A little book of eCARE for nursing

May 2018

Handy quick reference guides on how to use the system can be found here:

Nursing Topics

- Where to Start?
- Nursing Workflow
- Types of Documentation
- Where can I get help?
- Top Tips
- If something doesn't work……..
- Adult Quick View
- Adult Assessments
- Tasks
- Care Compass
- Icon Glossary

Where to Start?
Entering the system

- Turn the computer on by pressing the sensitive button on the lower aspect of the computer, which is on the right hand side.

- If a blue screen appears and asks for a password type in your network password that you normally use to access a computer.

- Place your smartcard on/in the reader depending on which device you are using.

- Double click on the eCARE icon on the desktop.

- Locate the icon that is relevant to the part of the system that you need to enter (ED First net, Wards/Departments Power chart). Click on the icon to enter the system.

- You will land on the Home page of the system.

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http://digital.mkuh.nhs.uk/info-for-staff/quick-reference-guides/

Where to Start?
First things First…..

In order to interact with patients you need to initially search for a patient in the search button on the tool bar, or if you are working on a ward / department you can set up a patient list and identify which location you are working in.

The advantage of clicking on a patient's record in a location list is that you will always have the right encounter in the system. Once the patient has been transferred or discharged from the list they will no longer show in the list.

If you have searched for the patient, the system will show you the patient's encounters. Please be careful to ensure that you pick the right encounter as recording in inpatient settings and outpatient settings are slightly different.

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Where to Start?
So you have identified a patient

Once you have double clicked on the patient's name in either the search results or on the patient list it will open the patient's record. The action of opening the record will ensure that you establish an electronic relationship with the patient.

If you want to pick a patient from a location list and you have used care compass, whiteboard or doctor's worklist the patient's name may be greyed out. There is a button at the top of the board where it states 'establish relationship'. Here you can select the whole list of patients or you can select individual patients that you may be interacting with. The system will then ask you to identify your role with the patient.

Where to Start?
Initial assessments

In order to get you started on the system a selection of assessments have been automatically triggered. This occurs when the patient registers into ED or alternatively is registered on the system and is admitted onto a ward/department. These can be found in 'Tasks' and under 'Patient Care'.

The assessments are required to be reviewed when the patient has been in the organization for six hours.

Assessments that are triggered on the system are:

- Adult Basic Admission Assessment (incl. Vitals, GCS, Pain assessment)

- Activities of Daily Living (a holistic overview of how the patient is)

- Environmental Assessment (bed space assessment, specialist equipment)

- Safety Assessment (MUST, Waterlow, Falls, Skin Assessments)

All of these can be found in the tasks in the main menu when in the patient's record.

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Nursing Workflow
where do you go next?

Once the initial assessments are completed, the results may trigger alerts if any responses that have been entered require further intervention/review. The alerts pop up on a little window and will suggest :care plans; warnings such as Amber/Red NEWS scores and actions to be taken to escalate and/or will request that you complete a Sepsis Screening Tool if the NEWS score is over 5.

Nursing Workflow assessments can trigger alerts

Care plans can be reviewed in Requests/Care Plans and will be under the suggested care plans - they can be accepted/rejected. If you accept them you will need to review, initiate and sign the documentation.

Vital observations that create NEWS alerts will require the nurse to manage how the patient's care is escalated. It will normally require increased frequency of vitals. This can be ordered in requests/care plans and Quick Orders with the frequency of assessments required applied.

If the Sepsis Screening Tool is initiated this will require documenting as a priority. If the patient is at risk of Sepsis urgent action and escalation is needed. Time is critical.

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Nursing Workflow
Handover, Situation/Background, Assessment and Recommendation

When you have a patients record open, in the menu there is an area called Nurse Workflow. The section is divided into four separate tabs: 1) Handover; 2) Situation/Background; 3) Assessment and 4) Recommendation.

1) Handover is a great tool to give an overview of the patient from presenting complaint, past medical history, medication, labs, vitals and any requests/orders the patient may be waiting for. It also enables smooth shift handover with staff documenting (free text) any specific elements that other nurses / MDT may need to see and obviously acts as a clear audit tool for accountability of care transfer from shift to shift.

2) Situation / Background consists of an area that has a number of squares with information in them. You can find diet, emergency contact and documents in here. This area can be edited for your personal preference; so if vitals is your main focus when looking after the patient and you like to see that first, you can colour the square and drag and drop the square to the top of the screen if required (you can do that by using the three lines and the arrow, which will allow you to adapt the page as you so wish).

