Soarian Clinicals for ED

February 2017

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CONFIDENTIALITY, PRIVACY AND SECURITY ISSUES

Working in an electronic world creates new challenges for all of us in the healthcare field. Every employee at Lake Health signs a privacy agreement stating their agreement to the privacy regulations set forth by HIPAA and LAKE HEALTH guidelines. If you are not sure of the proper way to handle a particular situation, ask your supervisor or call the Compliance Hotline at extension 41121. Remember that protected health information applies whether the information is on paper, spoken or is in an electronic format.

- **All team members are required annually to review "Lake Health's Privacy and Security Agreement" and acknowledge that you understand them, either by signing a hard copy or by verifying you have reviewed them online.**
- **Inappropriate access of HIPAA information under a team member's identification can result in termination of the team member whose identification allowed the access.**
- **Soarian provides a wide gateway to patient information of many areas and patient information. Access to information however is based solely and limited to need, function or scope of work specific to your caseload of patients/census. HIPAA Privacy rules require specific patient's authorization for access to any information outside the scope of the responsibility assigned in relation to treatment, payment or healthcare operations.**
- **Protected healthcare information (PHI) should not be sent via e-mail unless it is protected by encryption (special password-protected software). LAKE HEALTH does utilize such a system.**
- **PHI is not the only information that should not be communicated through e-mail. Username and passwords are not to be sent via e-mail. The only secure way to transmit this information is by telephone or in face-to-face communication.**
- EDIS will provide team members access to the other two Emergency Department tracking boards
    - User should not toggle between the three tracking boards without a legitimate reason
    - IT Security will be monitoring activity for violations
- **Keep in mind that e-mails are transmitted as plain text so anyone along the way can view this information. Think of e-mail having the same type of security as a postcard would.**
- **Do not open suspicious attachments in your personal or work email.**
- **Do not right click to use the print function anywhere in Soarian. The information will print, but it will not include any identifying patient information (name, medical record number or account number). Always use the proper print function to print anything on Soarian.**
- **The ID badge is part of the team member identity and must be protected in a manner similar to the protection of a password for a clinical or financial system. Allowing someone to use your credentials (badge, password) is not allowed.**
- **It is against Lake Health policy and in some instances against the law to share an ID badge to gain entry to locked doors, medication ordering, or for single sign-on purposes.**
- **Proper log-off security protects patient information and prevents unauthorized actions under the wrong person's identity.**
- **You are responsible for what happens under your credentials (badge, password). Team members will be held responsible and accountable for all entries made and all retrieval accessed under their sign-on, even if such action was made by another person due to your negligence.**
- **Information Technologies conducts random "appropriateness of access" audits across all of our clinical systems as a proactive compliance measure. Any unauthorized access will be referred to the Lake Health compliance department for further action.**
- **Minimize non-work internet browsing on corporate devices at all times.**
- **Do not install software or change computer settings without authorization.**
- **Violating our privacy policies and procedures can result in termination of the individual.**

Using Single Sign On

1. **Tap Ctrl-alt-del** keys to lock the computer
2. **Tap your Employee ID badge** on the Proximity card reader.
3. **Type your employee ID** in the user name box
4. **Enter your Active Directory password** in the password box. (May need to create a new password.)

5. To lock the workstation, tap your badge on the prox card reader, **CTRL-ALT-DEL + ENTER**, or **press the windows key on your keyboard+ L**.

ALWAYS HAVE YOUR BADGE WHEN WORKING; YOU WILL NOT BE ABLE TO WORK WITHOUT IT.

IMPORTANT!!
BEFORE YOU WALK AWAY FROM YOUR COMPUTER YOU MUST MAKE SURE IT IS LOCKED. PRESS CTRL + ALT+ DEL THEN ENTER.

BEFORE YOU START USING ANY COMPUTER MAKE SURE THE LAST USER LOCKED IT. IF YOU DO NOT SEE A LOG IN SCREEN, PRESS CTRL + ALT+ DEL THEN ENTER TO LOCK THE COMPUTER. THEN UNLOCK IT AND LOG IN AS USUAL.

LOG ON AND OFF THE SOARIAN APPLICATION

To Log on to Soarian, click the icon on your desktop. SSO will log you in automatically. You will not know your Soarian password.

Read the **Hospital Disclaimer** carefully; so that you do not see this box again, click the check box in the left lower corner (**Don't show this again**). You must sign off that you agree with the disclaimer in order to be permitted access to Soarian. Click **I Agree** in the right lower corner of the box.

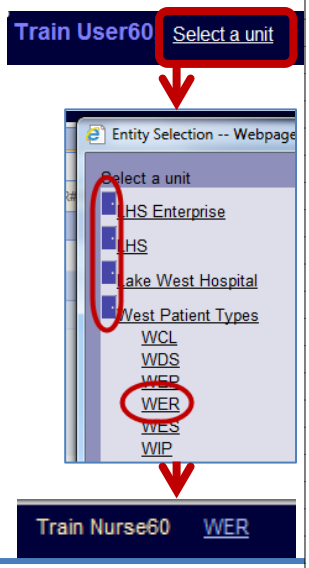
To Log out of Soarian, click the **Log off** button located in the upper right corner of the screen.

HEALTHCARE UNIT (HCU)

When you first log on, there will be a link next to your name to **Select a unit**. <u>You will not be able to obtain your census or chart information without first selecting your HCU.</u> You will only need to change this if/when you float to another facility.

To make your Healthcare Unit (HCU) selection:

1. Click on the Healthcare Unit link displayed next to your name on the Census screen (or click the link **Select a unit**).
2. Select the blue door next to **LHS**.
3. Select your **location** (Lake West, Madison Medical Campus or Tripoint).
4. Click the blue door next to West (or Madison or Tripoint) **Patient Types.**
5. Select the Patient Type (WER, MER, IER). Click **OK**.

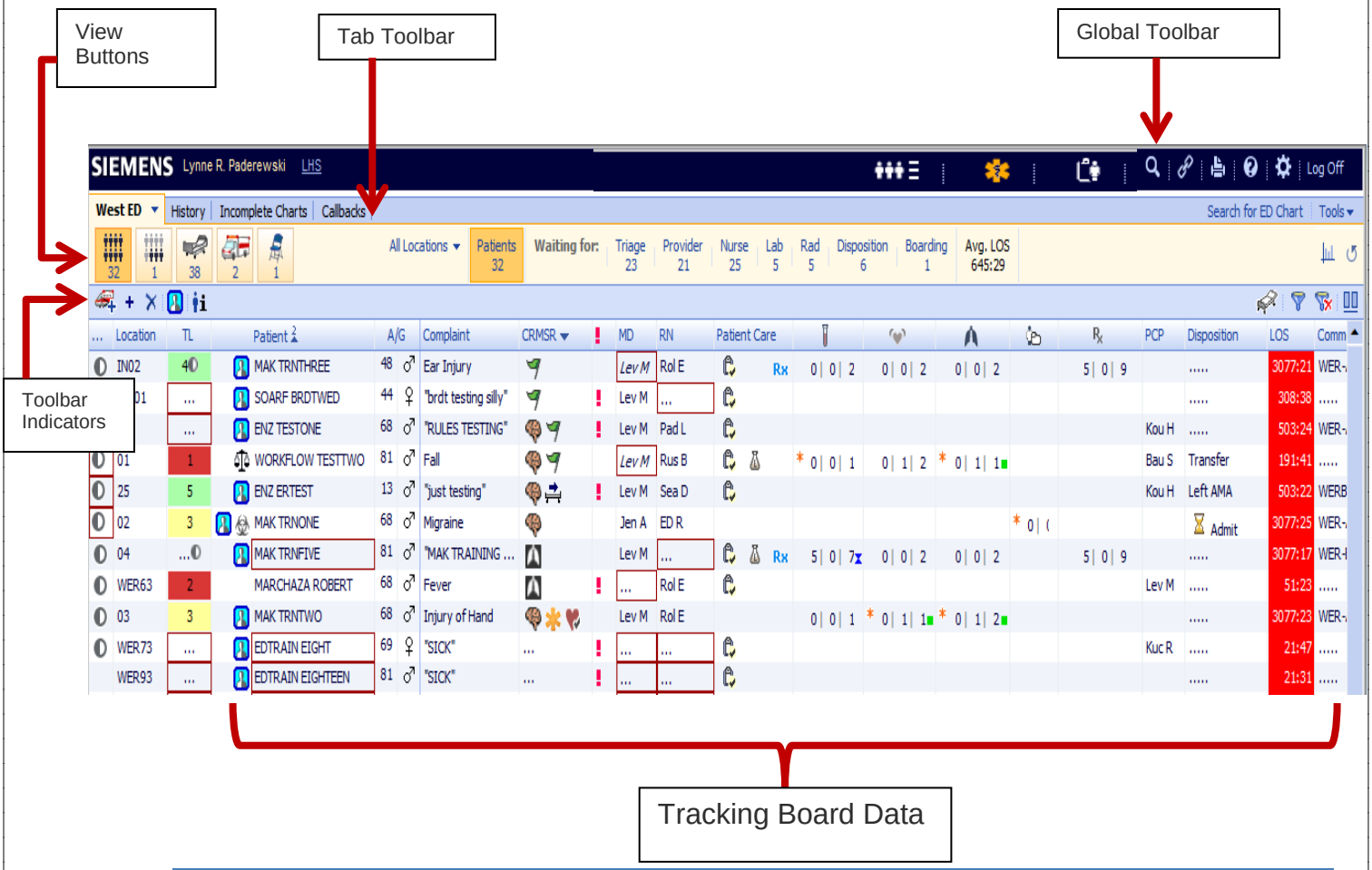


EDIS TRACKING BOARD

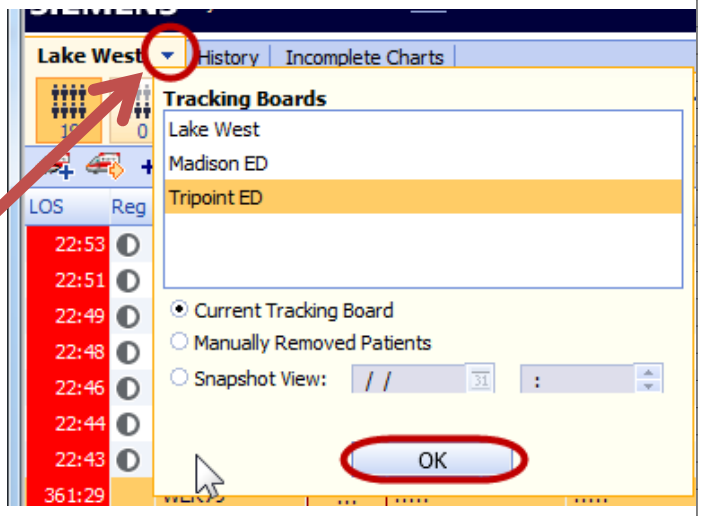
The Emergency Department Information System tracking board is the central hub of the emergency department, providing a quick snapshot of the ED operations, as well as the key indicators for each patient. At a glance, ED staff can see the number of patients in the department, their patients, in waiting room, and open beds.

The ED Tracking Board is the first screen the user will see when first logging into Soarian. Each user will have the tracking board default to their home department if the user works at West the tracking board will default to the West tracking board. If a team member floats to another emergency department the user will need to change the tracking board manually.

ANATOMY OF THE ED TRACKING BOARD



TAB TOOLBAR



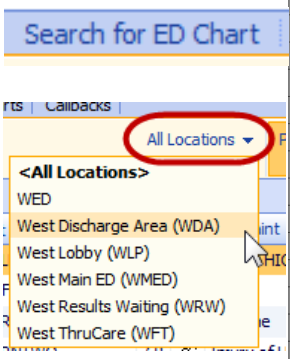
The view for each user will default to their home base. If you float to another location, you will need to manually change our Tracking Board view. Use the tab toolbar to toggle between ED Tracking Board locations. Click the pulldown arrow, select the ED (Tripoint, Madison, West), then click **OK**.

The **History** tab displays patients who had been on the tracking board during a specific time period. You can get a snapshot of a TB from a specific date/time.

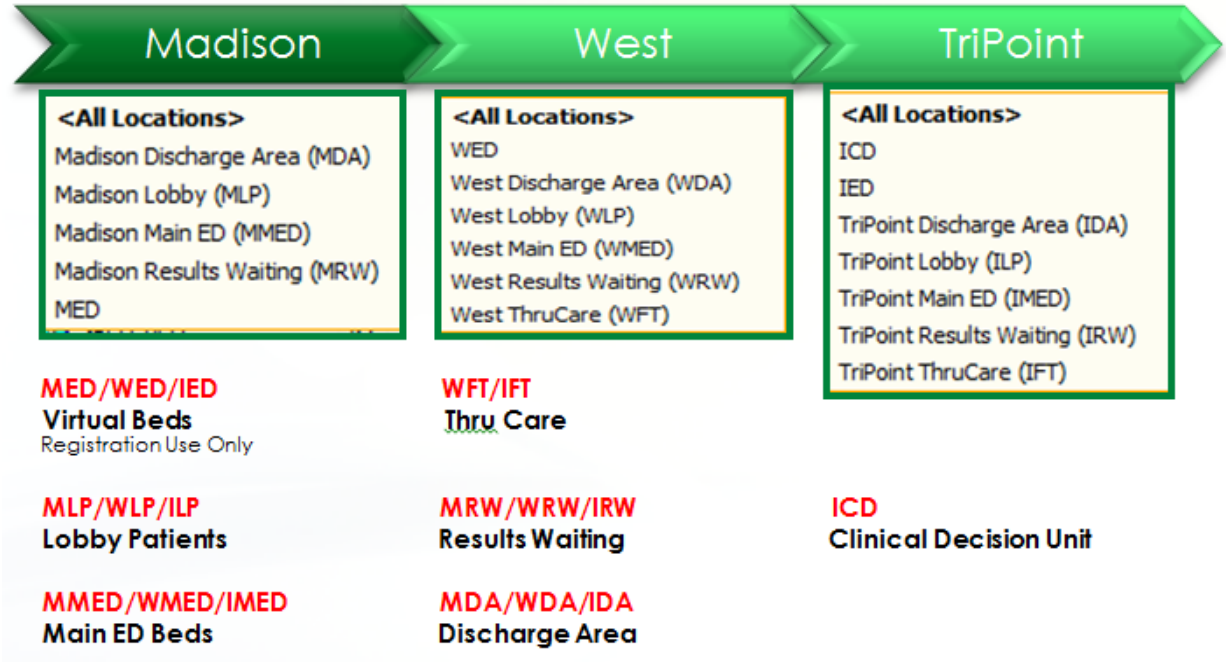
The **Incomplete Charts** tab displays incomplete documentation; these items need to be completed prior to the final chart completion. This list is specific to the EDTB view that you are

currently on. If you work in more than one ED, you must check the Incomplete Charts list for each location (West, TriPoint, Madison).

The **Search for ED Chart** tab is located on the far right side of the Tab Toolbar. Click on this tab to locate a patient's ED visit and access to the ED chart.



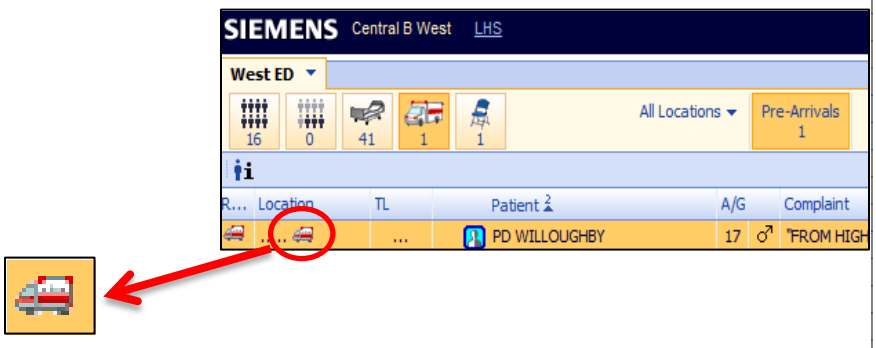
Once you have selected the EDTB for your location, you can filter which area within the ED you wish to see. On the View Buttons toolbar, use the pull down for **All Locations**. You can then select the particular location you wish to view, such as Lobby, Discharge Area, or Main ED. The location WED or IED are used by registration when assigning a "ghost" bed to a new patient.



CENTRAL TRACKING BOARD

The Central Tracking Board is a dedicated tracking board for EMS. It is view only, meaning no information gets entered directly onto the Central TB.

The display will show the squad name/city, and squad number. Once the patient is registered, it will show only the first three letters of the patient's last name.



Rooms reserved for EMS arrival displays on the Central TB with an ambulance icon. You will see the squad name, city and number, and the first three letters of the patient's last name to protect the patient's privacy.

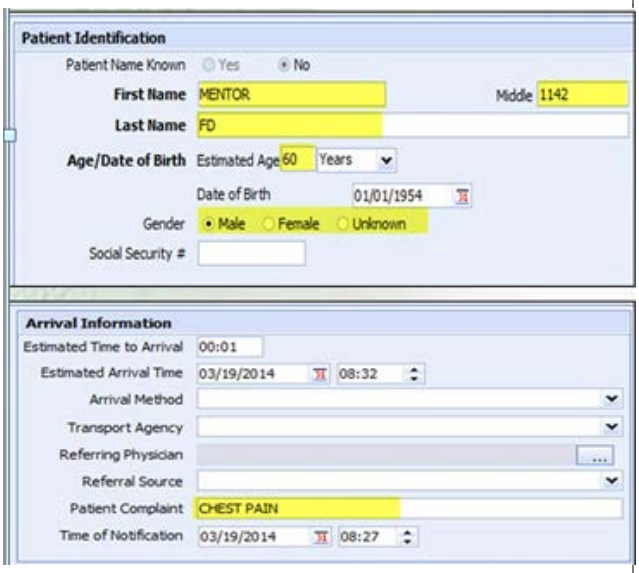
EMS PRE-ARRIVAL

The Add Pre-Arrival function allows the ED to create a pending patient and reserve a bed on the ED Tracking Board. A pre-arrival can be entered at any PC or WOW. The Central TB is view only; you will not be able to launch any documentation from this view.

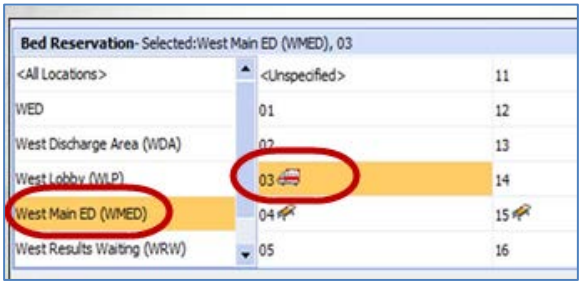
If you want to filter just the EMS arrivals, click the Pre-Arrivals filter on the View toolbar.

1. Click the Add Pre-Arrival icon from the toolbar.

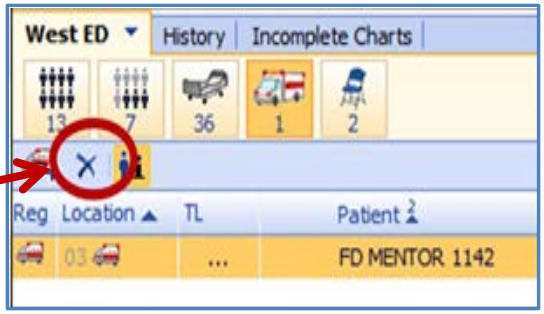
2. Complete the Patient Identification information.
    a. First Name = City of EMS
    b. Middle Name = Unit number
    c. Last Name – FD, Amb or PD
    d. Enter patients age and gender if known
    e. Enter patient's complaint in the Complaint field.



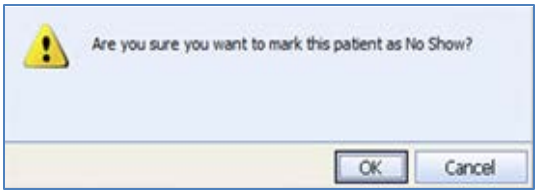
3. Select the location within the ED, Main ED or Thru Care.



4. When the patient arrives, the registrar assigns the patient a bed. The registrar will then remove the pre-arrival reservation as follows:

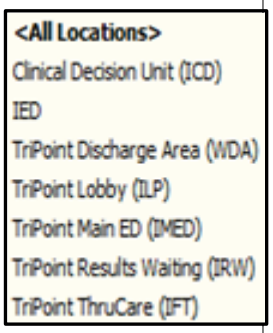


   a. Select Pre-Arrival entry on tracking board (row will be highlighted)
   b. Click X on the tool bar



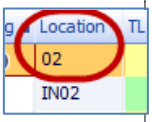
   c. An Alert box will display
   d. Select OK

UPDATING PATIENT LOCATION

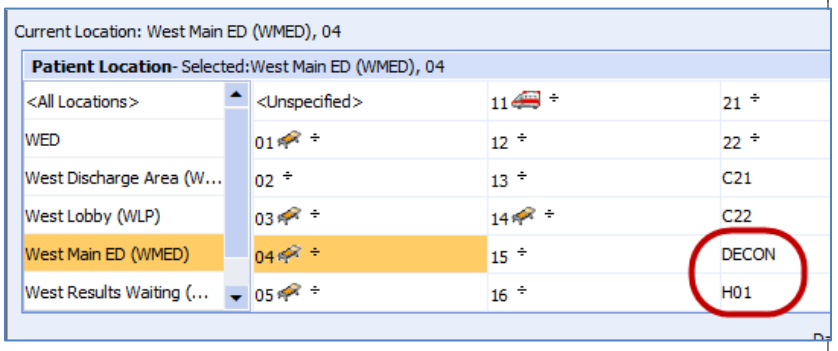


When a patient is registered, the registrar will assign a virtual bed location to the patient. This does not correlate to a physical bed. The **facility location** will be indicated by the prefix for the ED followed by ED (WED, IED). The **bed label** will be the prefix for the ED, followed by ER (WER, IER). Once the patient has a quick triage completed, the registrar will move the patient to an actual bed. If the patient is in the triage office at the time of registration, the patient will be placed in the lobby. As the patient moves throughout the ED, staff will need to be able to change the patient location on the tracking board as necessary.

To move a patient from one location to another, click the patient's current location on the EDTB.

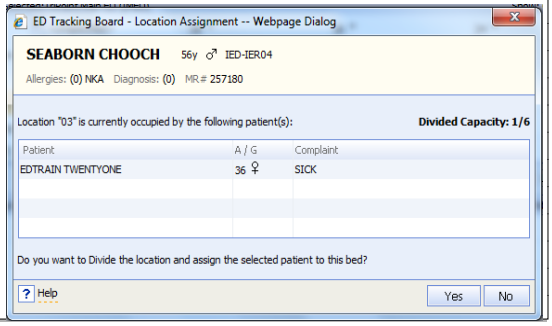


The Patient Location dialog box will open. On the right side of the window, select the location. On the left side, select the room/bed number. Rooms already occupied will have a bed icon next to the room number. The ambulance icon means the room is reserved for EMS arrival.



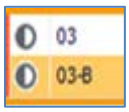
The Main ED included the Decontamination Room (DECON) and Hall Beds (indicated with "H"); the number on the Hall Bed id the number of the closest room.

The division sign ÷ indicates the room can be split, allowing for multiple patients to occupy the same room, such as a mother and her child. Each of these rooms has the capacity of 6 patients assigned to that one bed. When the user attempts to assign the second patient to



the room the dialog box will display identifying the room is occupied. The user will need to confirm they want to divide the bed.

The room number for the second person will display as B bed.

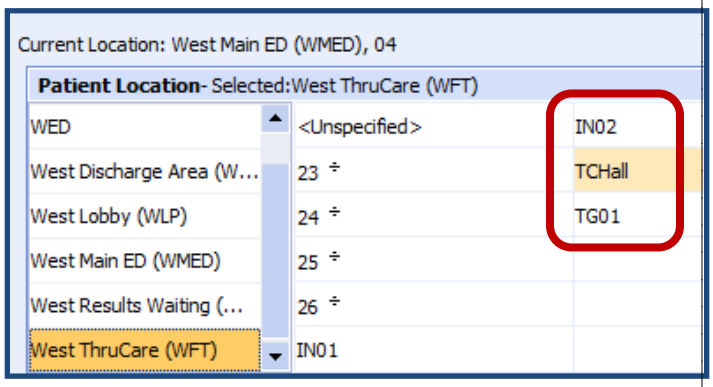


Additionally, in ThruCare location:

IN indicates the intake rooms at West and Tripoint used with the Physician First initiative.

TC indicated ThruCare at West and Tripoint.

TG is the Triage office.



Results Waiting Room – used for the lower acuity patients whom after initiation of care can return to the waiting room for results and disposition. The ED tracking board's designated location for the result waiting is RW. The nurse is able to use MAK to medicate patients in the result waiting area. E-prescriptions and discharge instructions will print to a designated printer in the Thru Care area.

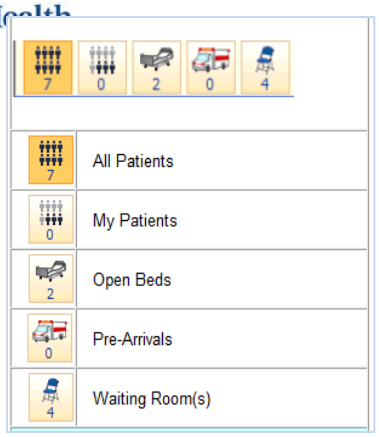
Discharge Area -The patient remains on the tracking board until the patient is discharged from STAR by the Support Assistant. Since the STAR discharge process may be delayed the **Discharge Area** was developed to allow the ED staff to move the patient from the assigned room in order to maintain accuracy of the tracking board.

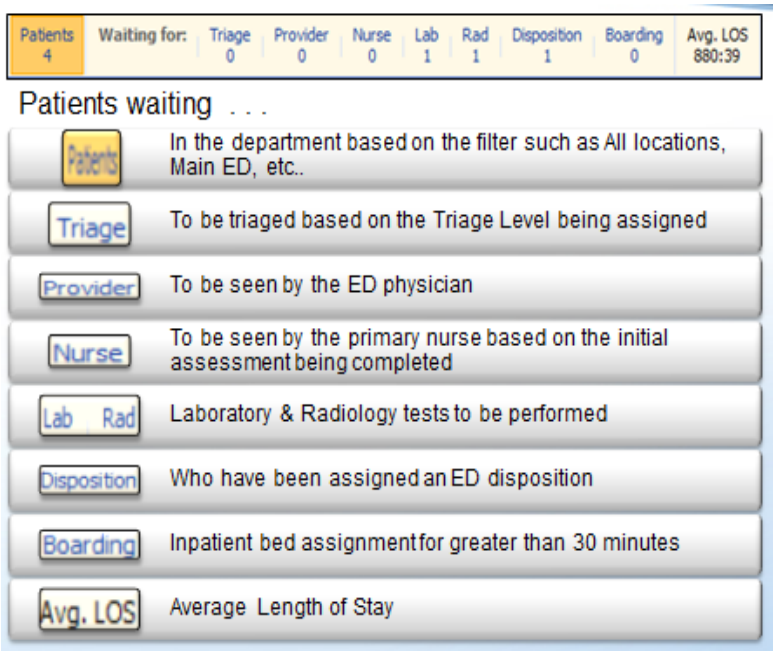
The patient should not be moved to the Discharge Area until the patient has been discharged and has left the department. By moving the patient to the discharge area the user will automatically cancels all orders in Soarian and MAK. The users will be able to complete documentation after the patient has been moved.

VIEW BUTTONS

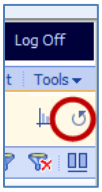
The View Button Bar provides the user with important statistical information of the current state within the department. The user will be able to quickly identify the number of patients in the ED, waiting room and anticipated arrivals.

Each button allows the user to filter the tracking board to create a unique view of the board only displaying patients for that category.



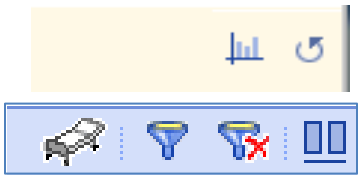


On the far right side of the toolbar is a refresh button. While the tracking board refreshed itself every minute, you many need to occasionally manually refresh the board.



TOOLBAR INDICATORS

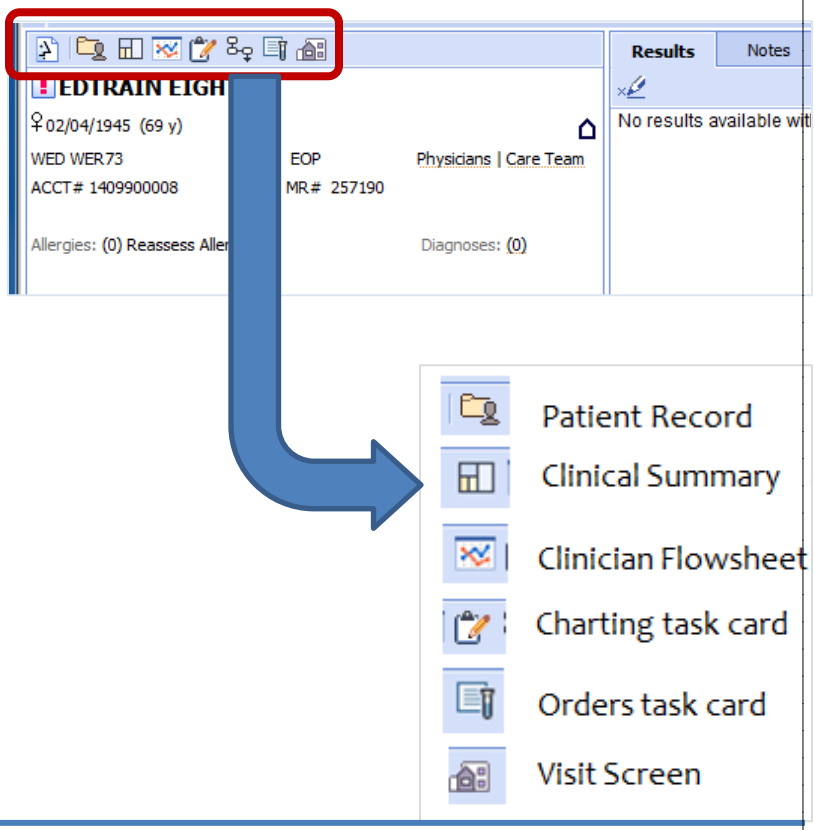
(Located below the View Buttons)



Toolbar Indicators	
	Add Pre- Arrival
	Not to be used at this time
+	Not to be used at this time
✕	Remove Patient from Board
	Not to be used at this time
	Add / Remove Similar Name Indicator
	Show / Hide Patient Specific Information

Toolbar Indicators	
	Show / Hide Open Beds
	Show / Hide Filter Row
	Clear Filters
	Refresh Board Manually
	Display Statistics
	Split Screen View

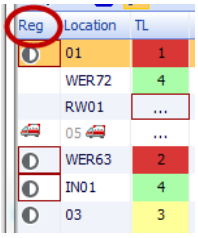
To see Patient Specific information, click on the patient's name on the tracking board. Click on the Show/Hide Patient Specific Information icon. The information displays in the lower half of your screen, next to the Results/Notes display.



COLUMN HEADERS

Registration

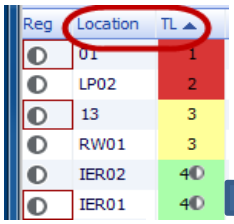
You can view registration status at a glance on the Registration (Reg) column.



