Guided Practice: Inpatient Nurse – Triage Admit Navigator

Exercise

To Complete Guided Practice outside of class:

- **Use this information to log in to the Epic PLY environment.**
- **Refer to your Tent Card for the User ID and Password for Inpatient Nurse.**
- **Refer to your Tent Card for your Guided Practice Jasmine patient.**

Scenario: Your patient presents at the Birthing Center; she is 38 weeks gestation and is saying she thinks her water broke.

Note: Some Birthing Centers have Nurses and Unit Clerks that admit patients; this process will remain the same.

1) Find your patient from your tent card under the **Labor and Delivery** tab in the **L&D Grease Board.**
2) The Patient status is **Assessment**.
3) Notice the patient row color, what color is it? _____what does it mean? _____. Where do you find that information? _____. (Hint: Legend or the L&D Status column)
4) Double click on your **Jasmine patient** to go to her chart.

Triage-Admit Navigator – You will use this navigator for:

- **Triage**
- **NST**
- **Admit**

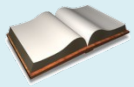
Starting at the top of the navigator and working your way down to the bottom will assure you have completed your documentation for all new admit patient.
For a Triage & NST patient(s) work your way down to the Assessment section.

1) Click on the **Navigators Button.**
2) The **Triage Admit** will open, this is your default navigator.

Before you begin the Guided Practice, **notice** the sections and what items are under each section.

Orders

1) Release Orders – Click on the blue hyperlink and **Release** any **Signed and Held Orders** you feel are appropriate.
2) BestPractice - Note: We will address the PTA BPA in the Home Med Section.



Overview

1) Arrival Info: Review this section. This information is entered by patient registration and flows over to the Navigator.
2) Travel Screen – This has been filled out. If it has not you will need to address all the travel questions.

3) Chief Complaint:
   a. **Enter Rule out spontaneous rupture of membranes** (492). Quick Tip! **A quick synonym you can enter is ROM**
   b. Click **Next**

5) Episodes – All pregnant patient needs to have an episode created. Current pregnancy Episode is linked.
   a. If you are seeing a patient for the first time and there is not an episode created. Double check to see that patient is register as OB not delivered.
   b. If a new Episode is not on the patient chart, a New Episode would need to be created by clicking on the New Episode button.

6) Dating: The patient's EDD was estimated from her _____?
7) Overview & Plan – Review with patient. This information flows over from the ambulatory visit.
8) Add'l Birth Plan Info – Review with patient. This information flows over from the ambulatory visit.
9) OB History: The patient tells you she had a SAB in 2 years ago.
   a. Click: + **Add Previous Pregnancy**
   b. Outcome Date: **y-2**
   c. GA: **14 weeks**
   c. Outcome: **Spontaneous AB**
   d. Living status: **Fetal Demise**
   e. Sex: **Unknown**
   f. Click: **Accept**
   g. **Mark as Reviewed**

   Notice the counts on the Pregnancy Line? What is it telling you? _____

10) Gender Identity/Sexuality – **Only fill out if you feel it is necessary.**
11) History -
   a. Medical History: The patient tells you she has Asthma and IBS. Fill this in on your own.
   You can Mark as Reviewed in each section or wait until the end.
   b. Surgical History – Add **Colonoscopy**
   c. Vaping – Fill this out on your own.

d. Social History – Fill this section on your own.

e. Functional Status – Only click yes for positive results.

f. Genetic Screen – Fill out on your own.

g. Mark as Reviewed.

12) OB Providers

a. Prenatal Provider: **Paul Kerns**

b. Delivering Provider: **Paul Kerns**

c. Baby's Primary Care Provider: **Rebecca Padilla**

d. Baby's Hospital Provider: **Rebecca Padilla**

Use **Add New Provider Button** to add a provider/specialty that is not listed above, if needed.

13) Result Console

a. Under Genetic/Other Screen: **Fetal Fibronectin, Negative,** Date**: w-6.** Patient reports that this was performed at a hospital in another state while she was on vacation.

