

Inpatient Nursing Student

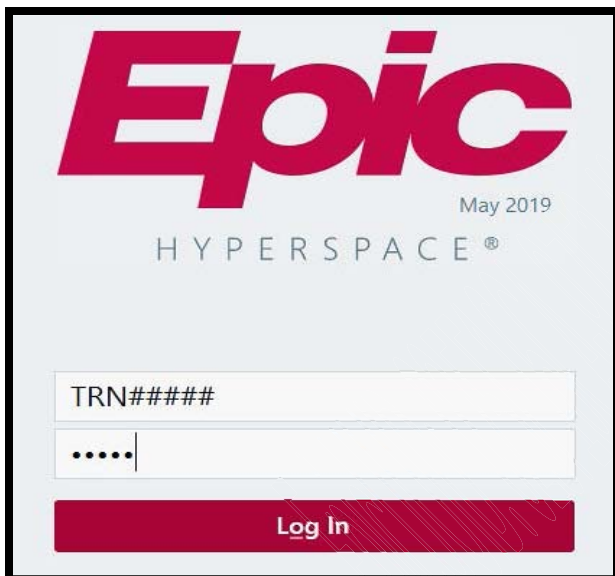
Begin Your Shift.....	2-7
Log in to Hyperspace.....	2
Sign In and Assign Yourself to Patients.....	3-4
My Lists vs Available Lists	5
Update Your Patient List Columns	6
Patient List Reports.....	7
Open the Patient Chart.....	8-10
Storyboard and Summary Reports	8
Chart Review and Result Review	9-10
Work List	10
Collect a Specimen.....	11-12
Document Vitals and an Assessments	13-14
Document Vitals and an Assessment.....	13-14
Assess Existing Lines, Drains, and Airways (LDAs)	14-15
Document Intake and Output and Review Reports.....	15-16
Add, Remove and Complete an LDA.....	15-18
Document Intake/Output	18-19
Administer Medications.....	20-23
Administer Medication and Edit	20-21
Administer a Multit-Dose Package.....	21
Administer a Vaccination and Update Immunizations	22
Administer a Med with a Ranged Dose	22-23
Administer a Med with a Partial Package.....	23
Receive a patient.....	24
Find a new patient and Take Over Patient Assignments.....	24
Navigators	25-26
Specimen Collection	25
Signed and held Orders/Unreconciled Orders	25
Overview of the Admission and Discharge table of contents	26
Extras.....	27-31
Start and Stop an IV Medicaiton.....	27-28
Manage Lines using the LDA Avatar	28-30
Manages Lines using Flowsheets.....	30-31

Begin your shift

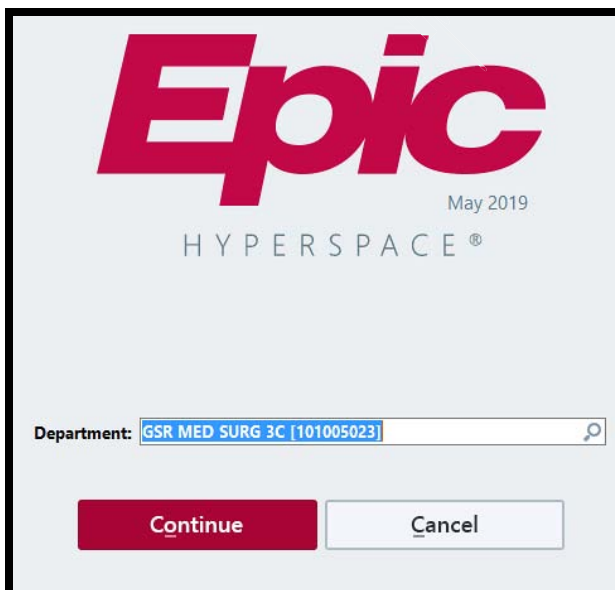
1. Log in to hyperspace.
2. Sign In and assign yourself to the patients you will be caring for this shift.
3. Get report and find out what's going on with your patients.
4. Plan for your shift.

Log in to Hyperspace

- **User ID:** Enter the **TRN number** on your tent card and press **Tab**.
- **Password:** Type **Train** and press **Enter** or click Log In.
- **Department:** GSR <spacebar> 3C
- ❖ The last department you logged into appears by default. You can search for a different department if you're logging in somewhere else.
- **Message of the Day:** Press **enter** or click OK



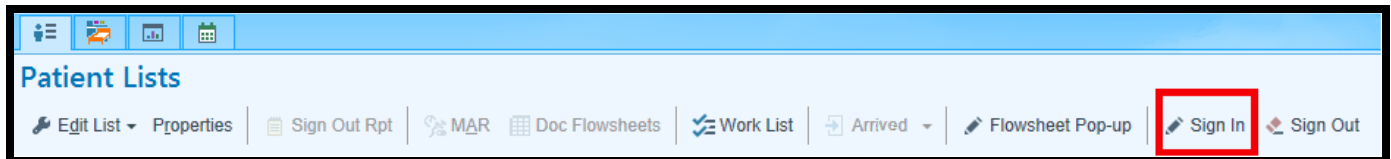
The image shows the Epic Hyperspace login screen. At the top is the Epic logo in red, with "May 2019" and "HYPERSPACE®" below it. There are two input fields: the first is labeled "TRN#####" and the second is masked with ".....". Below these fields is a red button with the text "Log In".



The image shows the Epic Hyperspace department selection screen. At the top is the Epic logo in red, with "May 2019" and "HYPERSPACE®" below it. Below the logo is a label "Department:" followed by a search box containing the text "GSR MED SURG 3C [101005023]". At the bottom are two buttons: a red "Continue" button and a white "Cancel" button.

Sign In and Assign Yourself to Patients

- The first thing we need to do is **Sign In** to indicate that we're here and taking over care of the patients. The **Sign In** activity makes it easy for managers and other clinicians to identify and contact a patient's caregivers.
- ❖ It is recommended that both the Precepting RN and Nursing Student assign themselves to patients.
- You are automatically signed out 30 minutes after your shift ends – at that point, your patient assignments end, and those patients no longer appear on your **My Patient List**.
- A **Sign In** window opened automatically when you logged in.
- ❖ If you closed it, click **Sign In** on the toolbar to reopen it.



1. Enter your typical shift information in the top section of the window.
 - **Start:** 0700
 - **End:** will auto populate when shift length is selected
 - **Shift length:** Click 12H
 - **Contact number or extension:**
 - ❖ If you're entering an extension, use # at the beginning
2. Next, add your department.
 - Type in the department: **GSR 3C Med Surg** and press **enter**

A screenshot of the 'Sign In' window. The window has a title bar that says 'Sign In'. On the left, there is a form with fields for 'Start' (0700), 'End' (1900), 'Contact #' (541-768-7609), and 'Comment'. There are also buttons for '4H', '6H', '8H', and '12H' (selected), and 'Phone' and 'Pager'. On the right, there are fields for 'Role' (Nursing Student) and 'Service' (—). A red arrow labeled 'Step 1' points to the 'Contact #' field. Below the form, there is a 'Departments' section. A red arrow labeled 'Step 2' points to a search box containing 'gsr' and a dropdown menu showing 'Recent' results, including 'GSR MED SURG 3C [101005023]'. The search box and dropdown are highlighted with a red rectangular box.

- Find all the patients with the last name from your classroom tent card and click the box next to the patient's name.
- Click **Sign In**.

The screenshot shows a list of patients in a table. A red box highlights a group of five patients, and a red arrow labeled 'Step 3' points to this box. At the bottom, another red arrow labeled 'Step 4' points to the 'Sign In (5 Patients)' button.

<input type="checkbox"/>	Patient Name	Room-Bed	MRN
<input type="checkbox"/>	Animal, TwoGeorge Alan <i>Male, 72 y.o., 08/05/1947</i>	G3201-G3201-89	10163220
<input checked="" type="checkbox"/>	Anjou, Bianca <i>Female, 32 y.o., 02/05/1988</i>	TRN ClinDoc MS-Med Surg 3C	310000010
<input checked="" type="checkbox"/>	Anjou, Carter <i>Male, 26 y.o., 02/06/1994</i>	TRN ClinDoc MS-Med Surg 3C	301000010
<input checked="" type="checkbox"/>	Anjou, Jace <i>Male, 17 y.o., 12/09/2002</i>	TRN ClinDoc MS-Med Surg 3C	303000010
<input checked="" type="checkbox"/>	Anjou, Lyle <i>Male, 45 y.o., 12/18/1974</i>	TRN ClinDoc MS-Med Surg 3C	208000010
<input checked="" type="checkbox"/>	Anjou, Molly <i>Female, 18 y.o., 02/06/2002</i>	TRN ClinDoc MS-Med Surg 3C	304000010
<input type="checkbox"/>	anjoupear, Bianca <i>Female, 32 y.o., 02/05/1988</i>	TRN ClinDoc MS-Med Surg 3C	310000032
<input type="checkbox"/>	Antelope, George Alan <i>Male, 72 y.o., 08/05/1947</i>	G3201-G3201-38	10163490
<input type="checkbox"/>	Apple, Bianca <i>Female, 32 y.o., 02/05/1988</i>	TRN ClinDoc MS-Med Surg 3C	310000011

At the bottom right, there is a button labeled 'Sign In (5 Patients)' with a green checkmark icon, and a 'Cancel' button with a red X icon.

