Inpatient Nurse Guided Practice

Introduction to Hyperspace

1. Log in using the **User ID** and **Password** from your login sheet and click **Log In**.

2. Read the **Message of the Day** and click **OK** and click **Remind Me Later**.

3. Select a the **12H** shift and fill in your **Role – RN**.
   - You can change the start time if needed.

4. Click in the **Role** field and type "**reg**".

5. Single click on **Registered Nurse**.
   - This will auto populate once it is selected the first time.

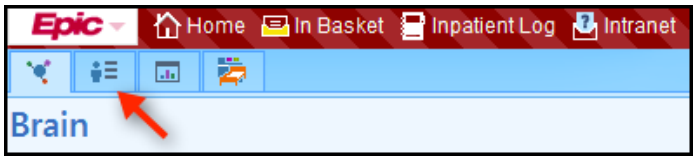
6. In the **Add department** field type "**IMC"** and press **Enter**.
   - The MED/SURG INTERMED CARE department displays.

7. Click on the **Patient column header** to sort the patients alphabetically.
   - Place a **checkmark** next to the "**Sam"** patient on your log in sheet.

8. Place a checkmark next the "**Neal**" patient on your log in sheet.
   - You should see the (2 patients) on the **Sign In** button.

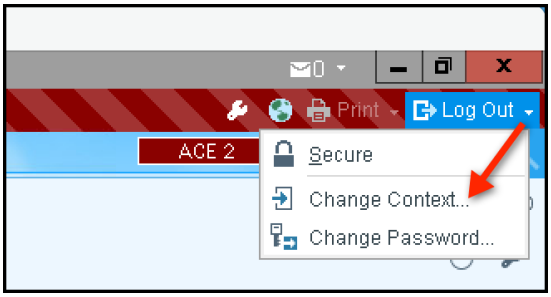
9. Click **Sign In**.

10. Open the **Patient Lists** activity.



11. Click the **arrow** next to the **Log Out** in the upper right.

12. Click **Change Context** and type "**med surg care**" in the search field.



13. Double-click on **MED/SURG INTERMED CARE** department.
    - Your title bar should now show the new department.
    - Remember you will not use the Log Out button but will use the ctrl + ~ to log out.

14. Locate the **Hyperspace Toolbar.**
    - Contains **quick buttons** for you to quickly jump to commonly used features.
    - Buttons are set up for you based on your role or specialty.

15. Click on the **Epic** button to see the menu.
    - Additional submenus are also available.

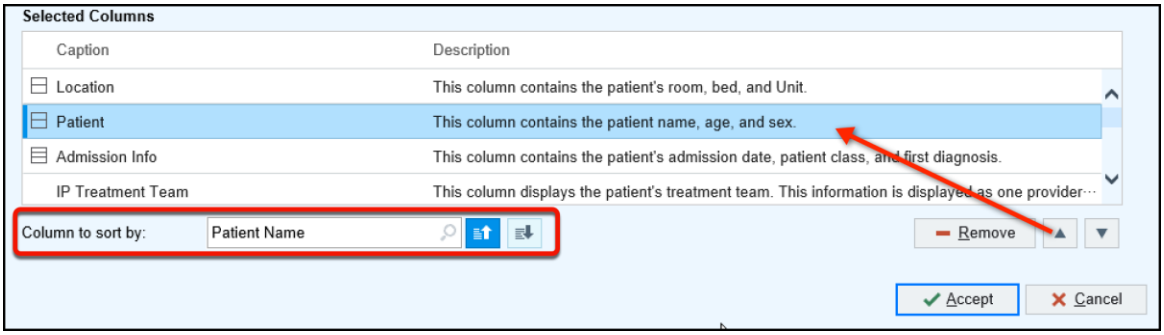
16. Hover over the **Reg/ADT** menu item to see other options.

Edit My Lists

1. Right click on the **ASP Nursing** folder in your **My List** section and select **Properties.**

2. In the **Name field** type the name you wish to give your list (i.e., Your Name).

3. Click on the **Patient** column and click the **up arrow** and type "**patient"** in the **Column to sort by** field and press **enter**. **This prompts you to select Patient name or Patient age/DOB**



4. Click **Accept.**

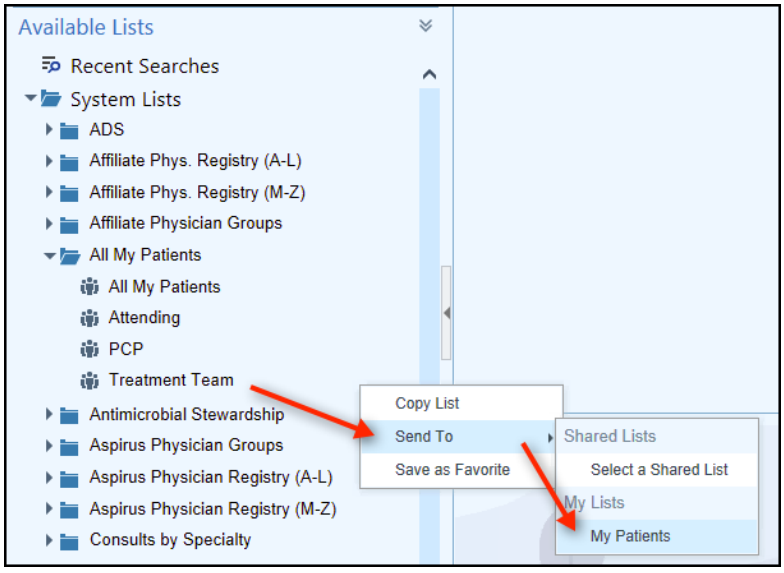
Adding the Treatment Team to My Lists

To see the patients you are assigned to, we'll add the **Treatment Team** system list folder to your personal **My Lists**. Remember, setting up your Patient Lists is a one-time setup. Your Treatment Team folder will remain under your **My Lists** folder for future use.

1. In the **Available Lists** section, click to open the **System Lists** folder.
    - Tip: drag the top of the Available Lists to see more of the list.

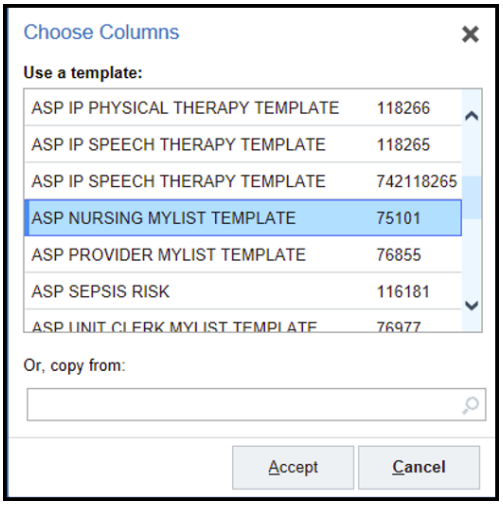
2. Click to open the **All My Patients** folder.

