SELF-GUIDED PRACTICE WORKBOOK [N149]
CST Transformational Learning

WORKBOOK TITLE:

Nurse – Oncology Inpatient

Last Updated: Jan 19, 2024

TABLE OF CONTENTS

SELF-DIRECTED PRACTICE WORKBOOK

Duration	**Estimate 7 hours**
Session Expectations	- This is a self-directed learning session. - The workbook provides a compilation of workflow scenarios and activities that are applicable to your role and work setting. They may not be in the exact chronological order that is outlined in your practice. - You will log into a practice training domain to complete activities described in this workbook. It has been designed to replicate the CST Cerner environment experience. - You will acquire a unique login, patient, and location to use in the training domain while following workbook instructions. For information on how to obtain your training login information, please see your CST Learning Journey email. - The learning activities will assist you to consolidate the skills and competencies required for using CST Cerner in the Inpatient and Ambulatory setting. - Not all professions use CST Cerner in the same way, so read carefully for instructions about activities that apply to your role.
Knowledge Quiz	- After completion of this workbook, there is a Quiz in Learning Hub related to this course that you are required to pass before being granted access to CST Cerner. - Your Practice Leads or others at your site may have additional learning activities planned.

USING TRAIN DOMAIN

You will use an online practice training domain to complete activities in this workbook (somewhat like a simulation). It has been designed to replicate CST Cerner as closely as possible.

Each learner has a unique training login that includes patient(s), location, and encounter number(s). You will check out your login information to use while following the instructions in the workbook. Instructions on how to check out your training domain information can be found in your Learning Journey email.

Please note:

- Scenarios and their activities demonstrate CST Cerner functionality in a broad overall workflow.
- An attempt has been made to replicate clinical scenarios but these will not correspond exactly with your live patients and workflow. Medications, diagnoses, and care plan activities may not be clinically accurate.
- Some clinical scenario details have been simplified for training purposes.
- Screenshot images in the workbook approximate what you see on the practice train domain screen but will not be identical. The screenshots are meant to give an idea where on the screen to look but specific names and data in the images should not be used. Instead, use your checked out login information. (For example, you may see a patient named Sara in a screenshot, but your checked out patient name is John. Use the patient's name John for your activity).
- Note recent updates to design are not reflected in the train domain. This includes orders within Regimens and PowerPlans. Any changes will be available in the clinical setting.
- Follow all written instructions to complete your activities.
- This icon denotes **Read Only** or **View Only** sections in the workbook where you review the material but do not perform an activity.
- Please refer to the resources sent to you in the CST Learning Journey email if you have any questions or require further assistance.

It is recommended that you complete the workbook in one sitting because the Training Domain environment resets every evening at 11:30 pm. Changes you have made will be lost and you will need to repeat the process of signing out a login and patients.

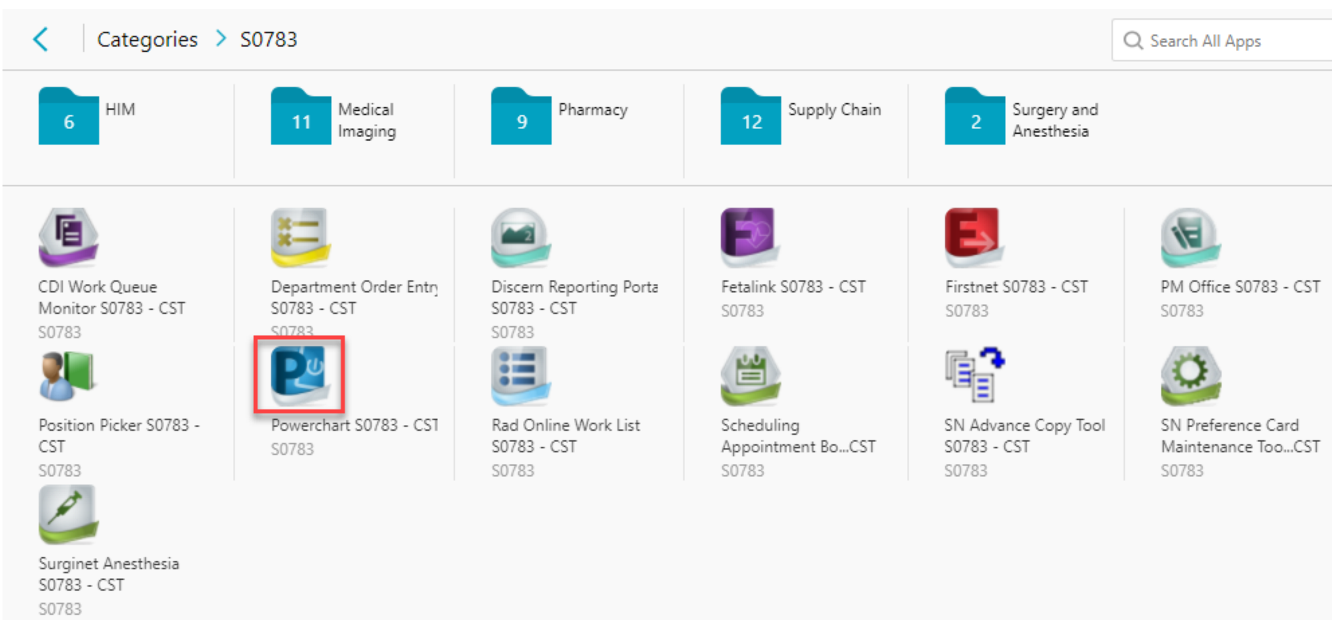
APPLICATION SELECTION

Upon logging on to CST Cerner you are presented with several folders to select from.

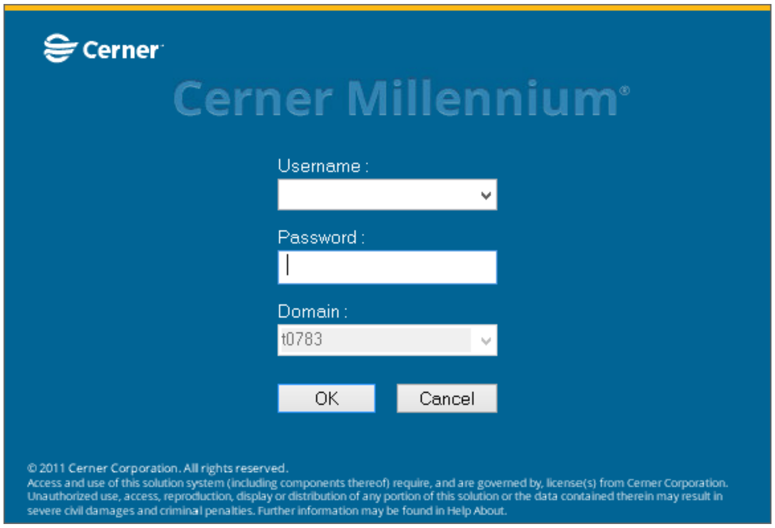
1. Please refer to the login instructions that you were provided and select the domain that was assigned to you by clicking on the corresponding folder.

Within these folders you will find a number of applications that are specific to different roles.

2. Select PowerChart by clicking on the **PowerChart**  icon.



3. Enter the login credentials provided to log into PowerChart.



PATIENT SCENARIO 1 – First Day Accessing CST Cerner

Learning Objectives
At the end of this Scenario, you will be able to: ▪ Create a Location Patient List ▪ Create a Custom Patient List ▪ Add a Patient from a Location Patient List to a Custom Patient List

SCENARIO

You are starting your shift on the unit using a new electronic clinical charting system, **CST Cerner**. You need to set up Patient Lists before adding your assigned patients and proceeding to other routines using CST Cerner.

You will complete the following activities:

- Landing Page Overview
- Create Patient Lists

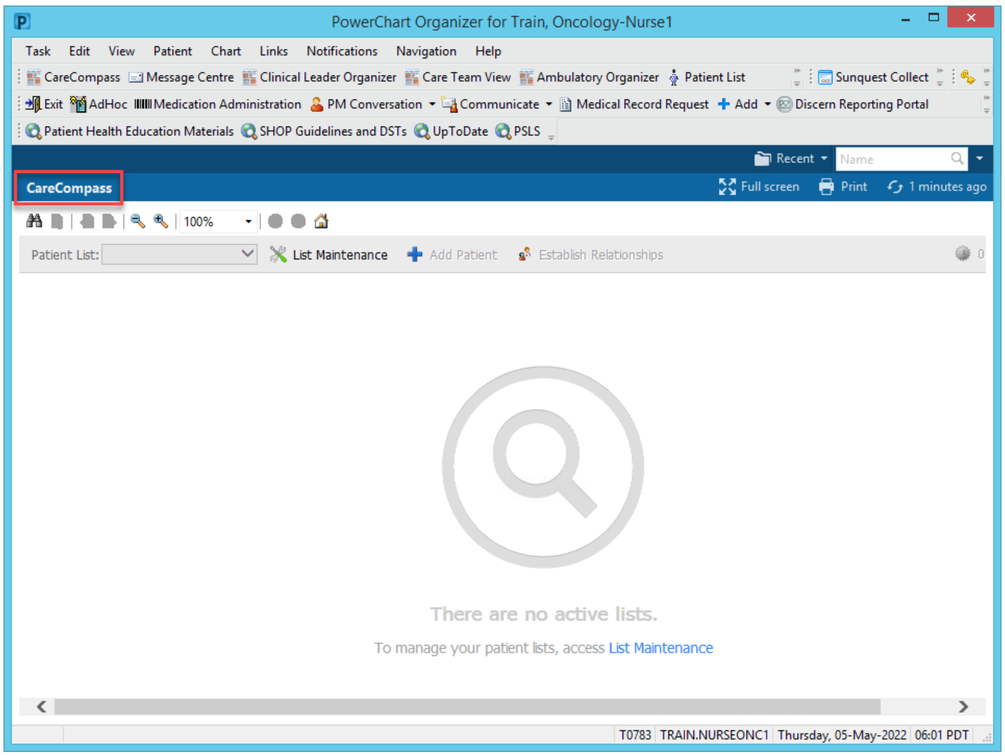
For the following activities, select the name of **patient A** as assigned to you from your CST Cerner Learning – Your workbook's logins and patients email.

Activity 1.1 – Overview of the Landing Page

Read Only

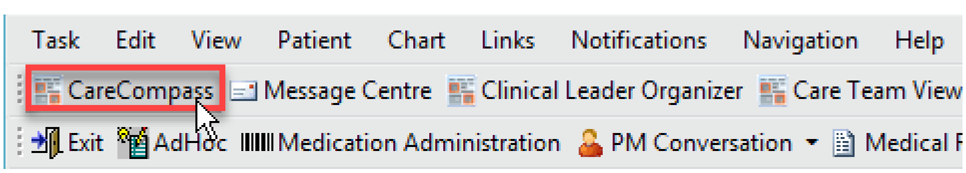
Different CST Cerner positions will have different landing pages. Each time you log into CST Cerner as an Oncology Inpatient Nurse, your landing page is **CareCompass**. CareCompass is used when you work in an inpatient unit (e.g. medical or surgical ward) and will be discussed later in the workbook.

When you access CareCompass for the first time, it appears blank. You will need to create patient lists in order to view patients in CareCompass.

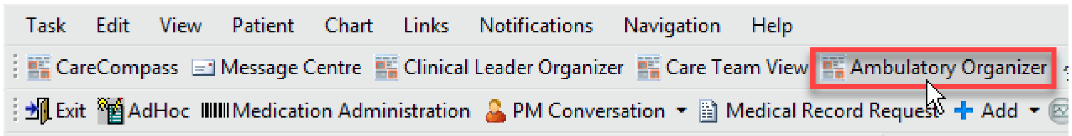


NOTES:

- Any application customized to be a landing page can also be accessed from your tool bar.



- Nurses who also work in the outpatient setting can access their clinic schedule by clicking on the **Ambulatory Organizer** in the toolbar. More information will be provided at the end of this workbook.



Key Learning Points

- The landing page for the Oncology Inpatient Nurse is **CareCompass**.
- CareCompass is used when you work in an inpatient unit.
- CareCompass is not used in the outpatient setting.
- Nurses who also work in the outpatient setting can access their clinic schedule by clicking on the Ambulatory Organizer in the toolbar.

Activity 1.2–Create Patient Lists

Patient Lists assist Providers and Clinicians in organizing patient data and locating patient charts. They are one of the methods for accessing your patient's chart because they can minimize the instances of selecting the incorrect **Encounter**.

As you learned in the required eLearning modules, selecting the right **Encounter** when documenting on a patient's chart is of utmost importance as not doing so can severely impact your patient's care.

There are two types of patient lists:

- **Automatically** populated by CST Cerner based on the selected criteria. For example, you can create a list of patients that are under a specific **Location**, **Medical Service**, and/or **Visit Relationship**. In this type of patient list, patients will be automatically dropped off the list once they do not meet the selected criteria.
- **Manually** maintained by the end user so that you can add or remove patients from the list (e.g. **Custom List**).

We will create a **Location** list and a **Custom** list in the following activities. This will allow you to select them when using CareCompass.

Location List

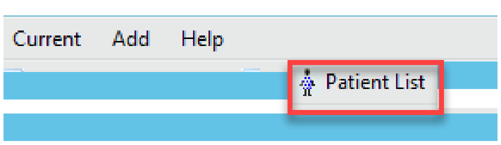
The **location list** will provide a list of patients by location. This can include wards and departments within the hospital.

NOTES:

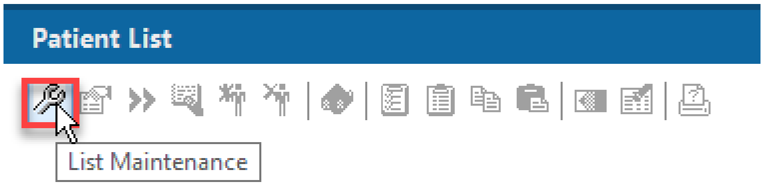
- If criteria are too wide, the list will take a long time to load and might have more patients than you need.
- If criteria are too narrow, you might not see the names of patients you need.

If a location list is not already created in the train domain for **BCC VA 5 East**, complete the following steps to create a location list:

1. Click on the **Patient List** icon in the toolbar.

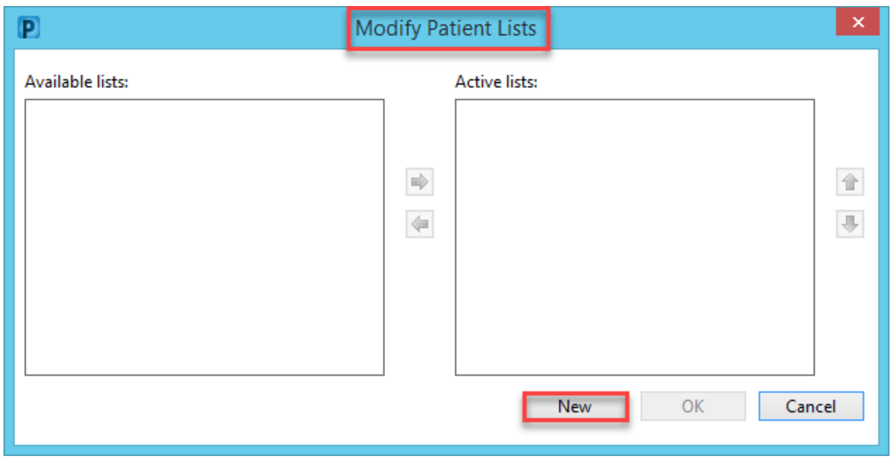


2. Click on the **List Maintenance**  icon.



The **Modify Patient Lists** window opens.

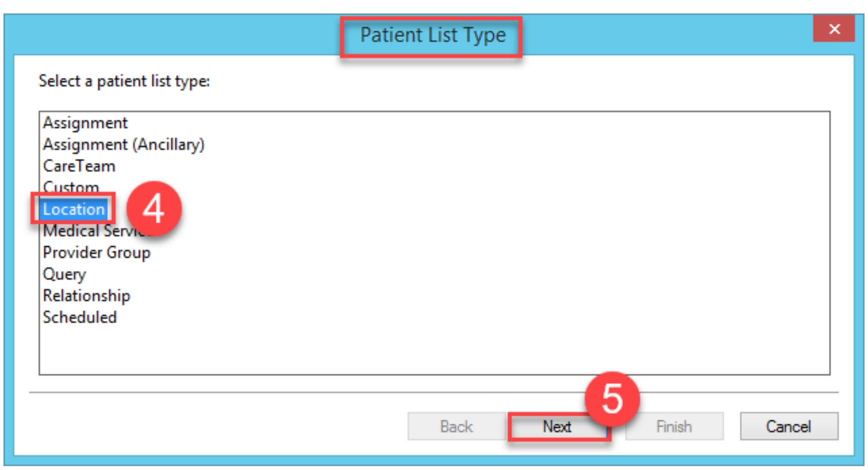
3. Click **New**.



A **Patient List Type** window opens.

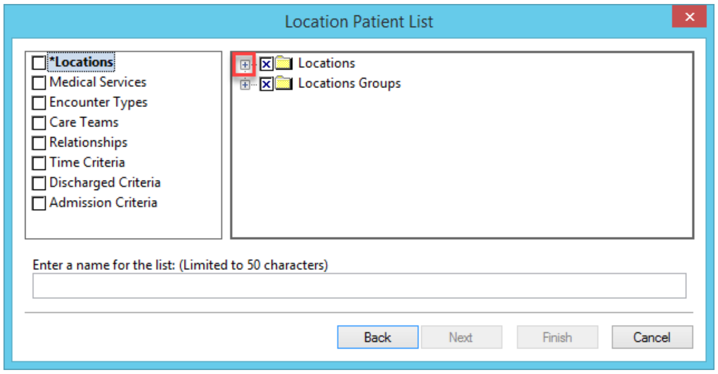
4. Select **Location**.

5. Click **Next**.



The **Location Patient List** window opens.

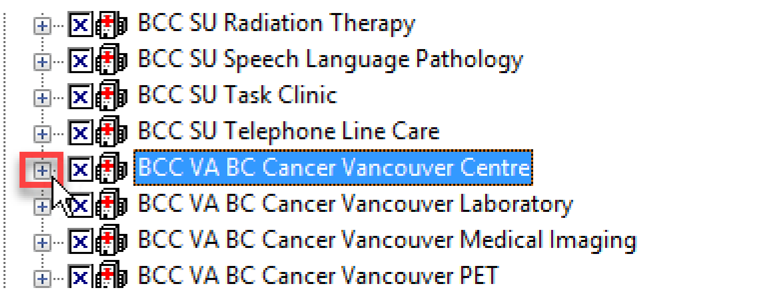
6. Click the **+ icon** to expand the Locations folder.



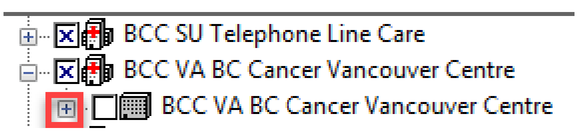
A location tree will display.

For this example, we will select **BCC VA BC Cancer Vancouver Centre**.

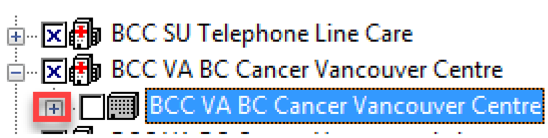
7. Click on the **+ icon** next to BCC VA BC Cancer Vancouver Centre location.



8. Click the **+ icon** again to expand the tree further.



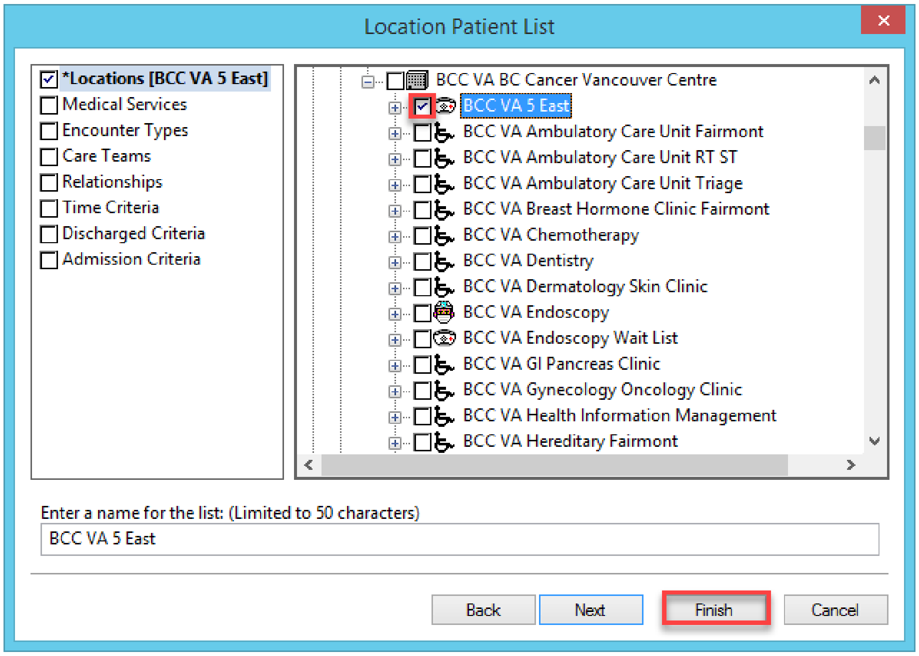
9. Click the **+ icon** further to expand BCC VA BC Cancer Vancouver Centre.



10. Click on the box next to **BCC VA 5 East** to select the location.

11. Note the List name automatically appears in the **Enter a name for the list** field.

12. Click **Finish** located at the far bottom right of the window.

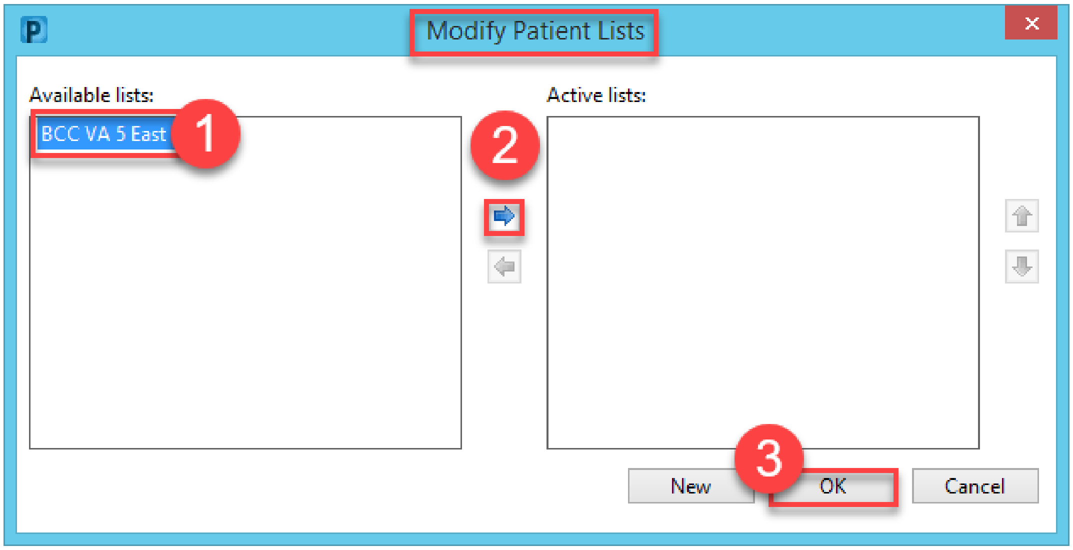


A **Modify Patient Lists** window opens.

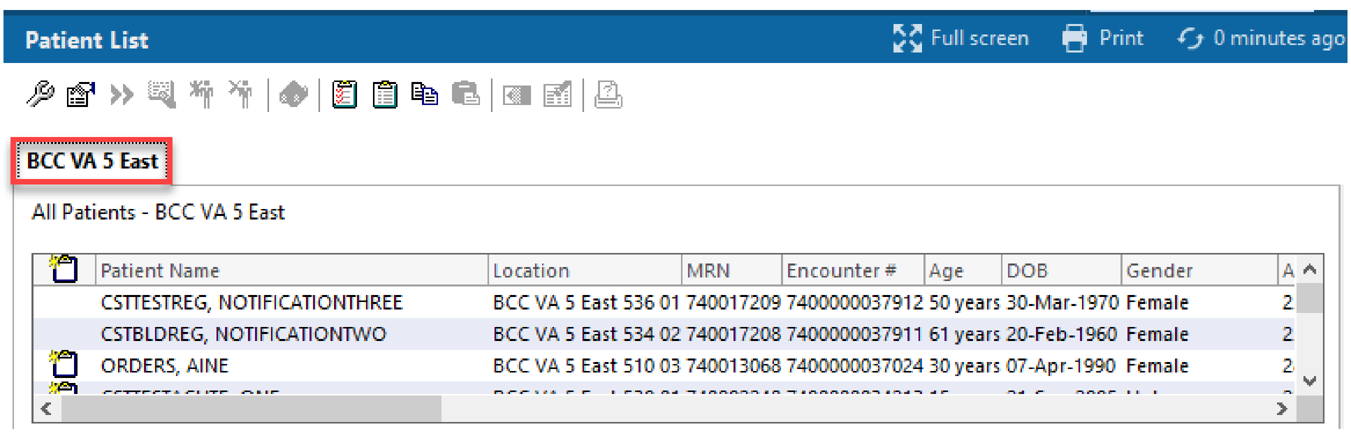
You have now created a Location List; however, it is not active. It is listed under the available list

To activate an available list:

1. Click the **Location list** you have just created.
2. Click on the **Arrow** to move it from the Available lists to the Active lists.
3. Click **OK**.



The new location list tab is now added. You may need to click the **Refresh** button to update the list display.



Custom List

Next you need to create a Custom Patient List that allows you to manually add patient(s) that is assigned to you and/or you cover for your colleague during breaks.

1. Click the **List Maintenance** icon.

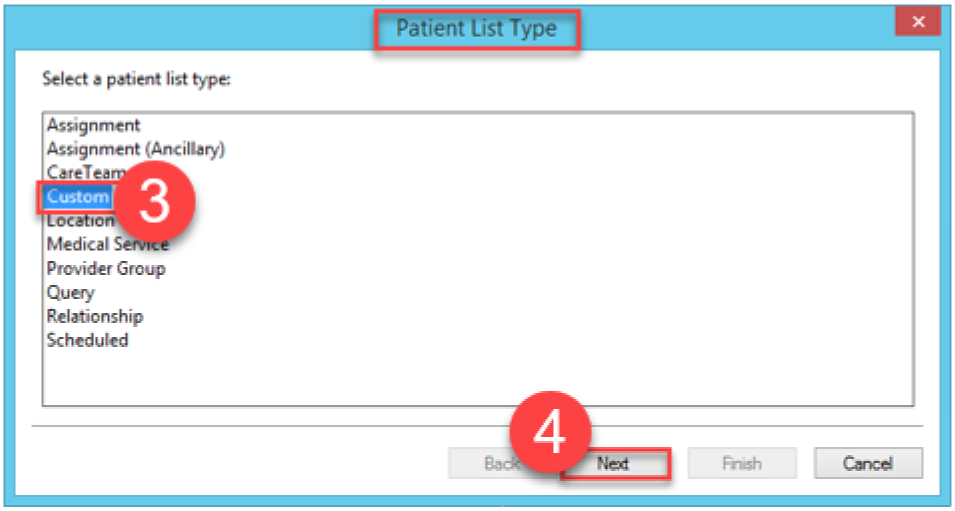
   A **Modify Patient Lists** window opens.

2. Click **New**.

   A **Patient List Type** window opens.

3. Select **Custom**.

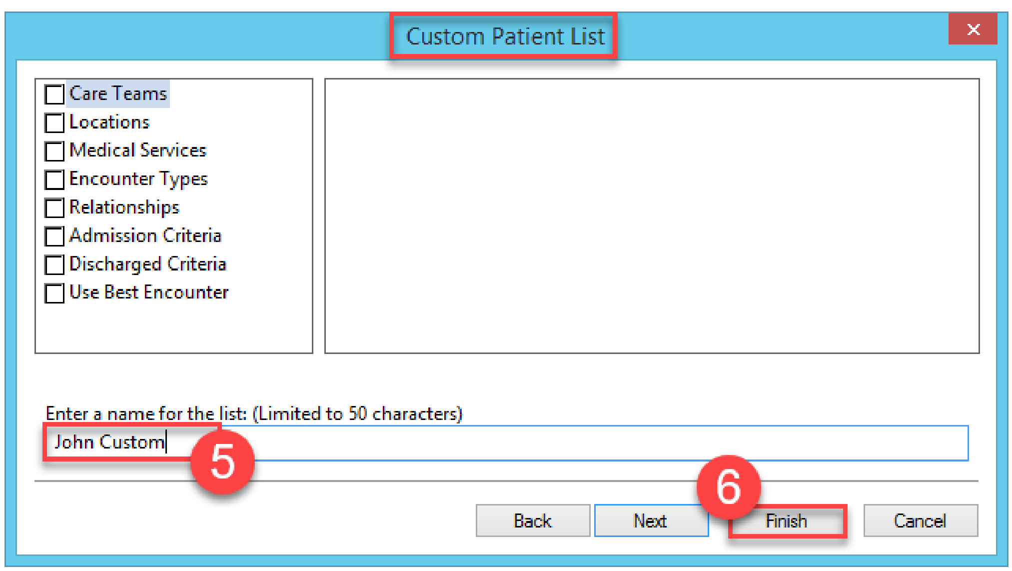
4. Click **Next**.



A **Custom Patient List** window opens.

5. Type in a name for the list = ***YourName Custom*** (for example *John Custom*) in the Custom Patient List window. Custom Lists need a unique name.

6. Click **Finish**.

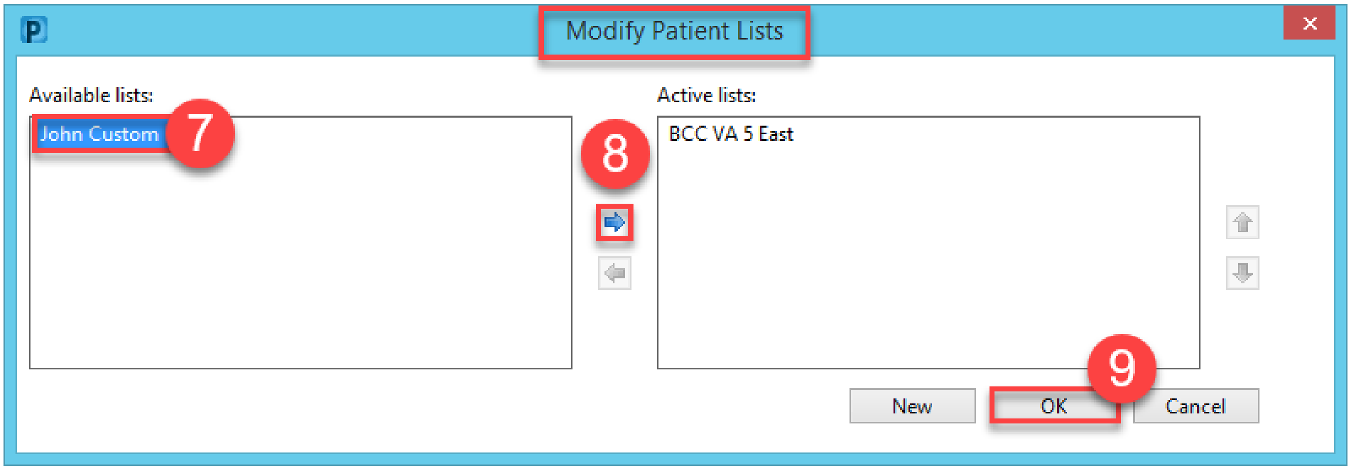


The **Modify Patient Lists** window opens.

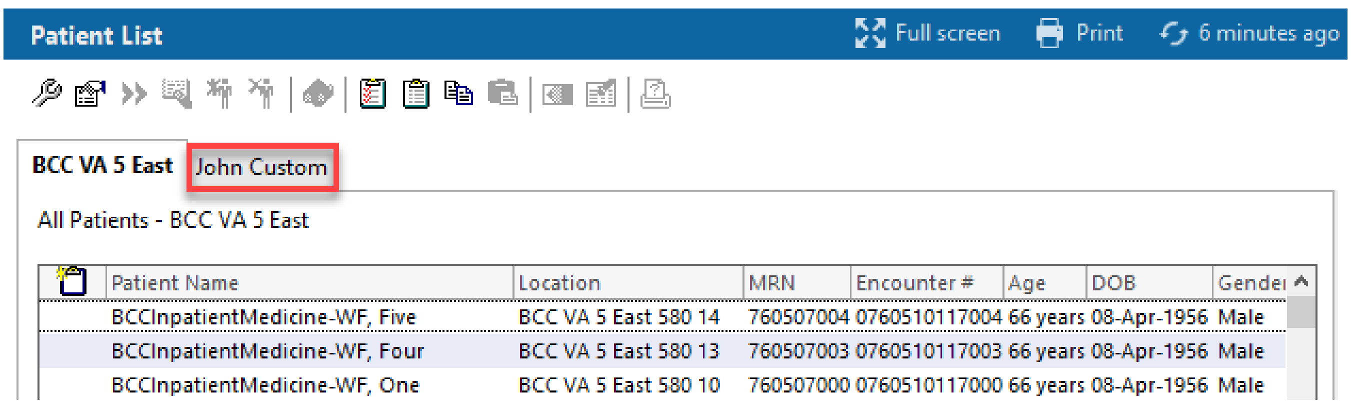
7. Select the newly created **Custom List**.

8. Click the **blue arrow icon** to move your Custom List to the right, under Active Lists.

9. Click **OK**.



The new custom list tab is now added.



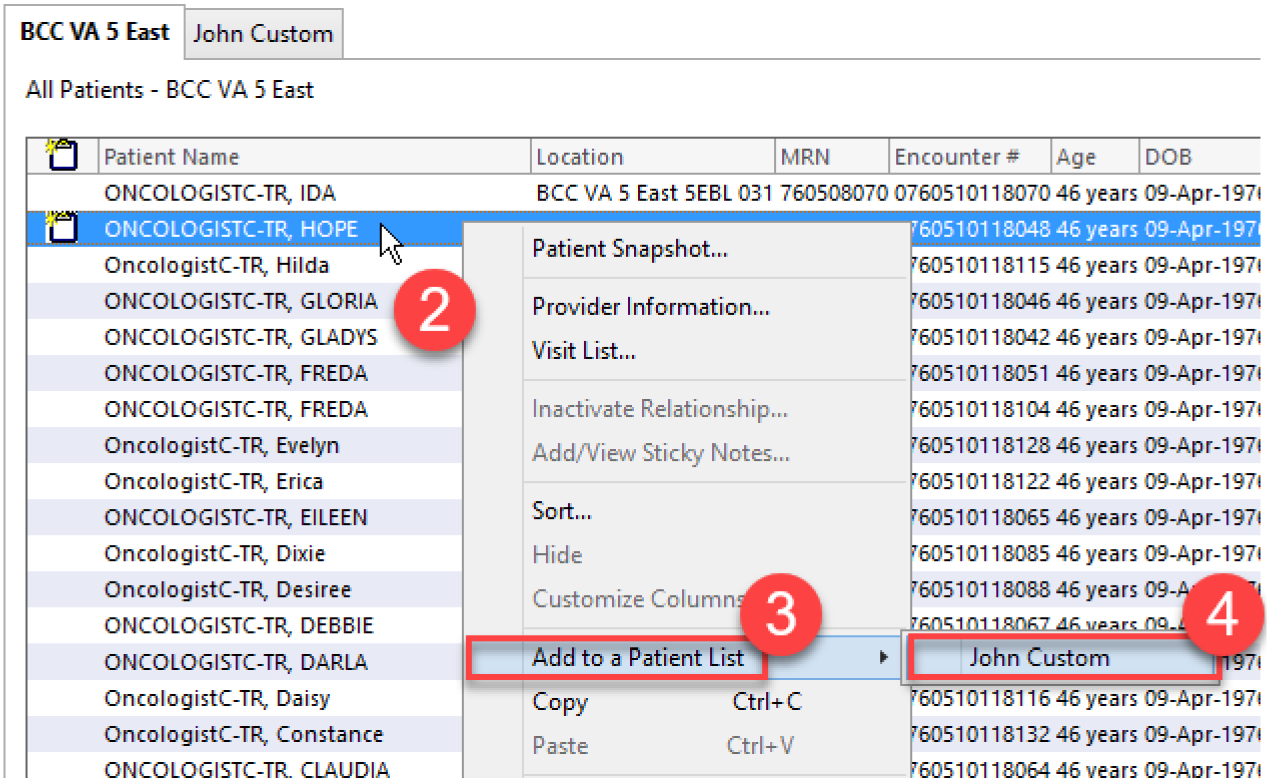
Adding a Patient to your Custom list

1. Locate your patient from the **location list** you created (refer to the login information provided for your Patient Name; images are examples only).

2. **Right Click** on the patient's name.

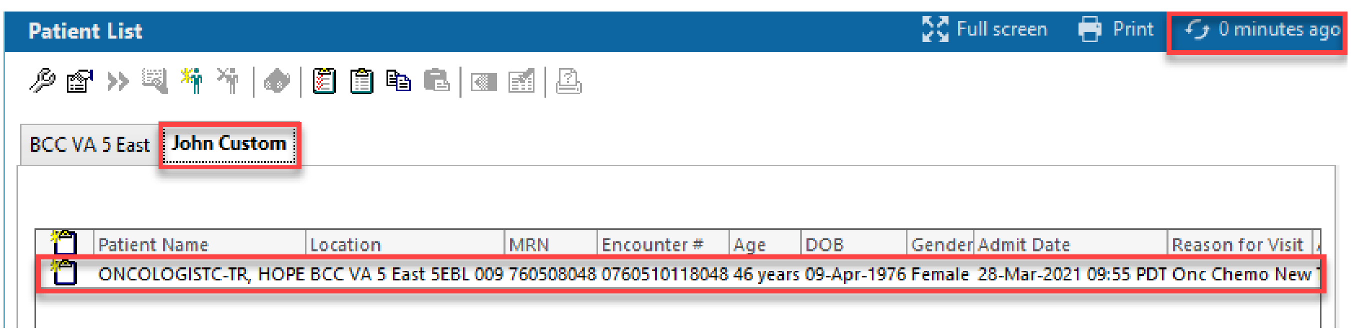
3. Click the Add to **Patient List.**

4. Select the **Custom List** you created.



5. Return to your Custom list tab.

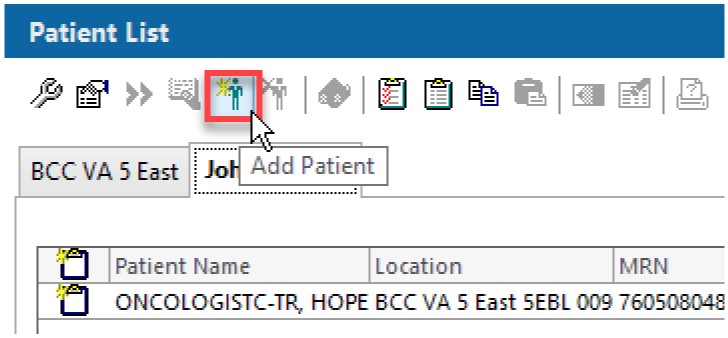
- **Refresh** the screen. The patient will now be on your custom list.



NOTES: READ ONLY

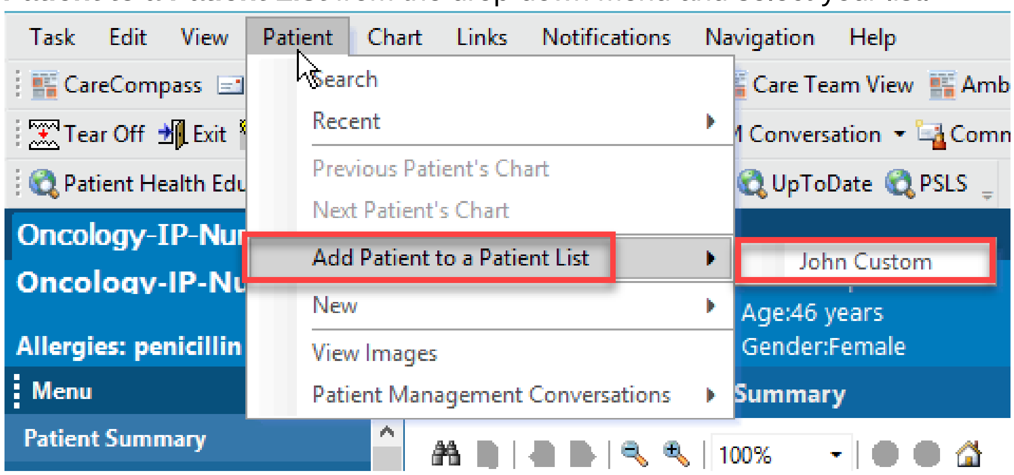
You can also add a patient to your list by:

a. Clicking the **Add patient** icon from the patient list.



AND/OR

b. If your are already in a patient's chart, Click **Patient** from the toolbar, select **Add Patient to a Patient List** from the drop-down menu and select your list.



WARNING:

- When manually adding a patient to the **Custom Patient List**, ensure this is the correct patient.
- When the patient is no longer under your care, ensure to manually remove the patient from the **Custom Patient List** by clicking the **Remove Patient** icon.

NOTE: For more information you can visit **CST Cerner Help** and search help topics for "patient lists"**.** CST Cerner Help is located at the top of your Toolbar and you can search by keyword any time you need assistance in the system. At the end of this workbook there is an activity on how to use CST Cerner Help.

Key Learning Points

- Patient list can be created and customized to the user's preference.
- Lists can be Active or Available (but inactive).
- Use the Refresh button to update the list view if needed.
- Custom Patient List needs to be updated throughout the shift by adding new patients when assigned and removing patients who are no longer under your care.

PATIENT SCENARIO 2 – Starting Your Shift

Learning Objectives
At the end of this Scenario, you will be able to: - Review CareCompass

SCENARIO

At the beginning of the shift, you receive report from the previous shifts nurse. You also review the patient information and tasks during handoff so that you know more about your patient and prioritize your care throughout the shift.

You will complete the following activities:

- Review CareCompass

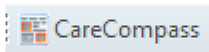
For the following activities, select the name of **patient A** as assigned to you from your CST Cerner Learning – Your workbook's logins and patients email.

Activity 2.1 – Review CareCompass

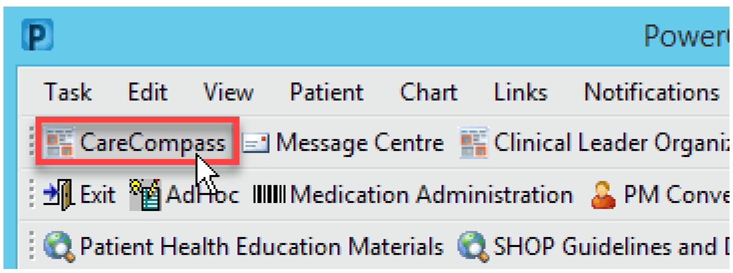
CareCompass displays key information about your patients, including important details such as allergies, resuscitation status, reason for visit, scheduled medications/tasks, orders, and results.

You have been introduced to **Care Compass** via emodule and learned about the basic layout, how to see your assigned patients and how information is shown in Care Compass via Patient List and Single Patient View.

We will practice establishing a relationship to access your patient's information.

1. Click **CareCompass** 

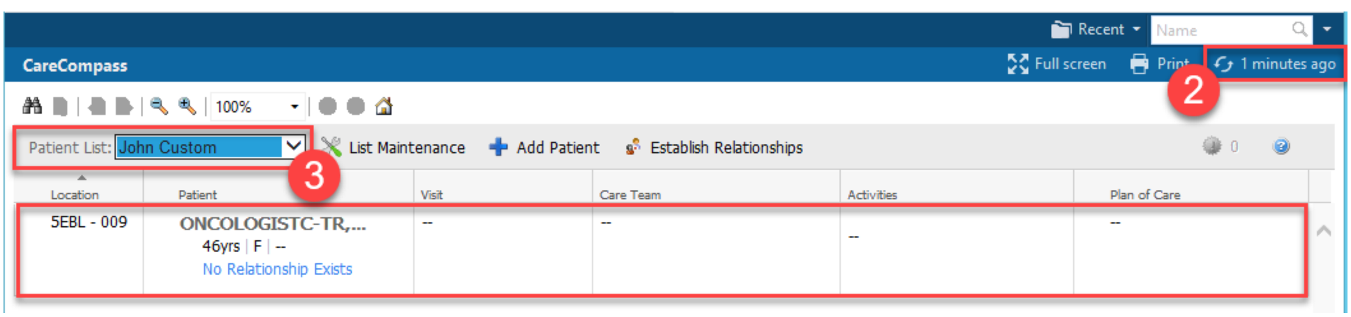
button on the toolbar**.**



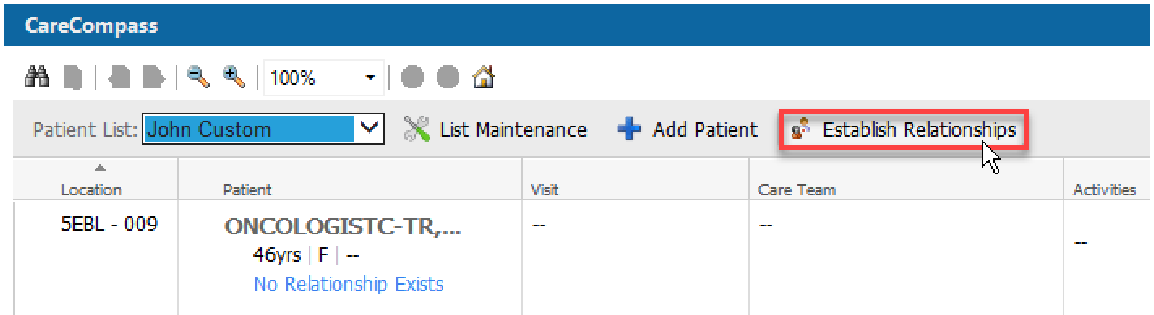
2. Click the **Refresh** icon to update the information displayed in **CareCompass**.

3. Select your custom list. CareCompass now displays patients from the **Custom Patient List**.

You have a limited view until you establish a relationship with your patients in the system, the only information visible about them is location, name and basic demographics.



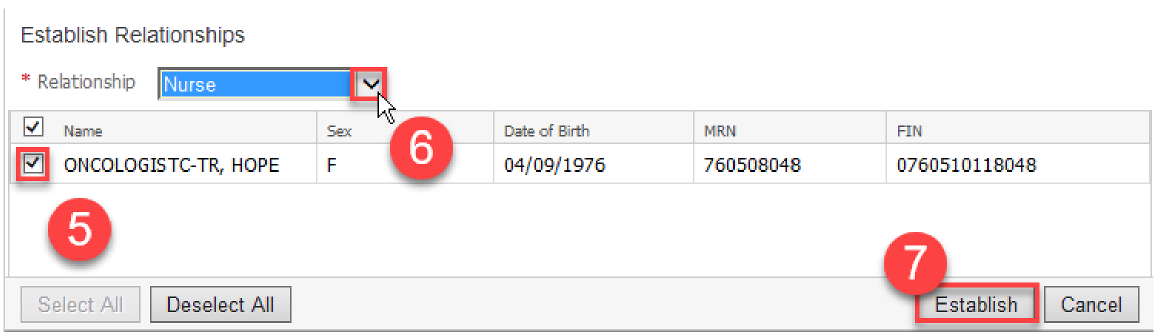
4. Click **Establish Relationships**.



5. Make sure the **checkmark** is present in the tick box beside the selected patient.

6. Select **Nurse** from the Relationship drop-down list.

7. Click **Establish**.



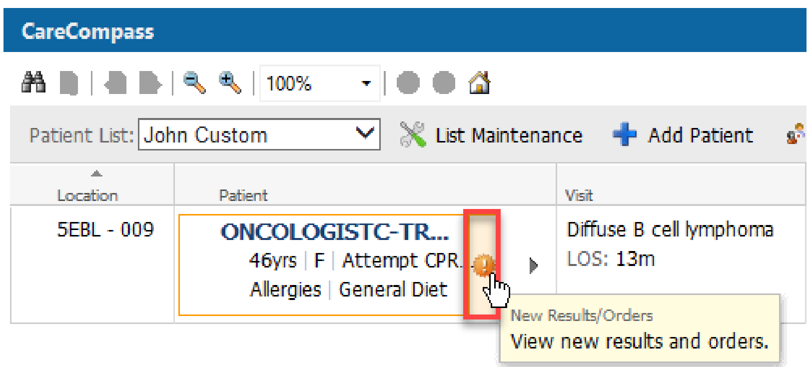
NOTE: Once established, the Nurse relationship will last for 13 hours.

Review New Orders/Results/Alerts in CareCompass

Notice the **orange New Results/Orders** icon next to your patient's name. This indicates that there are new non-critical results or orders or alerts that require review. This is the primary Nurse's responsibility to acknowledge and sign off the new orders/new results.

> **NOTE:** The **Red New Results/Orders** icon indicates new critical results or **STAT** orders requiring review.

1. Click the **New Results/Orders** icon beside the patient's name.



The **Items for Review** window opens.

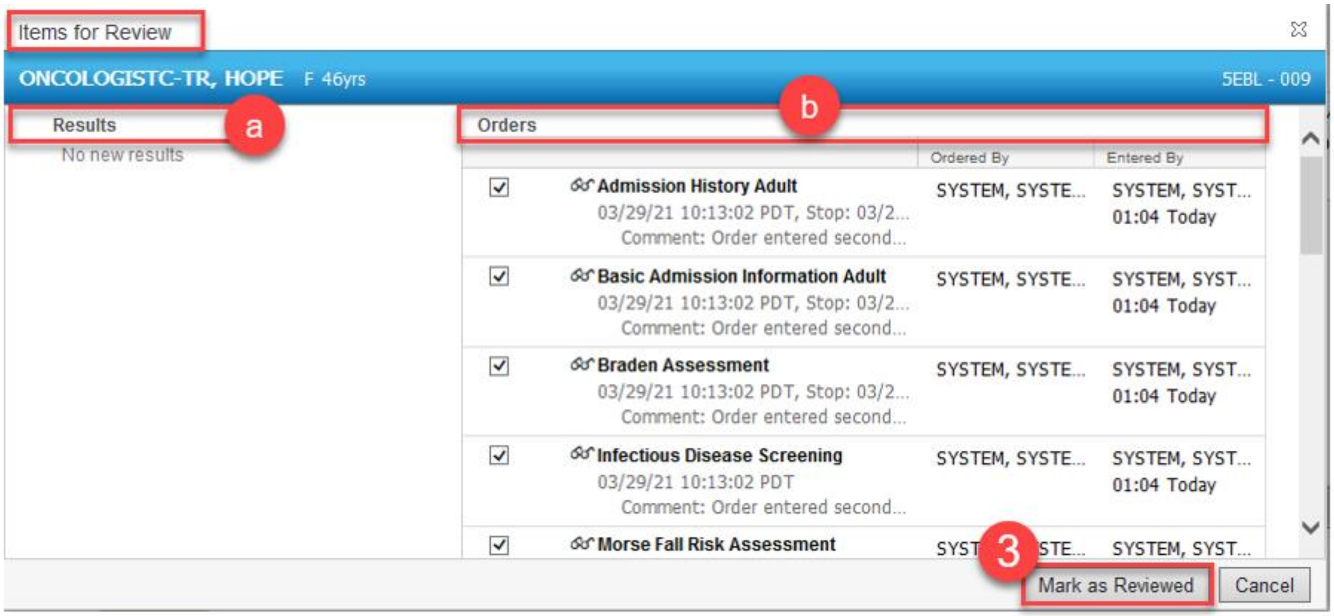
2. Review the list of new orders/results/alerts (Note: Screenshot is an example only).

- Note the split screen to show:

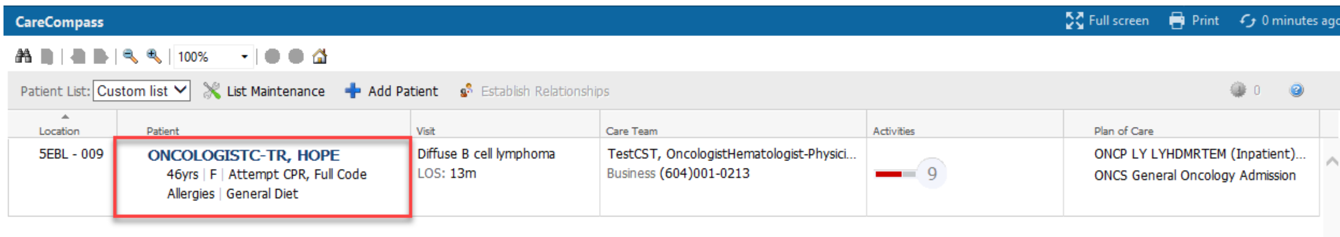
a. **New Results**: Note, the actual result will not display based on design.

b. New Orders

3. Click **Mark as Reviewed** after reviewing your orders.



- Note the New Results/Orders icon has disappeared.



NOTES:

- In the clinical settings, if the nurse has not marked the new orders and/or new results as reviewed within 12 hours of display, the New Results/Orders icons will automatically fall off from CareCompass.
- Due to the limitations in the training environment the New Results/Orders icons may not be visible in CareCompass as the display time limit may pass 12 hours.
- Recall in the Orders section of the Menu, **Orders for Nurse Review** button allows you to also review and sign off that new orders have been acknowledged by the Nurse.

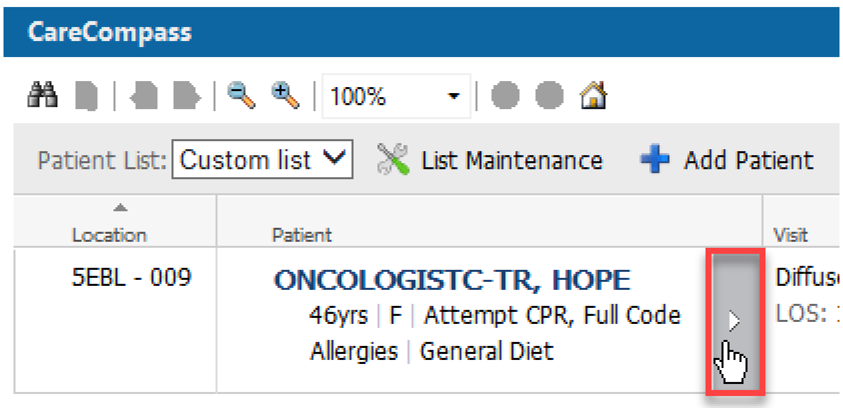
Review Tasks List in CareCompass

CareCompass also reminds Nurses about scheduled and unscheduled tasks. The tasks show up in a list format to notify the Nurses to complete specific patient care activities.

At the beginning of the shift and during handover, it is important for you to review any pending and/or overdue tasks that you need to complete and set priority throughout the shift.

To locate tasks for your patient in **CareCompass**:

1. Hover your mouse at the end of the Patient box and an **Open** icon appears.
2. Click the **Open** icon to open the **Single Patient Task** window.

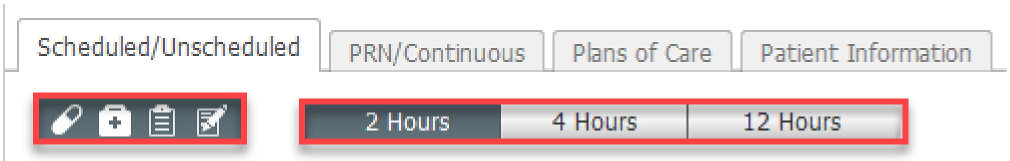


The **Single Patient Task** window opens defaulted to the first tab the **Scheduled/Unscheduled** tab.

3. Note the following in this view:

   a. Category Icons tab - Medication tasks, Patient Care tasks, Assessment tasks, and other tasks.

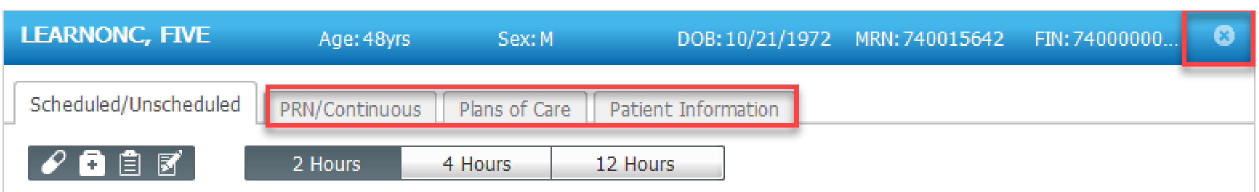
   b. Time periods Scheduled tab – display pending and overdue tasks that are scheduled in last 2, 4, and 12 hours.



4. Click on the other three tabs to become familiar with the content.

   - **PRN/Continuous** tab
   - **Plans of Care** tab
   - **Patient Information** tab

5. Click the **Close** icon to close the **Single Patient Task** window.



WARNING: **ALWAYS** click the **Refresh** icon to update the screen so that you can view updated information showing in **CareCompass**.

Key Learning Points

- CareCompass provides a quick overview of patient information including patient care activities, scheduled and unscheduled tasks and new orders/results/alerts for the patient.
- Patient list need to be created to view your patients in CareCompass.
- Prior to establishing a relationship with the patient, the only information visible about a patient is their location, name and basic demographics.
- The orange New Results/Orders icon indicates new non-critical results or orders for a patient requiring review.
- The red New Results/Orders icon indicates new critical results or STAT/NOW orders requiring review.
- Marking orders/results as reviewed indicates that the nurse has acknowledged the new orders/results.
- If the nurse has not marked the new orders and/or new results as reviewed within 12 hours of display, the New Results/Orders icons will automatically fall off from CareCompass.
- Pending and overdue tasks displayed in CareCompass are organized in different categories and time periods.
- Refresh the screen to update the information showing in CareCompass.

PATIENT SCENARIO 3 – Review Patient Chart

Learning Objectives

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

- Access the patient's chart.
- Select the appropriate encounter.

SCENARIO

At the beginning and throughout the shift, you access the patient chart to review patient information and chart about the patient.

You will complete the following activities:

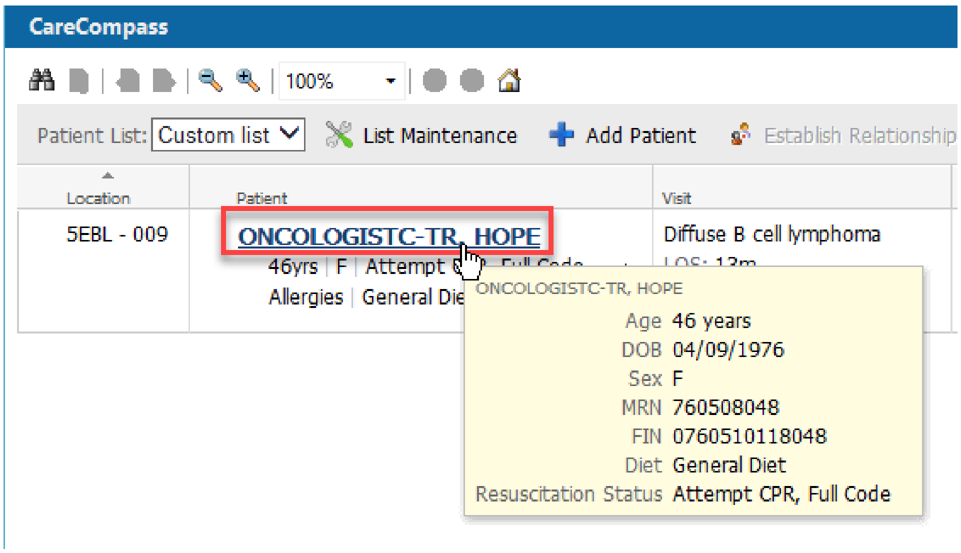
- Access Patients Chart
- Overview of Patient Chart
- Review Patient Summary
- Review Team Communication (Discoverable)
- Review and Update Allergies
- Review Documents, Labs, Vital Signs, and Imaging.
- Review Oncology Section in the Menu
- Review Appointments
- Review Orders
- Review Task on Single Patient Task List
- Review MAR Summary

For the following activities, select the name of **patient A** as assigned to you from your CST Cerner Learning – Your workbook's logins and patients email.

Activity 3.1 –Access Patient Chart

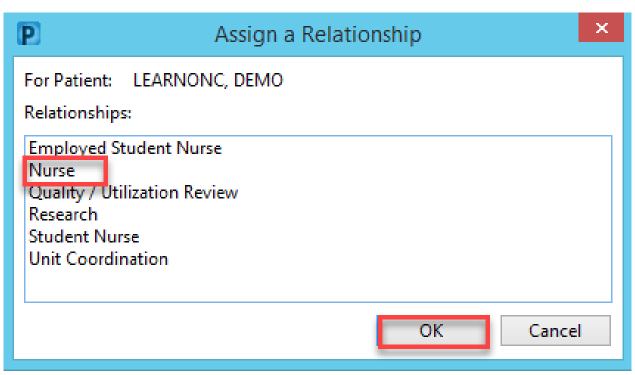
There is a several ways that you can access a patient's chart. For the following activitiy, you will open your patients chart through CareCompass.

1. Click on the **patient's name**. Note as you place your mouse over the patient's name additional information displays.

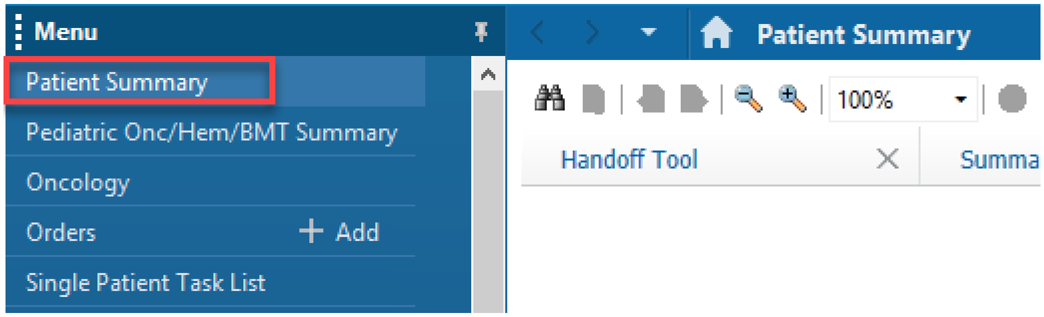


You have already established a relationship with this patient from CareCompass. However, note the following if you access a patient's chart outside of CareCompass for the first time:

- An **Assign a Relationship** window would appear.
  - Select **Nurse.**
  - Click **OK.**



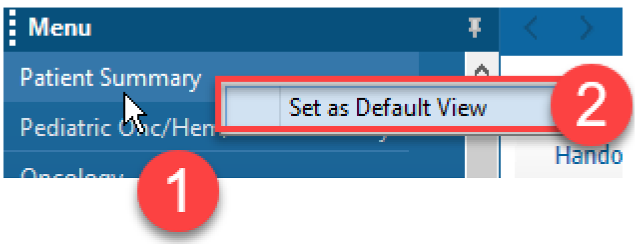
Opening the chart has taken you to your home page, the **Patient Summary**, as indicated by the lighter shade of blue on the Menu on the far left and the label next to the home icon. There will be more information on the Patient Summary later in the workbook.



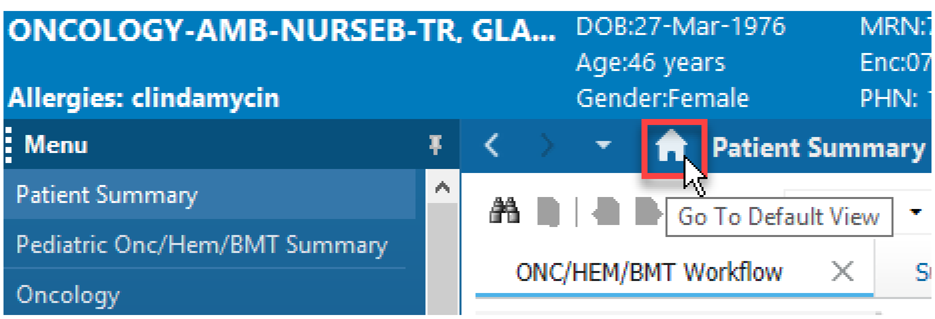
Note in the train domain if the default setting has taken you to the **Pediatric Onc/Hem/BMT Summary**, follow the below steps to set your default setting.

To adjust your default view to **Patient Summary:**

1. Right-click the **Patient Summary** section on the Menu.
2. Select **Set as Default View**.



As you navigate through the chart, you can return to your default view by clicking on the home  icon.



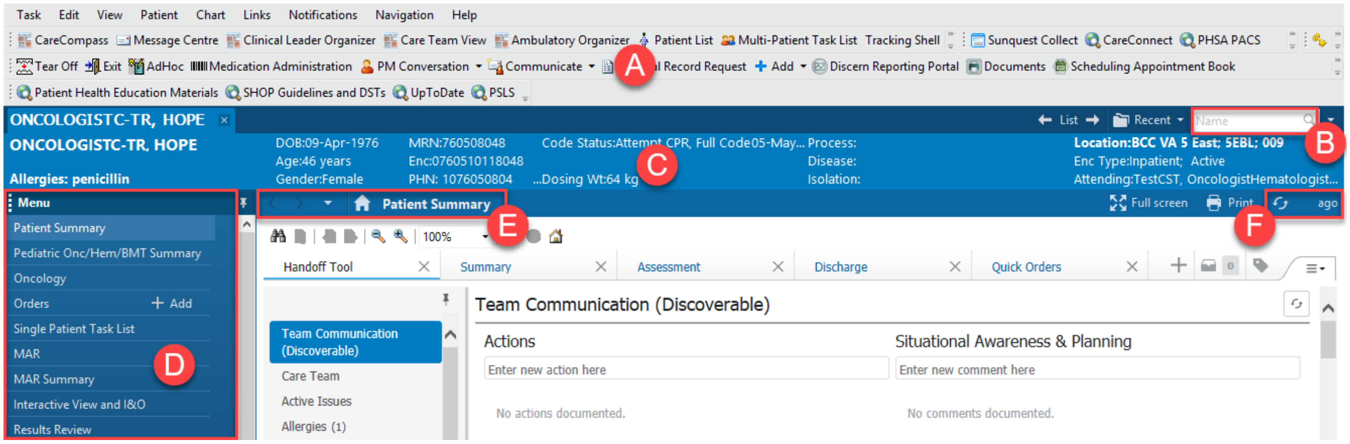
Key Learning Points

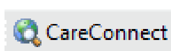
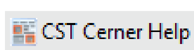
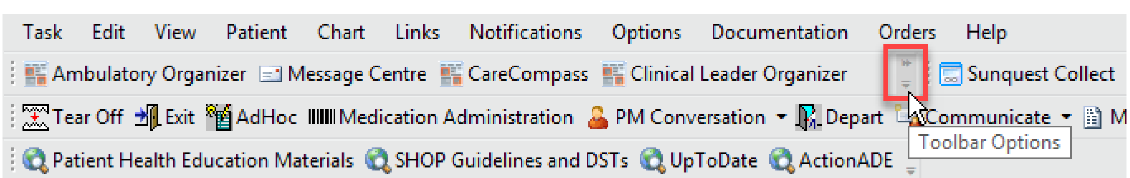
- Patient Chart can be accessed from CareCompass and Custom Patient List.
- Click on the patient's name to access the patient chart.
- Right-click on the patient's name to access specific parts of the patient chart.
- A relationship needs to be established to view the patient chart. The assigned relationship will last for 13 hours.
- Select the correct role when establishing your relationship with patients.
- **Patient Summary** is the landing page within the patient chart.

Activity 3.2 - Overview of Patient Chart

Read Only

Now that you have opened your patient's chart, we will review the Layout of the chart.



LEGEND	
A	**Toolbar** -- located above the patient's chart and contains buttons that allow you to access various tools within the CST Cerner. Some toolbar buttons connect to the external links. Here are few examples: • **CareConnect**  button forwards to the link that allows you to search for patient test results completed at any provincial facility. • **CST Cerner Help**  button connects to a website that allows you to search and review clinical information system functionality and workflow related topics, as well as, CST classroom workbooks. • If you are unable to view a specific button on the toolbar, note the toolbar option icon at the end of each section. Click on the icon to view more options via drop down menu. 
B	**Patient Search** -- allows you to quickly search for an individual patient by name or MRN. Be cautious as you may be presented with a list of encounters to select from. It is crucially important that you select the right encounter if you search for your patient in this manner.

