

Cardiac Cath Lab: Epic Charting

Adding a Patient to the Status Board

- Click open case located at the top of the epic screen
- Click the hour glass located in the patient section, then search for patient by medical record number and double click patient
- In location section, type adult cath lab
- Click New Case once all red stop signs are filled in
- Once in the case entry screen all stop signs must be filled in under the general information tab, the service is adult cardiology
- After all the stop signs are filled in under general information, click the additional information tab on the sign of the screen. All red stop signs must be filled in on this screen also. Isolation status and Blood Product sections must be filled in as well
- After this section is complete click schedule located at the top of the case and drag the patient into the lab and time that you want them scheduled. Once you drag them into the snapboard, they will appear on the status board and you are now able to open the case and chart.

Opening the Case

- Double click on the patient
- Click open case and then ok on the pop-up screen
- Close the patient then double click to re-open them.
- When the patient is re-opened, it will bring you to the Adult Cath Intra Op screen where you will document.

Events

- *Room Ready for Patient:* Will not be recorded by prep, needs to be entered prior to the patient entering the room by the staff. This should be marked when the room is ready for the patient to enter. This will also light the “R” in the CANDLER
- *In Room:* This will be entered by the charting nurse when the patient arrives into the room
- *Case Start:* This will be entered when the physician starts the case which is defined as the lidocaine stick.
- *Case Stop:* This will be entered at the end of the case and is defined as when the physician leaves the tableside.
- *Out of Room:* This will be entered when the patient is physically on the cart being wheeled outside into the recovery area or back to their room.
- *Periop Care Complete:* This will be entered by the cath lab nurse when the patient is being taken back to their room by the cath lab staff. This greys the patient out on the status board and communicates that the care of the patient is done in this area. This is taken care of by the

recovery nurse in the case that the patient goes to them prior to discharge.

- *Procedure Not Performed*: This will be marked when a case is cancelled. Once clicked it will ask you at what point the case was cancelled and must be documented.

CANDLER

- Consent
 - Anesthesia
 - Nurse Assessment
 - Documentation
 - Labs
 - Equipment
 - Room Ready
-
- CANDLER should be lit in the prep area prior to the arrival of the patient into the cath lab. In the case that the patient comes directly into the lab, it is the responsibility of the cath lab nurse to make sure that this documentation is completed.
 - CANDLER letters are lit by documenting in the Adult Cath section of the adult cath intra op screen. The nurse should document in the pre-procedure verification section.
 - By answering the questions located in the pre-procedure verification section, the CANDLER letters will appear.

Adult Cath Intra

The adult cath intra is where most charting will take place for the cath lab nurse during the case.

- *General Info*: This section gives you a snap shot of patient information
- *Allergies*: In this section the nurse will review the reported patient allergies and add any new allergies that the patient is reporting. Important allergies to note and report to the physician are heparin, latex (we do carry latex gloves in the lab), contrast, and shellfish.
- *Review PTA meds*: This will show the nurse a list of medications that the patient has reported prior to arrival. Important medications to note are blood thinners, blood glucose meds, and Viagra
- *Timeout*: This will be documented when the physician completes the timeout in the room. It should be pending until the end of the case because it is effected by the procedure section. At the conclusion of the case it will be verified and signed by the documenting nurse
- *WALDO*: This is where all patient lines will be documented. If a line is left in place ie: Swans, sheaths, ECMO, IABP, etc. it will need to be documented in this section. If no lines are left in place, the access site used will need to be documented as a surgical incision.
- *Restraints*: for every case you need to document whether you are restraining the patient. If no restraints are being used click no for both sections. If the patient

comes down restrained and they are continued on the table, you must document so under the proper section. Restraint documentation should then be done every fifteen minutes for the remainder of the case.

- *Adult Cath*: This section is where a bulk of the documentation will be done. Prior to the case, this is where the pre-procedure verification will be completed. This is also where pulses will be documented prior to the start of the case and at the conclusion of the case.
- *Staff*: All staff should be documented in this section. If a staff member cannot be added by name, they should be entered manually in the visitor section with their role in the cath lab.
- *Intra-Op Meds*: This is where meds given during the procedure will be charted. The only medications that will not be charted here are the first sedation dose which must be charted in the MAR with an order placed and any drips that are started during the procedure that will be continued when the patient leaves the cath lab. This includes vasopressors, nitroglycerine, and bivalrudin.
- *Procedures*: The procedure section is made up of two parts. The first part is the surgeon section. In this section, you can change the name of the primary physician performing the case. This must be done and match who is billing for the procedure. The second part is the procedure section. Each procedure that is performed during the case must be documented. For each procedure, the site must be documented. If you

are performing a procedure through the groin, inguinal is the proper documentation. Anesthesia type is usually none unless for some reason anesthesia resource is involved. If anesthesia is also being used for the case, you must add cath anesthesia resource under procedure as well. Wound class for all our procedures is class 1 clean wounds. Incision closure is always no layers unless a cut down is involved, in which case it would be documented as superficial layers only.

- *Handoff Report*: Is a cheat sheet that can be used when giving report. Nothing gets documented in this section.
- *Handoff*: This is where you document who you are giving report to. For most of our patients we document report given to other: 5C recovery RN at the bedside unless the patient is going to their room. Add your own name under report given by. In the discharged to section, pick the proper choice.
- *Nursing Notes*: This is where you can type your own note at the conclusion of the procedure.
- *Verify*: This is the last section you will document in. It will not let you verify your case until the procedure start and stop events are logged, the patient in and out of room events are logged, and the timeout is verified and signed. Once this is all completed and you are done documenting on the patient, you will verify your case.

Manage Orders

In this section, you can enter orders during a case. Orders that you should be entering include ACT orders. These should be entered whenever an ACT is performed during a case. The proper way to order an ACT is to order POC Activated Clotting Time.

Holding an ICU patient

When holding an ICU patient to await bed placement. Vital signs and access site assessments should be done q15 X 4, q30 x 2, then routinely. This along with your assessment will be documented under the flow sheet One Hour ICU tab.

Patient Transport

To put in patient transport, click on the patient that you would like to order transport for. Then click Patient transport located on the tool bar at the top of your status board. Under pick up from make sure you choose current bed. Drop off too choices are:

CD5 Cath Suite 1- 5316
CD5 Cath Suite 2 – 5345
CD 5 Cath Suite 3
CD5 Prep/Recovery W01
CD5 Prep/Recovery W02
CD5 Prep/Recovery W03
CD5 Prep/Recovery W04

Mode will always be cart (bring cart) or bed. Transport requirements should always be chart. If the patient is coming from ICU or traveling by bed, in the comments section please put send 2 transporters. After accepting the transport it will ask you a second time to accept. Transport can then be tracked under the tab that looks like a wheelchair located at the top of the screen. To expediate transport or for any issues with transportation call 55537.

Non-Patient Transportation

This will be used to send RHC biopsy specimens to pathology or for the transport of used crash carts.

- Sending a Specimen to pathology:
 - Highlight the patient that you are sending the specimen on, make sure they have a red band around their name
 - Click Non-Patient Transport
 - Under what needs to be moved? Type specimen and hit next
 - Start location will be either:
 - CD5 Cath Suite 1 – 5316
 - CD5 Cath Suite 2 – 5345
 - CD5 Cath Suite 3
 - Finish location will be anatomical pathology
 - Accept transport
- Returning a Soiled Crash Cart:

- Highlight the patient that you are sending the specimen on, make sure they have a red band around their name
- Under What Needs to be Moved? Type Equipment Soiled Crash Cart then hit next
- Start location will be either:
 - CD5 Cath Suite 1 – 5316
 - CD5 Cath Suite 2 – 5345
 - CD5 Cath Suite 3
- Finish location will be: CCD 2221 Crash Cart Room
- Accept transport
- Place crash cart in hallway outside of cath lab suite to be picked up.
- Make sure medication tray is taken out of the crash cart and left inside the control room
- Call pharmacy at 21299 and request that the tray be picked up and a new crash cart be brought up ASAP.