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Nursing Workflow
Handover, Situation / Background, Assessment and Recommendation

Continued…

3) Assessment tab is where you will find all documents, medication list, labs and any diagnostics the patient may have undergone.

4) Recommendation tab is where you will find plans of care, education and the discharge plan.

Types of Nursing Documentation: Clinical Note
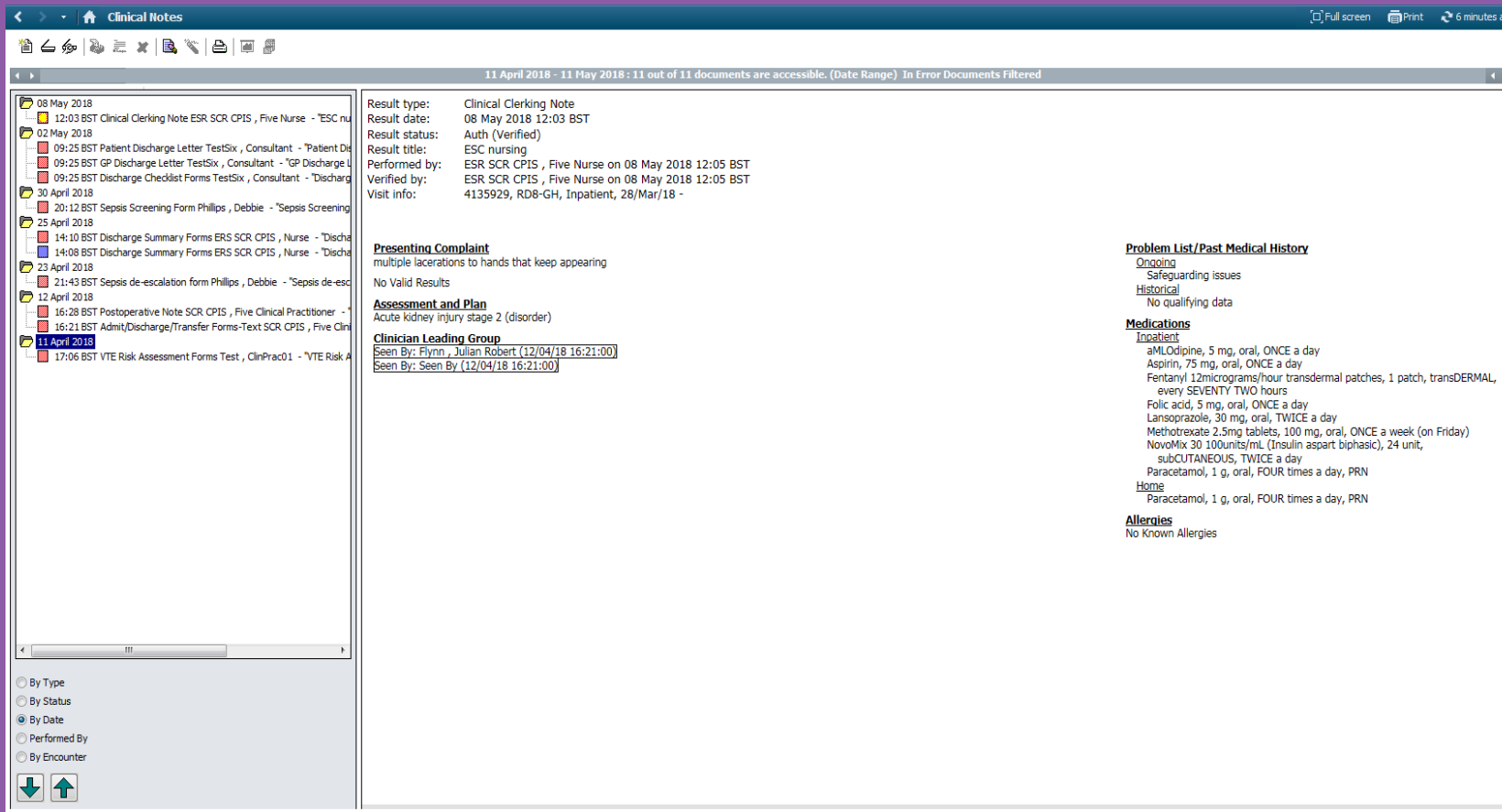
Purpose: for clinical staff to view patient care notes

Displays: All power forms, Clinical notes and documentation does not include iView documentation

