

**SELF-GUIDED PRACTICE WORKBOOK [N25]**  
CST Transformational Learning

WORKBOOK TITLE:

**Nurse: Ambulatory Oncology**

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## # SELF-GUIDED PRACTICE WORKBOOK

<b>Duration</b>	<b>8 hours</b>
<b>Before getting started</b>	<ul style="list-style-type: none"> <li>■ Sign the attendance roster (this will ensure you get paid to attend the session)</li> <li>■ Put your cell phones on silent mode</li> </ul>
<b>Session Expectations</b>	<ul style="list-style-type: none"> <li>■ This is a self-paced learning session</li> <li>■ A 30 min break time will be provided. You can take this break at any time during the session</li> <li>■ The workbook provides a compilation of different scenarios that are applicable to your work setting</li> <li>■ Work through different learning activities at your own pace</li> </ul>
<b>Key Learning Review</b>	<ul style="list-style-type: none"> <li>■ At the end of the session, you will be required to complete a Key Learning Review</li> <li>■ This will involve completion of some specific activities that you have had an opportunity to practice through the scenarios.</li> </ul>

## Using Train Domain

You will be using the train domain to complete activities in this workbook. It has been designed to match the actual Clinical Information System (CIS) as closely as possible.

Please note:

- Scenarios and their activities demonstrate the CIS functionality not the actual workflow
- An attempt has been made to ensure scenarios are as clinically accurate as possible
- Some clinical scenario details have been simplified for training purposes
- Some screenshots may not be identical to what is seen on your screen and should be used for reference purposes only
- Follow all steps to be able to complete activities
- If you have trouble following the steps, immediately raise your hand for assistance to use classroom time efficiently
- Ask for assistance whenever needed

## ■ PATIENT SCENARIO 1 – Navigating PowerChart as an Oncology RN

### Learning Objectives

At the end of this Scenario, you will be able to:

- Utilize and understand Ambulatory Organizer
- Utilize Tracking Shell and PowerChart Oncology
- Check-in a patient
- Document using PowerForms and IView

### SCENARIO

As an Ambulatory Oncology Nurse we are going to follow a patient through their journey. The patient has been diagnosed with metastatic breast cancer. She has been coming to the outpatient Ambulatory Chemotherapy Clinic for a few years on various treatments. Her most recent scans show disease progression on her current treatment BRAVCAP (oral Capecitabine) and her Oncologist has decided to change her chemo regimen. She is to start weekly Doxorubicin under protocol BRAVA7. Throughout the workbook you will be given more information on the patient enabling you to complete the activities.

As a Registered Nurse on the chemotherapy unit you will be completing the following activities:

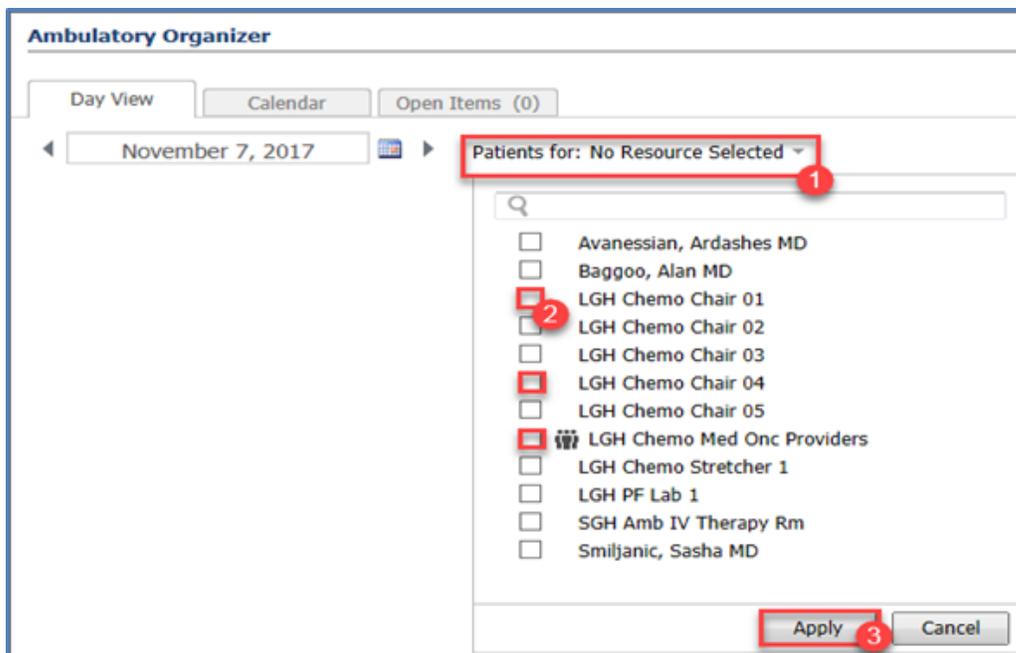
- Exploring Ambulatory Organizer
- Exploring Tracking Shell
- Assigning yourself a patient and putting in their location
- Documenting your assessments in IView and PowerForms
- Order Management
- Medication Administration

## Activity 1.1 – Ambulatory Organizer

Throughout the Clinical Transformation System (CIS) a hint to remember to help you navigate is ‘**Hover to Discover.**’

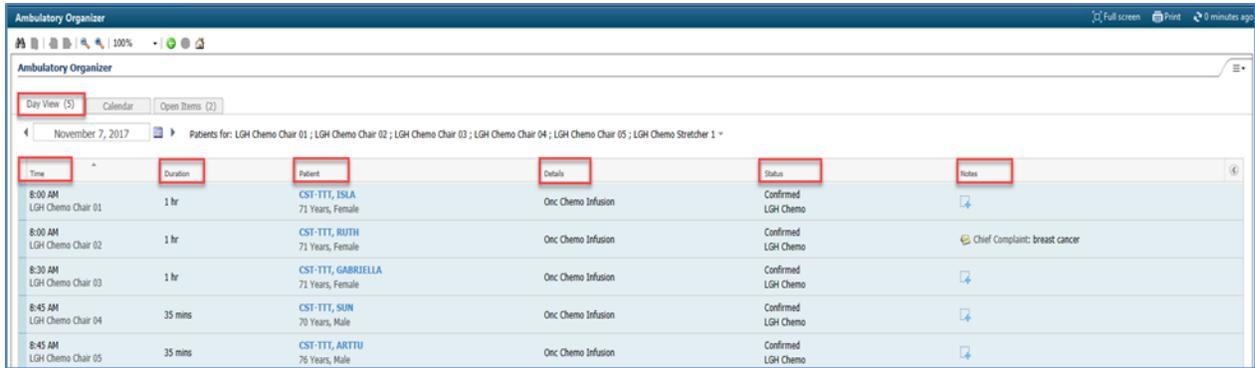
1 The **Ambulatory Organizer** allows the RN to select the appropriate resource, displays scheduled appointments, and provides staff with a framework to organize workflows at the day, week, or month level.

1. Click the down arrow beside **Patients for: No Resource Selected.**
2. Select the desired resource(s), or use the search window if not appearing in your recently used, set your resource to **LGH Chemo Chairs/Stretchers.**
3. Click **Apply** to populate the resources you selected.



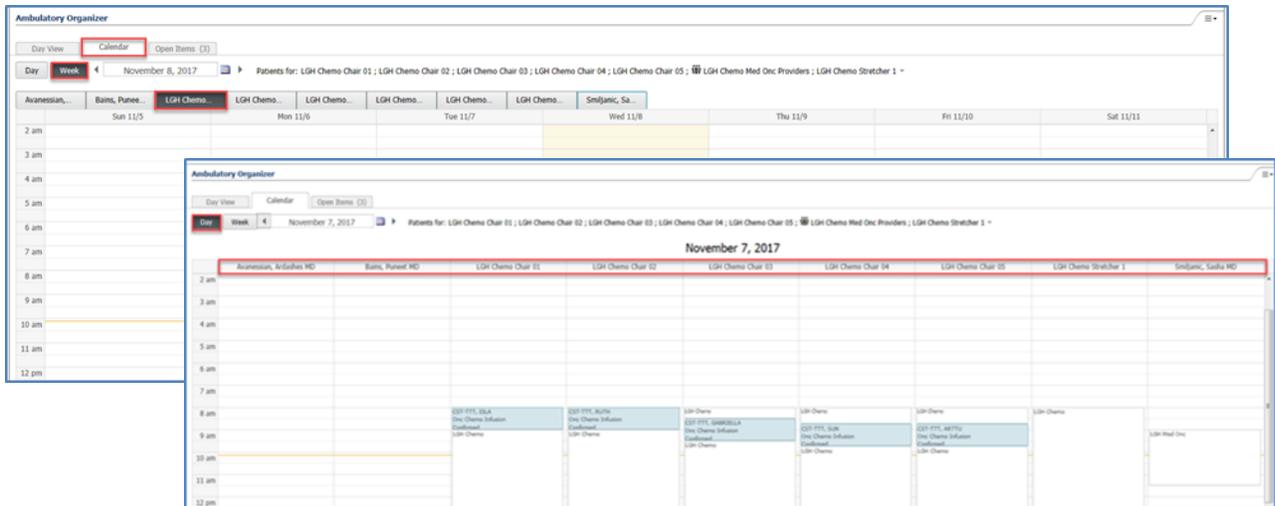
**Note:** You must select resources in each view of the Ambulatory Organizer.

2 **Day View** displays today’s appointments and appointment gaps with selected resources, location, duration, patient information, appointment details, status of appointment and any additional notes.



**Note:** The day view is the default view you see when you first log in but going forward, whichever view you were on last displays when you open Ambulatory Organizer.

3 **Calendar View** displays a resource’s schedule for a day or a week. Click the **Day** tab to view multiple resources side by side. Click the **Week** tab to view a single resource’s schedule.

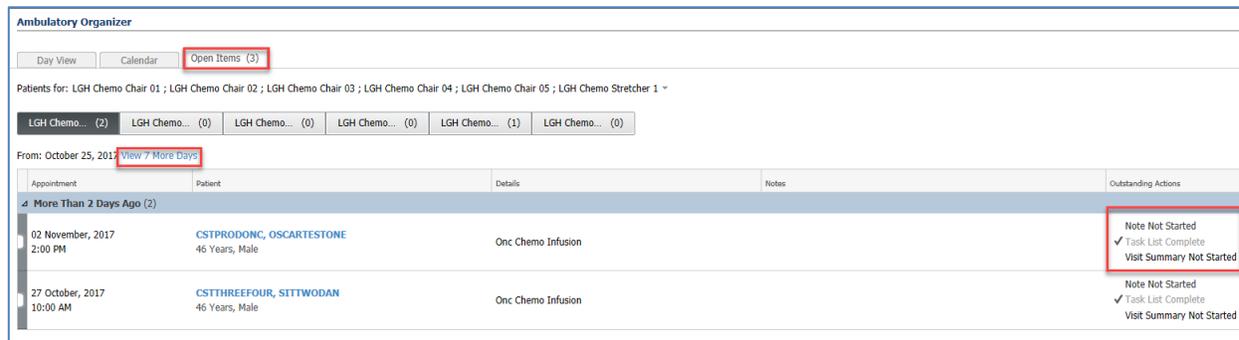


**Note:** A resource can be a person or a location.  Symbolizes a group of resources, again either grouped by location or people.

4 The color status on the far left of the Day and Calendar View, assists you to understand the flow of the clinic.

Color Status	Definition
	Light blue indicates a Confirmed appointment.
	Medium blue indicates a Checked In appointment.
	Green indicates a Seen by nurse, medical student, or custom status has taken place.
	Orange indicates a Seen by physician, mid-level provider, resident, or custom status has taken place.
	Dark grey indicates the appointment has been Checked Out.
	White indicates a No Show, Hold, or Canceled appointment (these appointment types are displayed if the system administrator has configured them to display).

5 **Open Items View** displays unfinished tasks for the resources displayed for a selected amount of days from when the appointment took place. To view more than the seven days displayed, click **View 7 More Days** (more for physician use).



**Note:** When multiple resources are selected, each resource is displayed as a tab across the top. The grey tab is the resource currently displayed in the view.

6 Explore the **Day View** and **Calendar View** for 5 minutes using the questions below to guide your discovery:

1. Select the **Time** Heading – What do you discover? (**Note: Chronological order is the default selection for Day View**)
2. Select the **Patient** heading – What do you discover?
3. Select the **Status** heading – What do you discover?
4. Under which column heading can you find the **reason for the patient’s visit**?
5. Where can you write a **free text note**?
6. Which icon allows you to **find words on the page**?
7. How will you see **updates** that have been made since you logged in?
8. What do you discover when you **hover over** the **icons** on the screen and the patient’s name and status in the **Day View** and the **Calendar View**?

### Key Learning Points

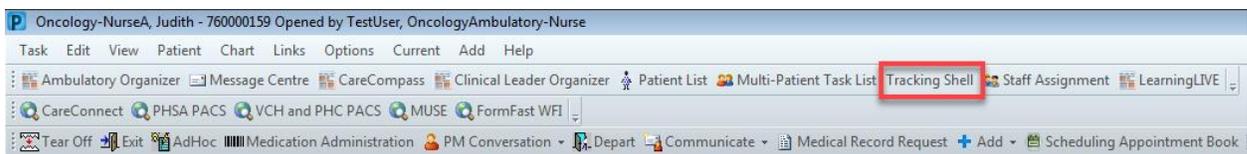
-  Ambulatory Organizer provides a framework to organize your day.
-  Different views are available to select, depending on your need.
-  Resources need to be selected for each view in order to see the corresponding information.
-  Ambulatory Organizer is used more in clinic settings.

## Activity 1.2 – Tracking Shell Navigation

The **Tracking Shell** serves as the desktop for linking health care professionals to vital patient and department information. Events can be added and removed to communicate patient status during their treatment. It is divided into three sections.

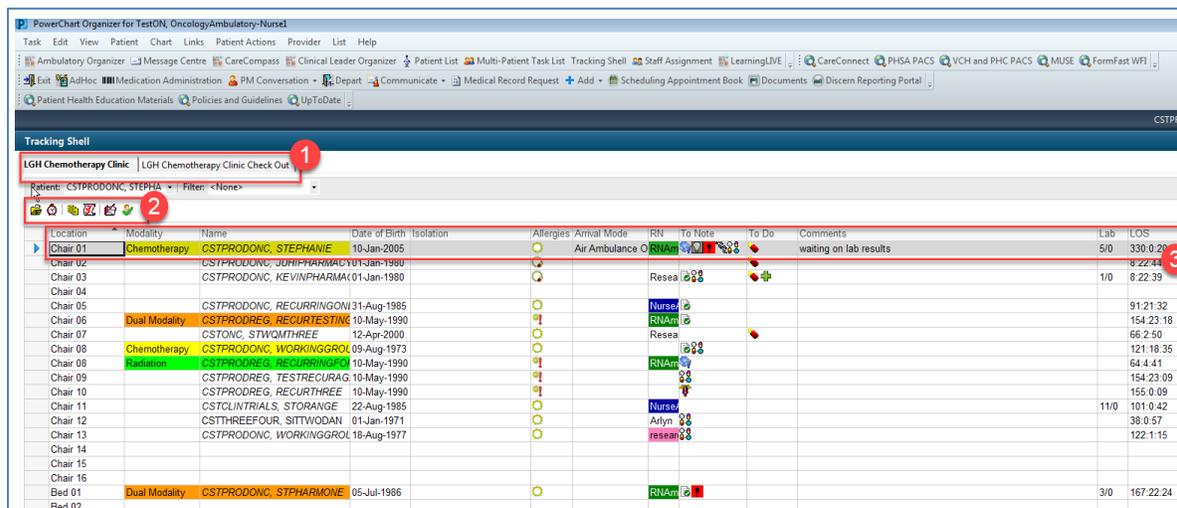
Your patient has arrived to the Chemotherapy unit for her first BRAVA7 treatment and the Clerk has checked the patient in through **Ambulatory Organizer**. As a nurse you will be monitoring the **Tracking Shell**. When a patient is checked in they will be populated into the waiting room, at the bottom of the Tracking Shell List. You are now ready to bring the patient into the room. Let's explore.

- 1 To access the **Tracking Shell** select the appropriate option from the toolbar at the top of your screen.



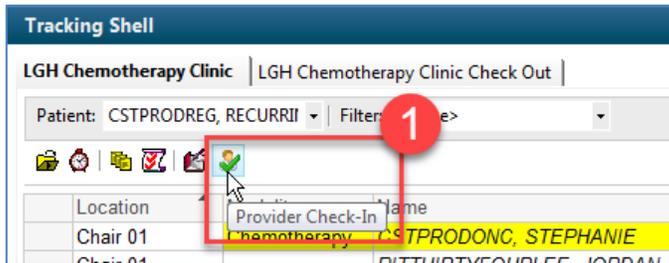
- 2 The **Tracking Shell** displays the following information:

1. **Tracking Lists** that are defined for specific functions. The **Check Out** list will be used by supervisors to show clinical data.
2. **Toolbar** that guides you to different functions.
3. The Column provides more detail about patients in the clinic at a glance (Location, Modality, Name, Date of Birth, Isolation, Allergies, Arrival Mode, RN, To Note, To Do, Comments, Lab, and Length of Stay).



3 When you arrive to work and are finished checking your patient’s chart, you access **Tracking Shell** to assign yourself to your patients and update their status and location. When you first enter Tracking Shell you need to check yourself in as a **Provider**.

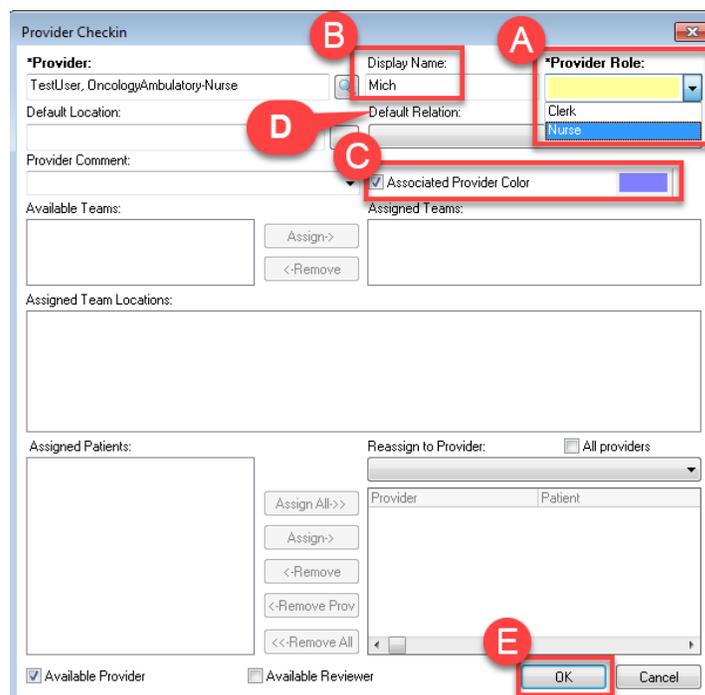
1. Click on the **Provider Check-In**  icon.



**Note:** The icon in the toolbar will change to the Provider Check-out  icon.

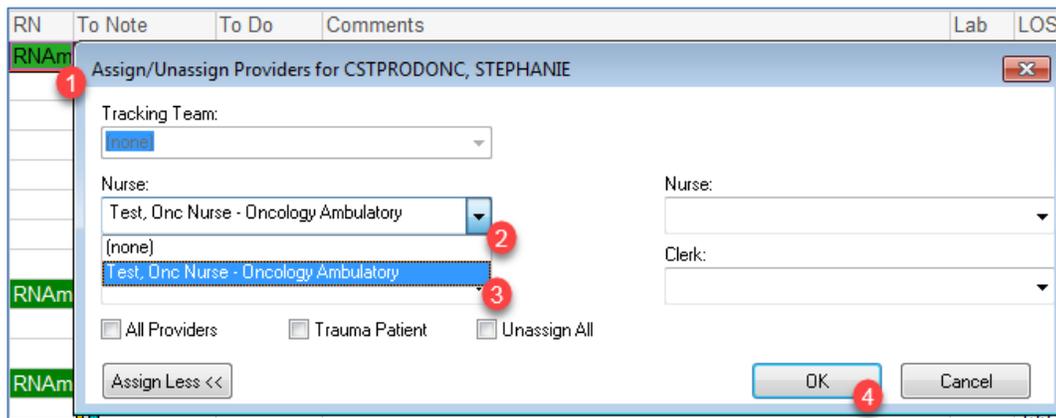
2. **Provider-Check In** Window pops up:

- A. **Provider Role** is the only mandatory field, select **Nurse**
- B. You can choose to create a **Display Name** to appear in the tracking shell (useful if nurses have the same initials).
- C. To associate a color to appear in the RN column you may select one (quick visual reference of who your patients are).
- D. You may select your **Default Relation** as well (limits need to establish a relationship when accessing your patients charts).
- E. Click **OK** to complete the process; you are now able to assign yourself patients.



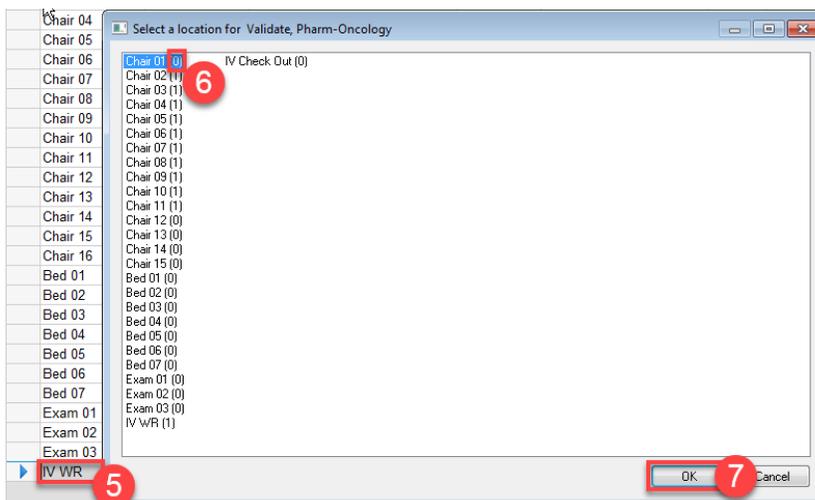
4 From the Tracking Shell you will assign yourself to be the nurse and assign the patient a chair.

1. Select your patient from the Tracking List, Please use the patient provided [**Oncology-NurseA, enter first name**]
2. Double-click the **RN** column in the patient’s row.
3. In the **Assign/Unassign** providers window, click on the **down arrow** to assign yourself as the nurse.
4. Click **OK** or **Enter** on the keyboard.



**Note:** You will notice your Associated Provider Color is updated in the RN column

5. Double-click the **location** listed in the patient’s row.
6. In the select window, double click on the **room/chair** that you are taking the patient to (select chair 01).
7. Click **OK**.



**Note:** The number of patient’s already in that location displays in parentheses.

5 Events are the time-stamped activities that occur during a patient's visit. Events are used to communicate the status of activities for a patient (e.g. Meds Ready will be added as an event by Pharmacy to communicate to Nursing the patient's chemotherapy is ready, nurses will add Patient Ready to treat icon to communicate all checks have been done and patient is ready). Events are depicted with icons and are visible in the 'To Note' and 'To Do' columns on the Tracking Shell. Position the mouse over the event to see what the event icon represents.

Icon	Description
	Blood Product Ordered
	Clinical Trial/Study
	Interpreter Required
	Outpatient Rx Ready
	Outpatient Rx Reminder
	Porter Called
	Procedural Sedation
	Provider Exam Needed
	Treatment in Progress
	Treatment on Hold
	Volunteer Needed
	Ready for Treatment
	Meds Ready

Using the following questions to guide you, discover more of the functionality of the tracking Shell, hint: 'Hover to Discover'

- Double click in **Arrival Mode** column, what do you discover?
- Right-click in the 'To Note' column, what do you see?
- Mark patient Ready for Treatment, and a Volunteer is Needed.
- Click in the **Comments** section and write 'please call patient's daughter when treatment is complete'.
- Double click on the **Allergy** section, what do you see?

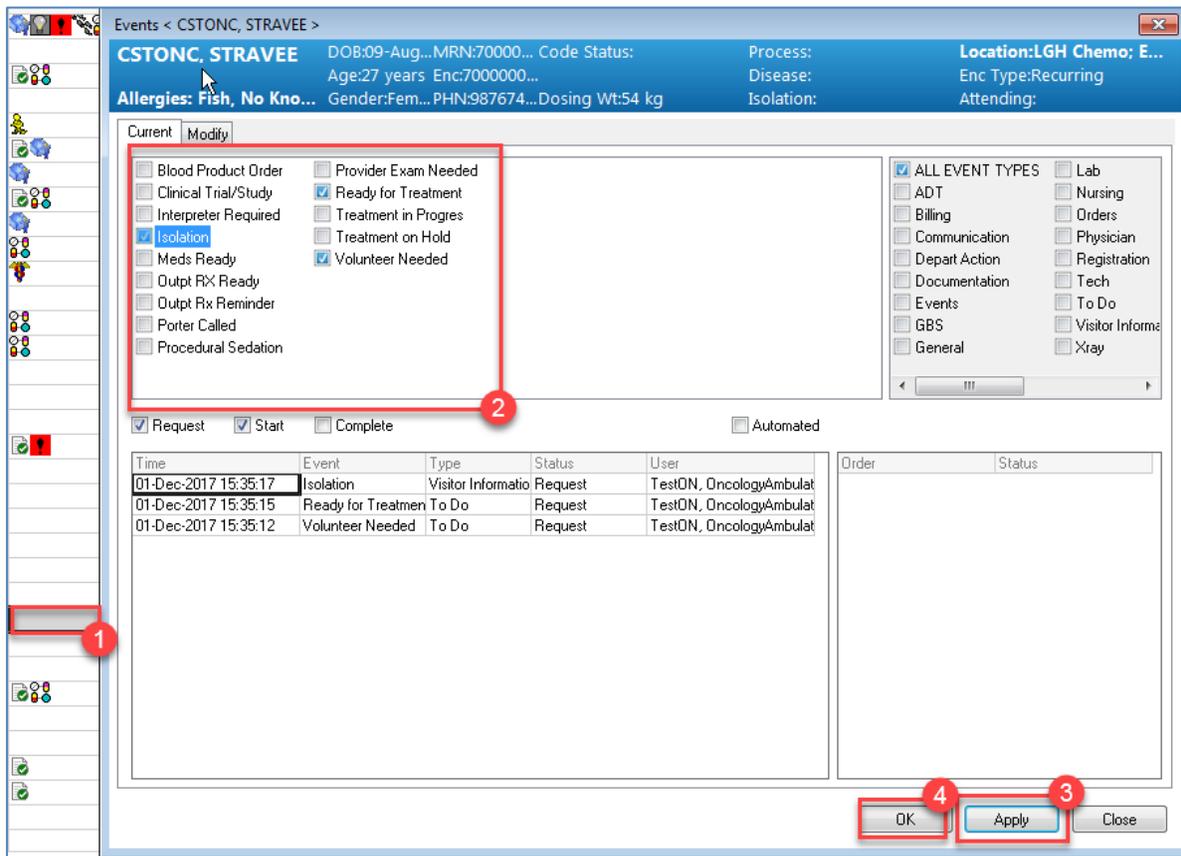
**Note:** The Lab column will display how many labs are ordered and if they have been completed.

Order	Time	Order Status	Departmental Status
CBC	27-Sep-2017 13:53	Ordered	Pending Collection
Bilirubin Total	27-Sep-2017 13:20	Ordered	Pending Collection
Platelet Count	27-Sep-2017 13:18	Ordered	Pending Collection
Differential	27-Sep-2017 13:18	Ordered	Pending Collection

6 To add a 'To Do' or 'To Note'

1. Right-Click in the corresponding column
2. Check the notes you would like to add to the Tracking Shell
3. Click **Apply**
4. Click **OK**

These will now display within the appropriate columns with the corresponding icons.



### To Remove or change the status of a 'To Do' or 'To Note'

5. Click on the **Down Arrow** in the **Status** cell
6. Choose the **Status** you would like to reflect.

Events < CSTPRODONC, RECURRINGONE >

**CSTPRODONC, REC...** DOB:31-Aug...MRN:70000... Code Status: Process: Location:LGH Chemo: C...  
Age:32 years Enc:7000000... Disease: Enc Type:Recurring  
Allergies: No Known All... Gender:Fem...PHN:987671...Dosing Wt:65 kg Isolation: Attending:

Current Modify

Blood Product Order  Treatment in Progress  
 Clinical Trial/Study  Treatment on Hold  
 Meds Ready  
 Outpt RX Ready  
 Outpt Rx Reminder  
 Porter Called  
 Procedural Sedation  
 Provider Exam Needed  
 Ready for Treatment

ALL EVENT TYPES  Lab  
 ADT  Nursing  
 Billing  Orders  
 Communication  Physician  
 Depart Action  Registration  
 Documentation  Tech  
 Events  To Do  
 GBS  Visitor Informa  
 General  Xray

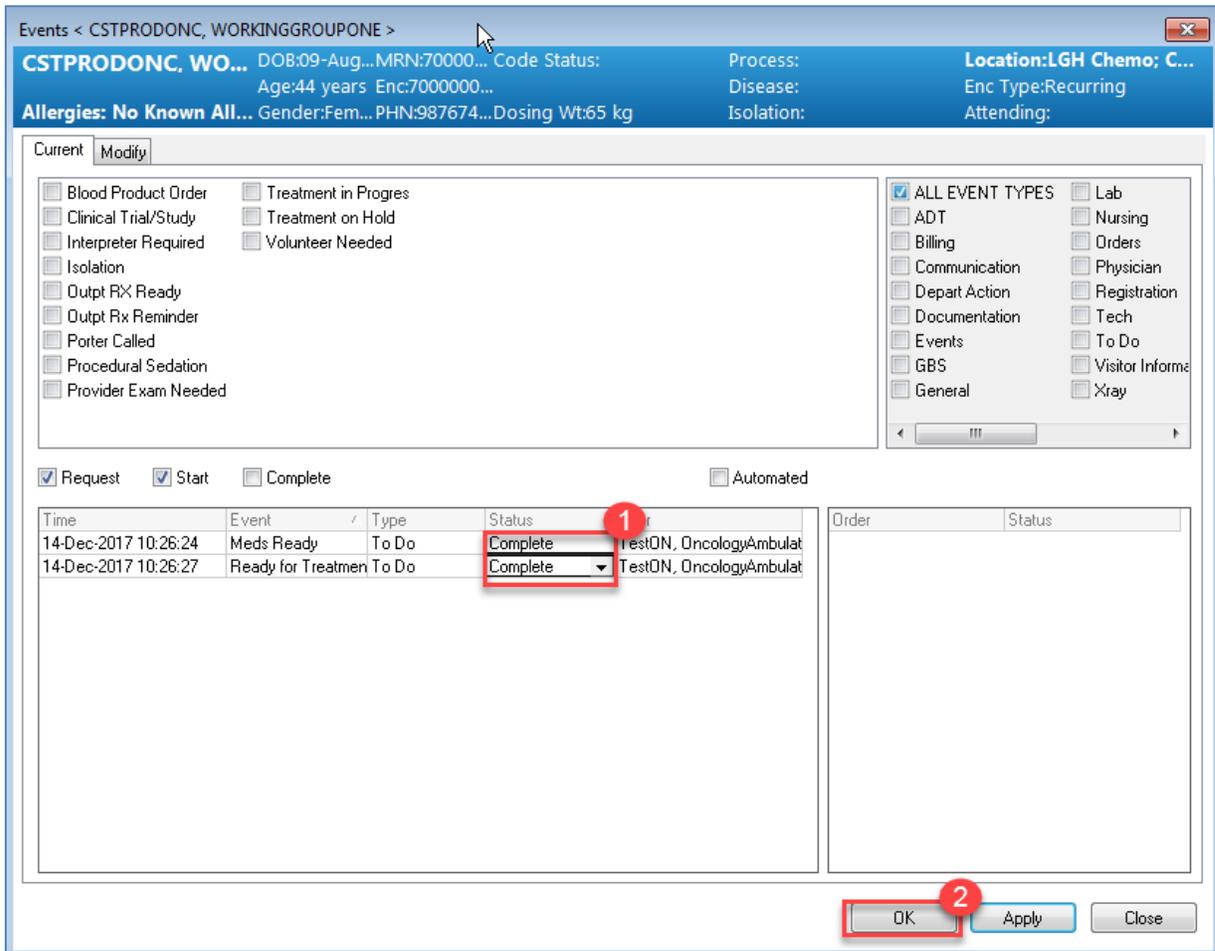
Request  Start  Complete  Automated

Time	Event	Type	Status	User
01-Dec-2017 15:31:04	Volunteer Needed	To Do	Request	TestON, OncologyAmbulat
01-Dec-2017 15:31:00	Isolation	Visitor Informatio	Request	TestON, OncologyAmbulat
01-Dec-2017 15:32:24	Interpreter Required To Do	To Do	Complete	TestON, OncologyAmbulat

Order Status

OK Apply Close

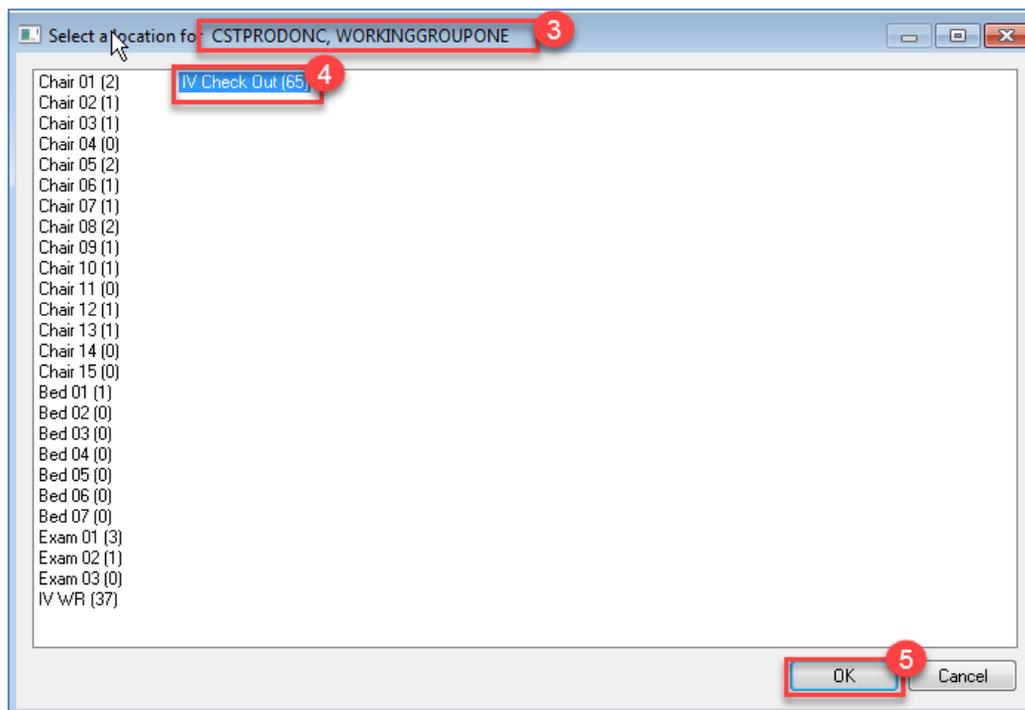
- 7 When the patient has completed treatment and you have finalized your charting. You will need to remove the associated **'To Note'**, **'To Do'**, and **Comments** created within the Tracking Shell. If these are not removed they will be carried forward to subsequent treatments. You will also have to check-out your patient from the Tracking Shell and check-out as a Provider.
1. Right-Click in the **'To Note'** column and complete the notes.
  2. Select **OK** to complete the removal of the icons.



**Note:** Delete the comments by back spacing in the Comments column.

Once the patient’s treatment is completed and they have left the Chemotherapy unit **Double-Click** on the **Location** column.

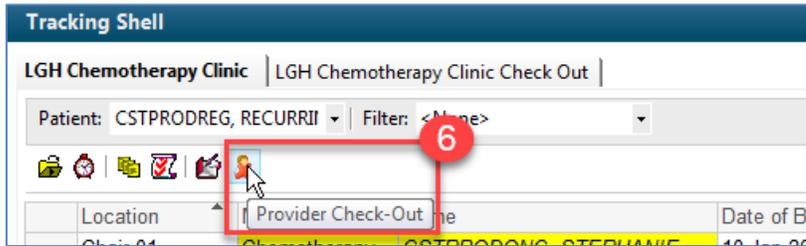
3. Make sure the **Location** you have selected corresponds with the patient you want to check-out.
4. Select **IV Check Out**.
5. Click **OK** to complete the action.



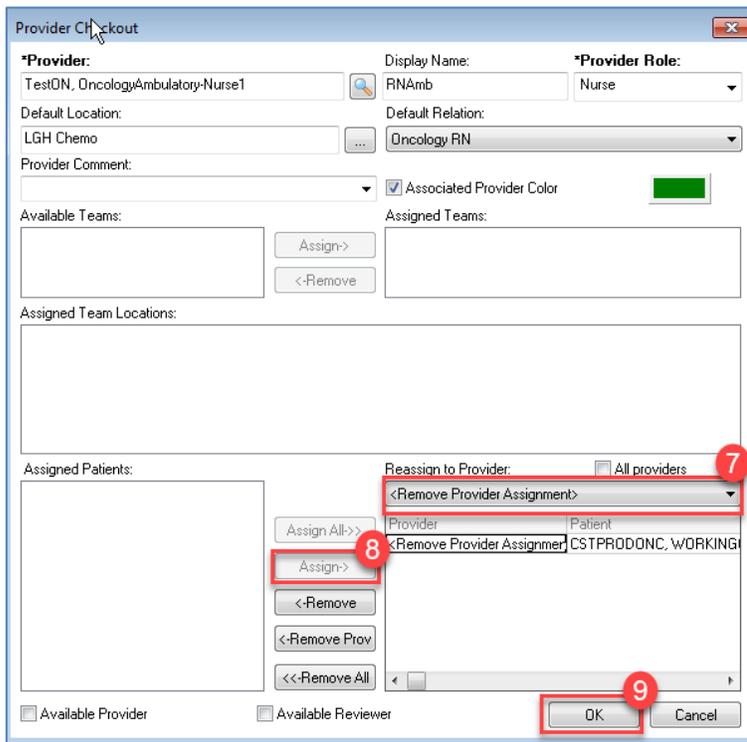
**Note:** Once the patient has been checked out you will not be able to access their chart from the Tracking Shell as they will drop off the list.

At the end of your day it is important to remember to **Provider Check-Out**, this will clear the list of patient’s you have assigned to yourself so that when you return to work you will be able to start with a fresh empty list.

6. Select the Provider Check-Out  icon.



7. Under Reassign to Provider select <Remove Provider Assignment>.
8. Move the patient's currently assigned to you by clicking Assign. This assign's the patient to be removed from your assigned list. You could also choose to assign them to another provider if you were handing over a patient to another nurse.
9. Click OK to complete the task and be Checked-Out as a Provider.



