Welcome to Epic Inpatient Nursing!

This booklet will be used to provide Epic practice as you work through the e-learnings.

You should have received an email with how to access the Epic playground from home. If you did not please contact the OD&L department at 815-935-3276.

After you complete one of the lessons within the olie lesson "Epic IP Nurse Classroom E Learnings", please come back to the booklet and complete the pages that correspond.

Lesson:	Pages that correspond in booklet:
The Brain	2-3
Flowsheets	4-6
Specimen Collection	7 (collect a lab)
LDA Avatar	7 (assess, remove, and add a line)
MAR & Glucommander	8-11
Unit Manager	11
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Admission Navigator	15
Care Plan	16
Education	17
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The remainder of the lessons give you a little extra information on pieces within Epic that are great to go through; however, we are unable to provide practice within the training for them.

Riverside
HEALTHCARE

INPATIENT RN 100/200 WORKBOOK

Begin your shift

Assigning Patients

In this exercise, you will Sign In for your shift and get acquainted with the Brain.

<u>TRY IT OUT</u>:

- Log In to Hyperspace with the User ID and Password found on your Classroom Info sheet

    o Select RMC Intermed

- From the Sign In Window, click Sign In

    o Use the "X" to delete the currently listed departments and search for the RMC Intermed.

    o Place your pager number in the Contact # field – you will need to put a # in front of your extension

    o Select the following patients with you last name:

        ▪ Kelsey

- If you get a "What's New" pop up, click **Show me later**

- Review the helpful hints for the Brain and click "Let's get to work"

Let's see where the pager number you just documented went.

- Double click on a patient name from the Brain.

- While on the Summary scroll down to the area you see the Treatment Team. Do you see your RN name and the extension you just documented? Why would this information be helpful during your shift within the Epic chart?

_____

_____

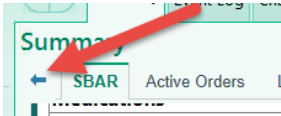Select the **X** by the patient tab name at the top to close this chart.

- Take some time to explore the patient cards and icons shown on the Brain

    o Hint: Hover to Discover or Single Click for more information

Get report

In this exercise, you will review a patient's chart.
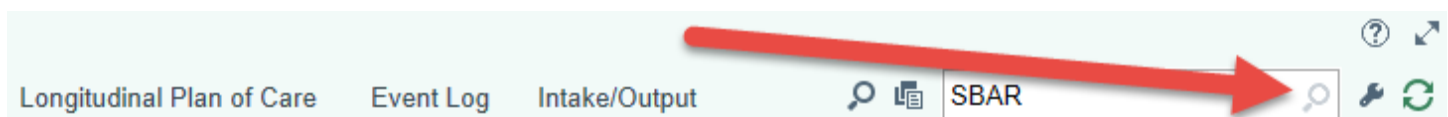
<u>PATIENT</u>: Kelsey

<u>TRY IT OUT</u>:

- Open a patient chart (hint: double click)

- Confirm chart is open to the **SUMMARY/SBAR** report

- I see the principal problem is: _____

- Does the patient have any LDA's? _____

  - Hint: Find the **Lines, Drains, and Airways** section of the **SUMMARY/SBAR** report.

- What are the current medications?

- When are the next meds due?

  - Hint: Use the **Report** link in the **Medications** section. Click the **Legend** link to view the Legend and determine Due medications.

  - Return to the **SUMMARY/SBAR** report.

    - Hint: click

- Does your patient have new orders to be acknowledged?

  - Hint: Find the **Orders to be Acknowledged** section

- What other information is available at your fingertips in the **SUMMARY/SBAR** report?

If You Have Time

- Explore the other reports (tabs) you have access to within the Summary Activity

- Open the search bar on the right to see even more reports you are able to access

Document vitals

<u>SCENARIO:</u>

You just visited your patient for the first time. You collected vitals and now you'd like to document them.

<u>TRY IT OUT:</u>

- Navigate to the Flowsheets Activity (Open Kelsey's chart if it is not already open)

- In the Flowsheets activity, which button should you click to document at the current time: **Add Col** or **Insert Col**?

- If you haven't already, add a time column for the current time in the **Vitals** Flowsheet.

- Document the following values:

  - Temp: 101.3 F

  - Temp Method: oral

  - Heart rate is 105 beats per minute, taken from the monitor.

