Paperlite for critical care
Reference Guide
INDEX

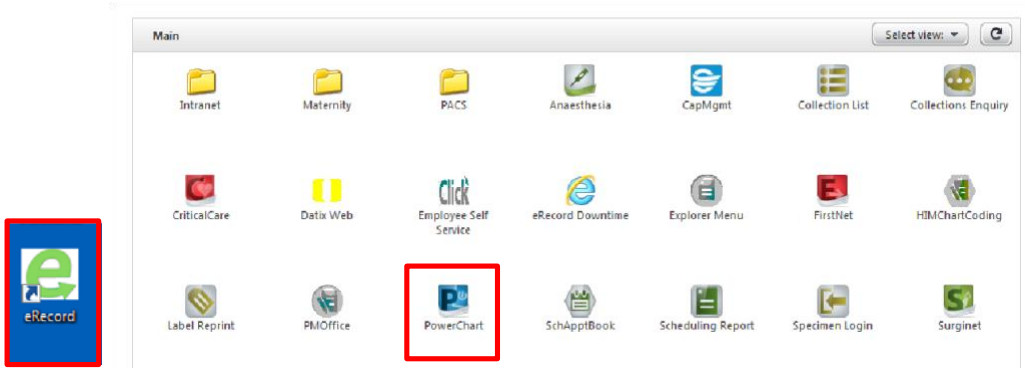
INTRODUCTION

The Trust Homepage has a direct link to Paperlite. This has resources such as PDF files etc for the Doctors handbook referenced below, links to YouTube videos etc.

The ICCU Patient short list has several dummy patients you can use to explore and test the contents of this guide. Please don't use actual patient notes to experiment with.

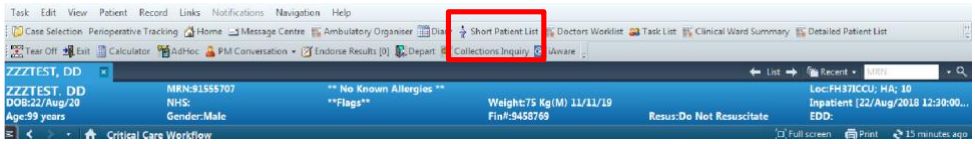
ORIENTATION

For access: E - Record -> Powerchart



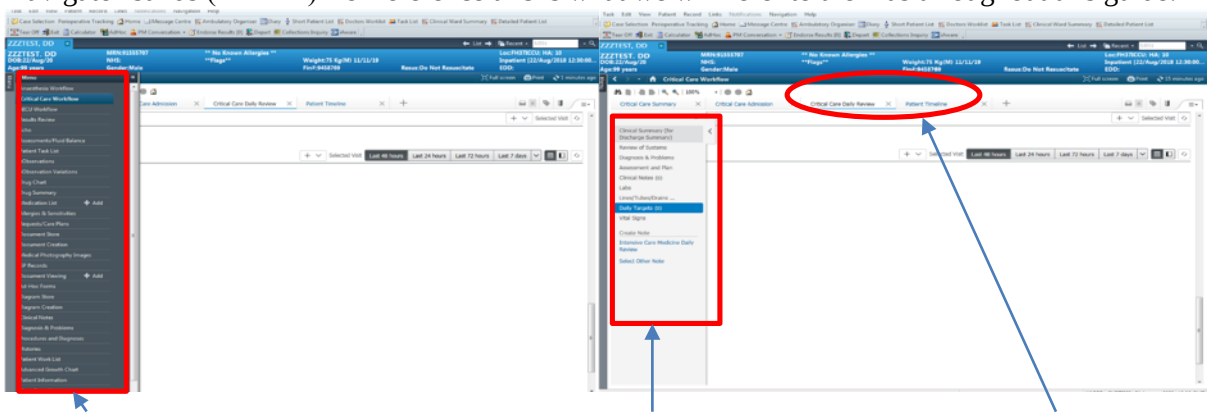
Short patient list

"Short patient list" should be your default, if it's not you can just click on short patient list.



You can find details of how to set up on page 7 of the Doctor e-record Pocket Guide "short patient list set up"

Navigator bands ("menu")- for reference this is what we will refer to them as throughout this guide:



Dark Grey Navigator Bands (main menu)

Light Grey Navigator Bands (menu in relation to the area you are in)

Tabs

How to personalise display

Within the pocket guide:

P12 “setting up navigator bands”

P16 “work flow set up”- can rearrange to your desired order. Instead of clinician workflow select critical care workflow.

P16 “personal note type list”- we use Intensive care Medicine list types.

Suggest you have:

- Intensive Care Medicine Admission Note
- Intensive Care Medicine Ward Round Note
- Intensive Care Medicine Progress note

Note all other notes can still be accessed (can click to see “all” rather than personal note types) but these will be the ones used most commonly.

HOW DO I? DAY TO DAY ADMIN

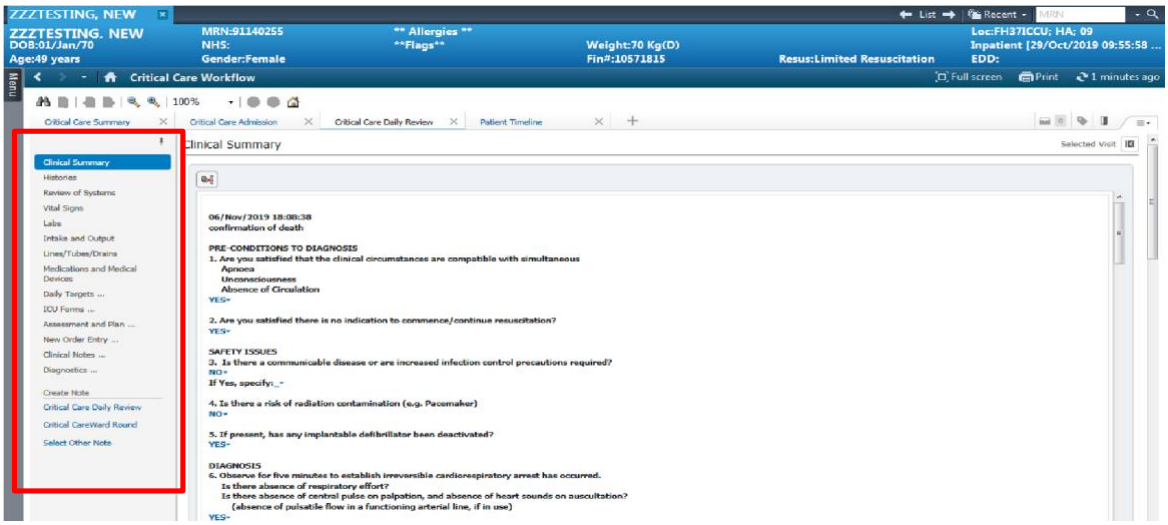
A note on admin: Paperlite offers multiple ways to record clinical notes. It also imports information from multiple documents and sources. An advantage is easy access to disparate information but the disadvantage is that notes can become a mass of almost identical text- this can make important data easy to miss.

In ICCU we have an agreed compromise to maintain a standard approach for clarity. These are not absolutes, but provide a guide to expectations for note keeping.

1) Do a daily review

Access correct patient-> Dark grey navigator band “critical care workflow” → light grey tab “Critical care daily review”

Light grey navigator bands are shortcuts to parts of the daily review.



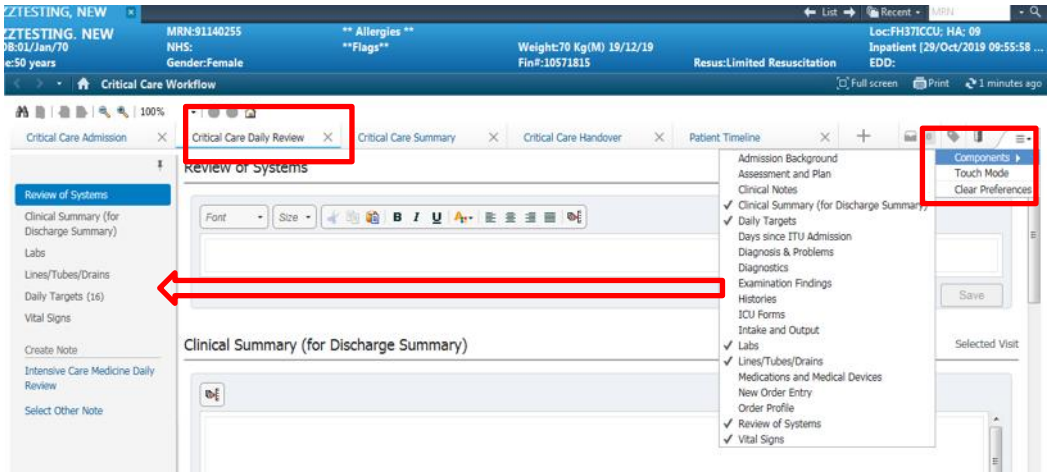
You can customise what comes up in your daily review by following instructions in the pocket guide P12 “workflow set up”:

Suggested that you should have:

- Clinical summary
- Review of systems

Also useful are Labs/ Lines/ Daily targets/ Vital signs

Once you have selected the components you wish to have on daily review, you can order them on the light grey navigator band, by clicking and dragging.



It is suggested you have the agreed components above in that order.

1a Clinical summary

This should automatically pull through from the admission document, and for some patients this may be enough (i.e. overnight stays).

For long stay patients may occasionally need updating with appropriate updates, but please don't delete original work. You could organise clinical summary by "**Admission history**" followed by "**Key events**" to remind people to keep this updated!

1b Review of systems

Where you write your daily review (ABCDE).

As noted above the ICCU team have agreed that we will maintain a "standard" approach for clarity of information that is required. In some cases more detail may be required – for example if patient needs a full neuro exam- this can be added in if needed.

The standard agreed upon can be seen in appendices at the end of this document and should be forwarded to you so you can copy and paste it into an autotext. It is also saved under test patient **ZZZTest.DD** in document viewing under Daily ICU and Admission ICU**.** For further details re autotext see P17 Pocket Guide "create autotext"

The document is "Daily review B1a".

The auto text for daily review should be labelled **@Daily_ICU**.

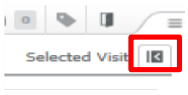
This can then be used as a baseline of the standard expected.

You can use the autotext in review of systems to complete most documentation including plan.

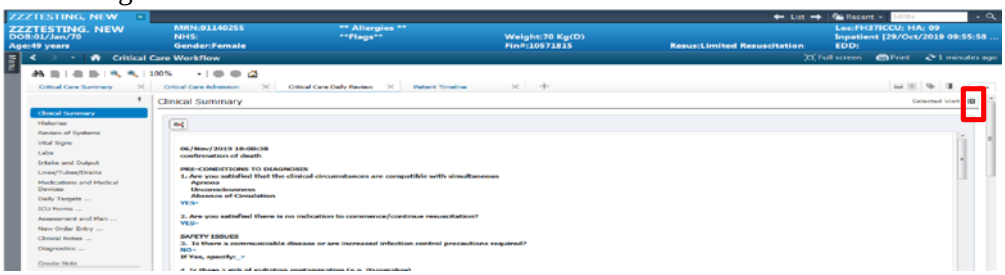
Splitting screens

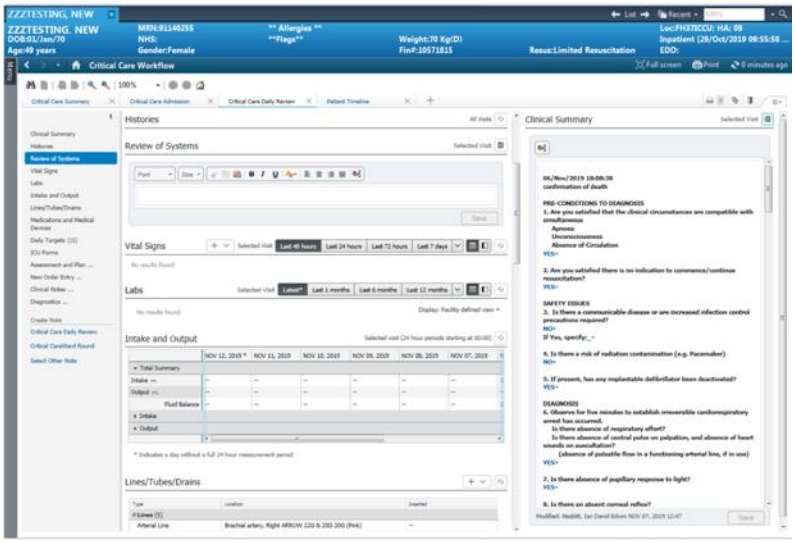
You can split the screen so you can dual view labs/lines etc whilst writing review of systems for example.

