Inpatient Cerner Navigation and Documentation For Nursing Students

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:

- Understand basic RN workflow in PowerChart.
- Recognize various tools within PowerChart
- 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.
- Adjust search criteria and modify documentation

INTRODUCTION

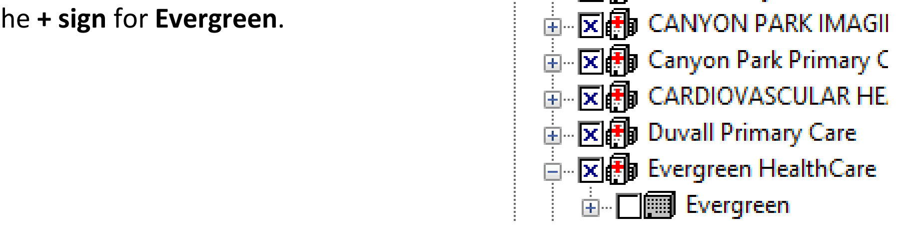
- Log in to the **NETWORK.**
- Log in to *PowerChart (*Cerner) using the training logins provided on separate sheet.
- NOTE: Remember your HIPPA training and the Privacy Rule:
  - You may not view your own patient record
  - You may not open any patient's record unless required for your job/clinical assignment.

Basic RN Workflow for Care Compass

1. When Nurses or Unit Techs first log into PowerChart it will open to CareCompass.
2. The Patient List on CareCompass will appear. This will be blank until you create locations.

   a. To build this list click on **List Maintenance** to the right of Patient List as shown above.

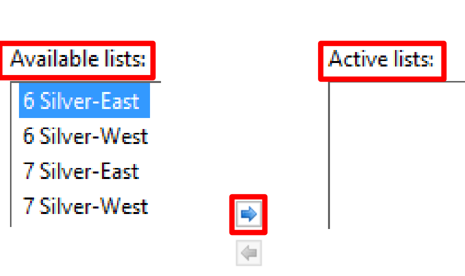
3. To add locations.
   a. Select **List Maintenance**
   b. Select **New**.
   c. Select **Location** and **Next**.
   d. Click on the **+ sign** next to the **Locations** folder, then click on the **+ sign** for **Evergreen HealthCare**, click on the **+ sign** for **Evergreen**.



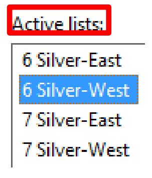
   e. Scroll down until you find **6 Silver-East** and check the box. Select **Finish**.
   Repeat steps 4a-d for **<u>6 Silver-West</u>**, **<u>7 Silver-East</u>** and **<u>7 Silver-West</u>**.
   ***Due to HIPAA protocols, you should only access the side and floor your assigned patients are located.

5T-PAIN-RXS-1
6 Silver-East
6 Silver-West
6SILE-RXS-1
Finish

   f. Highlight the location under **Available lists** and click on the blue arrow to move it to **Active lists**. Repeat this until all available lists are moved to the right under Active Lists.



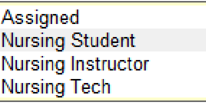
   g. Highlight a list and click on the up or down arrow to arrange them by floor. Click **OK** when finished.



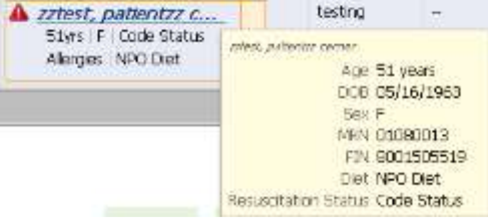
4. You are able to switch between units you've created by using the drop down box next to Patient List.

5. To chart on a patient or open a chart, a relationship must be established:
   a. Select **Establish Relationship**.

   b. Choose **Nursing Student** from drop down and **refresh**.

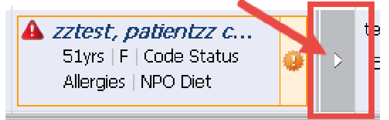


6. Once a relationshp is established, you will bbe able to see more details on a patient:
   a. Hover over patient name to see general information, diet, and code status.