  - Respirations are 23.

  - Blood pressure is 103/60.

    - *Tip*: You can use a space instead of a slash when you document blood pressure.

  - You collected BP manually from the patient's right arm. Keep the Patient Position cell blank for now.

  - SpO2 is 95% on Room Air

- You ask your patient to rate their pain on a scale of 0-10. They state their pain is at a 4. When you ask where the pain is, they point to their right knee, where the infection started. She describes the pain as aching and throbbing. Document that information.

- Click the **Last Filed** button to view the most recent documentation.

- The weight is unchanged since it was last filed, but you still document the value.

  - Tip: Height & Weight requires a unit of measure. The system will calculate the height to **cm** and weight to **kg**.

- The data you just entered currently appears with blue lines in the flowsheet cell, which indicates the information is pending and isn't yet filed.

- There are two ways to save the information.

  - Select File in the upper left corner of the screen. Click **File** now.

- Once you selected save, what popped up?

Best Practice Advisories (BPAs)

BPAs is an alert that something has changed in your patient's condition based on the information documented. It is important to look through the information and at appropriately. This may warrant a call to the provider if this is a new change.

- Select an **Acknowledge Reason** or your choice now.

Flowsheets Continued

- The documentation you recorded is still there, but the blue lines are gone so the documentation is now filed.

- You can also save the information by moving away from the flowsheet you're currently looking at.

  - You can open another tab in Flowsheets.

- In the Patient Position row (for BP), enter Lying.

- Click **File**.

- You just realized you entered the wrong data for respirations. The patient is actually breathing at 20 respirations, not 23. Fix the data in the chart and click File to save the data.

- You notice the black corner that appears in the edited cell. What do you think this means?

  - Hint: Use the **Legend**

- Check the audit trail for respirations:

  - Select the respirations cell that contains the data you changed.

  - In the Details report, expand the Show Audit section and review the audit trail of documented values.

    i. NOTE: The Audit Trail shows time taken AND time recorded.

Document assessments

SCENARIO:

In this exercise, you'll document an assessment.

TRY IT OUT:

- Open the Assessment Flowsheet.

  If you are an ICU RN please use the magnifying glass and wrench in the ICU Assessment flowsheet tab to get familiar with what you will be using. To search you will need to select the Override Template Order checkbox.

- You performed the assessment 20 minutes ago. Use the **Insert Col** button to add a time column for 20 minutes ago.

  - Tip: Enter n-20 as a shortcut.

- The Neuro assessment is within defined limits (WDL).

    - Hint: Use the Details report to review the defined limits. If you don't see the report, use the small blue arrow to the right of your flowsheet to expand it.

    - Select WDL for the assessment.

- The patient meets WDL criteria for HEENT and you didn't perform any HEENT interventions.

- Respiratory depth is regular. There is accessory muscle use. Bilateral breath sounds are clear

- Document an abnormal peripheral vascular assessment.

    - Hint: Click **PVS** from the Table of Contents

- Document edema on right lower extremity.

    - Use the paper icon to add a comment to specify the edema is on the right knee.

- Document an abnormal integumentary assessment. Choose your own values.

    - Click **ADD** in the cascading rows pop up, click OK

- **File** your documentation

If you have time: Document daily cares

If you are an ICU RN please use the magnifying glass to the left and find ICU Cares/Safety (you may need to go to the Facility Pref. List to find it). This includes the palliative care documentation.

SCENARIO:

Your patient is doing well and is starting to move around. You're ready to document daily cares.

TRY IT OUT:

- Open the Daily Cares/Safety Flowsheet.

    - Hint: You might need to search for this Flowsheet.

- Using your own clinical knowledge, document an assessment for Safe Environment. Choose your own values.

- While assessing mobility, you determine that your patient is up and moving around the room with little assistance. Document their activity.

    - Hint: Remember the mnemonic "left-click to pick, right-click to stick" when you're documenting from the Details sidebar report.

- *Challenge*: Document an assessment group without using your mouse:

    - Use the **Arrow Keys** and the **Spacebar**.

    - Press **Enter** to move to next row.

    - Press **F5** to view your choices.

- Press **F6** to add a comment.

Collect a lab

PATIENT: Kelsey

SCENARIO:

The physician ordered a urinalysis to be collected and sent to the lab. You'll collect the specimen, print the label, and send it to the lab.

