



## PCS Activities

### In Class Exercises

#### Exercise 1: Adding/Removing a patient to My List

1a. Add your patient to My List using Find Account (done with instructor)

Commented [SP1]: Any Location -> Find Account

Click on **Lists -> Find Account**

- Type in the name of the patient provided by your instructor and hit the Enter button on your keyboard
- Click the name cell that appears. It will take you to an expanded page of that patient.
- Select **Add to My List** from the footer buttons. There is no Confirmation button, but the patient will now be in your **My List**.

1b. Add a patient to My List using Edit My List

Click on **List -> My List**

- Click **Edit My List** from the footer buttons. This is an alternative way to add patients to your list by searching for patient name, MRN, department, bed number, or the nurse you are covering for.
- Click **Add Patient** button at the top
- Click the **Med Rec Number** field
- Scan the Medical Record Number (MRN) barcode of your neighbour's patient, or enter the MRN manually
- When the name appears, click the **Add** button at the footer
- Click **Save** on the bottom right corner. This returns you to your **My List** page

1c. Removing Patients

- From the **My List** page, click the name of your neighbour's patient that was added from Exercise 1b – this will highlight the entire row in green
- Click the **Remove From My List** button at the footer. **Do not** remove your original patient

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## Exercise 2: Opening Patient Chart

Click **Status Board**- this takes you to your **My List**

- Click on the name cell of your patient on the status board
- Open the patient chart by using one of the 2 ways:
  - Clicking the empty cell on the first column, under the folder icon, or
  - Clicking the **Open Chart** tab on the right side of the page
- Once you open the chart, it will default to the Worklist of the patient's chart

## Exercise 3: Add, Remove and Confirm Allergies

### 3a. Add New Allergy

- Go to the **Summary** tab
- Click the blue **Edit** button in the **Allergy/AdvReac** box
- Stay on the New tab and click "Any word" instead of "Starts with"
  - Type in the name of a new allergy - Strawberry
  - Click on the box that appears with the text "Strawberry"
- Note that "Strawberry" is now listed as an allergy in green text, with a red Edit button under Reaction
- Click on the red Edit button to choose the reaction. Select the reaction as Cough
- Add a second allergy of **Shellfish** by typing "Shellfish" in the search bar, and click on the box that appears with the text "Shellfish". Click the red Edit button and choose the reaction as Palpitations
- To add a secondary reaction, click on the Edit tab and type in as a comment: "Secondary reaction: Hypotension"
- Click the **Save** button on the bottom right corner of the page

### 3b. Remove allergies



- Click the blue **Edit** button in the **Allergy/AdvReac** box
- Stay on the Edit tab and place a checkmark beside **Strawberry**
- Click **Remove** in the footer buttons and type in the reason as “Wrong Patient”
- Click the **OK** button on the bottom right corner of the page, and then click **Save**

### 3c. Confirm Allergies (optional exercise)

- If a patient has had a previous admission, the allergies identified from that admission will appear in the **Allergy/AdvReac** box. If this is the case, the nurse only needs to Confirm the allergies. To do so:
- Click the blue **Edit** button in the **Allergy/AdvReac** box
- Stay on the Edit tab and place a checkmark beside each allergy. You can check all the items at once by clicking on the checkmark at the top left corner of the table
- Click **Confirm** from the footer buttons, then click **Save** button on the bottom right corner

### 3d. Review Allergies (optional exercise)

- To review whether the listed allergies/adverse reactions have been confirmed:
- Click the blue **Edit** button in the **Allergy/AdvReac** box
- Click into the Audit tab and view the history of edits made. Click **Cancel** on the bottom right corner to get out of the screen

**Exercise 4: Add, Cancel, and Discontinue Home Medications** (In most areas, updating the Home Medication List will be the responsibility of the pharmacy technician)

### 4a. Add new Home Medication- The patient reports they take Furosemide 40 mg PO Daily

- Click the blue **Edit** button in the **Home Medication** box
- Stay on the New tab, click into the Medication search bar, and type in the medication name - Furosemide
- When the medication appears below the search bar, click the + sign beside “Furosemide” to expand and view dosage options

- Select the most appropriate dose based on what the patient reports – choose “40 mg tablet”
- Ensure any field with an asterisk (\*) is filled in- Source and Last Taken. The patient states they last took the medication today at 0600 am:
- Click the downward arrow (also referred to as “the carrot”) in the cell under \* **Source** and pick “Patient” from the list of sources
- Scroll down. Click “Known” beside \* **Last Taken**. In the cell beside \* **Date/Time**, click the carrot and select Calendar- a pop-up will appear. Choose today’s date and type in 0600 beside Time. Click **OK**.
- Scroll down the screen. You can click into **Patient Comments** and enter any additional comments (e.g. “Patient states they are prescribed to take med BID but only takes it daily due to light-headedness”) - the physician will see this when they do the medication reconciliation
- Click **Save** on the bottom right corner

