

**2016**

Vanderbilt University Medical Center

VUMC

1/1/2016

**Pre-class tasks**

Clinical Systems

* **Complete timekeeper**
* **Assign roles for class for each clinical system including who teaches, who drives, and who roams**
* **Print class roster for sign in and have blank paper and tape available for student “name tags” to be placed on back of monitor.**
* **Put paper and laminated handouts, which includes training id cards at each computer station.**
* **Verify each terminal is working**

**STEPS TO PLAY BACK ORDERS FOR RN class**

1. Sign on with **TRAIAKO;** (see Training ID Information on RN NEO Class Materials page on SSS Website)
2. Go to the clinical desktop and **click on Wiz Train**
3. **Click on a patient name** **Click on Enter Orders (**If orders display in Left Window-**click D/C button** at bottom, select all and discontinue all orders)
4. Click **Patient’s Name in Upper Left Window**
5. Click **“Manage Personal Orders”**; click **NEO RN**
6. **Click Playback…** orders load… click  **Done**
7. Say NO to RASS, Admit order, (defer if it displays in instruction box))
8. Accept orders
9. Repeat this process for each patient on the unit

***PowerPoint Companion Guide – should be loaded and minimized*:**

In B319 –

1. open VMWare from the desktop
2. Open the connection for “LMS…”
3. Go to Internet via your choice of browser and open the SSS website.
4. Click on Training then RN NEO Class Materials
5. **Pull up slide #1 to show as users check into class.**
6. Minimize the screen.
7. Find the Clinical Remote Agent icon on the desktop click.
8. Remote into KFH. Use KFH for demonstration purposes, not Virtual environment.

In 407 and 1010 –

1. Use CWS for everything but Jeopardy.
2. Go to Internet via your choice of browser and open the SSS website.
3. Click on Training then RN NEO Class materials
4. **Pull up slide #1 to show as users check into class.**
5. Minimize the screen.

### Must use AWS for Jeopardy. Be sure to change plug for speakers from CWS to AWS for Jeopardy.

### Documents and Resources:

***Training Resources:*** *Distribute before class begins*

* **Resources include handouts and laminated pages on O-ring with training ID page**
* Handout #1 **Notes page**
* Handout #2 **One-time Setups**
* Handout #3 **Systems Access checklist**

### Introduction

1. **Introduce** trainers and preceptors.
2. **Inform** participants that the goal of this training class is to introduce them to the different clinical systems that nurses will use in patient care. The class is meant to be an overview.
3. **Familiarize** participants regarding timing for breaks and lunches (times may vary slightly based on class size. Explain where they can locate food. Lunch break will occur around 11 am and a break will be given before and after lunch.
4. **PLEASE** shut off and put away ALL technology and cell phones as breaks will be provided to check for messages. Please do not be tempted to log on to your work or personal e-mail during instruction time as we ask for your complete attention
5. **Inform** participants about the location of bathrooms.
6. **Explain** that questions are encouraged and will be taken at any time during the day.
7. **Explain** the Ask it Basket is used for questions about the systems but perhaps not necessarily about the material being presented at that moment. Questions about the material being currently taught should be asked in real time.
8. **Discuss** CAPS role and Help Desk. Show website and CAPS site.
9. **Explain** that the trainer responsibilities include delivering content, sharing process expertise, facilitating activities and evaluating comprehension. The preceptor’s responsibilities include monitoring individual and group practice providing technical support and answering questions during breakout activities.

## StarBrowser/StarPanel

**Introduction to StarBrowser/StarPanel**

**SHOW slide #2 Review objectives**

|  |  |
| --- | --- |
|  | **Build Conceptual Knowledge:**   * StarPanel is the full Electronic Medical Record application. It includes information about individual patients and groups of patients and menus to navigate to different parts of the Electronic Medical Record * StarBrowser is a view of the StarPanel Electronic Medical Record(EMR) * We will focus on this version as it was designed specifically to make navigation easier for the Inpatient Nursing Staff * StarBrowser includes a complete version of the Inpatient Whiteboard with full patient names * The screensaver version of the Whiteboard includes only patient initials and is HIPPA compliant |

|  |  |
| --- | --- |
|  |  |

### Logging On To the System

**Key Discussion Points**

1. **Explain** all handouts to be used in class.
   1. Laminated handouts will be referred to as discussed throughout the class
   2. Paper handouts
      1. **HANDOUT #1:** Refer users to the Notes page – brief overview of the systems to be discussed. Use this page to take notes throughout the class.
      2. **HANDOUT #3** Refer users toSystems access checklist and need to partner with security manager to get racfid assigned and setup.
2. **Explain** that the Inpatient Whiteboard (screen saver) is HIPAA compliant and that colors are triggered by complete or incomplete documentation (ex. green is complete, yellow is due, red is overdue).
3. **Explain** the login procedure and VCWS. All users will log on with a training ID non-virtual
   1. Allows a user to maintain the same documentation session from multiple workstations
   2. Allows a user to re-open their last charting session where they left off, regardless of their location
   3. Users can open each program at the beginning of the shift and leave open
   4. **HANDOUT #2** Refer users to one-time setups for VCWS
4. **Explain how to restart VCWS session** using the icon on the top right corner labeled Restart VM.
5. **Explain** that system-wide notifications (i.e., technical issues with a clinical system) will appear in one of two types of pop-up windows (the large ones in the middle of the screen and the small red box in the bottom right corner)
6. 

**Show** the red sign off button on the bottom left of the screen

### Defining StarBrowser Icons

|  |  |
| --- | --- |
|  | **Develop Conceptual Knowledge:**   * StarBrowser has icons, found on left side of the screen, which are the quick links created for ease of navigation for Inpatient Nurses. * Hovering over the icons displays a description or title of the icon’s related link. |

**Key Discussion Points**

1. **Click** on the StarBrowser icon
2. **Explain** the difference between StarBrowser and StarPanel
3. **Explain** StarPanel has no training environment, just training patients.
4. **Hover and explain** icons.

|  |  |
| --- | --- |
|  | ***Explain only:***  *Print, Go to Desktop, Sign Off, Launch HEO/Wiz Order, Launch HED, PMM, Kronos, Veritas, Email and Launch Help Desk.* |

1. **Point out** StarBrowser tab at bottom of screen that allows you to toggle back as necessary

### Defining StarPanel Menus

|  |  |
| --- | --- |
|  | **Develop Conceptual Knowledge:**   * The black menu bar located on the left of StarPanel hosts important navigational links that will be introduced in this section. |

**Key Discussion Points**

1. **Explain** how and why to logout completely and the two icons that perform this function.
2. **Discuss** the need to logout each time a user leaves a CWS related to HIPPA laws and unprotected access to our clinical systems.
3. **Explain** there are 3 ways to search for a patient: MRN, name, and SSN.
4. **Search** for a patient using Ztest, A. Return to patient census by clicking patient list from white tabs at top of page.
5. **Explain** the Help menu is used for:

|  |  |
| --- | --- |
|  | *updates, submitting a help desk ticket, etc.* |

1. **Explain** that main menu items appear in **red**. When free time is available, consider exploring the Informational Resources.
2. **HANDOUT #2:** Refer users to one-time setups for StarPanel Inpatient Whiteboard

|  |  |
| --- | --- |
|  |  |

### Defining StarPanel Tabbed Menu, Secondary Menu and Table

|  |  |
| --- | --- |
|  | **Develop Conceptual Knowledge:**   * Yellow tabs at the top of the screen are patient specific and white tabs are unit or census specific. |

