



From the Office of Clinical Informatics

Northern Light Health

Prep and Recovery Documentation

Neuromodulation Nurse

This self-guided workbook will allow the Neuromodulation Nurse to practice documentation in the procedural area, complementing the PromisePoint simulation courses and instructor-led education. Please note, the following scenario is designed to demonstrate functionality and may not be inclusive of all NL Acadia Hospital policies and procedures.

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Day In the Life Review

Preprocedure Tasks

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1. Find Your Patient
2. Perform Chart Review using the Preprocedure MPage
3. Check for Orders
4. Document Preprocedure Call
5. Use the Periop Tracking Board

Day of the Procedure Tasks

1. Use Case Selection
2. Using Perioperative Tracking Board
3. Review and Update Patient's Chart
4. Document Preprocedure Forms
5. Review and Activate Orders
6. Charting in Interactive View and I&O
7. Scanning Medications using BCMA
8. Discontinuing Preprocedure PowerPlans
9. Update the Tracking Board

Postprocedure Tasks

1. Document in Perioperative Doc
2. Review and Activate Orders
3. Document in Interactive View and I&O
4. Discharge Process – Returning Serial Patients
5. Discharge Process – Treatment Completed






Log into the System T108a

Select a Sign On from the list below, and Select a Patient from below for Practice.

NOTE: It's important to remember which patient you're using so you can practice scanning medications.

Acadia Surgical Nurse Sign On	Password	Surgical Patients	Wristband Barcode
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Prep and Recovery Workbook

TRACAMBRNSURG06	train44ing	SURGAHCPRA	FIN# 500000251 
TRACAMBRNSURG07	train44ing	SURGAHCPRB	AC500000251 FIN# 500000252 
TRACAMBRNSURG08	train44ing	SURGAHCPRC	AC500000252 FIN# 500000253 
TRACAMBRNSURG09	train44ing	SURGAHCPRD	AC500000253 FIN# 500000254 
TRACAMBRNSURG10	train44ing	SURGAHCPRE	AC500000254 FIN# 500000255 

Preprocedure Tasks

Find your Patient

- The Perioperative Tracking Board is a communication tool. The patients are populated when the case is scheduled. There are different tabs that are geared toward a specific phase. Please note that there are 5 different tabs for different phases of the procedural continuum. Each tracking board will differentiate on what patients will show. For example, ACTX PAT is usually used for calling your patients before the day of the procedure. In the live environment, the filter is defaulted to show patients scheduled for the next 14 days. The ACTX Preop tracking board will usually default to show patients for the day of the procedure. Here are the steps:
 1. Navigate to the Perioperative Tracking Board located in the toolbar.
 2. Because this is a preprocedure task, let's stay on the ACTX PAT board. Let's change the filter to **ACTX WORKBOOK FILTER**.
 3. Choose the patient assigned to the training sign on that you're using.
 4. Select the row and double click the blue arrow to the far left.

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5. The Assign a Relationship box should appear. Please select Patient Care and click OK.

Perform Chart Review using the Preprocedure MPage

1. It will default to the Ambulatory Nurse View.
2. Navigate to Menu and select Periop View.
3. Right Click and Select as Default .
4. there, you will see different tabs or MPages. We're going to pull in the appropriate ones and remove the ones we don't need.
 - a. Remove Admission, Handoff, InPt Summary, and Amb Summary by selecting the x.
 - b. Add by clicking on the + icon. Select Preprocedure.
 - c. Click on the + Sign again and we'll add in Discharge.
 - d. Select Patient Info & Story Mpage and move to the end.

Overview of Components

- **Let's start with the Preprocedure Workflow Mpage. This is where you will research or review data about your patient. Some components will also update your chart. The table of content will allow you to arrange the components to your workflow. Let's practice that now.**
 1. Locate Patient Information. Click and drag that up to the top.
 2. Please note in this component, it will provide information about your patient. Addresses and contacts can be listed here. This comes from Registration.
 3. Review the following components that could be useful for reviewing the chart. Most of them may be blank. It just means we have our work cut out.
 - a. Documents – click on BH Office Note to open it to review.
 - b. Home Medications (which will be blank)
 - c. Histories
 - d. Labs Flowsheet

Check for Orders

- **Ideally, we would like the proceduralist to place the order. Depending on the timeframe, a message sent via Message Center will be more appropriate. Because you're dealing with serial encounters, it's also a good idea to review the orders to make sure that PowerPlans used in previous visits are discontinued. Let's pretend that this is the first visit for the patient.**
 1. Click the **Orders Profile** component on the Preprocedure Workflow.

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2. Note there are is the **OP Electroconvulsive Therapy ECT and Ketamine Treatments** in a “planned” state in the View section.
3. Let’s review what is in the PowerPlan.
4. Note that there are two different phases: Pre Op and Post Op.
5. Selecting each of the phase will filter the orders.
6. Click the back arrow to return to the PreProcedure Workflow Mpage.