3. Right click on **Treatment Team** and **Send To** your list (the list you just created).
    - The 2 patients that you assigned yourself to when you Signed In now display in your My List.



Create Department List

1. Click the **Edit List** button above My Lists and select **Create My List.**
2. In the **Name field** type the name of you wish to give your list (i.e., IMC List or My Unit).
3. Click the **Copy button** and double-click on the **ASP NURSING MYLIST TEMPLATE (75101)**.
4. Move the **Patient** column to the top and sort on **Patient Name** (just like we did for your personal list.)
5. Click **Accept**.



Add Department to Department List

1. Collapse system list and open the **Wausau Hospital** folder.
2. Click to open the **All Nursing Units - WH** folder.
3. Right click on **Med/Surg Intermed Care** and **Send To** the department list that you just created.

Patient Lists Reports

The bottom half of the Patient Lists contains reports. These reports contain patient information that can be seen when single clicking on a patient. **Patient Lists Reports** are used to gather information on your patients without having to go into each individual chart (time saver).

1. Single click on your **Sam** patient.

2. Scroll through the **Required Doc** report.
   - **Let's** you know what **REQUIRED** information is due, overdue, upcoming or has already been completed. Use this report as your guide to keep you on task!
     - Green check = Completed
     - Red clock = Overdue

3. Open the **Overview Report** and scroll through.

4. Click the **Magnifying Glass** in search field on your Report Bar and select the **Due Meds** report.
   - The Due Meds Orders report displays but is not a quick button.

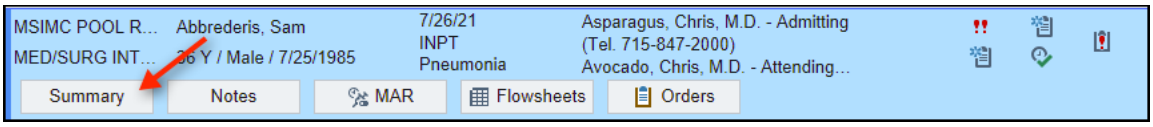
5. Click the **Wrench** next to the search field and select **Add or remove buttons from toolbar.**

6. In the **Add or Remove Buttons from Toolbar** window, click **Add Current.**
   - To **reposition report buttons** on your toolbar, use the **up/down arrows.**

7. Click **Accept**.

Reviewing the Chart

1. Return to **Patient Lists** activity and click the **Summary** button in Sam's row.



2. Click **Dismiss** for the **Admit Order BPA** and click **Let's Go.**

Storyboard

The Storyboard tells the story of the patient. **Who am I, what do you need to know about me, and why am I here**! The patient's picture or initials appears in the upper corner. **Patient's preferred name appears in bold. Hover to Discover** on the words or icons to see more detailed information.

1. Hover over the **Attending** section.
   - More information displays about the patient's treatment team including your name.

2. Hover over **Pneumonia**. (Sam's principal problem.)

Acknowledging Orders

When the provider places new orders for the patient, you as a nurse will need to Acknowledge those orders. **Acknowledging Orders means that you have seen the new orders, they are appropriate for the patient, and you will take responsibility for carrying them out.** It does not mean that they are given, or complete, just that you will carry them out the best you can.

1. Click on **Acknowledge Orders** in the **Storyboard** to open the window.
   - You can Acknowledge Orders by sections, individually or all at once.

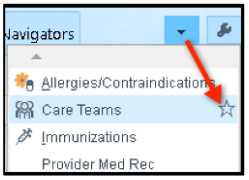
2. Click the **Acknowledge All** link.

3. Click the **X** in the upper right corner of your window to close.

Activity Tabs

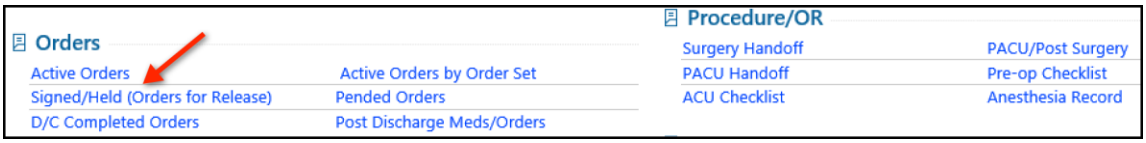
1. Confirm that you are looking at the **Overview Report** in the **Summary activity.**
   - This report is divided into sections. It's very easy on the eye! Links are inserted for easy access to specific reports. Notice that the Orders to be **Acknowledged is blank .** (You may have to refresh your page). This is because you acknowledged the patient's new orders from the Storyboard, but you are also able to acknowledge orders from the Summary Activity.

2. Click the arrow in the upper right and make the **Care Teams** a favorite by clicking the star icon.
   - You should now see it appear next to your Navigators activity



3. Open the **Index Clinician** report**.**
   - This report is divided into sections containing links for easy access to reports or patient information such as **Vitals, Active Orders, Medications etc**.

4. In the **Orders** section, click to open the **Signed/Held (Orders for Release).**
   - This report will show any orders that the provider has signed and held to be released when you assume care of the patient.



5. Open the **Orders** activity and click **Dismiss** for the **PTA Med Section BPA**.

6. Click on the **Signed & Held** orders tab.

7. Click on the **Click Here to Release Signed and Held Orders** hyperlink.

8. Check the **AWH Pneumonia – Adult** box.

9. Scroll to the bottom of the list and click **Release**.

10. Click **Continue** if the Potential Duplicate Orders Found message.

    - This is a training environment error and will not occur live.

11. Close the window.

12. Return to your **Overview** report in the **Summary** Activity.
    - Acknowledge these new orders by clicking **Acknowledge All.**

13. Open the **Chart Review** activity.
    - The **Chart Review** Activity contains **current and historical information**. Any time a patient has contact with the Aspirus Hospitals or Clinics an encounter is created. These encounters are divided into the appropriate tabs across the top of the activity.

    - The **Encounters Tab c**ontains all encounters including Office Visits, ER visits, Phone Calls etc.

14. Single-click on the **Admission** encounter to see the details on the right side of your screen.
    - The report includes hyperlinks that will take you to different places in the chart.