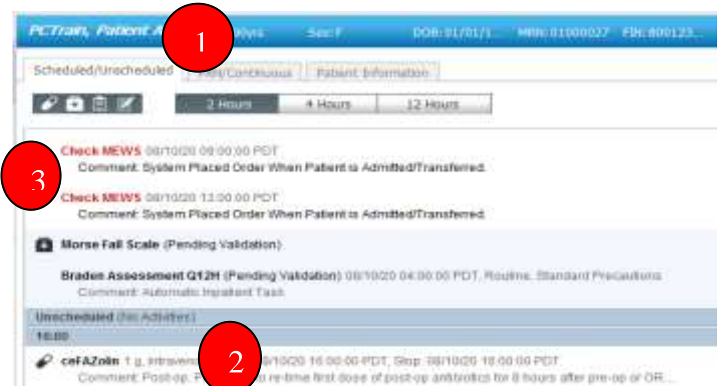


Task List:

7. Select the arrow at the end of the patient name. A task list will appear, to the right, with additional information on your patient. Three tabs will be displayed.

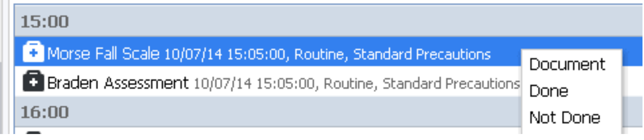


The first tab is **Schedule/Unscheduled**.
① Patient name, age, Sex, DOB, MRN, and FIN #
②Tasks and medications that will be due over the next 2, 4 or 12 hours
③Overdue task are displayed in red

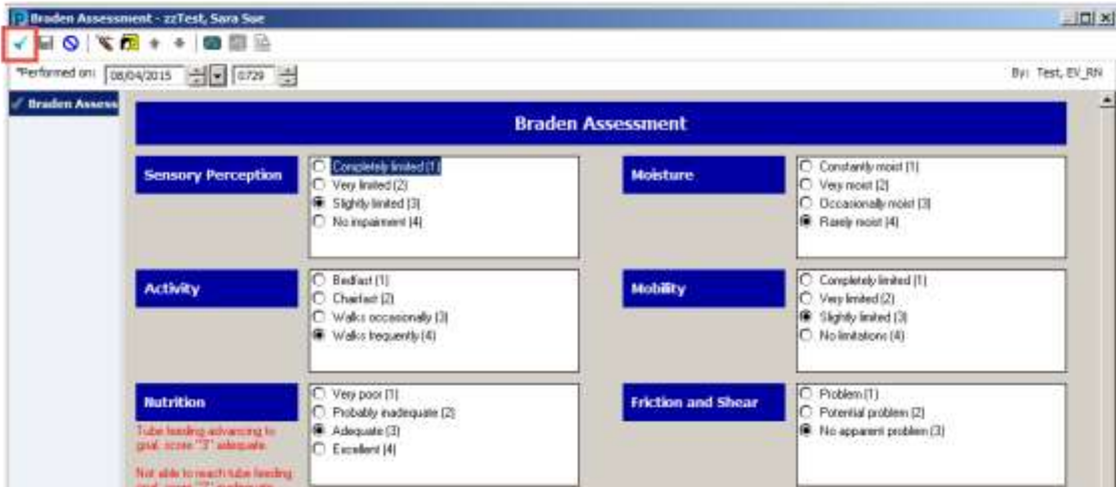


8. Completing Tasks: Select **Scheduled/Unscheduled**. Right click on the gray arrow next to the patients name to open task list view to complete tasks.

   a. Select the task, right click
      i. Select **Document,** to complete the task
      ii. Select **Done**, if already completed
      iii. Select **Not Done**, then give reasoning



9. Fill in your assessment. (All area with yellow backgrounds must be filled in). After reviewing, click on the green check mark in the upper left hand corner to sign the form.

