



From the Office of Clinical Informatics

Northern Light Health

Prep and Recovery Documentation

Pre and Recovery Surgical Nurse

This self-guided workbook will allow the Surgical Nurse in the Preop and Recovery 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.

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Day in the Life Review

Preop Phase

1. Use Perioperative Documentation
2. Document Using Preprocedure Workflow Mpage
3. Use AdHoc Forms – No Change in Forms
4. Use Interactive View to Document Assessments
5. Manage Orders
6. Scanning Meds Using BCMA

Phase II Recovery Phase

1. Review Tracking Board
2. Manage Orders
3. Scanning Meds using BCMA
4. Discharge Process
5. Admit, Transfer Process

Prep & Recovery Documentation

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.

Preop Documentation

Find your Patients



Scenario: You just started your shift, and you need to review upcoming cases.

- Our patients for today are located on the INL Whiteboard, which will function the same. Depending on the area, choose the appropriate tracking board. For example, the PreOp RN will choose the PreOp board; IntraOp/Circulator RN will choose the OR Whiteboard; PACU/Recovery RN will utilize the PACU Whiteboard.
 1. Perioperative Tracking is your default home screen button when you log in.
 2. Click the INOR Whiteboard tab.
 - To find our patients, we have created a special filter. In the filter dropdown select: INL WORKBOOK.
 3. Click the INOR PAT tab.
 - **Point out the filter dropdown** has an option for a PAT nurse to quickly see patients scheduled 14 days out.

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4. Go back to INOR Whiteboard.

Use the Perioperative Tracking Board



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

- Find your patient from the Workbook card and click once to highlight the row.
 1. Click the Yellow Arrow icon in the surgical toolbar.
 2. There are several tabs to the left side, when clicking a tab, the Event options change.
 3. 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.
 4. Select Pre and click In Preop
 5. Take a minute to point out the options under each tab.
 6. Click Ok to close
 7. Review the updated Status column.
- 8. **Modify an Event**
 - a. Double click the event in the status column to open the event window.
 - **Right-click** the event and select **Modify**.
 - b. We can also **remove** it or add another event.
 - c. Change the time back a few minutes ago and click ok.
- 9. **Free Text Columns**
 - a. Several columns are free text fields that can show in several Tracking Boards.
 - b. In the **Comments** column type in “Patient had coffee”.
 - c. Notice how this will also show in boards that have the comments column, as seen in the INOR Preop board.

Case Selection Overview

1. Navigate to the **Case Selection** in the toolbar.
 - a. We are prompted to put in the location we want to view. Select: INL OR.
 - b. This will now be your default location, but you can change it as needed by clicking it.
 - c. This view allows you to view cases by a particular date, person, case number, etc.

- d. It's important you remember to click **Retrieve** once you have put your criteria in.
- e. Our patients are scheduled on 7/24/2023 to 7/25/2023. Add that date to **From** and **To Date** fields, click **Retrieve**.

Case Selection Toolbar Overview

1. There are buttons running left to right above the search criteria.
2. **Check In:** used to check the patient in when they arrive, this puts a checkmark in the checkbox.
 - a. Checking a patient in: 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.
3. **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.

NOTE:	If scheduled correctly, there should be no need to associate the encounter upon check in. Please stress that if an encounter needs to be associated, please be careful and pick the right FIN. Failure to do so will cause a new case to be scheduled and redocumentation.
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4. **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.
5. **Print or Preview** - can print or preview the patient's surgical record or pick list.

Open Patient's Chart

1. Click the **Open** button at the bottom right or double click the **patient's** name to open the chart.
2. Assign your relationship: RN Surgical Services



NOTE:	In the live environment you may or may not receive the Not Associated With Your Facility alert. This pops up in class as the patients are registered to the Inland ORs.
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Perioperative Documentation

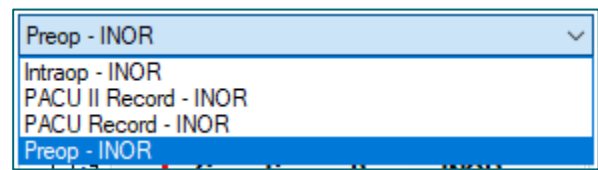
Perioperative Doc is specific to SurgiNet. Some documentation will update the tracking board. It's important to at least update any case times in real time.

1. Navigate to **Perioperative Doc** in the Blue menu.
 - a. Select **Preop Record**.
 - b. Review the Toolbar above the Record dropdown. We're going to point out what will be mostly used.

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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.

2. Review Record Location List through the dropdown.



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.

Review Comments section.

1. Each segment has its own comment box.
2. Click through each section to see if there are documentation in it.

*Review **Page Numbers** on the bottom of the Documentation Tab:*

1. 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.

Document Case Times - Preop

1. The check boxes with grey shading are all required.
2. Time/Date fields populate with the current time as soon as we click in the time field.
3. Using the Next button
4. 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.

Add a Segment

1. There may a time you need to add a segment, in this case we want to add the **Case Canceled** one.
2. Select the **Add Segment** icon from the toolbar.

- a. Click the **Case Canceled – Preop – INOR** from Available pane on the left.
- b. Use the **arrow** to move it to the Selectd pane on the right, click **Ok**.
- c. 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.
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Discontinue a Segment

1. Let's discontinue the **Cancel Case** Segment.
2. Select **Cancel Case**
3. Right **Click** and choose **Discontinue**.
4. Let's finish this documentation later.

Using Preprocedure Mpages to Meet Promoting Interoperability Requirements

- **To meet Promoting Interoperability requirements, we need to reconcile the following:**
 1. Allergies
 2. Home Medications
 3. Problem History
 4. Procedure History
- **We use Nurse View Preprocedure Workflow Mpages to document these sections and use the reconciliation buttons.**

Documenting Allergies

- **Navigate to the Nurse View link in the Menu. We will use the Preprocedure Workflow tab to document.**
 1. To add this tab select the plus sign to the right.
 2. Select the Preprocedure Workflow Mpage.
 3. Navigate to the Allergy Component.
 4. Click in the search field and search for **Fentanyl** and select the allergy from the results list.
 - **Severity:** Use clinical judgment when choosing severity if unknown choose unknown. Patient reports anaphylaxis, so let's choose **Severe**.
 - **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.

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- In the Reactions field, type anaphylaxis and select from the results list.
- The Status and Reaction Type fields have been prepopulated with Active and Allergy.
- Select Save at the top.
 - i. Notice that once this allergy is saved, the system automatically removed the NKA that was previously documented.
- 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.
- Click **Complete Reconciliation** - this button needs to be used for each visit to meet **Quality Measures**.

IMPORTANT: There are many places you can enter allergies. However, this is the only place that will automatically insert the category for you. Therefore, we recommend you enter allergies here.

Document Medication History and Preferred Pharmacy

➤ Patient Preferred Pharmacy

1. The tool doesn't work in Train, but this is a great place to verify it.
2. Navigate to the Home Medications component and click the Complete History button. Every medication must be addressed, and compliance documented for each.
3. 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.
4. Patient states she takes coumadin 2mg MWF and 5mg SUTTHSA.
 - a. Click the +Add button and make sure the dropdown is on Home Medications.
 - b. Click the brand folder and select the Coumadin folder.
 - c. Select both, 2 mg, and 5 mg - be sure to select and order sentence. Select Done.
 - 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 Compliance tab.
 - f. Enter the Status, Patient Source, and Last dose date/time fields.

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NOTE: Review the options within the Status field, particularly the “Still taking, not as prescribed” for the instance when the patient reports they take a half dose to save money.

- g. Select the **5mg** and click the Frequency field: type S to scroll and find SuTTHSa.
 - i. Select the **Compliance** tab.
 - ii. Enter the Status, Patient Source, and Last dose date/time fields.

➤ Unknown medications

1. 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.

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

➤ Click the back arrow at the top left to navigate back to your Nurse View.

1. Refresh the Home Medications Component in the **top right corner of the component**.
 - a. Note that your documented medications now display and the component is “stamped” with the user name and date/time that the compliance was completed.

Document Problem and Procedure Histories

➤ Open the Histories component.

1. 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.
 - From the list that displays, select Left Knee Injury.
 - 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**.
 - If you added the wrong problem, it can be removed using the Error option in the Status dropdown.
 - If the patient had a problem listed that no longer is a problem, we need to Resolve it.
 - 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.

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- a. Click the **Histories** header.
- b. Use the +Add button to add a procedure.
- c. Type Shoulder Surgery in the Procedure field and click the binoculars.
 - 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**.
 - Demo dragging the **History Data line over to the left** a little more to see the documentation fields and the Ok button.
 - Add the **laterality**.
 - 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.
4. Click the Mark all as Reviewed button. This is the button that meets our requirements.
5. Use the back arrow quick link to go back to the Preprocedure Workflow Mpage.

Documenting Immunizations

➤ **Preprocedure Workflow MPage - Immunizations Component**

1. Click the quick add button drop down and select Document History from the list. The Immunization - Historical Entry dialog box is opened.
2. Click Add Immunization, and a list of immunizations is opened in the Select Immunization box.
3. Select Measles, Mumps, Rubella (MMR), click Select, and the immunization is opened in the right column of the dialog box.
 - iii. Complete the required administration details.
 - iv. Administered date: Month/Year – January 2019
 - v. Source: Self
 - a. Click **Submit**.

Using AdHoc Forms – No change in Forms

NOTE:	You will use the same forms as they always do. Just show them how to access AdHoc Powerforms through the Admission Documentation component.
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- Open the Preprocedure Checklist Form and show them the Anesthesia/Sedation section AND Checklist section. These need to be filled out so that the anesthesiologists can pull that information into their notes.

Charting in Interactive View and I&O



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

1. From the Admission Documentation component, use the drop down and select **Periop System Assessments**.
2. **Periop System Assessments - 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 pane next to Vital Signs once results have been signed.
4. **Pain** - double click the blue cell under the time column to open all cells in this section.
 - a. Able to Self-Report Pain, - Yes.
 - b. If you have a confused or elderly patient who is not able to comprehend the Numeric Pain Scale, select No in Able to Self-Report. Then Select PAINAD.
 - c. Numeric Pain Scale: 2
 - d. Alertness Score Scale: this is a hyperlink to aid with documentation. Click the link to view the scale.
 - e. Click OK to close the window.
3. **Morse Fall Risk** - double click the blue cell under the time column to open all cells in this section.
 - a. History of Fall in 3 months, No.
 - b. Presence of Secondary Diagnosis Morse – click the blue hyperlink to see if the patient qualifies for this then document the correct response. Yes
 - c. Document your patient is alert and oriented, has a normal gait, and uses a cane. Your patient has an IV.

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- d. Mental Status Fall Risk - Oriented to own ability.
- e. The Morse Fall Risk Score will calculate after you click in that cell.
- f. In Universal Fall Precautions document Provide Proper Footwear.
- g. Click the green checkmark to Sign.

Morse Fall Risk Scale		<input checked="" type="checkbox"/>
History of Fall in Last 3 ...	No	
Presence of Secondary ...	Yes	
Use of Ambulatory Aid ...	Crutches, cane, walker	
IV/Saline Lock Fall Risk ...	Yes	
Gait Weak or Impaired ...	Impaired	
Mental Status Fall Risk ...	Oriented to own ability	
Morse Fall Risk Score	70	
Moderate and High Ris...		
Universal Fall Precautions	Provide Proper Footwear	

Right Click Menu Options

1. In the Vital Signs section, right click on the Temperature Method field previously documented.
 - Review **Modify** a Result.
 - Review **Insert** a new time column.
 - Review **Moving** documentation to a different time.
 - Review **Uncharting** results.

Document an IV

1. Navigate to Periop Lines Devices Procedures.
2. Peripheral IV section - click the Dynamic Group icon.
 - a. The Label opens.
 - b. Select IV Cannula, Forearm, Left, and 20 guage.
 - c. Click OK.
 - d. double click the blue cell under the time column. Use TAB to work through section.
 - e. In Activity, select Insert.
 - f. Patient Identified, select Patient Identification Band and Verbal.
 - g. Total Number of Attempts, document 1.
 - h. In Insertion Aid document Tourniquet.
 - i. Line Status, document Infusing without difficulty.
 - j. Line Care – select IV tubing labeled and secured with tape.
 - k. Dressing Activity - document Semipermeable/Transparent Membrane (Bioclusive dressing).
 - l. Click the green checkmark to **Sign**.

Periop Quick View - Customizing your view

1. A section may be hidden if it is not used very often.
2. Find item: we can search for it using the “Find Item” search field above the time column.
 - Start typing: **Isolation**
 - Select **Isolation Activity and Type**
 - This pulls into the filter area and the **Name of the Section** where it can be found is listed above it.
 - Look in the navigator for **Environmental Safety Management** but cannot find it. We know we are in the right Band because it was found when searching.

Environmental Safety Management section

1. Document in Precautions Observed and select Isolation.
2. Isolation Activity and Type: Initiate, Modified Contact Droplet.
3. Sign and refresh the screen.

Isolation Discussion

1. When the RN checks Initiate for Isolation Precautions, the Type selected will create a rule which fires an icon to CapMan.
2. It also places the Patient Isolation order, which updates the banner bar. This triggers the patient to the ICP Worklist for the infection preventionist to review and confirm the details are appropriate for the disease process.
3. It is important to know, that the most recent order is what displays in the banner bar. Meaning, if the lab result posts Positive for MRSA, the Patient Isolation order is triggered for Contact, which displays in the banner bar.
4. However, if the nurse then documents initiation of precautions and chooses Airborne, the order details will reflect the iView documentation and the banner bar will update to Airborne. RNs should be aware that their unit will have IP resources available for reference when the isolation type is unclear...they can also review the order to be sure their documentation matches the order.

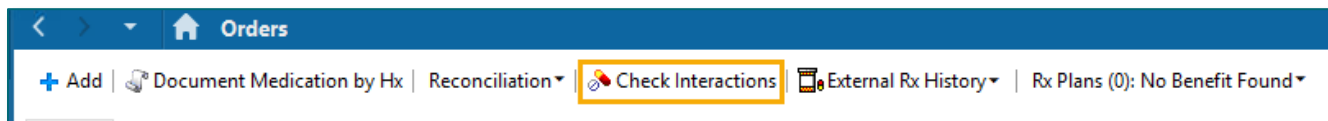
Using PowerPlans




Scenario: The anesthesiologist has “Planned” the ANES Pre Anesthesia Adult PowerPlan and you would like to initiate it.

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1. Navigate to the Orders link on the Menu.
 - a. Click the ANES Pre Anesthesia Adult PP.
 - 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. (Will need to show students this in the Post anesthesia powerplan.
2. Check interactions:
 - a. Select the fentanyl order. (This was not previously selected in this plan).
 - b. Click on the Interaction button located above the Order tab.



- c. Scroll down the PowerPlan to look for the interaction icon .
- d. There should be one next to Fentanyl.
- e. Let's check to see if the provider addressed this interaction.
- f. Hover over the interaction and click on the blue hyperlink.
- g. The Medication Clinical Decision Support (mCDS) window will populate.
- h. If the provider addressed any of the interactions, it would list under Reason. Expand the comment window by clicking the arrow to see who and what was documented.
- i. Click Continue to close out the window.
- j. Unselect the Fentanyl and refresh to move on in the class.

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

3. Select tylenol.
4. **Initiate the PP - Click the Initiate button.**
 - d. Physician name should populate with the provider who planned it.
 - e. Select **Electronic** for the Communication type.
 - f. Click **OK**.
 - g. Click **Orders for Signature**.
 - h. Click **Sign and Refresh**.

5. The PowerPlan will now show Initiated
6. Explain that the orders that were pre-selected are the only items in an ordered status.
7. Using Excluded Components
 - a. The **lightbulbs** don't show until we are in the Initiated ANES pp.
 - 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.

Scanning Medications Using BCMA

- **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. At the end of the workbook, there will be more opportunity 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.

Underdose Warning

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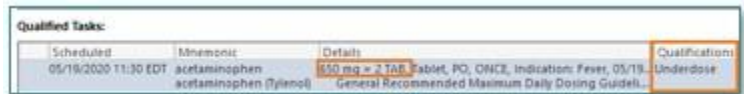
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1. Scan Acetaminophen 325mg on your medication sheet.

- An underdose warning appears.

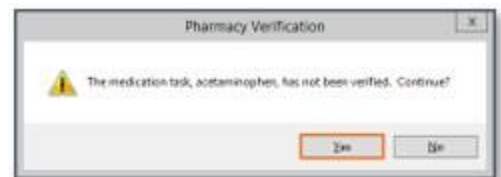
- Under the Qualifications column, the indication will say underdose.

- 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.



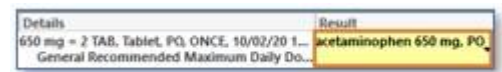
Scheduled	Minimost	Details	Qualifications
05/19/2020 11:30 EDT	acetaminophen acetaminophen (Tylenol)	650 mg = 2 TAB, Tablet, PO, ONCE, Indication: Fever, 05/19... General Recommended Maximum Daily Dosing Guideli...	Underdose

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.



- Fill in the **indication: fever**

9. Click OK.
10. Click Sign.



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

Finalizing Perioperative Documentation – PreOp



Scenario: The patient is ready to go to the OR.

1. Navigate to Perioperative Doc
 - a. **Preop Record** - be sure the dropdown opened to the correct record.
2. Finish Documenting the rest of your Case Times for **Patient Ready for Surgery** and **Transport to OR Time**.
3. Document PNDS Evaluation

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- 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.
4. Finalize the Preop Record
 - a. Click the **green flag** to finalize the record.
 - b. Yes, to finalize. Now you see the record in a form format.

NOTE:	If discrepancies exist between the surgery and anesthesia documents, the Perioperative Documentation Discrepancies dialog box will open. Resolve the discrepancies by filling in remaining fields.
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Un-Finalizing a Record – TALKING POINT

- If changes are needed, click the red flag to unfinalized, you will be prompted for a reason before the Ok button becomes active.

Discontinuing PreAnesthesia PowerPlans

NOTE:	When a patient no longer needs a PowerPlan, we need to discontinue it when the patient is in the room. We want to avoid giving the wrong meds for the phase.
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1. Navigate to Orders in the Blue Menu.
2. **Right click** option on the **ANES Pre Anesthesia Adult** PowerPlan.
3. The window lets us quickly d/c all orders in this subphase.
4. The Notice window will populate. Click OK after reading it.
5. Choose Discontinue Reason: **Completed**
6. If we want to keep any orders, uncheck boxes to keep them.
7. Click OK.

NOTE:	At this point you would initiate the ANES Post Anesthesia Adult PowerPlan. When the patient is discharged or transferred to the floor at the end of their PACU stay, this plan will also need to be discontinued.
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PHASE II RECOVERY DOCUMENTATION

Perioperative Documentation – Post Op (Phase II)



Scenario: The patient has come back from the OR and PACU. This patient is ready to go home or be admitted.

1. Navigate to Perioperative Doc

- a. Because we are in a finalized document, we need to navigate to the next document type following these steps:
 - Go up above the toolbars and click **Document**.
 - Chose **Document Type** and chose **PACU II Record - INOR**.

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 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.
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2. Case Times: Enter the **In PACU II** time.

- a. 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**.
- d. You will be prompted to add the entry, select **Yes**.

4. Document PNDS Evaluation

- a. **Again, 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.
- c. We will come back later to finalize the record.

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.

Additional Work with 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.
3. **Pain** documentation is documented postop in **Periop Systems Assessments**.
 - a. **Document postop pain**.
4. **Select Periop Quick View**.
 - a. Select **Sedation Assessment**.
 - b. Document in this section.

NOTE: Follow your hospitals policy for the sedation assessment. Remember the **RASS** score is a **hyperlink** to a reference guide your documentation.

5. **PADS score section** - have nurses document this which calculates the score and has a reference text link.
6. **Sign** the documentation.
7. Select **Periop Lines Devices Procedures**

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.

- a. Double click the blue cell under the time column.
 - b. In Activity select **Discontinued**.
 - c. Tab down to document **Infiltration Removal Score** through **Removal Reason**.
 - d. **Sign**.
 - e. **Right-click** the label for our IV and select: **Inactivate**
8. Reactivate a Dynamic group
 - a. If a dynamic group has been inactivated, we can bring it back by right clicking the label and selecting Activate.
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**

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- 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.**
 - **Sign.**
- b. Navigate to the **Nurse View** from the Menu.
- 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. Use the Discharge workflow page to guide you thru the requirements.

- Navigate to Nurse View and click the Discharge page. You may need to pull in that page. Click the + to pull it in.
- The Discharge page is configured with Gap Checking which means the required components have a red asterisk. This is a quick visual to see which components still need to be addressed. If there is a green checkmark it has already been completed.
 1. Follow Up - this section is shared by provider and nurses. The provider indicates follow up in the Discharge Summary and if it has not been completed in this section, nursing will add it.
 - The **PCP** is always listed in the first spot of Quick Picks.
 - Use the Search field if a different provider is needed.
 - Select the **PCP** and it will be listed in the section below.
 - Click **Modify** if more details are needed and save.
 2. Patient Education
 - The “This Visit” diagnosis and chronic problems would display on the left pane and suggested education will display on the right based on these entries.
 - **We must use one Suggested Education topic to meet Quality Measures.**
 - To add an education pamphlet from the general catalog select **More Options**.
 - Type **appendectomy** in the search field.
 - Select **After an Appendectomy**. A brief green checkmark displays indicating it has been added to the patient's education.

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- Select the X to close the window.

NOTE:	In the Added Education section you have options to Modify , Print , or Remove an individual Pamphlet.
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3. Discharge Documentation

- Use the **dropdown** in the upper right corner of the component, select the **Nursing Discharge Summary Form**.
 - **Once the patient has been discharged**, add the information to the DC section.
- Sign the form.

4. Home Medications - the provider will complete the Medication Reconciliation and this component should have a green checkmark.

- This is a great time to check the Patient's Pharmacy using the toolbar button if you haven't done it yet.
- It doesn't work in Train, and we should you earlier how to check it when updating the home medications too. There are a couple places to update it.

5. IV Stop Times

- If your patient had an IV, at Discharge a red asterisk will display as a reminder to document the IV Stop Times using the Infusion billing.
 - i. Pay attention to the End time to make sure it is accurate before signing Infusion billing.
- This should be done during the patient's stay from the MAR as medications or fluids get discontinued as documentation should be in real time.

6. Patient Discharge Instructions

- Once all the required documentation is satisfied, we need to print the Patient Discharge Instructions.
- At the bottom below Create Note click the **SurgiNet Discharge Instructions**.
 - If any **red asterisks** were not satisfied you will get an Override Discharge Requirements alert.
 - Use the **dropdown** to select the reason and click **Submit**.

Talking Point: In the live environment you will see the scheduled Procedure display in the Procedures Performed section automatically.

- Enter any specific instructions in the What to do next section.
- Enter special instructions for medication doses and when the next dose is due in the Medications section.

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- e. Click Sign/Submit

Talking Point: Do not print in class. In the live environment you would click Sign & Print. Review the document with the patient to take and have the patient sign the last page of the document for the hospital records.

Finalizing Perioperative Documentation - Post Op

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 PACU 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.

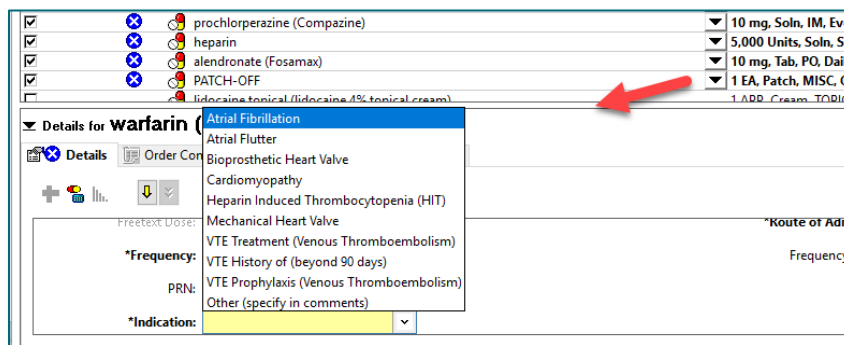
BCMA (BARCODE MEDICATION ADMINISTRATION)

- 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.



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