15. Use the tabs across the top of the activity as filters to filter the information that you would like to see.
    - Lab Tab (past, active and future labs)
    - Imaging Tab (past and current imaging reports)
    - Notes/Trans (past and current notes)
    - Media Tab (contains items that have been scanned into the chart including wound photos)

Documenting in Flowsheets

1. Open your **Sam** patient's chart to the **Flowsheets** activity.

2. Click **Add Col** to add a column for the current time.

3. In the **Vitals** group, click in the **Temp** cell and enter **"101.4"**.

4. Right-click on the temp cell and select **Significant Data**.
    - The data turns red, and it's highlighted in yellow.

5. Press **Enter** to move to the next field.

6. In the **Temp Source**, left click on **Oral**.
    - Because this is a single-select field, the cursor automatically moves to the next cell.

7. Press **Enter** to move to the Pulse field and type "**72**" and press **Enter** again.

8. In the **Heart Rate Source**, left click on **Monitor** and **Right**.
   - Since this is a multi-select field, you can "*left to pick, right to stick*" to document your selections and move to the next field.

9. Right-click anywhere in the box to move to the next field.

10. Enter "**18**" in the **Resp** cell and press **Enter**.

11. In the **Blood Pressure** field enter "**110/76**".
    - Hint: Use the space bar in place of the slash when entering the patient's BP.

12. In the **Mean Arterial Pressure** field type "**82"** and press **Enter.**

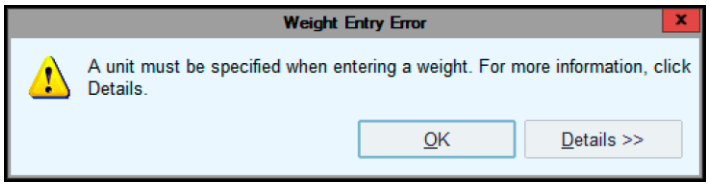
13. BP Location: **Right upper arm.**

14. BP Method: **Automatic**

15. Patient Position: **Sitting**

16. Press Enter and type "**98**" for the **Sp02**.

17. Click on the **Height and Weight** group in the table of contents.
    - When entering height and weight, you will need to specify the unit of measure.



18. Enter a **Height** of **"5'10"** and press **Enter.**

19. Left click on **Stated**.

20. In the **Weight** field enter "**175lbs"** and press **Enter.**

21. In the **Weight Method**, select **Standing Scale**.

22. Click **File** in the upper right in the toolbar.

Head to Toe Assessment (WDL)

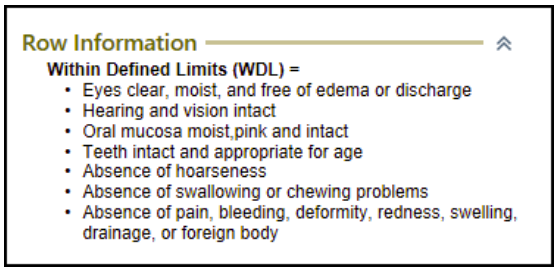
1. Open the **Head-to-Toe Flowsheet** and click the **Insert Column** button in the **Flowsheet** toolbar. **(EUPA)**

2. In the **Time** field, type "**h-1**" to document one hour in the past.
   - You can also use the clock to enter the time.

3. Click **Cancel** (if clock is open), then click **Accept**.

4. In the time column you just added, click in the **Neuro (WDL)** row.
   - The information for that cell displays in the **Details Report**.

5. Single-click on **WDL=Within Defined Limits**.



6. Click on the **HEENT** group in the flowsheet table of contents and click in the **HEENT (WDL)** cell.

7. In the **Details Report**, select **X=Exceptions to WDL** to additional rows to the flowsheet.

8. Click in the **Nose** row and left click on **Drainage/discharge, Mucus, Able to smell**.

9. Right-click anywhere to enter the selections in the flowsheet and click **File**.

LDA Avatar

1. Open the **LDA Avatar** from the activity toolbar.

2. Type "**piv**" in the **Add LDA** field and press **Enter**.

3. Left click your **mouse** on the right wrist.
   - An icon appears and the **Properties** window opens to the right.

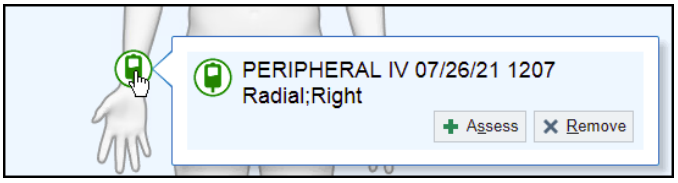
4. Fill in the following details for this IV. (Note: you don't have to complete all the fields.)
   - If you click on the incorrect button, click a second time to deselect.

Placement Date	T = today
Placement Time	N-30
IV Site Change Due	T + 4 (4 days from now)
Size	20 G
Catheter Length	1 inch
Insertion Attempts	1
Local Anesthesia	None

5. Click **Accept**.
   - The **Properties** details appear to the right of the Avatar.

6. Hover **over the right wrist.**
   - Notice that you can document an assessment or remove the LDA right from the Avatar.

7. Click **Assess**.



8. Click the selection button for **Site Assessment** and select (left click, right click) **Open to air, no redness, swelling or pain**.

9. For the **Line Status**, select **Saline Lock** and **Capped**.

10. For the **Dressing Status**, select **Gauze dressing** and click **Accept**.

11. Return to the **Flowsheets** activity and open the **LDAs** group from the table of contents.
    - The IV you just placed displays.

12. Click the blue hyperlink to document removal by clicking the **Edit** button.

13. For now, click **Cancel**.
    - You can also document removal in the Avatar.
    - LDA's will disappear from the Avatar when charted as removed.

Scenario: Let's assume it's hours later and Sam's PIV has infiltrated. First, you will add a line to the left forearm using your own selections. Once completed, you will follow the steps below to remove the infiltrated line.

Removing a Line

Before you remove a line, you want to be sure you assess the site.

1. Hover over the **Right, Wrist PIV** and select **Assess.**

2. Use your own selections for the **Site Assessment** based on your clinical knowledge and click Accept.

3. Hover over the **Right, Wrist PIV** and select **Remove.**

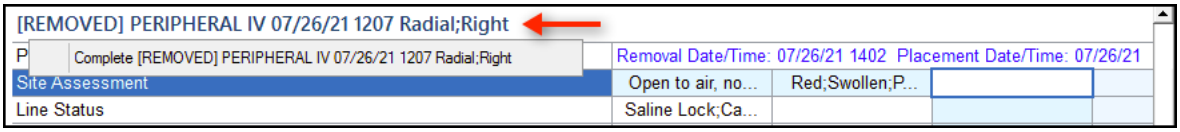
4. Removal Date = **Today (t)** and Removal Time = **Now (n)** and click **Accept**.

