



From the Office of Clinical Informatics

Northern Light Health

Intraop & PACU Documentation

Surgical Nurse for Inland/SVH

This self-guided workbook will allow the Surgical Nurse in the OR and PACU areas to practice documentation, 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 Inland or SVH Hospital policies and procedures.

Table of Contents

Day in the Life Review	2
Log into the System T108a (Millennium Train)	3
Using My Experience	3
Case Selection Overview (For Cases That Goes Directly to the OR)	3
Using Perioperative Tracking.....	4
Intraoperative Documentation.....	5
Perioperative Summary Overview	5
Using Surgeon PowerPlans (If Available).....	5
Scanning Medications Using BCMA.....	6
Charting in Interactive View and I&O	6
Perioperative Documentation Overview	7
Document the IntraOp Record.....	9
Pick List Overview	13
Continue and Finalize the IntraOp Record.....	16
Dahl Chase Specimen Process.....	16
PACU Documentation	17
Scanning Medications Using BCMA.....	18
Perioperative Documentation - Post Op.....	19

Interactive View I&O.....	20
Finalizing Perioperative Documentation - Post Op.....	22
Deactivate All Surgical PowerPlans	22
BCMA (BARCODE MEDICATION ADMINISTRATION)	22
Activate the BCMA PowerPlan.....	22
MAR ICONS.....	23
RIGHT CLICK OPTIONS UNDER MEDICATIONS	23
RIGHT CLICK OPTIONS MEDICATION TASK.....	24
MEDICATION ADMINISTRATION WORKFLOW	24
SCANNING AND ADMINISTERING MEDICATIONS	24
REVIEW THE MAR.....	28
ONGOING CONTINUOUS INFUSION DOCUMENTATION.....	28
CHARTING MEDICATIONS NOT GIVEN AND UNCHARTING MEDS.....	29
CHARTING MEDICATION RESPONSES	29

Day in the Life Review

Begin Shift

- 1. Use the Periop Tracking Board
- 2. Review Perioperative Summary MPages

IntraOp Documentation

- 3. Initiate SURG Intraop PowerPlans (if Available)
- 4. Scanning Meds Using BCMA
- 5. Use Perioperative Documentation
- 6. Use Pick List
- 7. Finalize the IntraOp Record

PACU

- 1. Initiate PowerPlans
- 2. Scanning Meds Using BCMA
- 3. Use Perioperative Documentation

4. Finalize the PACU Record

Log into the System T108a (Millennium Train)

Select a Sign On from the attached sheet, and Select a Patient for Practice.

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



Scenario: READ ONLY – When you float to the Inpatient side to help cover, use My Experience to change from the Surgical nurse position to the Nurse p1 position.

1. Click the **My Experience** toolbar button. You may need to use the **dropdown** to find it in the first toolbar.
2. **READ ONLY**
 - a. The **left** pane allows you to change position and views.
 - b. The **right** side allows you to set their **default** home screen.
 - c. We see the Surgical Nurse has **Perioperative Tracking** as the home screen default.
 - d. Click the **Nurse p1** and point out the right side changes to the views the IP nurse has.

Case Selection Overview (For Cases That Goes Directly to the OR)

1. Navigate to the **Case Selection** in the toolbar.
2. We are prompted to put in the location we want to view. Select: INL OR.
 - a. 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 7/24/2023 to 7/25/2023. Add that date to **From** and **To** 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.
 - c. **Associate Encounter** - this can be to associate an encounter if needed. It is not available once the patient has been checked in or if a FIN was associated during scheduling.

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Talking Point: If the case is scheduled right, you would not need to associate an encounter. Please point out the FIN column. If a FIN is already associated, it will show in this column. If you **must** associate the encounter, please let them know that it is important to pick the right encounter. **The correction of a wrong encounter is very time consuming which will involve rescheduling a case and redocumentation due to charges dropping on the wrong FIN.**

- d. **Change Add On Status** - allows us to make it an Add on if it was missed when creating the case. The Add-On column will update when this is used.
 - e. **Print or Preview** - can print or preview the patient's surgical record or pick list.
7. Check the patient in.
- a. **Checking a patient in:** Have student click once on the patient's row.
 - b. Click the **Check In** button.
 - c. Review the information before completing the Check In process.
 - d. Click OK.

