INPATIENT MEDICATIONS (IM)

NURSE'S USER MANUAL

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Department of Veterans Affairs
V*ISTA* System Design & Development

Revision History

Any changes subsequent to the initial release of this manual are listed below. The users should update the manual with the pages listed under the Revised Pages column.

Date	Revised Pages	Patch Number	Description
01/02	Title, i–vi, 1, 2, 21, 22, 61, 62, 89, 89a, 89b, 90-94, 111-118	PSJ*5*65	Updated the Title Page, Revision Page, Table of Contents, Menu Tree, Introduction Page, and the Index. The default Schedule Type determinations were updated for new orders and orders entered through CPRS and finished by pharmacy. A new option and report, Free Text Dosage Report, was added to the Unit Dose Reports. Included pages for double-sided printing.
01/02	Title, i, ii, 1, 2, 19, 20, 21, 22	PSJ*5*63	Updated the Title Page, Revision History Page, and the Introduction Page. The Schedule Type and Stop Date/Time were updated to include the ward and system parameters used in the determination of the stop date for one-time orders. Included pages for double-sided printing.
09/01	All	PSJ*5*50	Added this Revision History Page. Re-formatted the manual into sections. Added Patch Release changes and Pharmacy Ordering Enhancements (POE).
12/97			Original Released Nurse's User Manual.

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Since the documentation is arranged in a topic oriented format and the screen options are not, a menu tree is provided below for the newer users who may need help finding the explanations to the options.

	Menu Tree	Topic Oriented Section
	Align Labels (Unit Dose)	Output Options
	Discontinue All of a Patient's Orders	Order Options
EUP	Edit Inpatient User Parameters	Maintenance Options
	Hold All of a Patient's Orders	Order Options
IOE	Inpatient Order Entry	Order Options
IPF	Inpatient Profile	Order Options
	INQuiries Menu…	Inquiries Option
	Dispense Drug Look-Up	Inquiries Option
	Standard Schedules	Inquiries Option
	Label Print/Reprint	Output Options
	Non-Verified/Pending Orders	Order Options
	Order Entry	Order Options
	PAtient Profile (Unit Dose)	Output Options
	Reports Menu…	Output Options
	24 Hour MAR	Output Options
	7 Day MAR	Output Options
	14 Day MAR	Output Options
	Action Profile #1	Output Options
	Action Profile #2	Output Options
	AUthorized Absence/Discharge Summary	Output Options
	Extra Units Dispensed Report	Output Options
	Free Text Dosage Report	Output Options
	INpatient Stop Order Notices	Output Options
	Medications Due Worksheet	Output Options
	Patient Profile (Extended)	Output Options

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1. Introduction

The Inpatient Medications provides a method of management, dispensing, and administration of inpatient drugs within the hospital. Inpatient Medications combines clinical and patient information that allows each medical center to enter orders for patients, dispense medications by means of Pick Lists, print labels, create Medication Administration Records (MARs), and create Management Reports. Inpatient Medications also interacts with the Computerized Patient Record System (CPRS) and the Bar Code Medication Administration (BCMA) packages to provide more comprehensive patient care.

This user manual is written for the Nursing Staff, the Automated Data Processing (ADP) Application Coordinator, and other healthcare staff for managing, dispensing, and administering medications to the patients within the hospital. The main texts of the manual outlines patients' ordering options for new and existing orders, editing options, output options, and inquiry options.

The Inpatient Medications documentation is comprised of several manuals. These manuals are written as modular components and can be distributed independently and are listed below.

Nurse's User Manual V. 5.0 Revised January 2002
Pharmacist's User Manual V. 5.0 Revised January 2002
Supervisor's User Manual V. 5.0 Revised January 2002
Technical/Security Guide V. 5.0 Revised January 2002
Pharmacy Ordering Enhancements (POE) Phase 2 Release Notes V. 1.0
Pharmacy Ordering Enhancements (POE) Phase 2 Installation Guide V. 1.0

2. Orientation

Within this documentation, several notations need to be outlined.

- Menu options will be italicized.
  Example: *Inpatient Order Entry* indicates a menu option.

- Screen prompts will be denoted with quotation marks around them.
  Example: "Select DRUG:" indicates a screen prompt.

- Responses in bold face indicate what the user is to type in.
  Example: Printing a MAR report by ward group **G**, by ward **W** or by patient **P**.

- Text centered between arrows represents a keyboard key that needs to be pressed in order for the system to capture a user response or move the cursor to another field. **<Enter>** indicates that the Enter key (or Return key on some keyboards) must be pressed. **<Tab>** indicates that the Tab key must be pressed.
  Example: Press **<Tab>** to move the cursor to the next field.
  Press **<Enter>** to select the default.

- Text depicted with a black background, displayed in a screen capture, designates blinking text on the screen. This is provided for the written copy of the documentation.
  Example:

```
  (9)   Admin Times: 01-09-15-20
*(10)      Provider: INPATIENT-MEDS,PHARMACIST
```

- **Note**: Indicates especially important or helpful information.

- Options are locked with a particular security key. The user must hold the particular security key to be able to perform the menu option.
  Example: All options under the *PIck List Menu* are locked with the PSJU PL key.

- Some of the menu options have several letters that are capitalized. By entering in the letters and pressing <**Enter**>, the user can go directly to that menu option (the letters do not have to be entered as capital letters).
  Example: From the *Unit Dose Medications* option: the user can enter **INQ** and proceed directly into the *INQuiries Menu* option.

- **?**, **??**, **???** One, two, or three question marks can be entered at any of the prompts for on-line help. One question mark elicits a brief statement of what information is appropriate for the prompt. Two question marks provide more help, plus the hidden actions and three question marks will provide more detailed help, including a list of possible answers, if appropriate.

- ^ Caret (up arrow or a circumflex) and pressing **<Enter>** can be used to exit the present option.

3. List Manager

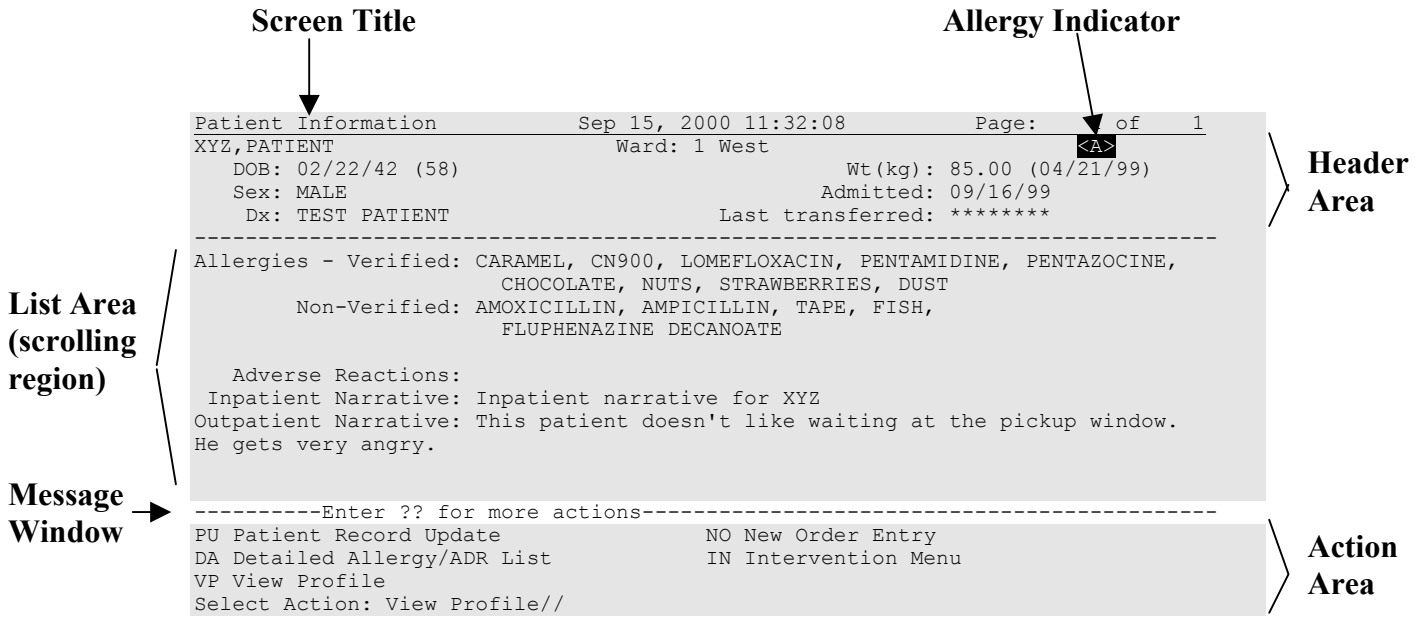
The new screen, which was designed using List Manager, has dramatically changed from the previous version.

This new screen will give the user:

- more pertinent information
- easier accessibility to vital reports and areas of a patient's chart the user may wish to see.

Please take the time to read over the explanation of the screen and the actions that can now be executed at the touch of a button. This type of preparation before using List Manager is effective in saving time and effort.

Inpatient List Manager



Screen Title: The screen title changes according to what type of information List Manager is displaying (e.g., Patient Information, Non-Verified Order, Inpatient Order Entry, etc).

Allergy Indicator: This indicator will display when allergy information has been entered for the patient. When the patient has Allergy/ADR data defined, an "<A>" is displayed to the right of the ward location to alert the user of the existence of this information (**Note:** This data may be displayed using the Detailed Allergy/ADR List action).

Header Area: The header area is a "fixed" (non-scrollable) area that displays the patient's demographic information. This also includes information about the patient's current admission. The status and type of order are displayed in the top left corner of the heading, and will include the priority (if defined) for pending orders.

List Area: (scrolling region): This is the section that will scroll (like the previous version) and display the information that an action can be taken on. The Allergies/Reactions line includes non-verified and verified Allergy/ADR information as defined in the Allergy package. The allergy data is sorted by type (DRUG, OTHER, FOOD). If no data is found for a category, the heading for that category is not displayed. The Inpatient and Outpatient Narrative lines may be used by the inpatient pharmacy staff to display information specific to the current admission for the patient.

Message Window: This section displays a plus sign (+), if the list is longer than one screen, and informational text (i.e., Enter ?? for more actions). If the plus sign is entered at the action prompt, List Manager will "jump" forward to the next screen. The plus sign is only a valid action if it is displayed in the message window.

Action Area: The list of valid actions available to the user display in this area of the screen. If a double question mark (??) is entered at the "Select Action:" prompt, a "hidden" list of additional actions that are available will be displayed.

3.1. Using List Manager

List Manager is a tool designed so that a list of items can be presented to the user for an action.

For Inpatient Medications, the List Manager gives the user the following:

- Capability to browse through a list of orders.
- Capability to take action(s) against those items.
- Capability to print MARs, labels and profiles from within the *Inpatient Order Entry* option.
- Capability to select a different option than the option being displayed.

3.2. Hidden Actions

A double question mark (??) can be entered at the "Select Action:" prompt for a list of all actions available. Typing the name(s) or synonym(s) at the "Select Action:" prompt enters the actions.

The following is a list of generic List Manager actions with a brief description. The synonym for each action is shown, followed by the action name and description.

Synonym	Action	Description
+	Next Screen	Move to the next screen
-	Previous Screen	Move to the previous screen
UP	Up a Line	Move up one line
DN	Down a line	Move down one line
FS	First Screen	Move to the first screen
LS	Last Screen	Move to the last screen
GO	Go to Page	Move to any selected page in the list
RD	Re Display Screen	Redisplay the current screen
PS	Print Screen	Prints the header and the portion of the list currently displayed

Synonym	Action	Description
PT	Print List	Prints the list of entries currently displayed
SL	Search List	Finds selected text in list of entries
Q	Quit	Exits the screen
ADPL	Auto Display (On/Off)	Toggles the menu of actions to be displayed/not displayed automatically
>	Shift View to Right	Shifts the view on the screen to the right
<	Shift View to Left	Shifts the view on the screen to the left

The following is a list of Inpatient Medications specific hidden actions with a brief description. The synonym for each action is shown followed by the action name and description.

Synonym	Action	Description
MAR	MAR Menu	Displays the MAR Menu
24	24 Hour MAR	Shows the 24 Hour MAR
7	7 Day MAR	Shows the 7 Day MAR
14	14 Day MAR	Shows the 14 Day MAR
MD	Medications Due Worksheet	Shows the Worksheet
LBL	Label Print/Reprint	Displays the Label Print/Reprint Menu
ALUD	Align Labels (Unit Dose)	Aligns the MAR label stock on a printer
LPUD	Label Print/Reprint	Allows print or reprint of a MAR label
ALIV	Align Labels (IV)	Aligns the IV bag label stock on a printer
ILIV	Individual Labels (IV)	Allows print or reprint of an IV bag label
SLIV	Scheduled Labels (IV)	Allows print of the scheduled IV bag label
RSIV	Reprint Scheduled Labels (IV)	Allows reprint of scheduled IV bag labels
OTH	Other Pharmacy Options	Displays more pharmacy options
PIC	Pick List Menu	Displays the Pick List Menu
EN	Enter Units Dispensed	Allows entry of the units actually dispensed for a Unit Dose order
EX	Extra Units Dispensed	Allows entry of extra units dispensed for a Unit Dose order
PL	Pick List	Creates the Pick List report
RRS	Report Returns	Allows the entry of units returned for a Unit Dose order
RPL	Reprint Pick List	Allows reprint of a pick list
SND	Send Pick list to ATC	Allows a pick list to be sent to the ATC

Synonym	Action	Description
UP	Update Pick List	Allows an update to a pick list
RET	Returns/Destroyed Menu	Displays the Returns/Destroyed options
RR	Report Returns	Allows entry of units returned for a Unit Dose order
RD	Returns/Destroyed Entry (IV)	Allows entry of units returned or destroyed for an order
PRO	Patient Profiles	Displays the Patient Profile menu
IP	Inpatient Medications Profile	Generates an Inpatient Profile for a patient
IV	IV Medications Profile	Generates an IV Profile for a patient
UD	Unit Dose Medications Profile	Generates a Unit Dose Profile for a patient
OP	Outpatient Prescriptions	Generates an Outpatient Profile for a patient
AP1	Action Profile #1	Generates an Action Profile #1
AP2	Action Profile #2	Generates an Action Profile #2
EX	Patient Profile (Extended	Generates an Extended Patient Profile

The following actions are available while in the Unit Dose Order Entry Profile.

Synonym	Action	Description
DC	Speed Discontinue	Speed discontinue one or more orders (This is also available in *Inpatient Order Entry* and *Order Entry (IV))*
RN	Speed Renew	Speed renewal of one or more orders
SF	Speed Finish	Speed finish one or more orders
SV	Speed Verify	Speed verify one or more orders

The following actions are available while viewing an order.

Synonym	Action	Description
CO	Copy an order	Allows the user to copy an active, discontinued, or expired Unit Dose order
DIN	Drug Restriction/Guideline Information	Displays the Drug Restriction/Guideline Information for both the Orderable Item and Dispense Drug
I	Mark Incomplete	Allows the user to mark a Non-Verified Pending order incomplete
JP	Jump to a Patient	Allows the user to begin processing another patient
N	Mark Not to be Given	Allows the user to mark a discontinued or expired order as not to be given

4. Order Options

The *Unit Dose Medications* option is used to access the order entry, patient profiles and various reports and is the main starting point for the Unit Dose system.

Example: Unit Dose Menu

```
Select Unit Dose Medications Option: ?

          Align Labels (Unit Dose)
          Discontinue All of a Patient's Orders
   EUP    Edit Inpatient User Parameters
   ESD    Edit Patient's Default Stop Date
          Hold All of a Patient's Orders
   IOE    Inpatient Order Entry
   IPF    Inpatient Profile
          INQuiries Menu ...
          Label Print/Reprint
          Non-Verified/Pending Orders
          Order Entry
          PAtient Profile (Unit Dose)
          PIck List Menu ...
          Reports Menu ...
          Supervisor's Menu ...
```

Within the Inpatient Medications package there are three different paths the nurse can take to enter a new order or take action on an existing order. They are (1) *Order Entry*, (2) *Non-Verified/Pending Orders* and (3) *Inpatient Order Entry*. Each of these paths differs by the prompts that are presented. Once the nurse has reached the point of entering a new order or selecting an existing order, the process becomes the same for each path.

When the selected order type (non-verified or pending) does not exist while the user is in the *Non-Verified/Pending Orders* option, the user cannot enter a new order or take action on an existing order.

Patient locks and order locks are incorporated within the Inpatient Medications package. When a user (User 1) selects a patient through any of the three paths, *Order Entry*, *Non-Verified/Pending Orders,* or *Inpatient Order Entry*, and this patient has already been selected by another user (User 2), the user (User 1) will see a message that another user (User 2) is processing orders for this patient. This will be a lock at the patient level within the Pharmacy packages. When the other user (User 2) is entering a new order for the patient, the user (User 1) will not be able to access the patient due to a patient lock within the **V***IST***A** packages. A lock at the order level is issued when an order is selected through Inpatient Medications for any action other than new order entry. Any users attempting to access this patient's order will receive a message that another user is working on this order. This order level lock is within the **V***IST***A** packages.

The three different paths for entering a new order or taking an action on an existing order are summarized below.

4.1. Order Entry
[PSJU NE]

The *Order Entry* option allows the nurse to create, edit, renew, hold, and discontinue Unit Dose orders while remaining in the Unit Dose module.

The *Order Entry* option functions almost identically to the *Inpatient Order Entry* option, but does not include IV orders on the profile and only Unit Dose orders may be entered or processed.

After selecting the *Order Entry* option from the *Unit Dose Medications* option, the nurse will be prompted to select the patient. At the "Select PATIENT:" prompt, the user can enter the patient's name or enter the first letter of the patient's last name and the last four digits of the patient's social security number (e.g. A9111). The Patient Information Screen is displayed:

Example: Patient Information Screen

```
Patient Information           Sep 11, 2000 16:09:05          Page:    1 of    1
ABC,PATIENT                      Ward: 1 EAST
   PID: 123-45-9111          Room-Bed: B-12        Ht(cm): ______ (________)
   DOB: 08/18/20 (80)                              Wt(kg): ______ (________)
   Sex: MALE                                     Admitted: 05/03/00
    Dx: TESTING                            Last transferred: ********

 Allergies/Reactions:
 Inpatient Narrative: INP NARR...
Outpatient Narrative:









          Enter ?? for more actions
PU Patient Record Update                NO New Order Entry
DA Detailed Allergy/ADR List            IN Intervention Menu
VP View Profile
Select Action: View Profile//
```

The nurse can now enter a Patient Action at the "Select Action: View Profile//" prompt in the Action Area of the screen.

4.2. Non-Verified/Pending Orders
[PSJU VBW]

The *Non-Verified/Pending Orders* option allows easy identification and processing of non-verified and/or pending orders. This option will also show pending and pending renewal orders, which are orders from CPRS that have not been finished by Pharmacy Service. Unit Dose and IV orders are displayed using this option.

The first prompt is "Display an Order Summary? NO// ". A **YES** answer will allow the nurse to view an Order Summary of Pending/Non-Verified Order Totals by Ward Group. The Pending Fluids, Pending IV, Pending Unit Dose, and Non-Verified totals are then listed by ward group.

Example: Non-Verified/Pending Orders

```
Select Unit Dose Medications Option: NON-Verified/Pending Orders
Display an Order Summary? NO// YES

Searching for Pending and Non-Verified orders..................................
```

```
                Pending/Non-Verified Order Totals by Ward Group

                             Pending       Pending       Pending
Ward Group                    Fluids            IV     Unit Dose  Non-Verified

SOUTH WING                         0            25             6            25
^OTHER                             0             1             0             0


1) Non-Verified Orders
2) Pending Orders

Select Order Type(s) (1-2): 1
```

The next prompt allows the user to select non-verified and/or pending orders for a ward group (**G**), ward (**W**), or single patient (**P**). If ward or ward groups is selected, patients will be listed by wards and then by teams. The user will then select the patient from the list.

```
1) Non-Verified Orders
2) Pending Orders

Select Order Type(s) (1-2): 1

Select by WARD GROUP (G), WARD (W), or PATIENT (P): GROUP

Select WARD GROUP: SOUTH WING
PHARMACY     HOME
...a few moments, please............
```

```
ORDERS NOT VERIFIED BY A NURSE - 1 EAST

 No.   TEAM                      PATIENT
--------------------------------------------------------------------------------
   1  TEAM A               BUTTONS,RED (0001)
   2  Not Found            ABC,PATIENT (9111)
   3  Not Found            BYROM,BUZZY (1111)
   4  Not Found            CHUNDLER,BILLY (2333)
   5  Not Found            COLNER,ANTHONY (7782)
Select 1 - 5: 2
```

----------report continues----------

Example: Non-Verified/Pending Orders (continued)

```
ORDERS NOT VERIFIED BY A NURSE - 2 EAST

 No.   TEAM                      PATIENT
-------------------------------------------------------------------------------
   1  Not Found            ANGEL,JOHNNY (5066)
   2  Not Found            BING,CHANDLER (3378)
   3  Not Found            CARR,DAVE (7289)
   4  Not Found            GUMP,BUBBA (2321)
Select 1 - 4: <Enter>

SHORT, LONG, or NO Profile?  SHORT// <Enter>  SHORT
```

A profile prompt is displayed asking the nurse to choose a profile for the patient. The user can choose a short, long, or no profile. If **NO** profile is chosen, the orders for the patient selected will be displayed, for finishing or verification, by login date with the earliest date showing first. When a Unit Dose order has a STAT priority, this order will always be displayed first in the order view and will be displayed in blinking reverse video. If a profile is chosen, the orders will be selected from this list for processing (any order may be selected). The following example displays a short profile.

