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<th>Page</th>
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<td>Reviewing Notes</td>
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<tr>
<td>Writing Notes</td>
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<td>Sticky Notes to Physicians</td>
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<td>LDA’s and Intake &amp; Output</td>
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<td>Document an IV Start</td>
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<td>Remove a Line</td>
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<td>Review I&amp;O</td>
<td>33</td>
</tr>
<tr>
<td>Administering IV Medications</td>
<td>34</td>
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<td>Patient Education</td>
<td>35</td>
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<td>Document a Learning Assessment</td>
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<td>Transport a Patient</td>
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<td>Discharge a Patient</td>
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<td>Transfer a Patient</td>
<td>38</td>
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<td>End of Shift</td>
<td>38</td>
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<td>Care Plan</td>
<td>40</td>
</tr>
<tr>
<td>Learning Home Dashboard</td>
<td>41</td>
</tr>
</tbody>
</table>
LOGIN
Login to the workstation using your 3x3 and network password, or badge swipe.

LOGIN DEPARTMENT

1. Launch CareConnect
2. Select the appropriate login department (*ask your Preceptor for the DEP ID*) or type the location and click the looking glass to view options.
   
   Example:

   Department: **SWMC 4N MED SURG [1501002100]**
   
   a. CGMC=Cottage Grove Medical Center
   b. KEMC=Ketchikan Medical Center
   c. PHMC=PeaceHarbor Medical Center
   d. PIMC=PeaceIsland Medical Center
   e. RBMC=RiverBend Medical Center
   f. STJN=St. Johns Medical Center
   g. STJO=St. Joseph Medical Center
   h. SWMC = Southwest Medical Center
   i. UDMC= University District Medical Center
   j. UGMC= United General Medical Center

   **Note:** Badge Swipe In and Log Out. Swiping In and Swiping Out does not completely End your Active Session.

   **Note:** The System will default to your last Login Department each time you Login.

PATIENT LISTS
Patient Lists is your Default Home Screen.

1. Search **Available Lists** to view a specific Unit:
   
   a. Open the appropriate Facility Folder (*example: Southwest Medical Center*):

   ![Southwest Medical Center](image)

   b. Open the appropriate Location Folder (*example: Units – Medical Center*):

   ![Units - Medical Center](image)

   c. Select the appropriate Unit (*example: SWMC 4N Med Surg*):

   ![SWMC 4N Med Surg](image)
2. A list of all the Patients in this Unit now appears:

<table>
<thead>
<tr>
<th>Room/Bed</th>
<th>Patient Name</th>
<th>Age/Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td>S404/1</td>
<td>Donotuse, Donotuse</td>
<td>30 y.o. / F</td>
</tr>
<tr>
<td>S416/1</td>
<td>Zalpilas, Susan</td>
<td>55 y.o. / F</td>
</tr>
<tr>
<td>TRN ADT SWMC 4N Med Surg Pool 1/Beds</td>
<td>Apricot, Dylan</td>
<td>11 y.o. / M</td>
</tr>
<tr>
<td>TRN ADT SWMC 4N Med Surg Pool 1/Beds</td>
<td>Lime, Asher</td>
<td>10 y.o. / M</td>
</tr>
<tr>
<td>TRN ADT SWMC 4N Med Surg Pool 1/Beds</td>
<td>Blueberry, Asher</td>
<td>10 y.o. / M</td>
</tr>
</tbody>
</table>

**STARTING YOUR SHIFT**

**Sign In**

Nursing Staff must **Sign In** and **Sign Out** for their shifts:

1. From **Patient Lists**, select the **Sign In** button in the workspace toolbar.
2. Select the appropriate Shift, enter your Contact#, Assign your Role, and select the appropriate Department:

   - **Department**:
     - ZZZZ SWMC 4S MED SURG
     - SWMC 2N MED SURG
     - SWMC 4N MED SURG

3. Select **Sign in**

   Note: 8 hours is the default selection for this Unit. If your Clinical rotation is for a partial shift, manually edit the shift times to override the default selections. This feature will allow auto **Sign Out** and **End My Assignments** when your shift ends.
Treatment Team

Find your Patient assignments and assign yourself to the Treatment Team for each Patient.