TRY IT OUT:

- Where in Epic can you print the specimen label and document the specimen collection?

- Use the **Brain** to document the collection this time.

- From the **Brain**, find the 1100-specimen collection task for your patient.

- Click on the specimen collection icon.

- Start by clicking the **Print Label** button to launch the specimen collection window and click **Print Labels**.

    - Note: You won't actually print the label in training.

    If you were on the unit you would be printing the labels at the desk and then logging out and walking down to the patient's room. Once you were ready to collect you would then log into the computer at the patient bedside and finish the process.

- From the Brain the option of Print Label changed to **Collect**. Select this now.

- You would scan the patient label at this point but will bypass this in training for now. Select and Override Reason and click Accept.

- Select the blue hyperlink that states to **Scan the label or Click to document the collection**.

    - You will override the specimen not scanned for training purposes.

- Fill in the required information and confirm the information is correct and click **Accept**

- What icon on the Brain indicates that your collection task is complete?

Assess, remove, and add a line

PATIENT: Kelsey

SCENARIO:

Your patient is due for some IV meds but first you'll assess and manage her active lines.

TRY IT OUT:

- Open LDA Avatar

    - Hint: Navigate to Flowsheets.

- Find the left PIV and document an assessment using your clinical judgement.

    - Hint: In the Avatar, hover over the left PIV and click **Assess** to open the assessment window.

- After your assessment, you decide to remove the existing left PIV and add a new line.

- Remove the left PIV. Document the current date and time for removal.

    - Hint: Hover to Discover!

- Add a new peripheral IV to the patient's left arm. Use your clinical judgement for the location/orientation.

    - In the **Add** field**,** search for "PIV".

- Document the properties.

- Don't forget to document your assessment!

    - Hint: Hover to Discover!

Administer medications

Adjust medication administration time

PATIENT: Kelsey

SCENARIO:

Your patient was gone this morning when he was supposed to receive his knee ointment.

TRY IT OUT:

- Navigate to the MAR for Kelsey.

- Click the **ALL** tab

- We need to adjust the Due time because Kelsey needs a dose now and then again at noon when it is ordered for.

    - Select the **Due** for 1200 dose first.

    - Adjust the Action to **Due**—doing this will remove the need for scanning since we are not actually administering it.

    - Select **Accept**.

    - Change the Time to the current time for administration now.

- When you accept you will see a Warning appear. This is asking if you want to Move or Add this time.

Add = Patient will have an extra dose at the current time and then proceed with the scheduled dose as planned.

Move = Patient will get same number of doses but the dose being moved will not be the originally planned time.

- Choose to Add this dose so we can be sure to apply it again at 1200.

Administer simple meds

PATIENT: Kelsey

SCENARIO:

Your patient is due for her application of knee ointment.

TRY IT OUT:

- Navigate to the MAR for Kelsey.

- Click the **All** tab

- Click **Show All Details** to see details for all the medications at the same time.

- Find the row for the erythromycin ointment.

  - Review the medication details.

- Click the blue **Due** button. In the med admin window, enter the following details:

  - Tip: Bypass the patient and medication scan with a reason of "scanner not available"

    You may get a warning saying the order start time is in the future...we will select **Yes** to administer the added does now.

    Since we are in the training environment there is not a pharmacist actively going through and verifying medications we will select **Yes** to that

  - **Action**: Given

  - **Date**: today

  - **Time**: due time

  - **Dose**: 1 application

  - **Off Schedule Reason**: Dose rescheduled

  - Click **Accept**.

- Notice the Given action that now appears on the MAR.

If you have time: send a message to the pharmacy

SCENARIO:

Imagine that you rescheduled the next dose of your patient's eye ointment, but you'd like the pharmacy to adjust the ongoing schedule forward by one hour.

TRY IT OUT:

- Create a message to the pharmacy about your patient's dose:

    - On the right side of the MAR, click the **Rx** button for the ointment order for which you already would have adjusted the next Due time.

    - The Send Message to Pharmacy window opens. Note that it already includes the patient's name and the relevant medication.

    - In the **Reason** field, enter Adjust Times and press **Tab**.

    - Write a note to the pharmacy in the **Message** field.

    - Click **Send**.

- To review the message, you just sent to pharmacy, click **Rx Messages** at the top of the MAR. Notice your message under the **Recent message history** header.