Example: Short Profile

```
Non-Verified/Pending Orders   Sep 12, 2000 10:18:17          Page:    1 of    2
ABC,PATIENT                      Ward: 1 EAST
   PID: 123-45-9111          Room-Bed: B-12        Ht(cm): ______ (________)
   DOB: 08/18/20 (80)                              Wt(kg): ______ (________)
   Sex: MALE                                     Admitted: 05/03/00
    Dx: TESTING                          Last transferred: ********

 - - - - - - - - - - - - - - - - - - A C T I V E - - - - - - - - - - - - - - - - -
   1    AMPICILLIN 1 GM                        C  09/07  09/14  A
        in 0.9% NACL 100 ML QID
   2 -> AMPICILLIN CAP INJ                     C  09/07  09/21  A
          Give: 250MG PO QID
   3 -> HYDROCORTISONE CREAM,TOP               C  09/07  09/21  A
          Give: 1% TOP QD
   4    MULTIVITAMINS 5 ML                     C  09/07  09/12  A
        in 0.9% NACL 1000 ML 20 ml/hr
   5 -> PROPRANOLOL 10MG U/D                   C  09/07  09/21  A
          Give:  PO QD
 - - - - - - - - - - - - - - -  P E N D I N G  - - - - - - - - - - - - - - - - -
+         Enter ?? for more actions
PI  Patient Information                SO  Select Order
PU  Patient Record Update              NO  New Order Entry
Select Action: Next Screen//  <Enter>    NEXT SCREEN

----------------------------------------report continues----------------------------------------
```

Example: Short Profile (continued)

```
Non-Verified/Pending Orders   Sep 12, 2000 10:23:33          Page:    2 of    2
ABC,PATIENT                       Ward: 1 EAST
   PID: 123-45-9111          Room-Bed: B-12        Ht(cm): ______ (________)
   DOB: 08/18/20 (80)                              Wt(kg): ______ (________)
   Sex: MALE                                     Admitted: 05/03/00
    Dx: TESTING                            Last transferred: ********
+
   6    MULTIVITAMINS INJ                        ?  *****  *****  P
          Give: Doctor's order.
   7    PROPRANOLOL TAB                          ?  *****  *****  P
          Give: 10MG PO TID
   8    TIMOLOL 0.25% SOLN,OPH                   ?  *****  *****  P   NF
          Give: 0.25% TOP OPH BID

          Enter ?? for more actions
PI  Patient Information                 SO  Select Order
PU  Patient Record Update               NO  New Order Entry
Select Action: Quit//
```

The nurse can now enter a Patient Action at the "Select Action: Quit//" prompt in the Action Area of the screen or choose a specific order or orders.

Nurses cannot take any actions on IV orders.

When the nurse holds the PSJ RNFINISH key, it will be possible to finish Unit Dose orders.

When the nurse holds the PSJ RNURSE key, it will be possible to verify non-verified orders.

4.3. Inpatient Order Entry
[PSJ OE]

The *Inpatient Order Entry* option, if assigned, allows the nurse to create, edit, renew, hold, and discontinue Unit Dose and IV orders, as well as put existing IV orders on call for any patient, while remaining in the Unit Dose module.

When the user accesses the *Inpatient Order Entry* option from the Unit Dose module for the first time within a session, a prompt is displayed to select the IV room in which to enter orders. When only one active IV room exists, the system will automatically select that IV room. The user is then given the label and report devices defined for the IV room chosen. If no devices have been defined, the user will be given the opportunity to choose them. If this option is exited and then re-entered within the same session, the current label and report devices are shown. The following example shows the option re-entered during the same session.

Example: Inpatient Order Entry

```
Select Unit Dose Medications Option: IOE  Inpatient Order Entry

You are signed on under the BIRMINGHAM ISC IV ROOM

Current IV LABEL device is: NT TELNET TERMINAL

Current IV REPORT device is: NT TELNET TERMINAL

Select PATIENT: ABC or A9111
```

At the "Select PATIENT:" prompt, the user can enter the patient's name or enter the first letter of the patient's last name and the last four digits of the patient's social security number (e.g. A9111). The Patient Information Screen is displayed:

Example: Patient Information Screen

```
Patient Information           Sep 12, 2000 10:36:38          Page:    1 of    1
ABC,PATIENT                       Ward: 1 EAST
   PID: 123-45-9111          Room-Bed: B-12        Ht(cm):        (        )
   DOB: 08/18/20 (80)                              Wt(kg): ______ (________)
   Sex: MALE                                     Admitted: 05/03/00
    Dx: TESTING                            Last transferred: ********

 Allergies/Reactions:
 Inpatient Narrative: INP NARR...
Outpatient Narrative:





          Enter ?? for more actions
PU Patient Record Update                NO New Order Entry
DA Detailed Allergy/ADR List            IN Intervention Menu
VP View Profile
Select Action: View Profile//
```

The nurse can now enter a Patient Action at the "Select Action: View Profile//" prompt in the Action Area of the screen.

4.4. Patient Actions

The Patient Actions are the actions available in the Action Area of the List Manager Screen. These actions pertain to the patient information and include editing, viewing, and new order entry.

4.4.1. Patient Record Update

The Patient Record Update action allows editing of the Inpatient Narrative and the Patient's Default Stop Date and Time for Unit Dose Order entry.

Example: Patient Record Update

```
Patient Information           Sep 12, 2000 14:39:07          Page:    1 of    1
ABC,PATIENT                      Ward: 1 EAST
   PID: 123-45-9111          Room-Bed: B-12        Ht(cm): ______ (________)
   DOB: 08/18/20 (80)                              Wt(kg): ______ (________)
   Sex: MALE                                     Admitted: 05/03/00
    Dx: TESTING                            Last transferred: ********

 Allergies/Reactions:
 Inpatient Narrative: INP NARR …
Outpatient Narrative:
```

```
          Enter ?? for more actions
PU Patient Record Update                NO New Order Entry
DA Detailed Allergy/ADR List            IN Intervention Menu
VP View Profile
Select Action: View Profile// PU
INPATIENT NARRATIVE: INP NARR...// Narrative for Patient ABC
UD DEFAULT STOP DATE/TIME: SEP 21,2000@24:00//
```

The "INPATIENT NARRATIVE: INP NARR...//" prompt allows the nurse to enter information in a free text format, up to 250 characters.

The "UD DEFAULT STOP DATE/TIME:" prompt is the date and time entry to be used as the default value for the STOP DATE/TIME of the Unit Dose orders during order entry and renewal processes. This value is used only if the corresponding ward parameter is enabled. The order entry and renewal processes will sometimes change this date and time.

When the SAME STOP DATE ON ALL ORDERS parameter is set to yes, the module will assign the same default stop date for each patient. This date is initially set when the first order is entered for the patient, and can change when an order for the patient is renewed. This date is shown as the default value for the stop date of each of the orders entered for the patient.

Note: If this parameter is not enabled, the user can still edit a patient's default stop date. Unless the parameter is enabled, the default stop date will not be seen or used by the module.

Examples of Valid Dates and Times:

- JAN 20 1957 or 20 JAN 57 or 1/20/57 or 012057
- T (for TODAY), T+1 (for TOMORROW), T+2, T+7, etc.
- T-1 (for YESTERDAY), T-3W (for 3 WEEKS AGO), etc.
- If the year is omitted, the computer uses CURRENT YEAR. Two-digit year assumes no more than 20 years in the future, or 80 years in the past.
- If only the time is entered, the current date is assumed.
- Follow the date with a time, such as JAN 20@10, T@10AM, 10:30, etc.
- The nurse may enter a time, such as NOON, MIDNIGHT, or NOW.
- The nurse may enter NOW+3' (for current date and time Plus 3 minutes *Note--the Apostrophe following the number of minutes)
- Time is REQUIRED in this response.

4.4.2. New Order Entry

The New Order Entry action allows the nurse to enter new Unit Dose and IV orders for the patient depending upon the order option selected (*Order Entry*, *Non-Verified Pending Orders*, or *Inpatient Order Entry*). Only one user is able to enter new orders on a selected patient due to the patient lock within the **V***IST***A** applications. This minimizes the chance of duplicate orders.

Unit Dose

For Unit Dose order entry, a response must be entered at the "Select DRUG:" prompt. The nurse can select a particular drug or enter a pre-defined order set.

Depending on the entry in the "Order Entry Process:" prompt in the *Inpatient User Parameters Edit* option, the nurse will enter a regular or abbreviated order entry process. The abbreviated order entry process requires entry into fewer fields than regular order entry. Beside each of the prompts listed below, in parentheses, will be the word regular, for regular order entry and/or abbreviated, for abbreviated order entry.

- **"Select DRUG:"** (Regular and Abbreviated)

Nurses select Unit Dose medications directly from the DRUG file. The Orderable Item for the selected drug will automatically be added to the order, and all Dispense Drugs entered for the order must be linked to that Orderable Item. If the Orderable Item is edited, data in the DOSAGE ORDERED field and the DISPENSE DRUG field will be deleted. If multiple Dispense Drugs are needed in an order, they may be entered by selecting the DISPENSE DRUG field from the edit list before accepting the new order. After each Dispense Drug is selected, it will be checked against the patient's current medications for duplicate drug or class, and drug-drug/drug-allergy interactions. (See Section 4.9 Order Check for more information.)

The nurse can enter an order set at this prompt. An order set is a group of pre-written orders. The maximum number of orders is unlimited. Order sets are created and edited using the *Order Set Enter/Edit* option found under the *Supervisor's Menu*.

Order sets are used to expedite order entry for drugs that are dispensed to all patients in certain medical practices or for certain procedures. Order sets are designed to be used when a recognized pattern for the administration of drugs can be identified. For example:

- A pre-operative series of drugs administered to all patients undergoing a certain surgical procedure.
- A certain series of drugs to be dispensed to all patients prior to undergoing a particular radiographic procedure.
- A certain group of drugs, prescribed by a provider for all patients, that is used for treatment on a certain medical ailment or emergency.

Order sets allow rapid entering of this repetitive information, expediting the whole order entry process. Experienced users might want to set up most of their common orders as order sets.

Order set entry begins like other types of order entry. At the "Select DRUG:" prompt, **S.NAME** should be entered. The **NAME** represents the name of a predefined order set. The characters **S.** tell the software that this will not be a single new order entry for a single drug but a set of orders for multiple drugs. The **S.** is a required prefix to the name of the order set. When the user types the characters **S.?**, a list of the names of the order sets that are currently available will be displayed. If **S.** (<**Spacebar**> and <**Enter**>) is typed, the previous order set is entered.

After the entry of the order set, the software will prompt for the Provider's name and Nature of Order. After entry of this information, the first order of the set will automatically be entered. The options available are different depending on the type of order entry process that is enabled– regular, abbreviated, or ward. If regular or abbreviated order entry is enabled, the user will be shown one order at a time, all fields for each order of the order set and then the "Select Item(s): Next Screen //" prompt.

The user can then choose to take an action on the order. Once an action is taken or bypassed, the next order of the order set will be entered automatically. After entry of all the orders in the order set, the software will prompt for more orders for the patient. At this point the user can proceed exactly as in new order entry, and respond accordingly.

When a drug is chosen, if an active drug text entry for the Dispense Drug and/or Orderable Item linked to this drug exists, then the prompt, "Restriction/Guideline(s) exist. Display?:" will be displayed along with the corresponding defaults. The drug text indicator will be <**DIN**> and will be displayed on the right hand corner on the same line as the Orderable Item. This indicator will be highlighted.

If the Dispense Drug or Orderable Item has a non-formulary status, this status will be displayed on the screen as "*N/F*" beside the Dispense Drug or Orderable Item.

- **"DOSAGE ORDERED:"** (Regular and Abbreviated

To allow pharmacy greater control over the order display shown for Unit Dose orders on profiles, labels, MARs, etc., the DOSAGE ORDERED field is not required if only one Dispense Drug exists in the order. If more than one Dispense Drug exists for the order, then this field is required.

When a Dispense Drug is selected, the selection list/default will be displayed based on the Possible Dosages and Local Possible Dosages.

Example: Dispense Drug with Possible Dosages

```
Select DRUG:    BACLOFEN 10MG TABS         MS200
         ...OK? Yes//  <Enter> (Yes)


Available Dosage(s)
      1.    10MG
      2.    20MG

Select from list of Available Dosages or Enter Free Text Dose: 1  10MG

You entered 10MG is this correct? Yes//  <Enter>
```

All Local Possible Dosages will be displayed within the selection list/default.

Example: Dispense Drug with Local Possible Dosages

```
Select DRUG:    GENTAMICIN  CREAM 15GM         DE101         DERM CLINIC ONLY
         ...OK? Yes// <Enter>  (Yes)


Available Dosage(s)
      1.    SMALL AMOUNT
      2.    THIN FILM

Select from list of Available Dosages or Enter Free Text Dose: 2  THIN FILM

You entered THIN FILM is this correct? Yes//  <Enter>
```

Note: If an order contains multiple Dispense Drugs, Dosage Ordered should contain the total dosage of the medication to be administered.

The user has the flexibility of how to display the order view on the screen. When the user has chosen the drug and when no Dosage Ordered is defined for an order, the order will be displayed as:

Example: Order View Information when Dosage Ordered is not Defined

```
DISPENSE DRUG NAME
Give: UNITS PER DOSE  MEDICATION ROUTE  SCHEDULE
```

When the user has chosen the drug and Dosage Ordered is defined for the order, it will be displayed as:

Example: Order View Information when Dosage Ordered is Defined

```
ORDERABLE ITEM NAME  DOSE FORM
Give: DOSAGE ORDERED  MEDICATION ROUTE  SCHEDULE
```

The DOSAGE ORDERED and the UNITS PER DOSE fields are modified to perform the following functionality:

- Entering a new backdoor order:
  1. If the Dosage Ordered entered is selected from the Possible Dosages or the Local Possible Dosages, the user will not be prompted for the Units Per Dose. Either the BCMA Units Per Dose or the Dispense Units Per Dose, defined under the Dispense Drug, will be used as the default for the Units Per Dose.

  2. If a free text dose is entered for the Dosage Order, the user will be prompted for the Units Per Dose. A warning message will display when the entered Units Per Dose does not seem to be compatible with the Dosage Ordered. The user will continue with the next prompt.

- Finishing pending orders:
  1. If the Dosage Ordered was selected from the Possible Dosages or the Local Possible Dosages, either the BCMA Units Per Dose or the Dispense Units Per Dose, defined under the Dispense Drug, will be used as the default for the Units Per Dose.

  2. If a free text dose was entered for the pending order, the UNITS PER DOSE field will default to 1. A warning message will display when the Units Per Dose does not seem to be compatible with the Dosage Ordered when the user is finishing/verifying the order.

- Editing order:
  1. Any time the DOSAGE ORDERED or the UNITS PER DOSE field is edited, a check will be performed and a warning message will display when the Units Per Dose does not seem to be compatible with the Dosage Ordered. Neither field will be automatically updated.

Note: There will be no Dosage Ordered check against the Units Per Dose if a Local Possible Dosage is selected.

- **"UNITS PER DOSE:"** (Regular)

This is the number of units (tablets, capsules, etc.) of the selected Dispense Drug to be given when the order is administered.

When a selection is made from the dosage list provided at the "DOSAGE ORDERED:" prompt, then this "UNITS PER DOSE:" prompt will not be displayed unless the selection list/default contains Local Possible Dosages. If a numeric dosage is entered at the "DOSAGE ORDERED:" prompt, but not from the selection list, then the default for "UNITS PER DOSE:" will be calculated as follows: DOSAGE ORDERED/STRENGTH = UNITS PER DOSE and will not be displayed.

If free text or no value is entered at the "DOSAGE ORDERED:" prompt, the "UNITS PER DOSE:" prompt will be displayed. When the user presses <**Enter**> past the "UNITS PER DOSE:" prompt, without entering a value, a "1" will be stored. A warning message will be generated when free text is entered at the "DOSAGE ORDERED:" prompt and no value or an incorrect value is entered at the "UNITS PER DOSE:" prompt.

- **"MED ROUTE:"** (Regular and Abbreviated)

This is the route of administration to be used for the order. If a Medication Route is identified for the selected Orderable Item, it will be used as the default for the order.

- **"SCHEDULE TYPE:"** (Regular)

This defines the type of schedule to be used when administering the order. If the Schedule Type entered is one-time, the ward parameter, DAYS UNTIL STOP FOR ONE-TIME, is accessed to determine the stop date. When the ward parameter is not available, the system parameter, DAYS UNTIL STOP FOR ONE-TIME, will be used to determine the stop date. When neither parameter has been set, one-time orders will use the ward parameter, DAYS UNTIL STOP DATE/TIME, to determine the stop date instead of the start and stop date being equal.

When a new order is entered or an order entered through CPRS is finished by pharmacy, the default Schedule Type is determined as described below:

- If the schedule is found in the ADMINISTRATION SCHEDULE file and the Schedule Type for that schedule is defined as ONE TIME, then the Schedule Type is ONE TIME.

- If no Schedule Type has been found and the schedule is “TODAY”, “NOW”, “STAT”, “ONCE”, “ONE TIME”, “ONE-TIME”, “ONETIME”, “1TIME”, “1 TIME”, or “1-TIME”, the Schedule Type is ONE-TIME.

- If no Schedule Type has been found and a Schedule Type is defined for the selected Orderable Item, that Schedule Type is used for the order.

- If no Schedule Type has been found and the schedule contains PRN, the Schedule Type is PRN.

- If no Schedule Type has been found and the schedule is “ON CALL”, “ON-CALL” or “ONCALL”, the Schedule Type is ON CALL.

- For all others, the Schedule Type is CONTINUOUS.

Note: During backdoor order entry, the Schedule Type entered is used unless the schedule is considered a ONE-TIME schedule. In that case, the Schedule Type is changed to ONE TIME.

- **“SCHEDULE:”** (Regular and Abbreviated)

This defines the frequency the order is to be administered. Schedules may be selected from the ADMINISTRATION SCHEDULE file or Non-Standard Schedules may be used. A Non-Standard Schedule is one that does not have a consistent interval between administrations. This field allows up to two spaces to be entered, (Ex. TID PC PRN). Unit Dose and IV recognizes Schedules in the following formats:

- QxH - Hourly Schedules where x is the number of hours between administrations

- QxD - Daily Schedules where x is the number of days between administrations

- QxM - Monthly Schedules where x is the number of months between administrations

While entering a new order, if a Schedule is defined for the selected Orderable Item, that Schedule is displayed as the default for the order.

- **"ADMINISTRATION TIMES:"** (Regular)

This defines the time(s) of day the order is to be given. If the schedule for the order contains "PRN", all Administration Times for the order will be ignored. In new order entry, the default Administration Times are determined as described below:

  - If Administration Times are defined for the selected Orderable Item, they will be shown as the default for the order.
  - If Administration Times are defined in the INPATIENT WARD PARAMETERS file for the patient's ward and the order's schedule, they will be shown as the default for the order.
  - If Administration Times are defined for the Schedule, they will be shown as the default for the order.

- **"SPECIAL INSTRUCTIONS:"** (Regular and Abbreviated)

These are the Special Instructions (using abbreviations whenever possible) needed for the administration of this order. This field utilizes the abbreviations and expansions from the MEDICATION INSTRUCTION file.

- **"START DATE/TIME:"** (Regular and Abbreviated)

This is the date and time the order is to begin. This package initially assigns the Start Date/Time to the CLOSEST ADMINISTRATION TIME, NEXT ADMINISTRATION TIME or NOW (which is the login date/time of the order), depending on the value of the DEFAULT START DATE CALCULATION field in the INPATIENT WARD PARAMETERS file. Start Date/Time may not be entered prior to 7 days from the order's Login Date.

- **"STOP DATE/TIME:"** (Regular)

This is the date and time the order will automatically expire. This package initially calculates a default Stop Date/Time, depending on the INPATIENT WARD PARAMETERS file except for one-time orders. For a one-time order, the ward parameter, DAYS UNTIL STOP FOR ONE-TIME, is accessed. When this parameter is not available, the system parameter, DAYS UNTIL STOP FOR ONE-TIME, will be used to determine the stop date. When neither parameter has been set, the ward parameter, DAYS UNTIL STOP DATE/TIME, will be used instead of the start and stop date being equal.

- **"PROVIDER:"** (Regular and Abbreviated)

This identifies the provider who authorized the order. Only users identified as active Providers, who are authorized to write medication orders, may be selected.