5. Return to the **Flowsheets** activity and open the **LDAs** group.

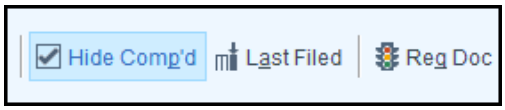
Hide Completed

Once a line, or documentation is completed you can "Hide" the completed group.

1. Right-click on the **[Removed] PERIPKHERAL IV** and **select Complete [Removed} PERIPHERAL IV.**
   - Note: Do not click on the blue hyperlink.



2. Locate the **Hide Completed** button in the toolbar.



3. Click the **Hide Comp'd** button and notice that your completed **Group is grayed out.** (May need to open the LDAS group again.)
   - This means that it is no longer active.
   - To **Reactivate** a group, right click in the **Group Header,** and **select Reactivate.**
   - Hiding completed groups is a good way to clean up your workspace making it easier to only see the groups that you are actively working with.

Document a Foley Catheter

Scenario: Let's assume the doctor has just placed an order for a Foley Catheter for our Sam patient. We placed the Foley but are now just getting time to document.

1. Open the **LDA Avatar** and type "**foley**" in the search field and press **Enter**.
2. Select the region on the body and document the **Placement Date** as today.
3. Document the time as **45 minutes** in the past. (n-45)
4. Scroll through the properties and document using your own clinical knowledge.
5. Click **Accept** when complete.
6. Return to the **Flowsheets** activity and open the **I/O** flowsheet.
7. Scroll to the bottom to locate the **Foley Catheter** you just documented.
8. Add a column and document an **Output** of **300** and click **File**.
9. Close **Sam's** chart by clicking on the X in the patient's name tab.

Medication Administration Record (Neal)

Scenario: Before we document medication administration for Neal, we need to update his PTA meds. Neal reports he has recently started taking Lasix. We will use the Admission navigator to update the med list. Later in this training, we will spend more time looking at and documenting patient care in this navigator.

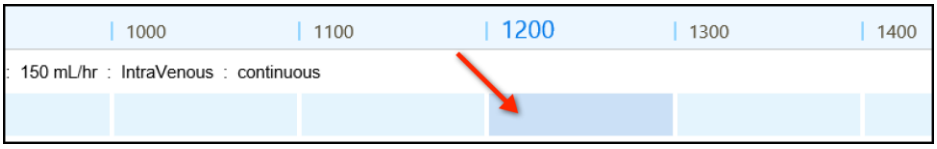
1. Open your **Neal** patient's chart to the **Navigators** activity, then open the **Admission** navigator.
2. Open the **Home Meds** section in the table of contents, type "**Lasix**" in the **New Prior to Admission Med** search field and press **Enter**.
3. Double-click on the **LASIX 20mg** tablet and document that he took it **Yesterday**.
4. Click **Accept**.
5. Open the **MAR** activity.
6. If the **Overdue Documentation** window displays, click **Close**.
7. Click on the **MAR** Note.
8. Type **"Patient likes meds crushed in applesauce"** and click **Accept.**
9. Open the **Legend**.
   - Use the Legend to understand the meaning of color codes and icons.
10. Close the **Legend** and click on the **background colors legend**.

11. Click anywhere on the **MAR** to close the legend.
12. Click the **Due** tab to view all meds with a Due Time.
13. Click the **PRN** tab to see meds without a due time.
14. Click on the **Scheduled** tab.
    - All these meds have due times, and some may be red meaning they are overdue.
15. Click on the **Continuous** tab and click the **Rx icon** for the **saline infusion**.
16. In the **Reason** field, select **New Bag of Continuous Infusion**.
17. Click **Send**.

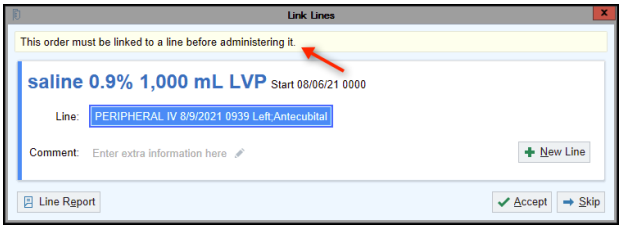
Administrating Medications

You will use **barcode scanners/Rovers** for medication administration; however, we **will override scanning** for the purpose of training.

1. Click on the **Due** tab and click the **0800 Due time** for the **COREG**.
2. In the **"Patient was not scanned"** window click the magnifying glass in the **Override Reason** field.
3. Select **Barcode Unreadable** and click **Override**.
4. Do the same for the medication alert.
5. Click **Continue Administration** for the **Medication not verified** alert.
6. Click in the **Time** field and type "**n**" for now and press **Enter**.
7. If the **Off Schedule Reason** field displays, click the selection button and select **Not given at scheduled time**.
8. Click **Accept**.
9. Click on the **Continuous** tab and click on the blue time block for the current hour. (*Do not click on the time.*)
   - The current time column has larger blue font.



10. Select an **Override Reason** and click **Override**.
    - **You** will only get a scanning alert for the medication because we overrode the patient barcode.
11. Click **Continue Administration** for **Medication not verified** alert.
    - When the pharmacist verifies the medication, this alert will not display.
12. Click on the **PERIPHERAL IV** line and click **Accept**.



13. Verify the details are correct, **Right Patient**, **Med**, **Date**, **Time**, **Dose** etc.

14. Click **Accept**.

15. Click on the **PRN** tab and document administering the **Tylenol**.
    - For training purposes, we will document that we administered the Tylenol 1 hour ago.

16. Select an **Override Reason** and click **Override** and click **Continue Administration**.

17. Type "**h-1**" in the time field and press **Enter**.

18. Scroll down to view the **Pain Assessment** and check the **0-10** pain scale box.

19. Document the patient's **Pain Score** and **Pain Location** on your own.

20. Scroll to the bottom of the screen to activate the **Accept** button.

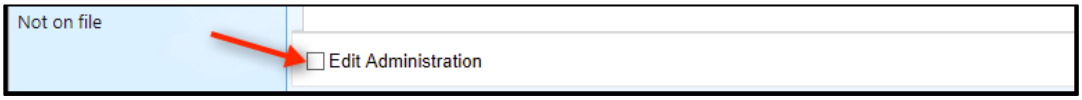
21. Click **Accept**.
    - An alert will display indicating that Pain Management has been applied to the patient's chart.

