ED RN Quickstart Guide

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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 couple of breaks along the way to recharge and refresh.

Any preliminary questions before we get started?

Logging into epic

*From your ED Nurse 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.***

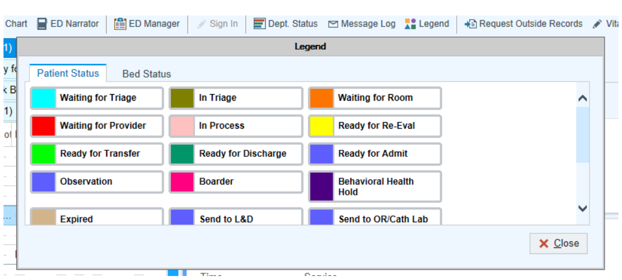
SCENARIO:

It is the start of your shift, and you are ready to get report and assume care of your patients.

Try it out:

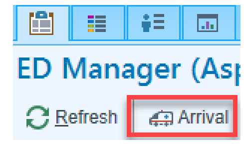
Your default workflow will be to use the ED Manager. Click **Sign in** to document the start of your shift.

- Enter a phone number and select your role if it is not defaulted in.



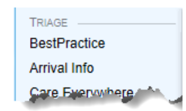
As the patient moves through their ED visit their patient status changes, their Status color will change as well. To manually change the patient's status, right-click in their row, and select the appropriate status from the status menu.

Arrive a patient

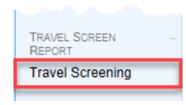


1. Click **Arrival** in the **ED Manager**. The Patient Lookup window opens.
2. Enter your Henry patient information and click **Find Patient**. The Patient Select window opens.
   - Double-click the appropriate patient.
   - If the search did not find a matching patient, click **Continue** and then create your Henry patient's other required info (SSN, DOB, and Gender)
   - Click **New** in the Patient Lookup window.

> **!** To avoid creating duplicate patients, the **New** button is not available until you search for a patient.



3. In the **Arrival Information** section of the Expected Pt Navigator, click **Arrived**.
   - The current date and time appear in the **Arrival date** and **Arrival time** fields, and the status changes to Waiting.
4. Enter any other information you have, such as means of arrival.



   - His wife drove him to the emergency room.
   - His 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.
5. Click **Close**. Now what care area does he appear in on the **ED Manager**?
6. In the Triage Navigator you must enter a **Triage Start** time.

Enter a chief complaint

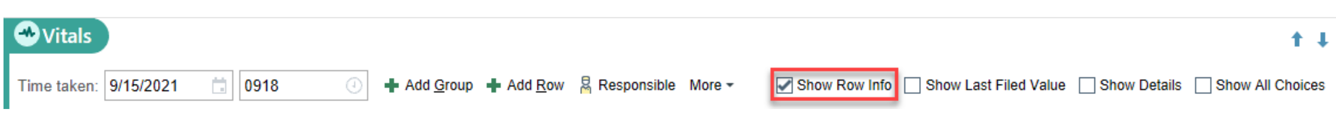
1. In the **Chief Complaint** section. Enter the first few letters of the complaint in the **Chief Complaint** field and press **Enter**. A list of matching complaints appears.
   - Henry's chief complaint is **chest pain**.
2. Enter a comment, if necessary.

Tip! *To move in the navigator click the section or use the keyboard shortcuts which saves and closes the current section:*
- *Click **Next** or press **F8** to close and save the current section while opening the section immediately below.*
- *Click **Close** or press **F9** to close and save the section.*

Document vitals

The information you enter in the vitals section automatically files to the patient's flowsheet.

At the top of the Vitals section you will see customization option checkboxes. Select **Show Row Info**, this will allow you to see additional information regarding screenings or documentation parameters.



1. In the vitals section, confirm the time and date that you took the patient's vital signs in the **Time taken** fields at the top of the section.
2. Use the fields and buttons to enter the patient's vitals.

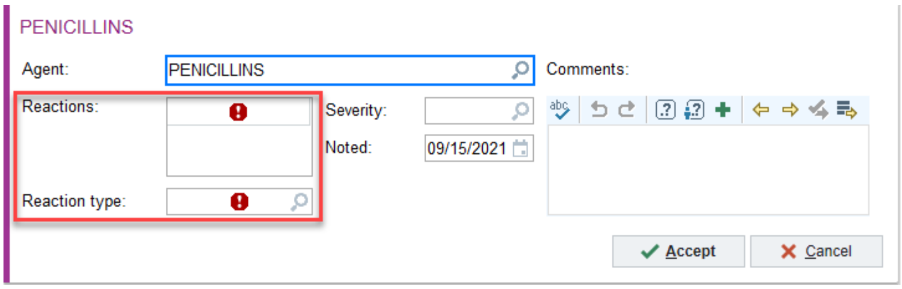
- Document a set of vitals using clinical details of your choice.

Tip! *When entering a patient's weight (lb, #), you must enter the units. When entering the patient's blood pressure or height, you can use a space between the two values. Units to use for height include 5f7i, 5'7", or 170 cm.*

3. Click to add a comment or click to flag data as significant.

Review the patient's allergies

1. Open the **Allergies** section.
2. Review the patient's allergies. If necessary, update the list:
    - **Henry** reports that he has had a mild allergic reaction to **penicillin** resulting in itching, rash, and hives.
    - After you enter the agent you will see hard stops for **Reactions** and **Reaction type**. Enter the reported information.



- To add an allergy, search for the agent and enter details about the allergy.
- To update an allergy, click the agent's name and edit the details as necessary.
- To indicate that the patient doesn't have any allergies, select the **No Known Allergies** check box.

3. After reviewing the patient's allergies with the patient, click **Mark as Reviewed**.

Want to save a click? Review the patient's allergies with the **Allergies** navigator section closed. If the patient's allergies haven't changed, you can mark them as reviewed without having to open the section.

Marking a section of the chart as reviewed is similar to initialing the paper chart. The chart is updated to indicate that you're the most recent person to mark the information as reviewed.

Document Other Triage Info

This section contains required information that we need to gather from the patient and document.

- Review and document the in the areas of this section, including the **MDRO Education**, **Trauma/Abuse Assessment**, **Values/Beliefs** and the **Suicide Questionnaire**.

Document patient history

The **History** section shows any pertinent medical history for the patient, as well as any surgical, family, and social history. As you review this information with the patient, document all positives and any pertinent negatives. If you don't need to update the history, click **Mark as Reviewed**.

If you need to make a change:

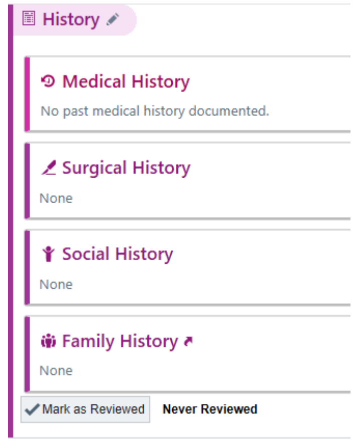
1. Open the **History** section.
2. Click the buttons to update the patient's history.

To enter more information about a problem or procedure, such as a date or comment, click .

3. To document a problem or procedure that isn't listed, enter it in the **Add** field.

    - To document a pertinent negative, search for it in the **Add** field and click **Pertinent Negative**.

4. Click **Mark as Reviewed**.



Update **Henry's** medical, surgical, social, and family history as needed to make sure it is complete:

- He states that he has had an appendectomy, tonsillectomy, and has a history of hypertension.
- Henry quit smoking cigarettes one year ago and never used smokeless tobacco.

Tip: If the patient can only give you the year enter the date as 01/01/Year. If they can give you the month: Mo/01/Year.

Document family history

If you verbally reviewed family history with the patient and no changes are necessary, click **Mark as Reviewed**. If you need to make changes:

1. Enter or update the relative's name and status.
2. Record pertinent positives and negatives for that family member:

    - Indicate a pertinent positive by clicking the cell at the intersection of the relative and the problem.
    - Indicate a pertinent negative using the **Neg Hx** row at the bottom.
    - Leave a comment by right-clicking in a cell. View a comment by hovering your mouse over the cell.

3. Click **Mark as Reviewed**.

Review home medications

1. Open the **Home Medications** section.
2. If the patient is taking a medication that appears on the list, click the buttons to indicate that she is taking the med and to indicate her last dose.

> Mark today or yesterday as the most recent dose for all unselected meds using the **Mark Unselected** buttons on the top right of the navigator section.

3. If a patient is taking a medication differently than it was prescribed, record the variance:

    a. Click the name of the med and change the order to match what the patient reports.
    b. Click **Add Med Note** to add additional free-text comments as needed.