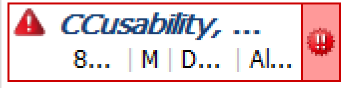


10. Completing Tasks from prior shift on the task list:
    a. For overdue tasks from previous shifts (Braden, Morse, PRN Pain Response, Medications) notify primary RN.

11. Throughout your day check Care Compass for new orders, results, and/or tasks. Refresh OFTEN to see new information for your patient.

12. To review orders:
    a. Click on orange or red box around patient name

Orange Box around patient name with Orange Circle containing '!' inside: 'New Results' or 'New Orders'. 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. If the user put the order in themselves, the orange or red box will not appear, the system assumes you are aware of the order because you entered it
    c. PLEASE always try to document your tasks from the task list instead of using Ad Hoc
    d. Remember to clean up your task list regularly throughout your shift and also prior to shift change report.

*** Students: Do not click **Marked as Reviewed** when reviewing orders from CareCompass.

Name Alerts – 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 - High Patient Risks i.e: Skin Risk, Fall Risk, Restraints, CIWAA score greater than 10

NIK (No Information Known) – patients who do not want outside people to call in and get information. DO NOT acknowledge that the patient is in the hospital

Activity Timeline – (at the bottom of CareCompass)

Red bar, on left end - Overdue tasks

Click 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)

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

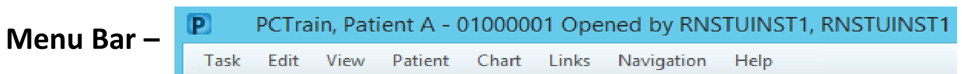
Review across the top of the patient chart

***open your assigneded PCTrain, Patient to review the following

Title Bar – zztest, angelique C - 00966952 Opened by Test, EV_RN

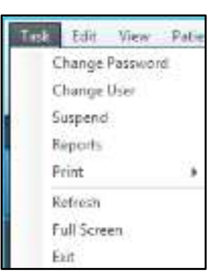
Shows **PATIENT NAME**, **MRN** and **NAME** of who opened the chart.

Menu Bar –



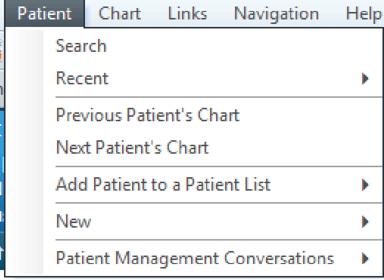
Task:

- Change User – use when you want your primary nurse or preceptor to cosign your documentation
- Exit - enables user to gracefully exit the *PowerChart* system.



Patient:

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



Icon Bar –

CareCompass – Click you return to your CareCompass

Service Directory – Most up-to-date hospital wide directory with every department's contact information (phone or pager)

Patient List – Find your patient on the **Patient List.** (Used by clinical staff, other nurses and unit techs)

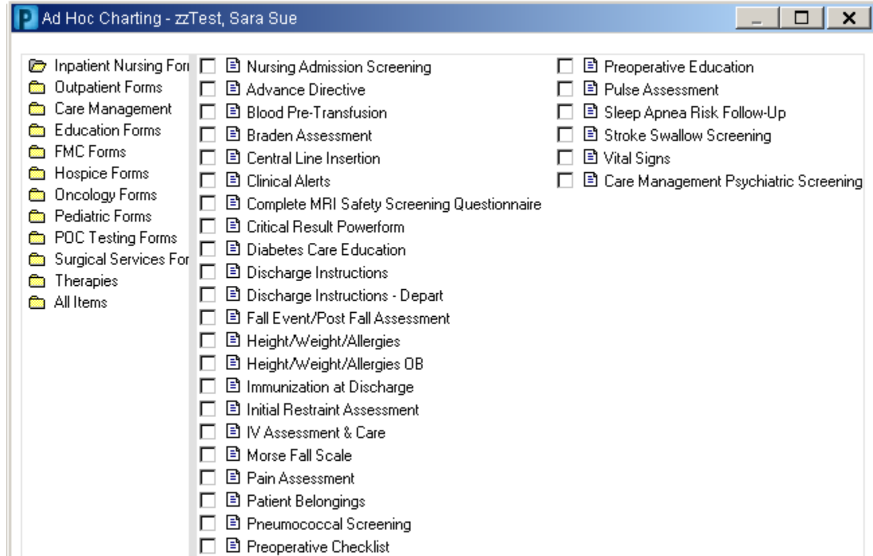
Links – provides access to online applications: i.e. DynaMed, Lexicomp, Lucidoc, & other resources.

