

Cerner Resource Guide



Table of Contents


Nursing Standards of Documentation	5
Nursing Standards of Documentation for Critical Care	17
Build a Custom List.....	18
Shift Report	19
Clinician Communication	19
To Change Navigator Bands	19
Resetting Navigator Bands (to change back to Defaulted Settings):	19
Consult to Physician Workflow	19
Transferring a Patient	20
Using CareAdmin Quick Reference Guide.....	20
Administer Medications Using CareAdmin	20
Reschedule a Medication.....	20
Un-Chart a Scanned Medication	21
Collect a Specimen Using CareAdmin	21
Using Filters for Specimen Collection	21
Reschedule a Collection	21
Mark a Collection as Not Done	21
Order Entry & Task List Quick Reference Guide	22
Order Entry	22
Modify Orders	22
Review Orders in PowerOrders.....	22
Address Order Alerts.....	23
Cancel/Discontinue an Order.....	23
Order Entry Details	23
Task List.....	24
Chart a Task with an Associated Form	24
Chart a Task Done	24
Chart a Task Not Done	25
PowerPlans & PowerForms Quick Reference Guide.....	25
Add a PowerPlan.....	25
Add an Order to a Phase	26
Create a Favorite.....	27
Manage PowerPlans	27
Discontinue a PowerPlan	27
PowerForms.....	28
Document a PowerForm from a Task	28
Document an AdHoc PowerForm	28
View a PowerForm.....	28
Orders Management on Admission	29
ED Holding PowerPlans.....	29
Taking Telephone Orders for Admission Orders and Home Medications	29
Manage the Blood Administration Process	29
Transfusion Workflow.....	29
Order a Blood Product	29
To initiate the Blood Transfusion PowerPlan:	30
Before you administer the blood product:	31
Document Blood Administration	32

Reviewing I&O.....	35
Communication Types in Cerner.....	36
Bedside Monitor Device Interface (BMDI).....	37
Associating Device to Patient.....	37
Acquiring Data from an Associated Monitor	38
Disassociate the Monitor from the Patient	38
Reboot Cerner Connectivity Engine (CCE)	38
Trouble Shooting Tips	38
Order Entry Details	39
Details that will need to be documented:	39
Nursing Staff will document Order Entry Details in the following ways:.....	40
Order Entry Details PowerForm.....	40
Location of Order Entry Details PowerForm in the Nursing Care AdHoc Folder	40
Location of Order Entry Details Section in the Admission History Adult PowerForm	41
Specimen Collection & Patient Safety	42
Patient Safety Events	42
Properly Using Specimen Collection in Cerner	42
Specimen Collection.....	42
Printing Specimen Labels and Collecting Specimens.....	43
Mark a Collection as Not Done	43
IV Infusion Billing/IV Stop Times.....	43
From the Task List:	44
From the MAR:.....	44
Restraint Process.....	44
IPOC (Plan of Care) Documentation and Updates	51
Initiating IPOCs.....	51
Documenting/Updating Goals/Indicators/Interventions	54
Admission/Discharge Workflow from Mpage.....	55
Complete Admission Workflow- New Task.....	56
Document Home Medications	57
Document Histories (Problems and Procedures).....	62
Complete the Complete Admission Workflow Task from the CareCompass or Single Patient Task List.....	65
COMPLETE ADMISSION HISTORY TASK- SECOND STEP OF ADMISSION INTAKE	65
Complete the Patient Preferred Pharmacy task once the patient's pharmacy is entered into the Patient Pharmacy Tool.....	67
Admission Systems Assessment Documentation	68
Weights	69
Clinical Reconciliation Quick Reference Guide	69
Home Medication Reminders	69
Allergies Reminders	70
Histories (Problems and Procedures) Reminders	70
Discharge Workflow Process	71
Discharge Planning.....	72
Problem List	72
Discharge Medications.....	72
Orders	73
Follow Up Appointments	73
"Saved Templates" is now the term for Saved Favorites within the Follow Up workflow component. 75	

Patient Education	76
Documents	77
Outstanding Lab/Rad Orders	77
Instructions From Care Team.....	77
eCQM/Core Measures	78
Stroke and Wafarin Instructions	79
Nursing Discharge Summary	79
Lines/Tubes/Drains	79
IV Stop Times	80
Readmission Risk Summary	80
Continuity of Care Goal/Interventions.....	80
Generate and Printing Discharge Instructions.....	81
Inpatient Discharge Instructions.....	81
Inpatient Discharge Instructions Components	82

Nursing Standards of Documentation

Documentation Category	Standard	Location in Cerner
Patient Handoff	Areas to Discuss: <ul style="list-style-type: none"> • 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)	<ul style="list-style-type: none"> • 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 <p>Notes:</p> <ul style="list-style-type: none"> • <i>Preference is for 0700 & 1900 VS to be obtained by Nurse during Bedside Shift Report to Calculate MEWS)</i> 	IView> Quickview band
Alarm Settings	<ul style="list-style-type: none"> • Q Shift during Bedside Report • Must Document the ACTUAL limits 	IView>Systems Assessment>Alarms Settings

Patient Weights	Clinical Dosing Weight: <ul style="list-style-type: none"> • On Admission • With MD/Phar.D. Order Routine/Daily Weight: <ul style="list-style-type: none"> • 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 : <ul style="list-style-type: none"> • 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  2.) Advance Directives	On Admission ensure that you Complete Reconciliation for the following: <ul style="list-style-type: none"> ○ Home Medications ○ Allergies ○ Problems On Admission REASSESS if unable to attain on admit <i>IF patient has a paper copy on file from previous admission then print, review,</i>	Access from the Admission/Discharge Workflow mPage Import Records>>Consent Granted>> Clinical Reconciliation buttons for Home Meds, Allergies and Problems Access Admission History Powerform from the TASK LIST

<p>3.) Columbia Suicide Risk Screening</p> <p>4.) Sleep Apnea Risk Assessment</p> <p>5. Travel Screening</p>	<p><i>have pt. or DPA initial, & place on patient current chart</i></p> <p>On Admission</p> <p>REASSESS if unable to attain on admission Complete Full Screening</p> <p>On Admission</p> <p>REASSESS if unable to attain on admission (Notify MD if positive screen)</p> <ul style="list-style-type: none"> ○ If Score >3 Inform MD & Monitor ETCO2 <p>On Admission</p> <p>REASSESS if unable to attain on admission</p>	
Patient Stated Goals	<ul style="list-style-type: none"> • Create on Admission • Review and Update at Discharge <p>Notes:</p> <p>If unable to obtain on admission, document ASAP!</p>	<p>Admission Workflow mPage</p> <p>Discharge Workflow mPage</p>
Patient Preferred Pharmacy	<ul style="list-style-type: none"> • On Admission <ul style="list-style-type: none"> ○ Reassess if unable to obtain ○ If already completed from previous visit- verify it is still correct- If it has changed UPDATE IT 	<p>Via PATIENT PHAMRCY Link on Tool Bar.</p> <p>Once complete- Document “done” via the task on the task list.</p>
Planned Powerplans (Physician’s Orders)	<ul style="list-style-type: none"> • On Admission (Initiate Admission PowerPlan and any other Powerplans needed based on patient specific needs. For Example: Glucose Control, CC or Tele Protocol, ETC) 	<p>Orders Profile section of the Patient’s Chart</p> <p>Use Care Compass to utilize Nurse Review Feature AND Nurse Review Feature in the</p>

	<ul style="list-style-type: none"> • Throughout Shift (Regularly check for new orders and initiate or discontinue as appropriate) • Evaluate during Chart Checks at 0500 & 1700 EVERYSHIFT <p>At Patient Handoff (Shift, Unit to Unit, or Facility to Facility)</p>	Orders Profile Section of the Patient's Chart
Initial Assessment	<ul style="list-style-type: none"> • Complete within 15 min of Admission complete the following: <ul style="list-style-type: none"> ○ Admission Arrival Time ○ Admission Assessment Complete ○ Admission Assessment Comment ○ Focused Assessment • Documented within 8 hr. of Admission 	IVView>System Assessment band Admission Arrival Time>>Admission System Assessment Section
Routine Assessment	<ul style="list-style-type: none"> • Tele/Med-Surg Q Shift • Critical Care Areas are Q 4hr 	IVView>Systems Assessment band
Comprehensive Pain Assessment	<ul style="list-style-type: none"> • On Admission • Q 12 hr. • Reassess after Applicable Timeframe of Intervention: <ul style="list-style-type: none"> ○ IV – 30 min ○ PO – 60-90 min ○ IM/SQ – 60 min ○ Non-Pharmacologic 60 min <p>Document Pain Goal:</p> <ul style="list-style-type: none"> ○ Pain Goal ○ Scale Used ○ Current Level ○ Location (if pt. has pain) ○ Quality (if pt. has pain) <p>Even if patient has no pain:</p> <ul style="list-style-type: none"> • Pain Goal • Scale Used Intensity=0 	IVView>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)	<p>Do Not use VS > 1 hr. old to calculate</p> <ul style="list-style-type: none"> • On Arrival to Unit • Calculate during Hand Off of Care • Change in Patient Condition 	<p>IView>Systems Assessment Band</p> <p>Pediatrics- Use the Pediatric Scales and Screens IVIEW band</p>
ABC Fall Injury & Morse Fall	<ul style="list-style-type: none"> • On Admission • Q Shift • Change in Level of Care • Change in Patient Condition • After a Fall Complete Post Fall Huddle 	<p>Admission History PowerForm</p> <p>IView>Systems Assessment Band</p>
SKIN Braden	<ul style="list-style-type: none"> • On Admission within 8 hours • Q shift • Skin Breakdown Prevention Interventions 	<p>IView>Systems Assessment</p> <p>IView>>QuickView>>Routine Rounding>>Skin Breakdown Prevention Interventions</p>
Wound/Dressing Changes	<ul style="list-style-type: none"> • On Admission • Discovery of Wound • When Wound Resolved • Transfer • At Discharge 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • On Admission • Q 3-5 hr. (PR, QRS, QT, & Interpretation) • With Any Change in Rhythm • Upon return from a procedure 	<p>Telemetry monitoring rhythm strips are placed in paper chart.</p> <p>Rhythm is documented in IView>Systems Assessment>Cardiac Rhythm Analysis section</p>
IV Sites	<p>Create a Dynamic Group for all sites:</p> <ul style="list-style-type: none"> • On Admission • Any New IV <p>Assess all sites:</p> <ul style="list-style-type: none"> • Q Shift (<i>Hourly</i> if receiving a vesicant medication) • Patient C/O Discomfort • Medication Administration • After Removal 	<p>IView>Lines & Drains band</p>

	<p>Notes:</p> <p>Ensure Documentation of Number of Attempts</p> <p>Inactive Dynamic Group when IV is Discontinued</p>	
<p>Tubes & Drains</p> <p>Includes but not limited to:</p> <ul style="list-style-type: none"> • Central Lines/PICC • Chest Tubes • GI Tubes • Surgical Drain 	<p>Create a Dynamic Group for all sites:</p> <ul style="list-style-type: none"> • On Admission • Any New Insertions • <p>Assess all sites:</p> <ul style="list-style-type: none"> • Q Shift • With Any changes • Per MD order <p>Notes:</p> <ul style="list-style-type: none"> • Ensure Documentation of Removal of Tube/Drain • Inactive Dynamic Group when Tube/Drain is Discontinued 	IView>Lines & Drains band
Foley	<p>Create a Dynamic Group:</p> <ul style="list-style-type: none"> • On Admission • Any New Insertions <p>Assess:</p> <ul style="list-style-type: none"> • Q Shift • With Any Changes • Per MD order <p>Notes:</p> <ul style="list-style-type: none"> • Document Foley Bundle & D/C Criteria q Shift • Ensure to Document Removal of Foley • Inactive Dynamic Group when Foley is Discontinued <p>Complete & Document Peri-Care</p>	IView>Lines & Drains
<p>Patient Education</p> <p>Suggested Topics but not limited to:</p>	<p>Learning Assessment:</p> <ul style="list-style-type: none"> • On Admission (Admission Powerform) 	<p>IView>Adult Education OR</p> <p>Ad Hoc>Education Folder</p>

<ul style="list-style-type: none"> • Plan of Care • Fall Precaution • Disease Process • Surgical Procedure • Diet Instructions • Diabetes • New Medications • Sepsis • Restraints • Risk for Infection • Heart Failure • Isolation • Malnutrition 	<ul style="list-style-type: none"> • Document each time education performed <ul style="list-style-type: none"> ○ Who was taught ○ Barriers ○ Readiness ○ Method <p>Patient Teaching:</p> <ul style="list-style-type: none"> • Q Shift • At Discharge (Must include Diagnosis this Admission) 	<p>Some Education topics will be Tasked (USE YOUR TASK LIST)</p>
<p>IPOC</p> <p>(Care Plans)</p>	<ul style="list-style-type: none"> • On Admission • Q 24 hr. • GOALS Must be Completed by an RN <p>INDIVIDUAL Plan of Care by adding a PATIENT SPECIFIC GOAL</p>	<p>For a New IPOC:</p> <ul style="list-style-type: none"> • Click Orders & Click Add (as you would for a new order) & Search IPOC • Initiate Suggested IPOC from the VIEW Section of the Orders Profile <p>To Update Q 24 hr.: Enter the Orders Profile & Click on the Document in Plan Tab</p>
<p>Restraints</p>	<p>Education Q Shift</p> <p>Plan of Care</p> <p>NON-VIOLENT Q2 hr:</p> <ul style="list-style-type: none"> ○ Circulation and Skin Integrity of Restrained Limb ○ Toileting, Food, & Fluids Offered ○ ROM & Rotate Sites if Possible ○ Position Changes ○ Vital Signs <p>VIOLENT Q 15 min:</p> <ul style="list-style-type: none"> ○ Circulation and Skin Integrity of Restrained Limb ○ Toileting, Food, & Fluids Offered ○ ROM & Rotate Sites if Possible ○ Position Changes ○ Vital Signs 	<p>USE YOUR TASK LIST</p>

	<ul style="list-style-type: none"> ○ Specific Behavior Requiring Restraint <p>DISCONTINUATION:</p> <ul style="list-style-type: none"> ○ 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 <p>Notes:</p> <p><i>These areas MUST be documented:</i></p> <ul style="list-style-type: none"> ○ <i>Pre-Restraint Alternatives Prior to Restraint Initiation</i> ○ <i>Reason for the Restraints</i> ○ <i>Type of Restraint Device</i> ○ <i>Criteria for Discontinuation</i> ○ <i>If VIOLENT Patient must be in Continuous Observation (can be through door or window)</i> ○ <i>Must Renew Order Q 24 hr.</i> ○ <i>Document all Patient Responses to less Restrictive Restraint Alternatives</i> 	
I & O	<ul style="list-style-type: none"> • Should be Documented in Real Time During Hourly Rounding: <ul style="list-style-type: none"> ○ Diet Type Q Shift ○ Meal % WITH EVERY MEAL (even if it is 0%) ○ Oral Intake ○ Outputs <p>Ensure you Validate accuracy at End of Shift</p>	IView>Intake and Output band
Meal and Oral Supplements	<p>All meal activity must be documented:</p> <ol style="list-style-type: none"> 1. Diet Type 2. Nutritional Activity (fed patient, patient refused, wears dentures, etc) 3. Breakfast % 4. Lunch % 	Iview>Quickview>Nutrition section

	<p>5. Dinner %</p> <p>6. If patient is NPO- document that in the meal type</p> <p>Oral Supplements- If ordered- must be administered and documented</p>	
Sheath	<p>Document the following Assessments:</p> <ul style="list-style-type: none"> • Pulse Check • Sheath Site • Circulation of Extremity • B/P & Heart Rate • Site Assessment <p>Frequency While Sheath in Place:</p> <ul style="list-style-type: none"> • On Admission • Q 15min X 1 hr. • Q 30min until Sheath is Removed <p>Frequency Once Sheath Removed:</p> <ul style="list-style-type: none"> • 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	<p>Initiating a Transfusion:</p> <ul style="list-style-type: none"> • 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 <p>Completion of Transfusion:</p>	IView>Blood Administration

	<ul style="list-style-type: none"> • Post-Transfusion VS • Date/Time Completed • Amount Transfused • Patient Response • Document Blood Intake and Saline Intake in I&O Band <p>Documenting a Transfusion Reaction:</p> <ul style="list-style-type: none"> • Type of Product • Amount Infused • Events surrounding Reaction • Actions Taken • Patient Response • Complete the Transfusion Reaction Report (MR-57) & Send to Blood Bank <p>Notes:</p> <p><i>Blood Transfusion must begin with 30 min after leaves Blood Bank and infusion must be Complete within 4 hours.</i></p>	
Chart Check	<p>Review completion of the following at 5am and 5pm daily:</p> <ul style="list-style-type: none"> • 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.