**Key Discussion Points**

1. **Explain** the tabbed menu items at the top of screen and the significance of the yellow and white tabs.
   * Some tabs are used exclusively for outpatient and will not be discussed
   * The tabs used by inpatient staff are Forms, Pt Chart, and Pt List
2. **Hover** over column headers will reveal additional information about the functionality.
3. **Explain** that StarPanel is a ONE CLICK application.
4. **Demonstrate** how to size frames by double click in white space, left click and drag grey line, and use of the frame sub tabs at the top of the screen.
5. **Explain** anything blue in StarPanel either performs a function, like sorting, or navigates you to somewhere, like to a document.
6. **Click** on column headers in the patient list and show sorting function
7. **Describe** the function and use of some of the headers like Publicity. Discuss the need to honor HIPPA laws.
8. Publicity is a way of ensuring a patient’s identity is protected.
9. Patients may be at Vanderbilt and request anonymity for a variety of reason including security. This may be related to violence, for example, a gang shooting or domestic dispute.
10. Also, a patient may request to be anonymous because they are famous or simply have not shared their admission with family and friends.
11. No matter the reason, we must relentlessly protect a patient’s identity.
12. The federal gov’t levies fines back to the individual, not the institution-Vanderbilt, when HIPPA laws are violated.
13. These fines are upwards of $10,000.

|  |  |
| --- | --- |
|  |  |

### Defining StarPanel Colors and Indicators

|  |  |
| --- | --- |
|  |  |

**Key Discussion Points**

1. **Show** Inpatient Whiteboard.
2. Explain that orders have two colors **blue** and **red**. **Blue** is for **routine orders** and **red** is for **STAT orders** or orders that are needed immediately. **In order to demonstrate this you must go to a LIVE unit** using the green icon at the bottom of the screen you should already have pulled up. Toggle back to the VDS link you have open to return to the training inpatient whiteboard.
3. **Explain** that colors and indicators vary by unit and preceptors will take time to explain their unit specific information.
4. **Explain** presence or absence ofspecificindicators is driven by the location of the CWS and varies from unit to unit. For example the NICU does not have a FALLS indicator, for obvious reasons. However, everyone has the labs indicator.
5. **Demonstrate** hover information box and color indicators to display more information.

**Introduction to the Actions Menu**

|  |  |
| --- | --- |
|  | **Reinforce conceptual knowledge for learners by explaining that:**   * The Actions Menu has links within StarPanel that allow you to navigate to different sections of the EMR. * It is a shortcut to access specific parts of the patient chart or to open forms for documentation. * One example of a link found within the Actions Menu is the Admission History Form. * When a link within the Actions Menu is clicked, the associated information will appear in the next frame. If you are clicking actions from frame one, the info will appear in frame two. It can be viewed by clicking the number 2 tab at the top to toggle between frames. * Remember, to eliminate multiple panels from opening, only use the “actions” word link that is next to the patient name. |

### Functionality of the Actions Menu

**Key Discussion Points**

1. **Demonstrate** the correct way to access and view the Actions Menu.

|  |  |
| --- | --- |
|  | *The benefit of using the “actions” link after a patient’s name allows you to keep only 2 or 3 frames operational and prevents you from being lost in opening unnecessary frames.* |

1. **Demonstrate** the steps necessary to change the Actions Menu default setting so that the default view is “Inpatient Nurses”
2. **Click** on the OPC link from the actions menu.
3. **Remind** users the 3 ways frames can be expanded, and resized now that the OPC is in frame 2.
4. **Refer** to the “One-time setup” handout for instructions on how to get the frame sub tabs.

|  |  |
| --- | --- |
|  | *After 4 frames are opened the only way to eliminate frames is to logoff and log back in again.* |

|  |  |
| --- | --- |
|  |  |

### Overview of Patient Care (OPC)

|  |  |
| --- | --- |
|  | **Develop Conceptual Knowledge:**   * Overview of Patient Care (OPC) provides a snapshot of a patient's care * Contains information pulled from multiple systems and is used to provide an overview. * The printed Overview of Patient Care (OPC) is used for shift changeover |

**Key Discussion Points**

1. **Reinforce** that the OPC is located within the Actions Menu.
2. **Show** the steps necessary to open the OPC.
3. **Show** expanding the panels to correctly view the OPC using the frame sub tabs and the *click in a white space* method. Explain either method is acceptable and is user preference.
4. **Explain** that each section is divided by section headers using the SBAR format or “Situation, Background, Assessment, Recommendations”.
5. **Emphasize** the following in the Situation section:
   1. Synopsis is in the middle section and describes patient’s history and typically reveals details surrounding their admission to the hospital. It is pulled from a provider document called Team Summary.
   2. Team Pager location-discuss why team pager is useful in contacting which team is responsible for the patient at any given moment.
   3. Take this opportunity to explain the layers of a teaching hospital and the resident hierarchy. Discuss use of words like provider or clinician instead of doctor.
   4. Blue text is a link to the document, for example a DNR/DNI code document. (does not work on training patients)
   5. Contact information appears from HED charting in Care Contact section of the chart
   6. Clinical Alerts appear: Code, Allergies, Isolation, Fall, Braden, Advance Directives
6. **Emphasize** the following in the Background section:
   1. Past medical/surgical history
7. **Emphasize** the following in the Assessment Section:
   1. Nursing Summary/Priority Problems from HED (off going nurse documents a nursing summary and the priority plans for the next shift)
   2. Assessments that have NOT met standards for specific system/pain
   3. Progress notes, consults, radiation, rehab (replaced with new notes if documented)
   4. Last available weight, 9 sets of V/S, Pain from HED, 24hr temperature ranges from HED, active lines, wound and incisions, drains, etc. This includes basically all information needed during nurse to nurse report.
   5. I&O from HED
   6. 24hr labs (bumps out yesterday’s result if there is new results)
8. **Emphasize** the following in the Recommendations section:
   1. Set of most current orders from HEO/Wiz
   2. When the admission comes from the ED the documentation of tests/procedures done in the ED display
9. **Explain** the location of the print feature at the top of the OPC. (do not print!)
10. **Demonstrate** steps for printing front and back of the OPC via Preferences in the Print function. Explain this is a one-time preference and will not be repeated with each print.

|  |  |
| --- | --- |
|  |  |

### All Documents

|  |  |
| --- | --- |
|  | **Develop Conceptual Knowledge:**   * All Documents is a record of any document that pertains to a patient’s medical history at Vanderbilt University Medical Center. |

**Key Discussion Points**

1. **Click** on All Documents in Actions Menu.

|  |  |
| --- | --- |
|  |  |

1. **Explain** how to search for a document, using “chest for chest xray”.
2. **Click** Radiology tab as an example, clicking the tab to show how all other documents are filtered away and only radiology documents are left.
3. **Reset** all documents view by clicking “All” tab.

### Fast Labs

|  |  |
| --- | --- |
|  | **Develop Conceptual Knowledge:**   * Fast Labs is used as an overview of lab results from a patient’s hospital stay. Hovering over links will display additional information. |

**Key Discussion Points**

1. **Click** Fast Labs from the Action Menu
2. **Hover** over links to view information boxes.
3. **Demonstrate or explain** tabs at the top will filter lab data to show only labs in that tab. For example if a blood bank sample has never been drawn, there will be no blood bank tab.
4. **Demonstrate** that clicking on any lab value will open a new window and display trending activity over the length of stay. **Red** will indicate out of range labs (use hover to see normal value for Vanderbilt lab). **Blue** indicates comments by lab result.
5. **Click** the “Graph Info” link for PCV to display a graph with additional lab value information. Close with X.
6. **Click** CBC and show all CBCs collected on this patient, also useful for trending data.
7. **Scroll** to show critical labs. Explain how critical labs are communicated to providers by page and results of notification can be seen by clicking on the yellow box.