Medication Issues:

To reach pharmacy to report shortages in hep saline or other medications, call pharmacy directly at 21299

Bed Assignments

When your patient is being upgraded to ICU, call 4-BEDS as soon as possible to let them know the need for an ICU and include if they are going to come out with a swan, EKOS, any line, or mechanical support (IABP, ECMO, Impella). To check

bed placement, click the tab at the top of the screen with the hospital. This will take you to the bed board screen. Once there Change your view to at a glance. This will give you a better view of the hospital bed situation. ICU beds are listed under critical. When the bed is assigned and clean, the room will have the patients name, be green, and have strips going diagonally on the side. A room being cleaned will be yellow and say cleaning. A patient receiving any mechanical support will need a bed on 4E the cardiovascular ICU. EKOS can go to MICU (9N or 9S) or the SICU (3E). swan placement can go to many ICU's. A patient without an assigned bed and mechanical support will need to be held by the cath lab RNs until a bed becomes available. Please see the bed escalation process for this information.

Snapboard

In the snapboard, you can rearrange cases. If a case is cancelled or rescheduled you can left click on the case and choose to remove it from the schedule instead of cancelling. This allows the case to be rescheduled by the scheduler.

UCMC Tools

Under the UCMC Tools tab, you will find many tools to help you throughout the day including lexi-comp, lab handbook, and epic tip sheets.

Event Reporting

In the case of a safety event that needs to be reported, click on the UCMC tools tab and choose Event Reporting. It will open up a separate window. Click on Event Reporting. Type in your UChicago Account information to log in. Choose the type of event and fill out the form appropriately and submit.

“Pre Op” template for EP

- Sign in to Epic
- Open “EP intra” folder
- 1 call 2-6545, request for patient to be escorted to Bay 24 or 25, obtain manila chart folder with pertinent patient labels, and verify patient wrist band. Instruct client to utilize admission kit for personal belongings storage and to wear only a gown as provided.
- 2. Open “**Order Management Folder**”. *Verify procedure order, pertinent blood work up, H&P, and place IV as directed per EP protocol. (If case is a device insertion procedure ie. ICD or pacemaker insertion, please be sure to insert PIV [peripheral IV] to the **Left arm** unless specified by Physician to place on right arm). Ie. Venogram for lead placement of Pacemaker or ICD placement procedure, or if case is a generator change please verify the placement of the device, right or left subclavian. For all other EP studies, bilateral groin prep is key.*
- Open “**Flowsheet**” folder
 1. Click “**pre-op assessment**” tab and fill the template. (Update events status board, upon completing templates)
 2. Click “**pre-op checklist**” tab and fill the template
 3. Click “**WALDO**” tab, add PIV insertion, any pertinent skin wounds as necessary. (remember to check for pertinent orders to be acknowledged, and blood work to be labeled with appropriate labels.
- Open “EP intra” folder
 1. Click on “**pre procedure assessment**”, “**restraints**”, “**staff**” folders and fill in templates.
 2. Update events status board.
 - a. When all SANDPO, all pre-op tasks have been completed ie. Patient has been prepped, Consent has been signed, bloodwork, H&P, personal belongings, all orders and tasks have been acknowledged. If no anesthesiologist involvement, then patient can be transported to Procedure room. *If time permits and no anesthesia involvement please encourage patient to void prior to procedure room transfer, also for all females of child bearing age you must conduct an HCG screen, and document in EPIC, There is a tab in the Pre-op checklist for this*

“Intra op” template for EP

While Prep procedure Nurse is prepping the client. The RT and monitoring Nurse are Prepping the room specific to the procedure ie. Supplies, Pertinent catheters, introducers, Sterile table, appropriate mapping equipment and device vendor. The nurse monitoring the case, must have IV lines, medications, Charge ticket forms, Oxygen, Defibrillator pads, Appropriate suction and other pertinent supplies prior to patient getting on the procedure table. Also, the Cardiolab system is of the Essence for proper live up to date charting during the procedure.

- Update events status board in EPIC
- Place “**Patient on the table**” proper ECG leads, Hands free Defib pads lead/defibrillator back up, reference patch pertinent to mapping system, 12 lead ECG for all Afib, VT ablations, EP studies device insertion for a HIS Lead Pacemaker/ICD. Non invasive Blood pressure every 5 minutes. EtCO₂. Oxygen nasal cannula. Make sure you have enough ACT cassettes and the ACT machine is ready with the QC completed.

- Monitoring RN **“Open cardiolab”** Choose **Pre procedure template** and fill in by clicking on the chronological tasks.
- If under general anesthesia, RN’s please make sure to have proper IV access and insert a Foley per MD order verification upon Deep sedation. This is to ensure proper I&O.
- For device placement, The team (nurses and techs) Have HALO bracket upon proper patient placement prior to Drape.
- Monitoring RN in **Cardiolab** fills in the proper tabs to prepare for timeout verification. Open **“EP intra”** folder in EPIC and click on Time out verification
- When “time out” is verified and completed, Open proper templates (eg. VT, Afib, Device anesthesia templates), and fill in chronological order for Live charting.
- Obtain a baseline ACT, for Afib ablations with transeptal approach. (Not required with Device procedures).
- In Epic, set up your **“intra-op meds”** template. *(please ensure that proper time is entered for medication administration in EPIC and in cardiolab, the times need to match as the 2 systems do not communicate)* note: Only 1 RN in the room with General anesthesia. With no Anesthesia support, 2 RN’s are needed, 1 to sedate the other to record.
- Upon draping the patient update **cardiolab**. Upon lidocaine administration update **cardiolab** and **EPIC** .
- Upon Puncture site or incision site. Click on **cardiolab** and in **EPIC** as official start time in “OR Events”

“Post procedure” Template for EP

*To ensure proper hand off, when procedure is complete. Call PACU charge nurse at **68862** And request a bay.*

- In **Cardiolab** and **EPIC** click on post procedure, fill in the templates on both systems.
- In Epic **WALDO** must be completed for proper handoff.
- In Epic **Flowsheets** I&O tab must be completed as well.
- PRINT report: In **cardiolab** Click to **“generate report and Edit”** click **“new”**. It will generate a report, once generated Highlight **“EP patient record”** once highlighted Click **“Edit.”** Review the report and make necessary change. Click **“FILE”** at top left corner and click **“print”**

GI Lab: Epic Charting

Events

- *Room Ready for Patient*: Will not be recorded by prep, needs to be entered prior to the patient entering the room by the staff. This should be marked when the room is ready for the patient to enter (MD has to be present). This will also light the “R” in the CANDLER
- *In Room*: This will be entered by the charting nurse when the patient arrives into the room
- *Case Start*: This will be entered when the physician starts the case which is defined as Scope in
- *Case Stop*: This will be entered at the end of the case and is defined as when the Scope is out
- *Out of Room*: This will be entered when the patient is physically on the cart being wheeled outside into the recovery area or back to their room.

CANDLER

- Consent
 - Anesthesia
 - Nurse Assessment
 - Documentation
 - Labs
 - Equipment
 - Room Ready
-
- CANDLER should be lit in the prep area prior to the arrival of the patient into the GI lab. In the case that the patient comes directly into the lab, it is the responsibility of the GI

lab nurse to make sure that this documentation is completed.

- C,D,R letters are lit by documenting in the Flowsheet and event section.
- By answering the questions located in the pre-procedure verification section, the CANDLER letters will appear.
- Complete CANDLER when is anesthesia case
- Conscious sedation case, need N,L,E completed before bringing the patient to the room.
- N,L,E is completed by the Pre-op Nurse
- C, D is completed by Pre-op or the MD when the consent and the H&P is completed.

GI Intra

The GI intra is where most charting will take place for the GI lab nurse during the case.

