Emergency Department Assessment and Documentation Guidelines with CST Cerner

Site Applicability

Lions Gate Hospital Emergency Department

Basic: RN, RPN, LPN

Requirements

Documentation of assessments, as outlined in this guideline, must be completed in Cerner

Need to Know

This guideline outlines the expectations for documentation and assessments for patients of various acuities in the emergency department. This guideline is not for use during downtime (see Code Grey guideline for downtime procedures).

Quick Links

Appendices

Guideline

Standard of Documentation

Below are documentation standards based on national CTAS guidelines and in alignment with the other emergency departments of the Lower Mainland.

Vital Sign and Frequency

*****Vital signs by itself is not considered ongoing documentation*****

CTAS	Physician to see *CTAS time goals	Vital signs		Head-to-toe	Focused assessment
		Initially/Until Seen by Provider	***Reassessment Once Seen by Provider***		
1	Immediately	Continuous	q 30min-1h	Initially and once per shift	q2h
2	15 mins	q 15min	q 1h		
3	30 mins	q 30 min	q 2h		
4	60 mins*	q 6o min	q 2h		Initially and q2h
5	120 mins*	Initially and q 2h			

Admitted patients and/or Area of Unit				
	Vital Signs	**Head-to-toe**	**Focused Assessment**	**Neurovitals**
Acute	q2h or if patient condition indicates	Once per shift/On arrival	q 2h	Once per shift/On arrival or if patient condition indicates
Critical Care/Resuscitations/Trauma	q5-15mins until stable then q 1h or if patient condition indicates		q 1h	q 1h or if patient condition indicates
First Aid	q2h or if patient condition indicates	CTAS 1-3 or if patient condition indicates	q 2h	CTAS 1-3 or if patient condition indicates

Intake	q2h or if patient condition indicates	CTAS 1-3 or if patient condition indicates	q 2h	Once per shift/On arrival or if patient condition indicates
Med/Surg	q 4h or if patient condition indicates	Once per shift/On arrival	q 2h	
Psych	Once per shift or if condition changes	Initially or if condition changes	q 2h	
Telemetry	q 2h or if patient condition indicates	Once per shift/On arrival	q 2h	Once per shift/On arrival or if patient condition indicates

General Emergency Nursing Standards of Care for Documentation (In Alphabetic Order)

- These are requirements for all patients in the department and in all areas.

Topic	Where to find in Cerner	Activities
Allergies	Under allergies Firstnet Triage Document	Verify allergies (even if it was checked at triage), update allergy band as needed
Chief Complaint		Write a chief complaint/mechanism of injury on **every** patient regardless of length of stay or reason for visit. For pediatrics, please see Chief Complaint for Peds Acceptable Emergency Nursing Framework Standards for this include: LOTARP • **L location** of pain • **onset** of pain (rapid/slow) • **T type** of pain (i.e. crushing, stabbing, also determine severity on 1-10 scale) • **A associated/aggravating** factors • **R radiating/relieving** factors • **P precipitating** factors ***OR***

		PQRST • **P precipitating** factors • **Q quality** of pain • **R region or radiation** of pain • **S severity** (rating on scale) • **T the time** the pain occurred
Clinical Comments	Located under Interactive View and I&O Choose the Clinical Comments	Used: • To report a subjective report on the patient's status at regular intervals during the patient's stay o See "Vital Sign and Frequency" for frequency • To clearly highlight the patient's condition *or* to summarize a focused assessment for other staff members • When patient is relocated to another area of the ED or when transfer of accountability (TOA) occurs • When a particular IView field cannot be found in a timely manner
ED Initial Assessment	Under IView ED Adult Systems Assessment ED Initial Assessment	This section may be used as part of ongoing documentation to quickly document ABCs (Airway, Breathing, Circulation)
End-of-shift	Orders Tab	During handover, patient orders are to be reviewed with oncoming staff including: • Any nursing tasks that are outstanding • Any medications that are pending • Any communication orders
Indigenous Navigator		Ensure that the patient has been asked whether they wish to self-identify and if they have, consider indigenous navigator
Interventions	**ED Adult Interventions** or **ED Pediatric Interventions** band.	Document interventions as soon as intervention is done. Refer to SHOP for documentation guidelines for specific interventions, otherwise guidelines per *Elsevier Clinical Skills* prevail. (*USERNAME:* VCH, *PASSWORD:* vch)

Line Interventions	**ED Lines** band	Document lines (IV, NG. Chest Tubes, Foley, Central Lines, etc.) under ED Lines band. Do not use clinical comments for line interventions. Refer to SHOP for specific documentation guidelines otherwise. To document under ED Lines include the following: • Size and type of line • Location, measurements • Number of attempts • Securement • Condition of line (e.g. patent, infusing, draining, etc.) • Patient's response (e.g. tolerated)
Medical History	Under Diagnoses and Problems	Review medical history recorded in triage and add anything additional to initial assessment/visit reason flagged annotation

Screening	Screening tool list Under *AdHoc* tab	On arrival, complete the **ED Screening - Adult (or Pediatrics)**, including:
		• Sepsis Screen
		• Falls risk screen
		• Violence risk screen
		• Sexual Assault screen
		• Suicide risk screen (**for MH patients and patients whose current presentation warrants a suicide risk screen**)
		• Social history
		  ○ Alcohol
		  ○ Tobacco
		  ○ Substance use

Task clean-up	ED launch point then hover over Nurse activities	It is the responsibility of the nurse who reviews a task to ensure that it is documented against or moved from the task list. • Tasks that are no longer required, they should be removed prior to shift change. • Tasks that are/were accidentally removed should be re-added.
Vital Signs	Under IView ED Adult Systems Assessment Vital Signs	See "Vital Sign and Frequency" for frequency based on CTAS and/or area of unit. • Blood Pressure(BP) • Heart Rate (HR) • Oxygen Saturation (SpO2) • Respiratory Rate (RR)

		• Temperature (T) • GCS (Glasgow Coma Scale) • Capillary Blood Glucose (CBG) (if diabetic and clinically relevant) • For Pediatrics: Weight in kilograms (KG) *****Vital signs by itself is not considered ongoing documentation*****

Area Documentation

Requirements

In addition to General Emergency Nursing Standards of Care for Documentation, these are requirements for certain areas of the department.