### Medication Administrations Record (MAR)

|  |  |
| --- | --- |
|  | **Develop Conceptual Knowledge:**   * MAR is used as a quick reference method to display what medications and what dosages have been administered to a specific patient including the time the medication was administered. |

**Key Discussion Points**

1. **Click** MAR from Actions Menu.
2. **Explain** thatMAR is displayed as a chart.
3. **Explain** solid black box, hollow box and yellow box to display details of these administrations. Explain each box represents an administration of the medication. An explanation of the types of display boxes is always visible at the top of the section.
4. Medication name and dosage information is displayed on the right side of the panel, and sorted into categories of types of medications.
5. **Click** name of the medication. Show all administration times for a single medication. Show closing of the box by single click within the box.
6. **Demonstrate** using the “Ctrl” key and discuss the information that can be obtained by clicking on the **blue** medication name link. You can also gain medication manufacturer data from your black menu bar “Informational Resources” including Micromedex and Lexicomp.
7. **The** cyan colored vertical bar indicates medications that were given in the OR and charted in the VPIMS perioperative charting system.
8. The solid **red line** indicates downtime. Talk about the *printed policy.*
9. The **blue** trending lines to indicate active current orders.
10. **Explain** that NOT ALL medications are currently captured in the MAR. For example, those given from Order Tracker in the ED.
11. **Change** default view to show a range of medication administration dates for length-of-stay based on the length of stay of your patient population. Those units with long stay patients need to only show 1-2 days as all days will lock up StarPanel when loading dozens of days.
12. “All days” is default view in the training environment and for live units “1” or “2” days should be selected.

### IVT Request Form & Dashboard

* Requests for the IVT are made from the Actions Menu in StarBrowser/StarPanel.
* The request form is self-explanatory and has several sections. Please fill out as much of the form as possible so the IVT can triage and prioritize your requests among the other requests made.
  1. **Click** the IVT Request Form from the Actions Menu
  2. **Emphasize** the hours the IVT is available
  3. **Show** the sections of the request form and explain importance of providing as much information as possible.
  4. **Save** the form. THERE IS **NO** TRAINING VERSION OF THIS FORM. THIS IS **DEMO ONLY**! **DO NOT SAVE FORM**!
  5. **Demonstrate** how to remove requests when access has been obtained before the IVT shows up
  6. **HANDOUT #2:** Refer users to handouts and one-time set ups for IVT dashboard instructions to save as a favorite.

### **Knowledge- Slides #3-13**

|  |  |
| --- | --- |
|  | Actions Menu  Activity: Quiz Show  Time:  Materials and prep: 2 buzzers, flip chart or white board.  Display Knowledge Check slides on PowerPoint companion.  Divide the class into two teams on opposite sides of room. Provide each team with a buzzer.  One trainer asks questions while another keeps score using flip chart or white board.  The first team to buzz in is allowed one chance to answer the question. If the question is answered incorrectly, the other team is allowed a chance. Teams may not buzz in until the trainer has finished reading the entire question.  Answers must be the name of the Actions Menu links.  In the event of a tie, use the tie breaker question.  Each correct answer earns 5 point. The team earning the most points wins a prize. (Candy, etc.) |

|  |  |
| --- | --- |
| **Question #** | **Answer Key** |
|  | **The link in the Actions Menu that is a record of any document that pertains to a patient’s medical history at Vanderbilt University Medical Center.**  All Documents |
|  | **The link in the Actions Menu that displays medications, dosages and time administered for a specific patient**  MAR |
|  | **The link in the Actions Menu that allows you to request assistance from the IV team.**  IVT request form |
|  | **The link in the Actions Menu that provides a snap shot of important information charted for a patient using the SBAR format**  OPC |
| **5.** | **The link in the Actions Menu that provides an overview of lab results from a patient’s hospital stay.**  Fast Labs |

 -**Sign Off - 15 minute break**

## Charting a New Patient’s Nursing Admission History

|  |  |
| --- | --- |
|  | **SHOW slide #14**  **Review objectives**  **Develop Conceptual Knowledge:**   * The Nursing Admission History section of a patient's chart is completed in StarPanel. * There are 4 types: Adult, Peds, OB and Psych * The form is completed when the patient is stable and admitted to a hospital unit for the first time in this occurrence. * It is critical to complete this form on all admitted patients ASAP * If a willing and able historian is present, patient or family, be diligent in completing the form in its entirety. * If the patient is already in the system, the nurse will verify the information is correct and then complete the rest of the information. |

**CASE STUDY INFORMATION:**

**You are admitting a 54 year old patient with complaints of a deep and productive cough for 1 week with progressively worsening phlegm. He has run a fever for 2 days with a t-max of 102.0 F. He has managed at home with Tylenol and Robitussin. He is otherwise a healthy middle aged man without complaints of pain to speak of. He does have a contracture of his hand that is a result of a childhood injury. He comes with a double lumen PICC which was placed prior to his transfer to the floor. His admission order was entered and he was immediately transferred to one of your many empty beds. He has antibiotics running in the proximal port. He has oxygen via a nasal cannula running at 2L. He has brought his medication list with him.**

**Key Discussion Points**

1. **Click** the Adult Admission History form on the Actions Menu.
2. **Demonstrate** and **explain** expanding the panel that displays the Admission History form.
3. Enter some examples of “Admission History Data” up to the section entitled “MedList Tool”.  
   Facilitator=patient role and Driver=nurse role for demonstration purposes.
4. **Explain** that the demographics section is pre-populated in the live environment.
5. **Enter** cough and fever for 2 weeks taking Robitussin and Tylenol in reason for admission field. Explain the flow of the form as 2 columns. Emphasize the importance of developing a routine to make sure no sections are missed in completing the form.
6. **Explain** the features of the Febrile Traveler fields.
7. **Explain** the way information from Interpreter services, present on admission, and pastoral care populate dashboards in other departments or prompt providers to act on current conditions of the patient-for example Home Infusion on admission.

### MLT (Med List Tool)

|  |  |
| --- | --- |
|  | **Develop Conceptual Knowledge:**   * MLT is the list of medications that a patient was taking prior to admission. * MLT can be updated throughout the patient’s stay. * Providers reconcile MLT at the patient’s admission and at the time of discharge. |

**Key Discussion Points**

1. **Demonstrate and explain** the location of the MLT section. Also mention that it can be accessed from the Actions Menu if necessary.
2. **Click** edit to open MLT.
3. **Explain** each of the MLTs on the training patients are different as they are edited each class we teach.
4. **Explain** that patients with a medication history will have medication that appears in the Patient Summary.
5. **Show** the edit function using any current medication.
6. **Click ADD** using Clindamycin or any other drug not already present, enter a new medication.
7. **Explain** the list of options for selecting the desired medication type.
8. **Explain** how to indicate the patient has no home medication or, you were unable to obtain information about home medications.
9. **Click** “Submit for Review” when you have completed MLT. Provider or pharmacist must review, edit, and finalize MLT. **Show** MLT indicators.

### Allergy Section of Admission History

|  |  |
| --- | --- |
|  | **Develop Conceptual Knowledge:**   * Allergy Section in the Admissions History form is a table that allows you to view existing allergies or to enter new allergies. |

**Key Discussion Points**

1. Explain, as with MLT, the allergies for each training patient will be different as edited from class to class.
2. **View** existing allergies.
3. **Enter** new allergy using morphine or bee sting and edit an existing allergy.
4. **Save** updated record.

### Immunization Section of Admission History

|  |  |
| --- | --- |
|  | **Develop Conceptual Knowledge:**   * The Immunization Screening section of the Admission History form allows you to view a patient’s past immunization records and allows you to enter new immunization information. * All fields of immunization screening are required. When enough information has been entered a red Stop message will appear. * Depending on the information entered in the Immunization and nutritional screening, ancillary departments will be notified and orders submitted for the patient to receive and the nurse to administer. |

**Key Discussion Points**

1. **Fill** all required fields using radial buttons.
2. If no radial buttons are present explain how the Immunization record and the Nursing Admission history form interface and actively communicate**.**
3. **Explain** that the flu screening questions will only appear during flu season, typically October to March..
4. **Generate** flu vaccine.
5. **Demonstrate** STOP by selecting “yes” at already received Pneumovax vaccine.

