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| **COURSE NAME & DURATION:** | | | **Cerner ED HCA Lesson Plan** |
| **COURSE AIMS & OBJECTIVES:**  **CONTACTS: HELEN TURNER, CLARE ASHCROFT & GEORGINA DAVIS** | | | **By the end of this training, trainees will be able to:**   * Logging On and Overview of Launchpoint * Overview of the Tracking Board * Be able to carry out Specimen Collection * Orientate around PowerChart Update Patient Details * Access and Record Fluid Balance/Assessments * Exit/Log Off |
| **COURSE TIMINGS:** | | | **Half-day session** |
| **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** | **Scenario 1:** A patient has arrived in the Emergency Department, presenting with UTI. They were brought in by Ambulance. The ED administrator registers the patient’s attendance. The patient then waits to be triaged and assessed. | |
|  | **Logging On and overview** | * 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, Turnaround times, ED Volume, Notices     - Useful internet links, e.g., **OLI.**   + On third row explain links including **Change user, Exit, and 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 Patients stats** – used by doctors/nurses   + **Department stats** – used by doctors/nurses * Above dept stats is search box to search the Tracking Board – demo a patient search use re-attender test patient | |
|  | **Overview of the Tracking Board** | * Talk through the icons across the patient bar   + **Room** column to see current location of patient   + **Acuity Level**, Triage score and colour reflects level chosen in the triage form   + **Patient info** (name age and gender) MRN no, resus status and allergy   + **LOS -** length of stay   + **SD DR NP RN STU (may vary due to location)**   + **Patient details** – reason for visit and comment bubble,   + A heart appears in the **Observations** column. This means that Vital Signs are available. Red heart = critical, Grey heart = normal; either colour heart seen with a red outline = Vital signs need to be re-assessed.   + **Pill icon** – to show what drugs have been prescribed, maybe able to use to prescribe PGDs   + **Test tube** icon - will show how you can request tests and also collect samples   + **ECG wave** – this indicates any ECG tests/results that have been carried out   + **Radiology icon** – will show any xrays/results that been carried out   + **Phone icon** – this will show if there has been a Dr/consult review requested for the patient   + **Status** Emphasis the changes of status on the screen that indicate when a patient is to be admitted, ready for transfer and when the bed is ready on the ward * Show that nurse and doctor the activities have been started on the patient which you have just registered. * 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** * 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 | |
|  | **PowerChart**  **orientation**  **Update patient details** | * Search for Patient using MRN number in Search field to enter patient record * Explain the patient banner – Patient name, allergy isolation status, 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 * **ED Clinical Information**   + Components can be reordered by dragging and dropping to new position.   + **Triage Review** all info already documented * **Histories** –Show the four tabs procedure, family, social and implants where they can record information about the patient and as an example record that the patient is a smoker * **Vital signs** - here you will see previously recorded obs. Show tabs to see previous recordings from past 24hr etc. Click on drop down arrow and select relevant system assessment to record further obs, demo how to record current obs * Double click on blue heading to activate column   + **Respiratory Rate – 15**   + **Oxygen Saturation target - 94 to 98%**   + **SP02 – 99**   + **SP02 Location Right Hand**   + **SBP/DBP Cuff 125/75**   + **Heart Rate Monitored 120**   + **Temperature 38** * Green tick to sign off   Click house Icon to return to patient record   * **ED/UTC forms** – All ELHT assessment forms can be found within this view, click to view more available forms * **Documents –** This is where you view all documents associated with the patient. To view a document, click on the document record and **View Document** * Show page master refresh and component refresh.   **User practical to record Vital Signs – Data Sheet** | |
|  | **Fluid Balance/Assessments** | * Go to **Fluid balance** component and click on heading to access screen * All the relevant point of care assessments are within the different band headings * Select **Point of Care Test** Segment * Within **All other point of care tests,** point out all the tests that can be manually entered * Next Select Fluid Balance * Double click in the Oral box and record that they had 200ml to drink * Double click in the Output box and record 200ml Urine Voided * Show **Balance** at the very bottom of the fluid balance chart * Green tick to sign off * Show how to modify figures and delete information – highlight and right click **unchart,** reason incorrect patient * Show how to Insert new time to retrospectively record * Click on graph icon * Change column date and time as required * Right click column header to delete if selected by mistake   **User practical to record fluid balances – Data Sheet** | |
|  | **Exit/Log Off** | Click Exit from the toolbar | |