- *General Info*: This section gives you a snap shot of patient information
- *Allergies*: In this section the nurse will review the reported patient allergies and add any new allergies that the patient is reporting. Important allergies to note and report to the physician are heparin, latex (we do carry latex gloves in the lab), contrast, and shellfish.
- *Review PTA meds*: This will show the nurse a list of medications that the patient has reported prior to arrival. Important medications to note are blood thinners, blood glucose meds, and Viagra

- *Timeout*: This will be documented when the physician completes the timeout in the room
- *WALDO*: This is where all patient lines will be documented. If starting a new IV, or adding NG or a PEG tube.
- *GI Intra-Proc*: This section is where a bulk of the documentation will be done. Prior to the case, this is where the pre-procedure verification will be completed. This is also where pulses will be documented prior to the start of the case and at the conclusion of the case.
- *Staff*: All staff should be documented in this section. If a staff member cannot be added by name, they should be entered manually in the visitor section with their role in the GI lab.
- *Intra-Op Meds*: This is where meds given during the procedure will be charted. The only medications that will not be charted here are the first sedation dose which must be charted in the MAR
- *Handoff Report*: Is a cheat sheet that can be used when giving report. Nothing gets documented in this section.
- *Handoff*: This is where you document who you are giving report to. For most of our patients we document report given to other: recovery RN at the bedside. Add your own name under report given by. In the discharged to section, pick the proper choice.
- *Nursing Notes*: This is where you can type your own note at the conclusion of the procedure or the procedure was done under anesthesia

- *Verify*: This is the last section you will document in. It will not let you verify your case until the procedure start and stop events are logged, the patient in and out of room events are logged, and the timeout is verified and signed. Once this is all completed and you are done documenting on the patient, you will verify your case.

Manage Orders

In this section, you can enter orders during a case. Orders including Pathology, Cytology, hematology, and chest X-ray.

Holding an ICU patient

ICU Patients go to the 6th or 5th floor post op or directly to the ICU room.

Patient Transport

Patient transport is set up by the charge nurse

Medication Issues:

To reach pharmacy to report shortages in hep saline or other medications, call pharmacy directly at 21299

Snapboard

All cases are scheduled and cancelled by the scheduler

UCMC Tools

Under the UCMC Tools tab, you will find many tools to help you throughout the day including lexi-comp, lab handbook, and epic tip sheets, and paging system.

Event Reporting

In the case of a safety event that needs to be reported, click on the UCMC tools tab and choose Event Reporting. It will open up a separate window. Click on Event Reporting. Type in your UChicago Account information to log in. Choose the type of event and fill out the form appropriately and submit.

EPIC GI EPIC Screen- Shot

GI/PUL/CERT WALDO **Sedation** GI INTRAOP THERAPEUTI... Adult VS Pain Wt

Search (Alt+Comma) Expanded View All 1m 5m 10m 15m 30m 1h 2h 4h 8h 24h Based On: 0700 Reset

Gastroenterology Procedure Unit CD5 Prep/Recov... 11/19/19

	0839	0844	0849	0854	0900
Level of Consciousness	Responds to c...	Responds to c...	Responds to c...	Responds to c...	
Patient Transported To:					
Patient Returned					

Pain Assessment

	0839	0844	0849	0854	0900
Pain Scale Used					Numeric
Pain Score					0
Location					None
Laterality					
Pain Type					
Goal Score					
Interventions Provided					
No Interventions					
GWN Pain Level					
Unable to assess/reassess					
Level of Activity					

Aldrete Score

	0839	0844	0849	0854	0900
Activity					2
Respiration					2
Circulation					2
Consciousness					2
Oxygen Saturation					2
Score					10

GI Intra-Proc Pulm-CERT TM

GI Intra-Proc Summary Report

Staff Complete

Search Staff + Add + Add Me + Add visitor

Surgeons	Panel	Role	Time In	Time Out
Kapuluru G Reddy, M.D.	Panel 1	Primary	<input type="text"/> <input type="button" value="Now"/>	<input type="text"/> <input type="button" value="Now"/>
Staff				
Carolyn Vasser-Webster		GI TECHNICIAN	<input type="text"/> <input type="button" value="Now"/>	<input type="text"/> <input type="button" value="Now"/>
Jennifer Maddox, R.N.		CIRCULATING NURSE	<input type="text"/> <input type="button" value="Now"/>	<input type="text"/> <input type="button" value="Now"/>
Visitors				
Dr. C. Muller, fellow		Ancillary Personnel	<input type="text"/> <input type="button" value="Now"/>	<input type="text"/> <input type="button" value="Now"/>

↑ Previous ↓ Next

PRE-PROCEDURE

- Summary Report
- Staff
- Pre-op Skin
- WALDO
- Positioning
- Timeout

GI PROCEDURES

- Therapeutic Ma...
- Doc Flowsheets
- Equip/Instr
- Intra-op Meds
- Implants
- Supplies

LABS/ORDERS

- Manage Orders
- Specimens

CLOSING

- Procedures
- WALDO
- Post-op Skin
- Core Measures
- Nursing Notes
- Handoff
- Debrief Checklist
- Verify

9:32 AM

GI Epic Tip Sheet Specimen

Microbiology labeled as (A,B,C)

Epic Order: No order needed

Epic Intraoperative Navigator:

Enter microbiology in the Specimen Section of Navigator

1. Culture and Sensitivity
 - a. Use a specimen cup with secure lid
 - b. Ask MD to specify what cup/ Medium to use
2. To send a specimen:
 - a) Obtain 1 Demographic label per specimen collected.
 - b) Lable specimen with letter/ name of the specimen
 - c) Placed a specimen order requestion with the specimen
 - d) Place specimen in the biohazard specimen transport bag X2
 - e) Send to microbiology via tube station
 - f) For Fecal transplant, please log the specimen in the log book in the charge room

Cytology labeld as (A, B, C)

Epic Order: An order entered for each specimen.

Epic Intraoperative Navigator:

Enter Cytology in the Specimen Section of Navigator

1. To send a specimen:
 - a) Obtain 1 Demographic label per specimen collected.
 - b) Lable specimen with letter/ name of the specimen
 - c) Placed a specimen order requestion with the specimen
 - d) Place specimen in the biohazard specimen transport bag X2
 - e) Send to Cytology via tube station
 - f) Provation report MUST be sent out with the Cysology specimen

Pathology labeled as (1,2,3)

Epic Order: One time order must be entered per patient.

Epic Intraoperative Navigator:

Enter Pathology in the Specimen Section of Navigator.

2. To send a specimen:
 - a) Obtain 1 Demographic label per specimen collected.
 - b) Lable specimen with Number/ name of the specimen
 - c) Placed a specimen order requestion with the specimen
 - d) Place specimen in the biohazard specimen transport bag X2
 - e) Send to Pathology via tube station
 - f) Provation report MUST be sent out with the Cysology specimen

Routine:

1. During open hours of pathology, send specimens via tube station to Pathology
2. After 6:45 pm weekdays, weekends, and holidays, specimens are placed in the specimen refrigerator. Or if you don't have a Provation report.

GI Epic Tip Sheet Specimen

3. Formalin:
 - a. Specimens must be fully submerged and floated. If not, place fresh in the refrigerator.

Hematology labeled as (A,B,C)

Epic Order: **One time order must be entered per patient.**

Epic Intraoperative Navigator:

Enter Hematology in the Specimen Section of Navigator.

3. To send a specimen:
 - g) Obtain 1 Demographic label per specimen collected.
 - h) Label specimen with Letter/site/name of the specimen
 - i) Place a specimen order request with the specimen
 - j) Place specimen in the biohazard specimen transport bag X2
 - k) Send to Hematology via tube station
 - l) Send a Provation report with specimen

GI Epic Tip Sheet Specimen

GI Procedure Specimen Collection Workflow

MD:

Responsibilities

- When collecting a polyp, the MD must inform staff that he/she sees a polyp or want to take a biopsy.
- Inform staff what type of equipment he/she wants to use to retrieve specimen (biopsy forceps, hot snare/cold snare)
- Identify location and inform procedure staff(nurse & tech)
- Specify the specimen jar number and specimen location with each specimen location

***Repeat to Tech the jar number and location**

TECHS:

Responsibilities

- Tech will gather all equipment needed to perform the collection of specimen, such as:
 - Biopsy forceps
 - Snares
 - Polyp trap
 - ERBE (Electrocautery Machine)
 - Prepare foot pad for the ERBE
- When opening a new specimen container always look into the jar for material
 - A clean jar should always remain particular free
- When the biopsy is obtained the tech takes the specimen from the retrieval equipment's (Snare, Biopsy Forceps, Polyp trap, Roth net)
 - A toothpick is used to remove the specimen from the biopsy cup
 - **Discard toothpick after every specimen collection**
- The specimen is placed on the Millipore paper
- Confirm with the MD that the specimen is retrieved and if he/she wants to take more specimens or close the specimen jar container
- Upon collection of a specimen information is repeat back to MD and RN
 - With specimen jar numbered and specimen location
- When Specimen is completed the specimen jar is closed
- After obtaining specimens the jar is labeled numerically **with black marker**
 - *Never number the jar before obtaining the specimen and closing the jar (exception red marker only)
- After completing the specimens process placed the labeled containers on the specimen table for RN to process

RN:

Responsibilities

GI Epic Tip Sheet Specimen

- Tech repeats to nurse the specimen jar number with specimen location
 - This information is documented on specimen collection sheet (optional)
- RN retrieve specimen from specimen table then labels the container with correct patient sticker
- Return all completed specimen documented sheets to its holding area (optional)

GI Epic Tip Sheet Specimen

Specimen Collection Jars



YES
-Not covering container lid



NO
-Covering container lid
-Results in patient identifiers being lost when jar is opened.