### Ancillary Screening of Admission History

|  |  |
| --- | --- |
|  | **Develop Conceptual Knowledge:**   * Beginby describing the required fields between the Immunization Screening and the Nutrition Screening on the patient chart. * Any item selected in the nutrition screening will result in a consult directly to nutrition for follow-up. * Other consults generated are case management, social work, chaplain, interpreter services, WIC, and child life services. |

**Key Discussion Points**

1. **Check** boxes appropriate to the patient’s condition or check “No problems identified at this time.
2. **Briefly** point out the remaining fields of the Admission History form.

### Saving the Admission History Form

|  |  |
| --- | --- |
|  | **Develop Conceptual Knowledge:**   * You can save as *draft* if the Admission History form can’t be completed due to the patient’s condition or other mitigating circumstances. * Once you save the Admissions History form as complete, you cannot change the information. You have to amend in the notes, any specific changes to be made. |
|  |  |

**Key Discussion Points**

1. **Demonstrate and explain** the purpose of “I Verify.”
2. **Save** as *draft* when it is not completed.
3. **Explain** that after saving the draft or final save a red alert will be displayed stating that the order was sent.
4. **Click** in All Docs to open draft form.
5. **Save** as complete.
6. **Add** an amendment through “All Docs” to the saved Admission History form with following information:

* Pt wife reports patient smokes 2ppd cigarettes for 20 years

### Admission History Group Activity

**IF time allows, and hasn’t already been done when demonstrated by facilitator.**

**SHOW slide #15**

|  |
| --- |
|  |

## Order Entry - HEO/Wiz

**Overview of HEO/Wiz**

|  |  |
| --- | --- |
|  | **Develop Conceptual Knowledge:**   * HEO/Wiz is used by clinicians for entering new patient orders and editing existing patient orders. * Wiz was developed at Vanderbilt and sold to McKesson and renamed HEO. You will hear it called both names. |
|  |  |

### Navigating HEO/Wiz

|  |  |
| --- | --- |
|  | **SHOW slide #16**  **Review Objectives**  **Develop Conceptual Knowledge:**   * HEO/Wiz is accessed through the clinical desktop by clicking on the icon with the blue wizard hat entitled WIZ through StarBrowser. * For the purposes of training we will be using the green wizard hat entitled Wiz Train from the desktop. |

**Key Discussion Points**

1. **Explain** the screen is called the Wiz STAT screen.
2. **Explain** the meaning of colors of the patient names; **blue** for routine orders and **red** for stat orders to be acknowledged.
3. **Explain** the icons and letters that may appear next to a patient’s name in the patient census list, the **purple p** and the Publicity status column.
4. **Click** thesort by bed/sort be name toggle bar**.**
5. **Explain** the “Stations”, “Services” and “Attending” columns.

!!

1. **Type** Ztest in the Patient name search box. Explain the name alert icon

Name alert icon only utilized for exact names, for example Wilson and Wilson. Icon will not be utilized for similar names like Anderson and Andersen.

1. **Demonstrate** the functionality of the “Go to desktop” button.
2. **Explain** the “click to sign off” button and the button that links to StarPanel.

|  |  |
| --- | --- |
|  |  |

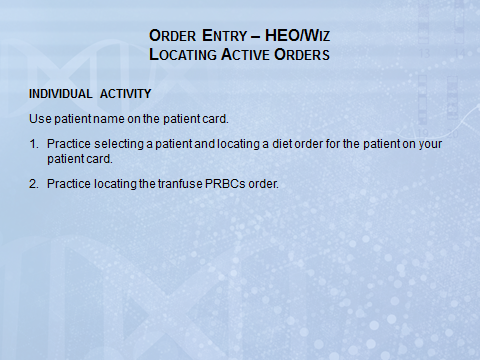
### Locating Active Orders

|  |  |
| --- | --- |
|  | **Develop Conceptual Knowledge:**   * Looking up orders is a way to verify active orders.      * When in the “looking up orders” mode, new orders can’t be entered and existing orders can’t be modified. * The orders that are displayed include patient information such as alerts, activity, diet, treatments, labs, medications and IV fluids. |

**Key Discussion Points**

1. **Direct** learners to use the patient name on the **TRAINING PATIENT CARD.**
2. **Click** a patient and click “lookup orders.” Locate an active order for guaiac stools.
3. **Click** “Done” to exit the lookup screen.

**SHOW slide # 17**

****

### Entering Orders

|  |  |
| --- | --- |
|  | **Develop Conceptual Knowledge:**   * There are five primary order types: verbal, telephone, written, protocol, and nurse-to-nurse. |

**Key Discussion Points**

1. You have called a provider to report a patient condition. The provider, Dr Test, is in traffic in his car. He asks that you enter a telephone order for a PCV in the AM @ 0500. He reminds you the patient can’t have sticks in her left arm. You agree and read back the details of the order including the patient name and the order with instructions.
2. **Demonstrate** the steps necessary to enter the following telephone order, pointing out that orders are entered on the right side, active orders are displayed on the left and order prompts are displayed top right
3. **Explain** the Common Orders found in the box on the top rightand how they are used.
4. **Type** PCV in the field
5. **Click** PCV (lab)
6. **Click** one time order in AM at 0500
7. **Type** “no lab draws from left arm” in comment field, and discuss how this field can be used to give nursing instructions.
8. **Click** done, noting order now displays in the left window in **blue** with no order number.
9. **Review details and click** accept orders.

### Requesting a Blood Product

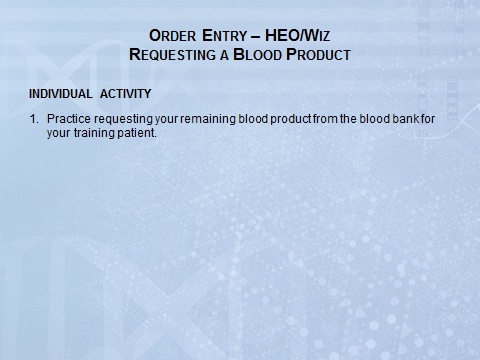
|  |  |
| --- | --- |
|  | **Develop Conceptual Knowledge:**   * A blood product is requested from the Blood Bank at the time the product is ready to be infused. This means that the patient must have IV access and has NS hung and ready to infuse. * HEO/Wiz is the system used to request the blood product. * Blood products are sent via tube station once the request is received and must be started within 20 minutes of receipt on the floor. |

**Key Discussion Points**

1. **Demonstrate and explain** requesting a blood product for a training patient.

* Select your patient
* Select protocol order
* Select the physician’s name
* Click on the active order for transfusion
* Click request blood product from Blood Bank
* Click Send
* Click done and Accept Orders

**SHOW slide #18**

****

### Order Entry Activity

**SHOW slide #19**

**Go over with students how to modify diet orders and then choose VUH diets to see the list of all diets.**

|  |  |
| --- | --- |
|  | Instruct the learners to complete the following actions as explained on the PPT Slide:  Enter the following order:   * Protocol order * Test, Physician * Diabetic diet consistent cho (carbohydrates) * HINT: Make sure you modify the old diet by clicking on it. You will find the ordered diet in a list called VUH diets. * Daily * NXT meal * Until discontinued   ASK learners if they have any questions.  SIGN OFF!! |

|  |  |
| --- | --- |
|  | **LUNCH TIME-encourage questions for the Ask it Basket!**  Instruct **learners to return in one hour to begin the afternoon session.** |

## Welcome back from break.

## Sign on

## Answer questions from Ask It Basket if appropriate.

## Encourage additional questions.

* Afternoon session will include HED/AdminRx. We will finish around 4 and will have a break around 2.