Using Perioperative Tracking

➤ Perioperative Tracking is your default home screen button when you log in. Tracking lists will allow you to access patient's chart, patient locations, requested or completed events, provider availability, and more. This is in the toolbar.

1. Click Perioperative Tracking icon.
2. Click the INOR Whiteboard tab.
 - a. To find our patients, we have created a special filter. In the filter dropdown select: Train Workbooks 7/24-7/25.
 - b. Hover your mouse over the first four icons. The first four icons will be used most often.

Button	Name and Action
	Scheduling Appointment Book: Opens the Scheduling Appointment Book.
	Surgical Case Check-In: Opens the Case Selection window, where you can search for and check in a patient.
	Open Patient Chart: Displays a menu for you to select a specific chart view. Once selected, the patient's chart opens and the selected view is displayed automatically.
	Set Events: Opens the Set Events window, in which you can manage the tracking events set for the case.

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- c. Free columns – Some columns will allow freetexting. Click in the column. If you see a prompt, you can freetext it.
- d. Setting Manual Events from the Communication Column.
 - i. Select your patient, then right-click and select **Set Event**.
 - ii. Click on the Communication Tab.
 - iii. Choose **Diabetic Patient** and click **OK**.
 - iv. Please note that the Communication Column shows the Apple icon.
- e. Select your patient by clicking once on the name to highlight. Double click the blue arrow in the far left column.
 - Select Open Patient's Chart
 - **Assign your relationship:** RN Surgical Services

Intraoperative Documentation

Perioperative Summary Overview

1. Click the **Periop Summary** link in the menu.
 - a. Each MPage Tab is set up to display the information most pertinent to the patient type, with filters and criteria specific to the Perioperative Summary.
 - Click each page to see the available information.
 - All three have some of the same components: allergies, vital signs, consolidated problems, etc.
 - b. Many components allow you to update patient data, eliminating the need to go to multiple links. This reduces time spent searching and streamlines data management.
 - Have students **practice** moving the components and putting colors on.
 - Click the **blue + sign** in the Vital Signs component, to shortcut to Interactive View.
 - Click the **house** icon to go directly back to the Periop Summary MPages.

Using Surgeon PowerPlans (If Available)

- The surgeon has “Planned” the SURG Intra Op PowerPlan (if available) and you would like to initiate it.
 1. Navigate to the Orders link on the Menu.

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- a. Click the **SURG Intra Op PP**.
 - b. Use the checkbox and select: **bupivacaine liposome (Exparel)** order.
2. Initiate the PP - Click the **Initiate** button.
 - a. Physician name: Let this default to the provider that ordered it.
 - b. Communication Type: **Verbal Requires Read Back**
 - c. Click **OK**.
 - d. Click **Orders for Signature**.
 - e. Click **Sign and Refresh**.
3. The PowerPlan will now show **Initiated** and the medication will be active on the MAR. You should be able to scan your medication.

Scanning Medications Using BCMA

- All surgical areas will be utilizing BCMA to scan their meds. Please refer to your PromisePoint simulation. You could take this course as many times you want. Please use the Scan to Order functionality if the orders are on paper. This is to ensure that all medication administration will be in the electronic MAR. We will review this later in class.

Charting in Interactive View and I&O

- If a new IV or urinary catheter has been placed by the Circulator Nurse for any reason before the case starts, documentation must occur in iView.
 1. Navigate to **Periop Lines Devices Procedures**.
 - a. **Peripheral IV** section - click the **Dynamic Group** icon.
 - The Label opens.
 - Select IV Cannula, Forearm, Left, and 20 gauge.
 - Click **OK**.
 - In Activity, select **Insert**.
 - Patient Identified, select **Patient Identification Band and Verbal**.
 - Total Number of Attempts, document 1.







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- If an Insertion Aid was used, document what was used.
- Line Status, document Infusing without difficulty.
- Line Care - document the IV tubing was labeled and secured with tape.
- Dressing Activity - document Semipermeable/Transparent Membrane (Bioclusive dressing).

b. Click the green checkmark to **Sign**.

