



Web Acute Provider Training Activities

In Class Activities and Exercises	Trainee to write down the answers on the lines below or to take notes
<p>Activity 1. Navigation of the Status Board Activity</p> <ul style="list-style-type: none"> • Locate your test patient on the Status Board <ul style="list-style-type: none"> ○ Where is your patient located as per indicated on the status board? ○ What is/are the special indicator/s for your patient? • Select Patient from the Rounds List to add to “My List” <ul style="list-style-type: none"> ○ Click on the Hamburger Main Menu ○ Select the option “select multiple patients” ○ Click on the patients you want to add by highlighting them in green ○ Then select the menu again and select “Add to Personal List” ○ Click on the Rounds Lists button and then the personal list to verify that the patients are there 	<p>Check off what you find and write down your findings. What/who is the:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Patient location - _____ <input type="checkbox"/> List Special Indicator/s _____ <input type="checkbox"/> Location of patient _____ <input type="checkbox"/> Number of patients on the Status Board _____
<p>Activity 2. Find a patient, open the chart, and return to the Status Board</p> <ul style="list-style-type: none"> • Click on the Find Patient Field search bar • Type in the last name and first name of a patient: <p>RVH – Test, Allied</p> <p>CGMH – Test, Connecting</p>	



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<p>HHCC – test, Mary</p> <p>GBGH - test,cathy</p> <ul style="list-style-type: none"> • On the Account Search by Patient Name select the accurate patient name and account. • A “Warning” overlay may appear, select the “Open Chart” button • You are in the chart, click the Home button on the Navigation Bar to return to the Status Board. 	
<p>Activity 3. Build Coverage</p> <ul style="list-style-type: none"> • Click on the double person silhouette icon beside the Rounds Patients List • Select “Edit Coverage” • Click on the “Search Providers” search field and type in the provider first name and last name zzTemplate,InDoctors. It will highlight the name in green. • Add the name to the favourite list by clicking “Add New Favourite.” Type in the name of the “Favourite” zzTemplate, InDoctors. • Select the check box for “Apply Coverage to Workload List” • Click the “Save” button when complete • To turn off the coverage select the double person silhouette to turn it into single one to turn off the coverage. This will only display your patient(s). 	

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<p>Activity 4.</p> <p>Workload</p> <ul style="list-style-type: none">• Compose a message<ul style="list-style-type: none">○ Click on the Menu on the Navigation Bar○ The Compose Overlay displays○ Select the message/task type “Clinical”○ Input in the subject line “Request for consultation”○ Select recipients (input the name of your colleague sitting beside you in class).○ Assign and “importance” to the message by selecting the encircled exclamation mark.○ Change the date to send on to the next date.○ Enter free text in the text box the select the “Save” button. • Manage Messages and Tasks<ul style="list-style-type: none">○ Select the Workload button from the Navigation Bar or the Tracker○ Select the consult request just sent to you○ Review the information in the message. Once reviewed, select “Complete”○ Remember, completing the Workload message does not close the consult request order that was sent to you. This consult order needs to be completed.	



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<p>Activity 5: Chart Activity</p> <p>Access your patient Chart by clicking the patient’s name on the tracker or the Chart button on the Navigation Bar. While viewing your patient’s chart complete the following</p> <ul style="list-style-type: none">▪ Review the Patient Header and the Reference Region▪ Enter the Resuscitation Status for your patient<ul style="list-style-type: none">○ Open the chart○ Click on the “No Resuscitation” red text on the Header○ Select the “Change” button○ Click on the “Code Status” field and select the “Full Resuscitation” status○ Click the “Sign” button○ Click “Yes” on the Confirmation overlay○ Enter the PIN number▪ Change the Flowsheet in view to the Hypertension Flowsheet<ul style="list-style-type: none">○ Select the flowsheet tab○ Click on the “Viewing” button○ Search for and select “Hypertension”○ Find the patient’s temperature▪ Access the eMAR<ul style="list-style-type: none">○ Click on the Medications Tab○ Click on the Current Infusion/Titration button (display view button)	<p>Check off what you find and write down your findings. What/who is/are the:</p> <ul style="list-style-type: none"><input type="checkbox"/> Problems listed on the Reference Region widgets _____ _____ _____<input type="checkbox"/> Medication on the Home Medications list _____<input type="checkbox"/> Button name to exit the chart viewer: _____



