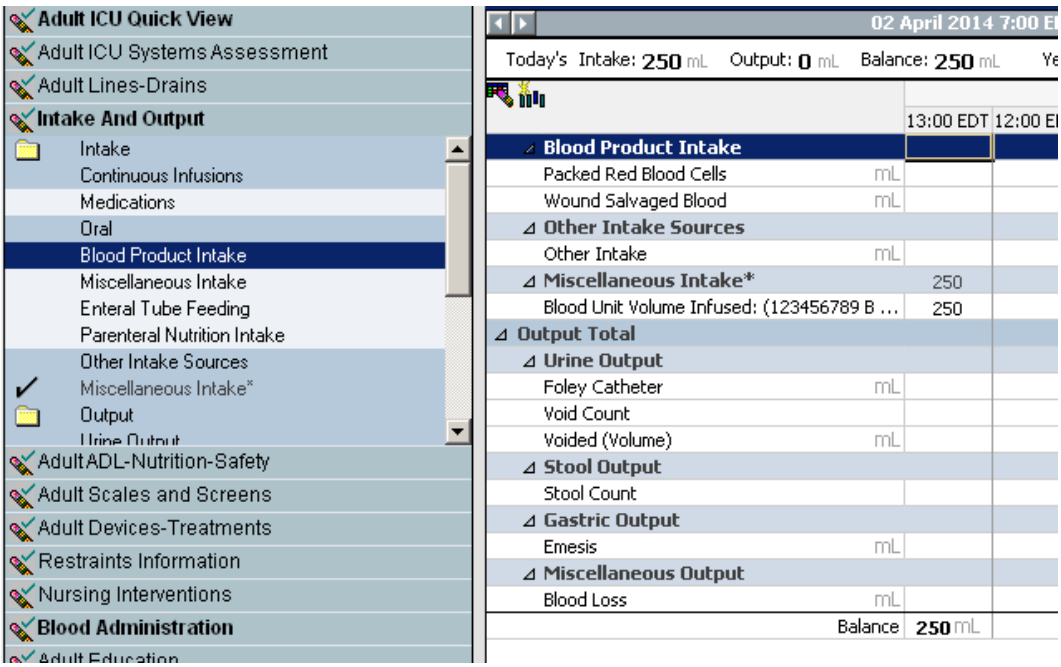
Note: At the completion of blood transfusion, continue documenting in the Blood Administration band to complete charting starting with the Volume Infused. Once documentation is complete, **Sign** and refresh.

		4/3/2014			
		13:30 EDT	13:22 EDT	13:18 EDT	12:52 EDT
123156451 B positive Red Blood Cells Irra...					
Pre-Transfusion Checklist				Blood b...	
Received from Blood Bank Time				13:20	
Auto/Autologous Transfusion				Yes	
Patient Blood Type				B positive	
Blood and Patient Information Verified				Yes	
Blood, # of Units/Products Given/Ordered				1	
Transfusion Equipment				Standar...	
Blood/Blood Product Volume Hung	mL			250	
Transfusion Start Time				4/3/201...	
Transfusion Rate:	mL/Hr			75	
Blood/Blood Product Volume Infused	mL	250			
Transfusion Stop Time		4/3/2014 1...			
Transfusion Completed		Yes			
Signs of Transfusion Reaction					
Transfusion Reaction Activities					
Patient Response		Tolerated ...			
Transfusion Comments					

Reviewing I&O

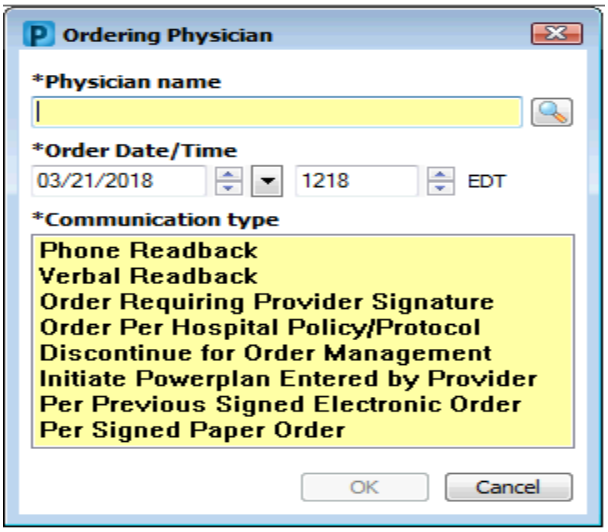
After documenting the amount infused, review the **Intake & Output** band to view the total amount of blood which has infused has been recorded properly.

Intake and Outputs should be documented in as close to real time as possible.



Communication Types in Cerner

Refer to the list below when selecting a communication type.



Phone Readback:

Used when a provider gives a non-provider orders over the phone.

Verbal Readback:

Used when a provider gives a non-provider verbal orders.

Order Requiring Provider Signature:

This communication type is used when orders are being placed by a NON-provider and other communication types are not applicable. Example: A Provider has ordered a wound care consult for the WOCN nurse. Once the WOCN nurse has evaluated the patient, orders are placed using **Order Requiring Provider Signature** communication type.

Order Per Hospital Policy/Protocol:

When a nurse is placing electronic orders that have been approved as a Policy/Protocol by the hospital, this communication type will be used. Example: Patient has had a foley catheter in for 24 hours and the nurse is implementing the CAUTI protocol. The nurse will discontinue the order for foley and the management orders using the **Order Per Hospital Policy/Protocol** communication type.

Discontinue for Order Management:

When nursing reviews the order profile and must "clean up" duplicate orders, obsolete orders, or any other orders not appropriate for the patient, this communication type will be used when discontinuing the orders. Example: Multiple CBC orders with a daily priority have been noted on the patient profile. The additional CBC orders can be discontinued using this communication type.

Initiate Planned PowerPlan Entered by Provider:

When a PowerPlan has been placed in a Planned Status by a provider, the nurse will use this communication type when initiating the plan. This communication type indicates the provider has entered the orders themselves- the nurse is just making them active.

Please Note: If a NON-provider has placed the PowerPlan the communication type will default. The nurse DOES NOT change the communication type if a default is present.

Example:

1.) Nurse 1 has a Verbal Order to enter an Admission PowerPlan for a patient who is coming into the hospital as a Direct Admit.
2.) Nurse 1 chooses the communication type of "Verbal Readback" and completes all of the details of the Admission PowerPlan with the provider on the phone. The plan is kept in a planned status as the patient is not at the hospital yet.
3.) Patient arrives on floor hours later
4.) Nurse 2 opens chart and chooses the planned Admission PowerPlan. When the nurse goes to Initiate the plan, the communication type window will fire- but because Nurse 1 has chosen "Verbal Readback"- this will default in the window.
5.) Nurse 2 leaves the default communication type and initiates the PowerPlan.

Per Previous Signed Electronic Order:

When an order has been placed electronically instructing the Non-Provider to follow up with additional orders/PowerPlans, this communication type should be used. Example: Order placed by provider in Admission PowerPlan for: Lab Order Instructions, If Hemoglobin drops below (X) please repeat order for Hemoglobin.

Per Signed Paper Order:

When orders have been written down on paper by a provider and they are now being electronically transcribed by a NON-provider, this communication type will be used. These orders were signed by the provider on paper.

Bedside Monitor Device Interface (BMDI)

Cerner has the ability to pull data from biomedical devices such as blood pressure machines and heart monitors.

Associating Device to Patient

From Patient's Open Chart:

1. Select IView/I&O from menu.
2. Click the **Associate Monitor** icon.
   - The Associate Monitor window displays.
3. Locate the unit, room, and bed that the patient is occupying and click on it.

4. Click **View Acquired Data.**
5. A box will appear allowing you to select the date and time to indicate how far back to include data that will be acquired. Change the date and time as needed.
   - If the patient has been on the monitor for a length of time, but you are just now associating your patient's chart to the monitor, change the time listed to the time the patient was placed on the monitor. This will allow you to pull in data previous to the current time.
6. Select **OK.**
7. The Associate Monitor window displays and shows the date/time that the data will include. Select **Associate.**
8. A pop up box will display asking if you would like to associate the patient to the indicated monitor. Select **Yes.**
9. Click **Close.**

Acquiring Data from an Associated Monitor

After a monitor has been associated to the correct patient, information can then be acquired.

1. In IView, select the appropriate section of which you will be acquiring data from the device (i.e. Vital Measurements)
2. Change time column frequencies if needed by right clicking on the time column and selecting the frequency (i.e. Q10 or Q15 min).
3. Double click on the blue head header of the time column to pull in the results.
4. Review the results populating in the time column.
5. Data will appear in the chart in purple text meaning they are unverified.
6. After verifying results and making adjustments if needed, select the Green Check Mark to sign the results, turning the text from purple to black.

Disassociate the Monitor from the Patient

When a patient no longer needs to be associated with a monitor, the device should be disassociated from the patient.

1. From IView/I&O, click on the **Associate Monitor** Icon.
2. Locate the patients name and monitor from the list and then click the **Disassociate** button.
3. Click the **Close** button.

Reboot Cerner Connectivity Engine (CCE)

If the Cerner Connectivity Engine, or CCE, has lost its connection to the network include the monitor ID number not populating in IView, as well as a stoppage in new data being collected in IView. If these problems occur, you may need to reboot the CCE to restore connectivity.

Trouble Shooting Tips

Find the CCE:

1. On the side panel of the CCE, press the **Power** button in the Off position, and hold for six seconds.
   - The CCE screen turns black and CCE shuts off.
2. Press the **Power** button in the On position, and hold for three seconds.
   - A green indicator light displays on the frame of the CCE, indicating that the CCE is turning on.
3. Wait as the CCE reboots, which takes approximately two to five minutes.

- While the CCE is turning on, the screen may be black and flash at this time. The Cerner logo displays after a few minutes. Finally, when the Devices and Systems icons display on the screen, the CCE has successfully rebooted.

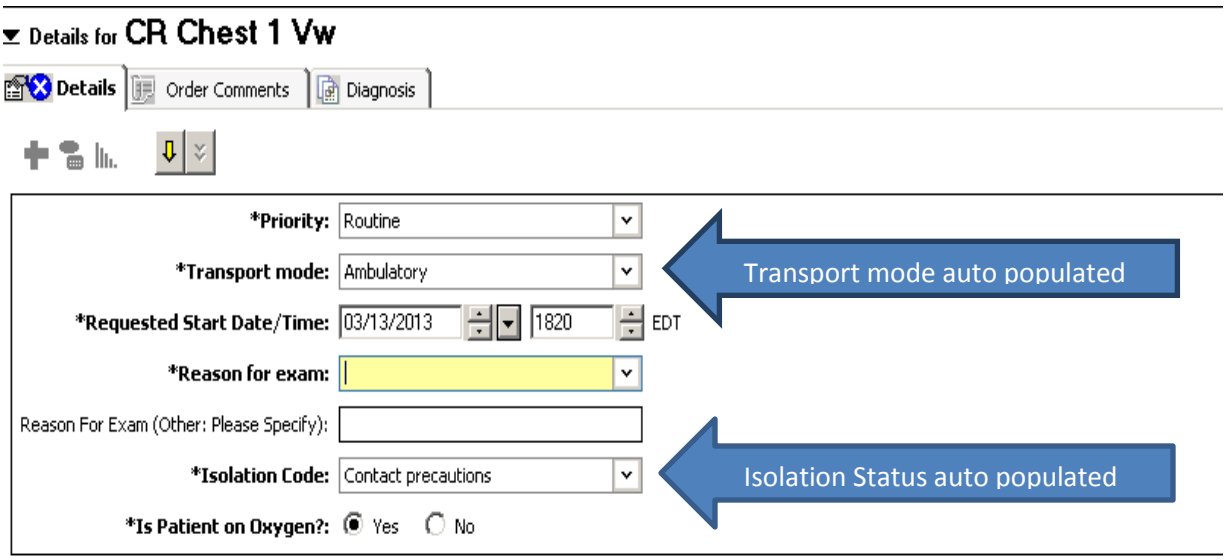
4. Once the CCE is rebooted, new data should be retrieved by IView.
   - If the Devices and Systems icons do not display, other problems may have occurred. In this case, consult the Service Desk.

Order Entry Details

Order Entry Details is documented in order to auto populate specific orders that have order detail fields that are included in the Order Entry Details Power Form. When the nurse updates the Order Entry Details Power Form with the appropriate information, the order details will automatically be filled out within the order.

- Transport mode can be found in Radiology orders
- Nurse Collect for lab orders
- Isolation Precautions for Radiology orders

Example: Nurse has updated the Order Entry Details Power Form with transportation, isolation, and oxygen order entry details. An order for a Chest X-Ray is placed. The following screen shot displays how the order details fields within the Chest X- Ray order have been auto populated with the Order Entry Details documentation:



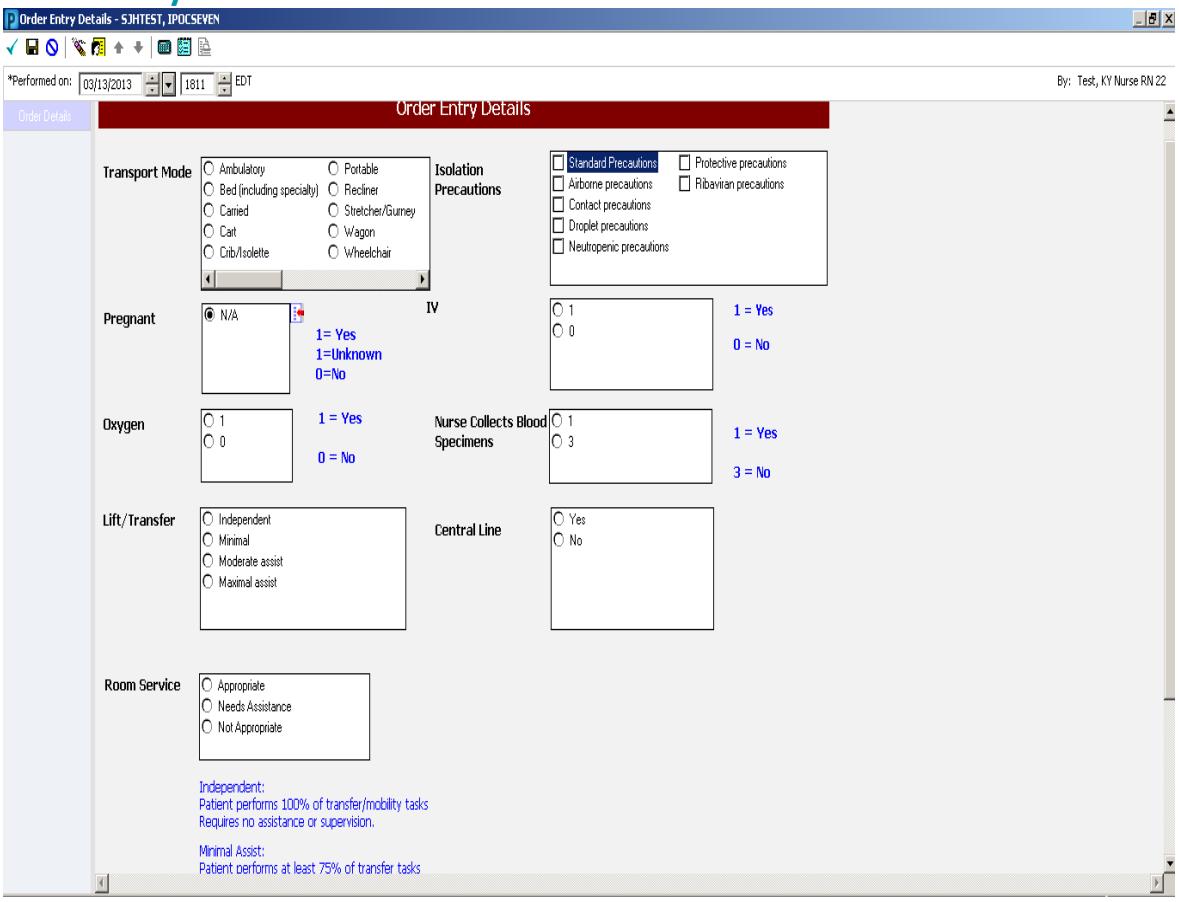
Details that will need to be documented:

- Transportation Mode
- Isolation Precautions
- Pregnancy Status
- IV
- Oxygen
- Nurse Collects Blood Specimens
- Lift/Transfer
- Central Line
- Room Service

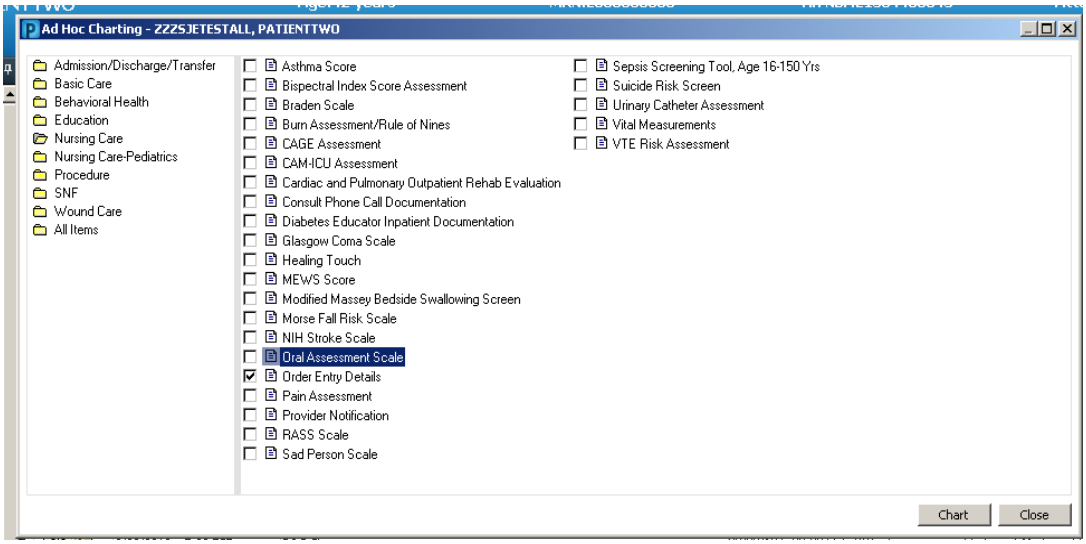
Nursing Staff will document Order Entry Details in the following ways:

- On Admission –"Order Details" is a section in the Admission History PowerForm.
- Every morning at 2am – this will be tasked to nursing and will link to the PowerForm
    - The previously entered order details will pull forward and if there are no changes, verify the information is correct and sign the power form
- AD HOC and manually update the Order Details Power Form any time Order Entry Detail updates are needed throughout the shift:
    a. Change in patient status that is applicable to Order Entry Details (i.e. patient on oxygen, patient has an IV, isolation status, central line in place, etc.).
    b. Change in Level of Care (patient has transferred from one nursing department to another-i.e. critical care to telemetry) that applies to these fields – need to Ad Hoc the form and add the details.
- The Order Entry Details Power Form can be found in the Nursing Care AD HOC Folder

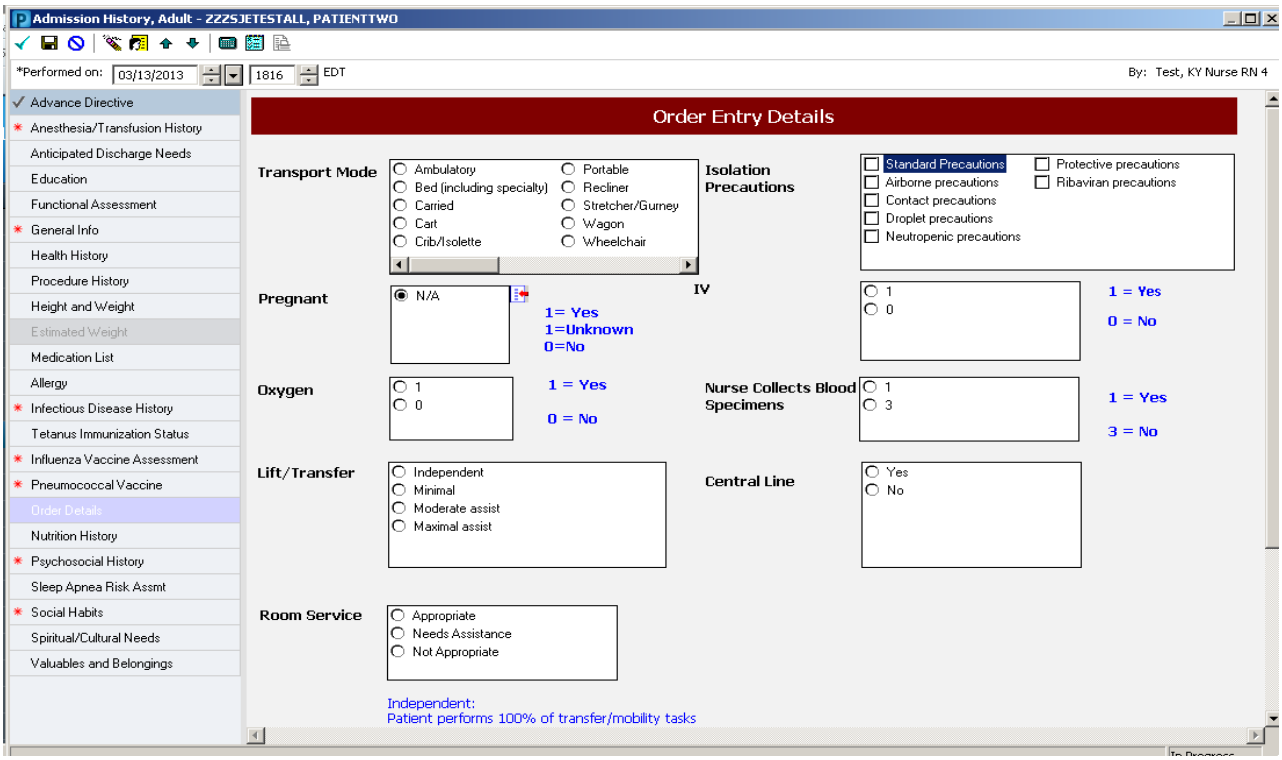
Order Entry Details PowerForm



Location of Order Entry Details PowerForm in the Nursing Care AdHoc Folder



Location of Order Entry Details Section in the Admission History Adult PowerForm



Specimen Collection & Patient Safety

Patient Safety is our top priority. When specimens are collected, it is imperative that the appropriate steps are taken to ensure that the correct patient, correct specimen, and correct labels are accounted for. **Prevention** is important to safeguarding our patients and providing them with the best care they can receive.

Patient Safety Events

Patient Safety Event: An eighteen month old toddler was brought in to the Emergency Department. The toddler's diagnosis required routine blood work to be tested. It took several attempts and multiple staff members to restrain the toddler to collect the sample. Once the sample was collected, it was not scanned at the bedside to ensure correct specimen with correct label. It was labeled incorrectly at the nurse's station and the child had to be stuck again multiple times to recollect the specimen. How would you feel if this was your child or loved one who is already ill or in pain?

Other Safety Events

- Specimen collected on wrong patient
- Mislabeling – wrong specimen labels used on collected specimens
- No labels – specimens are being sent to the lab with no labels
- Not scanning specimens – Specimens are labeled but Specimen Collection is not being completed in Cerner.

Properly Using Specimen Collection in Cerner

The Specimen Collection feature in Cerner is a safeguard if used properly for collections. **How?**

1. Scanning the patient wristband.
    - This is used in conjunction with patient identifiers.
    - Ensures that the correct patient and correct patient chart are being used for the appropriate specimen collection.
2. Specimen Labels are printed specifically for the collection that is to be completed.
    - Labels generated via Specimen Collection are the ones necessary for the lab to scan and run the specimens. Specimens should NEVER be sent to lab without the appropriate labels.
3. Specimens should be scanned to complete the collection process.
    - In the Specimen Collection window, complete the process by scanning the specimen labels and signing. This will remove the task from the task list and put the collection in a "collected status" on the Orders section of the patient's chart.

*See **Specimen Collection** on the reverse side for steps on properly completing this documentation in Cerner.

Specimen Collection

Specimen Collection ***MUST*** be completed in Cerner to ensure that ***Patient Safety*** is priority.

It is ***NEVER ACCEPTABLE*** to send specimens to the lab with no label or with a patient label. **ONLY labels printed specifically for that patient/specimen via the task list or through Specimen Collect are acceptable.** Please adhere to these requirements. (See process below for printing specimen labels)

Printing Specimen Labels and Collecting Specimens

Specimen labels can be printed from the task list or within the Specimen Collection process.

From the Task list:

1. Right Click on the specimen that is being collected.
2. Select **Print,** then select **Reprint Labels** and choose containers for which labels should be printed.
   The specimen labels will print to the printer chosen.

From Specimen Collection:

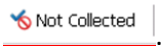
1. Select **Specimen Collection** 

from the toolbar to launch the specimen collection window.
2. **Scan** the patient's wristband to populate the due specimen collect tasks in the window.
3. Select the specimen for collection and click the drop down arrow  on the right hand side of the Specimen Collect window.
4. Select **Print,** and then **Print Label.**
   Note: The selected printer can be set as the default by selecting the **Set as Default Label Printer** box.
5. Select **Print.**
6. Collect the specimen from the patient.
7. **Place the labels** on the specimen containers and time and initial specimen labels.
8. **Scan** the specimen label(s) and click **Sign.** Transport the specimen to the lab.

***Note: Ensure that you have labeled the correct specimen with the correct label. Specimen Collect should be performed at the bedside.**

Mark a Collection as Not Done

Only Mark a Collection as "Not Done" if the specimen will *NEVER* be collected. This discontinues the lab order.

1. From the Specimen Collection window, Select the **Not Collected** icon 

.
2. Choose a reason that the specimen will not be collected.
3. Select which specimens will not be collected.
4. Click **Apply .**
5. Click **Sign**.

IV Infusion Billing/IV Stop Times

Once the IVF or IV piggyback Medication is administered and "signed off", the system will trigger the IV Stop Time Icon on the MAR and send a task to the Patient's Task List.