	<p>bedside to mark specimen as collected</p> <p>Send specimen with specimen label to lab.</p>	<p>DO NOT send specimen to lab by just placing a specimen label on the specimen without scanning and marking the specimen as collected.</p>
Problem List Update	<p>Update on Admission and Q shift:</p> <p>The problem list should be updated with all problems throughout the shift.</p> <p>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)</p> <p>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).</p>	<p>Admission Workflow mPage>>Problems/Procedures/Social History- Click on problems tab then the Problems/Procedures/Social History component header</p> <p>MENU>>Problems and Diagnosis</p>

RESOURCES:

Policy Stat: Policy and Procedure Library

Nursing Standards of Documentation for Critical Care

Documentation Category	Standard	Location in Cerner
Cardiovascular Assessment	<ul style="list-style-type: none"> VS Q 2 H or more frequently based on patient acuity 	IView>ICU Systems Assessment>Cardiovascular
ECG Strip	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> SWAN/GANZ readings per pt acuity Zero lines Q shift & any Δ's in positioning 	IView>Adult Lines and Drains <ul style="list-style-type: none"> Pulmonary Artery Line must be customized A separate Line must also be created for the Introducer under the Central Line Section
Pacemaker Settings	<ul style="list-style-type: none"> Pacemaker Settings & with any Δ's 	IView>Adult Systems Assessment>Pacemaker
Impella	<ul style="list-style-type: none"> Document you V/S, Device Assessment, Hemodynamics, Site Assessment, & Distal Pulses: <ul style="list-style-type: none"> Upon arrival to unit Q 15 min X 4 Q 30min X 2 then hourly Document the following Q I Hour: <ol style="list-style-type: none"> Performance Level, Flow Liters/min, Placement Signal, Motor Current, Pump Position, Purge Pressure, Infusion Rate, Power-AC or Battery 	IView>Adult Devices and Treatments>Impella Flowsheet
Ventilator	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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

	<ul style="list-style-type: none"> • Color of extremity Q 1 H or more freq • LOC & UOP Q 2 H • Check timing Q 1 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 <p>SAFETY CHECKS:</p> <ul style="list-style-type: none"> • Q 8 H : Slow Gas Alarm - ON • IABP Fill - AUTO • Timing - AUTO • Helium Level Amount of PSI <p>Q 1 H:</p> <ul style="list-style-type: none"> • Insertion site, Clean / Dry • HOB < 30° • Trigger Source • Pumping Ratio • No Blood Noted in Ext. Tubing 	
TOF	<ul style="list-style-type: none"> • Upon initiation Q 15min until Goal is met, then Q 4 H 	IView>Adult Scales and Screens>Neuromuscular Blockade <ul style="list-style-type: none"> ○ Must Customize to pull into Documentation
BIS	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 medications- 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.

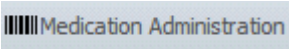



2. “Notify Physician of Consult” tasks to Nursing/Unit Secretary positions.
3. Nursing/Unit Sec calls physician office to communicate consult.
4. If the physician who is accepting the consult is different than the physician entered the nurse/US will modify the physician’s name in the “Consult to Physician” 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. 
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 the Task 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:


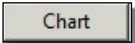

1. Select Task List from the Menu.
2. Double-click the appropriate PowerForm task.
3. Select the appropriate section from the Navigator on the left.

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.

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

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

	Component	Status	Details
MED Blood Transfusions_KY (Planned Pending)			
Patient Care			
Contingencies			
<input checked="" type="checkbox"/>	 Verify Patient Consent Obtained		For blood product transfusion
<input checked="" type="checkbox"/>	 Notify Provider Laboratory Results		Hct LESS than 21, Hbg LESS than 7
<input type="checkbox"/>	 Notify Provider Laboratory Results		FOR post-transfusion Platelet counts that rise less than 10,000
<input type="checkbox"/>	 Notify Provider Laboratory Results		PT GREATER than 20, INR GREATER than 1, aPTT GREATER than 55
<input type="checkbox"/>	 Notify Provider Laboratory Results		FOR post-transfusion Fibrinogen level less than 100 after cryoprecipitate transfusion
IV Solutions			
<input checked="" type="checkbox"/>	 sodium chloride (Normal Saline Flush)		10 mL, IntraVENous, Inj, Q12H
<input type="checkbox"/>	 sodium chloride (Normal Saline Flush)		10 mL, IntraVENous, Inj, See Comment, PRN IV Use
<input type="checkbox"/>	 Sodium Chloride 0.9% intravenous solution		500 mL, IntraVENous, Rate = 20 mL/Hr Infuse during blood transfusion
Medications			
Pre-Transfusion			
Details			

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

To initiate the Blood Transfusion PowerPlan:

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

12. Click **Initiate**.

+ Add | Document Medication by Hx | Reconciliation | Check Interactions | External Rx History | Rx Plans (0): In Process

Status: Meds History | Adm. Meds Rec | Disch. Meds Rec

Orders | Medication List | Document In Plan

View: MED Blood Transfusions_KY (Planned)
 Last updated on: 4/3/2014 12:28 EDT by: KYTRAINRN146, KY Nurse RN
 Alerts last checked on 4/3/2014 12:28 EDT by: KYTRAINRN146, KY Nurse RN

Patient Care Contingencies:

- ☒ Verify Patient Consent Obtained
- ☒ Notify Provider Laboratory Results
- ☒ Notify Provider Laboratory Results
- ☒ Notify Provider Laboratory Results
- ☒ Notify Provider Laboratory Results


IV Solutions:

- ☒ sodium chloride (Normal Saline Flush) 10 mL, IntraVenous, Inj, Q12H
- ☒ sodium chloride (Normal Saline Flush) 10 mL, IntraVenous, Inj, See Comment, PRN IV Use
- ☒ Sodium Chloride 0.9% intravenous solution 500 mL, IntraVenous, Rate = 20 mL/Hr

Details:

- TpN, For blood product transfusion, Laterality: Left
- Hct LESS than 21, Hbg LESS than 7
- FOR post-transfusion Platelet counts that rise less than 10,000
- PT GREATER than 20, INR GREATER than 1, aPTT GREATER than 55
- FOR post-transfusion Fibrinogen level less than 100 after cryoprecipitate transfusion

Dx Table | Orders For Nurse Review | Save as My Favorite | **Initiate** | Orders For Signature

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.

Component: MED Blood Transfusions_KY (Initiated)
 Last updated on: 4/3/2014 12:29 EDT by: KYTRAINRN146, KY Nurse RN
 Alerts last checked on 4/3/2014 12:28 EDT by: KYTRAINRN146, KY Nurse RN

Patient Care Contingencies:

- ☒ Verify Patient Consent Obtained
- ☒ Notify Provider Laboratory Results

Laboratory:

- Blood Bank: Type and Screen ONLY

Details:

- 04/03/14 12:29:00 EDT, For blood product transfusion, Laterality: Left
- 04/03/14 12:29:00 EDT, Hct LESS than 21, Hbg LESS than 7
- 4/3/2014 12:29 EDT

Dx Table | Orders For Nurse Review | Save as My Favorite | Orders For Signature

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.

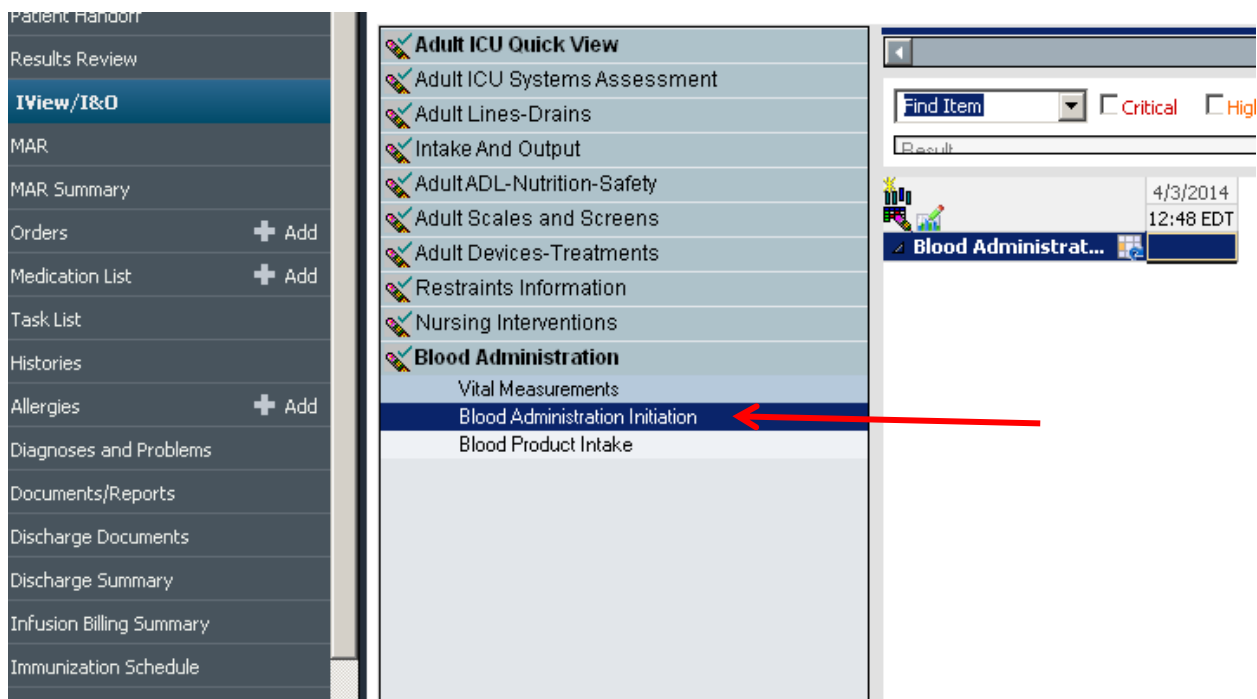
Facilitator Note: *If witness is not obtained, then the blood will not drop a charge.*

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**.

The screenshot shows a dialog box titled 'Dynamic Group - KYTrain, ClareTwenty - 15020'. It contains the following fields:

- Label:** 123456789 B positive Red Blood Cells Irradiated 4/5/2014 12:50
- Blood Unit ID Number:** 123456789
- Blood Unit Type:** A list box with options: A negative, A positive, AB negative, AB positive, B negative, **B positive** (selected), O negative, and O positive.
- Blood/Blood Product:** A list box with options: Platelets (single donor), Wound Salvaged Blood, Cryoprecipitate, Fresh frozen plasma, Platelets (random donor), **Red Blood Cells** (selected), and Whole blood.
- Special Needs Blood Product:** A checkbox for 'CMV negative' which is unchecked.

 At the bottom are 'OK' and 'Cancel' buttons.

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

The screenshot shows the 'Blood Administration Initiation' form. It has a header bar with the date '4/3/2014' and time '12:52 EDT'. Below the header, there is a row with the title 'Blood Administration Initiation' and a checkbox that is checked. Below this is another row with the text '<123456789 B positive Red Blood Cells Ir...' and a checked checkbox. At the bottom, there is a section titled 'Pre-Transfusion Checklist'. A red arrow points to the checked checkbox in the second row.

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.

Witness Required - KYTrain, ClareTwenty - 15020

Please enter a witness for the following results:

Item	Date/Time	Result	*Witnessed By
Blood and Patient Information Verified (123456789 B positive Re	4/3/2014 12:52 EDT	Yes	KYTRAINRN10, KY Nurse RN

OK Cancel

12. Select **OK**.

13. Select **Witness Sign**.

Witness Signature - KYTrain, ClareTwenty - 15020

Results for witness KYTRAINRN10, KY Nurse RN

Item	Date/Time	Result
Blood and Patient Information Verified (123456789 B po	4/3/2014 12:52 EDT	Yes

Witness Sign Cancel

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.

	13:20 EDT	13:18 EDT
Transfusion Reaction Activities		
Patient Response		
Transfusion Comments		
123156451 B positive Red Blood Cells Irra...		
Pre-Transfusion Checklist		Blood band on ...
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		Standard filter
Blood/Blood Product Volume Hung	mL	250
Transfusion Start Time		4/3/2014 13:21
Transfusion Rate:	mL/Hr	25
Blood/Blood Product Volume Infused	mL	
Transfusion Stop Time		
Transfusion Completed		
Signs of Transfusion Reaction		
Transfusion Reaction Activities		
Patient Response		
Transfusion Comments		

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

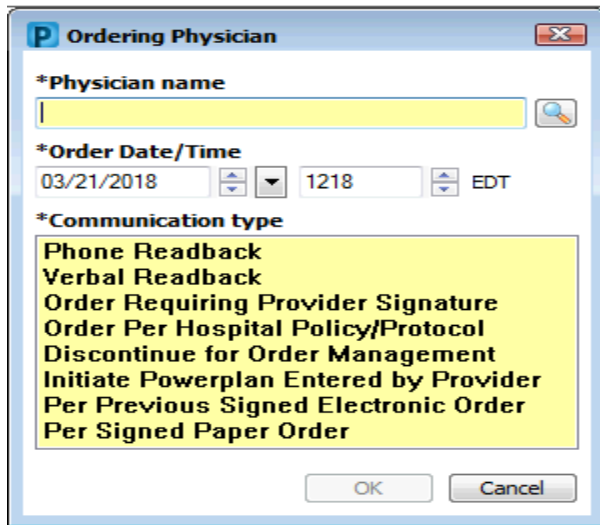
After documenting the amount infused, review the **Intake & Output** band to view the total amount of blood which has infused has been recorded properly.

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

Adult ICU Quick View		02 April 2014 7:00 E			
Adult ICU Systems Assessment		Today's Intake: 250 mL Output: 0 mL Balance: 250 mL Ye			
Adult Lines-Drains					
Intake And Output					
Intake					
Continuous Infusions					
Medications					
Oral					
Blood Product Intake					
Miscellaneous Intake					
Enteral Tube Feeding					
Parenteral Nutrition Intake					
Other Intake Sources					
Miscellaneous Intake*					
Output					
Urine Output					
Adult ADL-Nutrition-Safety					
Adult Scales and Screens					
Adult Devices-Treatments					
Restraints Information					
Nursing Interventions					
Blood Administration					
Adult Education					

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 for **CR Chest 1 Vw**

Details | Order Comments | Diagnosis

+ [Icons]

*Priority: Routine

*Transport mode: Ambulatory

*Requested Start Date/Time: 03/13/2013 1820 EDT

*Reason for exam: [Yellow Highlighted Box]

Reason For Exam (Other: Please Specify): [Empty Box]

*Isolation Code: Contact precautions

*Is Patient on Oxygen?: ☒ Yes ☐ No

← Transport mode auto populated

← Isolation Status auto populated

Details that will need to be documented:

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

Order Entry Details - SJHTEST, IPDCSEVEN

*Performed on: 03/13/2013 1811 EDT By: Test, KY Nurse RN 22

Order Details

Transport Mode <input type="radio"/> Ambulatory <input type="radio"/> Bed (including specialty) <input type="radio"/> Carried <input type="radio"/> Cart <input type="radio"/> Crib/isolette <input type="radio"/> Portable <input type="radio"/> Recliner <input type="radio"/> Stretcher/Gurney <input type="radio"/> Wagon <input type="radio"/> Wheelchair	Isolation Precautions <input type="checkbox"/> Standard Precautions <input type="checkbox"/> Airborne precautions <input type="checkbox"/> Contact precautions <input type="checkbox"/> Droplet precautions <input type="checkbox"/> Neutropenic precautions <input type="checkbox"/> Protective precautions <input type="checkbox"/> Ribavirin precautions
Pregnant <input checked="" type="radio"/> N/A <input type="radio"/> 1 = Yes <input type="radio"/> 1 = Unknown <input type="radio"/> 0 = No	IV <input type="radio"/> 1 <input type="radio"/> 0 <input type="radio"/> 1 = Yes <input type="radio"/> 0 = No
Oxygen <input type="radio"/> 1 <input type="radio"/> 0 <input type="radio"/> 1 = Yes <input type="radio"/> 0 = No	Nurse Collects Blood Specimens <input type="radio"/> 1 <input type="radio"/> 3 <input type="radio"/> 1 = Yes <input type="radio"/> 3 = No
Lift/Transfer <input type="radio"/> Independent <input type="radio"/> Minimal <input type="radio"/> Moderate assist <input type="radio"/> Maximal assist	Central Line <input type="radio"/> Yes <input type="radio"/> No
Room Service <input type="radio"/> Appropriate <input type="radio"/> Needs Assistance <input type="radio"/> Not Appropriate	

Independent:
Patient performs 100% of transfer/mobility tasks
Requires no assistance or supervision.

