Full Name (PRINT): _____ DATE: _____
RN or Psych Tech: _____
Your Unit#: T____ DH_____ MH_____ SPPO_____ Other_____

Inpatient RN Competency Checklist

Objective:

By the end of training class, the end user will understand the following Epic training topics that affect inpatient nursing.

Checklist:

Your Initials if you understood the training	Epic Topics	Type of Training: **TS** = Tip sheet **ACE** = Training environment hands on training **Other**	Why it's important:
Training Topics			
	Finding where the Epic Tip Sheets are located	Intranet or ucepic.org	Tip sheets created for reference and most are step by step instructions. Many of the most common Epic questions nurses have may already be in a tip sheet.
	Downtime Procedures	Ucepic.org	Understand where to go to find the downtime procedures policies. Found in Tip Sheets in ucepic.org
	Patient List {My List/Available (System) Lists}	ACE	The Available list (system list) is premade by the analysts. Use the Units folder to find other patients in different units.
	BRAIN (New from Epic 2018 upgrade)	ACE	The BRAIN is a new home activity where nurses can see all their tasks to complete for the shift. Nurses should use the BRAIN to make sure all their tasks are completed by the end of their shift.
	MAR – Scanning the patient	ACE	Understand how to properly scan the patient's armband and knowing which barcode to use on the armband when giving medications.
	MAR – Single Scan / Multi scan (stacking)	ACE	Users can scan multiple medications if they are being given at the same time.
	MAR – IV Fluid and IVPB / IV Lines	ACE	Understand how scan / document IV Fluids and IVPB / new bag / restarted / completion of IV Fluid bag UC Irvine Inpatient (with the exception of L&D/Post-Partum/NICU) Does NOT link Lines. Always skip when you get a link line window.
	MAR – med refusal	ACE	Understand how to document med refusal and if patient wants it later.
	MAR – Med reschedule (single vs. all future times)	ACE	Nurses have the ability to reschedule medications (one time or all future times). Understand when it is appropriate and NOT appropriate to use.
	MAR – linked meds	ACE	Understand that same medications may be linked automatically

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	MAR – Insulin SQ	ACE	When giving insulin SQ, the administrating nurse simply makes a comment of "Dose Verified by Nurse (name)" We do not require a co-signer by the second nurse in Epic system. Just write their name down in the comments box of administration window stating it was dose verified by the nurse (name)
	MAR – Override pulls	ACE	Override pulls must be linked to the order so it shows nurse just didn't pull a medication without a doctor's order. Also so we can properly charge the patient's insurance. See tip sheet.
	MAR – Drip Titration (Example: Vasoactive Drips)	ACE	Understand how use Epic functionality on drip titration. Can titrate through flowsheets.
	MAR – Drip Titration (High Risk – Insulin Drip and Heparin Drip)	ACE	High Risk drips such as Insulin Drip and Heparin Drip when being titrated should always be done in the MAR and when titrated should choose the action of RATE CHANGE DUAL SIGN.
	MAR - PCA	ACE	Understand how to document PCA. PCA has its own flowsheets. See tip sheet.
	MAR – send a message to pharmacy	ACE	You can use the messaging system in Epic instead of calling pharmacy.
	MAR Hold	Other	Means the order needs to be released first if you want to administer the medication. Or patient currently at a phase of care (example OR) where the primary nurse is not allowed to administer medications at this time.
	Flowsheets – Add vs. Insert Column	ACE	Add Column = current time; Insert Column = create a time column of your own.
	Flowsheets – Vitals / Device Integration	ACE	Understand how to validate/save device integrated data0
	Flowsheets – Assessment / how to document quickly	ACE	UC Irvine documents by exception. Fastest way to document in the flowsheet "Keep the mouse in the house".
	Flowsheets – mark a value as significant	ACE	Highlights the cell in yellow. Make sure to document your intervention when you mark a value as significant.
	Flowsheets – LDA Avatar / Add LDA	ACE	How to add and remove LDAs (lines, drains, airways, wound, and tubes); How to complete/reinstate LDAs.
	Documenting Care Plans	ACE	Understand how to properly create care plans here at UC Irvine. We use SOCs (Standards of Care) and then individualize our care plans. We do NOT use nursing diagnosis. Required once per shift.
	Documenting Education	ACE	Understand how to document Education. Required once per shift.
	Navigators - Transfer	ACE	Complete this when you send or receive a transfer from another unit.
	Shift Assessment navigator	ACE	Use/Complete this navigator when you are just continuing care
	Orders - acknowledging	ACE	The primary nurse acknowledges all orders on their patient during their shift. This just means they are aware of the order. It does not mean they have to carry out every single order. (Example: acknowledging a PT/OT/Speech or Radiology order).

