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| Epic ASAPEMERGENCY DEPARTMENT EMT/TECHNICIAN 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. We will take a break at the 2-hour mark.

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

Signing In and Getting Up to Speed

In this exercise, you will explore the Track Board and ED Manager to review patient information. If you get stuck and the hints don't provide enough assistance, consult your Learning Home or ask your instructor.

PATIENT: VAL

Reviewing Information

SCENARIO: It is the start of your shift, and you are ready to get report and assume care of your patients. You will get up to speed on your patient, see what brought her to the emergency department, and find out what needs to be done for her care.

TRY IT OUT:

* Let’s get started by logging in. From the tent card in front of you use the TRN number as the user ID, and Logins as your password.
* Next, we are going to sign in and get up to speed on the patient’s you’ll care for.
* Click the sign in button to document the length of your shift and indicate to others you are present and ready to care for patient’s. You will only need to sign in/out once a shift. Enter this information here now.

When you first logged in you were taken to the ED Manager screen; this is your default workspace. This screen shows the areas in which a patient might be located within the ED. Patient names become color coded when they are admitted; this color coding indicates where the patient is in the process of receiving care. To determine what the colors mean, there is a **Legend** button at the top of the screen; click on this now. Take just a moment to review the colors when you are finished, you can **close** the window.

* Now let’s review the Track board. Select the tab for the track board located on the top left of your workspace.
* At the top we have different tabs for different views. You can use these tabs to filter patients by status.
* Each view has columns that show different information. The columns will show you information such as:
	+ Icons that represent patient updates and provide warnings when documentation is due, like vitals.
	+ Some populate red values indicating that a patient is due for a reassessment.
* Each column contains information that is pertinent to the column header, and each icon designates a different notification.
* Hover over a few icons to learn more about what it represents
* You can also filter a workspace by clicking on a column header.
	+ Do that now and click any column header.

**Arriving and Triaging a Patient**

In this exercise, you will arrive a new patient to the ED.

**PATIENT:** your **Henry**

SCENARIO:

**Henry**, a 54-year-old male, presents to the ED with chest pain radiating to his left arm. The Registration staff is busy, so you arrive **Henry**.

**TRY IT OUT:**

We are going to see how to arrive a new patient into the ED.

* Click **Arrival** on the **Track** **Board** or **ED** **Manager**.



* Enter your **Henry** patient’s last name and click **Find Patient**.
* Choose your **Henry** patient
* Click **Select**.
* Mark **Henry** as arrived, and the current time and date will auto-populate.

 

* Document his arrival information.
* His wife drove him to the emergency room.
* Chief complaint is Chest Pain.
* Document the patient's **Travel** **Screening**.

 

Document that Henry has not been in contact with someone who has COVID. He has not had a positive test in the last 14 days.

He does not have any new or worsening symptoms. (Tip: you must select **None of these** if the patient does not have new or worsening symptoms). He has not traveled outside the U.S. in the last month.

* Click **Accept**.
* Close **Henry's** chart.
* Now what care area does he appear on the **ED Manager**?

Patient Status

Patient status is used for tracking within the department. Think back to your eLearning, how can you quickly see what the patient’s status is? By the color column located to the left of the patient’s name.

SCENARIO:

* Review **Val’s** clinical information and course of treatment with the tech giving report.

TRY IT OUT:

* Look at the columns next to **Val’s** name.
* Identify **Val’s** age, chief complaint, and length of stay.
	+ Hint: To save space, the column abbreviation "TT" is used for "Total Time."
* In what stage of the ED visit is **Val**?
	+ Hint: The stage of the ED visits your patient is currently in is also called the patient Status.
	+ Tip: If you forget what patient status the colors indicate, you can hover over the left-most column in a patient's row or the patient’s name to see a tooltip.

You can also change the patient’s status as they progress through their care. Let’s say our ***A patient is ready to be discharged. What if we roll him to the door, but he faints as soon as he stands up to leave? We’re not going to leave him there and head back into the ED, right? Of course not. We’ll bring him back with us. So, we need to change his status from Ready to discharge. To manually change the patient’s status right click in the patient’s row then select patient status and choose In Process.***

Now let’s continue exploring this patients’ information.