4. If a patient is no longer taking a medication that appears on the list, discontinue it:

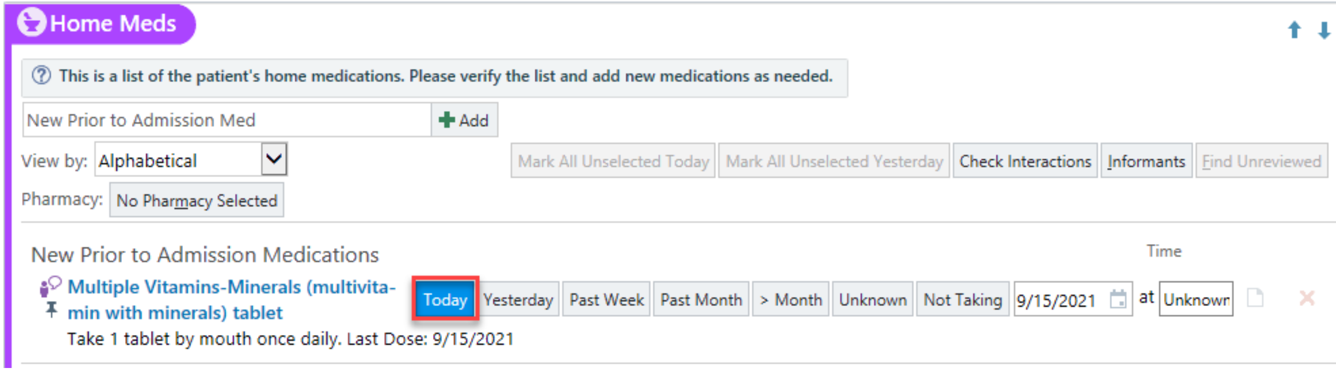
    a. Hover over the medication name, and then click on the far right.
    b. Enter a reason for discontinuing the medication.

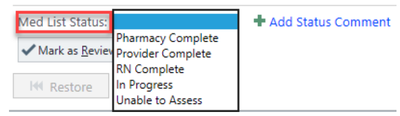
5. To add a medication the patient reports taking:

    a. Search for the medication in the **Add** field and double-click it in the list that appears.
    b. Enter information about the medication, such as the dose, when the patient started taking the med, and the frequency with which she takes it.

6. Click **Mark as Reviewed**.

Henry is not currently taking any home medications and has not taken anything for his pain, but reports that he takes a multi vitamin once a day.





- Select the appropriate **Med List Status** for your job role.
- The section must still be **marked as reviewed**, even if there are no meds to document**.**

If you can't completely review the list of medications, change the **Med List Status** accordingly.

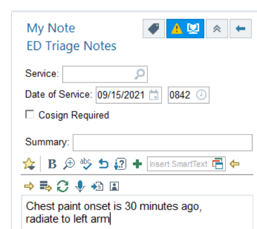
ⓘ	You can document the patient's preferred pharmacy by clicking **No Pharmacy Selected**. If a preferred pharmacy has already been documented for the patient, that pharmacy's name appears next to the button.

Document acuity

1. Open the **Acuity** navigator section.
2. Click the appropriate buttons to document acuity.
3. Click to add a comment, if necessary.
4. Once an acuity is assigned closing the section saves your work and ends Triage.

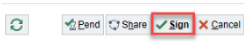
   - Assign **Henry** an acuity of **3**.

Document an ED Note



Go to **ED Triage Notes** and complete a free text a note for **Henry** in the far-right pane.

- Type, Chest pain onset is 30 minutes ago, is new, and radiating to left arm, etc.
- **Sign** the note.



Let's go back to the **ED Manager**.

- Hover over Henrys name, what is his current status?

Assign a patient to a bed

1. In the **ED Manager**, select your patient in the Waiting area.
2. Drag and drop your patient's name to an open bed or row, or on the bed or row for the bed held for them.

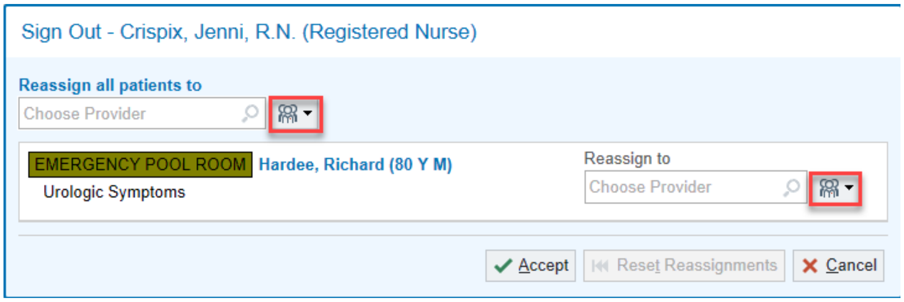
If you choose an open bed, the patient is assigned to that bed.

If you choose a held bed, you see a warning with the option to continue. Click **Yes** to assign the patient to that bed.

Assign yourself to a treatment team

1. You can edit a patient's treatment team easily in the **ED Manager**.
2. Right click on the patient and click **Assign Me**, or to add others use the Treatment Team option.
   - Assign yourself to **Henry**.
3. At the end of your shift if you still have patients assigned to you, you will need to reassign them.

4. When you Sign Out of the department you will be prompted to reassign your patients. You can either assign them all to the same person, or you can assign them individually to different nurses. Use the quick button to select people signed in on your unit.



Don't sign out or reassign your patient now, we will keep working with Henry throughout.

See when tasks are due in the ED Narrator

A timer appears in the Alerts Toolbox at the top of the ED Narrator to help you keep track of tasks you need to complete. This timer provides a visual reminder of when a patient's vitals and pain assessments are due.

The timer becomes active when you document your first set of vitals in the **Triage Navigator**. The next time you go to the **ED Narrator**, the timer appears in the Alerts Toolbox, measuring how long it's been since you last took the patient's vitals and performed a pain assessment.

Document vitals

1. In the ED Narrator, click the Vitals/Pain/I&O/Rounding toolbox.
2. Click the **Vitals** link.
3. In the Vitals form that opens in the Event Log, document the patient's vitals.
4. Click to add a comment, if necessary.

> You can mark any values you enter in the ED Narrator as significant to help call them out to the physician. To do so, hover over the vitals row you want to flag. A flag icon ( ) appears next to the icon. Click it to mark the values in that cell as significant. Click it again to remove it.

Associate and validate data from devices

If a device is already associated with a patient, skip to step 5. Otherwise, begin with step 1 to first associate a device with the patient.

1. In the ED Narrator toolbar, click **Data Validate**.
2. In the Flowsheets toolbar, click next to **Hide Device Data**, and then click **Associate Devices**.
3. In the **Add** field, look up the device you want to associate with the patient.
4. Once you've selected the device, click the **Variables** link to confirm which vitals you want pulled into the flowheet, and then close the Associate Devices window.
5. In the Flowsheets toolbar, click the **Hide Device Data** button in the toolbar.

If the button looks like , unvalidated device data does not appear in flowsheets. Click the button to show it.

If the button looks like , unvalidated device data appears in flowsheets in cells that have slash marks through them.

6. Click the time links to choose how often you want to import data from the monitor. For example, if you want to import data every 15 minutes, click the **15m** link.
7. Verify that the readings make sense. For example, if the patient's documented heart rate is 300, the monitor is probably malfunctioning. To fix incorrect data, click the value and change it manually.
8. Select the columns you've validated and click **File**.

To file one column, hover over the time header and click the arrow that appears. Choose File Selected.

To select multiple columns, click in the first column and drag your mouse to the last column. Click File Selected.

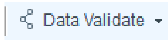
Try it out:

In the **ED Narrator** toolbar, click the carrot next to **Data Validate**. 

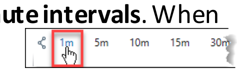
- From the dropdown select **Associate Devices.**
- Click **ADD** and select a device to associate.

The **Associate Devices** window opens.

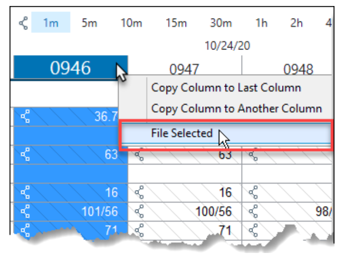
- Confirm you have selected the right device and click **Accept** and **Close**.

Now select the **Data Validate** 

button. You can change the view so data displays in **one-minute intervals**. When you see unvalidated data, you need to review it and then file it. **We will not be able to validate today.**



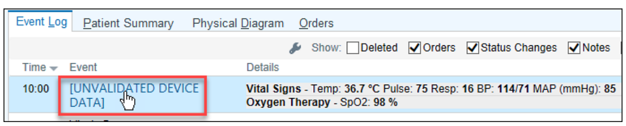
Data with slashes has not been filed to the patient chart. To validate data, highlight the data you want to file to the chart. Right click and select **File Selected**. This pulls the data into your patient's chart.



***<u>New data will not appear because no device is actually attached to your created patient</u>*.**

<u>In a Real-World Environment….</u>

If we were able to add a device to our patient that was actually connected, we could now go to the **ED Narrator** and confirm that you see **Vitals** events for the data you reviewed. Once you have associated your device, you can review Vitals and validate from the **ED Narrator**!



!	If the data isn't gathered continuously, like BP from a manual cuff, a reading must be taken close to the time listed in the column. Otherwise, the data can't be imported.

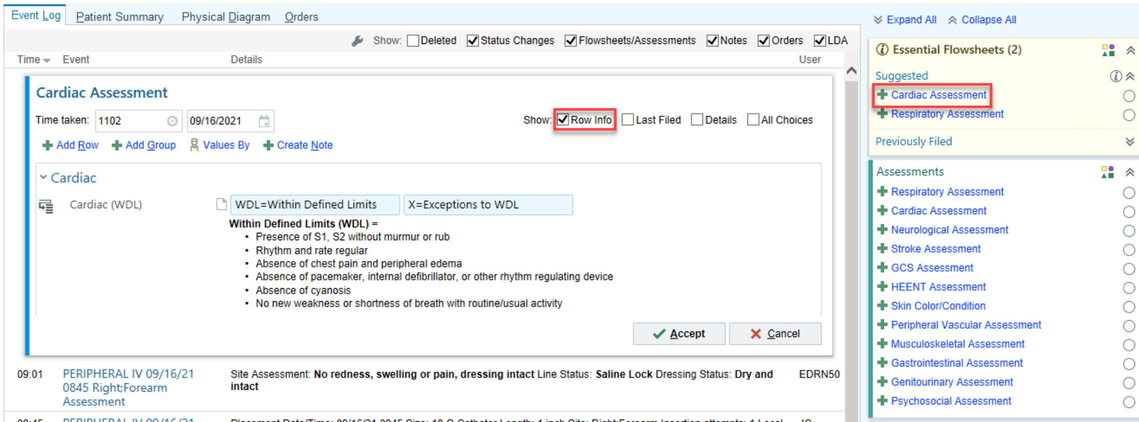
!	Data can only be imported when the system shows the patient in the bed the device is attached to. If you are unable to validate a patient's device data, first confirm his location on the ED Manager.