- **"SELF MED:"** (Regular and Abbreviated)

Identifies the order as one whose medication is to be given for administration by the patient. This prompt is only shown if the 'SELF MED' IN ORDER ENTRY field of the INPATIENT WARD PARAMETERS file is set to on.

- **"NATURE OF ORDER:"** (Regular and Abbreviated)

This is the method the provider used to communicate the order to the user who entered or took action on the order. Nature of Order is defined in CPRS. Written will be the default for new orders entered. When a new order is created due to an edit, the default will be Service Correction. The following table shows some Nature of Order examples.

Nature of Order	Description	Prompted for Signature in CPRS	Chart Copy Printed?
Written	The source of the order is a written doctor's order	No	No
Verbal	A doctor verbally requested the order	Yes	Yes
Telephoned	A doctor telephoned the service to request the order	Yes	Yes
Service Correction	The service is discontinuing or adding new orders to carry out the intent of an order already received	No	No
Duplicate	This applies to orders that are discontinued because they are a duplicate of another order	No	Yes
Policy	These are orders that are created as a matter of hospital policy	No	Yes

Example: New Order Entry

```
Patient Information           Feb 14, 2001 10:21:33          Page:    1 of    1
ABC,PATIENT                      Ward: 1 EAST
   PID: 123-45-9111          Room-Bed:             Ht(cm): ______ (________)
   DOB: 08/18/20 (80)                              Wt(kg): ______ (________)
   Sex: MALE                                     Admitted: 11/07/00
    Dx: TEST                              Last transferred: ********

 Allergies/Reactions:
 Inpatient Narrative: Narrative for Patient ABC
Outpatient Narrative:
```

```
          Enter ?? for more actions
PU Patient Record Update                NO New Order Entry
DA Detailed Allergy/ADR List            IN Intervention Menu
VP View Profile
Select Action: View Profile// NO   New Order Entry

Select DRUG: POT
     1   POTASSIUM CHLORIDE 10 mEq U/D TABLET           TN403
     2   POTASSIUM CHLORIDE 10% 16 OZ           TN403     N/F       BT
     3   POTASSIUM CHLORIDE 20% 16 OZ           TN403     N/F
     4   POTASSIUM CHLORIDE 20MEQ PKT           TN403         UNIT DOSE   INPAT
     5   POTASSIUM CHLORIDE 2MEQ/ML INJ 20ML VIAL           TN403     N/F
Press <RETURN> to see more, '^' to exit this list, OR
CHOOSE 1-5: 1  POTASSIUM CHLORIDE 10 mEq U/D TABLET         TN403
      1.    10
      2.    20
DOSAGE ORDERED (IN MEQ): 1

You entered 10MEQ is this correct? Yes//  <Enter> YES
MED ROUTE: ORAL// <Enter>  PO
SCHEDULE TYPE: CONTINUOUS//  <Enter> CONTINUOUS
SCHEDULE: BID      08-16
ADMIN TIMES: 08-16// <Enter>
SPECIAL INSTRUCTIONS: <Enter>
START DATE/TIME: FEB 14,2001@16:00//  <Enter> FEB 14,2001@16:00
STOP DATE/TIME: FEB 23,2001@24:00//   <Enter> FEB 23,2001@24:00
PROVIDER: INPATIENT-MEDS,PROVIDER// <Enter>
```

----------report continues----------

Example: New Order Entry (continued)

```
NON-VERIFIED UNIT DOSE        Feb 14, 2001 10:23:37          Page:    1 of    2
ABC,PATIENT                      Ward: 1 EAST
   PID: 123-45-9111          Room-Bed:             Ht(cm): ______ (________)
   DOB: 08/18/20 (80)                              Wt(kg):        (         )

  (1)Orderable Item: POTASSIUM CHLORIDE TAB,SA
       Instructions:
  (2)Dosage Ordered: 10MEQ
                                                        (3)Start: 02/14/01  16:00
  (4)     Med Route: ORAL
                                                        (5) Stop: 02/23/01  24:00
  (6) Schedule Type: CONTINUOUS
  (8)      Schedule: BID
  (9)   Admin Times: 08-16
 (10)      Provider: INPATIENT-MEDS,PROVIDER            (7)Self Med: NO
 (11) Special Instructions:

 (12) Dispense Drug                                  U/D        Inactive Date
      POTASSIUM CHLORIDE 10 mEq U/D TABLET           1

+         Enter ?? for more actions
ED  Edit                              AC  ACCEPT
Select Item(s): Next Screen// AC   ACCEPT
NATURE OF ORDER: WRITTEN// <Enter>

...transcribing this non-verified order....
```

```
NON-VERIFIED UNIT DOSE        Feb 14, 2001 10:24:52          Page:    1 of    2
ABC,PATIENT                      Ward: 1 EAST
   PID: 123-45-9111          Room-Bed:             Ht(cm): ______ (________)
   DOB: 08/18/20 (80)                              Wt(kg): ______ (________)

 *(1)Orderable Item: POTASSIUM CHLORIDE TAB,SA
       Instructions:
 *(2)Dosage Ordered: 10MEQ
                                                        (3)Start: 02/14/01  16:00
 *(4)     Med Route: ORAL
                                                        (5) Stop: 02/23/01  24:00
  (6) Schedule Type: CONTINUOUS
 *(8)      Schedule: BID
  (9)   Admin Times: 08-16
*(10)      Provider: INPATIENT-MEDS,PROVIDER            (7)Self Med: NO
 (11) Special Instructions:

 (12) Dispense Drug                                  U/D        Inactive Date
POTASSIUM CHLORIDE 10 mEq U/D TABLET           1
+         Enter ?? for more actions
DC  Discontinue           ED  Edit                  VF  Verify
HD  (Hold)                RN  (Renew)               AL  Activity Logs
Select Item(s): Next Screen// VF   Verify
...a few moments, please.....

Pre-Exchange DOSES: <Enter>

ORDER VERIFIED.

Enter RETURN to continue or '^' to exit:
```

IV

For IV order entry, the nurse must bypass the "Select DRUG:" prompt (by pressing <**Enter**>) and then choosing the IV Type at the "Select IV TYPE:" prompt. The following are the prompts that the nurse can expect to encounter while entering a new IV order for the patient.

This option is only available to those nurses who have Inpatient Order Entry access.

- **"Select IV TYPE:"**

These types include admixture, piggyback, hyperal, syringe, or chemotherapy. An admixture is a Large Volume Parenteral (LVP solution intended for continuous parenteral infusion. A piggyback is a small volume parenteral solution used for intermittent infusion. Hyperalimentation (hyperal) is long-term feeding of a protein-carbohydrate solution. A syringe type order is a type of IV that uses a syringe rather than a bottle or bag. Chemotherapy is the treatment and prevention of cancer with chemical agents and can be administered as a syringe, admixture, or a piggyback.

.

- **"Select ADDITIVE:"**

There can be any number of additives for an order, including zero. An additive or additive synonym can be entered. If the Information Resources Management Service (IRMS) Chief/Site Manager or Application Coordinator has defined it in the IV ADDITIVES file, the nurse may enter a quick code for an additive. The quick code allows the user to pre-define certain fields, thus speeding up the order entry process. The **entire** quick code name must be entered to receive all pre-defined fields in the order.

Note: Drug inquiry is allowed during order entry by entering two question marks (??) at the STRENGTH prompt for information on an additive or solution.

When an additive is chosen, if an active drug text entry for the Dispense Drug and/or Orderable Item linked to this additive exists, then the prompt, "Restriction/Guideline(s) exist. Display?:" will be displayed along with the corresponding defaults. The drug text indicator will be <**DIN**> and will be displayed on the right side of the IV Type on the same line. This indicator will be highlighted.

If the Dispense Drug tied to the Additive or the Orderable Item has a non-formulary status, this status will be displayed on the screen as "*N/F*" beside the Additive or Orderable Item.

- **"Select SOLUTION:"**

There can be any number of solutions in an order, depending on the type. It is even possible to require zero solutions when an additive is pre-mixed with a solution. If no solutions are chosen, the system will display a warning message, in case it is an oversight, and gives the opportunity to add one. The nurse may enter an IV solution or IV solution synonym.

When a solution is chosen, if an active drug text entry for the Dispense Drug and/or Orderable Item linked to this solution exists, then the prompt, "Restriction/Guideline(s) exist. Display?:" will be displayed along with the corresponding defaults. The drug text indicator will be <**DIN**> and will be displayed on the right side of the IV Type on the same line. This indicator will be highlighted.

If the Dispense Drug tied to the Solution or the Orderable Item has a non-formulary status, this status will be displayed on the screen as "*N/F*" beside the Solution or Orderable Item.

- **"INFUSION RATE:"**

The infusion rate is the rate at which the IV is to be administered. This value, in conjunction with the total volume of the hyperal or the admixture type, is used to determine the time covered by one bag; hence, the system can predict the bags needed during a specified time of coverage. This field is free text for piggybacks. For admixtures, a number that will represent the infusion rate must be entered. The nurse can also specify the # of bags per day that will be needed. Example: 125 = 125 ml/hr (IV system will calculate bags needed per day), 125@2 = 125 ml/hr with 2 labels per day, Titrate@1 = Titrate with 1 label per day. The format of this field is either a number only or <FREE TEXT > @ <NUMBER OF LABELS PER DAY > (e.g., Titrate @ 1).

Note: If an administration time(s) is defined, the number of labels will reflect the administration time(s) for the IVPB type orders. Example: one administration time of 12:00 is specified. The infusion rate is entered as 125@3. Only 1 label will print.

- **"MED ROUTE:"**

This is the route of administration for this medication (e.g., IV, SQ). If a corresponding abbreviation is found for this route in the MEDICATION ROUTES file, this module will print that abbreviation on its reports.

- **"SCHEDULE:"**

This prompt occurs on piggyback and intermittent syringe orders. A schedule prompt is a request to queue doses on a recurring basis. For instance, a response to the schedule prompt may be **Q5H**, which would be a request to give doses every five hours. If a non-standard schedule and non-standard administration times are entered, the IV integrity checker will flag this field with a warning and give the nurse an opportunity to re-edit. This field allows up to two spaces to be entered, (Ex. TID PC PRN).

Note: It might be inappropriate for some orders with non-standard schedules to be given administration times. For example, the administration times for Q18H (every 18 hours) will vary.

- **"ADMINISTRATION TIME:"**

This is free text. The nurse should enter the times of dose administration using military time such as 03-09-15-21.

- **"START DATE / TIME:"**

The system calculates the default start date/time for order administration based on the DEFAULT START DATE CALCULATION field in the INPATIENT WARD PARAMETERS file. This field allows the site to use the NEXT or CLOSEST administration or delivery time, or NOW, which is the order's login date/time as the default start date. When NOW is selected for this parameter, it will always be the default start date/time for IVs. This may be overridden by entering the desired date/time at the prompt.

When NEXT or CLOSEST is used in this parameter and the IV is a continuous-type IV order, the default answer for this prompt is based on the delivery times for the IV room specified for that order entry session. For intermittent type IV orders, if the order has administration times, the start date/time will be the NEXT or CLOSEST administration time depending on the parameter. If the intermittent type IV order does not have administration times, the start date/time will round up or down to the closest hour. The Site Manager or Application Coordinator can change this field.

- **"STOP DATE / TIME:"**

The system calculates the default stop date/time for order administration based on the STOP TIME FOR ORDER site parameter. The default date shown is the least of (1) the <IV TYPE> GOOD FOR HOW MANY DAYS site parameter (where <IV TYPE> is LVPs, PBs, etc.), or (2) the NUMBER OF DAYS FOR IV ORDER field (found in the IV ADDITIVES file) for all additives in this order. The Site Manager or Application Coordinator can change these fields.

- **"NATURE OF ORDER:"**

This is the method the provider used to communicate the order to the user who entered or took action on the order. Nature of Order is defined in CPRS. Written will be the default for new orders entered. When a new order is created due to an edit, the default will be Service Correction. The following table shows some Nature of Order examples.

Nature of Order	Description	Prompted for Signature in CPRS?	Chart Copy Printed?
Written	The source of the order is a written doctor's order	No	No
Verbal	A doctor verbally requested the order	Yes	Yes
Telephoned	A doctor telephoned the service to request the order	Yes	Yes
Service Correction	The service is discontinuing or adding new orders to carry out the intent of an order already received	No	No
Duplicate	This applies to orders that are discontinued because they are a duplicate of another order	No	Yes
Policy	These are orders that are created as a matter of hospital policy	No	Yes

- **"Select CLINIC LOCATION:"**

This prompt is only displayed for Outpatient IV orders entered through the Inpatient Medications package. The user will enter the hospital location name when prompted.

Example: New Order Entry

```
Inpatient Order Entry         Sep 28, 2000 14:59:35          Page:    1 of    1
ABC,PATIENT                      Ward: 1 EAST
   PID: 123-45-9111          Room-Bed: B-12        Ht(cm): ______ (________)
   DOB: 08/18/20 (80)                              Wt(kg): ______ (________)
   Sex: MALE                                     Admitted: 05/03/00
    Dx: TESTING                           Last transferred: ********

- - - - - - - - - - - - - - - N O N - V E R I F I E D - - - - - - - - - - - - - -
   1  ->PROPRANOLOL TAB                          C  09/28  10/12  N
         Give: 10MG PO TID
 - - - - - - - - - - - - - - - -  P E N D I N G  - - - - - - - - - - - - - - - -
   2    AMPICILLIN INJ                           ?  *****  *****  P
         Give: 1MG IVPB QID
```

```
         Enter ?? for more actions
PI  Patient Information                SO  Select Order
PU  Patient Record Update              NO  New Order Entry
Select Action: Quit// NO   New Order Entry

Select DRUG: <Enter>

Select IV TYPE: PIGGYBACK.
Select ADDITIVE: MULTIVITAMINS
              MIX-A-VIAL
  Restriction/Guideline(s) exist.  Display? :  (N/O): No// <Enter>  NO

(The units of strength for this additive are in ML)
Strength: 1 ML
Select ADDITIVE: <Enter>
Select SOLUTION: 0.9
     1   0.9% NACL           500 ML

     2   0.9% NACL           100 ML

     3   0.9% NACL           50 ML

     4   0.9% NaCl           250 ML
              BT
CHOOSE 1-4: 1  0.9% NACL          500 ML
INFUSION RATE: <Enter>
MED ROUTE: IV//IVPB  IV PIGGYBACK     IVPB
SCHEDULE: QID
     1   QID    01-09-15-20
     2   QID PC FAR    09-13-17-21
CHOOSE 1-2: 1      01-09-15-20
ADMINISTRATION TIMES: 01-09-15-20// <Enter>
REMARKS: <Enter>
OTHER PRINT INFO: <Enter>
START DATE/TIME: SEP 28,2000@20:00// T@2100  (SEP 28, 2000@21:00)
STOP DATE/TIME: OCT 3,2000@16:54//   <Enter>
PROVIDER: INPATIENT-MEDS,PROVIDER//  <Enter>

*** WARNING -- You have not specified an infusion rate.
Enter RETURN to continue or '^' to exit: <Enter>
```

----------report continues----------

After entering the data for the order, the system will prompt the nurse to confirm that the order is correct. The IV module contains an integrity checker to ensure the necessary fields are answered for each type of order. The nurse must edit the order to make corrections if all of these fields are not answered correctly. If the order contains no errors, but has a warning, the user will be allowed to proceed.

Example: New Order Entry (continued)

```
Orderable Item: MULTIVITAMINS INJ
Give: IVPB QID

[336]9111  1 EAST  09/28/00
ABC,PATIENT  B-12

MULTIVITAMINS 1 ML
0.9% NACL 500 ML

Dose due at: ________
QID
01-09-15-20
Fld by: ____  Chkd by: ____
1[1]

Start date: SEP 28,2000 21:00  Stop date: OCT 3,2000 16:54


Is this O.K.:  NO// YES
NATURE OF ORDER: WRITTEN// <Enter>
```

4.4.3. Detailed Allergy/ADR List

The Detailed Allergy/ADR List action displays a detailed listing of the selected item from the patient's Allergy/ADR List. Entry to the *Edit Allergy/ADR Data* option is provided with this list also.

- **Enter/Edit Allergy/ADR Data**
  Provides access to the Adverse Reaction Tracking (ART) package to allow entry and/or edit of allergy adverse reaction data for the patient. See the Allergy package documentation for more information on Allergy/ADR processing.

- **Select Allergy**
  Allows the user to view a specific allergy.

4.4.4. Intervention Menu

This option is only available to those users who hold the PSJ RPHARM key.

The Intervention Menu action allows entry of new interventions and existing interventions to be edited, deleted, viewed, or printed. Each kind of intervention will be discussed and an example will follow.

- **New**: This option is used to add an entry into the APSP INTERVENTION file.

Example: New Intervention

```
Patient Information          Sep 22, 2000 08:03:07          Page:    1 of    1
XYZ,PATIENT                      Ward: 1 West                          <A>
   PID: 222-32-4321          Room-Bed: A-6         Ht(cm): 167.64 (04/21/99)
   DOB: 02/22/42 (58)                              Wt(kg): 85.00 (04/21/99)
   Sex: MALE                                     Admitted: 09/16/99
    Dx: TEST PATIENT                     Last transferred: ********

Allergies - Verified: CARAMEL, CN900, LOMEFLOXACIN, PENTAMIDINE, PENTAZOCINE,
                        CHOCOLATE, NUTS, STRAWBERRIES, DUST
        Non-Verified: AMOXICILLIN, AMPICILLIN, TAPE, FISH,
                        FLUPHENAZINE DECANOATE

   Adverse Reactions:
 Inpatient Narrative: Inpatient narrative for XYZ
Outpatient Narrative: This is the Outpatient Narrative.


          Enter ?? for more actions
PU Patient Record Update                NO New Order Entry
DA Detailed Allergy/ADR List            IN Intervention Menu
VP View Profile
Select Action: View Profile// IN   Intervention Menu

                       --- Pharmacy Intervention Menu ---

NE   Enter Pharmacy Intervention        DEL  Delete Pharmacy Intervention
ED   Edit Pharmacy Intervention         VW   View Pharmacy Intervention
PRT  Print Pharmacy Intervention

Select Item(s): NE   Enter Pharmacy Intervention
Select APSP INTERVENTION DATE: T   SEP 22, 2000
  Are you adding 'SEP 22, 2000' as a new APSP INTERVENTION (the 155TH)? No// Y
  (Yes)
   APSP INTERVENTION PATIENT: XYZ,PATIENT           08-18-20     123459111     N
SC VETERAN
   APSP INTERVENTION DRUG: WAR
     1   WARFARIN 10MG           BL100         TAB
     2   WARFARIN 10MG U/D           BL100         TAB **AUTO STOP 2D**
     3   WARFARIN 2.5MG           BL100         TAB
     4   WARFARIN 2.5MG U/D           BL100         TAB  **AUTO STOP 2D**
     5   WARFARIN 2MG           BL100         TAB
Press <RETURN> to see more, '^' to exit this list, OR
CHOOSE 1-5: 1  WARFARIN 10MG         BL100         TAB
PROVIDER:    INPATIENT-MEDS,PROVIDER     PROV
INSTITUTED BY: PHARMACY// <Enter>  PHARMACY
INTERVENTION:    ALLERGY
RECOMMENDATION:    NO CHANGE
WAS PROVIDER CONTACTED: N  NO
RECOMMENDATION ACCEPTED: Y  YES
REASON FOR INTERVENTION:
  1>
ACTION TAKEN:
  1>
CLINICAL IMPACT:
  1>
FINANCIAL IMPACT:
  1>

Select Item(s):
```

- **Edit**: This option is used to edit an existing entry in the APSP INTERVENTION file.

Example: Edit an Intervention

```
Patient Information          Sep 22, 2000 08:03:07          Page:    1 of    1
XYZ,PATIENT                      Ward: 1 West                          <A>
   PID: 222-32-4321          Room-Bed: A-6         Ht(cm): 167.64 (04/21/99)
   DOB: 02/22/42 (58)                              Wt(kg): 85.00 (04/21/99)
   Sex: MALE                                     Admitted: 09/16/99
    Dx: TEST PATIENT                     Last transferred: ********

Allergies - Verified: CARAMEL, CN900, LOMEFLOXACIN, PENTAMIDINE, PENTAZOCINE,
                        CHOCOLATE, NUTS, STRAWBERRIES, DUST
        Non-Verified: AMOXICILLIN, AMPICILLIN, TAPE, FISH,
                        FLUPHENAZINE DECANOATE

   Adverse Reactions:
 Inpatient Narrative: Inpatient narrative for XYZ
Outpatient Narrative: This is the Outpatient Narrative.


          Enter ?? for more actions
PU Patient Record Update                NO New Order Entry
DA Detailed Allergy/ADR List            IN Intervention Menu
VP View Profile
Select Action: View Profile// IN   Intervention Menu

                        --- Pharmacy Intervention Menu ---

NE   Enter Pharmacy Intervention        DEL  Delete Pharmacy Intervention
ED   Edit Pharmacy Intervention         VW   View Pharmacy Intervention
PRT  Print Pharmacy Intervention
Select Item(s): ED   Edit Pharmacy Intervention
Select INTERVENTION:T   SEP 22, 2000       XYZ,PATIENT     WARFARIN 10MG
INTERVENTION DATE: SEP 22,2000// <Enter>
PATIENT: XYZ,PATIENT// <Enter>
PROVIDER: INPATIENT-MEDS,PROVIDER// <Enter>
PHARMACIST: INPATIENT-MEDS,PHARMACIST// <Enter>
DRUG: WARFARIN 10MG// <Enter>
INSTITUTED BY: PHARMACY// <Enter>
INTERVENTION: ALLERGY// <Enter>
OTHER FOR INTERVENTION:
  1>
RECOMMENDATION: NO CHANGE// <Enter>
OTHER FOR RECOMMENDATION:
  1>
WAS PROVIDER CONTACTED: NO// <Enter>
PROVIDER CONTACTED:
RECOMMENDATION ACCEPTED: YES// <Enter>
AGREE WITH PROVIDER:
REASON FOR INTERVENTION:

ACTION TAKEN:
  1>
CLINICAL IMPACT:
  1>
FINANCIAL IMPACT:
  1>
```

- **Delete:** This option is used to delete an entry from the APSP INTERVENTION file. The nurse may only delete an entry that was entered on the same day.

