SELF-GUIDED PRACTICE WORKBOOK [N27]
CST Transformational Learning

WORKBOOK TITLE:

Provider: Oncology (Workbook #1)

Last update: February 13, 2018 (v2)

CLINICAL + SYSTEMS TRANSFORMATION
Our path to smarter, seamless care

TRANSFORMATIONAL LEARNING

TABLE OF CONTENTS

SELF-GUIDED PRACTICE WORKBOOK

Duration	**3 hours**
Before getting started	■ Sign the attendance roster (this will ensure you get paid to attend the session) ■ Put your cell phones on silent mode
Session Expectations	■ This is a self-paced learning session ■ A 15 min break time will be provided. You can take this break at any time during the session ■ The workbook provides a compilation of different scenarios that are applicable to your work setting ■ Work through different learning activities at your own pace
Key Learning Review	■ At the end of the session, you will be required to complete a Key Learning Review ■ This will involve completion of some specific activities that you have had an opportunity to practice through the scenarios.

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 the System

Learning Objectives

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

- Navigate **Ambulatory Organizer**
- Access a patient's chart
- Navigate through the **Provider View**
- Use the **Oncology Tab** effectively

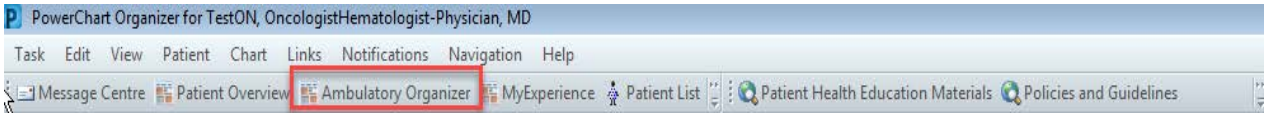
SCENARIO

When you arrive to work and login to the system you land on Message Centre (you will remember this functionality from the e-learning module), you go through your messages and then look at the Ambulatory Organizer to see what you have booked for the day.

The Ambulatory Organizer view provides a simple but comprehensive display of scheduled appointments for ambulatory providers. It provides a snapshot of the current day's appointments, including appointment times and details, patient information and status, outstanding items to be completed at each visit, reminders and appointment gaps. Ambulatory Organizer provides ambulatory physicians and other healthcare professionals with a framework to organize workflows at the day, week, or month level; to manage items that need to be completed with each visit; and to view previous visit items that were not completed.

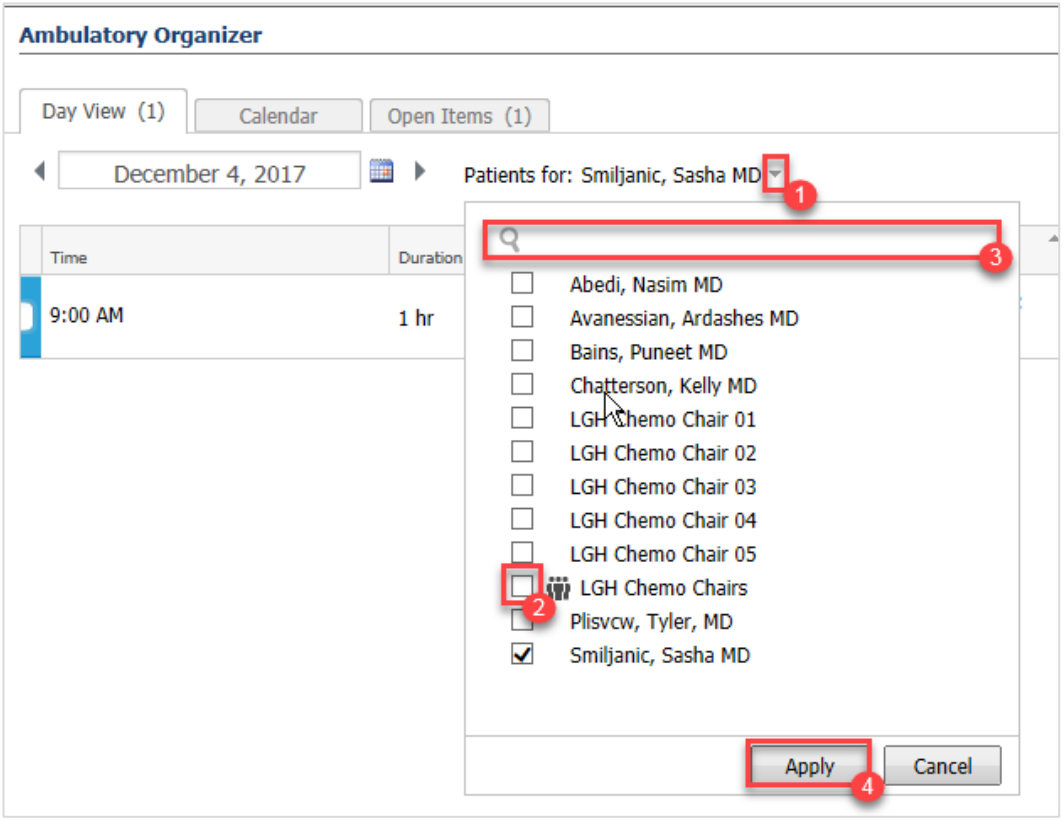
Activity 1.1-Working with Appointments in Ambulatory Organizer

1 To access the Ambulatory Organizer from Message Centre click on **Ambulatory Organizer** from the toolbar available at the top of the screen.



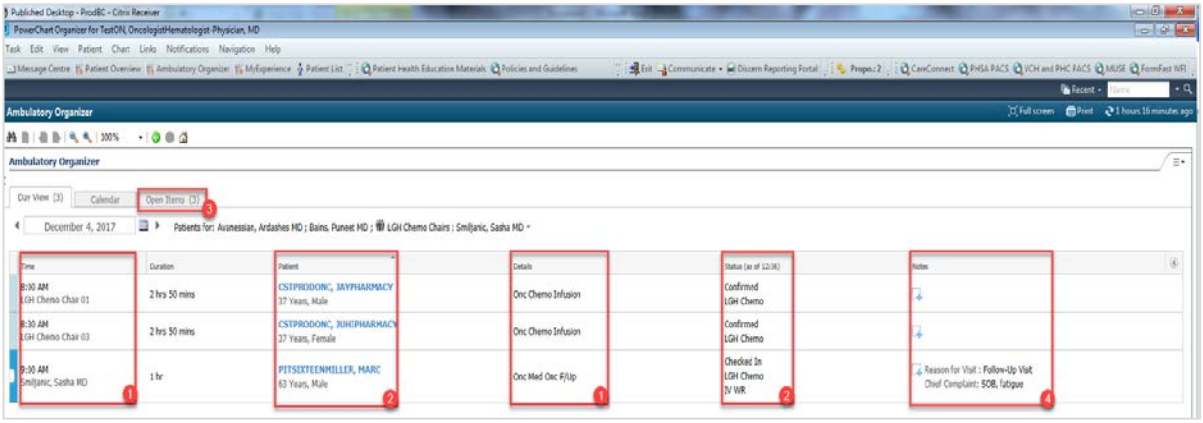
2 The **Ambulatory Organizer** defaults to your personal resource. You can see this from looking at **Patients for**:_____(your name should appear after the colon). To look at another resource:

1. Select the down arrow beside your name
2. Check the resource you are wanting to see if it appears
3. Alternatively search for the resource by name
4. Click Apply in order to see the corresponding resources information



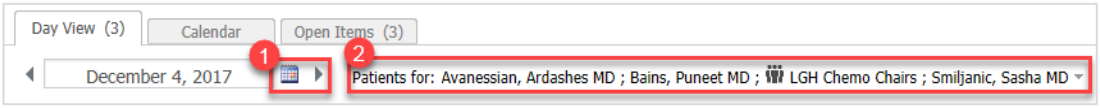
3 The **Ambulatory Organizer** provides a display of scheduled appointments for ambulatory providers, including:

1. Appointment times and details
2. Patient information and status
3. Outstanding items to be completed for each visit
4. Patient care related reminders



4 **Day View** is the first tab and it displays your appointments for the day:

1. Select a different date by using the calendar icon, then return to today's date.
2. Indicates your name and what facilities are included in your appointment list for the date.



5 You can also sort the appointment list by selecting one of the following column headings:

- Time
- Patient or
- Status

Note: Sorting with a single criterion removes facility headings and sorting chronologically by appointment time restores facility headings.

The colour status on the left side of the **Day View** and on the **Calendar View** assists you to understand the flow of the clinic.

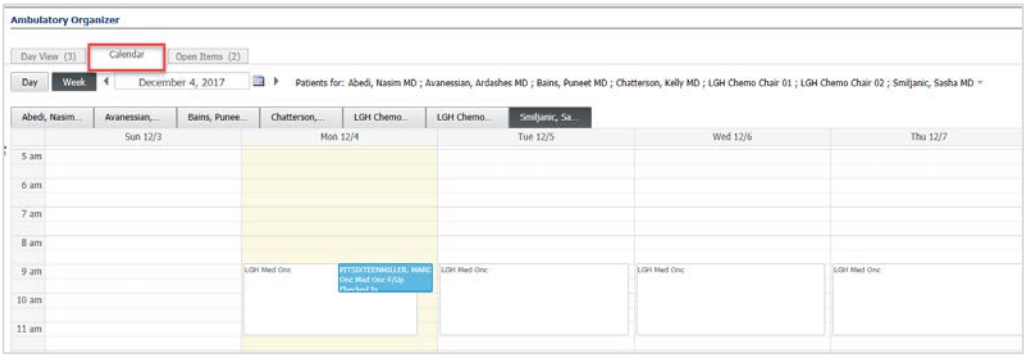
- Light blue – a confirmed appointment
- Medium blue – checked appointment
- Green – patient seen by nurse, medical student or other custom status
- Orange – seen by a provider or a resident
- Dark gray – appointment has been checked out

6 You can add a temporary comment to an appointment to share information between health care professionals.

1. Click the icon to open the Comments box.
2. Type the comment.
3. Click Save.

7 The next tab is the **Calendar View**.

- Click the **Calendar** tab to display your schedule for a day or a week interval.
- Rescheduled, cancelled, hold, or no-show appointments are not displayed in the **Calendar View**.



8 The **Open Items View** will display a list of appointments with any uncompleted actions for the patient, for example a missing consult note.

1. Click on the **Open Items** tab, in brackets you can see how many items are outstanding.

2. If you have more than one resource open, the dark grey shading is the resource which is reflected in the view.

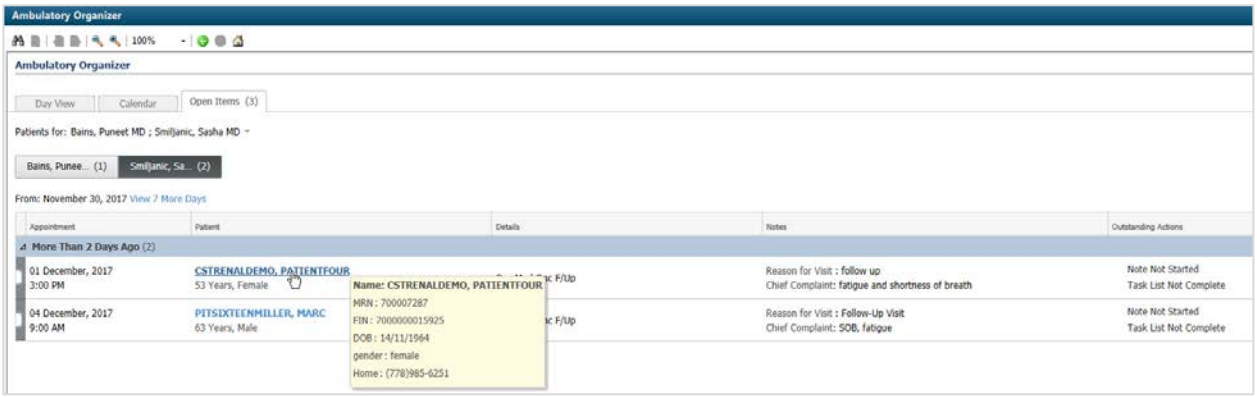
3. List displays next seven days from the date displayed. To display tasks for more than seven days, click **View 7 More Days.** Observe how with each click the date will adjust and display a time frame that is 7 days longer.

4. Under the **Outstanding Actions** columns you are reminded the note for the visit has not been started.

To complete the action, click the reminder.

Note: Creating Notes will be covered later in documentation.

9 Place the cursor over the patient's name to display patient demographic information. This action is called 'Hover to discover'.



Note: 'Hover to discover' is a standard technique across the Clinical Information System (CIS) – it displays more details or useful tips without leaving the current view.

Key Learning Points

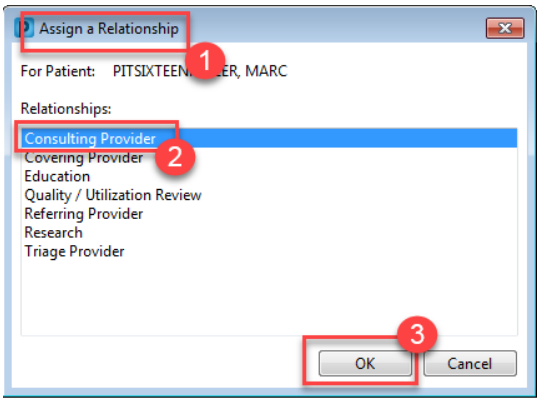
- Ambulatory Organizer allows you to see your scheduled appointments and offers three different displays to help you prioritize your day:
- Day View tab lists your appointments scheduled for a selected date and facility and informs about appointment status and details
- Calendar tab displays your appointments for a selected day or week
- Open Items tab display unfinished tasks for a single provider.

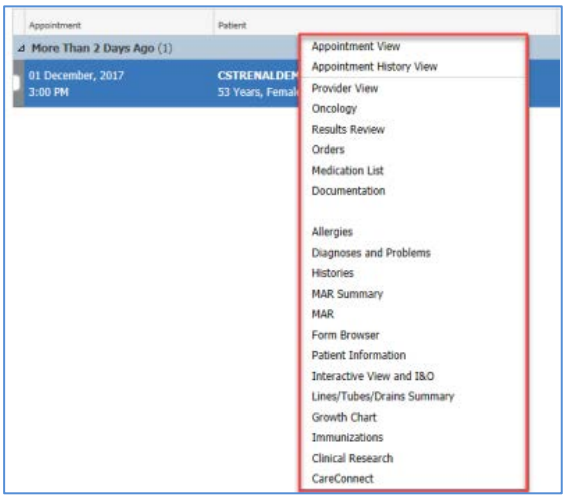
Activity 1.2- Accessing a Patient's Chart

For the Following activities, open the first patient provided to you in the classroom, last name: Oncology-PhyA, [*enter first name provided on card].*

1 You can open a patient chart from any view in **Ambulatory Organizer.**

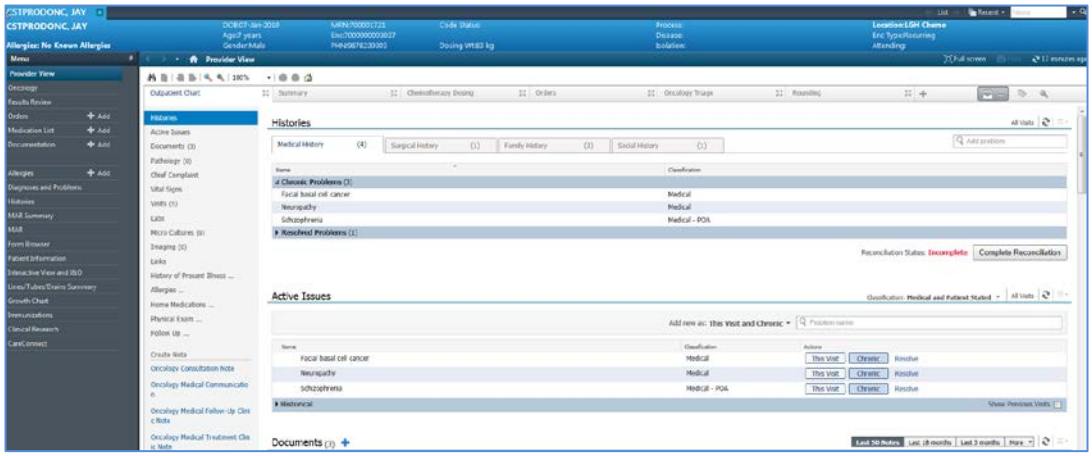
1. Click on the patient's name. When accessing the chart for the first time you must assign a relationship (similar to current day signature record in the patient chart).
2. Select your relationship
3. Click **OK**





Note: You can also Right-Click the patient's name and select the chart section you want to view from the drop-down menu and then assign a relationship.

2 The patient's chart displays. If the patient already has encounters in the CIS, you will have access to patient information such as allergies, histories, past visits and documents. However, some important and relevant information might still be on paper. Be sure to review the paper chart as well.



3 At the top of every screen of the patient's record, there is a **Banner Bar** allowing for proper patient identification. It displays demographic data, alerts, information about patient's location, and current encounter. (Encounters were covered in your E-Learning Module).

? Take a look at your current screen,
Is your patient:
☐ Male
☐ Female
What is the encounter type: _____

Note the **Refresh** icon and the timer showing how long ago the information on your screen has been updated.

? How long ago the information display was refreshed? _____

Click Refresh frequently to ensure that your entries are saved and the information is up-to-date.

Key Learning Points

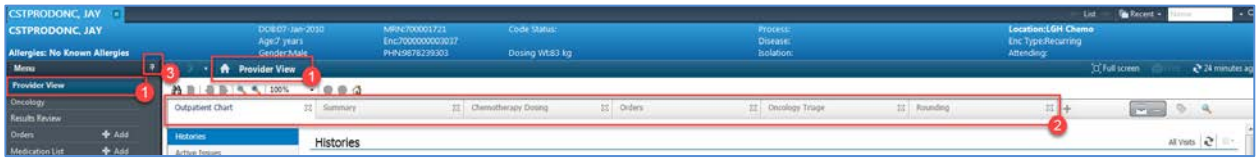
- You can access your patients chart from any view in Ambulatory Organizer.
- You must assign a relationship with the patient prior to viewing any chart content.
- Review the Banner Bar information to ensure you have selected the right patient and the right encounter.
- Remember to refresh your screen frequently.

Activity 1.3 – Provider View

1 The patient's chart opens in your current default view – the **Provider View**.

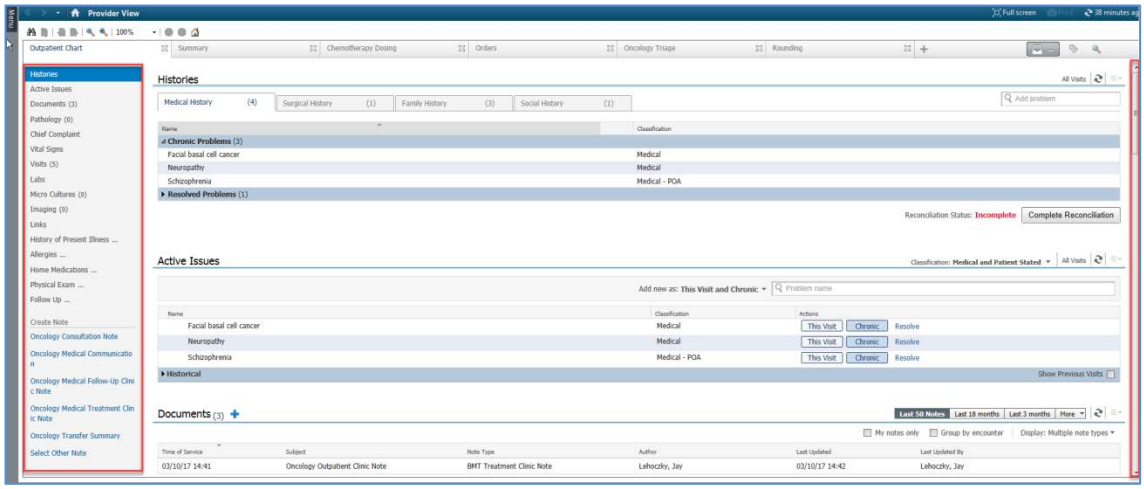
Provider View is organized with tabs – each designed to support the specific workflow. Tabs provide quick and convenient access to the sections of the patients' record relevant to this workflow.

1. **Provider View**-default view for Ambulatory Oncology Providers
2. **Workflow sections**:
    a) Outpatient Chart MPage
    b) Summary MPage
    c) Chemotherapy Dosing MPage
    d) Orders MPage
    e) Oncology Triage MPage
    f) Rounding MPage
3. Click the Pushpin icon to minimize the **Menu** and increase screen display size for relevant information.

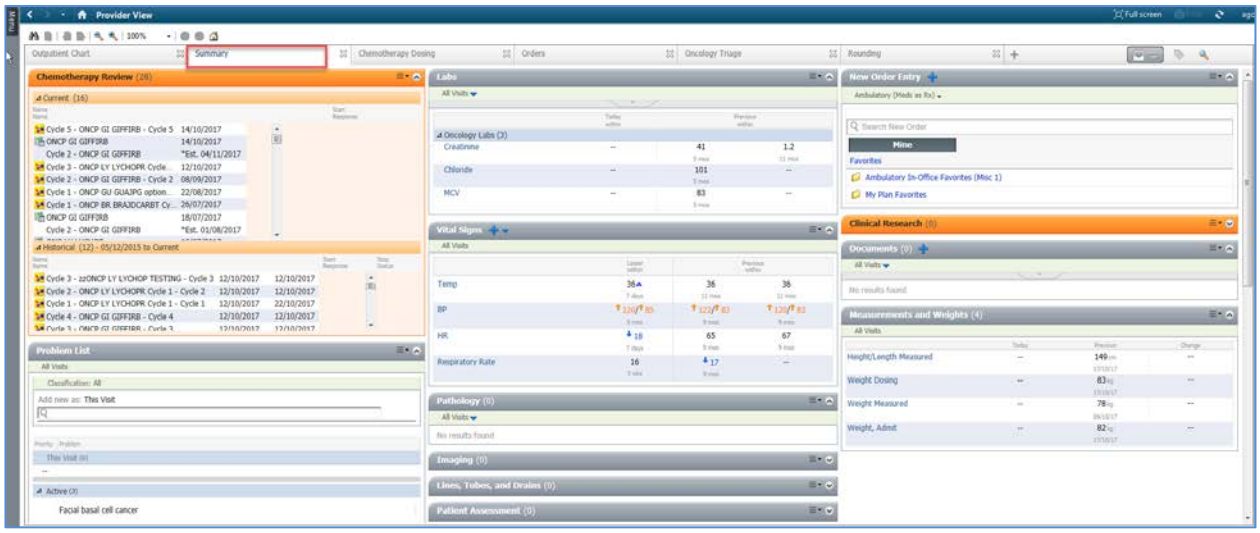


2 The **Outpatient Chart Mpage** tab displays patient's electronic information organized in sections called components, you will see components list on the left. The components list allows for reviewing the patient's chart in the most efficient way.