YES



NO
-Lid ajar
-Causes leakage of contents/loss of tissue
-Possible destruction of label
-Possible contamination of pneumatic tube system

How to Add Patients in Provation

- In Provation, select Scheduling (left task bar)
- Select New (top task bar)
- Enter MRN, click on locate
- Double-click on the correct patient to select
- Complete the following:
 - Procedure – click on the 3 dots to search procedure list
 - Time – Start time (scheduled proc. time)
 - Physician – GI provider
 - Status – Inpatient/Outpatient
 - Room – GI 1, 2, 3.....
 - Anesthesia – type of sedation
 - Additional Staff – select Referring MD

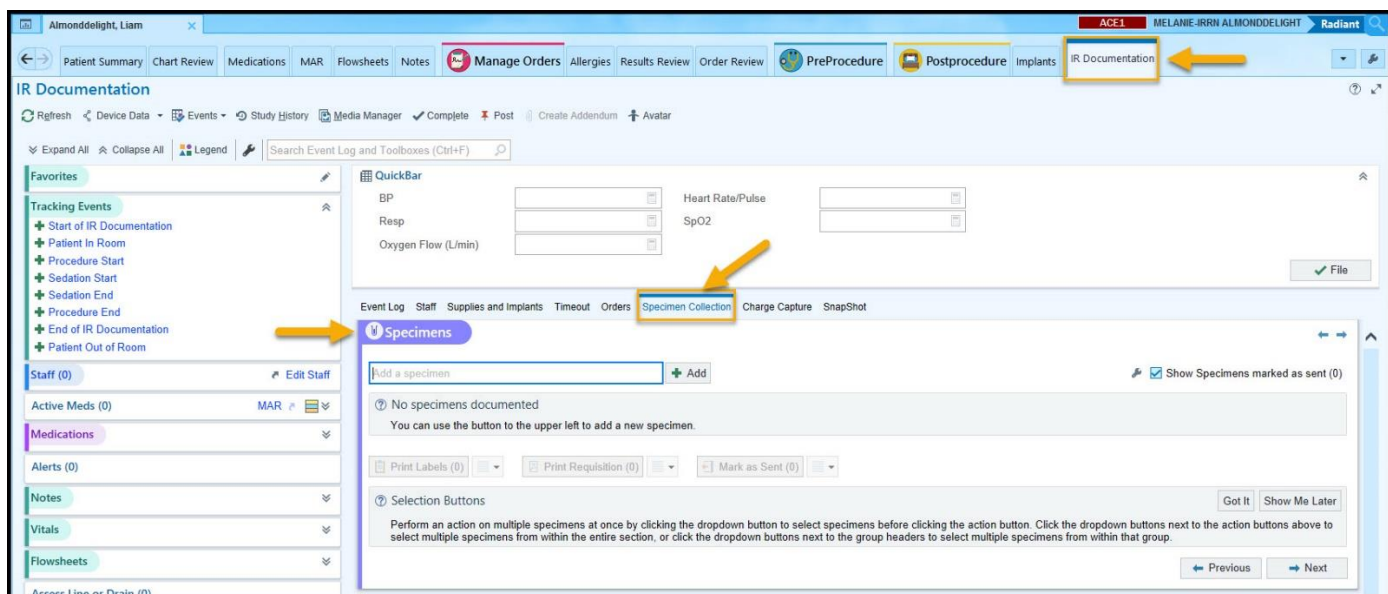
Epic Tip Sheet: Radiant/Beaker HPK: Intra-procedure Specimen Ordering, Collection, & Documentation for IR Nurses

Summary

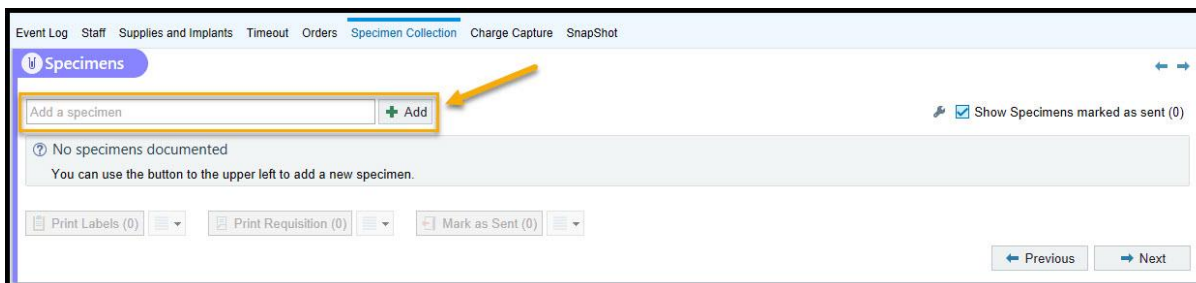
When a specimen needs to be collected and documented during an interventional radiology procedure, IR Nurses can utilize the **Specimen Collection** activity located in the IR Documentation (Intra-procedure) Navigator.

Step-by-Step

1. Locate and click on the **Specimen Collection** activity in the IR Documentation Navigator to begin documenting your specimen.

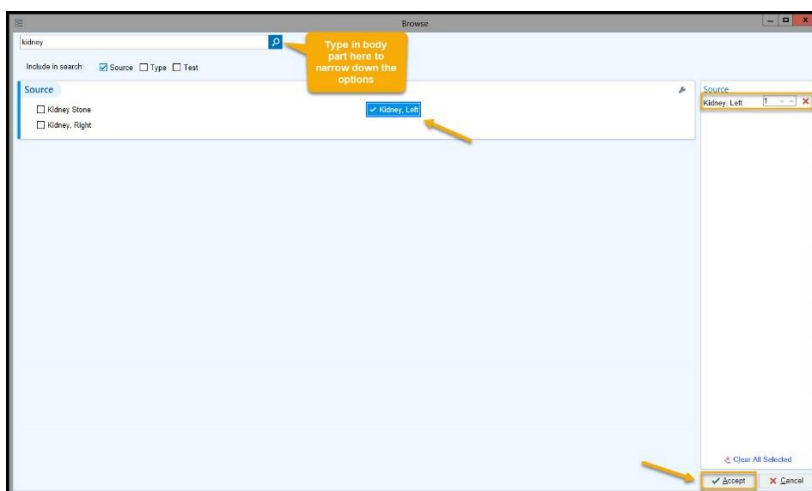
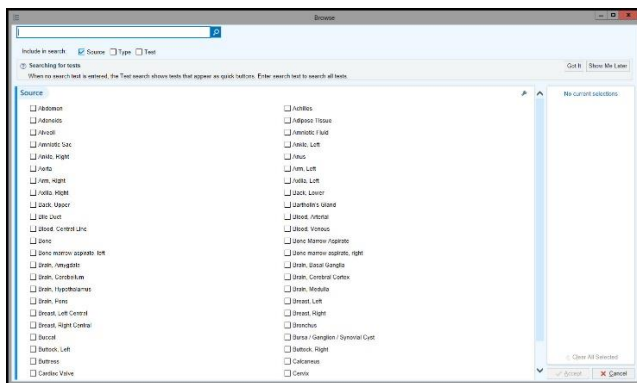