1. Search for Patients using **Search All My Patients** in **Patient Lists**.

2. Type partial names to search. *(example: Asher Apple can be searched using **App, Ash** or **Apple, A or Asher**)*.

3. If no results are found, change the search criteria using the **SWMC All Pts** button:

4. Right Click **Apple, Asher** and select **Assign Me**

5. I will do it again for **Apple, Dylan** and that is all the patients’ I have been assigned to for my shift.

---

6. Assigning myself to the Treatment Team allows several advantages:
   
   a. **View Only My Patients**. This allows the Caregiver to quickly find their patients and complete documentation without repeatedly searching for the patient in **Patient Lists** during their shift.
   
   b. The Treatment Team is viewable to other Caregivers. This allows smoother and faster communication between specialties *(examples: The Pharmacist and other Providers can contact the RN directly; the RN can contact Therapists, Spiritual Care, and other referrals personally; Receiving RN’s can contact the Primary Nurse prior to Transfer of Care Handoff, Registration, Security and Volunteer Services can contact the RN regarding Visitation parameters or to put Family Members directly in contact with the Nurse, etc.)*.
   
   c. **View the Treatment Team from Summary Activity>Overview Report**
   
   d. Use the blue hyperlink **Treatment Team** to edit members of the Treatment Team.
UNIT MANAGER

The Unit Manager is used by the Unit Clerk and Charge Nurses to Manage the Unit.

CENSUS

The Unit Manager provides a Unit Census. Unit Managers can “drag & drop” patients from one grouping to another to complete electronic Patient Movement. See Patient Movement Matrix in Learning Home Dashboard below to identify approved Patient Movement processes.

DIRECT ADMITS

The Unit Manager provides a list of Expected Direct Admit:

INCOMING TRANSFERS

The Unit Manager provides a list of Expected Incoming Transfers:

REVIEWING THE CHART

Patient Information can be reviewed from Inside and Outside of the Patient Chart.

OUTSIDE THE CHART

Reports

Reports can be viewed without ever opening the Patient Chart.
1. Single Select the Patient in **Patient Lists**.

2. Review Reports available from outside the Chart:

3. The **Profile** Report is a high level review of the Patient Profile: Attending Provider, Allergies, Isolation, Code Status, Height, Weight, Principal Hospital Problem, Treatment Team Members, and Length of Stay (LOS).

![Profile Report](image)

4. Use the Looking Glass to identify additional available Reports:

![Looking Glass](image)

**INSIDE THE CHART**

Additional Chart Review is completed from inside the Patient Chart.

1. Double Click on the Patient to Open the Chart:

**Patient Header**

The Patient Header is a quick way to review Patient Information:
Note: Key Information is highlighted in **Yellow** (examples: Allergies and Code Status).

### Activities

Activities are available to you along the left side of the Chart. They are an Index that guides your entire workflow:

1. The **Summary** Activity provides additional Reports that were not available from outside the Patient Chart and provides a quick way to review Patient Information with more detail: **Summary**
a. Similar to the Report Toolbar in Patient Lists, we can search even more reports using the Looking Glass and Wrench. In any applicable reports.

2. The Chart Review Activity allows you to review additional information; not necessarily associated with the current Encounter:

3. The Results Review Activity provides a Date Range Wizard to allow filtered Results:

   a. Select a Date Range and click Accept.

   b. Results appear for the designated time frame:

4. The Problem List Activity allows Nursing to review the Problem List for the Patient, but the maintenance of the Problem List is the responsibility of the Provider.
a. Hospital Problems are being addressed during the current Inpatient Encounter.
b. Non-Hospital Problems remain in the Patient’s Chart, but are not being addressed during the current Inpatient Encounter.
c. Chronic Problems are indicated by a Red Push Pin: 🚨
d. **Mark as Reviewed** is for the Provider to indicate that they have verbally reviewed the Problem List with the Patient or Family Member. The **Mark as Reviewed** button provides a Name and Time Stamp.

**DOCUMENTING PATIENT CARE**

Routine Patient Care can be documented in Navigators and Flowsheets. Each provide a streamlined workflow in different scenarios.

**NAVIGATORS**

Navigators are designed to streamline the workflow. The **Navigator** Activity contains multiple Navigators to meet the needs of common workflows:

<table>
<thead>
<tr>
<th>Navigators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission</td>
</tr>
<tr>
<td>Transfer</td>
</tr>
<tr>
<td>Discharge</td>
</tr>
<tr>
<td>Restraints and Seclusion</td>
</tr>
</tbody>
</table>

**Admission Navigator**

The **Admission** Navigator is used to streamline the Admission workflow. Each Navigator provides a **Table of Contents** to organize your documentation:
1. Select the word **Vital Signs** to document in this section.