- Click the component from the left side list to display a corresponding chart section, or use the scroll bar.

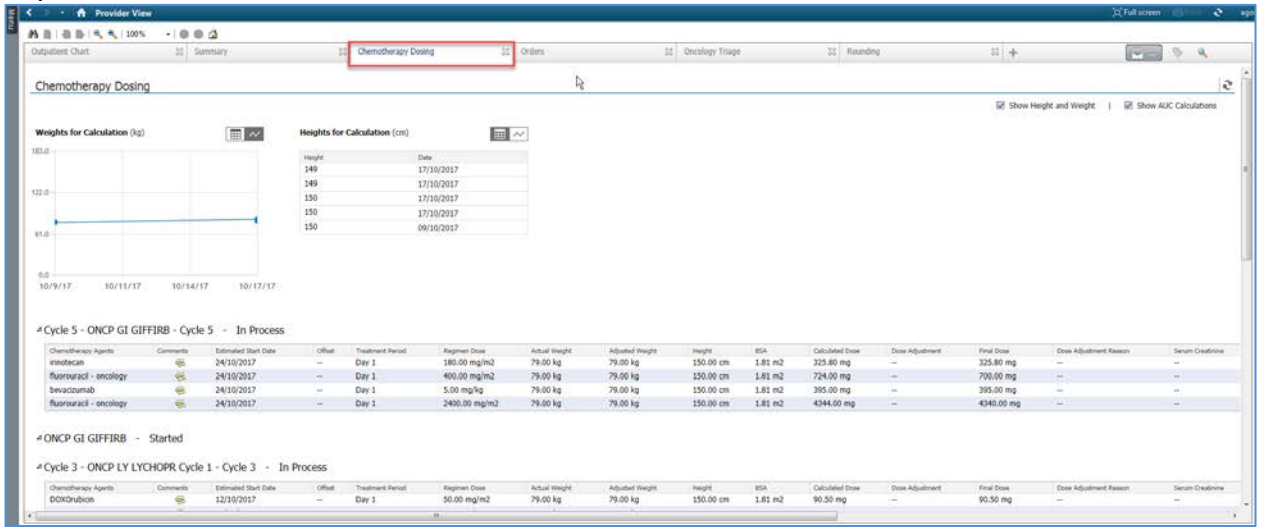


3 The **Oncology Summary MPage** contains components and information relevant to an Oncologist, removing the need to sift through information. You can position your mouse over applicable results for additional information. To modify or add to any data viewed within the summary, you can either click the widget heading or the add button to leave the Oncology Summary and navigate to a different location within the patient chart where you can modify the data.

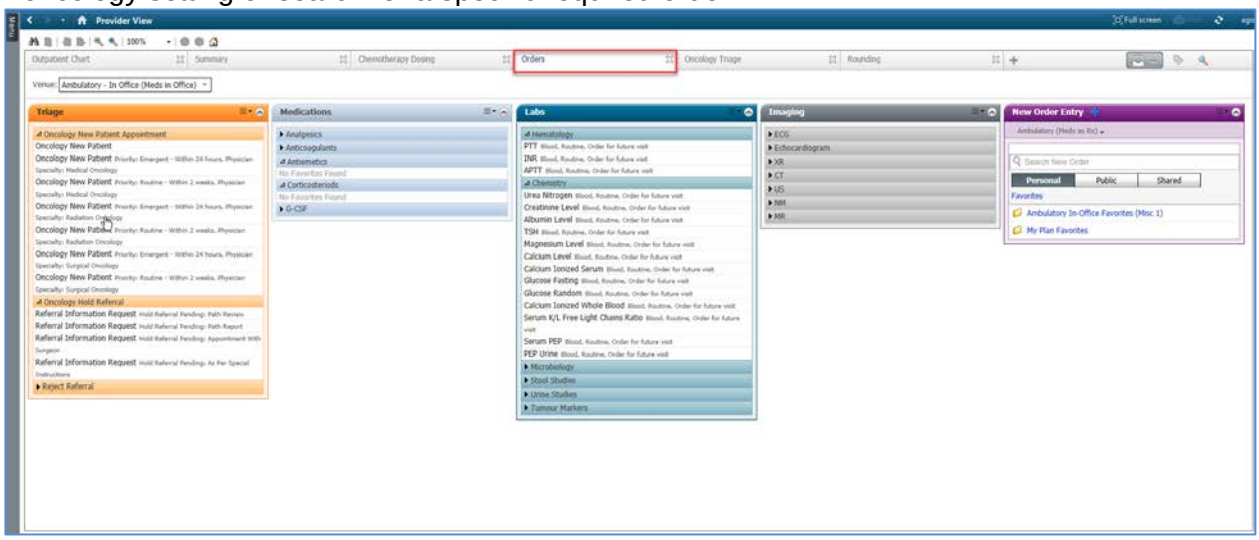


Take a few minutes to navigate around the page to familiarize yourself with the contents.

4 The **Chemotherapy Dosing Mpage** tab provides a historical view of the patient's weight and height which can be viewed by date or represented graphically. The page also displays all the regimens and plans ordered for the patient with the dosages delivered or to be delivered. This data is sorted in reverse chronological order with the most recent orders displayed at the top and completed items at the bottom.

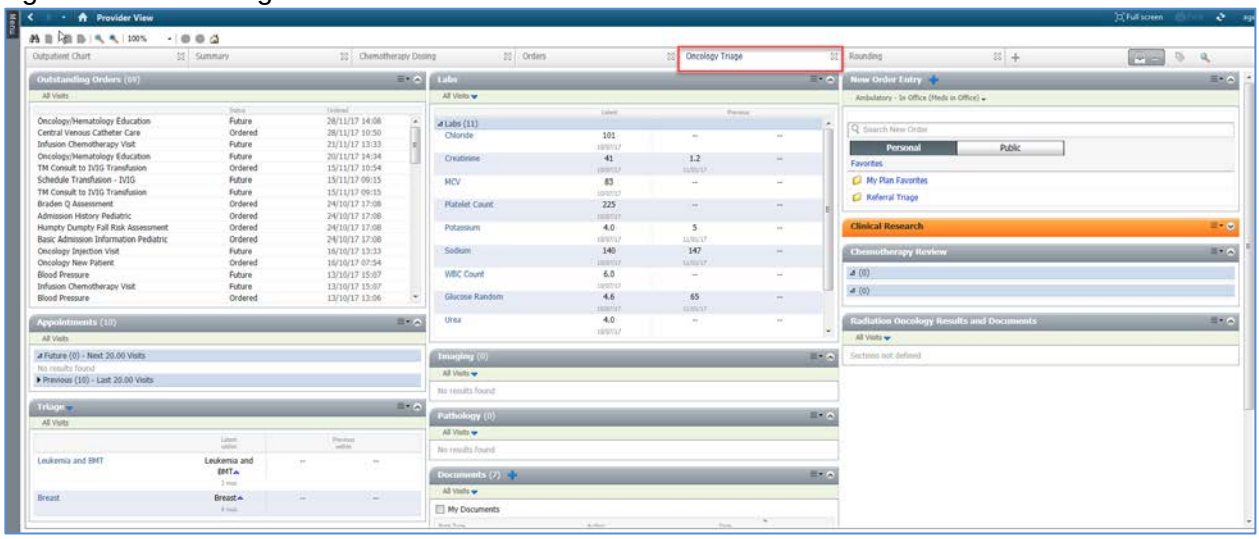


5 The **Orders MPage** tab layout allows the Oncologist to easily navigate frequently used orders in an oncology setting or search for a specific required order.

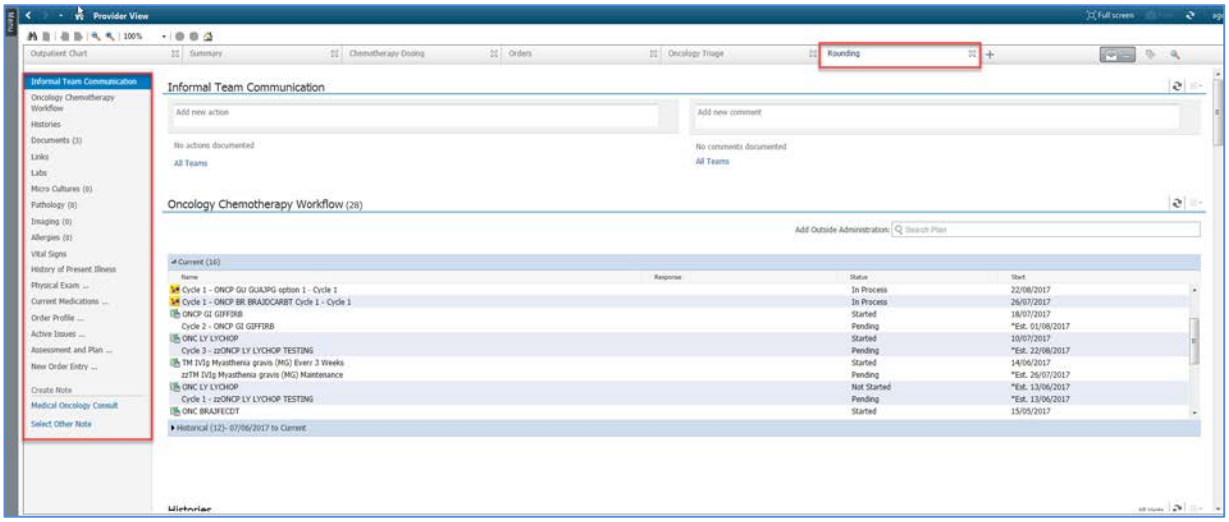


Note: Order entry will be covered later in this book

6 The **Oncology Triage Mpage** tab is a consolidated view of important information to help guide triage decision making.



7 The **Rounding MPage** tab is used most often in an inpatient setting as a handover tool between providers. Information is similar to the **Outpatient Chart MPage**, however it is organized in a manner to aide with workflow for handover.



Key Learning Points

- Provider View allows for ease of chart navigation.
- Tabs help aide in decision making.
- Tabs highlight data displayed for workflow purposes.

Activity 1.4 – Oncology MPage

1 **Oncology Flowsheet** - Displays clinical results in the context of the patient's chemotherapy treatment. Cycle labels are displayed above the flowsheet corresponding to the patient's relevant chemotherapy PowerPlans.

1. Access through the **Menu** by selecting **Oncology.**

2. **Flowsheet** is the first tab which will appear. **Note**: Columns in the flowsheet with no data will not populate.

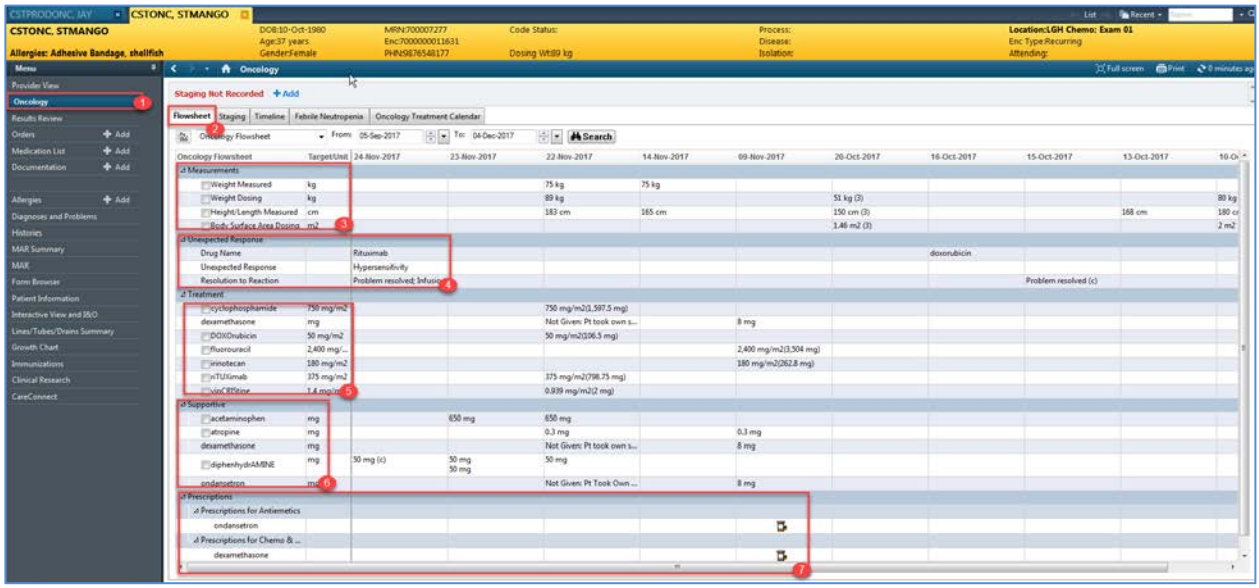
3. Both **Measured** and **Dosing** weights are displayed. These weights are pulled from IView and the Dosing Weight PowerForm respectively.

4. **Unexpected Response** information is populated if the patient has experienced an adverse event during their treatment at any time.

5. **Treatment** shows the chemotherapy treatment being delivered.

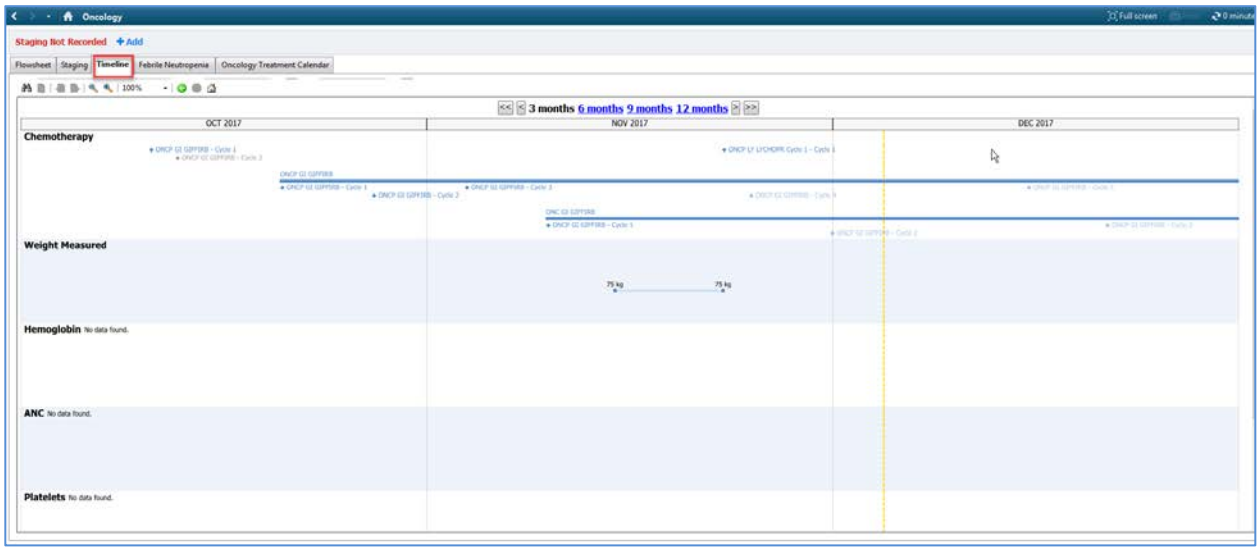
6. **Supportive** shows the supportive medications delivered during chemotherapy treatment.

7. **Prescriptions** list the patients' prescriptions that were given during treatment.

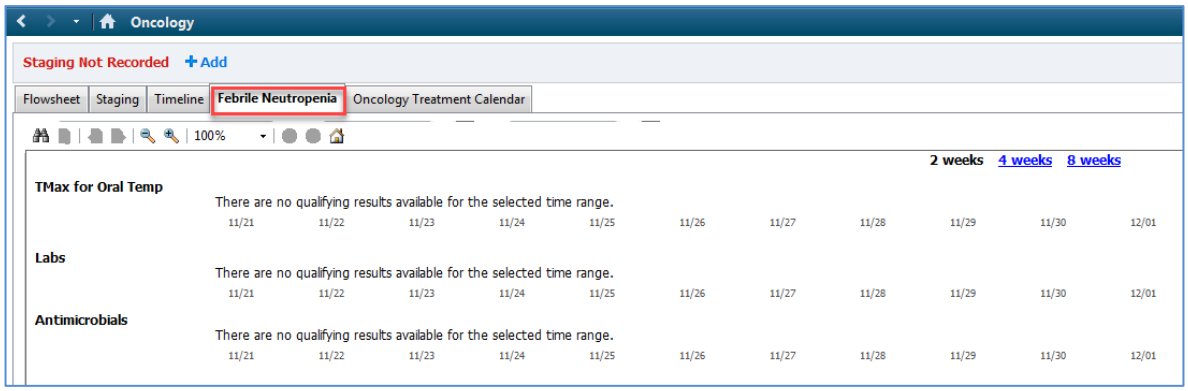


Note: Staging Tab is available and will be explained in a reference guide as the use has not yet been determined by Health Organizations.

2 The **Timeline** provides one view in which an Oncologist can review a patient's treatment in context to specific events in order to understand the impact of the treatment.

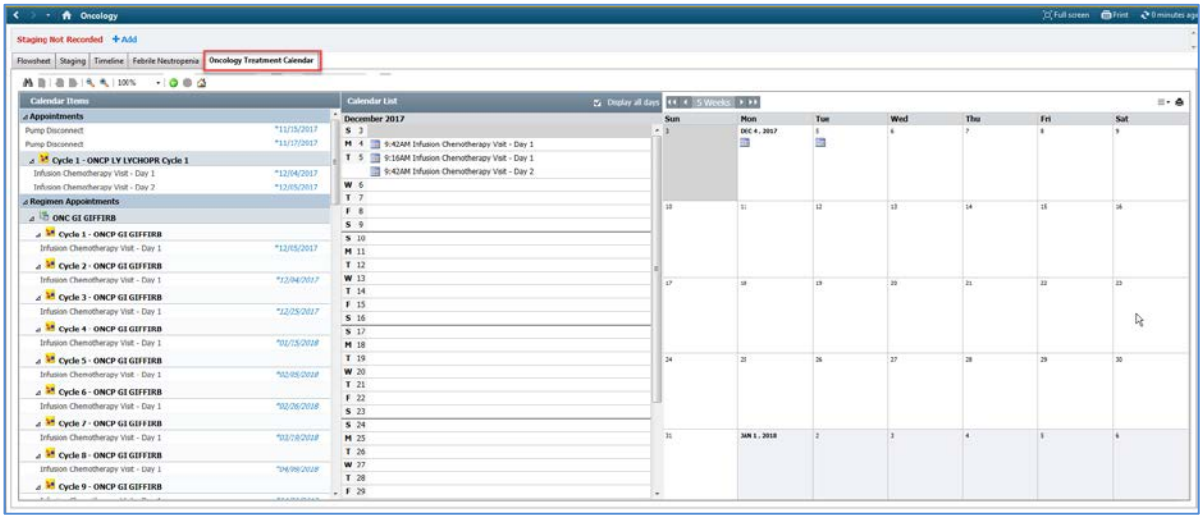


3 **Febrile Neutropenia** – Provides Oncologists with a specialized view for patients that are admitted to hospital for febrile neutropenia (intended for inpatient setting). The Oncologist has the ability to view the trend of the patient's temperature in relation to their absolute neutrophil count and which antibiotic(s) the patient is receiving.



4 The Oncology **Treatment Calendar** is designed to be a personalized summary of a patient's treatment including appointments, chemotherapy, and notes from the care team. It can be used to schedule future chemotherapy cycles and create printed calendars to be given to the patient. When working with plan and regimen details in the Calendar Item list, keep the following details in mind:

- Orders with an asterisk (*) indicate an estimated start date for a plan.
- Orders in italics are not yet ordered.
- Dates displayed in *italics* with an asterisk (*) indicate the order is not ordered



Calendar Items - This is a list of all appointments that are scheduled for a patient in a list of current and upcoming Regimens. You can also see a patient's prescriptions.

Calendar List - This is a list of upcoming events for a patient. Regimen appointments, medications, and other items are displayed in this list.

Calendar View -. The calendar is a visual representation of a patient's appointments, prescriptions, notes, and other important information regarding their treatment schedule. The calendar's first day displayed is always the current day of the week, not the first calendar day of the month.

For a given day, the Calendar View always displays a single icon for an event irrespective of the number of occurrences of the event in that day. This will make the Calendar View look more organized and singular.

Navigation Buttons - These buttons adjust the weeks displayed. Click the forward or backward arrow to move ahead or behind one week. Use the double arrows to move ahead or behind five weeks.

Key Learning Points

- The Oncology MPage includes 5 tabs which pull specific details into each, which optimize each view for specific oncology functionalities.
- The Flowsheet only populates columns if data is available (good place to view if a patient has had an adverse reaction to treatment).
- Further information on each tab can be found in Quick Reference Guides.

PATIENT SCENARIO 2 – Reviewing Patient Data and Updating Documentation

Learning Objectives

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

- Review Patient History
- Manage Patient Allergy Status
- Complete the Best Possible Medication History
- Understand and complete the Dosing Weight PowerForm

SCENARIO

You are now ready to go in to see your new patient. Together you review her personal and family history, allergy status, home medications and measurements:

- She has had a tonsillectomy in the past
- Her maternal grandfather had colon cancer and passed away two years ago as a result
- She has a severe (anaphylactic) allergy to Morphine
- Is experiencing anxiety regarding going forward with Chemotherapy
- Is needle phobic
- Will require a prescription for Lorazepam
- Current height: 168cm, Current weight 63kg

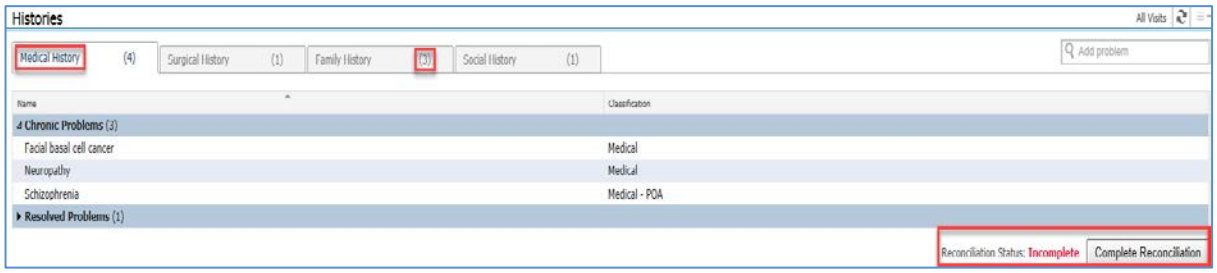
Activity 2.1 – Patient History

1 In the Provider View under the **Outpatient Chart MPage** the fourth section you will see is the **Histories**. When you open the patient's chart for the first time during the visit, the reconciliation status will be 'Incomplete.' For each component with Incomplete status, review and update the information as necessary and click Complete Reconciliation.

