



Audience Note: Cerner PowerChart training is for all students in the following inpatient areas Med/Surg, OSN, Oncology, ARU, Peds, FMC, GYN, PACU, PCU, and CCU

Purpose: To provide an introduction to Cerner PowerChart navigation and functionality.

Objectives: By the end of this training session, the participant(s) will be able to:

- Identify the principles of the HIPPA Privacy Rule as they relate to use of the *PowerChart* application.
- Navigate the PowerChart Organizer and Patient List
- Locate a patient, open and exit the patient chart.
- Navigate through the patient chart to locate and document clinical information.

INTRODUCTION

- Log in to the **NETWORK**.
- State **class objectives**.
- Log in to *PowerChart* using the training logins provided on the white label attached to the monitor.
- Review the HIPPA Privacy Rule:
 - You may not view your own patient record
 - You may not open any patient's record unless required for your job.

Quick Tips

T=Today

N=Now

Recent Patients

Refresh frequently

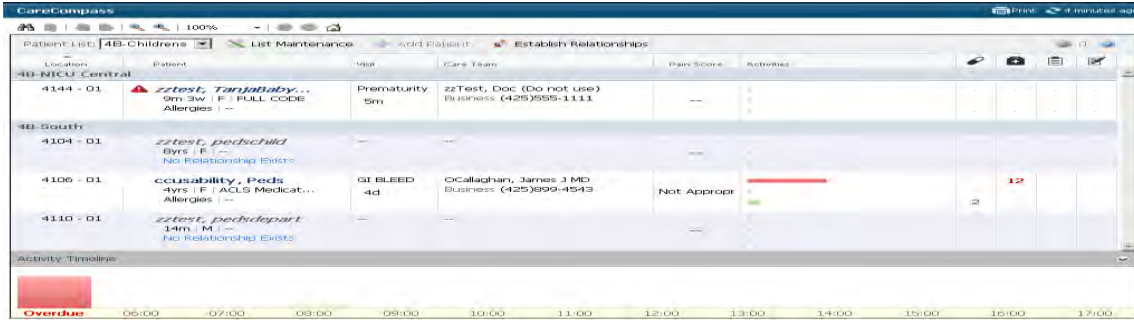
Right click for additional information
Trends & Graph

Navigation through PowerChart Organizer

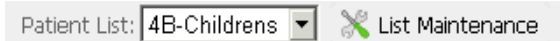
Nurses, HUCs and Unit Techs view will open to Care Compass, all other roles will open to the patient list.

Basic RN Workflow for Care Compass

1. When you first log into PowerChart it will open to Care Compass
2. The Patient Location List on CareCompass will appear

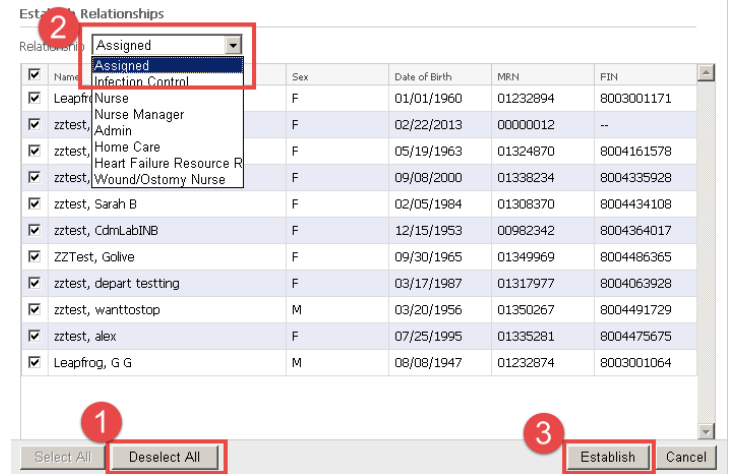


3. To change lists use the drop down box near the top left corner

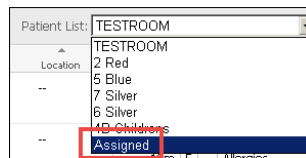


4. To assign yourself to patients

- a. Select the Establish Relationship button.
- b. All patients will be selected, ① "Deselect All" and select your assigned patients
- c. Select type of relationship from drop down box at top, will default to ② "Assigned"
- d. Select ③ Establish

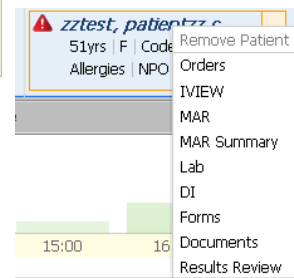
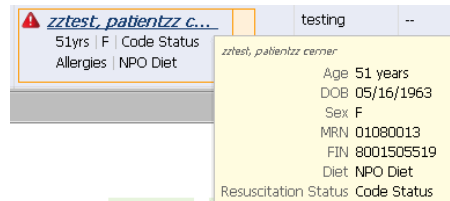


5. On the patient list drop down select "Assigned".



6. To see more details on a patient:

- a. Hover over patient name to see general information, diet, and code status
- b. You can right click on patient name to select a section of their chart you would like to view (Orders, IVIEW, MAR, etc.).