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	Orders - Releasing	ACE/Other	If nurses do not release an order, it will not be active and cannot be carried out. There are certain orders the primary nurse should not be releasing, that are not meant for them to release (Example: PACU orders only, Peri Op/Dialysis Orders). Usually the primary nurse should be releasing the Admission/Post Op orders.
	Orders – Entering Orders and the Order Modes to use	TS/ACE	Understand how to enter orders and which appropriate order modes to use. These order modes are also used by UCSD and UCI does not use all of them. Know which ones we can and cannot use.
	Orders – Nursing and Ancillary Orders	ACE	Understand which type of orders nurses can order on their own without the need for physician approval
	Orders – Mytonomy Educational videos	ACE	Nurses have the ability to enter education video orders (Mytonomy) on their own. Nurses can show these videos during patient stay and patients can also view these videos up to 14 days after discharge.
	Orders – Blood Order set	ACE	Understand how to order blood on behalf of a physician if needed.
	BPAM (Blood Product Administration Module) -Perfect Scenario -Transfer During Transfusion -Transfusion Reaction -Massive Transfusion -Warning Messages in BPAM	ACE	-New for Epic 2018. Will start scanning blood products as of December 8th, 2018. Changes the workflow of nursing documentation for blood. Get hands on training and understand the new workflow in Epic. See tip sheets if needed as a resource. -Document in the Suspected Transfusion Reaction flowsheets first before you collect lab specimen.
	Unit Manager – Patient Movement/Requesting Equipment or Translator	ACE	Unit Manager controls how patients are moved in Epic such as what unit / room they are in or where they will be going to. Nurses can also use Unit Manager to request from the Equipment Pool or request a Translator (Spanish/Vietnamese). Use blue phone for other languages.
	Unit Manager – Discharging the patient from Unit Manager	TS	Understand how to discharge/remove the patient from Unit Manager when the patient has physically been discharged from the unit.
	Discharge Navigator	ACE	Understand the Discharge Navigator when nurses get a discharge order.
	Discharge – Edit Med Details	TS/ACE	Nurses must edit the discharge meds for last dose taken and when to take the next dose. It is for patient safety.
	Discharge – Interfacility Discharge	ACE	Complete the discharge navigator first in order to print the AVS. Then follow the instructions for Interfacility Discharge found in the Index report under Things to Print.
	Patient Chart – Activities and Navigators	ACE	Activity - The main place where users enter and view data in Hyperspace. Navigator - A series of sections meant to follow a particular workflow, such as an Admission, Transfer, or Discharge. Certain sections in a navigator may link you out into an activity.

Full Name (PRINT): _____ DATE: _____
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	Results Review	ACE	Where your lab results are found; Time Mark to show you are aware of the results; Change from earliest to latest results.
	Notes Activity A. Physician/Nursing/Ancillary notes B. How to create a smartphrase	ACE	Where all physician and ancillary notes live. Some nursing notes also (Plan of Care/Nursing Shift Summary).
	Patient List Reports	ACE	This is how a nurse can quickly get information on the patient without opening the patient's chart. Know which reports are important: Such as Treatment Team; Required Documentation; MAR Hx; IPASS (ED to IP handoff).
	IPASS demo	Patient List	Created by Nursing Education for all inpatient RN staff. This is about a new nursing handoff that is being created for inpatient nurses to use starting early 2019.
	Patient List Columns	ACE	Customize columns to get quick information (New Rslt Flag, New Notes).
	MRI Checklist	ACE	MRI Screening Questionnaire found under Procedure Pass
	Epic Secure Chat	ACE	Secure chat is currently used for NON-urgent communication. If urgent or emergency such as critical labs, etc – page the provider/MD.

UC ePIC
Transforming Healthcare Together

Epic TIP SHEET

Epic Inpatient RN Tips

The information below is intended for basic information.

- **Know where the Epic RN Tip sheets are located:**
  Using the hospital computers or from home, go to http://ucepic.org/
- If page asks for your username and password, enter your username@hs.uci.edu, enter your password. (From home it will make you use DUO to authenticate)
- ➔ Tip Sheet button ➔ Training Material folder➔ ClinDoc (Inpatient RN and Ancillary staff folder) ➔ Nursing Tip Sheets folder

- **Maintaining Patient Lists with Treatment Team**
  - **Sign In** (button) – at the beginning of your shift. Enter your start/end shift time, work cell phone number.
    - This will place your name and info in the Treatment Team report. Patient shows in Treatment Team list.
  - **Assign Me** (right click) – during your shift when you get a new patient. Using Assign Me copies your information when you used Sign-In to your new patients. This will also place your name in the Treatment Team report.
  - **End my Assignment** (right click) – use when patient is permanently no longer in your care. This removes your name from the Treatment Team report.
  - Sign Out (button) – Used at End of your shift (or it will automatically sign you out 2 hours after your Sign-Out time). This removes all your patients from your Treatment Team list and the Treatment Team report. – best not to use this since it will automatically sign you out end of your shift.
  - Use the Patient List reports (Examples: Required Documentation, Treatment Team, [IPASS - ED to Inpatient Handoff], etc.

