



Ambulatory Clinical Intake Cerner Workbook Walk-In Care Clinical Staff

This self-guided workbook allows Walk-In Care Clinical Staff to practice common documentation using the optimized workflow. This complements PromisePoint simulations and instructor-led education.

Please note, the following scenario is designed to demonstrate the workflow and functionality of the new tools. It may not be inclusive of all Northern Light System and/or Hospital policies and procedures.

Patient Scenario:

49-year-old female patient presents to WIC with c/o of left wrist pain.

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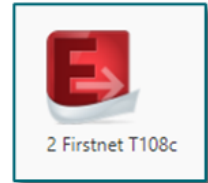
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Signing into Cerner Millennium

- From the Intranet page under Quick Links search for Cerner Millennium – Train (New Hire).
 - Cerner Millennium Train is where you can practice on training patients.
- Click the green plus sign to add **Cerner Millennium – Train (New Hire)** to your Quick Links.
- From Quick Links, click Cerner Millennium – Train (New Hire).
- Click the **PowerChart** icon.
- Enter the username and password provided.



Patients and Sign-ons

Password: train44ing

Sign On	Password	Patient
TRAMBRN30	train44ing	TRAIN, WICINWBA
TRAMBRN31	train44ing	TRAIN, WICINWBB
TRAMBRN32	train44ing	TRAIN, WICINWBC
TRAMBRN33	train44ing	TRAIN, WICINWBD
TRAMBRN34	train44ing	TRAIN, WICINWBE
TRAMBRN30	train44ing	TRAIN, WICINWBF
TRAMBRN31	train44ing	TRAIN, WICINWBG
TRAMBRN32	train44ing	TRAIN, WICINWBH
TRAMBRN33	train44ing	TRAIN, WICINWBI
TRAMBRN34	train44ing	TRAIN, WICINWBJ
TRAMBRN30	train44ing	TRAIN, WICINWBK
TRAMBRN31	train44ing	TRAIN, WICINWBL
TRAMBRN32	train44ing	TRAIN, WICINWBM
Sign On	Password	Patient

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TRAMBRN33	train44ing	TRAIN, WICINWBN
TRAMBRN34	train44ing	TRAIN, WICINWBO
TRAMBRN30	train44ing	TRAIN, WICINWBP
TRAMBRN31	train44ing	TRAIN, WICINWBQ
TRAMBRN32	train44ing	TRAIN, WICINWBR
TRAMBRN33	train44ing	TRAIN, WICINWBS
TRAMBRN34	train44ing	TRAIN, WICINWBT

Registering WIC Test Patient

IMPORTANT:

If your patient **does not** have a **WIC Intake Form task** in the Activities Column within WIC LaunchPoint, follow the steps below for registering your patient.

If the task is there, please **SKIP TO** Setting LaunchPoint Location.

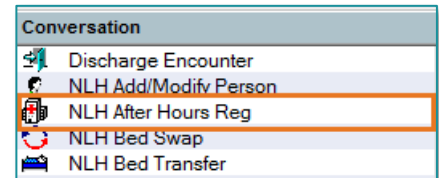


STEP 1: From the Millennium Storefront double-click PM Office T108c.

STEP 2: Enter Username and Password.

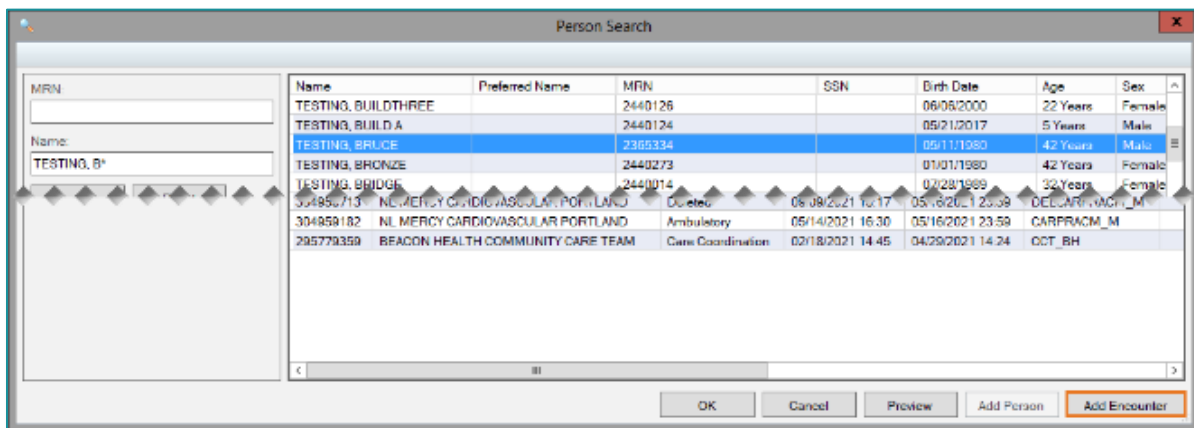
- Cannot use the FirstNet Usernames above for this task.
- Please use:
 - Username: **tramboff99**
 - Password: **train44ing**