- **DynaMed** – Tool for efficient and evidence-based patient care.
- **Lexicomp** – Medication resource tool to look up medications information such as IV compatibility interactions, patient education and more.
- **Lucidoc** –EvergreenHealth's policies and procedures

Exit – closes all applications.

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

AdHoc Charting – Categorized by disciplines (folders on left). Available forms are within a selected disciplines (on the right side).



Medication Administration – displays patient medications after you have scanned the patient.

Patient Education –Allows nurses to add Educational material to the patient's chart. (Only an option when in a patient's chart)

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.

Refresh or 'As Of' – updates all information entered on your patient. You must remember to refresh after making any changes and refresh often to see new orders or changes others have made.

Navigation Within the Patient's Chart

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

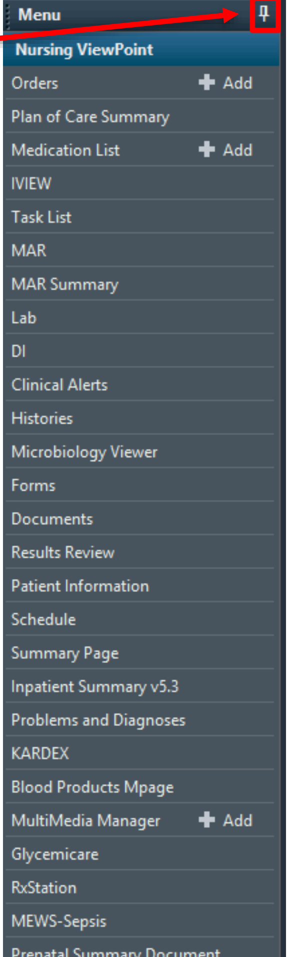
1. Patient Name – (active link) double clicking on the patient name will show general patient information.

2. MRN# (medical record number, patient's hospital ID) & FIN # (unique financial number for a specific visit) – both are displayed.

3. Other items found on the Banner Bar:
    a. Allergies, Code status, Patient Age, Date of Birth, Sex, Admission Date
    b. Encounter type, and Patient location (active link - shows General Information)
    c. Isolation Status – Standard, Contact, Contact Enteric, etc.

Navigation down the Menu Bar in the Patient's Chart

The menu bar is similar to the tabs in a hard chart.
Select the **pushpin** to keep it open on the left side of the patient's chart.



Nursing ViewPoint –Nursing Handoff, Nursing WorkFlow, Discharge Summary, Depart Process and Impatient Summary

Orders – Lists all active orders.

Plan of Care Summary – List of interdisciplinary plan(s) of care (IPOCs) for the patient. These are your nursing goals or nursing plan of care.

Medication List – List of the patient's current medications. This will be also covered with the Orders. There is also a list of the patient's home medications under | Document Medication by Hx |

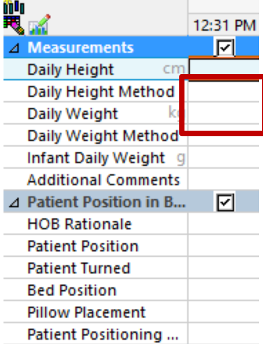
MEWS-Sepsis – modified early warning system with a computer calculated score of patient's possible sepsis status.