Document Preprocedure Call

- **The names and the content of the forms will change slightly in the live environment due to changes after the train domain was created.**
 1. We’re ready to make our call. IF you don’t remember the phone number, select your Patient Information component.
 2. Click Adhoc located in the toolbar.
 3. Locate ECT folder. In the live environment, this will move to the top.
 4. Select Preprocedure Call and select Chart.
 5. During your call, go through the section and fill out each sections.
 6. ID Risk Screen – Fill out whatever you like on this patient.
 7. Patient states she has an allergy.
 - a. Click Add and search for **Shellfish** in **Substance** using the binoculars
 - b. **Select Shellfish.** Click OK.
 - c. **Reaction:** type “**anaph**” and click the binocular.
 - d. **Select Anaphylactic reaction.** Click OK.
 - e. **Severity:** Use clinical judgment when choosing severity if unknown choose unknown. Patient reports anaphylaxis, so let’s choose **Severe**.
 - f. **Category:** Select **Drug**.
 - g. **Status:** Should default to Active.
 - h. **Other Fields:** These fields are not required but it’s best practice to fill this out fully. For now, let’s click OK.
 8. Education Needs – Please note what you can fill out in this section. Fill out what you like in this section.

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9. Anesthesia Sedation – This section is important for the CRNA. This section must be filled out so their Preassessment notes will populate with this information. Let's fill this out fully.
10. Preprocedure Instructions – Please read this section. Click yes to what is appropriate to the treatment. Note that some says ECT only. Let's fill this out with all Yes.
11. Click the green checkmark to sign the form.

Use the Periop Tracking Board

- Remember we added an allergy earlier. Please note that our allergies column is now updated on the tracking board.
 1. Click Perioperative Tracking in the Task Bar.
 2. Right-click your patient's Status cell; then click Set Events....
 3. The Case Tracking Set Events window appears. Maximize the window to see clearly.
 4. The PAT Tab will be the first one you see. Please note the other tabs on the side.
 5. Click PAT Complete event. Please note that it will move to the document side. It will state the date and the time with the event.
 6. Let's add another one to remove it. Let's select Pt. Request Call Back.
 7. Right click on Pt. Request Call Back. Note the options.
 8. Select Remove.
 9. Click OK at the bottom-right.
 10. The Status will now show PAT Complete.
 11. Let's free text a comment that will show in the other tracking board. Let's click into your patient's row in the Comments column.
 - a. Type 1st Treatment; MOCA, MADRS, CSSRS.
 12. The PAT Comments is another freetext box that is more for internal use. Other sites will assign a nurse's initial if they are working on that chart.
 - a. Type in your initials.

<p>NOTE: This information will show in some of the other tracking boards. Look at the other boards and choose the Workbook filters.</p>

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Day of the Procedure Tasks

Use Case Selection

- Usually the patient will be checked in through the scheduling book. If this does not occur, case selection is needed to create the Perioperative Documentation for the postop area.
 1. Navigate to the Case Selection in the toolbar.
 - a. We are prompted to put in the location we want to view. Select: **ACTX**.
 2. This will now be your default location, but you can change it as needed by clicking it.
 3. This view allows you to view cases by a particular date, person, case number, etc.
 4. It's important you remember to click **Retrieve** once you have put your criteria in.
 5. Our patients are scheduled on **7/19/2023**. Add that date to **From Date** fields, click **Retrieve**.
 6. **Case Selection toolbar**
 - a. There are buttons running left to right above the search criteria.
 - b. **Check In**: used to check the patient in when they arrive, this puts a checkmark in the checkbox. Let's check our patient in:
 - Click once on the patient's row.
 - Click the **Check In** button.
 - Review the information before completing the **Check In** process.
 - Click **Accept**.
 7. **Open Patient's Chart**
 - a. Click the **Open** button at the bottom right or double click the **patient's** name to open the chart.

NOTE: **Associate Encounter** - this can be to associate an encounter if needed. Normally you will not need to associate the encounter if scheduled correctly. Be careful to choose the right encounter. **Failure to do so will require a lot of redocumentation.**

Using Perioperative Tracking Board



Scenario: It's a normal day and some of the patient has checked in through the lobby. You just started your shift, and you need to review upcoming cases.

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- It's important to update the status of the tracking boards especially on the day of the procedure. It will communicate to the family board, so they know where in the procedural phase their family member is in.
 1. Select Perioperative Tracking from the toolbar.
 2. Click the ACTX Whiteboard tab.
 3. To find our patients, we have created a special filter. In the filter dropdown select: ACTX WORKBOOK.

Setting Events in Perioperative Tracking

 **Scenario: Your patient has arrived and is in Preop. Use Events to make an update to the tracking board status column.**

1. Find your patient and click once to highlight the row in the ACTX Preop Board.
 - a. Double click the status column in the row and choose **Select Events**.
 - b. Since our patient is not on the PAT tracking board, we will use the events under the **Pre** tab. They all work the same way.
 - c. Select **Pre** and click **In Preop**
 - d. Click **Ok** to close.
 - e. Review the updated **Status** column.
2. Modify an Event
 - a. Double click the event in the status column to open the event window.
 - b. **Right-click** the event and select **Modify**.
 - c. We can also **remove** it or add another event.
 - d. Change the time back a few minutes ago and click ok.

Review and Update Patient's Chart

 **Scenario: You are reviewing the chart with the patient the Problems, Allergies, Home Medications.**

- Even though some of this information can be documented in the ECT Clinical Record, some components can be updated in the MPages. Let's practice this.
 1. Navigate back to Preprocedure Workflow MPage.

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2. Select the row and double click the blue arrow to the far left and open the patients chart.

