

Allied Health Education

In Class Exercises and Independent Practice

In Class Exercises

Exercise 1: Patient Lists

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

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

Exercise 2: Open 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

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- 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 Intervention - Allied Health Snapshot Communication

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 “**Allied**” and hit the Enter key. Click the Next button by the footer until you see the option “**Allied Health Snapshot Communication**”

- Click on “**Allied Health Snapshot Communication**” and it will appear below the table
- You will now have 1 intervention listed below, ready to be added to the Worklist
- Click the **Save** button on the bottom right

Exercise 5: Change Status/Change View

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

- From the Worklist, select **Allied Health Snapshot Communication** 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.

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 **Allied Health Snapshot Communication**, which you changed the status of earlier
- Highlight the **Allied Health Snapshot Communication** intervention to change back to Active
- Click in the Last Done/Status due column and choose Active

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Exercise 6: Documentation

Add additional Interventions

- Open worklist
- Add
 - **Vital Signs**
 - **Informed Consent Assessment/Treatment** - notice all that exist for future reference
 - **Allied Health Snapshot Communication** (should already be on list)
 - **Discipline specific “___ General treatment plan”** (for OT, PT, SLP only) ie. SLP General Treatment Plan
 - **Discipline specific “___ / ___ General treatment record”** (for OT/PT/SLP and OTA/PTA/CDA). ie. OT/OTA General Treatment Record

Document - This will require therapists and assistants to work together. OTA's will document on the treatment record for the patient that the OTs have documented a treatment plan for. All Assistants will need to load a therapist's patient onto their list and document on that shared patient).

- Complete documentation for one of your patients that you are currently providing services for. Please follow the order indicated.
 - **OT/PT/SLP: 1) Discipline specific treatment plan (first 3 activities only), 2) Vital Signs 3) Allied Health Communication Snapshot,**
 - **OTA/PTA/CDA: 1) Vital Signs, 2) Informed Consent for Treatment 3) Discipline specific treatment record**
 - **RT: Vital Signs, Allied Health Communication Snapshot, RT Leisure Assessment**
 - **RD: Vital Signs, Allied Health Communication Snapshot, RD Nutrition Assessment**
 - **SW: Vital Signs, Allied Health Communication Snapshot, SW Women's and Children's Health**
 - Click on the in the “Now” column
- Click the Document button at the bottom of page
- Document details
- Save and Exit
- Return to worklist and note the last documented time now appears in minutes

Exercise 7: Back Time, Edit, Undo Intervention

- Select **Informed Consent Assessment/Treatment** and click in the NOW column
- Click Document
- Note the green box on the top right hand side of the assessment which includes the date, current time and your initials
- Use the “top carrot” to produce the drop down box
- Change the time in the box to the time the assessment occurred (**0900**)
- Click OK
- Note the time now says 0900 in the top right hand corner
- Proceed to document the consent details
- Save and Exit

Edit

- Realize you made a mistake and **you documented consent obtained from patient but it was actually the SDM**
- Click on the Last Done time cell
- Defaults to the History tab
 - Includes all activity events for the intervention
 - Created - when the intervention was initially added
 - Document - displays the activity date/time and user that documented

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- Not Done - displays the activity date/time and user that documented the intervention as note done
- Click the Document for the date/time that you documented
- Click the Edit button at the bottom of the page
- The intervention documentation displays, click the second Edit button at the bottom of the page
- Documentation is highlighted so **change the consent obtained to SDM**
- Save and Exit
- Note the history tab now displays Edit Result below Document
- Click Flowsheet tab to view the change
- Click Back to return to the worklist

Undo

- It's a bad day and now you realize you documented on the wrong patient and need to undo the documentation
- Select **Informed Consent Assessment/Treatment**
- Click on the Last Done time cell on the worklist
- Defaults to the History tab
- Click the Document for the date/time that you documented
- Click on the Undo/Save button at the bottom of the page
- Answer yes you want to undo the documentation
- Answer Wrong Patient as the reason for undo from the lookup
- Note that history tab now displays Undo below Document
- Click Back to return to the worklist

Exercise 8: Set Note Preference and Document Note

- We are going to set your preference today and you will also need to do this at Go-Live
 - Click on Write Note
 - Notes open up with a list of all of the standard note types
 - Select Manage Favourites
 - Select the applicable note type by clicking the box next to the note
 - Save

Document Note

- Click on the Write Note Tab in the DO portion of the EMR
- Click the note type you added as your note type and you will be taken to a blank screen in which to document
- To add the focus as the first line of the note, select the Text button in the footer buttons
- Select the Focus subject that best describes the note subject you wish to enter
- Document the note using SOAPE format
- Save with PIN

Exercise 9: Add a Note to an Assessment to link the note and the assessment

- Select the **Vital Signs** and open the assessment, document the first couple of queries
- Select Add Note from the bottom of the screen
- Click on desired note type
- Select SOAPE note template
- Document additional information related to the general treatment plan to supplement the assessment
- Save with PIN