IVEW – Patient assessments are documented here. All documentation done by the Student RN in IVIEW will show as unauthenticated until the primary RN signs it.

Entering Information into IVIEW

1. Click on the IVEW tab to open the flowsheet for documentation. It will first open to the **Vitals.**

2. Double click on the **time** to open whole column to chart

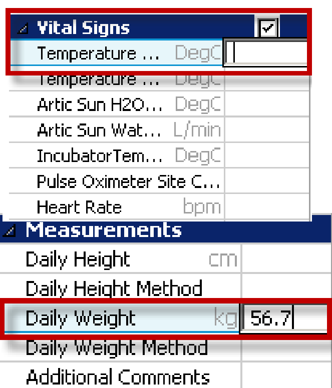


Or

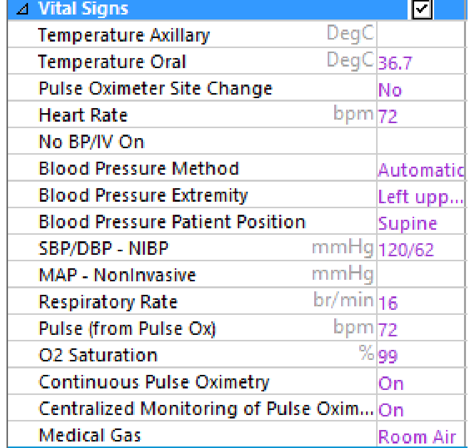
3. Double click in the **blue header** above the section to activate the section to enable data entry.

Or

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



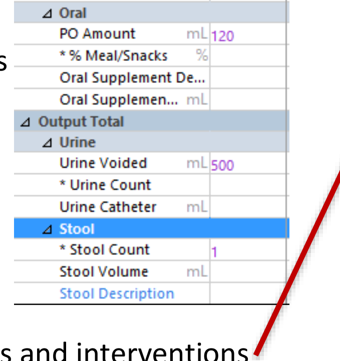
4. The documentation will be purple until it is signed.



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. **Isolation Status** – must be documented in IVIEW if the patient is under any type of special isolation precautions. Patient Isolation is located in the Vitals band directly below the Vital Signs.

7. **Intake and Output** –Enter the patient's I&O. i.e oral, urine, stool ect).



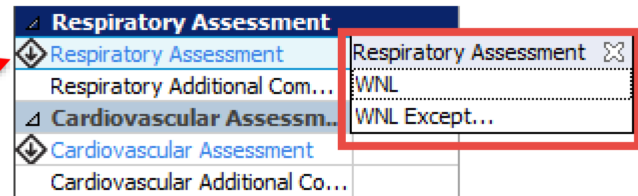
Interventions
Abductor pillow
AM care
Arctic Sun
Boots - On
Boots - Off
CHG Bath
CPM Machine
Enema
Heating Pad
HOB elevated
HS care given
Lenard Splints
Incentive spirometer
Ice pack
Linen Change
O2 tubing protectors on
Oral care

8. **Interventions** – Document on activities and interventions

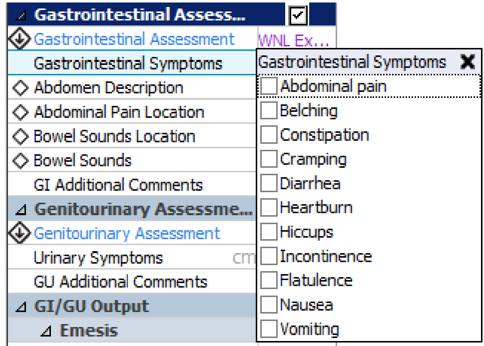
Documenting by Exception for the Routine Nursing Assessment

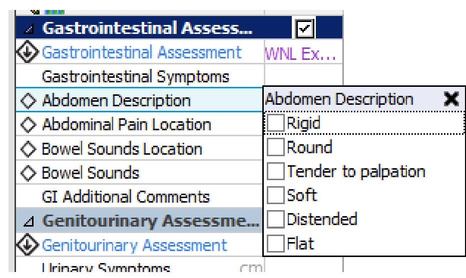
Assessment documentation in IVIEW is described as charting by exception. The following examples are under **Routine Assessment**.