STEP 3: In the Conversation band, double-click NLH After Hours Reg (third option from top).



STEP 4: Within the Name section, reference the sign-on patient above.

STEP 5: Select patient then click Add Encounter.



STEP 6: In the Facility Name search field, type NL MERCY WALK, then press the ENTER key.

STEP 7: Select NL MERCY WALK-IN CARE GORHAM and click OK.

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STEP 8: Fill in the required yellow fields:

- Patient Type: **Outpatient**
- Chief Complaint: **LEFT WRIST PAIN**
- Nurse/Ambulatory: **EXGORM_M**
- IP Attending/OP Ordering Prov: **Test, Provider**
- Medical Service: **Emergency Medical**
- INS1 Effective for Encounter? **Y**
- Click **OK**
- If Health Plan is required (a notification will appear).

- Click **Search for Subscriber...**
- Select **By Plan Name** tab.
- Within Health plan search field: **Type Self**
- Single click **Self Pay XX- Self Pay**
- Click **OK**.

- INS1 Effective for Encounter?: **Y**
- Click **OK**.
- The following address(es) failed to validation: **YES**
- Click the box “Do not print documents” then click **OK**.
- The patient’s name and FIN will be assigned to the WIC LaunchPoint Waiting Room.
- Click **OK**.
- You can log out of the conversation window at this time.
- Log back into FirstNet with the username and password on page 3.

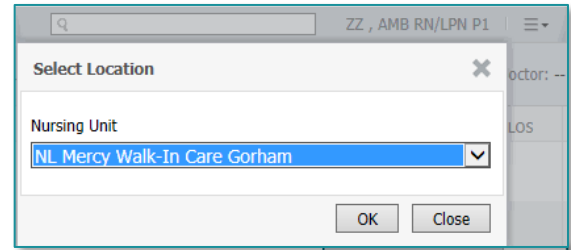
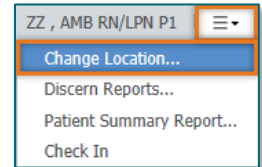
Document	Printer
EMMC ADULT WRISTBAND	h1403 emmc wic reg
EMMC FACESHEET	h087 - emh mall reg
EMMC INDIVIDUAL HIGGINS LABEL	h1822 emmc w i c

The following NL WALK-IN CARE BANGOR aliases have been assigned for TESTING, BRUCE:
FIN NBR: 336162516

Set LaunchPoint Location

From the LaunchPoint Walk-in Care screen:

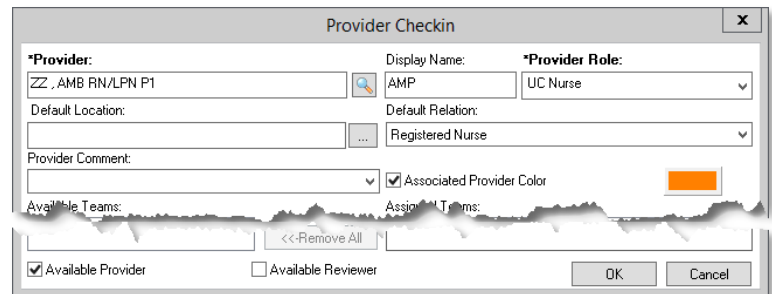
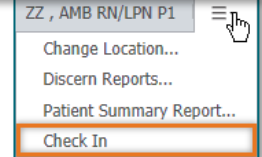
- Click the **Options** dropdown arrow.
- Click Change Location.
- Click the Nursing Unit dropdown arrow and select **NL Mercy Walk-In Care Gorham**. (For the purposes of training exercise, do not select a different location.)
- Click OK.



