Nurse

This instructor guide describes the structure and content of the Nursing training for the Monarch Phase I Cerner system conversion. This is the second of a two part course which also includes a Web Based Tutorial component to build the basic skills.

Audience: RN, LPN
Format: Web-Based Training and Instructor-Led Component
Duration: 8 hrs, clinical documentation
Web-Based Tutorial Prerequisite: Yes
Instructor Notes: Have reference guides at each station prior to class arrival.
Have Cerner username and password card attached to each case study.
Have patient name attached to case study for student pick up.

Topic/Time	Content	Teaching Points
Introduction 00h:05min	1. Introduction o Instructor Name o Class Purpose & Length o Show me/ Let me model: See a task then do it. o Go Live date 2. Distribute Reference Guides 3. The objective of this class includes: o Highlight key functions and features of Cerner to provide basic knowledge of the system. o Demonstrate and practice common tasks performed by you and your staff	Refer to this periodically Reminder: No texting, no email in class Put cell phones on vibrate, if you find it necessary to leave class to take the call. Please understand we will not be going back over the content. Please turn Vocera's off except managers.
Access 00h:10min	1. Briefly discuss aspects of EMR security and confidentiality issues related to HIPPA and the Joint Commission Regulations. o Do not leave the computer while still signed on unless you are in Suspend mode. o All users can be tracked based on their association to the patient. o Do not access charts that do not apply to your current job or caseload. o Do not to share passwords. 2. How to login o Use of badge to log in for production ▪ Tap badge. ▪ Type password ▪ Click on Citrix icon ▪ Wait for single sign on to load username and password. ▪ Click on the Cerner folder. ▪ Click on the production folder ▪ Click on PowerChart ▪ Single sign on will log them directly into PowerChart. o The long way to log into Citrix ▪ Log into Windows ▪ Click on the Internet icon ▪ Click on Looking for HQNet ▪ Click on Citrix Client (4th blue bullet in	

<table>
<tr><th>Topic/Time</th><th>Content</th><th>Teaching Points</th></tr>
<tr><td></td><td>the right side column)
▪ Log into Citrix using the windows sign on
▪ Click on the Cerner Folder
▪ Click on the Train folder
▪ Click on PowerChart
▪ Sign into PowerChart
o Log into train using provided sign on and password.</td><td></td></tr>
<tr><td>Navigation
00h:05min</td><td>1. Review the following components:
o Demonstrate how to select a timeframe.
o Demonstrate how to select a relationship
▪ Briefly discuss the use of relationships for tracking purposes and reporting.
o Title Bar (top bar, application and name of user)
o Menu bar
o Toolbar</td><td>If you have patients that populate the PAL that you have never cared for before, you may see a screen that asks you to assign a relationship. Select your relationship by clicking the down arrow and clicking on the relationship that is presented (in this case primary nurse).</td></tr>
<tr><td>Patient Activity List (PAL)
00h:20min</td><td>1. PAL is an individualized list of patients and tasks
o Explain Components, icons and Navigation
o Creating a list
▪ Create by Assignment
▪ Create by Location (Charge nurse
▪ Will auto-populate in production based on the programmed computer location.
▪ In production patients that are unassigned, discharged or transferred will stay on the list for 2 hours to give staff the opportunity to chart.
o Lag Time is set for 2 hours: This means that any change in assignment, discharge or transfer will result in that patient remaining on the staff member’s list for 2 hours to ensure ample time to complete charting..</td><td>Explain PAL icon refresh time.

Label PAL with student’s initials.