Zoom out screen (Ctl+ scroll out or navigation tab, zoom) until you see this icon next to the components, just right of "Selected Text" (Clicking this again, or CTRL-scroll out will return to a single column view)



Then click that icon next to Review of systems/ Clinical summary (or whatever you choose) to move it to the right hand side.

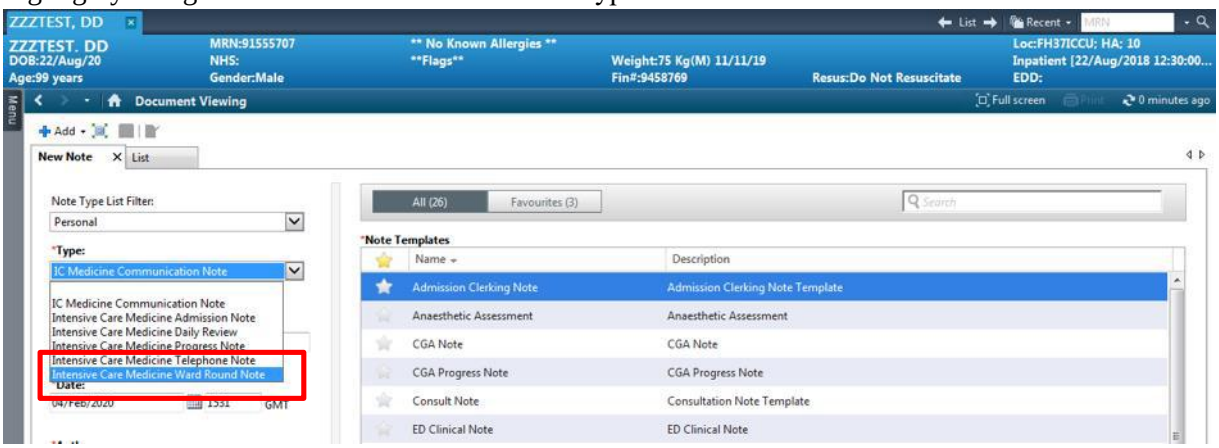




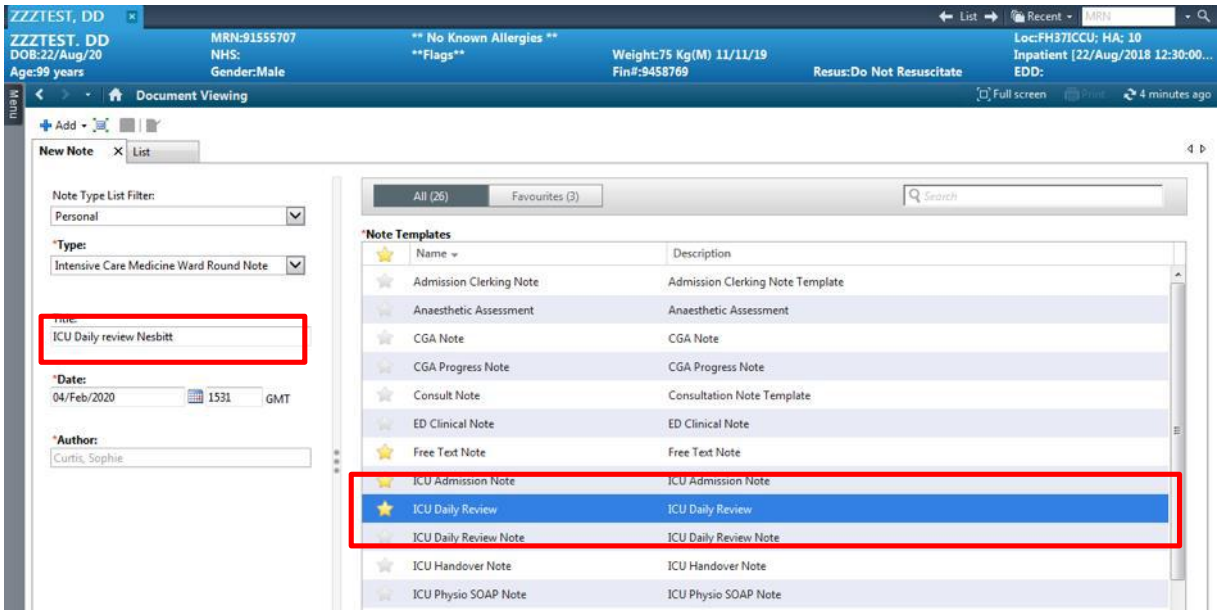
You can then scroll independently left and right side of the screen, allowing you to check some items whilst simultaneously writing.

Saving or submitting

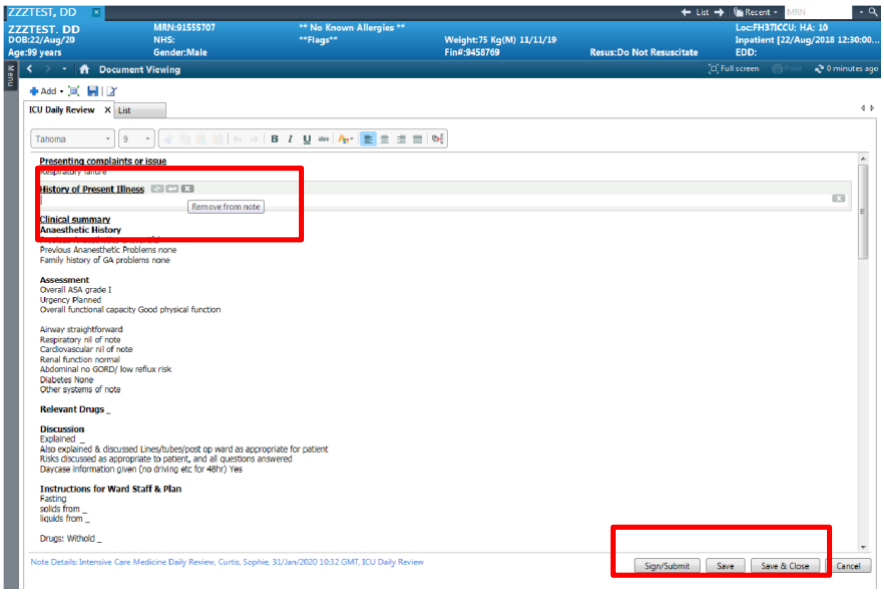
Light grey navigator tab→ "select other note" →Type "Intensive care Medicine ward round note"



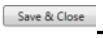
Make sure it is titled something appropriate i.e. “ICU Daily review Nesbitt” and use the template ICU Daily Review.



A summary view will come up, you can use this to review or add/edit your daily summary. You can also “tidy up” the summary by getting rid of extra parts if they are not of relevance (i.e. History of present illness/nursing narrative/examination findings/family communication/days since ICU admission/resus details/ procedures) by clicking the X button that comes up when you hover over that part.



To complete for consultant to see and review (default):

SAVE & CLOSE  → again make sure the <u>type is set to intensive care medicine ward round note</u> and make sure the title is something appropriate i.e. ICU Daily review Nesbitt.

To complete and submit if a consultant is not going to be reviewing (rare!)

SIGN/ SUBMIT  → follow as per above re setting the type and title.

If you accidently sign and submit, the consultant may add their notes as an addendum (but this is harder to see/search for in retrospect. They may choose to add a separate progress note -which will be unlinked to your note).

<u>An alternative..</u>

You can opt to create a note before completing daily review (essentially bypasses work done in workflow, which for some people can be quicker but will mean that data added i.e. in clinical summary will not be pulled through for others therefore this will have to be updated and saved separately).

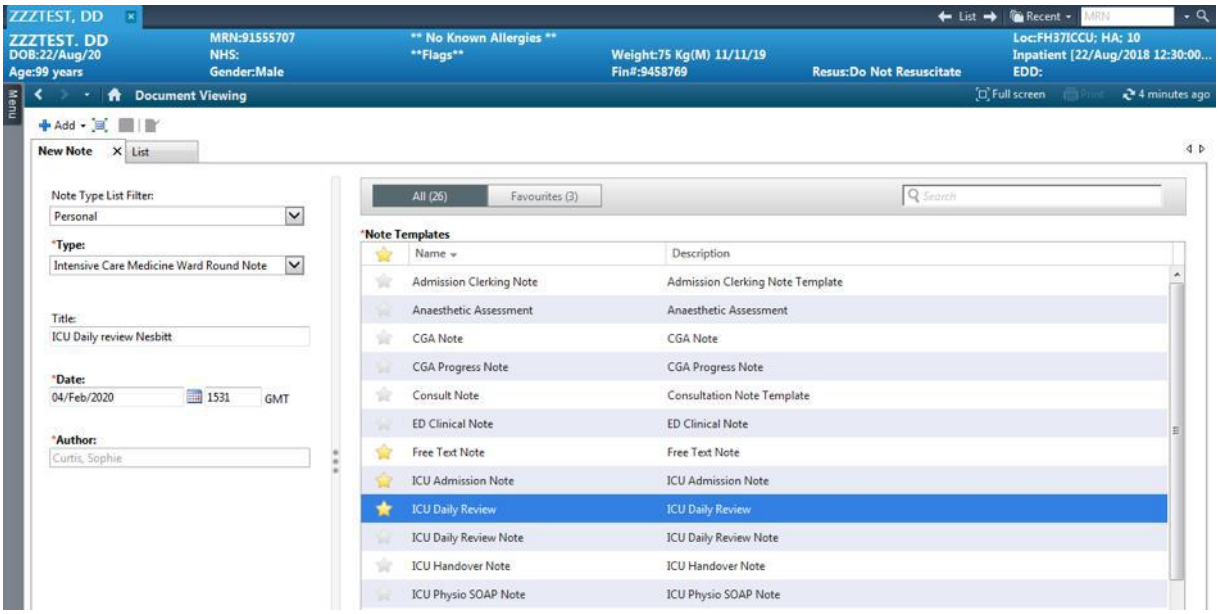
Critical care workflow→ Critical care daily review tab → Light grey navigator band " select other note"

As above:

Type - "Intensive Care Medicine Ward round note"

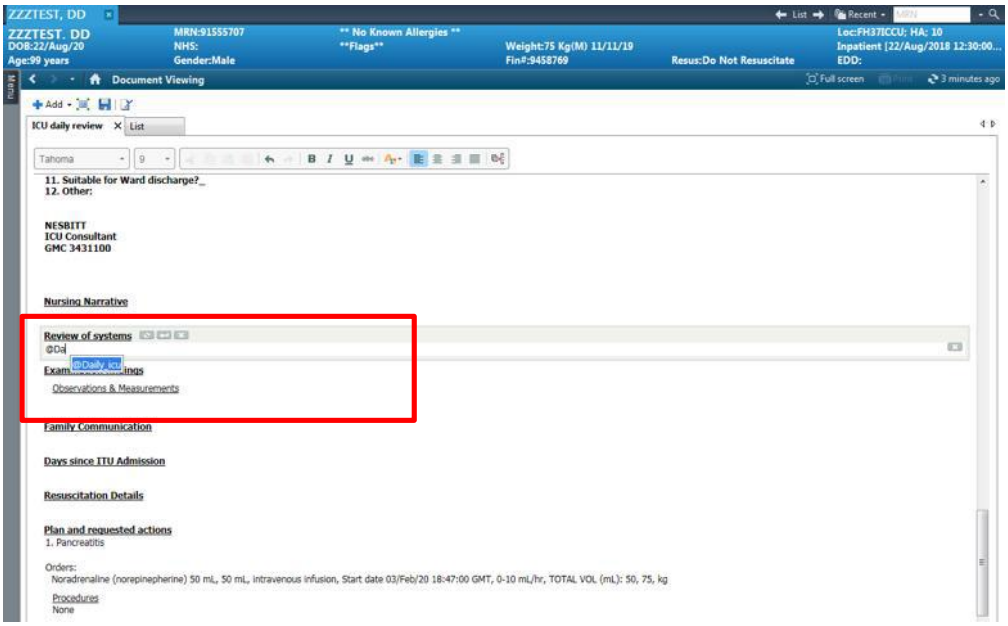
Title- something appropriate i.e. ICU Daily review Nesbitt

Note template – ICU Daily Review



→Click "Ok"

You can then complete the sections required, and "tidy up" the sections not required as described above. Autotext will still work in this setting.



