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| **COURSE NAME** | | | **Cerner Millennium ICU Nurse/HCA Lesson Plan (non labs)** |
|  | | | **By the end of this training, trainees will be able to:** |
| **COURSE AIMS & OBJECTIVES:**  **Consultant - Paul Dean** | | | |  |  | | --- | --- | | Login to PowerChart and set homepage to preferred one via My Experience | Utilise the Critical Care Worklist and I-PASS | | Navigate CareCompass and set up ward lists | Utilise Lines/Drains/Tubes | | Establish a relationship with a patient | Request orders (e.g. referrals) | | Transferring to CRIC | Complete a Critical Care Minimum Data Set | | Use the various options in the CareCompass ‘activities’ view | View test results using Results Review | | Use the Care Plans and Orders screen and complete a CRIC Nursing Admission Care Plan | Complete a Nursing Handover | | Record an assessment and a pain score | Utilise the Step Down/Transfer process | | Record fluid balance | Discharge Patient Home process | | Review the Drug Chart and administer medicines | Create a Nurse Handover SBAR Note / understand Plans of Care – structure and how to request | |
| **COURSE TIMINGS:** | | | **Full day** |
| **TRAINING ENVIRONMENT:**   1. classroom environment (if applicable and available), or 1 to 1 environment, either face-to-face or remotely via Teams/Hurdle/Dameware 2. Training will be user led and directed by the Trainer; c) equipment needed: 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 requirements: Patient 1** needs admission to CRIC via ED due to severe chest pain; some PRN meds already rescribed & 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, fire exit, etc.) * Data Protection & Information Governance: logout when left unattended, not viewing own records, not sharing account details, auditable system * Training session objectives and timings | | | |
| **Timing** | **Main Topics and Functions Covered** | **How to:** | |
| 5 | **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 | |
| 5 | **Organiser overview; change default homepage to preferred one** | * Give overview of PowerChart screen, inc. **Organiser** (toolbars at top of screen) and **eCoach** (QRGs) * Select any patient and give overview of **Patient** **Banner**, **MPages, components** and **left** **menu** * Show delegates how to change default homepage to preferred one (e.g. **CareCompass**) from: * **View>My Experience>CareCompass>Critical Care Nurse>Save** * Trainer – don’t do this but explain that user would need to log off and back in to see any changes * Return to **CareCompass** via the **Organiser** | |
| 5 | **Patient search; recent patients; refresh;** | * Show patient search (recommended patients are selected from a list/view, i.e care compass) and ‘**Recent’** drop-down in top-right of screen – this will list your last nine pts records visited * Make delegates aware of **Refresh** icon to see the most up-to-date info. **Explain users will need to do this regularly** | |
| 5 | **CareCompass:adding CRIC to patient list 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>Ward CRIC>Finish** (explain users can click ‘next’ to add further wards before clicking ‘finish’) * Select **RBH Ward CRIC,** move it to **Active** **Lists** and click **OK**. Note: discharge criteria **must** also be set to “Only display patients that have not been discharged” as this avoids recently discharged patients also displaying on the list * 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. Can also add & remove wards as necessary * **Establishing patient relationships**: explain this is to activate clinical data for the patients you are caring for. * Click the **No** **Relationship** **Exists** link for the patient you are caring for. Only perform this step if 'No Relationship Exists' * 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 under your care as required | |
|  | **Configuring the MPTL** | 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 the referral has been made, 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 by CRIC to the referral (CRIC staff to tell referring wards where to find this), and a ‘**consultation’** form for all **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 the **Time Frames** and **Patient List** tabs to make sure MPTL displays the correct information, as follows: * **Time Frames:** update **From**, **To** time frame (**Jan to Dec, 12 month period).** Explain you can put any time frame you require * **Patient List:** ensure **Choose a Patient List** is ticked, **Departmental View** is selected, and then select the required trust location or ward(s), e.g., **RBH Level 2 / RBH Ward CRIC** * Click **Save** and then click **OK** * 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 the** ‘**completed’ status should be unticked on user accounts** as this will also display all 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** * Repeat the above steps for **Contacts** tab * **MPTL config. is now complete** | |
