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| **COURSE NAME** | | | **Cerner Millennium ICU (CRIC) Doctor Lesson Plan** |
| **COURSE AIMS & OBJECTIVES:**  **WSL: Paul Dean** | | | **By the end of this training, trainees will be able to:**   * Login to PowerChart * Create a ward list from the homepage and establish relationship with a patient * Navigate the Critical Care Worklist and record clinical activity * Record patient history (home meds, diagnosis, problems, etc) * Understand Plans of Care – structure and how to request * Review the Drug Chart and administer meds * Request orders * Complete a Specimen Collection and print/re-print labels * Review radiology, vitals, and nursing assessments * Complete Consultant forms * Follow step down/transfer process * Discharge patients from the ward |
| **COURSE TIMINGS:** | | | **Full day** |
| **TRAINING ENVIRONMENT:**  1 to 1 environment, either face-to-face or remotely via Teams/Dameware  Classroom environment (if applicable and available).  Training will be user led and directed by the Trainer.  Equipment needed (dependant on system): laptop/PC/projector  **SET-UP REQUIRED/INFORMATION NEEDED FROM SYSTEM SUPPORT:**  User account(s) created.  User account(s) details.  Level of access/user profile.  **SET-UP REQUIRED/INFORMATION NEEDED FROM SYSTEM SUPPORT:** User account(s) created; user account(s) details; level of access/user profile.  **PDP requirements: Patient 1** needs admission to CRIC via ED due to severe chest pain; some PRN meds already prescribed & administered; some pathology/microbiology results and some meds for review (for orange icon to present); doctor’s form that needs completing (for red icon to present); illness severity already recorded; some docs to open and view.  **Patient 2** needs to have a more detailed record, i.e. some critical vitals to make it more relatable, some PRN and continuous meds already prescribed & administered, etc. | | | |
| **INTRODUCTION:**   * Training room Health and Safety (fire alarm, etc.) * Data Protection, Information Governance, logout when left unattended, not viewing own records, not sharing account details, auditable system * Training session objectives and session timings | | | |
| **Timing** | **Main Topics and Functions Covered** | **How to:** | |
|  | **Login to Millennium and PowerChart** | * Open **Microsoft** **Edge** web browser. The **Online** **Intranet** (OLI) should open * Select **IT** **Systems** in navigator to left of window * Scroll down and type’ **millennium’** in the search field under **Clinical** **Systems** * Click **Millennium** * Login to **Cerner Millennium** (usernames are not case sensitive but passwords are) * Login to **PowerChart** (usernames are not case sensitive but passwords are) * Explain that Imprivata (single -sign-on) should auto. log the user into their PowerChart account from go live | |
|  | **Organiser and Critical Care Worklist overview** | * Give overview of the **Organiser** (toolbars at top of screen), including **eCoach** * Show delegates how to change their Organiser view and MPages selection to their preferred one (e.g., Critical Care Worklist) as follows: **View > My Experience > Critical Care Worklist > Intensivist > Save** * Trainer – don’t do this but explain that user would need to log off and back in to see any changes * Click the **Critical Care Worklist** iconin the **Organiser** | |
| 10 | **Creating a Patient List in Doctors Worklist and establishing a patient relationship** | * New accounts will not display any ward lists from the **Patient** **List** drop-down. On first login, new users will need to click **List Maintenance >New>Location**>**Royal Blackburn Teaching Hospital>Level 2>RBH Ward CRIC** (explain users can click ‘next’ to add further wards) * Click **Discharge** **Criteria** and select “Only display patients that have not been discharged”. This avoids recently discharged patients also displaying on the list * Click **Finish** * Select **RBH Ward CRIC** andmove it to **active** **lists** * Click **OK** and refresh screen (make delegates aware of refresh) * Use the **List** drop-down to select **RBH Ward CRIC** * Show delegates how to manage their patient lists: from the **Lists** drop-down, select **Patient** **List**, click **List** **Maintenance** and make active/available as required * **Establishing patient relationships**: explain this is to activate clinical data for the patients you are caring for. Stress the importance of only viewing information for the patients under your care * Click the **No** **Relationship** **Exists** link for the patient you are caring for * The **Establish** **Relationship** dialog box opens with the patient(s) you have selected. From the **Relationship** drop-down, select the nurse relationship and click **Establish.** A relationship is now established between the user and the selected patient * Repeat the ‘establish’ process for other patients as required | |
