Epic Flowsheets –Adult (in-patient)

Please review the following table to make sure you have the appropriate flowsheets for the area that you are working in.

Unit	Flowsheets	Additional Flowsheets for specific unit
Mitchell 3SE,3SW 4SW, 4NE, 4NW, 5SW, 5SE, CCD 8W, 9E, 9W, 10W	Adult VS Pain Wt, Assess, Daily Care, I&O, WALDO, Skin/Braden/Wound, Blood Transfusion, Suicide, Restraint	No additional flowsheets for these areas
Mitchell 3N	Adult VS Pain Wt, Assess, Daily Care, I&O, WALDO, Skin/Braden/Wound, Blood Transfusion, Suicide, Restraint	Post-Partum, Peritoneal Dialysis, OB assessment, hemodialysis
CCD 4W	Adult VS Pain Wt, Assess, Daily Care, I&O, WALDO, Skin/Braden/Wound, Blood Transfusion, Suicide, Restraint	Lobectomy
CCD 8E	Adult VS Pain Wt, Assess, Daily Care, I&O, WALDO, Skin/Braden/Wound, Blood Transfusion, Suicide, Restraint	Bedside Swallow
CCD 9E & 9W	Adult VS Pain Wt., Assess, Daily Care, I&O, WALDO, Skin/Braden/Wound, Blood Transfusion, Suicide, Restraint	No additional flowsheets for these areas

CCD 10E/10C	Adult VS Pain Wt, Assess, Daily Care, I&O, WALDO, Skin/Braden/Wound, Blood Transfusion, Suicide, Restraint	Adverse Events Stem Cell Infusion, CAR-T, ECOG
3 Burn	Adult VS Pain Wt, Assess, Daily Care, One Hour ICU, WALDO, I&O, Adult Needs Assessment, Bedside Procedure, Blood Transfusion, Restraint	Adult Burn
3E	Adult VS Pain Wt, Assess, Daily Care, One Hour ICU, WALDO, I&O, Adult Needs Assessment, Bedside Procedure, Blood Transfusion, Restraint	No additional flowsheets for this area
4E	Adult VS Pain Wt, Assess, Daily Care, One Hour ICU, WALDO, I&O, Adult Needs Assessment, Bedside Procedure, Blood Transfusion, Restraint	No additional flowsheets for this area
8N&S	Adult VS Pain Wt, Assess, Daily Care, One Hour ICU, WALDO, I&O, Adult Needs Assessment, Bedside Procedure, Blood Transfusion, Restraint	No additional flowsheets for these areas
9N&S	Adult VS Pain Wt, Assess, Daily Care, One Hour ICU, WALDO, I&O, Adult Needs Assessment, Bedside Procedure, Blood Transfusion, Restraint	No additional flowsheets for these areas

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CD main OR, DCAM main OR,	WALDO, Adult VS Pain Wt Pre-Op Checklist, Pre-Op Assessment, Peds PreOp, PACU, I&O, PCA, Epidural/Intrathecal, Monitoring, Blood Transfusion	No additional flowsheets for these areas
CD5 and CD6 prep/recovery	Pre-Op Assessment, Peds PreOp, PACU, I&O, WALDO, PCA, Epidural/Intrathecal, Monitoring, Blood Transfusion	No additional flowsheets for these areas
Please note that these additional Flowsheets may be helpful :	**Sepsis Screening, Project Walk, Pre-OP Checklist, PCA, Epidural, Care Companion, Virtual MDR, Team time out, sedation, Resp Therapy flowsheet**	

Epic Reports –Adult (in-patient)

What is an Epic Summary Report?

When first looking at a patient's chart, it's useful to have a consolidated summary of information about the patient, such as previous visits, history, medications, hospitalizations, and immunizations. The Summary Reports allow clinicians to review a patient's medical details in one place, instead of the separate tabs. The Summary Reports show different types of patient information, including overviews of the patient's care and detail reports for allergies, the problem list, daily orders, and more. Additionally, the Event Log and Intake/Output activities can also appear as views in the Summary activity, which helps reduce the number of clicks required for clinicians to review patient information.