|  | **MPTL - accepting/**  **rejecting patients referred to CRIC** | * Band 7’s will double click the referral from the **Referral** tab to open and read it. If the referral is elective, the **Elective** **Referral** window wiil appear, where they can select **‘Accepted’**. Show **‘Rejected’** option and the comments / reason for rejection freetext box * Accept the referral and sign the form * The referral will disappear from the referrals list if ‘completed’ has not been selected in **Task** **Display**, otherwise it states the task has now been **completed** (green tick) * **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** | |
|  | **Transfer patient to CRIC;** | * Once patient is physically on the ward, select the patient’s record. Next, from the **Organiser**, click the **PM** **Conversation** icon and select **‘Transfer’** * Complete **‘Transfer Reason’** **field, highlighted in yellow. Explain all yellow fields are mandatory within the system** * Click on the **‘Bedboard’** Icon and select correct bed for patient to be transferred into * Click **‘OK’** at bottom right hand side of the screen * Refresh the patients record and check that the **‘Loc:’** (location) has changedto **‘CRIC’** in the patient banner | |
|  | **Overview of Patient Record** | * Give overview of **Patient** **Banner,** which contains the encounter, i.e. the current episode of care * Explain more than one can access a record at the same time but only one user can make changes to it at any one time * Give overview of the **Nurse View** **MPages**. These contains **components** that, 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 * **Nurse** **View** also has a refresh icon and so does each component – use individual ones as refresh is quicker | |
| 5 | **Assign patient to a CRIC care team** | * Within the patient record, navigate to the **‘Care Team’** component, click on the drop down icon next to the **plus** symbol, click **‘Assign clinical staff team’**, and click **‘Critical Care (RBH)’.** Next, in the scenario, select **Urgent** **Referrals** * Go to the **Critical Care Worklist** within the organiser * From the **List** drop-down, click **Manage Care Team Lists**, from **All Facilities**, select **RBH**, from **Medical Service**, select **Critical** **Care,** tick **CRIC urgent referrals** and click **Save** * Use the **List** drop-down to select **CRIC urgent referrals -** patient should now be populated in the list * Click on the patient’ name, select the ‘**Critical Care Admission’ MPage** and click on the **‘Consultation form’** component * Click ‘**Critical Care Consultation’** and complete the form as appropriate * Once the form is signed and completed, this is now available in **left menu / Form Browser** for review (can also be modified via right-click) * **NOTE: REMEMBER TO REMOVE PATIENT FROM THE ‘CRIC – URGENT REFERRALS TEAM’ WITHIN THE ‘CARE TEAM’ COMPONENT (POSSIBLY DONE WITHIN HANDOVER AS MENTION IN THE FULL DAY CRIC MEETING, PROCESS YET TO BE DECIDED BY TEAM)** | |
| 10 | **Care**  **Compass overview and features** | * Give a **CareCompass** overview. This is an interdisciplinary 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. CareCompass 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.   CareCompass 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 columns and features:**   1. **Location** - room/bed details 2. **Patient** – dispays demographics and any recorded allergies. Hover over the patient’s name to see their age/RXR/MRN/DOB/diet.   **Orange icon** will appear if pathology/microbiology results or meds need to be reviewed); **red icon** if a doctor’s form(s) needs completing. **NB – these icons will only appear** **only once a relationship** **has been established with a clinician**.   * Trainer to click these icons against **Patient 1** and select **mark as reviewed**. Note they are now removed from view. Hover over patient details below name to see their **illness** **severity**, which can be updated by clicking into column and updated  1. **Visit** – LOS = length of stay. Hover over this to display reason for visit, admission dare and target discharge date 2. **Care Team** – data will only appear only once a relationship has been established 3. **EWS Total and Risk Level** columns – patient’s latest early warning score and risk level (low/med/high). **This will only appear after a set of obs has been recorded.