Triage

Topic	Where to find in Cerner	Complete
Triage note		Complete a triage note, regardless of LOS or reason for visit
Triage location	"comments" column in Launchpoint	Acute Waiting Room (ACWR) - used for patients who are registered but have not been triaged. Patients are moved to a different location once triaged—care space or different waiting area. ACWR - If no acute care space is available and the patient is waiting in the main waiting room (MWR), the patient will be placed electronically under MWR stretcher #1..2..3. which is noted under the "comments" column in ***Launchpoint***
Triage Documentation	Firstnet Triage document	**For ALL patients**: • Complaint Orientated Triage (COT) Descriptor • CTAS score • Emergency Nursing Standards of Care for Documentation **For direct to care space patients**: • Deferred triage must be completed by primary nurse • ADE risk screen - select "unable to obtain" • Infectious Disease risk screen - select "unable to obtain" • COT Descriptor • CTAS score

Resuscitations and Trauma

Topic	Where to find in Cerner	Activities
Applicable areas		All areas of the ED
Documentation		The Nurse Team leader or dedicated charting RN must document any interventions, including medication administration performed by another RN or MD (indicate name and title), patient's subjective or objective response (i.e. changes in vital signs)
Use of Cerner with paper documents	Indicate on Cerner under ***Flagged Annotation*** that nursing documentation is currently done on paper.	Whenever paper documents are used for nursing documentation (i.e. trauma form, or resuscitation form), charting does not occur concurrently in the Cerner system. Transition from paper to Cerner at SHIFT CHANGE or upon transfer to a different nursing unit (**unless patient remains unstable**). The following will need to be transcribed: • The latest set of vital signs • The latest set of pertinent assessment findings • Any antibiotics administered • Any ongoing infusions (e.g. vasopressors) • All lines (ie. IV, CVC, foley, NG, chest tubes, etc) • Total intake and output volumes All other items (such as Advanced Cardiac Life Support (ACLS) medications, shocks, physician interventions) do not need to be recorded in Cerner if it is already documented on paper.
Cardiac Arrest (**in-patients in ED**)		All patients are to be documented on CODE BLUE documentation.
Unstable patient (including out-of-hospital arrests)	**Emergency Nurses Progress Note** or **Emergency Nurses Assessment Note** or as a **Freetext Note** within Cerner.	Use <time> - <description> format. Chart in narrative form. Example: 0824-patient has increased work of breathing, audible stridors, physician called, RT paged. 0829- O2 78% on RA, patient placed in DTU 4, preparing for intubation.

Medications and Blood Products	On **PAPER** and/or **Freetext Note** within Cerner	Recommended that medications and blood products are written in ALL-CAPs. *Example:* "AMIODARONE 150mg IV given to IV in left arm."
CTAS 1-3 Trauma		Use the **Trauma Nursing Assessment Record**

Acute Care

Topic	Where to find in Cerner	Complete
Applicable areas		Resus, DTU, AC 201-219, any admitted patients in Intake/First Aid aid/ACACWR during overcapacity

Documentation Frequency		Documentation should be done AT MINIMUM q1-2h for all patients in an acute area (more frequently, if required).
		Documentation includes any of the following:
		• Completing the initial assessment
		• Documenting the ED adult assessment under one of the following areas:
		  ○ ED Initial Assessment
		  ○ Clinical comment
		  ○ Flagged annotations
		  ○ *Any* applicable section of iView other than Vital Signs
		• Documenting an intervention in ED Adult/Pediatric Interventions or ED lines

Reason for visit/Initial Assessment	The **standard and recommended location** of initial assessment/reason for visit is as a **flagged annotation** in one of the early time columns in iView.	Write a visit reason (history) on every patient in an acute care area, regardless of length of stay or chief complaint. Acceptable Emergency Nursing Framework Standards for this include LOTARP **OR** PQRST.
Head-to-Toe Assessment	Under **ED Assessment - Adult** form	Document a complete head-to-toe assessment on arrival, at shift change, and as needed The minimum requirements for head-to-toe (with relevant **IView** sections in brackets) are: • Airway (Primary Airway Assessment)

Head-to-Toe (continued)	Relevant **iView** sections in brackets	○ Airway patency • Breathing (Respiratory) ○ Respiratory assessment ○ Respiratory sounds • Cardiovascular (Cardiovascular) ○ Cardiac assessment ○ Heart sounds ○ Edema • Neurological (Neurological) ○ GCS, +/- Level of Consciousness (LOC) ○ Pupils ○ Hand grips ○ Leg strength • Gastrointestinal (Gastrointestinal) ○ Abdominal sounds ○ Abdominal assessment ○ Last bowel movement • Genitourinary (Genitourinary) ○ Urinary assessment ○ Last urinary assessment ○ Last menstrual period (for females of child-bearing age) • Psychosocial (Psychosocial)