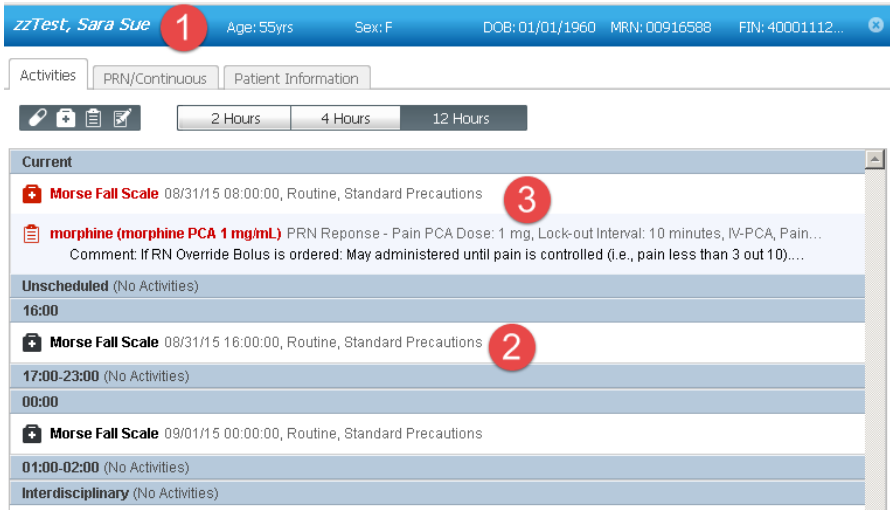
- c. Select the arrow at the end of the patient name. Single patient view will appear with additional information on your patient. Three tabs will be



displayed.

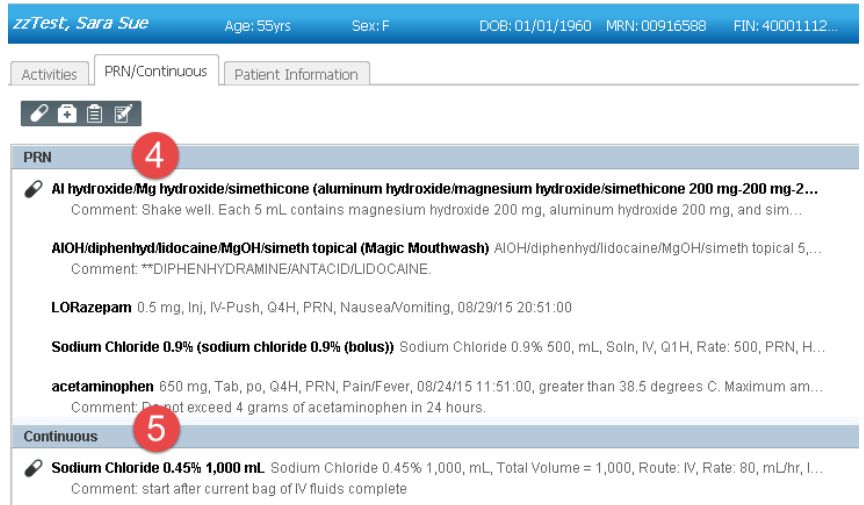
The first tab is **Activities**.