** Obs can be recorded either directly in PowerChart or via Patientrack 4. **Activities** will display tasks to be completed from placed care plans and orders placed. These will display dates and times when they are due and can be completed or documented from here. A **grey or red bar** will be visible along with number of tasks requiring completion. **Red bar indicates overdue task(s).** As tasks are completed, they are removed and number will decrease      * Hover over the red or grey bar to see the activities’ categories. **Trainer note: DON’T open activities till next section.**  1. **Plan of Care** displays planned, suggested and initiated care plans, and any placed orders. The **Discharge Care Plan** will auto. trigger when the patient is admitted to the hospital (only used once patient is being discharged from trust). The **CRIC** **Discharge Checklist** will trigger when the patient is admitted or transferred to CRIC. | |
| 30 | **Using the activities column and**  **initiating the CRIC Admission Care Plan** | * Open **Activities** for **Patient 1**. User can either click: a) arrow to the right of patient’s name, or b) the ‘activites’ bar * Explain each of the following tabs: * **Scheduled/Unscheduled** - tasks due in next 2, 4, or 12 hours. Scheduled tasks are ordered automatically on admission. **If wording is in red, this means one or more are overdue**; if in black this means still within timeframe * Not all tasks are for nurses to complete – some are **interdisciplinary**, i.e. for other job roles to complete instead (e.g. **a VTE is** **not a nurses’ job and needs completing by the doctors).** Tasks will disappear once completed * **PRN and Continuous** medication * **Plans of Care** – same links as those in the ‘Plan of Care’ column * **Patient Info**. – location; resus. status; allergies; high risks; visit details; care team * Return to **Plan of Care** tab and select **Critical Care Admission Care Plan** bundle. The **Care Plans and Orders** screen opens * Give overview of **Care Plans and Orders** screen. These are groups of orders such as assessments, diagnostics, medications, referrals, and other items * In the **View** navigator to the left, expand ‘**Suggested** **Plans’** and select **Critical Care Admission Care Plan** * Care plans 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 will move from **Planned>Initiated>Discontinued** or **Planned>Initiated>Completed.** Care plans have outcomes (targets) and interventions. Some entries have sticky notes containing useful information * The **Critical Care Admission Care Plan** has been pre-configured with a number tasks – any with a **grey box  are mandatory**, any with a white box are recommended but optional. **White ones can only be selected / de-selected once plans have been accepted** * If user doesn’t want to make any changes to the plan, just click **Initiate** **Now**. However if changes need making to the plan then user **MUST** click **Accept**. Trainer to click **Accept** * Make any required changes to white boxes and click **Initiate Now** * Complete the **Property Form.** Explain all fields in yellow or with an asterisk are **mandatory.** Complete form and sign it * **Lightbulb icons** means those components within that plan have now been initiated * Click **Orders For Signature** * Components within each care plan will trigger to be completed later from ‘**activities’** in **CareCompass** and signed. Some may contains mandatory fields - these will have a **blue X.** Select each entry, complete as required, and click **Sign** * **CareCompass** opens. The **Critical Care Admission Care Plan** has now been removed from the **Plan of Care** column * Open **Activities** and show that the CRIC admission care plan’s tasks now appear in **Scheduled**/**Unscheduled** for documenting at their pre-defined times * Click any ‘suggested plan’ link in **Plan of Care** column to re-open the **Care Plans and Orders** screen and show that plan has moved from ‘**suggested’** to ‘**nursing’ (initiated)** * Select **Done** to return to **CareCompass** | |