Registration Indicators	
○	Needs Registration
◐	Quick Registration
🚗	Pre-arrival
<Blank>	Full Registration
▭	leaving Unit w/o Full Registration

Triage Level

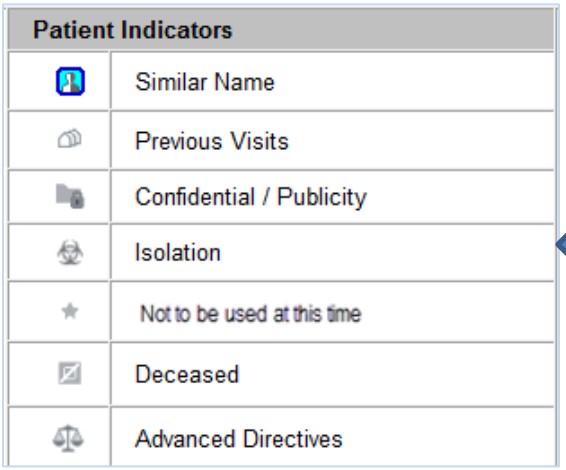
Triage Level (Emergency Severity Index)	Red	ESI 1 & 2
	Yellow	ESI 3
	Green	ESI 4 & 5

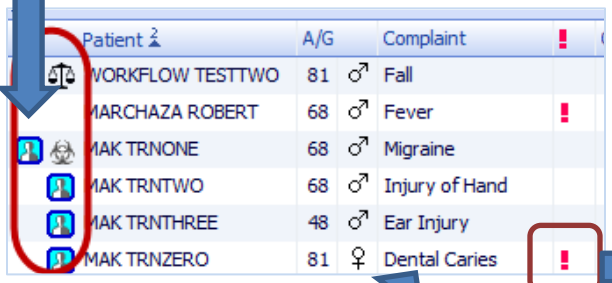


Triage Indictors	
<Blank>	Needs Triage
◐	Triage Started

PATIENT INDICATORS

Similar name indicator can be turned on or off at the user's discretion.

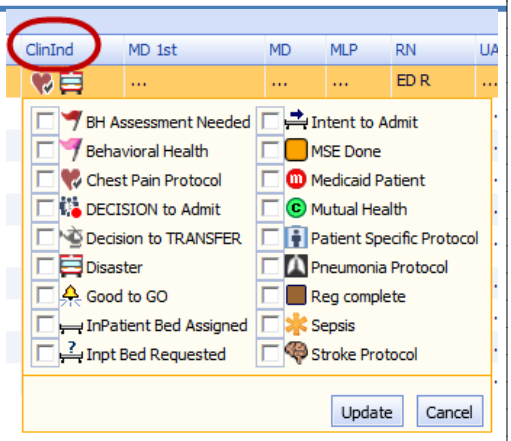




The patient's complaint will fill forward from STAR registration, and will appear in quotes. If free texting do not use any special characters. Once the triage has been documented, the complaint will replace the STAR complaint without

Patient Alerts icon displays when there is something that needs your attention, such as a reminder that home meds have not yet been collected or there is an order for a physician consult. Click on the icon to view the alert details. Clicking on the alert icon will open the alert, so you can read the details and enter a clinical note as needed. When you see a physician consult has been ordered, the nurse is to contact the consulting physician, and can then write a clinical notes in the alerts area indicating the phone call had been made.

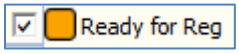
CLINICAL INDICATORS



ClinInd include Core Measure indicators. These icons appear when the user triggers a Core Measure protocol from the nursing documentation. Manually checking a Core Measure will also trigger an assessment to the nurse's worklist.

Some indicators are used to identify the admission process and other patient conditions. The bed icons are driven from the admission orders. Bed Requested will be checked from the completed Admission order. Bed Assigned will be checked from the completed Bed Assignment Received order.

The  icon indicates the need for a pre-certification from Kaiser insurance or the V.A.

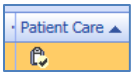
The 

icon, when checked, indicates the Medical Screening Exam has

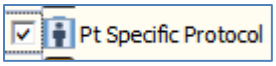
been completed by the physician and the registrar can then complete the registration. The registrar will remove the check mark when done.

If a consent form is not signed at the time of registration, the registrar is to add the appropriate clinical indicator for Unsigned Consent. Once the consent is signed, the registrar will remove the icon.

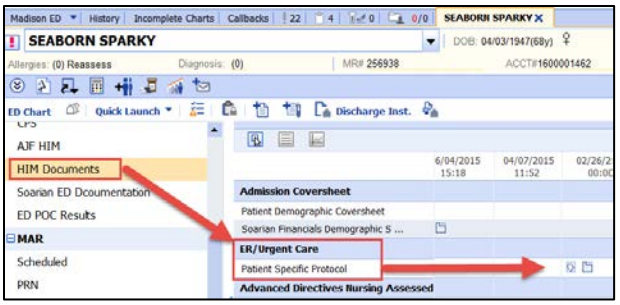
When you see the Sepsis alert, that is an indication your patient has met at least two SIRS criteria. The ED Sepsis Sreening assessment will be on your Patient Care worklist for you to complete.



In collaboration with Case Management, Primary Care Providers and Lake Health Specialist the Department of Emergency Medicine has developed a patient-centered plan to better care for patients who make frequent trips to the emergency department, have repeated inpatient hospital stays, or require a specific plan of care due to their medical condition. These individuals will have patient specific protocol developed by a multi-disciplinary team to ensure improved communication between health care providers and consistency in patient care.



The standard work for Patient Specific Protocol is as follows:

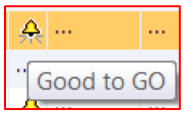


- Patient Specific Protocol Scanned into patient's HIM record
- Patient Registers in the Emergency Department
- Clinical Indicator appears on ED Tracking Board
- ED Staff go to ED Chart
- Select HIM Documents
- Search for ER/Urgent Care Section
- Navigate to Patient Specific Protocol page to right until Paper Icon is displayed
- Click on Paper Icon to Open the Patient Specific Protocol Documentation
- Provide ED Provider with copy of the Patient Specific Protocol for review

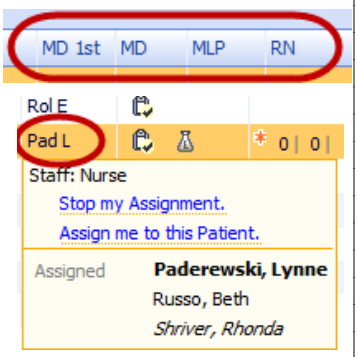
The standard work for the Decision to Admit icon will be the SA will manually add the icon when he/she initiates the page or phone call to the anticipated Admitting Attending. This will create a time stamp of the ED physician's Decision to Admit which is needed for the ED Benchmarks & Reporting.

The Decision to Transfer Icon will be used when the ED Attending initiates the call to transfer the patient to a higher level of care.

Discharge Notification to the nurse is how the physician lets the nurse know that the discharge packet is complete and the patient is ready for discharge. This will populate automatically upon the physician's completion of the Discharge & Follow up instructions.



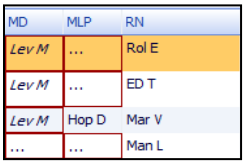
STAFF ASSIGNMENTS



Physicians, nurses or other staff assignments can be made manually on the tracking board. The nurse completing the initial assessment will automatically be assigned as the **Primary** to the patient. If necessary this can be manually changed. ED techs will assign themselves as **Secondary,** as will members of Crisis Intervention.

Click the appropriate column to make the necessary assignment.

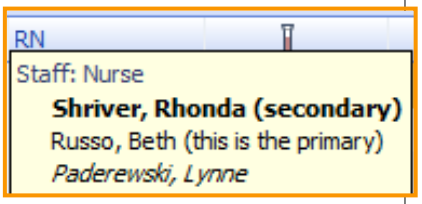
Other staff, as they have contact with the patient, will record that here as well.



The primary physician or MLP will display in normal font. The Physician First Provider will display in italics.

Under the RN column, the nurse completing the initial assessment will be displayed as the primary nurse. Only the first three letters of the last name and first initial will display. The name can be changed manually if necessary.

The red square indicates the patient has not yet been assigned a primary nurse.



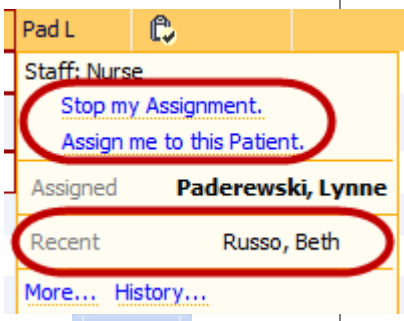
Hovering over the abbreviated nurse's name displays the nurse's full name, plus other assigned staff and recorded contacts.

To assign yourself or another staff member to a patient click on the RN column. Assignments can be changed any time as needed.

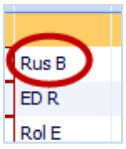
- If assigning yourself as primary, select "**Assign me to this Patient as Primary**". ***ED nurses will utilize this assignment.***
- If assigning yourself as secondary, select "**Assign me to this Patient**". ***ED techs and Crisis staff will use this assignment.***
- If you are just recording that you had contact with this patient select "**Record the Contact I had with this Patient**". ***Radiology is an example of who will use this option.***
- Click **More** when you are assigning another staff member to this patient as either primary or secondary.
- Clicking on the **History** link will display all these changes.

To change or end an assignment, click on the assigned name in the RN column.

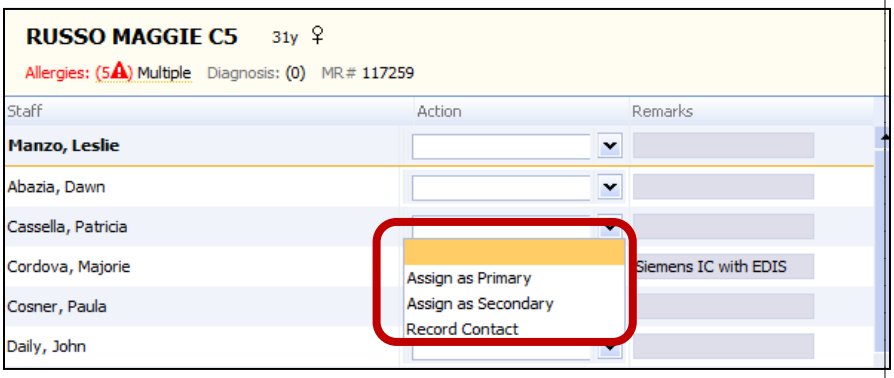
- If ending your assignment, click "**Stop my Assignment**"
- If you are currently assigned as primary but wish to become secondary, select "**Assign me to this Patient**"
- If you are not already assigned as primary, you will have the option of doing so as described above.



- You can also see a list of any staff who had been previously assigned to this patient.

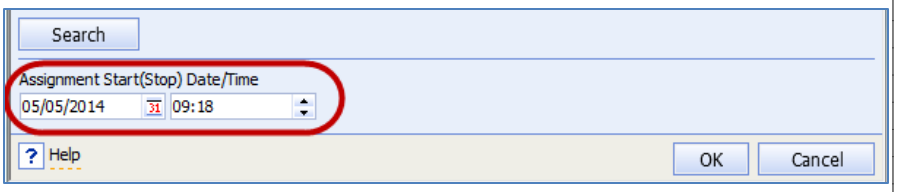


To assign other staff members or a physician to a patient, click in the appropriate provider's column, then click **More**. The Assign Staff dialog box will open.



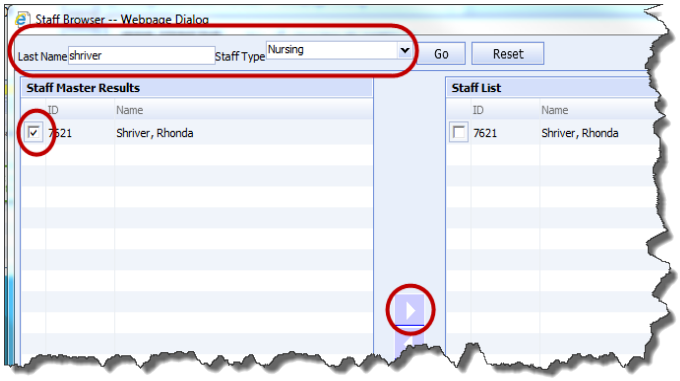
Locate the name of the person to assign, then using the pulldown next to the name, select they type of assignment you wish to make. This can also be used to stop an assignment.

The assignment start time can be edited to provide and accurate timestamp of the physician's first contact with the patient.



If you need to, you can search for a staff member's name. In the Assign member dialog box, at the bottom, click **Search**.

1. Type the staff member's **Last Name**, and selelct the **Staff Type**.
2. Click **Go**.
3. **Select** staff member's name; **click** white arrrow in the middle to move name to right side. Click **Save,** then **OK.**.



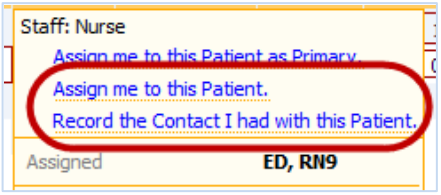
Physician and Mid Level Practioner assignments are made in the same manner as the nursing and tech staff. The Scribes will be responsible for making the physician assignments most of the time.

The **Physician First** column will display on all three ED tracking. The Physician First physician will manually assign him/herself to the patient in the appropriate column.
If the patient is moved to the Main ED and then managed by another physician the Physician First name is not removed from the tracking board but the Main ED physician will be assigned to the MD Column by either the physician or scribe. This allows for accurate timeline of the throughput process. **Scribes** will assign themselves as secondary in the MD column.

Mid-Level Providers will assign themselves to the appropriate column selecting **Assign as Primary**.

ANCILLARY STAFF

The **Crisis team** will utilize the RN column to track patient contact and assigning themselves as the secondary. If the social worker makes contact with the patient prior to a social service consult the social worker will "Record Contact I had with this Patient".



When the social worker receives the social service consult and initiates their evaluation the user will manually assign as the secondary assignment.

The **Radiology** staff standard work will include recording contact with the patient when they arrive in the ED to take the patient for their procedure. This recorded contact will be seen in the staff assignment with the name in italics.

When the user clicks on **History** the detail timeline is viewable from the dialog box with the Name, Assignment Type, and Date/Time of the encounter.

Staff: Nurse	Assignment Type	Start Date/Time
Nocera, Michelle	Recorded Contact	04/26/2014 15:48
Seaborn, Debra	Assigned (Primary)	04/13/2014 18:47
Role, EDNurse	Assigned (Primary)	04/13/2014 18:38

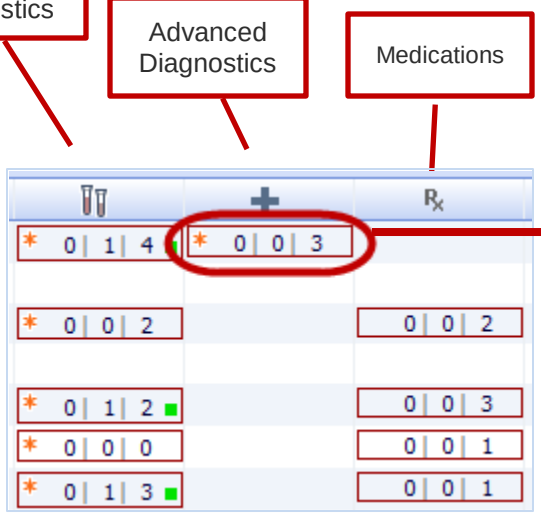
ORDERS AND RESULTS

The Orders and Results column contains order count indicators which will provide order status information at a glance. The order column has been divided into three categories: Basic Diagnostics, Advanced Diagnostics and Medications.

Basic Diagnostics include lab orders and general imaging testing. The delay indicator (red box around the order indicators) will be triggered if the orders have not been initiated within **30 minutes** from the time the order was placed.

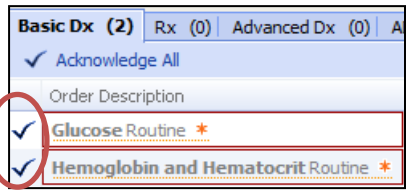
Advanced Diagnostics include the following orders: CT Scan, MRI, Ultrasound, Nuclear Medicine, Urine Specimens. The delay indicator will trigger **90 minutes** after the order had been placed.

Pharmacy Column allows the clinician to track the medication orders and identify delays with medication administration. The delay indicator will be triggered if the medications have not been addressed within **30 minutes** from the time the order was placed.



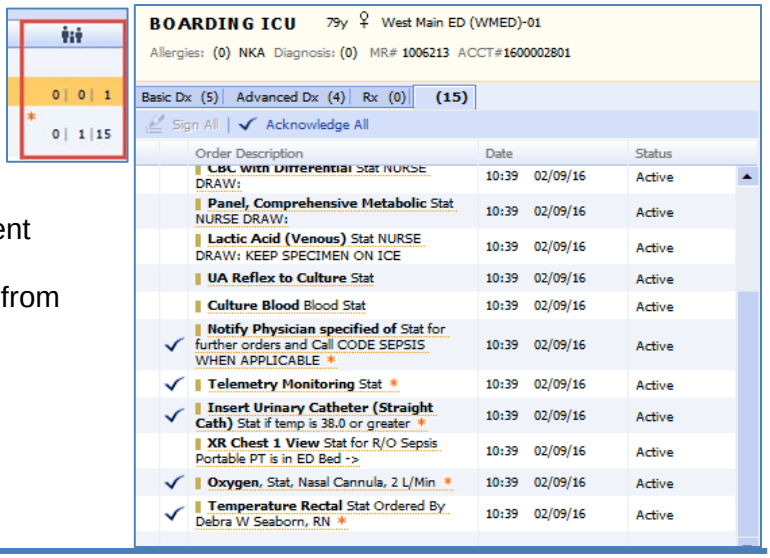
Orders / Results Columns	
1	Delay
2	New Orders to be acknowledged
3	Orders in progress
4	Orders Completed
5	Total Orders Red Text = 1 or more Critical Results
6	New Results Critical Result Abnormal Normal

Note also that orders can be orders dialog box by clicking the



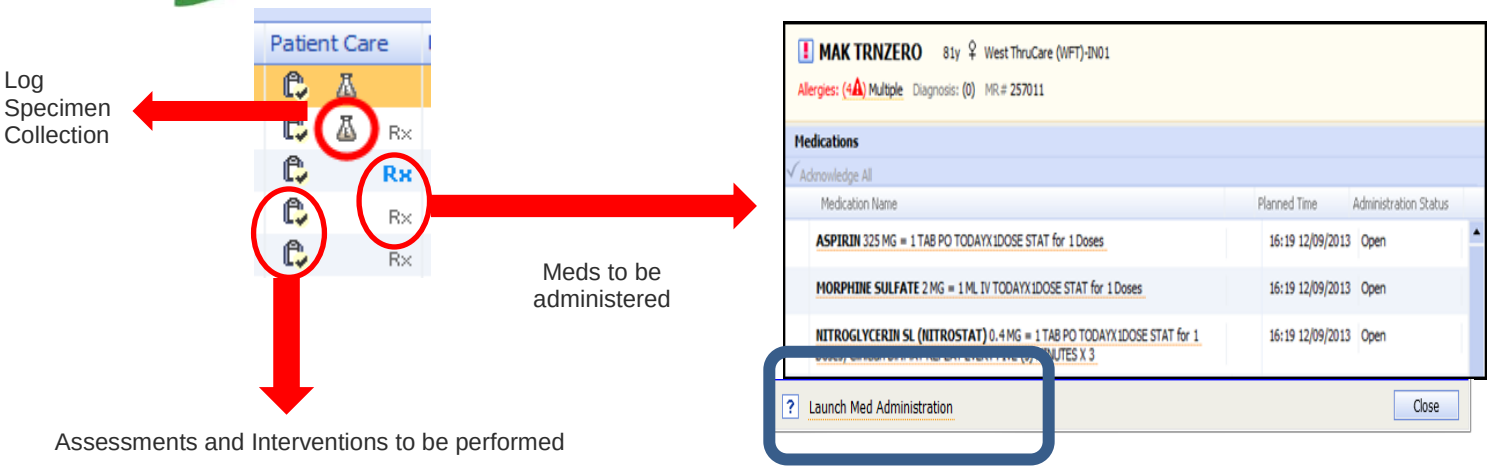
New Orders Column

This column displays all orders for each patient; diagnostics, medications, nursing and patient care orders. When the patient is admitted, but still in the ED, the nurse will be able to track new inpatient orders, acknowledge orders, document interventions and access documentation from the EDTB.

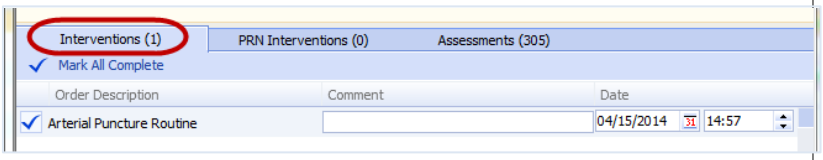


Patient Care orders column provides the user a quick launch to document interventions and assessments not found elsewhere within provider documentation

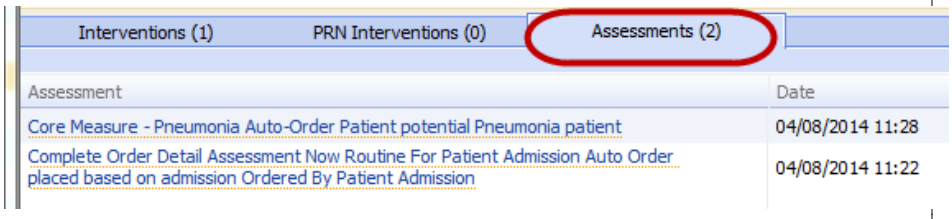
PATIENT CARE ORDERS (INTERVENTIONS, ASSESSMENTS, LOG SPECIMEN COLLECTION, MEDICATIONS TO BE ADMINISTERED)



Clicking on the Rx icon on the Tracking Board will allow the user to view the medication orders. Clicking on the **Launch Med Administration** link will launch the user into MAK.

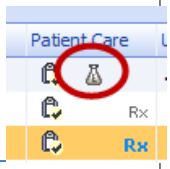


Interventions are driven by orders placed within the ED Guidelines or CPOE orders. Select the clipboard icon, and select the Interventions tab. The number next to Interventions" indicates the number of incomplete interventions for this patient. The first tab displays scheduled interventions; the second tab displays PRN interventions. The purpose of this list is to identify any non-medication or non-diagnostic orders. Examples of interventions are splint application, insert IV access, wound care, bladder irrigation, and many others. The nurse will check the intervention, mark it complete. The nurse will then locate the appropriate procedure note and complete the documentation. Interventions are also accessible in the ED chart view.



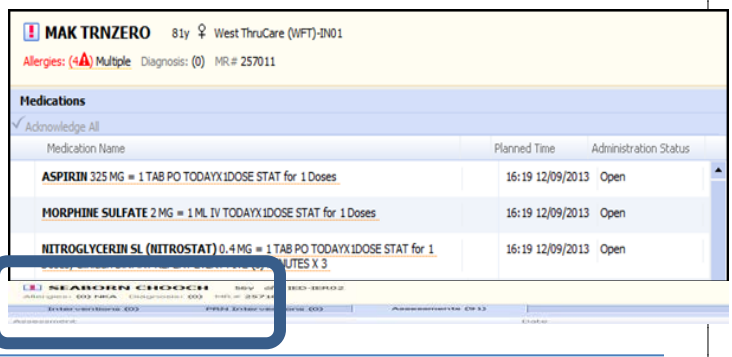
Assessments are driven the Patient Care column by orders or by workflows. Examples of ordered assessments are sepsis, behavioral health and core measures.

Log Specimen Collection icon displays when an order is placed for any specimen collection. The user will be able to document the collection of the specimen by clicking on the icon in the Patient Care column.



Medications to be Administered are accessible in the Patient Care column via the Rx icon. The light blue icon indicates the medication is ready to be administered; the gray icon indicates the medication had not been autoprofiled, requiring the pharmacist to validate the order.

Clicking on the Rx icon will allow the user to view the medication orders. Clicking on the **Launch Med Administration** link will launch the user into MAK.

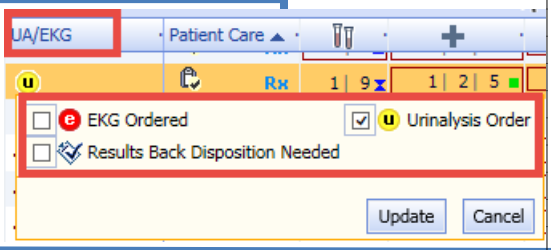


URINE AND EKG COLUMN

Urine and EKG Column is used to address the timeliness of urine specimen collection and the completion of EKGs. When an order is placed for a urinalysis, urine drug screen or an EKG, the icon will be displayed on the tracking board. Once the EKG has been done and/or the urine specimen collection had been done, the user will manually remove the icon from the display.

There is a third indicator which the nurse will use once all tests have been resulted to communicate to the physician that the patient is awaiting disposition.
Click icon to open pop up box

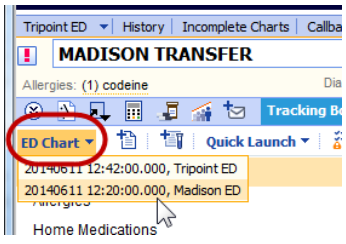
1. Click on check mark to remove
2. Click Update
3. Icon will be removed
4. The user will need to document the EKG completion found in the intervention tab in order to document name and time of the physician notification.

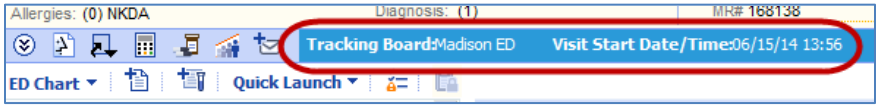


VIEW DOCUMENTATION FROM ANOTHER ED

If a patient travels from one ED to another during a single encounter, the receiving ED needs to have access to the previous ED's documentation. You need to be in the View Chart to access this informaiton.

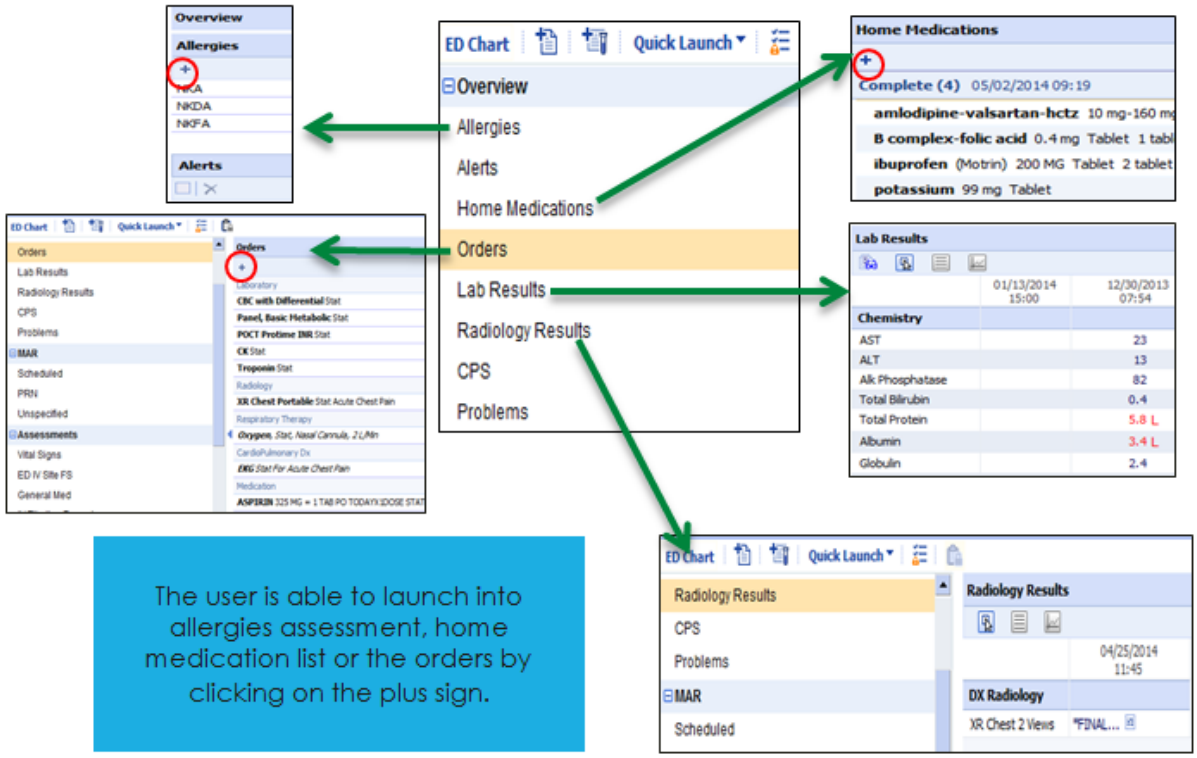
1. Click on patient's name on TB.
2. Select **View Chart**.
3. In the upper left corner, use the pulldown to select the previous ED.
4. You will see a blue banner appear, displaying which tracking board you are viewing.



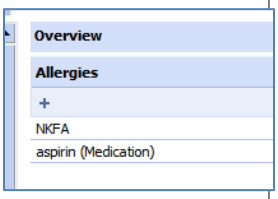


ALLERGIES, HOME MEDICATIONS, ORDERS AND RESULTS

The first tab is an overview of the critical information: Allergies, Home Medications, Orders and Results.



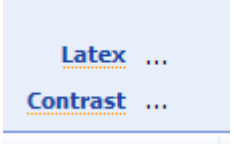
ALLERGIES



To enter allergies in View Chart, click on **Allergies** from the left side bar. If allergies have previously been assessed you will see them in the Overview area to the right.

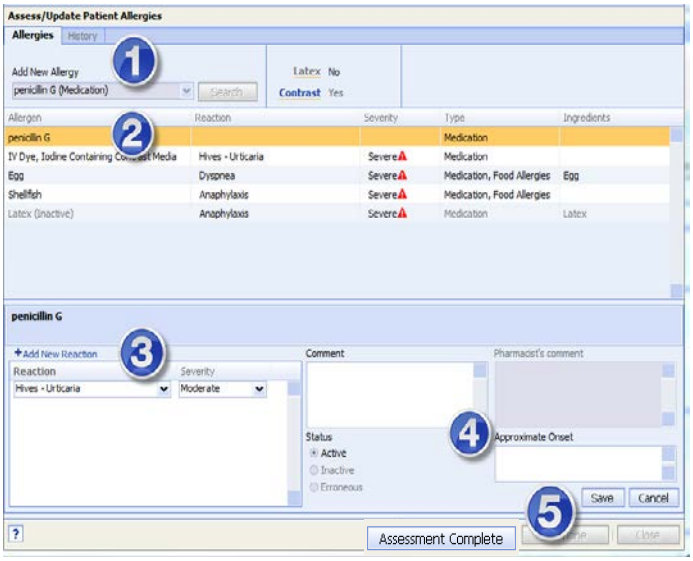
If allergies have not been assessed you will see a message to Reassess If this is a new patient, the Patient Allergy window opens where you need to address the Latex and Contrast allergies. Save when complete.

Allergies. Click on the **+** to being entering allergies.

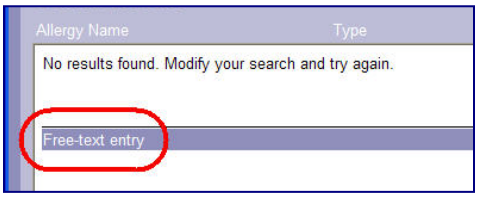


First address the Latex and Contrast allergies. Click on the “Latex” or “Contrast” link. Select the appropriate information; save when complete.

To enter an allergy:

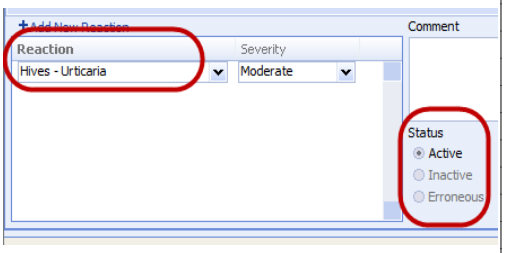


1. Search allergy (or use pulldown)
2. Allergy displays
3. Select reaction
4. Add comment / onset
5. Click Save.
6. Soarian will automatically add food allergies as both a food and medication.
7. If a food allergy cannot be found when searching, it will need to be entered as a Free Text Entry. **Select the "Food Allergies" category when entering.**
8. When finished click Assessment complete.



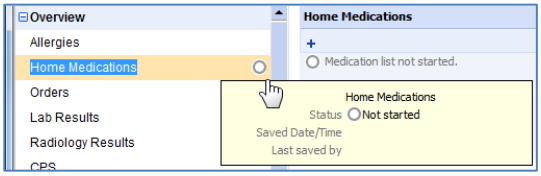
To edit an allergy, click on allergy name and edit Reaction or Status in the lower half of window. Click Save, enter reason for revision, and click Assessment Complete.