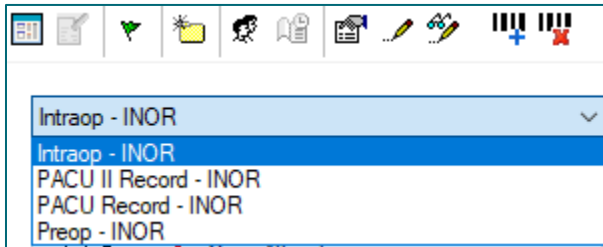
Perioperative Documentation Overview

1. Navigate to **Perioperative Doc**.
2. Select **Intraop – INOR**.
 - a. Review the Toolbar above the Record dropdown. We're going to point out what will be mostly used.

Button	Name and Action
	Finalize: Opens the Documentation Deficits dialog box, which displays the list of documents that require completion. This button is only available in the Documentation tab.
	Add Segment: Opens the Add Segment dialog box, allowing you can add a segment that was not included in the selected case originally.
	Case Attendees: Opens the Case Attendance dialog box. This button is only available in the Documentation tab.
	Case Times: Opens the Case Times segment template. You must complete the template before you can finalize the document. This button is only available in the Documentation tab.
	Barcode Scan - Use Mode: Not in use currently. Coming Soon.
	Barcode Scan - Waste Mode: Not in use currently. Coming Soon.

b. Review **Record Location List**.

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- c. Point out the Perioperative Tabs below the Record Location List drop down: **Documentation** and **Pick List**. You can navigate back and forth.

NOTE: There are required documentation which is displayed by the red exclamation points. The goal is to get green checkmarks next to each segment to finalize the record. Either fill out the information or discontinue the segment if it the system allows it.

- d. Review **Comments** section.
- Each segment has its own comment box.
 - Click through each section to see if there are documentation in it.
- e. Review Page Numbers on the bottom of the Documentation Tab:
- This indicates the number of pages that make up the segment that is currently being viewed. The colored-in number indicates which page is currently being displayed.

3. Documenting Case Times

- The check boxes with grey shading are all **required**.
- Time/Date** fields populate with the current time as soon as we click in it. Document the **In Room Time** and **Start Time**.

4. Using the Next button

- The **Next** button will move you thru the pages and the segments in the **flow of the case**, not in the order the segments are displaying in the navigator.

5. Using Documentation boxes workflow

- Surgical Procedures** is an example of a Documentation box.
- Documentation boxes have a **scroll bar** to help us see what else needs to be documented.
 - We need to be careful that we add to the row and not create a second row for the same documentation.
- To make changes, click in the **box on the procedure row**, make updates as needed to **Procedure modifiers, start time, wound class**.
- Click **Next**, continue to make the appropriate changes on the second page.
- Then we use the **Modify** button to add the changes in the Documentation box.
- Scroll** to view the changes to the procedure row.

g. We will need to do this to add the **Stop Time** later.

6. Add a Segment

- a. There may a time you need to add a segment, in this case we want to add the **Case Canceled** one.
- b. Select the **Add Segment** icon from the toolbar.
- c. Click the **Case Canceled** from Available pane on the left.
- d. Use the **arrow** to move it to the Selectd pane on the right, click **Ok**.
- e. This will be placed in the Documentation Segment Tab alphabetically.

NOTE: There may be an occasion that the case will be cancelled. This segment should be used because it will update all tracking boards.

7. Discontinue a Segment

- b. The segments with the **red exclamation points will prevent** you from finalizing the record if they are not used and not discontinued.
- c. We will do this later in class.

Document the IntraOp Record

➤ Again the goal is to fill out the required data in each segment to get a green checkmark. This is where you would need to explore each segment. Here is a few to get started:

- Safety Checklists 1) Sign In
- Case Times
- Surgical Procedures
- Case Attendees
- Fire Risk Assessment
- General Case Data
- Patient Care Devices
- PNDS Evaluation

1. Access **Case Attendees** and **Case Times** through the toolbar.
 - a. Remind students that if anytime they need to document **Case Attendees** and **Case Times** while in another segment, instead of navigating to those segments, they can access those forms or segments through the toolbar.
2. **Safety Checklist 1) Sign In** – Please note that there are multiple pages to this form. You may see less or more, it depends on the size of your monitor.