2. Alter the date/time of the reading using shortcuts *(examples: for **TIME**; **n-15** is **NOW MINUS 15 MINUTES. h-1** is **HOURS MINUS ONE. For **DATE**; **t** is **TODAY, t+3** is **THREE DAYS FROM NOW)**.*
3. Select **Last Filed** to view the last data filed in this section (also viewable in Flowsheets):  

4. Select **All Choices** to see all available choices as buttons:

5. To File documentation in Navigators:
   a. Select **Close** to close the section:
   b. Select **Next** to move on to the next section:
   c. Select another section from the **Table of Contents**.

Documentation can be completed in Navigators using the **Table of Contents** as a guide to streamline the workflow. Following the order of the sections recommended, but is not required.

**Transfer Navigator**

The **Transfer** Navigator is used to streamline the Transfer workflow. Each Navigator provides a **Table of Contents** to organize your documentation:

- **Med Rec Status**: this must be completed by the Provider and must be current to allow any ADT (Admission/Transfer/Discharge) Event, or any change in the Patient’s Phase of Care (examples: Pre-Op, Intra-Op, Post-Op).
- **SBAR Handoff**: this can also be found in the **Summary** Activity and must be used to complete Nurse review at the Bedside for any Transfer of Care.
- **Running Infusions, LDAs/Wounds, etc.**: These should be reviewed at Handoff.
- **Progress Note**: A Nursing Note can be written here to document the Transfer of Care and Report Complete.
- **Signed/Held Orders**: These Orders are not Active and should be released by the Receiving Nurse after the Transfer is complete (both physical and electronic) to ensure that Orders dispatch Caregivers to the right location (examples: Pharmacy Medications, Lab Phlebotomists, Xray Technicians, etc.).

**Discharge Navigator**

The **Discharge** Navigator is used to streamline the Transfer workflow. Each Navigator provides a **Table of Contents** to organize your documentation:
**FLOWSHEETS**

The Flowsheets Activity provides traditional documentation formatting for subsequent and additional assessments, actions, and interventions not covered in Navigators:

**Flowsheet Templates**

Flowsheets are identified by the Tab at the top of each Flowsheet:

Unresulted Labs: These should be reviewed prior to Discharge and confirmed as appropriate, DC’d, or completed.

Running Infusions: These should be reviewed here and stop time documented in the MAR prior to Discharge. Tip: Use the hyperlinks to jump to the MAR.

LDA Removal: Lines, Drains, Airways and Wounds (LDA's) will largely be removed/resolved prior to Discharge. Review them here and use the hyperlinks to jump to Flowsheets to complete documentation.

Med Rec Status & Progress Note: See Transfer Navigator outline above.

Discharge Planning: This section should have been completed upon Admission. If Case Management is not involved, update this section now.

Patient Education: this can also be completed in the Education Activity.

Discharge Instructions Section: document Add Med Detail, Diet, Appointments, Follow-Ups, Misc Orders, and Instructions to include in the Discharge Instructions that are printed on the After Visit Summary (AVS).

Discharge Zones: This is required documentation for Core Measures. It will help determine which Discharge Instructions will print for the patient and should correspond with your selections (examples: Adult/Postpartum/Pediatric, Ortho/Oncology/Behavioral Health, etc.).

Emergency/PHI: Complete this section to identify and confirm Emergency Contacts for the Patient prior to Discharge.
They can also be Wrenched In and “pinned” to the Flowsheets you use frequently:

If you do not know the name of the Flowsheet, simply select the Looking Glass to view all available options.

Selecting the Looking Glass will open a Flowsheet Template window. The default search is within the Preference List. Select the Facility Pref List to view even more Flowsheet Templates:

**Flowsheet Workflow**

Flowsheets provide a Table of Contents to streamline your documentation:

Select Check All or Uncheck All to guide you through your workflow and only view the sections you want to work in, and hide the sections that you have completed:
**Flowsheet Functionality**

Use the Workspace Toolbar to modify Flowsheets:

1. Use **Add Col** to add a column for the current time:

2. Use **Insert Col** to add a column at a previous time:

<table>
<thead>
<tr>
<th></th>
<th>8/21/15</th>
<th>8/22/15</th>
<th>8/23/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>0828</td>
<td>1935</td>
<td>0242</td>
<td>1125</td>
</tr>
<tr>
<td>134.6 cm</td>
<td>134.6 cm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>65 lb</td>
<td>68 lb</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Use blue time intervals to change the flowsheet view:

4. Use **Show Device Data** to validate and file monitor data streaming from interfaced devices such as Fetal Monitors, Physiological Monitors and Vents:

5. Use **Last Filed** to view the last filed values on the right side of the template:
6. Use **Req Doc** to identify required documentation status:

<table>
<thead>
<tr>
<th>Required Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation complete</td>
</tr>
<tr>
<td>Documentation incomplete</td>
</tr>
<tr>
<td>Documentation coming due</td>
</tr>
<tr>
<td>Documentation overdue</td>
</tr>
</tbody>
</table>

**Flowsheet Documentation**

Flowsheet Documentation is completed by selecting the appropriate cell for the Column (Date/Time) and Row (Subject): ![Flowchart Image]. There are different ways to document within the cell, but the paper icon is always available for a comment. Simply click on the paper icon to open the Comment Entry Window: ![Comment Entry Window] and click **Accept**. The comment is indicated by lines on the paper icon and the comment can be viewed by hovering the mouse over the paper icon: ![Comment View]

1. **Free Text:** Type in the cell *(example: 98.6°F)***

2. **Looking Glass:** click the Looking Glass in the cell to open the Category Select Window: ![Category Select Window] and click **Accept**.

3. **Details Box:** Left-click to “pick” and Right-click to “stick”. When the Details box indicates that the Caregiver can **Select Multiple Options**, left-click to select each option and right-click to complete your selections and move on to the next cell: ![Details Box Selections]
a. Use the Details Box to identify parameters such as Within Defined Limits (WDL), Min/Max, and Warning limitations:

![Details Box Example](image)

b. The Details Box also provides additional information, such as Value Information, First Filed Value and hyperlinks to Job Aides.

4. Cascading Rows become available to the Caregiver based on their documentation. Flowsheet Templates are kept clean and tidy and additional rows open up for documentation as needed (example: Documenting **Continuous** in the **Pulse Oximetry Type** Row, opens up additional rows for continued documentation).

a. Cascading Rows are indicated by this icon:

b. Documentation occasionally triggers additional rows:

![Cascading Rows Example](image)

### File Flowsheet Documentation

Pink text in Flowsheets indicates that the Documentation is not yet filed (or “saved”). There are several ways to File documentation in Flowsheets.

1. File button in the Workspace Toolbar:

2. Opening another Flowsheet Template (example: switching from **Vital Signs Flowsheet** to **Simple Assessment Flowsheet** will **File** all documentation in progress).

3. Navigating away from the **Flowsheets Activity** (example: switching from **Flowsheets Activity** to **Education Activity** will **File** all documentation in progress).

4. Black Text has been Filed in Flowsheets:
Legend in Flowsheets

Use the **Legend** button to identify unfamiliar icons in cells:

![Legend button](image)

NOTES

Use the **Notes** Activity to review and write Notes:

![Notes button](image)

REVIEWING NOTES

1. Review **All Notes** or filter by Note Type (*example: Progress, Consult, H&P, etc.*):  
   ![Author Name: Sidney Apple, Author Type: Registered Nurse, Status: Signed](image)
2. View the Note in the **Notes** Activity, on the bottom half of the screen:

![Table of notes](image)

WRITING NOTES

1. Write a **New Note** by selecting the **New Note** button to open the Note Window:
a. Indicate the **Type: Nursing Note**

b. Search **SmartText** to pull in Note Templates:
   
   i. Begin typing to pull in specialty or encounter specific notes:

   ii. Click **Accept** to pull in the Note Template:

   iii. *** indicates free text.

   iv. Use F2 to move through the yellow sections where documentation must be completed. Drop-down menus will open to speed documentation.

   v. Click **Send** to come back to the Note later.

   vi. Click **Sign** when the note is complete.
2. View the Note in the **Notes** Activity, on the bottom half of the screen:

**WRITING NOTES FROM FLOWSHEETS**

The easiest way to write a Nursing Note about a specific set of values is to write the Note in Flowsheets.
1. Select the pertinent data by left clicking in a cell, holding the mouse button down, and dragging to the last desired cell:

![Image of selected data]

2. Right click on the selected data and select **New Note**:

![Image of Flowsheet Notes window]

3. The **Flowsheet Notes** window appears:

4. Select **Insert Data**

5. The selected Data is inserted into the Note. Free Text any additional comments needed to complete the Note:

![Image of inserted data]

6. Select **Sign**:

7. Return to **Notes** Activity to view your Note:

![Image of signed note]

**STICKY NOTES**

Sticky Notes are viewable in the **Summary** Activity.
Sticky Notes to Physicians

Use Sticky Notes to Physicians to communicate with Providers. The Note can be seen when the Provider (Attending or Rounding Partner) accesses the Chart. This communication can be used for non-urgent communications.

