EMR Practice Script and Proficiency Guide

Medical – Emergency Department - Adult

Introduction:

This **Practice Script** and **Proficiency Guide** have been designed to support the development and consolidation of your EMR skills.

The **Practice Script** section walks you through a patient scenario and asks you to perform several activities in the EMR related to patient care and the patient's journey.

The optional **Proficiency Guide** section can be used as either an informal self-assessment tool or as part of a facilitated assessment if required.

To complete these activities, please:

1. Open the **Practice Domain** using the **Monash Health Citrix Portal** https://portal.monashhealth.org/vpn/index.html

   If you are accessing the Practice Domain from outside Monash Health you can access the Citrix Portal here

   For additional assistance on using the **Portal** to find the **Practice Domain,** please call IT support on 95947255 and select option 1.
2. Click on **FirstNet**
3. Log into the EMR **Practice Domain** using one of the Usernames and Passwords listed below
4. Please use the **Patient Name(s)** associated with your Username as listed on the Username and Patient List Table (see below)

Username and Patient List:

Username	Password	Patient Name	Ward/Location
TRAINDocED01	cerner	Brianone Emergency	DDH ED
TRAINDocED02	cerner	Briantwo Emergency	DDH ED
TRAINDocED03	cerner	Brianthree Emergency	DDH ED
TRAINDocED01	cerner	Brianfour Emergency	DDH ED
TRAINDocED01	cerner	Brianfive Emergency	DDH ED

Practice Script Instructions:

1. Work your way through each of the **Practice Script a**ctivities
2. If you need additional information to work through this **Practice Script** refer to the Monash Health EMR website https://emrmonashhealth.org/ and click on **Resources** to access any of the following supporting documents
   - Quick Reference Guides (QRGs)
   - Training Videos
   - Key Workflow Videos
   - Workflow Posters

   Once you are using the Monash Health Live EMR, you can also click on **eCoach** to access these resources.

3. After you have completed the Practice Script activities, you can check your skills against those listed in the **Proficiency Guide** (below) to assess your readiness to use the EMR.

Please note:

- Multiple staff can use the same username and patient in the **Practice Domain** at the same time. If you discover that another user has already Practiced using your patient, you can select another patient and/or log in from the list below.
- All data entered in the **Practice Domain** is cleared/refreshed nightly at 2400-0200hr.

Practice Script

Scenario:

You are an ED Registrar and have just commenced your shift in the Emergency Department at Dandenong and have been assigned to the Acute Care Team. You have picked up 'Brian Emergency' and have moved the patient to Fast Track Treatment Room 1 to do your initial assessment as the department is bed blocked.

Activity:

Enter LaunchPoint then Check In under the Acute Care Team.

1. *Click on LaunchPoint in the toolbar at the top of the screen*
2. *Select "D ED, D SSU" as the location*
3. *Find the menu icon on the top right corner of LaunchPoint and select "Check In"*
4. *Provider Role: Treating Clinician*
5. *Default Relation: ED Registrar*
6. *Available Teams: all available teams*
7. *Select OK when finished*

Search for your patient and assign them to the Gold Team and update their location to Fast Track, 01

1. *Find Brian Emergency in the Waiting Room list*
2. *Click on the column titled "TC Nurse EPS MDT" to assign yourself as the provider*
3. *Click Assign in the TC (treating clinician) row*
4. *Change Brian's team to Acute Care Team under the column titled "T"*
5. *Change Brian's room location to Fast Track, 01 under the column titled "Room"*
6. *Brian will now be available in the My Patients tab*

Scenario:

You have just taken a history from Brian, who has presented with 2 days of right upper abdomen pain, 9/10 intensity. He has also been feverish and vomiting. He has a Problem history of GORD and Hypertension. He had his appendix removed as a child. He consumes 5 standard alcoholic drinks per day. You now need to document this history.

Brian also states that he is allergic to tramadol and peanuts and only takes Ramipril 5mg and Esomeprazole 40mg, both in the morning.