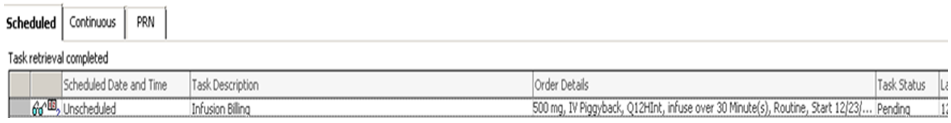
REMINDER: Document an IV Stop Time/Vol Infused for EVERY IV bag that is taken down/replaced (IVF, IV gtts, Piggybacks, etc)

This documentation can be completed from:

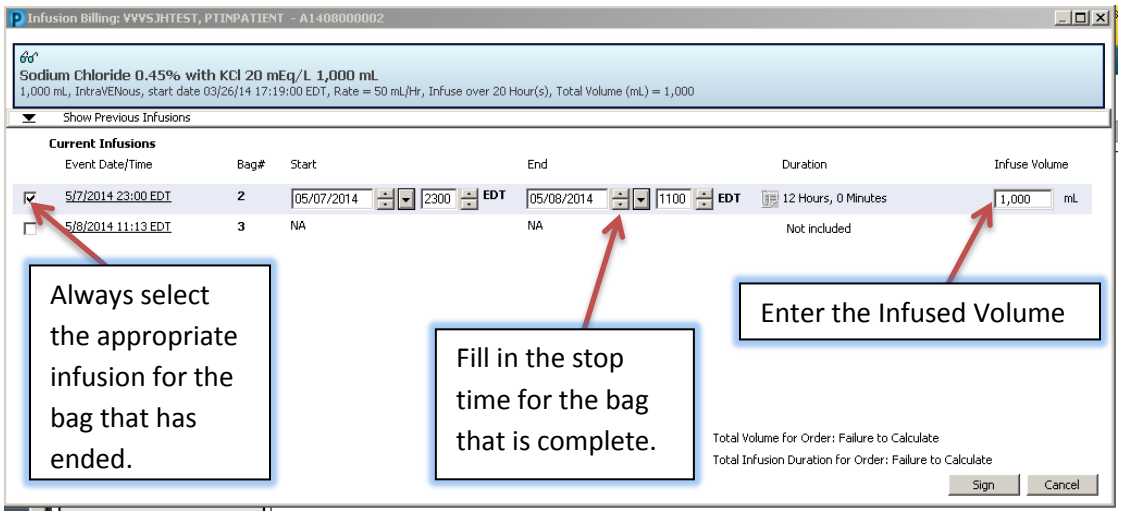
1. Patient's Task List-by selecting the Infusion Billing Task **OR**
2. MAR-by selecting the Infusion Billing Icon

From the Task List:

1. Double click the Infusion Billing Task



2. The IV Stop Time Documentation Box will display



3. Check the box next to the appropriate Medication that you are documenting the stop time for (if more than one is listed)
4. The IV Stop Time field will display as required
5. Enter the appropriate END Time and INFUSE VOLUME
    - Infuse Volume = Volume infused from time of initiation (not just the amount that infused during the shift)
    - The Infuse Volume DOES NOT flow into the I&O Band
6. Select **Sign**

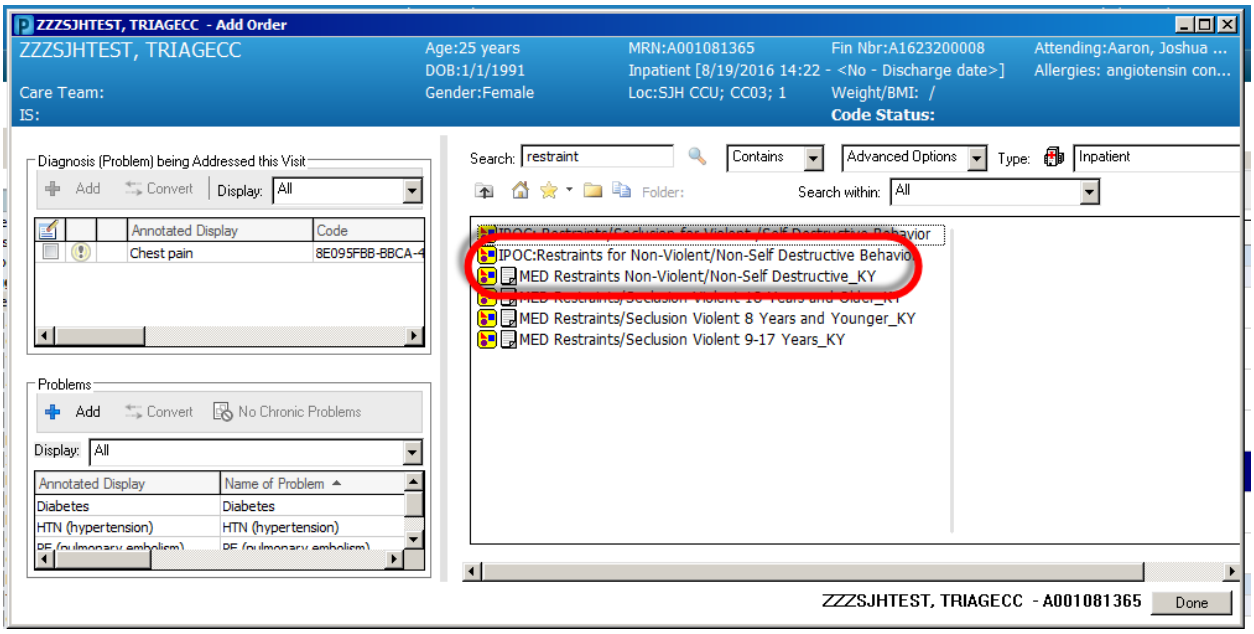
From the MAR:

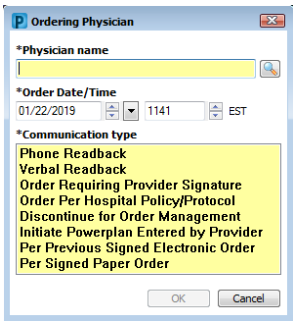
1. Select the Infusion Billing Icon
2. Follow steps 2 – 6 as outlined above.

Restraint Process

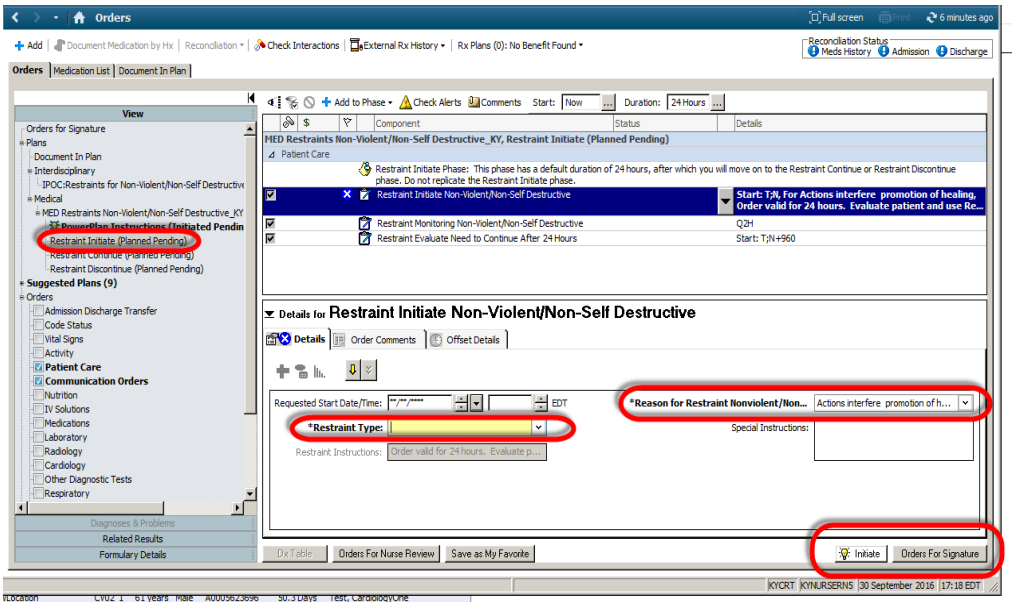
IMPORTANT: Clinicians need to place only ONE order for both *ordering* and *continuing* restraints. Once the initial order is placed, all consecutive orders will be generated from the **original** order located in the Orders View box. UNLESS RESTRAINTS HAVE BEEN DISCONTINUED AND THERE IS A NEED TO REINITIATE THEM DO NOT PLACE ANOTHER ORDER FROM THE ORDERS TAB FOR RESTRAINTS!

INITIAL RESTRAINT ORDER:

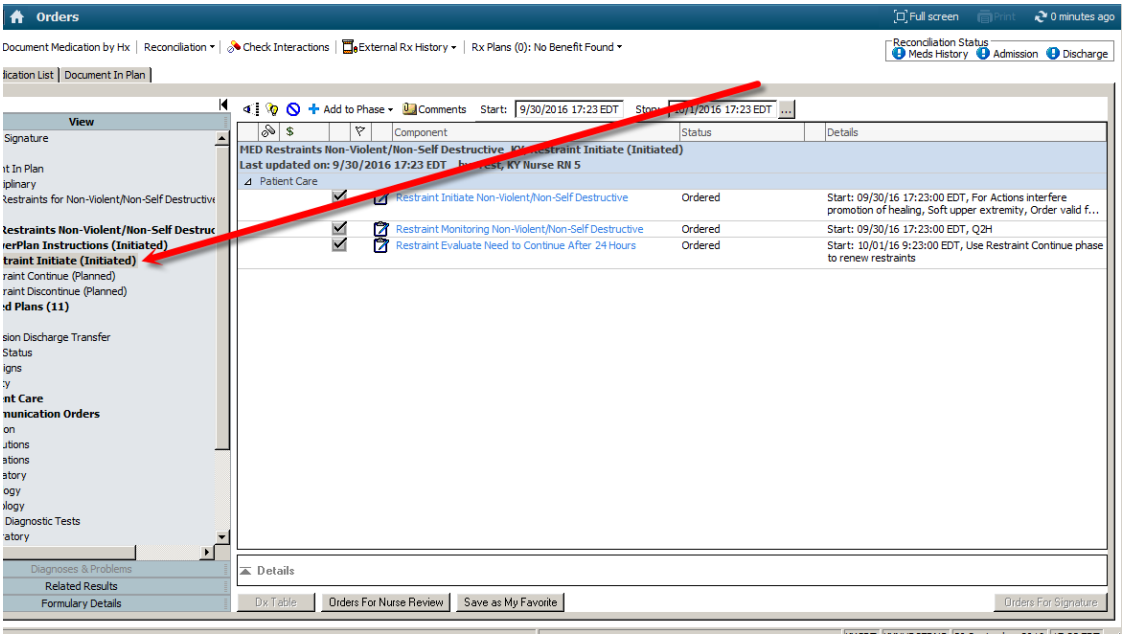




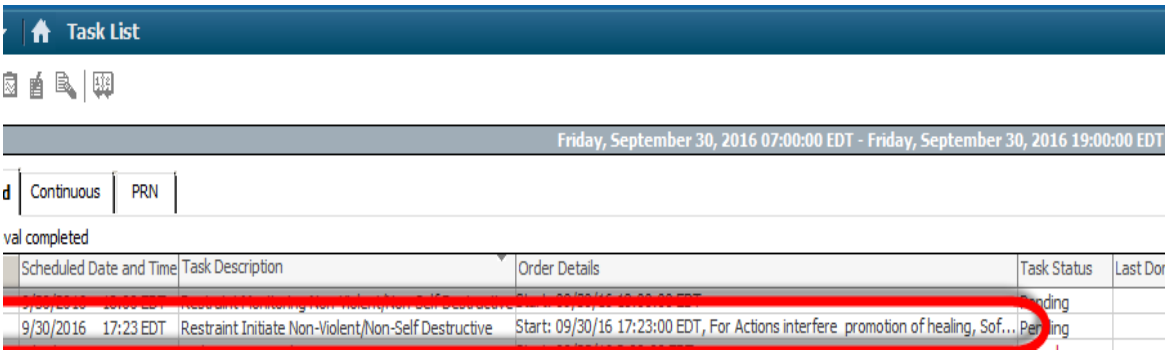
Review the Restraint PowerPlan Instructions and select/complete the Restraint Initiate Phase. Once the Initiate Order details of Reason and Type completed, initiate and Sign the PowerPlan.



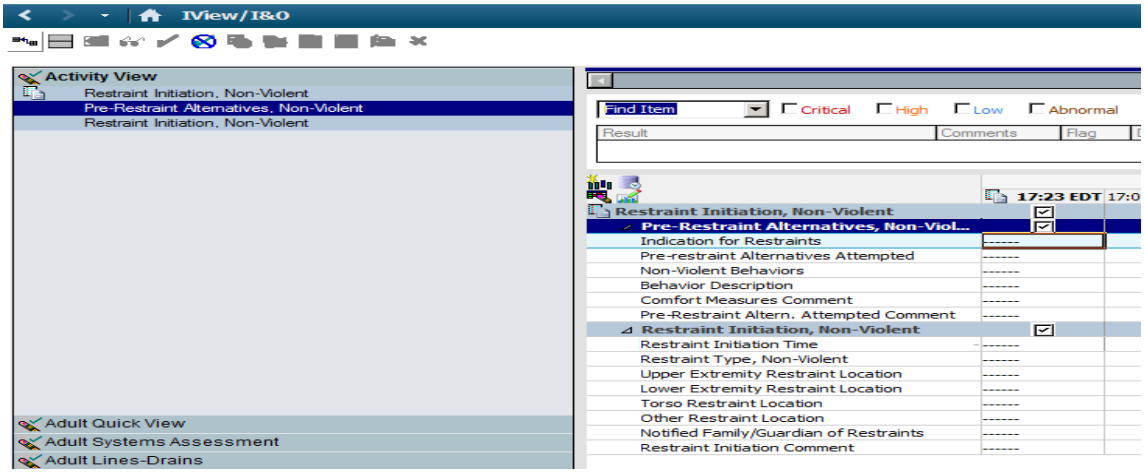
Review the orders and note that PowerPlan is “initiated” and the restraint orders display in the orders Profile.



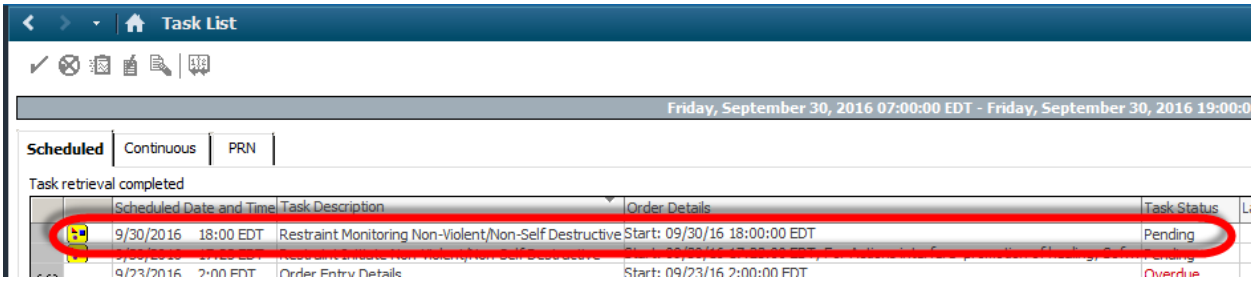
The restraint Initiate Task will display on the Task List



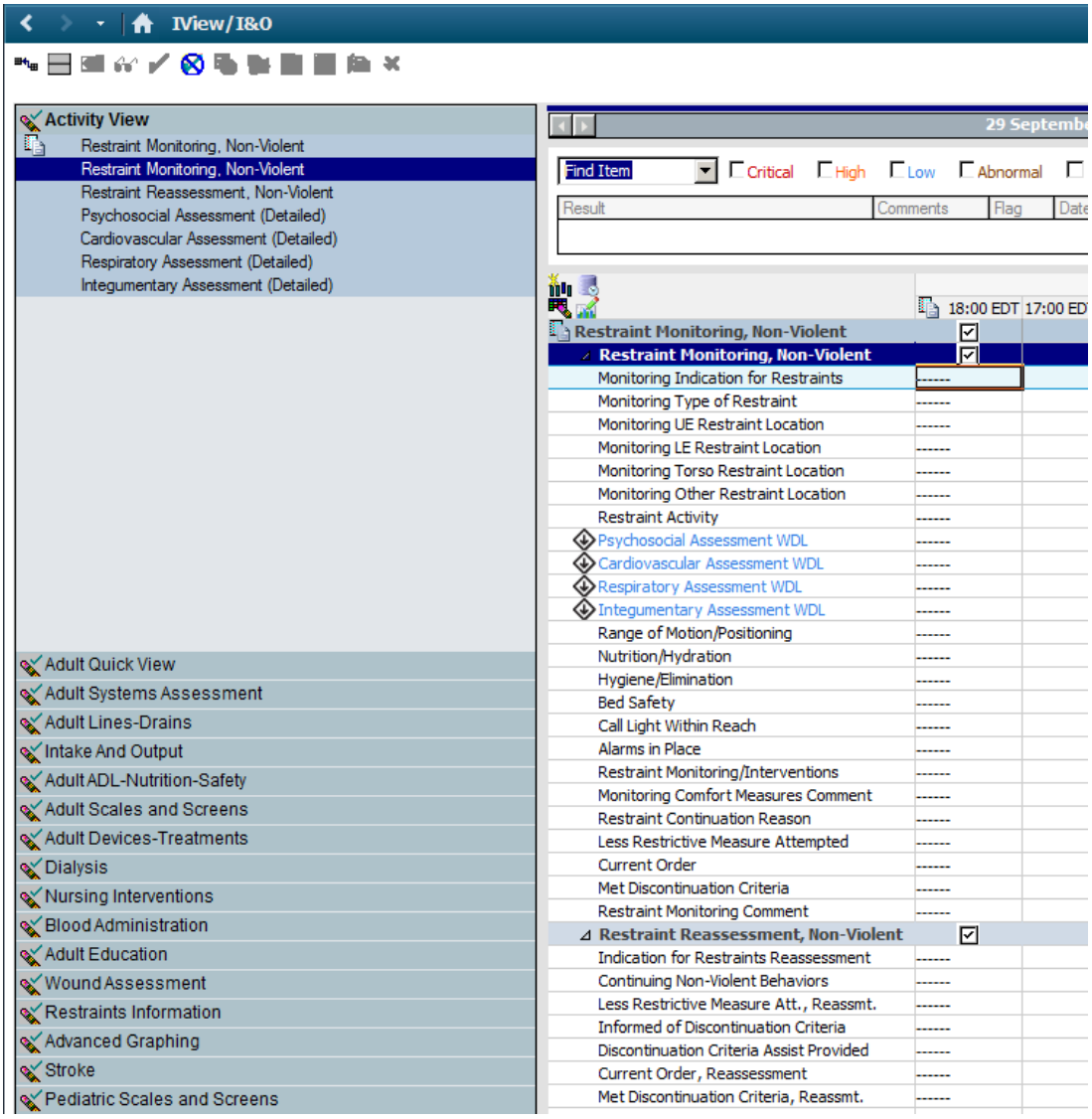
Complete the Initiation documentation



The Monitoring Task will display for every two hours in the task list.

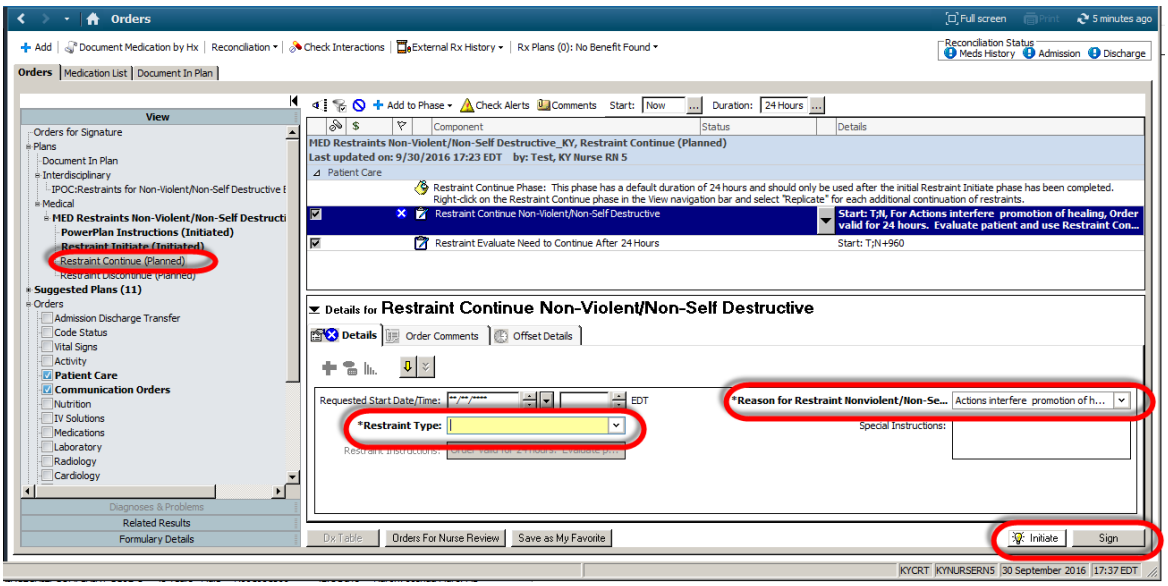


Complete the monitoring documentation

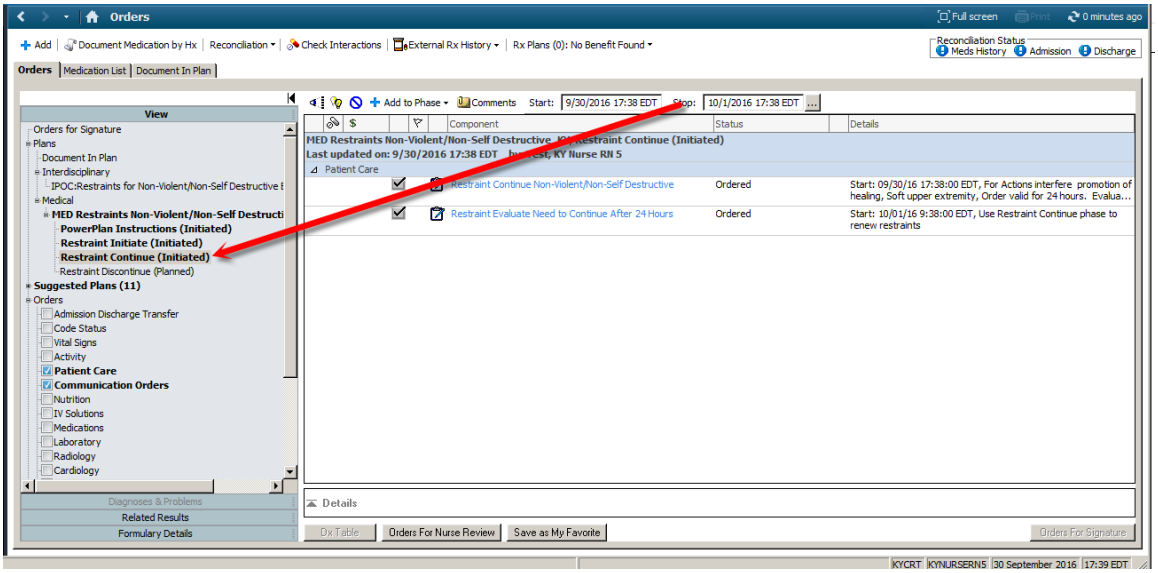


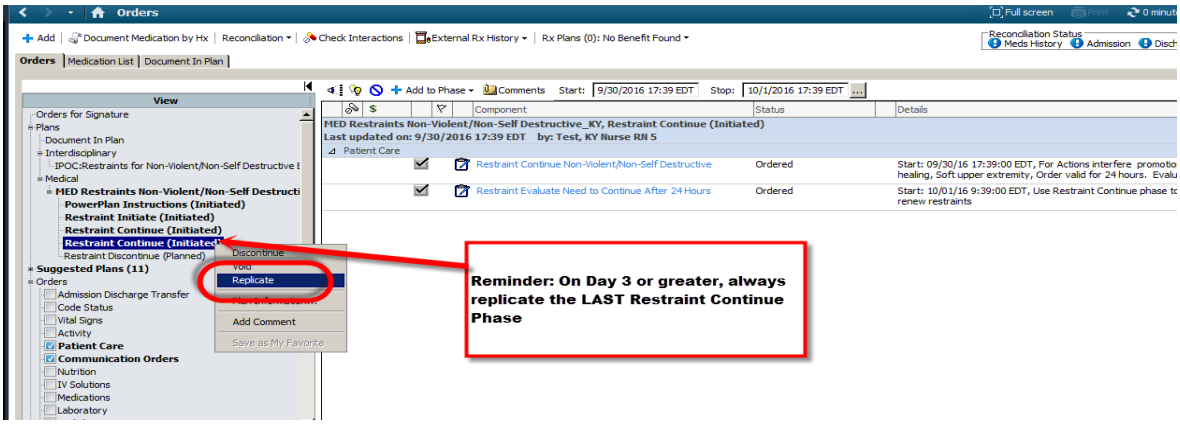
Non-Violent/Non-Self-Destructive Restraint orders are to be continued every 24 hours. Open the order's profile and select the Restraint Continue Planned Phase. select/complete the Restraint Continue

Non Violent Non Self Destructive Order Once Continue Orders completed, Initiate and Sign the PowerPlan.

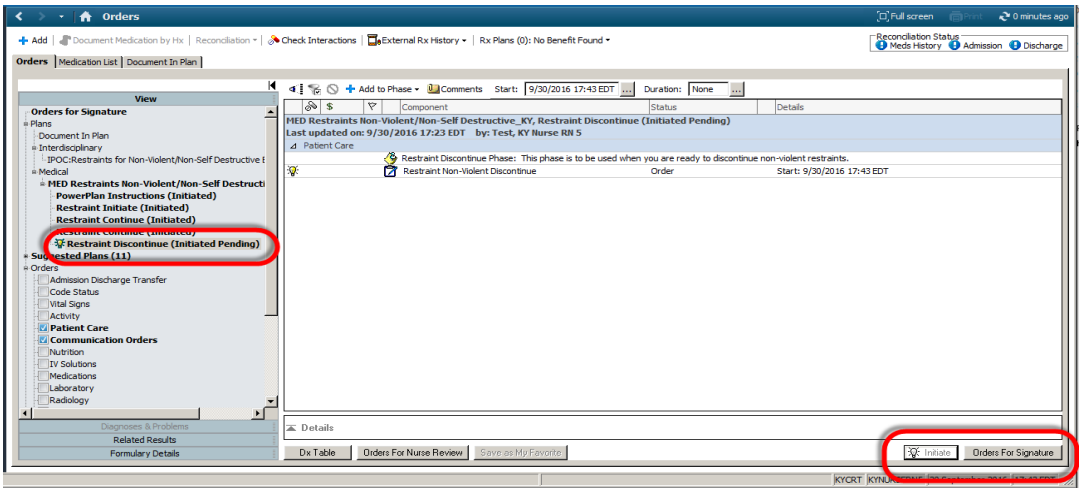


Review the orders and note that the Continue Phase is initiated and the restraint orders display in the orders Profile.