Administer IV medications

PATIENT: Kelsey

SCENARIO:

Your patient is due for an IV med. Document that you started a new bag at the due time. **Try it from the Brain this time**.

   ** Remember in the live environment, you will be scanning the patient wristband and the medication**

TRY IT OUT:

- Click the Medication Icon

- For the IV fluid (1100), click "Document".

- Bypass the scans with a reason of "scanner not available".

- Link the line (select Medial Port).

- Note your Action defaults to New Bag.

- For the sake of training, change your start time to "**n-15**". Confirm the rest of the details listed in the med admin window and complete your administration.

Stop an IV med

Now, let's stop the infusion so you learn how to document stopping an IV med on the MAR.

- Open the MAR and find the row for the IV antibiotic.

- The infusion was running for 5 minutes and then you stopped it.

- Click the "due stopped" button.

- In the med admin window:

    - **Action**: Stopped is defaulted in

    - **Date**: today is auto filled

    - **Time**: **N** for now

- Click Accept and see the Stopped action listed on the MAR.

Edit an administration

SCENARIO:

The time you recorded for the Stopped action is incorrect. Edit the administration details to reflect accurate timing.

TRY IT OUT:

- Find the row for the infusion you just stopped.

- Edit the stopped action to be **5** minutes earlier than you originally entered.

    - Hint: Click the Stopped action and select the **Edit administration** check box.

Arriving a Transfer Patient

SCENARIO:

Pablo, a renal failure patient, is being transferred from the ICU. He just arrived on your floor and the charge nurse assigned you to care for him during this shift. The unit clerk, who usually performs transfers, is busy. You need to confirm Pablo's transfer.

In training, you will be transferring Pablo from RMC ICU to RMC Med-Surg. You'd follow the same steps for any other inter-unit transfer.

TRY IT OUT:

- Open the RMC Med-Surg Unit Manager.

- Find Pablo (he's an incoming transfer) and complete the transfer.

    - Drag and Drop Pablo into an open bed on the manager

    - Click Transfer

- Where does Pablo now appear in the Unit Manager?

- Assign yourself to Pablo:

    - Right click on Pablo and choose **Treatment Team**

    - Click **Add Me**, and Accept

    CHECK YOUR WORK:

    Your Pablo patient should no longer be in the Incoming Transfers section
    You might need to click **Refresh**

Managing Orders

In this exercise, you'll practice working with the common orders from your unit. You'll need to know how to navigate and use the Orders activity for review and for making modifications as requested by the physician.

- PATIENT: <mark>Carlos</mark>

** You will search for your Carlos patient from Patient Lists and Assign Yourself (R click-Assign Me) **

Entering, Modifying, and Discontinuing Orders

Your patient's family asks you how they can get in contact with a spiritual advisor. One way to do this is with a consult order.

TRY IT OUT:

- Open Carlos' chart

- Navigate to Orders Activity

- Place a **Nursing Consult to Spiritual Care** order for your patient.

- Document the Reason for Consult: **Family requesting spiritual advice**.

- Sign the order per protocol (**no cosign** required). Fill in **Martin Stitch** as the ordering provider.

SCENARIO:

Dr. Martin Stitch calls and asks you to make some changes to your patient's orders.

TRY IT OUT:

- Find the patient's active orders.

- Discontinue the patient's diet order.

    - When you discontinue an order, it appears crossed out on the **Active** Tab. Orders you've discontinued also appear in the Orders sidebar.

- Modify the frequency of the vitals order. For example, if it's currently once every four hours, you might change it to once per shift.

- Change the rate for the Sodium Chloride Infusion.

    - Remember, You can **Modify** rate or frequency, but when you change the form or route, the pharmacy must dispense a new med—so you need to **Discontinue** the current order and place a new one.

- The physician called back and said not to change the vitals order. Remove it from the list of orders that will be changed when you click sign.

    - Hint: Hover over the order to find the X button.

- You're called away to assist with another patient and the physician can't stay on hold until you're ready to sign. Because you won't be able to keep him on the phone to help you deal with any alerts or warnings when you sign the orders, you should save the changes you have queued up.

SCENARIO:

While you were busy, your patient got restless and started picking at their IV line. You call Dr. Stitch back, but he's still stuck in traffic. He tells you to put in an order for non-violent restraints. He'll check on the patient as soon as he arrives at the hospital.