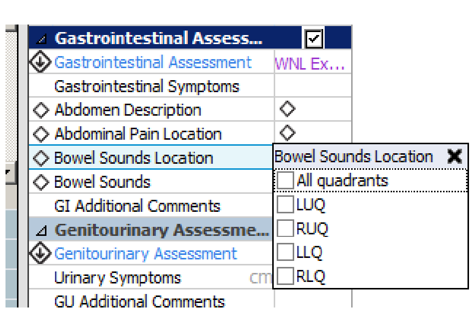
1. If your assessment for a specific system is **W**ithin **N**ormal **L**imits (WNL), you can just select WNL. A reference is available for you to see what the normal limits are for that system.



2. 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.

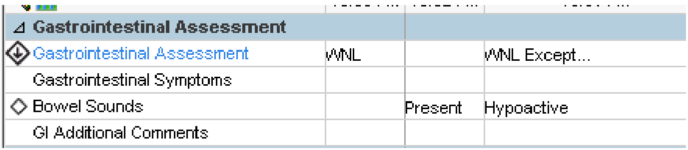






3. If the patient's condition improves and the system assessment is now normal, at the time the assessment becomes normal the nurse will need to document to show how and when the patient assessment is normal by selecting WNL for that system.

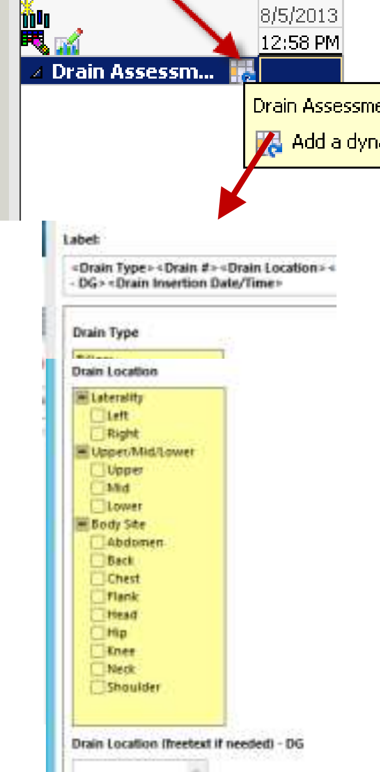
4. After the documentation shows what the normal value is, WNL can now be documented. From then on, as long as the assessment continues to be WNL, this may be documented.



Documenting dynamic groups

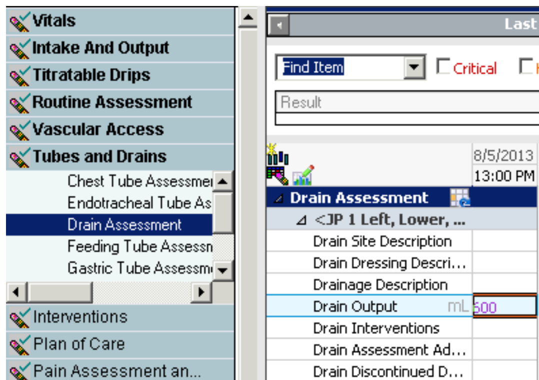
1. In Tubes and Drains, select Drain Assessment.

2. To add a drain, click on the grid to Add a dynamic group .

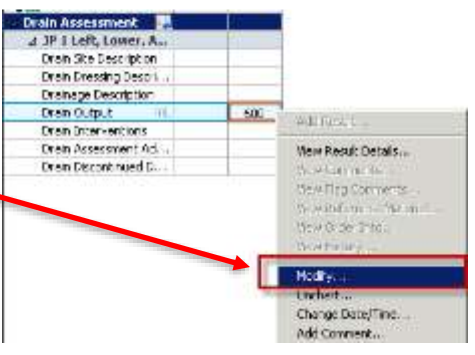


3. Fill in Drain type, Drain #, Drain location, and D insertion date/time. ***Make sure to fill in the date even if you do not know the exact time. In this case, leave the time blank.