Document an assessment

When you document assessments in the narrators, you chart by exception, marking systems as within defined limits (WDL) or as an exception to WDL (X).

1. In the right-hand toolbox, expand the Assessments group. Hover over a button or click to expand a section.
2. Click the link for the assessment you want to perform, such as a Cardiac assessment.
3. In the Assessment form in the Event Log, click **WDL** or **X**. If you click **X**, new fields appear. Use them to document abnormalities.
4. Click to add any necessary comments.
5. Click **Accept**.

i	A icon appears next to a flowsheet assessment in the narrator toolbox when it's been documented on. Hover over the green check to see when the last assessment was completed. A blank circle means the assessment has not yet been documented on.



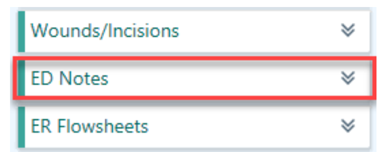
*Be sure to check your **Row Info** box so you know what you're charting.*

Based on chief complaint there will be suggested assessments.

- For **Henry**, select **X= Exceptions to WDL** and mark some exceptions pertaining to his chest pain.

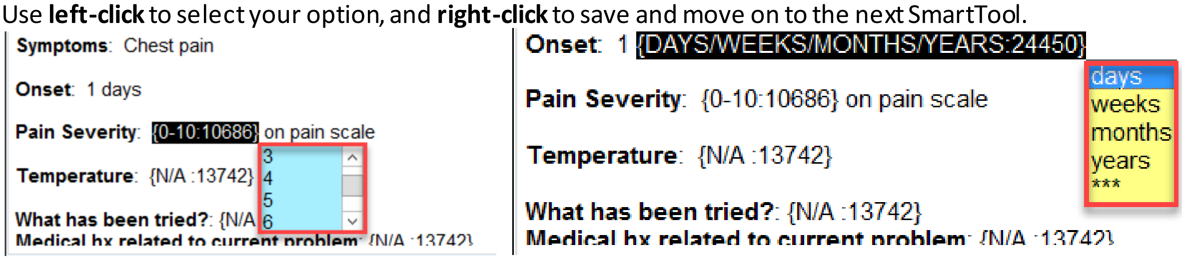
Write an ED Note

In the toolboxes on the left you will find the ED Notes toolbox. Use the + button to add an ED Note. In the Event Log your note will open, if you would like a larger field to edit, use the icon to open a pop-out window.



Try it out:

- In a note use what we call a dot phrase, type: .triage
- A window will pop up, select the male triage note and hit enter.
- Scroll to the top of the note and click at the beginning of the first line.
- Use the **f2** key on your keyboard to find the wildcard (***) and SmartTools that you will need to complete.
- The wildcard fields are free text fields that need to be entered. You don't have to delete the ***, if you start typing it will fill in the field.
- When you complete a *** wildcard field use the **f2** key to open the next SmartTool.
- In a SmartTool a blue box means you can pick multiple options, and yellow means you pick one option.
- Use **left-click** to select your option, and **right-click** to save and move on to the next SmartTool.



***Tip!** F2 to get you through, left to pick, right to stick.*

SmartTools are used in many places within Epic, you will also see them if you need to give a patient a Work or School Excuse.

Place an order

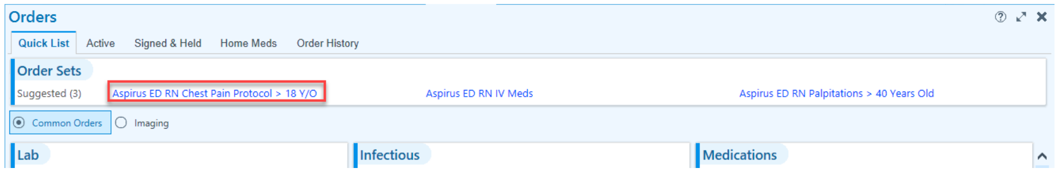
Use the Orders activity to enter orders.

SCENARIO:

While **Henry** waits to be seen by a provider, you are going to get some orders started.

Try it out:

- Open Henry's chart (dismiss any popups for now) and go to the **Orders** activity. Notice the suggested Order Sets in the Quick List.
- Double click the **ED RN Chest Pain Protocol >18 Y/O** order set.



There are several orders pre-selected.

Note the red exclamation point for the **Labs-Chest Pain RN Protocol**.

- Select **Chest Pain – Onset < 3 Hours**.

Some orders have a yield symbol there are recommended items that you should act upon. They are not hard stops and you can continue to place orders without addressing.

- Click on the EKG order in the list at the right. Address the yield sign.
- After you finish modifying the orders, **Sign** the orders.
- Review any order validations and click **Accept.**
- Select the order mode of **Per Protocol WITH signature**.
- Search for an ordering provider by typing in the name **Ron Add** if it does not auto complete select Ronnie Adder.

The provider you select appears by default as the authorizing provider. Your training nurse name auto populates as well.

Place common orders from quick lists

Quick lists are targeted lists of common orders that automatically appear in the Orders activity based on certain clinical information that's been documented, such as chief complaint. You can select medications, labs, and protocols from quick lists without having to search.

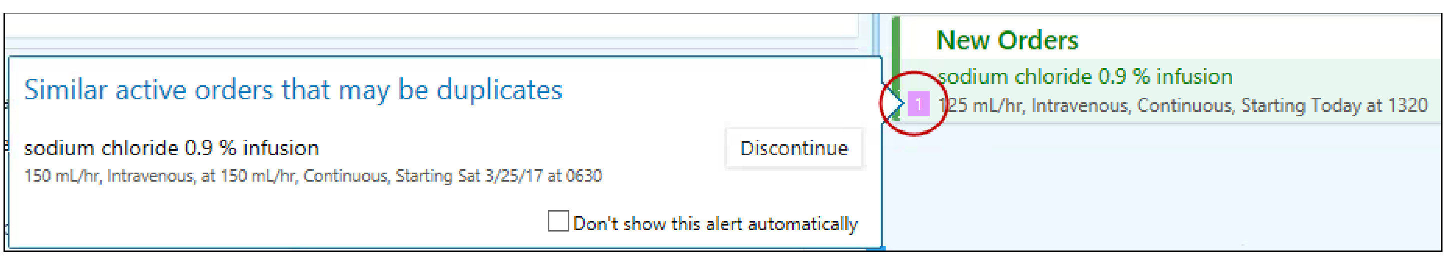
1. Go to **Orders > Quick List**.
2. Click a quick list button to see the orders in that list.

The Quick Orders, Imaging, and Nursing Communication lists include common emergency orders for all patients in the ED.

Targeted quick lists, such as Chest Pain or Peds Quick Orders, can also appear based on clinically relevant information in the patient's chart.

3. Select the check box for each order you want to place.
4. Review the orders in the Orders sidebar and click **Sign**.

If you select an order that's already active for the patient, it appears highlighted with a number in the Orders sidebar. Click the number to review possible duplicates before signing the order.



Place individual orders

If the order you want doesn't appear in a quick list, search for it individually.

1. Enter the first few letters of the order in the **Place new orders or order sets** field in the sidebar and press **Enter**.
2. Select the order you want in the medication search window that appears and click **Accept**. The order appears in the sidebar.
3. Click the Summary Sentence to open the Order Composer and make changes to your order.
4. When you're finished selecting orders, click **Sign**. The Providers window opens.

5. Enter an appropriate order mode.
6. Enter the ordering provider.
7. Verify that an appropriate provider is also listed in the fields under Authorizing Providers. Click **Accept**.

> Click to remove an order you don't want.

Place multiple orders with an Order Set

Order Sets help you quickly place multiple related orders. For example, there are Order Sets for pneumonia, hypertension, and abdominal pain.

> Use an Order Set to order blood transfusions. Blood Order Sets include pre-transfusion labs, the blood bank request, the transfuse order for the nurse, and transfusion-related meds.

Choose an order Set

Search for an Order Set in the **Place new orders or order sets** field, the same way you search for individual orders. To preview an Order Set, click . With an Order Set selected, click **Open Order Sets**.

> If the ordering provider wants you to use his customized Order Set, click **Advanced** and enter the ordering provider's name in the **User** field. Select the check box beside the Order Set and click **Accept**. Then click **Open Order Sets**.

Select orders

In an Order Set, select the appropriate orders for your patient. Some orders might be preselected for you.

Check boxes ( ) indicate that you can choose one or more orders within a section.

Option buttons ( ) indicate that you can choose only one order within a section.

A stop sign ( ) indicates a required section.