- ① Patient name, MRN, and FIN #
- ② Activity Tasks and medications that will be due over the next 2, 4 or 12 hours
- ③ Overdue task will be displayed in red



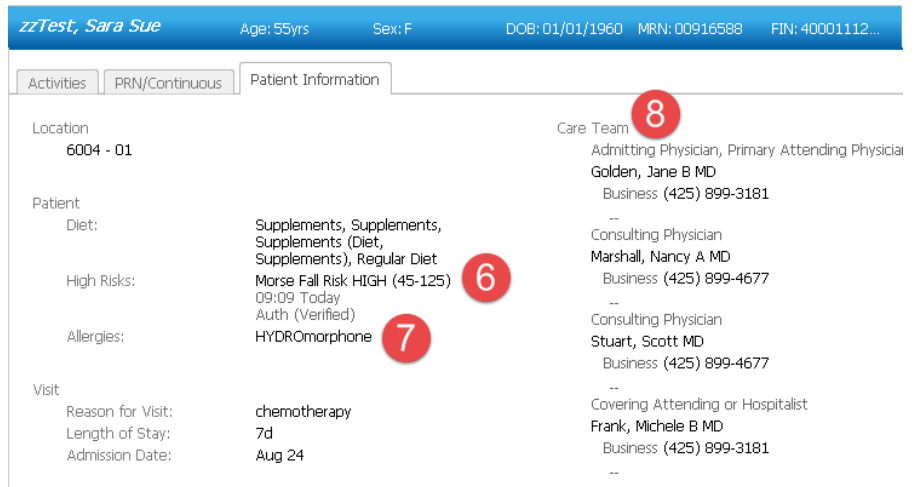
The next tab is **PRN/Continuous**

- ④ PRN Medications
- ⑤ Continuous Medications



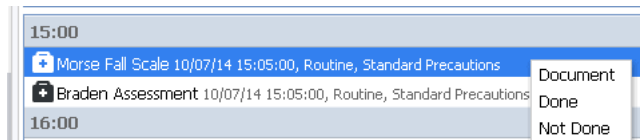
The last tab is **Patient Information**

- ⑥ High risk indicators for you patient
- ⑦ Allergies
- ⑧ Care Team members and contact information



7. Completing Tasks: Click on the gray arrow next to the patients name to open single patient view to document tasks.

- a. Select the task
 - i. Select Done, if already completed
 - ii. Select Document to be taken to the powerform
 - iii. Select Not Done, then give reasoning



8. Completing Tasks that are not applicable to your shift (Students should inform the primary RN):

- a. For tasks from previous shifts (Braden, Morse, PRN Pain Response, Medications):
 - i. Select the task
 - ii. Select Not Done
 - iii. Select Task Maintenance

9. At the beginning of your shift complete/clear all pending/overdue tasks from your shift. There should be no red bar in the activities column or on the left side of the Activity Timeline

10. Throughout your day check Care Compass for new orders, results, and/or tasks.

11. To review orders:

- a. Click on orange or red box around patient name



Orange Box around patient name with Orange Circle containing '!' inside: 'New Orders' or 'Abnormal Lab Results'
Click on the Orange Circle in the box to view/review these items



Red Box around patient name with Red Circle containing '!!' inside: 'STAT Orders' or 'CRITICAL Results'
Click on the right end of the box to view/review these items

- b. Click on orange or red icon in top right corner of Care Compass.
 - i. Click on the icon to see the breakdown of the details
 - ii. Click on specific patient to review results

Review

Order	Action	Ordered By	Entered By
<input checked="" type="checkbox"/> Regular Diet 06/14/11 07:40:00, No Modifiers	Order Jun 14, 2011 07:40	zzTest, Whee...	Chacko, Jessy B



Patient	Results	Orders
<i>ZZTEST, ROXIRCONSULT</i>	--	1
<i>ZZTEST, LIKOSKY</i>	--	8
<i>zztest, hct</i>	--	3
<i>CCusability, Hospice</i>	1	7

- c. If the user put the order in themselves, the box will not appear, the system assumes you are aware of the order because you entered it
- d. PLEASE always try to document your tasks from Single Patient view instead of using Ad Hoc
- e. Remember to clean up your task list regularly throughout your shift and also prior to shift change report.

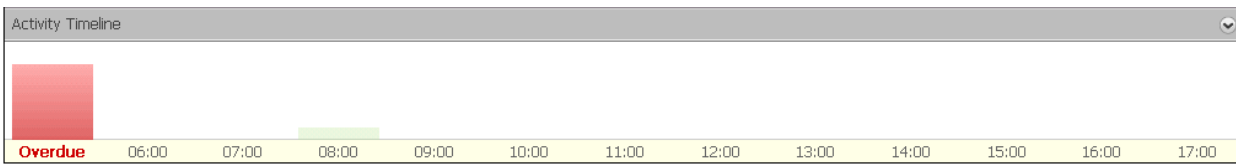
12. Name Alerts:

- a. Patients with similar names will be italicized.