Refer to icon job aid.
Recommend the PAL be created by assignment. CREATES A “MY LIST”
Point out the bottom scroll bars.</td></tr>
<tr><td>Patient List
00h:20min</td><td>1. Patient list the patient census
o Explain Components and Navigation
o Creating a patient list
▪ Create by Location
▪ Will be populated automatically in production based on the computer’s programmed location.</td><td>Show the multiple locations, but most people will not be using this feature (except NICU, CCU/ICU)
Show how to sort by name, bed, etc.</td></tr>
<tr><td>Patient Search
00h:15min</td><td>1. How to locate a single patient
o Enter Patient name in Name box on upper right side of screen.
o Hit Enter or Binoculars icon
2. Review components and navigation options on Patient Search screen: Verify that correct patient case is selected by noting the Admit date, Location, Med Service or FIN number
3. Have students open chart by clicking on visit then clicking OK.</td><td>The Patient Search screen allows the user to modify search parameters.
The patient search allows the end user to select previous visits.
Note: If a previous visit has been selected and charted on, end user will need to manually cancel the entry and re-enter it into the active chart.</td></tr>
<tr><td>Opening Patient Chart
00h:10min</td><td>1. Opening the chart to Patient Care Summary
o Explain components and navigation of chart screen
o Identify banner</td><td>Chart should open to the Patient Care Summary</td></tr>
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<tr><td></td><td>▪ Name (other patient demographics)
▪ Location
▪ Refresh button
▪ Search box
▪ Allergies
o Identify navigation menu (menu on left)
▪ Demonstrate tacking the menu open
▪ Demonstrate how to locate the menu if un-tacked.
▪ Recommend the menu remain tacked open.
2. Have students return to the PAL and open the chart of their assigned patient by double clicking on the name.</td><td></td></tr>
<tr><td>Stretch Break
00h:05min</td><td>In class stretch break</td><td>In class stretch break or activity</td></tr>
<tr><td>Hand Off Review
00h:05min</td><td>1. Receiving report
o Patient Care Summary
o Open SBAR report: SBAR report displays the same information as Patient Care Summary in a familiar nursing format. Will be printed for providing information during testing.
o Discuss Paper MAR: Paper MAR generated from paper chart
2. Review Orders
3. Review PAL to ensure tasks are completed. Check for overdue tasks</td><td>Note: The Kardex will be going away. Handoff will be in front of computer.</td></tr>
<tr><td>Completion of Admission History
0h:40 min</td><td>Common New Admission Tasks
1. From the PAL
o Double click on Admission Task icon (heart with thermometer).
o Screen opens to Task box.
o Deselect all
o Click on Admission History task
o Click Chart
2. Admission History
o Complete documentation
o Navigation within the admission form.
o Demonstrate the General screen
▪ Point out circular buttons allows only single selection.
▪ Point out square buttons allows several to be selected.
▪ Text boxes allow for typing.
3. Enter New Allergies
o Add new allergy
o Reviewing previous allergies
o Modify previous allergies
o Canceling an allergy
o Free texting allergies is not allowed
4. Medical History/Problems list
o Add problem
o Update problem
o Cancel a problem
o Resolve a problem
o Enter Isolation Precautions
▪ Enter isolation as a medical problem</td><td>Scenario – Nurse has new admission. Find assigned patient via the PAL.

Reiterate that full form will need to be completed and staff will need to explore full contents on own.

The blue circle with the white “X” in it means that this is a mandatory field and will need to be filled out for the form to be finished.

Use data set #1 for data entry exercise of past medical history, allergy and medication history.

Past medical history goes into Problem field.
Have students enter 3 past medical problems. Use SNOMED or ICD9 for problem list.
Infectious problem will need to be entered as history and as order
Only Infectious Disease nurse can remove or modify isolation codes.</td></tr>
</table>

