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| **COURSE NAME & DURATION:** | | **Cerner ED Doctors Lesson Plan** |
| **COURSE AIMS & OBJECTIVES:**  **WSL: Helen Turner** | | **By the end of this training, trainees will be able to:**   * Log on * Be able to navigate around Firstnet LaunchPoint and the Emergency Department Tracking Shell * Check in and Check Out Patients to themselves whilst on shift * Be able to navigate around Powerchart and update the Patient Record * Prescribe and Administer Medication * Understanding and creating care plans * Make Referrals to Teams across the Trust * Understanding and Action Discern Notifications * View Results for Patients * Create and Update ED / UTC Forms with Information about the Care Patients are Receiving * Create and Update the ED Clinical Note Component * Be able to do the Decision to Admit (DTA) Process * Discharge the Patient from ED * Use the Quick Visit Tool to Assess and Treat a Patient * Access and Use the Results Call Back Feature * Exit/Log Off |
| **COURSE TIMINGS:** | | Full day |
| **TRAINING ENVIRONMENT:**  Classroom or 1 to 1 environment, either face-to-face or remotely via Teams/Hurdle/Dameware  Training will be user led and directed by the Trainer.  Equipment needed, dependant on situation: laptop/PC/projector/headset  **SET-UP REQUIRED/INFORMATION NEEDED FROM SYSTEM SUPPORT:**  User account(s) created.  User account(s) details.  Level of access/user profile.  PDP information for test patients | | |
| **INTRODUCTION:**   * Welcome the participants to the session, facilitate introductions * Follow the PowerPoint presentation to introduce the agenda. * Training room: mobiles off or silent/health and safety (fire alarm, fire exit procedure) * Awareness of Data Protection & Information Governance - logout when left unattended, not viewing own records, not sharing account details, auditable system * Training session objectives and timings * **Explanation of some common Cerner Millennium terminology,** e.g. MPages; components; ‘treatment service’ = specialty (e.g. dermatology); ‘facility’ = location; ‘conversation’ = function (e.g. book/cancel an appt.; print a letter);’ encounter’ = care episode; I-View = ‘assessments and fluid balance’ * New patients registered in Cerner from go live will be issued a Medical Records Number (MRN); existing patients will keep their RXR number * More than one user can access a patient’s EPR at same time and modify it * Training materials availability: Quick Reference Guides (QRGs) on OLI; QRG videos on YouTube | | |
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| **Timing** | **Main Topics and Functions Covered** | During this lesson we will work through two different scenarios taking you on different patient journeys that will allow you to experience Cerner Millennium’s full potential for your job role |
|  | **Scenario 1** | A female with a UTI, temperature, and moderate pain with a DTA |
|  | **Logging On**  **Overview of LaunchPoint and Emergency Department Tracking Shell** | * Launch Cerner and double-click **FirstNet icon** * Overview of **ED LaunchPoint**   + Toolbar across top – explain taskbar and other headings first     - **Task** – change password, change user etc     - **Patient** – search and view recent   + **ED LaunchPoint** on second row – this is the home button.   + Explain **ED Realtime dashboard** length of stay, Turn around times, ED Volume, Notices   + Show useful internet links eg **OLI.**   + On third row explain links including **Change, Exit, PM Conversation**.   + Demo how to customise toolbar buttons by clicking on small downward arrow on the right, add/remove buttons and customise. Then buttons can be moved as required   + On the row with the blue man/plus sign show different tab headings. Users can mainly use the **All Patients** tab but can be filtered into different locations using the tabs. Explain resus, majors, minors etc.   + Underneath this the next row contains filter buttons you can turn on/off, waiting room, empty beds, critical and no disposal   + Explain **My Patient** – used by doctors/nurses   + **Department** – used by doctors/nurses   + From **Burger Icon** show **Change Location** and **SDEC** view * Above department is search box to search the Tracking Board – demo a patient search use re-attender test patient * View icons across the patient bar * **Room** column to see current location of patient, * In the **Acuity Level** column: Shows the triage score and colour reflects level chosen in the triage form. * The following items appear in the **Patient Information** column:   + Patient Name, date of birth, age and MRN number   + Allergies and resus indicator is present. * **Length of stay** * **SD DR NP RN STU**, Shows which clinicians are assigned to each patient **(may vary due to location)** * **Patient details** – reason for visit and comment bubble to add further information, * If a heart appears in the Observations column. This means that Vital Signs are