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<ul style="list-style-type: none">○ Select the Home Medications Option○ Expand the details of the medication by clicking on the chevron ▪ Access the Chart Viewer<ul style="list-style-type: none">○ Click the More Button on the Navigation Bar○ Select the Chart Viewer Option○ Separate the chart view from the browser to open two chart browsers○ Close the chart viewer when completed	
<p>Activity 6: Widgets</p> <p>On the Reference Region and Summary Tab in the Chart, complete the following:</p> <ul style="list-style-type: none">▪ Special Indicator entry<ul style="list-style-type: none">○ Select the Special Indicator widget on the Reference Region○ Click in the search field and select Falls Risk, then click the save button ▪ Modify Widgets on the Summary Tab<ul style="list-style-type: none">○ Select the Cog wheel○ Within Widget Preferences, on the Summary Tab click “Add New Widget” and then select MOH COVID-19 screening○ Click on the widget and uses the arrows to move it up the list, to the left to the right column	



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<ul style="list-style-type: none">○ Click the Save button	
<p>Activity 7: Problem List Management</p> <p>Review the History and Problems List from the Reference Region and the Chart Tab</p> <ul style="list-style-type: none">▪ Enter a New “Active” Problem<ul style="list-style-type: none">○ Click on the Problem Widget on the Reference Region○ Click on the Search for: New Problem field and type in “COPD”○ CLICK on the Star for COPD to add the problem to the favourites list○ Select the “Active” button for COPD to add the problem to the Active List○ Add another problem of “Pain” in the similar fashion▪ Enter a new “Surgical Problem”<ul style="list-style-type: none">○ Click on the Search for: New Problem field and type in “biopsy”○ Select the “History” button for Hx of biopsy to add the problem to the surgical history list which will populate the Medical History list first○ Click on the chevron of the Hx of biopsy problem to reveal the details for the problem history additional fields○ Find the Category label and click on the caret beside Medical	



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<ul style="list-style-type: none">○ From the Drop down menu select “Surgical”○ Hx of biopsy should now be located under the Surgical History section○ Select the “Save” button <p>▪ Inactivate a Problem</p> <ul style="list-style-type: none">○ Click on the Problem Widget on the Reference Region○ Click on the yellow star beside the “New Problem” field to view the favourites list○ Click on the problem “Pain”○ Locate the Status label and click on the caret beside the “Active” status○ Change the status to “Resolved” by clicking the radio button (circle button) on the on the R/I/R side○ Select Save○ The problem “Pain” should no longer be on the	<p>List the problems that are present on the problem list within the reference region.</p> <hr/> <hr/> <hr/>
<p>Activity 8: Allergies</p> <p>To document allergies, access your test patient:</p> <ul style="list-style-type: none">▪ Add a new allergy of “Pollen” by clicking on the Allergies widget on the reference region▪ Click on the search field and type in the word “Pollen”▪ Select “Grass Pollen”▪ Select the following options on the Allergy/AdvReac overlay	



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<ul style="list-style-type: none">○ Type: Allergy○ Severity: Intermediate○ Status: Will always default to “Verified”○ Reaction – Difficulty breathing○ Enter a comma beside difficulty breathing and additional text.○ Enter in comments below, “Patient take Benadryl”▪ Add an allergy to Banana<ul style="list-style-type: none">○ Type: Reaction○ Severity: severe○ Reaction: hives○ Click the save button▪ Remove Allergy<ul style="list-style-type: none">○ To remove the allergy, click on the problem widget○ Select the allergy to Banana.○ Click on the box beside the title banana and then select the bottom left button “remove” to remove the allergy from the list or click the red X to the right of the line item.	
<p>Activity 9: Provider Documentation and DMO</p> <p>Open a document of choice. Within the document do the following activities:</p> <p>Enter Blood Pressure</p> <ul style="list-style-type: none">▪ In a document template, select the button “Add content”	



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<ul style="list-style-type: none">▪ The Add Section overlay displays▪ Click on the “Search Sections” search bar and type in “vital signs?”▪ Click on vital signs then select Apply.▪ Within the Vital Signs section, locate the white column labeled “New” and click into the white box for blood pressure▪ Enter a blood pressure value of 140/90.▪ Click Save <p>Create Quick Text</p> <ul style="list-style-type: none">▪ Click on the Clinic Note▪ Select the “A” on the Meditor bar to “insert text”▪ Click Quick Text from the menu▪ On the Quick Text overlay select “Edit”▪ Click on “Create New Trigger” ▪ Type the trigger code in the box, .iax and type in the description field – “Initial Assessment”▪ Type in the statement in the text field, <i>“Ms. X came to the clinic for an initial assessment to assess her current health problem []”. (Note: the closed brackets are for dictation purposes)</i>▪ Once complete click Save and then insert <p>Enter Canned Text</p> <ul style="list-style-type: none">▪ Click on the Clinic Note▪ Select the “A” on the Meditor bar to “insert text”▪ Click on Canned Text	