C	**Banner Bar** -- displays patient demographics and important information that is visible to anyone accessing the patient's chart.
D	**Menu** located on the left below the Banner Bar allows you to access different sections of the patient chart. This is similar to the coloured dividers within a paper-based patient chart. The menu bar can be pinned or unpinned to remain open or closed by clicking the pin icon.
E	**Navigation** Icons -- clicking the icons will navigate the chart: **Back** icon : previous page, **Forward** icon : next page, **Home** icon : home page, **Recent View** icon : displays a list of recently visited pages.**Navigation** Icons -- clicking the icons will navigate the chart:
F	**Refresh** icon 1 minutes ago -- clicking this icon will update the currently displayed page/section of the patient's chart with the most recent entries. Notice the time since the last refresh is displayed.

NOTES:

- The chart **does not** automatically get updated until you click the **Refresh** icon. It is important to refresh the screen frequently as other clinicians may be accessing and documenting in the patient chart simultaneously.
- Each page must be refreshed **independently**, refreshing on one screen does not necessarily refresh other screens.
  - There are a few exceptions to this statement, such as Ambulatory Organizer which refreshes automatically.

End of Read Only

Key Learning Points

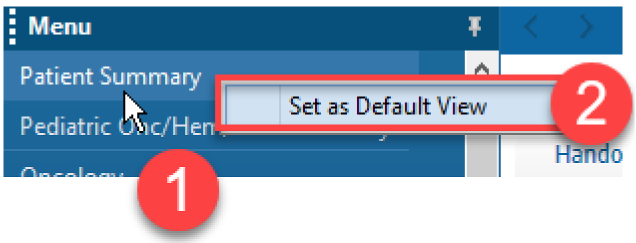
- The Toolbar is used to access various tools within the CST Cerner.
- The Banner Bar displays patient demographics and important information.
- The Menu contains sections of the chart similar to your current paper chart.
- The PowerChart does not refresh automatically. Refresh icon should be used regularly.

Activity 3.3 – Review Patient Summary

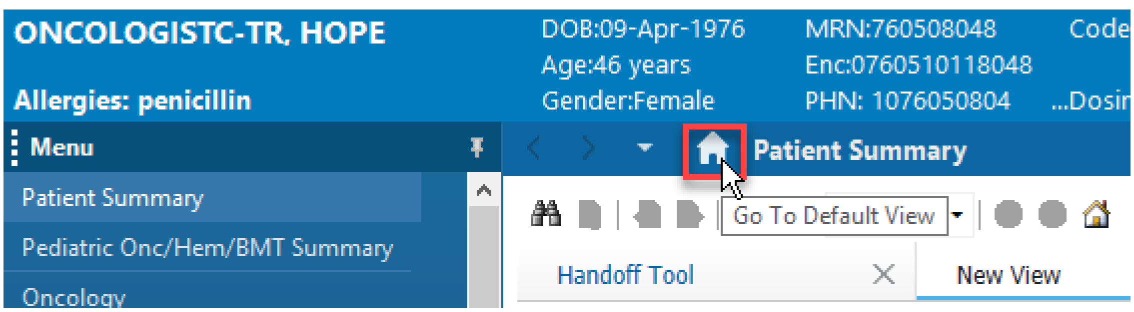
Any section in the Menu can be set as a default view when opening the chart. For learning purposes you will set your default to **Patient Summary**.

To adjust your default view to **Patient Summary:**

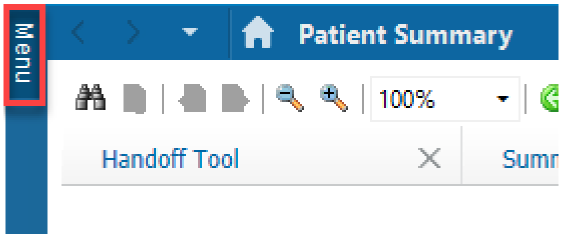
1. Right click **Patient Summary** in the Menu.
2. Select **Set as Default View.**



As you navigate through the chart, you can return to your default view by clicking on the home  icon.



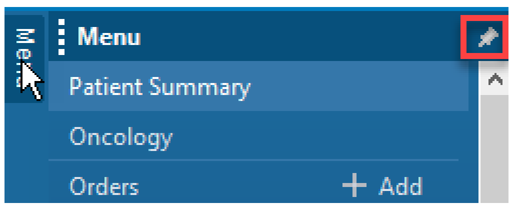
NOTE: If you **do not** see this Menu, it may be set to a minimized state. In this case, the word Menu is shown as a tab with vertical writing. Proceed with the following steps:



1. Move your mouse over the word Menu.

   The **Menu** expands.

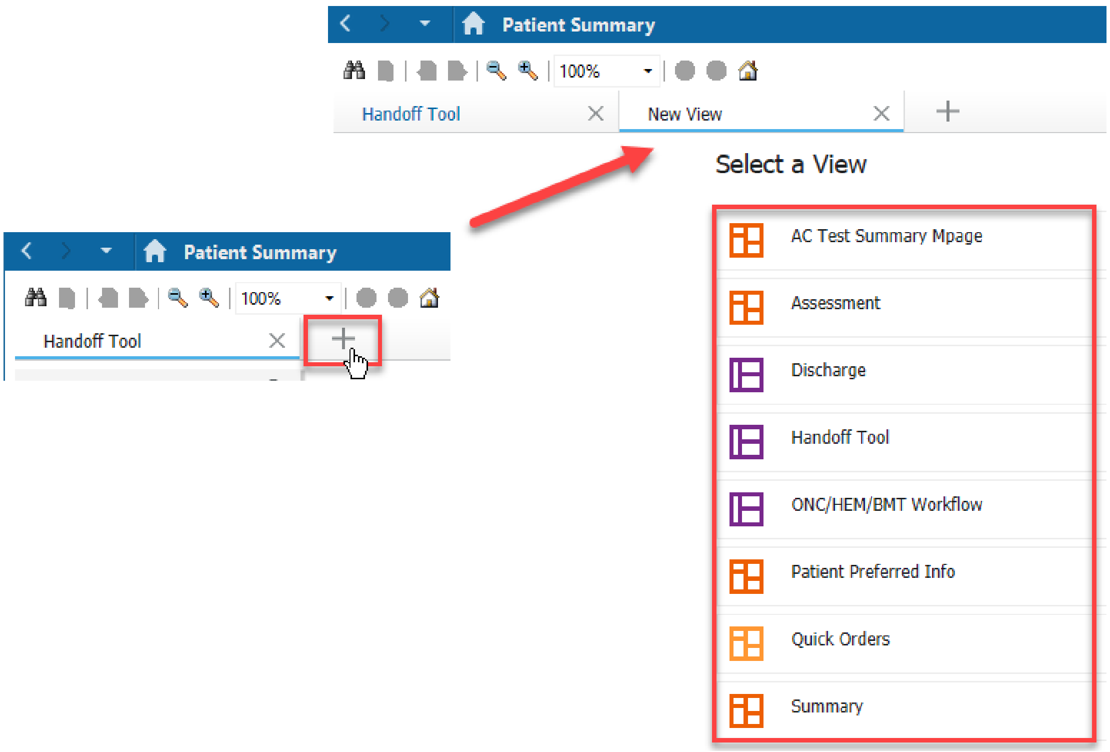
2. Click the **push pin** icon to pin the Menu.



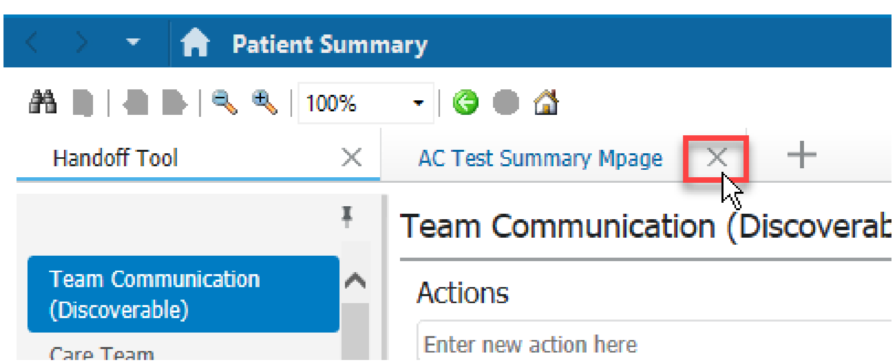
3. Note the push pin icon can be clicked again to hide the Menu. Keeping it open or closed is a matter of personal preference.

Patient Summary Tabs

There are different pages available in the **Patient Summary**. They are designed to support specific workflows. In the inpatient setting, some common workflow pages include **Handoff tool**, **Summary**, **Assessment**, **Discharge**, and **Quick Orders**. There is also an **ONC/HEM/BMT Workflow** page developed for the Oncology Nurse. This list is not inclusive. If you are missing the mentioned pages from your view, add them using the **+ button** located to the far right of the last page. A list will appear to select your view. We will be discussing the contents of each page in the next few activities.



1. Not all workflow pages will be applicable to your clinical practice. Those that are not can be closed by clicking the **X** on the right side of the page. (Images are example only)



NOTE:

- Once your pages are selected, they are defaulted to appear each time you sign in to a patient's chart.
- The order of the workflow pages can be customized by dragging and dropping the pages.

Let's view the pages that you have selected. Click on each page as you review its contents.

Handoff Tool

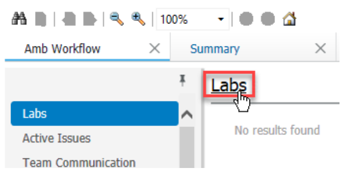
The **Handoff Tool** page provides a workflow that can be used to guide shift handover/transfer of care. For example, during handover report at shift change, admission to a ward, and transferring care to another clinician. The Handoff tool contains information pulled in from other areas of the chart into this page.

This workflow page is **designed** to assist you in organizing your work via components and hyperlinks.

Note the following regarding the design:

a. **Components for viewing and inputting data**

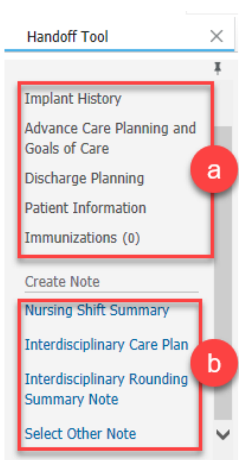
- These components have **Black Text** and offer two functions:
  - **View information –** you can have a quick view of the information by clicking on the component header that will bring up the pertinent section of the menu.



  - **Add Information** – Some components allow for adding discreet pieces of information (e.g. Allergies) while other components allow for narrative documentation Team communication (Discoverable) by entering information in a free text box.

b. **Hyperlinks to complete dynamic documentation**

- These hyperlinks have **Blue Text** and are used for creating new notes.
- Clicking on one of these hyperlinks will forward you to the Documentation page that allows you to type new notes. You will learn more about how to create a narrative note using Nursing Narrative Note later in the workbook.

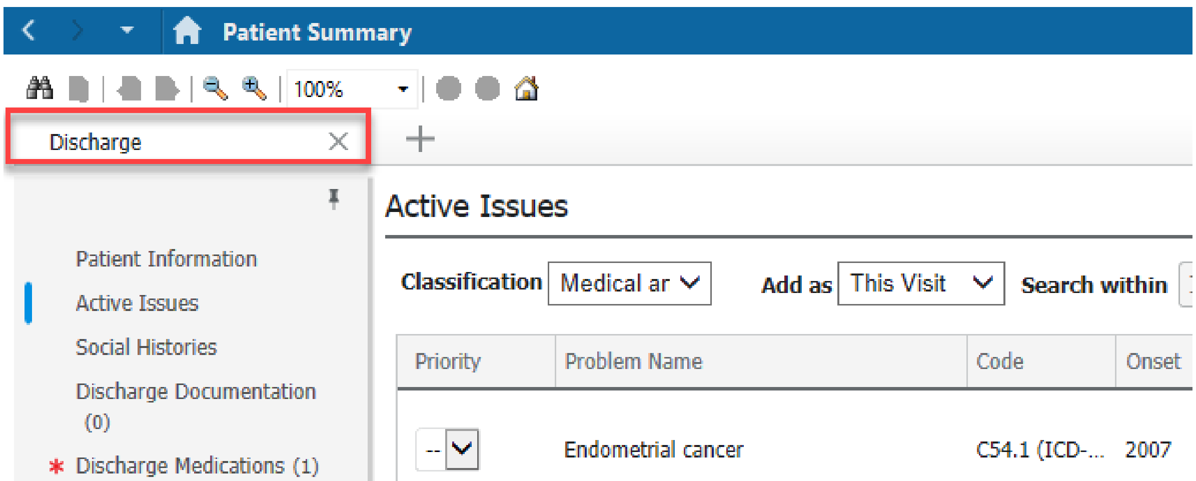


NOTES:

- Each component section can be individually updated by clicking the **Refresh** icon.
- You may customize the order of the components in the list by dragging and dropping a component.

The other workflow pages that have this layout are:

- **ONC/HEM/BMT Workflow** page which is designed to support the workflow of the Oncology nurse.
- **Discharge** page which has been designed to support the workflow for Discharge.



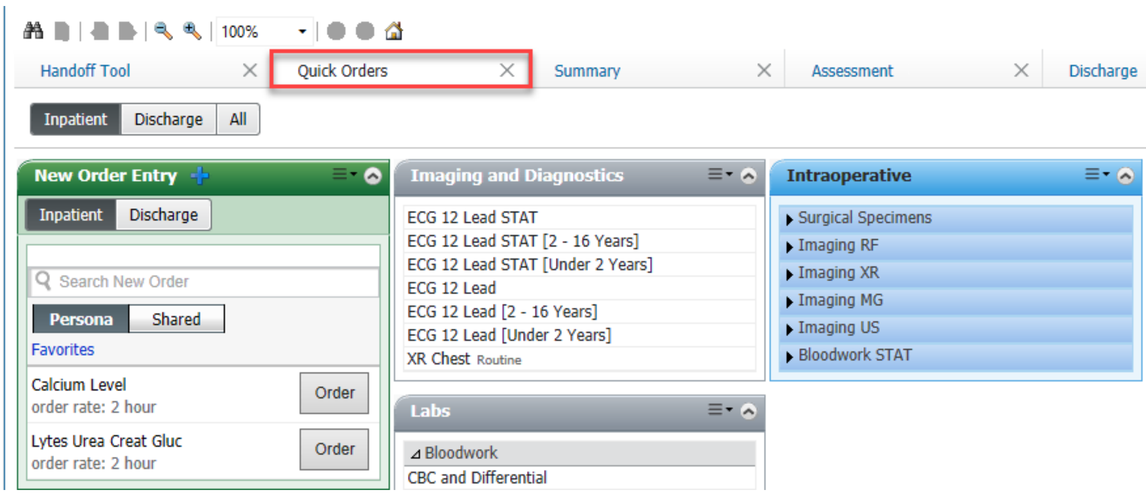
Optional you can add the other tabs to become familiar with the content of each. You will receive more practice in your workflow review sessions.

Let's click and review the other tabs that we previously add to become familiar with its contents and layout.

Quick Orders Page

Quick Orders page displays several categories that represent an aspect of patient care (e.g. Nurse Initiated Activities) and is tailored to the user. You may use Quick Orders page to place orders. This page also displays outstanding orders.

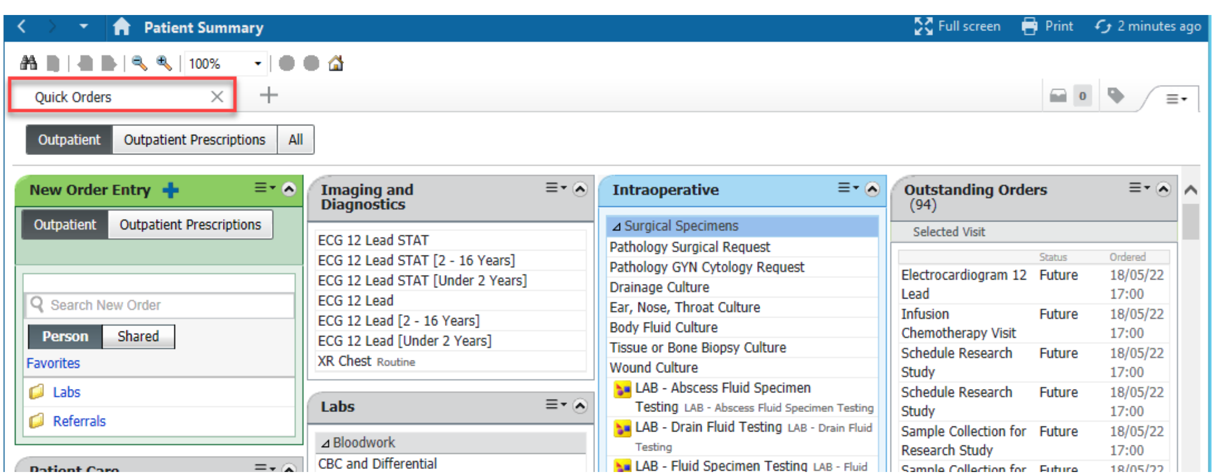
Explore the various available orders on this page. Order entry will be covered later in this workbook.



Summary Page

Summary page provides a quick view of the information about the patient such as Visit Summary, Labs, Current Medication, Outstanding Orders, and so on in dashboard format. The information is organized in different categories.

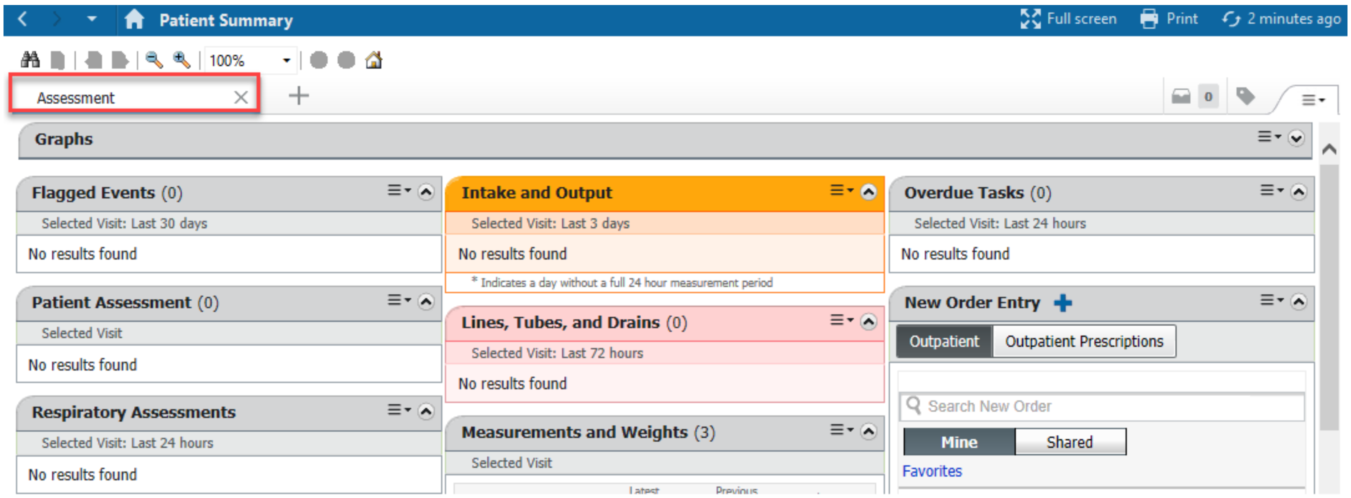
- Clicking on some category headings directs you to the corresponding pages where you can view more detailed information. For example, if you click on **Outstanding Orders**, you will be directed to the **Orders** page.



Assessment Page

Assessment page displays a dashboard with highlights related to flagged events, patient assessment, overdue tasks, outstanding orders, and so on. All the information showing under the **Assessment** page is pulled from various parts of the chart.

- Clicking on some category headings will forward you to the corresponding page and view more detailed information.



Key Learning Points

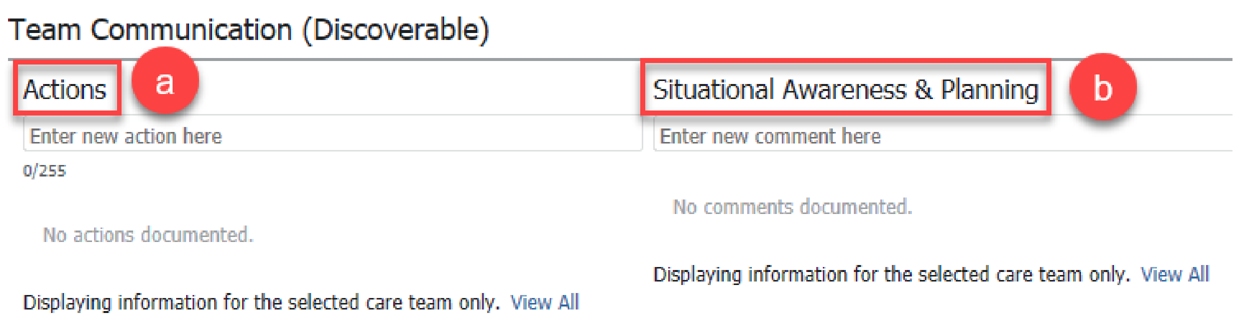
- Various pages make up the **Patient Summary** home page in the Patient chart.
- Some pages are designed with components that allow for documentation and viewing while others are designed in a dashboard format that summarize or categorize information.
- An order page is available that houses some commonly used orders that is tailored to the end user.
- Links to **Notes** are at the bottom of the component's list, where different note types can be documented.

Activity 3.4 – Review Team Communication (Discoverable)

Team Communication (Discoverable) is a component within the workflow pages that are used to review key information from other members of the healthcare team. These notes convey actions required or things that warrant awareness. This component will be used often in the inpatient setting and it is recommended to place this component at the top of your list.

a. Use the **Actions** to create a list of to-do action items.

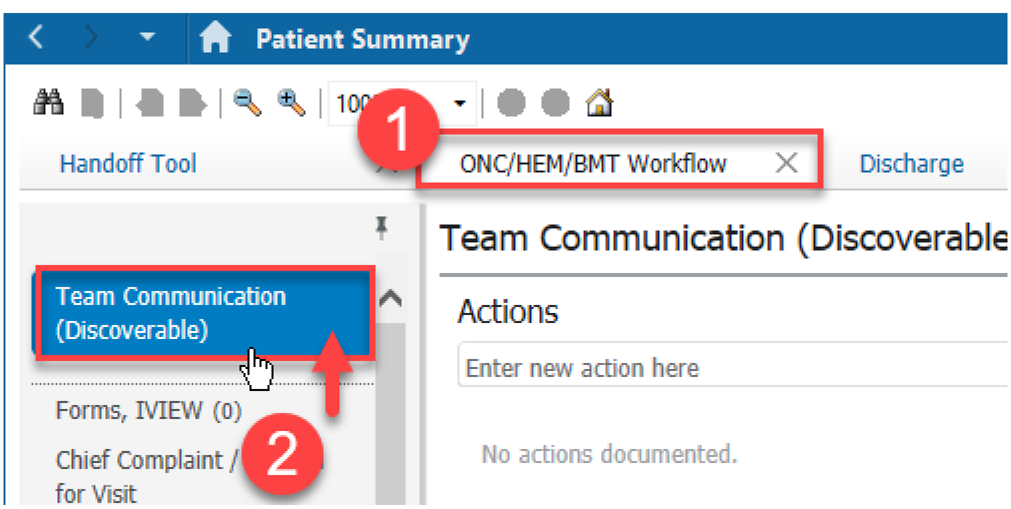
b. Use the **Situational Awareness & Planning** section to leave a comment.



To document an **Action** in the **Team Communication (Discoverable)** component:

1. For this example, Click **ONC/HEM/BMT Workflow**. (Note this component may be available in other workflow pages. Example, Visit Summary)

2. Click and Drag the **Team Communication (Discoverable)** to the top of your list.

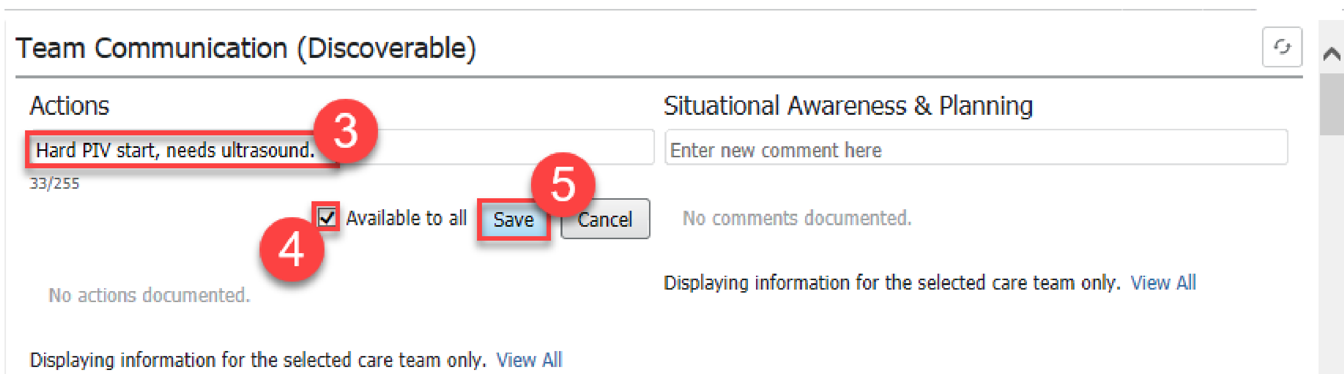


3. Click in the free text field under Actions and Type *Hard PIV start, needs ultrasound.*

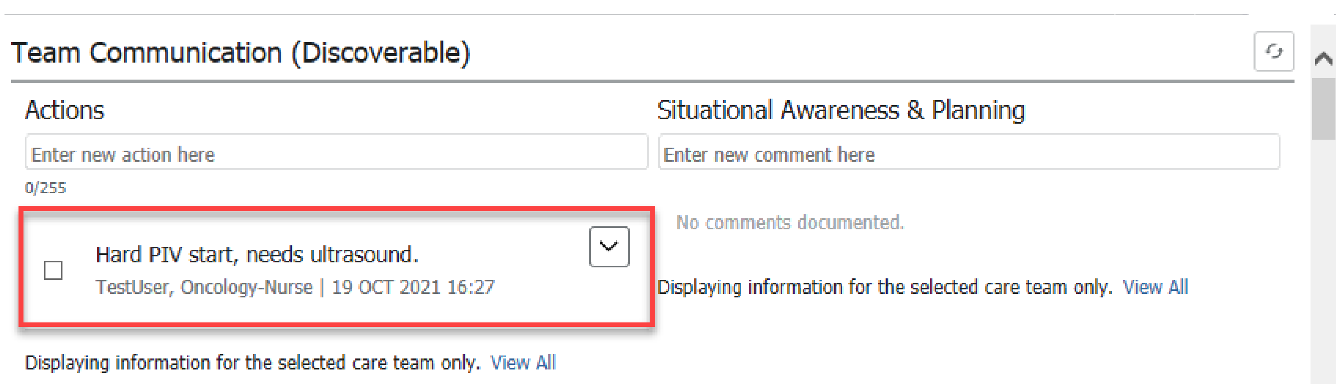
4. Put a **checkmark in the tick box** beside Available to all after entering an action and/or a comment.

   - Available to all **MUST** be selected so that other interdisciplinary care team members can review the saved actions/comments, edit the note (if necessary), delete actions and comments that are no longer applicable, and check off completed actions in Team Communication (Discoverable).

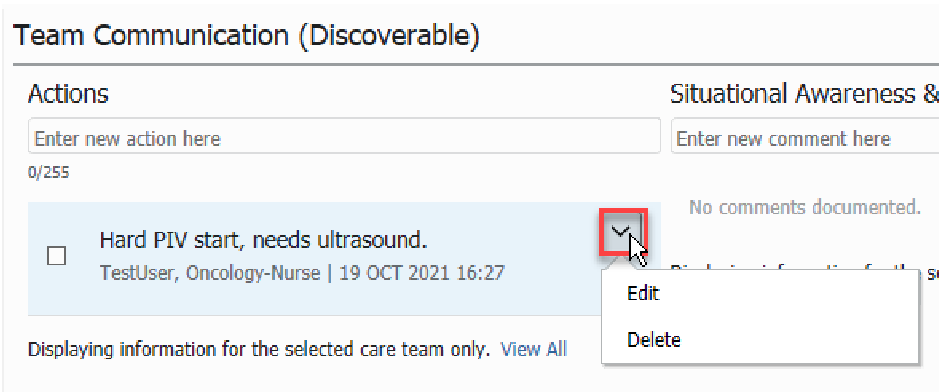
5. Click **Save**.



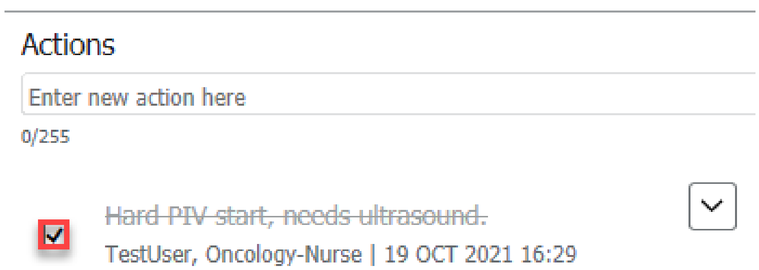
Your action appears with end user name, date and time.



6. Note if you Click the **down arrow** ˅ the drop down menu expands to either Edit or Delete your action.

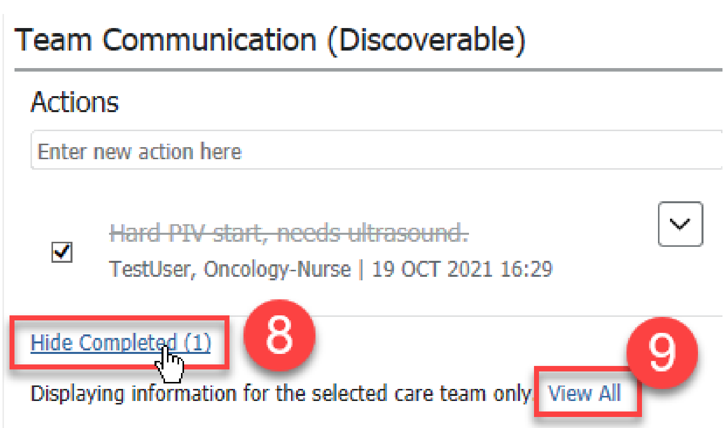


7. When an action has been completed, **put a checkmark in the tick box**. The completed action will be crossed off.



8. Click the blue link under the comments to either hide or show completed actions

9. Click **View All** hyperlink that is located below **Actions** section or **Situational Awareness & Planning** section to view the full list of both recently saved and historical actions and comments.



IMPORTANT:

- Follow site policy for appropriate use of this component.
- This tool does not replace verbal communication between interdisciplinary team members when related to patient care and is not to be used for communicating critical patient results or urgent need.
- Information documented in Team Communication (Discoverable) becomes part of the legal chart and is retained and discoverable by a formal request for release of information to Health Information Management (HIM).

Key Learning Points

- **Team Communication (Discoverable)** is a component within the workflow pages that are used to review key information from other members of the healthcare team.
- These notes convey actions required, reminders or key components of the patient's care plans
- Information documented in Team Communication (Discoverable) becomes part of the permanent patient chart

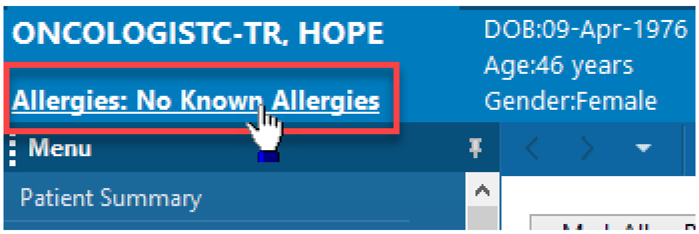
Activity 3.5 –Review and Update Allergies

As an Inpatient Nurse, review patient's allergy status at the beginning of the shift, at every transition of care, and before administering any medications. Allergy information is carried forward from one patient visit to the next.

You can find patient's allergies on the **Banner Bar** and in the **Allergy** component of the **workflow pages** (e.g., **Handoff Tool** or **ONC/HEM/BMT Workflow**).

To review more comprehensive information about allergy status including allergic reaction:

1. Click the allergies on the **Banner Bar**.

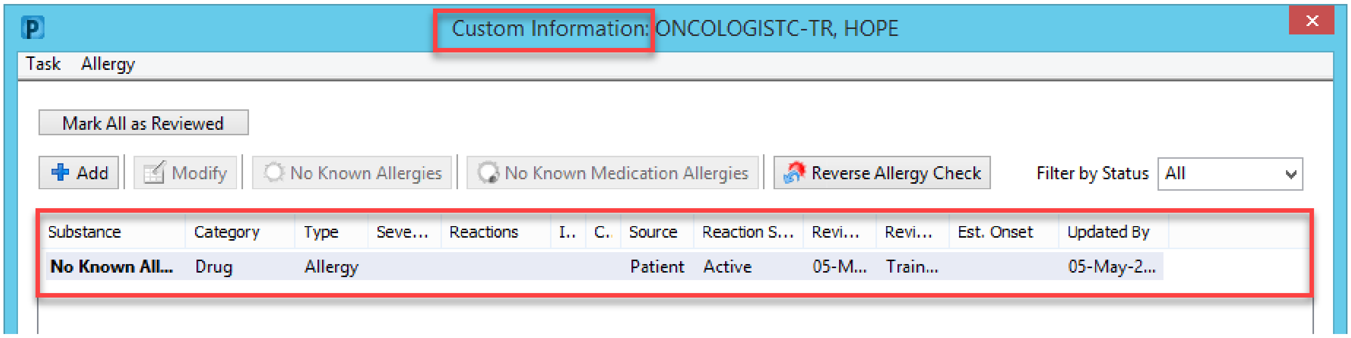


A **Custom Information** window opens.

NOTES: In order for the pharmacy to dispense, they must see that the allergy record has been reviewed by a provider. When there is no information available, you can use other options:

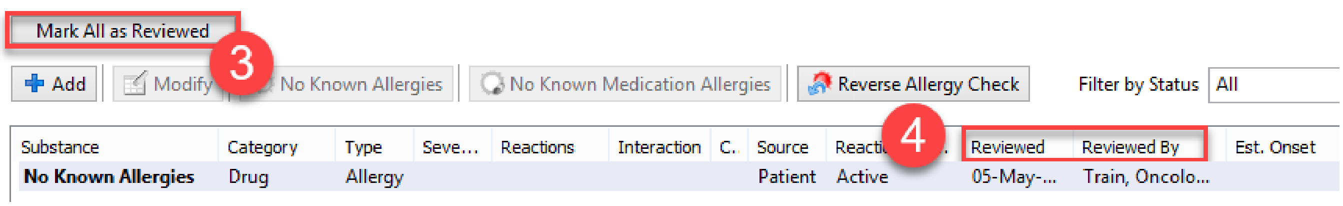
- No Known Allergies
- No Known Medication Allergies

2. Note the comprehensive table with patient's allergic reaction information:

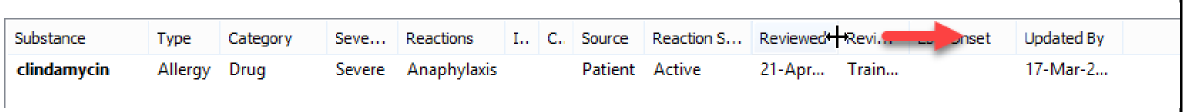


3. If no change is required, click **Mark All as Reviewed** Mark All as Reviewed to update the date and time of the last allergy review.

4. Note the **Reviewed** and **Reviewed By** columns have now been updated.



NOTE: In the train domain, you may have to adjust your view to see the content within the columns. Hover your mouse over the line dividing the Reviewed and Reviewed By header columns. A single vertical line appears with opposing arrows. Click and drag to adjust your view.

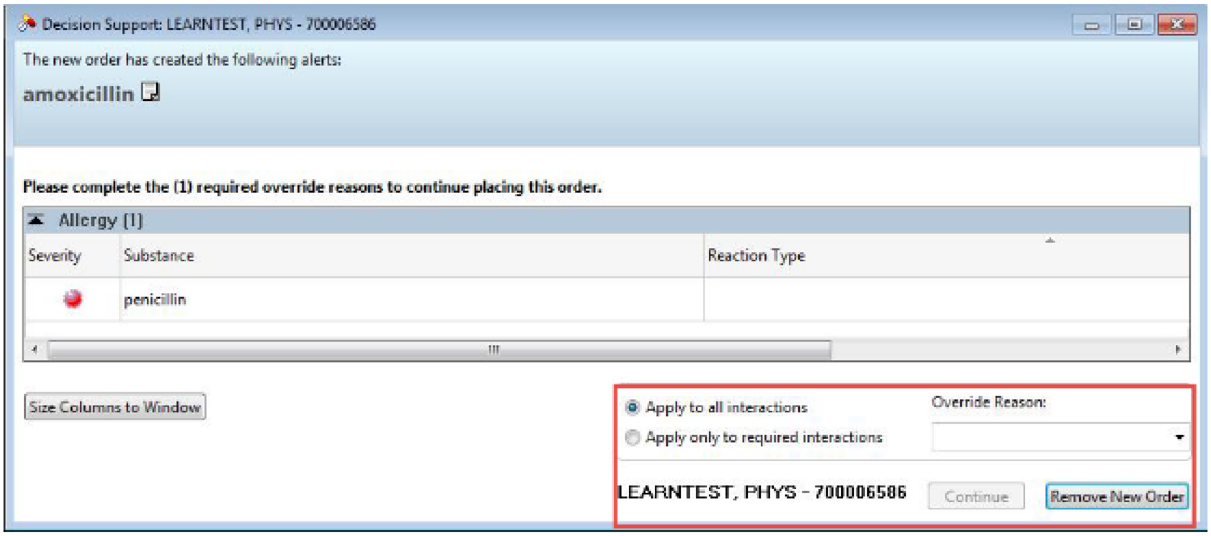


5. Click **OK**.

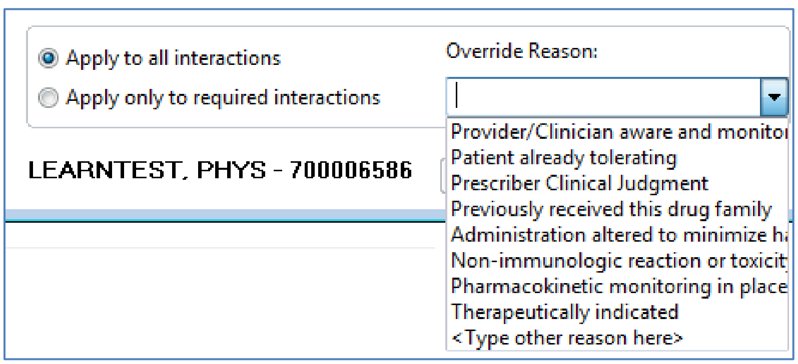
Read Only

CST Cerner keeps track of the allergy status and will automatically prompt you when the information is not up-to-date. It will also track allergy-to-drug interactions.

When placing an order with an allergy contradiction, an alert will display:



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



End of Read Only

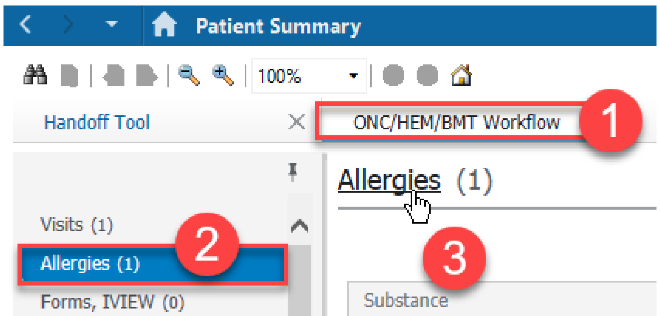
WARNING: CST Cerner's allergy checking will not cover all possible combinations; clinical judgment is still required to avoid medication errors.

Add an Allergy

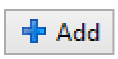
In CST Cerner patient allergies can be added and updated by providers and clinicians (for example nurses and dietitian). It is important to add a patient's allergies prior to any ordering because of the built-in allergy and medication conflict checking system.

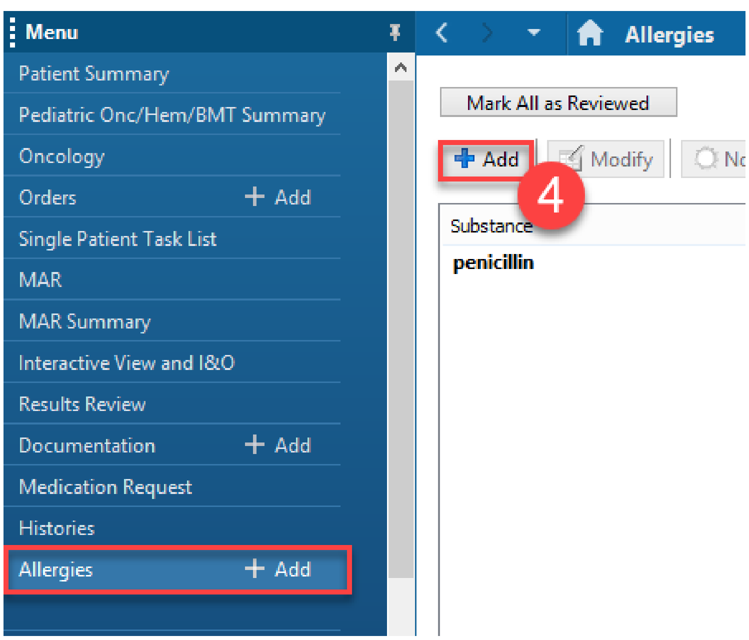
To add an allergy from the workflow pages.

1. Click the **ONC/HEM/BMT Workflow** page.
2. Click the **Allergies** component.
3. Click the **Allergies** header link to add a clindamycin allergy to your patient's health record.



You will be taken to the allergies band under **Menu**.

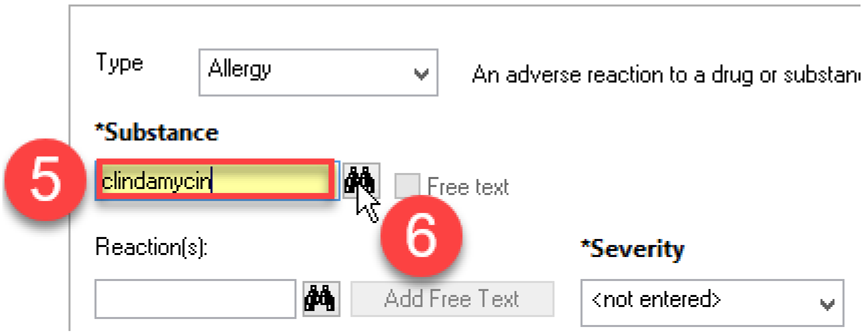
4. Click **Add**  .



An **Add Allergy/Adverse Effect** window opens.

5. Type *clindamycin* in the **Substance** field.

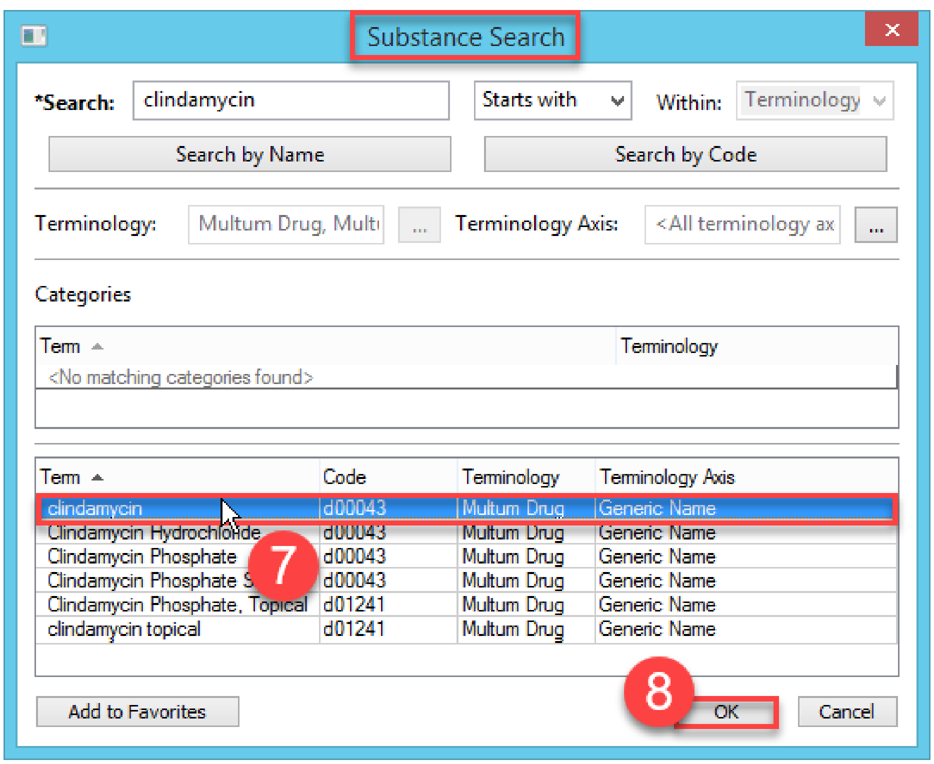
6. Click on the **binoculars** icon or press enter on the keyboard to find the correct allergen.



A **Substance Search** window opens.

7. Select **Clindamycin** (Code d00043) from the list displayed.

8. Click **OK** to return to the Add Allergy/Adverse Effect window.



NOTE: You must search for allergies recorded in the system to select and document; only pharmacists can enter free-text allergies.

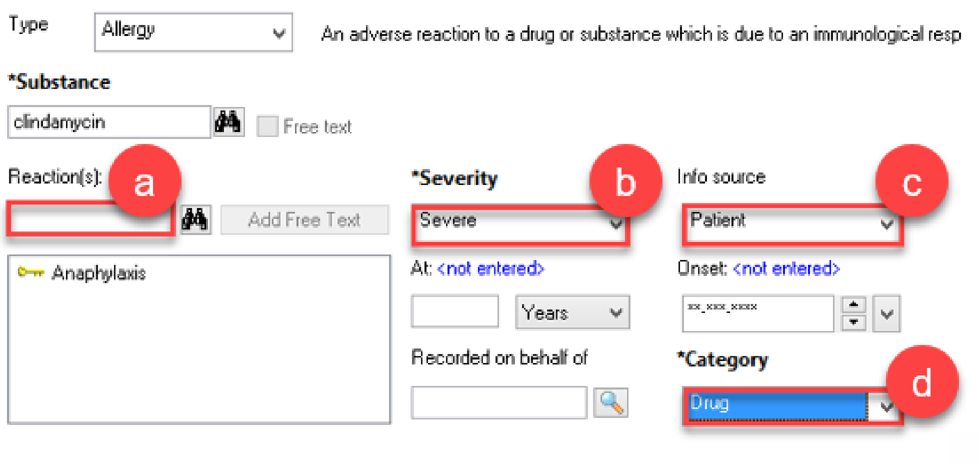
9. Add the following to the appropriate fields:

    a. **Reactions (s):** Search for *Anaphylaxis* (Code 82530). Note once selected the reaction appears in a field below the search field.

    b. **Severity:** *Severe*

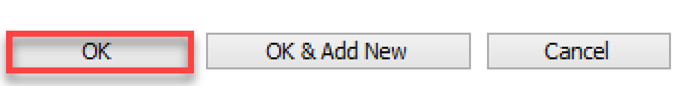
    c. **Info Source:** *Patient*

    d. **Category:** *Drug*

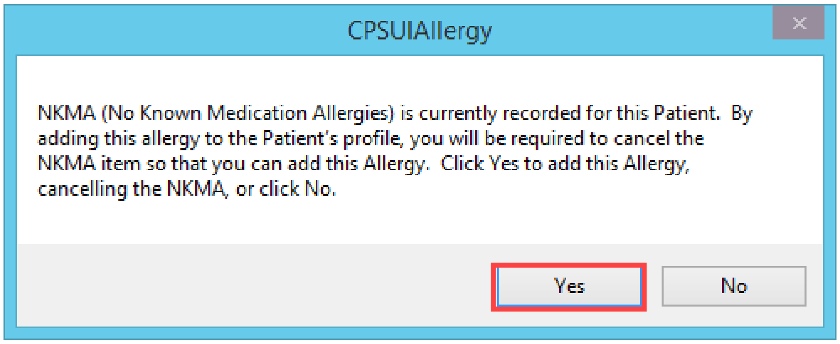


NOTE: In the Category field: “Other” allergy can be placed (other food, other contrast, other medication, other environmental are some of the options offered) which will prompt pharmacy to investigate.

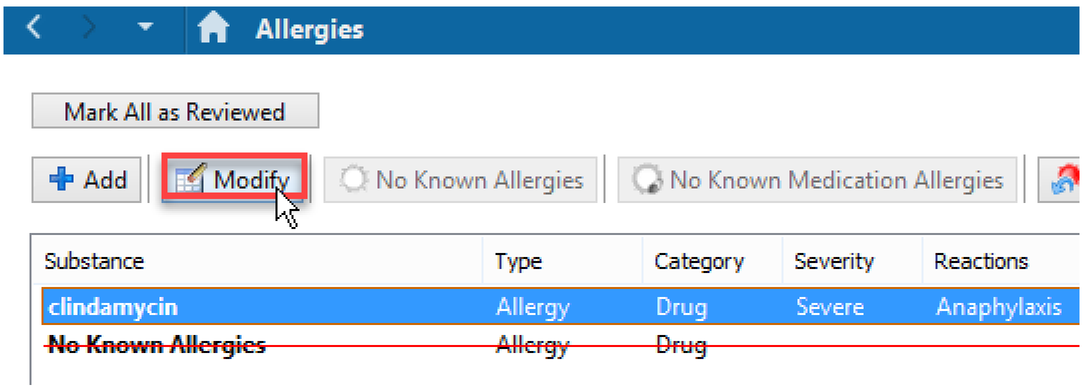
10. Click **OK** to save the information.



11. If the patient previously had no medication allergies recorded, you will receive a pop-up notification alerting you to the fact that by adding the drug allergy, you are canceling the NKMA status. Click **Yes**.

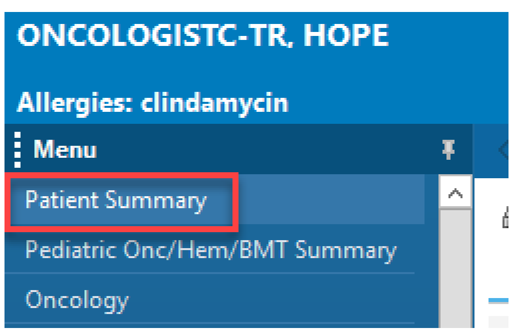


The allergy is now documented. It is possible to modify any details of the documented allergy by selecting the allergy and clicking the **Modify** button.

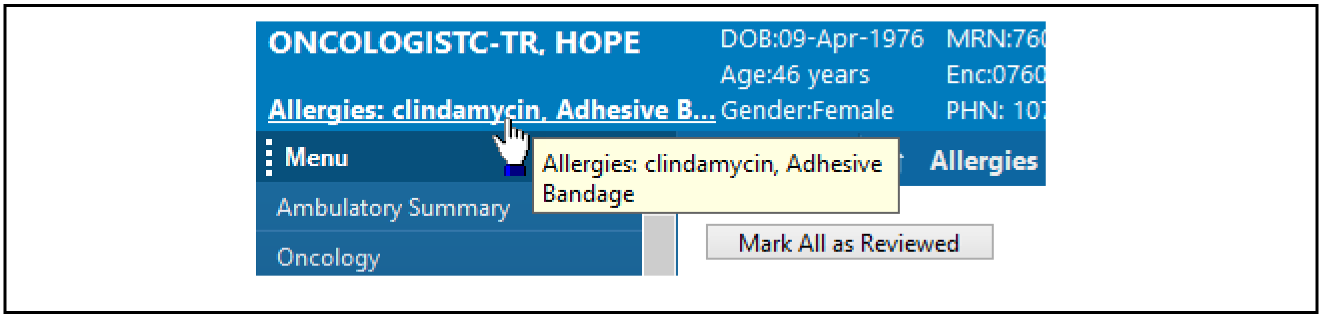


NOTES:

- The allergies that you just documented on will flow into the Banner Bar. Ensure you refresh your screen to view your most recent entry.

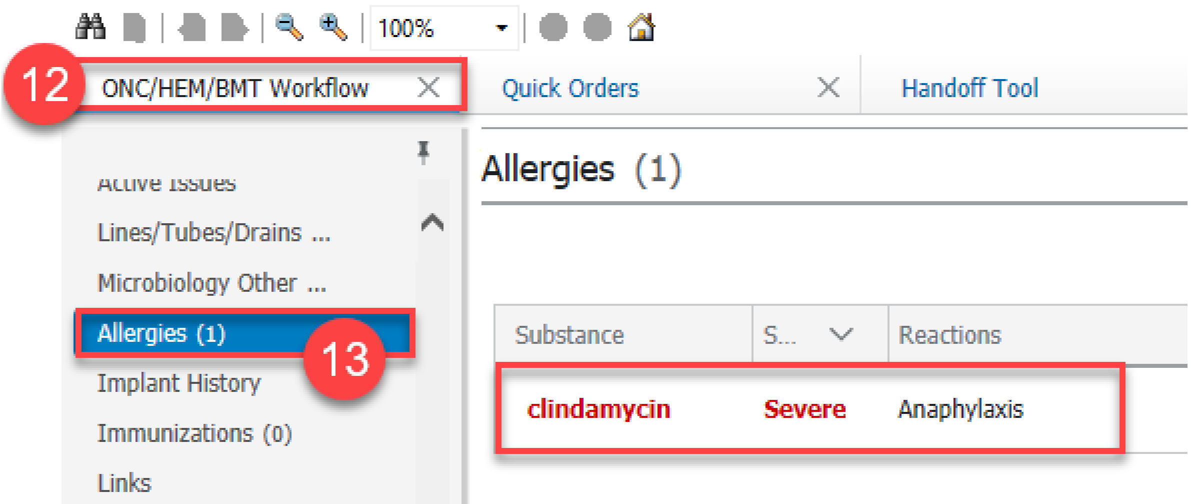


  - Allergies in the banner bar are sorted by severity (most to least). If the allergies listed are longer than the space available, the text will be truncated. You can Hover to Discover to see the full list. (See image as an example).



12. Click the to return to the **Ambulatory Summary** View and ensure you are on the **ONC/HEM/BMT Workflow** page.

13. Click **Refresh** and return to the **Allergies** component to see the updated allergies list.



Key Learning Points

- Review allergy status at the beginning of the shift, at every transition of care, and prior to administering medication.
- Allergy information can be found on the Banner Bar and in the Allergy component of the workflow pages.
- Allergies display with the most severe allergy first on the Banner Bar.

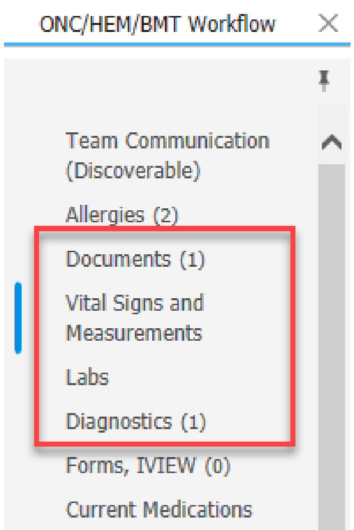
Activity 3.6 - Review Documents, Vital Signs and Measurements, Labs, and Imaging

Review of the patient's documents and results can be viewed before seeing the patient or during the visit.

The preferred method for accessing your patient's documents and results is from the workflow pages that align with specific clinical workflows. In fact, most of the headings of the components on the workflow pages are hyperlinks, that once clicked, will direct you to a corresponding band in the **Menu**.

1. Navigate to the component list on the **ONC/HEM/BMT Workflow** page.

2. Ensure **Documents**, **Vital Signs and Measurements, Labs** and **Diagnostics** are located at the top of your list for easy of navigation in the following activity.



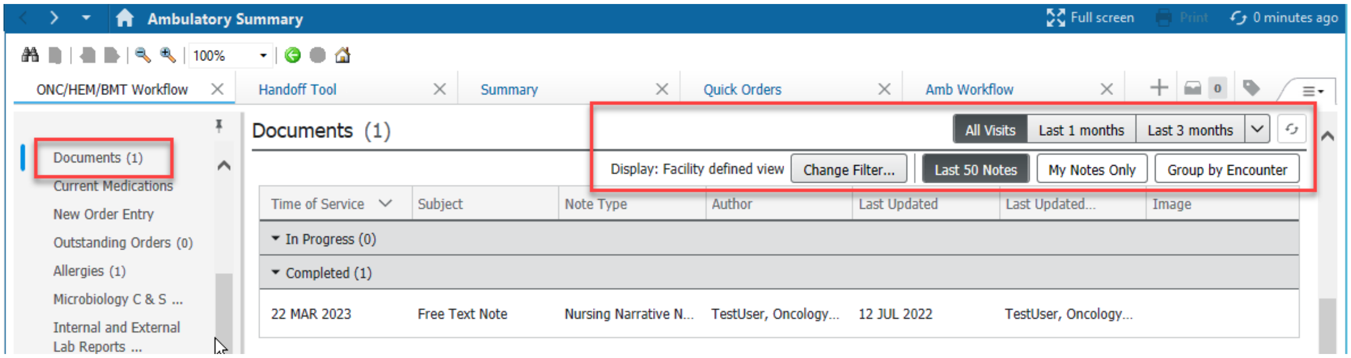
Keep in mind this list is not inclusive for viewing the contents of the chart.

Filtering Documents

When accessing the patient's electronic health record using CST Cerner you might find a large amount of information and documentation from Providers, Nurses, Allied Health who have previously assessed the patient. You have an option to filter the view to help navigate through the documentation.

There are two methods to filter your documentation:

a. From the **Documents** component within the workflow pages.



OR

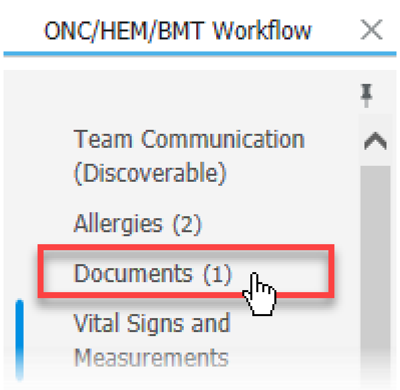
b. From the **Documentation Filter**.

The **Documentation Filter** section allows a more in depth filtering system. Both filters are independent of one another.

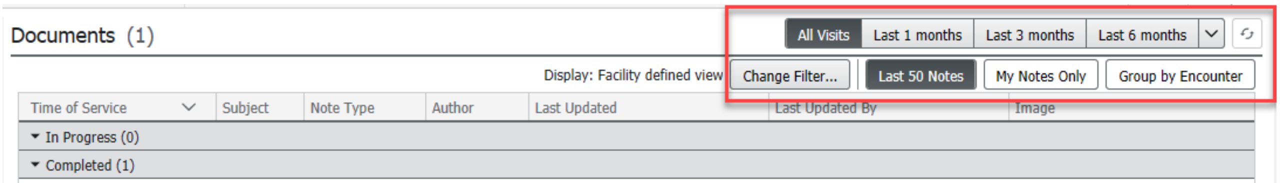
Documents Component

To filter documentation within the **Documents** component in the workflow pages:

1. Ensure you are on the **ONC/HEM/BMT Workflow** in the Ambulatory Summary view.
2. Click **Documents** component.



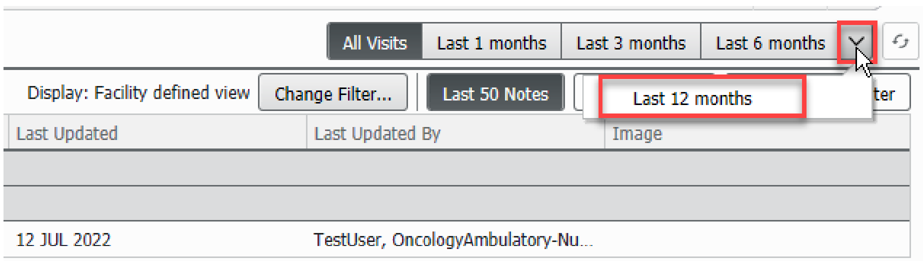
3. Note the various filters on the far-right side.



You can filter by time:

1. Click the **down-arrow** located at the far right of the filter to see additional filter options.

2. For this example, select **Last 12 months**.

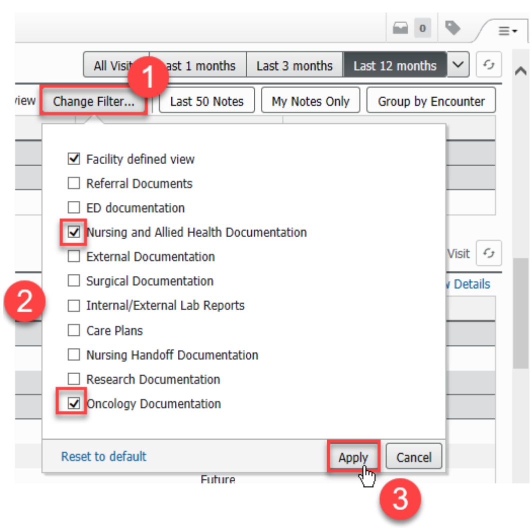


You can filter by type:

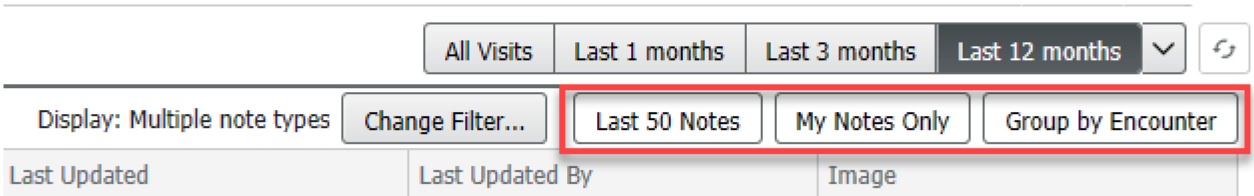
1. Click the **Change Filter** button. Note the options available.

2. For this example, ensure **Nursing & Allied Health Documentation** and **Oncology Documentation** is selected.

3. Click **Apply**.

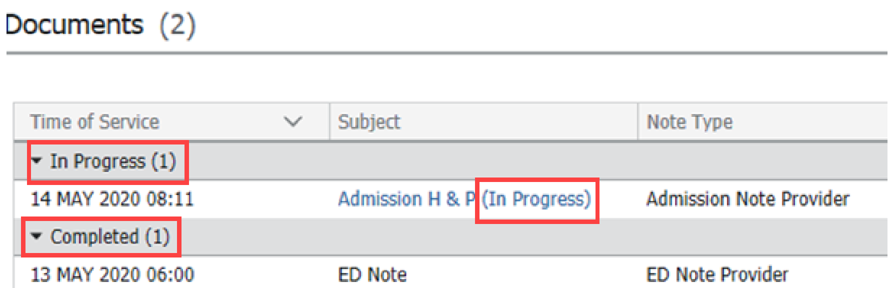


Additional filters can be applied to display the Last 50 Notes. My Notes Only, and/or Group by Encounter.

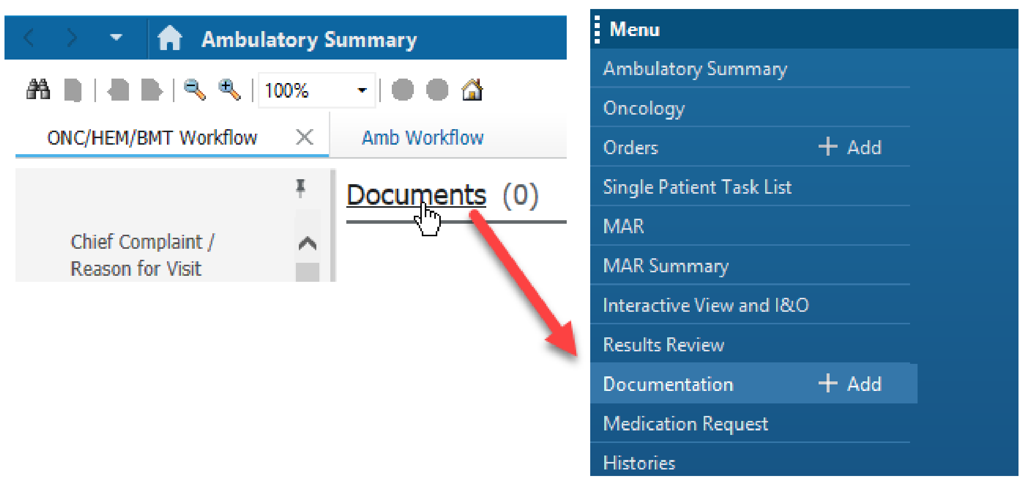


NOTES: **(READ ONLY)**

- **Completed** and **In Progress** notes are categorized separately on the workflow pages.



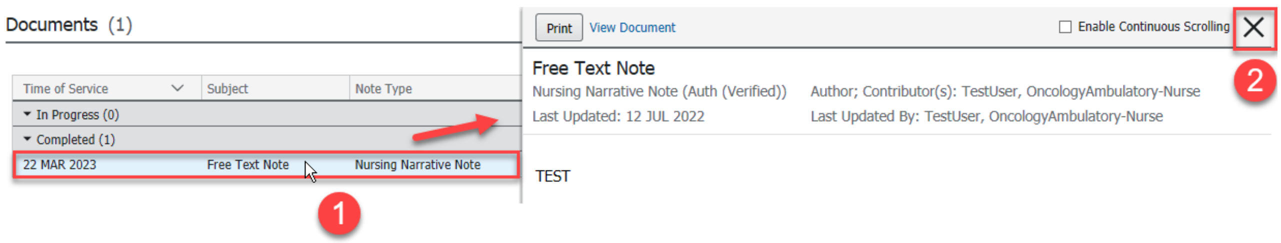
- Clicking the **Header** will navigate you to **Documentation** from the **Menu.**



Selecting Documents within the Document component

1. Select the document named **New Patient Teach** or **Free Text Note** to display the contents of the document in a split screen.

2. Click the **X** to close the split screen.

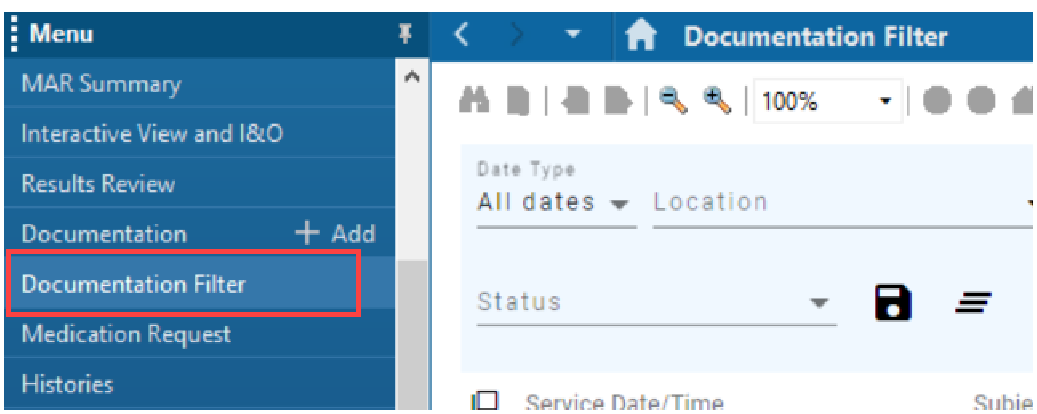


NOTES:

- In the clinical setting, if you do not see the document, you are looking for, check to see if your filters are set correctly. The document list can get quite long as it pulls documentation from across all encounters.
- A full list of documents can be viewed via **Documentation** in the **Menu**.

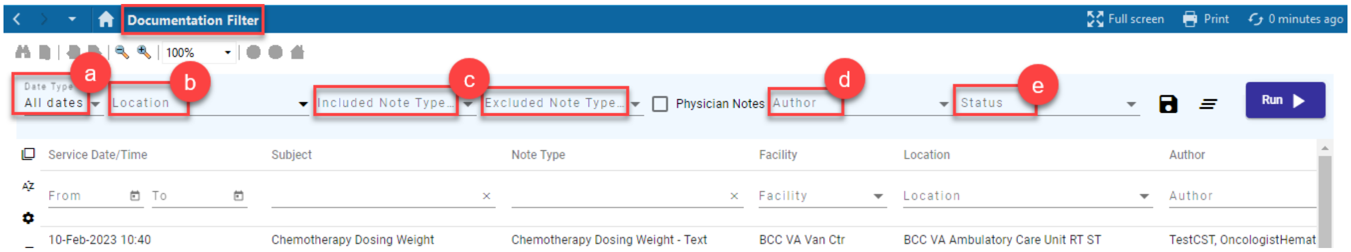
Documentation Filter

1. Navigate to **Documentation Filter** from the **Menu**.



The **Documentation Filter** window opens.

