

# electronic Record for Intensive Care (eRIC)

# **User Guide**

April 2017 Version 2.0





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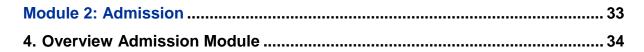






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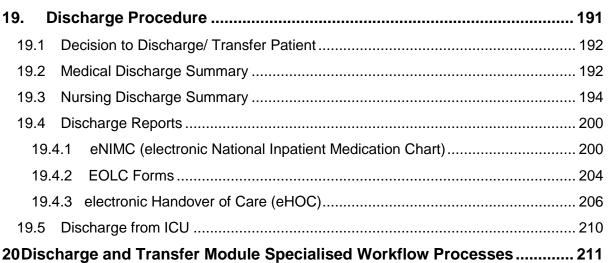


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# eRIC User Guide

## **Module 1: Introduction**

Introduction







## 1. Overview

## 1.1 What is eRIC?

#### A unique clinical system created by ICU clinicians for critically ill patients.

Based on iMDsoft's MetaVision 6, eRIC is a system that integrates clinical data every minute from bedside monitors, ventilators and other specialised equipment in one configuration for Adult, Paediatric and Neonatal ICUs using evidence-based clinical practice.

Once deployed across the 43 ICUs of NSW, eRIC will be one of the largest enterprisewide ICU clinical information systems in the world.

## **1.2** Why is it necessary?

ICUs are highly complex environments and the most data-intensive part of any hospital. Compared to regular wards, in an ICU thousands more data points are recorded daily. A specialised electronic solution is required to provide the complex, minute-by-minute patient monitoring and analysis necessary to safely manage the critically ill.

## **1.3** What are the benefits?



#### For patients

With a focus on clinical safety and evidence based practice; eRIC is expected to contribute to a reduction in mortality rates across the state.



#### For clinicians

Purpose-built by NSW clinicians, for NSW clinicians, eRIC is a holistic system that supports clinicians in caring for critically ill patients by reducing the risk of clinical error.



For the hospitals of NSW

Improved efficiencies in patient flows and work practices with the ability to benchmark across the state.







## 1.4 Intended Audience

This User Guide is intended primarily to be used by ICU Clinicians who will be using eRIC on a daily basis. This group will include:

- ICU Management Staff
- ICU CIS Manager
- ICU Nursing Staff (Super Users and End Users)
- ICU Medical Staff (Super Users and End Users)
- ICU Administrative Staff
- ICU Data Manager
- ICU Allied Health Staff
- ICU Pharmacists

It may also be accessed and used by Non-ICU Ad hoc and Non-ICU Read Only Staff

## 1.5 Purpose

This User Guide is intended to provide the requiste information that will enable you to:

- Develop a high level understanding of eRIC
- Manage to effectively use the common parts of eRIC's screen
- Navigate effectively around eRIC tabs, views and forms
- Create an electronic admission for a patient admitted to ICU using eRIC
- Develop a high level understanding of the menus, tabs and views that will be used to plan the ICU daily routine in eRIC
- Effectively use the relevant forms in eRIC to document assessment, management plans, completion of tasks and clinical events
- Prescribe and validate doses, tasks and actions in eRIC
- Understand medication terminology specific to eRIC
- Undertake the prescription and validation of medications, including fluid therapy, enteral feeds and parenteral feeds, blood and blood products prescription and administration in eRIC
- Understand speciliased medication prescription and administration processes in eRIC
- Discontinue medications in eRIC
- Understand discharge and transfer terminology specific to eRIC
- Comprehend the procedures in eRIC involved in discharging / transferring / transporting a
  patient from ICU.

## **1.6 Scope of this User Guide**

This version of the User Guide is for version 6.4 of Metavision. It provides information on currently available functionality and specialised workflow process. This will continue to evolve and information will be supplemented accordingly with addendums.

Updates will be provided to the ICU CIS Manager and they will be responsible for updating material accordingly into the User Guide.





## 1.7 Structure of the User Guide

The User Guide comprises of five modules.

- Module 1: Introduction
- Module 2: Admission
- Module 3: Daily Routine
- Module 4: Medication
- Module 5: Discharge and Transfer

The User Guide can be used for the following:

- As a reference document for face-to-face training (Slide Notes in the training slides refer back to the user guide for more detailed information)
- It **should** be used as a reference manual post training.

There are also a number of other tools that can be used to help you for self-directed learning. The hard copies will be located in the eRIC Resource Folder. Soft copies can be accessed on the ACI eRIC Intranet webpage. Intranet Link: <u>eRIC section on the ACI intranet</u> The eLeaning will be available on HETI / My Health Learning. <u>http://hetionline.health.nsw.gov.au</u>

Learning Material includes:

- PowerPoint training slides
- eLearning modules (Videos and Simulations)
- Quick Reference Guides (QRGs)
- Activity sheets
- Training Case Study

When working through the activities in the slide packs you can refer to the User Guide. Ideally you will have access to a simulation 'eRIC training environment' allowing you to log-in and to complete the activities.

### **1.8 Important Information**

## **NOTE:** This is used to annotate an important piece of information that needs attention.

## **1.9 Disclaimer**

This User Guide is provided to assist you with understanding how to use eRIC effectively. In recognising that different structures, procedures and protocols exist in current ICU environments, it cannot and does not provide guidance specific to your practice.

This guide is not an exhaustive list of all actions your ICU may need to undertake and should be used in conjunction with the other provided resources.

In addition, requirements, processes, forms and other information in the User Guide is subject to change, so you will need to check the currency and accuracy of information with your local ICU CIS Manager.







## 2 Introduction Module

This module will introduce you to 'Getting started' with eRIC. It will provide you with an understanding of the screens, tabs, views and forms whilst enabling you to acquire the skills required for navigating eRIC.

## 2.1 What is a Clinical Information System?

A Clinical Information System (CIS) is an information system designed to be used specifically in the critical care environment. It integrates the many computer systems found in a modern hospital, such as pathology and radiology, with an electronic patient record. This provides easy bedside access for clinicians.

With a CIS, patient information that was formerly recorded by staff caring for the patient on paper charts is collected and entered into a computer located at each bedspace. Observations, including blood pressure, heart rate, oxygen levels and temperature along with medications and fluids are all recorded in this clinical information system. As necessary, staff will also enter notes. Once the patient is discharged from the Intensive Care Unit, the relevant information is printed and placed in the patient's medical record. An electronic Handover of Care document (eHOC) is also generated and published to eMR. eRIC is the CIS that will be used across NSW Health for Intensive Care Units.

## 2.2 Getting Started



 In order to use eRIC you will have to login with your personalised StaffLink username and password

**NOTE:** It is important to realise that anything done within eRIC will be attributed to the person logged in.

Before entering anything into eRIC make sure you are logged in. This is easy to check and can be seen in the Status Bar. This is at the bottom left of your screen.

					2010	
✓						
Messages 1	Active user: Daniel Williams	Current Patient Location PN	1B-ICU Status: Adm	itted Research Stu	dies:	
·						

Make sure that when you are finished updating eRIC you log off.

The system is currently set to auto log out in **5 minutes** without any mouse and keyboard activity.



## 2.3 Troubleshooting inability to Log-In to eRIC

eRIC Login Screen message 'Incorrect user name or password' (you may have forgotten your username and/or password)



*Step 1:* Ensure your StaffLink ID and password are entered as per your computer credentials.

**Step 2:** If you still get the above error message, call State Wide Service Desk 1300 28 55 33 to reset your StaffLink password. You will be issued a temporary password and will need to login to StaffLink and reset your password before logging in to eRIC.

Step 3: You can now login using your health ID and new password.

Step 4: If you still get the above error message, contact your local CIS Manager.







## 2.4 Terminology

There is some important terminology that every eRIC user must know. This is outlined in the table below:

Term	Description
Login	Log in to eRIC using your user name and password.
Logout	Log out of eRIC. This is a simple action that brings you back to the login screen and allows a different user to use eRIC.
On-the-fly	Changing things temporarily without customising. You can modify eRIC's appearance and most functionality at any time, but your changes will not be saved.
Parameter	Parameters are the building blocks of eRIC. A parameter can be a physiological measurement, a lab result, or any other data describing the patient's condition.
Validate	Confirm/verify parameter value, condition, or action. Validate that a medication has been administered to a patient. <b>NOTE:</b> This action is taken to confirm the data entered is correct. When you manually enter data it is automatically validated. Data coming in from machines and other interfaced objects needs to be validated, to ensure that it is correct. Lab results will come into eRIC as validated parameters.
Data Point	A data point is usually derived from a measurement and can be represented numerically and/or graphically. It consists of clinical data or parameters that are captured or recorded in the system.







## 2.5 Work List

#### Work List Full Screen Mode

-admit and Admitted Only 🔹	Search		Last refresh: 0 Minutes									
Patient Search	Alerts	Days i Work List	Admitting Diag	Problem List	Past Medical Hx	Medical Plan	Nursing Plan	Ventilation	Acu	Social	Discharge	
My List	MRSA;VRE;B urkholderi	8.03 day (s) Patrick and Bill	out of hospital cardiac arrest	decreased GCS PROLONGED Do	IHD, HT		Sit out of bed	Invasive	1-1	Lives alone	For dischar today	
Change Patient Set	UTKI IOTOETT	(3) Medical, Default	cardiac arrest	PROCONGED DO							tooay	
Change Work List Display +	✓ NSW >											
Allow Default Layout James Thorogood *86753	VRE;Burkh deria cepa	Medical, Discharge Neonatal	fall									
04 (ACTIVE) Freddy Mercury*0101010	None	Nursing	Post op cranioplasty for	ICH Seizures	flatulance	777				Non smoker ETOH- 10-20g/day		
05 (ACTIVE) Charlie Chicken • 2323232,		Nursing, In-charge day(s)	Burns							Nil		
06 (ACTIVE) Harry longfield • 512745 • 20/	MRSA	18.95 hour(s)	Cardiac arrest out of hospital	AKI HTN	T2DM	Ward cleared Pt stable						
07 (ACTIVE) Whooflung Dunge 65782	VISA	18.95 hour(s)	Infective excerbation COPD	AKI	Flatulence	Cleared for WARD NOT for return t				Lives at home alone		
08 (ACTIVE) Molly NELL • MRNTEST001	None	1.01 day (s)	respiratory failure	COPD SBO	WARTS	as above	keep alive					
09 (ACTIVE) Jessica Henley • 12548457		17.92 hour(s)	Suspected polypharmacy OD	Polypharmacy OD Intubated & Ven						lives alone (estranged from		
10 (ACTIVE) Hamish Andy*0000001*12/1	None	13 day (s)	Polypharmacy Overdose	polypharmacy overdose ? fluox	depression							
11 (ACTIVE) Anitha Kavitha • 15689-H2,		4.01 day (s)										
	MRSA;VRE;E SBL	3.82 day (s)	Test UAT-OR									
Patient Set	MRSA	9.86 day (s) Shelly and Ivy	sectis			VA VA	/ork List [	Displa	v	Family coming in today	Not for	

This is the first screen the user will see on 'Logging In'.

Select a patient from the work list to take you into the Patient Clinical Overview tab. To return to the Work List, it can be accessed via several methods; Menu Button  $\rightarrow$  select a Patient for the Full Work List OR the Green Census tab to the right of the screen for the Census Work List.

The Work List displays a list of patients and their data.

- It clearly identifies which is the currently selected patient, and enables the user to view
  patient details, to navigate rapidly between patients, and to open the required patient
  record/documentation, or to perform other actions on the selected patient record (for
  example: opening the Patient File).
- It enables the creation and use of a personalised Patient Set, called **My List**, which assists the user in managing and maintaining their own list of patients.
- It enables system parameters, customised parameters, forms and notifications to be displayed to the user, for multiple patients simultaneously. For example: Alerts, Ventilation Mode, Research Studies

There are two ways to view the work list, as a full work list or as a Census work list. The work list is generated as a combination of a Patient Set and a Work List Display, which are independent of each other and which can be changed independently.

- A Patient Set is a set of patients which match specific criteria, as defined by a customizable search guery e.g. 'Pre-admit and Admitted Only' Patient Set.
- A Work List Display is a customised layout for the Work List that defines the data that is presented in the Work List, for the patients included in the selected Patient Set. This display will be different for Doctor, Nurse, and Nurse-In Charge.

Depending on the customisation settings, there may be multiple Work List Displays and multiple predefined Patient Sets available to you for selection





#### Work List in Sliding Patient Census Mode

The green work list tab, displayed on the left edge of the screen when you are on the patient 'Flow sheet' allows you to open and close the sliding patient census mode work list

Graph Overview Vital Signs Vent	-	_	< Nº11	Nursing	Medical	Add Progress Note
to	Pre-admit and Admitted Only	•	Clinical			euro / Pain
200	Search		Overview	Vical Si		Ou Ou
150	Last refresh: 0 Minutes	\$	44 4 Go to 🔹 🕨	₩ <u>10/</u>	12/15 M 6 <sup>00</sup> AM	07:10 <sup>7®</sup> ам
0	BED 01 (ACTIVE) Master Patient • 8011008 • •	•		200 180 160	Work List in	
	BED 02 (ACTIVE) Webex Demo • 8011108 • •	٠	ABPd ABPm NIBPs	140 120 100	Pinned Censu Mode	s
	BED 03 (ACTIVE) Training Patient • 1234567		VIBPd NIBPm SpO2	80 - 60 40	Iviode	
	BED 05 (ACTIVE) Stanley Ipkiss • 542436432		<ul> <li>RR (Total)</li> </ul>	20		
	BED 06 (ACTIVE) Jimmy Fallon •123324234	.*	HR Weight (Drug Calco	lations)		
Work	BED 15 (ACTIVE) ICU Patient • 999888 • •	•	Cardiac Rhythm ABPs ABPd			
Tab			ABPm			
			NIBPs NIBPd			

In Sliding Patient Census mode the work list is presented as a vertical bar on the left edge of the screen, displaying only the patient column element of the work list. The work list can be pinned in place and you can then switch between patients and search for patients easily.

**NOTE:** The tab view that was last selected remains when switching between patients. Once a particular patient is selected the tab views can be changed – this is useful to use during clinical handover of several patients.

#### **Patient Sets**

Patient Sets are specific sets of patients. There are two types of Patient Sets:

- 1. Predefined Patient Sets
- 2. My List Patient Sets

**Predefined Patient Sets** – these are created via the Customisation Tool only (these are pre-defined). They can be viewed and used by all users, but cannot be modified. By selecting a particular Patient Set, you can quickly and efficiently display a list of patients in the Work List. The selected Patient Set is compiled by means of the system searching the eRIC production database for patient records that correspond to the predefined search query criteria. e.g. 'Pre-admitted and Admitted Only Patient Set'

e-admit and Admitted Only 🔹	Search				utes 🤄							4
tient	Alerts	Days i	Work List	Admitting Diag	Problem List	PMHx / Proble	Medical Plan	Nursing Plan	Ventilation	Acu	Social	Discharge
01 (ACTIVE) Justin Philip LATHAM • 39!		7.09 day (s)										
02 (ACTIVE) Min CLOSE 400465-H272		64.88 day(s)										
03 (ACTIVE) Min UPDATE • 400464-H2;		64.88 day(s)										
04 (ACTIVE) Freddy Mercury • 0101010	MRSA	70.72 day(s)		Post op cranioplasty for	ICH febrile 39	flatulance	777				Non smoker ETOH- 10-20g/day	
05 (ACTIVE) Charlie Chicken • 2323232		69.94 day(s)		Burns							Nil	
06 (ACTIVE) Harry longfield • 512745 • 20/	MRSA	54.96 day(s)		Cardiac arrest out of hospital	AKI HTN	T2DM	Ward cleared Pt stable					
07 (ACTIVE) Whooflung Dunge • 65782	VISA	54.96 day(s)		Infective excerbation COPD	AKI	Flatulence	Cleared for WARD NOT for return t				Lives at home alone	
08 (ACTIVE) Ritchie Rich • 141237 • 04/09/	None;MRSA VRE;Burkh		Patrick and Bill	out of hospital cardiac arrest	decreased GCS PROLONGED Do	IHD, HT		Sit out of bed	Invasive	1-1	Lives alone	For discharg today
09 (ACTIVE) Jessica Henley • 12548457,		54.91 day(s)		Suspected polypharmacy OD							lives alone (estranged from	
10 (ACTIVE) Colin Albert ANDERSON •		26.01 day(s)										
11 (ACTIVE) John Roberts • 345678 • •	MRSA	23.8 day (s)										
12 (ACTIVE) Sanjana Raghav® NK-Man	MRSA;VRE;E SBL	57.99 day(s)		Test UAT-OR								
13 (ACTIVE) Burgess Sam • 416350 • 29/09	MRSA	49.08 day(s)		sepsis, nn	None	Spicegirl	chase septic screen	A			IHD	
14 (ACTIVE) James Thorogood • 86753	VRE;Burkhol deria cepa			patient had a fall	ards						no family	





**My List Patient Set** – this is a personalised set of patients that you manage by adding and removing patients to and from the My List set.

To add a patient to 'My List' right click on the patient and select 'Add to My List'

Work Lis	st												,	
re-admit and Adr	mitted Only 🔹	Search			Last refresh: 9 Minutes 😐 🛇									
atient		Alerts	Days i	Work List	Admitting Diag	Problem List	PMHx / Proble	Medical Plan	Nursing Plan	Ventilation	Acu	Social	Discharge	
<b>01 (ACTI\</b> Justin Philip	Add to My List		7.1 day (s)											
02 (ACTI) Min CLOSE	Edit MRN		64.88 day(s)											
03 (ACTI) Min UPDAT	Chronological V Patient File	iew	64.88 day(s)											
04 (ACTI) Freddy Mer	Readmit	SA	70.72 day(s)		Post op cranioplasty for	ICH febrile 39	flatulance	???				Non smoker ETOH- 10-20g/day		
05 (ACTI) Charlie Chic	Set Current Record privacy		69.94 day(s)		Burns							Nil		
06 (ACTIVE) Harry longfield		MRSA	54.96 day(s)		Cardiac arrest out of hospital	AKI HTN	T2DM	Ward cleared Pt stable						
07 (ACTIVE) Whooflung Du		VISA	54.96 day(s)		Infective excerbation COPD	AKI	Flatulence	Cleared for WARD NOT for return t				Lives at home alone		
08 (ACTIVE) Ritchie Rich • 1-		None;MRSA; VRE;Burkh	69.97 day(s)	Patrick and Bill	out of hospital cardiac arrest	decreased GCS PROLONGED Do	IHD, HT		Sit out of bed	Invasive	1-1	Lives alone	For discharg today	
09 (ACTIVE) Jessica Henley			54.92 day(s)		Suspected polypharmacy OD							lives alone (estranged from		
10 (ACTIVE) Colin Albert Al			26.01 day(s)											
11 (ACTIVE) John Roberts®		MRSA	23.8 day (s)											
12 (ACTIVE) Sanjana Ragha		MRSA;VRE;E SBL	57.99 day(s)		Test UAT-OR									
13 (ACTIVE) Burgess Sam		MRSA	49.08 day(s)		sepsis, nn	None	Spicegirl	chase septic screen	A			IHD		
14 (ACTIVE)		VRE;Burkhol	77.14		nations had a fall	ande						no family		

#### Work List Display

The work list display is useful because it has role pertinent information displayed (for example the Medical Work List Display has information on Antibiotics and the Medical Job List, the Nurse In-Charge Work List Display can be customised to display current patient condition, the Nursing Work List Display can show the allocated nursing staff for each patient, and the nurse patient ratio such as 1-1, 1-2, 1-3 via acuity)

admit and Admitted Only	Search	) (		utes 😂							
Patient Search	Alerts	Days i Work List	Admitting Diag	Problem List	Past Medical Hx	Medical Plan	Nursing Plan	Ventilation	Acu	Social	Discharge
My List Change Patient Set	MRSA;VRE;B urkholderi	8.03 day (s) Patrick and Bill	out of hospital cardiac arrest	decreased GCS PROLONGED Do	IHD, HT		Sit out of bed	Invasive	1-1	Lives alone	For dischart today
Change Work List Display +	V NSW +	Medical, Default									
Allow Default Layout	VRE;Burkh deria cepa	Medical, Discharge Neonatal	fall								
04 (ACTIVE) Freddy Mercury 0101010	None	/ Nursing	Post op cranioplasty for	ICH Seizures	flatulance	222				Non smoker ETOH- 10-20g/day	
05 (ACTIVE) Charlie Chicken • 2323232,	L L	Nursing, In-charge day(s)	Burns							Nil	
06 (ACTIVE) Harry longfield *512745 * 20/	MRSA	18.95 hour(s)	Cardiac arrest out of hospital	AKI HTN	T2DM	Ward cleared Pt stable					
07 (ACTIVE) Whooflung Dunge*65782	VISA	18.95 hour(s)	Infective excerbation COPD	AKI	Flatulence	Cleared for WARD NOT for return t				Lives at home alone	
08 (ACTIVE) Molly NELL MRNTEST001,	None	1.01 day (s)	respiratory failure	COPD SBO	WARTS	as above	keep alive				
09 (ACTIVE) Jessica Henley 12548457		17.92 hour(s)	Suspected polypharmacy OD	Polypharmacy OD Intubated & Ven						lives alone (estranged from	
10 (ACTIVE) Hamish Andy* 0000001 * 12/1	None	13 day (s)	Polypharmacy Overdose	polypharmacy overdose ? fluox	depression						
11 (ACTIVE) Anitha Kavitha • 15689-H2,		4.01 day (s)									
12 (ACTIVE) Sanjana Raghav* NK-Man	MRSA;VRE;E SBL	3.82 day (s)	Test UAT-OR								
13 (ACTIVE) Garry GRYLLS • 400325-H2,	MRSA	9.86 day (s) Shelly and Ivy	sepsis				Sit out of bed today	Invasive	1-1	Family coming in today	Not for dsicharge

**NOTE:** Some things on the work list view are auto populated (e.g. past medical history, problem list, alerts, job list) and some things are able to be manually entered. The medical job list auto populates from the Job List on the Medical Ward Round Note.





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Specific information such as the current patient condition for 'Nurse-in charge' work list display needs to be manually entered by double clicking on the cell. Another such example is the free text box for populating the Allocated Staff in the 'Nursing Work List Display'. Double click on the cell under 'Allocated Staff' and a text box will open up – enter details into this and it will then populate the Work List.

	Work List				
	Pre-admit and Admitted Only 👻	Search	O Three	List refresh: 1 Minutes 🔹 😂 Eight - Cell Properties	8
	Patient	Allocated V A		-	Social Discharge
	02 (ACTIVE) YOGI Bear 324678 • •		Allocated Staff		
	03 (ACTIVE) Sam Burgess*0416350**	ዀ፞፞፞፞ר	Entered by:	Work List - Staff	
	01 (ACTIVE) Samuel Burgess*416350**	a 1	Time:	18/01/2017 15:38	
	04 (ACTIVE) Three Eight • 333338888885,		Karla		
	05 (ACTIVE)				
Click All	ocated Sta	ff			
	1 I	-	Validation		Nil
and the	text box		idated By	1	
			Attributes		- The second sec
opens u	ρ		Warning	Comment:	
		_	Error	- Log	1
	15 (ACTIVE) Jessica Brown 00000087f			· • • • • • • • • •	
	Han Solo+MR++			Save Sano	







## 2.8 Patient Search

You can search for a particular patient by using the drop down patient search menu. This will open the basic search window.

- Basic searches can be performed according to an entered search term, e.g. If you know the Patient First Name, Last Name and or MRN – you can perform a Basic Search.
- Advanced searches can be used if you do not know patient details. This can be
  performed according to an entered search query (constructed on the fly) or according to
  the predefined Patient Sets that have been customised.

Searches are performed in both the production and archive databases, regardless of the database currently in use.

For an Advanced patient search – Click on 'Advanced Search' Button in the top right corner of the 'Patient Search' window. This opens up the 'Advanced Search' box.

Example of performing an advanced search for 'Released' patient:

- Choose 'Field' = Patient Status, 'Field Operator' = Is, 'Value' =Released.
- After entering details for searching Click '**Run**' to start the search.

					B Patient Search	×
Work List					Basic search bunty thomas Find	Advanced search
Pre-admit and Admitted Only 🔹	Search			Last refresh:	Patients Bed Patient miffler Patient Name: Status Date of Birth History Admission Datetime	Hidden Recon
Patient Search	Sex	Age (ye	LOS	Admission	00 bunty thomas Released 12/03/1970 23:22 0 12/09/2016 15:04	^
My List	Male	36.1	8.04 day(s)		Advanced Sear	rch
Change Patient Set	mare		010 1 009(0)	-	Basic Search Advanced Sear	
Change Work List Display >	Female	46.6	2.38 day(s)			*
Allow Default Layout		0.0	22.98 day (s)		Additional Information Departments Parameters Roles	٤
04 (ACTIVE) Freddy Mercury*0101010	Male	70.7	16.47 day (s)		Name From Date To Date	*
05 (ACTIVE) Charlie Chicken •2323232,	Male	26.0	15.78 day (s)			
06 (ACTIVE) Harry longfield • 512745 • 20/	Female	28.0	19.15 hour (s)		Add Patientity to My List	Close
					L	

	earch			Back to basic searc
Run	🕂 Insert 🗶 Delete 👍 Gro	oup 🔗 Ungr	oup Patient set:	
And/Or	Field	Field Operator	Value	
I	Patient Status	ls	1	<b>*</b> 4
			Pre-admission	-
Patients			Admitted	ici i
Bed	Patient Identif Patient Name	e: Status	Released	
			Closed	
		No Matchi	ng Records	





## 2.9 Main Screen Overview

- Once you select a patient this opens up the Clinical Overview tab with the Patient Flow Sheet.
- There are a number of parts of the screen that you should become familiar with.
- The Flow Sheet displays a continuous record that begins with the patient's admission date and ends when the patient's record is closed.

The Flow Sheet displays information including patient information within windows. These can

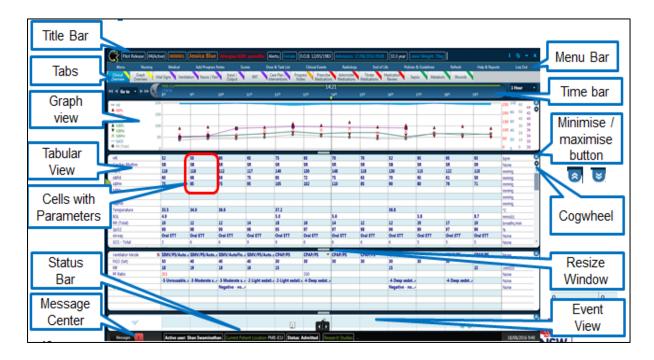
be customised in a number of ways. Each window can be minimised or maximised simply by clicking on these icons. They can also be resized by dragging on the resize icon.

**NOTE:** Some window views have hidden rows e.g. Under Vital Signs tab – the **Cardiovascular section** contains *Hidden Rows*: they are populated when the form in the 'Nursing Menu' is completed e.g. Circulation Observations, OR if the parameter is being monitored e.g. Patients with PiCCO will have monitoring of CCO.

This same principle applies to all views clicking on the cog wheel will reveal if there are hidden rows for that section.

Components of the main screen are:

- 1. Title bar and status bar
- 2. Menu Bar
- 3. Buttons
- 4. Tabs
- 5. Views
- 6. Parameters
- 7. Cells
- 8. Time Bar







## 2.9.1 Title and Status Bar

#### Title Bar

 This is located at the top of the screen and displays patient information, such as Patient Name, Department Name, Medical Record Number, Date of Birth. It is similar to the 'patient sticker'. It also includes information about allergies and alerts (e.g. infectious status).

#### **Status Bar**

- This is located at the bottom of the window.
- The Status Bar is also customizable and generally displays the date and time and additional patient / department information. It is set to display active user, department currently logged into, patient status and any participating research studies. The PAS Alerts also show up on the Status Bar.
- It also displays the Message Centre. This flashes in case a certain action (dose or task related) needs to be done. It shows the number of pending messages and includes builtin severity colours, red if there are unread messages and green if there are no unread messages (this will be explored in more detail in the Daily Routine and Medication module).

## 2.9.2 Menu Toolbar

There is a primary toolbar (called the Main Menu Toolbar) and secondary toolbars. Toolbars HOLD buttons. Buttons perform actions (examples of buttons are MEDICAL, NURSING). There are also floating toolbars that allow scheduling of tasks.

#### Main Menu

- This is your main menu, located at the top of the screen
- It is composed of sub-menu buttons
- The majority of these sub-menus are customised to open additional sub menus. Some will open further sub menus or Modules e.g. The Nursing Menu opens Sub Menu's 'Input /Output Devices and Observations' → Lines → Central Venous Catheter → CVC Lumen 3

#### **Sub Menus**

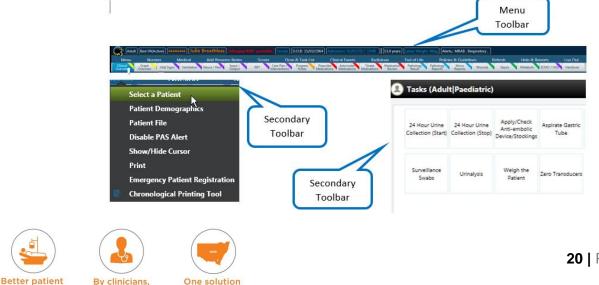
outcomes

clinicians

- These are also known as a **Menu** within a **Menu**
- They can be either a Menu or a Floating toolbar

across NSW

 Every button can open additional toolbars, perform specific actions, open forms, open separate applications and more.



**Menu items** are displayed on the Main Menu Toolbar and they are used for opening modules, performing automatic actions (such as documentation of a clinical event), opening menus (secondary toolbars) and performing a variety of other functions.

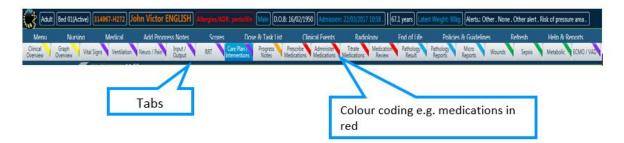
#### **Buttons**

Toolbars contain buttons. Buttons perform actions (e.g. of buttons are MEDICAL, NURSING). Every button can open additional toolbars, perform specific actions, open forms, open separate applications, and more.

Pilot Release 04(Active) 0000001	Add Progress Notes	les/ADR: penicWin Scores	Alarte - Comaio Dose & Task List	D.O.B: 12/05/19 Clinical Events	83 Admission: 1 Radiology	7/08/2016 09:00 . 33.1 End of Life	9 year Latest Weight: Policies & Guidelines	Refresh	Help & Reports	i 🔁 - X
Clinical         Graph         Vital Signs         Veal           Overview         Vital Signs         Veal         Veal         Veal           44         Go to         > > >>         P >>>         27/07.5         8/1	923 1023	ut/ RRT		press Prescrit stes Medicati 13 <sup>21</sup>	be Administer ons Medications 14:21 14 <sup>20</sup>	Titrate Medicabi Medications Review	or Sepsis Met	about youngs	1921	1 Hour
Opens a seconda toolbar / menu	ural Pain Scale cial Expression sper Limbs		the Dose Fask list	e move		tive move *	A A 1. Rema 2. Partia 1. Toler	entire Iy best	hes the screen	
Opens forms	BPS-Total CPOT - Facial Expression CPOT - Facial Expression CPOT - Vet Compliance / CPOT - Vet Compliance / CPOT - Total	8 1-Tense 1-Protection 1-Intubated, 1-Tense, rigid 4		1-Tense 1-Protection 0-Intubated 1-Tense, rigid 3	6		4 0-Relaxed, ne+ 0-Absence of+ 0-Intubated+ 0-Relaxed 0		0-Rela 0-Abs 0-Intru 0-Rela 0	
Timed Inter	Accent Windows 2000 Sore	CANHOU WIN		cumen terven		2005				×
CRRT	ECM	~	IABP	VA		Ventilation (Invasive)	Ventilation (Non-Ir	wasive)		

## 2.9.3 Tabs

The Tabs bar is located under the Menu Toolbar. Each tab is made up of display views. A coloured bar on the top right hand corner indicates tabs with similar functionality or purpose. Tabs are like the pages within the patient file, often holding similar material on the single tab.



The groups in the tabs are highlighted by colours. The colours are:

- Yellow: Review patient information. Clinical Overview and Graph Overview
- Purple: Where observations are captured (commonly used as nursing tabs). Vital Signs, Ventilation, Neuro/Pain, Input/Output, RRT, Care Plans/ Interventions, ECMO/VAD
- Orange: Progress notes
- **Red:** Medications Prescribe medication, Administer Medication, Titrate Medication, Medication Review.
- Blue: Pathology
- Green: Sepsis, Metabolic, Wounds



#### Scroll buttons

 If there are more tabs than can be displayed on the screen, you can scroll using arrows that are located at the end of the tab row. These arrows bring more tabs into view.

#### Types of Tabs

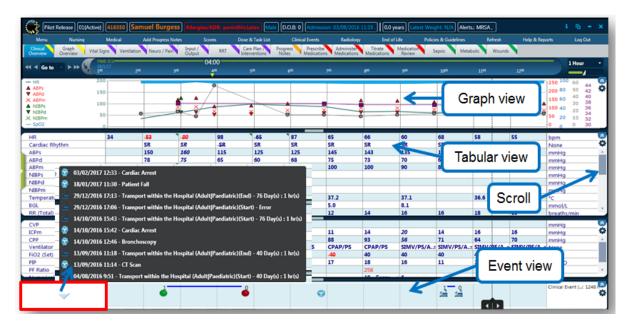
- Time Related Tabs views that display time indications (Clinical Overview, Graph Overview, Vital Signs etc.)
- Non-Time Related Tabs comprised only of view(s) that do not display time indication e.g. Progress Notes Tab.

### 2.9.4 Views

There are a number of views that can be used within eRIC. They each have their own representing icon and are:

- Graph view
- Tabular view
- Event view

Each view can hold parameters. The parameter within the view may require the use of the scroll functionality to view all the parameters.



#### Tabular view

The tabular view displays time-related patient data in a tabular format. In this view, parameters are displayed on the left column and their values are displayed in the centre columns, according to the time selected in the time columns. The parameter types which are displayed in a tabular view include: numeric, numeric with tag, text, free text, check box, formula, grouped, date-time, mapped and image. Some values are displayed in cells automatically, such as data read from bedside devices. Data in these cells can be viewed and edited, if necessary. Data can also be entered manually into empty cells.

**NOTE:** Time columns in the Flow sheet represent a selected time interval, not a specific time. In the tabular view, the value displayed in a time column is the first value available for the time interval, and not necessarily the value from the start time of the column. For example, heart rate values were not entered between 9:00 and 9:15; at 9:16 a value of 95 bpm is entered. In such an instance, if the Flow sheet is set to one-hour intervals, the 9:00 column displays 95, even though the time of this value is 9:16.



#### Graph view

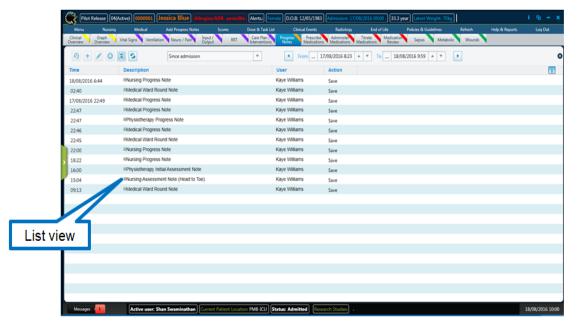
The Graph View displays validated time-related patient data in a graphic form. A graph can display up to ten parameters. Parameter values are viewed in the form of an X-Y graph. The Y-axis represents the parameter values. The X-axis represents the times of the main screen columns. It is divided into the time intervals currently displayed in the main screen tab. The parameter names are displayed to the left or on the top part of the graph. Each parameter name and its graphic indicator are displayed as the same colour and shape.

#### **Clinical Event view**

The Clinical Event view displays clinical events entered for the patient. These are quick icons which represent a clinical incident which occurred to the patient. They can be point-in-time events (e.g. planned extubation), or timed events (e.g. Transfer to OT for surgery).

#### **List View**

The List View enables you to view data in the form of a list. This view is used specifically for progress notes. Users will be able to view progress notes in a chronological list. The default will have the forms collapsed; however, users can expand the individual form, all forms, or open the form session browser.



#### **Nomogram View**

Nomograms are used clinically to help clinicians analyse patient data. It displays data points of a pre-selected image, often determined by clinical data factors. Growth charts and Phototherapy commonly use this view.

#### **View Properties**

Every view has a 'Properties' symbol. This can be used to make changes to the view display and its filtering. You can perform actions and change the view properties (on-the-fly) using the cogwheel button. Each view can be collapsed and expanded using the minimise and maximise buttons located in the upper right corner of the view. Each view size can also be adjusted 'on-the-fly' using the resize icon in the middle of the view.





	250 100 60 44 <b>3</b>		symbol which ca to make chang	es to the	
Graph view properties	General 🕨		display and f	litering.	
	HR ▶	Graph View Properties: Cli			
	ABPs ►	General Pa	rameters		
	ABPd ►	View name:	Clinical Overview (Adult)	<ul> <li>Hide error data</li> </ul>	
	ABPm ►	View caption: Name location:	Hide •	<ul> <li>Enable 'Jump to signal'</li> <li>Mark flagged signals</li> </ul>	
Comment selected values	NIBPs ►	Font size:	8 * *	Scale font size:	A ¥
Add bookmark	NIBPd 🕨 🄊	Admission Color:	Default 🧾		
Remove this view	NIBPm 🕨 🇭	Intra-op color:	Default		
Copy graph to clipboard	SpO2 🕨 📥	Post-op color:	Default 4		
	RR (Total) →	Grid lines	Show all 💌		
	Temperature 🕨				

### 2.9.5 Parameters

Parameters are the building blocks of the eRIC application. They are what make the views, tabs, forms etc., and are where and how data is captured.

#### Parameter Types

The parameter types available for use on the main screen and in forms include:

- Numeric for numeric measurements (for example, heart rate, blood pressure, temperature)
- Numeric with tag when a particular symbol needs to be shown with the number (for example, pupil dilation 2+)
- Text when an attribute is described in words and selected from a customised list, (for example, ventilation mode). Every text value can be given a numerical equivalent value to perform calculations
- Free text text can simply be entered in a main screen cell or in a form
- Formula performs a mathematical function, e.g. GCS Total.

**NOTE:** Need to click **Save** for some formula parameter (normally underlined) to display the result –e.g. on Burns Form after the TBSA Dermal % and TBSA Full thickness % are entered - the TBSA Total % will only display after 'Save' is pressed

- Check box a binary parameter indicating either true or false
- Grouped displays values from two or more parameters in one cell (for example, systolic / diastolic blood pressure)
- Date and time can display a date and/or time
- **Mapped** Mapped parameters are parameters that are linked to and draw data from external sources. These are non-editable in eRIC (e.g data from PAS)

Identifier			
Patient Identifier	DLSCWS002-D230	8	Linked sign denotes
√Title	Mr	8	mapped parameter
Given Name	Sam		C
Family Name	Burges		C

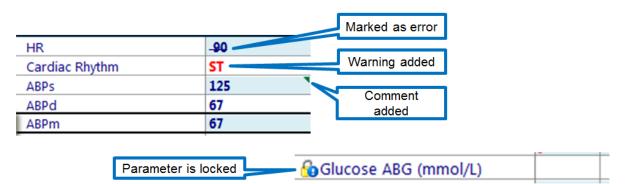
 Image – allows editing and display of graphic images (for example, an image of the human body used to mark the location of drains or wounds, Wounds and Burns Images)





- **Clinical event** allow documenting of clinical events that occurred to the patient and are displayed as icons on the Events view. They can be point-in-time events or timed events
- Depending on the data point, the application will determine the best parameter type to capture it.

## 2.9.6 Cells



There are a number of indicators that will give you information on the contents of a cell. These are:

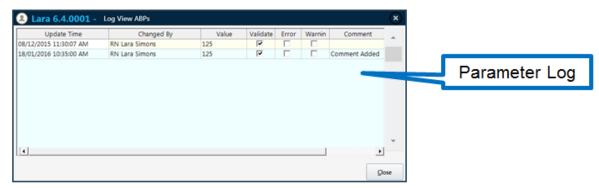
- Blue Normal value
- Red Warning added
- Error a value stamped with a strikethrough mark

🗛 Lock icon – Read only value

There are also a number of statuses that you can apply to a cell, e.g. if the value in a cell is not correct, you can mark it as an error. This is done by right clicking on the cell and selecting the status.

The cell statuses are:

- Italics: if there are any data points within the interval displayed. Devices capture data every minute; however clinicians will most commonly view the screen at a larger interval, likely every hour. Therefore there are 59 other data points not being displayed
- Validate entered manually or validated as correct by a user (confirming a value entered is correct – e.g. the ABP (M), this may be incorrect if arterial line waveform trace is poor or if the transducer is zeroed at the wrong level)
- Mark Error value will not be used in automatic calculations. This is done for those
  values that may be incorrect, e.g., if the SpO<sub>2</sub> value is incorrect because the saturation
  probe fell off the patient's finger
- Warning draws the attention of clinical staff to this value
- Comments can be viewed in the cell tooltip or properties
- Log view all actions that were performed on a specific cell



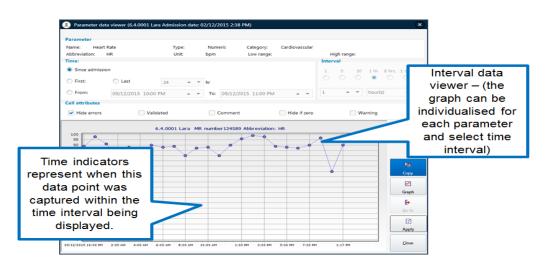




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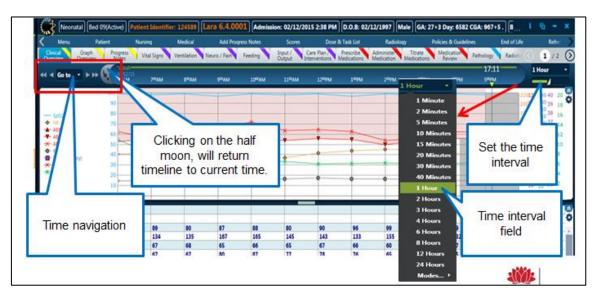
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- **Cell Properties** View cell properties and perform some actions such as adding a comment, mark as error & add warning
- Interval data viewer Display the data of a specific parameter according to various filters. It can be used both for informational and navigational purposes. The Data Viewer can be opened in two formats: Interval Data Viewer and Parameter Data Viewer. The Interval Data Viewer opens by default displaying values only from the chosen interval, while the Parameter Data Viewer opens by default displaying all the parameter values
- Add bookmark Columns can be bookmarked to ensure that significant data remains on display. For example, a column containing an event can be bookmarked to ensure that subsequent shifts are aware of the incident. Bookmarks mode displays only columns with bookmarks. If any columns remain once the bookmarked data has been displayed, they will display data in fixed intervals to the right of the final bookmark
- **Fixed Bookmark** Displays all bookmarked data within the range of the current fixed columns. For example, if there is a bookmark at 17:15 and you are using one-hour intervals, the columns will display data from 17:00, 17:15, 18:00, and so on
- Time Indicator: When within that interval was the data entered, at the beginning, middle, end etc.



## 2.9.7 Time Bar

The Time bar represents the timeline displayed in the Flow sheet.



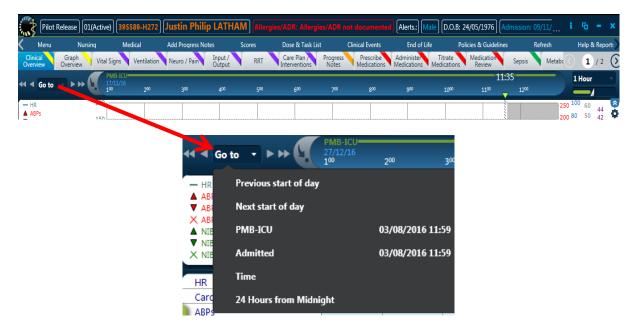


#### **Time Navigation**

- The navigation icons are located at the left of the Time Bar. These icons enable you to scroll back and forth in time-related views.
  - << Move one page back
  - < Move one column back
  - From Go to → select from a drop down list → Time / Admission
  - >Move one column forward
  - >> Move one page forward
  - Go to current time

#### Time Bar can easily be changed.

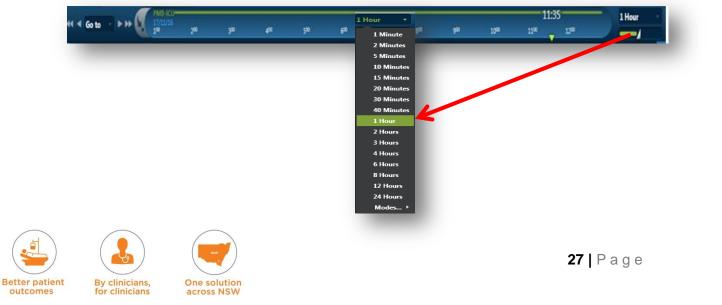
You can set the start point. This is done with the go to scroll bar. To do this simply click on the drop down and choose your start point, e.g., when the patient was originally admitted.



**NOTE: Setting time to current time -** You can set the current time as the start point. To start from 'now' simply click on the relevant part of the time bar as shown below.



**The Time Interval** can also be modified straight from the time bar. Just click on the interval drop down list and make your selection.



#### Time Interval Menu

- Two parts to this menu Field and Slider
- Time Interval Field Drop down menu that determines the interval of the Time Columns.
   From 1 min all the way to 24 Hours
- Time Interval Slider A slider bar that determines the interval of the Time Columns. The same options as Field.

You can use the time bar to setup and customise your Flow sheet. The time bar sets your timeline in terms of where your Flow sheet starts and over what sort of period (this is an on the fly change).

#### **Time Columns**

- Data is displayed in time columns, which are indicated on the top part of the screen below the tabs row
- Each column header shows the start time of the interval this column displays
- When the date changes within the same window, it is displayed above the time in the column header
- When a single continuous patient record is shared across multiple departments, the name of the department in which a patient's record is located is indicated under the timeline.

#### Time Cursor

- The time cursor is the vertical line that is displayed on top of the display views when clicking your mouse
- The time cursor displays tooltips for each display view. These tooltips display further information regarding the time the cursor is placed upon.

There are also a number of modes you can use:

#### Modes

- Automatic: the time interval changes to accommodate the entire duration of the admission on screen
  - Note: this mode involves numerous calculations and therefore can take more time to load than other modes
- Data Driven: only displays columns that contain values.
  - Note: in this mode different time column intervals can be displayed simultaneously on the Flow sheet. (Columns can be 1 day, and 1 min on the same screen)
- **Shift Mode**: displays one hour intervals, and the last column displayed is the last hour of the current shift. (Shift can be setup in customisation)
- Fixed Bookmarks: columns can be bookmarked. This mode displays only columns with bookmarks
- **Range**: permits the view of a specific time period. The user defines the start and finish time, with the time intervals calculated automatically, based on the time period.

## 2.10 Forms

• There are several forms that will need to be completed in eRIC e.g. the 'Safety Checklist', 'Admission Summary Form', 'CVAD Insertion Form'.

#### Purpose of the forms

- Allows users to enter & display patient information in an organised manner.
- It contains any type of data required in your department. Data is mostly made up of parameters, which can later be displayed in other places in the system.
- Forms can be used in relation to specific actions or windows:





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- Forms attached to events
- Forms attached to orders
- Forms attached to the Patient File (e.g. Admission form and Demographic form).

#### **Form Structure**

A form's main components:

- Header contains the Patient name, form name and session details (e.g. new Session), form sessions, times & icons representing the status of the session version
- Session Browser contains data that was inserted into the patient's record at various times and by who, it is a chronological list of the previous saved sessions of the form
- **Tabs** used to divide information into major categories, similar to pages
- Frame contains objects such as parameters, action buttons, images, and order list objects
- Parameters data components within the system. These can have specific properties applied when displayed in a form. E.g. Display last value, display current value (this minute), display a default value, display value from a specific time period, display only if the value has been validated. Parameters can also have specific controls applied; if the text is bold it means it is a mandatory field which must be completed in order to save a form session. If the parameter has an underline, it means that there is a description attached to the parameter, which can be clicked and the description read. The parameter can be displayed in 3 ways on a form; as the name saved to the parameter, as the abbreviation saved to the parameter or as a free text label
- Buttons General buttons: save, mark session as error, sign or Action buttons, such as print, or open another form etc. Some of these buttons are found at the bottom of the form or within the form session browser.

		Header
19/0 Reason for Admission	ess - Admission Summary (Adult) : New Session 1/2017 12:23 A V Shone Johanna Peters / PM8-JCU Breason for Admission Patient Type Adult V	
Part Medical History Admission Findoga An22CS	Reason for Admission Fall from building site (the storey) Closed fracture to L nemur Closed fracture to L nemur Multiple contraines Multiple contraines Bruising and lacerations to Lide of head. Proleine routed L forearm and wrist and L leg.	
Tabs		
	Medicarlon Reconciliation Medical Retrieval Report Patient Demographics	Save and Close
Print	•	Save Save and Cone Cancel

#### **Completing a Form**

**NOTE:** Always ensure that you are making entries as a 'new session' (**do not** write over another user's session OR previous sessions that you have saved and closed).

- Check the user name, patient name, date and time
- Use the drop 'down arrow' or the 'scroll' to scroll between sessions
- Select 'Save and Close' to save and close your session.

#### Note Lock

 There is a code snippet on all 'Notes' (Progress Notes, Medical Ward Round Notes, Assessment Notes, Echocardiogram Report)







- The code snippet shows a dialog box notifying the 'currently logged in user' that clicking 'Save' on a saved note will create another session and save it under their user name
- The dialog box will show for all new sessions regardless whether the user is reviewing or intentionally creating a new note.

<b>S e e</b>			7 02:56 PM ) By : Power administrate	or Andrew Ville	1.00	New	۵ ا
Vedical Ward Rou Ward Round Tear	and the second second						
Ward Round Tear	m Andrew						
stimated Date o	of Discharge 09/01/	2017					
		2017					
Insert Assessment I							
ssessment / Exa	amination						
	MetaVision					×	
			his Form. This saved session will be ag	ainst your user name. I	f this is correc		

#### **Unsaved Data Prompt Window**

If any form in eRIC is commenced and unsaved, when eRIC automatically logs-out the user from inactivity **(set log out time is 5 mins):** eRIC will save the data entered for that user. When the user logs back in, they will receive a prompt of 'unsaved data' and be directed back to the form for completion

(2) Unsaved Data		**	×		
The following item(s) were lef	t open when auto logout occurred:				
Туре	Subject	Time			
Form builder	Admission Summary (Adult)	18/10/2016 15	:11		
			Click 'Op allow the to contin the form	e user lue with	
Discard All	Open		Close		

## **3** Technical Troubleshooting for eRIC

## 3.1 Connecting patient bedside monitor and medical devices to eRIC

When a patient is admitted to ICU, medical devices such as Monitors, Ventilators, Non-Invasive Ventilators (NIV) and CRRT machines need to be connected to eRIC. Each bed area will have a Digi (Terminal Server) that acts as a gateway to send data from the medical devices to the eRIC application. The patient monitor is always connected to the Digi but the medical devices will need to be individually connected.





The Digi allows for labelling of individual medical devices. There are 8 ports and the labelling is text colour coded to the 'colour coded cable' for each device. E.g. Ventilator 'Blue Text' matches 'Blue Cable', Monitor 'Red text' matches 'Red Cable' (Colour coding is site specific)

### 3.2 Troubleshooting the inability to view Monitor and Medical Device Data in eRIC

When information from the medical device cannot be seen in the eRIC application, perform the basic troubleshooting steps outlined below. If you are unable to resolve the issue contact the local CIS Manager.

**NOTE**: remember you can always enter data from devices manually provided the eRIC application is accessible. If there is a problem with viewing data from medical devices in eRIC, ask the following questions:

#### 1. Is this happening in the Entire Department?

If so, contact your local CIS Manager and enter data manually until it's resolved.

2. Is this happening only in one bed area?

If the answer is yes:

Step 1: Check that the Digi is properly connected to the power outlet and the power is turned on

Step 2: Check that the Digi is properly connected to the network socket

Step 3: Restart the Digi and disconnect the power outlet, wait for 2 minutes and reconnect.

If the issue still persists, perform the next steps (as seen below per each device). If this does not solve the problem, contact your local CIS Manager and enter data manually until it's resolved.

#### 3. Is this happening for one medical device only?

If the answer is yes:

Step 1: Make sure the right coloured cable from the medical device is connected to the correct port at the Digi box (check the label of the port)

**Step 2:** Make sure that the connector (the part between the cable and the Medical Devices) is properly connected

**Step 3:** Replace the connector and the cable on the Medical Devices with an alternate cable connector (to rule out faulty cable).

If the issue still persists, contact your local CIS Manager and enter data manually until it's resolved.





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# eRIC User Guide

## **Module 2: Admission**

Admission



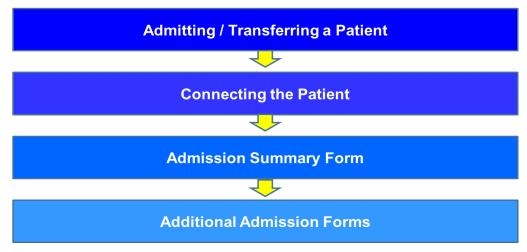




## 4. Overview Admission Module

This module is will provide you with the knowledge on how to create an electronic admission for a patient into ICU using eRIC. It will also introduce you to all the electronic forms that need to be completed as part of the admission procedure.

## 5. Admission Procedure



#### **Admitting / Transferring Patient**

The patient is admitted in PAS as per the normal admission process. The admission procedure in eRIC commences when the patient physically arrives in ICU. Login to eRIC and the patient should be visible on the Work list in the 'Pre-admitted' status. Use the 'Patient File' window to allocate the patient an ICU bed in eRIC and check the admission date and time.

The patient may be transferred into ICU from the Emergency Department, from another department such as a ward due to a change in the patient status requiring admission into ICU, or from another hospital.

The procedure to admit the patient will be initiated by the ICU ward clerk or admitting nurse.

#### **Connecting the Patient**

When the patient arrives physically into ICU, the usual patient admission processes are followed, the patient is connected to the patient monitor which then allows data on patient observations such as vital signs to be viewed on eRIC when the user logs in. Additional devices such as the ventilator will also be connected to the patient (and thus eRIC via the Digi.

#### **Admission Summary Form**

Admission summary form, which has sub-forms, needs to be completed next. There are forms that have to be completed at the time of admission and others that can be completed at a later time. These forms provide all the information required to capture the patient's case. If all the information is not known on admission, it can be completed as an ongoing form as and when the information becomes available.

#### **Additional Admission Forms**

In addition to the admission summary, there are additional forms that need to be completed as part of the admission process (e.g. safety checklist, pressure area risk assessment).



## **5.1 Patient Registration / Admitting a Patient**

The patient is admitted to ICU in PAS – this automatically results in the patient being admitted in eRIC in 'Pre-Admitted' status (no bed allocated)

The admission procedure in eRIC commences when the patient physically arrives in the ICU.

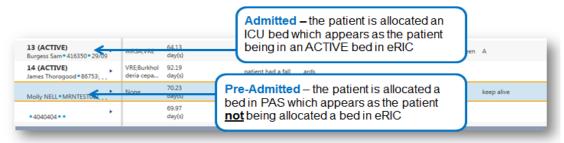
The patient may be transferred into ICU from another department such as a ward, the emergency department (ED), Operating Theatre, or from another facility.

Patient admission will be initiated by the ICU ward clerk or admitting nurse. Use the 'Patient File' window to change status to 'Admitted' and allocate the patient an ICU bed in eRIC and check the admission date and time.

Work List Pre-admit and Admitted Only	Court I	Last refresh: 0 Minutes 🔹	×
Patient O1 (ACTIVE) VOG Rear*324578**	Allocated S., Alerts Days L. mystique None 204.87	Admitting Problem List PMHx	/ Pro., Medical Plan Nursing Plan Ventilation Acu., Social Discharge.,
02 (ACTIVE) Semul Burgets 426330+03 03 (ACTIVE) Sem Burgets 406350+301 04 (ACTIVE) Three Eight #333388888, 05 (ACTIVE) Sears 65/st #400325+ 06 (ACTIVE) Jestick Burs 466464+18/10 07 (ACTIVE) Data 496464+18/10 07 (ACTIVE) Bart Long *5263545410; 12 (ACTIVE) Bart Long *5263545410; 12 (ACTIVE)	Samuel Burgess - P      Patient Identifier: 416350      Visit ID:      First Name: Samuel Last Name: Burgess      Status: Admitted      Status Date Time: 03/08/2016      Bed: Showa B      From Time: 15000000	* 11:59 * * [02(Active) *]	<ul> <li>Use the 'Patient File' window to:</li> <li>Change status to Admitted</li> <li>Allocate the patient an ICU bed in eRIC and check the admission date and time.</li> </ul>
tert tert*8673309** 14 (ACTIVE) Sam Burgen*OLSCW5002 15 (ACTIVE) Jessica Brown*00000875	From Time: 17/02/2017 Log Patient Location For	0 Profession 00(Active) 00(Active) 10(Active) 11(Active) 13(Active) 16(Active) 5(Active) 5(Active)	Apply OK Dose

#### **Case Status**

The Case status is set to 'Admitted' or 'Pre-Admitted'



## 5.1.1 Patient File

Information about the patient that includes basic demographic information, admission date/time and log of patient journey can be accessed from the 'Patient File' window.

The **Patient File** is used to view patient information after they are registered in the system. It can be used for:

- PAS updates,
- to check patient bed status movement, and
- for transferring a patient between beds (bed swap)

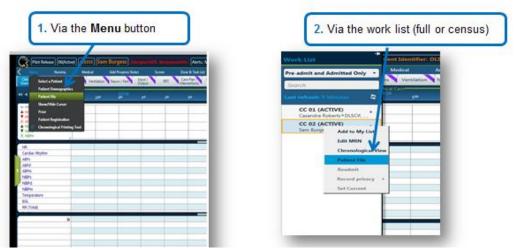
The CIS manager will use it to update a status from 'Released' to 'Closed' after discharge once all the data in eRIC is complete.



#### Edits can be made to the patient file when PAS is down. NOTE: Edits should be made in the PAS unless PAS is down.

The Patient File can be accessed in two ways:

- 1. Via the 'Menu' button on the main screen toolbar and selecting the 'Patient File' button
- 2. Via the work list (full or census) and clicking the action menu arrow ( > ) of relevant patient and selecting the 'Patient File' button



#### **Patient File Window:**

Better patient

outcomes

By clinicians.

for clinicians

One solution

across NSW

The patient file window has many information windows.

The 'Patient File' is used to view patient information after they are registered in the system. It can be used for 'PAS' updates, to check patient bed status movement.

It is also used for making changes to admission status.

Patient Status indicates if the patient is in a 'Pre-Admitted', 'Admitted', 'Released' or 'Closed' status. Released is when they are discharged from ICU and the record can still be edited. Once the status is 'Closed' the electronic record can no longer be edited.

The buttons at the base of the window included the 'Log', 'Patient Location' 'PAS' and 'Chronological View'.

	Sam Burge     Patient Identifier:     Visit ID:     First Name:	416350 416350 Sam		<sup>Comments</sup> ent Admissi	on Status	Î
	Last Name: Status: Status Date Time:	Burgess 2 Admitted 21/07/2016 14:57			on oldida	
Used to view the Patient Log	Bed: From Time:		Chronologic al View	Do not transfer to a	Apply OK	v Glose
have	ck change: been mao atient's sta	de to a	AS ates			
<u> </u>						
						36

#### 1. Log

This button is used to view the Patient Log, which lists all changes that were made via the Patient File. It also has a link button to 'Transport History'.

#### 2. Patient Location

This will show and track the changes that have been made to the patient's status; a window opens, displaying the patient's periods of admission, bed number, department ownership and times that the patient was in transport.

#### 3. PAS

The PAS button, when clicked, will update information from the Patient Administration System.

Click on 'PAS' button – two options will appear – 'Automatic' or 'Compare Data'. Select 'Automatic'. Do not choose 'Compare data' since the patient's information for the ICU medical record is to be the same as in PAS.