Activity:

Enter your patient's chart via LaunchPoint and complete the ED Doctor Workflow by working through the subheadings

1. *Click on your patient's name under the column titled "Patient Information" to enter the chart*
2. *The default view when entering a patient's chart is the ED Doctor Workflow*

Complete Past Medical Problems

1. *Scroll to the Histories heading*
2. *In the Problems section, add "Hypertension" to the Search within SNOMED CT and select the appropriate problem from the drop-down list*
3. *Repeat the process for "GORD"*

Note: Problems = past medical history (SNOMED CT terminology)

Complete Past Procedure History

1. *Select the Histories heading to hyperlink to other history tabs*
2. *Select the Procedure tab and choose the Add button*
3. *Search for the procedure Appendicectomy and choose the appropriate catalogue item*
4. *Click OK*
5. *Add any other relevant information and select OK*

Complete Social History

1. *Select the Social tab and double click in the details section of Alcohol*
2. *Enter the relevant information*
3. *Click OK*

Navigate back to ED Doctor Workflow and refresh the screen to see histories documented under each tab

Review previously documented Allergies/ADRs

1. *Click the Allergies/ADRs title in the Banner Bar*
2. *Click Mark All as Reviewed*
3. *Click OK to finish*

Document Home Medications

1. *Navigate back to the ED Doctor Workflow*
2. *Scroll to the Home Medications heading*
3. *Click the Meds History title in the Status section (this will link you to the Document Medication by History window)*
4. Add *Ramipril 5mg oral in the morning*
5. *Add Esomeprazole 40mg oral in the morning*
6. *Click Document History when finished*

Complete the History of Presenting Complaint

1. *Scroll to the History of Presenting Complaint heading*
2. *Document "2/7 RUQ pain, 9/10. Associated fever and vomiting" in the free-text field*
3. *Click Save when finished*

Scenario:

After examining Brian, you find that he has severe right upper quadrant tenderness and is Murphy's positive. Your impression is that he has acute cholecystitis. Your plan is to: 1. Bloods, 2. Analgesia, 3. Abdo US, 4. Keep fasted + IV fluids, 5. Gen Surg consult.

Enter an ICD-10-VEMD Diagnosis of 'Severe abdominal pain Acute abdomen'

You will also need to order a Consult and Bed Request under Gen Surg at Clayton.

Activity:

Document the Physical Examination findings

1. *Scroll to the Physical Exam heading*
2. *Document "Right upper quadrant tenderness, Murphy's positive" in the free-text field*
3. *Click Save when finished*

Document the Clinical Assessment & Management Plan

1. *Scroll to the Clinical Assessment & Management Plan heading*
2. *Document "Impression: Acute cholecystitis"*
3. *Document "Plan: 1. Bloods, 2. Analgesia, 3. Abdo US, 4. Keep fasted + IV fluids, 5. Gen Surg consult"*
4. *Click Save when finished*

Create "ED Initial Assessment" note

1. *Tag any relevant pathology results to include in the document*
2. *Click ED Initial Assessment in the left-hand Navigator under the Create Note section (this will link you to the Documentation section in the Table of Contents)*
3. *Sign/Submit when finished using the correct naming convention "Team" "Role" "Reason" (i.e. DDH ED Registrar Initial Assessment)*

Enter an ICD-10-VEMD Diagnosis of 'Severe abdominal pain Acute abdomen'

1. *Select Diagnosis, Alerts and Problems from Main Menu*
2. *Select Add in the Diagnosis dialogue box*
3. *Search Severe Abdominal Pain Acute Abdomen*
4. *Select the appropriate ICD-10 VEMD diagnosis*
5. *Select OK*
6. *Ensure Type is "Principal" and select OK*

Navigate back to ED Dr Workflow and refresh the screen

Order a Bed Request (via Quick Orders)

1. *Navigate back to the ED Doctor Workflow and click on the ED Adult Quick Orders tab*
2. *Navigate to ED Common Consults/Referrals to add "Consult to General Surgery"*
3. *Click the "Bed Request to Wards" order in the Disposition Orders section*
4. *Click on the Orders for Signature icon (i.e. shopping cart) to modify the orders*
5. *Click Modify Order Details*
6. *Consult to General Surgery*
    a. *Consult to: xGeneral Surgery Consults D*
    b. *Consult Reason and Question: Acute cholecystitis*
    c. *Relevant History and Examination: RUQ pain, Murphy's positive*
    d. *Contact Details of Referring Clinician: ED Reg x1234*
7. *Bed Request to Wards*
    a. *Specialty: General Surgery*
    b. *Bed Type: Dandenong Gen Surg*
8. *Click Sign when finished*

Note:

- You will still need to contact the consulting Registrar to verbally discuss your patient
- Location abbreviations:
    - B = Casey
    - C = Clayton
    - D = Dandenong
    - K = Kingston
    - M = Moorabbin
    - N = Cranbourne

Scenario:

Brian's pain has resolved with analgesia and fluids. He has been reviewed by Gen Surg who do not feel that admission is warranted at this stage. Document a progress note detailing this information.