* Does the patient have any orders to acknowledge?
* Does the patient have any abnormal lab results?
* Let’s take a closer look at this patient. Find your patient and double click to open their chart.
* Cancel any warnings and notification windows that may popup.
	+ Go to the **Chart** **Review** activity. The Chart Review activity is used to review encounters, notes, labs, and images from all patient encounters. Each tab filters different criteria.
* Click the Encounters tab. The encounters tab shows a chronological list of this patient’s encounters. At the top of the activity there are filters you can use to further drill down information. You can also filter information within each tab.
	+ Hint: You may need to remove any default filters in order to see additional information.
* Let’s continue exploring Open the **Notes** tab
* Does the patient have any notes?
	+ Click a note to open a view-only window for reading, and review.

ED narrator

Now let’s review the ED Narrator. The ED Narrator is your primary workspace, and it is where you will complete most of your documentation. From here you will document interventions, assessments, and procedures. In this exercise we will review the parts of the Narrator and document some information for our patient.

PATIENT: **Val**

ED Narrator parts

To the far left of your workspace you will see the narrator toolbox. Here you will see alerts, overdue tasks, and medications. The toolbox also contains suggested flowsheets based on the patient’s chief complaint. If there is documentation that is required to complete, you will find it here.

Next is the Event Log. The Event Log is a timeline of all events and assessments that have been documented for the patient. Information such as chief complaint, nursing assessments, and the ordering and administering of medications.

The next tab is the patient summary tab. This is the same report you have on the track board.



Finally, we have the orders tab which is where orders, and order sets can be placed.



To the far right we have a toolbox that is grouped by the type of documentation. All the documentation here, again files to the event log. Once you document an assessment on your patient a green check mark appears next to the assessment in the narrator to indicate the assessment has been completed.

Documenting Comfort interventions

SCENARIO:

Our patient states that they are cold. We will want to document this intervention.

Val would like a blanket.

TRY IT OUT:

* On the right-hand side under Additional Interventions select Thermoregulations Interventions.
* Update the time: n-5
* In this section document that you gave the patient a warm blanket
* Then click Accept.

Documenting an assessment

SCENARIO:

**Val** is due for a vitals reassessment.

TRY IT OUT:

* Using your clinical knowledge, document the patient's vitals.
	+ Hint: In the **ED Narrator**, find the **Vitals/Pain Assessment** link to start documenting.
	+ Tip: When entering a patient's blood pressure, you can use a space between two values. The system will put in the "/" for you.
	+ Tip: When entering a patient's height, weight, and temperature, you must enter the units. Try "f" for feet, "i" for inches, and "#" for pounds.
	+ Hint: If you erroneously enter a value that is beyond expected ranges, the system will alert you.
* Click **Accept.**
	+ Tip: You don't have to click **Accept** every time you document in the **Event Log**. If you leave the patient's chart, close the activity, or open another assessment, your documentation is *automatically saved.*

CHECK YOUR WORK:

* Does the **Event Log** show the vitals you just documented?

DOCUMENT SPECIMEN COLLECTION TASKS

SCENARIO:

Document a Urine Specimen

TRY IT OUT:

* In the **ED** **Narrator**.
* Click **Urine Specimen from the toolbox to the right.**
* Update the time
* Document how the specimen was sent.

documenting wound Care

Your patient has an existing pressure injury on her right foot. Document your findings and wound care provided.

PATIENT: **Val**

SCENARIO:

**Val** is a known diabetic and has a preexisting pressure injury on her right foot/heel that requires care.

TRY IT OUT:

Only document on sections that are within your scope of practice.

**Document wound care provided.**

* Select the **Wound/Incisions** flowsheet.
* Select Pressure Ulcer
* Complete all appropriate assessment and wound care documentation needed, for example:
	+ Date first assessed: t
	+ Time First Assessed: n-10
	+ Present on Hospital Admission: Yes
	+ Stage 3 pressure injury to right heel x 3weeks
	+ Use “**Other**” and/or additional **Comment** icon as needed.
* Click **Accept** when you are done.

Documenting adding an LDA

Now we will document insertion of an IV. Lines are also referred to LDAs, which stands for Lines/Drains/Airways.

* On the left side of the workspace select Line Placement from the toolbox.
* Click PORT-A-Cath
* From your clinical knowledge fill in all the insertion information.