available. Red heart = critical, Grey heart = normal If either colour heart has a red outline then vital signs need to be re-assessed. * **Meds - Pill icon** – to show what drugs have been prescribed. Quick link into prescribing for the patient * **Labs -Test tube** icon - will show how you can request tests and also collect samples * **ECG - ECG wave** – this indicates any ECG tests/results that have and can been carried out * **Imaging - Radiology icon** – will show any xrays/results that been carried out and quick link to order * **Consult - Phone icon** – this will show if there has been a Dr/consult review requested for the patient and can be reordered from here * Explain the patient summary view by clicking on the white space beside the patient’s name. It will give a summary of any notes / details that have been added.   Click On Emergency Department Button and give a brief overview of **Emergency Department Tracking Shell**  Briefly explain the following:   * **RBH ED All Patients** – Shows all live patients * **Patient Search** - Start typing to filter Patient by name * **WR** – waiting room numbers * **Total** – Total Numbers * **Avg LOS** – Length of stay * **Median LOS** – Length of stay * **Filter** – select drop down to filter as required   List tool bar   * **Pre Arrival Form** * **Pre Arrival Actions** * **ED Quick Patient Registration** * **ED Full Patient Registration** * **Downtime ED Full Patient Registration** * **ED Booked ED Full Patient Registration** * **Set Events** – view encounter history * **Patient Summary Report** – detailed list of encounter events, give overview of report * **Discern Reports** – ED reports – Historic reports * **ED Police Handover**   Need to Point out the following Tabs   * **RBH ED Checkout** * **RBH ED Breaches** * **ED Discharge last 36hr** * **Ed in Transit** * **RBH ED incomplete documentation -** Use filter **My Patients Doc** to see your own workload * **RBH ED majors, Minors** * **RBH NHS 111** * **RBH Pre arrival** * **RBH ED providers** * **RBH ED Recently Transferred** * Talk through the icons across the patient bar * **Note** * **Sepsis** * **Room/Bed** column to see current location of patient, Double click here to move if required * **P Acuity Level**, Triage score and colour reflects level chosen in the triage form. * **Name** (name age and gender) MRN no, resus status and allergy, * **Age** * **A** Hover over icons to see Allergy status * **Reason for Visit** * **EWS** Hover to see score info * **To Do List -** Hover on Icons Info will display Time, Event, Status, Duration and User Information * **Activities** Hover on Icons Info will display Name and Details * **Complete -** Hover on Icons Info will display Time, Event, Status, Duration and User Information * **Decisions-** Hover on Icons Info will display Time, Event, Status, Duration and User Information * **Specialty-** Hover on Icons Info will display Name, Time, result and user * **Bed Reservation – bed request Status** * **ETA/LOS** - Length of Stay * **DR, ENP, RN, STU, MEDS, PRN** - Clinical Staff Assignments |
|  | **Check in/check out** | **From ED Majors Using Patient 1**   * Check in and check out is used to assign yourself to patients in the department * From the right click hamburger icon drop down arrow and select check in * Check in as follows: Display name - **User Initials**, Provider Role – **Doctor** input Default Relation – **Clinical Practitioner** and Associated Provider colour as directed by Helen Turner * Click **OK** * Demo how to check out by clicking on the drop down arrow again. * Find patient in all patients and under **DR** column header click and assign yourself as DR * Find patient in all patients and under **DR** column header click **Show Assign /unassign Others** * To be assigned to patients they must first check in as an available clinical staff member. * Alongside this show users how to unassign themselves from their patients   **User Practical to check in** |
|  | **Update Doctor Activities** | * Show that nurse and doctor Activities have been started on the patient which was registered by the admin staff. * Any activities that need completing by the doctor can be done so by clicking on the icon  and selecting the relevant activity. * Highlight **Complete Not Clinically Ready** and select **Complete** * Activity is now actioned |
|  | **Overview of Powerchart** | * Go back into Launch Point * Click on patient’s name to enter Powerchart ED View * If the accessible info alert pops up at this point you can click **Access Info** and complete information as required. Click **Green Tick** in the top left to save and close * Explain the patient banner – Patient name, allergy isolation status, Safeguarding Flag/Alerts (A window will also appear when you open up the patient record), age, DOB, Resus status, NHS number, MRN number, Sex, location, department and Consultant details * Show **menu** collapse to the left – This menu shows all aspects of the patients notes, but it is better to use a Mpage as it is more user specific * Show users the Components View tabs and related MPages, use the plus sign to show how to add more MPages * Explain MPages in workflow order, going through each component * Highlight the Body Maps, mainly used for minor injuries (currently not available but should be come go live) * Mention Triage Review, review of data that has been recorded by the ED triage nurse and update as required * Explain config. (drag/drop of components to preferred location / either demo or arrange components prior to lesson)   Go through the following components:   * **Safeguarding (CP-IS/FGM-IS)** – View any safeguarding concerns here * **History of presenting complaint or issue** * Demo use of **Contextual view** to scroll through documents whist writing clinical note (some screen sizes will not display so may need to adjust size to 75%) * **Allergies and Adverse Reactions –** view what has been documented by nursing staff – show how to add an allergy – search for **codine** and select severity - **Moderate** Category **Drug** Reaction **Rash** * **Save** * **Clinical narrative** use this and keep adding to it * **Show Auto** **Text** is used to insert a template or a frequently used term for ease of documenting clinical notes * From the text editor toolbar, click * Click * Enter an abbreviation for the text in the **Abbreviation** box. .a * Enter a description in the **Description** box. Add a test description to the box * Click in the Text Entry pane. * Enter the required text. * Click **Save**. * Click  The Auto Text phrase is now available each time the abbreviation is typed in a note. * In the appropriate Note, or box in a workflow, enter the auto text abbreviation where you want the auto text phrase to be displayedby typing .a Available auto text abbreviations are displayed as you type. * Select the auto text abbreviation from the displayed list, and press **ENTER**. The auto text phrase is displayed in the note. * **Histories** get users to add a procedure and social history – Click on Heading Procedure -Add **Tonsillectomy** Social Add **Tobacco** and complete details * **Review of systems** free text * **Examination findings** free tect * **Diagnosis and Problems** - add a problem Add as – **This visit** – Search – **UTI** Double click on problem then **OK** Add a further problem – **Chronic - Asthma** * **Clinical Images -** view images if required * **Plan and requested action** (anything placed in Quick Order will appear here) * **Information and advice given** – Give advice to drink plenty of fluids * **ED/UTC Hospital Attendances** – shows previous visits   **User Practical to add a Problem** |
|  | **Prescribing and Administering Medications** | * From **LaunchPoint** select the Tablet icon, click **Open Patient Record** Powerchart opens, navigate to **Quick Orders** m-page * Overview of Quick Orders View - Show **ED Common Radiology Requests**   Search for a prescription in **Requests/Care Plans** – Cefalexin 500mg three times a day explain allergy alert and select override reason  Select **Pain Care Plan**  Click on **Green Order Basket**   * **Modify Details** * **Initiate Now** Care plan * **Orders for Signature** * Fill in all remaining missing fields. For **Cefalaxin** Fill in mandatory fields Anti-Infective Indications – **Genital Tract – Lower UTI** Give Additional Dose Now – **YES** Duration – **3** Duration Unit - **Day** * Close Patient record and Demo that their actions create task for the nurses and show how they are displayed on LaunchPoint. * Click **Medication Administration** icon in top bar and scan patient’s wrist band to positively ID them. * Select medicines to be administered from list * Scan medicine container to match prescription, show override if no bar codes * Click into Results field and click on small arrow to open Charting Form. Complete fields in charting form as required. Also show Not Given and select reason (add ‘comment’ if selected reason does not provide enough information in itself) * Witnessed by – Search for **Surname Training** Forename **EDDoctor** * OK to complete * Witnessing meds – second checker will require the other clinician to sign (use an insulin or IV medicine to trigger a second signatory) this will also the triggered on Controlled drugs. * Close Patient record and Demo that their actions create task for the nurses and show how they are displayed on LaunchPoint.   **User Practical to Prescribe and Administer using Patient 1 – Data Sheet** |
|  | **Care Plans**  **Bundles** | Give an overview of Care Plans: these are groups of orders such as assessments, diagnostics, medications, referrals, and other items, and are structured to guide and measure progress toward a goal related to a problem or condition. Plans can also be designed to support a procedure or process. The components of a Care Plan will vary depending on its design and type of plan used.  Care Plans can go through several phases. Typically, a plan or phase will move from Planned →Initiated → Discontinued or Planned → Initiated → Completed.   * From **New Order Entry** component search for **Gentamicin Care Plan (Adult/Paed) and Select** * Click on Orders for Signature and sign * Tick or untick recommendations as required * Click **Initiate Now** * Click **Orders for signatures** * Orders will display * Complete mandatory fields as required * **Sign** * Order will now be displayed in Order profile and relevant tasks will be initiated |