❖ To find your patients easier, you can click the Patient column title to alphabetize your list

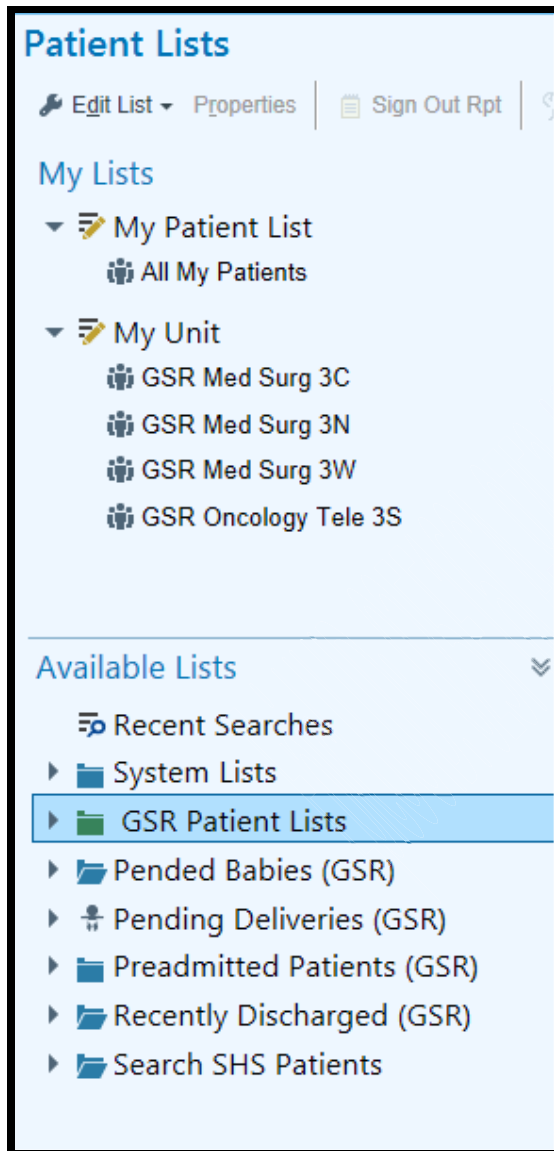
The screenshot shows the header of a patient list. The 'Patient' column title is highlighted with a red box. To the right, it says '0 Patients Selected' and 'Select all'. There are also 'X' and 'up arrow' icons.

<input checked="" type="checkbox"/> GSR MED SURG 3C	0 Patients Selected	Select all	X	up arrow
Patient	Room-Bed	MRN	Currently Assigned	

- ❖ If you receive additional patients during your shift from new admits or transfers, click the Sign In activity again, place a check mark next to the patient to assign them to yourself, and click the Update Sign In at the bottom to complete. Your patient assignments are now updated.
- ❖ If a patient is transferred out of your care, click the Sign In activity, uncheck the box next to the patient's name to unassign yourself from the patient's treatment team and click the Update Sign In button.
- ❖ If you are ending your shift early, click the Sign Out activity on the toolbar. You will automatically be unassigned all patients that you assigned yourself to.

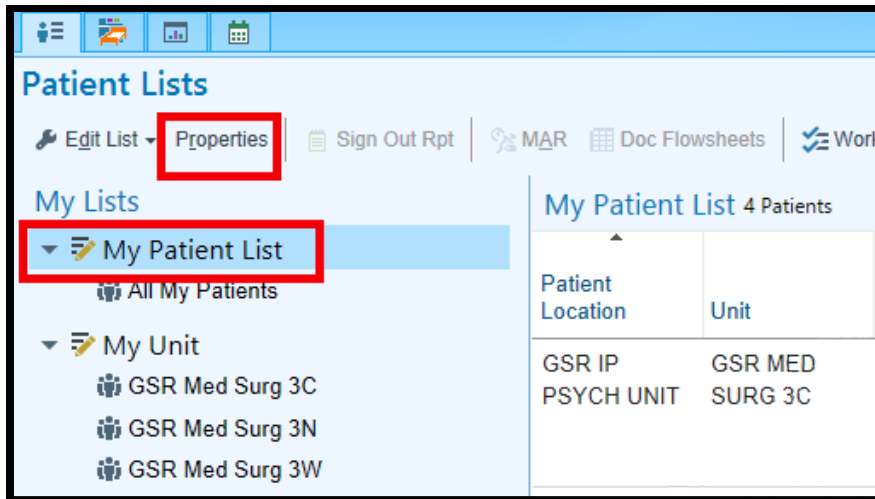
My Lists vs Available Lists

- The **My List** section contains lists of patients you are keeping track of. The **My Patient List** displays the patients that you assigned yourself to at the beginning of your shift when you did the **Sign In** activity. The **My Unit List** contains departments that you have added from The **Available Lists** section.
- The **Available List** section contains lists of patients that the system updates and maintains based on certain criteria, such as Recently Discharged. You can use the Recently Discharged system lists to find patients who were discharged within certain time periods (24HR, 3Day, 7Day). The available list will default to the site based on the department you are logged in as.

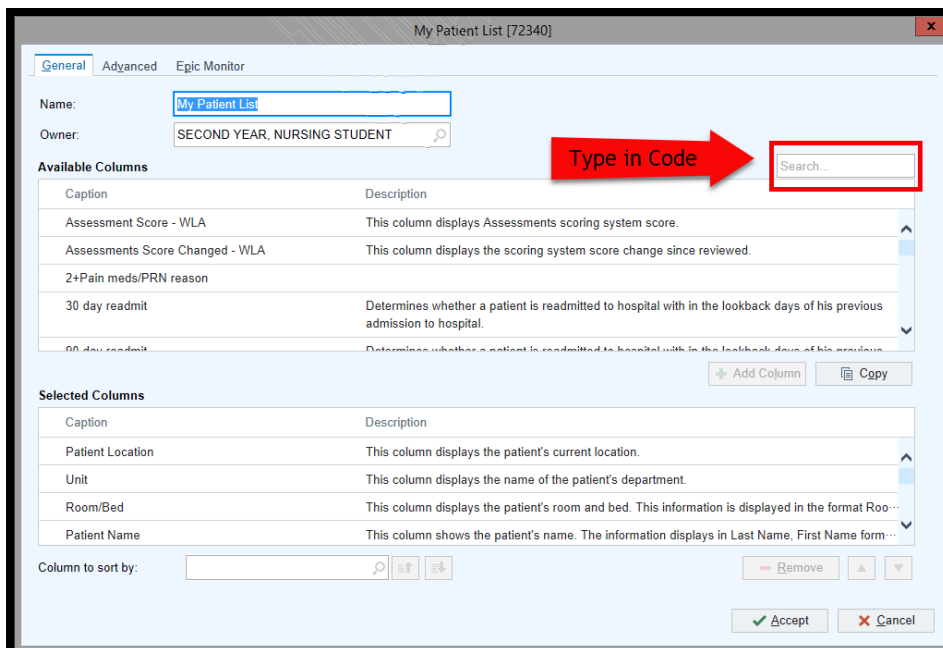


Update your Patient List columns

- You can add, rearrange, or remove columns in lists you create to make it easier to find the information you use most often.
- Select your **My Patient List** and click **Properties**.



- To add a new column to your list, select the column from the list of Available Columns and click **+ Add Column**.
- To save time scrolling through a long list of available columns, use the Search field to look up columns by keyword, such as **Code**.
- To remove a column you no longer want to appear in your list, select the column from the list of Selected Columns and click **- Remove**. Note that some list templates have required columns, which you can't remove.
- To rearrange the order of the columns in your list, select a column in the Selected Columns list and use the arrow buttons to move it up or down.
- Click **Accept** to save your changes.