Intake

Topic	Activities
Applicable Areas	Intake ****(see Acute Care for patients admitted but placed in intake due to overcapacity)****
Documentation Frequency	Documentation should be done: • On arrival • When any assessment is performed • With any intervention that is done • Document the time communication occurred between the provider and nurse. If any patient's stay is prolonged (waiting for consults, waiting for tests or awaiting results), a status update in ***Clinical comment*** or any relevant ***IView*** section should be done q2h.
Focused Assessment	Detailed nursing assessment of specific body system(s) related to the chief complaint or presenting problem and can be recorded in either: • The chief complaint (on arrival - in a **flagged annotation**)

	• **ED Initial Assessment** - document ABCs Relevant section of IView (preferred)

First Aid

Topic	Activities
Applicable Areas	First Aid (FA) **(see Acute Care for patients admitted but placed in first aid due to overcapacity)**
Documentation Frequency	Documentation should be done: • When any assessment is performed • With any intervention that is done If any patient's stay is prolonged (waiting for consults, or awaiting results), a status update in ***Clinical comment*** or any relevant ***iView*** section should be done q2h.
Focused Assessment	Detailed nursing assessment of specific body system(s) related to the chief complaint or presenting problem and can be recorded in either: • The chief complaint (on arrival - in a **flagged annotation** for history**,** ***iView*** for assessment findings**,**) • **ED Initial Assessment** - document ABCs Relevant section of IView (preferred)
Vital Signs	If performing a **Procedural Sedation** in First aid, see SHOP for documentation guidelines.

Pediatrics (PEWS)

Topic	Activities
Applicable Areas	In all ED areas
Documentation Frequency	Primary assessment RN is responsible for assessing the patient and repeating Vital Signs and PEWS. • RN is responsible for alerting the physician as per PEWS protocol PEWS Escalation Aid. For documentation and re-assessment guidelines, refer to the PEWS protocol
Pediatric Early Warning System (PEWS)	Initially done at triage and then q 2h with Vital Signs

Chief Complaint for Peds	Write a chief complaint/mechanism of injury on **every** pediatric patient regardless of length of stay or reason for visit. Acceptable Emergency Nursing Framework Standards for this include: CIAMPEDS: • **C chief** complaint • **I immunizations** • **A allergies** • **M medications** • **P past** medical history • **E events** surrounding illness or injury • **D diet and diapers** • **S symptoms** associated with illness or injury
Pediatric Assessment Triangle (PAT)	Initially done and then q 2H • **Airway & Appearance** – Tone, Interactive, Consolability, Look or Gaze, and Speech or Cry. • **Breathing** – Work of breathing • **Circulation** – Skin colour and skin perfusion (such as pallor, cyanosis, or mottling)
Weight	Should be done initially at triage with VS and recorded in kilograms (kg).

Mental Health

Required

- All mental health patients require a suicide screen on arrival
- A Mental Status Exam (MSE) which includes affect, behavior and cognition must be completed on arrival and at shift change
- Reference: Psychiatric Emergency Assessment & Treatment (PEAT) Documentation Guidelines

Topic	Where to find in Cerner	Activities
Applicable area		All areas of the ED
Mental Health Act(MHA) Documents		**MHA Form 4** and **6** are electronically available All other MHA forms are paper based including **Form 5, 13, 15**, and **16** and can be found in Form Fast. • **Form 4** and **5** to be completed by a physician

Assessment and Mental Status Exam		A **head-to-toe assessment** should be done initially. A *focused* assessment (*focused* assessment is a detailed nursing assessment of specific body system(s) related to the chief complaint or presenting problem) should be done q 2h or if patient condition indicates it should be more frequent (such as in the case of an overdose secondary to a suicide attempt/ideation). Complete a Mental Status Exam (MSE) for mental health patients governing three areas of assessment under **Mental Status Exam** in the **ED Mental health**: • Affect (i.e. the patient's appearance, eye contact) • Behavior (i.e. observable actions, speech) • Cognition (i.e. thoughts, feelings, insight) The MSE is completed on arrival, at shift change, and with any significant changes to the patient's presentation.
Clinical Comments		In addition, note the time that Mental Health Stability Unit RN (MHSU) or psychiatry was paged and/or consulted.
Suicide Screen and assessment	This is conducted with the **ED Screening - Adult.**	All MH patients require a suicide screen on arrival (can be done at triage and communicated to primary RN). Notify Patient Care Coordinator (PCC)/Pivot RN and PENN RN if ***positive*** screen and acute care space is not available immediately. Facilitate security sitter watch as appropriate.
Close Observation		All patients certified under the Mental Health Act in the ED are automatically on q 15min close observation. Including circulation, sensation, movement (CSM) checks when chemical/physical restraints are in use. Document under **Behaviour Log** in the **ED Mental Health** band OR under **Clinical Comment.** • Patient location • Patient activity

Restraints: Mechanical, Chemical, Environmental

Requirements

****All patients who are in restraints must have a Provider's Order in Cerner****

Topic	Where to find in Cerner	Activities
Applicable areas		In Acute Care/Resuscitation
Orders for Restraint		A Prescriber's Order must be obtained for all patients who are in restraints. A nurse may take a verbal for a restraint order. A nurse may also place patients in restraints without an order in an *Emergency Code White* situation and then obtain an order within an hour of the event taking place
Restraint Documentation	Relevant sections in iView under **ED Mental Health** band, **Restraints** section	Please refer to restraint guideline on specifics related to the different types of restraints: Mechanical, Chemical, Environmental VCH Guideline: Restraints Document all assessments (i.e. relevant components of MSE) prior to initiation of restraints. **On initiation of restraints** complete: • Restraint prevention • Restraint initiation • Restraint information **Ongoing** complete: • Restraint monitoring • Restraint evaluation • Nursing Narrative Note with frequency: ○ q 1hr for patients in physical restraints ○ q 2hr for patients in quiet room ○ Titling convention Date, Shift, and "Restraints"
	Document in **Restraints Monitoring** and **Restraints Evaluation** Sections.	**q15min** assessment for the duration of physical and environmental restraints. **q15min x2; q 30min x2; then q 1h** assessment for chemical restraints ONLY. **On Discontinuation** complete: • Restraint Information