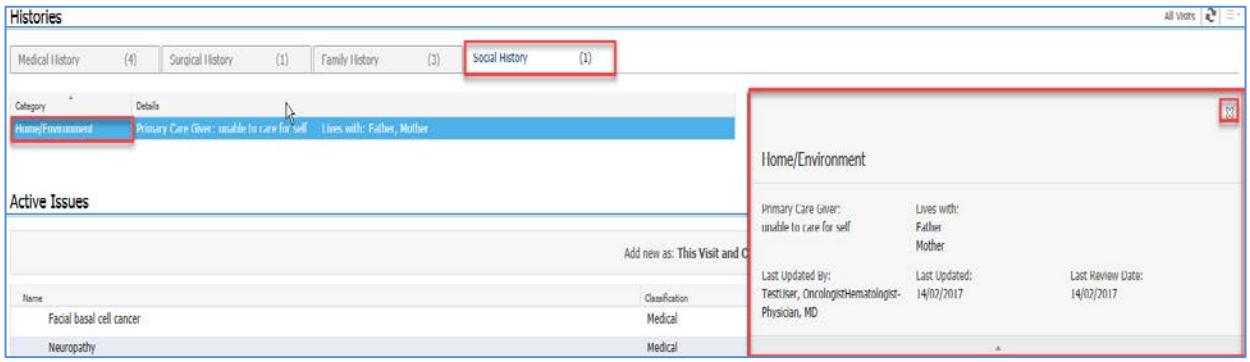
There is a separate tab for each history type. The number in brackets indicates how many entries are in each tab.

- How many entries are under Social History _____
- What other medical problems does this patient have? _____

Click the specific history tab to display these entries without leaving the current view.



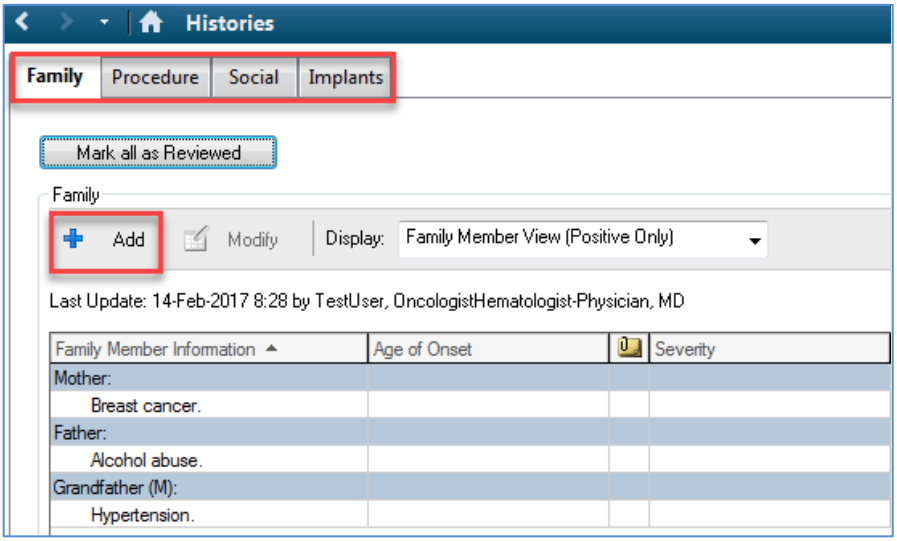
2 Click the item on the list to split the screen and display more details without leaving the Outpatient Chart tab. Then click the X to remove the split screen.



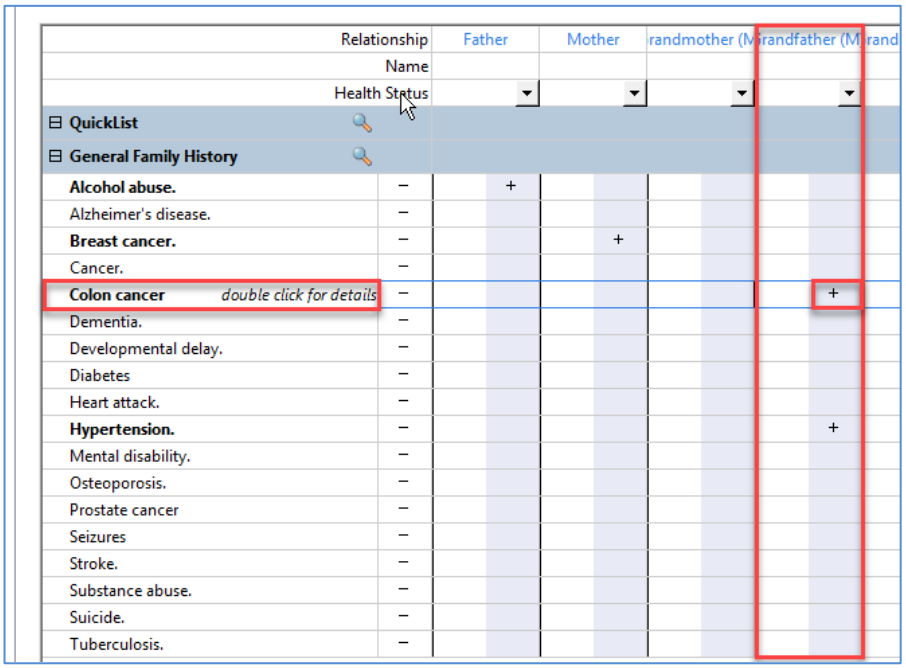
3 To add a new entry to patient histories, click the component heading **Histories**.

The Histories window opens. Note the separate tabs to enter each history (family, procedure, social, and implants). Add to the patient's Family History:

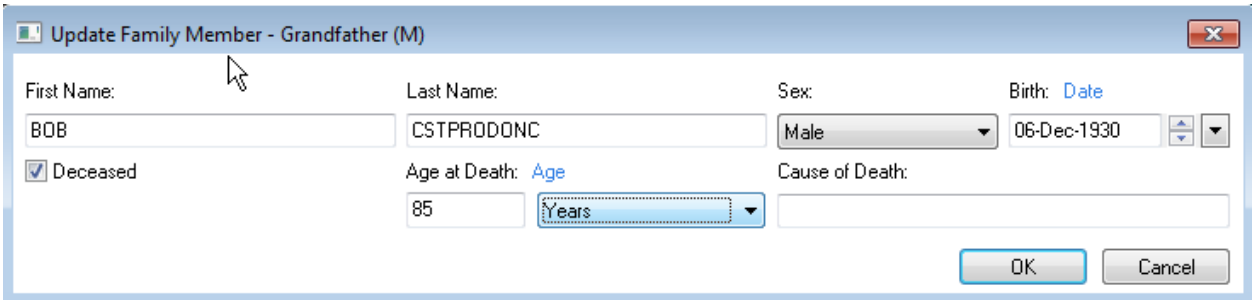
Select the Family tab and click the Add icon.



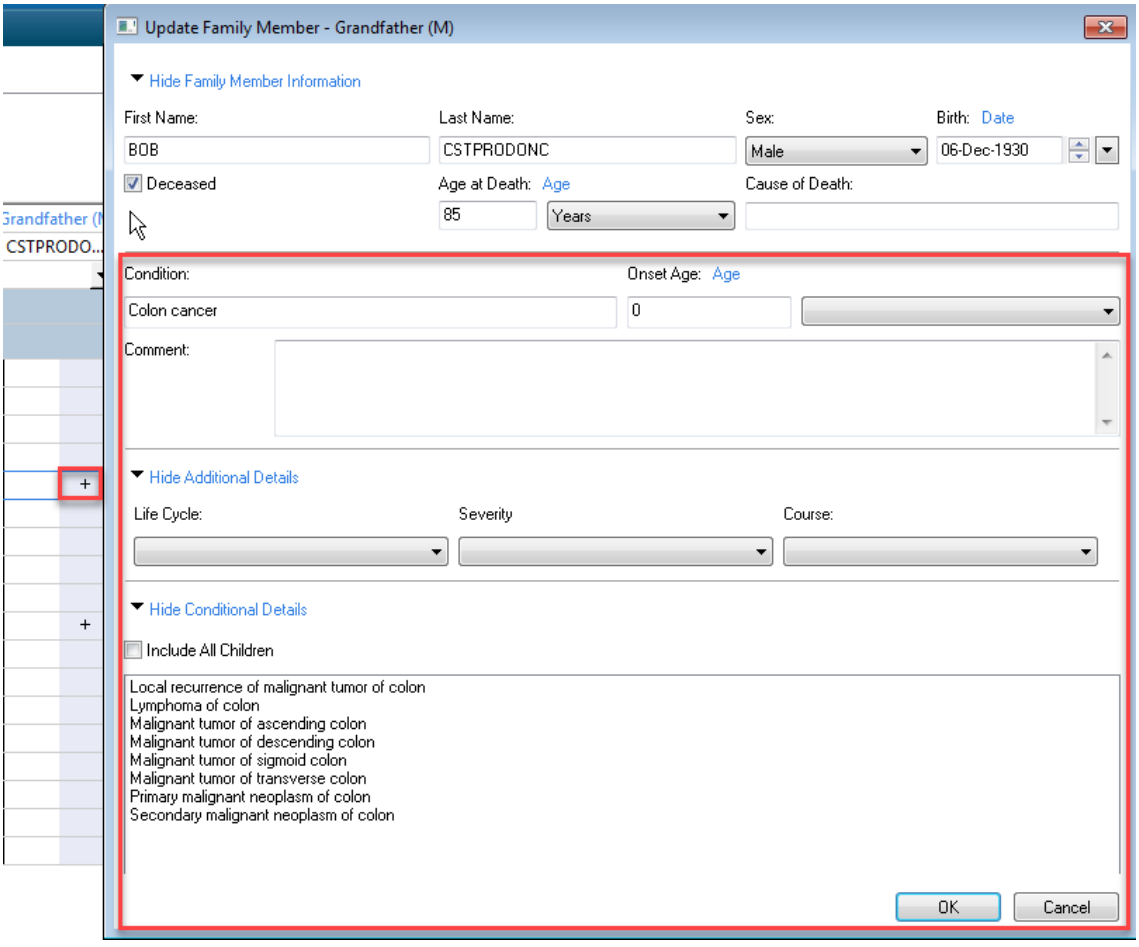
4 To practice, add that the patient's maternal (M) grandfather had colon cancer by placing a positive sign in the corresponding cell.



5 You can also add information about the family member you are entering history on by clicking on the relationship header and completing any relevant data. Then click **OK**.

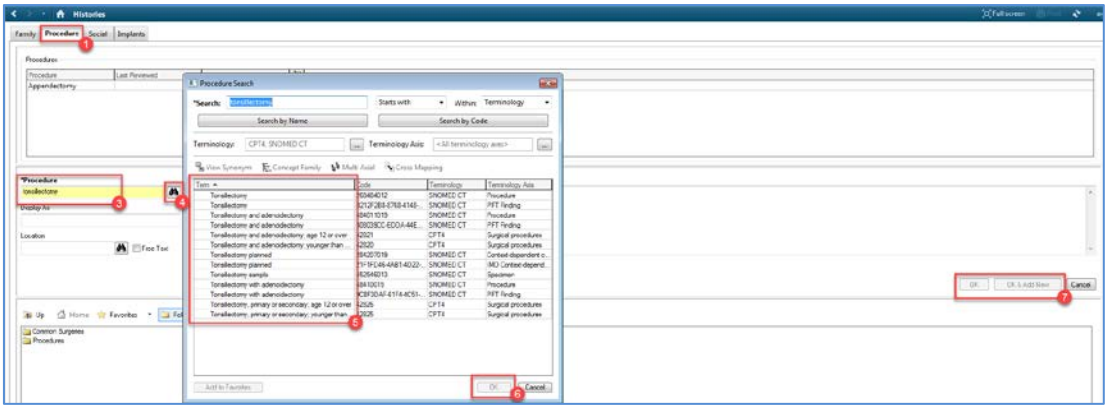


6 To add more detail about the family history Double-Click in the corresponding cell and complete any relevant condition information. Then click **OK** to save the information and close the window.



7 If you want to practice, add to the Procedure History: add the patient had a tonsillectomy last year.

1. Select **Procedure** tab
2. Click  icon
3. Complete the mandatory field marked by asterisk and highlighted yellow with procedure done
4. Click the  icon
5. Select the appropriate procedure
6. Click **OK**
7. Click **OK** or **OK & Add New** if there are more procedures to be entered



To return to the **Provider View** use the navigation buttons  or select **Provider View** from the **Menu**.

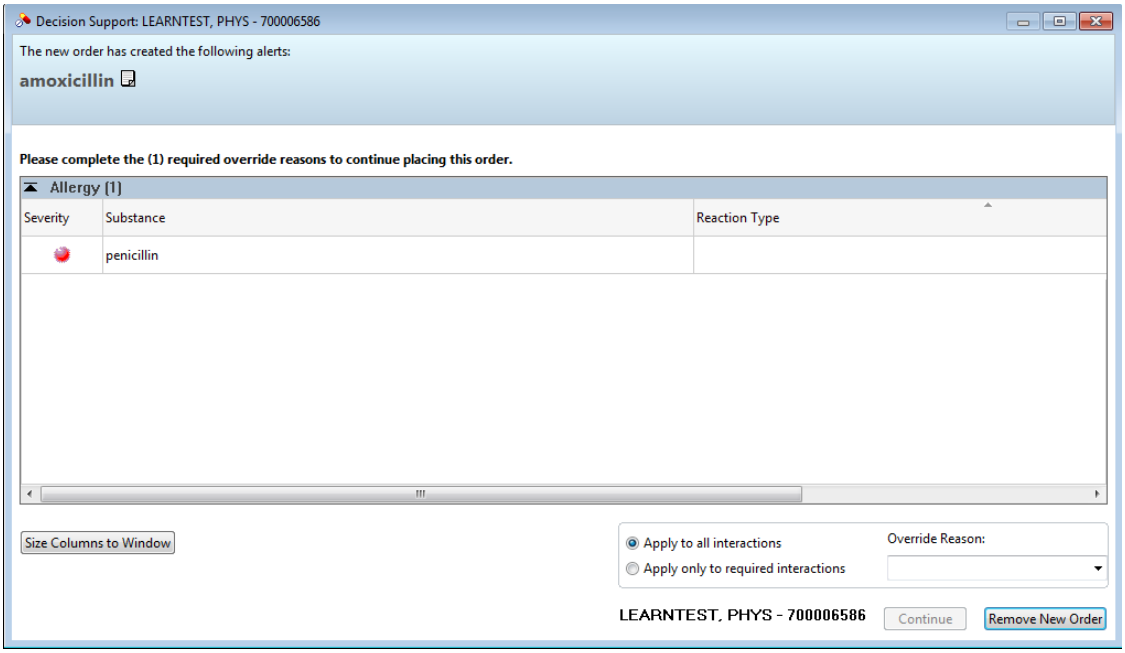
Key Learning Points

- Display more information without leaving the current view by clicking the row, the corresponding tab, or by 'hover to discover'.
- Reconcile the status of incomplete components when you review patient's chart for the first time.
- Procedures will be added when taking a patient's history on admission or triage when the procedure wasn't already documented in the Clinical Information System.
- To search for a term, type the first few characters to display more selections.

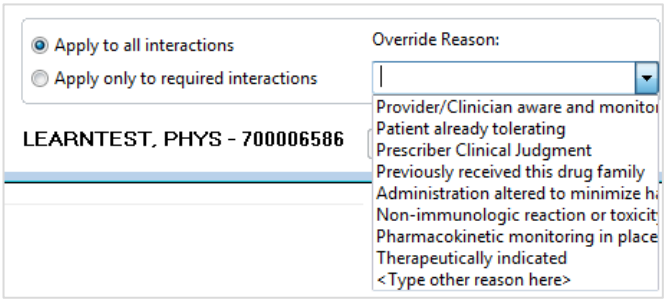
Activity 2.2 – Review and Update Patient Allergy

Allergy information is carried forward from one patient visit to the next. The CIS keeps track of the allergy status and will automatically prompt when the information is not up-to-date.

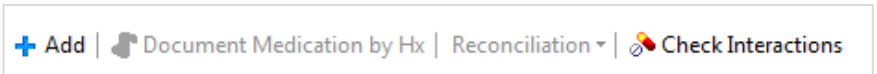
1 The system will track allergy-to-drug interaction. When placing an order with an allergy contraindication an alert is displayed.



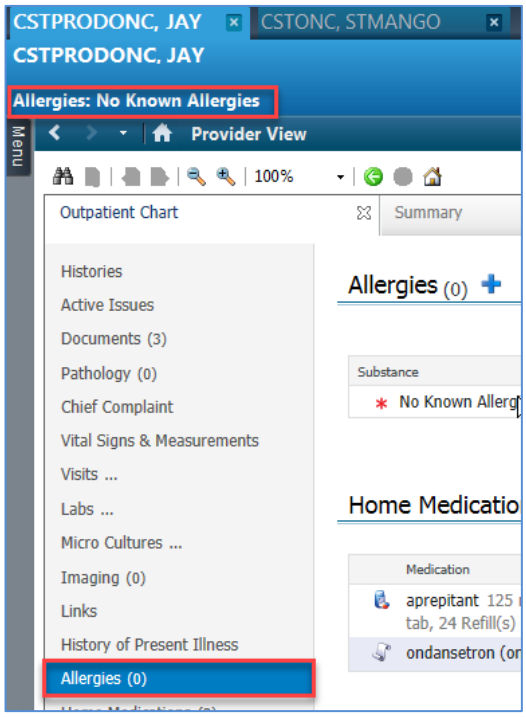
Note: You can either remove the order and select another medication, or continue with the order by overriding the alert and documenting the reason:



The CIS allows you to check for drug-to-drug interactions by clicking the **Check Interactions** button:

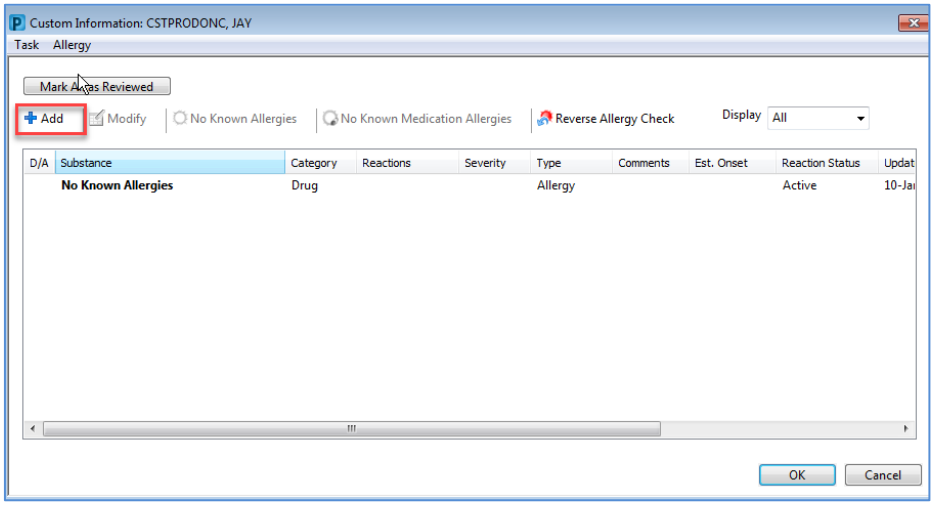


2 When you need to update the patient's allergies, the best way is to begin at the **Banner Bar**. Allergies are listed there accordingly to severity. 'Hover to discover' to display more details. Click to open the window where you can enter or update allergy information.



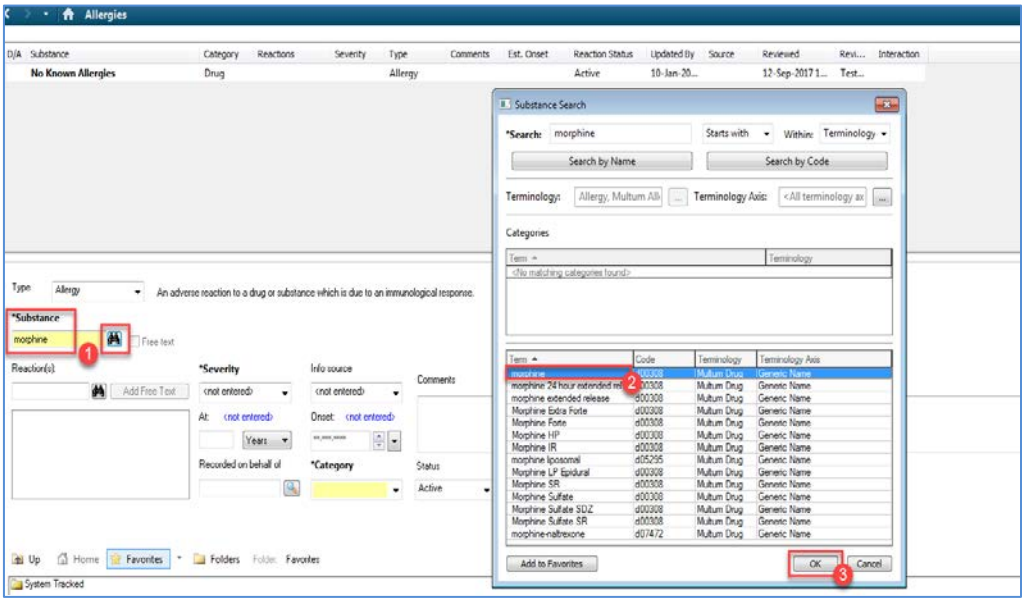
Note: Alternatively you can select Allergies from the Outpatient Chart under Provider View to update the section.