| 10 | **Critical Care Worklist overview** | * Give overview of **Critical Care Worklist** and explain how to use some of its key components:   **Critical** **Care** **Worklist** is an interdisciplinary summary workflow solution that guides you, as a clinician, in planning and prioritising the care of your patients and provides you with the correct information at the right time. The **Critical** **Care** **Worklist** displays 90% of all the information you need about your patients directly, including important details such as allergies, resuscitation status, reason for visit, and care plans.  The **Critical** **Care** **Worklist** empowers you to make informed decisions faster because you will receive nearly real-time data about each of your assigned patients in a comprehensive view in the context of their plans of care. In addition, you can also directly document patient activities and click links to access other important parts of your patients’ charts (electronic care records).   * Explain the columns: * **Location** (ward and bed details) * **Patient** demographics / view any allergies. NB – the following icons will appear against patients here but only once you have established a relationship: **orange icon** = pathology/microbiology results ready for viewing; **red icon** = meds to be reviewed or a doctor’s form that needs completing. Click icons and then **mark as reviewed**. These are now removed from view. * Hover over patient to see their illness severity, which can be updated by clicking into column and updated * **Visit** – LOS = length of stay * **Activities** shows number of tasks still requiring completion. This number will reduce as they are done. Hover over the red or grey bar to see activities’ categories. **Red bar** = overdue tasks. * **Plan** **of** **Care** shows patient care plans in place. This will auto. display ‘1 suggested care plan’for every new admission – this is the **Discharge Care Plan. Trainers’ note:** a VTE is **not** the nurses’ job and needs completing by the doctors | |
|  | **MPTL - accepting/**  **rejecting urgent referrals to CRIC** | Scenario – ward refers patient to CRIC via **New Order Entry**. All referrals made to CRIC will appear as patient tasks in the ‘referrals’ tab of the **MPTL** (Multi-Patient Task List). Once this is completed, the ward telephones CRIC to inform of this so that they can view the referral and assign it to the CRIC care team. A verbal comms (contact) will be added to the referral (CRIC staff to tell referring wards where to find this), and a ‘consultation’ form for **urgent** referrals will be also added by the CRIC doctors.   * Click on **MPTL** icon in the **Organiser toolbar** * Right click on **grey bar** (left or right) and customise **Referrals** tab. Update **Patient List** and **Time Frames** to make sure MPTL displays the correct information * Ensure **Patient List** is ticked, **Departmental View** is selected, and then select the required trust location or ward(s) * Update **From**, **To** time frame (**Jan to Dec, 12 month period).** Explain you can put any time frame you require * Repeat the above steps for **Contacts** tab * Click on **Options** (above the **Organiser)** and ensure you have **Task View**, **Navigator** and **Indicators** ticked * From **Options,** select **Task Display** * Select chosen **Status** (**trainer to explain** that **completed status should be unticked on user accounts** as this will display all status completed within the configured time frame but **KEEP TICKED FOR TRAINING**) * Select **Task Types** required for CRIC (all that contain the word ‘critical’), then click **Save** and **Close** * **MPTL config. is now complete** * Band 7’s will then double click on the referral. If the referral is elective, the **Elective** **Referral** window will appear, where you can select **‘Accepted’**. Show **‘Rejected’** option and the comments / reason for rejection freetext box * Sign the form * The patient should now have disappeared from the referrals list (complete) * **NOTE: IF THE REFERRAL IS AN URGENT ONE, YOU WILL BE PRESENTED WITH THE CONSULTATION FORM AND NOT THE ‘ELECTIVE REFERRAL’ WINDOW. URGENT REFERRALS WILL BE MAINLY MANAGED BY THE CRIC DOCTORS** | |
