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SOUTH ISLAND TERTIARY CARE CPOE PRACTICE CHANGE SUPPORT PLAN FOR CLINICAL TRANSFORMATION TEAM

JANUARY 5, 2024

South Island Tertiary Care CPOE Practice Change Support Plan for CTT

Purpose of this tool

This support plan is intended to guide and support clinical leaders, mentors and other support resources through the major **practice changes** that Computerized Provider Order Entry (CPOE) brings for nursing and allied health staff.

- Provide awareness, guidance and support on the key high impact practice changes that will be impacting staff with CPOE implementation.
- Provide guidance and links to associated resources that can be used to support staff in understanding the WHY? and adopting the changes.

Directions:

1. Review this document to understand and plan how you will use it to prepare for CPOE Implementation
    a. Identify the Key Practice's that apply to the unit/care area and staff you are supporting
    b. Validate and prioritize the Key Practices to address by considering how much of a gap exists between current state practice on your unit and the stated practice standard
2. For each Key Practice selected:
    a. Read "What do I need to Know, AND What do I need to Do"
    b. Review the resources
    c. Print and carry a copy of the Practice Alert and/or Practice Pointer associated with the Key Practice and carry it with you during rounding
3. Track and Report out issues/challenges being met at the unit level via the POD meeting
4. Track the team's Progress of meeting and adopting the stated practice change via survey or chart audits (tools will be provided)
5. Communicate progress and success with the team/staff at regular intervals
6. Connect with your IHealth Practice Consultants for questions, coaching and guidance as needed

CLINICAL DOCUMENTATION: Inpatient Admission Documentation Practice Change Support Tool for CTT

Included Roles: All clinicians (Nurses & Allied Health)
Nursing and Allied Health students

Current State	Future State/ What do I need to know?	What do I need to do?	Resources
There is **considerable** variation between staff members, units and programs in degree and comprehensiveness of patient admission documentation. Variation in admission documentation produces inconsistency in care and lack of a comprehensive source of truth for patient admission information. **Practice Expectation** Upon admission, Nurses are responsible for documenting a selection of patient assessment, screening and history information which includes: • BPMH • Measured Weight • Admission History (including Prehospital Functional Screener) • Skin Assessment (Braden) • Risk of Violence Screening • Antibiotic Resistance Organism (ARO) Screening • Patient Valuables and Belonging's • Discharge Planning	**Practice Standard/Expectation** Timely, accurate and comprehensive Admission Documentation provides not only foundational patient information for informed interprofessional care, but also the needed information for the essential first step in Discharge Planning, which begins at the time of admission. Upon patient admission to an inpatient unit, the EHR **tasks nurses** to complete all required admission documentation which includes: • BPMH • Measured Weight • Admission History PowerForm (includes Prehospital Functional Screener) • Braden Skin Assessment • Risk of Violence Screening Tool • Antibiotic Resistance Organism (ARO) Screening PowerForm • Valuables and Belonging PowerForm • Discharge Planning PowerForm I.e. How tasks display in Care Compass	**Understand** Each interprofessional team member is responsible for contributing to and documenting patient admission information in alignment with their professional scope and organizational practice expectations. Timely and comprehensive admission documentation lays the foundation for informed interprofessional care and supports discharge planning **Review** The information in the future state/what do I need to know column. The Admission Documentation Practice Pointer in the resources column The education supports in the	Admission Documentation Practice Pointer **Nursing Education Resources** Review and Completing Tasks from Care Compass WIKI page BPMH Overview Documenting BPMH WIKI page Violence Risk Screening Tool WIKI page Initiating Discharge Planning Documentation on Admission WIKI page **Pre-Hospital Functional Screener Resources:** Cognition Workflow Elimination Workflow

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	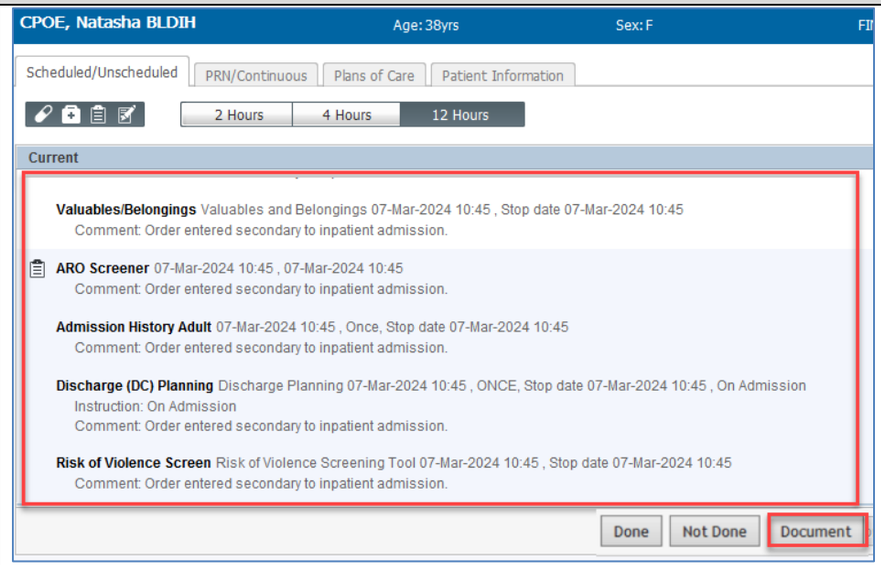 The admission assessment and documentation tasks that display in Care Compass supports nursing to: • Know what documentation must be completed upon admission • Efficiently navigate (links to the associated documentation) • Track completion of required documentation (when the task is used to access the documentation, the task disappears when associated documentation is signed)	resources column as needed **Support** Support Clinicians with your knowledge of this practice at Clinical POD meetings, change readiness events, unit huddles and in conversation/ communication with clinician's on the unit	Medication Workflow Mobility Workflow Nutrition and Swallowing Workflow Pain Workflow Social and Family Support Workflow

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	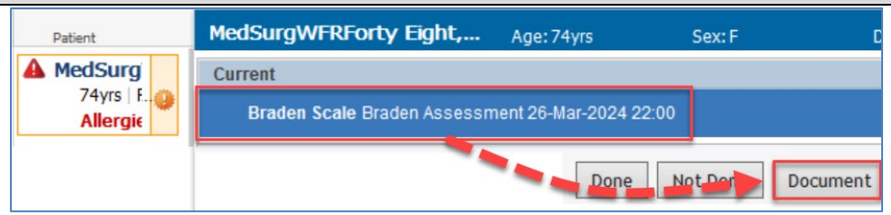 Using the tasks in Care Compass to guide Admission documentation supports Clinicians to meet organization and professional requirements.		

Associated Policy, Procedure, Guidelines, and Regulatory Standards:

Transitions in Care Policy *(coming soon)*
Adult Health History on Admission Procedure