You can then save and close or Sign and submit.

2) Do an admission

This is similar to the above and can be done by the standard or alternative way. You access via Critical care work flow→ Critical care admission tab.

You should have

- Reason for admission (short reason i.e. Type 1 respiratory failure)
- Clinical summary
- Review of systems

The standard that has been agreed to be in review of systems is "admission A3a" in the appendix.

The autotext should be labelled as **"@admission_ICU"**

Again please "tidy up" (X) any unnecessary extra information (Examination findings/safety alerts/social context/procedures).

Save or submit?

Can save and close if consultant will be reviewing patient soon. If not sign and submit and they will add a note i.e. if late/overnight.

Drugs for admission

Please prescribe all patients regular meds and suspend them (if appropriate).

ICU quick pick/ ICU admission/ ICU infusions if helpful for quickly prescribing ICU medications.

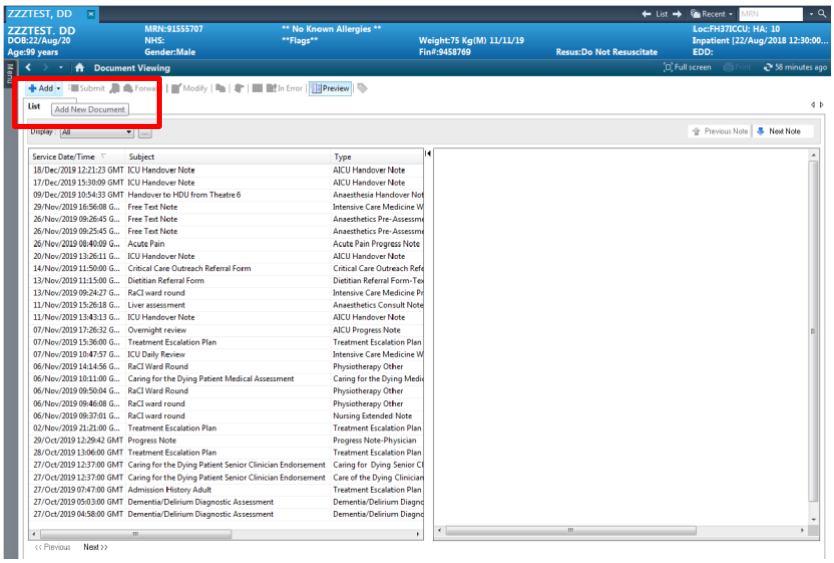
P18 – Pocket Guide "Order and prescription favourites"

3) Write a review for ward/ progress note

This is useful for conversations with other teams/ updates about patients/ cardiac arrests/ discussion with relatives as well as reviews when you see patients on the ward.

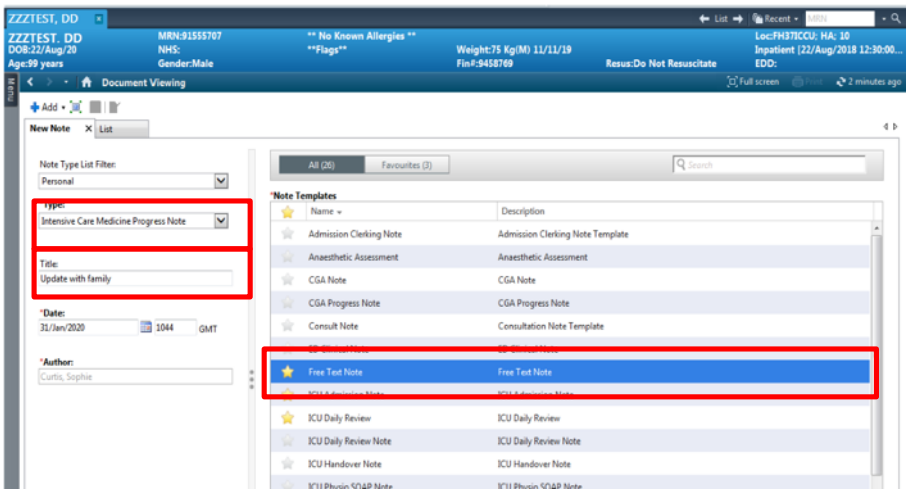
Dark grey navigator tab→ document viewing

Click→ +Add

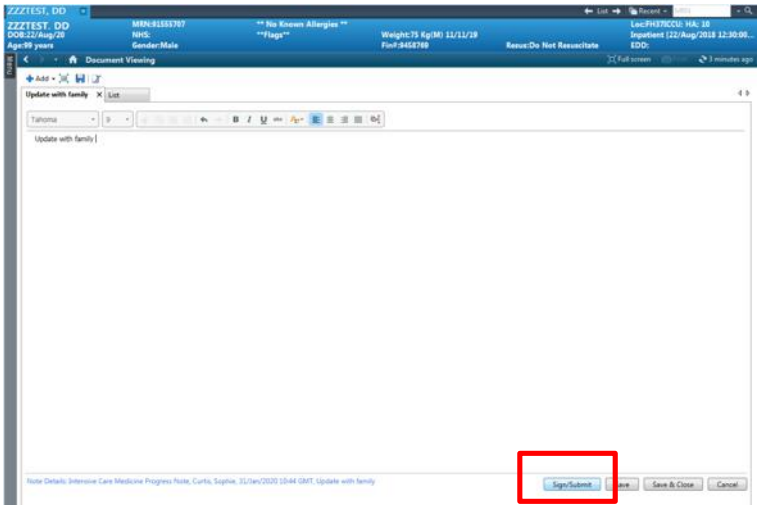


Choose type as intensive care medicine progress note:

Then Title it something appropriate. You can choose the template which will determine what prefilled boxes come up.
In general, free text is useful for this.

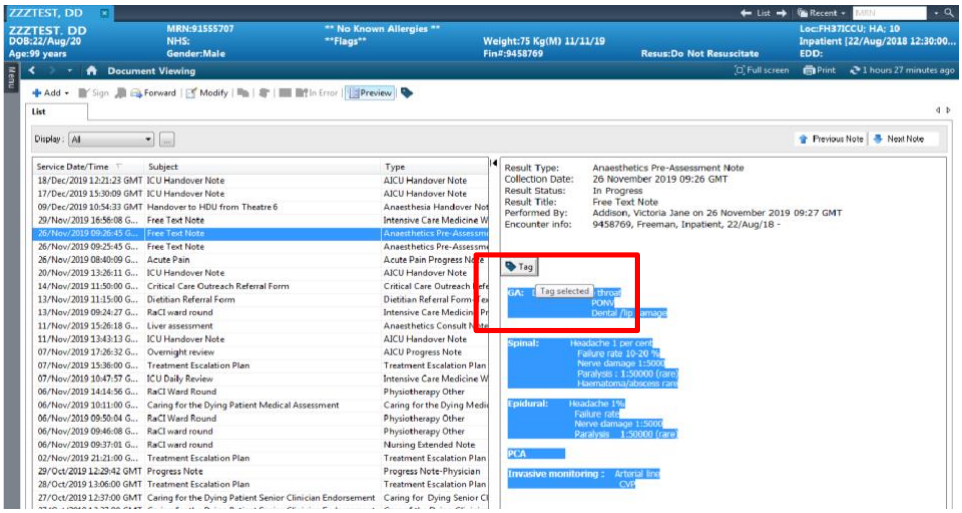


You should put who you are at the end of the document (P17 “create autotext” for signature). When you have completed you can sign and submit the document.

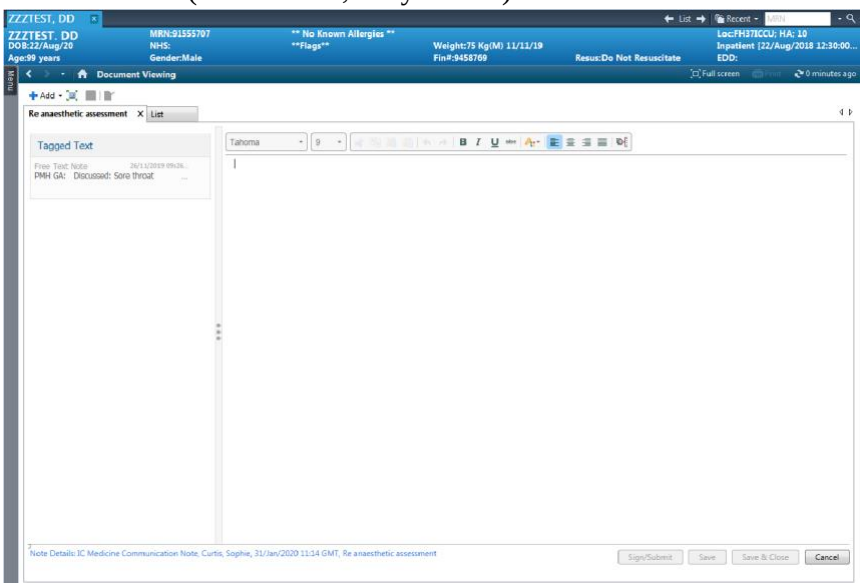


4) Tag and transfer data

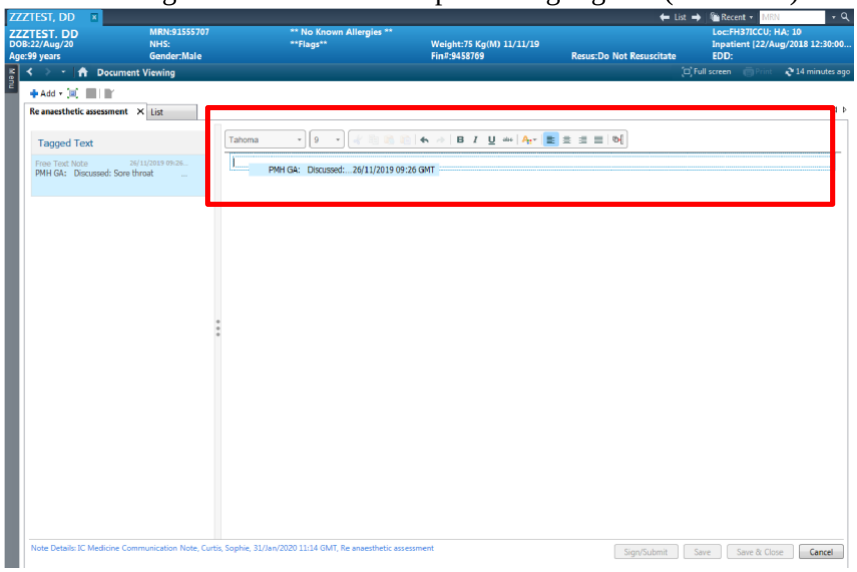
Highlight data that you want, a button will come up saying TAG- click this



It will come up on the left side of the screen when you are somewhere within workflow that you can transfer data to (i.e. text note, daily review)



Click and drag over- make sure the space is highlighted (see below)



Particularly useful for radiology reports that should (but don't always) automatically come through to document viewing.

5) Make and manage auto texts

P17 Pocket Guide "Create autotext"

As noted above ICCU have agree that will have an auto text for @daily_ICU and @admission_ICU – It is also suggested you have one for your "signature" @signature (your name and contact details)

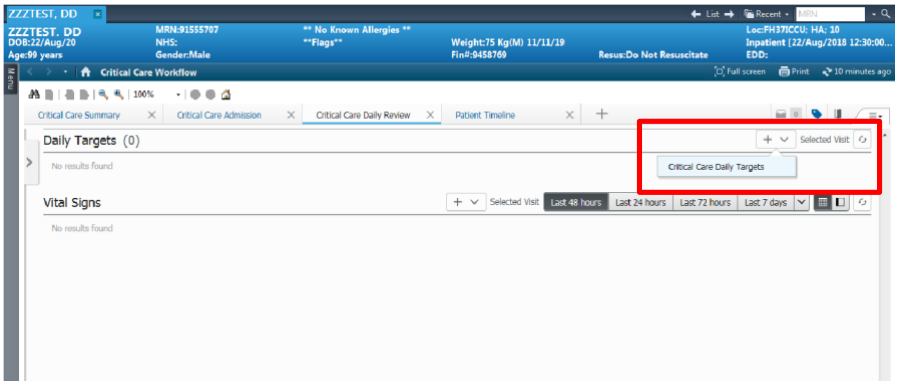
You can also make an auto-text for anything that makes your life easier.