Activity:

1. *In the ED Workflow tab Scroll to the More dropdown in Create Note and select Other Note Type*
2. *Choose ED Progress Note from the Type*
3. *Select Free Text Note from the Note Templates*
4. *Select OK*
5. *Enter the progress information and Sign/Submit*
6. *Change title to Team: Reason (DDH ED Medical Progress Note)*
7. *Sign*

Note: The Progress Note can be addended as many times as needed to reflect ongoing progress of the patient condition by accessing this note from Documentation and modifying

Scenario:

You are going to discharge Brian Emergency home but need to provide him with a discharge summary and complete the discharge process. They are a WorkCover patient and will need to have compensable billing added for the ECG that was done by Andy Draper.

Activity:

Order the 12 lead ECG

1. Navigate to the *ED Doctor Workflow and click on the Compensable Billing tab*
2. *Click on "ECG – 12 lead"*
3. *Click on the Orders for Signature icon (i.e. shopping cart) to modify the orders*
4. *Click Modify Order Details*
5. *Consultant Involved? Yes*
6. *Consultant Name: Draper, Andy*
7. *Click Sign when finished*

Complete the Discharge Medication Reconciliation

1. *In the ED Workflow select Discharge Medication Reconciliation from the Discharge Checklist*
2. *Select pill bottle for any script required*
3. *Select green arrow to add any unchanged home medication to the discharge summary*
4. *Select red box to stop any medications that do not need to continue*
5. *When all fields have a response select Reconcile and Sign*

Complete and document the Discharge Summary via the ED Doctor Workflow including:

1. Navigate to the *ED Doctor Workflow and click on the ED Workflow tab*
2. *Tag any relevant ED Progress Notes or Gen Surg Review Note to include in this document*
3. *Tag any relevant pathology results to include in the document*
4. *Scroll to the Discharge Additional Recipients heading and add any Providers to be sent the discharge summary*
5. *Click Discharge Summary in the left-hand Navigator under the Create Note section (this will link you to the Documentation section in the Table of Contents)*
6. *Review the information*
7. *Drag the tagged text and drop into the relevant area (note: tagged pathology will automatically pull through)*
8. *Complete any relevant missing details*
    a. *Discharge Plan*
    b. *Advice to GP and other medical practitioners*
    c. *Advice to Patient*
9. *Sign/Submit when finished using the correct naming convention "Team" "Role" "Reason" (i.e.DDH ED Registrar Discharge Summary)*

Complete the ED Timeout

1. *Navigate back to the ED Doctor Workflow and click on the Discharge Process icon in the top right corner*  *(this will link you to the Depart Process window)*
2. *If any statutory information is required, they will appear as yellow mandatory fields e.g. ED Driving Change, Injury Surveillance*
3. *Click the pencil icon next to the ED Timeout section*
4. *Review the latest vital signs*
5. *Patient Disposition: Discharge*
6. *Open Discharge Section*
7. *Patient vital signs recorded within 60 mins of discharge: Yes*
8. *Vital Signs safe for discharge: Yes*
9. *Peripheral IVC removed prior to discharge: Yes*
10. *Discharge at own risk: No*
11. *Click the back-arrow icon* 
12. *Click the green tick to sign the form*

Note: If patient qualifies for Compensable Billing (WorkCover, TAC, etc.) a reminder with appear

*Complete Discharge/Transfer Patient
(*not currently available in Train and Practice Domain)

1. *Click the pencil icon next to the Discharge/Transfer Patient*
2. *Select the Discharge Disposition and Follow Up/Transfer responses from the drop-down boxes in Discharge Information*
3. *Select Date and Time of Discharge. Use T = Today, N = Now.*