4. Add a drain volume
   - Double click in the Drain Output field, then enter the amount 600.
   - Sign data, by clicking the green check mark, then refresh the screen.

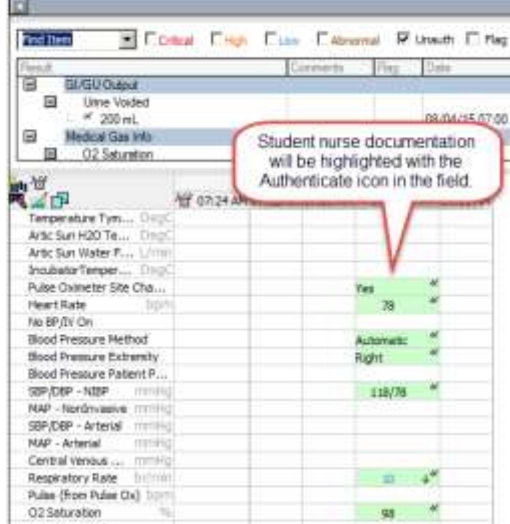


5. Modify Patient Data
   - Right click in the field where you just charted and select **Modify**



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

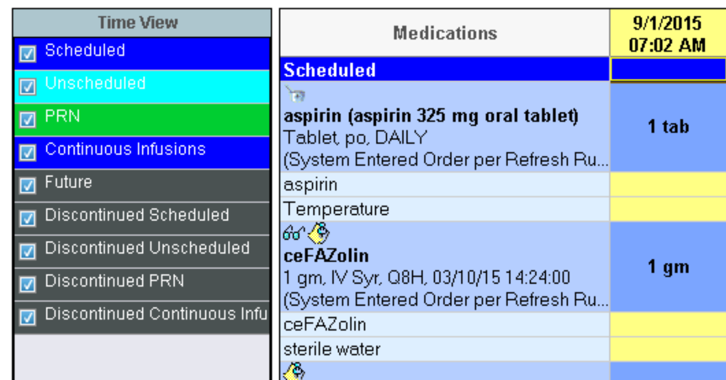
6. The student nurse documentation in IView will be displayed as shown on the right.



7. All documentation done in CareCompass will then show as pending validation until the primary RN cosigns the charting in the student nursing sign-off band using this icon is at the top of IView in the RN's view.

MAR

Medications should never be given by the RN student without observation from an RN or the student's instructor. Immediately before the medication is given it should be scanned, reviewed and documented in the patient's chart at bedside.

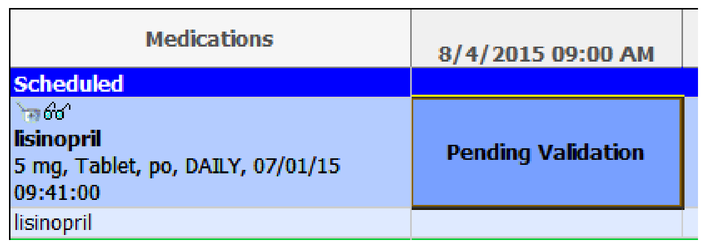


Open the MAR to review the scheduled, prn and IV medications.

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. Scan both the patient's armband & the medication

***Remember to look at your **Medication Administration** screen after each medication is scanned.This ensures the medication actually scanned. The scanners on the floor BEEP even if the medication did not scan or if additional steps are needed before scanning the next medication.

Medications will show Pending Validation until cosigned by the primary RN or student's RN instructor.