4b. Enter a Non-Formulary Medication – patient states they take a “pink pill”

- Click the blue **Edit** button in the **Home Medication** box
- Click on the New tab, click into the Medication search bar, and type in “Pink Pill” (note – “No Matches Found” will appear below)
- Click the **Free Text** cell to the right and above the search bar. Choose Medication.
- Complete the mandatory fields (Source and Last Taken), and enter as many details as possible about Dose, Units, Route, and Frequency. E.g. Pink Pill- 1 tab PO Daily.

Note: Any non-formulary medications will appear with a red **NF** and question mark (?) beside the name

- Click the **Save** button on the bottom right corner

4c. Cancel Home Medication - use to remove when you didn’t mean to add

- Click the blue **Edit** button in the **Home Medication** box
- Place a checkmark beside Furosemide
- Click **Cancel** in the footer buttons
- Click the carrot beside \* **Cancel Reason** - choose Wrong patient

- Click **OK** in the bottom right corner, then click **Save**

#### 4d. Discontinue Home Medication

- For when you are reviewing the home medications with the patient and they tell you they are no longer taking a medication on the list
- Click the blue **Edit** button in the **Home Medication** box
- Place a checkmark beside "Pink Pill"
- Click **Discontinue** in the footer buttons
- Click the carrot beside \* **Discontinue Reason** - choose Patient no longer taking
- Click **OK** in the bottom right corner, then click **Save**

### Exercise 5: Medical/Surgical History and Special Indicators

#### 5a. Add a COVID-19 Vaccination Status

- Click the blue **Edit** button in the **Medical History** box
- It will default to the **Picklist** tab. Expand the **COVID-19 Vaccination Status** category by clicking the "+" sign – choose Vaccine series started
- Click the **Save** button on the bottom right corner

#### 5b. Add new Medical History from Picklist

- Click the blue **Edit** button in the **Medical History** box
- It will default to the **Picklist** tab. Expand the **Endocrine** category by clicking the "+" sign - choose **Diabetes Mellitus** - note that it is now added to the list above, but in **green font**, indicating that it is not yet saved.
- Click the **Save** button on the bottom right corner

#### 5b. Add new Medical History using Search

- Click the blue **Edit** button in the **Medical History** box
- It will default to the **Picklist** tab. This time, click on the **Search** tab and type in "cancer colon"



- Select **Cancer, Colon** – note that it is now added to the list above, but in **green font**, indicating that it is not yet saved.
- Click **Save**

5c. Review and confirm Medical/Surgical History

- If a patient has had a previous admission, the medical and surgical history identified from that admission will appear in the **Medical History** and **Surgical History** boxes. If this is the case, the nurse only needs to Review the histories to confirm
- Click the blue **Reviewed** button in the **Medical History** box
- Note the text update in the Medical History box- it will now state, "Last Reviewed \*today's date and time\* by \*your name\*" - this indicates that the medical history has been reviewed for this visit

5d. Remove Med/Surg Hx problem

- Click the blue **Edit** button in the **Medical History** box
- Place a **Checkmark** beside Diabetes mellitus and click the **Remove** button by the footer
- Click the **Save** button on the bottom right corner

5e. Add a new Social History

- Click the blue **Edit** button in the **Social History** box
- From the options, choose "Lives Alone", "Apartment" and "Disability CPP"- you may have to scroll to view all the options
- Click the **Save** button on the bottom right corner

5f. Review Special Indicators

- Click the blue **Edit** button in the **Special Indicator** box
- Click the carrot in the Special Indicator search bar to view all the available options. Choose Hearing and/or Vision Assist
- Click **Save** on the bottom right

**Exercise 6: Add a Standard of Care (SOC)**



- Go to the **Worklist** tab in the “Do” section of the EMR
- Click the **Add** button at the footer
- It will default to the Interventions tab. Click on the **Standards of Care** tab. Click the Next button at the footer to until see **SOC Medical** on the list.
- Select SOC Medical. Click **Save** on the bottom right

Note: In Go-Live, you would add the SOC appropriate to your unit (e.g. SOC Critical Care, SOC Medical, SOC Newborn, SOC OB Birthing, SOC OB Triage, SOC OB Birthing, SOC Paediatric, SOC Rehab, etc.)