Documenting Allergies

1. Locate Allergies component to the left. Patient states that she forgot she has an allergy to Penicillin.
 - a. Click in the search field and search for **Penicillin** and select the allergy from the results list. The pane window should open from the right.
 - b. **Category:** Note how the category is automatically set to drug, this is important as it will allow the system to do cross checking for medications that contain this allergy.
 - c. **Severity:** Use clinical judgment when choosing severity if unknown choose unknown. Patient reports anaphylaxis, so let's choose **Severe**.
 - d. **Reactions:** Start typing Anaphylaxis and select it.
 - e. **Status:** Should default to Active.
 - f. **Reaction Type:** Should default to Allergy
 - g. **Other Fields:** These fields are not required but it's best practice to fill this out fully. For now, let's click **Save**.
 - h. Click **X** to close the pane.
 - i. Click the minutes ago button. This should update the blue banner bar.
2. At any time if you need to remove or modify an allergy, click the row and in the pane chose the Modify button. Then use the status dropdown to resolve or mark in error if it is added by mistake.

Document Medication History and Preferred Pharmacy

1. You're ready to document the compliance history.
2. Navigate to the **Home Medications** component and click the Meds History link.
3. Let's maximize the window to see **Patient Preferred Pharmacy**.
 - a. Inform nurse the tool doesn't work in Train, but this is a great place to verify it while in the Document Medication by Hx window.
4. Explain that every medication must be addressed, and compliance documented for each.
5. Let's add **Spiriva**: right-click and select **Add/Modify Compliance**.
 - a. The patient is still taking as prescribed. Enter the Last Dose date/time as: **T and 0700**.

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6. Add a new medication with varying doses. Both doses must be documented separately, so orders with varying dose can be ordered for each day correctly.
 - a. Patient states she takes coumadin 2mg MWF and 5mg SUTTHSA.
 - b. Click the **+Add button** and make sure the dropdown is on **Home Medications**.
 - c. Click the **brand** folder and select the **Coumadin** folder.
 - Select both, **2 mg, and 5 mg** - be sure to select and order sentence.
 - Order sentences provide fields for prescriptions later at discharge if needed.
 - d. Select the **2mg** and click the Frequency field: type M to quickly find MWF.
 - e. Select the **5mg** and click the Frequency field: type S to scroll and find SUTTHSA.
 - **Remember to add last dose/date time.**

<p>NOTE: When a patient tells you they have a new medication that they do not remember the name or dose, we can document as a free text and do the follow up to find out what it is and make an update later.</p>

IMPORTANT: If we add a medication as a free text, we must use the checkbox at the bottom Leave Med History Incomplete - finish later.

7. Click **Document History**.
8. Click the **Complete History** button on the component.

Document Problem and Procedure Histories

1. Open the **Histories** component.
 - a. Only **Problems** can be documented directly in the **Histories** Component.
2. **Problems** - use the search box to add a problem: **Left Knee Injury**. As you type, a pop-up box will display with options to select from.
 - a. From the list that displays, select **Left Knee Injury**.
 - b. The problem is now added to the patients Problem list.
 - To add more details about the Problem just added, click the problem.
 - A Detail box opens to the right.
 - Click **Modify**.
 - c. If you added the wrong problem, it can be removed using the **Error** option in the **Status** dropdown.

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- d. If the patient had a problem listed that no longer is a problem, we need to **Resolve** it.
- e. Click the **Complete Reconciliation** button on the component.
3. **Procedure History** - click the procedure tab. Since we cannot chart from this section, use the **Histories** header to link to the tool on the menu.
 - a. Click the **Histories** header.
 - b. **Do not use** the Mark All as Reviewed button here as it does not hit our requirements.
 - c. Use the +Add button to add a procedure.
 - d. **Add Shoulder Surgery**
 - You may need to change the dropdown from “Starts With” to “**Contains**” and click the search by name button.
 - Select **History of Shoulder Surgery**. Click OK.
 - Add the **laterality** and choose **Left**.
 - The other fields are not required but adding the **year** is helpful.
 - Click the blue **Date** and change to year and add **2019**.
 - Click the **Ok** button.
 - e. Use the back arrow quick link to go back to the Preprocedure Workflow page.
 - f. Click the refresh button within the component to see the procedure we added.

Document Preprocedure Forms

- **These forms may change slightly in the live environment. There has been changes since the creation of the education.**
1. Click **AdHoc** in the toolbar.
 - a. The Ad Hoc Charting window appears.
 2. Click the **ECT** folder.
 3. Select the **ECT Clinical Record** check box.
 4. Click **Chart**.
 - a. The ECT Clinical Record window appears.
 5. Click **Outpatient** in the Preparation/Chart Ready section.

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- Click into and document each form, following the list on the left-hand side of the screen: **Allergy, Medication List, and Education Needs, Comments, Orientation and Mood, CSSRS Screener (Suicide Risk Screening), MADRS Montgomery-Asberg Depression Scale, and MOCA Form.**

NOTE: In the live environment, the CSSRS will be the frequent screener and the MADRS and the MOCA will be separate ad hoc forms.

- Click the **Sign** icon.
 - The Ad Hoc Charting window appears.
- Click OK.
 - The patient's chart displays.
- Click the **Refresh** icon.

Review and Activate Orders

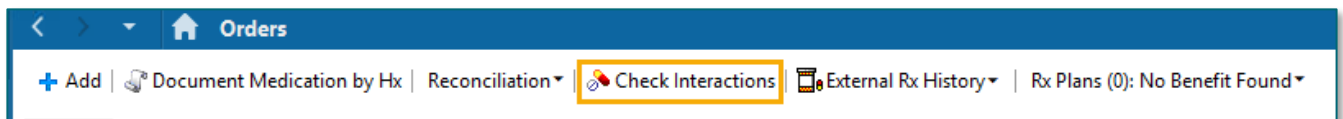


You are ready to review and activate any planned orders.