Types of Nursing Documentation: Documents
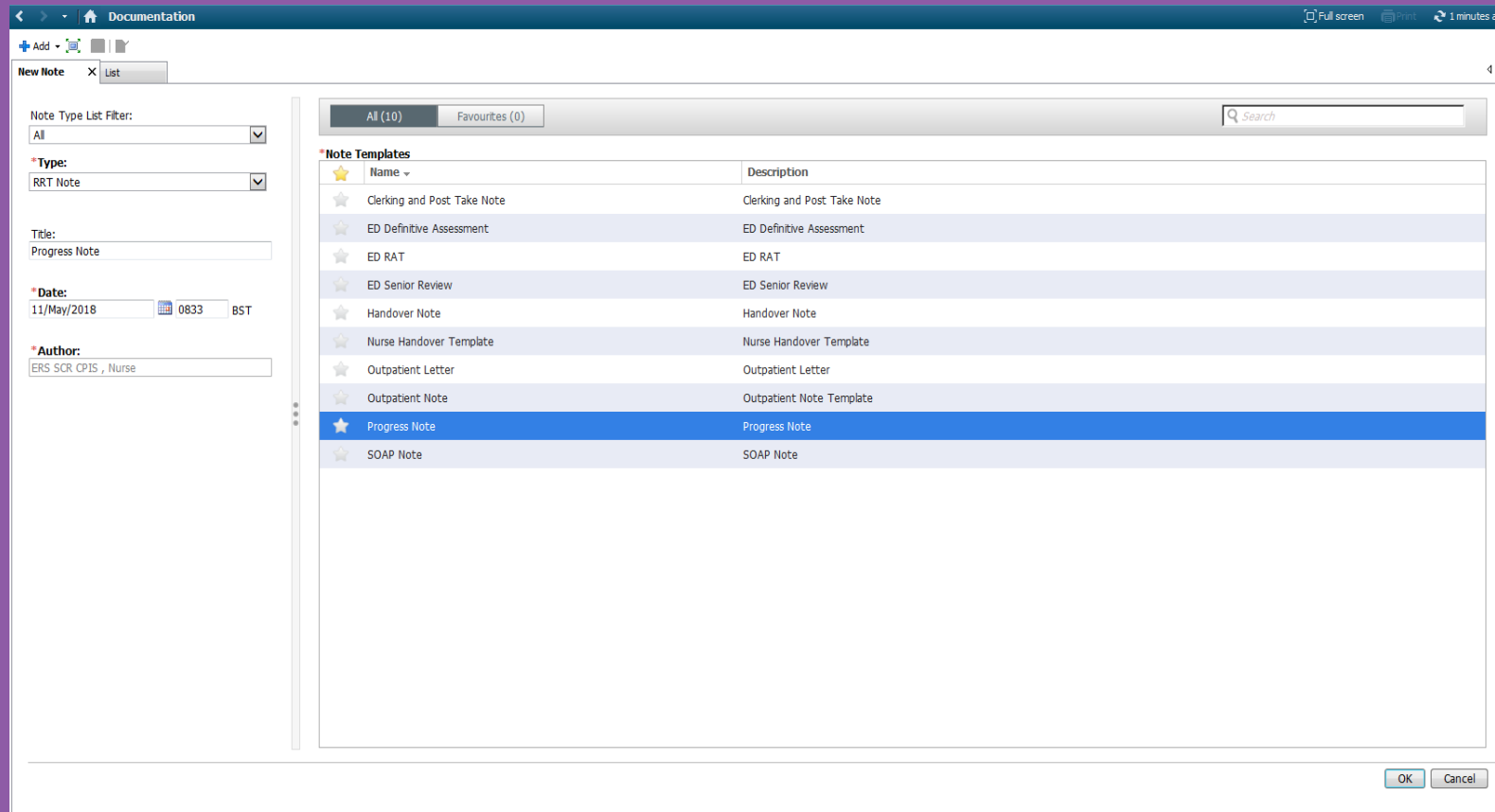
- **Purpose:** to create templated documents that draw information from the system

- **Displays:** Documentation - some power forms are not visible in documentation and can be found in forms or clinical note

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Where can I get help (digital)

- eCoach - when you are in the eCARE system there is a button called eCoach on the toolbar

- Microsite - Digital.mkuh.nhs.uk is the Trust's eCARE microsite. When you enter the site and select 'Info for staff' there are all sorts of things that will help you such as Quick Reference Guides, Videos and frequently asked questions (FAQs)

- IT - the team staff a helpdesk and are available on 87000. They will take calls on any issues to do with logging on, role issues, eCARE system issues and, of course, anything wrong with the computer itself.