| 5 | **Assign patient to a CRIC care team** | * Navigate to patient record and select the ‘**CRIC** **Manage’** MPage * Select **Care Team** componentand click on the **‘plus +’** icon in the top right * Select required CRIC care team, e.g. urgent etc. * To remove patient from the selected care team, click back into the care team they were added to and on the right-hand side select **‘remove’**   **NOTE: REMIND CRIC CARE ALS STAFF TO REMOVE PATIENT FROM THE CRIC CARE TEAM’ WITHIN THE ‘CARE TEAM’ COMPONENT AFTER HANDOVERS (MORNING AND EVENING) UNLESS PATIENT IS STILL UNDER REVIEW** | |
| 40 | **Overview of patient record & Admission Clerking** | * Select **Patient 1**. The patient record is opened using **Doctor’s View** * Explain the screen details/orientation **–** patient’s details appear in the blue Patient Banner, which contains the encounter, i.e. the current episode of care * Show **patient** **search** and ‘**Recent’** drop-down (both in top-right of screen). This will list your last 10 pts records visited * Explain more than one can access a record at the same time and make changes to it * Make delegates aware of **Refresh** icon to see the most up-to-date info. Explain users will need to do this **regularly** * Explain **left** **Menu** * Give overview of **Doctor’s View** from its **MPages**. These contains components and, as a group, make up the workflow for that MPage. These will be used depending on what stage your patient is at * MPages can be closed down with **X** if not required and opened using **+**. Components can be dragged/dropped to preferred location, and added/removed from the selected MPage via **burger icon (ellipses)** to right of screen * and demo how to add and remove these pages * Explain **components** in the navigator and show how these can be dragged/dropped to preferred location * **Admission** **Clerking** process: work through the **Admission** **MPage** to record assessment of **Patient 1** * **Presenting complaints or issues** component – **Trainer to record Chest Pain** * **History of presenting complaint or issues** – free text box. Once completed, click **Save** * **Clinical** **summary** – free text box * Diagnosis – Would come back to this with users later to show how this updates * Care Team – Care Teams involved will be displayed in here - The named clinician details for the ward appear here (shown further on in the lesson plan) * **Documents** – Show this is where any documents added to the patient record can be reviewed * **Problem** **List** – reinforce: a doctor enters a **coded diagnosis/problem**. Explain chronic diagnosis added (chest pain) will remain on the pts record and will live across all visits. The workflow is designed to capture this data in various components in one go or come back to and complete as and when to finally complete it and put it in to a document * **Histories** – In this component several can be added **Procedures/Social/Family**. Show how to record and add a procedure of **appendicectomy** * **Social** **History** – add an example, e.g., smoking and/or alcohol intake * **Review of systems –** free text has been mentioned multiple times but here you can now **mention the auto text and manage the auto text feature.** Show how to search for existing auto text – they all begin with a special character, normally a dot * Show delegates how to create an auto text. Example as follows: (BE AWARE CRIC WILL HAVE THEIR OWN PREFIXED AUTOTEXTS) * Click **Manage** **auto** **text** * Click **+ Add** * At **Abbreviation** field **type .drink** to show how to create a drop-down * Type some free text info. Trainer to copy and paste a large paragraph from one of their Word docs. If you place underscores (aka placeholders) at certain points this allows you to tab to that point using F3 key and type required info * Go to first placeholder and click **Create drop down**. Enter a few drink options (you can have one set as a default) * Click **Save**. Demo how the new auto text works | |
