



NL EMMC

ASC Content Documentation Workbook

Endoscopy Nurse

This self-guided workbook will allow the Endoscopy RN to practice documentation, complementing the PromisePoint simulation courses. Please note, the following scenario is designed to demonstrate functionality and may not be inclusive of all NL EMMC policies and procedures.

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Signing into Cerner Millennium

- This will be done in the BUILD environment.
 - Navigate to EMMC Intranet.
 - In the search window, type Cerner Millennium (Build)
-

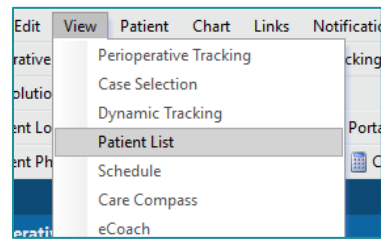
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Endoscopy Nurse

- Username: CLWRN1
- Password: train44ing

Accessing Test Patients

- Navigate to **View** at the top of the chart.
- Click on Patient List.
- Click on anyone of those patients to open the chart.



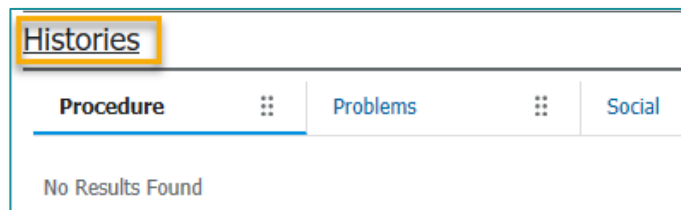
NOTE: Some patients may have multiple alerts. Click through them.

Nurse View

- Navigate to Nurse View in the Menu.

Preprocedure Workflow MPage Components

- Patient Information
 - Please note that this is new component that is only specific to the surgical nurse position.
- Histories
 - In this component, you can review but also add histories. To add a procedure history:
 - Click on the component title.

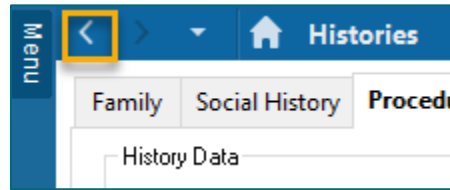


- Click on Add.
- Type in Colectomy in the search box.
- Select the first item in the list.
- Click OK.

- Fill out additional details if needed.
- Click OK.

NOTE: Before leaving this page, you can update **Implants, Social History, and Family histories.**

- Click the back button to go back to Nurse View.





- **Documenting an Allergy**

- Select the **Allergy** component.
 - In the Add Allergy search box on the far right, type Lisinopril. As you type, a box will display. Select the appropriate medication.
 - On the right, a box will display for further documentation of this allergy.
 - In **Severity**, select Mild.
 - In **Reactions**, type Cough.
 - In **Source**, select Patient.
 - If an onset date is known, this can be documented.
 - Click the **Save** button.
 - The allergy has been added. Click the **X** in the documentation box to close it.
 - If the patient has no additional allergies, click the **Complete Reconciliation** button.
 - Reconciliation status will display as Complete with your name and the date/time in which the reconciliation occurred.
 - Click the **Complete Reconciliation** button after reviewing/updating the Allergies.




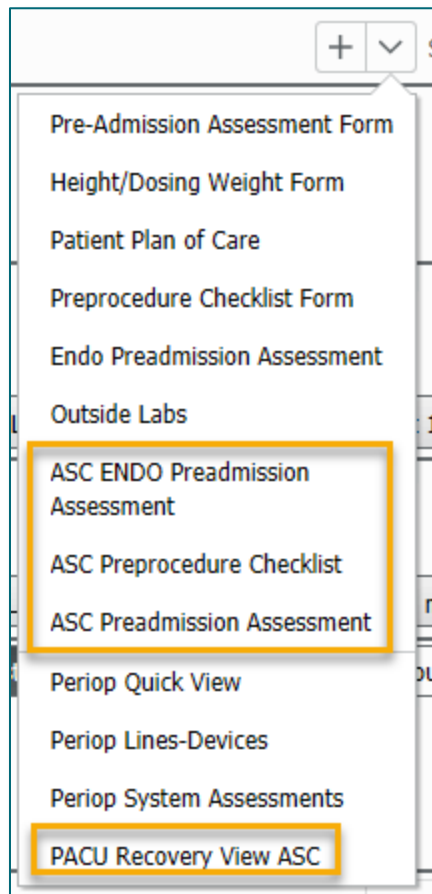
- **Documenting Home Medications**

- Select the **Home Medications** component.
 - Click the **Meds History**  to document the patients home medications.
 - The Document Medication by Hx window should appear.
 - To add a medication, click .
 - Medications should be selected from the folders if possible.
 - Type Multivitamin in the search box.