Respond to medication warnings

Medication warnings appear when you sign an order that might interact dangerously with other medications, food, or allergies. A warning might also prompt you to check the dose of the medication, duplicate therapies, or IV compatibility.

When a warning appears, you can either remove the order or override the warning.

1. Click **Remove** next to each order that you want to cancel. If you remove all orders, the **Override and Accept** button changes to **Accept** at the bottom of the window.
2. To enter an override reason for individual medications, select an override reason next to each one.
3. To enter one override reason for all of the medications on the list, select an override reason at the bottom of the window.
4. Click **Override and Accept** when you are finished entering override reasons, or click **Accept** if you chose to remove all orders.

CHECK YOUR WORK:

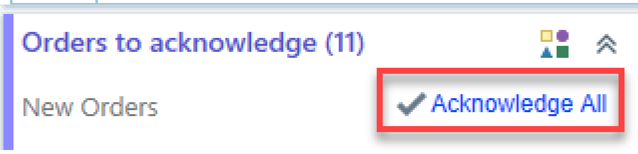
Go to the **Event Log** in the **ED Narrator** and verify that your protocol orders appear with an event of Orders Placed. Narrator

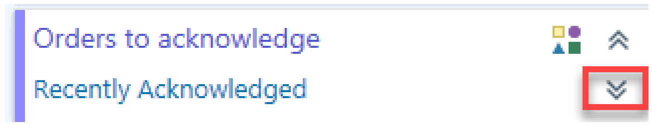
Find and acknowledge new orders

Acknowledging an order lets others know that you have seen the new order, and are taking responsibility for making sure it is carried out. Check for any new orders to acknowledge by following these steps:

1. On the ED Manager review the **Unack** (Unacknowledged) column. The icon indicates that there are orders to be acknowledged.
2. Select the patient's row, and then click **ED Narrator** on the ED Manager toolbar.
3. In the Acknowledge Orders toolbox on the left side, click the **Acknowledge All** link, or acknowledge individual orders by clicking their name.

> You can also find and acknowledge new orders in a patient's chart. If a patient has new orders, they appear in the **Acknowledge Orders** group in the **ED Narrator**. Click an order's name to acknowledge it, or click **Acknowledge All**.





Use the drop-down under **Recently Acknowledged** to review orders or undo recent Acknowledgedments.

Document medication administrations

1. In the ED Narrator, scan the patient's wristband.
2. Scan the barcode on the medication you want to administer.

If the dose has multiple components, such as two tablets, scan each component individually. The partial dose is denoted by a icon.

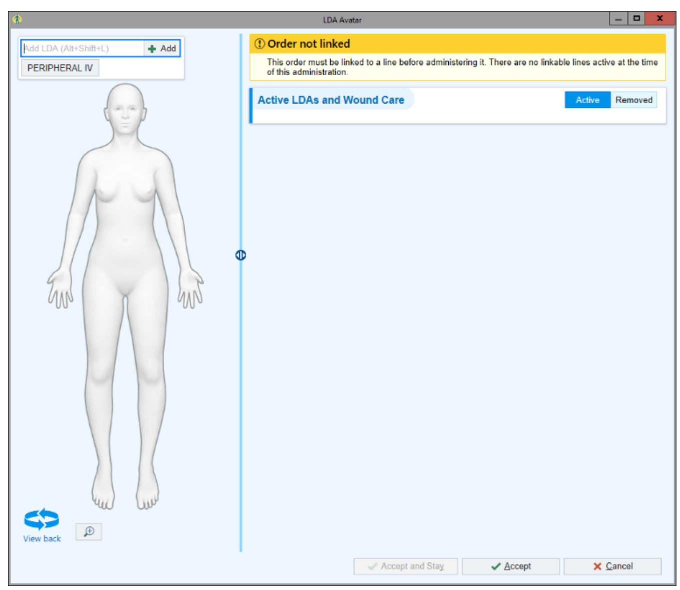
If the patient has multiple meds due at the same time, scan them all now.

If you can't scan the barcode, click the med in the Active Meds & Blood toolbox group. In the Warning window, select the correct override reason, such as Barcode Unreadable, and click Accept.

3. Verify that the action, dose, and other details are correct for all meds.
4. Click **Accept**. The administration appears in the Event Log, with your initials in the User column.

For your **Henry** patient start the saline from the MAR toobox.

- Select the **New Bag** action.
- You will not be able to scan in training, please use the **MAR Edit** Override action.
- Click **Continue Administration** on the Medication not verified pop-up.



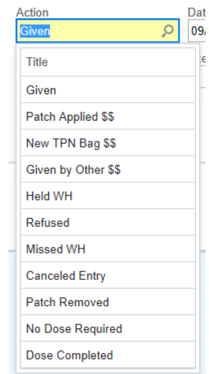
Add a Line

If your patient does not have an existing line, the **LDA Avatar** will pop-up to add a line.

- Select the appropriate LDA.
- Click on the site location on the avatar.
- Fill out the date (**t**= today), time (**n-10**= 10 minutes ago).
- Then complete the size, catheter length and other pertinent information (except removal).
- Click **Accept**.

The MAR Administration window will open, verify the information is correct and **Accept**.

Fix a mistake in medication administration documentation



*This is just a demo, the **New Bag** action is the correct action as it was originally entered.*

1. In the **ED Narrator**, locate the medication administration in the Event Log.
2. Click the blue administration link.
3. On the Administration window, select the **Edit administration** checkbox on the lower left underneath the order summary. If an Administration Warning window appears, enter an override reason and click **Accept**.
4. In the **Action** field, choose the appropriate selection from the list.
5. Enter an appropriate selection in the **Reason** field.
6. Make any other changes or add a comment.
7. Click **Accept**.

Overview of the MAR

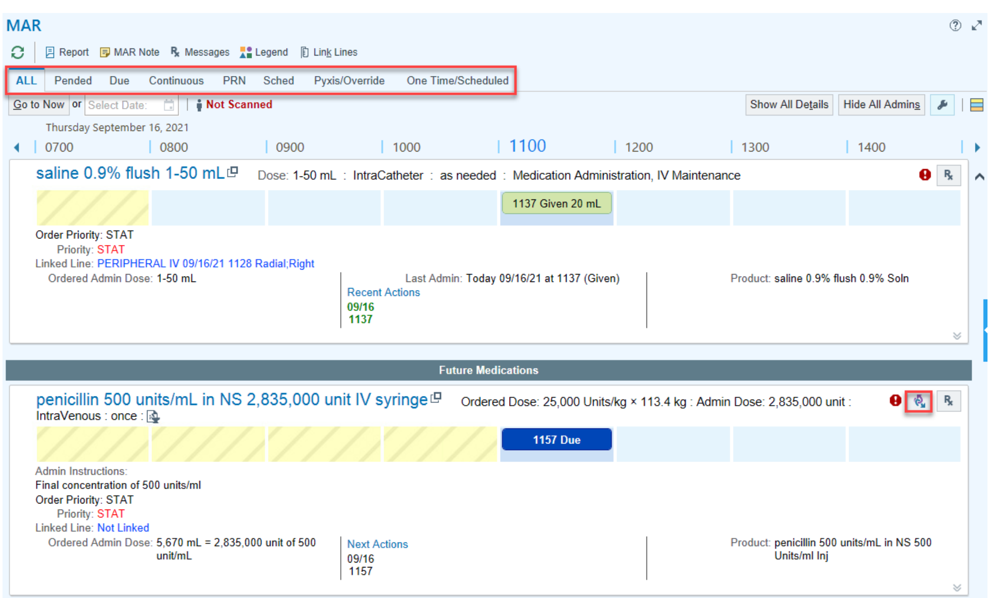
To jump to the MAR from the ED Narrator, click **MAR** in the Active Meds & Blood toolbox group.

Get oriented to the MAR

- Each row on the MAR represents a med that has been ordered for a patient.
- Due times and past actions (such as Given) appear on a med's row.
- To see more information about a specific med, including recent actions and the linked line, click in the white space for the med.
- Some rows on the MAR are different colors. Active meds appear with light blue rows. To see what the other row colors mean, hover over the legend.
- Each column on the MAR represents one hour of time. Any due times within that hour appear in the hour's column. For example, if a med is due at 1045, it appears in the 1000 column.
- The **ALL** tab opens first. To narrow the list, use the other tabs to see only meds that meet certain criteria (such as PRN) or meds that are specific to certain treatments (such as Chemo).
- Different icons appear on the rows for different meds. To see what each icon means, check the **Legend**.
- You can hover over an icon to see what it means, or click it to take an action. For example, click to review med interaction information.

Try it out:

Add an order for penicillin to your **Henry** patient. You will need to select an override reason because of his allergy. Once completed, come back to the MAR to view.



Customize the MAR

A. You can make some changes to the way meds appear on the MAR using the buttons that are always visible:

To see details for all medications, click Show All Details.

To hide administrations and due times, click Hide All Admins. Hiding administrations makes each row thinner, so you can see more meds at the same time.