3 To add a new allergy to the patient's record, click the Add icon on the toolbar. Record that the patient has a severe anaphylactic allergy to Morphine.



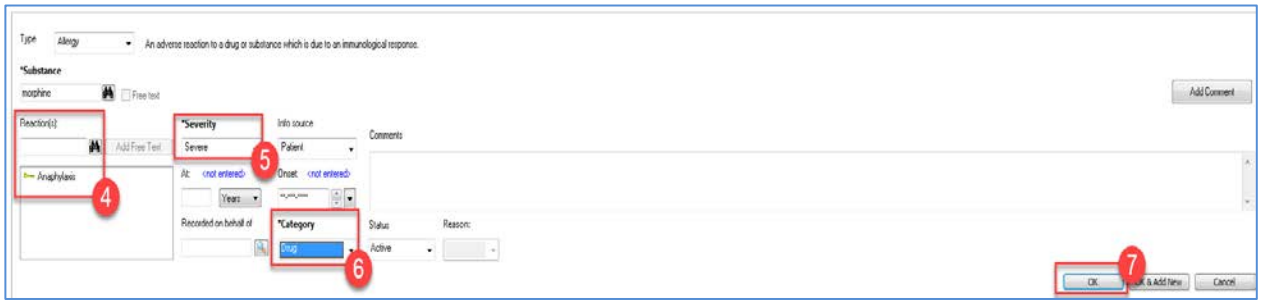
4 To add the above noted allergy:

1. Search for Morphine in the **Substance** box using the  to execute the search
2. Select **Morphine** from the list which populates
3. Click **OK** to return to the Add Allergy/Adverse Effect Window

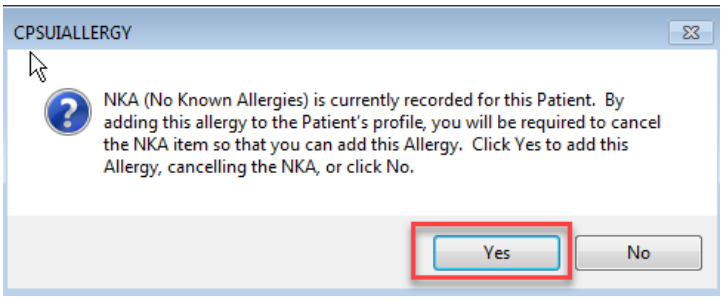


5 Complete the entry by adding the other two mandatory fields and any other information which may be of importance (recommended to complete reaction even though it is not marked as mandatory):

4. Enter reaction is ‘Anaphylaxis’ using the  icon.
5. Enter Severity ‘Severe’
6. Enter ‘Drug’ for Category
7. Click **OK** to save the information and close this window

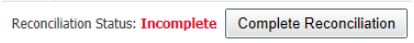


6 Patient's allergy record is updated. If the patient was previously recorded to have No Known Allergies an alert window pops up asking you to verify the information you have entered.

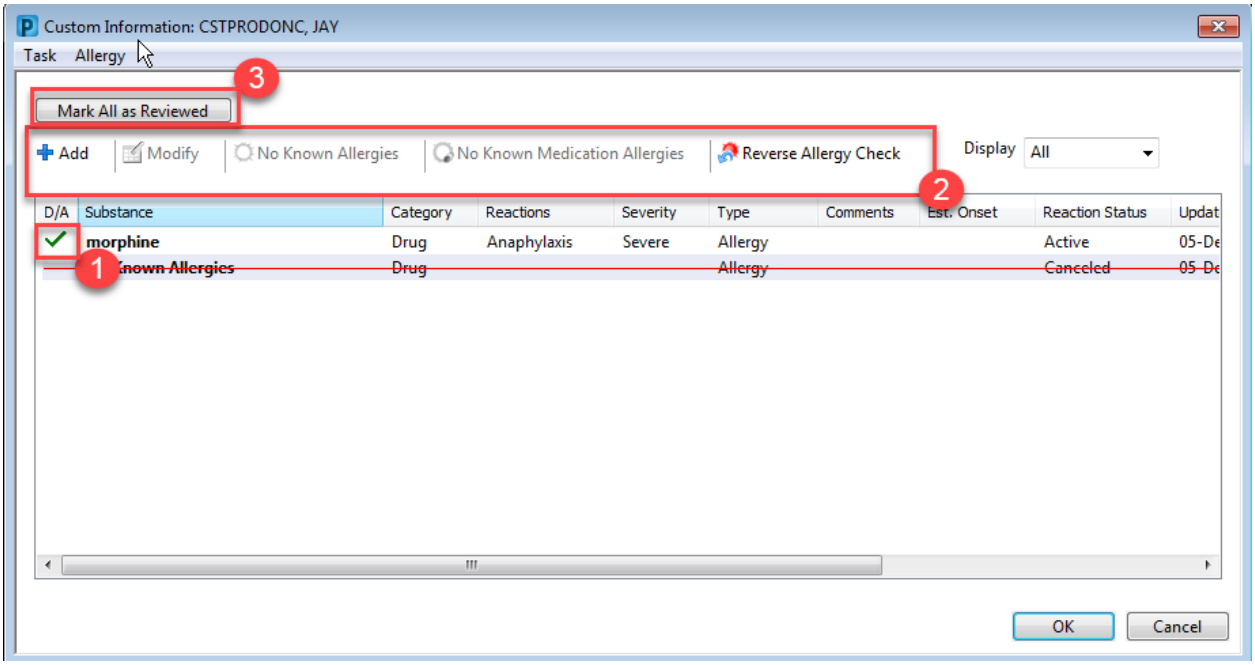


1. The green checkmark  indicates drug allergies
2. The toolbar provides other options for ease of use in entering information for patients without allergies
3. Select **Mark All as Reviewed** to complete the review or if no changes are required

In order for the pharmacy to dispense, they must see that the allergy record has been reviewed by a provider. Alternatively, from the Outpatient Chart you can select



to complete the process.



Note: If you want to modify the existing record, choose the allergy requiring modification, click Modify. To Practice change the Severity to Mild and Reaction to rash for the Morphine.

Key Learning Points

- You can review, add, or modify patient allergies at any time by clicking the allergy line on the Banner Bar.
- Patient allergies and interactions are monitored by the CIS.
- Review is completed when Mark All as Reviewed is selected or Complete Reconciliation is selected from the Outpatient Chart in Provider View.

Activity 2.3 – Best Possible Medication History (BPMH) Review and Update.

The BPMH is:

- The most current medication record
- The best possible list of medications based on available information

It includes all prescription and non-prescription medications.

It is a systematic medication history using multiple sources of information plus a client interview.

Ideally, all medication information is verified by more than one source.

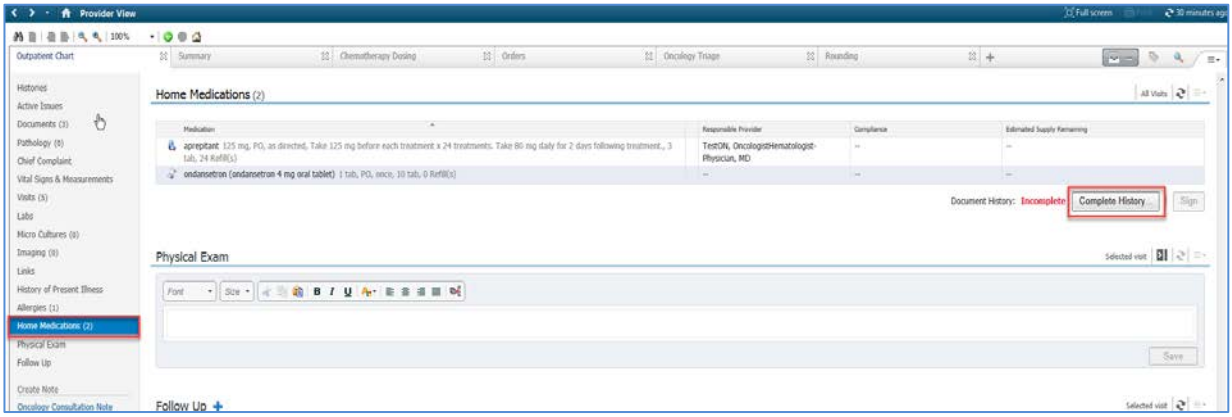
It is not simply a list of prescribed medications. Rather, it must also include information about how the client is currently taking the medications, even though it may be different from how it was prescribed.

1 Now you will review a best possible medication history (BPMH) and reconcile current medications if appropriate. The CIS offers a few tools to manage medications:

1. **Home Medications** component lists home medications entered for this visit and medications carried forward from the last discharge if documented in the CIS.

2. **Medication reconciliation** allows you to manage all home and current medications and create new prescriptions in one convenient screen. You can see the status of medication management indicated by the following icons:

means incomplete
means complete
means partial completion



The home medication record must be completed before performing admission medication reconciliation

The home medication record is updated and verified by a pharmacy technician. When a pharmacy technician is not available, it can be entered by a medical student or a nurse. In some situations you, as a provider, may need to update this record.

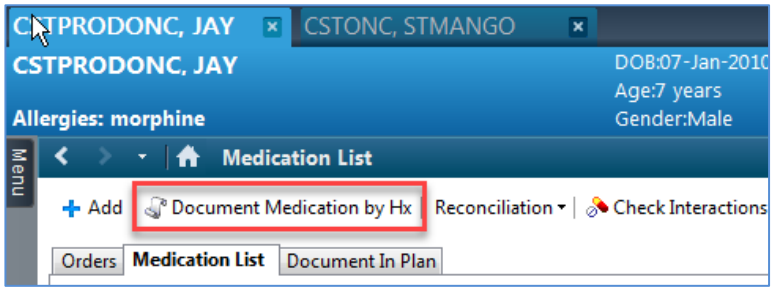
Click the **Home Medications** component from the list. When the Meds History has not been signed off, it is clearly marked *Incomplete* and the status will also be marked by a icon.

It is important to know that home medications can be updated at any time, even if the status clearly states 'complete':

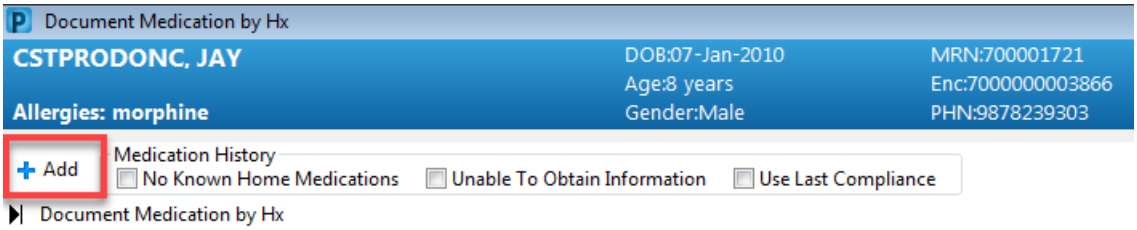
- For incomplete history, click **Complete History** to update
- To update a completed home medication list, click the **Home Medications** heading.

2 For this scenario, you will add Salbutamol inhaler 1 puff QID PRN:

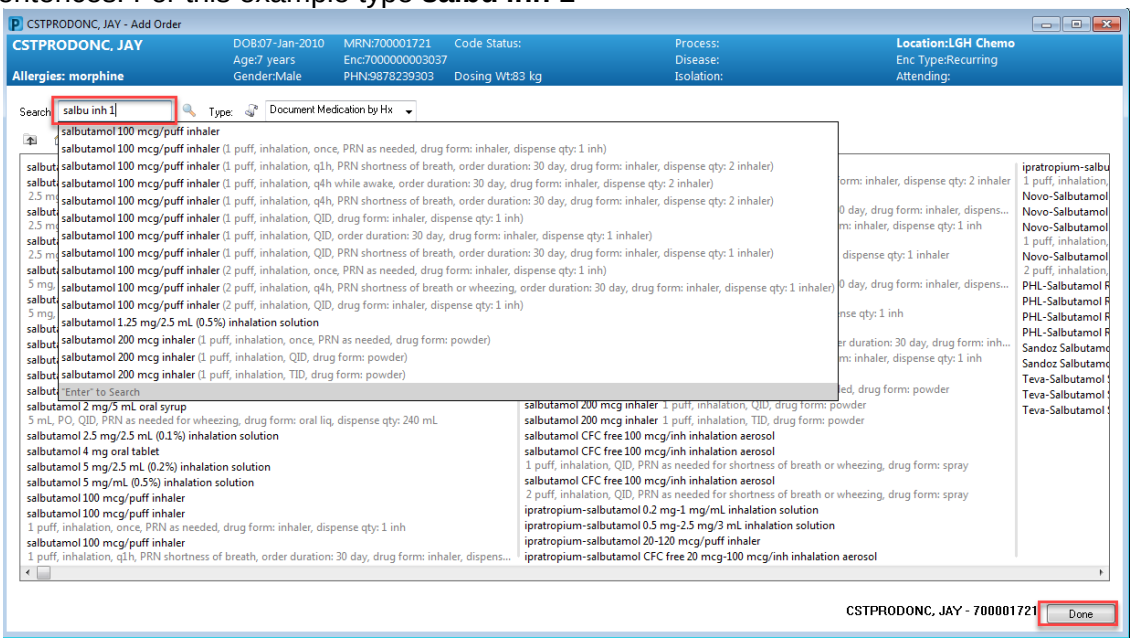
1. Click **Home Medications** heading
2. In the Medication List window, click **Document Medication by Hx**.



3 Click the Add button on the Medication List toolbar.

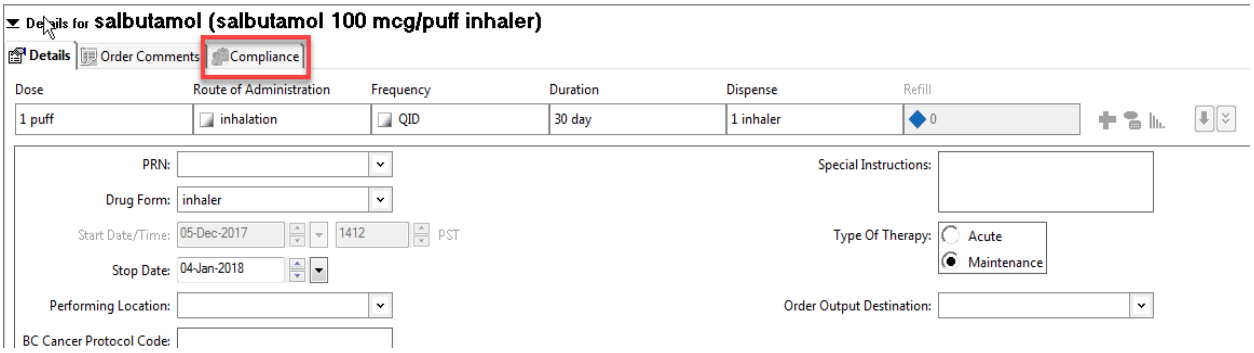


4 Start typing in the **Search** box the first three or four characters: salbu. A list of frequently used Salbutamol order sentences is displayed. If you do not see your choice at the top, press **Enter** to display the full catalogue. To truncate the list, add more details to display more relevant order sentences. For this example type **salbu inh 1**

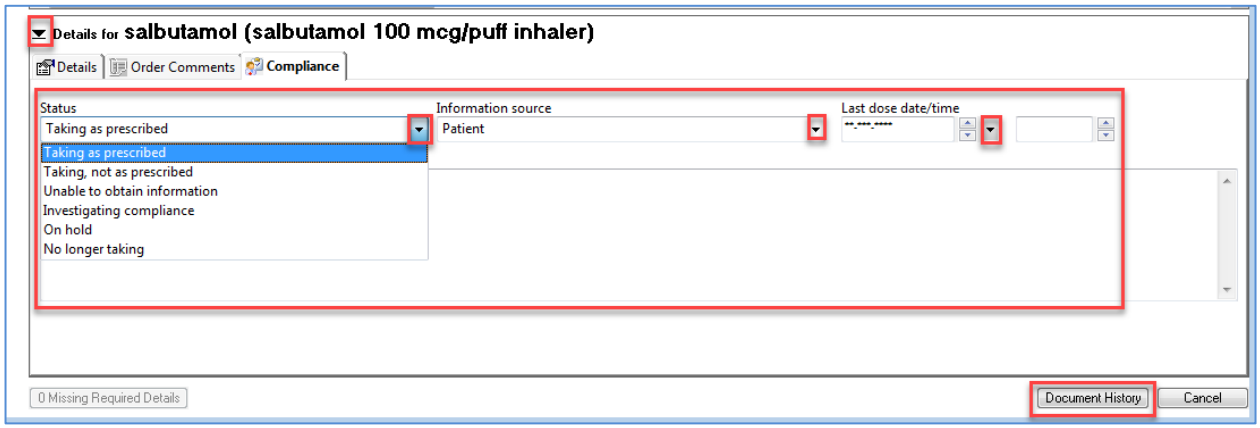


Click the appropriate sentence to select the medication and its details with one click. If you do not have other medications to add, click **Done** at the bottom right corner.

5 Details for Salbutamol display for your review. In many cases, it is important to know if the patient is following the prescription and when the last dose was taken. Click the **Compliance** tab.

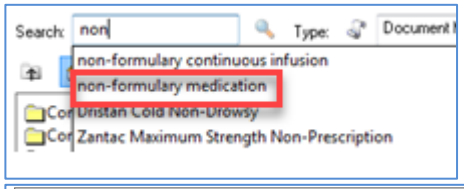


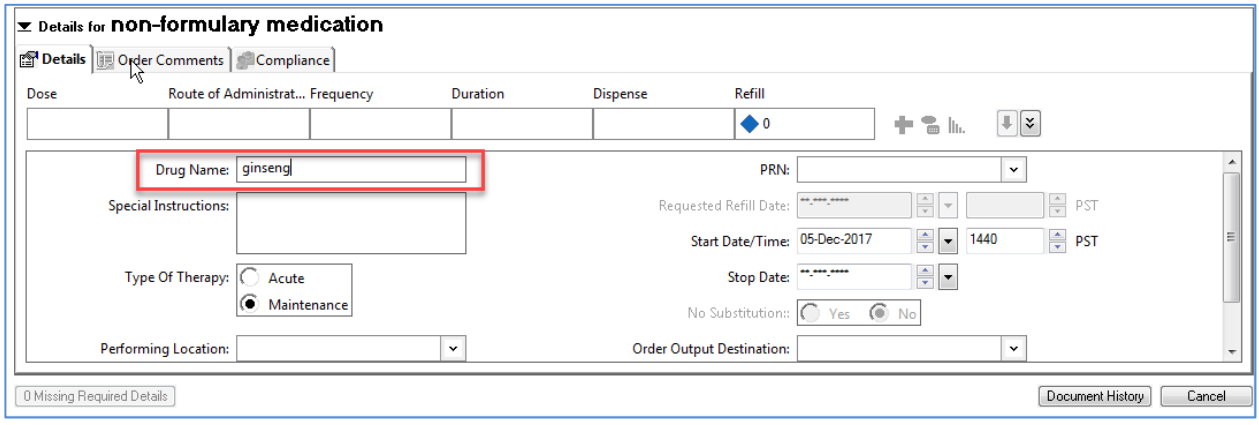
6 Use the drop-down lists to select appropriate options for status and information source, and to add when last dose was taken by the patient.



Note: Click Details to collapse or expand details for any order on the list.

7 To practice, repeat steps to add Yasmin 21 tab PO Qdaily, and add the non-formulary medication ginseng. Search for non-formulary and type the name of the medication under details.

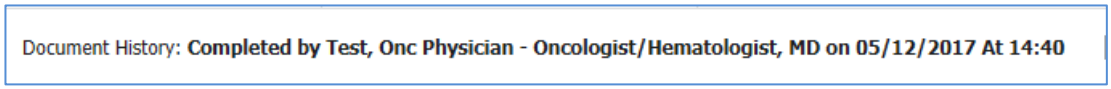




To complete the process, click **Document History**.

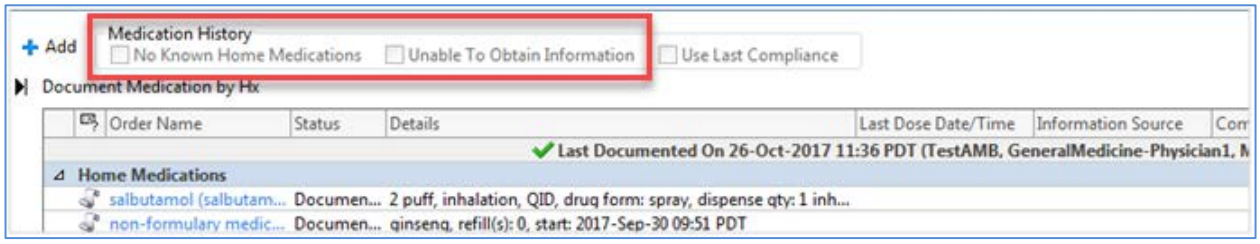
8 Use navigation buttons to return to your default screen – Provider View:

Coming back to the Outpatient Chart tab, ensure the Medication History has been completed.



Another indicator is to see the green checkmark when in the Medication List screen next to the status.

In cases where BPMH might not be available, this should be documented by selecting **No Known Home Medications** or **Unable to Obtain Information.**



Remember to click Refresh to update your view with the new entry and review the list (the status line displays the reviewer).

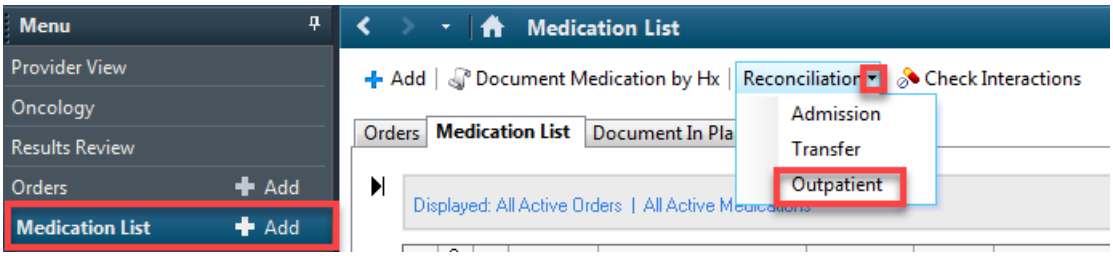
9 Now you are ready to complete the medication reconciliation to determine which medications the patient should stop taking, which medications she should continue at home, and if prescriptions need to be created.