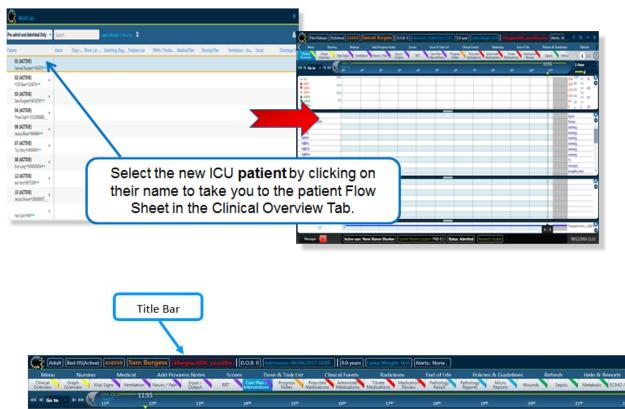
#### 4. Chronological View

This provides an overview of the patient bed status and movement between units – this is for ICU units that have more than one pod

The comments field is a free text field which can be used to add any comments the clinicians wish to capture (e.g. when cancelling an admission or discharge)

#### Admitting a new patient to ICU

The first screen on logging in to eRIC is the Work List. Select the patient WHO has just been admitted into ICU and click on their name to take you to the patient flow sheet in the Clinical Overview Tab.

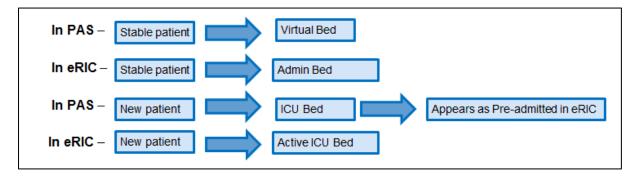


Check patient admission details on Patient Title Bar



# 5.1.2 Admitting a patient to a Surge /Swing Bed

- The patient may be admitted to ICU as a surge patient:
  - A surge patient scenario usually occurs when a new patient has to be admitted to the ICU but there is no physical bed
  - To make a bed available, the stable patient who is medically fit for discharge from ICU but a physical bed is not available on the wards, is moved to a chair or to the corridor
- The steps to facilitate this transfer:
  - ➤ In PAS transfer stable patient to virtual bed
  - ➤ In eRIC transfer stable patient to Admin bed
  - In PAS transfer new patient into ICU bed, this will result in them appearing in Preadmitted status in eRIC
  - → In eRIC the new patient needs to be assigned an Active bed in eRIC
- When a ward bed becomes available for the 'stable patient':
  - ➤ In eRIC Complete standard discharge process for the patient
  - ➤ In PAS The receiving ward will transfer the patient to the ward bed.



# 5.1.3 Creating a Bed Swap

If patients need to swap beds in the ICU during the ICU stay, do this in eRIC with a three step transfer as outlined in the example below (also needs to be done in PAS).

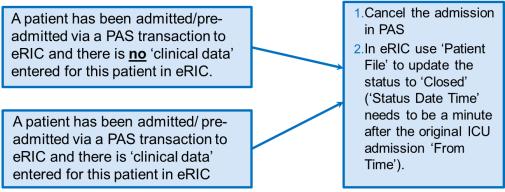
atient Identifier:	10001-c101	Co	omments
isit ID:	10001-c101	v	Example: patient from Bed 1 swapping with patient in
irst Name:	Sam		Bed 2 (using 'Admin bed' as the empty bed)
ast Name:	Burgess		Transfer patient from 'Bed 1' to 'Admin bed'
tatus:	Admitted	•	
tatus Date Time:	20/03/2017 14:38		Transfer patient from 'Bed 2' to 'Bed 1'
ed:	Show all Bed 01(Active)	•	Transfer Patent from 'Admin bed' to 'Bed 2'
rom Time:	20/03/2017 1. None		Do not t





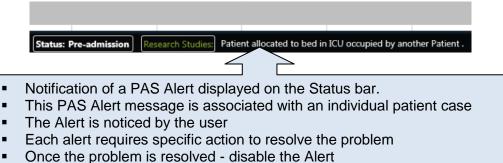
# 5.1.4 Cancel Admission

There are a few possible scenarios which may require cancelling the patient's admission to ICU, as outlined below:



# 5.1.5 PAS Alerts

Transactions that occur in PAS that trigger alerts in eRIC can be viewed as an alert on the 'Status Bar'



The Disable Alert Window is accessed from the 'Menu' < 'Disable PAS Alert'

🎆 Pi	lot Release 01(Active)	500038-H272	Hannah Toot - Disable PAS Alerts : New Session
Men	u Nursing	Medical	·
Clini Overv	Select a Patient	Ventilation	16/03/2017 13:41 🔺 🔻 🚱 Sharon Shunker / STG-CICU 😵 Previous Session 😨 🔻
	Patient Demographics		16/03/2017 13:41 🔺 🔻 😏 Sharon Shunker / STG-CICU
< <	Patient File	800	Please use this form to disable PAS Alert(s)
- HR	Disable PAS Alert		
A AB	Show/Hide Cursor		
▼ AB × AB	Print		Disable Patient has multipule Active Cases for the same Hospital Stay
	Patient Registration		
	Chronological Printing Te	l	
HR			Disable Patient admitted to ICU when already admitted to the ICU under a different Hospital Stay
Cardiac I	Rhythm		
ABPs			o not click 'Save' as
ABPd			
NIBPs		ti	his may enable other 🛛 📉 🔀 Save and Close 🖉 Cancel
NIBPd			-

There are two PAS Alerts:

# **1. PAS Alert: Patient has multiple Active Cases for the same Hospital Stay Cause:**

- A patient is admitted to ICU via PAS (in the pre-admitted status)
- If the Emergency Patient Registration Window is used to create a new case for the same patient, this will create multiple active cases.



#### Action:

- Open the unnecessary case
- Go to 'Patient File' and update status to 'Released', to release the previous admission
- Open the necessary case
- Open Disable PAS Alert Form, disable the alert and click 'Save and Close'

# 2. Patient admitted to ICU when already admitted to the ICU under a different Hospital Stay

Cause:

 If a patient is currently admitted in ICU and a case file from a previous encounter in ICU is opened this alert is raised

#### Action:

Open Disable PAS Alert Form, disable the alert and click 'Save and Close'

# 5.1.6 Registering / Admitting a patient when PAS is down

If the PAS system is 'down' the user can manually register a patient.

#### **Downtime registration**

In this scenario, PAS is down, or the interface from PAS is down.

1. Open the 'Emergency Patient Registration' Window from the 'Menu'

<b>**</b>	Pilot Release 01(Active)	416350 Sami	uel Burgess) [C	Patient Registr	ation				×
< M	enu Nursing	Medical	Add Progress Notes	Patient Identifier:	>> 9999999-A999		Comments		
Clini Overv	Select a Patient Patient Demographics	entilation	Neuro / Pain Ou	Visit ID:		•			
	Patient File	100		First Name:	John				
	Disable PAS Alert Show/Hide Cursor			Last Name:	Cena				
	Print Emergency Patient Registra			Status:	Admitted	•			
	Chronological Printing Tool			Status Date Time:	16/06/2016 15:09	• •			
HR				Bed:	Show all Bed 11(Active)	•			
ABPs	c Rhythm			From Time:	16/06/2016 15:09	• •	Do not transfer	to archive database	
ABPd ABPm				Log Pati				Apply	OK Glose
NIBPS				Loca	110n				

- 2. Click the PAS button on the **Emergency Patient Registration** form. The HIS (Hospital Information System) patient list form appears.
- 3. Search for the patient in the CACHE using the known **MRN**, or **First Name** and **Last Name** (If the MRN is available in the CACHE search, errors will decrease).

ent Identifier:	В	It HIS putient			
t ID:		Search for:			Find
Name:		Patient Ident	ifier: Patient Name:	Admission	
		400500-H272	iNew ha Y	14/11/2016 09:53:2	s 🚺
t Name:		7537-H272	Malcolm Henry M	ORGAN 30/11/2016 14:19:4	2
tus:	Pre-admission	▼ 500470-H272	Kiren 01 Y	17/11/2016 08:14:4	3
tus Date Time:	27/01/2017 10:19	400493-H272	Yttest DISCHARGE	E 16/12/2016 14:21:0	9
		400501-H272	Kc1 KC	21/12/2016 16:20:2	0
	Show all None	¥ 400325-H272	Garry GRYLLS	15/11/2016 12:39:0	2
n Time:	27/01/2017 10:19	▲ ¥ 400528-H272	Ke1 KC	21/12/2016 16:30:0	•
	fent Forms PAS	A411111-H27	2 KK Yaga	29/11/2016 15:13:1	9
og Loci	ation Porms PAS	378114-H272	Beverley JOHNSO	N 16/11/2016 15:12:2	s •

- On the HIS patient list type the MRN or Patient Name or part of either in the Search for text box and click 'Find'
- Highlight the matching row and click Register
- The Emergency Patient Registration form reappears with Patient Identifier, First Name and Last Name containing the expected values. Visit ID is empty.







If patient not found in CACHE:

- 1. On the Emergency Patient Registration form, enter:
  - MRN into Patient Identifier
  - First Name
  - Last Name
- 2. Leave Visit ID blank.
- 3. Select Status = Admitted
- 4. Select an 'Active Bed'
- 5. Check that the admission time to ICU (From Time) is the same as the Status time
- If the correct MRN is not known, then follow the local procedure to find the correct MRN or get a downtime MRN. If there is no local procedure create a temporary MRN with the pattern ICU-xxxxxx (e.g. ICU-10001) in eRIC.
- If any of first name, last name, date of birth and sex is not known then follow the local procedure to choose temporary values
- Click **OK**. The eRIC main screen appears
- Open the 'Patient Demographics Form' from the Main menu. The form will be empty except for Patient Identifier, Given Name and Family Name
- On the Patient Demographics form 'Patient Details tab'- enter the Date of Birth and Sex.
   NOTE: eRIC will overwrite the linked (?) information including identity (first name, last name, date of birth, sex) and all other demographic once the Resynchronise with PAS workflow completes. For this reason avoid entering any personal demographic information
- On the Patient Demographics form click **Save and Close**. The eRIC main screen reappears and the process is complete.

**NOTE:** Always check and confirm that PAS is down and there is no patient already admitted in eRIC via PAS. Using the Emergency Patient Registration window to admit a patient in eRIC who has already been admitted in PAS will create a PAS Alert 'Patient has multiple Active Case for the same Hospital Stay'.

#### **Resynchronise with PAS workflow**

This is the workflow to restore the link between PAS and eRIC and refresh the personal information from PAS. This cannot begin until PAS is available; the person is registered and they have an active Facility MRN in PAS.

The workflow depends on whether the Case MRN is the same as, or different to, the active PAS MRN. The Case MRN will be different to the active PAS MRN if it is a temporary MRN which will never be known to PAS e.g. 'T-1234567' or has become inactive in PAS because it was merged before this workflow.

#### Resynchronise with PAS (Case MRN is the same as the active PAS MRN)

Use this workflow when the Case MRN is the same as the active PAS MRN. (In PAS follow the local procedure to do a dummy update of the patient data in PAS).

- Select Patient File from the 'Menu' menu. The Patient File form opens
- Click the 'PAS' button select 'Automatic'
- Click OK. eRIC changes the patient identity and demographics on the Case.
- The workflow is complete.





Patient Identifier:	416350	Comments	
Visit ID:	416350 💌		
First Name:	Sam		
Last Name:	Burgess		
Status:	Admitted 🔹		
Status Date Time:	12/07/2016 14:57		
Bed:	Show all 06(Active)		
From Time:	12/07/2016 14:57	Do not transfer to	o archive database

Resynchronise with PAS (Case MRN is different to the active PAS MRN)

Use this workflow when the Case MRN is different to the active PAS MRN.On the Work List, right click on the Case. A context menu appears:

- Kiran2 YAGA 800042-H2: iran2 YAGA • 800042-H2: Cache N1 K Y • 405345-H2 io MISKO • MRN123 Add to My List date DBupdate Edit MRN Cac A31 Updated N Chronological Vie 400abc-h272• Patient File Readmit Steve Test • Ste • STEPHEN (EMERGENCY RE e user:
- On the context menu, select Edit MRN. The Edit MRN form appears
- NOTE: If instead eRIC presents the error 'Changing hospital number is not allowed while working with Person ID policy', then contact your CIS Manager. This error means the Case already has an AUID and so may not have its MRN changed
- Type the active PAS MRN into the New MR Number field and leave both Account Number fields empty:

STEPHEN (EMER	RGENCY REGISTRATION)
Current MR Number:	99999999-D203 (EMERGENCY REC
New MR Number:	SJM000-D203
Current Account Number:	
New Account Number:	<b>•</b>
	OK <u>C</u> ancel

- Click OK
- Follow 'Resynchronise with PAS (Case MRN is the same as the active PAS MRN)' to finish the workflow.





# 5.1.7 Patient Demographics

Open the Patient's Demographics Menu from the 'Menu' menu.

- View patient demographic information synchronised with PAS in the linked (
- There are several additional windows that can be opened using the buttons on the left they include information on the Patient Details, Contacts, PAS Contacts, GP and Carers and Medical Officers
- The information in Patient Details, Contacts and PAS contacts is linked from PAS to eRIC
- The information on GP and Carers and Medical officers is not linked from PAS (this information should be viewed in PAS which is considered the source of truth)
- The following PAS contacts correctly appear in the 'Patient Demographic' form (Contacts tab) in eRIC:
  - PAS NOK will be populated as the eRIC Primary Contact
  - ✤ PAS Emergency Contact will be populated as the eRIC secondary contact
  - PAS Primary Care Giver will be populated as the eRIC Alternate Contact 1
- MRNs with a length of 4 or less characters are automatically entered in eRIC to appear the same as they do in PAS.

👤 Freddy M	ercury - Patient Demogra	phics (Adult) : New Session			×
24/1	1/2016 10:07 🔺 🔻	Sharon Shunker / PMB-ICU			⊗Previous Session
Patient	Identifier			Details	÷
Details	Patient Identifier	1010101		Country of Birth	
Contacts	Title	Ø		Aboriginal and Torres Strait Islander	
PAS	Given Name	Freddy	ð	Religion	
Contacts	Family Name	Mercury	ð	Marital Status	
GP and Carers	Preferred Name		ð	Preferred Language	
Medical	√Date of Birth	19/01/1946 08:12 🔺 🔻 🤣		Interpreter Required	<b>•</b>
Officers	√ Sex	Male 🔻 🔗		Date of Death	□ ▲ ▼ 6
				Time of Death	□ ▲ ▼ 6
i.	Contact Details				
	Home Contact 1		P	Business Contact 1	
	Home Contact 2		ð	Business Contact 2	
	Home Contact 3		P	Business Contact 3	
-	Residential Address			Mailing Address	*
	<			- Mailing Address	÷
Print				Save	Save and Close Cancel
				Jave	

Interpreter required is not messaged from the PAS. ICU staff should refer to PAS for this information.

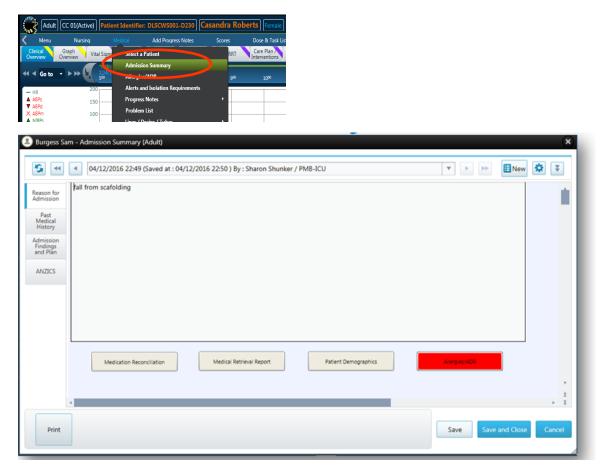
**NOTE:** Ordinarily PAS broadcasts an electronic message when patient information changes; eRIC receives the electronic message and automatically updates the Case to match PAS.





# 5.2 Admission Summary Form

Once the patient is admitted there are additional forms that need to be filled in to complete the admission process. The first one is the Admission Summary Form. This is accessed from the 'Medical' menu from the menu bar  $\rightarrow$  select **Admission Summary**  $\rightarrow$  this opens the **Admission Summary** form.



There are several tabs in the Admission Summary Form that need to be completed. These are accessed by the four tabs on the left hand side of the form. The forms are 'Reason for Admission', 'Past Medical History', 'Admission Findings and Plans', 'ANZICS'.

- 1. Reason for admission this form includes a free text box
- 2. Past Medical History this includes a free text box for past medical history, family and social history. It also requires you to indicate the patient's smoking status if they are a current or ex-smoker there is additional information that is required (in the form of drop down boxes that automatically open)
- **3.** Admission Findings and Plans there is a free text box for 'findings on examination', 'admission plan'. Includes an Alerts drop down box for selecting patient's infectious status e.g. MRSA or VRE. There is also an Alerts (eMR) drop down box. The examining Medical Officer needs to enter their name in the relevant box at the bottom of the form
- 4. **ANZICS** The ANZICS form is an important data form that has several mandatory sections that have to be completed:
  - Mandatory sections can be identified as they are in bold and have a tick. The Admission Summary cannot be saved and exited until all mandatory sections are completed





- Copy Hospital Admission Source, Hospital Admission Date/Time, Mode of Transfer to Hospital, Hospital Transferred From and Care Type from PAS. All Mandatory fields must be completed
- This form includes the button for accessing the 'Advanced Clinical Care Directive' form. There is the ability to scan an existing advanced care directive into eRIC. It also has a link button to state wide and local policies and guidelines

**NOTE:** Chronic Conditions (both Apache II and Apache III) have strict pre-determined criteria to be met – this criteria can be viewed by clicking on each of the <u>underlined</u> Chronic Conditions titles.

eason for dmission	ANZICS and NFR							
	Hospital Admission Source (Adult)		•		ed Clinic Directive			
Past Medical History	√Hospital Admission Date/Time	18/01/2017 05:44 PM	•		Directive			
dmission	Mode of Transfer to Hospital		•					
Findings and Plan	Hospital Transferred From							
ANZICS	Medical Escort	Yes No						
	√ Unit Admission Source	Emergency department	•					
	Admission Date/Time	19/12/2016 00:00						
	√ Care Type	ICU			•			
	√ Elective Admission	Elective surgery + Unplanned IG	CU/HDU admissio	on = Non-elective	•			
	√Emergency Response Admission	No			•			
	√ Treatment Goals for Admission	Full active management			•			
	√ Pregnancy Status	Not pregnant			•			
	√ Respiratory Arrest Pre-Admission	No respiratory arrest			•			
	√ Cardiac Arrest Pre-Admission	No cardiac arrest			•			
	Thromboembolism Prophylaxis				•			
	√ Chronic Conditions Apache II		√ <u>Chronic Co</u>	nditions Apache III				
	<ul> <li>Respiratory</li> </ul>		AIDS					
	Cardiovascular		Hepatic					
	Liver		Lympho					
	Renal		Metasta	tic cancer				
	<ul> <li>Immunosuppressive disease</li> </ul>		Leukaen	nia/Myeloma				
	<ul> <li>Immunosuppressive therapy</li> </ul>		Immuno	osuppressed				
	N/A - None of these conditions		Cirrhosi	s				
			🗆 N/A - N	one of these conditions				
			Diabetes			•		
				Type 1 Diabetes				
				Type 2 Diabetes				
				Gestational Diabetes				
								- (-h)
				Other (Secondary Diab	etes, p	revious gestational diabete	is, impaired fasting gluco:	e/giucose intolerance)

There are four buttons at the bottom of the 'Admission Summary Form' that require additional information.

- Medication Reconciliation this can be completed by the ICU Pharmacist or the ICU medical officer. It does not have to be done immediately at the time of admission, but should be completed within the first 24 hours when possible
- Medical Retrieval Report if the patient has been transferred in by the medical retrieval team, the report can be scanned into this section
- Patient Demographics view and check the information here. View patient demographic information has synchronised with PAS in the linked (𝒜) fields. This information is on the Patient Details, Contacts and PAS Contacts tabs. All other fields on these tabs, and all fields on the GP and Carers; and the Medical Officers tabs; will be empty. View this information in PAS
- Allergies /ADR this needs to be completed with existing allergies, new allergies and intolerances.





#### Allergies /ADR

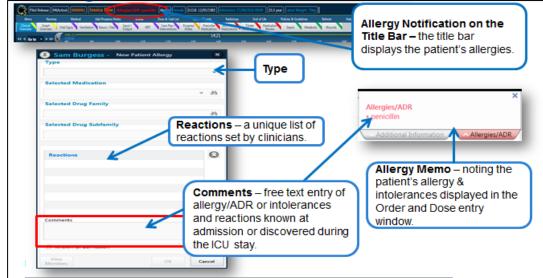
- To add new allergies click the 'add allergy' icon
- It is mandatory that the Allergy / ADR form is completed as part of the admission procedure
- Users are expected to review the Allergies / ADR form each time any changes are made to the 'Admission Summary Form'. It will not allow you to close the Admission summary form without opening and reviewing the Allergies/ ADR form.

Sam Burgess - Allergies/ADR & Intolerances		×
No allergies/ADR or intolerances reported	•	F H
Latex allergy Latex allergy reported Known at Admission Reactions Allergies/ADR		٣
Allergies/ADR Known at Reactions	Comment	
Allergies pane	To add a new allergy click the Add Allergy icon	ې ۵
Intolerances Intolerance Items Known at Reactions	Comment	
Intolerance Items Known at Reactions	Comment	3
Intolerances pane		0
	Save	Qose

- **The New Patient Allergy** window will open (The New Patient Allergies window is context-sensitive, meaning the second dropdown menu changes according to the allergy **Type** selected). The Type Window offers:
  - Drug Family
  - Sub Family
  - Medication (the list of medications as per the customisation module)
  - Ingredient (the list of ingredients as per the customisation module)
  - Miscellaneous

#### **Comments and Known at admission**

This allows the user to document a free text comment and if the allergy/ADR or intolerance was known at admission or discovered during the ICU stay (this comment is what displays on the Allergy /ADR section of the orderable window)





#### **Allergy Notifications**

- A number of components work together in eRIC to keep you informed of allergies
- These include: Title bar, Status bar and Allergy memo within the medication module.

**NOTE**: Allergies are displayed on the title bar but **do not** sync with eMR allergies. Any allergies discovered in ICU (or any change in allergy status in ICU) will have to be entered into eRIC and into the eMR.

#### Title Bar

When a patient's allergies have been documented, the title bar displays the patient's allergies and/or intolerances, providing you with ongoing notification of a patient's allergies and intolerances.

Menu					Dose & Task List	Clinical Events	Radiology	End of Life	Policies & Guidelines	Refresh	Help & Reports	Lo	og Out
Clinical Graph Verview Overview	v Vital Signs	Ventilation Neu	ro / Pain Input Outpu	rrt rrt	Care Plan / P Interventions	Progress Prescrib Notes Medicatio	Administer Medications	Titrate Medications Review	Sepsis Me	tabolic Wounds			
Go to      ▼ ▶ ▶	PMB-ICU					1	4:21					1 Ho	ur
Go to	823	923	1023	1123	1223	1323	14 <sup>23</sup>	1523 1623	1723	1823	19 <sup>23</sup>		-4
- HR	200											250 100	<sup>60</sup> 4
ABPs ABPd	150											200 80	50 4
< ABPm												150 60	40 4
NIBPs NIBPd	100	•	A	ä	🗶 🛛 💈	×	×		-• ·	*	<b></b>	100 40	30 3
< NIBPm	50	<b>)</b>		<b>ě</b>	8 8			Î		Ý		50	20 3
<ul> <li>SpO2</li> <li>RR (Total)</li> </ul>													10 3 0 3

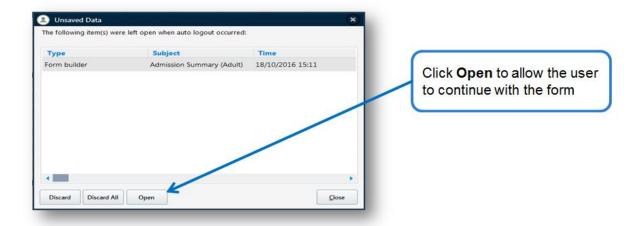
#### **Allergy Memo**

An Allergy Memo is found in the top right-hand corner of the Order and Dose Entry windows, noting the current patient's allergies and intolerances.

Once the Admission Summary form is complete select 'Save and Close'. The Admission Summary form can be accessed from the bottom of the 'Medical ward round note'. It also populates information into the Medical Discharge Summary.

#### **Unsaved Data Prompt Window**

If the Admission Summary form in eRIC is commenced and unsaved, when eRIC automatically logs-out the user (auto log out set for > 5mins of inactivity): eRIC will save the data entered for that user. When the user logs back in, they will receive a prompt of 'unsaved data' and be directed back to the form for completion.







# 5.3 Additional Admission Forms

There are several additional forms that will need to be completed on admission.

### 5.3.1 Nursing Forms on Admission

Some of the additional nursing forms that need to be completed on admission can be accessed from the 'Nursing' menu. They include:

- Safety Checklist
- Alerts and Isolation Requirements
- Lines and Tubes this has a submenu for each line /tube /drain
- Patient Belongings Form
- Weights & Dimensions
- Burns patients will require a Burn Body Chart to be completed

Overview     Overview     Output     Output       Safety Checklist       FASTHUG       ABPs       ABPs       ABPd       NIBPd       PCA / Epidural / Nerve Block       NIBPs       Cardiac Rhythm       Clinical Procedure Safety Checklist (Timeout)       ABPS       NIBPS       NIBPM       Veights and Dimensions	(Adult) [CC	01(Active)	Patient Identifie	er: DLSCWS001-	D230 Ca	isandra F
Overview       Overview       Select a Patient       Output       Kit         Safety Checklist       Safety Checklist       Safety Checklist       Solution       Sol	Kenu	Nursing	Medical	Add Progress	Notes	Scores
Image: Solution of the second seco		in Select			Input / Output	RRI
HR       Alerts and Isolation Requirements         ABPd       Observations         NIBPs       Input / Output Devices and Observations         NIBPd       PCA / Epidural / Nerve Block         K       NIBPm         Cardiac Rhythm       Schedule a Task         ABPd       Progress Notes         ABPd       Progress Notes         ABPd       Nursing Management Plan         NIBPs       Research Studies         NIBPm       Patient Belongings         Temperature       Weights and Dimensions	44 4 Go to 🔹 🕨	FASTH	IUG		500	60
ABPd       Observations         A NIBPs       Input / Output Devices and Observations         NIBPd       PCA / Epidural / Nerve Block         HR       Schedule a Task         Cardiac Rhythm       Clinical Procedure Safety Checklist (Timeout)         ABPd       Progress Notes         ABPn       Nursing Management Plan         NIBPs       Research Studies         NIBPm       Patient Belongings         Temperature       Weights and Dimensions	— HR	Allergi	ies/ADR			
ABPm     Observations     >       NIBPs     Input / Output Devices and Observations     >       NIBPd     PCA / Epidural / Nerve Block     >       HR     Schedule a Task     >       Cardiac Rhythm     Clinical Procedure Safety Checklist (Timeout)     >       ABPS     Clinical Procedure Safety Checklist (Timeout)     >       ABPA     Progress Notes     >       NIBPs     Nursing Management Plan     >       NIBPM     Patient Belongings     >       Temperature     Weights and Dimensions     >		Alerts	and Isolation Requ	uirements		
NIBPd       PCA / Epidural / Nerve Block         NIBPm       PCA / Epidural / Nerve Block         HR       Schedule a Task         Cardiac Rhythm       Timed Interventions         ABPS       Clinical Procedure Safety Checklist (Timeout)         ABPd       Progress Notes         ABPm       Nursing Management Plan         NIBPs       Research Studies         NIBPM       Patient Belongings         Temperature       Weights and Dimensions	× ABPm	Observ	vations		•	
NIBPm     PCA / Epidural / Nerve Block       HR     Schedule a Task       Cardiac Rhythm     Timed Interventions       ABPs     Clinical Procedure Safety Checklist (Timeout)       ABPd     Progress Notes       ABPm     Nursing Management Plan       NIBPd     Research Studies       NIBPm     Patient Belongings       Temperature     Weights and Dimensions		Input /	Output Devices a	nd Observations	►	
HR     Timed Interventions     Image: Solution of the solut		PCA /	Epidural / Nerve B	lock	•	
Cardiac Rhythm     Timed Interventions     Image: Cardiac Rhythm       ABPs     Clinical Procedure Safety Checklist (Timeout)     Image: Cardiac Rhythm       ABPd     Progress Notes     Image: Cardiac Rhythm       ABPm     Nursing Management Plan     Image: Cardiac Rhythm       NIBPs     Research Studies     Image: Cardiac Rhythm       NIBPM     Patient Belongings     Image: Cardiac Rhythm       Temperature     Weights and Dimensions     Image: Cardiac Rhythm		Schedu	ule a Task			
ABPs     Clinical Procedure Safety Checklist (Timeout)       ABPd     Progress Notes       ABPm     Nursing Management Plan       NIBPS     Research Studies       NIBPM     Patient Belongings       Temperature     Weights and Dimensions		Timed	Interventions		•	
ABPd     Progress Notes     Image: Constraint of the second secon		Clinica	I Procedure Safety	Checklist (Timeou	rt)	
NIBPS         Nursing Management Plan           NIBPd         Research Studies           NIBPM         Patient Belongings           Temperature         Weights and Dimensions		Progre	ss Notes		•	
NIBPd         Research Studies           NIBPm         Patient Belongings           Temperature         Weights and Dimensions		Nursin	ig Management Pl	an		
NIBPm         Patient Belongings           Temperature         Weights and Dimensions						
Temperature Weights and Dimensions		Patien	t Belongings			
BGL Destines Destine Discharge	BGL	_				
RR (Total)	RR (Total)			2		
Nursing Discharge Summary		_	ig Discharge Sumn	nary		

#### Safety Checklist

This contains information on routine safety checks that need to be attended on admission and subsequently as per unit protocol.

L) Casandra Roberts - Safety Checklist (Adult): New Session			×
14/04/2016 13:10 🔺 🔻 🚱 Sharon Shunker / *Critical Card	e 😢 Prev	vious Session	\$ ₹
Safety Checklist Self Inflating Resuscitation Bag, w	ith Mask	of Appropria	te Size Preser
Self Inflating Resuscitation Bag, with Mask of Appropriate Size Present and Ready for Immediate Use	Yes	No	
PEEP Valve Present and Working	Yes	No	
Yankaeur Sucker and High Suction Present and Ready for Immediate Use	Yes	No	
Oropharyngeal Airway(s) of Appropriate Size Present	Yes	No	
Portable Oxygen Cylinder Level > ¾ Full	Ves	No	
Ventilator Settings Checked and Alarms Set Appropriately		•	
Monitor Alarms Checked and Set Appropriately		•	
Transducers Levelled and Zeroed		•	
IV Emergency Port Available		•	
Safety Checklist Complete	No		* *
Sav	re Sa	ave and Close	Cancel





#### Alerts and Isolation Requirements

- This allows the entry of information relating to the patient's infectious status and isolation requirements – it also has a link at the bottom of the page to policies and guidelines (statewide and local). This alert will appear with the patient information on the Title bar
- Infection such as MRSA, VRE etc. may be present on admission or may be detected during the ICU stay. If detected during the ICU stay – need to tick 'No' for Present on Admission and then need to enter the Date it was Detected (this is important as it populates into the MRO Operational Report)

Eric Master - Alerts and Isolation Requi	ements : New Session	×
20/12/2016 4:37 PM 🔺 🔻 🧮	Power administrator Andrew Villegas / *Adult	🙁 Previous Session 🔅 🔻
Alerts and Isolation Requireme Additional eMR Alerts		
Alerts and Isolation Requirements		▲
Alerts None MRSA MRSA VRE ESBL MRAB VISA CRE Burkholderia cepacia Clostridium difficile Respiratory Varicella Cytotoxic	✓MRSA Present on Admission       Yes       ✓ No       ,Date Detected         ✓MRE Present on Admission       Yes       ✓ No       ,Date Detected         ✓CRE Present on Admission       Yes       No       Date Detected	▼       19/12/2016       ★       ▼         ▼       19/12/2016       ▲       ▼
/ Immunosuppressed Other / Precaution Type	- Comments	
Room Pressurisation Neutropenic Policies and Guidelines		*
	Sav	ye Save and Close Cancel

- The clinician needs to enter 'Name of Infection' & if it was 'Present on Admission' and 'Date Detected' to each MRO infection – MRSA, VRE, ESBL, MRAB, VISA, and CRE
- As the clinician clicks each MRO infection from the Alerts selection, they will see the box to enter 'Present on Admission' and 'Date Detected'. The form will show a pop-up window requiring an answer to whether the infection was present on Admission.

Eric Master - Alerts and Isolation Requi	rements : New Session					(x
20/12/2016 4:37 PM 🔺 🔻 【	Power administrator Andrev	/ Villegas / *Ad	ult		S Previous Session	¢ ¥
Alerts and Isolation Requireme Additional eMR Alerts						
Alerts and Esolation Requirements						
Alerts						
MRSA	✓ MRSA Present on Admissio	n 🗌 Yes	💌 No	Date Detected	✓ 19/12/2016 ▲ ▼	
VRE VRE	√VRE Present on Admission	Ves	No	Date Detected	✓ 19/12/2016 ▲ ▼	
C ESBL				,		
MRAB						
VISA						
CRE CRE	✓ CRE Present on Admission	Yes	No	Date Detected		
<ul> <li>Burkholderia cepacia</li> </ul>	MetaVision	_ 105	140	(X)		
Clostridium difficile						
Respiratory	Please ensure the Prese	nt on Admission	check box	is complete		
Varicella		OK				
Cytotoxic						
Immunosuppressed						
Other						
/ Precaution Type Tier 1	- Co	mments				
Room Pressurisation						
Neutropenic						
Policies and Guidelines						
	2					
						±
						÷
				Sav	e Save and Close	Cancel





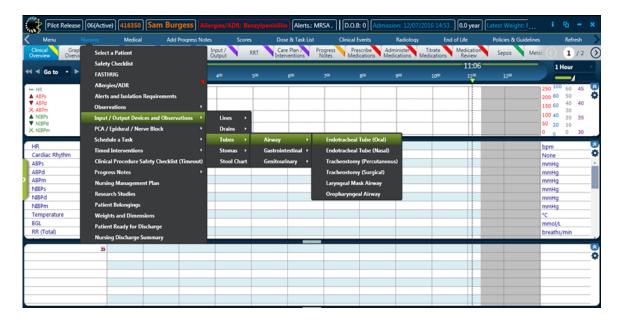
By clinicians

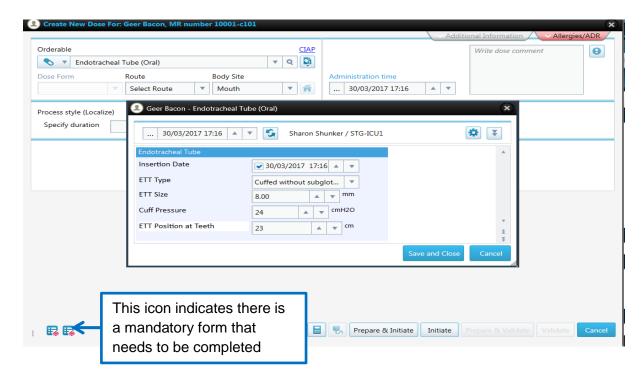
clinicians

#### Lines and Tubes

This is accessed via **Nursing**  $\rightarrow$  **Input/ Output Devices and Observations**  $\rightarrow$  choose desired 'Lines' 'Drains' 'Tubes' 'Stomas'. The individual sub menus then allow the nurse to choose which line the patient has, and also enter information about it (see e.g. below for ETT).

A complete list of all the lines and tubes can then be viewed on the Input / Output Screen.









#### **Patient Belongings Form**

This form needs to be completed on admission. It is signed by the person checking the belongings and the person verifying the belongings.

Casandra Roberts - Patient Belongings : New Session		×
14/04/2016 14:15 🔺 💌 🔄 Sharon Shunker / *Critical Care	S Previous Session	* *
Patient Belongings		and the second second
Clothing		
Effects		
Items with Security		
		· · ·
		* *
Print	Save Save and Close	Cancel

#### Weights and Dimensions

This form needs to be completed with the patient's height, weight and weight to be used for drug calculations. If the patients weight (Drug Calculations) is changed – all medications that are weight based prescriptions need to be re-prescribed (this is because the original weight is retained in the Order Details Window)

14/04/2016 14:19 🔺 🔻 Sharon Shunker / *Critical Care	
	¥
Weights and Dimensions	
J Height 152 🔺 🔻 cm	
/Weight (Latest) 54 kg On 14/04/2016 12:52:00	
√Weight (Admission) 56 ▲ ▼ kg √ <u>BMI</u> 23.4	
√ <u>Weight (Ideal)</u> 45.1 ▲ ▼ kg J <u>BSA</u> 1.494 m <sup>2</sup>	
Drug Calculation Weight	
Drug Calculation weight Drug calculation weight general principles:	
<ul> <li>Medical staff to complete.</li> <li>If overweight, use ideal weight or adjusted weight.</li> </ul>	
<ul> <li>If normal or underweight, use actual weight.</li> <li>If normal or underweight, use actual weight.</li> <li>There will be exceptions for some drugs. Discuss with your pharmacist.</li> </ul>	
Inere will be exceptions for some drugs. Discuss with your pharmacist.	
√ <u>Weight (Drug Calculations)</u> 52 ▲ ▼ kg	
	±
Save Save and Close O	¥ Cancel





By clinicians.

for clinicians

#### **Burn Body Chart**

Patients with burns will need additional forms completed. Under 'Medical' menu there is a 'Burns Admission Management' form. The nurse will need to complete the 'Body Chart', this can also be accessed from the 'Wounds' tab.

Active)	nt Identifier: [	DLSCWS001-D	0230 Casar	ndra Robe	rts Female	D.O.B: 02/1	2/1981
ursing	Medical	Add Progress N	Notes S	icores	Dose & Task List	Cli	nical Events
Wounds	Sepsis	Metabolic	ECMO / VAD	Handover			
		400	500	6 <sup>00</sup>	700	800	900
aiting signatur	e Sign No	ow!	Bod	ly Chart			ngs
5							
	Wounds *Critica 14/4/10 aiting signatur	Aursing Medical Wounds Sepsis Critical Care 1/4/4/16 300 Biting signature Sign No	Wounds Sepsis Metabolic Critical Care 14/4/16 300 400 Add Progress N Metabolic 400 400 400 400 400 400 400 40	Wounds Sepsis Metabolic ECMO / VAD Critical Care 14/4/16 300 400 500 atting signature Sign Now! Boo	Wounds Sepsis Metabolic ECMO / VAD Handover Critical Care 1////1/6 300 400 500 600 aiting signature Sign Now! Body Chart	Wounds     Sepsis     Metabolic     ECMO / VAD     Handover       1/1/1/10     300     400     500     600     700       aiting signature     Sign Now!     Body Chart     Ong	Wounds         Sepsis         Metabolic         ECMO / VAD         Handover           1000000000000000000000000000000000000



This form is completed to indicate areas of the patient with a burn wound. 'B' is placed in the area a burn is present. A colour can also be added to indicate management of the wound. There is a button at the bottom called 'Burns Management' and the colour of this button will indicate if there are any active burns:

- Grey: no burns
- Orange: Burns with 'observation only' as the status
- Red: burns with 'active management' as the status



# 5.3.2 Medical Forms on Admission

#### **Burns Admission Management Form**

In addition to the forms in the 'Admission Summary Form', for burns patients, the ICU clinical staff will need to complete the 'Burns Admission Management' form.

2 Lara 6.4.0001 - Burns Management	18/01/2016 11:42 AM ) B	RN Lara Simons / *Adult V >>>> 🗄 New 🔅 😮
Burn Admission Summary	Summary Site: Head Description:	Inder Active management
Burn Area 2	Summary Site: Chest Description	44 4 08/12/2015 02-32 PM (Saved at: 08/12/2015 02-88 PM ) From cleaned for: 9N   arx Smore (*Advit     1
Burn Area 3	Summary Site: Hand B Description	pht Detrease Images
Burn Area 4	Summary Site: Description	New Diff. Davis Report Mr. Car
Burn Area 5	Summary Site: Description	Mechanism of Injury         Electrical         v         Time of Burn         @ 06/12/2015 1225         +         v           Other Mechanism         Hours Since Burn         238         Noves
Burn Area 6	Summary Site: Description	Patient was in a MVA and sustain major friction burns to his torso and upper bilateral legs. Deep dermal
Burn Area 7	Summary Site: Description	Please select ONE tool to assist in calculating the 785A% TB5A % Deemal 12 A * * % TB5A % Evel Tbickness 10 A * * % TB5A % Total 22 %
	Summary Site:	This calculation will any include Dermal and Full Thiskness, IR DOEI NOT include arytheme           Tetamus Up To Date         Yes         No         Tetamus Units         Yes           Ent Add         Yes         No         Current Thermoregulation         Yes         Yes           Component of Injury Circumferential         Yes         No         Exidence of Ocular Injury         Yes         Yes

A newly admitted patient to the ICU with burns will receive specialised care; to document this and plan further care, the clinician (Medical officer, burns fellow, nurse) opens the Burns Admission Management form to document the initial burn details. This is the first 24 hours of information, giving an overview of what happened and the actions taken. This is all static information which should not really change, other than an update of the initial TBSA% or burn details that were not captured initially. For ICU's that don't have burns as a regular occurrence, this does not have to be completed.

The Burns Admission Management form includes:

- The 'story' of what happened (when, where and how). The Time of Burn entered will be used to calculate the field 'Hours since Burn'. This is a formula and will auto calculate upon the form being saved. It is important because it is used to calculate the fluid resuscitation fields
- TBSA calculation (Rule of 9's or Lund and Browder). These will open to separate forms with the ability to document and draw on the desired areas. The user will then need to manually document the TBSA Dermal and TBSA Full thickness into the fields. The TBSA % total will calculate automatically ONLY ONCE THE 'Save' button is clicked on. (This applies to all formula parameters that are underlined – need to click on 'Save' to activate the formula)
- Burn depth documentation There are descriptions and information provided for all burn depth documentation. This is to aid in accurate calculations
- Upload images of the initial burns The user can upload images of the burns when the patient arrives in the ICU
- Pain, airway and ocular documentation (vital areas to monitor in the first 24 hours).
- Interventions completed (at the scene, the emergency room or ambulance)
- Fluid resuscitation for the first 24 hours (with Parkland formula calculations and urine output targets) these fields are auto calculated, user must enter the fluids previously given to patients, and the weight of the patient. The other fields will calculate when the user saves the form (NOTE: this is to be used when burn is < 8 hours old)</li>
- The user can access buttons to document actions which may have occurred during the burns admission, such as line insertion or local policy for further information.





for clinicians



The second tab, 'Ongoing Burn Care', documents the current burns for ongoing management with their site and description; there are action buttons to go from here to document the burns and the dressings.

#### **Diagnostics / Problem List**

The ICU medical officer needs to complete the problem list at the end of the admission process. This lists the Acute Active problems, Acute Resolved and the Chronic issues. This can be found under the 'Medical' menu and the 'Problem List' button.

asandra Roberts - Problem List : New Se	sion			
. 14/04/2016 14:57 🔺 🔻 🏹	Sharon Shunker / *Critical Care		Previous Session	*
plem List				
blem List (Acute - Active)	Problem List (Acute - Resolved)	Problem List (Chroni	c)	-
		Sav	e Save and Close	Cano

The values are also presented on the medical ward round note. The parameter will display the latest value. Therefore wherever the user completes the parameter, it will display the most up to date value in both the problem list form and the medical ward round note form.

#### 5.4 Review Tabs

#### **Clinical Overview Tab**

Once the admission procedure is completed, the Clinical Overview tabs can be used to view the patient's vital signs.









#### Ventilation Tab

This provides an overview of the patient's ventilation status.

	<b>1</b>		10**	1121	1223	1321	1421	152	1623	1723	1823	1923	1 Hour
ation (Invasive)													1 d/2 h/48 m
tilator Mode tilator Type				ot SIMV/PS/Auto XL Dräger Evita XL		CPAP/PS Dräger Evita XL	CPAP/PS Dräger Evit	CPAP/PS ta XL Dräger Evita XL	CPAP/PS Dräger Evita XL	CPAP/PS Dräger Evita XL	CPAP/PS Dräger Evita	CPAP/PS Dräger Evita XI	
ntilation	To Active	Activo	Activo	Activo	Activo	Active	Activo	Activa	Activo	Activa	Ami	Activo	Units
02	98	98	99	98	95	97	97	98	96		197	96	%
Ratio	201					330			Tabula	- \/:			None
2 (Set) (Set)	50	40	40	40	30 10	30	30 V 6	entilator (	Tabula	r view)		30	% cmH2O
	9			10	10	5	5	5	5	5	5	5	cmH20 cmH20
entilatio	n (Tabul	ar View	()	10		-		-	-	-	-	-	breaths/min
			· _	14	18	16	14	12	12	20	17	19	breaths/min
(Set)	500	500	500	500									mL
(Expired)	430	420	480	490	480	470	420	430	450	480	400	450	mL
oFlow	18 On	19 On	18 On	16 On	15 On				15			15	cmH2O None
w Trigger	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	L/minute
ay		Oral ETT	Oral ETT	Oral ETT	Oral ETT	Oral ETT	0	Airway (	Tabula	r View)		Oral ETT	
Type Insertion Date	Cuffed with s										th s 17/08/2016 1	1	
Size	7.50										7.50		
Cuff Pressure	20		22		24		26		26		26		
Pos. at Teeth/Nare	23		23		23		23		23		23		_
erial Blood Gases	5												Units
	7.31					7.38							pH
02	100.6					99.1							mmHg
02				_		32							mmHg
se Excess					_	-5.3							mmol/L

#### Input / Output Tab

This screen provides a view of the patient's input and output status and also the lines, tubes and drains that are insitu.

pup trait diversal       170       325       209       114       103       105       Drain and Tube Observations (Tabular View)         pup trait diversal       103       103       103       103       103       104       Dias       104         pup trait diversal       100       103       103       103       103       103       104       Dias       104         pup trait diversal       100       123       1455       150       1655       mt         Unive cotput diversal       200       100       60       80       50       160       110       90       70       100       40       mt         Vise cotput diversal       200       100       60       80       50       160       110       90       70       100       40       mt         Vise cotput diversal       200       60       80       50       160       110       90       70       100       40       mt         Stock Massurd Volme       200       200       200       200       200       200       200       200       200       200       200       200       200       200       200       200       200       200       200<	Menu Nursing	1	Medical	Add Pro	gress Notes	Scores	Dose & Task List	Clinical Events	s Ra	diology End of		icies & Guidelines	Refresh	Help & Repor	ts Log (
Imput Costability (htterval)         1/2		tal Signs	Ventila	tion Neuro /	Pain Input / Output	RRT		gress Prescribe Medicatio	e Admini Medicat	ster Titrate M ions Medications		epsis Metabol	ic Wounds		
Input         Input <th< th=""><th>4 4 Go to 🔹 &gt; &gt;&gt; 💽</th><th></th><th>:46</th><th></th><th></th><th></th><th></th><th></th><th></th><th>1620</th><th></th><th></th><th></th><th></th><th></th></th<>	4 4 Go to 🔹 > >> 💽		:46							1620					
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al be bord       or	Parenteral Nutrition Fluid In.	0	1	0	0	0	0	0	0	V	0	0	0	0	mL
Interest field logic direction (0)       0	Oral Fluids								_						mL
Other hald prive       O															mL
Beta         Post Cold (Data)		0	1	0	0	0	0	0	0	0	0	0	0	0	mL
page troid (order a)       170       225       090       116       103       103       105       Drain and Tube Observations (Tabular View)         page troid (050)       170       95       714       830       933       1036       1140       1036       1140       1036       1140       1036       1140       1036       1140       1036       1140       1233       1455       1.530       1.655       mt         Unice cotput (fill (mind))       200       100       60       80       50       160       110       90       70       100       40       mt       Mone mt         Unice cotput (fill (mind))       100       60       80       50       160       100       90       70       100       40       mt       Mone mt         Stock hassurd Volmed       200       100       60       80       50       100       100       90       70       100       40       mt       Mone mt         Stock hassurd Volmed       200       200       200       200       200       200       200       200       200       200       200       200       200       200       200       200       200       200       200       <			}												Lml
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	Endotracheal Tube (Oral)					1							м	outh	0 d/16 h/4 m
		100		-									-		

Lines/Drains/Tubes (Gantt View)



#### Fluid Balance (Tabular View):

- Top section lists fluid inputs, followed by totals. Next is Fluid Output, Output Totals, and then Balances. Specific totals (Drains, IV fluids, Blood Products, GI totals, Urine Totals and Dialysis) are also listed
- The majority of these will be coming in from other sources (e.g. medications and nutrition) which will all be 'Ordered'; and these will be formula parameters which will auto calculate per interval. The only input the user can manually enter is oral fluids (sip of water you gave the patient), GI tube input (medication flushed down with water) and other fluid input. The other values are for interpretation, not documentation. The totals are all formula parameters and therefore cannot be manually entered
- Output is manually entered, as this is often measured on an hourly basis. All outputs coming from hourly observations of drains and tubes will populate in the GI outputs parameter or Drain output parameter. The totals, however, will be auto calculated. Urine will be entered into the output totals
- Balance Totals are all auto calculated
- The next sections are closed by default, and when opened, will show a breakdown of where the individual outputs are coming from.

#### Drain and Tube Observations:

- When a patient has a line, drain or tube inserted in them, this is a foreign object, and therefore regular observations must be performed to ensure the safety of the patient. This information is displayed as 'hide empty rows' which is designed to only display a parameter if there is a value present. Therefore, if there is no data, it is set to not display or to 'hide' that parameter. All parameters within the tabular view will be linked to a form which will be completed when the process parameter is documented. Relevant values will be automatically displayed from the forms as they are completed, there will be no need to manually transcribe any values. There are a large number of drains and tubes the patient may possess and the majority may not be relevant for particular patients.
- By hiding rows, only the relevant parameters and values will be displayed making it easier for the user to view and interpret the data. The workflow for documenting a line, drain and tube will be outlined in the Daily Routine module.

**NOTE:** On the Input / Output Tab if a '0' value is displayed – this is a null value for a calculated field (formula field that pulls or is calculated from another area). Therefore in 'Drain Output' 0 does not = no drain loss, but means no drainage has been recorded.

#### Lines/Drains/Tubes (Gantt View):

• This is where the user can see which lines, drain or tubes are currently insitu for the patient and for how long (This is the cannula / catheter chart). The user can cease the process parameter from here when a line, drain or tube is removed.

# 6. Admission Module Specialised Workflow Processes

• Allergies/ADRs need to be recorded in eMR and in eRIC separately.







# eRIC User Guide

# **Module 3: Daily Routine**

Daily Routine







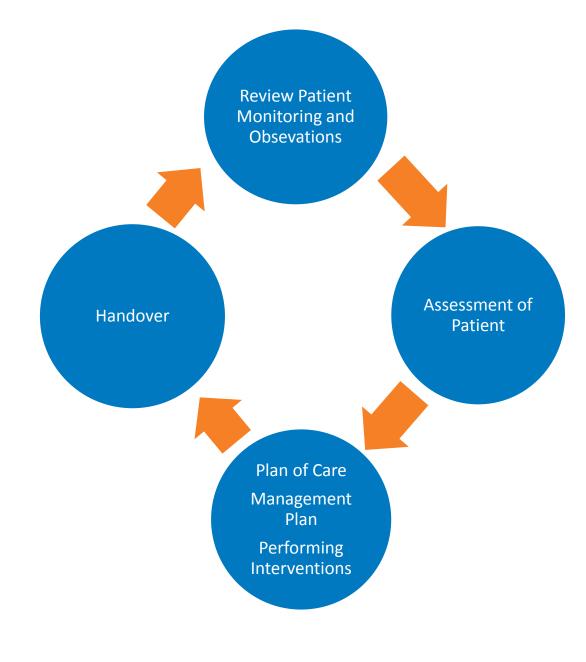
# 7. Overview Daily Routine Module

This module will promote your understanding of how to use eRIC as part of the ICU daily routine process for assessment and management of the patient.

This process includes reviewing the ICU patient, assessing the ICU patient, planning the care of the patient, documentation and handover of care to the next shift.

# 8. ICU Daily Routine

Care and management of an ICU patient is a 24-hour process, so the daily routine covers a 24-hour period and the various activities are generally based on each shift. The duration of the shift may vary for each ICU. The routine for each shift will commence with obtaining handover and then the activities can be broadly categorised under the following headings.







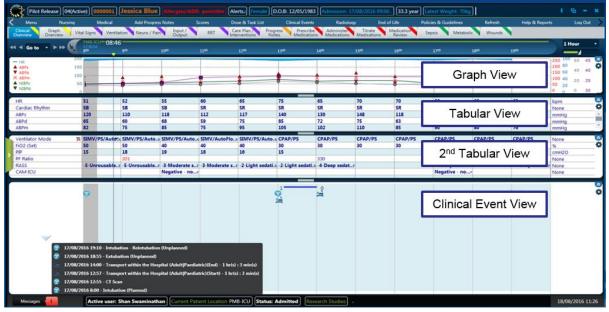
# 8.1 **Review Patient - Monitoring and Observations**

At the start of their ICU shift the clinician (nurse, medical officer, allied health, pharmacist) will review the patient parameters recorded in eRIC. This will include (but may not be limited to) a review of:

- The Clinical Overview tab and Graph view tab
- Vital Signs cardiac, respiratory, cardiovascular
- Ventilation (for those patients that are ventilated)
- Neurological Observations and scores
- Input /Output
- Medications

# 8.1.1 Clinical Overview

This will be the most viewed tab as it contains all the most common elements required for observation of care.



This view contains a

- Graph View on the top for tracking common patient vitals (HR, Blood Pressure, Oxygen saturation and Respiratory Rate).
- Tabular View of the data above and other important parameters.
- Second Tabular View on this tab will only show the parameters if there is data in them, hiding the empty rows. The parameters on this tabular view can be viewed at any time by clicking on the properties cogwheel, General → Show Empty Rows.

The Urinalysis will be displayed on the Clinical Overview tab.

• **Clinical Events View**. This is used to track events that have happened to the patient. This view keeps a record of all the previous clinical events that have occurred and can be viewed by clicking on the down arrow on the left hand side of the view. This will bring up a list of past clinical events with a date and time. By selecting one of these past events the user is transported back to the event. This ability allows for fast and effective movement through the Flow Sheet to view past clinical events and what the vital signs were at the time of the event.







# 8.1.2 Graph Overview

Menu	ed O4(Active) (4444444 Nursina Medie Vital Signs Ven				ts: MRAB, Respiratory, I 🕼 = 🗴 ex & Geidelenex Refersh Helto & Resourts Lon Chit Money, Wounds Septis Metabolic (CMO / Wal) Handover
<ul> <li>44 ≤ Go to</li> <li>HR</li> <li>A65;</li> <li>A87g</li> <li>X 887g</li> <li>X 887g</li> <li>X 887g</li> <li>X 887g</li> <li>X 887g</li> <li>CO</li> <li>CI</li> </ul>	► ►► ( ) () () () () () () () () () () () ()	274427 31 <sup>20</sup> 23 <sup>20</sup>	Note the	Cardiac	11:00 200 10 <sup>-1</sup> 20 <sup>-1</sup> 10 <sup>-1</sup> 20 <sup>-1</sup> 10 <sup>-1</sup> 20 <sup>-1</sup> 10 <sup>-1</sup> 20 <sup>-1</sup> 20 <sup>-1</sup> 10 <sup>-1</sup> 20 <sup>-1</sup> 10 <sup>-1</sup>
* \$p02	100 10 70 50 40 30 20 0		number of t columns	Respiratory	
BGL     Gucose Ran     Gucose	Immol(1) 8 neus Giucese 7 Aucose Immo 6 3			Metabolic	Will include relevant pathology results if available
HR Temperature AR (Tota) 	A) 100			Sepsis	Will include relevant pathology results if available
Ho Harmoglobin / Potassium AD Sodium (mmo 	A) 50 40 40	r: Sharon Shunker   Curr	Particle Country STC XUIT [Status: Admitted]	Laboratory	

#### Graph Overview tab

- This tabs status and layout is different to most of the other tabs in eRIC
- This tab has 24 columns whereas most other tabs have only 12
- This tab also has a different time default; it is set to 12hrs, not the standard 1 hour time interval. This is used to give the clinicians a high level graphical overview of the patient in several different key areas
- The four graphs are broken down into the follow areas:
  - Cardiac
  - Respiratory
  - Metabolic
  - Sepsis
- Only validated parameters will be displayed in the Graph view.





One solution

across NSW



eRIC User Guide - Module 3: Daily Routine

# 8.1.3 Vital Signs

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ardiac Rhythm	58	58	SR .	SR.	98	5R	\$R	SR .	58	SR	SR .	SR .	None	
ndiac Ectopy						114							Note	
Pi Pd	40	118	112	117	140	130	148	118	130	115	122	58	mmHg mmHg	
ha .	8	15	15	95	105	302	110			80	26	n	mnHg	
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This tab contains 3 tabular views for a more detailed breakdown of the vital signs. Most of this data will be automatically populated from the patient's monitor but some of it such as  $O_2$  delivery device,  $O_2$  flow rate, circulation observations may need to be manually entered.

**NOTE:** As per local guidelines the data must be validated at regular intervals and incorrect parameter information corrected manually or marked as error. A comment can be added to indicate why they are marked as error. Check the parameters when validating to ensure they are accurate. Validation is of the patient's physiological status NOT validation of eRIC correctly recording a device parameter (which may or may not have accurately captured the patient's physiological status). Any data that is not populating from the monitor or devices to eRIC will need to be manually inputted.

**NOTE:** Need to note the labelling of vital sign parameters on the monitor:

- Arterial Blood Pressure needs to be labelled 'ABP' (NOT 'ART')
- Temperature should be labelled 'Temp' (do not use labels that specify the source; the source can be specified using the 'Temp Source' parameter cell box on the 'Vital Signs tab').

If the patient needs the frequency of observations increased e.g. a patient requiring Thrombolysis observations, this should be validated at the relevant increased frequency. It can also be scheduled as a task with a reminder e,g, complete thrombolysis observations every 15 mins for first hour, followed by hourly for 4 hours, etc.

**Cardiac –** Heart rate and cardiac rhythm, ABP, NIBP, CVP, Temperature, BGL, Ketones, ICP, CPP, IAP (Intra-abdominal pressure).

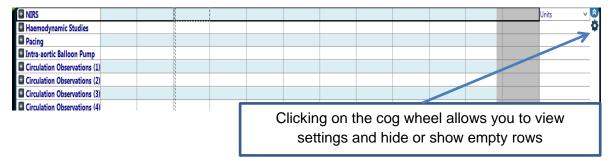
**Respiratory** – RR,  $SpO_2$ , Airway,  $O_2$  delivery device,  $O_2$  flow rate,  $FiO_2$ , humidification, pulmonary sounds, sputum information, patient position, head of bed elevation, PF Ratio **Cardiovascular** – This contains *Hidden Rows* \ they are populated when the form in the 'Nursing Menu' is completed e.g. Circulation Observations, or if the parameter is being monitored e.g. PiCCO monitoring, CCO.







eRIC User Guide - Module 3: Daily Routine



#### **Nursing Observation Forms**

Commonly used Observations that nurses will perform are located under the 'Nursing' menu; for example, Circulation Observations.

The form to complete for the Circulation Observations is located under: Nursing → Observations → Circulation Observations

**NOTE:** Completing and saving this form will populate the Vital Signs tabular view  $\rightarrow$  Cardiovascular.

Once this data has been completed, the data will remain on the Tabular view allowing the nurse to complete the observations straight from the tabular view instead of opening and saving the form each time. The same applies to all other observation forms.