Example: Delete an Intervention

```
Patient Information          Sep 22, 2000 08:03:07          Page:    1 of    1
XYZ,PATIENT                     Ward: 1 West                      <A>
   PID: 222-32-4321          Room-Bed: A-6         Ht(cm): 167.64 (04/21/99)
   DOB: 02/22/42 (58)                              Wt(kg): 85.00 (04/21/99)
   Sex: MALE                                     Admitted: 09/16/99
    Dx: TEST PATIENT                     Last transferred: ********

Allergies - Verified: CARAMEL, CN900, LOMEFLOXACIN, PENTAMIDINE, PENTAZOCINE,
                      CHOCOLATE, NUTS, STRAWBERRIES, DUST
        Non-Verified: AMOXICILLIN, AMPICILLIN, TAPE, FISH,
                      FLUPHENAZINE DECANOATE

   Adverse Reactions:
 Inpatient Narrative: Inpatient narrative for XYZ
Outpatient Narrative: This is the Outpatient Narrative.


          Enter ?? for more actions
PU Patient Record Update                NO New Order Entry
DA Detailed Allergy/ADR List            IN Intervention Menu
VP View Profile
Select Action: View Profile// IN   Intervention Menu

                       --- Pharmacy Intervention Menu ---

NE   Enter Pharmacy Intervention        DEL  Delete Pharmacy Intervention
ED   Edit Pharmacy Intervention         VW   View Pharmacy Intervention
PRT  Print Pharmacy Intervention
Select Item(s): DEL   Delete Pharmacy Intervention
You may only delete entries entered on the current day.

Select APSP INTERVENTION DATE: T   SEP 22, 2000       XYZ,PATIENT
   WARFARIN 10MG
SURE YOU WANT TO DELETE THE ENTIRE ENTRY? YES
```

- **View**: This option is used to display Pharmacy Interventions in a captioned format.

Example: View an Intervention

```
Patient Information           Sep 22, 2000 08:03:07          Page:    1 of    1
XYZ,PATIENT                       Ward: 1 West                          <A>
   PID: 222-32-4321          Room-Bed: A-6         Ht(cm): 167.64 (04/21/99)
   DOB: 02/22/42 (58)                              Wt(kg): 85.00 (04/21/99)
   Sex: MALE                                     Admitted: 09/16/99
    Dx: TEST PATIENT                     Last transferred: ********

Allergies - Verified: CARAMEL, CN900, LOMEFLOXACIN, PENTAMIDINE, PENTAZOCINE,
                        CHOCOLATE, NUTS, STRAWBERRIES, DUST
        Non-Verified: AMOXICILLIN, AMPICILLIN, TAPE, FISH,
                        FLUPHENAZINE DECANOATE

   Adverse Reactions:
 Inpatient Narrative: Inpatient narrative for XYZ
Outpatient Narrative: This is the Outpatient Narrative.


          Enter ?? for more actions
PU Patient Record Update                NO New Order Entry
DA Detailed Allergy/ADR List            IN Intervention Menu
VP View Profile
Select Action: View Profile// IN   Intervention Menu

                       --- Pharmacy Intervention Menu ---

NE   Enter Pharmacy Intervention        DEL  Delete Pharmacy Intervention
ED   Edit Pharmacy Intervention         VW   View Pharmacy Intervention
PRT  Print Pharmacy Intervention
Select Item(s): VW   View Pharmacy Intervention
Select APSP INTERVENTION DATE: T   SEP 22, 2000       XYZ,PATIENT
   WARFARIN 10MG
ANOTHER ONE: <Enter>
INTERVENTION DATE: SEP 22, 2000         PATIENT: XYZ,PATIENT
  PROVIDER: INPATIENT-MEDS,PROVIDER     PHARMACIST: INPATIENT-MEDS,PHARMACIST
  DRUG: WARFARIN 10MG                   INSTITUTED BY: PHARMACY
  INTERVENTION: ALLERGY                 RECOMMENDATION: NO CHANGE
  WAS PROVIDER CONTACTED: NO            RECOMMENDATION ACCEPTED: YES
```

- **Print**: This option is used to obtain a captioned printout of Pharmacy Interventions for a certain date range. It will print out on normal width paper and can be queued to print at a later time.

Example: Print an Intervention

```
Patient Information           Sep 22, 2000 08:03:07          Page:    1 of    1
XYZ,PATIENT                      Ward: 1 West                          <A>
   PID: 222-32-4321          Room-Bed: A-6         Ht(cm): 167.64 (04/21/99)
   DOB: 02/22/42 (58)                              Wt(kg): 85.00 (04/21/99)
   Sex: MALE                                     Admitted: 09/16/99
    Dx: TEST PATIENT                     Last transferred: ********

Allergies - Verified: CARAMEL, CN900, LOMEFLOXACIN, PENTAMIDINE, PENTAZOCINE,
                        CHOCOLATE, NUTS, STRAWBERRIES, DUST
        Non-Verified: AMOXICILLIN, AMPICILLIN, TAPE, FISH,
                        FLUPHENAZINE DECANOATE

   Adverse Reactions:
 Inpatient Narrative: Inpatient narrative for XYZ
Outpatient Narrative: This is the Outpatient Narrative.


          Enter ?? for more actions
PU Patient Record Update                NO New Order Entry
DA Detailed Allergy/ADR List            IN Intervention Menu
VP View Profile
Select Action: View Profile// IN   Intervention Menu

                       --- Pharmacy Intervention Menu ---

NE   Enter Pharmacy Intervention        DEL  Delete Pharmacy Intervention
ED   Edit Pharmacy Intervention         VW   View Pharmacy Intervention
PRT  Print Pharmacy Intervention
Select Item(s): PRT   Print Pharmacy Intervention
  * Previous selection: INTERVENTION DATE equals 7/2/96
  START WITH INTERVENTION DATE: FIRST// T  (SEP 22, 2000)
  GO TO INTERVENTION DATE: LAST// T  (SEP 22, 2000)
DEVICE: <Enter>  NT/Cache virtual TELNET terminal    Right Margin: 80//
PHARMACY INTERVENTION LISTING                  SEP 22,2000  09:20    PAGE 1
-------------------------------------------------------------------------------



INTERVENTION: ALLERGY

INTERVENTION DATE: SEP 22,2000         PATIENT:  XYZ,PATIENT
PROVIDER: INPATIENT-MEDS,PROVIDER      PHARMACIST:  INPATIENT-MEDS,PHARM
DRUG: WARFARIN 10MG                    INSTITUTED BY:  PHARMACY
RECOMMENDATION: NO CHANGE
WAS PROVIDER CONTACTED: NO             RECOMMENDATION ACCEPTED:   YES
PROVIDER CONTACTED:
                                                 ----------------------------
SUBTOTAL                                                        1
SUBCOUNT                                         1
                                                 ----------------------------
TOTAL                                                           1
COUNT                                            1
```

4.4.5. View Profile

The View Profile action allows selection of a Long, Short, or NO profile for the patient. The profile displayed in the *Inpatient Order Entry* and *Non-Verified/Pending Orders* options will include IV and Unit Dose orders. The long profile shows all orders, including discontinued and expired orders. The short profile does not show the discontinued or expired orders.

Example: Profile View

```
Inpatient Order Entry         Sep 13, 2000 14:53:53          Page:    1 of    2
ABC,PATIENT                       Ward: 1 EAST
   PID: 123-45-9111          Room-Bed: B-12        Ht(cm): ______ (________)
   DOB: 08/18/20 (80)                              Wt(kg): ______ (________)
   Sex: MALE                                     Admitted: 05/03/00
    Dx: TESTING                            Last transferred: ********

 - - - - - - - - - - - - - - - - - A C T I V E - - - - - - - - - - - - - - - - -
   1    AMPICILLIN 1 GM                          C  09/07  09/14  A
        in 0.9% NACL 100 ML QID
   2 -> AMPICILLIN CAP INJ                       C  09/07  09/21  A
          Give: 250MG PO QID
   3 -> HYDROCORTISONE CREAM,TOP                 C  09/07  09/21  A
          Give: 1% TOP QD
   4 -> PROPRANOLOL 10MG U/D                     C  09/07  09/21  A
          Give:  PO QD
 - - - - - - - - - - - - - - - -  P E N D I N G  - - - - - - - - - - - - - - - -
   5    MULTIVITAMINS INJ                        ?  *****  *****  P
          Give: Doctor's order.
+         Enter ?? for more actions
PI  Patient Information                 SO  Select Order
PU  Patient Record Update               NO  New Order Entry
Select Action: Next Screen//
```

The orders on the profile are sorted; first by status (ACTIVE, NON-VERIFIED, PENDING, PENDING RENEWALS) then alphabetically by SCHEDULE TYPE. Pending orders with a priority of STAT are listed first and are displayed in a bold and blinking text for easy identification. After SCHEDULE TYPE, orders are sorted alphabetically by DRUG (the drug name listed on the profile), and then in descending order by START DATE.

If a Unit Dose order has been verified by pharmacy but has not been verified by nursing, it will be listed under the ACTIVE heading with an arrow (**->**) to the right of it's number. Orders may be selected by choosing the Select Order action, or directly from the profile using the order number displayed to the left of the drug. Multiple orders may be chosen by entering the numbers of each order to be included separated by commas (e.g., 1,2,3), or a range of numbers using the dash (e.g., 1-3).

Note: The START DATE and DRUG sort may be reversed using the INPATIENT PROFILE ORDER SORT field in the INPATIENT USER PARAMETERS file.

4.4.6. Patient Information

The Patient Information action is displayed for the selected patient. This list contains the patient's demographic data, Allergy/Adverse Reaction data, and Pharmacy Narratives.

Example: Patient Information

```
Patient Information           Sep 13, 2000 15:04:31          Page:    1 of    1
ABC,PATIENT                      Ward: 1 EAST
   PID: 123-45-9111          Room-Bed: B-12        Ht(cm): ______ (________)
   DOB: 08/18/20 (80)                              Wt(kg):        (        )
   Sex: MALE                                     Admitted: 05/03/00
    Dx: TESTING                           Last transferred: ********

 Allergies/Reaction:
 Inpatient Narrative: Narrative for Patient ABC
Outpatient Narrative:
```

```
          Enter ?? for more actions
PU Patient Record Update                NO New Order Entry
DA Detailed Allergy/ADR List            IN Intervention Menu
VP View Profile
Select Action: View Profile//
```

4.4.7. Select Order

The Select Order action is used to take action on a previously entered order by selecting it from the profile, after the patient is selected and length of profile is chosen.

Example: Selecting and Displaying an Order

```
Inpatient Order Entry         Sep 18, 2000 12:44:21          Page:    3 of    3
XYZ,PATIENT                      Ward: 1 West                           <A>
   PID: 222-32-4321          Room-Bed: A-6         Ht(cm): 167.64 (04/21/99)
   DOB: 02/22/42 (58)                              Wt(kg): 85.00 (04/21/99)
   Sex: MALE                                     Admitted: 09/16/99
    Dx: TEST PATIENT                      Last transferred: ********
+
   9    CEFOXITIN 1GM PREMIX INJ                 ?  *****  *****  P
          Give: 100MG IM QD
  10    AMPICILLIN 500 GM                        ?  *****  *****  P
        in 0.45% NACL 1000 ML 100 ml/hr
  11    SULFAMETHOXAZOLE/TRIMETHOPRIM INJ,SOLN   ?  *****  *****  P   NF
          Give: 10MG IM QD
  12    SULFISOXAZOLE TAB                        ?  *****  *****  P
          Give: 1MG PO QID
 - - - - - - - - - - - - P E N D I N G   R E N E W A L S - - - - - - - - - - - -
  13    FAMOTIDINE INJ,SOLN                      ?  *****  *****  P
          Give: 10MG IV
----------Enter ?? for more actions-----------------------------------------------
PI  Patient Information                 SO  Select Order
PU  Patient Record Update               NO  New Order Entry
Select Action: Quit// SO   Select Order

Select ORDERS (1-13): 12
```

----------report continues----------

Example: Selecting and Displaying an Order (continued)

```
PENDING UNIT DOSE (ROUTINE)   Sep 18, 2000 12:44:35          Page:    1 of    2
XYZ,PATIENT                      Ward: 1 West                          <A>
   PID: 222-32-4321          Room-Bed: A-6         Ht(cm): 167.64 (04/21/99)
   DOB: 02/22/42 (58)                              Wt(kg): 85.00 (04/21/99)

 *(1)Orderable Item: SULFISOXAZOLE TAB
       Instructions: 1MG
 *(2)Dosage Ordered: 1MG
                                                     (3)Start: 09/18/00  12:00
 *(4)     Med Route: ORAL
                                                     (5) Stop: 09/22/00  22:00
  (6) Schedule Type: CONTINUOUS
 *(8)      Schedule: QID
  (9)   Admin Times: 07-12-15-20
*(10)      Provider: INPATIENT-MEDS, PROVIDER           (7)  Self Med: NO
 (11) Special Instructions:

 (12) Dispense Drug                                 U/D        Inactive Date
      SULFISOXAZOLE 500MG U/D                        1
+---------Enter ?? for more actions-----------------------------------------
BY  (Bypass)              DC  (Discontinue)         FN  (Finish)
Select Item(s): Next Screen//
```

The list area displays detailed order information and allow actions to be taken on the selected Unit Dose order. A number displayed to the left of the field name identifies fields that may be edited. If a field, marked with an asterisk (*) next to its number, is edited, it will cause this order to be discontinued and a new one created. If a pending order is selected, the system will determine any default values for fields not entered through CPRS and display them along with the data entered by the provider.

Actions, displayed in the Action Area, enclosed in parenthesis are not available to the user. In the example above, the actions Bypass, Discontinue and Finish are not available to the user without the appropriate keys.

Only users with access to the IV options will be allowed to take any actions on the IV orders.

4.5. Order Actions

The Order Actions are the actions available in the Action Area of the List Manager Screen. These actions pertain to the patient's orders and include editing, discontinuing, verifying, etc.

4.5.1. Discontinue

When an order is discontinued, the order's Stop Date/Time is changed to the date/time the action is taken. An entry is placed in the order's Activity Log recording who discontinued the order and when the action was taken. Pending and Non-verified orders are deleted when discontinued and will no longer appear on the patient's profile.

Example: Discontinue an Order

```
Inpatient Order Entry         Sep 28, 2000 13:32:18          Page:    1 of    1
ABC,PATIENT                      Ward: 1 EAST
   PID: 123-45-9111          Room-Bed: B-12        Ht(cm): ______ (________)
   DOB: 08/18/20 (80)                              Wt(kg): ______ (________)
   Sex: MALE                                     Admitted: 05/03/00
    Dx: TESTING                           Last transferred: ********

 - - - - - - - - - - - - - - - - - - A C T I V E - - - - - - - - - - - - - - - - - -
   1    MULTIVITAMINS 1 ML                       C  09/27  10/02  A
        in 0.9% NACL 500 ML QID PRN
 - - - - - - - - - - - - - - - - -  P E N D I N G  - - - - - - - - - - - - - - - - -
   2    AMPICILLIN CAP INJ                       ?  *****  *****  P
          Give: 250MG PO QID
   3    AMPICILLIN INJ                           ?  *****  *****  P
          Give: 1MG IVPB QID
   4    PROPRANOLOL TAB                          ?  *****  *****  P
          Give: 10MG PO TID


          Enter ?? for more actions
PU  Patient Record Update              NO  New Order Entry
Select Action: Quit// 2
```

```
PENDING UNIT DOSE (ROUTINE)   Sep 28, 2000 13:33:17          Page:    1 of    2
ABC,PATIENT                      Ward: 1 EAST
   PID: 123-45-9111          Room-Bed: B-12        Ht(cm): ______ (________)
   DOB: 08/18/20 (80)                              Wt(kg): ______ (________)
   Sex: MALE                                     Admitted: 05/03/00
    Dx: TESTING                           Last transferred: ********

 *(1)Orderable Item: AMPICILLIN CAP INJ
       Instructions:
 *(2)Dosage Ordered: 250MG
                                                    (3)Start: 09/27/00  15:00
 *(4)     Med Route: ORAL                          Req. Start: 09/27/00  09:00
                                                    (5) Stop: 10/11/00  24:00
  (6) Schedule Type: CONTINUOUS                    Req. Stop: 09/27/00  24:00
 *(8)      Schedule: QID
  (9)   Admin Times: 01-09-15-20
*(10)      Provider: INPATIENT-MEDS,PROVIDER            (7)Self Med: NO
 (11) Special Instructions:

 (12) Dispense Drug                                U/D        Inactive Date
      AMPICILLIN 500MG CAP                         1

+         Enter ?? for more actions
BY  Bypass                DC  Discontinue           FN  Finish
Select Item(s): Next Screen// DC   Discontinue

Do you want to discontinue this order? Yes//  <Enter> (Yes)
NATURE OF ORDER: WRITTEN// <Enter>
Requesting PROVIDER: INPATIENT-MEDS,PROVIDER//  <Enter>PROV    ...ORDER DISCONTINUED!



Select DRUG:
```

4.5.2. Edit

This action allows modification of any field shown on the order view that is preceded by a number in parenthesis (#).

Example: Edit an Order

```
ACTIVE UNIT DOSE              Sep 13, 2000 15:20:42          Page:    1 of    2
ABC,PATIENT                       Ward: 1 EAST
   PID: 123-45-9111          Room-Bed: B-12        Ht(cm): ______ (________)
   DOB: 08/18/20 (80)                              Wt(kg):        (        )

 *(1)Orderable Item: AMPICILLIN CAP INJ
       Instructions:
 *(2)Dosage Ordered: 250MG
                                                     *(3)Start: 09/07/00  15:00
 *(4)     Med Route: ORAL
                                                     *(5) Stop: 09/21/00  24:00
  (6) Schedule Type: CONTINUOUS
 *(8)      Schedule: QID
  (9)   Admin Times: 01-09-15-20
*(10)      Provider: INPATIENT-MEDS,PROVIDER            (7)Self Med: NO
 (11) Special Instructions:

 (12) Dispense Drug                                  U/D        Inactive Date
      AMPICILLIN 500MG CAP                           1
+         Enter ?? for more actions
DC  Discontinue           ED  Edit                  VF  Verify
HD  Hold                  RN  Renew                 AL  Activity Logs
Select Item(s): Next Screen//
```

If a field marked with an asterisk (*) to the left of the number is changed, the original order will be discontinued, and a new order containing the edited data will be created. The Stop Date/Time of the original order will be changed to the date/time the new edit order is accepted. The old and new orders are linked and may be viewed using the History Log function. When the screen is refreshed, the field(s) that were changed will now be shown in **blinking reverse video** and "This change will cause a new order to be created" will be displayed in the message window.

```
NON-VERIFIED UNIT DOSE        Sep 13, 2000 15:26:46          Page:    1 of    2
ABC,PATIENT                       Ward: 1 EAST
   PID: 123-45-9111          Room-Bed: B-12        Ht(cm):        (        )
   DOB: 08/18/20 (80)                              Wt(kg):        (        )

 *(1)Orderable Item: AMPICILLIN CAP INJ
       Instructions:
 *(2)Dosage Ordered: 250MG
                                                     *(3)Start: 09/13/00  20:00
 *(4)     Med Route: ORAL
                                                     *(5) Stop: 09/27/00  24:00
  (6) Schedule Type: CONTINUOUS
 *(8)      Schedule: QID
  (9)   Admin Times: 01-09-15-20
*(10)      Provider: INPATIENT-MEDS,PHARMACIST          (7)Self Med: NO
 (11) Special Instructions:

 (12) Dispense Drug                                  U/D        Inactive Date
      AMPICILLIN 500MG CAP                           1

+         This change will cause a new order to be created.
ED  Edit                                AC  ACCEPT
Select Item(s): Next Screen//
```

If the ORDERABLE ITEM or DOSAGE ORDERED fields are edited, the Dispense Drug data will not be transferred to the new order. If the Orderable Item is changed, data in the DOSAGE ORDERED field will not be transferred. New Start Date/Time, Stop Date/Time, Login Date/Time, and Entry Code will be determined for the new order. Changes to other fields (those without the asterisk) will be recorded in the order's activity log.