| 15 | **Documenting a safety assessment;**  **recording an accessible info. alert; record height and weight; record pain score** | * We will now document some of the tasks that are scheduled (i.e., auto. generated on admission) and also initated from the earlier **Critical Care Admission Care Plan** * The **Safety** **Assessment** (i.e. nursing risk assessments) is ordered automatically on admission. This **may** have already been documented if patient was transferred from another ward * In the scenario this needs recording. Select **Activities**, click **Safety** **Assessment** and then **Document** * The **Accessible info alert** will appear if this has not yet been recorded. Click the **Access** **Info.** button * **‘Does patient have access. info needs’** - select ‘yes’ radial button * For the demo, complete a simple problem, **NOT a diagnosis** * In the **Problem** section, click **Add**, type ‘hearing’ in the **Problems** search, and select **hearing aid** * Complete all mandatory fields, change ‘classification’ to ‘**accessibility’**. In this scenario the status is ‘active’ * Select ‘**yes’** at bottom of form and **sign** the form * **Assessments/Fluid Balance** **(aka iView)** appears. Give brief overview of **I-**View and show how any band can be added and removed via **View > Layout > Navigator Bands.** User would need to close PowerChart and log back in to see changes * In the **Adult Quick View** **band,** select ‘**measurements’**. **Important:** double-click the blue cell under ‘measurements’ to active that column * Record a measured height of **180cm** and weight of **80kg**. The patient’s BMI is auto calculated (only if you activate the column first). Click **green tick** to save * In the **Adult ICU Systems Assessments** band, click **Pain** **Assessment**, and double-click the blue cell to active column * Double-click ‘**Pain** **Present’** – **yes**; show preferred pain tool hyperlink (aka ‘**reference** **text’**) for decision support * Record a numeric pain scale of 5 * At ‘**nurse** **intervention**;’, select ‘**pharmalogical – see drug chart’** * Demo how ‘conditional fields’ work by selecting ‘patient taking opiods’ – **yes**. E.g., recording a sedation of ‘awake and alert’ populates sedation score of zero * Explain that falls, skin, bedrails, etc. can be recorded in the **Adult Systems Assessment** band * **Sign the chart** (**green tick**) * Select **CareCompass** icon in the **Organiser** and refresh the screen. The **Safety** **Assessment** has been removed from ‘**activities’** | |
|  | **Assessments/**  **Fluid Balance** | * Open your patient from **CareCompass**. Patient record opens * From the **Critical** **Care** **Manage** MPage**,** select the **Fluid Balance** component, and click the heading * **Assessment/Fluid Balance** (iView) opens * Select the **Adult Systems Assessment** band and select **Vital Signs** * Show delegates how to record a set of observations (any obs recorded via Patientrack will appear here) * Show to view previous observations (right-click on grey bar and select required time frame) * In the **Adult Systems Assessment** band, select the **‘Gastrointestinal’** section * Demo the **Bristol** **Stool** **Chart** here, to reinforce how to complete this short assessment * In the **Stool Type**, open ‘decision support’ (link in **blue)** to show the **type** **grades** available to users * Inform delegates to enter own choice of values at this point * **Trainers Note**: continue talking through the scenario - now that we have documented some stool info, we will move on to **fluid** **balance** to record some fluid input/output that **Patient 1** (from Patient Data Set) has been to the toilet and also had some fluids to drink * Select the **Fluid** **Balance** navigator band and explain the timeframes and mention **‘Today’s Intake/Output/Balance)’** row at top of screen * Demo an input of your choice to give delegates an overview on how to record – get them to do a practical on the scenario of a basic example * **Trainer**, record this: between 7 am and 8am, the patient had oral intake of tea **(200 ml)** and then between 8am and 9am the patient went to toilet - urine voided **150 ml** * Click **Sign** * **Today’s Intake** at top of screen displays total intake, output, and balance **(50ml)** * Explain the orientation of the chart – the view at default is on the current date & time and scroll to the right to view the past dates & times * Explain the following columns in the chart – iView will auto. perform a **Day** **shift** **total** at 12:00 hrs, a **Night** **shift** total 00:00 hrs and a **24-Hour Total** * Click **CareCompass** in the Organiser and navigate to **Activities**. Find **Commence Fluid Balance** (in the **Scheduled/Unscheduled** tab) and mark the fluid balance as **Done** * Complete date and time, and click **OK** - task has been removed from view * Open the patient’s record, select the **Critical** **Care** **Manage** MPage**,** and then the **Fluid Balance** component * **Refresh** screen – recorded data pulls through for review | |
