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| **COURSE NAME & DURATION:** | | | **Cerner Inpatient HCA Lesson Plan Adult/Paediatrics** |
| **COURSE AIMS & OBJECTIVES:** | | | **By the end of this training, delegates will be able to:**   * Login to Powerchart * Home screen – Care Compass list * Set up list maintenance and overview * Complete intentional rounding’s. NB – obs. will continue to be recorded on Patientrack within inpatient settings * Record height and weight (iView) and other assessments * Record Covid swab * New Order entry * Print labels and Wristbands. * Ward clerk duties. * Casenote Management * Log out |
| **COURSE TIMINGS:** | | | **2 hours** |
| **TRAINING ENVIRONMENT:**  Classroom environment  Training will be user led and directed by the Trainer.  Equipment needed (dependant on system): laptop/PC/projector/headset/dictation device  **SET-UP REQUIRED/INFORMATION NEEDED FROM SYSTEM SUPPORT:**  User account(s) created.  User account(s) details.  Level of access/user profile. | | | |
| **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 * Training session timings * Follow the PowerPoint presentation to introduce the agenda | | | |
| **Timing** | **Main Topics and Functions Covered** |  | |
| 5 | **Logging On** | * Launch **Powerchart** and login * Delegates to login to the TRAIN domain using details from the ‘delegate sheets’ | |
| 15 | **Powerchart overview** | * Give an overview of the orientation of Powerchart * Explain the session will cover some elements of configuring their account but there will also be an opportunity for all users to set up Cerner accounts **prior to go live** * **Configure Powerchart homepage**: from the toolbar click **View,** then select **My Experience.** * **Click CareCompass as the default view** * Click **Save,** exit the applicationand log back in * Explain the toolbar display along the top; touch on the features that they would mainly use | |
| 15 | **CareCompass overview** | * Overview of **CareCompass** and explain how to use some of its key components:   CareCompass 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. 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).   * New accounts will not have any lists. On first login, new users will need to click **List Maintenance / New / Location** and create their **ward list** * To manage your list(s) click List Maintenance (located to the right of the Patient List drop-down), then set by **location**. Choose **Royal Blackburn Hospital / Level 3 / ward C18A – Users can also narrow location down to Bay and Beds to create a list of only their patients -** Note: Discharge criteria must also be set to “Only Display patients that have not been discharged” this avoids recently discharged patients also displaying on the list. * 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 **Establish relationship button**, Tick the box next to the relevant patient and select the **HCA access role** from the drop down. Click **establish**. This is to ensure the correct users are accessing the correct patients on the ward.   Practical session for users  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 * Hover over patient to see their illness severity, which can be updated by clicking into column and updated * Visit columns – LOS = length of stay * 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 have been recorded. Observations are to continue being recorded in Patientrack system * Activities column 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. **Trainers Note:** do NOT record the Adult Basic Admission Assessment, direct the delegates to the Safety Assessment and explain you will go into it in more detail shortly * 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:** VTE to be completed by Nurses * **Note – if there are more than 10 patients on the configured list the plans of care column will not show** | |
|  | **Practical** | **Get users to Log in to PowerChart and configure CareCompass to RBH – Level 3 – C18A** | |
| 30 mins | **Activities column overview** | Show users the **Activities** column and complete relevant activities upon admission.  Click the number within **Activities** and explain each of the following tabs:   * **Scheduled/Unscheduled** tasks due in next 2, 4, or 12 hours. If wording is in red, means overdue; if in black this means still within timeframe. Mention that **most of these assessments are for the nurse to complete** – some are interdisciplinary, i.e. for other job roles to complete instead. Tasks will disappear once completed * **PRN/Continuous** – prescribed medication as the situation calls for it and continuous meds. NB - other non-meds tasks will also appear here such as catheters. * Plans of Care, i.e. assigned patient care plans and relevant info * Patient Info | |
