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| Logo, company name  Description automatically generated  Epic ANESTHESIA  Anesthesia Department  Anesthesiologist / CRNA Guided Practice |

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**Introduction**

Educational opportunities

Classroom training is one piece of your Epic education. Other opportunities to learn more before go-live include:

* **E-learning:**
  + E-Learnings can be rewatched.
  + There are also recommended after class e-Learnings to reference.
* **Independent practice** - Schedule time for practice sessions after class
  + Access our **Epic Playground** environment and continue your self-exploration through guided exercises found in this workbook.

*At your workstation, you have a Training Tent Card with your login information that will be needed for today’s training.*

If you have questions at any time, please don’t hesitate to ask.

***Any preliminary questions before we get started?***

**Logging into epic**

From your Anesthesia Training Tent Card, enter the **User ID** that starts with **TRN** into the User ID box. Your password is L**ogins**; then click on the **Log In** button. The Message of the Day will display. Customarily, this will display upcoming system downtimes. Be aware of what is in the Message of the Day. Click **OK.**

**preop documentation**

REVIEW PATIENT INFORMATION

**PATIENT**:  **Annie**

 **SCENARIO**: Today we're working with Annie. Annie is a 20-year-old female having a hernia repair procedure. Her case is coming up next in your operating room. It is time for you to review her case and begin documentation.

**TRY IT OUT:**

1. The first activity I see is the **Status Board**.
2. Click the **Find** button on the Status Board activity toolbar
3. Search for Annie’s last name, first name in search field and press **Enter**.
4. **Double-click** to pen her chart for preprocedure documentation.
5. The PreProcedure workspace is divided into two sections.
   * The left side contains information primarily for review.
   * The right side contains items to take action on.
6. Review patient information
7. Use the section on the left to review procedure information, **Vitals**, **OB/GYN** status, **Problem List**, **Allergie**s, **Medications**, and **History**
8. Mark relevant sections **As reviewed**

pre procedure evaluation

 **SCENARIO**: We write Annie’s note.

**TRY IT OUT:**

1. Navigate to **Pre-Evaluation**
2. Click **Create Note**
3. Review and update the **Problem List**.
   * Click plus to document a problem, minus for pertinent negative.
   * Only document minus if indicating absence of a problem is clinically relevant.
4. Click **+** for **PONV**
5. Enter additional information for PONV in the New Problem window if needed
   * Note File to History button will save to patient’s permanent History
6. Click **Add to Hx**, then **Accept**
   * Anything documented in the problem list will automatically pull into your pre-evaluation. This includes the historical problems from patient’s problem list.
   * Since your PreOp note is built around the Problem List, make sure that anything you think is significant is included on the problem list and mark items as relevant (or not relevant) for inclusion
7. Select **Physical Exam** on the top of the note workspace
8. Select the **Normal** macro from the tool bar
9. Choose a Mallampati score
10. Use the annotated image editor to mark a chipped tooth
11. Select the **Anesthesia Plan**
12. Choose an **ASA Score**, **General Anesthesia** and that **Informed Consent** was discussed with the patient
13. Review and **Sign** note

ready for procedure

**TRY IT OUT:**

1. Open the Review and Sign section of your Preprocedure Navigator.
2. Use Mark as Reviewed if you are not the attending provider for the case but are helping with preprocedure and want to indicate from your perspective, the preprocedure documentation is complete.
3. Click Ready for Procedure

pre-op / Post op orders

 **SCENARIO**: We place Pre-op Orders for Annie

**TRY IT OUT:**

1. Go to **Orders** activity
2. Place anesthesia orders from order set – enter “AWH ANE” – choose **AWH Anesthesia IP Preoperative/Postoperative**
3. Select orders of your choice and address any Red Stop Signs
4. Remember the \*\*\* serves as a wildcard for you to free text, use F2 button

anesthesia start

 **SCENARIO**: We start our billing time for Annie.

**TRY IT OUT:**

1. Select **Anesthesia Start**

**POST PROCEDURE**

HANDOFF TO RECOVERY NURSE

**PATIENT**:  **Annie**

 **SCENARIO**: After giving report to the PACU nurse, we document our handoff.

**TRY IT OUT:**

1. Record the handoff to the PACU nurse
2. Click **Anesthesia Stop/Handoff**
3. Update handoff time if needed
   * Anesthesia stop ends the billing time.

