Emergency Department Education
In Class Exercises

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Exercise 1: Reception Routine – Walk-In Patient

- Select Lists from the right-hand menu.

- Select Triage from the Lists table.

- Once on Triage Tracker, select Reception from right hand menu

- Select **Walk In**

- You all have a unique patient to practice. Naming convention for your patient is as follows:

  - Last Name = **TRAINRV**

  - First Name Format = **EDX_CurrentDate.** X is a number that is unique to each learner. Please look at the laminated sheet on your desk to find the number for your patient. For Example, first name for a patient on 2nd of July would be ED1_0702.

  - Sample Patient Name for RVH patient: TRAINRV, ED1_0702

  - Please confirm with the instructor to make sure you have correct name for your patient.

- Enter last name, first name of your patient in the patient identifier field and click search at the bottom of screen.

- Your patient has never been to RVH. So, your search should not return any results. If your search returns multiple patients then please check the last name and first name you entered and make sure it's correct.

- Click New Patient at the footer

- Complete all required information, denoted with an asterisk (*). Enter the birthdate and the age with automatically populate.

- Ensure that height and weight are recorded. This becomes critical during effective medication administration.

- Stated Complaint – What the patient tells you as the reason for their visit. This flows to ED Registration as Reason for Visit

- Enter the Chief Complaint **Abdominal Pain** (this will generate the Medical Directive after you save**)**

- **Do not enter** the Allergies/Home Medications/Patient Pharmacies or Special Indicators at this time this is a triage function

- Once information is entered select **Save.** If Save button is not active, check if any of the fields with * is missing information.

- You would notice a pop up indicating that medical directive order set is available for submission. **Select No, Thanks maybe later**.

- Note that you are back on triage tracker screen and the patient status, under the **status** column is indicated as **received**

Exercise 2: Triage (eCTAS Score will be entered manually)

● Stay on the ED Triage Tracker and click on the patient name to select the patient you just received.

● You would notice that selected patient is highlighted in green on tracker.

● Select **Triage** from the right-hand menu

● To bottom of the screen, under triage assessment table, you will see that there are **Triage Assessments**

● To document on the assessment checkmark the appropriate assessment

Note: that you can select more than one assessment to complete IPAC screening and
Triage Assessment at the same time

● Select **ED Triage Assessment RV and IPAC Screening**

● Click the **Document** button in the footer to start your **ED Triage Documentation**

   ○ Note different assessments associated to the triage assessment

   ○ Note that not all assessments and sections are open by default. For example, EMS Report and EDM Rapid Stroke Assessment are collapsed by default (feel free to open each assessment to review information by clicking the + sign to expand and the – sign to collapse)

   ○ Indicate the following in your documentation:

      ■ Patient has experienced a fall in the last 30 days

      ■ No travel risk

      ■ Negative COVID-19 Screening Result

      ■ Negative Screening for FRI and GI

      ■ Unsure of ARO positive

      ■ Add Droplet/Contact Precaution (only to be able to see on Status Boards)

   ○ Select **Save and Exit** button at the footer.

- ○ Note that both ED IPAC Screening and ED Triage Assessment RV have a last done date and time.

- Document **Allergies** – Click the **Allergies/Home Meds/Patient Pharmacies tab** in the header. Select **edit** next to Allergies/AdvReac.

- Select **Any word** and type and search for **Strawberry. Click on strawberry in the search result**. Add Bee venom protein as allergy in same way.

- Click the **red** edit button next to each allergy to add reaction type. Select the reaction to strawberries as **Rash-localized** and Bee venom protein as **anaphylaxis.**

  - ○ After entering Allergies select **Save** at the footer

- Document Special Indicator – Click on **Special Indicators** in the header bar. Using the drop-down carrot select **Hearing and/or Vision Assist.** Now let's add another special indicator. Select **new** in the header and follow the same steps to add **Falls Risk.**

  - ○ After entering Special Indicators select **Save** at the footer

Note: The BPMH is now completed as an intervention on the Worklist and will be discussed in more detail later in training

- Click on **Triage** in the header bar to return to triage assessment screen

- Click on the **tracker** button on the right menu to return to the triage tracker

- Manually update the status event to **Triaged**. **Click on the received status** for your patient under the status column and select **Triaged**.