Save; if finished click Assessment Complete.

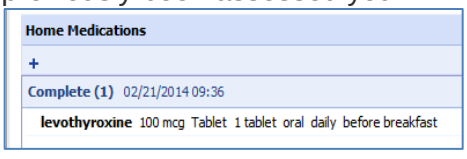


HOME MEDICATIONS

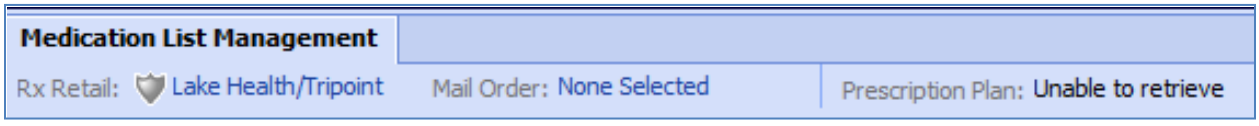
An indicator displays when home medications have not yet been charted.



To enter home medications in View Chart, click on **Home Medications** from the left side bar. If home meds have previously been assessed you will see them in the Overview area to the right.

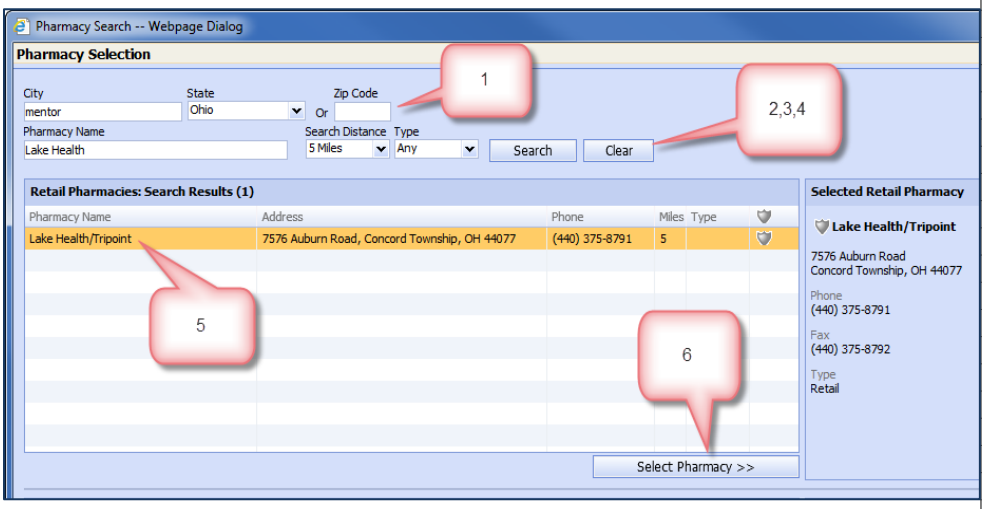


To facilitate e-prescribing for physicians, you will need to inquire from the patient as to which retail pharmacy or mail order pharmacy they would like their prescriptions sent to. While we encourage patients to use the Lake Health Pharmacy you can search on any retail or mail order pharmacy.

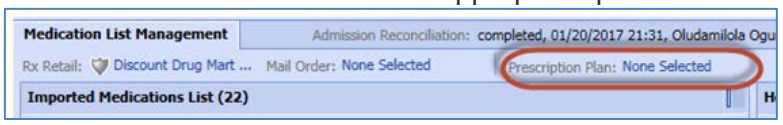


Clicking on the link for **Rx Retail** will open a window for you to enter information, allowing you to search for the appropriate retail pharmacy. Once you select the pharmacy, the information will be saved if the patient were to return to Lake Health.

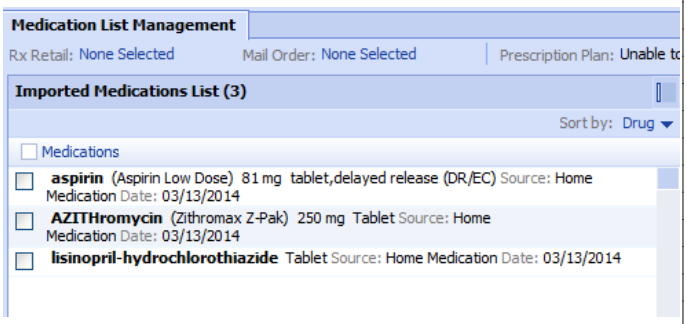
1. Enter the city and state of the pharmacy.
2. Enter the pharmacy name.
3. Enter search range (# miles).
4. Click **Search**.
5. Select the Pharmacy.
6. Click **Select Pharmacy.**



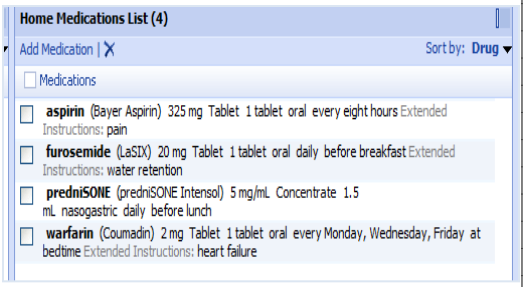
Another piece of information needed is the **Prescription Plan**. This information is only available if our clearing house for ePrescribing has the patient's information. When you **None selected** for the Prescription Plan you need to click that link and select the appropriate plan for that patient. This information is needed to prevent problems with prescription rejection which can cause delays in the patient's post discharge medication regime. The plan will have the patient's name attached.



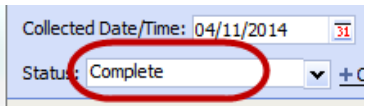
Imported Medications List will contain home medications listed on the last Discharge Medication list that was done, regardless of how long ago that was. Review these meds with the patient. If the patient is still taking these medications, click the check box to the left of the med and move them over to the current home medication list. Please remember to review carefully.



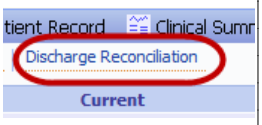
You can then add any new medications that the patient is currently taking. When completing the Home Medication List, obtain as much information as possible. Complete every field possible; this list will become the basis for the medication orders upon admission. Use the Reason field to state why the patient is taking the medication. Be sure to include when last taken, so the provider will know when the next dose is due.



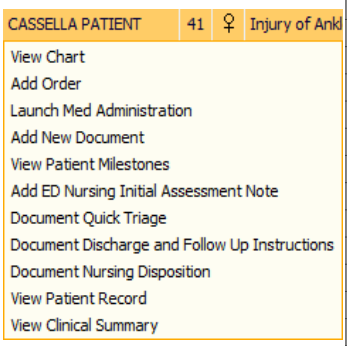
Make certain that the HML is signed as *Complete*.



The ED will only create a Discharge Reconciliation when there is a change in long-term home medication. When ready to discharge the in patient, (the physician writes discharge order in Soarian) the **Discharge Reconciliation** will be completed by the physician. **NOTE** – ***The Discharge Reconciliation is located on the orders screen, but can be printed from the Patient Record, the Charting screen or the Orders screen.***



PROVIDER DOCUMENTATION



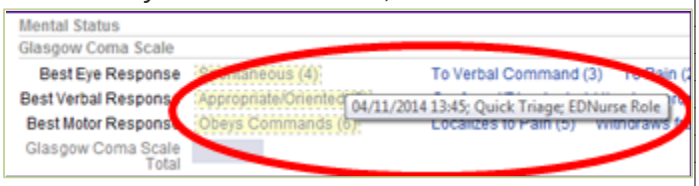
Many of the EDIS functions are available through the **Quick Launch** menu. The Quick Launch menu is available from the ED tracking board and the ED Chart View. To access from the ED tracking board, click on the patient's name.

To access from the Char View, click the **Quick Launch** tab. While in the Chart View, you can also click the **ED Chart** tab to add other documentation.

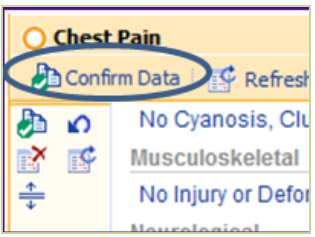
Lake Health Emergency Department's policy for charting requires the nurse to complete a primary and secondary assessment for every patient presenting to the Emergency Department. The nurse must document positive and negative findings specific to the presenting complaint. If a section of the assessment is not addressed by the nurse it will be considered not applicable to the patient's current complaint. This is what is referred to as **Charting by Exception.**

Frequency and scope of RN reassessment of patient during shift is determined by patient physical and/or behavioral status, response to therapeutic interventions and effectiveness of nursing plan of care. The types of changes or therapeutic interventions that may increase the frequency or scope of assessment by the RN include but not limited to: vital signs, level of consciousness/orientation, safety risk, pain, skin integrity/surgical wound status, intravenous infusions/intravenous access devices, monitoring equipment or medical devices, and/or medications.

When documenting you will notice some information already filled onto a form; this information may have come from Star registration, a previous ED visit, or previous documentation from the current visit. Hovering over the element will display a tool tip showing where the information came from. The triage documentation and nursing assessment will be limited to the current visit but information such as patient history can originate from a previous ED visit. The user has the options of confirming, deselecting or changing the information.



Icons will appear to the left of the new document for each section that hasinformation which filled forward from another source. The user can confirm all information for the entire document by selecting confirm data at the top of the assessment. The user will need to review and if appropriate, confirm the values section by section.



Confirm/accept data copied into document

Removes reference data; icon displays only if section contains reference data.

Expands section, displaying additional details

Resets section back to the last saved version

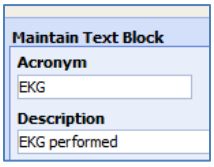
Refreshes reference data pulled from other documentation; icon only displays if sections contains reference data.

F12 Macro Function

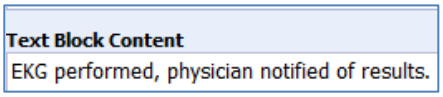
EDIS has a function within it that allows the user to create macros for themselves, so that you do not have to retype the same statements repeatedly. You can insert multiple macros in the same text box if warranted.

1. Click in any free text area, and press the **F12 key** on your keyboard.

2. In the **Text Macro** window, type in the Acronym for your macro.
   a. Make it short and something you will remember. For example, when an EKG was performed and you notified the physician, you can use the acronym EKG.
   b. Type a description of what the acrnym stands for, such as “EKG performed”.

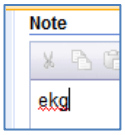


3. In the **Text Block Content** area, type the macro contents. Following the previous example, you can type “EKG performed, physician notified of results”.



4. Click **Save.**

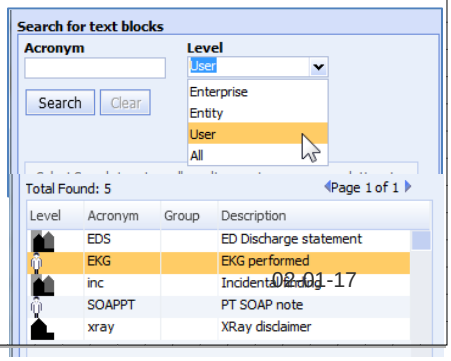
To retrieve the macro for subsequent patients:



1. Click in any free text area, and type the acronym for your macro.

2. Press **F12.** Your text will appear in the text box.

3. If you forgot the acronym, click in the text box and press F12.



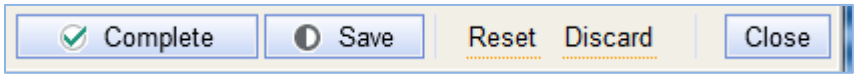
4. In the **Search for text blocks** area on the left side of the screen, under **Level**, select **User** if you just want to see

your macros; select **All** if you want to see all users' macros.

5. Select the macro you want to use, and click **Insert** in the lower right corner.
6. Press the space bar or enter key to keep your text from disappearing.
7. Click Complete when finished.

Documentation Status

When the document is completed, click the **"Complete"** icon at the end of the document. A user can leave the document in progress by selecting **"Save"**. If the user selects a template in error click **"Discard"** to remove the template without completing it. Discarded templates must be removed from the ED Documentation in the ED Chart View prior to completing and finalizing the chart. **Reset** returns the document to its last saved version.



Document Status Icons	
	Uncharted. No information has been recorded in this document.
	The document is uncharted and there are unsaved changes.
	The document is a draft and can only be seen by the author.
	The document is a draft with unsaved changes.
	The document is in progress. It is not complete, and other clinicians can read it.
	The document is in progress and has unsaved changes.
	The document is complete, and it may still be edited.
	The document is complete and has unsaved changes.
	The document has been marked erroneous. The contents should be disregarded.
	The document is final. It can no longer be edited. Any additions or corrections must be made via an addendum.

Uncharted or draft documents can be discarded.

In Progress documents can only be edited by the author. Discarding it will mark it erroneous.

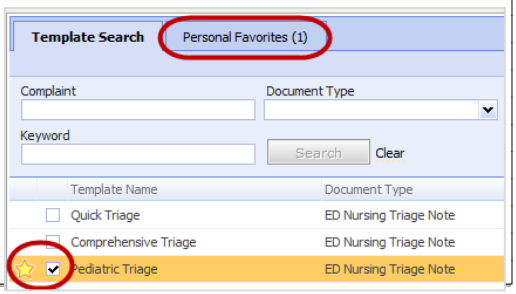
Completed documents can be edited by the original author.

Erroneous documents cannot be altered.

Finalized document; click Add Addendum to make corrections or add information

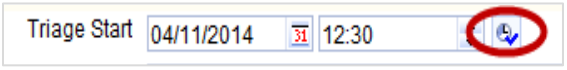
Triage Documentaiton

To document a Quick Triage on your patient, click on the patient name. From the **Quick Lanuch** list provided, select **Document Quick Triage**. The Triage document template will open.



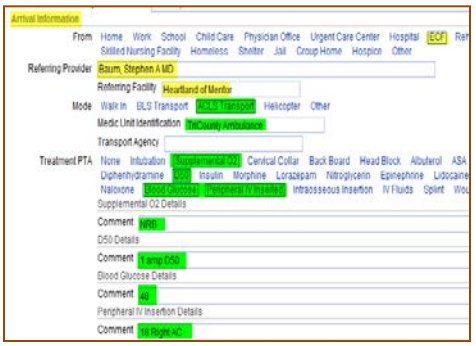
If the document you need is not on the Quick Launch, you can search for the document you want. From the quick Launch, select **Add New Document.** If for example, you need the Pediatric Triage form, select that from the Add New Document window. If it is a document that you want to save as a Personal Favorite, selelct the white star that appears when you select the document. The white star will turn yellow, indicating it is saved in your **Personal Favorites**.

Click the blue check icon to auto fill the current date and time.



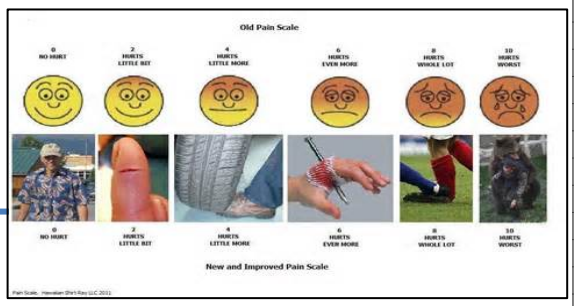
As you begin to document the Primary Treating Complaint, Soarian will make suggestions. If the complaint is being suggested, select that complaint. If at all possible, do not free text the Primary Complaint.

Arrival Information If the patient arrived from an extended care facility or nursing home, you will see the availability to provide additional information. There is also an area where you will record **Mode of Arrival and Treatment PTA**. You can enter the squad information and any interventions performed prior to patient's arrival.



Continue selecting appropriate responses throughout the triage document. Clicking on a term will select it. If you select something in error, click the term again to deselect it.

- Triage Vital Signs will carry forward to the vital sign flow sheet and the Initial Assessment and Provider Note.
- Pain assessment is the 5th vital sign and should be assessed with the triage vital signs. If the patient is experiencing pain additional documentation will open to provide more detail.

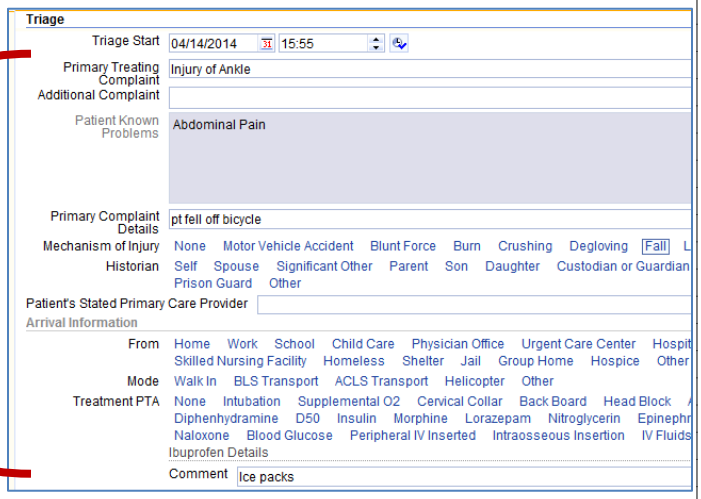


DOCUMENTATION COMPLIANCE

Currently Soarian provider codumentation does not allow for mandatory fields, where the user will be prevented from leaving a document if not completed. In all our other documentation, we are able to create mandatory fields, which provide hard stops if not completed.

It is mandatory by HIPAA and/or Lake Health policy and/or the Joint Commission that the follwing items are completed on every patient entering the Emegency Department.

On the Quick Triage/Triage form:



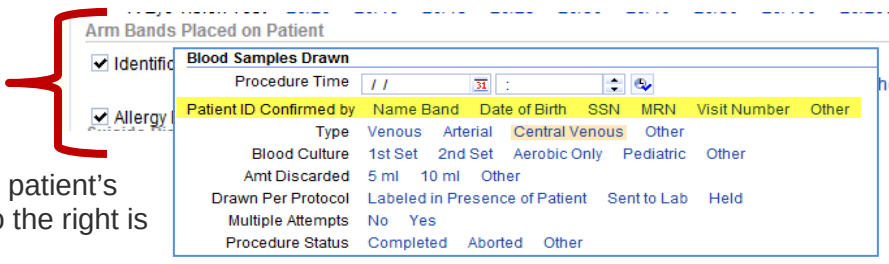
- **Chief Complaint**
- **Mode of Arrival**
- **Treatment Prior to Arrival (includes treatment administered at home before EMS arrival)**
- **Vital Signs including Pain asmt**
- **Height and Weight and Smoking Status for Meaningful Use**
- **LMP**
- **Smoking status**
- **Patient identification**

On the Primary assessment:

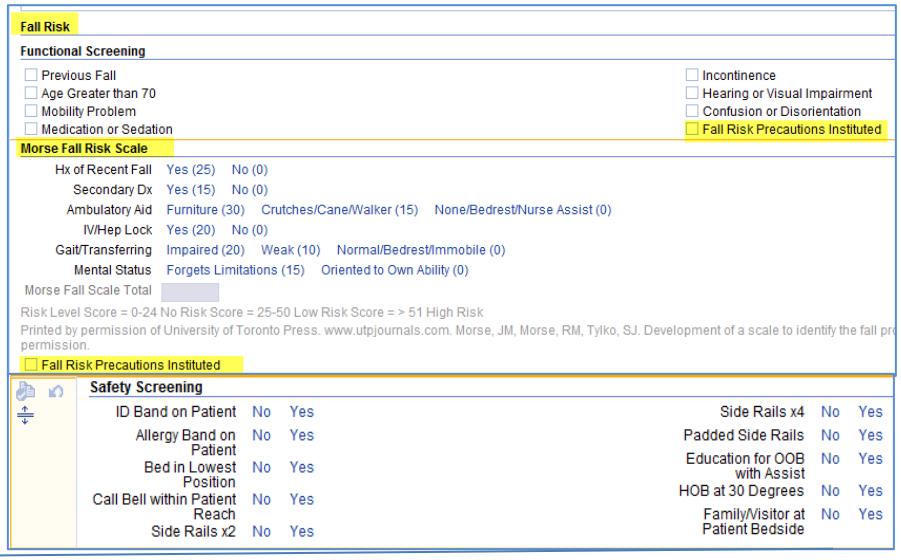
- **Neurological deficit/Glascow Coma Scale**
- **Airway**
- **Breathing**
- **Circulation**
- **Deficits**
- **Fall Risk**
- **Suicide risk**
- **Abuse and Neglect Screening**
- **Medication information (includes Home Medication list and Medication Administration Record (MAR)**
- **Skin integrety**
- **EMTALA**

Joint Commission requires us to use at least two patient identifiers when providing care, treatment and services.

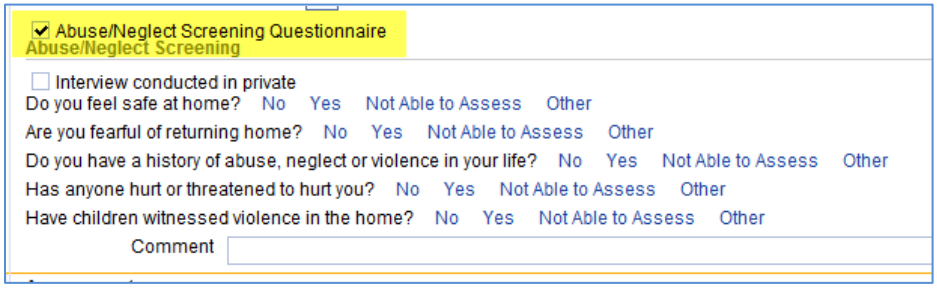
Throughout your documentation, there will be several places where the user will document confirmation of the patient's identification. The print screen to the right is one example.



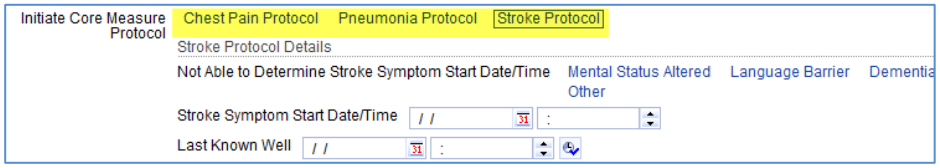
The **Falls Risk Assessment** is a Joint Commission requirement. It is located on the Initial Nursing Assessment. The user can also document Safety Measures taken to prevent falls in the Safety Screen and the Rounding Flow Sheet.



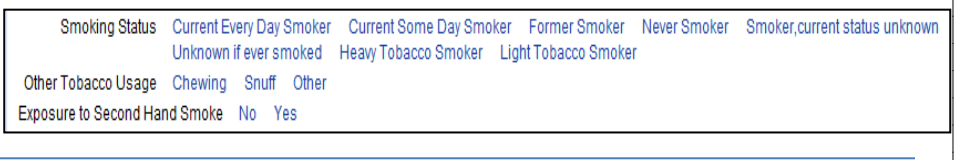
The **Abuse and Neglect Screening** is required for every patient presenting to the emergency department. This screening tool should be completed during the Initial Nursing Assessment.



Core Measures are a Joint Commission requirement. We can achieve compliance with help from the ED nurses in early identification, documentation and communication of interventions completed. We are given financial incentives from Medicare and Medicaid EHR Incentive programs for demonstrating "meaningful use" of the certified EMR in improving patient care.

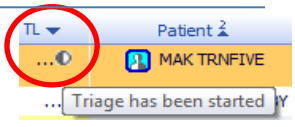


Core Measure 9 Objective is to electronically record the smoking status of every patient at the age of 13 or older. If confirmed the patient is a current or former smoker, additional documentation opens for you to complete.



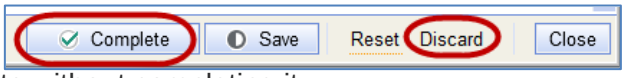
Medication Management is a Joint Commission requirement we can be in compliance with by collecting the patients home medications and recording the medication administrations in the ED. Both of these are easily accessible from the ED Quick Launch menu.

ESI Triage Level - Assigning of the ESI Triage Acuity must be completed by a Registered Nurse per Ohio State Nurse Practice Act.

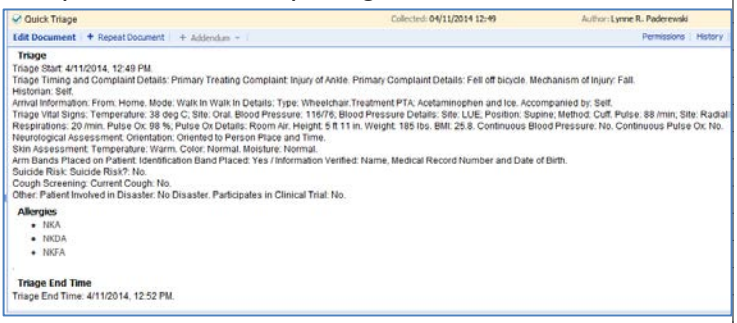


If the ED Tech completes the Quick Triage the tech will not assign the triage level. The tech will sign the note as complete. The nurse will open a second triage note and assign the ESI level and sign as complete.

When form is competed, click the **Complete** button at the end of the form. All the documented information will fill into the nursing documentation once that template is initiated. If you select a template in error, click **Discard** to remove the template without completing it.



Once completed, the documentation appears in text format. This can be edited if necessary by the author of the document.

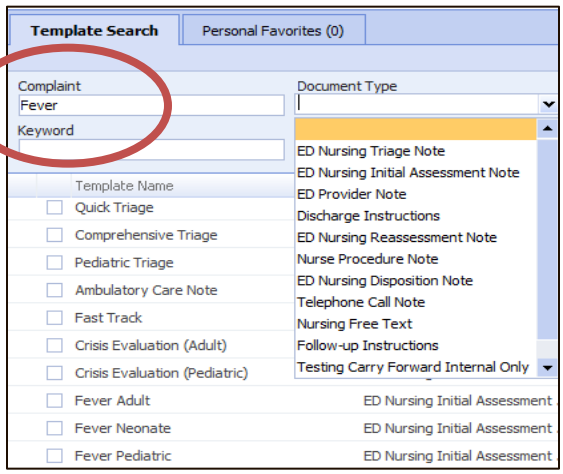


Users will click **Add New Document** from the Quick Launch menu to access the **Pediatric Triage** form.

ADD NEW DOCUMENT

INITIAL NURSING ASSESSMENTS

The user will access documentation from the quick launch menu and selecting **Add New Document** or selecting the Add Document icon in the ED Chart View.



The template search box will open; a list of complaint specific (based on treating complaint) documents will be available. A drop down is available to filter the list to a specific document type.

The user is able to deselect the complaint and search by keyword if needed.

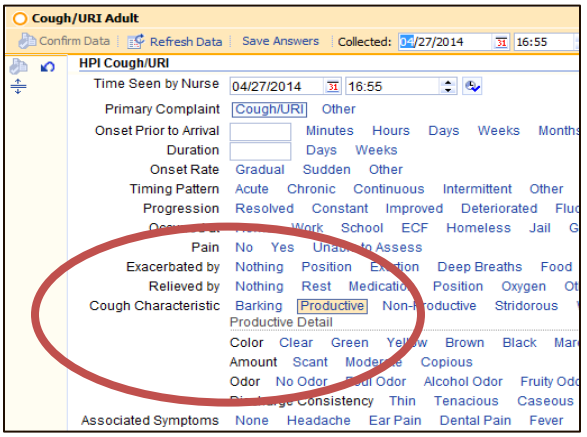
Users can also save a document to their **Personal Favorites** list.

Abdominal Pain Adult
Abdominal Pain Pediatrics
Altered Mental Status
Arm Pain/Swelling/Wound
Arm Trauma
Asthma/Wheeze Adult
Asthma/Wheeze Pediatric
Bite
Burn Adult
Burn Pediatric
Cardiac Arrest
Cellulitis/Abscess
Chest Pain
CHF/ SOB
Cough / URI Adult
Cough / URI Pediatric
Crisis Evaluation Adult
Crisis Evaluation Pediatric
CVA/Focal Neurologic Deficit
Dizziness
Dyspnea
Dysuria Adult
Dysuria Pediatric
Earache Adult
Earache Pediatric
ENT Foreign Body
Ear Trauma
Epistaxis
Eye Pain/Swelling/Redness
Eye Trauma
Fall
Fever Adult
Fever Neonate
Fever Pediatric
Flank Pain
GI Bleed
Generalized Pain
General Medical Adult
General Medical Pediatric
General Medical Recheck Adult
General Medical Recheck Pediatric
Genitourinary Adult
Genitourinary Pediatric
Headache
Head/Face Trauma
Hematological Complaint Adult
Hematological Complaint Pediatric
Hip Trauma
Hypertension
Known Ingestion Adult
Known Ingestion Pediatric
Laceration
Leg Pain/Swelling/Wound
Leg Trauma
Low Back Pain
MVA Adult
MVA Pediatric
Near Drowning
Neck Pain/Upper Back Pain
Oral/Dental Complaint Adult
Oral/Dental Complaint Pediatric
Palpitations
Plantar/Ankle Trauma
Psychiatric Complaint
Rash/Allergic Reaction
Seizures
Sexual Assault Adult
Sexual Assault Pediatric
Shoulder Trauma
Smoke/Chemical Inhalation
Sore Throat
Sting
Suspect Abuse/Neglect Adult
Suspect Abuse/Neglect Pediatric
Suspect Alcohol Abuse
Suspect Overdose/Suicide Adult
Suspect Overdose/Suicide Pediatric
Syncope/Near Syncope
Trauma Adult
Trauma Pediatric
Vaginal Bleeding Childbearing Age
Vaginal Bleeding Pregnant
Vaginal Bleeding Non-Childbearing Age Adult
Vaginal Bleeding Non-Childbearing Age Pediatric
Wound Recheck/Suture Removal
See Paper Chart

ED Provider Documentation provides over 80 Nursing Initial Assessments; each assessment has the foundation of a general medical or trauma template then adds additional documentation to address the specific complaint.

HPI – History of Present Illness

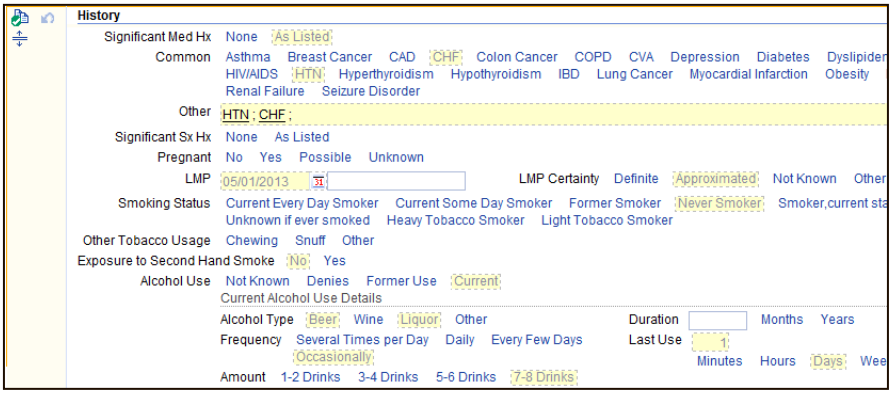
As the user documents additional documentation will open to provide details such as productive cough allows the user to document color, amount, etc…



History

The history section may have carried forward data from a previous ED visit. The user should confirm the accuracy of the documentation before accepting it.

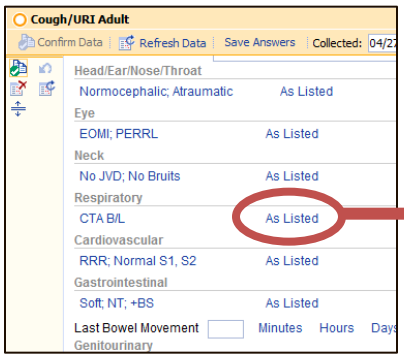
******Smoking Status is a mandatory element for Joint Commission******



Assessment

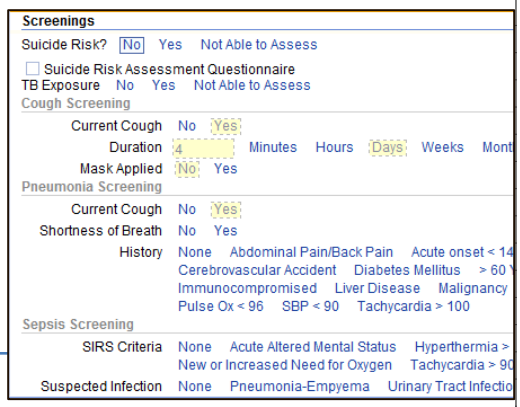
The assessment is a review of systems; each category displays the normal findings and an option to list abnormal findings. By selecting **As Listed** the user will be provided additional documentation for that category.