Minimal Assist:
Patient performs at least 75% of transfer tasks

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

Ad Hoc Charting - ZZ25JETESTALL, PATIENTTWO

Admission/Discharge/Transfer	<input type="checkbox"/> Asthma Score	<input type="checkbox"/> Sepsis Screening Tool, Age 16-150 Yrs
Basic Care	<input type="checkbox"/> Bispectral Index Score Assessment	<input type="checkbox"/> Suicide Risk Screen
Behavioral Health	<input type="checkbox"/> Braden Scale	<input type="checkbox"/> Urinary Catheter Assessment
Education	<input type="checkbox"/> Burn Assessment/Rule of Nines	<input type="checkbox"/> Vital Measurements
Nursing Care	<input type="checkbox"/> CAGE Assessment	<input type="checkbox"/> VTE Risk Assessment
Nursing Care-Pediatrics	<input type="checkbox"/> CAM-ICU Assessment	
Procedure	<input type="checkbox"/> Cardiac and Pulmonary Outpatient Rehab Evaluation	
SNF	<input type="checkbox"/> Consult Phone Call Documentation	
Wound Care	<input type="checkbox"/> Diabetes Educator Inpatient Documentation	
All Items	<input type="checkbox"/> Glasgow Coma Scale	
	<input type="checkbox"/> Healing Touch	
	<input type="checkbox"/> MEWS Score	
	<input type="checkbox"/> Modified Massey Bedside Swallowing Screen	
	<input type="checkbox"/> Morse Fall Risk Scale	
	<input type="checkbox"/> NIH Stroke Scale	
	<input type="checkbox"/> Oral Assessment Scale	
	<input checked="" type="checkbox"/> Order Entry Details	
	<input type="checkbox"/> Pain Assessment	
	<input type="checkbox"/> Provider Notification	
	<input type="checkbox"/> RASS Scale	
	<input type="checkbox"/> Sad Person Scale	

Chart Close

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

Admission History, Adult - ZZ25JETESTALL, PATIENTTWO

*Performed on: 03/13/2013 1816 EDT By: Test, KY Nurse RN 4

✓ Advance Directive

* Anesthesia/Transfusion History

Anticipated Discharge Needs

Education

Functional Assessment

* General Info

Health History

Procedure History

Height and Weight

Estimated Weight

Medication List

Allergy

* Infectious Disease History

Tetanus Immunization Status

* Influenza Vaccine Assessment

* Pneumococcal Vaccine

Order Entry Details

Nutrition History

* Psychosocial History

Sleep Apnea Risk Assmt

* Social Habits

Spiritual/Cultural Needs

Valuables and Belongings

Order Entry Details

Transport Mode <input type="radio"/> Ambulatory <input type="radio"/> Bed (including specialty) <input type="radio"/> Carried <input type="radio"/> Cart <input type="radio"/> Crib/Islette <input type="radio"/> Portable <input type="radio"/> Recliner <input type="radio"/> Stretcher/Gurney <input type="radio"/> Wagon <input type="radio"/> Wheelchair	Isolation Precautions <input type="checkbox"/> Standard Precautions <input type="checkbox"/> Airborne precautions <input type="checkbox"/> Contact precautions <input type="checkbox"/> Droplet precautions <input type="checkbox"/> Neutropenic precautions <input type="checkbox"/> Protective precautions <input type="checkbox"/> Ribavirin precautions
Pregnant <input checked="" type="radio"/> N/A 1 = Yes 1 = Unknown 0 = No	IV <input type="radio"/> 1 <input type="radio"/> 0 1 = Yes 0 = No
Oxygen <input type="radio"/> 1 <input type="radio"/> 0 1 = Yes 0 = No	Nurse Collects Blood Specimens <input type="radio"/> 1 <input type="radio"/> 3 1 = Yes 3 = No
Lift/Transfer <input type="radio"/> Independent <input type="radio"/> Minimal <input type="radio"/> Moderate assist <input type="radio"/> Maximal assist	Central Line <input type="radio"/> Yes <input type="radio"/> No
Room Service <input type="radio"/> Appropriate <input type="radio"/> Needs Assistance <input type="radio"/> Not Appropriate	

Independent:
Patient performs 100% of transfer/mobility tasks

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

Scheduled Continuous PRN

Task retrieval completed

Scheduled Date and Time	Task Description	Order Details	Task Status
05/08/2014 11:13 EDT	Infusion Billing	500 mg, IV Piggyback, Q12HInt, infuse over 30 Minute(s), Routine, Start 12/23/...	Pending

2. The IV Stop Time Documentation Box will display

Infusion Billing: VVVSJHTEST, PTINPATIENT - A140800002

Sodium Chloride 0.45% with KCl 20 mEq/L 1,000 mL
1,000 mL, IntraVENous, start date 03/26/14 17:19:00 EDT, Rate = 50 mL/Hr, Infuse over 20 Hour(s), Total Volume (mL) = 1,000

Show Previous Infusions

Current Infusions	Event Date/Time	Bag#	Start	End	Duration	Infuse Volume
<input checked="" type="checkbox"/>	5/7/2014 23:00 EDT	2	05/07/2014 2300 EDT	05/08/2014 1100 EDT	12 Hours, 0 Minutes	1,000 mL
<input type="checkbox"/>	5/8/2014 11:13 EDT	3	NA	NA	Not included	

Always select the appropriate infusion for the bag that has ended.

Fill in the stop time for the bag that is complete.

Enter the Infused Volume

Total Volume for Order: Failure to Calculate
Total Infusion Duration for Order: Failure to Calculate

Sign Cancel

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:

ZZZSJHTEST, TRIAGECC - Add Order

ZZZSJHTEST, TRIAGECC

Age: 25 years MRN: A001081365 Fin Nbr: A1623200008 Attending: Aaron, Joshua ...
 DOB: 1/1/1991 Inpatient [8/19/2016 14:22 - <No - Discharge date>] Allergies: angiotensin con...
 Care Team: Gender: Female Loc: SJH CCU; CC03; 1 Weight/BMI: / Code Status:
 IS: Code Status:

Diagnosis (Problem) being Addressed this Visit

Search: Contains Advanced Options Type:

Folder: Search within:

IPOC: Restraints for Unstable / Self-Destructive Behavior

IPOC: Restraints for Non-Violent/Non-Self Destructive Behavior

MED Restraints Non-Violent/Non-Self Destructive_KY

MED Restraints/Seclusion Violent 16 Years and Older_KY

MED Restraints/Seclusion Violent 8 Years and Younger_KY

MED Restraints/Seclusion Violent 9-17 Years_KY

Problems

Display:

Annotated Display Name of Problem

Diabetes Diabetes

HTN (hypertension) HTN (hypertension)

PE (pulmonary embolism) PE (pulmonary embolism)

ZZZSJHTEST, TRIAGECC - A001081365 Done

Ordering Physician

*Physician name

*Order Date/Time

01/22/2019 1141 EST

*Communication type

Phone Readback

Verbal Readback

Order Requiring Provider Signature

Order Per Hospital Policy/Protocol

Discontinue for Order Management

Initiate Powerplan Entered by Provider

Per Previous Signed Electronic Order

Per Signed Paper Order

OK Cancel

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.

Orders

Medication List Document In Plan

View

Plans

Document In Plan

Interdisciplinary

IPOC: Restraints for Non-Violent/Non-Self Destructive

Medical

MED Restraints Non-Violent/Non-Self Destructive_KY

MED Restraints Non-Violent/Non-Self Destructive_KY

Restraint Initiate (Planned Pending)

Restraint Discontinue (Planned Pending)

Suggested Plans (9)

Orders

Admission/Discharge Transfer

Code Status

Vital Signs

Activity

Patient Care

Communication Orders

Nutrition

IV Solutions

Medications

Laboratory

Radiology

Cardiology

Other Diagnostic Tests

Respiratory

Diagnoses & Problems

Related Results

Formulary Details

Medication List Document In Plan

Component Status Details

MED Restraints Non-Violent/Non-Self Destructive_KY, Restraint Initiate (Planned Pending)

Restraint Initiate Phase: This phase has a default duration of 24 hours, after which you will move on to the Restraint Continue or Restraint Discontinue phase. Do not replicate the Restraint Initiate phase.

Restraint Initiate Non-Violent/Non-Self Destructive Start: T/N for Actions interfere promotion of healing, Order valid for 24 hours. Evaluate patient and use Re...

Restraint Monitoring Non-Violent/Non-Self Destructive Q2H

Restraint Evaluate Need to Continue After 24 Hours Start: T/N+960

Details for Restraint Initiate Non-Violent/Non-Self Destructive

Order Comments Offset Details

Requested Start Date/Time: EDIT

*Restraint Type: Reason for Restraint Nonviolent/Non... Actions interfere promotion of h...

Restraint Instructions: Order valid for 24 hours. Evaluate p...

Initiate Orders For Signature

Location: LV02-1 61 years Male A001081365 SJH CCU TEST, Cardiology/CCU KYORT KYNURSERNS 30 September 2016 17:18 EDT

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

The screenshot shows the 'Orders' tab in a medical software interface. The left sidebar contains a navigation menu with options like 'Signature', 'It In Plan', 'Primary', 'Restraining for Non-Violent/Non-Self Destructive', 'Restraining Non-Violent/Non-Self Destructive', 'Restraining Initiate (Initiated)', 'Restraining Continue (Planned)', 'Restraining Discontinue (Planned)', 'Restraining Plans (11)', 'Restraining Discharge Transfer', 'Restraining Status', 'Restraining Signs', 'Restraining Care', 'Restraining Communication Orders', 'Restraining on', 'Restraining Actions', 'Restraining Story', 'Restraining Log', 'Restraining Diagnostic Tests', 'Restraining Story', 'Diagnoses & Problems', 'Related Results', and 'Formulary Details'. The main area displays a list of orders for 'MED Restraints Non-Violent/Non-Self Destructive'. The first order is 'Restraining Initiate (Initiated)' with a status of 'Initiated'. A red arrow points to this status. Below it, there are three other orders: 'Restraining Continue (Planned)', 'Restraining Discontinue (Planned)', and 'Restraining Plans (11)'. The bottom of the screen shows a 'Details' section with buttons for 'Dx Table', 'Orders For Nurse Review', 'Save as My Favorite', and 'Orders For Signature'.

The restraint Initiate Task will display on the Task List

The screenshot shows the 'Task List' tab in a medical software interface. The top bar indicates the date and time: 'Friday, September 30, 2016 07:00:00 EDT - Friday, September 30, 2016 19:00:00 EDT'. Below this, there are tabs for 'Continuous' and 'PRN'. The main area displays a table of tasks. The first task is 'Restraining Initiate Non-Violent/Non-Self Destructive' with a status of 'Pending'. A red circle highlights the 'Pending' status. The table has columns for 'Scheduled Date and Time', 'Task Description', 'Order Details', 'Task Status', and 'Last Done'.

Complete the Initiation documentation

The screenshot shows the 'Activity View' and 'Restraining Initiation, Non-Violent' documentation form. The left sidebar contains a navigation menu with options like 'Restraining Initiation, Non-Violent', 'Pre-Restraining Alternatives, Non-Violent', 'Restraining Initiation, Non-Violent', 'Adult Quick View', 'Adult Systems Assessment', and 'Adult Lines-Drains'. The main area displays a form for 'Restraining Initiation, Non-Violent'. The form has sections for 'Pre-Restraining Alternatives, Non-Violent' and 'Restraining Initiation, Non-Violent'. The 'Pre-Restraining Alternatives, Non-Violent' section includes fields for 'Indication for Restraints', 'Pre-restraint Alternatives Attempted', 'Non-Violent Behaviors', 'Behavior Description', 'Comfort Measures Comment', and 'Pre-Restraining Altern. Attempted Comment'. The 'Restraining Initiation, Non-Violent' section includes fields for 'Restraining Initiation Time', 'Restraining Type, Non-Violent', 'Upper Extremity Restraining Location', 'Lower Extremity Restraining Location', 'Torso Restraining Location', 'Other Restraining Location', 'Notified Family/Guardian of Restraints', and 'Restraining Initiation Comment'.

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

The screenshot shows the 'Task List' window with a header bar and a toolbar. Below the toolbar, there are tabs for 'Scheduled', 'Continuous', and 'PRN'. The 'Scheduled' tab is active. A table lists tasks, with the first row highlighted in red. The task is 'Restraint Monitoring Non-Violent/Non-Self Destructive' scheduled for 9/30/2016 at 18:00 EDT, with a status of 'Pending'.

Scheduled Date and Time	Task Description	Order Details	Task Status
9/30/2016 18:00 EDT	Restraint Monitoring Non-Violent/Non-Self Destructive	Start: 09/30/16 18:00:00 EDT	Pending
9/30/2016 2:00 EDT	Restraint Monitoring Non-Violent/Non-Self Destructive	Start: 09/30/16 18:00:00 EDT	Pending
9/30/2016 2:00 EDT	Order Entry Details	Start: 09/30/16 2:00:00 EDT	Pending

Complete the monitoring documentation

The screenshot shows the 'IView/I&O' window with a header bar and a toolbar. The 'Activity View' pane on the left lists various tasks, with 'Restraint Monitoring, Non-Violent' selected. The main pane displays the 'Restraint Monitoring, Non-Violent' form, which includes a 'Find Item' dropdown, a 'Result' field, and a table for monitoring data. The table has columns for '18:00 EDT' and '17:00 EDT'. The 'Restraint Monitoring, Non-Violent' row is highlighted, and the 'Restraint Reassessment, Non-Violent' row is also highlighted.

Find Item	Result	Comments	Flag	Date
Restraint Monitoring, Non-Violent				
Restraint Monitoring, Non-Violent				
Monitoring Indication for Restraints				
Monitoring Type of Restraint				
Monitoring UE Restraint Location				
Monitoring LE Restraint Location				
Monitoring Torso Restraint Location				
Monitoring Other Restraint Location				
Restraint Activity				
Psychosocial Assessment WDL				
Cardiovascular Assessment WDL				
Respiratory Assessment WDL				
Integumentary Assessment WDL				
Range of Motion/Positioning				
Nutrition/Hydration				
Hygiene/Elimination				
Bed Safety				
Call Light Within Reach				
Alarms in Place				
Restraint Monitoring/Interventions				
Monitoring Comfort Measures Comment				
Restraint Continuation Reason				
Less Restrictive Measure Attempted				
Current Order				
Met Discontinuation Criteria				
Restraint Monitoring Comment				
Restraint Reassessment, Non-Violent				
Indication for Restraints Reassessment				
Continuing Non-Violent Behaviors				
Less Restrictive Measure Att., Reassmt.				
Informed of Discontinuation Criteria				
Discontinuation Criteria Assist Provided				
Current Order, Reassessment				
Met Discontinuation Criteria, Reassmt.				

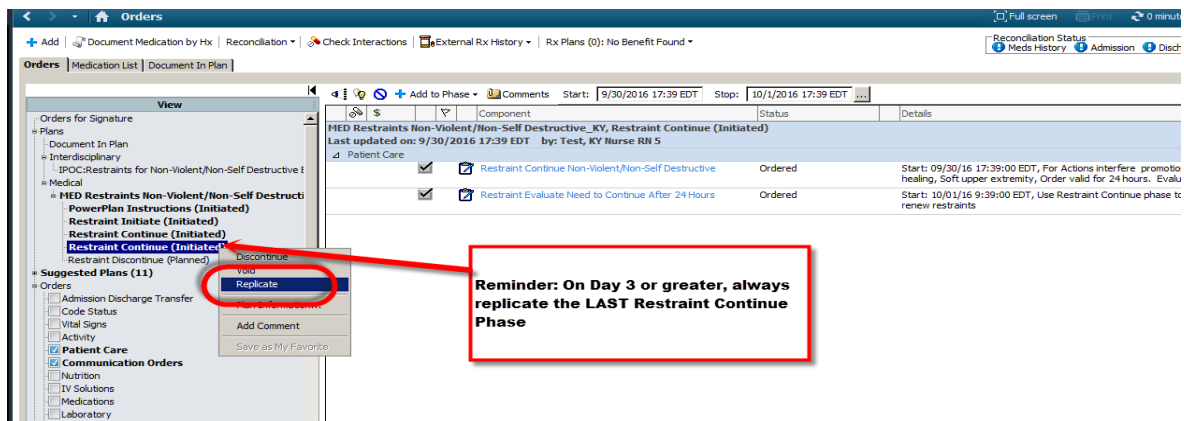
Non-Violent/Non-Self-Destructive Restraint orders are to be continued every 24 hours. Open the order's profile and select the Restraint Continue Planned Phase. select/complete the Restraint Continue

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

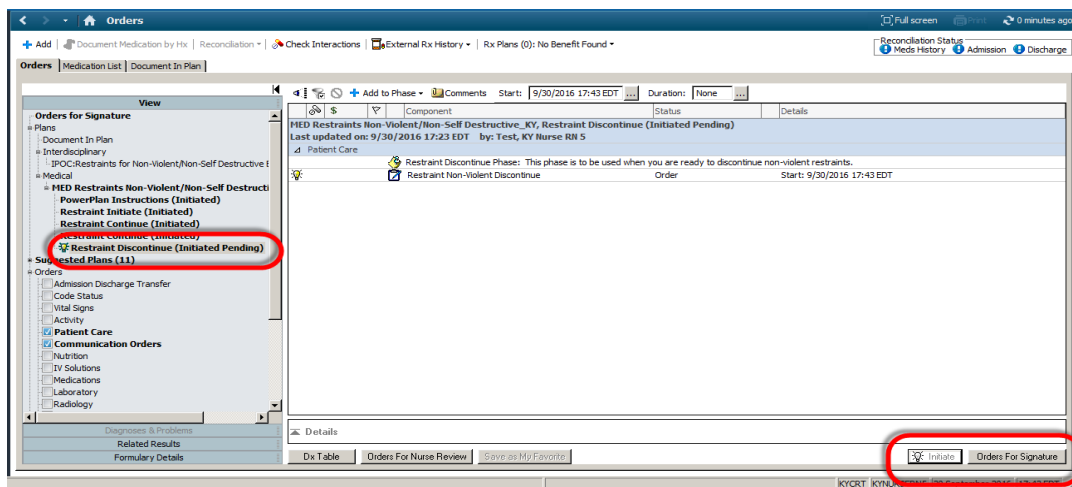
The screenshot shows the 'Orders' window with the 'MED Restraints Non-Violent/Non-Self Destructive' order selected. The left sidebar shows the 'Restraint Continue (Planned)' option under 'Suggested Plans (11)'. The main area displays the details for the 'Restraint Continue Non-Violent/Non-Self Destructive' order, including a 'Reason for Restraint Nonviolent/Non-Se...' dropdown and a 'Restraint Type' dropdown. The 'Initiate' and 'Sign' buttons are highlighted at the bottom right.