- **Getting Report**
  - Use Patient List Reports as described above (Treatment Team, Required Documentation, IPASS, etc) to get quick info on your patient; Look at the **BRAIN** to see all nursing tasks.
  - Use the **Summary** activity (where detailed reports are: Index report, Shift report, etc)
  - Index report – where you can acknowledge ALL orders; where you release and complete Blood Transfusion; where you can collect specimen, where you can complete tasks.
  - Shift report – one of the reports to view when receiving or giving report; where you can also collect specimen

- **Reviewing the Chart**
  Chart Review activity
  - Media tab– where you can find the hyperlink to wound images
  - Cardiology tab – where you can find the 12 lead EKGs
  - Imaging tab – link to PACS (radiology images)

- **Results Review**
  - Lab Results / Imaging results (written result)
  - Click the **TIME MARK** button to show you have seen the result and clear your New Results Flag column.
  - If a critical result is received, document in the **Flowsheets** or **Provider Notification** navigator.

- **Documenting in Flowsheets**
  - Add Col button – add time column now
  - Insert Col button – Add time column in the past
  - See **Device Integration Tip sheet for Vitals device integration**, etc.
  - Last Filed button – what was last documented on each row (not the last filed column)

- **Documenting an Assessment**
  - Use the Assessment navigator
  - Head to Toe Assessment
  - Some Flowsheets are hidden and must use the search engine to find them (example: Restraints)

- **LDAs (Lines, Drains, Airways, Wounds, Tubes)**
  - Use LDA Avatar button – See tip sheet
  - If patient is going home with a long term LDA (ex: PICC line), do NOT complete the LDA at discharge.

- **Arriving/Transfer the Patient with Unit Manager**
  - Check Unit Manager to make sure patient is in correct bed. If not in correct bed, device integration will not work properly and data will not pull into the flowsheets.
  - Receiving Admit / Transfers – (Usually done by Charge Nurse or HUSC) – Right click and Assign Bed in Unit Manager. When patient physically arrives in unit, then drag and drop the patient in the correct bed.
  - Use **Patient Transport** button for Equipment Pool or Translator for specific patients (Spanish or Vietnamese). Use phone if need translation in another language.

- **Admitting a Patient** (From ED or Direct Admit)
  - Use and complete the **Admission** navigator always
  - If OPA (our practice advisory) orders are triggered via the Admission navigator, make sure to **Sign** the orders. Use **Within Scope of Practice** order mode for admission triggered orders. You can select the attending MD as when using order mode Within Scope of Practice as will not make them co-sign the orders.

- **Receiving a transfer** (from within inpatient)
  - Complete the **Transfer** navigator
  - Make sure to **check/change the Blood Collection** status. ICU = always keep at **Nurse collect**. MS/Tele/Stepdown/Med Psych = keep at **Lab collect**. Always check this on all your patients.
  - Complete the **Shift Assessment** navigator.

- **Documenting Care Plans & Shift Summary**
  - See Tip Sheet for details step by step

Care Plan started at beginning of shift. It is completed near the end of the shift or if the patient is permanently leaving your care. The Care Plan is completed together along with Nursing Shift Summary Note.

1. Go to the Care Plan Activity
2. Click the **Manage Plan and Document Progress tab**.
3. RN since there isn't a care plan template yet] Select your care plan template on the left side (**Promotion of Health Safety** or Comfort Care/End of Life/Inpatient Hospice Care). If you are the first nurse (admitting nurse usually) to start the care plan, the click Apply Template and search for "UCI" and select Adult/Peds Plan of Care (or Comfort Care/End of Life/Inpatient Hospice Care for those types of patients).
4. Make sure you select **Document Progress** button. The Care Plan template will appear on the left, select it. Click somewhere in the middle to uncollapse it on the right side.
5. Check off your Standards of Care.
6. Select whether patient is Progress, Not Progressing, Resolved or Discharged.
7. Enter/Free Text your interventions. The **first four intervention** (boxes) are required.
8. Enter/Free Text patient/family stated goal (if its not there already there to check off).
9. Click NEXT on the bottom right. This will temporarily save your work.
10. Go on with your shift until it is time to complete the Care Plan along with your nursing shift summary
11. Go back to into the Care Plan activity, go to **Summary and Note tab**. Your care plan that you temporarily saved earlier should be there waiting for you to complete it.
12. Click the **ADD** button on the top right side in the middle of the page, this will add your Care Plan in the bib text box.

