



Web ED Activity Guide

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 Tracker Activity</p> <ul style="list-style-type: none"> • Locate your test patient on the tracker 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? ○ What do the numbers in a block of color represent? • Sort the tracker <ul style="list-style-type: none"> ○ Click on the caret (small triangle on the ED All tracker tab) ○ Click Sort Tracker on the menu ○ On the ED All Sort Options screen select the first field <ul style="list-style-type: none"> ▪ Select “Chief complaint ▪ For “Then by” ED Area ▪ For “Then by” Name ○ Click the “Apply” button 	<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"/> Special Indicator/s _____ <input type="checkbox"/> What does the number in colour represent? _____ <input type="checkbox"/> Location of patient _____ <input type="checkbox"/> Number of patients on the ED ALL TRACKER _____ <input type="checkbox"/> _____
<p>Activity 2. Find a patient, open the chart, and return to the Tracker</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: EDM, Four • On the Account Search by Patient Name select the account status REG ER status • On the “Warning” overlay, select the “Open Chart” button 	



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<ul style="list-style-type: none">• Click the Home Button or the Trackers button on the Navigation Bar to return to the Trackers	
<p>Activity 3. Sign Up for a patient and Undo Sign up</p> <ul style="list-style-type: none">• Click on the Sign up button (red text on the button says Sign Up)• Select the “Sign Up” option• To Undo the Sign Up, select the Sign Up button again and click on “Undo Sign Up.	
<p>Activity 4. New Priority Call Back</p> <ul style="list-style-type: none">• Select the “Priority Call Back” button• On the Call Back Overlay select the “Call Backs” button to open the drop-down menu• From the menu select “New Call”<ul style="list-style-type: none">○ Enter the actual date, the reason for a call○ For the Action select the option Enter “No Answer will Call Back”○ Select a priority for the call○ Enter a reschedule date and time○ Enter your test patient’s name, it will○ Select the recipient field and enter “Partner”○ Input a number 555-5555	



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<ul style="list-style-type: none">○ Click the save button○ Enter the ED Call back Note Document by selecting the document icon and enter a free text note. Click the sign button and then enter your four-digit PIN	
<p>Activity 5. Sign a Patient Out</p> <ul style="list-style-type: none">● Click on the Sign up button and then select Queue for Sign Out● You may receive a notification that no documentation has started for this patient, "would you like to start a new one now?"● Click on the sign outs tab to see your patient there● Select your patient and then enter the Sign Out Comment<ul style="list-style-type: none">○ Document "Monitor patient vitals"● Select the "Save" button● Review the patients that are signed out that are ready to be accepted for sign out● To remove the patient from the Sign-out list, select the white x in the red box● Find the patient on the tracker again	



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<p>Activity 6: 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	<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"> ○ Click on the Current Infusion/Titration button (display view button) ○ 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 7: 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 	



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<ul style="list-style-type: none">○ 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○ Click the Save button	
<p>Activity 8: 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”	



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<ul style="list-style-type: none">○ 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 he problem history additional fields○ Find the Category label and click on the caret beside Medical○ From the Drop down menu select “Surgical”○ Hx of biopsy should now be located under the Surgical History section○ Select the “Save” button <ul style="list-style-type: none">▪ Inactivate a Problem<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/>



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<p>Activity 9: 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<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.	



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<ul style="list-style-type: none">○ 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 10: 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”▪ 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	



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<ul style="list-style-type: none">▪ 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▪ 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”	



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<ul style="list-style-type: none"> ▪ 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 • 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 	



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<ul style="list-style-type: none">• Click the “Sign button after the PIN number is entered <p>Enter an ED 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○ 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.	



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<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.• Click the sign button to enter the four-digit PIN number to register the order• Click the “Sign button once the number is entered	



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<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	
<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).	



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<ul style="list-style-type: none">○ 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. <ul style="list-style-type: none">● 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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Case Scenarios	
<p>ED Visit Scenarios:</p> <p><u>Paeds</u></p> <p>A 5-month-old male patient was transported from home by his parents to the emergency department (ED). The patient has had an upper respiratory infection for over the past 24 hours with a moist cough and runny nose. Within the past few hours, the patient has become febrile, listless, and has audible rhonchi.</p> <p>The parents and the patient are immediately escorted to an exam room upon arrival at the hospital. The baby has slight circumoral cyanosis flaring nostrils and chest retractions. Upon arrival, the baby's vital signs are BP 74/palp, pulse 110, respirations 34 and shallow, and temperature 39.5 degree Celsius. The baby becomes unresponsive as providers are administering care to him.</p> <p>Paeds Scenario Instructions:</p> <ul style="list-style-type: none">• Sign-up for a patient on the tracker• Enter a document about the patient• eEnter the patient's problem on the problem list	