See table for different filter options:



LEGEND	
A	**Date Type**: Filter by days and Years.
B	**Location**: Filter by locations provided or type and search for location.
C	**Note Type**: Filter by typing in note type and searching.
D	**Author**: Filter by typing and searching for author of document.
E	**Status**: Filter by selecting one or multiple statuses, such as Anticipated, Auth (Verified), In Error, In Progress, Modified, and Unauth.

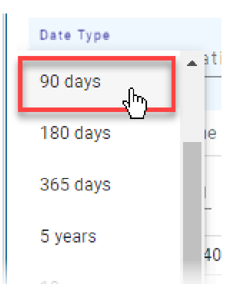
Note: you can use single or multiple filters to search for your documents.

The following steps will guide you through a multiple filter report to become familiar with the options available to you:

1. Click on the **down-arrow** in the column header labeled **Date Type**.

2. Note it has defaulted to **All Dates**.

3. Select the amount of days or years you would like to filter by. For this example, select ***90 days***.



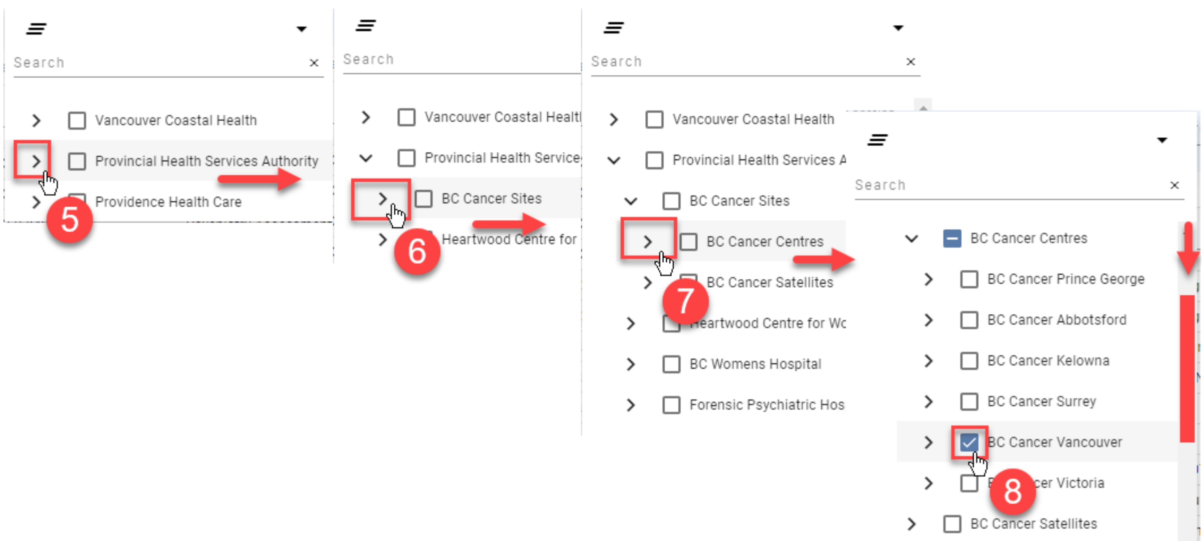
4. Click the **down-arrow** in the **Location** column header. Note that you can filter by location provided or type and search location.

5. Click the **right- arrow** next to Provincial Health Services Authority to expand your options.

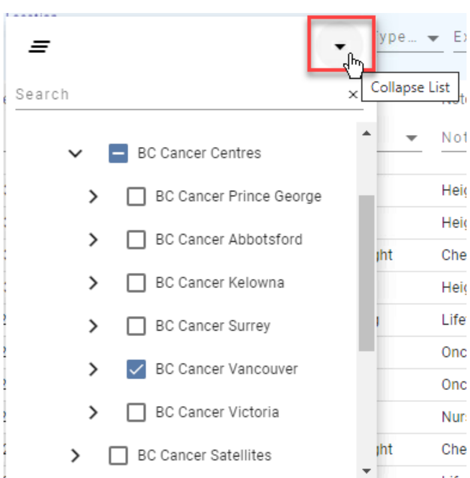
6. Click the **right-arrow** next to BC Cancer Sites.

7. Click the **right-arrow** next to BC Cancer Centres.

8. Scroll-down and select **BC Cancer Vancouver**.

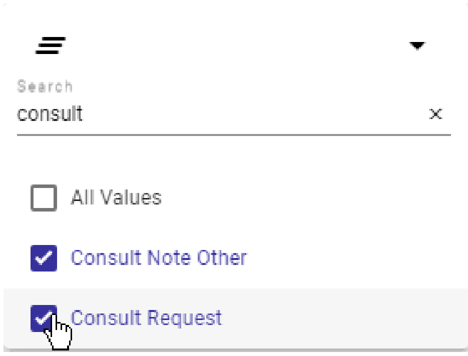


9. Click the **down-arrow** to collapse the list.

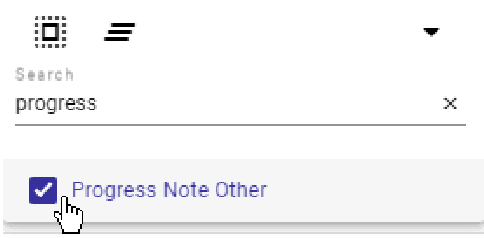


10. Enter the following into the appropriate fields and after every entry collapse the list:

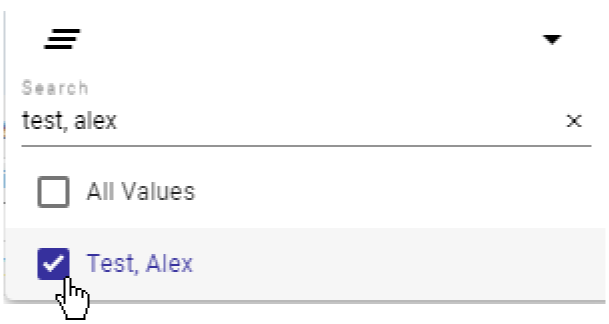
- **Included Note Type** (Filter by typing in note type and searching): Type *Consult* and select **Consult Note Other** and **Consult Request**.



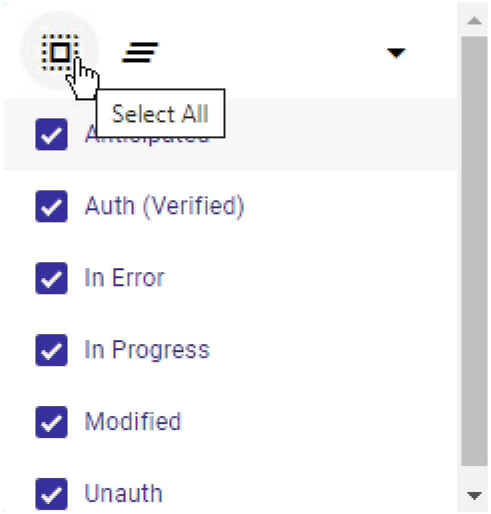
- **Excluded Note Type** (Filter by typing in note type and searching): Type *Progress* and select **Progress Note Other**.



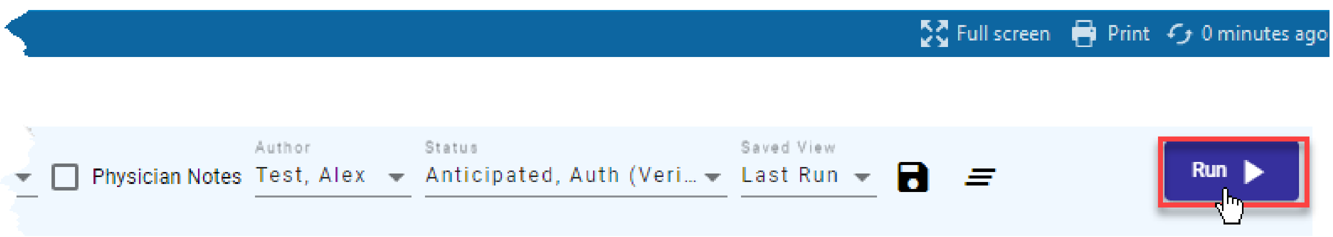
- **Author** (Filter by typing and searching for author of document): Type *Test, Alex* and select **Test, Alex**.



- **Status** (Filter by selecting one or multiple statuses, such as Anticipated, Auth (Verified), In Error, In Progress, Modified, and Unauth): For this example, select all by clicking on the dotted line surrounding a box icon.



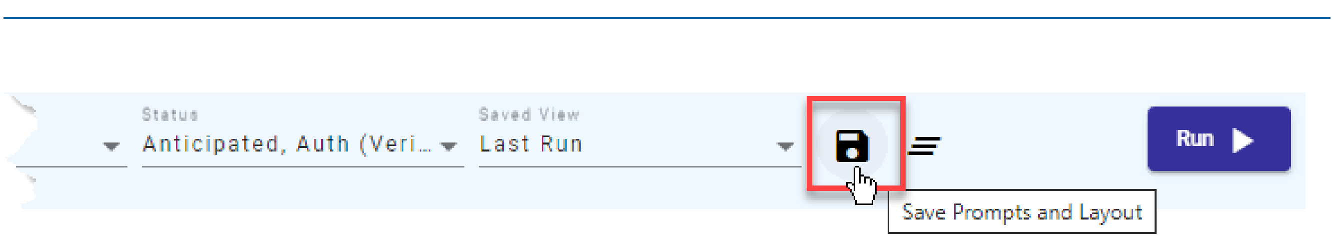
11. Click **Run** to view your filtered documents by your various selected filters.



Note: in the train domain there are limited documents to meet the criteria to filter and your results will state **No records qualified**. In the clinical setting, if no results appear, your filter criteria may be too specific, you may need to broaden your set filters.

To save your customised filters:

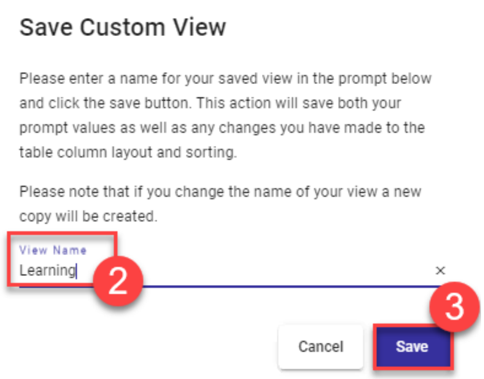
1. Click the **Save** icon.



The **Save Custom View** window opens. Requesting a name for your saved view.

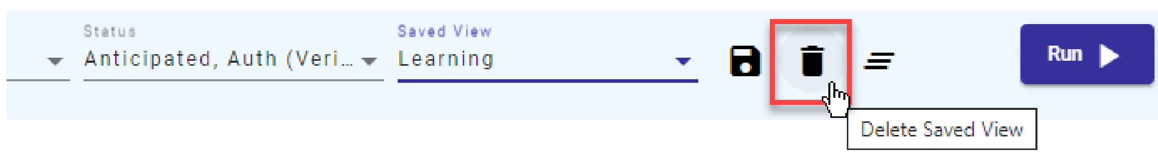
2. For this example, Type *Learning* in the **View Name** field.

3. Click **Save**.

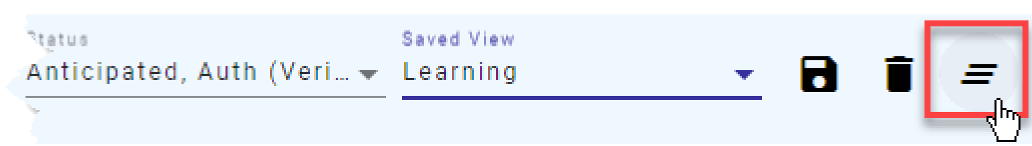


Now you will have the customized filter available to select in the saved view column

NOTE: **READ ONLY** You have an option of deleting any saved views by clicking the **Delete Saved View** icon.



4. Click clear prompts icon to start a new filter search.



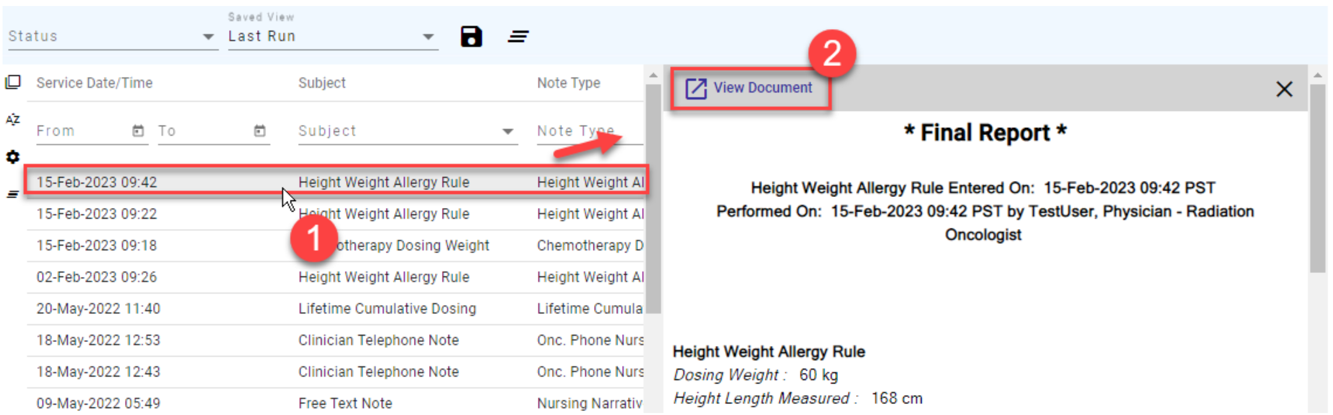
5. Click **Run**  to show the default setting of documentation with all dates.

NOTE: For further information of additional functions, advance sorting and layout settings please see CST Cerner Help topic: [Documentation Filter Workflow Page Overview]

Selecting Documents within Documentation Filter

To view a document:

1. Select and click on the row to display the contents of the document in a split screen.
2. Click the **View Document** icon to open the document in a new window.



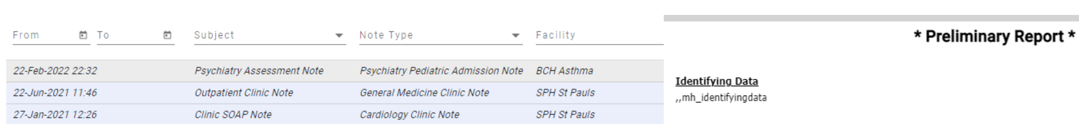
The report will display.

3. Click the **X**  to close the window.

NOTES: (Read Only)

- **In Error** documents will display in a lighter **red** colour.

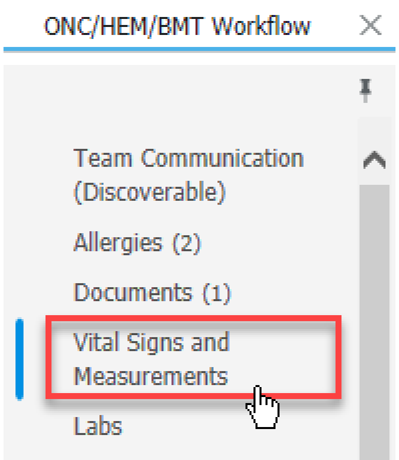
- **Preliminary** documents will display in a lighter blue colour.



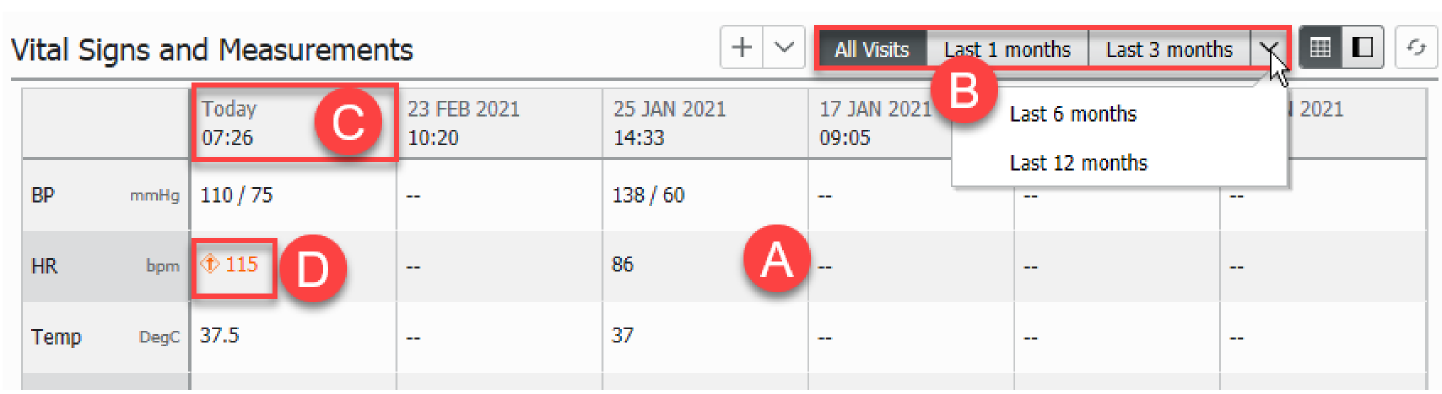
- **Highly Sensitive Information** and **Protected Note** types are filtered out for positions without access to view.

Vital Signs and Measurements

1. Navigate to the **Vital Signs & Measurements** component of the **ONC/HEM/BMT Workflow** page to display your patient's results. Hint: Click the **Home** icon to return to the Ambulatory Summary viewpoint.



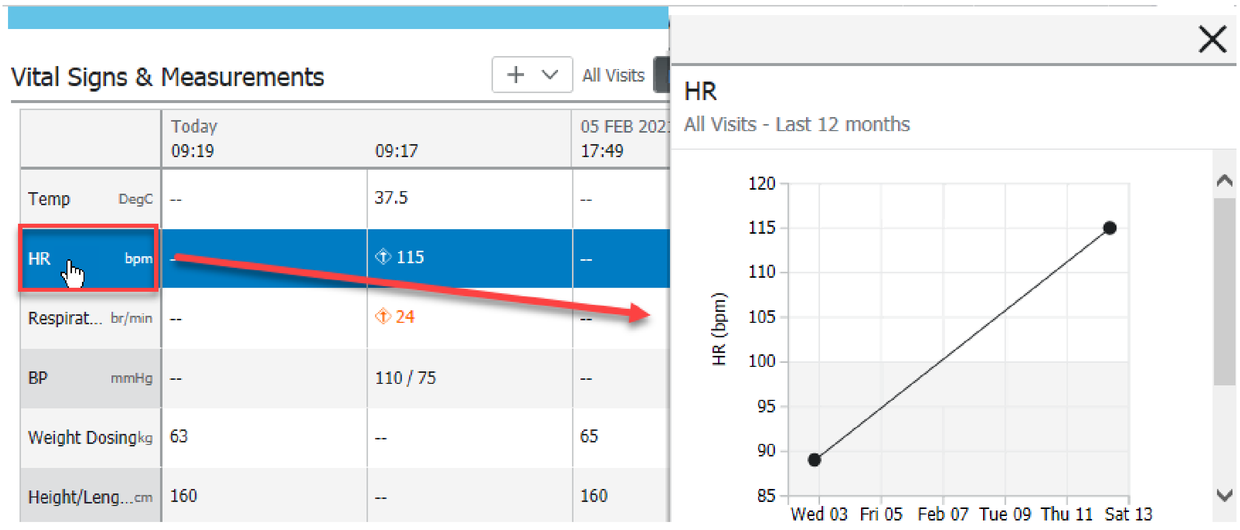
Let's review the layout.



Vital Signs & Measurements component	
A	The component is organized as a table.
B	Results can be filtered to a time period.
C	Table headings show the time the information was entered.
D	Vital signs have visual cues (colours and arrows) when they are out of range; for example, elevated heart rate 115.

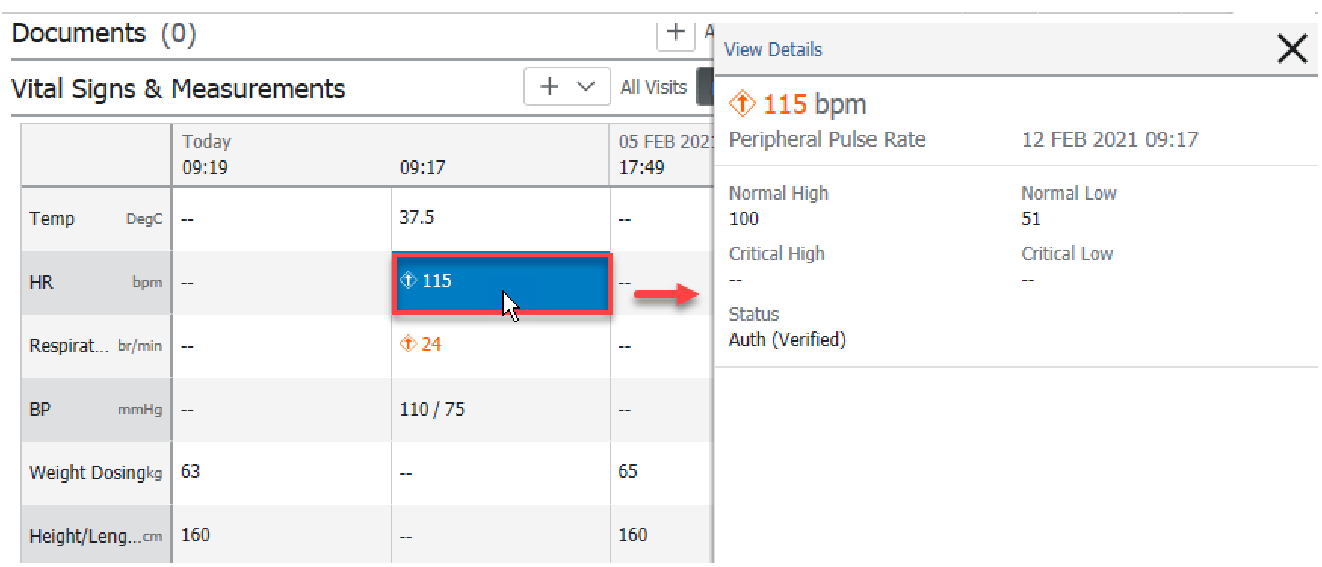
2. Click the **HR** measurement name.

   A **trend graph** appears.



3. Click measurement value for Heart Rate (Note the train domain may contain different values than the screenshots seen below).

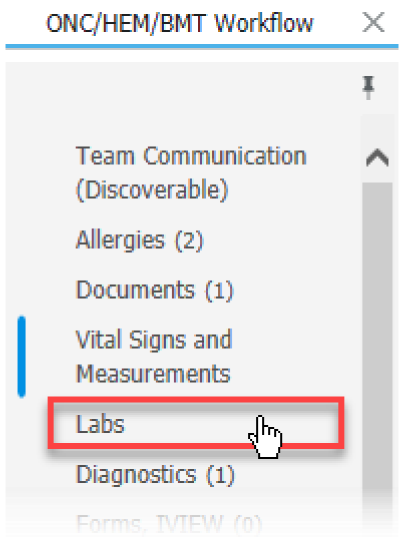
   The **View details** window opens.



4. Select **X** located at the far upper corner of the **View Details** window to close the view.

View Labs

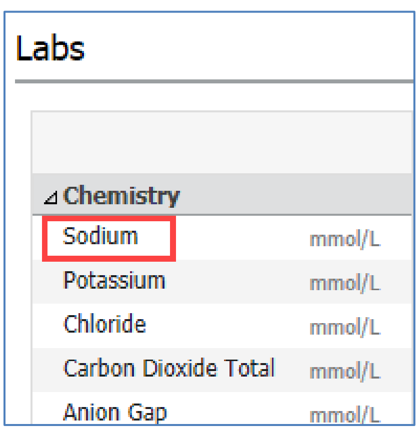
1. Click the **Labs** component from the **ONC/HEM/BMT Workflow** page**.**



2. Note the filter options by time period. If your labs do not appear in the train domain, select the **Last 3 months**.

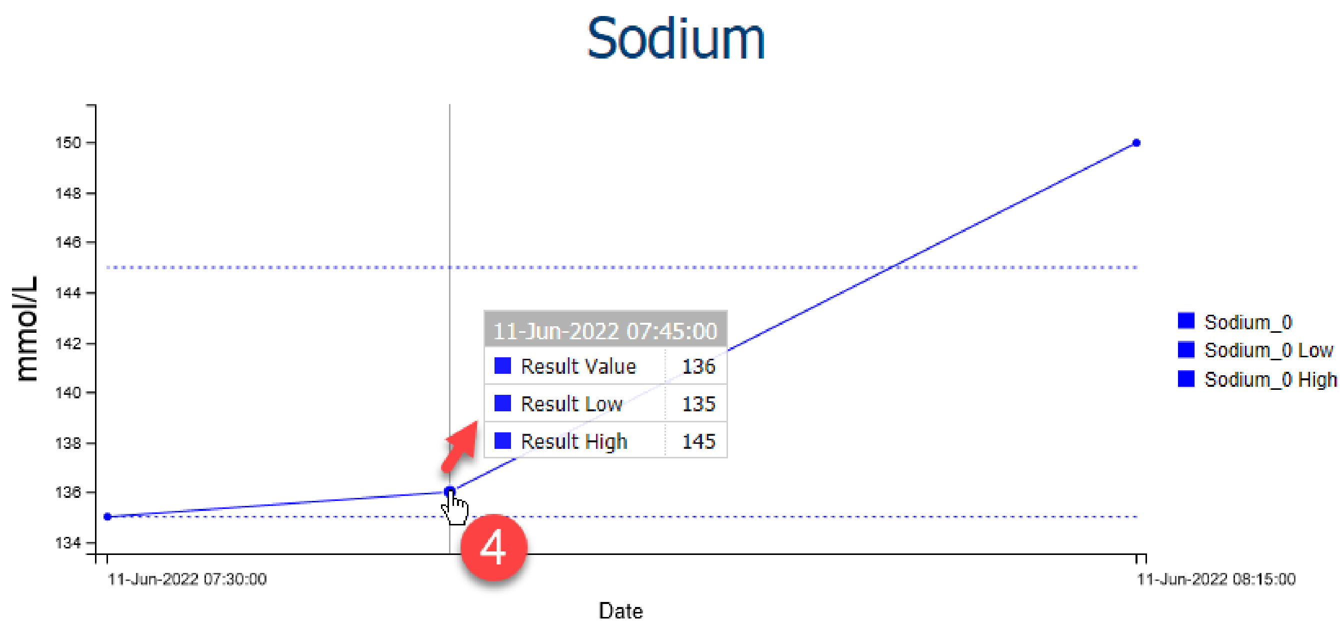
Trending Results

3. Click **Sodium** under the **Chemistry** section.



The **Lab Results Trending** window will open, displaying a graph of all results data points.

4. Hover your mouse over the data points on the graph to view the result value and reference range associated with it.



RESULT DATE/TIME	RESULT VALUE	NORMAL LOW	NORMAL HIGH	NOT GRAPHED
11-Jun-2022 08:15:00	150 mmol/L	135	145	
11-Jun-2022 07:45:00	136 mmol/L	135	145	
11-Jun-2022 07:30:00	135 mmol/L	135	145	

NOTE: Lab results may occasionally be produced on different analyzers/test kits, or may have come from a different Health Organization. This may result in lab work having different references ranges.

Lab values will *not* be graphed if:

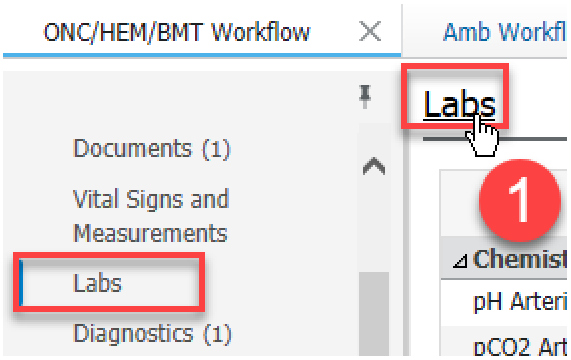
- Only one data point has been entered.
- Textual values (non-numerical data).
- Contains other non-numeric characters (such as < > ?).

5. Click the **X** button at the top right of the window to close.

Results Review

Results Review is a compilation of multidisciplinary documentation and flowsheets.

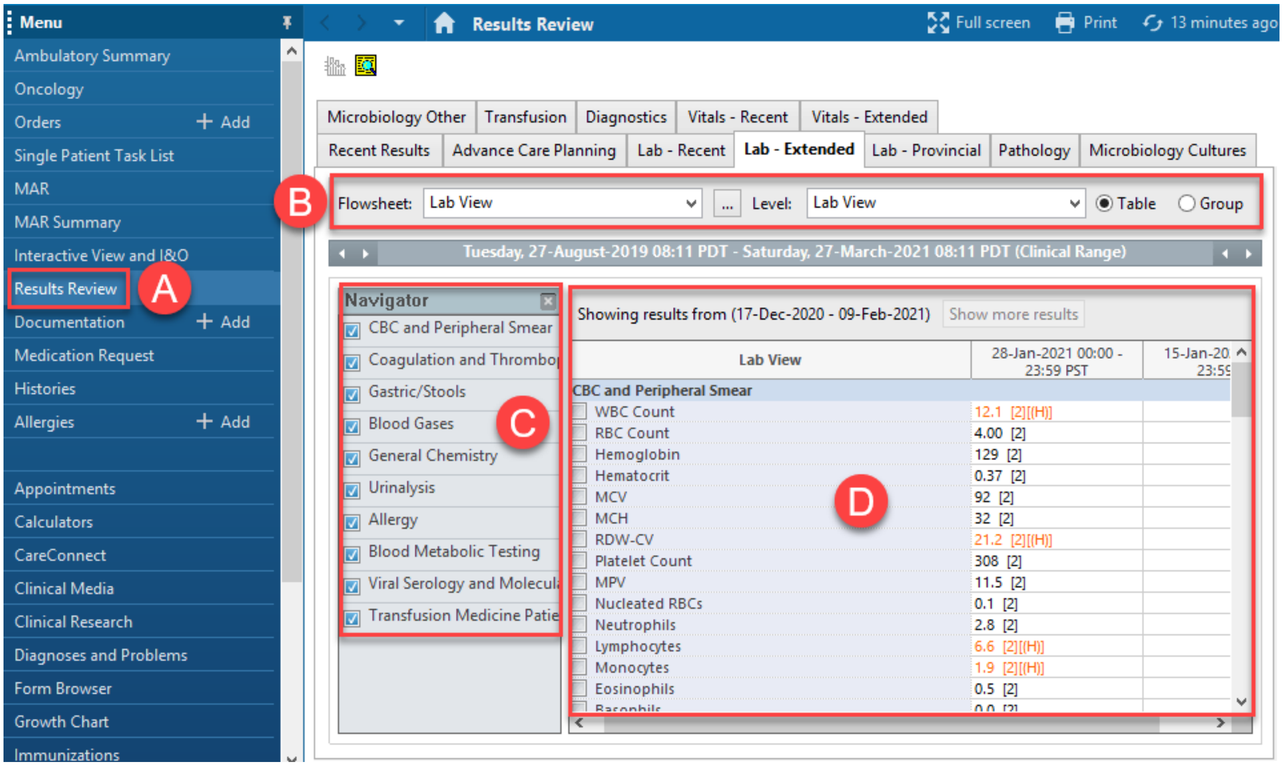
1. Click the **Labs** heading.



Results Review opens and is defaulted from this header to **Lab-Recent** view. **If your labs do not appear in the train domain, select the Lab Extended tab**.

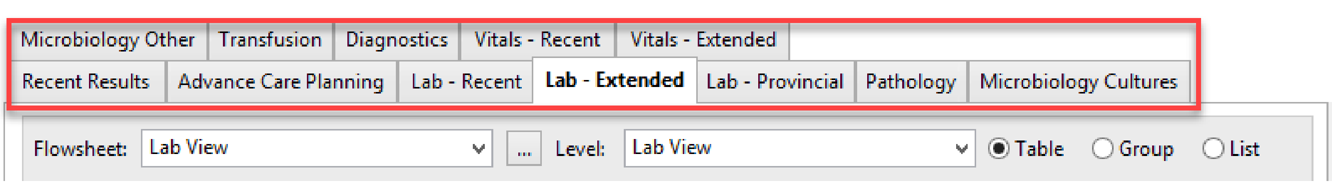
> **NOTE:** Other headers will navigate to different sections of the chart.

Let's review the components of **Results Review.**



LEGEND	
A	Navigation to **Results Review** in the **Menu**.
B	**Flowsheets**: display clinical information recorded for a person such as labs, cultures, transfusions, diagnostic imaging, vital signs, and other clinical documentation pulled from Interactive View and I&O (iView). Flowsheets contain both a **Navigator and the Results Display**.
C	**Navigator**: you can select a category within the navigator to view related results, which are displayed within the grid to the right.
D	**Results Display**: shows related results.

2. Click onto the various tabs to become familiar with each section.



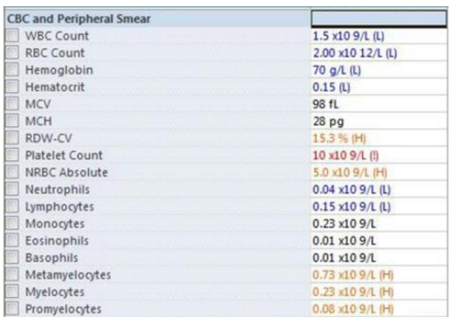
3. Note that you will have access to external lab results via the **Lab Provincial** tab.

4. In the clinical setting, select **Lab – Recent** to see your patient's most recent lab results.

5. Review your patient's recent lab results.

6. View the colours of specific lab results and what they indicate:

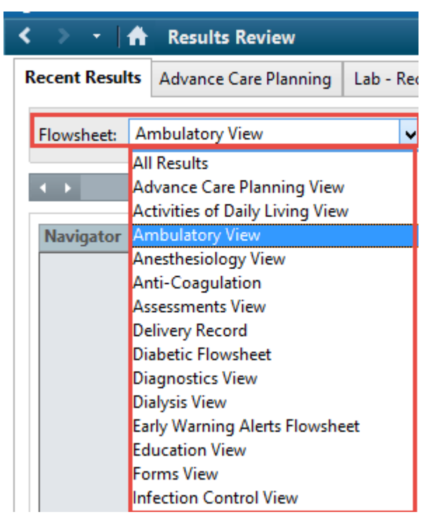
   - **Blue values** indicate results lower than the normal range.
   - **Black values** indicate the normal range.
   - **Orange values** indicate higher than the normal range.
   - **Red values** indicate critical levels.



CBC and Peripheral Smear	
WBC Count	1.5 x10 9/L (L)
RBC Count	2.00 x10 12/L (L)
Hemoglobin	70 g/L (L)
Hematocrit	0.15 (L)
MCV	98 fL
MCH	28 pg
RDW-CV	15.3 % (H)
Platelet Count	10 x10 9/L (!)
NRBC Absolute	5.0 x10 9/L (H)
Neutrophils	0.04 x10 9/L (L)
Lymphocytes	0.15 x10 9/L (L)
Monocytes	0.23 x10 9/L
Eosinophils	0.01 x10 9/L
Basophils	0.01 x10 9/L
Metamyelocytes	0.73 x10 9/L (H)
Myelocytes	0.23 x10 9/L (H)
Promyelocytes	0.08 x10 9/L (H)

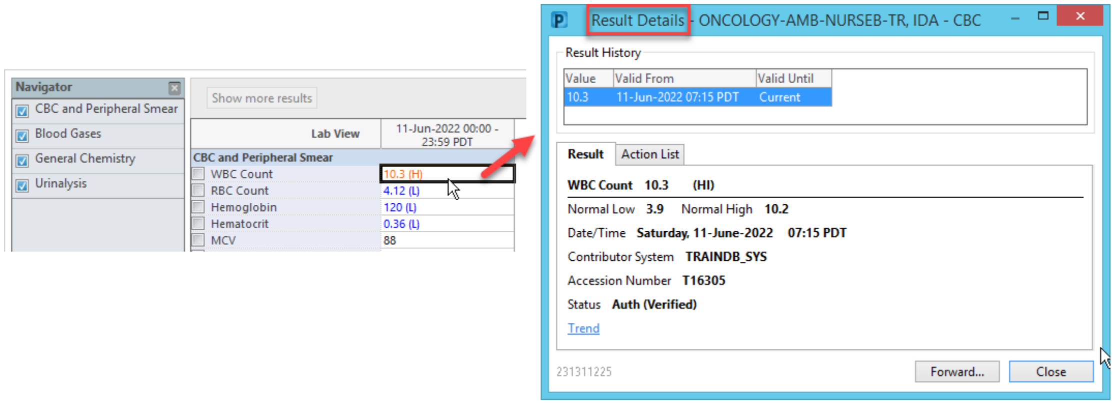
To help support your view there are a series of customized flowsheets.

1. Click the **Flowsheet** drop-down to display multiple Flowsheets for different clinical topics available to select.

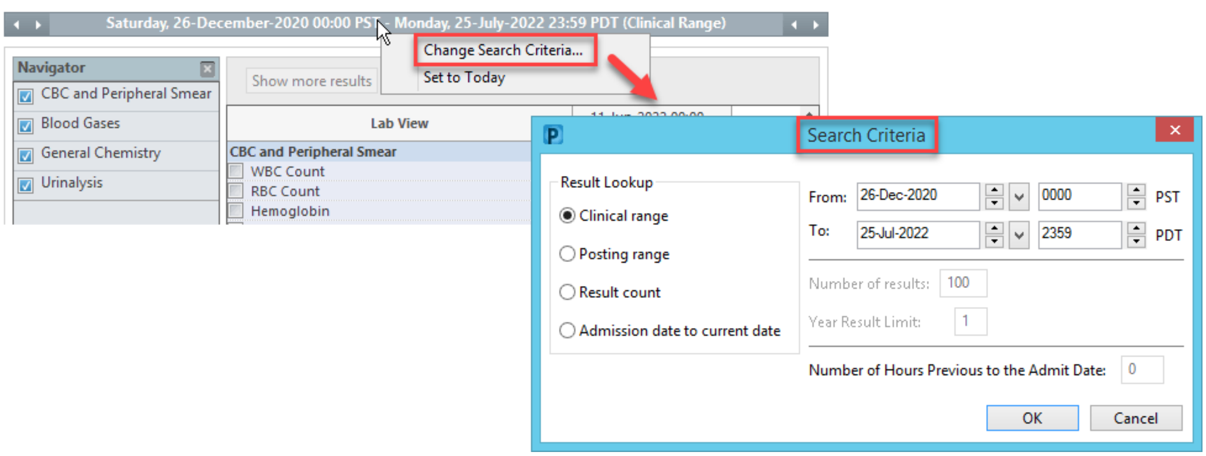


NOTES:

- Double-clicking on any value in **Results Review** will provide further results detail including a list of results History, Actions Associated to the value (For example, who had performed, verified, modified the value) and if any comments were added.

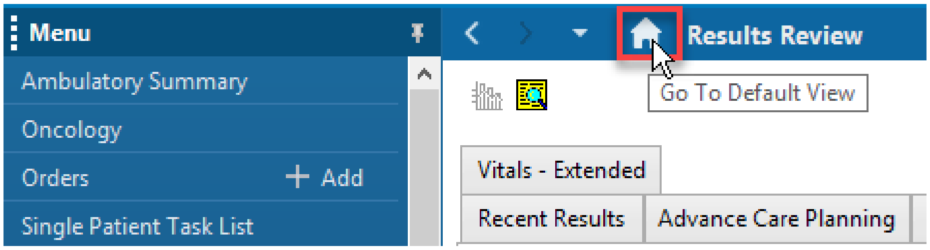


- Only information that has been documented will display in **Results Review**.
- You may have to use the scroll bar at the bottom of the results window to scroll to see all available results for the time frame. (May not be available in the training environment due to limited number of documented results).
- The view is based on the date range and the search criteria. This can be changed as needed by right-clicking on the grey Date Range bar and selecting **Change Search Criteria**.



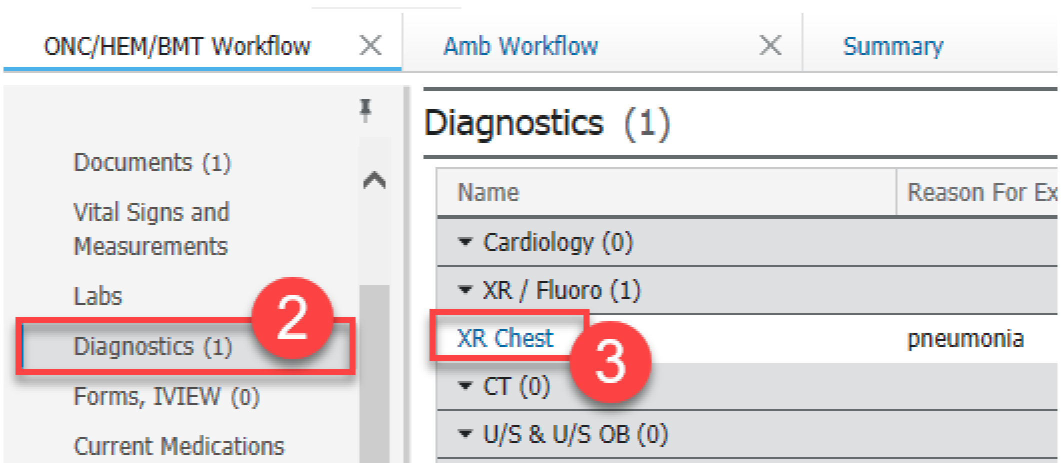
Viewing Imaging Results

1. Return to the **Ambulatory Summary** view by clicking the icon.

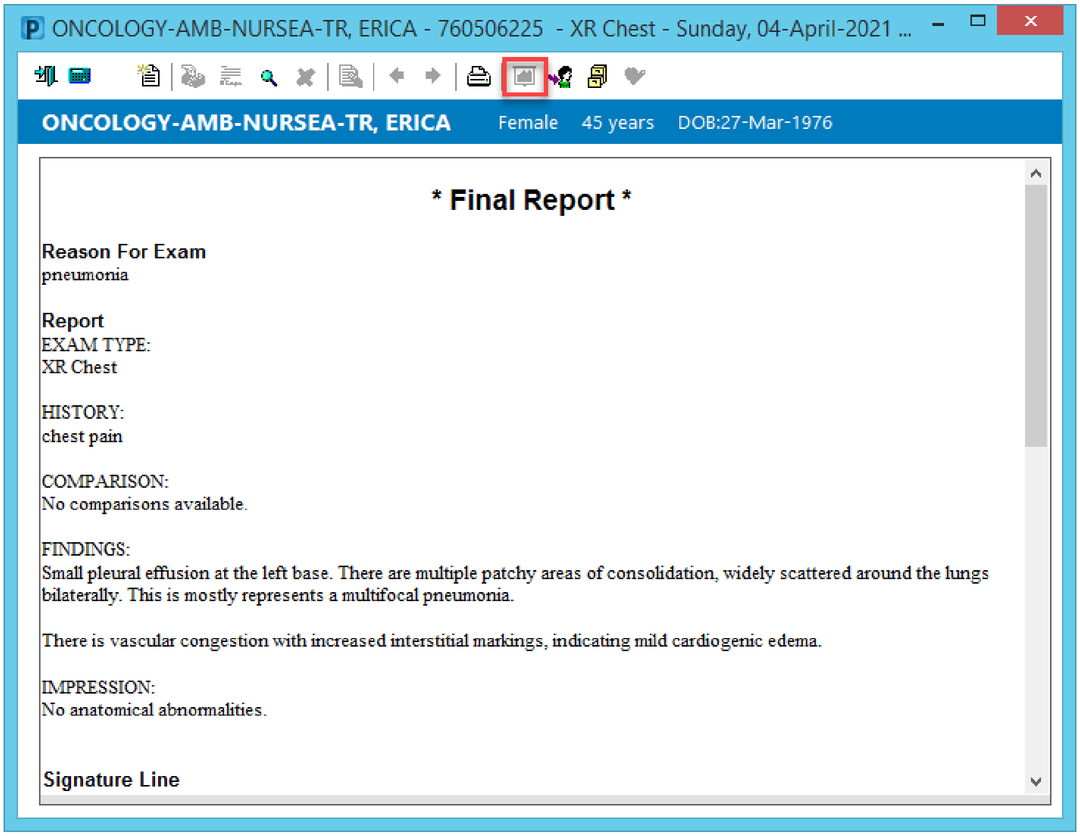


2. Click **Diagnostics** component in **ONC/HEM/BMT Workflow** to display a list of diagnostic reports.

3. To view a chest X-ray result, click **XR Chest** under the **XR/Fluoro** section.



4. The **XR Chest** report opens. You may click the **View Image** icon to view the associated images. Note: these are not available in the training environment.



5. Click the **Exit** icon to close the X-ray report.

Key Learning Points

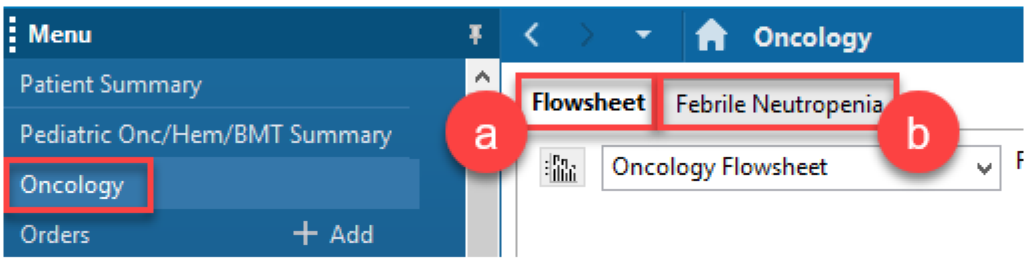
- Documents, Vital Signs, Labs, and Diagnostic Results are available on the Onc/Hem/BMT Workflow page.
- Use filters to display only pertinent information. Remember to check what filter is currently selected when moving between patient charts.
- Documents can be viewed and filtered from the Documentation Filter.
- You can review results for your patient in Results Review.
- Results are presented using flowsheets. Flowsheets display clinical information grouped by relevance.
- Results Review can be accessed on the Menu or in some of the workflow pages via specific component hyperlinked heading (e.g. Labs).

Activity 3.7 – Review Oncology Section in the Menu

Another key section of the patient's chart is the **Oncology** section. This is found below the Patient Summary section in the menu. It contains the following two tabs: a) **Flowsheet** b) **Febrile Neutropenia**.

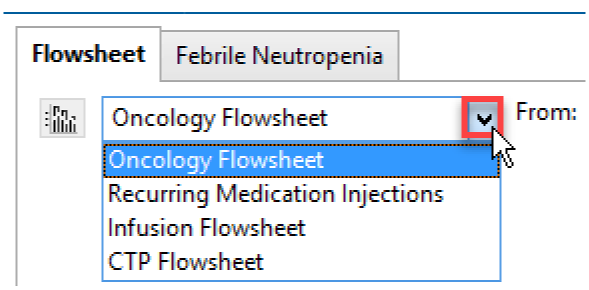
Note there is a third tab developed for the **outpatient areas only** called the **Chemo Calendar**. It is designed to show the patients infusion appointments and to be used to push out the scheduling result for future chemotherapy cycles in the Outpatient setting.

Let's review the Oncology Page Layout. Click on the **Oncology** section on the menu to review each tab.



a. The **Flowsheet** displays clinical results in the context of the patient's treatment. Information is not entered directly into the flowsheet but pulls from other charting done within CST Cerner, for example NCI Toxicity Criteria.

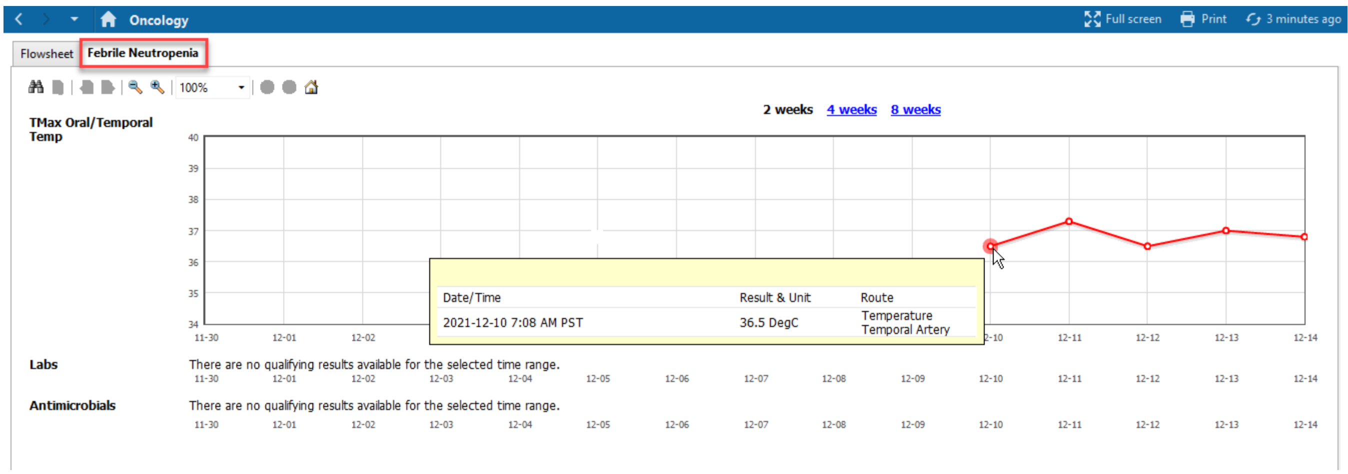
   - Several different flowsheets are available. Click the down arrow to filter the appropriate flow sheet. (Note recent updates to design are not reflected in this training domain).



- **Oncology Flowsheet** displays results based on the patient's chemotherapy treatment (e.g., Lifetime Cumulative Dose). More information on the Oncology flowsheet will be discussed in Activity 9.3 Oncology Medication Order verification and Documentation.

- **Hematology Flowsheet** displays results focused on hematological diagnosis/treatments and labs. (e.g., Hematology Medications, Treatment modifications)

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



NOTES:

- A maximum of five clinically relevant internal or external lab results will appear under this tab.
- Axillary temperatures will not appear on this tab.
- Hover to discover the data points to view Date/Time, Results and Route.

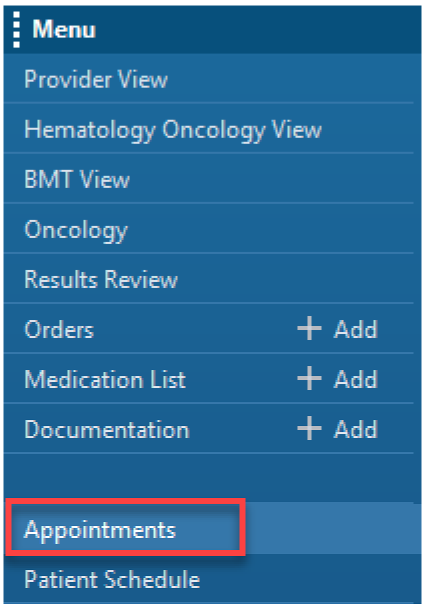
Key Learning Points

- The **Oncology** section in the Menu contains two tabs Flowsheet & Febrile Neutropenia.
- The **Flowsheet** tab contains several different flowsheets that display clinical results in the context of the patient's treatment.
- Information is not entered directly into the flowsheet but pulls from other charting done within CST Cerner.
- The **Febrile Neutropenia** tab used for patients that are admitted to the hospital for febrile neutropenia displays a trend of the patient’s oral or temporal temperature in relation to their absolute neutrophil count and the antibiotic(s) that the patient is receiving.
- Axillary temperatures will not appear in the **Febrible Neutropenia** tab.

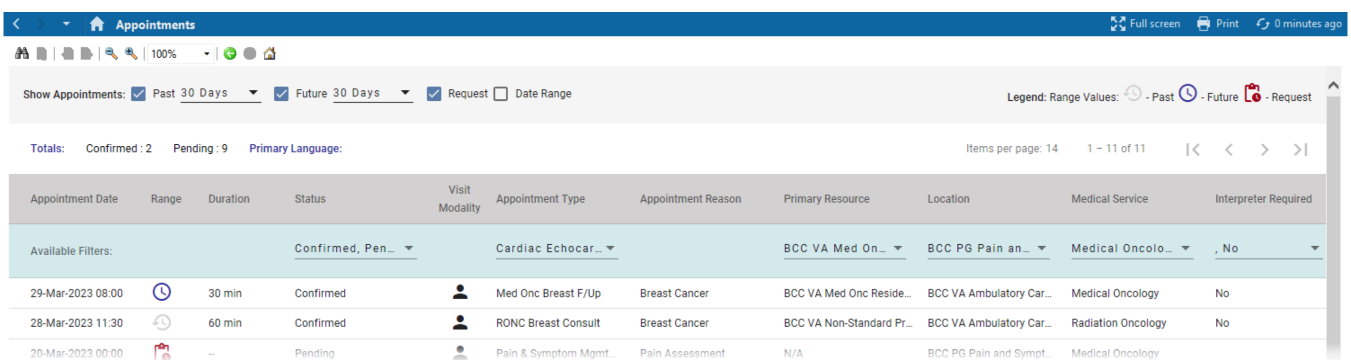
Activity 3.8 – Review Appointments

When viewing a patient's chart, users have the ability to view details regarding all scheduled and requested appointments using the **Appointments** section in the **Menu**. In addition to appointments at your clinic, you will be able to see appointments for your patient at all sites using CST Cerner. Note that some off-site appointments may appear in this section. Filters are also available to customize the view.

1. Click **Appointments** in the **Menu**.

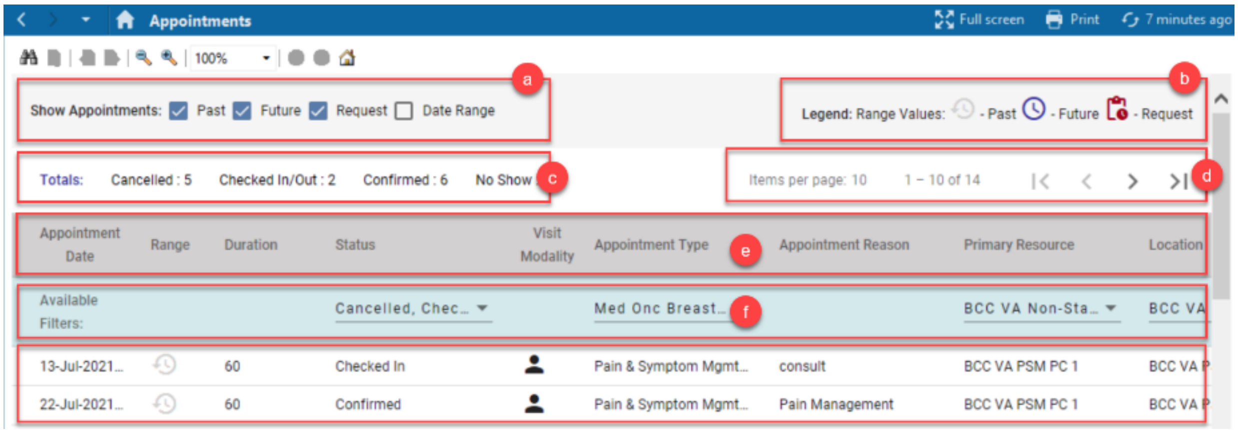


The patient's appointment(s) will display.

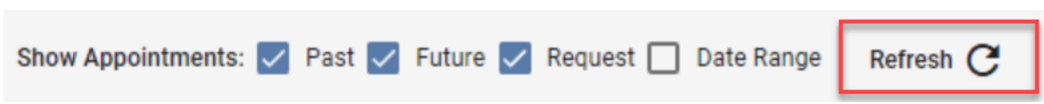


Read Only

2. Refer to the screenshot below for more information on the various components of the **Appointments** section in the chart:



a. **Show Appointments:** Filters allow you to select which appointments will display. Changing the default settings will display a **Refresh** button. Click **Refresh** when applying a different filter.



- You can filter to view the selected patient's appointments in the **Future** and/or the **Past**.
- You can also filter to view any **request** for appointments for the selected patient.

a. **Legend**: Icons indicating the status of appointments listed.

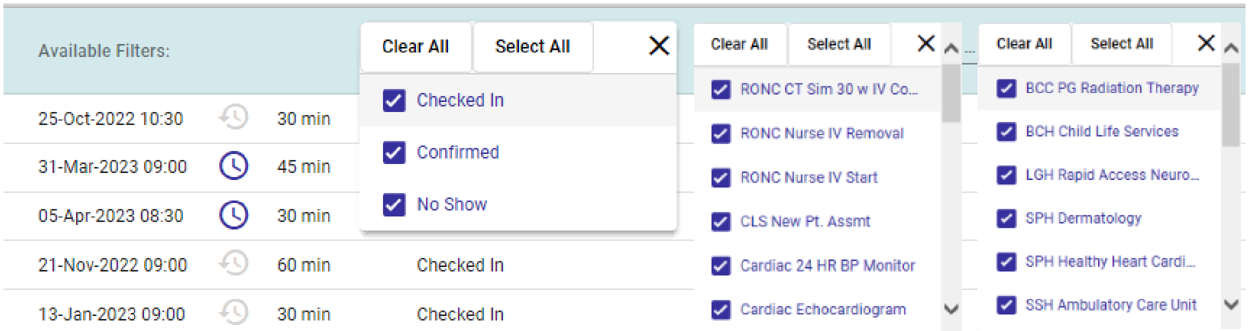
b. **Totals**: Total number of appointments by status.

c. Use these arrows to move to next page/previous page or last/first page.

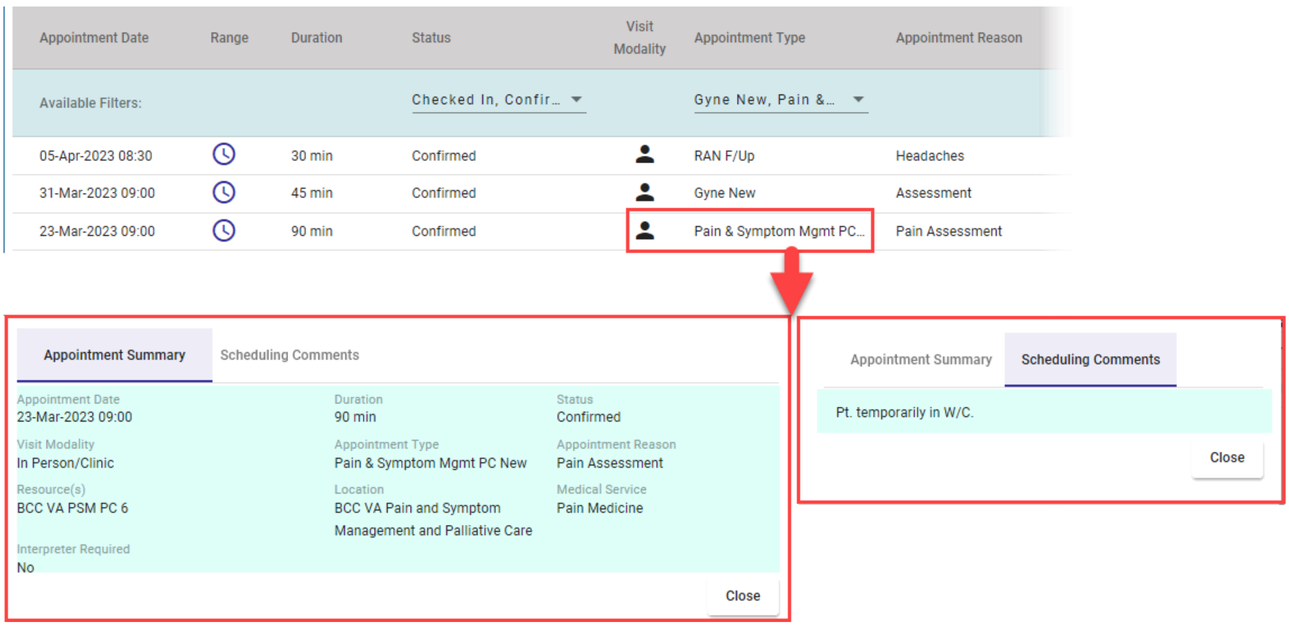
d. **Column headings**: Click a heading to change the order the items are displayed.

e. **Available Filters**: Click on a filter to view a drop-down arrow to view the available options. Deselect any options that you wish to remove from the list of appointments.

   - Please note that the options displayed are based on patient current appointment status. Example: The screenshot below does not display **Cancel** as this patient does not have any appointments in **Cancelled** status.



3. Click on the appointment to see **Appointment Summary** and **Scheduling Comments** tabs.



End of Read Only

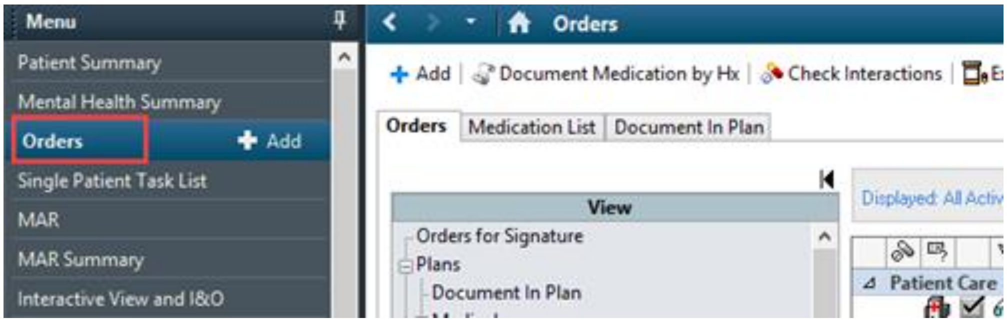
Key Learning Points

- The Appointments section in the Menu displays appointments at your clinic and at all sites using CST Cerner.
- Filters are available to customize the view.
- Click on the appointment to see Appointment Summary and Scheduling Comments tabs.

Activity 3.9 - Review Orders

At the beginning and throughout the shift, you review orders. Although you can have a quick view of the orders in the Orders component of the Handoff tool, the Orders page is where you can view the full details of the orders.

1. Select Orders from the Menu.



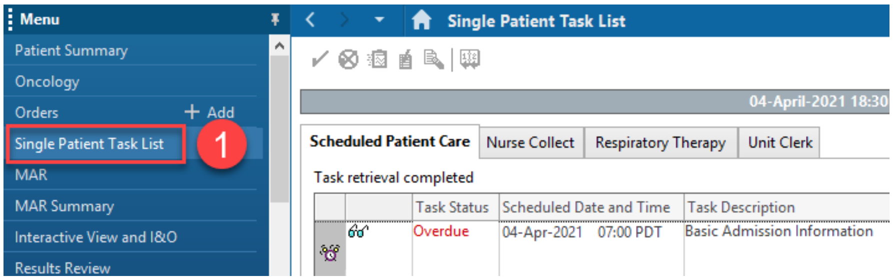
NOTE: The introduction of PowerPlans and Regimens and the general layout of the orders page will not be repeated in this activity. Please refer to **CST Cerner – Oncology Nurse: Introduction to PowerPlans and Regimens emodule.**

We will be reviewing our patient's inpatient orders later in the workbook.

Activity 3.10– Review Tasks on Single Patient Task List

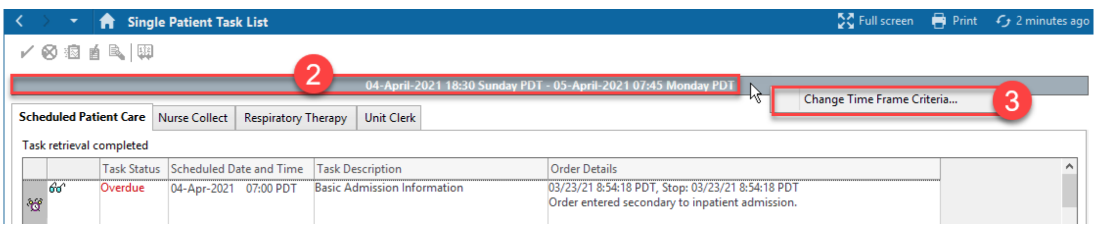
You have reviewed the patient tasks in **CareCompass** in Activity 2.1. While you are in the patient chart, you can also review patient tasks on the **Single Patient Task List (SPTL)**.

1. Navigate to the **Single Patient Task List** from the **Menu**.



2. Right click on the grey bar if no time frame has been set up.

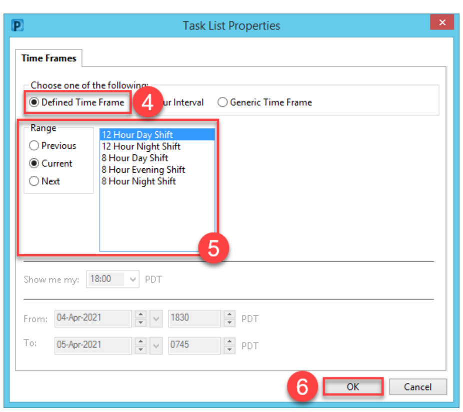
3. Select **Change Time Frame Criteria**.



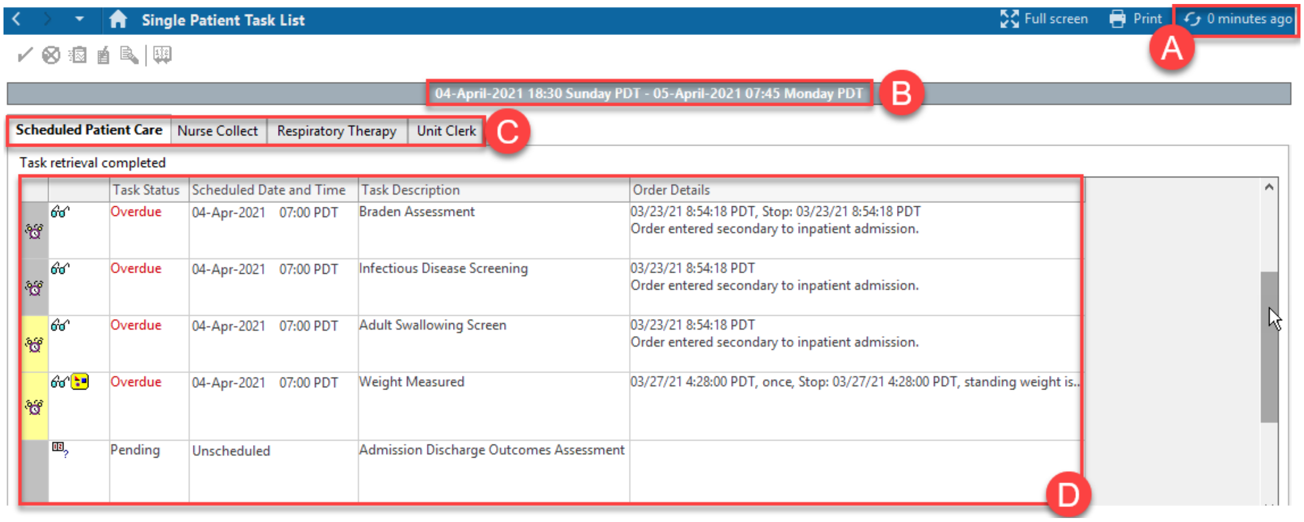
4. In the Task List Properties window and under Time Frame tab, select **Defined Time Frame**.

5. In the Range section, select **Current and a shift** (e.g. 12 Hour Day Shift).

6. Click **OK**.



The screenshot below illustrates key elements that you need to know when you review a task associated with your assigned patient on the **SPTL** (see explanations in the Legend Table).



LEGEND	
A	**Refresh Icon** – clicking this icon updates information showing in SPTL.
B	**Information Bar** – The grey Information Bar shows the time frame (far right) that you have set up in SPTL.
C	**Task Category Tabs** – The tabs include Scheduled Patient Care, Nurse Collect, Respiratory Therapy, and Unit Clerk. Click on the tab to review the task details that fall in each category.
D	**Patient Tasks List** - it displays details of the patient task including task status (i.e. pending, overdue), task scheduled date and time, task description, and order details.