| 5 | **CareAware** | * **CareAware** will be available in the toolbar in the live domain once the integration is complete. Data from most devices attached to the patient (e.g. pumps) will interface into **CareAware** and appears as a visual representation in PowerChart | |
| 10 | **Adding & completing a**  **CRIC Minimum Data Set; viewing and modifying completed forms** | * A **Critical Care Minimum Data Set (Admission)** needs adding to the Patient Chart (i.e. elec. patient record/EPR) * All forms are available from **AdHoc** icon in the **Organiser** * Open the **CRIC** **folder** * Tick the **Critical Care Minimum Data Set (Admission)** check box and click **Record** * Complete the form and **Sign** * Show delegates that all completed forms are saved in **left** **Menu>Form Browser** * Double-click previous form to open and view it * Close the form and show options on right-click, e.g. **Modify** | |
| 20 | **Critical Care Worklist,**  **I-PASS overview and handing over multiple patients** | * Show users they can also work from the **Critical Care Worklist** by selecting that icon from the **Organiser** * Give **Critical Care Worklist** overview - unlike CareCompass, this view displays clinicaldata, e.g. illness severity, diet, urinary cathether, isolation, MDT fit, etc. * Explain users will still need to **establish a relationship** if not already done to see this info * Show how to add/remove/reposition columns via **Layout** **Configuration** from **burger icon (ellipses)** on right of screen, and explain **filter** to right of screen * Nurse is now finishing shift. Use the **Critical Care Worklist** to handover multiple patients, e.g. at end of shift * Click to the right of patient’s name to view **I-PASS** (Illness severity, Patient summary, Actions, Situational awareness and planning) and give overview (acts like a mini-patient record, giving access to quickly view and edit parts of the patient’s record without having to fully open it) * Change illness severity to **Watch** (this will be visible later once the patient’s record has been selected). Click **X** to close **I-PASS** | |
| 20 | **CRIC Handover MPage and completing a Nurse handover** | * Select **Patient 1**. The patient’s chart opens * Highlight the illness severity (**I-PASS)** is also available on **Nurse** **View.** This is to the very right of of the MPage row * (e.g. ‘stable’ or ‘watch’) . This can be changed from here * Select **Vital** **Signs** component to show data recorded earlier is here but is view only. To edit, click the header to open **iView** * Select **Critical Care Handover** **MPage**. Previously documented data displays in relevant components. Review and document further clinical data within these components as required * Scenario – CRIC nurse needs to handover **Patient 1** * Click the **Handover/Transfer Documentation** component and then click the header – iView opens. Open the **Adult ICU Quick** **View** band and select **Shift/Bedside Handover** * Acticate columns and compete relevant sections, e.g. **Nurse Receiving Report, Nurse Giving Report**, and **Handover** **Comments** * Click **Sign** * Click the **Back** button and **refresh** the **Handover/Transfer Documentation** component – the **latest** recorded data appears * To see all handover notes, click the header to open iView | |
| 10 | **Record today’s weight** | * Select **Critical** **Care** **Manage** MPage. Give an overview ot the components on this MPage * Select **Fluid Balance** component and explain this displays today’s weight, previous weight and fluid balance info * To record today’s weight, click the heading to open **iView** * Selectthe **Adult Quick View** band and then **Measurements**. Activate column. In **Weight Measured,** record **82kg** and **sign** * Click **back** **button** and **refresh** the **Fluid Balance** component to see this recorded data | |
| 5 | **CRIC nursing note** | * Select the **Critical Care Manage** MPage * Use **Critical Care Nursing Note** component and click the ‘insert free text’ icon to record any adhoc documentation * Click **Sign/Submit** * Ensure the fields have been populatred correctly and click **Sign** * Click the **Back** button and locate the **Documents** component * Refresh this component and show the note has been saved here | |
|  | **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 - 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 anc click **‘Sign’** * Refresh the **‘Documents’** component and you sould see a small blue triange 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 of those changes | |