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<ul style="list-style-type: none">• Enter a Note in a document using DMO• Enter vital signs• Enter an ED order set for Paeds <p>Adult</p> <p>Patient is treated in the emergency department for diabetic ketoacidosis. Patient is diagnosed with Type 1 insulin-dependent diabetes. Diabetic ketoacidosis is a potentially life-threatening emergency. Patient is stabilized and discharged to home. According to the treating physician's documentation, the patient is expected to return to a diabetic ketoacidosis state within 24-48 hours without ongoing insulin therapy. Through the care plan process, patient may be determined eligible for coverage for insulin treatment and blood glucose monitoring, as well as physician visits directly related to diabetes and insulin management.</p> <p>Adult Scenario Instructions:</p> <ul style="list-style-type: none">• Sign-up for a patient on the tracker• Enter a document about the patient• Enter the patient's problem on the problem list• Enter a Note in a document using DMO	



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<ul style="list-style-type: none">• Enter vital signs• Enter an ED order set for diabetes/keto	
<p>ED Admission to unit Scenario (Manage Transfer)</p> <p>Patient presents to the emergency department with shortness of breath and angina due to pulmonary arterial hypertension. Patient has been unresponsive to standard calcium channel blocker therapy. Patient is stabilized in the hospital and will be transferred to the Medicine unit on a continuous infusion and the new visit medication Norvasc.</p> <p>ED Admission to unit Scenario Instructions:</p> <ul style="list-style-type: none">• Enter home medication for Tylenol 325mg PO and Ramipril 1.25 mg PO• Initiate a Manage Transfer process to Admit the patient to the Medicine floor<ul style="list-style-type: none">○ Enter medication order within the transfer for Norvasc○ Enter• Document patient problems• Document provider note	



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<p>ED Admission to Mental Health (Manage Transfer)</p> <p>Patient presents to the emergency department with suicidal gestures and attempts. Patient has been unresponsive to mobile crisis stabilization services. Patient is admitted for inpatient psychiatric care for stabilization and treatment services, including the use of fluoxetine. Patient was diagnosed with major depression. As documented by the emergency department physician, the patient is at risk of serious harm to self unless admitted for psychiatric care. The patient is stabilized in the inpatient environment on fluoxetine. The psychiatrist's documentation indicates that without ordered outpatient therapy and continued use of fluoxetine, the patient will likely need re-hospitalization within 24-48 hours. Through the care plan process, the patient's will go to see an outpatient clinic for treatment and receive an order for fluoxetine prescription.</p> <p>ED Admission to Mental Health Instructions:</p> <ul style="list-style-type: none">• Enter home medication for Abilify 2mg PO daily schedule and Ramipril 1.25 mg PO• Initiate a Manage Transfer process to Admit the patient to the Mental Health<ul style="list-style-type: none">○ Enter medication order within the manage transfer routine for fluoxetine 10 mg PO daily○ Enter allergy to carrots	



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<ul style="list-style-type: none"> • Document patient problems • Enter order for referral to Mental Health Outpatient • Document provider note and Inter Transfer Document 	
<p>ED Discharge Scenario</p> <p>Patient presents to the emergency department with complaints of chest pain. After workup in the emergency department, it is determined that the chest pain was a result of indigestion and heartburn and was not cardiac. Patient is treated in the emergency department with an antacid and symptoms are resolved. Patient is discharged to home with information about dietary interventions to reduce the risk of heartburn and prescriptions for ranitidine and Tums® tablets.</p> <ul style="list-style-type: none"> • enter patient problem on chest pain, • Update problem list with indigestion and heartburn • Complete Discharge ED report • Complete ED Discharge Plan <ul style="list-style-type: none"> ○ Reconcile problem list and medications ○ Enter a prescription for ranitidine and tums 	
<p>ED Admission Scenario (For Champion Training)</p> <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.</p>	



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<p>Current medication include Indapimide 2.5 mg 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>ED Discharge Scenario (For Champion Training)</p> <p>Patient presents to the emergency department with multiple worsening symptoms including fatigue, jaundice, weight loss, nausea, confusion, edema of the extremities and difficulty sleeping. The patient has a diagnosis of end stage renal disease and is admitted to the hospital. The patient's condition is stabilized and the patient is discharged to home. The attending physician has documented the need for outpatient hemodialysis three times per week to prevent placing the patient's health in serious jeopardy due to renal failure, which would likely occur within 48-72 hours. Through the care plan process, patient may be eligible to receive coverage for the outpatient dialysis treatment.</p>	