|  | **Admission Clerking continued and contextual view** | * **Examination** **findings** – free text field. Show how the **Contextual** **view** feature works - click the arrow in the top right to move it to right of screen. Do the same with another component – both can now be viewed in context to one another * **Clinical Images** – Explained further below * **Vital** **signs** – displays recorded obs from Patientrack. To see a graph view, click each one * **Allergies and adverse reactions** – typically this may have been collected by nurse but **show how to add two allergies: penicillin and peanut** * **Home Meds** – as part of the initial admission clerking, this will be completed by the doctors (add whatever home meds doctors like i.e., simvastatin). Mention ‘No Known Home Meds’ and ‘Unable to Obtain’ * On searching for a drug, explain ‘Aspirin’ and the order sentencing feature as this will pull the information through to the **medication** **reconciliation**. The order sentencing benefit is the use of one order sentence in the system for that prescription. Once a pharmacist has clinically checked/verified the meds entered, this will display a **green** **tick** in this component * **New Order Entry** – for ordering meds, referrals, care plans, etc. * Show how to add a **CRIC Care Plan**. Show users how to add this Care Plan to **favourites.** * The order is now placed with status below in the **Plan and Requested Actions** component**.** Explain this information will now be collated into a **dynamic** **document** * Select the **Critical** **Care** **Admission** **Clerking** **Note**. This is a dynamic document, i.e. pulls through data from other components. Users can still edit this via the **insert** **free** **text** icon * Templates will affect the look of the document – Explain the screen with each sections displaying the information entered and pulled through. PowerChart will auto remove the empty sections once sign/submitted * Once a review of the doc is completed, click **Sign**/**Submit** * Review the screen and click **Sign** * Documents can be forwarded. **Trainer to forward one in the session**. Open **Message** **Centre** fromthe **Organiser,** go to **Notifications,** then **Sent Items –** doc is there * Open **Menu>Form Browser** and show that document is saved here in the patient’s record * **Demo tagging:** Tag some text from an existing document within the **Clinician** **Workflow** MPage * Show **Ad-Hoc** icon within the Organiser at top of the screen – this is where all forms, inc. the **ReSPECT** form, can be found and completed * The **ReSPECT** form is in the **Admission/Transfer/Discharge** folder in the top left of the screen * The **ReSPECT** form can also be found within the components list on the MPages * **Run through this form with the clinicians as it is important to the CRIC staff** | |
|  | **Clinical Images** | * Filters are available to right of screen to view imported clinical images in the last month, 3 months, 6 months, etc. * These can be added to the patient’s record. **In the example, we will open the A.D.A.M. folder** * Click **+Add** * **DO NOT** click **Browse** yet * Select the required destination from the **Content** **Type** drop-down list on the right. Trainer to select **Ambulatory Summary** * Click **Browse** and select the required folder (if a **Citrix** **Workspace** dialog box appears, click **permit all access** and tick **‘do not ask me again’)** * Click **This PC** * Under **network** **locations**, double click on **p2085 (**[**\\elhtuknas\elhtuk**](file:///\\elhtuknas\elhtuk)**) (l:) drive** *(trainer – this is c2085 in the CERT domain)* * Open the **A.D.A.M Images** folder. Trainer to double click any image from the list * Image appears on left, under **Origination** * Under **Destination**, on the right of your screen, * Click on **blue arrow button** to move image across * Click on **Edit** icon * **Annotation Tool** appears. Maximise this screen * Show some options on the toolbar, inc. zoom in/out, rotate, etc. Use icons in toolbar as required to annotate the image * You can also add **drawings/texts** to image * Edit image name if required * Click **OK.** Add further images if required * Click **Commit** and then click **Close** * Click **Refresh** * Image(s) are now on left of screen as thumbnails under the **View Media** tab * Double click the image file in the main part of the screen to open and view it * Click **<** arrow to return to MPages * Select **Clinical images** component again and refresh screen | |
| 30 | **Critical Care Manage Workflow** | * Show user the **components** on the left-hand side so they can complete the relevant sections * Show delegates the component daily targets and explain that, per their workflow, this will need to be documented by completing a **Daily** **Review** dynamic doc | |