## Charting HED

**Introduction Horizon Expert Documentation (HED)**

|  |  |
| --- | --- |
|  |  |
|  |  |

**SHOW slide #20**

**Review objectives**

|  |  |
| --- | --- |
|  | **Reinforce conceptual knowledge:**   * Horizon Expert Documentation or HED is a clinical system for nursing documentation and it is separate from StarPanel and HEO/Wiz. * It hosts sections of the chart, with tabs such as Admin-Rx, which is used for medication administration and Assessment and Intervention, used for the nursing physical assessment. * It is accessed from the HED Train or HED icon located on the Desktop. * Care Organizer is a window that displays when you enter the HED application. * Care Organizer is used to make patient assignments, complete labs, confirm medications, and view medication schedules. * **Using the laminated sheets on the O-ring, find the page with patient’s name on a hospital armband. You will be using this patient for all activities in HED.** |

### Launching Care Organizer/HED

**Key Discussion Points**

1. **HANDOUT #2:** Refer to one-time setup for configuration and patient assignment instructions
2. **Explain** that in the **live** HED environment you would access HED from StarBrowser vs. the clinical desktop.
3. **Click** HED **train**.
4. **Explain** that when launching HED, Care Organizer is the first screen displayed. Care Organizer is a way to assign patients to a specific nurse, complete labs, and view medication schedules.

### Navigational Overview of Care Organizer

|  |  |
| --- | --- |
|  | **Develop Conceptual Knowledge:**   * Care Organizer has three rows of navigation. |

**Key Discussion Points**

1. **Show** the menu bar at the top of the screen with navigation options such as File, View, Patient, Report, Chart, Links and Help.
2. **Explain** that the menu bar is a row of navigational buttons that includes all patients, chart complete, census, patient select, encounters, create assignment, IV manage, HED and EXIT. Include that many of these buttons are not used in regular patient care by the bedside nurse.
3. **Click** row of radial buttons with navigation options such as “Overdues”, “To Do”, “Active”, “Current Shift”, and “Time Range.”
4. **Select** your patient from the bottom table.
5. **Click** “this patient/all patient” feature.

.

**Completing Labs in Care Organizer**

* Explain that only a demonstration of completing labs will occur.
* Mention…It is not easily replicated in the training region but remains critical to the notification of ordered labs to the nursing staff.

1. **Demonstrate** how to choose the “orders” from view in the top menu bar.
2. **Explain** this process as a way of notification of ordered labs and how to clear them from the to-do view.
3. **Demonstrate** how to complete a lab.
4. **Click** on complete from the bars toward the top of the screen.
5. **Choose** one of the urinalysis orders.
6. **Click** complete in the bottom right corner.
7. **Review** the lab now states charted, however it has been removed from the to-do view of the worklist.

### Confirming a Medication Order

**Develop Conceptual Knowledge:**

* **Medications are confirmed by toggling between the Care Organizer window of HED and StarBrowser.**

**Can anyone tell me why medication orders need to be confirmed?**

* We confirm medications for patient safety.
* The nurse is the last safety check before the medication is administered.
* You want to confirm that the drug is appropriate for your patient.
* You also confirm that the pharmacist processed the order as the physician ordered it and placed it on the correct schedule.
* Medications that need to be confirmed appear in yellow.
* All medications should be confirmed within the active view of Care Organizer.

**Activate prior knowledge for learners by explaining:**

* Confirming medication takes place in two systems that you are now familiar with: StarBrowser and Care Organizer.
* Administering medication takes place within the Admin-Rx tab of HED.

We will look at both of these processes in the next few lessons.

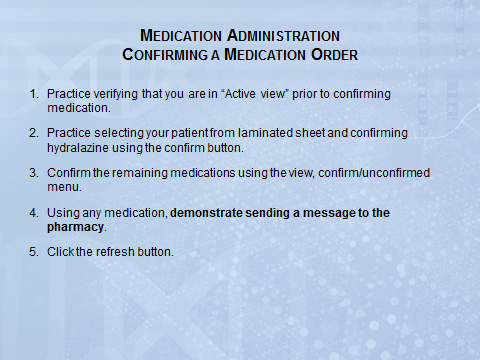
**Key Discussion Points**

1. **Reminder – use patient from the laminated sheet.**
2. **Demonstrate and explain** the steps for selecting and confirming a patient’s medication in Care Organizer.

|  |  |
| --- | --- |
|  | *Make sure you are in Active view when confirming medication otherwise only a certain time period will be confirmed.*   * **Select** patient from patient list in the lower frame of Care Organizer. * **Confirm** haldol using the confirm button in the top right hand corner. * **Toggling** back and forth between StarBrowser and Care Organizer**,** verify the right medication, right dose, right route, administration schedule is present, PCM number and physician order number match. * **Click** confirm |

1. **Demonstrate and explain** that multiple orders can be confirmed for the same patient.
2. **Using** the view confirm/unconfirmed menu confirm the remaining medications.
3. **Explain** thepopupwindow that opens for other medications that need to be confirmed.
4. **Demonstrate and explain** that clicking “Send Rx a Message” is the best method of communicating with the pharmacy
5. **Demonstrate** that the confirm button now displays history.
6. **Demonstrate and explain** using the refresh button becauseno screens self-refresh in Care Organizer or HED.

**SHOW slide #21**

****

### Administering Medication

|  |  |
| --- | --- |
|  | **Develop Conceptual Knowledge:**   * Once medications are confirmed in Care Organizer the administration can be charted in the Admin-Rx tab of HED. * We use the “To Do” view in Care Organizer to identify the medication administration times. We use the “Overdue” view as an alert to show medications that were not given at their scheduled time. * YELLOW Warnings will interrupt the process of administering medication and **should not** be ignored. The only way to see/acknowledge warnings as they occur is to scan meds with the screen in a position to actively view. * For example, warnings will occur when an incorrect dose is selected or the medication is administered too late, too early or when no medication order is found. |

**Key Discussion Points**

1. **Explain and list** the 5 Rights:

* The Right Patient
* The Right Medication
* The Right Dose
* The Right Route
* The Right Time

1. **Identify** medications that are due using the “To Do” view of Care Organizer.

* **Click** “Show Worklist” so that a timeline displays.
* **Click** the radial buttons “Overdues, Changes, To-Do” and column headers.
* **Show** the location of comments about medications.

1. **Administer** Hydralazine**:**

* **Scan** medication and address warnings.
* **Scan** the patient armband and address any warnings **if necessary**.
* **Explain** that the medication should be administered before confirming.
* **Save and Confirm.**

1. **Administer** D5 1/2 NS IV fluid.
2. **Explain** need to choose extra dose, scan the patient, then choose protocol (related to no schedule attached to IV fluids).
3. **Explain** how to reset scanner if it is not working properly.

**SHOW slide # 22**

|  |  |
| --- | --- |
|  | Instruct the learners to complete the following actions as explained on the PPT Slide:  Administer the following medications:   * Milk of Magnesia * Ondansetron (Zofran)   ASK learners if they have any questions.  Trainers:    Monitor to ensure that they remain on track:   1. Monitor learners and coach as needed. |

### Matched Medication Administration

|  |  |
| --- | --- |
|  | **Develop Conceptual Knowledge:**   * When a medication is scanned that has more than one order a Matched Medications popup window will display. * Admin-Rx is unable to identify which medication order to document against and the nurse will need to select the appropriate order. * High Alert medications require cosigning. * The medication identified universally by Vanderbilt in the adult hospital are chemotherapy, IV Potassium drip, IV Digoxin drip, IV Heparin drip, and IV Insulin drip |

**Key Discussion Points**

1. **Explain** what Match Medication means.
2. **Scan** the insulin tad pole first
3. **Choose** the top order which is the standard dose of 5 units
4. **Chart** the amount of insulin as 5 units
5. **Click** the site drop down and choose RARM
6. **Scan** the manufacturer bar code on the insulin bottle.
7. **Choose** the lower order for the sliding scale
8. **Chart** the amount of insulin needed for a blood glucose of 285 mg/dL
9. **Click** the site drop down and choose RARM
10. **Scan** the patient’s arm band
11. **Demonstrate** how to co-sign using the best practice method from the save and confirm screen
12. **Demonstrate** co-signing the administration of one of the students.
13. **Save and Confirm**

|  |  |
| --- | --- |
|  | *High Alert medications require cosigning.* |

1. **Explain** that not all Matched Medications are high alert, for example pain medications.

