|  |  |  |  |
| --- | --- | --- | --- |
| **COURSE NAME & DURATION:** | | | **Cerner ED Nurse Lesson Plan** |
| **COURSE AIMS & OBJECTIVES:**  **CONTACTS: HELEN TURNER, CLARE ASHCROFT & GEORGINA DAVIS** | | | **By the end of this training, trainees will be able to:**   * Log on and Access Launchpoint * To be able to Check in/Check out * Overview of Launchpoint and the Tracking Board * Access the Triage and Assessment Form and fill in accordingly * Place Orders for Bloods and Urine and Collect Specimens * Have an overview of PowerChart and be able to update patient details * Understanding and creating Care Plans * Access and update Fluid Balance/Assessments * How to record Lines, Drains, Tubes * Prescribe and Administer Medications * Access and complete Handover details * Transfer a patient to a ward area * Discharge a patient * Record a Pre-Arrival * Access and fill in the ED Ambulance Handover Form * Perform a Quick Visit * Exit/Log Off |
| **COURSE TIMINGS:** | | | **Full 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 | | | |
|  |  |  | |
| **Timing** | **Main Topics and Functions Covered** | **During this lesson plan we will follow three patient journey scenarios. First, we will give you an overview of Launch point** | |
|  | **Logging On** | * 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 * Useful internet links, e.g., **OLI.**   + On third row explain links including **Change user, 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 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 * Show that nurse and doctor 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**   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** * **RBH ED majors, Minors** * **RBH NHS 11** * **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 | |
|  | **Scenario 1** | A patient has arrived in the Emergency Department, presenting with a UTI. The ED administrator has registered the patient’s attendance. The patient then needs to be triaged and assessed. | |
|  | **Check in/Assign** | * From the right, click hamburger icon drop down arrow and select check in * Check in as follows: Display name - **User Initials**, Provider Role – **Registered Nurse** input Default Relation – **Nurse Access Role** and Associated Provider colour as directed by Helen Turner * Click **OK** * You can also change your location from the hamburger icon * Demo how to check out by clicking on the drop-down arrow again. * Find patient 1 in WR and under **RN** column header click and assign yourself as RN   User Practical to Check in and Assign themselves to Test patient | |
|  | **Triage and Assessment** | * Go back into launchPoint * Right-click on patient name to select **ED Called to triage form** if necessary, this will show and record that the patient has been called to triage, they will be given three attempts before being discharged. * Click on Nurses activities box and select **RBH Adult Triage and Assessment Form** then full overview of the power form   + Reason for visit has pulled through from registration **Urinary Problems**   + Consultant review may have criteria text to help with **NO**   + **The Manchester Triage System (MTS)** enables nurses to assign a clinical priority to patients, based on presenting signs and symptoms, without making any assumption about the underlying diagnosis   + Match reason for visit - **Urinary Problems** and update score to **Moderate Pain**, to amend go to the left and re-enter form to update. Back to the top to get to main page. **Show triage score**   + Presenting complaint – **Genitourinary** and relevant problems – **Pain on passing urine**   + Complete nursing notes **Write in some free text** – these will pull into the patient record   + Click on observations and complete **Yes** – complete vital signs with delegate participation   + Complete Pain Present Assessment **Yes** - Numeric – **7** – subjective – **moderate** Objective - **moderate**   + Allergies **Yes** – Add search and document – Show **Pollen** – **sneeze - mild - flora fauna**. **Penicillin** - **rash – severe - drugs**. These will stay on record forever until removed. **OK** Enter weight **75kg** and height **172cm**, point out to fill in either measured or estimated weight and height as appropriate   + Falls, - **Yes,** answer no to all in falls form   + Mental health, - Overview of form   + Safeguarding, - At risk General – free text patient is….   + Mandatory fields fill the rest in as **no/unaccompanied** * Show black ticks down left side of screen in menu, go back into form if required to update * Green tick to Sign off form * Discern Notification – each discern will be different for each patient and will appear when there is cause for concern. * View alert(s) and discuss care plan if appropriate * Task has disappeared from Nurse activities * Show other tasks that need completing by the nurse within nurse activities, for example, some may be triggered depending on what was filled in within the triage form. This can be explored more when carrying out scenarios in the practical. * Close box | |
|  |  | **User practical - Triage of patient – Data Sheet** | |