Patient List reports

- Patient List reports give you a quick view of a patient without opening the chart.
- Use the wrench to customize your default Patient List reports. You can:
 - Make the reports you use most appear as buttons on the toolbar, so you don't need to search for them.
 - Change the order in which reports appear on the toolbar.
- Note that you can't remove the Profile report button because it's required.
- From Patient Lists, single click on the patient you want to view reports on.
- Type in **Long** and press enter (this brings up the Longitudinal Plan of Care report).

The screenshot shows the 'Patient Lists' interface. On the left, there's a sidebar with 'My Lists' and 'Available Lists'. The main area displays 'My Patient List' with 4 patients. The first patient, 'Anjou, Lyle', is highlighted. Below the list, there's a search bar with the text 'Longitudinal Plan of Care' entered. A red arrow points to the search bar with the text 'Type Long'.

Patient Location	Unit	Room/Bed	Patient Name	Age/Gender	Problem	Coc Stat	Med Over	New Flag	Reassess	Pain	Shil Rec	Adr Rec
GSR IP PSYCH UNIT	GSR MED SURG 3C	TRN ClinDoc MS/Med Surg 3C	Anjou, Lyle	45 y.o. / M	Hypertension (Additional Hospital Problems)	F...	—	—	—	—	—	—
GSR MED SURG 3C	GSR MED SURG 3C	TRN ClinDoc MS/Med Surg 3C	Anjou, Jace	17 y.o. / M	Pneumonia (Principal Hospital Problem)	N...	—	—	—	—	—	—

- Then click the wrench button and click the **Add Current** button.
- Note that the **Longitudinal Plan of Care** report is now added to the list.
- Click **Accept**.
- ❖ You can use the arrows to change the order of reports as well as remove reports that you may not use by selecting the report and click remove.

The screenshot shows the 'Add or Remove Buttons from Toolbar' dialog box. It has a 'Default Report' field set to 'Profile'. Below it is a table with columns 'Report' and 'Button Name'. The third row is highlighted with a red box, showing 'Longitudinal Plan of Care' in both columns. At the bottom, there are four buttons: 'Add Current', 'Remove', 'Accept', and 'Cancel'. The 'Add Current' and 'Accept' buttons are highlighted with red boxes.

Report	Button Name
1 Profile	Profile
2 Due Meds	Due Meds
3 Longitudinal Plan of Care	Longitudinal Plan of Care
4	

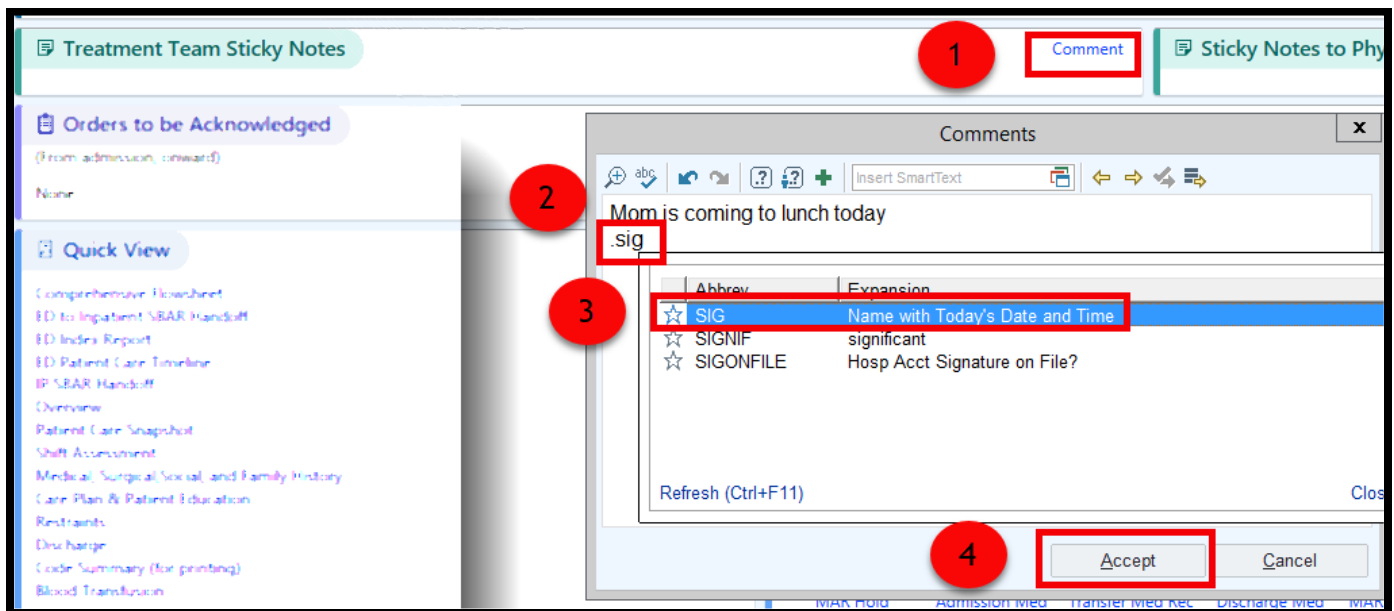
Open the Patient Chart

Storyboard

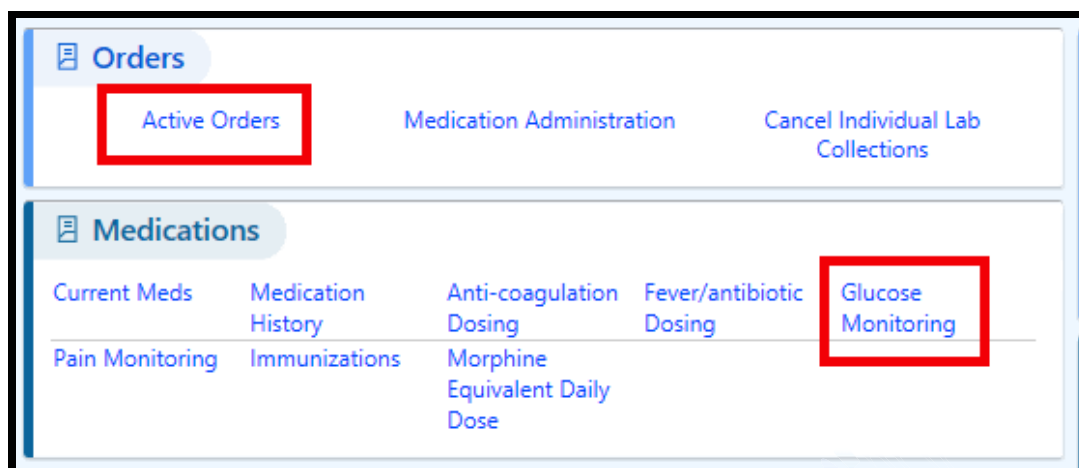
- On the left side of the patient chart, Storyboard helps you review basic patient information from anywhere in chart.
- Storyboard is interactive:
 - You can hover to see additional information.
 - You can click items to open the relevant activity.

Summary Reports

- When you open any patient's chart, the first activity you see is the **Summary** activity.
- Like the **Patient List** reports, **Summary** reports pull information from the rest of the chart and provide a lot of patient information in one place.
- The **Index report** is where you can:
 - View **Orders to be Acknowledged**.
 - In Epic, acknowledging an order means you've seen the order.
 - If clarification is needed, call the provider.
 - Ancillary orders are acknowledged by both nurse and ancillary provider.
 - For example, PT orders are acknowledged by the nurse and by the physical therapist.
 - This workflow ensures that both the nurse and ancillary provider are aware of the orders.
 - You can acknowledge orders one at a time, or all at once.
 - Click the order name if you need more information.
 - Take a moment to review the orders.
 - Write a **Sticky Note**.
 - ❖ **.Sig** is a **SmartPhrase** (a shortcut for your signature stamp).