If the Dispense Drug or Orderable Item has a non-formulary status, this status will be displayed on the screen as "*N/F*" beside the Dispense Drug or Orderable Item.

4.5.3. Verify

Orders must be verified before they can become active and are included on the pick list, BCMA Virtual Due List (VDL), etc. If AUTO-VERIFY is enabled for the nurse, new orders immediately become active after entry or finish (pending orders entered through CPRS). Orders verified by nursing prior to pharmacy verification are displayed on the profile under the active header marked with an arrow (**->**) to the right of the order number. When verify is selected and when the order has not been verified by the pharmacist, the nurse must enter any missing data and correct any invalid data before the verification is accepted.

Note: The ALLOW AUTO-VERIFY FOR USER field in the INPATIENT USER PARAMETERS file controls AUTO-VERIFY.

Example: Verify an Order

```
NON-VERIFIED UNIT DOSE        Sep 07, 2000 13:57:03          Page:    1 of    2
ABC,PATIENT                       Ward: 1 EAST
   PID: 123-45-9111          Room-Bed: B-12        Ht(cm): ______ (________)
   DOB: 08/18/20 (80)                              Wt(kg): ______ (________)

 *(1)Orderable Item: PROPRANOLOL TAB
       Instructions:
 *(2)Dosage Ordered:
                                                        (3)Start: 09/07/00  17:00
 *(4)     Med Route: ORAL
                                                        (5) Stop: 09/21/00  24:00
  (6) Schedule Type: CONTINUOUS
 *(8)      Schedule: QD
  (9)   Admin Times: 17
*(10)      Provider: INPATIENT-MEDS,PROVIDER            (7)Self Med: NO
 (11) Special Instructions:

 (12) Dispense Drug                                  U/D        Inactive Date
      PROPRANOLOL 10MG U/D                           1

+         Enter ?? for more actions
DC  Discontinue           ED  Edit                  VF  Verify
HD  (Hold)                RN  (Renew)               AL  Activity Logs
Select Item(s): Next Screen// VF
...a few moments, please.....

Pre-Exchange DOSES:
ORDER VERIFIED.

Enter RETURN to continue or '^' to exit:
```

If the Dispense Drug or Orderable Item has a non-formulary status, this status will be displayed on the screen as "*N/F*" beside the Dispense Drug or Orderable Item.

4.5.4. Hold

Only active orders may be placed on hold. Orders placed on hold will continue to show under the ACTIVE heading on the profiles until removed from hold. Any orders placed on hold through the pharmacy options cannot be released from hold using any of the CPRS options. An entry is placed in the order's Activity Log recording the user who placed/removed the order from hold and when the action was taken.

Example: Place an Order on Hold

```
ACTIVE UNIT DOSE              Feb 25, 2001@21:25:50          Page:    1 of    2
ABC,PATIENT                       Ward: 1 EAST
   PID: 123-45-9111          Room-Bed: B-12        Ht(cm): ______ (________)
   DOB: 08/18/20 (80)                              Wt(kg): ______ (________)

*(1)Orderable Item: ASPIRIN TAB                                          <DIN>
       Instructions:
 *(2)Dosage Ordered: 650MG
                                                     *(3)Start: 02/26/01  14:40
 *(4)     Med Route: ORAL
                                                     *(5) Stop: 02/28/01  24:00
  (6) Schedule Type: CONTINUOUS
 *(8)      Schedule: QD
  (9)   Admin Times: 1440
*(10)      Provider: INPATIENT-MEDS,PROVIDER            (7)Self Med: NO
 (11) Special Instructions:

 (12) Dispense Drug                                  U/D        Inactive Date
      ASPIRIN BUFFERED 325MG TAB                     2
+         Enter ?? for more actions
DC  Discontinue           ED  Edit                  VF  (Verify)
HD  Hold                  RN  Renew                 AL  Activity Logs
Select Item(s): Next Screen// HD   Hold

Do you wish to place this order 'ON HOLD'? Yes//  <Enter> (Yes)
NATURE OF ORDER: WRITTEN//  <Enter>       W...
COMMENTS:
  1>TESTING
  2>
EDIT Option: .  <Enter>
Enter RETURN to continue or '^' to exit: <Enter>

----------------------------------------report continues----------------------------------------
```

Example: Place an Order on Hold (continued)

```
HOLD UNIT DOSE                Feb 25, 2001@21:27:57          Page:    1 of    2
ABC,PATIENT                      Ward: 1 EAST
   PID: 123-45-9111          Room-Bed: B-12        Ht(cm): ______ (________)
   DOB: 08/18/20 (80)                              Wt(kg): ______ (________)

 *(1)Orderable Item: ASPIRIN TAB                                          <DIN>
       Instructions:
 *(2)Dosage Ordered: 650MG
                                                     *(3)Start: 02/26/01  14:40
 *(4)     Med Route: ORAL
                                                     *(5) Stop: 02/28/01  24:00
  (6) Schedule Type: CONTINUOUS
 *(8)      Schedule: QD
  (9)   Admin Times: 1440
*(10)      Provider: INPATIENT-MEDS,PROVIDER            (7)Self Med: NO
 (11) Special Instructions:

 (12) Dispense Drug                                  U/D        Inactive Date
      ASPIRIN BUFFERED 325MG TAB                     2
+         Enter ?? for more actions
DC  Discontinue           ED  (Edit)                VF  (Verify)
HD  Hold                  RN  (Renew)               AL  Activity Logs
Select Item(s): Next Screen//  <Enter>
```

```
HOLD UNIT DOSE                Feb 25, 2001@21:28:20          Page:    2 of    2
ABC,PATIENT                      Ward: 1 EAST
   PID: 123-45-9111          Room-Bed: B-12        Ht(cm):        (        )
   DOB: 08/18/20 (80)                              Wt(kg):        (        )
+

Entry By: INPATIENT-MEDS,PHARMACIST               Entry Date: 02/25/01  21:25

(13) Comments:
 TESTING









          Enter ?? for more actions
DC  Discontinue           ED  (Edit)                VF  (Verify)
HD  Hold                  RN  (Renew)               AL  Activity Logs
Select Item(s): Quit//  <Enter>
```

```
Unit Dose Order Entry         Feb 25, 2001@21:30:15          Page:    1 of    1
ABC,PATIENT                      Ward: 1 EAST
   PID: 123-45-9111          Room-Bed: B-12        Ht(cm):        (        )
   DOB: 08/18/20 (80)                              Wt(kg):        (        )
   Sex: MALE                                     Admitted: 05/03/00
    Dx: TESTING                            Last transferred: ********

 - - - - - - - - - - - - - - - - - - A C T I V E - - - - - - - - - - - - - - - - -
   1    ASPIRIN TAB                                C  02/26  02/28  H
          Give: 650MG ORAL QD









          Enter ?? for more actions
PI  Patient Information                  SO  Select Order
PU  Patient Record Update                NO  New Order Entry
Select Action: Quit//
```

Notice that the order shows a status of "H" for hold in the right side of the Aspirin Tablet order.

If the Dispense Drug or Orderable Item has a non-formulary status, this status will be displayed on the screen as "*N/F*" beside the Dispense Drug or Orderable Item.

4.5.5. Renew

Only active orders or those that have been expired no more than four days may be renewed. The default Start Date/Time for a renewal order will be determined by one of the following methods:

1. If a BCMA action is recorded as Given or Refused on the renewed order and the order contains administration times, the new start date will be calculated by adding the frequency of the order to the scheduled administration time against which the last action was recorded. The new start date will be used if it is in the future and it is less than the original stop date.

2. If a BCMA action is recorded as Given or Refused on the renewed order and the order does not have administration times, the new start date will be calculated by adding the frequency of the order to the BCMA administered time and rounding up to the next hour. The new start date wil1l be used if it is in the future and is less than the original stop date.

3. If no BCMA action has been recorded on the renewed order or an action other than Given or Refused has been recorded, the start date for the renewed order will be calculated using the Default Start Date Calculation ward parameter. These parameters are as follows:

   - **Default Start Date Calculation = NOW**
     The default Start Date/Time for the renewal order will be the order's Login Date/Time.

   - **Default Start Date Calculation = USE NEXT ADMIN TIME**
     The original order's Start Date/Time, the new order's Login Date/Time, Schedule, and Administration Times are used to find the next date/time the order is to be administered after the new order's Login Date/Time. If the schedule contains "PRN", any administration times for the order are ignored.

   - **Default Start Date Calculation = USE CLOSEST ADMIN TIME**
     The original order's Start Date/Time, the new order's Login Date/Time, Schedule, and Administration Times are used to find the closest date/time the order is to be administered after the new order's Login Date/Time. If the schedule contains "PRN", any administration times for the order are ignored.

Note: Only the regular finish and regular renew orders will calculate the start date using BCMA administered time. Speed finish and speed renew will not be affected.

After the new (renewal) order is accepted, the Start Date/Time for the new order becomes the Stop Date/Time for the original (renewed) order. The original order's status is changed to RENEWED. The renewal and renewed orders are linked and may be viewed using the History Log function. Once an order has been renewed, the original order may not be renewed or edited.

Examples:

1a. Standard schedule of Q12H. Administration times of 09 – 21. The 09:00 dose was administered at 08:45. The frequency in the order is 720. The order is renewed at 09:45. The start time of the new order is 21:00.

1b. Standard schedule of Q12H. Administration times of 10 – 19. The 10:00 dose was administered at 10:15. The frequency is 720. The order is renewed at 10:30. The start time of the new order is 22:00. The frequency for the schedule is 12 hours, but the administration times are only 9 hours apart. The system uses the frequency, not the textual information in the ADMINISTRATION TIME field.

2. Non-standard schedule of Q7H. The last dose was administered at 11:35. The frequency is 420. The order is renewed at 13:00. The last dose (11:35) plus the seven hours would be 18:35. Then, it's rounded up to the next hour. The start time of the new order is 19:00.

3a. (NOW) Order is renewed at 13:52. The start time of the new order is 13:52.

3b. (NEXT) Scheduled administration times are 10-14-18-22. Order is renewed at 14:35. The start time of the new order is 18:00.

3c. (CLOSEST) Scheduled administration times are 09-13-17-21. Order is renewed at 13:20. The start time of the new order is 13:00.

4.5.6. Activity Log

This action allows viewing of a long or short activity log, dispense log, or a history log of the order. A short activity log only shows actions taken on orders and does not include field changes. The long activity log shows actions taken on orders and does include the requested start and stop date/time values. If a history log is selected, it will find the first order, linked to the order where the history log was invoked. Then the log will display an order view of each order associated with it, in the order that they were created. When a dispense log is selected, it shows the dispensing information for the order.

Example: Activity Log

```
ACTIVE UNIT DOSE              Sep 21, 2000 12:44:25          Page:    1 of    2
ABC,PATIENT                      Ward: 1 EAST
   PID: 123-45-9111          Room-Bed: B-12        Ht(cm): ______ (________)
   DOB: 08/18/20 (80)                              Wt(kg): ______ (________)

 *(1)Orderable Item: AMPICILLIN CAP INJ
       Instructions:
 *(2)Dosage Ordered: 250MG
                                                     *(3)Start: 09/07/00  15:00
 *(4)     Med Route: ORAL
                                                     *(5) Stop: 09/21/00  24:00
  (6) Schedule Type: CONTINUOUS
 *(8)      Schedule: QID
  (9)   Admin Times: 01-09-15-20
*(10)      Provider: INPATIENT-MEDS,PROVIDER            (7)Self Med: NO
 (11) Special Instructions:

 (12) Dispense Drug                                  U/D        Inactive Date
      AMPICILLIN 500MG CAP                           1
+         Enter ?? for more actions
DC  Discontinue           ED  Edit                  VF  Verify
HD  Hold                  RN  Renew                 AL  Activity Logs
Select Item(s): Next Screen// AL   Activity Logs

   1 - Short Activity Log
   2 - Long Activity Log
   3 - Dispense Log
   4 - History Log

Select LOG to display: 2  Long Activity Log
    Date: 09/07/00  14:07     User: INPATIENT-MEDS,PHARMACIST
Activity: ORDER VERIFIED BY PHARMACIST

    Date: 09/07/00  14:07     User: INPATIENT-MEDS,PHARMACIST
Activity: ORDER VERIFIED
   Field: Requested Start Date
Old Data: 09/07/00  09:00

    Date: 09/07/00  14:07     User: INPATIENT-MEDS,PHARMACIST
Activity: ORDER VERIFIED
   Field: Requested Stop Date
Old Data: 09/07/00  24:00

Enter RETURN to continue or '^' to exit:
```

4.5.7. Finish

Nurses who hold the PSJ RNFINISH key will have the option to finish and verify orders placed through CPRS.

When an order is placed or renewed by a provider through CPRS, the nurse or pharmacist needs to finish and/or verify this order. The same procedures are followed to finish the renewed order as to finish a new order with the following exceptions:

> The PENDING RENEWAL orders may be speed finished. The user may enter an **F**, for finish, at the "Select ACTION or ORDERS:" prompt and then select the pending renewals to be finished. At this time, prompts are issued for the start date/time and stop date/time. These values are used as the start and stop dates and times for the pending renewals selected. All other fields will retain the values from the renewed order.

Example: Finish an Order

```
PENDING IV (ROUTINE)          Sep 07, 2000 16:11:42          Page:    1 of    2
ABC,PATIENT                       Ward: 1 EAST
   PID: 123-45-9111          Room-Bed: B-12        Ht(cm): ______ (________)
   DOB: 08/18/20 (80)                              Wt(kg): ______ (________)

 (1)  Additives:                                        Type:
 (2)  Solutions:
                                                     IV Room: BIRMINGHAM ISC
 (3)  Infusion Rate:                           (4)     Start: ********
                                            REQUESTED START: 09/07/00  09:00
*(5)      Med Route: IVPB                      (6)      Stop: ********
                                             REQUESTED STOP: 09/07/00  24:00
*(7)       Schedule: QID                          Last Fill: ********
 (8)    Admin Times: 01-09-15-20                   Quantity: 0
*(9)       Provider: INPATIENT-MEDS,PROVIDER      Cum. Doses:
*(10)Orderable Item: AMPICILLIN INJ
       Instructions:
 (11)   Other Print:
  Provider Comments: THIS IS AN INPATIENT IV EXAMPLE.
+         Enter ?? for more actions
DC   Discontinue          ED   Edit                 FN   Finish
Select Item(s): Next Screen// FN   Finish
COMPLETE THIS ORDER AS IV OR UNIT DOSE? IV// IV
Copy the Provider Comments into Other Print Info? Yes//   YES
IV TYPE: PB
CHOOSE FROM:
              A    ADMIXTURE
              C    CHEMOTHERAPY
              H    HYPERAL
              P    PIGGYBACK
              S    SYRINGE
Enter a code from the list above.

     Select one of the following:
          A         ADMIXTURE
          C         CHEMOTHERAPY
          H         HYPERAL
          P         PIGGYBACK
          S         SYRINGE

IV TYPE: PIGGYBACK
               **AUTO STOP 7D**

This patient is already receiving an order for the following drug in the same
class as AMPICILLIN INJ 2GM:

        AMPICILLIN CAP INJ                      C  09/07  09/21  A
        Give: 250MG PO QID

Do you wish to continue entering this order? NO// Y
Select ADDITIVE: AMPICILLIN//  ><Enter>
ADDITIVE: AMPICILLIN//
Restriction/Guideline(s) exist.  Display? :  (N/D): No// D

Dispense Drug Text:

     Refer to PBM/MAP PUD treatment guidelines
     RESTRICTED TO NEUROLOGY
(The units of strength for this additive are in GM)
Strength: 1 GM
Select ADDITIVE:
```

----------report continues----------

Example: Finish an Order (continued)

```
Select SOLUTION: 0.9
     1   0.9% NACL            500 ML

     2   0.9% NACL            100 ML

     3   0.9% NACL            50 ML

     4   0.9% NaCl            250 ML
                BT
CHOOSE 1-4: 2  0.9% NACL          100 ML
INFUSION RATE:  <Enter>

Select ADDITIVE:
Select SOLUTION: 0.9
     1   0.9% NACL            500 ML

     2   0.9% NACL            100 ML

     3   0.9% NACL            50 ML

     4   0.9% NaCl            250 ML
                BT
CHOOSE 1-4: 2  0.9% NACL          100 ML
INFUSION RATE:  <Enter>
```

```
PENDING IV (ROUTINE)          Sep 07, 2000 16:23:46          Page:    1 of    2
ABC,PATIENT                      Ward: 1 EAST
   PID: 123-45-9111          Room-Bed: B-12        Ht(cm):        (        )
   DOB: 08/18/20 (80)                              Wt(kg): ______ (________)

 (1)  Additives:                                          Type: PIGGYBACK    <DIN>
       AMPICILLIN 1 GM
 (2)  Solutions:
       0.9% NACL 100 ML
                                                       IV Room: BIRMINGHAM ISC
 (3)  Infusion Rate:                            (4)     Start: 09/07/00  15:00
                                             REQUESTED START: 09/07/00  09:00
*(5)      Med Route: IVPB                      (6)      Stop: 09/14/00  16:54
                                              REQUESTED STOP: 09/07/00  24:00
*(7)       Schedule: QID                          Last Fill: ********
 (8)    Admin Times: 01-09-15-20                   Quantity: 0
*(9)       Provider: INPATIENT-MEDS,PROVIDER      Cum. Doses:
*(10)Orderable Item: AMPICILLIN INJ
       Instructions:
 (11)   Other Print: THIS IS AN INPATIENT IV EXAMPLE.
+         Enter ?? for more actions
AC   Accept               ED   Edit
Select Item(s): Next Screen// AC
```

----------report continues----------

Example: Finish an Order (continued)

```
Orderable Item: AMPICILLIN INJ
Give: IVPB QID

9111  1 EAST  09/07/00
ABC,PATIENT  B-12

AMPICILLIN 1 GM
0.9% NACL 100 ML

Dose due at: _______

THIS IS AN INPATIENT IV EXAMPLE
QID
01-09-15-20
M2***
Fld by:       Chkd by:
1[1]

Start date: SEP 7,2000 15:00   Stop date: SEP 14,2000 16:54

Is this O.K.? YES//  <Enter>

2 Labels needed for doses due at ...

09/07/00 1500 : 09/07/00 2000 :

        3        6        9       12       15       18       21       24
..:..:..:..:..:..:..:..:..:..:..:..:..:..:..:..:..:..:..:..:..:..:..:..:..:
P
                                                ^              ^
                                                    N
Next delivery time is 1700 ***
Action (PBS) S// B
```

The requested Start and requested Stop date/time values were added to the order view to indicate the dates/times requested by the provider to start and stop the order. When the requested stop date/time is different from the default stop date/time, it will flash on the screen to alert the user finishing the order.

If the Dispense Drug or Orderable Item has a non-formulary status, this status will be displayed on the screen as "*N/F*" beside the Dispense Drug or Orderable Item.

A prompt has been added to the finishing process, "COMPLETE THIS ORDER AS IV OR UNIT DOSE?" to determine if the user should complete the order as either an IV or Unit Dose order. The prompt will be displayed only if the user selected the *Inpatient Order Entry* option to finish the order. Also, the prompt will appear only if the correct combination of the entry in the IV FLAG in the MEDICATION ROUTES file and the entry in the APPLICATION PACKAGES' USE field in the DRUG file for the order's Dispense Drug are found. The following table will help explain the different scenarios:

IV FLAG in the MEDICATION ROUTES file	Dispense Drug's Application Use	Which Order View screen will be displayed to the user	Special Processing
IV	IV	IV	None
IV	Unit Dose	Unit Dose	Prompt user to finish order as IV or Unit Dose
IV	IV and Unit Dose	IV	Prompt user to finish order as IV or Unit Dose
Non-IV	IV	IV	Prompt user to finish order as IV or Unit Dose
Non-IV	Unit Dose	Unit Dose	None
Non-IV	IV and Unit Dose	Unit Dose	Prompt user to finish order as IV or Unit Dose

4.5.8. Speed Actions

From the list of orders in the patient's profile, the nurse can select one or more of the orders on which to take action. The nurse can quickly discontinue this patient's orders by selecting Speed Discontinue, or quickly renewing an order by selecting Speed Renew. Other "quick" selections include Speed Finish and Speed Verify.

4.6. Discontinue All of a Patient's Orders
[PSJU CA]

The *Discontinue All of a Patient's Orders* option allows a nurse to discontinue all of a patient's orders. Also, it allows a ward clerk to mark all of a patient's orders for discontinuation. If the ALLOW USER TO D/C ORDERS parameter is turned on to take action on active orders, then the ward clerk will also be able to discontinue orders. This ALLOW USER TO D/C ORDERS parameter is set using the *Inpatient User Parameter's Edit* option under the *PARameter's Edit Menu* option, which is under the *Supervisor's Menu*.