Per hospital policy categories not addressed will be considered not applicable to the patient's presenting complaint.



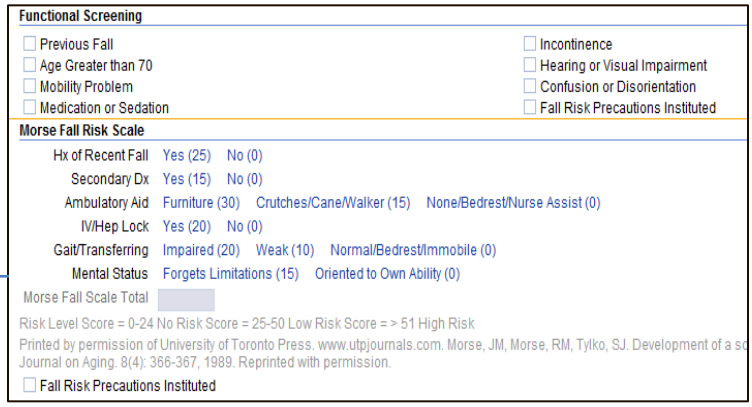
Screenings

The screening section focuses on potential infectious processes; TB, Influenza, Pneumonia, and Sepsis. The user will select risk factors then use critical thinking to initiate ED Guidelines.
The Suicide Risk screening is a mandatory element for the Joint Commission. The user will complete the Risk Assessment Questionnaire if needed



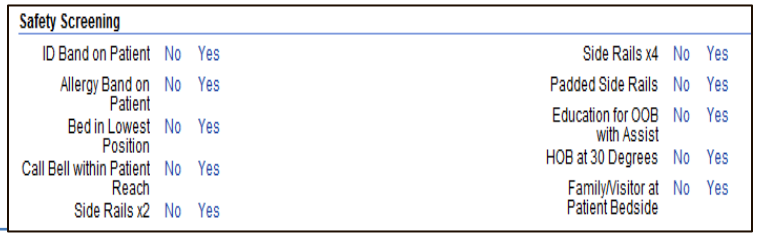
Functional Screening & Falls Risk

The functional screening & falls risk supports the **JC Patient Safety Goals**. The user will address the screening for every patient presenting to the ED then institute Fall Risk Precautions per policy.



Safety Screening

The safety screening affords the user the opportunity to document safety precautions that have been taken.



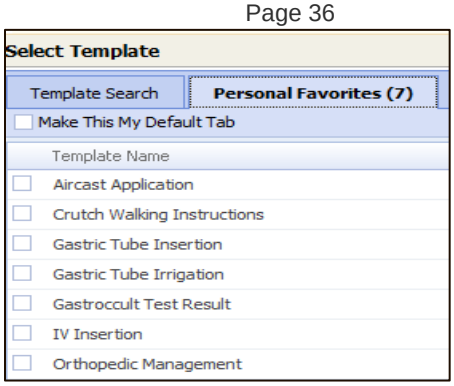
Nursing Procedure Notes

The Nurse Procedure Note will replace the multiple assessments within Soarian Clinicals.

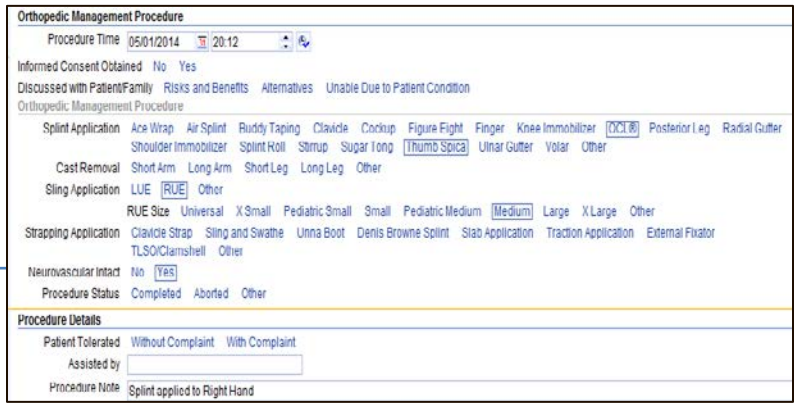
- Aircast Application
- Airway Maintenance
- Ambulation Trail
- Bleeding Control
- Blood Alcohol Draw
- Blood Glucose Monitoring
- Blood Samples Drawn
- Cardiac Monitor
- Crutching Walking Instructions
- Decontamination
- Evidence Collection
- First Aid Application
- Gastric Tube Insertion
- Gastric Tube Irrigation
- Gastroccult Test Result
- Hypothermic Intervention
- Intraosseous Insertion
- IV Insertion
- Nitrazine Test
- Orthopedic Management
- Ostomy Care
- Procedural Sedation
- Urinary Catheter Insertion
- Urine Dip Test
- Vascular Access
- Wound Dressing Application
- Wound Treatment

To select a document:

- Select Quick Launch or Add Document
- Click Nurse Procedure Note
- Complaint specific procedures will display



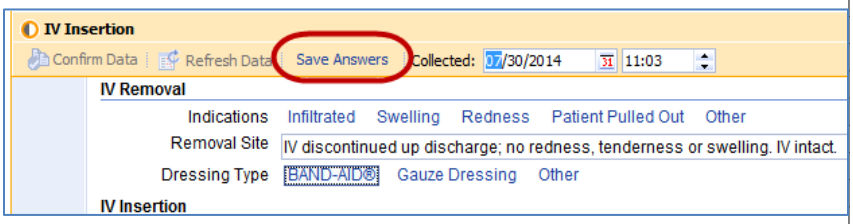
The procedure note can be completed by either a RN or ED Tech. The note allows the user to document laterality in the procedure note text box as well as documenting how the patient tolerated the procedure.

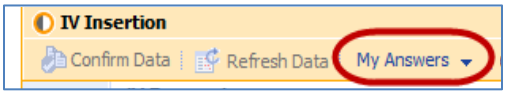


My Answers

My Answers is a way for the user to quickly insert previously saved answers on a particular template. You have the ability to document a normal exam on any template, for example, Abdominal Pain, Adult. When you have a patient presenting with abdominal pain, you will document all the positive findings, then add your saved answers for the rest of the normal exam.

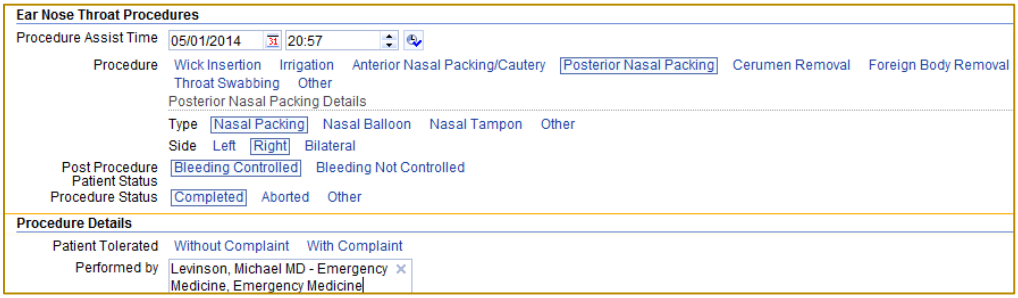
Aother example to use My Answers is for your IV insertion template. You can save your answers for a discontinued IV upon discharge. Document the "normal" template, and click **Save Answers**. Every time you need to document a discontinued IV upon discharge, you will open the template, and click **My Answers.** Everything you documented on the original template will fill into the current one. Change or update documentation as needed.



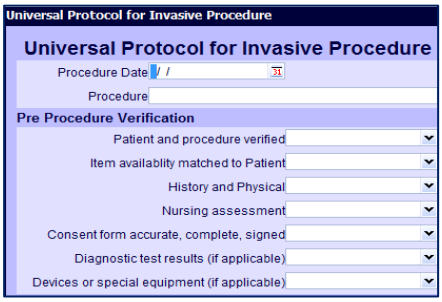


Nursing Procedure Assist Note

The user will document procedures completed by the provider as a nursing procedure assist note.



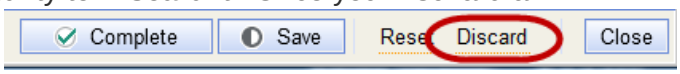
If the procedure meets the criteria for universal protocol the user will need to complete the *Universal Protocol for Invasive Procedure* found in the filter list assessment.

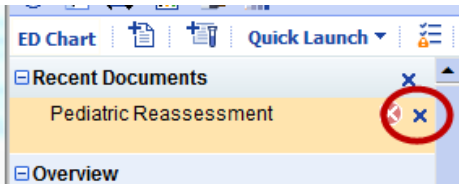


Nurse Procedure Assist Notes	
Arterial Puncture	Lumbar Puncture
Arthrocentesis	Nail Resection
Cardiac Intervention	Nurse Maid Elbow Reduction
Central Line Insertion	Orthopedic Reduction
Chest Tube Insertion	Paracentesis
Ear/Nose/Throat Procedure	Pelvic Vaginal Exam
Elbow Reduction	Pericardiocentesis
Epidural Blood Patch	Rectal Procedure
Eye Foreign Body Removal	Shoulder Reduction
Foreign Body Removal	Spinal Immobilization
Hip Reduction	Suture/Staple Removal
Incision & Drainage	Time Out
Intraosseous Insertion	Thoracentesis
Intubation	Urinary Catheter Insertion
Laceration Repair	Wound Treatment

ERRONEOUS ASSESSMENT

If you open a document in error, you have the ability to **Discard** it. Once you Dischard a document you are not able to retrieve it. Before you finalize the record, you will need to remove the document by clicking the **X**..

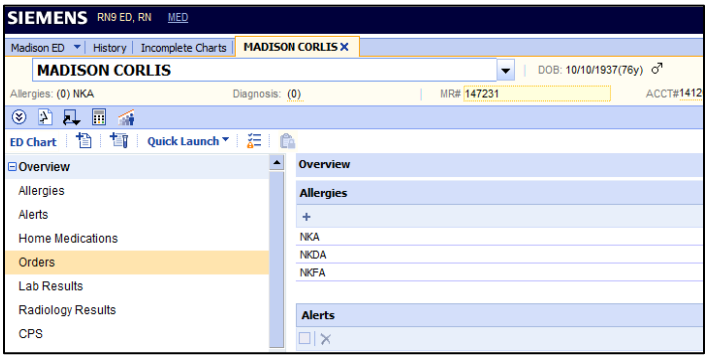




If you charted a flowsheet in error (Vital Signs, IV Titration, etc.) you need to go to the Patient Record in Soarian Clinicals to edit it. This will be explained later.

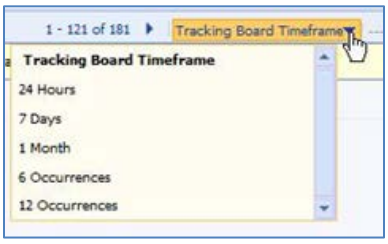
ED CHART VIEW

The ED Chart view is available on the Quick Launch menu on the EDTB, or by double clicking on the patient's name on the EDTB. The column on the left is called a **container** and functions like the divider tabs seen in a traditional chart.



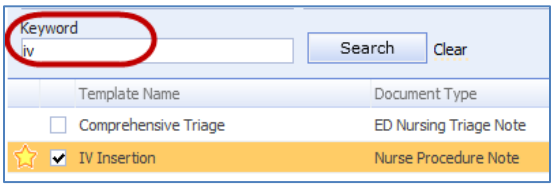
The **Overview** container is where you can view Allergies, Alerts, Home Meds, Orders, Lab, Radiology nad CPS results.

If you need to see a greater period of time that what is displayed for results, use the Tracking Board Timeframe pulldown to select the desired timeframe.

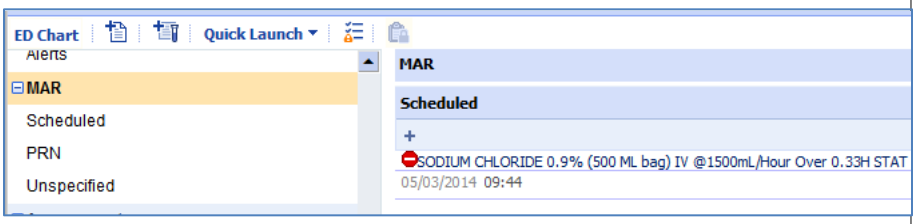


MAK/MAR/IV INSERTION

IV Insertion form is found by doing a keyword search in **Add New Document**. This form includes information on IV Insertion, IV Removal, and Procedure Details.



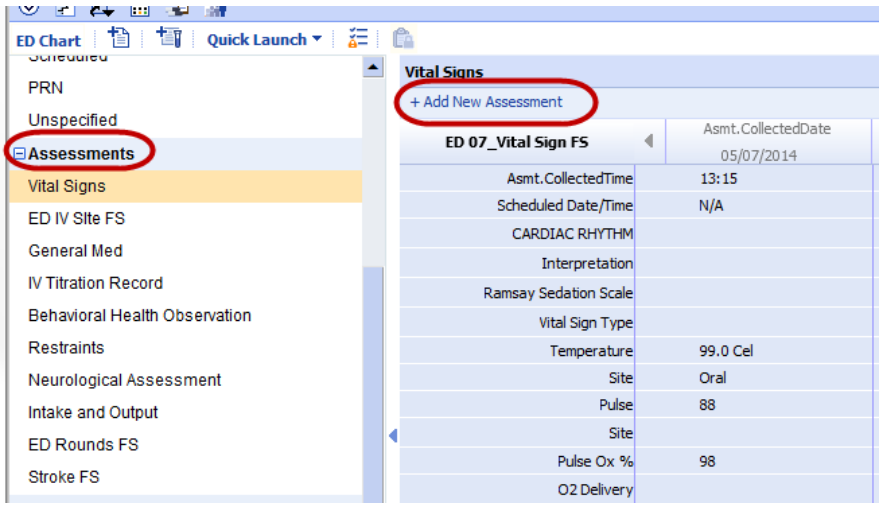
You will record the end bag time for IV drips in **MAK**. You cannot launch MAK from the ED chart view, but you can launch MAK from the ED tracking board. When you click on **MAR** in the chart view, you can view the Scheduled, PRN and Unspecified medications that have been ordered and were either auto-profiled or validated by Pharmacy. Clicking on the medication will allow you to see the Dispense Details, Dispense History, Order Details and Order History.



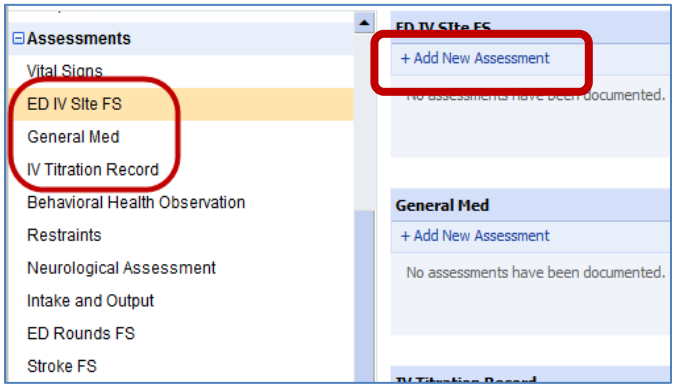
COLUMNAR FLOWSHEETS

Flowsheets are listed in the ED Chart View under Assessments. When you click on the flowsheet name, it opens in the main window. To add a new column, click **+Add New Assessment** at the top of the flowsheet.

NOTE: We currently do not have the abiltiy to create a default of celsius when recording temperature. Be sure to select and record the patient's temperature in Celsius.



The columnar flowsheets you will use in reagards to medication adminsitration are: **ED IV Site FS, General Med, and IV Titration Record.**

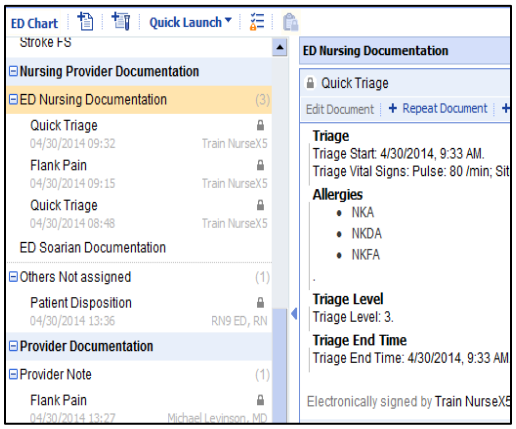


Click **+Add New Assessment** when you are ready to document.

Other flowsheets you will use are: **Vital Signs, Behavioral Health Observation, Restranints, Neurological Assessment, Intake & Output, Rounds, and Stroke flowsheets**.

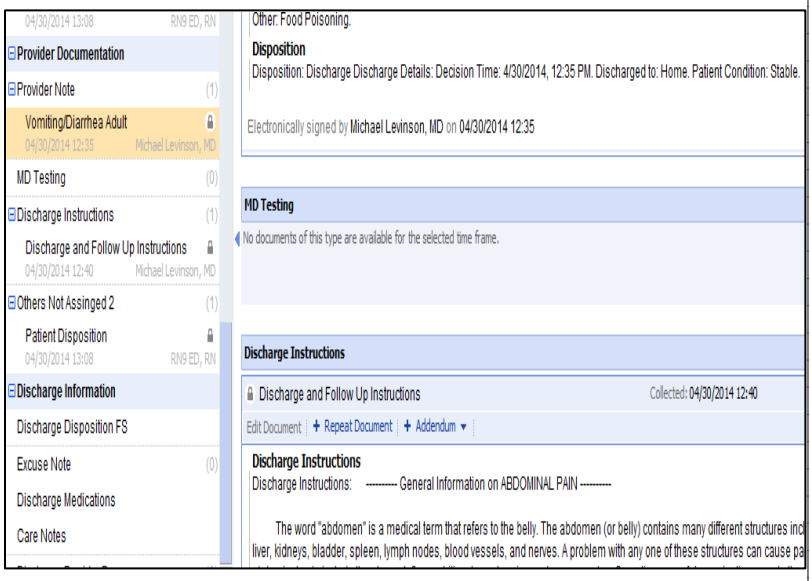
ED PROVIDER DOCUMENTATION

The user is able to view the documentation that has been opened and left in progress, completed, and finalized. The list will display in reverse chronological order so the most recent documentation will be at the top.
The user can edit any document he/she authored. He/she can choose to repeat the document from the ED Chart View. After the document is finalized the author of the document can also add an addendum if needed.



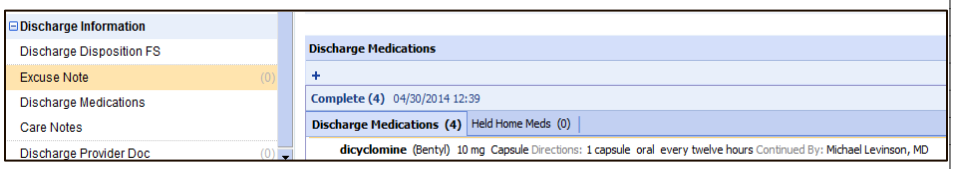
The ED Provider Documentation will be limited at this time since the ED physician will not document assessments or procedures in ED Provider Documentation at this time.

The **ED Provider Note** will be completed to provide disposition information. If the patient is being discharged the physician will complete the **Discharge and Follow up Instructions** to communicate the plan of care.



DISCHARGE INFORMATION

The Discharge Information category will file the documentation for the discharge process. If a physician provides a prescription generated through Soarian there will be a record of the prescription under Discharge Medications. By clicking onto the prescription the user will be able to view the details.

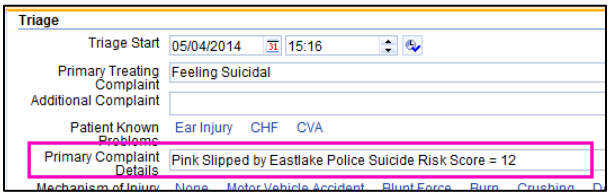


If Care Notes were generated for additional discharge instructions the user will be able to view the instructions by clicking onto the Care Notes within the file.

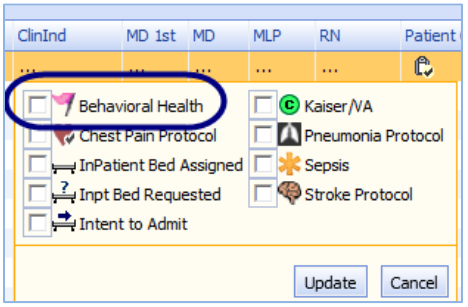
BEHAVIORAL HEALTH PATIENTS

Quick Triage Note

The quick triage note has a free text for Primary Complaint Details; document if the patient presents with a pink slip from a physician, social worker, or law enforcement.
The quick triage note does not have the same risk stratification scoring system used by the Emergency Department. The staff should complete the risk assessment and document the score in the primary complaint details as well.

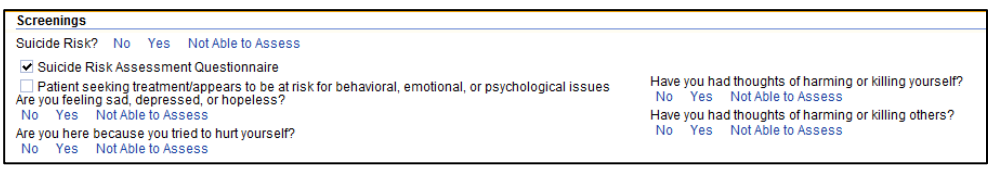


If the patient is identified as a patient that meets the criteria for Behavioral Health Observation either due to a pink slip being written or the Suicide Risk Score of 5 or greater, the team member will select the icon in the clinical indicator column and update.



Suicide Risk Assessment

Suicide Risk is addresses in the Quick Triage Note and in the Initial Nursing Assessment. If the patient is identified as a potential risk complete the Suicide Risk Assessment Questionnaire.



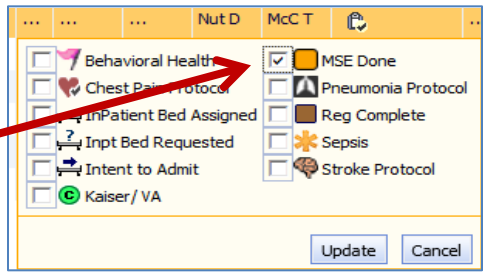
Behavioral Health Observation Flowsheet

The manual entry of the Behavioral Health icon on the ED Tracking Board will create a work flow which will push the Behavioral Health Observation flow sheet to the assessment work list every 15 minutes.

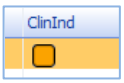
The user can also select the Behavioral Health Observation FS from the ED Chart View in the Assessments category.

If the ED is given additional resources to support the Behavioral Health population the team member will not have access to the ED Tracking Board. The PCA assigns him/herself to the HCU and select the HCU Patient Type of WER, IER, or MER. The PCA will then have access to the patients from their Census/Worklist.

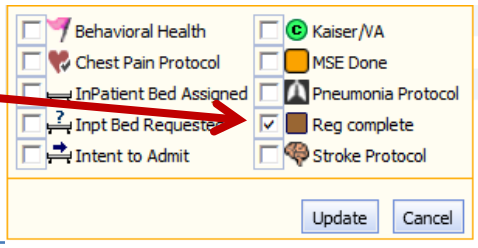
Medical Screening Exam (MSE)



After the Medical Screen Exam is completed the ED Physician (scribe) or MLP will activate the clinical indicator **MSE Done** on the tracking board to identify the practitioner is finished in the room and registration is now able to approach the patient to complete the registration process.



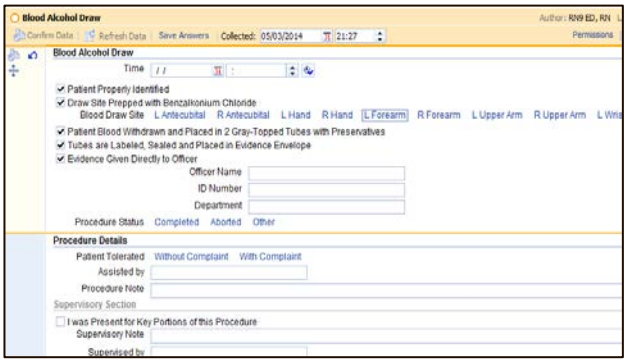
This is the "cue" to let Registration know they can now contact the patient to complete the registration.



Once the registrar has completed the registration, he/she will deselect the orange indicator and check the brown **Reg Complete** indicator.

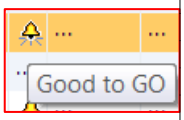
Forensic Cases

OVI - Law enforcement may request the ED team to draw blood for an OVI (Operating Vehicle Impaired) kit. The team member can document the process by selecting the Blood Alcohol Draw Note found in the Nurse Procedure Notes.



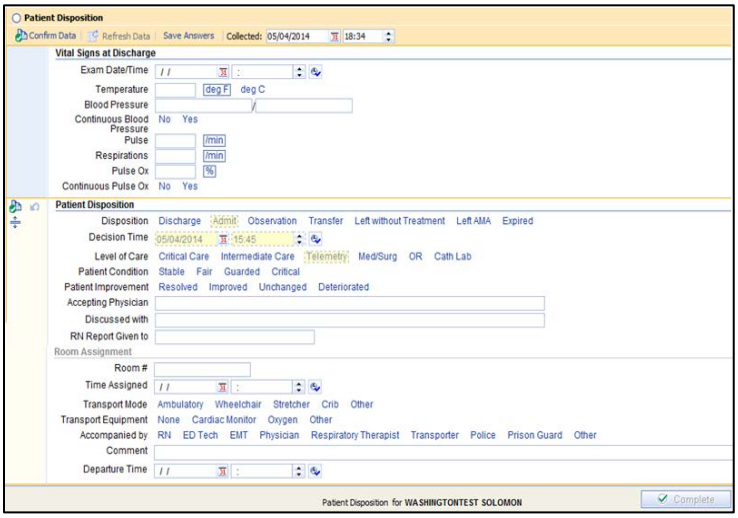
DISPOSITION DOCUMENTATION

Several different key elements are required in ED Provider Documentation in order to finalize the chart and transmit the documents to HIM. The physician will complete the disposition section of an ED Provider Note to capture the three required elements: clinical impression, condition, and disposition. The provider will then print the discharge packet, CareNotes and prescriptions as needed and place the paperwork in the chart. An icon will appear on the EDTB to let the nurse know the provider's discharge paperwork is complete and the nurse can discharge the patient.



Nursing Disposition

Every patient registered in the ED require a Nursing Disposition note.
The nursing disposition note is accessible in the quick launch menu from the ED tracking board or from the chart view. The disposition and decision time will carry forward from the ED Provider Note. Each disposition will have additional documentation open to provide more details.



You can open the Nursing Disposition at any time during the visit, save it as In Progress, so it will be on your incomplete worklist should you forget to complete it upon patient discharge.

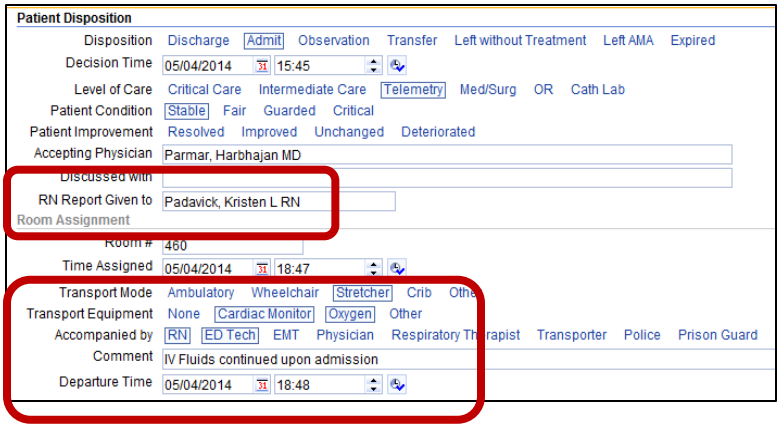
Admission

The ED physician will complete the ED Provider Note and place the CPOE Soarian Admission Order. The order will trigger an icon on the EDTB to indicate inpatient bed has been requested. The disposition column will also indicate "Admit".

When the Support Assistant receives the bed assignment the SA will change the icon from bed requested to bed assigned and enter the room assignment in the comment section.

To document the RN report was given, the user can start typing the last name of the RN and a drop down will display the RNs in the Soarian database.

The user needs to complete the mode of transfer, equipment and staff supporting the transport.



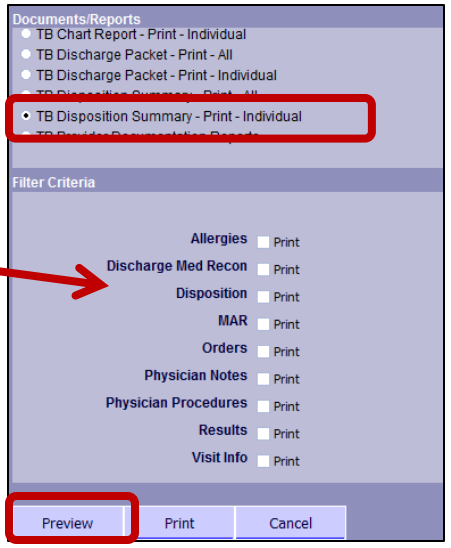
Transfer

The transfer documentation has key elements that are required meet EMTALA standards. The transfer details are required and the user must complete prior to transferring the patient.

Lake Health is also required to provide a copy of lab results, radiology exams, and the medical record.

The user will be able to print the medical record from the ED Chart View.

- Click on the Printer Icon on Tool Bar
- Select TB Disposition Summary Print- Individual
- Select Appropriate Filters
- Click Preview
- Click Print



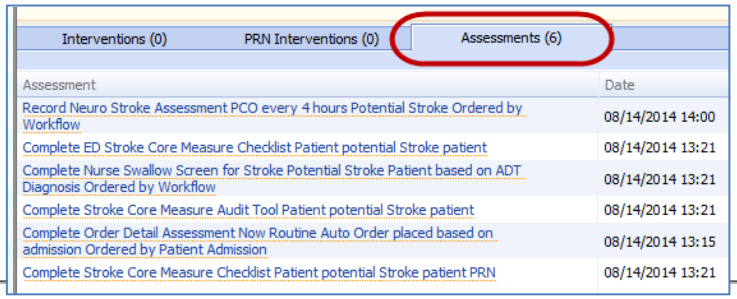
Patient Care Order Completion

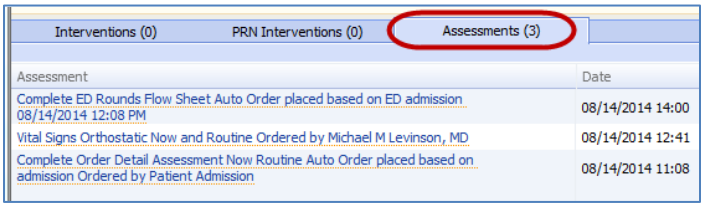
Prior to the patient leaving the ED and the finalization of the patient's chart, the nurse must make certain that all Patient Care orders have been addressed. These orders are accessed on the Tracking Board by clicking the PCO icon.

There is also an icon in the chart view.

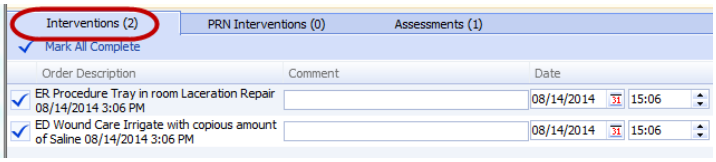
There are two types of PCO you may need to address; **Assessments** and **Interventions**. There are two tabs for Interventions, one for scheduled and one for prn.

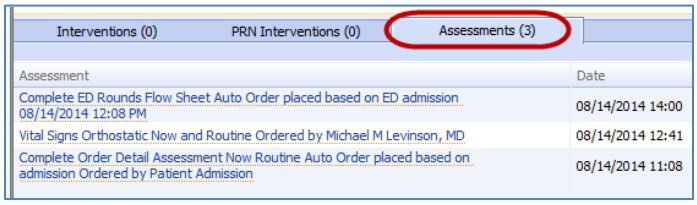
Examples of PCO that are assessments are below. You will click on the order name which will then open the assessment for you to complete.