14) Culture Results – GBS and All culture lab results can be found in this section,

15) Immunization Activity

a. Unit Clerk (or other appropriate staff), if applicable, will print the WIR (Wisconsin) or MICR (Michigan) immunization record.

b. **Mark as Reviewed,** if applicable.

c. Click the **back arrow** (above Navigator) to take you back to the Triage-Admit Navigator.

16) Immunization Questions

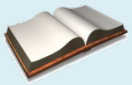
a. Has received the flu vaccine this season? Mark as you see fit.

17) Interpreter Services – Language the patient speaks and if there are any special needs.

a. This information comes from the patient upon registration.

18) Interpreter Needed – Answer on your own.

19) Directives - Advance Directives (For HealthCare) – Fill in on your own.



Medication

When a patient tells you she is taking a new medication, add the stated medication to the Medication list. Click **Mark as Reviewed** and the new medication will be added to the patient's medication list.

1) Review Home Meds – Fill in on your own. Mark as Reviewed when completed.

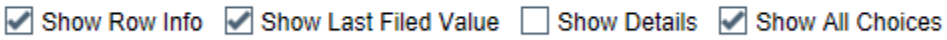
2) Allergies – Review the Allergies and add any additional ones on your own.

a. **FYI - If the patient has Malignant Hyperthermia, enter it in the Allergy section in Epic**.

b. Select **Review Complete – Mark as Reviewed**

Evaluation

1) Vital Signs
    a. Click Show Row Info, Show Last Filed Value and Show All Choices on the top of the Navigator.



    b. Fill out the entire vital signs section through the Pain Assessment.
    c. After you are done entering the patient information in the **Vital Signs** section go to **Flowsheets**.
        i. Open the **OB Vitals** (15004012).
        ii. Click on **Vitals** in the **Table of Contents**.
        iii. Is the charting you just entered there? _____
        iv. **Familiarize yourself with the OB Vitals Flowsheet**.
    d. Click the **back arrow** to take you back to the **Triage-Admit navigator**.
2) Labor Monitoring – Enter information on your own.
3) Cervical Exam – Enter information on your own.
4) NST - The NST section is for Outpatients NST's. Please review this section.
5) Whiteboard Notes - Items documented here flow to the Electronic Whiteboard.
    a. Status: **Laboring**
    b. Notes: **C/S- breech**
6) OB Provider Notified
    a. **Dr. Paul Kerns, MD**
    b. Complete the remaining portions of this section.
7) Critical Results
    a. Any Critical lab or EKG result that is called to you must be documented here.

Assessment

Your patient is in active labor and the baby is breech. Dr. Kerns indicates that the patient will be going to surgery for Cesarean Section.

Review each section as you are walking through this navigator.

1) Reminder: **Admit your Mother**.

Note: In some facilities the Unit Clerk will do this, for class, you will perform this step.

a. Go to the **L&D Grease Board**.
b. Click on your **patient name.**
c. **Right click, Admitted.**

2) **Pend the Baby in the Delivery Summary**. Refer to the **Delivery Summary Guided Practice**.
3) **Click navigator to return to the Triage –Admit Navigator and complete the OB Admission.**
4) **OB Admission – Fill in all these sections on your own.**
    a. **MSE Sign off- Wausau Only**
        i. Assessment/Fetal monitor Strip reviewer – Enter the name of the Medical Screen Examiner.
    b. Reviewed by - Leave blank unless you are working with a Student Nurse or SNI who needs their documentation reviewed.
    c. D/C Planning Screen - Fill this section out on your own.
5) Physical Assessment – Fill in this section on your own.
    a. Click on **Row Information** to see the **descriptions** to the **WDL**. Fill in this area on your own to familiarize yourself with this section of the navigator. Chart by exception, refer to the WDL definition for each system to know if you need to document on it.
    The corresponding **Flowsheet** is the **OB Physical Assessment** (15000127).
    b. You can add an LDA from this section of your navigator. Click on **+Add LDA** button at the top of the navigator. **Add a peripheral IV**.
6) Skin – All patients need to have Braden Scale documented every 8 hours or with a change in condition.
    a. **Fill this section out on your own**.
    b. **Braden Scale score will Auto calculate**
        Note: A Braden Scale score equal to or less than 18 (or any subset less than 3) will prompt you with a BPA to activate the Risk for Impaired Skin Integrity Care Plan.
    c. Address the Braden Scale Interventions that need to be addressed.
    d. Surgical/Procedural Skin Assessment: Only need to be address if the patient is gong to surgery. Fill this out for your C-section patient(s).
    e. Click Next.