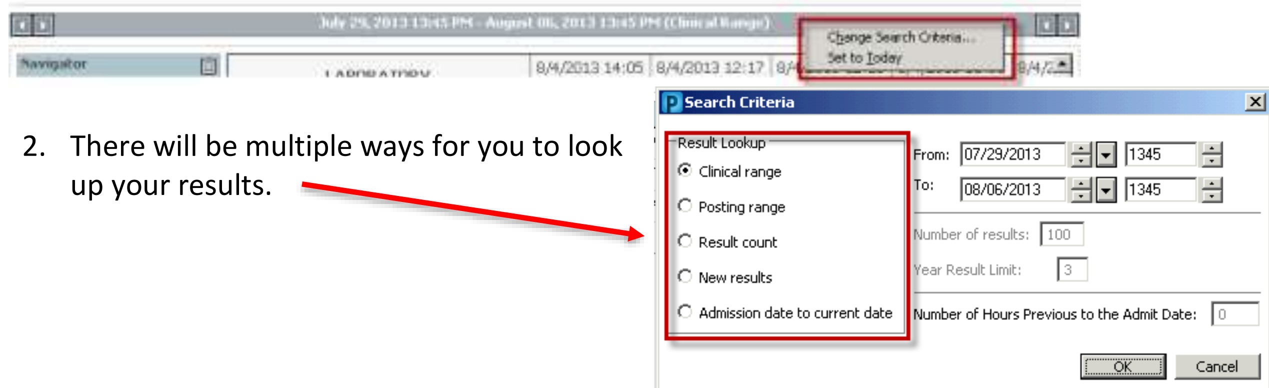
Any medications that are **RED** on the MAR please review with the primary RN before the end of your shift (why was the med not given at all or the time it was given late and why).

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.

1. Right click on the gray bar, select **Change Search Criteria**, and fill out the dates you need to view.



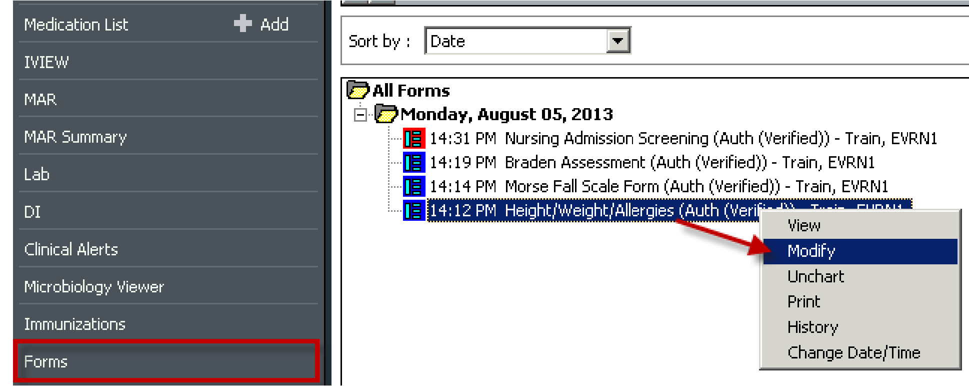
2. There will be multiple ways for you to look up your results.

DI – Diagnostic Imaging results will be displayed here.

Histories – Displays Social and Past Medical History

Forms – all completed forms from the task list & Ad Hoc can be found here.

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



Documents – Consults, previous discharge instructions, history and physical, admission health history reports and provider and nursing progress notes.

Results Review – Shows trends in IVEW documentation on the vitals

Patient Information – lists patient information, such as demographics, allergies, visit lists and growth chart.

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

KARDEX – Situation/Background/Assessment/Recommendation

Blood Products Mpage – Shows the patient's blood type, all blood products that have been administered to the patient, blood product orders, and available any blood products for the patient.

Glycemicare – Blood glucose levels if applicable.

RxStation – Location where medications can be queued to be pulled out of the medication room. Only queue medications that you have reviewed with the primary RN or your instructor.

<u>Charting Quick Tips:</u>

T=Today **Recent Patients** – shows last 9 patients

N=Now **Right click** for additional information

Refresh frequently so that you can see new orders and changes.