- Intranet - eCARE has it's own section on the Intranet full of useful information. This compliments the information available on the microsite Digitial.mkuh.nhs.uk

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Where can I get help (human)

- Masterclasses - after Go Live the eCARE project team will set up a series of masterclasses for those staff that want refreshers or feel that certain processes are taking them too long. Once the system has been live for six weeks Cerner work in collaboration with the Trust and send in a small team of coaching assistants who can ensure that they coach at a local level or share best practice with individuals who may want to know a more efficient way of doing things.

- Training - there will be ongoing training made available to all new staff and staff returning from periods of extended leave. This will be advertised on the intranet.

- Superusers - in each ward or department Superusers have been identified to ensure there is someone around on each shift to provide at the elbow support for staff. The Superusers will also know how to escalate any concerns and who best to contact for any particular issues.

- eCARE Buddies – the buddies are staff that have had additional awareness and training on the system or will have had involvement in the build and design of the software.

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What happens if something doesn't work?

- **Escalate, escalate, escalate…..**

- If you think that there is something in the system that isn't working as easily as you think it should or if you are clicking on something and nothing is happening then please let IT helpdesk know on ext:87000

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Adult Quick View

Purpose: Adult Quick View should have all the assessments that you may perhaps find at the end of the bed.

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Adult Assessments

Purpose: All other assessments that are on the system should be found in here. If you can't find anything in this section please refer to your folder and review the start, stop, continue as to whether the assessment is still on paper.

Tasks

Purpose: these can be reached in various ways in the system but one of the easiest ways is to go into the Task list itself from the Menu section. You can change the order of these by clicking in the column header so you could move the most recent to the top if you clicked on Scheduled Date and Time.

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http://digital.mkuh.nhs.uk/info-for-staff/quick-reference-guides/
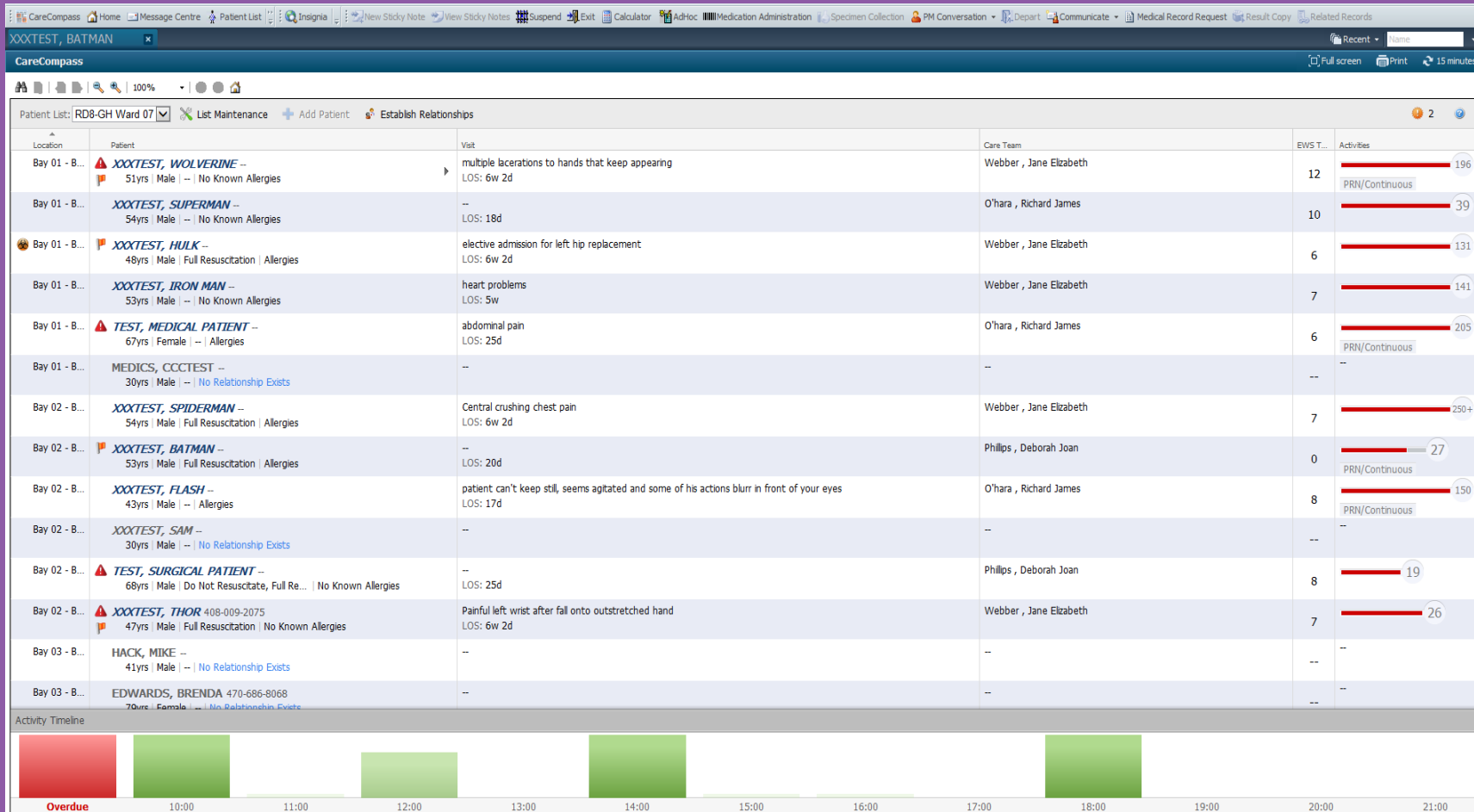
Care Compass