- View **Active Orders** and **Reprint lab labels**
- **Glucose Monitoring Report**



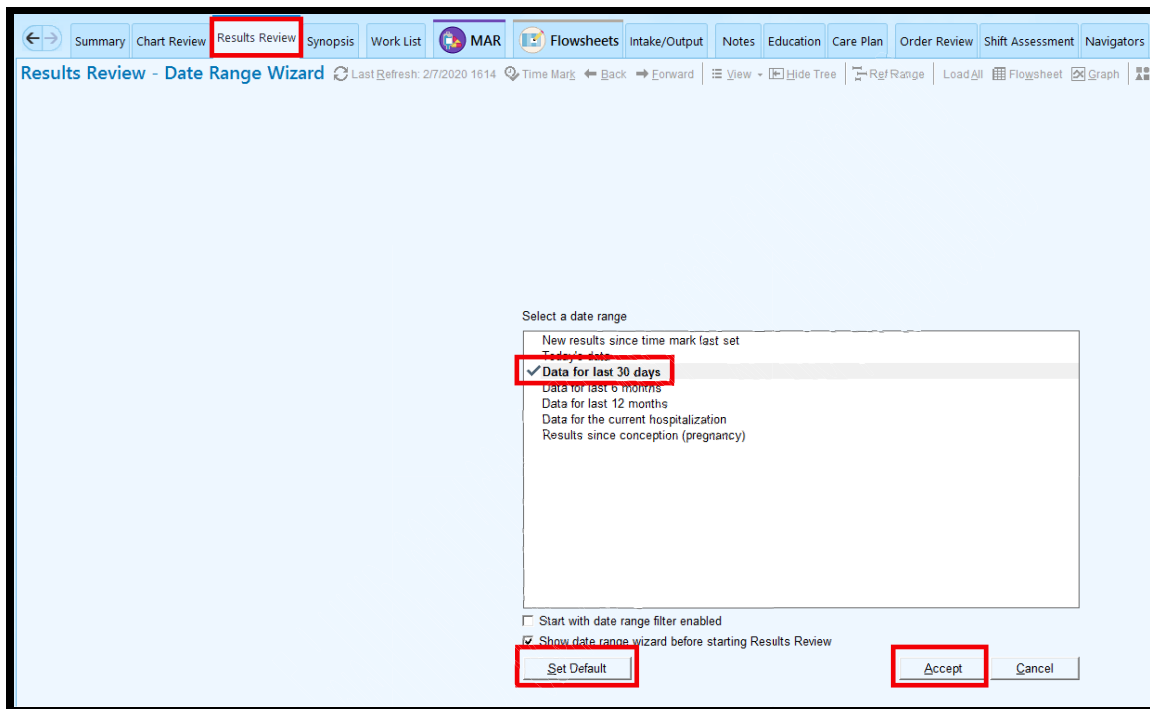
- The **Overview** report gives you a high-level view of the current admission. Information is organized into sections, such as vitals, labs, and medications.
 - Scroll through the **Overview** report, notice that some section headers have arrows next to them.
 - This means they're links. Hover to discover where the links will take you.
- The **Event Log** report is a helpful way to get caught up on the care the patient has received during their inpatient stay. Use the **Event Log** to view relevant events and documentation that have occurred during the admission and related visits.
 - Hover over an event to see a preview, such as trending information for a lab result.
 - Click an event to see more information, such as the full text of the note.
- Just like Patient List reports, you can use the **wrench** to add reports or change the order that the reports appear.
- Note that you can't remove the Index report because it's required.

Chart Review

- Quickly gather information about your patient from previous visits and admissions in the **Chart Review** activity.
 - **Chart Review** sorts documentation in the patient's chart into different tabs based on set criteria.
 - **Encounters**
 - **Notes**
 - **Medications**
 - **Labs**
 - **Card Proc**
 - **Letters**
 - **Media**

Results Review

- You can quickly find the most relevant lab results in **Results Review** by using default date ranges.
 - After you set a default date range, you will see data from this date range any time you open **Results Review** for any of your patients.
 - If you ever want to change the default date range, repeat these steps.
- Open your **Jace** patient's chart.
- Click on the **Results Review** Tab
- Select a date range.
- Click **Set Default** to save for future.
- Click **Accept**.

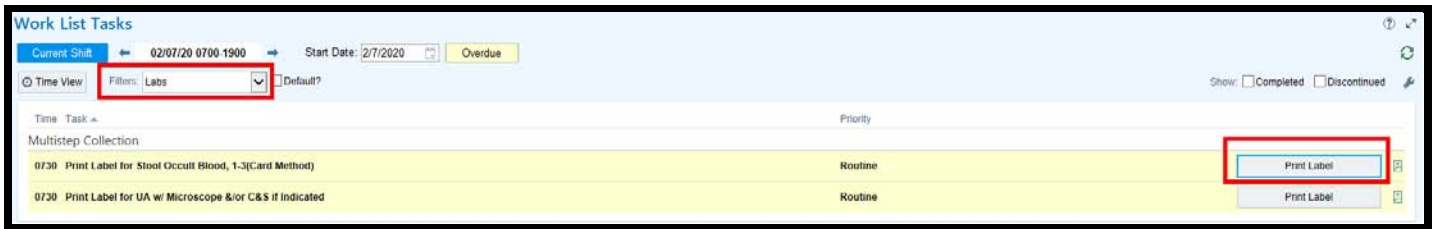


Work List

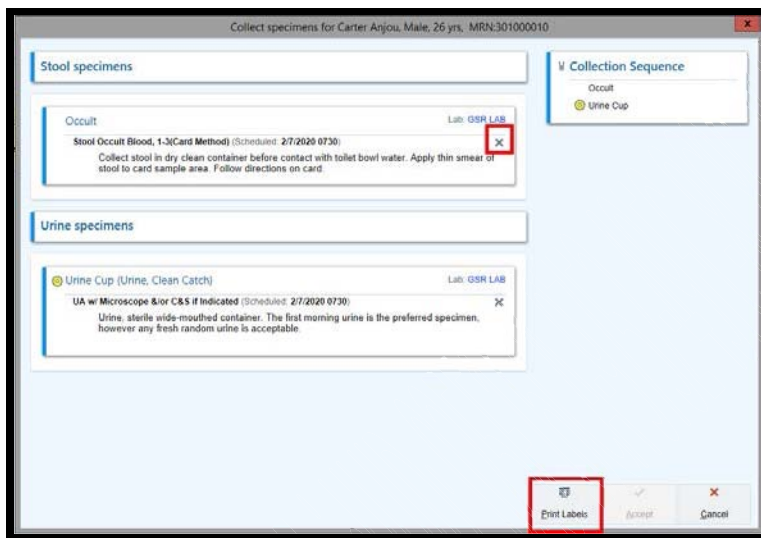
- Open your **Carter** patient's chart and click the **Work List** tab.
- You can change the way tasks appear and filter the tasks using the options at the top of the Work List. For example, you can:
 - Click the yellow Overdue button to see only the Overdue tasks.
 - If you're looking for tasks you completed already, use the Complete and Discontinued check boxes.
 - Select Labs in the **Filters** drop down menu to see only upcoming Labs on your **Work List**.
- Applying filters and changing views doesn't complete tasks but can help you manage tasks.
- How do you complete tasks on the **Work List**?
 - Complete the documentation in another activity. For example, if you administer a scheduled dose of a med from the MAR, the Work List task is automatically completed.
 - From the **Work List**, click Document or Complete to either complete the documentation or mark the task as complete.

Collect a Specimen

- We'll print labels and document the collection of a UA from the chart, since we have it open.
- ❖ You will want to Scan the patient's barcode to verify that you are working with the correct patient.
- Click **Print Label**.



- In the specimen collection window, you can see the specimens that need to be collected.
- ❖ To remove any specimens you are not collecting from the list, click the X in the corner
- Click **Print Labels**. Labels will not print today in the training environment.



- At this point, you'd go get the labels from the printer.
- Close the window to simulate logging out.
- Notice that the task button now says **Collect** instead of **Print Label**.
- ❖ Hint: You might need to exit the Work List and return to refresh the button name.
- Click **Collect**.

- Notice that the **Print Labels** button now says **Reprint Labels**.
- ❖ You can reprint the labels if they printed incorrectly.
- If there are any specific instructions, they appear on the specimen card.
- Normally, we'd scan the specimen label at this point.
- ❖ Because this is a training environment, we don't have specimen labels. Also, sometimes barcodes are smudged, or scanners aren't working. Here's how you'd proceed in those situations.
- Click the link called [Scan the label](#) or [click to document the collection](#).
- Verify that the collection information is correct:
 - Date and time
 - Collector
 - Collection unit
 - Specimen type
- ❖ You must document this collection information, or the lab won't be able to process the specimen.
- Click **Accept**.
- ❖ Notice the task drops off the Work List after it's complete.

Collect specimens for Carter Anjou, Male, 26 yrs, MRN:301000010

Urine specimens

Urine Cup 20G-038U0001 Lab: GSR LAB

1749 2/7/2020 SECOND YEAR, NURSING STUDENT Add Comment

Urine Draw type GSR MED SURG 3C

Urine, Clean Catch Urine, Clean Catch Urine Straight Cath Urine Minicath Urine Foley

Urine, Catheter

UA w/ Microscope &/or C&S if Indicated (Scheduled: 2/7/2020 0730)

Urine, sterile wide-mouthed container. The first morning urine is the preferred specimen, however any fresh random urine is acceptable.

Collection Sequence

Urine Cup 20G-038U0001.1

✓ All collections documented

Reprint Labels Accept Cancel

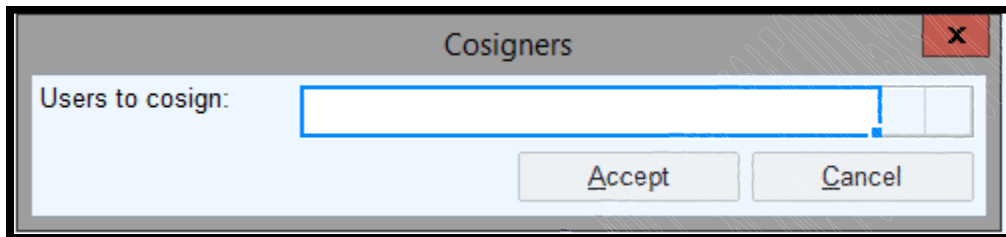
Documenting vitals and assessments

- You took vitals and performed a respiratory assessment on your **Carter** patient. Now you want to document it. In this section you will learn to:
 - Document vital signs in flowsheets
 - Document a respiratory assessment using cascading rows
 - Assess and LDA (lines, wounds, drains, and airways)
 - Add an LDA using the LDA Avatar
 - Document Intake/Output

Overview of Flowsheets

➤ Open **Flowsheets**.

- ❖ As a Nursing Student you will need to enter a Cosigner. You will enter your Preceptor's Name, but for training today we will use IPRN.



- At the top, you see a list of tabs for different flowsheets (Vitals, Assessments, etc.)
- On the left, there's a table of contents.
- Click a section to jump to it - helpful for long flowsheets
- For example, click Height/Weight to move directly to the Height and Weight group.
- In the center, you can see the rows and columns where you'll record documentation.
 - ❖ Each column is a time.
- On the right, the flowsheet sidebar shows details about the row you have selected.
 - ❖ Some rows have options you can choose from in the sidebar.


	1m	5m	10m	15m	30m	1h	2h	4h	8h	24h
Temp	1212									1000
Temp src										
Heart Rate										
SPO2 Pulse Rate										
Heart Rate Source										
Resp										
ETCO2 Non-Invasive										
SpO2										
SpO2 Post-Ductal (Left Foot)										
BP										
BP Location										
BP Method										
Patient Position										
LOC for MEWS										
Level of Consciousness										



Document vitals

- Select the **Vitals** tab.
- ❖ There are two ways to add a new time column to Flowsheets.
 - **Add Col:** Adds a column for the current time
 - **Insert Col:** Insert a column for a specified time
- Select the Temperature cell for your new time column.
- ❖ Notice the details report on the right. It shows you the values that can be entered, as well as last filed values.
- Enter the patient's temperature (39.9).
- Your documentation files automatically when you move to another screen, or you can click **File** to save at any time.

Document an assessment

- It's time to document a Respiratory assessment that we did 30 minutes ago.
- Select the **Assessment** tab.
- Select the **Respiratory** section on the table of contents.
- ❖ The assessment was done 30 minutes ago, so which button do I click to start documenting?
 - Insert Col
- ❖ As you complete your assessment, do you need to document in every single row?
 - No. Only chart in rows where the patient doesn't meet the defined limits.
 - If a patient doesn't have an exception for a particular row, don't document in that row.
 - If the patient is within defined limits for an entire assessment, document WDL for that assessment.
- When you click in the cell for the **Respiratory** assessment:
 - You can see the defined limits for the assessment in the Flowsheets sidebar.
 - The options for this cell are WDL and X.
 - If the patient meets the defined limits, you can just document WDL.
- This patient doesn't meet defined limits, so **enter X**.
- New rows appear automatically (these are called cascading rows).

GSR Med Surg 3C	
3/27/20	
1700	
Respiratory	
 Respiratory (WDL)	X
Respiratory Pattern	
Chest Assessment	
Bilateral Breath Sounds	
R Breath Sounds	
L Breath Sounds	

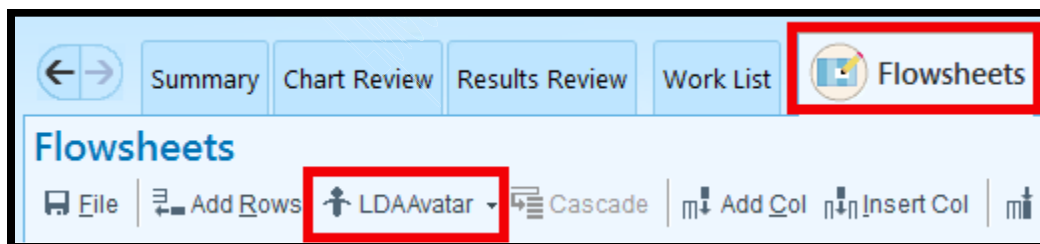
- When you enter certain values in rows with an  icon, other rows automatically appear below them.
- You can manually add additional rows, follow these steps:
 1. Click the  icon symbol in the flowsheet row. The Cascading window opens.
 2. Add rows by selecting them in the left pane and clicking Add.
 3. When you're done adding rows, click Accept and continue with your documentation.

Assess existing lines, drains, and airways (LDAs)

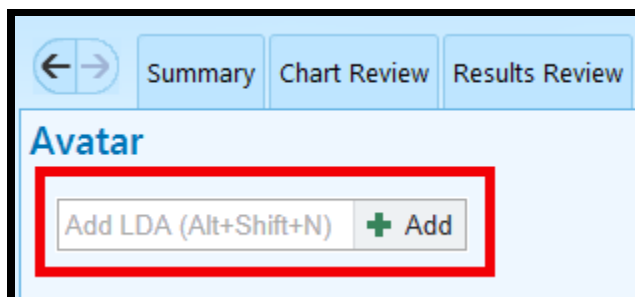
- In Epic, the following areas of documentation are referred to as **LDAs**:
 - Lines
 - Drains
 - Airways
 - Tubes
 - Wounds
- You just assessed **Carter's Peripheral IV** and it was clean, dry, and intact.
- Where do you document line assessments?
 - In **Flowsheets**, open the **IV Assessment** tab.
- Notice the IV Properties row:
 - Placement Date/time
 - Size
 - Orientation
 - Other information you can see if you hover over the link
- Document your Assessment:
 - Site assessment
 - Line status
 - Dressing status
- Different types of lines, drains, airways, tubes, and wounds appear on different tabs in **Flowsheets**.
 - If you can't find an LDA you're looking for, check a different tab.
- Lines, including IVs and central lines, appear on the **IV Assessment** tab.
- Drains (including catheters) and feeding tubes appear on the **Intake/Output** tab.
- Airways and wounds appear on the **Assessment** tab.

Adding a Drain using the LDA Avator

- Now we need to add a new drain to our **Carter** patient.
- Go to the **Flowsheets** tab.
- Open the **LDA Avator**.



- Click **Add** and search for **Foley**.



- Place the **Foley** on the Avatar.
- You will now get the Lines, Drains, Airways, Tubes, and Wounds Properties box.

- Enter the following details:
 - Placement Date: t
 - Placement Time: n
 - Additional information can be added later
- Click **Accept**.
- Notice the placement of the drain on the Avatar.
- Hover over the drain icon.
 - You can document an assessment or remove the drain from the Avatar.
 - Any documentation made from the Avatar will appear in Flowsheets.
- Where can you document a drain assessment?
- In **Flowsheets** to the **VS, I/O** tab.
- Notice the drain Properties row:
 - Placement Date/time
 - Catheter Type
 - Size
 - Other information you can see if you hover over the link

- You can edit LDA properties by clicking the link.
- Now Click the Edit button.
- Make edit and click **Accept**.