2. Click inside the **Add a specimen** source box to indicate the area of the body that the specimen is coming from.

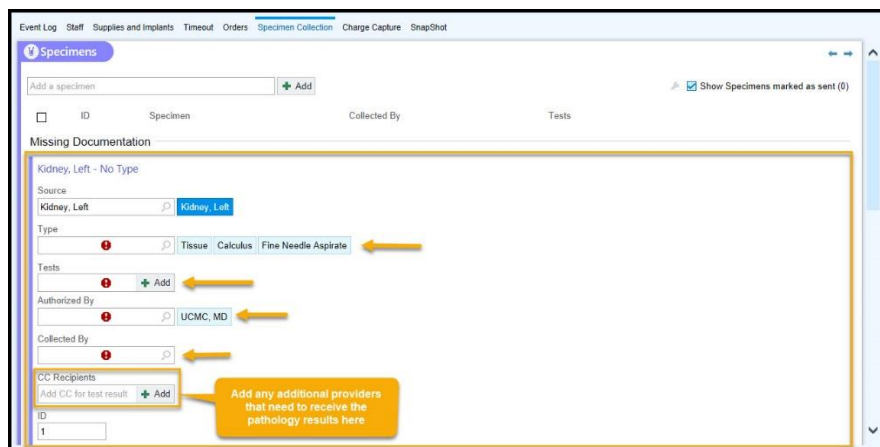


Epic Tip Sheet: Radiant/Beaker HPK: Intra-procedure Specimen Ordering, Collection, & Documentation for IR Nurses

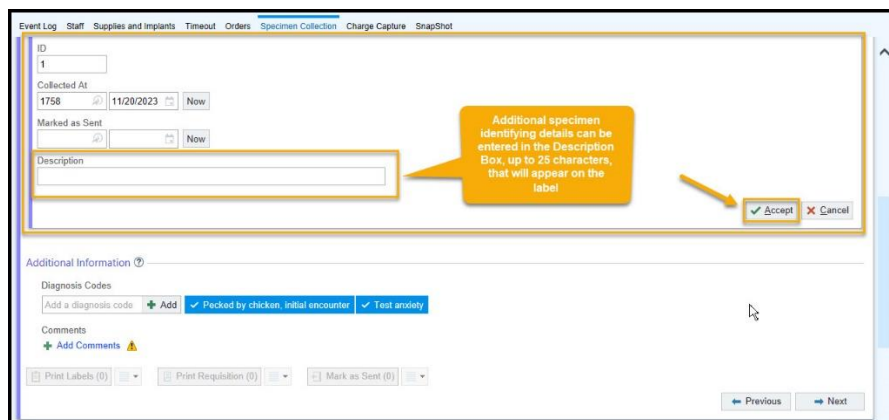
3. A box will open with all available source options. Type the name of the body part that the specimen has been taken from into the search box to narrow down your options. Choose a source and click **Accept** in the bottom right corner.



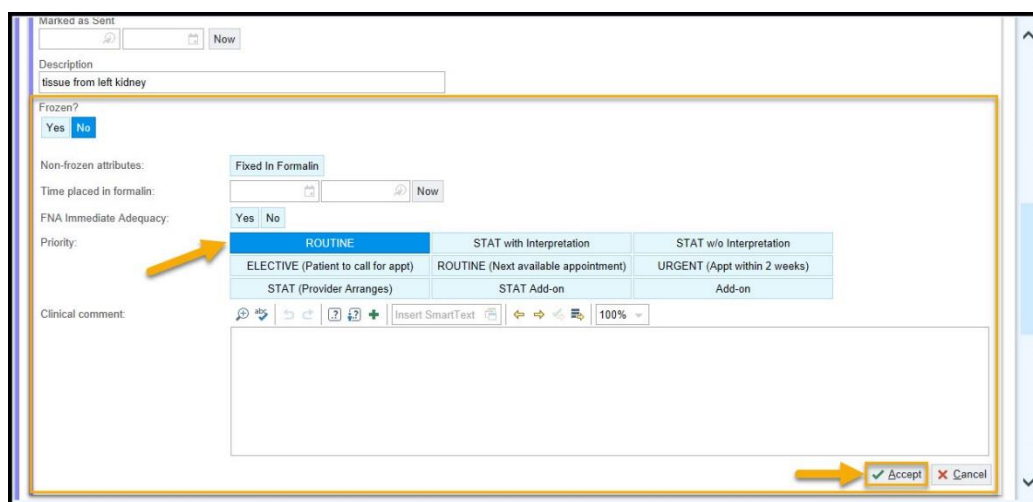
4. Fill in the necessary “hard stop” details for your specimen. Add additional providers that need to receive the pathology results in the **CC Recipients** box. Provide additional details that will help identify your specimen in the **Description** box. You can add up to 25 characters that will appear on the printed label.



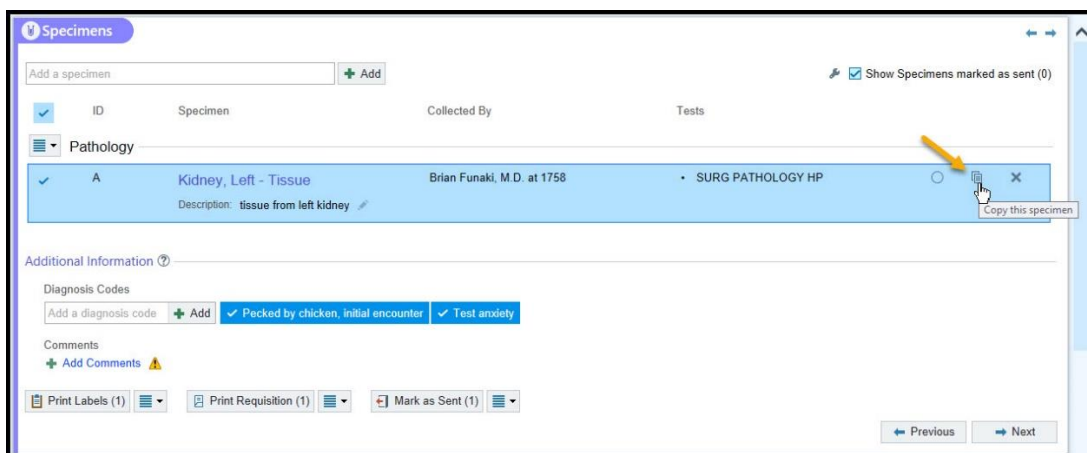
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5. As you fill in these details, additional questions may appear. Be sure to answer anything that applies and select a priority (ex: Routine or Stat). Click **Accept** once you have completed documenting the details.

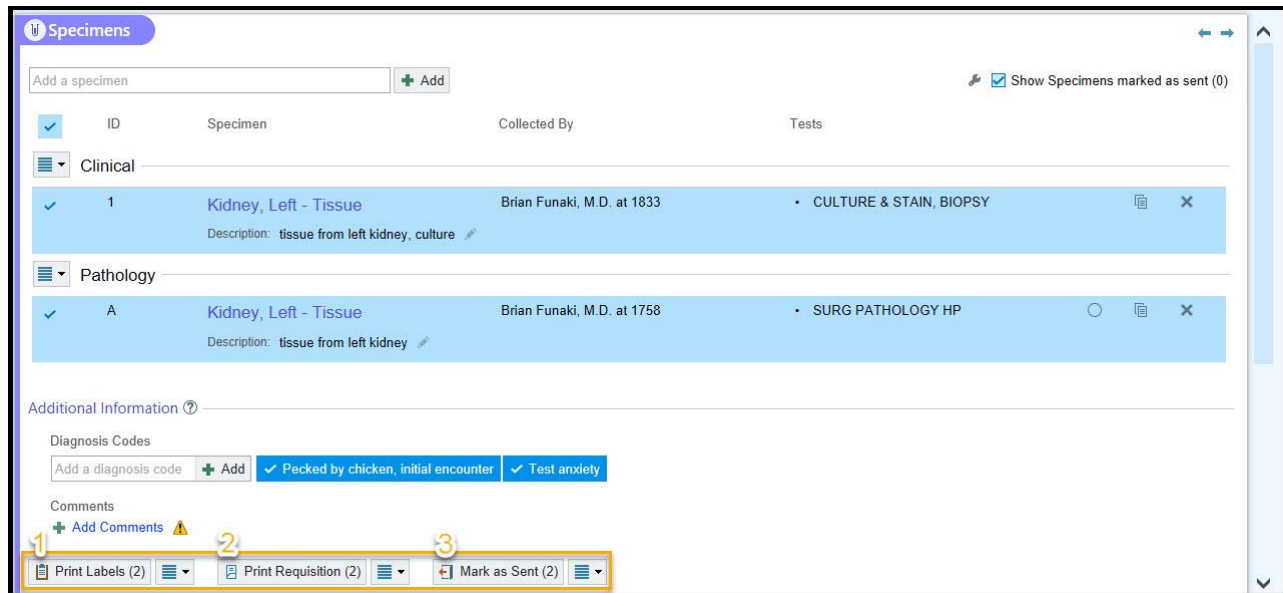


6. Your specimen will now be collapsed and appear as a hyperlink with a letter or number ID, specimen description, the collecting radiologist, and chosen tests. To document additional specimens, you can use the copy icon and open the specimen via the hyperlink to make necessary adjustments to the details.