Menu Nun	sing Medical	Add Progre	ss Notes	Scores Do	ose & Task List	Clinical Events			Life Po	olicies & Guidelines	Refresh	Help & Repo	rts Log
nical Grap rview Overvi	Select a Patient		Input / Output	RRT Ci	are Plan / Prog erventions No	gress Prescribe Medicatio	Administe Medication	Titrate N Medications	Aedication Review	Sepsis Metabo	lic Wounds		
	Safety Checklist												1 Hour
Go to 🔻 🕨	FASTHUG												
al Signs	Allergies/ADR												Units
	Alerts and Isolation	Requirements		65	75	65	70	70	52	65	65	63	bpm
rdiac Rhythm	Observations		Non-I	nvasive Ventilation		SR	SR	SR	SB	SR	SR	SR	None
diac Ectopy		ices and Observations	_	ation Observations									None
Ps		ices and Observations				130	148	118	130	115	122	110	mmHg
Pd	Schedule a Task			tion Observations		72	75	63	70	65	61	58	mmHg
Pm	Timed Intervention:		<ul> <li>Pacing</li> </ul>	1		102	110	85	90	80	76	71	mmHg
Ps (Secondary)	Clinical Procedure S	Safety Checklist (Time	out) IABP	Observations									mmHg
Pd (Secondary)	Progress Notes		▶ Near-	infrared Spectrosco	PY								mmHg
Pm (Secondary) Ps	- Nursing Manageme	nt Plan	Nitric	Oxide Order and Ot	servations								mmHg
SPd	Research Studies		Urinal						-				mmHg mmHg
													mining
spiratory	Patient Belongings			er Irrigation									Units
(Total)	Weights and Dimen	isions	Peript	eral Nerve Stimulat	tion	16	14	12	12	20	17	19	breaths/min
02	Patient Ready for D	lischarge	V.L.P.			97	97	98	96	99	97	96	96
way	Nursing Discharge	Summary	Food	Chart		Oral ETT	Oral ETT	Oral ETT	Oral ETT	Oral ETT	Oral ETT	Oral ETT	None
Delivery Device					_								None
Flow													L/minute
Flow		40			30	30	30		30	30	30		L/minute
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monary Sounds (L)	Clear	Clear	Clear	Clear	Clear	Clear	57.1	Clear	57.4	Clear	57.4	Clear	None
Imonary Sounds (R)	Clear	Clear	Clear	Clear	Clear	Clear		Clear		Clear		Clear	None
utum Amount		Small		Medium		Scant		Medium		Scant		Small	None
utum Colour		White		White		Blood stained		White		White		White	None
utum Consistency		Thin		Thin				Thin		Thin		Thin	None
tient Position	Low fowler's	Low fowler's	Low fowler's	High fowler's	High fowler's	Left lateral		Low fowler's		Right lateral		High fowler's	None
	5												Units
													Units

### 8.1.4 Ventilation

This view will allow the clinician to view all information relating to the patient's ventilation status. The data is automatically populated in eRIC from the ventilator – but the user MUST CHECK and Validate that it is correct (according to patient's actual physiological status) and accurate at regular intervals.

**NOTE:** Check Mode and parameters. If anything is incorrect or not populating this can be manually entered.

**NOTE:** The RR will auto populate only from the monitor (from the ECG). If the ventilator RR (Total) needs to be entered this will have to be a manual entry.



	( Mary Nacion	Kctive) 0000001	Add Progre		Scores D	ose & Task List	Circuit Fuent	i Radioko	v Indol		es & Guidelines	latest	Help & Report	ta Log C
Ventilation	the survey of the local division of the loca	Week Signe				are Plan . Prop	Prescribe	Administre	Tatate N	ledication and	nos Metaboli		rep a report	a 100 C
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Intervention	4 4 Go to - > >>	STORIE .			11 <sup>a</sup>									
	Vent of Browsivet	3												1431328
	Ventilator Mode	SMV/PS/Auto.	SIMV/PS/Auto	SMV/AutoFla	SWW/PS/Auto	CPAP/PS	CPAP/PS	(949/95	CPAD/PS	CPAP/PS	CPAP/PS	CPAP/PS	(949/95	-
Ventilator	entilator Type					L Dräger Evita XL	Dräger Evita XI							
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2	Sp02	95	98	99	58	95	97	97	98	96	99	97	96	unia la
	PF Ratio	201			-		330							None
	FIO2 (Set)	50	40	40	40	30	30	30	30	30	30	30	30	4
	50	5	10	10	30	10	10	10	10	10	10	10	10	001420
Ventilation	COP (Set)	5	10	10	30	10	5	5	5	5	5	5	5	cmH20
	RR (Set)	10	10	10	30									breaths/min
	RR (Total)	10	12	12	34	18	15	14	12	12	20	17	19	breaths/min
	> V1 (SHD	500	500	500	500									et.
	Vt (Expired)	430	420	480	490	480	470	420	430	450	480	400	450	eL.
	99	18	19	18	16	15				15			15	omH20
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	Flow Trigger	1.0	10	10	1.0	1.0	1.0	10	1.0	1.0	1.0	1.0	1.0	L/minute
A		1.										-		
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	Sertion Date	17/08/2016 1	-									17/08/2016 1	• 4	
1	ETT SIX	7.50				14		171				7.50		
	ETT Cuff Pressure	20		22		24		26		28		26		
	ETT Pos. at TeethyNare	23		23	-	23		23		23		23		
Pathology	Acterial Blood Gases	в												Units
ADC		7.31				1	7.38						1	pH
ABG		100.6					99.1						1	mmHg
	PaCO2 Base Excess	36.1			10		-5.3		-					mmHg mmol/l
	Sase Excess	17.0					-3.3	-						mmol/1

**Ventilation Dose** – a Dose view (Ventilation Timed Intervention) showing what type of ventilation the patient is on (Invasive or Non-invasive, also allows to record if on nitric oxide treatment). It provides information about how long they have been on the treatment for and can been used to calculate the number of ventilation days.

**Ventilator -** Tabular view providing the user with the ventilator information – Ventilator mode, type, type of humidification, humidification temperature, humidifier water checked.

Ventilator Mode			SIMV	
Ventilator Type			Dräger Evi+	
Humidification			Active	
Humidifier Temperature			36.2	
Humidifier Water Checked			Checked	
			5	

**NOTE:** When the Respironics V60 ventilator is set to Stand-by and connected to eRIC; the system receives data and therefore continues to populate some parameters into the ventilation observations.

*The recommended solution:* Disconnect the Respironics V60 device from the Digi when not in use. When the Respironics V60 device needs to be reconnected to the patient, ensure it is also correctly reconnected to the Digi using the correct colour coded cable and port.



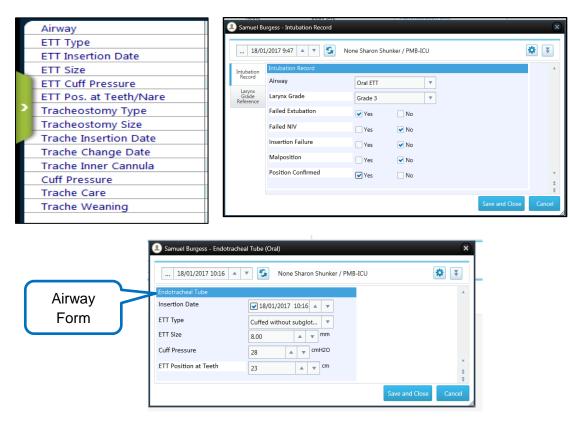


**Ventilation -** Tabular view for observations (both the ventilation observations and nitric oxide observations). It includes the following parameters (use the scroll bar on the right to scroll and view all parameters)

C	Ventilation	MV (Set)	*
	SpO2	MV (Expired)	
	PF Ratio	PIP	
	FiO2 (Set)	Mean Airway Pressure	
	PS (Set)	Plateau Pressure	
	PS + PEEP	Plateau Time	
	PS - PEEP	Inspiratory Time	
	IPAP	Insp. Ratio	
	EPAP	Exp. Ratio	
	C-Flex	I:E Ratio	
r.	PEEP (Set)	AutoFlow	
	Pinsp	Flow Assist	
	Thigh	Volume Parameter name: Flow	
	Tlow	HFOV / Category: Ventilation	
	Phigh	HFOV I Unit: cmH2O/L/sec	
	Plow	HFOV E Type: Numeric	Nitric Oxide Observations
	RR (Set)	HFOV Bilateral Chest Wiggle	INO (set)
	RR (Spontaneous)	HFOV Frequency	INO (measured)
	RR (Total)	HFOV iTime	NO2
	Vt (Set)	HFOV mPaw	
	Vt (Inspired)	HFOV mPaw Lower Alarm	Methaemoglobin (P.O.C)
	Vt (Expired)	HFOV mPaw Upper Alarm	Cylinder Content (Nitric Oxide)

**Airway –** Tabular view for airway information and observations for different airways the patient could have insitu.

This is initially populated on completion of the 'Airway Form' and 'Intubation Record'. The 'Intubation Record' will be located under Nursing  $\rightarrow$  Input /Output Devices and Observations  $\rightarrow$ Tubes  $\rightarrow$  Airway  $\rightarrow$  Endotracheal Tube OR Tracheostomy Tube (the extubation form will be located under Clinical Events)







eRIC User Guide – Module 3: Daily Routine

**Pathology –** Blood Gases – Tabular view showing data from the Lab for the different blood gases (Arterial, capillary, Venous and Mixed Venous).



#### 8.1.5 Neuro/Pain

This view allows clinicians to view information on the patient's neurological status (GCS), pupils, limb strength and ICP and CPP monitoring.

**Neurological (static)** – Information and scores that nursing will do and input on a regular bases for most if not all patients (e.g. GCS, pain and sedation and delirium check). To input the GCS right click on the individual parameter boxes and use the drop down menu to select the desired score. 'GCS – Total' Parameter is a formula parameter. This means that it will auto calculate the GCS Total, but only once all the required fields have data in them. It allows the clinicians to input the numerical pain score, sedation score and delirium score (the information for scores and individual forms for scores can be accessed from the 'Scores' menu). It can also be accessed by the buttons located at the bottom of this tab – clicking on them opens up the appropriate forms.

**Neurological (Dynamic)** – Tabular view for recording various different neuro and pain scores (ICP/CPP, Behavioral **Pain** Scale, CPOT, Alcohol Withdrawal Score and Clinical Opiate Withdrawal Score, Sensation Observations, Nerve Block etc.) **NOTE:** This tabular view will only populate data once the form has been completed. It allows

the clinicians to input the various scores (the information for scores and individual forms for scores can be accessed from the 'Scores' menu). It can also be accessed by the buttons located at the bottom of this tab – clicking on them opens up the appropriate forms.

**Toolbar –** buttons that open different forms that once complete the data will appear on the dynamic tabular view.

< Go to - > >> 💟					:46										1 Hour
	821	<b>9</b> 20	10 <sup>50</sup>	1120		1249	1379	1470	15 <sup>20</sup>	1629		73cm	1879	1929	
GCS															None
CS - Eye Response	1-None	2-To pain	2-To pain	3-To 1		3-To speech	2-To pain	2-To pain	2-To pain		pain	1-None	1-None	1-None	
CS - Verbal Response													a 1-No response.a		
CS - Motor Response	1-None	3-Flexion to pair	n3-Flexion to pai	nő-Loci	lise to	5-Localise to	<ul> <li>3-Flexion to pai</li> </ul>	m3-Flexion to pa	ain3-Flexion	to pain3-Fi	exion to pai	m3-Flexion to pai	in3-Flexion to pair	n3-Flexion to pair	•
CS - Total	3	6	6	9		9	6	6	6	6		5	5	5	
upils/Limbs										_					
) Pupil Size	3mm	3mm	3mm	3mm		3mm	3mm	3mm	3m <sup>2</sup>					4mm	
Pupil Reaction	Brisk	Brisk	Brisk	Brisk		Brisk	Brisk	Brisk	Br					risk	
) Pupil Size	Jmm	3mm	3mm	Jmm		3mm	3mm	Jmm	Br N	lour		ical (S	tatic)	1100	
) Pupil Reaction	Brisk	Brisk	Brisk	Brisk		Brisk	Brisk	Brisk	Br	eur	olog	ical (S	(auc)	risk	
) Arm Strength															
) Arm Strength					-								_		
) Leg Strength				_	-										
POT T							_								Units
POT - Facial Expression			0-Relaxed ne				1-Tense		0-Relaxed				0-Relaxed ne		
POT - Rody Movements			0-Absence of				2-Restlessness		0 Absence				0-Absence of		None
POT - Vent Compliance /					bated		2-Intubated		0 Intubat				0 Intubated		None
OT - Muscle Tension			0-Relaxed		se, rigid		1-Tense, rigid		0-Relaxed	eg			0-Relaxed		None
				4.160	ee, rigitu		a-rense, rigita		o netates				0		None
									0						None
OT - Total			0	2			0								
POT - Total Icohol Withdrawal Scale				2			0								
POT - Total Icehol Withdrawal Scale NS - Perspiration			0-No abnorma.	5			0								None
POT - Total Icohol Withdrawal Scale NS - Perspiration NS - Tremor			0-No abnorma. 0-No tremor				6		_						None
POT - Total icohol Withdrawal Scale NS - Perspiration NS - Tremor NS - Anxiety			0-No abnorma. 0-No tremor 0-No apprehe				0		<b>—</b>	_				٦	None None
POT - Total icohol Withdrawal Scale NS - Perspiration NS - Tremor NS - Antiety NS - Agitation			0 No abnorma. 0 No tremor 0 No apprehe 0 Rests norma.				0		Ne	eurol	ogic	al (Dvi	namic)	ך	None None None
POT - Total icehol Withdrawal Scale NS - Perspiration NS - Tremor NS - Anxiety NS - Aptation NS - Axilla Temp			0-No abnorma. 0-No tremor 0-No apprehe 0-Rests norma. 0-<= 37.0'C				0		Ne	urol	ogic	al (Dyi	namic)	٦	None None None
NOT - Total Icohol Withdrawal Scale NS - Perspiration NS - Arssiety NS - Ansiety NS - Assiety NS - Assila Temp NS - Nailla Temp NS - Nailla Temp			0-No abnorma. 0-No tremor 0-No apprehe 0-Rests norma. 0-c= 37.0°C 0-No evidenc				0		Ne	urol	ogic	al (Dy	namic)		None None None None
VOI - Nulsce Tension Toot - Total Techol Withdrawal Scale WS - Perspiration WS - Anxiety WS - Assisty WS - Assisty WS - Assistation WS - Mallucinations WS - Orientation WS - Total			0-No abnorma. 0-No tremor 0-No apprehe 0-Rests norma. 0-<= 37.0'C						Ne	urol	ogic	al (Dyi	namic)	)	None None None





clinician

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	Menu	Nursing	DLSCWSO		Add Progress I	
	inical erview	Graph Overview Vit	tal Signs 🔰 V	entilation	Neuro / Pain	In
	<ul> <li>Go to</li> </ul>	<b>(</b>	*Critical Care 21/4/16 400	500	600	
	SCS					
	GCS - Eye F		1-None			
		al Response	1-No respo			
		or Response	1-None			
	SCS - Total		3			
	Pupils/Lim		-			
	L) Pupil Siz		3mm			
	L) Pupil Re		Brisk			
	R) Pupil Siz		3mm			
	R) Pupil Re		Brisk			
	L) Arm Stre		None			
	R) Arm Str		None	_		
	L) Leg Stre		None			
	R) Leg Stre	ngth	None			
	Pain					
		Pain Scale (Move				
		Pain Scale (Rest)				
	iedation /	Delirium				
F	RASS		-5-Unrousa	T		
0	CAM-ICU		Negative	+		
4	Asleep/Awa	ike				

To input the GCS right click on the individual parameter boxes and use the dropdown menu to select the desired score. The same applies for pupils and limb

# 8.1.6 Input / Output

This view allows clinicians to view information on the patient's Input / Output and Fluid Balance status.

	Pilot Release 04(Acti	ive) 000	0001 Jessic	a Blue Allergie		Alerts: Female	D.O.B: 12/05/198	3 Admission:	17/08/2016 09:00	. 33.3 year	Latest Weight: 70			
	Kenu Nursing			ld Progress Notes		Dose & Task List	Clinical Event	s Radiok	xay Endio		Policies & Guidelines	Refresh	Help & Repo	rts Log O
	Clinical Graph Overview Overview Vit	tal Signs	Ventilation N	euro / Pain Input Outp	RRT	Care Plan / Pro Interventions N	gress Prescrib Medicatio	e Administer Medications	Titrate Medications	Medication Review	Sepsis Metabo	olic Wounds		
		PM 08:4	6 9 <sup>23</sup>											1 Hour
	Input													Units
	Crystalloid Input (Interval)	170	325	209	116	103	103	105	105	105	105	105	105	mL
	Colloid Input (Interval)	0	0	0	0	0	0	0	0	0	0	0	0	mL
	Blood Product Input (Interval)		0	0	0	0	0	0	0	0	0	0	0	mL
	Parenteral Nutrition Fluid In	0	0	0	0	0	0	0	0	0	0	0	0	mL
	Oral Fluids													mL
	GI Tube Input													mL
luid Balance	Enteral Fluid Input (Interval)	0	0	0	0	0	0	0	0	0	0	0	0	mL
	Other Fluid Input													mL
Tabular View	Totals Input													
	Input Total (Interval)	170	325	209	116	103	103	105	105	105	105	105	105	mL
	Input Total (Daily)	180	505	714	830	933	1,036	1,140	1,245	1,350	1,455	1,560	1,665	mL
	Input Total (LOS)	170	495	704	819	922	1,026	1,130	1,235	1,340	1,445	1,550	1,655	mL
	Output	200	100	60	80	50	160	110	60	90	70	100	40	
	Urine Output     Urine Output (Estimated)	200	100	60	80	50	160	110	60	90	70	100	40	mL
	Stool Measured Volume													None mL
	Gastric Aspirate (Returned)													mL
			_					_				_		m
	Nasogastric Tube 5													Units
	Tube Type	Wide bo	re			Wide bore	Wide bore		Wide bore		Wide bore		Wide bore	None
Drains &	Position at Nare	50				50								cm
Tubes	Drainage	Free dra	inage			Free drainage	Free drainage		Free drainage		Free drainage	_	Free drainage	None
Tubes	Drainage Volume	100												mL
Observations	Drainage Description	Brown				Brown	Brown		Brown		Brown		Brown	None
	Drainage Description	Normal	and the second se									_		
Tabular View	Drainage Description	Normai	urine									_		None
ines / Drains /	Lines													
	Arterial - Radial (R)	-												1 d/2 h/51 m
Tubes	Peripheral - Hand (L)													1 d/3 h/0 m
	Tubes													
Dose View	Endotracheal Tube (Oral)						-	-	-	-			Mouth	0 d/16 h/4 m
	choose and the follow												*********	

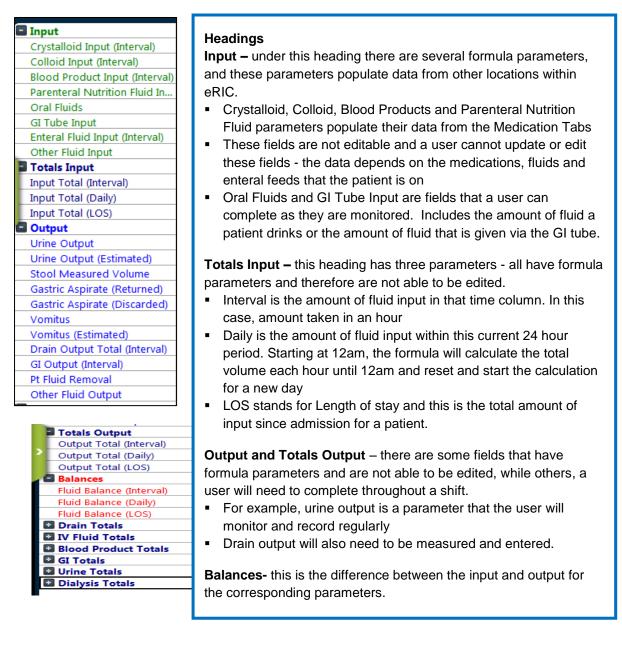
#### Input / Output tab - Fluid Balance Tabular View

- Clinicians can review fluid administration and fluid loss in this view.
- Nurses record urine output in this view
- The Fluid Balance view has several headings which can be expanded or collapsed
  This tabular view has many calculations automatically taking place for an up-to-date record of the patient's fluid balance. The data is taken from various sources such as infusions, medications, enteral feeds and other fluid inputs that the patient has had or is currently receiving.

Menu Nursing	Medical	D230 Sam Burges Add Progress Notes ation Neuro / Pain [	Allergies// Scon Dutput	The view has the following headings that are all expanded meaning all the parameters
	*Critical Care 21/4/16 22 2300 00	2/4/16 100 100	200	within this heading are viewed:
Input				—
Totals Input				<ul> <li>Input</li> </ul>
Output				
Totals Output				<ul> <li>Totals Input</li> </ul>
Balances				
Drain Totals				<ul> <li>Output</li> </ul>
IV Fluid Totals				
Blood Product Totals				<ul> <li>Totals Output</li> </ul>
GI Totals				
Urine Totals				Balances
Dialysis Totals				
>				



**NOTE:** On the Input / Output Tab if a '0' value is displayed – this is a null value for a calculated field (formula field that pulls or is calculated from another area). Therefore in 'Drain Output' 0 does not = no drain loss, but means no drainage has been recorded.



The view also has the following headings that are all pre-collapsed, meaning all the parameters within this heading cannot be seen without expanding the heading.

# **NOTE:** These headings will remain closed with or without data and it is a clinician's responsibility to expand and look at these parameters.





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- Drain Totals
- IV Fluid Totals
- Blood Products Totals
- GI Totals
- Urine Totals
- Dialysis Totals

Drain Totals IV Fluid Totals Colloid Input (Daily) Colloid Input (LOS) Crystalloid Input (Daily) Crystalloid Input (LOS) IV Fluid Input (Interval) IV Fluid Input (Daily) IV Fluid Input (LOS) Parenteral Nutrition Fluid In... Parenteral Nutrition Fluid In... Blood Product Totals GI Totals Urine Totals Dialysis Totals Dialysis Input Total (Interval) Dialysis Input Total (Daily) Dialysis Input Total (LOS) Dialysis Output Total (Interval Dialysis Output Total (Daily)

**NOTE:** Fluid that is removed during Hemodialysis should be entered in 'Other Fluid Output' add a comment to say that this was removed during hemodialysis.

Pilot Release 01(Acti	ive) 416350	Samuel	Burgess	Male D.0	D.B: 0	nission: 03/08/20	16 11:59 .	0.0 year	st Weigh
Kenu Nursing	Medica	l Add	Progress N	otes	Scores	Dose & Task List	Clir	nical Events	Radi
Clinical Graph Overview Overview Vit	al Signs Ve	ntilation Neu	ro / Pain	Input / Output	RRT	Care Plan / Interventions	Progress Notes	Prescribe Medications	Administe Medicatio
4 4 Go to 🕞 > >> 🗐	PMB-ICU 29/12/16 2300	30/12/16 000	100	200	- 03:00 300	400	500	600	700
Gastric Aspirate (Returned)									
Gastric Aspirate (Discarded)									
Vomitus									
Vomitus (Estimated)			-		13				
Drain Output Total (Interval)	0	0	0	🕘 Co	mments				×
GI Output (Interval)	0	0 200	0	Remov	ed during He	modialysis			
Other Fluid Output	100	200	100		cu during ric	Inioularysis			
Output Total (Interval)	100	200	100						
Output Total (Daily)	397	200	300						
Output Total (LOS)	499	699	799						
Balances									
Fluid Balance (Interval)	-98	-198	-98						
🖬 Channel Drain - Pleural (L									-
Cumulative Drainage Volu	20	20	20						
EVD - (L)							-	<u>о</u> к <u>с</u>	lose
Cumulative Drainage Volu	22	22	22						
Pt Fluid Removal		100	2	00	100				
Other Fluid Output								2,000	
Totals Output								5	

Blood loss is recorded under 'Other fluid output' with comment as to what loss it is e.g.
 PV Blood loss or loss from a wound or laceration





Input Total (LOS)	19,600	19,600	)	19,600	19,600
Output		1			
Urine Output					
Urine Output (Estimated)				Output: 100 mL	
Stool Measured Volume			Time: 06/10	/2016 3:00	
Gastric Aspirate (Returned)			Entered by:	Kaye Williams On:	
Gastric Aspirate (Discarded)			06/10/2016	12:52	
Vomitus			Comment:		
Vomitus (Estimated)			PV blood lo	SS	
Drain Output Total (Interval)	0	b l		0	0
GI Output (Interval)	0	þ		0	0
Pt Fluid Removal		<u> </u>			
Other Fluid Output		100			
Totals Output		1			
Output Total (Interval)	0	100		Mark Error	
Output Total (Daily)	0	100		Warning	00
Output Total (LOS)	3,547	8,647		-	,647
				Comments	
5		1		Log	
		1		Cell properties	
		2		Interval data viewe	-
		}			·
		1		Add bookmark	

#### Drains and Tubes Observations

This tabular view of Drain and Tubes Observations is where a user will continue to record observations on Lines/Drains/Tubes that are currently running, e.g. for nasogastric tube, ICC observations.

Nasogastric Tube					
Tube Type					Wide bore
Position at Nare					50
Drainage					Free draina.
Drainage Volume					50
Drainage Description					Light green
ICC - Apical (L) #1				1	
Drainage Volume .				<pre>{</pre>	40
Total Volume in Drain					150
Cumulative Drainage Volum					40
Swinging/Draining/Bubbling					S/D/B
Suction (cmH2O)					20
Suction (kPa)					
Drainage Description					Serous
Site Condition					Clean
Drain Care					Drain secu

#### Lines/Drains/Tubes – Dose View

This view (Gantt) shows what Lines/Drains/Tubes are currently insitu and how long they have been in for (this is like the cannula / catheter chart).

				111.11					
					<u>}</u>		1		
Drains									
ICC - Apical (L) #1			Chest	Upper (Left)					0 d/6 h/2 m
						 		•	
Tubes									
Nasogastric Tube						Nare (Right)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		0 d/1 h/39 m
					8				

#### Lines /Drains/ Tubes

\_

**NOTE:** To record that a line/drain or tube is insitu navigate to either:

Nursing  $\rightarrow$  Input / Output Devices and Observations  $\rightarrow$  select the one you need Medical  $\rightarrow$  Lines / Drains / Tubes  $\rightarrow$  select the one you need



Both menus lead to the same action. A line started from the nursing path can be started from the medical path as well.

Many of these forms will be filled in at the time of admission as the patient may come with pre-exiting Lines/Drains/Tubes.

In the menu there are many different options for lines/ drains/ tubes (over 100 just for the lines). Select the Lines/Drains/Tubes required and this will take you to a specific form that needs to be completed. With this there may be another mandatory sub form that needs to be completed. See example below for L Apical ICC.

(Adult) CC 02(A	Nuroing	Burge	S Allergie	s/ADR: /	Allergies/ADR no	et documen	Alerts.:	ale D.O.B: 1	7/11/1964	Admission: 0	2/04/2016 07:	i 6	- ×
🖌 Menu Nur	Nursing	gress Note	es S	cores	Dose & Task	List	Clinical Events	Radiology	End	of Life	Policies & Guidel	ines Refre	esh
Clinical Grap Overview Overvie			Input / Output	RRT	Care Plan / Interventions	Progress Notes		Administer Medications	Titrate Medications	Medication	Pathology P Result	Repo:	12 (
Overview Overvi	Safety Checklist		Output	_	<ul> <li>Interventions</li> </ul>	Notes	08:00	viedications •	Medications •	Review	Result	1 Hour	
📢 ┥ Go to 🕒 🕨	FASTHUG		400				800		1000			I Hour	
Input Total (Daily)	Allergies/ADR	•	0	0	0	0	b	0	0	0	0	_	
Input Total (LOS)	Alerts and Isolation Requirements		750	750	750	750	750	750	750	750	750	mL	_
Output	Observations .	•											
Urine Output	Input / Output Devices and Observat	tions 🕨	Lines	•					100			mL	
Urine Output (Estin Stool Measured Vo	PCA / Epidural / Nerve Block	•	Drains	•	Thoracic	ICC -	Apical (Left) #1					None mL	
Gastric Aspirate (R	Schedule a Task		Tubes		Gastrointestinal		Apical (Left) #2					mL	
Gastric Aspirate (D	Timed Interventions		Stomas		Genitourinary		Apical (Right) #1					mL	
Vomitus	Clinical Procedure Safety Checklist (	Timeout)	Stool Cl		Neurological		Apical (Right) #2	þ				mL	
Nasogastric Tube	Progress Notes	•	Stoor G		Other Drains		Mid (Left) #1					Units	~
Orogastric Tube	Nursing Management Plan						Mid (Left) #2						
Nasojejunostomy Orojejunostomy T	Research Studies						Mid (Right) #1						
Drojejunostomy I Nasoduodenal Tu	Patient Belongings						Wid (Right) #1						
Oroduodenal Tub	Weights and Dimensions						wid (Right) #2 Basal (Left) #1						
PEG / Gastrostom	Patient Ready for Discharge						sasai (Left) #1 Basal (Left) #2						
PEJ Tube													
Transpyloric Tube	Nursing Discharge Summary						Basal (Right) #1					_	_
ains						-	Basal (Right) #2						
C - Apical (L) #1					Chest, Upper (	e	stinal Catheter #1					0 d/6 h/14 m	
bes							stinal Catheter #2			*******		0 0/01/14 11	
lasogastric Tube							el Drain - Pleural (		Nare (Righ	nt)		0 d/1 h/51 m	_
							el Drain - Pleural (						
							otomy Reservoir #1						_
							otomy Reservoir #2	2					
						Perica	rdial Drain #1						_
Messages 1	Active user: Sharon Shu	nker	rrent Patient	Location	*Critical Care	St Perica	rdial Drain #2	s:				22/04/201	6 11:50

Adult CC 02(Active)	Medical ges Allers	jies/ADR:	Allergies/	ADR not d	ocument	d Alert	s.:) [Male] [D.O.B: 1	7/11/1964	Admission: 02	2/04/2016 07:	. i 6	- ×
Kenu Nursing	IVIEUICAI Notes	Scores	Dose	& Task List	с	linical Event	s Radiology	End	of Life	Policies & Guide	elines Re	efresh 💙
Clinical Graph Overview Overview Vi		RRT		Plan /	Progress	Prescrib	e Administer	Titrate	Medication			12 5
*Crit	Admission Summary		interv	citatoris	Hotes			medications	nenen	neson		
44 4 Go to • • • • • • • 22/4/	Allergies/ADR			600		800		1000	1100	1200		
Input Total (Daily) 0	Alerts and Isolation Requirements	0		0	0	h	0	0	0	0		*
Input Total (LOS) 750	Progress Notes				750			750	750	750	mL	
Output	Problem List											
Urine Output	Lines / Drains / Tubes	•	Lines →					100			mL	
Urine Output (Estimated) Stool Measured Volume	PCA Order	•	Drains +	Thorac	ic	> IC	C - Apical (Left) #1			_		
Gastric Aspirate (Returned)										_		
Gastric Aspirate (Discarded)	· ·		Tubes -								mL	
Vomitus	· · · ·										mL	•
Nasogastric Tube	· · · · · ·	eout)									Units	<b>~</b> (≈
Orogastric Tube				Other	Drains						0.110	- a
Nasojejunostomy Tube	Event Manager History											
Orojejunostomy Tube	Burns Admission Management					IC	C - Mid (Right) #1					
Nasoduodenal Tube	Research Studies					IC	C - Mid (Right) #2					
Oroduodenal Tube     PEG / Gastrostomy Tube	eNIMC				_	IC	C - Basal (Left) #1			_		
PEG / Gastrostomy Tube	Medical Discharge Summary					IC	C - Basal (Left) #2			_		
Transpyloric Tube		Note:       Score:       Doce & Task List       Clicitation Cleanses       Mole (activity)       Clicitation Clicitations       Mole (activity)       Paticitation Clicitations       Paticitations       Paticitations       Paticitations       Paticitations       Paticitations       Paticitations       Paticitations       Paticitations       Paticitatinations       Paticitations										
				92.92	-	IC	C - Basal (Right) #2					_
Drains						м	ediastinal Catheter #	1				
ICC - Apical (L) #1			Chest	Upper (Left)		— м	ediastinal Catheter #	2			0 d/6 h/18 m	· · · · · · · · · · · · · · · · · · ·
Tubes								-				
Nasogastric Tube								(Rig	iht)		0 d/1 h/55 m	
								-				
								#2				
							ricardial Drain #1					×
Messages 1	tive user: Sharon Shunker Current Patie	ent Locatio	n *Critical	Care Stat	us: Admi	tte Pe	ricardial Drain #2				22/04/2	016 11:54







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Create New Dose For: Sam B	urges, MR number DLSCWS002-D230		A didition and	Information 🛆 🗸 Allerc	jies/ADR
Orderable       ICC - Apical (L) #1       Dose Form     Route       Y     Selection	CLAP V Q St Body Site ct Route V Chest, Upper (Left) V St	Administration time		Internation Anerg	<b>9</b>
rocess style (Localize) Specify duration	hour <b>v</b>				
	This symbol indicates a mandatory form that needs to be completed				
E	Dose Log	Prepare & Initiate	Initiate Prep		Cance

The ICC drain has a mandatory form attached seen in the bottom left hand corner. If a clinician doesn't see that the **Lines/Drains/Tubes** has a mandatory form attached and selects 'Initiate' without completing the form, the system automatically opens that form. The process parameter cannot be initiated without the completion of the form.

As with other forms in eRIC, there are certain fields that are mandatory on this form and need to be completed before the form can be saved. These mandatory fields are highlighted in **bold**.

In the following example, once this form is completed, it will populate data on the tabular view allowing a clinician to continue to record site observations on the drain directly in the tabular view.

ICC Form					Input /C	Dutpu	it tab	view			
14/01/2016 10:12 * *	John Smith / *Adult			<b>\$</b>	Adult Bed 09(Active)	<u>л</u>					
ICC - Apical Left #1					Menu Nursing Clinical Graph Overview Vit	Medic	al Add	Progress Notes	Scores	Dose & Task Li Care Plan Pro	007#55
Proceduralist	Dr Barry Allen				Overview Overview	23:00	10/22/05	Output	100	Interventions No	iotes N
Size					44 4 G0 to • P PP U	11 <sup>00</sup> PM	12 <sup>00</sup> AM	1 <sup>20</sup> AM	2 <sup>00</sup> AM	3 <sup>20</sup> AM	4 <sup>29</sup> AM
	3		Ŧ		Input						
Drain Sutured	Yes No				Crystalloid Input (Interval)	128	228	128	128	128	128
	e tes				Colloid Input (Interval)	0	0	0	0	0	0
Drainage Volume	15 .		mL.		Blood Product Input (Interval) Parenteral Nutrition Fluid In	6	0	0	0	0	0
			121		Oral Fluids			-			-
fotal Volume in Drain	20 🔺		mL		GI Tube Input						
winging/Draining/Bubbling	12.2				Enteral Fluid Input (Interval)	85	35	35	35	35	35
anight of an angle of a bound	D/B		Ŧ		Other Fluid Input				_		
uction: Use the unit of measure	that corresponds to the devic	e bei	ng used.		Totals Input Input Total (Interval)	163	263	163	163	163	163
f there is no suction, please ent			-B asea		Input Total (Daily)	4.312	263	426	589	752	915
					Input Total (LOS)	6.490	6.753	6.916	7.079	7.242	7.405
Suction (cmH2O)	A 7	cmi	H2O		Output				.,		
	la de la deservación de	-	10.		Urine Output	40	10	10	20	50	45
uction (kPa)	A		kРа		> Urine Output (Estimated)				_		_
Drainage Description	1		Ŧ		Stool Measured Volume			100			
	Haemoserous				Gastric Aspirate (Returned) Gastric Aspirate (Discarded)		_	_	_		-
ite Condition	Dressing intact										
					Nasogastric Tube 5						
	Clean				Tube Type		Fine bore 20	_		Fine bore 20	-
	Reddened				ICC - Apical (R) #2		20	-	_	20	
	Swollen				Drainage Volume			50		10	
					Total Volume in Drain			10		60	
	Induration				Cumulative Drainage Volum	10	110	160	60	170	70
	C Tender				Swinging/Draining/Bubbling		_	S/D/B	_	S/D/B	
					Suction (cmH2O) Drainage Description			Serous		Serous	
	Painful				Site Condition			Disselan in		Descing later	
	Oozing				Lines						_
	Exuding				CVC1 Lumen - U (L)	-					
							******		*******	*****	******
	Bleeding			*	Peripheral - Arm, Lower Drains	******	*******		********	*****	
Drain Care					ICC - Apical (R) #2	Chest, Upper (R	ight				
	Assessed			\$	Tubes				*******	*****	******



Another example of a commonly used form is the **CVC Form.** 

				Addit		gies/ADR
Orderable           Orderable           V         CVC 3 Lumens - IJ (L)           Dose Form         Route           V         Select	Body Site	<u>CIAP</u>	Administration time	•	Write dose comment	θ
Process style (Localize) Specify duration	hour 💌					
	Attached Forms – the symbol opens		-			

- Nursing → Input / Output Devices and Observations → Lines → Central Venous Catheter → CVC 3 Lumen → CVC 3 Lumen –IJ (Left)
- Medical → Lines / Drains / Tubes → Lines → Central Venous Catheter → CVC 3 Lumen → CVC 3 Lumen –IJ (Left)

The CVC lines all have attached forms - CVC Insertion / Removal Record. One CVC Insertion / Removal Record form is to be completed if the CVC is inserted in the ICU. The other form is used if a patient is admitted to the ICU with a CVC already insitu. These forms replicate the current state form for CVC (CVAD) surveillance. There are two tabs on the form Insertion and Removal.

When the CVC is inserted, the inserting clinician can complete this form and it will be saved and attached to this process parameter. When the CVC is removed, the second tab on this form (Removal Tab) is completed to document the removal. As with other forms in eRIC, there are certain fields that are mandatory on this form and must be completed before the form can be saved. These mandatory fields are highlighted in **bold**.

Once the forms have been completed, the process parameter is ready to start. This is done by selecting Initiate.

Other Huld Output				2,000	i.				
Totals Output									
Output Total (Interval)	200	100	0	2,000	0	0	0	0	0
Output Total (Daily)	200	300	300	2,300	2,300	2,300	2,300	2,300	2,
Output Total (LOS)	699	799	799	2,799	2,799	Mark Error			
Balances						Revise			
Fluid Balance (Interval)	-198	-98	2	-1,998	2				
						Readministe	r		
🖬 Channel Drain - Pleural (🖛						View Dose			
Cumulative Drainage Volu	20	20	20	20	20	View Section	•		
						Stop			
Lines						•			
Arterial - Radial (R)						Pause			
CVC 3 Lumens - IJ (R)						Dose Log			
Peripheral - Other	hicke hicke hick hick hick hick hick		ha fa ha ha ha ha ha ha ha ha h		General ▶	CVC Insertio	n / Removal Re	cord (IJ, Right)	
Peripheral - Other	-	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			* 15:09 >	Central Vend	ous Catheter In	sertion at Other S	Site

To view the form once the line has been initiated, right click anywhere along the running Lines/Drains/Tubes process parameter.

Select the process parameter (which will be identified as the starting time and not general). At the bottom of that menu are the forms attached to that process parameter, and select the one required to be viewed.



#### **Recording Subcutaneous Line**

Need to select Nursing  $\rightarrow$  Lines  $\rightarrow$  Peripheral Other

		Medical	Add F	rogress Not	tes	S	icore	:s	Dose & Task List		Clinical Events	Radiolog	У
rapi ervi	elect	a Patient			In Ot	put / utput		RRT	Care Plan / Interventions	Progres Notes		Administer Medications	Tit Medi
S	afety	Checklist			-		0	3:00					
F.	ASTH	IUG				200		300	400	500	600	700	
(R A	llerg	ies/ADR						1					
	lerts	and Isolation	Requirements					-					
	)bsen	rations											
tec In	nput	Output Devi	ces and Observa	ations ►		Lines	Þ		Central Venous Cathe	ter ⊧			
tal (al) So	ched	ule a Task				Drains			Arterial Catheter		0	0	
-	imed	Interventions				Tubes			Peripheral Catheter	•	Peripheral - H	land (Left)	
out c	linica	I Procedure S	afety Checklist	(Timeout)		Stomas			PICC		Peripheral - F	land (Right)	
en Pi	rogre	ss Notes				Stool Cl	nart		Dialysis Catheter		Peripheral - A	urm, Lower (Left	)
	lursin	ig Manageme	nt Plan			300			PAC / Atrial Catheter		Peripheral - A	rm, Lower (Rigi	ht)
-	lesea	ch Studies				799			Implanted Port		Peripheral - C	ubital Fossa (Le	ft)
P	atien	t Belongings							Midline Catheter		Peripheral - C	ubital Fossa (Ri	ght)
ter v	Veigh	ts and Dimen	sions			2			Intraosseous Catheter		- Peripheral - F	oot (Left)	
- <b>P</b> P	- atien	t Ready for D	ischarge						ECMO / VAD		- Peripheral - F	oot (Right)	
-		g Discharge S	-			20		20	20	20	Peripheral - S		
											Peripheral - S	-	
nage Volu.	1	22	22	22		22		22	22	22	Peripheral - S		
nage Volu.		25	25	25		25		25	25	25	Peripheral - 0		
lage volu.	4		25	25		23		23	2.5	23	renpherai - C		

This then opens the Lines Orderable Form.

**NOTE:** In Route  $\rightarrow$  specify 'subcutaneous' OR 'Regional Nerve Block'  $\rightarrow$  specify body site e.g. 'Abdomen', add comments if necessary  $\rightarrow$  click Initiate.

	e i i i i i i i i i i i i i i i i i i i						CIAP				26G Butterfly Subcutaneous	θ
♥ ▼	Peripheral	- Other				•	Q 🛱				Needle for Palliative Analgesia	-
ose Forr	n	Route			Body Site			Administ	ation time			
		Subcut	t	•	Abdomen		•	03/	03/2017 10:24	▲ <b>▼</b>		
	yle (Localiz	->										
	duration	2)										
specify	uuration		hour	•								
								Co-sign fo	r administration			
								Co-sign us			Password:	
								Co-sign us	er:		Password:	

This then populates on the Input/ Output tab view as Peripheral Other, use the hover to bring up the yellow box with details.





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Input Total (LOS)	4,962.2	4,962.2	4,962.2	4,962.2	4,962.2	4,962.2	4,962.2	4,962.2	1	4,962.2	4,962.2	4,962.2	4,962.2	mL	
Output									1						_
									į.						~
🖬 Drain #1 🛛 🚍									}					Units	<u> </u>
Drainage Volume						10			1	Dose Detail		_		mL	
Total Volume in Drain						10			1	Peripheral -				nL	_
Cumulative Drainage Volu						10	10	10		10 Subcut Abd				nL	- 1
Vacuumed						No			1	Administrat	on time: 03/03,	2017 10:18		None	_
Drainage Description						Haemoser+	-		1			/C needle for F	alliative Analgesia	None	
Site Condition						Dressing i+	-		1	Dose Status				None	
Drain Care						Assessed; +	-		•		Status: Not Pre Section de			None	_
										Peripheral -		ldll5			
Lines											t time: 03/03/20	)17 10:18			
Peripheral - Other										A				0 d/4 h/19 m	
Drains															_
Drain #1							Abdomen (Left	)	<b>&gt;</b>	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				0 d/4 h/42 m	
Messages 1	Active us	er: Sharon Sh		unt Patient Loc	ation PMR-IC	U Status: A	dmitted	Research S	Studio	s] .				03/03/2017 1	1.3

# 8.1.7 Medications

Medications will be covered in detail in its own module. Part of the review of the patient will involve a review of the medication tabs.

Medications have four tab views as shown below: Prescribe Administer Titrate Medication Medications Medications Review

#### **Prescribe Medication**

ICU medical staff will use the 'Prescribe Medications' tab 'Order Timeline' view for prescribing all medications – this will include IV fluid orders and drugs that run as continuous infusions.

Pilot Release 04(Active	•) [00000	01) Jessica B	ue Aller		cillin Alerts.: Female	D.O.B: 12/05/1983		100 . 33.3 year Latest Weigh	it: 70kg			
Menu Nursing Clinical Graph Vital	Medical	Add Prog entilation Neuro		Scores	Dose & Task List	Clinical Events Progress Progress Progress	Radiology End	of Life Policies & Guidelin Medication Sepsis	nes Refresh Metabolic Wound	Help & Reports	Log C	out
Overview Overview	08:32	entilation Neuro	Pain	utput RR	Interventions	Notes Medications N	Iedications Medications	Review Sepsis	Metabolic Wound	8	1 Hour	
Go to · · · · ·	17/1/16 8 <sup>21</sup>	928	1023	1120	1223	1323 1423	1528	1623 1723	1828	1923		
Actions awaiting sig	inature	Sign Now!	<	Prescribe	Prescribe Fresh Blood Pro and Albumin	ducts Prescribe TPN Products	Medication List	Weights and Dimensions	CLAP	Antimicrobial Stewards Policies and Guideline	Ng./ es	>
Medications	Í								í .			
Ceftriaxone 1 g,IV,8D (08:00 20:00),Injection										\$	9	
entanyl 500 microg,IV,Continuous,Inject		2	)	_		10					microg/hour	r
leparin 5,000 Unit(s),Subcut,BD (08:00										5,000	Unit(s)	
fagnesium sulfate 20 mmol,IV,Once Only,Injection	ð										mmol	
icotine 21mg/24hrs Patch Patch Transdermal Morning (0											Patch	
antoprazole 40 mg,IV, 10:00,Injection		*									mg	
otassium chloride (mmol) 20 mmol,IV,Once Only,Infusion		*									mmol	
PRN Medications			_									
Netoclopramide 10 mg,IV, every 8 hour, Injection											mg	
Fluids/Blood Products	1											
odium chloride 0.9% 1,000 mL/V, Continuous, Infusion.	200		_						100		mL/hour	
odium chloride 0.9% 00 mLIV, Continuous, Infusion.	1										mL/hour	
Nutrition												
Messages	_				cation PMB-ICU Stat	tus: Admitted Research	Construct				18/08/201	

**NOTE**: The Medication List on the Prescribe Medication tab – is useful for reviewing the whole list of Patient medications. It needs to be set to a 7 day view so that weekly medications can be reviewed.

#### **Administer Medication**

The 'Administer Medication' tab is used to view medications that have been administered and medications that are due and when they are due (this is in a Cardex view). However it is better to use the 'Dose &Task List' to view medications that are due to be administered.

Cardex Dose view is a timeline display on the Flow sheet, showing the status of both planned and administered doses. The doses in the Cardex Dose view are displayed in different colours according to the time of their planned administration. This view will be covered in more detail in the medication module.





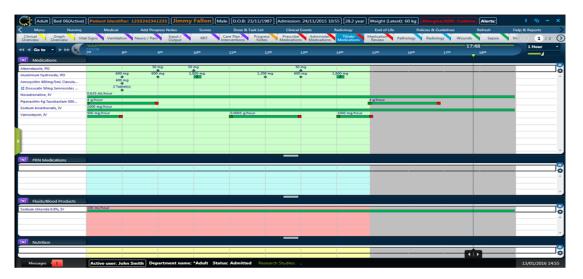
eRIC User Guide - Module 3: Daily Routine

Adult Bed 06(Active)	Patient Ident	tifier: 123324234	1235) [Jimm	y Fallon Male	D.O.8: 23/11/1	987 Admission	: 24/11/2015 1	255 28.2 year	Weight (Latest	): 60 kg Allergiew	ADR: Codeine	lierts:	i na -	*
Kenu Nursing	Medical		gress Notes	Scores	Dose & Task List			Radiology	End of Life	Policies & Guio	lelines Ref		Help & Reports	>
Clinical Graph Overview Vita	al Signs Ventila	ation Neuro / Pa	n Input/ Output	RRT Cinto	re Plan / Progr inventions Noti	ess Prescribe Medication	6 Administer Medications	Titrate Medications	Review P	sthology Radiolog		Sepsis	Me 🕓 🚺 / 2	$\sim$
<f 4="" go="" to="" 🔹="" 🕨="">&gt;&gt; 💽</f>	*Adult 13/1/16 700										17:48	<u>م</u>	1 Hour	-
(  Medications											, T			
# Abacavir 600mg Lamivudine						S						$\odot$		
Albendazole		-	Y	✓ x2	<b>N</b>	2	K K	X2	<u></u>	$\odot$				-
Aluminium hydroxide		K K	<b>S</b>	🗹 x 2	,	S 82	<b>S</b>		<u> </u>	$\sim$	_			
Amorycillin 400mg/SmL Clavula					- <b>-</b>			<b>a</b>			ē			
# Docusate 50mg Sennosides	-	<b>S</b>						-						- 1
Piperacillin 4g Tazobactam 500mg	S							8						- 1
Sodium bicarbonate										_				- 1
Vancomycin									-			ę		- 11
														- 1
														- 11
														- 1
														- 1
2		-						-					_	- ×.
PRN Medications														
Paracetamol				1										<b>_</b>
														- 6
														- 1
						_								
Fluids/Blood Products														
														1
													_	
													_	
						-								
(     Nutrition														
	-	_												~
Messages 1	Active user: .	John Smith De	partment name	Adult Status	Admitted Re	search Studies:							13/01/2016 1	4:53

#### **Titrate Medications**

The 'Titrate Medications' tab is where you can view medications that are running and see the rate and performed actions. This is a 'Gantt view'.

The Gantt Dose view is a timeline dose display, displaying doses as bars and diamond symbols. This view is useful for managing running doses. This view will be covered in more detail in the medication module.



#### **Medication Review**

The 'Medication Review' tab has additional sub menus and forms for New Medication Review, Dispensing Report and Pharmacy Progress Notes. It provides access to CIAP and policies and guidelines. Medication Reviews that are written by the Pharmacist will appear as an alert in 'Red' at the top of the Medical Ward Round Note.

			ical	Add Progress Not	les	Scores	Dose & Task	List	Clinical Events	End of Life	Poli	cies & Guide
v l	Graph Overview	Vital Signs	Ventilation	Neuro / Pain	Input / Output	RRT	Care Plan / Interventions	Progress Notes	Prescribe Medications	Administer Medications	Titrate Medications	Medication Review
o to	(	STG-ICU1 31/3/17	100	200	200	400	E00	c00	700	000	000	10:1 10 <sup>00</sup>
o to		000	100	2 <sup>00</sup>	300	400	5 <sup>00</sup>	6 <sup>00</sup>	7 <sup>00</sup>	800	900	
		o Overview	Overview Vital Signs	Overview Vital signs Ventilation	STG-ICUI			Overview Vital signs Ventulation Neuro / Pain Output RKI Interventions STG-CUI	Overview     Vital signs     Ventilation     Neuro / Pain     Output     KR1     Interventions     Notes       5 to     > b     StG-COUL 31/3/17     100     200     300     400     500     600	Overview     Vital signs     Ventilation     Neuro / Pain     Output     KK1     Interventions     Notes     Medications       5 to     > to     \$13,17.7     100     200     300     400     500     600     700	Overview     Vital signs     Ventulation     Neuro / Pain     Output     NRI     Interventions     Notes     Medications       > to     > >>>     \$TC=CULT     \$TC=CULT <td>Overview Vital signs Ventulation Neuro / Pain Output NRI Interventions Notes Medications Medications Medications</td>	Overview Vital signs Ventulation Neuro / Pain Output NRI Interventions Notes Medications Medications Medications



### 8.2 Assessment

Nursing and medical assessment of the ICU patient forms an essential part of the daily / shift routine. The forms for documenting the assessment findings can be found under the 'Nursing' menu, 'Medical' menu or the 'Add Progress Notes' menu.

In addition, the scores for a patient, such as 'Falls Risk Assessment' and 'Pressure Injury Risk Assessment', will also need to be attended and documented.

Adult Bed 01(Active	) <mark>314967-H272</mark> J	ohn Victor El	NGLISH	Allergies/ADR: penicillin Male D.O.B: 16/02
Menu Nursina	Medical	Add Proare	ss Notes	Scores Dose & Task List
nical Graph rview Overview Vi	tal Signs Ventilation	Neuro / Pain	Input / Output	R Alcohol Withdrawal Scale scril
	STG-CICU			Behavioural Pain Scale
🖣 Go to 🔄 🕨 🔛	7/4/17 5 <sup>00</sup>	600	700	CAM-ICU
put Total (Daily)	212	364	677.7	Critical-Care Pain Observation Tool
iput Total (LOS)	1,238.2	1,390.2	1,703.9	Clinical Opiate Withdrawal Scale
utput				Falls Risk Assessment Tool
rine Output				Glasgow Coma Scale
rine Output (Estimated)				2
tool Measured Volume				Injury Severity Score
astric Aspirate (Returned)				Physiotherapy Assessment Tool
astric Aspirate (Discarded)				Pressure Injury Risk Assessment
omitus				
omitus (Estimated)				Manual Handling
rain Output Total (Interval)	0	0	0	ICU Scores
I Output (Interval)	0	0	0	ANZICS
t Fluid Removal				

# 8.2.1 Nursing Assessment

This occurs at the start of each shift and it can be documented as per local practice guidelines as a Nursing Assessment Note (Head to Toe) *OR* Nursing Assessment Note.

To access the forms via the 'Nursing' menu, go to:

Nursing  $\rightarrow$  Progress Notes  $\rightarrow$  Nursing Assessment Note (head to toe) *OR* Nursing Assessment Note (ABCDEFG).

Menu N Clinical Grap Verview Overvie	Select a Patient		Progress Prescrib	Administer Titrate Medicatio	Policies & Guidelines Refresh Sepsis Metabolic Wounds	Help & Reports	Log Out
verview Overvie	Safety Checklist	nput / RRT Care Plan / Dutput Intervention	s Notes Medicatio	ns Medications Medications Review	sepsis Metabolic Wounds		
9 + /	FASTHUG	Ψ.	From	17/08/2016 8:23 A 🔻 To 18/	08/2016 12:30 🔺 🔻 🕨		
lime	Allergies/ADR		User	Action			
	Alerts and Isolation Requirements		Kave Williams				2
8/08/2016 11:50	Observations +			Save			
06:44	Input / Output Devices and Observations   Schedule a Task		Kaye Williams	Save			
02:40	Timed Interventions		Kaye Williams	Save			
7/08/2016 22:49	Clinical Procedure Safety Checklist (Timeout)		Kaye Williams	Save			
22:47	Progress Notes	Nursing Assessment Note Olead to	a Tee)	Save			
22:47	Nursing Management Plan	Nursing Assessment Note (ABCDE)		Save			
22:46	Research Studies	Nursing Progress Note	e Williams	Save			
22:45	Patient Belongings	Family Meeting Note	e Williams	Save			
22:00	Weights and Dimensions	Research Progress Note	e Williams	Save			
18:22	Patient Ready for Discharge	Trauma Tertiary Survey Note	e Williams	Save			
16:00	Nursing Discharge Summary	Referral/Consultation Form	e Williams	Save			
15:04	®Nursing Assessment Note (Head to Toe	)	Kaye Williams	Save			
09:13	#Medical Ward Round Note		Kaye Williams	Save			

**Nursing Assessment Note (Head to Toe):** this consists of free text boxes that need to be completed. Each time you open the assessment form it takes you to a new session. Previous session entries can be viewed and accessed from this form or from the 'Add Progress Notes' menu.

Better patient outcomes by clinicians, for clinicians across NSW



**NOTE:** When entering a new assessment always check that you are documenting in a new session and not overwriting someone else's session or adding to someone else's session. You can open and read a session that has been entered by someone else, but if you want to make an entry you need to open a new session. Check the session user name, date and time.

22/04/2016 15:00 🔺 🔻 🏹	Sharon Shunker / *Critical Care		Previous Session	*
rsing Assessment Note				
neral Note				
	Allows you to coroll between accessor			
urological Assessment	Allows you to scroll between session	ns		
spiratory Assessment				
· · ·				
Print		Save	Save and Clos	e Car
Print		Save	Save and Clos	e Car
		Save	Save and Clos	e Car
	ment Note (Head to Toe) : New Session	Save	Save and Clos	e Car
	ment Note (Head to Toe) : New Session Kaye Williams / STG-CICU			e Car
John Victor ENGLISH - Nursing Assess				,
John Victor ENGLISH - Nursing Assess				,
John Victor ENGLISH - Nursing Assess				,
John Victor ENGLISH - Nursing Assess				,
John Victor ENGLISH - Nursing Assess				,
John Victor ENGLISH - Nursing Assess				,
John Victor ENGLISH - Nursing Assess				,
John Victor ENGLISH - Nursing Assess				,
John Victor ENGLISH - Nursing Assess				,
John Victor ENGLISH - Nursing Assess				,
John Victor ENGLISH - Nursing Assess				,
John Victor ENGLISH - Nursing Assess				,
John Victor ENGLISH - Nursing Assess           10/04/2017 8:24       *       *       *         Social Assessment        Nursing Management Plan				,
John Victor ENGLISH - Nursing Assess				,

At the bottom of the Nursing Assessment form is the 'Medical Ward Round' button – clicking on this opens up the 'Medical Ward Round' form.



# 8.2.2 Wound Assessment

Wound Assessment forms part of the nursing and medical assessment. Detailed findings and description of wounds as well as the wound management plan is documented under the Wound tab view.

Clinical Graph Verview Vital Sign	Medical S Ventilation	Allerg	Scores Dose	rts.: Female D.O.B: 12, & Task List Clinical re Plan Progress Notes N		End of Life Titrate Medication	Policies & Guidelin		Help & Reports	Log Out
Go to     Current Wounds	<u>7</u>		nd Status	12 <sup>23</sup> 13 <sup>23</sup> Ongoing Burn Dressing	1423 2	16 <sup>20</sup>		Shoppi	ng Cart	
W_Foot Right Status 2 W_Leg Right Status 1		vvour		Un	der active management der active management		Ē	Tab	oular	)
Wound & Burns Care Orders Vound Care - Leg Right 3 oprat, Once Only, comfeti det Vound Care - Cert Right 1 oprat, Once Only, Rij middle to		* *					C	Order 1	rimeline	
Wounds & Burns unds sund Care - Foot Right 1 sund Care - Leg Right 3		⊻ ⊻					ſ	Car	rdex	
Messages	tive user: Shan	Supplication (Gr	rrent Patient Location PM	R. I.C.I.) (Statur: Admitta	Research Studies:				19	/08/2016 14

The tab is broken down into four views:

- Wounds shopping cart this view contains a shopping cart to validate all wound treatments that are planned for the patient
- Wounds tabular view from this view a user can see how many wounds the patient has and the current status of each
- Wound care order timeline view of the treatment and the status of the care for the patient (this view will be talked about in more detail in the medications lesson)
- Wounds cardex this view allows a user to see what treatment and medications are due and when they are due.

**The Order timeline view** enables a user to view and manage a patient's treatment plan and doses on a continuous timeline. It also displays all of the treatments that a patient is, was, or will be undergoing (the orders timeline view can also be utilised in the planning stage).

#### The shopping cart view has two buttons on it:

Body chart (This button opens up the body chart → click on the area of the wound → this opens a new window that allows Wound Details, Management Log and images to be entered). The wound detail form is used for entering wound status, type, location, description, dressing, relevant wound details and treatment plan of the wound. The management log is used for documenting the wound care progress notes. The Images button allows scanned pictures / images of the wound to be uploaded.





One solution



asters   Male   D.O.B: 29/01/19	937] [Admission: 02/02/2015 0:00] [78.9 year] [Weig	ht (Latest): 97 kg	Allergies/ADR: penicillins,adrenal cortical storoids
Thomas Masters - Wound N	lanager : New Session		9
Overview Data (System) Body Overview (Click Save to R	lefresh On Screen Data)		
Overview (Click Save to R Body Overview (Click Save to R Click	ent	s Management	sok Empty Empty Empty Empty Save Save and Class Cancel
: Sandbox - Adult Status: Ad	mitted Research Studies: T.E.X.T.A .		
Com Russons - Woun	d - Hand Left 1 : New Session		×
24/04/2016 16:0		er / Sandbox - /	Adult SPrevious Session 🔅 🔾
Detail	Management Log		Images
Detail			
Wound Status	<b>•</b>	Date Identifie	ed
Present on Admission	Yes No		▲ <b>▼</b>
Wound Type	Burn Pressure injury Skin condition Surgical wound Traumatic wound Extravasation Other		
Wound Location		Infection	
Length	▼	mection	No sign Suspected
Breadth	▲ ▼ cm		Suspected (swab atten
Depth	cm		Confirmed
			Save Save and Close Cancel





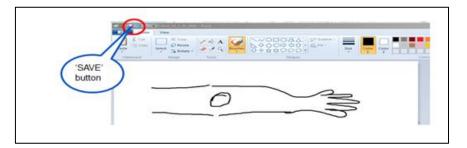
Ongoing Burn Dressing (This button opens up the Burns Area Form → click on the relevant Burn area → this allows you to enter details about the Burn wound and the management of the wound. The button at the bottom of this window 'Schedule Dressings' can be used to schedule ongoing dressings).