![Sticky Notes to Physicians](image)

Treatment Team Sticky Notes

Similarly, use Treatment Team Sticky Notes for non-urgent communications with other members of the Treatment Team.

![Treatment Team Sticky Notes](image)

Note: Use Sticky Notes to communicate to other Caregivers that access the Chart. The Sticky Note is not a permanent part of the Medical Record. There is no way to know who read it, who deleted it, and when it was removed. Any pertinent medical information should not be documented here. Sticky Notes are discoverable in litigation.

MANAGING ORDERS

There are several places to view and manage Orders.

![Managing Orders](image)

Note: Nursing Students cannot take Verbal Orders, Enter, Acknowledge, or Release Orders. The Nurse assigned to the patient will need to complete these actions.

1. **Summary** Activity:
   a. **Overview** Report:
      i. The **Overview** Report will alert Nursing Staff to **Signed & Held Orders** in need of Release:
ii. The **Overview** Report will alert Nursing Staff to New Orders that need to be **Acknowledged**.

<table>
<thead>
<tr>
<th>Orders to be Acknowledged</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Orders</td>
</tr>
<tr>
<td>Ordered</td>
</tr>
<tr>
<td>08/22/15 0038</td>
</tr>
<tr>
<td>Discharge patient</td>
</tr>
<tr>
<td>Start: 08/22/15 0037, End: 08/22/15 0037, Once, R</td>
</tr>
</tbody>
</table>

iii. The PeaceHealth definition of Acknowledging Orders is that the Nurse has acknowledged the Order for appropriateness (example: *An Insulin Order for a Diabetic Patient is appropriate. An Ambulate Patient Order is inappropriate for a comatose patient and the Nurse should not acknowledge the Order and instead, reach out to the Provider for appropriate Orders*).

b. **Active Orders** Report:

i. The **Active Orders** Report is an overview of all currently Active Orders for the Patient:

![Summary](image)
### Current Scheduled Medications (Future)

<table>
<thead>
<tr>
<th>Ordered</th>
<th>Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/21/15 0901</td>
<td>dextrose 5% and sodium chloride 0.45% with KCl 20 mEq/L infusion 80 mL/hr, Intravenous, Continuous</td>
</tr>
</tbody>
</table>

### Current Continuous Medications (Future)

<table>
<thead>
<tr>
<th>Ordered</th>
<th>Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/21/15 0901</td>
<td>dextrose 5% and sodium chloride 0.45% with KCl 20 mEq/L infusion 80 mL/hr, Intravenous, Continuous</td>
</tr>
</tbody>
</table>

### Current PRN Medications (Future)

<table>
<thead>
<tr>
<th>Ordered</th>
<th>Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/21/15 0901</td>
<td>albuterol (PROVENTIL HFA; VENTOLIN HFA) inhaler 2 puff 2 puff, Inhalation, Every 4 Hours PRN</td>
</tr>
<tr>
<td>08/21/15 0845</td>
<td>morphine injection 2.06 mg 0.1 mg/kg, Intravenous, Every 4 Hours PRN</td>
</tr>
</tbody>
</table>

### Nursing Assessments

<table>
<thead>
<tr>
<th>Start</th>
<th>Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/21/15 1200</td>
<td>Pain assessment Every 4 hours</td>
</tr>
<tr>
<td>08/21/15 0900</td>
<td>Pulse Oximetry, Continuous</td>
</tr>
<tr>
<td>08/21/15 0900</td>
<td>Notify physician Until discontinued</td>
</tr>
<tr>
<td>08/21/15 0900</td>
<td>Intake and Output Every shift</td>
</tr>
</tbody>
</table>

### Nursing Activities and Treatment

<table>
<thead>
<tr>
<th>Start</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/21/15 0900</td>
<td>Bed rest Until discontinued</td>
</tr>
</tbody>
</table>