Provider Check-In

From the LaunchPoint Walk-in Care screen:

- Click the Options dropdown arrow.
- Click Check-In.
- Click the **Provider Role** dropdown arrow.
- Click the appropriate provider role:
 - UC MA
 - UC Nurse
- Click the **Default Relation** dropdown arrow.
 - Clinical Assistant
 - Licensed Practical Nurse
 - Registered Nurse
- Click the appropriate default relation.
- Select the Associated Provider Color check box.
- Click the associated provider color you want to use.
- Click OK.
- Select the Available Provider and Available Reviewer check boxes.
- Review to confirm the information is correct.
- Click OK.



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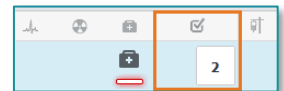


Use the Activities Tab

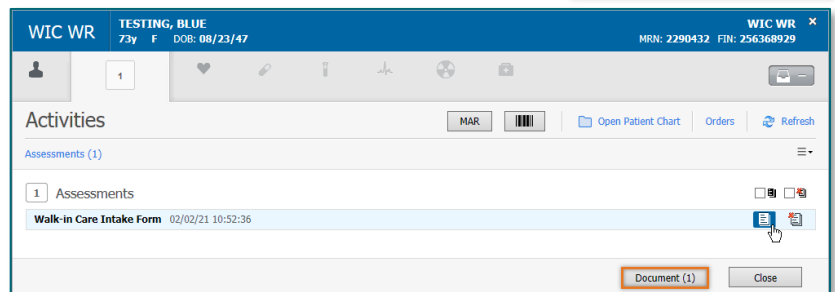
Document the Walk-in Care Intake Form

Complete the following applicable fields and sections that apply to your sites policy and processes. For the intent of this training and demonstration purposes, you will complete the Walk-In Care Intake Form.

- From **WIC LaunchPoint**, click the **Nurse Activities icon** in the Activities column to open the Activities tab.



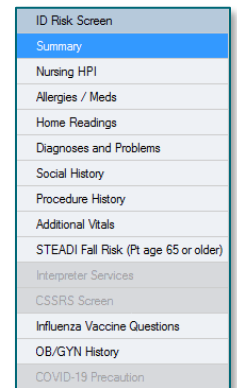
- Select the Walk-In Care Intake form:
 - Select the **Document** icon for the Walk-in Care Intake Form.
 - Click **Document**.



ID Risk Screen

The Walk-in Care Intake Form appears and defaults the ID Risk Screen tab.

- Have you traveled within the past 6 weeks OR Have you had contact with an ill person who has traveled within the past 6 weeks? Select **No**
- In the last 6 months, have you been HOSPITALIZED, overnight, outside of the Continental USA: Select **No**
- In the Risk Factors and Symptoms/MDRO Surveillance:
 - For Risk Factors for COVID-19: Select **No** to all questions.



Summary


- Please enter the following within each of these sections:
- Primary Language: **English**
- Chief Compliant:** “Left wrist pain”
- Measurements:
 - Height /Length Measured: **169**
 - Weight: **76**
 - Temperature: **37**
 - Temperature Method: **Temporal Temperature**

- Peripheral Pulse Rate: **80**
- Respiratory Rate: **20**
- Cuff Location: **Arm, right**
- Cuff Method: **Machine**
- Systolic/Diastolic BP: **120/80**
- SpO2: **99**
- Size of Cuff: **Regular**
- Pain:
 - Pain Present: Yes, actual, or suspected pain
 - Numeric Pain Scale: **6**
 - Primary Pain Character: **Aching, Discomfort, Throbbing**
 - Primary Pain Location: **Wrist, left**
- Additional Pain Location? **No**

Social History

- Click the **Social History** section.
- If the patient has been **previously seen** at another NLH Hospital or practice, the social history details will be documented. **If the patient indicates no social history changes**, it is imperative to document “**Social History Reviewed No Changes**” at the bottom of the form, to indicate what section did not change in the patient’s social Social History section. **Do NOT** use the **Mark all as Reviewed** button.

Social History Reviewed No Changes	Smoking Cessation Education
<input type="checkbox"/> Tobacco <input type="checkbox"/> Alcohol <input type="checkbox"/> Substance abuse <input type="checkbox"/> Sexual <input type="checkbox"/> Abuse/Neglect <input type="checkbox"/> Nutrition/Health <input type="checkbox"/> Home/Environment <input type="checkbox"/> Exercise <input type="checkbox"/> Employment/School <input type="checkbox"/> Spiritual/Cultural	<input type="checkbox"/> Pt advised to quit tobacco use: Discussed Cessation <input type="checkbox"/> Pt advised to quit tobacco use: Educational material provided <input type="checkbox"/> Pt advised to quit tobacco use: Maine Tobacco Helpline offered <input type="checkbox"/> Pt advised to quit tobacco use: Pharmacy referral <input type="checkbox"/> Pt advised to quit tobacco use: declines all interventions at this time <input type="checkbox"/> Other:

- The Tobacco, Electronic Cigarette/Vaping, Alcohol, Substance Use History, and Abuse/Neglect are required categories to be completed.
- Tobacco must be documented at least once every calendar year. A red asterisk * will appear next to the Tobacco section if it is due to be reviewed for the patient.
- If no documentation exists, click the  button to begin documenting in the Social History Tool.
- In the Tobacco Section, select: Never (less than 100 in lifetime).

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- Smokeless Tobacco use: **Never**
- Scroll to **E-Cigarette Use: Never**
- Scroll to the **Alcohol** section and select **Current** in the **Use** dropdown menu.
- Type: **Beer**
- Frequency: **1-2 times per month**
- Scroll down to Substance Use History and select **Denies** from Use dropdown.
- Scroll to the **Abuse/Neglect** section and select the following:
 - Feels unsafe at home: **No**
 - Safe place to go: **Yes**
- Click the **OK** button to **exit** the Social History tool.



Nursing HPI

Enter the following:

Patient fell on left wrist three hours ago while biking. C/o left wrist pain, swelling and tenderness.
Pt. has iced the site as well as taken Tylenol and Advil for pain.

Depression Screening

- PHQ-2: Feeling down, depressed, hopeless – Not at all
- PHQ-2: Little Interest, pleasure in activities – Not at all
- Since the score was 0, no additional evaluation is needed at this time.

Social Determinants of Health

Document the following information:

- Within the past 12 months we worried whether our food would run out before we got money to buy more?
Never
- Within the past 12 months the food we bought just didn't last and we didn't have money to get more? **Never**

STEADI Fall Risk

- Have you falling in the past year? **1Fall with injury**
- Ambulatory Patient? **Yes**

Interpreter Services

- Translator Required: **No**

CSSRS Screen

- Question 1: Have you wished you were dead or wished you could go to sleep and not wake up?
 - Select **No**
- Question 2: Have you actually had any thoughts of killing yourself?
 - Select **No**
- Question 6a: Have you done anything, started to do anything, or prepared to do anything to end your life?
 - Select **No**

Influenza Vaccine Questions

- Is the patient due for a vaccination? **No**

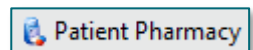
COVID Screen

- Patient Type; **Patient, Hospital**
- **Vaccine Not Available**

Sign the form by clicking the green check in the upper left corner of the form.

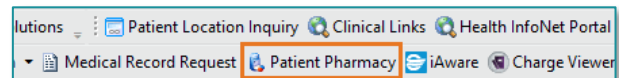


Document a Patient Preferred Pharmacy



Once the Walk-In Care Intake Form is complete, the **Complete Patient's Preferred Pharmacy** task is available within the Nurse Activities. The patient's pharmacy can be verified by completing these steps **without** navigating inside the patient chart:

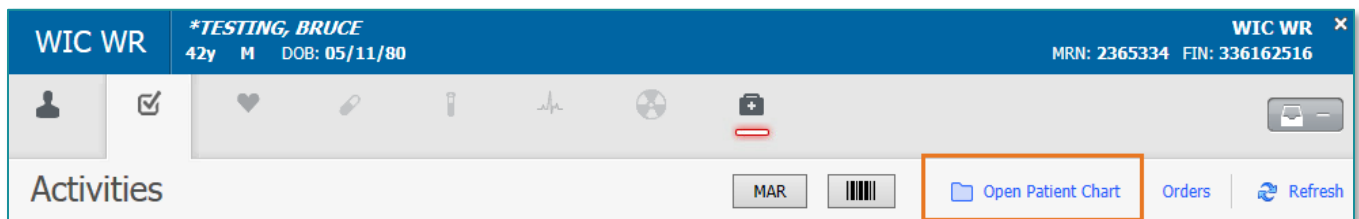
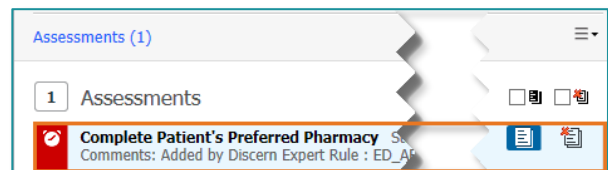
- Click **Patient Pharmacy** from the upper toolbar.
 - The Review Patient Preferred Pharmacy window will open.
 - The city is going to default to the location in which the patient lives. You may want to delete the city and search by Pharmacy Name only, especially if the patient lives in a small town that may not have a pharmacy.
- Type **Miller Drug** in the Pharmacy Name field.
- Type **Bangor** in the City.