Symbols (Hover over these symbols to see further information):

-  **Biohazard symbol** - Patient Isolation Status
Will appear if patient has any isolation status other than Standard Precautions
-  **Red Triangle** - Patient High Risks
Includes: Skin Risk, Fall Risk, Restraints, CIWAA score greater than 10

Activity Timeline



Red bar, on left end - Overdue tasks

Hover to see what type of tasks are overdue, enter patient information window to document

Hourly Green Bars - Visual cue of upcoming nursing tasks, (medications, patient care, charting)

Hover on green bar to see a breakdown of type of task for specified hour.

Review across the top of the patient chart

Title Bar



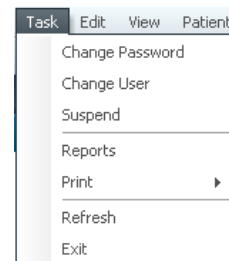
Shows **PATIENT NAME**, **MRN** and **NAME** of who opened the chart.

Menu Bar



Task

- Change User
- Reports – reports vary depending on location. Common reports include: discharge instructions, active orders, medication lists, etc.
- Print – Medical Record Publish. Prints patient medical record information
- Exit - enables user to gracefully exit the *Powerchart* system.



View

- Patient List - this menu item is grayed out if patients have not been assigned, or a patient list has not been built.
- Patient Tracking – Tool to help track patients through the organization.

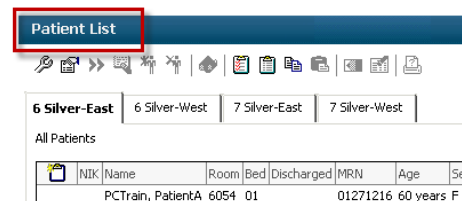


Patient

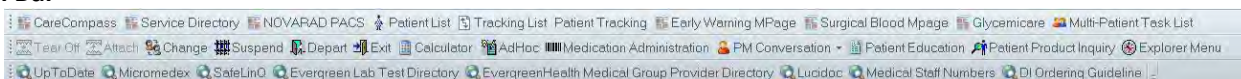
- Search – Locate patient by FIN # or 3 patient identifiers
- Recent – shows recent patient charts



Patient List - Find your patient on the **Patient List**



Icon Bar –



CareCompass - Will be covered for nurses in Documentation and Orders class. HUCs and Unit Techs will view LMS video.

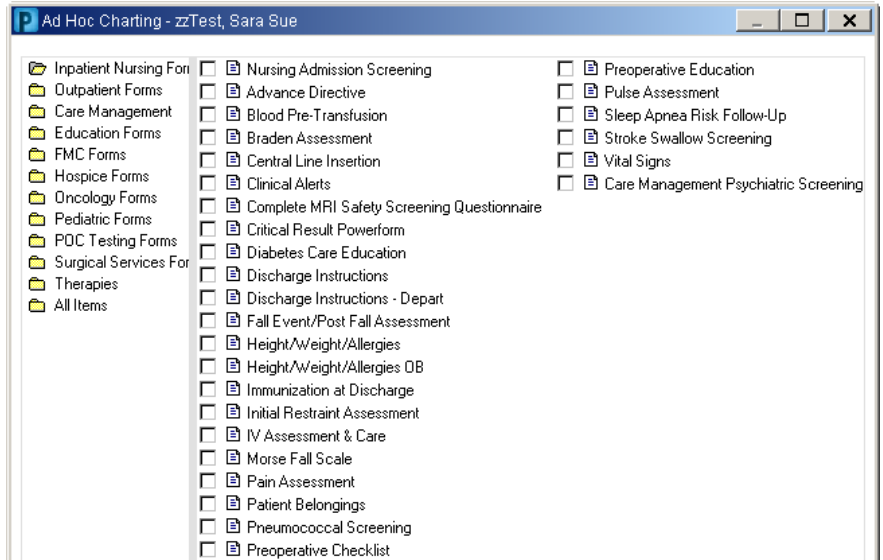
Tracking List – Shows an overview of all inpatient beds. Transfers should be completed from the tracking board. The tracking list is used primarily by the House Supervisor, Charge Nurses, and Float nurses to see empty beds, and general acuity of patients.



Exit – closes all applications.

Calculator – Clinical Calculator: a conversion tool that includes formulas that convert inches to centimeters, IV fluid rate, CCs per hour etc.

AdHoc Charting – available charting blank forms categories are arranged in a tree on the left. Available forms are displayed within selected categories on the right side of the window.



Medication Administration – displays patient medications after you have scanned the patient or manually searched for the patient information.