  - ○ This alerts the Registration clerk to complete the registration as the patient auto files to the Registration tracker

  - ○ This also updates the eCTAS TOA to auto complete in eCTAS

- eCTAS documentation would also occur at this time

- Triage nurse may need to assign a room or zone depending on the facility

- Patient would wait to be registered

Once registered, the status event auto updates to Waiting Room and the patient auto files to the Waiting Room tracker, dropping off the triage tracker

Exercise 3: Sign Up and Rooming (your patient will need to be registered)

- Select **Lists** from the right-hand menu.

- Select **Waiting** from the Lists table to get to the Waiting Room Tracker

- Stay on Waiting Room Tracker

- Click on **name of the patient you just triaged to highlight in green**

- Click **Sign Up** from the right side of the screen. Note that the patient disappears from the waiting room tracker.

- The patient populates in ED All tracker and My List Tracker.

- Select **Lists** from the right-hand menu.

- Select **ED ALL** from the Lists table to get to the **ED ALL Tracker**

- Note that your name now appears in the nurse field for this patient, on the ED All Tracker**.**

- The patient will also display on **My Lis**t tracker, which contains list of all patients you have signed up for and manually added.

- Select **Lists** from the right-hand menu.

- Select **My Lis**t from the Lists table to get to the **My List tracker**

- Place the patient in an ED room manually. Click on the room field in the room column of tracker and select a room that is unoccupied (i.e., has a count of 0).

- Click **Save** after selecting the room. Note the room is updated on the tracker.

- Upon Signing Up, the status automatically changes from **Waiting Room** to **To Be Seen** in ED All Tracker and My List Tracker. Note the last column on your tracker to review status.

Exercise 4: Adding an ED Focused Assessments

- Stay On My List tracker and select your patient by clicking on patient name. You would notice that your patient is highlighted in green on the tracker.

- **Open Chart** by selecting the space in the chart column on the left of the tracker or by clicking **open chart** on the right side of the tracker.

- Chart opens to the **Worklist** section by default**.**

○ Worklist will be auto populated with assessments because the Chief Complaint of Abd Pain was added earlier

● Add an additional intervention to the Worklist by selecting **Add** in the footer bar

● Search for "**ED**" and click **enter** on the keyboard

  ○ Click Next in the footer until you find **ED Gastro-intestinal Assessment.** Click on this assessment to add it to the Worklist.

● Once again select the Search bar at the top of screen and enter "**MI**"

  ○ In this example we are going to select multiple interventions.

  ○ Select **MI CT or US Preparation** and **MI Send Patient**

● You would notice that all three assessments have been checked off in the table below.

● Click **Save** in the footer**.**

● You would notice that all three assessments have now been populated on the Worklist.

Exercise 5: ED Flowsheet

● Click on the **ED Flowsheet** from the right-side menu

● To add items to this flowsheet. Select the **Items** drop-down carrot, in top left corner, and select **Get More Items**.

● Search for "**CC**" and click **enter** on the keyboard.

● Click **next** in the footer until you find **CC Ventilation Invasive**.

● Select **CC Ventilation Invasive** and click **Save** in the footer.

● Now let's change the frequency of these assessments to **Q5mins**

  ○ To do this select the **frequency field** to the right of Items tab. Using the drop-down carrot, you can choose from a range of frequencies.

Exercise 6: Document ED Assessments

Document ED Assessments

● Return to Worklist by clicking on **Worklist** on right side of screen

- Request Pharmacy to perform BPMH by documenting on the **ED BPMH Assessment**

  o Find **ED BPMH** assessment in the **Care Item** column and place a **checkmark** in the **Now** column (the one highlighted in green) beside the ED BPMH care item.

  o Click **Document** from the footer bar. This will open the flowsheet for documentation.

  o Select **Requested** as a response to ED BPMH question. This will send a request for Pharmacy to complete.

  o Select **Save** and **Exit** in the footer

  o This should take you back to the Worklist screen and you will notice the Now column next to ED BPMH will say **Done**.

  o Click **refresh** in the footer bar and this with disappear.

  o Return to Tracker by clicking on **Tracker** on right side of screen.

  o Ensure **Requested** appears in the **BPMH** column. This will flag pharmacy to complete BMPH for your patient.

Document on the **MI CT or US Preparation and the MI Send Patient**

- This is a **communication tool** between Medical Imaging (MI) and ED Department to ensure patients are sent for imaging only when the prep is complete, and MI is ready to receive the patient.