Examples of interventions are displayed below. Interventions just require you to click the checkmark for each one that has been completed. There is a small comment field if you need to type a very short note regarding the intervention.

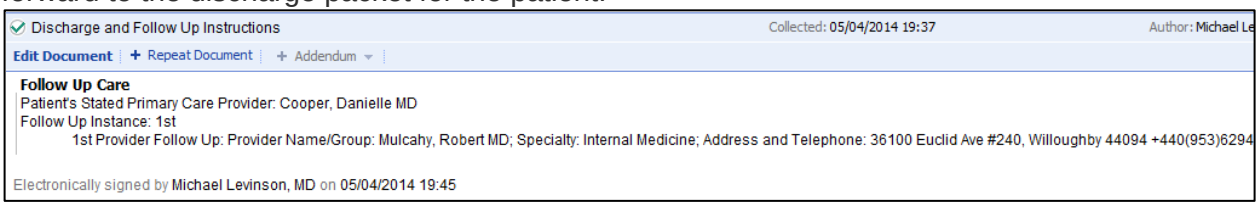




Discharge

Physician Standard Work

The physician is required to complete the disposition section of the ED Provider Note in ED Provider Documentation to capture the diagnostic impression, condition, and disposition. The physician will complete the Discharge & F/U Instructions. The follow up instructions will carry forward to the discharge packet for the patient.

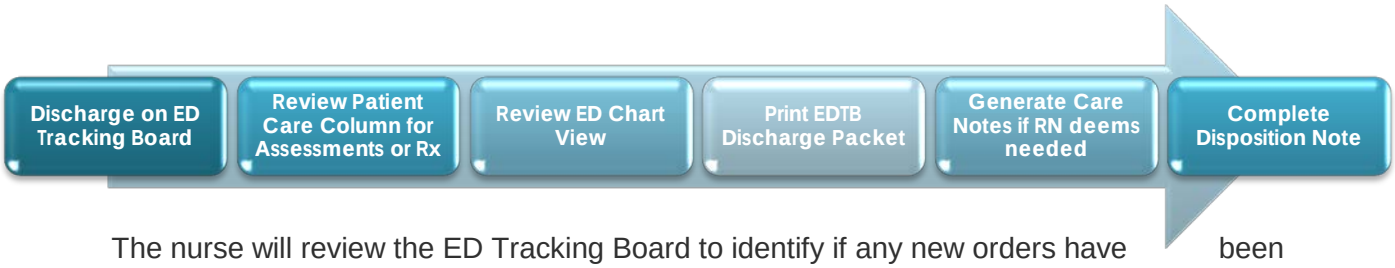


The physician will continue with placing CPOE orders for the discharge plan including splints, dressings, medications, etc… After the orders are place the physician will reconcile the home medication list if needed then generate the home going prescriptions. It is important the physician generates the electronic prescriptions in order to have the documentation within ED Chart.

Nursing Standard Work

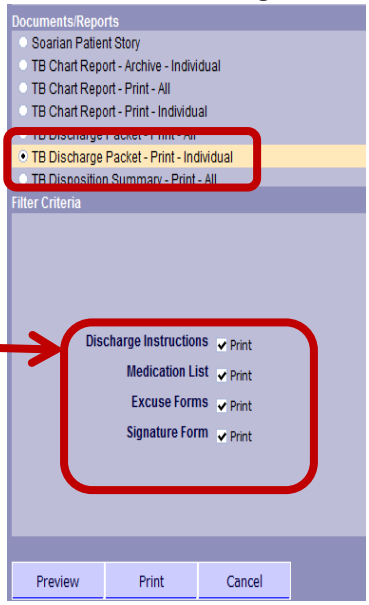
The ED Tracking Board and the ED Chart View allow for the nurse to easily review the chart for outstanding orders and reassessments prior to discharge.

The nurse will be notified of the discharge with a trigger on the ED Tracking Board Disposition Column and the chart being placed in the discharge rack.



The nurse will review the ED Tracking Board to identify if any new orders have been written. The Patient Care Column will identify new interventions or assessments, and the Rx icon for new medication orders. The nurse can look at the orders and results columns for the orange star indicating new orders to be acknowledged.

The user will go the ED Chart View to navigate down the left column and review results. The nurse can review the MAR to ensure medications, response to medications, and IV End Bag Time has been documented. The nurse will review the ED Provider Documentation; the provider note will have the diagnostic impression, follow up plan, and discharge medications.



- The nurse will generate discharge instructions by clicking on the printer icon
- Select TB Discharge Packet – Individual
- Select filters
- Click on Preview
- Click on Print

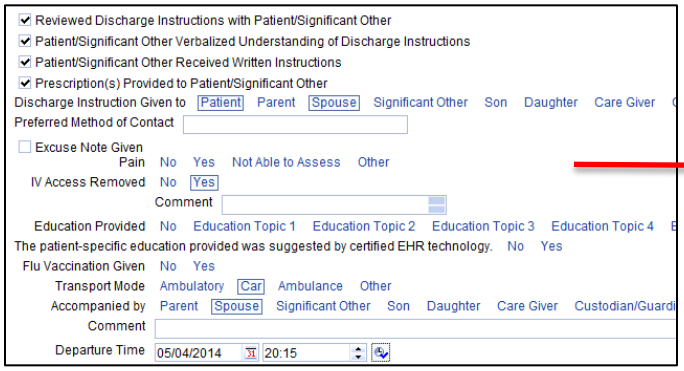
If the nurse determines the patient requires additional discharge information he/she will generate disease specific **Care Note** Instructions.

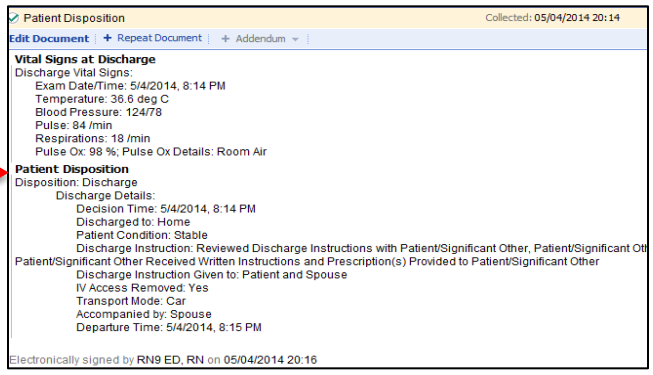
The nurse will complete the discharge documentation by completing the **Nursing Disposition Note** which includes documentation of vital signs, education provided, and discharge instructions. **The Nursing Disposition Note is a requirement for every patient registered in the Emergency Department.** The documentation provides information needed for Meaningful Use (decision to admit and departure time), ED Metrics (disposition, decision to admit, bed assignment given and departure time) and Finance (disposition, condition, mode and equipment used for transport and departure time).

Patients who are currently on an oral diabetic medication and receive IV Contrast during their ED visit receive instructions to stop taking their oral diabetic medication for the next 48 hours. The standard work is to place the instructions within the ED Provider Documentation, Discharge and Follow Up Instructions template.

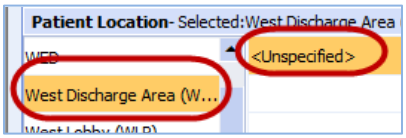
The CT Tech will enter a macro in the discharge and follow up instruction template and assign a target co-signer (the ED Provider ordering the exam) then save the document

The ED Provider will place their cursor in front of the macro and enter the patient's unique instructions. The ED Provider will be able to dictate into the text box with Dragon as long as the cursor is placed in front of the inserted macro.





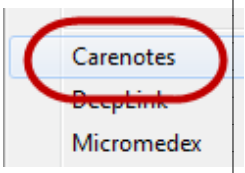
When the patient physically leaves the department the user should move the patient to the Discharge Area on the tracking board in order to maintain accuracy of the EDTB. The nurse can complete documentation even if the patient is in the Discharge Area but any outstanding orders will be cancelled with the move.



CARE NOTES

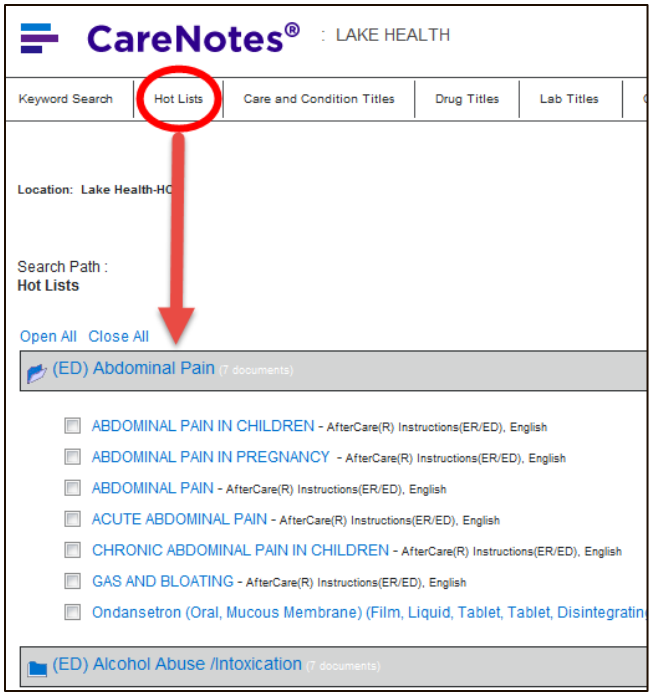
The minimum requirement for the discharge instructions will be the "Discharge & Follow Up Instructions" completed by the ED provider in Provider Documentation. These instructions will print with the TB Discharge Packet. If the nurse assesses a need for additional information for the patient or the caregiver he/she can generate additional instructions including disease specific or age specific instructions, diet, devices, or medications.

The user can launch into CareNotes from anywhere in Soarian by right clicking on the mouse then selecting CareNotes from the drop down. Care Notes will include a header with the patient information if the user launches into CareNotes when in the ED Chart View or within Soarian clinicals. CareNotes also has Hot Lists which has a folder for each of the top discharge diagnosis at Lake Health.



When the user opens the folder several different instructions will open to include age considerations, devices, diets and medications appropriate for that particular diagnosis. The user can select as many of the topics as needed. The user can also search by keyword if needed.

The user can also launch into CareNotes right to the diagnosis specific information by highlighting the diagnostic impression in the ED Provider Note, right click, and select CareNotes



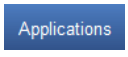
Care Notes prints patient specific information, including the patient's name. Preview the document prior to printing to assure you have the correct patient's name on the document.

CareNotes Request for Change

Change Request form can be used when:

- what you are searching for cannot be found in CareNotes.
- you found the topic, but the content is missing information.
- you found the topic, but the content needs to be revised or removed.

To Access the Change Request form:

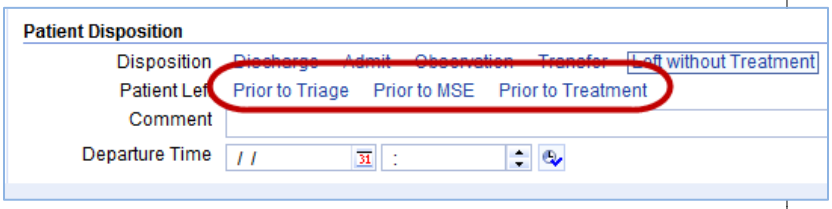


- Open the Lake Health intranet.
- Click on the Applications tab.
- Scroll to the Clinical Applications section.
- Click on the CareNotes Change Requests icon.
- Fill in the top portion with your identifying information.

- Select one of the checkboxes.
- Follow instructions provided; give as much detail as you can in the space provided.
- Submitting the form will generate an email to the CareNote Administrator who will evaluate the request and provide feedback to the sender.
- You will receive an email confirmation informing you of the steps that will be taken.

LEFT WITHOUT BEING SEEN / AMA

The nurse will document Left without Treatment in the **Nursing Disposition Note**. The nurse will determine when the patient left: Prior to Triage, Prior to Medical Screening Exam, or Prior to Treatment.



The ED physician will complete the ED Provider Note which will capture the AMA Assessment; this will carry forward to the Nurse Disposition Note and can be confirmed by the ED Nurse.

DOA / DAA

The ED physician will document expirations in the ED Provider Note which will carry forward to the Nurse Disposition Note for the nurse to complete. The ED Nurse will be required to complete the Death Assessment within Soarian which can be found in the Filter List on the Charting screen.

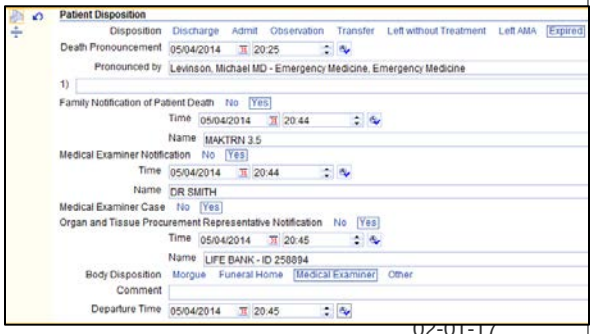
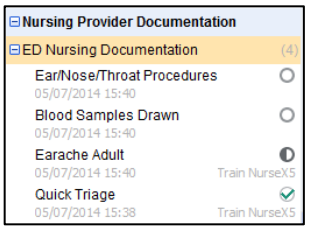


CHART COMPLETION

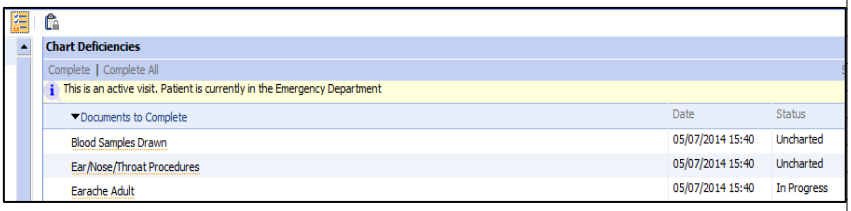
It is imperative every nurse and physician focus on the details of the chart completion process to ensure the chart is sent to HIM in a timely manner with all the clinical documentation completed to ensure accurate charges and billing for the ED visit.



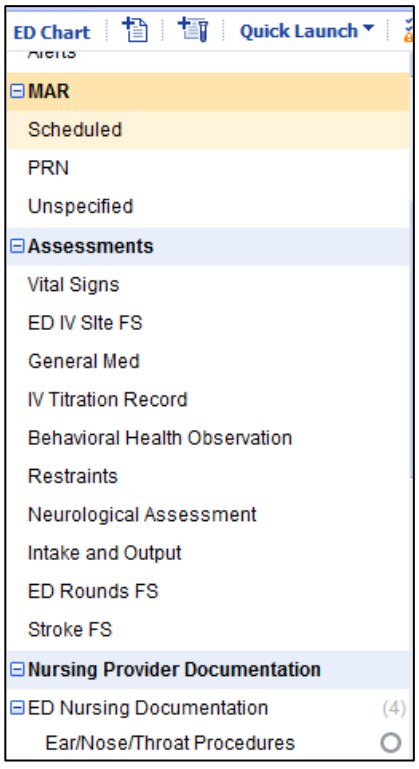
During the nurse to nurse handoff at shift change the off-going nurse should review the ED Nursing Documentation in the ED Chart View to ensure all the documentation is complete. The green check indicates the document is complete. This list will only include documentation that has been started; the user will need to verify if other documentation needs to be added. The nursing documentation should be reconciled prior to the off-going nurse leaving the unit.

The user is able to view chart deficiencies for the patient by clicking on deficiencies icon located in the ED Chart View tool bar. The user is able to launch into the document by clicking on the name of the document. Again this will only provide a list of documents that have been opened and not completed.

Each user should review the ED Chart View at the time of discharge or shift change. The user should review the left column starting at the top and review each category



- Overview
  - Allergies & Home Medication List completed
  - Orders Completed
- MAR
  - Medications Administered
  - Response to Medication Documented
  - End Bag Time Documented
- Assessments
  - Flow Sheets Completed
  - Intake and Output
- Nursing Provider Documentation
  - Quick Triage
  - Initial Nursing Assessment
  - Procedure Notes
- Discharge Information
  - Nursing Disposition Note(for every patient)

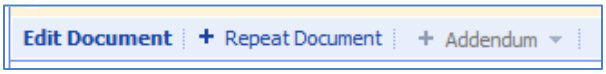


The user preferably will complete the document prior to the patient leaving the department, but due to patient flow especially

in Thru Care and Physician First this may not be a viable option. The user can document after the patient has left and has been moved to the discharge area. *Remember all orders will be cancelled when the patient is moved to the discharge area.*

Edit a Document

Only the author of a document is able to edit it. If you are not the author, you will need to add an addedum to it. You can also create a second document by clicking **Repeat Document** and making your changes on the new document.



To edit a completed document, open the document, click Edit. On the far right side, use the pull down Go To which takes you to a specific section of the document.

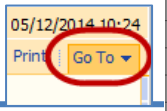
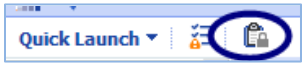
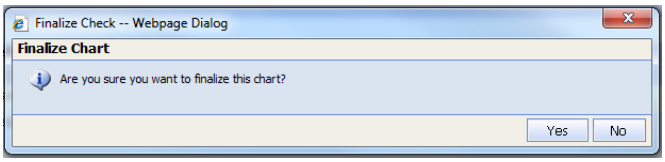


CHART FINALIZATION

Chart Finalization is the action of clinicians completing their portion of the ED Chart. Both the physician and the nurse take part in the chart finalization. Chart finalization needs only to be performed for the patient's chart by one user for nursing and one user for the physician. The ED does not need to be finalized by every provider, nurse, or ED tech that has charted on the patient's record. Only when both disciplines have finalized their portions of the ED Chart will the chart be considered finalized. When the chart is finalized the ED Chart will then be transmitted to HIM. ***Every patient registered in the ED require a finalized chart.***

The user will click on the finalize chart icon located in the ED Chart tool bar. When the Chart Finalization is executed, a chart deficiency check is performed. If there are no deficiencies found for the role for which the user is performing chart finalization, a dialog box will display. Click yes to finalize the chart. Click no to cancel chart finalization and return the ED Chart View.

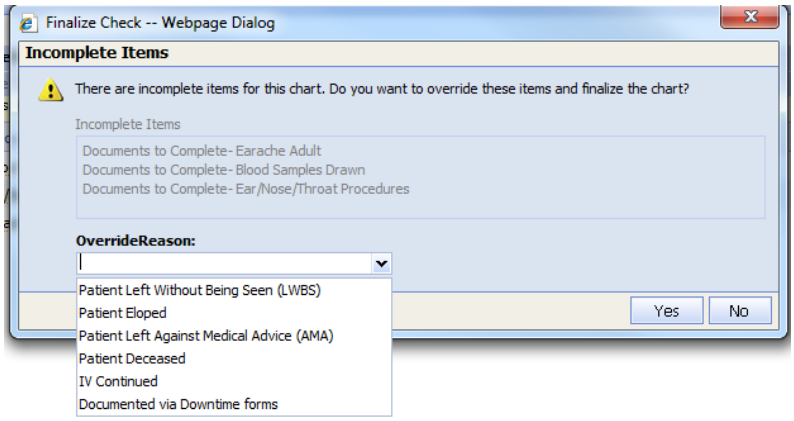




If deficiencies are found a pop up window will appear with a list of incomplete items; the user should x out of the incomplete items and complete the incomplete documentation. After the incomplete documentation is reconciled the user can proceed with the chart finalization process. **You will need to refresh the screen.**

Override

Some of the chart deficiencies will not be able to be reconciled such as a patient who left without being seen or patient that has an IV that is continued at the time of admission or transfer. In these cases the user will be given the option to override and continue with the chart finalization process. The override option should be limited to the approved reasons; this will be closely monitored for compliance by the ED Leadership team. If users are diligent in

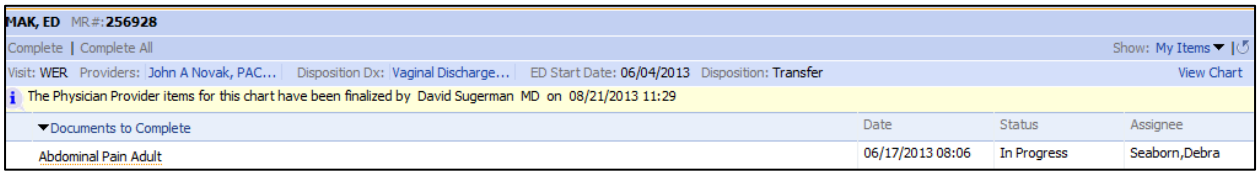


reviewing the ED Chart at shift change and prior to the patient leaving the override situation will only occur for the reasons in the drop down menu.

INCOMPLETE CHARTS TAB

The incomplete charts tab is located on the tab bar of the ED Tracking Board; the user can review and complete chart deficiencies using this tab. The expectation for completing charting is within 24 hours of the patient's discharge. If the chart has not been finalized the user can document as if the patient was still in the ED, i.e. "Edit Document", "Repeat Document" or "Complete". When the documentation is completed the user will then follow the chart finalization process.

If the chart has been finalized, the user will not have access to the finalized documents; the user will be required to complete an addendum.
Individuals who work in more than one of the Emergency Departments will be required to view the Incomplete Charts Tab within each Tracking Board.



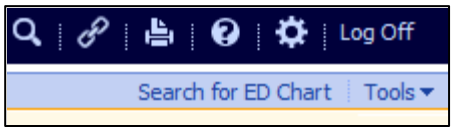
ADDENDUM

Once Physician and Nurse chart finalization has occurred, the ED Chart is considered finalized. Any documentation on the patient's chart is added as an addendum. There are two types of addendums:

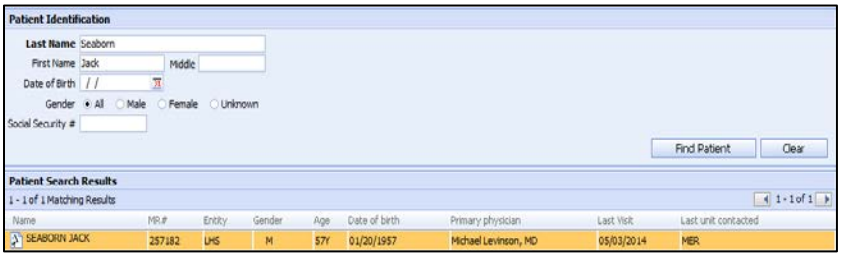
- Chart Addendum - is when a new document is added to the patient's finalized chart.
- Document Addendum – is when a document with a Final status is appended.

Chart and Document Addendums do not require a subsequent chart finalization. If there is a deficiency with the document it will display in the Incomplete Charts Tab as a deficiency. Once the document is saved with a complete status, it will be placed in a Finalized status.

VIEWING PREVIOUS ED VISITS

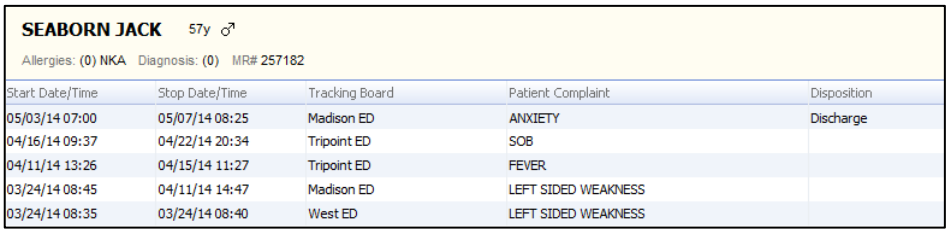


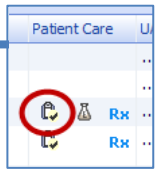
Users will be able to view previous ED visits within the ED Tracking Board by clicking on "Search for ED Chart" located in the tool bar to the right.
Enter patient information
Verify MR# & Date of Birth
Select correct patient, click OK.



Select visit to be viewed. Click OK.

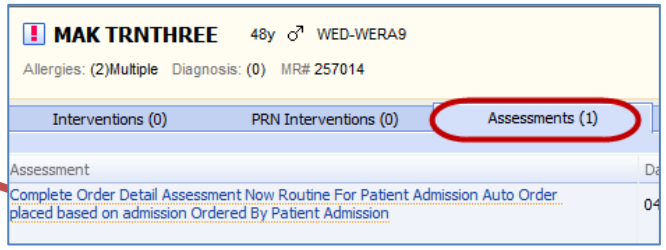
The chart will open in the ED Chart View as if it was an active patient. The user can review the discharge instructions and CareNotes while making discharge call backs. He or she can verify the treating physician and prescriptions (as long as the physician used ePrescriptions) by clicking on Discharge Medications.





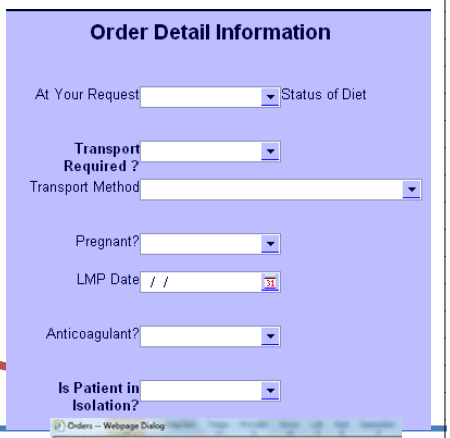
ORDER DETAIL INFORMATION FORM

When a patient is registered, the Order Detail Information form will be on your Patient Care worklist to complete. To access, click on the **Patient Care** icon and select the **Assessment** tab. Click on the **Order Detail Assessment** order.



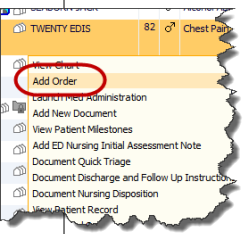
This form contains information that is required on some of the order detail screens. Completing this form will mean that you do not have to fill in this same information on each individual order detail screen as you are placing new orders for your patient.

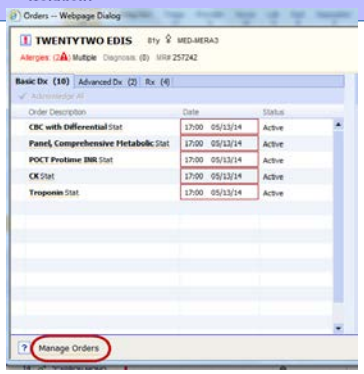
Note on the Order Detail form is a checkbox for **Isolation Precautions**. If a patient requires isolation precautions there will be a Biohazard icon displayed in the patient banner. This field will be checked with the reason for isolation displayed.



THE PLACE ORDERS SCREEN

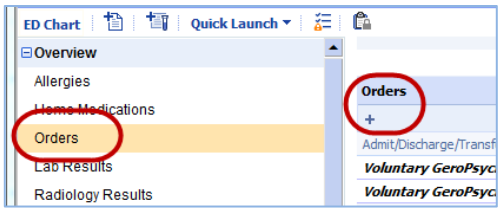
The quickest way to enter an order is from the **Quick Launch** menu. Click on your patient's name, and from the Quick Launch menu select **Add Order**. You can also use the Quick Launch menu from the ED chart view.



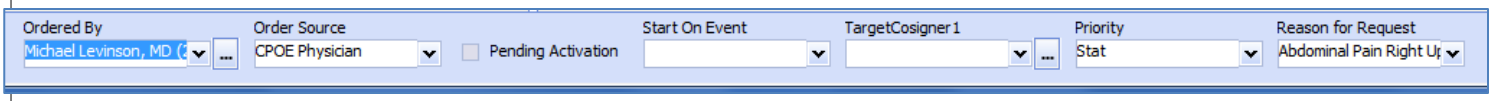


You can also access the Orders screen when viewing **Orders and Results** column. In the lower left corner of the Orders dialog box, click **Manage Orders.** This will take you to the Orders screen where you will complete the Session Details.

Access the Orders screen from the Chart View by single clicking on orders from the Overview container. Click the **+** under the Orders tab.

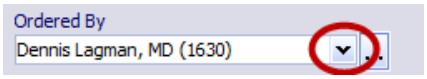


On the bottom of the Orders screen, you will need to fill in the **Session Defaults**. By filling in this information you will not need to complete the fields on each individual order detail screen.

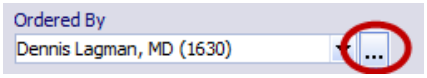


Be certain the Ordered By field reflects the proper caregiver. This information is saved as part of the legal medical record and needs to be accurate. The order is assigned to the "Ordered By" physician, and the ordering physician will receive the test results from the ordered tests. Entering the wrong name is falsifying the patient's medical record.

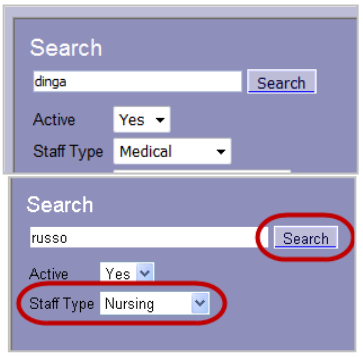
Fill in the **Ordered By** field; if the physician name you need is not in the pulldown for Ordered By, you need to search for that physician.



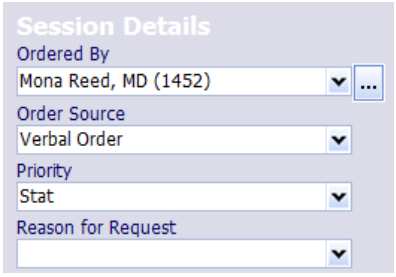
If the ordering physician is not listed, then click on the ellipsis located to the right of the Ordering By field.



1. In the Search window type the first few letters of the ordering physician's name. Click **Search**.
2. Select the physician name and click the **Add** button.
3. If you are placing an order requested by a nurse, you will need to search for the nurse's name. Click the ellipsis next to the Ordered By field to open the Search window. Type the nurse's name in the Search field, and select **Nursing** as the **Staff Type**. Click Search and click on the correct name, and then **Add**, in the lower portion of the window.
4. Entering an incorrect provider on orders creates a lot of extra work for a lot of people. The nurse who made the error will need to correct the order(s). Be very careful when entering a physician's name.



Continue filling in **Order Source** and **Priority.** Order Source will be **ED Guidelines**, **Written** or **Verbal Order VBR**. Priority for the ED is always **STAT**. It is very important that the correct order source and priority be selected so that the order will be processed properly in Soarian, Lattice and in MAK.



The default for ED nurses is Verbal Order VBR. If the nurse is placing orders contained in an ED Guideline, the nurse MUST select ED Guideline as the Order Source. If the nurse places

orders after the initial guideline has been entered, or an order that was not part of an ED Guideline, the Order Source must be Verbal Order.

IT IS STRONGLY RECOMMENDED THAT PRIOR TO ENTERING NEW ORDERS THE USER CHECKS TO SEE WHAT ORDERS HAVE ALREADY BEEN PLACED.

You can also access the Orders screen when viewing **Orders and Results** column. In the lower left corner of the Orders dialog box, click **Manage Orders.** This will take you to the Orders screen where you will complete the Session Details.

The table to the right lists the icons and what they stand for, as they will appear in the Order screen of the Unsigned Orders window

Indicator	Description
Dark Text	Order status = Active
Dark Text Italics	Order status = Active, requires a co-signature or acknowledgement
Light Text	Order status = Inactive, On Hold, Discontinued, or Invalid
Light Text Italics	Order status = Inactive, requires a co-signature or acknowledgement
	Your hospital organization can define medication orders to display this indicator when the medication order is changed by the pharmacy. Your hospital organization can display the details of pharmacy changes in the order's tool tip.
	Order has been revised
	Order is approaching expiration
	Verbal Order
	Order was entered in the pharmacy application
	Medication patient brought from home. Does not interface with the Pharmacy application.

Two other icons you will see in the ED in regard to medication orders.

 Order is auto-profiled

 Order is not auto-profiled

PLACING AN ORDER

If there is ANY question about what should be ordered, refer to the patient's Physician for clarification before any order entry is done.

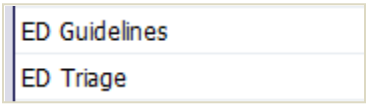
Before placing new orders, view the current orders screen to see what orders have been placed and are still active. This is important to help prevent a duplicate order from being placed. Also give special attention to a previously ordered diet and patient care order. If a new diet is being ordered you must first discontinue the current active diet order before placing a new diet order.