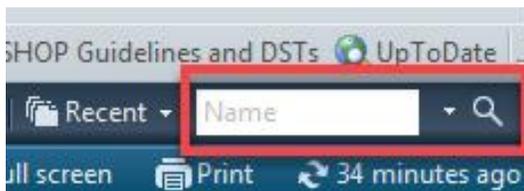
**Note:** You will notice you have checked out as the toolbar icon will change back to allow you to do a Provider-Check-In.

### Key Learning Points

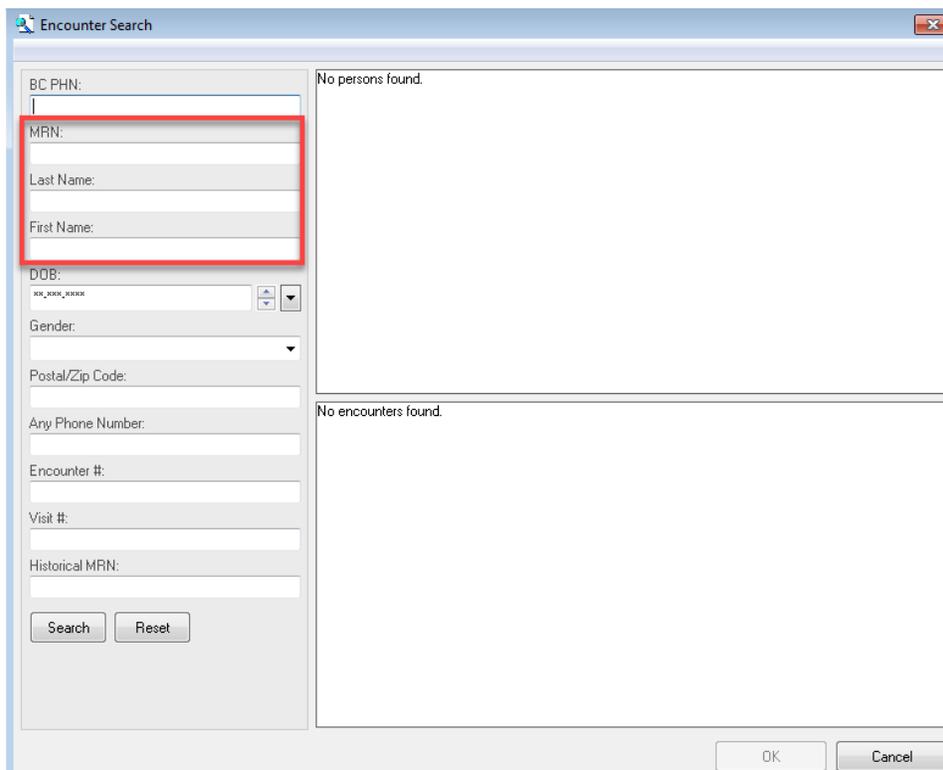
- Tracking Shell is a communication tool between staff, in particular nursing and pharmacy.
- In order to be able to assign yourself to a patient you must check yourself in at the beginning of the day.
- Patients are assigned into their location from the tracking shell.
- You must remove/delete any icons and comments that you do not wish to carry forward.
- Check out the patient at the end of treatment; after removing the icons and comments.
- Provider Check-Out must be done at the end of your shift to remove patients from your provider assignment list.

## Activity 1.3 – Accessing a Patients Chart

- 1 Having done a provider check-out in the previous exercise your patient will no longer be in the Tracking Shell. Another way to access a patient's chart is by using the Search  function in the upper right hand corner of your screen. You can type the patient's name right in the box or open the search window to search through other means.



Open the patient you had assigned yourself in the last exercise [**Oncology-NurseA, enter first name**].

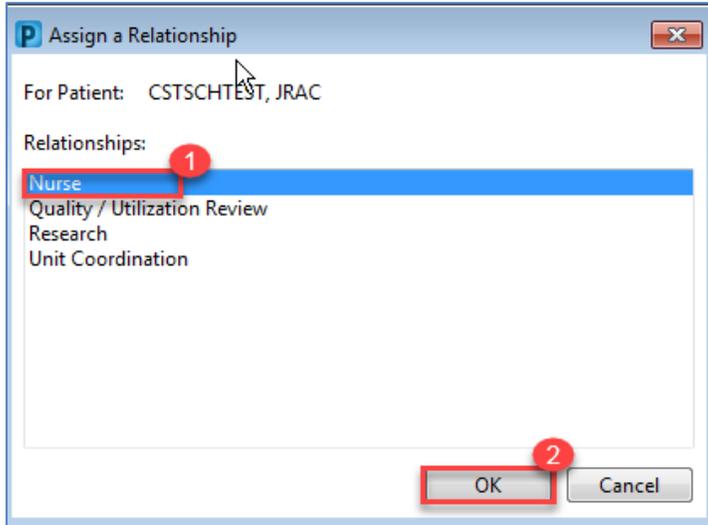


**Note:** As you will remember from e-learning it is important to select the correct encounter if a patient has multiple encounters. For the Chemotherapy Clinic setting you are looking for the patient's Recurring Encounter.

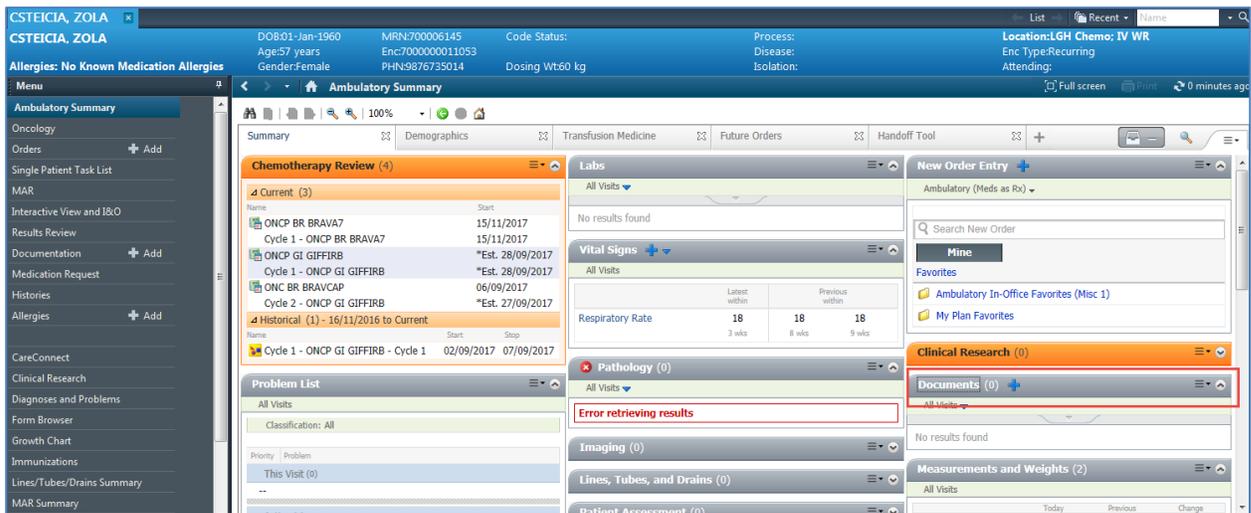
Your patient has now settled in her chair and is ready for treatment. You begin to ask her about side effects from her previous chemo treatment, as she was previously on BRAVCAP and is now to start BRAVA7. In order to begin documenting our assessment, follow the steps below:

2 When you access the chart for the first time, you are prompted to **Assign a Relationship** with the patient, this is the same as signing the signature record in a chart currently.

1. Select **Nurse**.
2. Click **OK**



3 The **Ambulatory Summary** screen (known as an mPage) of the chart is the main screen which appears as an Ambulatory Oncology Nurse when you first open a patient's chart. This screen is a snapshot into various sections of the patient's chart and is a good place to begin to navigate from.



**Note:** If a patient is enrolled on a clinical trial, the Clinical Research Component contains more information regarding the trial as well as contact information for the Clinical Nurse Coordinator. A process note would also be added within the banner bar.

### Key Learning Points

- You can access a patient's chart right from Tracking Shell.
- To see the patient's chart you must establish a relationship in order to view the contents.
- The main screen to appear as an Ambulatory Oncology Nurse is the Ambulatory Summary screen which is a snapshot of various sections within the chart.

## Activity 1.4 – Charting in IView

Nurses will complete most of their documentation in **Interactive View and I&O (IView)**. IView is the electronic equivalent of current state paper flow sheets. For example, vital signs and pain assessment will be charted in IView.

Your patient provides you with the following information when asked about her time between treatments:

- Mild nausea alleviated with prochlorperazine and occasional marijuana use
- Appetite unchanged, eating 75% improves with marijuana.
- Diarrhea (5 loose stools x 3 days) she called the helpline and used loperamide to good effect.
- Long standing neuropathy affecting and limiting some of her ADLs; trouble doing up buttons.
- The patient notes she has taken both her dexamethasone (12mg) and ondansetron (8mg) right before coming in the room. You clarify the anti-emetic schedule for the next few days and write out a calendar for her.

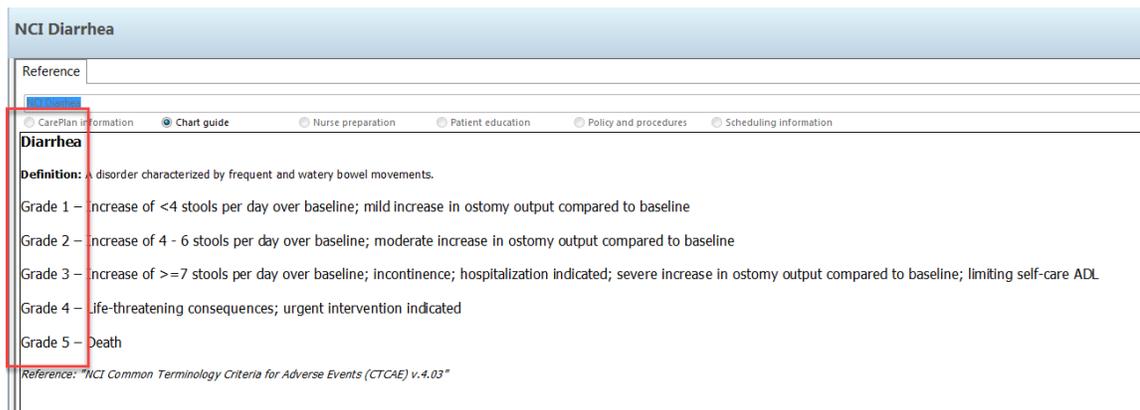
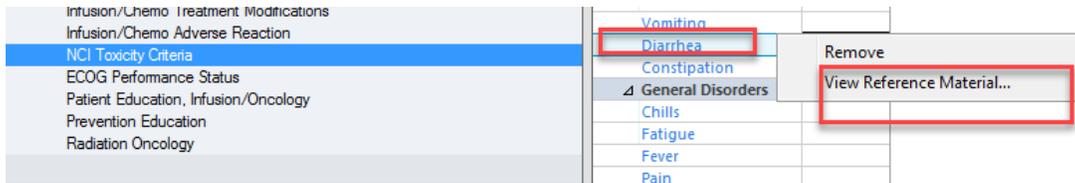
Now let’s use this information to start charting!

**1** Select Interactive View and I&O within the Menu. Now that the IView page is displayed, let’s view the layout.

1. A **band** is a heading that has a collection of flowsheets (**sections**) organized beneath it. Below the **Infusion-Oncology** band is expanded displaying the sections within it.
2. The set of bands below **Infusion-Oncology** are collapsed. Bands can be expanded or collapsed by clicking on their name.
3. A **section** is an individual flowsheet that contains related assessment and intervention documentation.
4. A **cell** is the individual field where data is documented.

**2** Select the **Infusion-Oncology** band and navigate down to the **NCI Toxicity Criteria** section to chart the patient’s side effects. Let’s chart her diarrhea.

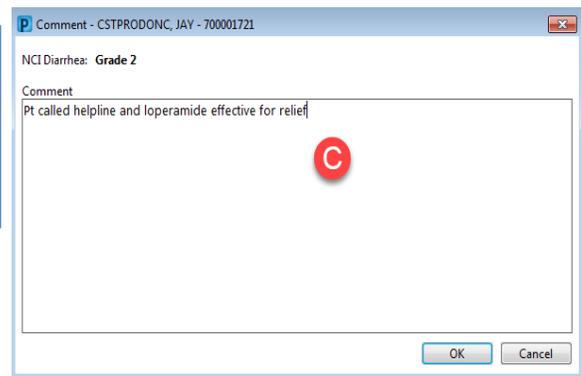
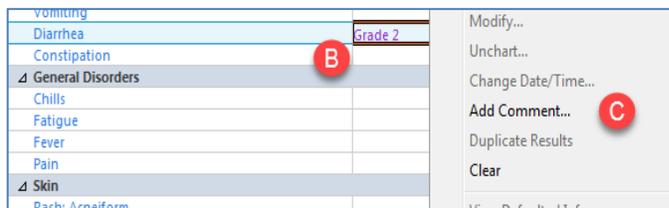
A. Notice that **Diarrhea** is written in blue which means there is reference text linked. Double-Click to bring up the NCI Diarrhea Grading tool.



B. Per the grading tool let’s make the score a 2 in the results box. Click in the box and a drop down menu appears. Select Grade 2 (notice the writing is in purple, this means it has not been saved to the chart yet).

C. Right-Click on the results section to add a comment that the patient called the helpline and the diarrhea was alleviated with loperamide.

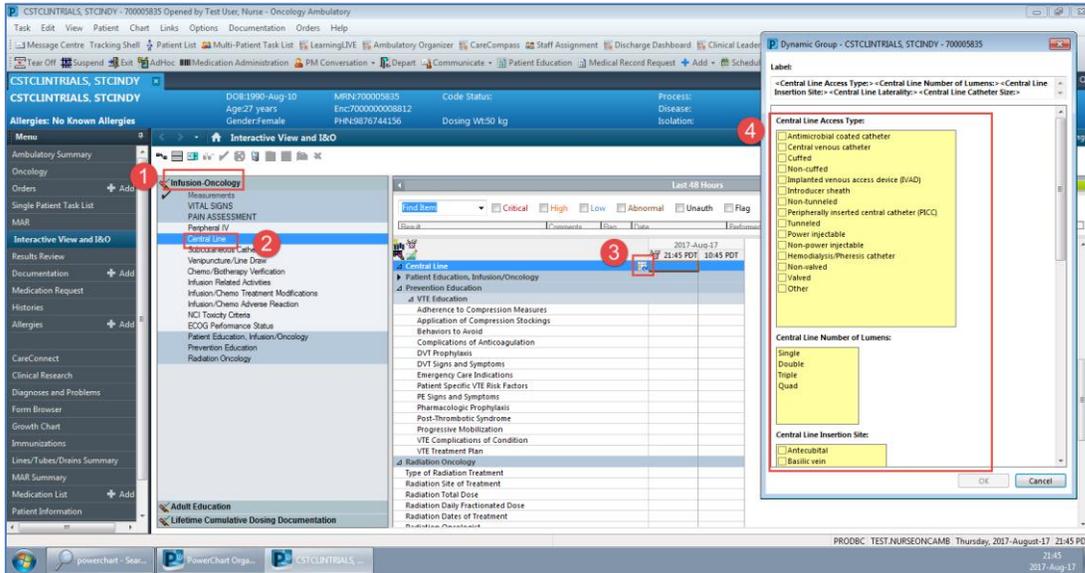
Go to the Nausea sub-section in the NCI Toxicity Criteria to document about patient’s nausea.



3 The patient has an IVAD which she describes as her life saver but notes the bigger needle is required as she frequently has trouble with blood return when coming in for lab work.

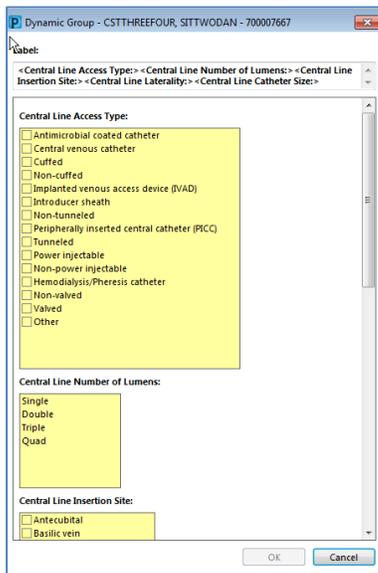
Let's document the IVAD access- follow along with the instructions:

- Locate **Infusion-Oncology** band (1) and click **Central Line** section (2).
- Click on the  symbol (3) to create a dynamic group (4).

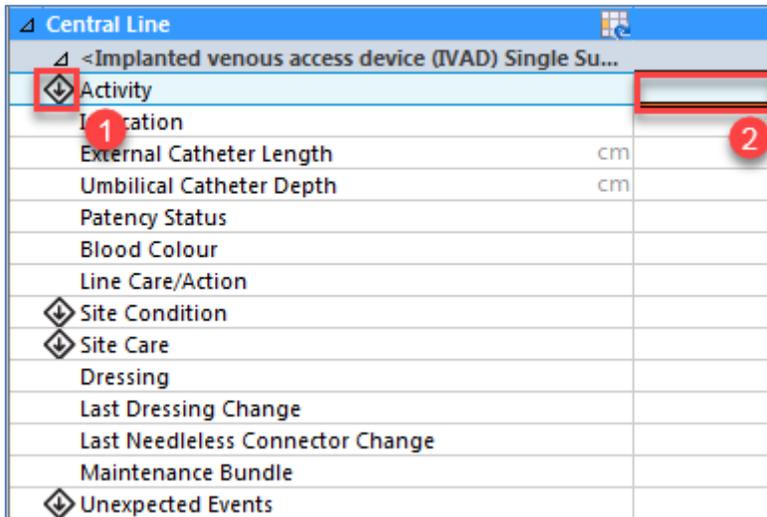


4 Dynamic groups allow the documentation and display of multiple instances of the same grouping of data elements.

- Document you accessed your patients Right IVAD, single lumen with a 19g 3/4" Huber needle.



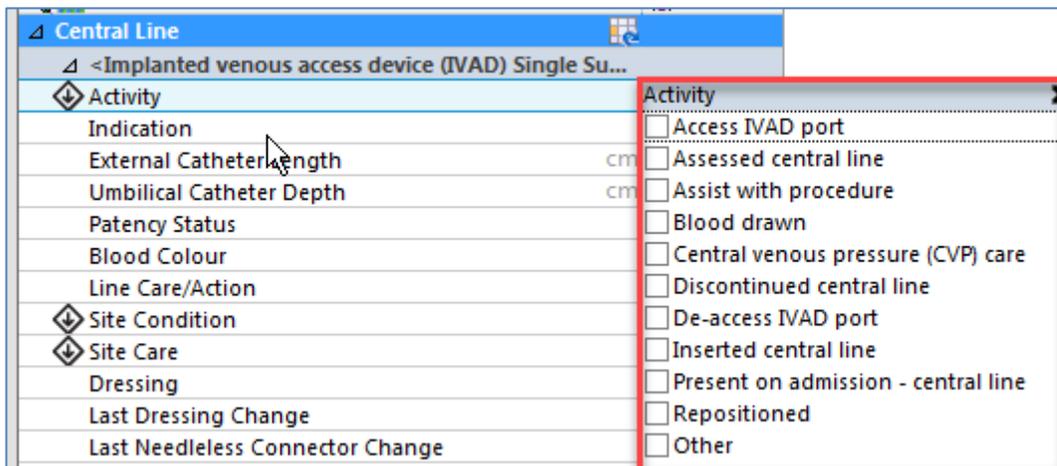
- 5 To enter more information about the IVAD, you can see from the  (1) that there is a conditional field which will help guide you in your documentation



Central Line	
<Implanted venous access device (IVAD) Single Su...	
 Activity	
Indication	
External Catheter Length	cm
Umbilical Catheter Depth	cm
Patency Status	
Blood Colour	
Line Care/Action	
 Site Condition	
 Site Care	
Dressing	
Last Dressing Change	
Last Needleless Connector Change	
Maintenance Bundle	
 Unexpected Events	

**Note:** The conditional field  can be seen in some cells such as Activity, indicating that there is additional documentation to be completed. The diamond icon  indicates the additional documentation cells that appear as a result of these responses being selected. These cells are not mandatory.

- 6 Double click in the cell where you would like to document. Check the box that you accessed the IVAD and drew Blood.

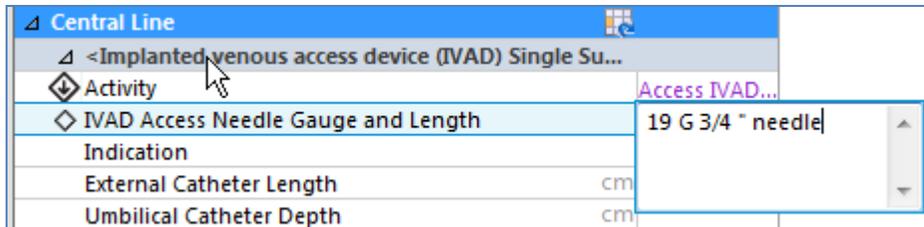


Central Line	
<Implanted venous access device (IVAD) Single Su...	
 Activity	
Indication	
External Catheter Length	cm
Umbilical Catheter Depth	cm
Patency Status	
Blood Colour	
Line Care/Action	
 Site Condition	
 Site Care	
Dressing	
Last Dressing Change	
Last Needleless Connector Change	

Activity

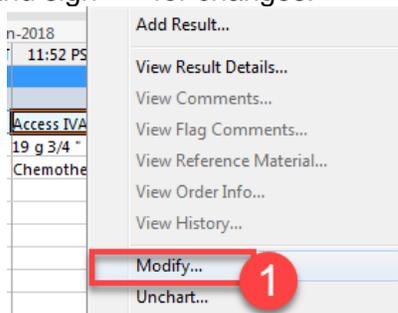
- Access IVAD port
- Assessed central line
- Assist with procedure
- Blood drawn
- Central venous pressure (CVP) care
- Discontinued central line
- De-access IVAD port
- Inserted central line
- Present on admission - central line
- Repositioned
- Other

- 7 You then document the needle gauge and length by clicking  and opening a free text box to add your info. Click  to sign.

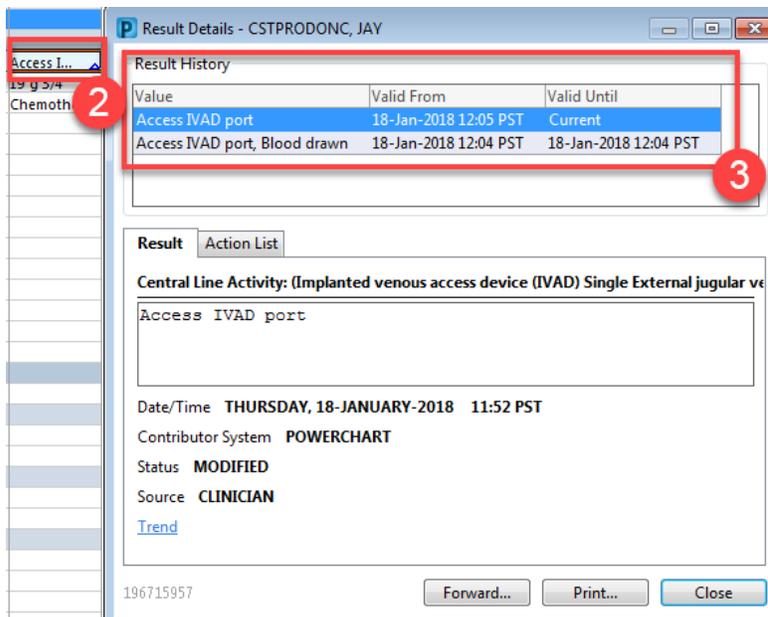


**Note:** Text colour will change from purple to black when signed (official part of the chart).

- 8 After you clicked the sign you realized you did not draw blood from your patient's Port. Go to the cell (box) where you recorded 'Blood Drawn' (1) and Right click Select '**Modify**' unselect Blood Drawn and sign  for changes.



You can see the small blue triangle  indicating the modification (2). Double click on the cell and you will see the history of the documentation (3). **Sign** the document.



You provide the patient with the information and side effect profile of Doxorubicin, which she recalls from her first treatment of her breast cancer. You reinforce the most common side effects and management strategies. The patient then tells you she has been feeling a little faint, you do a set of vitals:

- BP 110/64
- HR 88
- RR 16
- O2 96% on RA
- T 36.2

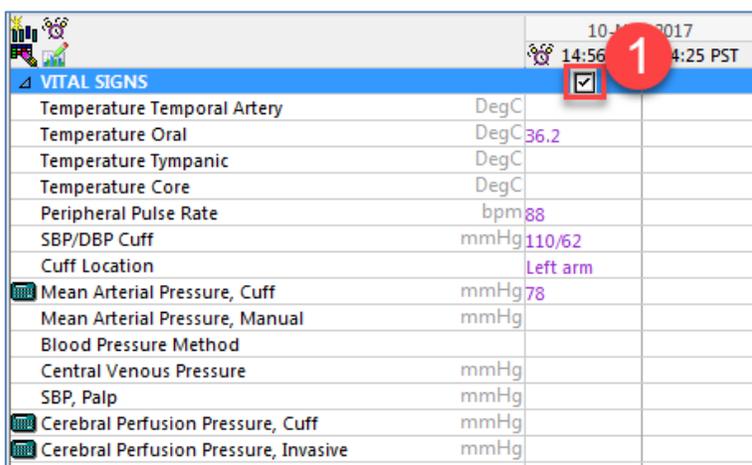
She notes she hasn't been drinking plenty of fluids lately and usually feels this way when she is unable to get a reasonable amount of fluids down. You educate her on proper fluid intake and mention you could call the doctor to have some fluids added to her treatment today but she is positive she will be able to increase her intake. You also let her know that if she continues to feel faint with increase fluid intake that she is to call the helpline as she may require some IV Hydration.

**9** Let's practice and input the vital signs in IView:

Locate the Vital Signs Band and click to select. To make entry easier double click on the header (1) to select the field and enter results in succession:

- T 36.2
- HR 88
- BP 110/62 Left Arm
- RR 16
- O2 96 % RA

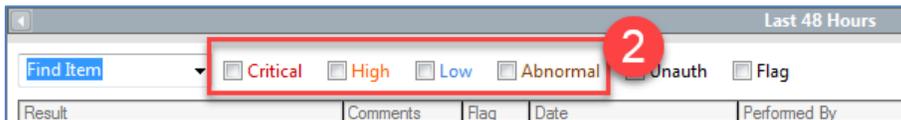
Click to  sign.



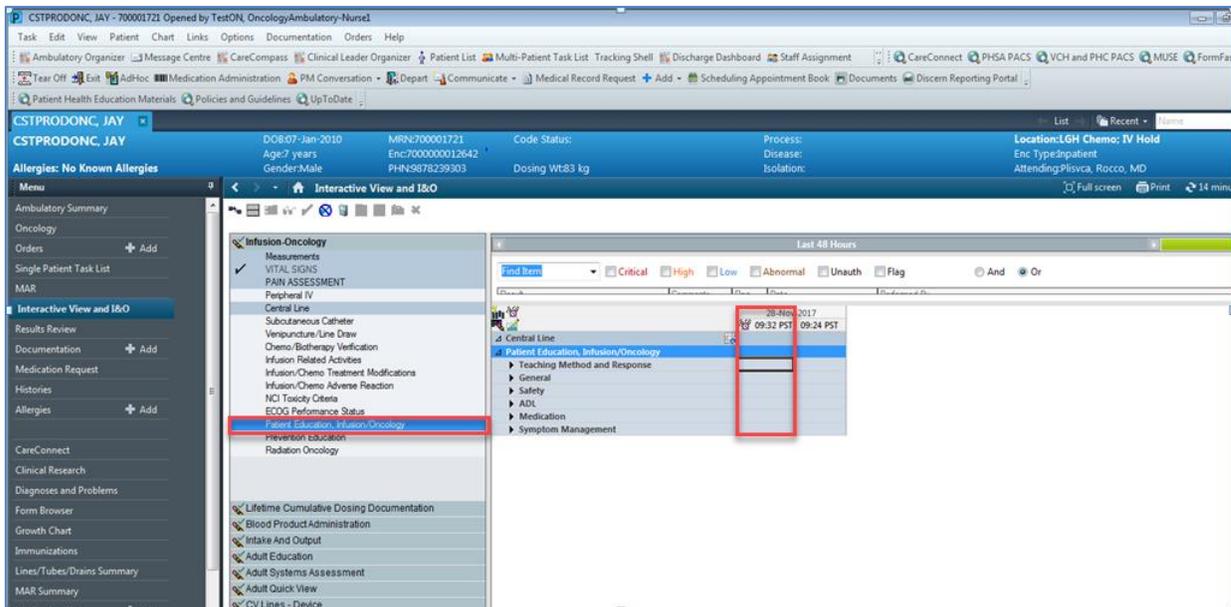
VITAL SIGNS		10-11-2017
		14:56 4:25 PST
Temperature Temporal Artery	DegC	
Temperature Oral	DegC	36.2
Temperature Tympanic	DegC	
Temperature Core	DegC	
Peripheral Pulse Rate	bpm	88
SBP/DBP Cuff	mmHg	110/62
Cuff Location		Left arm
Mean Arterial Pressure, Cuff	mmHg	78
Mean Arterial Pressure, Manual	mmHg	
Blood Pressure Method		
Central Venous Pressure	mmHg	
SBP, Palp	mmHg	
Cerebral Perfusion Pressure, Cuff	mmHg	
Cerebral Perfusion Pressure, Invasive	mmHg	

10 You can select vital signs to display through result type (2).

- **Critical** = red
- **High** = orange
- **Low** = blue
- **Abnormal**= brown



11 Expand the Patient Education, Infusion/Oncology Band within IView to practice documenting educating the patient on proper fluid intake. Include the patient’s response to teaching and follow up instructions.



### Key Learning Points

- Nurses will complete most of their documentation in IView.
- IView contains flowsheet type charting.
- Documentation will appear in purple until signed. Once signed, the documentation will become black.
- The newest documentation displays in the left most column.
- Double-click the blue box next to the name of the section to document in several cells, the section will then be activated for charting.

## Activity 1.5 – Charting a PowerForm

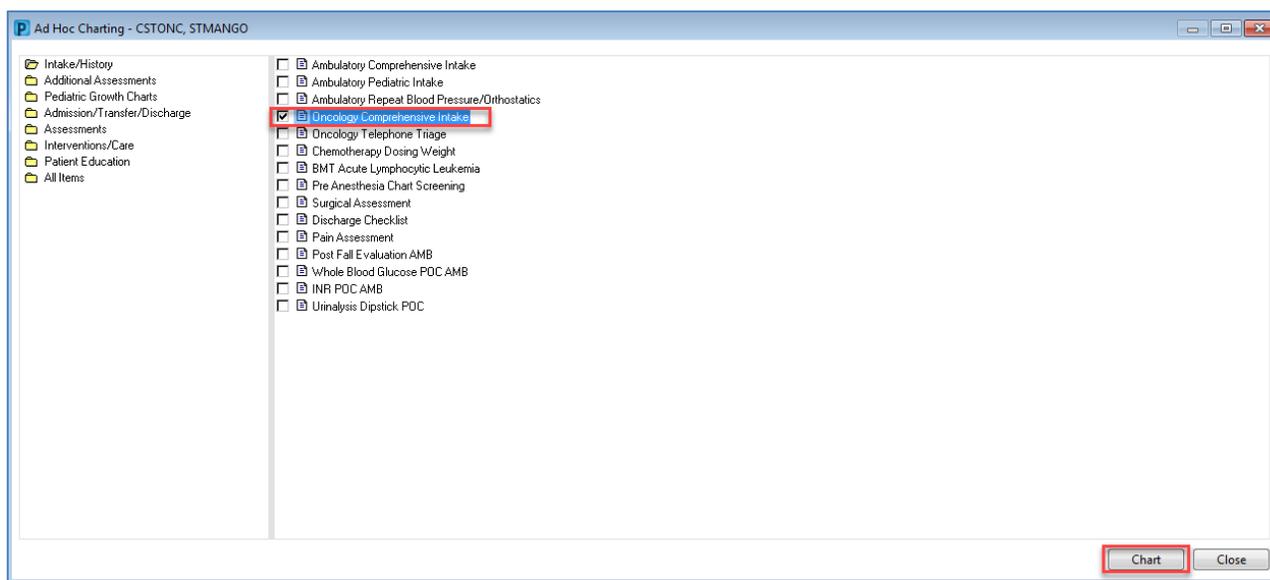
**PowerForms** are the electronic equivalent of paper forms currently used to chart patient information.

Data entered in **PowerForms** can flow between IView flowsheets, Clinical Notes, Problem List, Allergy Profile, and Medication Profile. The **AdHoc** folder is an electronic filing cabinet that holds any PowerForm you may need to document on.

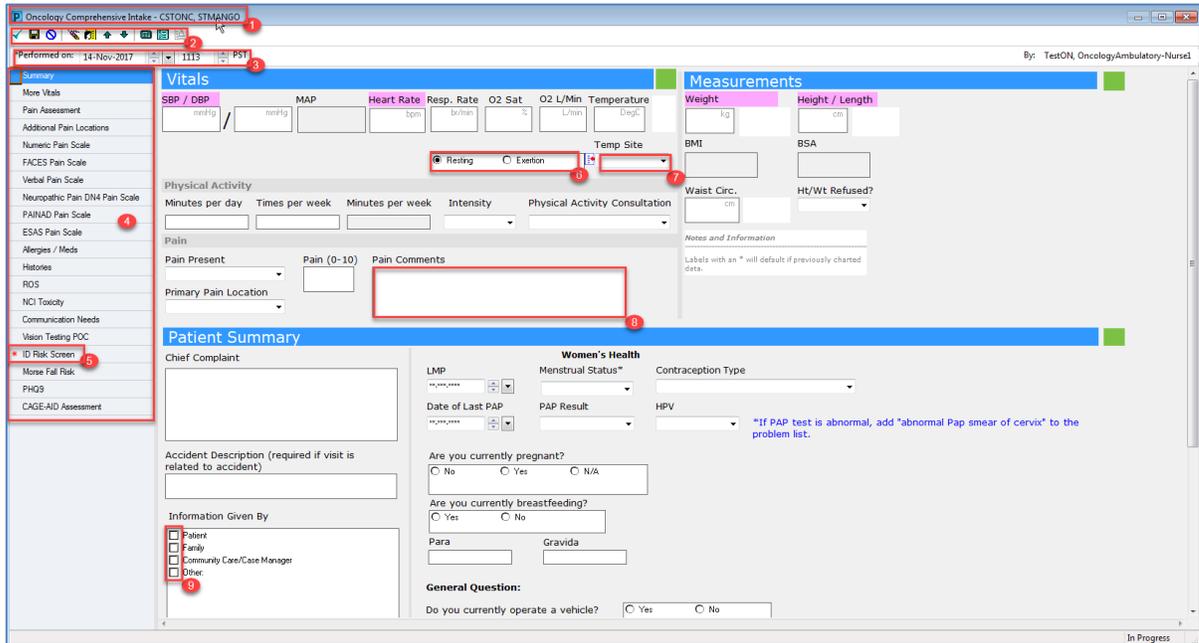
In the Oncology Ambulatory setting these forms would likely be used more in the clinic visit setting, especially upon initial visit. Although your patient is in for her chemo treatment today let's go in and look at the Oncology Comprehensive Intake Form that we would have filled out while working in clinic. The Oncology Comprehensive Intake Form includes the patient's height, weight, vitals, allergies, medication by history, procedure/social history, and assessment forms and scales. The patient also reminded you while accessing her IVAD that she is allergic to Band-Aid adhesives and prefers the paper tape, which has not been documented.

1

From the patient's chart you can access blank documents (PowerForms) from clicking on . Then select the appropriate form (**Oncology Comprehensive Intake Form**). Click **Chart**.



- 2 The table of contents on the left hand side of the popup window allows you to work through the PowerForm in descending order. When the form is completed, the upper left toolbar allows you to sign, save, cancel, clear, or obtain result info. Select and explore the form to find functionality that is not listed below.



As you can see, the form is made up of a number of elements. Review the elements and their corresponding numbers on the above diagram.

1. In the information bar you can see the title of the form and the patient's name.
2. Toolbar icons.
3. If you need to change the name date and time that the form was completed you can do so here.
4. The form has multiple sections and you can see the section titles here.
5. The red asterisk indicates that there are mandatory fields in this section.
6. Radial (circular buttons allow you to select only 1 answer).
7. The arrow to the right indicates a drop down menu. Click to see the options.
8. Blank boxes allow you to type free text.
9. Square buttons allow you to select multiple answers.

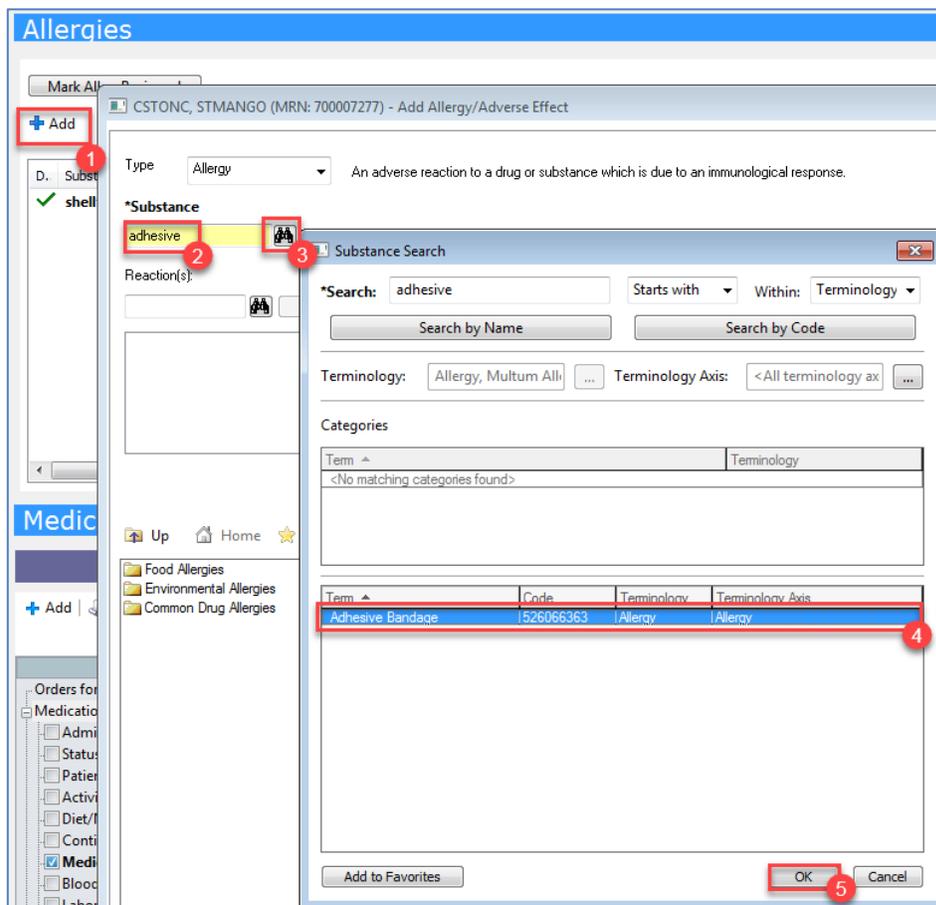
Icon	Action
	<b>Sign Form.</b> Charting entries are recorded and are displayed on the patient's chart. Results are accessible immediately to others.
	<b>Save Form.</b> This button saves your entries and returns you to the previous window. When you save a form, an In Progress status is displayed in the status bar at the bottom right of the form. Documentation up to this point is not displayed until the form is signed.
	<b>Cancel.</b> This button cancels your entries and returns you to the previous window.
	<b>Clear.</b> This button clears your entries and allows you to begin again.
	<b>Result Info.</b> This button allows you to enter the name of the person for whom you are entering ad hoc charting. The system records the charting in the name of that person but tracks that you were the individual who actually entered the results into the system. The person's name you selected, along with the date and time, are shown on the coloured banner near the top of the window.
	<b>Previous.</b> This button opens the previous section.
	<b>Next.</b> This button opens the next section.
	<b>Clinical Calculator.</b> This button opens the Online Clinical Calculator window that allows you to calculate the answer to the selected formula.