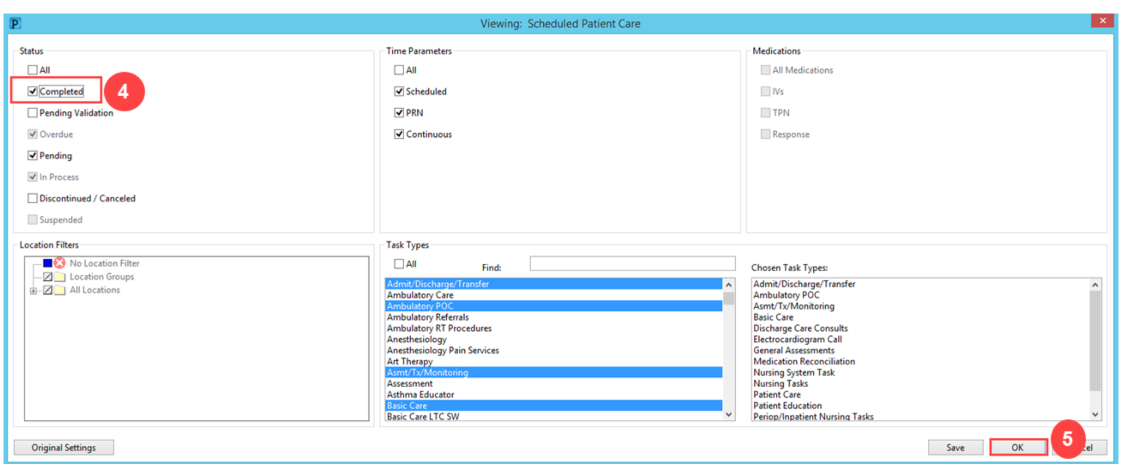
Read Only

Single Patient Task List (SPTL) displays pending and overdue tasks by default. The completed tasks are removed automatically from the task list. If you want to view the completed task showing back on the **SPTL**, you need to change the task display.

1. While on the **SPTL**, select the **Scheduled Patient Care** tab.

2. Click **Option** on the toolbar.
3. Select **Task Display** from the drop-down menu.

4. In the **Viewing: Unit Collect** window, put a checkmark beside **Completed**.
5. Click **OK**.



Return to the **SPTL**. You can now view the completed task(s) for your patient on the **SPTL**. Please refer to the screenshot below as an example.

NOTE: You need to change the task display if you want to review completed tasks under other tabs.

End of Read Only

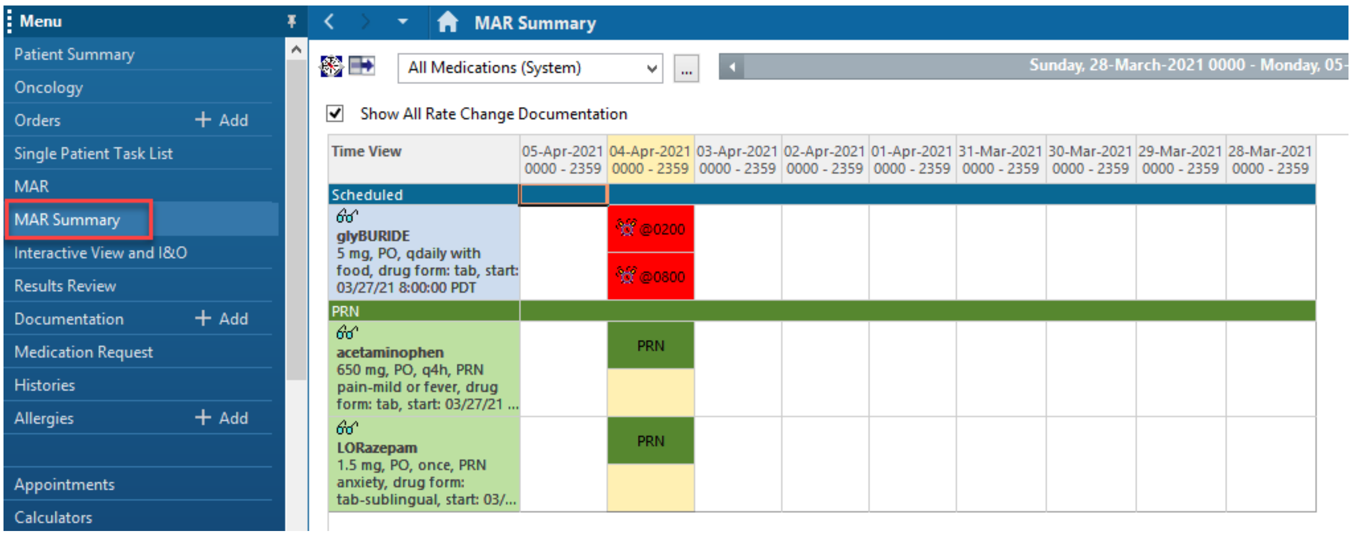
Key Learning Points

- Single Patient Task List (SPTL) displays specific tasks for one patient in the patient chart.
- Click the Refresh icon to ensure you can see the most current tasks.
- Click the Task Category tab to locate a task category and review the task list with information including task status, task scheduled date/time, task description, and order details.
- SPTL displays pending and overdue tasks by default.
- Change the task display of each tab to review completed tasks.

Activity 3.11 – Review MAR Summary

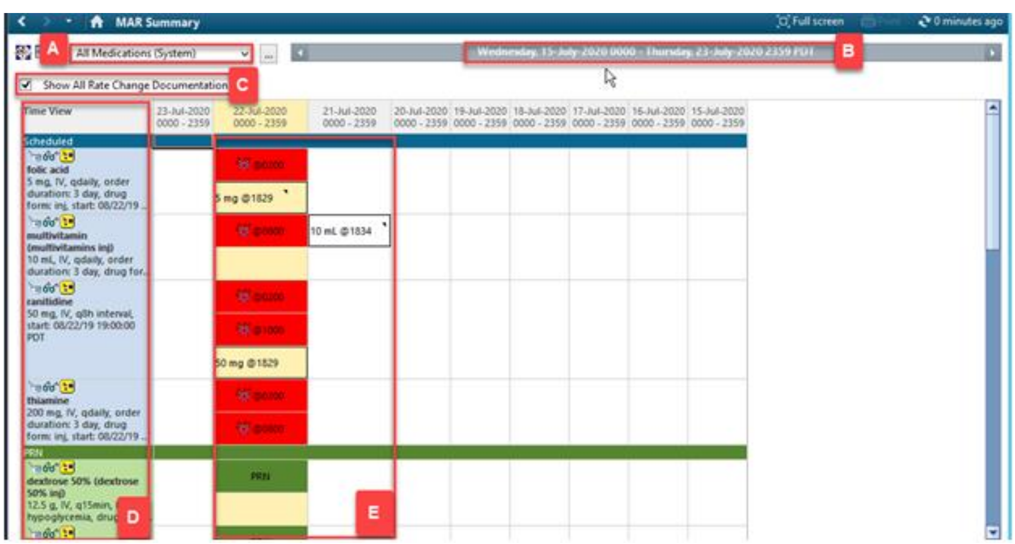
At the beginning of the shift and at every transition of care, you may want to review medication administration charted by other nurses. **MAR Summary** provides various information pertaining to the dosages of the medications given, last medication administration times, and the titratable infusion rates of the medication infusions.

1. Select **MAR Summary** from the **Menu**.



Read Only

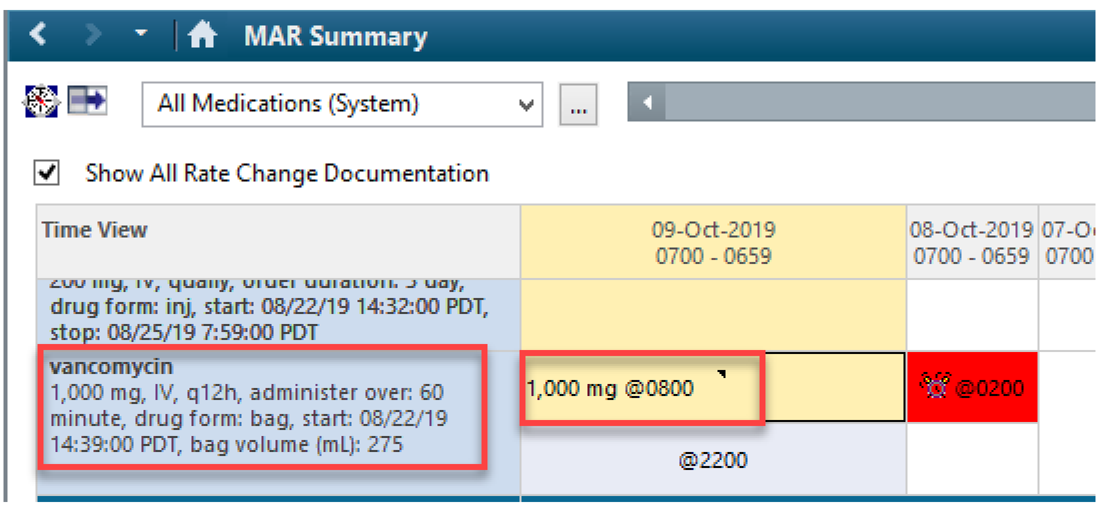
Let's review the key features in the **MAR Summary** (see explanations in the Legend Table).



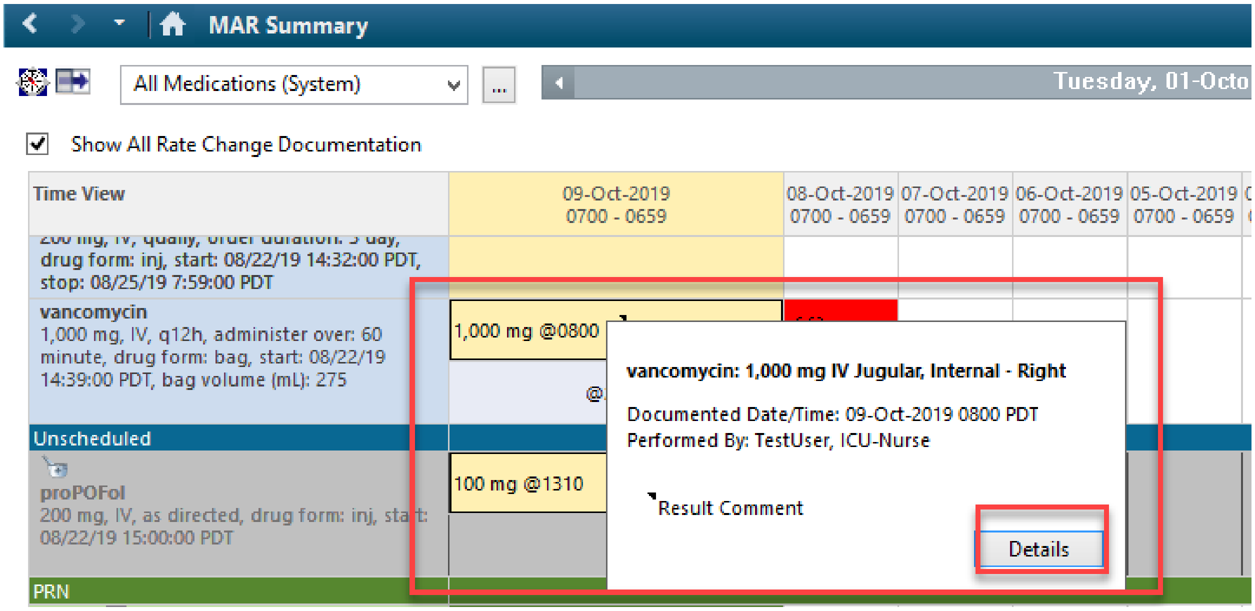
LEGEND	
A	**Filter Display** – the **MAR Summary** is defaulted to display all medications (active and inactive). Select an option from the Filter Display drop-down list to modify the view of the **MAR Summary** if needed.
B	**Date Range of the Display** – the MAR Summary is defaulted to display all medications for the last 7 days, current date, and the next day. It is arranged in **reverse chronological order**.
C	**Show All Rate Change Documentation -** indicates the titratable infusion rate change of the medication infusion.
D	**Time View** – display current medication orders that are organized in different categories including **Scheduled**, **Unscheduled**, **PRN**, **and Continuous Infusion**.
E	**Medication Administration Information** – each date range column display medication administration information such as last given time and dosage, overdue medication task, titratable infusion rate change.

To review last medication dose given:

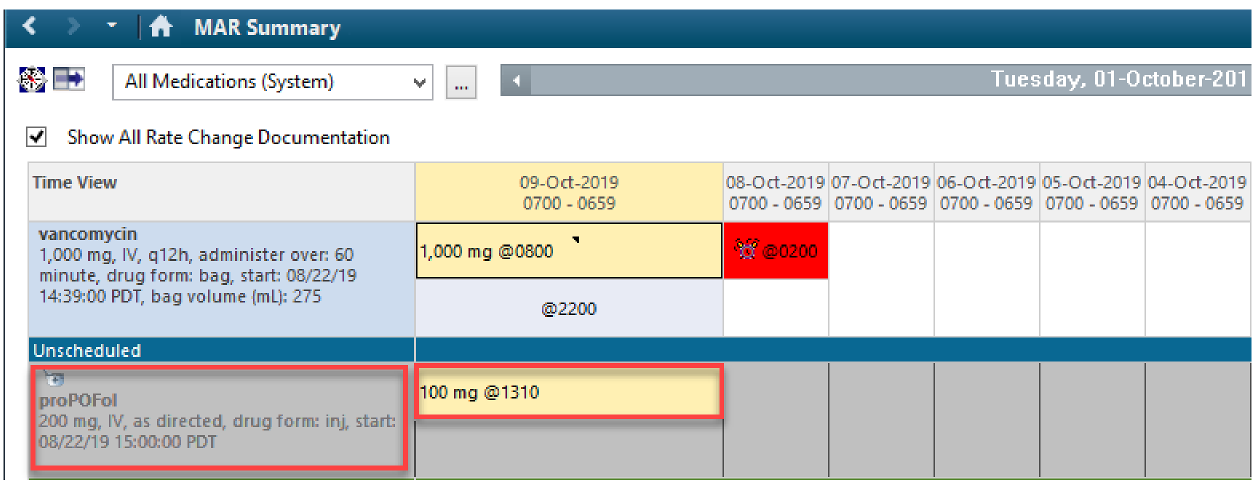
- Select a medication to be reviewed. The medication that has been administered displays with the actual dose given and the last given date/time.



- Hover the cursor over the administered medication to bring up extra details about the administration.
- Click Details to review more information.

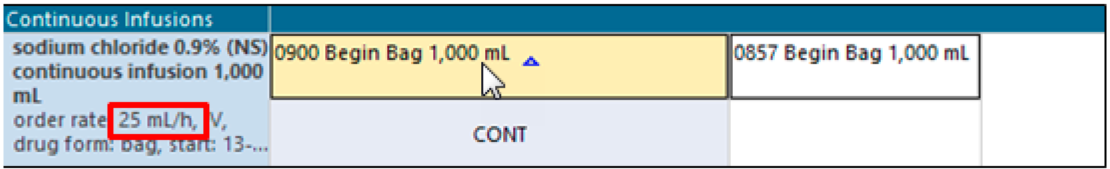


- Medications that have been discontinued are greyed out. The dosage and the last given time still display.

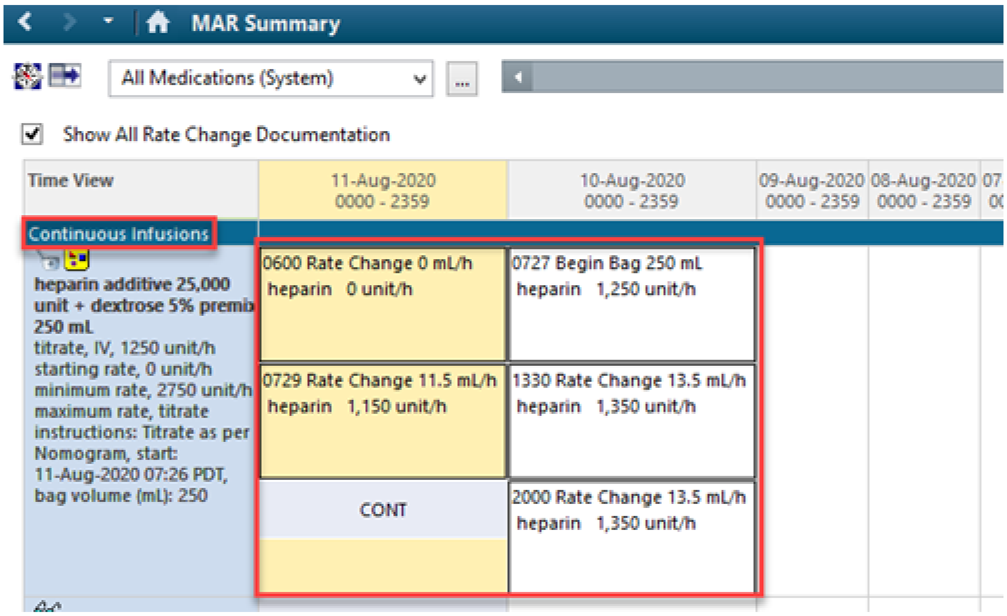


To review continuous infusions:

- In the **Continuous Infusion** category, select a continuous infusion (e.g. Normal Saline infusion) or a medication infusion (e.g. Heparin Infusion) to be reviewed.
  - For non-titratable continuous infusions (e.g. Normal Saline infusion), the infusion bag start time and the administration documentation change time display on the **MAR Summary**. The upward pointing arrow beside the order details indicate an administration documentation change was made.



- For titratable medication infusions (e.g. Heparin Infusion), the documented dosage infusion rates and the date/time for the rate change display on the **MAR Summary**.



End of Read Only

Key Learning Points

- MAR Summary provides various information pertaining to the dosages of the medications given, last medication administration times, and the titratable infusion rates of the medication infusions.
- MAR Summary is arranged in reverse chronological order and shows medication administration information for the last 7 days, current date, and the next day as default.

PATIENT SCENARIO 4 – Admission Documentation in Interactive View (iView) and I&O

Learning Objectives

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

- Demonstrate an understanding of the documentation options in the Oncology unit.
- Document, Modify and Unchart your Documentation in iView.

SCENARIO

You have a patient, diagnosed with Lymphoma, due for admission on your inpatient unit. Your patient is due to receive Methotrexate. You have reviewed patient information in CST Cerner prior to the patient's arrival to the ward. After the patient arrives you take vital signs and complete the initial assessment on the new patient. You are ready to document your findings in CST Cerner.

You will complete the following activities:

- Overview of Interactive View and I&O
- Document in Interactive View and I&O

For the following activities, select the name of **patient A** as assigned to you from your CST Cerner Learning – Your workbook's logins and patients email.

Activity 4.1 – Overview of Interactive View and I&O

Read Only

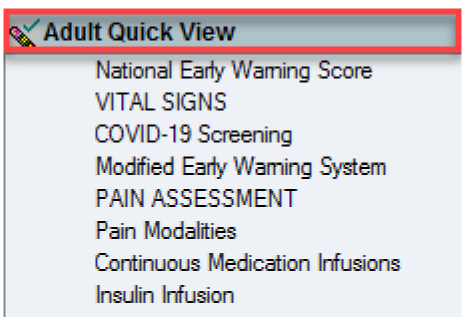
Interactive View (IView) is the electronic equivalent of current state paper flow sheets.

You have been introduced to **Interactive View (IView)** via emodule and learned to identify the basic functionality of Interactive View, recognize the interactive View and I&O displays and learned how to document in Interactive View and I&O.

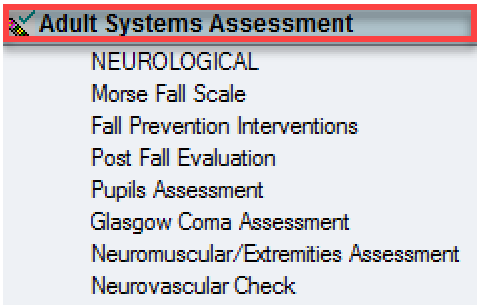
We will not repeat the general layout or customization but introduce you to other bands in IView most commonly used. There are many different sections to each band that will allow you to assess and document a patient's condition and interventions. Further discussion on the different bands will be reviewed in your workflow review session.

1. Select **Interactive View and I&O** within the Menu. Now that the **IView** page is displayed, let us click through some of the common bands that the Oncology Nurse may use to document the vitals and assessment findings. Note you will have an opportunity to chart in each band in future activities.

Adult Quick View is where you can document your vitals and assessment findings.

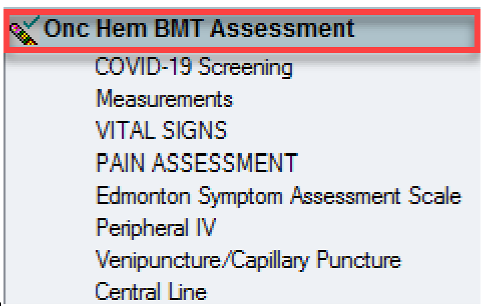


Assessment findings can also be documented in **Adult Systems Assessment** iView band. The sections within the Adult Systems Assessment band are organized according to the body systems such as Neurological system, Respiratory system, Cardiovascular system, and so on.



All chemotherapy related IView documentation should be in the **Onc Hem BMT Assessment** band in IView.

The **Onc Hem BMT Assessment** band houses a variety of Oncology specific sections, including NCI Toxicity, Chemo/Biotherapy Verification, and Infusion/Chemo Adverse Reaction.



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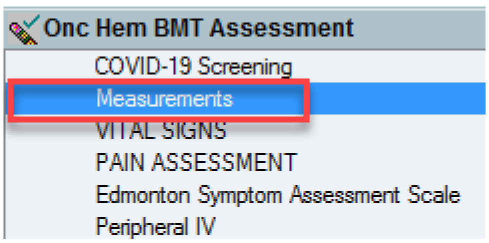
NOTE: You do not have to document in every field in iView, aim to only document what is appropriate for your assessment and follow appropriate documentation policies and guidelines at your site.

Activity 4.2 – Document in Interactive View and I&O

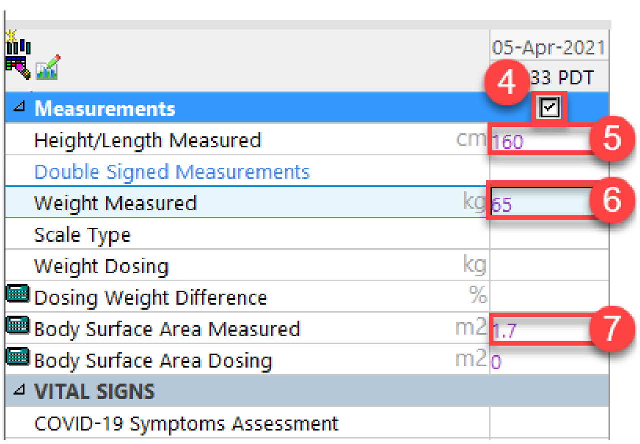
In the emodule you practiced entering vitals in the Adult Quick View Band. You can go to this band for further practice. However, in this activity, you will practice entering height and weight with a second signature.

To document your patient's height and weight with a second signature:

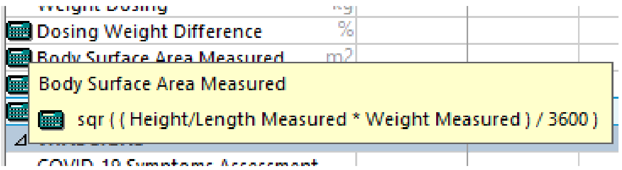
1. Click to expand the **Onc Hem BMT Assessment** band.
2. Click **Measurements**.



3. Note the first column furthest to the left always represents the current date and time.
4. **Double Click** on the cell next to the Measurements header to activate the entire documentation section. This allows you the option of using the **Enter** or **tab** on the keyboard to navigate to subsequent cells. In this example, it will automatically calculate the patient's body surface Area Measured when you enter the height and weight.
5. Under Height/Length Measurement, type *160*.
6. Under Weight Measured, type *65*.
7. Note the Body surface Area has been automatically calculated.



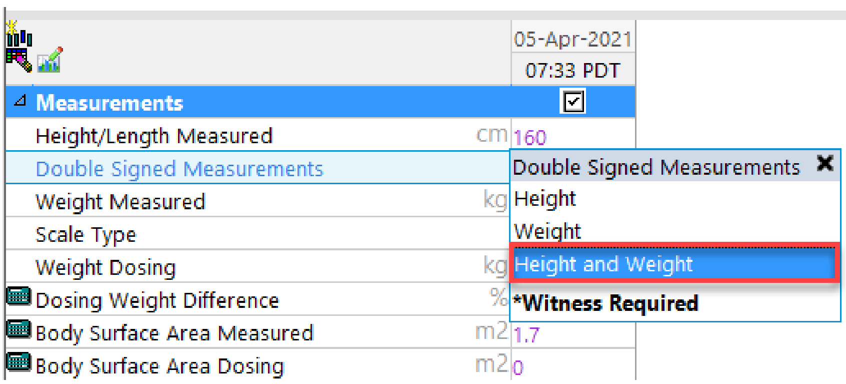
8. Hover to Discover the Calculator Icon. This icon will provide the details of the calculation.



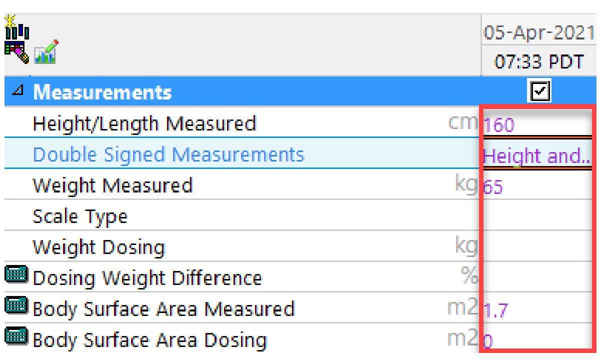
Per your Health Authority policy, if **Double Signed Measurements** are needed for **Height and Weight** then **click** the cell beside double signed measurements.

9. Click on the cell next to **Double Signed Measurements**.

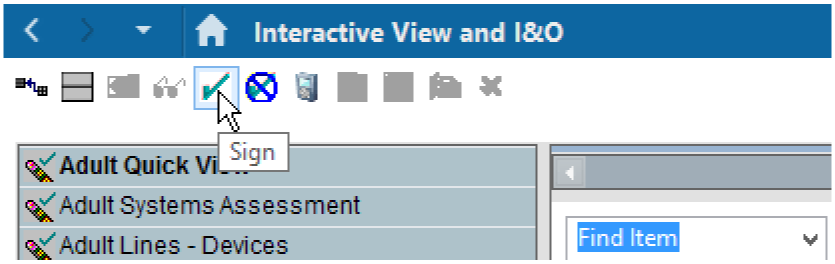
10. Select **Height and Weight** from the Double signed Measurements box.



11. Note the color of the text in the cell is purple prior to signing.

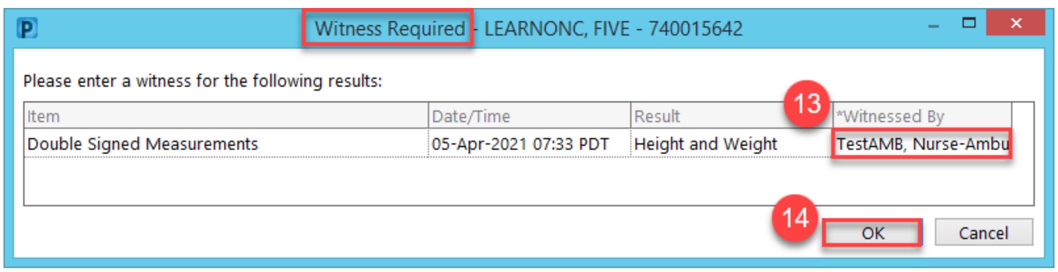


12. Click the **sign** button located below the navigation bar.



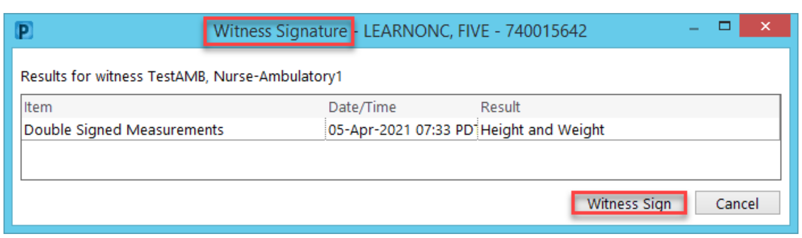
13. A **Witness required** window opens which allows the second nurse or health care worker to add their credentials. For training only, we will be using a test user as a witness. Type **TestAMB, Nurse-Ambulatory1** in the Witnessed by field.

14. Click **OK**.



The **Witness Signature** window appears with details of what is being signed.

15. Click **Witness Sign**.

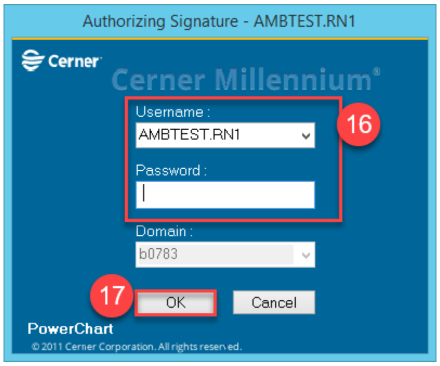


16. The witness would ensure their username is correct and type in their password. For this training example, use the following with no spacing:

Username: **AMBTEST.RN1**

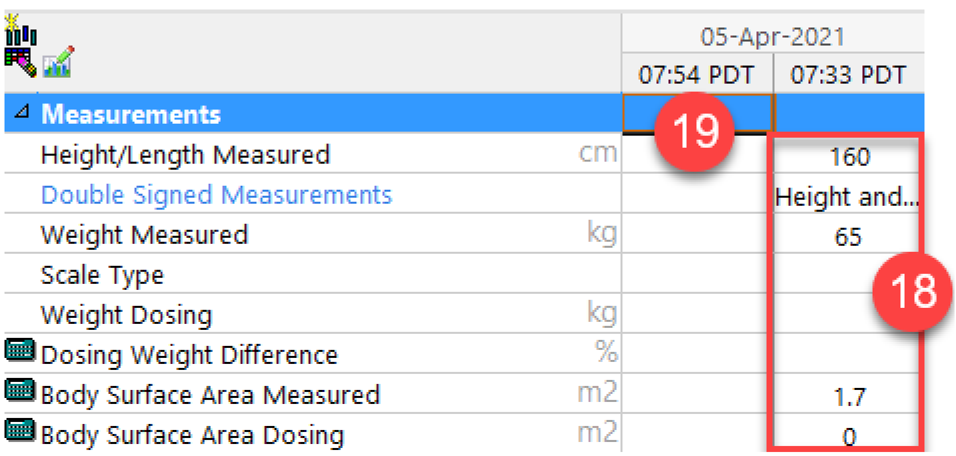
Password: **Train.2019**

17. Click **OK**.



18. Note the colour change of your documentation from **purple** to **black** once signed.

19. Also, notice that a new blank column appears after you sign in preparation for the next set of charting. The columns are displayed in actual time. You can now document a new result for the patient in this column. The newest documentation is to the left.

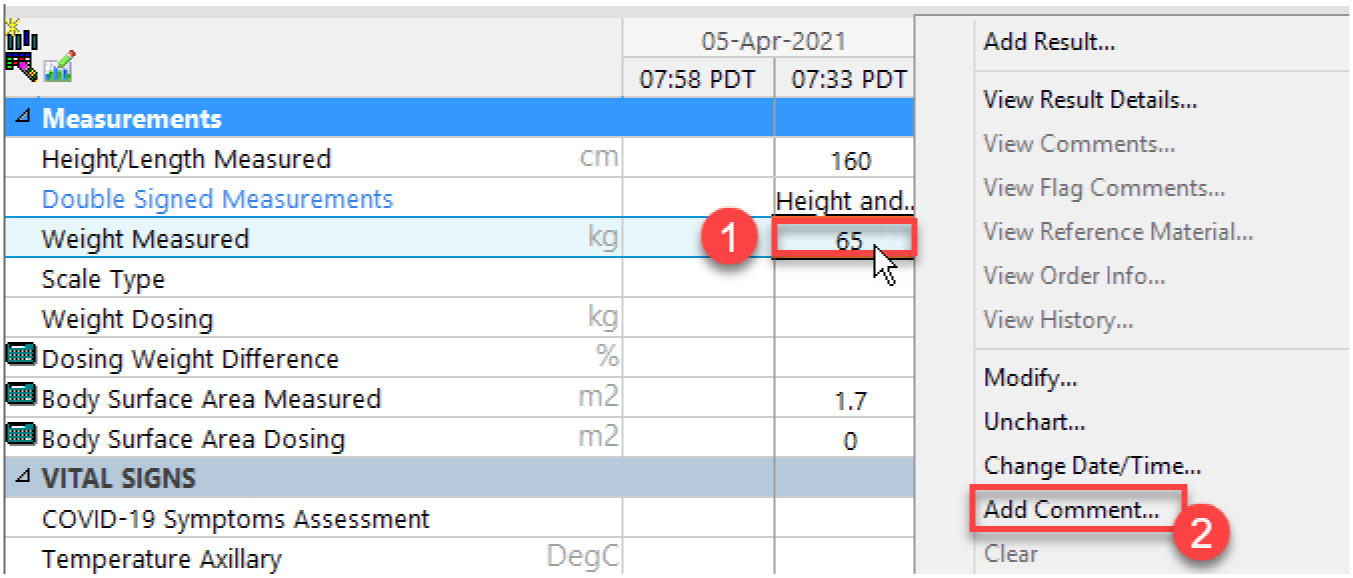


Add a Comment in Interactive View and I&O

A comment can be added to any cell to provide additional information. For example, you want to clarify that your patient weighed on the scale closest to the entrance. In this example, you will add a comment to the documentation you had just signed.

1. Right-click on the documented weight value that you just entered **65**. Note the different options in the drop-down menu.

2. Select **Add Comment…**

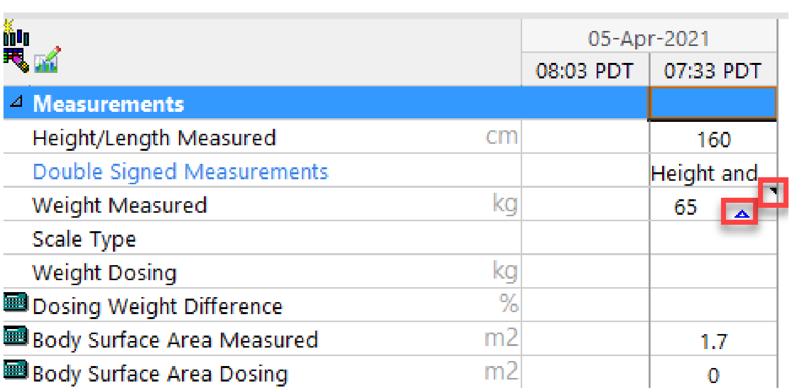


The **Comment** window opens.

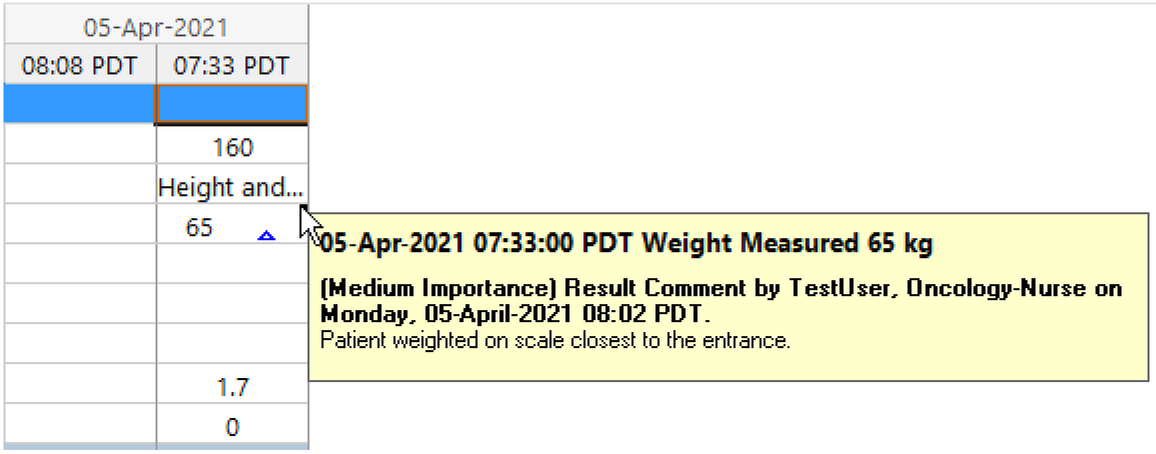
4. Type *Patient weighted on scale closest to the entrance*. We will type a spelling error (weighted) so we can go back in to correct it.

5. Click **OK**.

6. Note a modified icon displays next to the value and Result comment or annotation comment icon is noted in the far-right upper corner of the cell. If the comment was added prior to signing in the previous activity when you had added the weight measured, the modified icon would have not appeared.



To view your comment hover over the Result comment or annotation comment icon.

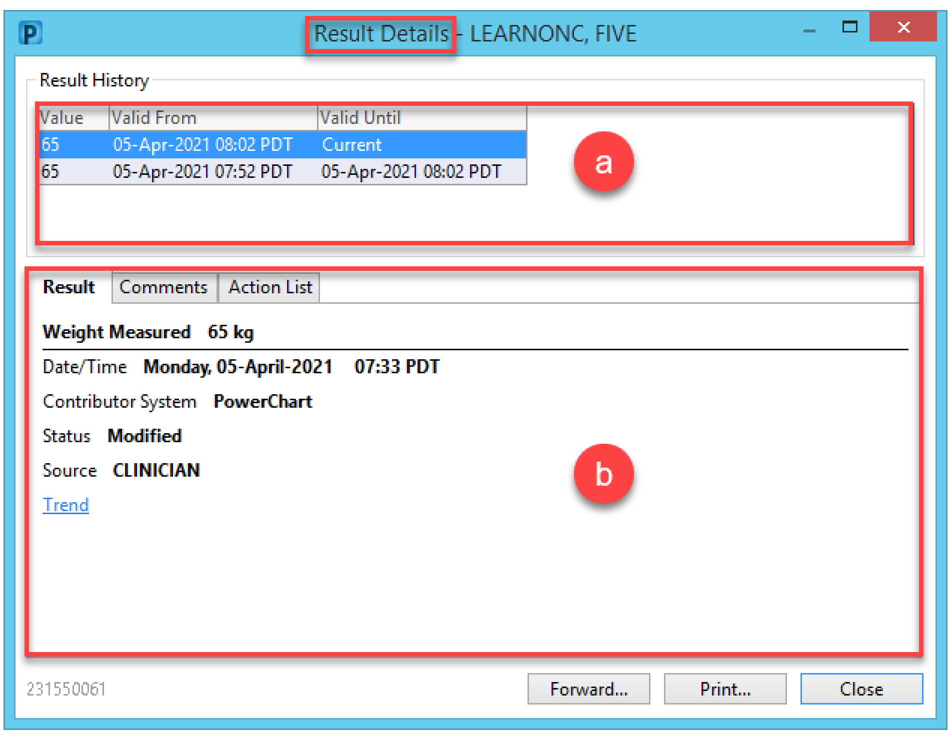


7. Double -click on the cell.

Result Details window opens with a split screen.

a. **Result History** List with the most current change displaying at the top.

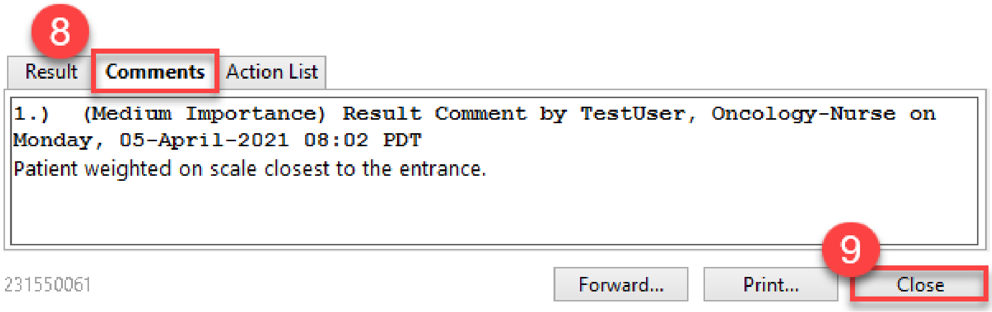
b. **Details** displaying the selection from the Result History list. Note the various tabs that contain the Results, Comments and Action List.



8. Select **Comments** tab to view your comment.

   - You noticed an error in your comment you want to change **weighted** to **weighed** and add **the** prior to the word scale.

9. Click **Close**.

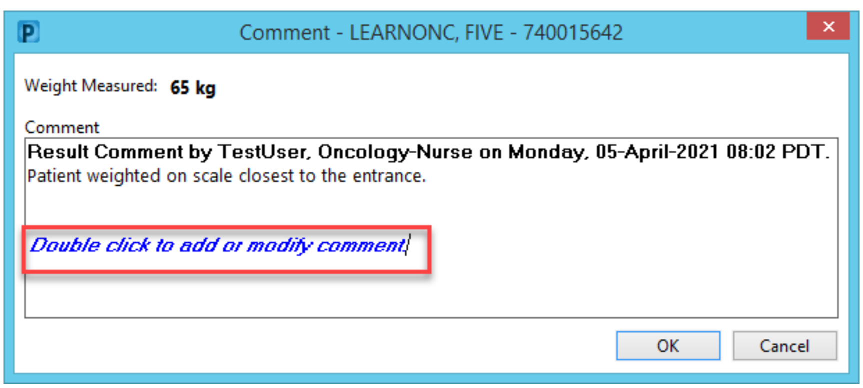


10. Right click on the **cell**.

11. Click **Add comment…** from the drop-down menu.

    The **Comment window** opens.

12. Note the instructions ***Double click to add or modify comment***.

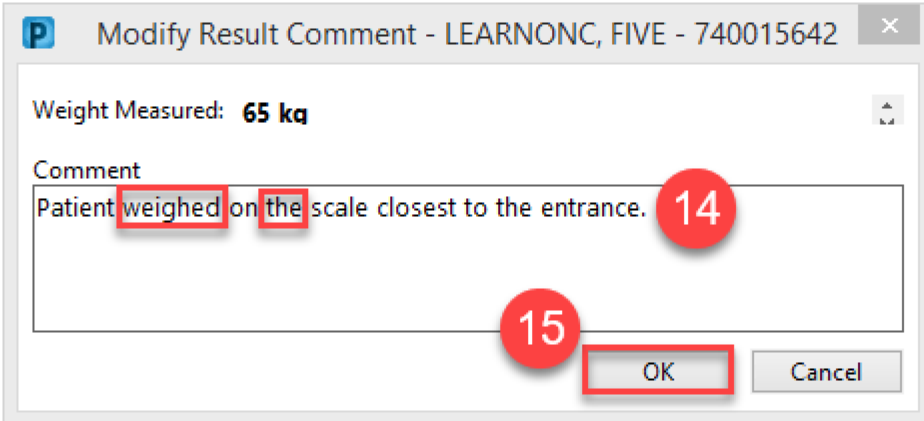


13. Double Click inside the window.

    A **Modify Result Comment** window opens.

14. Perform your correction. Patient **weighed** on **the** scale closes to the entrance.

15. Click **OK**.



16. Note the comment window displays your correction.

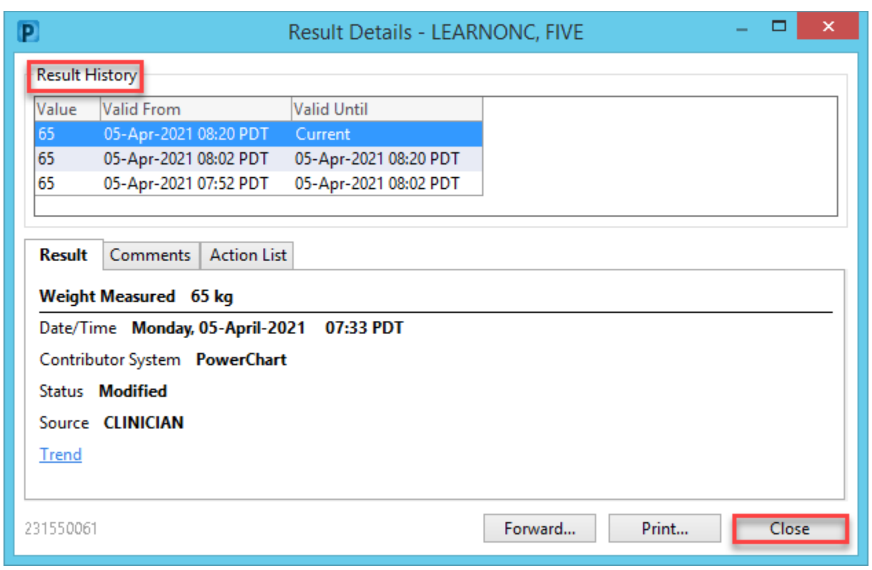
17. Click **OK** to close the comment window.

18. Double click on the cell Weight Measured 65kg.

    A **Result Details** window opens.

19. Review the Result History where you can find the list of your initial weight entry, additional comment, and modification. All entries and modifications are recorded in the system.

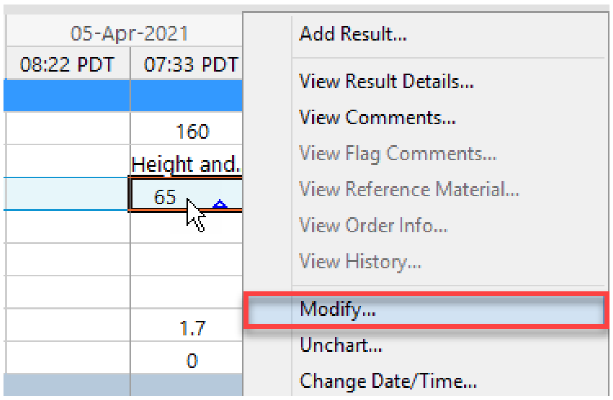
20. Click **Close**.



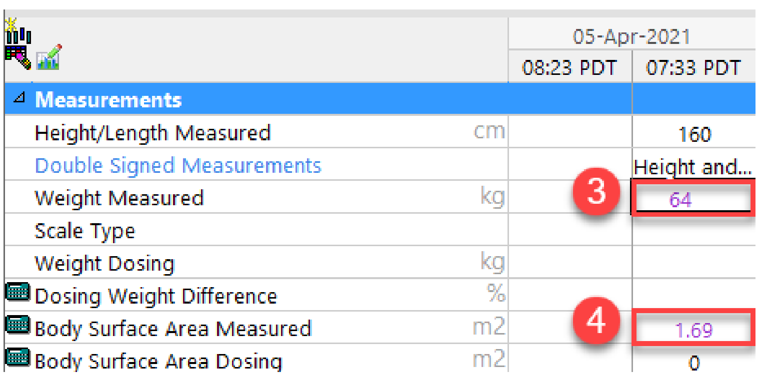
Modify in Interactive View and I&O

You have modified the comment, but you are also able to modify the value which you entered.

1. Right Click on **Weight Measured** Cell.
2. Click **Modify…** from the drop-down menu.



3. Type *64*.
4. Note the color of the text in the cells modified is **purple** prior to signing. In this example the Body Surface Area Measured calculation changed the value from 1.7 to 1.69.



5. Click the **sign** button.
6. The values have been modified.

Change the Time Column in iView

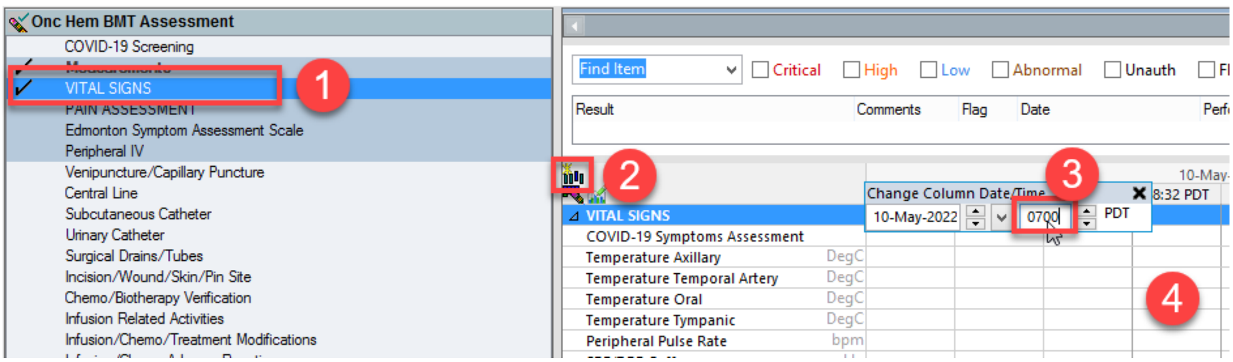
You can create a new time column and document late entry under a specific time. For practice, you will back enter the patient's temperature at 07:00 hour.

1. Select the **Vital Signs** section in the **Onc Hem BMT Assessment** band.

2. Click the **Insert Date/Time** icon.

3. In the **Change Date/Time** window, change the time to ***0700***.

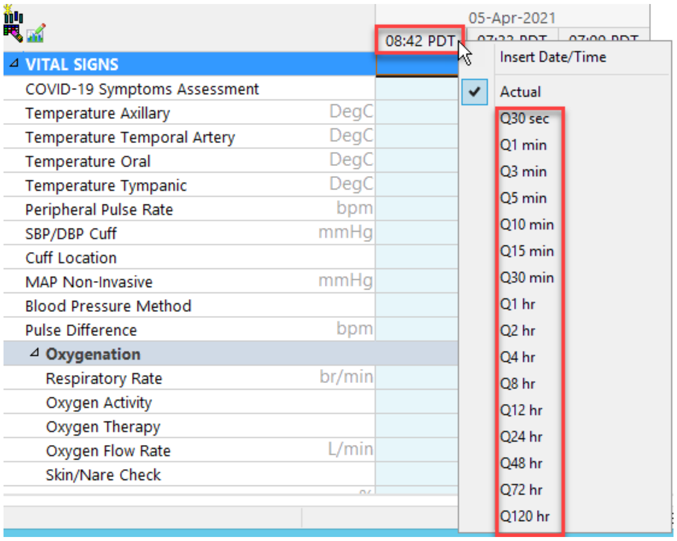
4. Click outside the **Change Date/Time** window or press enter on your keyboard to close the window.



5. In the 07:00 hour time column, double click the documentation field for **Temperature Oral** and enter ***36.9.***

6. Click the **Sign** icon.

IView documentation is defaulted to chart under the actual time. If you need to document vital signs more frequently (e.g., q15 min), right click on the current time heading and select an appropriate time interval. When frequent documenting vital signs is no longer applicable, right click on the current time heading and select **Actual.**

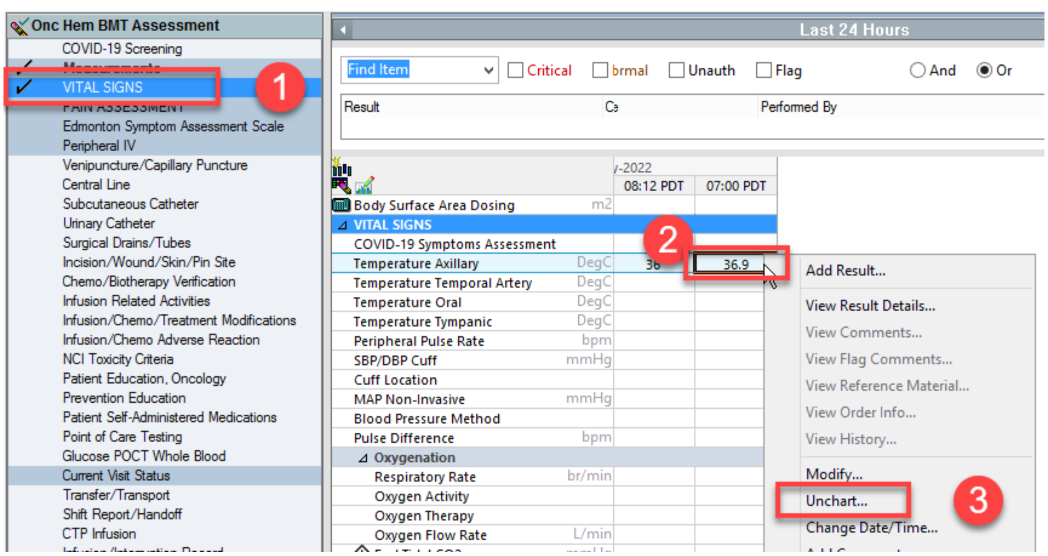


Unchart in Interactive View and I&O

The Unchart function will be used when the information was charted in error and needs to be removed. For example, a set of vital signs is charted in the wrong patient's chart.

For this scenario, the temperature documented in the previous activity was meant to be documented on one of your other patient's chart and needs to be uncharted.

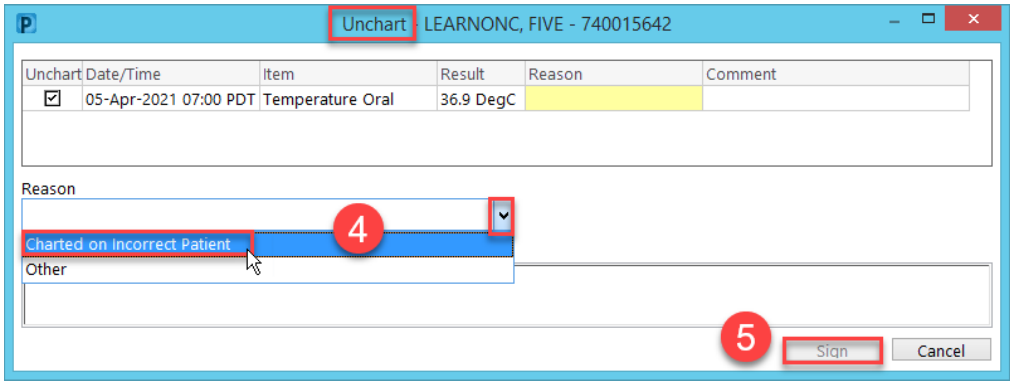
1. Ensure you are in the **Vital Signs** section in **Oncology Assessment** band.
2. In the 07:00 hour column, right-click on the documented value of **36.9** for Temperature Oral
3. Select **Unchart**.



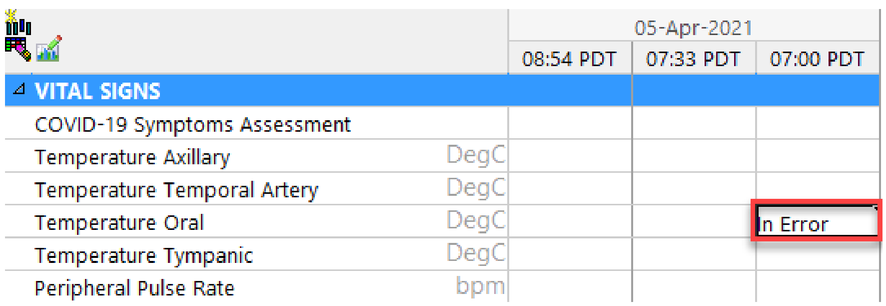
The **Unchart** window opens.

4. Select **Charted on Incorrect Patient** from the Reason drop-down.

5. Click **Sign**.



6. The words **In Error** with the **Result Comment or Annotation** icon also appear in the field.



Document a Dynamic Group in Interactive View and I&O

In this Scenario the patient has an existing Implanted Venous Access Device (IVAD).

Dynamic groups allow documented data to display multiple instances of the same grouping of data elements. Examples of dynamic groups include **wound assessment, IV sites** or **Central Access,** and **chest tubes**.

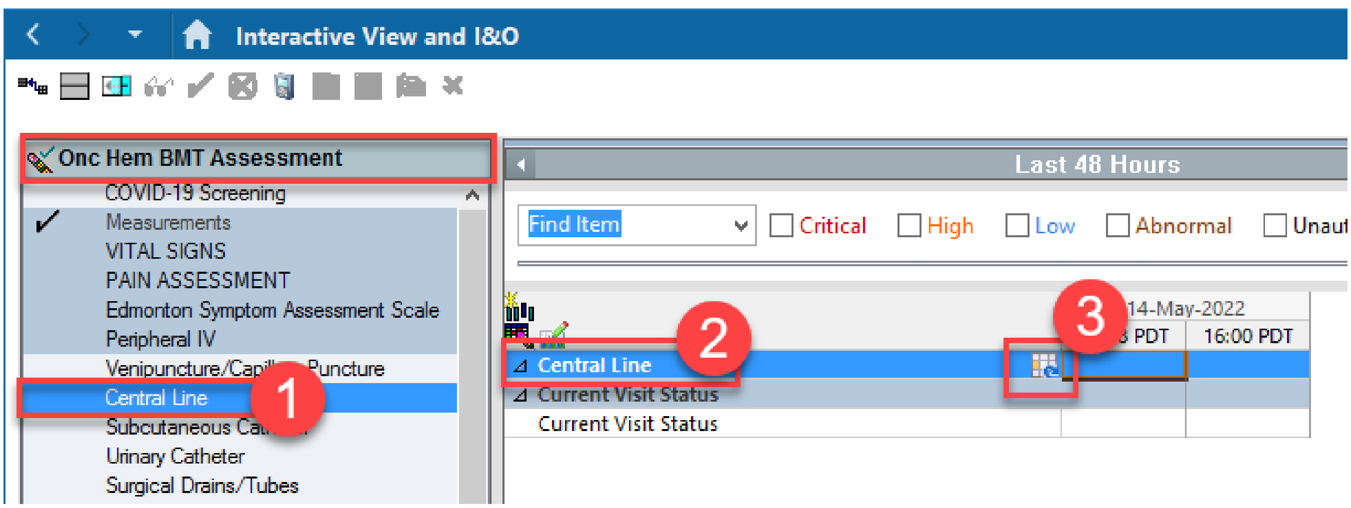
A dynamic group allows you to **label a line, wound,** or **drain with unique identifying details**. You can add as many dynamic groups as you need for your patient. For example, if a patient has two peripheral IVs, you will have a dynamic group for each.

NOTES:

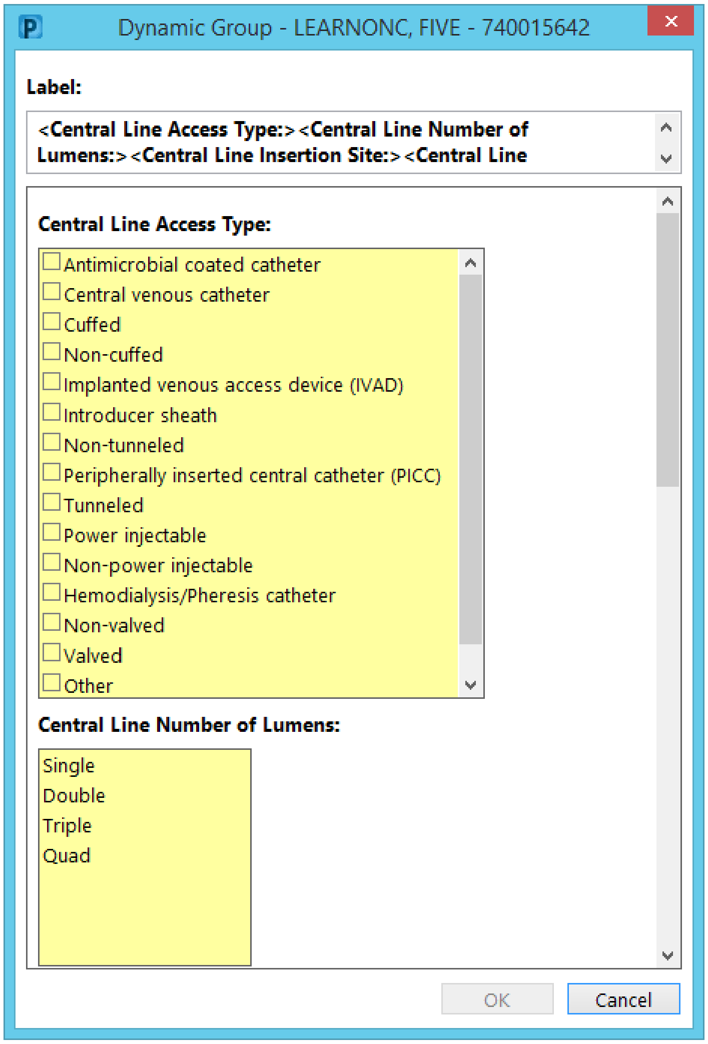
- To chart on an IV/Central line access a label needs to be created.
- Before creating double check that an existing label has not already been established.

Let's create a dynamic group for an already existing Implanted Venous Access Device (IVAD).

1. Click **Central Line** in the **OncHemBMT Assessment** band in Interactive View and I&O.
2. Note under the **Central Line** section where details of each section display there are no individual fields or cells for you to document.
3. Click on the **Dynamic Group**  symbol. This allows you to create a **label** for the IVAD.



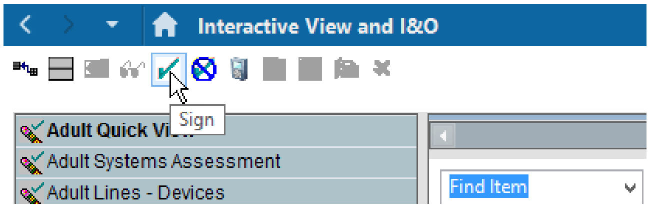
The **Dynamic Group** label window opens with required fields highlighted in yellow.



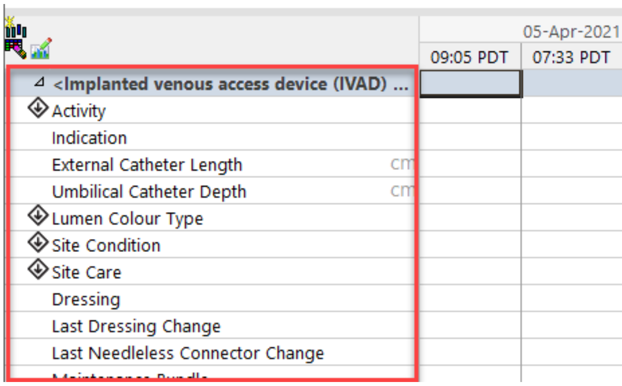
4. Select the following data to create a label and then click **OK**.

   - **Central Line Access Type:** Implanted venous access device (IVAD)
   - **Central Line Number of Lumens:** Single
   - **Central Line Insertion Site:** Subclavian vein
   - **Central Line Laterality**: Right
   - **Central Line Catheter Size:** This is not a required field and is not applicable to our type of Access. Therefore, we will not select a size.

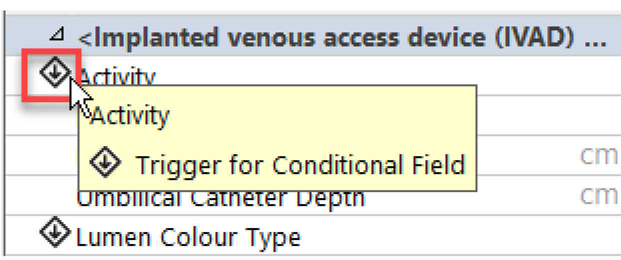
5. Click the **sign** button.



You have now created a label and it appears in IView below Central Line with additional documentation fields.



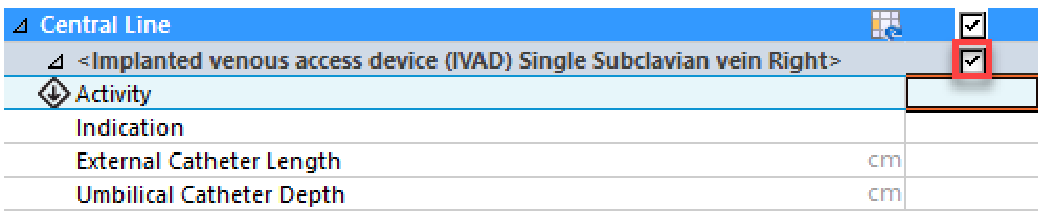
6. Hover to Discover the Trigger for conditional field icon. It indicates that there is additional documentation to be completed if certain responses are selected.



Now that you have created the label **Implanted Venous Access Device (IVAD)**, let's enter information about the IVAD:

1. Double click in the **cell next to the label** you just created to activate the entire documentation column.

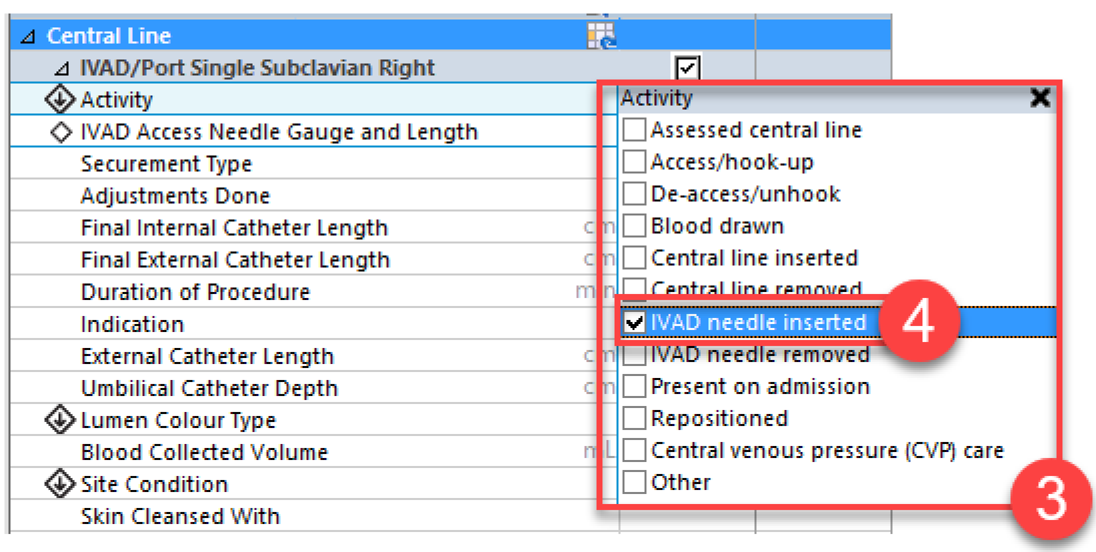
2. **Remember** this allows you the option of using the enter key or tab on the keyboard to navigate to subsequent cells.



Once you double click on the label, the first drop-down menu is available to you. In this example it is **Activity**.

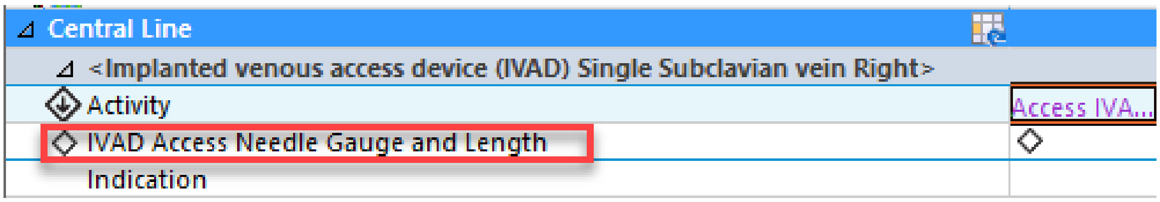
3. Note the various options available to you in the drop-down menu.

4. Select the **appropriate activity**. For this example, we will select **IVAD needle inserted**.

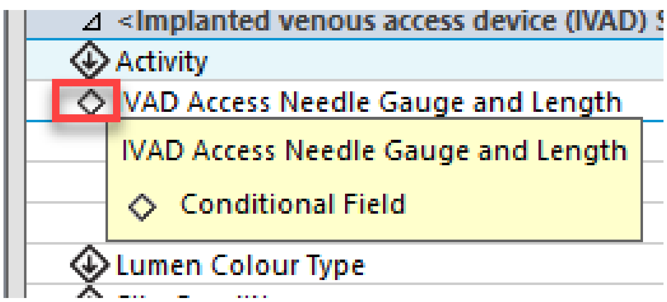


5. Press **Enter or Tab** on the keyboard.

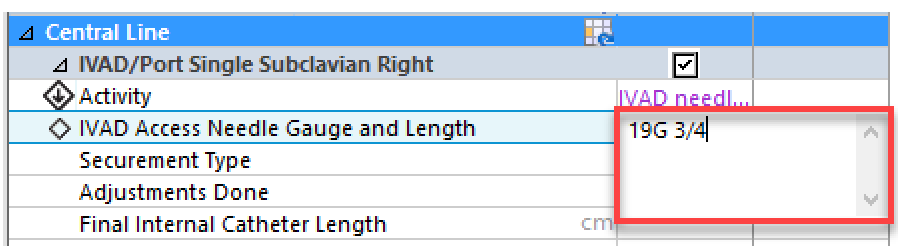
6. Note an additional row appears. In this example, **IVAD Access Needle Gauge and Length**.



7. Note the **Conditional Field** Icon. This is the additional documentation that was triggered from selecting the activity. Not ever activity will trigger this functionality.