6) <u>Write Treatment Escalation Plan (TEP) and Write a DNACPR</u>
P22 Pocket Guide "Modify Resuscitation Status"

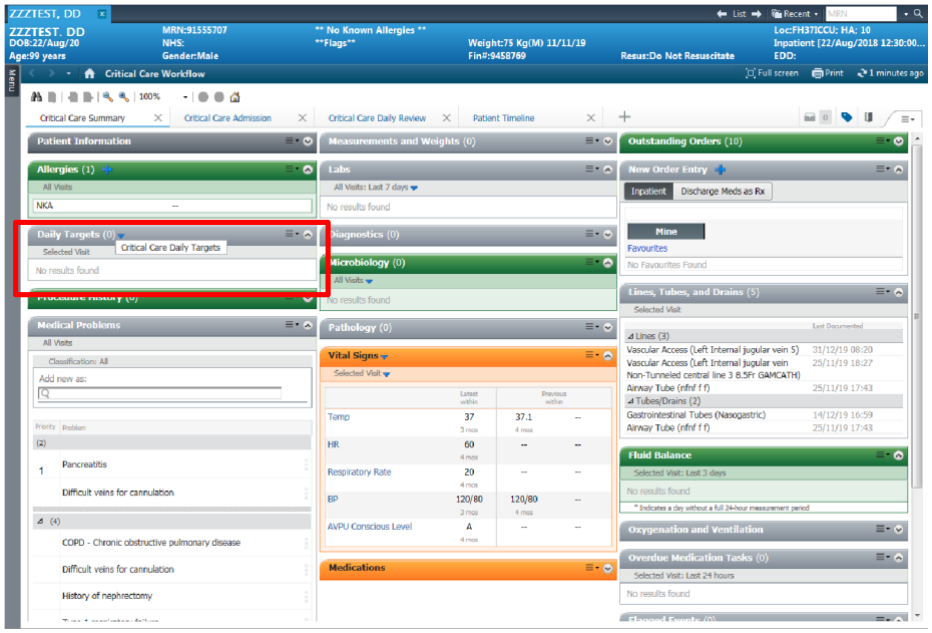
Please also write a progress note regarding discussions that have taken place in relation to this.

7) <u>Do ICU daily targets</u>

The quickest way to add daily targets during your daily review/ admission is on the light grey navigator band "daily targets"

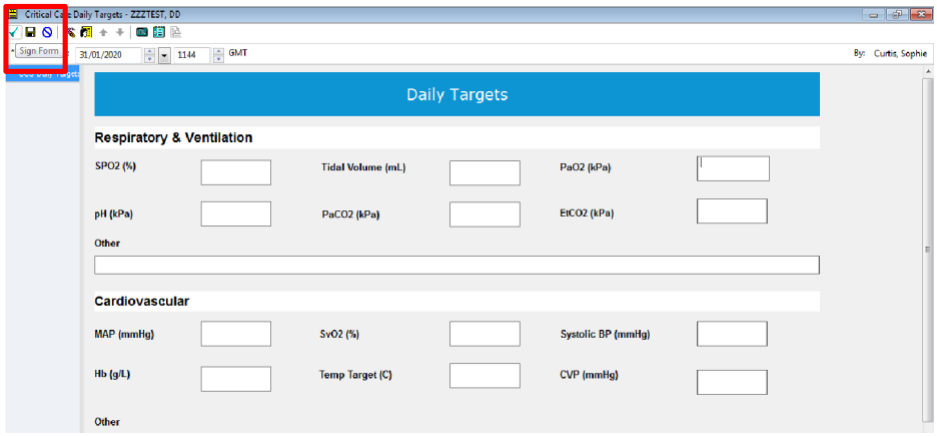


Alternatively, on critical care workflow→ Critical care summary tab→Daily targets→ Click on arrow next to daily target→ Click on box that comes up "Critical Care Daily Targets"



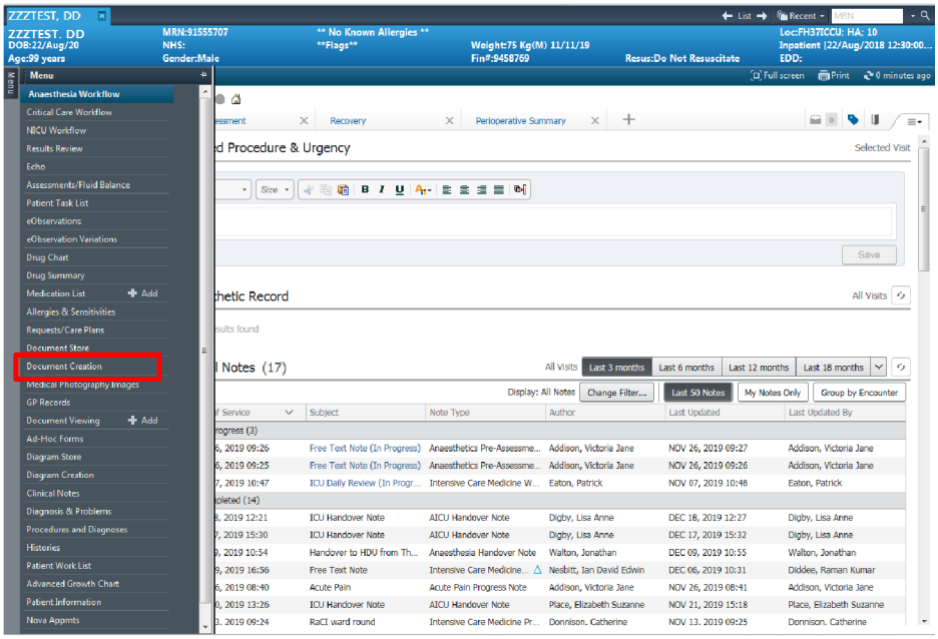
It will then bring up the box below, which you can fill in targets (they don't all have to be filled).

When you are finished click the green arrow to sign the form. Please also tell the nurse looking after patient.



8) Do discharge to ward letter

On dark grey navigator bands →document creation



After a few seconds a box will come up as below

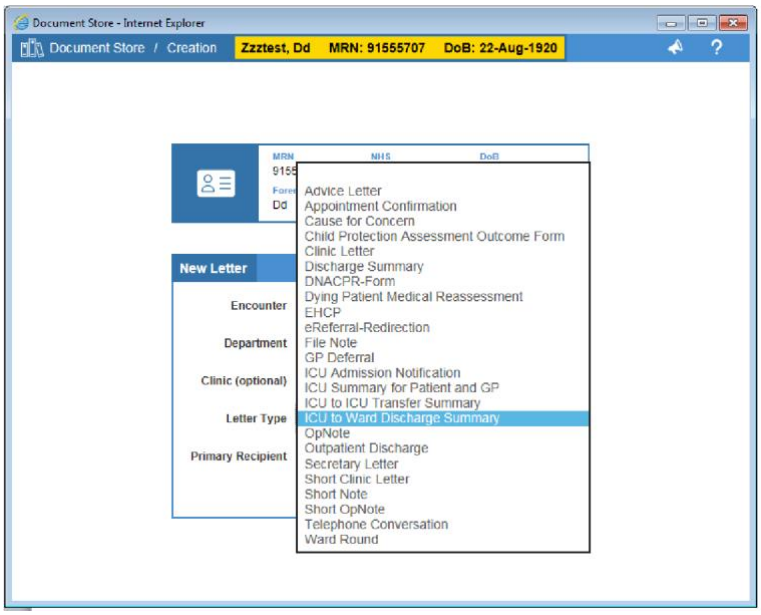
Encounter: Make sure have the correct visit "encounter"- it will be listed under the parent specialty i.e. general surgery.

Department: should be changed to intensive care medicine

Clinic: can click Freeman but not strictly a clinic letter so can leave blank

Letter type: ICU to Ward Discharge summary

Primary recipient: Other, unless you want letter to go to GP

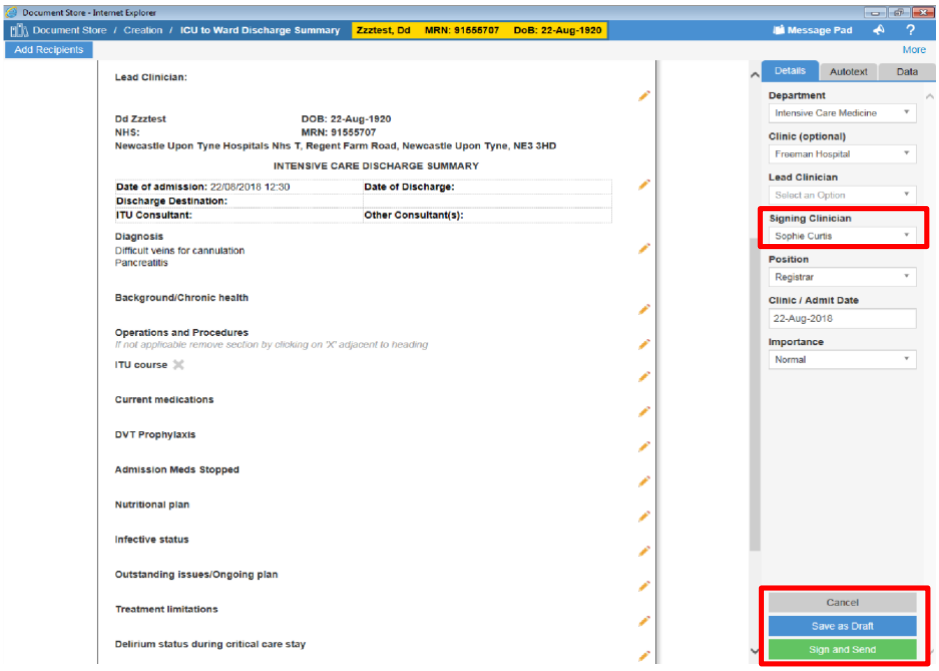


Then complete the letter parts. If one of the titles is not relevant then you can cancel it by X sign.

You should put on who you have handed over to and ideally which ward they are discharged to.

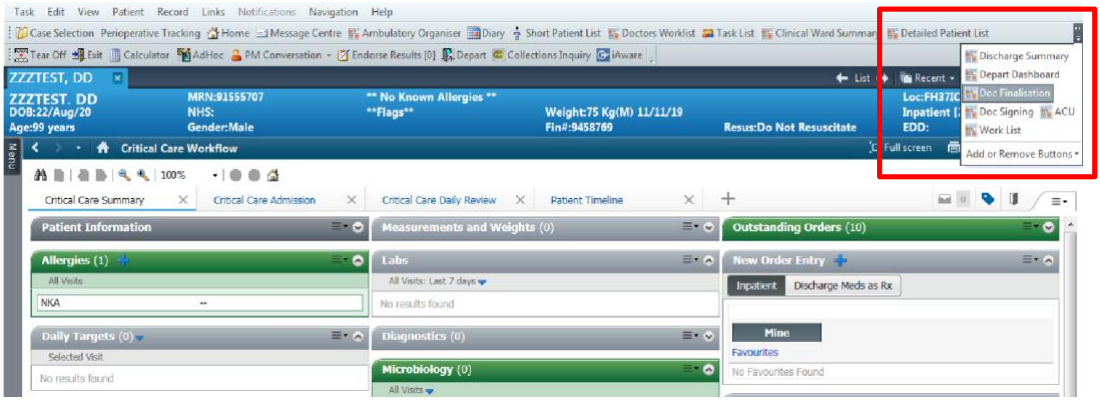
Lead clinician – ICU consultant who has reviewed them pre-discharge.

<u>You</u> are the signing clinician. If your name is not listed you need to call IT to make sure you have the correct privileges.