		• Restraint Education • Restraint Debriefing See also Close Observation under Mental Health Act section above

Discharge and Admission

Requirements

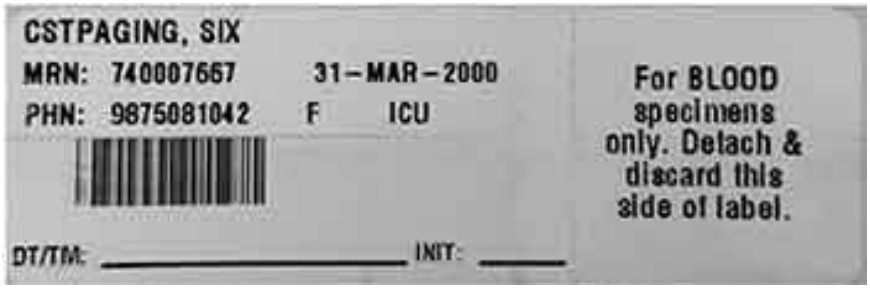
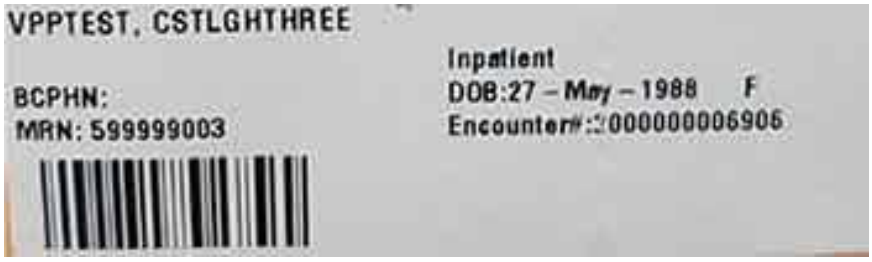
Topic	Activities
Applicable areas	All areas of the ED
Review prior to discharge and admission	Prior to any discharge or admission transfer, nurses are expected to review any outstanding tasks or medications that need to be completed and ensure the relevant individuals (UCs, receiving nurse) are aware of the task.
Discharge Documentation	Ensure under **ED Lines** - any IVs or Foleys, etc. that were inserted and removed and not required upon discharge are documented as such. Ensure discharge instructions have been provided. If initial vital signs are out of range for the patient's baseline, prior to discharge by an RN and/or LPN a reassessment of vital signs and a focused assessment should be completed and documented. Under **Disposition Documentation** for ***Discharge***, all relevant fields should be completed before the patient is removed from Launchpoint • Document a *free text* note in **Discharge Comments** if the patient is discharged by the physician prior to RN or LPN discharge instructions or reassessment vital signs and/or focused assessment
Admission Documentation	Complete the *Valuables/Belongings* form Complete a *Transport Ticket*. Under **Disposition Documentation** for ***Admit,*** all relevant fields should be completed.
Pre-Op Checklist	The Pre-Op Checklist must be completed as thoroughly as possible for any patients going to the operating room or for endoscopy.

	Presently additional COVID-19 screening form must be completed and can be found in **Ad Hoc.*
Have you considered…?	Things to consider when the patient initially presents to ED to start the discharge process: • Indigenous Navigator • OT/PT/SLP • CML • Social Worker

Communication

Topic	Activities
Applicable areas	All areas of the ED
Launchpoint comments	Use the "Nursing comment" field for any important comments that are relevant to nursing only that may assist in patient flow and organization. Use the "Staff comment" field for comments relevant to all staff members; typically any consults, reminders, timing of diagnostic tests, non-urgent requests for physicians. **Patient Summary Page** can be used to view detailed patient information including all flagged annotations and clinical comments. ******This is not an area for legal documentation ******
Situational Awareness and Team Communication	This is not used in the ED, but consulting services may enter information in this section when a patient is admitted so it should be reviewed regularly. This is found under "**Patient Summary - ED Handoff Tool**" ******This is not an area for legal documentation and is removed after the chart has been discharged. ******

QUICK REFERENCE: LABELS

Description	Label
Armband Label	
Blood Specimen	
Non-Blood Specimen	
Chart Label	

ORDER STATUS

Status	Description
Cancelled	Order was terminated before it started
Completed	Order has reached its stop date/time or the associated task was completed
Discontinued	Order was terminated after it has been completed at least once
Future	Order is scheduled for a future visit
Incomplete	Order is entered but has required fields that do not have information
In Process	Order has a preliminary result and is awaiting a final result

PROCESS ALERTS DESCRIPTION (See CERNER Help for additional Process Alerts)