This option is then used to discontinue the selected orders. If a non-verified or pending order is discontinued, it is deleted completely from the system.

4.7. Hold All of a Patient's Orders
[PSJU HOLD ALL]

The *Hold All of a Patient's Orders* option allows a nurse to place all of a patient's active orders on hold in order to temporarily stop the medication from being dispensed, or take all of the patient's orders off of hold to restart the dispensing of the medication.

The option will take no action on individual orders that it finds already on hold. When this option is used to put all orders on hold, the system will print labels, for each medication order newly put on hold, indicating on the label that the medication is on hold. Also, the profile will notify the user that the patient's orders have been placed on hold; the letter **H** will be placed in the Status/Info column on the profile for each formerly active order.

When the option is used to take all orders off of hold, the system will reprint labels for the medication orders that were taken off hold and indicate on the label that the medication is off hold. Again, this option will take no action on individual orders that it finds were not on hold. The profile will display to the user that the patient's orders have been taken off hold.

Example 1: Hold All of a Patient's Orders

```
Select Unit Dose Medications Option: Hold All of a Patient's Orders

Select PATIENT: XYZ,PATIENT           222-32-4321   02/22/42   A-6

DO YOU WANT TO PLACE THIS PATIENT'S ORDERS ON HOLD? Yes//  <Enter> (Yes)

HOLD REASON: SURGERY SCHEDULED FOR 9:00AM
...a few moments, please....................DONE!
```

To take the orders off of hold, choose this same option and the following will be displayed:

Example 2: Take All of a Patient's Orders Off of Hold

```
Select Unit Dose Medications Option: HOld All of a Patient's Orders

Select PATIENT:    XYZ,PATIENT         222-32-4321   02/22/42   A-6

THIS PATIENT'S ORDERS ARE ON HOLD.
DO YOU WANT TO TAKE THIS PATIENT'S ORDERS OFF OF HOLD? Yes// <Enter>  (Yes)............
.....DONE!
```

Note: Individual orders can be placed on hold or taken off of hold through the *Order Entry* and *Non–Verified/Pending Orders* options.

4.8. Inpatient Profile
[PSJ PR]

The *Inpatient Profile* option allows the user to view the Unit Dose and IV orders of a patient simultaneously. The user can conduct the Inpatient Profile search by patient, ward, or ward group. If the selection to sort is by ward, the administration teams may be specified. The default for the administration team is ALL and multiple teams may be entered. If selecting by ward or ward group, the profile may be sorted by patient name or room-bed.

When the user accesses this option from the Unit Dose module for the first time within a session, a prompt is displayed to select the IV room. When only one active IV room exists, it will be selected automatically. The user is then given the label and report devices defined for the IV room chosen. If no devices have been defined, the user will be given the opportunity to choose them. If this option is exited and then re-entered within the same session, the current label and report devices are shown.

In the following description, viewing a profile by patient is discussed, however, ward and ward group are handled similarly.

After the user selects the patient for whom a profile view is needed, the length of profile is chosen. The user can choose to view a long or short profile or, if the user decides not to view a profile for the chosen patient, "NO Profile" can be selected. When **NO Profile** is chosen, the system will return to the "Select PATIENT:" prompt and the user may choose a new patient.

Once the length of profile is chosen, the user can print the patient profile (by accepting the default or typing **P** at the "SHOW PROFILE only, EXPANDED VIEWS only, or BOTH: Profile//" prompt), an expanded view of the patient profile (by typing **E**), or both (by typing **B**). The expanded view lists the details of each order for the patient. The activity logs of the orders can also be printed when the expanded view or both, the expanded view and profile, are chosen.

The advantage of this option is that by viewing the combined Unit Dose/IV profile of a patient, the user can quickly determine if any corrections or modifications need to be made for existing or future orders based on Unit Dose or IV medications already being received by the patient. Sometimes the nurse must revise a prospective order for a patient based on the Unit Dose or IV medications already prescribed for the patient.

Note: For Unit Dose orders, the long activity log shows all activities of an order, while the short activity log excludes the field changes, and shows only the major activities. For IV orders, the short and long activity logs give the user the same results.

Example: Inpatient Profile

```
Select Unit Dose Medications Option: IPF  Inpatient Profile

You are signed on under the BIRMINGHAM ISC IV ROOM

Current IV LABEL device is: NT TELNET TERMINAL

Current IV REPORT device is: NT TELNET TERMINAL


Select by WARD GROUP (G), WARD (W), or PATIENT (P): Patient

Select PATIENT: ABC,PATIENT         123-45-9111   08/18/20   1 EAST

Select another PATIENT: <Enter>

SHORT, LONG, or NO Profile?  SHORT// <Enter>  SHORT

Show PROFILE only, EXPANDED VIEWS only, or BOTH: PROFILE// BOTH

Show SHORT, LONG, or NO activity log?  NO// SHORT

Select PRINT DEVICE: 0;80  NT/Cache virtual TELNET terminal
```

```
               I N P A T I E N T   M E D I C A T I O N S       09/21/00  12:33
                         WHOEVER YOU WANT IT TO BE HEALTHCARE SYSTEM
 - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -
 ABC,PATIENT                        Ward: 1 EAST
    PID: 123-45-9111      Room-Bed: B-12            Ht(cm): ______ (________)
    DOB: 08/18/20  (80)                             Wt(kg): ______ (________)
    Sex: MALE                                     Admitted: 05/03/00
     Dx: TESTING
 Allergies:
       ADR:
 - - - - - - - - - - - - - - - - - A C T I V E - - - - - - - - - - - - - - - - -
   1  -> AMPICILLIN CAP INJ                      C  09/07  09/21  A
           Give: 250MG PO QID
- - - - - - - - - - - - - - N O N - V E R I F I E D - - - - - - - - - - - - - -
   2     DOXEPIN CAP,ORAL                        ?  *****  *****  N
           Give: 11CC PO Q24H
 - - - - - - - - - - - - - - -  P E N D I N G  - - - - - - - - - - - - - - - -
   3     MULTIVITAMINS INJ                       ?  *****  *****  P
           Give: Doctor's order.

- - - - - - - - - - - - - - - N O N - A C T I V E - - - - - - - - - - - - - - -
   4     AMPICILLIN 1 GM                         C  09/07  09/14  E
         in 0.9% NACL 100 ML QID
----------------------------------------------------------------------
```

----------report continues----------

Example: Inpatient Profile (continued)

```
Patient: ABC,PATIENT                          Status: ACTIVE
Orderable Item: AMPICILLIN CAP INJ
  Instructions:
Dosage Ordered: 250MG
                                                Start: 09/07/00  15:00
     Med Route: ORAL (PO)                        Stop: 09/21/00  24:00
 Schedule Type: CONTINUOUS                   Self Med: NO
      Schedule: QID
   Admin Times: 01-09-15-20
      Provider: INPATIENT-MEDS,PROVIDER
                                                Units   Units   Inactive
 Dispense Drugs                            U/D  Disp'd  Ret'd   Date
-------------------------------------------------------------------------
 AMPICILLIN 500MG CAP                      1    0       0

ORDER NOT VERIFIED
Entry By: INPATIENT-MEDS,PROVIDER                   Entry Date: 09/07/00  13:37
Enter RETURN to continue or '^' to exit:

    Date: 09/07/00  14:07     User: INPATIENT-MEDS,PHARMACIST
Activity: ORDER VERIFIED BY PHARMACIST
-----------------------------------------------------------------------
Patient: ABC,PATIENT                          Status: NON-VERIFIED
Orderable Item: DOXEPIN CAP,ORAL
  Instructions:
Dosage Ordered: 11CC
                                                Start: 09/20/00  09:00
     Med Route: ORAL (PO)                        Stop: 10/04/00  24:00
 Schedule Type: NOT FOUND                    Self Med: NO
      Schedule: Q24H
   (No Admin Times)
      Provider: INPATIENT-MEDS,PROVIDER
Special Instructions: special for DOXEPIN
                                                Units   Units   Inactive
 Dispense Drugs                            U/D  Disp'd  Ret'd   Date
-------------------------------------------------------------------------
 DOXEPIN 100MG U/D                         1    0       0
 DOXEPIN 25MG U/D                          1    0       0

ORDER NOT VERIFIED
Entry By: INPATIENT-MEDS,PROVIDER                   Entry Date: 09/19/00  09:55
Enter RETURN to continue or '^' to exit:
-----------------------------------------------------------------------
Patient: ABC,PATIENT                          Status: PENDING
Orderable Item: MULTIVITAMINS INJ
  Instructions: Doctor's order.
Dosage Ordered:
                                                Start: ********
     Med Route: IV PIGGYBACK (IVPB)              Stop: ********
 Schedule Type: NOT FOUND                    Self Med: NO
      Schedule: QID
   (No Admin Times)
      Provider: INPATIENT-MEDS,PROVIDER
                                                Units   Units   Inactive
 Dispense Drugs                            U/D  Disp'd  Ret'd   Date
-------------------------------------------------------------------------

Provider Comments:
THIS IS AN INPATIENT IV EXAMPLE.

ORDER NOT VERIFIED
Entry By: INPATIENT-MEDS,PROVIDER                   Entry Date: 09/07/00  14:12
```

4.9. Order Check

Order checks (allergy/adverse drug reactions, drug-drug interactions, duplicate drug, and duplicate class) are performed when a new medication order is placed through either the Inpatient Medications or CPRS applications. They are also performed when medication orders are renewed or during the finishing processes. This functionality will ensure the user is alerted to possible adverse drug reactions and will reduce the possibility of a medication error due to the omission of an order check when a non-active medication order is renewed.

The following actions will initiate an order check:

- Action taken through Inpatient Medications to enter a medication order will initiate order checks (allergy, drug-drug interaction, duplicate drug, and duplicate class) against existing medication orders.
- Action taken through Inpatient Medications to finish a medication order placed through CPRS will initiate order checks (allergy, drug-drug interaction, duplicate drug, and duplicate class) against existing medication orders.
- Action taken through IV Menu to finish a medication order placed through CPRS will initiate order checks (allergy, drug-drug interaction, duplicate drug, and duplicate class) against existing medication orders.
- Action taken through Inpatient Medications to renew a medication order will initiate order checks (allergy, drug-drug interaction, duplicate drug, and duplicate class) against existing medication orders.
- Action taken through IV Menu to renew a medication order will initiate order checks (allergy, drug-drug interaction, duplicate drug, and duplicate class) against existing medication orders.

The following are the different items used for the order checks:

- Checks each Dispense Drug within the Unit Dose order for allergy/adverse drug reactions.
- Checks each Dispense Drug within the Unit Dose order against existing orders for drug-drug interaction, duplicate drug, and duplicate class.
- Checks each additive within an IV order for drug-drug interaction, duplicate drug, and duplicate class against solutions or other additives within the order.
- Checks each IV order solution for allergy/adverse reactions.
- Checks each IV order solution for drug-drug interaction against other solutions or additives within the order.
- Checks each IV order additive for allergy/adverse reaction.
- Checks each IV order additive for drug-drug interaction, duplicate drug, and duplicate class against existing orders for the patient.
- Checks each IV order solution for drug-drug interaction against existing orders for the patient.

Override capabilities are provided based on the severity of the order check, if appropriate.

Order Checks warnings will be displayed/processed in the following order:

- Duplicate drug or class
- Critical or significant drug-drug interactions
- Critical or significant drug-allergy interactions

These checks will be performed at the Dispense Drug level. All pending, non-verified, active, renewed, and active Outpatient orders will be included in the check. Order checks for IV orders will use the Dispense Drugs linked to each additive/solution in the order. If the order is entered by Orderable Item only, these checks will be performed at the time the Dispense Drug(s) are specified. The checks performed include:

- Duplicate Drug - If the patient is already receiving an order containing the Dispense Drug selected for the new order, the duplicate order will be displayed and the user will be asked whether or not to continue. Entry of duplicate drugs will be allowed. Only Additives will be included in the duplicate drug check for IV orders. The solutions are excluded from this check.

- Duplicate Class - If the patient is already receiving an order containing a Dispense Drug in the same class as one of the Dispense Drugs in the new order, the order containing the drug in that class will be displayed and the user will be asked whether or not to continue. Entry of drugs in the same class will be allowed.

- Drug-Drug Interactions - Drug-drug interactions will be either critical or significant. If the Dispense Drug selected is identified as having an interaction with one of the drugs the patient is already receiving, the order the new drug interacts with will be displayed.

- Drug-Allergy Interactions - Drug-allergy interactions will be either critical or significant. If the Dispense Drug selected is identified as having an interaction with one of the patient's allergies, the allergy the drug interacts with will be displayed.

Note: For a Significant Interaction, the user who holds the PSJ RPHARM key is allowed to enter an intervention, but one is not required. For a Critical Interaction, the user who holds the PSJ RPHARM key must enter an intervention before continuing.

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5. Maintenance Options

All of these maintenance options are located on the *Unit Dose Medications* menu.

5.1. Edit Inpatient User Parameters
[PSJ UEUP]

The *Edit Inpatient User Parameters* option allows users to edit various Inpatient User parameters. The prompts that will be encountered are as follows:

- "PRINT PROFILE IN ORDER ENTRY:"

  Enter **YES** for the opportunity to print a profile after entering Unit Dose orders for a patient.

- "INPATIENT PROFILE ORDER SORT:"

  The Inpatient profile will sort orders either by medication or by start date of order. Choose the applicable method.

- "LABEL PRINTER:"

  Enter the device on which labels are to be printed.

- "USE WARD LABEL SETTINGS:"

  Enter **YES** to have the labels print on the printer designated for the ward instead of the printer designated for the pharmacy.

5.2. Edit Patient's Default Stop Date
[PSJU CPDD]

This option is locked with the PSJU PL key.

The "UD DEFAULT STOP DATE/TIME:" prompt accepts the date and time entry to be used as the default value for the STOP DATE/TIME of the Unit Dose orders during order entry and renewal processes. This value is used only if the corresponding ward parameter is enabled. The order entry and renewal processes will sometimes change this date and time.

When the SAME STOP DATE ON ALL ORDERS parameter is set to yes, the module will assign a default stop date for each patient. This date is initially set when the first order is entered for the patient, and can change when an order for the patient is renewed. This date is shown as the default value for the stop date of each order entered for the patient. However, if a day or dose limit exists for the selected Orderable Item, and the limit is less than the default stop date, the earlier stop date and time will be displayed.

6. Output Options

Most of the Output Options are located under the *Reports Menu* option on the *Unit Dose Medications* menu. The other reports are located directly on the *Unit Dose Medications* menu.

6.1. PAtient Profile (Unit Dose) [PSJU PR]

The *PAtient Profile (Unit Dose)* option allows a user to print a profile (list) of a patient's orders for the patient's current or last (if patient has been discharged) admission, to any device. If the user's terminal is selected as the printing device, this option will allow the user to select any of the printed orders to be shown in complete detail, including the activity logs, if any. The user may print patient profiles for a ward group, ward, or by patient.

Example: Patient Profile

```
Select Unit Dose Medications Option: patient Profile (Unit Dose)


Select by WARD GROUP (G), WARD (W), or PATIENT (P): P  Patient

Select PATIENT: ABC,PATIENT         123-45-9111   08/18/20   1 EAST

Select another PATIENT: <Enter>

SHORT, LONG, or NO Profile?  SHORT// <Enter>  SHORT

Show PROFILE only, EXPANDED VIEWS only, or BOTH: PROFILE// <Enter>

Select PRINT DEVICE: <Enter>  NT/Cache virtual TELNET terminal
```

```
                  U N I T   D O S E   P R O F I L E           09/13/00  16:20
                          WHOEVER YOU WANT IT TO BE HEALTHCARE SYSTEM
- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -
 ABC,PATIENT                        Ward: 1 EAST
    PID: 123-45-9111      Room-Bed: B-12             Ht(cm):        (        )
    DOB: 08/18/20  (80)                              Wt(kg): ______ (________)
    Sex: MALE                                      Admitted: 05/03/00
     Dx: TESTING
 Allergies:
      ADR:
 - - - - - - - - - - - - - - - - - A C T I V E - - - - - - - - - - - - - - - - -
   1  -> AMPICILLIN CAP INJ                     C  09/07  09/21  A   NF
          Give: 250MG PO QID
   2  -> HYDROCORTISONE CREAM,TOP               C  09/07  09/21  A   NF
          Give: 1% TOP QD
   3  -> PROPRANOLOL 10MG U/D                   C  09/07  09/21  A   NF
          Give:  PO QD

View ORDERS (1-3): 1
```

----------report continues----------

Example: Patient Profile (continued)

```
     ---------------------------------------------------------------------
Patient: ABC,PATIENT                            Status: ACTIVE
Orderable Item: AMPICILLIN CAP INJ
  Instructions:
Dosage Ordered: 250MG
                                                 Start: 09/07/00  15:00
     Med Route: ORAL (PO)                         Stop: 09/21/00  24:00
 Schedule Type: CONTINUOUS                    Self Med: NO
      Schedule: QID
   Admin Times: 01-09-15-20
      Provider: INPATIENT-MEDS,PROVIDER
                                                 Units   Units   Inactive
 Dispense Drugs                              U/D  Disp'd  Ret'd   Date
---------------------------------------------------------------------------
 AMPICILLIN 500MG CAP                        1    0       0

ORDER NOT VERIFIED
Entry By: INPATIENT-MEDS,PROVIDER                   Entry Date: 09/07/00  13:37

Press RETURN to continue:
```

6.2. Reports Menu
[PSJU REPORTS]

The *Reports Menu* contains various reports generated by the Unit Dose package. All of these reports are QUEUABLE, and it is strongly suggested that these reports be queued when run.

Example: Reports Menu

```
Select Reports Menu Option: ?

   7      7 Day MAR
   14     14 Day MAR
   24     24 Hour MAR
   AP1    Action Profile #1
   AP2    Action Profile #2
          AUthorized Absence/Discharge Summary
          Extra Units Dispensed Report
          Free Text Dosage Report
          INpatient Stop Order Notices
          Medications Due Worksheet
          Patient Profile (Extended
```

6.2.1. 24 Hour MAR
[PSJU 24H MAR]

The *24 Hour MAR* option creates a report that can be used to track the administration of a patient's medications over a 24-hour period. The 24 Hour MAR report includes:

- Date/time range covered by the MAR using a four-digit year format
- Institution Name
- Patient demographic data
- Time line
- Information about each order

The order information consists of:

- Order date
- Start date
- Stop date
- Schedule type (a letter code next to the administration times)
- Administration times (will be blank if an IV order does not have a schedule)
- Drug name
- Strength (if different from that indicated in drug name)
- Medication route abbreviation
- Schedule
- Verifying pharmacist's and nurse's initials

The MAR is printed by ward group (**G**), by ward (**W**), or by patient (**P**). If the user chooses to print by patient, the opportunity to select more than one patient will be given. The system will keep prompting, "Select another PATIENT:". If an up arrow (^) is entered, the user will return to the report menu. When all patients are entered, press **<Enter>** at this prompt to continue.

Note: If the user chooses to select by ward, the administration teams may be specified. The default for the administration team is ALL and multiple administration teams may be entered. If selecting by ward or ward group, the MAR may be sorted by administration time, patient name or room-bed.

There are six medication choices. The user may select multiple choices of medications to be printed on the 24 Hour MAR. Since the first choice is ALL Medications, the user will not be allowed to combine this with any other choices. The default choice is "Non-IV Medications only" if:

1. The MAR ORDER SELECTION DEFAULT parameter was not defined.
2. Selection by Ward group.
3. Selected by patients and patients are from different wards.

The MAR is separated into two sheets. The first sheet is for continuous medications and the second sheet is for one-time and PRN medications. When the 24 Hour MAR with orders is run, both sheets will print for each patient, even though the patient might only have one type of order. The user can also print blank MARs and designate which sheets to print. The user can print continuous medication sheets only, PRN sheets only, or both. The blank MARs contain patient demographics, but no order data. Order information can be added manually or with labels.

Each sheet of the 24 Hour MAR consists of three parts:

1. The top part of each sheet contains the patient demographics.

2. The main body of the MAR contains the order information and an area to record the medication administration.

    a. The order information prints on the left side of the main body, and is printed in the same format as on labels. Labels can be used to add new orders to this area of the MAR (Labels should never be placed over order information already on the MAR). Renewal dates can be recorded on the top line of each order.

    b. The right side of the main body is where the actual administration is to be recorded. It is marked in one-hour increments for simplicity.

3. The bottom of the form allows space for signatures/titles, initials for injections, allergies, injection sites, omitted doses, reason for omitted doses, and initials for omitted doses.

At the "Enter START DATE/TIME for 24 Hour MAR:" prompt, indicate the date and the time of day, in military time, the 24 Hour MAR is to start, including leading and trailing zeros. The time that is entered into this field will print on the 24 Hour MAR as the earliest time on the time line. If the time is not entered at this prompt, the time will default to the time specified in the ward parameter, "START TIME OF DAY FOR 24 HOUR MAR:". If the ward parameter is blank, then the time will default to 0:01 a.m. system time.