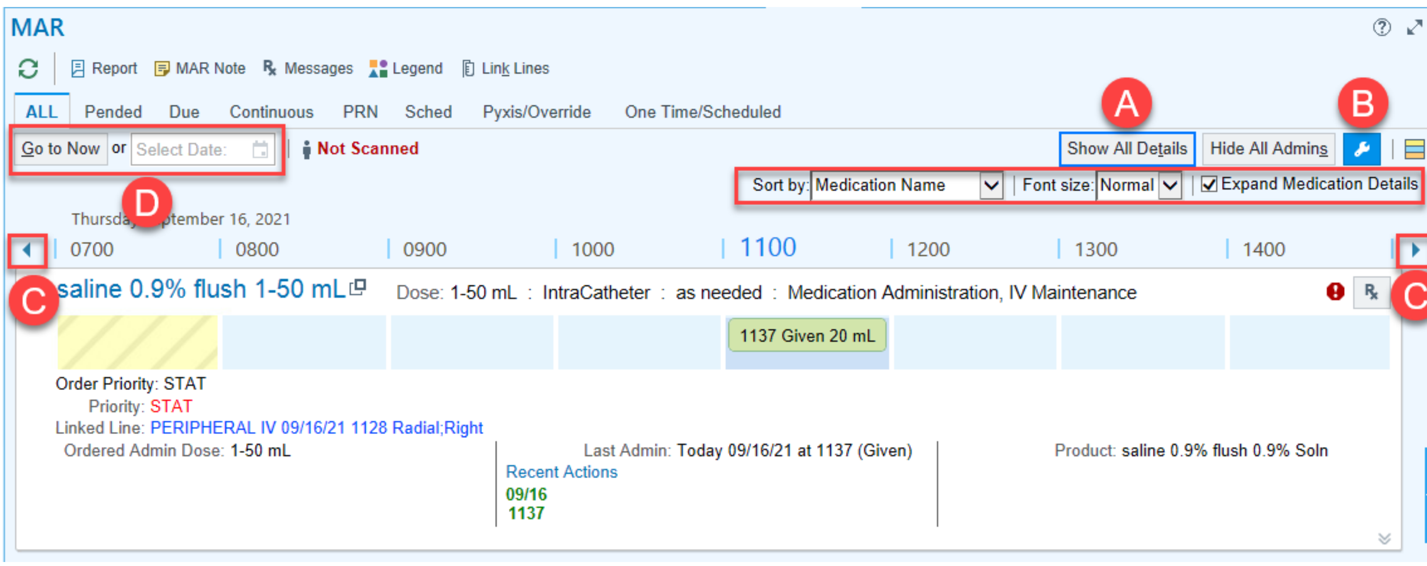
B. You can make other changes to the way meds appear by clicking and using the additional options:

Choose an option in the Sort by: Medication Name field to change the way meds are sorted. For example, you might sort by route so you can prepare all the due PO meds before you prepare the IV meds.

Select ☑ Expand Medication Details to see medication details for all meds every time you open the MAR.

C. To see med information for past and future shifts, click the ◀ and ▶ arrows in the timeline.

D. To see information for a specific date, enter that date in the **Select Date** field. Return to the current time by clicking Go to Now.



Handle unreadable barcodes

1. Document the administration manually by clicking in the cell for the med's due time, selecting the correct Override reason, and clicking **Accept**.
2. Click ℞ next to the order. Send a message to pharmacy with a **Reason** of Barcode Doesn't Scan.

Understand and act on MAR warnings

The color of a warning can help you determine how likely an action is to cause potential patient harm. Warning colors generally progress in severity from white (the lowest severity) to yellow, then orange, then red (the highest severity).

ℹ	Use keyboard shortcuts to quickly Accept (**Alt+A**) or Cancel (**Alt+C**) a warning.

Dose, rate, and unit warnings

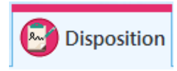
Dose, rate, or unit warnings appear when you enter a dose, rate or unit in the MAR that's different from what was ordered.

These warnings appear when you're titrating a medication that was ordered with a fixed dose and rate. If you have been authorized to adjust the medication, enter an override reason and click **Accept**

Enter a disposition for the patient

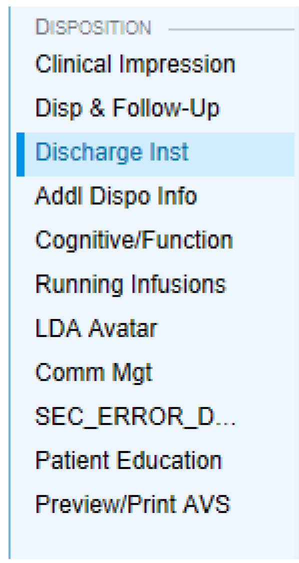
Notice there are three tabs underneath Disposition – **Discharge, Admit/Transfer,** and **Expired.** Let's start under the **Discharge** tab. Click on that now.

1. Open the **Disposition** navigator section in the Disposition activity.



ⓘ	When a patient's status is Ready for Discharge, his chart automatically opens to the Disposition Navigator.

2. Enter a disposition, if the physician hasn't already documented one.
   - In **Henry's** Dispo Navigator open the **Disposition and Follow-Up** section.
   - Select **Home.** To see other Dispo options you can use the button in the search bar.
   - Indicate that Henry should follow up with his PCP tomorrow if symptoms worsen. Since he doesn't have a PCP listed, click New and use the search magnifying glass and search **ste phil**. Select the correct location (Wausau) for Steven Phillipson so that follow-up documentation can be sent appropriately.



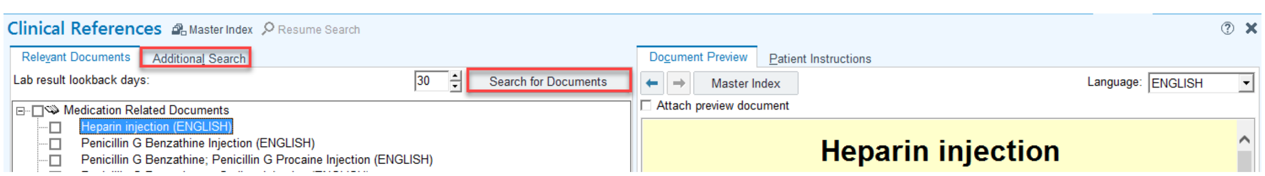
3. Add more text in the **Comments** field by typing or using SmartTools, if necessary.
4. Complete any SmartLists or wildcards in the **Comments** field.

Remember: To use your quick keys to save your work and move on to the next section. **F8** to navigate.

Enter Discharge Instructions

Using the link in the **Discharge Instructions** section Go to References/Attachments add needed patient education to their discharge.

- Review the suggested documents for **Henry**, select the appropriate education, and search for additional helpful education.
- You can edit the education in this tab, or in the Discharge Instructions activity to make it patient specific.
- When you check the box next to the document it will attach to the discharge instructions.

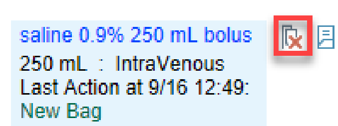


Enter Addl Dispo Info

In this activity you will indicate patient condition upon discharge.

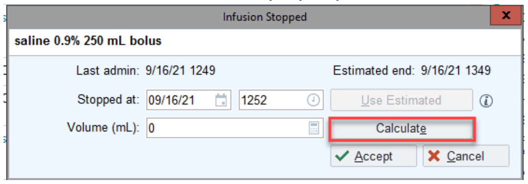
- **Henry** will be leaving by himself, in good condition. Select the correct indications for his discharge.
- Make sure that you have your **Row Info** on!

Continue on in the Navigator completing the:



- **Cognitive/fuction status** to indicate the patient's well being.
- **Running infusions and the LDA Avatar** to document the stop and removal actions.

- This is more easily taken care of in the **ED Narrator**, where you can stop the infusion and document the IV removal.
- When you end the infusion you will need to enter the volume given. Use the **Calculate** button in the infusion pop-up to auto fill the volume row.

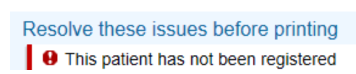


- **Communication Management** is used to send any letters or information needed.
  - Select the **Patient** button for the To: field.
  - Use the **Other** button to open the Template search.
  - Find the **Off work** letter template.
  - Use **f2** to get you through the SmartTools in the letter.
  - **Left-click** to pick Work, and **right-click** to save and open the next list.
  - Enter any relevant information in the *** wildcard fields, or delete them if not needed. Then **f2** to the next SmartTool or Wildcard.
  - Because there's no provider listed for Henry the SmartTool to pull in the provider name in the letter (@ENCPROVNMTITLE@) will not populate.
- **Patient education** to indicate how the discharge instructions were communicated and received.

Prepare the After Visit Summary

Print the AVS

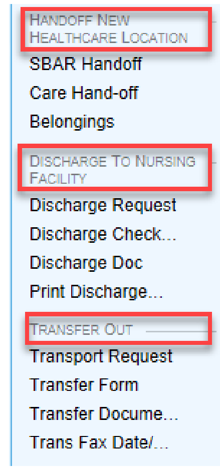
1. Go to the **Preview/Print AVS** section of the Disposition navigator.
2. A preview of the After Visit Summary appears. The top of the preview includes an explanation of what documentation needs to be completed and whether it's required. If there is a hard stop you will be unable to print.
   - Henry's AVS will not be printed as he hasn't been registered.
   - Address any other hard stops that come up that you can.



3. Change the language the AVS will print in by selecting a language from the Language dropdown in the lower-left corner.
4. Change the font the AVS will print in by selecting a font size in the lower-left corner.
5. Review the AVS and click **Print** in the lower-left corner. The patient's discharge instructions are printed along with the AVS.

> The AVS is updated based on any documentation you and other clinicians enter. To review how an AVS looked when you printed it for the patient, select the **Encounters** tab in Chart Review. Select the ED visit and, in the Disposition section in the sidebar, click the **AVS** link.