13. Once the care plan is added, go to the bottom of it and click Enter 2-3 times to make space.
14. Then click **Insert SmarText** box on the top of the big text box. Enter "Shift" then select the **UCI IP NURSING SHIFT SUMMARY** and click Accept.
15. This will pull in the last 12 hours of documentation from these 3 flowsheets:
    a. Provider Notification
    b. Critical Results Notification
    c. Nursing Shift Summary Note
16. Once you have pulled in your nursing shift summary note at the bottom of your Care Plan, click **SIGN** to complete the note.

- **Documenting Education**
  - See Education Tip sheet
  - Go to Education activity
    - If brand new patient, document assessment first (one time only)
    - Document education points

- **Collecting Labs – Collect your labs in Epic. Review the separate training video for collecting labs.**

- **MAR / IV Medications**
  - Scan the 2D barcode (square) on patients armband for medications
  - Use linear barcode for glucometer
  - Always link your LDAs
  - Make sure to link your Override Pulls (if any) to the order (need to get the order)
  - Insulin Drip and Heparin Drip always require Dual Sign (use Change Rate Dual Sign)
  - Insulin Drip Calculator (see tip sheet)
  - Insulin SQ - free text **Dose Verified by Nurse** (name) check in the comment box (the other nurse's name)
  - If you ever see mandatory POSS documentation in the MAR, always select the option of **UCI – Refer to RASS**. **UCI only documents RASS**.
  - POSS is for UCSD only.

- **Titration**
  - UCI Health Orange Medical Center has pump integration (we use Baxter pumps) See Baxter Pump Integration Training videos at ucepic.org website ➔ **Training Videos** ➔ Baxter Pump Integration
  - If unable to integrate pump with Epic, then do manual documentation below with titratable drugs.
  - Titratable drugs (ex: dopamine drip) – initial administration (new bag) should always documented in the MAR
    - Can then titrate through the flowsheets in the DRIP Flowsheet
  - **High Risk Titratable drugs (ex: Insulin Drip and Heparin Drip)** – initial administration (new bag) documented in the MAR, in titration/change of rate requires an action of **Rate Chang Dual Sign** which is also done through the MAR.

- **Intake and Output Calculation**
  - For simplicity sake and to avoid any miscalculation on your intake and output , the SAFEST way to do intake and output is to just:
  - If you able to pump integrate, then use the Infusion Verify button to pull and document your Intake.
  - In unable to pump integrate then you must manually enter your intake/out:
    1. **Create your time columns manually (every hour if need be for ICU patients) for each patient.**
    2. **Manually enter your intake and output each time for each patient.**

       This will avoid any confusion or miscalculation. **Do NOT use the calculator button** in the flowsheet row as it may miscalculate your intake and output depending on the situation.

- **Managing Orders (Ordering)**
  - Nurses can only use certain order modes at UCI:
    - Telephone/Verbal – to be used on emergent situations
      - Doctors are responsible for entering their own orders most of the time.
    - Within Scope of Practice
      - Use when you trigger orders in the Admission Navigator
    - SNP (Standard Nursing Protocol)
    - Maintenance – To clean up duplicate NURSING orders only. If possible duplicate medication / lab / or procedure, have provider review the orders and let them discontinue it.
  - There is a difference between acknowledging orders and releasing orders
    - **Acknowledging** orders means you are aware of the order, but the order may not necessarily be for the primary nurse to carry out or complete.
      - You can acknowledge ALL orders in the **Index** report
      - Or you can acknowledge each order individually in the **Manager Orders** activity
    - **Releasing** an order means that the order was originally on hold. Releasing an order means the order will be active. If an order is not released, the order is still on hold meaning no one can carry it out. For example if there is a hold order on an X-ray, Radiology will not see the order until the order is released. When you release an order, it will also show up to be acknowledged.
      - You can release orders in the Manager Orders activity
      - Or you can release orders in the Admit/Transfer navigator
    - When a patient is transferred to different level of care (example: from OR to Med/Surg floor) – all the orders will be placed on a hold after the doctor reconciles them. The receiving nurse will need to release

the orders once the patient arrives on their floor.

