HOW WILL MY ROLE CHANGE?

A snapshot into the new day-to-day role of a

AR (TEAM LEAD)

WHERE WE ARE NOW...	SAFER. BETTER. SMARTER.
Patients tell their story over and over again.	The creation of a longitudinal chart where information (e.g. allergies, home meds, a patient's medical history, etc.) is accessible visit to visit and across multiple sites.
Kardex is only accessible at the nursing station and the information on the Kardex is not always reliable and up-to-date.	Expanse has a snapshot view that summarizes the patient's care. It's like a self-transcribing Kardex that automatically updates in real-time as documentation occurs.
Important patient information is scattered throughout the paper chart. Searching through paper medical records and online content is time-consuming and can be confusing.	Centralized multidisciplinary care plans, multiple people can access the record at the same time, improved and customized status boards, and surveillance tools for better care coordination.
Orders require transcription and medications must be faxed to the pharmacy.	Orders are entered directly and automatically by providers (e.g. physicians) and flow to the appropriate departments—no transcription or co-signatures for medications.
A new best possible medication history is created at each patient visit.	A medication list can easily be retrieved and updated at every patient visit.
Handwritten orders are sometimes illegible and prone to transcription error.	Orders are entered directly by the provider and are legible. The 'Interaction checker' module reviews orders at the time of entry and alerts the provider of interactions before the order is filled.
A nurse checks medications manually on the chart and then takes it to the patient to be administered.	Barcodes on patient wristbands and medication labels are scanned to verify all requirements of safe medication administration: right patient, right medication, right dose, and right time.
Vital signs are handwritten or batch entered in the chart and are often not done in real-time.	Vital sign information from cardiac monitors directly flows into the patient record (ICU, ED, PACU & NICU) in real-time.
The physician guides the discharge process. Information on discharge is scattered throughout the chart.	Universal discharge: everyone on the care team is contributing to the discharge plan, creating a multidisciplinary approach that can start anytime during the patient's admission. A paper patient discharge summary is generated with standard design and predictable information.
People are creating personal reminders and to-do lists to stay on track.	A work list is generated for each patient, indicating when and what care is needed.
Several manual steps involved in the transfusion of blood product process.	Scan and verify blood products with information stored in a patient's Transfusion Administration Record (TAR) to meet all requirements of safe transfusion administration.

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