Different Discharge Reports



You will see three different sections, based on the path of your discharge will direct which sections of documentation to complete and what reports to print for your patient.

- **Handoff New Healthcare Location**: this is used when a patient is discharged to another healthcare facility.
- **Discharge to Nursing Facility**: this is used when a patient is discharged to a skilled nursing facility.
- **Transfer Out**: this is used when a patient is discharged from current facility and transferring to another facility.
    - The Transfer Form is also known as the **EMTALA** form and is **required** documentation with every transfer to a new facility.
- Take a moment and click through the reports to see what you will need to document and print for patients. <u>Make sure your row info is on</u> so that you can see all the details necessary.

View and enter charging information

In order to maintain accuracy and consistency, charging is done automatically whenever possible based on the documentation in a patient's chart. However, you need to review the charges in the system, change them if necessary, and file them.

1. Open the **Charge Capture** activity. Charge Capt... If you don't see the activity, you may need to click ... to view more activity tabs.
2. To view charging information, click **Facility Charge Calculator** under the Facility Charge subsection. The charge calculator opens.

Select the Legend tab on the right side to see how the system calculates charges. Legend If you want to accept the charges that the system calculated by default, click Accept. To close the charge calculator and enter more charges, click Cancel.

- If you click Accept, but then edit the chart, or add missing charges you will need to update your charge using the **Facility Charge Calculator** again.

3. To manually enter other charges, go to the **Search for new charge** field and search by charge name or click **Add** to choose from a list.
4. Browse the preference lists and select the check boxes next to the charges you want to enter.
5. In the Charges to be Accepted Upon Closing the Section subsection, review the charges you selected and click **Accept Charges** to file them.

If you didn't select any new charges, you can close the Charge Capture section to file charges.

Try it out:

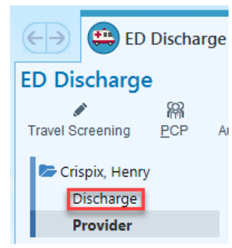
- Check out how many points you've gotten on Henry using the **Facility Charge Calculator** button. Click **Cancel**.
- At the top of Charge Capture, in the Billing Provider field, enter **Adder, Ronnie**.
- Now in **IV Administration** add in two fitting IV charges using the quick buttons.
- Click on the **Accept Charges** button to add them to the FCC.
- Use the **Add** field to search for **wrist brace** and add one to the FCC. (This is not clinically accurate, this is just for a training example)
- Go back to the **ED Narrator** and document a **Cardiac Intervention** (found in the Interventions toolbox on the right side).

- Expand the **Additional Interventions** toolbox and add a **Thermoregulation Intervension** of ice and warm blankets.
- Now go back to **Charge Capture** and see how many points you have. If it seems incorrect, you can use the **Legend** to see how many points something is worth, and edit the number row on the right. For example: **Cardiac Interventions** are 30 points per occurrence.
- Click **Accept** when you feel the charge is complete.
- Close out of Henry's chart and go back to the **ED Manager**.

Discharge a patient from the ED

1. On the **ED Manager**, select the patient you want to discharge and click **Discharge**.
2. Enter the patient's discharge information, including the discharge date, time, disposition, and destination.
3. Click **Discharge**. The patient is discharged and disappears from the ED Map, Track Board, and ED Manager.

Try it out:

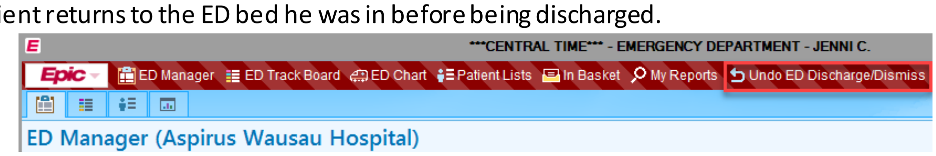


- For **Henry**'s ED Discharge you'll need to enter a Referring Provider: **ron add** and **Tab** for text completion.
- Navigate to **Discharge** on the left.
- Fill out the date (**t**= today) and time (**n**=now)
- The hard stops need to be addressed for disposition and destination. Use the button in each field to see your options and select the appropriate value for home discharge.
- There is no hard stop in the **Discharge diagnoses** field, but you must enter a free text diagnosis here or you will not be able to discharge him.
- Now use the Discharge button in the lower right to send him on his way. Read the warnings, but click **Continue.**
- Back in the ED manager, notice that Henry is gone!

What if I accidentally discharge a patient?

1. In the top toolbar find the **Undo ED Discharge/Dismiss**.
2. In the Undo Discharge window, select the patient.
3. Click **Undo**. The patient returns to the ED bed he was in before being discharged.

Use the steps above to bring **Henry** back to the ED Manager. Read the warnings, but click continue.



Knowledge Check!

Now you're going to arrive a new patient with a shoulder dislocation.

- Enter a name and personal information of your choosing.
- Go through the arrival and triage narrator documenting information in each area with clinical data.

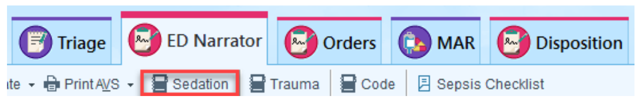
Trainer Check- if you have questions or need assistance ask now!

- Go to **Orders** and search for a non-suggested order set, type: **Blood** and select the order set Aspirus ED Adult Blood Administration.
- Address the hard stop.
- Use the drop down arrows in each section to view available orders. Add a **saline infusion**.

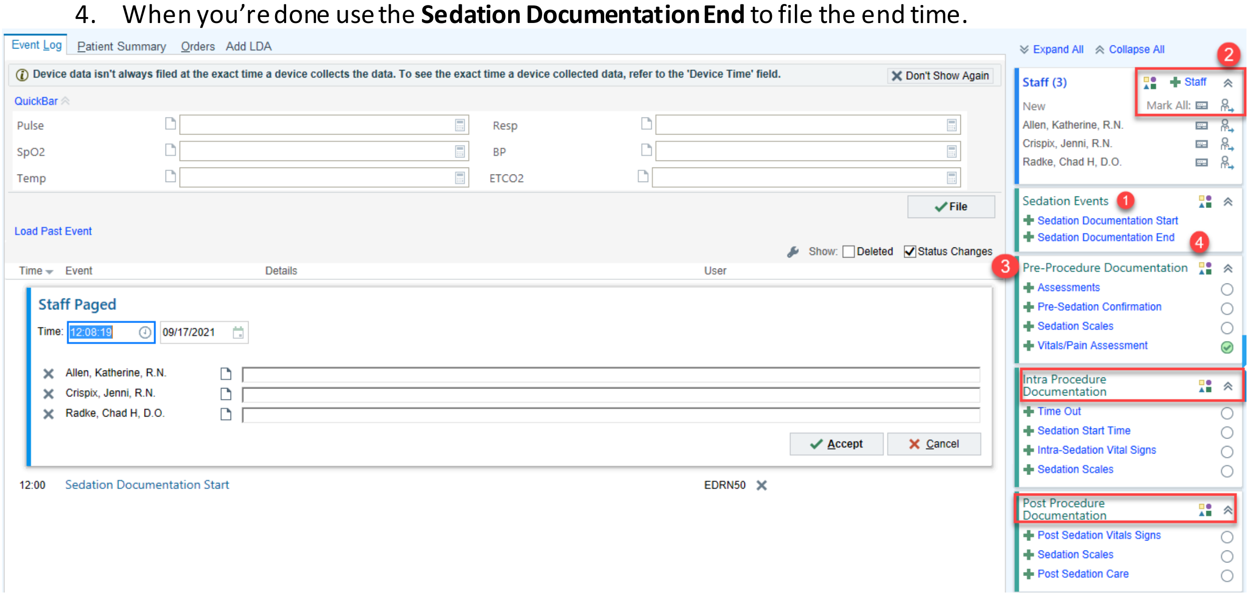
- Back in the **Orders** activity, add a medication from the Quick List and any other orders you'd like.
- Click **Sign** and address hard stops to accept.
- Back in the Narrator, acknowledge orders, add a line via the **Line Placement** toolbox, then administer your medications.
- Pick two assessments in the **Assessments** toolbox to complete on your patient. Don't forget to check your **Row Info**, and make sure you document some exceptions.

Sedation Narrator

We use many narrators in Epic, the workflow for each narrator is similar. You will practice on the Sedation Narrator with your new patient.



- Open the Sedation Narrator on your patient's chart.
  1. Accept the **Sedation Documentation Start** time and page all staff you selected.
  2. Use the arrived button in the Staff toolbox to mark all as arrived.
  3. Go through the narrator documenting the **pre**, **intra** and **post procedure**.
  4. When you're done use the **Sedation Documentation End** to file the end time.



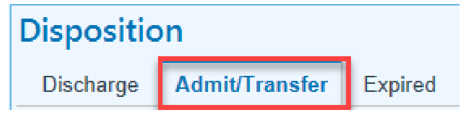
Knowledge Check!

Go back into the **ED Narrator**.

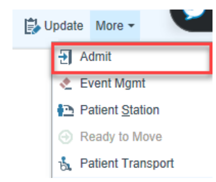
- Complete documentation in the **ER Flowsheets**, **Restraints**, **Patient Education** in the toolboxes on the left.
- Document a **Test or Order Completed**, an **Intervention** and an **Additional Intervention** in the toolboxes on the right.
- Add an ED Note and type: **.shou** to find a SmartText note (.shoulderinjurycv) and **enter** to select, to document a shoulder injury.
- Work through the SmartTools. **F2** will get you through! **Accept** to file your note.