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<ul style="list-style-type: none"> ▪ Click on the search Canned Text Field and type in the letter F for “Focus” and select “F.Family/Caregivers” ▪ Click the “insert” button on the upper right-hand corner <p>Enter Formatted Data</p> <ul style="list-style-type: none"> ▪ Click on the Clinic Note ▪ Select the “A” on the Meditor bar to “insert text” ▪ Click on the “search formatted data” field and type in Vital signs ▪ Click on the star for “Last Response Vitals” to “favourite” this option ▪ Select “Last Response Vitals” ▪ Click Insert ▪ Click the sign button and enter the four-digit PIN number <p>Add an addendum to a signed document</p> <ul style="list-style-type: none"> ▪ Open your signed note ▪ Click Addendum ▪ Type in changes in the open text ▪ Select the sign button and enter PIN number 	
<p>Practice DMO</p>	
<p>Activity 7: Enter a Single Order and Order Set</p> <p>Single Lab Order</p> <ul style="list-style-type: none"> • Open the order management screen 	



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<ul style="list-style-type: none">• Select the Enter tab and then type in Electrolytes in the Search all field• Select the Electrolytes order• Change the order directions to “Stat”• Locate the CBC order on the Favourites list on the Order Management screen• Click on the chevron for the CBC order string to expand the order details screen• Click the sign button to enter the four-digit PIN number• Click the “Sign button after the PIN number is entered <p>Enter an Admission Order Set plus a single medication order using the process orders functionality</p> <ul style="list-style-type: none">• Select “Sets”• Type the word “ED” in the search bar• Select the order set “ED Chest Pain” by clicking on the plus sign which will add it to the Process Orders tab• Next, Search for the medication order Dilaudid 2mg PO Q4HR• Select the order plus sign which will add it to the Process orders tab• Select the Process Orders tab to enter all of the order details and then save the order. For the ED Chest Pain order set review and enter the following:<ul style="list-style-type: none">○ Review the reminders, reference links and protocols○ Select Point of Care Testing: Capillary Blood Glucose○ Lab: Liver Function Tests	



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<ul style="list-style-type: none">○ RAD CHEST 1vw Portable Stat○ Peripheral IV/Saline Lock (Ins./Maint.)○ Convenience set - order the Medications – Non-Opioid Analgesics● Enter the Dilaudid order detail 1-2 mg PO Q4HR PRN● Select the SUBMIT button and enter the PIN number to save it. <p>Enter a DI Order</p> <ul style="list-style-type: none">● Click on the Search Orders/Sets search field and enter RAD Abdomen 1vw● Click on the chevron for the DI order string to expand the order details screen● Click on the Frequency field and change the input from “Routine” to “Urgent,” the location from “Imaging” to “Determine by patient” and change the service date to the next two dates by clicking on the calendar● Click on the “Relevant Clinical Information” required field and enter/type in “abdominal pain”● Click on the No button answer to indicate that the patient is not pregnant● Click on the field history of falls and select the option, “fell in the last 31-90 days”● Select the Problem field, it will open the Problems and History List overlay, select a diagnosis to add to the order by check a box “Add to Order” then click Save.	



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<ul style="list-style-type: none"> • Click the sign button to enter the four-digit PIN number to register the order • Click the “Sign button once the number is entered 	
<p>Home Medications</p> <ul style="list-style-type: none"> • To review and add additional home medications • Click on the Home Medication widget on the reference region • Click on the New button, select the search field • Enter home medication of Bisoprolol 10 mg Daily. Select Bispropyl Furmarate. Last taken at 0800 today and reported by patient • Enter home medication of Tylenol 500 mg Q4h prn for occasional pain • Use the + sign to open the string of the desired medication • Select the most appropriate dose based on what the patient reports • If the route and dose are not exactly what the patient uses this may be modified in the next screen • Modify the medication for route, frequency etc. as the patient reports, then Save 	
Case Scenarios	
Web Acute Visit Scenarios:	