- **Ordering & Documenting Blood Products**
  See BPAM (Blood Product Administration Tip Sheets for full details on documentation of blood. MD will usually enter the blood order.
  1. Once you know the blood product is ready for pick up, enter a nursing order called **Request for Blood Product.** The order mode to use is **Within Scope of Practice.** You can use the attending doctor's name as the ordering Physician. It will NOT go to the MD for co-signature. This is just a nursing order to have the blood product tubed up to you.
  2. Once you physically have the blood in your hands, go to the BLOOD flowsheet inside the patient's chart.
  3. There is button on the left of the blood flowsheet called **Transfuse Release Report**, click on it.
  4. From the report you can see how many need to be released and transfused. **Only click Release every time you have a blood product in your hand**. Do NOT release all at once if you only have one unit physically on hand.
  5. Releasing a blood product just releases new flowsheet rows for you to document on.
  6. Once you click Release, scroll down in your blood flowsheet and find your flowsheet rows to document on.
  7. Create your time column to do the double check with the 2nd nurse. (Don't forget to enter your pre-transfusion vitals)
  8. From your time column when you did the double check with the 2nd RN, click on your Action row, then click on the Syringe icon.
  9. A window will appear and ask if you want to link the lines, make sure to link your line**.**
  10. Another window will appear asking you to scan the patient's wristband, scan the patient's square barcode on the patient's wristband.
  11. It will now ask you to scan all the blood products barcode. Scan the barcodes on the blood product, it will automatically know where to place it.
  12. Once everything matches, enter your starting rate and answer anything it requires. It will take you back to the blood flowsheet after you click Accept.
  13. (15 minutes later) enter your vitals and then go straight to your rate row and enter a new rate if you increased it.
  14. If everything is fine and the unit completed transfusion, create a new time column on when it completed, click on the Action row and select **STOPPED** action to complete the task.
  15. Again it will ask you to link the line, click **SKIP**. Answer anything the window is requiring you to answer. Then click Accept.
  16. It will take you back to the flowsheet. On the same time column you documented STOPPED, click on your VOLUME row and then click on the calculator. A window will appear that will give you a suggested volume. You can change the volume manually if you do not agree with it.
  17. Click on the **ACCEPT AND COMPLETE** button from that window to complete your task. The flowsheet rows will automatically disappear/hide itself.
  18. When you are ready for your next unit , follow the steps again starting with the nursing order of Request for Blood Product.

- **Restraints**
  - **UC Irvine uses Restraints SOC (Standards of Care) – Read it.** Found on Sidebar > Summary tab > click the chevron (>>) button to see list > Select UCI Standard of Care Links > Adult/Peds SOC > Restraints & Seclusion
    For Medical Restraints:
    - Nurse documents initial administration of restraint in **Restraints** flowsheet (use search engine to find it)
    - Nurse documents by exception if there were any changes.
    - Nurse does not need to document every 2 hours if there are no changes.
    - Nurse should still check on patient every 2 hours.
    - Nurse will see in the restraint flowsheets (for medical) saying "Q2H monitoring" – this is for UCSD where they document every 2 hours.
  - Restraint orders need to renewed every day.
  - **For Behavior Restraints documentation – Psych nurses check their unit about restraint documentation policy**.

- **Documenting End of Shift**
    - Care Plan and Nursing Shift Summary done together - Done at End of Shift or when your patient leaves your care permanently (example: patient transferred to different unit.
    - Make sure your Intake and Output are documented.
    - Check your **Required Documentation** report to make sure all documentation was completed for your shift
    - Check any orders to acknowledge or tasks to complete in the Index report
    - Check your **BRAIN tab** to make sure all tasks are completed for your shift.

- **Discharging the Patient**
    - Use and complete **Discharge** Navigator
    - See Discharge Tip Sheet
    - **Patient cannot be (released) discharged unless banner warning from pharmacy goes away**. If banner is showing in the discharge navigator, it means Pharmacy has to review the discharge meds first.
    - **Make sure the Discharge Meds is edited with the last dose given and when to take the next dose.**
    - The discharge instructions is called AVS (After Visit Summary). This cannot be printed without a discharge order (meaning you can't click on the print button).
    - Sending patient to our UCI Psych Units or Acute Rehab Unit (ARU) - patient must be discharged first. This is NOT a transfer. The admitting doctor must accept them first also. The receiving nurse (Psych or ARU) must do the complete admit process (going through the admission navigator and completing it when the receive the patient).
    - If patient expires, document in the **Patient Expiration** flowsheet (use search engine in Flowsheet)
    - Patient must be discharged in Unit Manager in order to get rid of the name in the system. This requires a discharge order.

Activity – usually all about the same type (such as Flowsheets activity is all about flowsheets)
Navigator – usually a number of activities put together to make documentation easier. May navigate you to other activities to do documentation.

Summary activity – All about reports. Use **Index** report to acknowledge orders; **Collect Lab Specimen**; Where you can release Blood Transfusion units;

Chart Review activity - SnapShot tab– where you can find the hyperlink to wound images Cardiology tab – where you can find the 12 lead EKGs, ECHOs, etc; Imaging tab – link to PACS (radiology images)
Synopsis – UC Irvine RNs **DO NOT USE** THIS.
Results Review activity- Lab Results / Imaging results (written result)
Click the **TIME MARK** button to show you have seen the result and clear your New Results Flag column. If a critical result is received, document in the flowsheets or provider notification navigator.

Legacy Chart activity – Old charting system (QUEST/Allscripts) documentation before Epic Go-live (Before November 4th, 2017)

Allergies activity – Where nurses can update the allergies. NOTE: Only MDs can remove allergies

History activity– MD will usually update the patient History. Nurses have the ability to update also but nurses leave it to the MDs. Not the same as nurse's Admission history.