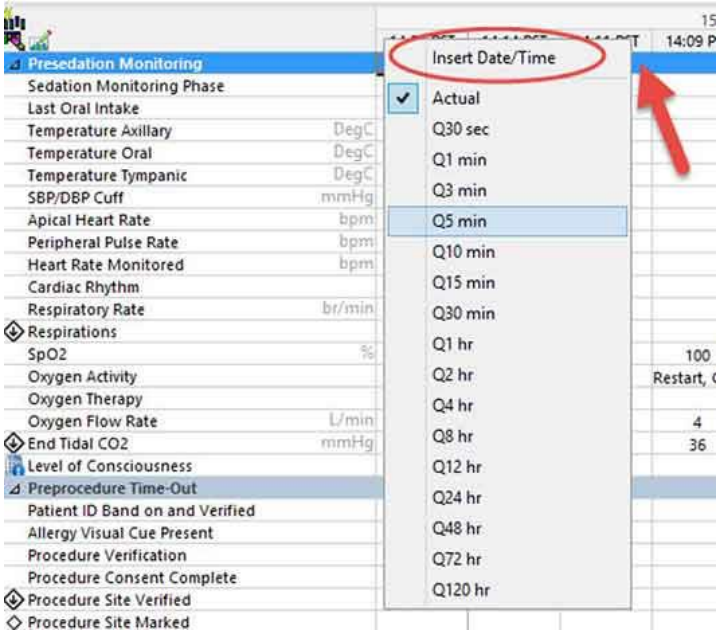
Status	Description	When to Add	When to Remove
Falls Risk	Patient has been assessed for falls risk and has been found to have an increased risk of falls	When the assessment has been completed and the patient is found to be at risk of falling	When the assessment has been completed and the patient is found to NOT be at risk of falling
Isolation Precaution	Patient has been assessed for infectious disease and has been identified to need isolation precautions initiated	Anytime the patient self identifies as having an infectious disease (ie. MRSA, TB, Influenza-like illness, etc.) or when the staff recognize potential infectious symptoms on assessment	When the assessment has been completed and the patient is found NOT to be an infectious disease risk—after consultation with physician and/or infection control practitioner
Communication Barrier	Factors causing a barrier to clear communication with the patient. This could include sensory deficits such as deafness, being mute, having a language barrier, or cognitive deficit that makes communication a challenge	When clinical assessment has found that there is a challenge to communication between the patient and caregivers that could impact their care	If the challenges in communication are resolved or are no longer present

Seizure Precautions	The patient is at risk of having seizure activity and precautions are in place to ensure their safety in the event of a seizure	When precautions are requested or put in place to ensure patient safety	If or when the precautions for safety during a seizure can be removed
Cytotoxic Precautions	The patient is within the cytotoxic precautions period after having received a cytotoxic medication	When the patient has received a cytotoxic medication as per policy	When the precautionary period that is indicated in policy has elapsed, often 48 hours after the last dose
Palliative Alert	Flagged by the palliative care program to indicate that the patient is receiving palliative care processes. If Palliative Alert not in place when patient arrives in ED, it can be placed manually or on *Launchpoint* by the ED Unit Clerk.	The Palliative Care program will apply this alert when they enroll the patient. This alert may not be applied by others outside of that process. It may take time for this alert to show on CERNER.	The Palliative Care program will manage this alert if it needs to be removed. This alert may not be removed by others outside of that process
Violence Risk	The patient has been assessed and has been found to have an increased risk of violence using the standardized tool for assessment	When a risk has been assessed and a violence alert care plan has been documented	When the patient has been assessed and found to not be at risk
Difficult Airway or Intubation	The patient has physiological components that limit their airway or could pose challenges during intubation	When a risk has been assessed and the information about a difficult intubation or airway needs to be communicated	If or when the airway components are resolved and no longer pose a risk
Special Care Plan	A care plan is in place that spans across care settings (e.g. Familiar Faces)	When the care plan is established and needs to be communicated across encounters or care settings	When the care plan is no longer in place and the alert can be removed

No Ceiling Lift	The patient is not to be lifted using an overhead lifting device. This is to communicate across care settings	When it is determined that patient-specific components restrict the use of an overhead lift	When the restriction on lifting devices can be removed safely
On Research Study	The patient is currently participating in a research study and that information needs to be known across care teams	Research coordinators/nurses will apply this alert when the patient begins participating in a clinical research study	When a patient is no longer participating in a clinical research study, the alert will be removed
Visitor Restrictions	The patient prefers to restrict visitors at this time. This is used in conjunction with registration functions to communicate visitor restrictions	When visitor restrictions are implemented, the documentation and alert will be put in place	When visitor restrictions are no longer needed, the alert may be removed

ADJUSTING TIME COLUMNS

In some instances, you may be required to *insert* a time column into iView, or to automatically create time intervals to complete your charting. To do this, right-click on the time row in iView and the following will pop-up:



- Selecting Insert Date/Time will add a custom date/time field to iView

- Selecting any of the time intervals will automatically convert the iView time columns to time intervals. For example, selecting Q15 min will cause iView to display time columns of 10:00-10:14, 10:15-10:29, and so forth. To change back to real-time charting, select "Actual".

References

This document has been adapted from: In draft SPH ED Documentation Guidelines with CST CERNER (2020).

Accreditation Canada. (2019). Standards Emergency Department.

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Canadian Association of Emergency Physicians. (1998). Implementation guidelines for the Canadian Emergency Department Triage and Acuity Scale (CTAS). Retrieved on January 26, 2021 from: http://ctas-phctas.ca/wp-content/uploads/2018/05/ctased16_98.pdf

Considine, J., Potter, R., & Jenkins, J. (2006). Can written nursing practice standards improve documentation of initial assessment of ED patients. Retrieved on January 26, 2021 from: https://www.sciencedirect.com/science/article/pii/S1574626706000243?casa_token=FUT74qhGQDYAAAAA:0_EvdUWZyTRuoG4dGIWGFNGDkKnGz3DjVKoFZXh2FYPlDog-x-kU5NoCMSmCiXXCJ1rxR4zMYoA

Horeczko, T., Enriquez, B., McGrath, N. E., Gausche-Hill, M., & Lewis, R. J. (2013). The Pediatric Assessment Triangle: accuracy of its application by nurses in the triage of children. *Journal of emergency nursing*, *39*(2), 182–189. https://doi.org/10.1016/j.jen.2011.12.020

Vafaei, S.M., Mazari, Z.S., & Heydari, A., et. Al. (2018). Nurses' perception of nursing services documentation barriers: a qualitative approach. *Electronic Journal of General Medicine,15(3)*, 1-8.

Related Documents

Medication Administration and Bar Code Scanning: http://shop.healthcarebc.ca/CST_Documents/CSTMedicationAdministrationPolicy.pdf

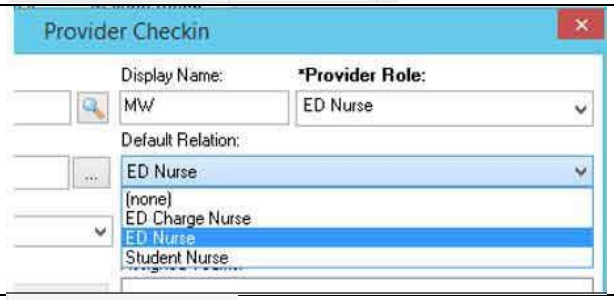
Nurse Initiated Activities: http://shop.healthcarebc.ca/PHCPHSAVCH/BCD-11-11-40001.pdf

Appendices

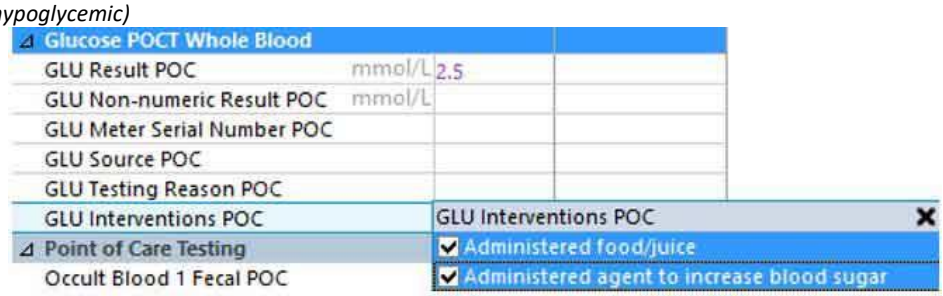
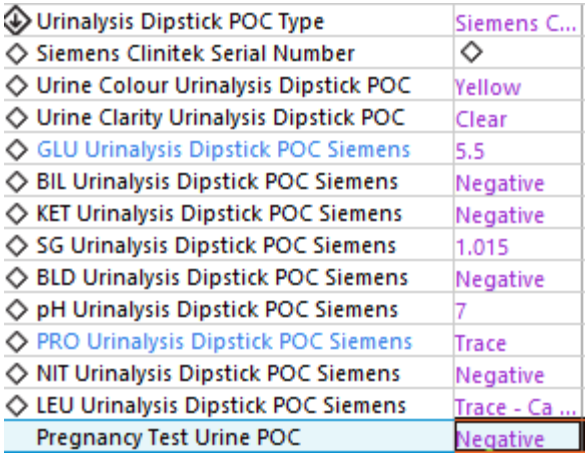
Appendix A: DAILY SHIFT ROUTINES

Topic	Description
Start of Shift	Ensure in appropriate location (LGH Emergency Department, LGH ED Hold) • Check-in to the system as ED Nurse
When Receiving a Patient*	• Assign self to patients

*Assigning self to patients in FA and INTAKE can help the physicians with communicating with the most responsible nurse involved in a patient's care

SCREENSHOTS/EXAMPLES	
	
Provider Role and Default Relation should be ED Nurse	
Click on the column next to the patient's name (EDMD MLP RN) to assign self to patient	

Appendix B: COLLECTING BLOOD/URINE SPECIMENS

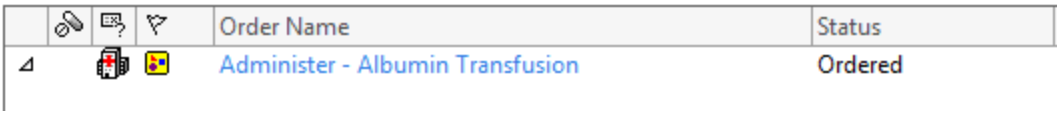
Topic	Activities
Point-of-Care Blood Glucose	Document in iView: ED Adult Interventions > Glucose POCT Whole Blood GLU Result POC *Or* GLU Non-numeric Result POC GLU Interventions POC (*if hypoglycemic)* 
Point-of-Care Urine Testing	Document in IView: ED Adult Interventions > Point of Care Testing Urinalysis Dipstick POC Type: choose “Clinitek Status” or “Siemens Multistix 10SG” Fill in lab parameters Pregnancy Test Urine POC (if applicable) Dispose of Clinitek printout 
Specimens for Lab	If patient is unstable, collect bloodwork and label containers with the Cerner-generated labels and ensure the following are written on the label: • Collection time/date • Initials • Specimen source • Ensure orders are back-entered into the system.
Arterial Blood Gases (ABG)	The ABG order will print a requisition; to re-print the requisition, right-click the ABG order in the Order Profile and select Reprint Requisition If ABG is collected prior to order entry, ensure “Collected: Yes” is selected in the order entry details when placing the order

