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| **COURSE NAME & DURATION:** | | | **Cerner Millennium Outpatient Nurse Lesson Plan (non-labs)** |
| **COURSE AIMS & OBJECTIVES:** | | | **By the end of this training, delegates will be able to:**   |  |  | | --- | --- | | Login to PowerChart, configure the homepage to Ambulatory Organiser and navigate around this screen | Complete ‘nurse to supply meds’ tasks from the MPTL | | View orders | Record urinalysis results | | Change patient status to *With Nurse* | View outpatient appointments | | Record a patient’s accessibility information | Viewing documents and clinical images | | Use and create auto text | View and administer prescribed medications | | View outpatient referrals and clinical info. recorded by the clinicians | Pre-Op nurses – completing a pre-op assessment form | | Records a set of obs. inc. height & weight |  | |
| **COURSE TIMINGS:** | | | **Half day (3.5 hrs)** |
| **TRAINING ENVIRONMENT:**  Classroom (if applicable and available) 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: laptop/PC/projector/headset/webcam/barcode scanner/delegates’ data sheets  **SET-UP REQUIRED/INFORMATION NEEDED FROM SYSTEM SUPPORT AND CERNER:**  User account(s) created / user account(s) details / relevant PDPs (Patient Data Profiles)  **INTRODUCTION TO SESSION**   * PowerPoint with training session agenda/objectives and timings * 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, fully auditable system. * Training materials will be available on eLancs SharePoint website on OLI, i.e., Quick Reference Guides (QRGs) and some short videos. These will also be available via the e-Coach icon within PowerChart. * 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’. * Advise all OP nurses that OP clinicians will outcome their own patients using PowerChart app. The trust will no longer provide clinicians with paper outcome forms for them to send outcome instructions to reception staff. The reception will send all case notes for patients that DNA to the clinician for them to record the DNA. * More than one user can view a patient’s chart at the same time but only one can modify it at that time.   **TRAINER NOTES:**   * Outpatient nurses working in adult & paeds should attend this session, but paeds nurses will need to be shown how to record and manage allergies at end of this session. * Any nurses running their own clinics (e.g., derm. minor ops) should attend the full day *OP Doctor/Advanced Nurse Practitioner* session, as they’ll need to record and manage allergies, document clinical information, prescribe meds, place orders for follow up appts, order procedures, etc. * Pre-Op nurses should attend this session – they’ll select the required pre-op list from *Ambulatory Organiser,* select the required patient andcomplete a *Pre-OP Assessment Form* from the AdHoc icon > surgery folder. | | | |
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| **Timings** | **Main Topics and Functions Covered** | **How to:** | |
| 10 | Login to PowerChart and configure account | * Login to **PowerChart**. Explain that Imprivata (single -sign-on) will auto. log the user into their PowerChart account * If **Ambulatory** **Organiser** doesn’t appear at login, click the **Home** icon in the **Organiser** * Give an overview of the **Organiser** (toolbars at top of screen) * The **eCoach** icon allows access to Quick Reference Guides (QRGs) and some You Tube videos * Show delegates how to change their Organiser view and MPages selection to Ambulatory Organiser as follows: **View > My Experience > Home > Nurse > Save** (trainer – don’t do this but explain that user would need to log off and back in to see any changes * Click **Home** in the Organiser. **Ambulatory Organiser** opens | |
| 5 | Configuring Ambulatory Organiser | * **Ambulatory** **Organiser** will need to be configured so that it displays the clinics / location that the user requires * In the scenario, we need to set this to the dermatology service * From the **Day** **View** tab, click the **‘patients for: no resource selected’** drop down * Type ‘derm’ in the search field and press enter * Select **Dermatology** **Service** and click **Apply** * Select **Today’s date** from the calendar | |
| 10 | Clinic selection; Ambulatory Organiser overview;  screen refresh | * Give **Ambulatory** **Organiser** overview – provides a simple, comprehensive view for ambulatory physicians and their staff to efficiently access and manage their outpatient clinic schedule * **Day View** - patients will appear according to selected criteria from appts booked in RPAS, allowing a view of patients’ details and their appt. status (confirmed, checked in, cancelled, DNA) * **Calendar** – to view all empty and booked slots by day or week * Explain timeline on right of screen. This displays all booked and empty slots for the selected date or week. Remind users that clinics 8 weeks or more in future may appear empty, this may be because The Booking Centre haven’t yet booked from their PTLs (holding lists) * **Trainer – don’t mention ‘Open Items’ or ‘Upcoming’ as these not often used per Jay Pudaruth, Cerner trainer** * Patients will either use the self-check-in kiosk or book in at reception, where admin staff will manually check patient into clinic and check/update demographics * Trainer: don’t give overview of **Message Centre** pane until later in the session | |
| 5 | Change patient status to **With Nurse**; patient selection | * **Status column:** once patient has been checked-in by Reception staff (or patient uses self-check-in kiosk), HCAs and nurses will change this to **With Nurse.** Colour of row will change as patient’s status is updated * **Notes** (non-clinical) can be created here. These are temporary, i.e. will **NOT** be saved in the patient’s record * Explain **timeline** on right of screen displays all booked and empty slots for the selected date or week * Scenario: **Patient 1, Sam Edley, MRN 1002866**, has been referred by GP to dermatology due to atopic eczema, and has a new appt. with Dr. B. Arun * The binoculars icon can be used to find the patient * This patient has been checked into clinic. Change the status of **Patient 1** to **With** **Nurse** * Status changes to green. Click on **Patient 1** to open their record. **This is the recommended way to open a pt. record** to ensure correct encounter selection, rather than use ‘patient search | |
| 5 | Record patient’s accessibility info alert | * If not previously recorded, the **Accessible info alert** will appear * Click **Access Info**, then select **Yes** if applicable (trainer to select ‘**yes’** in scenario) * Click **Add** (under ‘Problems’) * For the demo, add **hearing aid** * At ‘**classification’** select **accessibility** and click **OK** * At ‘**problem documented’** select **‘yes’** * Sign the form * Patient record opens in the **Nurse View** appears, displaying the patient’s chart * The previously saved accessibility form, and all other existing forms, can be viewed and edited in **left** **menu > Form Browser** | |
| 5 | Overview of Nurse View/Patient Banner/left Menu | * Give overview **Patient** **Banner**, i.e., documented allergies, demographics, CP-IS (child protection safeguarding), this encounter * Click patient’s name to display address and contact details * **Always check the Patient Banner contains the correct patient and encounter**. Explain encounter info. to the right of the Patient Banner – in this case the clinic appt. date/time/location is visible. User **MUST** ensure the correct encounter is visible. Other encounters can be viewed and selected via left click * Explain **left** **Menu**. Menu positions are fixed and cannot be adjusted * To display GP info., select **left menu > Patient Information > Care Provider Summary** tab * Some **safeguarding issues** can be identified in the **Patient** **Banner**, but all the patient’s documented safeguarding concerns are available for view in **left** **menu > Problem List** * PowerChart remembers the last nine patients (**recent** **patients** drop-down), even after the user logs off | |
| 5 | Configuring nurse view MPages and components | * **Nurse** **View** contains various nursing workflows, also known as **MPages** (i.e., Millennium Pages), and provides a consolidated view of information contained throughout the electronic medical record * If a required workflowis not present (e.g., Outpatient),click **+** at end of the row and select it. This can be dragged to the left so that it’s the first workflow that the user lands on * Workflows contain **components**. Give overview of some Outpatient workflow components, e.g., vital signs and home medications * Users can drag and drop components up and down according to preference | |
| 5 | Overview of useful components that allows the nurse to prepare for the patient’s appt. | * Give overview of the **Documents** component. This contains patient docs and notes that have been created in PowerChart, and also paper forms that have been scanned or uploaded into the system (e.g., patient questionnaires) * Docs can be previewed by selecting the required one. It will preview on the right-hand side in a pop out window * **Clinical** **Portal** is being discontinued so GP referrals via eRS (elec. referral system) will be uploaded to the **Documents** component * Give overview of the **Presenting complaints, History of presenting complaints,** and **Clinical summary** components. These are used to view clinical info. recorded by clinicians | |
| 10 | Recording obs; measure height and weight | * Explain OP staff will **NOT** use the Patientrack eObs. link in the toolbar as they’ll record all obs in PowerChart * Select the **Vital Signs** component and click the **plus (+)** icon * **Assessment/Fluid Balance** (aka **iView**) screen appears * Give brief overview of iView – assessments, etc. are stored in various bands to left of screen * **Vital Signs**should already be auto selected (this is under the **Adult Quick View** band) * **IMPORTANT: double-click the date/time column to activate it**. The user MUST do this to ensure anything that needs to calculate will be enabled (e.g., BMI and NEWS scores) * Additional date/time columns can be inserted via right-click but **MUST** be double-clicked to become activated * Any assessment questions in **blue text** are ‘reference text’ – user can click the text to display relevant info * Any assessment questions with an **arrow in a diamond** will trigger **conditional fields** – i.e. user to make appropriate selections based on recorded info.  |  |  | | --- | --- | | **Temperature** | **37.0** | | Under the **Adult Quick View** band,  select **Measurements:** | | | **Height/Length Measured** | **184cm** | | **Weight Measured** | **85kg** |   **Trainer to record the following obs. Use tab key to move down to the required obs.**   |  |  | | --- | --- | | **Respiratory Rate**: **17** | **17** | | **SpO2**: **98** | **98** | | **Sp02 Location**: **right hand** | **Right hand** | | **SBP/DBP Cuff** (systolic blood pressure/diastolic blood pressure) | **110/60** | | **Pulse** (heart rate monitored) | **80 bpm** | | **Consciousness (ACVPU)** | **Alert** |  * Press tab key - **BMI** is auto-calculated (will only do so providing the column is firstly double-clicked) * Click the **green tick** (top-left of screen) to sign the form (to quit, the user would click the blue X) * Click home icon to return to **Nurse View** * Refresh **Vital Signs** component to see this info. updated | |
| 10 | Recording urinalysis | * Urinalysis devices in PowerChart are known as ‘point of care’ devices. Process the urine sample as normal using the urinalysis device. The results from the receipt will need manually recording in PowerChart * Select the **Vital** **Signs** component and then click the header - **Assessments/Fluid Balance** (aka iView) opens * Select the left-hand **Point of Care Tests** band (NB - if this band isn’t listed, user will need to add it via View > Layout > Navigator Bands>move point of care testing to ‘current document types’>click OK>click exit>log back in) * Click **Urinalysis,** then **double-click** adjacent to ‘urinalysis’ to activate the column   IGNORE-NOT AVAILABLE IN TRAINING  IGNORE-NOT AVAILABLE IN TRAINING   * Record the values in fig. right * To save the urinalysis recording, click the **green tick** icon * Show options on right-click of this recording (e.g. view result details, modify, change date and time, unrecord, add comment). Click **home** icon to return to **Nurse View** * To see the saved urinalysis, select the **Vital** **Signs** component and click the header * **Review>Recent Results** opens | |
| 10 | Placing orders | * Inform nurses running nurse-led clinics (e.g., ‘derm. drug monitoring f/up’), they can use **New order entry** to request follow up appts. These will be scheduled (booked) by reception staff when the patient checks out, or by the Booking Centre * Select the **New order entry** component * Example - type ‘**derm. drug monitoring f/up’** in the **‘Search New Order Results’** field * The order is now placed in the **Orders for Signature** (shopping basket). A green number depicts the number of orders currently in the basket * Click thebasket (Orders For Signature) and then **Modify Details** button * The **Orders for Signature** screen appears. **Blue X’s** mean there are missing mandatory fields in those orders * Show how to create a **favourites** **folder** - right click the order and select **Add to Favourites**. The folder has now been created and this order has been added to it. Going forward, you can use the **star** **icon** to add further orders to your favourite folder (you cannot use the star icon until the folder has been created) * Complete the required details. Explain all yellow fields are mandatory. * Click **Sign.** Any order missing required field(s) will display a warning * The order has now been placed * Under the ‘**New** **order** **entry’** heading, open the tab named **Mine** (adjacent to ‘home’) - this is where your favourites are saved for easy access. To remove a favourite, click the star icon | |