Medications activity– history of ALL medications placed on the patient whether are active or discontinued.

Intake/Output activity – totals the I/Os. Do cannot document in the Intake and Output activity. You document the I/Os in the flowsheet.

Flowsheets activity – Where RNs do most of their documentation such as Vitals; Head to Toe assessment; Patient Belongings; Daily Care; etc.

MAR activity – Medication Administration Record. Always scan the patient's 2D barcode on their wristband before giving meds. Then scan the medications.

Notes activity – Where all MD notes will be (H&P, progress notes, consult notes, etc). Also Ancillary notes (Case Manager, Social Worker, PT/OT/Speech, etc) and nursing notes:

Education activity – documentation of Education to patient/family by RNs

Care Plan activity – Where care plan and nursing shift summary are created. Pulls in 3 flowsheets into the nursing shift summary: Critical Results / Provider Notification / Shift Summary flowsheets. See tip sheet at ucepic.org

Order Review activity – all the orders placed on the patient. Active or discontinued.

Manage Orders activity – Where active orders live. Where you can also enter orders on behalf of physicians or nursing orders. Nurses only take telephone/verbal orders from physicians on emergent situations here at UC Irvine Health.

Provider Notification navigator – Where RNs can document that they have contact the MD on critical results or something important (provider notification)

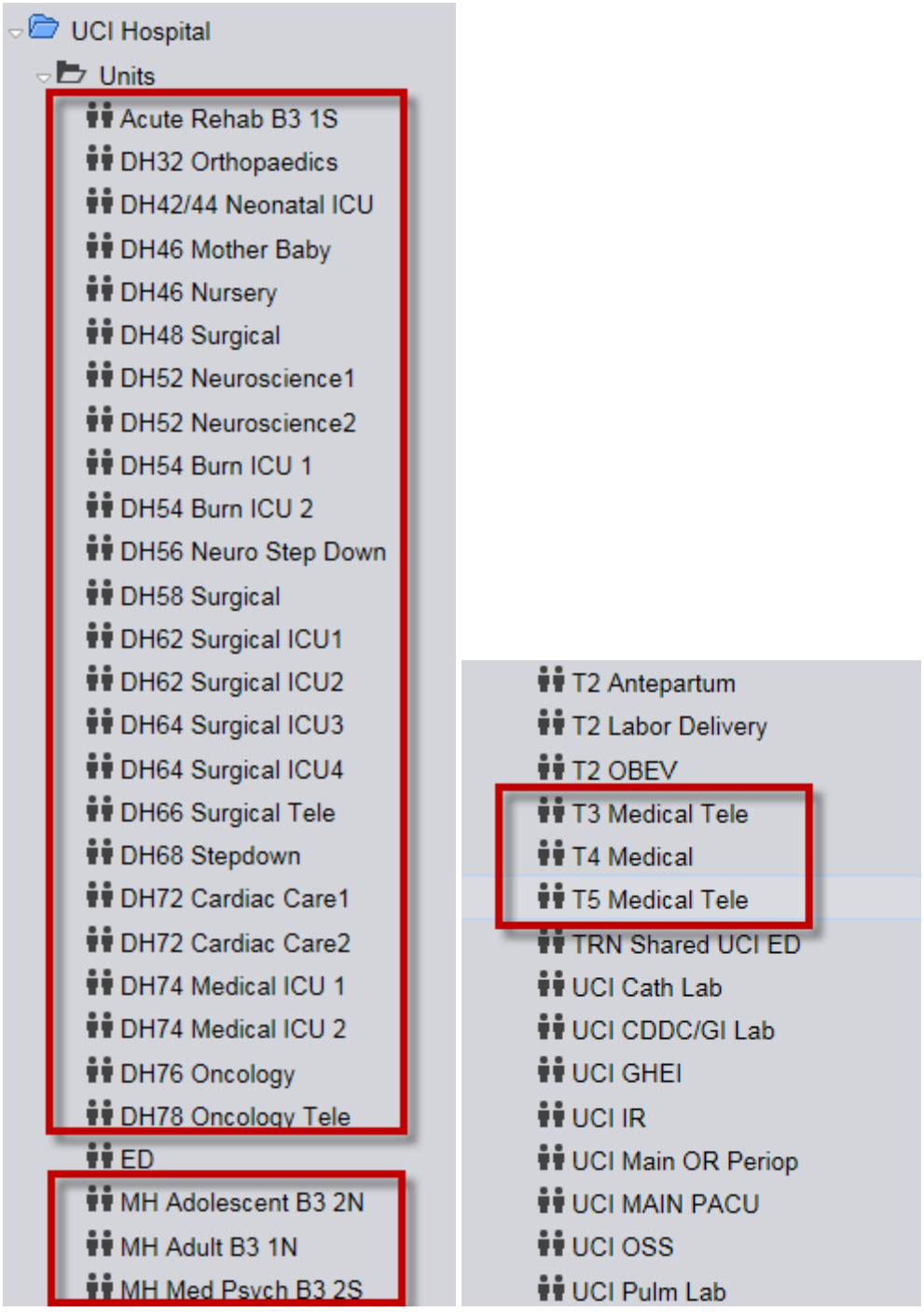
Procedures-OR navigator – The only thing this is used by inpatient RNs is the pre-op check list before sending patient to OR. The rest is meant for Peri-op Nurses. If doing bedside procedure with MD, then go to **PROCEDURES** flowsheet.

Admit-Txfr-Disch navigator – Where inpatient RNs do their Admission documentation/ Transfer documentation (within inpatient units)/ Discharge Documentation.

Shift Assessment navigator – Where nurses do their daily documentation. If you receive a transfer from a different unit, complete the Transfer navigator, then complete this Shift Assessment Navigator.
Misc Documenation – I/Os from OR – VIEW ONLY for inpatient RNs.

Activity – usually all about the same type (such as Flowsheets activity is all about flowsheets)
Navigator – usually a number of activities put together to make documentation easier. May navigate you to other activities to do documentation.

Physical (Inpatient) Units at UC Irvine Health – use this list to find your correct Epic department in PRD (Live) environment when you sign into Epic at the start of your shift.



High Risk Medications

UCI Health

Reduction Strategies for High Risk Medications

A. Independent double checks at the time of administration including programming the pumps and at hand-off (e.g., change of shift, transfer…) include all of the following steps:

1. The administering practitioner shall check the medication against the order in the electronic health record and program the pump if applicable.
2. After the pump has been programmed and prior to administration, a second qualified practitioner shall independently review the order, the label on the medication leading to the pump and the pump settings to verify that:
   a. The correct medication and concentration were hung for the correct patient;
   b. The correct pump settings have been entered (e.g., loading dose, continuous basal rate, incremental bolus dose, lock-out interval);
   c. The pump has been set for the correct infusion rate;
   d. The correct library entry was used for pump programming (when applicable).
   e. The practitioner programming the pump and the practitioner performing the independent double check shall document these activities in the medical record.
   f. At hand-off, the receiving practitioner shall perform independent double-check as described above and document these activities in the medical record.
3. If the administration does not involve a pump, a second practitioner shall double-check the medication dose against the order independently and document in the electronic health record prior to administration.

B. Dose verification shall include the following steps:

1. The administering practitioner shall obtain and prepare the medication.
2. The second qualified practitioner shall verify that the intended medication and dose were obtained and prepared correctly.
3. Documentation of dose verification is NOT required.

C. Two pharmacists will independently verify parenteral nutrition orders, and check first dose of pediatric/neonatal medications prior to dispensing

High Risk Medications

UCI Health

High risk medications	Storage			Prescribing / order verification process		Preparing, labeling, dispensing			Administration				PTMonitoring
	Segregate in pharmacy	Segregate in floor stock or Pyxis	Specialstorage outside of pharmacy	Notes	Special Pre-dispensing Check by pharmacy	Dispensed with high alert sticker	Independent double-check	Special preparation	Pump for infusions	Independent double-check	Dose verification	Special consideration	Special monitoring
Chemotherapy agents (excludes Hormone Modifiers as defined by AHFS)	•		Except for mytomycin ophthalmic kit	Initial order by attendings and fellows only. Treatment plans are built in the electronic health record.	Order is reviewed and verified by 2 pharmacists.	"Chemo"	•	Prepare in containment-primary engineering control. Double check by RX of final preparation. Gravimetric is used to confirm the expected weight and volume of compounded sterile preparations.	•	•		Chemocertified staff only	Blood count and other labs
Neuromuscular blocking agents (NMB)	•	• in A-carts, OR, procedural areas, pre-op, PACU, ICUs and ED only.	Warning on Pyxis removal screen "Causes Respiratory Arrest – Patient must be ventilated".		Mechanical ventilation	•		Prepared in RX or OR during code only	•			Discard partially used vials, syringes, drips immediately after administration or upon order discontinuation	Continuous cardiac, train of four, neurostimulator monitoring
Insulin	•	•	Only insulin lispro as Floor Stock		Insulin drip order with dose calculator, Insulin, Hypoglycemia and Hyperkalemia order sets are built in the electronic health record.	Infusions		Dispense patient specific product except for insulin lispro. Drips prepared in Pharmacy only with standard concentration of 1 unit/mL (except in an emergency in OR)	•	Infusions	IVP SQ Pump reservoir refill		Blood glucose
Digoxin injection	•		Different strengths segregated		Order for mg or mcg, not by volume			Prepared in RX (except in an emergency)					Vital signs, evidenceofdigoxin toxicity
Epoprostenol (Flolan), treprostinil (Remodulin)							•	Prepared and dispensed by Pharmacy		•			
Epinephrine (when drawing up in syringes)	•		Epinephrine 1:1000 are stored in RX except for 1 mL ampules						•		• including route verification		
Oxytocin IV infusion during labor only										•	Follow Oxytocin Induction and Augmentation of Labor policy.		
NICU heparin flushes 2 units/mL, 10 units/mL, 100 units/mL		•	High alert bin	Have prebuilt orders in the electronic health record.		•	2 units/mL			•			
Warfarin				Pharmacy manages per Therapeutic Anticoagulation policy. Best Practice Alert in the electronic health record if having epidural catheter is in place.	INR			Unit dose and exact dose provided				Verifydosewith patient prior to administration	Coagulation lab values

High risk medications	Storage			Prescribing / order verification process		Preparing, labeling, dispensing			Administration				PTMonitoring
	Segregate in pharmacy	Segregate in floor stock or Pyxis	Specialstorage outside of pharmacy	Notes	Special Pre-dispensing Check by pharmacy	Dispensed with high alert sticker	Independent double-check	Special preparation	Pump for infusions	Independent double-check	Dose verification	Special consideration	Special monitoring
Unfractionated Heparin injection, infusion (except SQ & flushes), argatroban infusion and t-PA infusion *low-molecular weight heparins(ex. Enoxaparin, fondaparinux) are excluded.			Limited access to appropriate personnel	Pharmacy manages heparin and argatroban infusions per Therapeutic Anticoagulation policy. Best Practice Alert in the electronic health record if having epidural catheter is in place.	Coagulation lab values			Premixedused when possible; drip concentration standardized. Pharmacy prepares heparin IV bolus dose.	●	●	IV Push	Heparin IV bolus are not allowed from heparin drip via pump library.	Coagulation lab values
Patient-controlled Analgesia (PCA)			ProfiledPyxis		Electronic Health Record has prebuilt reversal agents			Prepared in RX; Commercial preparationsused when possible; Concentrations standardized	●	●		Lock box for controlled substances	Paincontrol, respirationrate, sedation level
Analgesic / sedative infusions					Electronic Health Record has prebuilt orders per the Critical Care Infusion Titration Guidelines policy.				●				
Epidural Analgesic Infusions				Best Practice Alerts in the electronic health record if epidural catheter is in place in concurrent with systemic anticoagulants.	Electronic Health Record has prebuilt epidural order set with hard stop dosing limits	"ForEpidural administration"			●	●		Epidural catheter placed by anesthesia provider; Lock box for controlled substances	
Concentrated, undiluted injections of magnesium and potassium	●		Stored in crash carts, anesthesia carts, and perfusionist trays only		Serum electrolyte levels		●	Commercial preparationsused when possible. Each vial will be sealed in a high alert baggie with additional safety labels.	●				Serum electrolytes
Magnesium sulfate 20 g/500 mL				Follow Perinatal: Administration of Mangesium sulfate policy.						●			Follow Perinatal: Administration of Mangesium sulfate policy.
Sodium chloride 3%	●	●	Stored in selected Pyxis machines only with High Alert sticker on Pyxis cubie and warning screen		Serum sodium levels	Infusions	●	Commercial preparations used whenpossible.	●				Serum electrolytes
Sodium chloride 23.4%	●	●	Stored in selected Pyxis machines for emergency use only with High Alert sticker on Pyxis cubie and warning screen upon removal	Order by attendings or fellows only		●	●	Stored in Pyxis cubie labeled high alert. Each vial will be sealed in a high alert baggie with additional safety labels.			●	Give IVPvia central line. Must obtain approval from an attending or fellow prior to administration.	Serum electrolytes
Parenteral Nutrition (PN)	Separate storage areas for ingredients used to compound pediatric/neonatal PN from				Serum electrolytes, renal and hepatic functions Require 2 pharmacists to independently verifying the orders		See Pharmacy policy: Parenteral Nutrition (PN) Verification, Preparation and Checking						
Investigational medications	●	●			Verification of signedconsent forms			Prepared in Pharmacy only. Dispensing records maintained.	●	●			For study protocol.

Attachment "A"

Timeliness of Scheduled Medications	
STAT	**Within 15 minutes**
NOW	**Within 1 hour**
Time Critical Scheduled Medications	
Frequencies of</= 4 hours: Every 1 hr Every 2 hrs Every 4 hrs	Within 30 minutes Before or after the scheduled time
Non Time Critical Scheduled Medications	
Frequencies> 4 hours and< 24 hours: BID or Every 12 hr TID or Every 8 hr QID or Every 6 hr	Within 1 hour Before or after the scheduled time
Frequencies of>/= 24 hours: Daily, Weekly, Monthly medications	Within 2 hours Before or after the scheduled time
Once Prior to Discharge	As soon as able during the visit or stay in the area