

Daily Key Messages Day: 11

Attention: RJH Clinicians, Physicians, Midwives, and support staff.

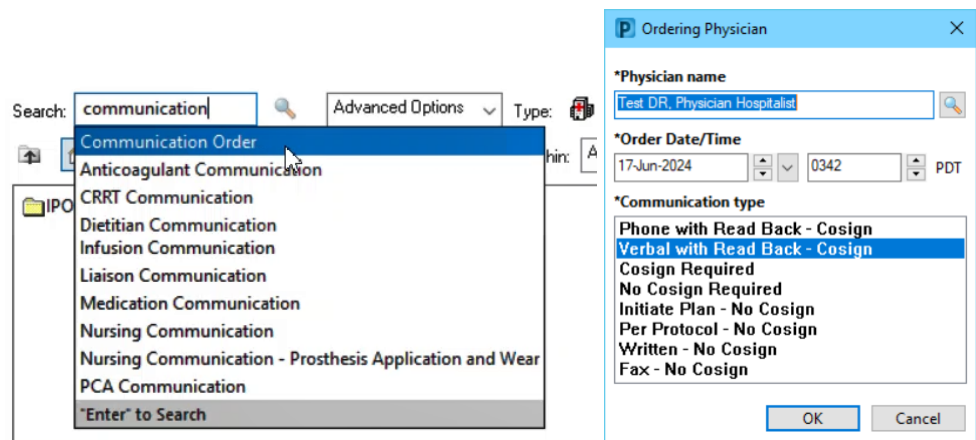
PRACTICE REMINDERS


Entering verbal and telephone orders- Free Texting specific instructions

What we heard: Knowledge gap reported on how and when to enter a free text order for specific instructions that was given by a provider verbally or over the phone.

What you need to know: All orders received from a provider must be entered into the order profile. (Providers should remain in contact with the nurse when the order is being placed)

What you need to do: Nurses enter a “Communication Order” to be able to free text specific instructions that a provider has communicated. Select the most appropriate communication order type. Nurses should continue to document Provider Notification in IView after they have provided information to a Provider.

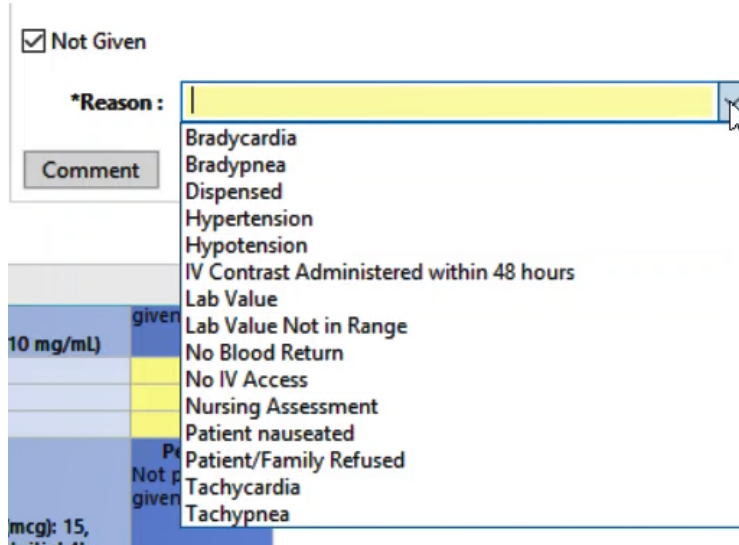


	<p>▼ Details for Communication Order</p> <p>Details Order Comments Diagnoses</p> <p>+ [Icons]</p> <p>*Requested Start Date/Time: 17-Jun-2024 0405 PDT</p> <p>Constant order: <input type="radio"/> Yes <input type="radio"/> No</p> <p>*Special Instructions: Insert nasal packing for epistaxis and notify provider if bleeding does not resolve in 20 min</p> <p>Priority: <No Items></p>
<p>Performing PPID and Scanning Patient ID Bands</p>	<p>What we heard: Nurses were reporting that barcode scanning of patient labels on paper was not working</p> <p>What you need to know: Scanning a patient label that is not affixed to the patient can lead to PSLs events and patient harm. Scanning the patient ID band is done AFTER performing PPID procedures in alignment with Island Health policy.</p> <p>What you need to do: Perform PPID procedures using 2 patient identifiers prior to providing treatment. Scanning the patient ID band ensures there is matching of the confirmed patient with the correct medication and specimen orders in the patient record.</p> <div data-bbox="477 1268 1094 1524" style="border: 1px solid #ccc; padding: 5px;"> <p>Global, Test Six 26034835 92030058898  15-AUG-1964 (M) 59 Years BC 9876-801-596 Test DR, Physician Hospitalist **ID Band**</p> </div>
<p>When to mark a medication task as Not Given vs. Not Done</p>	<p>What we heard: Nurses want more clarity on when to mark a medication task as Not Given versus Chart Not Done.</p> <p>What you need to know: Document a medication Not Given when there was intent to give a medication. Document a task as Chart Not Done when</p>

you need to clean up tasks where there was no intent to give the medication.