Suggested—all areas:

- **IP Orders RN Overview:** all active nursing orders, including orders to be acknowledged
- **IP Orders Reports for RN's:** links to additional reports, such as RN Task, Blood Product transfusion, Orders overview, Orders history
- **Due Meds:** upcoming due meds
- **IPE Clinical Summary:** shared among all IP clinicians who have wrenched in, and pulls high level information in addition to message board/communication notes
- **IP Clinical Hand Off:** Electronic SBAR, pulling data and allows manually entered communication notes other nurses can see
- **IP Accordion – ICU:** not just for ICU, pulls clean view of flowsheet hemodynamics, intake/output information, and more. It is easy to navigate through time.
- **IPE Care Plan and Patient Education:** viewing all documentation done in these activities, in report format
- **Event Log:** allows timeline of events and access to reports that can be filtered by flowsheets, LDAs, MAR, Notes, Patient movement, and results
- **I/O:** intake/output, sections can be expanded to get more detail on infusions,

Suggested—certain care areas:

- **Blood Summary:** especially for units that give a lot of blood products
- **Baby Delivery Report:** L&D, etc
- **OR Surgery Summary:** post-op units, surgery information for this admission
- **MAR Report:** also available on the toolbar in the MAR, multi-day view of all drug actions
- **Education History:** great layout of all patient education provided, or in progress (better view of education than the Care Plan & Patient education report provides)
- **MAR Report:** also available on the toolbar in the MAR, multi-day view of **all** drug actions
- **Pain Documentation Overview:** great alignment of pain assessments, drug admins, and reassessments

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How to add in Epic Summary Reports on Patient List

1. Go to your patient list.
2. Ensure that split screen is active. You may have to click arrow to open this up.
3. Click on the wrench to add in the report you would like to have. Click "add or remove buttons from toolbar"
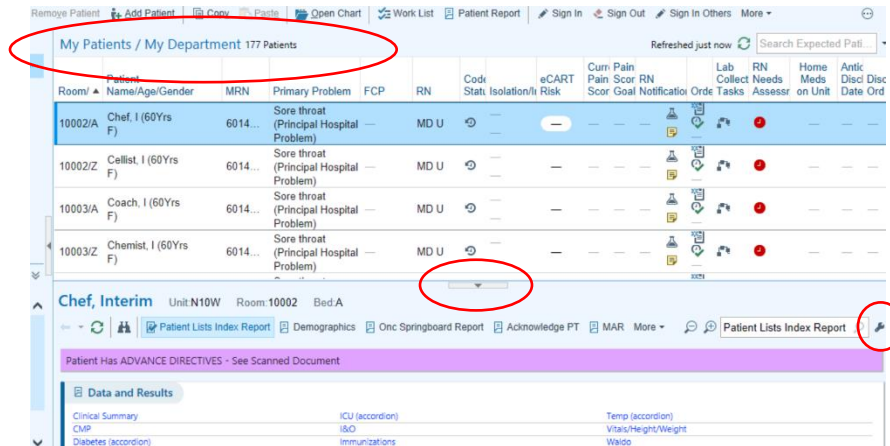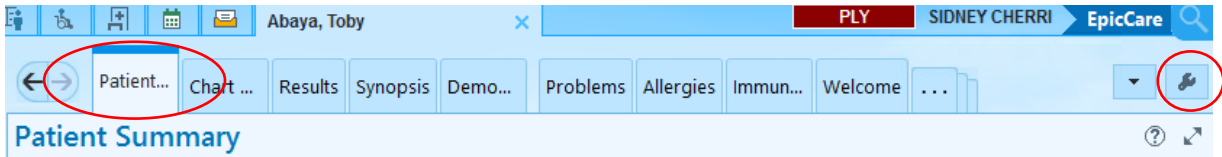