|  | **Referrals** | * From LaunchPoint, right click on the patient and select ED Referrals form to open the ED referral form. * Explain you can refer to multiple teams from here. * For this example, we are going to select the Acute Care Team * Tick box **Acute Care Team** * Select **Medical** Speciality * And Add Reason Free text and bleep number * Click green tick to save and submit * This will alert the relevant teams   Show telephone Icon  **User practical to add a referral** |
|  | **Message Centre** | * Click on the Message centre button in the toolbar * Message Centre Tabs: * **Inbox Tab**: The Inbox tab is built to be used by many disciplines. You will use this tab to send and receive messages or to sign or review documents from students and other clinicians. Those clinicians who use Dynamic Documentation will be able to see their saved documents under the Inbox tab. * **Proxies Tab**: You will likely not use this tab unless you receive a great deal of documents and/or messages and want someone to manage your Inbox while you’re away. If you wish you can choose to put an Out of Office Message on your Message Centre while you’re away. * **Pools Tab**: A pool is an identifiable group of people who share a common Inbox. You can add yourself to a pool from the Pools tab. You can also access the shared Inbox from the same tab. If a referral is done to a Specialty nurse team or specialty consultation via New order entry. The user will reply via message centre straight into the shared inbox with accepted or rejected. If you are the accepting or rejecting on behalf of the specialty consultant team (Pool), you can also reply via the shared inbox to accept or reject the referral. You will then need to select the request/care plans in the blue menu, find the request, right click and mark as completed. * **Sending a Message from Message Centre:** * Click on the word Messages in the Inbox. Click the Communicate button to the right. * A New Message window appears.   Note: You can use the binoculars after the Patient field to fill in the Patient. You will need to choose the correct patient and encounter. The easiest way to fill in this field is to ‘**Send a Message While in the Patient’s Chart.’** Enter **Patient 1s MRN**   * In the To field enter the last name of the clinician to whom you wish to send a message. Use Training AHP * Press **Enter** (or the binocular button at the end of the field). * The **Address** **Book** opens and shows potential matches. Double click on the correct match. * The correct match moves to the Send to window on the right. Press **OK**. * The name will appear in the **To** field. Other fields on the upper half of the screen include: CC field: Use if you want to cc others on the email. * Include Me checkbox: Use if you want to send the message to yourself as well. * Subject field: Either enter your own subject or use one of the templates in the drop down arrow. * At the bottom of the screen you should also note the following the Actions section which you can use if you wish and the Remind section which you can use if you want to remind yourself or others when an item needs to be completed. * Click Send to send the message. |
|  | **Discern Notice** | * View alerts and discuss patient care plans as appropriate – explain the importance of the discern and how it is audited, they should be acting on the advice given |
|  | **ED / UTC forms component** | * Departmental forms are available from here * Demo **Resus Status Change** - **Immediate Change Necessary** and **CPR Attempts NOT Recommended** * Green Tick to save and close * Resus Status is now updated in Patient Banner * Any forms saved will NOT be available for other users to view until they are signed. These will then be available for all users to see in the Documents component. Users will go to Menu, Form Browser to sign forms in progress |
|  | **ED Clinical Note** | This is known as a ‘dynamic document’, where other completed forms are published into a dynamic doc. The dynamic document pulls through data from the Components completed and some information that may have been documented in other forms. The doctor **must** complete and sign an **ED Clinical Note** for each patient.  Review the above note, amend as required, once you have completed all the relevant components in ED View, scroll to the bottom of the component menu and select the blue link to **ED Clinical Note**. This will pull all your information into a final document. Explain how the document can still be added to at this stage, and some headings can be removed if needed. Empty headings with no data will automatically be removed upon signing.   * Click **Sign/submit** and then click **Sign** * Can be forwarded by searching in forward option and whether they want them to review or sign. Brief practical for user to send to their neighbour. * Refresh page, navigate to the **Documents** component, show how the **ED Clinical Note** is now available here * Also show and demo the **ED Handover note** * Show and Demo **AD Hoc Forms** Show Emergency Department folder |