| 20 | **Care Plans & Referrals** | * Open **Order** **Profile** component and click the header. **Requests/Care Plans** opens * Give an overview of the **Care** **Plans** and **Orders** screen: 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** * Open **Suggested Plans** to the left and select **Critical Care Plan on Admission – Adult** bundle * Next step is to either accept or reject this recommendation. In the demo click **Accept** * Care plans have outcomes (targets) and interventions. Some entries have sticky notes containing information. * Select the required pain score – in the demo tick ‘**numeric’**. This will trigger onto **Activities** in the nurses’ **CareCompass** view for a task to be completed * Click **Initiate Now** * Property form opens - Yes/No is a mandatory requirement in care. Complete form and sign * Click **Orders for Signature** * Other required bundles within this care plan will trigger to be completed and signed * Now we will add a referral to another team e.g., **‘pain team’** * In the **‘New order entry’** component, click the **Public** tab and open the **Adult Critical Care** folder to see all CRIC orders are available one place (if referral isn’t listed then manually type in the search box for the referral) * This component is also used to refer to AHPs and teams. In the scenario, type ‘**referral to pain team’** and select it * Click **Orders for Signature** to proceed with these requests * Click **Modify** **Details** * Fill out the relevant fields * Click **‘sign’** to complete the referral | |
| 10 | **Overview of Doctor to Doctor Handover** | * Go to **I-PASS** (top-right of screen, under the refresh button), review patient and add info as required. Trainer to select **Watch** * Click **Clinical** **Summary** component and free text details (SCENARIO IS CHEST PAIN to relate to storyline) * Open **Lines**/**Tubes**/**Drains** component and click the header. **I-View** opens * select the **Adult Lines Drains Tubes** band. * At **Central** **Line**, click the **Repeatable** **Group** (RG) icon This contains a series of mandatory fields and the user **must** select one from each section. Click **OK** once completed * This RG has now been recorded in grey directly under ‘Central Line’ * To activate the column, double-click the blue box adjacent to ‘Central Line’ and underneath the required date/time * At **Activity** select **insert** **new** **site** and complete fields * The LocSSIPs (**Local Safety Standards for Invasive Procedures**) will appear * (NB – ‘performing procedure’ is member of staff). Click **Sign** * Click back in the activity field on now’s date and time and select **‘discontinue’** to record the removal of the line. * Complete reason etc and then show how to right click the Line heading e.g. jugular vein and click **‘Inactivate’** * Navigate to patient menu and give overview of the Tasks which may need to be completed * Go to **Critical** **Care** **handover** MPage in patient record and select the **‘other note’**. Show **Critical Care Consultant** **progress note>Consultant Ward round** | |
|  | **Review of patients on the ward** | * Navigate to the ‘**Handover’** MPage and select the **‘Select Other Note’** component at the bottom left of the component’s column * Within note templates, double click **‘Critical Care Daily review’** * Show how to add information into the review template * Click on ‘Sign/submit’ at the bottom right of the screen * In the ‘Type’ field, start typing ‘Crit’ for critical care and select the **‘Critical Care – Daily Review’** note type and click **‘Sign’** * Go back to the **‘Handover’** MPage and click on the ‘**Documents’** Component * Click the refresh symbol and your Daily Review will now appear in the ‘**Documents’** section of the patients record | |
|  | **Revising and viewing amendments to documents** | * To revise a document, left click on the document you want to revise * A panel should appear on the right-hand side of the screen, click on **‘Modify’** * Another box will appear with the option to ‘Addend note’ or **‘Revise note’ – always click revise note or you will not get the chance to revise again if addend note is selected.** * Click **‘Ok’** * You will be taken into the document to modify anything you need to – make some changes * Click **‘Sign’** * Refresh the **‘Documents’** component and you should see a small blue triangle next to the document you revised * To view who made the revisions, left click the document and click **‘View document’** * When the document opens, on the top toolbar at the very far right, click the **‘Tracked Changes’** icon * This shows detail of who changed what within the document and displays dates and times as well | |