Note: You can view linked notes and assessments in EMR Patient Care and Notes

Exercise 10: Back time, Amend, Undo a Note

- Click on the Write Note Tab in the "Do" portion of the EMR desktop
- Click your "Note Type"
- Click on the Detail button on the right hand side of the screen

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- Change time of documentation to **0900**
- Go back to enter note by clicking Note Text button
- Document patient note
- Save with PIN

Amend (Edit) Note

- You need to Amend to add an **Evaluation** to the SOAPE format
- Click on the Notes tab from the Worklist on the See portion of the EMR
- Select the note to Amend
- Click the Amend button at the bottom of the page
 - Enter your addendum to your earlier note
- Save

Undo Note

- Still a bad day and you have documented all this on the wrong patient
- Click the Notes tab on the See portion of the EMR
- Select the note you wish to Undo
- Click on the Undo button at the bottom of the page
- Provide reason for Undo – **Wrong Patient**
- Save

Exercise 11: Diet and Diet Communication Orders

- Provider: Attending
- Source: Telephone
- Order Healthy Heart diet - make sure to search for "diet" by ANY WORD
 - Choose the primary diet
 - Regular diet = DAT
 - Review the options available for diets
 - If your patient has complex needs, such as small frequent meals and fluid restrictions, this will need to be edited within the diet
 - Restrictions
 - Secondary Diet - Fluid Restrictions, Small Frequent Meals and enter details for fluid restriction under additional instructions
 - Note that Fluid texture and Food texture auto default but can be changed if required
 - Select the carrot to display dropdown, delete regular and choose from the list
 - Isolation - will default based on the isolation order and is included in the diet order to ensure it prints on the current diet report
 - Submit

Diet Communication Orders

- Provider: Attending
- Source: Telephone
- Order Ensure TID

Exercise 12: Referral

- Enter a Referral for yourself
- Then, wait as we will review the process for you to know you have new referrals next as a group

Exercise 13: Stop/Cancel Orders

- Select New Orders.
- Provider: A screen will pop up that requires you to identify the ordering provider (if there is an MRP this will default. If the ordering provider is not the MRP or there is no doctor defaulted, you will need add one. Click on the carrot in the other provider line. In the search bar type **zz** and click the enter button on the keyboard, select **ZZTemplate, IPDoctor**

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- Source: Click on **Telephone Read Back**
- Click **OK**
- Click Name make sure Any Word is highlighted, if not select Any Word
- The order is: PFT, ABG
- In the order line type **PFT**, from the list select PFT
 - Notice that your [QUEUE] has a 1 in the button
 - That's what you have in your shopping cart
- Click in the Order field (it will be highlighted in green) and type ABG, select Arterial Blood Gases
 - Notice that your (QUEUE) has two orders in your shopping cart
- Click **Next**
- Select **Routine**
- Click **Submit** and enter **PIN** and hit enter on the keyboard.
- Select the **Orders** tab in the "Do" section of the EMR
- Find the **PFT** order.
- To make searching easier click on the word **Current** Orders in the blue bar on the table and it will sort the list alphabetically
- Click on the word **Ordered** in the **status cell** on far-right side of the PFT order, select **stop**
- A new page may open
- It may prompt you to enter in the Provider and Source details and hit **OK**
- After selecting **Stop** you will need to enter a **Stop Reason**, select from the drop-down list
- Select **Entered in Error**
- Save by clicking **OK**
- Click **Submit** in footer and enter **Pin** then hit **Enter** on your keyboard

Note that the order status is now **Stop Requested**, and a stop date/time appears, both in **red** font

Exercise 14: Manage Referral from the Status Board

- Go to Lists and select your discipline specific Referrals by All Locations
- Note the Green Checkmark in the New Referral column and the reason for the referral in the Referral Reason column
- Add patient to your My List
 - Highlight the patient
 - Click Add to My List from the footer button
- Open the worklist and locate the discipline specific order and place a checkmark in the Now column
- A screen will appear outlining the Order Detail and Item Text entered at the time of ordering
 - Select close from the bottom menu
 - Select Document from the bottom menu and document the treatment status (Hold, In Progress, or Discharged) this information will update the status board
- Documentation of assignments of PT/OT/SLP assistants are also required in the Discipline Assistant Assessment section
- When complete click Save and Exit
- A prompt will suggest interventions to add to the worklist, select, once added document and click Return to Status Board

Exercise 15: Manage Orders to view referral orders and specify a timeframe

For example - New referral orders over a weekend

- Select Manage Orders from the main menu
- Select By Location
- Template - Select your discipline from the drop down list

Note the Order Dates - default date range is 1 day

- Change the order dates to start and end based on your timeframe
- Click Compile in the footer buttons
- Active referrals for your discipline for the timeframe specified display

Exercise 15: Workload Measurement - Direct Patient Care and Non Patient Care

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- Select 'Clinical' > 'PCS Status Board'.
- Status Board displays the preferred status board.
- Click 'Indirect' on the right hand menu bar.
- Click the appropriate Location to open the NSR menu.
- Click 'Open' on the bottom menu bar.
- Click in the 'NOW' column to select the Care Item to be documented.
- (Note: multiple selections can be made at once).
- To remove an incorrect selection, click on the selected checkmark.
- To save, click 'Document' on the bottom menu bar.
- Click 'Save'.
- Once complete, click 'Status Board' on the right hand menu.
- Again, Click 'Status Board' board from the right hand menu to return to the status board.