22. Click **OK**.

Editing an Administration

1. Click the **Given** action for the TYLENOL.

2. The details of the med will be grayed out, **checkmark the box** on the lower left to **Edit Administration.**



3. Click **Continue Administration.**
    - You can change any details previously documented.

4. For now, click **Cancel** and **Discard** and close the chart.

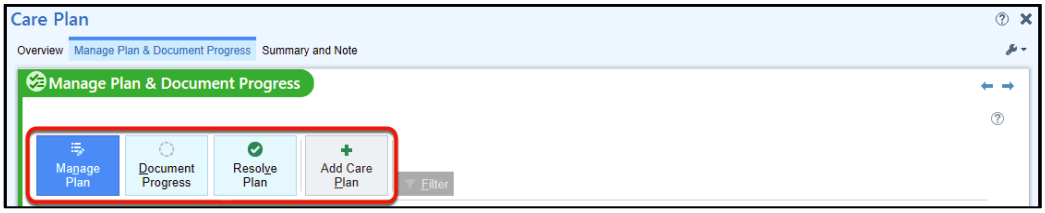
Care Plan (Sam)

1. Select your **Sam** patient and double-click to open the chart.

2. Open the **Care Plan** activity.

3. Open the **Manage Plan & Document Progress** tab. (Click Let's Get to Work.)
    - Use the **Document Progress** button to quickly document the outcome on goals or interventions.

- Use the **Resolve Plan** button to resolve Care Plans that are no longer needed.
- Use the **Add Care Plan** button to add a Care Plan Template.

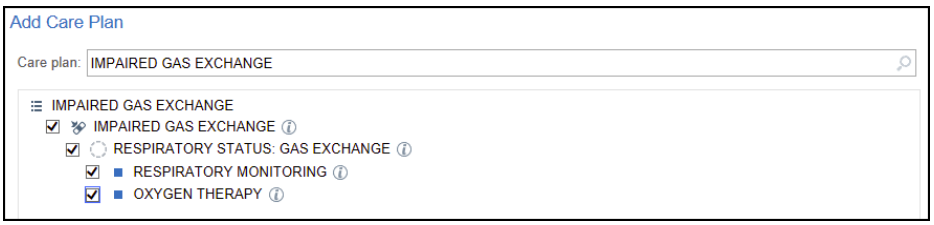


4. Click **Add Care Plan.**

5. Type **"gas ex"** in the **Care Plan** search field and press **Enter**.

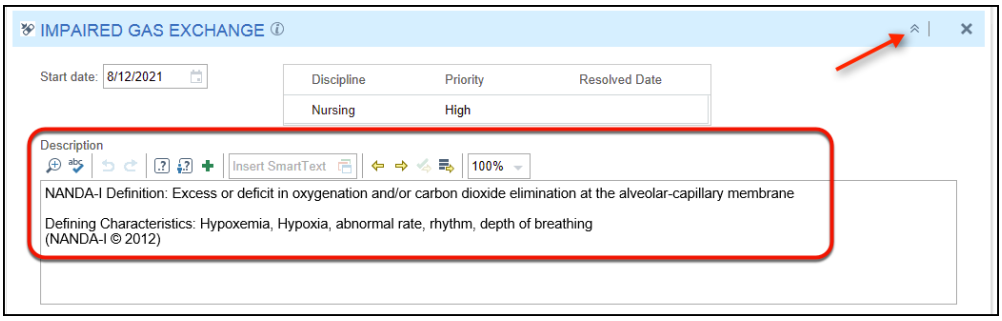
6. Single left-click on **IMPAIRED GAS EXCHANGE** and check all the boxes.

7. Care Plan **Problems**, **Goals** and **Interventions** appear in a **tree-like format, or table-of-contents** (TOC).
   - **Band-Aid:** Items are Problems
   - **Circular Icon:** Items are Goals
   - **Blue Square:** Items are Interventions
   - **(i) Icon**: Shows additional details about an item



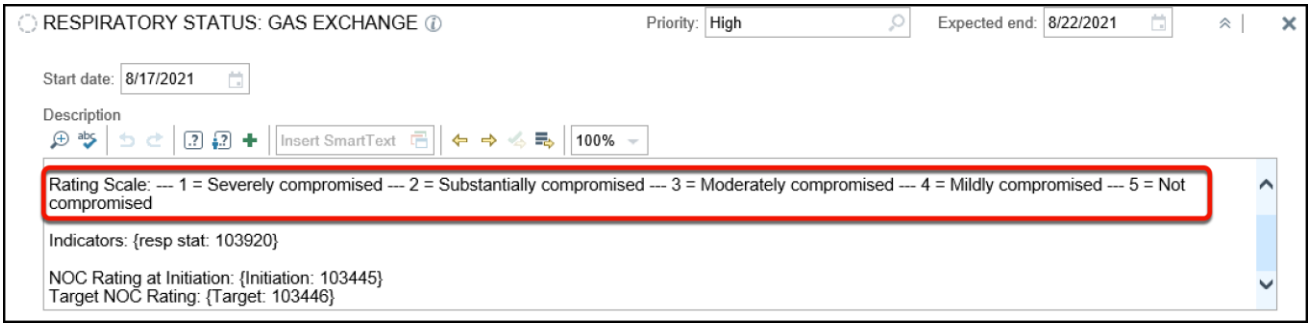
8. Click **Accept** and return to the **Manage Plan** tab.

9. Click the **"chevron"** arrows for **IMPARIED GAS EXCHANGE** to open the description.



10. Click the chevron a second time to collapse.

11. Click the chevron to open the details of the **Respiratory Status: Gas Exchange**.



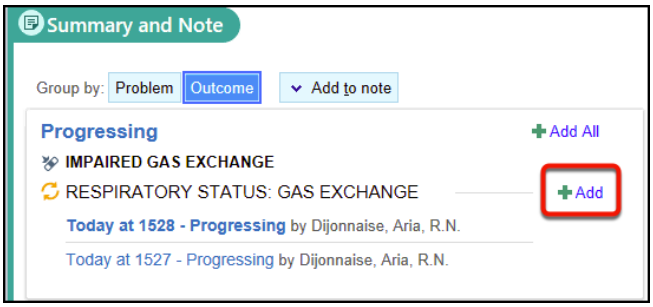
12. Click in the beginning of the **Description** box and press the **F2** key.
    - This moves your cursor to the first SmartTool.
    - The 3 asterisks *** indicate a wild card.
    - Wildcards must be addressed or deleted before documentation can be accepted.
13. Type "**.cpnew**" and press **Enter**.
    - We just used a SmartPhrase. SmartPhrases are always preceded by a dot.
14. Click the **F2 key** again.
15. Right-**click** in the blue box and click **OK** for the alert.
    - This should only happen in the training environment.
16. Click the **F2 key** again.
    - Now we see a SmartList with a yellow background. This indicates a single-select list.
17. To select a rating, "**Left click to pick and right click to stick**" on **3.**
18. Click **OK**.
19. Press the **F2** key again and select **5**, then click **OK**.
20. In the lower left of the screen, click **Mark as Reviewed**.
21. Click the blue **Next** button.