29/12/2016 13:42 🔺	None !	Sharon Shunker / PM	IB-ICU	🕄 Previo	us Session 🔅 🔾
Burn Area(s)					
Burn Area 1	Summary	Site: Chest Description: partie	I thickness burn		
Burn Area 2	Summary	Site: Description:			
Burn Area 3	Summary	Site: Description:			
Burn Area 4	Summary	Site: Description:			
Burn Area 5	Summary	Site: Description:			
		Site:			
Burn Area 6	Summary	Description:			\$
Burn Area 6				Save	and Close Cancel
el Burgess - Burn Area 1 : New Se 29/12/2016 13:45 • V	ssion				
el Burgess - Burn Area 1 : New Se 29/12/2016 13:45 A V Se 29 Burn Care	ssion None Sharon Sh	Description:	(fabr	[	And Close Cancel
1 International State St	ssion	Description:	/ <b>Status</b> Debridement	Under active	and Close Cancel
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el Burgess - Burn Area 1 - New Se 29/12/2016 13:45  V Sum Care Sum Care Site Cleansing Solution Depth Primary Dressing Compression	ssion None Sharon Sh	Description:	Debridement Ointment Secondary Dressing	Under active	and Close Cancel
el Burgess – Burn Area 1 : New Se 29/12/2016 13:45 A V Sine Care / Site / Site Description Cleansing Solution Depth Primary Dressing Compression Exudate Description	ssion None Sharon Sh	Description:	Debridement Ointment Secondary Dressing	Under active	and Close Cancel
el Burgess – Burn Area 1 : New Se 29/12/2016 13:45 A V Sine Care / Site / Site Description Cleansing Solution Depth Primary Dressing Compression Exudate Description	ssion None Sharon Sh	Description:	Debridement Ointment Secondary Dressing	Under active	and Close Cancel

#### Saving Images

Images – Burns / Wounds or any other images:

- Users should choose the Save button to save images and not the 'Save As' button
- The **Save** button automatically saves the image in a central depository in the database that can be accessed by other users, whereas if the 'Save As' button is used, users may have the choice, and access rights, to save the image to another location
- This will be an issue for other users who logon and try to view the image as they will not have access to it







# 8.2.3 Medical Ward Round

The Medical Ward Round Note contains free text boxes used to document:

- Assessment / Examination (Option of Inserting Assessment Headings)
- Significant Interventions and Events (allows users to maintain an ongoing account of the significant interventions and events during a patients stay)
- Data is cumulative, each previous record pulls into the new form
- Problem List (Active, Resolved, Chronic)
  - Data is cumulative, each previous record pulls into the new form
- Medical Management Plan
- Job List
- There is a tick box at the bottom of the form Are end of Life Care discussions likely to occur in the next 24-hours?

The Medical Ward Round field is very important as the data is cumulative, each previous record populates into a new form so a doctor can see and remember past events that have happened. Data from the medical ward round also feeds into the Medical Discharge Summary form.

If there is a medication review recommended by Pharmacist an alert for this appears on the Medical Ward Round note

Like all progress notes, each time you open the form it takes you to a new session. Previous session entries can be viewed and accessed from this form or from the 'Add Progress Notes' menu.

Pilot Release D		10001) Jessica Blue Allergies/ADR: per rdical Add Progress Notes Scores		i/1983 Admission: 17/08/2016	09:00 . ] [33.3 year ] Latest W End of Life Policies & C		Help & Reports	1 % - X
Clinical Graph Overview Overview	Vital Signs	A		escribe Administer Titrate lications Medication Medication	Medication	Metabolic Wounds	нер а мрота	tog oor
9 + / 0	ي (ي	Altergies/ADR Altergies/ADR Alerts and Isolation Requirements	▼ From	17/08/2016 8:23 🔺 🔻	To 18/08/2016 12:30	A Y 🕨		•
Time	Bescr RNursi	Progress Notes +	Medical Ward Round Note	Action				÷.
18/08/2016 11:50 06:44	@Nursi	Problem List Lines / Drains / Tubes	Medical Progress Note SITO Family Meeting Note 3005	Save				
02:40	Medic Medic	IABP Insertion / Removal Physical Restraint(s) Order	Acute Pain Service Note ams Research Progress Note ams	Save				
22:47	@Medk	Clinical Procedure Safety Checklist (Timeout) Nitric Oxide Order and Observations	Trauma Tertiary Survey Note Echocardiography Report	Save				
22:47 22:46	@Physi @Medk	Burns Admission Management Research Studies	Referral/Consultation Form 3ms Medication Reconciliation 3ms	Save				
22:45	@Medk @Nursi	eNIMC Medical Discharge Summary	Resuscitation Plan Note ams Kaye Williams	Save Save				
18:22	®Nursing	Progress Note	Kaye Williams	Save				
16:00		erapy Initial Assessment Note Assessment Note (Head to Toe)	Kaye Williams Kaye Williams	Save Save				
09:13		Ward Round Note	Kaye Williams	Save				
Messages 1	Active	user: Shan Swaminathan Current Patient L	ocation PM8-ICU Status: Admitted	Research Studies:				18/08/2016 12:31

**NOTE:** Never open another person's note and add to it – ALWAYS open a NEW SESSION.





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1 Sam Burges - Medical Ward Round Note : New Session			•	•
22/04/2016 15:49 🔺 💌 🏠 Sharon Shunker / *Critical Care	SPrevious Session	\$	¥	
Medical Management Plan				
			]	
				l
Are find of life Discussions Likely to Occur in the Next 24br				l
Are End of Life Discussions Likely to Occur in the Next 24hrs				
Nursing Assessment Admission Sumr	nary FASTHUC	;	* *	
Print Save	Save and Close	Ca	ancel	

The buttons at the bottom of the form allow access to the 'Nursing Assessment' form, 'Admission Summary' form and 'FASTHUG' form.

# 8.2.4 Scores

- The Scores for the patient such as 'Falls Risk Assessment' 'Pressure Injury Risk Assessment' will need to be attended and documented.
- These can be accessed from the 'Scores' menu → select desired score → click on it to open the form → complete requisite information → this will then populate the appropriate view (e.g. sedation score will appear in the Neuro/Pain tab view).

Some of the Score forms have buttons that open new forms. The 'Falls Risk Assessment Tool' (example below), has a button on the bottom of the form that opens the 'Falls Risk Management Plan' and also links to 'Policies and Guidelines'.

Rdult	01(Active)	A143121-H	272 Eric Master	Allergies/ADR:	No allergies/ADR or intoler	ances re
Menu	Nursing	Medical	Add Progress Not	es Scores	Dose & Task List	Clinical E
Clinical Overview	Graph Overview	/ital Signs	Ventilation Neuro / Pai	n Input Outpu	Alcohol Withdrawal Scale	ress
	_	PMB-ICU			Behavioural Pain Scale	
🔫 🖣 Go to	- > > <b>A</b>	31/3/17 12 <sup>00</sup> AM	100AM	21	CAM-ICU	400A
	2	00			Critical-Care Pain Observation To	ol
	1	80			Clinical Opiate Withdrawal Scale	
HR ABPs	1	60			Falls Risk Assessment Tool	
ABPd	1	40			Glasgow Coma Scale	
× ABPm     ABPs	1	20			Injury Severity Score	
▼ NIBPd	-	00			Physiotherapy Assessment Tool	
× NIBPm — SpO2		80			Pressure Injury Risk Assessment	
- <b>O</b> - RR (Total)		60 40			Manual Handling	
		20			ICU Scores	•
		0			ANZICS	





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1 Sam Burgess - Falls Risk Assessment Tool (Adult) : New Session					×
24/04/2016 17:22 • 💌 🏠 Sharon-Ann Shunker / Sandbox - Ad	lult		(	Previous Session	<b>\$</b>
4. Toileting					
A.) Are there any alterations in urination? (i.e. frequency, urgency, incontinen	ice, nocturia)	Yes to any = 2		4A.	•
5. Transfer Score, means from bed to chair and back					
A.) Independent - use of aids to be independent is allowed			5A.		v
Minor help - one person easily or needs supervision for safety Major help - one strong skilled helper or two normal people; physical can sit Unable - no sitting balance, mechanical lift					
6. Mobility Score					
Walks with help of one person (verbal or physical) Wheelchair independent including cornering Immobile	Add scores for question 5 and 6 togeth If total value equals or between 0-3 then score = 0 If total value equals or between 4-6 then score 7	er	6A.		•
Falls Risk Assessment Score					
A score of >=9 means the patient is at risk of a fall and must have a docur	mented falls management plan.		fotal Score	Not Assessed	
NB If the patient scores less than 9, use clinical judgement to determine if th e.g. due to polypharmacy, psychotropic or opiate medication.	e patient could still be at risk of fall				
Please refer to the Policies and Guidelines and initiate a Falls Risk Assessme	nt Management Plan.	Falls Risk Management Plan	Policies an	d Guidelines	4 5
			Save	Save and Close	Cancel

Abbe of hospital admission <ul> <li></li></ul>		Seginal The / GES   Labe		
COU admission date       If 1000/001717144       Network         COU admission date       If 1000/001717144       Network       Officecomy         Electric surgery       Electric admission       If the admission planed/       Electric Admission         Cadde arrest in previous 24       If the admission planed/       Electric Admission       If the admission planed/         Cadde arrest in previous 24       If the admission planed/       If the admission planed/       If the admission planed/         Cadde arrest in previous 24       If the admission planed/       If the admission planed/       If the admission planed/         Cadde arrest in previous 24       If the admission planed/       If the admission planed/       If the admission planed/         Cade arrest in previous 24       If the admission planed/       If the admission planed/       If the admission planed/         Cade arrest in previous 24       If the admission planed/       If the admission planed/       If the admission planed/         Cade arrest in previous 24       If the admission prophylexis       If the admission prophylexis       If the admission planed/         Cade arrest in previous 24       If the admission planed/       If the admission planed/       If the admission planed/         Date of birth       If the admission planed/       If the admission planed/       If the admission planed/       If the ad	circle reality	scang das des l'eas		
Cur demission det       F 1/02/2013 1244       Cut demission source       O'Encompy         Electre surgery       Electre Burgery       West the admission planned/       Electre Admission         Cur due and the admission admission       Internet openies       Internet openies       Internet openies         Cur due admission       Internet openies       Internet openies       Internet openies       Internet openies         Cur due admission admission       Internet openies       Internet openies       Internet openies       Internet openies         Cur due admission admission       Internet openies       Internet openies       Internet openies       Internet openies         Paised Debit       Internet openies       Internet openies       Internet openies       Internet openies         Date of Binh       If Internet openies       Internet openies       Internet openies       Internet openies         Date of Binh       If Internet openies       Internet openies       Internet openies       Internet openies         Sex       Female       Program       Residering Internet openies       Internet openies         Date of Binh       Integram       Integram       Integram       Integram         Date of Binh       Integram       Integram       Integram       Integram         Date of Binh				
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Treatment gals on admission	CU admission date	F 17/03/2017 17:46 Refrest	ICU admission source	OTJRecovery
Cardia arrest in previous M order of an emergency response? Type of care on admission Type of ca	lective surgery	Elective Surgery	Was the admission planned?	Elective Admission 💌
hours?	reatment goals on admission	×		
Carefordiantiantianti di la construccióne programma della construccióne programma della construccióne programma della construccióne della construcció	ardiac arrest in previous 24 ours?		Type of care on admission	
Participant index     Factorial indexes key     Biological indexes key       Date of birth     pr     Biological indexes key     Biological indexes key       Height     170 cm     Weight     60 kg       Sex     Female     prestancy status of a female     w       Detected birth     mdgenous     Besternal postcode     1435       Discharge deta     100 oxforme     w	are unit identifier	-	Thromboembolism prophylaxis	
Patent identifier     4     Studiatial linkage kay     INCONSISTENT       Date of Birth     pr     2020212777     Age     ps     rear     0       Height     170 on     Weight     60 kg     Inconsistent linkage kay     0       Indigenous status     Indigenous status     Residential postande     Inconsistent linkage kay     1435       Discharge detail     Inconsistent linkage kay     10U indoame     Inconsistent linkage kay     Inconsistent linkage kay		CAREUNIT		
Date of Birls     IF				
Date of Binh     pr     piccologizarra     Age     piss     rear     0       Height     170 cm     Weight     60 kg       Sex     Female     pission     e       Indigenous status     Pregulancy status of a female     v       Discharge belak       ICU douburge decision date	abent identifier	4	Statistical linkage key	,
Sex Premale Porparent riskus of a female Discharge beilder Discharge beilde DOU discharge decision dete Comparent Porparent	Date of Birth	02/03/1978	Age \$9.1 ye	
Indigenous status Indigenous status Indigenous status Residential postocide 1435 Discharge data ICU sicharge decision date ICU si	leight	170 cm	Weight	60 kg
	jex -	Female		
ICU discharge dete r 1CU sutcame S	ndigenous status	Indigenous	Residential postcode	1435
ICU discharge decision date	ischarge Details			
	CU discharge date		ICU outcome	T
Date of hospital discharge Hospital outcome	CU discharge decision date			
	Date of hospital discharge	<b>_</b>	Hospital outcome	<b>_</b>
	NOT SELECT THE "ANZIES B	ecord Complete" CHECKBOX UNTILLAL	L DATA FIELDS HAVE BEEN COMPLETED	
10 NOT SELECT THE "ANZICS Record Connelete" CHECKBOX UNTILLAIL DATA FIELDS HAVE BEEN COMPLETED				
	· Ready for Expant			
00.001 SELECT THE "ANZICS Record Complete" CHECKBOXUNTILLALL DATA FIELD SHAVE BEEN COMPLETED				

#### **ANZICS** Data Form

This form is located under the scores menu. It will be used to capture data required for the ANZICS Data submission.

- It captures the demographics and most of the information from the ANZICS tab within the admission summary.
- The APACHE III AND APACHE II Chronic conditions are captured
- Diagnosis is documented here.
- Most physiologic findings are going to be recorded at this tab. Majority of the items are automated However, some fields are manual like GCS and a few others.

# 8.3 Plan of Care / Interventions

The 'Care Plan and Interventions' tab is where nurses plan the care for a patient.

#### Plan of Care

- Upon completion of the nursing assessment, nurses can develop a plan of care/interventions for the shift.
- This can be entered in the Nursing Management Plan (free text box) or can be entered as scheduled tasks and timed interventions. If entered as scheduled tasks and timed interventions, then as outlined above, they can be viewed in the 'Care Plan / Interventions' tab.
- On completion of the Medical Ward Round, medical staff can develop a Medical Management Plan. This is a free text box within the Medical Ward Round form.





Plan of care will include:

- Scheduled tasks
- FASTHUG check
- Review Pathology
- Review Radiology
- Document and review clinical events
- Complete progress notes these are done contemporaneously includes the daily / shift management plan for the patient
- Monitoring and management of special supportive therapies such as RRT, ECMO, IABP, pacing.

		Pilot Release 04(Acti Menu Nursing	Medical	Add Progress		ires Doge	a tax list	<b>Clinical Events</b>	Radiolog	y End of Li	fe Polici	ies & Guidelines	Refresh	Help & Reports	s Log Out
		Clinical Graph Overview Vit	al Signs Ventila	ition Neuro / Pa	in Input / Output	RRT	re Plan / Progr reventions Not	ess Prescrib Medicatio	Administer Medications	Titrate N Medications	ledication Review	Sepsis Metabo	olic Wounds		
		44 4 Go to 🔹 > >> 🐙	PM8-ICU 17/8/16 8 <sup>23</sup>	09:32 9 <sup>21</sup>	1023			13 <sup>23</sup>	1423	1521	16 <sup>23</sup>	1723	1823	1923	1 Hour
	_	Assessment Frequency													None
		Vital Sign Frequency													
Care Plan		Blood Glucose Frequency													
ourerium		Neuro Assessment Frequency	(												
	· ·	Gastric Aspirate Frequency													
	- 1	Urine Output Frequency													
		Pressure Area Care Frequenc	ý	1											
		Mobility & Hygiene													-
		Pressure Area Care Patient Position		Low fowler's	.7 Mattress - pre		Mattress - pre High fowler's			Low fowler's		Right lateral		High fowler's	
		ROM Exercises	Low towier s	Low towler's	Low towier's	High towier's	High towler's	Lett lateral		Low towier's		Kight lateral		High towier's	
		Arm Splints													-
		Leg Splints		1											
		VTE Prophylaxis										-			
		Hygiene Performed		Eve care:Mout.	đ	Eye care;Mout									
		Ventilation													
		O2 Delivery Device		1											
	1. K	Subglottic Suction						Yes		Yes		Yes		Yes	
Timed															
nterventions		Ventilation													
ner venuona		Ventilation (Invasive)													1 d/5 h/48 m
	i	(o) Tasks						-							
asks Cardex		-													
		Perform Oral Care		<ul> <li>✓</li> <li>✓</li> </ul>		<ul> <li>✓</li> <li>✓</li> </ul>		<ul> <li>✓</li> <li>✓</li> </ul>		<ul> <li>✓</li> <li>✓</li> </ul>		<ul> <li>✓</li> <li>✓</li> </ul>			
View		Perform Pressure Area Care				<b>S</b>		<b>S</b>		<b>S</b>		<b>S</b>		1	
	- 1	Wound Care - Foot Right 1		S S											
	1 I	Wound Care - Leg Right 3													
asks Order		Orderable			Menu button	Freque		ler	ation	Ordered by		Start de	te & time	Stop	
	$\sim$	Perform Oral Care			-				ect Body Site	Kaye William				No time limit	
Profile View						every 2									
	4 I	<ul> <li>Perform Pressure Area Care</li> </ul>			-	every 2	hour	Sel	ect Body Site	Kaye William	IS	17/08/2	016 10:00 AM	No time limit	
				3 0 0				1111							
Toolbar	$\sim$	Actions awaiting sign	nature Sign	RT.	Schedule a Tasi	Timed	Interventions	FASTHUG							

**Care Plan –** assessment frequency sub heading allows a nurse to plan when and the frequency of specific different care to be given to a patient, such as how often to perform eye care, oral care, and pressure area care. There is also a checklist subheading to help prompt the nurse of actions that they need to take.

**Timed Interventions** – a dose view showing what timed interventions that a patient is on and how long they have been on them for. These include the patient's ventilation status and interventions such as CRRT (Continuous renal replacement therapy), ECMO and VAD.

**Tasks** – a Cardex view of tasks that have to be performed on patients. These are tasks that a nurse has scheduled for patient care such as urine sample collection, when ECG's are to be performed, and when an updated patient weight is to be recorded. This view is the same as the Cardex view for medications.

**Tasks** – an order profile view is a list style view for viewing and managing a patient's treatment plan. All tasks that the patient has assigned to them can be edited, modified and stopped from this view.

**Toolbar –** this final view has a shopping cart to sign off new tasks and treatments planned for the patient. There are several buttons that open floating toolbars with action buttons on them to schedule and perform tasks and treatments for a patient.





# 8.3.1 Schedule Tasks

Go to **Nursing** menu  $\rightarrow$  select **Schedule a Task**  $\rightarrow$  choose task that a nurse can assign to a patient  $\rightarrow$  once task chosen this will open a new window to allow the nurse to set frequency of the task and the duration of the task.

Menu Nu	rsing Medical Add Progress	Notes	Scores	Dose & Task List	Clinic	cal Events	Radiology	End of Life	Policies & Guidelin	es Refres	sh
Clinical Grap Verview Overvi	Select a Patient	Input / Output	RRT	Care Plan / Interventions	Progress Notes	Prescribe		itrate Media lications Rev		diok 🔇 🚺 /	/ 2
	Safety Checklist								21:47	1 Hour	
< Go to 🔹 🕨	FASTHUG	1400	1500	1600		1800	1900	2000 2	100 2200		
Assessment Frequ	Allergies/ADR	24 Ho	ur Urine Colle	ction (Start)						None	~
Vital Sign Frequenc	Alerts and Isolation Requirements	24 Ho	ur Urine Colle	ction (Ston)							
Blood Glucose Free	Observations			mbolic Device/Stock	linas						
Neuro Assessment	Input / Output Devices and Observations		te Gastric Tul		lings						
Gastric Aspirate Fro Urine Output Frequ	PCA / Epidural / Nerve Block		Sample	Je							
Pressure Area Care	Schedule a Task		e Giving Set								
Mobility & Hygie	Timed Interventions			my Inner Cannula							
Pressure Area Care	Clinical Procedure Safety Checklist (Timeou								~	_	
Patient Position ROM Exercises	Progress Notes	. Chang	e Urinary Cat	heter							
Arm Splints	Nursing Management Plan		ct Interpreter								
Leg Splints	Research Studies			or Substitute Decisi	ion Maker						
/TE Prophylaxis	Patient Belongings	Cross	Match								_
	Weights and Dimensions	ECG									
	Patient Ready for Discharge	Eye Ca					,				
Tasks		Flush I	Feeding Tube		_						
sh Feeding Tube	Nursing Discharge Summary	Microl	biology Speci	men							
form a Cross Match		Oral C	are								
form Eye Care		Pressu	re Area Care								
form Oral Care		Remo	ve GTN Patch								
Orderable	* Menu b	tt Sched	uled Task (Ot	her)		Order	ed by	Start da	te & time Stop		
Flush Feeding Tube		▼ Start F	asting Patien	t	Sit	e Sharo	n-Ann Shunker	24/04/2	016 9:36 PN No time limi	it	
		Survei	llance Swabs			_					_
0 Actions await	ting signature Sign Now!	Urinal	ysis		ug						
		Weigh	the Patient								

Example of scheduling a task – ECG

Irderable			CIAP		Additional Information Allergies/Al
🔊 🔻 Perform a	n ECG		🔻 Q 📮	PRN PRN Indication	
lose Form	Route V Select Route	Body Site           The select Body Site	• ñ	TDS (08:00 14:00 20:00)	<b>v</b>
tart Next Scheduled Do: nd	5e v			Comments	
No Time Limit	×				Frequency of the ECG
osing weight : 50kg	As of 6 016 17:31			Free Text Medication Name:	
	Duration of t	he Task			
	Duration of t	he Task			
	Duration of t	he Task			
	Duration of t	he Task			
	Duration of t	he Task			

When an order of a task is created, a nurse can review and make changes to suit what is required for the task.

- The important fields are the Frequency and Time fields:
  - Frequency: this determines how often the task will be performed
  - **Time**: this is how long the task will be running for select a start and end time. Another option is to start the task and leave it running until it is no longer required, at which point a nurse can stop it via the order profile view
  - Clicking ok confirms the task.



	Indication that a task not been signed f		
Orderable M	TDS (08:00 14:00 20:00)	Location Select Body Site	
	chedule a Task Timed Interventions	rastikus essarch Studies:	
Tasks to be s	signed for	<ul> <li>Actions awaiting signature</li> </ul>	Sign Now!
Nothing to b	e actioned	Actions awaiting signature	e Sign Now!

- Once a task has been scheduled, it has one further step before becoming active it needs to be signed off.
- The task will go into the **shopping cart.** This allows a nurse to schedule several tasks and then sign them all off at once.
- To sign off all tasks in a nurse's shopping chart, click the Sign Now button. The number in the shopping cart indicates the number of tasks that are awaiting a signature.
- Another indication that a task has not been signed is when the order profile view has a small red arrow in the right corner of the task.

C Resolve	ige 🛄 🛛	efer action	
ignature re-authentication required.			
Description	Action	Issue	Response
Perform an ECG TDS (08:00 14:00 20:00)	Create	No Issue	
Take a Blood Sample Once Only	Create	No Issue	
Weigh the Patient Night (18:00)	Create	No Issue	

- Clicking the Sign Now button on the shopping cart brings up the Signature Review window. This window includes everything in the shopping cart that needs to be signed for.
- This window also reviews the task and checks for issues. If no issues are found, a nurse can sign for the tasks by clicking the Sign Now button.



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Signature Review				×
Z <sub>2</sub> Resolve ℤ <sup>+</sup> <sub>R</sub> View and Acknowledg	ge 🔩	Defer action	C Discard action	
Signature re-authentication required.				
Description	Action	Issue		Response
Perform an ECG TDS (08:00 14:00 20:00)	Create	No Is	sue	
Take a Blood Sample Once Only	C 🕢 U	lser Re-Auti	nentication X	
Weigh the Patient Night (18:00)	c			
		r Name Jol	the Consists	
			nn Smith	
	Pas	sword		
			OK Cancel	
			Cancer	
<				,
3		0	- defensed ( discussed	Sign Now! Sign Later
3 actions awaiting signature, 3 actions read	ly for signatu	ire U action	s deferred / discarded	Sign Now: Sign Later

- After clicking the Sign Now button, the User Re-Authentication window displays.
- A nurse re-enters their login password and selects OK.
- This validates the orders for the tasks and makes them active for the patient.

(0) Tasks								
Perform an ECG					2			<sup>0</sup>
Take a Blood Sample	Comp	leted Tasks 🛛 📄						Ť
Orderable	Menu button	Frequency	Location	Ordered by		Start date & time	Stop	
Perform an ECG	•	TDS (08:00 14:00 20:00)	Select Body Site	John Smith		12/01/2016 8:00	No time limit	0
Weigh the Patient		Night (18:00)	Select Body Site	John Smith		14/01/2016 18:00	No time limit	
Actions awaiting signature     Sign Now!	Valida Schedule a Task	ated Tasks	us					¢
		Jult Status: Admitted Research						
Messages 41 Active user: John Smith	repartment name. Au	luit Status: Admitted Accellui	Studies:					14/01/2016 11:17
Tasks			_					
Perform an ECG					2			<sup>®</sup>
Take a Blood Sample			Ľ					
Drderable	Menu button	Frequency	Location	Ordered by		Start date & time	Stop	
C Protection BCG	<b>*</b>	TDS (08:00 14:00 20:00)	Select Body Site	John Smith		12/01/2016 8:00	No time limit	0
Veigh the Pate	•	Night (18:00)	Select Body Site	John Smith		14/01/2016 18:00	No time limit	
Discontinue a Task	Ļ							
Actions awaiting signature Sign Now	Schedule a Task	Timed Interventions FASTHI						0
Actions awaiting signature Sign Now	Scheoure a rais.	Titled Intervencions PAGITE	05		() -			
Messages 4	Department name: *Ad	dult Status: Admitted Research	h Studies: .					14/01/2016 11:19

- To discontinue (stop) a task in the order profile view, uncheck the box next to the task.
- This uncheck action needs to be approved (validated, signed for) and therefore adds an action to a nurse's shopping cart.
- After clicking Sign Now, a similar signature window appears under the action column instead of **Create**, the action is **Discontinue**.





By clinicians.

for clinicians

# 8.3.2 FASTHUG

Part of a shift routine is checking and validating that essential care has been attended for the ICU patient. The FASTHUG acronym is used to do this (Feeding, Analgesia, Sedation, Thromboembolic Prophylaxis, Head of Bed elevation, Ulcer Prophylaxis, Glucose Control). The FASTHUG button is located at the bottom of the 'Care Plan / Interventions' tab view.

44 4 Go to	PMB-BCD	09:32			erventions No	- 1941	ons Medications		Review 349			-	1 Hour	- 3
1 1 60 10 V P W	811	9-11	10 <sup>20</sup>	1129	1201	13 <sup>10</sup>	1428	15 <sup>20</sup>	16 <sup>11</sup>	1721	18 <sup>20</sup>	1921		
Assessment Frequency			10				A						None	~
Vital Sign Frequency								_				-		
Blood Glucose Frequency														
Neuro Assessment Frequency	1							-						
Gastric Aspirate Frequency														
Urine Output Frequency											-	-		
Pressure Area Care Frequence Mobility & Hygiene	¥													
Pressure Area Care		Mattress - pre		Ba and the	Mattress - pre									
Pressure Area Care Patient Position	Low fowler's	Low fowler's	Low fowler's	High fowler's	High fowler's			Low fowler's		Right lateral		High fowler's		
ROM Exercises	Low rowter's	Low rowner's	Low rowier's	righ towier's	righ towler's	Lett lateral		Low rowier's		Right lateral		riigh rowier's		
Arm Splints											-			
Leg Splints											-			
VTE Prophylaxis	1													
Hygiene Performed	11	Eve care:Mout.		Eye care;Mout.			1					-		
Ventilation		cye care, moor		cye care, mout.	1									
O2 Delivery Device							//							
Subglottic Suction						Yes		Yes		Yes		Yes		
		- N.				-	in the second se	No. of Concession, Name			10	tates 1		
Ventilation														
Ventilation (Invasive)													1 d/5 h/48 m	
							-							-
(•) Tasks														
Perform Oral Care		2		8		8		8		8		8		-
		8		8		8		8		8		8		
Perform Pressure Area Care				199								199		
Wound Care - Foot Right 1		Y												
Wound Care - Leg Right 3		3 19				_		_						_
Orderable			Menu button	Freque	incy	Lo	cation	Ordered by		Start da	te & time 💠	Stop		
Perform Oral Care			-	every 2	bour	Se	lect Body Site	Kaye Williams		17/08/20	016 10:00 AM	No time limit		
		1												
Perform Pressure Area Care				every 2	: nour	26	lect Body Site	Kaye Williams	RC	17/08/20	016 10:00 AM	No time limit		1
							1							1
Actions awaiting sign	nature Sign		Schedule a Tao	k Time	Interventions	FASTHUG								
				C 940.04		-								1
Messages	Active	Shan Swaminat	Comment Part	sent Location PN	B-ICU Status:		esearch Studies:						18/08/2016 1	14-1

- Clicking on this button opens up a new session for entering the FASTHUG. A clinician can use the 'Previous Session' button to view previous sessions.
- Once each area is reviewed the alphabet changes from lowercase to uppercase and this is displayed on the 'Care Plan / Interventions' tab view. It can also be viewed in the Work List view.
- For example, if it displays as 'FAStHug', this indicates that Thromboembolic Prophylaxis, Ulcer Prophylaxis and Glucose Control have not been reviewed.
- After 24 hours the acronym automatically changes back to lowercase

24/04/2016 21:48 🔺 🔻	Sharon-Ann Shunker	/ Sandbox - Adult	8	Previous Session	¥
FASTHUG					<b>^</b>
Feeding	<b>•</b>	Comments			
Analgesia	•	Comments			
Sedation	•	Comments			
Thromboembolic Prophylaxis	•	Comments			
Head of Bed	<b></b>	Comments			
Ulcer Prophylaxis	<b></b>	Comments			
Glucose Control	<b></b>	Comments			
Assessment	fasthug				1





By clinicians

for clinicians

# 8.3.3 Alerts and Isolation Requirements

The Alerts and Isolation Requirements Form is accessed from the 'Nursing' menu: Nursing  $\rightarrow$  Alerts and Isolation Requirements

Alerts for Infection / MRO's may be known on admission or maybe acquired as part of the ICU stay. If known and present on admission – enter this at the time of admission. If they are acquired during the ICU stay – enter the date detected. This is important for generating accurate information on the MRO Operational Report.

The clinician needs to enter 'Name of Infection' & if it was 'Present on Admission' for each MRO infection – MRSA, VRE, ESBL, MRAB, VISA, and CRE.

As a clinician selects each MRO infection from the Alerts selection, they will see the box to enter 'Present on Admission' and 'Date Detected'.

The form will be saved if you click 'Yes' to present on admission. While clicking 'No' will have another pop-up requiring you to place the 'Date Detected' for when the infection was detected.

The option 'Other Infection (Comment)' is available under Alerts. This parameter is intended to capture other MROs that are not mentioned within the Alerts Selection.

Eric Master - Alerts and Isolation Requirements of the second	ements : New Session	×	
20/12/2016 4:37 PM  Comparison Control Additional Evolution Requireme	Power administrator Andrew Villegas / *Adult	2 Previous Session 🔅 🔻	Enter the <b>Date</b>
Alerts and isolation Requirements  Alerts  None  MIRSA  VRE  ESBL  MIRAB  VISA	JMRSA Present on Admission Yes  No Date Detecte JVRE Present on Admission Yes  No Date Detecte		Detected for when the infection was detected.
CRE Burkholderia cepacia Clostridium difficile	VORE Present on Admission Yes No Date Detected  MetaVision		
Respiratory     Varicella     Cytotoxic	Please ensure the Present on Admission check box is complete     OK		
Immunosuppressed     Other			
Precaution Type     Tier 1     Room Pressurisation     Neutropenic     Pelices and Guidelines	T Comments		
		۲ غ خ	
		Save and Close Cancel	



# 8.3.4 Review Pathology

All of a patient's pathology data will automatically populate in eRIC – this can be viewed via the 'Pathology' tab. Some of this data can also be viewed via other tabs, e.g. ABG will also be viewable on 'Ventilation' tab and lactate on 'Sepsis' tab.

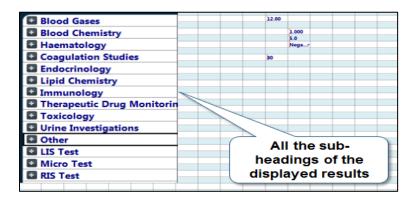
Tabs will only display results when there is data in the results column.

**Data Driven**: in this mode, only columns that contain values are displayed. For example, if you apply Data Driven mode to a Flow sheet tab displaying lab data, the Flow sheet displays only those columns where at least one lab result has been included.

**NOTE:** In data driven mode, different intervals can be displayed simultaneously on the Flow sheet. For example, some columns can be one day apart, and others just one minute apart, as a function of the data being presented.

**NOTE:** for people who are colour blind and cannot see the colour RED. When there is an abnormal result in Pathology, only the colour red indicates that it is abnormal in the eRIC pathology Flow Sheet. A user can use the tool tip (hover with mouse) to see the details of the abnormal result. Hence, if a user is colour blind and unable to see the colour 'RED', they need to hover over results with the mouse to see abnormal results.

	Policies &	Guidelines	Refn	esh	Help & Rep	orts
	edication Review	Pathology Result	Patholo Report	gy M s Rej	icro ports	Wounds
_					12:00	
AM	8 <sup>00</sup> AM	9 <sup>00</sup> AM	10 <sup>00</sup> AM	1100AM	1200PM	100PM
					Ĩ.	
			-		-	
	_				-	-
			_			

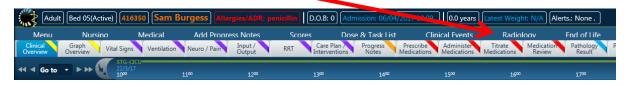






# 8.3.5 Review Radiology

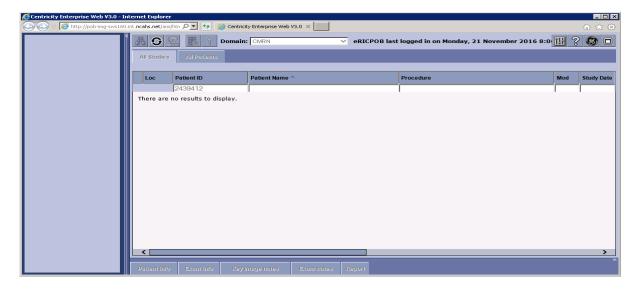
- eRIC will provide an interface with the local radiology information system, which will allow radiology reports to be viewed in eRIC by ICU clinicians at the bedside
- After the patient is in the ICU, using eRIC' clinicians can view the Radiology Images and Reports of the patient
- On the eRIC main screen select 'Radiology' from the Menu



- The PACS Application will appear in the Internet Browser
- If the patient has radiology result, the PACS Application with the respective result will be displayed (always check to make sure you are reviewing the correct patient's results).

	e managemente	TUDES OWNSORD	P	🛨 🤕 Centricity Enterprise Web V3.0 🛪 📃									
		R R 7 5	Domain: SGH	sghicu last logged in on Tuesday, 20 Sept	ember 2016	11:17:1	11 AM.					l	H ? 🜒 [
in 015 2:43:49 AM 6 series	St Geor	e Studies S	i Saonga Padama										
2 inages	Loc	Patient ID	Patient Name *	Procedure	Img	Mod	Study Date	Time	Exam Status	Online	RIS exam ID	Referring Physician	Location
	80			CR Wrist Right		CR	22/04/2011	10:46:46 PM	Anonousd	-,	1020267		ICUSG
100				CT Brain	120	CR	26/11/2015	2:43:49 AM	Approved	, i	2792643		Teuse
- 48			1	CR Chest	120	CR	18/08/2016	6:38:51 AM	Approved	Y	3058721		ICUSG
Corv/Axial A., 27 Inages	80			CR Chest	1	CR	18/08/2016	5:11:18 PM	Approved	, v	3059607		ICUSG
	EO			CT Pulmonary Angio	337	CT	18/08/2016	8:02:45 PM	Approved	, v	3059687		ICUSGH
	EŪ			CR Chest Mobile Round	1	CR	19/08/2016	8:09:06 AM	Approved	v	3059862		ICUSG
	EÚ			CR Chest	1	CR	20/08/2016	12:11:41 AM	1000 C 100 C 100 C	Ŷ	3060964		ICUSG
$\sim$	EC			CR Chest	1	CR	20/08/2016	8:57:50 AM	Approved		3061001		ICUSG
	ED			CR Chest Mobile Round	1	CR	21/08/2016		Approved	÷	3061635		ICUSGH
	ED			CR Chest	1	CR	22/08/2016		Approved	v.	3062232		ICUSGH
	B			CR Chest	1	CR	23/08/2016		Approved	÷	3063623		ICUSGH
	RD			CR Chest	1	CR	23/08/2016	6:58:53 PM	Approved	v	3064658		ICUSGH
ironal 35 inages	80			CR Chest	î	CR	24/08/2016		Approved	Ŷ	3064823		ICUSGH
accountry .	вū			CR Chest Mobile Round	1	CR	25/08/2016		Approved	Ŷ	3066162		ICUSGH
$\sim$	BC			CR Chest	1	CR	25/08/2016		Approved	Ŷ	3067031		ICUSGH
( )	ed			CR Chest Mobile Round	1	CR	26/08/2016		Approved	Ŷ	3067292		ICUSGH
	80			CR Chest	1	CR	27/08/2016		Approved	Y	3068329		ICUSGH
	80			CR Chest	1	CR	28/08/2016	12:50:01 PM		Y	3069028		ICUSGH
	RE			CR Chest Mobile Round	i	CR	29/08/2016		Approved	Ŷ	3069463		ICUSGH
	ed			CR Chest Nobile Round	î	CR	30/08/2016	12:03:01 PM	100000000000000000000000000000000000000	Y	3071014		ICUSGH
	80			CR Chest	î	CR	30/08/2016		Approved	Y	3071993		ICUSGH
				CR Chest Mobile Round		CR	31/08/2016		Approved		3072262		

If the patient doesn't have any radiology result, the following screen message will be displayed:



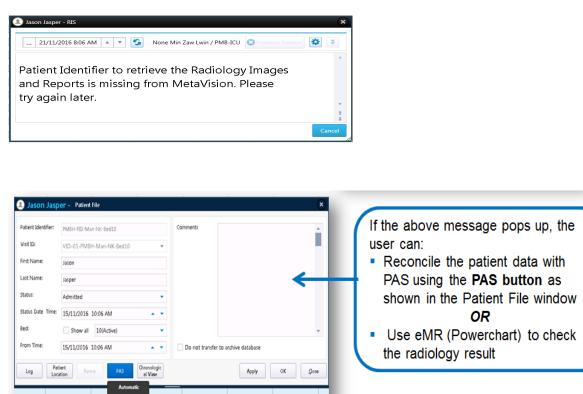




By clinicians

for clinicians

If the patient record in eRIC is created manually, without using the PAS integration (as in downtime registration), the following message will pop up:



If the configuration within eRIC for Radiology is not configured properly, the following message will pop up. In this case, please contact the CIS Manager:





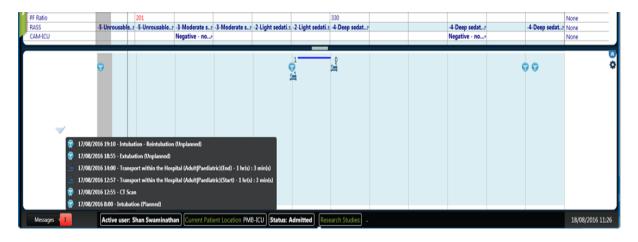
By clinicians.

for clinicians



# 8.3.6 Clinical Events

The clinical events view is at the bottom of the 'Clinical Overview' tab. This is used to enter new clinical events and to track previous events that have happened to the patient. This view keeps a record of all the previous clinical events that have occurred and can be viewed by clicking on the down arrow on the left hand side of the view. A list of past clinical events with a date and time can also be viewed. Selecting a past event a clinician is provided with further details of the event.



The list of clinical events is located on the title bar under the menu **Clinical Events**. Some common examples of clinical events are:

- ✤ Cardiac Arrest
- CT Scan
- Patient Fall

roares	s Notes	Scores	Dose & Task List	Clinica	l Events	Radiolog	v	Fnd of Life	I
in ,	Input / Output	RRT Care I	Plan / Progress ntions Notes	Prescrib Medicatio	llergic/Adverse l	Reaction	dication	Pathology Result	Patholo Repor
	output	, interve	Huons Hotes		ngiogram		CVICW	Resolution	перы
	1500	1600	1700		ronchial Lavage			2000	
	19~	1600	1/~		ronchoscopy			2055	
					ardiac Arrest				
				Ca	ardiopulmonary	Arrest			
				Ca	ardioversion				
				CI	hest Reopening			<u> </u>	
		Ī		CI	linical Event (Oth	ner - Once)			
		¥	·	CI	linical Event (Oth	ner - Timed)			
		Ĭ . Ĭ	Ý 🐳 🗘		T Scan				
					rain, Removal of	(Unalassad)			
						(Onpianneu)			
	114	110	105		chocardiogram			105	
	ST	ST	ST	E	G			ST	
	100	110	99	Er	ndoscopy			110	
	52	63	52	Б	ctubation (Unpla	inned)		53	
	68	80	68	н	aemorrhage			68	
					ne, Removal of (	Unplanned)			
					umbar Puncture				
		37.7						36.7	
		5/./			IRI		-	36.7	
	16	27	30	Pa	atient Fall			27	
	98	99	100	Pe	ericardiocentesis			98	
				Pr	neumothorax				
				P	ulmonary Embol	us		3	
	180	150	105		espiratory Arrest			50	
	-301.3	-359.7			espiratory Arres			-135.1	
	-301.3	-359.7	-349				-	-135.1	
	for all and	£. 11			epsis Confirmed			for allows	
	fasthug	fasthu	g fasthi	Su Su	urgery			fasthug	
				Т	ransport within t	he Hospital		_	
					-				
s	VC-SIMV/	PS VC-SI	MV/PS VC-S	IMV/PS	VC-SIMV/PS	VC-SIN	IV/PS	VC-SIMV/	PS
	40	40	40		40	40		28	
	18	15	15		17	18		18	





Selecting the **Clinical Event** that needs to be recorded will open up a new window. In this window, confirm the **Clinical Event** under the Clinical Event heading. If a user selects the wrong event it can be changed by using the drop down arrow to open a list to scroll through, or by selecting the binoculars icon. This will brings up the list with a clear field to type the event name. Selecting **Cancel** on the window and starting again is another option.

In the Clinical Event Properties there are two fields:

- Time: this is where the time of the event is entered
- Comments: any notes or information of the event can be entered. These notes can be viewed anytime the event is viewed

Sam Burgess - Add New Clinical Ever	nt 🗙
Category	
Clinical Events	Find
Clinical Event	
Cardiac Arrest 🔹 🏦	
Clinical event properties Time 24/04/2016 21:50	•
Attached form Materials	OK <u>C</u> ancel

- There are two types of clinical events events that can occur at any given point in time, or over a period time (Continuous events)
- The **Initiated** check box is selected this is an indication that the event has started and the end time is unknown e.g. Transport of patient
- Continuous events are displayed differently on the Clinical events view. Given point in time events are displayed using a variety of different dots.







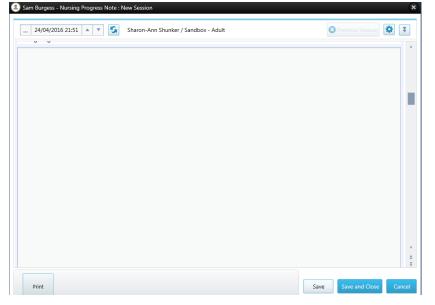


# 8.3.7 Progress Notes

All clinicians need to document progress notes for an ICU patient into eRIC. Progress notes are documented contemporaneously.

To select Nursing Progress Notes go to:

Add Progress Notes  $\rightarrow$  Nursing Notes  $\rightarrow$  this will open a new session



To select Medical Progress Notes go to:

Add Progress Notes  $\rightarrow$  Medical Notes  $\rightarrow$  this will open a new session

Sam Burgess - Medical Progress N	ote : New Session		
24/04/2016 21:51 🔺 🔻	Sharon-Ann Shunker / Sandbox - Adult	S Previous Session	¥
dical Progress Note			ī.
nical Team	▼ Q		
nical Team Contact Number			
edical Progress Note			
Print		Save Save and Close Ca	

# **NOTE:** Always ensure that you are making entries as a 'new session' (do not write over *another* user's session)

- Check the user name, patient name, date and time
- Use the drop down arrow or the scroll to scroll between sessions. You can open and read
  a session that has been entered by someone else but if you want to make an entry –
  you need to open a new session
- Select 'Save and Close' to save and close your session.





#### Note Lock

- There is a code snippet on all 'Notes' (Progress Notes, Medical Ward Round Notes, Assessment Notes, Echocardiogram Report)
- The code snippet shows a dialog box notifying the 'currently logged in user' that clicking 'Save' on a saved note will create another session and save it under their user name
- The dialog box will show for all new sessions regardless whether the user is reviewing or intentionally creating a new note.

					10000		1000	1.000
S 4 10/01/2017 02:56	PM (Saved at : 10/01/2017 0	02:56 PM ) By : Power administrator Andrew Vi	le *	2	24	New	\$	÷
ledical Ward Round Note								
ard Round Team Andrew								1
								-
stimated Date of Discharge 09/0	1/2017 🔺 👻							
Insert Assessment Headings	10 - N - N							
ssessment / Examination								
esting								
Antavision					6	3		
						3		
2 You are ab	iout to save a session of this !	Form. This saved session will be against your use	r name. 3	this is		3		
2 You are ab	iout to save a session of this I if not, click 'No'	Form. This saved session will be against your use	r name. # 1	this is				
2 You are ab	rout to save a session of this I if not, click 'No'		r name. ž	this is				
2 You are ab	out to save a session of this i if not, click 140'	Form. This saved session will be against your use	r name. ¥	this is				
2 You are ab	out to save a session of this l if not, click 'teo'		r name. Ø	this is		<		
2 You are ab	iout to save a session of this I if not, click 'No'		r name. Ø	this is				

The Progress Notes tab is entirely made up of a list view. This is where a user can review all the progress notes for a patient.

🛞 [Adult] [Bed 09(Activ	e) Patient Identifier: 124589 Lara 6	5.4.0001 Male D.O.B: 02/12/19	97 Progress Notes	2/2015 2:38 PM [18.1 y	rear Weight (Latest):		-dipine; analgesics	[e i 🖷 - >
Menu Nursin Clinical Graph			Task Ling Col	nical Events Radio		Policies & Guidelines	Refresh	Help & Reports
Clinical Graph Overview Overview	Vital Signs Ventilation Neuro / Pain	nput / RRT Care Plan / Dutput Interventions	Progress Press Notes Medic	ations Medications Me	Titrate Medication dications Review	Pathology Radiology Wou	inds Sepsis	Me 🔇 1/2 (
9 + / 0	Since admission	Ψ.	From .	. 02/12/2015 2:38 PM	▲ ▼ To 13/01	/2016 1:25 PM 🔺 🔻 🕨		•
Time	Description		User	Action				±
12/01/2016 9:54 AM	@Medical Ward Round Note		RN Lara Simons	Save				
09:51 AM	@Medical Ward Round Note		RN Lara Simons	Save				
09:49 AM	ENursing Assessment Note (Head to Toe	)	RN Lara Simons	Save				
09:45 AM	@Family Meeting Note		RN Lara Simons	Save				
24/12/2015 10:20 AM	@Problem List		RN Lara Simons	Save				
14/12/2015 1:29 PM	Medical Ward Round Note		nurse nurse	Save				
01:25 PM	#Medical Ward Round Note		nurse nurse	Save				
01:24 PM	@Medical Ward Round Note		nurse nurse	Save				
01:23 PM	Medical Ward Round Note		RN Lara Simons	Save				
08/12/2015 3:35 PM	Social Work Domestic Violence AVO		RN Lara Simons	Save				
03:33 PM	#Social Work Domestic Violence AVO		RN Lara Simons	Save				
02:45 PM	Nursing Progress Note		RN Lara Simons	Save				
02:08 PM	ENursing Progress Note		RN Lara Simons	Save				
02:07 PM	@Nursing Progress Note		RN Lara Simons	Save				
01:43 PM	Medical Ward Round Note		RN Lara Simons	Save				
01:42 PM	Dietetics Progress Note		RN Lara Simons	Save				
01:41 PM	#Family Meeting Note		RN Lara Simons	Save				
01:41 PM	Speech Pathology Progress Note		RN Lara Simons	Save				
01:40 PM	EMedical Progress Note		RN Lara Simons	Save				
01:40 PM	#Social Work Progress Note		RN Lara Simons	Save				

#### Ways to read Progress Notes

There are two different ways to view Progress Notes:

- Clicking the '+' symbol next to the Progress Note to be read this expands the note. Clicking the '-'symbol will collapse the note and return it back to normal. Clicking the symbol will open and close all entries
- 2. Expanding the note to be read and then double clicking the text. This will open the form in which the progress note was recorded.





If a clinician is on a specific tab and they want to review some progress notes, they can do so without switching between tabs and by the using the preselected progress note filters. This action adds a list view to the tab currently selected.

Navigate to Add Progress Notes → Progress Notes Filters → select the filter required

Menu Nursing	Medical	Add Progress	Notes Sco		& Task List	Clinical Events	Radiology	End of Lif		& Guidelines	Refre	sh	Help & Reports	Log
Clinical Overview Overview	Vital Signs Ventil				re Plan / Progr rventions Not	es Prescribe Medication	Administer Medications	Titrate Medications	Review Sep	isis Metabi		ounds		
	PMB-ICU	Medical	Notes								18	:51		1 Hour
🛛 🚽 Go to 📑 🕨 💆	823	921 Physiot	herapy Notes									_		
- HR	200 1	Pharma	cy Notes	•								-		250 100 60
ABPs		Dietetic	s Progress Note	<b>_</b>										
	150		Pathology Progres	Note										200 80 5
ABPm	100				L .		▲							150 60 3
NIBPs	100		Vork Notes		2	×	×			<b>_</b>		-	<b></b>	100 40
NIBPm	50	Pastora	I Care Progress Not	e 🚼	8				2	<b>.</b>		¥	<b>***</b>	20
SpO2		Occupa	tional Therapy Pro	ress Note										
RR (Total)	0	Other N	lotes											0 0 0
R	52		s Notes Filter		Aedical Filter		70	70	52	65	65	1	63	bpm
ardiac Rhythm	SB	SB	S NOTES FIITER				SR	SR	SB	SR	SR		SR	None
BPs	110	118	112	117	lursing Filter		148	118	130	115	122		110	mmHg
8Pd	60	68	59	75 P	harmacy Filter		75	63	70	65	61		58	mmHg
BPm	75	85	75	95 P	'hysiotherapy Filte	r	110	85	90	80	76		71	mmHg
IBPs				s	ocial Work Filter									mmHg
IIBPd					ulied Health Filter									mmHg
ll8Pm														mmHg
emperature	33.5	34.0	36.6	C	ccupational Thera	py Filter			36.8					*C
GL	4.9				peech Pathology F	ilter	5.6			5.8			8.7	mmol/L
R (Total)	10	12	12	14 0	vietetics Filter		14	12	12	20	17	}	19	breaths/mir
pO2	98	98	99	98	astoral Care Filter		97	98	96	99	97	1	96	%
lirway	Oral ETT	Oral ETT	Oral ETT	Oral ETT			Oral ETT	Oral ETT	Oral ETT	Oral ETT	Oral ET	7	Oral ETT	None
3CS - Total	3	6	6	9	9	6	6	6	6	5	5		5	None
entilator Mode	SIMV/PS/Auto.	* SIMV/PS/Auto	a SIMV/AutoFlo.a	SIMV/PS/Auto.a	CPAP/PS	CPAP/PS	CPAP/PS	CPAP/PS	CPAP/PS	CPAP/PS	CPAP/F	s v	CPAP/PS	None
O2 (Set)	50	40	40	40	30	30	30	30	30	30	30		30	%
p	18	19	18	16	15				15				15	cmH2O
F Ratio	201					330								None
ASS	-5-Unrousable.	+ -3-Moderate s	-3-Moderate s	-2-Light sedati.	-2-Light sedati.a	-4-Deep sedat	•		-4-Deep sedat	•	-4-Dee	sedat	•	None
AM-ICU			Negative - no						Negative - noa					None
												-		
						8					_	<b>i</b> 🖘 🖘		
					2	<u></u>								

This new view automatically compresses the other views on this tab.

**NOTE:** this view is not permanent - it is an on-the-fly change and can be reset by refreshing eRIC.

🖹 [Pilot Release] [0-	4(Active) [0000001	Jessica Blue	Allergies/ADR:	penicillin Alerts:	[Female] [D.O.B	: 12/05/1983][ <mark>Adm</mark>	ission: 17/08/2	016-09:00 . ] [33.3	year][Latext Wei	ght: 70kg			1 G	-
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		r: Kaye Williams		ation PMB-JCU										

#### **Progress Notes for Referrals to Specialist Teams**

There is a Referral / Consultation Form for a referral to be made to a specialist team – e.g. 'Wound Care CNC' or 'Stoma Therapist Nurse' OR a medical specialist team referral such as 'Mental Health Team' or 'Plastics Team'.

This form is located under Add Progress Notes  $\rightarrow$  Nursing Notes  $\rightarrow$  select Referral/Consultation Form: *OR* 



#### Add Progress Notes $\rightarrow$ Medical Notes $\rightarrow$ Referral/Consultation Form.

The Referral is made using this form and the team when they review the patient can write into the 'Consultants Report' section of the form. This then appears under the 'Progress Notes' tab view.

**NOTE:** In addition to completing the Referral /Consultation form in eRIC - The normal process for requesting a consult should still be adhered to i.e. referral through eMR consult request or phone consult request.

Pilot Rel										
Menu	Nursing	Medical	Add Pro	ogress Notes	Scores	Dose 8	& Task List	Clinica	l Events	Radio
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Better patient outcomes

By clinicians, for clinicians One solution

across NSW

# 8.3.8 Sepsis Tab

Menu Nursing Clinical Graph verview Overview	Medi /ital Signs	ventilation	ld Progress Not	Input / Output	PPT	Dose & Task List Care Plan	Progress	cal Events Prescribe	End of Life Administer	Titrate	ies & Guidelines Medication	Refr Sepsis	resh Help & Re Metab ( 1 / 2
verview Overview	PMR-ICU	ventilation	euro / Pain	Output	KKI I	nterventions	Notes N	Medications	Medications M	edications	Review 22:18	Sepsis	
◄ Go to ▼ ► ↔ 4.	3/8/16 11 <sup>59</sup>	1259	1359	1459	1559	16 <sup>59</sup>		1859	1959	20 <sup>59</sup>	22:18		1 Hour
													250 45 60
- ABPm - HR					1								-200 -150 40 40
- Temperature	0												100 35 20
- RR (Total)													-50 30 0
[emperature													None
Temperature		36.0	37.0	38.5	39.0	37.0	37.5	38.0					None
Temperature Source													
luids													
Urine Output (Interval)	0	0	0	0	0	0	0	0	0	0	0	0	
nput Total (Interval)	106.2	108	108	108	108	108	123.1	103	103	103	106	106	
					_								
Antibiotics													
THREFOLIES													
	_						_						
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This tab can be used to review data relating to Sepsis, such as:

- Vital Signs
- Fluid Management
- Antibiotic Therapy
- Inotropes and vasopressor support

#### Male D.O.B: 0 Pilot Release 01(Active) 416350 Samuel Burgess 2 / 2 Wou 22:18 44 4 Go to 🕞 Þ ÞÞ 💽 1 Hour å BG Ghycaemic Manage ¢ ā Gastric Aspirate (Returned) Gastric Aspirate (Discarded) . omitus IV Glucose (Daily) 0 Active user: Share n PMB-ICU Sta 02/02/2017 14:25

# 8.3.9 Metabolic Tab Review

This tab can be used to review Metabolic data, such as:

- BGL
- Glycemic control
- Nutrition
- Gastric output / aspirate / losses
- IV Glucose therapy



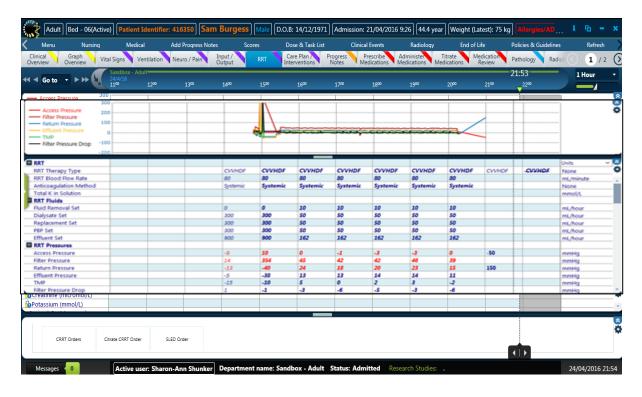
# 8.4 Special Therapies

### 8.4.1 RRT (Renal Replacement Therapy)

The RRT tab is used when prescribing and monitoring **Renal Replacement Therapy**, and will be used by both nurses and doctors.

The tab is broken down in to four sections:

- 1. Graph view to review different pressures relating to the Renal Replacement Therapy
- Tabular view contains some parameters that will be auto populated via the dialysis machines – all auto populated data MUST be checked and validated. There will also be observation parameters that the nurses will complete during Renal Replacement Therapy that may need to be manually entered, e.g. Patient fluid removal per hour
- 3. **Second tabular view** contains pathology parameters and will populate data from lab results that relate to Renal Replacement Therapy
- 4. RRT toolbar contains buttons with forms to:
  - CRRT orders
  - Citrate CRRT order
  - SLED order



#### **RRT Prescription**

There are three available RRT Prescription Forms:



Complete the Prescription Form for CRRT:

 Below is an example of CRRT order form for CVVHDF with effluent dose 25ml/kg/hr with Hemosol BD for Dialysate, PBP and Replacement Fluid and Heparin Anticoagulation







- The prescribing Doctor needs to click the 'Sign' button and choose 'Save and Sign' → enter their 'Password' → click 'Ok' (this saves and closes the form)
- Any modifications to the CRRT Order form must be entered as a 'New Session'.

dications for CRRT			
	Mode	CVVHDF	
Acid-base			mL/kg/hr
Fluid balance	Dose	25	▲ ▼ mL/kg/nr
Hyperkalaemia	Dose Weight	70	🔺 🔻 kg
Ureamia	Dose Rate	1,800	🔺 🚽 mL/hour
Toxin/Drug removal     Other	Review Weight	]	
ther			
ood Flow		-	
ood Flow Rate 180 🔺 👻 mL/r	minute Filter ST 10	0	
ialysate Fluid		Iter Replacement Fluid	
ialysate Fluid Hemosol B0	PBP / Pre-F	Themosol	BO
ther Dialysate Fluid	Other PBP	/ Pre-Filter Fluid	
dditive 20 🔺 🔻 mmol Potassium chloride	▼ Additive	20 🔺 🔻 mmol Pota	assium chloride
nal Potassium Concentration in Bag 4	mmol/L Final Potas	sium Concentration in Bag	4 🔺 🔻
Pialysate Fluid Rate 900	mL/hour Pre-Filter R	ate	700
luid Removal	Post-Filter F	eplacement Fluid	
ml /hour	Post-Filter		BO
Negative balance	Net  Post-Filter		
Neutral balance     Balance Inclusion / Excl		20 🔺 👻 mmol 🛛 Pota	assium chloride
O No fluid removal	L.	sium Concentration in Bag	
		-	4 •
	Post-Filter	cate	200 🔺 🤻

#### Anticoagulation for RRT

Anticoagulation Options and link to order forms – are located at the bottom of the CRRT Order Form and SLED Form

Anticoagulation Orders			
Stat Heparin Dose	Continuous Heparin Order	Stat Other Anticoagulant Dose	Continuous Other Anticoagulant Order
No Anticoagulation Required			4

The anticoagulation prescription for CRRT will depend on the patient and the ICU CRRT Guidelines. The choice maybe No Anticoagulation required, Stat Heparin Dose, Continuous Heparin Order, Stat Other Anticoagulation Dose or Continuous Other Anticoagulation Order.