VERBAL ORDERS

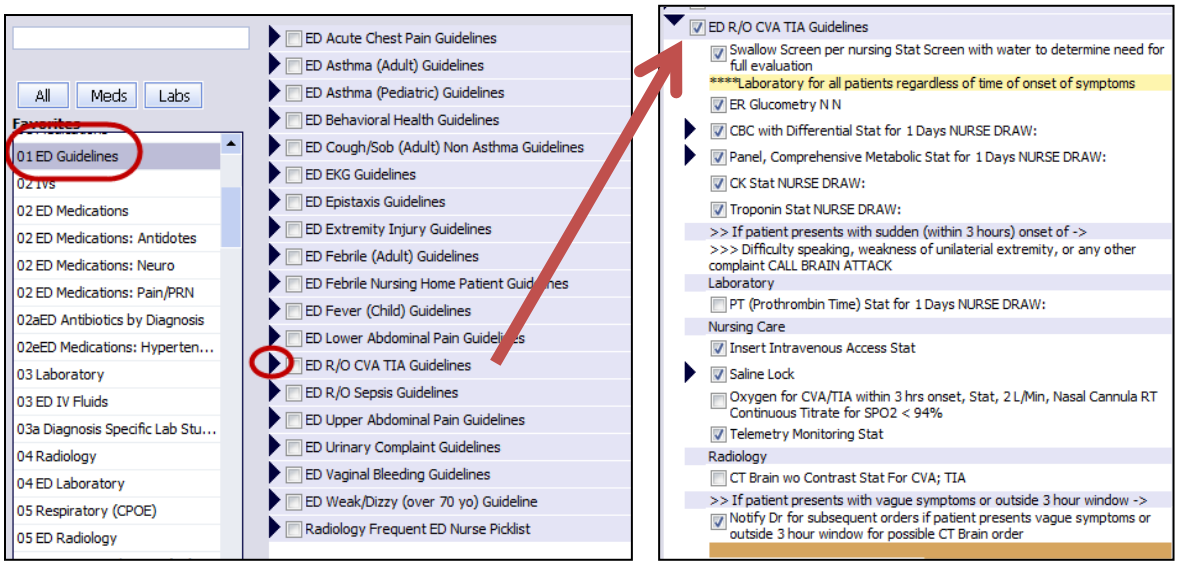
Verbal orders are orders given to the nurse by a physician or mid-level practioner (MLP) for the nurse to enter into Soarian.

ED SPECIFIC ORDERS

There are orders built that are ED specific. These orders are accessed from the Favorites list.



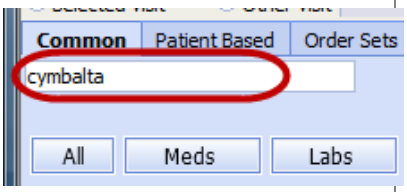
ED Guideline orders are predefined order sets that are used in the ED. It enables the user to select an entire group of orders at one time. Click the black triangle next to the order set needed. Then click the checkbox next to the guideline name to accept all the pre-checked orders. You can uncheck any orders not required and check others that may not be pre-checked.



Patient Care Guidelines

- Operational tool to assist in clinical decisions
- Detailed & patient focused
- Based on procedure or clinical conditions
- Recommended course of action for meeting standards of care
- Sources of continuity, quality of care and range of acceptable practices & options that can be adapted to specific needs

The **Search** function is available on the Common tab. Only use Search when the order you are looking for is not in any of the ED order groups. Do not use Search after selecting other orders until

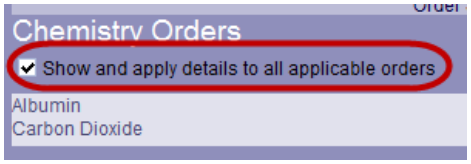


after you have added them to the order session. **Use the Search function either before you select any other orders, or after you have added them to the order session.**

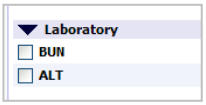
ORDER DETAIL FORM

Once the orders to be placed have been selected, an **Order Detail** form will appear for each order that had been selected. You are encouraged to complete as many of the fields on the form as possible. If you attempt to save an order without completing all the required fields, you will receive an error message to that effect. The required fields will be highlighted in pink.

If you did not complete the **Session Details** screen, you will need to complete the Priority, Order Source, Ordering Physician and Reason for Request (when applicable) fields on all order detail screens. **Priority for the ED is always STAT.** ED Orders must be selected from the ED picklists, must be a one-time order, and ordered by an ED physician for them to be processed properly. Lab orders must also be marked Nurse Collect.



1. You will see on some order detail forms a checkbox for **Show and apply details to all applicable orders.** This is used when all the orders in the same display group, or category, (such as Chemistry) and have the same Priority Ordering Physician, frequency and duration.

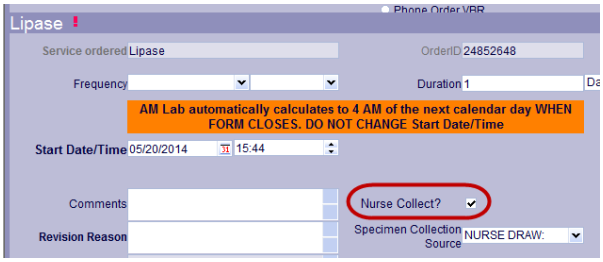
   You can click the checkbox for **Show and apply details to all applicable orders,** and Soarian will combine all the orders and apply the same information to each of the individual orders. You will only need to complete one order detail form for all the applicable orders. Soarian lists which orders are included.

   The orders are all placed on one order detail form, but are listed individually on the order screen once you have completed the order detail forms.

2. Most Order Detail forms include a field called **Frequency**. For **ED** orders, since the priority as STAT, leave the Frequency field blank.

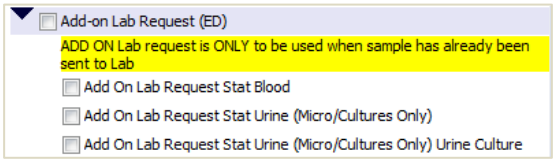
   

3. Laboratory order detail forms have a check box for **Nurse Collect?**

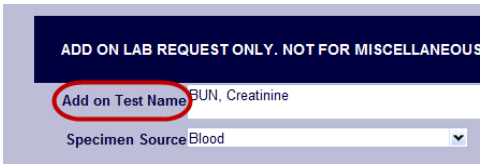
   1. This is the default for ED lab orders. If Nurse Collect is not checked the order will not show up on the ED staff's Lattice. Lab orders that are not selected from the ED Lab picklist will need to have Nurse Collect checked.
   2. Labs that were entered incorrectly, such as not checking Nurse Collect or not marking the order STAT, must be discontinued and ordered correctly.
   3. For Micro specimens you must indicate the specimen source on the form.
   4. **Add On Lab Requests**

a. This process is only for patients who have had a previous blood draw.



b. Open the ED Laboratory Favorites list**. Check the appropriate Add On Lab Request.**

c. In the Order Detail screen, enter the name of the test you want to add in the **Add on Test Name** field.



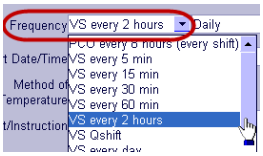
d. Use one order form for multiple tests as long as they are for the same color tube. If labs are a different color tube you need a separate order detail form.

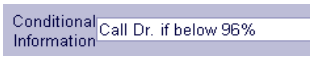
e. If a redraw is needed, the facilitator I notified through Veriphy.

f. The order can be seen in the Patient Record under **General Lab**.

f. *If necessary, the lab will call the ED and alert the staff for the need of a redraw. You will need to place the order again in Soarian prior to redraw.*

5. **Tailor orders to your needs**. Some orders will have default start/stop dates and times based upon the actual order, and/or default frequency. The start/stop pre-set times are based on LHS policy. **Tailoring of orders should be done with caution on sets that are required inclusion; i.e. Post-op Vital Signs are already set with the appropriate start times for each consecutive order.**



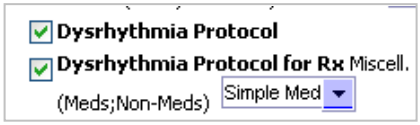


- Some orders require additional information to call physician with results. This information should be entered in the Conditional Information field of PCO's.

6. Some orders appear as an order set, where it looks like you are placing one order but it is actually two orders.

- Sometimes the checkboxes are grayed out, indicating the two orders must always be placed together. You have to remember when one of these orders gets discontinued you also have to discontinue the other one.

- Sometimes the checkboxes are not grayed out, giving you the option to place both orders or not depending on what the physician wants ordered.

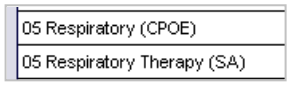


  i. Fax the Dysrhythmia order to pharmacy
  ii. Communication order shows up on nurses worklist

7. ***RT treatment orders are only placed if RT is to come and do the treatment. If ED staff is doing the treatment, you will only place medication orders.***

- ***Respiratory treatments to be administered by the ED nurse will have RN INH frequency. Respiratory treatments to be administered by Respiratory will have INH frequency.***

- You will see two listings for Respiratory Orders on the Favorites list. The RT SA orders are for the secretaries. The RT CPOE orders are for the physicians and CPOE nurses as they are treatment and medication orders combined.



  i. RT orders include many other frequency options, including the option for **PRN.**

- **All Respiratory administered orders placed in Soarian must also be phoned to RT.**

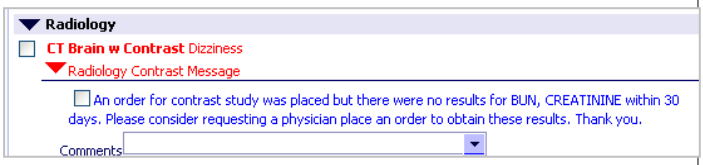
- **If you are placing an RT order with a specified frequency AND a PRN frequency, you need to place two separate orders. One for the specified frequency (for example, Q4H) and a second order for PRN frequency.**

- **If you are placing 2 RT orders, each with a different frequency and/or a different medication, place two separate orders. You will need to override the duplicate order message.**

- O_2 order is automatically until discontinued. If the order is to be a PRN order, you must manually write PRN in the comments field **for this particular order only**. **Do not order a treatment which has a one-time duration with a comment PRN in the Comment field.**

- For **Inhaler Subsequent** orders, you must enter **Daily** with the frequency option. Failure to so this will result in a one-time order only.

8. Rule for Contrast studies: any order that involves contrast, the workflow goes to lab to check for BUN and Creatinine done within past 30 days. (Some studies may look for different tests to have been resulted.)

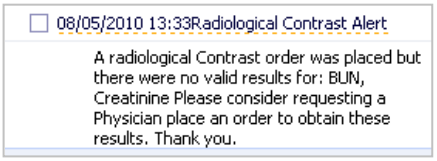


   - If done and results are within normal range, will get "normal" message.

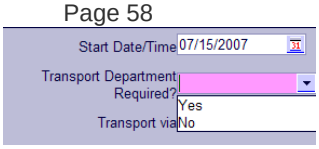
   - If lab test not done or lab results are not within the normal range, will get message indicating what result is missing or results out of range.

   - Different colors on order's screen: **red** = rule that is triggered, i.e., clinical checking; **blue** = written rule, i.e., the message as to what the rule is for, action if needed, to be done

   - If no lab results or out of range results message is received, need to check the checkbox and enter a comment (lab test ordered). If out of range results, can flip over to patient record and view results. MD can choose to proceed with test or not. If no results MD needs to order lab work; can place both others at one time. Can enter comment and save order.

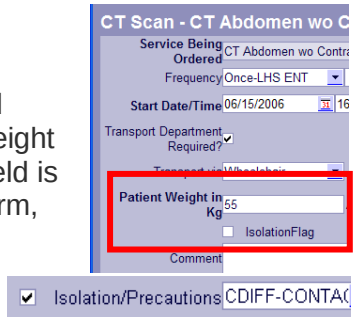


   - If no lab results or out of range results message is received an alert will be on your worklist which needs to be addressed.



9. Radiology Order Detail forms has a field to identify whether a patient will require assistance from Transport. IN THE ED TRANSPORT REQUIRES? WILL ALWAYS BE **NO**. (This should fill forward from Order Detail Assessment.)

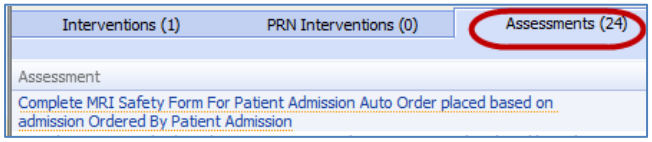
10. Pay special attention to **laterality**! **DOUBLE CHECK IF IT IS RIGHT OR LEFT.**



11. Radiology orders contain a field for the **Patient Weight**. This field should be populated with information from previously recorded Weight and Height on the Triage or Nursing assessment. If the Weight field is not populated when you are filling out the radiology order detail form, you must obtain the **accurate** weight for the patient and enter the information.

12. Note also on the Order Detail form is a checkbox for **Isolation Precautions**. (This should fill forward from Order Detail Assessment.)

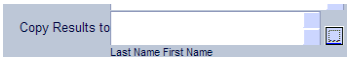
13. Many Radiology order detail forms include additional notes indicating a prerequisite must be completed before the patient is sent for the test.

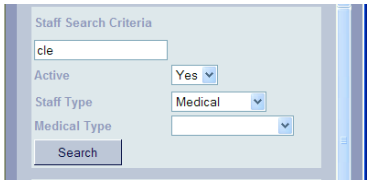


- When the MRI orders are placed, the MRI Safety Assessment populates your Patient Care worklist. Most of the information will already be filled in (fills forward from the admission assessment). When the assessment is completed, it will automatically print in Radiology.
- Many other order detail forms have similar links on them. Please follow all instructions for printing, completing and faxing the forms to Radiology prior to the patient being sent to Radiology. The Contrast Risk form will also automatically at the completion of the order process.

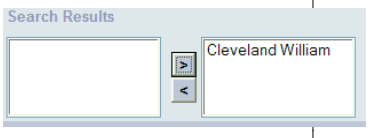
14. If the test is to be a portable test, and there is not a separate order for the portable test, type **PORTABLE** in the comments field.

15. There may be times when a result will need to be sent to a physician other than the ordering physician. There is a field on some order detail forms to indicate where the results are to be sent.

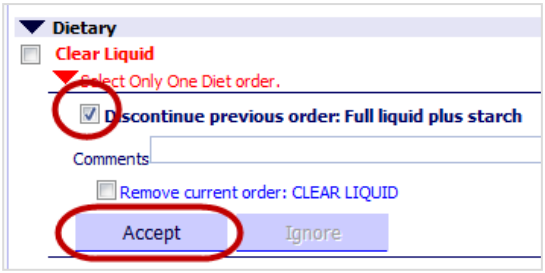




- Click on the ellipsis next to the **Copy Results to** field.
- If you would like the results sent to a physician, enter the search criteria for the physician. Click Search. You can select multiple physicians to send results to.
- When you have finished making your selections, click on the physician name, then click the arrow pointing to the right.
- Click **OK** when finished. Your selections will appear in the **Copy Results to** field.



16. Commonly ordered diets in the ED are listed under **07 ED RN Interventions/Diet**. There is a separate category for Common Diet Orders (ED).
17. ***Dietary orders must contain only one checked diet.*** When you need to add other dietary instructions, put those instructions in the Instructions field. DO NOT USE ANY PUNCTUATION MARKS OR HIT THE ENTER KEY WHILE ENTERING INFORMATION IN THIS FIELD. If you do, dietary will not receive the information.
18. Dietary orders will default to a frequency of three times a day.
19. When a patient has a current diet order and you add a new one without first discontinuing the first order, you will see a conflict in the Unsigned Orders window.



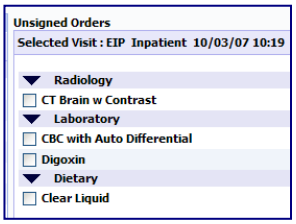
    - If you want to discontinue the previous order, check the box to discontinue it, then click accept.
    - When placing an **TIMED** NPO order (i.e., NPO after midnight):
        i. Make sure the order start time is valued appropriately (suggest to use today's date with 23:59 as the time),

        ii. Use the pulldown in Comment field when conflict presents and select ***Timed NPO for Procedure.***

        iii. Next click **Ignore. This will allow the sending of the TIMED order.**
20. **EKG orders must be entered in Soarian, even if the EKG has already been completed!**
21. Some Order Detail forms, such as an electrocardiogram, will have a field for **Interpreting Physician**. If known, use the pull down to select the appropriate name or group. If this information is not known, select **Roster** from the list.

After the first Order Detail form has been completed, in addition to the **Next** button, there will be a **Previous** button in the left lower corner to allow you to return to a previous Order Detail form if necessary.

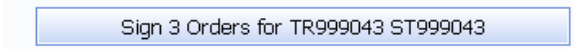
1. **When ordering multiple sets of orders at one time, clicking the Cancel button will cancel all the orders you have completed.** If you need to cancel one individual order only, click the **Remove Order** button located in the upper third of the Order Detail form.
2. Click **Order and Finish** after the last order detail form is complete. (When the last Order Detail form appears, there will not be a Next Order button in the left lower corner of the window.) Close the Order Picklist window.
3. The orders will appear in the **Unsigned Orders** list on the right side of the Orders screen. The orders will be separated by service category.



4. Make sure all the orders listed are correct.
   - If you need to remove an order, check the order you do not want, and click the **Remove** button located at the bottom of the New Orders window.

   - If you need to edit an order detail, click on the order in the New orders window and the Order Detail form will open.

5. Make certain you have the right number of orders, and that you are on the right patient's record. To complete the order process, click the **Sign** icon located in the lower right corner of the window. The orders will appear in the **Current** window of the Orders screen.



Lab Panel Reference Guide

If panels are ordered together in one order session, use the appropriate Combined Panels located in the Frequent Lab Order Favorites list**. If tests in the individual panels are ordered separately the lab system automatically CANCELS one as a duplicate.** If panels are ordered in a different order session, you will receive an error message.

If the panels listed below are ordered, then in a different order session an additional panel duplicates:	Revoke the duplicate panel. Enter orders for the individual tests listed below:
If BMP ordered, then Renal duplicates	Albumin
	Phosphorus
If CMP ordered, then Renal duplicates	Phosphorus
If Renal Ordered, then BMP duplicates	No additional tests are needed.
If Renal ordered, then CMP duplicates	AST
	Alk Phosphatase
	ALT
	Bilirubin Total
	Total Protein
If CMP ordered, then Hepatic duplicates	Bilirubin Direct
	Bilirubin Total
If Hepatic ordered, then CMP duplicates	BMP

Panels	BMP	CMP	Renal	Hepatic
Components	***	Albumin	Albumin	Albumin
	***	Alk Phosphatase	***	Alk Phosphatase
	***	ALT	***	ALT
	***	AST	***	AST
	***	Bilirubin Total	***	Bilirubin Total

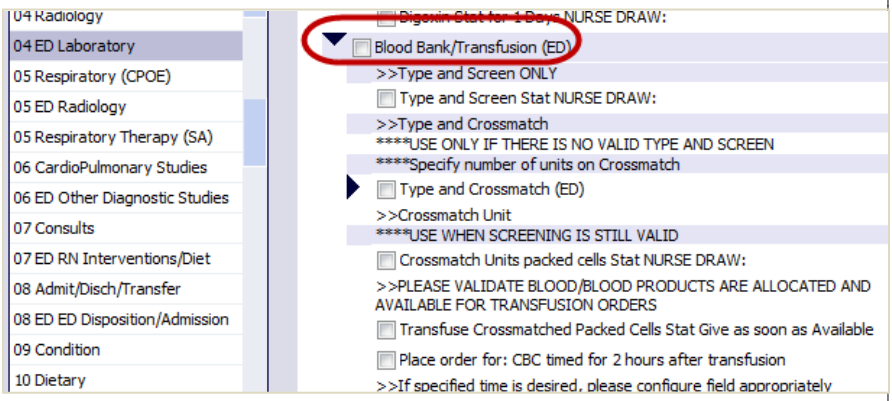
	BUN	BUN	BUN	***
	Calcium	Calcium	Calcium	***
	Carbon Dioxide	Carbon Dioxide	Carbon Dioxide	***
	Chloride	Chloride	Chloride	***
	Creatinine	Creatinine	Creatinine	***
	Glucose	Glucose	Glucose	***
	***	***	Phosphorus	***
	Potassium	Potassium	Potassium	***
	Sodium	Sodium	Sodium	***
	***	Protein Total	***	Protein Total
	***	***	***	Bilirubin Direct
	***	***	***	Bilirubin Indirect

BLOOD TRANSFUSION ORDERS

If order is written as "type and cross" the actual order to be placed in Soarian is "type and screen". There is no separate order for an emergency transfusion of ***un-crossmatched*** blood. For un-crossmatched blood, use the carbon paper form.

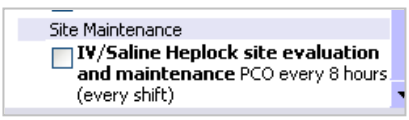
The Blood Product Unit Requisition will print TO THE LAB with any blood product order. ED staff collects the sample and labels with lattice label. Sample is then sent to the lab.

Orders are found under ED Laboratory > Blood Bank/Transfusion (ED)

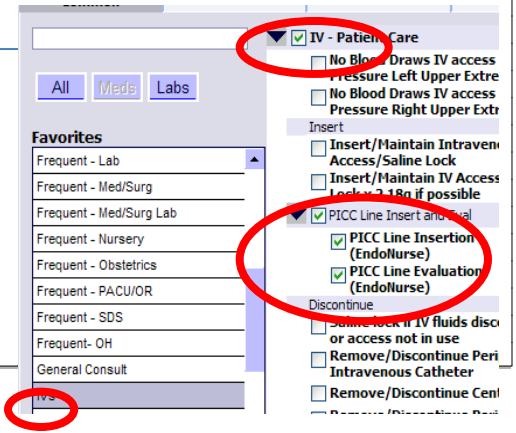


IV Site – these orders are listed separately on Favorites list as IVs. Select **IV-Patient Care** for the Patient Care Order.

The order you need to select for regular maintenance (regular tubing or dressing changes for example) is under **Site Maintenance.** This order will appear on your worklist every shift.

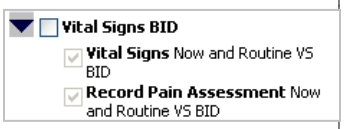


PICC Line Orders – It is very important that when you are entering a PICC Line order you check **PICC Line Insert and Eval**. Please do not uncheck the 2 orders that are listed below the heading. The Endo nurses need both of these orders checked for documentation.



Vital Signs; these orders are listed separately on Favorites list as Vital Signs. Note: There is an order for VS q4h then q shift. It is listed as two orders, but they are to be ordered together. When you open the triangle both of these orders are checked off already. This means that the VS are to be charted q4h for the first 48 hours, then q shift from then on.

Vital Sign and Pain assessment orders are ordered as a set, but are actually two separate orders. If one gets discontinued, you must remember to discontinue the other.



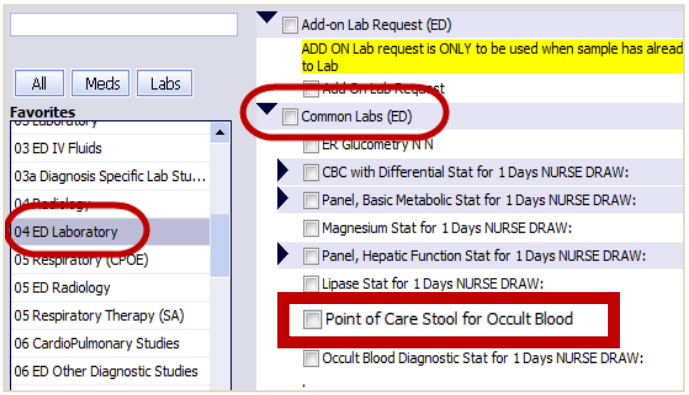
If you need a VS order to appear on the worklist at specific intervals, locate the specific order for that interval. If you need to place a VS order that is not on the list, any VS order detail screen may be changed in the Frequency dropdown.

POINT OF CARE AND PATIENT CARE ORDERS

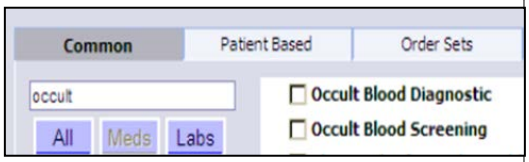
ED **Point of Care**, Stool for Occult Blood order can be found under **04 ED Laboratory** on the Favorites list. Click the black triangle next to Point of Care Testing to view the POC orders. If you must search for a POC order, you must type **Point** in the search box above the Favorites list. Otherwise it is very likely that the wrong order will be placed.

To place a Point of Care order for **Occult Blood** in the ED, locate **ED Laboratory** on the Favorites list. Select **Common Labs**.

DO NOT USE THE ONE listed under Laboratory>Hematology. **The Point of Care Order** for occult blood testing is used only where this test is performed at the patient bedside.

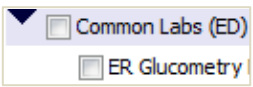


There are two orders that should be used when sending the specimen to the LAB. The LAB will actually run and result the test if either of these orders are entered.



Once ordered the assessment (where you will document results) will appear on your worklist.

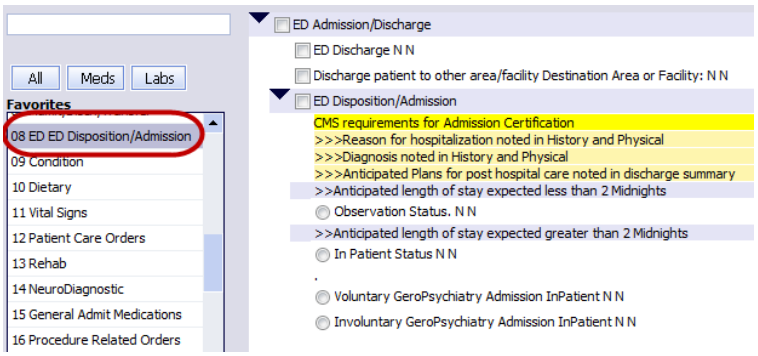
POC Glucose for ED is listed under ED Laboratory > Common Labs > ER Glucometry.



CSF is sent on a paper requisition to lab. This order is not currently in Soarian.

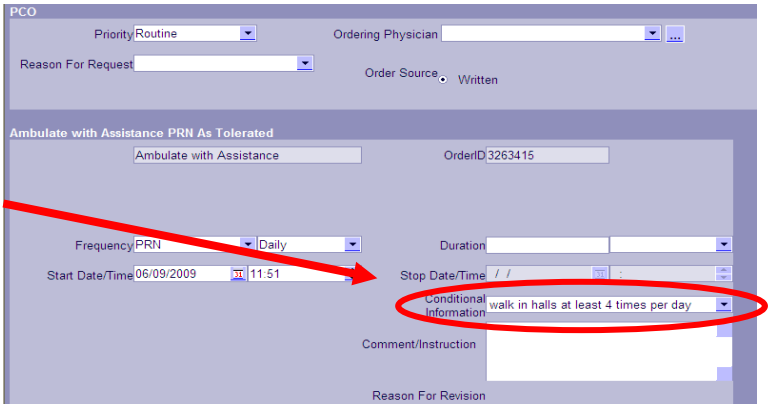
ADT Orders

- ED CPOE admission orders will be placed by the ED physician or mid-level practitioner.
- They are listed under **08 ED ED Disposition/Admission** in Favorites list.
- Decision to admit time is the time the admitting physician was paged.
- When signed (saved), the order prints a requisition to the secretary in the ED. The SA will then make the change in STAR.

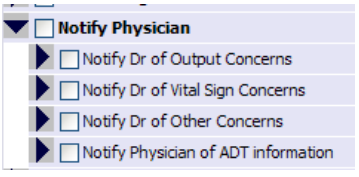


Working with Patient Care Orders:

- **Orders can be modified for specific needs by using the frequency fields and the "Conditional Information" field. Use the Conditional Information drop down list or free text your information.**



- **Some Patient Care Orders will have default start/stop dates and times based upon the actual order. These pre-set times are based on Lake Health policy.**
- **If the PCO is a one-time order, leave the Frequency field blank.**
- **PCO for testing all stools, use the PRN frequency. If this is a physician order, then place an order for each stool tested and complete the intervention.**
- **If a PCO is cancelled, future occurrences will fall off of the nurse's worklist. Current or past occurrences that have not yet been charted will remain on the worklist.**
- **A revision in a PCO with future occurrences will actually cause Soarian to discontinue the order and replace the original order with a new order, based on the change. If you receive a message that an order cannot be revised you will need to discontinue that order and place a new one with the updated information.**



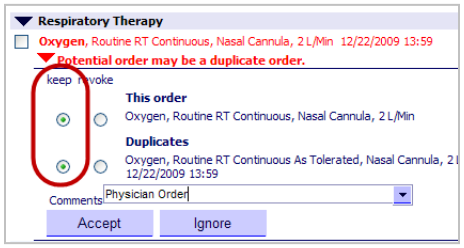
- **Some of the PCO are for communication only. These send information to a worklist regarding parameters of care.**

IF YOU DISCONTINUE A PCO, YOU NEED TO REMEMBER TO CHECK YOUR WORKLIST. THERE MAY BE OCCURRENCES ON IT WHICH YOU WILL NOT BE CHARTING ON. YOU NEED TO OPEN THE ORDERS ON YOUR WORKLIST AND MARK THEM AS NOT BEING ABLE TO COMPLETE DUE TO THE ORDER BEING CANCELLED.

DUPLICATE ORDERS

Duplicate Checking will alert the user to a duplication of an order. Typically an order will be flagged as a duplicate if the same order had been processed within the past four hours, such as order for Radiology and Laboratory. Other orders may have a longer time span, up to 24 hours.

Dietary orders however, are not set to alert the user to a duplicated order. When you place a dietary order, you will see a warning to cancel the current dietary order before placing a new one.



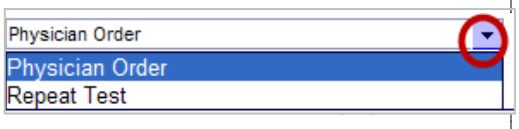
When ordering certain types of services, you will be able to place both a one-time order and a PRN order for the same service. You may choose to accept the "duplicated" order. Select the radio buttons under the **Keep** column, and use the pull down to enter a comment such as Physician order. Click **Accept** and continue with the order process.

<u>When you see an alert that a duplicate order has been created, it is critical that you review both orders before determining which order to proceed with and which one to cancel, or to process them both.</u> **<u>DO NOT OVERRIDE THE DUPLICATE ORDER WARNING MESSEGE WITHOUT FIRST DOUBLE CHECKING THE ORIGINAL ORDER.</u>** <u>You may not need to create the duplicate order.</u> If you just need to create an order for additional tests, call the receiving department and they will add the tests to the original order. Be sure to check with the physician or nursing supervisor if you have a question as to how to proceed.

1. The duplicate order will appear in the **Current Ordering Session** with instructions to follow and/or choices on how to proceed. Click on the red triangle to view your instructions.

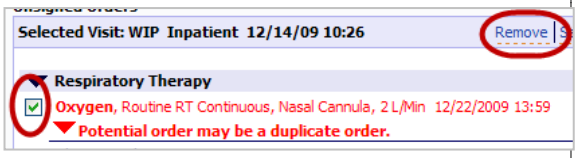
2. The user will not create the duplicate order in most cases. To try to do so will result in another message in the Order Session Summary alerting you to the fact that you are creating a duplicate order. For Laboratory and Radiology orders, this will cause one or both of the orders to be cancelled by the receiving department's system.

3. In the **<u>rare</u>** occasion that you do need to create a duplicate order, select the **Keep** radio button on the



duplicate. In the Comment box, use the pull down to select or type in the reason for the duplicated order. **YOU MUST ALSO CALL THE RECEIVING DEPARTMENT WITH THE ORDER INFORMATION.** The second order will be kicked out of the receiving department system and will appear as cancelled in Soarian.