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<p>Adult</p> <p>History of Present Illness</p> <p>HK is an 83 yo woman complaining of pruritic “hives” (small red bumps) one day ago on trunk and thighs accompanied by nausea and light-headedness. Her left eyelid also became swollen. Symptoms occurred at rest and lasted two hours.</p> <p>Unfortunately, we had no camera in the office during her initial. The swelling of her eyelid lasted a bit longer than the bumps on her trunk and thighs. Her light-headedness represented presyncope.</p> <p>She had many similar episodes in the past six months. During one episode, she had syncope and was hospitalized. She was diagnosed with orthostatic hypotension.</p> <p>Past Medical History</p> <p>Osteoarthritis: hip arthroplasty 10/04 Osteoporosis Labyrinthitis Colon cancer stage II: 2000</p>	

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<p>Her fluoxetine was begun recently, thinking that her recurrent presyncope could be caused by depression.</p> <p>ROS: nausea/emesis and dizziness with pruritic rash, some memory impairment, no fevers, no headache, no palpitations, no chest pain or dyspnea</p> <p><i>Social History</i></p> <p>Her family believes that she has been under unusual emotional stress and believes that stress is contributing to her current presentation. She moved from her home to a life care community six months ago and has been anxious and unhappy. She moved to Ontario one week ago.</p> <p><i>Physical Examination</i></p> <p><u>BP</u>: 150/68 (not orthostatic)</p> <p><u>Cardiac</u>: regular rate in 80s, normal exam</p> <p><u>Skin</u>: patch of erythema on back and trunk beneath bra strap, erythema over beltline, red papules on lower anterior chest, ecchymoses on shoulders and legs. The rash seen on exam is different than the transient rash that she had one day ago.</p> <p><i>Laboratory Findings</i></p> <ul style="list-style-type: none"> • normal chemistries and blood counts • Positive ANA, 1:160 (may be unrelated to her main diagnosis) 	



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<ul style="list-style-type: none"> • ESR normal <p>Adult Scenario Instructions:</p> <ul style="list-style-type: none"> • Enter the patient’s problem on the problem list • Enter a Note in a document using DMO • Document findings in a document template like General Adult • Add Document Section Enter vital signs 	
<p>Admission to from ED to ICU (Manage Transfer)</p> <p>Jesse Higgins is a 40-year-old man/ woman who presented to ED with 2 days of cough, fever, and breathlessness. They returned from a business trip to China 1 week ago. They have no previous medical problems. Patient to be admitted to ICU.</p> <p>Requires CXR to investigate ARDS. In ED Patient had transmission-based precautions applied that need to carry forward to ICU, antibiotics given empirically for CAP (ceftriaxone 1g IV daily and azithromycin 500mg IV daily), and oxygen applied. Prior to transfer to ICU the patient can speak sentences, has ongoing dyspnoea, and the following vitals: T38.5 P110 R30 BP 110/70 SpO2 94% on high flow oxygen. Plan is for insertion of an arterial line and ongoing monitoring in ICU.</p> <p>ED Admission to ICU Scenario Instructions:</p> <ul style="list-style-type: none"> • Initiate Manage Transfer (done by ICU provider) 	



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<ul style="list-style-type: none">• Enter home medication for Metformin 500mg PO daily and Ramipril 1.25 mg PO BID• Enter medication within Transfer Routine – ceftriaxone• Enter Problems into the History and Problems from the reference region• Enter ICU Order set<ul style="list-style-type: none">○ Diet as per protocol○ order for Oxygen to be given immediately after transfer○ Chest xray• Document provider note	
<p>Web Acute Transfer to Rehab (Manage Transfer)</p> <p>69 y.o. male with R TTA due to necrotizing fasciitis. To be admitted to Rehab unit post-surgery. Associated medical conditions included DM type 2 and history of stroke with resulting R hemiplegia and some cognitive impairment. He previously worked as an accountant, but stopped working due to his stroke. He lives with his spouse who still works 5 days/week, and an adult daughter who is attending school. Previously he was ambulating independently without an assistive device, independent for all his ADL's, but was mostly housebound.</p> <p>No complaints of pain or phantom pain (0/10). His goal was to ambulate independently with a prosthetic and return home.</p>	



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<p>ROM: R hip extension to neutral only. Hip abd 200 o/w WNL (within normal limits) Strength: R hip ext 2+/5, hip abd 2-/5, knee ext 4/5 Increased tone of R hip add/IR and knee ext</p> <p>Well healed incision along anterior aspect of distal stump. No areas of skin break down on stump or contralateral limb. No edema. Static sitting balance was good, but decreased ability to move outside BOS to the Right. Berg = 4/56</p> <p>ED Admission to Rehab Instructions:</p> <ul style="list-style-type: none">• Enter home medication for Abilify 2mg PO daily schedule and Ramipril 1.25 mg PO and metformin 500mg po daily• Initiate a Manage Transfer process to Admit the patient to rehab<ul style="list-style-type: none">○ Enter medication order within the manage transfer routine for fluoxetine 10 mg PO daily○ Enter allergy to carrots• Document patient problems• Enter order for referral to physiotherapy• Document provider note and Inter Transfer Document	
Web Acute Discharge Scenario	