- Heparin needs to be prescribed using the appropriate template. Use the comments section to document the desired APTT. Pre built heparin templates for CRRT will not have an attached mandatory form. If a bolus is required use the medication workflow for 'Continuous Infusions with Bolus Loading Dose'
- The Heparin Prescription needs to be signed as per other medications from the 'Prescribe Medication' Tab.
- The Heparin infusion will be viewable on the 'Prescribe Medication' and 'Titrate Medication' Tab and not on the RRT Tab.



eRIC User Guide - Module 3: Daily Routine

R Create Order For: Samuel Burgess, MR number 416350	Additional Information Allergies/ADR	
Image: Set Dose and Rate     Image: Set Dose and Rate     Image: Set Dose and Rate     Image: Set Dose and Rate	CLAP         PRN         PRN Indication           Heparin X Units Subcut Injection at Selected times [Adult]         Heparin X Units IV Bolus Once Only LOADING dose [Adult]           Heparin 25,000 Units in 250 mL Sodium Chloride 0.9% IV Continuous Infusion [Adult]         Heparin 10.000 Units in 50 mL Sodium Chloride 0.9% IV Continuous Infusion [Adult]           Heparin Catheter Lock 50 Units in 5 mL Sodium Chloride 0.9% Once Only [Adult]         [Adit]           Heparin Catheter Lock 50 Units in 5 mL Sodium Chloride 0.9% Once Only [Adult]         [Adit]           t(s)         In 50 mL S         200 Unit(s) / mL         68.57 - 342.86 Unit(s)/kg/D         [Adit]	E.g. Heparin anticoagulation – Prescribed and signed from 'Prescribe Medication' tab.
Dose Rate Dose Rate 200 - 1.000 Unit(s)/hour  Start Now  V	Total volume (0.3429 - 1.7143 50 mL Titrate to aPTT of 35 -40 (as per Heparin for CRRT PROTOCOL)	Once validated will be viewable on the 'Titrate Medication' tab.
End No Time Limit  Dosing weight : 70kg As of 29/08/2016 12:56 PM	Free Text Medication Name: Order Log OK Cancel	

### **Citrate Anticoagulation**

Samuel Burgess - Citrate Continuous Renal Replacement Therapy Order No     Samuel 3 (29/12/2016 19:07 (Saved at : 29/12/2016 19:10 ) By: Non		Citrate CRRT Order Form.
Acid-base	ication(s) for Citrate Anticoagulation Surgery within 48 hours Active bleeding	Complete the Prescription Form for Citrate CRRT
Ureamia Control Contro	Dose Dose Maistr	The prescribing Doctor needs to click the 'Sign' button and choose 'Save and Sign' $\rightarrow$ enter their 'Password' $\rightarrow$ click 'Ok' (this saves and closes the form)
Blood Flow       Blood Flow Rate     150 <ul> <li>w</li> <li>mL/minute</li> <li>Filt</li> </ul> Dialysate Fluid           Other Dialysate Fluid           Other Dialysate Fluid           Additive <ul> <li>w</li> <li>mmol</li> <li>w</li> </ul> Final Potassium Concentration in Bag              4              w           Dialysate Fluid Rate              500              w	er ST 100 PBP/ / Pre-Filter Replacement Fluid PBP/Pre-Filter Fluid Prismocitr Other PBP / Pre-Filter Fluid Additive 20 A V mmol Potassium child de Final Potassium Concentration in Bag 4 A V Pre-Filter Rate 1.500 A V	Any modifications to the CRRT Order form must be entered as a New Session
Image: Second	Post-Filter Replacement Fluid       Post-Filter Fluid     Sodium chloride 0.9%       Post-Filter Fluid Other	Calcium Chloride is Prescribed and signed from 'Prescribe Medication' tab.
Comments Calcium Chloride Magnesium Sulfate	Post-Filter Rate	Once validated will be viewable on the 'Titrate Medication' tab.
Cacum Chonde Magnesum Surate	Sign Save Save	and Close Cancel





#### 8.4.2 Extracorporeal Membrane Oxygenation & Ventricular Assist Devices

#### ECMO / VAD tab is for prescribing and monitoring Extracorporeal Membrane

**Oxygenation** and **Ventricular Assist Devices**. This tab will be used by both nurses and doctors, and is broken down in to four sections:

- 1. **Two graph views** (VAD and ECMO Pressures) record the pressure required of the devices to filter the blood
- 2. **Tabular view** contains observation parameters, some of which will be auto populated via the machine. There will also be other observation parameters that nurses will fill out throughout the treatment
- 3. ECMO toolbar contains buttons with forms to complete:
  - ECMO orders
  - Checklist
  - Risk Assessment Checklist
- 4. **ECMO orders** area where doctors prescribe ECMO treatment for a patient. From this toolbar, nurses will open two forms
  - a) The Checklist to be performed regularly throughout the ECMO treatment
  - b) The **Risk Assessment Checklist** to be performed before the treatment commences to help evaluate the risks associated with the treatment.

t Go to → ▷ ▷ ▷ C 310.07 30 30 30 30 30 30 30 30 30 30 30 30 30	2040	2140	2240	2340	4/3/17 040	140	240	340	40	05:52	640	18
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KOP III												26
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Pre Membrane Press 150     Post Membrane Press 100												
50												
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ost Membrane Press 78	40	120	107	170	168	160	155	120	101			mmHg
essure Difference 40	44	60	50	52	48	50	57	51	49			mmHg
Imp Speed 2,240	2,240	3,240	3,240	3,240	3,250	3,240	3,240	2,660	2,670			rpm
ump Flow 2.02	2.06	3.50	3.50	3.48	3.48	3.52	3.41	3.46	2.50			L/minute
IS Flow 6.0 MO Resistance 19.8	7.0	7.0	7.0	7.0	7.0 13.8	7.0	7.0	7.0	7.0			L/minute
	21.4	17.1	14.3	14.9	13.8	14.2	16.7	14.7	19.6			mmHg/L
ck Flow Cannula Flow												mL/minu
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kygenator Check embrane Image												None
rcuit Check												None
	37.3	37.3	37.5	37.4	37.4	37.3	37.0	37.4	37.4			None *C
	37.3	37.3	37.5	37.4	37.4	37.3	37.0	37.4	37.4			
MO Temp (Blood)												*C
MO Temp (Water) Fluid Removal												
bs Comments												mL
02 (Measured) 100	100	100	100	100	100	100	100	100	100			None
(intensured)	7.46	100	4.46	7.40	100	7.41	100	7.36	100		7.37	pH
02	61.2		61	122		157		72.2			79.1	mmHg
02	35		35	36		37		44			47	mmHg
telet count (x10^9/L)			35	30		51					47	x10^9/L
(electrodin (x20 3/c)												g/L
т												9/1
т												sec
п												sec
rinogen												g/L
												JU/mL
												IU/mL
II Heparin LMW (U/mL)												







### 8.4.3 IABP (Intra-Aortic Balloon Pump)

This is another special therapy that an ICU patient may require. A medical officer completes the IABP insertion form and a nurse sets it up as a timed intervention as checks will need to be done regularly.

Create New Dose For: Sam Burgess, MR	number 416350			×
			Additional Information	Allergies/ADR
Orderable	CIAP <b>v Q</b>		Write dose comment	θ
Dose Form Route Select Route	Body Site           ▼         Select Body Site         ▼	Administration time 24/04/2016 21:55	<b>A V</b>	
Process style (Localize) Specify duration hour	•			
	Ordered by: Sharon-Ann S	ihunker 🔻		
-		Prepare & Initiate		Court
	Dose Log	Prepare & Initiate	Initiate Prepare & Validate V	/alidate Cancel

Under **Nursing**  $\rightarrow$  **Observations**  $\rightarrow$  **IABP** – the IABP Observation Form is located and can be completed. These observations will then populate in the 'Cardiovascular' view on the vital signs view tab.

Sam Burgess - Intra-aortic Ba	alloon Pump	Observations	: New S	ession			×
25/04/2016 12:41	<b>▼ %</b>	Sharon-Ann	Shunker	/ Sandbo	x - Adult	SPrevious Session	* *
Intra-aortic Balloon Pump Obse	ervations						-
Balloon Volume		<b></b>	👻 mL				
Timing			-				
Ratio			•				
Augmentation Setting			•				
Trigger			-				
Tubing			•				
Radial Pulses			•				
IABP HR		<u> </u>	bpm				
IABP BPs		<b>A V</b>	mmHg				
IABP BPd		<b>A V</b>	mmHg				
IABP BPm		<b>A V</b>	mmHg				
Diastolic Augmentation		<b>A V</b>	mmHg				
Inflate			▲ <b>▼</b>				
Deflate			•				*
1:2 Timing Check	Yes	No					* *
					Save	Save and Close	Cancel

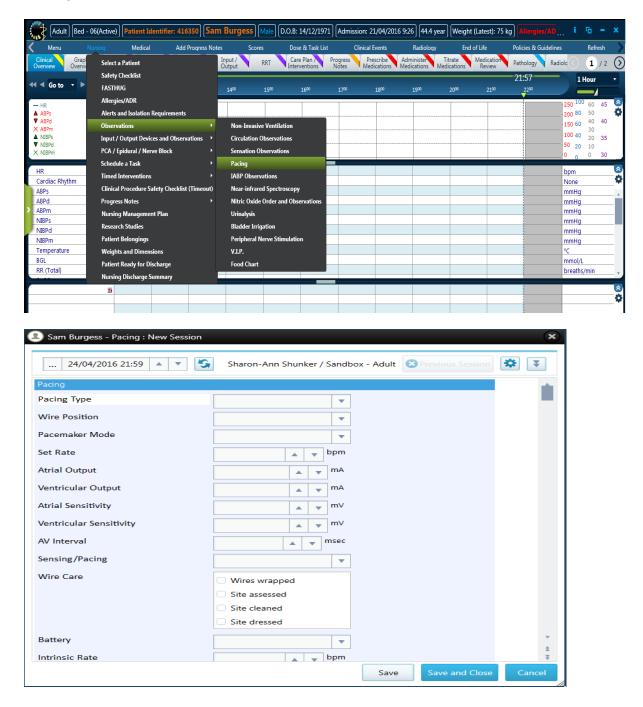




#### 8.4.4 Pacing

Pacing is another common ICU therapy. To attend observations - complete the Pacing Observations Form:

Under **Nursing**  $\rightarrow$  **Observations**  $\rightarrow$  **Pacing** – the Pacing Observation Form is located and can be completed. These observations will then populate in the 'Cardiovascular' view on the vital signs view tab.







### 8.4.5 Nitric Oxide

The 'Nitric Oxide Order and Observation' form can be accessed from either the 'Nursing' or 'Medical' menu. For the 'Nursing' menu it's located under observations.

(Adult) Bed - 06(Active) Patient Ide	entifier: 416350 Sam Burgess	Male D.O.B: 14/1	L2/1971 Admission: 2	21/04/2016 9:26	] [44.4 year ] [W	/eight (Latest):	75 kg Allergies/AD	i 🙃 =	×
Menu Nursing Medical	Add Progress Notes Scores	Com Die		Events R rescribe Admir	ladiology hister Titrate	End of Life Medicatio	Policies & Guideline		
Overview Overview	ect a Patient mission Summary	RRT Intervention	n Progress Pr ons Notes Me	dications Medica	ations Medicati	ons Review	Pathology Radi		$\odot$
44 4 Go to → ► ► 4 24/4/1 1100 Alle	ergies/ADR	1500 1600	1700	1800 1	900 200	2100			
ABPS IFO Pro	rts and Isolation Requirements gress Notes							250 100 60 45 200 80 50	¢
▼ ABPd × ABPm 100 Pro	blem List							150 60 40 40 30 100 40 20 35	
VIBPd 50	es / Drains / Tubes							50 20 10 0 0 0 30	
LID	P Insertion / Removal /sical Restraint(s) Order							bpm	ŝ
Cardiac Rhythm	nical Procedure Safety Checklist (Timeout)							None mmHg	<b>¢</b>
	ric Oxide Order and Observations							mmHg mmHg	1
NIBPS NIBPd Bur	ns Admission Management							mmHg mmHg	
	earch Studies IMC							mmHg °C	-
BGL Me	dical Discharge Summary							mmol/L breaths/min	-
Ξ									ŝ
									¢
									-
									-
			20120						×
Messages 0 Active user:	Sharon-Ann Shunker Department r	name: Sandbox -	Adult Status: Admi	tted Research	Studies:			24/04/2016 21:	
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Sam Burgess - Nitric Oxide Ord	der and Observations : New Se	ssion				×			
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24/04/2016 21:57 🔺 🔻	Sharon-Ann Shunk	er / Sandbox	- Adult 😣 Prev		\$ ₹				
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Nitric Oxide Order and Observation						<b>^</b>			
iNO (set)	A V ppm	ו							
iNO (measured)	ppm	ı							
NO2	ppm	ı							
Methaemoglobin (P.O.C)	▲ <b>▼</b> <sup>%</sup>					-			
Cylinder Content	<b>A</b>	Star	rt Nitric Oxide Therapy	/		*			
		[	Save Sa	ve and Close	Cance				

Once the form is completed and Nitric Oxide Therapy commenced, the information can be found under the 'Ventilation' tab view.

Adult Bed - 06(Act	ive) Patien	t Identifier	: 416350 Sa	m Burgess	Male	D.O.B: 14/12/197	1 Admis	sion: 21/04/201	.6 9:26 (44.4 y	ear Weight	(Latest): 75 k	g Allergies/AD	i (	ò -
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Clinical Graph Overview Overview	/ital Signs	Ventilation	Neuro / Pain	Input / Output	RRT	Care Plan / Interventions	Progress Notes	Prescribe Medications	Administer Medications	Titrate Medications	Medication Review	Pathology Ra	diok 🔇 🛛	1 / 2
( 4 Go to 🔹 > >> 🖌	Sandbox - A 25/4/16 200	Adult 300	400	500	600	700	800	900	1000	1100	12:00	1300	1 He	
	200	200	400	2	000	140	9	900	10.0	1100	1200	19		
itric Oxide													0 d/0 h/1 n	n
Ventilator Mode												~		
Ventilator Type														
Nitric Oxide Observations	5												Units	
INO (set)											20		ppm	
INO (measured)											20		ppm	
NO2											10		ppm	
Methaemoglobin (P.O.C)											1.0		%	
Cylinder Content (Nitric Oxi	de)										200		None	

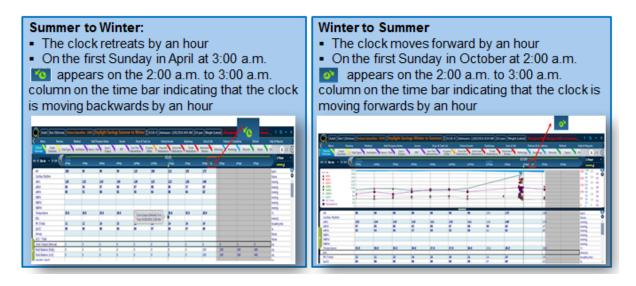
### 8.5 Handover

On completion of a shift medical and nursing staff can handover patient care by using the local handover process. The relevant 'tab' views (e.g. Clinical Overview, Graph Overview, Ventilation, Medication, Progress Notes) can be used to facilitate handover.



# 9. Daylight Savings

Summer to winter clock changes is set to match Australian Eastern Daylight Savings Time. An icon appears on the time bar on eRIC indicating the change in the clock.

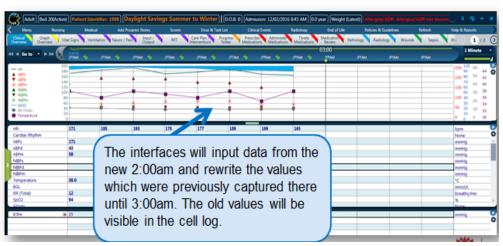


# 9.1 Daylight Savings – Summer to Winter

The clocks will move BACKWARDS 1 hour when the daylight saving summer to winter change occurs.

#### Flow sheet:

- At DST, the time will move from 3:00am to 2:00am, the interfaces will input data from 2:00am and re-write the values, previously captured there until 3:00am. The old values will be visible in the cell log.
- Recommended Specialised Process: Add comments to the affected cells indicating that these values occurred during DST.
- As the application can only display one data item per interval, data flowing from devices during the second instance of that same hour will not be seen with out checking the cell history/log.
- Laboratory and pathology results: Potential for lab results not to display in correct order, which may lead to an incorrect impression of patient condition. Double check results for this hour in eMR.



# The Repeated Column



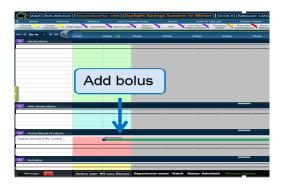


By clinicians

for clinicians

#### **Running Infusions:**

- The record of fluids entered into the patient during the DST hour will be missing. Only one hour of fluid is recorded on the flow sheet when two hours of fluid have entered the patient.
- **Recommended Specialised Process:** Add boluses to account for the missing recorded fluid for all running infusion and ensure the Fluid Balance Chart (FBC) is accurate.



#### **Medication Orders:**

- Individual doses due at 3:00am will be in 'immediate' status form 2:00am until 4:00am, it will display as 'Late' form 4:01am. (as per the NSW Grace Period customisation)
- The 'Immediate' period will be lengthened by 1 hour.
- The dose will remain due at 3:00am, however as 2:00am is repeated it will remain within the 'Grace period' for longer.
- Medications given between the 2:00am to 3:00am period before the DST change will appear to have occurred in the future when the clock changes at 3am

**Recommended Specialised Process:** At the time of validation of the medication add a comment to say if they were validated 'Pre' or 'Post' DST.

Pilot Release 10(A	Active) 416350 Sa	muel Burgess	S D.O.B: 0 Adm	ission: 16/01/2017 0	200. 0.0 years La	atest Weight: N/A			cumented Alerts:						
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Clinical Graph Overview Overview	Vital Signs Ventilatio	n Neuro / Pain	Input / Ri Output	Care Plan / Interventions	Progress Presci Notes Medica	ribe Administer tions Medications	Titrate Medication Medications Review	Sepsis	Metabolic Wounds						
41 4 Go to • > >> (	PMB-ICU				20:11				21/1/17					1 Hour	•
41 4 00 10 · P PP 0	20/1/17 16 <sup>00</sup>	1700	1800	1900	2000	2100	2200	23 <sup>00</sup>	21/1/17 0 <sup>90</sup>	100	200	fe i	300		
Medications															
Cephalexin															-6
Propofol															

#### Fluid Balance:

 Add missing fluid to a manually entered 'Other Fluid Input' (NOTE: This is not to be done if a bolus is already added to running infusions, as this will automatically account for the missing fluid).

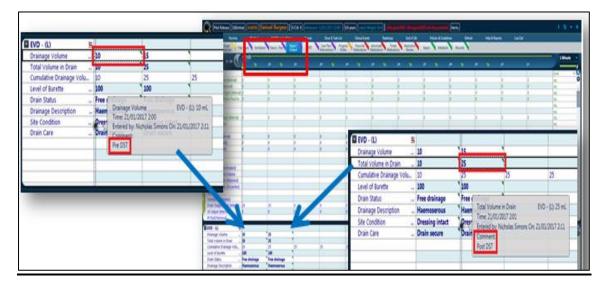
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Clinical Gr Overview Ove	aph rview Vital	Signs Venti	ation Neuro /	Pain Input / Output	RRT	Care Plan / Interventions	Progress Prescr Notes Medica
44 \land Go to 🔹	> >> (Y	Adult 2/4/16 1100PM	3/4/16 12 <sup>00</sup> AM	100AM	2 <sup>00</sup> AM <b>10</b>	03:00 3 <sup>90</sup> ам	4 <sup>00</sup> AM
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Colloid Input (Int	erval) (	)	0	0	0	þ	0
Blood Product In	put (Interval) (	)	0	0	0	p	0
Parenteral Nutrit	ion Fluid In (	)	0	0	0	o	0
Oral Fluids							
GI Tube Input							
Enteral Fluid Inp	ut (Interval)	)	0	0	0	þ	0
Other Fluid Input	1						
Totals Input							
Input Total (Inter	val) (	)	0	0	100	100	100
Input Total (Dail)	0 0	)	0	0	100	200	300
Input Total (LOS	) (	)	0	0	100	200	300
Output							
Urine Output						5	
Urine Output (Es	timated)						
Stool Measured	Volume						
Gastric Aspirate	(Returned)					1	
Gastric Aspirate	(Discarded)					1	





#### Drain Output:

- Add a comment detailing whether it was documented 'Pre' OR 'Post' DST for all Drainage output recorded in the 02:00 to 03:00 time period
  - For example: The drainage output at 02:00 'Pre' DST is recorded at 02:00 with comment 'Pre' DST. The drainage output at 03:00 when DST changes (which will now be the second 02:00) will be recorded at 02:01 with a comment that this was the output 'Post' DST. This is because this data is contained in a 'Repeated Column'.



#### Form Sessions:

- All forms will carry the same timestamp which is the actual local time at the point of saving (e.g. two or more forms can be stored at 02:00).
- A form saved at 2:12am BEFORE daylight savings, and then a form saved at 2:02am AFTER daylight savings will be displayed in descending order, therefore the 2:02am will display as the after the 2:12am form in the progress notes list view.
- Which is incorrect as the actual events of the patient happened in the reverse order.
- Recommended Specialised Workflow Process: Record on each session if it is was documented pre and post DST for any notes in that hour.

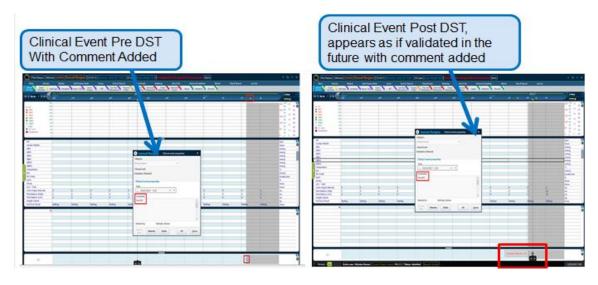
Menu Nurs	ing Medical	Add Progress Not	es Scores	Dose &	Task List	Clinical Ev	ents	Radiology	End of Life	Policies & Guidelines	Refre
linical Graph erview Overview	Vital Signs Ventilation	Neuro / Pain Inj Ou	nut / RRT	Care Plan / Interventions	Progress Notes	Prescribe Medications	Administer Medications	Titrate Medications	Medication Review Patho	ology Radiology W	ounds
9 + 🖉 🕄	<ul> <li>S</li> </ul>			•		From 12,	/02/2016 8:43	AM 🔺 🔻	To 12/02/20	17 12:53 PM 🔺 🔻	•
me	Description				User		Action				
3/04/2016 2:42 AM	Nursing Progress No	e			RN Lara S	imons	Save				
2:12 AM	Physiotherapy Progre	ss Note			RN Lara S	imons	Save				
2:02 AM	Physiotherapy Progre	ss Note			RN Lara S	imons	Save				





#### **Clinical Events:**

 Any events that occur in the 2:00am to 3:00am period will need a comment to indicate if this occurred 'Pre' OR 'Post' DST.



#### **Timed Interventions**

 During the Summer to Winter additional hour that is missing in the timed intervention record, 'Validate' the process again with a specific duration of 1 hour.

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## 9.2 Daylight Savings – Winter to Summer

The clocks will move FORWARDS 1 hour when the daylight savings winter to summer change occurs

#### Flow Chart:

- The interfaces will input data from 3:00 a.m. leaving the 2:00 a.m. to 3:00 a.m. column blank. The column is NOT disabled; the user could manually enter data here. It would however be tracked that it was not coming from a device, that it was manually entered.
- Recommended Workaround: Add comments to the affected cells indicating that these values occurred during DST.
- There should be no effect on laboratory and pathology results.

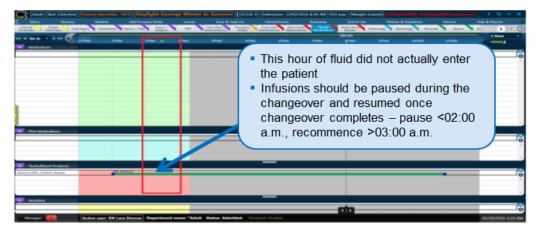


## The Empty Column

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#### **Running Infusions:**

- When the clock moves forwards from 2:00 a.m. to 3:00 a.m. the record of fluids entered into the patient would indicate an extra hour of volume than what was actually infused into the patient.
- **Recommended Workaround**: Infusions are paused during the changeover and resumed once changeover completes pause <02:00 a.m., recommence >03:00 a.m.



#### Medication Orders:

- Individual doses due at 2:00 am, will be in 'immediate' status from 1:00am until 3:00am, it will display as 'Late' from 3:01am.
- The 'Immediate' period will be shortened by 1 hour.
- The dose will remain due at 2:00am, however be in a late status from 3:01am onwards.
- Medications will appear to be in 'Late' status because the grace period is shortened.
- Recommended Specialised Process: At the time of validation of the medication add a comment to say if they were validated 'Pre' or 'Post' DST.

Validate A	Mark Not Cancel Action Invisiblened	Modify	View		-Sign for parations							
vag a column	header here to group	by that column										
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3 Rupo				2/10/2016 06:00 A	м 2	00 mg	PO	every 4 hour		Pending		
D Rupe	ofen			2/10/2016 10:00 A	M 2	00 mg	PO	every 4 hour		Pending		
6 Glucos	ae 10%			2/10/2016 11:00 A	M 1	.000 mL	Central Venous	Continuous	500 mL/hour	Pending		
3 Bup	ofen			2/10/2016 02:00 P	м 2	00 mg	PO	every 4 hour		Pending		
S Rupe				2/10/2016 06:00 P	м 2	00 mg	PO	every 4 hour		Pending		
C Rupe	ofen			02/10/2016 10:00 P	м 2	00 mg	PO	every 4 hour		Pending		
S Bups	ofen			03/10/2016 02:00 A	м 2	00 mg	10	every 4 hour		Pending		
	header here to group		_		_		$\rightarrow$					
Order		A				nediate ce perio			low	Order Comment		PRN Indication





By clinicians

clinician

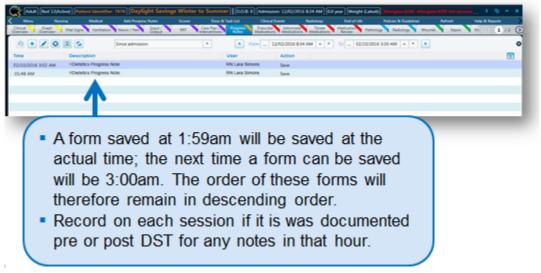
#### Fluid Balance:

 If orders are paused during the changeover and resumed once changeover completes then this would reflect accurately on the Fluid Balance Chart

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food Product Input (Interval)	0	0	0	0	0	0	0	0	p	0	0	0	mL.	- <u>1</u>
arenteral Nutrition Fluid In	0	0	0	0	0	0	0	0	p	0	0	0	mL.	
Dral Fluids													mL.	
3 Tube Input													mi.	
Interal Fluid Input (Interval)	0	0	0	0	0	0	0	0	ø	0	0	0	mL.	
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#### Form Sessions:

- The list of notes is sorted in descending order showing the latest time first and at the top
  of the list. In this example the 3:02AM note will show above the 1:48AM note. Which is
  correct.
- Record on each session if it is was documented pre and post DST for any notes in that hour.



**NOTE:** A progress note should be entered at 03:30 to reflect all changes / events / medication administration that occurred in the DST hour.

#### **Clinical Events:**

By clinicians

clinicians

 Any events that occur from 02:00 will reflect the DST, as at 02:00 the clock changes forward to 03:00.





#### **Timed Interventions**

• During the Winter to Summer additional hour that is added in the timed intervention record, a user could 'Pause' the process for 1 hour.

	NUMBER OF THE OWNER	10441	02:00							1 Hour	
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ose Action	Action Entry Date & Tim	e Ordered By				Details	8				

## **10. Daily Routine Module Specialised Workflow Processes**

- Under Clinical events Cardiac Arrest there is no functionality to record all the detailed information, documentation and notes of a cardiac arrest. All this information will need to be documented in the Progress Notes
- Reports such as the ECHO report cannot be scanned and uploaded they will need to be viewed in 'Powerchart'.







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# eRIC User Guide

**Module 4: Medication** 

Medication







## **11. Overview of Medication Module**

This module will provide the users with requisite knowledge and skills to review, prescribe, administer and discontinue medications, blood and blood products, enteral feeds and Total Parenteral Nutrition in eRIC.

## **12. Medication Terminology**

There is certain terminology for medications that is specific to eRIC that you need to familiarise yourself with.

TERMINOLOGY	DEFINITIONS
Parent Order	A Parent Order creates individual doses that belong to that order plan, which is the prescription.
Orphan Dose	An orphan dose refers to an unplanned, once only dose of a medication. Orphan doses are applicable only to those medications which have an 'orphan dose template' attached. For example Nurse Initiated Medications and Telephone Orders. They are prescribed via the Administration tab (by the nurse right clicking 'new dose' on the left-hand side of the view).
Orderable	The treatment (medication, infusion, task) that is being ordered which needs to be given to the patient.
Order Entry Window	This refers to the order entry window used to create the order for medications and tasks for the patient.
	Contains fields such as: Name of medication, quantity, rate, duration, route of administration, frequency, etc.
Medication Group	Medications belong to different medication groups (e.g. Enteral feeds displayed under nutrition, 0.9% sodium chloride under fluids).
Complex Medication	A medication containing 2 or more medications such as Sulfamethoxazole/Trimethoprim.
Ingredients	The component parts of a complex medication.
Medication	This can be any type of medication with any unit including mass and volume units. Blood Products, fluids, enteral feeds and TPN are all customised as medications.
Additives	A mass or volume based medication that can be added to medications/diluents.
Diluent	A volume based medication / fluid that can be added to dilute medications.
Dose	A single instance of a medication that can be administered to the patient. It can result from an order or as a stand-alone orphan dose.
Brand	The brand name of a specific medication. Multiple brands may be available for a single medication. Usually a single manufacturer has a single brand for the same medication with active ingredients, e.g. The medication with the active ingredient Paracetamol is supplied as multiple brands: Panadol, Panamax.





Dose Form	The form in which pharmaceutical products are marketed for use, typically comprising a mixture of active drug components and non- drug components. Depending on the method of administration they come in several types. E.g. for the oral administration method, common dose forms include tablet, capsule, or oral suspension. Various dose forms may exist for a single particular medication and brand, since different medical conditions can warrant different routes of administration.
Product	The combination of brand name, dose form and strength, for example, Panadol 500mg Tablet, Perfalgan1000mg Injection.
Pending Dose	This is a dose which is due in the future. It is a non-validated dose whose grace period has not started yet.
Immediate Dose	A dose is <b>Immediate</b> during the grace period (one hour before and after the scheduled time)
Late Dose	A dose is <b>Late</b> when the current time is later than the end of the grace period
Expired Dose	Doses become expired if the parent order is discontinued or marked as error

## **12.1 Medication Tab Views**

There are four Medication tab views: 'Prescribe Medications' 'Administer Medications' 'Titrate Medications' and Medication Review'.

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Clinical Overview	Graph Overview Vita	al Signs 🛛 Ve	entilation Ne	uro / Pain	Input / Output	RRT	Care Plan / Interventions	Progres Notes	Prescribe Medications	Administer Medications	Titrate Medications	Medication Review	Spsis
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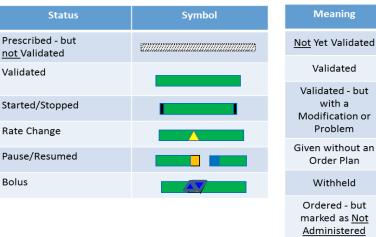


## 13. Legends / Symbols

Several legends / symbols relating to medication are found in eRIC.

## 13.1 Prescribe Medication Tab - Orders Timeline View

#### **Continuous Frequency e.g. IV infusion**



### **Continuous Frequency:**

**Prescribed – but not Validated (Expected):** For each minute where there is a dose with status not validated (Pending, Immediate, Late), the system displays an unfilled 'hatched' bar. Displays from first dose start until stop or until the time horizon is reached.

Validated (Administered): For each minute where there is a dose with status running or initiated and reported, the system displays a solid bar.

**Started/Stopped:** A black thick vertical line shall be at the beginning and at the end of the infusion bar to indicate the starting and stopping time.

**Rate Change**: For the rate change action on a running dose, an up arrow or down arrow (according to the direction of the change), filled with yellow colour, is displayed at the planned action time.

**Paused/Resumed:** For each dose that has been paused and then resumed, The solid bar will have a gap. An orange block indicates the action time of the pause and a blue block indicates the action time of the resume.

**Bolus:** Two yellow triangles tightly together on the running dose document a bolus was administered at that action time.

### Non Continuous / Medications without an Infusion Time:

**Not Yet Validated:** If the dose status is Pending / Immediate / Late / Expired (no information has been reported about the dose), an unfilled diamond is displayed.

Validated: If the dose was validated as expected, a filled diamond is displayed. Validated with a Modification / difference to plan made: If the dose was given differently to the original order plan- it will display as a half-filled diamond. This Includes TBD or a dose validated at a time different to the order (such as early in the grace period).

**Given Without a Plan:** If the dose was validated and no planned order exists (unplanned dose), a filled diamond with an unfilled circle in the centre is displayed. (unscheduled doses not yet covered). They are referred to orphan doses in eRIC. This will occur with telephone orders and nurse initiated doses.

Withheld: If the dose status is withheld, an unfilled diamond with a 'X' in the centre is displayed.

**Ordered but not administered:** If the dose status is made Not Administered, an unfilled diamond with a filled centre is displayed.



### Medications without an Infusion time

Symbol

## **13.2** Administer Medication Tab – Cardex View

		(Roult) Bed	- 06(Active) 41635	Sam Burg	gess Allerg			iperacillin	Nerts: Other	Risk of press	aure area ,	Male D.O.B: 1	4/12/1971	Admission:	
		Clinical Grap	Nursing Med		Progress Notes			& Task List Plan Pro	Clinical Ev press Pres		Radiology inister Ti	End of Life trate Media ications Rev		cies & Guidelines hology Path:	Refresh
Status	Symbol & Color	Overview     Overview       Image: Contract of the second s	C. Dardon	790	1300	1900	15/7/16 199		Da :	900	16/7/16 100	rations Rev 13	05	19 <sup>00</sup>	6 Hours
Pending		Cephazolin Fentanyi Heparin	Ì		)			<b>S</b>	<b>S</b>	8	2	8	ì	8	
Immediate	$\sim$	Paracetamol				ý	<b>S</b>	y Y	Ø	¥ ¥	V	¥ ¥		0	
Initiated															
Validated (Done)		PRN Medication						-							
Late	<u></u>	Morphine Naloxone	3 X 2												
Expired		Fluids/Blood Pr	adust:					_							
Withheld		ter Huldsyslood H													
Not Administered		(o) Nutrition													
PRN	$\bigcirc$	Messages 💶	Active	iser: Sharon-Ar	nn Shunker	Current Patien	t Location San	idbox - Adult	Status: Adm	nitted Res	earch Studies	<b>↓</b>			16/07/2016 13:

**The Cardex dose view** that is seen on the 'Administer Medication' tab is a timeline display of doses in the patient's medical record, showing both planned and administered/validated doses. All doses are shown in a tabular format. Each dose is displayed in an individual cell as an icon with a distinctive background colour. The Start Time of the dose sets the time interval in which the dose appears.

**Grace Period** is a defined time period within which a dose or dose action should be executed. When a dose is within its grace period, it will display with 'Immediate' status (see the above Legend about Statuses).Green is used to indicate the 'Immediate' status. The grace period currently set is 60 minutes before and 60 minutes after the prescribed time. A dose should be validated within the grace period. For example, if the dose is planned to start at 06:00; a clinician will be able to validate the dose at any time from 05:00 and it will be in an (Green) Immediate status until 07:00.

**Status** of a dose is indicated in the Cardex view and gives clinicians valuable information about medication administration.

The following status definitions can be seen in both the Cardex Dose view and Dose & Task Reminder.

- Pending a non-validated dose whose grace period has not started yet. A pending dose can be viewed in the Cardex view but cannot be validated (since you cannot validate future doses).
- Immediate a dose is Immediate when the Grace Period of the dose has started.
- Done/Validated These are doses that have been documented as administered or commenced.
- Late a dose has not yet been validated and the Grace Period has expired.
- Expired late doses change to expired status after being late for an extended period of time (7 days)
- Withheld The Clinician has selected Withheld for that dose.
- Not Administered a dose that wasn't administered and is no longer expected.
- PRN this status indicates the drug will be given on as needed basis (pro re nata –'as the situation demands').





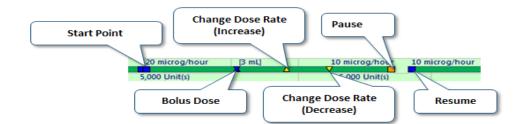
## **13.3 Titrate Medications Tab - Gantt View Running Orders**

**Gantt dose view** is a timeline dose display, displaying doses as bars and diamond symbols. This view is useful for managing running doses (infusions). Therefore, it is used only for administered doses. You cannot administer or see pending doses from this view.

Gantt doses, unlike Cardex doses, contain values rather than colour codes. This enables the user to monitor the amount of medication administered per time period (depending on the time interval set).



#### **Gantt View Symbols**



Menu Ni	ursing	Medical	Add Progr	ess Notes	Scores	Dose & Task List	Clinical Ever	nts Radi	ology E	ind of Life	Policies & Guidelines	Refresh	Help & Reports	Log Out
Clinical Graph Iverview Overview	Vital Signs	Ventil	ation Neuro / P.	ain Input / Output	RRT	Care Plan / Interventions	Progress Prescr Notes Medicat	ibe Administe	Titrate Medications	Medication Review	Sepsis Metab	olic Wounds		
≪ Go to → ► H	PMB-I 17/8/1 823	cu- 09:0	9 921	1023	1123	1223	1323	1423	1523	1623	1723	1823	1923	1 Hour
Medications		T	<u>,</u>	10		11-	<u> </u>	14-	15	10	11-	10	19	_,
ntanyl, IV			20 m	icrog/hour	_			10 microg/hour						
gnesium sulfate, IV		20 mr	nol/hour											
toprazole, IV				ig/hour										
assium chloride (mmol),			10 mmol/hour											
oofol, IV	40 1	mg/hour	20 mg/hour		10 m	p/hour		10 mg/l	nour					
PRN Medications														
		-												
Fluids/Blood Prod	lusta	- í						-						
ium chloride 0.9%, IV		mL/hours										100 mL/hour		
ium chloride 0.9%, IV		<u>3 mL/</u>	hour											
Atuanitina					_			_						_
Nutrition														
		- ( i )												





## **14. Medication Workflow**



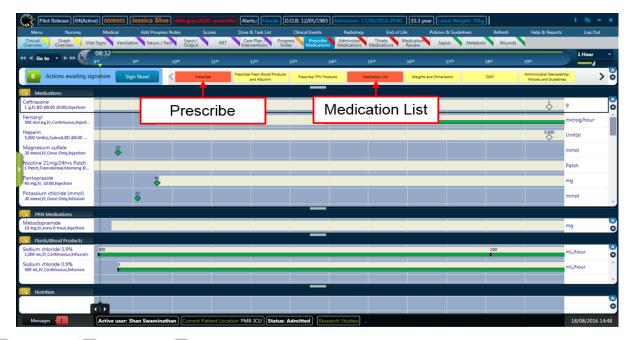
This constitutes the workflow around medication. Medication tabs and views will be used by both Medical and Nursing staff. Pharmacists will also utilise these tabs.

Medications include:

- Medications that are regular orders with scheduled doses, TBD doses (To be decided = Variable dose), PRN medication orders, and once only medications.
- Medication Infusions
- Fluids .
- **Blood and Blood Products** .
- **TPN (Total Parenteral Nutrition)**
- **Enteral Nutrition**

#### **Review Medication** 14.1

Medical staff, nursing staff, and pharmacists will need to review the patient's current medication. This is done from the 'Prescribe Medications' tab view - go to 'Medication List'.





outcomes

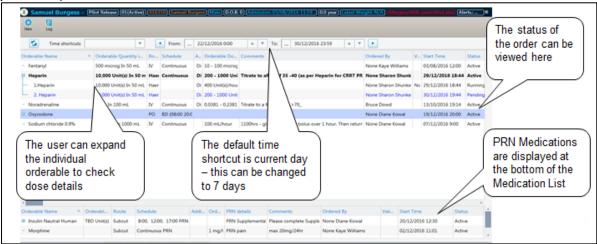


The 'Prescribe Medication' order timeline view can be used to review a patient's current medication.

**NOTE:** The time interval may need to be changed to a 24 hour view (to review all the medications ordered).

**NOTE:** The Medication List is opened via a button from the Prescribe Medication tab and is similar to viewing a medication chart that includes medication name, dose, route, frequency and time, comments and status. This defaults to the current day – the view must be changed to a 7-day view so that weekly medications can also be reviewed.

The Medication List 'From' and 'To' date and time should be changed to review 7 days – as this will enable the user to view medications which are non-daily (e.g. Vitamin K -x 3 times per week).



The 'Titrate Medication' tab view can be used to review the running doses such as infusions.

## **14.2 Prescribe Medication**



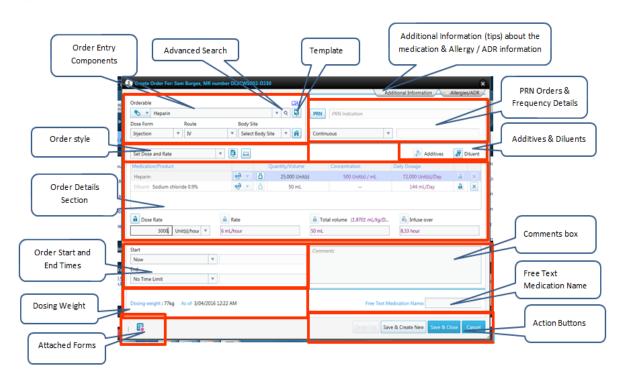
#### Creating a new 'Order Plan' involves the following 2 steps:

- 1. Step 1: Entering the prescription details
- 2. Step 2: Finalising the order

Once the user selects 'Prescribe', the Order Entry window will open to create a Parent Order/Planned Order. Most medications have pre-built templates (choose the desired template).



**Order Entry Window:** The order entry window has the following sections (they will be explained below):



### Step 1: Entering the prescription details

Start by searching for the Orderable / medication you wish to prescribe.

Searching for an Orderable:

- The Orderable field presents a list of the names of all the customised medications, brand names and products that are available for selection. By default it will search generic medications and brand names.
- The Orderable list can also present a list of the names of all the customised products that are available for selection. A product is a medication with a brand name, strength and a dose form e.g. Panadol 500mg Tablet.

#### 1. Order Entry Components

This section includes the name of the medication or enteral feed that you want to prescribe.

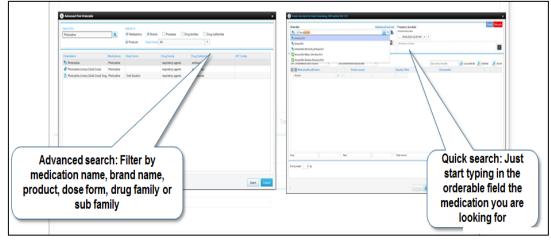
			Find Orderable
	Orderable	aline	CIAP V Q Q
	Dose Form	Route	Body Site
	Infusion	<ul> <li>Central Venous</li> </ul>	▼ Select Body Site ▼ 🕋
Ō Pr		The icons represent which orderable type is being searched.	You can change the search field to search medication and brands, products or recently used templates. By Default the window will open to search Medication and Brands





#### 2. Advanced Search

The advanced search button can also be used to find the Orderable.



#### 3. Order Template

- Prescribing medications is facilitated by the ability to select an order template from a list of available order templates for each orderable
- The list of available templates for the selected orderable is accessed by selecting *Templates* in the Order Entry window, and should automatically appear once you select the orderable from the search window. Only templates appropriate for your department will be available for selection
- Selecting an order template automatically enters pre-customised values into various fields in the Order Entry window, although some fields have been left empty in the template for the intended purpose of them being filled at the time of prescribing
- If required, you can edit the pre-customised values in the template.

rderable	_			PRN PRN Indication
S Voradree	Route	Body Site	▼ Q	
ose Form		body Site		Noradrenaline 4mg in 100mL Sodium chloride 0.9% IV Continuous Infusion [Adult]
				Noradrenaline 8mg in 100mL Sodium chloride 0.9% IV Continuous Infusion (Adult)
	Υ.			Noradrenaline 15mg in 100mL Sodium chloride 0.9% IV Continuous Infusion (Adult)
Aedication/Produc				
redication/Produc	a	Quant	ty/Volume	Noradrenaline 6mg in 100mL Glucose 5% IV Continuous Infusion [Adult]
				Noradrenaline 12mg in 100mL Glucose 5% IV Continuous Infusion [Adult] Noradrenaline 24mg in 100 /L Glucose 5% IV Continuous Infusion [Adult]
lose Rate		Rate		I volume Infuse over
lart nd		orderable is ates will app desired o	ear – sele	
	iq			Medication Name:

#### Dose Form

- From the dose form field, a list of dose forms will be available for selection that is appropriate for the route selected
- A dose form is the form in which pharmaceutical products are marketed for use, for example it could be tablet, eye drops, injection, or infusion
- The dose form will determine the available route and body site.



#### Route

This is the route by which infused and non-infused medications are administered, for example Rectal, Oral, Central Venous, IV, Subcutaneous, etc.

#### **Body Site**

The physical location on the patient's body where a medication is placed or a certain line goes through, for example, right upper arm, right hand, etc. This section is not compulsory and is more frequently used for such things as eye drops, topical creams etc.

Orderable		CIAP
💊 🔻 Noradrenaline		* Q 📮
Dose Form	Route	Body Site
Infusion 🗸 🔻	Central Venous 🔻	Select Body Site 🔻 🕋
Dose Form	Route	Location

#### 4. Additional Information about the medication and Allergies / ADR information

The Additional Information tab presents additional information related to the selected orderable, e.g. monitoring of drug levels for vancomycin.

The additional information can be viewed here for medications and products. This information is specific to this particular orderable. If no additional information is available for the medication or for the product, then the tab will be disabled.

Vancomycin			CIAP	PRN Indication		
lose Form	Route	Body Site		Phil Industry	1	
Select Dose Form	<ul> <li>Select Route</li> </ul>	<ul> <li>Select Body Site</li> </ul>	* 首	6 hrly (00:00 06:00 12:00 18:00)		
Specify Diluent & Infu Medication/Product		-		4	Additives	Piluent
Vancomycin		ecuting the ord			mg/kg/Day (0 mg/Day)	a ×
		y to review the on and allergies		al		

(2) Create Order For: Lara	6.4.0001, MR number 124589	X
Orderable	Medication Info	× Virtual Product/ Product Info
Vancomycin Dose Form Select Dose Form	Tip Consider dose adjustment in renal impairment. Dose per actual body weight. Vancomycin Trough	
Specify Diluent & Infuse Medication/Product	13.0 mg/L ( as of 09/12/2015 10:00 PM ) Vancomycin Random 12.0 mg/L ( as of 09/12/2015 10:00 PM )	
Vancomycin	64 - 0	Additional Information Allergies/ADR
B Dose Rate	This tab present addition this orderable. The inforr medication is displayed of Product information on the	on the left and the
Next Scheduled Dose		

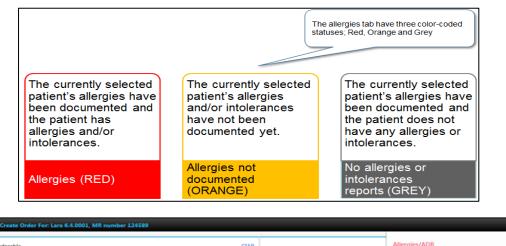




#### Allergies / ADR information:

The tab in the orderable screen will display in different colours depending on the patient's allergy/ADR status.

The allergies tab has three color-coded statuses; Red, Orange and Grey. Allergy status should be entered as part of admission – but ALWAYS MUST be checked as part of the procedure for 'Prescribing' and 'Administering' medication.



rderable Vancomycin	* Q	PRN PRN Indication	Allergies/ADR
ose Form Route Select Dose Form 💌 Select Rout	Body Site           e         ▼         Select Body Site         ▼	6 hrly (00:00 06:00 12:00 18:00)	Intolerances • Gluten
Specify Diluent & Infuse Over Now	· 📮 🎞		Additional Inf
fedication/Product	Quantity/Volume	Concentration	Daily Dosage
/ancomycin	💀 🔻 🖸		mg/kg/V gy) 🔒 🗙
Dose Rate	A Rate		ent allergies/ADR and nformation relating to the

The Allergy status displays on the title bar of the flow sheet.

Pilot	t Release 04(Activ	re) 00000	001 Jessica Pit	Je Aller	gies/ADR: penicilli	n Alerts. Fema	D.O.B: 12/0	5/1983 Admiss	ion: 17/08/2016 0	9:00 . 33.3 ye	ar Latest Wei	ght: 70kg		i G	- ×
Menu	Nursing	Medical	I Add Prog.	ss Notes	Scores	Dose Priask List	Clinical B	vents Ra	siology End	l of Life	Policies & Guide	lines Refresh	Help & Reports	Log	Dut
Clinical Overview	Graph Overview Vita	I Signs	Ventilation Neuro /	Pain O	utput KRT	Care Plan / Interventions	Progress P Notes Mc	rescribe dications Medic	nister Titrate ations Medications	Medication Review	Sepsis	Metabolic Wound	6		
eel 🛋 Go to		PMB-ICU 17/8/16 8 <sup>28</sup>	923	1023	11 <sup>29</sup>	12:31	1320	1420	1529	1623	1723	1823	1923	1 Hour	
Ac	ctions awaiting sig	gnature	Sign Now!	<	Prescribe	Prescribe Freih Blood Pr and Albumin	Prescrib	e TPN Products	Medication List	Weights	and Dimensions	Chò	Antimicrobial Stewardship/ Policies and Guidelines		>
0. Medicat	ations														
Ceftriaxone 1 g.IV,8D (08:0	:00 20:00),Injection												<del>ا</del> ک		4
Fentanyl 500 microg,IV,	V,Continuous,Inject		20	_				10					m	icrog/hour	

The notification symbol next to the orderable name has been pre customised, therefore cannot be changed via the application. A '!!!' notification of Allergy / ADR appears when the user attempts to order a medication with a known Allergy / ADR.

When a prescriber attempts to 'Sign the order' or a nurse attempts to administer/validate a dose, they will not be able to do so without having to 'Resolve' the issue. Clicking on 'Resolve' opens up the Allergy / ADR window with the notification alert. To prescribe or administer a medication to which the patient has a known allergy to, local policy will need to be complied with, and the prescriber will have to re-enter their password within eRIC to proceed.



The reason or explanation for overriding the allergy should be entered in the comments box; this is limited to 500 characters.

Orderable	CIAP			ormation Allergies/AD
S - IIII Benzathine benzylpenicilli	n 🔻 Q 📮	PRN PRN Indication		
Dose Form Route	Body Site		Selected times	
MR Injection IM	🔻 Select Body Site 🔻 📻	Selected times	<b>*</b>	× 4
No Infused Over			(	🔊 Additives 🛛 🐺 Dilue
Medication/Product	Quantity/Volume	Concentration	Daily Dosage	
IIII Benzathine benzylpenicillin				a ×
	orderable will display with '!!	mone to the		
Dose Rate	name. More detail about not	fication will be	Infuse over	
Start	name. More detail about noti coming up		Infuse over	
Start Next Scheduled Dose	name. More detail about not	fication will be	Infuse over	
Start Next Scheduled Dose End	name. More detail about noti coming up	fication will be	Infuse over	
Start Next Scheduled Dose	name. More detail about noti coming up	fication will be	Infuse over	
Start Next Scheduled Dose End	name. More detail about noti coming up	fication will be	Infuse over	

#### 5. Frequency details

- Frequencies enable you to set how often the medication should be given to the patient. The frequency options that are available depend on the medication selected.
- Orders can be set to be administered at the following different frequencies:
  - Continuous
  - Once only
  - Pre-set timings (customised in eRIC)
  - Selected Times enables presciber to select specified times of the day
  - Set Intervals enter a time interval between doses. For example, administer a dose every 12 hours.

D Modify Order for Sam Burgess, MR number	416350					×
Orderable		CIAP	Ado	ditional Information	Allergie	s/ADR
Pantoprazole			PRN PRN Indication			
Dose Form Route	Body Site		PRICE	Specify interval		
Injection 🔻 IV	<ul> <li>Select Body Site</li> </ul>	▼	Set interval	hou	ır.	-
			8 hrly (06:00 14:00 22:00)			
Specify Diluent & Infuse Over Later 🛛 🔻	📬 🛛 🚈 🖉		BD (08:00 20:00)	🔊 Additives	- <b>F</b>	luent
Medication/Product	Quant	tity/Volume	Continuous	Daily Dosage		
Pantoprazole	eð - Ö	40 mg	Morning (08:00)		а	×
Diluent Water for Injections	😌 🔻 🗿	10 mL	Night (20:00)		a	×
			Selected times			
			Set interval			
Dose Rate Rate			Total volume ( mL/kg/Day)	Infuse over		
			10 mL			
-						
Start Selected dose of the day on 💌 3/6/	2016 🔺 🔻 8:00	0 AM	Comments			
End	2016 - 4 8:0	U AM				
No Time Limit						
Dosing weight : 80kg As of 24/05/2016 10:57	АМ		Free Text Me	dication Name:		
				Order Log C	ж	Cancel

**NOTE:** If a drug like Insulin is to be given 3 times a day (with breakfast, lunch and dinner), but the dose is different for each time – this will need to be prescribed as three separate orders.

#### Scheduling a PRN Order

- Select the **PRN check box.**
- PRN Indication Enter the clinical reason for ordering the treatment (mandatory).
   NOTE: Max. Dose per 24 hr. (this should be entered in the comments field) Enter the maximum dose that can be administered per 24 hour period.



- PRN therapies are planned so that the patient receives a dose only as needed, based on a practitioner's clinical assessment.
- When it is determined that a dose is needed, the dose can be administered at any time. If a PRN dose is given too soon, a warning will appear and the clinician will have to enter a reason for giving a dose sooner than expected.
- If the medication you are prescribing is a PRN then all the order details must still be completed.
- Active PRN orders appear on the Cardex and List view regardless of time interval viewing.

It is important prior to administering any medication - including PRN Medications - to always go to the 'Order Details' window and perform the 5 Rights of Drug Administration and **check** all the order details.

#### **PRN order with Titratable Rate**

- If a titratable rate is required for the PRN medication, the lower limit is prescribed as the dose and the titratable range and instructions entered in the 'Comments' box. The nurse will administer it in increments as required within 1minute intervals.
  - ➔ e.g. PRN Morphine 2-6mg to keep pain score <5. Prescribe 2mg as the dose. In comments box write PRN Morphine 2-6mg to keep pain score <5.</p>
  - ➤ Nurse needs to administer 4 mg Morphine
  - The nurse will check the order in the 'Order Details' window' administer the medication then validate it in increments as required within 1minute intervals.
  - The nurse will validate 2mg @ 19:40 and validate the second 2mg @ 19:41 (with comment in the warning box stating 4mg was required to relieve the pain)

Morphine           lose Form         Rour           Injection         IV	te 🗸	Body Site Select Bo	CIAP	Pain Set interval	Specify interval	our 🔻
No Infused Over	T E	<u>متن</u> ة (ف			Additives	🐺 Diluen
Medication/Product			Quantity/Volume	Concentration	Daily Dosage	
Morphine		• <del>0</del> - €	2 mg			a ×
				Total volume		
				Administer 2mg to 6mg Mor Maximum dose per 24 hours		
	-					
Now	•					
tart Now nd No Time Limit	<ul> <li>▼</li> <li>▼</li> </ul>					







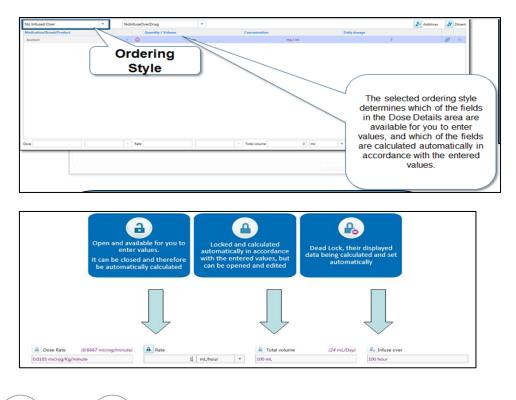


Pilot F	Release 01(Acti	ve) 416350	Samue	l Burgess	Male D.O.B	0 Ad	mission: 03/08/201
< Menu	Nursing	Medical	Add	Progress Notes	Scores		Dose & Task List
Clinical Overview	Graph Overview Vit	al Signs Ve	ntilation	euro / Pain	Input / Output	RRT	Care Plan / Interventions
🔫 ┥ Go to	► ►► 4.	19:20	19 <sup>21</sup>	19 <sup>22</sup>	19 <sup>23</sup>	19 <sup>24</sup>	19 <sup>25</sup>
Act	tions awaiting si	gnature	Sign Now!		Prescribe		Prescribe Fresh Blood Pro and Albumin
🕢 Medicati	ions						
Fentanyl 500 microg,IV,0	Continuous,Inject	10 - 100					
Heparin 10,000 Unit(s),H	Haemodialysis, Co	400					
Noradrenalin 4 mg,IV,Contin		0.0381 - 0.2381					
> Oxycodone 30 mg,PO,BD (	08:00 20:00),MR						
O PRN Me	dications	Ń			_		
Insulin Neutr TBD Unit(s), Sul	al Human ocut, 8:00, 12:00						
Morphine 2 mg,IV, every 4	hour,Injection					<b>2</b>	2

**NOTE:** Alternate and preferred option for Variable Dose PRN is to have a separate order for the lower dose rate and separate order for higher dose rate

#### 6. Order Style

- The ordering style is set by the dose form and route selected.
- There are two groups of order styles (infused and non-infused).
  - Infused needs an 'Infused over time'
  - Non-Infused Does not need an 'Infused Over Time'
- The ordering style is selected to suit the administration method of that medication
- The ordering style determines what kind of order details will be available, for example, a
  continuous frequency will have fields such as dose rate and total volume enabled, where
  as a tablet prescribed once a day will not require these details to be entered
- Each order style will have a locker template associated with them. The locker templates will determine which fields in the dose entry details are editable and which will be auto calculated for the user. You will find many of the fields in the order entry window have a small locker symbol next to them; these will be, open, locked or dead locked.







#### 7. Additives and Diluents

- Additives and diluents are added to the order entry by selecting the corresponding icon
- Multiple additives can be added (e.g. the additives to TPN. Additives to TPN are covered further in TPN Order)
- A Diluent can be added to the prescription –There is a **Diluent for Reconstitution** and **Diluent for Administration**.
- Diluent for Reconstitution is selected to Specify Diluent and Infuse over Later.
  - Often the Diluent for Reconstitution is not added at the time of prescription, but left for the nurse to add at the time of administration.
  - For example, 250ml Sodium Chloride 0.9% for administration of Vancomycin 1gm. The Medical Officer will prescribe the 1 gm of Vancomycin and the nurse can add it into the order entry at the time of administering the drug.