PM Conversations – Patient Management Conversations – provides access to forms relating to transfers, discharging, nursing actions, etc.

- Transfer – receiving unit will process the patient transfer.
- Discharge – **note:** only discharge a patient once they have **physically** left the hospital. All active orders are **discontinued** from Cerner at that point
- Cancel Transfer - orders suspended because of a patient's temporary change of location can be given a Transfer/Cancel status.
- Cancel Discharge – the Physician will need to be contacted to reactivate orders in the system.
- Nursing – this form enables the Nurse to update patient information like the POLST or Advanced Directive.
- Inpatient registration – this form is use during transfers. It is very important to select correct accommodation.



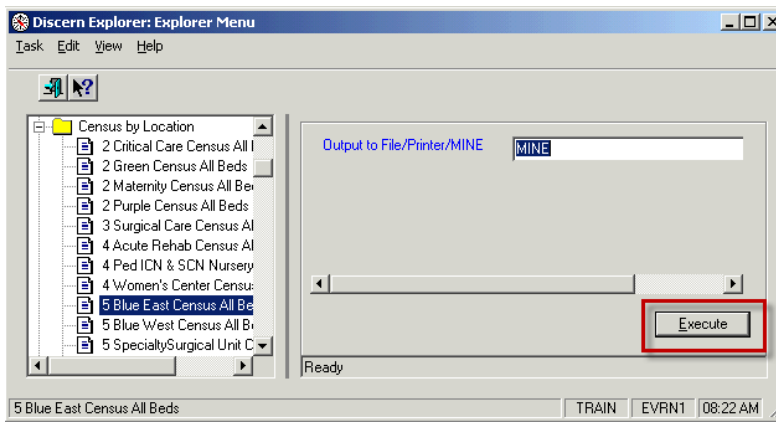
Patient Education – Allows nurses to add Educational material to the patient’s chart.

Depart – Used by the nurses when discharging a patient from the hospital. Patient Education and Depart will be covered in the Documentation and Orders class.

Explorer – enables end users to print census lists, RN worksheets, MD round lists, and other reports.

- To print a census list, double click on Main Menu and Select Census by Location
- Select the desired unit Census and click Execute

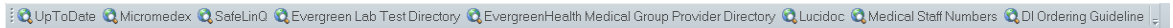




Documents – enables end users to print Patient information such as Face Sheets, arm bands, or ADT labels.

Collections Inquiry - view collections scheduled or collected through the current time, ability to reprint labels for specimens as needed.

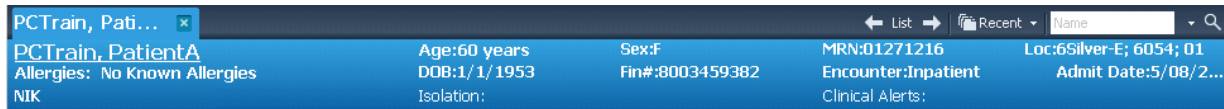
Links – provides access to online applications: Up to Date, Micromedex, SafelinQ, Evergreen Lab Test Directory, EvergreenHealth Medical Group Provider Directory, Lucidoc, Medical Staff Numbers, DI Ordering Guideline.



Refresh Or 'As Of' – updates all information entered on your patient. You must remember to refresh after making any changes.

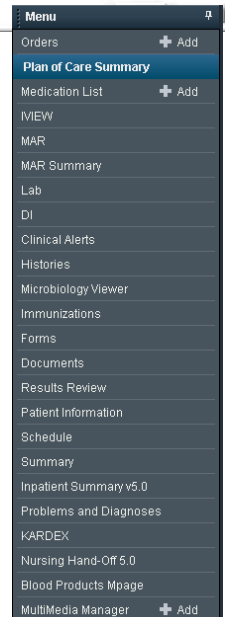
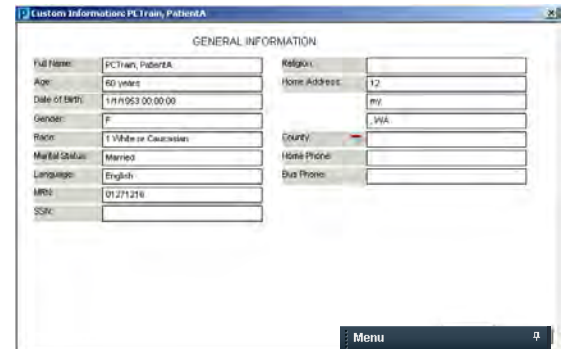


Navigation Within the Patient's Chart



Demographic Bar – Displays information regarding the patient's current visit

- Patient Name** – (active link) double clicking on the patient name will show some general patient information.
- MRN#** (medical record number) & **FIN #** (unique financial number) – both are displayed.
- Other items found on the Banner Bar:
 - Patient Age, Date of Birth, Sex, Admission Date
 - Encounter type, and Patient location (active link - shows General Information)
 - No Information Patient (NIK)
 - Isolation Status
 - Clinical Alerts



Navigation down the Menu Bar in the Patient's Chart

The menu bar is similar to the tabs in a hard chart.