Now you will see the line appear in the **ED Narrator Toolbox** under **Existing LDAs** as a hyperlink with icons next to it. You can now click on this link to document your initial assessment

documenting LDA removal

In this exercise, you will document an IV removal for your patient.

PATIENT: **Val**

SCENARIO:

Your patient is going to be discharged and it’s time to remove her IV. Remember, all existing Lines, Drains, and Airways (LDAs) are listed in the left side of the **ED Narrator** underthe **Existing LDAs in the toolbox**. This documentation follows the patient throughout their encounter (I.e., If the patient is admitted, the initial ED placement and IV assessment data continues to display here).

Since we need to remove and document the patient’s IV removal for discharge, which hyperlink should you click? The one in the **Event** **Log** or the one in the **Existing LDAs** toolbox?

* Answer: The one in the **Existing LDAs** toolbox.
* The **Event Log** link should only be used to edit *previous* documentation, not for *new* documentation.

TRY IT OUT:

* Click the **red X** next to the appropriate IV to be removed.
* Scroll down to the bottom of the properties window and fill out the following information.
	+ R**emoval date: t**
	+ **Removal time: n**
	+ **Removal Reason (ANY)**
	+ **Add a comment** (Hint: click on paper icon)of “patient being discharged to home”.
	+ **Post Removal Assessment**.
* Then click **Accept**.

CHECK YOUR WORK:

* The removal is shown in the **Event** **Log**, and the **Existing LDAs** toolbox is still there but, shows the IV as **Removed**.

# Documenting AN ed note

Depending on which facility you work in, it may be necessary for you to create a note documenting cares given or patient information that does not fall into any other category.

## ED note

TRY IT OUT:

* If you will be expected to enter notes, you will access the link in the **ED Notes** section of the **ED Narrator Toolbox**. Click on this now.
* Once the section opens, click on **+ED Note**.
* A note box will display that will allow you to enter in a note for the patient. **Type a short note**.
* Once complete, check for accuracy and spelling, and click on **Accept.**

Your note can then be viewed by anyone in the patient’s chart through the Notes tab, Chart Review tab, and in the Event Log.

**Discharging a Patient**

During this exercise, you will complete the discharge process on your patient.

PATIENT: your **Henry**

SCENARIO:

The doctor has seen the patient, applied sutures to the wound, and documented the procedure. The patient is now ready to be discharged.

**TRY IT OUT:**

Find and open your Henry **'s** chart from the **Track Board and single click in his row**.

Use the **Dispo** activity to document the following:

* Dismiss any BPA’s
* Click on **Addl Dispo Info** from the navigato**r.**
* Document the **Condition on Discharge**

Use your clinical experience to document the other sections including **Discharge Instructions**.

* Click **Preview/Print AVS** from the quick button list. 

Look at the information you added. Because this is training, you will not print the AVS. However, when discharging a patient, you can easily print the AVS and discharge instructions. Before the patient leaves the hospital, you need to ensure that all the patient's registration information has been documented. From the **Track Board**, determine the patient's registration status.

Henrys registration is complete, and the practitioner has marked the patient as ready for **Discharge**.

* Close the patient’s chart.
* To discharge the patient to **home or self-care,** highlight your **Henry** patient on the **Track Board** and select **Discharge**.
* Enter **ED Discharge Information,** including any hard stops  and discharge diagnosis, then select **Discharge**.

**CHECK YOUR WORK:**

Go back to the **Track Board**. Check to see if your Henry patient has been removed from the **Track Board**, and **ED Manager**.

**Congratulations you have completed this lesson**

**Answer Key**

* Identify **Val’s** age, chief complaint, and arrival time.
	+ 30 years old, Abdominal Pain, arrival time will vary depending on the time of training
* In what stage of the ED visit is **Val**?
	+ In Process
* Does the patient have any orders to acknowledge?
	+ Yes
* Does the patient have any point-of-care tests needing collection?
	+ No
* Go to the ED Manager. What information can you see about patients at-a-glance without opening the chart?
	+ Patient status, chief complaint, acuity, treatment team assignment, total time, etc.
* How can you tell which patients are due for reassessments?
	+ Answers will vary depending on the time of day. There is a red alarm icon in the patient status column.
* Does the patient have any notes?
	+ Yes, an ED Triage Note and a Progress Note.