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

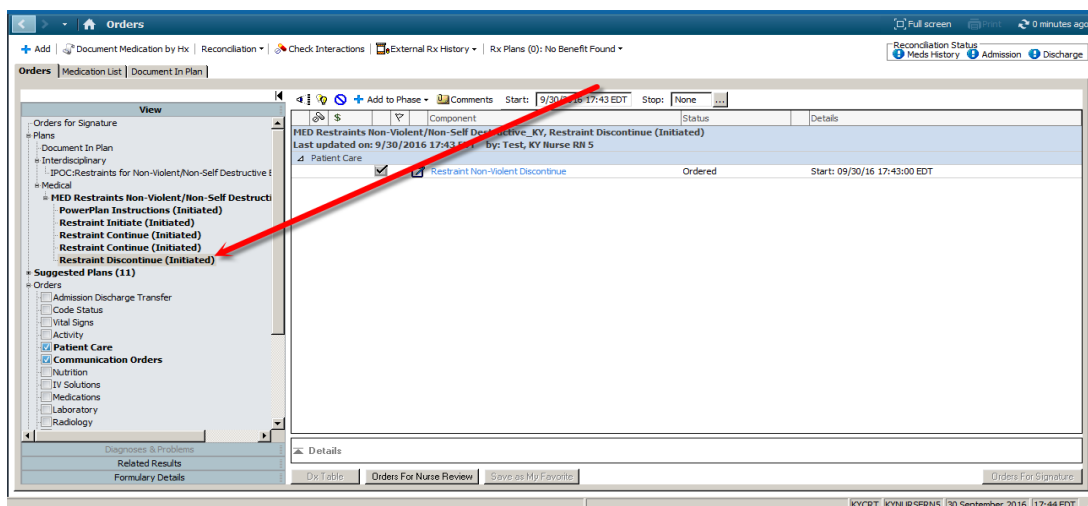
The screenshot shows the 'Orders' window with the 'MED Restraints Non-Violent/Non-Self Destructive' order selected. The left sidebar shows the 'Restraint Continue (Initiated)' option under 'Suggested Plans (11)'. The main area displays the details for the 'Restraint Continue Non-Violent/Non-Self Destructive' order, including a table of orders with columns for 'Component', 'Status', and 'Details'. The 'Initiate' and 'Sign' buttons are highlighted at the bottom right.



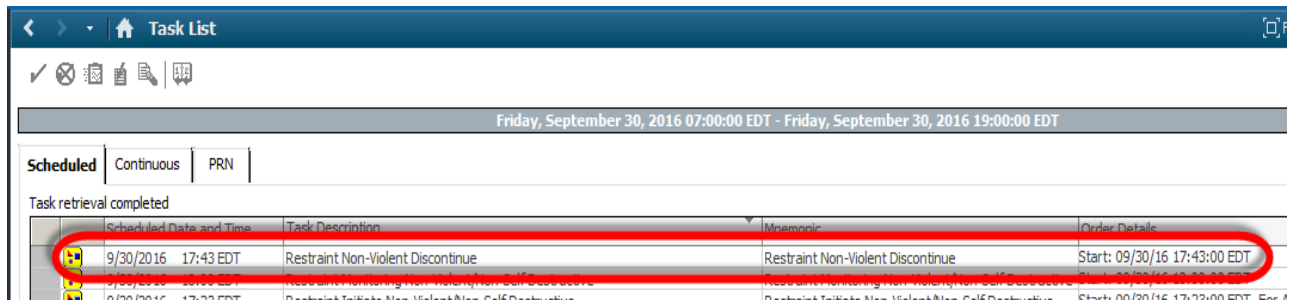
Once appropriate to discontinue the Non Violent Restraints, open the order's profile and select the Restraint Discontinue Planned Phase. Select/complete the Restraint Non Violent Discontinue Order, Initiate and Sign the PowerPlan.



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

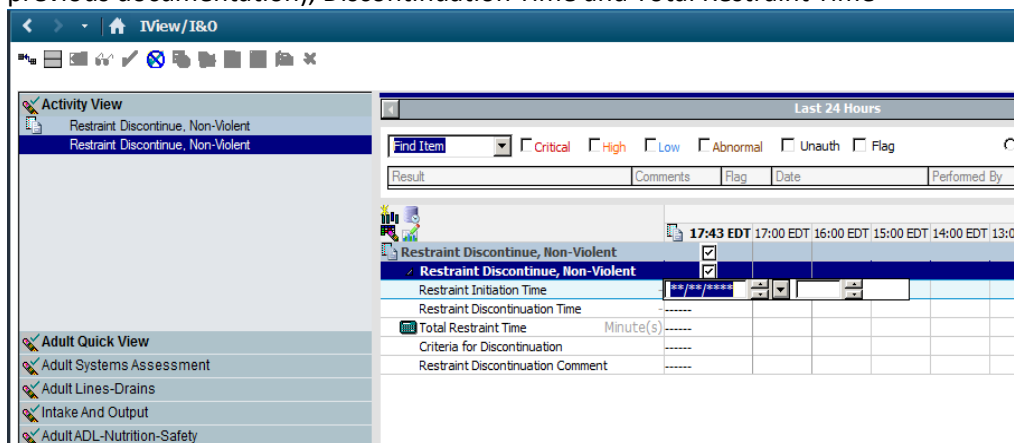


The restraint DiscontinueTask will display on the Task List



Scheduled Date and Time	Task Description	Mnemonic	Order Details
9/30/2016 17:43 EDT	Restraint Non-Violent Discontinue	Restraint Non-Violent Discontinue	Start: 09/30/16 17:43:00 EDT
9/30/2016 17:43 EDT	Restraint Non-Violent Discontinue	Restraint Non-Violent Discontinue	Start: 09/30/16 17:43:00 EDT
9/30/2016 17:43 EDT	Restraint Non-Violent Discontinue	Restraint Non-Violent Discontinue	Start: 09/30/16 17:43:00 EDT

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



Activity View

- Restraint Discontinue, Non-Violent
- Restraint Discontinue, Non-Violent

Adult Quick View

- Adult Systems Assessment
- Adult Lines-Drains
- Intake And Output
- Adult ADL-Nutrition-Safety

Last 24 Hours

Find Item: Critical ☐ High ☐ Low ☐ Abnormal ☐ Unauth ☐ Flag

Result	Comments	Flag	Date	Performed By
Restraint Discontinue, Non-Violent			17:43 EDT	
Restraint Discontinue, Non-Violent			17:00 EDT	
Restraint Discontinue, Non-Violent			16:00 EDT	
Restraint Discontinue, Non-Violent			15:00 EDT	
Restraint Discontinue, Non-Violent			14:00 EDT	
Restraint Discontinue, Non-Violent			13:00 EDT	

Restraint Discontinue, Non-Violent

Restraint Initiation Time:

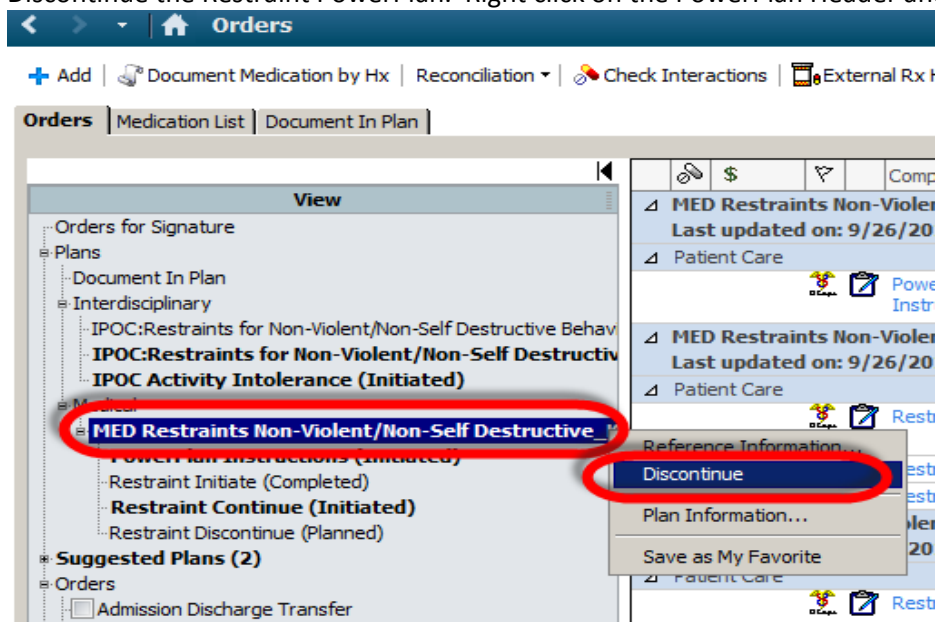
Restraint Discontinuation Time:

Total Restraint Time: Minute(s)

Criteria for Discontinuation:

Restraint Discontinuation Comment:

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



Orders | Medication List | Document In Plan

+ Add | Document Medication by Hx | Reconciliation | Check Interactions | External Rx

View

- Orders for Signature
 - Plans
 - Document In Plan
 - Interdisciplinary
 - IPOC:Restraints for Non-Violent/Non-Self Destructive Behavior
 - IPOC:Restraints for Non-Violent/Non-Self Destructive Behavior
 - IPOC Activity Intolerance (Initiated)
 - MED Restraints Non-Violent/Non-Self Destructive**
 - Power Plan Instructions (Initiated)
 - Restraint Initiate (Completed)
 - Restraint Continue (Initiated)
 - Restraint Discontinue (Planned)
 - Suggested Plans (2)
 - Orders
 - Admission Discharge Transfer

MED Restraints Non-Violent/Non-Self Destructive

Last updated on: 9/26/20

Patient Care

Power Instr

MED Restraints Non-Violent/Non-Self Destructive

Last updated on: 9/26/20

Patient Care

Rest

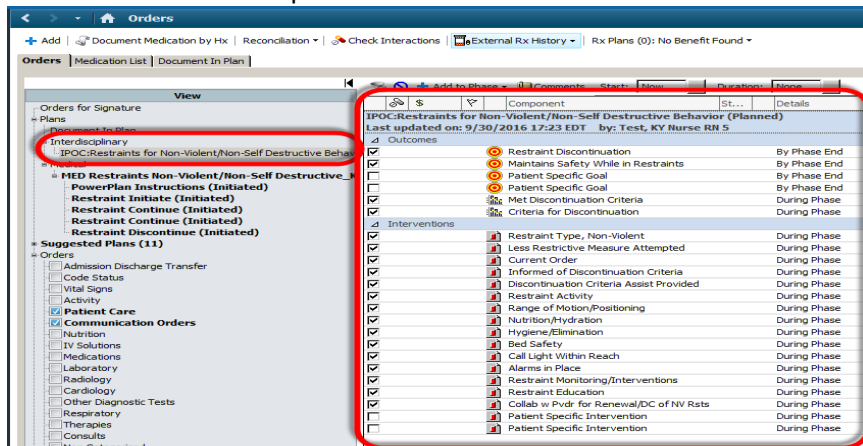
Reference Information...

Discontinue

Plan Information...

Save as My Favorite

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

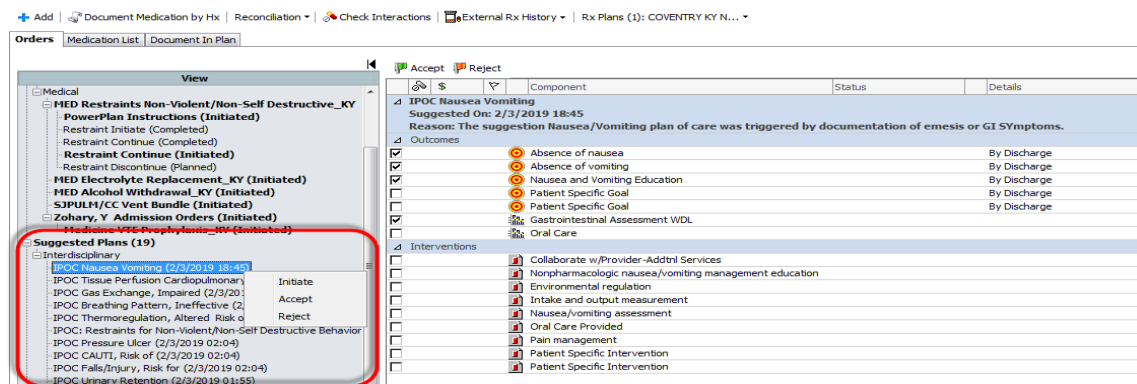
The IPOC Goals, Indicators and Interventions should be updated by a registered nurse at a minimum of Q 24 hours and when there is a change in status.

- 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 IVEIW 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.

Diagnoses & Problems

Diagnosis (Problem) being Addressed this Visit

Problems

Search: IPOC

My Favorite Plans

IPOC Activity Intolerance

- **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.

IPOC Activity Intolerance (Initiated Pending)

Outcomes

Interventions

Details

Outcome Details

Outcome Duration: 1

Duration Unit: Days

Codified Duration: By Discharge

Modify

Outcome Duration and Unit- Hours, Days, etc. Enter the applicable targeted number and unit.

Codified Duration- By Discharge if the goal is more generalized and by discharge is appropriate.

- 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"

IPOC Joint Replacement (Planned Pending)

Component	Status	Details
4 Outcomes		
<input checked="" type="checkbox"/> Maintain Patient Safety	By Discharge	
<input checked="" type="checkbox"/> Mental status intact	By Discharge	
<input checked="" type="checkbox"/> Cardiovascular Status at Baseline	By Discharge	
<input checked="" type="checkbox"/> Neurovascular Function Intact	By Discharge	
<input checked="" type="checkbox"/> Respiratory Status at Baseline	By Discharge	
<input checked="" type="checkbox"/> Maintains Pain Level Within Pt's Goal	By Discharge	
<input checked="" type="checkbox"/> Mobilize Post Op Day 0	Within 24 Hours	
<input checked="" type="checkbox"/> Mobilize Post Op Day 1	Within 1 Days	
<input checked="" type="checkbox"/> Mobilize Post Op Day 2	Within 2 Days	
<input checked="" type="checkbox"/> Mobilize Post Op Day 3	Within 3 Days	
<input checked="" type="checkbox"/> Maximizes Level of Mobility	By Discharge	
<input checked="" type="checkbox"/> Skin integrity intact	By Discharge	
<input checked="" type="checkbox"/> Surgical Dressing Intact	By Discharge	
<input checked="" type="checkbox"/> Absence of infection signs and symptoms	By Discharge	
<input checked="" type="checkbox"/> Maintain/achieve optimal nutritional requirements	By Discharge	
<input checked="" type="checkbox"/> Adequate Urinary Output	By Discharge	
<input checked="" type="checkbox"/> Maintain/achieve optimal bowel function	By Discharge	
<input checked="" type="checkbox"/> Glucose level within specified parameters	By Discharge	
<input checked="" type="checkbox"/> Progressing towards discharge	By Discharge	
<input checked="" type="checkbox"/> Patient Specific Goal # 1	By Discharge	Modify
<input checked="" type="checkbox"/> Patient Specific Goal # 2	By Discharge	
<input checked="" type="checkbox"/> Neurologic Assessment WDL		
<input checked="" type="checkbox"/> Cardiovascular Assessment WDL		
<input checked="" type="checkbox"/> Respiratory Assessment WDL		
<input checked="" type="checkbox"/> Pain Present		
<input checked="" type="checkbox"/> Activity Tolerance		
<input checked="" type="checkbox"/> Walking Distance		
<input checked="" type="checkbox"/> Weight Bearing		
<input checked="" type="checkbox"/> Integumentary Assessment WDL		
<input checked="" type="checkbox"/> Gastrointestinal Assessment WDL		
<input checked="" type="checkbox"/> Genitourinary Assessment WDL		

Details

Dx Table Orders For Nurse Review Save as My Favorite Initiate Sign

Details

Outcome Details Offset Details

Description	Outcome Duration	Duration Unit	Codified Duration
Patient 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




IPOC Joint Replacement (Planned Pending)




































Component	Status	Details
4 Outcomes		
<input checked="" type="checkbox"/> Maintain Patient Safety	By Discharge	
<input checked="" type="checkbox"/> Mental status intact	By Discharge	
<input checked="" type="checkbox"/> Cardiovascular Status at Baseline	By Discharge	
<input checked="" type="checkbox"/> Neurovascular Function Intact	By Discharge	
<input checked="" type="checkbox"/> Respiratory Status at Baseline	By Discharge	
<input checked="" type="checkbox"/> Maintains Pain Level Within Pt's Goal	By Discharge	
<input checked="" type="checkbox"/> Mobilize Post Op Day 0	Within 24 Hours	
<input checked="" type="checkbox"/> Mobilize Post Op Day 1	Within 1 Days	
<input checked="" type="checkbox"/> Mobilize Post Op Day 2	Within 2 Days	
<input checked="" type="checkbox"/> Mobilize Post Op Day 3	Within 3 Days	
<input checked="" type="checkbox"/> Maximizes Level of Mobility	By Discharge	
<input checked="" type="checkbox"/> Skin integrity intact	By Discharge	
<input checked="" type="checkbox"/> Surgical Dressing Intact	By Discharge	
<input checked="" type="checkbox"/> Absence of infection signs and symptoms	By Discharge	
<input checked="" type="checkbox"/> Maintain/achieve optimal nutritional requirements	By Discharge	
<input checked="" type="checkbox"/> Adequate Urinary Output	By Discharge	
<input checked="" type="checkbox"/> Maintain/achieve optimal bowel function	By Discharge	
<input checked="" type="checkbox"/> Glucose level within specified parameters	By Discharge	
<input checked="" type="checkbox"/> Progressing towards discharge	By Discharge	
<input checked="" type="checkbox"/> Patient Specific Goal # 1	By Discharge	
<input checked="" type="checkbox"/> Patient Specific Goal # 2	By Discharge	
<input checked="" type="checkbox"/> Neurologic Assessment WDL		
<input checked="" type="checkbox"/> Cardiovascular Assessment WDL		
<input checked="" type="checkbox"/> Respiratory Assessment WDL		
<input checked="" type="checkbox"/> Pain Present		
<input checked="" type="checkbox"/> Activity Tolerance		
<input checked="" type="checkbox"/> Walking Distance		
<input checked="" type="checkbox"/> Weight Bearing		
<input checked="" type="checkbox"/> Integumentary Assessment WDL		
<input checked="" type="checkbox"/> Gastrointestinal Assessment WDL		
<input checked="" type="checkbox"/> Genitourinary Assessment WDL		
<input checked="" type="checkbox"/> Post Discharge Assistance Arranged		
5 Interventions		
<input checked="" type="checkbox"/> Collaborate w/Provider-Addtl Services		
<input checked="" type="checkbox"/> Other Devices/Treatments as Ordered		
<input checked="" type="checkbox"/> Antithrombotic Therapy		

Details

Dx Table Orders For Nurse Review Save as My Favorite Initiate Sign

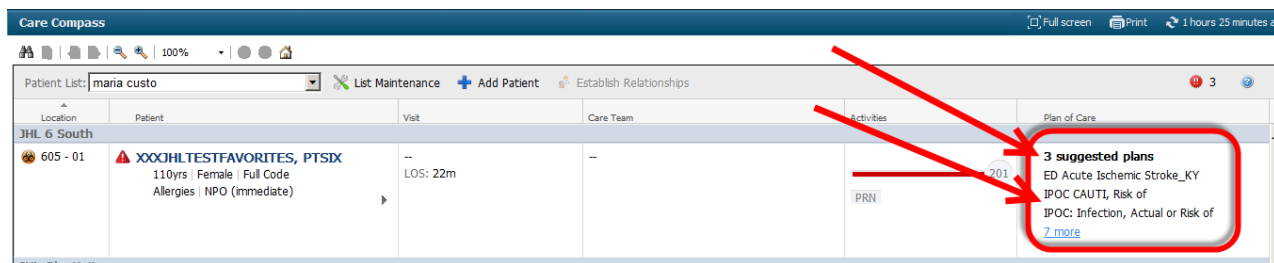
Documenting/Updating Goals/Indicators/Interventions

- 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.