Note: If patient has been placed in Left Department Location on LaunchPoint – date and time will automatically prefill

Proficiency Guide:

How to use the Proficiency Guide

1. Select a username, login, and patient from the Username and Patient List Table (see above)
2. For each activity's assessment, consider the following:
   - **Proficient**- You are able to confidently complete the activities without assistance or using any additional references. You are ready to complete these tasks in the Live EMR.
   - **Needs Assistance/References-** In order to complete the activity, you need to ask for a small amount of assistance or consult a reference. You may want to review the online material related to this subject.
   - **Unable to Complete-** At this time, you are unable to independently complete this activity and require a large amount of assistance or need a reference to walk-through the activity. A large amount of additional review is required in this area.

Proficiency Guide

Scenario: Admit and Discharge a Patient from the Emergency Department
Activities: General Set Up
Check into Launchpoint
Understand, Interpret and navigate LaunchPoint
Assign patients to yourself or another clinician
Interpret the Emergency Tracking board, identify and open the patient summary of patient's currently in the Emergency Department
Search for a patient via UR/MRN and select the correct patient and encounter
Review and identify documentation incomplete, pending and complete on LaunchPoint
Move patients from 1 ED location/cubicle to another in LaunchPoint
Open a patient chart from LaunchPoint
Navigate and interpret information within the patient chart Table Of Contents including the: Results Review, Observation Chart, MAR, MAR Summary, Interactive View, Documentation, Notes, Form Browser etc
Document a patient's measured height and weight; and document dosing weight in the interactive view
Document a patient's Allergy/ADR history from LaunchPoint and Banner Bar

Activities: ED Initial Assessment Documentation Workflow
Understand and Interpret the details within the Banner Bar
Review and Document patient's Allergy/ADR history
Access Goals of Care PowerForm and read within the Documentation, Notes and Form Browser
Review, interpret and document patient's past medical problems in the Histories section Problems - searching from the SNOMED catalogue
Review, interpret and document family history
Review, interpret and document procedural (surgical) history
Review, interpret and document social history
Review, interpret and document patient's home medications
Document HOPC
Document Physical Examination using auto text (E.g. .EXAM)
Document a Clinical Assessment and Management Plan
Generate and review an ED Initial Assessment Note
Sign the ED Initial Assessment note and update title with: Team-Role-Reason
Document a patient's diagnosis from the ICD10 VEMD catalogue from the Diagnosis, Alerts and Problems Menu

Activities: ED Progress Note Documentation Workflow
Create ED Progress Note to document ongoing patient progress
Sign the ED Progress note and update title with: (Unit) ED Medical Progress Note
Modify an existing ED Progress Note to denote progress changes
Sign the addendum to the ED Progress Note

Activities: Quick Orders
Using Quick Orders, appropriately order pathology tests to be collected
Using Quick Orders, appropriately order Radiology investigation
Using Quick Orders, appropriately order a medical consult
Using Quick Orders, appropriately order a referral to an MDT service (allied health service)
Using Quick Orders, place a patient care order to review vitals every 30min
Using the Quick Orders of the ED Doctor Workflow, order blood products and relevant administration instructions
Using the Quick Orders, appropriately order medications

Activities: Medication Ordering
Order an antimicrobial medication and input an approval number
Document a dose review required for a medication
Suspend a medication order
Resume a medication order
Cancel and Re-Order a medication
Cancel/Discontinue a medication
Order a medication with more than one route
Ordering an oral medication
Change dose administration times when ordering a medication
Order a prn medication
Order a medication with the first dose to be administered a day later
Order a Bag by Bag infusion
Order an infusion sequence
Order prednisolone, dexamethasone or amiodarone tapering
Order vaccinations

Order regular insulin
Order supplemental insulin
Withhold a Single Dose of a Medication
Reschedule a Single Dose of a Medication
Reschedule the administration times of a medication after it has been ordered
Administer a medication from the MAW
Order a TDM medication with an order for the levels to be taken at the appropriate time
Ordering blood products e.g. PRBC and albumex

Activities: Bedside Procedure Documentation
Document the insertion of a line/device from the interactive view
Document ED procedures in Interactive View
Document ED Critical Care Procedures in Interactive View
Document PoCUS findings in PoCUS PowerForm
Understand the workflow of taking bloods i.e. printing labels, take bloods

Activities: Admission to SSU Workflow
Review and order essential medications for a patient
Show understanding and need to document a patient's diagnosis from the ICD10 VEMD catalogue from the Diagnosis, Alerts and Problems Menu
Document any relevant injury surveillance for the patient
Place a relevant SSU Bed Request OrderSet for the patient
Complete the ED timeout and document the relevant status for a patient admitting to SSU

Activities: ED/ SSU Review Note Workflow
Review the patient from LaunchPoint and the TC Comments and Patient Summary
Review previous documentation (E.g. Admission Notes or ED Progress Notes) and tag information applicable to the current note
Review patient record information (E.g. Problems List) and update if relevant
Understand and Interpret the patient MAR/MAR Summary
Understand and Interpret the Results Review
Understand and Interpret the Observation Chart
Document a review of problems, physical examination, Clinical Assessment and Management Plan

Generate the SSU Review note
Sign the review note and update title with: Team-Role-Reason (E.g. DDH ED Consultant SSU Review Note)

Activities: Admission to Ward Workflow
Review and order essential medications for a patient
Show understanding and need to document a patient's diagnosis from the ICD10 VEMD catalogue from the Diagnosis, Alerts and Problems Menu
Order relevant compensable billing for the patient
Document any relevant injury surveillance for the patient
Place a Bed Request order for the patient
Complete the ED timeout and document the relevant status for a patient admitting to the ward
DO NOT do discharge medication reconciliation

Activities: Admission to Another Monash Health Site Workflow
Complete a Medication Cross Encounter Reconciliation
Show understanding and need to document a patient's diagnosis from the ICD10 VEMD catalogue from the Diagnosis, Alerts and Problems Menu
Order relevant compensable billing for the patient
Document any relevant injury surveillance for the patient
Place a Bed Request Order for the patient
Complete Cross Encounter Reconciliation just prior to patient departing
Complete and generate a patient discharge summary with relevant Team-Role-Reason name (E.g. Emergency Medicine – Registrar – Transfer Note)
Complete the ED timeout and document the relevant status for a patient transferring
Complete the Depart Process via LaunchPoint or the Patient Chart

Activities: Discharge to a Non-Monash Facility Workflow
Complete the Medication Discharge Reconciliation
Create and print a discharge prescription via the Medication Discharge Reconciliation
Modify and change a previously completed discharge prescription from the Orders Menu
Show understanding and need to document a patient's diagnosis from the ICD10 VEMD catalogue from the Diagnosis, Alerts and Problems Menu
Order relevant compensable billing for the patient
Document any relevant injury surveillance for the patient

Review and tag any relevant investigations or documentation relevant to include in the discharge summary if applicable
Generate the patient's discharge summary
Save the Discharge Summary and update title with: Team-Role-Reason (E.g. DDH ED Consultant Transfer Note)
Complete the ED timeout and document the relevant status for a patient transferring to another facility
Complete the Depart Process via LaunchPoint or the Patient Chart

Activities: Discharge Home Workflow
Complete the Medication Discharge Reconciliation
Create and print a discharge prescription via the Medication Discharge Reconciliation
Modify and change a previously completed discharge prescription from the Orders Menu
Show understanding and need to document a patient's diagnosis from the ICD10 VEMD catalogue from the Diagnosis, Alerts and Problems Menu
Order relevant compensable billing for the patient
Document any relevant injury surveillance for the patient
Review and interpret the Medication Management Plan status completed by pharmacy if applicable
Review and interpret MDT discharge planning documentation if applicable
Enter a patient's clinical summary and discharge plan
Document advice to the patient via the auto text .Advice
Search and include a patient's GP and relevant private specialists in the Additional Recipients
Review and tag any relevant investigations or documentation relevant to include in the discharge summary if applicable
Generate the patient's discharge summary
Save the Discharge Summary and update title with: Team-Role-Reason (E.g. DDH ED Medical Discharge Summary)
Complete the ED timeout and document the relevant status for a patient going home
Complete the Depart Process via LaunchPoint or the Patient Chart

Notes:

If Required by Manager or Unit:

Facilitator Name and Designation: _____

Facilitator Signature: _____ Date_____/_____/_____