4. In most cases when you create a duplicate order, you will need to remove the duplicate order.



   a. One option is to remove the order from the Current Ordering Session window. Check the order that you need to cancel. This order should be the only one with a green check mark next to it.

   b. Click the **Remove button.**

   c. If you need to cancel the original order, select the radio button in the **Keep** column for the order you wish to keep, and click the radio button under **Revoke** for the order(s) you wish to cancel.

   d. Click **Accept.**

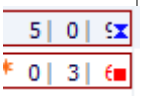
   e. Continue the order process for the correct order. You will not be able to sign the order session until all conflicts have been resolved.

      i. If you need to keep both the original order and the duplicated order, you MUST enter the reason for the duplication in the **Comments** field.

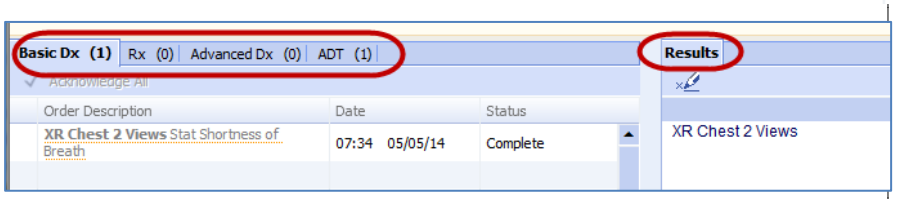
      ii. Click **Accept.**

5. If the need does arise when you need to create a new, second order and discontinue the first (original) order, then select the **Discontinue Previous Order** option. You cannot discontinue the first occurrence of a recurring order, or an order that is In Progress, or has been resulted.

VIEW CURRENT ORDERS FROM ED TRACKING BOARD

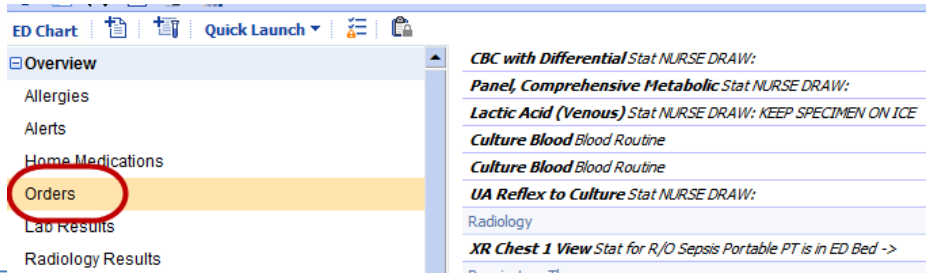


To view orders from the Tracking Board, click on any of the order count indicators. You will not only be able to see all the orders but you will also see any tests that have been resulted.



VIEW CURRENT ORDERS FROM ED TRACKING BOARD

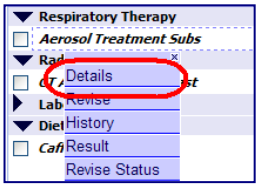
To view orders in the tracking board, select the patient's name, and click View Chart. On the left navigator, select **Orders**.



VIEW CURRENT ORDERS FROM ORDERS SCREEN

The default **Time** view is since registration. The default **Order Status** is everything. You have the option viewing orders from Since Registration, or from the Past 3 or 7 Days.

You also have the option of sorting orders by date, type or other options. Click the **Sort Options** triangle to view your options. Click **OK** when finished.

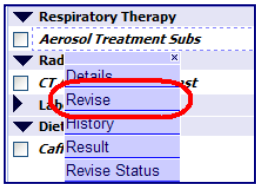


To **View** an order detail left click on the order in the Order Session Summary window and select **Details**. When finished viewing the Order Detail form, click the **Close** button.

Remember you can also view orders in the Patient Record and in the Clinical Summary.

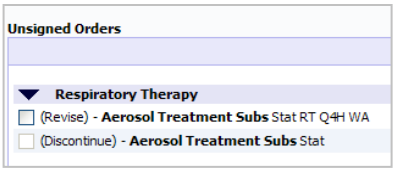
REVISE CURRENT ORDERS FROM ORDERS SCREEN

Revising of orders should not be routinely done. Revising an order with future occurrences will actually cause Soarian to discontinue the order and replace the original order with a new order, based on the change. Best rule of thumb is NOT to revise an order but to discontinue it and replace it with a new one. ***NO interfaced or Service Provider order is to be REVISED (LAB, RAD, Dietary, Respiratory Therapy, ETC). If you need to revise a lab order cancel the original lab order, and call the lab when you are placing the new order.***



Do not revise a PRN order to a scheduled order. You need to discontinue the PRN order and place a new order for the frequency specified.

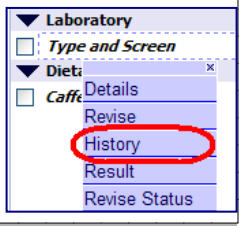
1. Left click on the order in the Current Orders window. Select **Revise**.
2. In the Order Detail form make the necessary changes or corrections. **You must enter a reason for revision in the Reason field located near the bottom of the Order Detail form.**
3. If you are creating a second edit on the same order, the **Reason for Revision** field will contain the original comment; enter your comment after the original comment.
4. Click **Apply** when finished.
    a. The corrected order will appear as discontinued.
    b. The revised order will appear marked as revised.
    c. Only the current active order is displayed in the Current Order window.



5. Click the **Sign** icon when you finished.
6. Once the order has been signed, it will appear in the **Current Orders** window on the left side of the screen. You will see the triangle icon indicating the order had been revised. The discontinued order will appear in faded print.

VIEW ORDER HISTORY

Order History will display any user who had accessed the order: when it was ordered, if it was edited, when and by whom, when it marked in progress by the receiving department, and when it was completed.



1. Left click on the order and select **History**.
2. View the order history. Click close when finished.

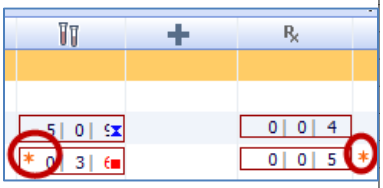
ORDERS TO BE ACKNOWLEDGED

Orders To Be Acknowledged is used to verify orders which have been entered into the system on a patient's record. It is a good way to know when there are new CPOE orders.

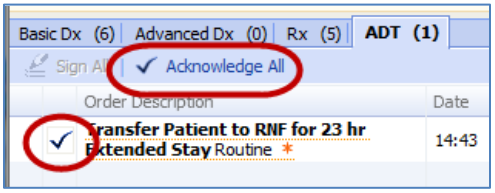
Orders should be acknowledged in Soarian at the same time the nurse is verifying them on the tracking tool and physician order sheet.

Orders To Be Acknowledged Tracking Board

Orders to be Acknowledged will have an orange star idicator.

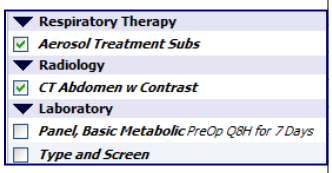


1. Click in the area of the order status.
2. Click on each tab to view orders. Orders that have not been acknowledged will have the **orange** star following the order name. The orange star will fall off once orders are acknowledged. It will reappear when new orders have been placed.
3. Click the ✓ next to the order, or click **Acknowledge All**.

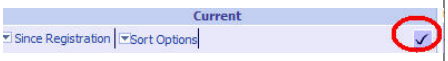


Orders To Be Acknowledged Orders Screen

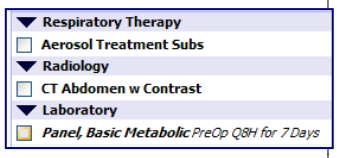
To **Acknowledge** an order from the Order window:



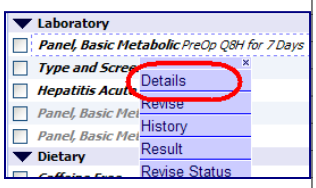
1. Select the order(s) in the Current Order list. An order that has NOT been acknowledged will appear in ***italicized*** font. A green check mark will appear in the check box.
2. Click the **Acknowledge** check icon located in the bottom right corner of the Current Orders window.



3. The order will no longer appear italicized in the Current Orders list indicating it has been acknowledged.
4. You can view the Order Detail form by left clicking on the order name in the Order Session Summary window. Select **Details**.



5. You can view the History if you are not sure whether an order had been acknowledged. To view Order History:
   a. Left click on the order and select **History**
   b. View the order history.
   c. When finished, click **Close.**



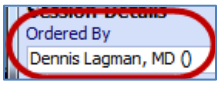
DISCONTINUE AN ORDER FROM THE ORDERS SCREEN

To discontinue an order is equivalent to canceling or stopping the order. **An order is not to be discontinued if the receiving department has started the procedure or process which had been ordered or if the order has been resulted. Only the receiving department can discontinue the order at that time.** To determine if an order can be discontinued, slide your mouse over the order in the Current Orders window. If the order displays an **Active** status, you may be able to discontinue the order. You can also click on the order and open it to view the status. Never discontinue an order that is **In Progress**. If the order is a recurring order you must call the receiving department to cancel the first occurrence.

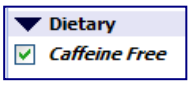
(While Soarian will permit the user to discontinue an "In Progress" order, it will cause errors in the system if done in Soarian. Please contact the receiving department immediately if you accidentally discontinue an "In Progress" order.

- If an order is cancelled, future occurrences will fall off of the nurse's worklist. **Current or past occurrences that have not yet been charted will remain on the nurse's and PCA's worklist.**
- Many orders are placed as a set. You must remember that if you are discontinuing one order you also have to discontinue the other order. For example, Vital Signs and Pain assessment or Speech Therapy and Barium Swallow.

To **Discontinue** an order from the Orders screen, fill in the **Session Default** with the physician's name.



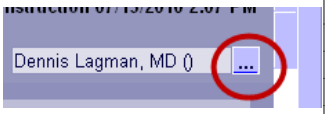
Select the order(s) in the Current Orders window. A green check mark will appear in the check box. Multiple orders can be selected.



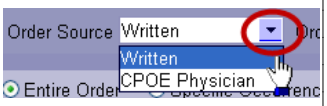
Click **Discontinue** located under the Current Orders window**.**

The **Reason for Discontinue** window will open. Note the **Order Source** and **Ordered By** fields.

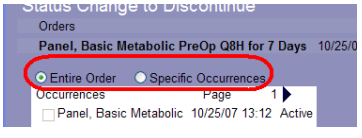
- **The physician (or nurse's) name MUST be updated to display the physician who discontinued the order. Use the browse button to search on the name. If you filled in the Session Default the physician name should be displayed.**



- **The Order Source must be Written. (It will only be CPOE physician if the CPOE physician/nurse is the one who is discontinuing the order him/herself.)**

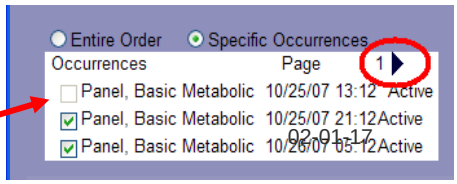


For each order to be discontinued, select the radio button for **Entire Order** or **specified Occurrences**.



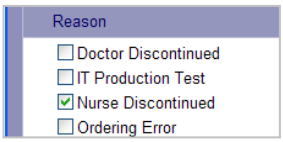
If discontinuing Specific Occurrences, you will need to select any or all occurrences to be discontinued.

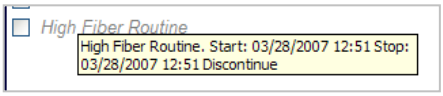
Use the page forward/backward buttons to be sure all occurrences are cancelled that need to be. Note in this example you cannot cancel the first occurrence of the lab



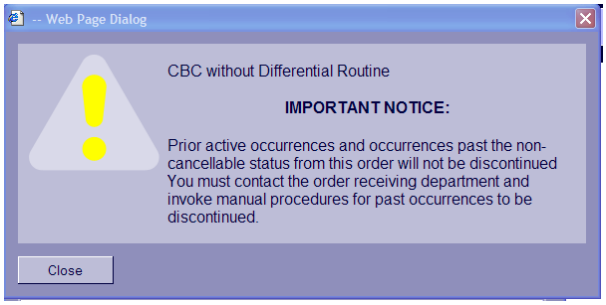
order. (It is grayed out.)

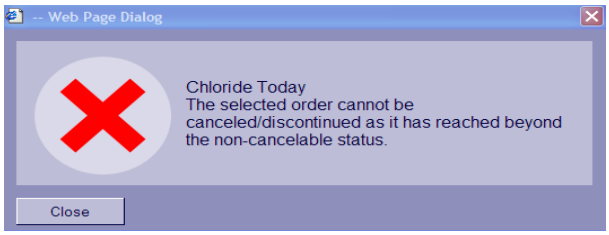
- Select the **Reason** that the order is to be discontinued. Keep in mind that different orders may have different reasons for discontinuing.
- When the appropriate boxes have been selected, click **OK.**
- The order will appear in the **Order Session Summary** window.
- You must click the **Sign** icon to complete this process.
- The order text will appear faded.
- When you hover over the discontinued order in the Current Order window, you will see a text box indicating the order had been discontinued.
- An order discontinued by radiology or the laboratory will appear as cancelled; if you look in the order detail it will indicate the reason why it was discontinued. The history will show that the order was discontinued by lab/rad.

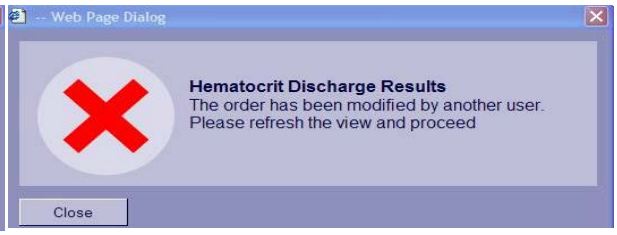




Attempting to discontinue an order past the start date/time will result in the following warning. When you see this message, ONLY CONTACT THE LAB IF THE ORDER BEING CANCELLED IS A RECURRING ORDER. If this is a one-time order, DO NOT CALL THE LAB TO CANCEL.







If you attempt to cancel an order which is in progress and receive either of the two the following messages, you must contact the lab to cancel the order.

NOTE: Once a patient is discharged in Soarian Financials, all active orders are cancelled. Results will continue to post, but orders will appear to have been cancelled in Soarian. If the discharge was done in error and the discharge is cancelled (the patient is returned to an inpatient status), ORDERS ARE NOT REACTIVATED. They must be re-entered into Soarian.

ASSESSMENTS VIA THE CHARTING SCREEN

Icons in the Assessment Window :

To go back to filtered list (called the assessment browser)	
View previous assessment	
Add a note	
Revision History	
Revert to previously saved assessment	
Save assessment	
Error or missing information on an assessment	

SETTING THE STATUS OF AN ASSESSMENT

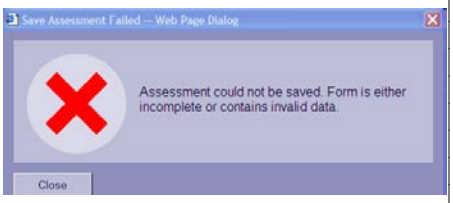
a. **Complete** – select only when you are completing the entire assessment. Once you status as Complete one chapter of a CHAPTERED Assessment all the chapters will have a status of Complete whether you documented on them or not.

b. **In progress** – select if you are unable to complete the entire assessment at present time but will return to complete later.

c. **Unable to complete** – select if you are unable to complete at present time and will not be completing at a later time.

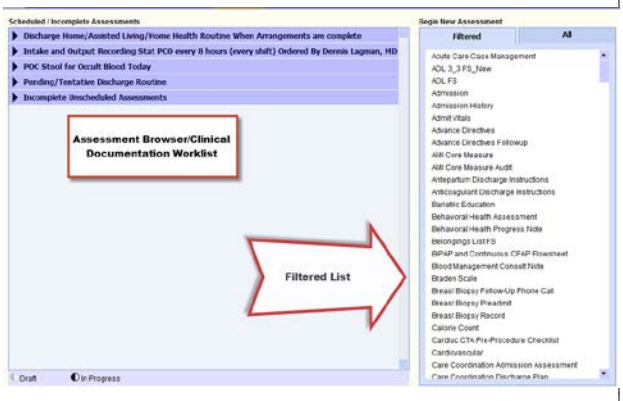
d. **Erroneous** – only available when editing an assessment; once status is set to Erroneous the assessment will no longer be visible on the Patient Record.

If you receive an error message indicating you are unable to save the assessment, it is likely that you did not complete one or more of the mandatory fields. Close the error message window, and locate the field(s) that is highlighted in pink. Pink in an element is indicating the mandatory field that is incomplete.



ASSESSMENT FORMS FILTERED LIST

There will be very few assessments that you will need to open from the Charting screen for ED outpatients. In the Charting Screen, from the left side of the window, select **Assessments**. Patients who are boarding in the ED as an Observation or Inpatient will have inpatient documentation listed there as well.

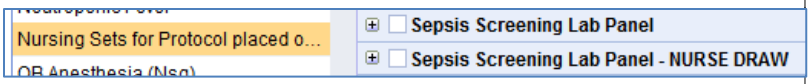


Some of the assessments you will access are the Sepsis Screening, Suicide Risk, Post Fall Reassessment, ED Behavioral Health Flowsheet and the Suicide Risk Flowsheet.

The area in the center of the widow is the **Assessment Browser.** This area is where scheduled and incomplete assessments are displayed. The Filtered list on the right will only display assessments that are charted on by ED staff.

Per Lake Health Policy "Hospital patients are monitored routinely for Systemic Inflammatory Response Syndrome (SIRS). Any patient with 2 or more positive SIRS criteria will have the Sepsis Screening Panel ordered to assess for Organ Dysfunction / Severe Sepsis. The I Team is called if the patient is positive for one or more the Organ Dysfunction Criteria."

When an inpatient meets two SIRS criteria a SIRS/Sepsis Alert assessment will appear on the Charting screen worklist. You must complete this assessment, and make sure all the appropriate lab tests have been completed. If the patient meets two or more criteria, you need to place the Sepsis Screening Lab Panel using the Order Source **CoSign Required**. This will place orders for the appropriate lab tests, and will place the Sepsis Screen Phase 2 assessment on the worklist. If the patient meets any one of the criteria, a **Code Sepsis** is to be called.

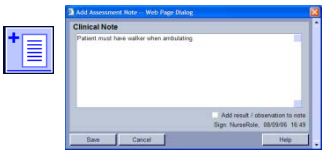


There are exclusion criteria, which if met, you will need to complete the **SIRS Alert Criteria Assessment** located on the Filtered List. Exclusion criteria are as follows:

o CIWA Score 6 or greater	Pause for 24 hours
o Post Op Patient (SCIP Checklist)	Pause for 24 hours
o Patient on antibiotics for known sepsis	72 hours from 1st dose of antibiotics
o Post CardioThoracic Surgery	48 hours from patient's arrival to ICU
o AMI/STEMI	48 hours from patient's arrival to unit
o DNRCC or Hospice	Pause throughout hospital stay

ADDING A CLINICAL NOTE TO THE ASSESSMENT

You have the ability to add a clinical note during the assessment process. The note will be able to be seen under the Clinical Documentation Flowsheet in the Patient Record. You will know there is a note attached to the assessment by the red triangle next to the checkmark or by viewing the History tab in the Patient Record.



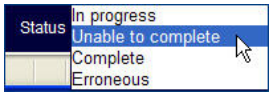
1. Click the **Note** icon on the assessment screen.
2. Type your note in the Clinical Note window. Click **Save** when complete.

COMPLETING/VIEWING INCOMPLETE ASSESSMENTS IN THE CHARTING SCREEN

When you sign an assessment as In Progress, the incomplete assessment will be seen in the **Assessment Browser** of the Charting screen. If you are not sure whether or not you saved it in progress, always check the Assessment Browser first. If your assessment is not listed here, it will be

displayed as complete in the Patient Record. You may need to click the **Refresh** icon in order to see your recently completed assessment. DO NOT OPEN A SECOND ASSESSMENT.

1. To open the assessment, click on the dark blue triangle to the left of the assessment name. In the expanded list, select the assessment.
2. The assessment form will open.
3. Complete as directed above.
4. If you are unable to complete the assessment click in the status field and select **Unable to Complete;** enter note as to reason.



COMPLETING IN PROGRESS ASSESSMENT FOR DISCHARGED PATIENT

To complete an **In Progress** assessment after discharge, you must access the assessment within 24 hours. You will find the assessment in the Assessment Browser on the Charting screen.

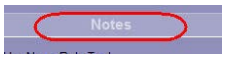
When you need to edit or add a note to an assessment after 24 hours post discharge you need to contact HIM for instructions. Use the HIM fax sheet which is located on the LAKE HEALTH Intranet under Soarian>Other E Forms.

DO NOT REQUEST AN HIM EDIT TO COMPLETE A FORM LEFT IN PROGRESS. After a patient is discharged, the forms created in Soarian are electronically sent to the HIM system and are automatically statused as Complete.

To edit a previously saved assessment you will access the assessment through the Patient Record using the **Edit** function if it is within 24 hours of completion. Never edit a form past 24 hours of completion

ADDING A CLINICAL NOTE TO AN ASSESSMENT IN THE PATIENT RECORD

1. Using the Flowsheet pull down list on the left side of the screen, select **Clinical Documentation**. Locate the assessment.
2. Click the assessment icon to open; click the **Notes** tab.
3. Type your note in the Clinical Note window. **Save** when complete.
4. An assessment which had a Clinical Note attached will appear with a red triangle in the Patient Record.



EDITING AN ASSESSMENT IN THE PATIENT RECORD

Once an assessment has been completed, you will have the option to edit it. **YOU MUST EDIT THE ASSESSMENT IN THE PATIENT RECORD. If it is an assessment that was recently completed, you may need to click the refresh icon in the Patient Record in order to see it displayed.**

Per Lake Health guidelines, you are only permitted to edit the assessment if it is within 72 hours of completion.

To edit an assessment, open the Patient Record. Select the Clinical Documentation flowsheet, and locate the assessment. Click on the assessment icon, and click the **Edit** button. Save when finished.

After an assessment has been edited you will see a white triangle next to the document icon on the Patient Record. If the assessment has a note attached, it will display with a red triangle in addition to the yellow triangle.

ERRONEOUS ASSESSMENT

Marking an assessment erroneous is an edit. You must adhere to the rules for editing.

In the event that information is documented and saved on an incorrect patient's electronic medical record you are required to mark the assessment as **Erroneous**. You need to use the Edit function as described above. When an assessment is marked Erroneous, it will not be displayed on the Patient Record as such. The assessment can be located using the Search function (Patient Data tab). The history attached to the assessment will detail what was done, when, why and by whom.

NOTE: **If any one form of a chaptered assessment (such as the Admission Assessment) is marked as Erroneous, all the chapters in that assessment will be marked Erroneous and will no longer be able to be seen from the Patient Record.** Therefore, if only one form of a chaptered assessment is to be marked Erroneous, create a clinical note in the incorrect assessment indicating why this assessment was erroneous. Include the correct information in the clinical note.

VIEWING THE ASSESSMENT CLINICAL NOTE IN THE PATIENT RECORD

A clinical note written with an assessment will not be saved until the assessment has been signed as complete. It will not be able to be seen with the assessment in the Patient Record, but the **red triangle** next to the assessment icon will indicate a note had been written for that assessment.

1. Using the Flowsheet pull down list on the left side of the screen, locate the type of result you would like to see. In this lesson, we will be looking at a **Clinical Documentation**.

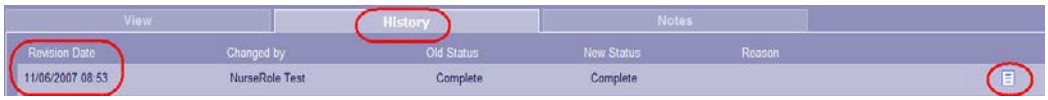
2. If the documentation you are searching for does not appear:
   a. Change the span of time you are looking at. OR
   b. Change the number of occurrences. The **Occurrence** icon is located above the display area. The occurrences displayed will depend on the settings of the Navigator bar (or timeline above).
   c. Click the **Refresh** icon above the result window after making your selection.

3. The red triangle on the assessment tells you there is a note attached, but not when the note was written. To see when the note was written:

a. Open the assessment in the Patient Record.

b. Click the **History** tab.

c. The **History** tab will display a note icon if a note had been attached to the assessment. The note icon is displayed on the far right side of the window. The date and time the note was written is displayed on the far left of the line.

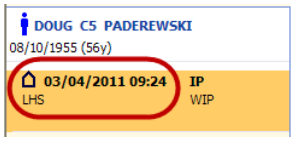


d. Look in the Clinical Note section of the Patient Record to locate the note by date and time indicated in the History screen.

The Clinical Notes will display in reverse chronological order. Select the note icon for the note you wish to view.

CREATING A NEW CLINICAL ASSESSMENT/FLOWSHEET AFTER DISCHARGE

Once the patient is discharged you will notice that the "Assessment" option on the left side of the charting screen is no longer displayed. To be able to access an assessment you need to open the visit in Soarian. **But remember, you can only document in the patient's record up to 72 hours after the patient is discharged.**



If patient is no longer on your census, locate the patient by searching using the correct account number. Once you locate your patient, **make sure the correct account number is displaying in the Patient Header**. If the account field is blank, open the Visit window. The patient registration screen will be displayed. Click on the visit date on left side of screen; make sure you are clicking on the correct visit date.

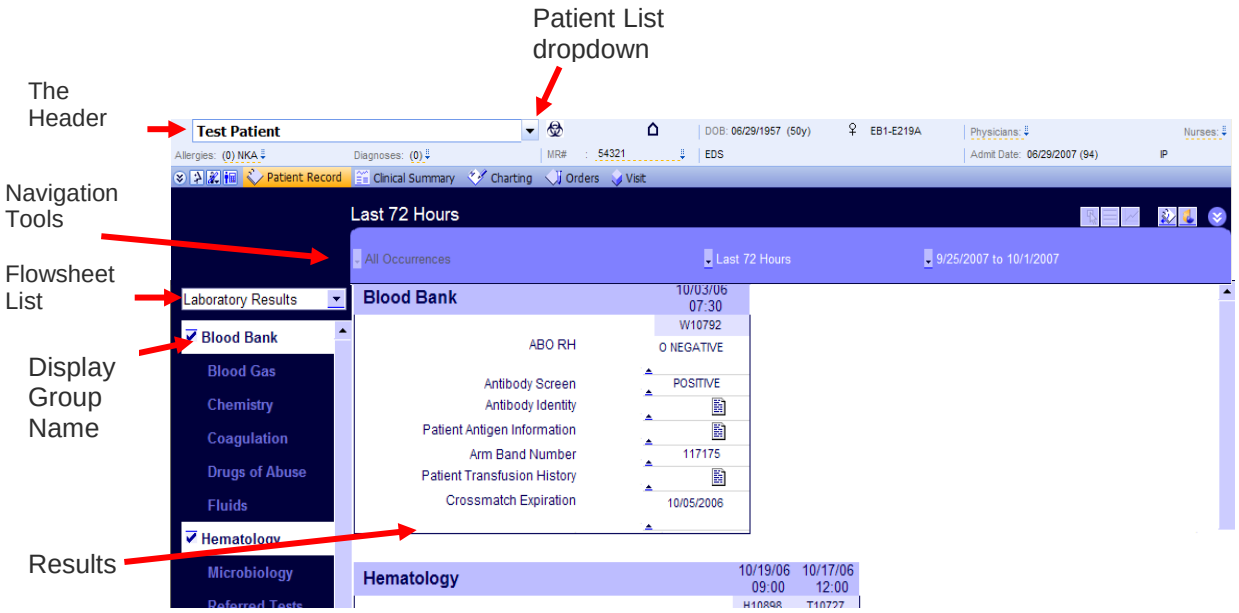
Return to Charting screen to create documentation.

THE PATIENT RECORD

The **Patient Record** screen is where you will go to view orders, medications, results, assessments, and clinical notes, as well as scanned documents, such as a physician's consultation report or H&P. Advance Directive information is found here as well.

The information in the Patient Record is divided into **Flowsheets**. Examples of Flowsheets are Orders, Medications, Laboratory Results, Radiology Results, and Clinical Documentation. Most Flowsheets are further divided into Display Groups. An example of a display group for Laboratory is Hematology or Blood Bank.

You can access the Patient Record from the expanded census on the Census screen using the **Patient Record Icon** located to the right of the patient name.



Navigation Tools

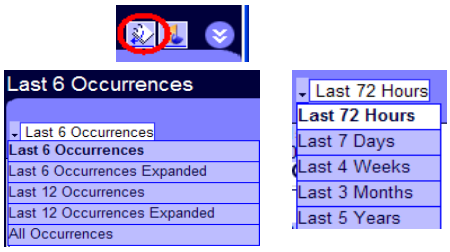
Each of the Navigation tools has a preset default you will see when you open the Patient Record. However, they all have a drop-down list (small black triangle to the left of the tool), so that you can change the selection as needed.

If the results you are searching for are not displayed, select a longer time frame or more occurrences on the Navigator.

If the patient record appears grayed out, lick the **Refresh** icon.

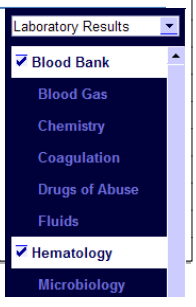
Use the Reset Preference icon to return to default settings.

Use the **Occurrence Drop-Down** or the **Time Frame** drop downs to change your viewing options.



Use the drop down to open the calendar to select a different date range. You can either type in the **To** and **From** date in the date filed on the calendar, or use the selection buttons to select the month and day.

Results Flowsheet



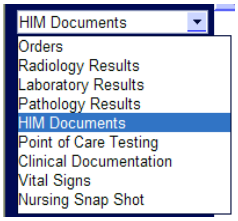
1. Using the Flowsheet pull down list on the left side of the screen, locate the type of result you would like to see.

2. The results will display, listed across in reverse chronological order. The time shown below the date is the time the result was created.
3. Lab results followed by an ellipsis (three dots) indicate documentation attached to a numeric result. It could also indicate a corrected result; if it is a corrected result, it will be accompanied with a white triangle. Click the ellipsis to view the detail. The red L or H indicates abnormal low/high result.

4. The Report icon on a result indicates a report with details of the result. Left click on the icon to open the details of the report. A white triangle indicates an edited report.

5. Most staff can click the **View Image** button on the Radiology results which allows the user to view the actual radiological image.

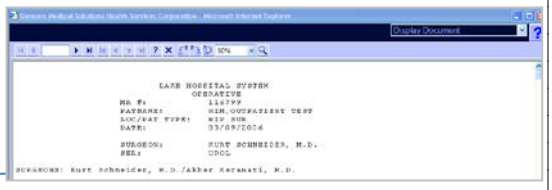
VIEWING DICTATED AND SCANNED DOCUMENTS



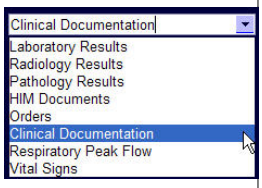
Scanned reports are those reports that are scanned directly into the HIM system. This might include an occasional radiology or laboratory report, emergency room records or a history & physical. Scanned reference laboratory reports and outside lab results will display under the Laboratory Flowsheet and not in the HIM document section. Critical Care flowsheets from a previous visit will be listed under "Critical Care Documentation". As records are scanned into the HIM software, HIM sends a pointer to the clinical side so that you can view the report.

1. Using the Flowsheet pull down list select **HIM Documents**.

2. To view an HIM document, click on the **HIM Document** icon. The document viewer will open, displaying the attached document. Use the scroll bar on the right to view the entire document.



VIEWING ASSESSMENTS IN THE PATIENT RECORD



1. Using the Flowsheet pull down list on the left side of the screen to locate nursing documentation, select **Clinical Documentation**.
2. If the documentation you are searching for does not appear check your settings on the Navigation Bar: OB, ED and GeroPsych each have their own flowsheet.
   a. Click the **Refresh** icon above the result window after making your selection. OR

   b. Change the span of time you are looking at. OR
   c. Change the number of occurrences. The **Occurrence** icon is located above the display area.

3. The Assessments display group will appear. The document icons will be displayed in reverse chronological order. Click the assessment icon for the assessment you wish to view.