|  | **Assessments /Fluid Balance – Record Measurements** | * Click on the patient to take the delegates in to the patient record * Click the Left Menu and select Assessments/Fluid Balance * Explain the **Navigator** **Bands**. This view will display various patient assessments and where observations can be viewed. Each band is split into many assessments for example Vital Signs, and others. * Click on **Adult Quick View** to select the **Measurements** Assessment   **Ensure you double click the blue banner before recording any assessments as this will activate the values within that section.**   * Demo completing a height and weight for your patient – explain as you enter values the system will auto calculate the BMI * Explain to delegates that any recorded data not yet saved in the record appear in **purple**. Once the assessment has been signed at end of process this will change to **black** * Click the Green tick (sign) to save details entered | |
|  | **Practical** | **Users to complete Height and Weight following data set.** | |
| 40 | **Intentional Rounding** | Show delegates the **Nurse Rounding** from Adult Quick View.   * Click the Nurse rounding assessment * Get delegates to enter own values * Show how conditional fields work – depending on the value selected this may generate further fields to be completed. * Click Green tick (sign) to save details entered   **Complete Activities of daily living from Adult Quick View**  Only complete one of the below as an example   * Activity * Patient safety Management/advice * Nutrition ADL (activity for daily living) * Hygiene ADL * Oral Health Assessment * Click Green tick (sign) to save details entered   **Complete the Gastrointestinal Assessment from Adult System Assessments**   * Click on Adult System assessments band * Select Gastrointestinal. * Demo the Bristol Stool Chart here – to reinforce how to complete this short assessment * Click the **Stool Type** in **Blue** to show the Type grades available to users * **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 has been to the toilet and had some fluids to drink * **Highlight** – The stool value entry will pull through into the Fluid Balance chart * Click on the **Fluid Balance** - Explain the screen with the timeframes and the columns view Input/Output * 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 * Delegates to record at 7 am the Patient had some Oral intake of tea (200ml) and then at 8 am patient went to toilet Urine voided (50 ml) * Click Green tick (sign) to save details entered * Explain the Today’s Intake at the top and how it displays the totals and the Balance also incorporate that they will be able to see todays and yesterday’s * 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 date & time * Show users the chart will do a Day shift total at 12:00 hrs, a Night shift total 00:00 hrs and a 24-Hour Total * Allow delegates to spend some time here to navigate and familiarise with the chart. Bring to focus blood output/vomit output etc and get them to document further values * Click the Home icon to return to the patients record. | |
|  | **Practical session for users – users to complete Nurse rounding/nutritional ADL’s/Bristol stool chart.** | | |
|  | **New Order Entry** | * PowerChart will open the record and display the **Nurse View** * Explain the screen details/orientation * Patient details appear in the **blue banner** – Check the correct encounter is selected. Show this on the right * Any **Flags/Alerts** will be displayed in this banner * Show **‘Recent’** drop down in blue banner – explain it will list your last 10 pts records visited and explain the importance of **refresh** * Explain **MPages** (tabs) displayed – Tell users this will be used depending on what stage your patient is at and demo how to add and remove these pages * Explain **Components menu** and show how these can be shuffled. This can also be configured using the burger drop down menu on the right. Click components and untick anything you no longer wish to see. * Click on **Manage** workflow * Click or scroll to the **New Order Entry** component – explain that this function will be used to place orders by various clinicians and the HCA can use this to place an order to add a reminder of the hourly nurse rounding to the **Activities** list on **Carecompass** view for each patient.   **Ordering Assessment reminders**   * Search for ‘Nurse Rounding’ – click the item. * Highlight the orders basket – number of items added will be displayed in green * Explain the user **cannot** make orders as favourites until they’ve created a **favourites** **folder**. To do this: * Click the **Orders for Signature** tray * Click **Modify Details** * Right-click the required order(s) * Click **Add to Favourites** * Click **OK.** The folder has now been created and the selected order(s) have been added to the user’s favourites folder * All orders will now show on screen. If there are any missing fields, this will show as a  next to the order * Complete mandatory fields– select **Every ONE hour** from the list of options * Click **Sign** * Return to **CareCompass** view – Click **Refresh**   Click on **Activities** to show the **Nurse Rounding** assessment as a task. | |
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|  | **Practical** | **Users to place an order for the Nurse Rounding – Every hour** | |