4. Search for report you would like to add. Click accept.
   - Tip: Be sure to remove an existing report if you do not want it, and add new ones in the empty positions as you scroll to the bottom. Arrows up/down will allow you to reposition these
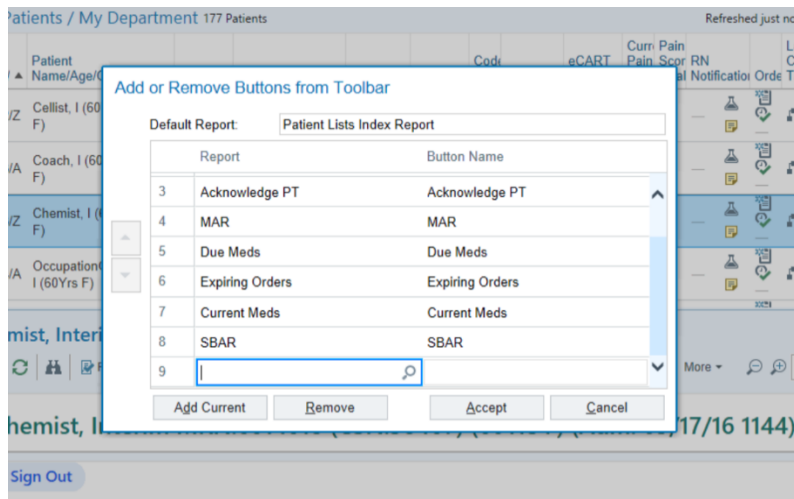
How to add in Epic Summary Reports in Patient Summary

1. Access a patient chart and ensure you are in Patient Summary. These changes will affect all patient charts going forward.
2. Click on the wrench to add in the report you would like to have. Click "add or remove buttons from toolbar"

3. Search for report you would like to add. Click accept.
   - Tip: Be sure to remove an existing report if you do not want it, and add new ones in the empty positions as you scroll to the bottom. Arrows up/down will allow you to reposition these
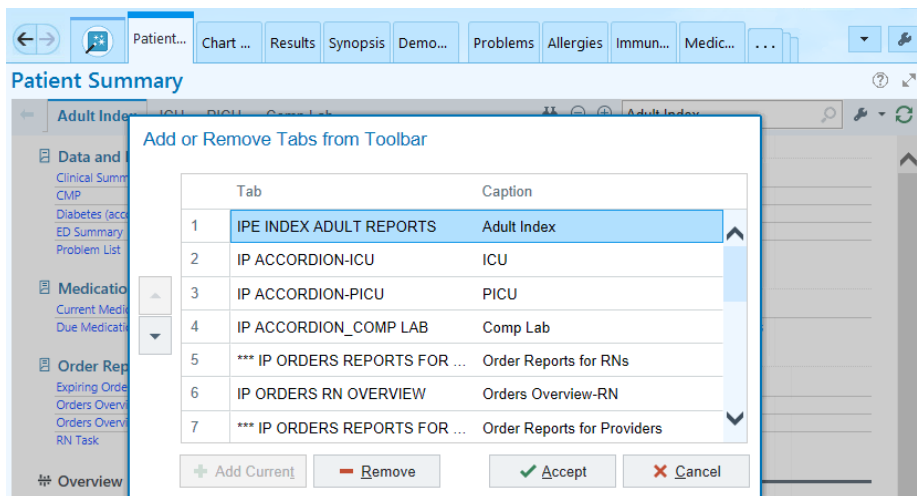
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Care Plans:

- RN must document on at least one goal in the care plan per shift
- You may use existing care plans or add new ones by adding template
- To document on goals, click on document on goals, select appropriate outcomes and click next. Click on the green plus signs to add the goals you want to be in your note. Add nursing note below and click accept. Documentation will populate in the notes tab

Education:

- Click education tab and ensure learning assessment is completed.
- Go to unresolved education. Select points that patient was educated on. On the right hand side fill out form (learner, readiness, method, response) and file.

Care Companion Documentation:

- NSA sitting with patient will document under the "Care Companion" documentation flow sheet q1hr.
- Suicide Documentation
  - Done under "Suicide Observation" documentation flow sheet
  - NSA with patient must document q15min
  - RN is to document on flow sheet q4hr
- Cohort Companion Documentation
  - RN/NSA must monitor patient q1hr.

Restraints:

- MD must reorder restraints q24hrs for Non-Violent Behavior
- Documentation on Restraints ordered for Non-Violent Behavior is done on in the flow sheet q2hr
- MD must reorder restraints q4hrs for Violent Behavior
- Documentation on Restraints ordered for Violent Behavior is done on in the flow sheet q15 min
- Patients with Restraints for Violent Behavior must have 1:1 care companion