As you go through the forms pay attention to the following icons

Icon	Action
 Add	Add e.g. problem, diagnosis, allergy etc.
	Search e.g. allergy, procedural history.

- 3 To practice documenting in the form we will add the patients allergy to Band-Aid/adhesives:
  1. Click **Add**
  2. Type *adhesive*
  3. Click Binoculars to find the correct allergen
  4. Select allergy from list
  5. Click **OK**

Complete required fields; asterisk and highlighted yellow.



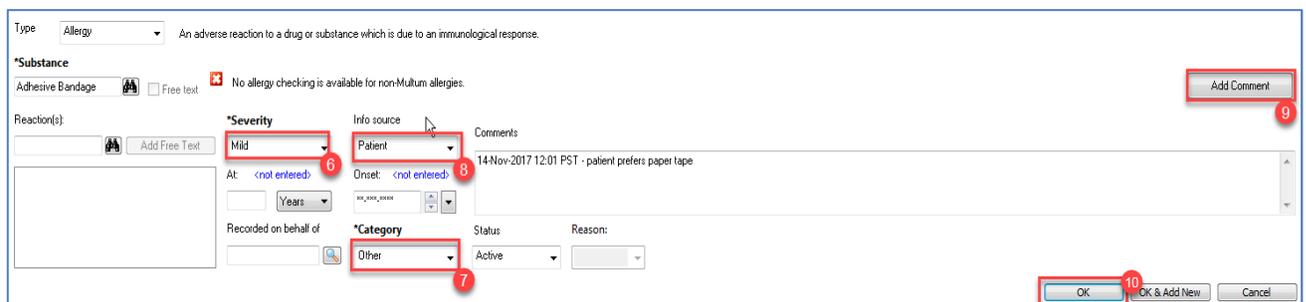
**Note:** Allergies in the banner bar are sorted by severity (most to least). If the allergies listed are longer than the space available, the text will be truncated. Hovering over the truncated text will display the complete allergies list.

6. Fill in **Severity**
7. Fill in **Category**

Fill in any other information that may be obtained or pertinent.

8. Info source
9. Click **Add Comment** and write: Patient prefers paper tape
10. Click **OK**

In order to complete our actions we must sign. Click 



The screenshot shows the 'Allergy' entry form in PowerChart. The form includes fields for Substance, Severity, Info source, Category, Status, and Reason. A comment field is also present. Red boxes and numbers highlight the following elements:

- 6: Severity dropdown menu (set to 'Mid')
- 7: Category dropdown menu (set to 'Other')
- 8: Info source dropdown menu (set to 'Patient')
- 9: Add Comment button
- 10: OK button

**Note:** You may also document allergies by double-clicking on the allergy status in the patients blue banner bar or by double clicking in the allergy column in the tracking shell .

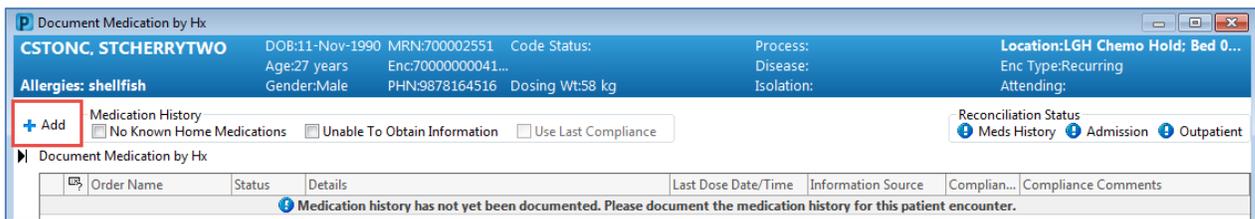
- 4 An accurate and comprehensive medication history is needed before medication reconciliation can be completed by the provider. This is known as the Best Possible Medication History (BPMH). A Pharmacy Technician will complete the BPMH where possible. Where a Pharmacy Tech is unable to do so, the BPMH may need to be completed by the Clinic Nurse. Please refer to the BPMH Quick Reference Guide for detailed instructions on how to complete this when necessary.

Information documented in the BPMH pulls forward into the Admission Medication Reconciliation that the provider will complete. Medications by History (from the **Oncology Comprehensive Intake Form**), select **Allergies/Meds** from the menu.

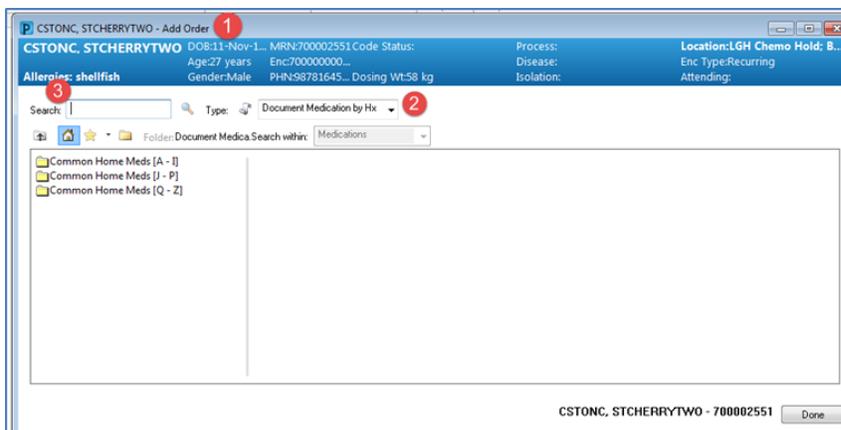
1. You can see that the **Meds History** has been completed.
2. Click on **Document Medication by Hx**



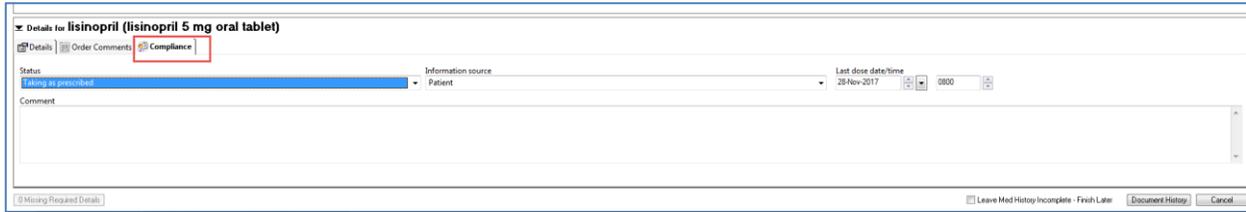
**Document Medication by Hx** window will open. Click on the **Add** button.



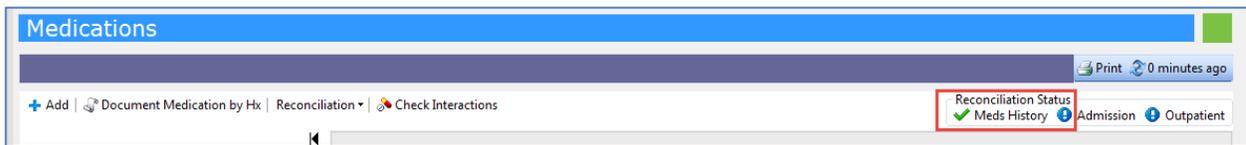
1. The **Add Order** window will open.
2. Note that **Document Medication by Hx** displays in the Type box to indicate the type of order.
3. Type the name of the first medication that you want to document in the search box, select from the drop down. Continue to add all medications that Patient is taking and then click **Done**.



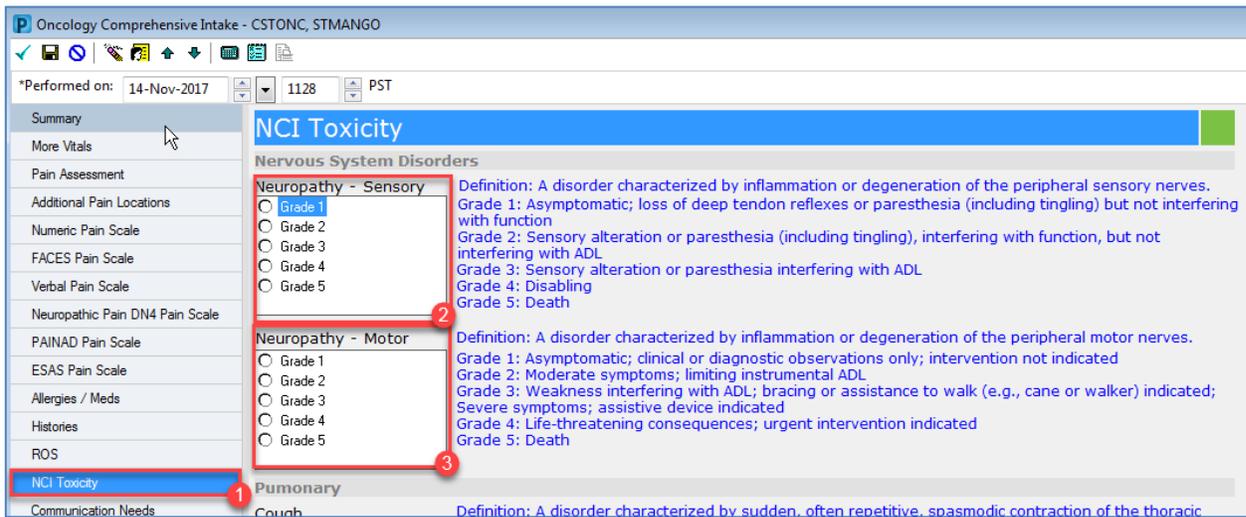
The screen will return to the Document Medication by Hx window where you can add **Details** to the medication history including **Compliance**. When you have finished adding details and compliance click on the **Document History** button.



This will take you back to the Medication section of the Oncology Comprehensive Intake form and a green checkmark will display beside the **Meds History** under the **Reconciliation Status**.



- 5 Document the patient’s neuropathy using the NCI toxicity portion of the Oncology Ambulatory Intake PowerForm.
  1. Click on **NCI Toxicity**
  2. Give Sensory Neuropathy a Grade 3
  3. Give Motor Neuropathy a Grade 2



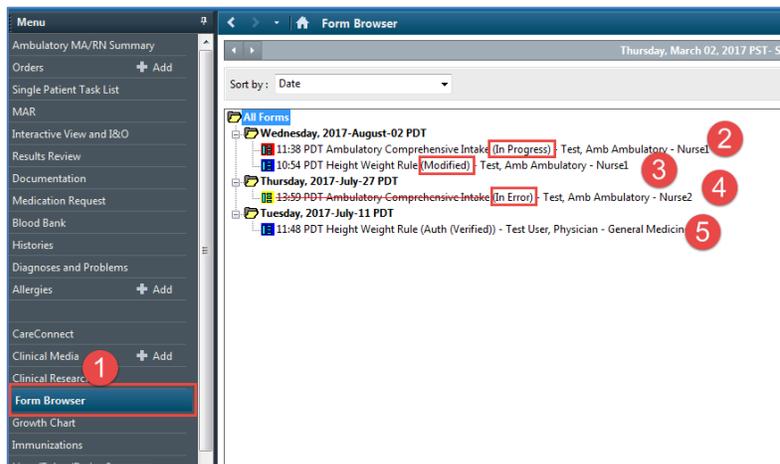
**Note:** If you get called away to see another patient before you complete a form click the save icon. Do this now.

This will save the form for you to complete later. Please note that no one else will be able to see the form until it is signed.

6 Click on **Form Browser** in the **Menu** on the left of the patient chart.

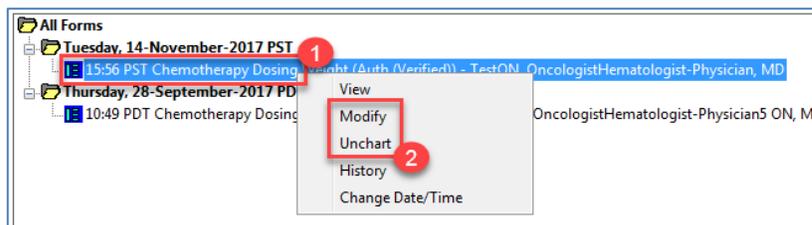
**Form Browser Overview:** The **Form Browser** is where users can refer back to any additional or “Adhoc” documentation. This gives the user the ability to modify or unchart Adhoc documentation charted in error.

1. Form Browser access on the Menu.
2. Form that has been saved (not yet completed and signed- only viewable by you).
3. Form that has been modified.
4. Form that has been uncharted after being charted in error.
5. Form that is completed, signed and saved



To Modify or Unchart:

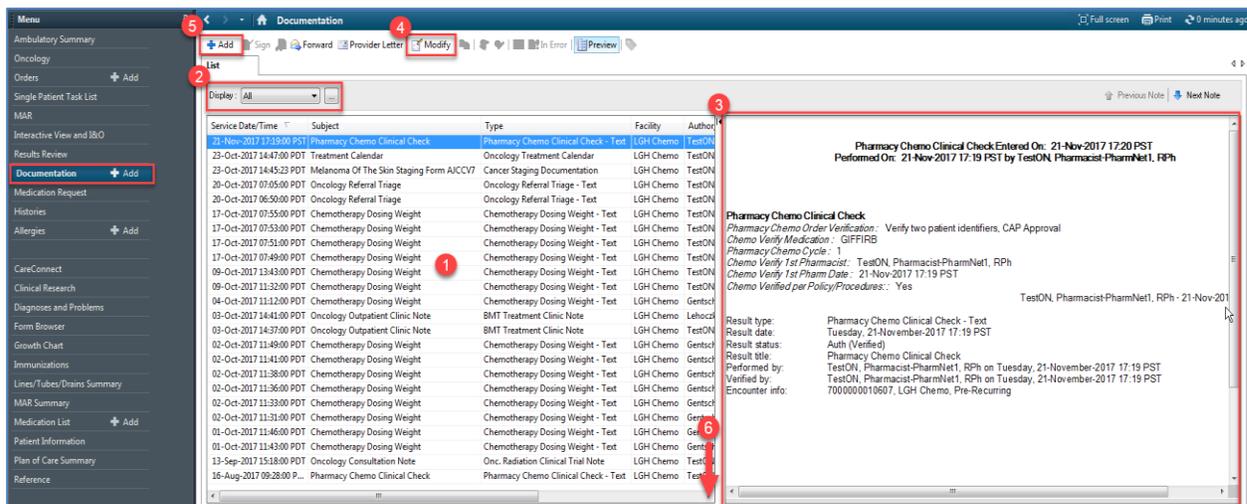
1. Right-click on the document you wish to perform the action too.
2. Select to either Modify or Unchart, either modifying your document or providing a comment as to the reason for Uncharting.
3. Lastly sign ✓ for the changes made.



**7 Documentation Overview:** The document list provides a link to all clinical documentation for the patient including clinical notes and Dynamic documentation in addition to PowerForms. This list provides you with a quick and easy way to view all available notes associated to a patient.

From the document list, you can review existing documents and create new documents for the patient. With the Document Viewing component, you can complete the following tasks:

1. View a list of all available clinical documents for the patient.
2. Filter the document list by document type, status, date, and more.
3. Preview a document in the preview pane.
4. Modify an existing document.
5. Add a new document.
6. Scroll to next list of documents



**Note:** You can only view unsigned Adhoc documentation in the Form Browser tab.

### Key Learning Points

- PowerForms are forms used to chart patient information.
- The AdHoc button in the toolbar is one way to locate a new PowerForm.
- PowerForms may be broken up into several sections. Section headings are displayed to the left side of the PowerForm.
- Saved PowerForms can be found in Form Browser.
- Until PowerForms are signed the information is not shared with other healthcare professionals.
- Important to complete and sign work whenever possible.

## PATIENT SCENARIO 2–Medication Administration

### Learning Objectives

At the end of this Scenario, you will be able to:

- Use the Oncology Tab for chemo checks
- Navigate the MAR
- Perform closed loop medication administration
- Document patient taking their own medication
- Order a medication

### SCENARIO

You have completed assessing your patient and charting all the necessary information. You will now go through the process of checking the chemotherapy (which likely would occur prior to the patient arriving, but for purposes of this workbook we have added it into this section). Once your checks are complete and the medication is verified as safe to give you will administer the Doxorubicin.

Continue to use the same patient for this scenario [**Oncology-NurseA, enter first name**].

As a Registered Nurse on the chemotherapy unit you will be completing the following activities:

- Order Verification and Documentation
- Activating Chemotherapy Orders
- Closed Loop Medication Administration
- No Cosignature Required Orders
- Cancel/Discontinue an Order

## Activity 2.1-Oncology Medication Order Verification and Documentation

### Understanding the structure of Chemotherapy Orders:

**PowerPlan:** One individual order set or cycle of treatment. The orders are broken out into phases of **treatment and days of treatment**.

**Regimen:** A grouping of **PowerPlans** or individual cycles of treatment. One regimen may equal an entire protocol.

**Naming convention for Regimen:** ONC is the folder name.

The folder name is followed by the diagnosis and the protocol name.

eg. ONC BR BRAVA7.

**Naming convention for PowerPlan:** ONCP is the folder name

Same as above with “P” added to identify it as a plan. The folder name is followed by the diagnosis and the protocol name eg. ONCP BR BRAVA7

Zero Time orders- added to PowerPlans as an anchor order to allow accurate timing and sequencing on the eMAR (Electronic Medication Administration Record).

### PowerPlan Phase structure:

Phase	Start Date/Time	Action
☒ Chemotherapy (Day 1 to 2)	*Est. 2017-Jul-17 08:00 PDT	Order for future visit ▼
☒ Next Cycle Labs (Day 1)	*Est. 2017-Aug-07 08:00 PDT	Order for future visit ▼
Prescriptions	2017-Jul-17 08:00 PDT	Order now ▼
Scheduling	2017-Jul-17 08:00 PDT	Order now ▼

This structure allows for the phases to be processed at different time points. The chemotherapy and lab phases are future orders which require order completion (final doses) and activation. While the scheduling and prescription phases are set to order now allowing for chemo appointments to be scheduled in advance and prescriptions to be processed and picked up now.

### Note: The **Chemotherapy Phase** Includes:

- Pre-chemo metrics (indicators)
- Pre or post hydration (if recommended in protocol)
- Pre-meds

1. Blue note types divide the PowerPlan into phase headings (e.g. Chemotherapy, Next Cycle Labs, Prescriptions, Scheduling)
2. Green note types divide the PowerPlan into sections (e.g. Pre-Chemo Metrics, Pre-Medications, Treatment Regimen, Post-Treatment)
3. Yellow note types provide instructional information(e.g. Frozen Gloves, No Ice Chips, Ensure patient has taken pre-med, See Patient Handout)
4. Details contain instructions that are directed to the pharmacy for med preparation or nursing for med administration (e.g. diluent information or special administration set details)

Component	Status	Dose ...	Details
<b>ONCP BR BRAJDCARBT Cycle 1 - Cycle 1, Chemotherapy (Day 1) (Future - Review Required) *Est. 26-Jul-2017 08:00 PDT - 26-Jul-2017 22:00 PDT</b>			
Last updated on: 25-Jul-2017 15:59 PDT by: TestON, OncologistHematologist-Physician, MD			
Additional review required. Review request sent to message center pool LGH Chemo Provider Pool on 25-Jul-2017 15:59 America/Vancouver.			
<b>Pre-Chemo Metrics</b>			
Pre-Medications			
Patient to take own supply of pre-medications. RN/Pharmacist to confirm. Patient to take dexamethasone 8 mg PO BID for 3 days starting one day prior to DOCetaxel. Patient must receive 3 doses prior to treatment.			
ondansetron	Review Required	8 mg, PO, once oncology, drug form: tab, first dose: Routine, start: 26-Jul-2017	Prior to treatment Day 1
dexamethasone	Review Required	8 mg, PO, once oncology, drug form: tab, first dose: Routine, start: 26-Jul-2017	Prior to treatment Day 1
Optional: Frozen gloves starting 15 minutes before DOCetaxel infusion until 15 minutes after DOCetaxel infusion; gloves should be changed after 45 minutes of wearing.			
<b>Treatment Regimen</b>			
Zero Time	Review Required	once oncology, 26-Jul-2017, Future Order, Day 1	
DOCetaxel	Review Required	96.75 mcg IV, once oncology, drug form: bag, first dose: Routine, start: 26-Jul-2017	In 100 to 500 mL (non-DEHP bag) Sodium Chloride 0.9% (NS) over 1 hour (use non-DEHP tubing). Day 1 Target...
CARBOplatin	Review Required	791.92/9 mg, IV, once oncology, drug form: bag, first dose: Routine, start: 26-Jul-2017	In 250 mL Sodium Chloride 0.9% (NS) over 30 minutes. Day 1 Target Dose: CARBOplatin 6 AUC (CARBOplatin)...
acetaminophen	Review Required	325 mg, PO, once oncology, PRN other (see comment), drug form: tab, first dose: Routine, start: 26-Jul-2017	For headache and rigors. Day 1
<b>ONCP BR BRAJDCARBT Cycle 1 - Cycle 1, Next Cycle Labs (Day 1) (Discontinued) *Est. 27-Sep-2017 14:01 PDT - 30-Oct-2017 22:50 PDT</b>			
Last updated on: 30-Oct-2017 22:50 PDT by: SYSTEM, SYSTEM Cerner			
Differential (CBC and Differential)	Ordered	Blood, Routine, Unit collect, Collection: 2017-Sep-27 14:01 PDT, once	
Platelet Count	Ordered	Blood, Routine, Unit collect, Collection: 2017-Sep-27 14:01 PDT, once	
Creatinine Level	Ordered	Blood, Routine, Unit collect, Collection: 2017-Sep-27 14:01 PDT, once	
MUGA scan or echocardiogram prior to cycle 1 and Cycle 5 then every 3 or 4 months until completion of treatment:			
NM MUGA		T;N	
EC Echocardiogram		T;N	
Bilirubin Total		Blood, once, Order for future visit	
Protein Level (Total Protein Level)		Blood, once, Order for future visit	
Albumin Level		Blood, once, Order for future visit	

Details

Orders For Cosignature | Orders For Nurse Review | Save as My Favorite | Orders For Signature

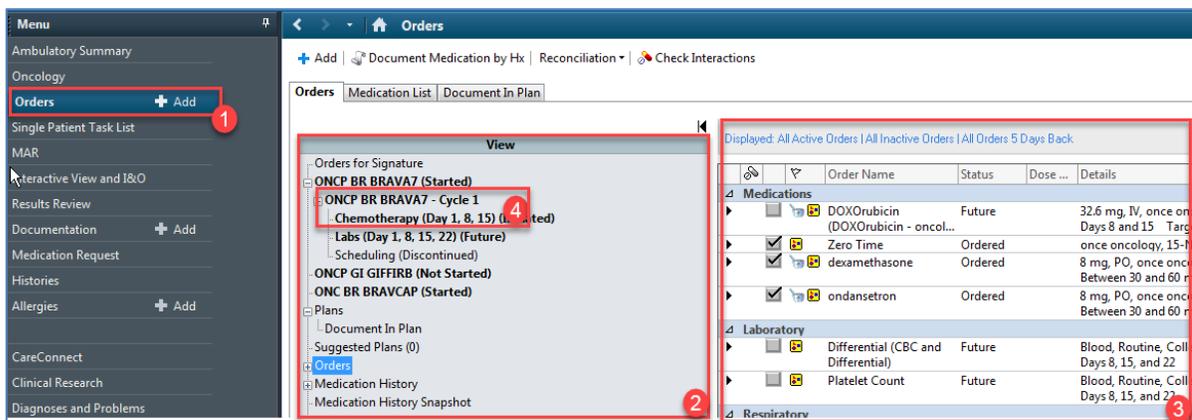
PRODRCL ONTEST.ONAMBRN1 Wednesday, 29-November-2017, 09:49:PS

1 The Orders Page is where you will access a full list of the patient’s orders:

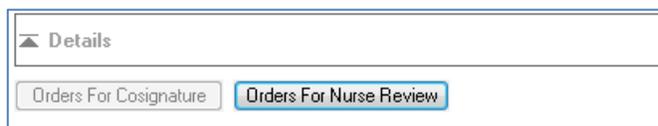
1. Select **Orders** from the **Menu**
2. On the left side of the Orders Page is the Navigator **View** which includes several categories including:
  - **Plans**
  - **Categories of Orders**
  - **Medication History**
  - **Reconciliation History**
3. On the right side is the **Order Profile** where you can:
  - Review the list of orders

Moving the mouse over order icons allows you to **hover to discover** additional information.  
 Some examples of icons are:

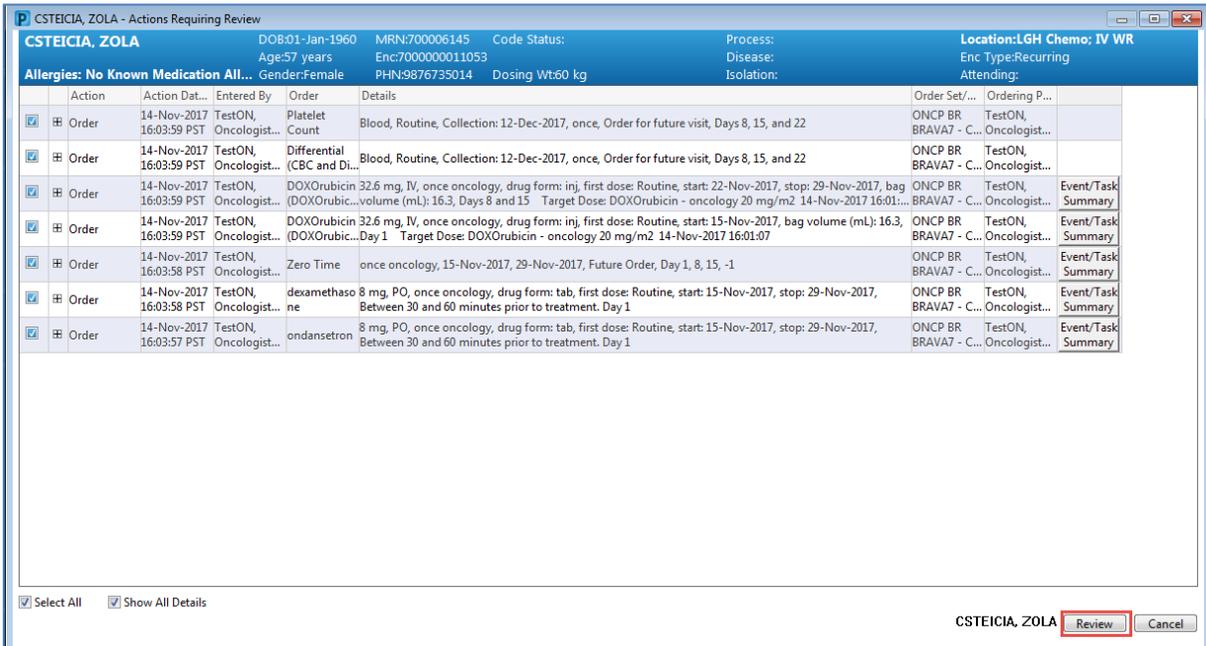
  -  Order for nurse to review
  -  Additional reference text available
  -  Order part of a PowerPlan
  -  Order waiting for Pharmacy verification
4. From the Orders screen scroll through the **View** tab of the navigator to find the **Regimen/PowerPlan** orders.



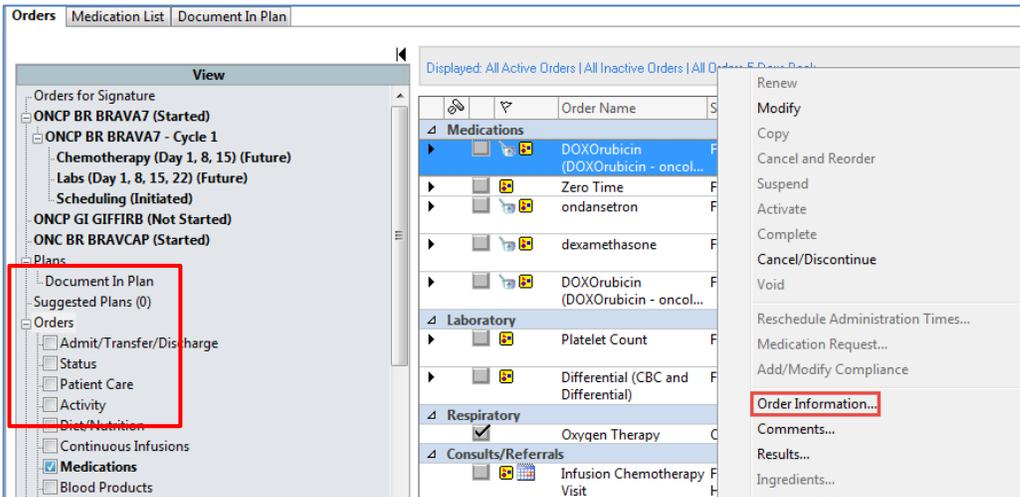
2 Check the Orders by selecting **Orders for Nurse Review**.



A screen will pop up that will give you a view of all of the chemo orders for the patient. Click **Review**.

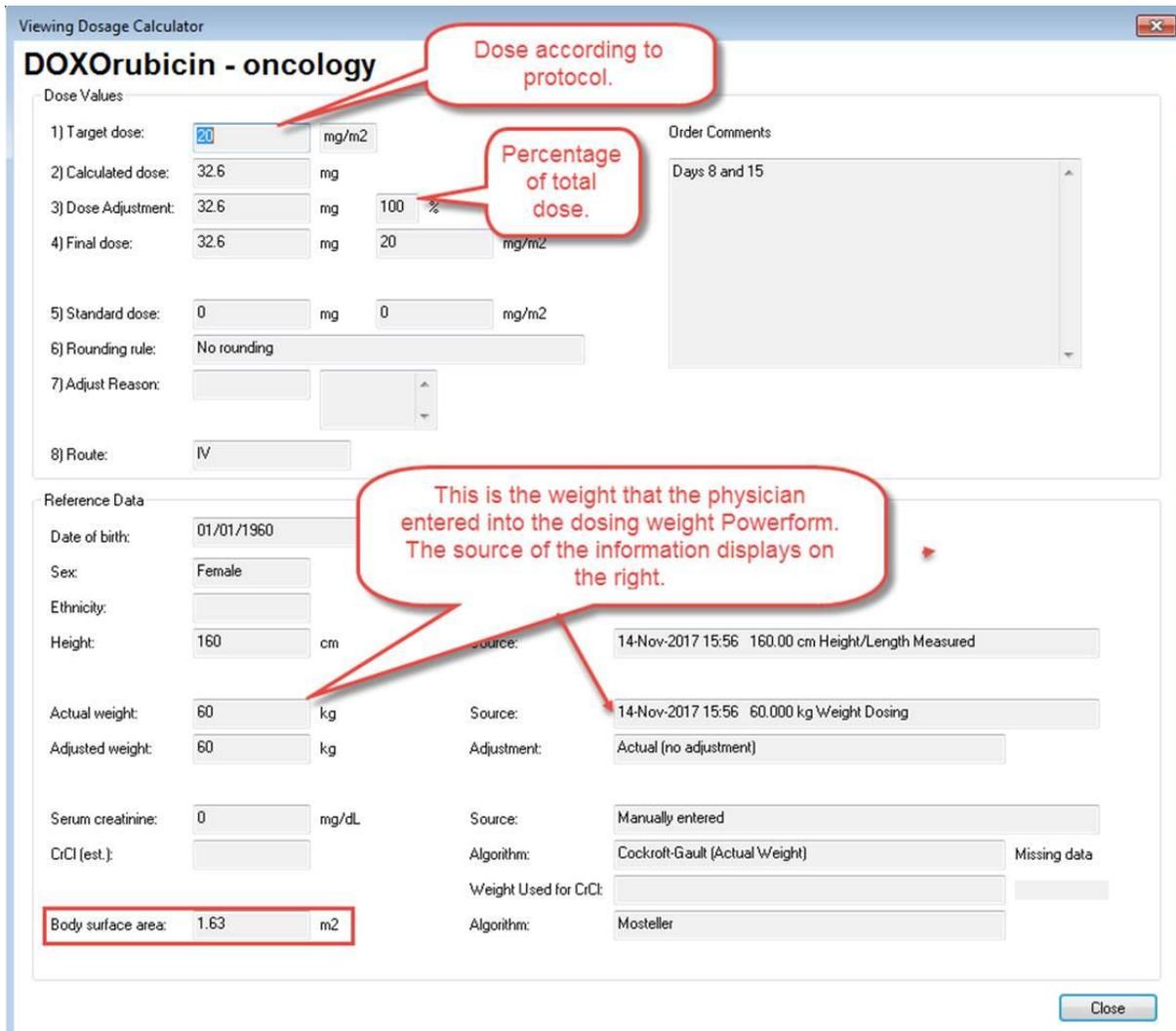


3 This will bring you back to the Orders screen. To see more information about an order, you can hover over the details section and a yellow text box will appear providing this information. To access the dosing calculator right click on the order selected and click **Order Information**.



**Note:** You can filter the order view by selecting which orders you would like to view.

- 4 From the Order Information Window select the **Dose Calculator Icon**  for each chemotherapy drug to be administered. The Dose Calculator will allow you to see the Height, Weight, BSA and any lab values used by the system to calculate the doses. View this screen to verify that the appropriate values have been used.



**Viewing Dosage Calculator**

**DOXOrubicin - oncology**

Dose Values

1) Target dose: 20 mg/m2

2) Calculated dose: 32.6 mg

3) Dose Adjustment: 32.6 mg 100 %

4) Final dose: 32.6 mg 20 mg/m2

5) Standard dose: 0 mg 0 mg/m2

6) Rounding rule: No rounding

7) Adjust Reason:

8) Route: IV

Order Comments

Days 8 and 15

Reference Data

Date of birth: 01/01/1960

Sex: Female

Ethnicity:

Height: 160 cm

Actual weight: 60 kg

Adjusted weight: 60 kg

Serum creatinine: 0 mg/dL

CrCl (est.):

Body surface area: 1.63 m2

Source: 14-Nov-2017 15:56 160.00 cm Height/Length Measured

Source: 14-Nov-2017 15:56 60.000 kg Weight Dosing

Adjustment: Actual (no adjustment)

Source: Manually entered

Algorithm: Cockcroft-Gault (Actual Weight) Missing data

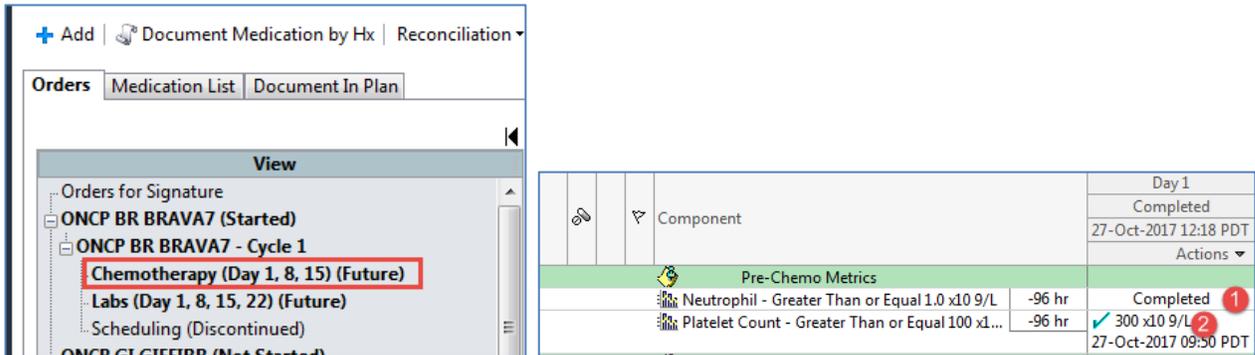
Weight Used for CrCl:

Algorithm: Mosteller

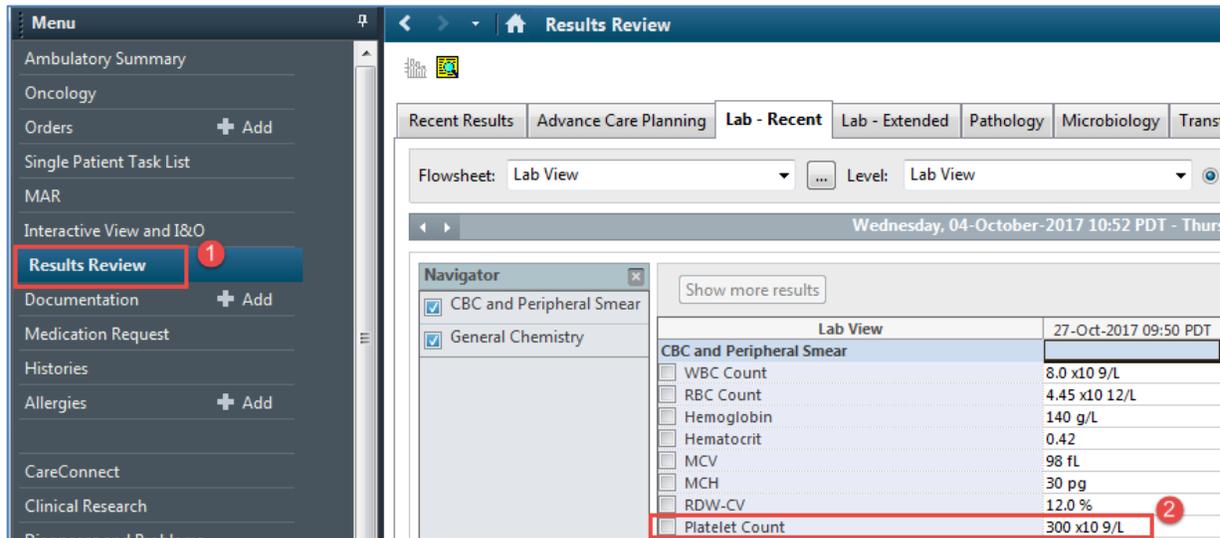
Close

**Note:** In the Dosing Calculator the ‘actual weight’ is not the measured weight which is located in IView. Both are pulled into the Oncology Tab.