|  | **Create a free text note** | * Scroll down to the bottom of the components and select other note. * In type choose “nursing progress note” * Choose the template “free text note” and click OK. * Add free text information and click sign/submit. * Click Submit. * The note will now be available to view in the Documents component. | |
|  | **Practical** | **Users to create a nursing progress note document** | |
|  | **Print Wristbands & Labels** | * Click on **CareCompass**. * From **Organiser Toolbar** click on **Access Management Office**. * Under **Conversation** tab double click on **Documents Qualifier**. * **Search** and **select** patient. * Select **inpatient encounter**. * **Documents Qualifier** window appears. Click **OK**. * Untick **Admission Label** **– No address and Wristband - Child** box. * Select **Admission Label** and click on **Edit**. * Select **printer** from **dropdown list**. * Update number of copies if needed. * Click on **Ok**. * Select **Wristband - Adult** and click on **Edit**. * Select **printer** from **dropdown list**. * Click on **Ok**. * Click on **Ok** again to print **labels** and **wristband**. * Click on **X** to close **Access Management Office**. | |
|  |  | **Ward Clerk Duties** | |
| 10 | **Logging On**  **Overview** | * Selec the Access Management office icon in organiser toolbar. * Overview of **PM** **Office, (Conversations, Bed board, worklists)** * **Show quick links to other systems.** | |
| 10 | **Admit a Patient** | * Under **Conversations** select **Inpatient Non-Elective Admission** * Complete **Person Search – Patient 1** (if using smart card enter forename, surname, gender and DOB) * Click **Add encounter** * Type in **Facility** name – Royal Blackburn Hospital and select details RBH LEV 2 and use ward RBH B6 * Complete mandatory fields (Yellow) as required, including selecting bed from **Bedboard** * Click **OK**. Patient is now admitted   The labels and wristband popup will automatically display on Admission. Follow steps below to print adhoc wristbands and label. | |
|  | **Use the Bedboard.** | * Click the Bedboard band on the left, * Find ward B6, RBH, LEVEL 2, RBH B6 * This will display all patient currently admitted to the ward. | |
| 15 | **Transfer a Patient – Patient 1** | * Demo to delegate do not allow them to transfer their patients * Right click their patient 1, hover over conversations and select transfer. * Complete mandatory fields as required including selecting bed from Bedboard tab. **Check the Miyaflow bed confirmation box at the bottom so see if a specific bed has been recommended from the bed management team.** * Click Ok, Patient has now been transferred. | |
| 5 | **Home leave – Patient 1** | Patient is required to leave the ward for an appointment outside of the NHS   * Right click their patient, hover over conversations and select Home leave. * Search for patient 1 * Complete mandatory fields on the **Home** **Leave** screen * Click **OK** * **Return patient from home leave** * Right click their patient, hover over conversations and select Home leave. * Search for patient 1 * Complete mandatory fields * Click **OK** – returns patient back to original bed | |
| Practical – Users to Find ward B6 on the bedboard band - place and remove their patient from Home leave. | | | |
| 5 | **Discharge patient from the ward. – Patient 1** | Talk through with delegates that mainly all discharges will be actioned and completed by a **nurse** on ward areas, but on occasion it may be necessary to complete this action. THIS MUST ONLY BE DONE IF ALL DOCUMENTS AND MEDICINES HAVE BEEN ACTIONED FOR THE PATIENT.   * Right click their patient, hover over conversations and select Discharge. * Complete all the mandatory fields (Yellow) * Click **OK**. Patient will now be discharged from the ward. | |
| Practical – Users to Discharge their patient from ward b6 | | | |
|  |  | **HIM Patient Information app.** | |
| 5 | **Request Case Notes –** | * Open **HIM** **Patient** **Information** app (Health information management) * Log in using Smart card. * Click on search icon next to patient name and find their hca Patient * Input in the requesting location field (ward B6) and request type (acute admission) * Input date and time required on the left * Click **Send** **Request** * Complete note in contents to give more information * Click **Save** * Casenotes have been requested   **This can also be done via the HIM Tracking Application and selecting the patient information request button.** | |
| 5 | **Track Case notes** | * Open the **HIM Tracking** app. * Log in using smart card. * Search for HCA Patient using the search bar and select the relevant encounter. * Any patient notes will be displayed on the right with the current location shown. * Right click on the Case note you wish to track and select **Quick update, selected records location**. * Use the Location view to find your area. Find ward RBH B6 and select. * The location will now display with the new location selected. * To add a note to this, select the Add/display notes icon on the toolbar. * Type in the exact location – in ward cupboard and select the save icon.  1. This note will now display on the patients blue banner. | |
| **Assessment** | | | |