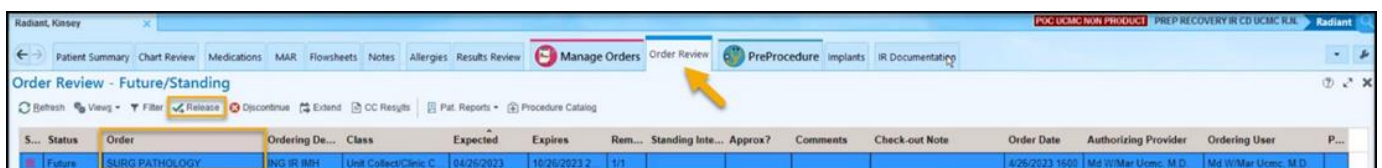
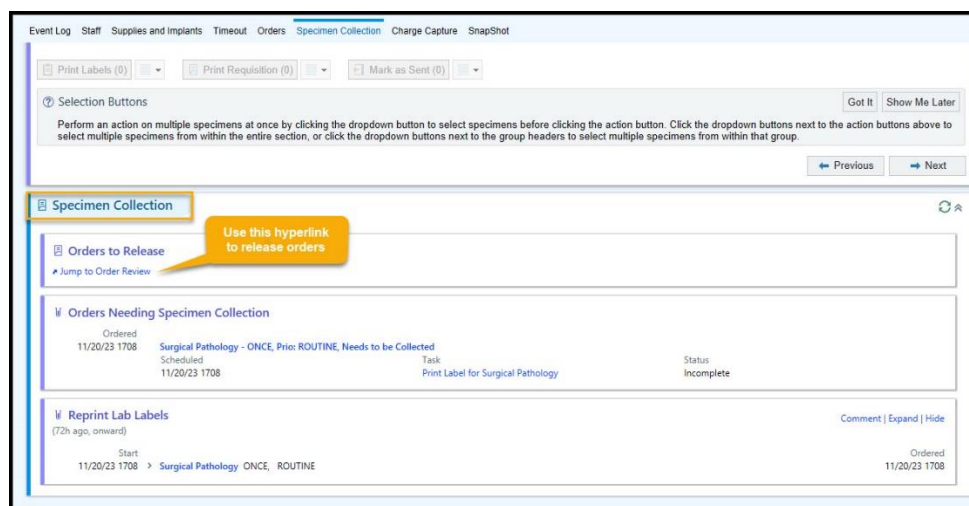


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- Once you have completed your documentation on all specimens, under **Additional Information**, locate and click the **Print Labels** button, which is the first button to the bottom left in this area.
- Place the labels on the corresponding specimens. Locate and click the **Print Requisition** button, then click the **Mark as Sent** button. This completes your specimen collection and documentation workflow.



- If specimen orders were placed prior to the procedure, you can release those orders and print labels using the **Specimen Collection** section, located under the Specimens section. Locate **Orders to Release** and click on the **Jump to Order Review** hyperlink to release any Future/Standing Orders.

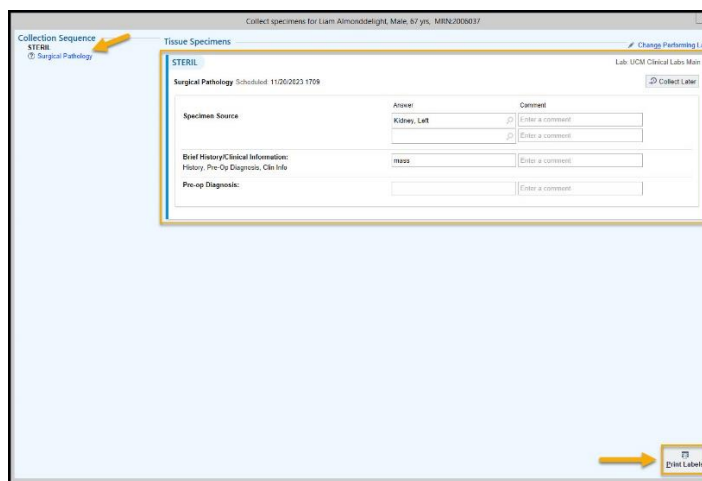


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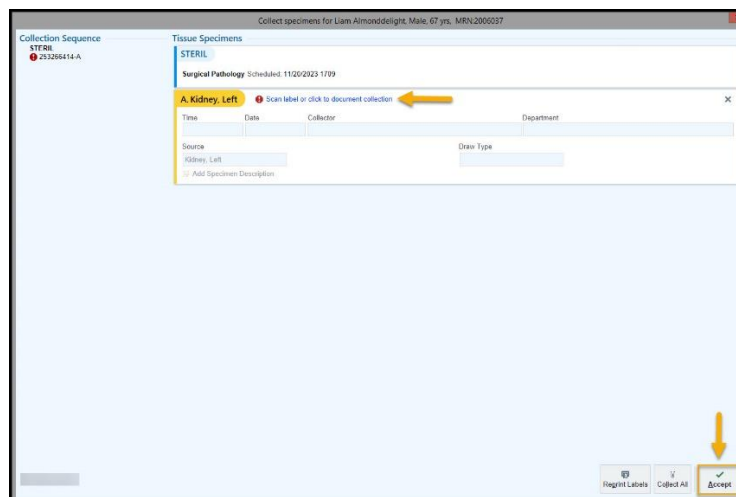
10. Released specimen orders will populate in the **Orders Needing Specimen Collection** section with a Task to print the label. Click **Print Label for Surgical Pathology**.



11. After you click the hyperlink, a **Collect Specimens** box will open, displaying each order in the collection sequence. Fill in the appropriate details for each specimen if needed and click **Print Labels** in the right corner.



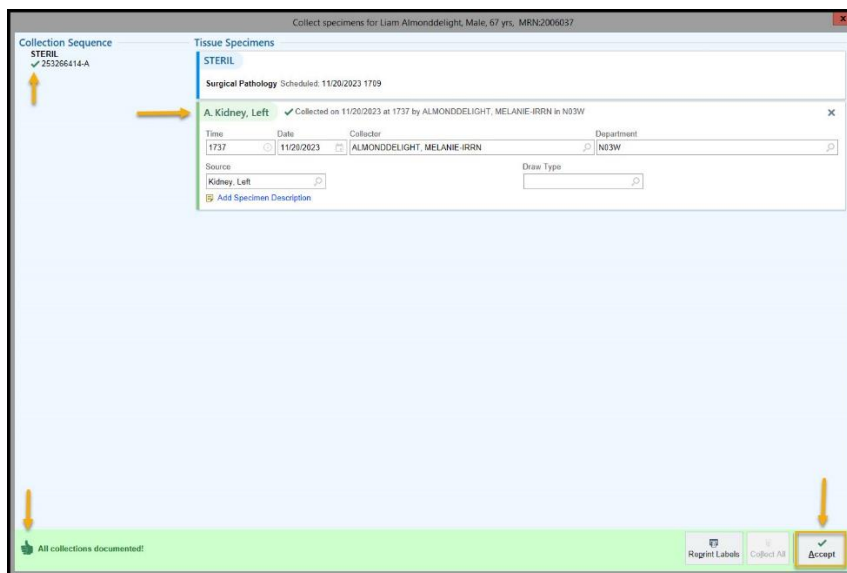
12. Now, you will scan the specimen label to document the collection details. Click **Accept** in the bottom right corner.