- Close this screen and click “x” on the next screen so that you can move on to checking lab results. Select the **Chemotherapy phase** of the PowerPlan. This will display the Pre-chemotherapy metrics. A  green check mark and the lab result will display if the lab results are within the set parameters for treatment to proceed (2) a red “x” will display if the parameters are not met. Completed displays if the lab was collected and no result matching this field is available (1).



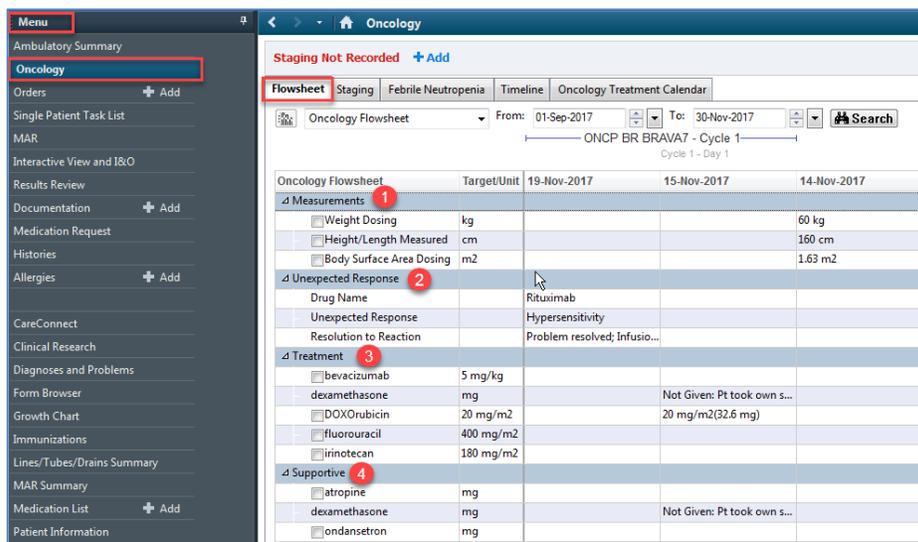
- You can also view a comprehensive list of results by selecting **Results Review** from the menu.



**Note:** For outside labs you will still need to use CareConnect (not available in the train domain). In future you can select CareConnect from the Menu which will bring you into the patient’s results.

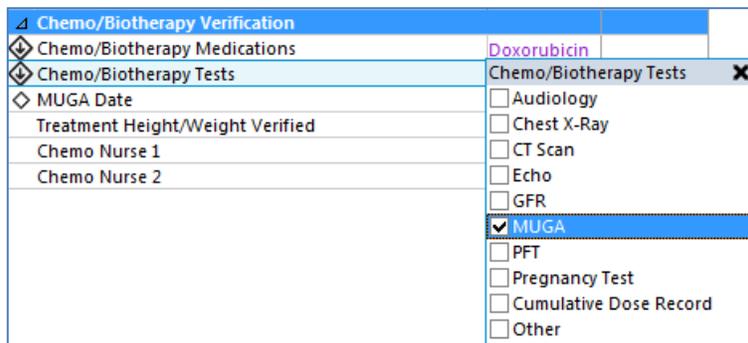
7 The Flowsheet is another useful tool within the chart for medication verification it is under the **Menu** in the **Oncology Tab**. The Flowsheet:

1. Provides both the measured weight which is pulled in from IView and the dosing weight which the provider has documented for treatment.
2. The Unexpected Response section is pulled in from IView if the patient has had an adverse reaction (otherwise this information will not be populated).
3. The Treatment section shows medications which have been given.
4. The Supportive section shows medications given to support the chemotherapy being given (e.g. anti-nausea medications, anticholinergics such as atropine, and steroids).



**Note:** You may explore the other tabs, there will be Quick Reference Guides (QRGs) to speak to these tabs and their function.

8 Now navigate to IView and select the **Chemo/biotherapy verification** section. Document the medications within the protocol; a conditional field will open to enable you to document any test results that you reviewed.



9 Document that you verified the height and weight used to calculate the patient’s chemotherapy.

		15-Nov-2017	
		11:53 PST	11:52 PST
Chemo/Biotherapy Verification			
Chemo/Biotherapy Medications		Doxorubicin	Doxorubicin
Chemo/Biotherapy Tests		MUGA	MUGA
MUGA Date		13-Nov-2017	13-Nov-2017
Treatment Height/Weight Verified		Yes	Yes
Chemo Nurse 1			TestON, On...
Chemo Nurse 2		Steffler, Lori	

**Note:** you double checked in the Dose Calculator as well as the summary page. Enter your name to indicate that you completed the verification. If a second nurse is required, by policy, to independently check the orders then they can complete the process and sign as Chemo Nurse 2.

### Key Learning Points

- A Regimen is a set of PowerPlans
- A PowerPlan is equivalent to one cycle of treatment.
- You must nurse review all orders and look at order information for dosing calculation verification.
- Important to be within the right phase of the PowerPlan to see the required information.
- Use the Ambulatory Summary page to navigate to other required results (labs, imaging, documentation).
- Chart your checks in IView.

## Activity 2.2 – Activating Chemotherapy Orders.

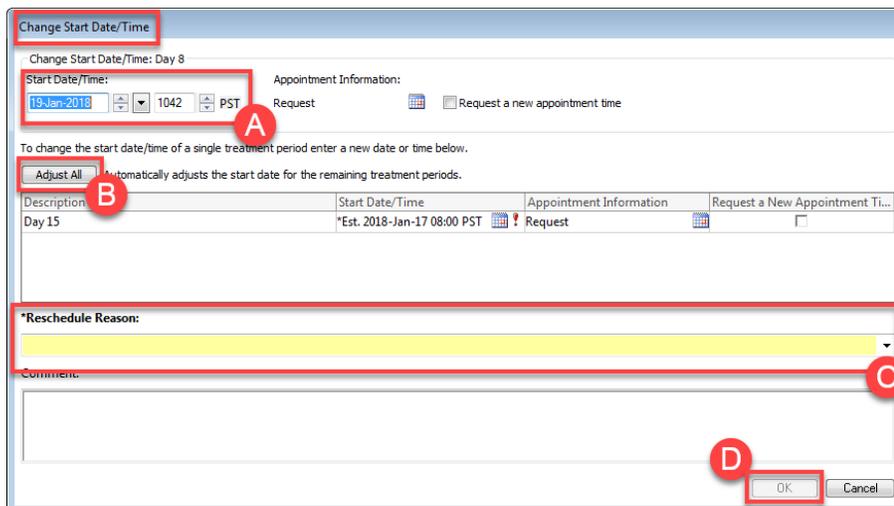
1 From the patients chart

1. From the Menu click on **Orders**.
2. From the **Orders** screen scroll through the **View** tab of the navigator to find the **Regimen/PowerPlan** orders.
3. Click on the **Cycle 1 Chemotherapy Phase**
4. Select the down arrow ▾ beside **Activate Actions** from the **Day 1** column.
5. Select **Activate**.

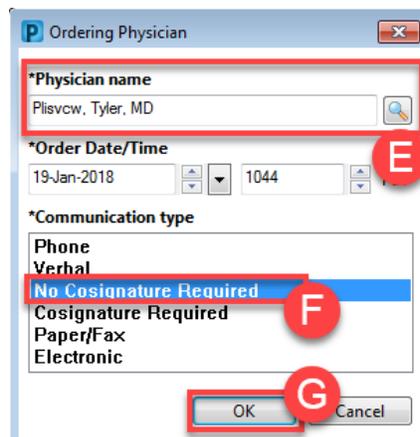
The screenshot displays the 'Orders' interface. On the left, a navigation pane shows 'View' selected, with 'Medications' checked. The main area shows a table of orders for 'ONCP BR BRAVA7 - Cycle 1, Chemotherapy (Day 1, 8, 15) (Future)'. The table has columns for 'Day 1', 'Day 8', and 'Day 15'. A dropdown menu is open for the 'Day 1' column, with 'Activate' highlighted. The table includes components like 'ondansetron', 'dexamethasone', and 'DOXOrubicin (DOXOrubicin - oncology)'. The 'Zero Time' treatment regimen is also visible.

Since this is a train domain the estimated dates of treatment are not accurate and will require you to change them when attempting to activate. This could similarly happen when doctors select an estimated start date for a patient's first cycle or if a cycle is delayed due to toxicities or other reasons.

6. The **Change Start Date/Time** window will pop up.
  - A. The Start Date/Time will default for today; leave it as is.
  - B. When the treatment consists of multiple days the future dates will need to be adjusted. Click **Adjust All**; you will see the corresponding dates adjust according to the new start date (you may need to expand the screen to see this section).
  - C. Select a **Reschedule Reason**; select **Other** for this activity.
  - D. Click **OK**.



7. The **Ordering Physician** Window will pop up.
  - E. Enter the **Physician's name**; enter Plisvcw, Tyler.
  - F. Select **No Cosignature Required**. Depending on your Health Organization's policies for rescheduling, if within the allowable timeframe no cosignature would be required. However, if rescheduled for toxicities then a direct doctor's order must be given.
  - G. Click **OK**.



- Click **Orders for Signature**, one last sign off to say that you have done your checks and Click **Sign** then **Refresh** . This will change the order status from a 'future' status to an 'ordered' status.

ONCP BR BRAVA7 - Cycle 1, Chemotherapy (Day 1, 8, 15) (Initiated) *Est. 15-Nov-2017 11:58 PST - 29-Nov-2017 08:30 PST			
Last updated on: 15-Nov-2017 11:58 PST by: TestON, OncologyAmbulatory-Nurse2			
		Component	Day 1
			Initiated
			15-Nov-2017 11:58 PST *Est
			Actions 
<input checked="" type="checkbox"/>		 ondansetron 8 mg, PO, once oncology, drug form: tab, first dose: Routine... Between 30 and 60 minutes prior to treatment. Day 1	-30 min Ordered
<input checked="" type="checkbox"/>		 dexamethasone 8 mg, PO, once oncology, drug form: tab, first dose: Routine... Between 30 and 60 minutes prior to treatment. Day 1	-30 min Ordered
Treatment Regimen			
<input checked="" type="checkbox"/>		 Zero Time once oncology, 15-Nov-2017 12:28 PST, 29-Nov-2017 08:30 ...	0 hr Ordered
<input checked="" type="checkbox"/>		 DOXOrubicin (DOXOrubicin - oncology) 32.6 mg, IV, once oncology, drug form: inj, first dose: Routin...	Ordered

### Key Learning Points

- Activate Orders from the correct Regimen/PowerPlan.
- Click to Sign Orders as a last sign off stating your checks are completed.
- Remember to refresh your pages to see changes.

## Activity 2.3 – Closed Loop Medication Administration

Medications will be administered and recorded electronically by scanning the patient’s wristband and the medication barcode. Scanning of the patient’s wrist band helps to ensure the correct patient is identified. Scanning the medication helps to ensure the correct medication is being administered. Once a medication is scanned, applicable allergy and drug interaction alerts may be triggered, further enhancing your patient’s safety. This process is known as closed loop medication administration

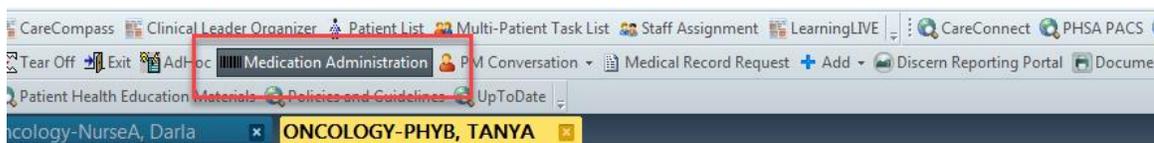
**Note:** IV medication volumes will flow from the MAR directly into the intake and output section of IView.

Tips for using the barcode scanner:

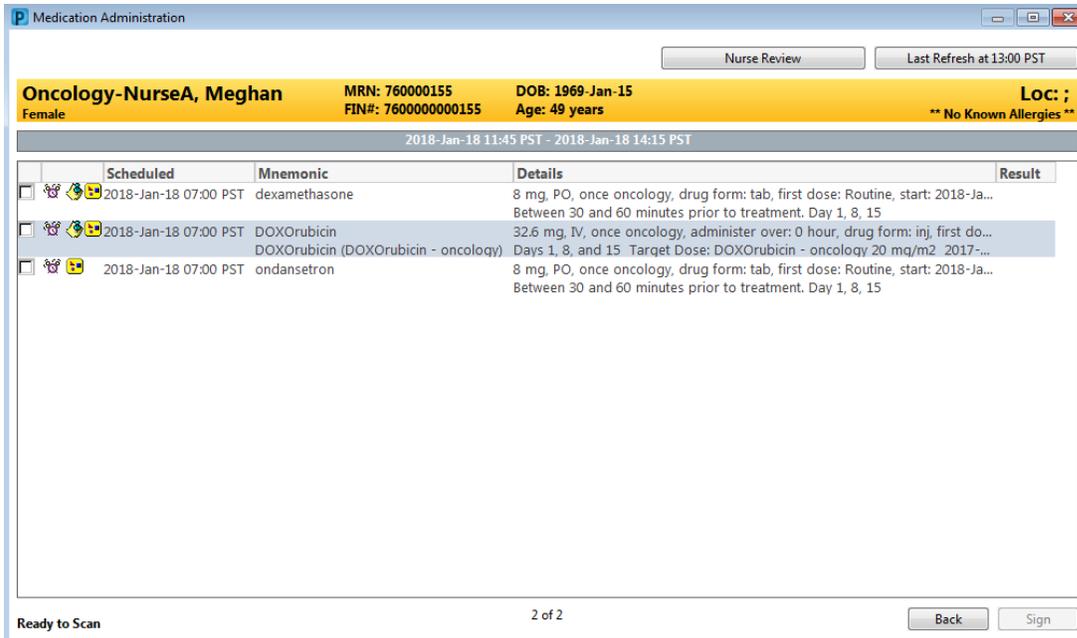
- Point the barcode scanner toward the barcode on the patient’s wristband and/or the medication (Automated Unit Dose- AUD) package and pull the trigger button located on the barcode scanner handle
- To determine if the scan is successful, there will be a vibration in the handle of the barcode scanner and/or, simultaneously, a beep sound
- When the barcode scanner is not in use, wipe down the device and place it back in the charging station

1 To begin the medication administration process:

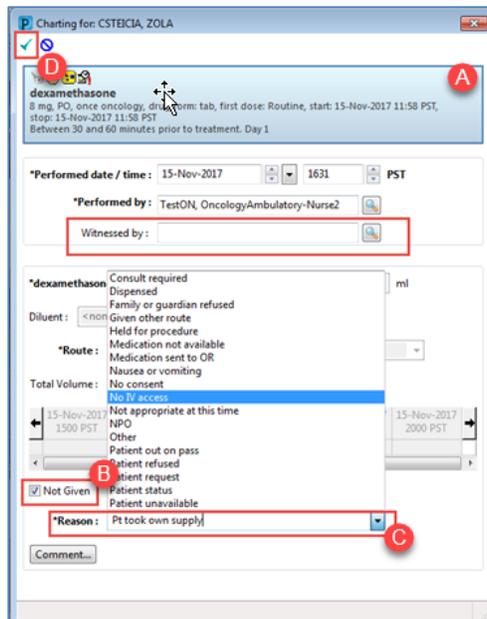
1. Select MAR from the Menu.
2. Review the Medications on the MAR this gives you a general overview of what medications are due for today. This is best done by selecting the **Plan View** as medications are listed in the order of administration based on the PowerPlan. The default view is the Time View which displays medications by alphabetical order
3. Choose the **Medication Administration Wizard (MAW)** from the toolbar.



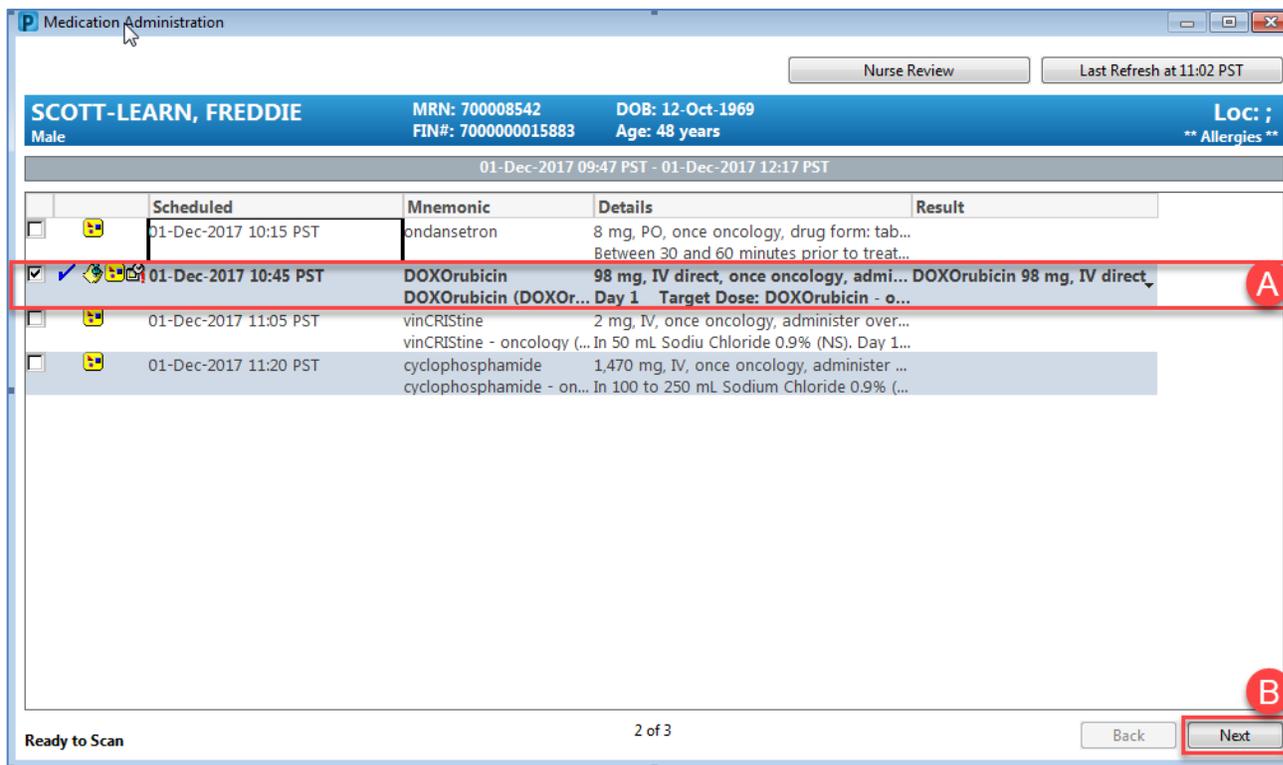
4. Scan the patient’s wristband; a window will pop up displaying the medications that you can administer. (Note: this list populates with medications that are scheduled for 1 hour ahead or 1 hour behind the current time).



5. Since the patient has taken their own supply of Dexamethasone, Right click on the Medication task for Dexamethasone and select **Chart Details**, a window will open.
  - A) Check the medication against the order details (blue box at the top).
  - B) Check the **Not Given Box**
  - C) Enter **Patient took Own Supply** in the **Reason** box.
  - D) Click on the **Green Check Mark** to sign.



6. The medication drops off the medication administration window.
7. Scan the Medication Label for the Doxorubicin.
  - A) The Medication will appear selected in the Medication Administration window.
  - B) Click Next to verify this is the correct Medication scanned.



- C) Details of the medication to be administered pop up in the next window, verify these are correct and click sign. You would now administer the medication.

**Medication Administration**

**SCOTT-LEARN, FREDDIE** MRN: 700008542 DOB: 12-Oct-1969  
Male FIN#: 7000000015883 Age: 48 years Loc: ;  
\*\* Allergies \*\*

**DOXOrubicin (DOXOrubicin - oncology)**  
98 mg, IV direct, once oncology, administer over: 5 minute, drug form: inj, first dose: Routine, start: 01-Dec-2017 10:45 PST, stop: 01-Dec-2017 10:45 PST, bag volume (mL): 49  
Day 1 Target Dose: DOXOrubicin - oncology 50 mg/m2 01-Dec-2017 09:58:43

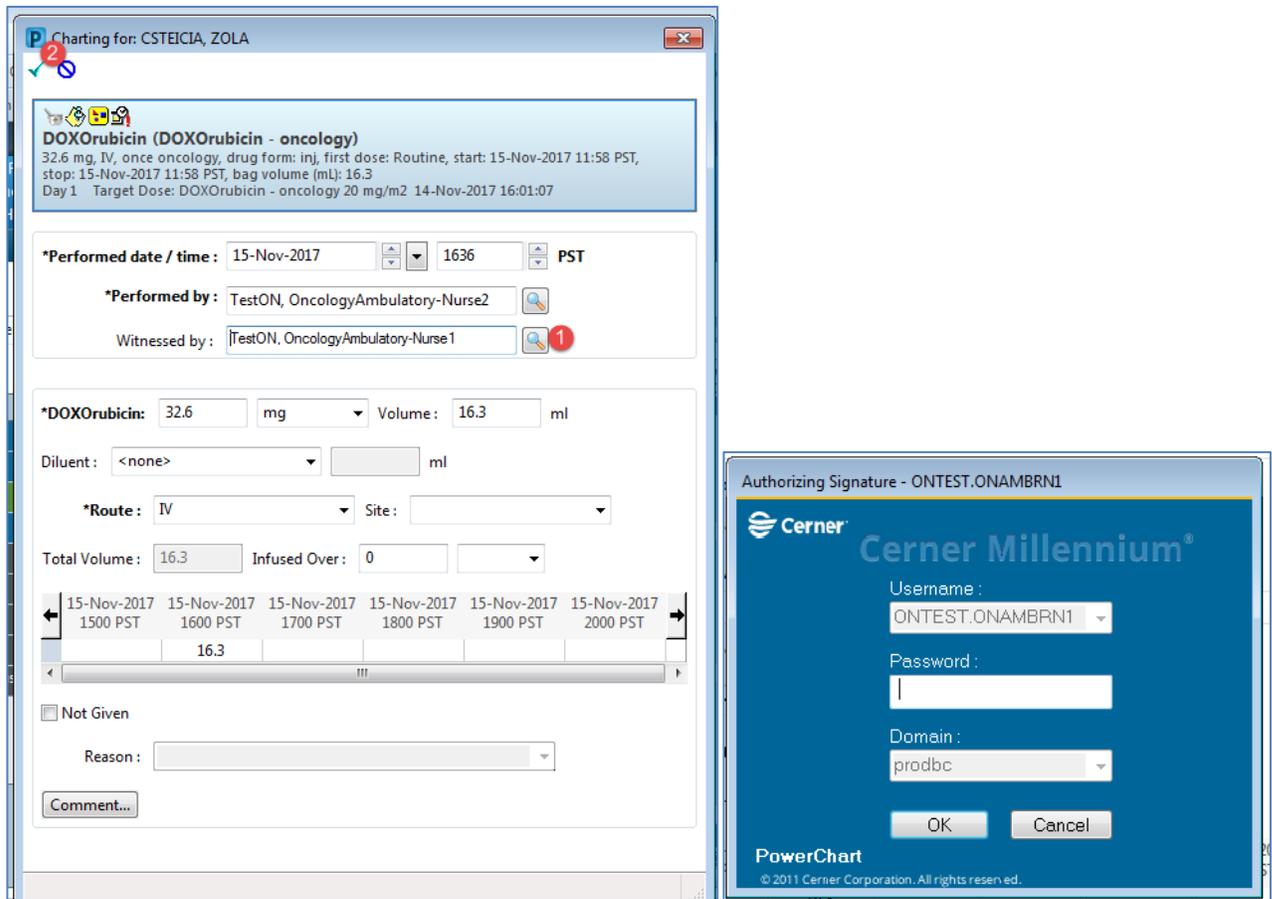
**Performed**  
Date/Time : 01-Dec-2017 1104 PST Diluent : <none> mL  
Performed By : TestCST, OncologyAmbulatory-Nurse5 ON Total Volume : 49 mL Infused Over : 5 minute

**DOXOrubicin :** 98 mg  
**Route :** IV direct

01-Dec-2017 1000 PST	01-Dec-2017 1100 PST	01-Dec-2017 1200 PST	01-Dec-2017 1300 PST	01-Dec-2017 1400 PST	01-Dec-2017 1500 PST
	49				

Ready to Scan 3 of 3 Back Sign

In certain centers a nurse witness is required. In these instances once the medication has been verified through scanning you would Right-Click to populate the Charting window which allows for the nurse witness to be entered (1) and signed (2).



You have now signed that you have given a pre-medication (Pt took own supply) and the Doxorubicin.

### Key Learning Points

- Use the MAR page to review medications to be given for the day, best in the Plan View.
- Open the Medication Administration Wizard to scan patient's wristband and medications.
- Click Sign to finalize process.

## Activity 2.4 – Place a No Cosignature Required Order

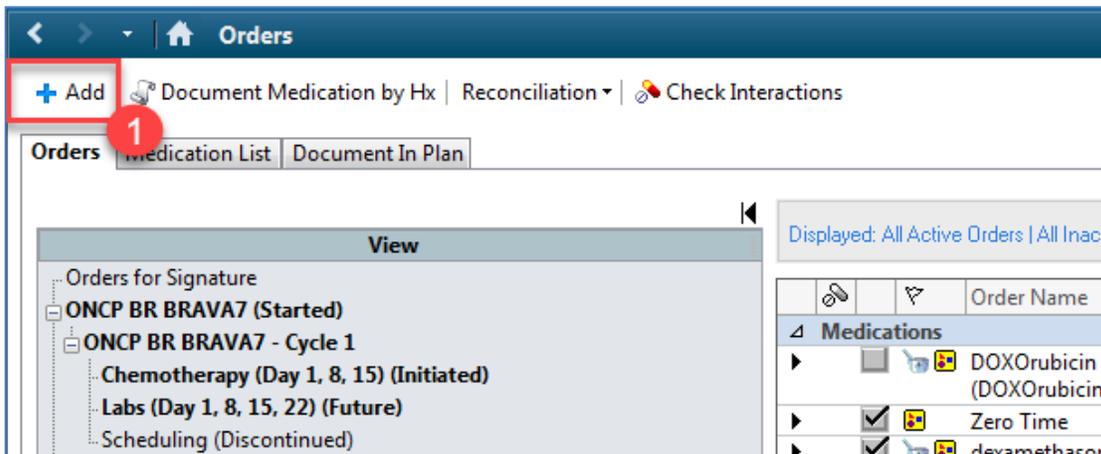
The patient tells you she is having some mild headache pain near the end of the drug administration, with no other accompanying side effects. She would like to have some Tylenol but has not brought any with her.

Nurses can place the following types of orders:

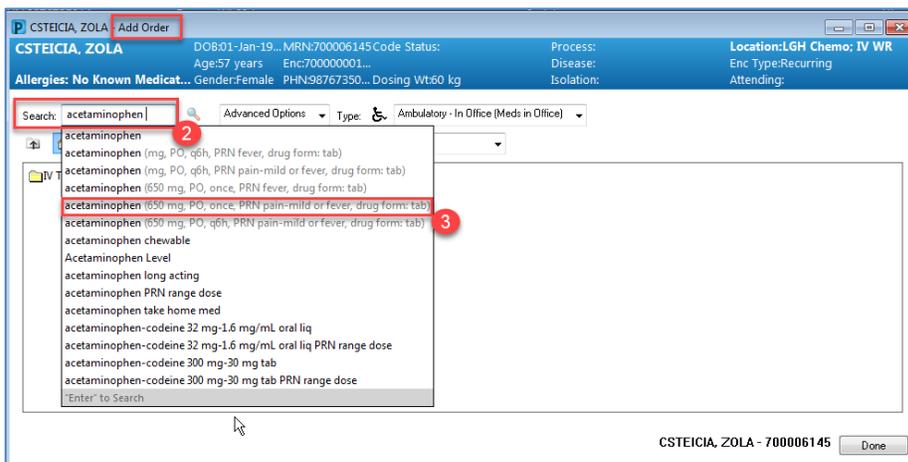
- Orders requiring a cosignature of the provider, e.g. telephone and verbal orders
- Orders that do not require a cosignature, e.g. order within nursing scope, Registered Nurse Initiated Activity (RNIA).

1 To place an order that does **not** require a cosignature:

1. Click the **Add** button  within the **Orders Page**. The **Add Order** window opens.



1. Type *acetaminophen* into the search window and a list of choices will display.
2. Select **acetaminophen** with order sentence of (650 mg, PO, once, PRN pain-mild or fever, drug form: tab). Order sentences help to pre-fill order details.



The **Ordering Physician** window opens.

4. Type in the name of the patient's Attending Physician
5. Select **No Cosignature Required** and click **OK**

**Note:** If the order were verbal or phone based you would select the corresponding communication type. Verbal and phone orders that are entered in the system automatically get routed to the ordering provider for co-signature. These orders are only encouraged when a physician cannot enter the order directly into the Clinical Information System (CIS) themselves.

6. Click **Done** and you will be returned to the Orders Page and see the order details.

7. Click **Sign**

8. Click **Refresh** 

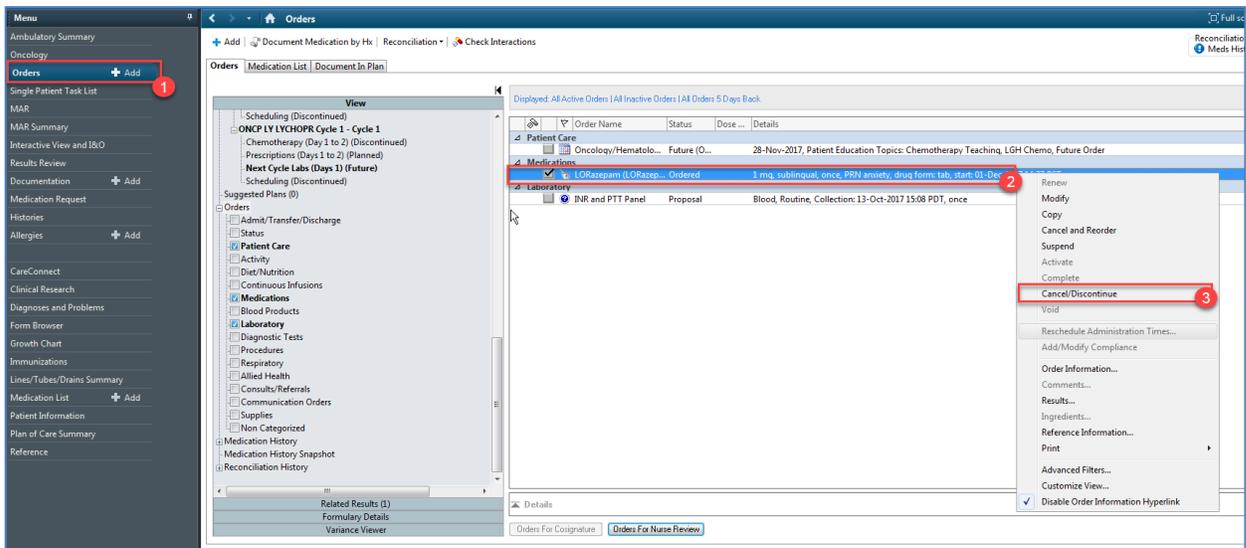
## Key Learning Points

- If an order is a RNIA use No Cosignature Required.
- You must enter the patient's Physician information to proceed

## Activity 2.5 – Cancel/Discontinue an Order

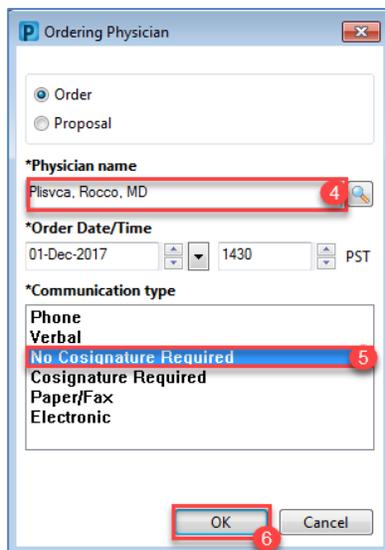
You had contacted the doctor earlier for an Ativan order as the patient was feeling anxious arriving to the Ambulatory Chemotherapy Clinic, the doctor had entered an order upon your phone conversation. Now, speaking to the patient further she does not feel this is necessary, so you go ahead and cancel the order. Follow the steps below.

- 1 To Cancel/Discontinue an order:
  1. Go to the Orders screen from the Menu.
  2. Right-click order Lorazepam.
  3. Select Cancel/Discontinue.



Ordering Physician pop-up window will appear. Fill out required fields highlighted yellow.

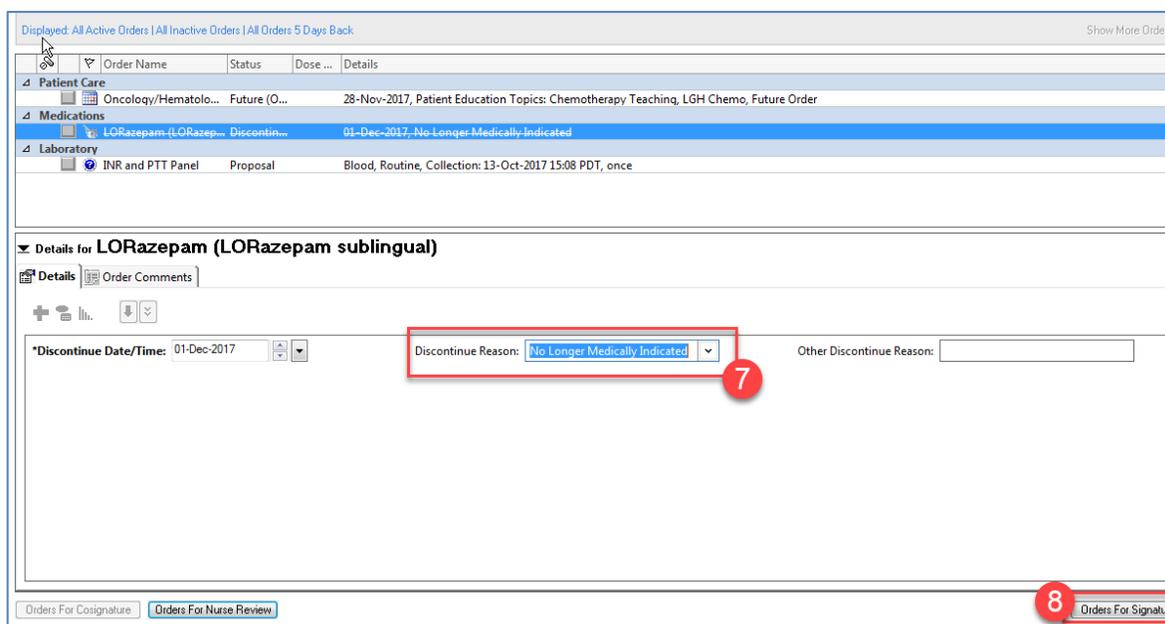
4. Physician name = type name of Attending Physician (Plisvcw, Tyler)
5. Communication type = No Cosignature Required
6. Click **OK**



The 'Ordering Physician' dialog box contains the following elements:

- Radio buttons for 'Order' (selected) and 'Proposal'.
- A text field for '\*Physician name' containing 'Plisvca, Rocco, MD', with a red box and number 4 around it.
- A date and time field for '\*Order Date/Time' showing '01-Dec-2017' and '1430' PST.
- A list for '\*Communication type' with options: 'Phone', 'Verbal', 'No Cosignature Required' (highlighted with a red box and number 5), 'Cosignature Required', 'Paper/Fax', and 'Electronic'.
- 'OK' and 'Cancel' buttons at the bottom, with a red box and number 6 around the 'OK' button.

7. You may fill in the Discontinue Reason.
8. Review order to discontinue and click Orders For Signature



The screenshot shows the 'Details for LORazepam (LORazepam sublingual)' screen. The 'Discontinue Reason' dropdown menu is highlighted with a red box and number 7, showing 'No Longer Medically Indicated'. At the bottom right, the 'Orders For Signature' button is highlighted with a red box and number 8.

**Note:** Refresh page. The order will no longer be visible on order profile.

### Key Learning Points

- Right click to cancel/discontinue.
- Both of these actions will remove orders from patient's Order Profile.

## PATIENT SCENARIO 3 – LYCHOP-R

### Learning Objectives

At the end of this Scenario, you will be able to:

- Utilize the titration documentation in iView
- Navigate to and view the Lifetime Cumulative Dosing
- Chart an infusion reaction/adverse event

### SCENARIO

You arrive on the unit and log in to your first patients chart to begin the chemo checks. The patient is new and just started LYCHOP-R. Today is the patient's first Rituximab infusion. He received Cycle 1 Day 1 yesterday afternoon.

When performing your chemo checks you calculate your Rituximab titration rate increases per first time Rituximab protocol. Starting the infusion at 50mg/hr for the first hour and then increasing by 50mg/hr every 30 minutes to a maximum of 400mg/hr.

The pump beeps and the patient is ready for the next rate increase (200mg/hr). You adjust the pump to reflect these changes and within a few minutes the patient notes they are feeling warm and appear flushed.

You respond by stopping the infusion and assessing the patient further. The patient notes they are beginning to have a tingle in their throat and trouble breathing; you hang Benadryl 50mg IV immediately. You have the patient sit up in the chair and take a set of vitals. The patient notes they are beginning to breathe easier but still feel quite warm. You have an MD come over to assess. The MD decides to restart the Rituximab per the hypersensitivity protocol once the symptoms have subsided.

After the medication is given the symptoms subside and you start the patient at one rate lower than the reaction occurred at. You continue to monitor, the patient completes the medication with no further concerns.