Dose Form Route Body Site	CLAP Additional Information Altergreet/ADR	
	Nolume Concentration Daily Dosage 20 mL Water for Inj	<b>/</b>
Dose Rate Rate	A Total volume Infuse over	This is the diluent for Administration
kat Now v No Time Limit v	This is the diluent for <b>Reconstitution</b> e.g. Water for Injection	e.g. sodium chloride 0.9% fo administration o
losing weight : 70kg As of 25/08/2016 12:56 PM	20ml to reconstitute vancomycin	vancomycin

#### 8. Order /Dose Details

To set the order / dose details, enter values for the required fields:

- ✦ Quantity/Volume
- Concentration
- Dose Rate (weight based unit)
- Rate (volume based unit)
- Total volume
- Infuse over

#### **Quantity / Volume**

This section is used to enter the dose of the medication e.g. Heparin dose 5,000 units.

					Additional Information	<ul> <li>Allergies/ADF</li> </ul>
Neparin			<u>⊂IAP</u>	PRN PRN Indication		
ose Form	Route	Body Site			Selected times	
Injection	<ul> <li>Subcut</li> </ul>	<ul> <li>Select Bo</li> </ul>	ody Site 🔻 🕋	Selected times	▼	<b>*</b> +
No Infused Over		▼ ▲			Additives	🐺 Diluer
Medication/Produc	t		Quantity/Volume	Concentration	Daily Dosage	
		• <del>0</del> •	5,000. UI	nit(s) 🔻		a ×

#### Some medications, such as a Propofol Infusion, have both quantity and volume.

Orderable			CIAP		Additional Information A	llergies/AD
🔊 🔻 Propot	fol		🔻 Q 📮 🕫	PRN PRN Indication		
Dose Form	Route	Body Site				
Injection	▼ IV	<ul> <li>Select Body</li> </ul>	/ Site 🔻 🕋 🛛	Continuous	<b>•</b>	
Set Dose and Ra	te	-			Additives	🛱 Diluer
			Constanting Administration	cocentration	Daily Dosage	
Medication/Prod	uct		Quantity/Volume	Chicentration	bully bobuge	





clinician

#### Daily Dosage

This is automatically calculated once the dose and frequency of the medication is specified.

#### Dose Rate / Rate

The prescribed medication can have a set 'Dose Rate' or a set 'Rate'. The Locker templates determine which values can be entered and which values are locked.

If a clinician wishes to prescribe 'Dose Rate' but the 'Dose Rate' field is locked:

- 1. Click on the 'Rate' Lock Icon (it will now be locked)
- 2. 'Dose Rate' will become unlocked
- 3. Enter into the field

Create Order For: YOGI Bear, MR nu	umber 324678			dditional Information 🔼	Allergies/ADR
Drderable           T         Noradrenaline           Dose Form         Route           Injection         T	Body Site	CIAP V Q Q ite V A	PRN PRN Indication		
Set Dose and Rate	× 🗎 🔤			additives 🔊	Piluent
Medication/Product		Quantity/Volume	e Concentration	Daily Dosage	
Noradrenaline	🕫 🗸 🙆	6 mg	0.06 mg / mL	0.72 - 28.8 mg/day	a ×
Diluent Glucose 5%	📌 🔻 Ö	100 mL		12 - 480 mL/day	a ×
Dose Rate     O microg/Kg/minute	Rate 0.5 - 20 mL/hour		Total volume (0 - 0 mL/kg/day)	<ul> <li>Infuse over</li> <li>5 - 200 hour</li> </ul>	
Dose Rate	Rd	te	Titrate to a MAP of _70		
Dosing weight : kg			Free Text M	dication Name:	
			Order Log	ive & Create New Save (	& Close Cano

'Dose Rate' is a mass based unit (e.g. mg/hr) and 'Rate' is a volume based unit (e.g. ml/hr).

#### **Titratable Rate**

The rate for infusions may be a fixed rate or 'titratable rate'. See the example below for a Propofol infusion with a titratable rate.

Noradrenaline		CLAP ▼ Q Q	PRN	PRN Indication			
njection V Route	Body Site  Select Body	Titrate	rate	rusi	*		
Set Dose and Rate	× 🗈 🖂	butto			additives	#	Diluent
Aedication/Product		Quantity/Volum	10	Concentration	Daily Dosage		
Noradrenaline	10 × 60	6 mg		0.06 mg / mL	0.72 - 28.8 mg/day	a	×
Diluent Glucose 5%	😌 🔻 Ö	100 mil			12 - 480 mL/day	a	×
- 0 microg/Kg/minute	0.5 - 20 mL/hour		100 mL		5 - 200 hour		
art Vow Id Vo Time Limit	Titrat	table te	Titrate t	o a MAP of _70			
osing weight : kg				Free Text	Medication Name:		

**NOTE:** Drugs such as Noradrenaline may need to be prescribed with instructions that relate to how clinicians should titrate the rate of medication. 'Rate titration' instructions are to be placed in the Comments box, which indicates the MAP to which the infusion rate is titrated.



Create Order Fort Lara 6.4.0002, MR of Orderable     V Norderenaline     Dose Form     Route     Infusion     V     N	Continuous I of 'Set Dos	al Officer is presc infusion with a Or e & Rate' they ha elect the 'Rate Tit Button	der Style ave the	Additional Information Altergier/ADR Orders commonly need to be prescribed with a rate titration, thus allowing the clinician the freedom to change the dose rate of a
Set Dose and Rate	- 📮 🔤			infusion, while staying with in a pre-defined
Medication/Product	Qu	antity/Volume	Concentration	range which suits the patients clinical
Noradrenaline	•ê - Ō	4 mg	0.04 mg / mL	condition
Diluent Sodium chloride 0.9%	😎 👻 🙃	100 mL		24 - 48 mL/Day 🔒 🗙
Dose Rate (0.6667 - 1.3333 microg/mi 0.0103 - 0.0205 microg/Kg/minute	n a Rate 1 - 2 mL/hour		Cotal volume (24 - 48 mL/	Day) Be Infuse over
Start			Titrate to a MAP of 12	
Now	• /			
End No Time Limit				
NO TIME LIMIT			L	
		Rate' and ' Infuse be entered as a ge	Text Medication Name:	er Log Save & Create New Save & Close Cancel

#### **Total Volume**

- This can be entered; or
- It may be automatically calculated based on the Diluent. For example, this Fentanyl infusion has a 50ml Diluent for Administration of Sodium Chloride 0.9%- and this automatically calculates the total volume to be 50ml.

Orderable				CIAP	Add	itional Information	Notes	<ul> <li>Aller</li> </ul>	gies/ADR
💊 🝸 Fentar	syll			* Q					-
Dose Form	Route		Body Site		Administration time				
Injection	* IV	×	Select B	lody Site 🔻	12/05/2016 16:04	A Y			
Set Dose and Ra	ite	- <b>D</b>			(	🞜 Copy products	Additives	#	Diluent
	ong product			Product Am	ount South Motor	ne Concentra	tion		
Fentanyl			•ð •	ō	500 micr	og 10 mi	crog / mL	a 🕂	×
Diluent Soc	lium chloride 0.9%		•ð -	ō	50 mL			a +	×
					Order Comment				
Order Summary					Choren Commingent				
Infuse over: 8.33	60 microg/hour Rate 3 - 25 hour Frequen 5 16:04 Stop: 5 dose	cy: Continuou							
Dose Rate: 20 - Infuse over: 8.33 Start: 12/05/2010	3 - 25 hour Frequence	cy: Continuou Is							
Dose Rate: 20 - Infuse over: 8.33 Start: 12/05/2010	8 - 25 hour Frequen 5 16:04 Stop: 5 dose	cy: Continuou Is			Co-sign for administration Co-sign user nurse		word:		

#### Infuse Over

This is the duration over which the infusion will run e.g. Vancomycin 1gm in Sodium Chloride 0.9% 100ml will 'Infuse over – 2 hours'.

						dditional Information			
Orderable           Vancomycin		×	CIAP Q D P	RN PRN Indication					
lose Form Route	Body Site					Specify interval			_
Infusion V IV	▼ Select Bo	ody Site	* 🐔 Se	et interval	Ψ.	12	hour		٣
Specify Diluent & Infuse Over Now	× 📮 📖					🔊 Additi	ves 🔤	P Dik	ent
Medication/Product		Qui	antity/Volume	Concentration		Daily Dosage			
Vancomycin	<del>69</del> -	19	In 20 mL Water	for I 8.3333 mg /	/ mL	28.57 mg/kg/Day (	2.000	a	×
Diluent Sodium chloride 0.9%	•6 ·	õ	100 mL			2.86 mL/kg/Day (20	0 mL/	a	×
Dose Rate	Rate			Total volume (3.4286 n	nL/kg/D	a Infuse over	bour		Ŧ
Dose Rate 500 mg/hour	Rate 60 mL/hour		120	Total volume (3.4286 n 0 mL	ml./kg/D	_	. hour		¥
500 mg/hour tart			120	0 mL	nL/kg/D	_	hour		¥
500 mg/hour tart	60 mL/hour		120	0 mL	nl/kg/D	_	hour		¥



#### 9. Order Start and End Times

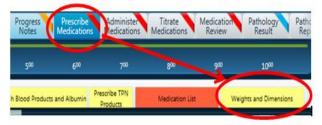
This allows the starting and ending times to be prescribed for an infused dose. The Start Time defaults to 'now' and it is not compulsory to set an End Time.

#### 10. Comments Box

Used for entering special instructions, e.g. target MAP to titrate the noradrenaline infusion, maximum 24 hour dose for PRN medication, medication specific brand names that need to be prescribed such as Coumadin for warfarin.

#### **11. Dosing Weight**

This is the weight used for drug calculations that has been entered in the **Weights and Dimensions** window. As part of the prescribing process, ensure the patient's weight and height are entered in the 'Weight and Dimensions' form which can be accessed by selecting the **Prescribe Medication** tab.



12/07/2016 14:35	🔺 🔻 🈘 S	haron-Ann Shunker / S	Sandbox -	Adult	8 Previous	Session	¥
Veights and Dimensions							
leight	165	🔺 🔻 cm					
Weight (Latest)	80	🔺 🔻 kg	On	21/04/2	2016 10:20:00		
Veight (Admission)	85	🔺 🔻 kg		<u>BMI</u>	29.4		
<u>Veight (Ideal)</u>	61.4	🔺 🚽 kg		<u>BSA</u>	1.874	m <sup>2</sup>	
Veight (Adjusted)	68.8	🔺 👻 kg					
Drug Calculation Weight							

**NOTE:** changing the dose weight will result in a change of dose for all medications where the prescribed dose is weight dependent (i.e. when dose is prescribed in mg/kg/hour). If the patient's weight is changed – all medications that are weight based prescriptions need to be re-prescribed (because original weight is retained in the parent order and displayed in the Order Details Window).



#### 12. Attached Forms

Certain medications such as Heparin Infusions may have mandatory attached forms that need to be completed as part of the order prescription.

Create Order For: Sam Burgess, MR numbe	er 416350							
					Ac	Iditional Information	Allerg	es/ADR
Orderable			<u>CIAP</u> ▼ <b>Q</b> 🐯	PRN	PRN Indication			
Dose Form Route	Body Si	to	· •	PRN	PRIN Indication			
Injection V IV	<ul> <li>Select</li> </ul>		Site 🔻 😭	Continu	ious			
Set Dose and Rate 🔹	<u>نه</u>					Additives	F	Diluent
Medication/Product			Quantity/Volume		Concentration	Daily Dosage		
Heparin	•	ō	25,000 Unit(	s)	500 Unit(s) / mL	Unit(s)/Day	a	×
Diluent Sodium chloride 0.9%	<b>6</b> •	Ō	50 mL			mL/Day	a	×
Dose Rate	,			50 mL		₽ Infuse over		
Start Now 💌 End No Time Limit				Comme	nts			
Dosing weight : 80kg mandator	y atta	che				edication Name:	lose	Cancel

#### **13. Action Buttons**

The three buttons at the bottom of the prescription window:

- 'Save and Create New' allows you to save the current order and create a new order this way multiple orders can be created and signed for together
- 'Save and Close' allows you to close the order once complete
- 'Cancel' cancel current order.

Dosing weight : 80kg As of 24/05/2016 10:57 AM	Free Text Medication Name:
: 🖪	Order Lo Save & Create New Save & Close Cancel

#### Prescribing Variable Dose Orders (called TBD in eRIC) TBD – 'To Be Determined' as the dose is variable.

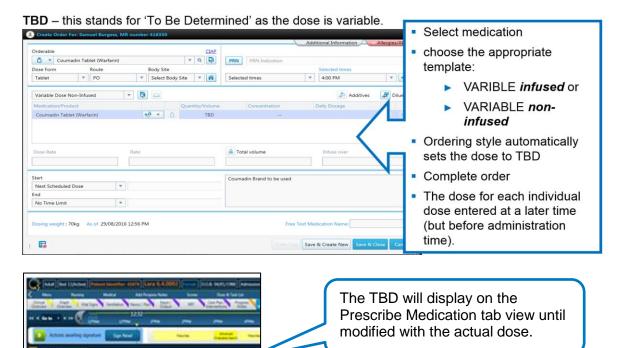
- Select the desired medication and choose the appropriate template, which may be for VARIBLE *infused* or VARIABLE *non-infused*
- For example, (COUMADIN) Warfarin VARIABLE dose PO at selected times
- Selecting this ordering style automatically sets the dose to TBD (To Be Determined) and allows the dose for each individual dose to be entered at a later time prior to administration of each dose
- For example, in the case of prescribing Warfarin, it may be necessary to vary the dose according to the INR results
- Order prescription needs to be completed and the 'Dose' is modified later once the blood result is back.





#### See the example below for Warfarin.

**NOTE:** For some drugs such as this one, it is important to check the brand name – e.g. Coumadin. This is only visible in the Order Details window).



**NOTE:** Medications such as Metaraminol that will need to be given as bolus increments and Diazepam as per Alcohol Withdrawal Scale policy will also be prescribed as PRN, with dose being TBD. Order dose details will be in the Comments Box.

Create Order Fo	r: Eric Lis Three, MR	number 10282293-C213		Additional Information Allergies/ADR
Orderable			<u>CIAP</u>	
💊 🔻 Metarar	minol	•	۹ 🗳	PRN <sub>C</sub> PRN Indication
Dose Form	Route	Body Site	Meta	raminol X mg in X mL Sodium chloride 0.9% IV Continuous Infusion [Adult]
Injection	▼ IV	<ul> <li>Select Body Site</li> </ul>	<ul> <li>Metai</li> </ul>	raminol X mg IV Bolus Once Only [Adult]
			Meta	raminol TBD mg IV Bolus every X minutes PRN [Adult]
Variable Dose No	n-Infused	💌 📴 📖		+ Additives + Diluent

#### **Free Text Medications**

If the medication does not exist in the medication catalogue – The solution is to prescribe using the 'Free Text Medication' function.

DO NOT use free text for prescribing unless there is no available orderable.

 Type 'free text' into the orderable search field. The free text medication templates will appear, choose the appropriate template.

Orderable	
S Tree Text Medication (mL)	<b>v</b> Q
S Free Text Medication (Application)	*
Free Text Medication (Dressing(s))	
S Free Text Medication (Drop(s))	
🔊 Free Text Medication (mg)	
S Free Text Medication (mL)	
💊 Free Text Medication (mmol)	
S Free Text Medication (Unit(s))	





 All Order Details must be entered for the medication. The medication name MUST be written in the Free Text Medication Name box located in bottom right hand corner of template. DO NOT WRITE THE NAME IN THE COMMENTS BOX.

		er 416350											Add V	itional Infor	mation 🛆	<ul> <li>Allergies/</li> </ul>
Orderable						ç	IAP									
💊 🔻 Free Text Medica	ation (Application)					• Q		PRN	PRN Indication							
Dose Form	Route			Body Site			-					s	elected times			
Select Dose Form	▼ Select R	oute		Select Body Site	e	<b>•</b>	ñ	Selected	times			•				•
No Infused Over	×	<b>D</b>												4	Additives	🚚 Dil
Medication/Product			Quantity	/Volume			C	Concentratio	n			Daily Do:	sage			
Free Text Medication (App	olication)	<b>e</b> ð 🗸	õ	1 Applic	ation											а
Dose Rate			Rate					Total	volume				Infuse over			
Dose Rate			Rate					A Total	volume				Infuse over			
tart			Rate						volume	RIBER: Do	NOT enter med			omment fiel	ld ********	
itart Next Scheduled Dose			Rate							RIBER: Do	NOT enter med			omment fiel	ld ********	*****
Start Next Scheduled Dose ind			Rate					****				lication n	ame into this co			
Dose Rate Start Next Scheduled Dose End No Time Limit		▼ ▼	Rate					****	******** PRESCI			lication n	ame into this co			

#### NOTE:

- Free text medications will not appear on the printed eNIMC and MUST be manually entered (check last page of eNIMC for Free Text Medications).
- Free text medications do not automatically populate in the Fluid Balance enter volumes manually

#### Step 2: Finalising the order

#### **Complete Mandatory attached Forms**

Certain drugs will have mandatory attached forms. For example, Warfarin has a form with the INR details.

#### Save and Create New

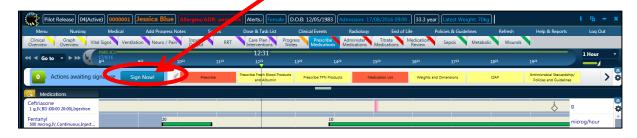
Clicking on the 'Save & Create New' button allows the medical officer to continue to order more medications. These can then be signed for together.

#### Save and Close

Clicking on the 'Save & Close' button will close the Order Entry window and take the Medical Officer back to the 'Prescribe Medication' tab.

#### Sign Now

From the shopping cart, click on the 'Sign Now' button to sign all prescribed orders.









If there are any dose issues, once all dose actions are resolved, the Medical Officer will need to sign the prescriptions. This is done by re-entering their password in the pop-up box. Only the user logged in can enter their details here, so a user must ensure they are the user logged in before prescribing a medication. Until the order is signed, no other users will be able to view the order or administer the medication.

Signature Review			×
전화 Resolve 전화 View and Acknowledg		Defer action	
Signature re-authentication required.			
Description	Action	Issue	Response
Fentanyl 500 microg IV Continuous	Create	No Issue	
Pantoprazole 40 mg IV BD (08:00 20:00)	Create	User Re-Authentication     X	
Paracetamol 1 g NG 6 hrly (00:00 06:00 12	Create		
Propofol 500 mg IV Continuous	Create	User Name Sharon Shunker	
Sodium chloride 0.9% 90 mL IV Continuous	Create	Password	
Vancomycin 1 g IV BD (08:00 20:00)	Create		
		OK Cancel	
6 actions awaiting signature, 6 actions read	y for signa	ure O actions deferred / discarded	Sign Now! Sign Later

## 14.2.1 Prescription Examples

### **Oral Medication**

Prescribing Paracetamol 1gm 6<sup>th</sup> hourly

Create Order For: Sam Burge	ss, MR number 416350			Additional Information / Allergies/ADI
Orderable Paracetamol Dose Form Tablet Tablet Po	Body Si Select	CIAP	PRN PRN Indication Set interval	Specify interval
No Infused Over	× 📴 📟			🔊 Additives 🛛 🐺 Diluent
Medication/Product		Quantity/Volum	e Concentration	Daily Dosage
Paracetamol	• <del>6</del> -	<b>1,000 m</b>	g	50 mg/kg/Day (4,000 mg 🔒 🗙
tart			Comments	
Now	•		Comments	
nd				
No Time Limit	•			
Dosing weight : 80, kg			F	ree Text Medication Name:
				er Log Save & Create New Save & Close Cano



- Select medication 'Paracetamol' with template 'Paracetamol X mg PO every X hours (Adult)'
- Dose Form automatically populates as 'Tablet', Route as 'PO'
- Need to set interval this is chosen to be 6<sup>th</sup> hourly
- Order style is 'No Infused Over' as this is an oral order
- The dose of 1gm (1000mg) is entered under the 'Quantity / Volume' section
- Start time is 'Now' and 'no end time' is specified
- The order details are complete so you can 'Save and Create New'.

#### Intravenous Medication

Prescribing Hydrocortisone IV Bolus 100mg every 8 hours

	. Jamuel Burge	ss, MR nui	mber 41635	0					Add	litional Informat	ion 🛆	Alleraie	s/A[
Orderable					CIAP	2		_					
North Hydroco	rtisone				v Q 🐯		PRN	PRN Indication					
Dose Form	Route		Body S	ite						Specify intervi	al		
Injection	▼ IV		▼ Select	t Body	Site 🔻 🕋		Set inte	rval	•		8 hou	ir	
No Infused Over		•	<b>B</b>							<b>\$</b>	Additives	<b>"</b>	Dilue
Medication/Produc	t				Quantity/Volum	ne		Concentration		Daily Dosage			
Hydrocortisone			• <del>0</del> •	ō	100.	mg	-			4.29 mg/kg/Da	y (300 mg	/ a	>
art							Comme	atr					_
Now		•					Comme	11.5					
nd													
No Time Limit		•											
No Time Limit	g As of 29/08		i6 PM					Free Text	Me	dication Name:			

Select Template – Hydrocortisone Xmg IV Bolus every X hours (Adult)

- Dose Form automatically populates as 'Injection', Route as 'IV'.
- For frequency select 'Set Interval' select interval as 8 hours
- Order style is 'No Infused Over'
- The 'Quantity / Volume' is 100mg
- Start time is 'Now'.

The order details are complete - so you can 'Save and Create New'.

#### **Intravenous Infusion**

Prescribing Midazolam 50mg in 50ml Sodium Chloride 0.9% IV Continuous Infusion

Ereate Order For: Sam Burgess, MR number 0416350				(×)
			Additional Information Additional Information	lergies/ADR
Orderable	CIAP			
🔨 🔻 Midazolam	▼ Q D)	PRN PRN Indication		
Dose Form Route	Body Site           V         Select Body Site         V         Image: Control of the select Body Site	Continuous	•	
Injection + IV	Select body site	Continuous		
Set Dose and Rate 💌 📴 🚟			🔊 Additives	Piluent
Medication/Product	Quantity/Volume	Concentration Dai	ly Dosage	
Midazolam 😌 🔻	Ö 50 mg	1 mg / mL	0.3 - 3 mg/kg/Day (24 - 240 mg/Day)	a ×
Diluent Sodium chloride 0.9%	0 50 mL		24 - 240 mL/Day	a ×
Dose Rate	a Rate	Total volume (0.3 - 3 mL/kg/Day,	) 🔒 Infuse over	
1 - 10 mg/hour	1 - 10 mL/hour	50 mL	5 - 50 hour	
	-		-	
Start		Titrate Midazolam to RASS +1 to -1		
Now				
End				
No Time Limit				
Dosing weight : 80kg As of 29/07/2016 3:24 PM		Free Text Medica	ition Name:	
1			Order Log Save & Create New Save & Clos	





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- Select Template Midazolam 50mg in 50ml Sodium Chloride 0.9% IV Continuous Infusion
- Dose Form automatically populates as 'Injection', Route as 'IV'
- Frequency automatically populates as 'Continuous'
- Order style is 'Set Dose and Rate'
- The 'Quantity / Volume' is automatically populated from the template
- A 'Titratable Rate' is chosen 'Rate' needs to be set set as 1-10ml/hour
- Use comments box to provide instructions for rate titration e.g. Titrate sedation to RASS +1 to -1
- 'Dose Rate' and 'Infuse Over' is automatically calculated
- Start time is 'Now' and End time is specified by 'Number of Doses'
- The order details are complete you should 'Save and Create New' or 'Save and Close'.

#### 'Sliding Scale' / Supplemental Insulin

See Below Example of how to order 'Sliding Scale' / Supplemental Insulin – It has a mandatory attached form to be completed with the range of BGL and the units of Actrapid. It is ordered as a PRN medication and will need the Frequency specified.

Screate Order For: Samuel Burgess, MR number 416350	Additional Information Allergies/ADR	i 16 - ×
Orderable           Image: Constraint of the second	CIAP CIAP	Refresh Help 1 / 2 1 Minute Jours Infusion [Adult]
Variable Dose Non-Infused	[Actrapid] Insulin Neutral Human SUPPLEMENTAL INSULIN Subcut Injection at Selected times PRN [A [Humulin R] Insulin Neutral Human X Units Subcut Injection at Selected times [Adult]	
Actrapid 100units/mL Injection (Insulin Neutral 😍 🔻 🧴	TBD X	ng Jnit(s)/hour
Dose Rate Rate	Total volume Infuse over	ng Jnit(s)
Start Now V End	Please complete Supplemental Insulin Sliding Scale in the attached form.	ng
No Time Limit   Dosing weight : 70kg As of 29/08/2016 12:56 PM	Free Text Medication Name:	nL/hour
	Order Log Save & Create New Save & Close Cancel	, 30/12/2016 20:47

(1) Samuel Burgess - Supplemental Insulin Orders - Act	rapid		×
30/12/2016 20:45 🔺 🔻 🏠 None Sha	iron Shunker / PMB-ICU		* *
Supplemental Insulin Orders			<u>به</u>
Sliding scale insulin alone is NOT recommended, c Remember: Adjust routine insulin based on supple If unsure, seek advice.			
Special instructions:		Name of Insulin: Usually the same as the routine short acting insulin	Actrapid
(for example "With meals only")			
Latest BGL recorded: 15.1 mmol/L (Recorded at:	19/12/2016 06:00)		
If the BGL (mmol/L) is:		then adminis additional:	ter
8.1 - 12 mmol/L or value:	mmol/L to value:	mmol/L value:	2 A Unit(s)
12.1 - 16 mmol/L or value:	mmol/L to value:	mmol/L value:	4 Unit(s)
16.1 - 20 mmol/L or value:	mmol/L to value:	mmol/L value:	G Unit(s)
			Save and Close Cancel





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#### GTN patch

When ordering GTN patch, the medical officer must fill out a mandatory form scheduling a daily task for removal of the GTN patch. When the GTN patch order is discontinued, the daily task is not automatically discontinued.



Remove GTN Patch and uncheck the box at the beginning of the task. The nurse must then confirm this action by clicking on the Sign Now button located at the bottom left hand corner of the screen.

*Alternate:* Click on the down arrow (menu button) and select discontinue  $\rightarrow$  continue with confirming this action by clicking on the Sign Now button.

**NOTE:** All prescribed orders need to be signed to complete the prescription. They are signed from the shopping cart that opens up the signature window and requires the prescriber to enter their password. Any issues with the prescription will come up with a message and need to be resolved prior to proceeding with the order, e.g. of issues – no total volume entered, no rate entered, mandatory form not completed (see below section on 'Finalising the order').

## 14.2.2 Prescribing: Things to Remember

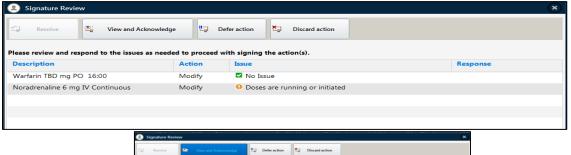
When using 'Modify' parent order for some medications, it creates an additional dose

**NOTE: DO NOT USE** the 'Modify' action from the parent order. If changes need to be made Discontinue the order and prescribe a new order.

- When using Modify to change comments section (eg 'titrate MAP to...'), the prescriber needs to 'Sign' for the modify action.
- This creates a 'Issue' of 'Doses are running or initiated' → Select 'View and Acknowledge'.
- This brings up a pop up box with a warning that doses are currently running, if you proceed with modify action the system will apply a stop action to the running dose.
- Select 'Do not Stop' action from the pop up Warning window
- The decision to modify the titratable MAP or any comments that get added / modified MUST be communicated to the nurse / relevant clinician, so that they can action it. An entry should also be made in the progress notes.

(If the prescriber selects 'Stop' a second order is created for validation on the dose take list and from the cardex view - The nurse will then be prompted in the 'dose task list' to 'stop noradrenaline' and then to 'Validate a new dose')





Description	Action	Issue	Response
Warfarin TBD mg PO 16:00 Noradrenaline 6 mg IV Continuous	Modify	No Issue	
	Warn A do If you will a initia	Modify Noradrenatine ing: concernently running (or initiated). is processify with modify action, the system pply a stop action to the running (or ted dose. do you want to proceed? Step Do not step	

#### Prescribing Arterial Line flush (i.e. 500mLs @ 3mLs/hr)

Arterial Line flushes should be charted by ICU doctors in the 'Prescribe medications' tab, 'Sodium Chloride 0.9%, 500mLs, Intra-arterial, rate of 3mL/hr'. Should also include 'venous' option for CVP transducers and other venous routes with a flush device.

**NOTE:** Currently whilst the Alcohol Withdrawal Scale (AWS) is in the eRIC database the standing orders for sedation per score is not available on eRIC. This causes an issue with dosing of sedation as current practice is that an indication is documented as 'per AWS' Standing sedation orders should be prescribed as Titratable PRN orders. If the drug is Diazepam (for example), it can be prescribed as a 'Titratable PRN' medication with indication being AWS– use the process outlined above in (page 125) and enter in comments box to administer as per AWS policy.

#### Ordering electrolytes with diluents.

When ordering electrolytes in diluents, the Doctor must create a new order of the actual electrolyte. Adding a diluent is optional (as the nurse may administer the electrolyte in the burette of the already running maintenance solution). *Doctors should <u>not</u> prescribe a diluent (e.g. 0.9% NaCl) AND then list electrolytes in the* Comments section of the order.

#### Ordering Calf Compressors and anti- thrombosis stockings

Medical/Clinical Staff can use the Ordering window and the orderable is 'Apply/Check Antiembolism Device/stocking'. Type 'apply' in the order entry component to bring it up as an option to select. It will be set as a 6 hourly Nursing task to 'Apply/Check Anti-embolism Device/stocking'

Orderable					CIAP	
💊 🔻 Apply	//Check /	Anti-embolic Device/	'Stockings	▼ Q	₿.	PRN PRN Indication
Dose Form		Route	Body Site			
		Select Route	<ul> <li>Select Bod</li> </ul>	ly Site 🔻	龠	6 hrly (00:00 06:00 12:00 18:00)
End No Time Limit		•				
						Free Text Medication Name:





#### Use the Comment Box to enter the 'Indication' for the prescribed medication.

#### **Brand Names**

 BRAND names will only display in the 'Order Details Window'. They will not display in Prescribe medication view, Administer Medication Cardex view or in Dose & Task List.
 Example – Prescribing Oxycontin MR Tablets PO 12 hourly

2 Create Order For: YOGI Bear,	MR number 324678			Additional Information 🛆 🗸 Allergies/ADR
Orderable OxyContin MR Tablet Dose Form MR Tablet V PO	(Oxycodone) Body Site V Select Bo		RN PRN Indication	Specify interval
No Infused Over	▼			Additives 🗗 Diluent
Medication/Product		Quantity/Volume	Concentration	Daily Dosage
OxyContin MR Tablet (Oxycodo	ne) 🍕 🔻 (	10 mg (10 mg)		0.35 mg/kg/day (30 mg/d 🔒 🗙
Dose Rate	Rate		Total volume	Infuse over
Now	<b>v</b>	Co	omments	
End				
No Time Limit	•			
Dosing weight : 85kg As of 24,	/02/2017 1:57 PM		Free Tex	xt Medication Name:
I			Order Log	Save & Create New Save & Close Cancel

Administer Medication Cardex View and Dose & Task List View (does not have the BRAND name details)

Menu	Nursing	Medical	Add Progress No	tes S	cores	Dose & Task Lis	ŧ	Clinical Events	End of Life	_	cies & Guidelines	Refresh	Help & R	epc
Clinical Overview	Graph Overview Vital Si	gns Ventilation	Neuro / Pain	Input / Output	RRT	Care Plan / Interventions	Progress Notes	Prescribe Medications	Administer Medications	Titrate Medications	Medication Review	Sepsis Meti	ab 🔇 🚺 /	2
🛯 🚽 Go to	3/3	IB-ICU /17										0:49	1 Hour	
	000	100	200	300	400	500	600	700	800	900	1000	- <sup>1100</sup>		
A Modical	tions													
Oxycodone														_
.,	_													
												-		
												-		
												1		

ag a	column header here to group by that colu	nn							
	Orderable	Start Time▲	Quantity/Volume	Route	Frequency	Dose Rate	Dose Status	Order Comment	
	Nutrison Protein Plus Multi Fibre	08/08/2016 22:	. 1,000 mL	NG	Continuous	20 mL/hour	Late		
]∥ •	Fentanyl	02/09/2016 03:	. 500 microg in 50 mL	IV	Continuous	10 - 300 microg/hou	Late		
	Sodium chloride 0.9%	07/12/2016 21:	. 1,000 mL	IV	Continuous	100 mL/hour	Late	1400 - bolus 250mls 141	7 - bolus 250ml 1
1	Sodium chloride 0.18% and Glucose 4%	08/12/2016 10:	. 1.000 mL	IV	Continuous	50 mL/hour	Late	1030hrs Give 250 ml cha	llenge over 1 hour
1	Noradrepaline	26/02/2017 15	6 mg in 100 ml. Glu	IV.	Continuous	0.5 - 20 microg/minu	Late	Titrate to a MAP of80_	
1	Oxycodone	03/03/2017 11:	. 10 mg	PO	every 8 hou		Immediate		
+			. <u>20 mg</u>				Pending		
	Oxycodone	04/03/2017 03:	. 10 mg	PO	every 8 hour		Pending		
ag a	o column header here to group by that colu	nn							
	Orderable	Start Time▲ Q	uantity/Volume Ro	oute Frequ	ien Dose Ra	te Dose St	Order Comm	ient	PRN Indication
1	ndansetron	PRN 4 r	ng IV	every	8 h	Pending			nausea





Use the 'Order Details Window' to check medication as this has the BRAND name details

Notes Allergies/ADR
erval
8 hour v
Additives 🗳 Diluent
e
'day (30 mg/d 🔒 🗙
2F

## 14.2.3 Prescribing Blood and Blood Products

- The Medical Officer needs to follow a specific workflow to prescribe Blood Products which is slightly different to how normal medications are prescribed. The volume of the red cell unit or FFP unit is not known until the product arrives in the unit, therefore the rate cannot be prescribed in the prescription.
- Each separate bag is prescribed as a separate dose allowing each to be checked and cosigned individually as per policy.

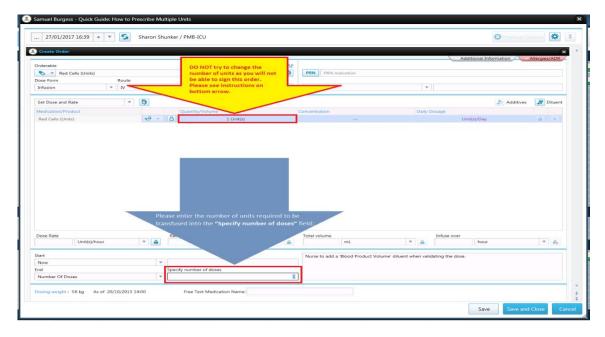
#### Work Flow for Blood and Blood Products

Select  $\rightarrow$  Prescribe Medications tab  $\rightarrow$  click the **Prescribe Fresh Blood Products** button.

👌 (Adult	CC 02(A			io][Sam B						
Menu	Nur	sing	Medical	Add Prog	ress Notes	Scores	Dose & Task	List	<b>Clinical Events</b>	
Clinical verview C	Graph Verview	Vital Sign		n Neuro / F	Pain Input Outpu	rt RRT	Care Plan / Interventions	Progres	Prescribe Medication	Ad Me
◄ Go to	<b>&gt;</b> >>	17/5/2 1300	al Care 6 1400	1500	160	• 179	1800		2000	
O Actio	ons awai	ting signatu	re Sign	Now!	<	Prescribe	Prescribe Fresh Bloom		escribe TPN Pro	ducts
Madicatio	0.E				_		-			
Pres	cribe F	resh Blood	Products a	nd Albumi	in (Adult)					
Pres	cribe F	resh Blood	Products a	nd Albumi	in (Adult)					
		resh Blood		nd Albumi						
Fresh	Blood P	roducts an	d Albumin	Cell Save	r Blood					
Fresh Red C	Blood P	roducts and	d Albumin <sup>ozen Plasma</sup> Re	Cell Save	r Blood					
Fresh	Blood P	roducts and	d Albumin	Cell Save	r Blood					
Fresh Red C	Blood P iells Plate nit 1 U	roducts and elets Fresh Fro nit 1	d Albumin <sup>ozen Plasma</sup> Re	Cell Save ed Cells Washed 1 Unit	r Blood					
Fresh Red C 1 Un	Blood P iells Plate nit 1 U If mu	roducts an elets Fresh Frr nit 1 ultiple units are	d Albumin ozen Plasma Unit required please u	Cell Save d Cells Washed 1 Unit	r Blood	Covo-depleted Pla	Red Calls V	Nacherl		
Fresh Red C 1 Un Red	Blood P iells Plate it 1 U If mu	roducts and elets Fresh Fro nit 1	d Albumin <sup>ozen Plasma</sup> Unit	Cell Save ad Cells Washed 1 Unit use this guide lasma Cry	r Blood	Cryo-depleted Pla Multiple Units				
Fresh Red C 1 Un Red Multip	Blood P iells Plate it 1 U If mu	roducts and elets Fresh Fr init 1 ultiple units are Platelets	d Albumin vzen Plasma Unit required please u Fresh Frozen Pl Multiple Un	Cell Save ad Cells Washed 1 Unit use this guide lasma Cry	r Blood					



- To prescribe 1 unit of red cells select the Red Cells 1 unit button. This will result in the Order Entry window opening with pre-defaulted information
- If more than 1 unit of any blood product is required, check the instructions by clicking on the yellow button 'If multiple units are required please use this guide'



- NOTE: The units are prescribed as 'Number of Doses' (see below). Therefore, if you want 2 units, specify this in the 'Specify Number of Doses' section as 2
- The dose rate for blood products is selected to determine the duration to infuse the blood product. For example, if 2 units are required and dose rate selected = 1 unit per hour, then 2 units will run over 2 hours
- The order is prescribed in units, with no volume defined, as the volume is unknown at time of prescription
- The nurse will enter the volume at time of dose administration.

						Ad V	lditional Information 🔎	<ul> <li>Alle</li> </ul>	rgies/Al	
rderable       Red Cells (Units)       ose Form     Route       Infusion.     IV		ody Site Select Bod	v Site	CIAP Q Q () () () () () () () () () ()	PRN /	PRN Indication				
Set Dose and Rate	•	<b>B</b>			-		s Additives	#	Diluent	
Aedication/Product				Quantity/V	/olume	Concentration	Daily Dosage			
Red Cells (Units)	0 - <del>6</del> ,			1 Unit(s)			Unit(s)/Day	а	×	
	•									
art Now	÷				NURSE: PI	ease add a 'Blood Prod	uct Volume' diluent when	n validat	ing 🔺	
nd		umber of d	loses				as the surplus of units a			
Number Of Doses	•	Specify number of doses				PRESCRIBER: DO NOT try to change the number of units as you will not be able to sign this order.				
osing weight : 00kg As of 12/07/2016 3:13 PM	0		_		-0	Free Text I	Medication Name:			



## Example of prescribing 4 units FFP:

- Click on Prescribe Fresh Blood Products and Albumin button → click on Fresh Frozen Plasma Multiple Units button
- This opens the order entry window select 'Number of doses' to be 4
- Select Dose Rate of 2 units/hour (meaning each unit will run over 30 minutes)
- When order is complete 'Save and Close'
- Medical Officer to sign for order prescription.

## Administering FFP 4 units:

- Go to Administer tab view
- Right click on the due dose of FFP
- Select Validate this takes you back to the order entry window
- Perform the safety checks that are routinely done when administering blood and blood products
- Enter the total volume for that unit as displayed on the FFP flask this is done by the nurse entering a 'Blood Product Volume' diluent for that unit
- Co-sign order and close this window.

Orderable Fresh Fro Dose Form Infusion.	Route	)	Body Site Select I		CIAP V Q		ration time 07/2016 23:10	* <b>v</b>	Write dose comr	nent	θ
Set Dose and Rate		× D	3		D			Copy pro		ives	Diluent
Medication/Product      Fresh Frozen Plasma (Unit(s))      Difuent Blood Product Volume			્યું ર અને ર				Quantity/Volume 1 Unit(s) 200. mL		0.005 Unit(s) / mL	a	+ ×
Dose Rate		ARate 400 mL/h				Total 200 mL	volume		Infuse over		
)rder Summary						Order Cor	nment				
requency: Continu	Jous Start: 12/07/	2016 23:10	Stop: 4 do	ses		dose.	ease add a 'Blood Pr ER: DO NOT try to ch			-	
osing weight : 80k	g As of 12/07/2	016 3:13 PM									
	g ////////////////////////////////////	10 5.15 1 10				Co-sign fo	r administration				
							D	ose Log		al. and Clo	se Can

## 14.2.4 Enteral Feeds

Enteral feeds are also prescribed from the medication order entry window. The desired feed is chosen as the orderable, the route (such as NG) selected and the desired hourly rate of the feed is also selected. Bolus feeds can also be prescribed by selecting the appropriate template.

Modify Order for Sam Burges	s, MR number 416350		\ \	- Additional Information 🛆	~ Allergies/AD
Orderable		<u>CIAP</u>	PRN PRN Indication	Additional Information	Allergies/AU
Dose Form Route Enteral Feed  VG	Select Bod	ly Site 🔻 🕋	Continuous	•	
				🔊 Additives	🔐 Diluer
Medication/Product		Quantity/Volume	Concentration	Daily Dosage	
Jevity Can	😌 🗸 🖸	1,000 mL		12 mL/kg/Day (960 mL/	Day) 🔒 🗙
Dose Rate	Rate     40 mL/hour     Specify date and time		Total volume (12 mL/kg/L 1,000 mL Comments	Day) A Infuse over 25 hour	
Date And Time	· 13/07/2016 23:		Comments		
nd					
No Time Limit	-				
Dosing weight : 80kg As of 12/	07/2016 3:13 PM		Free Te	xt Medication Name:	
				Order Log	OK Cano





## 14.2.5 TPN Orders

If the 'Prescribe TPN Products' button is selected from the Prescribe Medication view, the appropriate hospital must be chosen which links to the local hospital TPN Templates (as below).

6 b b + + + + + + + + + + + + + + + + +	Pilot Release         O6(Active)         416350         Sam Burge           Menu         Nursing         Medical         Add Proc           Clinical         Graph         Vital Signs         Ventilation         Neuro /	SS Allergies/ADR: Benzylpr gress Notes Scores Pain Input / RRT	Dose & Task List Care Plan A Interventions Care Stark List Care Stark List Notes	D Admission: 12/07/2016 14 Clinical Events Radiolog Prescribe Administer Medications Medications	y End of Life Titrate Medication	eight: N Policia Sep
Select local hospital TPN Template Sanuel Burges - TPN - SIG	Go to     ►     15/7/16     500     600       O     Actions awaiting signature     Sign Now!       Medications       ientamicin       IBD mg,IV, 16:00,Injection	700 800	Prescribe Fresh Blood Products			1
Image: Second Previous Second P	A-H I-P Q-Z Q-Z St George	(Adult)				
Prescribe TPN         TPN Addut (triple phase with electrolytes) (SMOFKabiven)         Clicking the Prescribe TPN           Infuse: 2430 mt         button will open the order		MB-ICU	revious Session			
	Prescribe TPN Adult (triple phase with electrolytes) (	SMOFKabiven)	۸ 	button	will open the	

Orderable	dult [SMOFKabiven] (tr	iple phase with	electrolyt	es) 🔻 Q 🔯	PRN	PRN Indication				
Dose Form	Route	Bo	dy Site							
Infusion.	▼ IV	<b>▼</b> 5	elect Bod	y Site 🔻 🕋	Continu	lous	•			
Set Dose and R	ate	- D						🔊 Additives	4	Diluent
Medication/Prod	duct			Quantity/Volume		Concentration	D	aily Dosage		
TPN Adult [SM	OFKabiven] (triple pha	se with ele 📢	- Ō	2,436 mL				mL/Day	a	×
Jose Rate		a Rate			A Tota 2,436 ml	al volume L		Infuse over		
tart						L		Infuse over		
tart Now		Rate			2,436 ml	L		A Infuse over		
itart Now					2,436 ml	L		A Infuse over		
Dose Rate Start Now End No Time Limit		•			2,436 ml	L	ext Medi	Infuse over cation Name:		



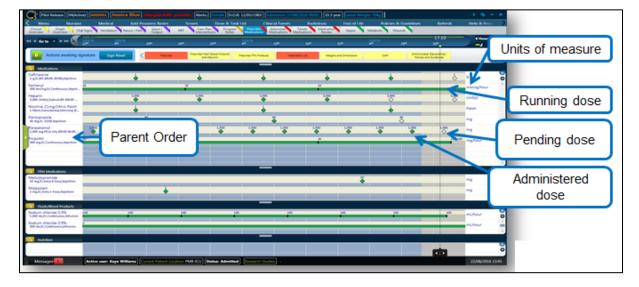
## **TPN Additives**

Set Dose and Rate		
Trace Blements Adult (Baste     Q     Q     ml / ml     ml/g/Day (0 ml/Day)       Dose Rate     Image: Comparison of the second	Quantity/Volume	oncentration Daily Dosage
LSI6 mL USE Additive DL		
to add Trace		Use Additive button
Aart Comments Elements' to TPI	v	to add 'Trace Elements' to TPN

- For TPN bags that are custom made at site: Enter the orderable 'TPN Adult Custom' with a unit of 'Bag' The prescriber would need to individually add in the Additives and their quantity
- Upon checking and validation, the nurse would see the full details on the Order Details Window, this will facilitate their checking of the TPN bag label.

## 14.2.6 Prescribe Medication Tab Order Timeline View

All the prescribed medication orders can now be viewed in the prescribe medication view.



The prescribe medication view enables clinicians to view and manage the treatment plan of a patient. The prescribe medication tab displays the following:

- Parent Order Plan the left column of the view displays the parent order plan information, including the orderable name and order plan details
- Current / Future Doses doses associated with each order, in 'Current' or 'Pending' status
- The right column displays the prescription's unit of measure







 Running Doses - a background light coloured bar indicates running doses (e.g. a green bar indicates a currently running dose, a striped bar indicates a running dose that needs to be commenced).

If the medication order needs to be altered from this view, it can be done by right clicking on the required medication in the 'Parent Order' (to change the entire order).

Pilot Rel	ease 06(Active	e) [416350] [S	am Burgess	Allergies/ADI	
< Menu	Nursing	Medical	Add Progress	Notes	Scores
	Graph verview Vital	Signs Ventilati	on Neuro / Pain	Input / Output	RRT
🔫 ┥ Go to 🚽		2200 PMB-ICU21:45	2300	16/7/16 000	100
Actio	ns awaiting sig	nature Sig	n Now!	Prescrib	pe
Medication	s				
Gentamicin TBD mg,IV, 16:00,1	njection				
Midazolam 50 mg,IV,Conti	Modify Renew				
Paracetamol 1,000 mg,PO,et	Discontinue Mark as error		1,000		
> PCA Fentany 96 hour,IV,Cor	Withhold Ord Reschedule	er			aaaaaa
Warfarin TBD mg,PO, 16	Log				
	View				
PRN Medic	ations				

OR, right click on the 'Dose' to change just the dose.

K Menu	Nursing	Medical	Add Progre	ss Notes Sc	ores	Dose & Task List	CI
Clinical Overview C	Graph Overview Vita	al Signs Ventilat	tion Neuro / Pai	in Input / Output	RRT	Care Plan / F Interventions	Progress Notes
44 ┥ Go to 🕞	• • • <b>(</b>	PMB-ICU 15/7/16 16/ 2300 110		17/7/16 11 <sup>00</sup>	2300	18/7/16 11 <sup>00</sup>	2300
0 Actio	ons awaiting si	gnature Sig	jn Now!	Prescribe	•	Prescribe Fresh Blood Prod and Albumin	lucts Pr
0. Medication	าร						
Gentamicin TBD mg,IV, 16:00,	Injection		TBD	TBD		TBD	
Midazolam 50 mg,IV,Continu	ious,Injection	1 - 10	General ZZZ TBD	Modify			
Paracetamol 1,000 mg,PO,ever	y 6 hour,Tablet	1,0001,000 1,000	16:00	7 N		000 1,000 1,000 00 Stop: No time limit	t 000 1,0
PCA Fentanyl B 96 hour,IV,Contir		96 	Dose	Details			
Warfarin TBD mg,PO, 16:00	),Tablet		At 7 IV Adr	micin Injection TBD m mg/kg/day ministration time: 16/0 Status: Pending	- -	твр \$	
🕢 PRN Medie	cations		Prepa	ration Status: Not Pre	pared		
	od Products				_		-

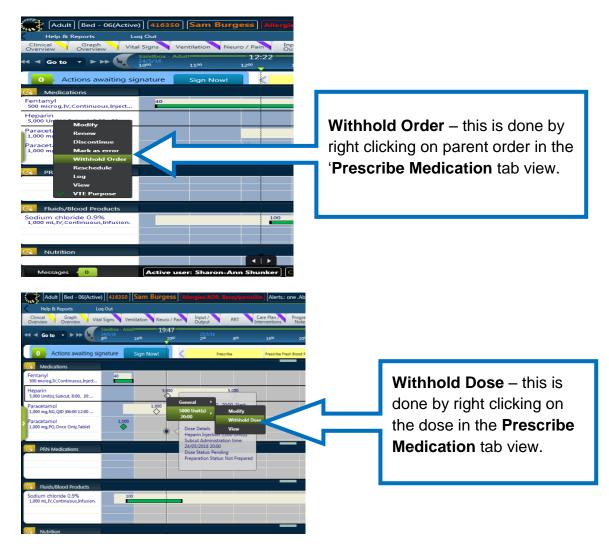
**NOTE:** right clicking on an individual dose only changes that particular dose, and the parent order will NOT change.

It is recommended NOT to use 'Modify' to change a prescription. Only use Modify for prescribing the Dose for TBD medication and if the prescribed 'Titrate to MAP' for inotropes and vasopressors needs to be changed



## Withhold Order / Withhold Dose / Release Withheld Order

The clinician can choose to withhold an entire order which will withhold all future doses OR the clinician can withhold a dose.



It is displayed as a cross out for that dose:

Medications		
Fentanyl 500 microg,IV,Continuous,Inject	40	
Heparin 5,000 Unit(s),Subcut, 8:00, 20:		5,000

An order that has been 'Withheld' can be released by right clicking on the parent order and selecting 'Release'. This, like all medication related actions, will need to be signed for by the clinician.

Signature Review			2
전국 Resolve 한국 View and Ackno	wiedge	efer action	
Signature re-authentication required.			
Description	Action	Issue	Response
Vancomycin 1 g IV Once Only	Release	No Issue	



## **Modify Action**

- NOTE: DO NOT USE the 'Modify' action from the parent order. If changes need to be made, 'Discontinue' the order and prescribe a new order
- Only use 'Modify' to make changes to comment box instructions or to prescribe dose for TBD medication



- When using Modify to change comments section (eg 'titrate MAP to...'), the prescriber needs to 'Sign' for the modify action
- This creates an 'Issue' of 'Doses are running or initiated' → Select 'View and Acknowledge'.

	×		
🕼 Resolve 😂 View and Acknow	ledge 🗔 D	efer action	
	-		Response
Warfarin TBD mg PO 16:00	Modify		
Noradrenaline 6 mg IV Continuous	Modify	Oses are running or initiated	

- This brings up a pop up box with a warning that doses are currently running, if you
  proceed with modify action the system will apply a stop action to the running dose.
- Select 'Do not Stop' action from the pop up Warning window
- The decision to modify the titratable MAP or any comments that get added / modified MUST be communicated to the nurse / relevant clinician, so that they can action it. An entry should also be made in the progress notes. (If the prescriber selects 'Stop' a second order is created for validation on the dose take list and from the cardex view - The nurse will then be prompted in the 'dose task list' to 'stop noradrenaline' and then to 'Validate a new dose')

Call Resolve 😫 View and Ackne	wledge	Defer action	
Please review and respond to the issues as			
Description	Action	Issue	Response
Warfarin TBD mg PO 16:00	Modify	No Issue	
-	If you will a initial	se is currently running (or initiated). proteced with the modify action, the system pply a stop action to the running (or ted) dose. do you want to proceed? Stop De not stop	,
2 actions awaiting signature, 1 actions	ready for signatur	e 0 actions deferred / discarded	Sign Now! Sign Later

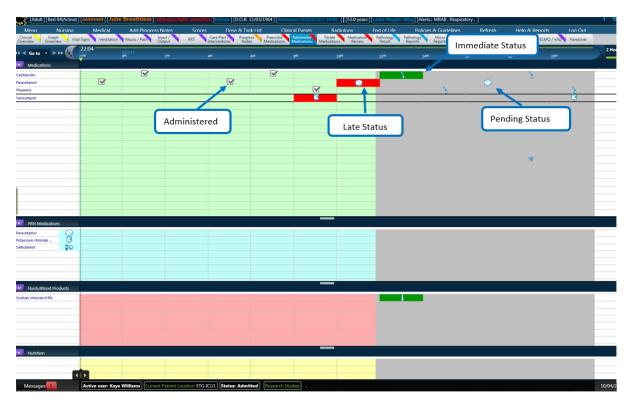






## 14.3 Administer Medications

Nurses can use the 'Administer Medication' tab view to view the medication doses that need to be given and those already given. The Time Interval selected will determine what is viewable on this tab view (e.g. screen shot below shows a 6 hour time interval).



Medications have to be checked with the 5 Rights of Drug Administration from the 'Order Details' Window, prepared and administered. Once they have been administered the medications then have to be validated (this is the eRIC terminology for signing that a dose has been given).

Validating a Dose - this can be done in two ways:

- From the Dose & Task List- this is opened either by cloicking n Dose & Task button (main menu bar) or via Messages (flashing red) → Doses, tasks and actions waiting to be validated button
- 2. From the Administer Medication tab Cardex view

## 14.3.3 Doses, Tasks and Actions waiting to be validated

Medication doses and tasks that are due can be viewed from the 'Dose and Task list', which is opened either from the 'Message Centre' or 'Dose & Task' button (Main menu bar)

- Message Centre: Located on the bottom left hand corner of the Status Bar. If the Indicator is flashing red it means that there are pending or overdue doses or tasks to be validated with an immediate or late status:

  - Immediate Status medications (in the grace period one hour before and one hour after) are in 'Green'
  - Pending Medication (due in the future) are in 'Blue'. PRN medications will always be pending
- Opening the Dose & Task List Clicking on the 'Doses, tasks and actions waiting to be validated' button opens up this window OR use the 'Dose & Task List' menu





 Dose & Task List available actions include: Validate, Modify, Marking a Dose as Not Administered, View Dose.

	Messages 1		Active	user	RN Lar	a Simons				
	-	くと					31.41			
0	Dose & Task List (Sam Burges) Filter: S	tatus: Pending, Imm	rediate, Late; Selecter	d Medication	Groups; Start: Fre	am the first dose, End	1		X	x
V	Filler Mark Nat Caree Actor Mon	aty Ves	Properties Co-Sign Fo Properties							
Drag	g a column header here to group by that	column								
	Orderable	Start Time A		e Route	Frequency		Dose Statu	S Order Coming	The second second	
	A Water	19/05/2016		NG	600. 140.		Late <		Late	•
	Vancomycin	19/05/2016	14:.19	N	Once Only		Late			
	8 Heparin	19/05/2016	16: 5.000 Unit(s)	Subout	BD (08:00 2		Immediate		Immediate	1
	S Paracetamol	19/05/2016	16:_19	NG	6 hrly (00:0		Immediate		mmeulate	Н
	> Pantoprazole	19/05/2016	20 40 mg	DV.	Night (20:00)		Pending			ł,
	> Fentanyl	19/05/2016	20 500 microg in 50	mL_IV	Continuous	20 - 100 microg/hou.	Pending	Titrate to keep	CPOT pain score <4	
	Voradrenaline	19/05/2016	20 6 mg in 100 mL 0	Sluc IV	Continuous	0.5 microg/minute (0.	Pending	Titrate to a M		٩.
	🖨 Water	19/05/2016	22: 50 mL	NG	6:00, 14:0		Pending		In the future	н
	S Paracetamol	20/05/2016	0019	NG	6 hrly (00:0		Pending	-		
Drag	g a column header here to group by that	column								1
	Orderable	Start Time 4	Quantity/Volume	Route 8	Frequen Dose Ra	te Dose St.	Order Com	ment	PRN Indication	
	S Ondansetron	PRN	4 mg 1	IV T	DS (08:0	Pending	~		PRN	
							<	_	Medication	

## 14.3.4 Process for Administering Medications

NOTE: Use the 'Dose & Task List' to view which medications are due to be administered
Select the medication by ticking the check box. Open each medication individually and

- Select the medication by ticking the check box. Open each medication individually and check the 'Order Details' by ticking the check box
- From the 'TOOLBAR' at the top of the 'Dose & Task List' window select 'View'.

	ST Partiel Colorfor			tores Alexander Constant	3 Ver Pagentes Colophies				
ag a column header here to group by That colu	$\mathbf{U}$			Drag a column health have to group by that column					
Ordenative	that Tona . Cambolithma . Br	alle Frequency Drug Rate	Dear Status Order Comment	Odvate Constant	Start Time + Quantity/Volume	Rode	Preparency Done Rate	Done Statu	a Order Comment
a canan	representation of the later of the		and a second state state of the second second second	C O Departore	24/02/20106 201. 31 mg	PD	80 0800 2.	Late	
Openyl tentrate Serg 24he Patra	62/01/2017 08	militmal Moning D.	ale 4-Place open the attached form in or-	C O Caynolme	25/12/2004 @k 30 mg	PD	80-0800 Z.	-1.01	
				D Ogentere	25/12/2016 20 30 mg	PO	80 6800 2	Late .	
) ferangi	12/81/281/14_500 microgin 90 mil. N	Continuous 3 - 220 mong/hour.	intestate	2 Dauges	3/12/004 20 . 31 mg	20	10-09102	Late	
Remove GTN Patch	62/11/2	nidemal Night (2000)	hending						
) Gentance	60/51/2717 #_ 180 N	Moning (D., 490 mg/day (7 mg/k.,	hending	E Cartan o	01/12/0004 08 190	IV.	Moning (L. 400 mpilay (7 mpila	L. Late :	
Change and the Seng Stee Face	65/01/2017	istemal Motorg D.	Fending Please open the attached form in or.	C Center	10/12/0014-08., 10 mL	W	Money D.	144	NOTE Peace specify the medication name
3 Noradranaline	85/71/2017 0. 5 mg in 100 mL Gut N	Continuous 1-30 microgiminal	fending Titrate to a MAP of55	🗌 😨 Gyoley at anite Sing 24kis Ratch	FUIL2 2018 GB., 1 Patch	Turoder	nai Moning D.	Life	Please cases the attached form, in pr
3 Canad	01.01/2017 10: 10 HL N	Morning G.	Fending NOTE Please specify the medication name.	Drag a column heads were to group by that other	2 C				
ig a column beader here to group by that colu				Ordentie	Stat. See	laute Pre	gen. Dos Rey Dos 31.	. Order Com	ment Mitibidiation
Ordenative	Bet Treat Que synthese State	Region., Door Rate Door St.	Order Constant PRN3rdicature	D Q Oxforence	1781 - CAR - CAR			Max 16mg/	
O Charlemon	PRN 4mg PD	every Sin. Pendro	das jūng (1995) nautes	Constant and the second		ant _ 84	h th Annatas	1000	and further without the advantation
V Sector Remark and		The second s	Sum and a farmer bet farmer and be						Core.
ect All Late and Immediate	Medication	with Imme	diate status	Medicatio	n with Lat	e s	tatus	-	- 4

NOTE: Selecting 'View' will open up the 'Orderable' window. This defaults to the 'Current Dose' view – SELECT the 'ORDER DETAILS' window to check dose details → Perform the 5 Rights of Drug Administration → Prepare the dose → Administer the dose



	View Doos For Samuel Burgess, N Order Details  Uurrent Dose Orderable Orderable OxyContin MR Tablet (Oxy		1. Right		Allergies/ADR
2. Right Drug	Doce pr Route Utablet V PO nfused Over cation/Produc	Body Site   Select Body Site    Guantity/Volc	BD (08:00 20:00)	v Daily Dosage	4 Dight Time
3. Right Ro	ute	रसे र वे 30 mg	(30 mg)	0.86 mg/kg/Day (60 mg/.	4. Right Time
	Start Selected dose of the day on End No Time Limit Dosing weight : 70kg As of 29/08/2016 12:56 PM	▼ 19/12/2016 ▲ ▼ 8:00 PM		ree Text Medication Name: reated on 19/12/2016 13:06, Ordered by Dose Log	

- Once the medication has been administered it needs to be signed for. This is called 'Validate' in eRIC
- Log back in open the 'Dose & Task List' Select all the medications that have been administered → From the 'TOOLBAR' at the top of the 'Dose & Task List' window select 'Validate'

Versee Adverseed	33 1 m	C de la									
Drag a column hander here to group by that colu	-										
Orderette	Start Terms	Quantyryou		NAM .	frequency	Dune Rete			Order Comment		
Ramove GTN Patch	00/00/2017 2				Neget (2000)			ate .	(		
O Norman	et et church	140		(1199) (1	August de	and manhair of a		-			_
· Centert	81/01/2017 0	8. 20 mL	1	/ î.	Malong B.			Livi I	NOTE Preside specify th	e medication same.	
🗑 😡 Gycwyl trintratie Smg/24hrs Patch	02/01/2017 0	e_1neh	To	instermal.	Moorang (D.			Lafe:	Please open the a	flacted form, in bi-	
😵 💧 Red Cells (Jivila)	80,01/20171	0_1Uvetal	11		Continuous	1 United Now		Late	NURSE Please add a 'B	load Product Vela.	
8 3 Fertand	02/01/2017 1	4	ià mi N		Continuent	1 - 200 microg/t	100-1	innediate			
Remove GTN Patch	02/01/2017 2				Name (2000)	0		Pending			T
C Gentamein	01/01/2017 0		21			400 mg/day (7 m					1
Drag a column hander have to getter by that colu							in and				
Orderable		Quantity/Volume	-	1000	. Dois Re			Order Curre		PIN Indication	
O Ordansetion		4 mg	10	every 6				Un they'r		TAUNA	
The second second second second		TER		-		D				P	
Select All Late and Immediate		THE .	2000	**** *	8						

## NOTE:

- Use the Current Dose Window to sign for administration
- Recheck all the drug details that you are signing for
- Check time of administration is correct
- A second nurse /doctor must co-sign, if required.