Lines, Drains, Airways, Tubes, and Wounds Properties

Urethral Catheter

Property	Value
Placement Date	2/18/2020
Placement Time	1416
Urinary Catheter Placed in ED?	
Inserted by another (name)	
Pre-existing Site?	
Catheter Type	Double-lumen
Tube Size (Fr.)	
Catheter Balloon Size	10 mL
Urine Returned	Yes
Removal Date	
Removal Time	
Removal Reason	

Value	Comment	Time Recd	User Taken	User Recd	Show Audit
2/18/2020		02/18/20 1416	Aonesauce, David, CNA	DA	

Value: 2/18/2020, Comment: , Time Recd: 02/18/20 1416, User Taken: Aonesauce, David, CNA, User Recd: DA, Show Audit:

Accept Cancel

Edit

Remove a drain

- Go to **Flowsheets** to the **VS, I/O** tab.
- Notice the Urethral Catheter in the table of contents on the left.
- Click the **LDA Avatar** button.
- On the Avatar, hover over the drain.
- Click Remove.
- On the properties window, document the following details:
 - Removal Date: t
 - Removal Time: n
 - Removal Reason: Occluded
- Click **Accept**.
- Return to the **VS, I/O** tab of **Flowsheets**.
- Notice the old drain's group is now labeled as **[REMOVED]**.
- ❖ Removing an LDA means it's no longer attached to patient.

Flowsheets

File Add Rows LDA

Daily Cares/Safety VS, I/O

Search (Alt+Comma)

Hide All Show All

Vitals	<input checked="" type="checkbox"/>
Pain	<input checked="" type="checkbox"/>
Nutrition	<input checked="" type="checkbox"/>
Intake (mL)	<input checked="" type="checkbox"/>
Output (mL)	<input checked="" type="checkbox"/>
Urine	<input checked="" type="checkbox"/>
Stool	<input checked="" type="checkbox"/>
Gastrointestinal	<input checked="" type="checkbox"/>
[REMOVED] Ureth...	<input checked="" type="checkbox"/>
CBI	<input checked="" type="checkbox"/>
Unmeasured Output	<input checked="" type="checkbox"/>

Complete a drain

- We don't want to see this LDA anymore now that it's been removed, so let's complete it. Completing an LDA means we are done with all assessment documentation.
- Right-click the removed drain and select Complete.
- The completed LDA disappears, to reduce clutter.
- Clear the Hide Comp'd box on the toolbar if you need to see completed lines.
- To recap:
 - ❖ When an LDA is done, remove it and then complete it.
 - ❖ Completing LDAs keeps the chart uncluttered.

Document Intake and Output

- Document your **Carter** patient's Intake and Output.
- Where do we document this in the chart?
- Go to **Flowsheets**, open the **Intake/Output** tab.
- Find Intake on the table of contents.
- Click **Add Col.**
- ❖ **Make sure that documentation falls within your shift.**
- Click the **P.O.** cell.
- Enter an amount.
- Click **File** or exit the patient's chart.

View I/O totals

- You can see a graph of your patients Intake/Outputs
- Go to Summary activity > Intake/Output report

Intake/Output

Table

Graph

Cumulative

Refresh

I/O Flowsheet

<

3/27/2020

>

Shift

Expand All

Collapse All

+

		Mar 26 - Mar 27			Mar 27 - Mar 28		
		0700 - 1859	1900 - 0659	Daily Total	0700 - 1859	1900 - 0659	Daily Total
In	P.O.	50		50			
	Total Intake (mL/kg)	50 (0.6)		50 (0.6)			
Out	Urine (mL/kg/hr)	100		100			
	Total Output	100		100			
Net	I/O	-50		-50			
	Since Admit	-50	-50	-50	-50	-50	-50

Document Volume in Flowsheets

- Document your **Carter** patient's Intake and Output.
- Where do we document this in the chart?
 - Go to **Flowsheets**, open the **Intake/Output** tab.
- Find the infusion group for IV med that was recently administered.
- Looking at the Dose or Rate row. You can see:
 - when the med was started
 - when it stopped, because the dose or rate is zero
- Click **Add Col.**
- Click the **Volume** cell.
- Enter Volume amount.
- Click **File** or exit the patient's chart.

The screenshot shows the Epic Flowsheets interface. At the top, there are tabs for Summary, Chart Review, Results Review, Synopsis, Work List, MAR, Flowsheets, Intake/Output, and Notes. The 'Flowsheets' tab is active, and the 'Intake/Output' sub-tab is selected. On the left, there is a search bar and a list of vital signs and assessments, including Weights, Nutrition, Intake (mL), diphenhydrAMINE (B...), Output (mL), Unmeasured Output, and Drain (LDAs). The 'diphenhydrAMINE (B...)' entry is selected, showing a start time of 02/08/20 1230. The main area displays a table with columns for time intervals (1m, 5m, 10m, 15m, 30m, 1h, 2h, 4h, 8h, 24h) and a 'Based On' column. The 'Volume (mL)' row is highlighted, showing a value of 100. The 'Add Col.' button is highlighted with a red box.

- ❖ **CRITICAL:** Always check the pump and document the volume that actually infused. The volume on the infusion pump is the source of truth.
- ❖ Epic is only as accurate as your documentation.

Administer medications

- In Epic, to administer a med you:
 - Scan the patient's barcode.
 - Scan the med's barcode.
 - Verify and update the dose, rate, and other information on the admin form.
 - This is how we check the five rights: Patient, med, route, dose, time.

Overview of the MAR

- Go to the **MAR**.
- Each medication has a row, and there are columns corresponding to one-hour time blocks.
 - ❖ Actions such as due times, administrations, and rate changes appear in the appropriate time block.
- Use the arrows to the right and left of the time columns to move forward and backward in time.

Administer a Medication

- Scan a patient's wristband to start the administration from the **Patient Lists**.
 - ❖ If a patient's wristband doesn't scan, open the MAR, choose the correct override reason (for not scanning the patient), and get a new wristband printed as soon as possible.
 - ❖ Not Scanned warnings are monitored to ensure compliance with hospital policy.
- Scan your **Molly** patient's wristband on your tent card.
- Scan the Advil 600 mg tablet on your medication handout.
 - ❖ In training we may not have access to scan
- In the medication administration window, you can review order details and document administration details.
- For some meds, related flowsheet documentation appears. An example is a Pain Assessment for pain medications.
 - ❖ This will prompt a cosign from your precepting nurse.
- Verify the following details:
 - The correct med action is being documented.
 - The correct date is noted.
 - The correct time is noted.
 - The correct route is noted.
 - The dose we are administering.
 - Document your **Pain Assessment**.
- Click **Accept**.
- A Given action appears on **MAR**.
- Hover over the Given action.
- Other actions you might see: Hold, New Bag, Stopped, Not Given, others
 - ❖ The system will check the dose you scanned against the dose ordered. If there's a mismatch, a warning appears.
 - ❖ If you're administering a partial package, select Partial Package as the override reason.

Edit an administration

- You just realized that you documented the medication at the wrong time. If necessary, you can update a documented administration.
- Find your recent administration of Advil.
- Click the administration to see more information about it.
- Select the **Edit administration check box**. (It's at the bottom of the administration summary.)
- The fields in the administration window can now be edited.
- Update the time to be earlier than originally documented.
- Click Accept and notice the updated time of administration.
- ❖ If a message about updating flowsheet documentation appears, click Yes.

Administer a Multi-Dose Package

- Some medications, like inhalers or eye drops, are dispensed in multi-use packages. In that case, scan the barcode on the package itself.
- You should already be in **Molly's** MAR. If not Scan Molly's wristband on your tent card.
- Scan the **Ocean nasal spray** on the medication handout.
 - The administration form opens for sodium Chloride (OCEAN) 0.65% nasal spray.
 - Look at the Dose field. What appears there?

Medication

× sodium chloride (OCEAN) 0.65 % nasal 2 spray : Dose 2 spray : Each Nare : As needed : Other, Congestion

Show Flowsheet

Ordered Admin Amount: 2 spray
Dispense Location: Central Pharmacy
Frequency: As needed
Route: Each Nare
Order Dose: 2 spray
Order Start Time: Today 03/10/20 at 0600
PRN Reasons: Other
PRN Comment: Congestion
References: Lexi-comp

Action: Given
Route: Each Nare
Dose: 2 spray

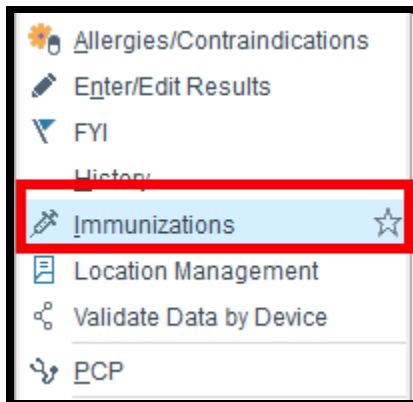
- ❖ Since Ocean is always dispensed in a multi-dose, multi-use package, the system doesn't warn you. It assumes you are only going to give the ordered dose, so that's what appears in the **Dose** field: 2 sprays.
- Click **Accept**.