    - This field allows you to document any additional information regarding the Care Plan using the DAR. (Date – Actions – Response).

Let's assume some time has passed and Sam's breathing has improved. Return to the **Manage Plan & Document Progress** tab.

22. Click **Document Progress** and select **NOC Rating 4**.
23. Click **Next** on the bottom right of your screen to go to the **Summary and Note** tab.
24. Click **Add** to add your findings to the note.

- If you had more than one problem, you could click **Add All**.



25. In the body of the **Note Template,** you can free text relevant information, type **"Patient is doing well."**

26. Click **Sign**.

Education (Sam)

1. Open the **Education** activity.

A learning assessment needs to be completed on every patient you are educating. If there is more than one learner, you can add additional learners from the **Assessment** tab.

2. Click the **Create New** button.

3. Complete the **Learning Assessment** using the following details:

Primary Learner	Patient
Barriers Primary Learner	None
Language Primary Learner	English
Learning Assessment – Preferred Method of Learning	Reading, Demonstration
Previous Knowledge	No experience
Assessment Answered By (Relationship)	Patient

4. Click **File** in the lower right corner.

5. Click the **Education tab** and **Add Title** on the lower left of your screen.

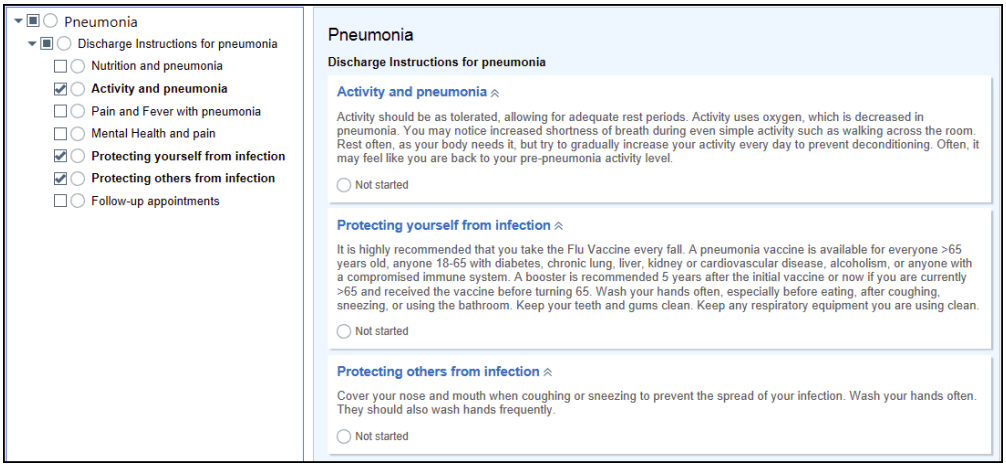
6. Type **"pneumonia"** in the search field and press **Enter**.

7. Select the **TITLE_ PNEUMONIA WH.**

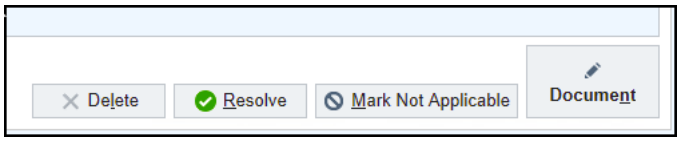
8. Select the topic **Discharge Instructions for pneumonia**
   - We'll keep all the teaching points.

9. Click **Accept.**

10. Click the **checkboxes** for **Activity and pneumonia, Protecting yourself from infection**, and **Protecting others from infection**.



11. Click **Document** in the lower right corner.

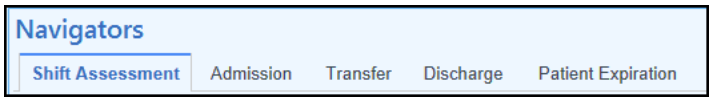


12. Fill in all required fields using your own selections.

13. Click **File.**

Admission (Sam)

1. Open the **Navigators** activity.



2. Open the **Admission** navigator.

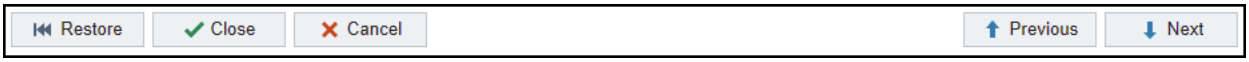
3. Open the **Release Orders** section.
   - Signed and Held orders are not active until they are released. (We have already released Sam's orders.)

4. Click **Close**.

LDAs/Vital Signs/Allergies

1. Open the **LDA Avatar** section in the table of contents.
   - This is the same section we accessed from the Flowsheets activity.

2. Click back on the **Navigator** activity and open the **Vital Signs** section.
   - The Vital Signs section within the Navigator opens to a Flowsheet.
   - This Flowsheet looks a little bit different than the Flowsheet Activity.
   - This is more like a **"point and click"** type Flowsheet.
   - Notice the current **Date and Time** automatically displays and the selections appear as buttons instead of a list like we saw in the Flowsheets activity.
   - Use the **Calendar** or **Clock** icons to enter a more **specific time** (i.e., N-30).
   - Check the **"Show Last Filed Value"** box to show last filed data
   - Use the **"paper"** icon to enter a comment
3. Locate the buttons at the bottom of the **Vitals** section.



Restore	Undo all changes in the section.
Close	Save and close the section.
Cancel	Undo all changes in this section and close.
Previous	Move to the previous section of the navigator.
Next	Move to the next section of the navigator.

4. Click **Close**.

5. Open the **Allergies** section.
   - The patient Allergies are displayed with the Severity and Reaction Type.
   - Use the **"Add a new agent"** search field to add a new allergy.

6. Click in the **Add a new agent** field, type **"strawberries"** and press **Enter.**

7. Click the magnifying glass in the **Reactions** field and double-click on **Itch**.

8. In the next row, type "**rash**" and press **Enter**.

9. Select a **Reaction** type of **Allergy**.

10. Document the **Severity** as **Low**.

11. Click the **Mark as Reviewed** button.

Reconcile Home Meds

1. Open the **Home Meds** section**.**
2. Click on the name of the pharmacy and deselect by clicking the yellow star.
3. Type "**cvs**" in the **Name** field and press **Enter**.
   - The system searches for pharmacies that are near the patient's and clinic zip codes.
4. Select the **CVS** pharmacy in **Wausau** and make it the preferred pharmacy by clicking the star.
5. Click **Accept**.

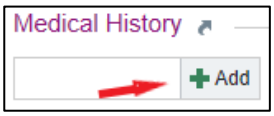
Scenario: Sam reports that he last took some of his meds this morning and he is no longer taking the Kenalog. He also reports a new med that needs to be added to the list.

