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UHS FUSION

UHS FUSION is the fully integrated clinical electronic health record (EHR) (being) deployed at all UHS acute care facilities. Utilization of this EHR in a meaningful manner both promotes and is imperative to Quality:

- Enhanced patient safety
- Improved clinical efficiencies
- Increased physician functionality
- Advanced information exchange

Regulatory and accrediting bodies that have assisted in defining our FUSION configuration include Centers for Medicare and Medicaid Services, the Joint Commission, Get with the Guidelines, the National Quality Forum, and the American Reinvestment and Recovery Act.

Throughout this material, you will see an icon. This indicates a function or action within the FUSION system that contributes to meeting certain key quality initiatives.

This Guide contains examples of documentation to be used for class learning activities. These are examples ONLY. The user of the Electronic Health Record is responsible for ensuring that any information documented on a patient is accurate and complete. If a question arises about what or how to document any information, guidance should be sought from a supervisor or manager.
Starting your Day

1. Log into FUSION using your assigned log on.
2. Double-click the PowerChart Icon to open the login window.
3. Enter your assigned training user name in the User Name box.
4. Press TAB to move the cursor to the Password box. Enter the password.
5. Click ok.

Refresh Button

The Refresh Button is used to update your view of the chart and ensures you are viewing the most current information on the organizer and patient chart sections. It reflects the time that has elapsed since the last time the page or tab has been refreshed.

Patient List

In your role, you will be primarily working with two types of patient lists: A Location list and A Custom List. In this section you will learn how to create and use both.

The Patient List button displays a unit census. The Location list displays the patients on the nursing unit. A custom list can be created to include the patients you are caring for that day. You cannot add or remove patients from a Location list only from your Custom list.

Scenario

Create a Location List. This information will be on your training card.

1. Click Patient List on the Organizer toolbar.
2. Click the icon.
3. Click New.
4. Select Location and click Next.
5. Click the plus sign next to the location.
6. Click the plus sign next to the hospital.
7. Click the plus sign next to the hospital.
8. Select the unit by clicking on the name. Multiple locations can be selected. The locations will enter into the name field at the bottom of the window.
9. Click Finish.
10. Select the unit from the Available Lists and click the arrow to move the unit to the Active Lists.
11. Click OK.
**Scenario**

Patient A is your assigned patient today. Please create a custom list and assign your patient to your list.

- **Create a custom list**
  1. Click the Wrench icon.
  2. Click New.
  3. Select Custom and click Next.
  4. Name the list.
  5. Click Finish.
  6. Select the Custom List from the Available Lists and click the Arrow to move the list to the Active Lists.

- **Add your patient to the list.**
  1. Select the patient from the Location List.
  2. To highlight more than one patient from the list use the Ctrl key.
  3. Right-click on the highlighted patient name.
  4. Select Add to Patient list from the menu and click your custom list (what you named it) then press tab.
  5. Click Refresh.
  6. The patient name will appear on your custom list.

- **Adding and Removing a Patient Using the Patient Icons.**
  1. From your custom list click the add patient icon.
  2. Enter the patient’s last name, MRN# or FIN# into the search field and select search.
  3. Select the correct patient and encounter.
  4. Click OK. Refresh. The patient is now added to your custom list.
  5. The patient will stay on your list until removed by you regardless of the disposition of the patient.
  6. To remove the patient from your list, highlight the patient in your custom list.
  7. Click the Remove Patient icon. The patient’s name will be removed.

**Care Compass**

Care Compass is a workflow tool to help organize, prioritize, and plan patient care. Nurse Review of new orders/results and task documentation are performed from Care Compass.

- From this one spot you can view the following:
  - Patient location
  - Name, age, sex
  - Allergies
  - Code Status
  - Reason for Visit
- Length of Stay
- Admitting Physician
- How many activities are due on this patient at this time

**Refresh Care Compass to show your Custom List.**

1. Select Care Compass from the toolbar.
2. Click the button to refresh.
3. Select your custom list from the Patient List drop down.

**Establish Relationships with your patients.**

Establishing a relationship allows you access into the patient’s information.

1. Click the Establish Relationships.
2. Choose the correct relationship.
3. Click Establish button.

**The Patient Information Bar provides a summary of new orders, results and notifications.**

- An orange exclamation point displays if there is a non-critical result or order for the patient.
- A red exclamation point displays if there is a critical result or order for the patient.
- If you click the grey arrow after the exclamation points, it will open up the single patient view where you can then view:
  - Activities and Medications due
  - Orders
  - Plans of Care
  - Patient Information
    - Full list of consulting physicians
    - MRN and FIN
    - DOB

**Shift Report**

You will use Care Compass, SBAR, Results Review, Plans of Care, and MAR Summary for bedside shift report. During shift report, begin with Care Compass to identify any new orders or results and any overdue tasks on your patient. Take the WOW to bedside, include the patient in report, and update the White Board.
**Scenario**

You receive report on Patient A from the night shift nurse.

- **Check Care Compass for patient information.**
- **Perform Nurse Review on Patient A.**

1. Click 🔄 to open orders that need reviewed.
   a. Orange = new orders or results
   b. Red = STAT orders or critical results

- Open the single patient view to review more patient details.

1. Click the ▶ in the far right of the Patient column to open the single patient view.

2. From the single patient view you can look through the tabs to view the information contained in the patient’s chart without fully opening the chart.

1. **Activities**- can look at medication, patient care, assessment and other activities based on an hour time frame.
2. **PRN/Continuous**-Will show all PRN and Continuous tasks for this patient.
3. **Plans of Care**- Shows all of the IFOC’s that have been started on this patient.
4. **Patient Information**- slightly more in depth information than what is on the multi-patient view.

**Patient’s Chart**

The chart Menu/TOC (Table of Contents) is used to navigate to the different sections of the chart. These sections are used to view, modify, or add information. Individual medical records are like single patient charts. Below is an example of what you will see when you first open your patient’s chart. The TOC defaults to the SBAR tab when first logging into the chart. This lesson will start at the top and work down.
Chart Tool Bar

At the very top of the screen is the chart tool bar.

From here you will find the links and tools to change what happens on a chart level for your profile.

- **View** - will let you change to Care Compass, Patient Task List, Patient List and multiple other views of charts.
- **Patient** - will let you search for patients, pull up recent charts and add patients to your custom list.
- **Chart** - Will let you open up any section that is listed in the TOC in the currently open chart
- **Links** - Will open up the external reference links you have on your toolbar
- **Navigation** - Will allow you to adjust the navigator bands in IView.

As Nursing Students the Icons most used will be:

- **Adhoc** - opens up all available form for charting and documentation, such as nursing note.
- **Care Compass** - links back to care compass
- **Patient List** - Your Custom lists
- **MicroMedex** - link to medication reference website, great for checking medication interactions
- **Lippincott** - Link to Lippincott’s website that has demonstrations of procedures.

Demographic Bar

The demographic bar is the band displayed at the top of the patient’s chart. Nurses can only have two charts open at a time; the best practice is to only have one patient chart open at a time so that errors in charting do not occur. Each chart displays the demographic bar in a different color to help differentiate between patients.

The toolbar will show all the face sheet type information for the patient: **Name, Age, Allergies, DOB, FIN, MRN, Attending, Sex, Height Weight, Code Status and Location.**

The name of the patient is a quick link to all of the patient’s personal information.

The allergies section is a quick link to the full list of the patient’s allergies and reactions.

Learning Live

LearningLIVE is an online help tool located as a menu item and from the toolbar in PowerChart. This feature provides “how to” information, available in pdf or short video format, for Providers and Nursing/Ancillary staff on a range of topics covering PowerChart, FirstNet, and SurgiNet. The main view will have a Spotlight topic and Hot Topics as well as all current changes to PowerChart. Learning Live can be accessed from two locations in PowerChart.

One is at the top of the chart in the toolbar.
The other is at the bottom of the Table of Contents in the patients chart.

**Table of Contents (TOC)**

The table of contents also referred to as TOC or Menu is a list of all the sections in the chart. These are like the tabs in a paper chart or a list of contents in a book.

Open the Patient’s chart to view the TOC

**SBAR**

Use the SBAR to review the most current information on the patient. The SBAR is typically used in Shift Hand Off. There are 3 tabs: Situation Background, Assessment and Recommendation.

Click on the SBAR tab. (The chart should always default to this tab)

**Situation Background**- Shows the current data on:

- Problems- shows current problems with the patient.
- Measurements- This is the only place to change daily and dosing weights
- Diagnoses- Current listed diagnoses
- Physician Notification- You can leave NON-URGENT communication to any Doctor here.
- Lines, tubes and Drains- you can see where and how many the patient has.
- Overdue Tasks- Important to discuss with the off going nurse about what is left to do to care for the patient.
- Patient background- will list many of the same items as the patient banner bar.
- Consult orders- All of the consultations that have been ordered for the patient.

**Assessment** – Shows the current data on:

- All assessments done within the selected time frames.
- Each widgets time frame can be customized.

**Recommendation**- Shows the current data on:

- Plans of care
- Patient/Family education
- Order Entry- you can search here for shared orders and favorites of other users to use as your own.
• AdHoc Charting - you can search here for all the forms stored in the AdHoc folders. You can also save your most used forms.

Results Review

- Click on the Results Review Tab.

- From here you can locate lab results, radiology results, and clinical information in Results Review. Abnormal labs are color coded. Red –Critical, Orange- Abnormal but not critical, Black- Normal range.

IView with IO

- The IView with IO section is where you will spend the majority of the time while using Cerner. This is where all the charting happens. You can view all the patient data in real time, meaning that the information documented is immediately available to all other users (after a refresh of course). IView is made up of Navigator bands based on body systems and activities.

An important tip to remember about charting in IView is that many of the fields are conditional fields. This means that you have to select one box for the section that you chart in to open up. For example: You want to chart the on your patients Glasgow coma scale. You must first click in the Neuro Additional Parameters Monitored and then select the box labeled Glasgow Coma Assessment and then the field to document the Coma Assessment will open. Each conditional field will have this icon next to it: 

These are the main Navigator bands. Your view may have more or less depending on where you are doing your clinical.
Vitals Quick View - This is where you will put in all your vital signs. If you are in a critical care area, this is also where titrations are adjusted.

Select the Vitals Quick View Navigator Band and enter vitals on your patient.

Body Systems Assessment I - This section is where the upper half of the body assessment occurs.

- Neurological, HEENT, Cardiovascular, Neurovascular and Respiratory is charted here.

Select the Body Systems Assessment I band. Select the Neurological Section. Double click in the Neuro Additional Parameters Monitored; check the Glasgow Coma Assessment box. Press tab. Chart that your patient opens their eyes to pain, has incomprehensible speech, obeys simple commands.

Body Systems Assessment II - This section is where the lower half of the body assessment occurs.

- Gastrointestinal, Genitourinary, Musculoskeletal, Integumentary

Select the Integumentary section. Double click in the Integumentary Symptoms section; check the skin abnormality box. Press tab. Now click the dynamic group icon. Chart that your patient has bruising on their right upper arm.

Functional-Psychosocial-Safety – This section is where you will chart your patient's activity, fall scale, hygiene and safety checks.

Select the Functional-Psychosocial-Safety band. Double click in the Function and Safety Documentation section; check the box on the fall scale. Press tab. Chart that your patient has a history of falls, with a history of secondary diagnosis, no ambulatory aid, the patient has an IV, they are on complete bed rest, and they are forgetful.

Vascular Access and Drains-Tubes-This section is where you will add new IV’s, central line, and drains.

Select the Vascular Access and Drains – Tubes band. Select the Peripheral IV section. Click the dynamic group icon. Please chart that you have started an IV on your patient it is a right antecubital, over the needle 20 gauge IV.

Intake and Output-This is the section where you will document all of your patient’s intake and output. Some of the fields will auto-populate based on drips and charted medications.

Select the Intake and Output Band. Highlight the Oral Intake section. Document that your patient ate 75% of their breakfast and 250ml in fluids.

Orders

The Orders section is used to place, view, modify, cancel, and work with various types of orders. From here you can view additional order information and modify how the orders are displayed.

As a Student Nurse you will not be allowed to place or modify any orders. However, you can view order details and history. You can also modify how the orders are displayed.

Select orders tab. From the Display drop down menu select All Active Medications. Highlight one of the orders and right-click, select Order Information.

MAR

Use the MAR to review all the medications in a reverse time order for your patient.

MAR Summary

Use the MAR Summary to review previously administered and future medications due for your patient. Physicians
only have the MAR Summary to view the patient’s medications.

**Duties throughout your day**

The following information is related to processes and documentation that may occur throughout the day.

**Nursing Handoff of Care**

The Nursing Handoff of Care task enables quick documentation with a witness of change of shift report.

- Complete the change of shift report documentation from Care Compass.
  1. Open the single patient view.
  2. Click the Nursing Handoff of Care task in the PRN/Unscheduled section and click Document.

**Working with Tasks**

Tasks are created when nursing care and some lab/diagnostic orders are placed. For example, admission orders/tasks are generated when a patient is admitted. Tasks can be completed from the Care Compass. There are three types of tasks:

1. Tasks that open a form to be documented and signed. (For example, Basic Admission Information Adult, Admission History Adult, and Readmission Risk Assessment).
2. Tasks that open to IView for documentation. (For example, Activity Ambulate, Braden Assessment).
3. Tasks that are documented as Chart Done/Chart Not Done. (For example, Admission Assessment Adult, Transfuse Blood Product, and Add Discharging Physician).

**Scenario**

While in Care Compass you notice the Order Entry Details task for your patient.

- Complete the task from Care Compass.
  1. Click the task (Order Entry Details).
  2. Click Document.
  3. Complete all fields.
     a. Transport Mode: Ambulatory
     b. Isolation Precautions: Contact
     c. IV: Yes
     d. Fall Precautions: No
     e. Pregnant: No
     f. Oxygen: No
     g. Blood specimen Nurse Collect: No
  4. Sign

**Chart Task Not Done**

Tasks that cannot be completed must be documented as Chart Not Done.
Scenario
Dr. Jones contacted the Consulting physician, Dr. Adams, directly.

Chart Patient A’s Consult task as Chart Not Done.
1. In Care Compass, right click on Consult task.
2. Select Chart Not Done.
   a. Reason Not Done: Other
   b. Comment: Dr. Jones called Dr. Adams
3. Sign

Change Task Time
When documenting a task that opens to IView a current date and time column is activated. If you didn’t perform the task at that time, you should change the date and time in order for the task to complete and fall off the task list.

1. Select the Activity task in the Care Compass and click Document.
2. IView opens with the current time.
3. Click on the Change Task Documentation Time icon.
4. Enter the date/time the task was performed, and select the checkbox next to the task; click OK.
5. Column with performed time is available to document task details.
   a. Enter the distance walked as 25 feet and Effort: Good.
6. When you sign the charting, the task will complete.

Reschedule a Task
Rescheduling a task is used when a task is due but cannot be completed at the scheduled time. For example, a task becomes due while a patient is off the floor. The nurse will reschedule the task to be completed upon the patient’s return to the floor.

Scenario
The bathing task is due but the patient is off the unit.

1. From the Patient Task List in the TOC, right click on the task.
2. Select Reschedule this Task.
3. Enter the appropriate time in the field.
4. Click OK.
Collect Specimens via WOW/Bedside Computer

Specimens can be collected using the Specimen Collection button on the toolbar. Labels are printed when the order is entered. If a label is lost it can be reprinted from Care Compass.

Click the Specimen Collection button and collect the specimen.

1. Right click on the UA task> choose Print labels.
2. Print the label.
3. Click on the Specimen Collection.
4. Scan your patient wristband.
5. List of available Lab orders will display. Current default view is both Nurse Collect and Lab Collect.
6. Scan your specimen label.
7. Click Sign.

Medication Administration

All medications will be administered from the MAR using scanning devices.

Scenario

Medications are ordered to be given to your patient.

Follow the steps below each time medications are administered:

1. While in the MAR, complete Nurse Review by clicking on the eyeglasses icon if needed.
2. Review the MAR in the medication room and pull appropriate medications from the Pyxis.
3. To view the sliding scale for insulin, hover over the medication field.
4. Take medications and WOW into the patient room.
5. Document a new set of vital signs and pain assessment in IView if appropriate for your patient.
6. Enter Vitals in IView:
   a. Temperature: 37C
   b. Temperature Method: Oral
   c. Peripheral Pulse: 76
   d. Respirations: 16
   e. BP Site: Left arm
   f. Blood Pressure: 134/76
   g. Pain Assessment Tool Utilized: Numeric Pain Scale
   h. Pain Level Acceptable: No
   i. Numeric Pain Scale: 5=moderate pain
7. Sign

Open the MAR and administer the medications

1. Click the Medication Administration Wizard (MAW) button from the toolbar.
2. Scan the patient.
3. Scan all medications.

Scan the Vancomycin.
1. Each time a medication is scanned compare the order information in the Details column with the Results column. The Results column displays the scanned medication.
2. Address all required fields.
3. Address Early/Late Reason.

**Scan the Tylenol.**

1. Acknowledge the 24 hour dose verification.
2. Scan the barcode a second time
3. Acknowledge the 24 hour dose verification.
4. Compare the order to the scanned medication.
5. Acknowledge the vital signs.

**Scan the Insulin.**

1. Enter information as needed.
   a. Blood sugar: 245
   b. Enter the dose
   c. Site: Left arm
2. Close the details window.

**Scan the Morphine.**

1. Compare the scanned medication with the order.
2. Complete the required Rate field.
3. If there is not a Basal rate ordered place a 0 in the rate field.

**Scan the Heparin.**

1. Compare the scanned medication with the order.
2. Verify the dose as calculated by pharmacy on the initiation of a new heparin infusion.
3. Complete the required fields including the name of the witnessing nurse.
4. Click OK.

**Scan the Sodium Chloride.**

![Sodium Chloride Image]

1. Site: select appropriate site.
2. Click OK.
3. Administer and start the medications.
4. Make sure the patient takes the medications before signing oral medications.
5. Sign.
6. Refresh the MAR.

**Additional actions from the MAR**

- The patient is at PT. Reschedule the medication for one hour from now.

8. Right click the task box and select reschedule this dose.

- Address the Med Effect task from the MAR or the Care Compass.

9. The Med Effect task can be addressed for PRN medications in the MAR and Care Compass.
10. Complete both the Medication Effect section and the Follow up Pain Assessment section.

**Change of Shift Witness of Heparin and Other Medications**

All medications that need witnessed at change of shift are documented in IView.

- **Witness the heparin.**

1. Open IView.
2. Select the Adult Quick View band.
3. Select IV Titrations section.
4. Insert a current date/time.
5. Double click the heparin units/kg/hr cell to add a single result.

<table>
<thead>
<tr>
<th>heparin units/kg/hr</th>
<th>Rate mL/hr</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.2</td>
<td>12</td>
</tr>
<tr>
<td>14</td>
<td>15</td>
</tr>
</tbody>
</table>

6. Enter the current rate.
7. Right-click and select “Add Comment”.
8. Enter the witness’s name.
9. Click “Comment” and enter a comment as appropriate.
10. Click “Apply”.
11. Have the witness put in his/her password.
12. Sign
Documenting Titration Rate Changes

Titration is documented in IView.

**Scenario**

The PTT result is 52 and the Heparin drip may need to be adjusted.

**Review the Heparin protocol order and note the titration rate.**

1. Open Orders from the TOC.
2. In the Navigator click on the Heparin Infusion order under Plans.
3. Click the icon.
4. Click the Supplemental Heparin and Labs order under Plans.
5. Note the titration orders.

**Document the titration of the heparin increase by 1 ml/hr (100 units/hr) as orders on Patient A.**

1. Open IView.
2. Select the Adult Quick View band.
3. Select IV Titrations section.
4. Insert a current date/time.
5. Double click the heparin ml/hr cell to add a single result.
6. Enter the updated rate.
7. Sign.

**If a witness is needed, follow the below steps:**

8. Right-click and select “Add Comment”.
9. Enter the witness's name.
10. Click “Comment” and enter a comment as appropriate.
11. Click “Apply”.
12. Have the witness put in his/her password.

**Nursing Plans of Care**

Nursing Plans of Care are suggested to the nurse based on charted patient data or can be ordered by the nurse or any member of the interdisciplinary team. For example, the Fall Prevention and Management EBN Adult Plan of Care is suggested when a high fall risk score is charted.

The components of a Plan of Care include:

11. Initiate
12. Outcomes/Goal 📇
13. Intervention 📝
14. Indicator 📊

**Documenting in Plans of Care**

**Scenario**

*Patient B* is complaining of increased pain.

Review the IPOC Acute Pain Plan of Care and document Control of Acute Pain as NOT met. Open the smart template/PowerForm to view data that is gathered to provide the clinician the ability to assess a particular issue.

1. Click on Orders.
2. Click the IPOC Acute Pain Plan of Care from the Navigator.
3. Open the Document in Plan tab.
4. Click either the icon to document that the goal was Met/Not Met or the icon to open a smart template/PowerForm.
5. Click the icon for Control of acute pain.
6. Click Not met and enter a Reason and Action.
7. Click the icon for Pain Signs and Symptoms Reviewed.
8. Smart templates are PowerForms that contain viewable data and fields for entering interventions taken.
10. Under Pain Interventions Taken, enter a free text intervention.

**Admission Workflow**

**Scenario**

You received a phone call from the ED and *Patient B* is being admitted to your floor.

**Add new patient to your list**

Using Care Compass, add Patient B to the Custom List by searching for the patient.

1. Click the Add Patient button from Care Compass.
2. Verify the MRN, FIN, admission date, and discharge date to ensure the correct patient and encounter are selected.

**Receive Report**

Establish a Relationship with Patient B and open the chart.
Basic Admission Information Adult Form

Scenario

The nurse is ready to document the admission tasks.

- Document that the patient has bunny slippers and a robe in the Basic Admission Information Adult form from Care Compass.

  1. From Care Compass, single patient view, click the task.
  2. Click Document.
  3. Complete the first set of vitals, safety, and valuables/belongings as appropriate.

- Temp: 37.6
- RR: 18
- Pulse: 82
- BP: 142/84
- O2 Saturation: 96% on 2L nasal cannula

Patient Preferred Pharmacy

- Document the Patient’s Preferred Pharmacy to receive electronic prescriptions.

The upgrade to enable importing external medications has also given the ability to electronically send prescriptions to a patient preferred pharmacy. What is important about this step is the provider cannot complete the electronic routing of the prescription if the preferred pharmacy has not been entered. The process for entering the pharmacy is very simple.

1. There are several different ways to get to the Patient Pharmacy screen.
   a. From any location in the patient chart in the Toolbar, there will be a Patient Pharmacy Icon. Just be aware that based on your Toolbar set up it may be hidden in a drop down field.
   b. The Preferred Pharmacy box will open

2. If there is no preferred pharmacy entered the box will default to the Search tab. If there is a pharmacy entered the window will default to show the Patient Preferred tab.

3. The search fields will auto populate the city based on the Patient’s listed home of record upon admission.
   a. This may need to be adjusted based on whether or not you are having trouble finding the specified preferred pharmacy.
   b. Enter the name of the Pharmacy in the Pharmacy Name field and click on search.
   c. All the possible options for that name/city combination will populate. To select the correct one and add it to the patient, Right-Click on the chosen pharmacy and choose Add to Patient Preferred.
4. The pharmacy will then populate to the Patient Preferred tab. Each patient can have up to 5 pharmacies listed on the preferred tab.

5. The pharmacy listed at the top in Bold will be the default pharmacy. To change the default pharmacy, right-click on one of the other pharmacies listed and select Set As Default.

   a. This will move it to the top of the list and be the available choice when the provider is sending the electronic prescription.

6. To remove a pharmacy that the patient is no longer using. Go to the Patient Preferred tab and right-click, choose Remove.

**Admission History Adult Form**

*Document the Admission History Adult form for Patient B from Care Compass.*

1. From Care Compass, single patient view, click the task.
2. Click Document.
3. General Information section:
   a. Admitted From: ED
   b. Suicidal Ideation: None
   c. Clinical Trial Participant: None
4. Language:
   a. Primary Language: Spanish
   b. Preferred Language: English

5. Contact Information:
   a. Emergency Contact: Snow White, spouse, cell 999-555-1212
   b. Would patient like to name a support person: No
   c. Would the patient like anyone to be notified of this admission: No

6. Subjective section:
   a. Pain Symptoms: Yes
   b. Numeric Rating: 4
   c. Pain Level Acceptable to Patient? No
   d. Primary Pain Location: Head
   e. Document the laterality, quality, radiation, onset, duration, associated symptoms, aggravating factors, and alleviating factors.
   f. Click the icon to close the pain form.

7. Date of Last Bowel Movement: Yesterday’s date

8. Past Medical History section:
   a. If a history (Past Medical History/Problems, Family History, Procedural History, Social History) is documented it will cross encounters.
   b. Add Hypertension as a problem.
   c. Click OK.

9. Pressure Ulcer Present on Admission? No

10. ID Screen section:
    a. MRSA Screening section:
        i. Does the patient have a previous history of MRSA? No

11. Family History section:
    a. Document Father is positive for Acute Myocardial Infarction, pertinent negative Diabetes Mellitus Type 2.
    b. Document Mother is positive for Hypertension and Hypothyroidism, pertinent negative Diabetes Mellitus Type 2.
    c. Document Sister has a Negative Health Status.
    d. Click the OK button.

12. Allergies Section:
    a. Mark all as Reviewed. Will demonstrate how to add new Allergy at a later time.

13. Meds/Immunizations-Adult section:
    a. Influenza Vaccine Status: Not received
    b. If no Contraindications, select Previously Immunized this flu season.
    c. Note the Inclusions box greys.
    d. Close the page.
    e. Pneumococcal Vaccine Status: History of pneumococcal vaccination

14. Procedure History section:
    a. Add Cholecystectomy.

15. Anesthesia/Transfusions page:
    a. Are Blood Transfusions Acceptable to Patient in an Emergency? Yes
16. Nutrition section:
   a. Home Diet: Regular
   b. Nutrition Risk Factors: None

17. Functional page:
   a. Mobility Assistance Prior to Admission: Independent
   b. ADLs: Independent

18. Living and Resources page:
   a. Lines/Tubes Present on Admission: None

19. Social History page:
   a. Add alcohol
      i. Use: Current
      ii. Type: Beer
      iii. Frequency: 1-2 times per week
   b. Smoking History: Never Smoker
      i. Did the patient smoke cigarettes anytime during the last 12 month prior to hospital arrival? No

20. Psychosocial/Spiritual page:
   a. Do you receive comfort from spiritual practices: Yes
   b. Do you have cultural practices you would like to be honored: No

21. Advanced Directives page:
   a. Advanced Directive: None
   b. Patient wishes to receive.... No

22. DC Needs page:
   a. Discharge to: Home Independently

23. Modified Morse Fall Risk page:
   a. Yes to all Yes/No Questions
   b. Use of Ambulatory Aid: Furniture
   c. Gait Weak or Impaired Fall Risk: Impaired
   d. Mental Status: Forgets Limitations

24. Abuse/Neglect Assessment page:
   a. Have you been threatened or physically hurt by someone with the past year: No
   b. Current presentation indicates.. No
   c. Reported history... None
   d. Reported history or evidence of any of the following: - Required field

25. Education Needs page:
   a. Patient/Family Education Needs: Advance Directives, Plan of Care
   b. Barriers to Learning – None evident
   c. Patient Learning Style Preference: Demonstration
   d. Family Learning Style Preference: Demonstration and Printed Materials
Discern Notifications

Discern Notifications are designed to alert nursing of high risk factors associated with the patient.

- Read and acknowledge the message regarding Patient B being a high fall risk.

1. Clear the message using the red X on the left side of the window.
2. MINIMIZE the box to ensure that Discern Notifications continue to display.
3. Follow the recommendations.

Documenting Height/Weight

The initial documentation of a new admission consists of Allergies, Ht/Wt, and Home Medications. This information is needed before medications can be entered into FUSION.

- Scenario

The patient arrived and you are ready to document their Height/Weight and Allergies.

- Document the Height and Weight if not already documented using the SBAR Measurements Widget.

![Measurements Widget]

Nursing Note

Nursing Notes are only used when you need to document something not covered anywhere else, these are for uncommon events and conversations with patients or family that need direct quotation. If a Nursing Note is used, inform the oncoming nurse at Shift Report

a. If you save a nursing note- you are the only one who can ever see this until you save it. Do NOT save your notes. Write what you need to and Sign them

b. Do not repeatedly open and modify your nursing notes. This will create strike-outs in your charting that when viewed by others looks like a mistake was made in your documentation. Use one note and move on to another note at another time.
c. To find the nursing note or any type of note navigate to TOC→Notes→Clinical Documentation→Whatever not you are looking for.

- Nursing notes are found in the Progress Notes→Nursing Progress notes
- folder.

**Scenario**

The nurse discussed with the patient their status and possible need for intubation prior to transfer.

*Document the conversation in a Nursing Note.*

1. Open AdHoc in the SBAR.
2. Type “Nurs”.
3. Select Nursing Note.
4. Complete the note and sign.

You can also find Physician Progress Notes in the same area.
Discharge Process

When a Discharge Request has been ordered by the provider, the Discharge Process on the TOC will turn red and have a triangle with an exclamation point icon. The left side of the page shows the actionable items and informational items are listed on the right side. The Discharge Readiness Checklist shows actions that require completion. Some circles will automatically fill such as Medication Reconciliation and others need to be manually filled such as Patient Education.

Scenario

Discharge orders are written for Patient A. Document the follow-up instructions and education. The orders include discontinuing the Normal Saline IV fluids and the IV site. IVs should be documented as discontinued before discharging the patient.

Complete Discharge Documentation

- When discharging a patient be sure to document all pertinent areas of the chart.
  - Complete the Intake & Output.
  - Address any Interdisciplinary Plans of Care and complete them.
  - Complete any Quality Measures, if needed.
  - Complete any running infusions.
  - Check the MAR for any Med Effect or Med Tasks.
  - Complete any outstanding tasks – including the Add Discharging Physician task.

Add Discharge Follow-up and Patient Education

1. Open the Discharge Process section of the TOC.
2. Document the patient should follow up with Dr. Douglas Ball’s office in 3-5 days.
   a. Click on the + in Follow Up tab. The patient education window will open.
   b. Who: Provider Search
      i. Start typing Ball, D and the doctor’s name will populate
   c. When: 3-5 days
   d. Comments: 05-Double click on “Call to schedule next business day”.
   e. In the Edit Comments box add “and ask for Dr. Ball’s nurse, Jane”.
   a. Click on the Instructions tab of the Patient Education Window.
   b. Patient Education: Select Cardiology.
   c. Double click on Taking Medications for your Heart.
      i. Note that the Selected Instruction is fully customizable. You can edit however necessary to be specific for your patient. These instructions will print out with the patients other discharge paperwork.
   d. Click Ok.

- Complete the Valuables and Belongings and the Discharge documentation.
1. Click the blue drop down arrow to open Valuables and Belongings.
2. Click on the drop down arrow and choose a selection.
3. Click “Valuables and Belongings”.
4. Complete the form.
5. Sign form.
6. When all sections are completed click Review and Sign.

**Document Medication Leaflets for Lasix.**
Additional items can be addressed by clicking Review and Sign.

1. From the Discharge Process click Review and Sign.
2. Click on icon next to Medication Leaflet.
3. Search for the medication (Lasix), choose the generic.
4. Click OK.

**Review the Inpatient Discharge Summary and add Comments as appropriate.**
The Inpatient Discharge Summary can be viewed from the Depart Process. After all information has been entered print and review with the patient.

1. Print the discharge papers.
2. Take the printed documents into patient’s room to explain discharge papers.
3. Nurse receives the signed sheet from the patient and places this in the patient’s hard chart.
4. Place a checkmark next to “Family/patient verbalizes understanding…” in the bottom left corner of page. The checkbox is required. (highlighted in yellow)

**Complete any remaining Plans of Care documentation and discontinue the plan.**

1. From Orders, click on Document in Plan tab.
2. Chart all data elements as Met or Not Met.
3. Once all data elements are charted, right-click the Plan of Care name in the navigator.
4. Select Discontinue.

**Discontinue IV**

**Document the intake of IV fluids from the Intake and Output band in IView and document the discontinuation of the IV order and the IV site.**

1. Open Intake and Output band.
2. Select Continuous Infusions.
3. Double-click the Continuous Infusion row under the desired time header to activate the column.
4. Review the fluid amount that enters automatically.
5. Change the amount as appropriate.
   a. For the last hour of the infusion follow these steps:
      i. Right click on the cell below the time column of the last hour of infusion.
      ii. Select Chart Details. Enter the amount of fluid infused.
      iii. Click Apply.
      iv. Sign.
6. Discontinue the Sodium Chloride infusion order from Orders.
a. You discontinue so the system stops calculating the intake and output.
b. Right-click on Sodium Chloride order and choose Cancel/Discontinue.
c. Enter Ordering Physician.
d. Complete the order.

7. Discontinue and Inactivate the peripheral IV site from the Vascular Access and Drains-Tubes band in IVView.
   a. Activity: Discontinue
   b. Site condition: No complications
   c. Drainage description: None
   d. Dressing: Dry/Removed
   e. Patency: No complications

8. Sign
9. Right click on the label and select Inactivate.