**Hit or Myth-slides #23-38**

|  |  |
| --- | --- |
|  | Medication Administration  Activity: Hit or Myth  Time:  Materials and prep: Coin, flip chart or white board  Display Knowledge Check slides on PowerPoint companion.  Divide the class into two teams on opposite sides of room.  One trainer asks questions while another keeps score using flip chart or white board.  Toss a coin to see which team goes first. The team that goes first gets one chance to identify whether the statement on the slide is a hit (correct) or a myth (incorrect).  Each correct answer is worth 5 points. If a team gets an answer incorrect the other team gets the next question.  Answers must be “Hit” or “Myth”.  In the event of a tie use the tie breaker question.  Each correct answer earns 5 point. The team earning the most points wins a prize. (Candy, etc.) |

|  |  |
| --- | --- |
| **Question #** | **Answer Key** |
|  | **Calling the pharmacy via telephone is the best method of communication about a medication**  Myth – Clicking “Send Rx a message” is the best method for communicating with the pharmacy. |
|  | **IV fluids are scanned into Admin Rx. Nurse will select “extra dose” and scan the patient armband. Then the nurse will choose “protocol.” This will chart the fluid and account for the missing schedule and is expected behavior.**  Hit |
|  | **Medications are confirmed in Care Organizer**  Hit |
|  | **Warnings from the system will only occur when no medication order is found.**  Myth – Warnings from the system will occur when an incorrect dose is selected, medication is administered too late or too early, or when no medication order is found. |
|  | **Multiple orders can be confirmed for the same patient in Care Organizer**  Hit |
|  | **The Five Rights are:**  **The right dose**  **The right medication**  **The right patient**  **The right route**  **The right unit**  Myth - The five Rights are: The right dose; The right medication; The right patient; The right route; The right time. |
|  | **To confirm medications you should be in Active View in Care Organizer.**  Tie Breaker – Hit – To confirm medications you do have to be in Active View in Care Organizer and will be confirming ALL doses. |

**eCDR Charting**

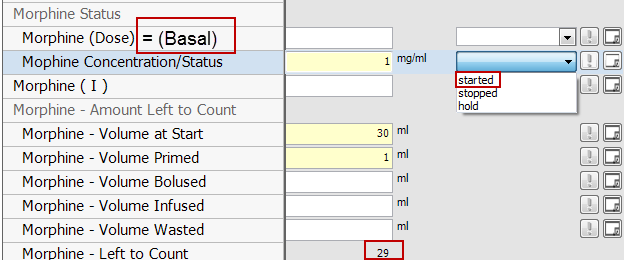
**Key Discussion points**

**eCDR is used to capture volume specific narcotic infusion information. OR and PACU staff who do not use HED so not chart in the eCDR.**

1. **Explain** that the process for charting Controlled drugs is now electronic.
2. **Scan** the PCA in the AdminRx tab like any other drug.
3. **Click** on eCDR tab.
4. **Demonstrate** steps to starting and infusion**.**
5. **Chart** 1 mg/ml in Concentration/Status
6. **Chart** 30 ml in Volume at Start
7. **Chart** 1 ml in Volume Primed
8. **Chart** 29ml Left to Count
9. **Demonstrate** co-sign (Co-sign **required** for start, new vial/bag, rate changes, and ending)
10. **Save and Confirm**

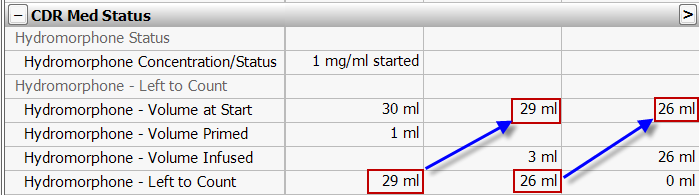
**Starting PCA**: Enter the Concentration and Status,

Volume at Start, and if needed, Primed amount. Left to Count will auto calculate.



**Charting every 4 hours**: Left to Count becomes the Volume at Start for the next charting session

1. **Discuss** charting every four hours includes left to count, volume infused, and new left to count. Does **NOT** require co-sign.



**Cosigning**:

Best Practice is to Cosign together using your RACF ID. VUNet ID can be used if necessary (as taught with Matched Medication)

**\*\*Remember\*\*  
At this time, release all students from VPH, NICU, NBN, and Labor and Delivery at this time. Remind them they will have an LMS to complete regarding HED charting basics.**

**Navigational Overview of HED**

|  |  |
| --- | --- |
|  | **Activate Prior Knowledge:**   * HED is a clinical system used for nursing documentation. * At Vanderbilt, we chart by exception. We do **not** chart normal values, duplicate information, or information not used to make clinical decisions. * The PLAN tab will be the first tab displayed followed by the Vitals I&O tab * All assessment documentation, regardless of patient location, will be charted in the ASSESSMENT tab. * The INTERVENTIONS tab is separate to make it easier to go directly to documenting care rendered. * The DEVICES tab will be used to document information re: devices – ICP, LVAD etc.. * The EDUCATION tab consolidates all education related documentation – including discharge readiness. * Are you the type of person that wants to see everything in one place, and doesn’t mind scrolling? Use the ALL DOC tab where most data from the other tabs will be displayed. * Every care category in the left menu bar of the ASSESSMENT tab must be addressed to complete an admission assessment. * ALL CAPS of items in the left menu bar designates required documentation for every shift and change in level of care. * Data required for approved population based decisions support (Braden PU scale, Glascow coma scale) or to meet current regulatory requirements must be addressed every shift. |

**Key Discussion Points**

1. **Explain** brieflythe top menu bar items and their function. Highlight the use of CHART. (Links will be addressed during the instructional portion of the lesson)
2. **Open** and close the patient census.
3. **Locate** allergy information.
4. **Explain** the function of the refresh button.
5. **Explain** the use of Monitored VS. Discuss users who will be going to units that use Philips cardiac monitors will be taught how to slave data to HED when they are with their preceptor.
6. **Locate** the patient demographics.
7. **View** all tabs by clicking on drop down arrow on far right of screen.
8. **Explain and demonstrate** the function of the down arrow located on the far right of tabs with drop down boxes and how to move up and down the drop down menu using the arrow keys on the keyboard.