- Remember that the provider has placed a planned PowerPlan. Let's activate the PowerPlan. In the live environment, according to the provider's workflow, you may also see it activated on the day of the procedure.

Activate your phase of the Planned PowerPlan

- Navigate to the Orders link on the Menu by selecting the **Order Profile** header
 - Click OP Electroconvulsive Therapy ECT and Ketamine Treatments – OP Treatments Pre Op Phase (Planned)
 - Show the nurses at the bottom of the PP there is a note:
 - Provider Communication: Nurse may initiate upon patient arrival.
 - Point out the orders that have been **pre-selected** with checkmarks.
- Click on the **Interaction** button located above the **Order** tab.



- Because the provider has not selected any premeds for this patient, there should be a “No Orders available for checking alert”.

IMPORTANT: Follow your site policies on alerts when initiating PowerPlans.

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3. Initiate the PP - Click the **Initiate** button.
 - a. Physician name should populate with the provider who planned it.
 - b. Choose Verbal Order. This will change in the Live Environment.
 - c. Click OK.
 - d. Click **Orders for Signature**.
 - e. Click **Sign and Refresh**.
4. The PowerPlan will now show **Initiated**.

NOTE: Only the orders that were pre-selected are the only items in an ordered status.

Charting in Interactive View and I&O



Scenario: You are ready to document your patient's vital signs and an IV insertion.

NOTE: The Train environment is not going to be the same as the Live environment. The functionality will be the same. In the live environment, you may not see a lot of the fields because it may be default close to view.

1. Navigate to the **Interactive View I&O** in the Menu by Clicking on the Admission Documentation header
2. Electroconvulsive Therapy - Vital Signs section
 - a. Double click the blue cell under the time column.
 - b. A checkmark in the blue cell means all cells in the Vital Signs section are open.
 - c. Use the tab key on your keyboard to tab thru cells.
 - d. Have students chart the vital signs section and sign with the green checkmark.
3. A **checkmark** displays in the navigator once results have been entered and signed.
4. **Point of Care Testing BH** - double click the blue cell under the time column to open all cells in this section.
 - a. Urine Pregnancy POC Results – Document Negative.
 - Right Click Options
 - Review Modify a Result.
 - Review Insert a new time column.
 - Review Moving documentation to a different time.

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- Review Uncharting results.
5. Document an IV
- a. Navigate to **Peripheral IV**.
 - b. **Peripheral IV** section - click the Dynamic Group icon.
 - The Label opens.
 - Select IV Cannula, Forearm, Left, and 20 gauge.
 - c. In **Activity**, select **Insert**.
 - d. **Patient Identified**, select **Patient Identification Band** and **Verbal**.
 - e. **Total Number of Attempts**, document 1.
 - f. If an **Insertion Aid** was used, document what was used.
 - g. **Line Status**, document **Infusing without difficulty**.
 - h. **Line Care** - document the IV tubing was labeled and secured with tape.
 - i. **Dressing Activity** - document **Semipermeable/Transparent Membrane (Biocclusive dressing)**.
 - j. **Sign**
6. Review the rest of the band and see what fields you would fill out in this phase.

Scanning Medications Using BCMA

NOTE:	We're just going to scan one medication (acetaminophen) to get the basic of scanning. At the end of the workbook, there will be a separate section for more in depth training. I encourage going through the alerts.
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1. Verbally and Visually verify the correct patient chart is open by looking at the patient information in the banner bar.
2. Open the **Medication Administration Wizard (MAW)** from the top toolbar within the patient's chart.
3. Scan the patient identifier barcode. The FIN above the barcode should match the FIN within the chart that is opened. Scan the barcode for your patient on your sheet.

Underdose Warning

1. Scan Acetaminophen 325mg on your medication sheet.

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a. An underdose warning appears.

b. Under the Qualifications column, the indication will say underdose.

c. It is important to note that when there is an order for more than one dose of the same medication to be given, it is important to scan each barcode, to make sure the correct medication is given to the patient.

Scheduled	Mnemonic	Details	Qualifications
05/19/2020 11:30 EDT	acetaminophen acetaminophen (Tylenol)	650 mg = 2 TAB, Tablet, PO, ONCE, Indication: Fever, 05/19/2020 11:30 EDT General Recommended Maximum Daily Dosing Guideli...	Underdose

2. Scan the medication barcode again.

3. Click Yes to bypass the Pharmacy Verification screen.

4. The warning will be satisfied.

5. The scanned medication has a missing order detail, which is indicated by the blue circle/white x.

6. Click the yellow **Result Column**.

7. A new window will open.

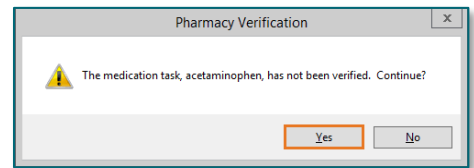
8. There is a required field highlighted in yellow.

a. Fill in the indication: **Pain**

9. Click **OK**.

10. Click **Sign**

11. **Return to Periop View**



Details	Result
650 mg = 2 TAB, Tablet, PO, ONCE, 10/02/20 1... General Recommended Maximum Daily Do...	acetaminophen 650 mg, PO

Update the Tracking Board



Scenario: The patient is being moved to the ECT Room.

1. Navigate to the ACTX Preop Board.

2. Right click in the row of your patient.

3. Choose the Intraop Tab and select Pt in Room.

Discontinuing Preprocedure PowerPlans

➤ When a patient no longer needs the PowerPlan, we need to discontinue it when the patient is in the room. We want to avoid giving the wrong meds for the phase.

