**IView:**

IView is a means of viewing and documenting a wide variety of patient data in a single area. In this section, we demonstrate the basics of using IView and the general workflow across the IView bands.

In the Navigator of IView, you can customize what sections are displayed, what data is included, and how that data is organized. From this view, you can:

- Write directly to the chart
- View results details

**When do you have to Document?**

- At assumption of care, document a full assessment.
- When patient status changes or new information is available.
- Per unit protocol.
- Once per shift, review each band that is required for assessments or mandatory documentation.

**IView Overview**

IView is accessed through the patient’s chart menu. It is often listed as one of the top items. Clicking the IView button opens IView in the screen with the top band displaying.
## IView Navigation

<table>
<thead>
<tr>
<th><strong>IView Tools (1)</strong></th>
<th>These tools are available to use in IView. Click the boxes and arrows icon [ ] to open and close the Navigator. Closing the Navigator allows for more room for the flowsheet.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Navigator (2)</strong></td>
<td>The navigator displays the different views available for you to use. The views are identified as bands in the navigator. You can resize the navigator by clicking and dragging the bar between the navigator and the window to the right.</td>
</tr>
</tbody>
</table>
| **Date Range Bar (3)** | The information date range bar is used to select the retrieval range for results and other information displayed by date.  

*Note: click the arrows at the ends of the gray bar or right click on the gray bar to change the date ranges.*  |
| **Filter Options (4)** | You can filter the type of results IView is currently displaying. You can select to search for Critical, High, Low, Abnormal, Flag, and Unauthenticated results. You also can search for a particular item in the filter options section. |
| **Results (5)** | This area displays the critical, or high, low values that were selected in Filter Options. |
| **IView Flowsheet (6)** | This is where the results are displayed and documented in a spreadsheet format, similar to a flowsheet. Along the left side are section headings with individual items. Result values are displayed in the individual cells for section items and date and time. |
IView Bands

IView Bands are used to navigate within IView. Click the desired band to open it.

The sections available in the view are listed under the bands.

- **Dark Blue**: indicates the section you are currently in
- **Checkmark**: indications sections with documentations
- **Red Exclamation Point**: a critical value is within the section
- **Medium Blue**: opens to view in the *Flowsheet*
- **Light Blue**: must be clicked to open in *Flowsheet*

Band Types

Based on the band type, the items within that band may be different. Regardless of the band and items, the concepts of documentation and other functionality are the same across the disciplines. Below are some examples of different band types based on your role in nursing:

- ☐ **HW** = Hospital Wide (used for General Nursing)
- ☐ **CC** = Critical Care (used in ICU)
- ☐ **ED** = Emergency Department
- ☐ **SN** = SurgiNet
- ☐ **OB** = Maternal/Child
- ☐ **NB** = Newborn
- ☐ **BH** = Behavioral Health
- ☐ **RT** = Respiratory Therapy
Add a Band

If you need a band that isn’t a part of the normal IView bands for your area, you can add it to your IView list.

Step 1  Click on **View**.

Step 2  Hover over **Layout**.

Step 3  Click on **Navigator Bands**...

Step 4  The **Navigator Documents** appears. Left-click to highlight the **appropriate Navigator Band types** from the **Available Document Types** list.

Step 5  Click on the **right arrow** so your selections appear in the **Current Document Types**.

Step 6  Click on the **up/down arrow** to navigate up and down your **Current Document Types**.

Step 6  Click **OK** to save your changes.
Change Time Interval

This setting specific to each individual IView Band.

This setting will revert to the default between patients/visits. It is recommended to make these changes on a per patient basis rather than a “one size fits all” default.

1. Right-click on the desired time column to display the menu.
2. Select the appropriate time interval (ex: Q30min).
3. You can also enter a specific time by click Insert Date/Time.
4. You can enter the actual time by clicking on Actual.
5. Click anywhere outside the cell to set the change.

A Search Criteria Warning message displays for frequency intervals that will generate excessive columns (EX: Q5 min interval). If the frequency interval is desired, continue by selecting the desired option from Result Lookup or Clinical Range and click OK. It’s important to change the frequency interval back to the original.

To insert a column with a current or specific time use the instructions below:

Step 1
Click on the Insert Date/Time icon.

Step 2
The Change Column Date/Time window appears.
Input the desired Date/Time, then click anywhere outside this window to save the changes.

Step 3
The new date and time appears.
Documenting Results

Open a Band

1. Double-click **desired time** column to open all sections within a band.

2. Checkmarks display in the section with titled rows indicating open sections are activated.

- **Press Tab** to navigate from cell to cell.
  
  - In a cell, if an answer was a single select, when you choose the answer, you will progress automatically to the next cell.
  
  - You can also use your cursor to click on a cell if you want to skip down without touching every cell.
  
  - Certain cells may auto populate with values once you tab into them (you can change these values if desired). These are usually carrying forward a last charted value, or calculation fields that auto-calculate values from previously charted information.

Open a Section

1. Double-click the **blue section title bar** directly below the correct time of the section. A checkmark displays at the top of the section.

2. You will be able to navigate only in this section by tabbing from cell to cell, or using your cursor.

Open Individual Cell

1. Double-click on the cell to open and enter your results.

2. You will not be able to navigate by tabbing. You will need to click within each cell to enter the data.
Enter and Signing the Results

To enter data into a cell, you may either type the information into the corresponding box, or there will be a drop-down menu option. Some information may auto-populate from calculators of last charted value.

1. Enter the information.
2. Click on the green checkmark to sign the form. The font colors from your entries turn from purple to black.

Add Comment

To enter a comment for a documented result in IView, use the instructions below:

1. Right-click the on the charted result.
2. Select Add Comment,
3. The Comment box opens. Enter your comment.
4. Click OK.
5. A black triangle displays in upper right corner indicating a comment.

6. Hover over to open a box with the documentation

Modifying/Uncharting Signed Results
There may be times when you have signed your documentation but later need to make a change or unchart the information. Modifying or changing documentation does not require charting a reason for the change, however one should include a comment with a reason for the change.

Modifying Signed Results

1. Right-click on the result to be modified.

2. From the drop-down menu, select Modify.

3. Make the change to the result.

4. Click Sign when finished.
5. The new result displays along with a small blue triangle indicating a change was made.

6. Double-clicking the triangle next to the modified result opens a window with information about the result documentation history.

**Unchart Signed Results**

Uncharting signed results may need to occur if the information was entered on the incorrect patient, or for other reasons. You will be required to enter a reason for the un-charting of signed documentation.

1. Right-click the result you want to un-chart.
2. Select Unchart…
3. Click the Reason drop-down arrow to select the correct reason. You may also select Other then enter the reason in the Comment field.
4. Click Sign.
View Result Details

You can get information on the results and see an audit trail of who did what, and when to see an audit trail of documentation.

1. Right-click on the desired result.
2. Click View Result Details...
3. Click Close to finish.

IView Band in Detail

In this section, we briefly discuss the most commonly used Bands in IView.

Frequent Monitoring

Frequent Monitoring is the band in which you document common tasks such as Vital Signs, pain assessments, physician communication, etc.

- Notice that the section highlighted in light blue means that section has been opened in the flowsheet.
- Documenting in this band is straightforward. You either enter the data in the field or you are given a drop-down menu from which to select the appropriate information.
Physician Communication/Critical Lab Values

It is important that all physician communication is documented.

1. Open Communication Physician to allow for documentation in all necessary cells.
2. Document in Contacted Provider, Notified by, and Notified of abnormal labs.

Bedside Monitor Device Interface (BMDI) Data Population in IView

Once the BMDI is associated to the patient, data (such as temperature, HR, and SPO2 readings from the monitor), will automatically pull into IView when you double click in the time column where you wish to document.

The text displays in purple for the nurse to validate before signing. Erroneous values can be modified or removed prior to signing.

Adding a Dynamic Group

Some bands in IView require a dynamic group to be created for documentation. For example, if you click on Pain Group in the Frequent Monitoring band:

1. From the Pain Group, click on the Dynamic Group icon.
2. Double left-click on **<Pain Location>**.
3. The *Dynamic Group* appears, select the *appropriate pain location*.
4. Click **OK** to save the changes.
5. Enter details of the documentation.

**System Assessment**

Your patient systems assessments are documented here. Follow your facility’s policy as to when you are required to complete assessments.

By using the Navigator customization function, you can select which sections of the Systems Assessment band show in your flowsheet. If one of the systems/sections does not display in the flowsheet, click on it in the navigator.

In the Navigator, the names in all capitals are the systems. Below the system are the subsections. These subsections will have specific fields to document. To open in the flowsheet, click on the system or subsection.

For Example:

A. **NEUROLOGICAL** is the system. In the flowsheet, it has its own set of data to document such as LOC.

B. Below **NEUROLOGICAL** in the Navigator is Stroke. Clicking Stroke opens the subsection in the flowsheet. Stroke has its own specific fields to be documented including LOC.

**Important:** It is not necessary to both fields. Documenting in one LOC will populate all LOC fields throughout.
Clicking an item that is in blue font, opens a reference window with more information about that item. These reference materials provide support in your decision making.

<table>
<thead>
<tr>
<th>Frequent Monitoring HW</th>
<th>Systems Assessment HW</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEENT</td>
<td>Cardiac, Respiratory</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Neurological</td>
</tr>
<tr>
<td>Skin</td>
<td>Skin</td>
</tr>
<tr>
<td>Neurological</td>
<td>Gastrointestinal</td>
</tr>
<tr>
<td>swallow Screen - RN</td>
<td>Central nervous system</td>
</tr>
<tr>
<td>NS/urological</td>
<td>Psychological</td>
</tr>
<tr>
<td>swallow Screen</td>
<td>swallow Screen</td>
</tr>
<tr>
<td>Full Skinf Screen</td>
<td>Full Skinf Screen</td>
</tr>
<tr>
<td>Intra-Abdominal Wound</td>
<td>Intra-Abdominal Wound</td>
</tr>
</tbody>
</table>

**Trigger for Conditional Field**

- **A.** Under the Swallow Screen – RN subsection, is the Swallow Screen action with an icon (عقد) in front of it. “Action” means there are tasks to complete and document regarding the Swallow Screen. The icon means there is a drop-down list of these tasks in which to document.
  
  *عقد* = Trigger for conditional field

- **B.** Click in the **Swallow Screen action field**. A drop-down menu opens. If you select yes, the screen was performed, the list (as shown here) opens.

- **C.** Navigate to each field and answer **appropriately**.

- **D.** The Swallow Screen score is automatically calculated. In the Swallow screen outcome field, click the appropriate response to the score.
Score Calculator

Another icon is shown next to the Braden Scale. This is a calculator which indicates that a score will be determined for this scale. Clicking on the scale opens a text box displaying what patient responses are assessed.

A. To open the scale, double-click the subsection header in the correct time column

B. This places a checkmark in the field and opens the first field in which to document the patient’s response to the first task. It is a drop-down list from which you choose the response. You can move to the next field with each selection using your cursor or the tab key.

C. A score is calculated and entered into the Score field based on your documentation.

Once you have finished your documentation on the Systems Assessment HW Page, Sign.
Restraints

Restraints ordering and documentation have three states: Initiate, Continue/Monitor, and Discontinue. These steps demonstrate Non-Violent/Non-Self-Destructive restraints. If you are applying Violent/Self Destructive restraints, follow the SAME steps, just be sure to select the Violent options.

Phase 1: Initiate Restraints (Ordering/Applying)

**Nurse Responsibility:** RN initiating new episodes of restraints.

Note: Steps 1-14 are performed ONE time per restraint episode.

**Step 1**
Find the orderset called **Restraint/Seclusion – Subphase**

You must use this orderset. Ordering any other way is INCORRECT.

**Step 2**
Enter the **Attending Physician’s Name** and **Communication Type**.

You must contact the doctor for this order.

**Step 3**
You will notice some orders within the orderset are pre-selected. **Leave those alone.**

Do not uncheck! We want those to be ordered.
Step 4
Select the **Restraint Apply: Non-Violent/Non Self-Destructive**.

Step 5
Right-click and select **Modify** to complete the mandatory fields within **Restraint Apply order**.

Step 6
Complete the mandatory fields within the **Restraint Apply order**.

**TIP:** Hold the **Ctrl** key on your keyboard to multi-select (ex: Right Wrist and Left Wrist).

Step 7
Click **Orders for Signature**, then click **Sign**.
Step 8

Validate the Restraint Seclusion Subphase orderset is initiated on the patient’s record.

This orderset will **automatically**:

- Generate the Restraint Apply task.
- Generate the order for Restraint Monitor under Patient Care (as well as the Q2 hour tasks).

![Image of Vew with Restraint/Seclusion - Subphase (Initiated) highlighted]

Step 9

🌟 Important: **Initiate and document the care plan:**

‘Restraints-Non-Violent/Non-self-destructive MCP’

![Image of Restraints-Non-violent/Non-self-destructive MCP]

**Customize the care plan per the patient’s specific needs!**

Step 10

Document the Restraint Apply task (found in the Alerts/Restraints tab of your Task).

![Image of Task with Alerts/Restraints highlighted]

Step 11

The Restraint Apply task will take you to IView to set up the Restraint Group. Click on **Add a Dynamic Group** icon.

![Image of Activity View with Restraint Apply Non-Violent highlighted]

Step 12

Identify the location and type of restraints.

![Image of Dynamic Group - ZTTESTAPRICA, SOUTH - 3582 with Location of restraints highlighted]
**Step 13**
Select the *correct Restraint category type: Non violent/Non self-destructive.*

<table>
<thead>
<tr>
<th>Restraint Apply: Non-Viol...</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper extremities, bilateral...</td>
<td>✓</td>
</tr>
<tr>
<td>Restraint category type:</td>
<td></td>
</tr>
<tr>
<td>Non-violent action:</td>
<td>Non violent/Non self-destructive</td>
</tr>
<tr>
<td>Physician Communication - R...</td>
<td>Violent/Self Destructive</td>
</tr>
</tbody>
</table>

**Step 14**
Select the *Restrain Non-Violent action: Apply/Initiate* and document ALL the fields that appear.

**Phase 2: Continuing Restraints**

**Nurse Responsibility:** Each nurse on every shift while the patient is in restraints:

- Step 15: done once a day while patient is in restraints.
- Steps 16-17: done EVERY shift while the patient is in restraints.

**Step 15**
Obtain the order to continue the restraints every day (q24 hours)

**Step 16**
Complete the Restraint Monitor Task every 2 hours by documenting all the fields in IView.

**Please note:** Never skip the documentation of q2 hour monitoring. If we miss one monitoring task, we have a fall-out.

**If you take your patient out of restraints for longer than what is required for ADLs, then the restraints are considered DISCONTINUED, and you would need to perform steps 18-25 below.**
Step 17

Important: Continue to document in the care plan every shift.

Phase 3: Discontinue Restraints

Nurse Responsibility: the nurse who discontinues the restraints.

- Steps 18-25 are done once per restraint episode.

Step 18

Enter the single order called **Restraint Discontinue: Non-Violent/Non-Self Destructive**

Step 19

You do not need to contact the doctor for this order as instructions to discontinue the restraints were included in the original Restraint/Seclusion Subphrase orderset.

- Enter the attending physician’s name.
- Choose **Entered by Provider** as the Communication type.

Step 20

Sign the order.

Step 21

By entering this order, it will automatically:

- Complete the Restrain/Seclusion Subphase orderset.
- Discontinue the **Restraint Monitor** order/tasks.
- Generate a task for **Restrain Discontinue** on the Schedule Care task list.
Step 22
Double-click on the Restraint Discontinue task in the Scheduled Care task list to document.

Step 23
The task will take you to IView. Document the action Discontinue and complete all the fields that appears.

Step 24
Finalize any documentation on the Restraint care plan for your shift.