If a pop-up screen appears indicating you have duplicate interventions, click the **Resolve Now** button.

- You will be taken to the Adjust Duplicate Interventions page.
- Click on the “Active” box of the status column of one of the duplicate interventions you want to remove (Not the item with its source listed as SOC.Med)
- A drop-down will appear with a list of status options- change the status to “Inactive”
- Once you resolved the duplicate interventions, click **Back** at the bottom right to be taken back to the Worklist

#### Exercise 7: Add an Intervention

Stay on the **Worklist** tab. Click the **Add** button at the footer

It will default to the **Interventions** tab. Stay on this tab and click **Any Word**

Click into the search bar and type in “IV” and hit the Enter key. Click the Next button by the footer until you see the option “IV: Peripheral Assessment”

- Click on “IV: Peripheral Assessment” and it will appear below the table
- Click into the search bar again and type in “Family”- when options appear, click “Family Meeting”
- You will now have 2 interventions listed below, ready to be added to the Worklist

- Click the **Save** button on the bottom right

#### Exercise 8: Change Intervention Frequency

- From the Worklist, select **Vital Signs** so it becomes highlighted in green
- Click on the frequency of the assessment (on the right margin of the name cell, under the clipboard with clock icon)
- A drop-down selection box will appear. Choose **Q4HR**.
- Note: If you would like to view more options of frequencies available, click the carrot on the drop-down selection box. A pop-up will appear with the complete list of frequencies.

#### Exercise 9: Add Item Detail to an Intervention

- From the Worklist, click into the empty cell under the Question mark column for Vital Signs
- Click on the blue **Edit** icon in the **Text** box, and type in "Patient prefers left arm for blood pressure"
- Click **Save** and then **Back**.
- Note- now on the Worklist, an icon with the letter "I" will be shown in the previously empty box for Vital Signs. The "I" icon indicates there is additional information to view for this intervention.



### Exercise 10: Change Status and Change View

10a. **Change Status** – to be used when a care item is no longer required

- From the Worklist, select **IV: Peripheral Assessment** so it becomes highlighted in green
- Click into the Status/Due cell of that assessment; a drop-down list will appear. Choose **Complete**. The item will now be filtered out from the Worklist.

10b. **Change View** – to view care items with all statuses (default is only Active and Hold items)

- From the Worklist, select the **Change View** button at the footer
- Put a checkmark beside **Complete**; leave the other checkmarks as is
- Click **OK** at the bottom right
- Now on the Worklist you will see “IV: Peripheral Assessment”, which you changed the status of in Exercise 9a

### Exercise 11: Resolve Clocks

- Click one of the clocks for the **Purposeful Rounding**. A checkmark will appear beside the clock
- Click the **Not Done** button at the footer. A list of reasons will appear.
- Select the <FREE TEXT> option and type in “Pt off the unit for x-ray”. Hit the Enter key.
- Note the red “X” that appears beside the clock
- **Refresh** button at the footer- The clock will now be gone

### Exercise 12: Documentation

- From the Worklist, select **Vital Signs** so it becomes highlighted in green
- Click in the empty cell under the **Now** column so a checkmark appears. Click **Document** at the footer
- Enter the following vital sign values:

- Temp: 36.9    Temp source: Oral
- Pulse location: You must select "Add a Pulse Location". Select Left Radial and click "OK". The pulse fields will now become accessible to enter the information.  
HR: 78    Method: Palpation
- RR: 14
- SpO2: 99%    Oxygen Delivery Method: Room air
- BP Location: You must select "Add a Blood Pressure Location". Select Right Arm and click "OK". The BP fields will now become accessible to enter the information.  
BP:130/70    Patient Position: Supine
- Click **Save and Exit** at the bottom right corner

### Exercise 13: Documentation- Physical Assessment / I&O / Height & Weight

13a. From the Worklist, find **Adult Physical Assessment** and click into the empty cell under the green **Now** column so a checkmark appears in the cell. Click **Document** at the footer

- Starting at Neurological Assessment, select "Within Defined Standards (WDS)" for each system as they pop up until you get to Respiratory Assessment.
- In Respiratory Assessment, select "Significant Findings".
  - Under Signs and Symptoms, check off Cough.
  - Under Observation, select Normal for Respiratory Depth
  - Under Chest Expansion, select Symmetrical
  - Under Chest Wall Shape, select Normal
  - Under Auscultation of Chest Sounds, select a location and click OK. Under Breath Sounds, select Fine Crackles. Under Air Entry, select Normal
  - Under Oxygen, select Room air
  - Under Cough Description, select Occasional
  - Under Sputum, select Sputum amount not seen by nurse
- In GI Assessment, select "Within Expected Standards"