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- Click **Search**.
- Right-click the **Miller Drug LTC** pharmacy.
- Click **Add to Patient Preferred**.
- Click the **Patient Preferred** tab to review that the pharmacy was added.
- Hover over the pharmacy name to gather additional location and contact details.
- Click **OK**.
- Select the **Complete Patient's Preferred Pharmacy** task from within Activities on WIC LaunchPoint.
- Click **Document**
- Click **OK**

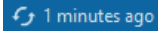


- Click **Open Patient Chart** to navigate to the **WIC Nurse MPage**

WIC Nurse MPage

When opening the patient's chart from the Nurse Activities column on WIC LaunchPoint, please use the **Minutes Ago** button so the information from the Intake form flows to the WIC Nurse MPage.

The WIC Nurse MPage is a new MPage that was customized for Walk-In Clinical staff to allow for documentation to fit the needs of the patient and to streamline the discharge process. Components can be moved to allow for further customization.


- Click the **Minutes Ago** (Refresh) so information flows to the WIC Nurse MPage. 
- The Chief Complaint was refreshed from the Intake Form.

Home Medications


Home Medications are required to be documented from the MPage.

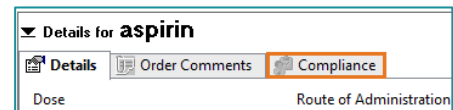
- Select the Home Medications Component.
- Click **Meds History** next to Status



- Review the patient’s medications with the patient. We want to add that the patient is taking aspirin 81 mg PO Daily to the patient’s medication list.
- Click the **Add** button  in the top left corner of the window.
- Type **aspirin** in the Search field.
- Select **aspirin 81 mg, Chew tab, PO, Daily, #90** order sentence.
- Click the medication to view the medication details. Adjust the dose or frequency if the patient is taking the medication differently than the order sentence indicates.

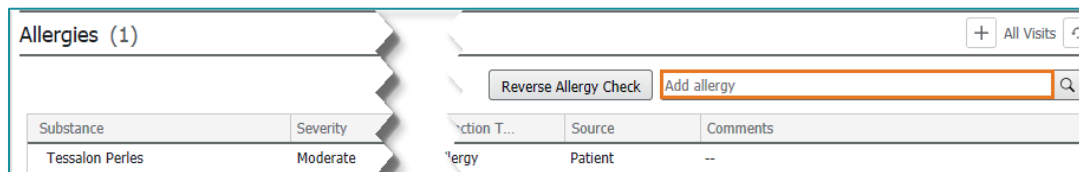
Modify Compliance

- Click the **Compliance** tab in the Details pane.
- Select **Add/Modify Compliance**.
- Click the **Status** dropdown arrow. Select **Still Taking**.
- Enter **date and time the last dose** was taken. If taken today, enter “T” to populate today’s date.
- Document the **time**.
- Click **Document History** once completed. You are returned to the Home Medications component, and a **green checkmark** now displays next to Meds History 



Allergies

- The patient reports having an **allergy to Lipitor**.
- To add **Lipitor** as an allergy, type **Lipitor** in the **Add allergy search field**.



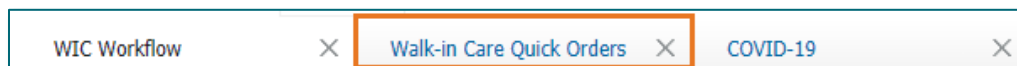
- The allergy window will open; all areas marked with an * need to be filled in.
- **Severity:** select **Moderate** from the dropdown.
- **Reactions:** type **hive** in the **add reaction search field**; select **Hives**.
- **Source:** Patient
- Click **Save**.
- Click **Complete Reconciliation**.