Appendix C: BLOOD TRANSFUSIONS

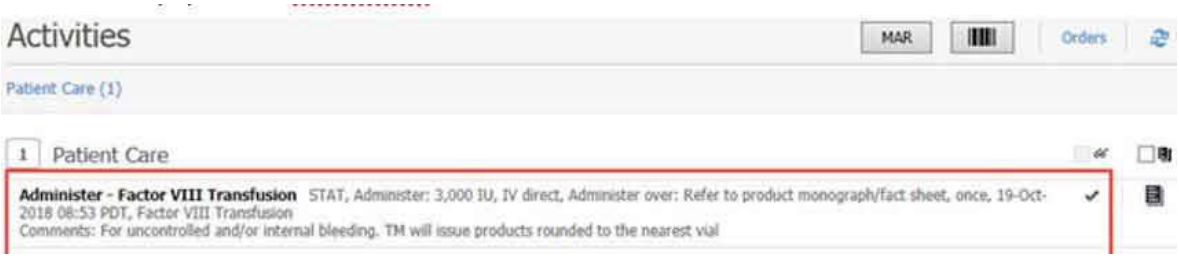
Refer to Blood Components/Products: Administration Procedure

For the purposes of *start time*, *stop time*, *transfusionist*, and *witness*, the blood bank transfusion record is the source of truth. All other documentation will be done in iView.

The order for blood products is Administer - <Blood Product> Transfusion. For example:

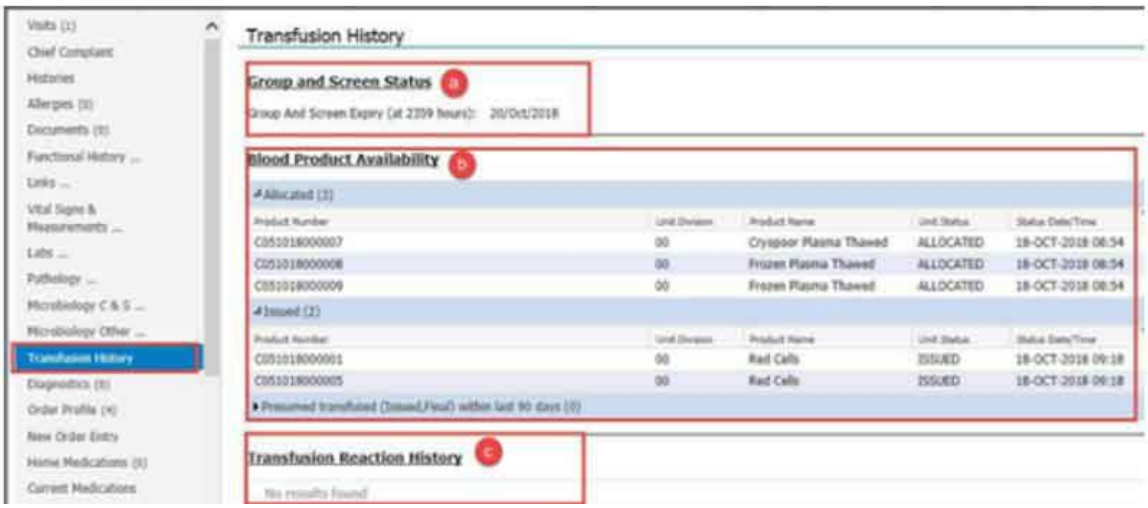


A task should populate in LaunchPoint.

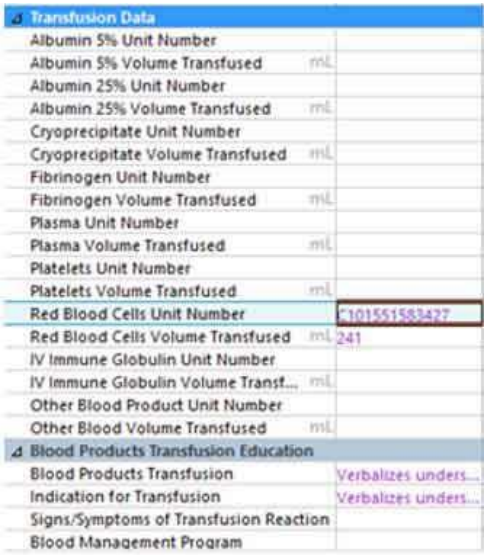


Do NOT complete this task until all units have been transfused.

In the patient's chart, the ED workflow tab in the Patient Summary will have a section for *Transfusion History*:



If there's a current Group and Screen, it will show in the area labelled "A". When the blood product is ready, it will show in the area labelled "B" (including any blood products that have already been issued. If the patient has a history of a transfusion reaction, it will show in "C".