By clinicians.

for clinicians

### About the Current Dose Tab

- Contains details similar to the order entry window.
- Administration time is the scheduled time when this dose is due. If the dose is not being given at this time it should be changed to reflect the time you are giving the dose at.
- Dose comment can be used to enter comments for this specific dose.
- If it is a titratable medication the current rate should be entered.

Validate dose for Samuel Burgess, MR number Order Details     Orderable     Orderable     Fentanyt     Dose Form     Route		Additional Information Noter White dose com		
Injection V V	Select Body Site	2017 14:46 A V Copy products Addit Quantity/Volume Concentration 500 microg 10 microg / ml. 50 ml	hes Diluent	
Ensure correct Administration Time is entered	So mi.	nent		Co-sign by second person (who performed the check) entering their username and password
	Co-sign for a Co-sign user	administration	A and Close Cancel	

### Diluents

- Certain IV medications may require a 'Diluent for Reconstitution' or a 'Diluent for Administration'
- The Diluent does not need to be specified at the time of prescribing the medication Choose 'Select Diluent and Infuse over Later'
- The clinician administering the medication will usually prepare the medication following the unit's protocol
- Diluents can be entered into eRIC at the time of Validating the order
- Most often, the Diluent for Administration will be entered during validation and used to calculate the Total Volume
- The Diluent for Reconstitution is not mandatory to enter.

Diluent for Reconstitution (not mandatory)		Orderative Source Form Roule Dest Form Roule	Body Site * Salent Body Site *	1.1mp.00.000 ford	Manage along parameters		Administratio
(not mandatory)			τ <sup>φ</sup> + Δ	event Quantity Volume () 400 mg	-		
Crear Summery Oder Comment	(not	A second s			The second se	10	
	(individuol j)	a second s	/12/2018 08:00 Shope No tona land	Order Comment			



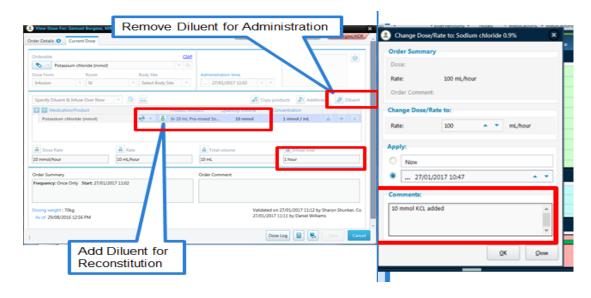


**NOTE: Alternatively,** the medication may be added to the burette of the already running 'maintenance fluid'. In this case, there is no need to enter a Diluent for Administration. Adjust the rate of the maintenance fluid during medication administration on the 'Titrate Medication' tab.

**Example**: Administering KCL 10mmol/10ml in 90ml 0.9% Sodium Chloride (total volume 100ml) over 1 hour - using a burette with maintenance fluid 0.9% Sodium Chloride running at 50ml/hr. The rate of maintenance will need to  $\uparrow$  for that hour and run at 100ml/hr.

### At time of validating the administration:

- Remove the Diluent for Administration
- In the Diluent for Reconstitution section- add in 'Pre-Mixed Solution' with volume 10ml
- The Infuse Over section should be to administered over 1 hour.
- In the Titrate Medication tab, the rate of maintenance fluid can be increased to 100ml/hr as KCL 10mmol was added to 90ml of 0.9% Sodium Chloride in the burette to infuse over one hour
- Add a comment to Change Dose/Rate box to indicate why the rate was increased for that hour.







## 14.3.5 Administer Medication Tab Cardex View

The Administer Medication tab is displayed in a tabular format called the 'Cardex view'. Each dose is displayed in an individual cell, as an icon with a distinctive background colour indicative of its given / due status.

Status	Symbol & Color
Pending	$\bigcirc$
Immediate	$\bigcirc$
Initiated	
Validated (Done)	
Late	8
Expired	
Withheld	$\sim$
Not Administered	
PRN	$\bigcirc$

Immediate doses are indicated by the colour green and late doses by the colour Red. These can be validated.

To validate a dose from this tab, follow the steps: Right-click the cell containing the dose; a menu opens.

This menu has two options:

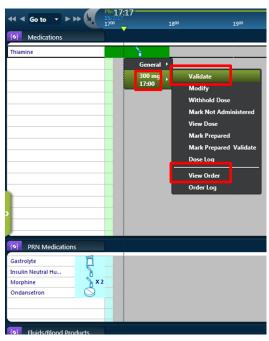
General and the time of the specific dose.

- Select the time of the dose; a sub-menu opens.
- Select View Order; the Current Dose
  [administration dose entry] window opens with the
  dose details filled in and the details of the order
  plan the dose is associated with.
- NOTE: Go to the 'Order Details Window' perform the 5 Rights of drug administration prepare medication.
- Log out administer the medication
- Log back in Right click the dose
- Select the time of the dose; a sub-menu opens.
- Select Validate the Current Dose [administration dose entry] window opens
- NOTE: Ensure all the details of administration are correct
- Co-sign the dose (this is the term for obtaining a second signature) Click Val. And Close; the Validate window is closed and the dose is displayed as validated on the Cardex view.









Cardex available 'Dose' actions include:

	to 🔹 🕨	*	14/7/16 100	700	1300	1900	15/ 1 <sup>00</sup>
{ø} Me	dications						
Cephazoli	n		<u>}</u>		1		
Fentan	General	•					
Heparin	1 g * 6:00		'alidate Iodify				
Paracet	1 g * 14:00		Vithhold Dose	•			
	1 g 14:00		lark Not Adm iew Dose	ninistered			
2	1 g 22:00	• N	lark Prepared	and the same of the			
-		N	lark Prepared	Validate			
-		D	lose Log				
{Ø} PRI	N Medicatio	ns v	'iew Order				
Morphine		C	order Log				
Naloxone		ð					

**Right Click:** 

- Validate: to document that you administered a medication, with the date and time, dose details and co-sign if applicable
- Modify: modifying a dose enables you to edit an individual dose (dependent on user permissions)
- Withhold: you can withhold a dose that has not been validated yet (e.g. a dose was withheld because the patient was scheduled for surgery). A dose with a withheld status can still be validated if there is a change of mind
- Marking a Dose as 'Not Administered': a dose can be set as Not Administered when a
  dose has not been physically administered such as the patient was vomiting and could
  not tolerate their tablet. A dose marked as Not Administered can still be validated if there
  is a change of mind
- View Dose: the user can open the dose and view the details in a read only format
- **Dose Log:** the user can read a chronological log of the actions performed to that individual dose.

## 14.3.6 Completing Administration of Medication

Once all the details are completed, the medication, if required will need a co-sign to complete the validation.

## Co-sign for administration

- Co-signing is always enabled, and is mandatory for some medications according to NSW Health Policy and legislation. The person who is co-signing must enter their user name and password
- Only users with the appropriate permission to co-sign will be able to co-sign. Permission settings will be pre-customised
- For the dose actions where co- signing is mandatory (e.g.Validate and Initiate), the user will be unable to finish the action without a co-signature
- NOTE: The ICU clinician (Doctor / Nurse) who has checked the preparation and administration of the medication must enter their user name and password to co-sign
- Once all the details have been completed in the dose entry window the user can click **Val.** And **Close** to validate that the dose has been administered.





### Example of 'Validating' a dose of Cephazolin

Validate dose for Orderable Cephazol		nomber 41	Body Sit	to.	CIAP	Administ	Additional In	formation Notes V	Allergies/ADR	
Injection	▼ IV	Ŧ		Body Sit	te 🔻		07/2016 14:00 🔺	•		
Specify Diluent & I		- D			Product Am			y products 🔊 Additives	Piluent	
Medication/ Cephazolin	Product		<b>e</b> ∂ →			ount ater for Inje	Quantity/Volume	9.0909 mg /	Enter Dilu	ent
	n chloride 0.9%		<b>€</b> ∂ ×	Ō		·	100 mL	d	for administra	tion
🔒 Dose Rate		🔒 Rate				🔒 Total	volume	a Infuse over		
1,000 mg/hour		110 mL/h	our			110 mL		1. hou	• •	
Order Summary Frequency: 8 hrly (0 Stop: No time limit	6:00 14:00 22:00)	Start: 10/07,	/2016 06:0	00		Order Con	Ente	r Infuse over me period		
Dosing weight : 80kg As of 24/05/2016	Get the ch	ecking	the				r administration	Password: •••		
	administ	ration t	to co-	sign			Dose	Log 🔲 🖳 Val. and C	lose Cancel	

- Open the 'Dose & Task List'
- Select Cephazolin Dose to be Validated
- Select 'View' use the 'Order Details Window' to perform the 5 Rights of drug administration
- Prepare and administer the dose
- Log back in and re-open 'Dose & Task List'. Select 'Validate'
- Re-check all the details in the 'Order Details Window'. Use the 'Current Dose Window' to enter all relevant administration details
- Get an authorised clinician who has witnessed the preparation, checking and administration to co-sign the administration of the medication
- Click the 'Validate and Close' button.

## Validating Blood Product Administration

Red Cells (Units)	<u>CIAP</u> ▼ Q Q	PRN PRN Indication		Validate dose for Samuel Burgess,	MR number 416350	
Infusion. V Route	Body Site           V         Select Body Site         V <ul> <li></li></ul>	Continuous	¥	Medication Info		Virtual Product/ Product Info
Set Dose and Rate	* 🔁 🖼		Additives	-SP http://www.transfusion.com.au/		
Medication/Product	Quantity/Volur	ne Concentration	Daily Dosage	To		
Red Cells (Units)	🤫 🔻 🙆 1 Unit(	5)	24 Unit(s)/Day	Commence administration within 30 minute	s of removal from controlled storage.	
Dose Rate	a Rate	a Total volume	a Infuse over 1 hour	Ho		
tart	Specify date and time	NURSE: Please add a 'Blood Produ	ict Volume' diluent when valid	ating		
Date And Time	<ul> <li>02/01/2017 10:41</li> </ul>	dose.				Additional Information / Notes /
nd Number Of Doses	Specify number of doses	PRESCRIBER: DO NOT try to chang able to sign this order.	ge the number of units as you	will not be		

- The standard checking procedure for checking blood products and Patient details MUST be followed
- Go to 'Dose & Task list'. Select Ordered Blood Product → click View → check the Blood Product Prescription details from the Order Details window
- Click on the additional information button for more information on administration of blood products
- After product administration is commenced, reopen Dose & Task list → validate the administration.



## **Validating Rate Titration Orders**

- When the dose entry window opens for a rate titration order (such as a fentanyl infusion) the corresponding Dose, Rate and Infuse over fields that hold a range in the order entry will be empty
- Check the order details window for prescribed ranges for titration, check the comments box for specific instructions on titration e.g. Titrate noradrenaline to keep MAP >70mmHg or Titrate Propofol to keep RASS -1 TO +1, titrate Fentanyl to keep CPOT < 4</li>
- The clinician needs to enter the starting rate in the 'Rate' field (Rate changes can be done from the 'Titrate Medication' tab - see section on Titrating Medications)
- Validation for Infusions is at the time of commencement of a new syringe or flask the change of rate will be done from the titrate medication tab view
- The system will warn the administering user when documenting a value outside of the range set and require the user to document a reason for this discrepancy
- The order detail window and dose views will display these ranges as well as the order and dose logs.

	Validate dose for Samuel Burgess, MR nue Order Details     Previous Prepared/Validate		Additsi idate dose for Samuel Burgess, MR	Notes Altergres/ADR
	Orderable           Orderable         Fentanyl           Dose Form         Route           Injection         V	CIAP V Q Body Site V Select Body Site V	which has prescribed, the clinicia	inistering an infusion a rate titration range , at the time of validation n needs to enter the
	Set Dose and Rate v			to of the infusion
	Dose Rate	Rate 5. ml/hour *	Total volume	Solution over
If a rate is entered which is outside the prescribed	Order Summary Dose Rate: 5 - 100 microg/hour Rate: 0.5 - fuse over: 5 - 100 hour Frequency: Contin Stop: No time limit		Order Comment	This will automatically be calculated once the infusion rate is entered
range in the Order Plan the user will be notified	Order Summar entered by the titration ranges Window' to view	prescriber related of the prescriber related of the prescriber relation of	ting to er Details	Dose Log 📄 🖳 Vill and Close Cancel

## Validating a Withheld Dose OR a Not Administered Dose

A dose with 'Withheld' status OR a 'Not Administered' status can be updated and validated if necessary. For example, a dose was withheld because the patient was scheduled for surgery, however, later on the surgery is cancelled, so the withheld status needs to be updated and the dose administered as planned.

To validate a witheld dose, follow the steps below:

- Via the administer medications view, Right-click the dose that was set in 'Withheld' OR 'Not Administered' status, and select Validate; the Override Withhold window opens
- Enter a reason for overriding the action
- Click [OK]; the override reason is saved.

Override withhold	Free Text Medication (mL)	10 mL 🗙
Reason to override v	vithhold	
None		-
Comments:		
IVC has been resited		<u> </u>
	<u>о</u> к	Cancel







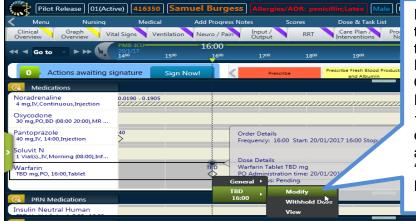


Dose Administration Issue	25		•
Resolve	ew & Acknowledge Adjust Future S	Start Times Co-Sign All Defer	
ome of your doses and/or running do lease respond to the issues below.	use actions could not be validated.		
Description	Start Time	Issue	Issue status
Cephazolin 1 g	14/07/2016 14:00	Missing data	
		Missing validation co-sign	
			,
	were validated. 1 awaiting validation		Validate Cancel

If there are any issues when validating a dose the 'Dose Administration Issues Window' will open and allow the user to resolve any issues that are preventing the action to be completed.

- Issues include: a missing mandatory co-sign, missing administration data, attempting to validate a dose that is scheduled too far in the future or a dose that requires an allergy alert to be resolved.
- The user can select the items individually and perform relevant actions on the issues:
  - 1. **Resolve:** the dose entry window will re-open and allow the user to make the necessary adjustments. This could also be the Allergy alerts window
  - 2. View and Acknowledge: enables the user to review details of the issue, acknowledge that they have seen the details and have decided to proceed anyway
  - 3. Adjust Future Start Times: when attempting to validate planned dose(s) or task(s) where the start time is in the future, the Future Doses window opens on top of the Dose Administration Issues window. Users can adjust the times of the doses to ensure they are not in the future and therefore can be validated
  - 4. Co-Sign: if the dose requires a co-signature, the user can co-sign for individual doses
  - 5. **Defer**: enables the user to postpone the signing action, which means that particular dose will not be validated

## Validating TBD Variable doses



Prior to administration of the variable (TBD) dose the doctor has to go the Prescribe Medication Order Timeline view  $\rightarrow$ Right click the medication  $\rightarrow$  select **Modify**  $\rightarrow$ enter the dose  $\rightarrow$  View and Acknowledge the 'Modify Action' in the Dose Issue Window





- The nurse will view, administer and validate the medication at the due time from Dose and Task List
- Go to 'Dose & Task list'. Select Ordered TBD medication → click View → check the details from the Order Details window
- After administration, reopen **Dose & Task List** → validate the administration.

## **Allergy Alert Window**

Lara 6.4.0002 - Allergy/ADR	Alert		
Allergy/ADR Alert		Importar	
Potential Allergy/ADR or Intole	erance to Alprazolam		
Warning: The patient may be Order: Alprazolam Start time: 19/01/2016 at 12:57 PM Status: Unsigned action	the patie allergy/ADR	onent in this order. order in which ent has an or Intolerance	Warning Bar to indicate the severity of the potential allergy/ADR or intolerance
Allergy/ADR or Intolerance	Reactions	Recorded Comments	
Alprazolam (Medication)	Agitation, Moderate	<	Details regarding the potentially allergy/ADR or Intolerance
To proceed, re-enter your password.	The action the user r to proceed with prescription	the	
		1	Proceed Cancel

If the user is attempting to validate a drug that the patient has an allergy to, the alert appears in the 'Dose Administration Issue Window':

- Select 'Resolve' upon selecting 'Resolve' in the Dose Administration Issues Window, the Allergy Alert window opens
- Allergy Alert window displays allergen and intolerance items
- The Allergy Alert window for orders and/or doses displays the orders and/or doses to which the patient has an allergy or intolerance, as well as details regarding the potential allergy or intolerance
- A warning level bar in the top right corner of the window indicates the severity level of the allergy
- Below the Allergies List, a message is displayed about the action you are allowed to perform.

The user can add a comment to detail why they wish to proceed with the administration and override the allergy/ADR or intolerance warning in the comments box; this is limited to 500 characters.

**NOTE:** The clinician will need to follow the department protocol if they wish to continue to administer the dose with an allergy/ADR notification. NSW have customised this to be a password re-entry in eRIC. The user who is logged in must re-enter their password.

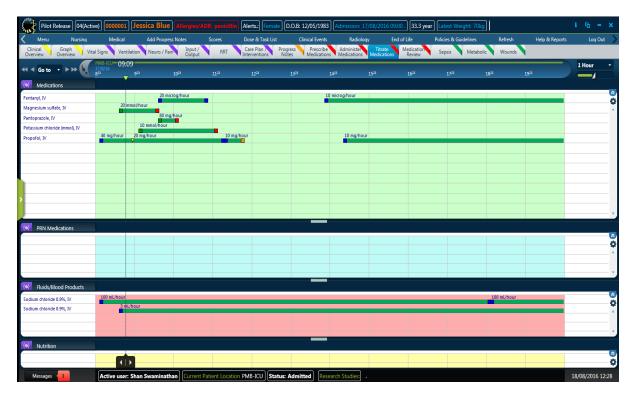






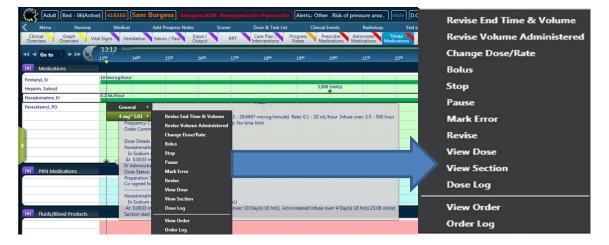
## **14.4 Titrate Medication**

This tab is useful to view validated and running doses, and to titrate medications. You can only see doses that have been validated on this view - you cannot see future doses. You cannot validate doses from this view either. The Titrate Medication tab is a timeline dose display (called Gantt dose view). This displays doses as bars and diamond symbols.



## Performing Actions via the Gantt Dose View Right-click Menu

Actions that can be performed by right clicking on the running dose include:

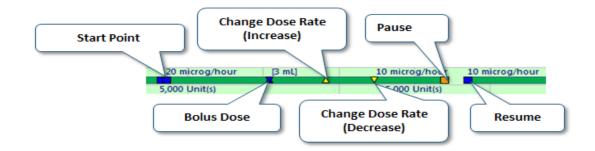


Some dose actions are applicable for running doses only. Therefore, the right-click menu of a running dose will display some actions that are not displayed on the right-click menu of the same dose in the 'Administer Medication' tab dose generated from an order plan.





A Continuous Running Dose with Actions is displayed as below:



## **Change Dose Rate**

- Right click on the medication running infusion and select 'Change Dose/Rate' this opens up the change dose rate window
- Enter the new dose, or rate for the dose, in the Dose or Rate fields. When you change one of the values- the other value changes accordingly
- In the Apply area, enter the required time for the change (you can either indicate a specific time or select Now)
- Click [**OK**] to execute this action.

100 microg/hour		Change Dose	/Rate to: Fentanyl	The top section of window will show current running ra user can enter the
	General >	Dose:	100 microg/hour	desired dose rat
Revise End & Volume	500 microg 12:35 PM 🔸 💳	Rate:	10 mL/hour	
Revise Volume Administered	bo mg nour	Order Commen	c	
Change Dose/Rate Bolus		Change Dose/F	Rate to:	
Stop		Dose rate:	100 <b>^</b>	microg/hour
Pause		Rate:	10 🔺	<ul> <li>mL/hour</li> </ul>
Mark Error		_		
Revise		Apply:		
View Dose		Now		
View Section		• 14/01	/2016 2:57 PM	· · ·
Dose Log		Comments:		
View Order				A
Order Log			)	
		an right click on		*
	wish to mo	g infusion they dify and select		QK Close
	from the do	se action menu		
			·	







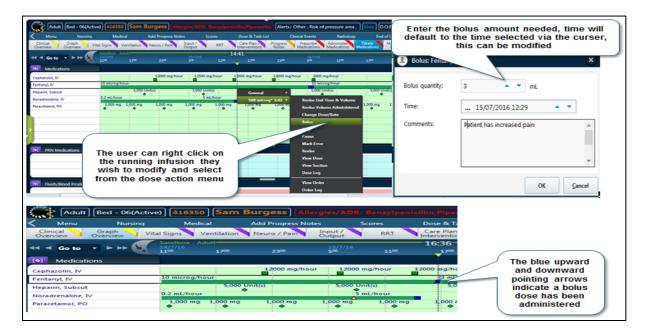
### **Bolus Action**

• The Bolus action enables you to record a one-off bolus for a medication infusion. This is shown as an increased dose rate over a one-minute period.

To perform the Bolus action:

- Right click a running dose, and select Bolus; the Bolus window opens.
- Enter the Bolus quantity and time
- Click [OK] to execute this action.

The bolus is displayed in the Gantt as blue upward and downward pointing arrows i.e. a blue arrow pointing upwards and a minute later as a blue arrow pointing downwards. The quantity administered in the Bolus is noted next to the two arrows.



## **Pause Action**

The **Pause** action enables you to pause a dose. A dose that is paused can later be resumed.

- To pause a dose right click the dose in the Grid or Gantt Dose view; the menu opens
- Click Pause the Pause window opens with the name of the dose in the title bar
- In the Apply area, enter the time you want to pause the dose (you can either indicate a specific time or select Now), then click [OK] to execute this action
- A paused dose is marked with an orange square at the end of the bar in the Gantt dose view. When ready to resume right click and select **Resume**.

1 mL/hour (2 mL) 500 mg/hour	General →		Enter the time the pause will be placed, time will default to the time selected via the
Revise End & Volume	4 mg 1:35 PM →	Pause Noradrenaline	curser, this can be modified.
Revise Volume Administered		Analys	inounieu:
Change Dose/Rate		Apply:	
Bolus	N	Now	
Stop		14/01/2016 3:02 PM	A
Pause			
Mark Error		Comments:	
Revise			A
View Dose			
View Section			*
Dose Log			
View Order			QK Close
Order Log			
	The user can rig	abt click on	(2 m)
	the running inf		[2 mL]
	wish to pause a	and select	
	from the dose a	ction menu	





### **Revise Action**

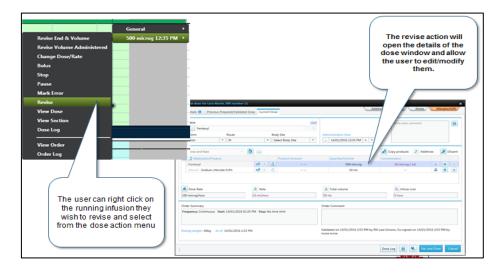
The Revise action enables you to edit the details of the dose via the Dose Entry window.

**NOTE:** Only use this if absolutely necessary. Unlike other dose actions, this action affects the entire dose and replaces any data that was entered before the revision. Therefore, it is important to note that this option is used for correcting mistakes in entering the dose, and not for recording changes in the process.

All actions on the dose will be tracked in the dose log.

When performing a rate change on a medication infusion, if order 'Revise' function is used by the prescriber to change the rate of the infusion of the Order – the rate of the whole order (for that particular dose/ syringe /bag) will change to reflect the 'revised' rate . This will also result in errors in the calculated infusion rate- so the order is incorrect and the fluid balance will be affected.

*The recommended solution:* If using 'Revise' is absolutely necessary then the clinician will need to use the 'dose log' to check the rate and changes that were made to that particular order. They will then need to update the changes in a chronological sequence from the start of that dose / syringe / bag to the current time when the 'revise' action was performed.



### Mark as Error Action

The Mark Error action enables you to mark a validated dose as an error, for example, if a nurse validated a dose in eRIC however the dose was never administered to the patient, the dose can be marked as an error.

# **NOTE:** a dose that is 'Marked as Error' will disappear from the Cardex and Gantt view altogether and can never be given again. A once only dose will have to be charted to replace the dose marked as error or else the patient may miss a dose of medication.

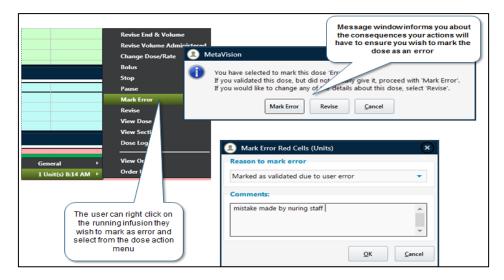
To mark a dose as error:

- In the Gantt view, select the eligible dose you want to mark as an error. Via the right-click menu, select 'Mark Error'; a message window opens informing you that if you validate this dose but did not actually give it, you should proceed with the 'Mark Error' action
- If you click 'Mark as Error', another window will open
- From the Mark Error window, you can enter:
  - ✤ Reason for error select from the list a reason the dose is being marked as an error
  - Comments manually enter a comment about why the dose is being marked as an error
  - Click [OK]. The dose is removed from the view and will not be visible until the next dose is due.









## **Revise Volume Administered Action**

The Revise volume administered action lets you revise the administered volume of a dose.

For example if the order is for 0.9% sodium chloride 1000ml and you only administer 300ml, you will need to 'Revise' the volume administered.

- Right click the dose that you want to revise; the menu opens.
- ➤ Click Revise Volume Administered
- ✤ The Revise Volume Administered window opens.
- Select one of the buttons 'Quantity Remaining' or 'Quantity Administered' and enter the volume in the bag at that time of this report
- Click [OK] the window closes and the dose is updated in the Titrate Medication view (Note that this changes the rate of the entire infusion).

**NOTE:** It is recommended not to use 'Revise Volume' but to use 'Stop' instead and then 'Administer' and 'Validate' the new fluid bag / infusion. Using the 'Revise Volume' will alter the rate the infusion was running at.

Change I Bolus Stop	e Administered Servise Volume Administered X
Pause Pause Readmin Finish St Mark Err Revise View Sec 1,000 mL 12:46 PM Dese Log The user can right of the running infusion wish to Revise the V Administered for solvet from the doce	Initiated or validated quantity: 1000 mL Quantity administeredprevious report: 700 mL Quantity remainingprevious report: 300 mL Quantity remaining: Quantity remaining: Quantity administered: 300 mL Report date_time: 19/01/2016 2:41 PM Rate: 3000 mL/hour
select from the dose menu	QK Cancel

 If there have been boluses or rate changes on an infusion - it is not possible to use the 'Revise End Time & Volume' to signal a bag is complete and a new dose is starting – this is because it comes up with an error message which will not allow this action (Message: You cannot perform this action as there are actions already performed after this time) *The recommended solution:* Use 'Stop'. Then 'Validate' a new dose of the infusion that has been stopped



 Infusion bag/syringe finishes before the predicted end time in eRIC and a new infusion bag/syringe is started e.g. Fentanyl infusion predicted to finish at 18:00, however it finishes at 14:00

*The recommended solution:* This often happens because eRIC does not take into account priming volume. The nurse simply **Stops** the running infusion in the Titrate Medication tab in eRIC at the time the infusion bag is finished, and then **Validates** a new continuous infusion Dose (which will be created when the infusion is stopped).

## 14.5 Examples of Specialised Medication Workflow Processes

## 14.5.1 PCA / Epidurals / Nerve Blocks

🔊 🔻 PCA Morphi	ine 1mg/mL in Sodium	n chloride 0.9%	CIAP <b>• •</b>	PRN PRN Indication		
Dose Form	Route	Body Site	PCA N		oride 0.9% 50 mL at X mL/hour PC/ oride 0.9% X mL PCA IV Bolus Only	
	V	Č			Additives	🗳 Dilue
Medication/Product			Quantity/Volume	Concentration	Daily Dosage	
Dose Rate	R	late		Total volume	Infuse over	
	R	ate		Total volume Comments	Infuse over	
Dose Rate	R	iate			Infuse over	

- PCA can be prescribed as PCA with background infusion or PCA Bolus only
- Choose the appropriate template
- Prescribe as a volume of syringe
- Attached PCA Order form in the order entry window will need to be completed.
- For PCA bolus Only details see attached form, the Nurse needs to enter Rate of 0.001mL/hour for Zero Background rate at the time of administration (even though there is no background infusion)

	oute Body Site PCA IV	<ul><li><li><li><li><li><li><li><li><li><l< th=""><th>Continuous</th><th>Prescribe volume</th><th></th></l<></li></li></li></li></li></li></li></li></li></ul>	Continuous	Prescribe volume	
Set Quantity Or Volume O		ty/Volume		of syringe	Diluent
	Sodium chloride 0.9' 🤨 🔻 🧴	50 mL	K .	-	<b>a</b> ×
Dose Rate	Rate		A Total volume	Infuse over	
Dose Rate	Rate		Total volume	Infuse over	
tart			50 mL For PCA Bolus Only det		
tart Now nd	Mandatory		50 mL For PCA Bolus Only det	ails see attached form	
			50 mL For PCA Bolus Only det	ails see attached form	
tart Now nd	Mandatory		50 mL For PCA Bolus Only det	ails see attached form	





By clinicians.

clinicians

 PCA Order form contains the PCA order details – also has a button that links to the PCA Naloxone Prescription

°CA Program		
CA Bolus Dose: Unit	mg 🔻	
Bolus Dose	1 mg = 1 mL	
ock Out Period	5 minute	
ackground Infusion Rate	Enter Infusion rate details into the "Rate" section of the actual prescription order	
Naloxone Order		
For sedation score 3 or wh urgent medical review. Co	nen sedation score is 2 and respiratory rate less than or equal to 5 breaths per minute. Obtain mmence resuscitation including administering prescribed naloxone until respirations greater t edation score less than or equal to 2. Provide ventilatory assistance if required.	
For sedation score 3 or wh urgent medical review. Co	mmence resuscitation including administering prescribed naloxone until respirations greater t	

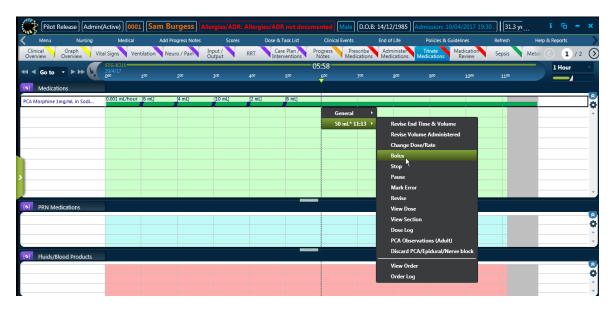
 The PCA Observation form needs to be completed. Access this from 'Nursing' Menu → Observations → PCA Observations – this then populates onto the Neuro / Pain Tab.

Sam Burgess - PCA Observations (Adult)						(	×
20/04/2017 11:02 🔺 🔻 😘 SI	haron Shunker / STG-ICU1				*	¥	
Patient Controlled Analgesia Observations						4	
Pain on Movement	6		•				
Pain at Rest	4		•				
Nausea and Vomiting	No		•				
Sedation	1 - Easy to rouse		•				
PCA Delivery							
Total Volume Infused (cumulative)	6	•	mL				
Volume Infused this Hour	4	•	mL				
Background Infusion Rate	0	•	mL/	hour			
Total Demands (cumulative)	10		•				
Sucessful Demands (cumulative)	6		•				
PCA Program Checked	Yes		•				
						1	
			Save	and Close	C	ancel	





 Nurses will use the titrate medication tab to enter hourly cumulative bolus dose and hourly PCA Observations (observations can also be attended from the Neuro/ Pain tab)



## **Epidural Orders**

 Epidurals will be ordered by strength of infusion. All the order details such as bag volume will need to be entered (They can be prescribed as continuous infusions or as 'Epidural Rescue Bolus' or PCEA with Background or PCEA Bolus Only)

Orderable				2	
🔊 🔻 Ropivac	aine 0.2% Fentanyl 4n	nicrog/mL	•	٩	PRN PRN Indication
Dose Form	Route	Body	Site		Ropivacaine 0.2% Fentanyl 4microg/mL X mL at X mL/hour Epidural Continuous Infusion [Adult]
Pain Infusion	<ul> <li>Epidural</li> </ul>	<ul> <li>Sele</li> </ul>	ect Body Site	•	Ropivacaine 0.2% Fentanyl 4microg/mL X mL Epidural Rescue Boliss every X minutes PRN [Adult]
				,	Ropivacaine 0.2% Fentanyl 4microg/mL X mL at X mL/hour PCEA with Background [Adult]
Set Dose and Rate	e	ن <b>سن</b> ة 🔁 🔻		1	Ropivacaine 0.2% Fentanyl 4microg/mL X mL PCEA Bolus Only [Adult]
Medication/Produ	ct		Quan	ntity/V	Ropivacaine 0.2% Fentanyl 4microg/mL X mL at X mL/hour Regional Nerve Block Continuous Infusion [Ad
		- 6e	ō		Ropivacaine 0.2% Fentanyl 4microg/mL X mL Regional Nerve Block Rescue Bolus every X minutes PRN [A
Ropivacaine 0.2%	Fentanyl 4microg/ml				
Ropivacaine 0.2%	Fentanyl 4microg/ml				Ropivacaine 0.2% Fentanyl 4microg/mL X mL at X mL/hour PCRA with Background [Adult]

## • Prescribe Epidural using the appropriate template.

Pain Infusion The Pain Infusio	Body Site           The second	Continuous	Prescribe volume
Set Dose and Rate Medication/Product		antity/Volume	of bag
Ropivacaine 0.2% Fentanyl 4microg	g/mL 🍕 🔻 🧿	200. mL 🔍 🔍	mL/kg/day (0 mL/day) 🔒 🗙
Dose Rate	a Rate	Total volume 200 mL	Infuse over
Now			
ind	• Ma	ndatory Epidural order form	





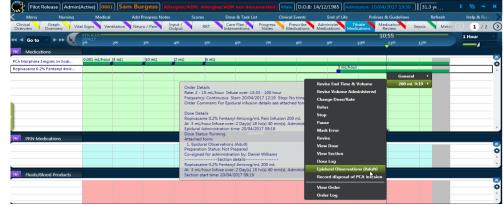
• Complete attached Epidural Order Form (e.g below for Infusion Only)

20/04/2017 12:09 🔺 🔻	Sharon Shunker / STG-ICU1			* *
heckbox				
✓ Infusion Only	Rescue Bolus Dose	PIEB	PIEB + PCEA	
nfusion Only		Rescue Bolus Dose		
fusion rate (mL per hour)	Enter Infusion rate details into the "Rate" section of the actual prescription order	delivering the ep	bolus to be administered via idural solution as prescribed issessed as competent can de	above. ONLY registe
tart Rate	3 🔺 🔻 mL/hour	A rescue bolus o rescue bolus ter	lose must be prescribed with a	an additional order us
		la	cknowledge that a rescue bolu prescribed as a PRN order	us dose prescription i
CEA (Patient Controlled Epidural .	Analgesia)	PIEB (Programmed	Intermittent Epidural Bolus)	
fusion rate range (mL per	Enter Infusion rate details into the "Rate" section of the actual	PIEB Bolus Dose		× ×
our)	prescription order	PIEB Lockout Inter	val	× ×
tart Rate	🔺 🚽 mL/hour	Delay Time till Fir	st Bolus (If Applicable)	× ×
CEA Bolus Dose	mL			
				E I I I I I I I I I I I I I I I I I I I

 Complete Epidural observations Form. Access this from 'Nursing' Menu → Observations → Epidural Observations (Has two windows Epidural observations and Dermatones chart)

👤 Sam Burg	gess - Epidural Observations (Adult)			×	Sam Burgess - Epidural Observations (Adult)	×
20/0	4/2017 12:14 🔺 🔻 🚱 Sharon Shunke	er / STG-ICU1		*	20/04/2017 12:14 * Y Sharon Shunker / STG-ICU1	¢ ;
Epidural Observatio	Epidural Observations			1 A A A A A A A A A A A A A A A A A A A	Epidural	-
ns	Catheter Position at Skin	20 🔺 🔻	cm		Closenato	Thorac
Dermatome s	Site Condition	<ul> <li>Dressing intact</li> </ul>			Dermatome	T1
		Clean			Cervical	12
		Reddened				12
		Swollen				
		Induration				
		Tender				15
		Painful				T6
		Oozing				T7
		Exuding				<b>T8</b>
		Bleeding				Т9
	Epidural Program Checked	Yes	T			T1           T2           T3           T4           T5           T6           T7           T8           T10           T11           T12
	Infusion Rate	3 🔺 🔻 mL,	/hour			T11
	Set Bolus Dose	0 🔺 🔻	mL			112
	PCEA Total Demands	A	•			A
	PCEA Successful Demands	A	•			W -
	Infused Total (Cumulative)	3	mL	* *		
			Save and Close	Cancel	Save and C	lose Cancel

- Ongoing Epidural hourly observations will be attended from the Titrate Medication tab or the Neuro / Pain
- It will populate into the Neuro / Pain Tab.







### **Nerve blocks**

 Regional Nerve Block solution is similar to Epidural solution with the exception that the prescriber is required to prescribe 1 order per Nerve block site to satisfy legal requirements of nursing staff signing for initiation and cessation of separate infusions.

### **Discarding PCA /Epidural and Nerve Block Infusions**

- The ICU Medical officer needs to discontinue the order.
- The nurse will stop the infusion from the Titrate Medication Tab.
- The form to be completed for Discarding PCA / Epidural and Nerve Block Infusions is accessed from right clicking on the infusion from the Titrate Medication Tab. It can also be accessed from the Current Dose Window.
- Complete the details including discarded volume
- The witness who sighted the disposal must sign the form. The person logged into eRIC is the other person responsible for the disposal of the infusion.

Sam Burgess - Discard PCA/Epidural/Nerve block : New Session		0
19/04/2017 11:13 🔺 🔻 🚱 Sharon Shunker / STG-ICU1	¢ ¥	
Discard PCA/Epidural/Nerve block		a t
Medicine Description Morphine PCA 💌		
Date and time infusion discarded v20/04/2017 12:33		
Total discarded drug:		
Infusion disposed by: Sharon Shunker		
The WITNESS who sighted the disposal of the infusion MUST sign the button below. The person logged into eRIC is the other person responsible for the disposal of the infusion.		
Comments		
s	ign	*
sign si	ave and	sig N

## 14.5.2 Bolus Fluid Order / Rate Change Prescription

- A bolus fluid order (or a change in rate for a few hours) can be prescribed from the current running maintenance fluid using the 'Comments' section of the existing order
- Go to Prescribe tab and right click on current maintenance fluid select 'Modify'
- In the 'Comments' box the prescriber needs to specify bolus fluid, date and time of administration and that it should be given as a bolus using the current maintenance fluid flask
- Prescribers can also use the same procedure to specify a rate change such as increase to 250ml/hr for a few hours – need to include the date and time.

			Modil	y Order for Samuel Burgess, MR numb		onal Information	Allerg	ies/ADI
Orderable				y order for samuel burgess, intenante	er #10550			
Sodium chloride 0.9%	>		🔹 Q 🔯	PRN PRN Indication				
Dose Form Route	B	Body Site						
Infusion. <b>v</b> IV	-	Select Body	Site 🔻 🕋	Continuous	•			
Set Dose and Rate	★ D	ä				Additives	.#	Diluer
Medication/Product			Quantity/Volume	Concentration	Di	aily Dosage		
Sodium chloride 0.9%	• <del>0</del>	E	1.000 mL		34	1.29 mL/kg/day <i>(2,400 n</i>	a	×
Jose Rate	ate			Total volume (34.2857 m	L/kg/	A Infuse over		
	100 mL/h	our		1,000 mL		10 hour		
Start	100 mL/hd	our te and time		1,000 mL Administer a bolus of 250ml s		10 hour	urrent	flask o
itart Date And Time	100 mL/hd	our	5 🔺 🔻	1,000 mL		10 hour	urrent	flask o
Dose Rate Start Date And Time End No Time Limit	100 mL/hd	our te and time	5 🔺 👻	1,000 mL Administer a bolus of 250ml s		10 hour	urrent	flask o





Description     Descripti     Descripti     Description     Description     Description	<ol> <li>ICU Doctor / Prescriber:</li> <li>When you sign the modify order, an issue comes up as "doses are running or initiated"</li> <li>Choose 'View and Acknowledge'</li> <li>A warning box pops up as there are currently running doses. Choose 'Do not stop'</li> <li>Communicate to the nurse to administer a bolus dose.</li> <li>Once the bolus has completed, return to the orderable window and remove the comment.</li> </ol>
	<ol> <li>ICU Nurse:</li> <li>Right click on the medication and view the order with the comment to administer the bolus from the 'Prescribe medication' order timeline view</li> <li>Go to 'Titrate Medications' tab and administer the bolus</li> <li>Once the bolus has completed check the prescriber has returned to the orderable window and remove the comment</li> <li>The comment will remain in the dose log</li> <li>The same procedure applies to 'Rate Change'.</li> </ol>

## 14.5.3 Continuous Infusions with Bolus Loading Dose

### **Prescription Example**

This is an example of prescribing an infusion with a loading dose – the drug is bivalirudin with a bolus loading dose of 0.25mg/kg followed by a maintenance rate of 1.75mg/kg/hr.

## Order screen after selecting the LOADING and MAINTENANCE template

rderable				SAD					
🏷 🔹 Bivalirudin				- Q 📮	PRN Indication				
lose Form	Route		Body Site						
Injection	* N		<ul> <li>Select Body Site</li> </ul>	* #	Continuous	*			
Set Dose and Rate	· Þ	-					additives 🕹	2	Diluen
Aedication/Product			Quantity/Volume		Concentration	Daily C	losage		
Skalinudin		- Ö	250 mg		5 mg / mL		42 mg/kg/Day (4,200 mg/Day)	a	×
Diversi Sodium chloride 0.5	ni 📌	* Ö	50 mL		_		8.4 mL/kg/Day (840 mL/Day)	.a.	×
	(175 mg/ho <b>ոց ೪գյիօս</b> 1		Rate Nijhour		Total volume     Total volume	(84 <i>m</i> ,49,01)	<ul> <li>Influes over</li> <li>241 hour</li> </ul>		
175					50 ml.	(8.4 m, 4g, Day			
278 27		35 #			50 mL		143 hour	he order	
Doose Rufus 5.778		35 -	nL/hour		50 mL			the order	
2.75		35 -			50 mL LOADING dose: Administer an inital LOADING b		143 hour	the order	

- The prescriber will need to type in the loading dose in the comments section. They will need to do the manual conversion of the recommended dosing of mg/kg to mg for this patient (0.25mg/kg for 100kg weight = 25mg). The maintenance dose rate will be included in the usual 'Dose Rate' or 'Rate' field. The loading and maintenance dose template is used for one dose only. Subsequent maintenance dose should be prescribed with the maintenance dose template.
- The administrating nurse needs to go to the 'Order Details' Window' read the order comment and recognise the loading dose. The nurse will give the loading dose as prescribed and then set the maintenance rate.
- The nurse then needs to 'Validate' the loading dose and maintenance dose



## ICU Nurse:

- 1. 'Validate' the loading dose and maintenance dose
- 2. Validates the infusion at the prescribed maintenance rate. Go to the 'Titrate Medications' tab, right click on the dose at the start of the infusion and choose 'Bolus' (the 'Bolus' is used to indicate the loading dose)
- Calculate the equivalent mg to mL conversion and enter it into the bolus dose screen (in the example previously, 25mg = 5mL). The time entered needs to reflect the time the bolus was given so the administration time may need to be modified to reflect the start of the infusion

Go to P + + (	Ventilation Neuro / Pain Output / Outpu	RRT Care Plan Pr Interventions P	pores P Ne 12 <sup>20</sup>		
Medications allirudin, M	115 mg/kg/hour General				6
	200 mg 9:13 • Preuro pt car Deter Content Administra in MANTENANCE Des Details In Socian Content In Socian Content In Socian Content Naministra in Mantenata Des Socials	Norme View Dose View Section Dose Log View Order Order Log	Bolus quantity: Bolus quantity: Time: Comments:	5 • T mL 13/01/2017 9:13 • T	Â
PRN Medications	Bivalirudin 250 In Sodium ch At 1.75 mg/kg Administered in	dministration by: None nurse nurse -Section details	71 minist.	ок	ancel

After clicking OK, an indicator messages that the bolus dose has been administered with the details in the dose log and floating tool tip. The infusion continues to run at the prescribed maintenance dose rate. If further doses are required, a separate order needs to be created using the maintenance dose template. The maintenance doses work similarly to the decision summary for infusions with a loading dose.

I Go to	09:23	10%	1100	1200	13 <sup>80</sup>	1400				
Medications	Ĭ									
alirudin, M	175 mg/	ig/hour	Create Date Far Ed	Route Mit namker 123414799	Body Sta v Saket Body Sta	CM + 0.0	FIN //// Indexton		Addresse Information / V	Allengies
	3		Set Dose and Rate Medication/Product Bisalisatin Discrit Scillum offer	• () in e0 •			(incuntration 5 mg / ml.	Dudy D	ADDIVE	1 1 1
			Des for     Des for     Des for	(3) egebeci	A tao It militar		A Tota volume Some	dhif mc, hg Dagi	A. Man inter	
					33 mil/hour				LAI hour	



## 14.5.4 Continuous Infusions with Loading Dose

The following screenshots are reflective of prescribing Dexmedetomidine with a loading dose followed by a maintenance rate.

3 Cruate Order For	Eric Master, MR number 1234567	10		
-				Additional Information
Orderable		CIAE		
Desmark	ntomidine	* Q Q	PRN PRN Indication	

Order screen after selecting the LOADING and MAINTENANCE template

Infusion * N		* Select Body Site	- #	Continuous	(v)				
Set Dose and Rate v	0						Additives	<b>a</b> 0	luent
Medication/Product	Quan	ony/Volume	0	concentration	Daily D	osage .			
Dexmedetomidine	+ - D	200 microg		4 microg / mL	2.4+1	72 microg/kg/Day (240 - 7,	200 microg/Day/	ā	1.00
Ciliant Sodium chloride 0.9%	0 - 0	50 mL			0	16 - 18 mL/kg/Day (60 - 1.6	00 mil/Dayd	a.	×
	-			_			-		
a Dose P	ding infusion			a Total volume	mended by	uctions to be prescriber as uired			
Loa	nicrog/hour) 🚔 Rate			a	mended by requ	prescriber as uired			
infusion rate	nicrog/hour) A Rate		3	a Total volume	mended by requ	prescriber as lired	intenance rate aff		

- From the template the following fields have their values defaulted into the order: Dose Form, Route, Frequency, Quantity/volume, dose titration button and number of doses which is 1 dose (order finished once one 50mL syringe is finished). The 'loading instructions' are defaulted into the comments field
- The dose titration field is selected by default. This allows the prescriber to order the infusion with a DOSE RANGE (maintenance infusion rate loading infusion rate)
- The loading infusion rate (e.g. 0.1-3 microg/kg/hr) is entered per local protocol
- The 'loading instructions' for the infusion in the comments field can be amended as required. The comments that are not applicable will be removed.

## Validating Infusions with Loading Dose ICU Nurse:

- 1. Follow normal procedure for viewing, administering and validating new infusions
- 2. Check the comments section for the loading dose rate and duration of administration
- 3. Start the infusion with the LOADING dose
- 4. Specify the 'Dose Rate' starting rate as per the instructions shown on the prescription for the loading dose
- 5. After 20 minutes, go to the titrate tab and will change the dose/rate to 0.4 microg/kg/hr. This would be the rate for the remainder of the first syringe. In this case, the nurse must remember to lower the infusion rate after 20 minutes as there will be no active alerts to remind them







### ICU Doctor / Prescriber:

Before the first syringe has finished, the doctor needs to prescribe the MAINTENANCE dose as a new order – this will be used for ongoing infusions.

PRN PANALCONTON PRN PANALCONTON PRN PANALCONTON Continuous Concentration icrog 4 microg / mL Values	v         Image: Second se	Dilu 27 a a
icrog 4 microg / mL	Additives Daily Dosage 24 - 36 microg/Rg/Day (240 - 3.600 microg/Rg/Day	y a
icrog 4 microg / mL	Additives Daily Dosage 24 - 36 microg/Rg/Day (240 - 3.600 microg/Rg/Day	y a
icrog 4 microg / mL	Daily Dosage 2.4 - 36 microg/kg/Day (240 - 3.600 microg/Day	y) a
icrog 4 microg / mL	2.4 - 36 microg/kg/Day (240 - 3,600 microg/Da)	
mL		
5	0.6 - 9 mL/kg/Day (60 - 900 mL/Day)	a
Values		
	haintenance comment	
1		
A Total volume	(0.6 - 9 mL/kg/Day) 🔒 Infuse over	
Contraction Total volume	(0.6 - 9 mL/kg/Day) 1.33 - 20 hour	
50 mL	and the second	
50 mL	1.33 - 20 hour	
50 mL "MAINTENANCE infusion tem	1.33 - 20 hour	
50 mL	1.33 - 20 hour	
	defaulted	defaulted Maintenance comment

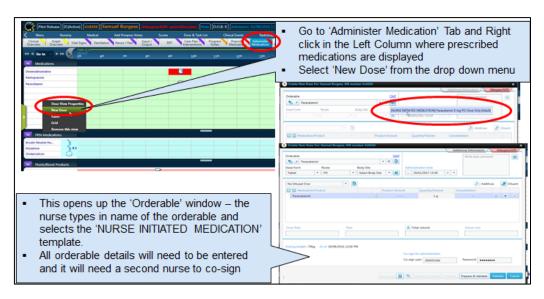
## ICU Doctor / Prescriber:

- Create a new MAINTENANCE order once the LOADING dose and the MAINTENANCE dose for the first syringe is completed
- Select the Dexmedetomidine MAINTENANCE template. The same fields are defaulted, except for the comment field which will not contain any 'loading dose instructions'
- The maintenance rate range is entered (e.g. 0.1-1.5 microg/kg/hr) and the MAINTENANCE order is saved.

## **ICU Nurse**

Administer and validate the new maintenance order.

## 14.5.5 Nurse Initiated Medications







By clinicians

for clinicians

## 14.5.6 Telephone Orders

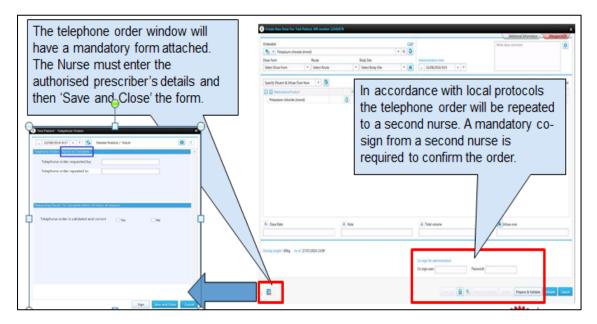
The telephone order is received and confirmed by two nurses as per local policy – this can be written into the progress notes and the order administered. The two nurses are then required to record it as a telephone order using the template and validate it.

- Telephone Orders can be recorded using the 'Orphan Dose Template' functionality which allows for the prescription of a one-off unplanned dose
- The Nurse receiving the telephone order navigate to the Administer Medications tab and right clicks in the medications Cardex view to order a new dose

(Adult	Bed 04(Active)	24681234 Jasc	on Bourne) 🛛	llergies/ADR	: Allergi	es/ADR not docu	mented A	lerts.:	0 Admissio	n: 03/08/201
Menu	Nursing	Medical	Add Progress N	lotes	Scores	Dose & Task	c List	Clinical Even		ology
Clinical Overview	Graph Overview Vit	al Signs Ventilation	Neuro / Pain	Input / Output	RRT	Care Plan / Interventions	Progress Notes	Prescribe Medications	Administer Medications	Titrate Medications
୶ 🔺 Go to	> >>	*Adult 10/8/16 500				800			1000	1100
Medication	ons									
	Dose View Prop	erties								
	New Dose									
	Gantt									
	Grid									
	Pamous this via									

 The Nurse will type the orderable in the order search window and select the Telephone Order template attached to the specific medication. Each medication identified as likely to be required for a telephone order will have a separate orphan dose 'Telephone Order' template assigned. Most fields in the template will be blank and require input from the Nurse.

rderable           •         Potassium chlo	oride (mmol)		CAP	Write dose coment	0
ose Form	Route	Body Site	TELEPHONE ORDER) Potassium	chloride X mmol Infusion Once Only [Adult]	
	• 0				🔊 Additives 🛛 🖉 Diluset
Medication/Prod	loct	Product Amount	Quantity/Volume	Concentration	

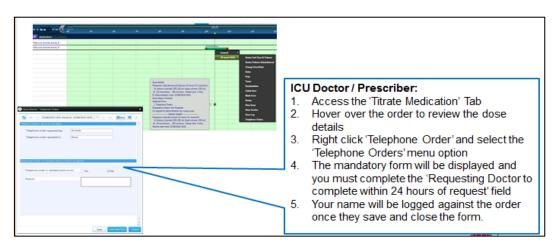








In accordance with New South Wales health policy the medical prescriber will be required to confirm the order is correct within 24 hours.

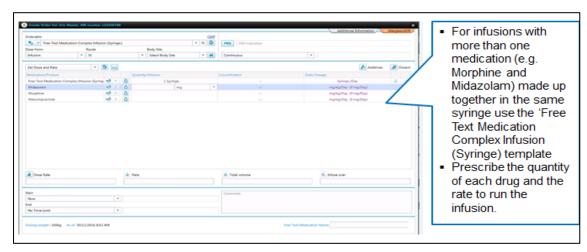


## 14.5.7 Infusions with multiple ingredients

When infusions are prescribed with multiple ingredients e.g. Additives such as trace elements added to Soluvit, this will not show on the Order Timeline view or Dose Task List. It needs to be checked from the 'Order Details' Window.

Overview Overview	tal Si PM	Orderable Soluvit N Dose Form Infusion V IV	Body Site V Select Body Site V		PRN Indication	
Go to Constant of the second s	000	Specify Diluent & Infuse Over Now Medication/Product Solwit N		folume fial(s).	Concentration 0.1 Vial(s). / ml.	Additives P Dauent
Medications		Trace Elements Adult (Easter ATE)		0 mL	1 mL / mL	0.14 mil/kg/day (10 mil/d
lydrocortisone 100 mg,IV, every 8 hour, Injection		Dose Rate     0.25 Via(b),/hour	A Rate 2.5 mL/hour	a Tota 10 mL	al volume (10 ml/day	A Infuse over     A hour
loradrenaline 4 mg,IV,Continuous,Injection	0.0	Start Selected dose of the day on	20/1/2017 A V 800 AM	Comme	enti	
Dxycodone 30 mg,PO,BD (08:00 20:00),MR		End No Time Limit				
antoprazole 0 mg V 1400 Dilection	-	As of 29/08/2016 12:56 PM				Andication Name:
oluvit N Vial(s)IV.Morning (08:00).Inf		Party any very 2012 12:30 PM			Created or	0rder Log OK Cores

## 14.5.8 Free Text Medication Complex Infusion

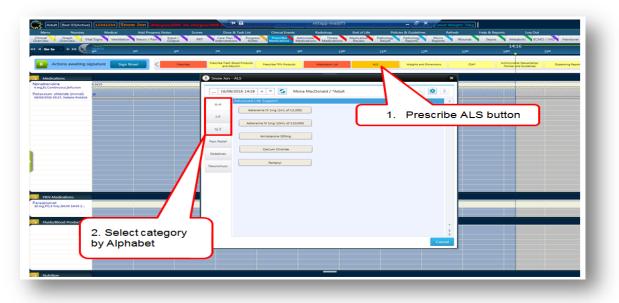




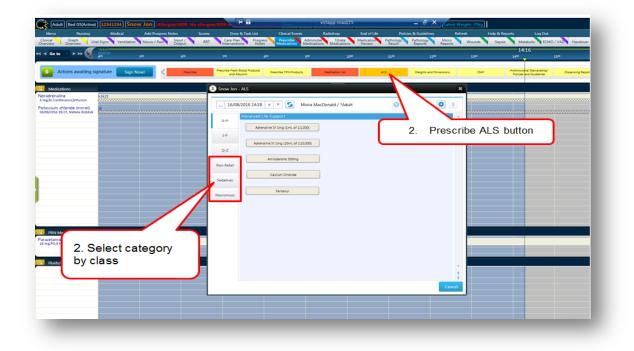
## 14.5.9 ALS Drugs

The Cardiopulmonary Resuscitation paper form is intended to be completed by hand **during** the arrest; however prescribing and validating of the ALS medications into eRIC is intended to occur **after** the arrest (preferably immediately after) by the medical officer and registered nurse.

• **Option 1** Prescriber selects the 'ALS' button on the Prescribe Medication tab. Each medication is grouped alphabetically i.e. A-H, I-P, Q-Z.



• **Option 2** Prescriber selects the 'ALS' button on the Prescribe Medication tab. Each medication is categorised according to their appropriate class.





Inderable Advenative Isse Form	Router * N	findy Site * Select Body Site		Mit Indiation			IF	<ul> <li>The selected medication will</li> </ul>
No Influent Over Rodicationy Product Advenatione	• 8 - + 4	Quantity/Volume 1990 microg in Erect	0	contration 5.000 microg / vel.	Daily Decage	Addres Diset		have the relevant ALS template assigned and the
								appropriate fields defaulted according to ANZCOR ALS guidelines (Version 11.5).
						$\langle$		<ul> <li>The prescriber and nurse would sign and validate</li> </ul>
Suue Flate	La			Total votures	Muerow	$\leq$	η	would sign and validate each ALS medication
Nore Rute Safe Name M					Mus our	<		would sign and validate

## 14.6 Discontinue Medication

When a medication needs to be discontinued, it is done from the 'Prescribe Medication' tab view.

- Right click on the medication and select 'Discontinue'
- This will then flash as an 'action' awaiting signature
- Clicking on this opens the signature review window and the medical officer will need to sign for the discontinue action for the order
- It will not be discontinued if the action is not signed.

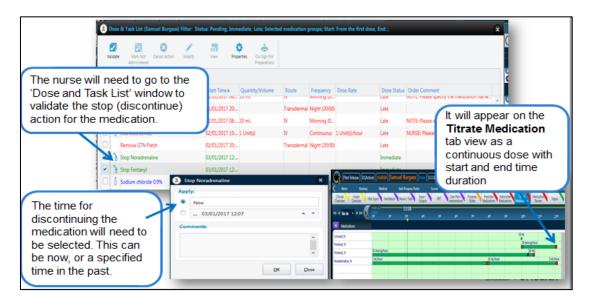


## Discontinuing Infusions: For IV Infusions

- Go to 'Prescribe Medication' tab view.
- Right click on the medication and select 'Discontinue'
- This will then flash as an Action awaiting signature



- Clicking on this opens the signature review window and the medical officer will need to sign the discontinue action for the order
- It will not be discontinued if the action is not signed
- The nurse will then need to go to the 'Dose and Task List' window to validate the stop (discontinue) action for the medication.
- The time for discontinuing the medication will need to be selected. This can be now, or a specified time in the past
- It will then appear on the 'Titrate Medication' tab view as a continuous dose with start and end time duration



## Discontinuing and discarding residual volume of scheduled medication infusions -

The comments box under the 'validate discontinue' window should be used to enter the volume discarded as well as the full name of the second clinician checking and witnessing the discarding of the medication.

			ediate, Late; Se	•					د
Validate Mark Not Administered		Modify View Pr	roperties Co-Si	Sign For arations					
Drag a column header h	nere to group by th	nat column							
Orderable		Start Time▲	Stop Fen	tanul		×	Dose Status	Order Comment	
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Paracetamol		24/05/2016 18					Pending		
🗌 🍾 Heparin		24/05/2016 20					Pending		
Paracetamol		24/05/2016 22	• 2	24/05/2016 13	3:33	· · ·	Pending		
Paracetamol		25/05/2016 06	Comments	s:			Pending		
🗌 🍾 Heparin		25/05/2016 08					Pending		
Drag a column header h	here to group by t	hat column			<u>O</u> K	Close			
Orderable		Start Time▲ C	Quantity/Volum	ne Route	Frequen Dose Rate	e Dose S	St Order Comm	ent	PRN Indication
				No it	items to display				
Select All Late and Imm	ediate			No i	items to display				Close
Select All Late and Imm	nediate			Noi	items to display				Close
Select All Late and Imm				dbox -					Close
Select All Late and Imm		► ++ <b>(</b>	Sanc 24/5 1000	dbox -			1200		

40 microa/hour





Fentanyl, IV

By clinicians.

for clinicians

#### 14.7 Medication Review Tab View

This view can be used by both Medical Officers and Pharmacists to review the patient's medication related issues. It includes:

- New Medication Review Window
- Dispensing Report button (to print current prescriptions for pharmacy use only for dispensing)
- Pharmacy Progress Notes shortcut button
- CIAP (link to CIAP) button
- Antimicrobial Stewardship/Policies and Guidelines shortcut button.

	A	dult	Be	d - 06	5(Acti	ive) 416	350 Sam	Burgess A	lergies/ADR:	Benzylpe	nicillin Alerts.:	one ,Absco	nder Male	D.O.B: 14/12/	1971 Admiss	sion: 21/04/201
	Hel	p & F	Repor	ts		Log Out										
Clini Overv				aph rview	V	/ital Signs	Ventilation	Neuro / Pain	Input / Output	RRT	Care Plan / Interventions	Progress Notes	Prescribe Medications	Administer Medications	Titrate Medications	Medication Review
4   ◀	6-		•		M	Sandbox 24/5/16	- Adult									15:25
	GO	το			A	500	6 <sup>00</sup>	700	800	900	1000	1100	12 <sup>00</sup>	1300	1400	1500
			New	/ledicati	ion Rev	view	Dispensin	g Report	Pharmacy Pro	ogress Note	c	AP	Antimicrobial S	itewardship/Policie	s and Guidelines	

#### **Medication Review Window**

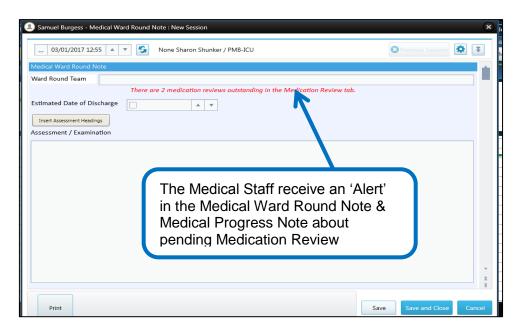
The Medication Review window that can be used to enter information about a medication issue that requires clinical review.

This Review Note is entered by the Pharmacist and Medical Staff receive an 'Alert' in the Medical Ward Round Note & Medical Progress Note.

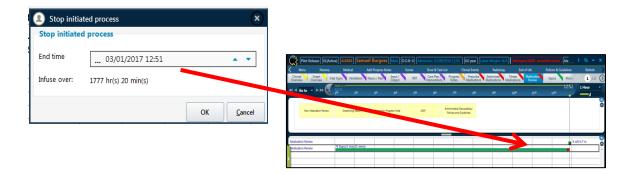
👤 Sam Burgess - N	ledication Review					×
24/05/2016	15:19 🔺 🔻 🏠 Sharon-/	Ann Shunker / Sand	lbox - Adult		•	¥
Medication(s)						
Recommendation	-Select-				•	1
Reason	None				•	1
* Please provide r	more detail in the plan section					
Plan						
Date Issue Identifie	ed 🗌	<b>A V</b>	Date Resolved		]	
To be completed	by medical staff			Consult Form		
Action Taken	O Plan accepted		Alternative Plan			
	<ul> <li>Alternative plan</li> </ul>					
	To be decided					
						*
Drug Chart Changed	O Yes					*
Pharmacy	·					







Menu	Release   01(Activ	Medical	Add Progress N		Scores	Dose & Task	8/2016 11:59 .	ical Events	Radiology	End	of Life	Policies & Gu	uidelines	
Clinical Iverview	Graph Overview Vita	I Signs Ventilation	Neuro / Pain	Input / Output	RRT	Care Plan / Interventions	Progress Notes	Prescribe Medications	Administer Medications	Titrate Aedications	Medication Review	Sepsis	Metab	$\langle \rangle$
d Go to	• • •	PMB-ICU 3/1/17 100 200	300	400	500	600	700	800	900	1000	1100	1200	12:42	1
Nev	w Medication Review	Dispensing Report	Pharmacy P	Progress Note	CIA	,	Antimicrobial Stewa Policies and Guide							
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		******		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	emenne						****			
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edication Rev M f C E	Medica form, ac deciding Decideo	ction it b g on 'All	by <b>Acc</b> ternat Once	cepti e Pla revie	i <b>ng P</b> an' or ewed	lan, 'To k sele	oe ct			Medication	Revi Rea Viev Viev Revie Stop	ise dminister w Dose w Section p	G	enera
rdication Rev f C C	Medica form, ac deciding Decideo <b>Stop</b> fro	ction it b g on 'Ali d Plan'.	by <b>Acc</b> ternat Once Medic	e Pla e Pla revie ation	i <b>ng P</b> an' or ewed n Revi	lan, 'To k sele ew ta	oe ct ab –			Medication I Administrati Dose untus:	Revie Read View Revie Stop on ti Pau:	ise dminister w Dose w Section p se	G	enera
f C E	Medica form, ac deciding Decideo <b>Stop</b> fro	ction it b g on 'Ali d Plan'. om the l	by <b>Acc</b> ternat Once Medic	e Pla e Pla revie ation	i <b>ng P</b> an' or ewed n Revi	lan, 'To k sele ew ta	oe ct ab –			Medication I Iministrati	Revie Revie Revie Stop on ti Pau: Dos	ise dminister w Dose w Section p		ene







#### **Dispensing report**

The dispensing report can be used to print a report of all the medications a patient is currently on which can then be sent to pharmacy for dispensing. The default is to only show the current day's orders. If a future dose is required to be dispensed, the date default should be changed to include that day.

							Patien	t Info	mation		
							Patient	Identifi	er		
							Combin D.O.B	ed Give	n Name an	d Fami	ly Name
							Sex				
Medications											
Orderable Name	Orderable Quantity in Dil. Vol	Route	Dose Form	Schedule	•	Additives t Details		Ordera Dose/I Dil. Ra	Rate at	Orde	red By
Heparin	5,000 Unit(s)	Subcut	Injection	8:00, 20	:00					Sharo	on-Ann ker
Vancomycin	1 g In 10 mL	IV	Infusion	Once On	ly	Diluent: Water fo Injection	r i			Share	on-Ann ker
Sodium chloride	1,000 mL In 1000 mL	IV	Infusion.	Continue	ous		-,	100 ml	L/hour	Share	on-Ann ker
Paracetamol	1,000 mg	PO	Tablet	Once On	ly					Sharo	on-Ann ker
Paracetamol	1,000 mg	NG	Tablet	QID (06:0 18:00 22:						Sharo	n-Ann ker
Propofol	500 mg In 50 mL	IV	Injection	Continue	ous	Diluent: Diluent)	( 50 mL	20 - 10 mg/ho mL/ho	ur: 2 - 10	Sharo	on-Ann ker
Fentanyl	500 microg In 50 mL	IV	Injection	Continue	ous	Diluent: Sodium ( 0.9%)		10 - 10 microg		Sharo Shun	on-Ann ker
PRN Medication	e										
Orderable		Route	Dose Form	Schedule	Additiv ent De	es/Dilu tails	Orderab Dose/Ra Dil. Rate	te at	PRN India	ation	Order
Name	Quantity in				ent De	tails					

#### **Pharmacy Progress Notes**

This window enables a Pharmacist to enter notes regarding medications, and provides details if a medication review has been completed, as well as if any medication issues have been identified. A prescriber should refer to the Medication Review tab if any issues have been identified.

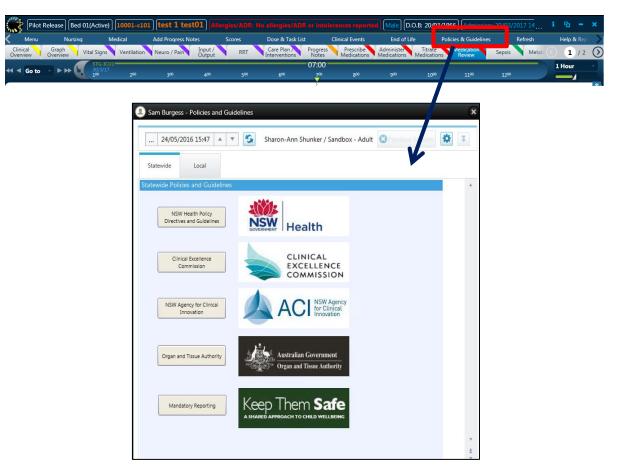
Sam Burgess - Pharmacy Progress Note : New Session	()	ĸ
24/05/2016 15:49 🔺 🔻 🏠 Sharon-Ann Shunker / Sandbox - Adult	Previous Session	
Pharmacy Progress Note		
Medication Review Completed No Medication Issues Identified Medication Issues Identified		
Pharmacy Progress Note		





#### Antimicrobial Stewardship/ Policies and Guidelines

Within the Prescribe Medication tab and the Medication Review tab is the Antimicrobial Stewardship Policies and Guidelines button. The user will be redirected to the site's local Antimicrobial Stewardship Guidelines site.



The Policies & Guidelines Menu provides a link to statewide and local guidelines.

# **15. Medication Module Specialised Workflow Processes**

These are important processes to be aware of when prescribing and administering medications in eRIC.

#### **Prescribe Medication Specialised Workflow Processes**

- Revise Medication Action: Revising a dose replaces all previous data on the dose and all previous changes.
- PRN medication The maximum 24 hour dose must be entered in the comments section.
- Changes to dose weight any changes that are made to the dose weight will result in a change of dose for all drugs for whom the dose prescription is weight based (e.g. prescribed as 5mg /kg/hr). If dose weight is changed, the medication should be prescribed again as a new order because the original weight is retained in the Order Details Window.
- **Brands** for medication where the brand name is of significance this needs to be entered in the 'Comments' box of the order entry window. The brand name will not be







visible on the 'Prescribe' OR 'Administer' medication tab and always needs to be checked in the Order Detail Window prior to the medication being administered.

- Modify start date and time orders with a start date/time in the future, changing the start date/time in the 'Modify Order' window and clicking OK does not change the start date/time in the chart. Also does not create an action awaiting signature.
- Specialised Workflow Process DO NOT use 'Modify' to change start date or time
   Reschedule Action When a dose is rescheduled the starting dose time changes to incorrect dose time.
  - → Specialised Workflow Process DO NOT use 'Reschedule' action.
- Revise End Time & Volume Unable to Revise End Time and Volume if any previous action was performed to that dose, e.g. after giving a bolus dose. The following message pops up 'You cannot perform this action since there are actions already performed after this time'.
  - Specialised Workflow Process DO NOT use 'Revise End Time and Volume' action. Stop infusion that has finished and commence and validate the new infusion.

#### Administer Medication Specialised Workflow Processes

- Discontinuing and discarding residual volume of scheduled medication infusions The comments box under the validate discontinue window should be used to enter the volume discarded as well as the full name of the second clinician checking and witnessing the discarding of the medication.
- **Rate Changes** If the rate was changed but not documented in eRIC, the clinician needs to make the retrospective changes to rate in chronological order.
- Administering and Validating Medication/ Fluids/ Enteral Feeds / Blood and Blood Products – Always use 'View' button and check the parent order in the 'Order Details Window' to prepare the medication for administration. Once administered it can be signed for by selecting the 'Validate' button and validating that it was given from 'Current Dose' window.
- Validating future doses will not trigger alert when frequency is 'Set Interval' -Always check order details and do not rely on warnings, alerts and prompts.







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# eRIC User Guide

# Module 5: Discharge & Transfer

& Transfe Discharge







# **16. Overview Discharge and Transfer**

This module is will provide users with a high level view and understanding of the procedures involved in discharging, transfering and transporting a patient from ICU using eRIC.

# **17. Discharge and Transfer Terminology**

There is terminology for discharge and transfer that is specific to eRIC that you need to familiarise yourself with.

TERMINOLOGY	DEFINITIONS
Pre-admitted	The patient is allocated a bed in PAS which appears as the patient <b><u>not</u></b> being allocated a bed in eRIC
Admitted	The patient is allocated an ICU bed which appears as the patient being in an ACTIVE bed in eRIC. When a patient is registered with Admitted status and assigned to a bed in eRIC, data from medical devices begins to flow into the patient's clinical record.
Released	When a patient is moved out of the ICU ward, they are being discharged to another ward or facility. The medical record can still have some data entered and saved, results from Pathology and Laboratory can still be entered onto the flow sheet
Closed	Patient will not be returning for additional treatment, no data can be entered into the patient file. The file can only be viewed
Discharged	<ul> <li>The patient is being moved from ICU to one of the following areas:</li> <li>Discharged / Transferred to ward</li> <li>Discharged to another hospital</li> <li>Discharged home</li> <li>Patient left against medical advice</li> <li>Patient died in the ICU</li> </ul>
Transfer/Transport	The patient is being transferred to another area in the hospital or out of the hospital for a short period of time, e.g. transport to radiology for CT scan or transport to operating







# **18. Transporting a Patient**

This refers to the process whereby the patient is being transported to another area in the hospital or out of the hospital for a short period of time, e.g. transfer to radiology for CT scan or transfer to Operating Theatre or Cardiac Cath Lab.

While a patient is in 'Transport', the flow of data from medical devices is stopped and the patient is not associated with a specific ICU bed.

- If a patient needs to leave for a procedure (example to Radiology for CT scan), then they
  need to be placed in transport status
- This is recorded as a Clinical Event
- Go to the Clinical Event menu → choose Transport within Hospital
- This opens the add new clinical event window
- Select Transport within Hospital and choose the start time
- When a patient returns, mark the end time to end the clinical event
- Open the **Transport Guidelines Checklist** from the button at the bottom of the 'Transport Clinical Event' Window (as seen below).

Menu	Nursing	Medical	Add Progress Notes	Scores	Dose & Task List	one ,Absconder Male	Radio
		Signs Ventilation		nput / RRT		Progress	Administer Medication
■ Go to -		Critical Care 1/6/16 00 700	800		Add Naw C		×
HR	200			Sam Burges	<ul> <li>Add New Cl</li> </ul>	linical event	<u> </u>
ABPs	150			Category			
ABPd				Clinical Events		- Find	-
ABPm NIBPs	100						
NIBPd	50			Clinical Event			
NIBPm				Transport within the H		ae 🐓 🐴	
R ardiac Rhythm BPs BPd BPm IIBPs IIBPd				Clinical event proposed Start time		▲ ▼ Initiated	
JIBPM							<u></u>
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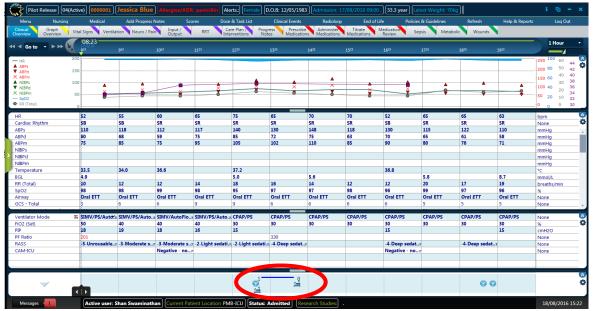


#### **Transport Guidelines Checklist**

This needs to be completed prior to transporting a patient out of ICU. It includes all the transport safety checks including checks for Neurological status, vital sign monitoring, airway safety, ventilation, circulation, monitoring, medications, etc.

Sam Burges - Transport Gu	uideline	s Checklist (Adult Paediatric)		×
21/06/2016 16:52	•	Sharon Shunker / *Critical Care	*	¥
Transport Destination				
Patient Transport Checklist				
Explaination and Consent		Review patient transport guideline     Explain procedure to patient and carer if appropriate     Gain consent if required		
GCS		- Neurological status is stable or acceptable		
Airway		- Airway is secure - Check pulmonary sounds - Respiratory status is stable or acceptable		
Ventilation		- Calibrate and check ventilator		
Ventilation		- ETCO2 monitoring		
Ventilation		- Ensure adequate oxygen supply (2 cylinders) - check cylinders are full		
Ventilation		- Test self-inflating resuscitation bag		
Ventilation		- Intubation equipment, portable suction, suction catheters and sterile gloves		
Circulation		- Cardiovascular status is stable or acceptable - Intravenous access patent, secured and simplified - Transport monitor/defibrillator - check battery is charged, recalibrate and set alarm limits		
Monitoring		- Obtain baseline observations before leaving the unit and continue observations as required		-
Medication		- Adequate supply of resuscitation, inotropes, analgesia, sedation and other patient specific medications	_	*

#### The transport will appear on the 'Clinical Overview' tab view under clinical events.

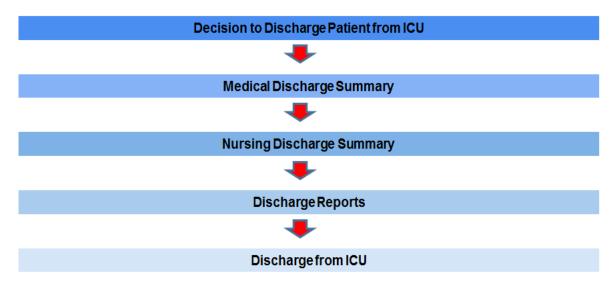


If transport is going to be prolonged (e.g. in Operating Theatre), the relevant and necessary forms should be printed, e.g. eNIMC, observation of vital signs. This can be done from the 'Transfer Print Bundles' located in **Menu**  $\rightarrow$  **Print**  $\rightarrow$  **Print Bundles**  $\rightarrow$  **Transfer**. In some areas the clinicians can login remotely to have read-only access.

Once a patient returns to ICU, reconnect all medical devices (refer to technical troubleshooting in Module 1 – Introduction). Enter any manual data that needs to be entered and mark the 'end time' to end the clinical event. Perform a head to toe assessment of the patient.



# **19. Discharge Procedure**



#### **Decision to Discharge/ Transfer Patient from ICU**

Note to discharge patient made in Medical Ward Round Note. 'Unit Discharge Decision Date / Time' is completed.

#### Medical Discharge Summary

Update patient information, Enter Unit Discharge Date/Time, Discharge information, Medical Management Plan, Medication Reconciliation, prepare eNIMC (do not print till discharge is imminent)

The decision to discharge a patient is documented in the Medical Ward Round Note (information from the last ward round note will automatically feed into the Medical Discharge Summary).

#### **Nursing Discharge Summary**

Check admission and patient details, NOK informed, clinical data updated prior to discharge, complete nursing discharge checklist

#### **Discharge Reports**

Generate and print discharge documents and reports – can be done using the 'Print' bundles, print eNIMC, eHOC, EOLC forms, Resus Plan. Additional forms such as IV Fluid orders, Insulin chart, may need to be completed

#### **Discharge from ICU**

- Check that the 'Unit Discharge Decision Date / Time' is completed (in the Patient Ready for Discharge Form and the Medical Discharge Summary)
- Go to the 'Patient File' window and change the status from 'Admitted' to 'Released'. Check that the discharge date and time is correct
- The receiving ward will admit the patient to the ward bed in PAS, which will result in the patient being transferred out of ICU in PAS
- If patient is being discharged to another hospital or home, then they need to be 'Released' in eRIC and discharged in PAS by the ICU Ward clerk or ICU Nurse.







#### **19.1 Decision to Discharge/ Transfer Patient**

The most common discharge / transfer scenarios include:

- ICU to ward within the same hospital
- ICU to different hospital/facility
- ICU to home
- Patient left against medical advice
- Patient died in the ICU

The decision to discharge a patient is documented in the Medical Ward Round Note. Information from the last ward round note will automatically feed into the medical discharge summary.

# **19.2 Medical Discharge Summary**

The Medical Discharge Summary is accessed from the Medical Menu.

Menu Nursing		Add Progress Notes	Scores	Dose & Task I	list Clinic
Clinical Graph Overview Overview V	/ital Signs Select :	a Patient	RRT	Care Plan / Interventions	Progress Notes
44 🖪 Go to 🔽 Þ ÞÞ 🖣		sion Summary es/ADR	800	900	1000
0 Actions awaiting	-terrestro.	and Isolation Requirements ss Notes	· · ·	Prescribe Fresh Blood and Albumin	
Medications	Proble	m List			274.12
Noradrenaline 4 mg,IV,Continuous,Infusion	Lines / PCA Or	Drains / Tubes der			
Noradrenaline 4 mg,IV, Continuous, Infusion	1111	sertion / Removal al Restraint(s) Order			
Pantoprazole 40 mg,IV,Night (20:00),Injection	Clinica	Procedure Safety Checklist			
Paracetamol 1 g,NG,6 hrly (00:00 06:00 12:0		Oxide Order and Observation Manager History	15		
Vancomycin 1 g,IV,BD (08:00 20:00),Infusion		Admission Management ch Studies			
	eNIMC				
PRN Medications	Medica	I Discharge Summary		_	

There are two tab views on this form that need to be reviewed:

- 1. Medical Discharge Summary
- 2. Interventions and Events / Plans

Sam burge	es - Medical Discharge Summary (Adult) :	New Session					
14/06	5/2016 16:03 🔺 🔻 🄄 Sharon S	hunker / *Critical Care			😢 Prev	ious Session	\$ ₹
Medical Discharge	Medical Discharge Summary						
Summary	✓ Hospital Admission Date/Time	€ 06/04/2016 18:00	•	Unit Admission Date/Time	10/05/2016 06:35	,	
nterventio ns and Events /	Unit Discharge Decision Date/Time	▶ 14/04/2016 09:46	•	Unit Discharge Date/Time		<b>A V</b>	
	Discharge Against Medical Advice			Unit LOS	35.39 day(s)		
	Attending Physician - Name			√Height	170 🔺 🔻 cm	I.	
				Weight (Latest)			
	Reason for Admission						
	√Reason for Admission						
	Mr Sam Burgess is 45 year old man wh who fell 3 metres from a scaffold. Injuries: He suffered a closed fracture t bruising and lacerations to left side of	o his left femur and a close	d fracture	to his left wrist, multiple contusions			
						ve and Close	





By clinicians

for clinicians

**1. Medical Discharge Summary –** Information about length of stay, who was the attending physician at discharge and overview of their past medical history and reason for stay.

The Unit Discharge Decision Date and Time *OR* 'Discharge Against Medical Advice' **must be entered.** This is important for tracking delays to discharge. It will feed from here into the Patient Ready for Discharge form OR vice-versa.

The 'Medical Discharge Summary' has data pulled into it to help auto complete the form. This data includes:

- Unit Admission Date/Time This will pull in the admission date of the patient
- Unit LOS This is a formula parameter and will automatically calculate the length of the patient's stay (based on their admission and discharge date)
- Reason for Admission This pulls from the Admission Summary Form (Completed by Medical Officer)
- Past Medical History This pulls from the Admission Summary Form (Completed by Medical Officer).

At the bottom of the medical discharge summary TAB there are three buttons:

 Print eNIMC – Opens the eNIMC launcher form. From this new form the medical officer can follow the instructions and then print the eNIMC. (this should only be printed when discharge is imminent.

#### **NOTE:** Print all pages of the eNIMC

- Admission Summary Opens the admission summary form for review
- Allergies Opens the patient Allergies information for review.
- 2. Interventions and Events / Plans Contains information about the patient's stay, if any significant events occurred during their stay and a medical plan for discharge. This tab contains two forms which allow for data to be pulled in from other sources in eRIC.
  - Significant Interventions and Events Located on the Medical Ward Round Note form
  - Medical Management Plan Located on the Medical Ward Round Note form. This
    makes the Medical Ward Round Note form a very important form to keep updated and
    accurate as this feeds vital information to the discharge summary.

Once all information has been completed, tick the check box at the bottom of the 'Interventions and Events' window that says 'Finalise Medical Discharge Summary'. The summary can be printed using the 'Print' button and then 'Save and Close' the window.

16/06	/2016 13:11 🔺 🔻 😘 Sharon Shunker / *Critical Care	\$	Ŧ
fedical scharge ummary			
erventio is and ents /	Medical Management Plan		
	/Medical Management Plan		
	He had surgery – ORIF to # L Femur and # L Wrist He is DAY 35 in ICU , was intubated and ventilated. Extubated on Day 10 and required reintubation for fluctuating GCS , poor cough and sputum retention. Was extubated again on 24/04/2016		
	He is due to be discharged to the orthopaedic ward today (14/06/2016).		
		_	
	Finalise Medical Discharge Summary		
	Phalise Medical Discharge Summary		
		_	





#### **Medication Reconciliation**

#### ICU to Ward Discharge & ICU to different Hospital/Facility

- Review patient's current medications in eRIC from the **Prescribe Medication** tab view.
- Cease / discontinue unrequired medications in eRIC
- Review outpatient medications and any other medications the patient may have been on prior to arrival in ICU
- Prescribe all (old, new, modified) medications that will be required on discharge from ICU into eRIC
- Review Administer Medication tab view to ensure all doses that are due have been administered and validated
- When discharge is imminent (and the discharge time has been confirmed) the eNIMC will need to be generated. Check medication on eNIMC and print ALL pages of eNIMC.

#### ICU to Home Discharge

- Follow same steps as above
- Instead of printing eNIMC, the patient will need a medication discharge prescription.

#### Patient left against medical advice or Patient died in the ICU

• Review and cease all medications in eRIC.

#### Allergies / ADRs and Alerts

- Review allergies and ADRs. Chart allergies status and ADRs in eMR
- The medical officer should check that allergies / ADRs are also accurately recorded on the eNIMC
- Document pregnancy status into eMR (if detected in ICU)
- Enter all Alerts into eMR.

#### 19.3 Nursing Discharge Summary

- For a patient discharge to be complete, the Nursing Discharge Summary needs to be completed
- The Nursing Discharge Summary is accessed from the Nursing Menu
- This form contains fields that are auto populated and cannot be edited. These fields are
  marked with a locked field symbol, and the data within the locked fields are populated
  from other forms completed during the patient's stay.

There are three tabs on this form that need to be reviewed:

1. Admission Details / Demographics: an overview of the patient; why they have been admitted and their previous medical history. Information on the patient's weight and dimensions and their current family contacts and status.

This tab contains areas on the Nursing Discharge Form that have locked fields. This is a list of the fields in this tab:

- Reason for Admission populates from the Admission Summary Form (Completed by Medical Officer)
- Past Medical History populates from the Admission Summary Form (Completed by Medical Officer)
- Weights and Dimensions This needs to be entered with the latest current weight
- BMI & BSA a formula parameter that is calculated based on the patient's height and weight
- Social includes information on Primary Contact, Social Work Review and last Family Conference
- Allergies review allergies and update status if necessary.





17/06		Sharon Shunker / *Critical Care	Servious Session	1
Admission Details /	✓Reason for Admission 👔			
Demogra	Mr Sam Burgess is 45 year o worker who fell 3 metres fro	ld man who was admitted to the ED on the 6/04/2016 at 18:00. His Patient ID m a scaffold	) is 041-63-50. He is a construction	
Clinical Data	Injuries: He suffered a closed	fracture to his left femur and a closed fracture to his left wrist, multiple cont	tusions and a mild concussion. He has	
	bruising and lacerations to h	eft side of head, swollen bruised L forearm and wrist and L leg.		
Checklist				
	🗸 Past Medical History 🔒			
	He has no significant medica	al history and takes no medications.		1
	Weights and Dimensions			
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- 2. Clinical Data: This tab view is updated with information on the patient's most recent vital sign observations and clinical information using a system-based approach. All of this data needs to be manually entered (using most recent data), each section has a comments box to enter additional information. Information includes:
  - Neurological GCS and Pain Scale
  - Respiratory Airway, O<sub>2</sub> administration, respiratory observations, Tracheostomy information.
  - Cardiovascular Cardiac rhythm, HR, Blood pressure
  - Metabolic Blood glucose level, temperature





By clinicians, for clinicians

- **Gastrointestinal** information on feeds, bowels last opened date, patient's diet information can be entered in the GI comments box.
- **Renal –** IDC details and urine output
- Integumentary Skin assessment, pressure area information and pressure area care management plan
- Lines /Drains / Tubes This section will show the status of any Lines / Drains / Tubes running during the previous and next 24hrs.
- **3.** Checklist: This tab is used to ensure all actions necessary for patient discharge are completed.
  - Discharge Information outcome i.e. survived ICU, transferred to another ICU/ HDU/Hospital, died in ICU. Information on discharge destination
  - Check that the medication chart (eNIMC), fluid orders chart and insulin chart are completed. Check that the patient has an ID Band, old notes, imaging and belongings with them. Check for any alerts
  - When the ICU nurse hands over the patient in the ward, they will need to log in to eRIC. After completing the handover of care, the names of both the ICU nurse handing over, as well as the receiving nurse taking over care of the patient, needs to be entered in the signature box on the checklist tab.

👤 Sam Burge	es - Nursing Discharge Summary (Adult) : New Session			×
17/06	/2016 11:19 🔺 🔻 😘 Sharon Shunker / *Critical Care		S Previous Session	\$ ₹
Admission Details /	Discharge Information			
Demogra	Unit Outcome	•		
Clinical Data	Unit Discharge Destination			
Checklist	Checklist			
	Ward Medication Chart Complete	Old Notes / Imaging with Patient	•	
	Ward Fluid Orders Chart Complete	√ Alerts	None	
	Insulin Sliding Scale Charted	Patient Belongings Updated	<b></b>	
	ID Band(s) Present Yes No	Patient Belongings		
	Signatures			
	Nurse Handing Over			
	Nurse Receiving Handover			
				•
				*
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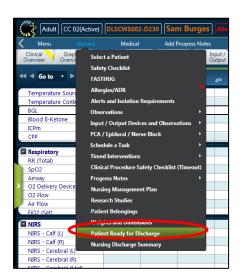






#### Patient Ready for Discharge Form

This is accessed from the Nursing Menu and can be used to check that all discharge documentation has been completed. The Unit Discharge Decision Date/Time **OR** 'Discharge Against Medical Advice' MUST be filled out (this is important for tracking Exit Block and delays to discharge).



Sam Burges - Patient Ready for Discharge : New Session
17/06/2016 11:57 🔺 🔻 🏠 Sharon Shunker / *Critical Care 😢 Previous Session 🔅 🟹
Patient is Now Medically Cleared for ICU/HDU Discharge
By completing the date and time field below, you are now clearing this patient for discharge from your department. Please ensure you complete all discharge documentation as soon as possible. - Medical Discharge Summary - Nursing Discharge Summary - ANZICS APD / ANZPICR review forms - Medication Reconciliation - NIMC
√Unit Discharge Decision Date/Time 14/04/2016 09:46 🔹 🔻
Discharge Against Medical Advice
Save Save and Close Cancel

The Unit Discharge Decision Date/Time can and should be updated based on clinical requirements, ie if a patient deteriorates and is not fit discharge until a later date – the revised decision date/time should be updated within eRIC.

- If the 'Unit Discharge Date and Time' changes due to any reason need to add a comment under 'Cell Properties' stating that the Unit Discharge Decision has been reversed. This will display on the 'Patient Ready for Discharge Form' with a comment indication.
- When the patient is due for discharge update the 'Unit Discharge Decision Date and Time' and add another comment.



#### Scheduled Tasks

Go to the Care Plan / Interventions Tab and select all scheduled tasks and discontinue them.

- To discontinue (stop) a task in the order profile view, uncheck the box next to the task or by clicking on menu arrow of that task and selecting discontinue.
- This uncheck action needs to be approved (validated, signed for) and therefore adds an action to a nurse's shopping cart.
- After clicking Sign Now, a similar signature window appears under the action column instead of **Create**, the action is **Discontinue**.

#### **Print Bundles**

All relevant discharge documents can be printed from the 'Print Bundles' accessed from the 'Menu'  $\rightarrow$  'Print'.

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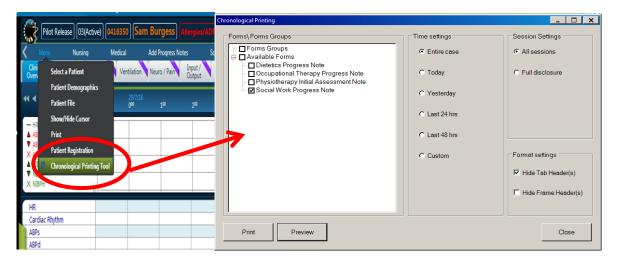
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#### **Chronological Printing Tool**

The Chronological Printing Tool can be used to print chronological reports for selected times and sessions.



**Chronological Printing Tool** - DOB and Phone number not being displayed and Patient's address are partially displayed in the header in CPT reports. Within Patient Demographics sessions, DOB and Address gets captured correctly and Home Contact 1 displayed as PAGER PERSONAL.

*The recommended solution:* Staff should be made aware to recognize this issue. This will need to be checked and manually entered or patient label attached.

**NOTE:** when printed, a barcode will appear on the bottom of the form that needs to be crossed out.

	UR#: 0416350	
	Adm Date: 28/07/2016	
	First name: Sam	
	Last Name: Burgess	
	DOB:	Affix patient label here
	Sex:	
	Address:	
	Department Name: PMB-ICU	Phone: XXX-XXXXXXX Fax: XXX-XXXXXYY
	Progress Notes Inpatient	
	28/07/16 15:14	Social Work Progress Note
	Saved by: Sharon Shunker At: 28/07/16	15:14 Signed by:
	Social Work Progress Note	
	Social Work Progress Note family meeting attended with wife	
-		
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	Fage: 1/1	Date printed: 29/07/16 09:23





#### **19.4 Discharge Reports**

The discharge reports that need to be completed include:

- Medical Discharge Summary (print from print bundles)
- Nursing Discharge Summary (print from print bundles)
- eNIMC print from tab at the bottom of the Medical Discharge Summary
- eHOC can be generated from the 'Medical Menu' → eHOC OR 'Nursing Menu' → eHOC. The eHOC will be generated on-screen into a PDF viewer. Within the PDF viewer the user may save or print the report. eHOC needs to be manually published to eMR.
- EOLC Forms:
  - Advanced Care Directive there may be a scanned document for the advanced care directive
  - Resuscitation Plan in eRIC in addition, the hospital/state-wide resuscitation plan document should be completed
  - Declaration of brain death form needs to be completed for organ donation brain dead patients
  - Donation after circulatory deaths form needs to be completed for organ donation patients who are for donation after circulatory death.

Additional paper ward-based forms that may need to be completed include:

- IV fluid order form
- Insulin chart
- PCA / Epidural Form
- Chemotherapy Chart

Additional paper ICU-based forms that may need to be completed include:

ANZICS APD/ ANZPICR review forms.

For patients who die in ICU:

- Death Certificate
- Coroners Referral and checklist

## **19.4.1** eNIMC (electronic National Inpatient Medication Chart)

This is an electronic version of the National Inpatient Medication Chart (NIMC)

- The design for eNIMC aims to replicate the format and content of the current NSW standard paper NIMC as far as possible into a format that is printable from eRIC
- Medications and other substances currently not appearing on the paper NIMC will not be printed on the eNIMC
- The eNIMC is intended to support the transition of patients from ICU to the ward
- It can also be printed to support medication management where the patient is temporarily absent from the ICU for a prolonged period. For example, while in the operating theatre or Cath lab, or attending a test or procedure out of the department.
- The eNIMC can be launched via:
  - The Medical Discharge Summary (at the bottom of the form)
  - Or by navigating to **Medical** menu  $\rightarrow$  **eNIMC**.





eRIC User Guide - Module 5: Discharge and Transfer

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Cheving Crack Vial Spr Select a Patient Administra Concernanty Administration Administration	Z1/06/2015 22:42 * V Sharon Shurker / "Critical Care	S Previous Session
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Clicking on the eNIMC button will open an *eNIMC pre-generation screen* which provides tips for the clinician prior to printing and after printing eNIMC. A warning message is displayed on screen if the eNIMC PDF has been generated previously.

Eric Master - eNIMC Launcher : New Session	×
11/01/2017 9503 A V S Power administrator Kevin Sam / *Adult	Previous Session
NEMC	۰. ۱
Before Printing:	After Printing:
1) The patient's discharge from your ward is IMMINENT.	1) REVIEW and CONFIRM the eNIMC content.
2) Medication Reconciliation has been performed by medical officer.	2) On Page 1, sign the TOP and the Allergies/ADR box
	3) Sign EACH Prescription
Warning Lost Generated By: Power administrator Martined Fok Lost Generated 11/01/2017 8:23:48 PM Plasse ansure the Medicetter Administration Record in aRIC is correct and up to date.	<ul> <li>4) Review the list of FREE TEXT MEDICATION and other medications on the last page of the eNIMC (these medications may require manual prescription on the relevant charts if clinically appropriate)</li> <li>5) If applicable, fill in the Maximum PRN dose / 24 hours</li> <li>6) <sup>a</sup> IF the patient is no longer being discharged: <ul> <li>Ensure printed eNIMC is clearly marked as CEASED</li> <li>RE-ENTER any new presciption(s) or dose(s) into eRIC</li> </ul> </li> </ul>
Comments	- File the Ceased p Generate eNIMC Button
	the eNIMC of "Free Text meancation — and our er meancations that require manual prescription for ongoing continuation of care.
	I understand the requirements of a printing the eNIMC  Enterties of ENC
	Save Style and Clese Cancel

A major benefit of the eNIMC is to reduce transcribing errors and improve legibility and patient safety.

#### **Before Printing**

- Ensure that the discharge is imminent approximately 30 minutes before actual predicted time to leave ICU to avoid the need of dealing with the printed eNIMC should the discharge decision be reversed
- Check that a medical reconciliation has been performed by the ICU Medical Officer.

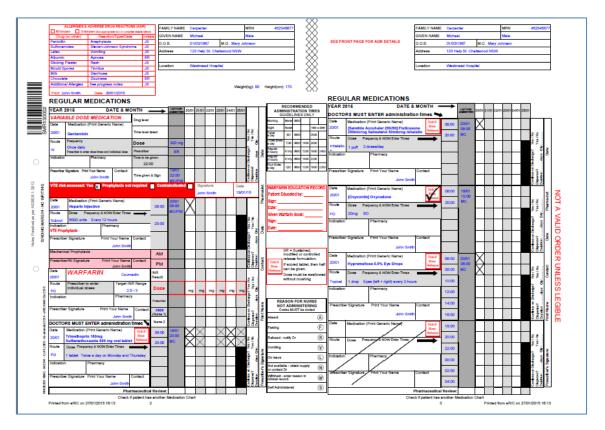
#### **After Printing**

- Review and confirm the eNIMC content (compare with Prescribe Medication and Administer Medication tab views)
- Fill in and sign the VTE Risk assessment details; if applicable, manually prescribe mechanical VTE





- Maximum PRN doses must be manually entered
- NOTE: Check all Free Text Medications on the last page of the eNIMC and manually enter all Free Text Medications
- Additional prescribing on a paper NIMC may be needed if the maximum number of charts has been printed (10 charts)
- NOTE: Verify and sign the Allergies/ADR details at the top of Page 1 and Page 2 on every chart printed. If there are more than nine Allergies/ADR, handwrite initials on the last row, next to 'Additional Allergies. See Progress Notes'. If PRN medication is prescribed, fill in the maximum 24 hour dose
- The eNIMC must be signed at the 'Top' of Page 1 on every chart
- Each medication order must be signed (Indication for the medication must be entered where clinically appropriate)
- In the rare case where the medication name does not appear in its entirety due to the size
  of the available space, the clinician may choose to handwrite the missing characters.
- Provided the clinician is authorised to generate the eNIMC PDF, and the acknowledgement checkbox is ticked, the PDF for eNIMC is displayed on screen for preview and verification by the clinician
- The clinician then has the option of printing the eNIMC or cancelling out of the preview without printing. In the latter case, eRIC continues to be used for prescribing and administering.
- If the patient is no longer being discharged:
  - Ensure eNIMC is clearly marked as ceased
  - Re-Enter any new/updated prescriptions and/or administration into eRIC
  - File the ceased paper eNIMC into the patient file.









eRIC User Guide - Module 5: Discharge and Transfer

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- Check if additonal charts are required. A separate paper-based order form may need to be completed for:
  - ✤ IV fluid order form
  - Insulin chart
  - → PCA / Epidural Form
  - Chemotherapy Chart

Once printed, the verified and signed eNIMC is the source of truth for medication and can be used for prescribing/administering additional medications as required. eRIC should **no longer** be used for prescribing/administering unless the discharge decision is reversed.

The eNIMC is affected, when at any stage during prescribing in eRIC, the user validates the dose and then later modifies the dose quantity in the Titrate Medication section. What will happen is that when the eNIMC is generated – for that medication - the last administered section for the dose quantity prints '0'(ZERO) . It will happen for the following types of medications (PRN, Variable dose, VTE, Warfarin).

*The recommended solution:* Medical staff need to be reminded that the previous documented administered doses in the generated eNIMC need to be checked that they are accurate AND not '0'.



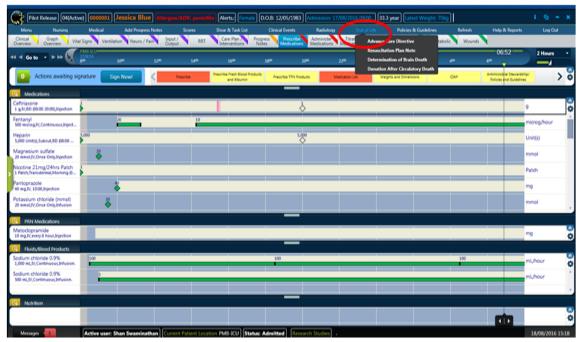




eRIC User Guide - Module 5: Discharge and Transfer

#### 19.4.2 EOLC Forms

End of Life Care forms can be accessed and printed from the 'End of Life' menu.



#### **Advanced Care Directive**

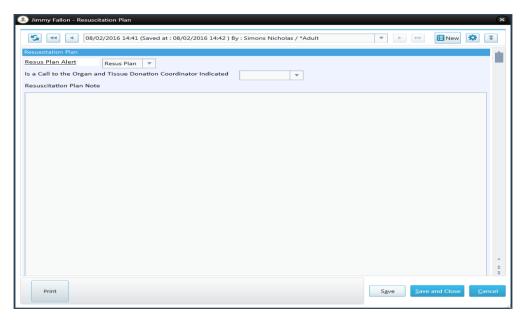
The advanced care directive window contains information on whether the patient has an existing advanced care directive which has been reviewed. A paper-based version of the advanced care directive should be completed and included in the discharge reports.

Jimmy Fallon - Advance Care Directive					×
S (Sav	ed at : 08/02/2	2016 14:40 ) By : Simons		w 🌣	¥
Advance Care Directive					
Advance Care Directive Exists	🗸 Yes	No	Policies and Guidelines		
Advance Care Directive Reviewed	Yes	No			
Scanned Documents					
4				Þ	
New Edit			Import list		
Comments					
					*
					÷
			S <u>a</u> ve Save and Clo	ose <u>C</u> ai	ncel



#### **Resuscitation Plan**

- This form allows clinicians to formulate a resuscitation plan for patients in ICU
- The form has a Resus (Resuscitation) Plan alert parameter on it that indicates if there is a Resus Plan in place
- If there is a plan, the form should be saved with 'Resus Plan' selected. This alert will
  change the Title bar for that patient to indicate that a Resus Plan has been put in place
- On discharge from ICU, the hospital/state-wide resuscitation plan document MUST be completed.



# Declaration of brain death (needs to be completed and printed for organ donation brain dead patients)

This is a copy of the current state form for determination of Brain Death in a patient. This form requires two doctors to complete it, for it to be a valid document.

- The first doctor completes the form → select Sign → Save and Sign → enter user name and password.
- NOTE: A second doctor must click on New Session → enter all assessment findings → select Sign → Save and Sign → Enter user name and password → select Save and Close to ensure entered data is saved for that session. If the second doctor verifying brain death only clicks on 'Sign' the data entered will not be saved.

Immy Fallon - Determination of Brain Death : New Session			×
08/02/2016 15:12 🔺 🔻 🚱 Simons Nicholas / *Adult		S Previous Session	<b>\$</b>
Known cause of irreversible loss of brain function         There is acute brain pathology consistent with the irreversible loss of brain function.         Dector A:       Specify condition         Dector B:       Specify condition         Period of continuous observation of apparent loss of neurological function.         For determination of brain death by clinical examination there has been at least a 4 hour period of observation of specific solution in the basent cough/tracheal reflex and no spon (Note: When the cause of brain injury is hypoxia-ischemia, clinical testing for brain death should be del rewarming to 35 °C when therapeutic hypothermia has been used.)         The 4 hour period of observation began at	ervation and mechanical ventilation		
Determination of brain death by clinical examination Preconditions 1. Hypothermia is not present - temperature is >35 *C (Specify temperature) 2. Blood pressure is adequate (e.g MAP>60 in an adult) 3. Sedative drug effects are excluded 4. There is no severe electrolyte, metabolic or endocrine disturbance	Doctor A           Q1.        *            Q2.         Yes         No           Q3.         Yes         No	Doctor B       A     V       Yes     No       Yes     No	
<ol> <li>There is to serve electropy metabolic of endocrine instabance</li> <li>Neuromuscular function is intact</li> <li>It is possible to examine the brain-stem reflexes (including at least one ear and one eye)</li> <li>It is possible to perform apnoea testing</li> <li>Clinical testing</li> </ol>	Q4.         Yes         No           Q5.         Yes         No           Q6.         Yes         No           Q7.         Yes         No	Yes     No       Yes     No       Yes     No       Yes     No	4 <del>1</del> 4
Print	Sign	Save Save and Close	<u>C</u> ancel





By clinicians

clinicians

**Donation after circulatory death** needs to be completed and printed for organ donation patients who are for donation after circulatory death.

This a copy of the current state form for documentation of Death in a patient following circulatory death. The attending Intensive Care Consultant or other designated doctor determines that there is irreversible cessation of circulation of blood in the patient's body and all the criteria for organ donation after circulatory death have been met.

08/02/2016 15	:14 🔺 🔻 拓	Simons Nicholas	s / *Adult			e	<b>3</b> Previous Session	**	Ŧ
onation After Circula	atory Death								
rgan Donation - D	ocumentation of De	ath Determined	by Absence	of Vital Signs F	ollowing Circul:	atory Death			
Under the law in I Human Tissue Act	NSW, a person has die t 1983).	ed when there is	irreversible c	essation of circu	ulation of blood	in the perso	n's body (s 33		
attending Intensiv	f organ donation afte vist or other designat e doctor must certify	ed doctor detern	nines that the	re is irreversible	cessation of cir	culation of b			
. Intensive therapies w	ere withdrawn at:		-		ndotracheal tube,	ventilatory su	pport, inotropic suppo	ort)	
Comment									
I have determined by	the absence of vital signs	that death has occ	urred.						
	the absence of vital signs	that death has occ	urred.	Yes	No				
	the absence of vital signs atures were present:	that death has occ	urred.	Yes	No				
			urred.	Yes	No No				
	atures were present:	lity Yes	No	Ves Yes	No				
	atures were present: Immobil	lity Yes		Yes	No				
All of the following fe	eatures were present: Immobil Apno Absent skin perfusio sility on the arterial line o	n Yes		U Yes	No				
All of the following fe Absence of pulsat	eatures were present: Immobil Apno Absent skin perfusio sility on the arterial line o	lity Yes	No No No	- Yes	No				
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## **19.4.3 electronic Handover of Care (eHOC)**

The eHOC Report provides a Clinical summary of the patient's ICU stay

- The eHOC is an electronic Hand Over of Care report that has been developed in extensive consultation with clinicians, from within and outside the ICU
- It is generated at the time of patient discharge from the ICU
- The eHOC Report can be used by all clinical staff and:
  - used for handover of care by ICU to clinical staff on the ward the patient has been transferred to
  - used for handover of care when the patient is discharged out of ICU to another hospital.

#### eHOC: Sections and Sub-sections

- Administrative Details
- Event (this ICU Admission)
  - Problems /Diagnosis
  - Medical History
  - Clinical Synopsis
  - Clinical Interventions Performed
- Nursing Discharge Summary
- Medications
  - Current medications at the time of discharge from ICU.
  - Medications withheld in ICU
  - Outpatient medications ceased within ICU
  - ➤ Anti-microbial medication administered in ICU
- Medical Plan
- Vital Signs (24 hours prior to transfer)
  - Pulse and Respiratory Rate

One solution

cross NSW

Blood Pressure







- ➤ Temperature
- ✤ Fluid Balance
- ➤ Weights and Heights (latest)
- Resuscitation Plan
- Referrals / Consultations

#### eHOC: How to Generate

- The eHOC can be generated from the 'Medical Menu' → eHOC OR 'Nursing Menu' → eHOC
- The eHOC will be generated 'on-screen' into a PDF viewer
- Within the PDF viewer, the user may save or print the report
- The eHOC can also be manually published to eMR

Menu Nursing	Medical dd Progress No	tes Scores	Dose & Task List	10 M M	Nursing Medical	Add Progress Notes	Scores	Dose & Task
Clinical Graph Overview Overview	/ital Si Select a Patient	RI	RT Care Plan Interventio	Clinical Overview Ove	acrect a Patient		Input / R Output R	RT Care
	Admission Summary				Safety Checklist			
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			DWW		Allergies/ADR			
	00 Alerts and Isolation Requir	ements		HR	Alerts and Isolation Requ	irements		
- 00.	80 Progress Notes	•		ABPs ABPd	Observations			
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	40 Lines / Drains / Tubes	•		▲ NIBPs ▼ NIBPd	Schedule a Task		-	4
NIBPs	00 E IABP Insertion / Removal			X NIBPm	Timed Interventions		8	
NIBPO				SpO2	Clinical Procedure Safety	(heads list (Timeseut)		Ť
	60 Physical Restraint(s) Order		\$	-O- RR (Total) 		Checkist (Timeout)		
- RR (Total)	40 Clinical Procedure Safety C	hecklist (Timeout)		-	Progress Notes			
- Temperature	20 Nitric Oxide Order and Ob	servations			Nursing Management Pla	•		
	0 Burns Admission Managen	nent D		HR Cardiac Rhythm	Research Studies		85	95
HR			95	ABPs	Patient Belongings		165	14
Cardiac Rhythm	nexcercit studies		95	ABPd	Weights and Dimensions		100	110
ABPs	16 eNIMC		145	ABPm	Patient Ready for Dischar	ge 📃	130	12
ABPd	11 Medical Discharge Summa	ny	110	NIBPS C	Same Same	arv	125	13
ABPm	eHOC		125	NIBPd NIBPm	eHOC		85 95	70
NIBPs	Choc III	123	130	Temperature	29.1	38.6	38.5	37

#### Publishing eHOC to eMR

The eHOC when generated can be published to eMR

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eHOC Report	
Publish Report	Last published details Creation Date/Time: 30/03/2017 10:40:37
	Document Status: Interim Transmission Status: Error

Click on the 'Publish' button

← → Ø http://virtric-mdbs	108. nswhealth.net:83/Default.aspx? 🎗 - 😋 🎑 eHOC Rep	rt Viewer ×	(mark)(interaction)	Street, Street, St.	(liter)	<u>- □ ×</u> ↑★☆
eHOC Report						
Publish Report Publishing a report queues	this eHOC report for sending to EMR. Do you wish	proceed?			Last published detail Creation Date/Time: Document Status: Transmission Status:	s 30/03/2017 10:40:37 Interim Error
Confirm	Cancel					

Click on Confirm if you want to proceed with sending the eHOC report to eMR



eRIC User Guide – Module 5: Discharge and Transfer

← → @ http://virtric-mdb908.nswhealth.net/83/Default.aspx? タ・ c @ eHOC Report Viewer ×	
eHOC Report	
This document has succesfully been submitted to the eMR.	Last published details Creation Date/Time: 31/03/2017 16:40:51 Document Status: Interim Transmission Status: Sending in progress

• A message is displayed confirming that the document has been successfully submitted to eMR.

#### Location of eHOC in eMR

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ic , David John	Age:61 years	SecHale	Loc:ICU SGH; -; 09	** Allergies Not Recorded **	
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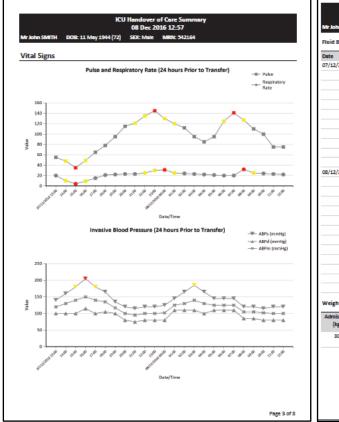




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# Example of an eHOC

Mr John SMITH DOB: 11 May		
	START OF DOCUMENT	
Administrative Details		
Port Macquarie Base Hospital	- Port Macquarie Base Hospital Intensive Care	
Discharged From ICU	Yes	
Unit Admission Date	07/12/2016 12:00	
Unit Discharge Decision Date	08/12/2016 11:30	
Unit Discharge Date	08/12/2016 12:00	
Patient Address	55 George St Chatswood	
	NSW 2067	
	Australia	
Author	James Corder (Medical (prescribing))	
Document Status	Final	
Event		
Septic shock		
Septic shock Problems (Acute-Active) Hypoxic respiratory failure Acute renal failure		
Septic shock Problems (Acute-Active) Hypoxic respiratory failure Acute renal failure Hypotension		
Septic shock Problems (Acute-Active) Hypoxic respiratory failure Acute renal failure Hypotension Problems (Acute-Resolved)	ion)	
Septic shock Problems (Acute-Active) Hypoxic respiratory failure Acute renal failure Hypotension Problems (Acute-Resolved) Upper airway bleed (post intubat	ion)	
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ate	Time	Total Fluid Input (mL)	Total Fluid Output (mL)	Fluid Balance (mL)
7/12/2016	13:00	310	60	250
	14:00	450	480	-30
	15:00	500	600	-100
	16:00	520	480	40
	17:00	520	530	-10
	18:00	400	120	280
	19:00	230	315.5	-85.5
	20:00	300	310	-10
	21:00	250	100	150
	22:00	400	50	350
	23:00	460	500	-40
8/12/2016	00:00	60	0	60
	01:00	20	0	20
	02:00	20	0	20
	03:00	20	0	20
	04:00	20	20	0
	05:00	20	50	-30
	06:00	125	100	25
	07:00	250	300	-50
	00:00	300	300	0
	09:00	120	125	-
	10:00	20	0	20
	11:00	100	20	50
eights and F	leights (Latest)	100	20	60
Admission (kg)	Latest (kg)	Ideal (kg) Adjusted Body (kg)	Drug Calculation Dry (k (kg)	g) Wet(kg) Height (cm)
80	75 (08/12/2016 12:55)	70.7 72.4	80 75	85 175





Page 5 of 8

#### 19.5 Discharge from ICU

The discharge process is completed once the patient is ready to be sent out of ICU and received into the area to which they are being discharged.

#### For patients being transferred to another ward in the same hospital:

- The patient's status needs to be changed to 'Released' in the 'Patient File Window'. This
  is done by the ICU nurse or the ICU ward clerk
- The receiving ward will admit the patient to the ward bed in PAS
- In all cases, once the patient's status is 'Released' in eRIC, this will stop data from any device updating the patient's record and remove the patient's association to the ICU bed in eRIC; but medications will continue and hence a medication reconciliation needs to be done.

Patient Identifier: Visit ID: First Name:	400323 Eric Cache1	•	Comments	Î		<ul> <li>On the <b>Patient File</b> form- check that the Status has changed to Released.</li> </ul>
Last Name: Status: Status Date Time:	TEST Released	•	]	$\left\{ \right\}$	ſ	<ul> <li>On the Work List check that the patient is no longer</li> </ul>
Bed:	27/06/2016 16:54	•		Ŧ		in an ACTIVE bed
	27/06/2016 1654		Do not transfer to archive database Apply OK	Qose		

# For patients being discharged home, those who leave against medical advice and those who die in ICU:

- Ensure that the medical and nursing progress notes are updated and details about the patient's discharge or details about the patient's death are documented
- The ICU Ward Administrative Officer or ICU Nurse needs to go to 'Patient File Window' and manually change the patient status to 'Released' in eRIC. They also need to discharge the patient from ICU in PAS
- While the patient is in 'Released' status data can still be entered in eRIC
- Once the patient status is 'Closed' no data can be entered in eRIC. The file can only be viewed
- For CIS Manager: Do not change record status to 'Closed' until all documentation is complete
- For Brain Death patients, enter 'Brain Death' time as date and time of death (the patient is only 'Released' from eRIC and discharged from PAS after the retrieval surgery or transfer out of ICU is completed)

#### Change in patient status

- 'Admitted' to 'Released' This is updated in the 'Patient File' window by the ICU nurse or ICU ward administrative officer, when the patient is discharged out of ICU
- Released Status Closed Status This should be a manual process, performed by the CIS manager, and done on a case by case basis, when deemed clinically appropriate, and once the medical record is completed





 Closed Status – Archive Database - This is an automatic process which will occur after the patient has been in a closed status for 48 hours. This allows the production database to remain relatively small, and therefore keeps performance of the production database fast.

#### NOTE:

 Medications, Infusions that were running and Lines, Drains & Tubes that were insitu at the time of discharge will be stopped by the CIS manager when the status is 'Closed'

#### **Searching for Released Patients**

The 'Patient Search' on the Work List drop down menu can be used to search for the 'Released Patient List'.

- This opens up a Patient Search Window
- If you know the Patient First Name, Last Name and or MRN you can perform a Basic Search
- If not click 'Advanced Search', this opens the 'Advanced Search' box (for example for 'Released' patient search choose Field = Patient Status, Field Operator = Is, Value = Released). After entering details for searching Click 'Run' to start the search.

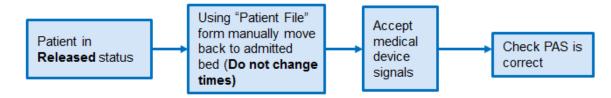
#### Cancelling a Discharge /Transfer

• The discharge may need to be cancelled.

OR

• The wrong patient may have been incorrectly discharged.

#### Actions to be followed if either of the above occurs:



# 20 Discharge and Transfer Module Specialised Workflow Processes

- The need to print paper forms as required, when the patient is being transported from ICU to other areas /departments within the hospital that do not use eRIC. e.g. OT, Radiology. These departments will have view-only access
- The Nursing Handover Checklist requires the signature of the handing over ICU nurse AND the receiving ward nurse. The ICU nurse will need to log-in to eRIC on the ward and enter the name of the ward nurse receiving handover on the ward.