Note:

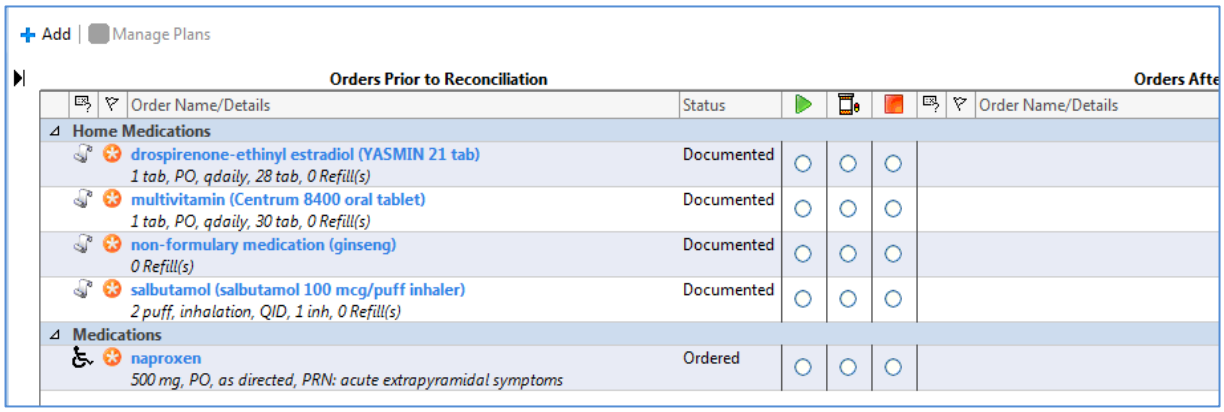
1-It is practical to reconcile home medications before placing your own medication orders so that you don't have to reconcile the most recently placed orders.

2- Medications within a chemotherapy PowerPlan will appear on the Outpatient Reconciliation once they have been activated (by the nurse) and are yet to be signed for; Should you chose to complete Medication reconciliation outside of the recommended workflow it is possible that PowerPlan medications will appear on the reconciliation list. Medications within a PowerPlan will be denoted by the Powerplan Icon and should not be reconciled, they will drop off of the list once the nurse has signed for them.

- Click the **Medication List** from the Menu, click the down arrow and select **Outpatient** from the menu options.



10 A list of medications prior to reconciliation is displayed.

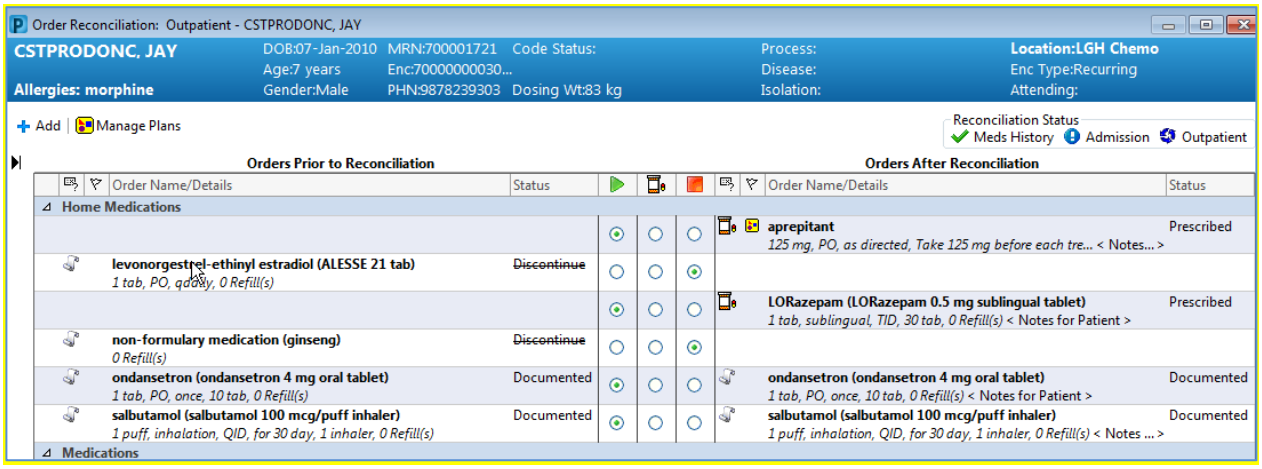


The reconciliation window displays the current status of medications. Hover to discover over the icons to check what they indicate:

_____	_____
_____	_____
_____	_____

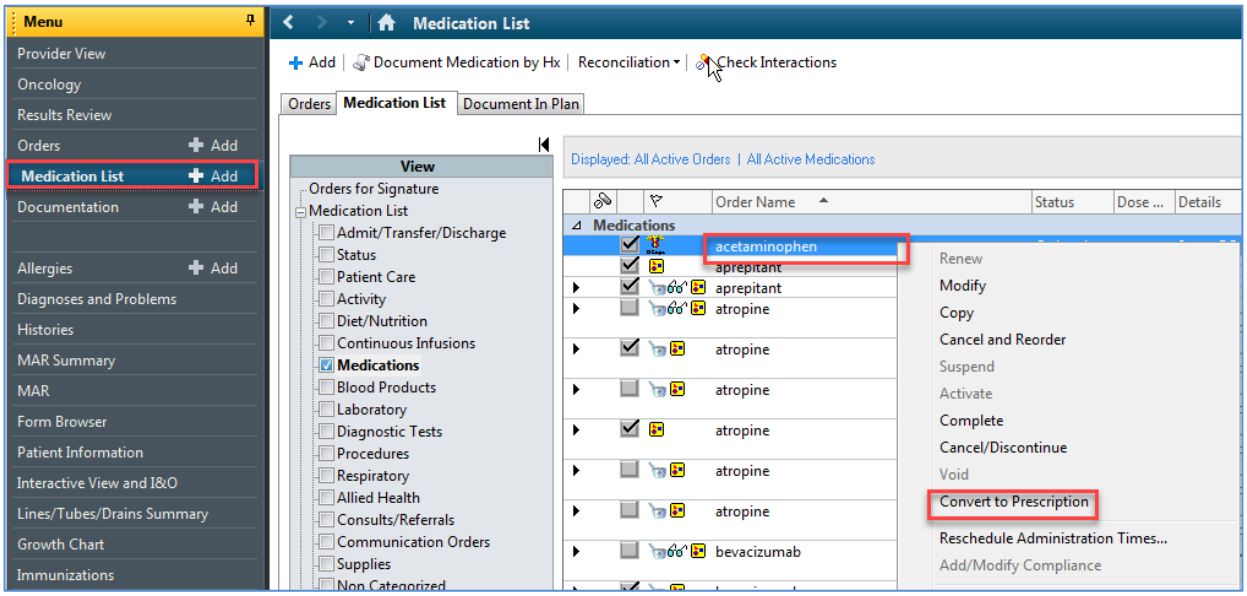
Decide to continue certain medications and to discontinue others. Check off the corresponding column.

11 Once all the medications are reconciled, click **Sign** (bottom right corner) to complete the process. The button will not be available until you address all medications listed.



The prescription for the medication will automatically be printed.

12 You can also create a new prescription (medication renewal) for one of the patient's medications from the Medication List view. Select **Medication List** from the **Menu**. This displays the list of current medications. **Right-Click** the medication and select **Convert to Prescription**.



Key Learning Points

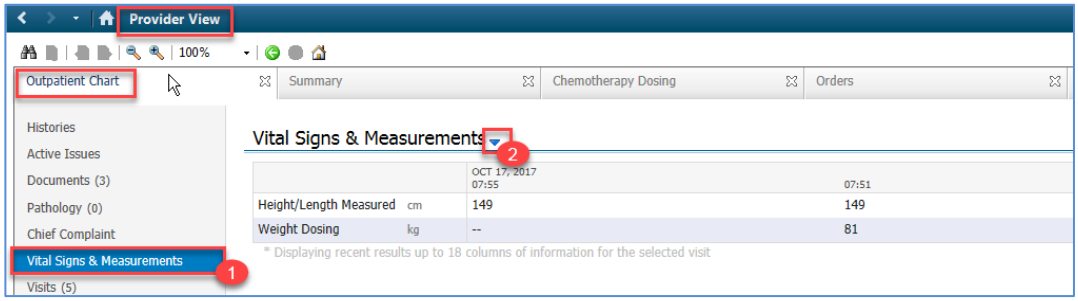
- Medication History must be completed before the medication reconciliation.
- A home medication can be added to a complete medication history when information becomes available.
- The Outpatient Medication Reconciliation screen displays home and current medications allowing continuing or discontinuing any listed medication.
- When using the Search box, type the first characters of the term to limit the list of possible entries.
- You can create a prescription from the Outpatient Medication Reconciliation in the Outpatient Chart workflow view.
- You can create a prescription from the Medication List under the left side Menu.

Activity 2.4 – Dosing Weight 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.

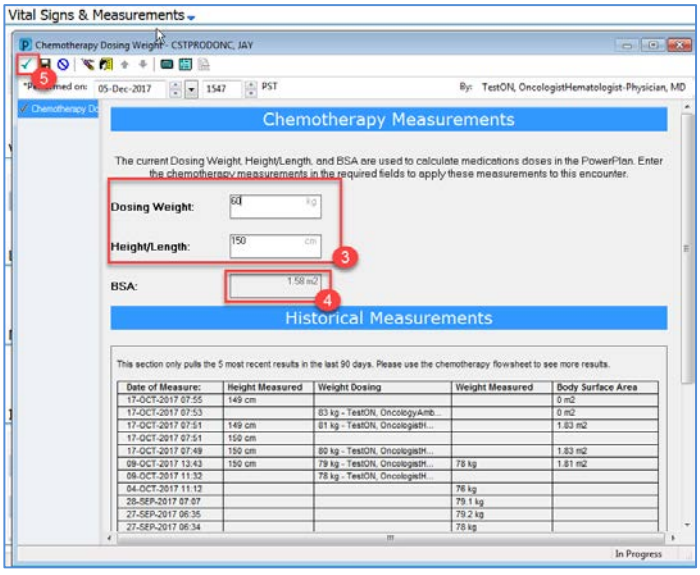
1 To access the Chemotherapy Dosing Weight PowerForm go to the Provider View under the Outpatient Chart:

1. Select Vital Sign & Measurements
2. Click the down area beside the heading, select the Chemotherapy Dosing Weight (only option provided).

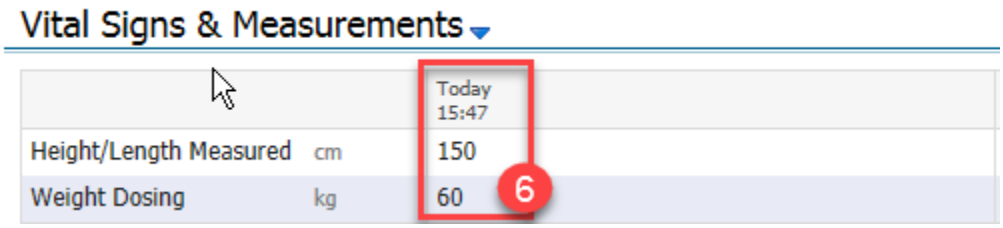


The form opens in a new window:

3. Complete both the Dosing Weight and Height/Length
4. BSA automatically calculates with the above data entered
5. Click the to sign the document



2 You can see the data has populated under the Vital Sign & Measurements.



Note: These metrics also pull into the Dosing Calculator.

Key Learning Points

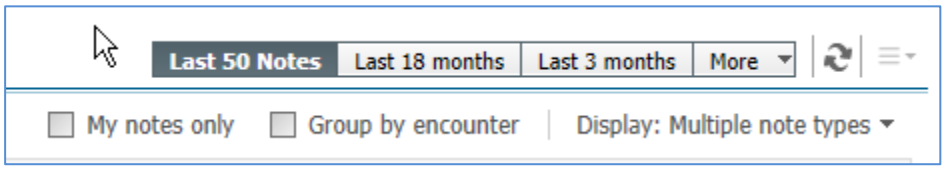
- PowerForms push data into other sections of the chart.
- As an Oncologist the Chemotherapy Dosing Weight PowerForm pushes into the Dosing Orders.

Activity 2.5 – Review Labs, Imaging, and Documents

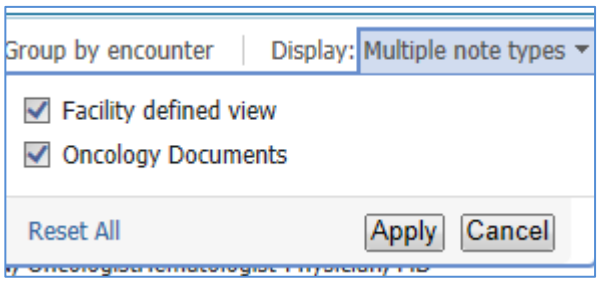
In order to review specific sections of information in a patient's chart, it is best to navigate from the Provider View. From the Provider View multiple tabs can be used to view information. As an Oncologist working in the outpatient setting the main tab will be the Outpatient Chart tab. The below method will describe how to access the following information from this tab.

1 When using the CIS, you may be faced with large amounts of information. For many components, you can filter documents in many ways. For example, in the Documents component, you can:

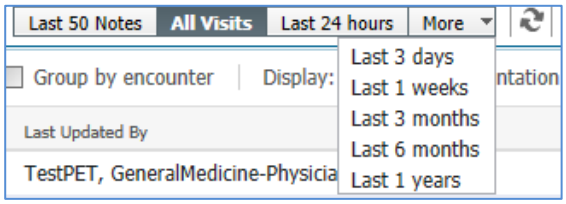
- Display notes from the **Last 24 hours** or **My notes only**
- Use **Group by encounter** to see notes for the current encounter only
- Limit documents to **Last 50 notes**
- Access notes for **All Visits**



You can also display notes by **Facility defined view** or **Oncology Documents**.



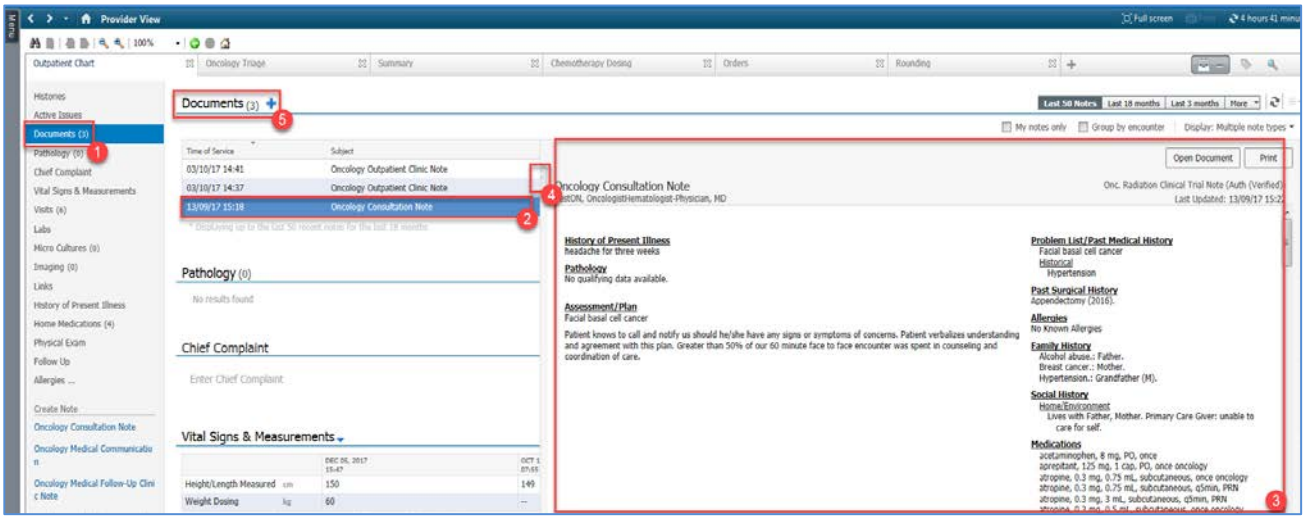
You can also select a custom time range by expanding the options under **More.**

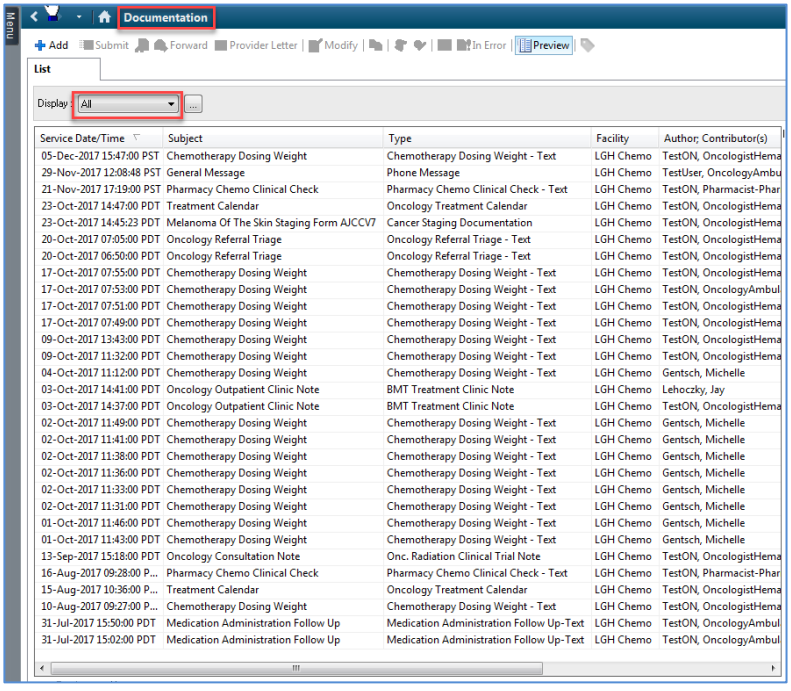


Note: If you select a specific filter, the selection narrows and you may not display all of the relevant information.

2 To access Documentation:

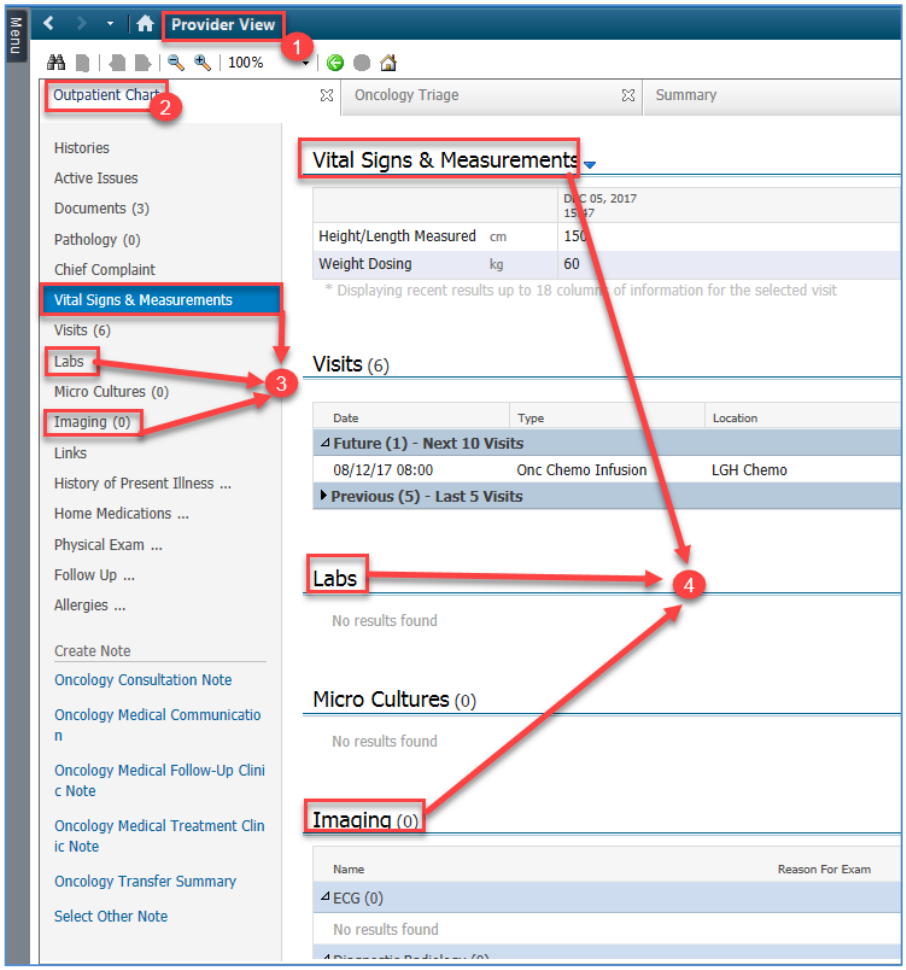
1. Either scroll or click **Documents** from the options to the left.
2. Select the document you would like to view
3. A window displays with the document content without leaving the screen
4. Click the tab to close the split screen
5. Clicking the component heading **Documents** will take you to the documentation section of the chart and display the full list of documents available