|  | **PowerChart**  **Orientation**  **And updating patient details** | * 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 * **ED Clinical Information**   + Components can be reordered by dragging and dropping to new position.   + **Triage Review** all info already documented * **Safeguarding (CP-IS/FGM-IS)** – View any safeguarding concerns here * **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   + Click on the Histories Tab and navigate to the **Social** Tab, click on the plus/Add button and record Use - Current Smoker, Type – Cigarettes, Tobacco use per day – 10, number of years – 5. Click OK to close and save   + This will populate the tobacco histories field.   + Refresh PowerChart to see updated Histories field in the social tab * **Diagnoses and Problems** Add a problem by selecting **Add as**: Chronic in dropdown and In the search bar type in **Diabetic** and select the correct problem from the list. * **Home Medications –** Select **Meds History** and show No known home medications then **Document History** button from the bottom right * **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 * **ED/UTC forms** – All ELHT assessment forms can be found within this view, click to view more available forms that are not in nurse activities * **Demonstrate** that an **ED Ambulance handover form** is available * Click - Ambulance Handover form will open * Fill in all Yellow Mandatory fields * Ambulance Handover Date and Time - **Today’s date and Time** * Ambulance Handover Details – Ad hoc fill in * ED Chief Complaint - fill in adhoc asking trainees for typical scenario * Click Green Tick to save and close * **Documents –** This is where you view all documents associated with the patient. To view triage assessment form, click on the document record and go to the modify icon which is a paper and pencil. Modify as required and click save. There will be a blue triangle in the docs component to show its been modified once refreshed * Show page master refresh and component refresh. | |
|  | **Care Plans** | 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 **Pain Care Plan**. Select **Pain Care Plan – Adult** * Click on Orders for Signature and sign * Tick or untick recommendations as required * Click **Initiate Now** * Click **Orders for signatures** * Orders will display * **Sign** * Order will now be displayed in Order profile and relevant tasks will be initiated | |
|  | **Fluid Balance/Assessments** | Go to **Fluid balance** component and click on heading to access screen  **Show how to Associate and Disassociate Device/Monitors**   * Show the Monitor Icon * Explain that Monitors will be listed according to area and can be associated and disassociated as required * Show where they can access skin assessment, falls assessment, peak flow on asthmatic etc * All the relevant point of care assessments are within the different band headings * Adult quick view for vital signs input Vital signs as follows * Double click on blue heading to activate column   + **Respiratory Rate – 15**   + **SP02 - 99**   + **SBP/DBP Cuff 125/75**   + **Heart Rate Monitored 120**   + **Temperature 38** * Green tick to sign off * 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 vitals and fluid balance on their patient – Data Sheet | |
|  | **Inserting Lines, drains & tubes** | **Lines-tubes-drains-device**  Peripheral IV  Click on Peripheral IV and click small graph icon as before   * Peripheral IV# **1** * Peripheral IV Laterally **Left** * Peripheral IV Site **Dorsal Metacarpal Vein** * Peripheral IV Catheter Type **Over the Needle** * Peripheral IV Catheter Size **16** * **Click OK** * Double click Blue Heading to activate column * Activity **Present on Admission** * PIV Insertion Date **Known** * Present On Admission Insertion Date **Current Date** * Segment **Airway Management** * Double click Blue Heading Airway Management * Patient Airway Status **Patient with support** * Manual Airway Management **Other – type Guedel** * Airway Toleration **Well** * Resuscitation Device at Bedside **Yes** * **Green Tick to Save**   Click on Peripheral IV to record Assess/Care   * Double click Peripheral IV Blue Heading to activate column * Activity **Assess/Care** * PIV Insertion Date **Known** * Present On Admission Insertion Date **Current Date** * Line Care – **Secured With Tape** * Line Status - **Flushes Easily** * Site Assessment – **No Complications** * VIP – **Site Appears Healthy** * Site Care – **Cold compress** * Dressing Activity – **Changed** * Dressing Date Changed – **Today and Now** * Dressing Condition – **Dry** * **Green Tick to Save**   Click on Peripheral IV to record - **Remove IV**   * Double click Peripheral IV Blue Heading to activate column * Activity **Remove** * PIV Insertion Date **Known** * Present On Admission Insertion Date **Current Date** * Line Care – **Secured With Tape** * Line Status - **Flushes Easily** * Site Assessment – **No Complications** * VIP – **Site Appears Healthy** * Site Care – **Cold compress** * Dressing Activity – **Removed** * Dressing Date Changed – **Today and Now** * Dressing Condition – **Dry** * Removal – **Plaster Applied** * Removal Reason – **No Longer Indicated** * Removal Authorisation – **search for Nurse Access Role Test** * **Green Tick to Save**   Point Out other Options within Recovery Lines Tubes and Drains Band  Overview of Navigator Bands and show that other Bands are available by selecting **View** from the top toolbar, **Layout** then **Navigator Bands**   * Select **ABCDEF Band** and show all other ED bands | |