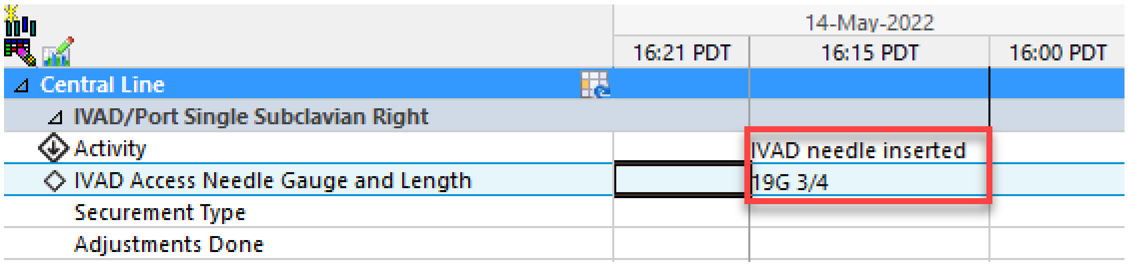
8. *Type 19G ¾* " needle in the free text box.



9. In the clinical setting, you would continue to document other relevant information about the Access IVAD Port as appropriate.

10. Click the **sign** button.

- The text should change from purple to black and a new blank column appears in preparation for the next set of charting.



NOTE: If you are documenting a central line for the first time you will need to select **Central line inserted** as the Activity.

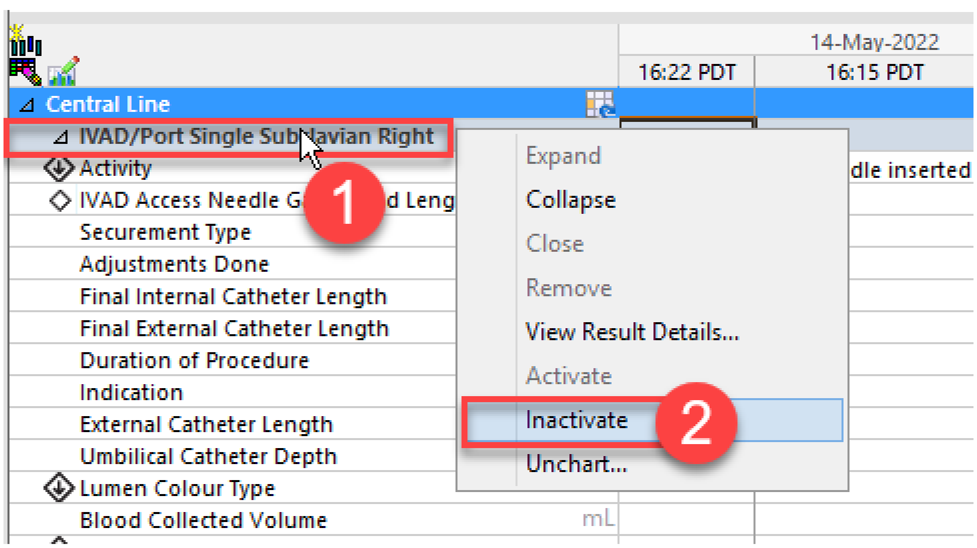
Now you can document tip placement and length of catheter (e.g., PICC)

Inactivate a Dynamic Group

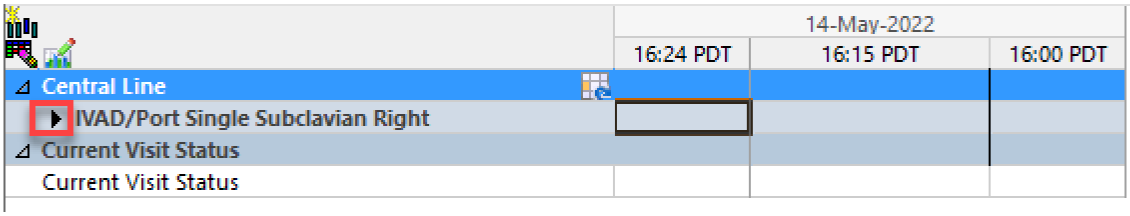
Dynamic groups **<u>must be inactivated</u>** once they are removed. For example, if you inserted a PIV for treatment and you remove it you need to inactivate the dynamic group after completing your documentation.

Practice this function with the dynamic group you have just created.

1. Right click on the **<u>dynamic group label</u>** for the IVAD.
2. Select **Inactivate.**

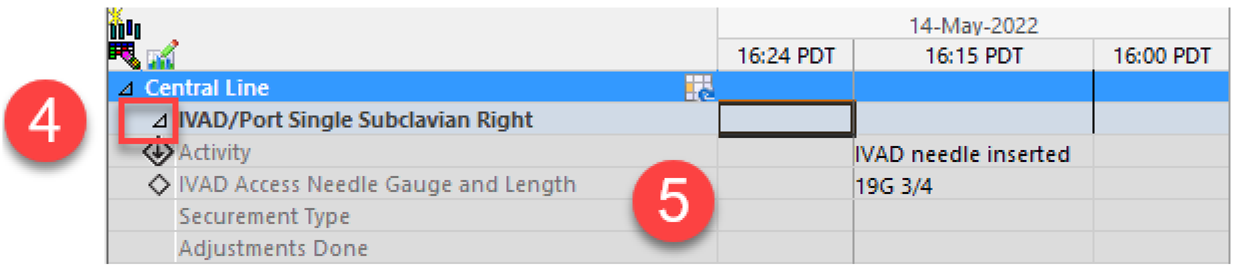


3. The Dynamic group label collapses.



4. Click the arrowhead icon to expand the details.

5. Note the documentation area is greyed out so that you cannot document on this group.



NOTE: Central lines will generally not be inactivated unless they are removed. If you accidentally inactivate a dynamic group, you can right-click to activate the group again.

Key Learning Points

- Always sign your documentation once completed.
- Results can be modified and uncharted within iView.
- The information you unchart remains in the chart as “In Error”.
- A comment can be added to any cell in iView.
- If required, you can create a new time column by clicking the Insert Date/Time icon and document under a specific time.
- Right click the current time heading to change the time interval if needed.
- **Dynamic Groups** allow documentation of related data elements such as IVAD or central lines.
- **Conditional icons** appear in IView when additional documentation is related to the selections made.
- Dynamic groups **must be inactivated** once they are removed.
- Inactivated dyamic group remains in the view, but is unavailable, meaning clinicians can not document on it (unless they reactive it).

PATIENT SCENARIO 5 - Admission: Complete Admission Tasks in CareCompass

Learning Objectives

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

- Complete Admission tasks in CareCompass

SCENARIO

When a patient is admitted to the inpatient unit, some admission tasks and documentations are required to be completed within a certain period of time after admission and as per site policy. After assessing the patient, you are going to complete a few admission tasks.

You will complete the following activities:

- Complete Admission Task

For the following activities, select the name of **patient A** as assigned to you from your CST Cerner Learning – Your workbook's logins and patients email.

Activity 5.1 – Complete Admission Tasks

As you recall in Activity 2.1, you have already reviewed the tasks list displayed in CareCompass. Tasks are activities that need to be completed for the patient. They are generated by certain orders or rules in CST Cerner. When you have an admission, some admission tasks have already been pre-populated in CareCompass. Below are the examples:

- Basic Admission Information
- Admission History
- Braden Assessment
- Infectious Disease Screening
- Morse Fall Risk Assessment
- Valuables and Belongings

Based on the scope of practice and site policy, you complete the admission tasks in a timely manner. Most of the admission tasks are related to documentation. For practice, you will document two types of admission tasks.

Complete PowerForm Documentation Admission Task

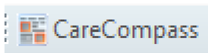
You will now document on the **Basic Admission Information** PowerForm. This form is used to document a patient's allergies, weight and height, and to review and document home medications. In the previous activity, we had recorded the patient's weight and height with a second signature in IView. If you recorded the measurements in this formthe information would appear in IView.

One requirement of the **Basic Admission Information** PowerForm is to indicate the Dosing Weight. A few points about the Dosing Weight:

- The most recently entered Dosing Weight populates into the Banner Bar.
- **This is critical to be ACCURATE, as this does flow into the Dosage Calculator** for calculating chemotherapy dose. While the Provider will still review and document the dosing weight and is responsible for checking it for accuracy, the weight entered on this form flows into the Banner Bar as well, until a new dosing weight is entered.
- Dosing weight crosses encounters, therefore, to mitigate any risk of using the incorrect measurement the Dosing Weight should be verified prior to any weight-based medication administration.

WARNING: The **Dosing Weight** entered on the **Basic Admission Information PowerForm** is critical because it flows into the Dosage Calculator for calculation of chemotherapy dose. Nurses should ensure accuracy in their measurement and documentation at this step.

Let's complete the **Basic Admission Information task**.

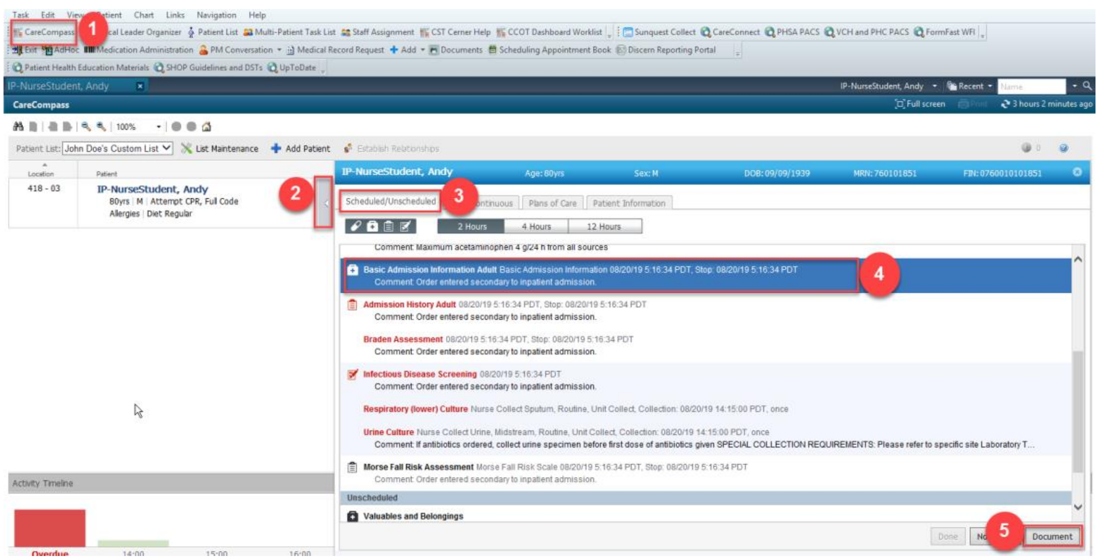
1. Click the **CareCompass**  button on the toolbar.

2. Locate your assigned patient in CareCompass and click the Open  icon to the right of your patient's name to open the Single Patient Task window.

3. Click the **Scheduled/Unscheduled** tab.

4. Select **Basic Admission Information**.

5. Click Document to open the **Basic Admission Information** PowerForm.

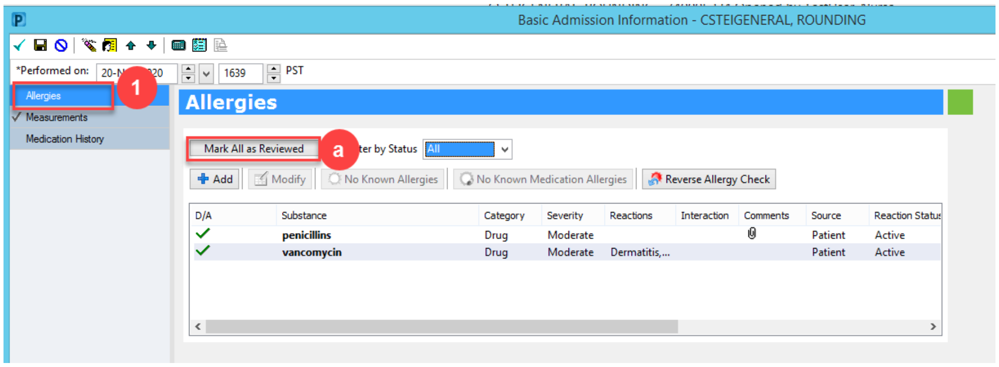


NOTES

- When a task is associated with documentation, clicking **Document** takes you directly to the appropriate documentation within the patient's chart.
- If **Not Done** is selected, you must provide a reason.

1. Select the **Allergies** section.

   a. Review allergies and select **Mark All as Reviewed** if no change**.**



NOTE: If you need to add an allergy, you will click the **Add** Add button and follow the same steps as you have already learnt in Activity 3.4 to fill out the details.

The dosing weight has been pre-populated because the provider has entered chemo orders with confirmed chemotherapy dosing weight.

For practice, to document your patient's measurements and see how the information appears in Results review:

1. Select Measurements Section, type the following:

   - Weight Measured: *70 kg*
   - Height/Length Measured: *158 cm*

Best Possible Medication History (BPMH)

You have been introduced and practiced **BPMH** via emodule **Authorized User: PharmaNet Integration and Documenting BPHM**

We will not repeat this activity in this workbook. However, recall the following:

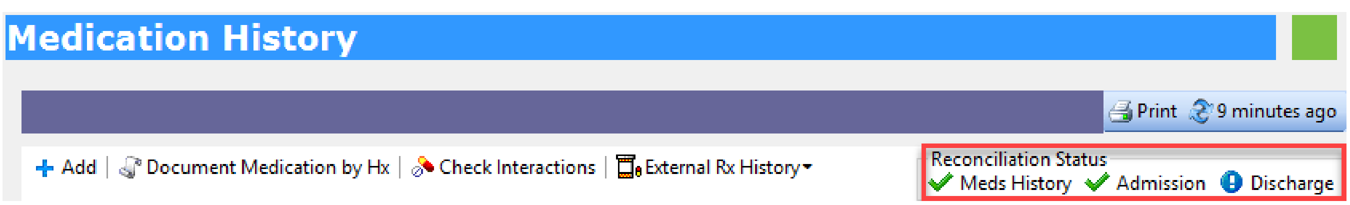
BPMH represents a consolidated list of the patient's home medications. This information can be updated based on information contained in **PharmaNet** in addition to data gathered during your assessment. The BPMH can be completed by a nurse, pharmacy technician, pharmacist, medical student, resident, or provider. The frequency of conducting BPMH is determined by site policy; check with your site.

BPMH must be completed prior to the provider conducting a medication reconciliation, which involves making decisions regarding reconciling the patient's home medications with any new medication orders.

There are multiple places to document the BPMH in the chart. However, you can use the **Basic Admission Information** PowerForm to document this task. This will ensure that all existing medications that the patient is taking are up to date.

A BPMH has already been completed in the train domain.

1. Click **Medication History** section.
2. Note the status of medication management in the top right corner of the Medications section.



3. Recall the icon definitions you will see in this section.

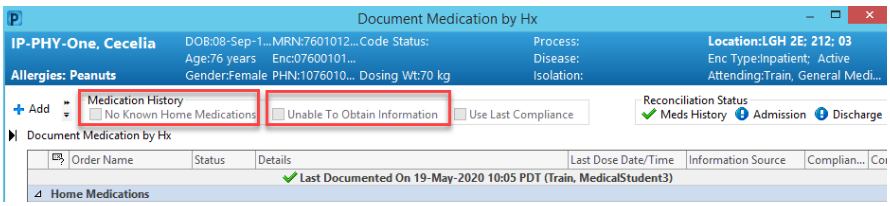
means complete

means incomplete

means in progress

NOTES:

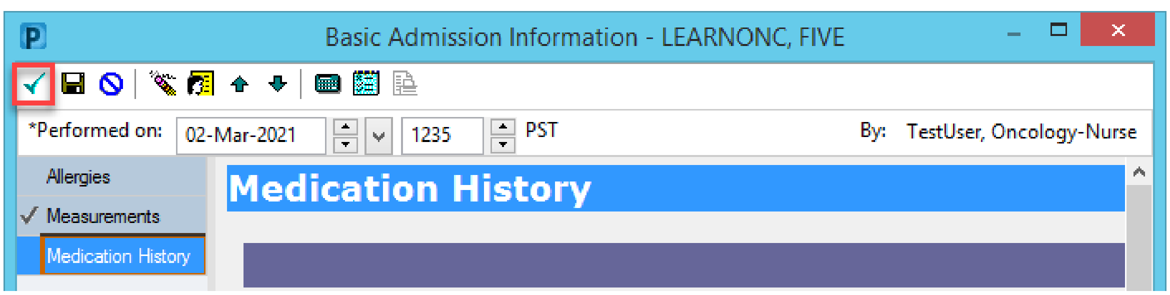
- Home medications can be updated at any time, even if the Meds History status indicates complete.
- In some cases, you may document that the patient has no home medications, or you are unable to obtain information.
- Click the Home Medications heading and select **No Known Home Medications** or **Unable to Obtain Information** respectively.



- If you select **Unable to Obtain Information**, this usually must be updated within 24 hours. Refer to site policy.
- Medications not listed in PharmaNet (for example over the counter vitamins and supplements) are added using the “non-formulary medication” order entry.

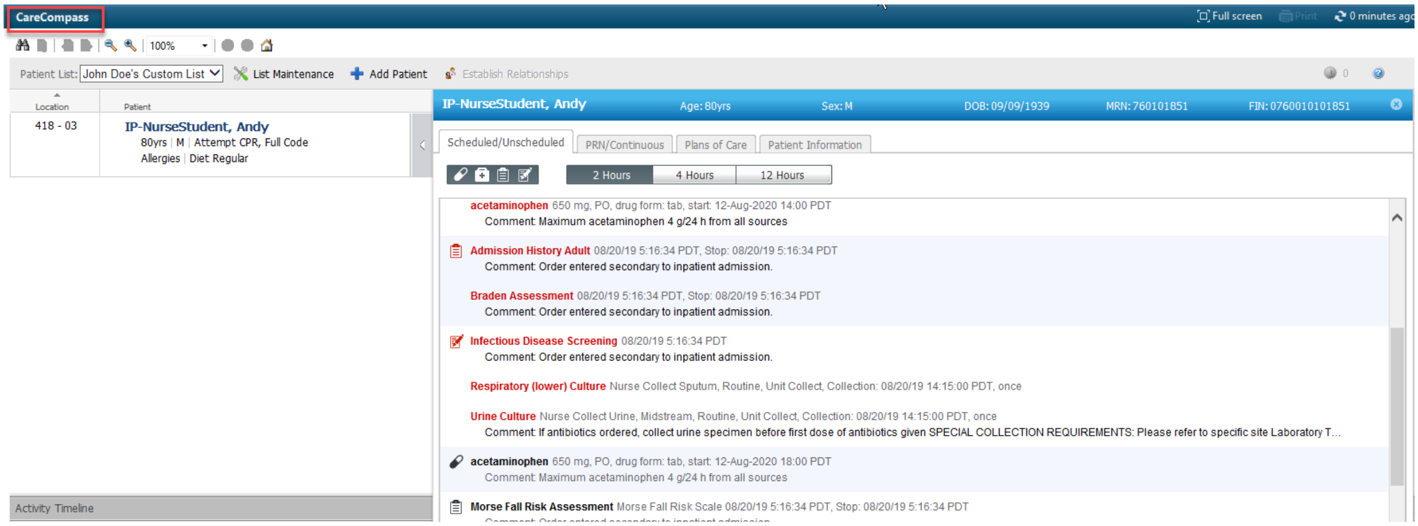
Documentation is not complete unless signed.

4. Click the **green checkmark** to sign the documentation that you have completed.



NOTE: Clicking the **Sign** icon makes the **PowerForm** viewable by anyone looking at the patient’s chart. If you click the save icon it will save the form for you to complete later. When you save a **PowerForm**, no one else will be able to see the form until it is signed. Best practice would be to sign and modify versus saving.

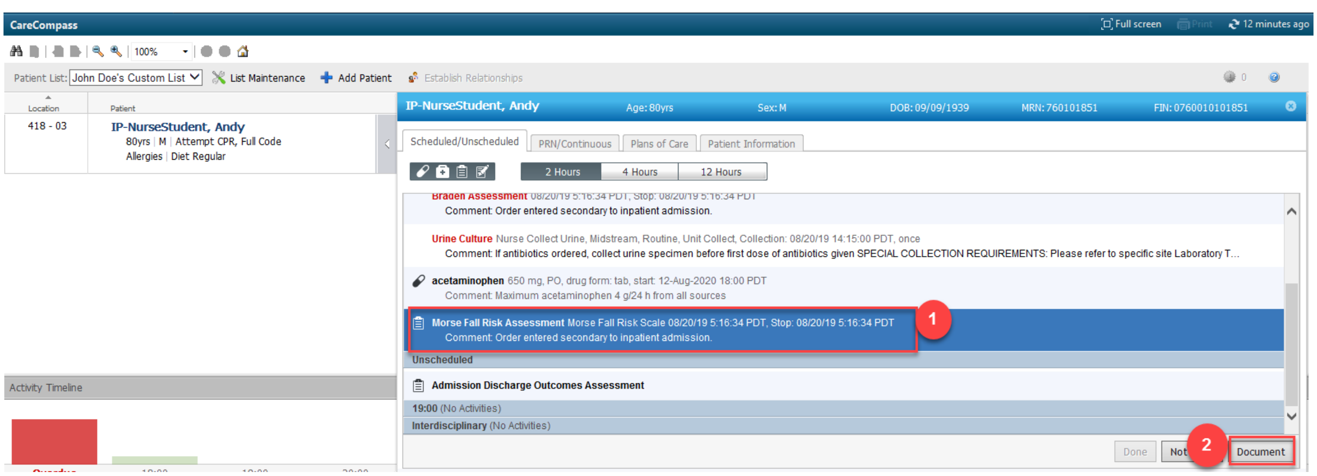
After signing the **Basic Admission Information** PowerForm, you return to **CareCompass**. The completed **Basic Admission Information Adult** task now falls off from the patient's task list.



Complete IView Documentation Admission Task

Let's complete another admission task in IView- **Morse Fall Risk Assessment**:

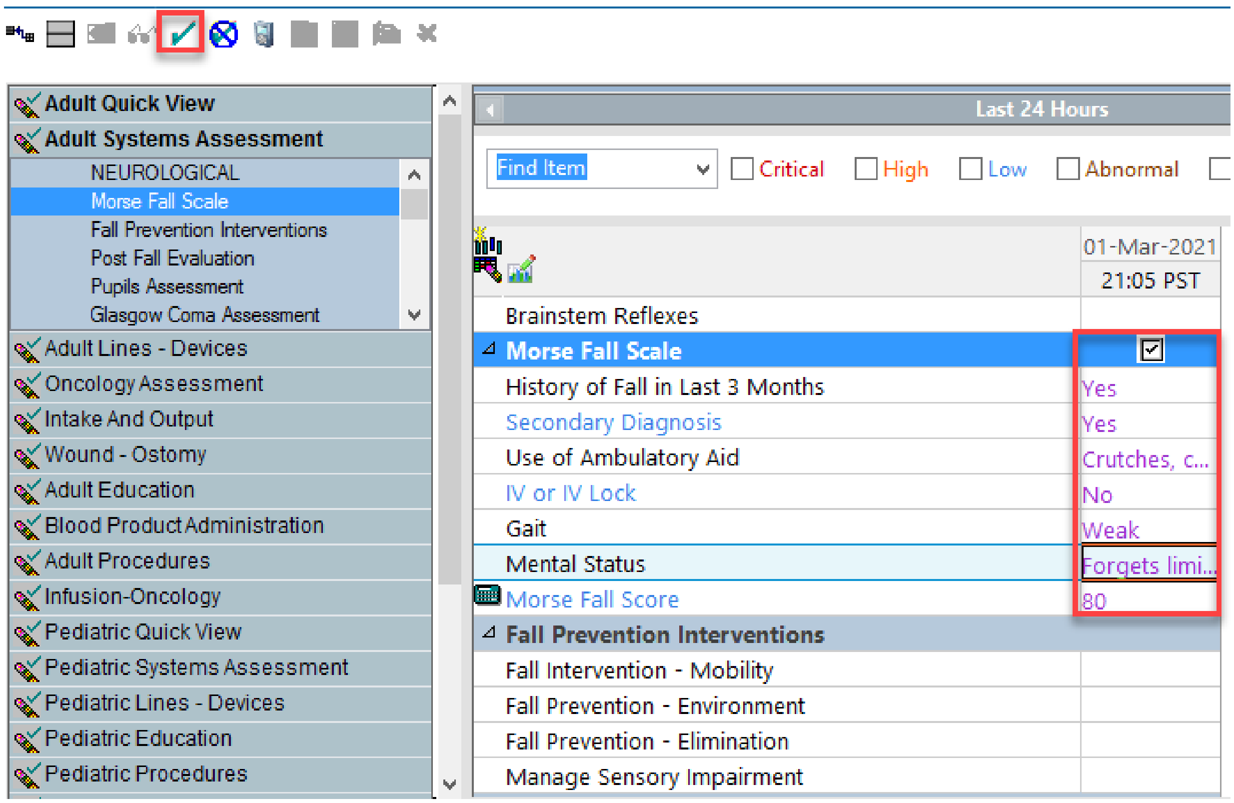
1. Select **Morse Fall Risk Assessment** from the task list in CareCompass.
2. Click **Document** to direct you to the Morse Fall Score section in Interactive View and I&O (iView).



3. In the current time column, double click the blue box  next to the **Morse Fall Score** section and document the following data:

- **History of Fall in Last 3 Months:** *Yes*
- **Secondary Diagnosis:** *Yes*
- **Use of Ambulatory Aid:** *Crutches, cane, walker*
- **IV or IV Lock:** *No*
- **Gait:** *Weak*

4. Click the **Sign** icon.



Note the following:

- A **Morse Fall Risk Score** is automatically calculated based on the information input during documentation. Note for this activity the calculated score is **80.**
- Once the admission Morse Fall Risk Score is complete, this task will be removed from **CareCompass**.
- You notice that your patient's Morse Fall Risk Score is high. Following the local policy, you will add the **Falls Risk** process alert on **Banner Bar** of the patient chart and collaborate with other health care team members to carry out appropriate interventions to prevent falls. You will learn how to add the process alert later in this workbook.

- If you want to review the tasks that are completed in **CareCompass**, you will go to the **Single Patient Task List** within the patient ‘s chart. You make sure that the **Complete** status is added in the task display.

NOTE: For the purpose of training, other additional Admission tasks will not be addressed in this activity.

PATIENT SCENARIO 6 – Ongoing Care: Add Process Alert

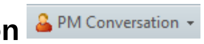
Learning Objectives
At the end of this Scenario, you will be able to: ■ Add Process Alert

SCENARIO
When you document the fall risk assessment as one of the admission tasks, you notice that your patient has a high Morse Fall score, indicating that they have a high risk of falling. You need to communicate and share this finding with other health care team members. You will complete the following activity: ■ Add a Process Alert For the following activities, select the name of **patient A** as assigned to you from your CST Cerner Learning – Your workbook's logins and patients email.

Activity 6.1 – Add a Process Alert

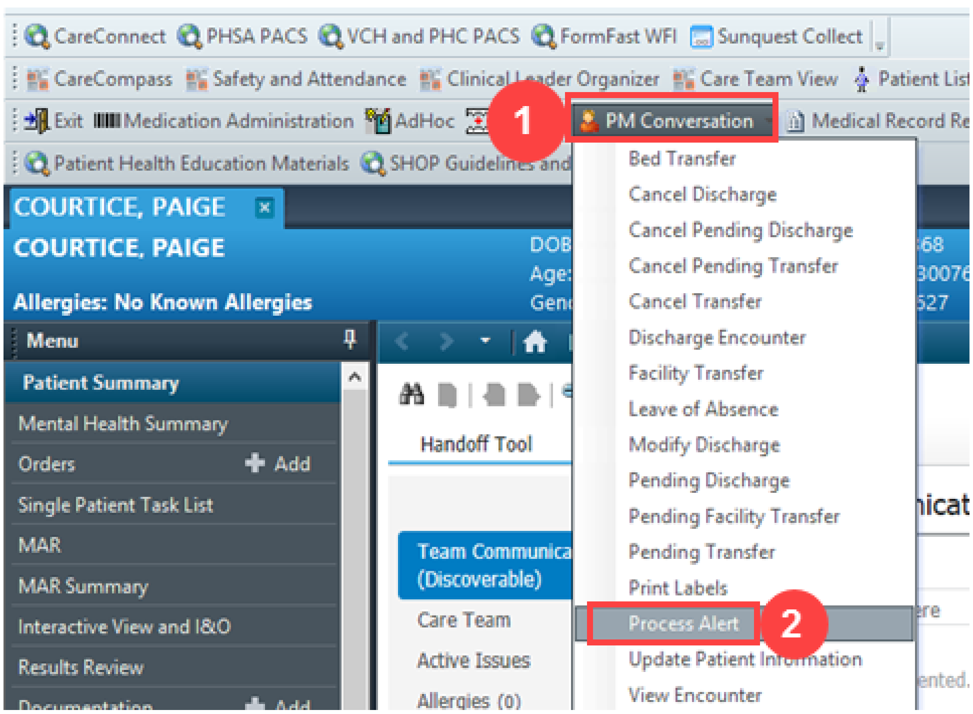
In CST Cerner, process alerts are flags that highlight specific concerns about a patient (e.g. fall risk, violence risk, HAZARDOUS Drugs Group 1, etc.). These alerts display on the **Banner Bar** and can be viewed by the providers and other clinicians who access the same chart.

Since your patient has a high Morse Fall score, a **Falls Risk** process alert is added to the patient's chart as per site policy. You can add a process alert by using **Patient Management (PM) Conversation**.

1. Within the patient chart, click the drop-down arrow within the **PM Conversation** 

   button in the toolbar.

2. Select **Process Alert** from the drop-down menu.

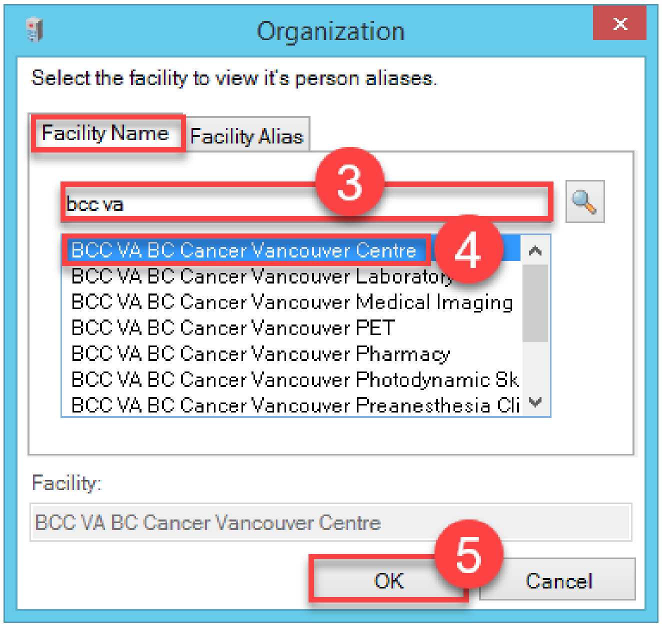


   The **Organization** window opens.

3. In the search field under the **Facility Name** tab, type ***BCC VA*** and press **Enter** on your keyboard. In clinical practice, insert your facility information.

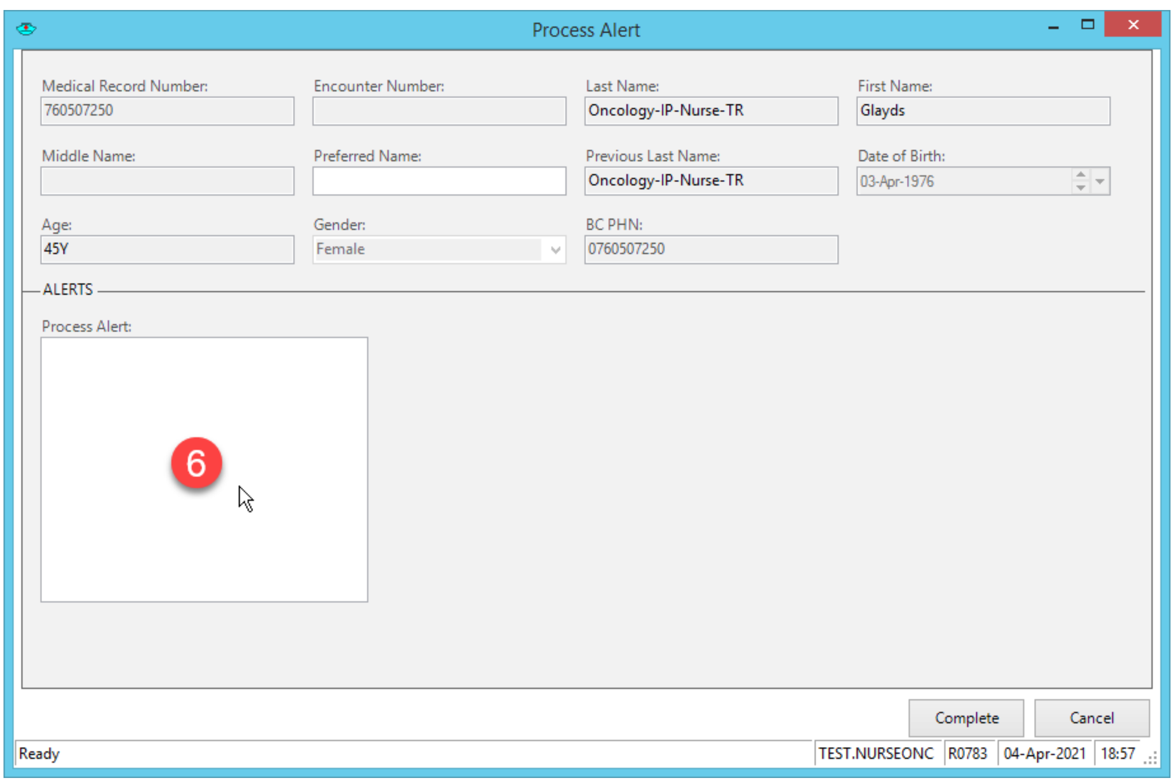
4. Select **BCC VA BC Cancer Vancouver Centre**.

5. Click **OK.**



The **Process Alert** window displays. To activate the **Falls Risk** process alert on the patient's chart:

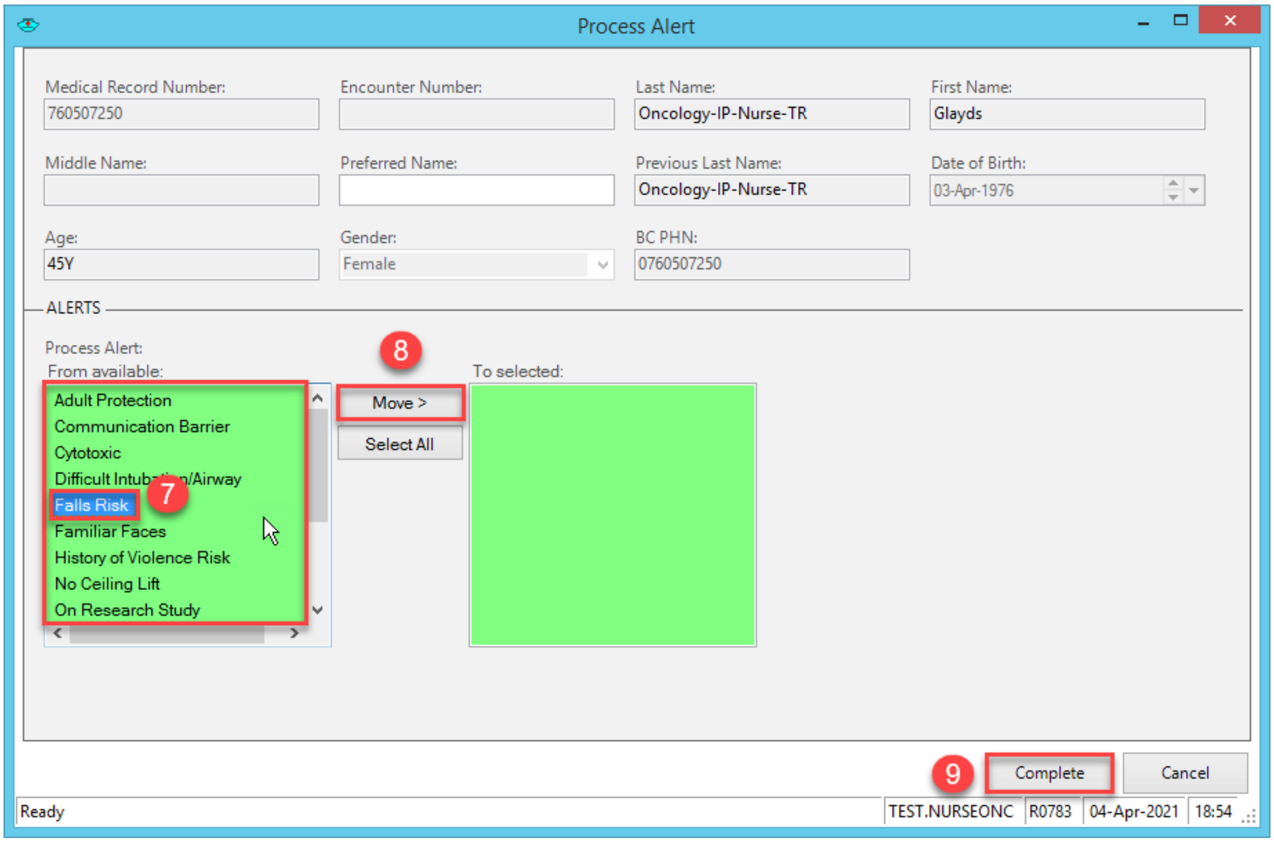
6. Click the white empty **Process Alert** field to show a list of alerts that can be applied to the patient for display.



7. Select **Falls Risk**.

8. Click **Move** to relocate the Falls Risk alert to the To Selected box.

9. Click **Complete**.



10. Click the **Refresh** icon to update the chart and display the process alert on the **Banner Bar** where it is visible to all those who access the patient's chart.

NOTE: Multiple alerts can be activated at once. Alerts can be removed using the same process in **PM Conversation**. Site policies and practices should be followed with regards to adding and removing specific flags and alerts.

Key Learning Points

- Adding Process Alerts via PM Conversation allow providers and clinicians to see specific concerns related to the patient on the Banner Bar.

PATIENT SCENARIO 7 – Ongoing Care Document: Powerforms via AdHoc folder

Learning Objectives
At the end of this Scenario, you will be able to: ▪ Demonstrate an understanding of PowerForms and where to locate them. ▪ Document on a PowerForm.

SCENARIO
During ongoing care, you may complete other PowerForms that can be accessed from Adhoc in CST Cerner. You will complete the following activities: ▪ PowerForm Overview ▪ Document a New PowerForm obtained from AdHoc ▪ Modify and Unchart an Existing PowerForm ▪ Review the Document you created. For the following activities, select the name of **patient <u>A</u>** as assigned to you from your CST Cerner Learning – Your workbook's logins and patients email.

Activity 7.1 - PowerForm Overview

Read Only

You have been introduced to **PowerForms** via emodule and learned to find a PowerForm via **AdHoc** AdHoc folder in the Toolbar, complete a PowerForm, sign, save, and modify a signed and finalized PowerForm via Documentation section in the Menu.

We will not repeat the general layout or functionality. However, we will focus on charting on a commonly used form, modify via Form Browser, and learn how to Unchart the document.

PowerForms replace your paper forms. If the paper form is not a PowerForm, then you would find a repository of PDF paper forms in **FormFast** on the Toolbar which is addressed in your eModule FormFast WebForm Imprint.

Data entered in **PowerForms** can flow between iView flowsheets, Provider and Clinician Clinical Notes, the Problem List, Allergy Profile, and Medication Profile.

You must be in the Patient Chart to open the Inpatient PowerForms.

Some Oncology examples of PowerForms are **BCC Fertility Assessment** PowerForm. You will review your most common forms in your workflow review sessions.

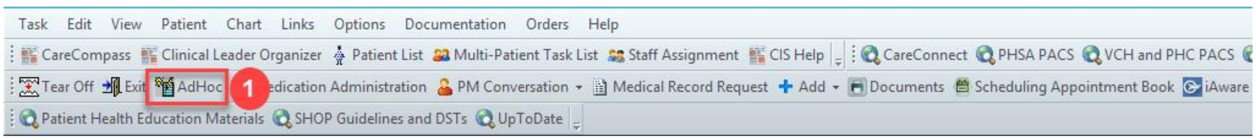
End of Read Only

Activity 7.2 – Document a New PowerForm Obtained from Adhoc

In Activity 5.1, you have accessed the **Basic Admission Information** PowerForm via **CareCompass** and completed the relevant documentation as part of the admission process. During ongoing care, you may need to complete other PowerForms as per site practice. For instance, you will fill out the **Perioperative PreProcedure Checklist** PowerForm when you prepare the patient for surgery.

For practice, you will complete the **Valuables and Belongings** PowerForm.

1. Click the **AdHoc** AdHoc button on the toolbar**.**

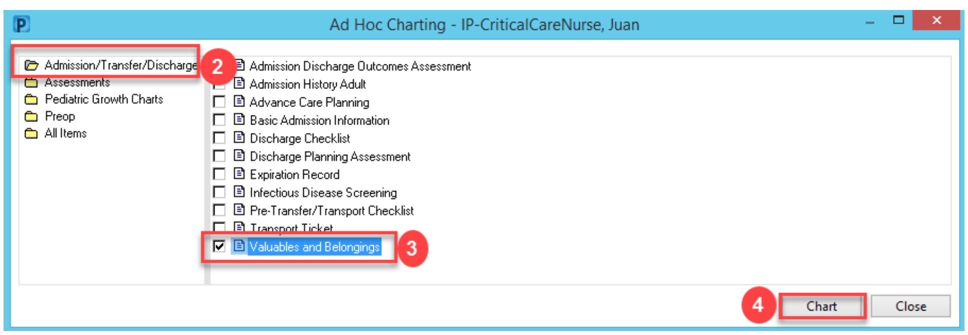


The **Ad Hoc Charting** window opens.

- The **Admission/Transfer/Discharge** folder is now open and a list of Powerforms is displayed on the right side of **Ad Hoc Charting** window.

2. Select **Valuables and Belongings** PowerForm.

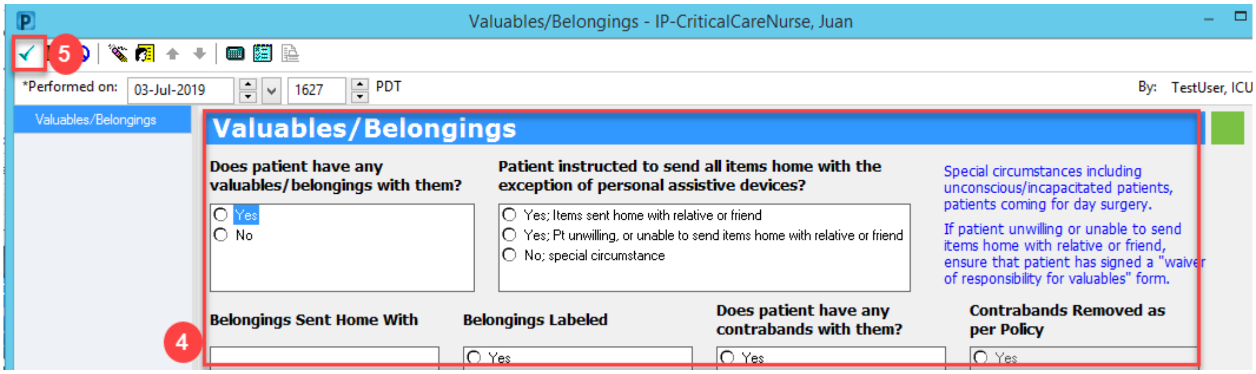
3. Click **Chart**.



4. Fill in the following fields:

- **Does patient have any valuables/belongings with them?:** *Yes*
- **Personal Device:** *Glasses*
- **Numbers of item:** *1*

5. Click the **Sign** icon.



NOTE: Some PowerForms may have sections with a red asterisk and yellow fields, indicating that there are mandatory fields which must be completed before signing.

WARNING:Using **Save Form** icon is discouraged because the documentation it is not part of the patient's chart until it is signed.

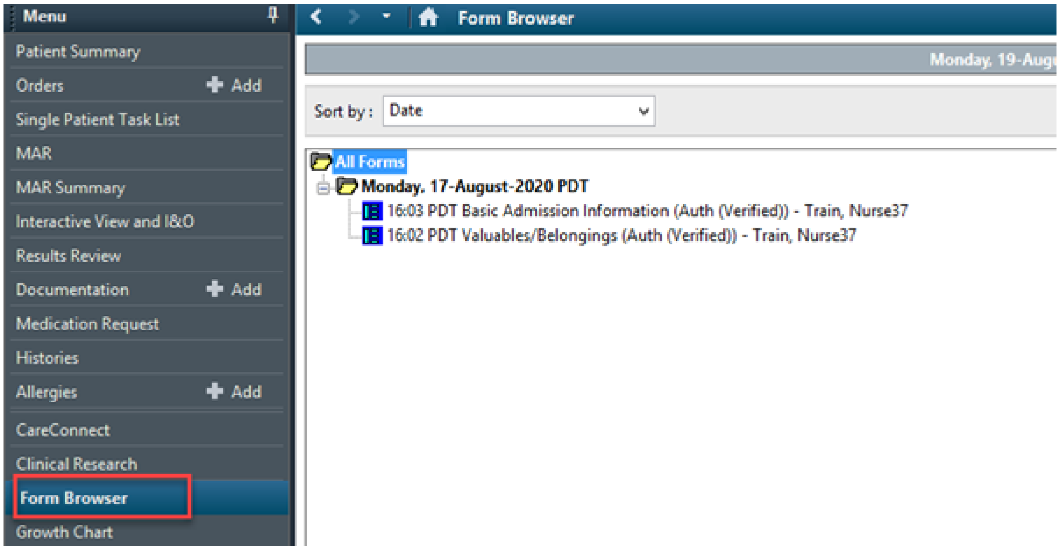
Key Learning Points

- PowerForms are electronic forms used to chart patient information.
- The AdHoc button AdHoc on the toolbar allows you to locate a new Powerform on an as needed basis.
- Sections with an asterisk indicate there are mandatory fields which must be complete before signing.
- Always sign the PowerForm so that it becomes legal part of the chart and changes made by other clinicians can be tracked.

Activity 7.3 – Modify and Unchart an Existing PowerForm

It may be necessary to modify PowerForms if the information was entered incorrectly or additional information needs to be added to the PowerForm.

To review your forms, navigate to the **Form Browser** from the **Menu**.

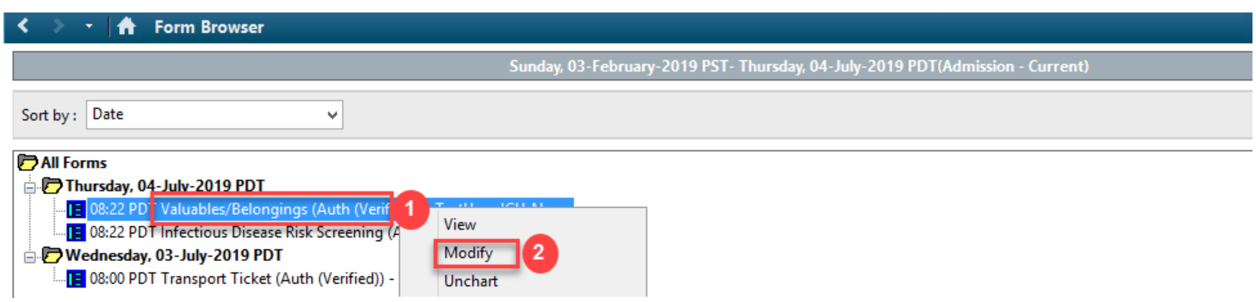


Modify the PowerForm

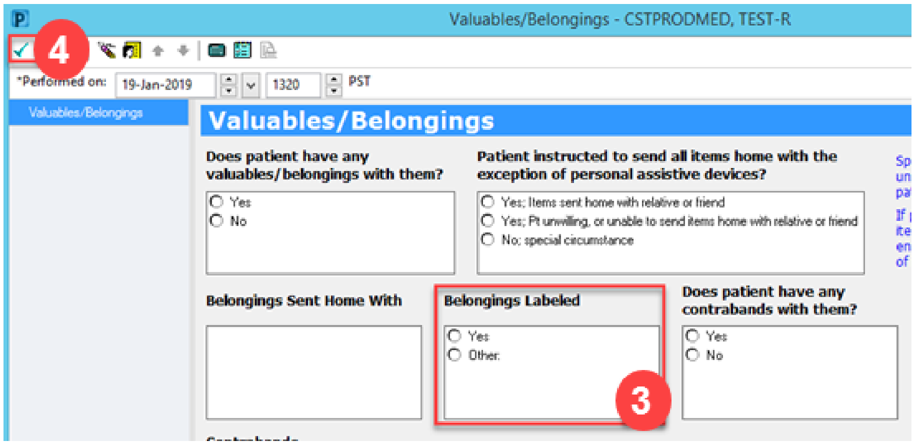
In the emodule you had modified via the documentation section of the menu. You will practice modifying the entry via Form Browser.

Let's select **Valuable/ Belongings** PowerForm in **Form Browser** and modify it:

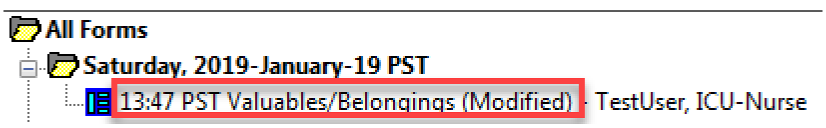
1. Right-click on the most recently completed **Valuable/Belongings** PowerForm in **Form Browser**.
2. Select **Modify**.



3. Select ***Yes*** in the **Belongings Labeled** field.
4. Click the **Sign** ✓ icon to complete the documentation.



When you return to this document in **Form Browser**, it will show the document has been modified.



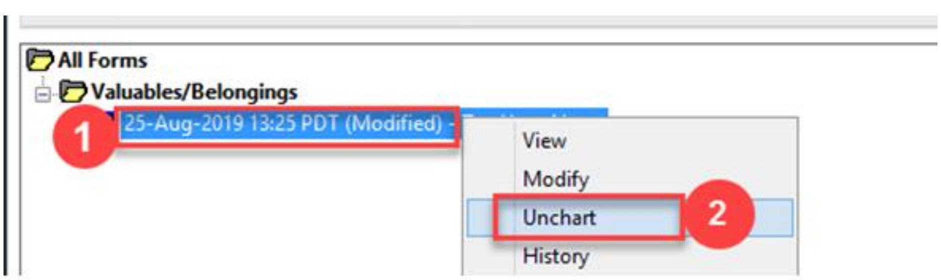
Unchart the PowerForm

Read Only

For learning purposes, let's say the **Valuables/ Belongings** PowerForm has been documented on the wrong patient.

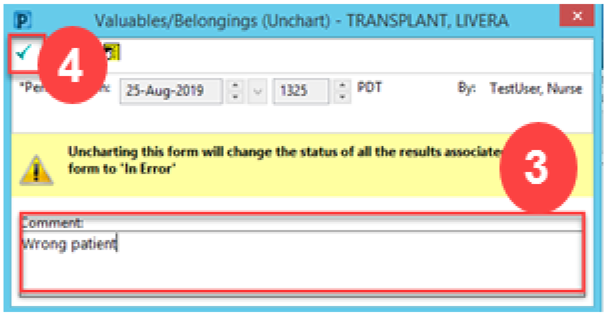
To unchart the PowerForm:

1. Right-click on the existing **Valuables/Belongings** PowerForm.
2. Select **Unchart**.

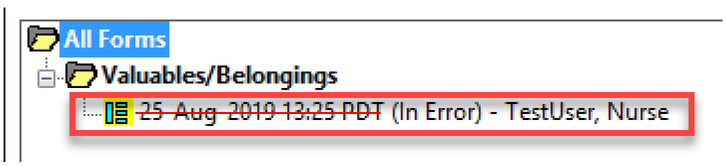


3. The **Unchart** window opens. Enter reason for uncharting in the **Comment** box: ***Wrong patient***.

4. Click the **Sign** ✓ icon.



Uncharting the PowerForm will change the status of all the results associated with the PowerForm **In Error**. A red strikethrough will also show up across the title of the PowerForm.



End of Read Only

Key Learning Points

- Completed PowerForms can be accessed through the Form Browser.
- Modify a completed PowerForm if the information needs to be added or amended.
- A modified PowerForm will show up as (Modified) in the Form Browser
- Unchart a completed PowerForm if it has been charted in error.
- An uncharted PowerForm will show up as In Error in the Form Browser

Activity 7.4 – Review the Document You Created

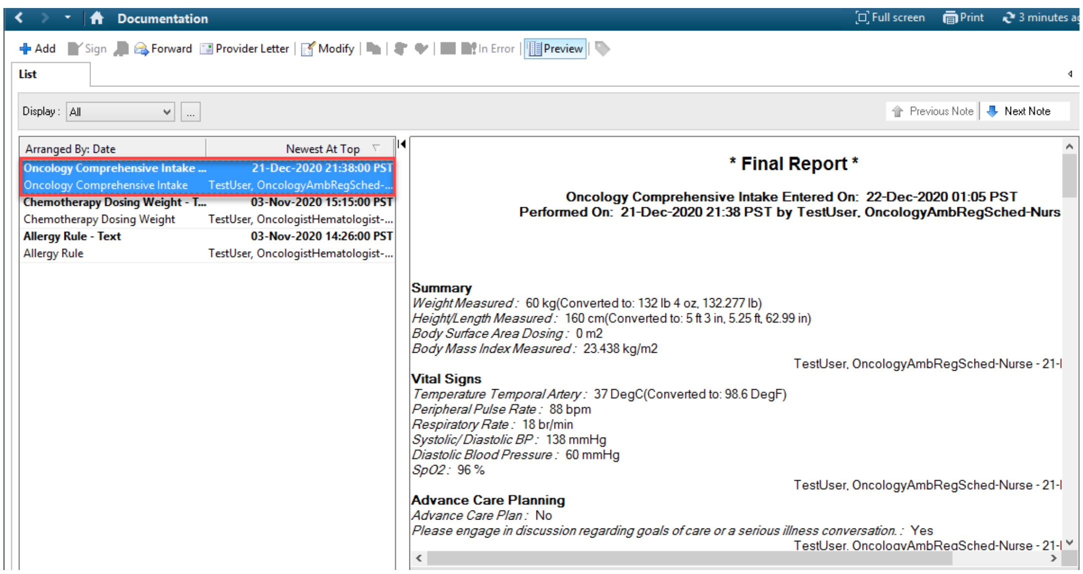
Now that you have completed and signed a PowerForm, we will review how your documentation will appear.

Once you sign a document the data will convert into text. This only occurs for forms that are signed, not forms that are saved.

As you have already practiced viewing documentation from the workflow page, we will view this documentation from the Menu.

1. Click **Documentation** from the Menu. Note documents may include notes by nursing or another clinician, a physician consult note, a physician daily rounding note, or even a diagnostic imaging report.

2. Select the Valuables and **Belongings** PowerForm you had just filled out.



Key Learning Points

- Once you sign a document it will be converted to text.
- You can review all documents placed on a patient chart in the Documentation section of the Menu.
- Documents may include notes by nursing or another clinician, a physician consult note, a physician daily rounding note, or even a diagnostic imaging report.

PATIENT SCENARIO 8 – Ongoing Care: Manage Orders

Learning Objectives

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

- Understand communication types and the types that route to the providers message centre for cosignature.
- Place orders
- Cancel/Discontinue an order

SCENARIO

During ongoing care, you not only review orders, but also place orders on your patients in certain situations and as per site policy.

You will complete the following activities:

- Place orders
- Ordering Physician Window
- Cancel/Discontinue an Order

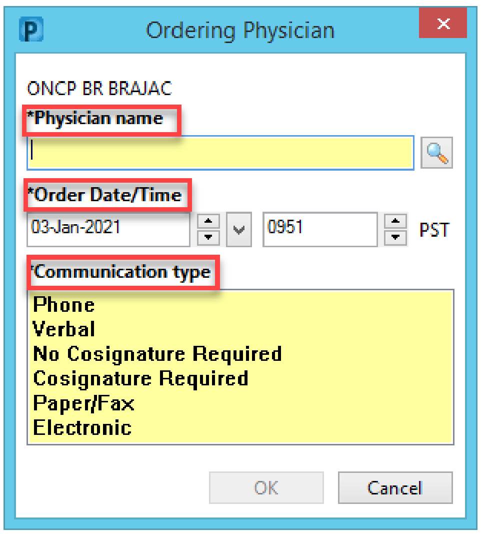
For the following activities, select the name of **patient** **A** as assigned to you from your CST Cerner Learning – Your workbook's logins and patients email.

Activity 8.1 – Overview of Ordering Physician Window

Read Only

It is important to follow your Health Authority policy regarding placing nursing orders.

Anytime a nurse places an order they will be prompted to identify the Ordering Physician, confirm the date and time (defaulted to Today and Now) and choose the appropriate communication type that initiated the placement of the order.



The Communication Type determines if the order will be routed to the providers message centre for cosignature.

Communication Type	Use When	Cosignature Required
Phone	An order is received via telephone from a provider when provider is unable to enter own orders.	Yes
Verbal	An order received verbally from a provider, who is physically present, in an urgent or emergent situation.	Yes
Cosignature Required	Any order that does not fit the other categories but will require provider co-signature when ordered by non-providers.	Yes

No Cosignature Required	An order which does not require a co-signature, including Nursing Initiated Activities and Consult/Following Orders for Allied Health.	No
Paper/Fax	An order was written on paper and transcribed into the patient chart.	No
Electronic	For use by pharmacy staff only in the medication verification process only. Not to be selected for any orders.	No

End of Read Only

Key Learning Points

- Communication Type determines if the order will be routed to the providers message centre for cosignature.
- Required fields are always highlighted yellow.

Activity 8.2 – Place Orders

Throughout your shift, you place the following orders as per scope of practice:

- Orders that require a cosignature from the provider e.g., telephone and verbal orders
- Orders that do not require a cosignature e.g., order within nursing scope, Nurse Initiated Activities (NIA)

When a nurse is required to place an order, they can search for orders in a variety of ways.

a. **Add** Icon + Add in the Orders section of the Menu.

b. **Add** icon + Add in the Orders page.

c. Quick Orders in the Patient Summary page.

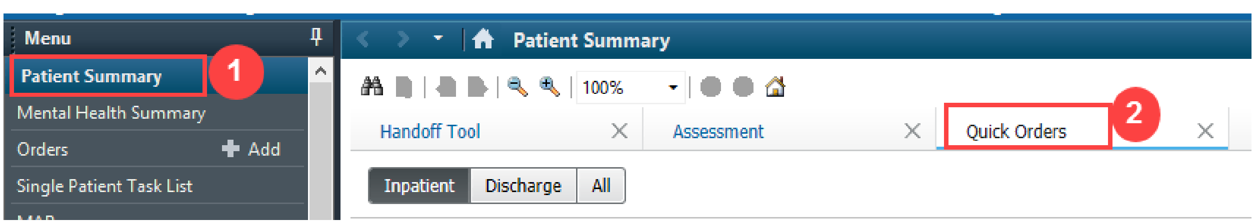
From these areas orders can be searched for by individual name or by accessing specialty or personal favourite folders.

We will practice placing an order from the **Quick Orders** page and then the **Add** Icon + Add .

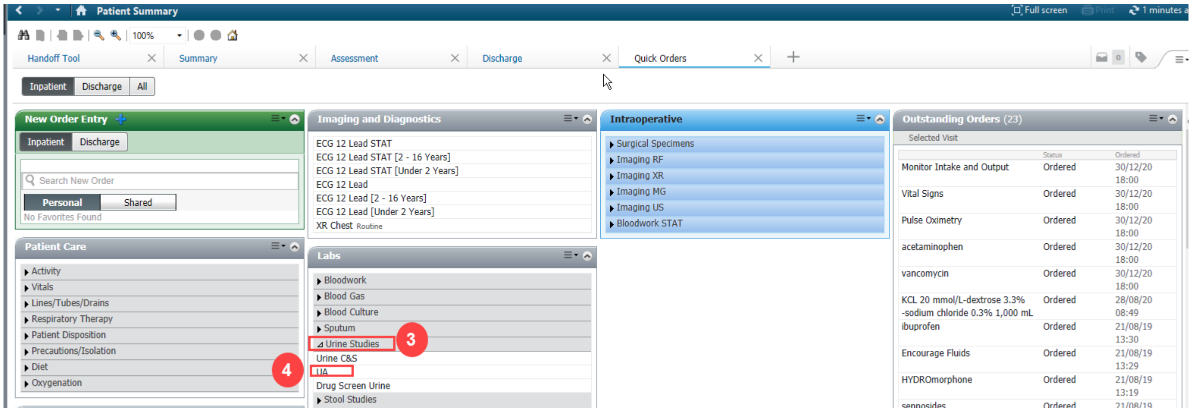
Place an Order Using Quick Orders

You are going to place a Urinalysis order from the **Quick Orders**. You were discussing the patient with the provider by phone but he is not by a computer to place the order and will have to co-sign later.

1. Navigate to **Patient Summary** from the **Menu**.
2. Select the **Quick Orders** page.



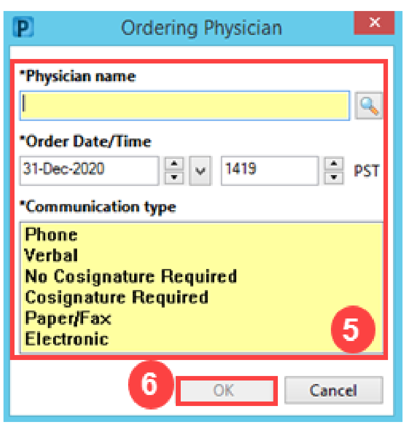
3. In the **Lab** category, expand **Urine Studies** sub-category.
4. Select **UA** order.



5. In the **Ordering Physician** window, enter the ordering provider's name and select appropriate communication type. For practice, enter the followings:

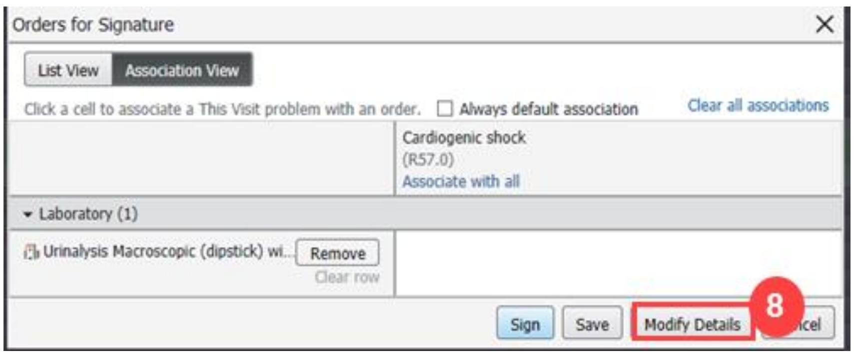
   - Physician Name: **Test, Alex**
   - Communication Type: ***Phone***. Note, this will be forwarded to the physician's inbox for co-signature.

6. Click **OK**.



7. Click the **Orders for Signature**  icon.

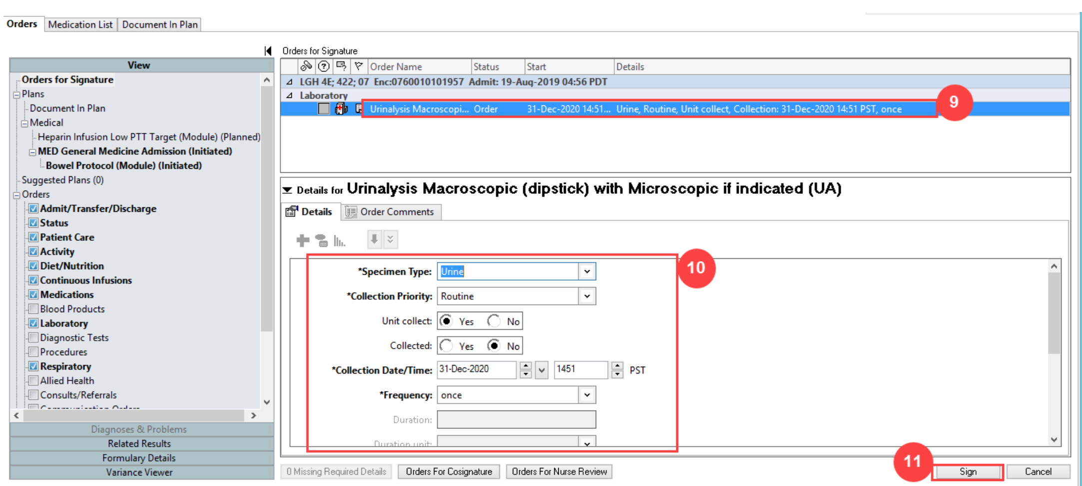
8. Click **Modify Details** in the Orders for Signature window.



9. Click the order sentence for Urinalysis Macroscopic (dipstick) with Microscopic if indicated (UA).

10. In the **Order Details** section, review the accuracy of the pre-populated information and make changes if needed.

11. Click Sign to activate this order.



Place an Order Using Ad Hoc Ordering on the Orders Page

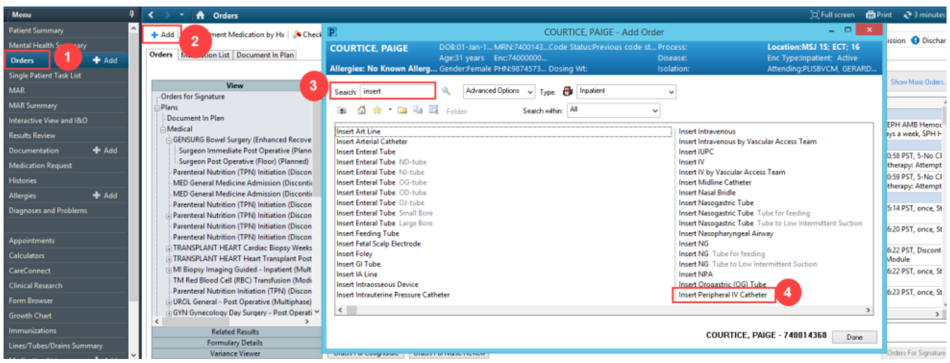
You are going to place an Insert Peripheral IV order via Ad Hoc Ordering on the **Orders** page.

1. Navigate to **Orders** from the **Menu**.

2. Click the **Add** + Add button.

3. In the **Add Orders** window, type ***insert*** in the search field and press **Enter** on the keyboard to view search results.

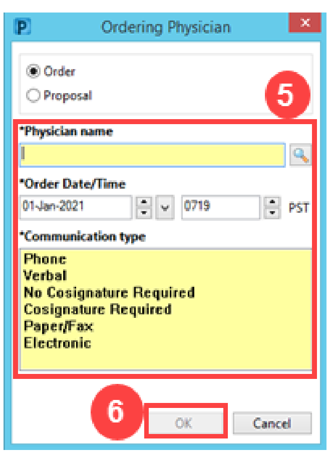
4. Select **Insert Peripheral IV Catheter**.



5. In the **Ordering Physician** window, enter the ordering provider's name and select appropriate communication type. For practice, enter the following:

   - Physician Name: **Test, Alex**
   - Communication Select: **No Cosignature Required**.

6. Click **OK**.

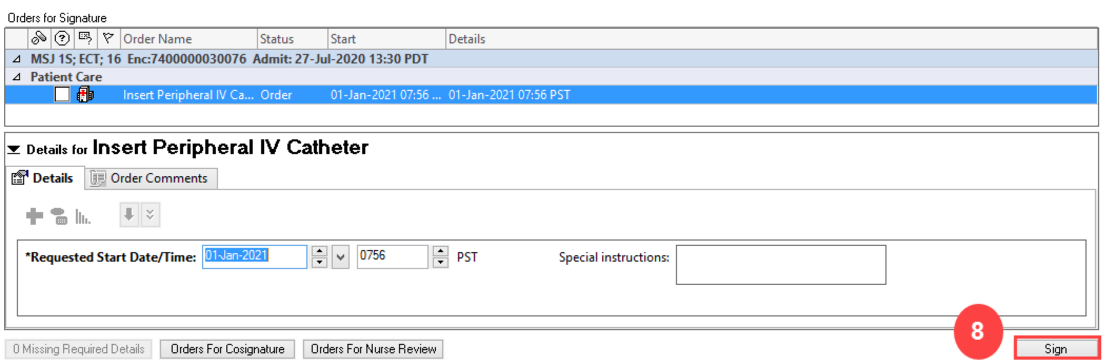


NOTE:

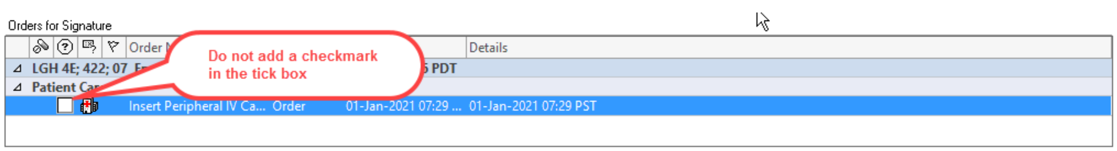
- Make sure **Order** is selected in the **Ordering Physician** window.
- Some no cosignature required orders do not trigger to open the **Ordering Physician** window.

7. Click **Done** to close the **Add Order** window.

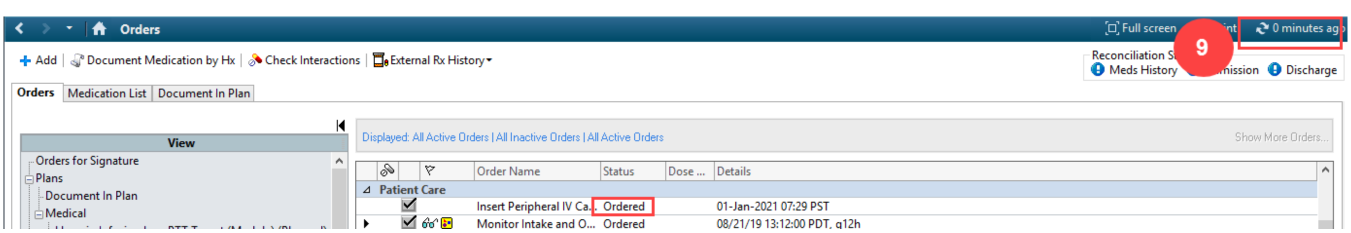
8. **Review** the order and Click Sign.



WARNING: **DO NOT** add a checkmark in the tick box beside the order sentence because putting the checkmark will make the order become a proposed order. Proposed orders cannot be activated until they are signed by the Provider.



9. Click the **Refresh** icon to change the order status from **Processing** to **Ordered**.



Key Learning Points

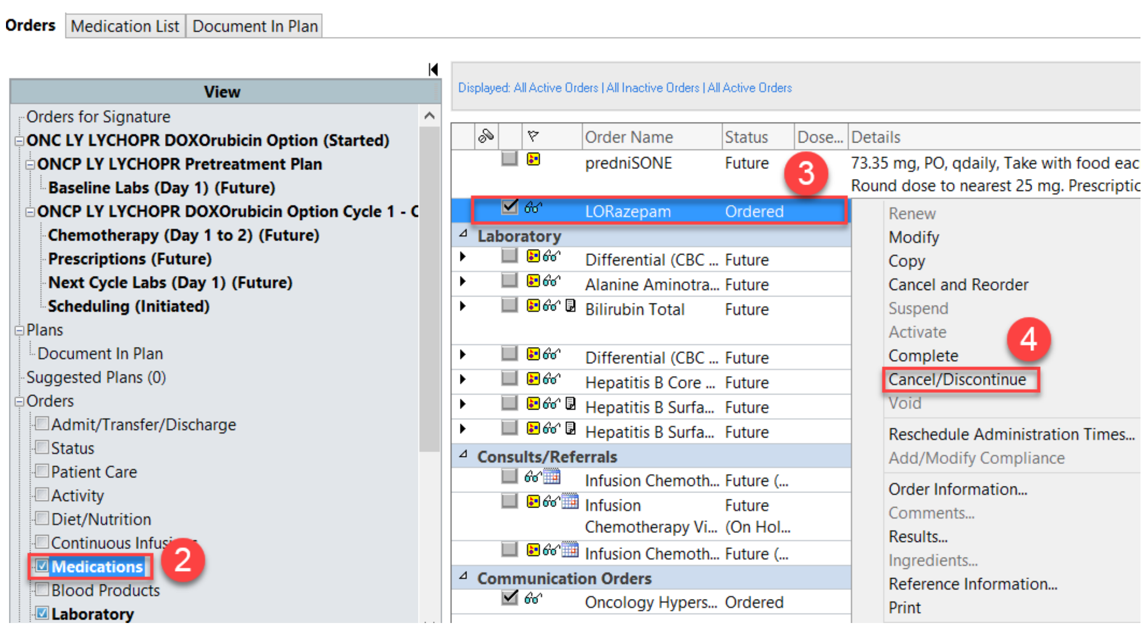
- Inpatient Nurse can place orders that do not require a cosignature (e.g., order within nursing scope) and orders that require a cosignature from the provider (i.e. verbal or phone orders).
- You may place an order by either using Quick Orders or adding an individual order on the Orders page.
- Some orders require additional details to be added.
- Enter the ordering provider's name and select appropriate communication type in the Ordering Physician window.
- **DO NOT** put a checkmark in the tick box beside the order sentence as putting the checkmark will make the order become a proposed order that cannot be activated until the provider has signed the order.

Activity 8.3 – Cancel/Discontinue an Order

You had contacted the doctor earlier for a Lorazepam order as the patient was feeling anxious arriving to the Inpatient unit; 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.

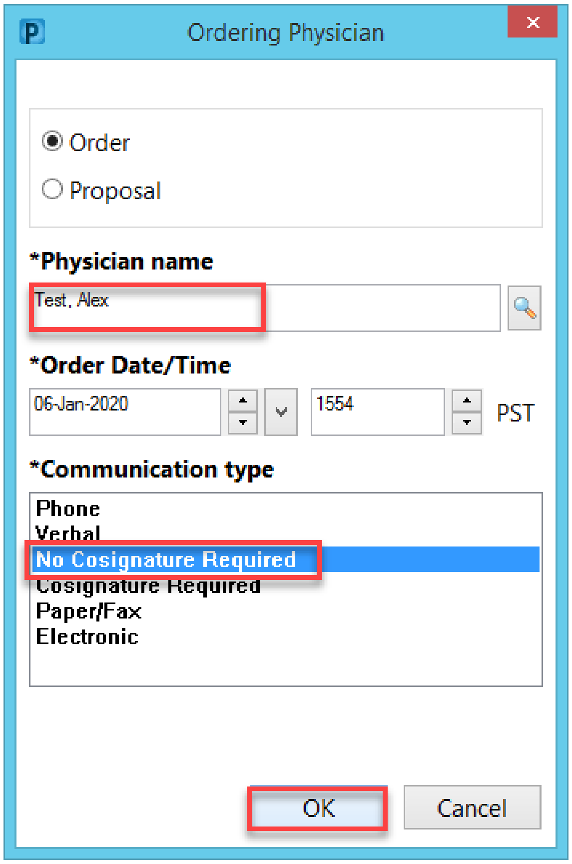
Follow the steps below to cancel Lorazepam.

1. Navigate to the **Orders** screen from the Menu.
2. Select **Medications** under the Order View.
3. Right-click order **Lorazepam**.
4. Select **Cancel/Discontinue**.



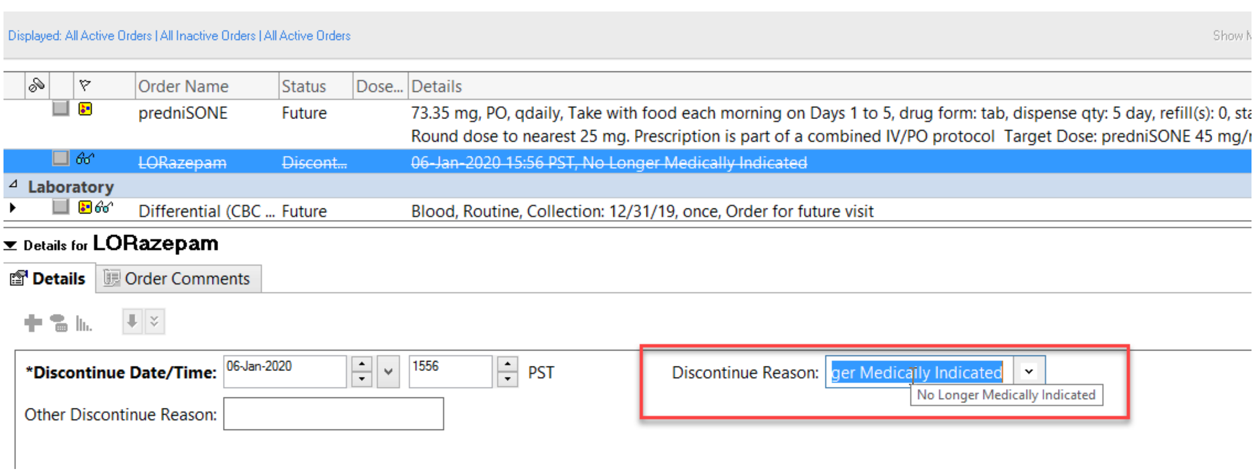
The Ordering Physician pop-up window will appear.

5. Fill out required fields highlighted yellow.
   - Physician name: **Test, Alex**
   - Communication type: **No Cosignature Required**.
6. Click **OK**.



This returns you to the **Orders** page. The **Details for Lorazepam** expand in the **Order profile**.

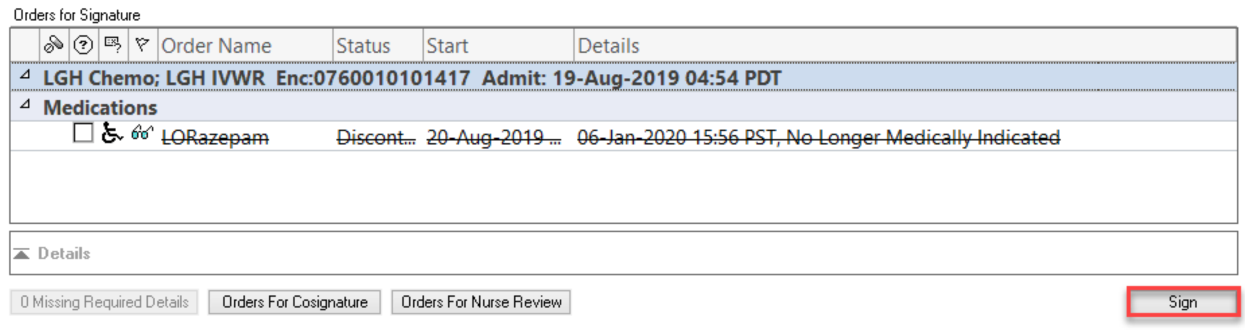
7. Select Discontinue Reason as **No Longer Medically Indicated**.



8. Click  to process the orders.

9. **Review** the Orders.

10. Click Sign .



11. Click **Refresh** .

The order has been discontinued. And will no longer be visible from the Active Orders view. .

Key Learning Points

- **Right click** to cancel/discontinue an order.
- A discontinue reason must be documented.

PATIENT SCENARIO 9 – Chemotherapy Order Verification

Learning Objectives

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

- Review Orders
- Understand Oncology PowerPlans and Regimens
- Perform Chemo checks
- Review and document Lifetime Cumulative Dosing

SCENARIO

You have assessed the patient and documented their height and weight in Interactive View with a second signature. You will now go through the process of checking the chemotherapy. Once your checks are complete and the medication is verified as safe to give you will administer the medications that were ordered for your patient.

You will be completing the following activities:

- Review Oncology PowerPlans and Regimens
- Orders for Nurse Review
- Oncology Medication Order Verification and Documentation
- Overview of Additional Phases
- Lifetime Cumulative Dosing

For the following activities, select the name of **patient A** as assigned to you from your CST Cerner Learning – Your workbook's logins and patients email.

Activity 9.1 –Review Design of Oncology PowerPlans and Regimens

As you have been introduced to the general structure of PowerPlans and Regimens in the Intro to PowerPlans and Regimens eModule, we will proceed with a quick general overview and then discuss the specific design of Oncology PowerPlans.

PowerPlans and Regimens Overview

Before viewing the orders we will review some definitions to recognize the different types of formats that orders are presented to you. PowerPlans are different from individual Orders.

PowerPlans:

PowerPlans are similar to pre-printed orders (PPOs), allowing the provider to plan and coordinate care by defining sets of orders that are often used together. The provider can adapt PowerPlans to fit their needs.

- They can select and deselect individual orders from the PowerPlan list.
- They can add orders that are not listed in the PowerPlan.
- They can add other modules (order sets) that are not listed in a PowerPlan.

Regimens:

A Regimen is a grouping of PowerPlans that make up a treatment protocol.

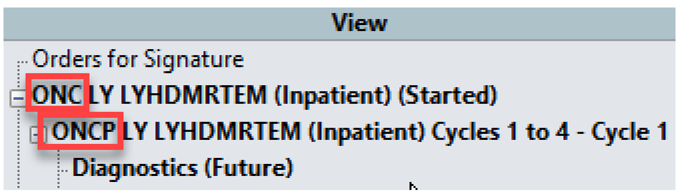
Regimens can be viewed by clinicians to determine where a patient is in their treatment plan.

NOTES:

- PowerPlans are marked by the icon.
- Regimens are marked by the icon.

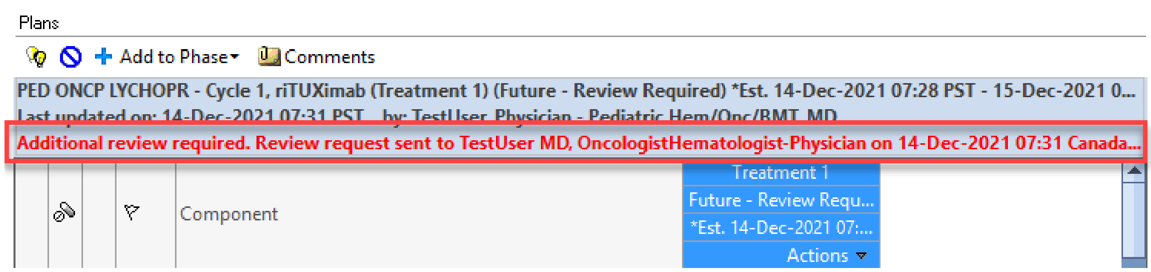
Understanding the Design of Oncology PowerPlans

- The most common order you will see for Systemic Oncology is a **Regimen** with a combination of single phase and multiple phase Day of Treatment PowerPlans. Note Prescription plans are only built as PowerPlans.
- There are chemotherapy regimens designed to accommodate care in the outpatient setting and inpatient setting.
  - In some situations, you will see outpatient protocol orders in the inpatient setting. This will be discussed further in your workflow review session.
- **ONC** is the prefix for the naming convention of some Oncology Treatment Regimens (e.g., ONC LY LYHDMREM).
- **ONCP** is the prefix for the naming convention of some Oncology Treatment PowerPlans (e.g., ONCP LY LYHDMRTEM).



- Each Oncology PowerPlan has a link to view BC Cancer Agency Protocols.
- Per policy, some Chemotherapy orders require double signature.

NOTE: In the Order Profile, when a PowerPlan still requires a second signature a red message will appear under the PowerPlan stating **Additional review required** and who the request was sent to. You will not be able to activate these orders till the second signature has been signed off. Note,screenshot is an example only.

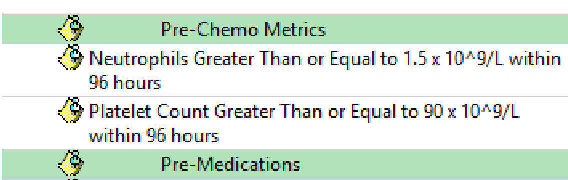


- Oncology PowerPlans in both the inpatient and outpatient settings are organized into **Phases** which allow for orders within phases to be processed at different time points: Note the following:
  - Phases will only be seen if they are required by the selected PowerPlan.

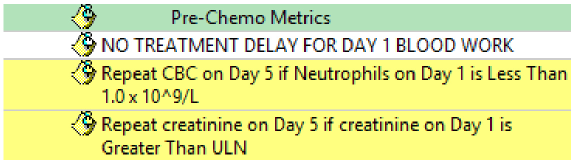
- There are separate phases built for **Chemotherapy, Diagnostic, riTUXimab** and **Lab** phases. They are **future orders** which require order completion (final doses) by physicians and activation by nurses or providers.
- Phase specific to the Outpatient setting include:
  - **Prescription phases** which default to a **future order** status for pharmacy to activate**.**
    - Similar to chemotherapy, prescriptions will require the provider to verify the dose in the Dosage Calculator.
    - The **prescription icon** indicates that it is a prescription.
  - **Scheduling phase** is set to **order now** allowing for chemo appointments to be scheduled in advance for the outpatient setting.
- Phase specific to the Inpatient setting includes:
  - Chemotherapy Related Orders
  - Chemotherapy related Labs
  - Alkalinizing Regimen
  - Pretreatment Labs
  - Hydration
- In some PowerPlan phases, you will have additional sections that may include.
  - Hypersensitivity Management
  - Supportive Care

- In inpatient Oncology PowerPlans, there are no Pre-Chemo Metrics. However, providers may order an outpatient plan in the inpatient setting. For reference, see screenshot below to show how it may be displayed in the outpatient PowerPlan. Here you can see the Pre-Chemo Metrics references from the protocol. The two examples are not inclusive.

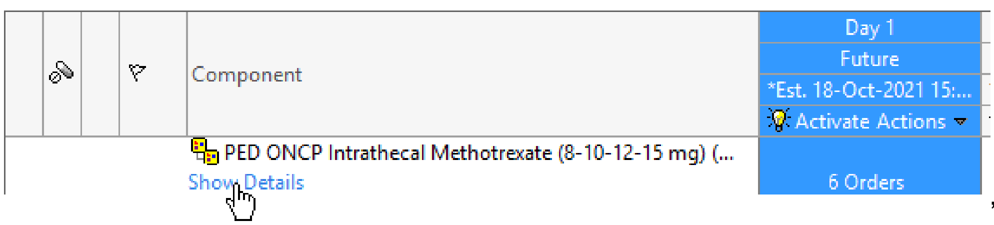
Example A



Example B



- There are differences in the timing of activation of phases by nurses in the outpatient and inpatient setting. This results in some aspects of treatment being built into separate phases (for example, Hydration). For an inpatient, the nurse should activate each phase as required, and should click the Activate All button when available.
- The initial PowerPlan of Outpatient Regimens will be a PreTreatment Plan which is not the case for Inpatient Regimens; instead they will have a Pretreatment lab phase built into the PowerPlan.
- In the inpatient setting, the Chemo calendar is not used to schedule the next admission for Inpatient treatment. Note at BC Cancer it is managed through Admit to Inpatient for Planned Chemotherapy order located in the scheduling phase of the PowerPlans.
- Within PowerPlans orders maybe built as a module indicated by the icon.
  - A module is a group of orders embedded within a PowerPlan as a single component.
  - Details of the Module can be displayed by clicking the Show Details blue link.



”

- Very few Oncology Adult PowerPlans are design with modules. Modules are mainly built within Pediatric Oncology PowerPlans.

In the next several activities, you will navigating through the phase of a Chemotherapy order, review the order components and review the additional sections or phases that you may see in other PowerPlans.

NOTES:

- Chemotherapy Orders placed for outpatients and inpatients are entered as **Future Orders** and have their status set to Future. The Order is **activated** once the patient has arrived for treatment, the nurse has completed their assessment and determined that it is safe to proceed with treatment, and the medications have arrived on the unit.
- In Chemotherapy/Rituximab phases, **Zero Time** orders are added to PowerPlans as an anchor order to allow accurate timing and sequencing on the MAR (Medication Administration Record). No additional action is required for time zero order within PowerPlans.

Key Learning Points

- A PowerPlan is equivalent to one cycle of treatment, and can be comprised of multiple phases.
- A Regimen is a set of PowerPlans
- ONC is the prefix for all Oncology Regimens
- ONCP is the prefix for for all Oncology PowerPlans.
- Oncology PowerPlans have a link to BC Cancer Agency protocols.
- Oncology PowerPlans are organized into phases.
- The Zero Time order is timing anchor in the Chemotherapy/Rituximab phases of all PowerPlans. No additional action is required for time zero order within plans.
- Modules are mainly contained in Pediatric Oncology PowerPlans. Modules are marked by the icon.

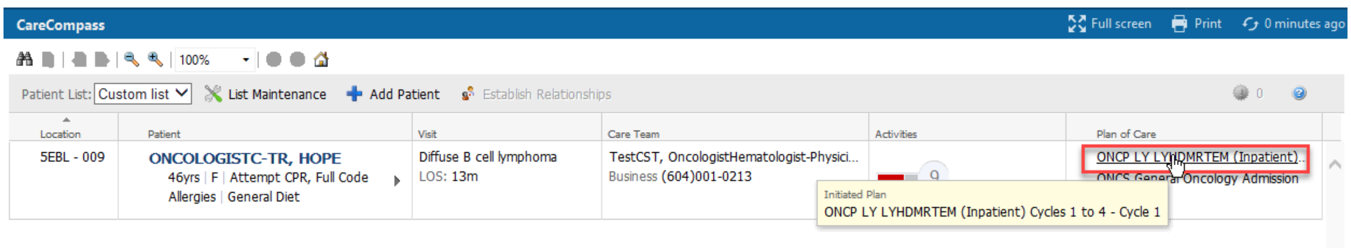
Activity 9.3 – Perform Oncology Medication Order Verification and Documentation

Oncology medication order verification and documentation involves different parts of the patient's chart, including the Orders, Oncology section of the Menu and Results Review.

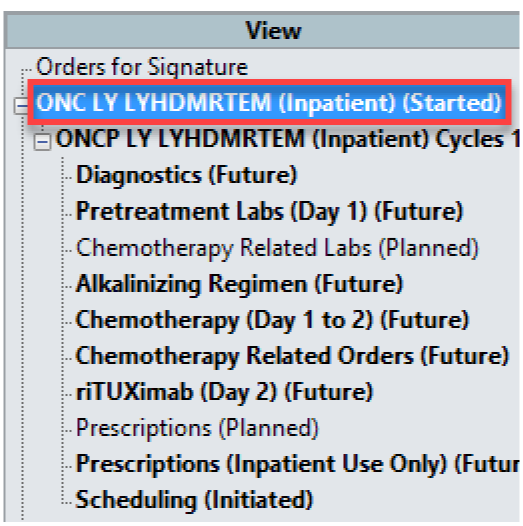
As an Inpatient Oncology Nurse, you would review each phase of the Oncology PowerPlan that was placed by the Provider. We will begin by reviewing the Chemotherapy Regimen that was placed by the Oncologist/Hematologist.

To check Chemotherapy orders against protocol within the PowerPlan:

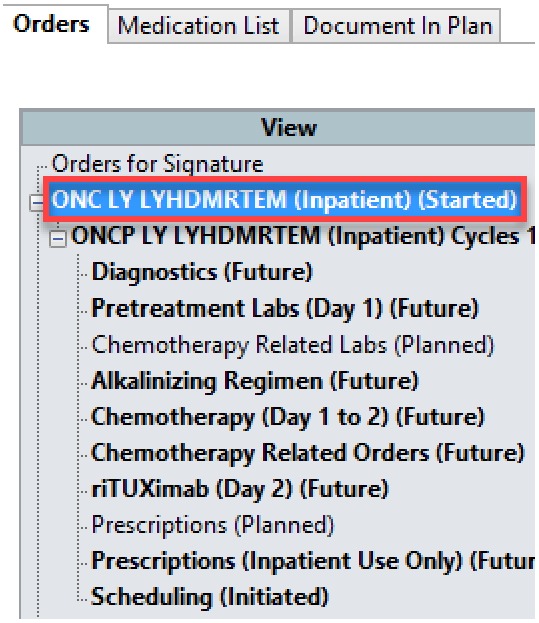
1. Click the **ONCP LY LYHDMRTEM (Inpatient)** PowerPlan in CareCompass.



The **Orders** page opens.



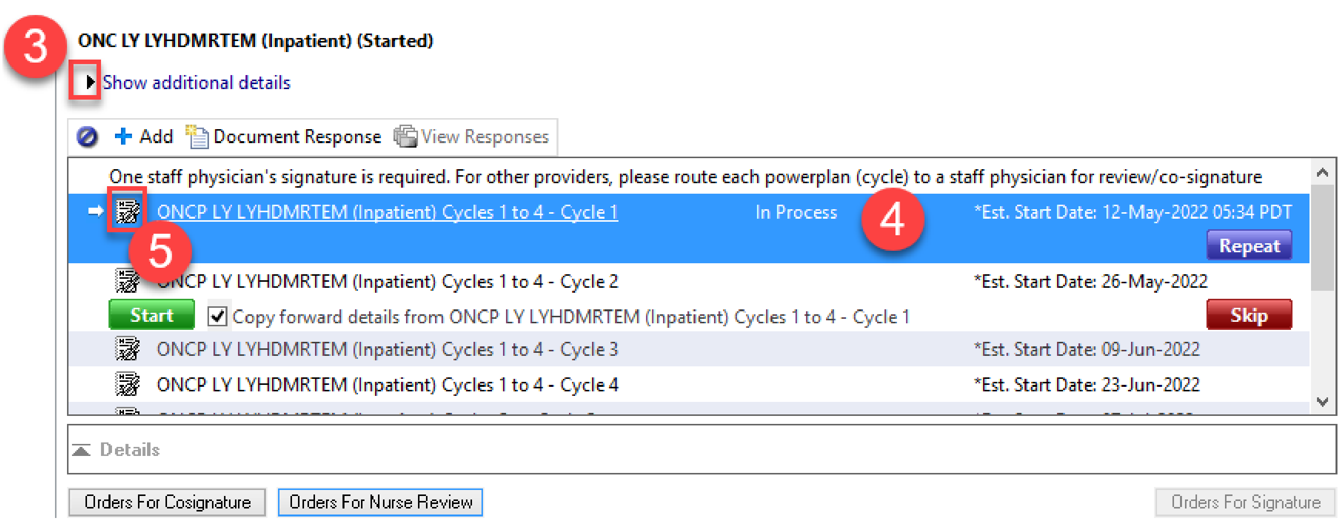
2. Click on the Regimen **ONC LY LYHDMRTEM (Inpatient).**



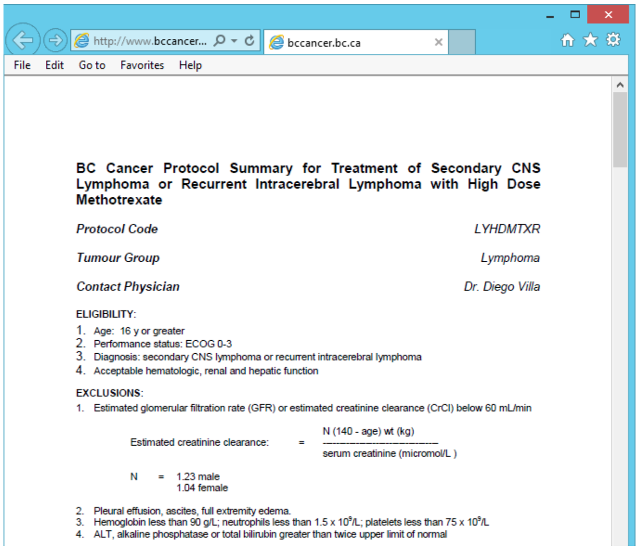
3. Click the arrowhead facing to the right next to **Show additional details**. The Regimen description displays.

4. The current or in progress PowerPlans are highlighted when you first click on the regimen. Remember that Oncology PowerPlans are denoted by ONCP.

5. Select the **protocol** link icon.

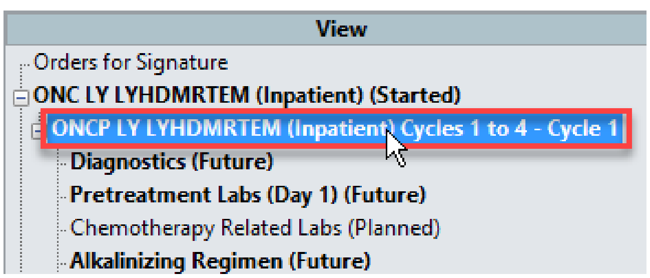


A link to **BC Cancer Agency Protocols** appears. You can keep this up for your reference as needed.



6. Click the red X located at the right upper corner to close the window.

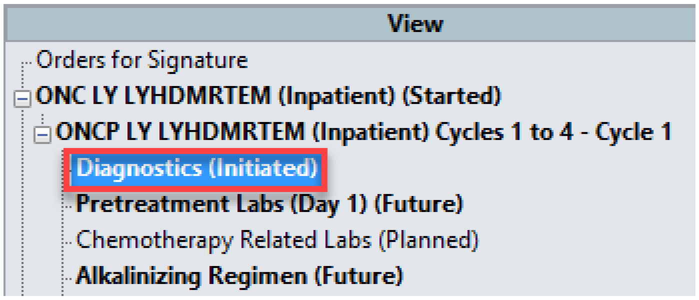
7. Select the **ONCP LY LYHDMRTEM (Inpatient) Cycles 1 to 4 – Cycle 1** from the **Order View**. Note this is a multi-day, multi-phase PowerPlan.



Now review and verify the different phases in the **ONCP LY LYHDMRTEM (Inpatient) Cycles 1 to 4 – Cycle 1** PowerPlan. Note as mentioned previously each phase maybe activated at various points in time. Note we will be reviewing and activating orders for Day 1.

1. Click the **Diagnostic** phase. This phase includes diagnostic tests required prior to the Inpatient treatment.

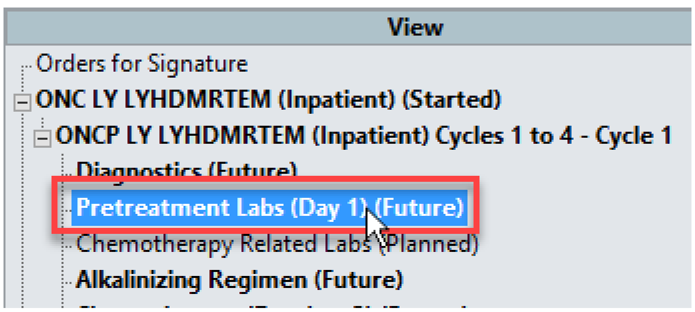
2. Note a chest Xray has been ordered and completed.



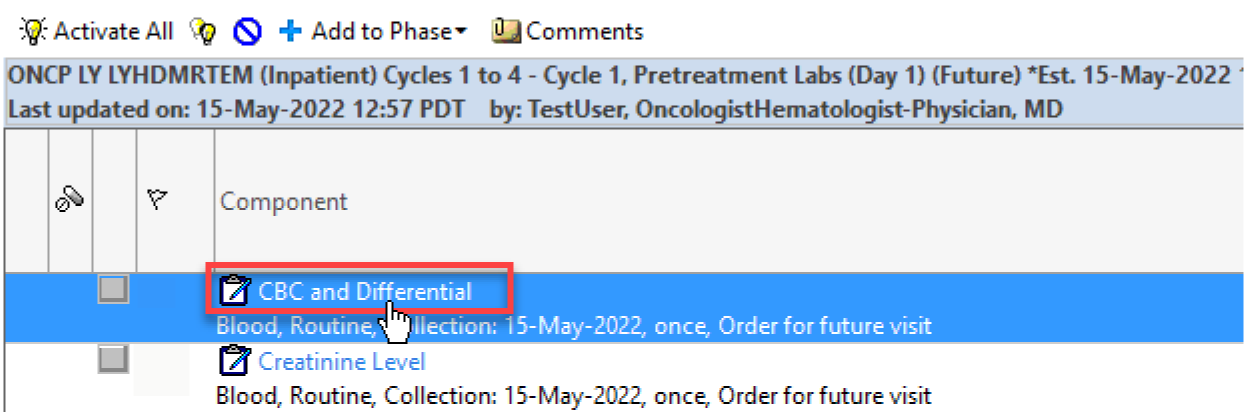
Prior to continuing your review of the chemotherapy orders you may want to initiate your pretreatment labs. Labs are not ordered until the nurse activates the order.

To activate the lab orders:

1. Click **Pre-treatment Labs** phase.

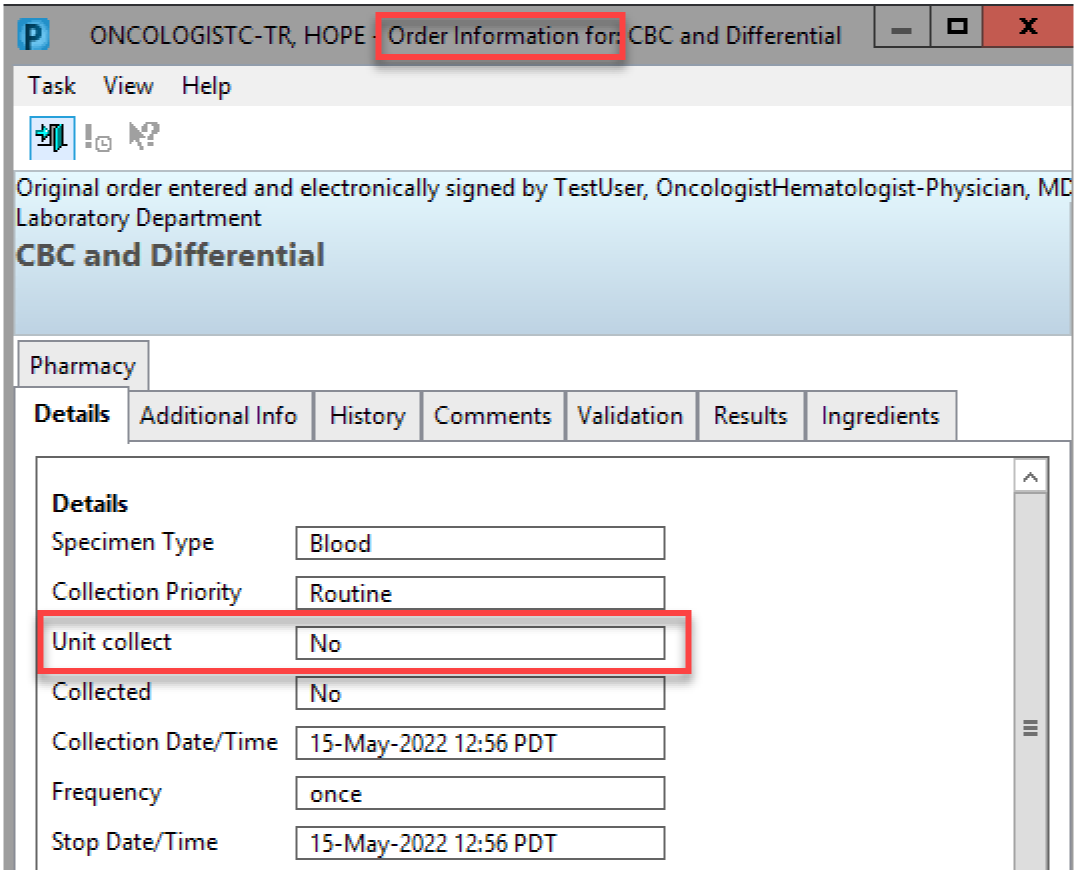


2. Review that all required labs have been ordered.
3. Click on the first lab **CBC and Differential**.

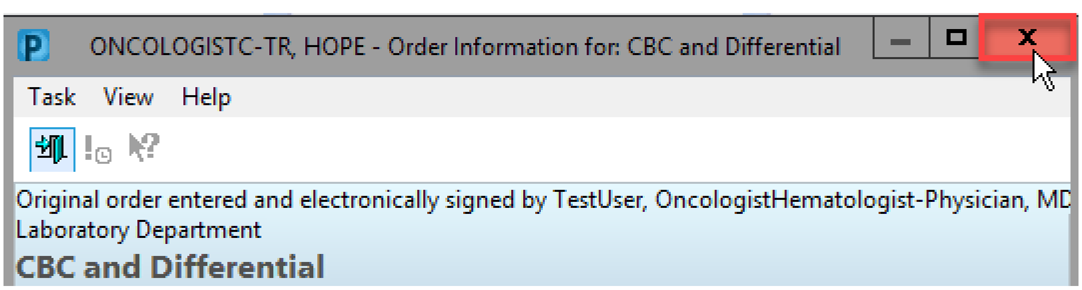


An **Order Information for** window opens. This window will provide additional order details and is available for all orders in CST Cerner.

4. Check that the **Unit Collect** setting **yes/no** is correct. For further information on how to modify the Unit collect Modify Lab Orders within Day of Treatment PowerPlans and Unit Collect Specimen Collection Unit Collect (Inpatient)

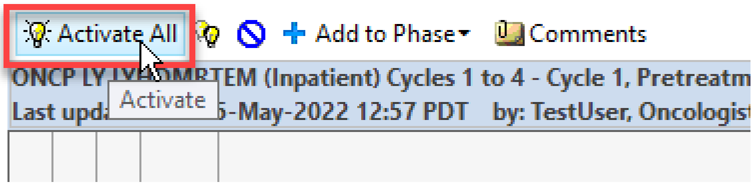


5. Click the **X**  icon to close the window.



You would repeat steps 2-7 to check all orders. For training purposes, we will assume these steps have been completed for all labs prior to activation.

6. Click **Activate All**.



7. A **Change Start Date/Time** window may appear in the train domain because there is a discrepancy between the estimated date of the treatment and the day you are activating the PowerPlan in the train domain. For learning purposes, click **OK** to proceed.

8. Note your future orders now state activate.

9. Click 

10. **Review** orders.

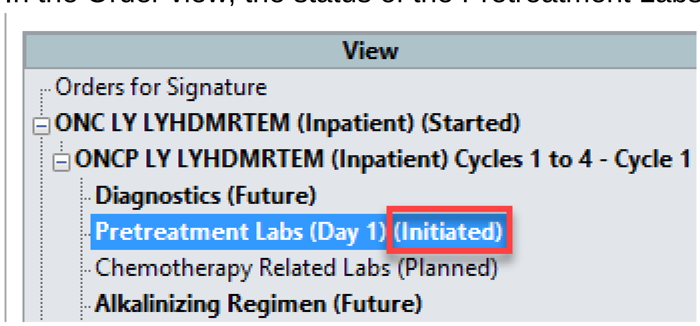
11. Click 

.

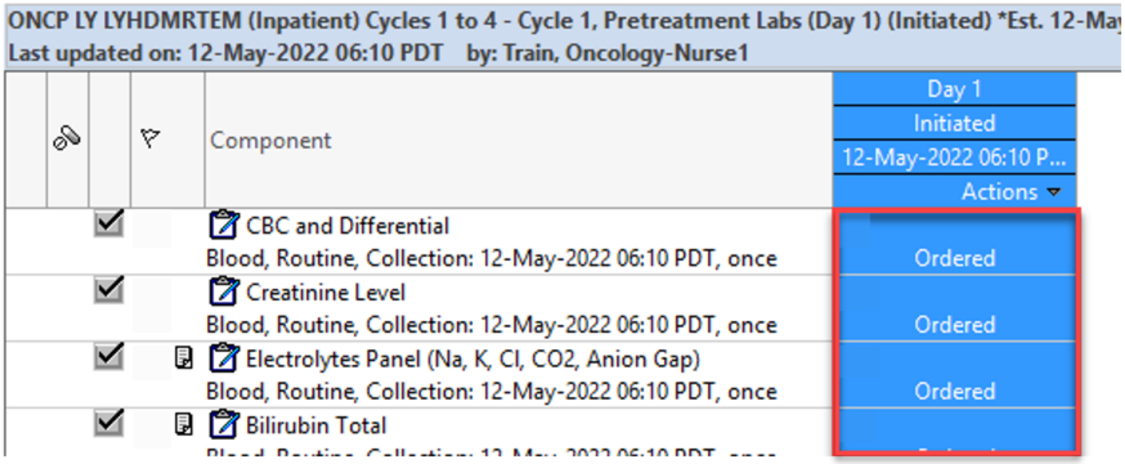
12. Click **Refresh** .

13. Note the following:

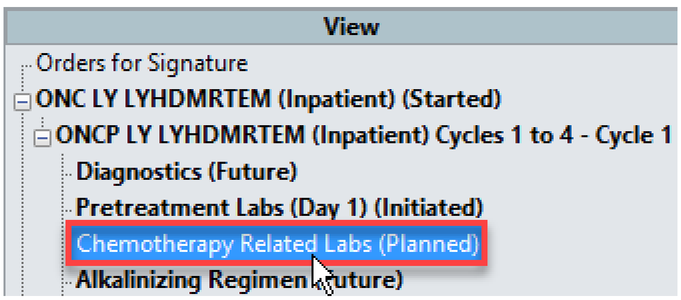
    - In the Order view, the status of the Pretreatment Labs phase has changed to Initiated.



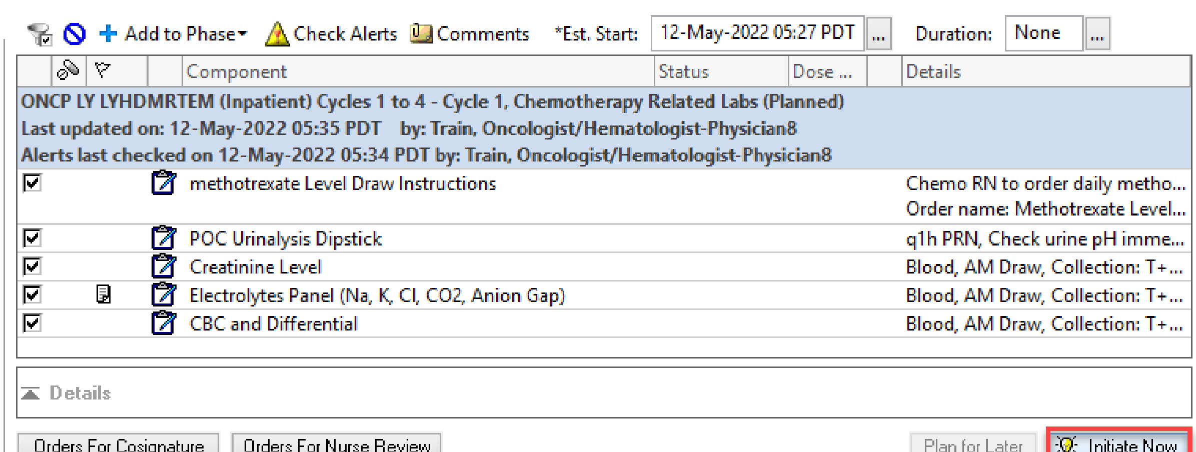
    - In the Order Profile, each order status has changed to Ordered. This status has triggered the lab to come collect these samples. Note if the labs are for unit collect they will be available to collect with Sunquest Clinical Collect.



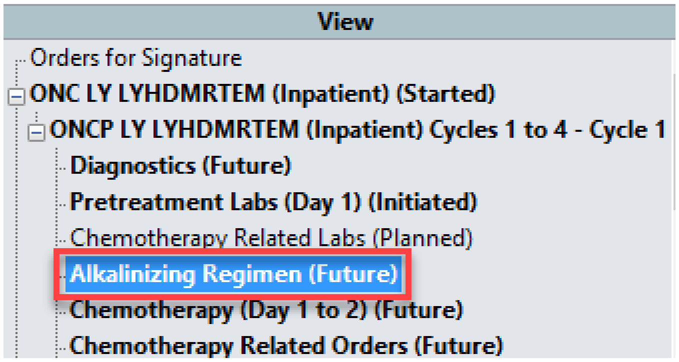
14. Click **Chemotherapy Related Labs** phase. This phase is for lab studies that need to be done during the hospital stay to monitor side effects, tolerance and/or drug levels.

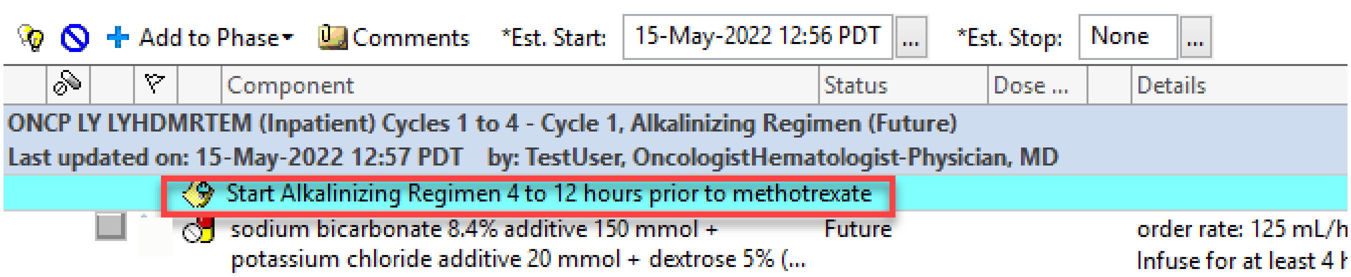


15. Note the orders associated to this phase. This order would require activation by clicking **Initiate Now**. This should not be done until after the Alkalinizing Regimen has begun and you are ready to proceed with chemo and need to collect the 1st urine dip for pH.

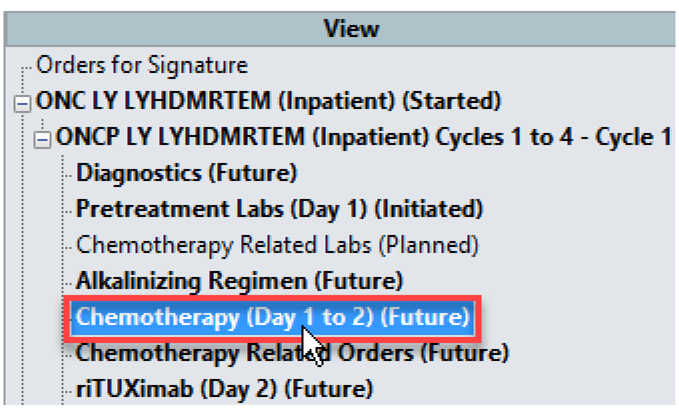


16. Click **Alkalinizing Regimen. Review the orders.** The Alkalizing Regimen phase would be activated prior to the chemotherapy phase in our example. Note the **Blue note** types, indicating nurse instructions specific to this protocol for timing of the Alkalizing Regimen.



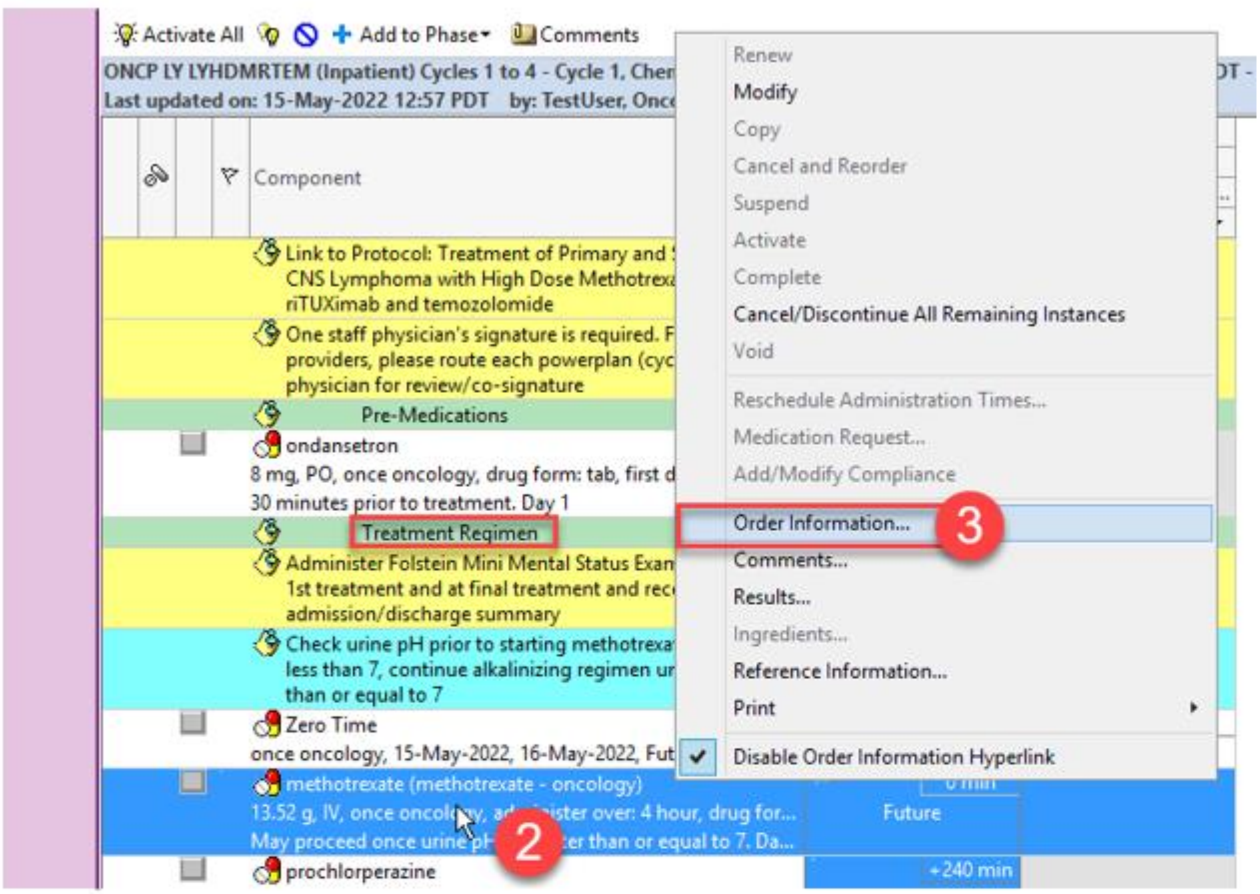


17. Click **Chemotherapy (Day 1 to 2)**. This phase contains the chemotherapy medications and the zero time order.



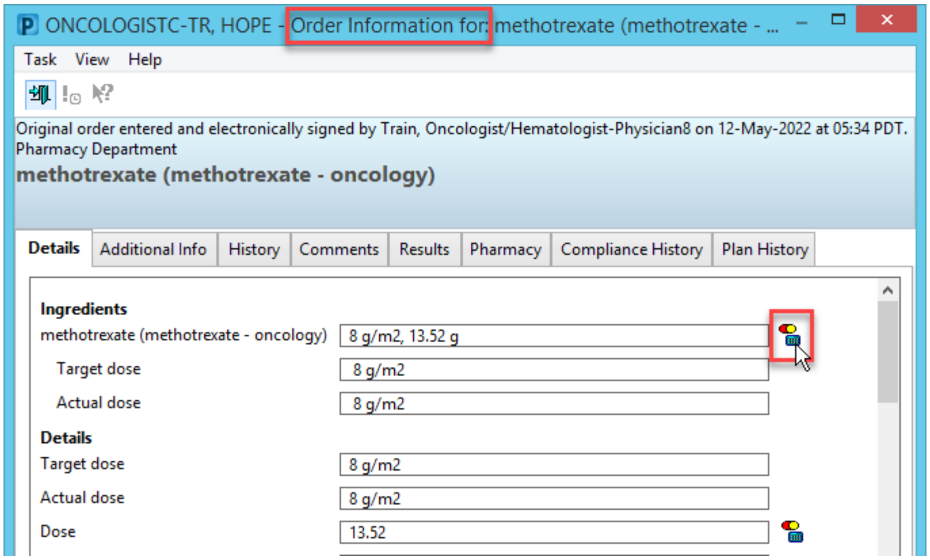
To verify the medications within the PowerPlan:

1. Navigate to the **Treatment Regimen** section.
2. Right-click on the **methotrexate** order sentence to access the dosing calculator. Recall from previous activity you are also able to click on the order name to open the Order Information for window.
3. Select **Order Information**.



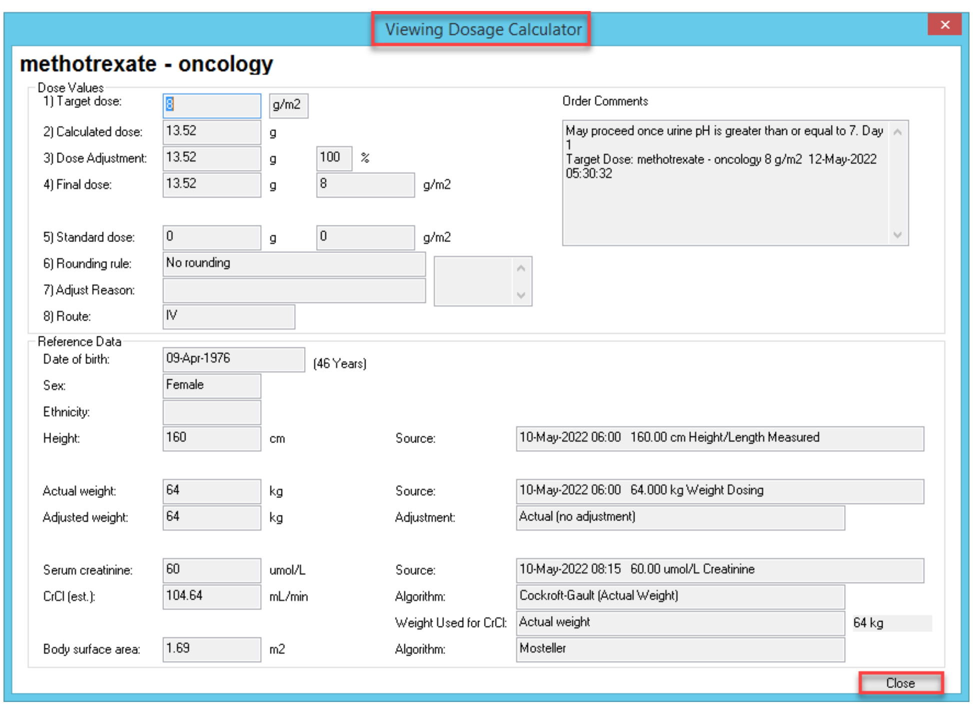
An **Order Information for:** window opens.

4. Click the Dosage Calculator icon .



The **Viewing Dosage Calculator** opens.

5. Verify the Height, Weight, BSA and any lab values used by the system to calculate the doses. Ensuring the information used is accurate.



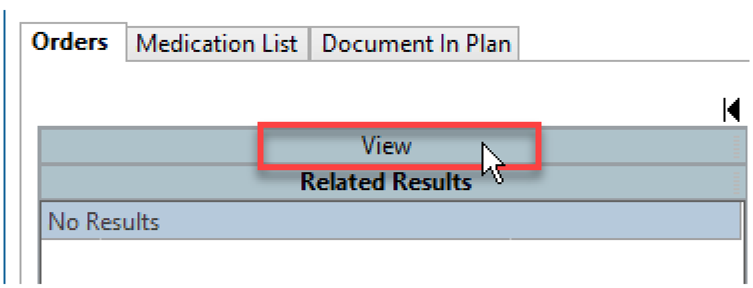
6. Click **Close**.

7. Click  to close the Order Information window.

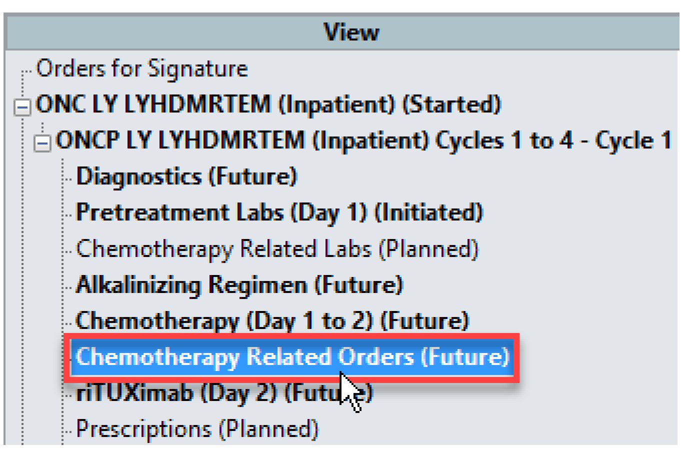
8. Note you would be required to repeat these steps for each weight based medication that was ordered.

> **NOTE**: In the Dosage Calculator the 'actual weight' is not the measured weight which nurses document in IView. The 'actual weight' is the most recently documented **dosing weight** documented at the time of ordering the PowerPlan. The Oncology Provider workflow is to document dosing weight just prior to ordering the PowerPlan.

9. Note in this example, **Related Results** displays on the left side of your screen. Click **View** to return back to the Orders **View**.

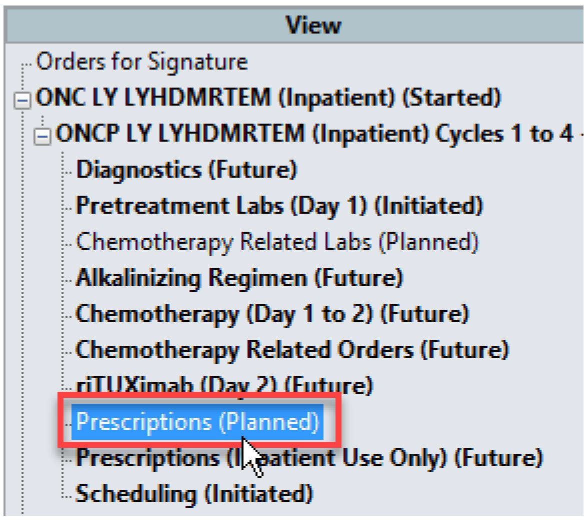


10. Click on to the **Chemotherapy Related Orders** phase. This phase contains orders such as Supportive Care Medications, PRN medications and Nursing Orders. This phase would be activated when the chemotherapy phase is being activated.



11. Click **riTUXimab** (Day 2) phase. Rituximab is a separate phase to allow for different timing of administration. This order is for Day 2, however, this would normally be checked as part of your chemo clinical check. For the purposes of efficiency in learning, we will not complete the step by step check of the orders in this phase.

12. Click **Prescriptions** phase. This phase houses oral systemic therapy treatments that are dispensed by the outpatient oncology pharmacy. Note the Provider would only order in this phase for the patient to take at home for alternate cycles.



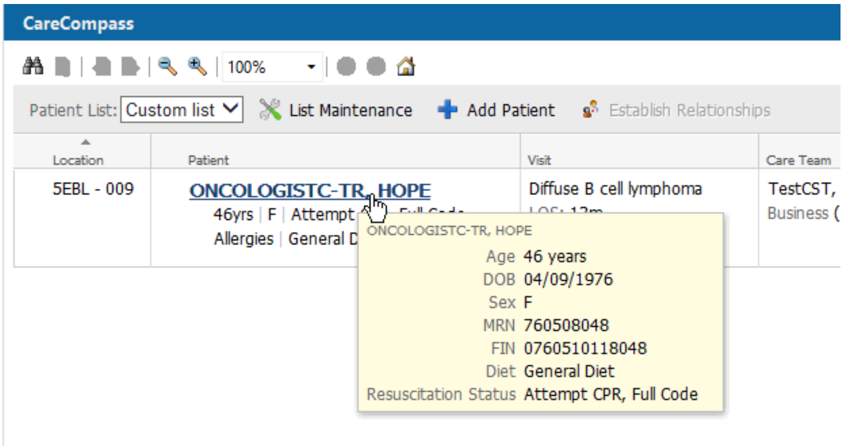
13. Click **Prescriptions** (Inpatient Use Only) phase. This phase houses the medications to be delivered as an inpatient. Let's assume the patient will still be in hospital on Days 7-11. You would verify and activate this medication at the appropriate time. For training purposes, we will leave this order as we are administering the chemotherapy first.

14. Click **Scheduling** phase. Note the **Admit to Inpatient for Planned Chemotherapy** order is facility flexed to BCC and is the order to request the bed for admission for the next cycle. You may also find a **Follow Up – Clinic –Oncology On Treatment** order within this phase. Providers may opt to place this order if they wish to see the patient in clinic in between admissions. Verify in the clinical setting the various scheduling orders used per site.

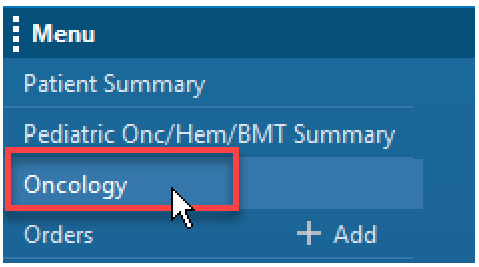
15. Click **Done** after reviewing your orders. You have now returned back to CareCompass.

Review Oncology Flowsheet

1. Click the **patients name** to return to the patient's chart.

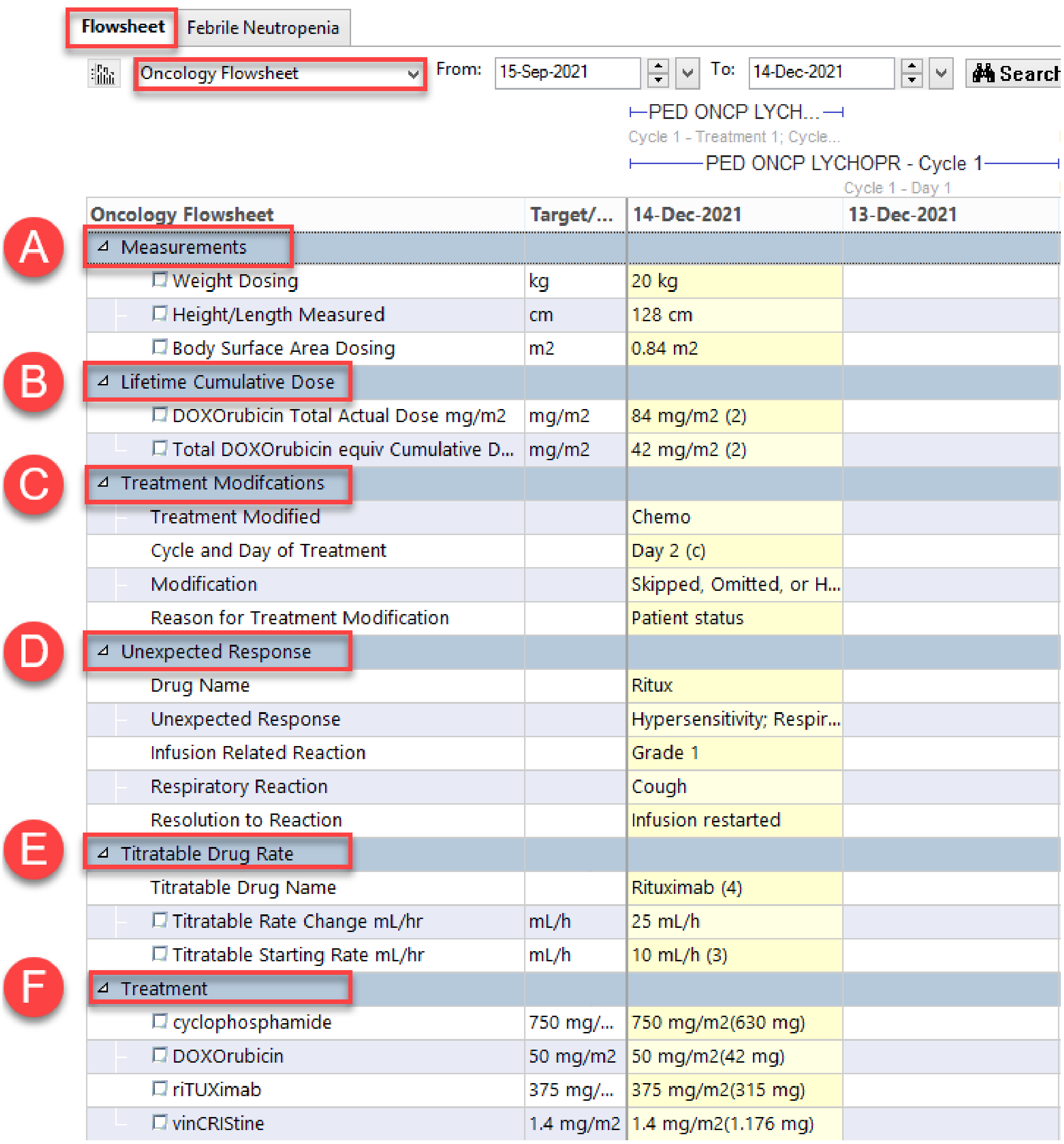


1. Click **Oncology** page under menu.



Read Only

The **Oncology Flowsheet** is a useful tool within the chart to support your clinical check of the chemotherapy orders, located under the Menu on the **Oncology** page. Information is not entered into the flowsheet but pulls from other charting done with CST Cerner. Note the following headings will not appear on the flowsheet unless documentation is available. (Note: screenshot values are examples only to demonstrate how each section displays). The Flowsheet contains the following headings:



Oncology Flowsheet	Target/...	14-Dec-2021	13-Dec-2021
Measurements			
Weight Dosing	kg	20 kg	
Height/Length Measured	cm	128 cm	
Body Surface Area Dosing	m2	0.84 m2	
Lifetime Cumulative Dose			
DOXOrubicin Total Actual Dose mg/m2	mg/m2	84 mg/m2 (2)	
Total DOXOrubicin equiv Cumulative D...	mg/m2	42 mg/m2 (2)	
Treatment Modifcations			
Treatment Modified		Chemo	
Cycle and Day of Treatment		Day 2 (c)	
Modification		Skipped, Omitted, or H...	
Reason for Treatment Modification		Patient status	
Unexpected Response			
Drug Name		Ritux	
Unexpected Response		Hypersensitivity; Respir...	
Infusion Related Reaction		Grade 1	
Respiratory Reaction		Cough	
Resolution to Reaction		Infusion restarted	
Titratable Drug Rate			
Titratable Drug Name		Rituximab (4)	
Titratable Rate Change mL/hr	mL/h	25 mL/h	
Titratable Starting Rate mL/hr	mL/h	10 mL/h (3)	
Treatment			
cyclophosphamide	750 mg/...	750 mg/m2(630 mg)	
DOXOrubicin	50 mg/m2	50 mg/m2(42 mg)	
riTUXimab	375 mg/...	375 mg/m2(315 mg)	
vinCRIStine	1.4 mg/m2	1.4 mg/m2(1.176 mg)	

	Treatment			
	cyclophosphamide	750 mg/...	750 mg/m2(630 mg)	
	DOXOrubicin	50 mg/m2	50 mg/m2(42 mg)	
	riTUXimab	375 mg/...	375 mg/m2(315 mg)	
	vinCRIStine	1.4 mg/m2	1.4 mg/m2(1.176 mg)	
G	Supportive			
	dimenhyDRINATE	1 mg/kg	1 mg/kg(20 mg)	
	ondansetron	0.15 mg/kg	0.15 mg/kg(3 mg)	
	sodium chloride 0.9%	mL	73.5 mL 30 mL 283.5 mL	
H	Transcribed Administered Medication			
	Transcribed Administered Date		14-Dec-2021	
	Transcribed Administered Medication		etoposide (c)	
	Transcribed Administered Dose		130 mg	
	Transcribed Administered Route		IV	
I	Prescriptions for Chemo & Others			
	predniSONE			
J	Infusion/Interruption Record (Blinatumomab)			
	Volume Infused	mL	50 mL	
	Infusion/Interruption Record Comment		TEST	
	Length of Interruption	Minutes	5 Minutes	
	Reason for Interruption		Bag change	
	Battery Change		Yes	
	Reservoir Volume	mL	10 mL	

LEGEND	
A	**Measurements** provide both the measured weight which is pulled in from IView and the most recently documented dosing weight recorded by the provider.
B	**Lifetime Cumulative Dose** displays previously delivered doses of medications that require Lifetime Cumulative Dosing calculations. You will review more information later in the workbook.
	NCI Toxicity Criteria shows any documented toxicities that have been noted in the patient's chart (e.g., diarrhea, mucositis), pulled in from IView or relevant PowerForms.
C	**Treatment Modification** displays any modifications the treatment being modified and the reason why.
	Labs display various lab results specifically to chemotherapy treatment (e.g., Hematology, Chemistry, cancer markers). Note not available on the screenshot.

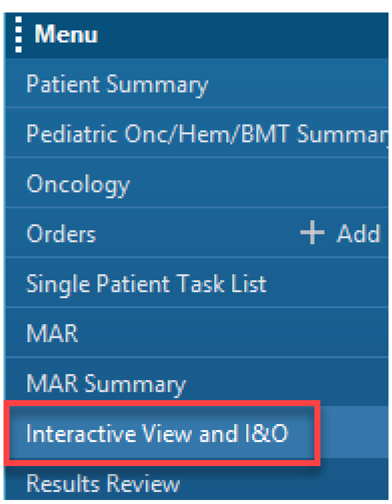
D	**Unexpected Response** displays any adverse reaction that has been documented in IView. This will allow you to see if the patient has a history of adverse reactions to any medication at any location using CST Cerner.
E	**Titratable Drug Rate** displays titratable drugs and their rate changes.
F	**Treatment** displays any medication(s) given for chemotherapy treatment.
G	**Supportive** displays any medication (s) given to provide supportive care during Chemotherapy. (e.g., anti-nausea medications, anticholinergics such as atropine, and steroids).
H	**Transcribed Administered Medication** displays medications documented in the related section of IView. This section in IView was designed for use by nurses who are responsible for documenting medications administered as part of a chemotherapy regimen at a non-Cerner site.
I	**Prescriptions and Chemo & Others** display any prescriptions given to the patient to support their treatment protocol.
J	**Infusion/Interruption Record** display interruption data that has been documented in the Infusion/Interruption Record in IView (typically used to document interruptions in long infusions like Blinatumomab).