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- Select 1 tab PO Daily.
 - Click **Done** to navigate back to Document Medication by Hx window.
 - Fill out the compliance tab by putting in last dose date/time.
 - Click **Document History**. You are returned to the Home Medications component and a green check mark now displays next to Meds History. Status:  Meds History
- **Admission Documentation Component**
 - In the Admission Documentation component, this will display all the PowerForms and iView Bands specific to the ASC content.
 - Click on the drop-down arrow to view the content.



- **Documenting Preferred Pharmacy**
 - Locate **Patient Pharmacy** in the Toolbar and click.
 - The city is going to default to the location in which the patient lives. You may want to delete the city and **search by Pharmacy Name only**, especially if the patient lives in a small town that may not have a pharmacy.
 - Enter **Hannaford** and click **Search**.
 - The Pharmacy location(s) will display to the right.

- Right-click the correct location and select **Add to Patient Preferred**.
- Click **OK**.
- Click the **Patient Preferred** tab to review that the pharmacy was added.
- Hover over the pharmacy name to gather additional location and contact details.

ASC Preprocedure Checklist PowerForm

If the ASC or the ASC Endo PreAdmission Assessment form has been filled out, some of the information will prepopulate in this form. Ideally, most of the information will be reviewing the information and documenting only what has changed.

Accessing the ASC Preprocedure Checklist PowerForm

- Navigate to the **Admission Documentation** component.
 - Click the drop-down arrow and select the **ASC Preprocedure Checklist Form**.

Documenting in the ASC Preprocedure Checklist Form

- **Please Review All of the Sections and practice document in the form.**
- **Documenting Anesthesia/Sedation Section (IMPORTANT)**

NOTE: Please check to see if this is filled out. If not, fill out all the questions. This will flow to the anesthesiologist's notes.

- In **Anesthesia History**, select Prior general anesthesia.
- Select None in **Patient Anesthesia Reaction**.
- Select Unknown for **Family History of Adverse Reactions**.
- In **Moderate Sedation History**, select “No prior sedation for procedure”.
- In **Family Anesthesia Reaction**, select None.
- In Symptoms of Sleep Apnea, you could multiselect. Let's not document in this box since the patient does not have any of the symptoms of sleep apnea.
- In Postoperative Nausea and Vomiting Risk Assessment, select the following:
 - Yes for female.
 - Yes for smoker
 - Yes for History PONV or Motion Sickness
 - Yes for Postop Opioid Administration Planned

NOTE: The PONV Risk should auto calculate the PONV Risk.

- **Documenting Perioperative Protocols**
 - Fill out at least the minimum documentation in this section:
 - Click in the correct column in the Patient Safety box. Please note the required field for Safety Checklist Complete.

- Fill out Patient Rights as applicable.
- **Sign** the form by clicking the green checkmark in the upper left corner.

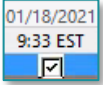
Document PACU Recovery View ASC in Interactive View and I&O (iView)

- In the **Admission Documentation** component, click the drop-down arrow and select **PACU Systems Assessments ASC** to navigate you to iView. Please explore and practice documenting in the different sections to familiarize yourself with where to document your assessments.

NOTE: This iView Band should be used for prep and recovery. This band has all the required document, including IV insertions.

Documenting Vital Signs

NOTE: BMDI will be used for recovery.


- iView opens to the selected band.
 - The **Vital Signs** section defaults open. Double-click in the blue banner below the date and time to get a checkmark.
 - This will allow you to tab quickly through the section as you document.
 - Double-click in the **Temperature** cell and document 38.4. Note the temperature in Fahrenheit will calculate for you.
 - In **Temperature Method**, select Oral.
 - In **Cuff SBD/DBP**, document a systolic blood pressure of 136 and a diastolic blood pressure of 86. Note the Cuff MAP Estimate is calculated for you.
 - In **Cuff Location** select Arm, left.
 - In **Cuff Method**, select Machine.
 - Tab to **Pulse Rate** and document 110.
 - Tab to Cardiac Rhythm and click the + sign next to the patient's baseline rhythm. Open **Sinus Rhythms** and select **Sinus Tachycardia**.
 - If the patient is experiencing any ectopy, open **Ectopy Description** and **Ectopy Pattern** to complete that documentation.
 - Tab to **Respiratory Rate** and document 24.
 - In **Oxygen Delivery**, select Room Air.
 - Tab to **Oxygen Saturation** and document 88.
 - Notice the checkmark next to the **Measurements** section. Open the Measurements section, the patient's height has populated in the Measurements section from the Height/Dosing Weight form. The patients Dosing Weight will display in the banner bar. **Daily** or weekly **Measured weights** are documented in the **Measurements** section.