- Medical Imaging will start documenting on **MI CT or US Preparation** assessment to indicate the preparation needed for CT or US.

- This will turn **blue**, the **two arrows forming a circle under P column** on the tracker.

- This will serve as a prompt for ED nurse to view this information and start the prep.

- Once the prep is complete, ED nurse will indicate completion by documenting on **MI CT or US Preparation assessment**.

- MI will then document In the **MI Send Patient** Assessment to indicate MI is ready to receive the patient.

- This will turn blue, **the two arrows forming a circle under S Column of the Tracker**; prompting the ED nurse to send the patient.

- So, the patient will be sent to imaging when both "S" and "P "columns have blue circular arrows

- Today you will be completing both the Medical Imaging portion and ED portion of this communication

- Document on **MI CT or US Preparation**
  - Place a **checkmark** in the **Now** column beside the MI CT or US Preparation Care Item and click **Document** in the footer.
  - From here decide whether your patient is going for a CT or US and select **2** prep items from the **ED Medical Imaging Prep Required** section.
  - Click **Save and Exit**
  - Select **Tracker** from options on the right side. Select **Yes** to close chart.
  - Note that the "**P**" column, for this patient, should have **double arrows in a circle** and information in secondary status board beside the CT/US Prep.
  - Open patient chart again and go back into the **Worklist.**
  - Once again place a **checkmark** in the **Now** column beside the MI CT or US Preparation Care Item and click **Document** in the footer.
  - Document in the **ED Prep for CT/US completed** section this time as the ED nurse, saying you have finished prep.
    - Select **preparation requirements** that have been **completed**.
    - **If giving water**, indicate the time patient started drinking water in the CT PO Prep Time field.
    - Click **Save and Exit**
    - This will return you to the worklist
  - From here, place a **checkmark** in the **Now** column next to the **MI Send Patient** Care Item and click **Document** in the footer
    - Select **Send to CT** or **Send to US** depending on your original selection
    - Click **Save and Exit**
  - Select **Tracker** from options on the right side. Select **Yes** to close chart.
  - Note that the "**S**" column, for this patient, should have **double arrows in a circle** and updated information in secondary status board beside the CT/US Prep.
  - Since both "S" and "P" arrows are blue, you can now send the patient to Medical Imaging.
  - Update Status to **In MI**
    - Click in the status cell of the patient tracker and select **In DI**

- o Now **CANCEL** both assessments on worklist and blue arrows on My List should turn Grey. (REMEMBER: This is the only time the status of cancel will likely be used from Worklist)
  - To cancel Care Item on worklist, select **Open Chart** from options on the right. The chart opens into worklist section by default.
  - Click on the cell in **Status/Due** column for MI CT or US Preparation. A drop-down box will open and select **Cancelled**
  - Repeat the process for MI Send Patient Care Item.
  - Return to the **Tracker** and notice the arrows under P and S section are now greyed out.
  - Let's assume that your patient is now back from MI. Change the Status back to **In Room**
  - **Notice every time you change the status of a patient, it resets the Event Time on the patient status board.** Event time can be noticed right under the status.

- Document **ED Adult Physical Assessment**

  - o Open patient chart again. It opens to worklist section by default.

  - o Place a **checkmark** in the **Now** column next to **ED Adult Physical assessment** care item and click **document** in the footer**.**

  - o Document the patient has GI significant findings with Abd Pain by clicking **plus beside ED Gastrointestinal Assessment.**

  - o Patient now has nausea and vomiting

  - o Bowel sounds are present in all four quadrants

  - o Click **Save and Exit**

- Repeat the steps to document **ED Pain Assessment** & **Vital Signs**

  - o **Note you can place a checkmark next to both interventions and click document. This will allow you to document multiple interventions at the same time.**

View ED Assessments in the EMR

- Select **Patient Care** from options on the right side

- Select assessments to view by clicking on the square box beside assessment name

- Click **View Snapshot in the footer**

- Click back in the footer to get back to list of assessment

Exercise 7: Back Time, Edit, Undo Intervention

Back Time:

- Return to Worklist by selecting **worklist** from options on the right side.