Exercise 17: Hold Queue

- Open your assigned patient's chart and click **Orders**
- Click the **Hold Queue** button
- Click Create New Event from the footer
- Click on the carrot in the cell after *Event Reason and select Suggested Orders (Non-provider Clinician)
- Click on the carrot in the cell after *Facility and select the facility that is applicable.
- A timeframe box will appear. If there is a specific time associated with the order you can enter it, if not click OK.
- Enter some sample orders that you may typically recommend as per the previous process
- Select **Next** in the footer buttons
- Click **Submit** in footer and enter **Pin** then hit **Enter** on your keyboard
- The Hold Queue will turn Red and a yellow flag will appear.

Exercise 18: Medication Orders

- Open your assigned patient's chart and click **Orders**
- Click the **New Med** button
- Enter attending/MRP provider and select telephone as the source
- **Favourites** default, change to **Name** to search by med name
- Enter **Sal** for **Salbutamol**
 - The screen changes to show several medications that start with Sal
- Click Salbutamol
- Select Next in the footer buttons
 - Numerous strings will appear
 - Pick the one that most closely matches the order
 - **Salbutamol 100mcg Inhaled 6 puffs Q24h PRN**
- Checkmark this medication
- The screen expands to include the complete order
- The type defaults to PRN (you could change by clicking on the PRN field)
- Select the blue **Edit** button to expand the order detail
- At this point any of the fields in white could be updated.
- Find the ***Freq** click the **carrot** to open the drop-down list and if **Q24H** is not available click at the bottom of the list in the cell and type **Q24H** and click enter
- Click **Submit** in footer and enter **Pin** then hit **Enter** on your keyboard

Exercise 19: Patient Messages

- Select Msg/Task from EMR menu
- Opens to Inbox
- Select Create
- Account - Enter patient info to identify the patient - account number/ last name, first name
- Subject - Enter the message subject/topic
- Sender - Your name defaults
- Priority - Medium defaults

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- Frequency - Skip
- Send To
 - Select the provider you are sending the message to and their name will populate
 - Admitting, Attending/ED, Family
 - User - You can also select the provider or another user from the user list
- Recipient Group - Skip, not using yet
- Workgroup - Skip
- Printer - Skip
- Recipients - Providers and Users selected above will populate as the receivers of the message
- Message - Click Discussion in the footer buttons
 - Enter your message in the text box
- Click Send

New Messages

- Msg/Task will turn RED when you have new messages, Select
- Opens to Inbox, and you can see at a glance some message details
- Click the drop down to view the full message
- Checkmark the message
- Select View Selected from the footer buttons
- Read the message
- Click lists to return to the message page

Review Sent Messages

- Click the Inbox carrot
- Select Sent

You should see the message you sent

Exercise 20: Administer Medications

- Scan patient armband (from barcode handouts which should match your assigned patient for the class) – MAR opens - Note the Patient Verified in red font in top left corner of the patient header
Order: **Ipratropium 20 mcg Inhaler 2 puffs QID PRN, to a max of 12 puffs in 24 hrs**
- Find Ipratropium on the medication barcode list and scan the medication (you may need to cover up the barcodes on either side to get the correct medication)
- Note the **GREEN** barcode as well as dose and time (if applicable) appears in the med cell as you scan each med
- Order: Salbutamol 100mcg Inhaled 6 puffs Q24H prn
- Find Salbutamol on the medication barcode list and scan the medication (you may need to cover up the barcodes on either side to get the correct medication)
- Click the **UnSched** button in the footer
- Click **OK** (a summary screen appears for you to review before saving)
- Click **Save**

Exercise 21: Medication Refusal Not Given

Order: **Ipratropium 20 mcg Inhaler 2 puffs QID PRN, to a max of 12 puffs in 24 hrs**

- Find the medication on the MAR
- Your patient refuses to take the Ipratropium
- Since the medication is scanned and saved the medication cell (in the Today column) appears black user will need to undo scan the administration
- Click in the medication cell selecting **undo** from the drop-down menu
- Since this is a scheduled medication (SCH), you also need to document that the scheduled date/time was not given because the patient refused
- Click in the medication cell a drop-down menu appears select **Not Given**
- Select the reason the medication was not given **Patient Declined** from the menu that appears on the screen
- Click **OK**
- Click **Save**

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Exercise 22: Scan to Order – Verbal Order

- Scan your patient barcode to verify your patient.
- Scan a medication from your list of Medications that you have not entered an order on previously
- A pop-up screen will come up to tell you that there is not an order for that medication for that patient, and do you want to order it. Click Yes and order the medication as per the previous process.
- You will return to the MAR to conclude the administration process.