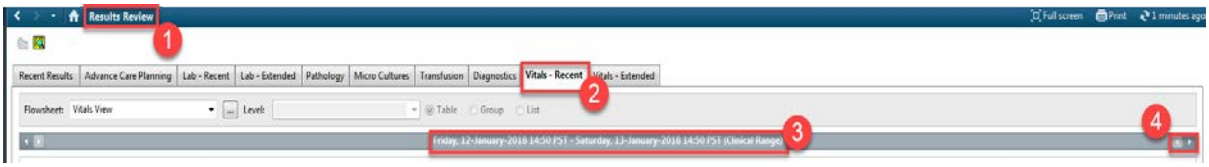
Service Date/Time	Subject	Type	Facility	Author; Contributor(s)
05-Dec-2017 15:47:00 PST	Chemotherapy Dosing Weight	Chemotherapy Dosing Weight - Text	LGH Chemo	TestON, OncologistHema
29-Nov-2017 12:08:48 PST	General Message	Phone Message	LGH Chemo	TestUser, OncologyAmbu
21-Nov-2017 17:19:00 PST	Pharmacy Chemo Clinical Check	Pharmacy Chemo Clinical Check - Text	LGH Chemo	TestON, Pharmacist-Phar
23-Oct-2017 14:47:00 PDT	Treatment Calendar	Oncology Treatment Calendar	LGH Chemo	TestON, OncologistHema
23-Oct-2017 14:45:23 PDT	Melanoma Of The Skin Staging Form AJCCV7	Cancer Staging Documentation	LGH Chemo	TestON, OncologistHema
20-Oct-2017 07:05:00 PDT	Oncology Referral Triage	Oncology Referral Triage - Text	LGH Chemo	TestON, OncologistHema
20-Oct-2017 06:50:00 PDT	Oncology Referral Triage	Oncology Referral Triage - Text	LGH Chemo	TestON, OncologistHema
17-Oct-2017 07:55:00 PDT	Chemotherapy Dosing Weight	Chemotherapy Dosing Weight - Text	LGH Chemo	TestON, OncologistHema
17-Oct-2017 07:53:00 PDT	Chemotherapy Dosing Weight	Chemotherapy Dosing Weight - Text	LGH Chemo	TestON, OncologyAmbul
17-Oct-2017 07:51:00 PDT	Chemotherapy Dosing Weight	Chemotherapy Dosing Weight - Text	LGH Chemo	TestON, OncologistHema
17-Oct-2017 07:49:00 PDT	Chemotherapy Dosing Weight	Chemotherapy Dosing Weight - Text	LGH Chemo	TestON, OncologistHema
09-Oct-2017 13:43:00 PDT	Chemotherapy Dosing Weight	Chemotherapy Dosing Weight - Text	LGH Chemo	TestON, OncologistHema
09-Oct-2017 11:32:00 PDT	Chemotherapy Dosing Weight	Chemotherapy Dosing Weight - Text	LGH Chemo	TestON, OncologistHema
04-Oct-2017 11:12:00 PDT	Chemotherapy Dosing Weight	Chemotherapy Dosing Weight - Text	LGH Chemo	Gentsch, Michelle
03-Oct-2017 14:41:00 PDT	Oncology Outpatient Clinic Note	BMT Treatment Clinic Note	LGH Chemo	Lehoczky, Jay
03-Oct-2017 14:37:00 PDT	Oncology Outpatient Clinic Note	BMT Treatment Clinic Note	LGH Chemo	TestON, OncologistHema
02-Oct-2017 11:49:00 PDT	Chemotherapy Dosing Weight	Chemotherapy Dosing Weight - Text	LGH Chemo	Gentsch, Michelle
02-Oct-2017 11:41:00 PDT	Chemotherapy Dosing Weight	Chemotherapy Dosing Weight - Text	LGH Chemo	Gentsch, Michelle
02-Oct-2017 11:38:00 PDT	Chemotherapy Dosing Weight	Chemotherapy Dosing Weight - Text	LGH Chemo	Gentsch, Michelle
02-Oct-2017 11:36:00 PDT	Chemotherapy Dosing Weight	Chemotherapy Dosing Weight - Text	LGH Chemo	Gentsch, Michelle
02-Oct-2017 11:33:00 PDT	Chemotherapy Dosing Weight	Chemotherapy Dosing Weight - Text	LGH Chemo	Gentsch, Michelle
02-Oct-2017 11:31:00 PDT	Chemotherapy Dosing Weight	Chemotherapy Dosing Weight - Text	LGH Chemo	Gentsch, Michelle
01-Oct-2017 11:46:00 PDT	Chemotherapy Dosing Weight	Chemotherapy Dosing Weight - Text	LGH Chemo	Gentsch, Michelle
01-Oct-2017 11:43:00 PDT	Chemotherapy Dosing Weight	Chemotherapy Dosing Weight - Text	LGH Chemo	Gentsch, Michelle
13-Sep-2017 15:18:00 PDT	Oncology Consultation Note	Onc. Radiation Clinical Trial Note	LGH Chemo	TestON, OncologistHema
16-Aug-2017 09:28:00 P...	Pharmacy Chemo Clinical Check	Pharmacy Chemo Clinical Check - Text	LGH Chemo	TestON, Pharmacist-Phar
15-Aug-2017 10:36:00 P...	Treatment Calendar	Oncology Treatment Calendar	LGH Chemo	TestON, OncologistHema
10-Aug-2017 09:27:00 P...	Chemotherapy Dosing Weight	Chemotherapy Dosing Weight - Text	LGH Chemo	TestON, OncologistHema
31-Jul-2017 15:50:00 PDT	Medication Administration Follow Up	Medication Administration Follow Up-Text	LGH Chemo	TestON, OncologyAmbul
31-Jul-2017 15:02:00 PDT	Medication Administration Follow Up	Medication Administration Follow Up-Text	LGH Chemo	TestON, OncologyAmbul

3 By Clicking on the component headings **Vital Signs & Measurements, Labs**, or **Imaging (4)** from the **Outpatient Chart** (2) in the **Provider View** (1) it will bring you to the Results Review window. You can easily navigate to these sections by selecting from the menu (3). Click on the **Vital Sign & Measurements.**

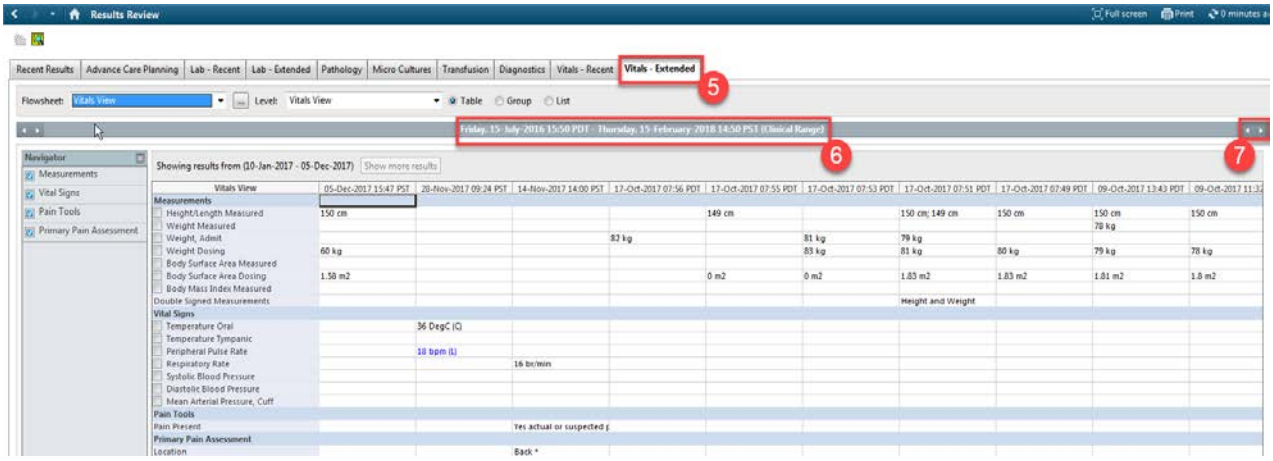


4 You will now:

1. Be in the **Results Review** Window.
2. The tab which opens is defaulted to the **Vitals-Recent** tab.
3. This tab has a predetermined time frame to look back upon, otherwise known as the **Clinical Range.**
4. You can choose to adjust the date range forward or backwards by 3 days at a time.



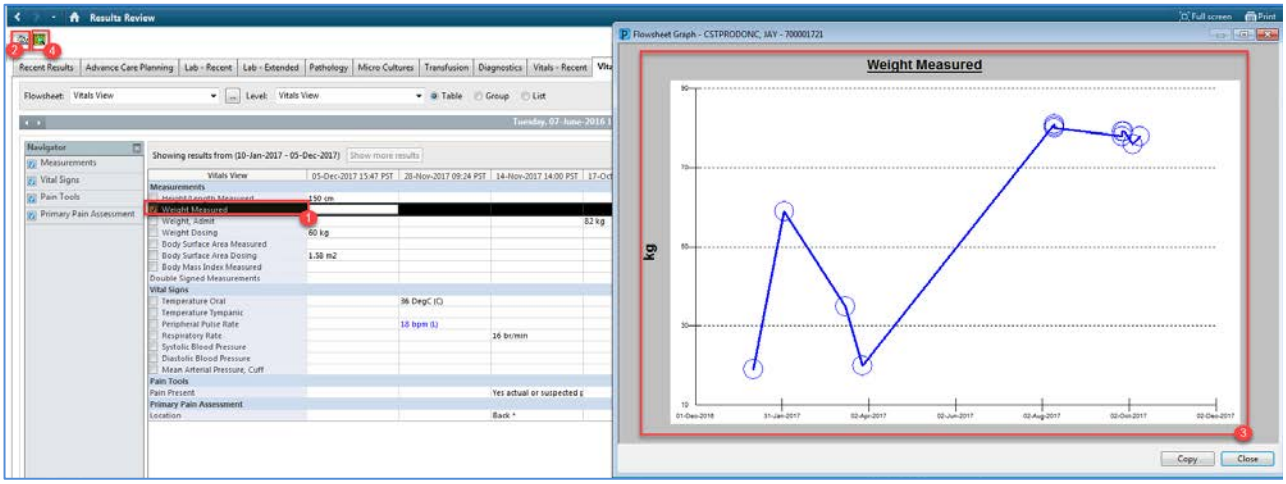
5. You can also choose to view **Vitals-Extended** tab.
6. This allows for a longer **Clinical Range** to be viewed.
7. You can choose to adjust the **Clinical Range** forward or backwards 6 months at a time.



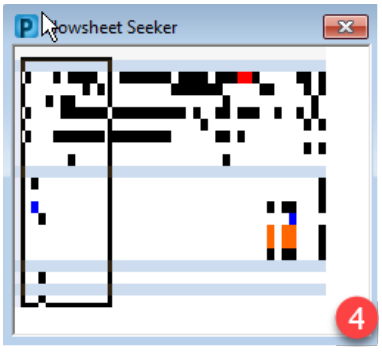
Note: Under the Lab tabs the view and options to change Clinical Range are the same.

5 **Results** view allows for graphing of data to note any trends or changes in a patients status. In the **Vitals-Extended** tab:

1. Check off **Temperature Oral**.
2. Click on the **Graph** icon.
3. Note the data you are wanting appears graphed in a pop up window.

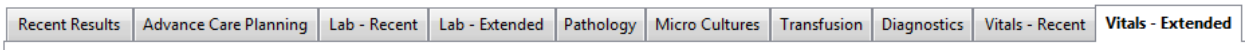


4. The **Seeker** icon is a quick locator tool that enables you to view a thumbnail sketch of the entire results flowsheet and focus on an area containing a cluster of results. The rectangle outlined represents the current screen display.



Note: These functions are also the same within the Lab tabs.

6 To access other results you would select the corresponding tab available within **Results Review**. If you are accessing the results from **Provider View** you would select the corresponding component heading be brought into the **Results Review**.



Note: For viewing any imaging that is available click on Diagnostics.

Key Learning Points

- You can filter the view range/type from the Provider View.
- You can preview documents and results within Provider View.
- Clicking on the component heading will take you into the corresponding section of the chart for a more comprehensive display.
- Within Results Review you can Graph results or choose to use the Seeker to hone in on a cluster of data.

PATIENT SCENARIO 3 – Chemotherapy Ordering

Learning Objectives

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

- Understand structure of Chemotherapy Regimens and Powerplans
- Order a Chemotherapy Regimen/Powerplan
- Managing cycles within Regimen
- Utilize dosing calculator for weight based medications

SCENARIO

As an Oncology Provider you are going to follow a patient through their journey. Your first patient is a 32 year old female born March 3rd, 1985. She has come to you via a referral made though her Surgeon, post right breast lumpectomy, now requiring chemotherapy. After reviewing her documents, labs, and imaging you decide she needs to be started on BRAJACT-G. Follow along to complete the required tasks.

As an Oncology Provider you will be completing the following activities:

- Navigating provider workflow MPage and Oncology flowsheet
- Ordering Chemotherapy plans and utilizing dosing calculator to adjust dosing
- Working with Regimens
- Ordering prescriptions

Activity 3.1 – Chemotherapy Orders

1 Understanding the structure of Chemotherapy Orders:

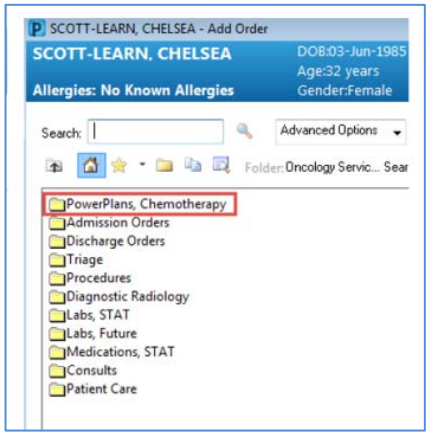
PowerPlan: One individual order set or cycle of treatment. The orders are broken out into phases of treatment and days of treatment**. Powerplans** are indicated by icon**.**

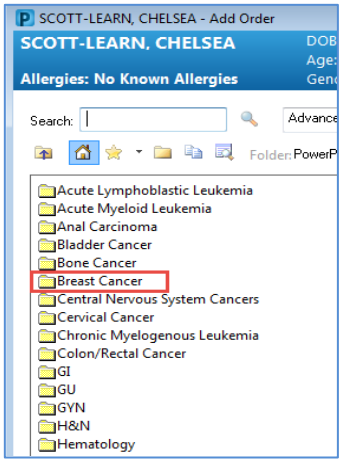
Regimen: A grouping of PowerPlans or individual cycles of treatment. One regimen may equal an entire protocol. Regimens allow clinicians to select a treatment regimen for a patient which shows the entire protocol including expected plans, cycles, dates of treatment, and status of each treatment cycle across time. Regimens can be viewed by clinicians to determine where a patient is in their treatment plan. The clinician view includes past, present, and future cycles of treatment. **Regimens** are indicated by icon**.**

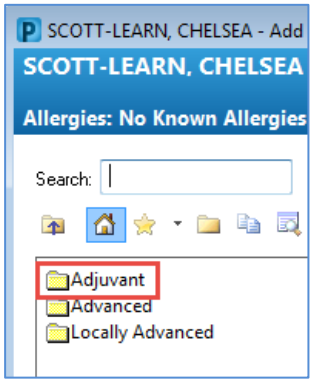
Note: the functionality of the regimen is different than a powerplan.

Naming convention for Oncology plans: ONC is the prefix for the naming convention of all Oncology plans.

From the orders tab click on The Powerplans, Chemotherapy folder → disease/tumor group→treatment intent→ Regimens/Powerplans







Hint: When searching for Oncology plans you can search by first two letters of tumor site (e.g. BR), protocol name, and/or ONC to filter list of Oncology plans.

Naming convention for PowerPlan: Oncology PowerPlans are indicated with a "P" indicating PowerPlan. (ex: 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). No additional action is required for time zero order within plans.

Regimens contain prebuilt Pretreatment Plans which may include:

- Labs
- Diagnostics
- Other supportive meds

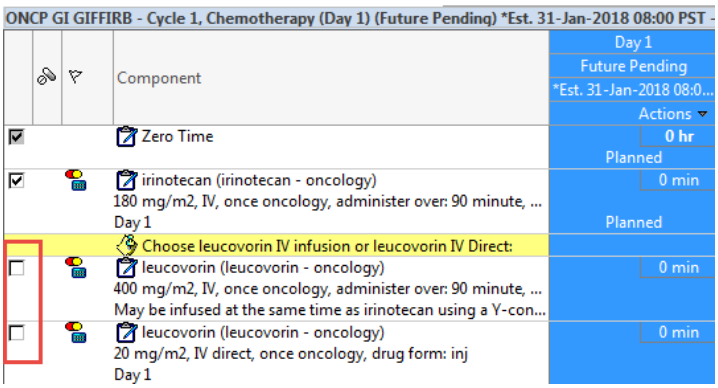
Oncology Powerplans are groups of orders categorized by phases, such as Chemotherapy, labs, diagnostics and scheduling which allow for orders within phases to be processed at different time points. The chemotherapy, diagnostic, and lab phases are future orders which require order completion (final doses) and activation. 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:

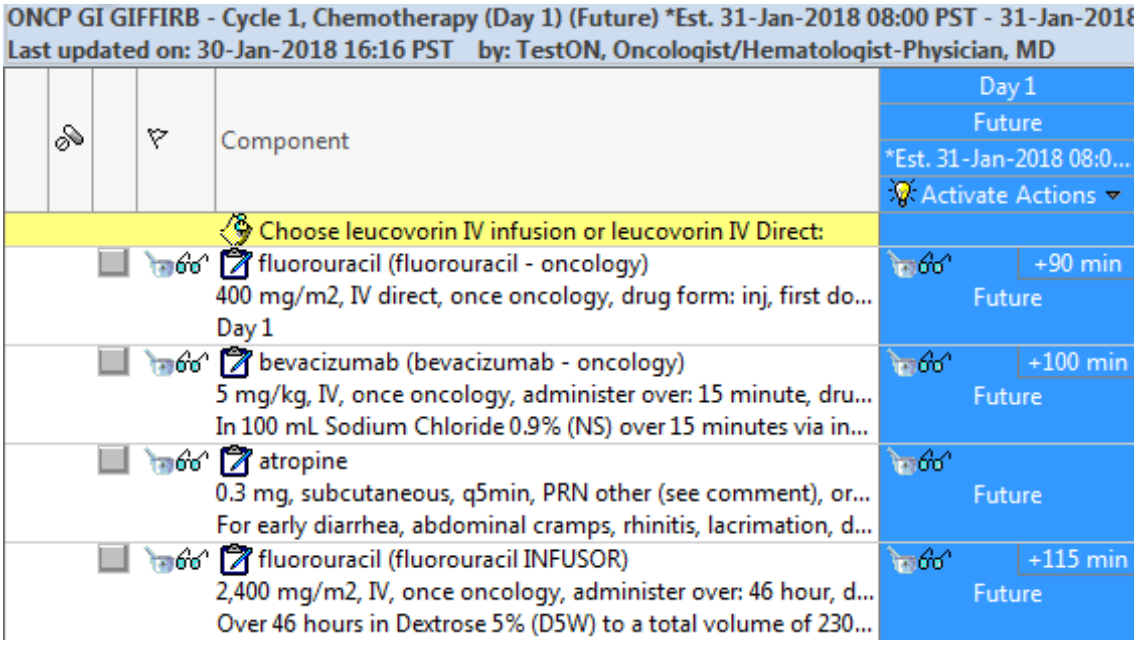
- Pre-chemo metrics (indicators)
- Pre or post hydration (if recommended in protocol)
- Pre-meds
- Chemotherapy
- Supportive medication

Future Orders and Planned State: The ideal workflow in PowerPlans is one in which the physician enters future order details on the orders in the phase and immediately 'future' initiates the phase. At future initiation (signing the orders), the orders in the phase enter a **Future** status. When the patient presents for the lab draw, or for treatment, the appropriate clinician then **Activates** the Orders from the **Future Orders View**, in the plan profile.

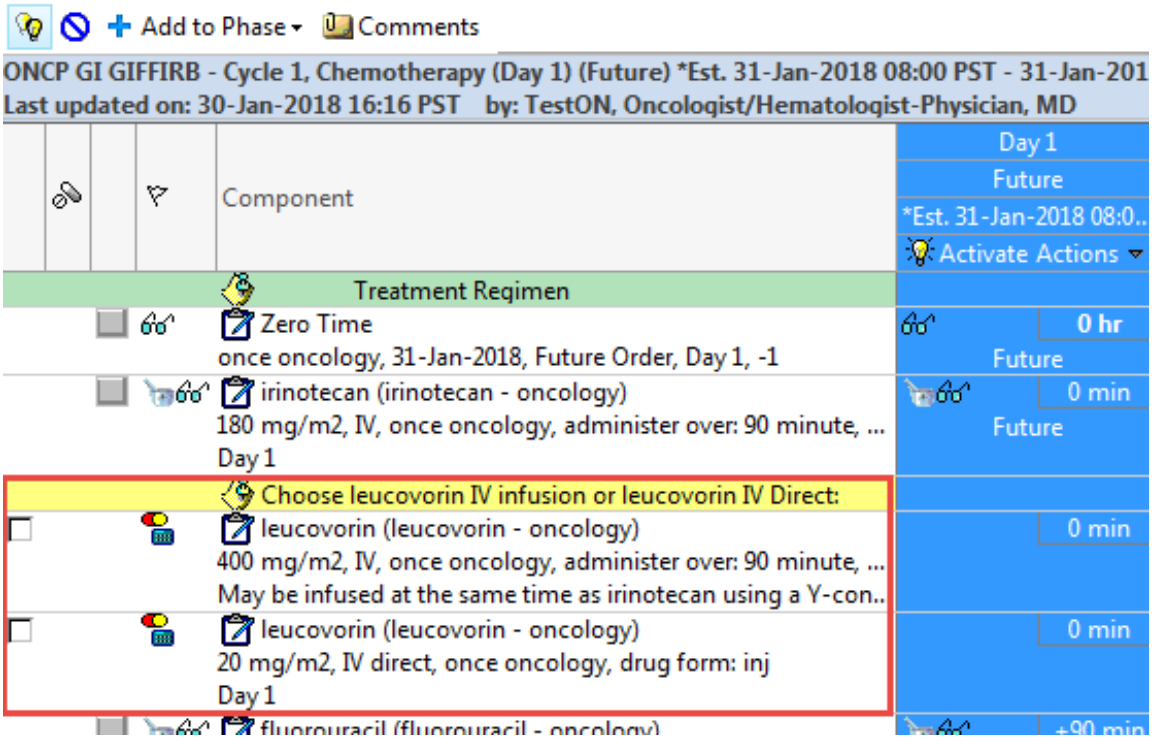
View Excluded Components is a feature within an Oncology PowerPlan that allows the provider to select a drug or IV fluid within a plan that was not originally selected upon initial plan placement. This feature allows the drug to remain with offsets pre-determined within the plan build. All of the components of a particular PowerPlan will be available for selection prior to signing. Some components are pre-selected, where others are optional. In the example below, the optional leucovorin treatments are not pre-selected.



Signing the orders without selecting one of the leucovorin options means that they will become an excluded component. In the Example below, the leucovorin does not display.



Clicking on the **View Excluded Components**  icon, will bring the orders not originally selected prior to signing back into view.