Intraop & PACU Documentation

- a. In the first page of this segment, there are no required field as indicated with no dark/shadowed boxes.
- b. Select what applies to the patient in the Chart Review.
- c. Select No for Blood Ordered
- d. Select Sedated for Mental/Emotional State
- e. Let's skip the Removable items question.
- f. Click Next to go to the next page.
- g. There are required fields in this page. Please note Site Marked, Patient identity..., and Site procedure Consent Confirmed has the shaded box. Let's fill those out.
 - When you fill those out, a checkmark will display in the gray boxes.
- h. Click Next.
- i. Fill out all of the required fields: Does the patient have any metal in their body?
- j. Click Next. Point out the green checkmark next to the segment in the Documentation Segment Tab when it goes to the next segment.

3. Case Times

- a. Recommended to update these throughout the case. Again point out in the toolbar to access the Case Time.
- b. Click **In Room Time**. Please note that the date and time will populate. Can change the time but recommend doing at least this in real time.
- c. Click **Next**. Please note that the red exclamation point is still present.

4. Surgical Procedure

- a. **Surgical Procedures** is an example of a Documentation box. The procedure should flow from the scheduling book.
- b. Documentation boxes have a **scroll bar** to help us see what else needs to be documented.
 - We need to be careful that we add to the row and not create a second row for the same documentation.
- c. To make changes, click in the **box on the procedure row**.
- d. Note that there are required field below. Click in the Start box to fill in a time and date.
- e. Fill out the required fields for Wound Class (Clean), Technique Details (Primary), and Scope (No).
- f. Click Next to show the Modify Entry box. Click Yes to save your documentation.

5. Click the **Case Time icon** in the toolbar. Click in the **Start Time** field to document time and date. Click **OK**.

6. General Case Data

- a. Notice that there is a lot of required fields. Fill out all required fields.
- b. Please note that if you use the Postop Same as Preop, it will copy the Preop Diagnosis.

7. **Case Attendees**

- a. The Case Attendees segment can be used at any time. It also uses the documentation box functionality. The surgeon should already be in the documentation field from scheduling.
- b. Click the surgeon in the documentation box to modify it.
- c. Please note that everything is filled out except for Time Out. Let's save that for later.
- d. Click **Clear**. We're going to add ourselves to the **Case Attendee**.
- e. Let's add our test sign on names by using the search icon – magnifying glass.
- f. Click in **Role Performed** and choose **Circulator 1**
- g. Click in **Time In**.
- h. Click **Add**. We're not going to document the Time Out yet.
- i. Please note that there are now two Case Attendees in the documentation box. Again, if you're in another form, and you need to document another case attendee, use the Case Attendee icon in the toolbar.

8. **Fire Risk Assessment**

- a. In this segment, there is one required field. Please read the red text on how to document this form.
- b. For example, I said Yes to everything. According to the red text, I have a score of 5.
- c. The required Field says I must document 1-3. So I will type in 3.
- d. Because this is High Risk, I fill out the box for High Risk in Plan and Intervention. Ensuring that I read thoroughly what should be the interventions.
- e. There should be an electrocautery section in this segment. Please read through it but no need to fill it out. Click Next. A green checkmark should appear.

9. **Patient Care Devices**

- a. Some segments will move an additional item to the **Pick List** if it's not on the pref card or on the table.
- b. Click the magnifying glass to search for an item.
- c. There are 3 tabs in the Find: All Items window.
 - General
 - Item Type
 - Advance

Intraop & PACU Documentation

- d. Let's make sure that we stay in the **General Tab** for now. The top part is a filter. It's recommended to check off Item Number, Description, Short description, and Clinical descriptions. Make sure that **Search for** says **Includes**.
- e. Click in the **Includes** freetext field. Type **Syringe** and click **Find Now**.
- f. Pick any syringe that is available in the list for educational purposes. Click **OK**.
- g. Click **Add** and then **Next**.
- h. The Pick List Update Confirmation box will populate. Please review this box.
 - Item information column will show the item.
 - Current Pick List – will let you know if this item already in the pick list. If it's a new item, the Current Pick List column will show blank.
 - Planned Changes – will let you review where it's going to make it's update. Most of the time it will document that it's Used.
- i. Click **OK**. This will move this to the pick list under the right category. We'll see if it moves there when we review the pick list.