Orders – Lists all active orders. See the Orders training manual for specific information.

Plan of Care Summary –

Medication List – List of the patient's current medications. This will be also covered with the Orders

IVEW – Patient information is documented here.

Entering Information into IVIEW

1. Click on the IVEW tab to open the flowsheet for documentation. It will first open to the Vitals and show the list of available flowsheet.

2. Double click in the blue header above the section to activate the section to enable data entry.

Or

3. Double Click in the cell you wish to document in.

4. The documentation will be purple until it is signed.

5. Sign your documentation by clicking on the green check mark at the upper left of the IVEW window. The documentation will now be black.



6. Enter I/O in the I/O fields

7. Enter Interventions - Click on the field next to Interventions to open the list.
8. Enter Turned left, AM care, Bed alarm on

IView Documentation

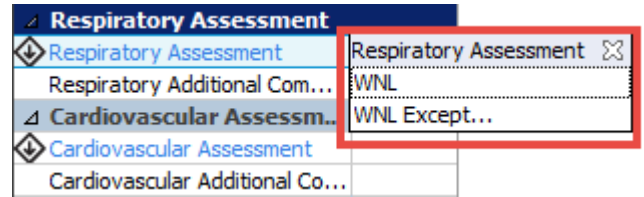
Isolation Status must be documented in IVIEW if the patient is under any type of

Last Updated 1/2017

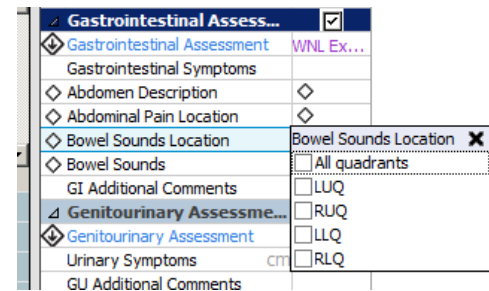
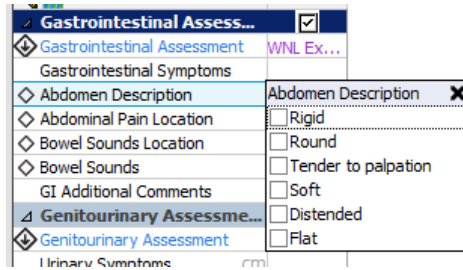
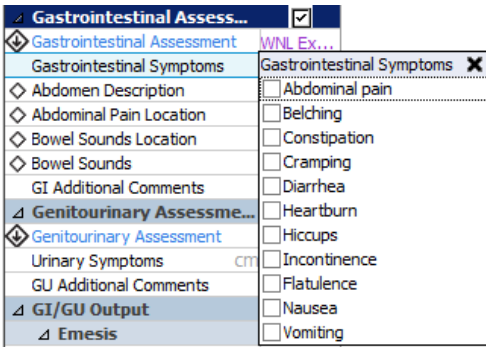
special isolation precautions. Patient Isolation is located in the Vitals band directly below the Vital Signs.

Documenting by Exception for the Routine Nursing Assessment

Assessment documentation in IVIEW is described as charting by exception. If your assessment for a specific system is Within Normal Limits (WNL), you can just select WNL. A reference is available for you to see what the normal limits are for that system.



- If there are exceptions to the assessment the nurse would choose WNL Except and additional assessment information will become available. Document only what is abnormal in that system assessment.