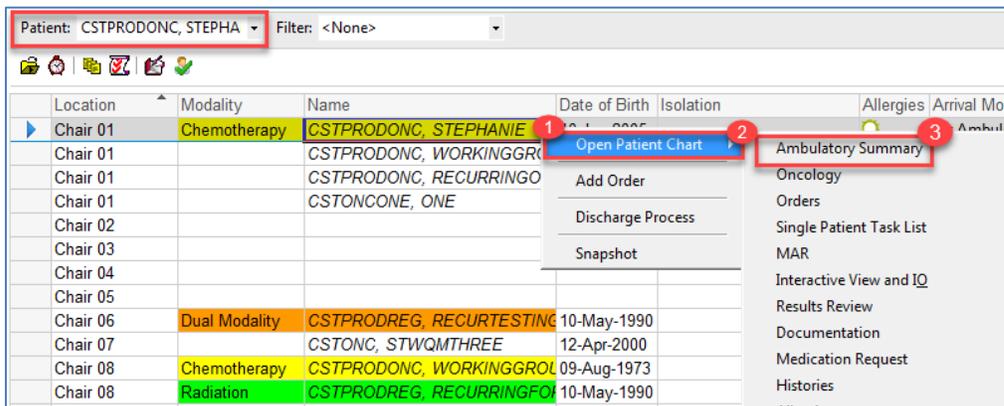
As a member of the Ambulatory Chemo unit you will be completing the following activities:

- Chemotherapy Checks
- Activate Chemotherapy Orders to be Administered
- Closed Loop Medication
- Titration Charting
- Managing Orders
- Adverse Event/Reaction Charting
- Lifetime Cumulative Dosing

## Activity 3.1 – Medication Order Verification and Documentation Process

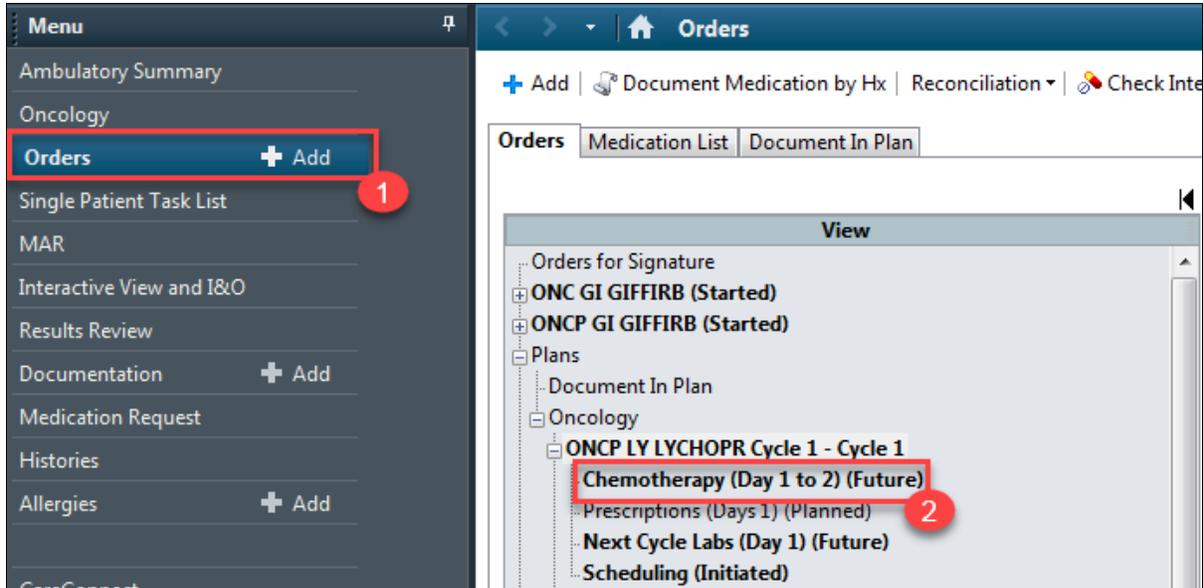
Using the patient provided to you, complete the following activities [**Oncology-NurseB**, *enter first name*].

- 1 To access your second patient navigate back to the Tracking Shell, assign yourself to be the patient's nurse and assign them chair 02. Click on the row of your patient (notice the patients name will populate in **the patient: section** and that the row is **shaded grey**).
  1. **Right-Click** on the patient's name.
  2. Click on **Open Patient Chart**.
  3. A list of sections within the chart appears in a dropdown menu, click on **Ambulatory Summary** (this is the main view of the patient's chart, you could also choose to jump to specific views when more comfortable with the location of necessary information).
  4. Ensure you have the correct patient open by verifying with the patient and the information in the blue banner (name, DOB and encounter).



**Note:** Alternatively with the patient selected you could use the icon to access the patient's chart or double-click on the beside the location of the patient.

- 2
1. In the patients chart from the menu, select **Orders**.
  2. From the **Orders** screen scroll through the **View** tab of the navigator to find the Regimen/PowerPlan orders.



**Note:**

- **PowerPlan:** One individual order set or cycle of treatment. These are broken out into phases of treatment and days of treatment.
- **Regimen:** A grouping of PowerPlans or individual cycles of treatment. One regimen may equal an entire protocol.
- **Naming convention for Regimen:** ONC is the folder name. The folder name is followed by the diagnosis and the protocol name. eg. ONC LY LYCHOPR.
- **Naming convention for PowerPlan:** ONCP is the folder name Same as above with “P” added to identify it as a plan. The folder name is followed by the diagnosis and the protocol name eg. ONCP LY LYCHOPR

3. Check all the orders by selecting **Orders for Nurse Review**. A new window pops up with all chemo orders and pre-medications for the patient (you should see the Acetaminophen, Diphenhydramine, and Rituximab).
4. Click **Review**

Action	Action Date	Entered By	Order	Details	Order Set...	Ordering ...
<input checked="" type="checkbox"/>	22-Nov-2017 09:53:46	TestON, Oncologis...	Differential (CBC and Differential)	Blood, Routine, Collection: 11-Dec-2017, once, Order for future visit	ONCP LY LYCHOPR ...	TestON, Oncologis...
<input checked="" type="checkbox"/>	22-Nov-2017 09:53:46	TestON, Oncologis...	riTUXimab (riTUXimab - st-Physician oncology)	798.75 mg, IV, once oncology, drug form: bag, first dose: Routine, start: 22-Nov-2017, stop: 23-Nov-2017, In 250 to 500 mL Sodium Chloride 0.9% (NS). Start at 50 mg/h. After 60 minutes increase rate by 50 mg/h every 30 minutes until rate = 400 mg/h unless toxicity occurs. Day 2 Target Dose: riTUXimab - oncology 375 mg/m2 22-Nov-2017 09:50:10	ONCP LY LYCHOPR Cycle 1 - Cycle 1, C...	TestON, Oncologis... Event/Task Summary
<input checked="" type="checkbox"/>	22-Nov-2017 09:53:46	TestON, Oncologis...	cyclophosphamide (cyclophosphamide - oncology)	1,597.5 mg, IV, once oncology, administer over: 20 minute, drug form: bag, first dose: Routine, start: 22-Nov-2017, In 100 to 250 mL Sodium Chloride 0.9% (NS) over 20 minutes to 60 minutes. Day 1 Target Dose: cyclophosphamide - oncology 750 mg/m2 22-Nov-2017 09:49:34	ONCP LY LYCHOPR Cycle 1 - Cycle 1, C...	TestON, Oncologis... Event/Task Summary
<input checked="" type="checkbox"/>	22-Nov-2017 09:53:46	TestON, Oncologis...	vinCRiStine (vinCRiStine - oncology (CAPPED))	2 mg, IV, once oncology, administer over: 15 minute, drug form: bag, first dose: Routine, start: 22-Nov-2017, In 50 mL Sodium Chloride 0.9% (NS). Day 1 Target Dose: vinCRiStine - oncology (CAPPED) 1.4 mg/m2 22-Nov-2017 09:49:05	ONCP LY LYCHOPR Cycle 1 - Cycle 1, C...	TestON, Oncologis... Event/Task Summary
<input checked="" type="checkbox"/>	22-Nov-2017 09:53:45	TestON, Oncologis...	DOXOrubicin (DOXOrubicin - onc...	106.5 mg, IV direct, once oncology, drug form: inj, first dose: Routine, start: 22-Nov-2017, bag volume (mL): 53.25, Day 1 Target Dose: DOXOrubicin - oncology 50 mg/m2 22-Nov-2017 09:47:18	ONCP LY LYCHOPR ...	TestON, Oncologis... Event/Task Summary
<input checked="" type="checkbox"/>	22-Nov-2017 09:53:45	TestON, Oncologis...	Zero Time	once oncology, 22-Nov-2017, 23-Nov-2017, Future Order, Day 1 to 2, -1	ONCP LY LYCHOPR ...	TestON, Oncologis... Event/Task Summary
<input checked="" type="checkbox"/>	22-Nov-2017 09:53:45	TestON, Oncologis...	acetaminophen	650 mg, PO, q4h interval, PRN other (see comment), drug form: tab, first dose: Routine, start: 22-Nov-2017, stop: 23-Nov-2017, For riTUXimab reaction prophylaxis. Give once prior to riTUXimab infusion then q4h if infusion exceeds 4h. Day 2	ONCP LY LYCHOPR Cycle 1, C...	TestON, Oncologis... Event/Task Summary
<input checked="" type="checkbox"/>	22-Nov-2017 09:53:44	TestON, Oncologis...	diphenhydrAMINE	50 mg, PO, q4h interval, drug form: tab, first dose: Routine, start: 22-Nov-2017, stop: 23-Nov-2017, For riTUXimab reaction prophylaxis. Give once prior to riTUXimab infusion then q4h if infusion exceeds 4h. Day 2	ONCP LY LYCHOPR Cycle 1, C...	TestON, Oncologis... Event/Task Summary
<input checked="" type="checkbox"/>	22-Nov-2017 09:53:44	TestON, Oncologis...	dexamethasone	8 mg, PO, once oncology, drug form: tab, first dose: Routine, start: 22-Nov-2017, Between 30 and 60 minutes prior to treatment. Day 1	ONCP LY LYCHOPR ...	TestON, Oncologis... Event/Task Summary
<input checked="" type="checkbox"/>	22-Nov-2017	TestON, Oncologis...		8 mg, PO, once oncology, drug form: tab, first dose: Routine, start: 22-Nov-2017, Between 30 and 60	ONCP LY LYCHOPR ...	TestON, Oncologis... Event/Task Summary

5. This will bring you back to the **Orders** screen. To see more information about an order, Right-Click on it and select **Order Information**.

Order	Details
<input checked="" type="checkbox"/> Zero Time	
<input checked="" type="checkbox"/> DOXOrubicin (DOXOrubicin - oncology)	
<input checked="" type="checkbox"/> vinCRiStine (vinCRiStine - oncology (CAPPED))	
<input checked="" type="checkbox"/> cyclophosphamide (cyclophosphamide - oncology)	
During riTUXimab infusion, if flushing, dyspnea, stop infusion and notify physician.	
<input checked="" type="checkbox"/> riTUXimab (riTUXimab - oncology)	

- Order Information...
- Comments...
- Results...
- Ingredients...
- Reference Information...
- Print
- Disable Order Information Hyperlink

- From the **Order Information Window** you can select the **Dose Calculator** **Icon** for each Chemotherapy drug to be administered. The Dose Calculator will allow you to see the Height, Weight and BSA used by the system to calculate the doses. View this screen to verify that the appropriate values have been used.

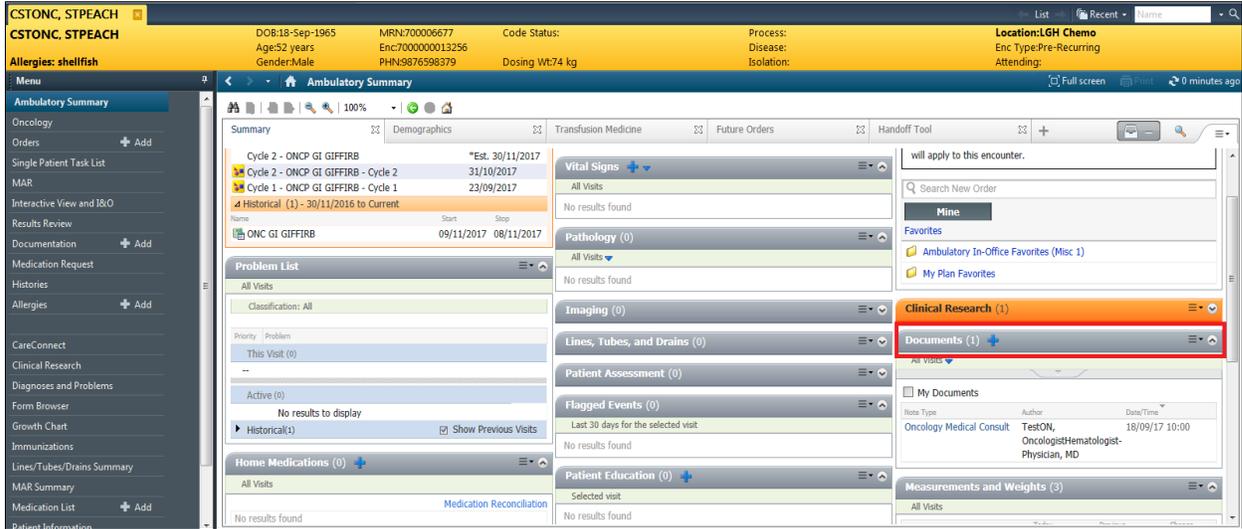
**Note:** Read the speech bubbles for some more insight.

- Close this screen and click “x” on the next screen so that you can move on to checking lab results. Select the **Chemotherapy** phase of the PowerPlan. This will display the Pre-chemotherapy metrics. A and the lab result will display if the lab results are within the set parameters for treatment to proceed. An will display if the treatment parameters have not been met. ‘**Completed**’ displays if the lab was collected and no result matching this field are available.

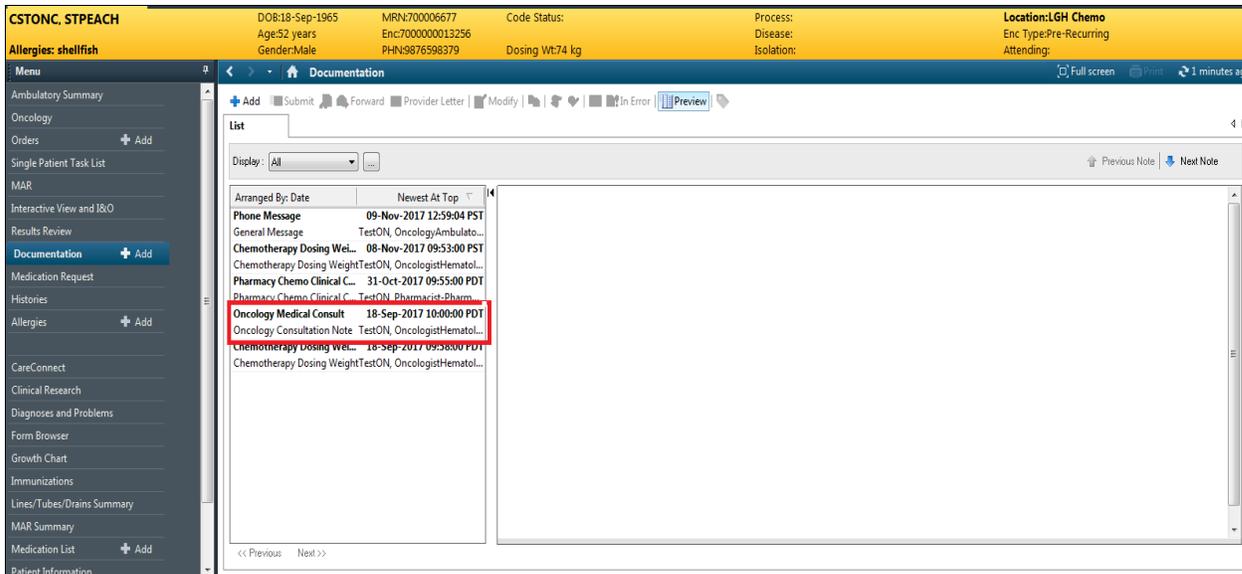
Component	Day 1
Pre-Chemo Metrics	Future
Neutrophil - Greater Than or Equal 0.8 x10 <sup>9</sup> /L	*Est. 22-Nov-2017 09:...
Pre-Medications	Activate Actions
Patient to take own supply of pre-medications. RN/Pharmacist to confirm. Patient to take aprepitant 80 mg PO once daily in the morning on days 2 and 3.	Completed

**Note:** You can view the remainder of the required labs from Results Review in the menu.

5 From the **Menu** select the **Ambulatory Summary Page**. This page is a summary of information about the patient. The information is pulled in from other places in the EMR (Electronic Medical Record) such as orders, documents, PowerForms and IV. From the **Ambulatory Summary Page** (MPage) you can check the patient’s lab results, VS, diagnosis, and PowerPlans ordered. Select the **Documents** widget to take you to the list of available documents. Here you can view the Medical Oncology Consult note created by the Provider.

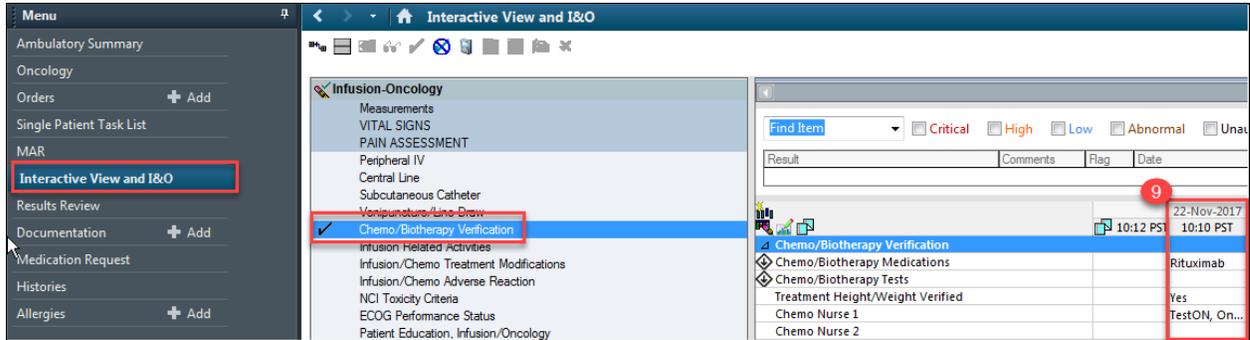


The screenshot shows the 'Ambulatory Summary' page for patient CSTONC, STPEACH. The patient's demographic information is displayed at the top: DOB: 18-Sep-1965, MRN: 700006677, Code Status, Process, Location: LGH Chemo, Age: 52 years, Enc: 7000000013256, Disease, Enc Type: Pre-Recurring, Gender: Male, PHN: 9876598379, Dosing Wt: 74 kg, Allergies: shellfish, and Attending. The left sidebar contains a 'Menu' with various options like 'Ambulatory Summary', 'Oncology', 'Orders', etc. The main content area is divided into several sections: 'Summary' (showing medication cycles for ONCP GI GIFFIRB), 'Vital Signs', 'Pathology', 'Problem List', 'Imaging', 'Lines, Tubes, and Drains', 'Patient Assessment', 'Flagged Events', 'Home Medications', and 'Patient Education'. A 'Documents' widget is highlighted with a red box, showing a list of documents including 'Oncology Medical Consult' dated 18/09/17 10:00.



The screenshot shows the 'Documentation' page for patient CSTONC, STPEACH. The patient's demographic information is displayed at the top. The left sidebar contains a 'Menu' with various options like 'Ambulatory Summary', 'Oncology', 'Orders', etc. The main content area shows a list of documents. The 'Documentation' widget is highlighted with a red box, showing a list of documents including 'Oncology Medical Consult' dated 18-Sep-2017 10:00:00 PDT, 'Oncology Consultation Note', and 'Chemotherapy Dosing Wei...'. The list is arranged by date, with the newest at the top.

- 6 Once you have completed your Chemotherapy Order Verification, navigate to IView, choose the **Chemo/Biotherapy Verification** section. Document the medications within the protocol; a conditional field will open to enable you to document any test results that you reviewed. Document that you verified the height and weight used to calculate the patient’s chemotherapy dose.



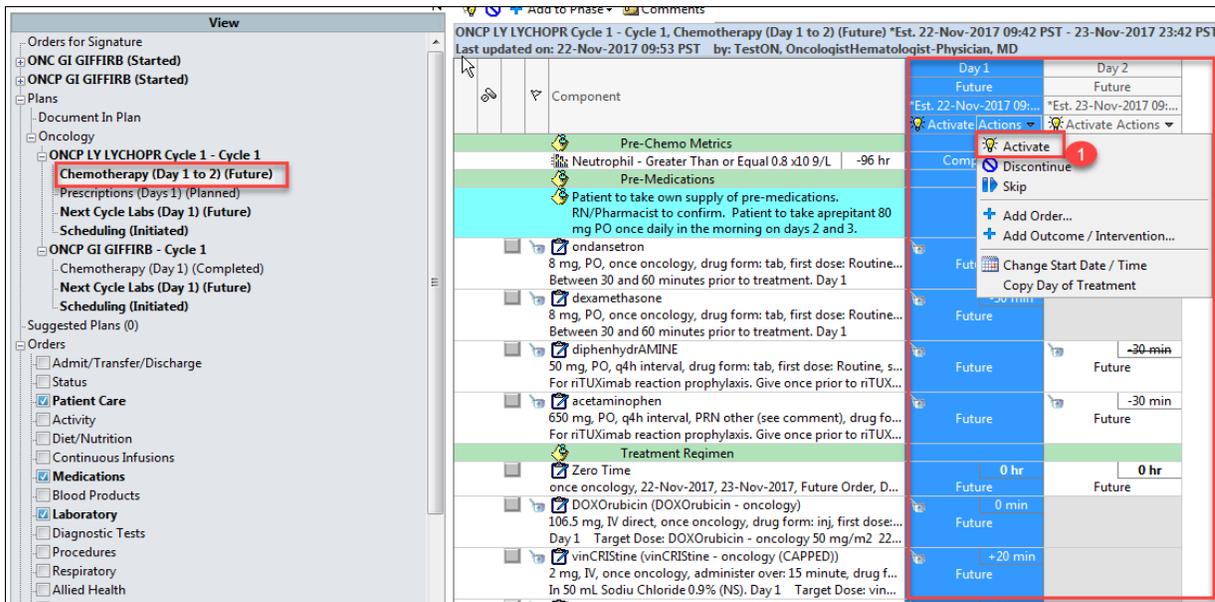
**Note:** You double checked in the dose calculator as well as the summary page. Enter your name to indicate you completed the verification. If a second nurse is required, by policy, to independently check the orders they can complete the process and sign as Chemo Nurse 2.

### Key Learning Points

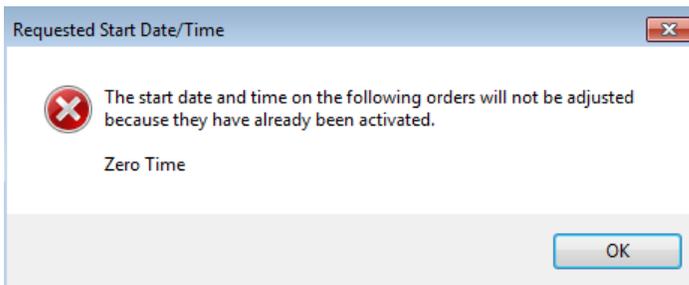
- A Regimen is a set of PowerPlans
- A PowerPlan is equivalent to one cycle of treatment.
- You must nurse review all orders and look at order information for dosing calculation verifying.
- Important to be within the right phase of the PowerPlan to see the required information.
- Use the Ambulatory Summary page to navigate to other required results (labs, imaging, documentation).
- Chart your checks in iView.

## Activity 3.2 – Activating Orders

- 1 From the menu click on **Orders**. From the **Orders** screen scroll through the View tab of the navigator to find the Regimen/PowerPlan orders. Click on the Cycle 1 Chemotherapy Phase, select **Activate Actions** from the Day 2 column (as you are looking to administer Cycle 1 Day 2), and select **Activate**.

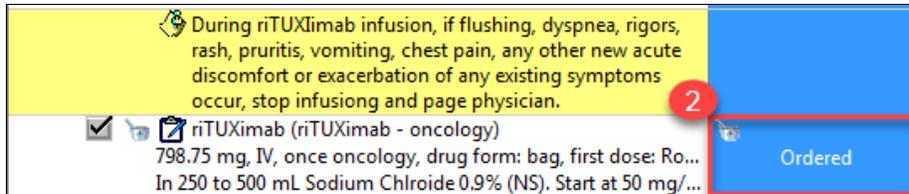


Remember since this is a train domain and the estimated date has passed you will have to change the start date/time (refer back to activity 2.2 steps 6-7 on pg. 46). The only difference is a warning message screen will appear:



This message is in reference to Cycle 1 Day 1 as the date is in the past and the medications have been activated and given; therefore they cannot be changed.

- 2 Click **Orders for Signature**...one last sign off to say that you have done your checks and Click **Sign** and **Refresh** . This will change the order status from a 'future' status to an 'ordered' status.

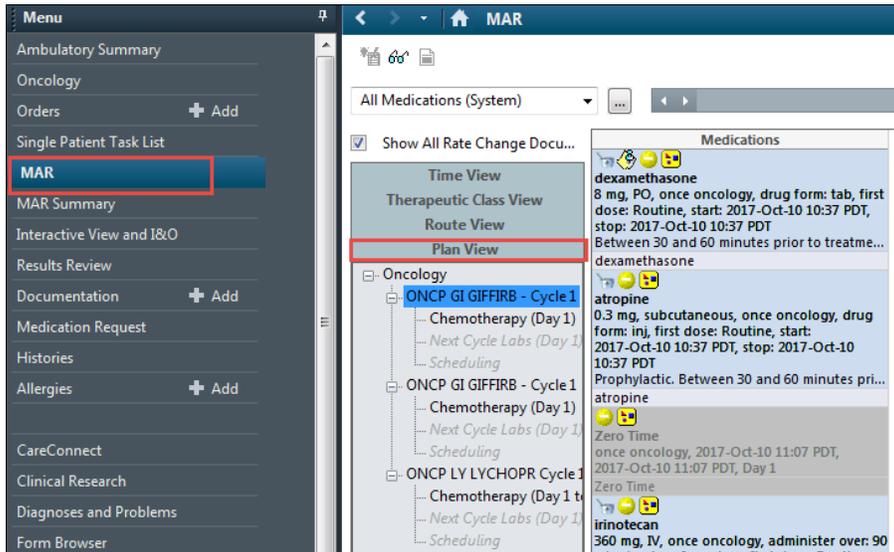


### Key Learning Points

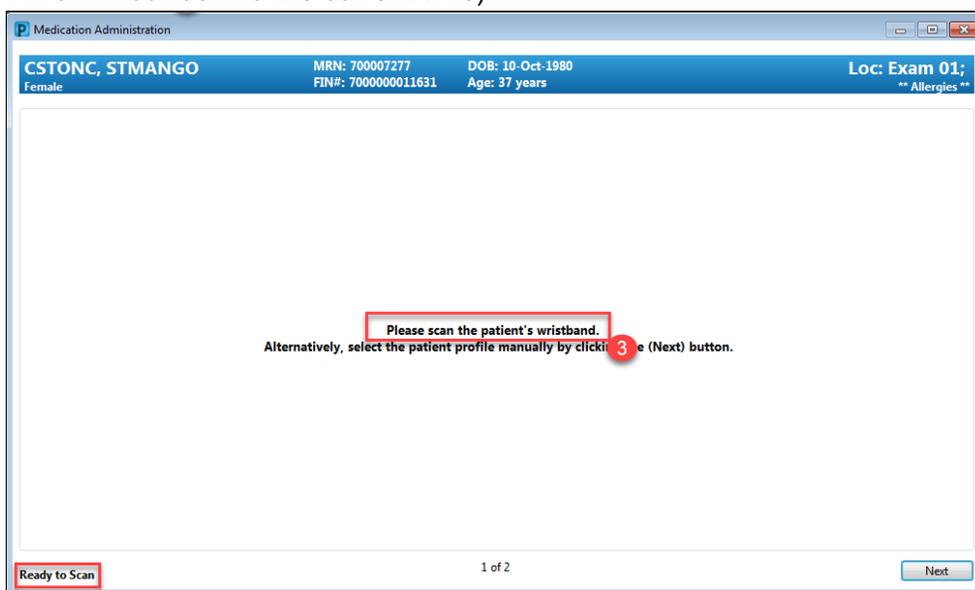
-  Activate orders from the correct Regimen/PowerPlan.
-  Click to Sign Orders as a last sign off stating your checks are completed.
-  Remember to refresh your pages to see changes.

## Activity 3.3 – Closed Loop Medication Administration

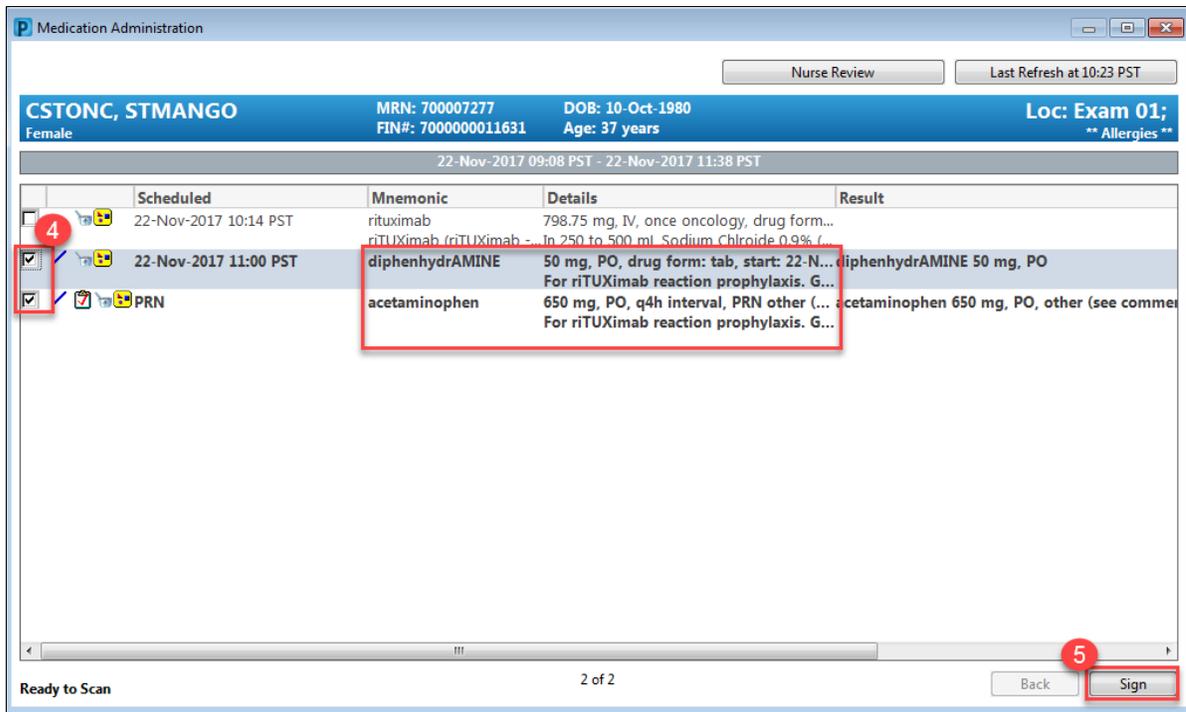
- 1 From the menu select **MAR** and review the medications that are to be administered for the patient. Remember this is best done from the **Plan View** where the medications within the Powerplan are listed in the order of administration.



- 2 Choose the **Medication Administration Wizard (MAW)**  from the toolbar .
3. Scan the patient's wristband, a window will pop up displaying the medications that you can administer. (**Note:** this list populates with medications that are scheduled for 1 hour ahead or 1 hour behind the current time).

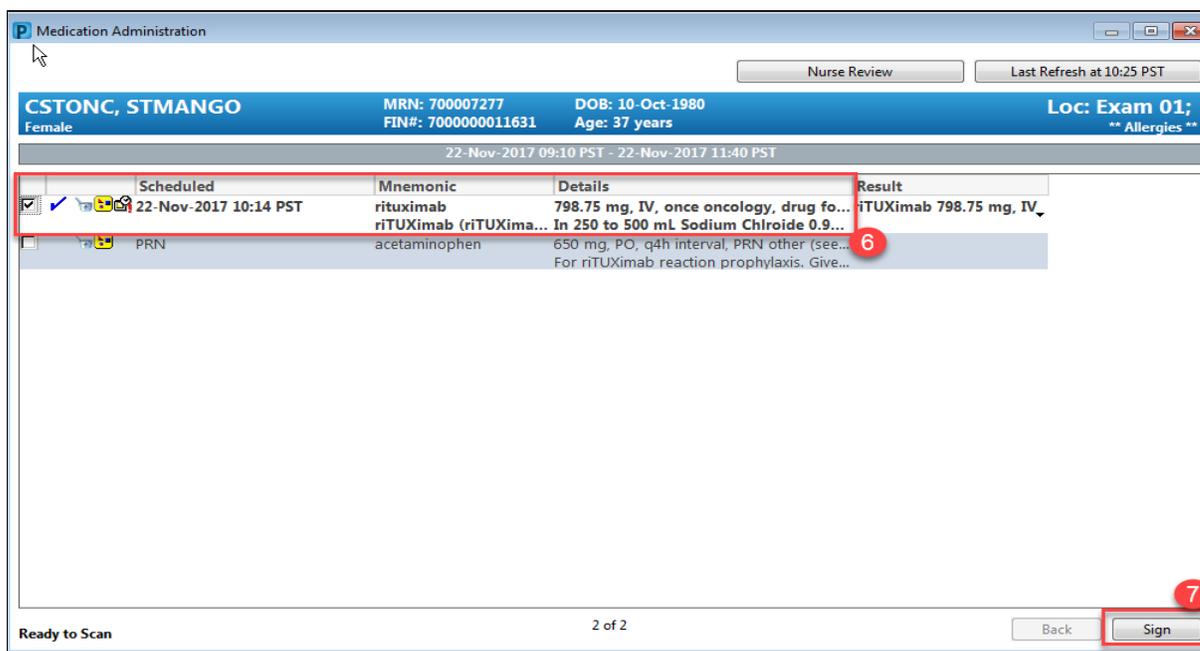


- Scan the medication label for the Acetaminophen and Diphenhydramine. The Medications will appear selected in the **Medication Administration Window**. Click **Next** to verify this is the correct medication scanned. Details of the medication to be administered pop up in the next window, verify these are correct.
- Click **Sign**. You would now administer the medication



- Repeat the same for the Rituximab administration. If a nurse witness is needed you can search for the name by entering name and clicking the binoculars icon. Clicking the  to sign. The administration will open up the Authorizing signature window where the Nurse Witness can enter their password.

7. Click **Sign**.



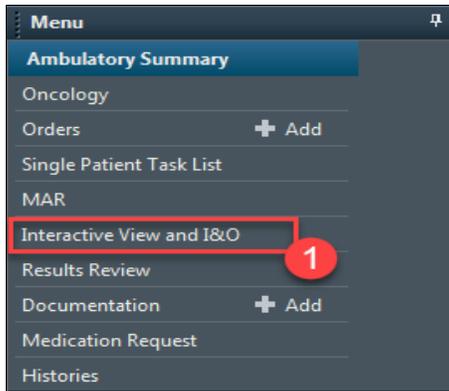
**Note:** You have now signed that you have given both pre-medications and the Rituximab.

### Key Learning Points

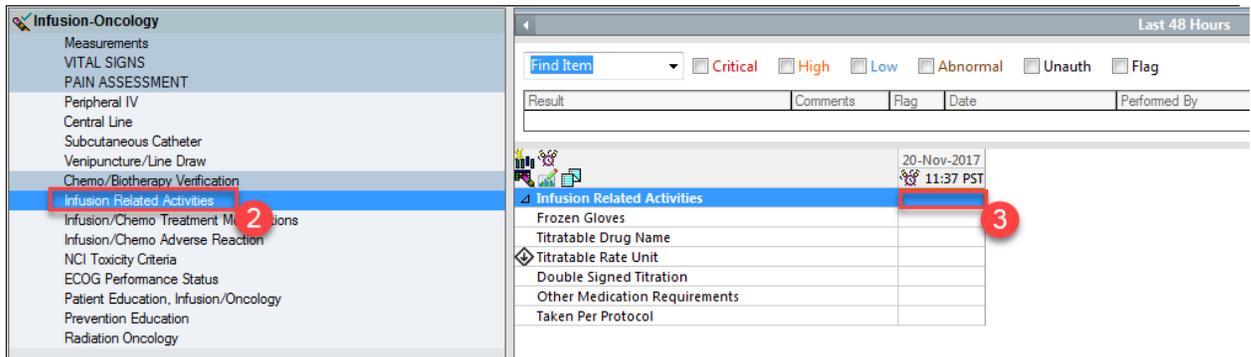
- Use the MAR page to review medications to be given for the day.
- Open the Medication Administration Wizard to scan patient's wristband and medications.
- Click Sign to finalize administration process.

## Activity 3.4 – Titratable Medication Charting

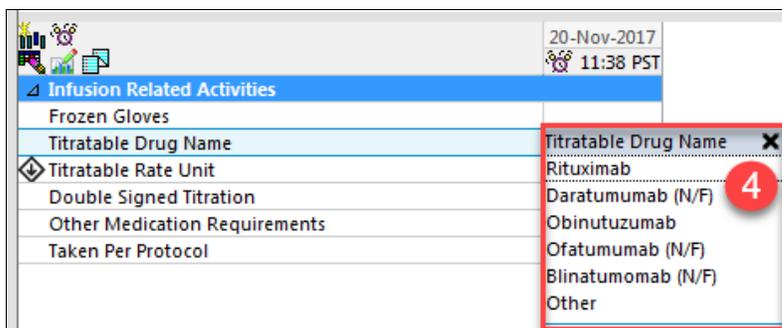
1. From the menu bar select **Interactive View and I&O**.



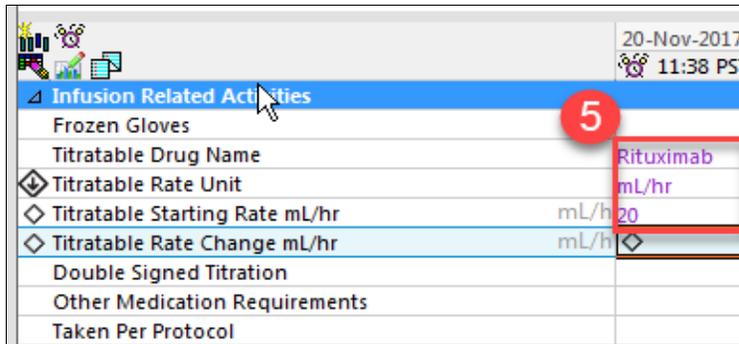
2. Under the **Infusion-Oncology Band** select **Infusion Related Activities**.
3. Now Double-Click in the **Titratable Drug Name** box.



4. From the list select the corresponding drug you have hung (in this scenario we are administering Rituximab).



- Choose the **Titratable Rate Unit**, which should be chosen as mL/hr to reflect your calculations. Chart the starting titration mL/hr. **The system does not omit the need to calculate the titration value.** For our patient use, height 183cm and weight 89kg, with a BSA of 2.13, Rituximab dose 799 mg mixed in a 325 mL bag of NS.

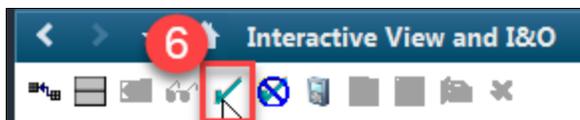


Rituximab Calculation Example based on the above patient information:

mg/hr	Time	mL/hr	Volume to be Infused
50	1 hour	20mLs	2mLs
100	30 mins	41 mLs	20.5 mLs
150	30 mins	61 mLs	30.5 mLs
200	30 mins	81 mLs	40.5 mLs
250	30 mins	102 mLs	51 mLs
300	30 mins	122 mLs	61 mLs
350	30 mins	142mLs	71 mLs
400	30 mins	Until complete	30.5 mLs to completion

2

- Sign** to save the data entered in the chart (hint: text colour changes from purple to black once signed).



- Once you perform a rate increase you can come back and document the subsequent increment calculated. Enter this value in **Titrateable Rate Change**. Continue this process until medication is completed or rate maximum has been reached.

Result	Comments	Flag	Date	Performed By
20-Nov-2017				
12:06 PST				
19-Nov-2017				
15:55 PST				
15:25 PST				
14:55 PST				
14:25 PST				
13:55 PST				
13:25 PST				
12:55 PST				
11:55 PST				
<b>7</b>				
<b>Infusion Related Activities</b>				
Frozen Gloves				
Titrateable Drug Name				
Titrateable Rate Unit				
Titrateable Starting Rate mL/hr				
Titrateable Rate Change mL/hr				
Double Signed Titration				
Other Medication Requirements				
Taken Per Protocol				

- If you need to adjust the time to reflect the time of the rate change. Right-Click on the time or date and select **Insert Date/Time**.
- Change the timeframe to reflect the time of the rate change.



**Note:** This feature can help if another nurse is covering your patient while on break. They can easily see the rates you have entered and at what time the adjustments were made.

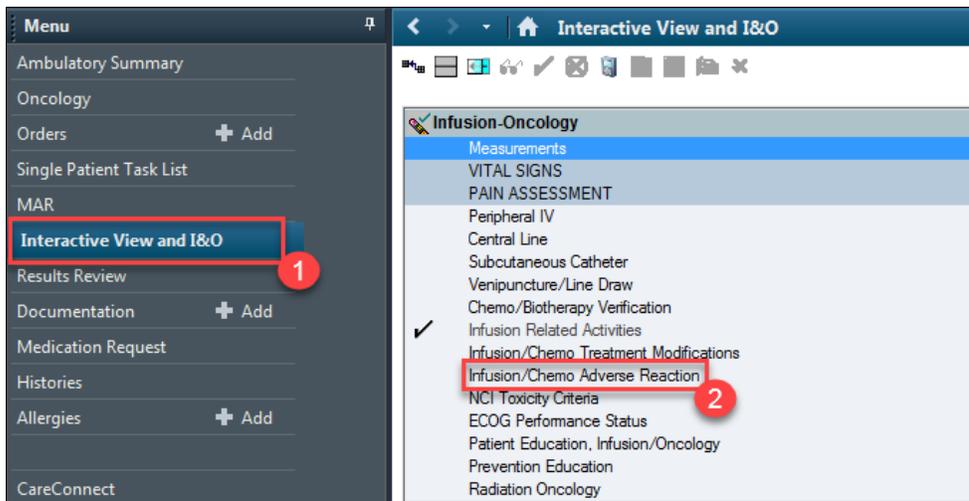
### Key Learning Points

- Titration charting is best done in mL/hr to reflect the calculations.
- Times can be adjusted to reflect time of rate change
- Titration charting in IView does not omit the need to perform calculations
- Titration table can help when nurses are covering breaks

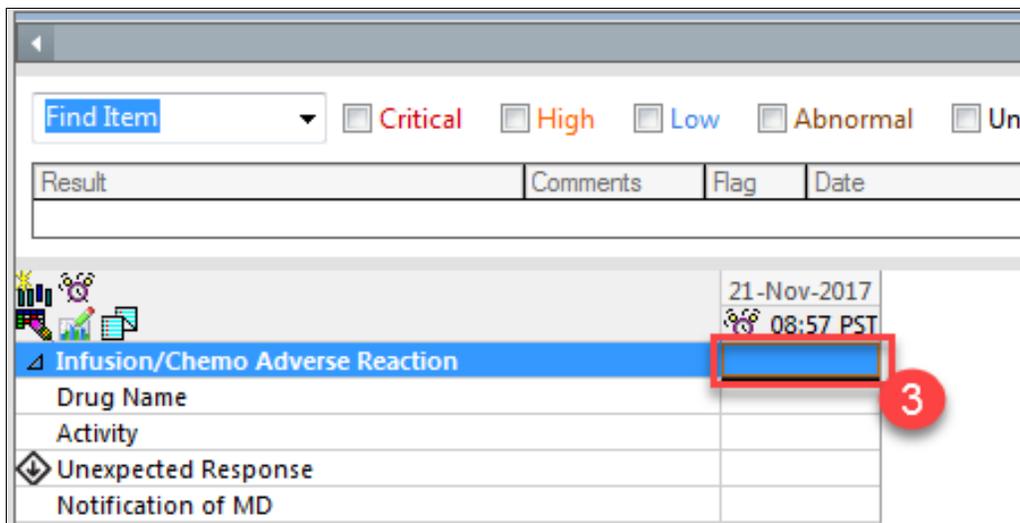
## Activity 3.5 – Reaction Charting

1 Once you have dealt with the reaction and the patient is settled you would complete the following charting to reflect the assessment and actions taken.

1. From the **Menu** select **Interactive View and I&O**.
2. Then from the **Infusion-Oncology Band** select **Infusion/Chemo Adverse Reaction**.



3. Double-Click on the box for **Infusion/Chemo Adverse Reaction** band to expand additional fields below.



**Note:** Hit Enter on the keyboard to jump to the next area of charting instead of using the mouse to click from box to box. You can collapse expanded bands by single clicking  icon to the left.

- Enter the drug causing the adverse reaction; in this scenario enter Rituximab. Hit **Enter**.
- Select the activity which is taking place (assess unexpected response). Hit **Enter**.

21-Nov-2017 08:57 PST		19-Nov-2017 14:00 PST	
<b>Infusion/Chemo Adverse Reaction</b> <input checked="" type="checkbox"/>			
Drug Name		Rituximab	4
Activity		Assess unexpected response	5
<input checked="" type="checkbox"/> Unexpected Response Notification of MD			

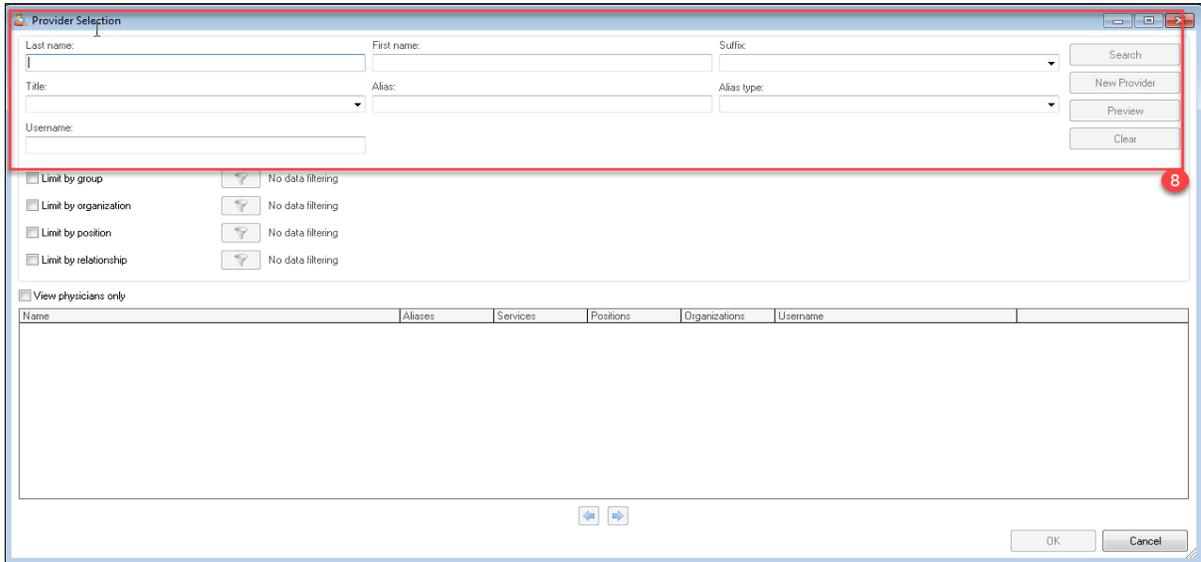
- Select the appropriate **Unexpected Response** being observed/ described by the patient. Hit **Enter**.

21-Nov-2017 08:57 PST		19-Nov-2017 14:00 PST	
<b>Infusion/Chemo Adverse Reaction</b> <input checked="" type="checkbox"/>			
Drug Name		Rituximab	
Activity		Assess unex...	
<input checked="" type="checkbox"/> Unexpected Response Notification of MD			
<input checked="" type="checkbox"/> Hypersensitivity <input type="checkbox"/> Neurologic Symptoms <input type="checkbox"/> Respiratory Symptoms <input type="checkbox"/> Systemic Symptoms <input type="checkbox"/> Cardiovascular Symptoms <input type="checkbox"/> GI Symptoms <input type="checkbox"/> GU Symptoms <input type="checkbox"/> Integumentary Symptoms <input type="checkbox"/> Extravasation <input type="checkbox"/> Flare reaction <input type="checkbox"/> Other			

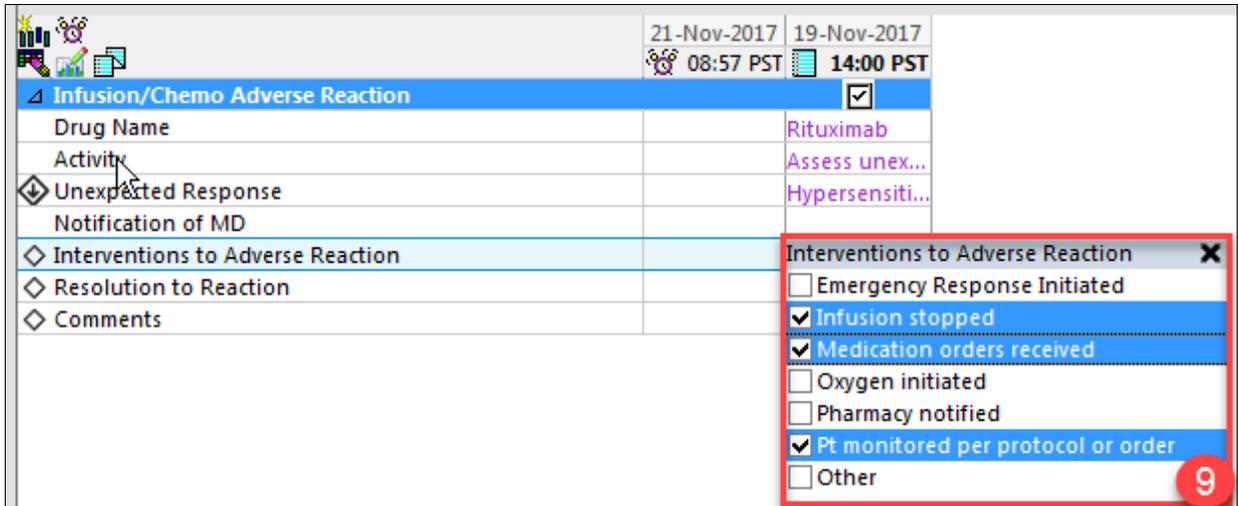
- Document the **Notification of the MD**. To do this use the mouse to select the magnify glass and complete the appropriate fields in the pop up window and then hit **Enter**.

21-Nov-2017 08:57 PST		19-Nov-2017 14:00 PST	
<b>Infusion/Chemo Adverse Reaction</b> <input checked="" type="checkbox"/>			
Drug Name		Rituximab	
Activity		Assess unex...	
<input checked="" type="checkbox"/> Unexpected Response Notification of MD			
<input type="checkbox"/> Interventions to Adverse Reaction <input type="checkbox"/> Resolution to Reaction <input type="checkbox"/> Comments			

8. Fill in the name of the MD who was notified or came to assess the patient and then click **OK** to take you back to the previous screen to complete the adverse reaction charting.

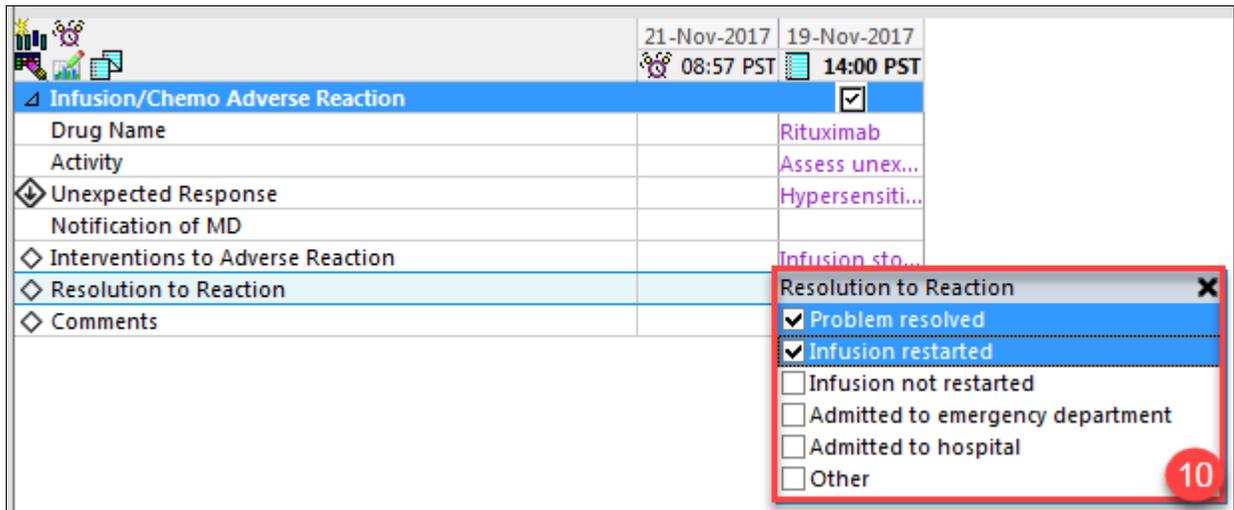


9. Select the interventions that were implemented. Hit **Enter**.



21-Nov-2017 08:57 PST	19-Nov-2017 14:00 PST	
<b>Infusion/Chemo Adverse Reaction</b> <input checked="" type="checkbox"/>		
Drug Name		Rituximab
Activity		Assess unex...
Unexpected Response		Hypersensiti...
Notification of MD		
Interventions to Adverse Reaction		<input type="checkbox"/> Emergency Response Initiated
Resolution to Reaction		<input checked="" type="checkbox"/> Infusion stopped
Comments		<input checked="" type="checkbox"/> Medication orders received
		<input type="checkbox"/> Oxygen initiated
		<input type="checkbox"/> Pharmacy notified
		<input checked="" type="checkbox"/> Pt monitored per protocol or order
		<input type="checkbox"/> Other

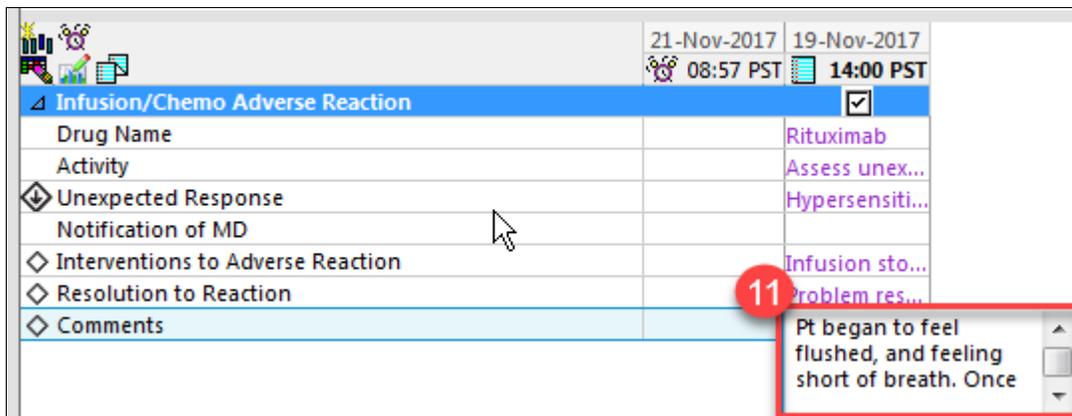
10. Select the resolution to the reaction. Hit **Enter**.



	21-Nov-2017 08:57 PST	19-Nov-2017 14:00 PST
<input checked="" type="checkbox"/> <b>Infusion/Chemo Adverse Reaction</b>		<input checked="" type="checkbox"/>
Drug Name		Rituximab
Activity		Assess unex...
<input checked="" type="checkbox"/> Unexpected Response		Hypersensiti...
Notification of MD		
<input checked="" type="checkbox"/> Interventions to Adverse Reaction		Infusion sto...
<input checked="" type="checkbox"/> Resolution to Reaction		Resolution to Reaction
<input checked="" type="checkbox"/> Comments		

- Problem resolved
- Infusion restarted
- Infusion not restarted
- Admitted to emergency department
- Admitted to hospital
- Other

11. You may also add any comments to explain the reaction scenario and reflect any detail which was not touched on in the above fields. Vital Signs would be charted in the corresponding band in IView.



	21-Nov-2017 08:57 PST	19-Nov-2017 14:00 PST
<input checked="" type="checkbox"/> <b>Infusion/Chemo Adverse Reaction</b>		<input checked="" type="checkbox"/>
Drug Name		Rituximab
Activity		Assess unex...
<input checked="" type="checkbox"/> Unexpected Response		Hypersensiti...
Notification of MD		
<input checked="" type="checkbox"/> Interventions to Adverse Reaction		Infusion sto...
<input checked="" type="checkbox"/> Resolution to Reaction		Problem res...
<input checked="" type="checkbox"/> Comments		

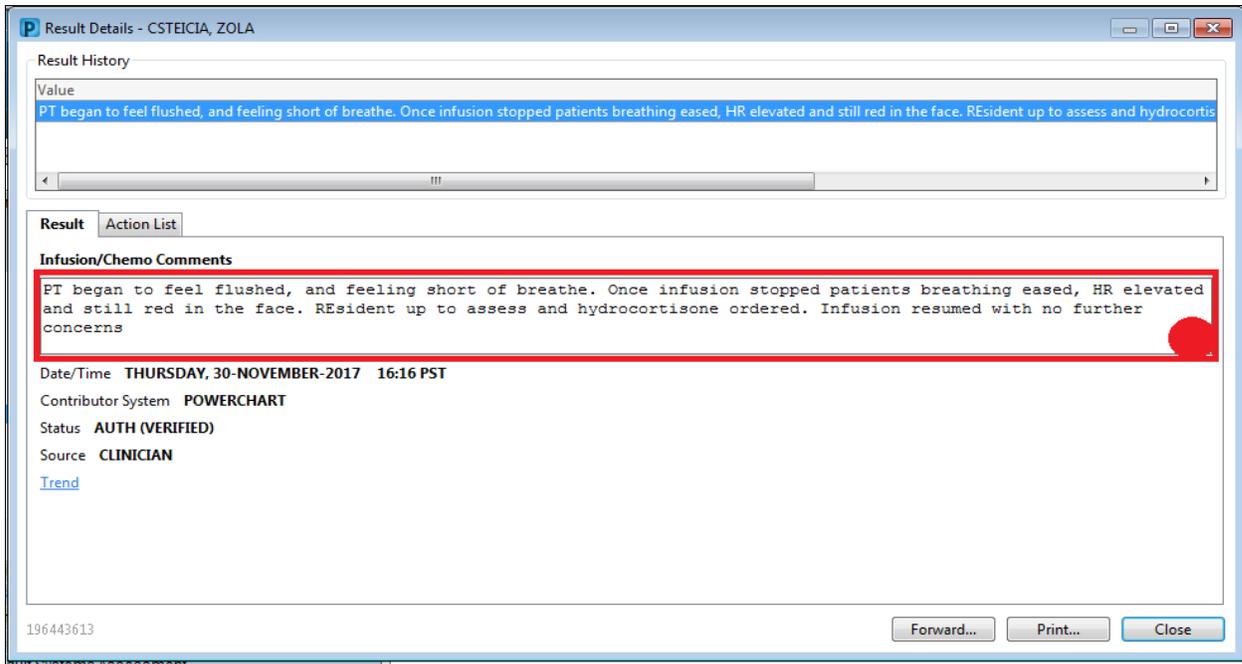
Pt began to feel flushed, and feeling short of breath. Once

12. Lastly, do not forget to sign the documentation by clicking on the Check Mark in the upper left-hand side of the screen.



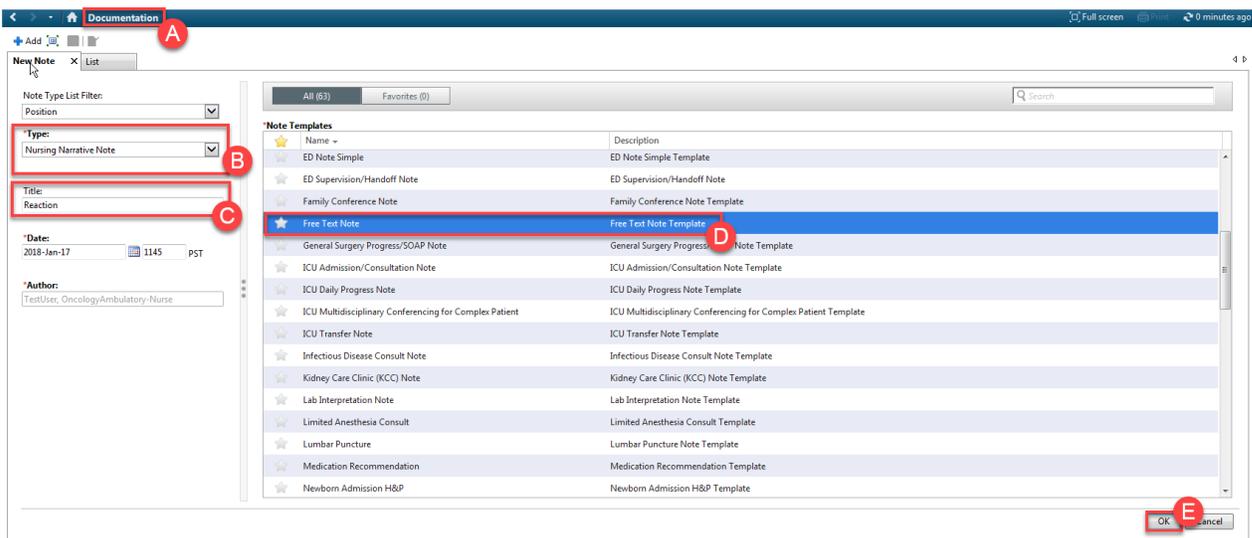
12

- To read the text added into the comments field or any other field you can double-click to populate the **Result Details**.

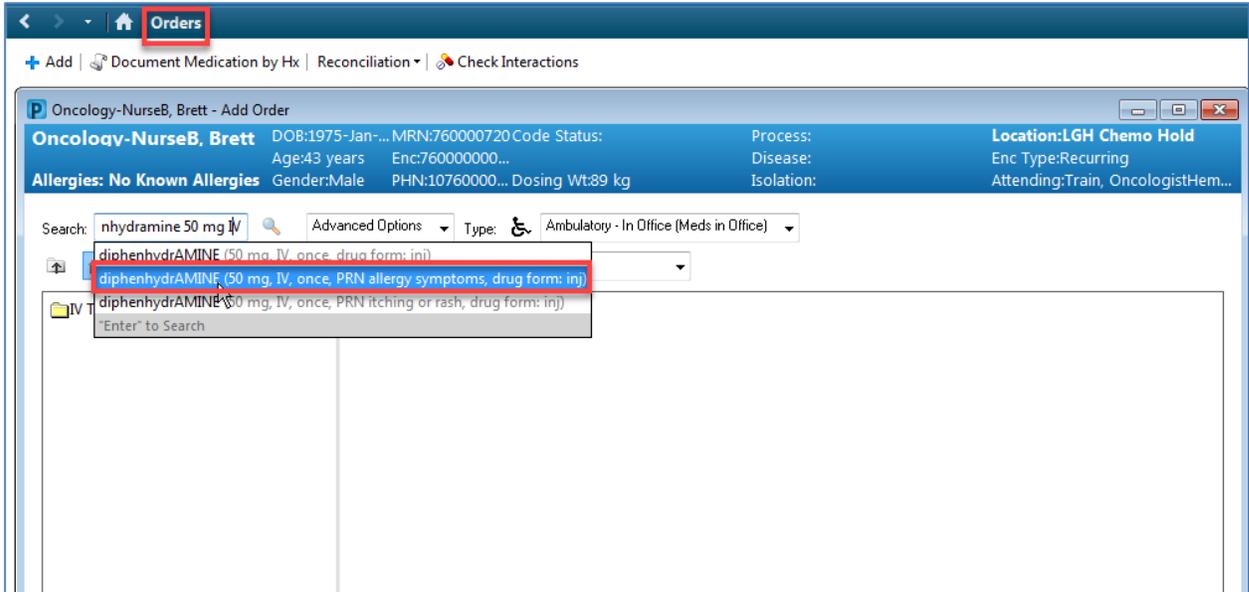


- Alternatively, if you required charting in more depth you could create a free text note within the Documentation section.

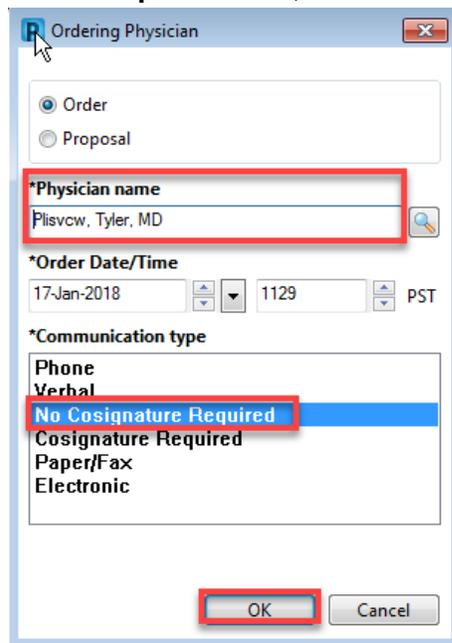
- Select **Documentation** from the Menu
- Choose the **Type** of note: **Nursing Narrative Note**
- Title** your note
- Select **Free Text Note** from the templates
- Click **OK**



15. To reflect the medications that were administered during the infusion reaction you would need to add an adhoc order. Navigate to the **Orders** section in the chart and place an order for **Diphenhydramine 50mg IV, once, PRN allergy symptoms, drug form:inj.**



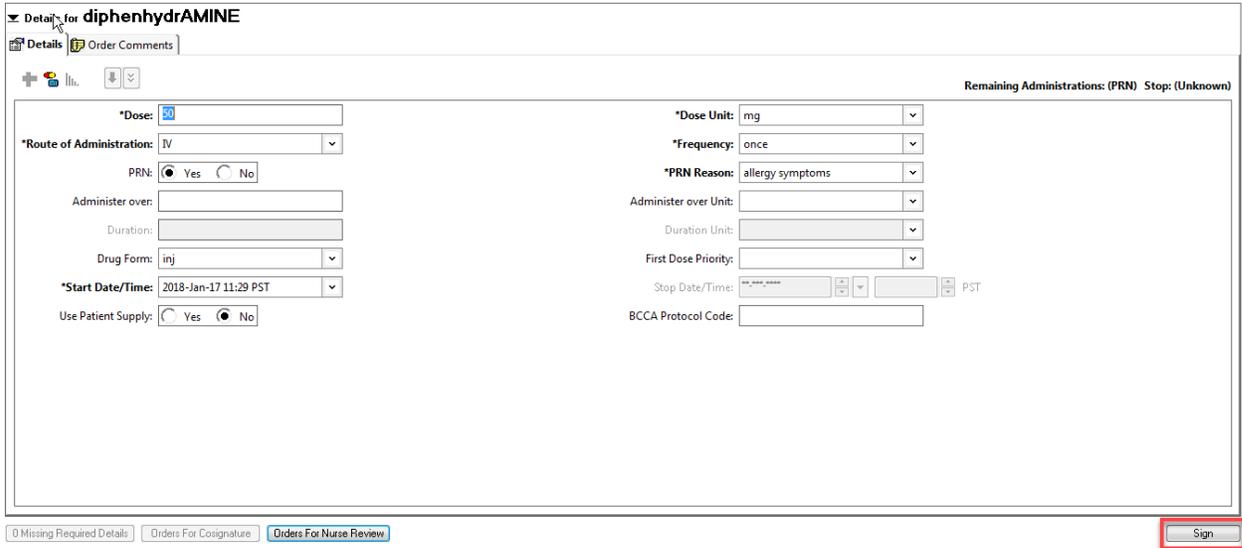
16. The **Ordering Physician** window will pop up, fill in the details. This is an RNA and therefore is a **No Cosignature Required** order, click **OK**.



**Note:** If other meds were given during the reaction they may require a different communication

type, depending on your Health Organizations Policies.

17. Select  from the order entry screen. You will then be on the **Details** screen, click **Sign**, or adjust the details if required and then sign.



Details for **diphenhydramine**

Details | Order Comments

Remaining Administrations: (PRN) Stop: (Unknown)

\*Dose: 50

\*Dose Unit: mg

\*Route of Administration: IV

\*Frequency: once

PRN:  Yes  No

\*PRN Reason: allergy symptoms

Administer over: \_\_\_\_\_

Administer over Unit: \_\_\_\_\_

Duration: \_\_\_\_\_

Duration Unit: \_\_\_\_\_

Drug Form: inj

First Dose Priority: \_\_\_\_\_

\*Start Date/Time: 2018-Jan-17 11:29 PST

Stop Date/Time: \_\_\_\_\_ PST

Use Patient Supply:  Yes  No

BCCA Protocol Code: \_\_\_\_\_

0 Missing Required Details | Orders For Cosignature | Orders For Nurse Review | **Sign**

18. You can navigate to the **MAR** and see this medication is now available. Since the medication has already been given during the reaction there is no need to access the MAW, as you won't be able to scan and verify.
- A. Select the **MAR** from the menu
  - B. Under the **Time View** looking at **PRN** medications
  - C. The **Diphenhydramine** order is available
  - D. **Right-Click** on the medication task
  - E. Click on **Chart Details**

19. The chart details window will pop up, you can adjust the time the medication was administered to reflect on your MAR.

- A. Change the time to reflect time given during the adverse reaction
- B. You may also add a **Comment** if you like
- C. Sign for the time administration

**Note:** Once you have clicked sign the medication task will now show complete with the time chosen reflected on the MAR.



### Key Learning Points

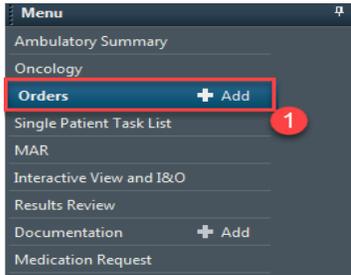
- Adverse reaction charting takes place in iView.
- IView bands can be expanded and collapsed to ease charting.

## Activity 3.6 – Lifetime Cumulative Dosing

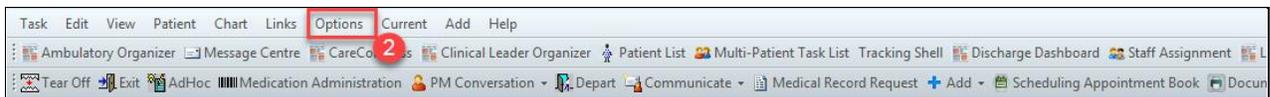
When you are doing your chemotherapy checks and need to review how much of a lifetime limiting dose of toxic medication has been given, there are views within the chart to help you.

1

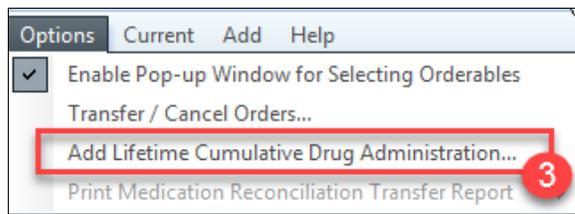
1. For the first option you must be within **Orders** under the menu.



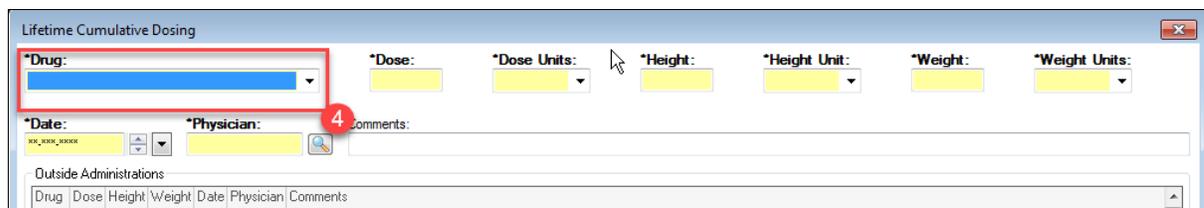
2. Once the orders screen is open, select **Option** from the top toolbar.



3. Choose the **Add Lifetime Cumulative Drug Administration**.

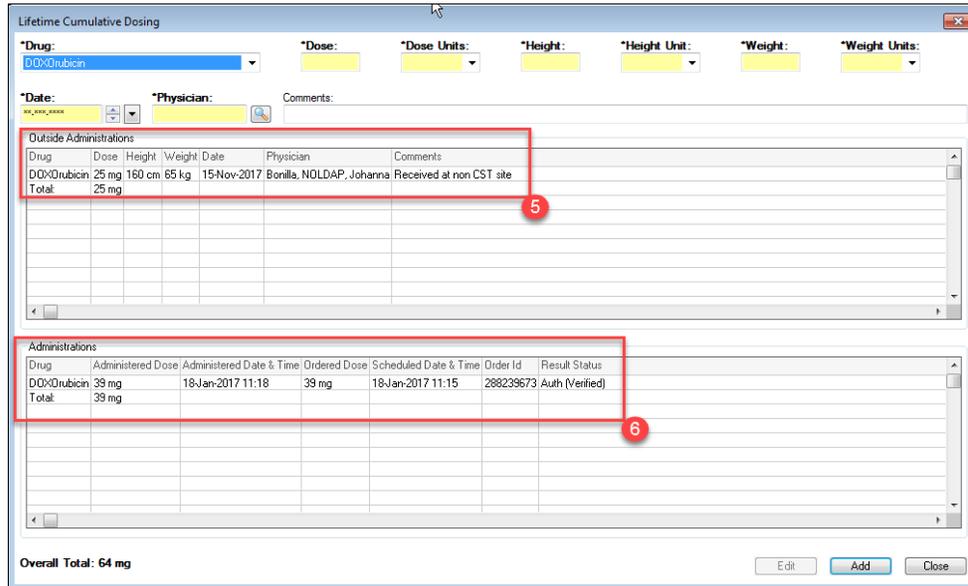


4. This will open a pop up window where you can select the drug you are required to review. From the dropdown menu select Doxorubicin (The Doxorubicin which was given yesterday for the patients Cycle 1 D1 will reflect in the Administrations).

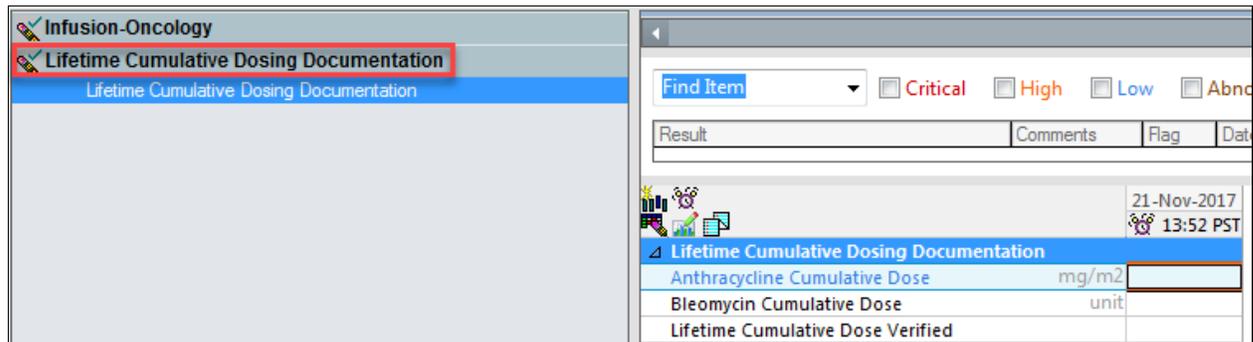


**Note:** If a patient has been given any of these medications outside of a Health Organization with Cerner, the amount will not automatically reflect but can be added in manually if the records are known.

- You can see the upper box in the window displays the Outside Administrations given. You should not have any results displayed here as this patient has not had any previous doses of Doxorubicin. You are also able to Add this information if the documentation is present.
- The lower box in the window displays the amount given yesterday.



- The Lifetime Cumulative Dosing band in IView is reserved for sites required to calculate the cumulative dosing as a part of the chemotherapy checks with the use of specified toxic medications (used in Children’s for their oncology patients). The previous doses administered or the outside doses recorded in Step 6 do not pull into this view.



## Key Learning Points

- Two options to view Lifetime Cumulative Dosing, only one will be used in the Adult Oncology setting.
- Main view from option on the main toolbar when you have the orders sections open.
- IView Cumulative Dosing Band only used in some hospitals (mainly Children's).
- Doses not administered in a Cerner site need to be added manually.

## PATIENT SCENARIO 4 – LUAVPP

### Learning Objectives

At the end of this Scenario, you will be able to:

- Recognize Dose Modifications within a PowerPlan
- Place the Ok to Proceed order when Treatment
- Use Handoff Tool and the Transport Ticket
- Change the encounter type
- Document on an Oncology Telephone Triage Powerform
- Use Message Center to forward a PowerForm

### SCENARIO

The patient has been diagnosed with Advanced Non-Small Cell Lung cancer. She has completed Cycle 2 of LUAVPP in the outpatient chemotherapy clinic and is here for cycle 3. Her most recent laboratory results indicated an elevated creatinine which required a modification to the dose of Cisplatin. During your chart review, you notice that the patient has a platelet count of  $99 \times 10^9/L$  which, according to the protocol, requires a delay in treatment. Throughout the workbook you will be given more information on the patient enabling you to complete the activities.

For this scenario please use the patient provided [**Oncology-NurseC, enter first name**].