|  | **Prescribing and Administering Medications** | * Return to ED LaunchPoint and use **Patient 1** * From **LaunchPoint** select the Tablet icon, click ‘**Open Patient Record**’, Powerchart pens, navigate to **Quick Orders m-page** * In Request /Care Plans – search for a new order - **Paracetamol** * Select Order sentence – dose 1g oral tablet four times a day PRN * Ordering Clinician window appears – select **PGD** – **OK** * Click on Green Order basket * Modify Details * Click on medication then fill in Mandatory fields * Give additional dose now if required - **NO** * Then **Sign** * Return to LaunchPoint and click on Pill icon to view order * Open **Patient 2** record * Click on Menu and select Drug Chart (Overview of drug chart scheduled/unscheduled/PRN *Set up patient with a variety of drugs)* * View medications scheduled * Click **Medication Administration** icon in top bar and scan patient’s wrist band to positively ID them. * Select Paracetamol from list * Scan medicine container to match prescription, show override if no bar codes * Click on Black arrow in results field and 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) * **OK** to complete * **Sign** to close window   An additional way to Administer Medication is via **Drug Chart** in the Blue Menu   * Click on Drug chart then select the **Pending Box** for Plasma Lite * Complete the charting form   + Witnessed by – Search for **Surname Training** Forename **EDNurse**   + Site – **hand left**   + **Apply**   Authorising signature Username **EDNURSE** Password **Cerner**  **Green Tick to confirm**   * Click back into **Plasma Lite 500ml** box   Bag information can now be updated such as recording a Bolus  Also explain that once significant time has passed that will also have the option to stop the bag from here  **Close** window once this has been explained  **User practical to Administer Meds using Patient 2** | |
|  | **Handover** | * House icon then **Handover Mpage** * Look through components and in **Nursing Handover Recommendation** get nurses to type in free text box * Show Contextual View * **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. * Nurse handover – **Nurse Handover SBAR Not**e complete as required * Go back into the **Document’s** component show completed form | |
|  |  | User Practical to complete handover note and create Auto Text – Data Sheet and Users Own Data | |
|  | **Request a bed and Transfer a Patient** | The bed management Team will use a System called MiyaFlow for bed allocation  Using **Patient 2** show the following steps   * Right click on patient - **Decision to admit** Confirm DTA **- Yes** * Fill in mandatory fields   + Date **T**   + Time **N**   + Source of Admission **Usual place of Residence**   + Lead Clinician – **Neilson** * **OK** * Patient Status now at Admission * Once bed has been allocated by bed management team this will update in Launchpoint * Right Click on Patient and complete the **Transfer Patient Location** Order choosing **Urology** as the Specialty. * 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** * 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 2 and discharge them to the ward – Data Sheet** | |
|  | **Scenario 2** | You receive a call that **Patient 3** will be arriving soon into the department. | |
|  | **Record a Pre-Arrival** | * Log onto FirstNet * Click the **Add Pre Arrival** icon – blue man with plus sign * Pre Arrival form is opened – fill in ad hoc as follows * Last Name * FirstName * Gender * Date of Birth * Explain that additional fields such as vital signs can also be inputted based on the patient’s symptoms and needs. * Inform that once a patient has come into the department a full registration of the patient will be carried out by the admin’ staff ad hoc and then the pre arrival form will be added to the patient’s record * Click **OK** to close and save   **User practice to fill in own pre arrival form based on delegates own scenario from personal experience Using Patient 3** | |
|  | **Scenario 3** | **Patient 3** has arrived and is in ED waiting area with an injury to their hand. Explain we will use the quick visit tool to assess and treat the patient | |
|  | **Quick Visit** | * From LaunchPoint Select Patient * ED Clinical Information M page * Click **Quick Visit** from components * From ED/UTC Quick visits list select **Hand Injury/Pain** * Diagnosis **Sprain of Hand** * Examination of findings **Select auto text** * Review of System auto text * Orders **Paracetamol** * Prescriptions **Paracetamol** * Follow ups **Return to UTC/ED – 5 – 7 days** * Submit * Select an Order sentence for Paracetamol * Double click on **Term – Sprain of Hand** (this will populate Verifying mapping details box) * Click **OK** * Order for Signature Window appears, click **Sign** * Complete all mandatory fields for the order by clicking on which appears in the bottom the window now displayed * Fill in Mandatory Fields   + Admission Med **Yes**   + GP to continue **No** * Click **Sign** * Allergies and weight if asked * Orders for signature mandatory fields then sign * Close * 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 * Order profile * All should be pulled through   User Practical to add Quick Visit – User inputs own data  **Exit ED View** | |
|  | **Exit/Log Off** | Click Exit from the toolbar | |