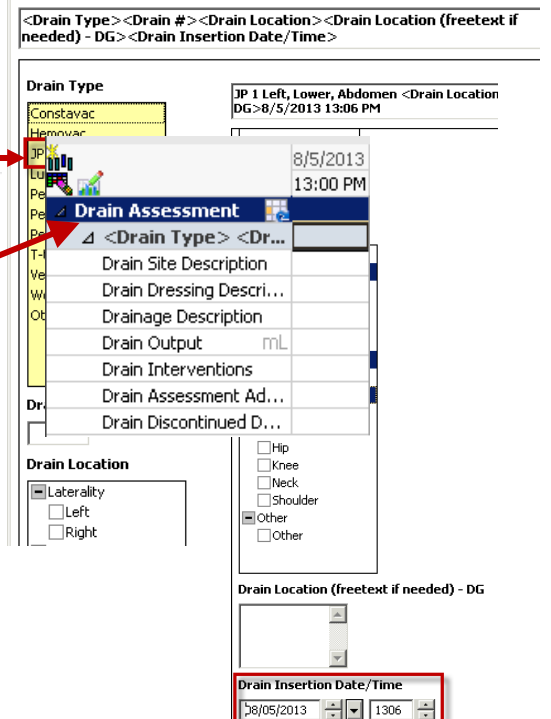
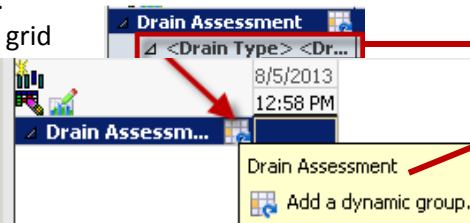
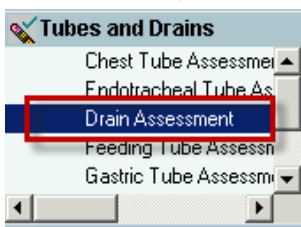


- If the patient's condition improves and the system assessment is now normal, at the time the assessment becomes normal the nurse will need to document to show how and when the patient assessment is normal.
- After the documentation shows what the normal value is, WNL can now be documented. From then on, as long as the assessment continues to be WNL, this may be documented.

Gastrointestinal Assessment			
Gastrointestinal Assessment	WNL		WNL Except...
Gastrointestinal Symptoms			
Bowel Sounds		Present	Hypoactive
GI Additional Comments			

Documenting dynamic groups

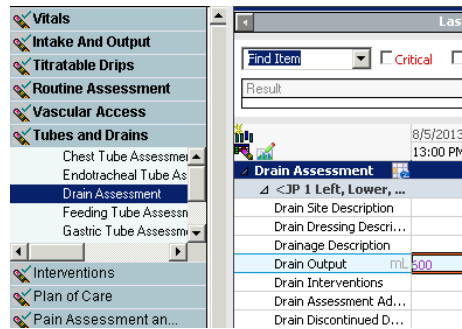
- In Tubes and Drains, select Drain Assessment as an example.
- To add a drain, click on the grid



- Click in between the brackets for <Drain Types> and determine Drain Type, Drain # and Drain Location. Be sure to scroll all the way to the bottom to enter the Drain Insertion Date/Time.

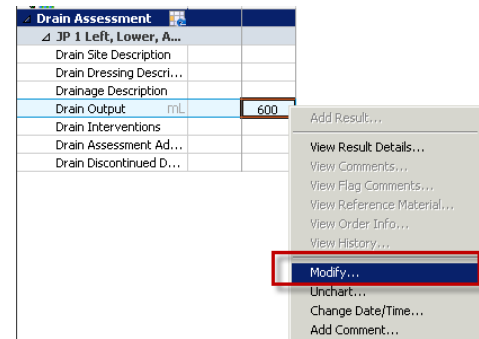
4. Add a drain volume

- Double click in the Drain Output field, then enter the amount.
- Sign data, by clicking the green checkmark, the screen will refresh.



5. Modify Patient Data

- Right click in the field and select Modify
- Enter the correct amount and sign. A delta sign will appear in the field indicating a change.



MAR

Open the MAR to review your scheduled, prn and IV medications.

Medication administration should be done using the hand held scanner. Click on the Medication Administration icon on the tool bar to open the scanner application.



Correct all red entries before the end of your shift...why the med was not given or time it was given late-why.

Time View	Medications	9/1/2015 07:02 AM
<input checked="" type="checkbox"/> Scheduled	Scheduled	
<input checked="" type="checkbox"/> Unscheduled	aspirin (aspirin 325 mg oral tablet)	1 tab
<input checked="" type="checkbox"/> PRN	Tablet po, DAILY (System Entered Order per Refresh Ru...)	
<input checked="" type="checkbox"/> Continuous Infusions	aspirin	
<input checked="" type="checkbox"/> Future	Temperature	
<input checked="" type="checkbox"/> Discontinued Scheduled	ceFAZolin	1 gm
<input checked="" type="checkbox"/> Discontinued Unscheduled	1 gm, IV Syr, Q8H, 03/10/15 14:24:00 (System Entered Order per Refresh Ru...)	
<input checked="" type="checkbox"/> Discontinued PRN	ceFAZolin	
<input checked="" type="checkbox"/> Discontinued Continuous Infu	sterile water	

MAR SUMMARY- provides a summary of all medications scheduled for the patient in the 24 hour period—highlighted in yellow or the period of which the Search Criteria banner is set to.