4. The following functions can be performed in the Patient Record:

a. View the assessment.
b. **Edit** the assessment if you completed it within the past 72 hours
c. View the **History**
d. Create a **Note** by clicking on the note tab.

5. When you have an assessment that is In Progress, you must access the assessment through the Charting screen to complete.
6. The icon with a line through it indicates an assessment chapter that has not been documented. It is located to the left of the assessment name on the chapter list in the Edit view of the Patient Record.

7. If there are multiple documents for the patient, you will see in the upper right corner of the assessment window **Scheduled**, and two triangles with **N/A** in the middle. Clicking the triangles will allow you to view the other documents from the one you opened.

Click the history tab to view the history of changes/edits or notes added to the assessment.

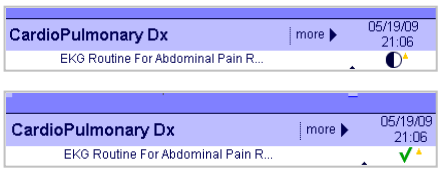
Departmental Documentation flowsheet houses documentation from other areas or departments such as PICC line documentation, Rehabilitation Department, Behavioral Health, Radiology and Respiratory Therapy.

Other areas have their own flowsheets, such as ED Documentation, OB Documentation, and Surgical Documentation.

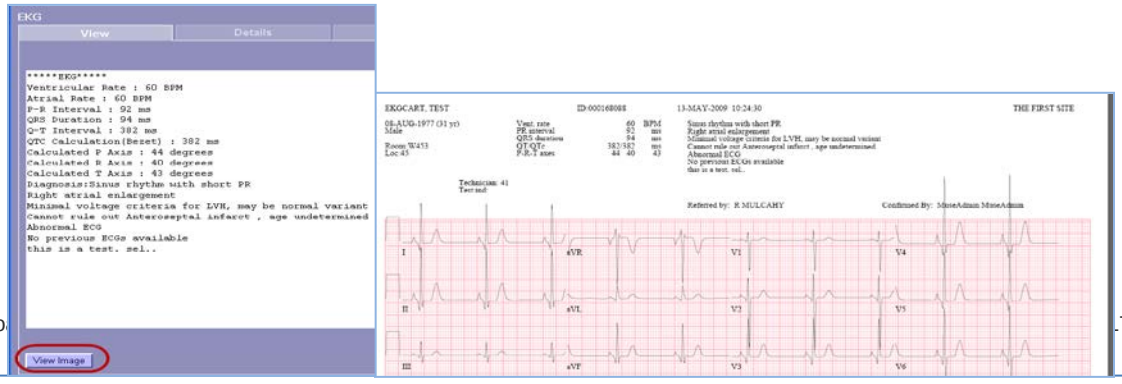
VIEWING EKG ORDERS AND RESULTS IN THE PATIENT RECORD

The Muse EKG system gets its orders wirelessly from Soarian. The EKG is performed and the EKG tracing will be left with the caregiver to place in the patient chart. The unconfirmed EKG is transmitted wirelessly to the Muse computer for editing by a Cardiologist.

The transmission of the EKG will place the Soarian order with a status of In Progress.
After the EKG is **confirmed by the Cardiologist**, the result is sent to Soarian along with the EKG tracing. The status of the order is now complete.



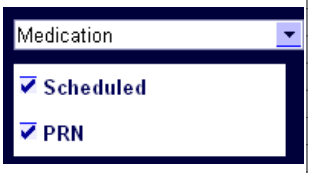
Once the Order is **complete**, the EKG tracing image can be found in the Soarian Patient Record under **Cardiopulmonary Reports**. Select the **report** icon on the right to view the report. Select **View Image** at the bottom Right.



VIEW ORDERS IN THE PATIENT RECORD

1. Use the **Navigation tools** for the time frame in which you need to view orders. The Occurrence option is not available when viewing orders.
2. Using the Flowsheet pull down list on the left side of the screen, select **Orders**.
3. Once the list of Orders appears, use the check boxes to select which Orders you wish to view.

VIEW MEDICATION ORDERS IN THE PATIENT RECORD



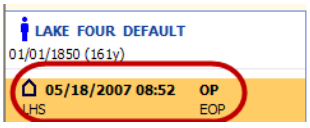
1. Use the **Navigation tools** for the time frame in which you need to view orders. The Occurrence option is not available when viewing orders.
2. Using the Flowsheet pull down list on the left side of the screen, select **Medications**.
3. Once the list of Orders appears, use the check boxes to select which Orders you wish to view – Scheduled and/or PRN.

VISIT SCREEN

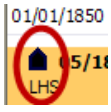
The Visit Screen allows you to view demographic information about the patient. Clicking on the patient name opens the Patient Demographics screen.

Information on the **Visit Screen** is the information that is gathered during the registration process. The visit screen is for viewing only. You will also be able to view any transfer or discharge information if available by clicking on the Transfer tab. If a patient record displays the Isolation indicator, you will be able to view the organism on the Visit Screen. The isolation indicator is entered through Star.

Discharged but within the past 4 days



If the patient had been discharged within the past four days, click on the Visit date to open the visit for charting.

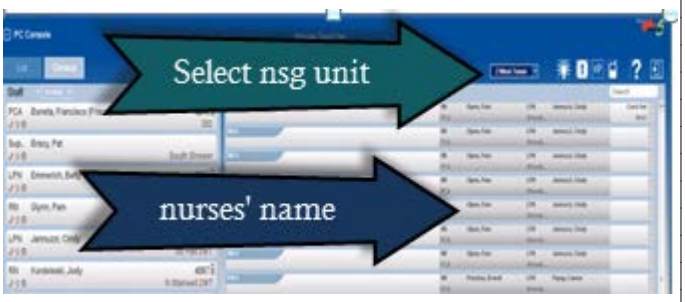


Once the four days has passed, you will no longer see the visit date on the Visit screen and will not have access to the Visit detail screen. Once the patient has been discharged, the active visit icon becomes a closed visit icon.

PC CONSOLE

PC Console is a patient bed board, displaying patient rooms and the nurse who is assigned to that room. This is useful when you are sending a patient to an in-patient nursing unit, and you need to contact the nurse who will be assigned to that patient.

Log into PC Console with your Active Directory (SSO) log in. In the top right area, select the unit you wish to view. The nurses names are displayed in the first gray area on the right side of the screen.



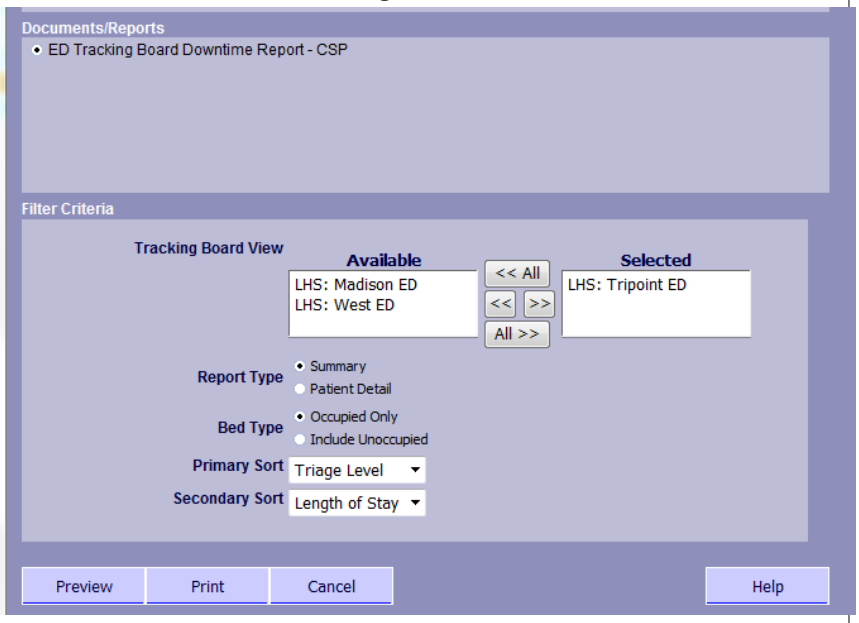
DOWNTIME REPORTS

For planned downtime, you will need to print out the Tracking Board Downtime Report. This will provide the users of all the current information that had been recorded and saved in the ED chart.

While on the Tracking Board view, click the print icon in the menu bar in the top right corner of your screen. In the dialog box, lower portion, select the ED you need the report for, and click the arrow to the right.

Select the **Report Type**, the **Bed Type** and the **Primary/Secondary Sort.**

Click **Print**.



OCTOPUS DOWNTIME INSTRUCTIONS FOR SOARIAN

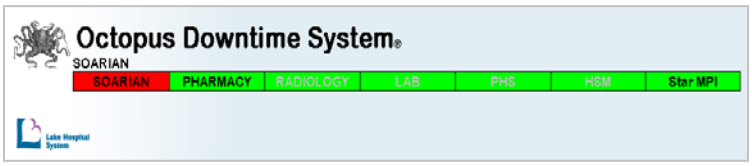
When there is a downtime for Soarian, you will be advised to use your downtime procedures. In order to be able to view what has been documented in Soarian prior to the downtime, you will access the **Octopus Soarian Downtime system**.

<u>The Octopus Soarian Downtime system is for viewing only. You cannot document in the downtime system.</u>

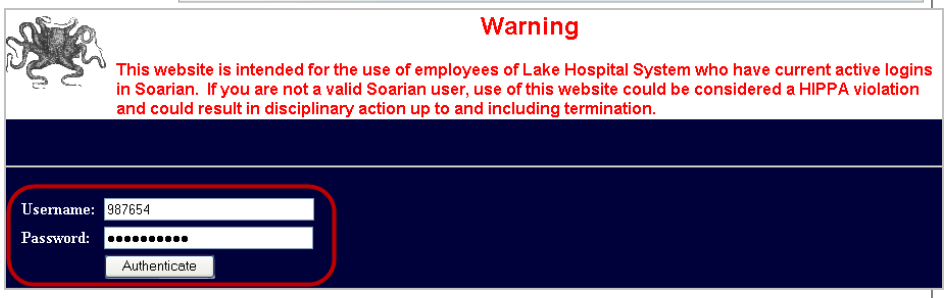
<u>LOG IN and PATIENT LOOK UP</u>

1. Select the Octopus Icon from the Desktop.

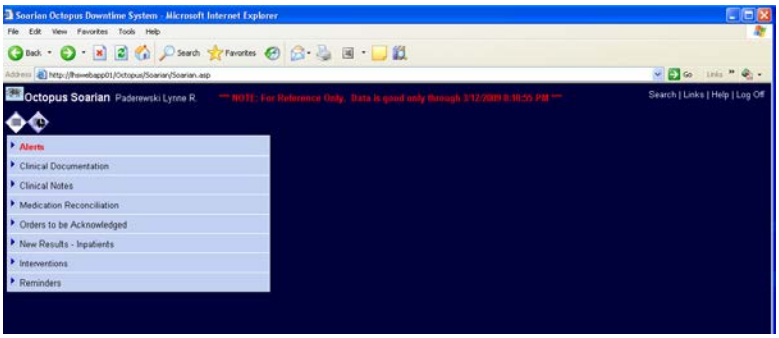
2. If Soarian is down, the **Soarian** link will be red. Click the red Soarian link.



3. In the **Soarian Downtime Viewer log in** window, you will need to type your **LHS domain User name and password**. (Your User name is your employee ID#. Your password may or may not be the same as your Soarian password.)



4. Click **Authenticate**.
   a. The screen will look very similar to the Soarian Portal screen, but it is not.



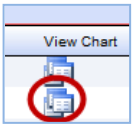
   b. The name displayed in the upper left corner is **Octopus Soarian**, followed by your name. Your healthcare unit (nursing unit) will not display.
   c. There is a message displayed in **red** across the top indicating how current the data is. The date and time will reflect the approximate time that the data was last sent from Soarian.

   d. The menu items in the upper right corner of the screen will open, but will all not quite function as they do in Soarian.

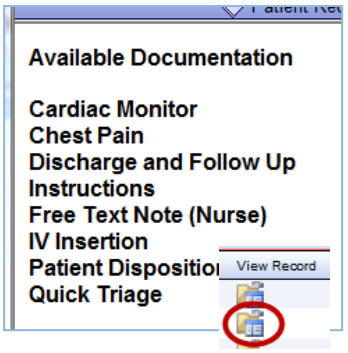
      i. You will use **Search** to locate your patients.
      ii. **Links** will allow you to access the applications listed.
      iii. **Help** will get you this document.
      iv. **Log off** will log you off the system.
   e. The worklist on the left side of the screen does not open. It is for display purpose only.
   f. You will not have a census display as you to in Soarian.

VIEWING THE ED TRACKING BOARD

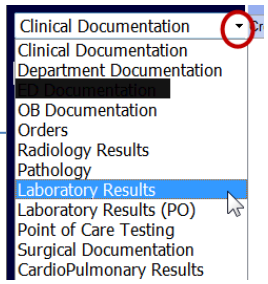
1. Click on the ED Tracking Board link at the top of the window.
2. Use the pull down and select your location.
3. Click the **View Chart ICON** to see patient documentation. Clicking on the patient name will not give you the Quick Launch menu or launch you into View Chart.



4. Once inside the chart, you can click on a heading in the navigator (under Available Documentation) on the left side of the screen) to view that particular information.
5. Click the X in the upper right corner to close the patient's record and return to the EDTB.



6. Click on the **View Record icon** to access the Soarian Patient Record; you will be able to view test results.
7. Use the pulldown and select the results you wish to view.



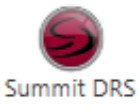
SUMMIT DESKTOP REPORTING SYSTEM

Summit DRS is a reporting system that Lake Health will be using during a Soarian Clinicals downtime. Octopus will also be available for end users to access Soarian Clinicals patient information.

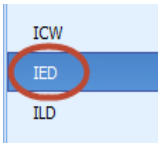
End users will access Summit DRS from an application called Citrix which will be added to designated desktop computers. These computers will be identified by a yellow keyboard.

Summit DRS is a view only system, you will not be able to directly print from the Citrix application.

- From your computer desktop, click on the **Citrix Access Gateway** icon.
- Enter your Username (employee ID) and Password. This is the same as you use for SSO.
- Click on the **Summit DRS icon**. It may take several seconds to open, especially the first time.



Due to the configuration of the ED locations, it is necessary to drill down to the patient's actual location to be able to review your patient's clinical information.



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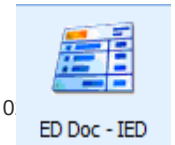
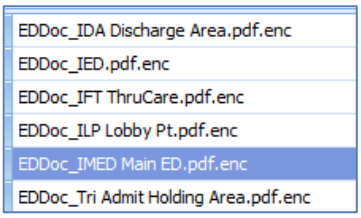
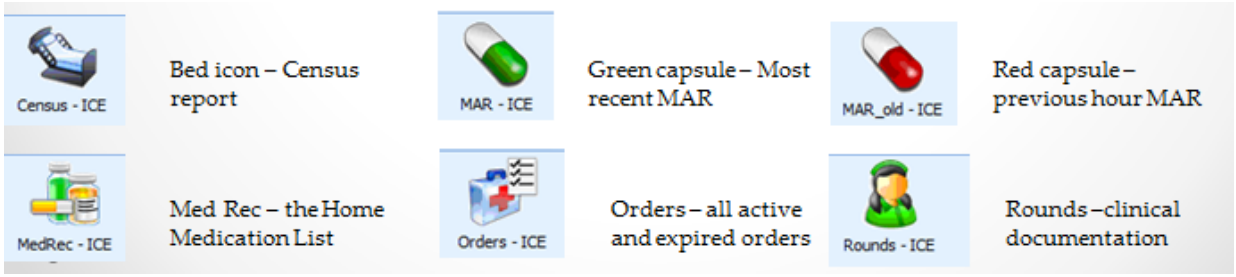


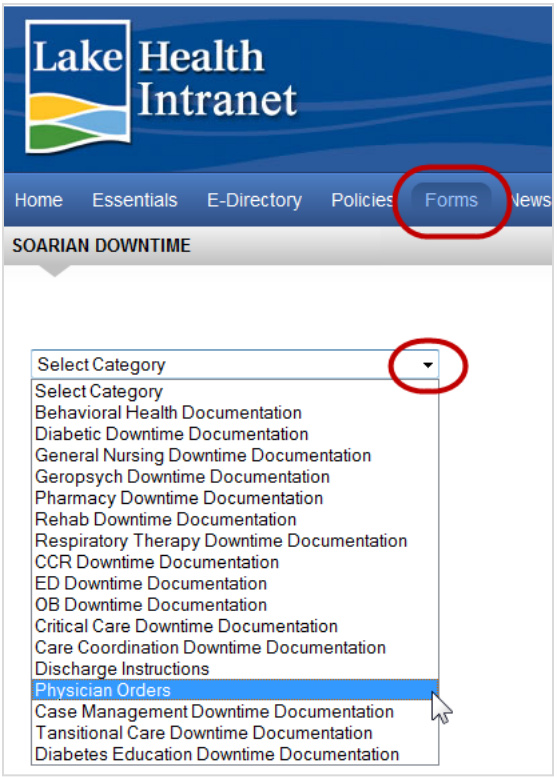
•On the right side of the screen, select IED, WED or MED. On the right side select the report you want to view.



•Select the specific patient location, and select/view the reports. You cannot print the reports.



DOWNTIME FORMS



Open Internet Explorer.

1. If the Lake Health Intranet does not open, type the address in the Address bar: https://lhintranet01/
2. Click the link for **Forms > Soarian Downtime**.
3. Use the pull down menu to select the category of forms you need.
4. Open and print each of the forms you need, one at a time.

For Downtime less than 1 hour, caregiver can use judgment to document using a downtime form or waiting for Soarian to come back up. Documentation will need to be re-entered into Soarian when it becomes available.

For Downtime greater than 1 hour, re-entry of documentation is not required. The downtime Canned Clinical note can be used once Soarian is available to the users (these notes must be added separately):

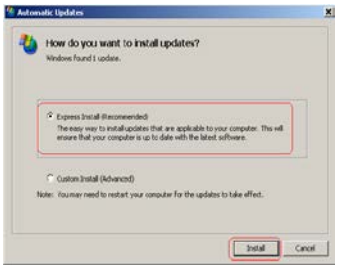
The Soarian System has been down. Please refer to the paper downtime forms for clinical documentation.

MAK down, med admin documentation completed on downtime MAR.

However, regardless of the length of the Downtime, Allergies and Home Medications MUST be re-entered into Soarian.

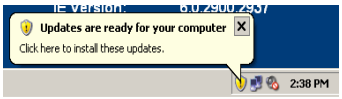
LAKE HEALTH MICROSOFT UPDATES NOTICE:

All Lake Health Team Members using Lake Health computers should monitor the pop-up notifications mentioned below and install updates when feasible.
PLEASE NOTE: Some of these updates ***may require a restart*** of the computer to complete the installation. **Please be sure to save any work or exit applications prior to any update installation**.



Microsoft Update Notice: The Update Icon will look like a Yellow Shield (as shown to the right and below). On a semi-regular basis the Updates notification will appear. When convenient please click on the notification, select Express Install, the Install button, and wait to be prompted to restart as needed.

Do not install any other type of computer updates other than those connected to the Microsoft update yellow shield icon. If you see any other update notice and you are in doubt call the helpdesk prior to installing the update. Further assistance can be obtained by contacting the Lake Health Information Technology Helpdesk at extension 41205.



CLINICIAN WOW TIP SHEET

The following tips will help you to receive the **highest performance** from your WOW.

1. **Keep it Clean** – Use our approved disinfecting wipes for routine WOW cleaning. Sometimes it's inevitable that meds, liquids and food items get on the keyboard or WOW. Wipe them down, especially when visibly soiled. Don't forget computer devices located in rooms and other nursing work areas too.
2. **Keep it Plugged in** when not in use. Some of our WOWs have an external battery some do not. Don't leave the next caregiver a dead WOW.
3. When unplugging your WOW, pull the electrical cord **from the plug** not from the cord when taking it out of the outlet.
4. Make sure all **connections are tight**. Power cords, plugs, usb connections (like the connections for your scanner and your mouse), wireless cards if you have them need to be snuggly connected.

TROUBLESHOOTING THE LAPTOPS/WOWS WIRELESS CONNECTION

1. If a laptop won't connect to the wireless and it has a touchpad above the keyboard area, check to see that the yellow internet sign is clicked to bright blue. This is a typical problem that gets clicked off quite frequently.

2. The other is a WOW won't connect to the wireless….There is a different wireless software that runs at startup (after you reboot). It has a status bar and blinks with a green checkmark….**THE USER MUST WAIT** for it to connect or MAK will not work. There is nothing else you can do but be patient until it connects.

WOW Auto-lock and Keys

The wows have locks for the work tray and the drawers. These should be kept in the Acudose for easy access for the users. Make sure your locks are available if needed. These were distributed to managers when we rolled out your device.

BASIC COMPUTER TROUBLESHOOTING

- If your computer locks up and you cannot use your mouse or keyboard, try to reboot your computer. Simultaneously press the **Ctrl Alt Delete** keys. If that does not cause your computer to shut down, press the power button. You should then be able to turn the power back on. If your problem persists, call the Help Desk.
- If you receive an error message giving you specific instructions to follow, follow those instructions.
- When you do encounter a problem, try walking through the steps with another user; this may help you identify the problem.
- Ask if anyone else is experiencing the same issue; perhaps this is a known problem and has already been reported to the help desk.
- Try to repeat the problem at a different workstation. This information will be helpful to the help desk.

- If you do need to contact the Help Desk, please provide them with the most detailed information you can. This includes:
    - Your name and location
    - The IP address of your computer, which is found on the desktop
    - What you were doing when the problem occurred
    - Report any and all error messages received

- If you experience difficulty with a particular patient record, please provide the Help Desk with the following information:
    - Patient Medical Record number
    - Time the error occurred
    - If problem is with an order, provide if possible the order ID number and the name of the order detail form or the test being ordered

CALL THE HELP DESK WITH ANY QUESTIONS OR PROBLEMS

EXTENSION 41205

NURSING STATIONS

TRIPOINT

ICD	Tripoint Clinical Decision Unit (CDU)
ICE	Tripoint Critical Care - East
ICW	Tripoint Critical Care - West
IED	Tripoint Emergency Department
ILD	Tripoint LDRP/Antepartum/OB- Triage
IME	Tripoint Medical Telemetry - East
IMW	Tripoint Medical Telemetry - West
INR	Tripoint Newborn Nursery
IRR	Tripoint PACU Overflow
ISC	Tripoint Nursery
IST	Tripoint Surgical Telemetry - East
ISU	Tripoint Same Day Surgery Overflow
ISW	Tripoint Surgical Telemetry - West
ITC	Tripoint To Come In

CONTINUING CARE CAMPUS

ZIG	Concord IP Geropsych Unit
ZIR	Concord IP Rehab Unit

MADISON

MED	Madison Emergency Dept.

WEST

W4E	West Div 4 East Wing (Med/Surg)
W4N	West Div 4 North Wing (Med/Surg)
W4S	West Div 4 South Wing (Med/Surg)
W4W	West Div 4 West Wing (Med/Surg)
W5E	West Div 5 East Wing (Med/Surg)
W5S	West Div 5 South Wing (Med/Surg)
WCE	West Critical Care East Wing
WCS	West Critical Care South Wing
WDC	West Discharge Lounge
WED	West Emergency Department
WLD	West Labor & Delivery
WMC	West Monitored Care
WNN	West Neuro
WNR	West Nursery
WPP	West Post Partum
WRR	West PACU Overflow
WS	West Short Stay Critical Care
WSA	West Stepdown Pod A
WSB	West Stepdown Pod B
WSC	West Stepdown Pod C
WSN	West Surgical ICU
WSU	West Same Day Surgery
WTC	West To Come In

Patient Type Codes

AOH	Willowick Occupational Health
AOP	Willowick Regular Outpatient
APO	Willowick Pre Admit Outpatient
ASE	Willowick Series Outpatient
AUC	Willowick Urgent Care
CMP	Campus Medical Procedure
CNA	Cancel Admission with Orders
COH	Campus Occupational Health
COP	Campus Regular Outpatient
CPO	Campus Pre Admit Outpatient
CSE	Campus Series Outpatient
FLO	Outreach Lab
FOH	Off Site Occupational Health
FPO	Pre-registration Outreach Lab
GOH	Chardon Occupational Health
GOP	Chardon Regular Outpatient
GPO	Chardon Pre Admit Outpatient
GSE	Chardon Series Outpatient
GUC	Chardon Urgent Care
HOH	Heisley Occupational Health
HOP	Heisley Regular Outpatient
HPO	Heisley Pre Admit Outpatient
HSE	Heisley Series Outpatient
ICL	TriPoint Cath Lab
IDS	TriPoint Day Surgery
IEP	TriPoint Endo Procedure
IER	TriPoint Emergency Room
IES	Extended Stay SDS
IIP	TriPoint Regular Inpatient
IMP	TriPoint Medical Procedure
IOH	TriPoint Occupational Health
IOP	TriPoint Regular Outpatient
IOV	TriPoint Observation
IPI	TriPoint Pre Admit Inpatient
IPO	TriPoint Pre Admit Outpatient
ISE	TriPoint Series Outpatient
LOP	LHPG offices
MCB	Contract Bill Madison Nursing Home
MNH	Madison Series Nursing Home
MOH	Madison Occupational Health
MOP	Madison Outpatient
MPO	Madison Pre Admit Outpatient
MSE	Madison Series Outpatient
MUC	Madison Urgent Care
OOH	Madison Clinic Occupational Health
OPO	Madison Clinic Pre Admit Outpatient
OOP	Madison Clinic Regular Outpatient
POP	Prime Health Regular Outpatient
PRE	Internal Pre-Admit (not used)
TOH	Tyler Occupational Health
TOP	Tyler Regular Outpatient
TPO	Tyler Pre Admit Outpatient
TSE	Tyler Series Outpatient
TUC	Tyler Urgent Care
UOH	Painesville Occupational Health
UOP	Painesville Regular Outpatient
UPO	Painesville Pre Admit Outpatient
USE	Painesville Series Outpatient
UUC	Painesville Urgent Care
WCL	West Cath Lab/Angio
WDS	West Same Day Surgery
WEP	West Endo Procedure
WER	West Emergency Room
WES	West Extended Stay
WIP	West Regular Inpatient
WMP	West Medical Procedure
WOH	West Occupational Health
WOP	West Regular Outpatient
WOV	West Observation
WPI	West Pre Admit Inpatient
WPO	West Pre Admit Outpatient
WPS	West Psychiatric
WRI	West Rehab Facility Inpatient
WSE	West Series Outpatient
XCB	Contract Bill Non OH Patient
XHC	Hill & Chapnick Roster
ZPS	CCC IP Geropsych
ZRI	CCC IP Rehab
XPL	Hill & Chapnick Outpatient

PRACTICE SCENARIO 1 – TECH

Patient presents to ED via Mentor 1142 Car vs Pedestrian Pt was crossing the street when struck by a minivan. Low impact hit on left side.

- c/o left ankle pain with deformity
- laceration to left shin 3x2 cm actively bleeding
- No LOC
- C-spine immobilized with c-collar and LSB
- NRB 15 liters
- IV 18 right AC Zofran 4 mg IV given for nausea 1000 ml 250 bolus given
- Air splint applied to LLE

1. Allergies – NSAIDs
2. Complete Home Medication List
3. On Arrival:
    a. Alert & Oriented x3, c/o as above
    b. Glasgow Comma Scale 15
    c. No respiratory distress
    d. Vital signs 36.8C P 102, R 20 BP 100/60 Pulse Ox 100% on NRB 15 Liters
4. Smoker ½ pack per day for 10 years
5. Occasional drinker, beer 2 a month
6. Denies drug use
7. Tetanus Update
8. Remove EKG and Urine Icon on EDTB
9. Document Nurse Procedure Note
    a. Bleeding Control
    b. RICE – FIRST AID
    c. IV Insertion with labs drawn
    d. Blood Alcohol Draw
    e. Cardiac monitor
    f. Urine dipstick
10. Nurse Procedure Assist Note
    a. C-SPINE – REMOVED BACKBOARD
    b. Laceration Repair
11. Add second set of vital signs
12. Complete Rounding FS
13. Open IV Insertion Note – Add new document – discontinue IV
14. Complete Nurse Disposition Note Vital Signs

15. Print EDTB Discharge Instructions
16. Create Care Notes discharge education

PRACTICE SCENARIO 1 - NURSE

Patient presents to ED via Mentor 1142 Car vs Pedestrian Pt was crossing the street when struck by a minivan. Low impact hit on left side

- c/o left ankle pain with deformity
- laceration to left shin 3x2 cm actively bleeding
- No LOC
- C-spine immobilized with c-collar and LSB
- NRB 15 liters
- IV 18 right AC Zofran 4 mg IV given for nausea 1000 ml 250 bolus given
- Air splint applied to LLE

17. Allergies – NSAIDs
18. Complete Home Medication List
19. On Arrival:
    a. Alert & Oriented x3, c/o as above
    b. Glasgow Comma Scale 15
    c. No respiratory distress
    d. Vital signs 36.8C P 102, R 20 BP 100/60 Pulse Ox 100% on NRB 15 Liters
20. Smoker ½ pack per day for 10 years
21. Occasional drinker, beer 2 a month
22. Denies drug use
23. Tetanus Update
24. Document Nurse Procedure Note
    a. Bleeding Control
    b. RICE – FIRST AID
    c. IV Insertion with labs drawn
    d. Blood Alcohol Draw
    e. Cardiac monitor
    f. Urine dipstick
25. Remove EKG and Urine Icon on EDTB
26. Nurse Procedure Assist Note
    a. C-SPINE – REMOVED BACKBOARD
    b. Laceration Repair
27. Add second set of vital signs

28. Complete Rounding FS

29. Response to Medication
    a. Verbalize documentation within MAK for response to Medication
    b. Verbalize process for end bag time in MAK
    c. Verbalize when RED STAR from MAK is removed & left on the board

30. Discharge - Nurse Procedure Note
    a. Air Splint
    b. Crutches
    c. Wound Dressing Application
31. Physician impression
    a. Ankle Fracture
    b. Laceration with sutures out in 7-10 days
32. Physician Discharge Instructions & F/U
    a. Follow up with PCP
    b. Edit Document
    c. Add 1st referral PCP in 2 days
33. Nurse Adds CareNotes
    a. Ankle Fracture
    b. Crutch Walking
    c. Wound Care
34. Open IV Insertion Note – Add new document – discontinue IV
35. Complete Nurse Disposition Note
36. Print EDTB Discharge Instructions
37. Review Chart deficiencies & Finalize Chart
    a. Verbalize reason for override
    b. Verbalize process for incomplete chart by another RN
38. Verbalize
    a. Steps that can be taken to avoid incomplete charts
    b. Expectation to Complete Incomplete charts and finalize process

PRACTICE SCENARIO 2 - NURSE

Patient walks in with active chest pain onset 30 minutes prior to arrival. + SOB, Nausea, Diaphoresis, Pain 8/10 nothing to relieve pain, ASA taken at home
A&O x3, Moderate SOB 2-3 sentences,

1. Complete Triage
2. Assess Allergies
3. Add Orders – ED Guidelines – Chest Pain
4. 2 mg Morphine IV
5. IV NS 75 ml/hr
6. Go to the charting screen. View the allergy screen. Add an allergy of strawberries or chocolate.
7. Document Nurse Procedure Note
    a. IV with blood drawn
    b. Cardiac Monitor
    c. Oxygen 2 liters NC
    d. Document 2nd IV
    e. Foley cath insertion
    f. Urine Dipstick
8. Remove EKG from EDTB
9. Patient goes into V-fib shocked at 200 J x1 – patient converts to sinus rhythm
10. Document Cardiac Intervention in Nursing Procedure Assist Note
11. Complete Nursing Disposition Note; Physician impression Acute MI, condition critical, ICU
12. Verbalize documentation for MAK response to medication and IV end bag time/continued IV for admission
13. Complete chart deficiencies
14. Review Chart deficiencies & Finalize Chart
    a. Verbalize reason for override
    b. Verbalize process for incomplete chart by another RN
15. Verbalize:
    a. Steps that can be taken to avoid incomplete charts
    b. Expectation to Complete Incomplete charts and finalize process