Purpose: The care compass will probably be a nurse's most regular port of call to see patients and look at activities. You can access tasks, patient visit details and it allows you to have an overview of all your allocated patients at any one time.

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Icon Glossary

Navigation Toolbar

Button	Action
	Home. Takes you to the Home view. By default, the Home view includes the Inbox Summary and Schedule, however, this view can be customized by your systems administrator to suit your facility's needs.
	Schedule. Opens the Schedule workspace. The Schedule allows you to see your schedule and those of others, in daily, weekly, and monthly views.
	Patient Chart. Opens the Patient list. The Patient list is a listing of all individuals that have a chart in the system.
	Message Center. Opens Message Center. Message Center allows you to quickly view and sign Results, Documents, Messages, and Orders. Through it, you can communicate with other clinicians.

Icon Glossary

Patient Context Toolbar

| Button	Action
BettyClark ✕	**<patient>** Indicates which patient's chart is currently active.
	Recent Patients. Allows you to open the chart of a patient that you recently viewed.
	Patient Search. Allows you to search for a patient's chart by patient name or Medical Record Number (MRN).
	As of. Tells you the last time the data on the display was refreshed. Click to perform a manual refresh.
	Previous Patient's Chart. Opens the chart of the patient listed just before the current patient.
	Next Patient's Chart. Opens the chart of the patient listed just after the current patient.

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Icon Glossary

Flowsheet Toolbar

Besides the general patient chart toolbar, the Flowsheet has a special toolbar that enables you to perform specific tasks quickly. A description of the buttons and their actions follows:

Button	Action
Graph	Generates a graph illustrating the selected data categories. See Graphing a Patient's Test Results
Seeker	Opens the Seeker to allow you to focus on an area of the flowsheet that contains results. Critical result values are represented in red. Areas of intense result activity are displayed with a wide bar; individual results are displayed as a line.
Sign	Allows you to sign all discrete results you have ordered but have not yet signed. Only the results in view on the screen are endorsed.
Bookmark	Marks all new results values as reviewed (read). If you have selected a font color for new results, this changes all the new results colored values to the default text color. Critical values retain their special color.
Sign Charting	Saves and signs any charting you have entered on a custom or activity flowsheet.
Cancel Charting	Cancels the charting session without saving any data.

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Icon Glossary

PowerNote Toolbar

	Open an Existing Note. Lets you select an encounter pathway, and open encounter and pre-completed notes. The Open Note dialog box opens.
	Save. Saves your work.
	Sign. Lets you sign the current encounter note. The Sign Note dialog box opens.
	Cut. Reserved for future use.
	Copy. Places a copy of the selected text onto the clipboard.
	Paste. Copies the text from the clipboard.
	Find the Specified Term. Lets you search for specific text. The Find dialog box opens.
	Print. Opens the print dialog box for your printer.
	Find Previous Recommended Term. Locates the next recommended term (indicated by blue text).
	Find Next Recommended Term. Locates the previous recommended term (indicated by blue text).

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Numbers to help you

- Superuser
(insert the number of your local Superuser here)

……………………………………..

- IT helpdesk

  ext: 87000

A little ebook of eCARE Nursing

Compiled by Sharon Webb, Chief Nursing Information Officer - May 2018

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