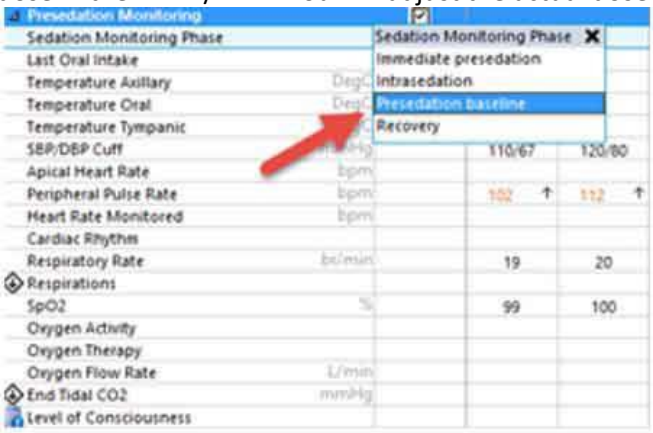
Topic	Activities
Obtaining Blood Products	When the transfusion history indicates blood products are ready, let the UC know and they will print out the requisition to give the porter. If there is no UC, head to the order profile, right click on the blood product order, and reprint requisition.
Initiating Infusions	Chart vital signs in iView: Blood Product Administration > Vital Signs Document the transfusionist, witness, and start time on the Transfusion Record Document the unit number of volume in bag in iView: Blood Product Administration > Transfusion Data Document transfusion education in iView: Blood Product Administration > Indication for Transfusion
Monitoring Infusion	Continue to chart vital signs in IView 15-minutes after starting infusion Every hour
Ending Infusion	Document end time on the Transfusion Record  If infusion was stopped early, modify volume transfused in IView: Blood Product Administration > Transfusion Data Once all units have been transfused, complete the task in LaunchPoint
Transfusion Reaction	Review the Blood/Blood Product: Transfusion Reaction Identification and Management Procedure Order the TM Transfusion Reaction Module (with "No Cosignature Required") on the patient. Note that the transfusion reaction form remains on paper and still needs to be completed and sent to transfusion medicine.

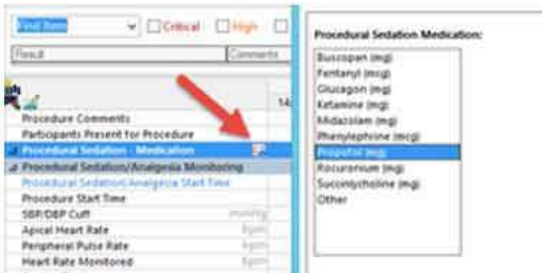
Appendix D: PROCEDURAL SEDATION

In Cerner workflow, there are four parts to procedural sedation:

1. Pre-Sedation Monitoring
2. Pre-Procedure Time-Out
3. The Procedure
4. Post-Sedation Monitoring

In iView, all documentation occurs in the **ED Procedural Sedation** band.

Topic	Activities
Pre-Sedation Monitoring	Document patient's baseline into iView ED Procedural Sedation > Pre-Sedation Monitoring Sedation Monitoring Phase: "Pre-Sedation baseline" Last Oral Intake Vital Signs (HR, RR, O2, SpO2, End Tidal CO2) Obtain the medications being used for the procedural sedation and sign for the total dose in the MAW/MAR. You will adjust the actual dose later. 

Pre-Procedure Time-Out	Ensure team and patient is aware of the procedure being performed and document into iView: ED Procedural Sedation > Pre-Procedure Time-Out: Procedure Verification Procedure Consent Complete Procedure Site Verified Procedure Comments: enter procedure being completed here Participants Present for Procedure  At this time, each medication should be added as a Dynamic Group under ED Procedural Sedation > Procedural Sedation - Medication 
Procedure Monitoring	Procedural Sedation/Analgesia starts when the first dose of sedation agent is given. Vital signs should be monitored **q5min** after each sedation medication. Document medications given and the current running total under ED Procedural Sedation > Procedural Sedation - Medications Document continuing monitoring in IView: ED Procedural Sedation > Procedural Sedation/Analgesia Monitoring: Procedural Sedation/Analgesia Start Time (time first sedation dose given) Procedure Start Time (time procedure actually started) Vital Signs (HR, RR, O2, SpO2, EtCO2).

Post-Procedure Monitoring	Once the procedure has finished, sedation monitoring should begin. Under ED Procedural Sedation > Sedation Scales: Sedation Scale Used: choose "Modified Aldrete Score" Complete Modified Aldrete Score – score should be calculated automatically ***Reminder: for discontinuing 1:1 monitoring, patient requires a score of 8 and above in** the **Modified Aldrete Score; reassess q15mins if scoring below 8*** Once patient scores 8 and above, continue to assess the Modified Aldrete Score and the three Discharge Criteria under ED Procedural Sedation > Discharge Criteria ***Reminder: criteria for discharge is a score of 13-16 from the sum of the Modified Aldrete Score plus the Discharge Criteria, with a total of 10 in the Modified Aldrete Score; reassess q15mins if does not meet this score*.** Complete the post-sedation monitoring data under ED Procedural Sedation > Postsedation Monitoring: Sedation Monitoring Phase: choose "Recovery" Procedure Stop Time (time procedure stopped) Sedation Stop Time (time patient recovers from sedation) Vital Signs (HR, RR, O2, SpO2)
Post-Procedure Medication Charting	Reconcile the charted medications by going to the MAR and *modifying* each medication's dose. Under "dose", change the number to the actual dose given during the procedure Sign

Appendix E: INTAKE/FIRST AID AND MSK ASSESSMENTS

Topic	Activities
Ambulation and Walk Tests	Chart in IView: ED Adult Interventions > Ambulate Ambulation assist Ambulation results Ambulation tolerance
Musculoskeletal Assessments	Chart in iView: ED Adult Systems Assessment > MUSCULOSKELETAL and create a dynamic group for each musculoskeletal injury group Chart as appropriate
Visual Acuity Scores	Chart in iView: ED Adult Systems Assessment > EENT Right eye symptoms Left eye symptoms Right eye visual acuity Left eye visual acuity Right eye visual acuity with correction Left eye visual acuity with correction

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Owners: *(optional)*	VCH
	Developer Lead: • Professional Practice Initiatives Lead, Coastal