| 5 | **Recording assessment and care of a line** | * From the **Critical** **Care** **Manage** MPage, select **Lines/Tubes/Drains** component then **click the heading** * **iView** opens. Select the **Adult ICU Lines/Tubes/Drains/Devices** band * This is where assessment and care of lines/IV/catheters is recorded. Explain **insertion is normally recorded by the doctors** * In the scenario, the Trainer **is** the doctor and will insert a central line to allow demo of assess/care of this line * To activate the **Central** **Line** column, double-click the blue box adjacent to ‘Central Line’ and underneath the required date/time * At **Central** **Line**, click the **Repeatable** **Group** icon This contains a series of mandatory fields and the user **must** select one from each section. Click **OK** once completed * This **Repeatable** **Group** has now been recorded in grey directly under ‘**Central** **Line’** * At **Activity**, select **insert** **new** **site** but Trainer **NOT TO COMPLETE** any further fields (click in white space to right of the screen) * The LocSSIPs (**Local Safety Standards for Invasive Procedures**) will appear * Trainer to only complete the \***mandatory** **yellow** \***LocSSIP** **fields** in the demo (NB – ‘performing procedure’ is member of staff). Click **Sign** * In the scenario, the nurse needs to record assessment and care of this line * At **Activity** select **Assess/Care**, then record data from the first ‘**conditional** **field’** icon  (explain a conditional field will prompt the user with options based on the previous selection) * Nurse **signs** the assessment   **\*IMPORTANT\***   * 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 sign * Show how to **right click** the **Line** heading (e.g. jugular vein) and click **‘Inactivate’** * Navigate back to the **‘Lines/Tubes/Drains** component and refresh – this will now show under **‘Discontinued’** | |
| 15 | **Ordering a referral** | * Click the **Home** icon to return to **Nurse View** * Select the **Critical** **Care** **Manage** MPage * Select **New order entry** component (inpatient button is selected by default), In the scenario, **Patient 1** needs referring to the Pain Team, Search for **‘Referral to Pain Team’** * Show delegates that as the orders are selected, they appear in the shopping basket icon (highlighted in green with the number of items displayed). This is called **Orders** **for** **Signature** * Click the ‘**Public’** tab and open the **Adult Critical Care** folder to see all CRIC orders are available one place * The **New order entry** component is also used to refer to AHPs and teams * Show how to make orders appear in **favourites** by rclicking the **star** **icon** next to the order. These are saved in the **‘Mine’** tab * Click **Orders for Signature** (shopping basket icon) to proceed with these requests * Click **Modify** **Details** and complete fields as required * Click **Sign**. All the orders have now been placed * Go to **Order** **Profile** component and show this is where orders will appear with the relevant status * Click the **Order** **Profile** header. **Requests & Care Plans** opens to show that referall’s details can be modified from here: under **View** on left, select **Consultations** to see the referral. If required, user can right-click to **Modify,** update referral as required and sign | |
| 5 | **Patient in isolation** | * Select **New Order Entry** component * Search and select **Isolate Patient > Orders for Signature > Modify Details** * Select the order and complete as required * Refresh **Nurse** **View** – isolation information appears in the patient banner * To cancel an isolation order, select the **Order Profile** component, select the request, and click **Cancel D/C** on right of screen * Click **Orders for Signature** and follow usual steps | |
| 5 | **Using Results Review to view results** | * Open left menu and select **Results Review** * To view radiolology results, e.g. XR chest, click the **Radiology** tab and double-click **XR chest** * You can also navigate around the other tabs available to you such as the **Recent** **Results** tab (NB – pathology and microbiology results won’t interface into PowerChart until 2024. There will be a link to ICE at go live to view pat lab results and order bloods) | |
| 10 | **Viewing a renal replacement therapy** | * Doctors will order a **renal replacement therapy – Citrate CVVHDF** but may plan it for later and not initiate the plan * If the RRT is planned for later, the nurses will do this at the appropriate time * This order wil generate meds, which will need to be administered by the nurses * Click the **Home** icon to return to **Nurse View** * Click the **Order** **Profile** component and click the header – **Requests/Care Plans** opens * Click the **Renal Replacement Therapy – Citrate CVVHDF (Planned)** to left of screen * Click **Initiate** **Now** * CRRT form appears – check details and **sign** * **Ordering Clinician** dialog box appears – complete as required and click **OK** | |