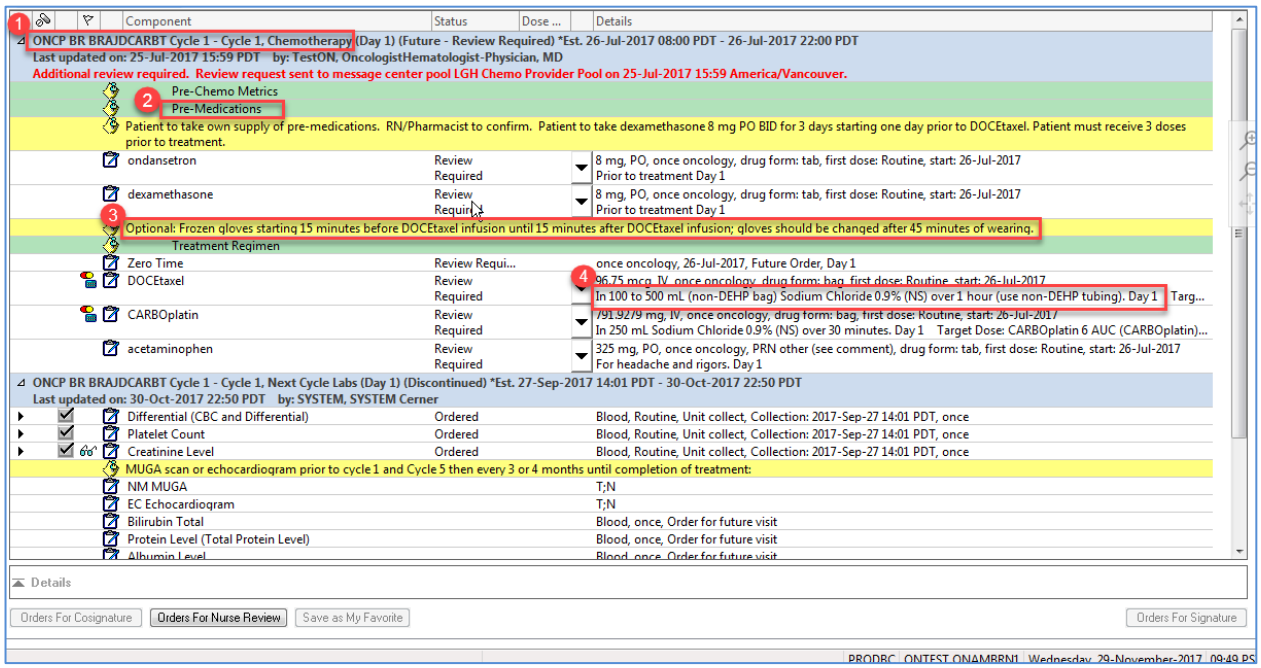


When viewing the orders, some things to make note of are**:**

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)

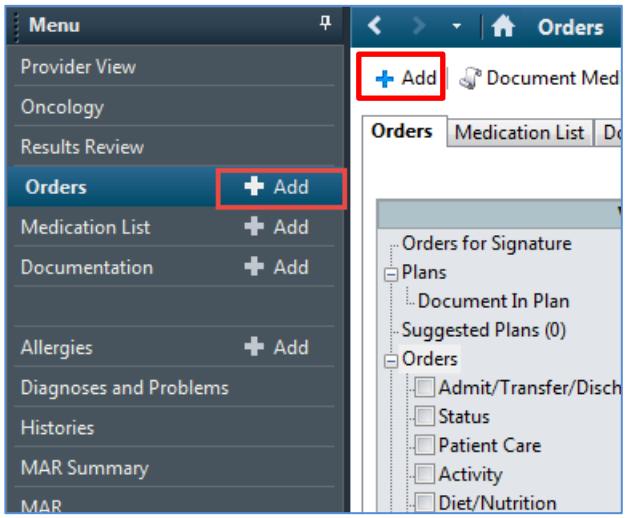
3. Yellow note types provide instructional information (e.g. Frozen Gloves, No Ice Chips, Ensure patient has taken pre-med, See Patient Handout)

4. Details contain instructions that are directed to the pharmacy for medication preparation or to nursing for medication administration (e.g. diluent information or special administration set details)



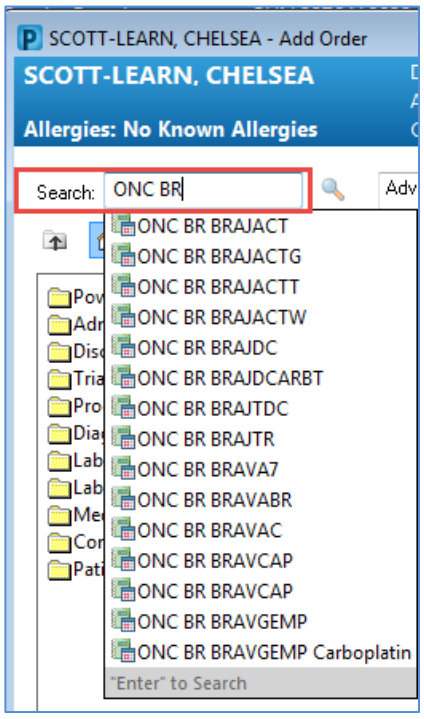
With your patient perform the following ordering tasks:

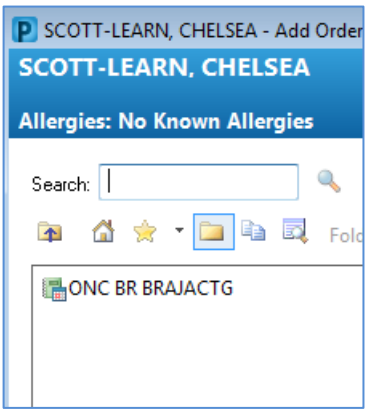
2 In order to place an order for a particular treatment, click on the + Add icon to right of **Orders** in the menu tab.



Note: You are able to access the Add New Order window by clicking the + Add icon above the orders tab.

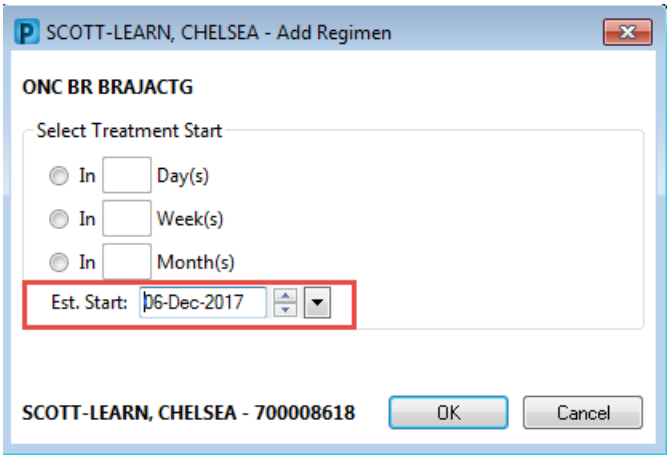
Search ONC BR to populate list of Oncology Breast plans. Select ONC BR BRAJACT-G Regimen.



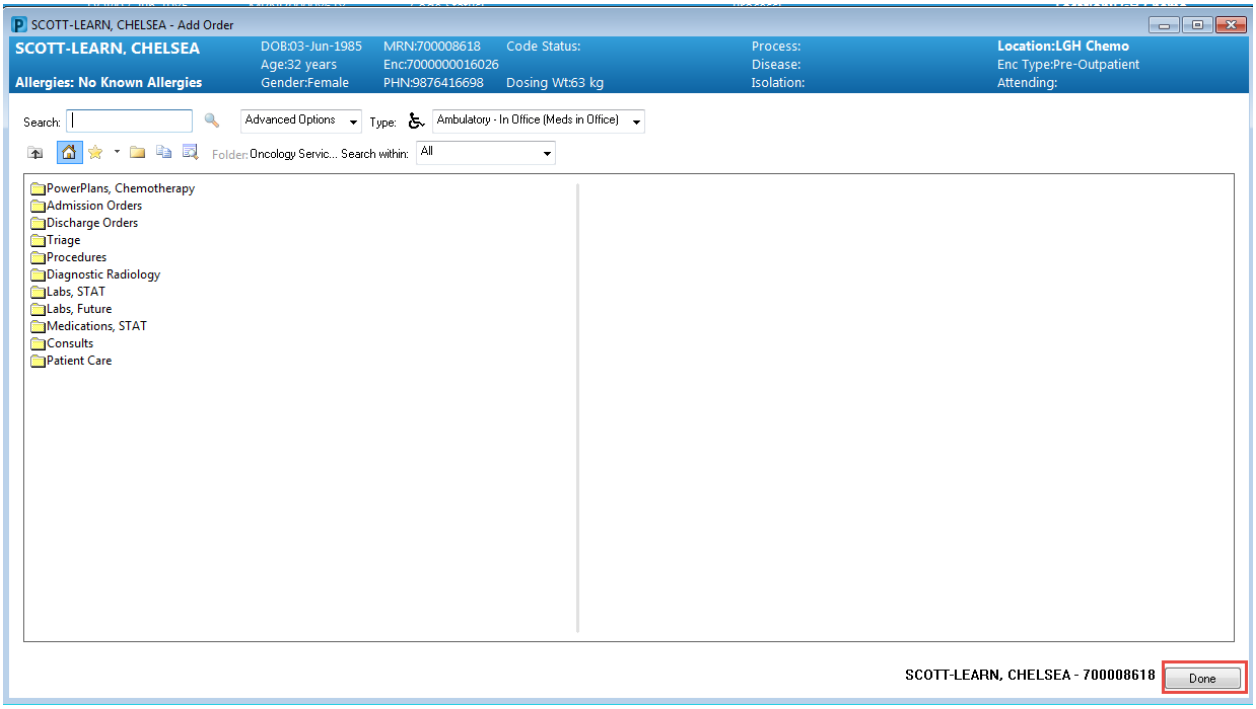


You will be required to enter an estimate start date/time. **Please note this is the READY TO TREAT date which will be used for reporting purposes**. For practice, enter today's date.

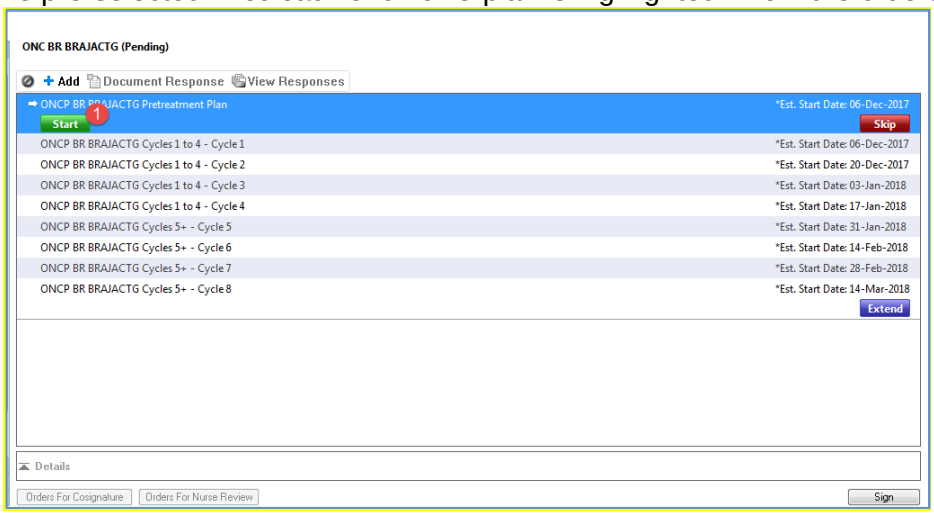
Note: Entering a value for the day, week(s), or month(s) field will automatically calculate the correct estimate start date and time from today. Click ok.



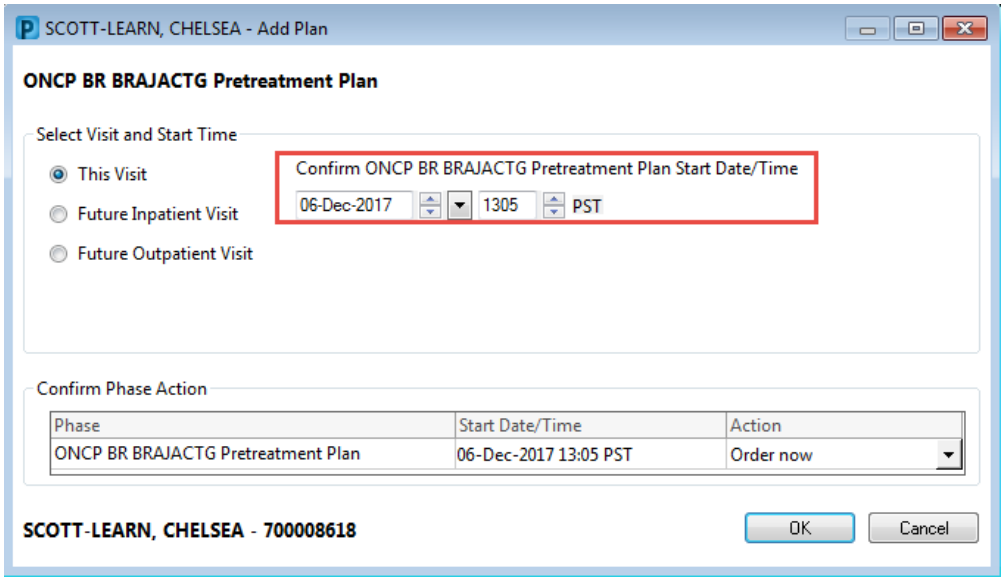
Click done in the add order window.



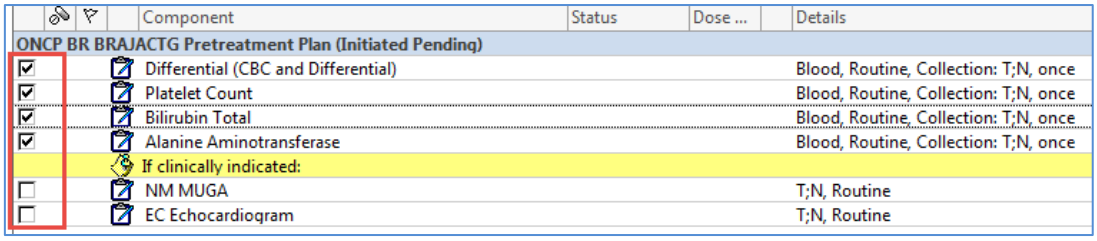
3 The pre-selected **Pretreatment** Powerplan is highlighted. From the orders profile view click **Start**.



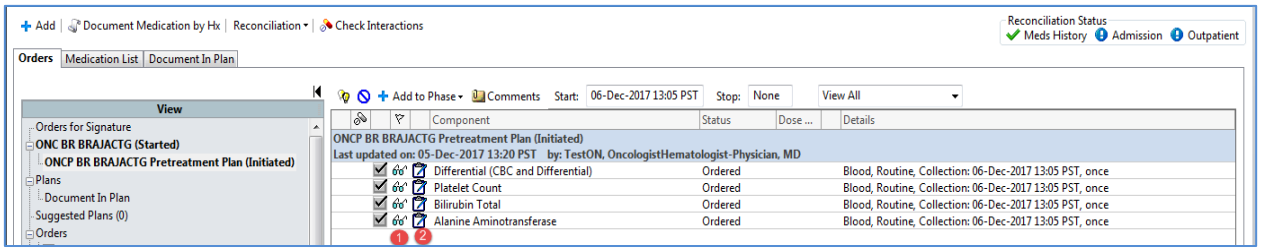
4 The add plan window opens. The ONCP BR BRAJACTG **Pretreatment Plan** is defaulted to start this visit. Confirm that the start date/time is correct and click **OK**.



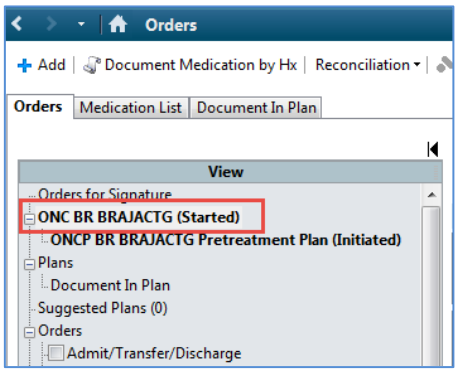
5 You are able to select and deselect pre-labs and diagnostics here by clicking the box to left side of the order within the ONCP BR BRAJACTG **Pretreatment Plan**.



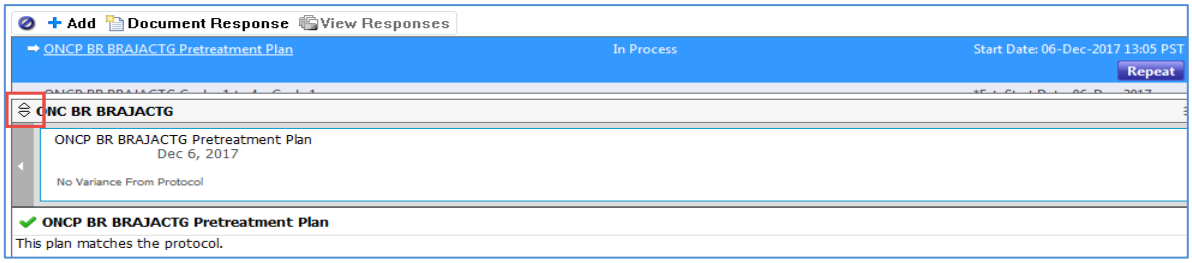
Click **Orders for Signature**. Review orders one last time and click **Sign**. Click . Note the icon to the left of the order (1) indicates order requires Nurse review and the icon indicates an order (2).



6 Click on ONC P BR BRAJACTG in orders profile.

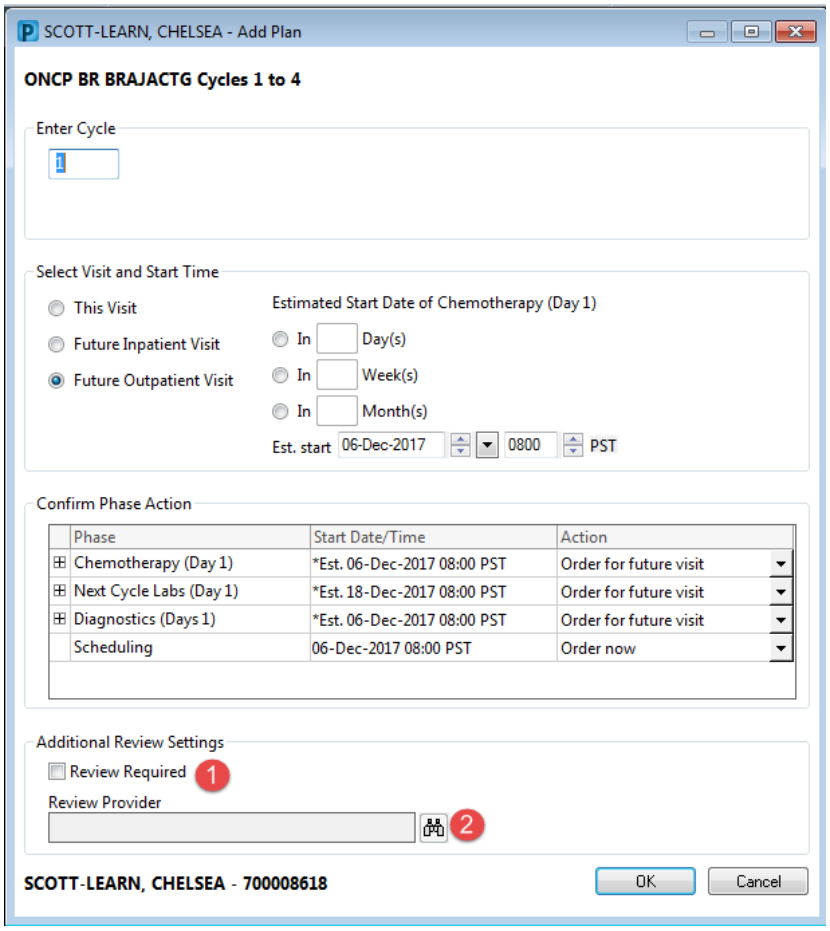


Click the down arrow to the left of the ONCP BR BRAJACTG **Pretreatment Powerplan** to minimize the Pretreatment plan. You can now view all of the cycles within the **Regimen**.