Topic/Time	Content	Teaching Points
	▪ Isolation will also need to be entered as an order ▪ Modifying/removing isolation code by Infectious disease nurse 5. Entering Medication by History o Entering new medication from home o Entering a non-formulary med by searching for "Misc med" o Modify current medication from previous admission o Removing a discontinued medication. 6. Signing versus saving to form browser 7. Print medication reconciliation form o While in patient chart Click task at top of screen o Click on reports o Select Meds Reconciliation Report for admission or discharge or transfer o Select printer o Click print	
Case study Time 00h:20min	Allow 15 minutes for case study work. Instruct student to utilize their case study to work on completing their history. Reminder to save history to work on and complete later unless 100% complete; then sign.	Students can complete the following forms on their own: ▪ Vaccine Protocol/Risk Assessment ▪ Procedure History ▪ Social History
Full Break 00h:15min	Full Break	Reminder of location of restrooms
Review of Admission Assessment 0h:40min	o Locate current task for the patient on the PAL o Click to select the admission assessment o Click Chart to access the assessment o Navigation and overview of activity view / Iview. ▪ Navigator, Bands, Sections, Time columns and cells o Chart Vital sign data o Systems Assessment (head to toe exam) ▪ WDL vs. chart additional ▪ WDL within defined limits is defined by the facility ▪ When the conditionality pops up must be completed documenting the defined limits. ▪ Review of Braden and Morse scales ▪ Allow students **15 minutes** to work through the assessment. ▪ Click green check mark to sign. o Add a dynamic group ▪ IV dynamic group. ▪ Sign entry o Go back to PAL – demo opening tasks and view that completed task is now off the instructor's list.	Adult and Pediatric/newborn Systems Assessment will contain data elements specific to those populations. See data sheet #2 for vital sign data, IV placement, assessment Capillary blood glucose is found on the vital signs flowsheet. Demonstrate use of within defined limits, and findings. Chart by exception
Order Review 00:h10:min	1. Review New Order Icon on the PAL o Search for Eyeglasses Icon on the PAL o Double Click on the eyeglasses o Orders requiring review will show in orders box	Rules for Orders for Nurse Review – i.e. USY enters orders, nurse must review. Nurse enters order, no system generated review, but will receive a new order icon. Nurses should always verify that orders

Topic/Time	Content	Teaching Points
	o Select desired orders click apply o Actions Requiring Review box opens o Click on orders that are correct and nurse is confident in signing o Click on apply o If nurse does not feel order is accurate, uncheck and do not apply o Nurse will need to compare the MAR to the paper chart and the computer. 2. Order review from the order screen o Open patient chart o Open order screen o Click on orders for nurse review in the bottom left hand corner o Review orders and sign those that the nurse is comfortable with. 3. New Order review o Orders that are entered by a nurse co-worker o Will appear as a clipboard icon on the PAL orders column. o Demonstrate clearing a new order review 4. Explain the following chart check o 24 hour chart check ▪ Utilize the paper MAR, paper chart and PowerChart orders ▪ Sign as completed on the paper chart as per current practice. o Change of shift check ▪ As per hospital policy	entered are correct.
LUNCH BREAK 00h:40min	Lunch Break for 30 minutes	Allocated 5 minutes to get out of classroom, 5 minutes to get back in
Medications Orders During Phase 1 00h:05min	Explain Medication process o Fax/scan orders to Pharmacy o Medications entered by Pharmacy into Pharmnet o If on meds Bar Coding / Bridge: continue current process. o New medications in time for printed MAR o New Medications after printed MAR will need to be hand written. o Single dose medications o Medication review	All medication orders will be entered into the system by the Pharmacy Remind staff to check allergies utilizing the patient banner prior to giving medications.
Review Patient Results 00h:20min	1. Select patient from PAL to open chart 2. Explain components and navigation of chart screen 3. Identify banner o Name (other patient demographics) o Location: Click to view number of previous encounter 4. Identify navigation menu (menu on left) 5. Open Results Review to view results o Set results for viewing o Right-click in date/time area o Choose Search Criteria o Click Admission date to current date button o Demonstrate using the results count	Legend located on Options button on toolbar Chart changes colors based upon other open charts Menu opens to last screen accessed

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<tr><td></td><td>option to look across visits.
6. Review Tabs on Results Review
o Recent Results
▪ Demonstrate Navigator checkbox functionality
▪ View Details and Comments
▪ Locate and explain Result Legend
o Vital Signs
o Laboratory
▪ Demonstrate views: Table, Group, and List
▪ List contains the “normal” ranges.
▪ Demonstrate use of comments for documenting critical lab result calls.
▪ Right click results to enter critical read back and confirm and action.
▪ This is a required step by the nursing staff.
o Radiology
o Assessments
o Education
o Blood product transfusion</td><td>Search Criteria set every tab