| 5 | Viewing and managing orders | * Select **left menu > Requests/Care Plans** (advise users they can also click either the **New** **Order** **Entry** or **Order** **Profile** component headers to access **Requests/Care Plans)** * All placed orders are available to view here * Orders can be cancelled/discontinued or cancelled/reordered via right click, but user will still need to click **Orders** **For** **Signature**, modify and sign it | |
| 5 | Viewing docs and images | * To view scanned images (e.g., clinical photos) and body maps added to the record by clinicians, select the **Clinical Images** component * Double-click the required document or image to view it | |
| 15 | Auto text | * Select any free text box component and explain the **auto text** feature. This is available in most free text components and helps to speed up the transcribing process. **They all start with a special character** * Auto text can be added to PowerChart by the user. These sit under ‘**My** **Phrases’** and are only available to that user * Any auto text created by the trust for **all** **users** sits under ‘**Public** **Phrases’**   Using existing auto text (‘Public Phrases’)   * Click within the free text component and press the full stop key on keyboard (or other special character as defined by the abbreviation). Pe-existing auto texts will appear for selection * Trainer to press the full stop key, click on any auto text that appears and press enter * Once the auto text is in the body of the component, it can be edited by the user as required   Creating basic auto text (‘My Phrases’)   * Click the **Manage Auto Text** icon * To add a new one, click the **+Add** button * Explain all auto text **must** start with a special character, e.g., a dot (.) * **Trainer:** type **.atopic eczema** in the abbreviation field (remember that abbreviations are case sensitive) and a brief description in description field * **Trainer:** copy & paste this in free text field:   ‘*atopic eczema (atopic dermatitis) is the most common form of eczema, a condition that causes the skin to become itchy, dry and cracked’.*   * Click **Save** and close screen. This has been saved in **My** **Phrases**, which can be edited & deleted * Give demo of how this new one works - type ‘.**ato’** and the above text should appear * Explain there are more advanced auto text options, but these will be explained after go live | |
| 5 | Referrals to other specialties | * Explain that inpatient areas will use PowerChart to refer to other specialites, e.g. AHPs and CRIC. **Outpatients will not use this functionality.** If an OP user needs to refer to another treatment function (i.e. specialty), e.g. district nurse/safe guarding team, they will stick with their current processes which will be either via ICE or a manual referral | |
| 5 | Viewing home meds and clinic prescriptions | * Click **Home Meds** component to view patient’s home medications that have been documented by clinicians and pharmacy * To view **all** the patient’s meds, inc. those prescribed in clinic, select the **Medications and medical devices** component | |
| 5 | Configuring the MPTL | * Give an overview of the **MPTL** (multi patient task list): all outpatient prescription orders, where prescribers mark meds as **'clinic nurse to supply'**, will generate tasks in the **MPTL.** Once the nurse has supplied these meds, these tasks must be marked as ‘**done’** to remove them from the list * Click **MPTL** icon in the **Organiser** * Click the **Nurse Collect/Supply** tab * Explain the MPTL will need to be configured with the correct time frame and patient list before it can display the required tasks for those patients * To do this, click **Options** (above the Organiser) and ensure **Task View**, **Navigator** and **Indicators** are all ticked * From **Options**, select **Task List Properties** * Select the required time frame in the **Times Frames** tab. For the training session, click the **Generic** **Time** **Frame** radio button * Select the required time frame - trainer to select **From**: today’s date, time 00:00; **To**: 12 months from now * Click the **Patient** **List** tab and tick **Choose a Patient List** * Trainer to drop-down **All** **Locations**, drop-down **BGTH**, drop-down **BGH Area 7**, and select **BGH Dermatology Outpatient Department** * Click **OK** (tip - can also click **Save** so the selection is remembered for future) * Time frame has now updated in the right of the grey bar * Return to **Options** and select **Task** **Display** * Under **Status,** tick **Pending** (ensure ‘completed’ status is **unticked**, otherwise it will display all status completed within the configured time frame) * In the **Task** **Types** field, click **Clinic Nurse Supply** (this should now appear in ‘Chosen Task Types’) * Click **Save** and then **OK** * MPTL configuration is now complete | |