NOTE: The following scenarios are examples of how the system updates the pick list when you complete documentation:

- When you document a new item (not on the Pick List) with a Used Quantity value of 1, the system adds a new row in the Pick List.
- When you modify a documented item with a Used Quantity value that is less than the Fill Quantity value, the system updates the existing row for the same item in the Pick List.
- When you modify a documented item with a Used Quantity value that is greater than the Fill Quantity value, the system adds a new row in the Pick List.
- When you modify a value for an existing item with the same Used Quantity value, the system adds a duplicate row in the Pick List.

10. PNDS Evaluation

- a. **This segment is how you document your care plan.** The letter and number in the parenthesis following the question correlate to the Comments in the Pre Care and Post Care Activity. These are your Plan and Interventions.
- b. Let's click through all the required fields.

11. Discontinue a Segment

- a. The segments with the **red exclamation points will prevent** you from finalizing the record if they are not used and not discontinued.
- b. Let's discontinue the **Cancel Case** Segment.
 - Select **Cancel Case**
 - Right **Click** and choose **Discontinue**

- c. To multi-select multiple segments to deactivate for time sake...
 - Click Document on the very top menu.
 - Select Case Logging
 - Hold down CTRL on keyboard to multiselect all except for what we have documented in.
 - Choose a reason in the drop down above Cancel. Click OK.

Pick List Overview




- The pick list is where you will document all items used in the case. When in the Pick List, the Physician or Procedure preference card will populate with all the usual supplies needed for the case. This list will be referred to multiple times during the case and you can toggle back and forth between the documentation and the pick list by clicking the tabs.

1. Click on the **Pick List tab**.
 - a. On the left side, the case number and the procedure will display. Below that are categories of the items.
2. **Review Toolbar icons:**
 - a. Save – Must save your pick list before leaving the tab.
 - b. Delete – Highlight the item in the list to delete.
 - c. Use (Go over later)
 - d. Fill (Go over later)
 - e. Return (Go over later)
 - f. Unused (Go over later)
 - g. Properties (Goes more into detail of the item and comes from the preference cards)
 - i. General tab – Last updates
 - ii. Specific tab – location, etc.
 - h. Regenerate Pick List – Will discard all existing items and make you start all over.
 - i. Barcode Icons is not in use currently.
3. **Comments section:**
 - a. Surgeon Comments – In use and comes from the Pref Card Maintenance tool
 - b. Case Cart Comments – Not in use.

Intraop & PACU Documentation

4. Pick List Documentation Columns:

a. Inventory Items Column

- i.  A consumable item..
- ii.  Reusable equipment that is schedulable.
- iii.  Sets or packs.

b. Description, Item Number, and Exclamation Columns

- i. Just point out the column. No need to clarify Description or Item Number.
- ii. Exclamation Point – will display duplicates if there are any.

c. Open, Hold, Fill, Used, Wasted, Return.

- i. **Open** – Indicates how many of the current item are opened and ready to use.
- ii. **Hold** – Indicates how many of a current item are on hand, but not opened.
- iii. **Fill** – This is the sum of the open and hold quantity. It is required that you Fill the case prior to using items.
- iv. **Used** – This the quantity that was used. This quantity will default from the Open quantity.
- v. **Wasted** – Indicates how many items were wasted.
- vi. **Return** – indicates how many items are to be returned.

5. Add an Item to the Pick List

- a. Click **Pick List** tab and highlight the procedure.

NOTE: If you highlight the case number, a Procedure Required warning will populate.

- b. Place your cursor in the search field box above the description section.
- c. Type **Tongue**, then select the magnifying glass to search.
- d. The Find window will appear. Select an item in the bottom half of the box.
- e. The item will appear in the Search field. Click **Add** to populate that item in the pick list.
- f. Click **OK**. The item will be seen directly below the search bar in the Description section.

6. Review Open, Hold, and Fill

- a. To document Used, Wasted, and Return, you must document all the first 3 columns. Think of this a checklist to make sure all the items/equipment is there for the case.
- b. You can sort and filter by category. Let's select the Needles and Syringe section.
- c. Remember we added a syringe from the Patient Care Devices segment earlier.
- d. Let's click on the procedure name to show all.

Intraop & PACU Documentation

- e. Start at the top of the **Fill** column and use the down arrow to go to the next line.
 - i. Entering 1 for a couple of items.
 - 1. You might see different alerts. Click Yes or No as desired.
 - ii. Let's leave a 0 for one of the Equipment.