“Lab called with critical results. Read back and confirmed. Exact action taken (name of doctor called, etc.) initials date and time. (F5)”</td></tr>
<tr><td>Charting Assigned Tasks from the PAL
00h:20min</td><td>1. Explain Assigned Tasked activities from the PAL
2. Explain components and navigation of chart screen
o Location of the legend
3. Demonstrate task documentation
o Documenting not done
▪ Select patient
▪ Double click on task icon
▪ Task form opens
▪ Right click on incomplete task
▪ Click Chart Not Done
▪ Provide reason for task not being completed
▪ Sign by clicking on green check.
o Rescheduling a task
▪ Select patient
▪ Double click on icon
▪ Task form opens
▪ Right-click task that needs to be rescheduled
▪ Click reschedule this task
▪ Enter new time and reason for reschedule
▪ Click OK
o Completion of tasks by charting
▪ Select patient
▪ Double click on icon
▪ Task form opens
▪ Select task wanted, ensuring others are not checked
▪ Click chart
▪ Appropriate form will open
o Documenting a task as done
▪ Right click on the task
▪ Click done.</td><td>An example patient refused or documented in but not from the task.

An example: Patient at testing or once a day task that is scheduled for more than an hour in the future.

Remind students this was done to chart the admission tasks

This will be used for discharges and lab collections</td></tr>
</table>

Topic/Time	Content	Teaching Points
	o Provider collect specimens ▪ Right Clicking on the task to print labels to bring to the bedside ▪ Collect the specimen ▪ Right-click on the task to Chart Done, which triggers the order in the lab 4. Briefly demonstrate the Activities and Interventions band on the Navigation Menu	Instruct students that the specimen labels are labeled with the color of the tube that should be collected. Label needs to be placed so it can be scanned. Vertical, without creases, bubbles or wrinkles at less than a 5 degree angle. The label (printed on demand) takes the place of the requisition and stamped sticker. Point out how to set the default print.
Charting PRN / Status Changes from the I-View 00h:20 min	1. Non assigned documentation from I-view 2. Explain components and navigation of chart screen o Location of the legend o Customize I-view o Adding assessment components o Set I-view user preference o Change time of documentation: Right click in time space enter time o Change time columns to reflect actual times of documentation: Right click on time column select actual. 3. Assessment change o Assessment ▪ Remind students that the functionality is the same as in Admission assessment but accessed from a different place. ▪ This is as needed charting. ▪ Does not clear tasks. o Variance ▪ Variance to be used as the documentation tool for charting actions, responses, phone, etc. ▪ Same as the progress note now o Demonstrate the I/O form ▪ Adding oral intake ▪ Adding urine output o Demonstrate adding a comment to the intake and output amounts. ▪ On the I/O form, enter intake ▪ Hit enter ▪ Right click on amount ▪ Click on add comment ▪ Type comment ▪ Then click OK o Customize the intake and output form. ▪ Add IV fluid dynamic group : D5NS volume infused 500ml ▪ Add a foley catheter: Output- 300cc	Add incentive spirometer to navigator Increase the font to 12. Example: change time to 30 min. ago and enter a temperature of 97.4 Variance takes the place of nurse's note. Use Data set # 4 for assessment change and Iview information and adding a comment
Education Documentation on I-view 00h:15min	1. Demonstrate education band on the Iview 2. Using the adding a comment to document the handouts / pamphlets given to the patient. 3. Use the Patient education pamphlets in tool bar. o Click on the patient education tab in the	

Topic/Time	Content	Teaching Points
	toolbar o Use the search box to find the educational handout required. o Will search alphabetically. o Click on the item o Click on print in the bottom right corner o Select printer.	
Blood Transfusion 00h:15min	1. Order is placed into PowerChart for transfusion 2. Requisition prints on unit for blood product 3. If more than 1 unit is requested at time of ordering, the second requisition must be printed (or photocopied). 4. Right click on the order 5. Staff takes requisition to blood bank for pick up. 6. Blood transfusion checks remain the same. 7. Demonstrate Documentation in PowerChart on Iview Blood transfusion band. 8. Demo documenting a transfusion reaction in Iview.	
Restraints 00h:10min	1. Review restraint process o Order process is the same o Transcribe into PowerChart ensuring the time the order is entered is changed to reflect the actual order time. 2. Demo documentation of checks found on I-view	Document that a pair of soft wrist restraints were applied.
Full Break 00h:15min	Full break	Full Break
Navigation Menu Documentation 00h:25min	1. Demonstrate adding new allergy o Click on allergy band in the navigation menu o Add allergy 2. Demonstrate adding a new problem o Falls must be added as a problem if it occurs during the admission. o History of isolation (MRSA) added as a problem and an order 3. Demonstrate adding a surgical/social history o In production remind them that Medical history is not on this band. 4. FOR PEDIATRIC NURSES ONLY o Growth Chart o Will provide a graphic representation of the child's height and weight on the growth chart. o When height and weight are entered into the assessment it will flow onto the growth chart.	Demonstrate adding an Egg allergy Add a problem of hypertension, mark as add to past medical history by resolving the problem in production.
Ad Hoc/ form browser Charting 00h: 25min	4. Ad hoc charting o Demonstrate completion of appropriate form from Ad Hoc located at the top of the screen. o View from form browser o Un-chart a form o Modify from form browser ▪ Length of time forms can be modified ▪ Length of time for forms to be complete o Demonstrate how to print from the form	For example: Use the post fall assessment form for demonstration purposes. Point out the other forms that are in the Ad Hoc folder. Right click on saved admission history and modify the past medical history to inactivate the hypoglycemia history. Forms can be modified over the course of the visit but date and time of modification will be recorded.

Topic/Time	Content	Teaching Points
	browser • Allow for 5 minutes of **Independent work** o Open saved forms o Modifying forms	Admission needs to be completed within 24H.
Transfer to different level of care or Discharge 00h: 25min	1. To the OR o Print current SBAR o Complete the Pre op check list on paper. o Print the Transfer Med Rec and Active Order Profile o Send the paper chart o Discontinue all activity and diet orders o Call the Pharmacy to have them discontinue/suspend Medication orders if the patient is going directly into the OR and not to OR holding. o Continue hand offs per policy 2. Transfer to different level of care. o Enter transfer order into PowerChart o Print Transfer Med Rec. o Complete the transfer task that results from the transfer order being placed. Save until patient leaves the floor. o When patient leaves the floor, sign and complete the transfer task. o Send paper chart. o Continue Teletracking handoff per policy. 3. Transfer to a different floor o Enter Transfer request into Powerchart. o Releases a requisition in admitting. o Complete transfer form, save until patient is leaving the location. o When patient leaves, sign. Releases a requisition stating the patient has transferred. 4. Discharge o Enter discharge order into PowerChart o Print Discharge Med Rec o Print Exit Care documents for education purposes. o Complete paper process o Done/Not done task completionon the PAL. o Patient will remain on the staff PAL for 2h after they leave to allow time to complete documentation.	VBMC transfer/discharge process in Teletracking remains the same.
Printing 00h:15min	1. Demonstrate SBAR printing o Access the SBAR from the navigation menu o Click on task at the top of the screen o Click on print 2. Demonstrate printing the chart or individual components o Click on task at the top of the chart o Click on MRP o Explain components and navigation of print screen. 3. Demonstrate printing the Meds Reconciliation Report for Admission/discharge/transfer	Remind that SBAR does not need to be printed for floor staff since it is accessible from the patient chart. Example of printing Lab results for a provider.

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While in patient chart Click on task at top of screen
Click on reports
Select Meds Reconciliation Report for admission or discharge or transfer
Select printer
Click print

4. Demo printing labels/facesheets from Standard register

With patient chart open
Click on the Standard register link
Note the patient name at the top of the screen
Click on Search forms
Click on the label/s (single or sheet) that is needed
Select printer.
Exit when complete.

</td><td></td></tr>
<tr><td>Down Time Policy
00h:05min</td><td>Review down time policy and procedures</td><td>Confirm policy and procedure with their managers</td></tr>
<tr><td>End of Shift Tasks
00h:05min</td><td>

Patient Summary, Cerner SBAR Review, PAL, MAR during Shift Report paper chart
Walking safety rounds

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<tr><td>Wrap Up
00h:05min</td><td>

Review Go-Live Date
Explain how to maintain skill and knowledge

PowerChart Practice
Web Based Tutorial
Reference Guides
Open lab prior to go live
Use of Check list

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