| 30 | **New order entries** | * Select the **Critical** **Care** **Manage** **MPage** * Demo **New Order Entry** component (‘inpatient’ is selected by default) * Search by typing the test name as required. * **Order referrals to theatre** * Order a **XR Chest** * Show users that, as the tests are selected, they appear in the shopping basket icon (Orders for Signature) * Click the shopping basket icon to proceed further with the test requests * Click **Modify** **Details**. The items on order will all be displayed in a list view * Explain the blue X icon represents missing required details - this is also displayed as a button on the bottom of this screen * Click and highlight all 3 tests to demo that the missing info would then **ONLY require completing once** * Show and explain the details section which now appears with mandatory sections highlighted to be completed – Talk through these sections: * **Clinical Details** – i.e. why it’s being ordered * **Bleep/Tel Number** * **All other mandatory fields** * Click **Sign**. The orders have now been placed * Go to **Order** **Profile** and show users this is where the orders will appear with the relevant status **Ordered** **(Awaiting Collection)** | |
| 10 | **Results Review** | * Demo **Results Review –** From the MPage go to the **Lab**s component and click the **Labs** header * This will directly open results review section where the individuals can view various tabs: Radiology, Vitals and Assessments that the patient has had completed/received * Explain the **Assessments** tab – will only display the assessments that the user has completed on the patient. All assessments are displayed in **left** **Menu**/**Assessments and Fluid/Balance (iView)** | |
| 15 | **Continuous renal replacement therapy** | * Navigate to the **New order entry** component * Search for ‘**renal replacement’** * Select ‘**citrate**’ care plan (Renal Replacement – Citrate cvv…..) * Click **Orders** **for** **Signature** (shopping basket) * Click **Modify** **Details** * Click **Initiate** **Now**. PowerPlan opens * Complete (see lookup table to fill in fields) and sign the form * Highlight all the orders on list to be completed (calcium) * Click **Orders** **for** **Signature** and sign the form * Go to **Critical Care Worklist** from the **Organiser** and refresh * Show **Renal** **Replacement** column has been populated * Click **Renal Replacement** column to show side panel. Click **open record** to go to **iView** * Select the **continuous renal replacement therapy** band and show delegates how to complete information | |
| 10 | **Message Centre** | * Click on **Message** **Centre** icon in the **Organiser** * Show how to send a basic message, search for patient and all patient information to be included in the message * Show **Inbox**, **proxies** and **pools** – click **Manage** to set these up * Show how to send reminders to self and attach documents from patients record to the message | |
| 20 | **Administering Medications** | * Select **Patient 1** * Open **left** **menu** and click **Drug** **Chart** to review it * Mention the drug chart should **NOT** be used for medicines administration as it does not support positive patient ID. It should ONLY be used to view drug info or updates to IV fluids information * Click **Medication Administration** in the **Organiser** * Scan patient’s wristband to positively ID them. **Stress the importance of scanning the patient’s wristband for patient safety** (trainer to click **Next** and select ‘no scanner available’) * To view details of the order, right click and select **Order Info.** Show the various tabs. These show how it’s to be taken, what the patient’s indication is, who ordered it, when it’s due, and which pharmacist has clinically checked it * Right click a med from the list that has **NOT** been administered and select **Record Not Done.** Select the specific reason, input any comments and **Sign** * To record the administration type (e.g., self- administered) and witnessing meds (e.g., second checker for controlled drugs), right click and select **Record Details** * Select a med that **has** been administered and click **Sign** * To view all administered meds. click the **Medications and Medical Devices** component – expand the **Administered** section to view them * Hover over date/time column to see who administered the meds | |