| 5 | **Complete a review of the continuous renal replacement therapy and administer meds** | * Click **CRIC Care Worklist** in the **Organiser** and **refresh**. Show that the **Renal Replacement Therapy** column has been populated for Patient 1 * Click the renal replacement column to show the side panel * In the side panel, click **Open** **Form** * Record outcome of review, click the **RRT – Citrate CVVHDF Settings** tab, check and **sign** * Select **Patient 1** and click **Medication Administration** in the **Organiser** * Scan the patient’s barcode (Trainer to click **Next** and select ‘no scanner available’) * Select each med that’s been administered and click **Sign** * Show options on right-click, e.g. **Record Not Done** * To view the administered meds. click the **Medications and Medical Devices** component – expand the **Administered** section to view them * For a more detailed view, open the left **Menu** and select **Drug Chart** * Hover over date/time column to see who administered the meds | |
| 10 | **Revisit care plan** | In the scenario, **Patient 1** needs a pain care plan accepting and then the nurse will update as and when required   * Select **Patient 1** and select the **Critical** **Care** **Manage** MPage * Open **Order** **Profile** and click the header. **Requests/Care Plans** opens * Click on **Suggested** and then select **Pain Care Plan – Adult** * Accept the **Pain Care Plan** and click **‘Initiate now’** * Complete the care plan as required * Navigate back to the **Requests/Care Plans** and click on **Pain Care Plan - Adult** * Select the **Document in Plan** tab (between the **Medication List** and **Manage** **Infusions** tabs). This is used to outcome each plan and should be completed at the end of each shift * Complete outcomes one at a time, i.e. met/not met with relevant reason / comments / actions * Can use the ‘clear’ icon if recorded in error: * Click **Sign** **Documentation** | |
| 5 | **Daily Review** | * Click **Home** icon to return to **Nurse** **View** s * Select the **Critical** **Care** **Manage** MPage * **Critical Care Daily Review** is a dynamic doc that will pull through recorded data such as all observations and measurements recorded for the day * Under **Create** **Note**, select **Critical Care Daily Review** * Add it as a favourite (makes it easier to select at later dates) * Click **OK** * Further info can be added using the ‘**insert free text’** icon within the relevant section * Click **Sign/Submit** * At **‘type’** select **‘Critical Care Daily Review’** * Click **Sign** * Doc has now been added to **the Documents** component | |
| 20 | **CRIC Step Down/**  **Transfer process** | * Click the **Step Down/Transfer** MPage * Demo the completion of the listed components in this view and explain some will be applicable for the Cons/Drs to complete * Select **Nurse Discharge Comments** component and free text as required * Example to use: **“information regarding dressing packs/wound, etc.”** * Explain this screen will auto. save regularly * Once it’s been agreed that the patient is ready to step down or transfer from CRIC, select the **Critical** **Care** **Step Down/Transfer Note** under **Create** **Note** (bottom of the components navigator) * Ensure all sections have been completed as necessary and click **Sign/Submit** * On the following screen, ensure note type is correct and click **Sign** * To view the completed note/document, select the **Documents** component and show delegates the completed note | |
| 10 | **Record the CRIC Minimum Data Set Discharge form**  **and Discharge Care Plan** | * Use **Ad-Hoc** button in the toolbar and click on the **‘Critical Care’** folder * Click the **CRIC Minimum Data Set Discharge** form * Click ‘**Record’** at the bottom of the screen * Complete form as required and click **save** (top left corner) * Navigate to the **‘New order entry’** componenet and select **‘Discharge Care Plan’** * Click the number one in the ‘basket’ and select **‘Modify Details’** * Select **‘initiate now’** at the bottom right hand corner of the screen * Select each of the plan’s component and complete as necessary * Click **Orders For Signature** again, then **Sign** * Plan is available to view from **Order** **Profile** component. Cl ick the header ‘**Requests/Care Plans’** to open the full request/care plan screen | |