1. Have the students right click option on the OP Treatments Pre Op Phase.

2. The window lets us quickly d/c all orders in this subphase.

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3. The Notice window will populate. Click OK after reading it.
4. Choose Discontinue Reason: **Completed**
5. If we want to keep any orders, uncheck boxes to keep them.
6. In the Ordering Physician Window, enter provider name and select appropriate Communication type: Verbal for now.
7. Click OK Select Orders for Signature. Select Sign

Postprocedure Tasks

 **Scenario: The patient has come back from the treatment room. This patient is ready to go home.**

Document in Perioperative Doc

- There is only one record. Again, what you see in TRAIN will not reflect what you see in the live environment. Documenting in Perioperative Doc will update the status on the whiteboard and the family board.

Overview of Perioperative Doc

- SurgiNet Postprocedure - ACTX record allows Nurses to quickly document case time to update the tracking boards.

Document Case Attendees and Case Times

1. Navigate to Perioperative Doc
 - a. The Postprocedure – ACTX record should default.
2. **Case Times:** Enter the In PACU I/PostProc time.
 - a. Click into the field. The date and time should populate without typing it in.
 - b. You can always adjust but best practice is to do this in real time as much as possible.
 - c. Click Next
3. **Case Attendees**
 - a. In the **Case Attendee** field, use the search button to add your nurse sign on.
 - b. Select in the drop down, the Role Performed.
 - c. Click Next
4. **Acuity**

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- a. Let's deactivate this segment. We will not need it.
- b. Right click on the segment and choose **Discontinue Acuity**.
- c. Select a reason through the dropdown: **Not Applicable to Case**
- d. Click OK.

5. PNDS Evaluation

- a. Let's deactivate this segment. We will not need it.
- b. Right click on the segment and choose **Discontinue PNDS Evaluation**.
- c. Select a reason through the dropdown: **Not Applicable to Case**
- d. Click OK.

6. We will come back later to finalize the record..

Review and Activate Orders

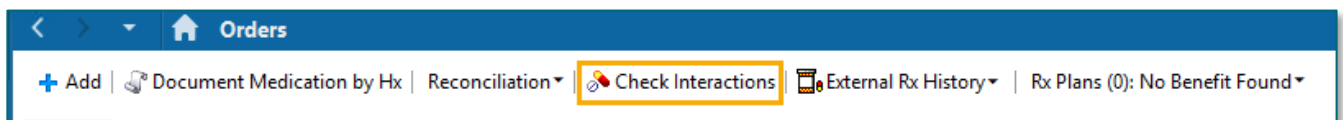


You are ready to review and activate any planned orders.

- Remember that the provider has placed a planned PowerPlan. Let's activate the PowerPlan. In the live environment, according to the provider's workflow, you may also see it activated on the day of the procedure.

Activate your phase of the Planned PowerPlan

1. Navigate to the Orders link on the Menu.
 - a. Click OP Electroconvulsive Therapy ECT and Ketamine Treatments – OP Treatments Post Op Phase (Planned)
 - b. Show the nurses at the bottom of the PP there is a note:
 - Provider Communication: Nurse may initiate upon patient arrival.
 - Point out the orders that have been **pre-selected** with checkmarks.
2. Click on the **Interaction** button located above the **Order** tab.



- b. Because the provider has not selected any premeds for this patient, there should be an No Orders available for checking alert.

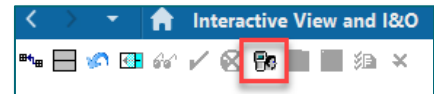
NOTE: Follow your site policies on alerts when initiating PowerPlans.

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3. Initiate the PP - Click the **Initiate** button.
 - a. Physician name should populate with the provider who planned it.
 - b. Select **Verbal** for the Communication type. This will be different in the Live Environment.
 - c. Click OK.
 - d. Click **Orders for Signature**.
 - e. Click **Sign** and **Refresh**.
4. The PowerPlan will now show **Initiated**.

Document in Interactive View I&O

1. Navigate to the **Menu** and click the **Interactive View and I&O**.
2. **Associate** the monitor for **BMDI** (Bedside Monitoring Device Interface). This allows the results to pull into the correct patient chart.
 - a. When a patient transfers to another unit or dept or is being discharged, we must **Disassociate** the monitor.
 - b. Click on the Associate Monitor icon.
 - c. Choose the BH-MS monitor listed in the Device List window.
 - d. This will not work in the domain so go ahead and hit **Cancel** and **Close**.
3. **Pain Assessment** documentation is documented postop in **Electroconvulsive Therapy**.
 - a. Have nurses document postop pain.
4. **PARS score** - have nurses document this which calculates the score and has a reference text link.
5. Look through the rest of this band and document what you will normally for **Post ECT Care**.
6. **Sign** the documentation.
7. **Inactivate a Dynamic Group Periop Lines and Devices**
 - a. When a Dynamic Group is no longer needed or the site can no longer be used, it is best to document the removal and reason and then inactivate the group.
 - b. This ensures it can no longer be documented on, if the patient has other dynamic groups and keeps the documentation.
 - c. **Right-click** the label for our IV and select: **Inactivate**
8. Reactivate a Dynamic group – Let's practice it.
 - a. If we inactivate a dynamic group on the patient's chart, we can bring it back by right clicking the label and selecting Activate.



Prep and Recovery Workbook

b. The removal documentation would also need to be uncharted if documented.