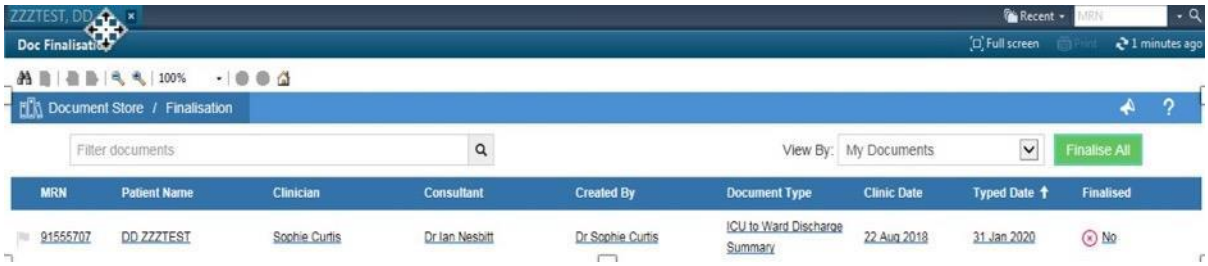


You can then "sign and send" (complete) the document or "save as draft" for later editing.

You can access later for editing on the top bar "doc finalisation"



A list of letters for finalisation will come up as below. You can click on the appropriate letter for editing.

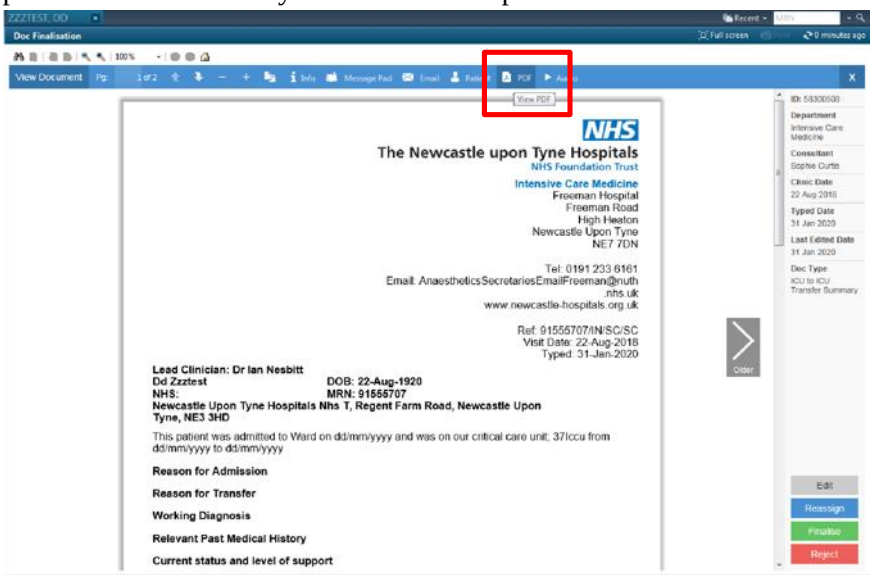


You can then edit/ finalise/ reject/or re-assign the document.

9) <u>Do discharge letter to another hospital or transfer letter</u>

As above but instead of ICU to ward discharge summary you select ICU to ICU transfer summary.

When the document is finalised, if you view it "PDF" will be an option on the top tab, allowing you to print it and take it with you to the next hospital.

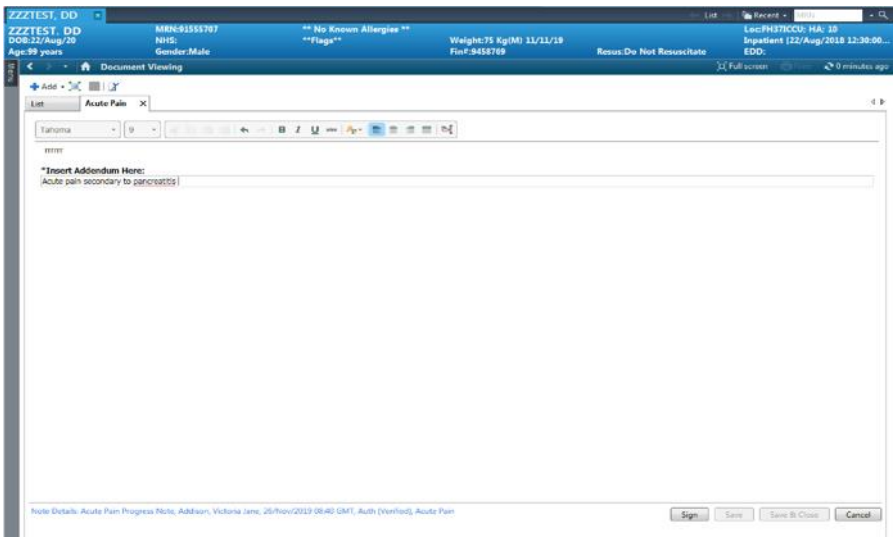


10) Add information to any document

If you have signed and submitted a document you cannot edit it, but you can add an addendum to it. The consultants will sometimes use this function to note any changes/agreement with the note.

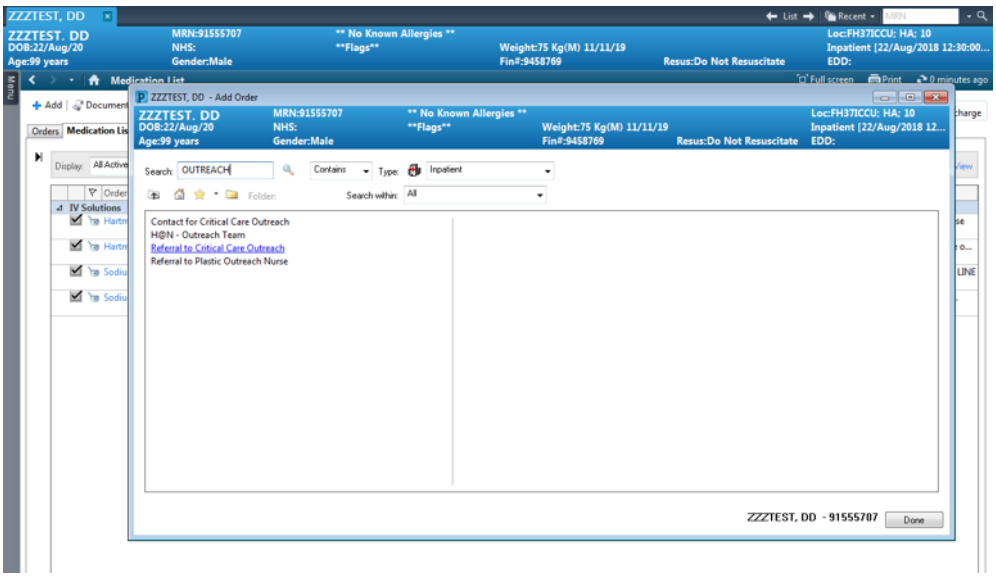
Please be wary of adding addendums at a later date/time and do not add notes to other people's documents as they may be missed. Add a progress note instead.

Dark grey navigator→ document viewing → double click onto appropriate document. It will come up as the below to add an addendum and then you can sign.



11) Refer to outreach

You can add a referral to outreach on the system as you would do with a prescription or order for a scan.



Nurses will do this for you before patient goes to the ward (as long as you tell them you want them referred to outreach!). If you are referring on the ward after reviewing patient, you should also call the outreach team (unless already be involved).

HOW DO I? DEVICES

12) Record lines and devices

P14 Pocket Guide "inserting lines and devices"

13) Record NG insertion

P14 Pocket Guide "inserting lines and devices"

Please note that NGs and CVCs have to be signed off as safe to use by you (on paperlite) before the nurses can use them. You should tell them they are safe to use verbally but they must be signed off (much like written charts were). If it is the end of your shift please hand it over!

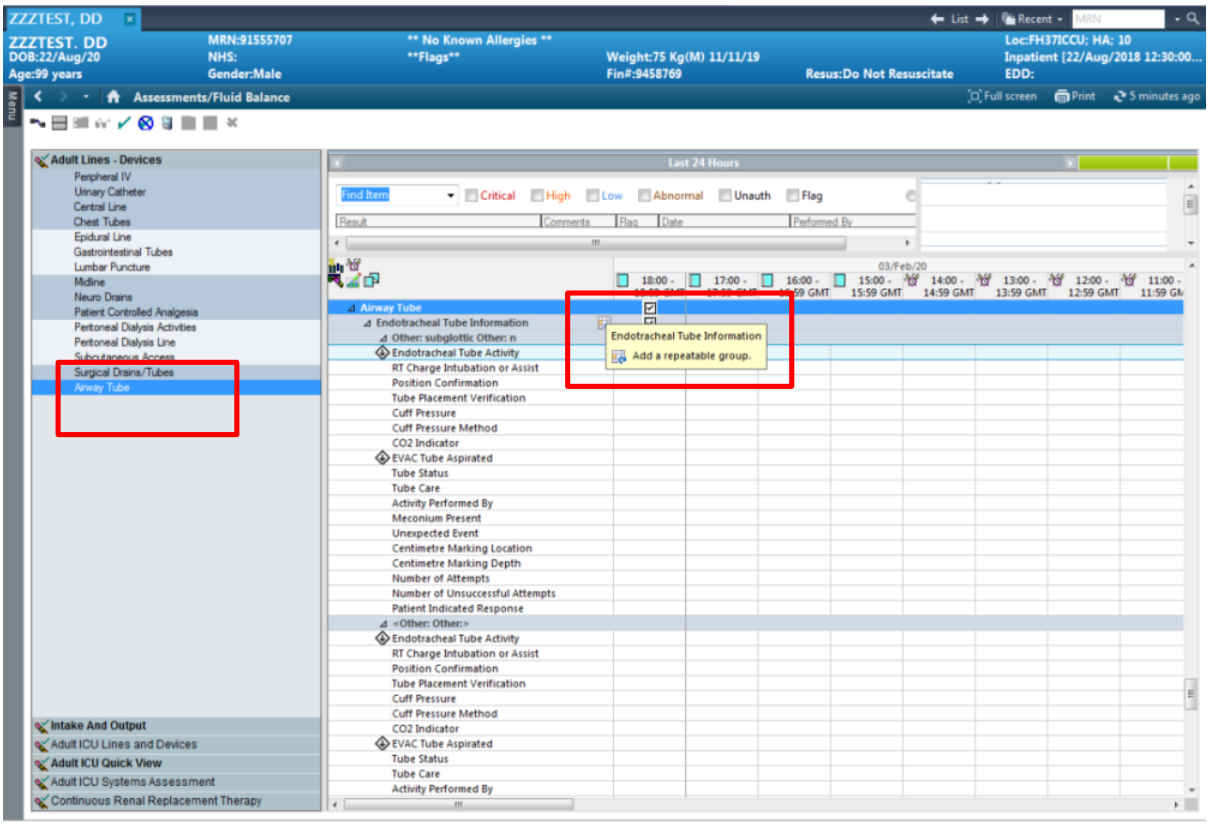
If you need to back date a line or NG (for example if a patient has been transferred from another hospital), you will need to scroll "back through time" and put it when they were inserted. If you insert data for a line and just type in that it was inserted on day X, the system will revert to telling you it was inserted on the day you put the data onto the system.

14) Record intubation/tracheostomy

As per P14 Pocket guide "Inserting lines and devices"

Dark grey navigator band "assessments and fluid balance"→Adult ICU lines and devices→ Airway tube

Click the small grid option, allowing new group to be added. Can either add ETT or tracheostomy.



Need to click the green arrow when completed.