| 10 | **Step down /**  **transfer patient** | * Click the **Step Down/Transfer** MPage * Select the **Medications and medical devices** component and review * Select the **PICUPS + Re-Referral** component and demonstrate that the clinicians can use this if need be * Show **Critical Care step down/transfer note** at the bottom of the components page | |
| 10 | **Discharge patient (including rec death)** | * **Click Discharge** dashboard icon in the **Organiser** * Give overview of columns. These would have been updated by the nurse and fed through to here. NOTE: Patient should have already been identified as MDT fit for discharge by the doctor * Start from **doctor’s** **worklist** and look at I-PASS. Enter new action then close screen * Select patient to open their ePR and click the **Discharge** **Meds** MPage * Select **Discharge** **Medication** component * Click **Discharge** (**Status**) on the right. The **Order Reconciliation Discharge** screen appears * Users must **NOT** use the ‘red’ (do not continue) column to stop a med because the reason for doing so will **NOT** appear on the discharge letter. To stop a med, right click it on the left and select **Cancel/DC**. Select a reason and sign * Show delegates the medications to continue/stop etc. Have a selection of 5 drugs e.g., for Acute Coronary Syndrome: Aspirin 75mg each morning, clopidogrel 75mg each morning, atorvastatin 80mg at night, ramipril 2.5mg at night, glyceryl trinitrate spray (two sprays when required) * To continue any med at discharge, use the **Create new rx** (prescription) pill box column. Notes can be added for the patient by clicking ‘Notes for Patient’ * To add any med that’s not in the list, click **Add, and** fill in details for new meds * Test the discharge meds process and **Send To** field. *Prescribe morphine liquid 10mg/5mL 5mg when required (*this illustrates how a medicine can be added at discharge, AND it is a Controlled Drug) * Click **Reconcile and Sign** * A **Discharge** **Prescription** window appears. If all discharge medicines are complete, leave the **medication** **for** **discharge** check box **ticked**. If not, the field needs to be left unticked and further meds can be added * The ‘medication for discharge’ order now sits in order. Ignore date/time fields * Click **Sign** (NB – if there are any c**ontrolled** **drug**s, click Sign and Print as these will need printing and signing * This will now appear as a green tick in the **Discharge** **Medications** component * The pharmacy team will receive a task for them to review this patient’s discharge medicines; they will ‘lock’ the patient to prevent further additions/changes. Ideally show this (would mean logging in as pharmacist to demo or having another patient already in this state) * If a decision is made to add amend medicines to discharge letter and the letter is ‘locked’, you must contact a pharmacist to have it unlocked * Show delegates **Discharge** MPage and complete all mandatory components, problem list component – problem for this visit needs to be there to complete the section. Add details to **clinical** **summary** and other fields from this screen. The **Inpatient Discharge Summary** is a dynamic document and will be built up from here * MDT Fit?? Find and show how to apply check this on Cerner * MDT Contributors component to be filled in by nurses, AHPs etc. **NOT** to be filled in by doctors * Person completing record select the form and fill in details * Key discharge information to be completed by nurse * Show tagging of text, tag a couple of items, and show luggage label with tagged items * Check **Documents** tab for previous GP discharge letters created and amend as necessary * Click the **Inpatient Discharge Summary** (GP letter), talk through headings and add tagged text, show foot note at bottom of document. Edit tag by clicking undo button and redrag into document. Complete, Sign/Submit and then Sign * Click the **Discharge** MPage and show delegates that the patient is now on the Discharge list for the nurses to continue with the discharge process * Show how to revise document * Sign/submit note, create note and submit   NOTE: IF PATIENT HAS DIED IN HOSPITAL, THIS CAN BE RECORDED IN THE ‘**KEY DISCHARGE’** SECTION ONCE THE VITALS HAVE BEEN RECORDED IN THE **ASSESSMENTS/FLUID BALANCE** SECTION (E.G. NO HEARTRATE, RESP ETC.), ADMIN WILL USE **PM OFFICE** TO OFFICIALLY RECORD PATIENT AS DECEASED   * Navigate to the **Discharge** MPage * Click on the **‘Key Discharge’** component * Click the drop-down icon next to the plus button in the top right-hand corner * Complete both the **‘Key Discharge Details’** and **‘Key Discharge Date’** forms | |
| **Assessment** | | | |