|  | **Decision to Admit (DTA)** | * Close patient record to return to ED LaunchPoint   Demo DTA - done by Nurse   * Right click on patient - **Patient Management** - **ED Decision to Admit** – **Yes** * ED Decision to admit form complete as required   + Decision to Admit Date and Time **T** and **N**   + Source of Admission **– Usual Place of Residence**   + Lead Clinician – **Neilson, Donald** (if concerns arise around this field, then need to speak to Helen Turner)   + **OK** * It now says **Admission** under ‘Status’ * On LaunchPoint complete Clinicians tasks that have flagged up from DTA   + Complete **Incomplete Disch Form**   + Right click select **Request Event** then select **Clinically Ready**   + Need to show patient is clinically ready for transfer-makes purple icon appear near resus/allergy icons, this helps with 4 hr breach time, also nurse co-ordinators responsibility * Follow the discharge process below accordingly to transfer needs   **Explain that the ED nurse in charge will right-click required patient from list, scroll down to Patient Administration, click ED Decision to Admit. Doctors and nurses in charge will need to the know process.** |
|  | **Discharge patient** | * Click patient from LaunchPoint to enter Powerchart * Select **ED Discharge Workflow** tab * Working from the components list, complete the red asterisk mandatory forms (NB – the ED Treatment form and ED Discharge form were previously recorded as ECDS)   + ED Discharge Information Form – Click the dropdown arrow, Discharge Status -**Treatment Complete,** Discharge destination **– Ward Physical ward outside ED,** Discharge Follow Up – **GP,** Will patient be provided with Discharge letter – **Not Provided** Add breach reason * Click **green** **tick** to complete and close * Discharge Medications – Click on **Discharge (Cross Encounter Transfer)** and select **green** **arrow** – continue after discharge – complete mandatory fields then **Sign** * Person completing record – click drop down arrow and select PowerForm, complete as required green tick to close and sign * Access **ED Discharge Summary** to view the discharge letter * Demo the **Discharge Summary & TTO** form so all elements are covered * With both forms, **Sign/Submit** and then **Sign** again * User is returned to m-page * Select the **Patient Leaving ED to be Admitted** conversation and complete   + Select **Transfer**   + **Fill in transfer details as required** * Patient will now disappear from ED LaunchPoint   **User practical to admit patient 1 and discharge them to the ward – Data Sheet** |
|  | **Scenario 2** | Patient 2 has now come in with an elbow injury attending ED, triaged and in the waiting area |
|  | **Quick Visit** | * From LaunchPoint Select **Patient 2** * ED Clinical Information M page * Click **Quick Visit** from components * From ED/UTC Quick visits list select **Elbow Injury/Pain** * Diagnosis **Injury of tendon of elbow joint** * Examination Findings **Select auto text** * Orders **XR Elbow Lt** * Prescriptions **Clindamycin and Paracetamol** * Follow ups **Return to UTC/ED – 5 – 7 days** * **Submit** * Double click on **Term – Injury of Tendon of elbow joint** (this will populate Verifying mapping details box) * Click **OK** * Select an Order sentence for Paracetamol * **Modify details** * Order for Signature Window appears, * Complete all mandatory fields for the orders * Fill in Mandatory Fields * Clindamycin   + Duration – **1 week**   + Indication **Free Text**   + Admission Med **Yes**   + GP to continue **New Short Term** * Paracetamol   + Admission Med **Yes**   + GP to continue **New Short Term** * XR Elbow Lt   + Priority **Urgent**   + Exam to be performed as **Inpatient**   + Reason for exam free text   + Transport **Walking**   + Bleep **123**   + Isolation precautions **Standard**   + Covid status **Not Suspected**   + Interpreter Required **No**   + Confirm correct Patient **Yes** * Click **Sign** * Allergies and weight may be prompted here * Go to Examination Findings Click **Refresh** * Auto text should be filled in click on blue sentences and ask delegates to fill in from Blue * Go to Diagnosis – should be pulled through * Drug chart from Blue Menu * Order profile * Discharge Meds * All should be pulled through   **Exit ED View**   * **User practical for a quick visit – User to add own Data** |
|  | **Exit/Log Off** | **Check out** then Click **Exit** from the toolbar |