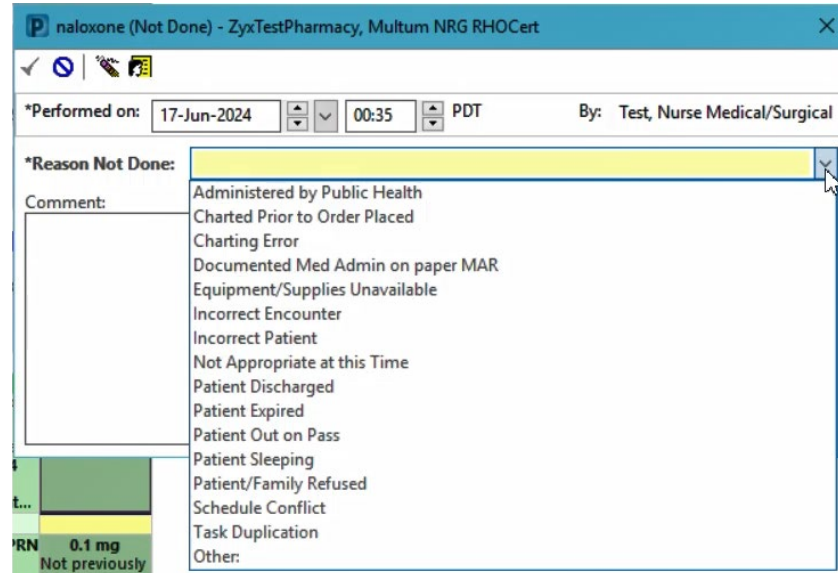
What you need to do:

Mark a task as **Not Given** for the reasons listed below:



A screenshot of a software interface showing a dropdown menu for marking a task as 'Not Given'. The menu is open, displaying a list of reasons. The 'Not Given' checkbox is checked. The dropdown list includes: Bradycardia, Bradypnea, Dispensed, Hypertension, Hypotension, IV Contrast Administered within 48 hours, Lab Value, Lab Value Not in Range, No Blood Return, No IV Access, Nursing Assessment, Patient nauseated, Patient/Family Refused, Tachycardia, and Tachypnea. A 'Comment' button is visible to the left of the dropdown.

Mark a task as **Chart Not Done** for the reasons listed below:



A screenshot of a software interface showing a dropdown menu for marking a task as 'Chart Not Done'. The dropdown is open, displaying a list of reasons. The task title is 'naloxone (Not Done) - ZyxTestPharmacy, Multum NRG RHOCert'. The 'Performed on' field shows '17-Jun-2024 00:35 PDT' and 'By: Test, Nurse Medical/Surgical'. The dropdown list includes: Administered by Public Health, Charted Prior to Order Placed, Charting Error, Documented Med Admin on paper MAR, Equipment/Supplies Unavailable, Incorrect Encounter, Incorrect Patient, Not Appropriate at this Time, Patient Discharged, Patient Expired, Patient Out on Pass, Patient Sleeping, Patient/Family Refused, Schedule Conflict, Task Duplication, and Other:.

<p>Appropriate use of Clinical Documentation</p>	<p>What we heard: Narrative documentation (i.e. Chart Annotation) is being utilized to communicate critical staffing levels.</p> <p>What you need to know: Use of narrative clinical documentation (i.e. Chart Annotation) to document unit staffing levels i.e. “Critically short staffed” fails to align with organizational and regulatory documentation practice standards.</p> <ul style="list-style-type: none"> • As per the Clinical Documentation Policy: <ul style="list-style-type: none"> ○ Clinical documentation is any written information about a patient/client that captures the care and/or services received ○ Clinically relevant information has a logical connection and benefit to the patient/client’s health status based upon assessment, medical treatment, diagnosis and/or identified by the patient/client ○ Clinicians must enter patient/client information using the designated data fields • BCCNM defines clinical documentation as written information about a patient/client that describes the care or service provided to that patient/client. • The Canadian Nurses Protective Society (CNPS) finds that clinical documentation is dictated by facility policy and procedures, should be concise, factual and objective... • Care area/unit staffing levels is not patient/client specific information and as such does not belong in their individual record of care. <p>What you need to do:</p> <ul style="list-style-type: none"> • Document relevant patient specific clinical information in the appropriate structured locations in the electronic health record (EHR) • Collaborate with your unit manager to report and address staffing issues. Use BCCNM Working with Limited Resources to support meeting practice requirements in critically short staffing scenario’s.
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	<ul style="list-style-type: none"> Consider using the PSLS system to capture any patient specific harm that may have resulted
	<p>What we heard: .</p> <p>What you need to know:</p> <p>What you need to do</p>

CPOE TIPS & TRICKS

<p>Troubleshooting and Recalibrating the Barcode Scanner</p>	<p>What we heard: Barcode scanners are occasionally not working</p> <p>What you need to know: Barcode scanners need to be paired to a workstation. If they become disassociated they will need to be recalibrated to resume scanning.</p> <p>What you need to do: Prior to recalibrating the scanner:</p> <ul style="list-style-type: none"> Check that the base of the scanner is connected to the computer. Login to the computer. <p>Recalibrating the scanner:</p>
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1. Lift the scanner from the base. Wait 1-2 seconds before proceeding with each next step.



2. Scan the QR code below.

- DS8178: Programming Barcode for DS8178. Last modified: 22-June-2022.



3. Scan the QR code found on the base of the scanner.



	<p>What we heard: Clinicians are discontinuing the ANES/SURG Multi-Modal Analgesia order set when they discontinue the advanced pain modality order set (e.g. ANES Epidural Analgesia Adult)</p> <p>What you need to know: The ANES/SURG Multi-Modal Analgesia order set should live on AFTER the advanced pain modality has been discontinued</p> <p>What you need to do: Do NOT discontinue the ANES/SURG Multi-Modal Analgesia order set when discontinuing the advanced pain modality order set</p>
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FEEDBACK



If you have feedback for us, please email IHealth@islandhealth.ca

FURTHER INFORMATION ON IHEALTH

Trying to remember what was in a previous Summary or Need an Update on IHealth?

Check out the following links:

Where Did I Read That?

<https://intranet.islandhealth.ca/ihealth/Pages/activation-1b.aspx>

IHealth Intranet Homepage

<https://intranet.islandhealth.ca/ihealth/Pages/default.aspx>