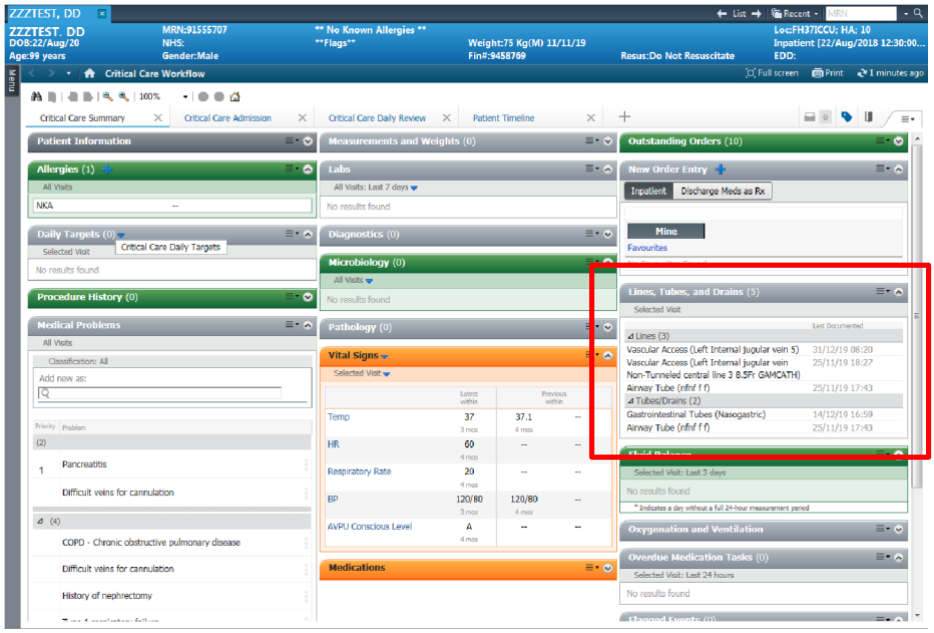
For intubations/tracheostomies you should also be completing a brief ICU progress note for the procedure. There is a paper tracheostomy insertion form (on the bronchoscopy trolley) which should be filled in (including device sticker)- this can be QR scanned and inserted to the notes. A brief ICU progress note is still completed pending return of the scanned document.

Ideally drugs given should be prescribed and signed for.

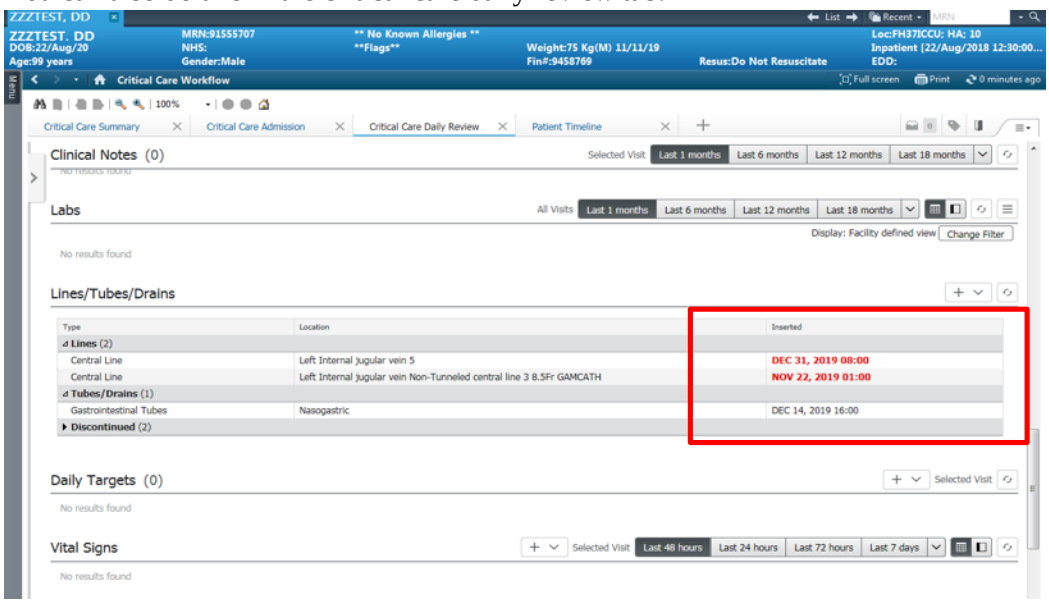
15) <u>Know when a device was inserted</u>

On Critical care workflow, critical care summary tab, section “Lines, Tubes, and Drains” -if

you hold the cursor over the line it will show you when it was inserted.



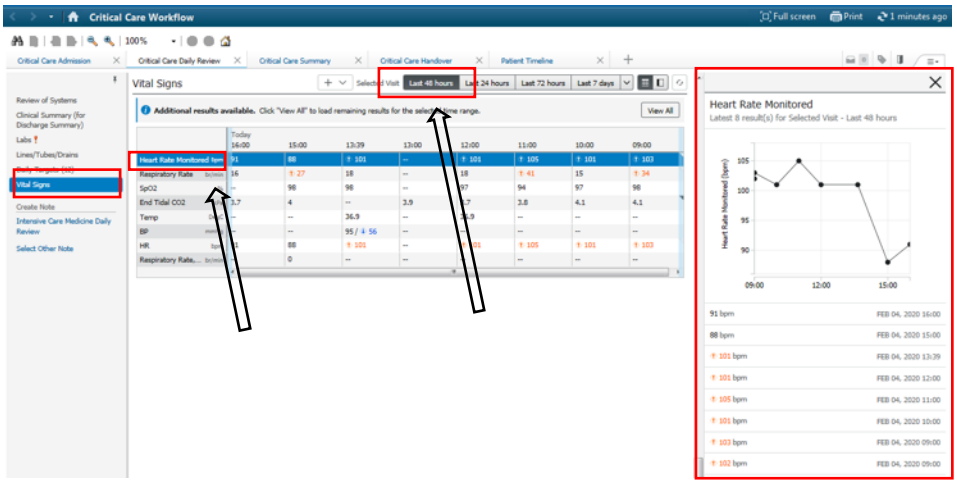
You can also do this in the critical care daily review tab.



Viewing additional details

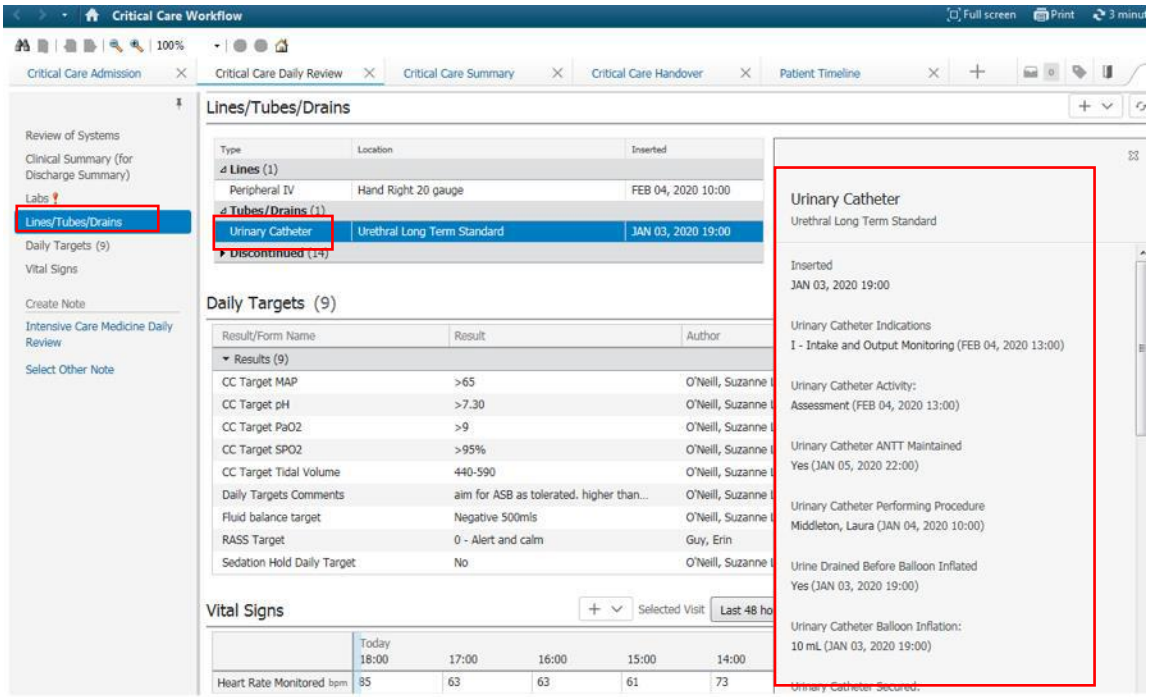
i. Vital Sign trends.

Open the Daily Review. In the Vital Signs Navigator band, clicking on the title of the parameter (e.g Heart Rate) and timeframe required will produce a graph



ii. Other data

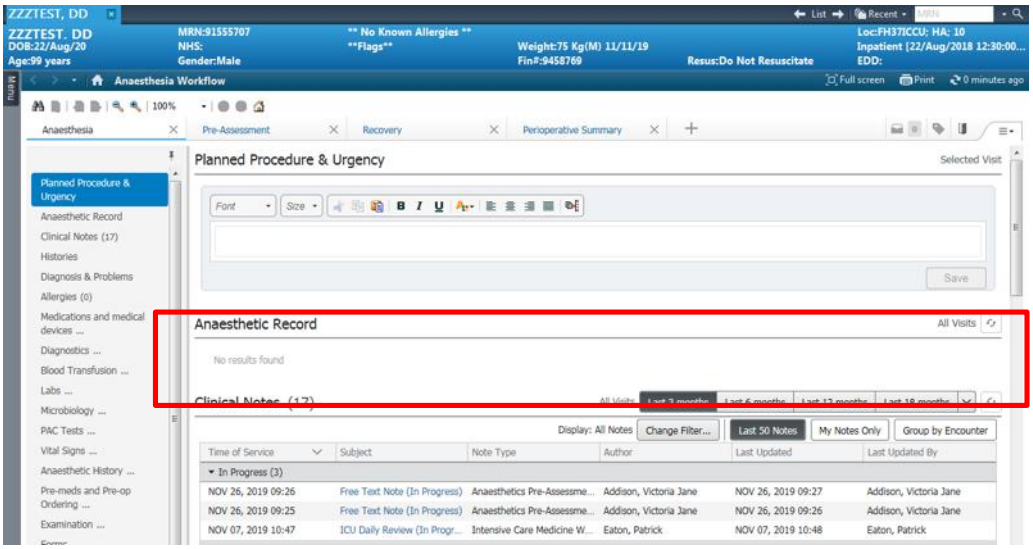
This is similar for lines, tubes, lab results etc: click the title to get more information.



HOW DO I? VIEW X

16) View anaesthetic chart

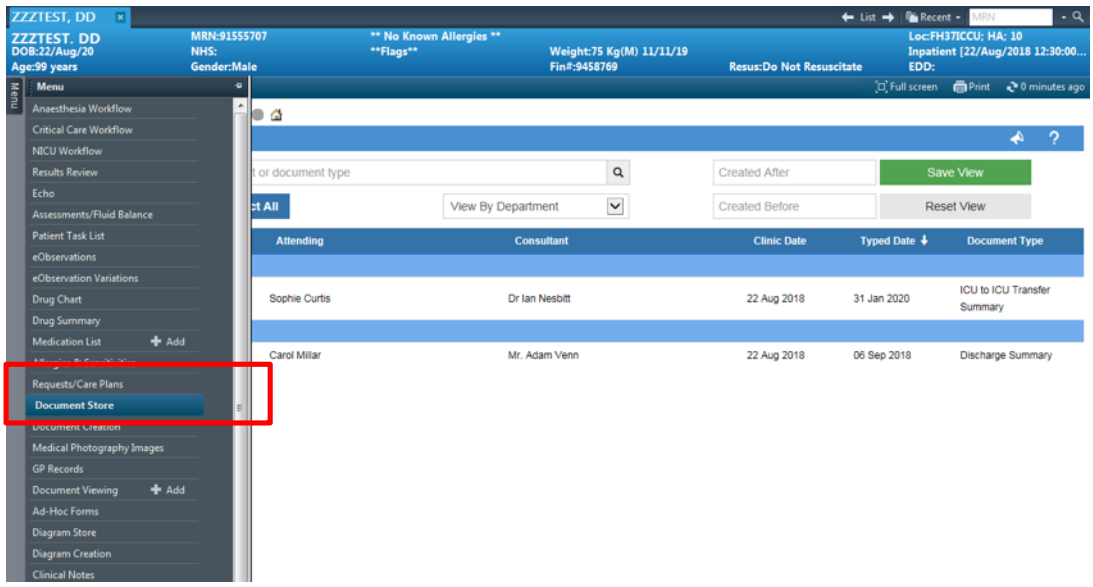
Dark grey navigator band- "Anaesthetic workflow"→ light grey navigator bands "anaesthetic record"→ it should be available to view here on an active patient.