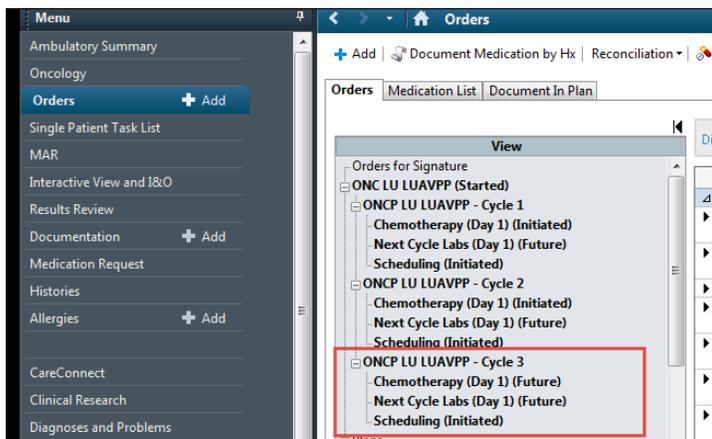
As a member of the Ambulatory Chemo unit you will be completing the following activities:

- Chemotherapy Checks
- Ok to Proceed Order
- Reschedule Chemotherapy and Lab Phase orders
- Adhoc Orders
- Patients in Transition
- Transport Ticket
- Switching Encounters
- Phone Message Encounters
- Oncology Telephone Triage Powerform

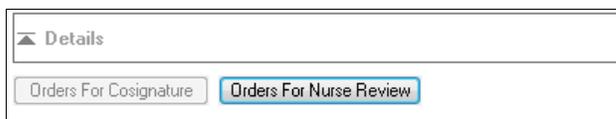
## Activity 4.1 – Dose Adjustments

For this scenario you can choose to pick your patient up from the Tracking Shell (assigning yourself as their nurse, or searching them by name from the menu).

- 1 From the **Menu** within the patient’s chart, click on **Orders**. From the Orders screen, scroll through the **View** tab of the navigator to find the Regimen/PowerPlan orders.

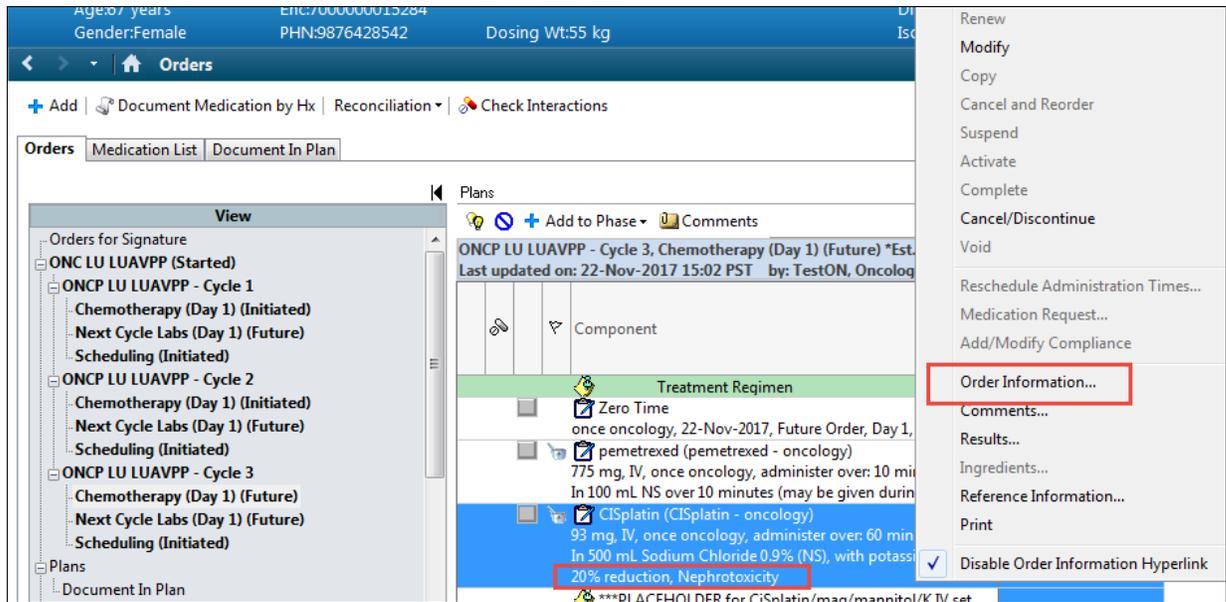


- 2 Check the Orders by selecting **Orders for Nurse Review**. A screen will pop up that will give you a view of all of the chemo orders for the patient. Click **Review**.

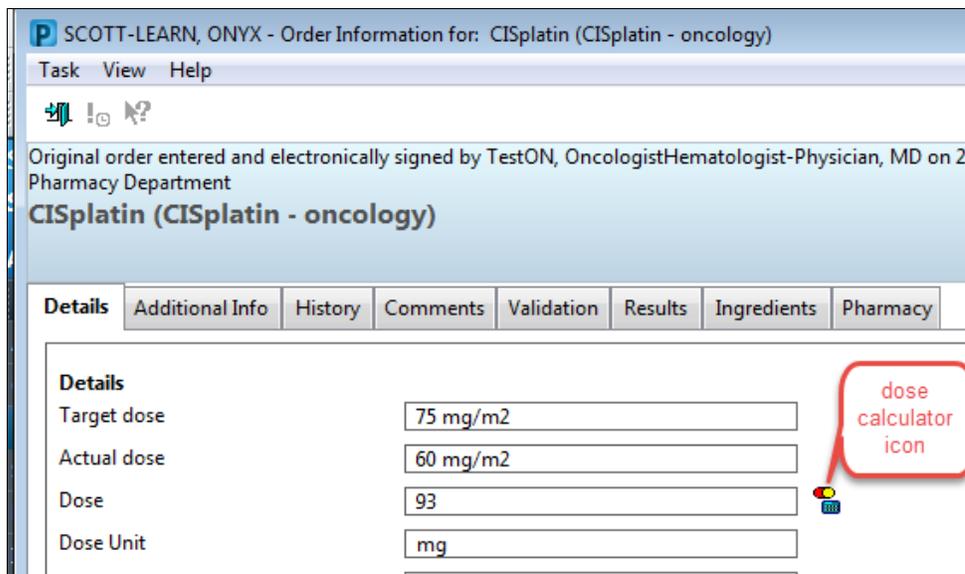


SCOTT-LEARN, ONYX - Actions Requiring Review							
SCOTT-LEARN, ONYX		DOB:23-Aug-1950	MRN:700008275	Code Status:	Process:	Location:LGH Chemo	
Allergies: penicillin		Age:67 years	Enc:700000015284		Disease:	Enc Type:Pre-Outpatient	
		Gender:Female	PHN:9876428542	Dosing Wt:55 kg	Isolation:	Attending:	
<input checked="" type="checkbox"/>	Order	22-Nov-201 7 15:02:25 ...	TestON, Oncologis...	Lactate Dehydrogenase	Blood, Routine, Collection: 11-Dec-2017, once, Order for future visit	ONCP LU LUAVPP - ... TestON, Oncologis...	
<input checked="" type="checkbox"/>	Order	22-Nov-201 7 15:02:25 ...	TestON, Oncologis...	Aspartate Aminotransferase	Blood, Routine, Collection: 11-Dec-2017, once, Order for future visit	ONCP LU LUAVPP - ... TestON, Oncologis...	
<input checked="" type="checkbox"/>	Order	22-Nov-201 7 15:02:25 ...	TestON, Oncologis...	Bilirubin Total	Blood, Routine, Collection: 11-Dec-2017, once, Order for future visit	ONCP LU LUAVPP - ... TestON, Oncologis...	
<input checked="" type="checkbox"/>	Order	22-Nov-201 7 15:02:25 ...	TestON, Oncologis...	Creatinine Level	Blood, Routine, Collection: 11-Dec-2017, once, Order for future visit	ONCP LU LUAVPP - ... TestON, Oncologis...	
<input checked="" type="checkbox"/>	Order	22-Nov-201 7 15:02:25 ...	TestON, Oncologis...	Platelet Count	Blood, Routine, Collection: 11-Dec-2017, once, Order for future visit	ONCP LU LUAVPP - ... TestON, Oncologis...	
<input checked="" type="checkbox"/>	Order	22-Nov-201 7 15:02:25 ...	TestON, Oncologis...	Differential (CBC and Differential)	Blood, Routine, Collection: 11-Dec-2017, once, Order for future visit	ONCP LU LUAVPP - ... TestON, Oncologis...	
<input checked="" type="checkbox"/>	Order	22-Nov-201 7 15:02:25 ...	TestON, Oncologis... Hematologi st-Physician , MD	CISplatin (CISplatin - oncology) PST	93 mg, IV, once oncology, administer over: 60 minute, drug form: bag, first dose: Routine, start: 22-Nov-2017, In 500 mL Sodium Chloride 0.9% (NS), with potassium chloride 20 mEq, magnesium sulphate 1 g and mannitol 30 g over 60 minutes. Day 1 Target Dose: CISplatin - oncology 75 mg/m2 22-Nov-2017 14:59:25	ONCP LU LUAVPP - ... TestON, Oncologis... Hematologi st-Physician (Day 1) , MD	Event/Task Summary
<input checked="" type="checkbox"/>	Order	22-Nov-201 7 15:02:24 ...	TestON, Oncologis... Hematologi st-Physic...	pemetrexed (pemetrexed - oncology) PST	775 mg, IV, once oncology, administer over: 10 minute, drug form: bag, first dose: Routine, start: 22-Nov-2017, In 100 mL NS over 10 minutes (may be given during prehydration). Day 1 Target Dose: pemetrexed - oncology 500 mg/m2 22-Nov-2017 14:54:19	ONCP LU LUAVPP - ... TestON, Oncologis... Hematologi st-Physic...	Event/Task Summary
<input checked="" type="checkbox"/>	Order	22-Nov-201 7 15:02:24 ...	TestON, Oncologis...	Zero Time	once oncology, 22-Nov-2017, Future Order, Day 1, -1	ONCP LU LUAVPP - ... TestON, Oncologis...	Event/Task Summary
<input checked="" type="checkbox"/>	Order	22-Nov-201 7 15:02:24 ...	TestON, Oncologis...	sodium chloride 0.9% (sodium chloride 0.9...)	1,000 mL, IV, once oncology, administer over: 60 minute, drug form: bag, first dose: Routine, start: 22-Nov-2017, Over 1 hour prior to CISplatin. Day 1	ONCP LU LUAVPP - ... TestON, Oncologis...	Event/Task Summary
<input checked="" type="checkbox"/>	Order	22-Nov-201 7 15:02:24 ...	TestON, Oncologis...	dexamethasone	4 mg, PO, once oncology, drug form: tab, first dose: Routine, start: 22-Nov-2017, 30 to 60 minutes prior to treatment. Day 1	ONCP LU LUAVPP - ... TestON, Oncologis...	Event/Task Summary
<input checked="" type="checkbox"/>	Order	22-Nov-201 7 15:02:24 ...	TestON, Oncologis...	ondansetron	8 mg, PO, once oncology, drug form: tab, first dose: Routine, start: 22-Nov-2017, 30 to 60 minutes prior to treatment. Day 1	ONCP LU LUAVPP - ... TestON, Oncologis...	Event/Task Summary

- 3 This will bring you back to the **Orders** screen. To see more information about an order, you can right click on the order and select **Order Information**. Note the dose reduction to Cisplatin.



- 4 From the **Order Information Window** select the **Dose Calculator Icon** . The Dose Calculator will allow you to see the Height, Weight and BSA used by the system to calculate the doses. View this screen to verify that the appropriate values have been used. This is where you will see more details about the dose reduction.



**Viewing Dosage Calculator**

**Cisplatin - oncology**

Dose Values

1) Target dose: 75 mg/m<sup>2</sup> (dose according to protocol)

2) Calculated dose: 116.25 mg

3) Dose Adjustment: 93 mg 80 % (Percentage of total dose)

4) Final dose: 93 mg 60

5) Standard dose: 0 mg 0 mg/m<sup>2</sup>

6) Rounding rule: No rounding

7) Adjust Reason: Nephrotoxicity Nephrotoxicity

8) Route: IV

Order Comments

In 500 mL Sodium Chloride 0.9% (NS), with potassium chloride 20 mEq, magnesium sulphate 1 g and mannitol 30 g over 60 minutes. Day 1

Reference Data

Date of birth: 08/23/1950 (67 Years)

Sex: Female

Ethnicity:

Height: 157 cm (22-Nov-2017 12:05 157.00 cm Height/Length Measured)

Actual weight: 55 kg (22-Nov-2017 12:05 55.000 kg Weight Dosing)

Adjusted weight: 55 kg (Adjustment: Actual (no adjustment))

Serum creatinine: 0.94 mg/dL (Source: Manually entered)

CrCl (est.): 50.42 mL/min (Algorithm: Cockcroft-Gault (Actual Weight))

Weight Used for CrCl: Actual weight 55 kg

Body surface area: 1.55 m<sup>2</sup> (Algorithm: Mosteller)

Close

- 5 Close this screen and click “x” on the next screen so that you can move on to checking lab results. Select the **Chemotherapy** phase of the Powerplan. This will display the Pre-chemotherapy metrics. A ✓ and the lab result will display if the lab results are within the set parameters for treatment, to proceed with treatment (2) and a red “x” will display if the parameters are not met. ‘Completed’ displays if the lab was collected and no result matching this field is available (1).

Orders Medication List Document In Plan

View

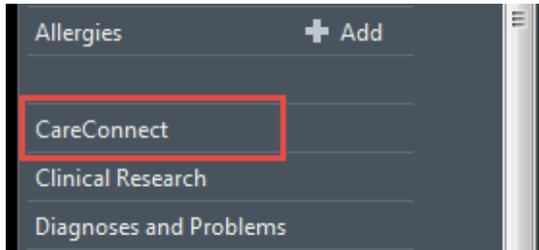
Orders for Signature

- ONC LU LUAVPP (Started)
  - ONCP LU LUAVPP - Cycle 1
    - Chemotherapy (Day 1) (Initiated)
    - Next Cycle Labs (Day 1) (Future)
    - Scheduling (Initiated)
  - ONCP LU LUAVPP - Cycle 2
    - Chemotherapy (Day 1) (Initiated)
    - Next Cycle Labs (Day 1) (Future)
    - Scheduling (Initiated)
  - ONCP LU LUAVPP - Cycle 3
    - Chemotherapy (Day 1) (Future)
    - Next Cycle Labs (Day 1) (Future)
    - Scheduling (Initiated)

			Day 1
			Completed
			27-Oct-2017 12:18 PDT
			Actions
Pre-Chemo Metrics			
Neutrophil - Greater Than or Equal 1.0 x10 9/L	-96 hr	Completed	1
Platelet Count - Greater Than or Equal 100 x1...	-96 hr	300 x10 9/L	2
			27-Oct-2017 09:50 PDT

**Note:** You can also view a comprehensive list of results by selecting Results Review from the menu.

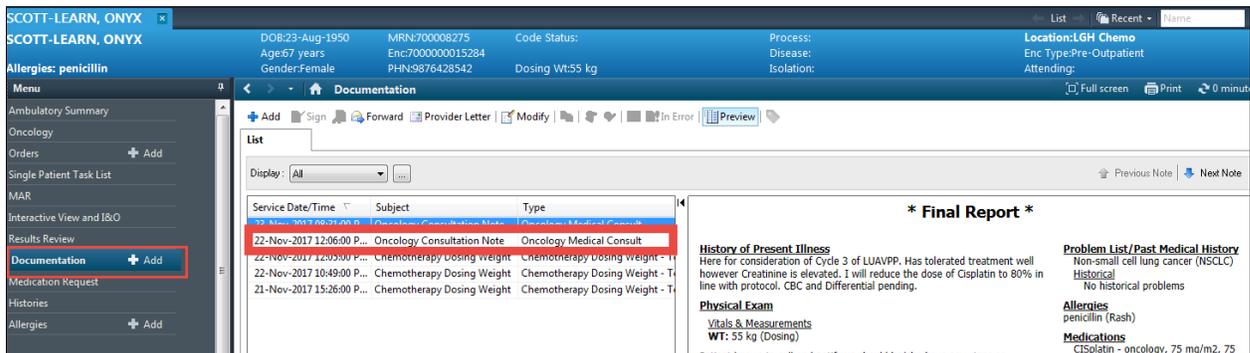
6 When the patient has their bloodwork collected from a non-Cerner site, the results will not be available in the Pre-chemo phase of the Powerplan, or in Results Review. These results will be available through an interface with **CareConnect**. Click on CareConnect from the **Menu** to link directly to the Patient’s results within CareConnect.



7 The results that you view in **CareConnect** for this scenario include:

- ANC  $1.6 \times 10^9$
- Plt  $99 \times 10^9$
- Hgb 110 g/L
- Cr 83\* umol/L
- AST 28 U/L
- ALT 35 U/L
- Bili 7 umol/L

Reviewing the results against the LUAVPP protocol you note that the platelet count of  $99 \times 10^9$  means that treatment parameters have not been met. You check the Oncologist documentation and see that the Provider was not aware of the low Platelet count. Click on **Documentation** from the Menu and select the **Oncology Consult Note**.

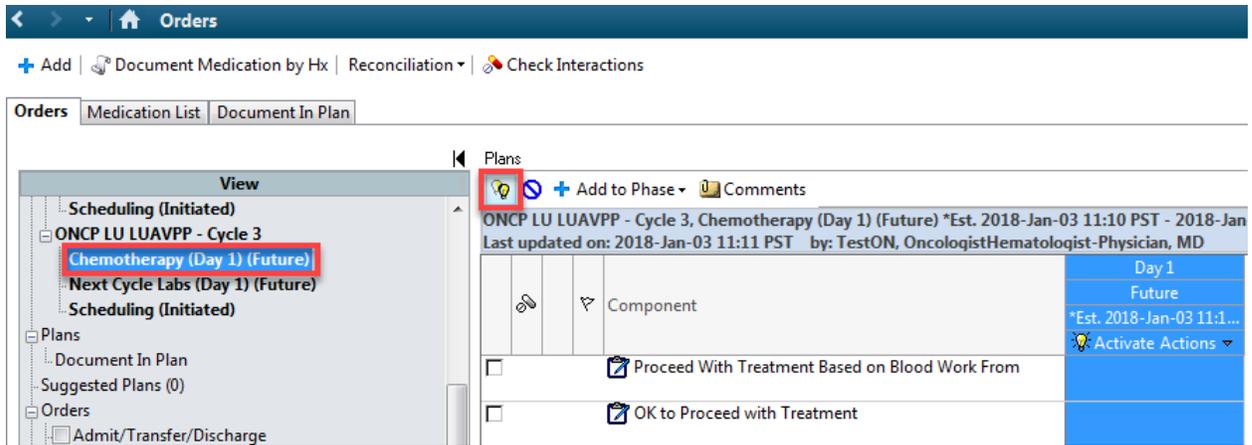


## Key Learning Points

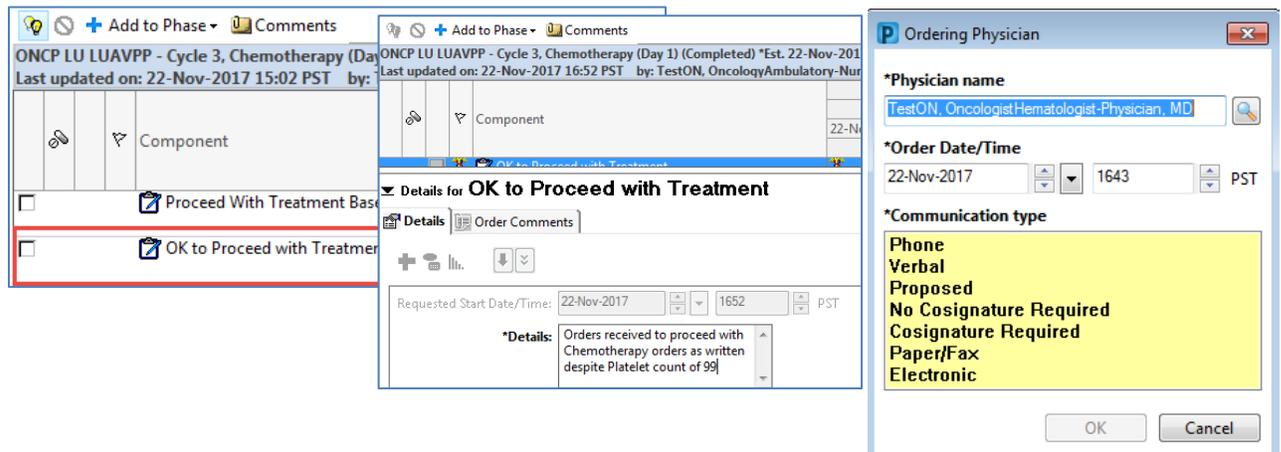
-  Dose reductions will display in the orders profile and additional details can be viewed from the dose calculator.
-  You can link directly to the Patient's results in CareConnect from within the patient's chart.

## Activity 4.2 – “Ok to Proceed with Treatment” Order

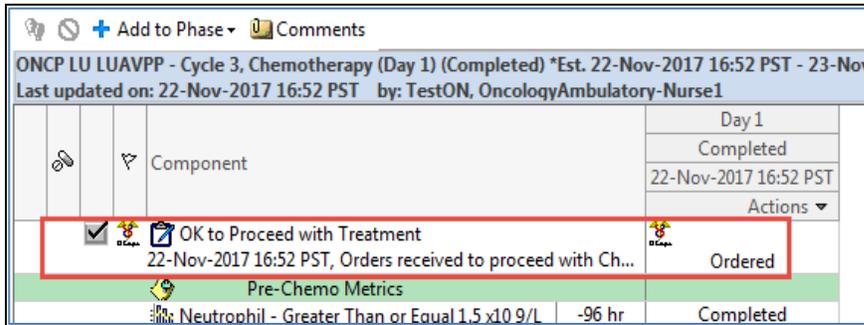
- 1 You call the provider to discuss this and since they are not at a Cerner site they give you a phone order to proceed with Chemotherapy as ordered. Navigate to the **Order** screen, select the **Chemotherapy Phase** and **Click** on the  icon.



- 2 The excluded components will display, check the box to select the **OK to Proceed with Treatment** order. Enter the details for the ordering provider, and add order details.



When you have finished entering all of the details, Click  , Click  , and Refresh  . This symbol  indicates that the order is yet to be signed by the Provider.



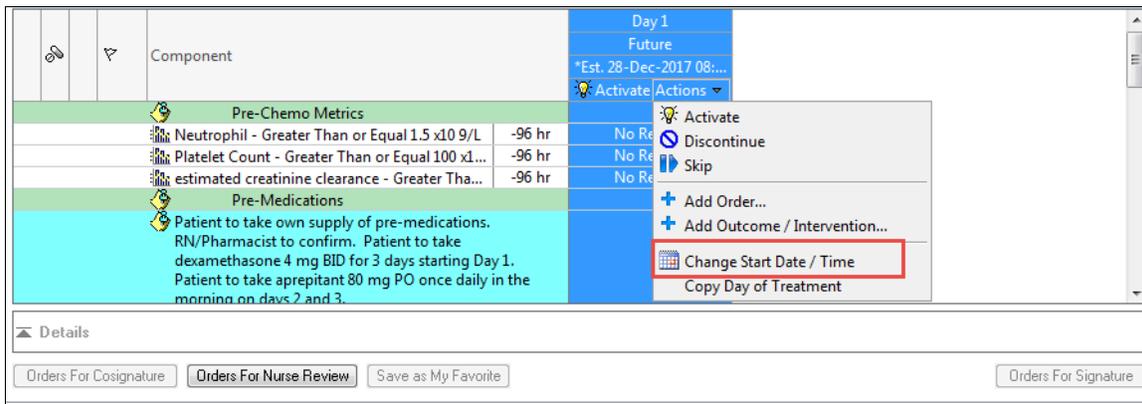
ONCP LU LUAVPP - Cycle 3, Chemotherapy (Day 1) (Completed) *Est. 22-Nov-2017 16:52 PST - 23-Nov-2017 16:52 PST		
Last updated on: 22-Nov-2017 16:52 PST by: TestON, OncologyAmbulatory-Nurse1		
Component	Day 1	Actions
<input checked="" type="checkbox"/>  OK to Proceed with Treatment 22-Nov-2017 16:52 PST, Orders received to proceed with Ch...	Completed 22-Nov-2017 16:52 PST	 Ordered
 Pre-Chemo Metrics		
 Neutrophil - Greater Than or Equal 1,5 x10.9/L	-96 hr	Completed

### Key Learning Points

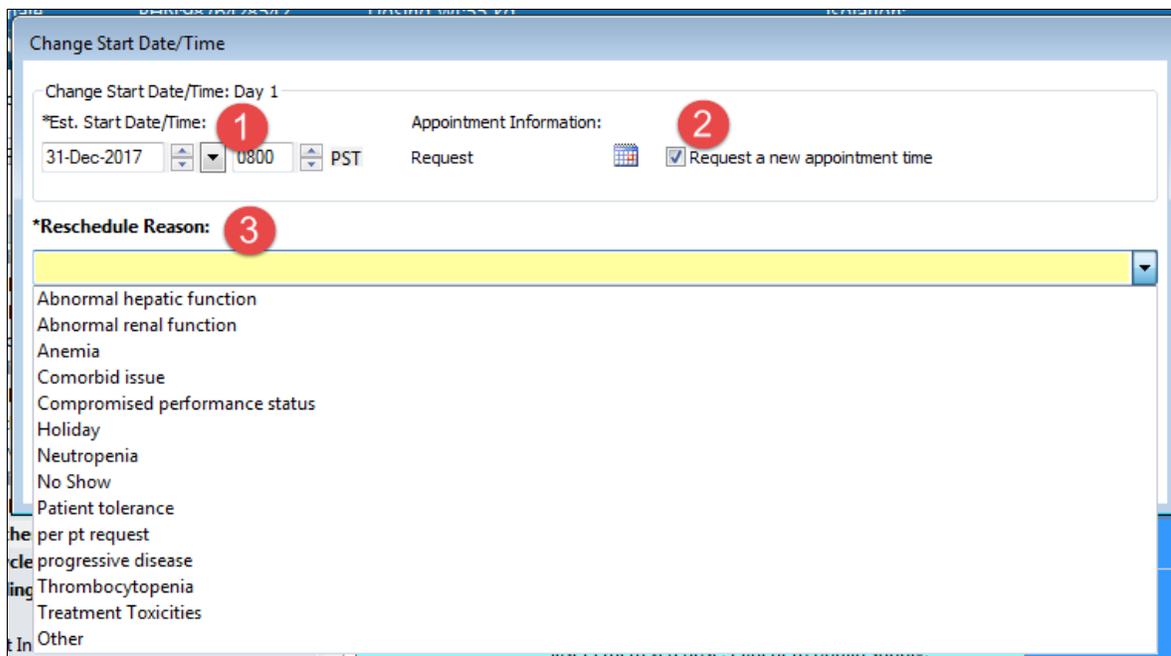
- There are two orders available within each oncology PowerPlan to support the workflow for when treatment parameters are not met; Ok to Proceed with Treatment and Proceed with Treatment Based on Blood Work From.

## Activity 4.3– Rescheduling from a PowerPlan

- Let’s say that in discussions with the Provider, the decision has been made to delay this cycle of treatment by 3 days. Click the down arrow beside Activate Actions and choose Change Start Date / Time.

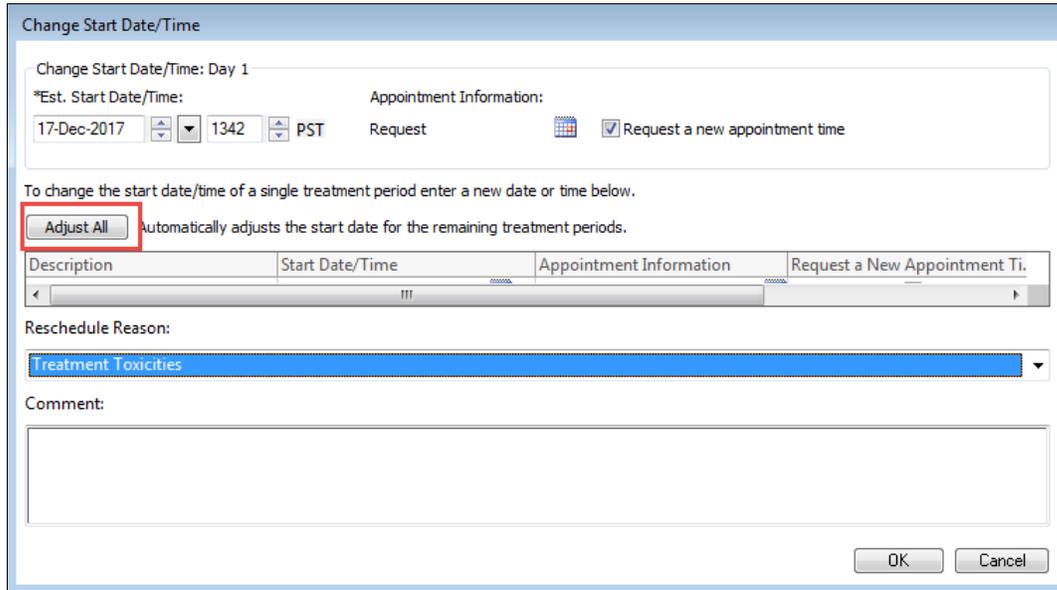


- Complete the Estimated Start Date / Time fields (1), select Request a new appointment time (2), provide a Reschedule Reason (3) and click **OK**.



**Note:** You must select Request a new Appointment time in order to notify the scheduler of the request.

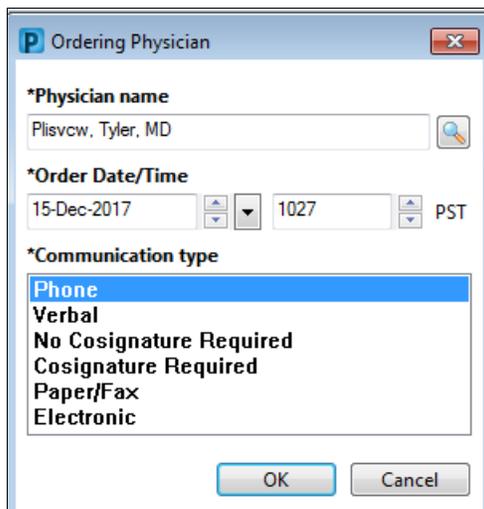
If this were a multi-day treatment Powerplan, all of the days would be rescheduled by clicking on the **Adjust All** button.



The dialog box is titled "Change Start Date/Time". It contains the following elements:

- Section: "Change Start Date/Time: Day 1"
- \*Est. Start Date/Time: 17-Dec-2017, 1342 PST
- Appointment Information: Request,  Request a new appointment time
- Text: "To change the start date/time of a single treatment period enter a new date or time below."
- Button: **Adjust All** (highlighted with a red box), "automatically adjusts the start date for the remaining treatment periods."
- Table with columns: Description, Start Date/Time, Appointment Information, Request a New Appointment Ti.
- Reschedule Reason: Treatment Toxicities (selected in a dropdown)
- Comment: (empty text area)
- Buttons: OK, Cancel

3 You will need to complete the details for the ordering Physician and click **OK**.  
Click **Orders For Signature**, Click **Sign**, and Refresh .

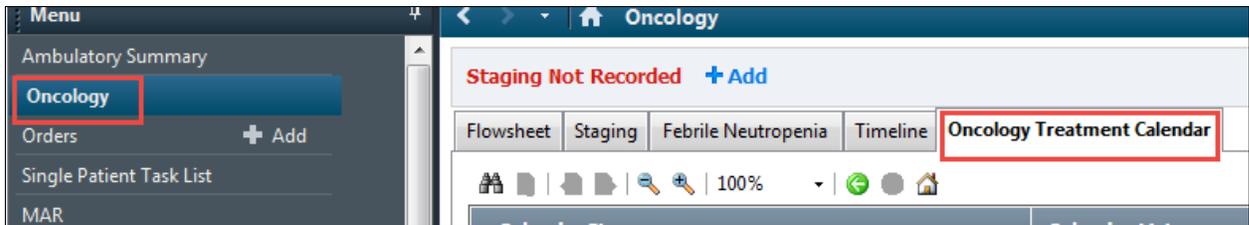


The dialog box is titled "Ordering Physician" and contains the following elements:

- \*Physician name: Plisvcw, Tyler, MD
- \*Order Date/Time: 15-Dec-2017, 1027 PST
- \*Communication type: Phone (selected), Verbal, No Cosignature Required, Cosignature Required, Paper/Fax, Electronic
- Buttons: OK, Cancel

- 4 Now let's say that you have had further discussions with the provider and it has been decided that the cycle of treatment will be delayed by a week and that all of the dates for the future cycles are to be adjusted. In this case you will not make the change request from the Day of Treatment (activate actions dropdown); this is best done from the Treatment Calendar.

Select the Oncology Mpage from the Menu, and click on the Treatment Calendar tab.

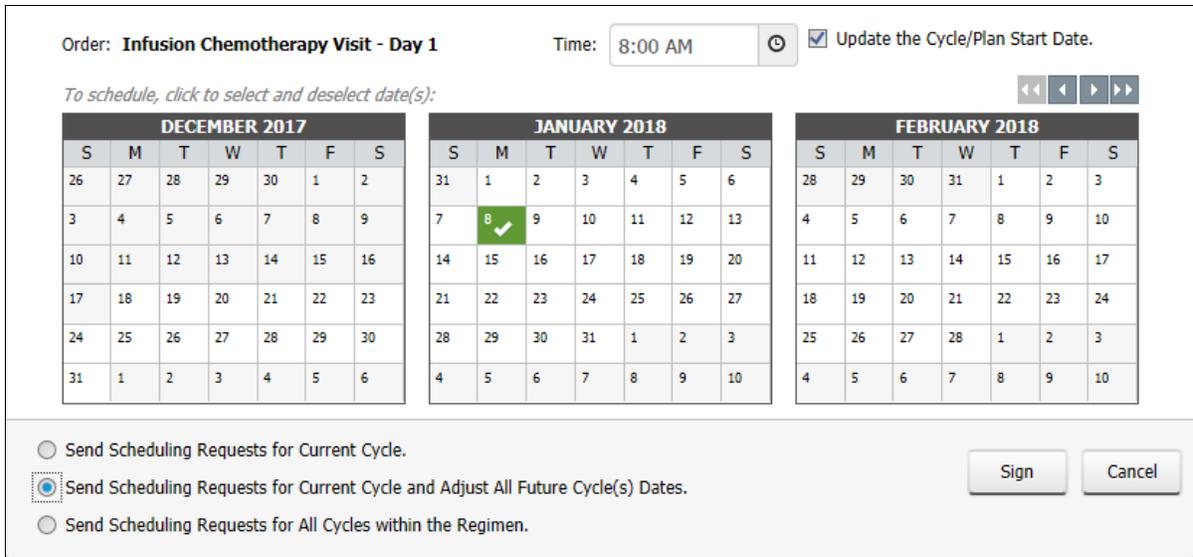


**Note:** Dates in italics indicate that the cycle has not been ordered and non-italicized dates mean the cycle has been ordered and a request has been sent to schedule the patient.

- 5 Click on date within cycle three to open **Add to Patient Treatment Calendar** window.

Calendar Items	
▾ Appointments	
▾ Regimen Appointments	
▾  ONC LU LUAVPP	
▾  Cycle 1 - ONCP LU LUAVPP	
Infusion Chemotherapy Visit - Day 1	<i>*11/22/2017</i>
▾  Cycle 2 - ONCP LU LUAVPP	
Infusion Chemotherapy Visit - Day 1	<i>*11/22/2017</i>
▾  Cycle 3 - ONCP LU LUAVPP	
Infusion Chemotherapy Visit - Day 1	<i>*11/22/2017</i>
▾  Cycle 4 - ONCP LU LUAVPP	
Infusion Chemotherapy Visit - Day 1	<i>*12/07/2017</i>

- 6 The **Add to Patient Treatment Calendar** Window opens. Click on the date that you wish to move the patient’s appointment to and click on the radial dial for **Send Scheduling Requests for Current Cycle and Adjust All Future Cycle(s) Dates**. Click **Sign**.



**Note:** Send Scheduling Requests for Current Cycle is useful if the patient is mid-cycle and you want to adjust their current cycle date, but not modify future cycles within the treatment plan. Send Scheduling Requests for All Cycles within the Regimen is used to schedule for cycles within a Regimen at one time.

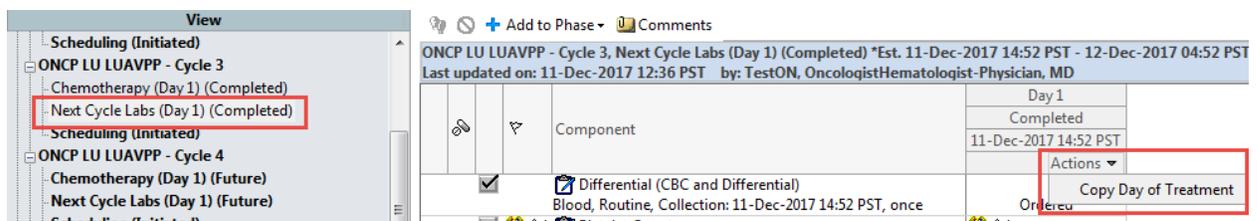
- 7 The **Oncology Treatment Calendar** will now display with all dates adjusted accordingly.

- 8 Now you will need to reschedule the lab phase of the Powerplan.

If the lab phase orders are still in a Future status **Next Cycle Labs (Day 1) (Future)**, changing the date/time closely follows the steps for changing the day of treatment, as in steps 1-3.

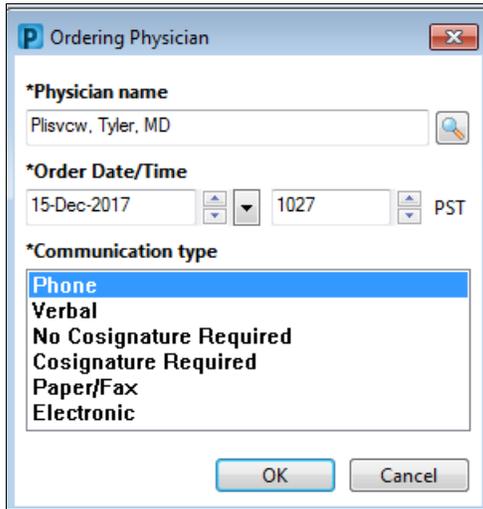
Follow these steps if the corresponding lab phase has already been Activated and Completed.

Select the corresponding Next Cycle lab phase from the Orders View, select actions from the Day of Treatment and click on Copy Day of Treatment.



**Note:** If labs are done at an outside facility the lab phase will not show as completed. You would then need to place an adhoc order (this will be discussed in section 2.4).