| 5 | MPTL – nurse to supply meds task | * A pending ‘clinic/ED nurse to supply meds’ task should appear for **Patient 1** * To find further info. about the task, right-click task, hover over **Open** **Patient** **Record**, and select **Requests/Care Plans** * Details of the med. (‘**salicylic acid topical 20% in emulsifying ointment’**) should be in the ‘**prescription’** section * Right-click on med. and select **Order Information** * Show some of these tabs. The **history** tabs shows who requested the med, date, time, etc. * Click exit icon in top left of screen * Return to **MPTL** and right-click the task for **Patient 1** * Show different options available, e.g., ‘record not done’ * In the scenario, the prescribed med. *has* been supplied, so select **Record Done** * Check/amend supply date and time if required, then click **OK** * Task is removed from list | |
| 15 | Administering meds in an OP clinic | * **Explain it’s essential that the Drug Chart in the left menu is opened before** using the **Medication** **Administration** **Wizard**, so the meds can be reviewed * Click **Drug** **Chart** in the **left menu** * Explain the drug chart itself must **NOT** be used for medicines administration as it does **NOT** support positive patient identification via casenote barcode scanning * Give overview of drug chart: where applicable, this will display scheduled meds (in this example **Bisoprolol 2.5mg, route - oral, once a day - morning**), unscheduled meds, already administered, still outstanding, etc. * Med. types can be ticked/unticked from **Time** **View** column as required * It’s best practice is to get the patient to take the medication BEFORE administering it in the **Medication** **Administration Wizard** window, otherwise this is difficult to undo * Click **Medication Administration** icon in the **Organiser.** The **Medication** **Administration Wizard** window opens * If available, the casenote barcode can be scanned, rather than inputting MRN or NHS number. **Before using the scanner**, show the workaround if there’s no scanner: * Click **Next**. In the **Override** **Reason** dialog box use the drop-down menu to select **No** **Scanner** **Available** you would click **Yes**… but click **No** in this scenario to demo the scanner * Scan the barcode on the patient’s wristband with a barcode scanner * In the scenario, the med. has been successfully administered (next scenario will show ‘not given’) * The patient has been prescribed **Bisoprolol 2.5mg**. Illustrate what happens when an **incorrect** product is scanned by scanning the **Bisoprolol 5mg** box. PowerChart *should* flag this as an error * Scan the correct **Bisoprolol 2.5mg** box, complete details as required and **Sign** * The med. is removed from **Meds. Admin. Wizard**. Close the wizard * Click **Refresh**. The medication and dosage has been documented as ‘**administered’** within the **Drug Chart** * Clinic nurse would then give patient the dose of Bisoprolol   Explain the following:  a) If the medication is being administered early or late (not PRN, i.e., as and when required), you will be prompted to give a reason before continuing.  b) If the dosage being administered is a value of more than one multiple, the barcode will need to be scanned the appropriate number of times  c) If the medication is administered parenterally (injected directly into the body), the user will be required to specify the site of administration | |
| 10 | Recording meds as not given | * In the **Drug Chart** (left menu), click the medication that is due to be administered (in scenario, the **Co-Dydramol 10mg**) * The ‘recording’ dialog box appears. Scroll down and tick the **Not Given** check box * Select an appropriate reason from the **Reason** drop-down list, e.g., ‘Patientrefused or declined’ * If required, click **Comment** and enter a comment as required * Click **OK** * Click **Sign** * Click **Refresh** * The medication administration has been recorded as ‘not given’ | |
| 10 | Amending Medication Administration | * In the **Drug Chart**, right-click the medication task to be modified (**Bisoprolol 2.5mg)** and select **Modify** * Amendthedetailsas required and click **Sign** * The medication administration details have now been modified | |
| 10 | Documenting procedures performed in clinic | **This Visit Procedures** component is used to document dressings, wound assessments, etc.  In the scenario the patient has had a dermabrasion of skin  Click the **This Visit Procedures <- Click Here** header/hyperlink  In the **Procedures** section, click **+Add**  In the **Procedure** section type ‘derm’, press enter, and double-click **dermabrasion of skin**  In the date and time fields, type T (today) and N (now). Complete the remaining fields and comments as required  Click **OK** (explain users can click **OK & Add New** to add further procedures)   * To view recorded procedures, open **left** **menu** and select **Diagnosis and Procedures**   There are numerous options on right-click, e.g., modify; view; remove | |