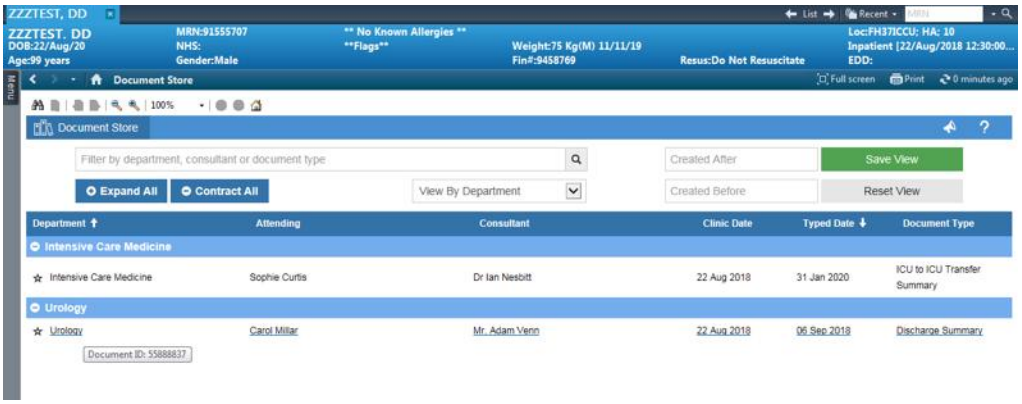
Recommended if you need more detail -Open up the Report Output as above. In the top left corner, just under the patient's name click on the little green icon for the anaesthesia app

17) View op note (and other clinic letters)

Dark grey navigator band→ "document store"

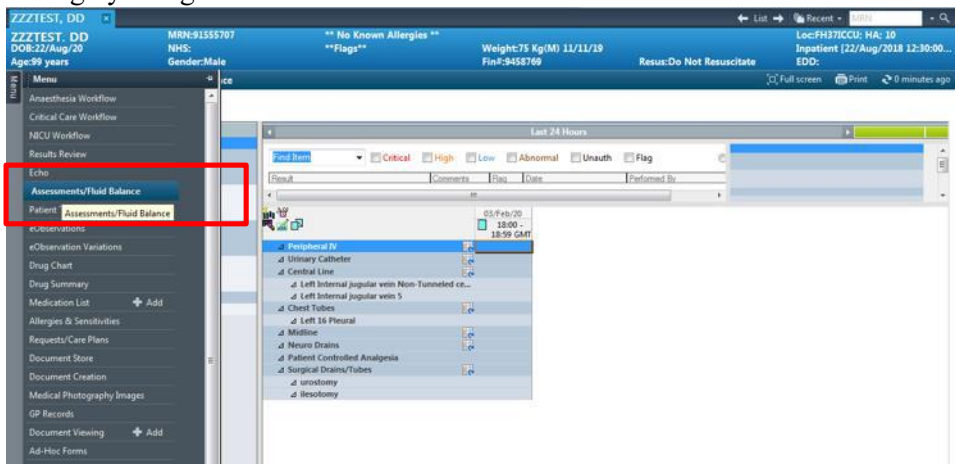


Click appropriate letter – they should be filed under correct department (note sometimes they are dated on date uploaded rather than date of operation, in theory these should now be the same!)

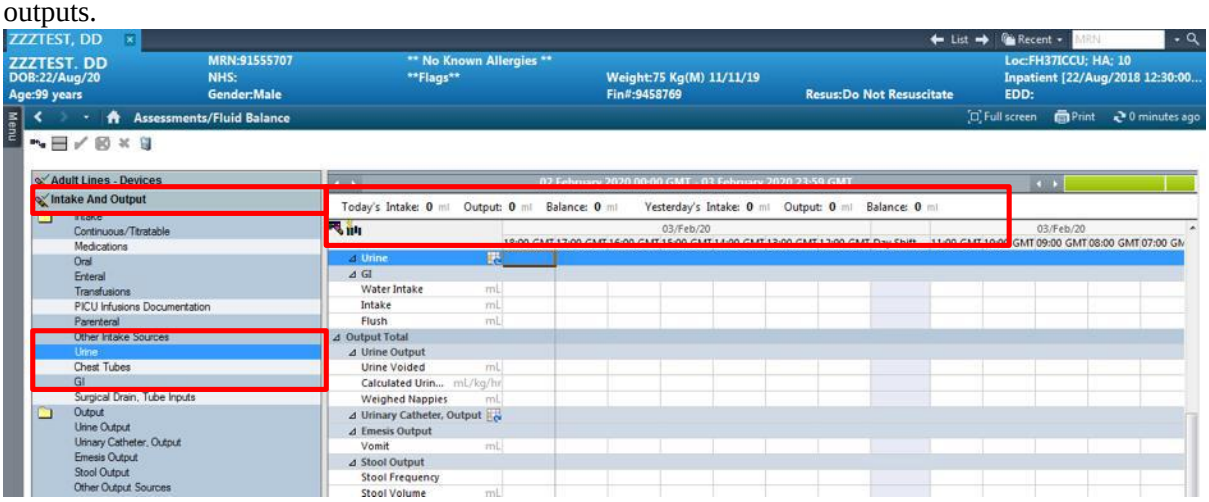


18) View fluid balance

Dark grey navigator band “assessments and fluid balance”

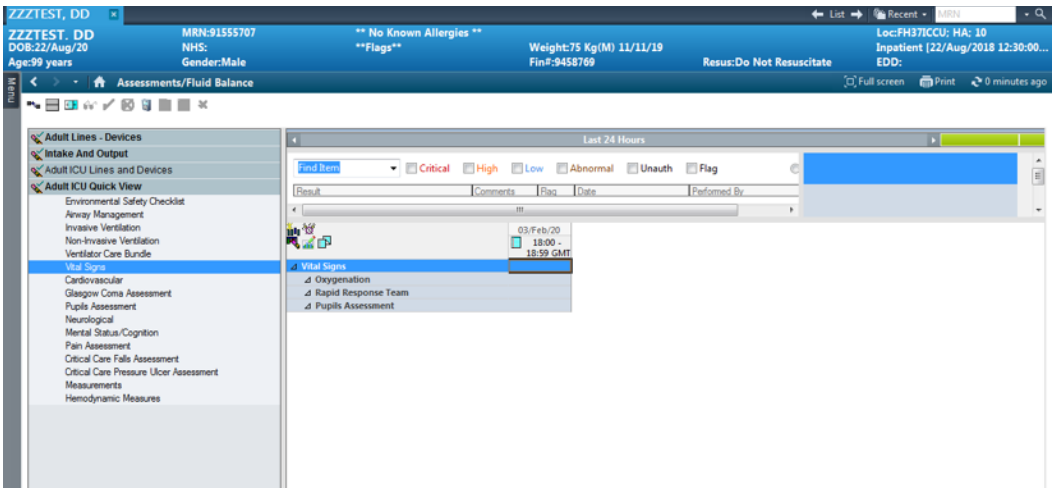


Click on “Input and output” on light grey menu. At the top of the screen it will show fluid balance and previous days fluid balance. You can select urine output/GI output etc if you want to just view these outputs.



19) View vital signs and ventilation

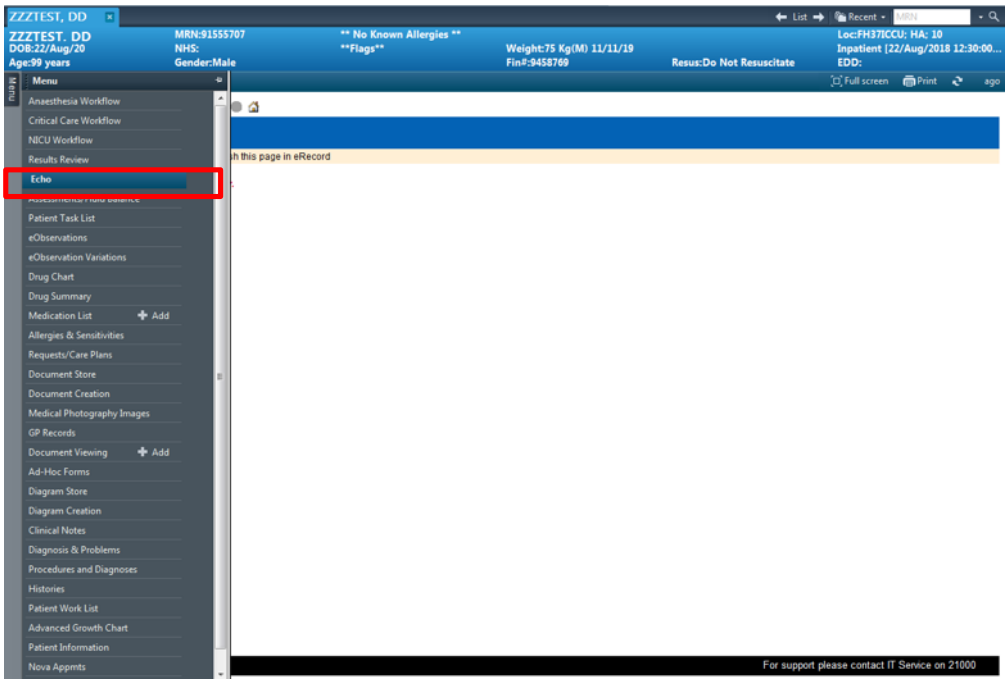
The best way to view vital signs is on assessment and fluid balance→ "adult ICU Quick view" →Vital signs (for vital signs) or Invasive ventilation for ventilation.



Please note that for ventilation it may look like an hour of a specific ventilator setting has been completed but it may in actual fact be that less than an hour has been completed (an hour is the smallest parameter the screen reads). There SHOULD be a note if less than an hour/ patient tiring etc- it will come up with a small triangle in the box if this is the case, which you can click on and view.

20) View ECHO

Echo is dark grey navigator band. If an echo has been completed it will be uploaded. There may be a number of Echos so choose the correct echo and click on it. In the bottom right hand corner there will be a series of thumbnails- one will look like a report – double click on it to view the echo report. If it doesn't open properly, close and re-open.