TIP: You can fill by category. Click on the category to open the section. Right click on the highlighted section. Select Fill.

7. Document Used and Wasted

- Document "Used" for the first item by clicking in the **Used Qty Column** to open the free text box.
 - Type in 1.
 - Remember that 0 that we documented in Fill, the Quantity Exhausted alert will appear.
 - Click Yes to keep 1 in the Wasted. Click No and it will revert to 0.
 - Click No.
- Document "Wasted" for the second item by clicking in the **Wasted Qty** to open the free text box.
 - Type in 1.
 - Choose an item wastage reason by clicking on the drop down arrow.
 - If the Quantity is Exhausted, you will receive a notice to ask if you would like to fill another item from SPD Core.
 - Click yes. It will allow you to keep 1 in the Wasted but update the Fill column to 2.

NOTE: Best Practice is to update this in real time and by item. It's not a good idea to use the right click menu to fill all. That is not accurate documentation. Flip back and forth from Documentation and Pick List as needed.

8. Delete an Item from the Pick List

- a. Select the item that we added earlier.
- b. Right-click the item to be deleted and select **Delete**. An alert will ask you if you want to continue to remove the item.
- c. Click the **Yes** button.

9. We're going back to finish up our documentation. Click **Save** before doing so. (floppy disc icon)

NOTE: If you don't save the Pick List before finalizing, it will not allow you to finalize the record.

10. Go back to the **Documentation** tab.

Intraop & PACU Documentation

Continue and Finalize the IntraOp Record

1. Continue through the documentation and always use your hospital's protocols and policies.
2. Check your record prior to finalizing the IntraOp Doc
 - a. An incomplete segment display with a **red** explanation mark in the Navigation pane.
 - b. Best practice is to click the Next button to review all segments prior to finalizing the Intraop Record.
 - c. Remember to discontinue a segment if it is required, but not needed for this case.
 - i. To multi-select multiple segments to deactivate for time sake...
 - ii. Click Document on the very top menu.
 - iii. Select Case Logging
 - iv. Hold down CTRL on keyboard to multiselect all except for what we have documented in.
 - v. Choose a reason in the drop down above Cancel. Click OK.
3. Click the **Green Flag** to Finalize your record even if there are red exclamation points next to the segment.
 - a. A Documentation Deficits window will pop up if any areas are missing data.
 - b. Click OK to get out of the box.
 - c. Click Surgical Procedure segment.
 - i. Select the procedure in the documentation box.
 - ii. Fill out the missing required documentation. Use the Prev and Next to make sure you look at all the pages.
 - d. Case Times: Click in the blank time boxes.
 - e. Case Attendees: Select each name in the documentation box. Fill out the missing details and click **Modify**.
4. Once all segments have a green check mark next to them, click the green Finalization Flag icon again.
 - a. Document Verified window will populate. Great job! No deficits.
 - b. Click **Yes**.
 - c. The Final Report displays. This will move over to **Documentation** in the chart.

NOTE: If discrepancies exist between the surgery and anesthesia documents, the Perioperative Documentation Discrepancies dialogue box will open.

Dahl Chase Specimen Process

- This specimen ordering, and collection process is used for any specimens that need courier pickup by Dahl Chase. This will remain the same.

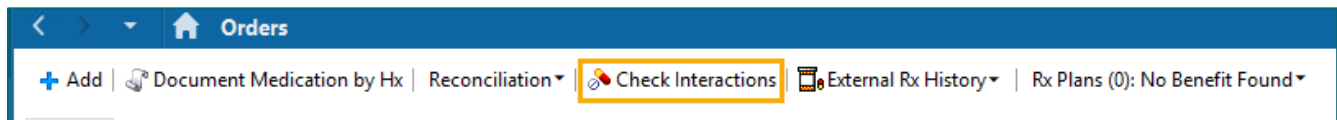
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PACU Documentation

- Scenario: The anesthesiologist has “Planned” the ANES Post Anesthesia Adult PowerPlan and you would like to initiate it before the patient is transferred from the OR. Before going through this step, have the students add Tylenol to their allergies.

1. Navigate to the Orders link on the Menu.

- Click the ANES Post Anesthesia Adult PP to highlight it.
- 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.