Hester Davis Risk Assessment tool

Falls and Falls prevention is a Quality priority and strategic goal for the Aspirus system. Our falls rate and falls with injury rate is higher than national norms. Aspirus is committed to turning this around, having set a falls improvement quality goal for both this year and next. The organization worked hard to find an evidence based tool that would assist our clinicians with risk identification based on key interventions to help mitigate falls. Several years ago the AWH Research council studied a variety of tools and noted that the Hester Davis model was the most effective solution as a best practice falls risk toolkit.

While you work though this section, please make sure the row information button is turned on.
Think about a real C-Section patient while you are filling this section out.

7) Falls – Fill this section out on your own

1. What risk does this patient have? _____
2. Is the patient's age calculated into the score? _____
3. Will the risk automatically generate a Care Plan? _____

HD Fall Risk Interventions

Now, we need to chart what interventions we plan to take for your patient. We will first need to document interventions for her level of risk. In the Decrease Fall Risk – Low Risk section, let's look at our options.

For all patients:

- We will follow Universal Fall Precautions.
- We will also individualize the HD Falls Care Plan by editing his goals and documenting a note specific to his needs.
- Our patient will receive a FALL RISK ID band.
- We also always provide patient and family education in regard to how to eliminate falls for all of our patient's.
- Instruct patient/family to call when getting OOB.
- Place a fall precaution signage outside door.

b. HD Fall Risk Interventions – Chart on your own.

Your **Side Bar** will need to be open. If the Hester Davis report is not wrenched in, wrench it in now.

(1) Click on the **Wrench** in the **side bar report**.
(2) Click in the **last row** and type in **HD**.
(3) Move the **report up to the first row**. By clicking on the **up arrow**.
(4) Make this your **default report**.
(5) Click **Accept.**
(6) Click on the **Hester David report**.

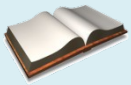
Keep you side bar open this will help you to complete the Care Plan.

8) Click on the **Care Plan Activity**
   a. You will see the Hester Davis Fall Risk interventions that auto applied to the patient care plan.
   b. **Low Fall Risk**
   c. **Fall Risk related to Prevention**
   d. We will address these later in the Guided Practice.
   e. Click the **back arrow** to take you back to the **Triage/Admit Navigator**.
9) Nutrition – Review and fill this section on your own.
10) DVT Risk Assessment Review and fill this section on your own.
11) Psychosocial Review – Review and fill this section on your own.
    These assessments are **mandatory** documentation sections for every patient.
12) Suicide Risk: Review and fill this section on your own.

We are required to complete the screening on all admitted patients. The screening will need to be repeated if the patient's condition changes. This will allow us to recognize and provide safe care for patients at risk for suicide by maintaining a safe environment and seeking appropriate resources. Notice, there are both adult and pediatric screenings. This Pediatric screening will be used for patients 12 and under. Infants are exempt.

Use this time to review what flowed from the Triage Admit Navigator to the Flowsheets.

- **Check the Antepartum Flowsheet. (15000028)**
- **Magnesium Flowsheet (15000059)**
- **Labor Flowsheet (15000000).**



The baby has been born by C-section. Complete the Delivery Summary. Admit your baby and name her using your usual admission workflow from the Delivery Summary.

Note: You will use this baby for the Newborn Admit Guided Practice.

This completes your **Triage-Admit Navigator** Guided Practice Session. This is not all inclusive of a typical workflow it only highlights specific portions of the Navigator**.**