### Imaging/Radiology Orders

<table>
<thead>
<tr>
<th>Start</th>
<th>Order</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/21/15 0905</td>
<td>X-ray femur bilateral 2 views 1 time imaging</td>
</tr>
</tbody>
</table>

### Lab Orders (Through next 24h)

<table>
<thead>
<tr>
<th>Start</th>
<th>Order</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/21/15 0900</td>
<td>CBC and differential Once</td>
</tr>
</tbody>
</table>
COLLECTING LABS AND POINT OF CARE TESTS

Collecting Labs and Point of Care Tests on the Unit functions based on the type of specimen and the Specimen Collection Status for the Patient.

SPECIMEN COLLECTION STATUS

Some Units default to Lab Collect and others default to Unit Collect (example: ED and OB default to Unit Collect). There are 3 ways to set Specimen Collection Status in the Patient Chart. Review the setting in the Patient Header:

1. **Admission Navigator** > **Specimen Collection**
2. **Flowsheets Activity** > **IV Assessment Flowsheet** > **Specimen Collection Status**

3. **Patient Header** > **Collection**. Normally, clicking in the Patient Header doesn’t initiate an action. Specimen Collection Status is an exception:

   Tip: Select the **Refresh** button in the Patient Header to update Specimen Collection Status.
WORK LIST

Use the **Work List** Activity to complete Tasks:

![Work List Screenshot]

1. **Overdue** tasks appear in **Yellow**.
2. **Skip** Tasks to remove them from the **Work List**.
3. **Doc** to jump to alternate activities to complete documentation (*examples: MAR and Flowsheets)*.
4. **Print Label** to print Lab Labels for Collecting Labs and Point of Care Tests.
   a. Once you select **Print Label**, the button changes to **Collect**: 
   b. Select **Collect** to open the Collection Window to complete documentation:
   ![Collection Window Screenshot]
   c. Red Stop Sign icons indicate a Hard Stop in documentation. This documentation must be completed to move on.
   d. Yellow Yield Sign icons indicate Recommendations in documentation. This documentation is not required, but is highly recommended before moving on – as it will often delay the workflow of yourself and others later on.

**Tip:** Use shortcuts such as “t” for “today” and “n” for “now” to speed documentation.

e. Once documentation is complete in the Collection Window, the task is removed from the Work List.
Tip: If the Print Label button does not appear on the Work List, verify that Specimen Collection Status is set to Unit Collect and a) call the lab to have them send the Lab Label for Unit Collection or b) call the Lab to cancel the Lab Collect and have the Provider re-enter the Order with the Unit Collect Status now in place.

5. **Reprint Lab Label** can only be done from the **Summary Activity>Active Orders>Lab Orders:**

![Summary Activity](image)

Note: **Reprint Lab Label** and **Collect** hyperlinks will appear here and both tasks can be completed from here as well as from the Work List.

**ADMINISTERING MEDICATIONS**

Medication Administration is documented on the Medication Administration Record (MAR).

**MAR**

MAR Documentation is completed in the **MAR Activity:**

Medications can be filtered by category:

- ALL
- Scheduled
- PRN
- Continuous
- Respiratory
- Due/Overdue
- Override Pulls
- Chem

**Messages to the Pharmacy**

1. Send messages to the Pharmacy in the Workspace Toolbar:
a. Send a generic message about the Patient or all Medications by selecting the **Rx Messages** button.

b. Select **Rx** in a Medication Row to send a message about a specific Medication:

---

**PRN Medications**

Obtain PRN Medications from the Pyxis dispensary per protocol and use barcode scanning to Administer Medications whenever possible.

1. Scanning the Patient ID Band will open the Chart to the **MAR Activity**.
2. Scanning the Medication will link the Administration to an existing Order in the MAR.
3. The Medication Administration Window will appear.
   a. Verify Order Information:

   ```
   acetylsalicylic acid (ASA) chewable tablet 325 mg
   Order: 1 tablet every 6 hours PRN
   Admin Amount: 1 tablet
   Admin Instructions: Not to exceed 4000 mg total acetylsalicylic acid dose from all medications in 24 hours.
   PRN Reasons: Moderate Pain (Pain Scale 4-6)
   References: Lex-Comp Drug Information
   acetylsalicylic acid: 0 mg/kg administered out of the max 75 mg/kg in the last 24 hours as of Sun Aug 23, 2015 2102
   ```

   b. Verify Administration Details:
c. Associated Flowsheet Rows appear to streamline documentation:

4. The Medication now appears as Given on the MAR:

    acetylsalicylic acid (ACETAMINOPHEN) chewable tablet 480 mg - Dose: 15 mg/kg x 30.8 kg - Admin Dose: 480 mg - Oral - Every 6 Hours PRN - Moderate Pain (Pain Scale 4-4) - Documented By: PHILINDOC, NURSING STUDENT

Tip: Hover over the Administration Documentation to view additional details:

Edit an Administration

1. Click on the Administration Documentation in the MAR to open the Details of the Administration:

2. Select the Edit Administration box: Edit administration

3. Edit the Administration Documentation and click Accept.

Override Medications

1. Pulling an Override Medication from the Pyxis Dispensary from a Profiled Pyxis (associated with a Patient) will trigger the Medication population on the Patient’s MAR. This Benadryl was pulled as an Override Medication without an Order and is indicated by a PINK bar:

2. Document the Administration using a Barcode Scanner.

3. The Medication Documentation drops to the bottom of the MAR under Completed Medications and can also be viewed by filtering the MAR by the
Override Pulls tab:

4. Reconciling Override Pulls must be completed when the RN retroactively enters the Order for the Medication.
   
   a. RN must select **Link Order** in the Order Details Box:
   
   b. The **Link Orders** Window appears for the RN to complete reconciliation of the Override Pull.

LDA’S AND INTAKE & OUTPUT

LDA is an acronym for Lines, Drains, and Airways. This section also includes Wounds, Tubes, and Incisions. Let’s review documenting an IV Start and reviewing I&O.

DOCUMENT AN IV START

1. **Flowsheets Activity>IV Assessment Flowsheet>Add LDA:**

2. The Lines, Drains, Airways, Tubes and Wounds window opens. Search for the appropriate LDA:
3. Select an Existing LDA or Select **Add New**:

4. The selection prompts the Caregiver to document the properties of the LDA:

   ![Property Definition Screen]

   **Note:** Leave Removal Documentation blank for future documentation. It is possible to Discharge Patients with Active Lines in Place and unresolved Wounds & Incisions. The Removal & Resolution must be documented during the patient’s next Encounter or when applicable.
5. Select **Accept**.
6. All Active Lines appear for Assessment in the **IV Assessment** Flowsheet under the Table of Contents:

   ![IV Assessment Flowsheet](image)

   7. The Line we just placed is viewable as a Row in the Flowsheet where we will document our IV Assessment:

   ![IV Assessment Row](image)

   **REMOVE A LINE**
   
   1. To edit the Properties of the LDA, select the blue hyperlink in the Flowsheet to open the Properties window.
   
   2. Select **Edit**:
   
   3. Scroll to the bottom of the Properties window to complete Removal Documentation.
   
   4. Select **Accept**.
   
   5. The Line now appears as [REMOVED] in the Flowsheet but the blue hyperlink remains to facilitate additional documentation as needed:

   ![REMOVED Line](image)

   **REVIEW I&O**
   
   Intake & Output can be reviewed in the **Intake/Output** Activity:
Intake & Output can be documented from the **Intake/Output** Flowsheet. Use I/O Flowsheet button in the Workspace Toolbar:

< > **I/O Flowsheet** or Flowsheets Activity > **Intake/Output** Flowsheet.

1. Document Unmeasured Output as an occurrence:

**ADMINISTERING IV MEDICATIONS**

Documenting IV Medications is similar to Documenting Oral, SubQ, and IM Medications.

1. Scanning the Patient ID Band will open the Chart to the **MAR** Activity.
2. Scanning the Medication will link the Administration to an existing Order in the MAR.
3. The Medication Administration Window will appear.
   a. Verify Order Information.
b. Verify Administration Details. Including the **Action**: 

c. Click **Accept**.

d. The Medication now appears as a **New Bag** on the **MAR**:

![](image)

```
1838 New Bag 80 mL/hr
```

e. To Document a new action

i. Select the appropriate cell (Medication/Date & Time) on the **MAR**

ii. Select the appropriate **Action**

iii. Select **Accept**

f. The New Action now appears on the **MAR**:

![](image)

```
1838 New Bag 80 mL/hr          1900 Stopped
```

Note: Stop Time documentation is required at PeaceHealth.