Please keep in mind that the MAR is designed to print on stock 8 ½" by 11" paper at 16 pitch (6 lines per inch). It is strongly recommended that this report be queued to print at a later time.

Example: 24 Hour MAR

```
Select Reports Menu Option: 24  24 Hour MAR
Select the MAR forms: 3// ?
     Select one of the following:

          1         Print Blank MARs only
          2         Print Non-Blank MARs only
          3         Print both Blank and Non-Blank MARs
Select the MAR forms: 3// <Enter>  Print both Blank and Non-Blank MARs

Enter START DATE/TIME for 24 hour MAR: 090700@1200  (SEP 07, 2000@12:00)

Select by WARD GROUP (G), WARD (W), or PATIENT (P): PATIENT

Select PATIENT:    ABC,PATIENT       123-45-9111   08/18/20   1 EAST

Select another PATIENT: <Enter>

Enter medication type(s): 2,3,6// ?
1.  All medications
2.  Non-IV medications only
3.  IVPB (Includes IV syringe orders with a med route of IV or IVPB.
          All other IV syringe orders are included with non-IV medications).
4.  LVPs
5.  TPNs
6.  Chemotherapy medications (IV)

A combination of choices can be entered here except for option 1.
e.g.  Enter 1 or 2-4,5 or 2.

Enter medication type(s): 2,3,6// 1
Select PRINT DEVICE: 0;132  NT/Cache virtual TELNET terminal
```

----------report follows----------

Example: 24 Hour MAR (continued)

```
CONTINUOUS SHEET                          24 HOUR MAR          09/07/2000  12:00  through  09/08/2000  11:59
 WHOEVER YOU WANT IT TO BE HEALTHCARE SYSTEM
                                                                                Printed on   09/20/2000  16:15
     Name:  ABC,PATIENT                          Weight (kg): ______ (________)           Ward: 1 EAST
      PID:  123-45-9111  DOB: 08/18/1920  (80)      Height (cm): ______ (________)       Room-Bed: B-12
      Sex:  MALE          Dx: TESTING                                                Admitted: 05/03/2000  13:29
Allergies:      ADR:
                             Admin
Order  Start    Stop         Times     12 13 14 15 16 17 18 19 20 21 22 23 24 01 02 03 04 05 06 07 08 09 10 11
-------------------------------------------------------------------------------------------------------------
      |        |
      ------------------------------------------------------------------------------------------------------
      |        |
      ------------------------------------------------------------------------------------------------------
      |        |
      ------------------------------------------------------------------------------------------------------
      |        |
      ------------------------------------------------------------------------------------------------------
      |        |
      ------------------------------------------------------------------------------------------------------
      |        |

-------------------------------------------------------------------------------------------------------------
|  SIGNATURE/TITLE         | INIT |  ALLERGIES   | INJECTION SITES   |  MED/DOSE OMITTED  |   REASON   | INIT |
|--------------------------|------|--------------| ------------------|--------------------|------------|------|
|--------------------------|------|--------------| Indicate RIGHT (R)|--------------------|------------|------|
|--------------------------|------|--------------| or LEFT (L)       |--------------------|------------|------|
|--------------------------|------|--------------| 1. DELTOID        |--------------------|------------|------|
|--------------------------|------|--------------| 2. ABDOMEN        |--------------------|------------|------|
|--------------------------|------|--------------| 3. ILIAC CREST    |--------------------|------------|------|
|--------------------------|------|--------------| 4. GLUTEAL        |--------------------|------------|------|
|--------------------------|------|--------------| 5. THIGH          |--------------------|------------|------|
|--------------------------|------|--------------|PRN:E=Effective    |--------------------|------------|------|
|--------------------------|------|--------------|    N=Not Effective|--------------------|------------|------|
-------------------------------------------------------------------------------------------------------------
   ABC,PATIENT                 123-45-9111  Room-Bed: B-12                                   VA FORM 10-2970
```

----------***report continues***----------

Example: 24 Hour MAR (continued)

```
ONE-TIME/PRN SHEET                          24 HOUR MAR          09/07/2000  12:00  through  09/08/2000  11:59
 WHOEVER YOU WANT IT TO BE HEALTHCARE SYSTEM                                        Printed on   09/20/2000  16:15
     Name:  ABC,PATIENT                              Weight (kg): ______ (________)           Ward: 1 EAST
     PID:  123-45-9111  DOB: 08/18/1920  (80)        Height (cm): ______ (________)       Room-Bed: B-12
     Sex:  MALE          Dx: TESTING                                                 Admitted: 05/03/2000  13:29
Allergies:      ADR:
                                 Admin
Order  Start     Stop            Times     12 13 14 15 16 17 18 19 20 21 22 23 24 01 02 03 04 05 06 07 08 09 10 11
-------------------------------------------------------------------------------------------------------------------
       |         |
       ------------------------------------------------------------------------------------------------------------
       |         |
       ------------------------------------------------------------------------------------------------------------
       |         |
       ------------------------------------------------------------------------------------------------------------
       |         |
       ------------------------------------------------------------------------------------------------------------
       |         |
       ------------------------------------------------------------------------------------------------------------
       |         |
-------------------------------------------------------------------------------------------------------------------
|   SIGNATURE/TITLE        | INIT |  ALLERGIES   |  INJECTION SITES   |  MED/DOSE OMITTED  |   REASON   | INIT |
|--------------------------|------|--------------|--------------------|--------------------|------------|------|
|--------------------------|------|--------------| Indicate RIGHT (R) |--------------------|------------|------|
|--------------------------|------|--------------| or LEFT (L)        |--------------------|------------|------|
|--------------------------|------|--------------| 1. DELTOID         |--------------------|------------|------|
|--------------------------|------|--------------| 2. ABDOMEN         |--------------------|------------|------|
|--------------------------|------|--------------| 3. ILIAC CREST     |--------------------|------------|------|
|--------------------------|------|--------------| 4. GLUTEAL         |--------------------|------------|------|
|--------------------------|------|--------------| 5. THIGH           |--------------------|------------|------|
|--------------------------|------|--------------|PRN: E=Effective    |--------------------|------------|------|
|--------------------------|------|--------------|     N=Not Effective|--------------------|------------|------|
-------------------------------------------------------------------------------------------------------------------
   ABC,PATIENT                 123-45-9111  Room-Bed: B-12                                    VA FORM 10-5568d
```

----------*report continues*----------

Example: 24 Hour MAR (continued)

```
CONTINUOUS SHEET                                   24 HOUR MAR                    09/07/2000  12:00  through  09/08/2000  11:59
 WHOEVER YOU WANT IT TO BE HEALTHCARE SYSTEM                                        Printed on   09/20/2000  16:15
     Name:  ABC,PATIENT                                   Weight (kg): ______ (________)              Ward: 1 EAST
     PID:  123-45-9111  DOB: 08/18/1920  (80)             Height (cm): ______ (________)          Room-Bed: B-12
     Sex:  MALE          Dx: TESTING                                                            Admitted: 05/03/2000  13:29
Allergies:      ADR:
                                                  Admin
Order   Start   Stop                              Times  12 13 14 15 16 17 18 19 20 21 22 23 24 01 02 03 04 05 06 07 08 09 10 11
-------------------------------------------------------------------------------------------------------------------------------
      |           |                              |01    |
09/07 |09/07 15:00|09/21/00 24:00(A9111)         |09    |
AMPICILLIN CAP INJ                              C|15    |         15             20             01                     09
Give: 250MG PO QID                               |20    |
                                                 |      |
                        RPH: PI   RN: _____|      |
       ---------------------------------------------------------------------------------------------------------------------
      |           |                              |01    |
09/07 |09/07 15:00 |09/14/00 16:54(A9111)        |09    |
AMPICILLIN 1 GM                                 C|15    |         15             20             01                     09
in  0.9% NACL 100 ML                             |20    |
IVPB QID                                         |      |
See next label for continuation                  |      |
       ---------------------------------------------------------------------------------------------------------------------
THIS IS AN INPATIENT IV EXAMPLE                  |      |
                                                 |      |
                                                 |      |
                                                 |      |
                                                 |      |
                        RPH: PI  RN: _____ |      |
       ---------------------------------------------------------------------------------------------------------------------
      |           |                              |      |
09/07 |09/07 17:00 |09/07/00 12:00(A9111)        |      |
HYDROCORTISONE CREAM,TOP                        C|17    |
Give: 1% TOP QD                                  |      |
                                                 |      |
                        RPH: PI   RN: _____|      |
       ---------------------------------------------------------------------------------------------------------------------
      |           |                              |      |
09/07 |09/07 17:00 |09/07/00 12:34(A9111)        |      |
HYDROCORTISONE CREAM,TOP                        C|17    |
Give: 1% 0 QD                                    |      |
                                                 |      |
                        RPH: MLV  RN:      |      |
       ---------------------------------------------------------------------------------------------------------------------
      |           |                              |      |
09/07 |09/07 17:00 |09/07/00 12:50(A9111)        |      |
HYDROCORTISONE CREAM,TOP                        C|17    |
Give: 1% TOP QD                                  |      |
THIS IS AN INPATIENT IV EXAMPLE                  |      |
                        RPH: MLV  RN: _____|      |
-------------------------------------------------------------------------------------------------------------------------------
|   SIGNATURE/TITLE            | INIT |  ALLERGIES    |  INJECTION SITES    |    MED/DOSE OMITTED    |     REASON     | INIT |
|------------------------------|------|---------------|---------------------|------------------------|----------------|------|
|------------------------------|------|---------------| Indicate RIGHT (R) |------------------------|----------------|------|
|------------------------------|------|---------------| or LEFT (L)         |------------------------|----------------|------|
|------------------------------|------|---------------| 1. DELTOID          |------------------------|----------------|------|
|------------------------------|------|---------------| 2. ABDOMEN          |------------------------|----------------|------|
|------------------------------|------|---------------| 3. ILIAC CREST      |------------------------|----------------|------|
|------------------------------|------|---------------| 4. GLUTEAL          |------------------------|----------------|------|
|------------------------------|------|---------------| 5. THIGH            |------------------------|----------------|------|
|------------------------------|------|---------------|PRN: E=Effective     |------------------------|----------------|------|
|------------------------------|------|---------------|     N=Not Effective|------------------------|----------------|------|
-------------------------------------------------------------------------------------------------------------------------------
   ABC,PATIENT                      123-45-9111  Room-Bed: B-12                          PAGE: 1         VA FORM 10-2970
```

----------report continues----------

Example: 24 Hour MAR (continued)

```
ONE-TIME/PRN SHEET                          24 HOUR MAR          09/07/2000  12:00  through  09/08/2000  11:59
 WHOEVER YOU WANT IT TO BE HEALTHCARE SYSTEM                                   Printed on   09/20/2000  16:15
     Name:  ABC,PATIENT                          Weight (kg): ______ (________)           Ward: 1 EAST
     PID:  123-45-9111  DOB: 08/18/1920  (80)    Height (cm): ______ (________)       Room-Bed: B-12
     Sex:  MALE          Dx: TESTING                                                Admitted: 05/03/2000  13:29
Allergies:      ADR:
                                Admin
Order  Start    Stop            Times     12 13 14 15 16 17 18 19 20 21 22 23 24 01 02 03 04 05 06 07 08 09 10 11
-------------------------------------------------------------------------------------------------------------------
       |       |

       -------------------------------------------------------------------------------------------------------------
       |       |

       -------------------------------------------------------------------------------------------------------------
       |       |

       -------------------------------------------------------------------------------------------------------------
       |       |

       -------------------------------------------------------------------------------------------------------------
       |       |

       -------------------------------------------------------------------------------------------------------------
       |       |

-------------------------------------------------------------------------------------------------------------------
|   SIGNATURE/TITLE        | INIT |  ALLERGIES  |  INJECTION SITES   |  MED/DOSE OMITTED  |   REASON   | INIT |
|--------------------------|------|-------------|--------------------|--------------------|------------|------|
|--------------------------|------|-------------| Indicate RIGHT (R) |--------------------|------------|------|
|--------------------------|------|-------------| or LEFT (L)        |--------------------|------------|------|
|--------------------------|------|-------------| 1. DELTOID         |--------------------|------------|------|
|--------------------------|------|-------------| 2. ABDOMEN         |--------------------|------------|------|
|--------------------------|------|-------------| 3. ILIAC CREST     |--------------------|------------|------|
|--------------------------|------|-------------| 4. GLUTEAL         |--------------------|------------|------|
|--------------------------|------|-------------| 5. THIGH           |--------------------|------------|------|
|--------------------------|------|-------------|PRN: E=Effective    |--------------------|------------|------|
|--------------------------|------|-------------|     N=Not Effective|--------------------|------------|------|
-------------------------------------------------------------------------------------------------------------------
   ABC,PATIENT                 123-45-9111  Room-Bed: B-12                  LAST PAGE: 2    VA FORM 10-5568d
```

6.2.2. 7 Day MAR
[PSJU 7D MAR

The *7 Day MAR* option creates a report form that can be used to track the administration of patients' medications.

The 7 Day MAR report includes:

- Date/time range covered by the MAR using a four-digit year format
- Institution Name
- Patient demographic data
- Time line
- Information about each order

The order information consists of:

- Order date
- Start date
- Stop date
- Schedule type (a letter code next to the administration times)
- Administration times (will be blank if an IV order does not have a schedule)
- Drug name
- Strength (if different from that indicated in drug name)
- Medication route abbreviation
- Schedule
- Verifying pharmacist's and nurse's initials

The MAR is printed by ward group (**G**), by ward (**W**), or by patient (**P**). If the user chooses to print by patient, the opportunity to select more than one patient will be given. The system will keep prompting, "Select another PATIENT:". If an up arrow (^) is entered, the user will return to the report menu. When all patients are entered, press **<Enter>** at this prompt to continue.

Note: If the user chooses to select by ward, the administration teams may be specified. The default for the administration team is ALL and multiple administration teams may be entered. If selecting by ward or ward group, the MAR may be sorted by administration time, patient name, or room-bed.

There are six medication choices. The user may select multiple choices of medications to be printed on the 7 Day MAR. Since the first choice is ALL Medications, the user will not be allowed to combine this with any other choices. The default choice is "Non-IV Medications only" if:

1. The MAR ORDER SELECTION DEFAULT parameter was not defined.
2. Selection by Ward group.
3. Selected by patients and patients are from different wards.

The *7 Day MAR* option also allows the nurse to choose whether to print one of the two sheets, continuous, PRN, or both. The MAR is separated into two sheets. The first sheet is for continuous medications and the second sheet is for one-time and PRN medications. When the 7 Day MAR with orders is run, both sheets will print for each patient, even though the patient might only have one type of order. The user can also print blank MARs and designate which sheets to print. The user can print continuous medication sheets only, PRN sheets only, or both. The blank MARs contain patient demographics, but no order data. Order information can be added manually or with labels.

Each sheet of the 7 Day MAR consists of three parts:

1. The top part of each sheet contains the patient demographics.
2. The main body of the MAR contains the order information and an area to record the medication administration.
    a. The order information prints on the left side of the main body, printed in the same format as on labels. Labels can be used to add new orders to this area of the MAR (Labels should <u>never</u> be placed over order information already on the MAR). Renewal dates can be recorded on the top line of each order.
    b. The right side of the main body is where the actual administration is to be recorded. On the continuous medication sheet, the right side will be divided into seven columns, one for each day of the range of the MAR. Asterisks will print at the bottom of the columns corresponding to the days on which the medication is not to be given (e.g., Orders with a schedule of Q3D would only be given every three days, so asterisks would appear on days the medication should not be given).
3. The bottom of the form is designed to duplicate the bottom of the current CMR (VA FORM 10-2970), the back of the current PRN and ONE TIME MED RECORD CMR (VA FORM 10-5568d). The MAR is provided to record other information about the patient and his or her medication(s). It is similar to the bottom of the 24 Hour MAR, but lists more injection sites and does not allow space to list allergies.

    For IV orders that have no schedule, ******* will print on the bottom of the column corresponding to the day the order is to expire. On the continuous medication sheet only, there might be additional information about each order under the column marked notes. On the first line, SM will print if the order has been marked as a self-med order. The letters HSM will print if the order is marked as a hospital supplied self-med. On the second line, WS will print if the order is found to be a ward stock item, CS will print if the item is a Controlled Substance and/or NF will print if the order is a non-formulary. If the order is printed in more than one block, the RPH and RN initial line will print on the last block.

The answer to the prompt, "Enter START DATE/TIME for 7 Day MAR:" determines the date range covered by the 7 Day MAR. The stop date is automatically calculated. Entry of time is not required, but if a time is entered with the date, only those orders that expire after the date and time selected will print. If no time is entered, all orders that expire on or after the date selected will print.

Please keep in mind that the MAR is designed to print on stock 8 ½" by 11" paper at 16 pitch (6 lines per inch). It is strongly recommended that this report be queued to print at a later time.

Example: 7 Day MAR

```
Select Reports Menu Option: 7  7 Day MAR
Select the MAR forms: 3// <Enter>  Print both Blank and Non-Blank MARs

Select TYPE OF SHEETS TO PRINT: BOTH// <Enter>

Enter START DATE/TIME for 7 day MAR: 090700@1200  (SEP 07, 2000@12:00:00)

Select by WARD GROUP (G), WARD (W), or PATIENT (P): PATIENT

Select PATIENT:    ABC,PATIENT       123-45-9111   08/18/20   1 EAST

Select another PATIENT: <Enter>

Enter medication type(s): 2,3,6// 1

Select PRINT DEVICE: 0;132  NT/Cache virtual TELNET terminal
```

----------*report follows*----------

Example: 7 Day MAR (continued)

```
CONTINUOUS SHEET                          7 DAY MAR                          09/07/2000  through  09/13/2000
 WHOEVER YOU WANT IT TO BE HEALTHCARE SYSTEMS                                  Printed on  09/20/2000  16:14
      Name:  ABC,PATIENT                        Weight (kg): ______ (________)           Ward: 1 EAST
      PID:  123-45-9111  DOB: 08/18/1920  (80)   Height (cm): ______ (________)       Room-Bed: B-12
      Sex:  MALE          Dx: TESTING                                              Admitted: 05/03/2000  13:29
Allergies:      ADR:
                                 Admin
Order   Start     Stop       Times    09/07    09/08    09/09    09/10    09/11    09/12    09/13      notes
-------------------------------------------------------------------------------------------------------------------
      |         |                   |________|________|________|________|________|________|________|
                                    |________|________|________|________|________|________|________|
                                    |________|________|________|________|________|________|________|
                                    |________|________|________|________|________|________|________|
                                    |________|________|________|________|________|________|________|
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      |         |                   |________|________|________|________|________|________|________|
                                    |________|________|________|________|________|________|________|
                                    |________|________|________|________|________|________|________|
                                    |________|________|________|________|________|________|________|
                                    |________|________|________|________|________|________|________|
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      |         |                   |________|________|________|________|________|________|________|
                                    |________|________|________|________|________|________|________|
                                    |________|________|________|________|________|________|________|
                                    |________|________|________|________|________|________|________|
                                    |________|________|________|________|________|________|________|
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      |         |                   |________|________|________|________|________|________|________|
                                    |________|________|________|________|________|________|________|
                                    |________|________|________|________|________|________|________|
                                    |________|________|________|________|________|________|________|
                                    |________|________|________|________|________|________|________|
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      |         |                   |________|________|________|________|________|________|________|
                                    |________|________|________|________|________|________|________|
                                    |________|________|________|________|________|________|________|
                                    |________|________|________|________|________|________|________|
                                    |________|________|________|________|________|________|________|
-------------------------------------------------------------------------------------------------------------------
|  SIGNATURE/TITLE        | INIT |         INJECTION SITES           |  MED/DOSE OMITTED  |   REASON   | INIT |
|-------------------------|------|-----------------------------------|--------------------|------------|------|
|-------------------------|------|   Indicate RIGHT (R) or LEFT (L)  |--------------------|------------|------|
|-------------------------|------|                                   |--------------------|------------|------|
|-------------------------|------|   (IM)                   (SUB Q)  |--------------------|------------|------|
|-------------------------|------|1.DELTOID             6. UPPER ARM |--------------------|------------|------|
|-------------------------|------|2.VENTRAL GLUTEAL     7. ABDOMEN   |--------------------|------------|------|
|-------------------------|------|3.GLUTEUS MEDIUS      8. THIGH     |--------------------|------------|------|
|-------------------------|------|4.MID(ANTERIOR) THIGH 9. BUTTOCK   |--------------------|------------|------|
|-------------------------|------|5.VASTUS LATERALIS   10. UPPER BACK|--------------------|------------|------|
|-------------------------|------|PRN: E=Effective   N=Not Effective |--------------------|------------|------|
-------------------------------------------------------------------------------------------------------------------
   ABC,PATIENT                    123-45-9111  Room-Bed: B-12                                   VA FORM 10-2970
```