#### Charting an Admission Assessment in HED

**Remind students we will be referring back to our case study from earlier to complete our charting in HED practices.**

**You are caring for a 54 year old patient with complaints of a deep and productive cough for 1 week with progressively worsening phlegm. He has run a fever for 2 days with a t-max of 102.0 F. He has managed at home with Tylenol and Robitussin. He does have a contracture of his left hand that is a result of a childhood injury. He comes from the ED with double lumen PICC which was placed in the ED. He has antibiotics running in the proximal port. He has nasal cannula running at 2L.**

***New information:* He has hypoactive bowel sounds and reports a-fib X 5 years without symptoms. He has a stage 1 pressure ulcer on his right buttock. He lives alone.**

|  |  |
| --- | --- |
|  | **Develop Conceptual Knowledge:**   * Vitals must be charted at least *once per shift* and requirements may vary between units. * To reduce repetitive charting of normal assessment details, chart WNL or WEL (within Expected Limits- formerly baseline ) for each care category. * Findings that are OEL (Outside Expected Limits) require supportive documentation (e.g. Tachycardia). This should be used for some recognized issue but not deemed a problem. This likely has no targeted interventions for the issue. This usually indicates something you will “continue to monitor.” * Identified Care Classification Category (Saba Model) problems require supportive documentation within the assessment section. * Typically you will ***not*** choose WNL, WEL, or OEL **and** a Saba Problem. The exception to that rule is the need to describe or identify some baseline known condition (ex. DM type 1) but the patient may be here for acute DKA. Communicating that the patient is a known diabetic and that he now has an acute exacerbation of that condition is important in telling the patient story. |

**Key Discussion Points**

1. From your colored card, look at the line YOUR PATIENT *FOR HED*. You can also refer to the page with the armband.
2. **Select** your patient in Care Organizer and clicking the HED button which opens the “PLAN” tab as a default.
3. **Click** “Show All” from left column to expand all of the available charting options of the vitals section of the patient chart.
4. **Click** “Show All” in the charting field to show all the components of the vital signs I/O fields.
5. If no charting fields are present, click the Chart button
6. Time can be adjusted back to time charted but not forward using the numbers on the keypad or the
7. **Move** across fields using the tab button
8. Change time to 30 minutes ago.
9. **Enter** the following information in the PAIN Assessment section:

* **Chart** pain of 6 on numeric scale
* **Document** pain location in Pain site (click other and annotate rib). There is a 240 character limit.
* **Click** sharp and stabbing for Pain description
* **Chart** Pain goal is 3

1. We will come back to Reassessment and discuss further in just a few minutes.
2. **Click** Neurological in the care category list (Show All if collapsed)
3. **Hover** over NEUROLOGICAL Assessment to display the normal values.
4. This neuro assessment will be the place to document the status and identify if there is a problem. Note the drop down box choices…
5. ASK What do WEL & OEL mean? Look at your Job Aide
   1. PROBLEMS: Abnormal finding rise to the level of being actual problems if:
      1. It is a problem for the patient/family
      2. The problem is one of the primary reasons the patient is hospitalized and will be a primary focus for care provided
      3. The problem will have targeted interventions to resolve
      4. The patient is at high risk to develop a serious complication
6. **Click** WNL as this patient has no issues with their neuro assessment.
7. **ASK:** Notice NEURO Assessment is in all caps. What does that mean? (Response – must be documented on every shift)
8. **Click** CARDIAC assessment in the left bar.
9. **Hover** over CARDIAC Assessment to display the normal values.
10. **Click** WEL since the cardiac issue is described as baseline for the patient. Annotate “A-fib X 5 years without symptoms per patient report”
11. **Click** Vascular/perfusion assessment and denote it as WNL.
12. **ASK:** “This care category is not in all caps. What does that mean?”(Response- must be documented upon admission and if abnormal must be charted every shift or as condition changes – but if WNL/WEL doesn’t need to be charted every shift.
13. **Click** RESPIRATORY Assessment from left bar.
14. **Click** Gas exchange alteration
15. **Document** 
    1. Wheezes present in BLL (what will we chart for upper lobes-correct, nothing!)
    2. Cough-productive
    3. Secretions- thick, yellow
16. **Click** GASTROINTESTINAL Assessment from left bar.
17. **Click** OEL, why? Because, remember he has hypoactive bowel sounds. However, this is NOT his baseline nor has it risen to the level of a problem with targeted interventions.
18. **Click** hypoactive in bowel sounds field.
19. **Click** RENAL Assessment from left bar. **Click** WNL
20. **Reproductive assessment should only be completed on patients with Gyn or GU issues.**
21. **Click** SKIN Assessment from the left bar. Choose Pressure Ulcer as the problem.
22. **Click** Start new Incision/Wound site and add details for the patient’s stage 1 right buttock pressure ulcer. No dressing is present, patient was unaware of breakdown. No drainage is present, size is 1cmX1cm.
23. **Demonstrate** using Links, from the top menu bar, to find skin/wound resources.
24. Lines category is used to capture data regarding the type of vascular access the patient might have. A box, similar to the one used to capture the patients pressure ulcer, will have fields to chart the patient’s IV.
25. **Click** Activity/Musculoskeletal Assessment
26. **Click** WEL and annotate left hand contracture from childhood injury.
27. **Chart** WNL for the remaining categories(Medication, Self-Care, Infection/Metabolic, and Psychosocial).
28. Note tabs with unsaved information have a **yellow** check mark on the tab.**Explain** that each HED tab charted on must be saved individually.
29. **Click** SAVE.
30. **Note** you have been directed to a confirm screen. From this screen you will choose Priority Problems and denote them as a way of personalizing the patient’s plan of care. Look down the list and note those categories where a problem was identified.
31. A priority problem is denoted by clicking on the exclamation point at the end of the data field. You will see the data turns **red** and is now considered a PP. Make Pain, Respiratory and Skin PPs for this admission assessment.
32. **Click** “Save and Confirm” **Explain and Demonstrate** how to modify entered information after “Save and Confirm”.

**Beginning and Discontinuing a Line in HED**

|  |  |
| --- | --- |
|  | **Develop Conceptual Knowledge:**   * Beginning a new line can be charted at the same time that the physical assessment is completed * **Location:** discuss importance of capturing of this information with regards to reimbursement for line infections that occur on lines placed outside of Vanderbilt vs those placed at Vanderbilt |

**Key Discussion Points**

1. **Chart** a new line in “Lines” using the following information :

##### Line type: PICC

##### Site: Cephalic

##### Side: Right

##### Number of Lumens: Double

##### Lumen Description: Proximal, Distal

##### Dressing: Chlorhex Drsg, Transparent

##### Secured with: Suture

##### Type “T” in date and time

##### Inserted by: Dr. Golightly

##### Response: c/o pain on insertion, site comfortable after procedure.

1. **Explain** that hovering over the magnifying glass icon will provide more information on the location and site of the line.
2. **Chart** an assessment of an existing line.
3. Maintaining, updating or discontinuing an existing line is accomplished by clicking the magnifying glass next to the line location. Typing the letter “T” in line removal will automatically enter the current date and time.
4. **Click** save then save and confirm
5. **Demonstrate** using magnifying glass to see details of existing line and click open box to show detail.
6. **End** an existing line using fields in lower portion of the box.
7. **Click** Save.
8. When line removal information is entered and saved the line shows \*Ended\* next to each piece of charted information.
9. **Explain** that fields will remain open to chart in for the purpose of charting on an infiltrated site, etc…
10. **Explain** fields will collapse when not charted in for 72 hours.

**Charting Short Term Goals**

* An interdisciplinary Plan of Care is started at admission and charted through discharge**.**
* It has several components including the nursing priority problems, and the associated short term goals.
* The RN identifies the problems through assessment and will identify 1-2, no more than 3 to focus on and denote as Priority Problems.
* Once Priority Problems are identified, a short term goal is chosen for that shift.

**KEY DISCUSSION POINTS**

1. **Click** the PLAN tab.
2. **Highlight** the assessment summary and how it is a starting point for choosing short term goals.
3. Short term goals must be specific, realistic, and measurable
4. **Click** pulmonary goals and choose “self-report ability to breathe comfortably” and “will exhibit improved lung sound”
5. **Click** pressure ulcer “will show no new skin breakdown/redness”
6. **Click** “Save” and “Save and Confirm.”

##### Charting Interventions

**KEY DISCUSSION POINTS**

1. **Click** the INTERVENTIONS tab
2. **Scroll** to the respiratory interventions
3. **Click** DB&C and Incentive Spirometry
4. **Scroll** to Skin interventions
5. **Look** forPressure ulcer care/interventions
6. **Click** stage 1 pressure ulcer
7. **Review** how to access Skin resources for Vanderbilt standard of care for Pressure Ulcers in Links.
8. **Recommend** making time to investigate all of the intervention fields to find commonly charted interventions for your unit. Remember to take credit for the interventions you perform in patient care.