- Scroll down the PowerPlan to look for the interaction icon .
 - There should be one next to acetaminophen.
 - Let's check to see if the provider addressed this interaction.
 - Hover over the interaction and click on the blue hyperlink.
 - The Medication Clinical Decision Support (mCDS) window will populate.
 - If the provider addressed any of the interactions, it would list under Comments. Expand the comment window by clicking the arrow to see who and what was documented.
 - Click Continue to close out the window.
 - Uncheck the tylenol and **select the Dilaudid** to continue with class.
2. Initiate the PP - Click the Initiate button.
- Physician name should populate with the provider who planned it.
 - Select **Electronic** for the Communication type.
 - Click **OK**.
 - Click **Orders for Signature**.
 - Click **Sign and Refresh**.
3. The PowerPlan will now show Initiated.
4. Using Excluded Components
- The **lightbulbs** don't show until we are in the Initiated ANES pp.

Intraop & PACU Documentation

- b. Click the lightbulbs to access all available orders.
- c. Click the link to **PACU Post Op Nausea and Vomiting**.
 - This time we see the orders that are available along with the ones previously ordered.
- d. If we need to order something, we need at least a phone order from the provider and a co-signature.
 - The nurse needs to **keep the provider on the phone while ordering** and perform read back.
- e. Click the **Zofran** order, select **Telephone - Requires Read back**.
 - Document **Read Back** in the order details.
 - Order for **signature** and **sign**. Refresh your screen.
- f. The **Zofran** will be on the MAR to administer as the order is active right away.

5. Discontinuing PowerPlans

- a. When a patient no longer needs the PowerPlan, we need to discontinue it.

NOTE: This should always be discontinued before the patient is transferred to the floor. Please prevent this PowerPlan being used on the acute floors.

- b. Demo the **right click** option on the **ANES Post Anesthesia Adult** pp.
- c. The window lets us quickly d/c all orders including subphases.
- d. If we want to keep any orders, use the check boxes to keep them.
- e. Cancel out of the window.

Scanning Medications Using BCMA

- All surgical areas will be utilizing BCMA to scan their meds. Please refer to your PromisePoint simulation. You could take this course as many times you want. Please use the Scan to Order functionality if the orders are on paper. This is to ensure that all medication administration will be in the electronic MAR.
- We're just going to scan one medication (acetaminophen) to get the basic of scanning. Please use the workbook for more in depth training. I encourage going through the alerts.
 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.

Overdose Warning

1. Scan Dilaudid 2mg INJ on your medication sheet.
 - a. An overdose warning appears.
 - b. Under the Qualifications column, the indication will say overdose.

NOTE: 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.



2. Click Yes to bypass the Pharmacy Verification screen.
3. The warning will be satisfied.
4. The scanned medication has a missing order detail, which is indicated by the blue circle/white x.
5. Click the yellow **Result Column**.
6. A new window will open.
7. There is a required field highlighted in yellow.
 - a. Fill in the **indication: pain**
8. Document the site.
9. Make sure we change the amount given to match what was drawn up and what was ordered.
10. Click OK.
11. Click **Sign**.

Perioperative Documentation - Post Op

- **Scenario: Your patient arrived in PACU.**
1. Navigate to Perioperative Doc

NOTE: If you cannot get past the finalized Preop or Intraop Record use this workflow.

- Go up above the toolbars and click Document.
- Chose Document Type and chose PACU Record.

NOTE:	RNs that float from different areas of the surgical area may select Document Type Prompt. Go through the above workflow and ensure that there is a black
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Intraop & PACU Documentation

checkmark next to the selection. This is a user preference and will always populate the Document Selection box when getting out of the chart and back in.

- a. Select **PACU Record – INOR**.
2. **Case Times:** Enter the **In PACU1/PostProc** time.
3. Click **Next** to get to Acuity segment.
4. **Acuity**
 - a. Add the **Acuity Start Time** by clicking the field.
 - b. Select **Acuity Level 1, 2 or 3** according to your organization's policy. **On the day of Go Live, the acuity level document should be available.**
 - Click the **Add** button to add to the documentation box at the top.
 - This Acuity level may be update before finalizing the record if needed.
 - Click **Next**.
 - c. We will come back later to finalize the record.