Administer a Vaccination

- Vaccinations are dispensed and administered much like any other syringe medication. The main difference is that you need to document a bit more information with a vaccination, and the patient's vaccination history needs to be updated.
- You should already be in **Molly's** MAR. If not, scan Molly's wristband on your tent card.
- Scan the **Pneumococcal Vaccine** on the medication handout.
- Complete the Required fields (Red Stop Signs) and Click **Accept**.

Immunization Information:					
Lot Number	NDC	VIS Date	Product	Manufacturer	Expiration Date
❗	0006-4943-00	❗		❗	❗

- The patient's immunization history also needs to be updated to reflect the vaccine you just administered.
- Open the Immunizations activity found under the More activity tab.



- ❖ You can Star Immunizations as a favorite for the tab to automatically show up in all patient charts.
 - Under the Administration History section, you see an immunization for Pneumococcal Polysaccharide, given on today's date.
 - When you document giving a vaccination on the MAR, it automatically updates the patient's immunization record! You don't actually need to do anything except mark the History as Reviewed.
- Close Molly's chart.

Administer a Med with a Ranged Dose

- Sometimes a medication might be ordered with a ranged dose. For tablets and capsules, you simply scan each tablet you give, and the **Dose field** is updated automatically.
- Scan **Molly's** wristband on your tent card.
- Scan the **Hydrocodone-Acetaminophen 5mg-325mg tablet** on the medication handout.
 - ❖ Notice we get a Cosign prompt. We will be documenting a pain assessment. That data will show in Flowsheets. This action requires your preceptor to cosign.
 - Note the order dose and the PRN comment on the left side of the screen. You could give either one or two tablets.
- Molly reports significant pain, an 8 out of 10, so you want to give a second tab.
- Scan the **Hydrocodone Acetaminophen** barcode again. What happens? The dose increases to 2 tabs.

- Try again. Scan the **Hydrocodone-Acetaminophen** barcode a third time.
 - ❖ This time, you get an administration warning because you are trying to give more Norco than what was ordered!
- You don't actually want to give Molly 3 tabs, so click **Cancel**.
 - You return to the administration form for the Norco order.
- Let's document Molly's pain. Click **8** in the 0-10 scale pain screening row under the Associated Flowsheet Rows section.
- Click **Accept** to file this administration and the associated flowsheet data.

Administering a Med with a Partial Package

- Many oral solids come in varying strengths. The system is smart enough to accept equivalent combinations of pills when you scan them.
- Find the **Prednisone (DELTASONE)** tablet 7.5 mg order on the **MAR**. Pharmacy is saying this med should be dispensed as 1.5 x 5 mg tablets.

predniSONE (DELTASONE) tablet 7.5 mg : Dose 7.5 mg : Oral : Every 4 hours PRN :

Admin Instructions:
Take with food

Ordered Admin Amount: 1.5 tablet (1.5 x 5 mg tablet)

- Scan the **Prednisone 5 mg** tablet on the medications handout.
 - Like you saw earlier with the ibuprofen, the administration window opens. The Dose field reflects the tablet you just scanned.
- Now you plan to give half of another tablet, so scan the Prednisone 5 mg tablet again.
 - You get the overdose warning again. The system thinks you're trying to give 10 mg when the order is for 7.5 mg.
- Since you only intend to give half of the second tab, click **Partial Package**.
 - The warning goes away, and the Dose field in the administration window is now blank. You'll need to manually enter the dose you give.
- Enter "7.5" in the **Dose** field and click **Accept**.
 - You return to the MAR. The green "Given" action appears for prednisone.

Receiving a Patient

- You are receiving a patient being transferred from another unit in the hospital.
- In this section you will learn how to:
 - Complete the admission and take over patient assignments
 - Complete admission documentation
 - Release signed and held orders

Find patient in other units

- Before your new patient arrives, you would like to review the chart.
- To find patients in other units, open **Patient Lists**.
- Remember the lists on the left:
 - My Patients shows you the patients you're assigned to.
 - My Unit shows all patients in the unit I'm logged in to.
 - The system lists under Available Lists show you lists of patients on a certain unit or patients who meet a certain criterion. For example, there is a list for all patients in the ICU.
 - ❖ The fastest way to find a specific admitted patient is to search Patient Lists. Check out the search field in the upper right of Patient Lists (not Chart Search). This field searches all admitted patients at the site you are logged into.
- In the search field, enter the first and last name on your **Carlos** patient from your classroom tent card and press Enter.
- When you find your **Carlos** patient, you can review the chart before he arrives on your unit.

Take over patient assignments

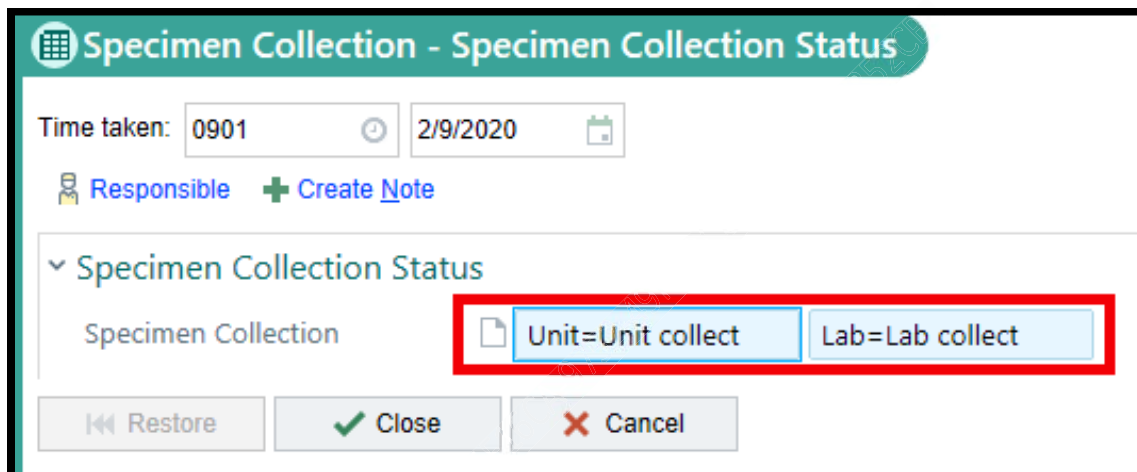
- Now that your **Carlos** patient has been transferred to your unit, you will take over as the nurse on the treatment team.
- To update patient assignments mid-shift, you will click the **Sign In** activity again.

Navigators

- What are navigators used for?
 - Navigators are a one-stop shop for documentation. You can complete many different types of documentation all on one screen. There are navigators for Admission, Transfer, and Discharge.
- Open the **Navigators activity** to the **Admission Navigator**.
 - Working your Navigator from top to bottom will ensure that you have completed all of your **required documentation** for your shift.

Specimen Collection

- Specimens can be either **Lab collect**, or **Unit collect**.
 - If a specimen is **Lab collect**, a phlebotomist will come collect it.
 - ❖ **Nurses don't see tasks for these specimens on their Work List.**
 - **Unit collect** specimens are collected by the nurse.



- ❖ If you change the collection status for the patient, the change applies to specimens that you haven't printed labels for yet.
- ❖ If you've already printed a label for a specimen, that specimen's collection status won't change.
- ❖ **CRITICAL:** Nurses are responsible for labeling the specimen—not with a patient label. Specimens must be labeled in order to be received by the lab.

Handle signed and held orders

- Signed and held means:
 - Physician from sending unit signed the orders before the patient was transferred.
 - Orders should not be active until patient arrives in receiving unit.
 - When the patient arrives in the receiving unit, the receiving nurse releases the orders to make them active. Use your judgement in releasing orders that are clinically necessary for the patient.
 - ❖ **CRITICAL:** The patient must be on the unit when you release orders. If you release the orders when the patient's location is wrong, meds will be delivered to the incorrect units, labels will go to the wrong printer, etc.

Unreconciled Orders

- The physician is responsible for reconciling orders before the patient is transferred from another unit.
 - ❖ A warning appears if reconciliation is not complete.
 - ❖ Contact the physician if you see the warning, so they can complete order reconciliation.
- If the physician does not reconcile a medication, it's put on MAR Hold.
 - ❖ If the patient needs a med that's on MAR Hold, document the administration as you normally would.