- In the Within Expected Standards Comments, type: Patient has history of Crohn's, currently experiencing mild cramping, pain and bloating.
- Under GI Symptoms, select Bloating, Pain and Cramps
- Click **Save and Exit** at the bottom right

13b. From the Worklist, find **IO Intake and Output** and click into the empty cell under the green **Now** column so a checkmark appears in the cell. Click **Document** at the footer and enter the following information:

- Oral Intake Amount (mL): 500
- Voided Urine Amount (mL): 400
- Emesis Amount (mL): 200
- Click **Save and Exit** at the bottom right

13c. From the Worklist, find **Height and Weight** and click into the empty cell under the green **Now** column so a checkmark appears in the cell. Click **Document** at the footer and enter the following information: (skip this exercise if already completed with instructor)

- Click on the carrot in Height field and a pop-up will appear. Click into "English" and enter height (5'8). Click OK. Auto-conversion to metric units will occur.
- Click into the Weight field, type in "77" and hit the Enter key. A pop-up will appear confirming 77kg. Click OK.
- Choose "Stated" as the Weight Source
- Click **Save and Exit** at the bottom right

**\*\* If you are working on Birthing Unit or Pediatrics:**

- Add the **Paediatric Admission Orientation** or the **OB Obstetrical Admission Assessment** into the Worklist
- Try documenting on either assessment following the same steps as above

#### Exercise 14: Back Time & Undo Documentation



#### 14a. Back Time Documentation

From the Worklist, find **Vital Signs** and click into the empty cell under the green **Now** column so a checkmark appears in the cell. Click **Document** at the footer

- Note the **green** box at the top of the page which shows the date, current time and your initials. Click on the top carrot on the far right to produce a date/time pop-up box
- Change the time to the time the assessment occurred (**0800**). Click OK
- Note that the time now says 0800 in the green box
- Proceed to document vital signs- choose any values
- Click **Save and Exit** at the bottom right

14b. Make an **Edit** to a documentation: From the Worklist, select **Vital Signs** so it becomes highlighted in green

- Click on the **View/Edit** button at the footer. It will take you to the last completed Vital Signs entry. If you completed more than one assessment, a horizontal scroll bar will appear above the date and time, showing the previous entries.
- Click on the value you want to change (Temperature) and click the **Edit** button at the footer. Change the temperature to 37.6 and click out of the box.
- Click **Save and Exit** on the bottom right

#### 14c. Undo

- From the Worklist, select **Vital Signs** so it becomes highlighted in green
- Click on the **Detail** button at the footer. It defaults to the **Item Detail** page
- Click into the **Flowsheets** tab. It will visualize all vital signs entries in a flowsheet format
- Click into the **History** tab
  - Includes all activity events for the intervention
  - Created: when the intervention was initially added to the Worklist
  - Document: displays the activity date/time and user who documented

- Not Done: displays the activity date/time and user that documented the intervention as note done
- Click on the entry of the vital signs you entered in Exercise 14a so that the row becomes highlighted in green
- Click the **Undo and Save** button at the footer. A pop-up will appear confirming that you want to undo the documentation- click Yes. Choose reason as Incorrect Patient
- Note that a new row is now present in the History table with the documentation that you just undid

Click **Back** at the bottom right corner to return to the Worklist

### Exercise 15: Write Note- Manage Favourites and Document

#### 15a. Selecting favourite note types

- From the “Do” portion of the EMR, click on the **Write Note** tab. It will default to the **Standard** tab at the footer, if you have not chosen your favorite templates yet
- Select the **Manage Favorites** tab at the footer. Check off Nursing and click Save at the bottom right
- It will now take you to the Favorites tab with Nursing listed
- Note that no favorites saved from the test environment will carry over to Go-live

#### 15b. Document a note

- From the Favorites tab, click into the **Nursing** note. You will be taken to a blank screen in which to document
- To type, you must stay between the two blue square brackets ([ ])
- To add a focus as the first line of the note, select the **Text** button at the footer
- Select the Care Planning focus (**F.Care Planning**) and type in the following info:
  - Subjective: Patient states they are concerned about the progress of their condition and future of returning home
  - Objective: Writer has noticed multiple questions from the patient about how they will manage if they return home



- Assessment: Physically patient has not changed
- Plan: Writer will request a meeting with Discharge Planning and Social Work
- Evaluation: leave this portion empty, as you have not evaluated the SOAP
- Select the **OK** button at the bottom right