| 5 | Viewing outpatient appointments | * Open **left** **menu** * Click **Appointments** * This component is divided into future and past appts. It will also display cancellations and no shows (DNAs) | |
|  |  | * In the components navigator, click **Select** **Other Note** (under **Create** **Note** section) * **Note** **Type** **List** **Filter**: select **All**   Choose the required **Note** **Type**. Select **Nursing Progress Note**   * Choose the required **Note Template** on the right. In the scenario, select the **Outpatient** **Note** template and explain note templates are ‘**dynamic documents’**, i.e., will pull data from all other populated components * **IMPORTANT** - the user **MUST** select the correct note template as this will impact the contents of the dynamic document (i.e., which component headings will pull through onto the document) * Notes are saved in the **Documents** component of the patient’s record * When a note template is selected, it populates the **Title** field on the left   Show users they can set letter templates as favourites (click the star icon)   * Click **OK,** bottom right. Letter template appears * Check letter for accuracy and click **Sign/Submit** * Click **Sign** * Show delegates the **Free Text Note** template if they don’t want anything pulling from the patient’s record | |
| 10 | Using Message Centre | * Click **Message Centre** icon in **Organiser** and give overview of **Message Centre** functionality. Staff will be able to: * Read, reply, and compose new messages * Create reminders * View documents sent by colleagues for them to review and/or sign * View lab results for all tests the user ordered * Providing this has been set up and agreed, users will be able to proxy (i.e., access on behalf of) another user’s messages, create and send messages on their behalf. The inbox owner will get a message stating who did this & when * To send a new message, click the drop-down next to the **Communicate** icon in the Organiser and select **Message** (can also send reminders to yourself or a colleague) * **New Message** window appears * In the **Patient** field, enter forename(space)surname and press enter or use **binoculars** to use different criteria (RXR, MRN) * In the **To** field, enter details and press enter or use binoculars to display address book * **Staff**, **Pool, or Distribution List** can be chosen by using the applicable radio button * Trainer to select **Staff**, search for another training account, and click **Add** * Move to **Send to** and click **OK** * To save the message to patient’s chart,tick **Save to Record** * Can browse for docs within PowerChart or on their local PC to send with a message * Type subject and then your message. Auto text is also available * Show available actions at bottom of screen. Can set a due date (bottom right of screen) * Click **Send** * Click **Message** **Centre** in **Organiser** and refresh – message appears in **‘sent items’** * Show numerous options on right-click   **Documents** – when you sign a note, you have the option to forward that note on to a colleague, for them to review or sign. This is where that colleague will see those documents  **Results** – test results for orders you’ve placed  **Results FYI** – nurses that don’t have access to place orders will need to select the doctor they’re ordering on behalf of. Those results will appear here for those doctors  **Message** **Centre** is also available from **Ambulatory** **Organiser** | |
| **Delegates to take the training session assessment via the Learning Hub. The pass mark is 80%. Any delegate that fails to pass after three attempts will need to book onto another training session.** | | | |
| **All delegates other than pre-op nurses can now leave the session** | | | |
|  | Completing a pre-op assessment form | * Click the **AdHoc** icon in the **Organiser** * Open the **Surgery** folder * Tick **Adult Preoperative Assessment** and click **Record** (this form can also be used for paeds) * Explain the form contains several sections, these are in tabs to the left of the screen * Any tab with a red asterisk contains mandatory fields. The ‘**sign’** icon in top left of screen will remain greyed out until this is done * Complete the form as required * Trainer to save the form part way through, using the save icon (floppy disk) in top left of screen, to show it can be returned to later and completed * Open the **left menu** and click **Form Browser** * Double-click the **Adult Preoperative Assessment** form to open it * Once all mandatory fields have been completed, click **Sign** in the top left of screen | |