Overview of the Admission Table of Contents

- Open the **Vital Signs** section.
 - The fields available here are the same as the **Vitals flowsheet**. When you document here, the values appear in Flowsheets and when you document in Flowsheets, the values appear here.
- Click New Reading button.
 - ❖ **Reminder: as a Nursing Student you will need to enter a Cosigner. You will enter your Preceptor's Name, but for training today we will use IPRN.**
- Enter a temperature
 - ❖ Along the top, you can specify the date and time of the documentation. The current date and time appear automatically, but you can update it if needed.
 - ❖ Remember: The information you enter here appears in Flowsheets, so you want the date and time to be accurate.
- In the upper right, you can see more details by selecting these check boxes (Row Info, Last Filed, Etc).
- Open the **Allergies** section.
 - Add a new allergy.
 - Enter reactions, severity, reaction type, and date noted.
 - Click **Mark as Reviewed**.
 - ❖ Indicates I've collected and reviewed this information.
- Open the **Home Meds** section.
 - Your patient informs you of a medication that's not on the list.
 - Add the medication.
 - Indicate the med was last taken yesterday.
 - Click **Mark as Reviewed**.
- Click down the table of contents to review each section of the **Admission Navigator**.

Overview of the Discharge Table of Contents

- The **Discharge Navigator** helps you get your patient ready for discharge.
- Click down the table of contents to review each section of the **Discharge Navigator**.
 - Unresulted Labs
 - Running Infusions
 - LDA Removal
 - Add Med Details

Extras

Administer IV

- Add, remove, and complete IV lines.
- Start and stop an IV medication.
- Document intake and output.

Start an IV med

- What is different about documenting IV meds, compared to other kinds of medications?
 - ❖ Patient needs an intravenous line
 - ❖ Document intake volumes
 - ❖ Medication dosages might be adjusted based on the patient's response
- When do you add a line to the patient's chart? Before or after administering the med?
 - ❖ Before.
- Steps for documenting IV meds in Epic:
 - Scan the med.
 - Link the med to the line.
- Document administration details as usual.
 - Open the MAR.
- What will you do first to administer the medication?
 - ❖ Scan the patient's wristband.
- Scan the medication barcode.
 - ❖ If you see a medication verification warning: In the training environment a pharmacist wasn't able to verify this medication, so it shows as unverified. We'll bypass this warning now, but in real life you would wait to administer until it's verified, unless it's an emergency.
- Link it to a line.
- This administration window is similar to the one we saw during the previous lesson. Do you see anything that's different?
 - ❖ There's linked line information on the left side.
 - ❖ The action is New Bag instead of Given.
 - ❖ There's an ordered infusion rate.
 - ❖ The order will be infused over a specified amount of time. (Not all meds have this.)
- Confirm the following details:
 - Action: New Bag
 - Date:
 - Time:
 - Dose:
 - Rate:
 - Linked line:
- Click Accept to document starting the infusion.
- Notice the new actions listed on the MAR.

Stop an IV med

- Time has passed and the infusion is complete.
- We need to document that the medication has stopped.
- Document a Stopped action on the MAR for the medication.
- Confirm the following details in the med admin window:
 - Action: Stopped
 - Date:
 - Time:
- Click Accept and notice the Stopped action on the MAR.

Manage lines in the LDA Avatar

Stop an infusion

- Your **Carlos** patient is complaining of pain and swelling at the insertion site.
- First stop the infusion that's currently running.
- Go to the **MAR**.
- Click the current time and document a Stopped action for the medication.
- Confirm the following details in the med admin window:
 - Action: Stopped
 - Date: today
 - Time: now
- Click Accept.
- Notice the Stopped action on the MAR.
- Now we can remove the line.

Remove and complete an IV line

- Thinking back to when we documented assessments, where do you assess and manage IVs?
 - ❖ Flowsheets
 - Open **Flowsheets** to the **IV Assessment** tab.
- Notice the IV groups for the current line(s).
- Click the **LDA Avatar** button.
 - On the Avatar, hover over the old line.
 - You can document an assessment or remove the line.
 - Click Remove.
 - On the properties window, document the following details:
 - Removal Date: t
 - Removal Time: n
 - Removal Reason: Infiltrated
 - Click **Accept**.
 - Return to the **IV Assessment** tab of **Flowsheets**.
 - Notice the old line's group is now labeled as **[REMOVED]**.
 - ❖ Removing an LDA means it's no longer attached to patient.

Flowsheets

File | Add Rows | LDAAvatar | Cascade | Add Col | Insert Col | Data Va

Vital Signs | Assessment | Intake/Output | **IV Assessment** | Daily Cares/Safety

Search (Alt+Comma) 🔍

Hide All Show All

- Specimen Collection ... ☒
- Infiltration / Phlebitis ... ☒
- IV Attempt / Unsucce... ☒
- Peripheral IV 2/8/201... ☒
- [REMOVED] Peripher... ☒**
- CVC Double Lumen 2... ☒

Cosign Report | Accordion | Expanded | View All

No department found

0724

Specimen Collection Status

Specimen Collection

Infiltration / Phlebitis Task Generation

NEW infiltration?

NEW phlebitis?

IV Attempt / Unsuccessful

Attempt #

Orientation

Site

Size-Type

Peripheral IV 2/8/2018 Right Antecubital

IV Properties	Placement Date/Time: 2/8/2018 10:00 AM
Site Assessment	WDL
Infiltration Assessment	
Phlebitis Assessment	
Line Status #1	*Infusing
Additional Site Care	
Dressing Status	
Reason Not Rotated	

[REMOVED] Peripheral IV 10/18/13 Left Forearm

IV Properties	Date Removed/ Noted Not
---------------	-------------------------

- We don't want to see this LDA anymore now that it's been removed, so let's complete it. Completing an LDA means we are done with all assessment documentation.
- Right-click the removed IV and select Complete.
- The completed LDA disappears, to reduce clutter.
- Clear the Hide Comp'd box on the toolbar if you need to see completed lines.
- To recap:
 - ❖ When an LDA is done, remove it and then complete it.
 - ❖ Completing LDAs keeps the chart uncluttered.

Add an IV line

- Now we need to add a new line to the patient.
- Open the **LDA Avatar**.
- Click **Add** and search for the line type.
- Place the new line on the Avatar.
- On the window that appears, confirm you chose the correct location/orientation and document the following:
 - Placement Date: t
 - Placement Time: n
 - Fill out additional details if desired
- Click **Accept**.
- Notice the new IV on the Avatar.

Restart an infusion

- Now it's time to restart the infusion. Where do you think we go to do that?
- Go to the **MAR**.
- Click the current time and document the Restarted action.
- Link it to the new line.
- Confirm the following details in the med admin window:
 - Action: Restarted
 - Date: today
 - Time: now
- Click **Accept**.
- Notice the new action listed on the MAR.
- Go to Flowsheets, do you see the current rate listed?

Manage lines in Flowsheets

Stop an infusion

- Same as above example.

Remove and complete an IV line

- Open **Flowsheets** to the **IV Assessment** tab.
- Click the blue link in the Properties row for the old line.
- Click Edit.
- Enter the following details:
 - Removal date: t
 - Removal time: n
 - Removal reason: Infiltrated
- Click **Accept**.

Add an IV line

- Same as above example.

Restart an infusion

- We can also restart the medication from **Flowsheets**.
- Go to the **IV Assessment** tab.
- Click **Add Col**.
- Click the **Rate** row of the medication we want to restart.

The screenshot shows the 'Flowsheets' application interface. The 'Intake/Output' tab is selected. On the left, there is a search bar and a list of items with checkboxes: Weights, Nutrition, Intake (mL), dextrose 5 % and 0.4..., diazepam (VALIUM) 5..., diazepam (VALIUM) 5..., and Output (mL). The main area displays a 'Cosign Report' button, 'Expanded' and 'View All' tabs, and a timeline from 1m to 24h. The timeline shows a medication infusion for 'dextrose 5 % and 0.45 % NaCl (D51/2NS) infusion - Peripheral IV 2/9/2012 Left Antecubital' with a rate of 0 and a syringe icon. A red box highlights the 'Rate' row.

- Notice the syringe.
- Click the syringe.

The screenshot shows the 'Administration Warning' dialog box. The header reads 'Patient was not scanned'. The main text says 'Scan patient barcode now or Select the MAR action and an override reason if required.' Below this, there are fields for 'Action:' and 'Override reason:'. The 'Action:' field has a dropdown menu and a red exclamation mark icon. The 'Override reason:' field is empty. At the bottom, there are 'Accept' and 'Cancel' buttons.

- Look Familiar?
 - Action: Restarted
- Click Accept
- You are now in the **MAR**.