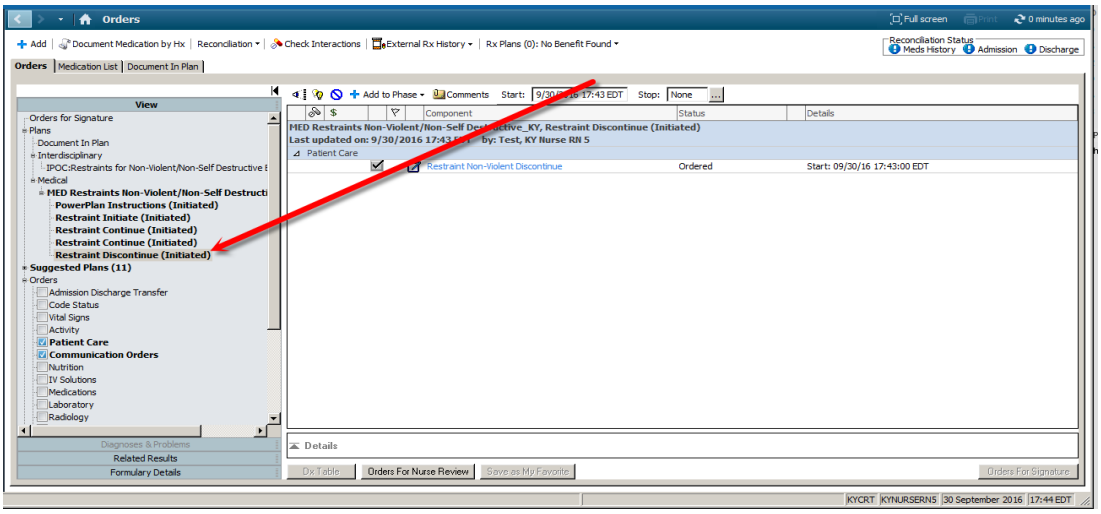




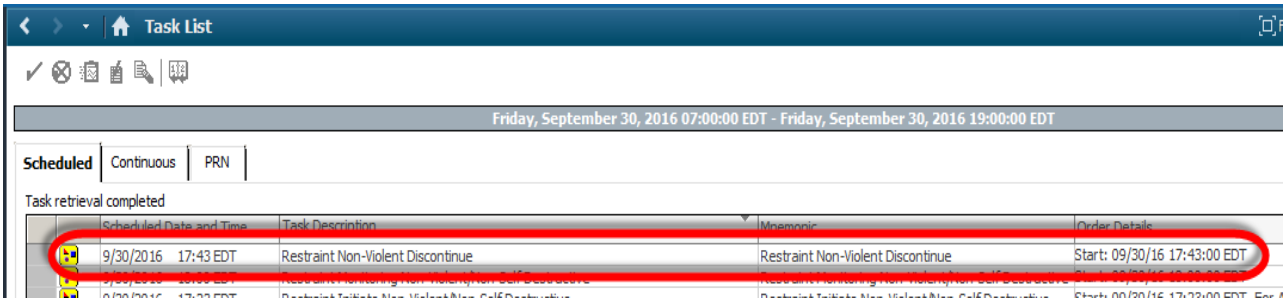
Once appropriate to discontinue the Non Violent Restraints, open the order's profile and select the Restraint Discontinue Planned Phase. Select/complete the Restraint Non Violent Discontinue Order, Initiate and Sign the PowerPlan.



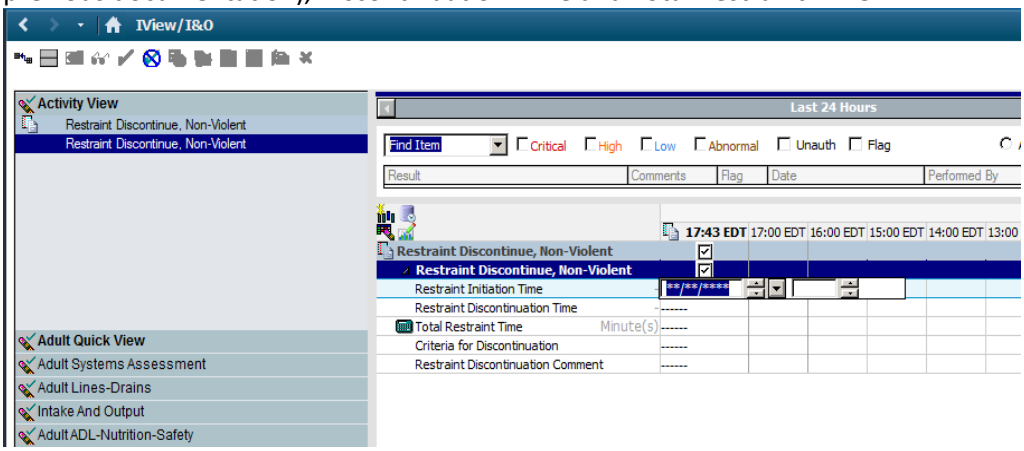
Review the orders and note that the Discontinue phase is initiated and the restraint orders display in the orders Profile.



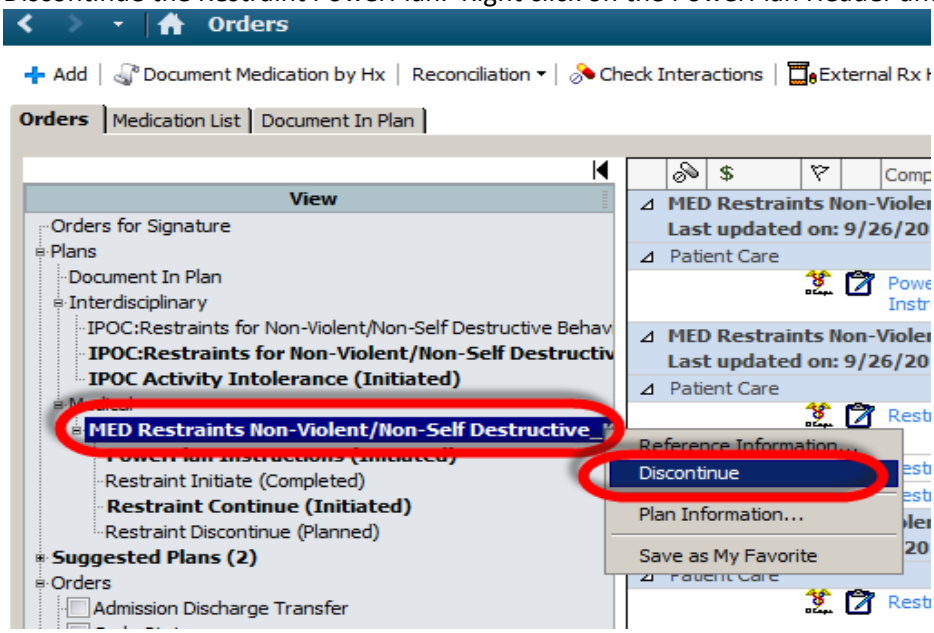
The restraint DiscontinueTask will display on the Task List



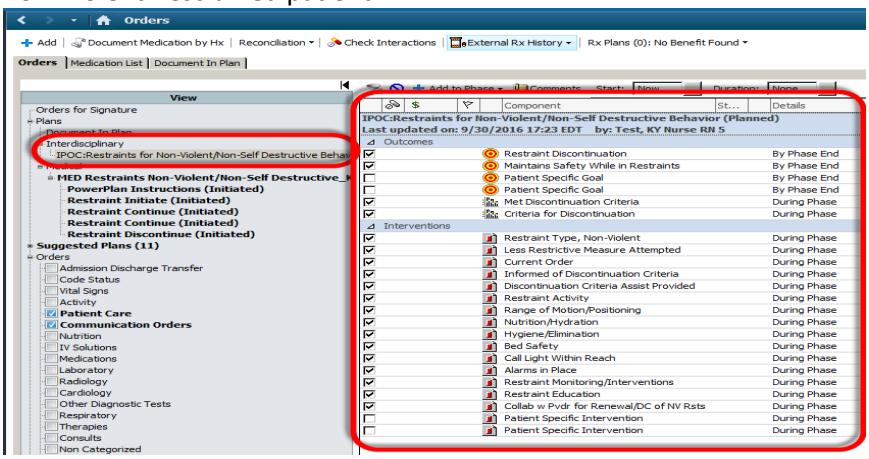
Complete the Discontinue Documentation-Including Initiation Time (this field will pull forward from the previous documentation), Discontinuation Time and Total Restraint Time



Discontinue the Restraint PowerPlan. Right click on the PowerPlan Header and select Discontinue.



The Non Violent/Non Self Destructive Restraint IPOC should be initiated and updated per policy on every non violent Restrained patient



IPOC (Plan of Care) Documentation and Updates

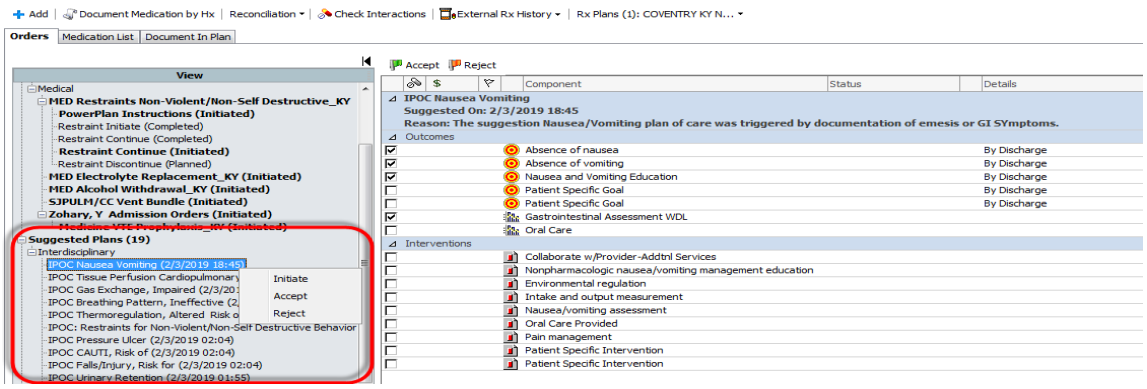
The IPOC Goals, Indicators and Interventions should be updated by a registered nurse at a minimum of Q 24 hours and when there is a change in status.

- GOALS MUST BE UPDATED! A registered nurse will have to update the goals. Documentation from IVEIW does not update these.
- Reminder- The assessment documentation from IVIEW that is a like for like match with the indicators and interventions within the IPOC will update automatically. The nurse does not have to double document you those when updating the IPOC. See below for examples.

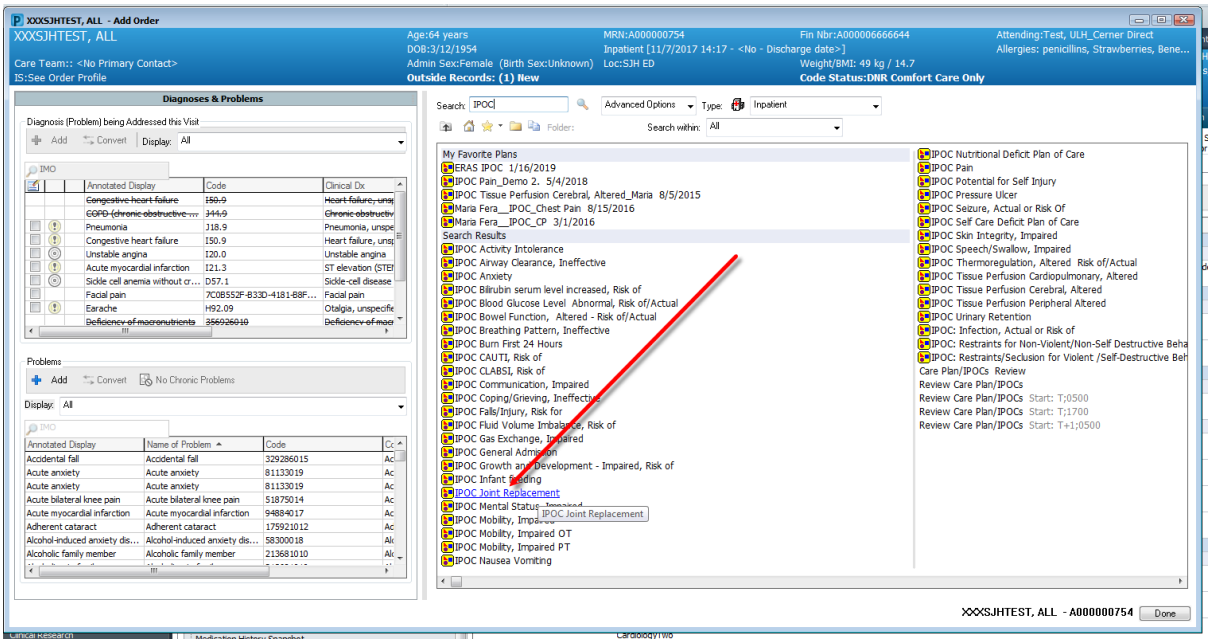
Initiating IPOCs

To Initiate a Plan of Care:

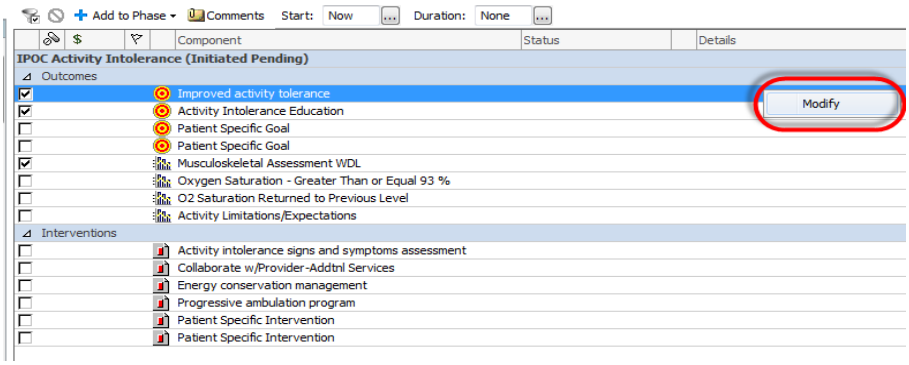
- Manually search for an IPOC in the Add Orders window.
- Suggested IPOCs can be reviewed and initiated from the INTERDISCIPLINARY category with in the Orders Profile
    - Once the nurse reviews the suggested IPOCs, he/she can select the ACCEPT Icon and then select or de-deselect appropriate Goals, Indicators and/or Interventions as appropriate before initiating

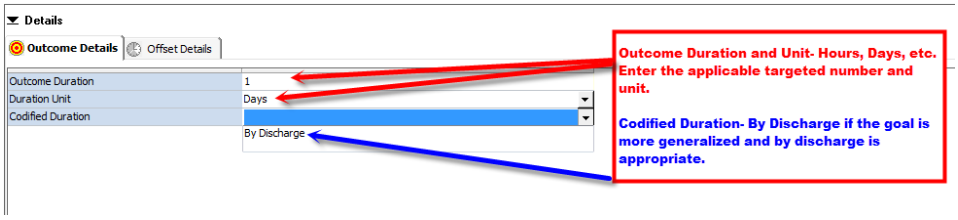


- Search for and select the applicable IPOC.

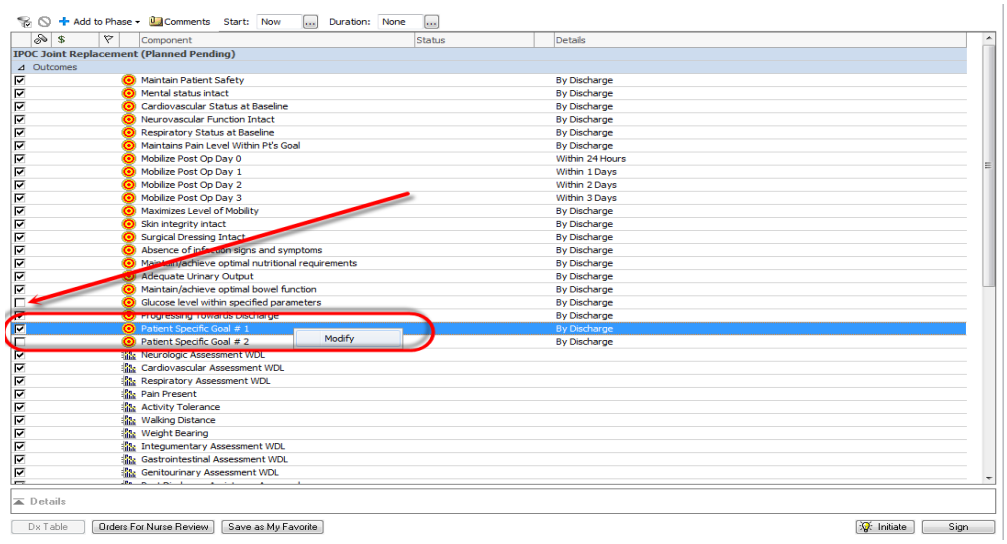


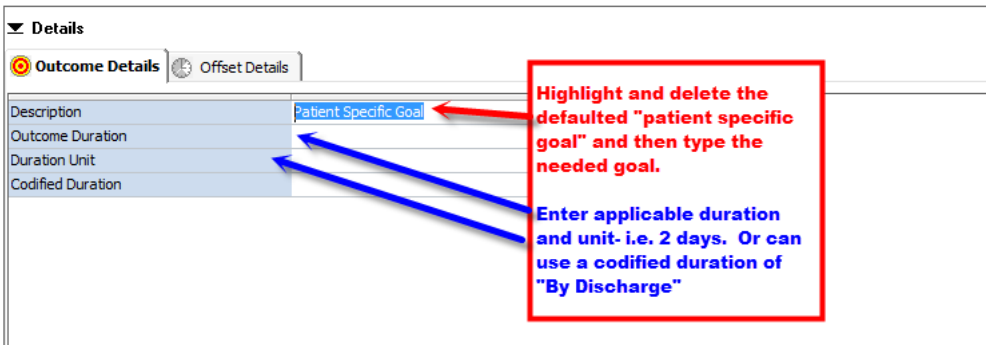
- **Target Date- Enter a target date in the details section**. Most IPOC Goals default to "By Discharge". However, you can change that if the goal is within a shorter time frame. For IPOCs that do not have a target date for each goal, be sure to add one prior to initiating.
  - Right click on the goal and select modify.
    - Outcome Duration- Enter the number.
    - Outcome Unit- Minutes, Days, etc.
    - Codified Duration- Select By Discharge if that is more applicable to the patient goal.



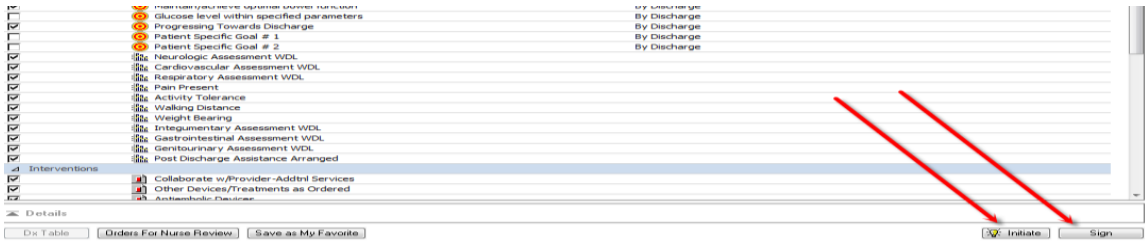


- Place a check mark for any additional needed goals, indicators, interventions to include them in the plan of care. This is how you make the plan of care specific to the patient's needs. An example below is from the Joint Replacement IPOC:
    - If the patient is a diabetic, put a check mark in the "Glucose level within specified parameters"
    - If the patient is on telemetry, place a check mark in the "Telemetry Status" intervention.
    - **For patient specific clinical goals -** place a check box for the Patient Specific Goal and the right click and select modify to type your patient's specific goal.
        - Highlight and delete the defaulted "patient specific goal" and then type the needed goal.
        - Enter applicable duration and unit- i.e. 2 days. Or can use a codified duration of "By Discharge"



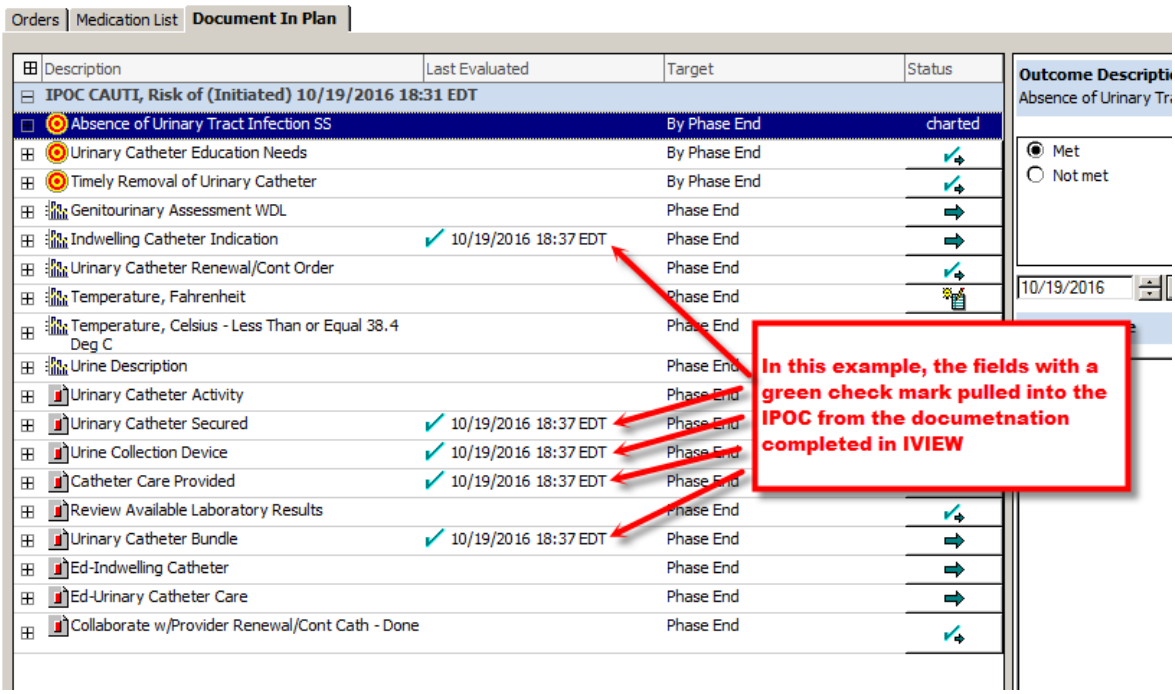


- Initiate and Sign the IPOC

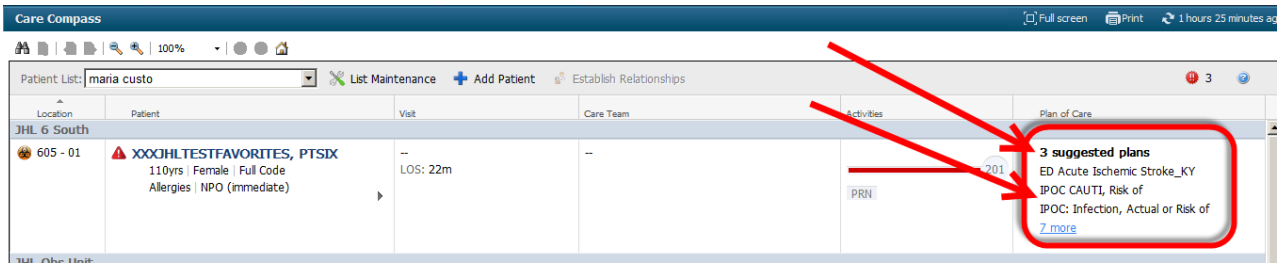


Documenting/Updating Goals/Indicators/Interventions

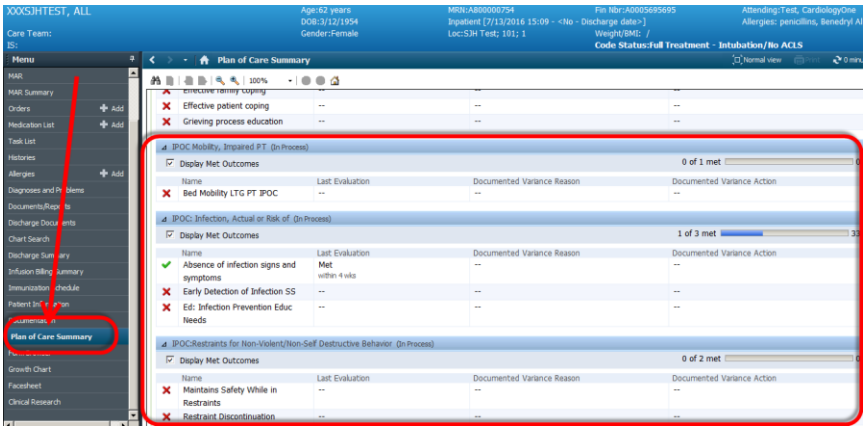
- IPOCs are updated with in the DOCUMENT IN PLAN Tab from the Orders Profile
- Each IPOC Contains Goals, Indicators and Interventions.
  - **Goals** display with – These are the patient's Plan of Care Goals. Assessment documentation does not update goals with in the IPOC.
  - **Indicators** display with - -Indicators are assessment elements which help measure whether or not a goal is moving towards being met.
    - If the Indicator is identical to those fields in the assessment documentation, the nurse's assessment documentation will automatically update the Indicator as Met vs Not Met. As well, documentation of the Indicator within the IPOC will update the identical field in IVIEW.
    - If the Indicator has already been documented with in the assessment and updated the IPOC, the nurse does not need to update the Indicator again within the IPOC.
  - **Interventions** display with – Interventions are to be documented as Done vs Not Done.
    - Same logic applies to the interventions. If the intervention is an identical field with in assessment/intervention documentation from IVIEW, the system will automatically update the IPOC.
    - For example, documenting the Urinary Catheter Bundle field within the Urinary Catheter IVIEW section updates the intervention as DONE in the IPOC.



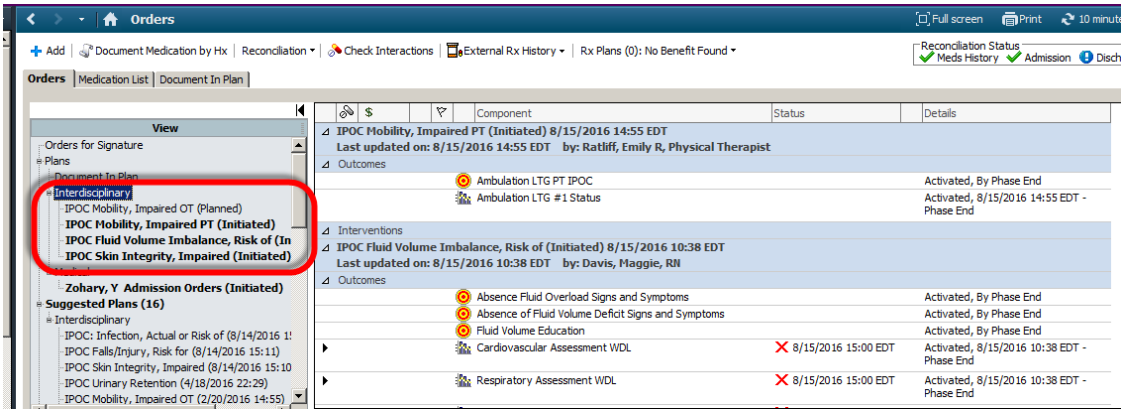
- Each patient's Initiated IPOCs can be reviewed in the following three areas:
  - CareCompass
  - Orders Profile



- Plan of Care Summary MPage



- Orders Profile



Admission/Discharge Workflow from Mpage

Recommended Admission History Documentation Workflow Overview:

- **FIRST- Complete Admission Workflow -New Task**
  - Nurse is to navigate to the Admission Workflow Mpage to reconcile and complete **Home Meds, Allergies, and Histories**.
  - Once complete- The nurse is to document "Done" against the task to complete the task and order driving the nurse to the Admission Workflow Mpage.

- **SECOND- Admission History -Existing Task**

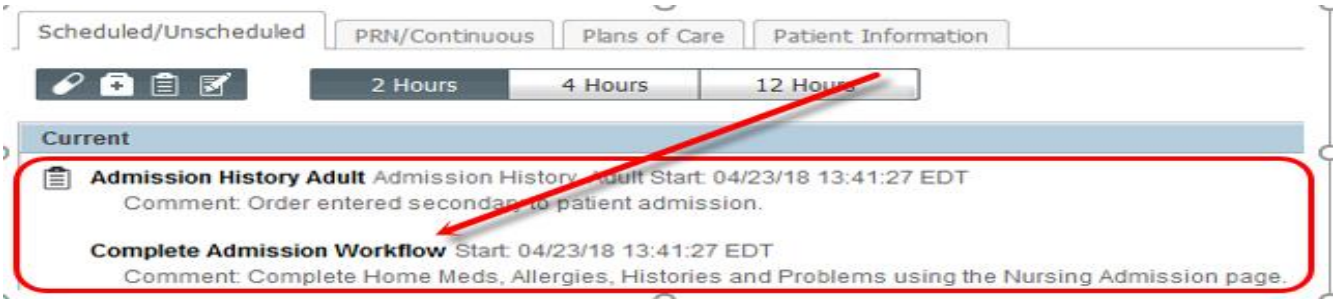
- Links to the Admission History PowerForm just as before. However, the Admission History PowerForm will no longer contain the sections for Home Meds, Allergies, Problems and Procedure History.

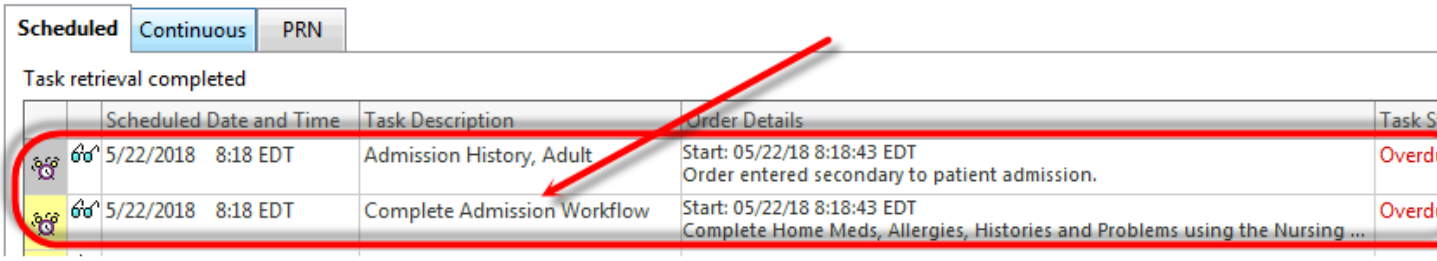
- **THIRD- Document Patient Preferred Pharmacy -Existing Task**
  - Nurse is to navigate to the Preferred Pharmacy Tool and enter the patient's preferred pharmacy information.
  - If the patient's pharmacy does not display in the tool, the nurse is to select "No Preferred Pharmacy"
  - Once complete- The nurse is to document "Done" against the task to complete the task and order driving the nurse to the Patient Preferred Pharmacy Tool.

- **Fourth - Complete Admission Systems Assessment** within appropriate time frame per policy
  - Initial Systems Assessment is documented in IVIEW
  - New section is available to document arrival time to admitting unit and date/time initial assessment completed.

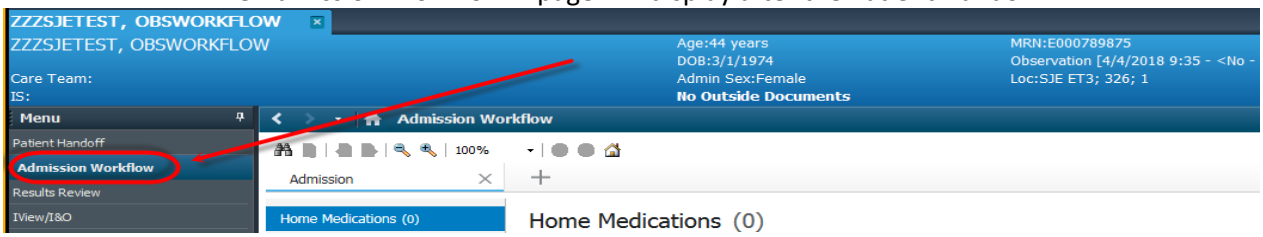
Complete Admission Workflow- New Task

- The Nurse will receive a Complete Admission Workflow task (via CareCompass/Single Patient Task List).



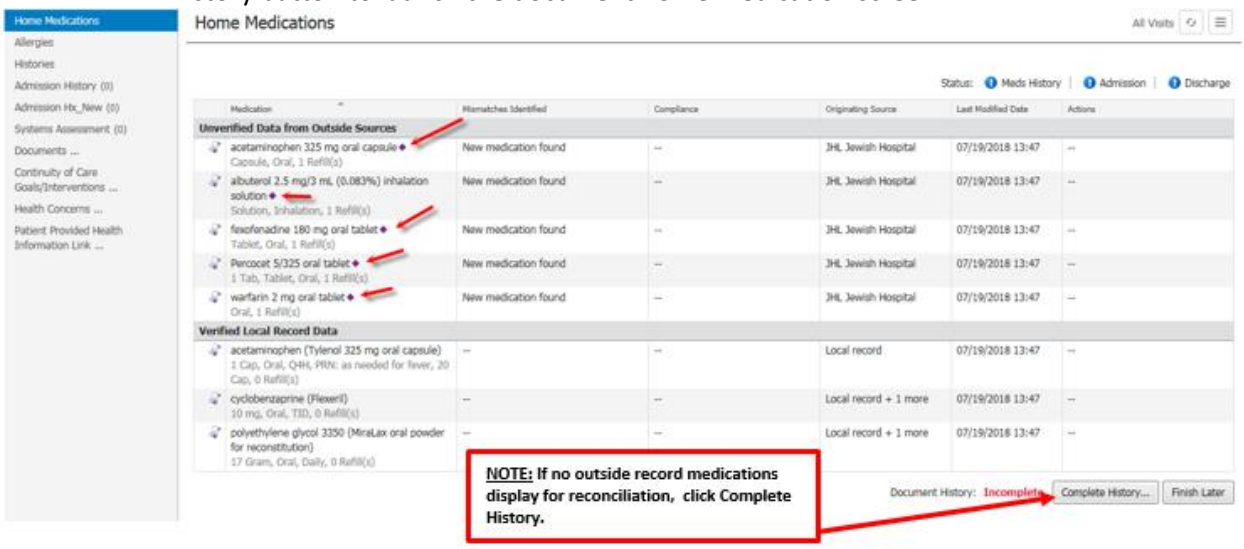


- Navigate to the Admission Workflow Mpage from the Menu/Table of Contents.
  - The Admission Workflow Mpage will display after the Patient Handoff.

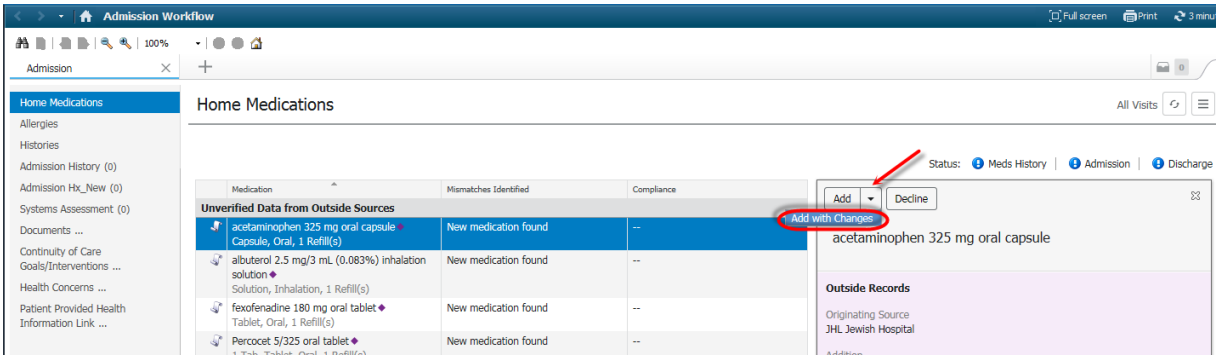


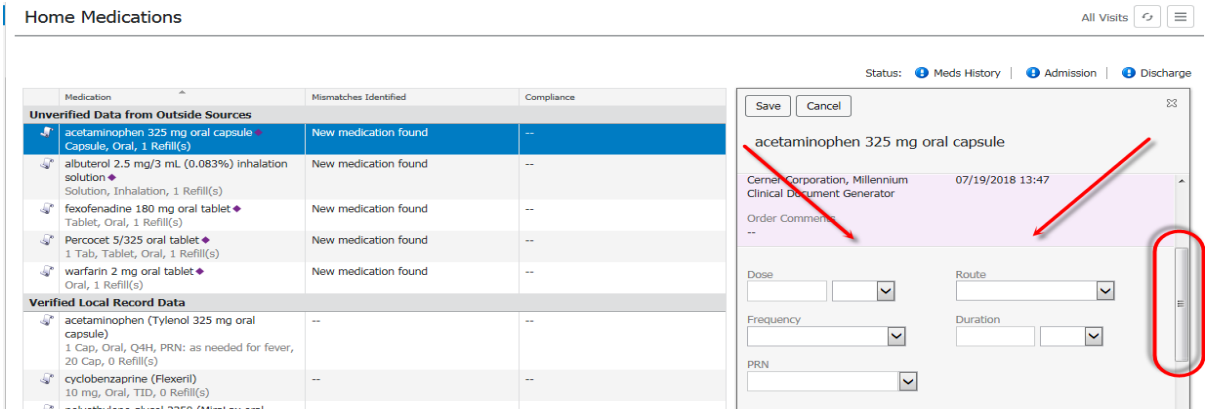
Document Home Medications

- **First – Reconcile** by adding or declining any medications that have automatically pulled in from outside records. Outside records will display with a purple diamond.
  - NOTE: If there are no outside records medications to reconcile – Click the Complete History button to launch the document home medication screen.

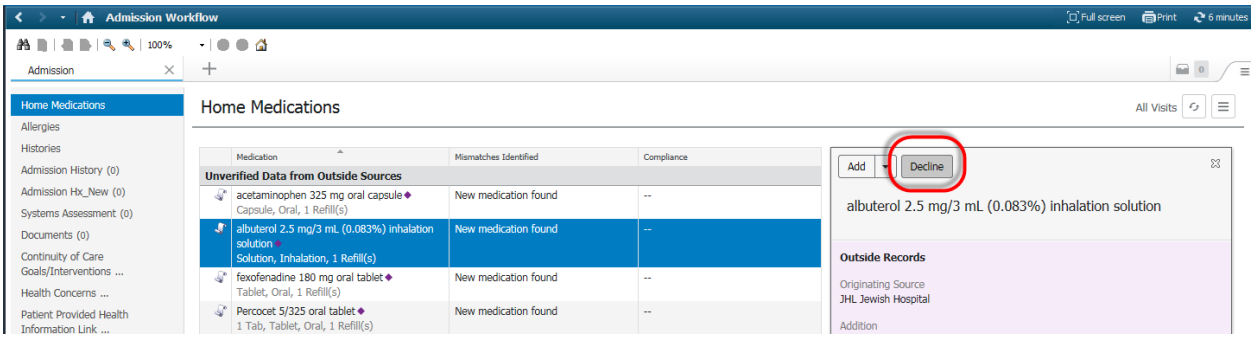


  - **To ACCEPT/ADD medications from outside records-** Click anywhere on the medication line and select **Add with Changes**. Use the scroll bar to update additional fields such as compliance and last dose.

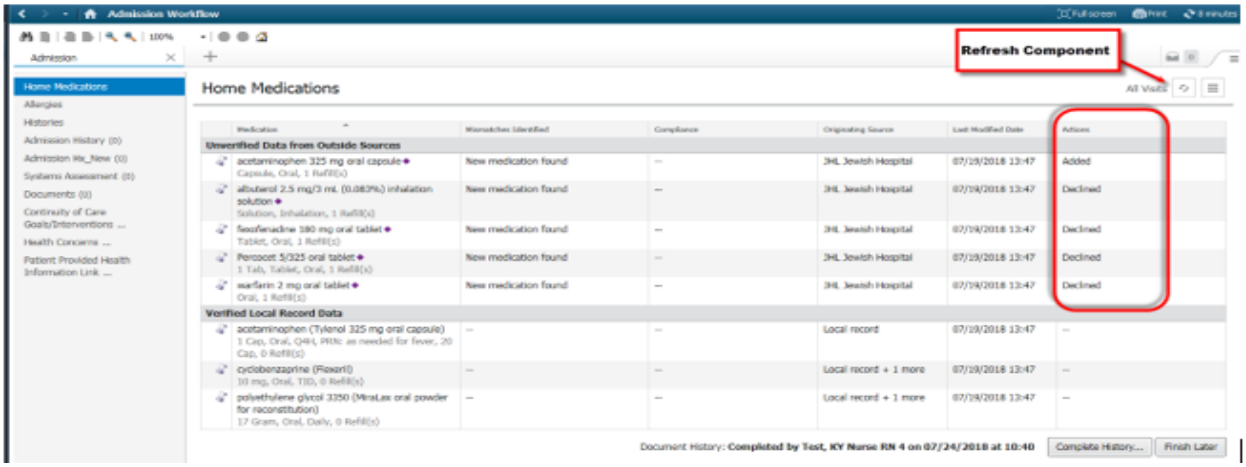




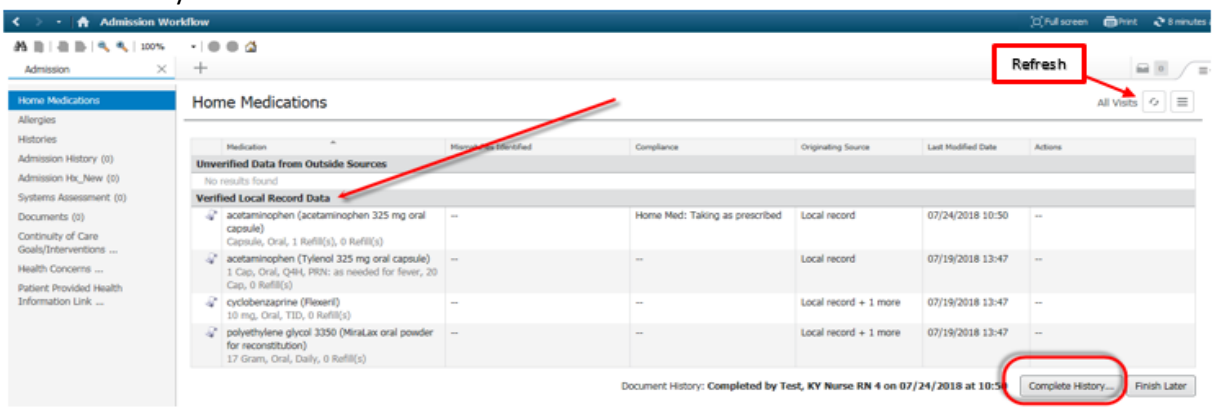
- **To DECLINE medications from outside records-** (For example- outside records are not up to date or a change in status has occurred) Click anywhere on medication line and select **Decline**.



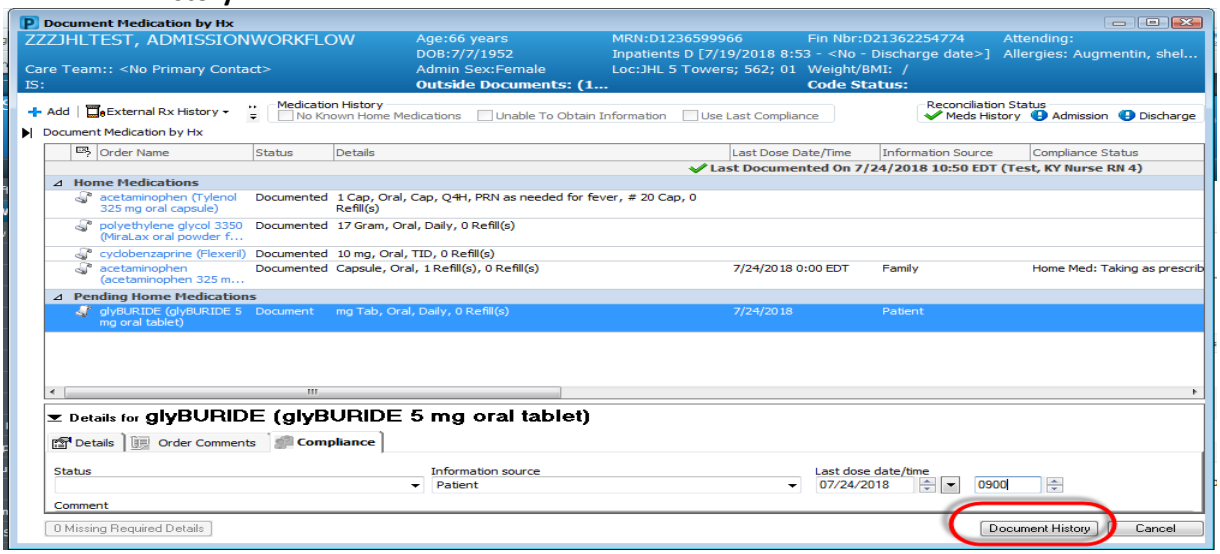
- The actions column will display the added/declined status for each outside record medication.



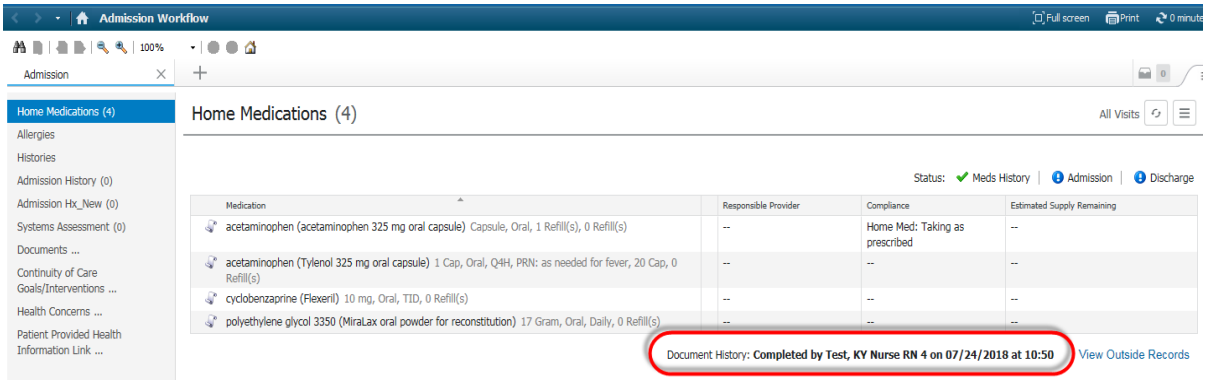
- Select the refresh button and the added medications will now display in the Verified Local Record Data section.
- Now that outside record medications have been reconciled, click **Complete History** to add any additional home medications.



- Review final list for all medications and make any remaining updates. Select **Document History**.

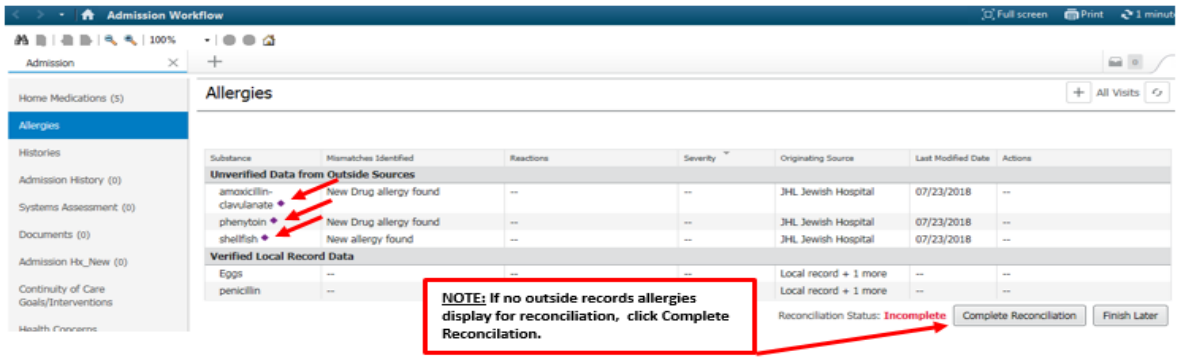


- The component will display Document History: Completed by clinician, date, and time.

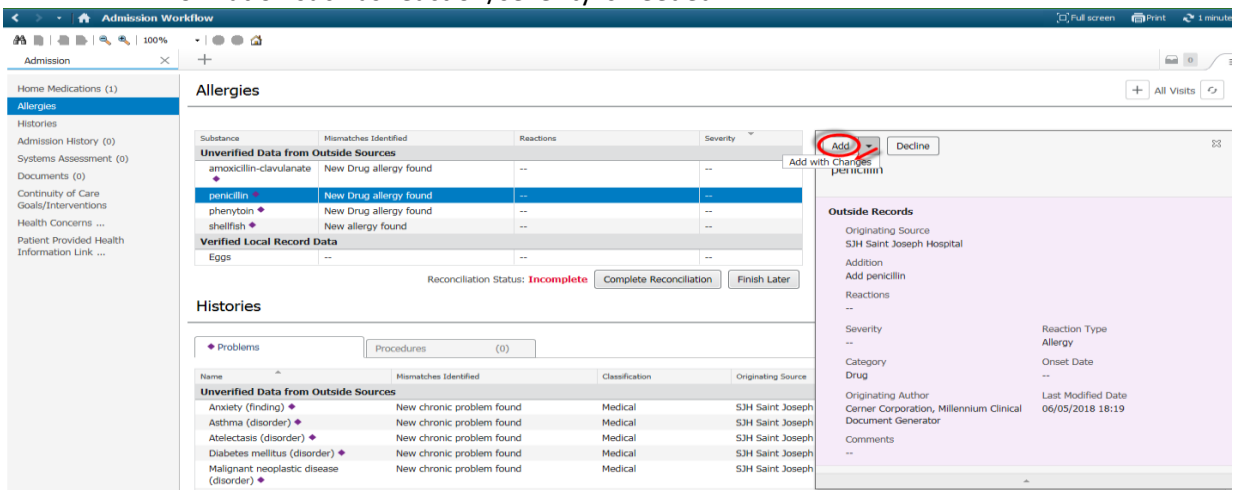


Document Allergies

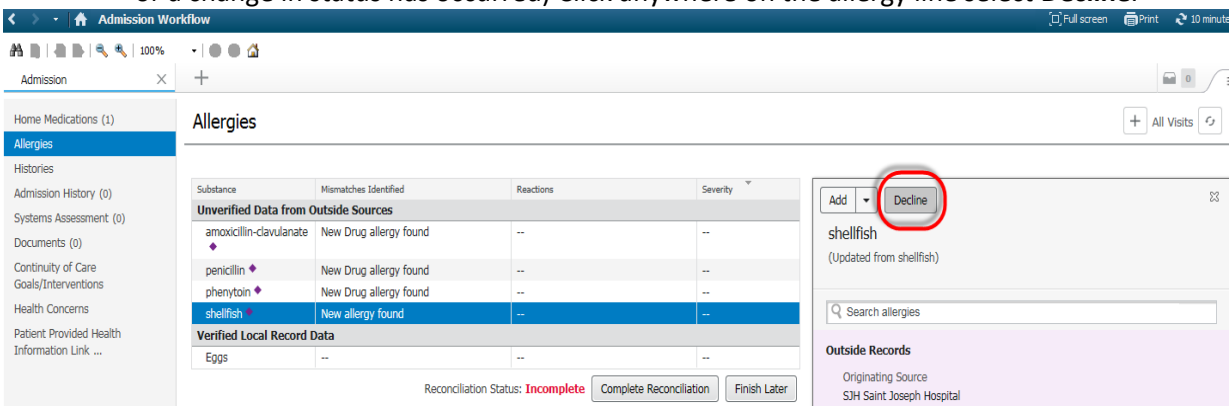
- **First - Reconcile** by adding or declining any allergies that have automatically pulled in from outside records. These will display with a purple diamond.
  - NOTE: If there are no outside record allergies to reconcile – Click the Complete Reconciliation button



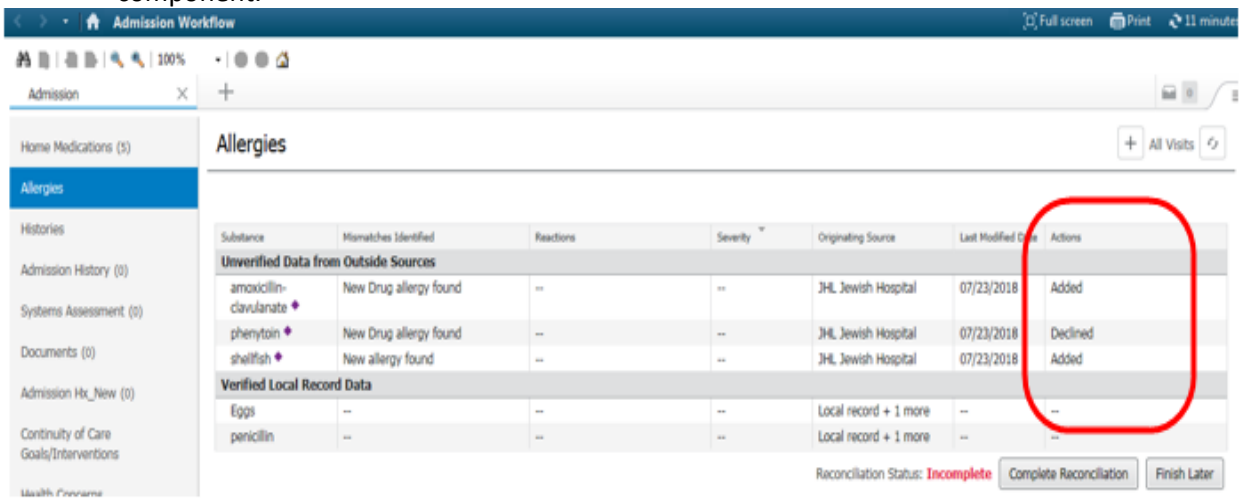
- **To ACCEPT/ADD allergies from outside records-** Click anywhere on allergy line select **ADD**. The user can also select the drop down and click on **Add with Changes** if additional information such as reaction/severity is needed.



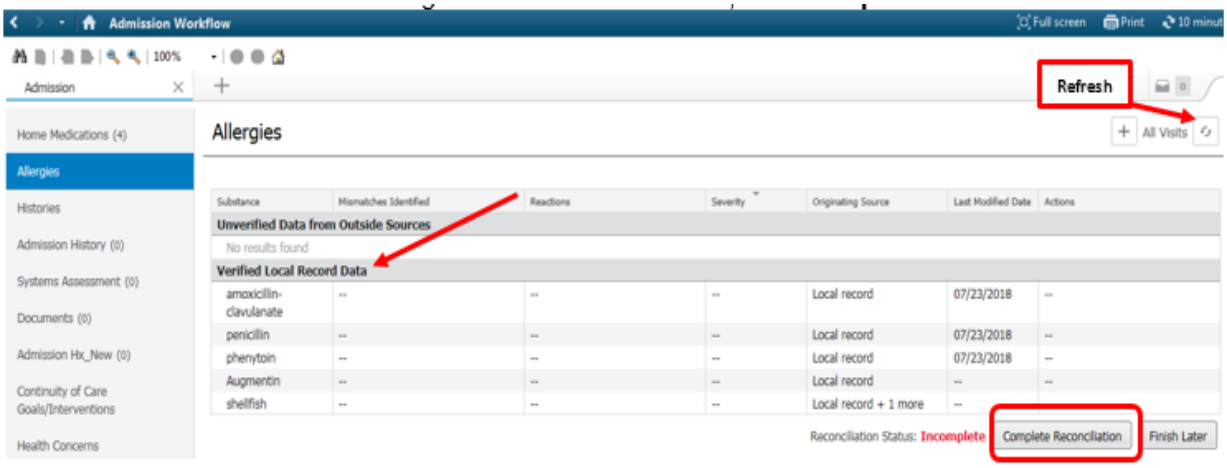
- **To DECLINE allergies from outside records-** (For example- outside records are not up to date or a change in status has occurred) Click anywhere on the allergy line select **Decline**.



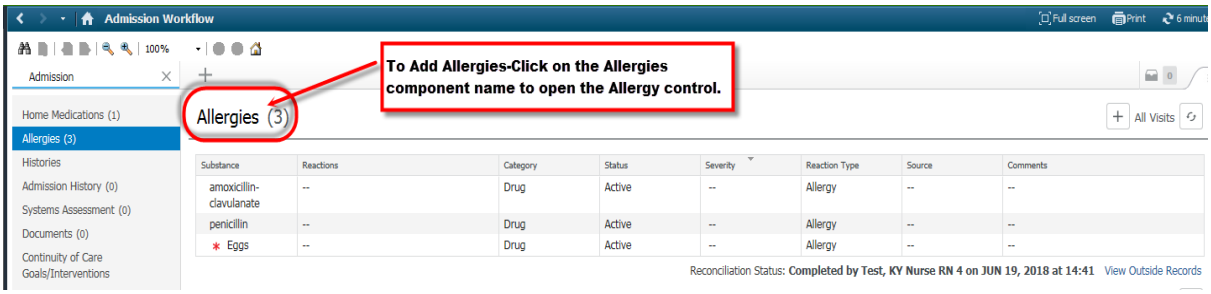
- The status of Added/Declined outside record allergies will display in the Actions column of the component.



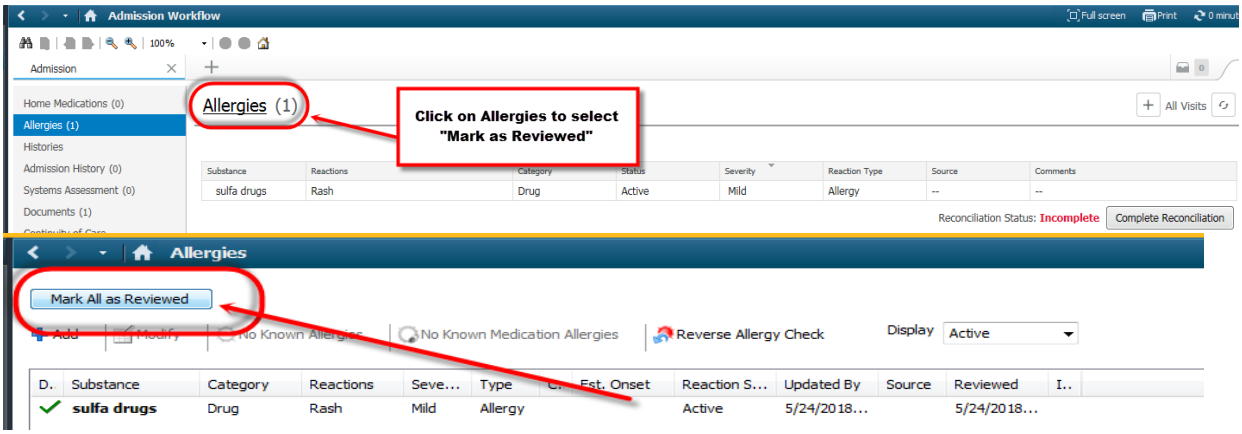
- Select the refresh button and the added allergies will display in the Verified Local Record Data section.
- Now the outside record allergies have been reconciled, click **Complete Reconciliation**.



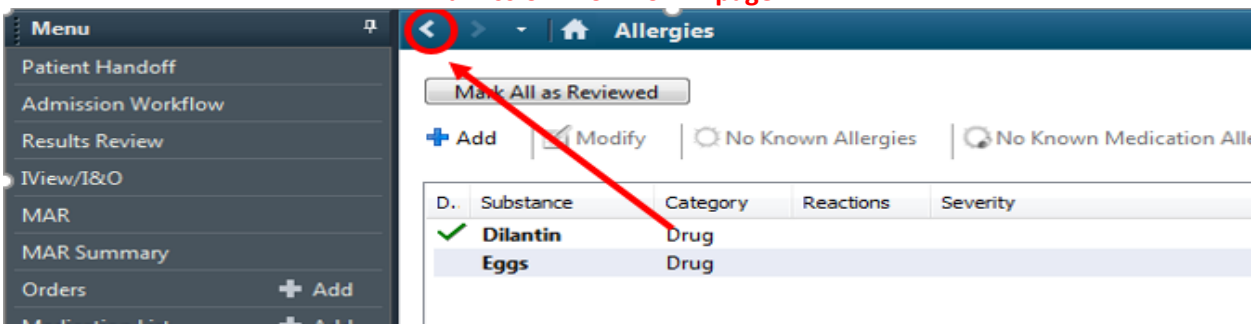
- **Second- Add/Modify new allergies** that were not displaying as part of the outside record reconciliation step.
  - Click on the Allergies component name to open the Allergy control and add/modify allergies as you do today.



  - NOTE**: Mark As Reviewed**-If Allergies already display from a previous admission and no new updates are needed, the clinician is to click on the Allergies link and then select the Mark All as Reviewed button.

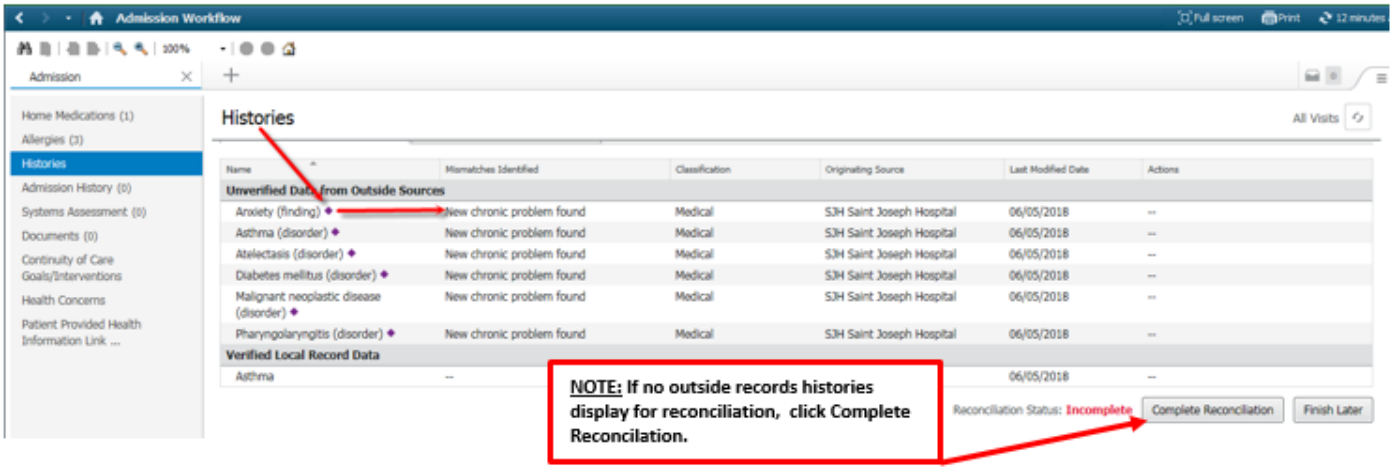


Once allergies have been marked as reviewed, click the Back button to navigate back to the Admission Workflow Mpage.

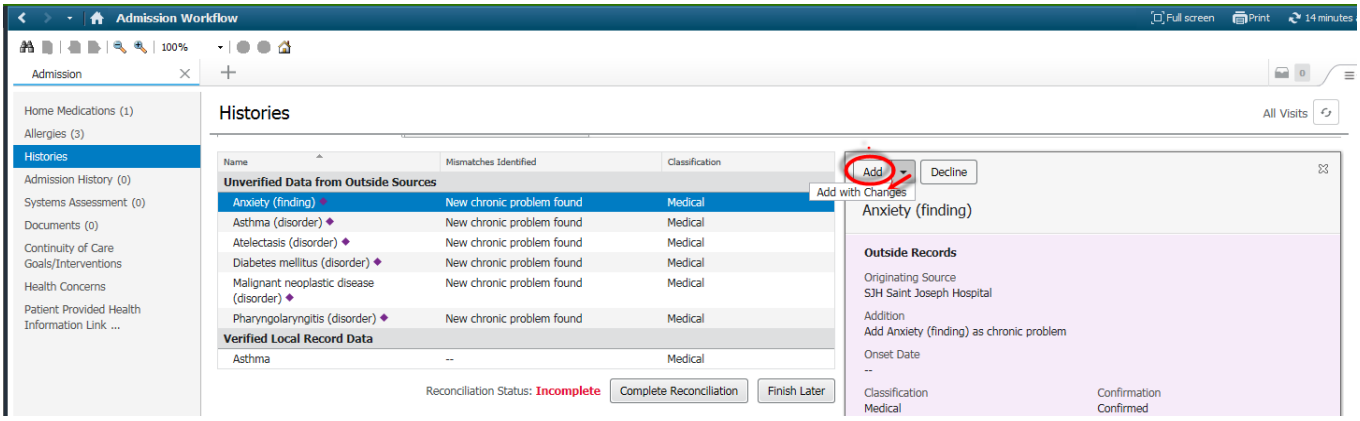


Document Histories (Problems and Procedures)

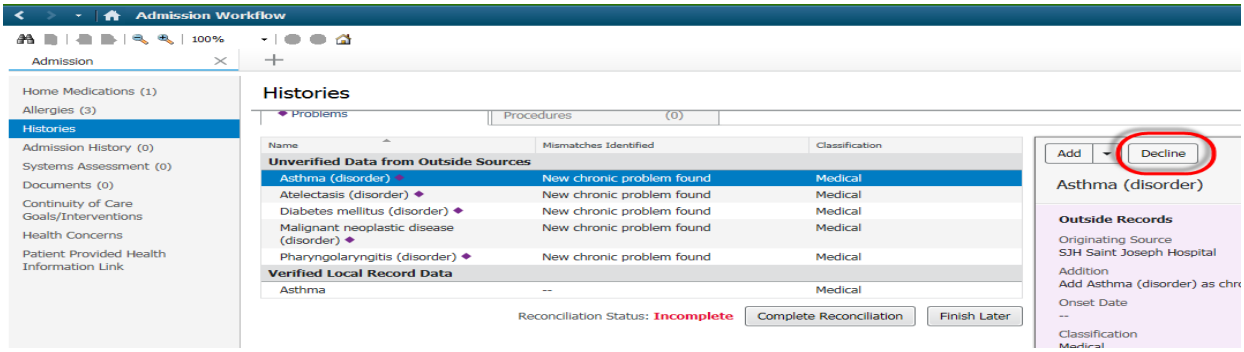
- **First - Reconcile any problems** that have automatically pulled in from outside records. These will display with a purple diamond.
  - NOTE: If there are no outside record problems to reconcile – Click the Complete Reconciliation button



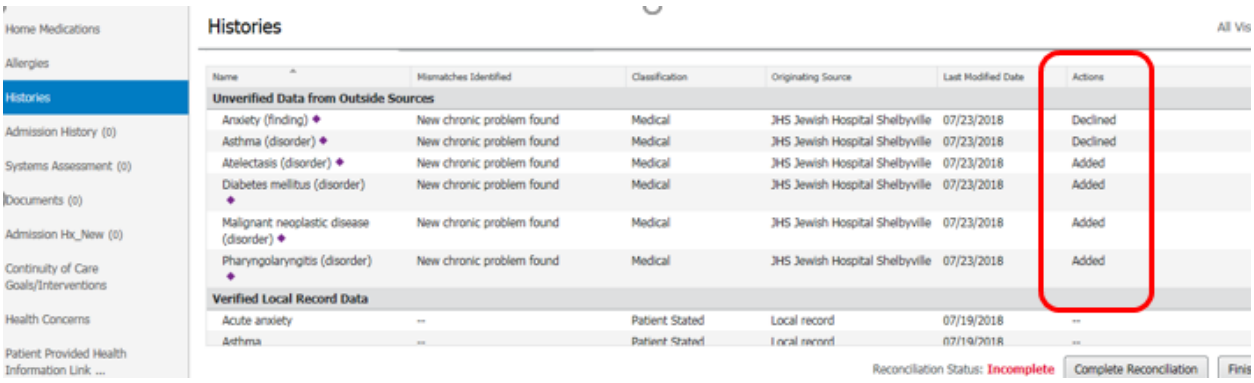
  - **To ACCEPT/ADD problems from outside records-** Click anywhere on the problem line and select **ADD**. The user can also select the drop down and then click on **Add with Changes** if additional information is needed.



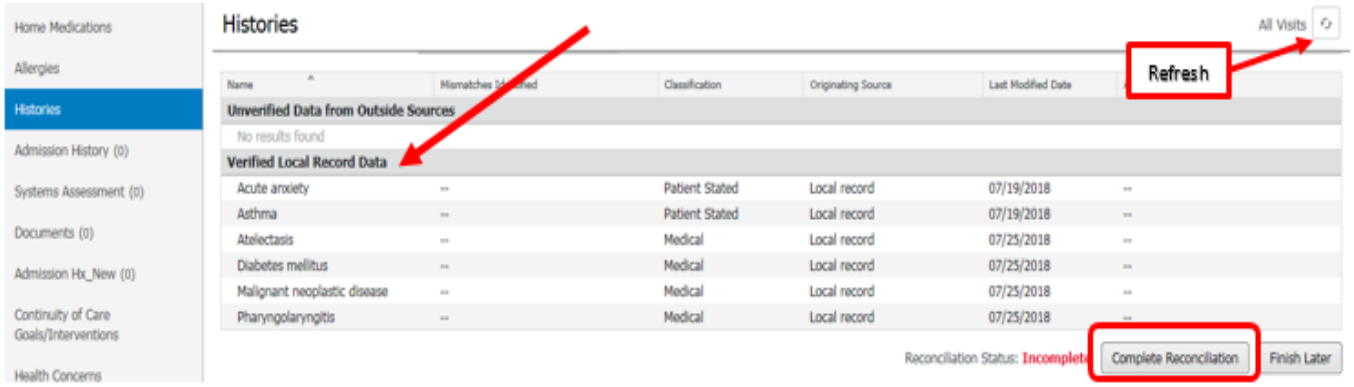
- **To DECLINE problems from outside records** (For example- outside records are not up to date or change in status has occurred) Click anywhere on the problem line and then select **Decline**.



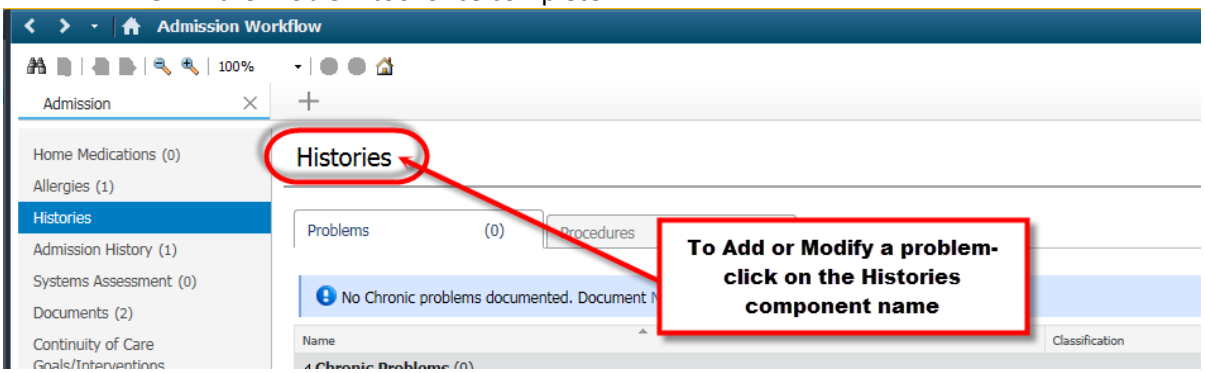
- The status of Added/Declined outside record problems will display in the Actions column of the component.

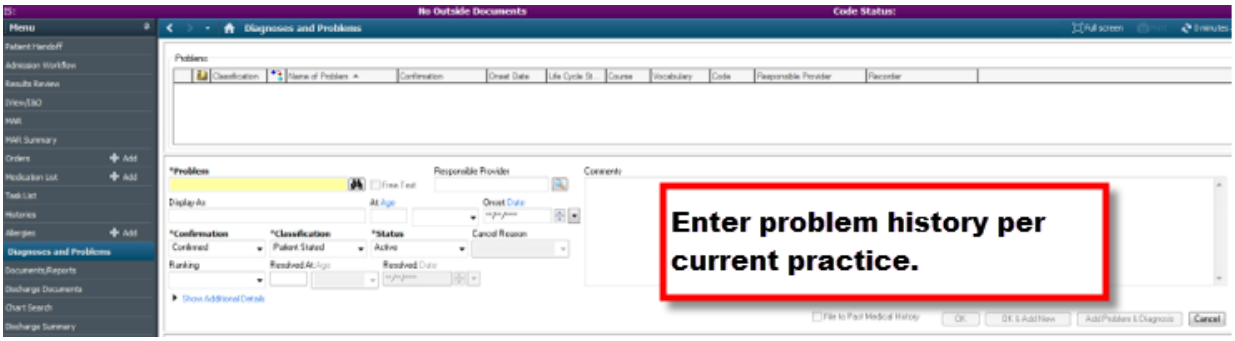


- Select the refresh button and the added problems will display in the Verified Local Record Data section.
- Now that outside record problems have been reconciled, click **Complete Reconciliation**.

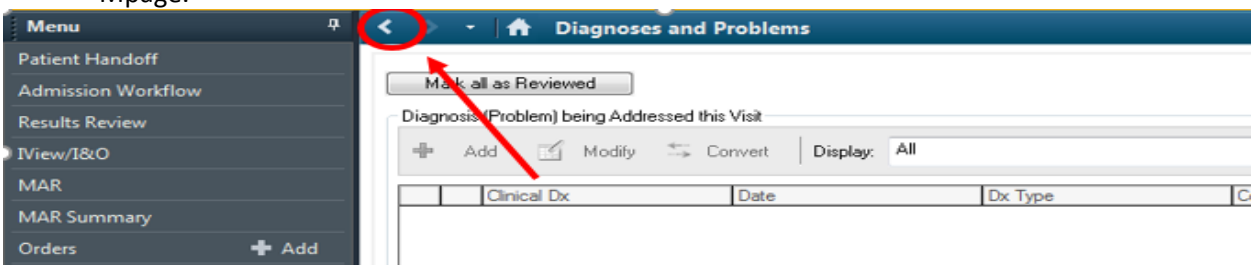


- **Second - Add New or Modify Existing Problem**- Click on the Histories component name to enter the Problem tool. Add appropriate problem information as you do today and select OK in the Problem tool once complete.

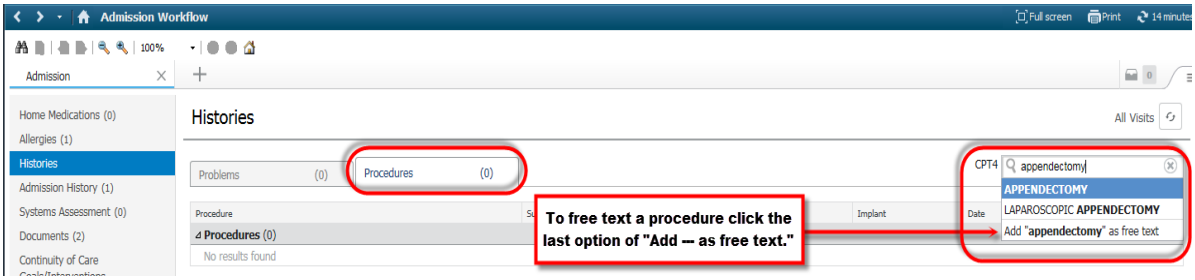


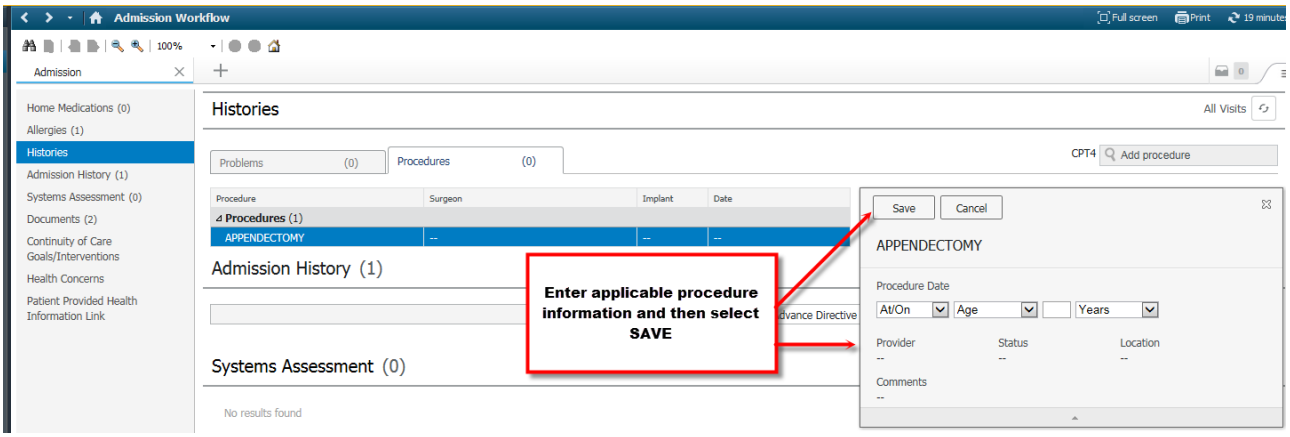


- When problems are complete, click the back button to return to the Admission Workflow Mpage.

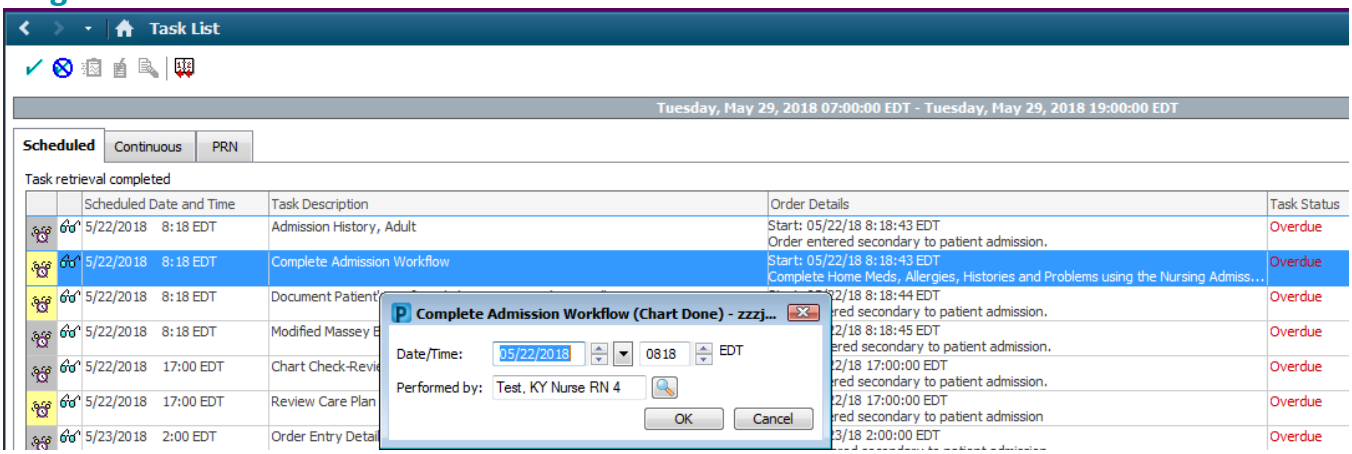


- **Third - Add Procedure-** Click on the **Procedures Tab** and then enter the name of the procedure in the **Add Procedure** search box.
  - A list of procedures to choose from will display. Select the appropriate procedure, enter applicable procedure information then select Save.
  - If the clinician chooses to free text the procedure, select the last option in the drop down list to add as a free text.



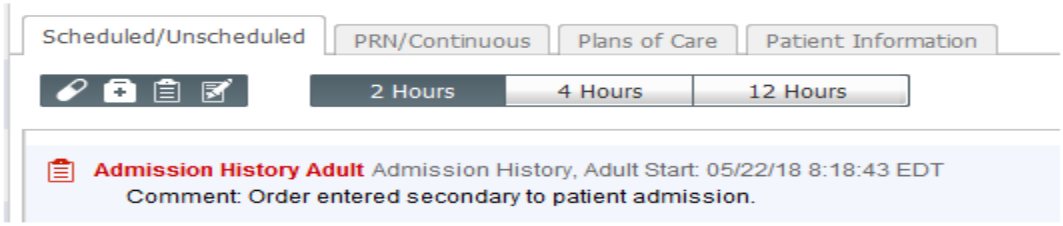


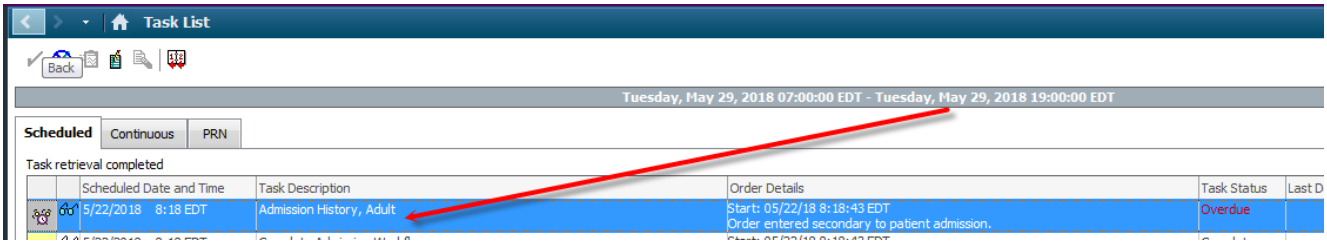
Complete the Complete Admission Workflow Task from the CareCompass or Single Patient Task List.



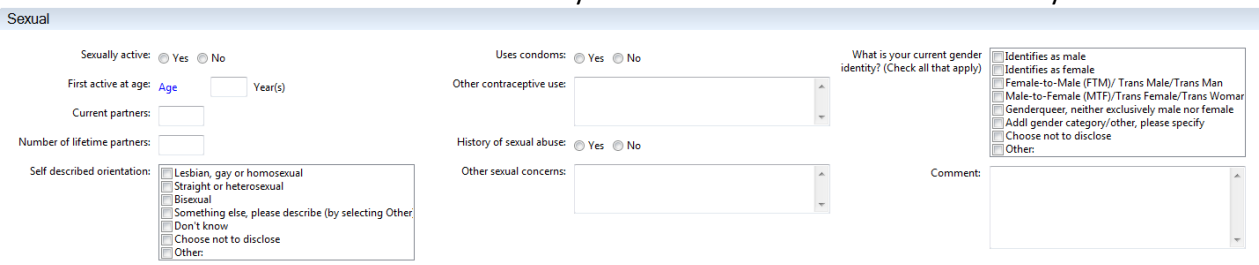
COMPLETE ADMISSION HISTORY TASK- SECOND STEP OF ADMISSION INTAKE

- The Nurse will receive a task (via CareCompass/Single Patient Task List) displaying "Admission History Adult".

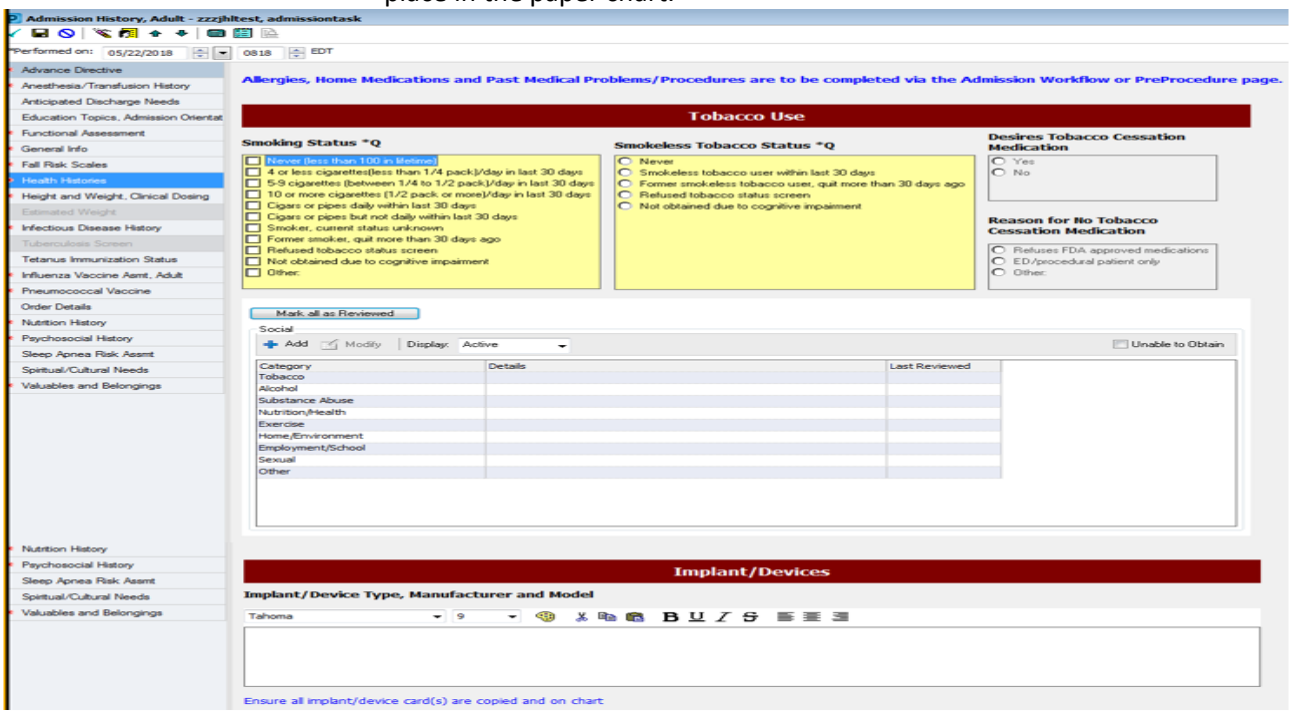




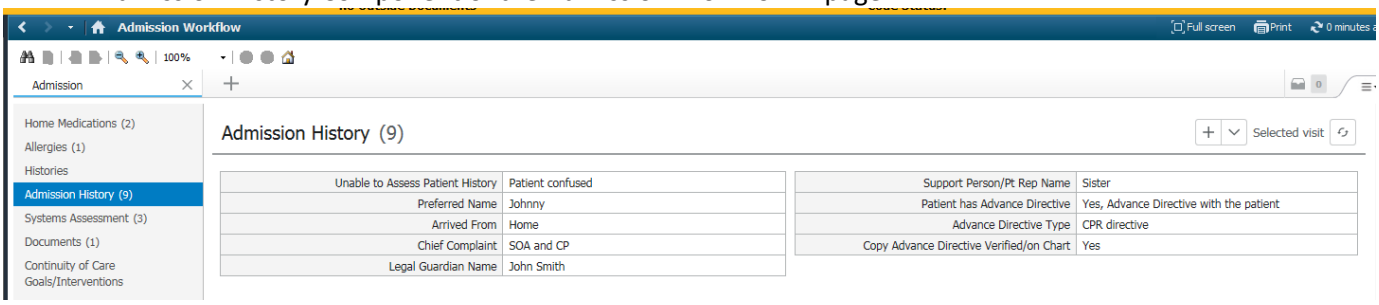
- Click on the task for the form to display.
- The following sections have been removed and will only be available in the Admission Workflow Mpage just as previously explained up above:
    - Home Medications
    - Allergies
    - Problems
    - Procedures
- A new section called Health Histories will display and include the documentation for the following <u>NOTE:</u> All fields are to be addressed:
    - Smoking Status
    - Smokeless Tobacco Status
        - Desires Tobacco Cessation Medication
        - Reason for No Tobacco Cessation Medication
    - Social History Control/Tool- enter additional social history information such as ETOH use, Substance Abuse, etc.
        - **Sexual Orientation Gender Identity (SOGI)-**Additional section added to the social history control can be documented as clinically indicated.



- Implant/Devices- New free text field for the nurse to enter the type of implant or device along with additional information if needed.
    - REMEMBER- Always get a copy of device and implant ID Cards and place in the paper chart.



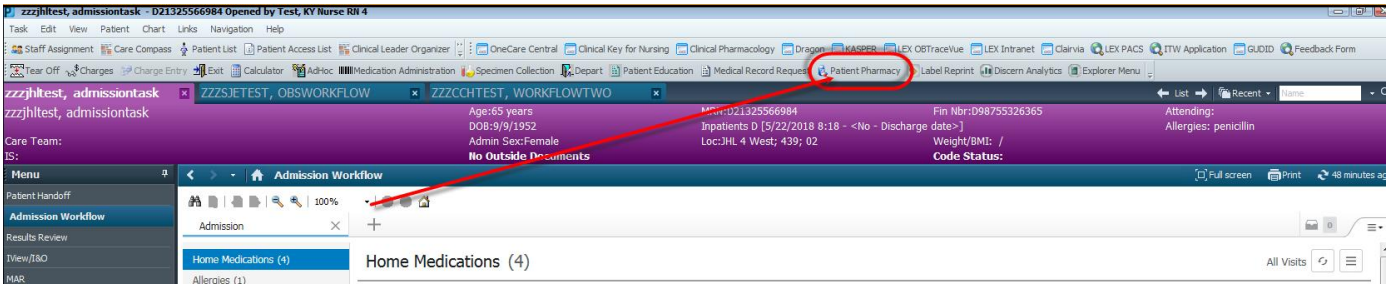
- Pertinent fields documented in the Admission History PowerForm will display within the Admission History Component of the Admission Workflow Mpage.



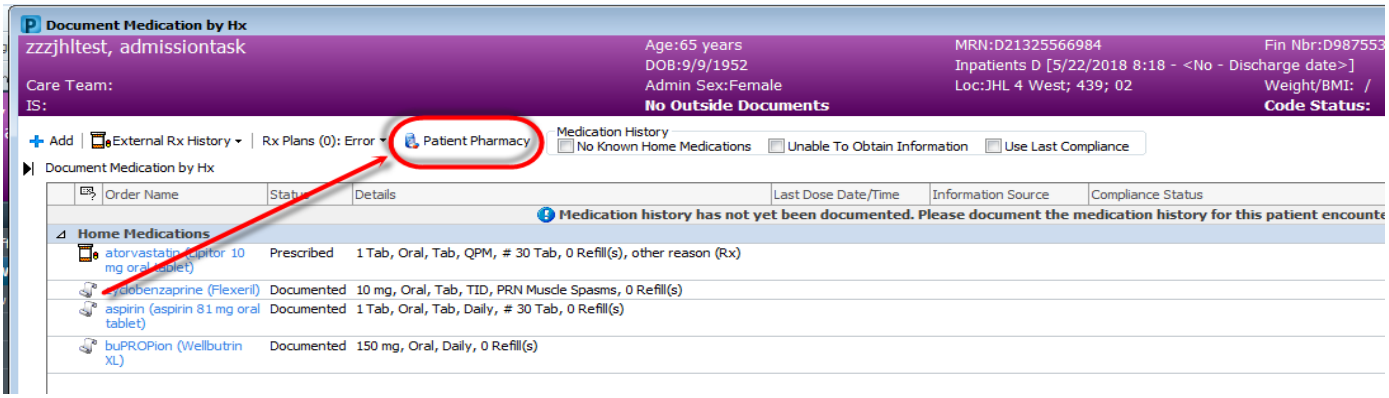
Complete the Patient Preferred Pharmacy task once the patient's pharmacy is entered into the Patient Pharmacy Tool

- The Patient Pharmacy Tool can be accessed one of two ways

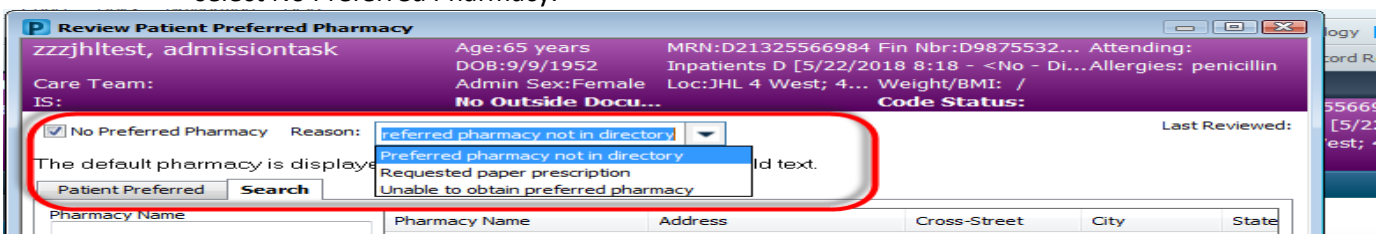
From the Tool Bar



From the Document Home Medication Tool

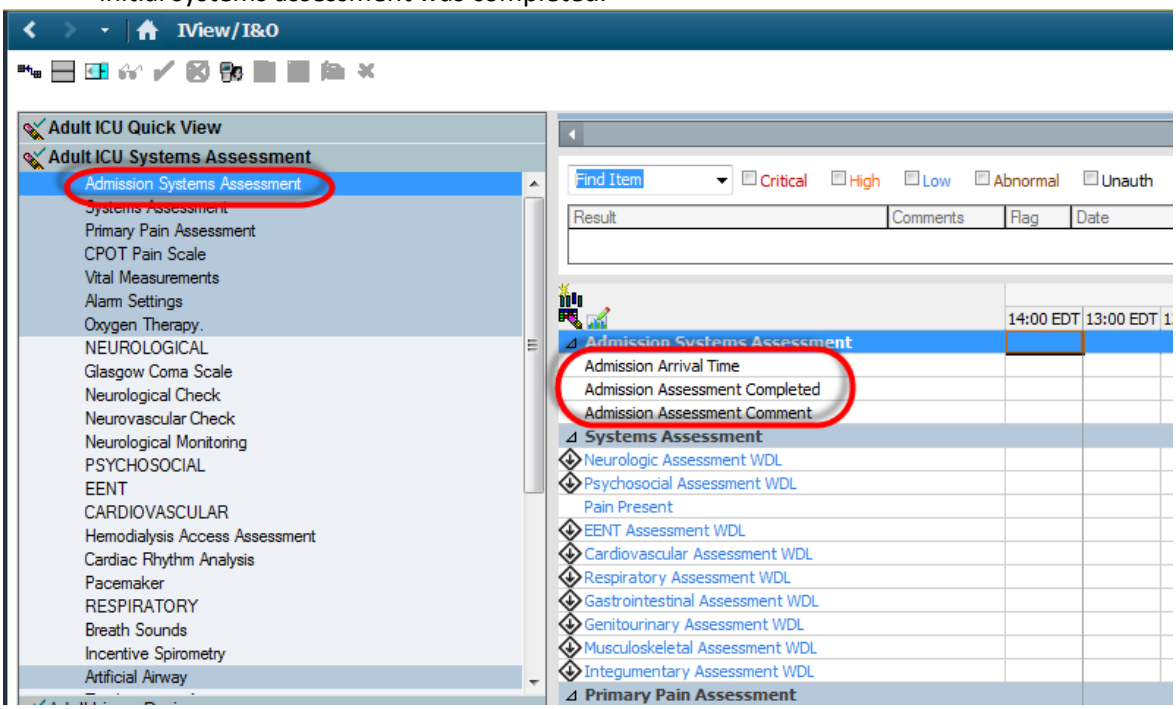


- Reminder- If the patient's pharmacy does not display in the search results, be sure to select No Preferred Pharmacy.

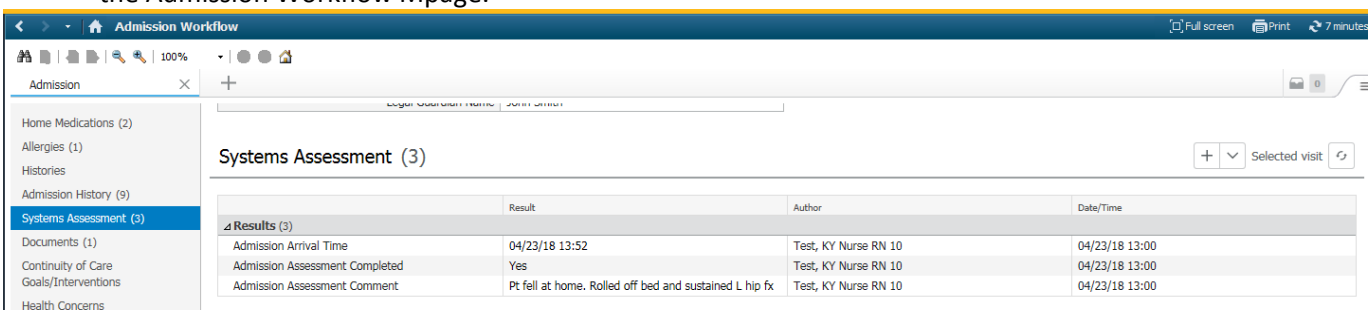


Admission Systems Assessment Documentation

- A new Admission Systems Assessment section will be available within each Systems Assessment IVIEW Band. This section is for the nurse to document the patient's arrival time to the admitting nursing unit and the date/time the initial head to toe assessment was completed.
- These fields, if documented, will pull into the Systems Assessment component in order to easily identify the date/time the patient arrived to the nursing unit as well as what date/time the initial systems assessment was completed.



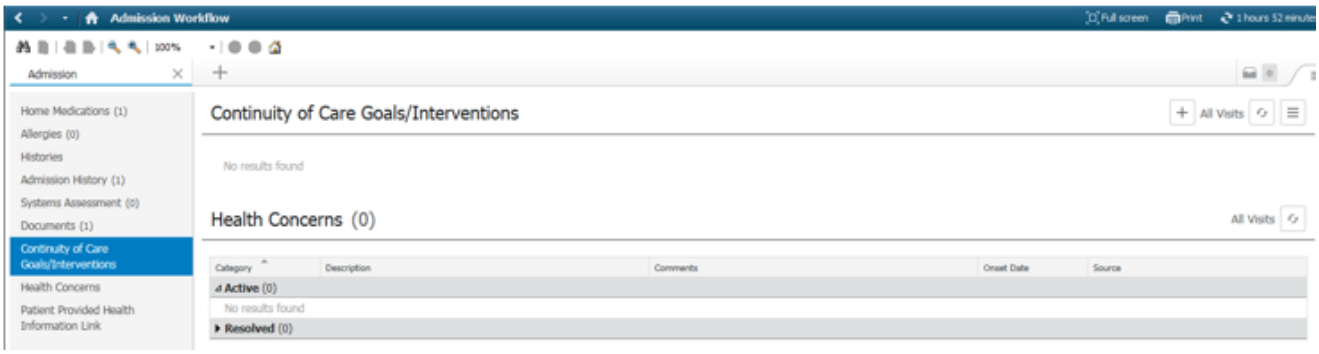
- The Admission Systems Assessment fields will pull into the Systems Assessment component of the Admission Workflow Mpage.



Additional PI Components within the Admission Workflow MPage- Not Required to be completed/documented by Nursing:

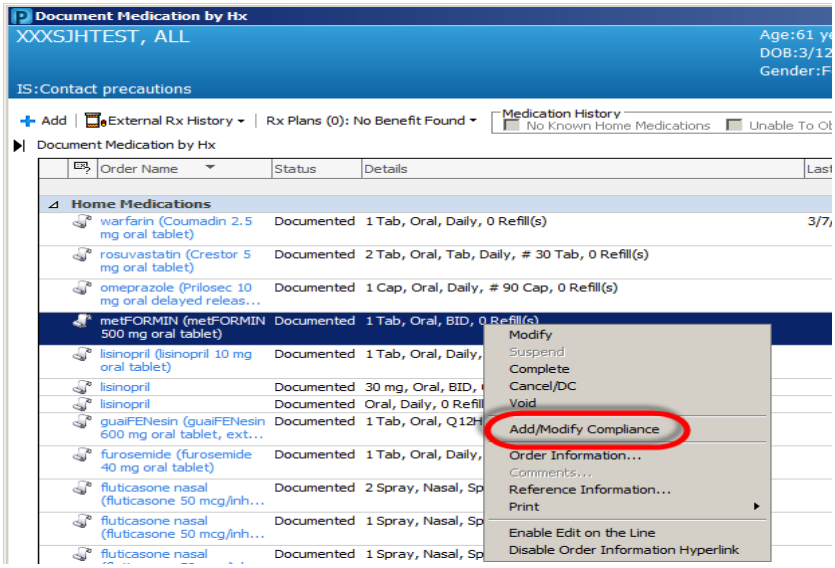
- **Continuity of Care Goals/Interventions (see additional tip sheet for more information)**
  - Clinicians can enter long term goals that are ongoing after discharge (for after the patient's admission- Not the same as the patient's Plan of Care during the patient stay)
  - These goals and interventions can be viewed by the patient within the patient's summary in the patient portal.
- **Health Concerns (see additional tip sheet for more information)**

- Nursing can view any health concern entered by the Case Management team. Health Concerns entered by Case Management do flow from encounter to encounter. As well, are viewable by the patient in the patient portal.



Weights

- Routine Daily Weights – go to Task List to complete & it will flow to iView.
- Update Clinical Dosing Weight – will flow to pharmacy. Clinical Dosing weight is entered on Admission History Power Form Documentation.
- **Documentation Home Medication History**



Clinical Reconciliation Quick Reference Guide

Home Medications, Allergies, Problems and Procedures will now be documented via the Admission Workflow mPage. Below is a quick reference guide with reminders on how to enter the clinical documentation.

Home Medication Reminders

- **No Outside Sources are available to review**

- If "No Results Found" displays- Click the COMPLETE HISTORY button and continue documenting home medications as you do today, once the Home Med tool displays.

- **Outside Sources are available for review**
  - If medications from outside sources display (meds with ◆)- Left click anywhere on the line and select ADD or DECLINE.
  - Once all outside source medications have been added or declined, click on the COMPLETE HISTORY button and continue documenting home medications as you do today, once the Home Med tool displays.
- **Home Medication Documentation within the Home Med Tool Reminders:**
    - Prescription bottles- COMPLETE
    - Update the added outside medications with the appropriate dose, route, frequency, last taken, etc.

Allergies Reminders

- **No Outside Sources are available to review**
  - If "No Results Found" displays- Click the COMPLETE RECONCILLIATION button.
  - Next, click on the Allergies header to open the Allergy tool.
  - Update Allergies as applicable:
    - Click Mark As Reviewed- for those allergies already entered from a previous visit.
    - Document No Known Allergies or No Known Medication Allergies if applicable.
    - Add any other additional allergies the patient may have
- **Outside Sources are available for review**
  - If allergies from outside sources display (allergies with ◆) - Left click anywhere on the line and select ADD or Decline.
  - Once all outside source allergies have been added or declined, click on the COMPLETE RECONCILLIATION button.
  - Next, click on the Allergies header to open the Allergy tool.
  - Update Allergies as applicable
  - Update Allergies as applicable:
    - Click Mark As Reviewed- for those allergies already entered from a previous visit.
    - Document No Known Allergies or No Known Medication Allergies if applicable.
    - Add any other additional allergies the patient may have

Histories (Problems and Procedures) Reminders

- **No Outside Sources are available to review**
  - If "No Results Found" displays- Click the COMPLETE RECONCILLIATION button.
  - Next, click on the HISTORIES header to open the Problem List tool.
  - Update Problem list as you currently do today.
- **Outside Sources are available for review**
  - If Problems from outside sources display (problems with ◆)- Left click anywhere on the line and select ADD or Decline.
  - Once all outside source problems have been added or declined, click on the COMPLETE RECONCILLIATION button.
  - Next, click on the HISTORIES header to open the Problem List tool.
  - Update Problem list as you currently do today.

- **Problem List Documentation Update Reminders**
    - For any problems that are no longer active for the patient (ie sore throat, pneumonia, cellulitis, etc)- be sure to change the status to RESOLVED.

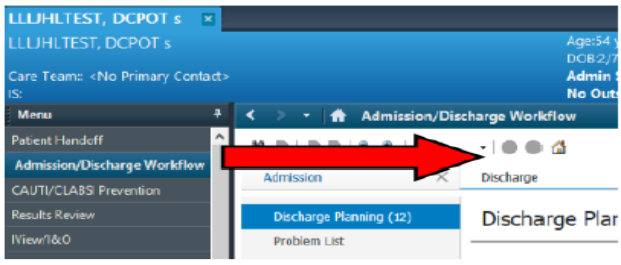
- **Procedures will not pull in from outside records.**
    - Click on the Procedure tab and enter the applicable procedural history.
    - To freetext from the mPage- Type the name of the procedure in the search field and select the last option of "Add "……" as freetext".

Discharge Workflow Process

Overview:

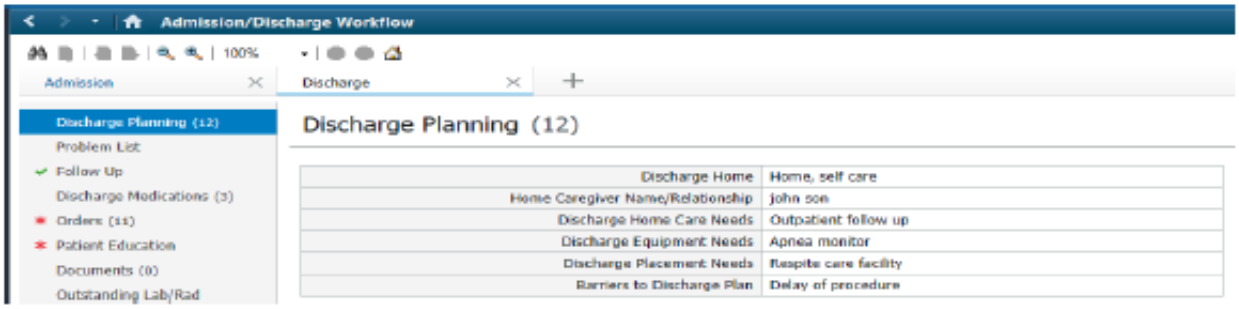
- Review discharge orders and coordinate discharge with care team, patient and family. (You can check for orders in the Order Profile and check for discharge information in the Discharge Planning component).
- Review and complete all components of the Discharge Workflow. There will be gap checking components that will have a red asterisk next to them, once completed they will change to a green check mark.
- Click on Discharge Instructions to generate a document with a preview of the patient handout. Review the document and edit as needed. Click Sign/Submit in the bottom right hand corner.
- The Sign/Submit Note screen will display. Click Sign and Print in the bottom right corner.
- Important information to know is that once the discharge Instructions are generated to a document, if changes are needed to be made, ALL the information previously documented will have to be re-entered.
- Note an * Asterisk indicates a gap checking component.

The Discharge Workflow page is located in the same section as the admission within the table of contents where nursing will complete discharge documentation.



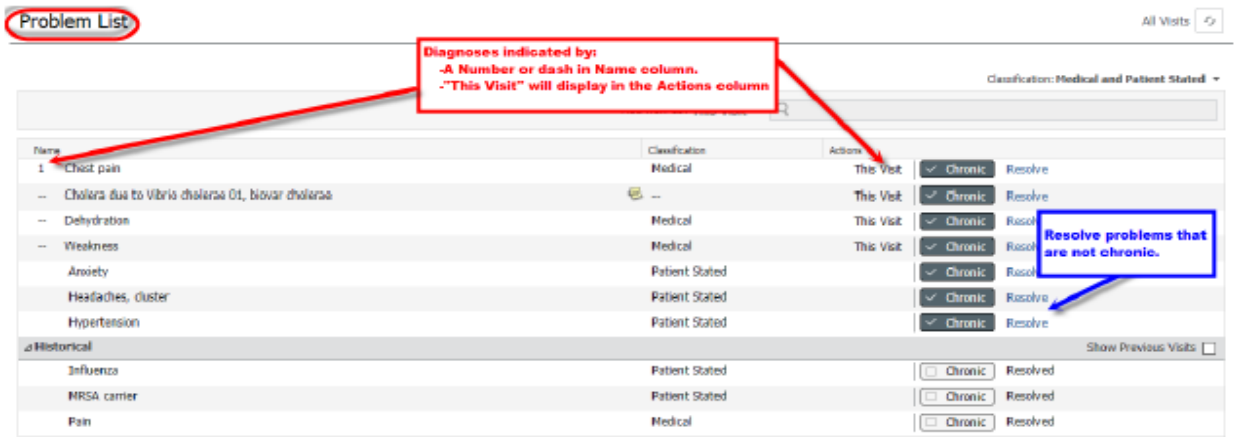
Discharge Planning

- Displays discharge planning documentation completed by case management.



Problem List

- Displays the patient's diagnosis and current problems from this visit that have a medical or patient stated classification.
- Resolve Problems at the time of discharge to ensure an up to date problem list. Resolved problems will move down to the Historical section.
    - Click on the blue resolved link, for any problems that are no longer active or have been resolved prior to discharge. This will help having an accurate problem list for future visits.
    - DO NOT resolve Diagnoses. Diagnoses can be identified with a number or dash in the first column or will display as "This Visit" in the column.
- DO NOT click on/deselect any chronic button. Deselecting the chronic button cancels the problem.
- Click on the problem list header to access the current problem/diagnosis tool.



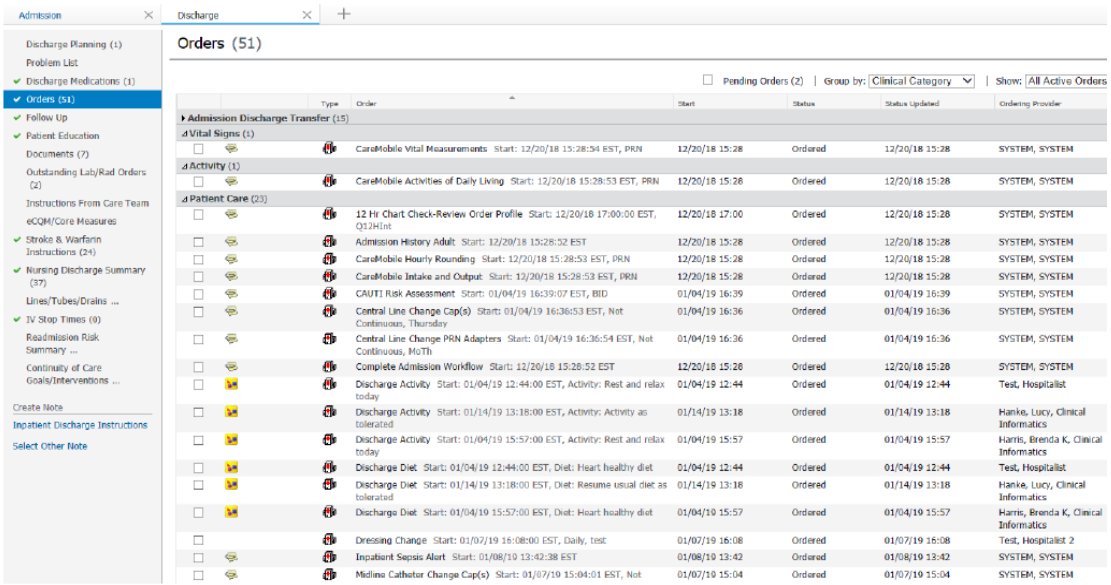
Discharge Medications

- Captures the current state of medication history and discharge medication reconciliation if completed.
- A red asterisk will display until the discharge medication reconciliation has been completed.

- Discharge prescriptions will display with a pharmacy icon.

Orders

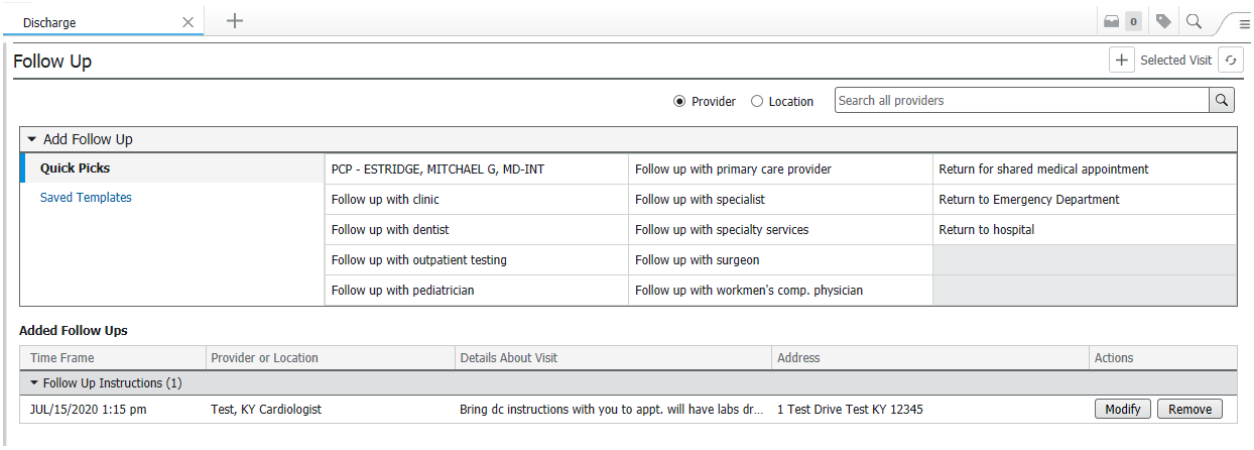
- Orders profile allows viewing of current active orders. If no discharge order is entered, there will be a red asterisk.
- Orders completed from the discharge powerplan will automatically pull into the printed discharge instructions.
- The orders will display under clinical categories and will be alphabetical.
- Majority of discharge orders will display in the patient care section.
- Clicking on the Orders header will navigate o the current orders profile.



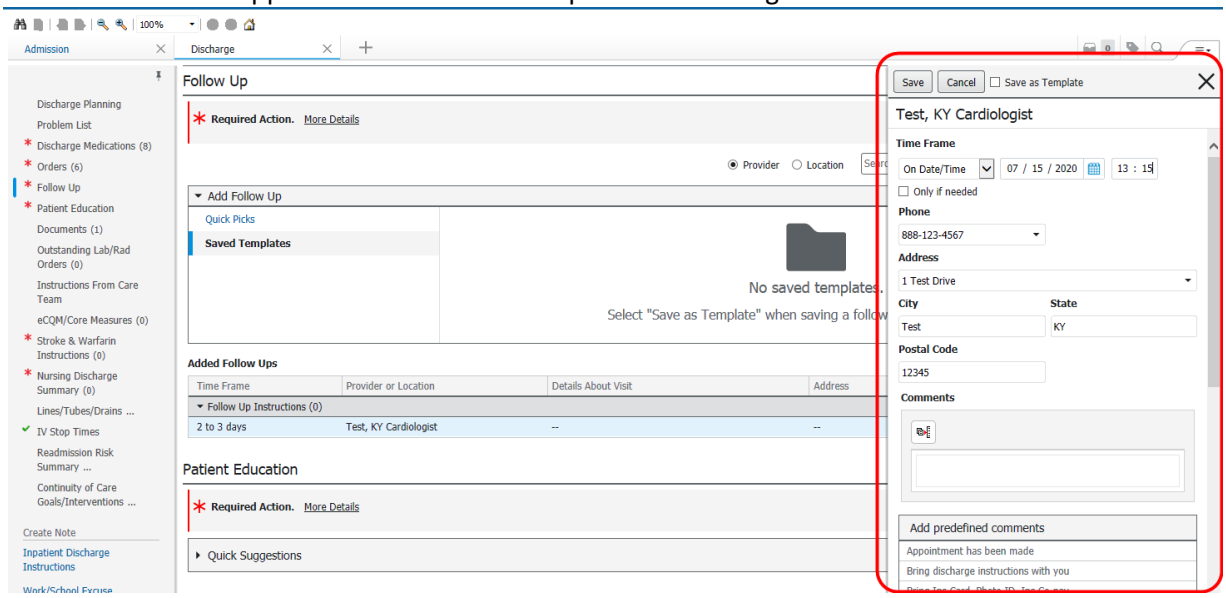
Follow Up Appointments

- To add a follow up, type provider or lcation name in the search bar, select appropriate time frame and comments if applicable. Click save when done.
- A red asterisk will remain on the menu component heading until at least one follow up appointment has been added.

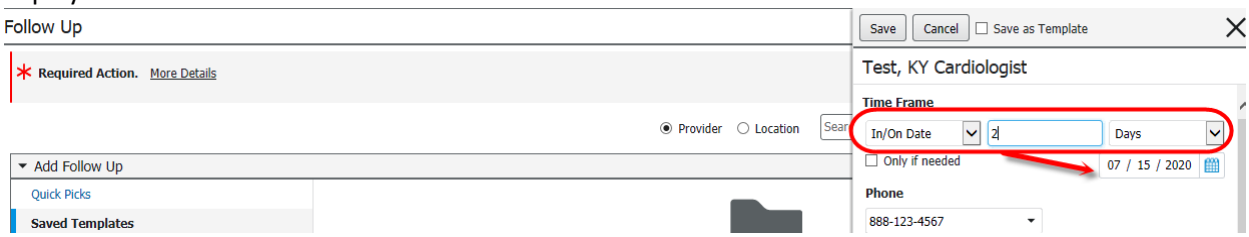
- All follow ups, whether appointments or not will show under the Follow U p Instructions" section.



1. Search for the desired provider by entering first or last name (note, even part of the name) and the select the appropriate provider. The additional details window will display to the right once
2. Enter the appropriate follow up information (date/time, comments, etc).
3. Select SAVE for the appointment to flow to the patient's discharge instructions.

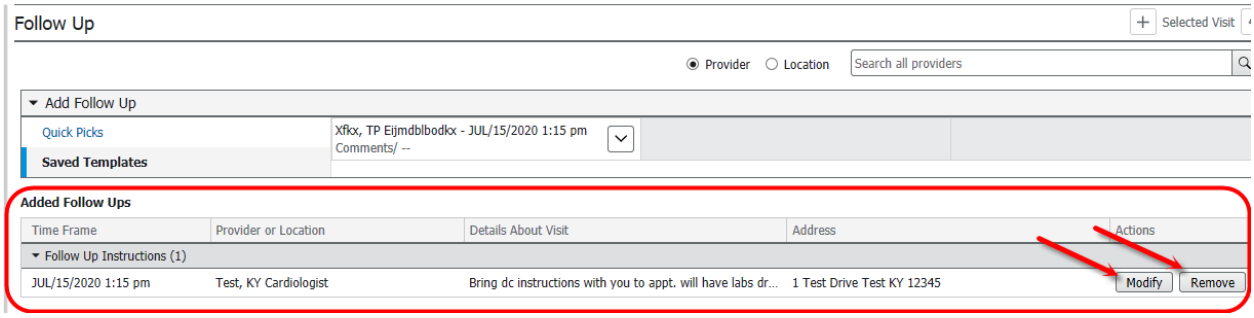


4. When selecting the Time Frame of In/On <<# of days>>- the system will also automatically display the correct date.



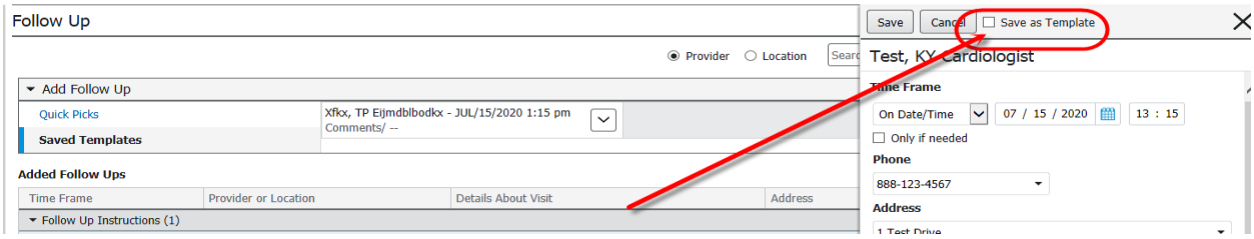
5. Follow Up appointments will display under the Added Follow Ups section.

6. To change/update or delete a previously entered follow up appointment, use the corresponding Modify and/or Remove buttons to the right.

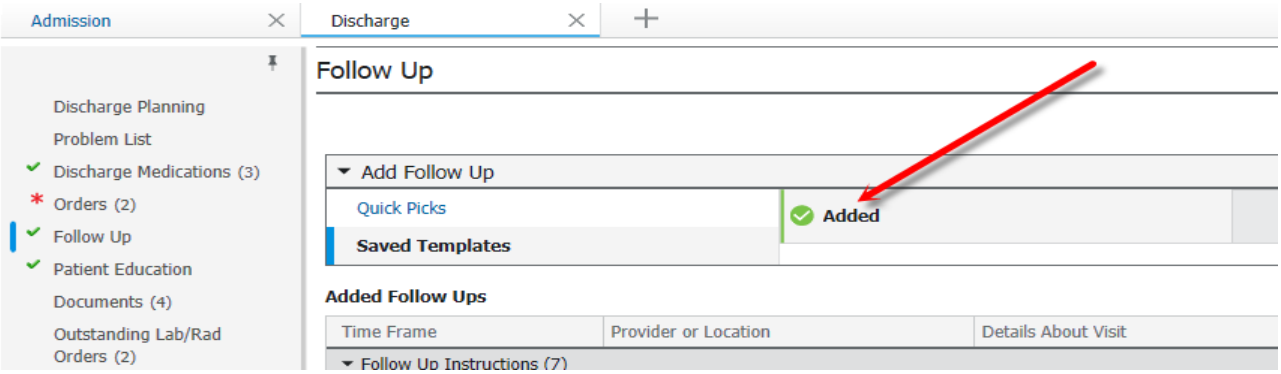


"Saved Templates" is now the term for Saved Favorites within the Follow Up workflow component.

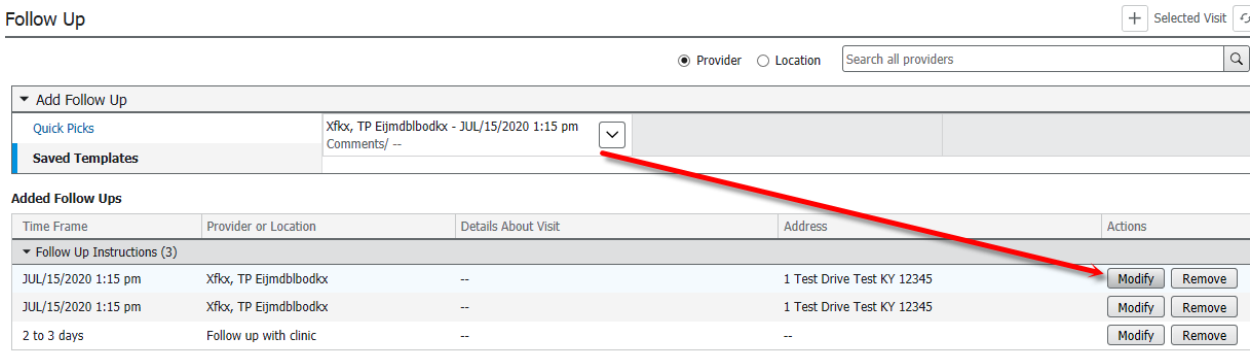
1. To save a provider to your favorites/templates, click on the "Save as Template" box prior to saving the entered follow up appointment.



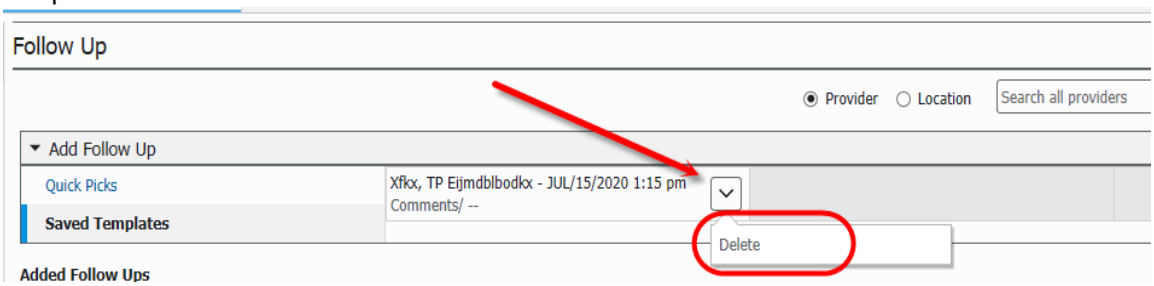
2. Click on "Saved Templates" to access your saved favorites.
3. Next, click on the desired saved provider follow up appointment. The system will display a green "Added" icon to notify the user that the appointment has been added. Next Modify the appointment with the applicable information for the patient.



4. To modify the added saved follow up appointment template/favorite- click on the Modify button for the corresponding appointment. The additional details window will pop up to the right-Make any additional upates (appt date/time, comments, etc).

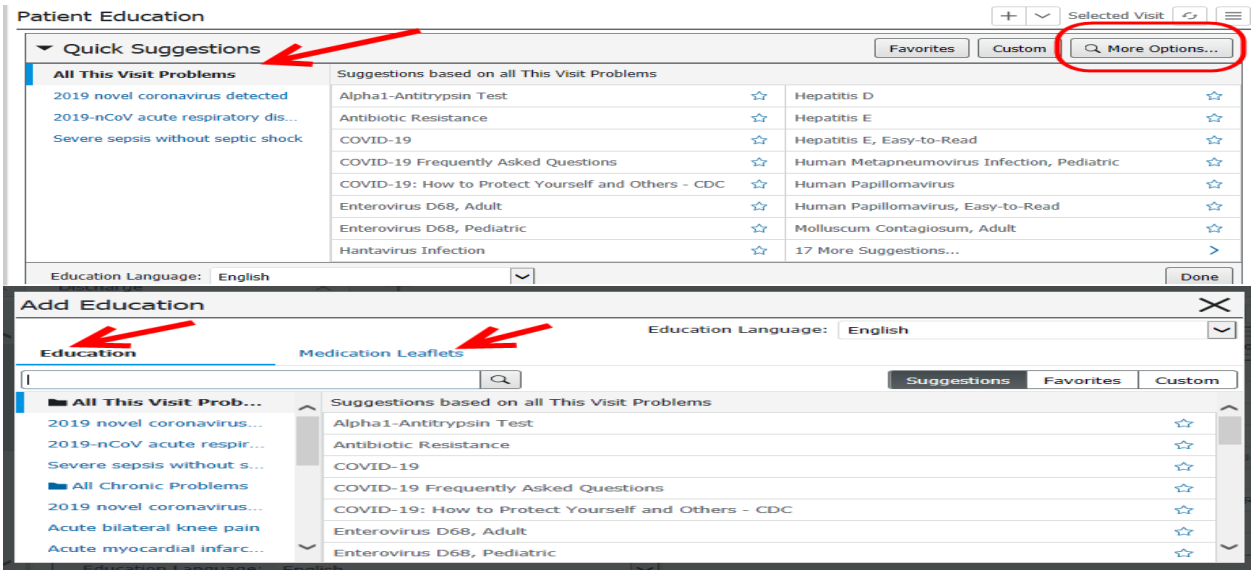


5. To delete a Saved Template, simply click on the Delete from the drop down arrow of the saved template.

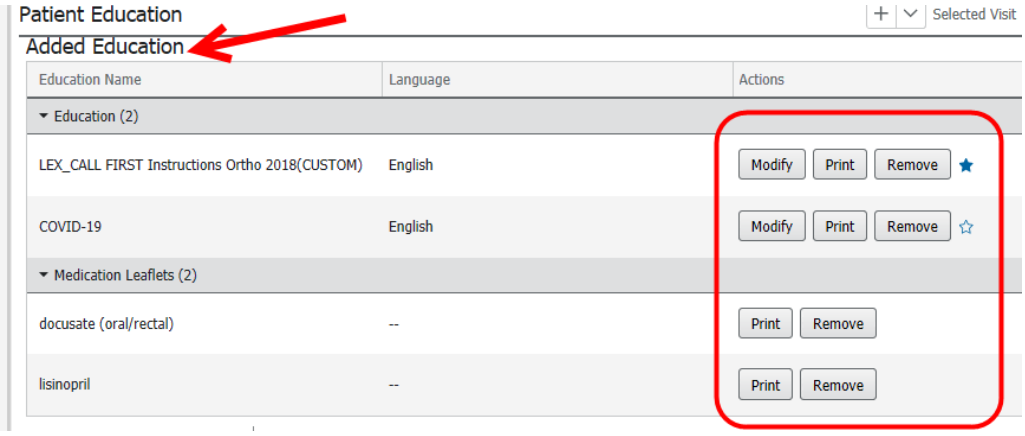


Patient Education

- Allows one to add, modify and print education and medication leaflets.
- A red asterisk will remain on the menu component heading until at least one eudcation leaflet has been entered.
- Suggested education based on the pateint's documented diagnopsis will display under the suggested table.
- Click on "More Options" to search for education leaflets that did not display under the suggested column. And then click on the desired Education vs Medications header.



- Selected education materials will display under the “Added Education” section
- Modify topics as needed by clicking on the “Modify” button.
- Click on the “Remove” button if added leaflet is no longer needed.

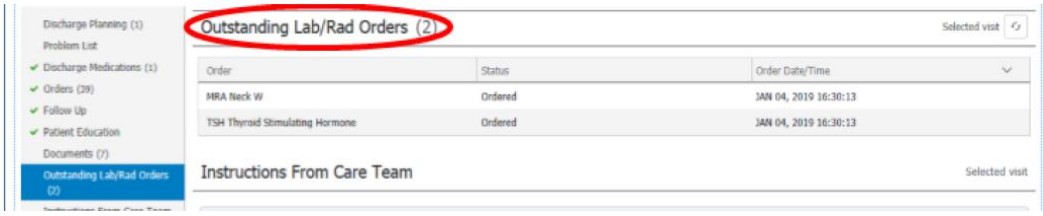


Documents

- Displays physician notes and ancillary notes surroudning discharge planning.
- Double click on the document to view the actual documentation.
- Clicking on the Document header will open the current Documents/Reports page.

Outstanding Lab/Rad Orders

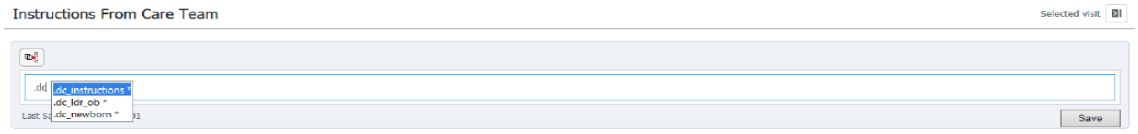
- Displays any outstanding Lab and Radiology orders.
- Clicking on the Outstanding Lab/Rad Orders header will navigate you to the Orders Profile.

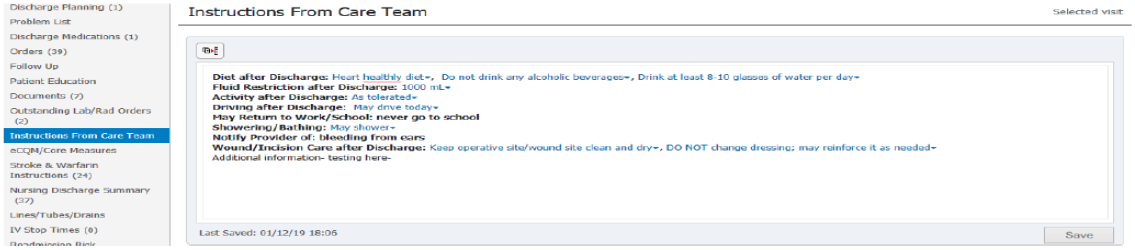


Instructions From Care Team

- Allows the provider or nurse to complete discharge instructions in the event a discharge PowerPlan was not utilized by the provider for the discharge instructions.

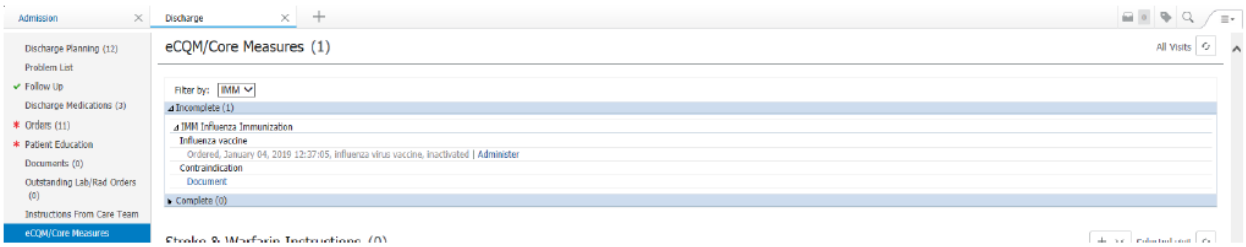
- Reminder- The Orders component will display the discharge PowerPlan/discharge orders within the pateint care section. If no PowerPlan was used, the nurse should pull in the appropriate .dc autotext to complete.
- Note- A provider can also pull in the dc autotext template. If this has been done, it will display in the component and the nurse only has to make any additional updates.
- DO NOT DELETE ANY PREVIOUSLY ENTERED INSTRUCTIONS IN THIS COMPONENT, unless it is no longer applicable.
- The .dc autotext will pull into the instructions from your care team section within the printed discharge instructions.
- Type .dc for the discharge instruction tempaltes to display, and selected the desired template.
- The user will need to delete any topic headers or rdop downs that are not applicable to the patient's discharge instructions.
- Freetext can be added anywhere in the component for additional instructions that are needed.
- This is a multi contributor component. Once again- DO NOT DELETE ANY PREVIOUSLY ENTERED INSTRUCTIONS IN THIS COMPONENT. Unless it is no longer applicable to the patient.
- Always remembe to hit SAVE at the bottom right hand corner of the component with each entry. If you do not hit save, the entered instructions will not save to the component for future use or flow into the printed discharge instructions.





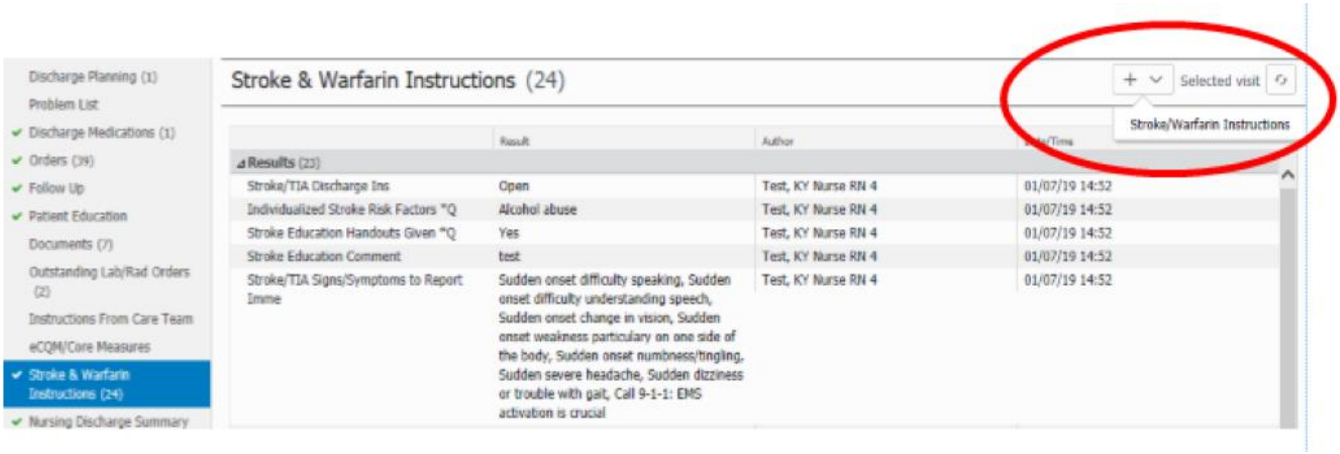
eCQM/Core Measures

- Displays the eCWM/Core Measures that is also available under the Patient HandOff.



Stroke and Wafarin Instructions

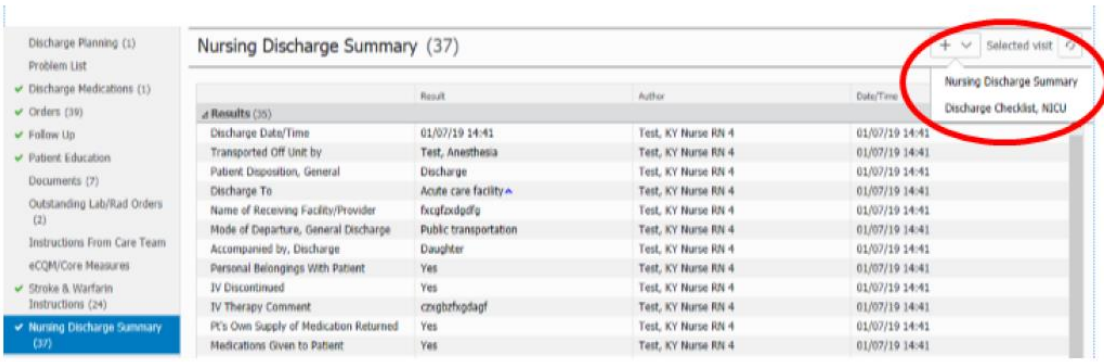
- Clicking on the plus icon will open the PowerForm fore Stroke/Warfarin Instructions.
- A red asterisk will remain on the menu component heading until the instructions have been addressed.
- Applicable stroke and warfarin documentation will display for viewing.



Nursing Discharge Summary

- Clicking on the plus icon  will display a drop down with the current PowerForm for Nursing Discharge Summary.
- A red asterisk will remain on the menu component heading until the Summary has been addressed.

*Note: The summary will be the last component of the discharge process to complete after the patient has left the building.



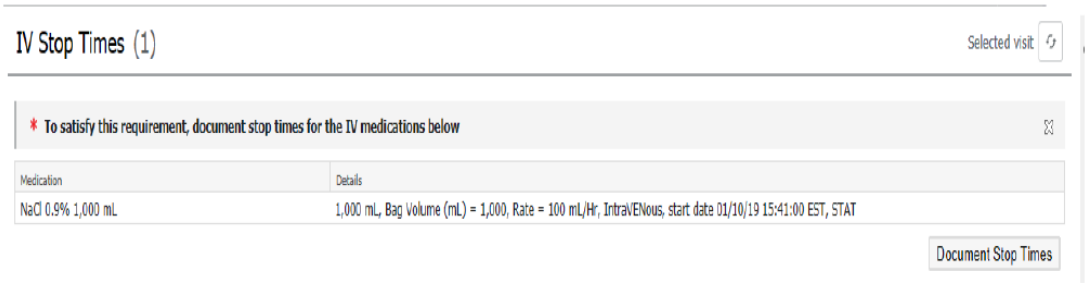
Lines/Tubes/Drains

- Displays all active lines/tubes/drains. (dynamic groups that are still open/activated).
- Inactivated lines/tubes/drains from IVEIW will dsiplay in the discontinued sections.
- Clicking on the plus icon will display a drop down with with the Audlt Lines-Draqins IVIEW band and clicking on this link will open IVEIW band to review or update documentation.

- Remember- always document the discontinuation of all lines and deactiveate the dynamic group.

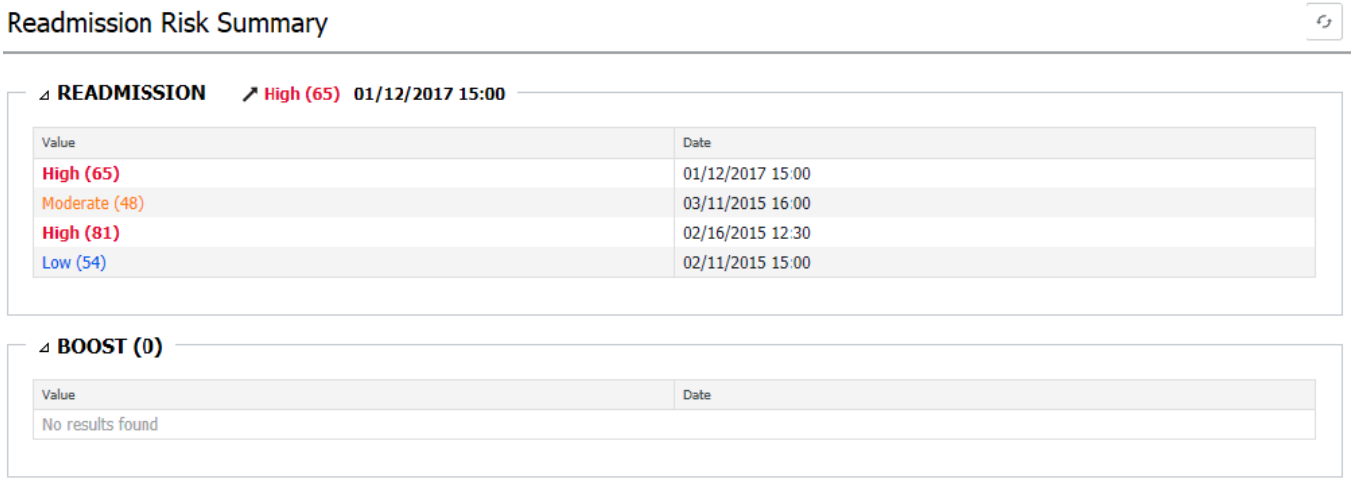
IV Stop Times

- Displays IV Infusions, that are still pending IV stop time documetnation.
- Click on "Document Stop Time" to update.



Readmission Risk Summary

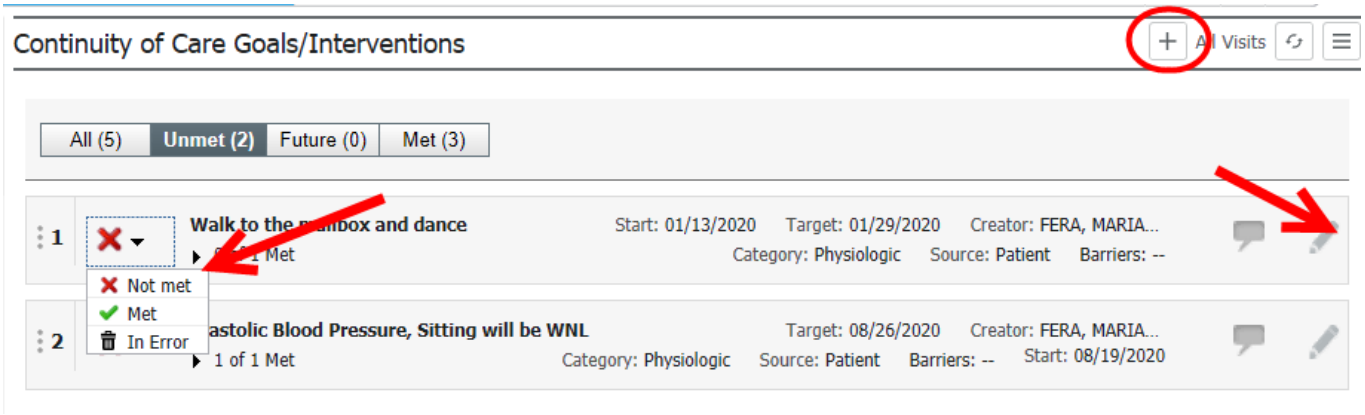
- Displays the readmission risk summary and the BOOST score for the current visit.
- Click on the desired score to display the contributing factors.



Continuity of Care Goal/Interventions

- Goal and interventions can be updated from this component.
- Each patient (if alert and oriented) is to have at least 1 patient stated goal per visit.

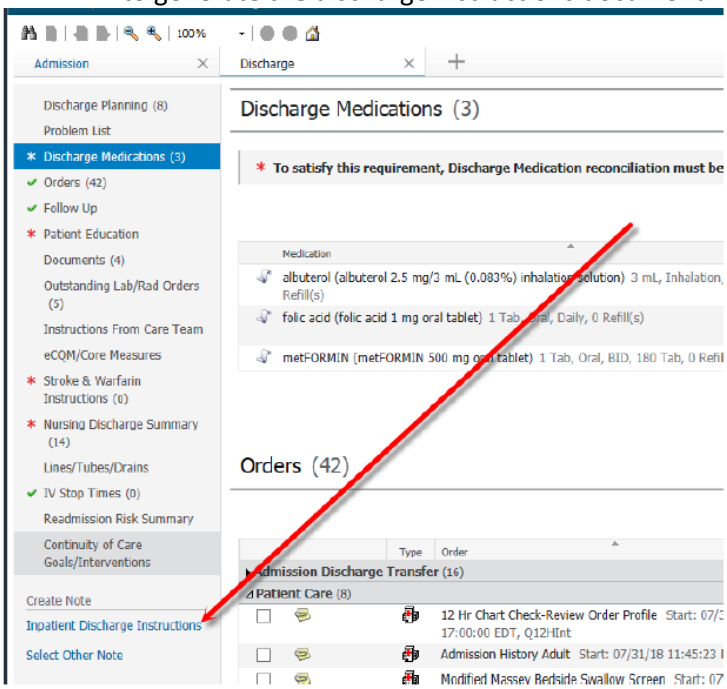
- These goals and interventions will display in the printed discharge instructions and the patient portal.
- Click on the  icon to add a new goal
- To edit a goal or intervention, click on the pencil.
- To mark a goal as met or not met, select the drop down arrow and click the desired icon



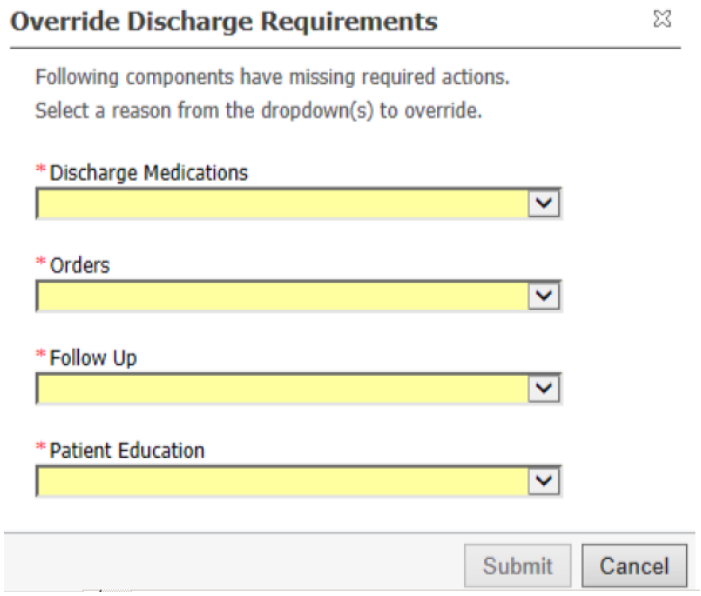
Generate and Printing Discharge Instructions

Inpatient Discharge Instructions

- Once all discharge components are completed, click on the Inpatient Discharge Instructions link to generate the discharge instructions document.



- The system will require an override reason if any of the below components are not completed:



Inpatient Discharge Instructions Components

The printed discharge instructions are divided into the following sections.

- Your Visit Summary
- What to do next
- Warfarin Instructions
- Medications
- Allergies
- Immunizations This Visit
- Stroke/TIA Instructions
- Education Materials
- Emergency Awareness and Preventative Care
- Patient Portal
- Test Results
- Signature Page

Only sections that contain documentation and instructions will print out once the nurse prints the discharge instructions.

You can remove certain sections from the printout by hovering over the component and clicking on the "X" to remove. In addition, you can always free text more information in the Patient Instructions component. This is the opportunity for the nurse to make sure that what they are handing the patient makes sense and will support their patient for a safe discharge. Review the document with the patient and remember that copy of this will be sent to the patient portal.

Your Visit Summary

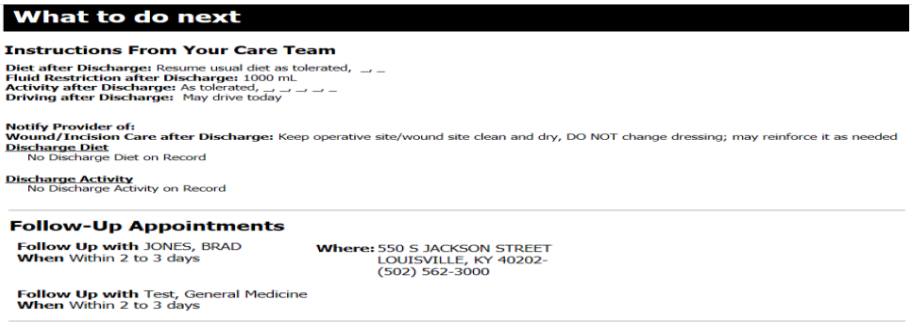
- Your Visit Summary section will include the following components.

- Your Care Team- displays admitting, attending, primary care and referring physicians.
- Your Diagnosis- displays the discharge diagnosis documented by your physician.
- These are your Goals- displays the goals and interventions entered.
- Tests Performed-displays any lab or rad test performed during the visit.
- Discharge Vitals- displays the most recent vitals taken within the last 4 hours.

- Each component can be removed or modified.
- Free text is allowed within each section.

What to do next

- This section will display instructions such as diet, driving instructions, wound care, etc. that was entered from the Discharge MPage.
  - Discharge orders from the Discharge PowerPlan will automatically pull in to this section.
    - Any orders that were note completed within the Discharge PowerPlan will need to be deleted/removed prior to printing.
    - If the provider did not complete the Discharge PowerPlan, then the information that the nurse entered into the Instructions from your Care Team component will display.
    - The nurse can add any additional information by feretext in this section. However, it is best to do that in the actual MPAGE, note- it will only be saved to this document. If the clinician is wanting it to save to the MPAGE for future use during the visit, then the nurse should cancel the generated document and navigate back to the discharge MPage and enter in the Instructions from you Care Team component, and then re generate a new discharge instructions document.
  - Follow Up Appointment information entered from the MPage will display after the Instructions from your Care Team.



Warfarin Instructions

- Any documentation from the warfarin PowerForm will pull into this section.

Warfarin Instructions

Indication for Warfarin Anticoagulation: Atrial fibrillation
Warfarin Anticoagulation Disposition: Initiated this hospitalization
Duration Warfarin Therapy: 3 months
Target INR: 2.0- 3.0
Physician to Manage Warfarin: aaa
Fax Order Form To: aaa
INR to be Drawn on: 01/07/19
INR to be Drawn at: aaa
Notify Provider of Signs/Symptoms of: Significant bleeding, Clot
Warfarin Bridging Therapy: Heparin
Warfarin Dose/Frequency: aaaa
Warfarin Bridging Therapy Dose, mg: 3 mg
Warfarin Bridging Therapy Dose, Units: 3 Units
Warfarin Bridging Therapy Route: Subcutaneously
Warfarin Bridging Therapy Frequency: Daily
Warfarin Edu Materials Provided to Pt: Coumadin booklet
Warfarin Special Instructions: 3

Medications

- Displays the discharge home medications as ordered by the Physician and DC Med Rec Pharmacist via the discharge medication reconciliation.
- The medications will be grouped by New, Changed, Unchanged, and Stop Taking.
- The nurse will document the next dose due in the Next column.
- The nurse can also free text any additional information in the Instructions and When columns
- UPDATES WITHIN THIS GRID DO NOT UPDATE THE MEDICATION HISTORY AND DISCHARGE MED REC TOOL. UPDATES WILL ONLY BE ON THE PRINTED INSTRUCTIONS DOCUMENT.
- ANY MEDICATION, DOSE, FREQUENCY CHANGES MUST BE MADE VIA THE DISCHARGE MED REC TOOL BY A PROVIDER OF PHARMACIST.

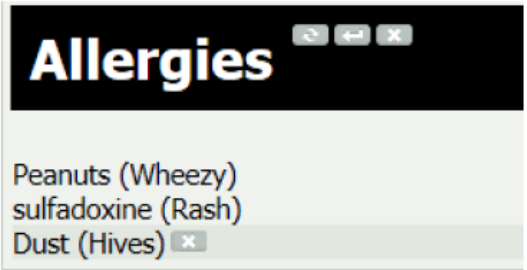
Medications

	What	How Much	When	Why	Instructions	Next Dose
New	aspirin (Aspir 81 oral delayed release tablet)	Tab1 Oral	Every Day	COPD (chronic obstructive pulmonary disease)		
Changed	metoprolol (Metoprolol Succinate ER 50 mg oral tablet, extended release)	1 Tablet(s) Oral	Every Day			
Unchanged	topiramate (Trokendi XR)	25 Milligram (s) Oral	Every Day			

	What	How Much	When	Comments
Stop Taking	ARIPiprazole (Abilify 5 mg oral tablet)	1 Tablet(s) Oral	Every Day	
Stop Taking	melatonin (Melatonin 3 mg oral tablet)	1 Tablet(s) Oral	At Bedtime	

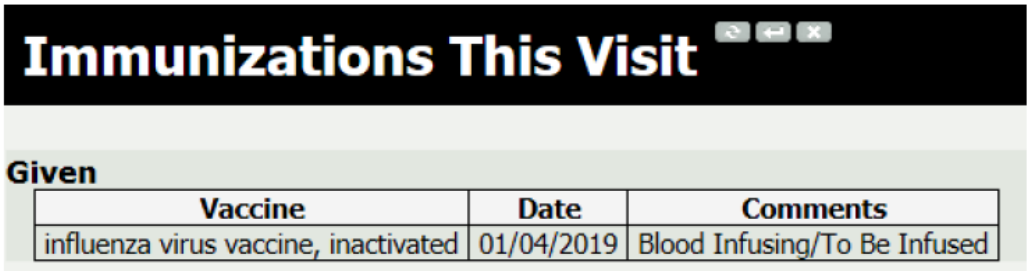
Allergies

- Active allergies with reactions will pull into this section.



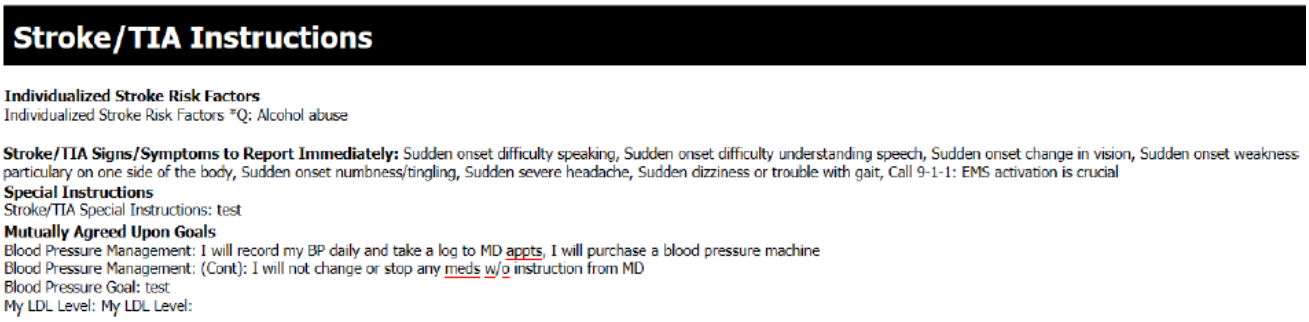
Immunizations This Visit

- Displays any immunization given this visit.
- Note: Comments documented from early/late reason will pull into the comment's column.



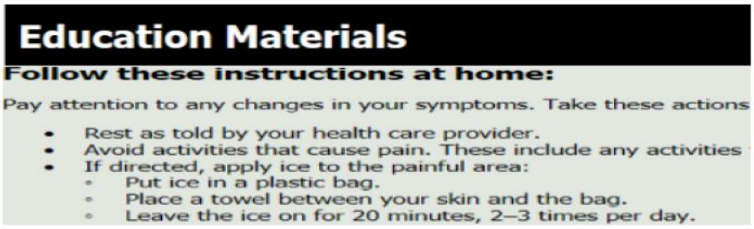
Stroke/TIA Instructions

- This section is pulling forward the Stroke Instructions forms documented on the MPage, to indicate if the patient needed Stroke Education.



Education Materials

- All Education Material added from the MPage will display.



Emergency Awareness and Preventative Care

- This section will print for each patient and cannot be removed.
- Each section is part of Joint Commission regulatory requirements for patient awareness and preventative care after discharge.

Emergency Awareness and Preventative Care

STROKE is an EMERGENCY
Every Minute Counts

Act **FAST** and Check for these signs:

FACE	Does the face look uneven?
ARM	Does one arm drift down?
SPEECH	Does their speech sound strange?
TIME	Call 9-1-1 at any sign of stroke

Stroke Risk Factors

Atrial Fibrillation (irregular heartbeat)	Diabetes	Family history of stroke
Heart Disease	Heavy alcohol use	High Blood Pressure
High Cholesterol	Physical inactivity and obesity	Smoking

Patient Portal

- Instructions on how to access My OneCare Patient Portal.

Patient Portal

Reminder: Be sure to sign up for the My OneCare patient portal, which gives you 24/7 access to your medical information — including these discharge instructions — using your computer, smartphone, or tablet. Just go to *kentuckyonehealth.followmyhealth.com* to get started. Questions? Call 1-888-670-9775.

Test Results

- The most recent of each lab result will display along with any radiology tests (only the test name) during the visit.

Test Results

Laboratory or Other Results This Visit (last charted value for your 12/20/2018 visit)

Hematology
01/04/19 12:28:00
WBC: 6.0 x10(3)/uL -- Normal range between (4.1 and 10.8)

Sign/Submit and Patient Signature

- The patient signature section will be the last to display. The nurse will sign this with the patient after reviewing the printed discharge instructions with the patient.
- Once the discharge instructions information has been reviewed, select the Sign/Submit Button.
- Do not click the Save or Save and Close button. This will only save the instructions and not print.
    - As a reminder, saved instructions can only be updated by the original user. A second clinician cannot make any updates.

Patient Name: LLLJHLTEST, DCPHY
I have received and understand this information and was given the opportunity to ask questions.
Patient/Representative Name: _____
Patient/Representative Signature: _____
Relationship to Patient: _____
Clinician/Hospital Representative Signature: _____
Date: _____

Note Details: Discharge Instructions, HANKE, LUCY M, RN PATIENT CARE 1, 1/13/2019 10:16 EST, Inpatient Discharge Instructions

Sign/Submit | Save | Save & Close | Cancel

Click on the SIGN & Print button to print the instructions.