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13. You will now see verification that your specimen has been collected and documented:

- A green checkmark appears in the top left corner under Collection Sequence.
- The Tissue Specimens area will be highlighted and outlined in green.
- A green bar will appear at the bottom, indicating that all specimen collections have been documented.



14. Click **Accept** in the bottom right corner to complete the workflow.

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Date	Summary of Revisions	User
5/8/23	Created/Revised for IR	Jessika Fuentes
11/20/23	Revised post IR Enhancement	Jessika Fuentes

Moderate Sedation Tip Sheet

Dietary Precautions

- Check with provider- NPO start time, Enteral feeding stop time, Oral Medication stop time
- Fasting may include:
 - ✓ No clear liquids- 2 hrs before
 - ✓ No light solid foods- 6 or more hours
 - ✓ No fatty foods or meat- 8 or more hour
 - ✓ Elective: Before elective sedation, oral intake will be curtailed as appropriate for age.
 - ✓ **Clear liquids:** 2 hours
 - ✓ **Breast milk:** 4 hours
 - ✓ **Infant Formula:** 6 hours
 - ✓ **Non-human milk:** 6 hours

**always consult with provider for exact limitations

Components of Informed Consent

- Intended Procedure
- Risk, benefit and alternatives
- Planned medications
- Intended level of sedation
- Risk associated with sedation

If the nurse discovers that the patient is not fully informed

The attending or designee must be notified

See policy PC13 Informed Consent for Procedures and Treatment

Prior to the procedure the RN must:

1. Verify designated driver
2. Confirm adherence to NPO
3. Confirm consent obtained
4. Confirm intravenous access
5. Perform baseline Aldrete score
6. Assess airway status (**cough, gag, and swallow reflexes**)

Emergency equipment must be readily available before, during, and after the procedure:

- ✓ Monitoring Device (VS, SpO2, EKG capable)
- ✓ Capnography/Capnometry
- ✓ Oral Suction
- ✓ Crash Cart/defibrillator
- ✓ Reversal agents

- ✓ Supplemental oxygen

Time out

Prior to starting the procedure a designated team member will conduct the final verification.

This includes:

- ✓ Correct patient identity
- ✓ Correct side and site
- ✓ Visual identification of site marking conducted (if appropriate)
- ✓ Accurate procedure consent form
- ✓ Agreement on procedure to be done
- ✓ Correct patient position
- ✓ Relevant images and results are properly labeled and appropriately displayed
- ✓ Patient specific safety concerns
- ✓ Availability of correct implants and critical equipment

Intra procedure

During the procedure the nurse must:

- Be ACLS, ATLS, PALS, or NRP certified in some areas
- Administer moderate sedation under MD supervision
- Administer medication to treat side effects and complications
- Perform ongoing assessment and monitoring
- Have no other responsibility but care solely for the sedated patient

Document:

- Procedure start and end time
- Document Vital Signs & Assessment **Q 5 Minutes**
- Name, dose, route, and time of all medications given
- Any complications including description of symptoms, VS, treatments, and response to treatment.

Sedation Medication: Medical Orders

- There must be a Medical Order in Place prior to administering any sedation medication.
- Subsequent doses needed intra-procedural may be entered as a verbal order by the RN.
- Each verbal order needs be entered as a verbal order and signed off in the eRX. Entering one cumulative dose is not permitted.
- All medications administered during the procedure must be documented in the ERX
- Any medications pulled from the Omnicell must be reconciled in the ERX.
- Any unused controlled substances must be wasted in accordance with Policy PC 109.

Intra procedure documentation

❖ Nurses should document: Start and stop time of the procedure

▪ Record of vital signs every 5 minutes including:

- I. Heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation, capnography/capnometry (documented by either numerical or graphical measurements)
- II. Sedation Evaluation

- III. Level of consciousness, pain assessment
- IV. Medication doses, administration times, and waste
- V. Patient blood pressure shall be recorded just prior to each additional dose of medication.
 - Oxygen Therapy: If used, an order is required for oxygen therapy
 - Any complications, adverse reactions or problems occurring during moderate sedation, including time and description of symptoms, vital signs, treatments rendered and patient's response to treatment.

EMR

EMR Documentation

Must Use the Correct FlowSheet which Includes all the Required Assessment Requirements!!

Cardiology-Heart & Vascular Imaging Center							
12/20/18							
	1550	1553	1555	1558	1600	1603	Last Filed
Vital Signs							
MPN							2025992
Patient Name							Mullen, Th...
Temp							36.6 (97.9...
Temp Source							Tympanic
Heart Rate:Pulse	83	86	87	101	92	89	93
Pulse Method							Pulse Oxi...
Resp	18	16	16	14	15	15	16
BP	↑ 141/66	136/69	135/65	132/71	137/66	140/64	132/78
BP Site (Cuff)							
MAP	87	87	85	91	86	85	101 mm/H...
MAP Method							Monitor
SpO2	99	98	99	99	97	99	100 %
Capnometry	41	43	45	31	37	39	39 mm/Hg
Capnometry Route							Nasal Cann...
FI02 (%)							21 %
Oxygen Flow (L/min)	2	2	2	2	2	2	0 L/min
O2 Delivery	Nasal Cannula	Nasal Cannula	Nasal Cannula	Nasal Cannula	Nasal Cannula	Nasal Cannula	Room Air
Additional Vital Signs							
Sedation Evaluation	Minimal	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate
Level of Consciousness							Responds to ...
Patient Transported To:							PACU
Patient Returned							

Sedation Evaluation

- Sedation Evaluation must be completed every 5 Minutes. Row Information in Epic provides instruction on how to evaluate a patient's level of sedation.

Expanded [View All](#)

[1m](#) [5m](#) [10m](#) [15m](#) [30m](#) **[1h](#)** [2h](#) [4h](#) [8h](#) [24h](#)

Based On: 0700 [Reset](#) [Now](#)

Cardiology-Heart & Vascular Imaging Center

12/20/18

	1553	1555	1558	1600	Last Filed
Vital Signs					
MRN					2025992
Patient Name					Mullen, Th...
Temp					36.6 (97.9...)
Temp Source					Tympanic
Heart Rate/Pulse	86	87	101	93	
Pulse Method					Pulse Oxi...
Resp	16	16	14	16	
BP	136/69	135/65	132/71	132/78	
BP Site (Cuff)					
MAP	87	85	91	101 mm/H...	
MAP Method					Monitor
SpO2	98	99	99	100 %	
Capnometry	43	45	31	39 mmHg	
Capnometry Route					Nasal Cann...
FI02 (%)				21 %	
Oxygen Flow (L/min)	2	2	2	0 L/min	
O2 Delivery	Nasal Cannula	Nasal Cannula	Nasal Cannula	Nasal Room Air	
Additional Vital Signs					
Sedation Evaluation	Moderate	Moderate	Moderate	Moderate	
Level of Consciousness					Responds to...
Patient Transported To:					PACU

12/31/18 1139

Sedation Evaluation

Group Information

Vital signs (heart rate, respiratory rate, blood pressure, O2 saturation, level of consciousness, and level of sedation) are recorded every 5 minutes for moderate to deep sedation. Blood pressure monitored and recorded prior to each dose of medication.

Row Information

Minimal
Patients respond normally to verbal commands, ventilatory and cardiovascular functions are unaffected.

Moderate
Patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain patent airway.

Deep
Patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate.

First Filed Value

Minimal
by Hawatha Morris, R.N. at 12/19/18 1009



Service Tasks (Non-Patient Transport)

Summary

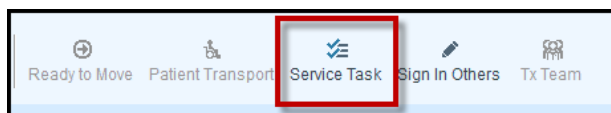
Enter a Service Task when anything other than a patient needs to be moved from one place to another in the hospital. This may be medical equipment, patient belongings, extra wheelchairs, oxygen tanks, etc. Non-patient requests are not tied to a patient. The request is sent to the transport team.