9 You will need to complete the details for the ordering Physician and click. OK



**Ordering Physician**

\*Physician name  
Plisvcw, Tyler, MD

\*Order Date/Time  
15-Dec-2017 1027 PST

\*Communication type  
 Phone  
 Verbal  
 No Cosignature Required  
 Cosignature Required  
 Paper/Fax  
 Electronic

OK Cancel

10 Your orders now display as a copy of Day 1.

ONCP LU LUAVPP - Cycle 3, Next Cycle Labs (Day 1) (Initiated Pending) *Est. 11-Dec-2017 14:52 PST - 21 Days			
Last updated on: 11-Dec-2017 12:36 PST by: TestON, OncologistHematologist-Physician, MD			
		Component	Day 1
			Completed
			11-Dec-2017 14:52 PST
			<div style="border: 2px solid red; padding: 2px;">                     Copy of Days 1                      Future Pending                      *Est. 15-Dec-2017 11:00 PST                      Actions ▾                 </div>
<input checked="" type="checkbox"/>		Differential (CBC and Differential) Blood, Routine, Collection: 11-Dec-2017 14:52 PST, once	Ordered
<input type="checkbox"/>		Platelet Count Blood, Routine, Collection: 11-Dec-2017 14:52 PST, once	Canceled
<input checked="" type="checkbox"/>		Creatinine Level Blood, Routine, Collection: 11-Dec-2017 14:52 PST, once	Ordered
<input checked="" type="checkbox"/>		Bilirubin Total Blood, Routine, Collection: 11-Dec-2017 14:52 PST, once	Ordered
<input checked="" type="checkbox"/>		Aspartate Aminotransferase Blood, Routine, Collection: 11-Dec-2017 14:52 PST, once	Ordered
<input checked="" type="checkbox"/>		Lactate Dehydrogenase Blood, Routine, Collection: 11-Dec-2017 14:52 PST, once	Ordered

11 Click on Actions from the Copy of Day 1 and choose Change Start Date / Time.

ONCP LU LUAVPP - Cycle 3, Next Cycle Labs (Day 1) (Initiated Pending) \*Est. 11-Dec-2017 14:52 PST - 21 Days  
 Last updated on: 11-Dec-2017 12:36 PST by: TestON, OncologistHematologist-Physician, MD

Component	Day 1	Copy of Days 1	Actions
Differential (CBC and Differential) Blood, Routine, Collection: 11-Dec-2017 14:52 PST, once	Ordered	Completed	+ Add Order...
Platelet Count Blood, Routine, Collection: 11-Dec-2017 14:52 PST, once	Canceled	Future Pending	+ Add Outcome / Intervention...
Creatinine Level Blood, Routine, Collection: 11-Dec-2017 14:52 PST, once	Ordered	11-Dec-2017 14:52 PST	Change Start Date / Time
Bilirubin Total Blood, Routine, Collection: 11-Dec-2017 14:52 PST, once	Ordered	*Est. 15-Dec-2017 11:...	Order
Aspartate Aminotransferase Blood, Routine, Collection: 11-Dec-2017 14:52 PST, once	Ordered		Order
Lactate Dehydrogenase Blood, Routine, Collection: 11-Dec-2017 14:52 PST, once	Ordered		Order

Details

Orders For Cosignature | Orders For Nurse Review | Save as My Favorite | Initiate | Orders For Signature

12 Complete the details for the new date and time and click OK. Click  , Click  , and Refresh .

Change Start Date/Time

Change Start Date/Time: Copy of Days 1

\*Est. Start Date/Time:

30-Dec-2017 | 0700 | PST

OK | Cancel

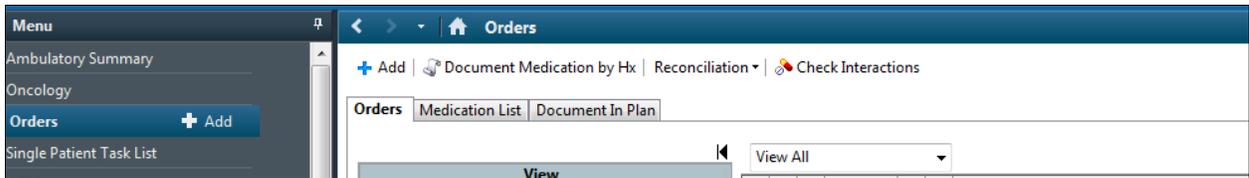
### Key Learning Points

- Change the Start date and time of a single cycle of treatment (including all of the treatment days) from the Day of Treatment within the Orders profile.
- Change the Start date and time of the lab phase within a Powerplan from within the Day of Treatment within the Orders profile.
- Change the Start date and time of multiple cycles of treatment from the Oncology Treatment Calendar.

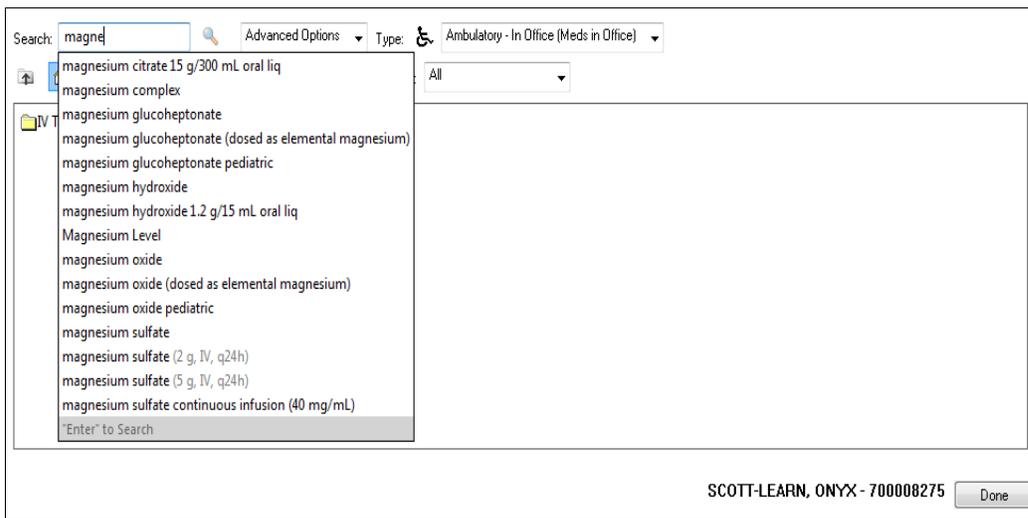
## Activity 4.4 - Place Adhoc Lab Orders

- 1 During the chemotherapy infusion the patient reports intermittent muscle cramping to lower extremities since her last chemotherapy infusion. You discuss with the physician and receive a verbal order for magnesium and serum ionized calcium level blood collection. You will enter the order for the lab to come to the unit to collect blood specimens.

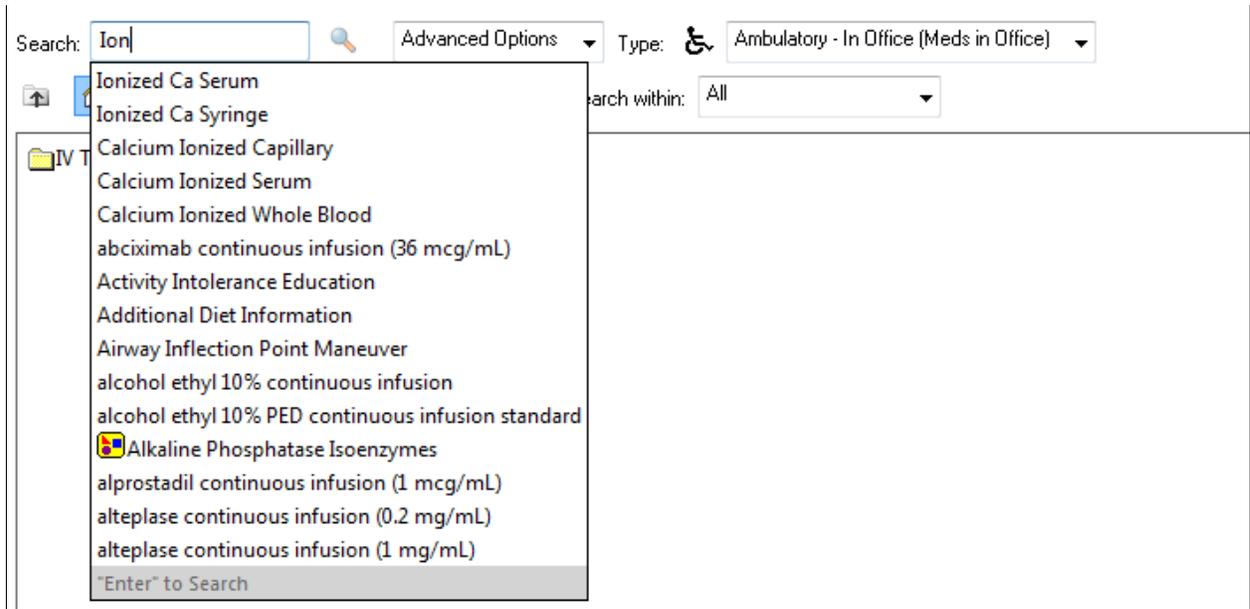
Navigate to the **Orders** screen and click on **Add**.



- 2 In **Add Order** search box begin typing Magnesium and select Magnesium Level from the drop down list. Enter the details of the Ordering Physician.

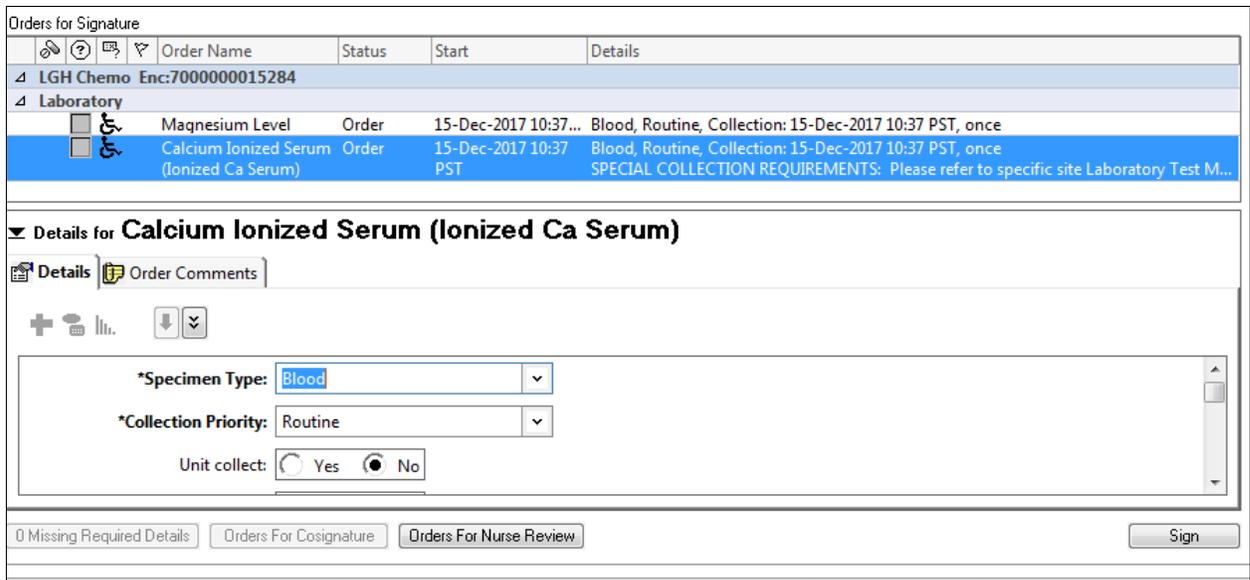


- In **Add Order Search** box begin typing Ionized Calcium and select Ionized Ca Serum. You will not need to enter Provider details. After selecting the calcium level click **Done**.



**Note:** The more detailed order sentence you select when placing the order, the less details you will need to fill out prior to signing.

- The **Orders for Signature** displays **Details** for each lab order placed which need to be reviewed prior to signing. Any changes specific to the order would be modified in the Details window.



- 5 The order defaults **Unit Collect 'No'** and **Collected 'No'** indicate once the order is placed the lab will come to the unit to collect the specimen. If the nurse in clinic is collecting the lab specimen, both Unit Collect and Collected must be changed to 'Yes'.

Unit collect:	<input type="radio"/> Yes	<input checked="" type="radio"/> No
Collected:	<input type="radio"/> Yes	<input checked="" type="radio"/> No

- 6 Select Specimen Type 'Blood' and scroll through Calcium Ionized Serum order details. Confirm all details are correct. Click on Magnesium Level order from Orders for Signature and repeat steps. After reviewing details click **Sign** and **Refresh** screen.

Upon refreshing the screen the Status of the order will display **Ordered**. The symbol  to the left of the order indicates the order is yet to be cosigned by the ordering Provider.

	Calcium Ionized Serum (Ionized Ca Serum)	Ordered	Blood, Routine, Collection: 15-Dec-2017 11:18 PST, once SPECIAL COLLECTION REQUIREMENTS: Please refer to specific site Laboratory Test Manual.
	Magnesium Level	Ordered	Blood, Routine, Collection: 15-Dec-2017 11:18 PST, once

### Key Learning Points

- When placing lab orders, it is essential that you review the order details for Unit Collect (Yes/No) and Collected (Yes/No) to ensure that specimens are collected and resulted in a timely manner.

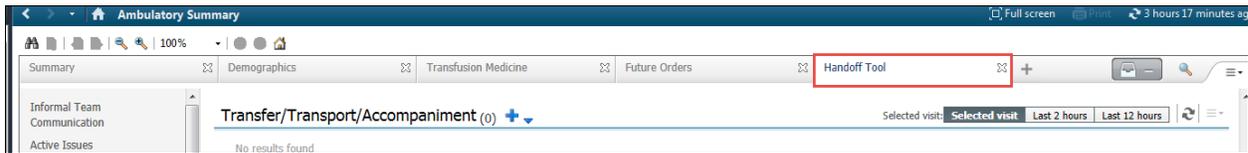
## Activity 4.5 – Patients in Transition

In the Oncology setting there are two scenarios where this may occur. Scenario A: a patient in the Outpatient Chemotherapy Unit may fall ill and need to be admitted to an Inpatient unit, or scenario B: an Inpatient may need to be transferred to the Outpatient Chemotherapy Unit for treatment.

Scenario A:

- 1 The **Handoff Tool** is a summary of information found within the patient’s chart. It is important to understand that the information that pulls into the Handoff Tool Mpage is set at the encounter level, which means that an Inpatient nurse and the Outpatient nurse may view different pieces of documentation on this Mpage. The purpose of this tool is to guide verbal handoff between units and we should be using the encounter that we are handing off from.

Within the patient’s chart and from the Ambulatory Summary, click on the Handoff Tool. Scroll through the page clicking on the headers to add additional details.



- 2 Click the blue down arrow next to the **Transport/Transfer/Accompaniment** section to open the selection of available PowerForms. Click on the **Transport Ticket**. Fill in all the appropriate information. The Transport Ticket is viewable across encounters. A completed Transport Ticket can be accessed from the Documentation tab in the Menu.



**Transport Ticket - CSTONCTHREE, THREE**

\*Performed on: 29-Nov-2017 12:13 PST By: TestCST, Nurse3 MM

**Status Orders and Allergies**

No qualifying data available.

**Allergies**  
No Known Allergies

**Active Process Alerts**

Communication barrier  Gender sensitivity  Palliative care  
 Cytotoxic  No ceiling lift  Seizure precaution  
 Difficult intubation/airway  On research study  Visitor restrictions  
 Fall risk  Special care plan  Violence risk

**Transfer From and To/Mode/Equipment**

**Transfer To** **Transfer From** **Mode of Transport**

Stretcher  Ambulatory  
 Wheelchair  Gaited  
 Bed  Other

**Equipment Accompanying Patient**

Airway management equipment  Defibrillator  Non-invasive blood pressure monitor  Resuscitation drugs  
 Cardiac monitor  Fetal heart monitor  Oxygen  Suction  
 Cardio/respiratory monitor  IV pump  Pulse oximetry  Other

**Sensory Deficits/ Activity Restrictions/ Additional Information**

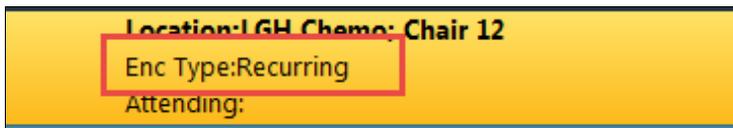
**Sensory Deficits**

Blind, left eye  Nonverbal  Quadriplegic  Other  
 Blind, right eye  Paralysis, left  Sensation/Touch deficit  
 Hearing deficit, left ear  Paralysis, right  Speech deficit  
 Hearing deficit, right ear  Paraplegic  Uncorrected visual impairment

3 Click the  to sign the form.

Scenario B:

4 When you are treating a patient on the Ambulatory Chemotherapy unit you will be working in their **Recurring Encounter** chart. This means that the MAR will only display the medications to be given on this encounter. For example, anything on their ordered protocol. If you need to administer a medication that has been ordered on their inpatient encounter, for example Dilaudid, you will need to access their inpatient MAR. To do this you will click on the **Enc Type** in the **Banner Bar**.



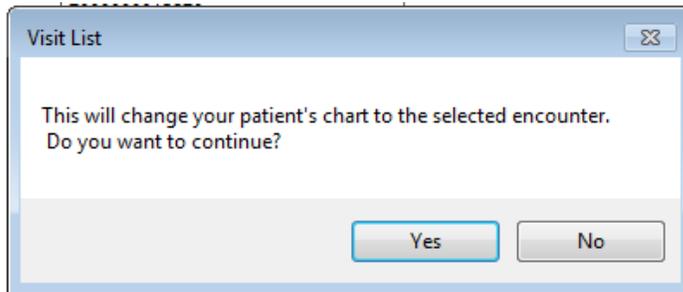
5 This will open the **Custom Information** window

**Custom Information: CSTTHREEFOUR, SITTWODAN**

Encounter Type	Location	Admit Date	Discharge Date	Encounter #	Medical Service	Reason for
Recurring	LGH Chemo Chair 12	27-Oct-2017 11:56 PDT		7000000012600	Medical Oncology	Cancer Tre
<b>Inpatient</b>	LGH 4E 420 01	25-Oct-2017 11:44 PDT		7000000012670	General Internal Medicine	Pain Manag
Outpatient	LGH Chemo Chair 01	23-Oct-2017 09:05 PDT	24-Oct-2017 10:47 PDT	7000000012492	Medical Oncology	Head and N

GENERAL INFORMATION

- 6 Click **Yes** on the **Visit List** Window to acknowledge that you are opening the **Inpatient Encounter** chart.



- 7 Access the **Inpatient Encounter** MAR and review any previous administrations of the dilaudid. Click on **Medication Administration** in the banner bar and proceed with Closed Loop Medication Administration.

**Note:** You will have to scan the patient's inpatient armband to access the medications within the MAR of the inpatient encounter chart.

Remember to return to the Recurring Encounter on the patient to continue caring for your patient in the outpatient clinic. If you forget to do this and then proceed to Activating the chemotherapy orders on the Inpatient Encounter, you will have to contact the provider to cancel and reorder the cycle of chemotherapy.

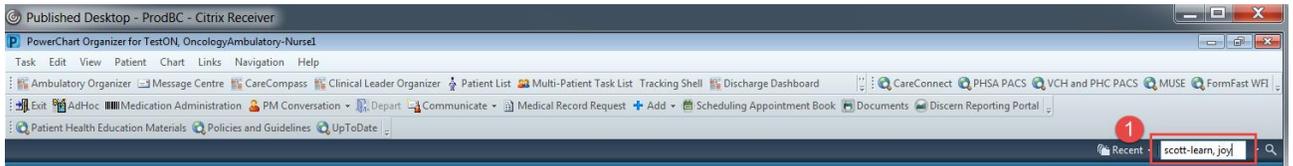
### Key Learning Points

- The Handoff Tool Mpage is used to guide verbal communication between nurses when patients are in transition.
- The Transport Ticket can be viewed across encounters from the documentation tab in the menu.
- The MAR is encounter specific; medications ordered on the Inpatient encounter will only appear on the Inpatient MAR
- Activating the Chemotherapy Powerplan places the medications on the MAR; ensure that you are in the recurring encounter before you activate the orders.

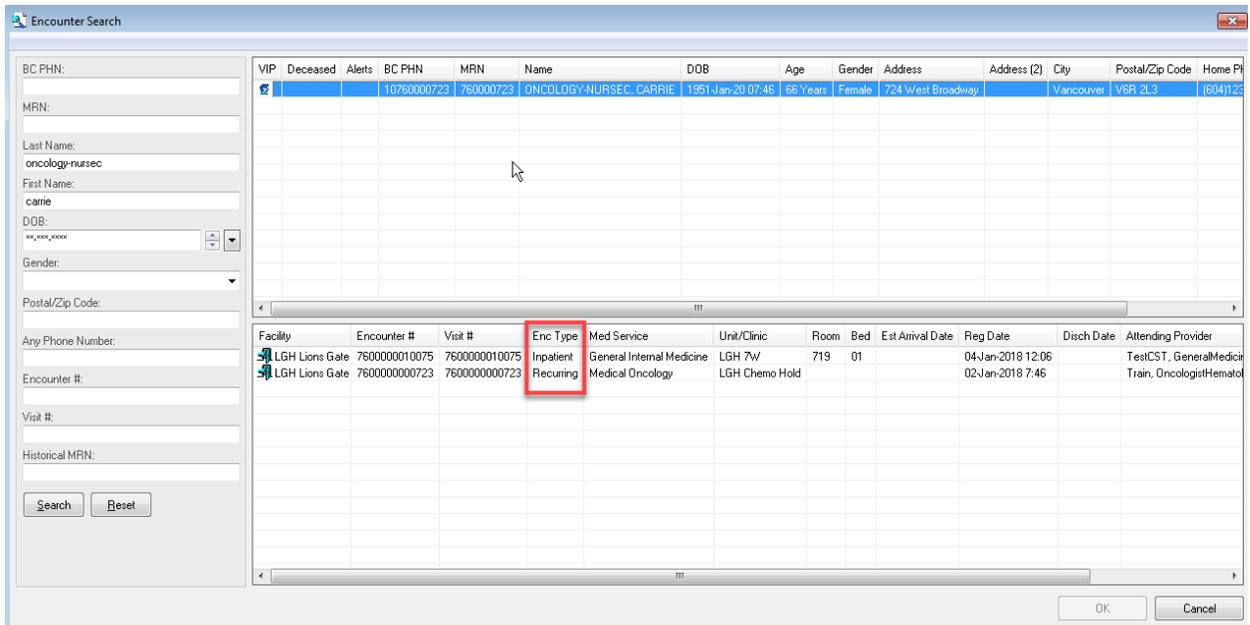
## Activity 4.6 – Oncology Telephone Triage

As an Ambulatory Oncology Nurse you may have to document the details of a phone call with a patient and you may need to communicate with the Provider.

- 1 Open the patient's chart using the search function.

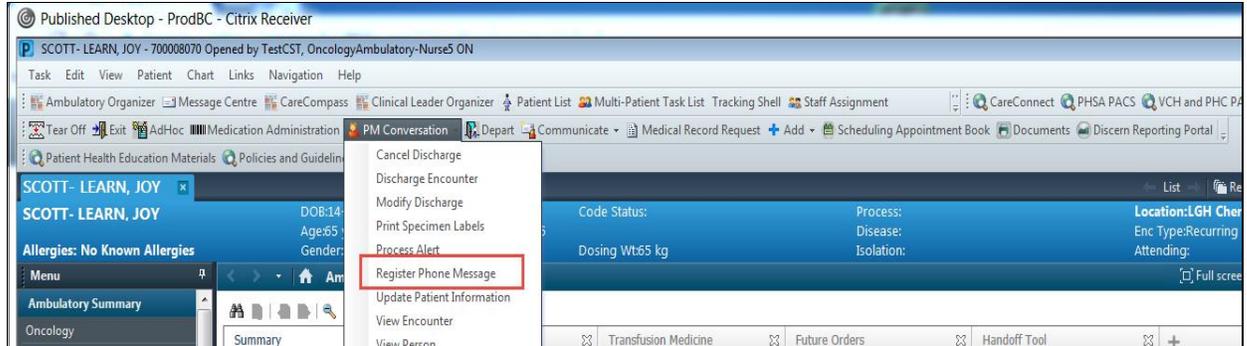


- 2 Select both the patient and the appropriate encounter. Click **OK**.

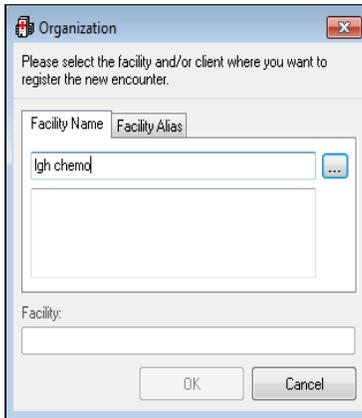


3 You may need to **Add an Encounter** if the call is not related to an existing encounter.

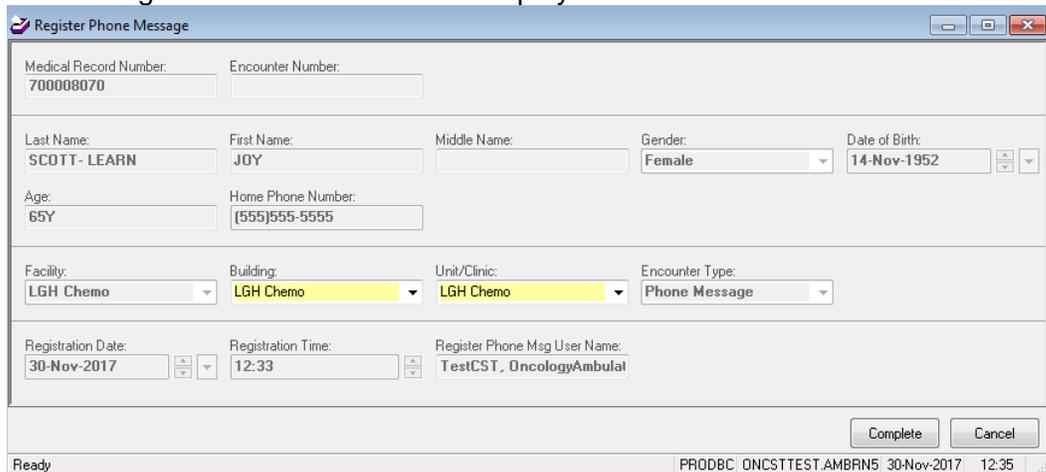
1. Once you have opened the patient’s chart select the down arrow from **PM Conversation** in the Organizer toolbar and choose **Register a Phone Message**.



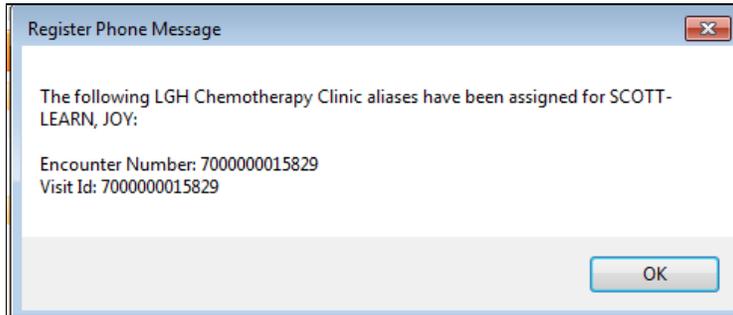
2. Enter the **Facility Name**



4 The **Register Phone Message** window will open. Confirm the details and click **Complete**. The Phone Message Encounter Number will display.



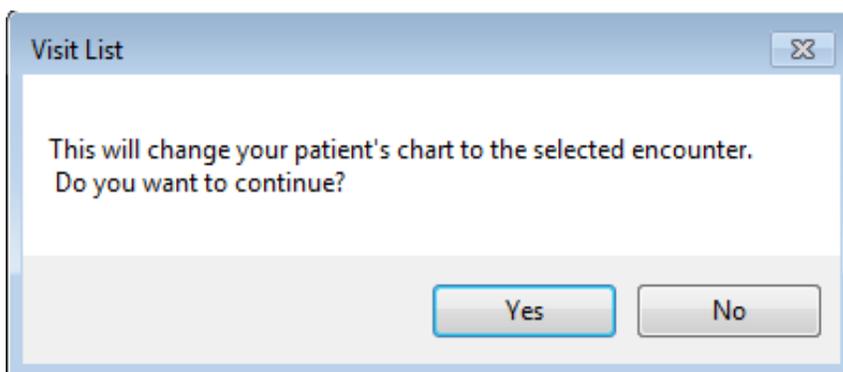
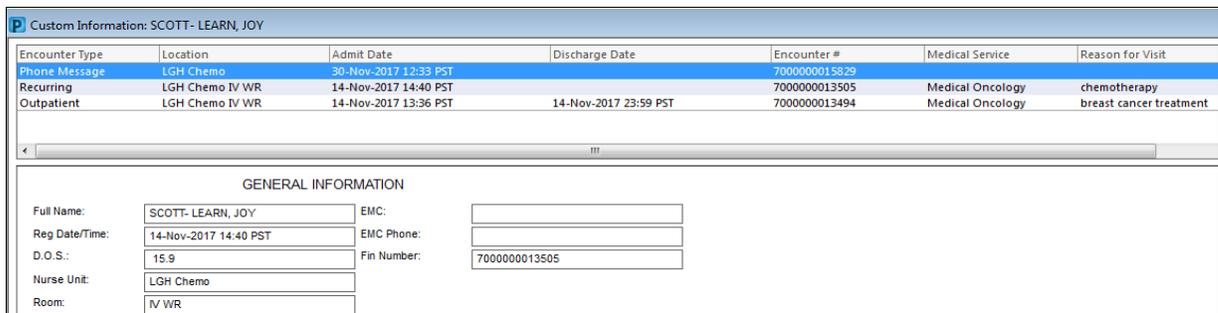
Click **OK**



- 5 You will remain in the patient’s chart on the **encounter** that you previously selected until you change the **Encounter Type**. To do this, click on **Encounter Type** in the banner bar.



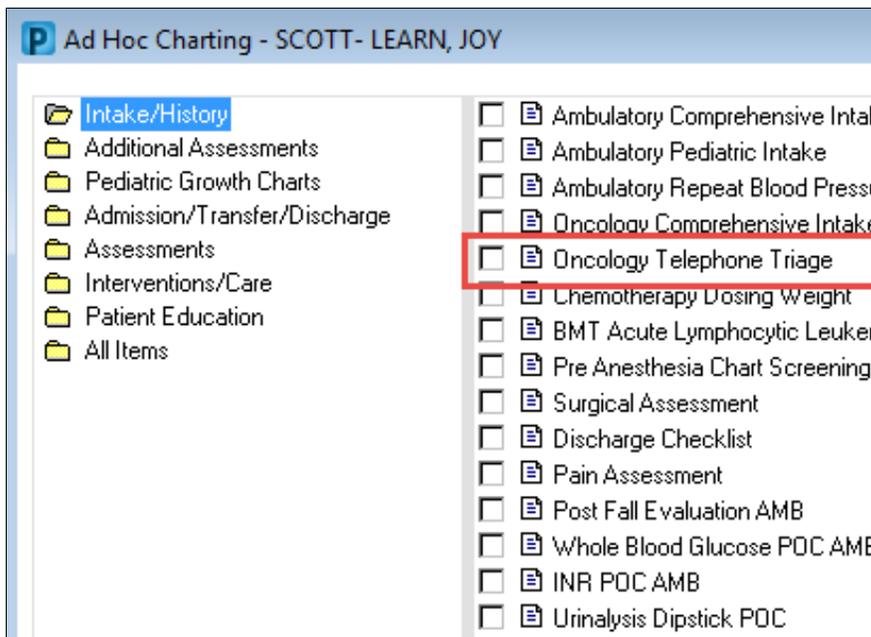
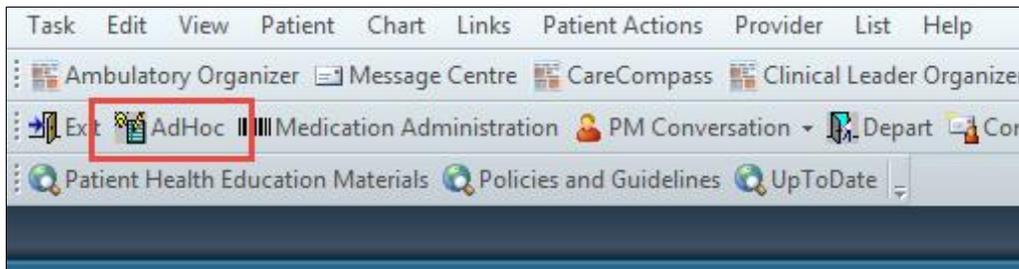
- 6 The **Custom Information** window will open. Select the **Phone Message** encounter and click **OK**, and click **Yes** on the **Visit List** window.



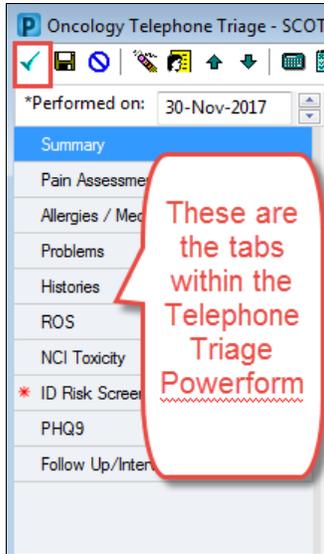
7 You will now be in the patient’s chart in the Phone Message encounter.



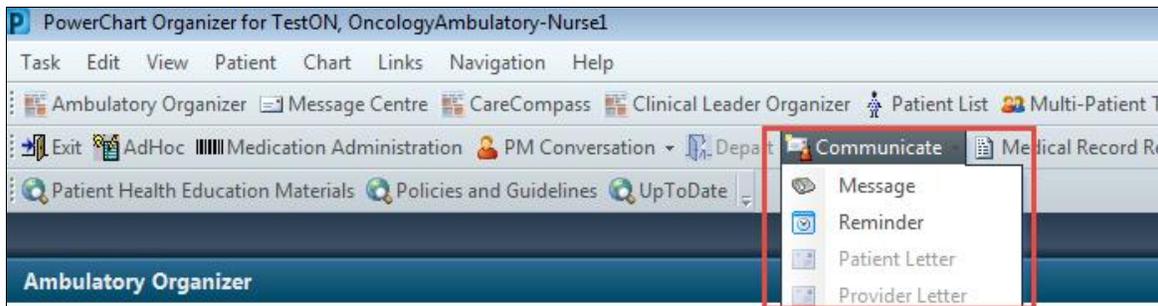
8 To document your assessment of the patient, access the **Oncology Telephone Triage** Powerform by selecting the AdHoc  button from the organizer toolbar. Check the box beside **Oncology Telephone Triage** and click **Chart**.



- 9 Select from the tabs within the Powerform to document your assessment and then click on the green checkmark ✓ to sign and save your documentation.

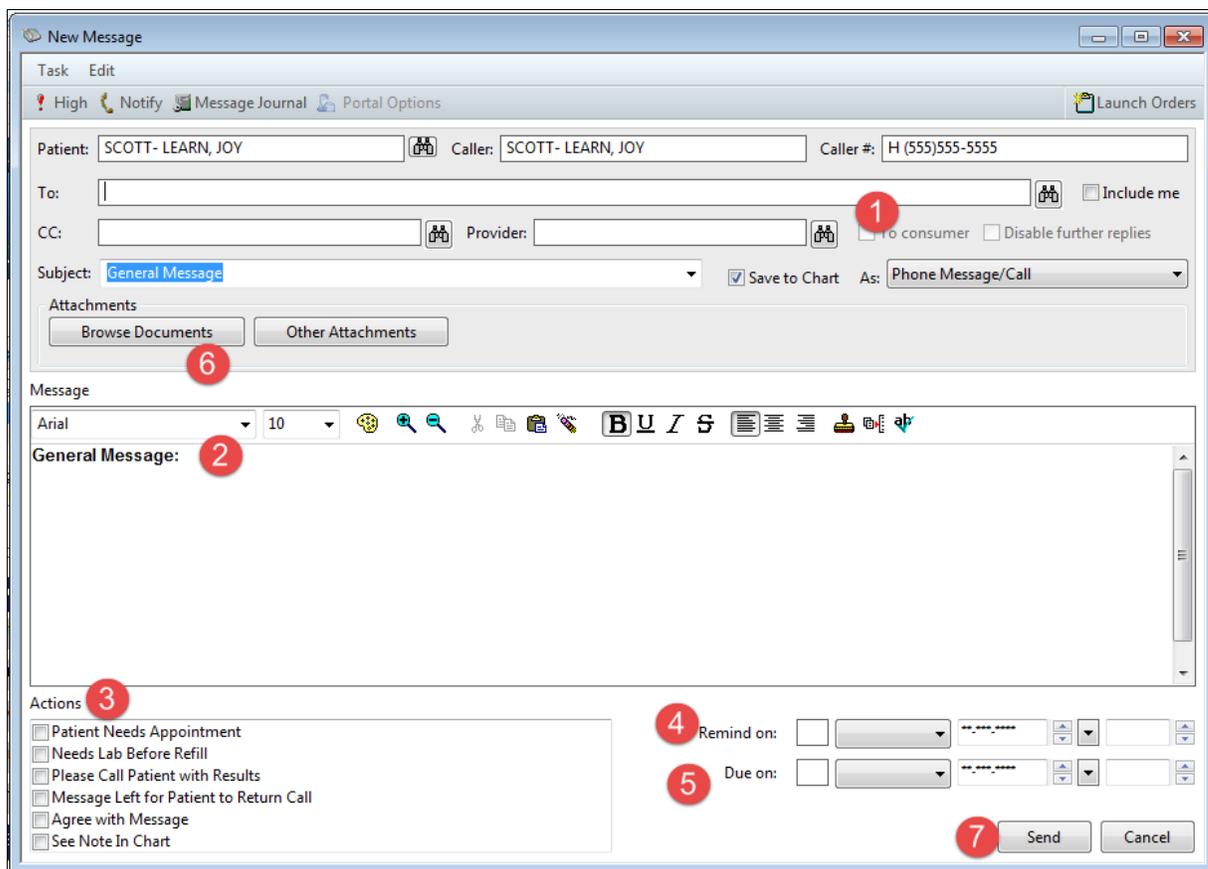


- 10 To share the details of the phone encounter with the appropriate provider, select the down arrow beside **Communicate** from the organizer toolbar in PowerChart, and then select **Message** from the drop-down list of options.



**Note:** This function is also available through Message Centre, a Quick Reference Guide will be available to describe Message Centre and its functionality.

- 11 The **New Message** window will open and will be pre-populated with your patient’s name and phone number.
1. Search for the name of the health care provider that you wish to send this message to.
  2. Use this space to write the body of the message.
  3. Selecting an item in the **Actions** list will pull the item into the body of the message when completed and sent.
  4. Enter date and time details into the boxes beside **Remind Me** in order to receive a reminder in your **Message Center** if you need to perform some follow up actions. The message will not appear in Message Center until this time.
  5. Enter date and time details into the boxes beside **Due on** in order to set a desired date/time to complete. Overdue messages within the message center will display in red font.
  6. If you have completed a more fulsome assessment that you have documented on the Oncology Telephone Triage Powerform, you can browse documents and attach the document to this message.
  7. Click **Send** when you are done.



### Key Learning Points

- Use the Telephone Triage PowerForm to document your assessment of a patient during a telephone call.
- Register a Phone Message Encounter Type if the issue is unrelated to an existing encounter

## End Book One

You are ready for your Key Learning Review. Please contact your instructor for your Key Learning Review.