**Charting re-assessment**

* Reassessment, per policy should be charted at least once on acute care floors and at least twice in the ICUs.
* On acute care floors, the response to care/recommendations counts as the second reassessment. This is possible because in order to accurately communicate whether or not a patient’s goals were met, another assessment must be done, we are constantly reassessing our patients.
* On ICU units, the reassessment is charted a little differently. Today you will learn the basics. Please know you may go back to your floor and be taught a slightly different way as the unit guidelines dictate many of the nuances in reassessment charting.

**Key Discussion Points**

**Click** Assessment tab and click Re-assessment and show all.

* + - * 1. Nurse can clearly indicate which category is being reassessed with the done check box (i.e. just neuro and resp but not GI). Response to care will be the next thing taught in this class.
        2. Reassessment documentation, whether done and no change noted and/or change occurred, refers back to the last time that category was assessed. The last time may be the shift head-to-toe assessment or may refer to the last focused reassessment.
        3. Frequency of reassessment and elements of reassessment included are driven by: written unit guidelines, standards, or protocols, patient problems or risk for problems, and/or provider orders for frequent reassessment (i.e. neuro-vasc checks q 2 hours post-op ortho surgery).
        4. **Chart** done for respiratory and then go to resp and chart diminished in lower lobes. This communicates the patient condition has slightly worsened and the only thing reassessed at this time is the patient’s resp status.
        5. This can be used to record any or all categories.

##### Charting Response to Care/Recommendations

|  |  |
| --- | --- |
|  | **Develop Conceptual Knowledge:**   * The response to care field is a free text note to indicate how the patient responded to the care/interventions you provided throughout the shift. Remember to include details that tie together your goals, your interventions, and the patient’s improvement or deterioration of status. * This note should be written toward the end of your shift to evaluate the success of your interventions and goal attainment. |

**Key Discussion Points**

1. **Click** the PLAN tab.
2. **Review** the Problem List
3. **Click** chart and “Show All”.
4. Chart “lungs sounds improved bilaterally with DB& cough, pt reports less pain and less SOB, continue to wean O2, encourage IS q2hr while awake.
5. Click done for “Discharge plan of care reviewed.” Remind users must be charted q24hr or unit standard.

**SHOW slide #39**

**Charting Patient Education**

|  |  |
| --- | --- |
|  | **Develop Conceptual Knowledge:**   * Patients require education prior to discharge. * The functionality here is the same as charting in any part of HED. * Psych has its own patient education tab and it is located on the right drop down menu under “VPH Education.” * One important piece of information that is charted in HED is the care contact. * This information can be updated throughout the patient stay. * The care contact flows from HED to the OPC so that the most current information is always available. |

**Key Discussion Points**

1. **Click** the “Education Record” tab in HED.
2. **Chart** one care contact. Explain should be updated as care givers change throughout a patients stay. New names should be added. Do not change or eliminate names in the list as previous charting could reference these contacts.
3. The two categories in ALL CAPS: Discharge Plan of Care Reviewed and Discharge Readiness are required charting each shift.
4. **Click** “Show All” to find the “Pulmonary Education”.
5. **Chart** the following information:

* Pulmonary->pulmonary care education ->condition -> teachback/verbalize understanding->patient and care contact #1

**Charting Patient Discharge**

* The patient’s Discharge Letter (DL) will print from StarPanel.
* Avoid repeating information included in the patient’s DL as it is saved in the patient’s medical record.
* Capture information pertinent to who was included in the discharge teaching and what materials were reviewed.
* Also, capture the unresolved problems and what plans have been made to address them after discharge.

**Key discussion points**

From the EDUCATION tab, locate the Learner Engagement field. **Choose** “handout review, ”Teachback/ Verb understanding,” “patient,” and “care contact #1.”

* + - * 1. **Click** “following expected course” under Discharge readiness.
        2. Discharge problems needing follow-up **chart** “pressure ulcer care by home health” This field should include outpatient plans for any unresolved issues.
        3. Type “discharge letter” in the HANDOUTS field. Please resist the temptation to chart items you have gone over that are included in the d/c letter. The d/c letter is part of the medical record and therefore does not need to be repeated documentation.
        4. A response to care must be written to summarize the patient’s discharge condition and response to your interventions for the shift.

#### 

# **Knowledge Check**

**SHOW slide #40**

|  |  |
| --- | --- |
|  | Comprehensive  Activity: Jeopardy Game  Time: 30 minutes  Jeopardy Setup Instructions  *Do not delete any items in PowerPoint. Before you edit the PowerPoint content read the directions and warnings contained within the PowerPoint game.*  Designate a facilitator who will be responsible for introducing the game, reading the categories at the start of the round. The facilitator is final authority on the correctness of the answer given.  Designate a game operator who is responsible for running the PowerPoint game.  Provide card or paper and pencil to each team captain (for “Final Challenge” answer only.)    Divide the class into two teams instructing them to select a team captain and choose a team name. The captain will be that team’s spokesperson and will answer the questions for each team (alternatively you can call on individual students within each team to answer questions).  At launch you will click “Start” button at bottom left of screen. Select team order from dropdown menu (First team is chosen randomly).  Select timer duration from the dropdown menu (60 Seconds).  Click “Submit.”  Click “START”  Popup “How many teams will be playing?” Enter 2.  Popup “Name of team 1.” Enter “*team name*”  Click “OK”  Popup “Name of team 2.” Enter “*team name*”  Click “OK”  Popup displays which team starts.  Click “OK”  Game Play Directions  The starting team selects the category and point value. (Timer starts when point value is clicked)  Beginning team confers with team members and decides on an answer. When the team captain provides the answer the Game Operator clicks continue. (Game Operator clicks correct or incorrect).  If a team gets the question right they score the number of points allotted for that question.  If a team gets the question wrong the point value is deducted from their score.    Game continues alternating between teams until all questions have been answered.  Teams with positive scores compete in the "Final Challenge".    When “Final Challenge” is clicked the popup box asks for each team’s wager.  Teams can wager any or all of their points. Teams have one minute to confer and decide on an answer. Each team writes their answer on a piece of paper and gives it to the facilitator.  Game Operator clicks “Yes” or “No” when popup asks if each team got the answer correct.  Computer adjusts scores based on wagers and winning team is posted. Ties are possible.  Congratulate Winners! Game Over. |

# **Survey and Assessment**

|  |  |
| --- | --- |
|  | Review any outstanding items; ask if there are any questions.  Guide learners to the Clinical Systems Evaluation found on the System Support web site. Allow time for thoughtful completion.  Thank learners for their time and attendance.  Dismiss Class! |

**Duties after Class**

1. Discontinue orders on all training patients
   1. Log on with Traiako ID to discontinue orders in Wiz Train.
   2. Click on a training patient name
   3. Click on Enter Orders
   4. Click on the D/C orders button
   5. Select Discontinue Orders
   6. Select All, then Discontinue
   7. Click done and follow prompts.

Repeat this process for all training patients

1. Put class roster in Program Coordinator office mailbox and she will update Amanita promptly;

*Instructions for Amanita incase Program Coordinator is out*

*In SSS On Call Manual*

*Systems Access*

[*Amanita Sign-On*](http://avalon.mc.vanderbilt.edu/proxy/local-jboss/amanita/amanita.html)

* 1. *Try to locate each student*
  2. *Remove the training flag if checked*
  3. *In comment, type RN NEO and the date of the class*
  4. *Click Update the profile*
  5. *Repeat this process for each student attending class*
  6. *If you have a no show, be sure to put the training flag on their account.*