Admit a patient

When a patient will be admitted, go to the **Disposition** activity and use the **Admit/Transfer** tab. Typically the provider will have verbalized whether the patient will be discharged or admitted, and set the appropriate disposition for the patient. When that disposition is set you will see the patient's row on the ED Manager change status (color). Remember, you can hover to discover what the status means, or you can use the legend to see what the status the color change indicates.

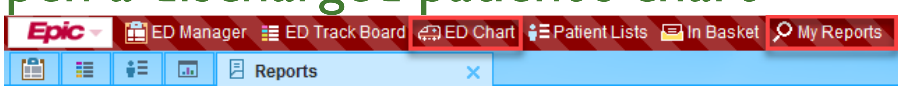


- Open the **Disposition** activity in your new patient's chart.
- Use the **Admit/Transfer** tab to work through the Dispo navigator.
- Open the **Disposition and Follow up** activity, and select **Inpatient**.
- Work through the navigator filling out **Addl Dispo Info**, **Running Infusions** and **Patient Education**.
    - o If the infusions will not continue to run on the floor you will need to stop them and remove the line, if the infusion will continue you do not need to do any additional documentation.
- In the **Care Hand-off** section you will document when and to whom you gave the report.
- **Belongings** is where you will account for all of the patient's belongings and if they will stay with the patient at bedside, be sent home, or be sent to the safe. You will also document if medications were brought to the ED by the patient and if so, that they were indeed sent home or stored safely.
    - o Document a few things here so you can see how different lists populate for each selection you make.
- If there are signed and held orders for your patient (remember: the *admitting* provider would have placed these), you will *see* them in the **Signed and Held Orders: Release Below** section. Do not release these orders, the Inpatient Nurse will release once the patient is on the floor.
- When the patient is leaving the ED, on the **ED Manager** click, drag and drop your patient into the **Off The Floor/Off Unit** area.



- In the toolbar click **More** to find the **Admit** button.
- In the **ED Encounter** section of the Admit Narrator fill in hard stop areas. You will also need to **Edit Providers** and add a provider.
- In the **Transfer** section address the hard stops, and select a room.
- To complete documentation use the Transfer button, **continue** through the warnings that come up.

Open a discharged patient's chart



- If you remember the name, or they're a recent patient you can use **ED Chart** to search for them or to view your recent patients.
- If you don't remember the name you can find patients using the **My Reports** activity.
    - o Use the **Library** and search for **ED My Patients**. Click on the report for your context location and click Run to view it.
    - o To save a report to the **My Reports** section use the star to make it a favorite.

    - o When the report opens you can click on the patient to view a summary of the ED visit.
    - o To open a patient's chart, select the patient and click **ED Chart**.

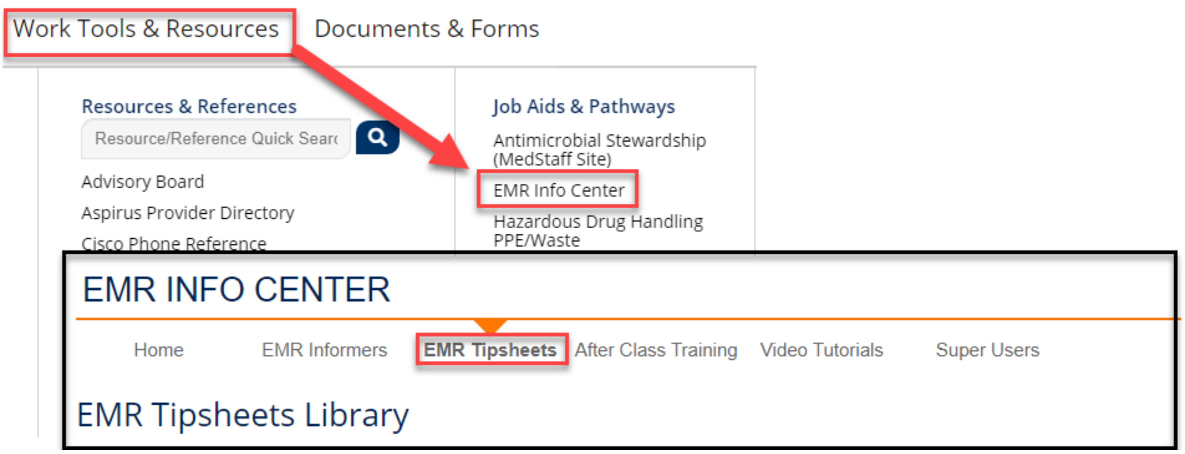
If you have incomplete documentation on a patient's chart you will get messages in your **In Basket** that will direct you on what is missing. Those messages will often open the patient chart for you, if the documentation calls for it.

FYI:

Use this section to try out other workflows and learn more about what you can do in Epic, and what Epic can do for you.

In addition to this section you can find much more information on the Aspirus Intranet, including a wealth of Tip Sheets to help guide you through issues or less common workflows.

On the Intranet, hover over Work Tools & Resources to get the dropdown menu, and select **EMR Info Center**. There you will find the Tip Sheets to search through, as well as other information to help you navigate Epic.



Arrive an anonymous patient

Arrive a patient as an anonymous patient if he can't identify himself. For example, arrive a patient as anonymous if the patient is unconscious without identification or family members to identify him.

1. Click **Arrival**.
2. In the Patient Lookup window, enter the patient's sex.
3. Select the **Anonymous** check box. The New button becomes available.
4. Click **New**. The Expect Navigator opens.
5. Enter the patient's arrival information in the Arrival Info section.

Indicate an expected arrival

If you know a patient is heading to the ED, indicate that he is expected.

1. Click **Arrival**.
2. Enter the patient's information, and click **Accept**. The Expect Navigator opens.
3. Open the **Arrival Info** section, enter an expected date, time, and any other information you know.
4. Click ✔ **Close**. The patient appears in the Expected care area in the ED Map and ED Manager.
5. To indicate that an expected patient has arrived, drag and drop the patient from the Expected care area to the Waiting care area or to the bed you held for them.

Indicate the expected arrival of a patient whose identity is temporarily unknown

In some cases, you'll need to document on an expected patient whose information is temporarily unknown. For example, the patient is en route and EMS know the identity but can't communicate it over the radio. However, you need to start pre-arrival documentation of the interventions done thus far by EMS. Once the patient arrives at the ED, you'll either reconcile the temporary patient record with the patient's actual record, create a new patient record if the patient hasn't been seen at your organization before, or mark the patient as anonymous if you're still unable to determine her name.

1. Click **Arrival**.
2. Enter as much information as you know about the patient, including age and sex.
   a. If you don't know the patient's SSN, enter 222-222-2222
3. Select the **Temporary** check box.
4. To create an ED encounter for the patient, click **New**. The patient appears in the Expected care area, and the Temporary Patient Navigator opens.
5. In the Temporary Patient Navigator, enter as much information about the expected arrival as you can.

> **!** Note that the patient cannot be arrived or roomed and orders can't be acted on until a registrar or nurse identifies the patient using the **Identify Pt** button from the Track Board or ED Manager.

Identify and merge temporary patients

When an expected, temporary patient arrives to the ED, you can either merge the temporary patient record with a real patient record or mark the patient as anonymous. After you identify the patient or mark them as anonymous, you can room them and act on orders for them.

Identify a patient as anonymous

1. Select the temporary patient's row on the Track Board and click **Identify Pt** on the Track Board toolbar.
2. Click **Identify as Anonymous**.

Identify a patient whose identity is known

If you know a patient's identity, search for a matching record in your system first. If one exists, merge the temporary record with the existing record. If there's no matching record, create a new patient record.

1. Select the temporary patient's row on the Track Board and click **Identify Pt** on the Track Board toolbar.
2. Click **Attempt to Merge**.
3. If the patient's identity matches an existing record in your system, select the existing record. Otherwise, jump to step 4.
   a. Review the temporary patient information in the Source Patient column with the known patient's information in the Target Patient column. The Merge Result column shows what the demographics for the Target Patient will be after the merge is complete.
   b. Select an appropriate merge reason and add a comment.
   c. Click **Merge**. Click **Merge** again to confirm merging the Source and Target patients.
      i. If there are differences between the Source and Target Patient demographics, you receive a warning to review the differences before continuing. To continue past the warning, click **Merge**.
   d. Click **Continue** when the merge status is complete.

4. If the patient's identity doesn't match an existing record in your system, click **Cancel** and then contact the registration team to have them create a new patient record using the patient's identifying information.
5. After you've merged with an existing record, the temporary patient row on the Track Board updates to show the patient's name.

!	If you need to change the Target Patient demographics, talk to the registration staff.

Hold a bed

If necessary, you can hold a bed for an expected patient, making sure that it's saved until he arrives. Mark a bed as held directly from the ED Manager or ED Map, or hold a bed while documenting an expected patient.

Hold a bed from the ED Manager or ED Map

1. Find an empty bed in an appropriate care area for the patient's condition.
2. Right-click the empty bed and select **Hold**.
3. In the Bed Hold window, enter the expected date, time, and any other information you know.
4. Click **Accept**.

The bed row changes color on the ED Map and ED Manager to reflect the held bed status.
In the ED Map, the comment you entered appears in the bed.
To view the information in the ED Manager, hover your mouse over that row.

Hold a bed while documenting an expected patient

1. In the **Arrival Info** section of the Expect Navigator, use the **Held room** and **Held bed** fields to reserve space for an incoming patient.