End of Read Only

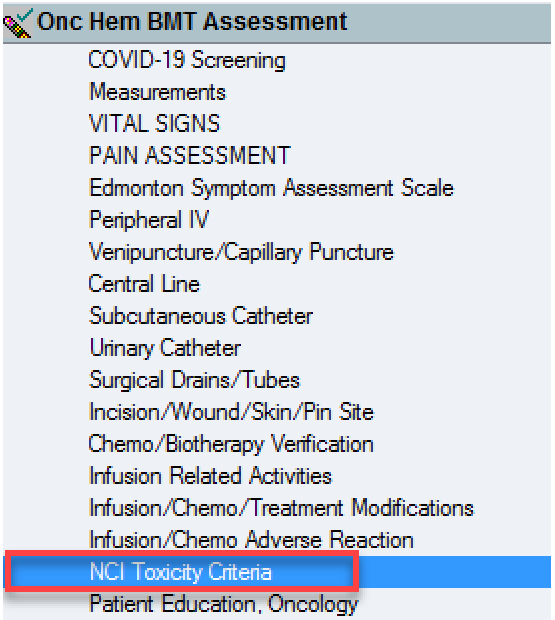
Document NCI Toxicity Assessment

To document your patients NCI toxicity assessment:

2. Click **Interactive View and I&O** (IView) from the Menu.

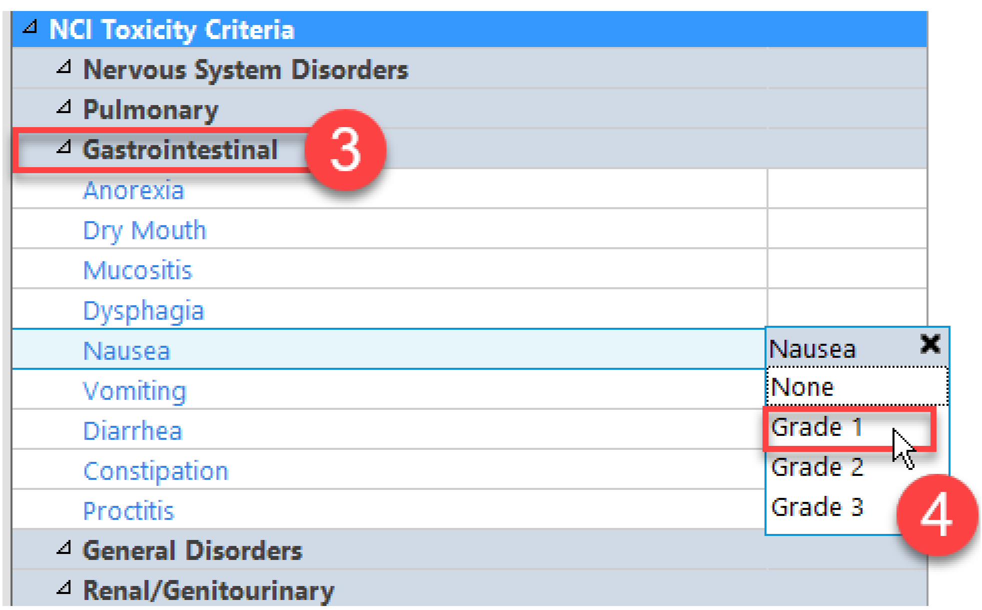


3. Select the **NCI Toxicity Criteria** section under the Onc Hem BMT Assessment section.



4. Click the **Gastrointestinal** section to expand the documentation fields.

5. Click the field next to Nausea and Select **Grade 1** from the drop-down menu. In the clinical setting, you would to continue to document your assessment in the various cells determined by your site policies.



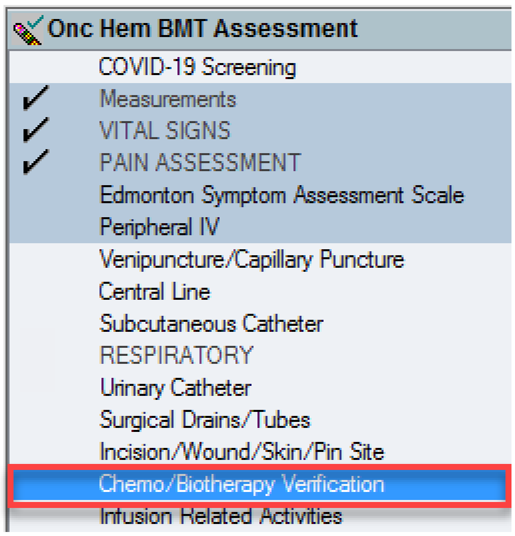
6. Click the **Sign** icon.

Document Chemo/Biotherapy Verification in Interactive View and I&O

Chemo/biotherapy verification in CST Cerner allows you to document your clinical check of the chemotherapy orders.

To document that you have done your verification, as per your clinic's policy.

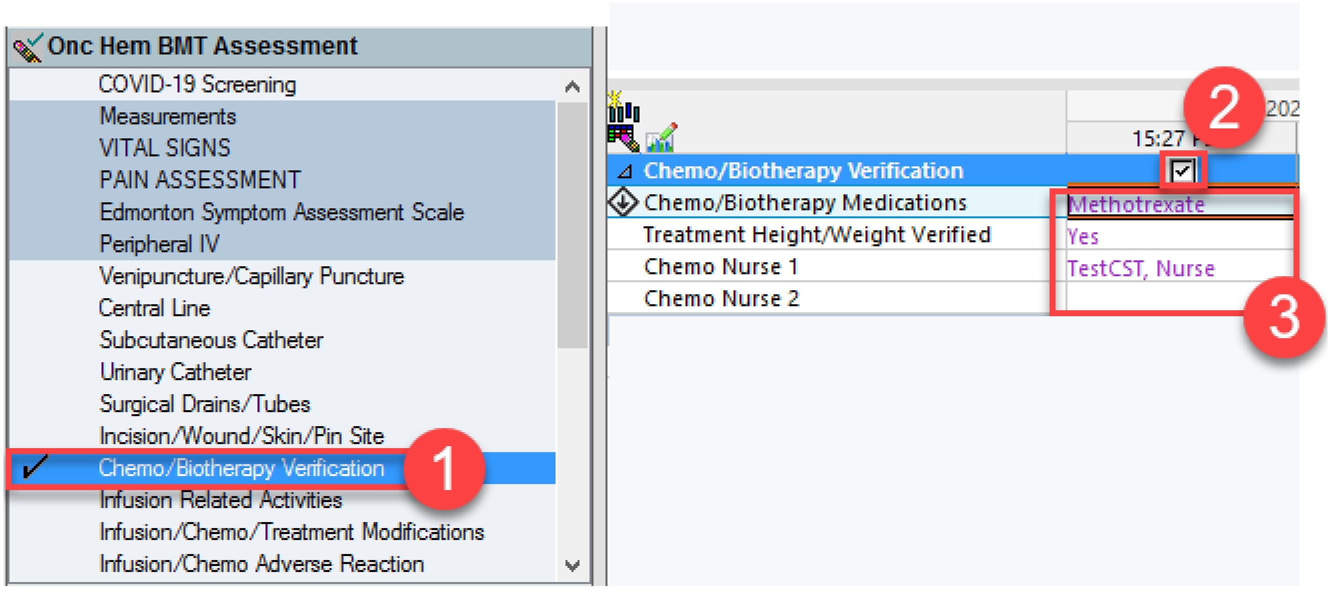
1. Select the **Chemo/Biotherapy Verification** in the Onc Hem BMT Assessment band.



2. Double Click on the **Header**.

3. Type the following in the appropriate cell:

    - **Chemo/Biotherapy Medications:** *Methotrexate* (medication to be administered)
    - **Treatment Height/Weight verified:** *Yes* (verified height and weight used to calculate the patient's chemotherapy/Biotherapy)
    - **Chemo Nurse 1:** Enter the login credentials provided to log into PowerChart. (Username)



4. Click the **green checkmark** ✓ to sign.

> **NOTE:** 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 under their own account.

Key Learning Points

- The **protocol for chemotherapy** can be located by selecting the Regimen from the **Order View**, then clicking the **protocol icon** in the **Order Profile** or access protocol documents per local process to reference protocol requirements while completing the clinical check of the chemotherapy orders.
- You must review all orders and look at order information for dosing calculation verification.
- In the Dosage Calculator the ‘actual weight’ is not the measured weight which nurses document in IView or PowerForm. Dosing weight is entered by the physician.
- It is Important to be within the right phase of the PowerPlan to see the required information.
- The eyeglass’s icon indicates an order requires to be reviewed by a nurse.
- Select Orders for **Nurse Review** once you have read through and reviewed your orders.
- The Oncology Flowsheet is another useful tool with the chart for medication verification.
- Chart NCI Toxicity Assessment in IView.
- Chart Chemo/Biotherapy verification checks in IView if required by your site policy.

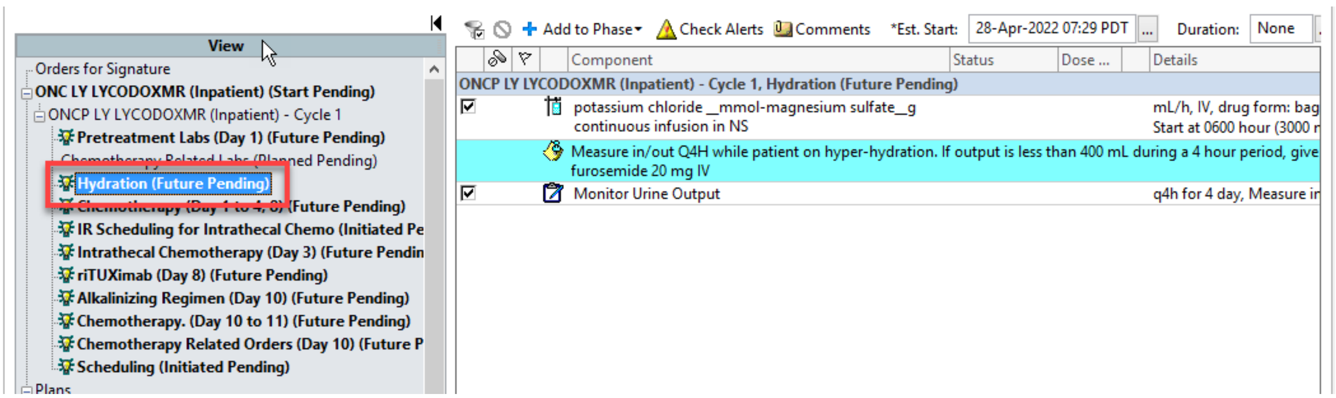
Activity 9.4 – Review of Additional Phases

Read Only

As you have only reviewed the phases of the PowerPlans in the Regimen **ONC LY LYHDMRTEM (Inpatient)** please note that there are additional phases that you may see in other plans.

Hydration

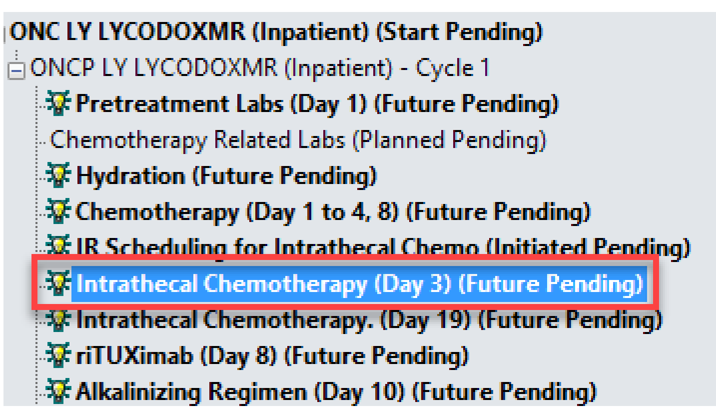
Hydration is ordered in a separate phase to allow more flexibility in extending the length of infusion and subsequent activation and administration of the chemotherapy.



Intrathecal

This is for medications that are administered via the intrathecal (IT) route. Intrathecal (IT) can be performed in Interventional Radiology (I.R.) or at bedside in both the inpatient and outpatient settings.

In the inpatient setting the intrathecal orders are in a separate phase to allow for appropriate sequencing of the medication and lab tasks.



Note the following Green headings or sections within the Intrathecal Chemotherapy phase:

a. Pre-treatment Labs

b. Pre-Chemo Metrics

c. Treatment Regimen

d. Cerebrospinal Fluid Labs

Activating the IT phase will put the **IT medications on the MAR**. When IT chemotherapy is being delivered in Interventional Radiology, the inpatient chemotherapy nurse will have to **coordinate** the time of **Activating the IT phase** with the **IR department**. In all cases of IT chemo administration, it is the provider's responsibility to sign for the medication administration on the MAR and obtain a co-signature/witness as required by policy.

> **NOTE**: For more information regarding the management of the intrathecal Chemotherapy refer to Administer intrathecal Chemotherapy in Inpatient and Outpatient Settings

End of Read Only

PATIENT SCENARIO 10 - Chemotherapy Medication Administration

Learning Objectives
At the end of this Scenario, you will be able to: - Activate an Order - Administer Medication using Closed Loop Medication Administration - Document Titratable Medication

SCENARIO

You have completed all pre-chemo checks. You will be required to select the Chemotherapy phase of the PowerPlan and activate the appropriate day of Treatment. You let pharmacy know that you are ready to treat your patient via phone call.

When the medication is ready. Pharmacy will communicate that the meds are ready. You will obtain the medication to administer. The nurse and witness will check the medication against the order details on the MAR and launch the Medication Administration Wizard.

You will be completing the following activities:

- Activate a Chemotherapy PowerPlan
- Perform Closed Loop Medication Administration

For the following activities, select the name of **patient A** as assigned to you from your CST Cerner Learning – Your workbook's logins and patients email.

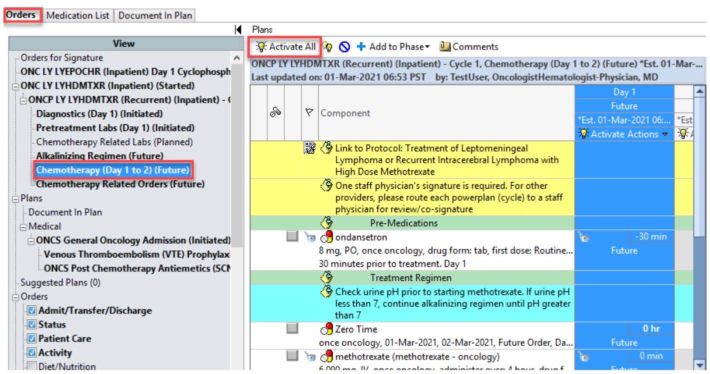
Activity 10.1 – Activating Chemotherapy Orders

Now that you have completed the required checks per your health organizations policy, the next step is to activate the chemotherapy orders. This places medications in an **Ordered** status. We will now activate the **Chemotherapy** phase of **Chemotherapy (Day 1 to 2) phase.** For Inpatient Chemotherapy patients, activation of the phase occurs on the first day of treatment. We are on Day 1.

1. Navigate to **Orders** on the **Orders** page.

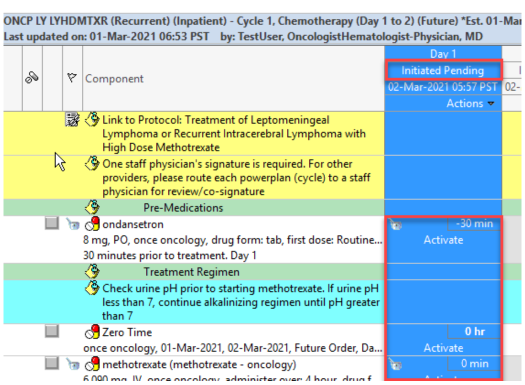
2. Select the **Oncology PowerPlan** to display the associated orders in Orders Profile.

3. Click **Activate All** Activate All from the Day of treatment column to activate all the orders for that phase.



4. A Change Start Date/Time window may appear in the train domain because there is a discrepancy between the estimated date of the treatment and the day you are activating the PowerPlan phase in the train domain. For learning purposes, select **Adjust All**, select **Other** for Reschedule Reason and Click **OK** to proceed.

The day of treatment status changes to **Initiated Pending** and the corresponding orders change to **Activate**.



2. Click Orders For Signature button to initiate the order.

3. **Review** each order.

4. Click Sign.

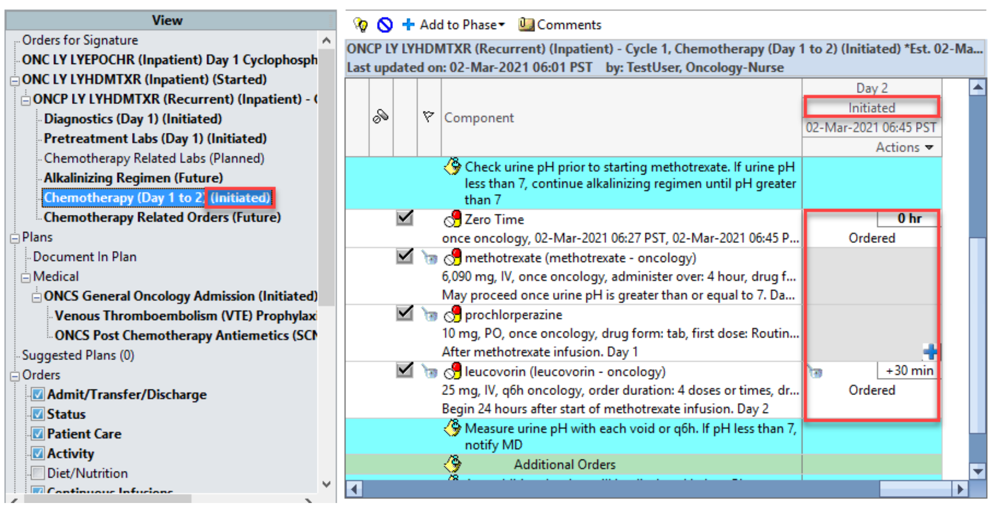
   You return to Care Compass.

5. Click the on the Regimen or PowerPlan in the Plan of Care to return to the orders page to view the changes to your order.

6. Click on the Chemotherapy (Day 1 to 2)

7. Note the following:

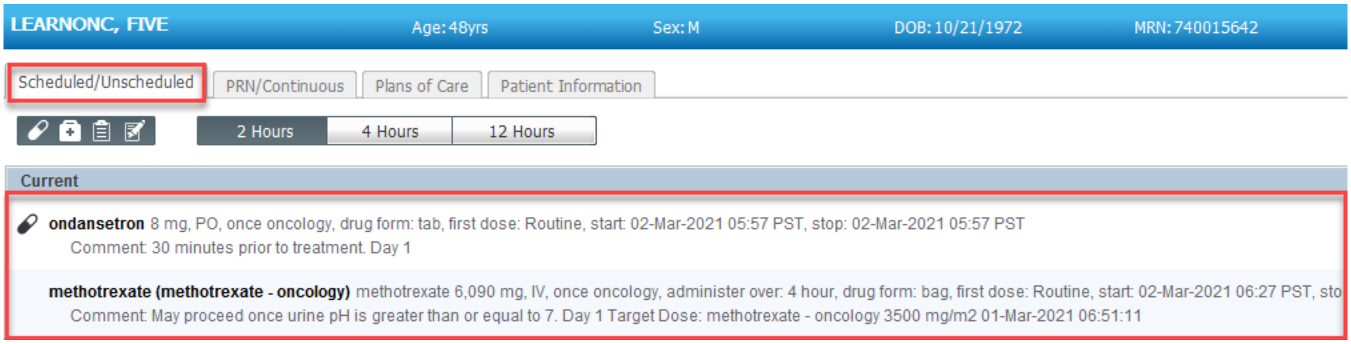
   - The Phase status in Orders View changes to **Initiated**.
   - Orders that have been **Initiated** display as **Ordered** in the **Order Profile** and display on the **MAR**.



8. Click **Done** to return to Care Compass.

9. Hover over the patient's name and the **Open** icon appears. Click the **Open** icon to open the list of task window.

10. Note the **medications** are listed on your Scheduled/Unscheduled task list.



Key Learning Points

- For an inpatient, the nurse should activate each phase as required, and use the Activate All button.

Activity 10.2 – 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 wristband 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.

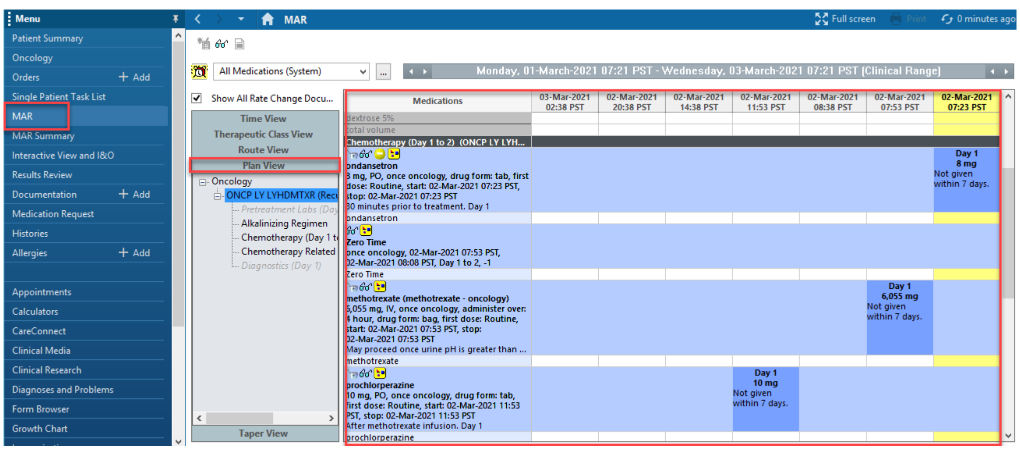
Once the orders have been verified, and activated, you can begin the Chemotherapy administration process. This will involve reviewing the **Medication Administration Record (MAR**) and using the **Medication Administration Wizard** (**MAW**) 

.

As you have been introduced to the MAR and use of the MAW in the e-learning module, we will note a few additional points and practice with one medication. You will receive further practice with a barcode scanner in your workflow review sessions. (See Help Topic: Barcode Scanner Overview)

To begin review the MAR to see what medications are due for today.

1. Select **MAR** from the Menu in your patients chart.
2. Note the different headings in the **Navigator View** on the left side of the **MAR** page. These allow you to filter the medications on the **MAR**. Notice that the default view is **Time View**. Select **Plan View** as it is recommended for Oncology PowerPlans.
3. Review the medications. Note that the yellow box is the most recent time.

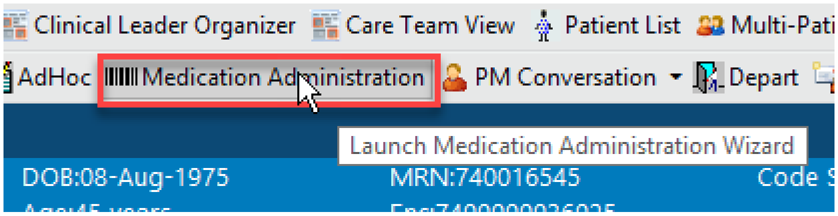


> **NOTE:** For information on the general layout of the Medication Administration Record (MAR), please refer CST Cerner Help topic: Medication Administration Record (MAR) Overview.

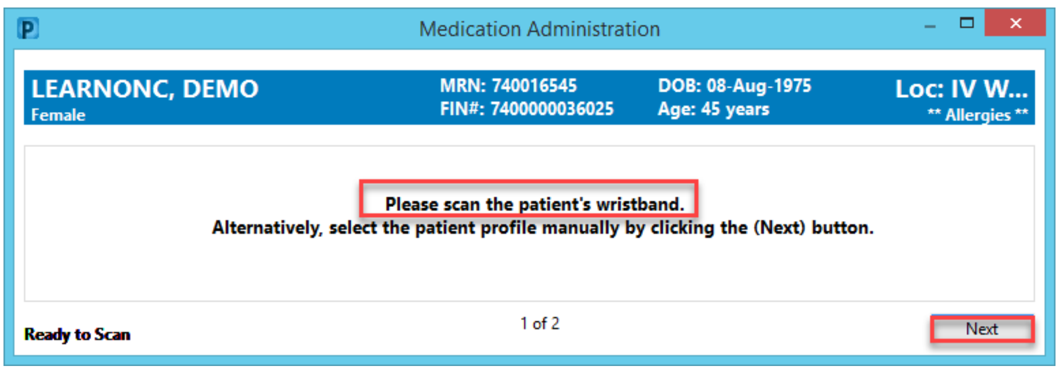
Next you will verify the medication in the **Medication Administration Wizard** (MAW).

In this example, we will verify the Ondansetron first as this is the first medication to be given.

1. Select the **Medication Administration Wizard** (MAW) from the toolbar.



2. Scan the patient's wrist band. If you do not have a scanner in the training environment. Click **Next.** In the clinical environment, scanning the patient's wristband is required for Closed Loop Administration.

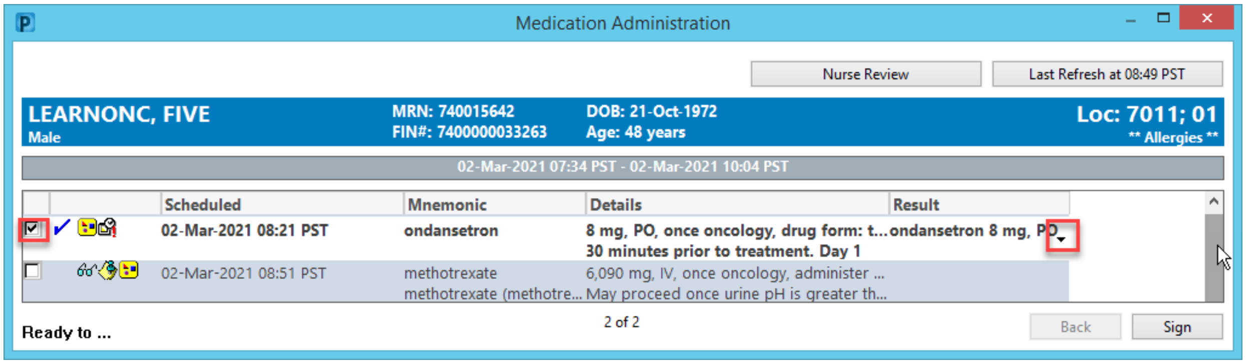


The **Medication Administration** window opens displaying the medications you can administer. Scheduled for 1 hour ahead, 1 hour past the current time and any overdue medications from up to 7 days in the past.

In the clinical environment, you would then proceed with scanning your medication and Charting for: window would open. If any of your medications still require review indicated by the glasses icon, Click the **Nurse Review** button at the top of the screen to review medications.

3. For training purposes, we will place a checkmark in the box next to **Ondansetron**. In the clinical settings, the checkmark will be auto populated after scanning the medication barcode.

4. For training purposes, we will also open the Charting for: window, this can be accessed even after the medication has been scanned. Click the **down arrow** that appears in the result column.

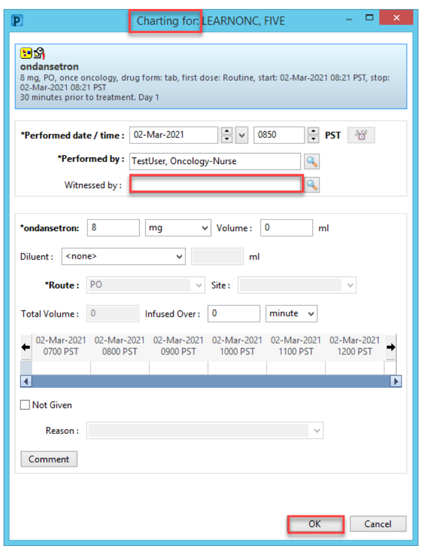


The **charting for**: window appears.

5. Confirm the details for accuracy.

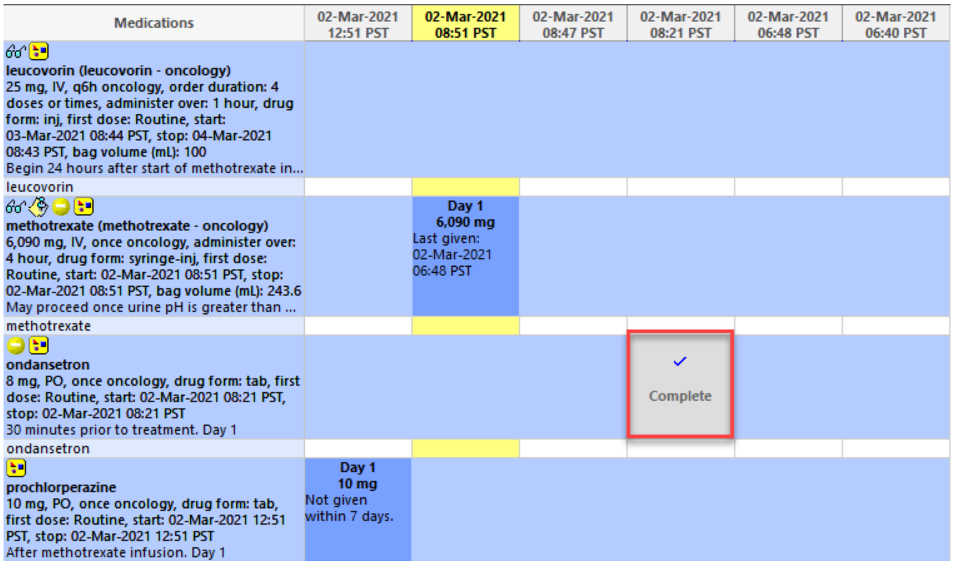
6. Note this window allows you add a witness in the Witnessed by field if a second signature is required.

7. Click **OK** to confirm the details.



8. Click **Sign** in the Medication Administration window.

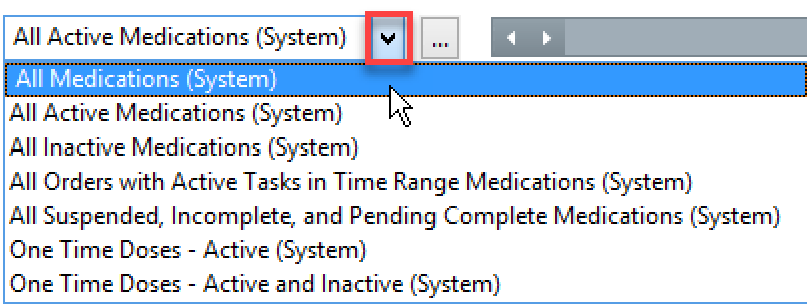
The Ondansetron states complete in the MAR.



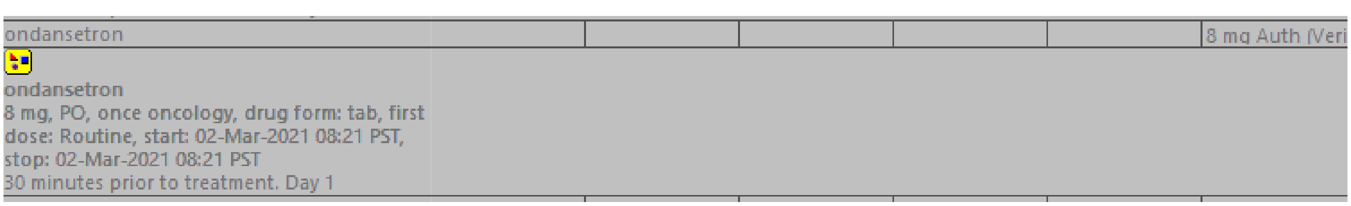
9. Click **Refresh** .

10. Note the Ondansetron may not appear in the scheduled view section. The default view is **All Active medications (System).**

11. Click the down arrow to change the view to see **All Medications (System)**



12. Note the medications documented are grey out under Discontinued Scheduled and it will be removed from your Patient task list in Care compass.



In the clinical setting, you would continue with closed loop medication process for all medications that need to be provided to the patient.

Key Learning Points

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

PATIENT SCENARIO 11 – Management of Medication Documentation and Reactions

Learning Objectives
At the end of this Scenario, you will be able to: ▪ Document Lifetime Cumulative Doses. ▪ Document Titratable Medication ▪ Document Hypersensitivity Reactions

SCENARIO

Please note though we are using a chemotherapy medication example, the steps to chart Titratable Intermittent Medication and Adverse reactions can apply to other medications.

DOXOrubicin was not part of our treatment plan. However, for learning purposes, you will document Lifetime Cumulative Dose for DOXOrubicin.

For this scenario, assume our patient is receiving Rituximab with a dose of 799 mg mixed in a 325 mL bag of NS, which makes the titratable starting rate 20mL/Hr. The patient's measurements are height 183 cm and weight 89 kg with a BSA of 2.13. You will then proceed to document based on calculations and patient tolerance a rate change of 100mL/Hr.

During the treatment your patient has developed a reaction. As their primary nurse, you have reported it to their provider or the provider on call depending on your site policy. The provider writes a communication order indicating their instructions for reaction management and for resuming treatment. Once you have provided interventions and your patient's reaction symptoms have subsided, you will need to complete the appropriate documentation.

As a Chemotherapy Nurse, you will be completing the following activities:

- Lifetime Cumulative Dosing
- Titratable Medication Charting
- Hypersensitivity Reaction

For the following activities, select the name of **patient A** as assigned to you from your CST Cerner Learning – Your workbook's logins and patients email.

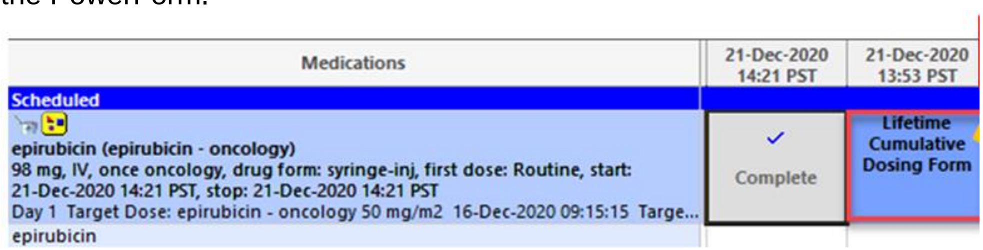
Activity 11.1 – Lifetime Cumulative Dosing

If you do not administer chemotherapy, please read through the activity for knowledge transfer.

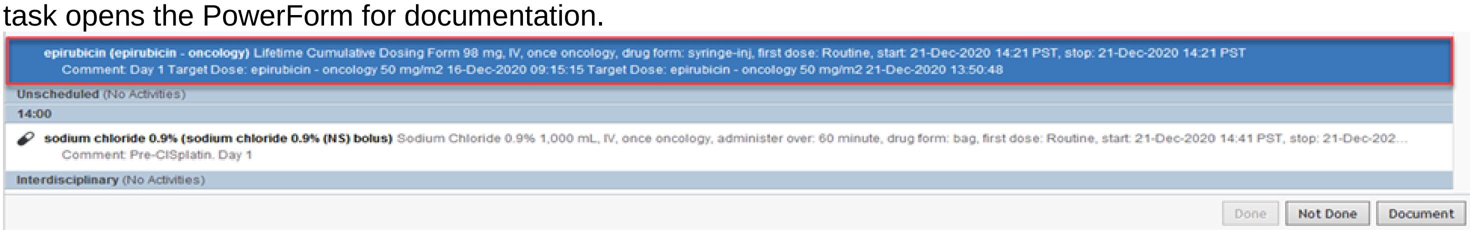
For patients on medications requiring monitoring of Lifetime Cumulative Dosing, a PowerForm is available to track the doses being delivered from a CST Cerner based site as well as input data on medications delivered outside of these sites.

> **NOTE**: If a patient has been given any Lifetime Cumulative medications outside of a Health Organization with CST Cerner, the amount will not automatically reflect but can be added in manually if the records are known. This is typically done by the provider or clinical pharmacists.

When the nurse signs for a medication that requires LCD calculation, they will be prompted on the **MAR** to complete this documentation. Note once administration is complete you would click the box to open the PowerForm.



In the inpatient area, the task will also appear in CareCompass under the task window. Clicking on the task opens the PowerForm for documentation.

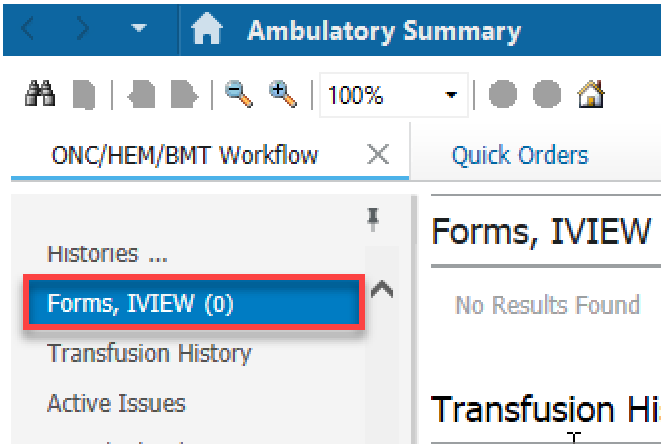


As the chemotherapy order selected in the train domain does not require an LCD calculation, you will access the PowerForm via the **Forms, IView** component in the ONC/HEM/BMT Workfow page.

In the train domain, we have added a previous recorded dose so that you may see the functionality of the PowerForm.

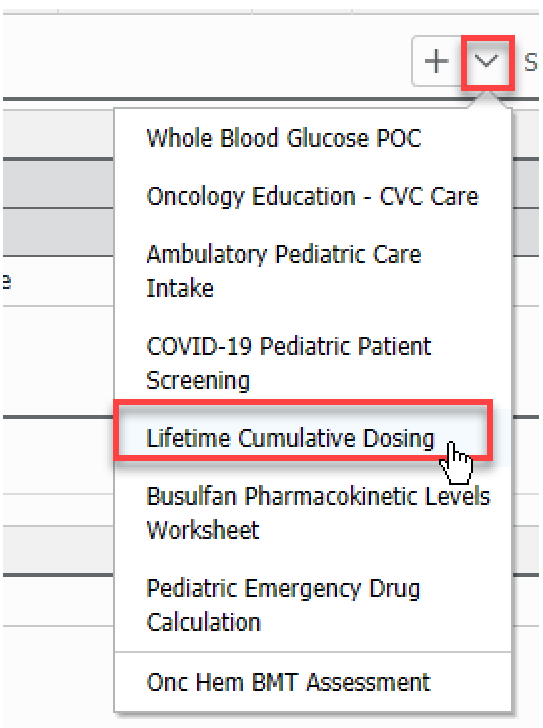
To access the PowerForm to track doses on medications delivered outside of a CST Cerner site:

1. Click the **Forms, IView** component in **ONC/HEM/BMT Workflow** page.



2. Click the down arrow next to the plus sign  .

3. Select **Lifetime Cumulative Dosing**.

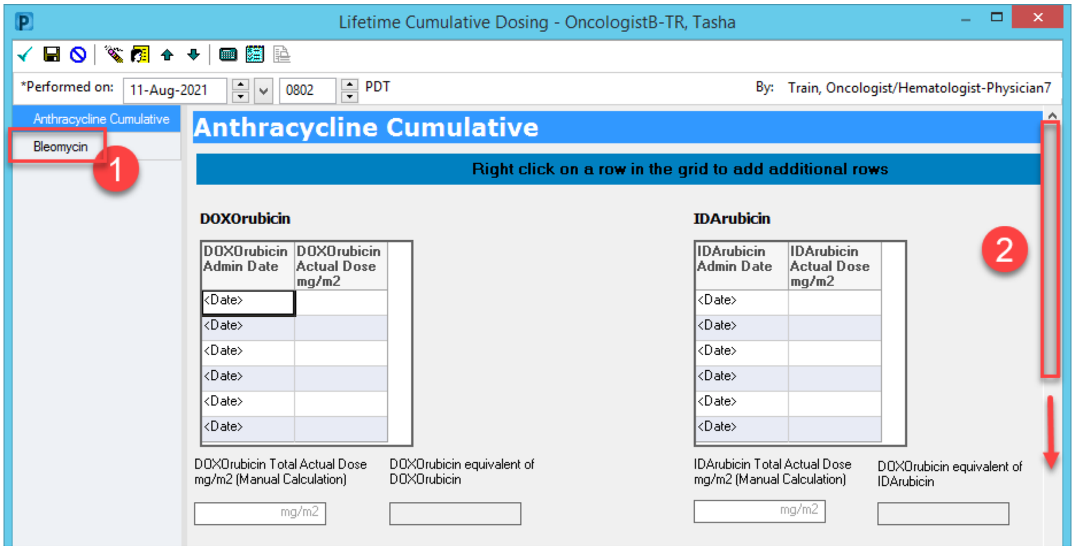


The **Lifetime Cumulative Dosing** PowerForm opens.

To document Lifetime Cumulative Dosing:

1. Note a separate section for Bleomycin.

2. Use the scroll bar to navigate the length of the form.



3. Note the conversion tables for both Adult and Pediatric located at the end of the form. These are used as a reference tool. All medication doses will be converted to Doxorubicin equivalent as per these tables.

Adult Conversion Table:

Drug	Conversion Factor to DOXOrubicin Dose: Multiply Total Dose by	DOXOrubicin Equivalent Dose
DOXOrubicin	X1	1 mg
DAUNorubicin	X0.83	0.83 mg
IDArubicin	X5	5 mg
epirubicin	X0.67	0.67 mg
mitoXANTRONE	X4	4 mg

The higher limit of the conversion factors are used for the calculations, refer to the BC Cancer Drug Manual for the suggested conversion factor range for each drug.

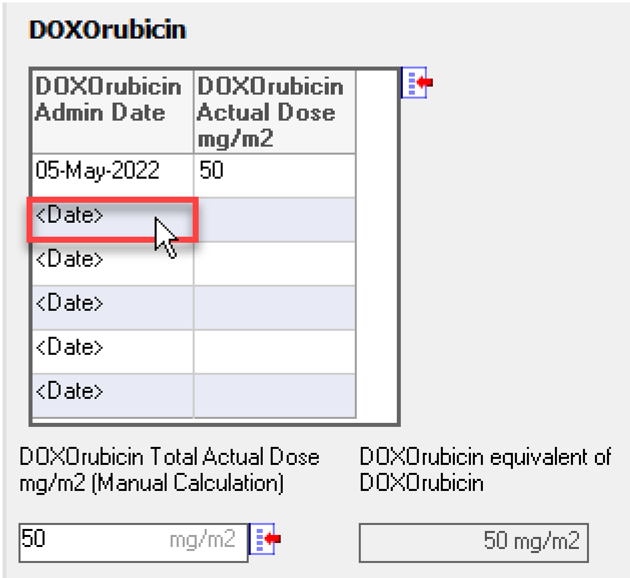
Pediatric Conversion Table:

Drug	Conversion Factor to DOXOrubicin Dose: Multiply Total Dose by	DOXOrubicin Equivalent Dose
DOXOrubicin	X1	1 mg
DAUNorubicin	X0.5	0.5 mg
IDArubicin	X5	5 mg
epirubicin	X1	1 mg
mitoXANTRONE	X10	10 mg

For drugs that are protocol dosed in mg/kg, use the following formula to calculate dose in mg/m2

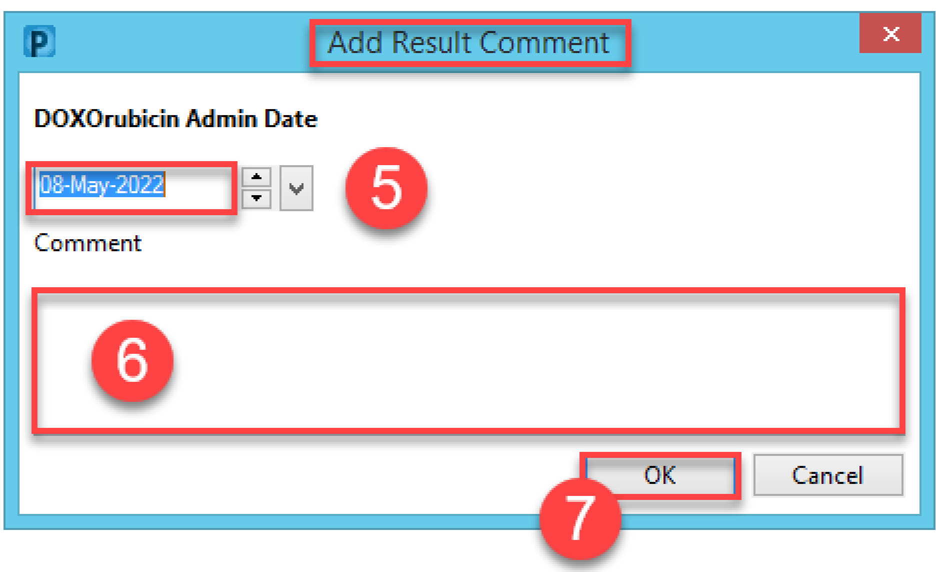
$$\frac{\text{Today's Dose in mg}}{\text{BSA}} = \text{mg/m2}$$

4. Click the **<Date>** field for DOXOrubicin.

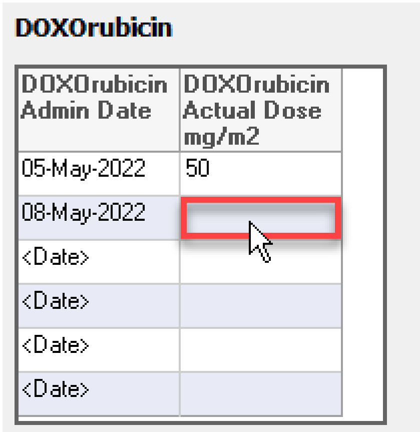


The **Add Result Comment** field displays.

5. Add the date.
6. Note the free text box to document a comment.
7. Click **OK**.

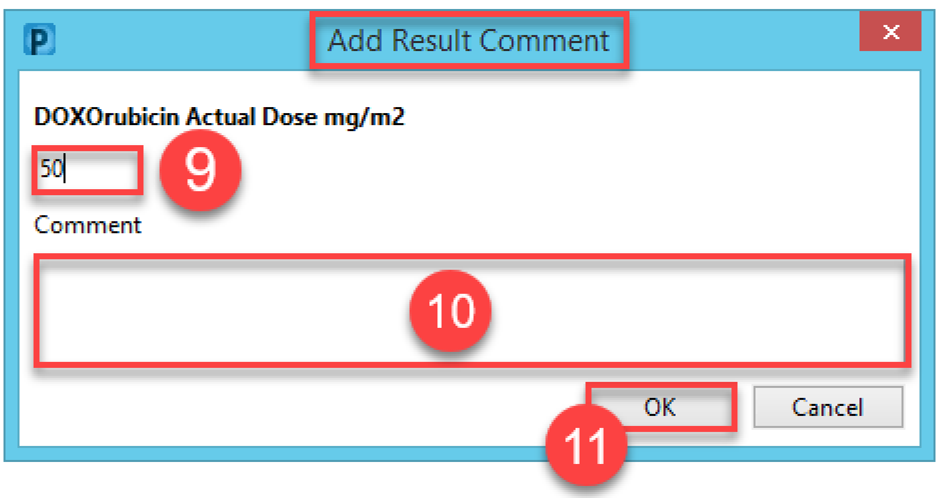


8. Click the Medication Actual Dose mg/m2 field.

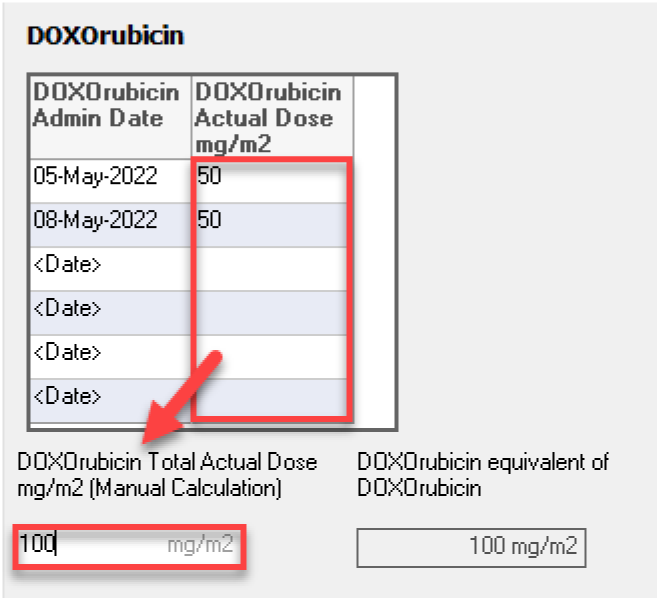


An **Add Result Comment** window opens.

9. Add the following Medication Actual Dose mg/m2: ***50***
10. Note the free text box to document a comment.
11. Click OK.

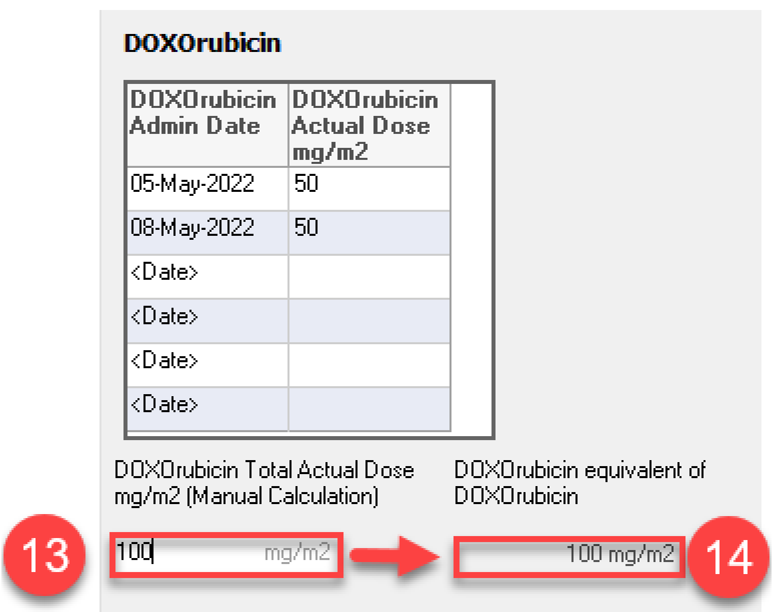


12. Manually calculate the **Total** Actual dose mg/m2 by **adding all the values from the Actual Total Dose mg/m2 column.**



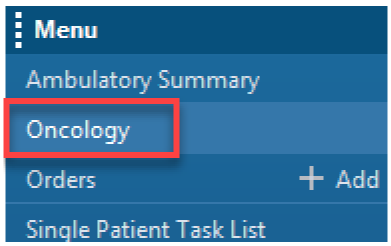
13. For this example, type *100* in the **DOXOrubicin Total Actual Dose mg/m2 (Manual Calculation)** field.

14. Note the DOXOrubicin equivalent values have been automatically calculated.



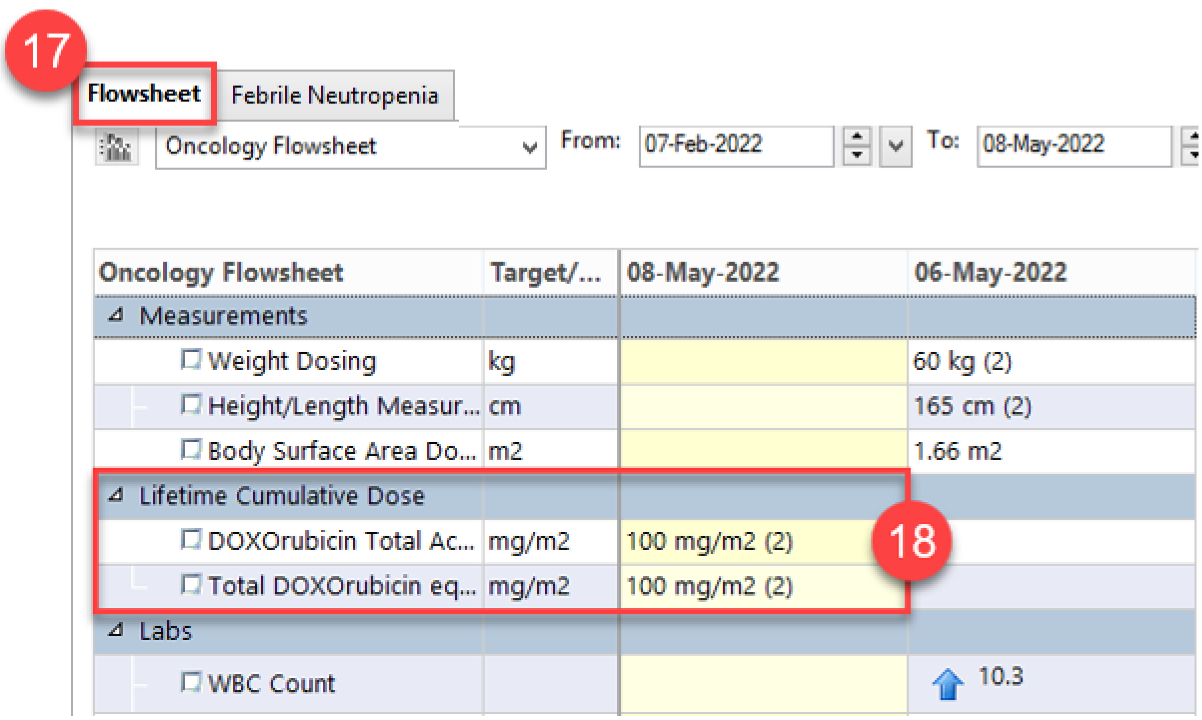
15. Click the **green checkmark** to sign the PowerForm.

16. Return to the **Oncology** section from the **Menu**.



17. Click **Flowsheet** page

18. Note your documentation will appear under the **Lifetime Cumulative Dose** section.



Key Learning Points

- **Lifetime Cumulative Dosing** can be viewed from the **Flowsheet** in the Oncology Section of the menu.
- A PowerForm is available to track the doses being delivered from a **Cerner** based site as well as input data on medications delivered outside of these sites.
- Tasks to complete the PowerForm will occur for doses delivered within cerner when the nurse signs for a medication that requires LCD calculation on MAR.
- In the inpatient area, the task will appear in CareCompass.

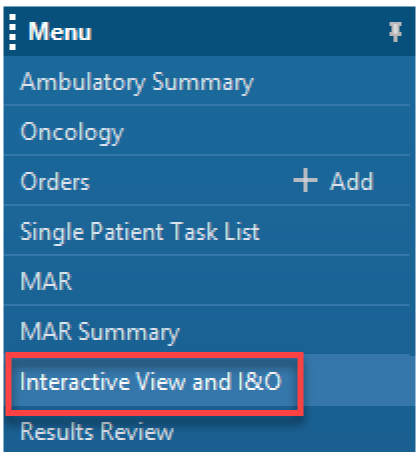
Activity 11.2 – Titratable Medication Charting

For this scenario, assume our patient is receiving Rituximab with a dose of 799 mg mixed in a 325 mL bag of NS, which makes the titratable starting rate 20mL/Hr. The patient's measurements are height 183 cm and weight 89 kg with a BSA of 2.13. You will then proceed to document based on calculations and patient tolerance a rate change of 100mL/Hr.

Document Titratable Starting Rate

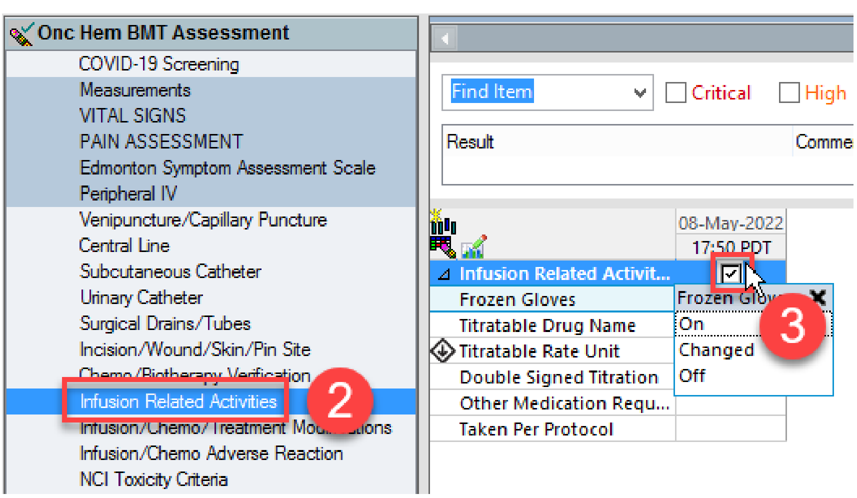
To document the Titratable Starting rate:

1. Select **Interactive View and I&O** from the menu bar.



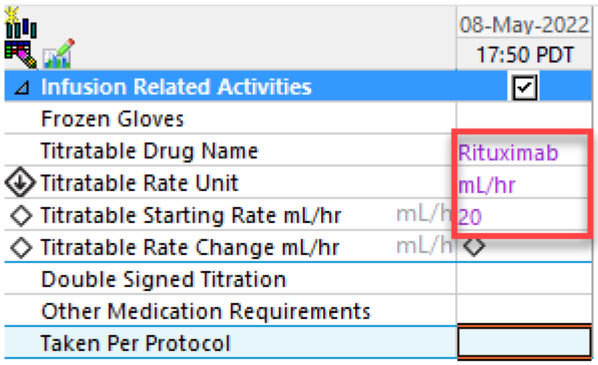
2. Select **Infusion Related Activities** under the **Onc Hem BMT Assessment** Band.

3. Double click on the **Header** cell to activate the column.



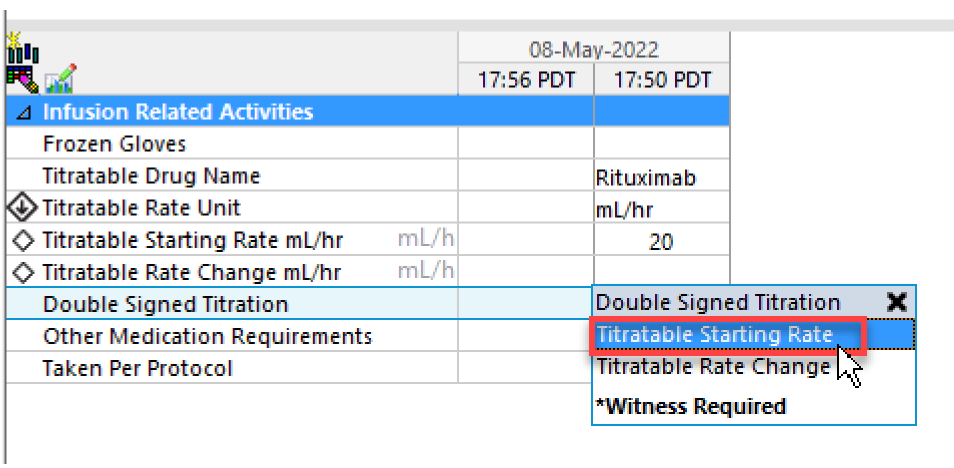
4. Type the following in the appropriate cell:

   - **Titratable Drug Name:** *Rituximab* (select the corresponding drug you have hung from the list
   - **Titratable Rate Unit:** *ml/hr* (value should be chosen that reflects your calculations)
   - **Titratable Starting Rate ml/hr:** *20* **The system does not omit the need to calculate the titration value.**



5. Click the **green checkmark** to sign.

6. **Read Only**: If a double signed titration is required, please have the witness document the **Double Signed Titration** in **IView**. They will be prompted to enter their username and password upon signing the documentation.

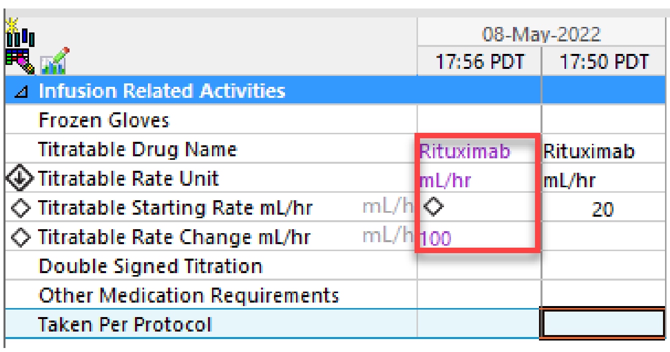


Document Titratable Rate Change

Document the subsequent increment calculated once you perform a rate increase.

To document the titratable rate change:

1. Double click on the **Header** cell to activate the column.
2. Type the following in the appropriate cell:
    - **Titratable Drug Name:** *Rituximab* (select the corresponding drug you have hung from the list
    - **Titratable Rate Unit:** *ml/hr* (Value should be chosen to reflect your calculations)
    - **Titratable Rate Change ml/hr:** *100* **The system does not omit the need to calculate the titration value.**



3. Click the **green checkmark** to sign.

Continue this process until medication is completed or rate maximum has been reached.

NOTES:

- 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.
- Recall you can **Click** on the icon or alternatively **right-click** on the time or date and select **Insert Date/Time** If you need to adjust the time to reflect the time of the rate change.
- The **titratable drug rate** will pull into the Flowsheet of the Oncology section of the menu.

Key Learning Points

- Titratable rate units should 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.
- IView documentation of titration charting can help when nurses are covering breaks.

Activity 11.3 – Hypersensitivity Reaction

Hypersensitivity Management is universal to both Inpatient and Outpatient protocols. When a Chemotherapy Regimen is ordered which contains medications that are more prone to cause adverse reactions, the hypersensitivity medications are built within the **Chemotherapy, Isatuximab** or **Rituximab** phase of the PowerPlan.

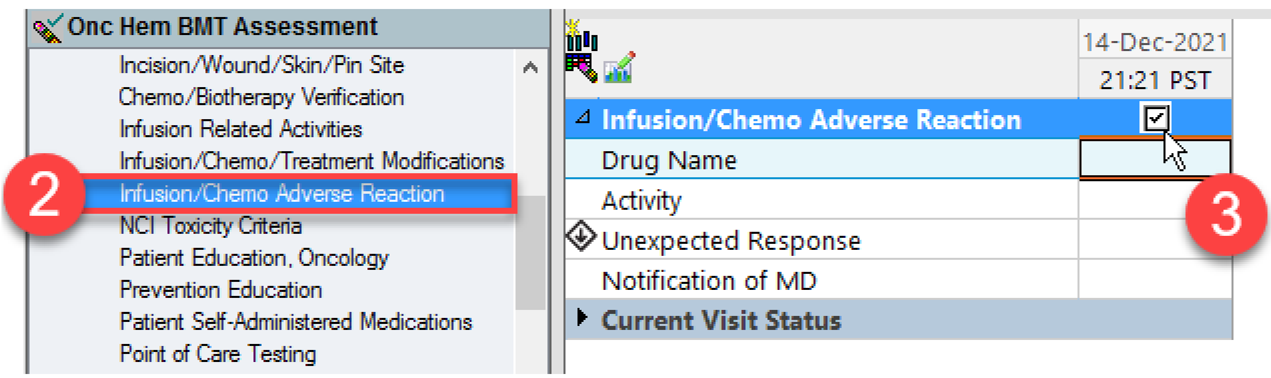
Through activation of the PowerPlan these medications are pushed to the MAR as PRNs.

Note that more will be discussed about documentation for hypersensitivity management in your workflow review session.

To document the adverse reaction in Interactive View and I&O:

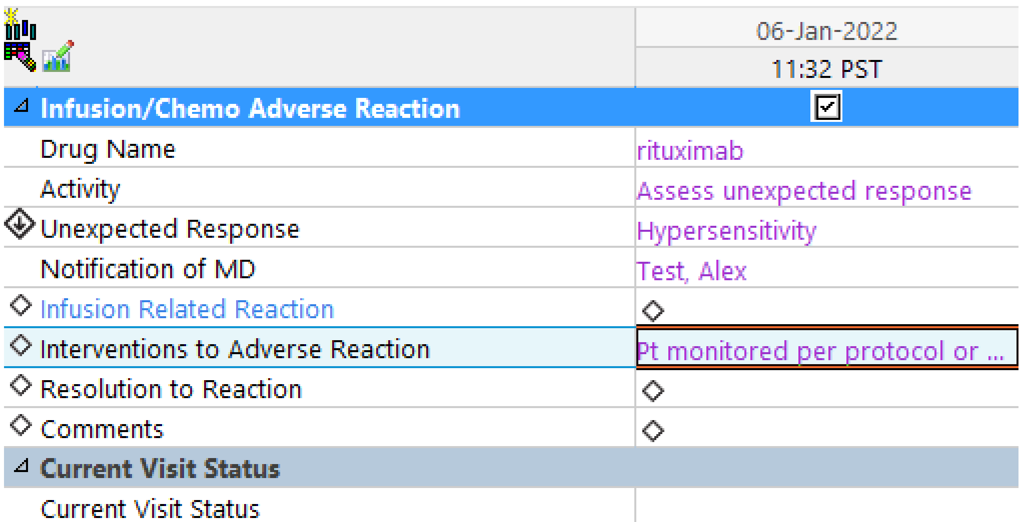
1. Select the **Infusion/Chemo Adverse Reaction** section from the Onc Hem BMT Assessment Band.

2. Double-click on the **Header** cell to activate the column.



3. Type the following in the appropriate cell:

   - **Drug Name:** *Rituximab* (the drug causing the adverse reaction)
   - **Activity:** Assess unexpected response
   - **Unexpected Response:** Hypersensitivity (being observed and/or described by the patient)
   - **Notification of MD:** *Test, Alex* (the name of the MD who was notified or assessed patient)
   - **Intervention to Adverse Reaction:** *Pt monitored per protocol or order*.
   - **Resolution to Reaction:** (likely documented at a later point)
   - **Comments:** (may be used to add any additional information which is not captured in the sections above.)



4. Click the **green checkmark** to sign

If you need to chart in more depth you can create a note within the Documentation section using Nursing Narrative Note and a Free Text template.

> **NOTE**: Vital Signs would be charted in their respective section within IView.

Key Learning Points

- Adverse reaction charting takes place in the **Infusion/Chemo Adverse Reaction** section from the Onc Hem BMT Assessment.
- Nursing Documentation notes may also be created if requiring in depth explanation.
- The adverse reaction charting pulls into the Flowsheet of the Oncology section of the menu.

PATIENT SCENARIO 12 – Discharge Patient

Learning Objectives
At the end of this Scenario, you will be able to: - Perform Discharge Patient Activities

SCENARIO
Throughout the shift, you may prepare your patient for discharge. You will complete the following activities: - Print Patient Discharge Handout - Discharge Documentation For the following activities, select the name of **patient** **A** as assigned to you from your CST Cerner Learning – Your workbook's logins and patients email.

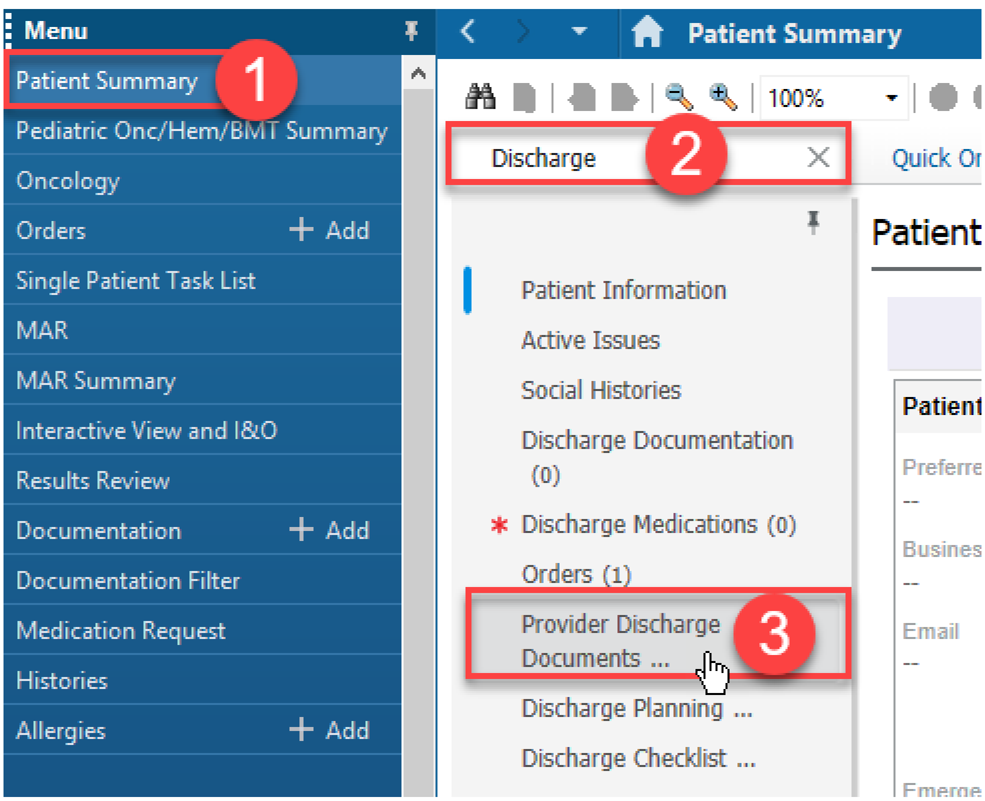
Activity 12.1 – Print Patient Discharge Handout

Discharge planning is usually done by the interdisciplinary team members during rounds. When the most responsible provider makes the decision that the patient is ready for discharge, Discharge orders, prescriptions, and follow-up tests and appointments will be placed by the most responsible provider. The provider will also create the **Discharge Summary** note and **Patient Discharge Handout**.