TRY IT OUT:

- Place a non-violent restraints order for your patient

- Sign this order as "per protocol (**cosign** required)", but not the saved orders. The physician will review and sign the other orders when he rounds on the patient.

- Fill in the Providers window with the appropriate information.

- CHECK YOUR WORK:

- As soon as you sign the orders, they become active. Go to the **Summary** activity. You should have a non-violent restraints order listed in the Orders to be Acknowledged section.

- Click **Acknowledge** to sign off that you have seen these orders.

Release signed & held orders

PATIENT: Pablo

SCENARIO:

The surgeon signed and held orders for your patient that should begin as soon as they arrive on the floor. You'll review and activate those orders.

Always make sure the orders you are releasing are for post-op care and not pre-op or intra-op.

TRY IT OUT:

- Open the patient's chart.

- How do you know that your patient has signed and held orders?

  15

- Open the **Orders** activity.

- Click the Signed & Held Tab.

- Review and release your patient's Signed and Held Orders.

- Go to the **Summary** activity and acknowledge all of the patient's new orders.

Admitting a Patient from the ED

PATIENT: <mark>Owen</mark>

SCENARIO: The charge nurse informed you that you're receiving a new patient from the emergency department.

TRY IT OUT:

- Use the Search feature in Patient Lists to find your Owen patient

- Assign yourself to the patient's Treatment Team and open the chart to begin admission documentation.

Documenting in the Admission Navigator

Now you will practice working through the admission navigator documentation for your patient.

TRY IT OUT:

- Find the **Navigators** activity and open the **Admission** Navigator

- Enter vitals for your patient and a pain score.

- Who was the last person to review your patient's allergies?

  - Hint: Check the **Allergies** section.

- Add an allergy to sulfa antibiotics, with a patient reaction of a rash.

  - Hint: You need to open the section to search for a new agent.

- Indicate that you reviewed this information with the patient (or a family member).

- Update the patient's medical, surgical, and family history by adding a few items you often see.

  - If you can't find an item you want to add in the list, search for it in the **Add** field.

- What prior to admission medications is your patient on?

- Add a couple prior to admission medications that you often see.

- Indicate when these medications were last taken:

  - Let's say all the medications except one were taken this morning. How can you document this efficiently?

  - Hint: There are buttons in the upper-right for **Mark Unselected Today** and **Mark Unselected Yesterday**.

- After clicking Mark Unselected Today, mark one of the patient-reported meds (the meds with a person icon) as more than a month since it was last taken.

■ In addition to adding medications to the list, you might need to remove some based on what the patient tells you. Remove one of the patient-reported medications.

- Hint: Click the red X on the right of the screen for that medication and then remove it.

■ Lastly, indicate that the medication list status is now **RN Complete** and indicate that you confirmed this information with the patient.

- Use the **Med List Status** field and **Mark as Reviewed** button.

■ With the remaining time, you have for this exercise, continue to explore the assessment portions of the Admission navigator. Fill out any sections you'd like to become more familiar with these sections.

Most of the navigator sections are either view-only reports that show information or flowsheet assessments where you can document by typing and clicking buttons

Documenting on the Care Plan

You're still working with Owen. You need to complete a **skin risk assessment** and add templates to his care plan.

TRY IT OUT:

■ Find the Assessment section of the Admission Navigator.

■ Document a Skin Risk Assessment

- Owen has limited sensory perceptions.

- His skin is very moist.

- He's bedfast and his mobility is limited.

- His nutrition is probably inadequate.

- Friction and shear might be a problem.

■ Based on your documentation, the system suggests adding a template to Owen's care plan. Add that template.

■ Open the Care Plan activity.

■ Document Expected End Dates.

■ What template was added automatically to Owen's Care Plan?

- Apply the General Patient Management template and add all Problems/goals.

  ➢ When Care Planning for your real patients, only select the problems/goals relevant to your patient.

Some time has passed, and you're ready to document Owen's progress...

TRY IT OUT:

- Resolve the problem of Pain.

    - Choose an appropriate outcome.

- Now you are ready to document outcomes for the remaining goals:

    - Click Document

- **Skin integrity is maintained or improved**:

    - Expand the goal by clicking on the double arrow

    - Outcome = **Progressing.**

    - Select a few appropriate associated interventions.

    - **Click Next**

- Follow the above steps for the rest of the goals.

- Once documentation is complete, you will see your Summary and Note.