Tip: If IV Infusion calculations for I&O do not match the pump volumes, the documentation should be edited to match the pump volumes. The pump is the source of truth.

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**PATIENT EDUCATION**

Patient Education is documented in the **Education** Activity:

---

**DOCUMENT A LEARNING ASSESSMENT**

The Learning Assessment must be documented for the appropriate Learner’s prior to documenting Education.

1. **Education** Activity>**Assessment** Tab>**Create New**
2. Document the Learning Assessment(s)
3. Select File (use File Incomplete to return to the Assessment at a later time).

**DOCUMENT EDUCATION**

Document Education provided to the Learner(s).

1. **Education Activity** > **Unresolved Education** Tab
2. Select **Add Title/AddPoint** as appropriate. Templates exist to ease selections:

3. Choose only applicable Titles/Topics/Points.
4. Select the Teaching Point in **Unresolved Education**:

![Unresolved Education](image)

5. Select the Learner and document Readiness, Method, and Response:

![Learner](image)

6. Documentation is reflected:

<table>
<thead>
<tr>
<th>Learner</th>
<th>Ready</th>
<th>Method</th>
<th>Res.</th>
<th>Comments</th>
<th>Taught By</th>
<th>Date</th>
<th>Time</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mom</td>
<td>E</td>
<td>E</td>
<td>VU</td>
<td></td>
<td>PH CLINDOC, NURSNG STUDENT</td>
<td>8/24/2015</td>
<td>1856</td>
<td>Done</td>
</tr>
</tbody>
</table>

7. Related Education Materials are populated and will print with the After Visit Summary at Discharge.

![Education Materials](image)

8. Select **File**

9. Education provided is indicated by a green check mark:

![Check Mark](image)

Tip: Education for Multiple Learners can be documented simultaneously as long as all Learners have the same levels of Readiness, Method, & Response by using the **Multiple** button.
TRANSPORT A PATIENT
Transport is requested from an Order for Imaging.

TICKET TO RIDE
Patients leaving the Unit without their Primary Nurse should carry a Ticket to Ride.

1. **Summary** Activity>Search Reports “Ticket”:

2. Select **Print** button in the upper right corner of the screen:

<table>
<thead>
<tr>
<th>Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address: 1218 West Street Madison WI 53705</td>
</tr>
<tr>
<td>SSN: xxx-xx-3419</td>
</tr>
</tbody>
</table>

Note: Never send a Patient off the Unit without a Nurse or a Ticket to Ride. This brief overview of the Patient’s Allergies, Hospital Problems, and Current Medications could be vital to Patient Care in the event of an Emergency during Transport.

DISCHARGE A PATIENT
Discharge Orders will prompt the Discharge process. Documentation is completed in the **Navigator Activity>Discharge Tab** (See **Discharge Navigator above**).

TRANSFER A PATIENT
Transfer Orders initiate the Transport process. Documentation is completed in the **Navigator Activity>Transfer Tab** (See **Transfer Navigator above**).

END OF SHIFT
Any Transfer of Care requires a bedside Nursing Report.
1. Complete **End of Shift** Note
   a. **Patient Lists**>**End of Shift** button:
   b. Complete End of Shift Documentation and click **Accept**:

   ![End of Shift Note](image)

   c. View the EOS Note in **Summary Activity**>**Care Plan**:

   ![Care Plan](image)

2. Review **SBAR Handoff** Report with Receiving Nurse
   a. **Summary Activity**>**SBAR Handoff**

   **Note:** When you completed the **Sign In** action at the Start of the Shift, your pre-selected shift times will prompt **Sign Out** and will **End My Assignments**. If your Shift Ends early remember to manually select **Sign Out** from **Patient Lists**.
CARE PLAN

The Plan of Care is a compilation of discrete data and Nursing Care Standards. It is dynamically populated by documentation, BPA’s and more.
Note: At PeaceHealth, there is no documentation within the Care Plan. It is a report of documentation already completed in the Patient Chart that is pertinent to the Plan of Care.

LEARNING HOME DASHBOARD

Your single best resource in CareConnect is your Learning Home Dashboard.

1. Access Nurse Guides using the hyperlinks to view Tip Sheets, Quick Start Guides and Step By Step Guides to guide you through any workflow.
2. Access PeaceHealth’s Policy C360 web page to search policies.
3. Use hyperlinks to access job aides such as Mosby’s.