post procedure evaluation

 **SCENARIO**: Annie is ready for sign out. We complete our post-op note.

**TRY IT OUT:**

1. Open the **Postprocedure Evaluation** section.
2. Write your Postprocedure evaluation
3. Apply the **Normal** macro
4. Use reports on left to update additional note details as needed
5. Review your note
   * The PACU vitals won't show during training but will in real life. For training only, you'll need to add vitals manually or delete the wildcards (\*\*\*) in the vitals section of the note. A note can't be signed if it still has wildcards in it.
6. Right-click and select **Refresh Smart Link** to pull in recent info if note was created before info was available.
7. **Sign** the note

review requirements

 **SCENARIO**: Before signing our encounter, we check for any missing items.

**TRY IT OUT:**

1. Go to **Postprocedur**e > **Requirements**
   * You will also see any outstanding requirements when you go to sign the record
2. Review outstanding required and recommended items
   * Recommended items in RED should be reviewed and addressed as needed before closing the encounter

sign the encounter

 **SCENARIO**: We sign our record to finalize it.

**TRY IT OUT:**

1. Click **Sign Record** to finalize it and indicate it is ready for billing
   * Remaining required and recommended items will appear here too, use link to update documentation if needed
2. Annie’s chart will close and you’ll return to the Status Board

**labor epidural**

find l&d patients

**PATIENT**:  **Peggy**

 **SCENARIO**: Peggy is in Labor and Delivery and is unsure if she wants an epidural. We perform a consult.

**TRY IT OUT:**

1. Go to the L&D Grease Board
2. Select your Peggy patient and open her chart for a consult
3. Click **Consult**

labor consults

 **SCENARIO**: We complete our Pre Procedure Evaluation.

**TRY IT OUT:**

1. Use sections to review vitals, OB/GYN status, problem list, allergies, medications, and history
2. Use the jump arrow on the top toolbar or scroll through the sections to review information
3. Click **Review** and select **Mark all as Reviewed**
4. Write the **Pre-Evaluation** note
5. Click **Create Note**
6. Select **Mark All Systems Normal** button in the Problem List
7. Click **OB/GYN** button
8. Document some choices
9. Document a **Physical Exam** > Use the **Normal** macro
10. Review the **Anesthesia Plan** > Select a Type of **Epidural** and **Informed Consent** with the patient
11. Accept your note

sign encounter

 **SCENARIO**: We sign our encounter.

**TRY IT OUT:**

1. **Sign** the record
   * Peggy’s chart should close
   * The Grease Board now displays a green mark that Peggy has had a Consult

epidural documentation

 **SCENARIO**: Some time has passed, and Peggy decided to proceed with the Epidural. We copy our consult note forward to save some time.

**TRY IT OUT:**

1. Find Peggy on the Grease Board and click the **Labor** button
2. Write your **Pre-Evaluation**
3. Select **Create Note**
   * Copy your consult note forward
4. Click the **Copy Forward** button on the Smart Tool bar
5. Highlight your previous note from the Copy Note pop up and click **Accept**
6. Add an **ASA Score** in **Anesthesia Plan**
7. Make any updates to the note of your choice
8. **Sign** the note

epidural orders

 **SCENARIO**: We place epidural orders for Peggy.

**TRY IT OUT:**

1. Open the **Orders** activity
   * Place orders from order set
2. Enter “AWH Labor”
3. Accept the **AWH Labor Epidural** order set
4. Fill out the Procedure Details order
5. Select the blue hyperlink
6. Place orders of your choice, including an epidural medication
7. **Sign** orders and close the **Orders** sidebar

begin the epidural

**TRY IT OUT:**

1. Open the **Labor** navigator
2. Mark the patient as **Ready for the Procedure**.
3. Click **Anesthesia Start**
4. Begin epidural procedure documentation
5. Macro automatically applies
6. Use a reminder to document **Staff**
7. Use **Add Me** to quickly add yourself to the case
8. Click in the grid your start time and Close