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<p>A woman presented with cough, fever, sputum and abnormal vital signs. Past medical history included diabetes mellitus, hypertension, surgery for hiatus hernia, ex-smoker (used to smoke 20 cigarettes per day) and an allergy to co-trimoxazole. She is independent and likes baking cakes, has got several rescued cats and likes horse riding. Current medication include doxazosin 2 mg PO once per day (od), and ramipril, 10 mg od. The patient was worried to get back home and feed her cats. The patient had low oxygen saturations. A value was agreed, above which a transfer home would be usually safe.</p>	
<p>Web Acute Admission Scenario (For Champion Training)</p> <p>Chief Complaint: You are asked to see a 58 year old white female who has been admitted to the hospital, twice a month, for the past 3 months. The patient has a complicated medical history. It is a Friday and you are asked to see the patient in 48 hours.</p> <p>History of the Present Illness: 58 year old white female with a long history of Multiple Sclerosis, recurrently admitted to the hospital with various types of infections. Most recent admission was for Urinary sepsis, secondary to MRSA (Methicilin Resistant Staph Aureus). The Patient requires the insertion of a PICC line to receive IV Vancomycin</p> <p>Previous Medical History:</p> <ul style="list-style-type: none">➤ Allergies: dust	



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<ul style="list-style-type: none">• ➤ Medications:<ul style="list-style-type: none">• Vancomycin, IV (1000 mg), IV, bid, for 10 days• Metformin (1000 mg); 1 tab, po bid• HCTZ (50 mg); 1 tab po qd• ➤ Illnesses:<ul style="list-style-type: none">• Multiple Sclerosis (20 year history)• Diabetes Mellitus (10 year history)• Hypertension• ➤ Surgical Procedures: none• ➤ Smoke: none• ➤ Alcohol: none• ➤ Hospitalization: multiple (Urosepsis Pneumonia; Cellulitis) <p>Family Medical History:</p> <ul style="list-style-type: none">• ➤ Hypertension – (paternal)• ➤ Diabetes (maternal) <p>Social History: patient lives at home with her two daughters. She is wheel chair confined and cannot work.</p> <p>Review of Systems:</p> <ul style="list-style-type: none">• ➤ Constitutional: No complaints of fever, chills, sweats, appetite is “fair”• ➤ CV: No c/o chest paint, SOB, dizziness	

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<ul style="list-style-type: none"> • ➤ Respiratory: No c/o cough, yellow mucus, wheezing, “gurgling in the chest” • ➤ GI: No N/V; no change in BM’s (no constipation) • ➤ GU: No c/o hematuria burning with urination; vaginal bleeding or spotting • ➤ Skin: No areas of skin breakdown noted • ➤ Neurological: Notes peripheral muscle weakness; notes paresthesias at UEs and LEs; cannot walk (uses wheel chair) <p>Physical Exam:</p> <ul style="list-style-type: none"> • ➤ VS:p=90(reg) RR=20 T=97.6F • ➤ BP: 150/100 O₂ % = 94% (RA) • ➤ Wt = 190lbs • ➤ General Assessment: A/O (x3) patient who looks older than stated age; in a wheel chair • ➤ HEENT: glasses in place; poor dentition • ➤ Chest: poor inspiratory effort, no rales, no rhonchi, no wheezing • ➤ CV: reg rhythm without murmur or gallop • ➤ ABD: soft; nontender, no organomegally • ➤ GU: No foley catheter • ➤ UE’s/LE’s: PICC line in place left antecubital area (no redness) • ➤ Skin: No areas of skin breakdown • ➤ Neurological: <ul style="list-style-type: none"> • Cranial nerves: nystagmus present • Cognition: A/O (x3) 	



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<ul style="list-style-type: none">• Muscle tone: generalized muscle wasting• Gait/coordination: balance is an issue; wheelchair confined• ➤ Psychiatric: flat affect; “tearing” over concerns of “being a burden” to her daughters <p>Web Acute Data Entry Instructions:</p> <ul style="list-style-type: none">• Enter Allergies• Enter Patient Problems• Document Chief Complaint and History of Present Illness• Enter Family History• Enter an order for Psychiatry consult	