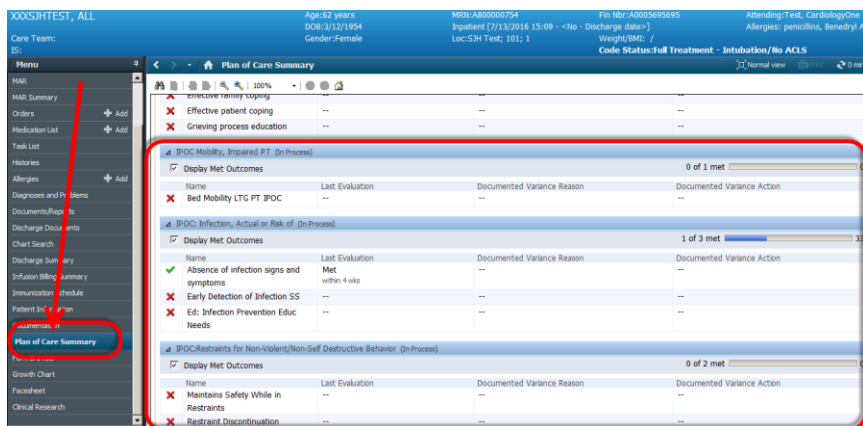
Orders Medication List Document In Plan						
Description	Last Evaluated	Target	Status		Outcome Description	
IPOC CAUTI, Risk of (Initiated) 10/19/2016 18:31 EDT					Absence of Urinary Tr	
 Absence of Urinary Tract Infection SS		By Phase End	charted		<input checked="" type="radio"/> Met <input type="radio"/> Not met	
 Urinary Catheter Education Needs		By Phase End				
 Timely Removal of Urinary Catheter		By Phase End			10/19/2016	
 Genitourinary Assessment WDL		Phase End				
 Indwelling Catheter Indication	 10/19/2016 18:37 EDT	Phase End				
 Urinary Catheter Renewal/Cont Order		Phase End				
 Temperature, Fahrenheit		Phase End				
 Temperature, Celsius - Less Than or Equal 38.4 Deg C		Phase End				
 Urine Description		Phase End				
 Urinary Catheter Activity		Phase End				
 Urinary Catheter Secured	 10/19/2016 18:37 EDT	Phase End				
 Urine Collection Device	 10/19/2016 18:37 EDT	Phase End				
 Catheter Care Provided	 10/19/2016 18:37 EDT	Phase End				
 Review Available Laboratory Results		Phase End				
 Urinary Catheter Bundle	 10/19/2016 18:37 EDT	Phase End				
 Ed-Indwelling Catheter		Phase End				
 Ed-Urinary Catheter Care		Phase End				
 Collaborate w/Provider Renewal/Cont Cath - Done		Phase End				

In this example, the fields with a green check mark pulled into the IPOC from the documentation completed in IVIEW

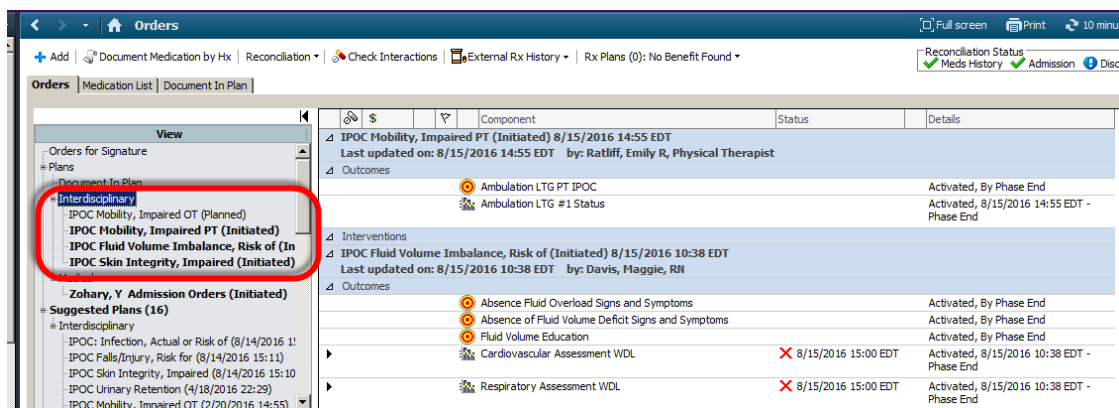
- Each patient's Initiated IPOCs can be reviewed in the following three areas:
 - CareCompass
 - Orders Profile



○ 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).

Scheduled/Unscheduled PRN/Continuous Plans of Care Patient Information

2 Hours 4 Hours 12 Hours

Current

Admission History Adult Admission History, Adult Start: 04/23/18 13:41:27 EDT
Comment: Order entered secondary to patient admission.

Complete Admission Workflow Start: 04/23/18 13:41:27 EDT
Comment: Complete Home Meds, Allergies, Histories and Problems using the Nursing Admission page.

Scheduled Continuous PRN				
Task retrieval completed				
	Scheduled Date and Time	Task Description	Order Details	Task S
	5/22/2018 8:18 EDT	Admission History, Adult	Start: 05/22/18 8:18:43 EDT Order entered secondary to patient admission.	Overd
	5/22/2018 8:18 EDT	Complete Admission Workflow	Start: 05/22/18 8:18:43 EDT Complete Home Meds, Allergies, Histories and Problems using the Nursing ...	Overd

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

ZZZSJTEST, OBSWORKFLOW

Care Team: ZZZSJTEST, OBSWORKFLOW

IS: Age:44 years DOB:3/1/1974 Admin Sex:Female MRN:E000789875 Observation [4/4/2018 9:35 - <No - Loc:SJE ET3; 326; 1 No Outside Documents

Menu

Patient Handoff

Admission Workflow

Results Review

IVIEW/I&O

Admission Workflow

Admission

Home Medications (0)

Home Medications (0)

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.

The screenshot shows the 'Home Medications' interface. On the left is a sidebar with navigation links. The main area displays a table with columns: Medication, Mismatches Identified, Compliance, Originating Source, Last Modified Date, and Actions. The table is divided into 'Unverified Data from Outside Sources' and 'Verified Local Record Data'. A red box highlights the 'Complete History' button at the bottom right, with a note: 'NOTE: If no outside record medications display for reconciliation, click Complete History.' The status bar at the top right shows 'Meds History', 'Admission', and 'Discharge'.

- **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.

This screenshot shows the 'Home Medications' screen with the 'Add with Changes' button highlighted in a red circle. The button is located in the 'Actions' column of the 'Unverified Data from Outside Sources' section. The table lists medications like acetaminophen, albuterol, fexofenadine, Percocet, and warfarin. The status bar at the top right shows 'Meds History', 'Admission', and 'Discharge'.

This screenshot shows the 'Home Medications' screen with the 'Add with Changes' dialog box open. The dialog box contains fields for 'Save', 'Cancel', 'Dose', 'Route', 'Frequency', 'Duration', and 'PRN'. The medication 'acetaminophen 325 mg oral capsule' is selected. The 'Add with Changes' button is highlighted in a red circle. The status bar at the top right shows 'Meds History', 'Admission', and 'Discharge'.

- 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 screenshot shows the 'Home Medications' section of the Admission Workflow. A table lists medications under 'Unverified Data from Outside Sources'. The 'Decline' button in the top right corner is circled in red.

Medication	Mismatches Identified	Compliance
Unverified Data from Outside Sources		
acetaminophen 325 mg oral capsule ♦ Capsule, Oral, 1 Refill(s)	New medication found	--
albuterol 2.5 mg/3 mL (0.083%) inhalation solution ♦ Solution, Inhalation, 1 Refill(s)	New medication found	--
fecofenadine 180 mg oral tablet ♦ Tablet, Oral, 1 Refill(s)	New medication found	--
Pericocet 5/325 oral tablet ♦ 1 Tab, Tablet, Oral, 1 Refill(s)	New medication found	--

Buttons: Add, Decline (circled in red)

Text: albuterol 2.5 mg/3 mL (0.083%) inhalation solution

Outside Records

Originating Source: JHL Jewish Hospital

Addition

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

The screenshot shows the 'Home Medications' section. The 'Refresh Component' button is circled in red. The 'Actions' column is also circled in red, showing the status of each medication.

Medication	Mismatches Identified	Compliance	Originating Source	Last Modified Date	Actions
Unverified Data from Outside Sources					
acetaminophen 325 mg oral capsule ♦ Capsule, Oral, 1 Refill(s)	New medication found	--	JHL Jewish Hospital	07/23/2018 13:47	Added
albuterol 2.5 mg/3 mL (0.083%) inhalation solution ♦ Solution, Inhalation, 1 Refill(s)	New medication found	--	JHL Jewish Hospital	07/23/2018 13:47	Declined
fecofenadine 180 mg oral tablet ♦ Tablet, Oral, 1 Refill(s)	New medication found	--	JHL Jewish Hospital	07/23/2018 13:47	Declined
Pericocet 5/325 oral tablet ♦ 1 Tab, Tablet, Oral, 1 Refill(s)	New medication found	--	JHL Jewish Hospital	07/23/2018 13:47	Declined
warfarin 2 mg oral tablet ♦ Oral, 1 Refill(s)	New medication found	--	JHL Jewish Hospital	07/23/2018 13:47	Declined
Verified Local Record Data					
acetaminophen (Tylenol 325 mg oral capsule) 1 Cap, Oral, Q4H, PRN: as needed for fever, 20 Cap, 0 Refill(s)	--	--	Local record	07/23/2018 13:47	--
cyclobenzaprine (Flexeril) 10 mg, Oral, TID, 0 Refill(s)	--	--	Local record + 1 more	07/23/2018 13:47	--
polyethylene glycol 3350 (MiraLax oral powder for reconstitution) 17 Gram, Oral, Daily, 0 Refill(s)	--	--	Local record + 1 more	07/23/2018 13:47	--

Document History: Completed by Test, KY Nurse RN 4 on 07/24/2018 at 10:40

Buttons: Complete History..., Finish Later

- 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.

The screenshot shows the 'Home Medications' section. The 'Refresh' button is circled in red. The 'Complete History' button is also circled in red.

Medication	Mismatches Identified	Compliance	Originating Source	Last Modified Date	Actions
Unverified Data from Outside Sources					
No results found					
Verified Local Record Data					
acetaminophen (acetaminophen 325 mg oral capsule) Capsule, Oral, 1 Refill(s), 0 Refill(s)	--	Home Med: Taking as prescribed	Local record	07/24/2018 10:50	--
acetaminophen (Tylenol 325 mg oral capsule) 1 Cap, Oral, Q4H, PRN: as needed for fever, 20 Cap, 0 Refill(s)	--	--	Local record	07/19/2018 13:47	--
cyclobenzaprine (Flexeril) 10 mg, Oral, TID, 0 Refill(s)	--	--	Local record + 1 more	07/19/2018 13:47	--
polyethylene glycol 3350 (MiraLax oral powder for reconstitution) 17 Gram, Oral, Daily, 0 Refill(s)	--	--	Local record + 1 more	07/19/2018 13:47	--

Document History: Completed by Test, KY Nurse RN 4 on 07/24/2018 at 10:50

Buttons: Complete History..., Finish Later

- 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.

Medication	Responsible Provider	Compliance	Estimated Supply Remaining
acetaminophen (acetaminophen 325 mg oral capsule) Capsule, Oral, 1 Refill(s), 0 Refill(s)	--	Home Med: Taking as prescribed	--
acetaminophen (Tylenol 325 mg oral capsule) 1 Cap, Oral, Q4H, PRN: as needed for fever, 20 Cap, 0 Refill(s)	--	--	--
cyclobenzaprine (Flexeril) 10 mg, Oral, TID, 0 Refill(s)	--	--	--
polyethylene glycol 3350 (MiraLax oral powder for reconstitution) 17 Gram, Oral, Daily, 0 Refill(s)	--	--	--

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

Substance	Mismatches Identified	Reactions	Severity	Originating Source	Last Modified Date	Actions
Unverified Data from Outside Sources						
amoxicillin-clavulanate	New Drug allergy found	--	--	JHL Jewish Hospital	07/23/2018	--
phenytoin	New Drug allergy found	--	--	JHL Jewish Hospital	07/23/2018	--
shellfish	New allergy found	--	--	JHL Jewish Hospital	07/23/2018	--
Verified Local Record Data						
Eggs	--	--	--	Local record + 1 more	--	--
penicillin	--	--	--	Local record + 1 more	--	--

- **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.

The screenshot shows the 'Allergies' section of the Admission Workflow. The 'Add' button is highlighted in the top right corner of the allergy line. The 'Add with Changes' button is also visible. The 'Outside Records' panel on the right shows the details for the selected allergy.

Substance	Mismatches Identified	Reactions	Severity
Unverified Data from Outside Sources			
amoxicillin-clavulanate	New Drug allergy found	--	--
penicillin	New Drug allergy found	--	--
phenytoin	New Drug allergy found	--	--
shellfish	New allergy found	--	--
Verified Local Record Data			
Eggs	--	--	--

Reconciliation Status: **Incomplete** Complete Reconciliation Finish Later

- **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 screenshot shows the 'Allergies' section of the Admission Workflow. The 'Decline' button is highlighted in the top right corner of the allergy line. The 'Add' button is also visible. The 'Outside Records' panel on the right shows the details for the selected allergy.

Substance	Mismatches Identified	Reactions	Severity
Unverified Data from Outside Sources			
amoxicillin-clavulanate	New Drug allergy found	--	--
penicillin	New Drug allergy found	--	--
phenytoin	New Drug allergy found	--	--
shellfish	New allergy found	--	--
Verified Local Record Data			
Eggs	--	--	--

Reconciliation Status: **Incomplete** Complete Reconciliation Finish Later

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

The screenshot shows the 'Allergies' section of the Admission Workflow. The 'Actions' column is highlighted in the top right corner of the allergy line. The 'Add' button is also visible. The 'Outside Records' panel on the right shows the details for the selected allergy.

Substance	Mismatches Identified	Reactions	Severity	Originating Source	Last Modified Date	Actions
Unverified Data from Outside Sources						
amoxicillin-clavulanate	New Drug allergy found	--	--	JHL Jewish Hospital	07/23/2018	Added
phenytoin	New Drug allergy found	--	--	JHL Jewish Hospital	07/23/2018	Declined
shellfish	New allergy found	--	--	JHL Jewish Hospital	07/23/2018	Added
Verified Local Record Data						
Eggs	--	--	--	Local record + 1 more	--	--
penicillin	--	--	--	Local record + 1 more	--	--

Reconciliation Status: **Incomplete** Complete Reconciliation Finish Later

- 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**.

The screenshot shows the 'Allergies' section in the Admission Workflow. The 'Reconciliation Status' is 'Incomplete'. A red box highlights the 'Refresh' button in the top right. Another red box highlights the 'Complete Reconciliation' button at the bottom right. A red arrow points from the 'Refresh' button to the 'Verified Local Record Data' table.

Substance	Mismatches Identified	Reactions	Severity	Originating Source	Last Modified Date	Actions
Unverified Data from Outside Sources						
No results found						
Verified Local Record Data						
amoxicillin-clavulanate	--	--	--	Local record	07/23/2018	--
penicillin	--	--	--	Local record	07/23/2018	--
phenytoin	--	--	--	Local record	07/23/2018	--
Augmentin	--	--	--	Local record	--	--
shellfish	--	--	--	Local record + 1 more	--	--

- **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.

The screenshot shows the 'Allergies' section. A red box highlights the 'Allergies (3)' link in the left sidebar. A callout box points to this link with the text: 'To Add Allergies-Click on the Allergies component name to open the Allergy control.'

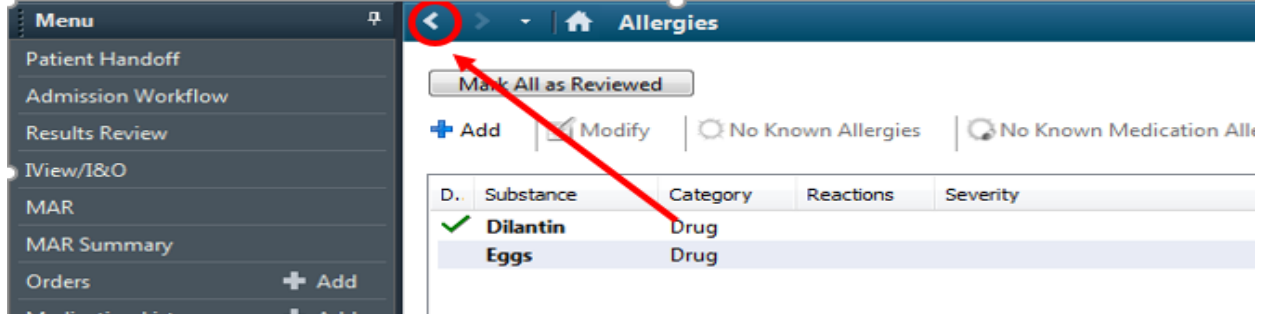
Substance	Reactions	Category	Status	Severity	Reaction Type	Source	Comments
amoxicillin-clavulanate	--	Drug	Active	--	Allergy	--	--
penicillin	--	Drug	Active	--	Allergy	--	--
* Eggs	--	Drug	Active	--	Allergy	--	--

- **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.

The screenshot shows the 'Allergies' section. A red box highlights the 'Allergies (1)' link in the left sidebar. A callout box points to this link with the text: 'Click on Allergies to select "Mark as Reviewed"'. Below the table, a red box highlights the 'Mark All as Reviewed' button.

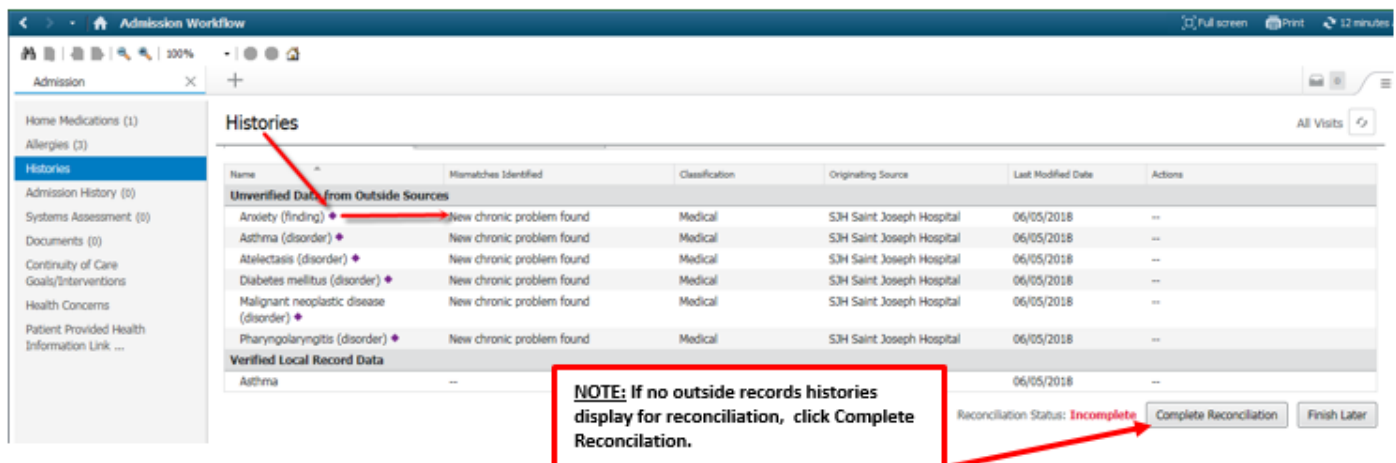
Substance	Reactions	Category	Status	Severity	Reaction Type	Source	Comments
sulfa drugs	Rash	Drug	Active	Mild	Allergy	--	--

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

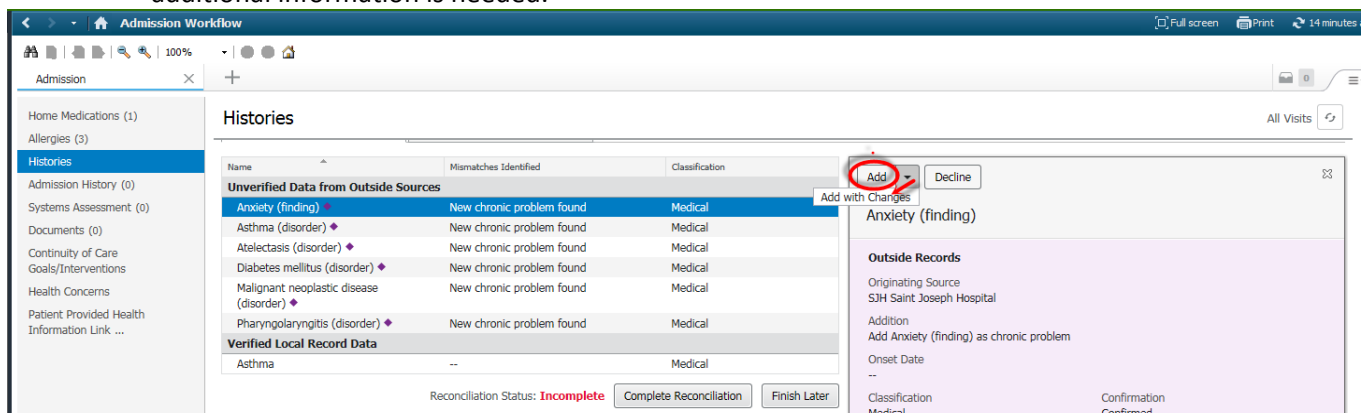


Document Histories (Problems and Procedures)

- **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**.

Admission Workflow

Histories

Name	Mismatches Identified	Classification
Unverified Data from Outside Sources		
Asthma (disorder)	New chronic problem found	Medical
Atelectasis (disorder)	New chronic problem found	Medical
Diabetes mellitus (disorder)	New chronic problem found	Medical
Malignant neoplastic disease (disorder)	New chronic problem found	Medical
Pharyngolaryngitis (disorder)	New chronic problem found	Medical
Verified Local Record Data		
Asthma	--	Medical

Reconciliation Status: **Incomplete** Complete Reconciliation Finish Later

Decline

Asthma (disorder)

Outside Records

Originating Source
SJH Saint Joseph Hospital

Addition
Add Asthma (disorder) as chr

Onset Date
--

Classification
Medical

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

Histories

Name	Mismatches Identified	Classification	Originating Source	Last Modified Date	Actions
Unverified Data from Outside Sources					
Anxiety (finding)	New chronic problem found	Medical	JHS Jewish Hospital Shelbyville	07/23/2018	Declined
Asthma (disorder)	New chronic problem found	Medical	JHS Jewish Hospital Shelbyville	07/23/2018	Declined
Atelectasis (disorder)	New chronic problem found	Medical	JHS Jewish Hospital Shelbyville	07/23/2018	Added
Diabetes mellitus (disorder)	New chronic problem found	Medical	JHS Jewish Hospital Shelbyville	07/23/2018	Added
Malignant neoplastic disease (disorder)	New chronic problem found	Medical	JHS Jewish Hospital Shelbyville	07/23/2018	Added
Pharyngolaryngitis (disorder)	New chronic problem found	Medical	JHS Jewish Hospital Shelbyville	07/23/2018	Added
Verified Local Record Data					
Acute anxiety	--	Patient Stated	Local record	07/19/2018	--
Asthma	--	Patient Stated	Local record	07/19/2018	--

Reconciliation Status: **Incomplete** Complete Reconciliation Finish

- 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**.

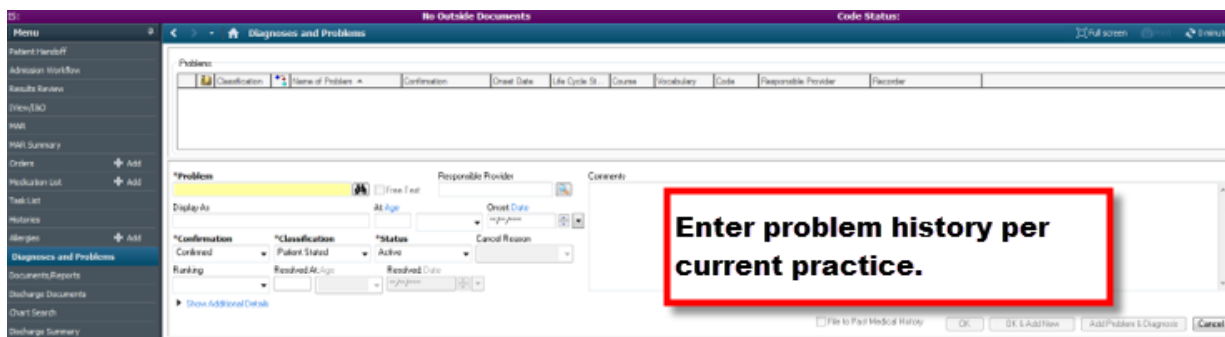
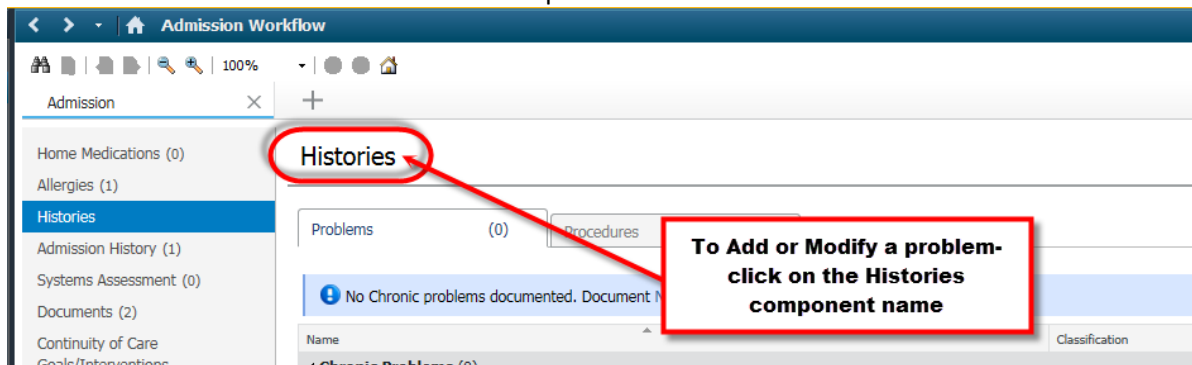
Histories

Name	Mismatches Identified	Classification	Originating Source	Last Modified Date	Actions
Unverified Data from Outside Sources					
No results found					
Verified Local Record Data					
Acute anxiety	--	Patient Stated	Local record	07/19/2018	--
Asthma	--	Patient Stated	Local record	07/19/2018	--
Atelectasis	--	Medical	Local record	07/25/2018	--
Diabetes mellitus	--	Medical	Local record	07/25/2018	--
Malignant neoplastic disease	--	Medical	Local record	07/25/2018	--
Pharyngolaryngitis	--	Medical	Local record	07/25/2018	--

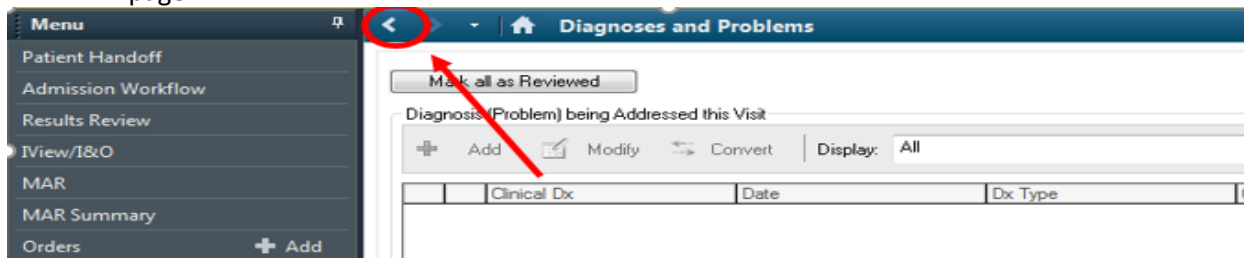
Reconciliation Status: **Incomplete** Complete Reconciliation Finish Later

Refresh

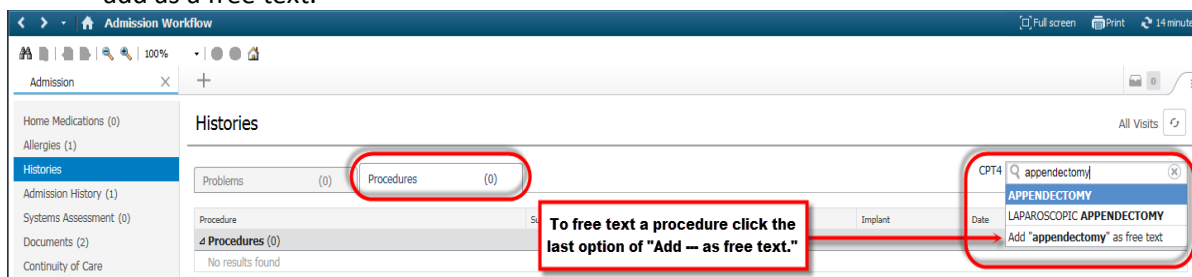
- **Second - Add New or Modify Existing Problem-** Click on the Histories component name to enter the Problem tool. Add appropriate problem information as you do today and select OK in the Problem tool once complete.



- 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.



Admission Workflow

Home Medications (0) Allergies (1) Histories Admission History (1) Systems Assessment (0) Documents (2) Continuity of Care Goals/Interventions Health Concerns Patient Provided Health Information Link

Histories

Problems (0) Procedures (0) CPT4 Add procedure

Procedure	Surgeon	Implant	Date
APPENDectomy	--	--	--

Admission History (1)

Systems Assessment (0)

No results found

Save Cancel

APPENDectomy

Procedure Date: At/On Age Years

Provider Status Location

Comments

Enter applicable procedure information and then select SAVE

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

Task List

Tuesday, May 29, 2018 07:00:00 EDT - Tuesday, May 29, 2018 19:00:00 EDT

Scheduled Continuous PRN

Task retrieval completed

Scheduled Date and Time	Task Description	Order Details	Task Status
5/22/2018 8:18 EDT	Admission History, Adult	Start: 05/22/18 8:18:43 EDT Order entered secondary to patient admission.	Overdue
5/22/2018 8:18 EDT	Complete Admission Workflow	Start: 05/22/18 8:18:43 EDT Complete Home Meds, Allergies, Histories and Problems using the Nursing Admiss...	Overdue
5/22/2018 8:18 EDT	Document Patient	2/18 8:18:44 EDT red secondary to patient admission.	Overdue
5/22/2018 8:18 EDT	Modified Massey B	2/18 8:18:45 EDT red secondary to patient admission.	Overdue
5/22/2018 17:00 EDT	Chart Check-Review	2/18 17:00:00 EDT red secondary to patient admission.	Overdue
5/22/2018 17:00 EDT	Review Care Plan	2/18 17:00:00 EDT red secondary to patient admission.	Overdue
5/23/2018 2:00 EDT	Order Entry Detail	3/18 2:00:00 EDT red secondary to patient admission.	Overdue

Complete Admission Workflow (Chart Done) - zzzj...

Date/Time: 05/22/2018 08:18 EDT

Performed by: Test, KY Nurse RN 4

OK Cancel

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".

Scheduled/Unscheduled PRN/Continuous Plans of Care Patient Information

2 Hours 4 Hours 12 Hours

Admission History Adult Admission History, Adult Start: 05/22/18 8:18:43 EDT
Comment: Order entered secondary to patient admission.

Task List

Tuesday, May 29, 2018 07:00:00 EDT - Tuesday, May 29, 2018 19:00:00 EDT

Scheduled Continuous PRN

Task retrieval completed

Scheduled Date and Time	Task Description	Order Details	Task Status	Last D
5/22/2018 8:18 EDT	Admission History, Adult	Start: 05/22/18 8:18:43 EDT Order entered secondary to patient admission.	Overdue	

- 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 **NOTE:** 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.

Sexual

Sexually active: ☐ Yes ☐ No

First active at age: Age Year(s)

Current partners:

Number of lifetime partners:

Self described orientation: ☐ Lesbian, gay or homosexual
☐ Straight or heterosexual
☐ Bisexual
☐ Something else, please describe (by selecting Other)
☐ Don't know
☐ Choose not to disclose
☐ Other:

Uses condoms: ☐ Yes ☐ No

Other contraceptive use:

History of sexual abuse: ☐ Yes ☐ No

Other sexual concerns:

What is your current gender identity? (Check all that apply)

☐ Identifies as male
☐ Identifies as female
☐ Female-to-Male (FTM)/ Trans Male/Trans Man
☐ Male-to-Female (MTF)/Trans Female/Trans Woman
☐ Genderqueer, neither exclusively male nor female
☐ Add gender category/other, please specify
☐ Choose not to disclose
☐ Other:

Comment:

- 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.

Admission History, Adult - zzzjhiltest, admissiontask

Performed on: 05/22/2018 08:18 EDT

Advance Directive

Anesthesia/Transfusion History

Anticipated Discharge Needs

Education Topics, Admission Orientation

Functional Assessment

General Info

Fall Risk Scales

Health History

Height and Weight, Clinical Dosing

Immunization History

Infectious Disease History

Tetanus Immunization Status

Influenza Vaccine Admin, Adult

Pneumococcal Vaccine

Order Details

Nutrition History

Psychosocial History

Sleep Apnea Risk Assmt

Spiritual/Cultural Needs

Values and Belongings

Allergies, Home Medications and Past Medical Problems/Procedures are to be completed via the Admission Workflow or PreProcedure page.

Tobacco Use

Smoking Status *Q

☐ Never (less than 100 in lifetime)

☐ 4 or less cigarettes (less than 1/4 pack)/day in last 30 days

☐ 5-9 cigarettes (between 1/4 to 1/2 pack)/day in last 30 days

☐ 10 or more cigarettes (1/2 pack or more)/day in last 30 days

☐ Cigars or pipes daily within last 30 days

☐ Cigars or pipes but not daily within last 30 days

☐ Smoker, current status unknown

☐ Former smoker, quit more than 30 days ago

☐ Refused tobacco status screen

☐ Not obtained due to cognitive impairment

☐ Other:

Smokeless Tobacco Status *Q

☐ Never

☐ Smokeless tobacco user within last 30 days

☐ Former smokeless tobacco user, quit more than 30 days ago

☐ Refused tobacco status screen

☐ Not obtained due to cognitive impairment

Desires Tobacco Cessation Medication

☐ Yes

☐ No

Reason for No Tobacco Cessation Medication

☐ Refuses FDA approved medications

☐ ED/procedural patient only

☐ Other:

Mark all as Reviewed

Social

Category	Details	Last Reviewed
Tobacco		
Alcohol		
Substance Abuse		
Nutrition/Health		
Exercise		
Home/Environment		
Employment/School		
Sexual		
Other		

Implant/Devices

Implant/Device Type, Manufacturer and Model

Tahoma

Ensure all implant/device card(s) are copied and on chart

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

Admission History (9)

Unable to Assess Patient History	Patient confused
Preferred Name	Johnny
Arrived From	Home
Chief Complaint	SOA and CP
Legal Guardian Name	John Smith

Support Person/Pt Rep Name	Sister
Patient has Advance Directive	Yes, Advance Directive with the patient
Advance Directive Type	CPR directive
Copy Advance Directive Verified/on Chart	Yes

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

The screenshot shows the Admission Workflow Mpage with the Patient Pharmacy tool icon circled in the tool bar. The tool bar includes various icons for patient management, including Patient Pharmacy.

From the Document Home Medication Tool

The screenshot shows the Document Home Medication tool with the Patient Pharmacy tool icon circled. The tool displays a list of home medications for the patient.

Order Name	Status	Details	Last Dose Date/Time	Information Source	Compliance Status
atorvastatin (Lipitor) 10 mg oral tablet	Prescribed	1 Tab, Oral, Tab, QPM, # 30 Tab, 0 Refill(s), other reason (Rx)			
gabapentin (Flexeril)	Documented	10 mg, Oral, Tab, TID, PRN Muscle Spasms, 0 Refill(s)			
aspirin (aspirin 81 mg oral tablet)	Documented	1 Tab, Oral, Tab, Daily, # 30 Tab, 0 Refill(s)			
buPROPion (Wellbutrin XL)	Documented	150 mg, Oral, Daily, 0 Refill(s)			

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

The screenshot shows the Review Patient Preferred Pharmacy tool with the 'No Preferred Pharmacy' option selected. The tool displays a list of pharmacies and a search bar.

☒ No Preferred Pharmacy Reason: **Preferred pharmacy not in directory**

The default pharmacy is displayed as: **Preferred pharmacy not in directory**

Requested paper prescription: **Unable to obtain preferred pharmacy**

Pharmacy Name: _____ Address: _____ Cross-Street: _____ City: _____ State: _____

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 screenshot shows the 'Adult ICU Systems Assessment' section in the IView/I&O interface. The 'Admission Systems Assessment' sub-section is highlighted with a red circle. It includes fields for 'Admission Arrival Time', 'Admission Assessment Completed', and 'Admission Assessment Comment', which are also circled in red. The interface shows a list of assessment categories on the left and a table of results on the right.

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

The screenshot shows the 'Admission Workflow Mpage' with the 'Systems Assessment (3)' section. The table displays results for 'Admission Arrival Time', 'Admission Assessment Completed', and 'Admission Assessment Comment'.

Results (3)	Result	Author	Date/Time
Admission Arrival Time	04/23/18 13:52	Test, KY Nurse RN 10	04/23/18 13:00
Admission Assessment Completed	Yes	Test, KY Nurse RN 10	04/23/18 13:00
Admission Assessment Comment	Pt fell at home. Rolled off bed and sustained L hip fx	Test, KY Nurse RN 10	04/23/18 13:00

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 RECONCILIATION 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 RECONCILIATION 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 RECONCILIATION 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 RECONCILIATION button.
 - Next, click on the HISTORIES header to open the Problem List tool.
 - Update Problem list as you currently do today.

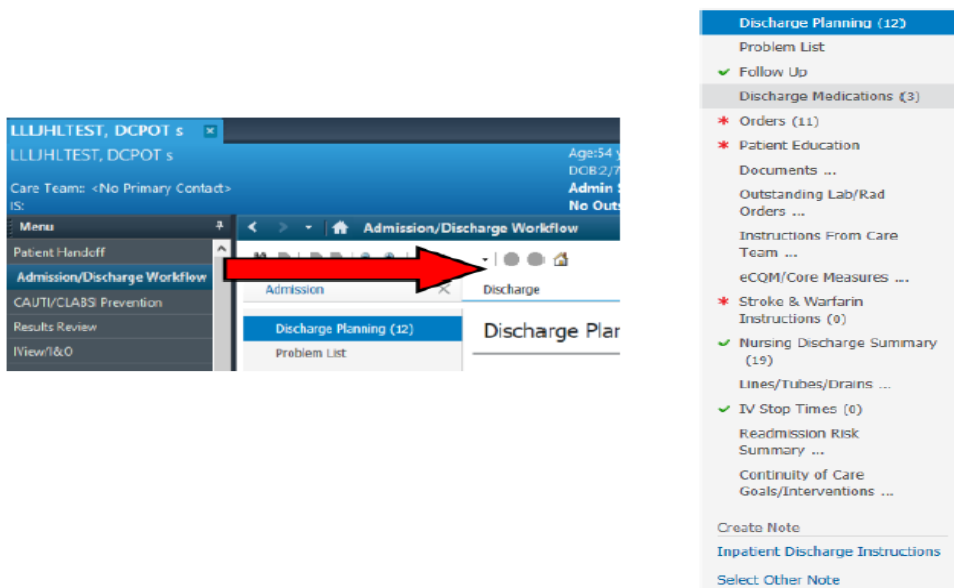
- **Problem List Documentation Update Reminders**
 - For any problems that are no longer active for the patient (ie sore throat, pneumonia, cellulitis, etc)- be sure to change the status to RESOLVED.
- **Procedures will not pull in from outside records.**
 - Click on the Procedure tab and enter the applicable 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.

Discharge Planning (12)	
Discharge Home	Home, self care
Home Caregiver Name/Relationship	John son
Discharge Home Care Needs	Outpatient follow up
Discharge Equipment Needs	Apnea monitor
Discharge Placement Needs	Respite care facility
Barriers to Discharge Plan	Delay of procedure

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.

Name	Classification	Actions	Chronic	Resolve
1 Chest pain	Medical	This Visit	<input checked="" type="checkbox"/> Chronic	Resolve
-- Cholera due to Vibris cholerae O1, biovar cholerae	Medical	This Visit	<input checked="" type="checkbox"/> Chronic	Resolve
-- Dehydration	Medical	This Visit	<input checked="" type="checkbox"/> Chronic	Resolve
-- Weakness	Medical	This Visit	<input checked="" type="checkbox"/> Chronic	Resolve
Anxiety	Patient Stated		<input checked="" type="checkbox"/> Chronic	Resolve
Headaches, cluster	Patient Stated		<input checked="" type="checkbox"/> Chronic	Resolve
Hypertension	Patient Stated		<input checked="" type="checkbox"/> Chronic	Resolve
Historical				
Influenza	Patient Stated		<input type="checkbox"/> Chronic	Resolved
MRSA carrier	Patient Stated		<input type="checkbox"/> Chronic	Resolved
Pain	Medical		<input type="checkbox"/> Chronic	Resolved

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.

Discharge Medications (3)

* To satisfy this requirement, Discharge Medication reconciliation must be complete.

Medication	Responsible Provider	Complete	Estimated Supply Remaining
albuterol (albuterol 2.5 mg/3 mL (0.083%) inhalation solution) 3 mL, Inhalation, Q6H, test, 120 Each, 0 Refill(s)	--	Home Medication: Taking, as prescribed	--
folic acid (folic acid 1 mg oral tablet) 1 Tab, Oral, Daily, 0 Refill(s)	--	Home Medication: Taking, as prescribed	--
metFORMIN (metFORMIN 500 mg oral tablet) 1 Tab, Oral, BID, 180 Tab, 0 Refill(s)	--	--	--

Document History: Completed by Hanke, Lucy, Clinical Informatics on 12/05/2018 at 14:02 View Outside Records

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 to the current orders profile.

Orders (51)

☐ Pending Orders (2) | Group by: Clinical Category | Show: All Active Orders

Type	Order	Start	Status	Status Updated	Ordering Provider	
Admission Discharge Transfer (15)						
Vital Signs (1)	CareMobile Vital Measurements	Start: 12/20/18 15:28:54 EST, PRN	12/20/18 15:28	Ordered	12/20/18 15:28	SYSTEM, SYSTEM
Activity (1)	CareMobile Activities of Daily Living	Start: 12/20/18 15:28:53 EST, PRN	12/20/18 15:28	Ordered	12/20/18 15:28	SYSTEM, SYSTEM
Patient Care (23)						
	12 Hr Chart Check-Review Order Profile	Start: 12/20/18 17:00:00 EST, Q12HInt	12/20/18 17:00	Ordered	12/20/18 15:28	SYSTEM, SYSTEM
	Admission History Adult	Start: 12/20/18 15:28:52 EST	12/20/18 15:28	Ordered	12/20/18 15:28	SYSTEM, SYSTEM
	CareMobile Hourly Rounding	Start: 12/20/18 15:28:53 EST, PRN	12/20/18 15:28	Ordered	12/20/18 15:28	SYSTEM, SYSTEM
	CareMobile Intake and Output	Start: 12/20/18 15:28:53 EST, PRN	12/20/18 15:28	Ordered	12/20/18 15:28	SYSTEM, SYSTEM
	CAUTI Risk Assessment	Start: 01/04/19 16:39:07 EST, BID	01/04/19 16:39	Ordered	01/04/19 16:39	SYSTEM, SYSTEM
	Central Line Change Cap(s)	Start: 01/04/19 16:36:53 EST, Not Continuous, Thursday	01/04/19 16:36	Ordered	01/04/19 16:36	SYSTEM, SYSTEM
	Central Line Change PRN Adapters	Start: 01/04/19 16:36:54 EST, Not Continuous, MoTh	01/04/19 16:36	Ordered	01/04/19 16:36	SYSTEM, SYSTEM
	Complete Admission Workflow	Start: 12/20/18 15:28:52 EST	12/20/18 15:28	Ordered	12/20/18 15:28	SYSTEM, SYSTEM
	Discharge Activity	Start: 01/04/19 12:44:00 EST, Activity: Rest and relax today	01/04/19 12:44	Ordered	01/04/19 12:44	Test, Hospitalist
	Discharge Activity	Start: 01/14/19 13:18:00 EST, Activity: Activity as tolerated	01/14/19 13:18	Ordered	01/14/19 13:18	Hanke, Lucy, Clinical Informatics
	Discharge Activity	Start: 01/04/19 15:57:00 EST, Activity: Rest and relax today	01/04/19 15:57	Ordered	01/04/19 15:57	Harris, Brenda K, Clinical Informatics
	Discharge Diet	Start: 01/04/19 12:44:00 EST, Diet: Heart healthy diet	01/04/19 12:44	Ordered	01/04/19 12:44	Test, Hospitalist
	Discharge Diet	Start: 01/14/19 13:18:00 EST, Diet: Resume usual diet as tolerated	01/14/19 13:18	Ordered	01/14/19 13:18	Hanke, Lucy, Clinical Informatics
	Discharge Diet	Start: 01/04/19 15:57:00 EST, Diet: Heart healthy diet	01/04/19 15:57	Ordered	01/04/19 15:57	Harris, Brenda K, Clinical Informatics
	Dressing Change	Start: 01/07/19 15:08:00 EST, Daily, test	01/07/19 15:08	Ordered	01/07/19 15:08	Test, Hospitalist 2
	Inpatient Sepsis Alert	Start: 01/08/19 13:42:38 EST	01/08/19 13:42	Ordered	01/08/19 13:42	SYSTEM, SYSTEM
	Medline Catheter Change Cap(s)	Start: 01/07/19 15:04:01 EST, Not	01/07/19 15:04	Ordered	01/07/19 15:04	SYSTEM, SYSTEM

Follow Up Appointments

- To add a follow up, type provider or location 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 Up Instructions” section.

Follow Up

Provider Location Search all providers

Add Follow Up

Quick Picks	PCP - ESTRIDGE, MITCHEAL G, MD-INT	Follow up with primary care provider	Return for shared medical appointment
Saved Templates	Follow up with clinic	Follow up with specialist	Return to Emergency Department
	Follow up with dentist	Follow up with specialty services	Return to hospital
	Follow up with outpatient testing	Follow up with surgeon	
	Follow up with pediatrician	Follow up with workmen's comp. physician	

Added Follow Ups

Time Frame	Provider or Location	Details About Visit	Address	Actions
Follow Up Instructions (1)				
JUL/15/2020 1:15 pm	Test, KY Cardiologist	Bring dc instructions with you to appt. will have labs dr...	1 Test Drive Test KY 12345	Modify Remove

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.

Follow Up

* Required Action. More Details

Add Follow Up

Quick Picks

Saved Templates

No saved templates. Select "Save as Template" when saving a follow up.

Added Follow Ups

Time Frame	Provider or Location	Details About Visit	Address
Follow Up Instructions (0)			
2 to 3 days	Test, KY Cardiologist	--	--

Patient Education

* Required Action. More Details

Quick Suggestions

Test, KY Cardiologist

Save Cancel Save as Template

Time Frame

On Date/Time 07 / 15 / 2020 13 : 15

Only if needed

Phone

888-123-4567

Address

1 Test Drive

City **State**

Test KY

Postal Code

12345

Comments

Add predefined comments

Appointment has been made

Bring discharge instructions with you

Print Instructions

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

Follow Up

* Required Action. More Details

Add Follow Up

Quick Picks

Saved Templates

Time Frame

In/On Date 2 Days 07 / 15 / 2020

Only if needed

Phone

888-123-4567

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

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

Follow Up

Provider Location Search all providers

▼ Add Follow Up

Quick Picks Xflox, TP Ejmdblbdokx - JUL/15/2020 1:15 pm

Saved Templates Comments/ --

Added Follow Ups

Time Frame	Provider or Location	Details About Visit	Address	Actions
▼ Follow Up Instructions (1)				
JUL/15/2020 1:15 pm	Test, KY Cardiologist	Bring dc instructions with you to appt. will have labs dr...	1 Test Drive Test KY 12345	Modify Remove

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

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

Follow Up

Save Cancel Save as Template

Provider Location Search

Test, KY Cardiologist

Time Frame

On Date/Time 07 / 15 / 2020 13 : 15

Only if needed

Phone 888-123-4567

Address 1 Test Drive

▼ Add Follow Up

Quick Picks Xflox, TP Ejmdblbdokx - JUL/15/2020 1:15 pm

Saved Templates Comments/ --

Added Follow Ups

Time Frame	Provider or Location	Details About Visit	Address
▼ Follow Up Instructions (1)			

- Click on “Saved Templates” to access your saved favorites.
- 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.

Admission Discharge

Discharge Planning

Problem List

✓ Discharge Medications (3)

* Orders (2)

✓ Follow Up

✓ Patient Education

Documents (4)

Outstanding Lab/Rad Orders (2)

Follow Up

▼ Add Follow Up

Quick Picks

Saved Templates

Added

Added Follow Ups

Time Frame	Provider or Location	Details About Visit
▼ Follow Up Instructions (7)		

- 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 updates (appt date/time, comments, etc).

Follow Up + Selected Visit

☒ Provider ☐ Location

▼ Add Follow Up

Quick Picks Xflox, TP Ejmdblbodkx - JUL/15/2020 1:15 pm

Saved Templates Comments/ --

Added Follow Ups

Time Frame	Provider or Location	Details About Visit	Address	Actions
▼ Follow Up Instructions (3)				
JUL/15/2020 1:15 pm	Xflox, TP Ejmdblbodkx	--	1 Test Drive Test KY 12345	Modify Remove
JUL/15/2020 1:15 pm	Xflox, TP Ejmdblbodkx	--	1 Test Drive Test KY 12345	Modify Remove
2 to 3 days	Follow up with clinic	--	--	Modify Remove

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

Follow Up + Selected Visit

☒ Provider ☐ Location

▼ Add Follow Up

Quick Picks Xflox, TP Ejmdblbodkx - JUL/15/2020 1:15 pm

Saved Templates Comments/ --

Added Follow Ups

Delete

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 education leaflet has been entered.
- Suggested education based on the patient's documented diagnosis 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.

Patient Education + Selected Visit

▼ Quick Suggestions Favorites Custom **More Options...**

All This Visit Problems

Suggestions based on all This Visit Problems		
2019 novel coronavirus detected	Alpha1-Antitrypsin Test	Hepatitis D
2019-nCoV acute respiratory dis...	Antibiotic Resistance	Hepatitis E
Severe sepsis without septic shock	COVID-19	Hepatitis E, Easy-to-Read
	COVID-19 Frequently Asked Questions	Human Metapneumovirus Infection, Pediatric
	COVID-19: How to Protect Yourself and Others - CDC	Human Papillomavirus
	Enterovirus D68, Adult	Human Papillomavirus, Easy-to-Read
	Enterovirus D68, Pediatric	Molluscum Contagiosum, Adult
	Hantavirus Infection	17 More Suggestions...

Education Language: English

Add Education Education Language: English

Education Medication Leaflets


▼ All This Visit Prob... 2019 novel coronavirus... 2019-nCoV acute respir... Severe sepsis without s... All Chronic Problems 2019 novel coronavirus... Acute bilateral knee pain Acute myocardial infarc...

Suggestions based on all This Visit Problems

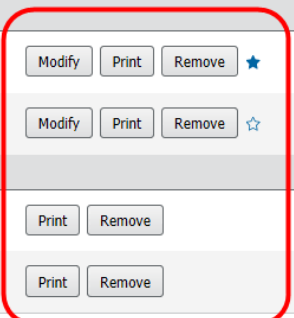
Alpha1-Antitrypsin Test	
Antibiotic Resistance	
COVID-19	
COVID-19 Frequently Asked Questions	
COVID-19: How to Protect Yourself and Others - CDC	
Enterovirus D68, Adult	
Enterovirus D68, Pediatric	

- 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.

Patient Education + | v | Selected Visit

Added Education 

Education Name	Language	Actions
▼ Education (2)		
LEX_CALL FIRST Instructions Ortho 2018(CUSTOM)	English	<div> <div>Modify</div> <div>Print</div> <div>Remove</div> <div>★</div> </div>
COVID-19	English	<div> <div>Modify</div> <div>Print</div> <div>Remove</div> <div>☆</div> </div>
▼ Medication Leaflets (2)		
docusate (oral/rectal)	--	<div> <div>Print</div> <div>Remove</div> </div>
lisinopril	--	<div> <div>Print</div> <div>Remove</div> </div>



Documents

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

Admission/Discharge Workflow Full screen Print 3 hours 23 minutes ago

Admission Discharge + | - | x | +

Discharge Planning (3) Problem List Selected visit Load 33 Notes Selected visit

Follow Up

Discharge Medications (13)

Orders (36)

eGDS/Case Measures

Patient Education

Documents (3)

Outstanding Orders (3)

Time of Service	Subject	Note Type	Author	Last updated	Last updated by
12/18/18 11:55	Discharge Instructions	Discharge Instructions	Test, KY Nurse RN 1	12/18/18 11:58	Test, KY Nurse RN 1
12/11/18 09:55	Discharge Instructions	Discharge Instructions	Test, KY Nurse RN 6	12/11/18 10:13	Test, KY Nurse RN 6
12/11/18 09:43	Discharge Note	Discharge Summary	Cox, Aaron, Center ITWorks	12/11/18 09:43	Cox, Aaron, Center ITWorks

* Displaying up to the last 30 recent notes for the selected visit

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.

Discharge Planning (3) Problem List Selected visit

Follow Up

Discharge Medications (13)

Orders (36)

Follow Up

Patient Education

Documents (7)

Outstanding Lab/Rad Orders (2)

Outstanding Orders (3)

Order	Status	Order Date/Time
MRA Neck W	Ordered	JAN 04, 2019 16:30:13
TSH Thyroid Stimulating Hormone	Ordered	JAN 04, 2019 16:30:13

Instructions From Care Team Selected visit

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 patient 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 templates to display, and selected the desired template.
- The user will need to delete any topic headers or dropdowns 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 remember 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.

Instructions From Care Team

Selected visit

.dc instructions
.dc ldr_0b *
Last S: dc_newborn *

Save

eCQM/Core Measures

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

eCQM/Core Measures (1)

All Visits

Filter by: IMM

Filter by: IMM	Incomplete (1)	Complete (0)
IMM Influenza Immunization	Influenza vaccine Ordered, January 04, 2019 12:37:05, Influenza virus vaccine, inactivated Administer Contraindication Document	

Stroke & Warfarin Instructions: (0)

Save


Stroke and Warfarin Instructions

- Clicking on the plus icon will open the PowerForm for 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.

Stroke & Warfarin Instructions (24)

Results (23)	Result	Author	Date/Time
Stroke/TIA Discharge Ins	Open	Test, KY Nurse RN 4	01/07/19 14:52
Individualized Stroke Risk Factors *Q	Alcohol abuse	Test, KY Nurse RN 4	01/07/19 14:52
Stroke Education Handouts Given *Q	Yes	Test, KY Nurse RN 4	01/07/19 14:52
Stroke Education Comment	test	Test, KY Nurse RN 4	01/07/19 14:52
Stroke/TIA Signs/Symptoms to Report Imme	Sudden onset difficulty speaking, Sudden onset difficulty understanding speech, Sudden onset change in vision, Sudden onset weakness particularly on one side of the body, Sudden onset numbness/tingling, Sudden severe headache, Sudden dizziness or trouble with gait, Call 9-1-1: EMS activation is crucial	Test, KY Nurse RN 4	01/07/19 14:52

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.

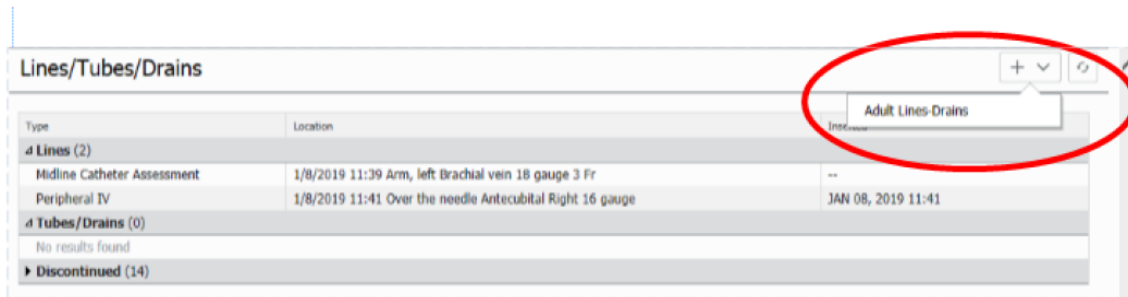
Nursing Discharge Summary (37)

Results (35)	Result	Author	Date/Time
Discharge Date/Time	01/07/19 14:41	Test, KY Nurse RN 4	01/07/19 14:41
Transported Off Unit by	Test, Anesthesia	Test, KY Nurse RN 4	01/07/19 14:41
Patient Disposition, General	Discharge	Test, KY Nurse RN 4	01/07/19 14:41
Discharge To	Acute care facility	Test, KY Nurse RN 4	01/07/19 14:41
Name of Receiving Facility/Provider	fxqfloxdpdg	Test, KY Nurse RN 4	01/07/19 14:41
Mode of Departure, General Discharge	Public transportation	Test, KY Nurse RN 4	01/07/19 14:41
Accompanied by, Discharge	Daughter	Test, KY Nurse RN 4	01/07/19 14:41
Personal Belongings With Patient	Yes	Test, KY Nurse RN 4	01/07/19 14:41
IV Discontinued	Yes	Test, KY Nurse RN 4	01/07/19 14:41
IV Therapy Comment	czgbrfhpdgf	Test, KY Nurse RN 4	01/07/19 14:41
PT's Own Supply of Medication Returned	Yes	Test, KY Nurse RN 4	01/07/19 14:41
Medications Given to Patient	Yes	Test, KY Nurse RN 4	01/07/19 14:41

Lines/Tubes/Drains

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

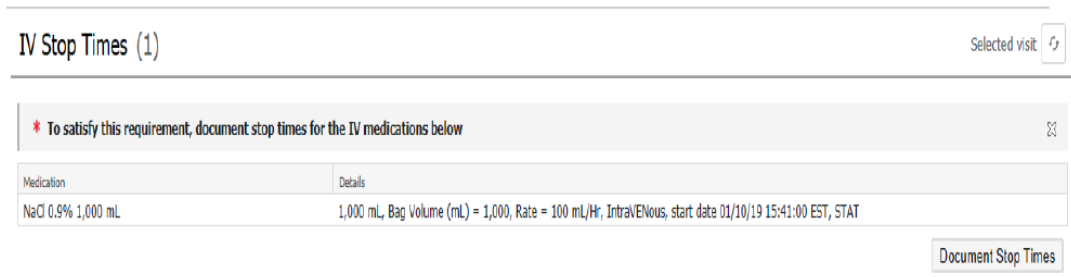
- Remember- always document the discontinuation of all lines and deactivate the dynamic group.



Type	Location	Insertion
Lines (2)		
Midline Catheter Assessment	1/8/2019 11:39 Arm, left Brachial vein 18 gauge 3 Fr	--
Peripheral IV	1/8/2019 11:41 Over the needle Antecubital Right 16 gauge	JAN 08, 2019 11:41
Tubes/Drains (0)		
No results found		
Discontinued (14)		

IV Stop Times

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



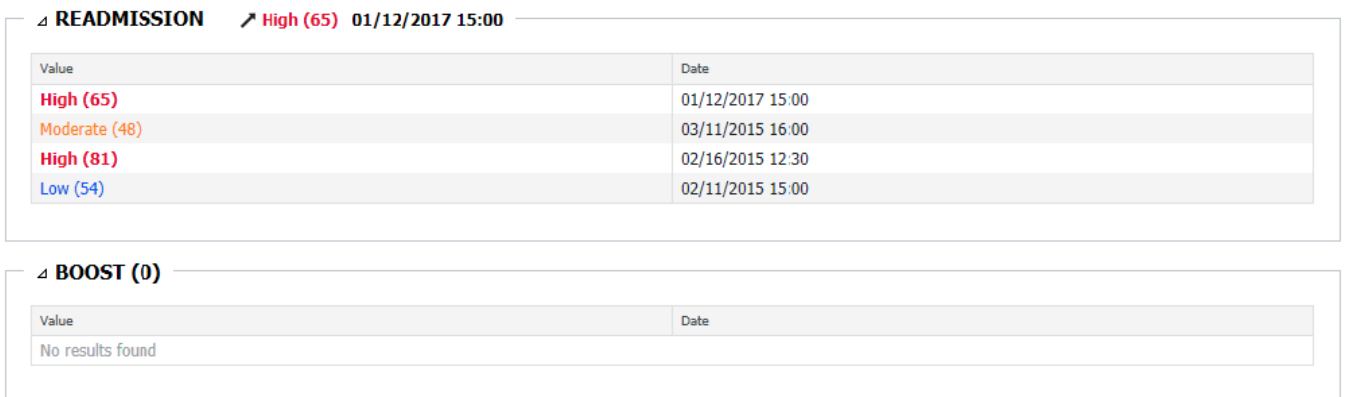
Medication	Details
NaCl 0.9% 1,000 mL	1,000 mL, Bag Volume (mL) = 1,000, Rate = 100 mL/Hr, Intravenous, start date 01/10/19 15:41:00 EST, STAT

Document Stop Times

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.

Readmission Risk Summary



READMISSION **High (65)** 01/12/2017 15:00


Value	Date
High (65)	01/12/2017 15:00
Moderate (48)	03/11/2015 16:00
High (81)	02/16/2015 12:30
Low (54)	02/11/2015 15:00

BOOST (0)



Value	Date
No results found	

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

Continuity of Care Goals/Interventions

 All Visits  

All (5) Unmet (2) Future (0) Met (3)

1		Walk to the mailbox and dance	Start: 01/13/2020 Target: 01/29/2020 Creator: FERA, MARIA...	 
		Not met	Category: Physiologic Source: Patient Barriers: --	
2		Systolic Blood Pressure, Sitting will be WNL	Target: 08/26/2020 Creator: FERA, MARIA...	 
		Met	Category: Physiologic Source: Patient Barriers: -- Start: 08/19/2020	
		In Error		

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.

Admission Discharge

Discharge Planning (8) Problem List

* Discharge Medications (3)

✓ Orders (42)

✓ Follow Up

* Patient Education

Documents (4)

Outstanding Lab/Rad Orders (5)

Instructions From Care Team

eCQM/Core Measures

* Stroke & Warfarin Instructions (0)

* Nursing Discharge Summary (14)

Lines/Tubes/Drains

✓ IV Stop Times (0)

Readmission Risk Summary

Continuity of Care Goals/Interventions

Create Note

Inpatient Discharge Instructions

Select Other Note

Discharge Medications (3)


* To satisfy this requirement, Discharge Medication reconciliation must be

Medication	Type	Order
albuterol (albuterol 2.5 mg/3 mL (0.083%) inhalation solution) 3 mL, Inhalation, Refill(s)		
folic acid (folic acid 1 mg oral tablet) 1 Tab, Oral, Daily, 0 Refill(s)		
metFORMIN (metFORMIN 500 mg oral tablet) 1 Tab, Oral, BID, 180 Tab, 0 Refill		

Orders (42)

Type	Order
Admission Discharge Transfer (16)	
12 Hr Chart Check-Review Order Profile Start: 07/31/18 17:00:00 EDT, Q12H-Int	
Admission History Adult Start: 07/31/18 11:45:23 I	
Modified Nassev Bedside Swallow Screen Start: 07	

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

Override Discharge Requirements 

Following components have missing required actions.
Select a reason from the dropdown(s) to override.

* Discharge Medications

* Orders

* Follow Up

* Patient Education

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.

Your Visit Summary	
Your Care Team Admitting Physician - AKHTAR, KAMRAN, MD-INF Attending Physician - AKHTAR, KAMRAN, MD-INF Primary Care Physician - AKHTAR, KAMRAN, MD-INF Referring Physician - AKHTAR, KAMRAN, MD-INF	Discharge Vitals
Your Diagnosis Chest pain, Chest pain Cholera due to Vibrio cholerae 01, biovar cholerae, Cholera due to Vibrio cholerae 01, biovar cholerae Dehydration Weakness	
These Are Your Goals • testing goal from admission mpage EDITED - Not met (Barriers: Cultural/Spiritual) Intervention:testing intervention from admission page Outcome:entering goal comment	
Tests Performed .Urinalysis Microscopic CBC no Diff (Hemogram) CMP Comprehensive Metabolic Panel HIV 1/2 Screen Antibody Troponin I	

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 not 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 free text 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 your Care Team component, and then regenerate a new discharge instructions document.
 - Follow Up Appointment information entered from the MPage will display after the Instructions from your Care Team.

What to do next	
Instructions From Your Care Team Diet after Discharge: Resume usual diet as tolerated, -- -- Fluid Restriction after Discharge: 1000 mL Activity after Discharge: As tolerated, -- -- -- -- Driving after Discharge: May drive today	
Notify Provider of: Wound/Incision Care after Discharge: Keep operative site/wound site clean and dry, DO NOT change dressing; may reinforce it as needed Discharge Diet No Discharge Diet on Record Discharge Activity No Discharge Activity on Record	
Follow-Up Appointments Follow Up with JONES, BRAD When Within 2 to 3 days Where: 550 S JACKSON STREET LOUISVILLE, KY 40202- (502) 562-3000 Follow Up with Test, General Medicine When Within 2 to 3 days	

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 (Aspirin 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.

Allergies

Peanuts (Wheezy)
sulfadoxine (Rash)
Dust (Hives)

Immunizations This Visit

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

Immunizations This Visit

Given

Vaccine	Date	Comments
influenza virus vaccine, inactivated	01/04/2019	Blood Infusing/To Be Infused

Stroke/TIA Instructions

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

Stroke/TIA Instructions

Individualized Stroke Risk Factors
Individualized Stroke Risk Factors *Q: Alcohol abuse

Stroke/TIA Signs/Symptoms to Report Immediately: Sudden onset difficulty speaking, Sudden onset difficulty understanding speech, Sudden onset change in vision, Sudden onset weakness particular on one side of the body, Sudden onset numbness/tingling, Sudden severe headache, Sudden dizziness or trouble with gait, Call 9-1-1: EMS activation is crucial

Special Instructions
Stroke/TIA Special Instructions: test

Mutually Agreed Upon Goals
Blood Pressure Management: I will record my BP daily and take a log to MD appts, I will purchase a blood pressure machine
Blood Pressure Management: (Cont): I will not change or stop any meds w/o instruction from MD
Blood Pressure Goal: test
My LDL Level: My LDL Level:

Education Materials

- All Education Material added from the MPage will display.

Education Materials

Follow these instructions at home:

Pay attention to any changes in your symptoms. Take these actions

- Rest as told by your health care provider.
- Avoid activities that cause pain. These include any activities
- If directed, apply ice to the painful area:
 - Put ice in a plastic bag.
 - Place a towel between your skin and the bag.
 - Leave the ice on for 20 minutes, 2–3 times per day.

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: LLLJHTEST, 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.

The screenshot shows a software window titled "Sign/Submit Note". The window contains several form fields and sections. At the top, there are dropdown menus for "Type:" (set to "Discharge Instructions") and "Note Type List Filter:" (set to "Position"). Below these are fields for "Author:" (HANKE, LUCY M, RN PATIENT CARE 1), "Title:" (Inpatient Discharge Instructions), and "Date:" (1/13/2019 1016 EST). There are also checkboxes for "Forward Options" and "Create provider letter". Below the form fields is a search bar labeled "Provider Name" with tabs for "Favorites", "Recent", and "Relationships". The main area of the window is divided into two sections: "Contacts" and "Recipients". The "Contacts" section has a table with columns "Default" and "Name". The "Recipients" section has a table with columns "Default", "Name", "Comment", "Sign", and "Review/CC". At the bottom right of the window, there are three buttons: "Sign & Print", "Sign", and "Cancel". A large red arrow points from the "Sign & Print" button in the bottom right towards the "Name" column in the "Contacts" table.

Sign/Submit Note

Type: Discharge Instructions
Note Type List Filter: Position
Author: HANKE, LUCY M, RN PATIENT CARE 1
Title: Inpatient Discharge Instructions
Date: 1/13/2019 1016 EST
☒ Forward Options ☐ Create provider letter

Provider Name (Search bar)
Favorites Recent Relationships

Contacts

★	Default	Name
---	---------	------

Recipients

★	Default	Name	Comment	Sign	Review/CC
---	---------	------	---------	------	-----------

Sign & Print **Sign** **Cancel**