epidural note

**TRY IT OUT:**

1. Use **Block Note** reminder
2. Select the **Labor Epidural** macro
3. Enter a **Start Time** and yourself as **Staff**
4. Mark **Checklist** complete.
5. Document the Epidural Infusion
6. Document additional medications of your choice
7. **Sign** the note and close the workspace
8. Click on the **Epidural Meds** reminder
9. Exit Peggy’s chart

round on epidural patients

 **SCENARIO**: Some time has passed, and you go to check on Peggy

**TRY IT OUT:**

1. Select Peggy and double click on the L&D board
2. Choose the **Labor Analgesia** record and Accept
3. Go to **Labo**r tab
4. Document **Face Time** from the toolkit and choose a time from the grid and Close

INDEPENDENT EXERCISE: wrap up epdirual documentation

**TRY IT OUT:**

1. Select the **Postprocedure** navigator, using the **Go to** jump button
2. Click **Anesthesia Stop/Handoff**
3. Write **Postprocedure** note
4. Use the **Normal** macro
5. For training purposes remove the \*\*\* in the Vitals section on the note (press F2 and press Delete button) this is only in the training environment
6. **Sign** your note
7. Click **Sign Record**, the chart should close and you are taken to the L&D Grease Board

**epidural to c-section**

epidural to c-section

**PATIENT**:  **Patty**

 **SCENARIO**: Patty needs an emergent C-section.

**TRY IT OUT:**

1. Select Patty patient and click C-Section button
2. In the window that appears, the C-section procedure defaults, click Accept
   * Patty’s preprocedure note is completed, feel free to review it
3. Add the appropriate macro to queue up case documentation
4. Click Macro from toolkit
5. On the Public tab choose Epidural to C-section
6. Click Accept
7. Document yourself as the anesthesiologist for this case with
8. Update Staff reminder
9. Document the Epidural to C-Section event
10. The remaining Intra-Procedure documentation will remain on paper at Go Live.

**floor procedues**

find patients

**PATIENT**:  **Melissa**

 **SCENARIO**: Melissa is in respiratory failure. We are called to the floor to intubate.

**TRY IT OUT:**

1. Go to Patient Lists and search for your patient

record procedure information

 **SCENARIO**: After intubating Melissa, we complete our documentation.

**TRY IT OUT:**

1. Select Procedure on toolbar
2. Select Intubation.
3. Click Intubation/Airway Placed Event
4. Use the reminder to write an Airway note
5. Apply a macro for **Adult Emergent**
6. Record Location and Staff
7. Document medications in your note
8. Note any other selections you would like and add additional comments of your choice
9. Click the Text button to review your note
10. Sign the procedure note and Close the section.

wrap up

**TRY IT OUT:**

1. Use main report window to view a summary of the record.
2. Click **Sign Rec** in the toolkit on the left to close the record
3. Sign your documentation

**rounding**

add patients to shared list

**PATIENT**:  **Melissa**

 **SCENARIO**: You want to round on this patient later, add her to a shared list for you and your partners

**TRY IT OUT:**

1. Right click on Melissa
2. Select Send To
3. Click Select Shared Patient List
4. Enter “AWH” and choose “AWH Anesthesia Rounding & Consults”
5. The next time you need to round on Melissa you can finder on this Shared Patient List
6. On the left side of Patient Lists, click the drop-down arrow and choose AWH Anesthesia Rounding & Consults.
7. This is where you and your partners will find patients who are on the inpatient floor and need to be been rounded on

consults and rounding

 **SCENARIO**: Some time has passed, and you would like to round on Melissa

**TRY IT OUT:**

1. Find patient on Shared Patient Lists
2. Highlight her and select the Rounding button on the toolbar
   * This does not create Anesthesia record
3. Select the Rounding navigator
4. Write a Progress note
5. Select a template Ex. Adult Daily Progress Note
6. Complete the note
7. Fill out the Subjective, Objective and Assessment/Plan
8. If desired, you can also create a consult note in this navigator
9. Exit Melissa’s chart