6. We'll assume no one has updated Sam's PTA med list.
7. Click **Today** for Sam's **Albuterol** and **Zyrtec**.
8. Change the **Time** to **0800** for both meds.
9. Click **Not Taking** for the **Kenalog**.
10. Click the paper icon and write the following "**patient reports he no longer uses**" and click **Accept**.
    - Your comment is highlighted in yellow, and the med is flagged for removal for the provider.
11. Click in the **New Prior to Admission Med** field and type "**Tyle**".
12. Double-click on the **"ACETAMINOPHEN-CONDEINE *3 300-30 MG"**.
    - The order composer opens.
11. Change the **Frequency** to **q6h prn** and click **Accept**.
12. Click the **Past Week** button for the Tylenol.
13. Click the **Informants** button in the upper corner and click on **Patient**.
14. Click **Accept**.
15. In **the Med List Status** field, select **RN Complete** and click **Mark as Reviewed**.

History

1. Open the **History** section.
   - Most used history diseases appear as quick buttons.

2. Document a **Medical History** of **Asthma** and **Appendicitis**.
   - Hint: If there is no button for required history, click the **+ Add** button.



   - Type **"appendicitis"** in the search field and press **enter**.
   - Double click on appropriate problem.

3. Click **Accept**.

4. Document a **Surgical History** of Hernia Repair.

5. Click the **Paper Icon** to leave a comment.
   - In the **Date** field type **"y-10"** and press **enter**.
   - Click **Accept.**

6. In the **Tobacco section**, be sure to fill in the **Yellow Caution** fields as it is **required on admission**

Travel Screening

1. Open the **Travel Screening** section which is used for **COVID-19** tracking.

2. Click on the purple **Travel Screening** heading to open the questionnaire.

Scenario: Sam has not had any contact with another person with Covid, has not had a positive test, has no symptoms. He has not traveled outside the United States.

3. Click **Accept** when complete.

Belongings

1. Open the **Belongings** section, check the **Vision** box under **Patient Belongings at Bedside** and check **Glasses**.

2. Check **Jewelry** and check **ring**.
   - When documenting items add comments describing the items.

3. Click the paper icon and type "**gold-colored band**", then click **Accept**.

4. Check **Clothing** and select several items on your own.

5. Check **Electronic devices** and check **Cell phone**. Add your own comment describing the phone.

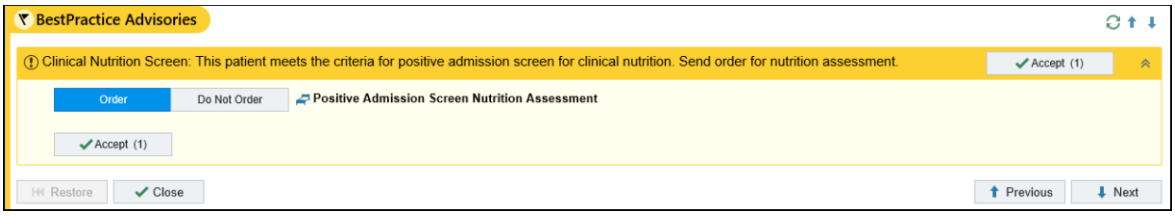
Screens

In the Screens section of your Navigator, if there are any Positive results, it will trigger a BPA for those screenings, which will auto generate a suggestion to place an order.

1. Open the **Nutrition** section.

2. Document **Yes** for the first 3 questions and **No** for the feeding tube question.

3. Open the **Best Practice** section that displays at the bottom of the **Screens** section.
   - The provider will see the BPA and act accordingly.



Assessments

In the **Assessments** section you can document specific assessments that can also be completed in the **Flowsheets** activity. Some of these assessments will also trigger BPAs that are specific to nursing.

1. Open the **Skin** section and document the following details for the **Braden Scale**.
   - Make sure everyone has the Show Row Info box checked before completing the documentation.

Sensory Perceptions	2=Very Limited
Moisture	1=Constantly moist
Activity	3=Walks occasionally
Mobility	2=Very limited
Nutrition	3=Adequate
Friction and Shear	2=Potential problem

2. Scroll down and click **Close**.
   - Your documentation triggers a BPA for nursing to add a skin integrity care plan.

3. Click **Accept**.

Transfer (Sam)

1. Open the **Transfer** navigator.

Scenario: We are still working with our Sam patient who was admitted for pneumonia. He is feeling better, and ready to be transferred to a Step-down unit.

2. Open the **LDA Avatar** section.
   - Decide if the patient's lines need to be removed, or if they will be ok for the new unit.

3. Use the **Back Arrow** next to the Activity Tabs to jump back to the Navigator.

4. Open the **Running Infusions** section.
   - Running infusions will appear in this section.

5. Open the **Due Meds** section.
   - Due Meds or Overdue meds will appear in this section as a reminder to administer if needed.

6. Open the **Belongings** section and make your own selections for **Patient Belongings at Bedside**.
   - Belongings are documented during Admission, Discharge and Transfer.
   - Some rows will be added based on your documentation.

7. Open the **Progress Notes** section.
   - Use this section to write any nursing notes as needed for the patient's transfer.

8. Click **Create Note.** Write a short note using your clinical knowledge that you would write to nurse who is receiving your patient from ICU to a step-down unit.
   - *Trainer Example: "Patient and family informed of transfer to new unit due to improved status. Patient is stable with no complaints of pain and minimal cough."*

9. Click **Sign**.

10. Open the **Signed/Held Orders** section.
    - This is another place where you can see if the patient has any signed and held orders.

11. Close **Sam's** chart.

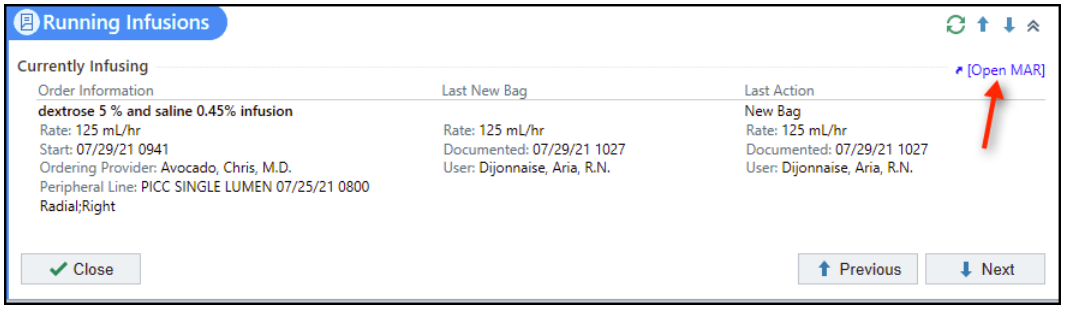
Discharge a Patient (Neal)

Scenario: Our Neal patient who was admitted for pneumonia is doing great and is ready to be discharged. Let's get started with his discharge process.