9. Annotations

a. **Annotations do not replace a phone call to the provider.**

- Left click on the time field.
- Right click and select Actions.
- Click on **Flag Annotation**
- Remember flagging an annotation allows the provider to assess information more quickly, and nursing as well.
- Add any clinical documentation as an example.
- **Subject Visitors**
- **Patient states No Male Staff in Room (always end an annotation with punctuation as last character is truncated on Patient Info and Story).**

b. Have nurses click the house icon to go to Periop View.

c. Go to **Patient Info & Story** and refresh to see the annotation we created.

d. Click the **dropdown** next to the house icon and select **Interactive View**.

e. **Use these shortcut buttons frequently to navigate thru the patient's chart.**

Discharge Documentation



Scenario: Your patient is ready to go home but has more treatments.

- It has been decided to remove the Discharge (Adhoc) PowerForm that was used for serial encounters. You can still use the paper instruction that is currently in use. The new workflow will be to use iView and Annotation. Normal Discharge MPage will be used for final treatment.

Bands to use for Serial Encounters Discharges

1. Navigate to the **Adult Education** band.
2. Look through the following sections:
 - a. Discharge Planning Education.
 - b. Discharge Safety Checklist
 - c. Pre and Post Procedure Education
3. Create an annotation. If flagged, this will flow to the Patient Info and Story.

Prep and Recovery Workbook

Finalizing Perioperative Documentation

1. Navigate to Perioperative Doc in the Menu.
2. Finish documenting all required fields in the segment until the green checkmark appears.
3. Finalize the Record
 - a. Click the **green flag** to finalize the record.
 - Resolve the discrepancies by filling in remaining fields if there are any.
 - b. **Yes**, to finalize. Now you see the record in a form format.

Discontinuing PowerPlans

1. If the patient is being discharged or admitted onto the floor, we need to discontinue all procedural PowerPlans and orders to ensure that these medications are not used on the acute floors or in future encounters.
 - a. Have the students **right click** option on the **OP Treatments Post Op Phase**.
 - b. The window lets us quickly d/c all orders in this subphase.
 - c. The Notice window will populate. Click **OK** after reading it.
 - d. Choose Discontinue Reason: **Completed**
 - e. If we want to keep any orders, uncheck boxes to keep them.
 - f. Click **OK**.
 - g. In the Ordering Physician Window, enter provider name and select appropriate Communication type
 - h. Click Orders for Signature, Sign and Refresh

Ketamine Process

- The Ketamine process is virtually the same workflow but using the:
 - Ketamine Clinical Record
 - Ketamine iView Band
 - BCMA will be used but utilizing proxy charting which will be covered in the workbook.
- Choose another patient that has a scheduled infusion through the tracking board or through case selection.
 - Tracking Board – use the filter Workbook
 - Case Selection – set the date for 7/20

Prep and Recovery Workbook

BCMA (BARCODE MEDICATION ADMINISTRATION)

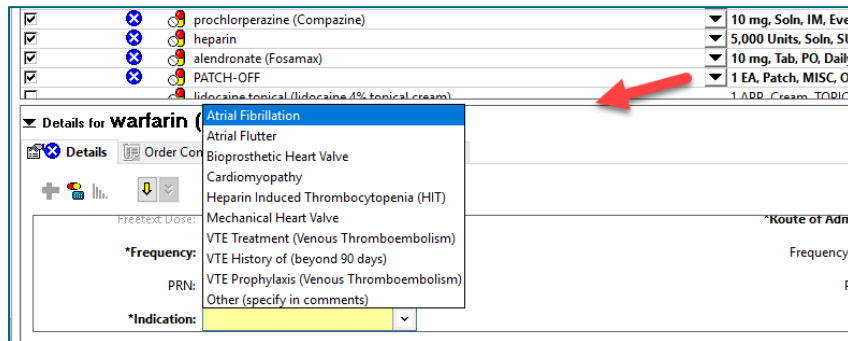
- Using the MAR for Medication Administration with BCMA (Barcode Medication Verification)
- The MAR is used to determine what medications are due and when.
- When a nurse is ready to remove medications from the Pyxis machine, HE/ SHE should review the MAR.
 - It's very important to click Minutes Ago to ensure that the most up-to-date information is used when preparing medications. The MAR does not automatically refresh when order changes are made.

Activate the BCMA PowerPlan

1. Navigate to Orders in the Menu (Blue).
2. Find the BCMA PowerPlan. There should be a Core phase in a "Planned State"
3. Note that all have the blue x next to it. That's because all are missing indications.
4. Select each medication, right click to modify. Choose any indications in the drop down.

NOTE:

If you can't see the details, hover over the double line until your arrow turns into a double line. Hold left click and drag up.



5. Click Initiate Now, Orders for Signature, and Sign.
 - a. If a provider's name comes up, type in Test, Provider and use Verbal.
6. Click the Minutes Ago button to refresh.
7. Navigate to the MAR in the blue Menu.

MAR ICONS

- Mortar/Pestle: Orders not verified by the pharmacist.
 - In an urgent/emergent situation such as in the operating room/procedural/recovery areas or the emergency room and in certain outpatient areas administering medications.

Prep and Recovery Workbook

- When the DBV alert is bypassed, the nurse will also have to Override a warning at the Pyxis. Override activity is tracked and audited by pharmacy and nursing managers on a regular basis.
- **Yellow Paper with Tack: Administration Note that provides administration info**
- **Yellow Icon with Puzzle Pieces: Orders placed within a PowerPlan.**
- **Red Diamond with Exclamation Point: STAT or NOW orders – notice task box is also red.**
- **Yellow Dot: Orders Pending Completion.**

RIGHT CLICK OPTIONS UNDER MEDICATIONS

- **Right click the Heparin medication**
 - Order Info - Click to see the History of the order, Details, Comments, and Additional Info
 - Reschedule Admin Times - A tool to reschedule all the admin times for this medication ... if patient cannot take with meals and such.
 - Reference Manual - Displays the Drug Reference for the nurse for the selected medication.