LAB – shows labs results

Adjusting the Search Criteria - Several of the pages may require you change the date range to view previously documented items.

- Right click on the gray bar and select Change Search Criteria.



2. There will be multiple ways for you to look up your results.

DI – Diagnostic Imaging results will display here if you have access.

Clinical Alerts - enter the reason a patient might need special care. Example: drug seeker or bulimic.

Histories – Displays Social and Past Medical History

Immunizations – List of previous vaccinations.

Forms - all Ad Hoc forms with charted information can be found here.

Modifying Entries Made on FORMS – Go to forms tab and RIGHT CLICK the form that needs to be modified or cancelled and enter the changed information.

Documents - Consults, previous discharge instructions, history and physical, admission health history reports.

Results Review – Shows IVEW documentation on the Education & Plan of Care, Vitals, Last 48 hours, Patient Care, and Respiratory Therapy

Patient Information - lists patient information, such as Demographics, allergies, visit lists and growth chart.

Schedule - contains any surgical schedules.

Inpatient Summary (Mpages) – provides a summary on the most current medical information, Vital Signs, Measurements, Orders, Documents, Medication List, Allergies, and Patient Information

Problems and Diagnosis – List of Problems and Diagnoses for the patient

KARDEX – Situation/Background/Assessment/Recommendation

RxStation – To queue meds (pre-select meds that you want to get for your patient)

Nursing Hand-Off – Ten Critical Elements needed for Hand Off of a patient.

Critical Elements		
PCTrain, PatientZZ M 25 years DOB: 01/01/1988 MRN: 01271265 FIN: 8003459431 Isolation: Visit Reason:		
Selected visit		
Attending	zzTest, Wheezy Baby	05/08/13 00:19
Physician:		
Service:	Med-General	05/08/13 00:19
Resuscitation	No results found	
Status:		
Isolation:	No results found	
Pain Score:	R leg	12/18/13 08:10
Daily Weight:	56	12/18/13 07:54
Assistive Devices (0)		
No results found		

Last Updated 1/2017

Blood Products Mpage – Shows the patient’s blood type, all blood products that have been administered to the patient, blood product orders, and if there are any blood products available for the patient in the lab.

Blood Products Mpage Print 0 minutes

Expand All / Collapse All

- Blood Type Results

Order	ABO Rh Antibody Scr	Hemosafe Elig	Expiration Date
Type & Screen (PSBC)	A POS Negative ABSC	Eligible	08/31/2014 23:59

- Blood Bank Orders Pending

Order	Order Date/Time	Details	Status
There are no blood bank orders pending for this patient encounter.			

- Blood Products In-House and Available

Product	Unit#	Expiration Date
There are no blood products in-house and available.		

- Previous Blood Bank Orders

Order	Order Date/Time	Details
Type & Screen	08/29/14 11:42:00	Blood, 08/29/14 11:42:00, RT - Routine, Collected, RT, Venous Draw, 08/29/14 11:42:00, PSBB (PSBC)
Red Blood Cells	08/28/14 10:39:54	2 Units, No Attributes, 4-Routine (4-8 hrs), 08/28/14 10:39:00, Hgb < 7g/dL/Hct < 21%, Evergreen Hospital, Blood, Stat, RT - Routine, Print Label, 600583

- Blood Orders

- Blood - Adult
- Blood - Neo
- Blood - Peds
- Emergent Blood & Heme Alert Orders
- Heme Alert

- Other Lab Results

Results	Today	Previous
Hgb	--	14.7 08/26/14 15:19:00
Hct	--	40.9 08/26/14 15:19:00
Platelet	--	320 08/26/14 15:19:00

- Other Labs Pending

Order	Frequency	Order Date/Time	Status
There are no other labs pending for this patient encounter.			

- Total Units Ordered/Dispensed this Encounter

Product	Total Ordered	Total Dispensed
Red Cells	2	1

- Previous Blood Transfusions

Product	Unit#	Dispensed Date/Time	Dispensed To	Volume
PRBC	999912	08/29/14 11:58:00	7Silver-E	250