Note that the **Notes** tab on the “See” section of the EMR is now listed in **red**, indicating that you have a new note present

#### Exercise 16: Add a Note

16a. **Add a note:** From the Worklist, select **Adult Physical Assessment** so it becomes highlighted in green

- Click on the **View/Edit** button at the footer. Once the previous assessment appears, click the Respiratory Assessment Parameters section so it becomes highlighted in green and click **Edit** at the footer.
- You can now select **Add Note** at the footer
- Choose the note type as Nursing and document that the patient’s respiratory status is WDS (within defined standards)- patient mentioned that they experienced mild breathlessness last trip to the bathroom. Symptoms resolved once back in chair.
- Click OK. A notepad icon will now appear the date/time/initials box, at the top of the page
- Click the **Close** button with the circled X on the top right corner. A pop-up will appear, prompting you to save the changes- click Save

#### Exercise 17: Back time, Amend, Undo Note

##### 17a. Back Time a Note

- Click on the **Write Note** tab. Select the Nursing note.
- Click on the **Detail** button on the right-hand side of the screen
- Click the carrot of the date and time box and a pop-up will appear. Change time of documentation to 1020. Click OK.
- Go back to enter note by clicking **Note Text** button on the right-hand side of the screen
- Select the **Text** button in the footer buttons. Find F.Safety/Risk from the list and select it



- "F. Safety/Risk" displays on the first line – type in "-Fall" to provide more detail for the subject line (F. Safety/Risk- Fall). Document:
- Subjective: Pt. states he lost balance when walking to bathroom
- Objective: Pt. found on the floor in bathroom, on buttocks
- Assessment: No apparent injuries, vital signs stable.
- Plan: Physician notified
- Evaluation: No new orders, will continue to monitor pt.
- Click **OK** at the bottom right

#### 17b. Amend (Edit) a Note

- From the **Notes** tab, click into the documentation you just completed in Exercise 16a (F. Safety/Risk- Fall)
- Once the documentation opens up, click the **Amend** button at the footer
  - Enter your addendum: **\*current time\*- patient states they are experiencing hip pain.**
- Click **OK**

#### 17c. Undo a Note

- You realize you documented the fall on the wrong patient. To undo the note-
- From the **Notes** tab, click into the documentation you just amended in Exercise 16b
- Click on the **Undo** button at the footer. Type in the Undo reason as Wrong patient
- Click **Save** at the bottom right. A pop-up will appear to confirm the action- select Yes

#### Exercise 18: Transfer of Accountability (TOA)

- TOA checklist: happens at shift change & during transfer between units (e.g., ICU to inpatient or ER to inpatient)



- From the **Worklist**, choose **TOA Transfer of Accountability** so the row becomes highlighted in green. If you do not have this item on your Worklist, add it now by selecting the Add button at the footer
- Select the empty cell under the **Now** column so a checkmark appears, and click **Document** at the footer
- Review the SBARD with the nurse you are completing the handover with. In Go-Live, you may want to:
  - Start from the Status Board and make sure there are no outstanding items such as unadministered medications, unacknowledged orders or unresolved Worklist items
  - The blue table under the Status Board can also be utilized to share information on VS, IV infusions, communication orders, activity tolerance and diet
  - You may also open the chart and go through tabs such as **Summary**, **Snapshot**, **I &O** and the **MAR**
- Both the incoming and outgoing nurse must complete the TOA assessment on their respective Worklists, and identify each other as the receiving/outgoing nurse

#### Exercise 19: Discharge Plan

##### (DO NOT COMPLETE IN ADVANCE OF INSTRUCTOR NOTIFICATION)

- From the “Do” portion of the EMR, click on the **Discharge Plan** tab. Here you can see the discharge plan as updated by the provider, and print the Discharge Plan as well as any Reports
- Check off the “Discharge Assessment (Generic)” on the Interventions row, and click into the blue **Doc** icon in the Interventions box. This will take you to the documentation page for the discharge assessment.
- Look through the assessment and fill in the following information:
  - Mode of discharge: Ambulatory
  - Discharged with: Family
  - Personal Belongings Returned: Yes
  - Home and Community Care: Existing Patient



- Click **Save and Exit** at the bottom right to return to the Discharge Plan page
- When the patient leaves, you must enter the appropriate information for the fields **Patient Disposition** and **Discharge Date/Time**. Click **Save** at the bottom right
- A discharge order must be present (shown in **Discharge Orders** box) before Meditech Expanse allow you can enter the Discharge Date/Time. After you hit **Save**, the patient header should update from ADM IN to DIS IN