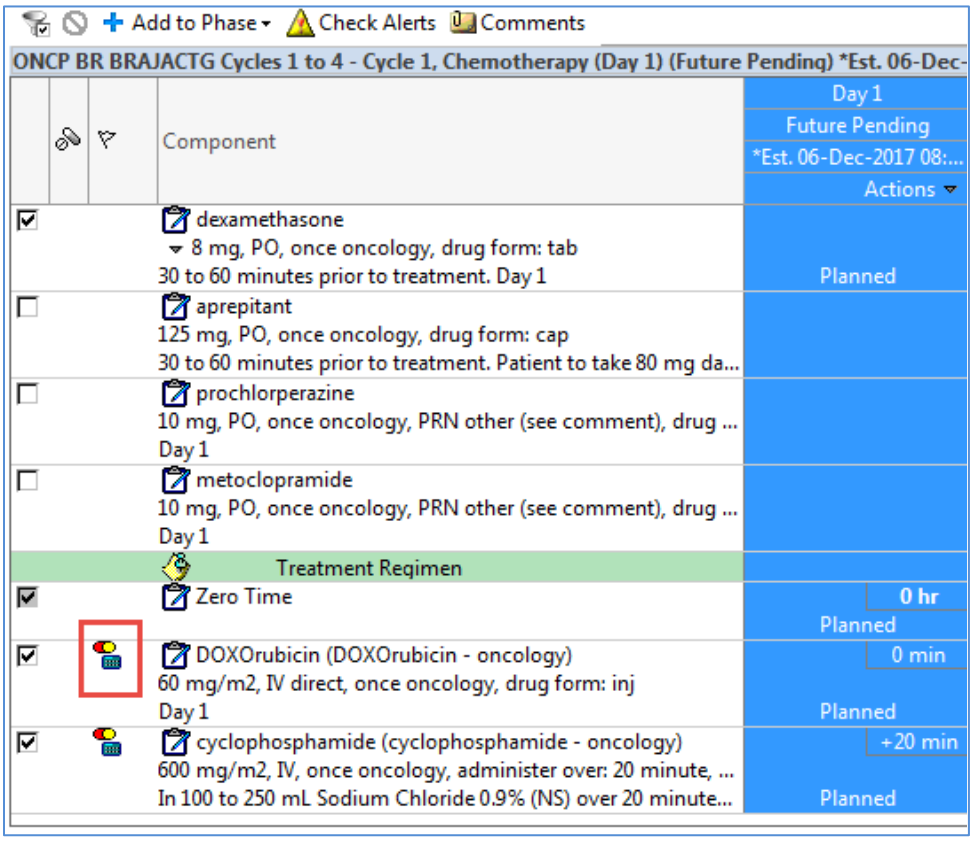
Click Start

7 The **Add Plan** window opens. Confirm the plan details here.



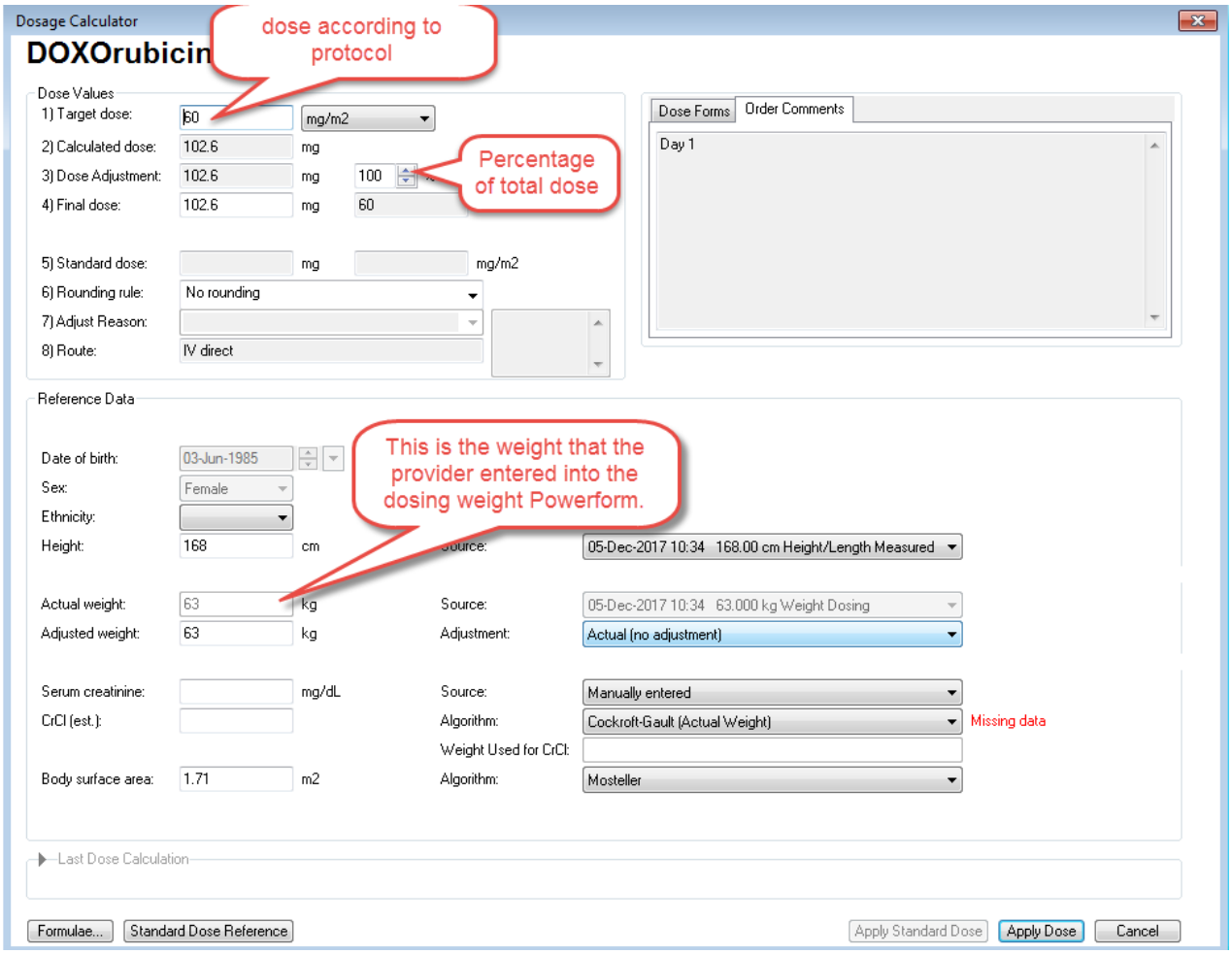
Note: If additional provider review is required click on the Review Required box (1) and search for Provider using the  icon. Click **OK**.

8 From the orders profile review the pre-selected pre-medications, pre-metrics, supportive medications, etc. Click on the icon beside the Doxorubicin order to access the dosing calculator.



Note: The pre-chemo metrics are predefined within the plans and built as indicators. You can filter the Regimen by preselected orders here using the funnel icon . Find the first Chemotherapy drug within the Chemotherapy phase.

Confirm the dosing details and click **Apply Dose**.



Note: Once the dose is applied (verified) the order sentence will become bold.

You will now be returned to the order profile screen. Access the **Dosing Calculator** for the Cyclophosphamide and repeat the dosing calculator review for all of the weight/BSA based medication dosing as needed.

9 Click Orders For Signature . Click Sign. Click refresh 2 ho.

Key Learning Points

- PowerPlans are equivalent to one Cycle of a Protocol
- Regimens are collections of PowerPlans, equivalent to an entire Protocol
- PreTreatment Plans may contain Labs, Diagnostics and some Supportive Meds
- The Dosing Calculator will need to be accessed for all weight/BSA based medications

PATIENT SCENARIO 4 – Clinic Note Documentation

Learning Objectives

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

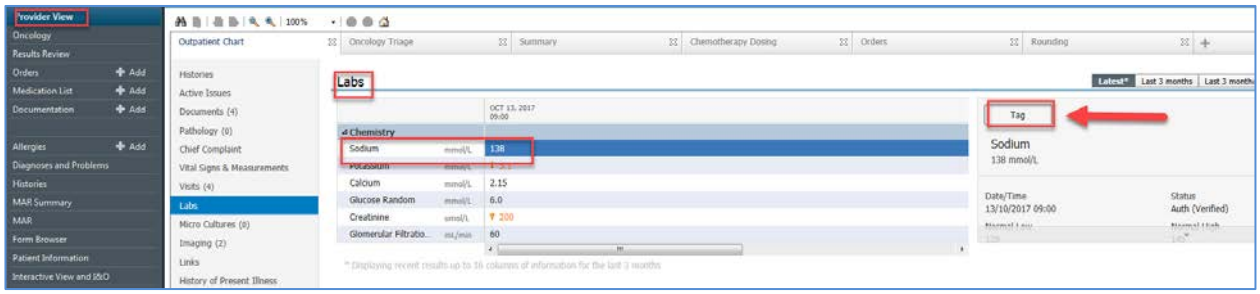
- Tag results for inclusion in a Note.
- Select appropriate Note Types and Templates
- Utilize Auto or Free text to populate a Clinical Note.

SCENARIO

Now that the patient's reason for visiting the clinic has been addressed, you will complete your documentation for the visit.

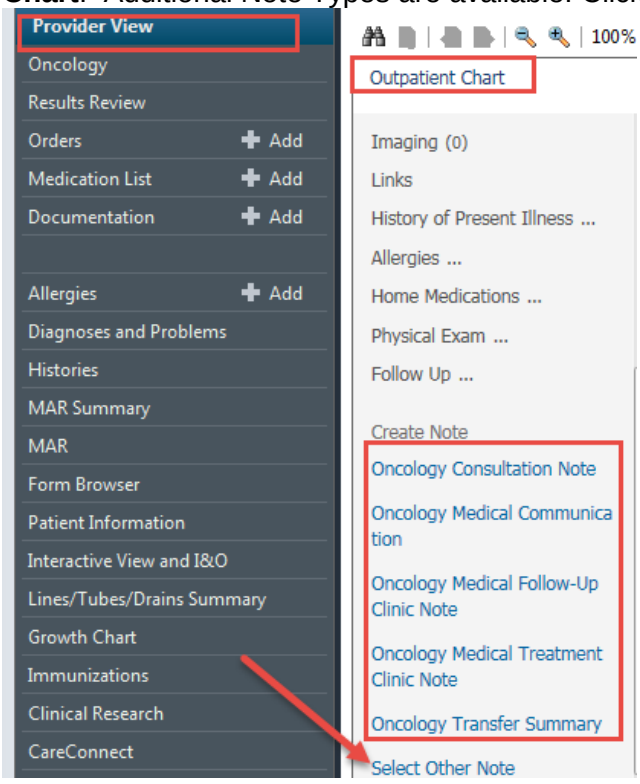
Activity 4.1 – Creating a Note

1 Start by “tagging” some results for inclusion in a Clinical Note. From the **Provider View**, click on **Labs** within the **Outpatient Chart** tab. Choose which values are pertinent; click on them one by one then click tag. Alternatively, hold the Shift key down and select multiple results to Tag all at once.

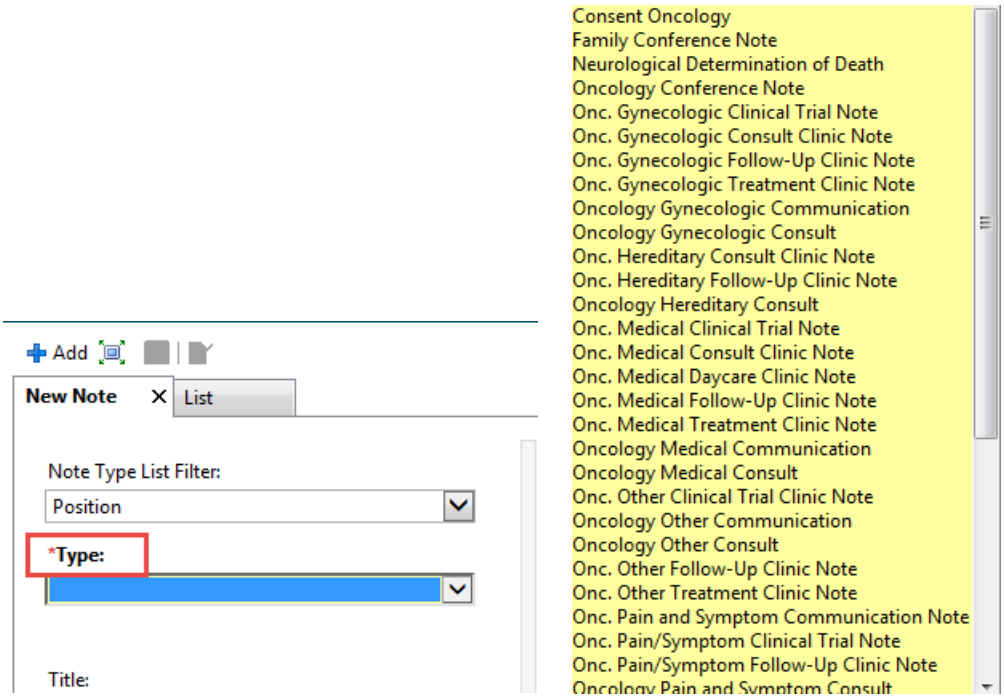


Note: the recommended workflow is to Tag results that you may wish to include in a Clinical Note at the time of reviewing the results

2 The top 5 communication note types display at the bottom left hand corner of the **Outpatient Chart**. Additional Note Types are available. Click **Select Other Note.**

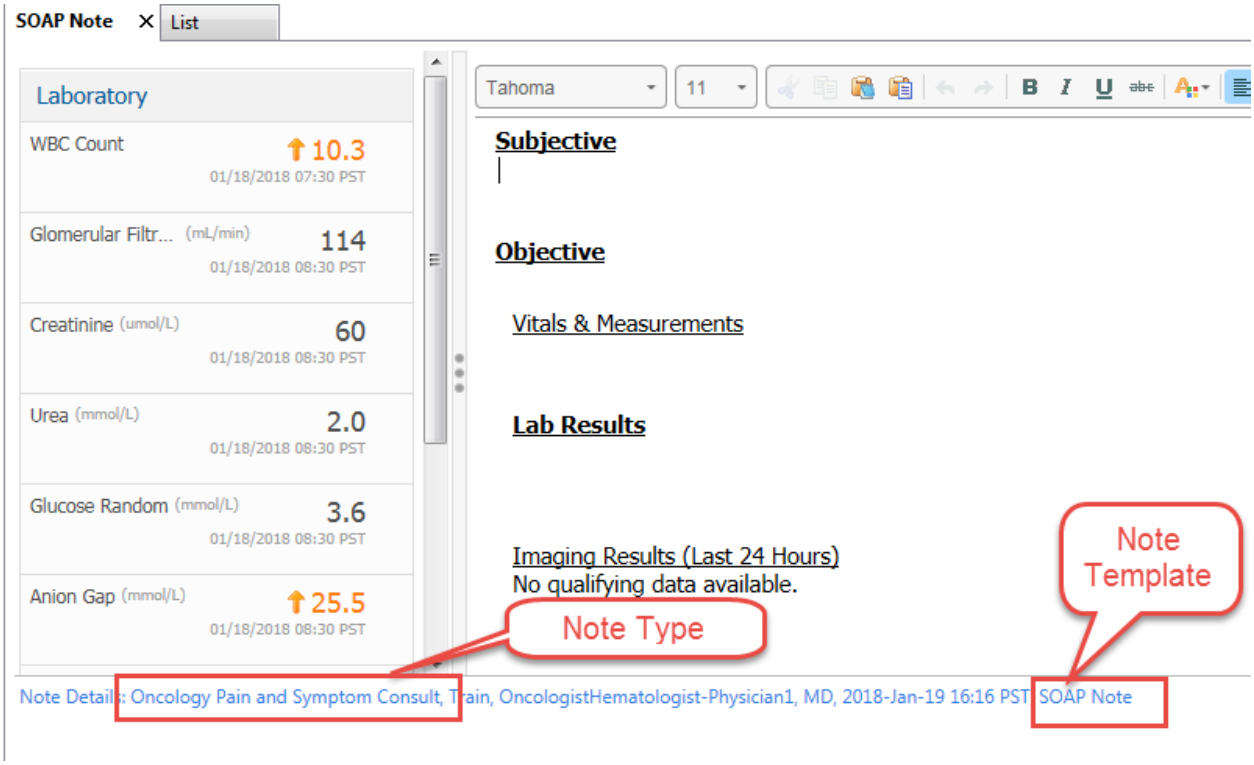


3 Click on Type to see the selection of available Note Types.

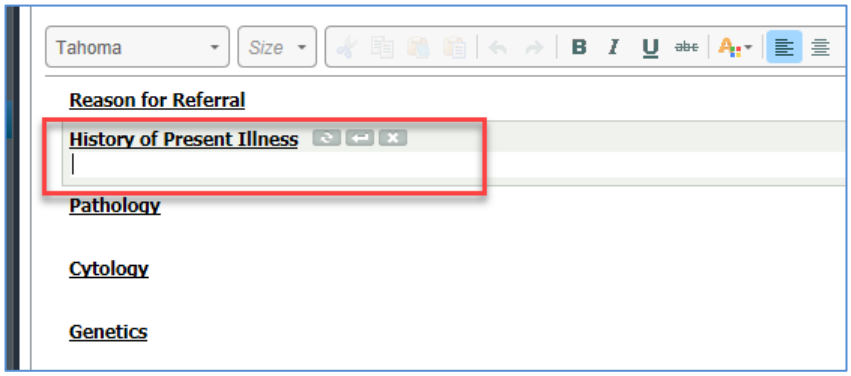


4 Once you have selected your Note Type you must also select a template. Note Templates allow you to organize your note with headers and use the related auto text.

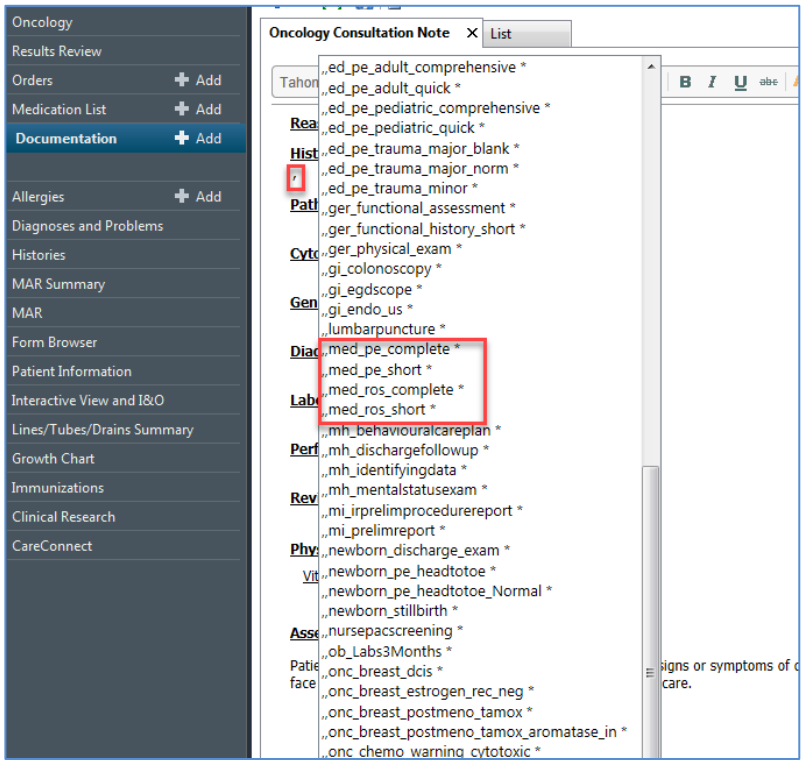
5 Try this; select the Note Type for Oncology Pain and Symptom Consult and the SOAP Note template and then click OK. You will know that you have done this right based on the details that appear at the bottom of your blank note.



6 Now, go back to your top five list and click on Oncology Consultation Note. Hover around headings within the note to refresh, insert free text or remove the heading from the note altogether.

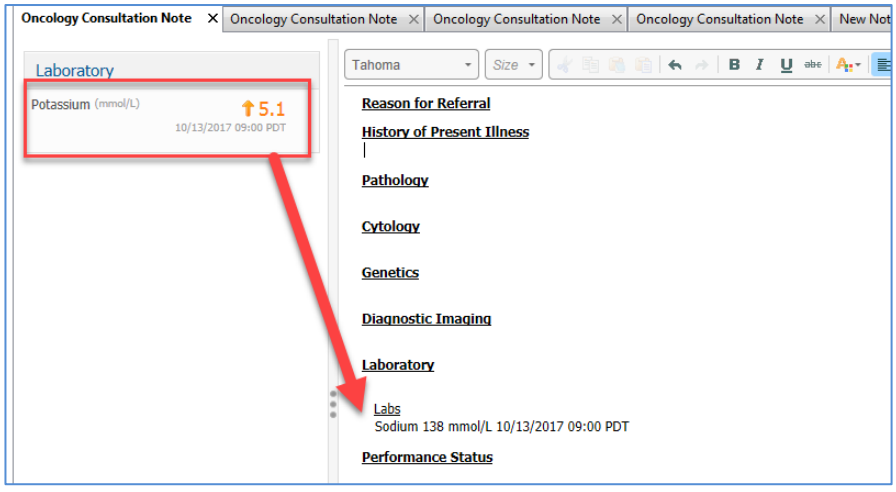


7 You can free text in the available space under each heading. Alternatively you can use auto text by typing a comma (,) and a drop down box opens. The commonly used oncology auto text can be found by typing **,,onc**. Double-click to choose an auto text and the chosen text will then automatically populate for you to edit as necessary.



Front End Speech Recognition (FESR) can also be used to populate the clinical notes.

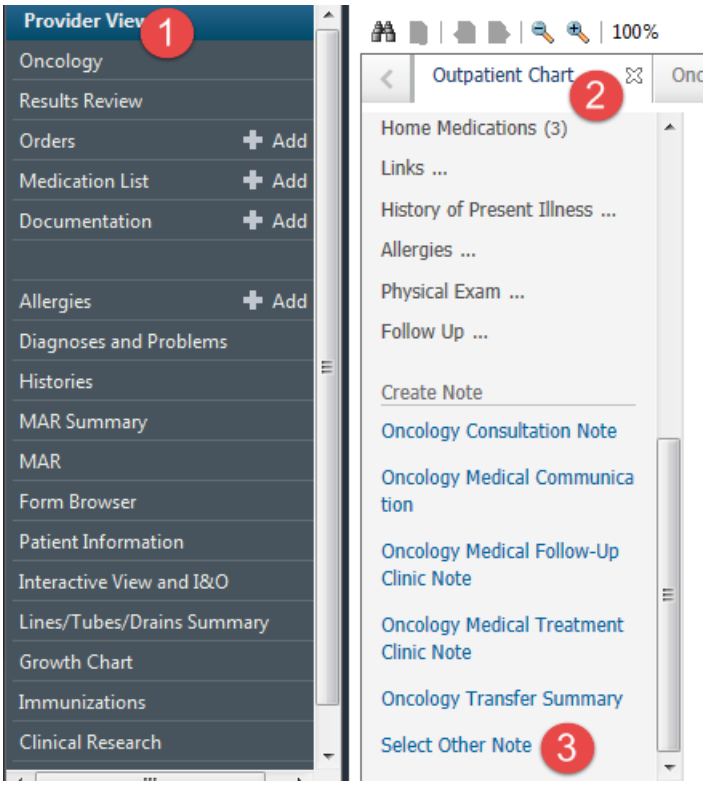
8 The lab values that you tagged will be on the left. Drag and drop these to the Lab section.

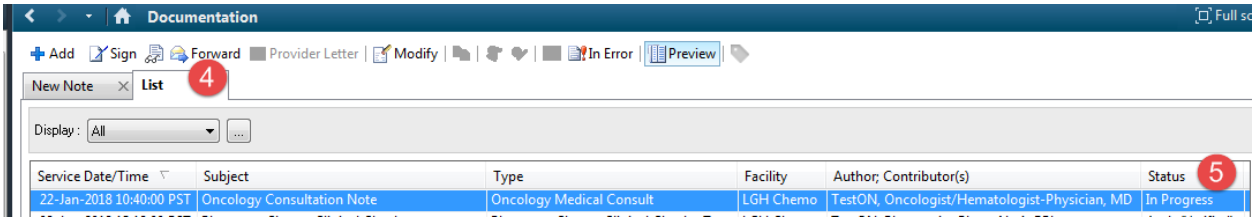


9 Continue to fill out your note. To complete documentation at a later time; click Save & Close at the bottom of the window. Your unfinished note will be under Documentation and the Status will be "In Progress."

Note: Documents in progress are not visible to other health care professionals.

10 When ready to finalize the note, go to **Provider View** and within the **Outpatient Chart**, select **Other Note,** click on **List** and choose the Note that you want to complete. Click **Sign/Submit** when done.





Key Learning Points

- You can access the most commonly used Note Types from the Outpatient Tab in the Provider View.
- Auto-Text can be used within the ‘Free-Text’ areas of a note. You access this by using a (,)
- FESR can also be used to populate a Note.
- While reviewing results, you can Tag them to easily pull them into your note.
- Remember, if you Save a note without signing it, it will not be visible to others.

End Workbook One

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