Interactive View I&O

1. Navigate to the **Menu** and click the **Interactive View and I&O**.
2. **Remind nurses to 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.
3. **Periop Quick View**
 - a. Have nurses document the following:
 - In Periop Arrival document **Anesthesia Summary Review**, select **Yes, Verbal**
 - Vital Signs – **Talking Point: BMDI will be used here.**
 - Activities of Daily Living
 - Activity – Patient Position/Activity
 - Hygiene ADLs – Comfort Measure
 - Pain Assessment – have them look through the Yes and No options.
 - Sedation Assessment – Have them look through this section.
 - RASS – point out the reference text in blue and how to access it.
 - Modified Aldrete Score – point out that it will calculate the score when filled out fully.

- Point out the reference text in blue and how to access it.

4. **Periop Lines Devices Procedures**

- If an IV have not been documented, have them create a dynamic group:
 - IV Cannula, Upper Arm, Left, 20 gauge.
 - Activity: Insert
 - Site Assessment: No Phlebitis...

5. **Sign** the documentation.

6. **Inactivate a Dynamic Group Periop Lines and Devices**

- Double click the blue cell under the time column.
- In Activity select **Discontinued**.
- Tab down to document **Infiltration Removal Score** through **Removal Reason**.
- Sign**.
- Right-click** the label for our IV and select: **Inactivate**

NOTE:	When the IV is no longer needed and has been, it is best to document the removal and reason and then inactivate the Dynamic Group. This ensures it can no longer be documented on, if the patient has other dynamic groups and keeps the documentation.
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7. **Talking Point:** Reactivate a Dynamic group

- If a dynamic group has been inactivated, we can bring it back by right clicking the label and selecting Activate.

8. **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**.

- Navigate to the **Nurse View** from the Menu.

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- 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.

Finalizing Perioperative Documentation - Post Op

➤ **Scenario: Your patient is ready to leave PACU.**

1. **Navigate to Perioperative Doc in the Menu.**
2. Finish document **Case Times**.
3. **Acuity Level:** If this needs to be updated be sure to **click the entry in the documentation box** that we already added, **fill out the rest of the required documentation (Acuity Stop Time)**, and **click Modify**.

NOTE: IF there is more than 1 acuity level during the PACU stay, this segment can add more levels.

4. **Finalize the PACU Record**

- a. If there are deficits, please address those now.
- b. Click the **green flag** to finalize the record.
- c. **Yes**, to finalize. Now you see the record in a form format. You can also see this in the Documentation section of the Chart.

Deactivate All Surgical PowerPlans

- Very important to deactivate all Surgical and Anesthesia PowerPlans. This will ensure that only appropriate medications will be given in the appropriate areas.

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.

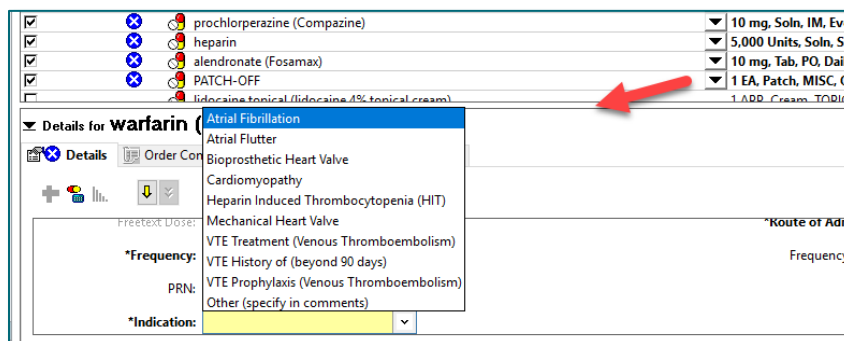
Activate the BCMA PowerPlan

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.



1. Click Initiate Now, Orders for Signature, and Sign.
 - a. If a provider's name comes up, type in Test, Provider and use Verbal.
2. Click the Minutes Ago button to refresh.
3. 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.
 - 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.

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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
- 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.
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- Scan the patient's wristband

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- 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.**
- 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.
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- The scanned medication does not match the order details.
- **Scan the second Warfarin (Coumadin) 2 mg, TABLET barcode.**

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- 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?
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- 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.
- 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,

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“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
- 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)

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- 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.

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.
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- 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**.

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- 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.
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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.
- 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.

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- 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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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.