Opening the Non-Patient Transport Form

The **Service Task** button is available in a variety of activities. It may appear in an activity's toolbar, sometimes under the More menu. You can also find it in the UCMC Tools menu. Refer to the table below to see how your role can find the button.

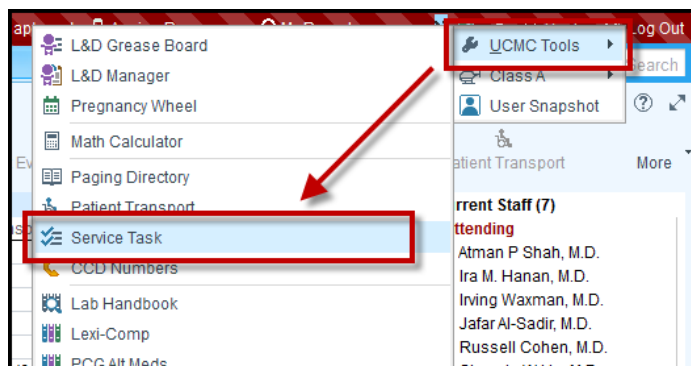
Activity Toolbar (More button)

Look for the Service Task button in the toolbar. Depending on the width of your screen, you may need to click the **More** button to find it.



UCMC Tools Menu

Most users can find the Non-Patient Transport button in the **UCMC Tools** menu. When using the button from this location, you may need to lookup the patient before entering the transport request.

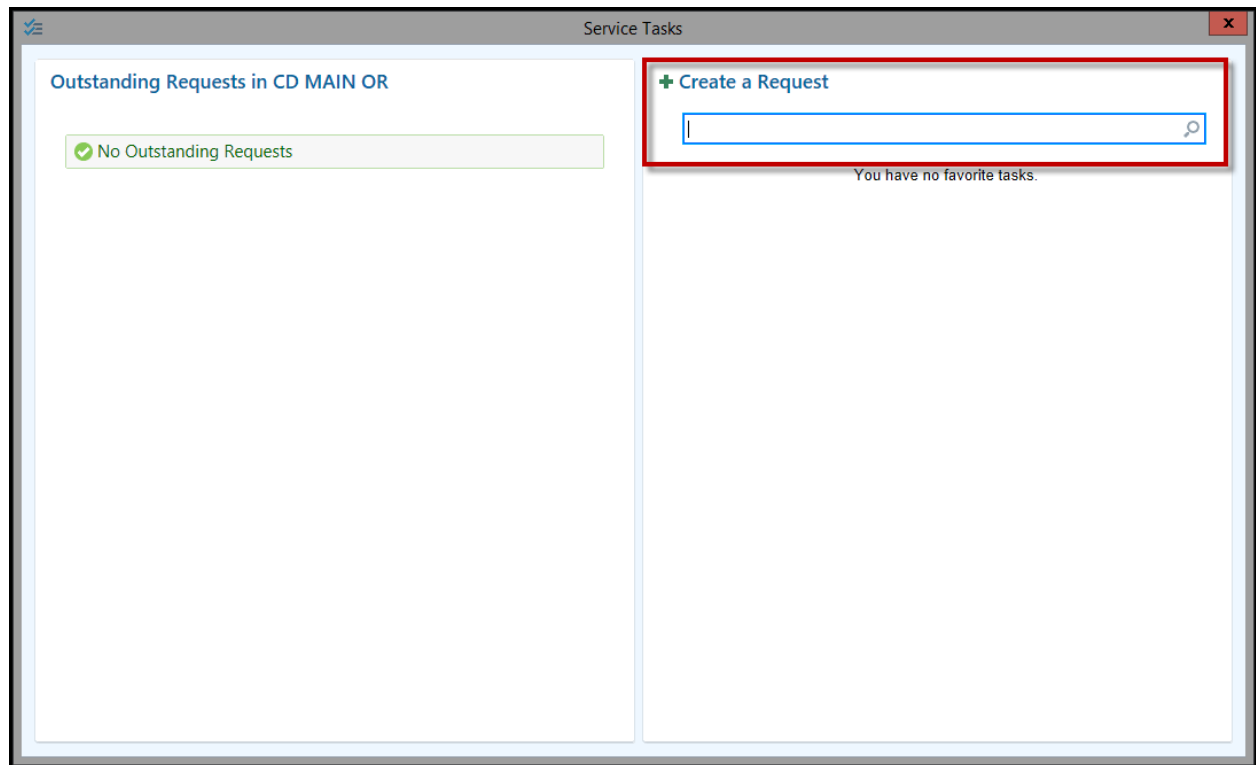


Role	Non-Patient Transport Button Location
Nurses, PSC	Unit Manager toolbar, Patient Lists toolbar
Ancillary Inpatient Staff	UCMC Tools menu
ED Staff	ED Track Board (All Patients) toolbar
OR Nurses	Status Board toolbar, Unit Manager toolbar
L&D Nurses	L&D Manager toolbar
Radiology Staff	Tech Work List toolbar, Front Desk Orders (very top main toolbar)

Service Tasks (Non-Patient Transport)

Requesting a Service Task

1. The Service Tasks window opens. In the **Create a Request** field, select the non-patient item to transport.



2. In the Creating window, enter the following:

- **Start and Finish Locations:** Enter the locations. These may be a unit location or a non-census location, such as a supply room.
- **Priority:** Defaults to "Normal." Adjust as necessary.
- **Phone #:** Enter a contact number or pager.
- **Mode:** Appears when moving people, such as visitors. Select a mode of transport.'
- **Comments:** Type any comments to provide further detail about the request.

Service Tasks (Non-Patient Transport)

* Creating - Cart Return ED

☆ Cart Return ED Change

Start Location

Finish Location

Priority Stat High Normal Low

Completion Time Next 0 minutes

Phone Number

Comments + abc ↶ ↷ ? + Insert SmartText ↶ ↷ More

Transport Job #22791 ✓ Create ✓ Create and Close ✗ Cancel

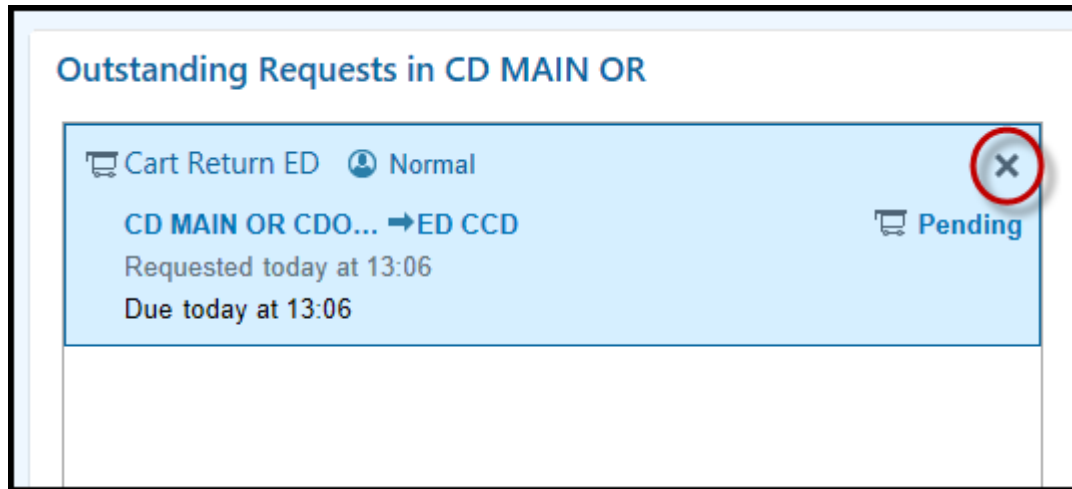
3. Click the **Create** button.

A request is sent to the transport team.

Editing or Canceling a Request

1. On the left side of the Service Tasks window, you can view your Outstanding Requests.
2. Click the X on the transport request to cancel the request

Service Tasks (Non-Patient Transport)



3. To edit the request, click on the request and then edit it on the right side of the window.