Step 25
🌟 Important: Discontinue the care plan

From the main orders page, right-click on the care plan and select Discontinue.
Fall Prevention

Fall prevention is a regulatory requirement and part of good patient care. All patients are fall risk assessed at the time of their admission. Subsequent assessment and patient education should occur during each shift and during hand off. For more education on Adventist Health’s Falls Prevention program, speak with your manager or your CIS Educator.

In this section, we demonstrate how to document a falls risk assessment in PowerChart.

A. The *Fall Risk Screen IView* section is in the Systems Assessment HW band.
B. Click the *Fall Risk Screen IView* to open the details.
C. Document as you would in any IView flowsheet.
D. Once you complete the assessment, a score will indicate whether the patient is a high risk or a low risk. In this demonstration, the patient is a high risk.

Because this patient is a high fall risk, the next documentation should be your prevention and intervention actions for the patient; discuss the risk with the provider, and have the patient/family sign the fall contract (if applicable).
This a sample screenshot of documenting the prevention and invention actions. When completed, sign the chart.

![Screenshot of prevention and invention actions](image)

Fall-Post Event

You will document your post fall patient care in this section. Follow hospital policy for all actions related to fall assessment and post fall documentation.

![Screenshot of fall-post event documentation](image)
Antiembolism Devices

To document IPCs (Intermittent Pneumatic Compression devices) aka SCDs (Sequential Circulation Device) or TED HOSE (aka Antiembolic stockings) go to Patient Care - Antiembolism Device.

It is also important to document patient refusal of antiembolism devices and notify the physician.

Skin Risk (Braden Score)

Skin Risks are documented in the Systems Assessment band of IView.
Drains, Tubes and Wounds

Document in this band as you would other bands. In this screenshot, we also included a Time Out Protocol documentation for a chest tube insertion. Follow your facility’s policy when you perform a procedure that requires a Time Out.

Lines and Procedures

In the Lines and Procedures band, you will document tasks such as insertion and maintenance of an arterial line, peripheral line and sheath removal. Documentation in this section is similar to most of the other bands.

1. Open the **band**.
2. Select the **task**.
3. Click the **Dynamic Group** icon next to the line group or procedure in which you want to document.
4. In this case, you will be prompted to select the location of the line.
5. Select the **Trigger Actions** needed.

6. The rest of the conditions open.

7. Chart accordingly in those fields. (They are drop-down and type-in fields). **Sign** when finished.

Patient Care

In the Patient Care band, you will document the tasks you are doing to manage your patient care. Documentation in this section is similar to most of the other bands.
Safe Patient Handling

Documenting safe patient handling indicates that you are ensuring your patient’s and your own safety. This is also a part of good nursing practice.

You assess and document safe patient handling at Admit and every shift, if mobility needs change, and whenever equipment is used for patient mobility/handling.

You will document safe patient handling in IView in several areas:
- Systems Assessment → Neuro, Musculoskeletal, Stroke, etc.
- Patient Care → Activity and Equipment
- Education → General Topics → Safety

This is an example of documenting Equipment.

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seizure pads in place</td>
<td></td>
</tr>
<tr>
<td>Skin protector in place</td>
<td></td>
</tr>
<tr>
<td>Bed alarm on</td>
<td></td>
</tr>
<tr>
<td>Call light</td>
<td></td>
</tr>
<tr>
<td>Telemetry electrodes</td>
<td></td>
</tr>
<tr>
<td>HOB position</td>
<td></td>
</tr>
<tr>
<td>Pressure devices</td>
<td></td>
</tr>
<tr>
<td>Pressure reducer</td>
<td></td>
</tr>
<tr>
<td>Skin/Circulation devices applied/present</td>
<td>SCD/IPC</td>
</tr>
<tr>
<td>Skin/Circulation devices removed</td>
<td></td>
</tr>
<tr>
<td>PI/Family refused Skin/Cir. devices</td>
<td></td>
</tr>
<tr>
<td>SCD/IPC minutes off min</td>
<td></td>
</tr>
<tr>
<td>TED hose minutes off min</td>
<td></td>
</tr>
<tr>
<td>Active warming device</td>
<td></td>
</tr>
<tr>
<td>Resuscitator bag/ Mask at bedside</td>
<td></td>
</tr>
</tbody>
</table>