Documenting Morse Fall Risk Scale

- Open **Morse Fall Risk Scale**. Double-click in the blue banner below the date and time to get a checkmark.
-

- Indicate the patient has not had a fall in the last 3 months,
- **Presence of Secondary Diagnosis Morse** – click the blue hyperlink to see if the patient qualifies for this then document the correct response.
- Document your patient is alert and oriented, has a normal gait, and uses a cane. Your patient does have an IV.
- The **Morse Fall Risk Score** will calculate after you click in that cell.
- **Required Interventions** will pre-populate. Double-click in the cell to view the required interventions that are pre-checked.
- **At Risk Interventions Morse Scale** appears, click in the cell and document Red Slippers provided.
- Open the **Braden Assessment** section. Double-click in the blue banner below the date and time to get a checkmark.
 - Document the applicable response for your patient in each of the Braden categories.
 - The Braden Score will automatically calculate.
 - Document the Braden Interventions as applicable for the patient.
- Sign the documentation for the Systems Assessment band by clicking on the green checkmark.

Documenting an IV Start

- Your patient has an order for Normal Saline at 100ml/hour and you have just started the IV, so let's get that documented.
- Select the **Peripheral IV** section and click the dynamic group symbol. 
 - The **Label** opens.
 - Select **IV Cannula, Forearm, Left, and 20 gauge**.
 - In **Activity**, select **Insert**.
 - **Patient Identified**, select Patient Identification Band and Verbal.
 - **Total Number of Attempts**, document 1.
 - 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 (Biocclusive dressing).
 - **Sign** documentation by clicking on the green checkmark.

Inactivating a Dynamic Group

- Once an IV, Urinary Catheter, or Drain/Tube has been removed, the dynamic group needs to be inactivated after documenting discontinued or removed.
 - Right-click the IV label – IV cannula Forearm Left 20 gauge and select **Inactivate**.
 - The dynamic group collapses and the dynamic group is inactivated.

- Click the carat to expand the inactivated dynamic group. Note that the documentation fields are grayed out and you are no longer able to document in this dynamic group.
 - If you forgot to document something prior to inactivating the dynamic group, right-click the label and select **Activate**. You will now be able to complete your documentation and then **Inactivate** the dynamic group.

Annotations

- Annotations are added to ensure that a provider reviews and is updated on a clinical situation. This is information that you feel that it is important, and the provider or other nursing staff must be in the know. It is also used to document something when there is no discrete field to document the information.

Annotations do not replace a phone call to the provider in an emergent situation.

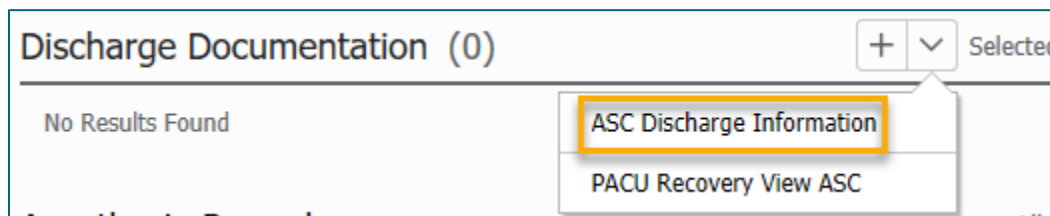
- In iView, left click on the time field.
- Right-click and select **Actions**.
- Click **Flag Annotation**.
- In the **Title**, enter **Cardiac Rhythm**.
- In the **Free text box**, enter **Patient experienced a brief episode of asymptomatic V-tach while arguing with spouse**.
- Remember flagging an annotation allows the provider to access information more quickly, and nursing as well.
- Review the **Patient Info and Story MPage** to view the annotation.

ASC Recovery and Discharge Workflow MPage

- This workflow page will work similarly to the Discharge Workflow MPage.

Document ASC Discharge Information PowerForm.

- Access the form by using the dropdown arrow in the component.

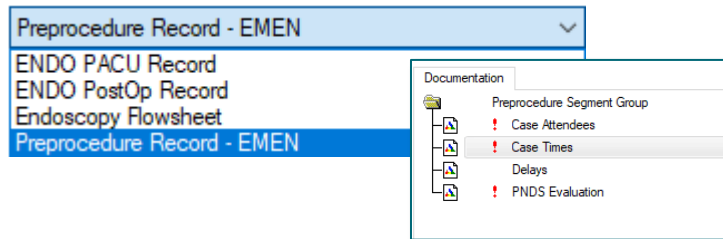


- Fill out the form as desired and click on the green check mark to sign it.

Additional Information

Changes to Perioperative Doc

- Preprocedure Record is new.
- To view the changes, navigate to Selection and search by date.
 - From Date: 6/1/2023.
 - Pick any patient.



BCMA

- Refer to BCMA workbook.