RIGHT CLICK OPTIONS MEDICATION TASK

- **Right click the Heparin medication task box**
 - Order Info - Opens the Order Info window reviewed above.
 - Task Info - Displays General information about the selected task and the History of the order.
 - Chart Not Done - Used to document that a medication was not administered and why. Example: A patient is refusing all medications.
 - **Reschedule This Dose** – if the medication *is not due yet* and we need to reschedule as a one-time change for instances where the patient is off the floor or patient feels nauseous. This does not change the rest of the admin times.

MEDICATION ADMINISTRATION WORKFLOW

- **In the Medication Room...**
 - Review MAR and prepare medications per hospital policy:
 - Do NOT open meds until at patient's bedside UNLESS they need to be cut, mixed, or a portion wasted (possibly with a witness – example: narcotics.)
 - Be sure to place cut pills back in original packaging to take to room so barcode scanning can be implemented at the bedside per policy.
 - If preparation is required, keep the barcode intact for scanning.
- **At bedside...**
 - Verbally/Visually verify the correct patient

Prep and Recovery Workbook

- Errors can occur when nurses use alternative workflows.
- Refresh Wizard
- Scan the FIN barcode on the patient's wristband
- Scan the meds and handle alerts
- Administer meds and Sign

SCANNING AND ADMINISTERING MEDICATIONS

➤ Fentanyl 50 mcg, IVP

- We are going to administer **Fentanyl 50 mcg, IVP**. This medication comes in a prefilled syringe and is dispensed from the Pyxis as 100 mcg so we will demonstrate the overdose alert.

Scenario: The OR has called and asked that the patient be given their ON-CALL Fentanyl. ON-CALL (PRN) orders are found in the **Unscheduled** section on the MAR.

- Scan the patient's wristband
- Scan the medication
- The DBV alert fires. (Pharmacy Verification)
 - For the purposes of class, only, click YES.
- **Overdose Warning: System thinks potential overdose because vial is 100 mcg and order is for 50 mcg**
- Click OK.
- Overdoses cannot be signed:
 - The Sign button is dithered
 - Fentanyl displays in red font, indicating the medication is an overdose.
- Result is highlighted in yellow, indicating that there is Missing Required Details and click the yellow cell to open the Chart Details window
 - Indication: Other
 - This is required for Pain Medications & Pre-Intervention Assessment.
 - If Pain is selected, you must complete location, scale, and intensity.
 - We are selecting other as we are giving this medication for the OR.
- Dose and Volume
 - The scanned barcode was for 100 mcg / 2 ml
 - **Change 100 mcg to 50 mcg.**
 - The Volume will clear when the dose is changed, and is required
 - **Enter 1 into the Volume field.**

Prep and Recovery Workbook

- Comment: If desired, comments can be added, but are generally not required
 - Click **Comment** and type, **Given per anesthesia request**
 - Click **OK** to close the Comment window.
 - Click **OK** to close the Chart Details window.
- Notice that the font is now black, the red icon is replaced with the blue checkmark, the Results match the order details, and the Sign button is now available.

➤ Medication 2: Coumadin 4 mg (tablets)

- Scan the first Warfarin (Coumadin) 2 mg, TABLET barcode.
 - The Filtered Task window displays with an Underdose qualifier

NOTE: We only scanned 2 mg and 4 mg is ordered.

- The scanned medication does not match the order details.
- Scan the second Warfarin (Coumadin) 2 mg, TABLET barcode.
 - Always scan each tablet to make sure you have the right medication.
 - The blue checkmark displays on the left of the Wizard indicating ordered details and the scanned results match
- Additional Fields Icon:
 - Point out the Optional Additional Documentation Fields icon (clipboard/red checkmark) in the icons column.
 - This icon displays whenever there is/are extra fields in the Chart Details window that should be addressed.
 - Click the icon or the results column to open Chart Details.
 - Food/Medication Interaction Education is the additional field.
 - **Select Education Provided**

NOTE: How do I know if the patient's been educated already?

- Answer: Click Trend to see prior documentation.
- Review the previous dose in the MAR to see education provided
- Click **OK** to close the Chart Details window.

➤ Medication 3: Normal Saline (Sodium Chloride) 250mL

- Whenever a new bag is hung, it needs to be scanned in the Wizard.

Prep and Recovery Workbook

- Subsequent actions (titrations, site changes, etc.) will be charted from the MAR.
- [Scan the Normal Saline \(Sodium Chloride\) 250mL barcode](#)
- The blue/white Missing Required Details icon appears, and the results cell is yellow.
- Open Chart Details
 - The window looks a little different for continuous solutions
 - **Change** is used to change the ingredients in a continuous infusion.
 - **Bag #** will default to the next number, automatically.
 - **Site is required. Select Left Arm**
 - **Volume and Rate** default in based on the order.
 - Click **OK**.

FAQ: What if the bag was hung before I got here, and it wasn't scanned?

Answer: In order to chart site changes, titrations, and wastes, the bag must be scanned into the system. If you need to scan a bag so you can chart on it, be sure to add a comment stating something like, "Patient arrived with IV hanging. Not previously scanned." If available, enter the actual start time and documenting nurse. (We'll go over this shortly.)