1. Open your **Neal** patient to the **Navigators** activity.

2. Open the **Discharge Navigator**.

3. Open the **Running Infusions** section.

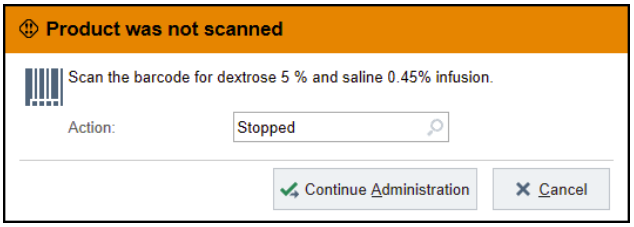


4. Click on the **Open MAR** hyperlink.

5. If you see an **Overdue Documentation** alert, click **Close**.

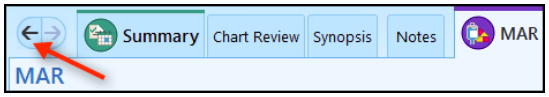
6. Click on the **Continuous** tab and click in the current time column.

7. In the **Patient was not scanned** window, change to **Action** to **Stopped**.



8. Click **Continue Administration** and click **Accept**.

9. Click the back arrow to return to the **Discharge Navigator**.



10. Open the **LDA Avatar** section.

11. Hover over the patient's **IV** and select **Remove**.

12. Enter a **Removal Date** of **today (t)** and a **Removal Time (n)**.

13. Click **Accept** and return to the navigator.

14. Open the **MAR Report** section.
    - Displays a medication report of due and overdue meds.

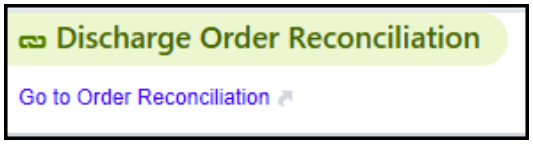
15. Open the **Med Rec Status** section.
    - Read only report of the patient's medications list, and meds needing review.
    - If the provider has reconciled the inpatient medications, the Discharge Orders Needing Review will be empty, and the Reviewed Discharge Orders will show the review.

16. Notice the **Lasix** displays under **Discharge Orders Needing Review**.

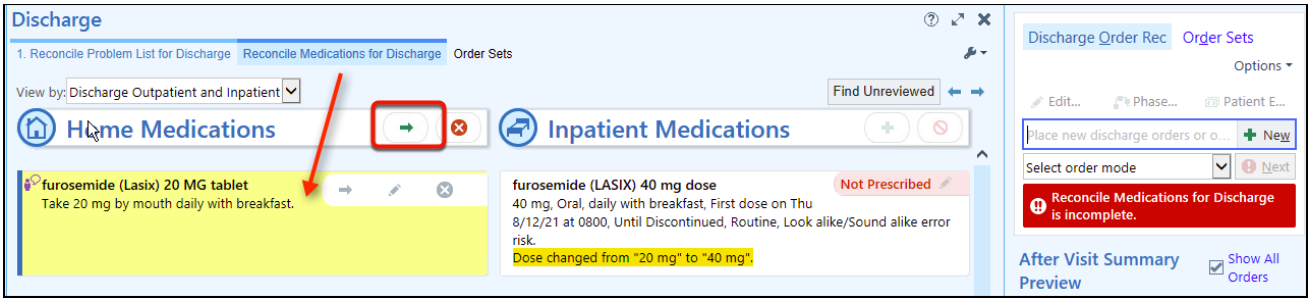
17. Click on the arrow in the upper right corner (next to the wrench) to open an additional activity.

18. Click on the star next to **Provider Med Rec** activity to make it a favorite.
    - You will now see **Order Reconciliation** appear in the activity toolbar.

19. Open the **Provider Med Rec** activity and click the **Go to Order Reconciliation** link under **Discharge Order Reconciliation**.



    - Orders that need to be reconciled will be highlighted in yellow.



20. Click the **green arrow** next to **Home Medications** to continue the medication.

21. In the **Select Order Mode** field, choose **Telephone with Readback**.

22. Type the name of the **Attending Provider** listed in the **Storyboard** and press Enter.

23. Click **Accept**, then click **Sign**.

24. Click the **X** in the upper right corner to return to the **Discharge Navigator**.

Belongings

1. Open the **Belongings** section and scroll to the **Medications Sent Home**.

2. Click **None to return**.

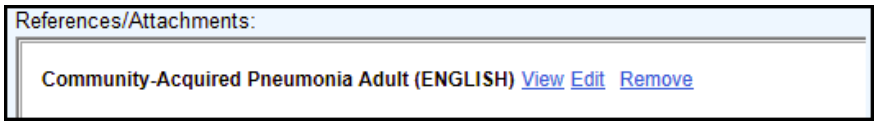
3. In the **All Belongings Accounted For** section, click **On Discharge**.

4. Click **Close**.

Discharge Instructions

1. Open the **Follow-Up** section under **Discharge Instructions**.
2. Click the **PCP** button.
3. How: **Call** > Why: **As needed if symptoms worsen.**
4. Open the **Expected Discharge** and click **Today** > **Afternoon**.
5. Open the **Pt D/C Instructions** section.
6. Click the **Go to Reference/Attachments** link in the upper right corner.

7. Place **a checkmark** in the box in front of **Community-Acquired Pneumonia Adult**. (2nd on list).
   - On the right side of your screen, you will see those instructions.
   - Use the **View**, **Edit** and **Remove** hyperlinks as needed.



   - The **Additional Search** tab allows you to look for other titles that are available.
8. Close the activity by clicking on the **X** in the upper right.
9. Open the **Education** section and place a check in the **Pain** and **Pain Rating** Scale.
   - If all the education points aren't taught, it's ok to not document on them.
10. Click **Resolve,** select **Education complete** for the **Reason** and click **Resolve.**
11. Click the back arrow to return to the navigator.
12. Open the **Resolve Care Plan** section.
    - If any Care Plan topics remain unresolved, you could complete the documentation here.
13. Click **Cancel** and open the **After Visit Summary** section.
    - Any items with a Red Stop Sign (hard stop) on the top of your page need to be addressed before the AVS can be printed.

14. Click the **Patient has unacknowledged orders** hyperlink.
15. Click **Acknowledge All** and return to the **AVS** (which is now an activity tab.)
16. Close **Neal's** chart.

This is the end of your guided practice.