The bed row changes color on the ED Map and ED Manager to reflect the held bed status.

Dismiss a patient who leaves without being seen

1. In the ED Map, ED Manager, or Track Board, click the patient's row or card in the Waiting or Expected area.
2. Click ✖ **Dismiss**.
3. Enter the departure date and time.
4. Choose a disposition.
   a. Optionally, add a comment about why the patient left without being seen.
5. Click **Dismiss**. The patient has been dismissed and disappears from the ED Map, Track Board, and ED Manager.

What if I assign a patient to the wrong bed?

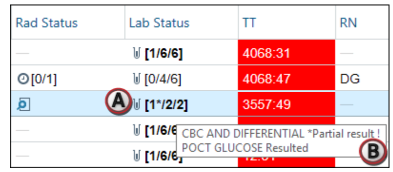
In the **ED Manager**, select the patient in the wrong bed and drag and drop him to the right bed. Or follow these steps to move the patient back to the Waiting care area if the patient was roomed in error:

1. In the ED Map or ED Manager, select your patient and drag him back to the Waiting care area. The Move Patient to Waiting Room window appears.
2. Select the **Patient roomed in error** checkbox.
3. Select **Restore patient to Waiting**.

4. Under Change patient status to, select an appropriate status for the patient, such as **Waiting for Room**.
5. Click **Accept**. The patient appears in the Waiting care area.

See if lab and imaging results are available

1. To check the status of lab and imaging results, look at the **Lab Status** and **Rad Status** columns on the Track Board.
2. The numbers in the column indicate how many labs or imaging studies have been resulted, how many are expected to be resulted during the encounter, and how many were ordered. An asterisk in the Lab Status column indicates that part of a panel order has been resulted.
3. For example, [1*/2/2] (A) means:
4. Two labs were ordered
5. Both are expected to be resulted this encounter
6. One order has been resulted and part of a panel order has been resulted
7. When you hover over the status cell, you can see which images or labs were ordered and whether a result is abnormal or critical (B). Abnormal and critical results are marked in the tooltip with an exclamation point or a double exclamation point, respectively.



Understand locked chart messages

1. To prevent you and your colleagues from double-documenting on a patient, the system locks parts of a patient's chart when you're documenting certain clinical information. For example, when you're documenting allergies, other clinicians can't document on that patient's allergies. When part of a chart is locked, you can still see that part of the chart and document in other parts.
2. To avoid locking the chart for other users, leave clinical documentation items when you're not actively documenting in them.
3. When a chart is locked, a message appears telling you that you can't document in that part of the chart.

Most chart lock situations are intuitive, like the allergies example above, but this one is less obvious: When someone is editing a patient's problem list, no one can edit that patient's allergies.

If your computer terminates unexpectedly when you're documenting in a chart, contact the help desk to unlock the chart for other users.

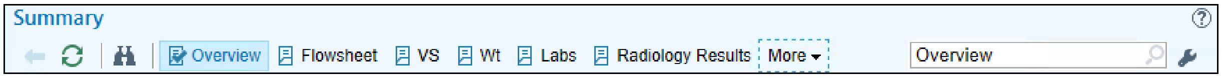
Review past visits

1. In a patient's chart, select the **Chart Review** activity tab. The first tab, **SnapShot**, is a collection of useful reports and links to information in the patient's chart.
2. The **Encounters** tab shows the patient's prior admissions, office visits, and ED visits, if any exist. The most recent encounter appears at the top.
3. Click the encounter you want to view. Details appear at the bottom of the screen. If they don't, click **Preview**.
4. Select another tab, such as Labs, to review other information like the patient's test results.

Click **Filters** to narrow down the information you see. The filter options and criteria you see are based on the information in a patient's chart, so they vary by patient.

Personalize your report toolbar

You can modify the report toolbar by adding or removing buttons, or by changing the order of the buttons or giving them new names. The report toolbar appears in many activities, such as Patient Lists and Summary, and looks something like this:



1. Click and select the reports that you want to appear as toolbar buttons.

Click Add Current to quickly add the report you are viewing.

2. Enter short display names (button names) so more buttons can fit on the toolbar.
3. Click the arrows (and) to change the button order. The first report will appear as a button on the left side of the toolbar.
4. Click **Accept**. The report buttons appear on the toolbar.

Pull a med on override before an order has been entered

If the order for a medication hasn't been entered into Epic yet, the med doesn't appear on the patient's automatic dispensing station (ADS) profile. If the patient needs the med STAT and you can't wait for the order to be entered, you can pull the med on override from the ADS and administer it. After the med has been administered, the order must be entered and you need to link the administration to the order.

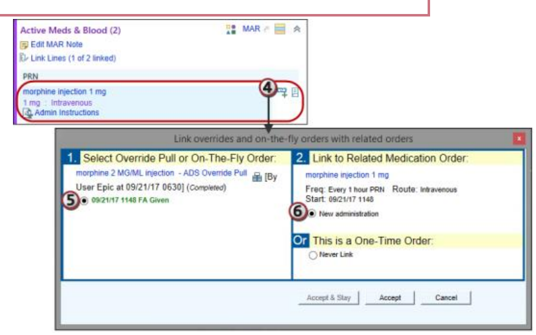
!	Pull the med from the ADS only for standing protocol orders or for verbal or telephone orders from the ordering provider.

1. Pull the med on override from the ADS, choosing the exact drug, form, and concentration from the provider's verbal order or the per protocol order. A brightly colored override pull row appears in the Active Meds & Blood toolbox on the ED Narrator.
2. Select the override pull row in the Active Meds & Blood toolbox and document medication administration as usual.

After you administer the medication, an order for the med must be signed. In most cases, the provider enters the order. If necessary, you might also enter the order using the telephone with readback or verbal with readback order mode.

After the order has been signed, link it to the med you administered.

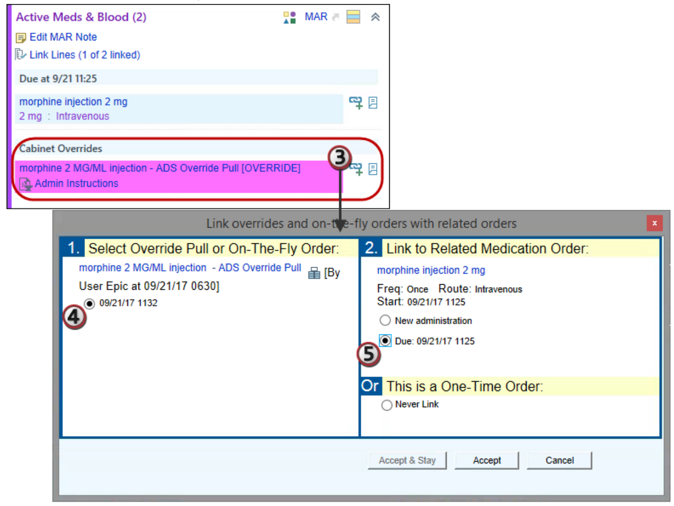
!	The order must exactly match the med you gave. If the order doesn't match, you won't be able to link the override pull to the order.



3. Find the medication order in the Active Meds & Blood toolbox.
4. Click .
5. On the left, select the med you pulled on override.
6. On the right, select the due time for the order that was just entered. If there is no due time, select New administration.
7. Click **Accept**. The order is now linked to the override pull in the system.

Pull a med on override when it hasn't been verified

If the order for a medication hasn't been verified yet, that med doesn't appear on the patient's automatic dispensing station (ADS) profile. If the patient needs the med STAT and you can't wait for verification, you can pull the med from the ADS on override, link the med to the correct order, and administer the med.



1. Pull the med on override from the ADS. Choose the exact drug, form, and concentration from the original order.
2. Find the medication override pull in the Active Meds & Blood toolbox on the ED Narrator.
3. Click .
4. On the left, select the med you pulled on override.
5. On the right, select the scheduled administration of the original order and click **Accept**. The override pull is now linked to the order in the system.
6. Administer and document the med as usual on the ED Narrator. An icon appears in the administration window when you document administration details.

- If there isn't a **Link to related order** link, the product you pulled doesn't match the product that was ordered. If you pulled the wrong product, return it to the machine and then pull the correct product.
- If the provider ordered the incorrect product, either you or the provider needs to discontinue the order and place the correct order. See the Orders guide for information on how to place orders.

Send a message to pharmacy

Send a message

1. In the MAR, click next to the med.
2. Indicate why you're sending the message, and then enter your message.
3. Click **Send**. The message is sent to the pharmacy.

When the pharmacy replies to your message, the icon turns to 1. The number in the bubble indicates the number of unread messages.

To send a patient message that is not medication-specific or to see a list of sent messages, click **Messages**. All messages sent in the past 12 hours appear in the message window.

View replies

When you receive a response from the pharmacy, a 1 icon appears in the **Messages** button on the MAR toolbar. If you sent the message about a specific medication, the icon also appears in that medication's row on the MAR.

1. Click 1 to read the reply from the pharmacy and see the message history.
2. Click the **Mark as read** link or the **Mark all as read** link. The 1 icons show updated numbers of unread messages. If all messages are marked as read, the icons disappear from the MAR.

ⓘ	Click **Mark as unread** when you've read a response that you want other nurses to review as well, like when a shift change is coming up.

ⓘ	See when the pharmacy responds and read messages without opening the patient's chart. In Patient Lists, the 1 icon appears in the **New Messages** column, and messages appear in the Rx Med Messages report.