➤ Medication 4: Compazine 10 mg TABLET

- When more than one order for the same medication/solution appears in the wizard AND/OR if more than one task for the same medication appears in the wizard, the nurse will need to pick the correct task to chart against.
- Scan Compazine 10 mg TAB
 - The patient has an order for PO (oral) Compazine and IM (intra-muscular) Compazine
 - The PO order is highlighted in green because it's the one that matches what was scanned.
 - When there are two or more tasks that match what is scanned, the nurse needs to manually select the correct task.
- Click OK.

➤ Medication 5: Symbicort 160/4.5 inhaler

- Handheld inhalation meds are dispensed with a patient-specific label.
- Remember, patient-specific labels are also dose-specific. This means, that if the dose changes after it's dispensed, it will be necessary to modify the scanned data in the Chart Details window.
- [Scan the Symbicort 160/4.5 inhaler barcode](#)
- In this example, the original order was for 2 puffs, but now the order is 3 puffs

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- Select the Medication Order from the Qualified Tasks section.
- Click OK.
 - Bypass Pharmacy for class today.
- Select the Results details column for Symbicort.
 - This patient self-administered this medication.
 - In the Performed by field type: **Patient**
 - This patient self-administered this medication.
 - Patient, Self Admin should appear in the field.
 - Change 2 puffs to **3 puffs**.
 - Click “comment” and note that **pharmacy to be notified to relabel RX with correct dose**.
- Click OK to close the window.

➤ Medication 6: Patch-Off Task Documentation

- Place a **check mark** in the box to the left (there is nothing to scan)
 - Review warning box: **Task has not been verified with a scan. Do you want to continue without scanning?**
 - Select: **Non-barcoded medication**
 - Click **Yes**
 - Bypass Pharmacy for class only today.
- Patches/Pastes are scanned when putting on and do not have barcodes to scan when taking off.
 - It will be necessary to bypass the medication scan for all patch-off tasks.
 - Patch-off medication scan bypasses **are not reported** to nursing leadership.

➤ Click Sign in the MAR Wizard to document medications were administered

NOTE:	Controlled substance patch-off tasks require a witness, so be sure to plan workflow accordingly.
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REVIEW THE MAR

- Last dose given
- Site for the Normal Saline
- Fentanyl has moved down to the Discontinue Unscheduled and now has a medication response block 30 mins after administration to re-evaluate the patient’s pain.

Prep and Recovery Workbook

ONGOING CONTINUOUS INFUSION DOCUMENTATION

- Scroll to the Sodium Chloride (0.9%) infusion.
- Right-click the task box and point out the Chart Details option.
 - This can be used to open the window.

NOTE: A left click the task box will also open the Chart Details window.

- The continuous infusions Chart Details window is a bit different because it allows the nurse to chart several possible actions taken on an infusion.
 - Look at the grid at in the upper section of the window.
 - Wherever barcode scanning is used, the Begin Bag line will display, but will be dithered. This is because Begin Bag must be documented using the Wizard.
 - Click to select the appropriate action.
 - Once an action is selected, the appropriate fields will display below.
- Documenting a Site and Rate Change:
 - Select Site Change in the grid.
 - Select **Right Antecubital Fossa**.
 - Select **Apply**.
 - Select Rate Change in the grid in the top section/window
 - Look at the bottom of the window to make sure the lower right corner says **Rate Change**.
 - Change the Rate to **125 mL/hr**.
 - A warning will appear stating that the new rate is different than the ordered rate.
 - Click **No** to cancel.
 - Click the **green checkmark** to sign.
 - Warning Box: Do you want to save the data entered? **No**

NOTE: This documents the new site on the MAR, but it is still necessary for the nurse to document the removal of the old IV (if applicable) and the insertion of the new IV (if applicable) in the Lines, Drains, and Tubes iView band.

CHARTING MEDICATIONS NOT GIVEN AND UNCHARTING MEDS

- From the MAR:
 - Right-click the Heparin task
 - Select: **Chart Not Done**
 - This can be used when the nurse needs to document a medication not given.

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- Reason Not Done: **Patient Refused**
 - Comment: Add as necessary
 - **Sign** using the green checkmark
- **Unchart – Used to cancel documentation.**
- The patient decided they now want the Heparin that we charted as Chart Not Done. We now need to Unchart Not Done so the task becomes available again.
 - **Right-click Heparin and choose: Unchart**
 - **Reason: Patient decided they wanted this medication.**
 - **Sign**

CHARTING MEDICATION RESPONSES

- **Whenever a medication with a possible pain indication or a PRN medication is charted, the Med Response task box will appear.**
- The task will be scheduled 30 or 60 minutes after the medication was administered.
 - The task will also appear on CareCompass and the Task List link.
- **Click to open one of the Med Response task boxes.**
- A PowerForm opens for the nurse to document the patient's response.
 - **Select the correct indication.**
 - Chart the patient's response (how this is done will vary, depending on what the indication).
 - **Make the appropriate selections**
 - **Sign.**

NOTE:	Pain documentation in this PowerForm will display in the Adult Systems Assessment Section in iView, in the Pain Assessment subsection.
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From the Office of Clinical Informatics
Northern Light Health

Prep and Recovery Workbook

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For questions regarding process and/or policies, please contact your unit's Clinical Educator or Clinical Informaticist. For any other questions please contact the Customer Support Center at:
207-973-7728 or 1-888-827-7728.