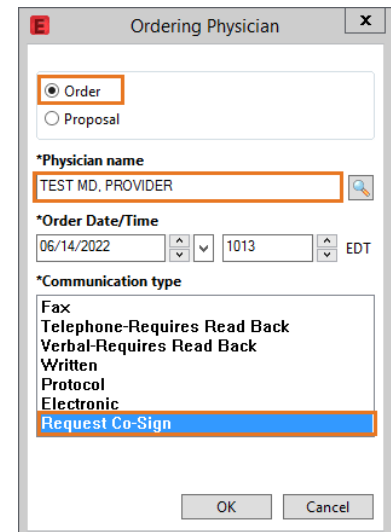
Order Entry

For nurses and medical assistance working in urgent care areas, the scope of order entry typically is limited to protocol orders based on the patient's clinical presentation. Today in class, we will be placing additional orders that are typically out of the scope of a protocol to demonstrate how they can be acted upon by clinical staff in the urgent care areas.

- Navigate to **Walk-In Care Quick Orders**.



- From the Supplies Component, click **WIC Ortho Device**.
- In the Ordering Physician Window, select: **Order**.
- Physician Name: **Test MD, Provider**
- Communication Type: **Request Co-Sign**
- Click **OK**.
- Navigate to the Orders for Signature window. 
- Click **Sign**.
- The ordering window will open.
- Within the Device section: **Other – Enter in Special Instructions**.
- Type of Arm Splint: **Wrist Splint Soft**
- Click **Sign**.



iView Documentation

- Navigate to WIC LaunchPoint.
- Click the Minutes Ago button if needed.
- Navigate to Nurse Activities on WIC LaunchPoint.
- A new task has appeared within Nurse Activities.
- Click **WIC Ortho Device** from Nurse Activities.
- Click **Document**
- iView will open to the Activity View band.
- Select **Other – type Wrist splint**

- Capillary refill distal to injury: **Less than or equal to 3 seconds**
- Pulse distal to injury: **Normal**
- Sensation distal to injury: **Pain**
- Injury range of motion splint/immob: **pain with movement**
- Click the **green check** to sign

Discharge Tasks

The remainder of the visit is addressed by the provider. He/She/They creates the visit note, including follow-up and patient instructions, completes the ambulatory visit summary, and provides the patient with any work/school notes.

NOTE: To streamline the discharge process, you will be working from the **Nurse WIC MPage**.

Navigate to the **Nurse WIC MPage** and proceed:

IV Stop Times

Document the stop time at time of patient discharge (at sites that document IV Stop Times).

- A **red asterisk** indicates an IV Stop Time has not yet been documented.

*** IV Stop Times**

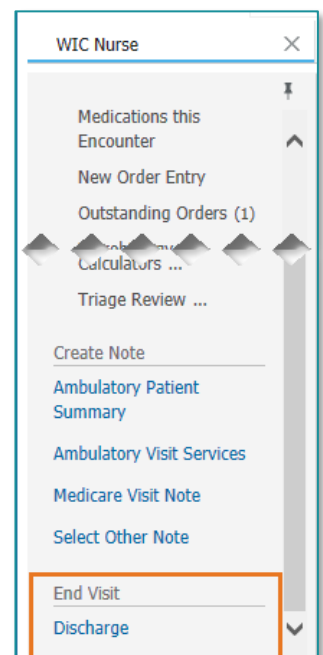
Ambulatory Patient Summary

- If you work at a location where the clinical team is responsible for printing the **Ambulatory Patient Summary**, select **Create Note**.

Discharge Visit

Discharge Visit is in the WIC Nurse MPage to streamline the discharge process.

- Under **End Visit**, select **Discharge Visit**.
 - This will launch the discharge patient conversation.
- Discharge Date: type **T** to populate today's date
- Discharge Time: type **N** to populate the time to now
- Discharge Disposition: For our patient, type **H** to populate **Home** from the dropdown. Click **OK**.
- Select **NLH Discharge** (if applicable).
- The patient is no longer in the room, and the bed status is set to **Dirty**.



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Notes about Discharging patients:

- **Do not leave** discharged patients on WIC LaunchPoint as pending lab and radiology results will not flow to Results Callback.
- If a patient was inadvertently left on WIC LaunchPoint for hours, **do not backdate the discharge date and time**, please discharge the patient, and notify the provider so that lab and radiology results can be reviewed in the patient's chart. Backdating the date/time will not allow results to flow to Results Callback.
- Failure to promptly discharge the patient will result in a patient safety risk and missed completed results.

Bed Status:

- To update the bed status, click the “**Dirty**” label in the patient information column on **LaunchPoint**.
 - Depending on your organization, housekeeping may complete this task, for the clinical staff in the practice may complete this step.
- Set the status to ****READY****. Please make note of the other statuses that are available.

For questions regarding process and/or policies prior to go-live, please reach out to a Super User or a local Clinical Informaticist.