HOW DO I? DRUGS

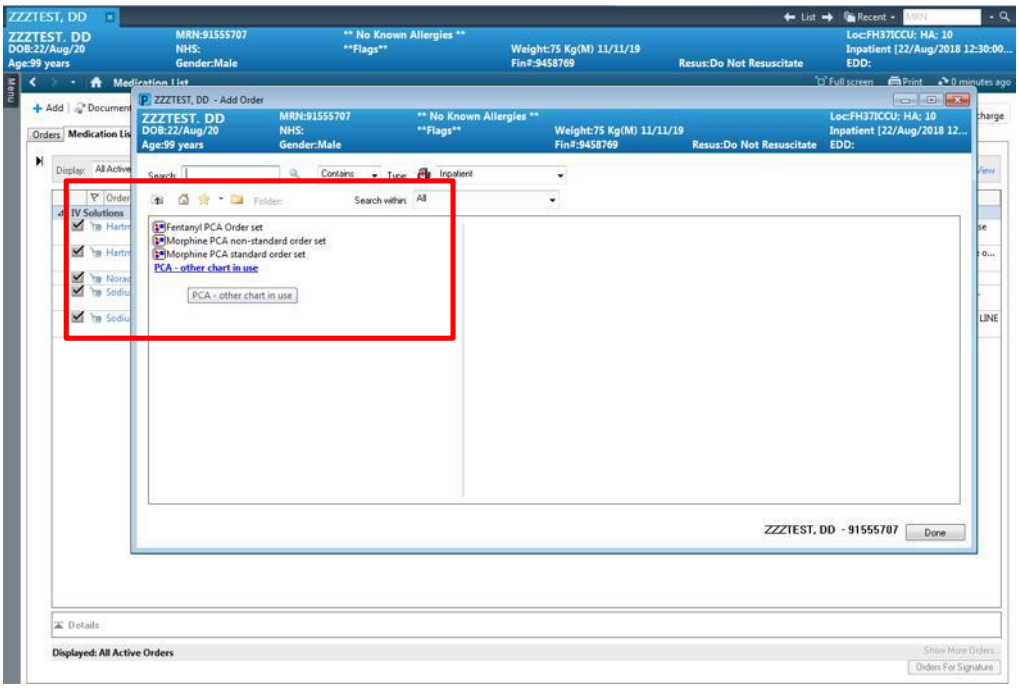
21) Adding a prescription

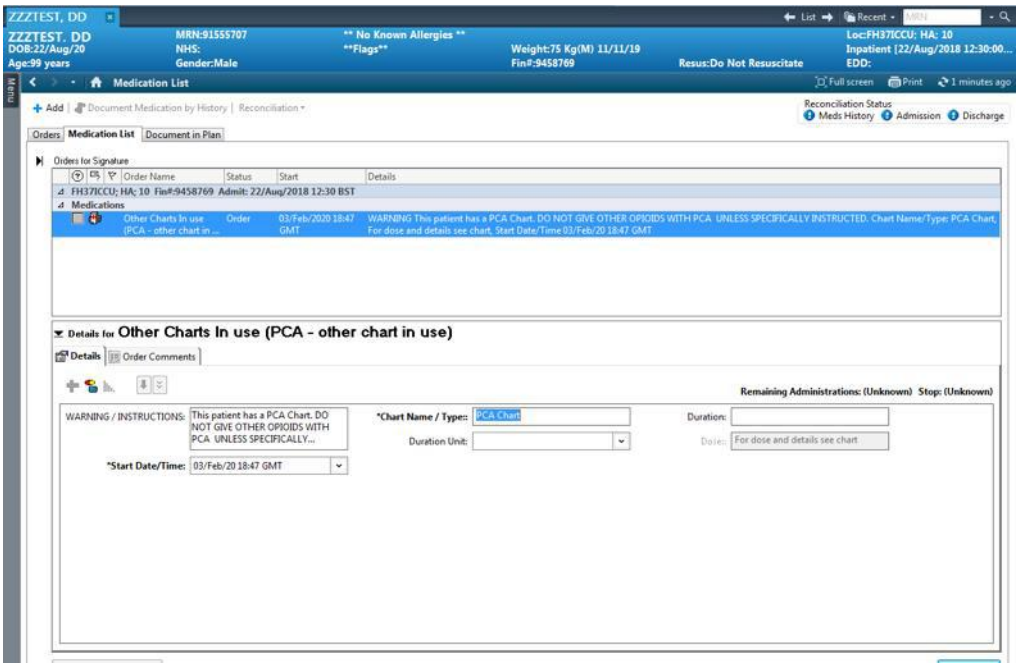
P19- Pocket guide "Adding a prescription"

22) Record PCAs and Record Epidurals

PCAs and Epidurals are still on paper charts for the moment, so these have to be completed at present. Please note at present Pain team reviews have also remained on paper so you will need to check the chart.

Despite paper chart- on Paperlite you should still prescribe that a PCA/epidural chart is in use. You do this as a prescription as per above.

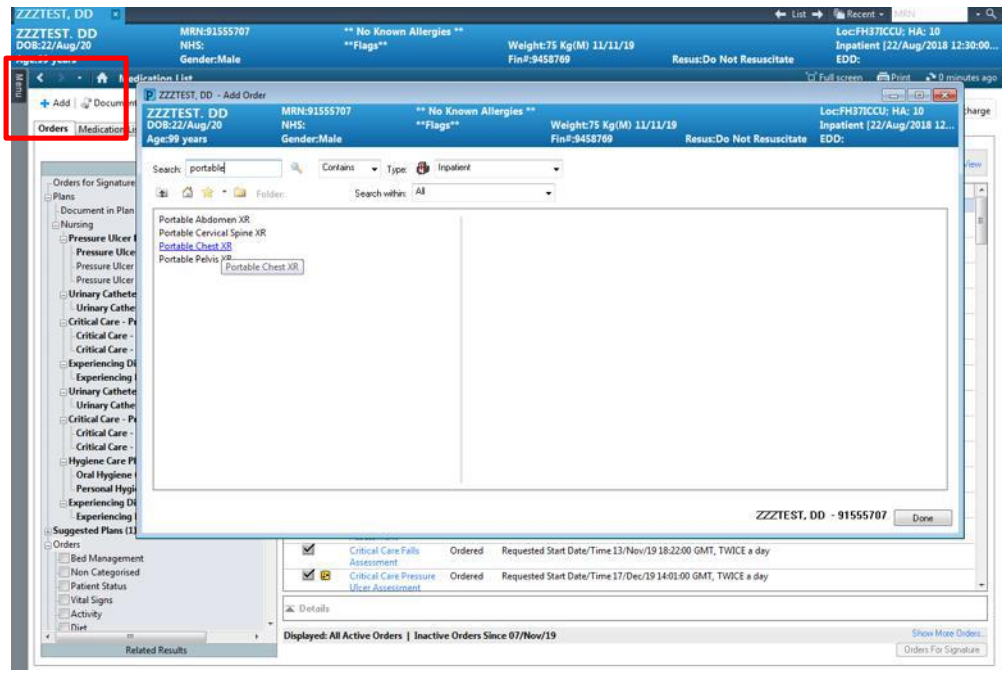




HOW DO I? REQUEST

23) CXR/Echo/Scan

Dark grey navigator band "medications" → add +



Search for the type of scan you are wanting and fill in clinical details.

Please request "portable Chest XR" rather than "CXR" for CXR on ICU.

If CXR for NG you need to state if attempted aspiration and if not why not.

For CXR/urgent Echos you will also need to call department. Urgent Echos may require cardiology registrar review. Urgent scans (CT/MRI) will need discussion with radiology on call. Routine scans should be discussed with radiology by the parent team.

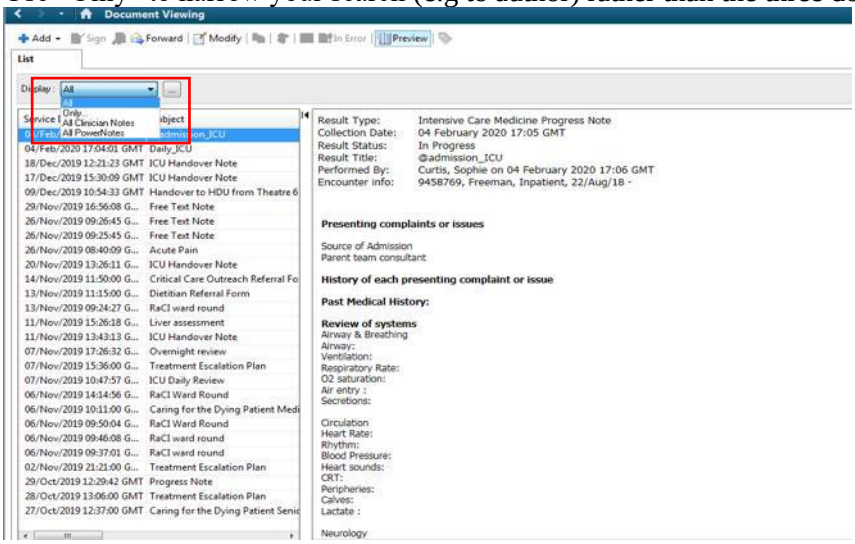
24) EEGs

EEGs are still a paper request (orange form).

HOW DO I? OTHER

25) Finding Specific notes in a Patient's record

In Document Viewing, you can filter to see all notes, or physician only notes etc.
Use "Only" to narrow your search (e.g to author) rather than the three dots "session filter" option



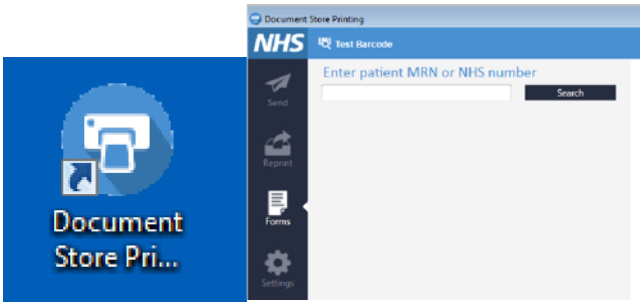
26) Printing QR Codes

QR Codes are used for paper work that is still done as a hard copy. Ideally, nursing/admin staff will do the QR coding, but this may mean the hard copy disappears for some time

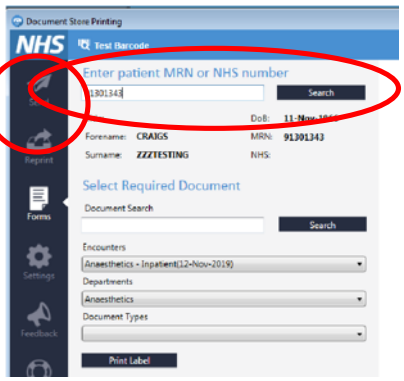
For us this currently this includes- consent forms/ transfer documents/ PCA/ Epidural/ nerve catheter/ GKI charts.

The point of these codes is so the hard copy can be scanned into the notes and stored in the appropriate way (linked to a specific patient, filed as a particular document type etc).

Double click on "document store printing" and Select Forms from left hand menu



Enter MRN and click search



Use either ‘Document Search’ or ‘Document Types’ dropdown to locate the required label and click ‘Print Label’ select required printer for area and click ‘Print Label’

27) Report faults

Can call IT ON 21000 if urgent or intermittent problem. If non urgent please see attached guide regarding how to do online (29)

28) IT failure

The Trust computers have a 15minute backup, so even with complete failure, only 15mins of data loss would be expected.

At worst, reversion to paper documentation would be required, with subsequent QR scanning to restore electronic records. There are stores of paper notes in the ICU reception office.

29) Reporting NON URGENT IT problems

For non-urgent faults/requested amendments, you can log issues online.

Click on the IT Service Desk link in Applications Resources on the intranet home page

Log in using your computer / eRecord login details.

Click on Report a Fault or Error

Click on eRecord/Clinical Applications

Click on Report a Powerchart Issue

You now see an online form that should be pre-populated with your details at the top, and two free text boxes at the bottom.

In the first box, start with a brief summary so IT can allocate the issue to the correct member of their team

e.g. ‘Paperlite Critical care workflow issue – not pulling through clinical summary’

Then please fill in as much detail as possible in the first box so IT can investigate and fix the problem:

- Which computer was it?
- Who was logged in to the PC - was it you or the generic login (e.g. Anaesthetist-33)?
- Who was logged in to eRecord?
- Where were you?
- What were you trying to do?
- What was the problem?

Put the patient’s MRN (if applicable) in the second box.

When complete- submit.

You will receive an acknowledgement email from IT service desk.

Appendix- Autotext Templates

@signature

Should include Name, Grade specialty, Dect phone no +/- GMC

ICU Daily review @Daily_ICU

Daily Chart B1a autotext
Airway: Breathing: Respiratory Examination- Respiratory Support- Circulation CVS examination- CVS support- lactate Renal/Fluid management: UO Fluid balance 24hrs Renal support- Urea Creatinine Abdominal: Examination- Nutrition- Drains- Bowel function- Neurology/Analgesia/Sleep: Musculoskeletal: IV Lines: Other: Labs of note: Microbiology of note: Max Temp last 24hrs WCC CRP Radiology of note: Summary/Plan:

ICU admission @Admission_ICU

Admission Chart autotext A3a

Presenting complaints or issues

Source of Admission
Parent team consultant

History of each presenting complaint or issue

Past Medical History:

Review of systems
Airway & Breathing
- Airway:
- Ventilation:
- Respiratory Rate:
- O2 saturation:
- Air entry :
- Secretions:

Circulation
- Heart Rate:
- Rhythm:
- Blood Pressure:
- Heart sounds:
- CRT:
- Peripheries:
- Calves:
- Lactate :

Neurology
- Sedation Score (RASS):
- Sedatives:
- CAM-ICU:
- GCS:
- Other findings:
- Analgesia:

Renal
- Urine Output:
- Oedema:
- Urea/Creatinine:

Gastrointestinal
- Abdomen:
- Wounds:
- Drains:
- Bowels sounds:
- Nutrition:

Musculoskeletal

Infection
- Temp:
- White Blood Count:
- C-Reactive Protein:
- Microbiology:

IV lines:

Other relevant Lab results:

Relevant Imaging:

Additional information:

Resuscitation details:

Safety alerts:

Social context & Family communication:

Plan and requested actions: