

EMR Practice Script and Proficiency Guide

General Medical

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 **PowerChart**
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)

If the Username, Password and Patient Details are unavailable – Exit the system and ensure that the Practice Domain icon has been selected

Username and Patient List:

Username	Password	Patient Name	Ward
TrainDocSMS01	cerner	Prince-a, Diana	B Tower Ward 3 (Casey)
TrainDocSMS02	cerner	Prince-b, Diana	B Tower Ward 3 (Casey)
TrainDocSMS03	cerner	Prince-c, Diana	B Tower Ward 3 (Casey)
TrainDocSMS04	cerner	Prince-d, Diana	B Tower Ward 3 (Casey)
TrainDocSMS05	cerner	Prince-e, Diana	B Tower Ward 3 (Casey)
TrainDocSMS06	cerner	Prince-f, Diana	B Tower Ward 3 (Casey)
TrainDocSMS07	cerner	Prince-g, Diana	B Tower Ward 3 (Casey)
TrainDocSMS08	cerner	Prince-h, Diana	B Tower Ward 3 (Casey)
TrainDocSMS09	cerner	Prince-i, Diana	B Tower Ward 3 (Casey)
TrainDocSMS10	cerner	Prince-j, Diana	B Tower Ward 3 (Casey)

Practice Script Instructions:

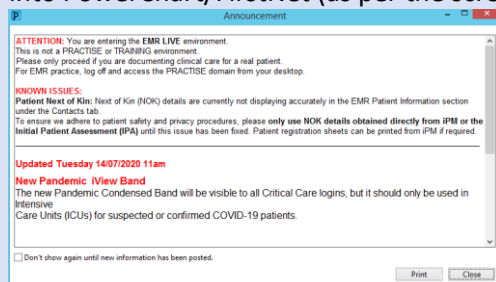
5. Work your way through each of the **Practice Script** activities
6. If you need additional information to work through this **Practice Script** refer to the Monash Health EMR website <https://emrmonashhealth.org/> and click on **Resources** to access any of the following supporting documents
 - Quick 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.

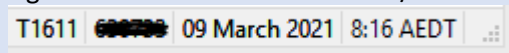
7. After you have completed the Practice Script activities, you can check your skills against those listed in the **Proficiency Guide** to assess your readiness to use the EMR.

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 practised 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.
- When entering the EMR Practice Domain, an Announcement window may appear when logging into PowerChart/FirstNet (as per the screenshot below).



To confirm that you are in the EMR Practice Domain, ensure **'T1611'** is the domain in the bottom right-hand-corner of PowerChart/FirstNet



EMR Practice Script

This document contains the following practice scenarios/case studies that apply to general patients. Each case/study or scenario can be completed collectively or individually. Some case studies teach the same functions of the EMR, but are different clinical scenarios:

- *Admitting A Patient- Basics(10min), page 3*
- *Going On The Ward Round And Documenting A Note - Basics (10min), page 6*
- *General Medication Ordering - Basics (10min), page 8*
- *Patient Discharging Home – Basics (10min), page 9*
- *Admitting A Patient – Advanced #1 (20min), page 11*
- *Admitting A Patient – Advanced #2 (20min), page 15*
- *Patient Discharging Home – Advanced (15min), page 20*
- *Ordering And Managing Warfarin Doses (5min), page 22*
- *Creating Favourites And Ordering Pathology, (5min), page 23*
- *Retrospective Documentation Of A MET Call (5min), page 24*
- *Ordering Medications On Admission (10min), page 25*
- *Setting Up The Message Centre To Receive Consults, And Setting Up Care Teams (10min), page 27*
- *Inpatient Medication Management, (5min), page 29*
- *Documenting Home Medications And Admission Reconciliation (5min), page 31*
- *Ordering Gentamicin And Red Blood Transfusion, (5min), page 32*
- *Creating A Patient List and Documenting Doctor-to-Doctor Handover, (5min), page 33*
- *Ordering Radiology And Pathology Investigations, (5min), page 33*

Scenario: Admitting A Patient (10min total)

Your patient presented to ED where they queried him for Community Acquired Pneumonia after having shortness of breath, cough, fever and developed a harsh, productive cough, mild fever 3/7 ago. Was managing with OTC Cold/Flu medications. He states that he was still working but feeling too unwell now

Patient has no limitation of treatment.

Patient has Hx of diabetes, hypertension, Stable Angina, GORD, Glaucoma, Arthritis, COPD. On presentation, we find there is a need to treat their diabetes due to unstable BSLs.

Patient also has Lower-Right-Quadrant Abdominal Pain to treat for further investigation. Patient has also experienced an allergy to cephalexin 3 months ago which produced a moderate rash.

Patient has difficult vascular access and will need a clinical alert placed

Investigating patient's family history, you find Father has history of Heart Failure and GORD, Mother has history of Hypertension. Patient also has an appendicectomy completed at Alfred Hospital last year October 10th.

Patient's has been taking home medications

- Perindopril 5 mg tab 1 tab oral daily – source: patient
- Paracetamol 500mg tab- 2 tabs oral FOUR times daily- source: patient
- Glyceryl Trinitrate 10mg/24hrs patch (Transiderm-Nitro 50), placed 8am, taken off 8pm daily
- Pantoprazole 40mg tab- 1 tab oral daily- source: patient: Not taking as prescribed (has been taking prn)
- Colecalciferol 25microg- 2 capsules daily- source: patient
- Metformin- Glibenclamide 500mg/2.5mg oral TWICE daily – source: patient
- Devil's Claw 166mg- 2 capsules daily- source: patient

Need to commence patient on benzylpenicillin 1.2 g intravenously, 6-hourly and clarithromycin 500 mg orally, 12-hourly; cease all other ABx

Impression of CAP.

Plan to consult with Endocrine to improve diabetic regime, increase dose of perindopril to 10mg and review.

The following QRG(s) will help with this practice script scenario. Also refer to the Monash Health website, and eCoach within PowerChart/FirstNet for access and links to these QRGs and others:

- [Overview Of Doctor View And Documenting Admission Note](#)
- [Documenting Goals Of Care](#)
- [Assigning A Care Team and Care Team Provider](#)
- [Diagnosis and Problems](#)
- [Document Family History](#)
- [Document A Procedure](#)
- [Allergy and ADR Documentation](#)
- [Documenting A Clinical Alert](#)
- [Document Patient's Home Medications](#)
- [Admission Medication Reconciliation](#)
- [VTE Prophylaxis Care Pathway](#)

Open the patient chart and navigate to the Doctor View. Customize and set up the doctor view to pull the HOPC, Physical Examination, Impression and Plan to the right as per below

Click on the AdHoc button in the EMR toolbar, select the Adult Goals Of Care form and document a relevant Goals of Care form for the patient. (Use the green tick to sign and document) the form. Then refresh the patient chart and confirm the goals of care form has updated in the patient's Banner Bar, and within the Goals Of Care component of the Doctor View

Scroll down the Doctor View and add the patient to your relevant unit via the Care Team

Review and update the patient's Chief Complaint to 'Community Acquired Pneumonia'

Update the problems list and add:
 'This Visit' problems: Community Acquired Pneumonia and Abdominal Pain
 'Chronic' problems: Hypertension, Stable Angina, GORD, Glaucoma, Arthritis and COPD
 'This Visit and Chronic': Diabetes
 From the problems list: click on abdominal pain > click on modify > update the 'display as' to say 'Lower-Right-Quadrant Abdominal Pain'.

From the 'Diagnosis, Alerts and Problems' Menu (i.e. not the Doctor View):
 Navigate to the Problems component > click add > click on the folder icon > add a clinical alert for difficult vascular access

Click on the heading 'Histories' from the Doctor View. Within the procedure tab, document the patient's history of appendicectomy, and within the family history tab, document the patient's family history

Document the patient's allergies and ADRs from the Banner Bar

Scroll down to the home medication documentation component > select the blue text hyperlink 'Med History' and document the patient's home medications.

After documenting the patient's home medications, open the Admission Reconciliation window, and continue the patient's home medications, commence patient on benzylpenicillin 1.2 g intravenously, 6-hourly and clarithromycin 500 mg orally, 12-hourly; cease all other Abx and anticoagulation on the patient's chart

The patient's WCC are elevated which we want to highlight in the admission assessment. Tag the WCC count and any other results you feel are relevant for the admission note.

Our medical patient also needs VTE prophylaxis. Complete the VTE prophylaxis care pathway and ensure that the patient has the appropriate VTE prophylaxis charted from the pathway. Cease any other anticoagulants currently charted.
Document the patient's HOPC
When completing the physical examination, you find that that the patient has unremarkable findings except that he has left basal crepitations. Document this, via the use of the .EXAM autotext and ensure you document the laterality of the basal crepitations.
Document your impression and plan for this patient, including your plan for any problems being treated on this visit.
Generate your admission note, curate the information.
Within the Social History, utilize the .social autotext and document the social history within the admission note.
Title your admission note with the format '<Team>-<Role>-<Reason>'
Save your admission note if you intend to edit the admission assessment, or sign to document into the patient record. Once signed, review the signed document in the Documentation menu.
Update the patient IPASS and document the doctor-to-doctor handover from the Doctor View

Scenario: Going On The Ward Round And Documenting A Note (10min total)

When reviewing a patient on the ward round, you find that the patient has significantly low potassium and the patient has developed further abdominal pain. The consultant is concerned about the patient's low potassium and wants the vitals to be reviewed every 30min until the potassium returns to the regular level. The consultant wants oral potassium ordered for 5 days only, and for the potassium levels to be reviewed after. The patient also needs an endocrine review for their uncontrolled BSLs.

The following QRG(s) will help with this practice script scenario. Also refer to the Monash Health website, and eCoach within PowerChart/FirstNet for access and links to this QRG and others:

- [Overview Of Doctor View And Documenting Admission Note](#)
- [Diagnosis and Problems](#)
- [Ordering Pathology](#)
- [Ordering Imaging](#)
- [Ordering Medications](#)
- [Order A Consult / Referral](#)
- [Placing A Patient Care Order](#)

Open the patient chart and navigate to the Doctor View. Customize and set up the doctor view to pull the HOPC, Physical Examination, Impression and Plan to the right as per below

Open the patient's IPASS and review the doctor-to-doctor handover

Scroll down to the 'Problems List' and add 'Hypokalaemia' as a 'This Visit' diagnosis

Scroll down to the 'New Order Entry' section of the Doctor View and order a Full Blood Exam and UEC test

From the 'New Order Entry' section, search for abdominal ultra-sound and select the relevant ultrasound test for the patient

From the 'New Order Entry', select the 'Vital Sign' patient care order

From the 'New Order Entry', select the Endocrine Consult' order <i>Note: Ensure you call/page the Endocrine team BEFORE placing the consult order</i>
Click the 'checkout box', icon in the doctor view > select 'modify orders', review each of the placed orders and review/modify the orders to reflect what the patient needs
From the Orders Menu, order Potassium Chloride 600mg MR tablets – 1 tablet orally daily for a duration of 5 days only
From the Doctor View pathology results component, tag the patient's most recent potassium level (<i>assume the level is 2.9</i>)
Document the patient's 'Review Of Problems, Impression and Plan text fields as per the ward round
Generate your ward round note and curate the information.
Title your admission note with the format '<Team>-<Role>-<Reason>'
Update the patient IPASS, and add actions to: review the patient's potassium level daily, follow up on the patient's radiology order results, and follow up with endocrine on the placed consult

Scenario: General Medication Ordering (10min)

A patient has CA-UTI without upper tract symptoms and needs Ceftriaxone 1g IV 24-hourly needing to be given at 2100 with the first dose to be given immediately.

The patient also needs:

Oral/IV Metoclopramide 10mg THREE times a day prn for nausea and vomiting (Max Dose 30mg/24hrs)

Oral/IV paracetamol 1000mg FOUR times a day (Max Dose 4g/24hrs), with preference for the oral route to be administered

Oral Oxycodone 5-10mg every 4 hours prn (Max Dose 20mg/24hrs)

IV Sodium Chloride 0.9% 1000mL continuous infusion to be given at a rate of 250mL/hr

The following QRG(s) will help with this practice script scenario. Also refer to the Monash Health website, and eCoach within PowerChart/FirstNet for access and links to this QRG and others:

- [Ordering Medications](#)

Navigate to the Orders Menu, search and select Ceftriaxone 1g.

Make the frequency 24-hourly.

Click on the frequency field drop-down and click the ellipsis icon. From the window that opens, change the dose intervals to 2100.

Ensure the first dose priority is 'NOW' to place a STAT dose to be given immediately.

Refresh and review the MAR/MAR Summary and ensure the doses are scheduled at the appropriate time

Navigate to the Orders Menu, search and select metoclopramide 10mg oral tablet – 10mg THREE times a day PRN for nausea/vomiting.

Then search and select metoclopramide 5mg/mL iv injectable – 10mg THREE times a day PRN for nausea/vomiting.

Ensure both have the same max dose of 30mg / 24 hours, and both have the special instructions "If multiple routes ordered: select and give most appropriate route only"

Navigate to the Orders Menu, search and select paracetamol 500mg oral tab – 1000mg FOUR times a day (Max Dose 4g/24hrs)

Then search and select paracetamol 1000mg/100mL intravenous solution and change the administration instructions to 1000mg FOUR times a day PRN for pain and fever.

Navigate to the Orders Menu, search and select oxycodone 5mg oral tablet- 4 hourly PRN for severe pain. In the dose field: enter '5mg'. In the special instruction, enter 'can give 5-10mg per dose' (*Note: an order sentence for oxycodone exists in the catalogue with these special instructions*)

Navigate to the Orders Menu, search for 'sod chlo' and press enter. From the available options in the catalogue, select 'sodium chloride 0.9% 1000mL Bag By Bag continuous infusion. In the continuous details, enter 250mL/hr in rate field.

Scenario: Patient Discharging Home (15min total)

A 67-year-old man presents to the emergency department with palpitations and dyspnea which began approximately 4 hours ago. He has a history of hypertension, diabetes, and gastroesophageal reflux disease. His current medications are lisinopril 10mg daily, metformin 500mg BD, and omeprazole 20mg daily. He has no history of congestive heart failure, stroke, or transient ischemic attack (TIA). He reports drinking 1 cup of coffee daily and 1-2 beers on the weekends. He denies binge drinking and the use of herbal or alternative medications. He quit smoking 10 years ago. His urine drug screen is negative.

Laboratory testing reveals normal thyroid function. D-dimer and cardiac biomarkers are normal. A chest radiograph does not show infiltrates, pleural effusions, blebs, or hyperinflation. His body mass index is 36 and he admits to snoring and daytime sleepiness. He is at high risk for obstructive sleep apnoea (OSA).

He appears to be in mild respiratory distress. Blood pressure is 88/60 mmHg, pulse rate is 140 bpm, respiratory rate is 24/min, and temperature is normal. Oxygen saturation is 90% on 40% oxygen by face mask. Cardiac exam reveals tachycardia with an irregularly irregular tachycardic rhythm. There are crackles in the lower lung fields.

Electrocardiogram demonstrates atrial fibrillation (AF) with rapid ventricular rate.

This 67-year-old man with hypertension and diabetes has a CHA2DS2-VASc score of 3. Due to renal function, the recommended anticoagulation is warfarin. Metoprolol 50 mg PO twice daily is initiated for rate control.

Optional Component: Complete the ED initial assessment required for a discharge, along with the other inpatient components required for this scenario. This practice script will otherwise assume the necessary admission and inpatient orders/documentation have been completed and the discharge now needs to occur.

The following QRG(s) will help with this practice script scenario. Also refer to the Monash Health website, and eCoach within PowerChart/FirstNet for access and links to these QRGs and others:

- [Discharge Workflow](#)
- [Discharge Medication Reconciliation](#)
- [Printing A Discharge Prescription](#)
- [Editing A Prescription](#)

Navigate to the Doctor View Discharge Workflow tab. Review and update the patient's doctor-to-doctor handover (IPASS)

From the Doctor View Discharge Workflow, select the Medication Discharge Reconciliation and create a discharge prescription with the patient's regular home medications continuing, and commencing on the patient's new AF medications.

Note: If the patient has been commenced on the appropriate Warfarin OrderSet, stop the OrderSet, and within the discharge reconciliation, add Warfarin (coumadin) 1mg, 2mg and 5mg oral tablets. For all 3 formulations, add the patient's warfarin dose in the special instruction (E.g. 'total daily dose of warfarin = 4mg daily). INR for review in 2 days post-discharge with GP required.

Note: In practice, the printed discharge prescription will need to be given to the pharmacist/pharmacy department. The pharmacist will also document the patient's Medication Management Plan On Discharge, which will populate automatically into the discharge summary. Ensure you discuss this with your pharmacist/pharmacy department before generating and completing the discharge summary.

You realise after completing the discharge reconciliation that you need to add paracetamol for the patient. Navigate to the orders menu and add the paracetamol as a prescription item

<p>Review and update the patient's diagnosis of Atrial Fibrillation from the problems list. From the problems list, click on the already entered Atrial Fibrillation > Click on 'Modify' > Update the status from 'discharge' to 'principal'. Ensure the patient's hypertension, diabetes, and gastroesophageal reflux disease are added as 'chronic' in the problems list.</p>
<p>Enter a patient's Clinical Summary and Discharge Plan</p>
<p>In the advice to a patient field, use the auto text .Advice and enter the advice given to the patient as per the scenario</p>
<p>In the 'Additional Recipient' Field, search for the patient's GP (Andrew White) who will receive the Discharge Summary electronically (<i>note: this will not happen within the practice domain</i>)</p>
<p>Review and tag any relevant investigations or inpatient documentation relevant to include in the discharge summary if applicable</p>
<p>Generate the patient's discharge summary</p>
<p>Save the Discharge Summary and update title with: Team-Role-Reason (E.g. Cardiology-Registrar – Discharge Summary)</p>

Scenario: Admitting A Patient – Advanced (20min total)

Chief Complaint:

77 y o woman in NAD with a h/o CAD, DM2, asthma and HTN on ramipril 5mg for 8 years awoke from sleep around 2:30 am this morning of a sore throat and swelling of tongue. She came immediately to the ED b/c she was having difficulty swallowing and some trouble breathing due to obstruction caused by the swelling. She has never had a similar reaction ever before and she did not have any associated SOB, chest pain, itching, or nausea. She has not noticed any rashes, and has been afebrile. She says that she feels like it is swollen down in her oesophagus as well. She denies any recent travel, recent exposure to unusual plants or animals or other allergens. She has not started any new medications, has not used any new lotions or perfumes and has not eaten any unusual foods. Patient has not taken any of her oral medications today.

Surgical History:

s/p vaginal wall operation for prolapse 2006; s/p Cardiac stent in 1999; s/p hysterectomy in 1970s; s/p kidney stone retrieval 1960s

Medical History:

+CAD w/ Left heart cath in 2005 showing 40% LAD, 50% small D2, 40% RCA and 30% large OM; 2006 TTE showing LVEF 60-65% with diastolic dysfunction, LVH, mild LA dilation
 +Hyperlipidemia
 +HTN
 +DM 2, last A1c 6.7 in 9/2005
 +Asthma/COPD
 +GERD
 +h/o iron deficiency anaemia

Social History:

Patient lives with daughter. Patient does all ADLs and IADLs with no/little assistance. She does own finances and drives. Patient has 4 daughters that all live in the area. Patient does not use tobacco, alcohol, illicit drugs.

Family History:

Patient's Dad died of liver cirrhosis at age 57, mom died of heart attack at age 60. She has 6 siblings who most died of cardiac disease. There is no family history of cancer.

Allergies/ADRs:

Ciprofloxacin – rash; Benadryl – causes mild dystonic reaction

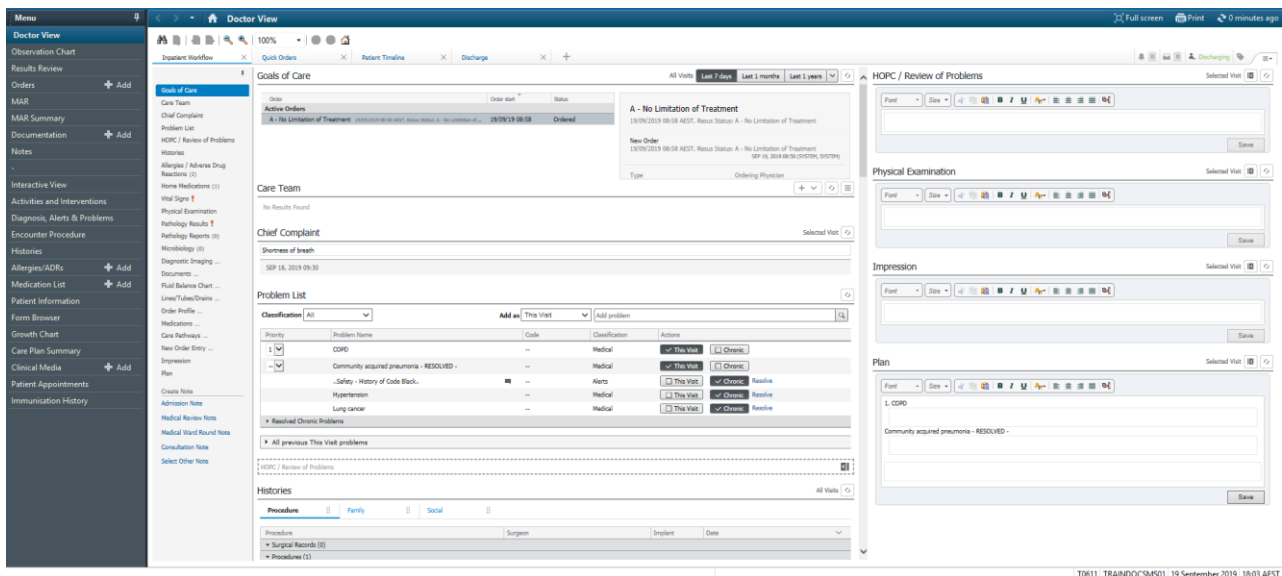
Medications:

Theophylline 600mg nocte – bronchodilator by increasing cAMP used for treating asthma
 Diltiazem 300 mg nocte – Ca channel blocker used to control hypertension
 Simvastatin (Zocor) 20 mg nocte- HMGCo Reductase inhibitor for hypercholesterolemia
 Ramipril (Altace) 10 mg daily – ACEI for hypertension and diabetes for renal protective effect
 Glipizide 5 mg daily (diabetes) – sulfonylurea for treatment of diabetes
 Omeprazole (Prilosec) 20 mg daily (prn for reflux) – PPI for treatment of ulcers
 Gabapentin (Neurontin) 100 mg bedtime – modulates release of neurotransmitters to treat diabetic neuropathy
 Metformin 500 mg mane – biguanide used to treat diabetes
 Aspirin 100 mg morning - prophylaxis for MI and TIA
 Fluticasone/Salmeterol - corticosteroid to treat airways in asthma/COPD
 Ipratropium 2.5 ml nebulized mornings - anticholinergic to treat airways in COPD

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- [VTE Prophylaxis Care Pathway](#)

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Scroll down the Doctor View and add the patient to your relevant unit via the Care Team

Review and update the patient's Chief Complaint to "swelling of tongue and difficulty breathing and swallowing"

ongoing chronic problems as "chronic" and any chronic issue which we will treat in hospital as "chronic and this visit"

From the 'Diagnosis, Alerts and Problems' Menu:
 Navigate to the Problems component > click add > click on the folder icon > add a clinical alert for difficult vascular access

Click on the heading 'Histories' from the Doctor View. Within the procedure tab, document the patient's surgical histories.

Document the patient's allergies and ADRs from the Banner Bar

<p>Scroll down to the home medication documentation component > select the blue text hyperlink 'Med History' and document the patient's home medications.</p>
<p>After documenting the patient's home medications, open the Admission Reconciliation window, and continue the patient's home medications, and commence patient on appropriate medications for this patient's scenario. Cease any other anticoagulants currently charted.</p>
<p>The patient's WCC are elevated which we want to highlight in the admission assessment. Tag the WCC count and any other results you feel are relevant for the admission note.</p>
<p>Our medical patient also needs VTE prophylaxis. Complete the VTE prophylaxis care pathway and ensure that the patient has the appropriate VTE prophylaxis charted from the pathway.</p>
<p>Document the patient's HOPC</p>
<p>When completing the physical examination, you find that that the patient has unremarkable findings except that he has left basal crepitations. Document this, via the use of the. EXAM autotext</p>
<p>Document your impression and plan for this patient, including your plan for any problems being treated on this visit.</p> <p><i>Plan:</i></p> <p>++Swollen tongue:</p> <ul style="list-style-type: none"> - Give patient corticosteroid to decrease inflammation and to protect against relapse after initial improvement. 4 days of Dexamethasone 10 mg IV tid. - Give patient antihistamine to block inflammation as well. 4 days of Diphenhydramine 25 mg bid. - ENT consult to rule out abscess or foreign object - Check C1 and C4 levels that would be decreased if the patient had C1 inhibitory complement deficiency - TSH level to check for hypo/hyper thyroid - Hold all oral home meds and keep patient NPO until airway swelling is reduced and patient can swallow easily <p>++Asthma/COPD:</p> <ul style="list-style-type: none"> - continue inhalers except theophylline - resume theophylline when patient can take oral meds ++DM - Patient is on corticosteroids that increase blood glucose levels, so put patient on sliding scale normal insulin to adjust for high sugars - Resume Neurontin for neuropathy when oral meds can be taken <p>++HTN</p> <ul style="list-style-type: none"> - Continue patient's BP control with Diltiazem drip 5mg/hour - HOLD ACEI that is most likely the cause of angioedema - Consider an alternative HTN medication to replace the ACEI. Can't use a HCTZ because of sulfa allergy. Also has asthma/COPD picture so beta blocker may not work well either. <p>++CAD s/p PCI in 1999</p> <ul style="list-style-type: none"> - Resume simvastatin and aspirin when patient is able to take oral meds <p>++GERD</p> <ul style="list-style-type: none"> - famotidine when oral meds are resumed

Generate your admission note, curate the information.
Within the Social History, utilize the .social autotext and document the social history within the admission note.
Title your admission note with the format '<Team>-<Role>-<Reason>'
Save your admission note if you intend to edit the admission assessment, or sign to document into the patient record. Once signed, review the signed document in the Documentation menu.
Update the patient IPASS and document the doctor-to-doctor handover from the Doctor View

Scenario: Admitting A Patient (20min total)

The patient is a 47 year old female with Crohn's Disease, DM, and HTN who presented to the ED after two days of severe abdominal pain, nausea, vomiting, and diarrhea. She stated that on Wednesday evening after being in her usual state of health she began to experience sharp lower abdominal pain that radiated throughout all four quadrants. The pain waxed and waned and was about a 4/10 and more intense than the chronic abdominal pain episodes she experiences periodically from her Crohn's disease. The pain was sudden and she did not take any medications to alleviate the discomfort. The abdominal pain was quickly followed by two episodes of partial diarrhea and soft stool that was tan in colour with no signs of blood. Her abdominal pain continued and she developed nausea and then vomited six times that evening before going to sleep. Overnight her abdominal pain worsened and she stayed in bed for most of the day on Thursday. She had nausea again all day but had no other episodes of diarrhea or vomiting that day and did not eat anything for fear of vomiting. She was able to drink water and keep it down. By late Thursday night, her pain had intensified to a 10/10 and she called 911 and was brought to the ER by ambulance from her home in Burlington. The patient also stated that she had just ended a three week course of prednisone four days ago, which she had started about a month ago at 60 mg and tapered herself down over a few days by 10 mg. She began the course of prednisone last month because she felt as if she was about to have a Crohn's flare at the time. The patient was last hospitalized at UNC for Crohn's disease exacerbation in March 2007. She denies any recent haemoptysis, constipation, hematochezia, melena, and changes in her bowel habits since Wednesday. She has been compliant with taking her medications for Crohn's and has been stable on her mesalamine, mercaptopurine, and omega -3-acid supplement.

Upon arrival to the ED, the patient was not given any other narcotics for her pain because of a past violation of a pain contract after a positive toxicology screen for cocaine resulted in her discharge from her family medicine provider and due to suspicion that she was narcotic-seeking.

Past Medical History

Crohn's disease, diagnosed 1998

Adenocarcinoma of terminal ileum 1998 - s/p resection of terminal ileum, rad and chemo, no mets.

hx of small bowel obstruction secondary to Crohn's Disease, T2DM, HTN, DVT and PE 2001, PUD, GERD, COPD, Posttraumatic stress disorder, Bipolar disorder, hx of multiple suicide attempts, osteoarthritis of knee joints, left knee arthroscopy, 1995, partial hysterectomy, 1990 nicotine dependence, 30 years

Medications

Cymbalta 60 mg po qday

Fluticasone furoate nasal spray 27.5 mcg prn

Salbuterol inhalation MDI 100microg 2 puffs QID prn for shortness of breath

Fish Oil (Omega 3 capsules) 900 mg QID

Mesalazine (pentasa) 500 mg QID

Zolpidem CR 12.5 mg nocte prn

fluticasone/salmeterol 250/50 2 puffs inhaled BD

Pantoprazole 40 mg daily

Paliperidone 3 mg daily

Sitagliptin/Metformin (Janumet) 50/500 mg daily

gabapentin 400 mg TID

conjugated g-estrogens (premarin) 0.625 mg daily

lisinopril 5 mg daily

mercaptopurine 50 mg BID

nexium 40 mg day
clonazepam 1.5 mg BID

Allergies: Penicillin, causes rash and anaphylaxis; morphine, causes itching, IV Contrast, causes tachycardia

Social History

Patient lives with her husband. She has 6 children who are in good health but do not live with her. The patient is on disability for her bipolar diagnosis and usually spends her days at home and caring for a sick older relative. She smokes half a ppd and has done so for the past 30 years. She states that she does not use any other drugs and that she does not consume alcohol. She has been involved in the distribution of crack cocaine for years in the past but stopped two years ago. While her husband is a crack user, she states that she has never been a user of any illicit drugs or narcotics. She is not physically active and her diet consists of small food portions but is generally unhealthy. She suffers from chronic abdominal pain secondary to her Crohn's, and also chronic right knee and lower back pain from a fall injury and osteoarthritis. She uses a cane when her knee and back pain become debilitating. She has a history of narcotic-seeking behaviour and has left during past hospital visits when narcotic medications would not be prescribed for her pain. She no longer receives narcotics from UNC after breaking her pain contract with her family medicine provider but it is unclear if she receives pain medications from an outside hospital. She has been incarcerated in the past for arson and attempted murder.

Family History

Mother - bipolar and Schizophrenia, "drank herself to death"

Father - living with diabetes, s/p CABG.

2 sisters with HTN

Maternal grandfather, leukemia

The following QRG(s) will help with this practice script scenario. Also refer to the Monash Health website, and eCoach within PowerChart/FirstNet for access and links to these QRGs and others:

- [Overview Of Doctor View And Documenting Admission Note](#)
- [Documenting Goals Of Care](#)
- [Assigning A Care Team and Care Team Provider](#)
- [Diagnosis and Problems](#)
- [Document Family History](#)
- [Document A Procedure](#)
- [Allergy and ADR Documentation](#)
- [Documenting A Clinical Alert](#)
- [Document Patient's Home Medications](#)
- [Admission Medication Reconciliation](#)
- [VTE Prophylaxis Care Pathway](#)

Open the patient chart and navigate to the Doctor View. Customize and set up the doctor view to pull the HOPC, Physical Examination, Impression and Plan to the right as per below

The screenshot displays the 'Doctor View' interface. The left sidebar contains a 'Menu' with various navigation options. The main content area is divided into several sections: 'Goals of Care' (showing an active order 'A - No Limitation of Treatment'), 'Care Team' (with 'No Results Found'), 'Chief Complaint' (shortness of breath), 'Problem List' (listing COPD, Community acquired pneumonia - RESOLVED, Safety - History of Code Black, Hypertension, and Lung cancer), and 'Histories' (with tabs for Procedure, Family, and Social). On the right, there are sections for 'HOPC / Review of Problems', 'Physical Examination', 'Impression', and 'Plan'.

Click on the AdHoc button in the EMR toolbar, select the Adult Goals Of Care form and document a relevant Goals of Care form for the patient. Then refresh the patient chart and confirm the goals of care form has updated in the patient's Banner Bar, and within the Goals Of Care component of the Doctor View

Scroll down the Doctor View and add the patient to your relevant unit via the Care Team

Review and update the patient's Chief Complaint to "abdominal pain"

Update the problems list and include the new diagnosis as 'this visit', ongoing chronic problems as "chronic" and any chronic issue which we will treat in hospital as "chronic and this visit"

From the 'Diagnosis, Alerts and Problems' Menu:
Navigate to the Problems component > click add > click on the folder icon > add a clinical alert for difficult airway

Click on the heading 'Histories' from the Doctor View. Within the procedure tab, document the patient's surgical histories.

Document the patient's allergies and ADRs from the Banner Bar

Scroll down to the home medication documentation component > select the blue text hyperlink 'Med History' and document the patient's home medications.

After documenting the patient's home medications, open the Admission Reconciliation window, and continue the patient's home medications, commence patient on relevant medications required

The patient's K+ and Neutrophils are elevated which we want to highlight in the admission assessment. Tag these results and any other results you feel are relevant for the admission note.

Our medical patient also needs VTE prophylaxis. Complete the VTE prophylaxis care pathway and ensure that the patient has the appropriate VTE prophylaxis charted from the pathway. Cease any other anticoagulants currently charted.

Document the patient's HOPC:

When completing the physical examination, you find that that the patient has unremarkable findings except that he has left basal crepitations. Document this, via the use of the. EXAM autotext

Constitutional - NAD, has been generally feeling well the last couple of weeks Eyes - no changes in vision, double vision, blurry vision, wears glasses ENT - No congestion, changes in hearing, does not wear hearing aids Skin/Breast - no rashes Cardiovascular - No SOB, chest pain, heart palpitations Pulmonary - hard to get a breath in but not short of breath, no cough Endocrine - No changes in appetite Gastro Intestinal - No n/v/d or constipation. Has not eaten because can't swallow solid foods. Genito Urinary - No increased frequency or pain on urination. Some urge incontinence with history of prolapse. Musculo Skeletal - no changes in strengths, no joint tenderness or swelling Neurologic - No changes in memory Psychology - No changes in mood Heme/Lymph - Denies easy bruising

General - NAD, sitting up in bed, well groomed and in nightgown Eyes - PERRLA, EOM intact ENT - Large swollen tounge and cheek on left side, tounge was large and obscured the view of the posterior oropharynx Neck - No noticeable or palpable swelling, redness or rash around throat or on face Lymph Nodes - No lymphadenopathy Cardiovascular - RRR no m/r/g, no JVD, no carotid bruits Lungs - Clear to auscultation, no use of accessory muscles, no crackles or wheezes. Skin - No rashes, skin warm and dry, no erythematous areas Breast - Psychiatry - Abdomen - Normal bowel sounds, abdomen soft and nontender Genito Urinary – Genital exam not performed since complaints not related. Rectal – Rectal exam not performed since no symptoms indicated blood loss. Extremeties - No edema, cyanosis or clubbing Musculo Skeletal - 5/5 strength, normal range of motion, no swollen or erythematous joints. Neurological – Alert and oriented x 3, CN 2-12 grossly intact.

Document your impression and plan for this patient, including your plan for any problems being treated on this visit.

Plan:

++Swollen tongue:

- Give patient corticosteroid to decrease inflammation and to protect against relapse after initial improvement. 4 days of Dexamethasone 10 mg IV tid.
- Give patient antihistamine to block inflammation as well. 4 days of Diphenhydramine 25 mg bid.
- ENT consult to rule out abscess or foreign object
- Check C1 and C4 levels that would be decreased if the patient had C1 inhibitory complement deficiency
- TSH level to check for hypo/hyper thyroid
- Hold all oral home meds and keep patient NPO until airway swelling is reduced and patient can swallow easily

++Asthma/COPD:

- continue albuterol and ipratropium nebs prn
- resume theophylline when patient can take oral meds ++DM
- Not on oral home meds
- Patient is on corticosteroids that increase blood glucose levels, so put patient on sliding scale normal insulin to adjust for high sugars
- Resume Gabapentin for neuropathy when oral meds can be taken

++HTN

- Continue patient's BP control with Diltiazem drip 5mg/hour
- HOLD ACEI that is most likely the cause of angioedema

<p>- Consider an alternative HTN medication to replace the ACEI. Can't use a HCTZ because of sulfa allergy. Also has asthma/COPD picture so beta blocker may not work well either.</p> <p>++CAD s/p PCI in 1999</p> <p>- Resume simvastatin and aspirin when patient is able to take oral meds</p> <p>++GERD</p> <p>- famotidine when oral meds are resumed</p>
<p>Generate your admission note, curate the information.</p>
<p>Within the Social History, utilize the .social autotext and document the social history within the admission note.</p>
<p>Title your admission note with the format '<Team>-<Role>-<Reason>'</p>
<p>Save your admission note if you intend to edit the admission assessment, or sign to document into the patient record. Once signed, review the signed document in the Documentation menu.</p>
<p>Update the patient IPASS and document the doctor-to-doctor handover from the Doctor View</p>

Scenario: Patient Discharging Home (15min total)

Conditions Impacting Hospital LOS: Pre-Existing:

- Hypertension, Type 2 diabetes with no known complications

Newly Developed:

- Acute kidney injury, Transaminitis Conditions

Not Impacting LOS:

- Iron deficiency anaemia; Risks: None

Upon arrival: Patient presented with five days of increased urinary frequency, urgency and dysuria as well as 48 hours of fever and rigors. He was hypotensive and tachycardic upon arrival to the emergency department. The internal medicine service was consulted. The following issues were addressed during the hospitalization:

Fever and urinary symptoms: A preliminary diagnosis of pyelonephritis was established. Other causes of fever were possible but less likely. The patient was hypotensive on initial assessment with a blood pressure of 80/40. Serum lactate was elevated at 6.1. A bolus of IV fluid was administered (1.5L) but the patient remained hypotensive. Our colleagues from ICU were consulted. An arterial line was inserted for hemodynamic monitoring. Hemodynamic were supported with levophed and crystalloids. Piperacillin-Tazobactam was started after blood and urine cultures were drawn. After 12 hours serum lactate had normalized, and hemodynamic had stabilized. Blood cultures were positive for E.Coli that was sensitive to all antibiotics. The patient was stepped down to oral ciprofloxacin to complete a total 14 day course of antibiotics.

On further review it was learned that the patient has been experiencing symptoms of prostatism for the last year. An abdominal ultrasound performed for elevated liver enzymes and acute kidney injury confirmed a severely enlarged prostate. Urinary retention secondary to BPH was the likely underlying mechanism that contributed to the development of pyelonephritis in this patient. He was started on Tamsulosin 0.4mg PO nocte and tolerated it well with no orthostatic intolerance. Post void residuals show 150-200cc of retained urine in the bladder. An outpatient referral to Urology has been requested by our team.

Elevated liver enzymes and creatinine. Both were thought to be related to end organ hypoperfusion in the setting of sepsis. Values improved with the administration of IV fluid and stabilization of the patients hemodynamic. Abdominal ultrasound with doppler flow and urine analysis ruled out other possible aetiologies. Liver enzymes remain slightly above normal values at the time of discharge. We ask that the patients' family physician repeat these tests in 2 weeks' time to ensure complete resolution.

Plan to continue home medications: Ramipril 10mg po daily, Metformin 500mg po BID
Commence: Ciprofloxacin 500 mg twice daily for 7 days and Tamsulosin 0.4mg po nocte
Cease any other medications

Follow-Up Instructions for Patient:

1. Fever and urinary symptoms: Should these symptoms return please contact your family doctor urgently or visit your nearest emergency department.
2. Dizziness: You have been started on a new medication for your enlarged prostate. If you experience dizziness upon sitting or standing please contact your family physician.

Follow-Up Plan Recommended for Receiving Providers:

<p>1. Dear Dr. Jay: Your patient was admitted to hospital with a diagnosis of pyelonephritis complicated by acute kidney injury and transaminitis. He likely has BPH which contributed to this. We have asked him to arrange follow up with you in two weeks' time. Please repeat his AST and ALT at that time to ensure that they have normalized. We have also referred him to our colleagues in urology for further assessment of his prostate.</p> <p>Patient has been notified to follow up in outpatients and will be contacted within 1 week to arrange an appointment.</p>
<p>Optional Component: Complete the admission documentation required for a discharge, along with the other inpatient components required for this scenario. This practice script will otherwise assume the necessary admission and inpatient orders/documentation have been completed and the discharge now needs to occur.</p>
<p>The following QRG(s) will help with this practice script scenario. Also refer to the Monash Health website, and eCoach within PowerChart/FirstNet for access and links to these QRGs and others:</p> <ul style="list-style-type: none"> - Discharge Workflow - Discharge Medication Reconciliation - Printing A Discharge Prescription - Editing A Prescription
<p>Navigate to the Doctor View Discharge Workflow tab. Review and update the patient's doctor-to-doctor handover (IPASS)</p>
<p>From the Doctor View Discharge Workflow, select the Medication Discharge Reconciliation and create a discharge prescription with the patient's regular home medications continuing, and commencing on the patient's new medications.</p>
<p><i>Note: In practice, the printed discharge prescription will need to be given to the pharmacist/pharmacy department. The pharmacist will also document the patient's Medication Management Plan On Discharge, which will populate automatically into the discharge summary. Ensure you discuss this with your pharmacist/pharmacy department before generating and completing the discharge summary.</i></p>
<p>You realise after completing the discharge reconciliation that you need to add paracetamol for the patient. Navigate to the orders menu and add the movicol as a prescription item</p>
<p>Review and update the patient's diagnosis from the problems list. From the problems list, click on the already entered > Click on 'Modify' > Update the status from 'discharge' to 'principal'. Ensure the patient's 'chronic' problems are in the problems list.</p>
<p>Enter a patient's Clinical Summary and Discharge Plan</p>
<p>In the advice to a patient field, use the auto text .Advice and enter the advice given to the patient as per the scenario</p>
<p>In the 'Additional Recipient' Field, search for the patient's GP (Andrew White) who will receive the Discharge Summary electronically (<i>note: this automated sending process will not happen within the practice domain</i>)</p>
<p>Review and tag any relevant investigations or inpatient documentation relevant to include in the discharge summary if applicable</p>
<p>Generate the patient's discharge summary</p>
<p>Save the Discharge Summary and update title with: Team-Role-Reason (E.g. Cardiology-Registrar – Discharge Summary)</p>

Scenario: Ordering And Managing Warfarin Doses
Your patient has developed Atrial Fibrillation on admission. As the medical physician, you are going to document this in the Problems list and order treatment.
Activity:
Document AF in the Problems List as a 'this visit' problem
Activity: From the Orders Menu, search for Warfarin and select the Order Set to initiate a person on warfarin. <i>Note: Warfarin Maintenance order sets are for patients who are already on warfarin and continuing their ongoing warfarin.</i>
Scenario: You are commencing the patient on warfarin for new Atrial fibrillation'
Scenario: You are commencing the patient on warfarin for new Atrial fibrillation' Select Day 1 of the Initiation Order Set. Select the appropriate dose for the patient's age as specified by the PROMPT Document linked to the Order Set. <i>Note: Here, you can also order an INR and a Dose Check.</i> Review the MAR to ensure that the patient has the Warfarin order and the Dose Check appearing on the MAR as prescribed.
Scenario: Now, imagine a day has passed since commencing warfarin: order warfarin for this patient today. Activity: <ul style="list-style-type: none"> • Return to the Order Set to order the dose for day 2. • Navigate to Order Profile and click the heading. • Select 'Warfarin Initiation – Day 2' within the View table on the left-hand-side of the screen. <i>Note: The Related Results which appear when entering Order Details shows the patient's most recent INR and eGFR.</i> <i>Note: Ensure not to order all 4 days at once, as this prescribes all medications at once – each dose must be prescribed on the corresponding day.</i>
Scenario: Assume we have now established the patient on a maintenance warfarin dose. Activity: Discontinue the initiation Order Set and Order Warfarin (Coumadin) Maintenance Order Set.
Scenario: Your patient is taking Coumadin 3mg and 4mg on alternating days for AF. Activity: Appropriately order the Warfarin, INR level and Dose Check Review the MAR to ensure that the patient has two separate warfarin dose charted <i>Note: Ensure that warfarin (coumadin) maintenance order set is selected and the alternating doses section is selected within the order set.</i>

Scenario: Creating Favourites And Ordering Pathology

You've been asked to review your patient. The nurse has told you that he has had 3 episodes of vomiting today. You want to prescribe ondansetron and fluids for the patient and order investigations.

Activity:

Search for Ondansetron via Orders Menu.

Select both the 4mg Oral Tablet and the 2 mg/mL injectable solution formulation with the same administration instructions.

Before signing the orders, right-click the orders and add them to your favourites folder.

Create a relevant folder (e.g. create a folder titled 'anti-emetics').

Note: This folder is accessible in either New Order Entry under the 'Mine' tab or in Quick Orders under New Order Entry.

From the Doctor View, navigate to the New Order Entry and order a UEC ensure Collection Priority is set to Stat.

Alternatively, go to the Quick Orders tab & select UEC under STAT Pathology. Click Sign.

Navigate back to the Orders Menu and search for Sodium Chloride 0.9% and select an appropriate sodium chloride 0.9% 1L bag to be administered at 100mL/hr with instructions to give a bolus from the bag of 100mL.

Note: Ensure you choose the order titled with 'BAG BY BAG'. Infusions titled with 'CONTINUOUS are restricted to critical care areas.

Scenario: Retrospective Documentation Of A MET Call

A MET Call is called for your patient due to Shortness of Breath. During the MET Call he had an ECG and VBG performed, was given Oxygen, a STAT dose of IV Furosemide 40mg, and a portable CXR was ordered.

You then alter his MET Call criteria to state he is not for METs unless RR >35 for the next 4 hours, other Observations remain the same.

Note: Following a MET Call it is the Doctors responsibility to order and document administration of medications used during the event.

Activity:

Use the MET Call Order set to place any continuous medication orders (infusions) and non-medication orders placed during the MET Call and document the administration.

Use the MAW to retrospectively document any non-infusion medications given during the MET Call using the 'Create Order and Document' function.

Go to Search >Add Order. Fill in remaining details ensuring to set the time as the administration time during the MET call and insert the doctor's name who ordered the medication in the Ordering Provider box

Alter the MET Call criteria via the Observation Chart in the Menu on the left-hand side of the screen by clicking the ACC/NRR button.

Create a Note at the bottom left of the Doctor Workflow.

- Note Type: MET/Code Blue and select Free Text Note.
- Use the Autotext .METCodeBlue and complete your note.
- Sign the note, saving it as Team- Role- Reason eg. Gen Med HMO MET Call.

<p>Scenario: Ordering Medications On Admission</p>
<p>Tony has just been admitted to your ward. He tells you that his wife has brought the rest of this medication as he forgot the names. You will now need to add these medications to his medication history and complete the admission reconciliation. Your patient tells you that he usually takes Exforge 5/80mg combination tablets every morning and uses a Lignocaine 5% Topical patch daily.</p>
<p>Activity:</p>
<p>Navigate to the Orders Menu and document the patient's regular home medications via the 'Document Medications by Hx' button</p>
<p>Add Exforge 5/80mg (amlodipine/valsartan) every morning Add Lignocaine 5% topical patch every morning</p>
<p>Continue the patient's home medications as an inpatient via the Admission Reconciliation screen.</p>
<p>Ensure the Lignocaine patch order automatically triggers a nursing order for patch removal.</p>
<p>Ensure the Exforge 5/80mg oral daily combination therapy undergoes therapeutic substitution when continuing as an inpatient in order to prescribe the individual components (Amlodipine 5mg and Valsartan 80mg)</p>
<p><i>Tip: When completing the discharge reconciliation, ensure you select to continue the patient's combination therapy if the patient is still continuing the same Amlodipine 5mg/Valsartan 80mg</i></p>
<p>Review the MAR Summary to ensure medications have been appropriately continued as an inpatient.</p>
<p>Scenario:</p>
<p>Tony is requiring some pain relief for his osteoarthritis. You have decided to prescribe Diclofenac 50 oral tablet TDS prn for pain.</p>
<p>Activity:</p>
<p>Navigate to the to the Orders menu</p>
<p>Add Diclofenac 50mg TDS PRN order sentence.</p>
<p>Scenario:</p>
<p>Tony states that he uses only 25mg at home and that his GP told him not to use too much due to his kidney function. You wish to change the order of diclofenac to 25-50mg TDS PRN.</p>
<p><i>Note: To prescribe a dose range for this medication, always fill the dose field with the lower dose (25mg) and enter in the special instruction box to specify the range (E.g. 25-50mg).</i></p>

From the Orders Menu, right-click the diclofenac order and select Cancel and Reorder, then change the dose to 25mg.

Complete the Special Instructions to show that the dose range is 25-50mg.

Scenario: Setting Up The Message Centre To Receive Consults and Setting Up Care Teams

You are the Gen Med Resident and have been asked to get a Gen Surg Consult at Clayton for your patient Diana Prince as she has developed RUQ pain & deranged LFTs and you are suspecting cholecystitis.

Activity:

Navigate to Orders Menu in the Table of Contents

Search for 'Consult to General Surgery'

- *Consult To: xGeneral Surgery Consults C*
- *Consult Reason and Question: cholecystitis*
- *Relevant History and Examination: RUQ pain & deranged LFTs*
- *Contact Details: 1234*

Note: In a real scenario you would also need to call the Consults Registrar to discuss the case.

Scenario:

You are now the Gen Surg Registrar at Clayton and have received a call from the General Medical Resident to consult on Diana Prince. It is your first day on the job and you need to set up your access to this consult service first before you can add this to your consults list.

Activity:

Navigate to the Message Centre then click Manage in the Proxies tab

Use the Given tab then click Manage

- *Allow Proxy to be Taken From: MConSults, General Surgery Consults C*
- *Allow Proxy to be Taken By: [Username]*
- *Available Items: Consults, Consult Orders*

Go back to Proxies tab and click Manage

- *Received tab then Add*
- *User: MConSults, General Surgery Consults C*
- *Select date range*
- *Grant all Available Items*

Review the consult order by double-clicking the consult you wish to view

Note: Do not click any box with OK in it until you have saved this patient to your list as this will delete the consult order.

Enter the patient chart and add General Surgery Consults to the Care Team

- *Click 'Prince-a, Diana Doc' in the top right corner next to the search bar to enter chart*
- *Assign Provider Team from the Care Team subheading: General Surgery Consults Clayton*

Navigate to the Doctor Worklist and click Care Team Lists from the menu button in the top right corner.

- *All Facilities*
- *General Surgery*

- Available Teams: General Surgery | General Surgery Consults Clayton (All Facilities)
- Open list in Doctor Worklist

Note: this is a shared list and can be curated by others.

Remove consult order from proxy message inbox

- Select consult order, then click either OK & Close, OK & Next, or Complete


Scenario:

You have finished consulting on Diana Prince and wish to remove him from your consults list.

Activity:

Enter the patient chart

Click on the General Surgery Consults Clayton care team and click Remove

Scenario: Inpatient Medication Management
Diana Prince is a 65-year-old male admitted with a perforated bowel and is for emergency theatre. He is currently hypotensive and has active melena. After doing a medication review you decide to mark the patient's Perindopril dose due tomorrow for review and suspend his Aspirin.
Activity:
Navigate to the Orders Menu
Modify the perindopril order and complete the Special Instructions field to state the review on tomorrow's date due to hypotension.
<i>Tip: Document the date the medication is to be reviewed rather than writing 'tomorrow'</i>
Suspend the Aspirin by right-clicking the order. Put 'Withhold' as the reason and '?perforated bowel' in the comments.
Review the Perindopril and Aspirin on the MAR to ensure that they have the review instructions and suspend function respectively.
Scenario:
You notice the patient is also on high dose prednisolone 50mg daily for his asthma exacerbation. You will need to stop this medication but with a weaning regimen as the patient forgot to cease this 2 weeks ago by mistake. You wish to order prednisolone wean for each day as the following: 50mg, 50mg, 25mg, 25mg, 12.5mg, 12.5mg, 5mg, 5mg, cease.
Activity:
Navigate to the Orders Menu
Order Prednisolone using the tapering function when ordering.  <ul style="list-style-type: none"> • Reduce by 50% of previous dose every 2 days • Final dose of 5mg. Stop final dose after 2 days • Remove/edit any steps in the planned regimen
<i>Tip: Use the % of Previous Dose to half medication. You can edit each tapered dose if needed.</i>
Review the MAR to ensure that the prednisolone weaning regime appears on the patient chart as intended
Scenario:
Tony's blood glucose levels have also been difficult to manage due to prednisolone, therefore you need to start supplemental Novorapid (flexpen). Tony has never used insulin before and weighs 85kg. You have already discussed this patient with the Endocrine registrar at Clayton and they will see Tony once you send the consult order.
Activity:
Navigate to the Orders Menu

Order the 'MED Supplemental novoRAPID (NOT previously on insulin) ADULT order set. Review the PROMPT guidelines

Select insulin aspart (novoRAPID Flexpen). Check the details match the PROMPT guideline

Select Consult to Endocrinology (for Clayton)

Scenario: Documenting Home Medications And Completing The Medication Admission Reconciliation

Tony has just been admitted to your ward. He tells you that his wife has brought the rest of this medication as he forgot the names. You will now need to add these medications to his medication history and complete the admission reconciliation.
Your patient tells you that he usually takes Exforge 5/80mg combination tablets every morning and uses a Lignocaine 5% Topical patch daily.

Activity:

Navigate to the Orders Menu and document the patient's regular home medications via the 'Document Medications by Hx' button

Add Exforge 5/80mg (amlodipine/valsartan) every morning
Add Lignocaine 5% topical patch every morning

Continue the patient's home medications as an inpatient via the Admission Reconciliation screen.

Ensure the Lignocaine patch order automatically triggers a nursing order for patch removal.

Ensure the Exforge 5/80mg oral daily combination therapy undergoes therapeutic substitution when continuing as an inpatient in order to prescribe the individual components (Amlodipine 5mg and Valsartan 80mg)

Tip: When completing the discharge reconciliation, ensure you select to continue the patient's combination therapy if the patient is still continuing the same Amlodipine 5mg/Valsartan 80mg

Review the MAR Summary to ensure medications have been appropriately continued as an inpatient.

Scenario:

Tony is requiring some pain relief for his osteoarthritis. You have decided to prescribe Diclofenac 50 oral tablet TDS prn for pain.

Activity:

Navigate to the to the Orders menu

Add Diclofenac 50mg TDS PRN order sentence.

Scenario:

Tony states that he uses only 25mg at home and that his GP told him not to use too much due to his kidney function. You wish to change the order of diclofenac to 25-50mg TDS PRN.

Note: To prescribe a dose range for this medication, always fill the dose field with the lower dose (25mg) and enter in the special instruction box to specify the range (E.g. 25-50mg).

From the Orders Menu, right-click the diclofenac order and select Cancel and Reorder, then change the dose to 25mg.

Complete the Special Instructions to show that the dose range is 25-50mg.

Scenario: Ordering Gentamicin and a Red Blood Cell Transfusion

Tony has been admitted with an LRTI and newly diagnosed left lower lobe malignancy. Following a biopsy his Haemoglobin has dropped and he has deteriorated on the ward. You have been asked to order 2 units of Packed Red Blood Cells (PRBC).

Tony does not have a valid Group and Hold and will need bloods collected before he can be transfused. He does not know his blood type and has never been transfused before. You wish to administer the 2 units of PRBC over 3 hours each.

Activity:

Search for the correct patient and enter the correct encounter

Order the HAEM Blood Product Transfusion Order Set and review the PROMPT guideline

Select the Blood Group and Antibody Screen pathology test

Select 2 bags of Red Blood Cells Product to order and complete the order details as outlined in the scenario

Scenario:

Your consultant has requested for you to start Gentamicin for Tony as they think he may also be developing pyelonephritis. After calculating the dose based on his renal function you decide to chart 240mg IV every 36 hours with the first dose now.

After reviewing the PROMPT guideline for ordering Gentamicin appropriately, you wish check gentamicin levels given Tony's abnormal renal function.

Activity:

Order Gentamicin 40mg/mL injectable solution as outlined in the scenario

Order 'Gentamicin Level 0-30 min post dose' timed study
Order 'Gentamicin Level 6-8 hrs post dose' timed study

Tip: Navigate to Pathology Results and click the heading. Select Aminoglycoside view within the Flowsheet bar. This gives information on all results relevant to the gentamicin prescribed.

Scenario: Creating A Patient List

You are about to commence the evening cover HMO shift for General Medicine and Intensive Care. You need to set up a patient list for both wards at Clayton.

Activity:

Create Patient List which includes both General Medicine and Intensive Care patients at Clayton.

- Location: MH Monash Medical Centre - Clayton
- *Medical Services: General Medicine, Intensive Care*
- *Encounter Types: Inpatient*

Access the Patient List in the Doctor Worklist.

- *Establish Relationships*

Scenario: Doctor-To-Doctor Handover

Diana Prince is one of the patients you managed during your shift who had sudden onset chest pain overnight. Even though his ECG was normal, you would like to alert the treating team to watch this patient. You wish to handover to the home team the outstanding tasks to chase the chest X-ray and troponin results.

Activity:

Open I-PASS (from Doctor Worklist or patient chart).

Document the details to handover.

- *Illness severity: Watch*
- *Patient summary: sudden onset chest pain overnight, ECG normal*
- *Actions: 1) Chase CXR, 2) Chase troponin*

Scenario: Ordering Radiology And Pathology

Your patient has pain & abdo swelling post-appendectomy. You want to get a CT Abdo Pelvis to out rule a post-op collection. You would also like to order routine bloods for this patient over the weekend.

Go to the Quick Orders Tab & navigate to the Radiology section. Select CT Abdo Pelvis with Contrast. Complete the Order Details.

Note the EMR does not replace clinical communication. In a real clinical scenario you would now be required to speak with radiology.

Within Quick Orders, navigate to the Pathology Section. Click FBC, UEC & CRP under the headings 'Tomorrow', 'in 2 days' and 'in 3 days'.

When modifying order details you need to enter Clinical Details. To do this for all orders at once, hold down the Ctrl button and click to highlight all orders, then enter Clinical Details.

It is a long weekend and you wish to place Path orders for 4 days click Add within the Orders for Signature page before entering Clinical Details. Add desired tests. Specify the date in 4 days and

ensure the time is set to 05:00 AM so that the order is set before that morning's pathology round starts.

Navigate back to the Doctor Workflow tab. All orders placed can be seen under the Order Profile section.

Note to get back to the doctor workflow ensure the doctor workflow tab is highlighted and not the quick orders tab. Hitting the main home button while the quick orders tab is highlighted will not take you back to doctor workflow

To cancel an order, navigate to Order Profile within Doctor Workflow. Select the Order you would like to cancel. Order Details appear on the right of the screen. Select Cancel/DC and sign to complete.

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: General Set Up
Activities:
Access personal inbox and locate: consults, orders and documentation requiring co-sign, and results requiring endorsement
Set up proxy access to another user's inbox
Set up proxy access to a consult service inbox to receive and view consult orders
Set up pool access to a medical service
Create a Patient List based on medical service and/or location
Create and add patients to a Custom Patient List
Understand, Interpret, navigate and customise the Doctor Worklist
Assign clinicians to a relevant Care Team
Assign patients to a relevant Care Team
Understand and Interpret the Doctor-to-Doctor Handover in the I-PASS via doctor worklist and the patient chart
Understand and Interpret the Perioperative Tracking navigation to identify and open the chart of patients scheduled for theatre
Understand and Interpret the Emergency Tracking board, identify and open the chart of patients currently in the Emergency Department
Search for a patient via UR/MRN and select the correct patient and encounter
Understand and interpret the eCoach navigation to find QRGs and self-help sources
Changing My Experience required for a given service/unit
Open a patient chart from the Doctor Worklist
Customize the Doctor View Inpatient Workflow

Move the writing components of the inpatient workflow (HOPC/Review Of Problems, Physical Examination, Impression, Plan and Assessment) to the side panel of the inpatient workflow
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
Document a patient's measured height and weight; and document dosing weight
Document a patient's Allergy/ADR history

Proficiency Guide
Scenario: Inpatient Admission Documentation Workflow
Activities:
Move the writing components of the inpatient workflow (HOPC/Review Of Problems, Physical Examination, Impression, Plan and Assessment) to the side panel of the inpatient workflow
Review and update the IPASS (doctor-to-doctor handover)
Understand and Interpret the details within the Banner Bar
Document a Goals of Care PowerForm and read within Documentation, Notes and Form Browser
Assign a patient to the unit Care Team
Review and Document patient's Allergy/ADR history
Document the patient's Chief Complaint
Review, interpret and document patient's diagnosis (this visit issues), ongoing chronic conditions, resolved chronic conditions and clinical alerts in the Problems List
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
Complete the VTE Prophylaxis Care Pathway and Order an appropriate VTE Prophylaxis for a patient
Review and tag relevant pathology results
Document HOPC
Document Physical Examination using auto text (E.g: .EXAM)
Document an Impression
Document a Plan
Update the IPASS (doctor-to-doctor handover tool) within the Doctor View with the illness severity, patient summary, actions and situational awareness and plan
Generate and review an Admission Note
Sign the admission note and update title with: Team-Role-Reason (E.g. General Medicine – Registrar – Admission Note)
Review and include an amendment to an Admission Note
Mark an Admission Note in Error

Proficiency Guide
Scenario: Inpatient Ward Round Workflow
Activities:
Move the writing components of the inpatient workflow (HOPC/Review Of Problems, Physical Examination, Impression, Plan and Assessment) to the side panel of the inpatient workflow
Review the patient IPASS doctor-to-doctor handover
Review previous documentation (E.g. Admission Notes or previous Ward Round Note) and tag information applicable to the current ward round
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, impression, plan and assessment
Update the patient IPASS and add actions that cannot be completed during the ward round
Using the New Order Entry field, appropriately order pathology tests to be collected on the next pathology round
Using the new Order Entry field, appropriately order pathology tests to be collected immediately
Using the new Order Entry field, appropriately order Radiology investigation
Using the new Order Entry field, appropriately order a medical consult
Using the new Order Entry field, appropriately order a referral to an MDT service
Using the new Order Entry field, place a patient care order to review vitals every 30min
Using the Quick Orders of the Doctor View, order blood products and relevant administration instructions
Using the Quick Orders of the Doctor View, order paracetamol and metoclopramide
Generate the ward round note

Proficiency Guide
Scenario: Inpatient Medication Ordering
Activities:
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
Show understanding for infusions: Bag-By-Bag vs Continuous orders
Order an infusion
Order an infusion sequence
Order prednisolone, dexamethasone or amiodarone tapering
Initiate a person on warfarin
Order warfarin maintenance
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

Proficiency Guide
Scenario: Bedside Procedure Documentation
Activities:
Document the insertion of a line/device from the interactive view
Move the writing components of the inpatient workflow (HOPC/Review Of Problems, Physical Examination, Impression, Plan and Assessment) to the side panel of the inpatient workflow
Review the patient IPASS doctor-to-doctor handover
Review previous documentation (E.g. Admission Notes or previous Ward Round Note) and tag information applicable to the current ward round
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
Using the New Order Entry field, appropriately order pathology tests to be collected on the next pathology round
Using the new Order Entry field, appropriately order pathology tests to be collected immediately
Using the new Order Entry field, appropriately order Radiology investigation
Using the new Order Entry field, appropriately order a medical consult
Using the new Order Entry field, appropriately order a referral to an MDT service
Using the new Order Entry field, place a patient care order to review vitals every 30min
Using the Quick Orders of the Doctor View, order blood products and relevant administration instructions
Using the Quick Orders of the Doctor View, order paracetamol and metoclopramide
Generate a procedure note
Document the procedure in the Encounter Procedure menu and add to history

Proficiency Guide
Scenario: Discharge Documentation
Activities:
Navigate and review the Doctor View: Discharge Workflow
Create and print a discharge prescription via the Medication Discharge Reconciliation
Modify and change a previously completed discharge prescription from the Orders Menu
Assign a principle diagnosis via the Problems List
Review and interpret the Medication Management Plan status completed by pharmacy
Review and interpret MDT discharge planning documentation
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 inpatient documentation relevant to include in the discharge summary
Generate the patient's discharge summary
Save the Discharge Summary and update title with: Team-Role-Reason (E.g. General Medicine – Registrar – Discharge Summary)
Forward the Discharge Summary to a Registrar or Consultant
Open the Discharge Summary, update the information, and sign with title: Team-Role-Reason (E.g. General Medicine – Registrar – Discharge Summary)

If Required by Manager or Unit:

Facilitator Name and Designation: _____

Facilitator Signature: _____ Date ____/____/____