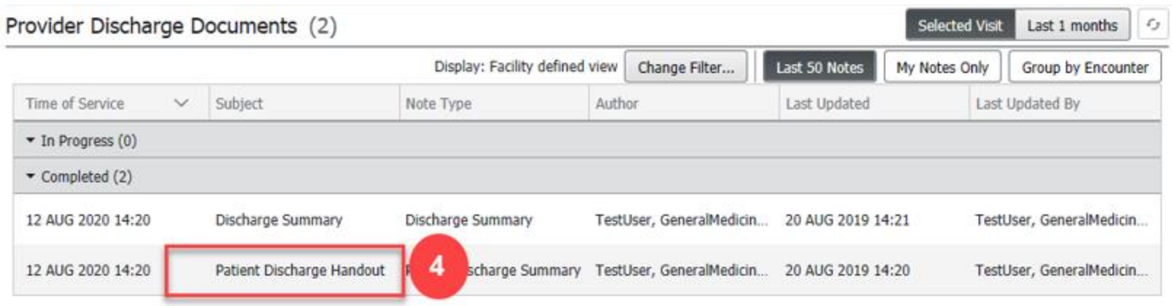
Along with the prescription and discharge instruction handouts, the **Patient Discharge Handout** is to be printed out and given to the patient before leaving the unit at discharge. It contains information such as medications to be taken at home, as well as follow up appointments and tests.

To print the Patient Discharge Handout:

1. Navigate to the **Patient Summary** from the **Menu**.
2. Select the **Discharge** page.
3. Select the **Provider Discharge Documents** component.

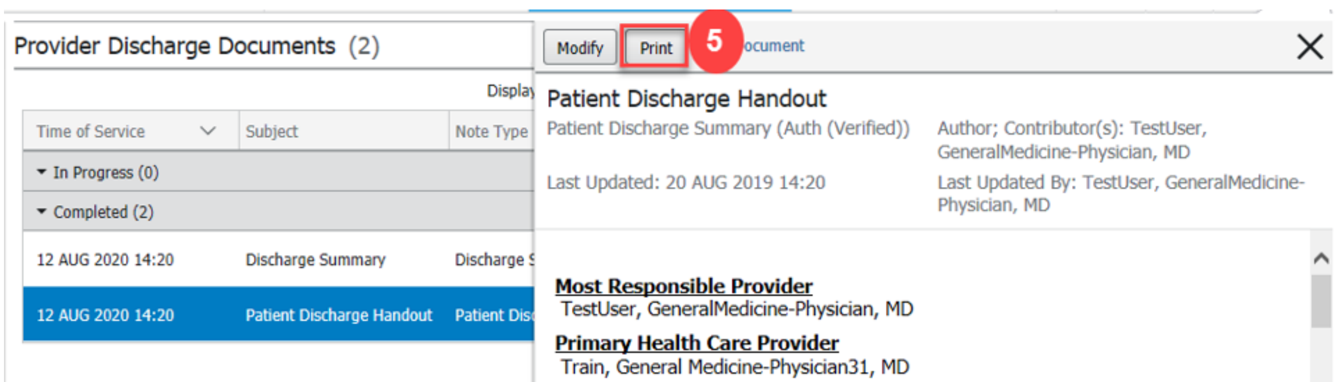


4. Select **Patient Discharge Handout** document.



The **Patient Discharge Handout** opens from the right side of the screen.

5. Click **Print**.

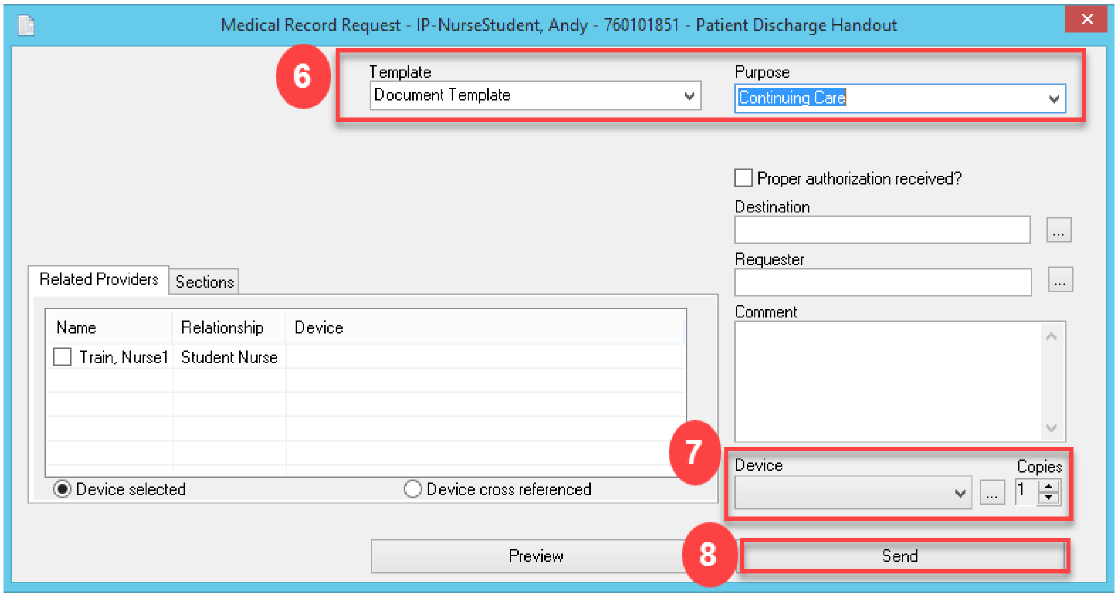


6. In the **Medical Record Request** window, fill out the followings:

   - **Template**: Document Template from the drop-down list
   - **Purpose**: Continuing Care from the drop-down list

7. Ensure you choose the correct printer from the **Device** drop-down list and indicate the number of copies to be printed out.

8. In the training environment, close the **Medical Record Request** window as there is no printer connected. However, in the clinical settings, click **Send**.



Key Learning Points

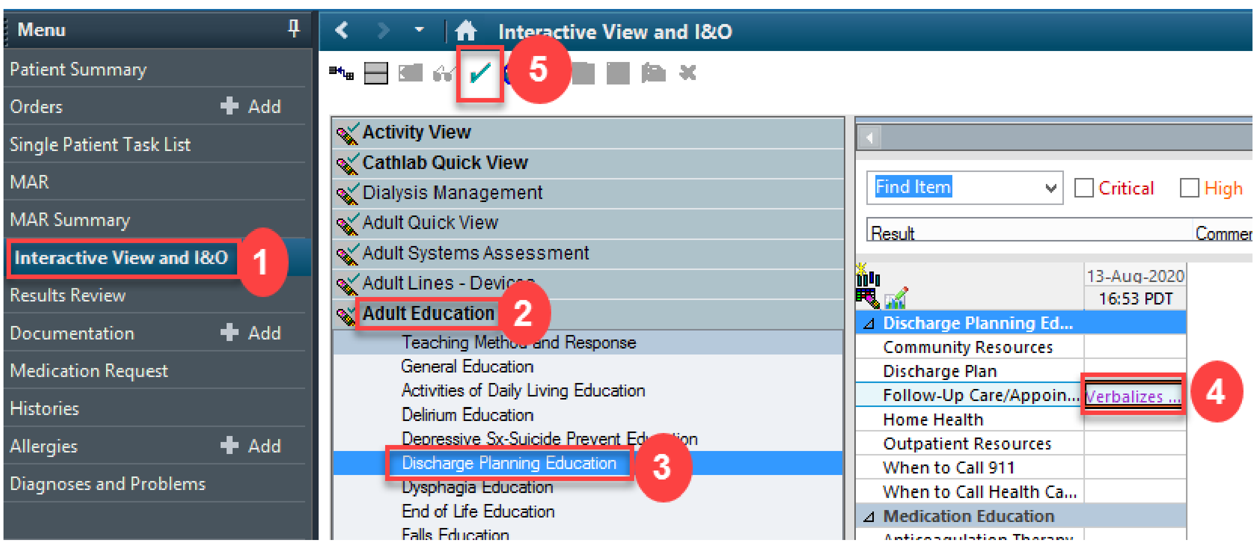
- The Patient Discharge Handout is completed by the provider to summarize the patient's information about the hospital stay, follow-up appointments and medications.
- You can preview documents by clicking on them in the respective workflow page component.
- You may print documents from the same preview window

Activity 12.2 – Discharge Documentation

Your patient is ready for discharge. Follow site policy regarding the discharge process, including providing discharge instructions.

If you provide discharge education, document the education provided in iView.

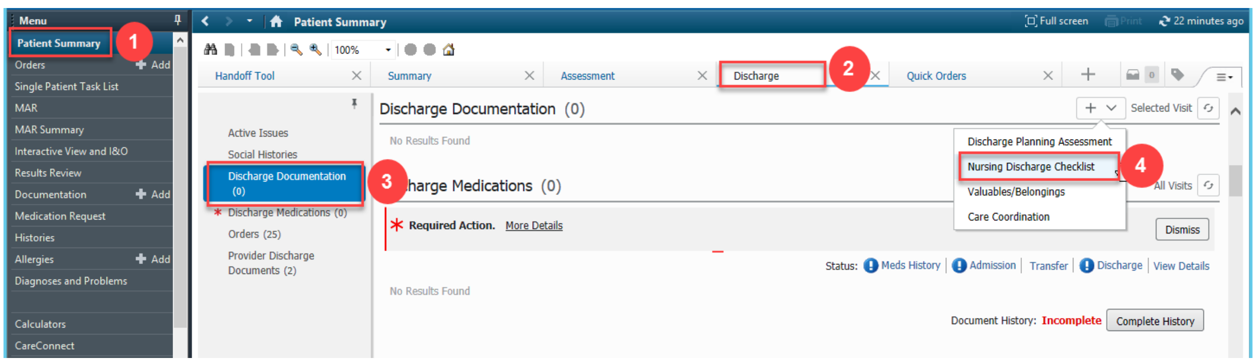
1. Navigate to Interactive View and I&O from the Menu.
2. Click on **Adult Education** band.
3. Select **Discharge Planning Education** section.
4. Double click on the **Follow Up Care/Appointment** field and document the following:
   - Follow Up Care/Appointment: ***Verbalize Understanding***
5. Click the **Sign** icon to complete documentation.



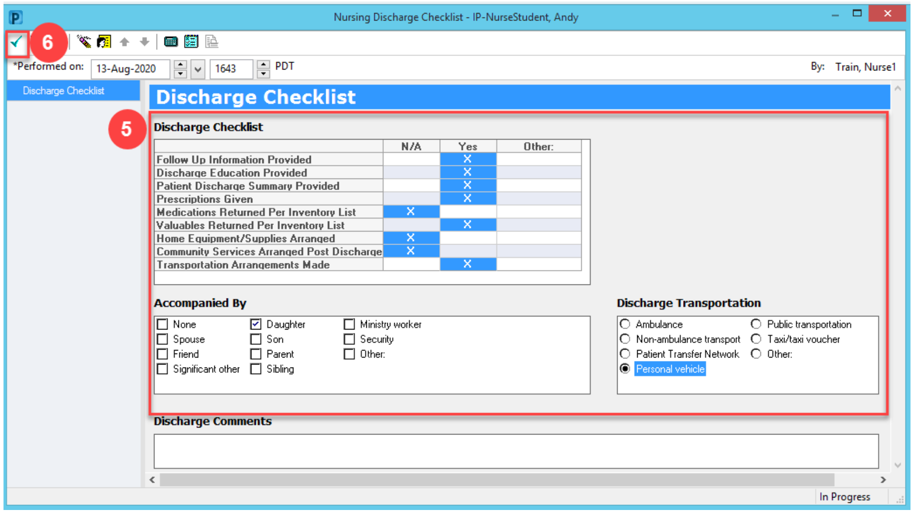
NOTE: Click the **Patient Health Education Material** button on the toolbar to access the external resource for patient education learning materials and handouts if necessary.

Your patient is ready to leave the unit. You are going to use the **Nursing Discharge Checklist** to make sure that your patient obtains all the required information, printed documents, prescriptions, and valuables and belongings before leaving the unit.

1. Navigate to **Patient Summary** from the **Menu**.
2. Select the **Discharge** page.
3. Select the **Discharge Documentation** component.
4. Click the drop-down arrow and select **Nursing Discharge Checklist** from the drop-down list.



5. Fill out the following information in the **Nursing Discharge Checklist** PowerForm:
   - **Follow Up Information Provided:** Yes
   - **Discharge Education Provided:** Yes
   - **Patient Discharge Summary Provided:** Yes
   - **Prescriptions Given:** Yes
   - **Medications Returned Per Inventory List:** N/A
   - **Valuables Returned Per Inventory List:** Yes
   - **Home Equipment/Supplies Arranged:** N/A
   - **Community Services Arranged Post Discharge:** N/A
   - **Transportation Arrangement Made:** Yes
   - **Accompanied By:** Daughter
   - **Discharge Transportation:** Personal Vehicle
6. Click the **Sign** ✓ icon.



REMINDERS:

- In the clinical settings, after returning the valuables and belongings to patient, modify the existing **Valuables and Belongings PowerForm** and chart ***Yes*** in the **Valuables Returned Per Inventory List** field.
- After the patient discharged from the system, the status of the Inpatient Encounter will change to **Discharged**. The patient will automatically be removed from the **Location Patient List** but ***NOT*** in the **Custom Patient List**. You **MUST** manually remove the discharged patient from the **Custom Patient List**.

Key Learning Points

- Document Discharge Education in iView.
- Document in the Nursing Discharge Checklist to ensure that the patient obtains all the required information, printed document, prescriptions, valuables and belongings prior to leaving the unit.
- Patient MUST be manually removed from the Custom Patient List after discharge.

PATIENT SCENARIO 13 – End of Shift Activities

Learning Objectives
At the end of this Scenario, you will be able to: ■ At the end of this Scenario, you will be able to: ■ Perform End of Shift Activities

SCENARIO
You follow site practice to prepare the end of shift. You will be completing the following activities: ■ Document Nursing Shift Summary ■ Provide Handoff Report ■ Document Handoff in iView For the following activities, select the name of **patient** **A** as assigned to you from your CST Cerner Learning – Your workbook's logins and patients email.

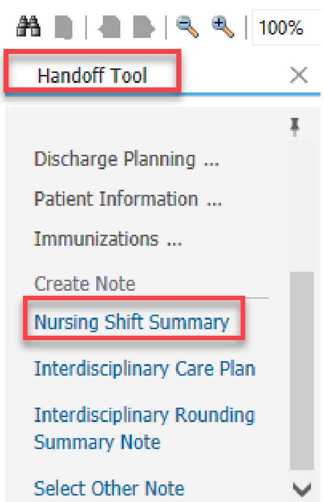
Activity 13.1 - Document Nursing Shift Summary

As mentioned in a previous activity, Team Communication (Discoverable) component can be used for documenting actions, reminders, or key components of the patient's care plans to communicate to other interdisciplinary care team members. This may be used if it is part of your sites workflow for end of shift activities. However, it doesn't replace documenting within PowerForms and IView.

Nurses should avoid duplicate documentation via narrative notes.

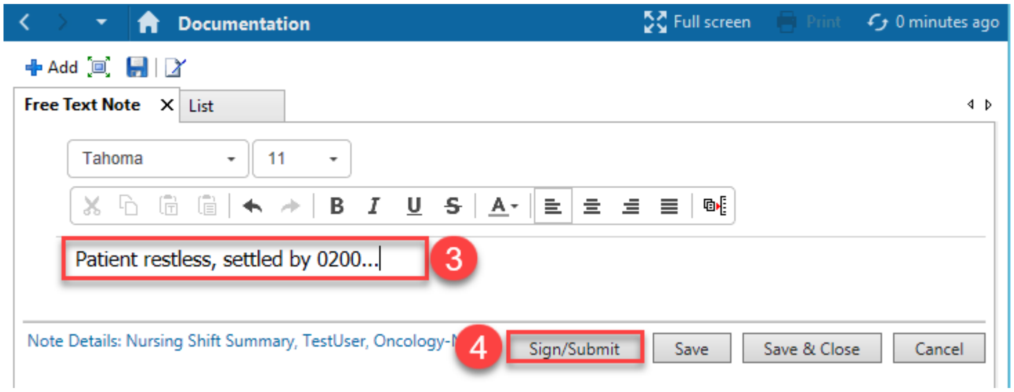
A narrative note is used to document details that have not been captured in the PowerForms and iView documentation. Charting a narrative note can always be applied to document the summary about the patient status on that shift or describe a flagged event that happened to your patient. This can be done by documenting in the **Nursing Shift Summary** note. Follow the steps below to create a **Nursing Shift Summary**:

1. Scroll down to the Create Note section and click on the **Nursing Shift Summary** blue link.



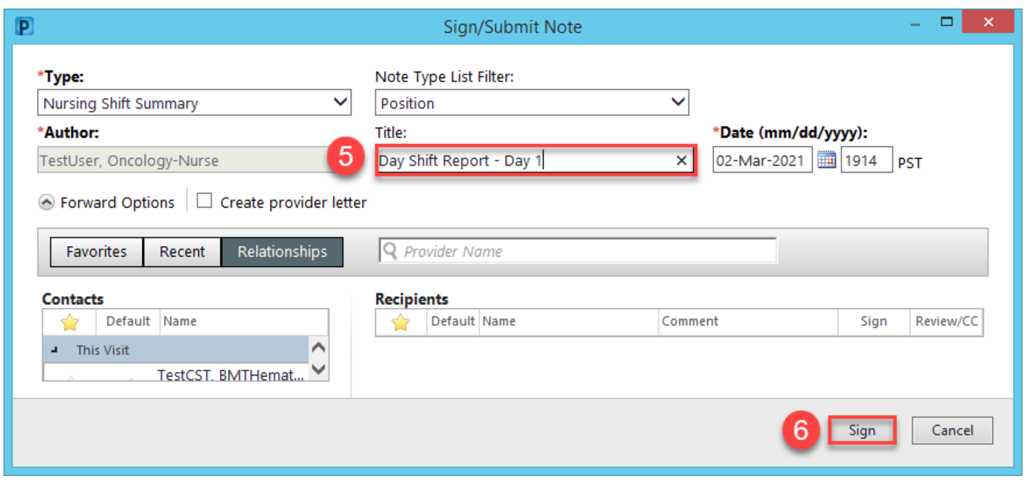
2. In the **Free Text Note** template, put the cursor in the free text note field and document the note content. For practice, **type** *Patient restless Settled by 2am….*

3. Click **Sign/Submit**.



4. In the **Sign/Submit Note** window, change the note title to the one that is more appropriate and relevant to the note content:
   - **Title**: *Day Shift Report – day 1*. (Please note the title is for training purposes only) Check in with your team the decision on titles to improve navigating through the team's documentation.

5. Click **Sign.**

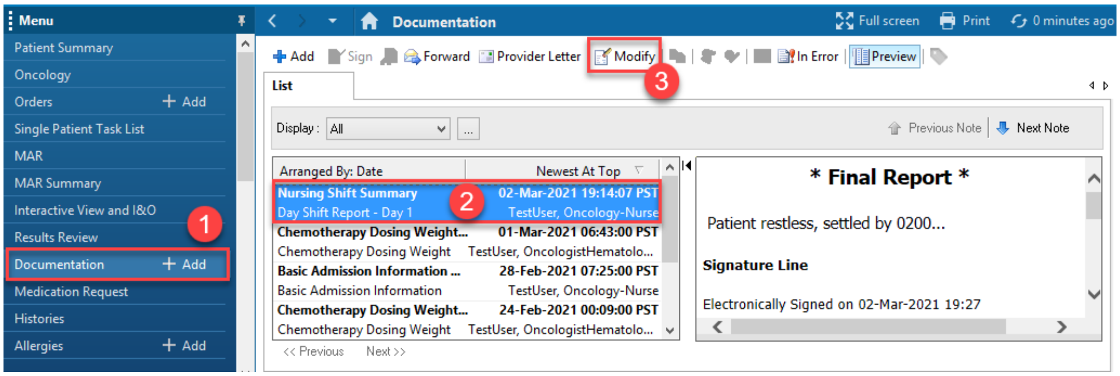


The completed **Nursing Shift Summary** notes can be reviewed in the **Documents** component of the **Handoff Tool** or on the **Documentation** page.

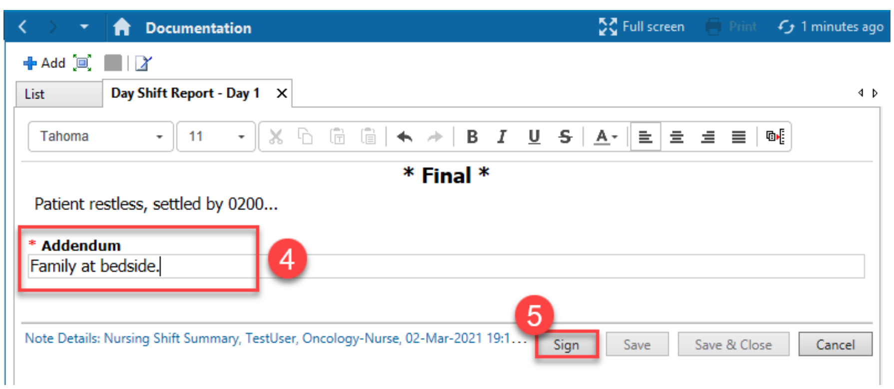
> **NOTE:** If you **Save** the documents the document status will be "In Progress" and the Note will be labelled *Preliminary Report. It will not be visible to other users until you **Sign** the document. This action will publish the note in the patient's chart.

To make a correction in the **Nursing Shift Summary** note:

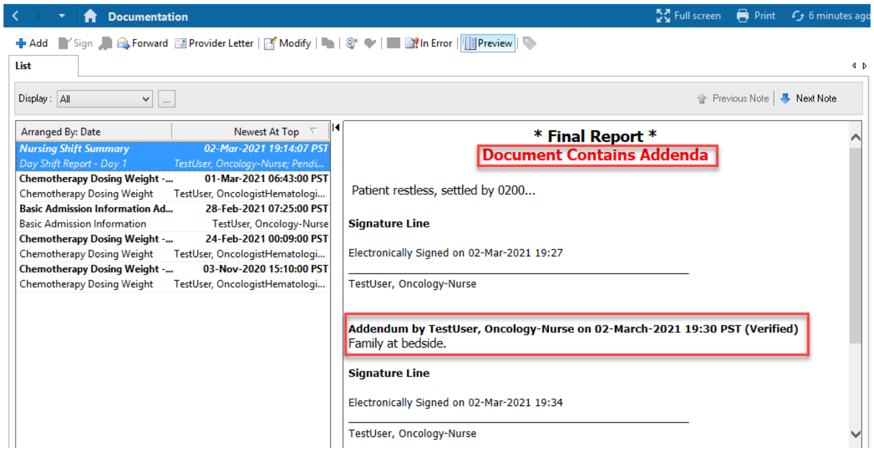
1. Navigate to the **Documentation** from the **Menu**.
2. Select the **Nursing Shift Summary** note that you want to make a correction on.
3. Select **Modify**.



4. Insert an addendum in the free text field. You cannot delete any text in the existing content.
5. Click **Sign**.

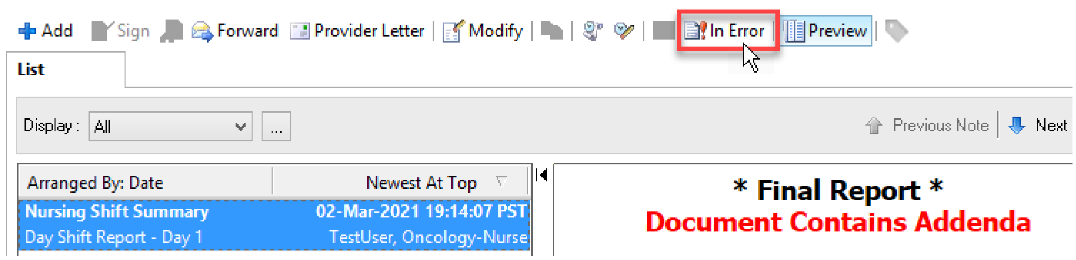


The modified document will have a red message to indicate that it contains addendum.

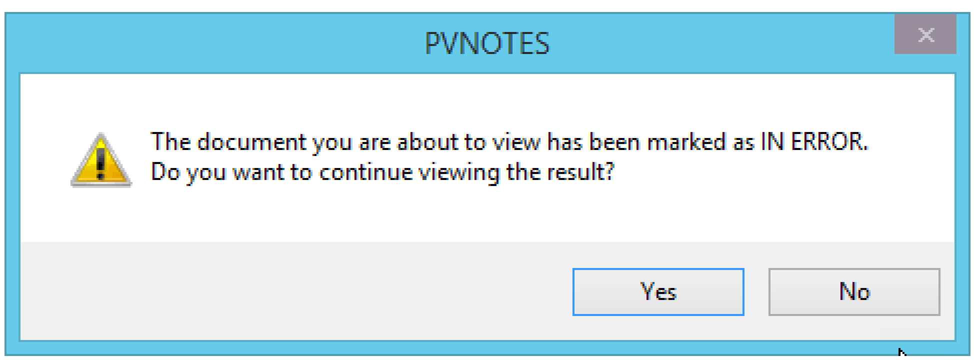


NOTES:

- Select In Error icon if you document a note on the wrong patient chart.



  - In the future a warning will appear anytime an end user tries to view a document that is labeled in error.



Key Learning Points

- A narrative note that is done in the Nursing Shift Summary note can be used to document the summary about the patient status on that shift or describe a flagged event that happened to your patient.
- The Nursing Shift Summary note that is signed can be modified or uncharted if needed.

Activity 13.2 – Provide Handoff Report

When performing shift handoff report at the end of the shift, review patient information from various parts of the patient chart with the oncoming nurse. Handoff report includes the following:

- Review pending and overdue tasks in **CareCompass**.

In the patient chart:

- Review information on the **Banner Bar** such as patient's name, age, location, allergy status, code status, dosing weight, process alert, disease alert, isolation alert.
- Follow the component list in the **Handoff Tool** to review information such as Team Communication (Discoverable), active issues, histories, Lines/Tubes/Drains, vital signs, Labs, Diagnostics Imaging reports, current medication orders, active orders, and so on.
- Review recent results and clinical documentations within different tabs and flowsheets of the **Results Review**.
- Review current orders (including modified orders), as well as, the statuses of the PowerPlans/Modules (i.e. initiated or planned) and orders (e.g. ordered (pending collection), complete, etc.) on the **Orders** page.
- Review medication administration information in **MAR Summary**.
- If applicable, review completed tasks in **Single Patient Task List**.

NOTE: Click the **Refresh** icon to update the information showing on the screen.

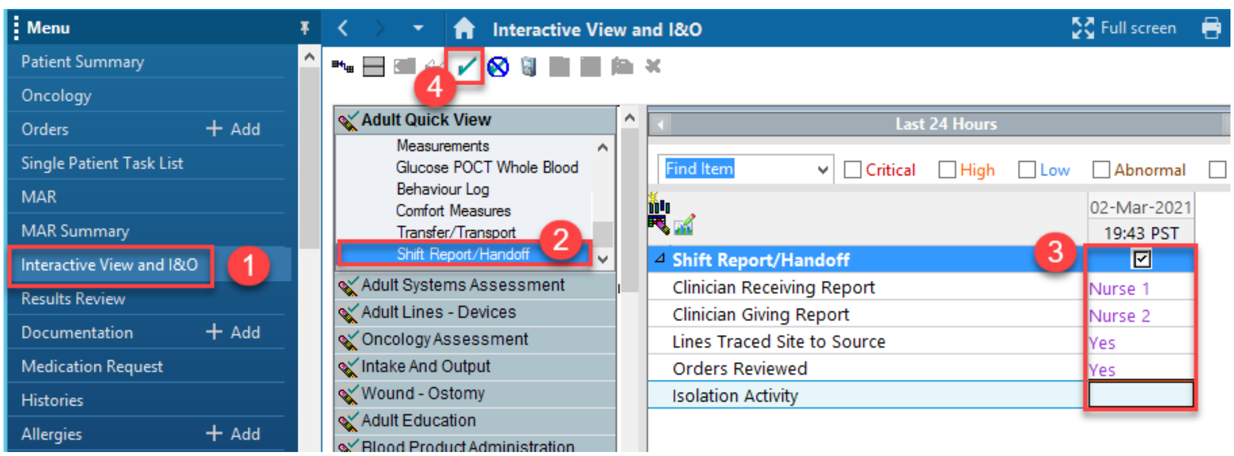
Key Learning Point

- Handoff report at the end of the shift involves reviewing information in CareCompass and various parts of the patient chart.
- Refresh the patient chart to review updated information.

Activity 13.3 - Document Handoff in iView

Document that you have given Report or Handoff in iView by completing the following steps:

1. Select Interactive View and I&O from the Menu.
2. Select **Shift Report/Handoff** section from the Adult Quick View band.
3. Document using the following data:
    - Clinician Receiving Report: ***Nurse 1***
    - Clinician Giving Report: ***Nurse 2***
    - Lines Traced Site to Source: ***Yes***
    - Orders Reviewed: ***Yes***
    - Isolation Activity: leave blank if not on isolation
4. Click the **Sign** icon.



Key Learning Point

- Document that you have given or received report in the **Shift Report/Handoff** section in iView

PATIENT SCENARIO 14 – CST Cerner Help

Learning Objectives
At the end of this Scenario, you will be able to: ■ Use CST Cerner Help to Access Information

SCENARIO
Remember that site specific policies and procedures are located on the SHOP Guidelines and DSTs . However, to guide you through the steps in Cerner we will be accessing CST Cerner Help resource. You will be completing the following activities: ■ Overview of CST Cerner Help For the following activity, **No** **Patient** required.

Activity 14.1 – Overview of CST Cerner Help

CST Cerner Help is a help system that provides just-in-time resources to assist you in your work.

CST Cerner Help contains:

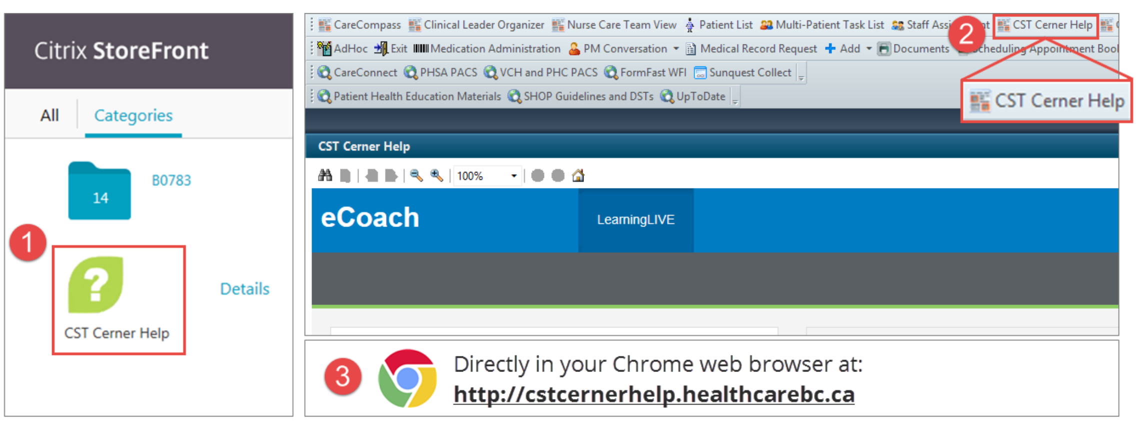
- Help topics that provide you with step-by-step, how-to information.
- Links to classroom workbooks, user guides, and other resource material.

> **NOTE**: Policies and clinical resources for the health authorities can be found on the SHOP site at http://shop.healthcarebc.ca

Accessing CST Cerner Help

There are three ways to access **CST Cerner Help**:

1. **Web browser** (Chrome preferred): http://cstcernerhelp.healthcarebc.ca/#t=CST_Cerner_Help.htm
2. **Citrix StoreFront**: Double-click the **CST Cerner Help** icon.
3. **PowerChart** or **FirstNet**: Click on the **CST Cerner Help** button from the **Toolbar** to access via **eCoach**.



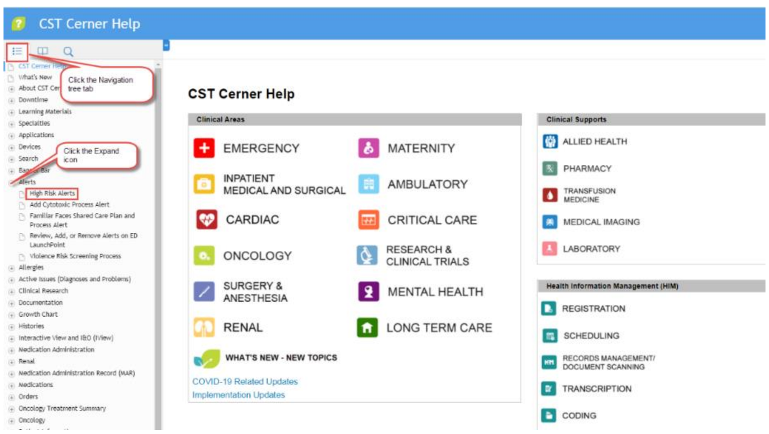
Finding a Help Topic

There are three different ways to find Help Topics on **CST Cerner Help**:

1. **Navigation tree**: You can use the navigation tree to find help topics by subject.

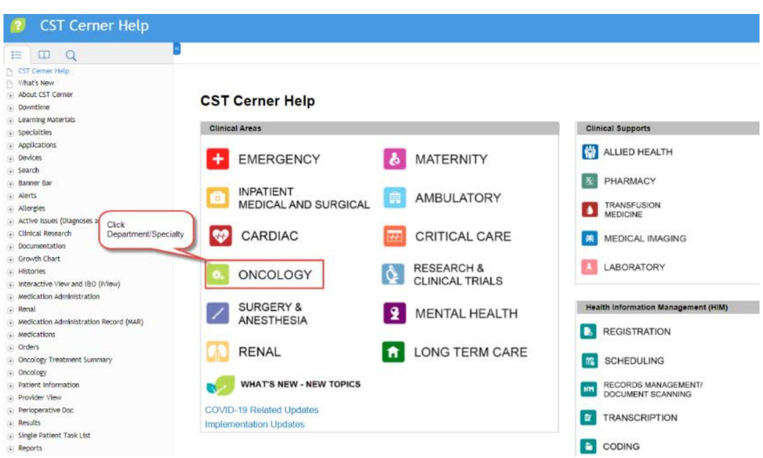
   - Click the icon to see Table of Contents.
   - Click the **Expand** icon beside a topic to see more information.
   - Click the **Collapse** icon to hide the embedded help topics.

   Activity: Find the topic **High Risk Alerts** in the Navigation tree.

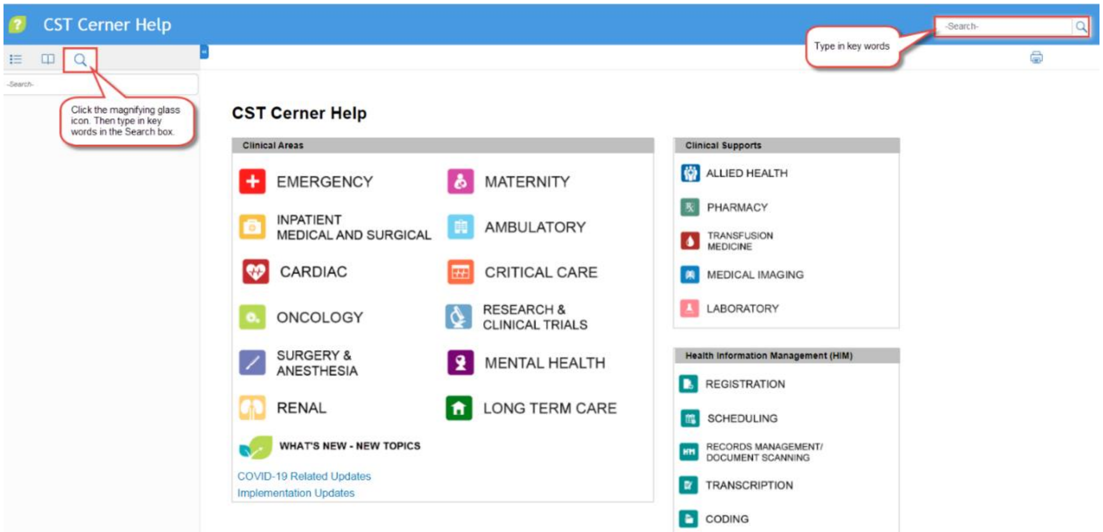


2. **Department/Specialty pages**: You can click your Department/Specialty to see relevant help topics.

   Activity: Navigate to your Department/Specialty page (e.g., ONCOLOGY shown below).



3. **Search box**: You can search for help topics using the Search box at the top of any page (or click the magnifying glass next to the navigation pane).



The **Search** system will look for search terms in the title, content, and key words of the **Help Topics**.

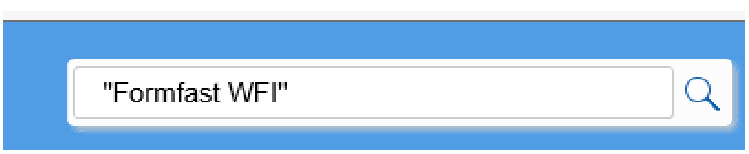
Tips for searching **CST Cerner Help**:

1. Type the key word(s) related to your topic (e.g., **FormFast**). Suggested search terms will appear in a drop-down menu for you to select.

2. To refine your search, you can try the following:

   - Add additional search terms (e.g., **FormFast document**)

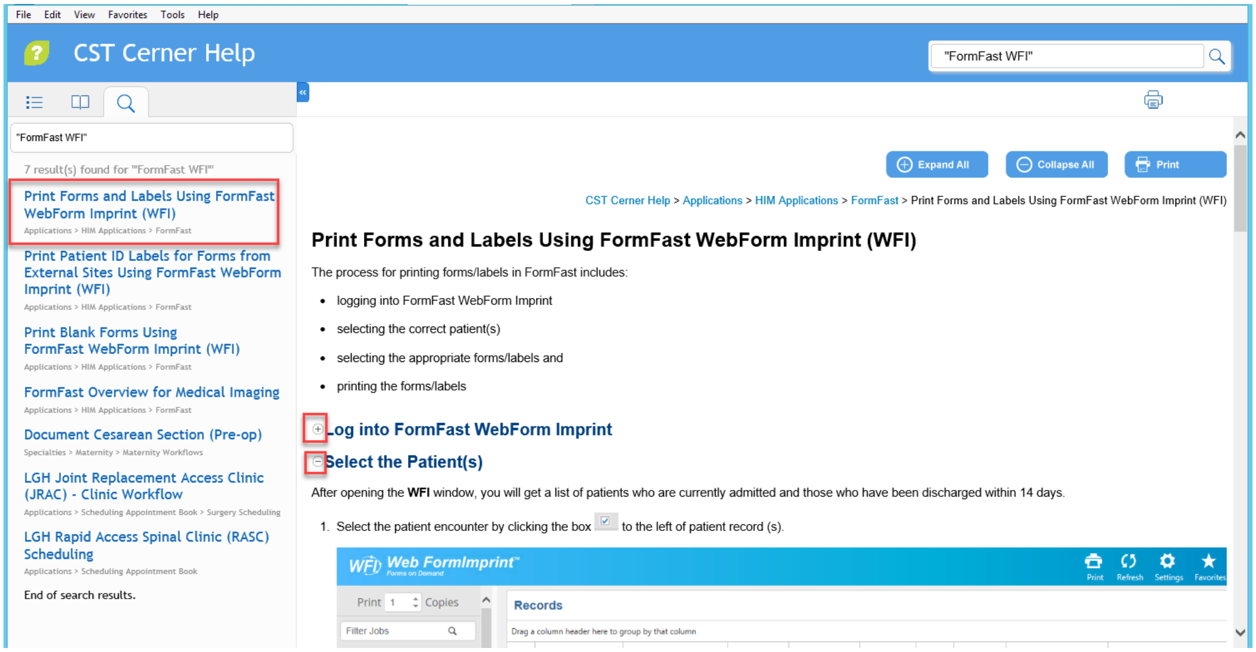
   - Use quotes (**“ ”**) around search terms if you want to find words that appear together in a specific sequence (e.g. **“FormFast WFI”**).



3. After entering the search term, select a topic from the list located on the left side of **CST Cerner Help** page.

   - Click the **Expand** icon ⊕ to open and view the sub-topic content.

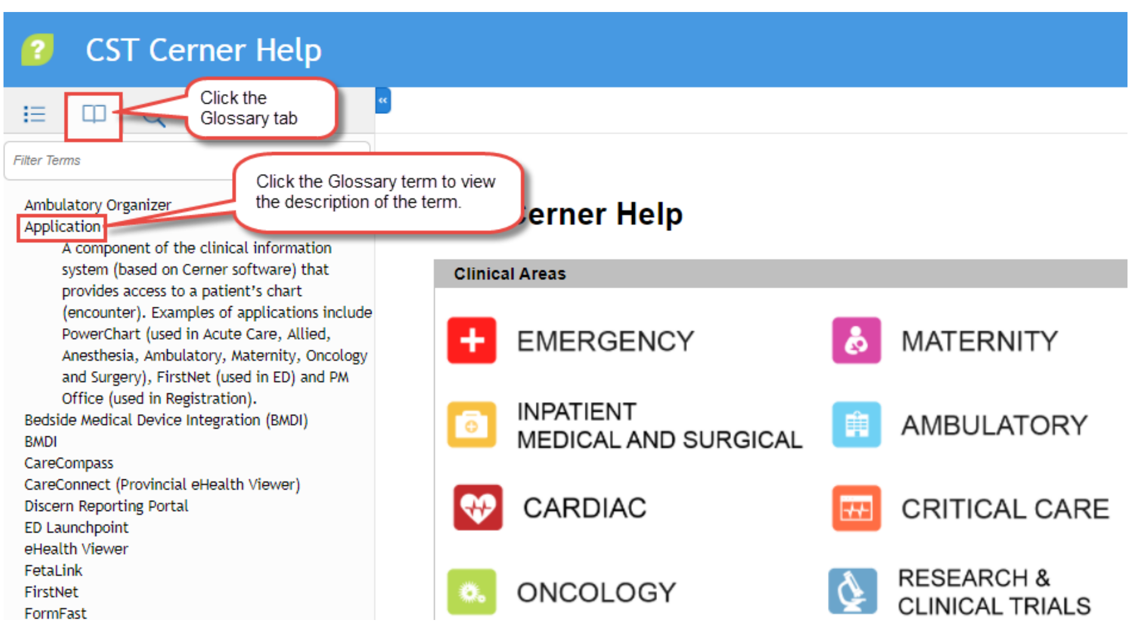
   - Click **Collapse** icon ⊖ to close the opened sub-topic content.



Using the Glossary

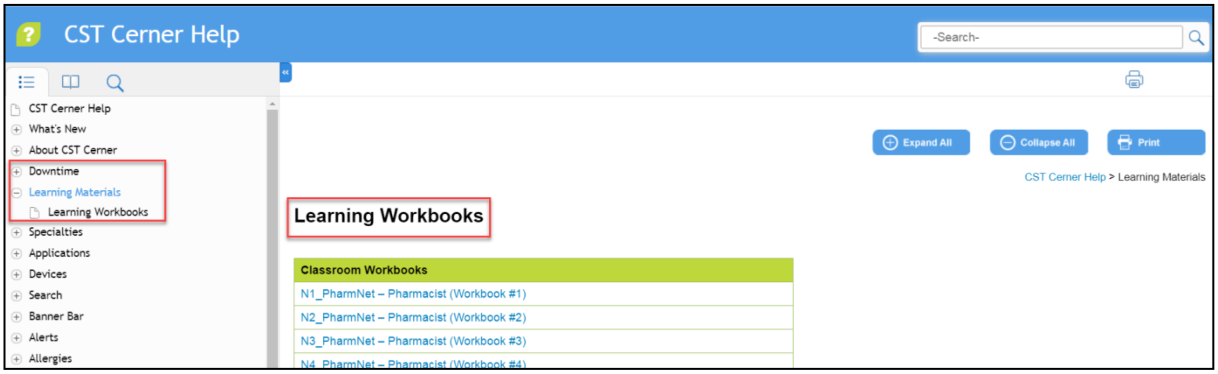
CST Cerner uses many terms that may be unfamiliar to a new user. The Glossary on **CST Cerner Help** provides a list of terms used in CST Cerner and their definitions.

Activity: Find the term, **Application**, in the Glossary.



Locating Learning Materials on CST Cerner Help

Use the Navigation Tree to access up-to-date **Learning Materials** (e.g., **learning workbooks** used in training sessions) and **Downtime** procedures.



SELF-GUIDED PRACTICE WORKBOOK [code]
CST Transformational Learning

Workbook Add-on: Accessing your patients when working in Ambulatory Clinics

If you are a nurse who also works in ambulatory areas, please complete this section.

Last Updated: Sep 9, 2023

PATIENT SCENARIO 1 – Access Clinic Schedule and View Patient Status.

Learning Objectives

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

- Set up your resources to open your clinics schedule.
- Demonstrate Ambulatory Organizer Functionality.
- Locate your Patient and view their status on the Ambulatory Organizer.
- Review the status options before and after check in.
- Understand how the Ambulatory organizer can support the flow of the clinic.

SCENARIO

You been assigned to the MDC area and require access to the ambulatory organizer to retrieve a list of the day’s patients and view your patient information. This is the first time using the application therefore you will need to set up the Ambulatory Organizer.

You will complete the following activities:

- Ambulatory Organizer Resources
- Add a Note to the Ambulatory Organizer

For the following activity, select any patient from the Ambulatory Organizer in the BCC VA ACU ST Resource Group.

Activity 1.1 – Ambulatory Organizer Resources

The **Ambulatory Organizer** provides a summary of the scheduled appointments for a selected **Resource** (provider or clinic) or group of resources (pool). The view includes patient information, appointment type and length, and visual cues notifying you of pertinent changes to the appointment status.

Selecting your patient from the Ambulatory Organizer can ensure that the correct encounter is selected.

Set-Up Ambulatory Organizer Resources

The **first time** you sign into Cerner you will notice that the Ambulatory Organizer has **No Resources** selected. Therefore, you will be required to set these resources to display the Clinics scheduled patients. Once you set up your resource it will stay as your default resource upon logging in, unless you change it.

HINT: Resources can be locations, people, tumour conferences or equipment (e.g. chairs) and you can select multiple locations or people to view at one time.

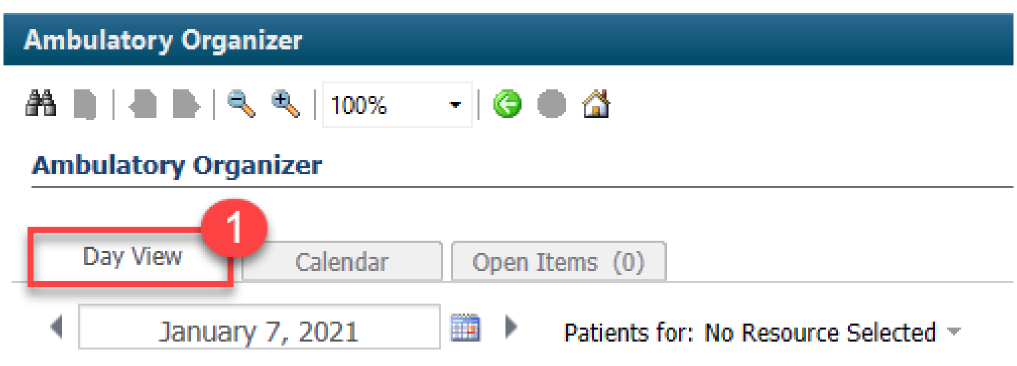
Ambulatory Organizer offers three different views to help you prioritize your day.

- **Day View** tab lists your appointments scheduled for a selected date and facility and providers information 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. You can open patient's chart in a specific location directly from that view.

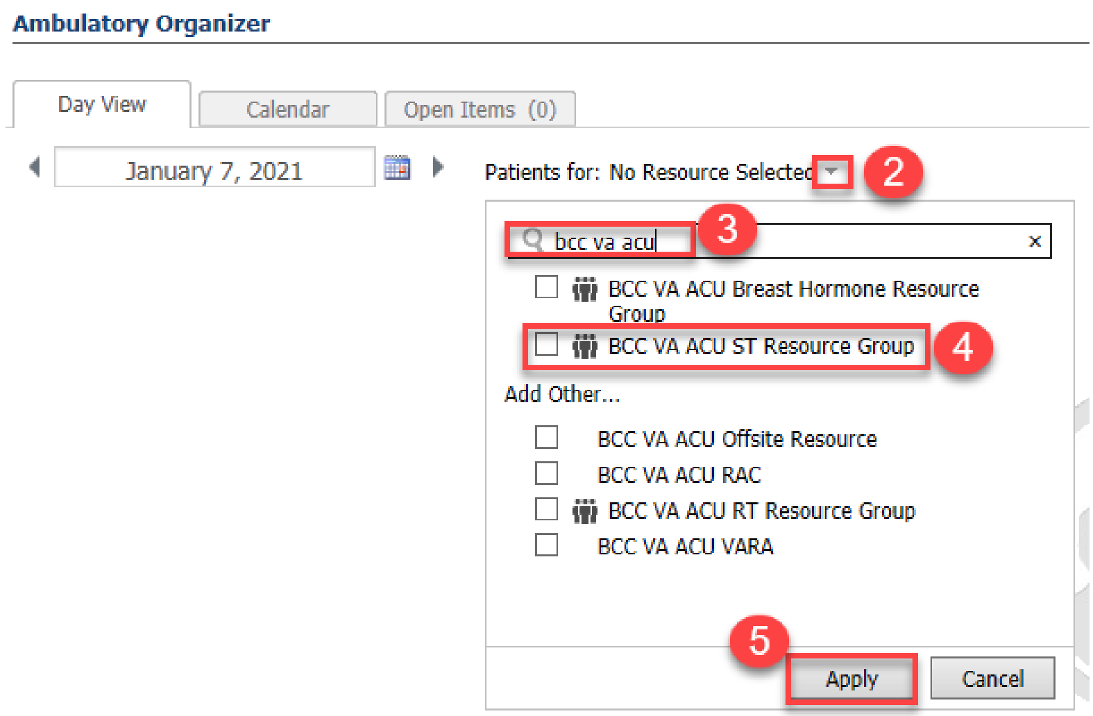
The main tab for the Oncology Ambulatory nurse is the Day View.

To set your resources for the Day view tab:

1. Check the **Day View** tab is selected within the **Ambulatory Organizer** window.



2. Click the downward button next to Patients For: Patients for: **No Resource Group Selected**.
3. Type your **Resource** name as noted in your Login Card that you have been provided with (e.g., BCC VA ACU ST Resource Group).
4. Click on the **Resource** tick box ☐.
5. Click the **Apply** button Apply to populate the Resources you selected.



You have now set the resource for the Day View. The clinic schedule populates. The appointment information populated in Ambulatory Organizer is pulled from data entered by the scheduling clerk.

NOTES:

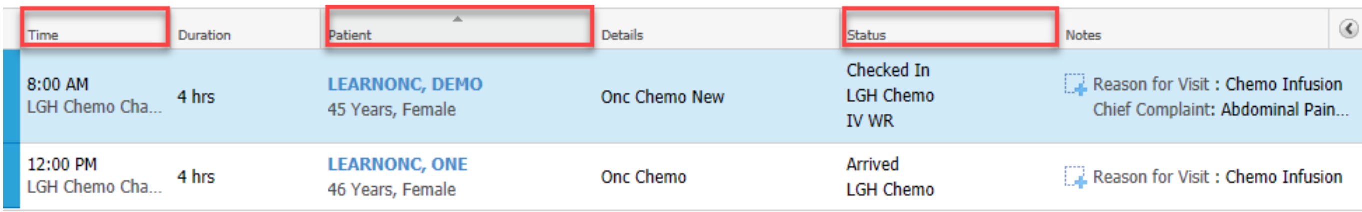
You must manually change or add to the Resources if you would like to view different appointments scheduled to a different resource.

You must set your desired Resource in each view that you use (Day View, Calendar or Open Items).

Layout of the Ambulatory Organizer

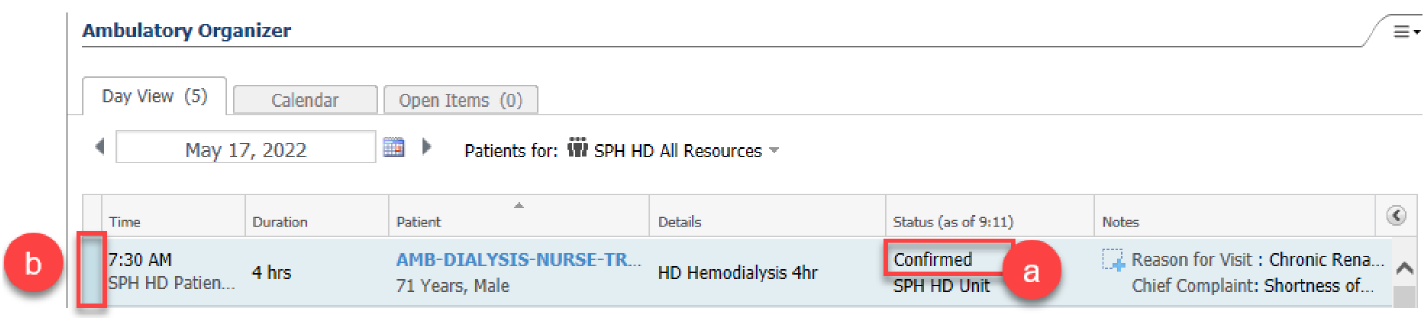
As you have already reviewed the individual columns in the emodule, **CST Cerner - Ambulatory Nurse: Introduction to Ambulatory Organizer** note the columns and how the patient's appointments display.

You can sort the details of each column header. For example, click the **Time** column heading to sort the appointments from the earliest to the latest or click the **Patient** columns heading to rearrange the patient names in alphabetical order.

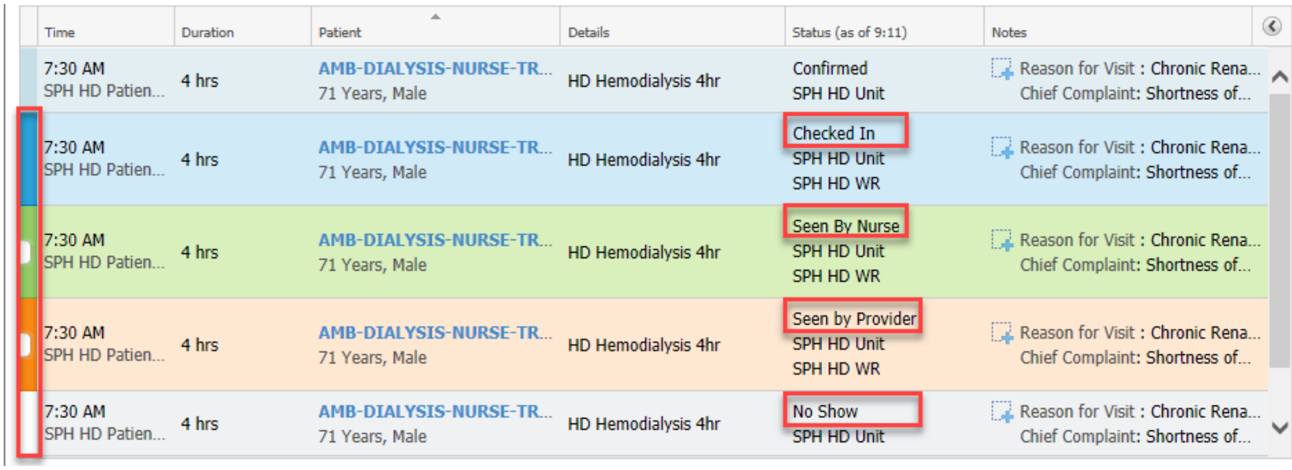


The Ambulatory Organizer uses colours to assists you in understanding the flow of the patients within the clinic.

The **colour status bar** on the left side of the time column and the entire appointment row changes colour based on various status. For example, when a patient is booked for a clinic, a) the status column states **Confirmed** and b) the colour status bar is a **light blue including the entire appointment row**. (Note screenshot is example only).



After the patient has been checked in, the completion of certain documentation by various members of the multidisciplinary team (e.g., clerk, nurse, or provider) will automatically update the patient status (Note screenshot is example only).

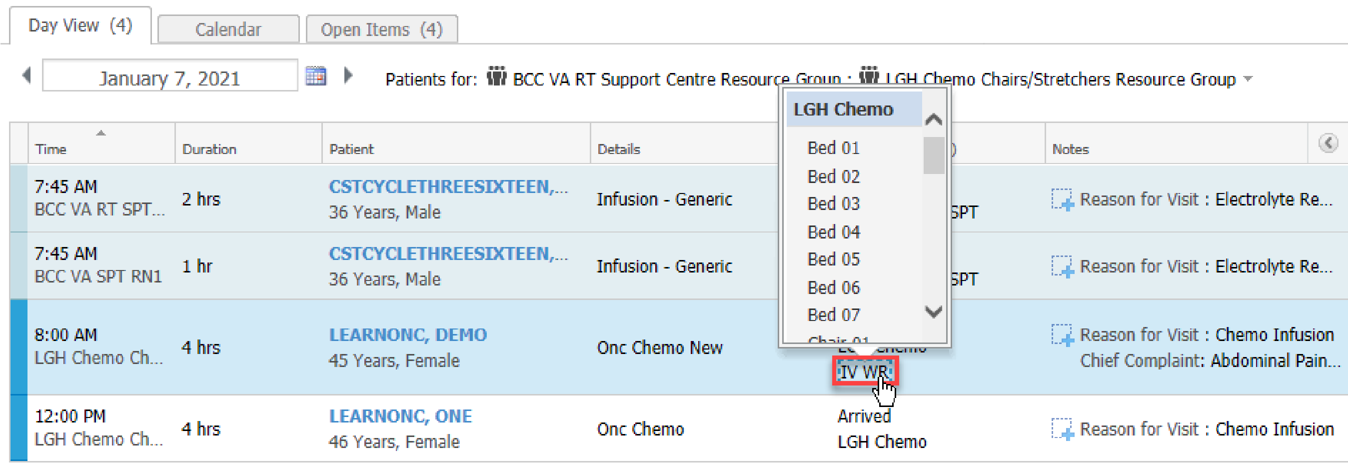


You will learn more about the functionality of the Ambulatory organizer and how to manually change the patient status in workflow review sessions.

See table below to explore some of the common colour statuses:

Colour 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. When the nurse signs nursing documentation the colour automatically changes to green indicating seen by the nurse.
	Orange indicates a **Seen By** physician, provider (physician), resident, or custom status has taken place. When the provider signs their documentation the colour automatically changes to orange indicating seen by the provider.
	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).

If your clinic designed rooms in the Ambulatory Organizer, you can select a room to track where each patient is located by clicking on the location field.



NOTE: Once the patient is checked in some infusion clinics will be using an alternative application to manage their patients within their clinics called the **Tracking Shell**. This application will be discussed further in a separate workbook for the Oncology Ambulatory nurse that administers Chemotherapy.

Key Learning Points

- Ambulatory Organizer has three different views: Day View, Calendar and Open Items.
- You must set your desired Resource in each view that you use (Day View, Calendar View, or Open Items).
- A Resource can be people, location or equipment.
- The Day View is the main view and displays a list of patients scheduled for the day based on the resource selected.
- The Ambulatory organizer can be sorted by Time, Patient Name or Status by clicking on the column header.
- A colour status bar assists you in understanding the flow of the patients within the clinic.
- A location field is available to assists you in identifiying the location of the patients within the clinic.

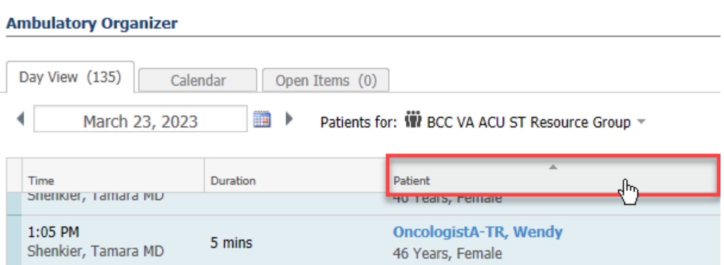
Activity 1.2 - Add a Comment to the Ambulatory Organizer

The **Day View** in the **Ambulatory Organizer** provides an option to add notes similar to a post-it note. You can add and delete as required. Ensure you check in with your unit if your team will be using this option.

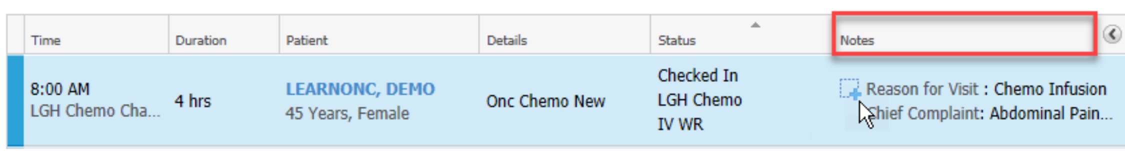
For example, you may want to notify the team in the system the patient has arrived and they are accompanied by family which may require a larger room.

For the following activity, select any patient from the Ambulatory Organizer and ensure you complete the activity by deleting the note.

1. Ensure Ambulatory Organizer is sorted by Patient Name. If it isn't already sorted from the previous activity, click on the column header Patient to rearrange the patient names in alphabetical order.



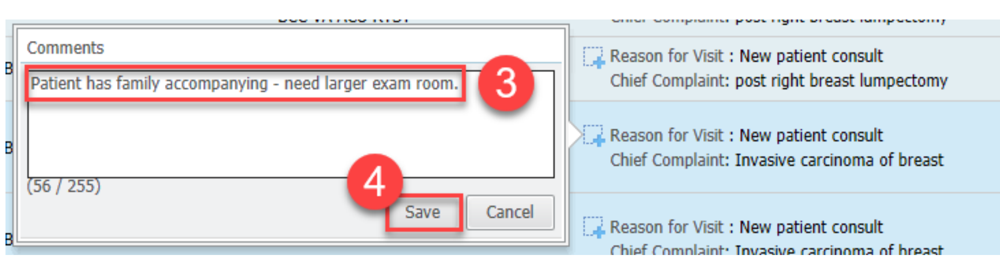
2. Click on your patient's **Notes** icon under the Notes column.



The **Comments** window opens.

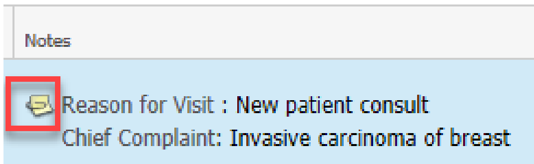
3. Type *Patient has family accompanying - need larger exam room*.

4. Click **Save**.



5. Click outside the box to close the window.

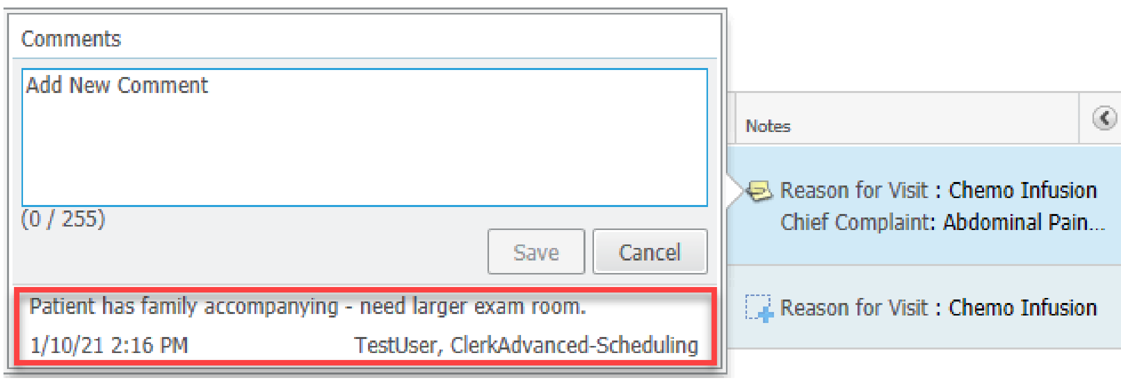
   Note a yellow piece of paper with a paper clip appears.



6. Click on the icon.

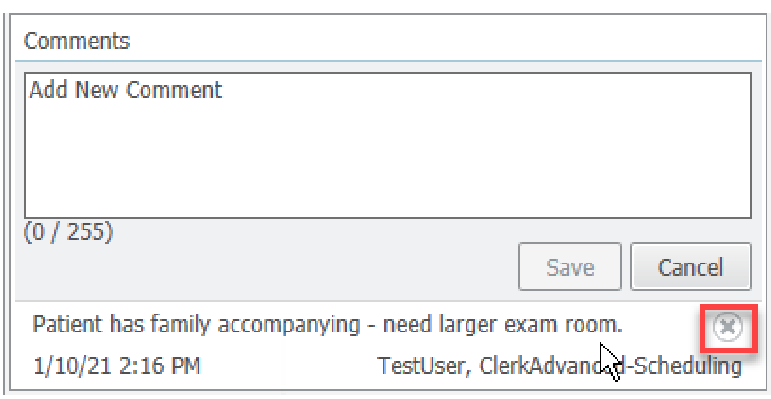
   A **Comments** window opens.

   Your note appears at the bottom of the window.



Once this comment has been addressed you may want to remove it.

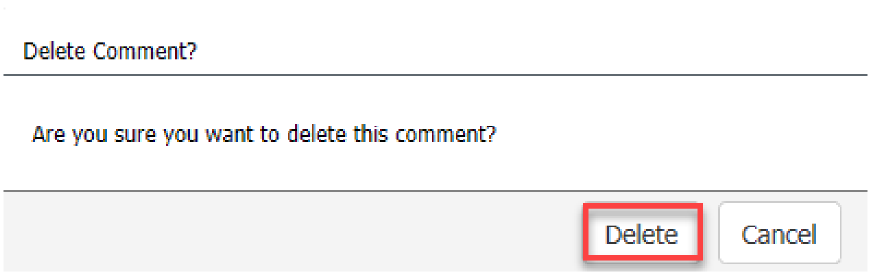
1. Hover your mouse over the note and an icon appears at the right top corner of the comment.



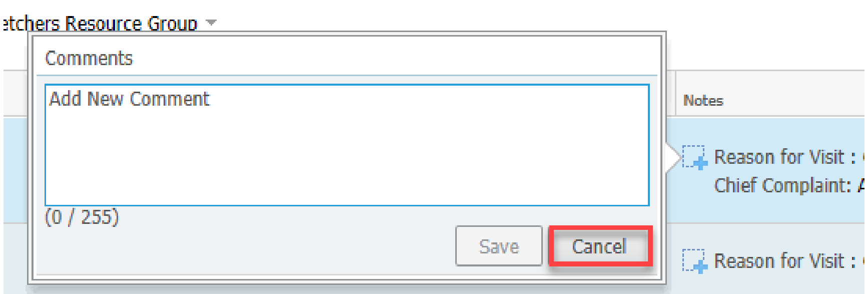
2. Click the icon.

   A confirmation box appears asking **Are you sure you want to delete this comment?**

3. Click **Delete**.



4. Click **Cancel** to close the comments box.



Key Learning Points

- Notes can be added and delete to the Ambulatory Organizer.

End of Workbook

You have completed the workbook and are ready for the **Q-N149 Quiz** located in the **Learning Hub**. Please refer to your instructions on the Learning Hub.

- Remember that you can learn more at any time by accessing the CST learning modules on **Learning Hub** (search by keyword ‘CST’).
- Digital copies of the workbooks are also available for you to access at any time from **CST Cerner Help** at the bottom of each **Clinical Area** page. The website can be accessed from anywhere including cell phones and tablets: **http://cstcernerhelp.healthcarebc.ca**
- You may wish to bookmark this link for future use.