- Place a checkmark in the **NOW** column besides Vital Signs Care Item

- Click **Document** in the footer

- Note the green box on the top of the assessment which includes the date, current time and your initials

- Click the **downward arrow** on right side of the box to produce the drop-down box

- Change time in the time box to the one hour prior to current time

- Click **OK**

- Note the time now says updated time in the top right-hand corner

- Proceed to document vital signs

- Click **Save** and **Exit**

Edit:

Realize you made a mistake and the patient was actually febrile at that time

- From the Worklist, click on the **Last Done** cell next to the Vital Signs Care Item

- A window will open that defaults to the **History** tab

  - Here you will find all the Historical Activity and Activity Type for the intervention selected.

    - **Created** - when the intervention was initially added
    - **Document** - displays the activity date/time and user that documented

▪ **Not Done** - displays the activity date/time and user that documented the intervention as note done

● Select the document you wish to edit

   o Click the **Edit** button from the footer

● The intervention documentation displays

   o Again, click the **Edit** button from the footer

   o This will allow you to change the date and time

● Select the **temperature field** and change the temp to **39.6**

● **Click outside the box in white space**

● Click **Save and Exit** from the footer

Note the history tab now displays Edit Result below Document

● Click **Flowsheet** tab in the header to view the change

● Click **Back** in the footer to return to the **Worklist**

Undo:

You're having a really bad day and now you realize you documented on the wrong patient and need to undo the documentation

   • Click on the **Last Done** cell next to the intervention you want to undo

   • Defaults to the History tab

   • Click the Document for the date/time that you want to undo

      o **Note you cannot undo edited documentation, you must undo the original document.**

   • Click on the **Undo/Save** button at the bottom of the page

   • Answer **yes** you want to undo this documentation

   • Answer **Incorrect 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** from the "Do" section on the right side of the screen
    - o Notes open up with a list of all of the standard note types
- Select **Manage Favourites**
- Select the applicable note, ie: **Nursing**, by check marking in the Favorite box next to the Document type
- Click **Save**

Document Note

- In the **Write Note** tab of the EMR
- Click the note type you added as your favorite and you will be taken to a blank screen in which to document a note
- 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 and click **OK**
- Enter your **PIN** and click **Save**

Exercise 9: Back time, Amend, Undo Note
Back Time Note

- Click on the Write Note Tab in the "Do" portion of the EMR desktop
    - o Click "Nursing Note Type"
    - o Enter some text in the note
    - o Click on the **Detail** button on the right-hand side of the screen
    - o Change time of documentation to **one hour prior** by clicking the drop-down carrot next to Date Time
- Go back to enter note by clicking **Note Text** button
- Add **Focus - Safety/Risk** by selecting **Text** in the footer
- Safety/Risk displays on the first line - add **Fal**l to the end to provide more detail for the subject line

- Document **patient fell when walking to the bathroom. No apparent injuries. Called physician. No new orders**.
- Click **OK** when finished writing note
- Enter **PIN** and click **Save**

Amend (Edit) Note:

- You need to Amend a note 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** from the footer
- Enter your amendment that the **patient still complains of hip pain**.
- Select **OK** once finished
- Enter **PIN** and click **Save**

Undo Note:

It is 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 in the footer
- Provide reason for Undo, enter – **Wrong Patient**
- Click **Save**
- A box will open stating "This note will be undone. Are you sure?"
    - Click **Yes**
- The screen will return to the all-notes page
- Note the status is changed to **Cancel** for the note you have undone.
- Select **Tracker** from the right-hand side of the screen.

Go to OM/eMAR Activities

Remember when Sets are reviewed, the New Sets button will have red lettering as a result of the Medical Directive

Followed by eMAR/BMV and TAR

Exercise 10: Prepare for Patient Admission

Admit Request: Use this to notify Registration/Bed Allocation that a bed is needed.

● Select **Admit** from the right-hand menu

● Select **Admit Request**

● Request Service - Select the service that the patient is transferring to

• Request Reason - Select **Patient to be Admitted (IN)**

• Requesting Location, Date and Time Needed default - no need to change

• Use Notes to enter any specifics related to the bed request
  ○ Telemetry, Isolation etc.
• Admit Info
  ○ Select the patient's current ED bed from the list
  ○ Enter the Admitting Diagnosis from the physician's transfer orders

● Check the patient status on the Tracker – it should auto update to Pending Admission

Exercise 11: TOA (Complete with the Person sitting next to you)

One person is the Receiving Nurse. One person is the ED Nurse. Then switch.