|  | **Bed request for another ward** | * Click **home** icon and select the **Critical** **Care** **Manage** MPage * Navigate to the **New order entry** component * Search for ‘**transfer patient location’** * Cick the **orders for signature** icon and click **Modify Details** * Select the order and complete as required with the **main specialty, target unit and transfer reason** * Click **Sign** * **Demo to all trainees** - To mark a patient as **Isolation,** place the order via **New Order Entry** and complete the order as required. This information will be highlighted on the patient banner and will also interface to **Miyaflow** (new bed board system) * To cancel a bed request or isolation order, select the **Order Profile** component and click to select the **isolation** order * From the right hand side, click **Cancel D/C** option – the order will appear in the basket icon * Click on the basket to **Modify details –** Note: If it’s an isolation being cancelled and removed, the user will be prompted to add a reason * Click **Sign** * The ‘**Bed** **Request’** details will display on the **whiteboard** view but user can also call the ward for more info | |
|  | **Transfer patient to ward** | * Click the **‘PM Conversation’** drop down icon within the toolbar and select **‘Transfer’** * Complete the **‘Transfer Reason’** mandatory field * Click on the **‘Receiving Building’** and select the relevant option along with the **‘Receiving Department/Ward’** * Click on the **‘Bedboard’** button and choose bed * **NOTE: THERE IS A MIYAFLOW BED CONFIRMATION BOX AT THE BOTTOM OF THE SCREEN IF THE BED MANAGEMENT TEAM HAVE CONFIRMED A WARD FOR THE PATIENT, INCLUDING BAY AND BED** * Complete the rest of the mandatory fields, then click **OK** at the bottom right hand corner to complete the transfer * You can check the transfer has complete by refreshing the patients record and viewing the location in the patients blue banner | |
|  | **Discharging a patient home** | * Clickthe **Discharge MPage** * Complete all the mandator components with the red \* against them, such as **Nursing** **Discharge** **Checklist** and **Key** **Discharge** **Information**. Once completed they will have a green tick against that component * Demo the completion of these components from the **far right drop-down list** * Show delegates that, as they complete the relevant components, this is highlighted on the **Discharge** **Dashboard** * Click the **Discharge** icon in the **Organiser.** The **Discharge Dashboard** opens * All the patients for the user’s ward identified as ready for discharge by the doctors is available from the **Discharge** icon: MDT done, AHP ready, complex needs, follow up, etc. * Explain the info displayed in the columns * Show delegates the **MDT Contributors** component (free text), where the nurses can add their information to pull through on the inpatient discharge summary, e.g., information regarding wound dressing packs   **Discharge meds**   * A ‘**Discharge** **meds** **ready for** **collection’** task will appear in **Care Compass’ activities** once Pharmacy have made the appropriate supply options (pharmacy supply, patient locker, PODH, etc.). No more phone calls to the ward! * The meds will be handed over to the patient as follows (**Trainer – this is a demo only):** * Search and select **Daniel Zzztest (MRN 13227)** * Select the **Discharge Medication** icon in the **Organiser. Nurse** **View** opens * Select the meds to be given, tick ‘**Given’** (top left of window) and click **Sign** * Show **Not Given** option * Once this is done, the activity **MUST** be documented on **CareCompass** as **done.** From **Activities**, click the **scheduled / unscheduled** tab and select the **Discharge Medication Ready** task * Click **Done,** record date and time meds have been handed over to patient and click **OK.** Task is removed * Show delegates the **Appointments** view from **left** **Menu**. Any f/ups requested and arranged for the patient would be available to view from here * Select the **Documents** component to view the **Inpatient** **Discharge** **Summary** (i.e. GP discharge letter) * Show how the medicines section details which medicines have been started, changed, or stopped * Scroll down left, click **Discharge** (under **End** **Visit**) and complete * Show how to print patient/carer copy of the discharge letter * Click the drop-down from **PM** **Conversation** icon in the **Organiser** and select **Discharge** * Complete fields as required and click **OK** * Click the **Critical Care Worklist** icon and **refresh** – patient has been removed from the list | |
| **Learning Hub Assessment** | | | |