    - Review your goal documentation on the left of the page.

    - You can add individual goals, or you can **add all** to your note.

    - In the Note section, update the date and time if necessary.

    - Review the goals that were added to your note.

    - At the End of Shift Summary prompt;

        i. Document a summary of your **patient's progress, barriers and significant changes during your shift**.

    - Sign your note.

        You can review and/or addend your Care Plan note from the Notes activity

Documenting Education

You need to teach Owen about treating his pneumonia and other aspects of his care. After referring to the list of teaching points, you explain tips for prevention of future illness to Owen and his mother.

TRY IT OUT:

- Open the Education activity to the **Assessment** Tab. Complete a learning assessment for Owen and his mother.

    - Document barriers to learning and learning preferences based on your clinical experience.

- Open the **Education** Tab. Add the title for **Pneumonia**.

- Select the check box next to the topics and points appropriate for your patient.

- Click **Accept** to add all the selected items to the tree.

- From the tree, select the topics you want to teach Owen and his mother.

    - Review the descriptions and any handouts.

    - Document that you taught them these topics and record their responses.

    - File the education.

    - If their responses are sufficient for completing the education, ✅ appears next to the appropriate titles, topics, and points. If the responses aren't sufficient, 🔄 appears.

- When you're completely done teaching something to the learners, you can resolve it:

    - Select a topic and click **Resolve**.

    - Select a reason of **Education Complete**.

- Resolved education no longer appears in the tree. The icon has changed to ✅.

    - To see it, click **All**.

    - If you select a resolved topic, you can **Reactivate** it. If you reactivate a piece of resolved education, it reappears on the active education tree.

    Any unresolved topics at the end of this admission carry over to the patient's next encounter

Discharging a Patient

- PATIENT: <mark>Lyle</mark>

Reviewing the Patient's Discharge Information

Lyle is a 45-year-old kidney stone patient who's recovering nicely. His labs aren't all resulted yet, but the physician has decided it's okay for Lyle to head home. Lyle is wondering which labs will be resulted after he goes home. While you're checking on those lab results, you decide to complete some of Lyle's discharge tasks.

TRY IT OUT:

Find your Lyle patient using patients lists, Right click and assign him to you

- Open Lyle's chart and acknowledge his discharge orders.

- Go to Flowsheets to stop Lyle's running infusions and document the I/O totals. (Use the calculated volume.)

- Open the Discharge Navigator. Document a final assessment for Lyle's line, then remove it.

SCENARIO:

You want to review the medications Lyle will be taking when he leaves the hospital so you can prepare to answer any of Lyle's questions.

<u>TRY IT OUT:</u>

- Which medications will Lyle resume taking at home?

  - Hint: Check the **Status** column in the **Med Rec Status** section.

- Which new medications is the physician prescribing?

Reviewing Discharge Instructions

Now, you need to review and update your patient's discharge instructions.

<u>TRY IT OUT:</u>

- Review the physician's medication orders and add any discharge instructions you have for Lyle, including when to take the medications.

- Review the activity and diet orders and supplement the discharge instructions with additional information and clarification as appropriate.

- If you have extra time, document symptoms, outside referrals, and appointment instructions for Lyle.

<u>CHECK YOUR WORK:</u>

- Preview the After-Visit Summary (AVS). Make sure the instructions you entered appear below the physician orders.

<p align="center">Close **Lyle's** chart.</p>

End your shift

Document shift I/O

PATIENT: Kelsey

<u>SCENARIO:</u>

Now you'll document your patient's intake and output to complete your shift documentation.

<u>TRY IT OUT:</u>

- Open Flowsheets to the tab you'll use to document intake and output.

- Use your clinical judgement to document the following additional intake and output values:

  - P.O intake (mL)

- Voided urine (mL)

- Unmeasured stool occurrence

Sign out

SCENARIO:

You're done with your shift and ready to go home. The last thing you need to do is check your Required Documentation is complete and sign out.

TRY IT OUT:

- From patient lists, single click on each patient and open the Req. Doc Report to confirm completion.

- From what workspace did you Sign In at the beginning of your shift?

- Go to that activity and click **Sign Out**.

    - This takes you off the treatment team of your patients.

    - Notice your My Patients list is now blank.

Always make sure you sign out before you leave.

(If you forget, the system will automatically sign you out an hour after your shift's end time)