● Click on **ED Snapshot** on the right side of the **Tracker** or in **patient chart**

● Review all tabs for the shift report

● Go to **Worklist** for the patient

  ○ Document **ED TOA Transfer of Accountability**

  ○ Indicate name of the nurse that provided report and the name of the nurse receiving report

*** Note the majority of ED assessments will auto-complete and will not flow to the worklist for the admitted patients. Only shared assessments with ED and Inpatients will flow to the worklist for the admitted patients***

Exercise 12: Discharge Plan

● Open the **Discharge Plan** from the "**Do**" section of the EMR

- Document on the ED discharge assessment

- Enter the **Patient Disposition** & **Discharge Date/Time**

    o If going to LTC add the name of the facility

- Patient header will update with DEP (ER)

- Patient drops off all Trackers except My List and Discharge Tracker

- Admitted or OR patients

    o If going to an inpatient location or to the OR do not discharge the patient

    o ED nurse manually changes the status event to update the tracker and alert Registration staff that the patient has been transferred

    o Registration clerk will depart the patient

    o Once discharged, patients appear on the Discharge tracker based on the visit date

    o A patient that was registered for a visit yesterday will appear on the discharge tracker for yesterday and not on today's date

- Discharge Packet – print and give to the patient

Patients below can be used as scenarios to practice when given access to Test Expanse.

Emergency Department – Independent Practice

Scenario 1 - Patient presents to ER. No previous account. Will be discharged home

- Receive the patient
  - Stated complaint is abdominal pain.
- Document ED Triage Assessment
  - Not EMS pt. No falls. No travel risk. Negative screening for COVID-IPAC.
- Chief Complaint entered – Abdominal Mass/Distention
- Choose not to execute Medical Directive for Abdominal Pain.
- Order Urinalysis.
- Document Allergies and Special Indicators
  - NKA
  - Patient has Hearing Impaired/or Vision Assist special indicator
- CTAS 3
- Assign patient to a room
- Sign up for patient.
- Complete pertinent medical/surgical history
  - Patient has hypertension
- Documents ED Physical Assessment
  - Pt has GI significant findings with Abd pain
  - Has nausea and vomiting
  - Bowel sounds are present
- Document Pain Assessment
- Document vital signs
- Document patient assessment
  - Patient is nauseated and vomiting, complaining of increased abdominal pain, some blood in urine.
  - Nurse adds ED Gastro-Intestinal Assessment.
  - Click on Re-Assessment and complete the assessment. MD notified.
  - BP 110/70. Resp 28. Temp 36.8. BS all 4 quadrants
- Order meds and IV fluids
  - Morphine 1mg IV Q2h PRN
  - Ondansetron 8 mg IV q8h PRN
  - 1000 mL IV BOLUS over 20 min, continue with RL rate 125 mL/h
- Acknowledge orders
- Document vitals
- Document IV Insert intervention
- Complete medication administration
- Document Discharge
  - Document ED discharge assessment, discharge disposition, discharge date and time
- View Discharge Packet (don't print)

Scenario #2 – Patient Presents to ER, Admitted as inpatient

- Receive the patient
    - Stated complaint is chest pain
- Document ED Triage Assessment
    - Recent history of falls and no travel history
    - MRSA history, contact isolation initiated
- Document Allergies and Special Indicators
    - Penicillin allergy
    - Special Indicator for Falls
- Add Chief Complaint to triage screen – Chest Pain with Cardiac Features
- Medical Directive pop up – click continue
- Enter CTAS 2
- Update Status to "Triaged"
- Assign patient to ED room
- Sign up for patient
- Complete pertinent medical/surgical history
    - Hypertension
- Review and confirm allergies
- Document assessments
    - ED Cardiac assessment
    - Vital Signs
    - Pain Assessment
- Initiate ED Chest Pain Medical Directive order set
    - O2 if saturations less than 92%
    - Insert Saline lock
    - ASA 160 mg chewed once
    - nitroglycerin spray 0.4 mg SL Q5 minutes PRN;
    - labs STAT; CBC, BMP, glucose, PT+INR, PTT, Troponin I, ECG (Specimen source defaults as Pre Collection Label)
- Administer meds
- Collect specimen for lab orders
- Order and give Morphine 2 mg
    - Document pain assessment