----------*report continues*----------

Example: 7 Day MAR (continued)

```
 ONE-TIME/PRN SHEET                          7 DAY MAR                        09/07/2000  through  09/13/2000
     WHOEVER YOU WANT IT TO BE HEALTHCARE SYSTEMS                               Printed on  09/20/2000  16:14
      Name:  ABC,PATIENT                        Weight (kg): ______ (________)          Ward: 1 EAST
      PID:  123-45-9111  DOB: 08/18/1920  (80)   Height (cm): ______ (________)       Room-Bed: B-12
      Sex:  MALE          Dx: TESTING                                             Admitted: 05/03/2000  13:29
Allergies:      ADR:

Order   Start      Stop                                          Order   Start       Stop
-------------------------------------------------------------------------------------------------------------
      |          |                         |                   |       |           |
                                           |                   |
                                           |                   |
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      |          |                         |                   |       |           |
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                                           |                   |
                                           |                   |
                                           |                   |
-------------------------------------------------------------------------------------------------------------
|  DATE  |  TIME  |  MEDICATION/DOSE/ROUTE     | INIT |      REASON       |     RESULTS       |  TIME  | INIT |
|--------|--------|----------------------------|------|-------------------|-------------------|--------|------|
```

Example: 7 Day MAR (continued)

```
 CONTINUOUS SHEET                                  7 DAY MAR                                    09/07/2000  through  09/13/2000
     WHOEVER YOU WANT IT TO BE HEALTHCARE SYSTEMS                                                 Printed on  09/20/2000  16:14
     Name:  ABC,PATIENT                                 Weight (kg): ______ (________)                    Ward: 1 EAST
     PID:  123-45-9111  DOB: 08/18/1920  (80)           Height (cm): ______ (________)                Room-Bed: B-12
     Sex:  MALE          Dx: TESTING                                                               Admitted: 05/03/2000  13:29
Allergies:      ADR:
                                                 Admin
 Order   Start       Stop                        Times    09/07     09/08     09/09     09/10     09/11     09/12     09/13     notes
-------------------------------------------------------------------------------------------------------------------------------------
      |           |                              |01    |*********|_________|_________|_________|_________|________|_________|
09/07 |09/07 15:00 |09/21/00 24:00(A9111)        |09    |*********|_________|_________|_________|_________|________|_________|
AMPICILLIN CAP INJ                             C|15    |_________|_________|_________|_________|_________|________|_________|
Give: 250MG PO QID                              |20    |_________|_________|_________|_________|_________|________|_________|
                                                |      |         |         |         |         |         |        |         |
                          RPH: PI   RN: _____|      |         |         |         |         |         |        |         |
      ---------------------------------------------------------------------------------------------------------------------------
      |           |                              |01    |*********|_________|_________|_________|_________|________|_________|
09/07 |09/07 15:00 |09/14/00 16:54(A9111)        |09    |*********|_________|_________|_________|_________|________|_________|
AMPICILLIN 1 GM                                C|15    |_________|_________|_________|_________|_________|________|_________|
in  0.9% NACL 100 ML                            |20    |_________|_________|_________|_________|_________|________|_________|
IVPB QID                                        |      |_________|_________|_________|_________|_________|________|_________|
See next label for continuation                 |      |         |         |         |         |         |        |         |
      ---------------------------------------------------------------------------------------------------------------------------
THIS IS AN INPATIENT IV EXAMPLE                 |      |_________|_________|_________|_________|_________|________|_________|
                                                |      |_________|_________|_________|_________|_________|________|_________|
                                                |      |_________|_________|_________|_________|_________|________|_________|
                                                |      |_________|_________|_________|_________|_________|________|_________|
                                                |      |_________|_________|_________|_________|_________|________|_________|
                          RPH: PI  RN: _____|      |         |         |         |         |         |        |         |
      ---------------------------------------------------------------------------------------------------------------------------
      |           |                              |      |_________|_________|_________|_________|_________|________|_________|
09/07 |09/07 17:00 |09/07/00 12:34(A9111)        |      |_________|_________|_________|_________|_________|________|_________|
HYDROCORTISONE CREAM,TOP                       C|17    |*********|*********|*********|*********|*********|*********|********|
Give: 1% 0 QD                                   |      |_________|_________|_________|_________|_________|________|_________|
                                                |      |_________|_________|_________|_________|_________|________|_________|
                          RPH: MLV  RN: _____|      |         |         |         |         |         |        |         |
      ---------------------------------------------------------------------------------------------------------------------------
      |           |                              |      |_________|_________|_________|_________|_________|________|_________|
09/07 |09/07 17:00 |09/07/00 12:50(A9111)        |      |         |         |         |         |         |        |         |
HYDROCORTISONE CREAM,TOP                       C|17    |*********|*********|*********|*********|*********|*********|********|
Give: 1% TOP QD                                 |      |_________|_________|_________|_________|_________|________|_________|
THIS IS AN INPATIENT IV EXAMPLE                 |      |_________|_________|_________|_________|_________|________|_________|
                          RPH: MLV  RN: _____|      |         |         |         |         |         |        |         |
      ---------------------------------------------------------------------------------------------------------------------------
      |           |                              |      |_________|_________|_________|_________|_________|________|_________|
09/07 |09/07 17:00 |09/07/00 12:50(A9111)        |      |_________|_________|_________|_________|_________|________|_________|
HYDROCORTISONE CREAM,TOP                       C|17    |*********|*********|*********|*********|*********|*********|********|
Give: 1% TOP QD                                 |      |_________|_________|_________|_________|_________|________|_________|
THIS IS AN INPATIENT IV EXAMPLE                 |      |_________|_________|_________|_________|_________|________|_________|
                          RPH: MLV  RN: _____|      |         |         |         |         |         |        |         |
-------------------------------------------------------------------------------------------------------------------------------------
|  SIGNATURE/TITLE             |  INIT  |          INJECTION SITES            |    MED/DOSE OMITTED    |     REASON      |  INIT   |
|------------------------------|--------|-------------------------------------|------------------------|-----------------|---------|
|------------------------------|--------|   Indicate RIGHT (R) or LEFT (L)    |------------------------|-----------------|---------|
|------------------------------|--------|                                     |------------------------|-----------------|---------|
|------------------------------|--------|   (IM)                   (SUB Q)    |------------------------|-----------------|---------|
|------------------------------|--------|1. DELTOID             6. UPPER ARM |------------------------|-----------------|---------|
|------------------------------|--------|2. VENTRAL GLUTEAL     7. ABDOMEN   |------------------------|-----------------|---------|
|------------------------------|--------|3. GLUTEUS MEDIUS      8. THIGH     |------------------------|-----------------|---------|
|------------------------------|--------|4. MID(ANTERIOR) THIGH 9. BUTTOCK   |------------------------|-----------------|---------|
|------------------------------|--------|5. VASTUS LATERALIS   10. UPPER BACK|------------------------|-----------------|---------|
|------------------------------|--------| PRN: E=Effective   N=Not Effective |------------------------|-----------------|---------|
-------------------------------------------------------------------------------------------------------------------------------------
   ABC,PATIENT                        123-45-9111  Room-Bed: B-12                    LAST PAGE: 1               VA FORM 10-2970
```

6.2.3. 14 Day MAR
[PSJU 14D MAR]

The *14 Day MAR* option creates a report form that can be used to track the administration of patients' medications.

The 14 Day MAR report includes:

- Date/time range covered by the MAR using a four-digit year format
- Institution Name
- Patient demographic data
- Time line
- Information about each order

The order information consists of:

- Order date
- Start date
- Stop date
- Schedule type (a letter code next to the administration times)
- Administration times (will be blank if an IV order does not have a schedule)
- Drug name
- Strength (if different from that indicated in drug name)
- Medication route abbreviation
- Schedule
- Verifying pharmacist's and nurse's initials

The MAR is printed by ward group (**G**), by ward (**W**), or by patient (**P**). If the user chooses to print by patient, the opportunity to select more than one patient will be given. The system will keep prompting, "Select another PATIENT:". If an up arrow (^) is entered, the user will return to the report menu. When all patients are entered, press **<Enter>** at this prompt to continue.

Note: If the user chooses to select by ward, the administration teams may be specified. The default for the administration team is ALL and multiple administration teams may be entered. If selecting by ward or ward group, the MAR may be sorted by administration time, patient name or room-bed.

There are six medication choices. The user may select multiple choices of medications to be printed on the 14 Day MAR. Since the first choice is ALL Medications, the user will not be allowed to combine this with any other choices. The default choice is "Non-IV Medications only" if:

1. The MAR ORDER SELECTION DEFAULT parameter was not defined.
2. Selection by Ward group.
3. Selected by patients and patients are from different wards.

The *14 Day MAR* option allows the nurse to choose whether to print continuous, PRN, or both. The MAR is separated into two sheets. The first sheet is for continuous medications and the second sheet is for one-time and PRN medications. When the 14 Day MAR with orders is run, both sheets will print for each patient, even though the patient might only have one type of order. The user can also print blank MARs and designate which sheets to print. The user can print continuous medication sheets only, PRN sheets only, or both. The blank MARs contain patient demographics, but no order data. Order information can be added manually or with labels.

Each sheet of the MAR consists of three parts:

1. The top part of each sheet contains the patient demographics.
2. The main body of the MAR contains the order information and an area to record the medication administration.
    a. The order information prints on the left side of the main body, printed in the same format as on labels. Labels can be used to add new orders to this area of the MAR (Labels should <u>never</u> be placed over order information already on the MAR). Renewal dates can be recorded on the top line of each order.
    b. The right side of the main body is where the actual administration is to be recorded. On the continuous medication sheet, the right side will be divided into 14 columns, one for each day of the range of the MAR. Asterisks will print at the bottom of the columns corresponding to the days on which the medication is not to be given (e.g., Orders with a schedule of Q3D would only be given every three days, so asterisks would appear on two days out of three).
3. The bottom of the MAR is provided to record other information about the patient and his or her medication(s). It is similar to the bottom of the 24-hour MAR, but lists more injection sites.

    For IV orders that have no schedule, **** will print on the bottom of the column corresponding to the day the order is to expire. On the continuous medication sheet only, there might be additional information about each order under the column marked notes. On the first line, SM will print if the order has been marked as a self-med order. The letters HSM will print if the order is marked as a hospital supplied self-med. On the second line, WS will print if the order is found to be a ward stock item, CS will print if the item is a Controlled Substance and/or NF will print if the order is a non-formulary. If the order is printed in more than one block, the RPH and RN initial line will print on the last block.

The answer to the prompt, "Enter START DATE/TIME for 14 Day MAR:" determines the date range covered by the 14 Day MAR. The stop date is automatically calculated. Entry of time is <u>not</u> required, but if a time is entered with the date, only those orders that expire after the date and time selected will print. If no time is entered, all orders that will expire on or after the date selected will print.

Please keep in mind that the MAR is designed to print on stock 8 ½" by 11" paper at 16 pitch (6 lines per inch). It is strongly recommended that this report be queued to print at a later time.

Example: 14 Day MAR

```
Select Reports Menu Option:  14 Day MAR
Select the MAR forms: 3// <Enter>  Print both Blank and Non-Blank MARs

Select TYPE OF SHEETS TO PRINT: BOTH// <Enter>

Enter START DATE/TIME for 14 day MAR: 090700@1200  (SEP 07, 2000@12:00:00)

Select by WARD GROUP (G), WARD (W), or PATIENT (P): PATIENT

Select PATIENT:    ABC,PATIENT       123-45-9111   08/18/20   1 EAST

Select another PATIENT: <Enter>

Enter medication type(s): 2,3,6// 1

Select PRINT DEVICE: 0;132    NT/Cache virtual TELNET terminal
```

```
 CONTINUOUS SHEET                          14 DAY MAR                          09/07/2000  through  09/20/2000
     WHOEVER YOU WANT IT TO BE HEALTHCARE SYSTEMS                                Printed on  09/20/2000  16:11
      Name:  ABC,PATIENT                       Weight (kg): ______ (________)           Ward: 1 EAST
      PID:  123-45-9111  DOB: 08/18/1920  (80)    Height (cm): ______ (________)       Room-Bed: B-12
      Sex:  MALE          Dx: TESTING                                              Admitted: 05/03/2000  13:29
Allergies:      ADR:
                              Admin   SEP
Order   Start     Stop      Times   07   08   09   10   11   12   13   14   15   16   17   18   19   20  notes
-------------------------------------------------------------------------------------------------------------------
      |         |                 |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
                                  |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
                                  |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
                                  |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
                                  |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
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      |         |                 |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
                                  |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
                                  |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
                                  |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
                                  |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
-------------------------------------------------------------------------------------------------------------------
      |         |                 |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
                                  |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
                                  |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
                                  |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
                                  |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
-------------------------------------------------------------------------------------------------------------------
      |         |                 |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
                                  |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
                                  |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
                                  |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
                                  |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
-------------------------------------------------------------------------------------------------------------------
      |         |                 |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
                                  |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
                                  |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
                                  |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
                                  |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
-------------------------------------------------------------------------------------------------------------------
|     SIGNATURE/TITLE     | INIT |          INJECTION SITES           |  MED/DOSE OMITTED  |   REASON   | INIT |
|-------------------------|------|------------------------------------|--------------------|------------|------|
|-------------------------|------|   Indicate RIGHT (R) or LEFT (L)   |--------------------|------------|------|
|-------------------------|------|                                    |--------------------|------------|------|
|-------------------------|------|   (IM)                   (SUB Q)   |--------------------|------------|------|
|-------------------------|------|1. DELTOID             6. UPPER ARM |--------------------|------------|------|
|-------------------------|------|2. VENTRAL GLUTEAL     7. ABDOMEN   |--------------------|------------|------|
|-------------------------|------|3. GLUTEUS MEDIUS      8. THIGH     |--------------------|------------|------|
|-------------------------|------|4. MID(ANTERIOR) THIGH 9. BUTTOCK   |--------------------|------------|------|
|-------------------------|------|5. VASTUS LATERALIS   10. UPPER BACK|--------------------|------------|------|
|-------------------------|------| PRN: E=Effective   N=Not Effective |--------------------|------------|------|
-------------------------------------------------------------------------------------------------------------------
   ABC,PATIENT                  123-45-9111  Room-Bed: B-12                                    VA FORM 10-2970
```

----------*report continues*----------

Example: 14 Day MAR (continued)

```
 ONE-TIME/PRN SHEET                              14 DAY MAR                    09/07/2000  through  09/20/2000
     WHOEVER YOU WANT IT TO BE HEALTHCARE SYSTEMS                                Printed on  09/20/2000  16:11
      Name:  ABC,PATIENT                      Weight (kg): ______ (________)           Ward: 1 EAST
      PID:  123-45-9111  DOB: 08/18/1920  (80)   Height (cm): ______ (________)       Room-Bed: B-12
      Sex:  MALE          Dx: TESTING                                              Admitted: 05/03/2000  13:29
Allergies:      ADR:
Order   Start       Stop                                    Order   Start       Stop
-------------------------------------------------------------------------------------------------------------
      |           |                   |                   |       |           |
                                      |                   |
                                      |                   |
                                      |                   |
                                      |                   |
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      |           |                   |                   |       |           |
                                      |                   |
                                      |                   |
                                      |                   |
                                      |                   |
-------------------------------------------------------------------------------------------------------------
|  DATE  |  TIME  |     MEDICATION/DOSE/ROUTE     | INIT |      REASON      |    RESULTS      |  TIME  | INIT |
|--------|--------|-------------------------------|------|------------------|-----------------|--------|------|
```

Example: 14 Day MAR (continued)

```
 CONTINUOUS SHEET                                        14 DAY MAR                                 09/07/2000  through  09/20/2000
     WHOEVER YOU WANT IT TO BE HEALTHCARE SYSTEMS                                                     Printed on  09/20/2000  16:11
     Name:  ABC,PATIENT                                        Weight (kg): ______ (________)                 Ward: 1 EAST
      PID:  123-45-9111  DOB: 08/18/1920  (80)                 Height (cm): ______ (________)             Room-Bed: B-12
      Sex:  MALE          Dx: TESTING                                                                  Admitted: 05/03/2000  13:29
Allergies:      ADR:
                                                   Admin   SEP
 Order   Start       Stop                          Times   07   08   09   10   11   12   13   14   15   16   17   18   19   20   notes
-------------------------------------------------------------------------------------------------------------------------------------------
      |           |                                |01    |****|____|____|____|____|____|____|____|____|____|____|____|____|____|
09/07 |09/07 15:00 |09/21/00 24:00 (A9111)         |09    |****|____|____|____|____|____|____|____|____|____|____|____|____|____|
AMPICILLIN CAP INJ                               C|15    |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
Give: 250MG PO QID                                |20    |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
                                                  |      |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
                          RPH: PI   RN: _____     |      |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
      ---------------------------------------------------------------------------------------------------------------------------------
      |           |                                |01    |****|____|____|____|____|____|____|____|****|****|****|****|****|****|
09/07 |09/07 15:00 |09/14/00 16:54 (A9111)         |09    |****|____|____|____|____|____|____|____|****|****|****|****|****|****|
AMPICILLIN 1 GM                                  C|15    |____|____|____|____|____|____|____|____|****|****|****|****|****|****|
in  0.9% NACL 100 ML                              |20    |____|____|____|____|____|____|____|****|****|****|****|****|****|****|
IVPB QID                                          |      |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
See next label for continuation                   |      |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
      ---------------------------------------------------------------------------------------------------------------------------------
THIS IS AN INPATIENT IV EXAMPLE                   |      |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
                                                  |      |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
                                                  |      |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
                                                  |      |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
                                                  |      |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
                          RPH: PI  RN: _____      |      |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
      ---------------------------------------------------------------------------------------------------------------------------------
      |           |                                |      |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
09/07 |09/07 17:00 |09/07/00 12:34 (A9111)         |      |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
HYDROCORTISONE CREAM,TOP                         C|17    |****|****|****|****|****|****|****|****|****|****|****|****|****|****|
Give: 1% 0 QD                                     |      |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
                                                  |      |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
                          RPH: MLV  RN: _____     |      |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
      ---------------------------------------------------------------------------------------------------------------------------------
      |           |                                |      |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
09/07 |09/07 17:00 |09/07/00 12:50 (A9111)         |      |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
HYDROCORTISONE CREAM,TOP                         C|17    |****|****|****|****|****|****|****|****|****|****|****|****|****|****|
Give: 1% TOP QD                                   |      |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
THIS IS AN INPATIENT IV EXAMPLE                   |      |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
                          RPH: MLV  RN: _____     |      |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
      ---------------------------------------------------------------------------------------------------------------------------------
      |           |                                |      |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
09/07 |09/07 17:00 |09/07/00 12:50 (A9111)         |      |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
HYDROCORTISONE CREAM,TOP                         C|17    |****|****|****|****|****|****|****|****|****|****|****|****|****|****|
Give: 1% TOP QD                                   |      |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
THIS IS AN INPATIENT IV EXAMPLE                   |      |____|____|____|____|____|____|____|____|____|____|____|____|____|____|
                          RPH: MLV  RN:           |      |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
-------------------------------------------------------------------------------------------------------------------------------------------
|      SIGNATURE/TITLE            | INIT |          INJECTION SITES           |    MED/DOSE OMITTED    |     REASON     |  INIT  |
|---------------------------------|------|------------------------------------|------------------------|----------------|--------|
|---------------------------------|------|   Indicate RIGHT (R) or LEFT (L)   |------------------------|----------------|--------|
|---------------------------------|------|                                    |------------------------|----------------|--------|
|---------------------------------|------|   (IM)                   (SUB Q)   |------------------------|----------------|--------|
|---------------------------------|------|1. DELTOID             6. UPPER ARM |------------------------|----------------|--------|
|---------------------------------|------|2. VENTRAL GLUTEAL     7. ABDOMEN   |------------------------|----------------|--------|
|---------------------------------|------|3. GLUTEUS MEDIUS      8. THIGH     |------------------------|----------------|--------|
|---------------------------------|------|4. MID(ANTERIOR) THIGH 9. BUTTOCK   |------------------------|----------------|--------|
|---------------------------------|------|5. VASTUS LATERALIS   10. UPPER BACK|------------------------|----------------|--------|
|---------------------------------|------| PRN: E=Effective   N=Not Effective |------------------------|----------------|--------|
-------------------------------------------------------------------------------------------------------------------------------------------
   ABC,PATIENT                        123-45-9111  Room-Bed: B-12                      LAST PAGE: 1           VA FORM 10-2970
```

6.2.4. Action Profile #1 [PSJU AP-1]

The *Action Profile #1* option creates a report form that contains all of the active inpatient medication orders for one or more patients. These patients may be selected by ward group, ward, or by patient. If selection by ward is chosen, the administration teams may be specified. The default for the administration team is ALL and multiple administration teams may be entered. If selecting by ward or ward group, the profile may be sorted by patient name or room-bed.

There are six medication choices. The user may select multiple choices of medications to be printed on the Action Profile #1 report. Since the first choice is ALL Medications, the user will not be allowed to combine this with any other choices. The default choice is "Non-IV Medications only" if:

1. The MAR ORDER SELECTION DEFAULT parameter was not defined.
2. Selection by Ward group.
3. Selected by patients and patients are from different wards.

The form is printed so the attending provider will have a method of periodically reviewing these active medication orders. If the user chooses to run this option by patient, the opportunity to select as many patients is given, but only those that have active orders will print.

Also on this profile, the provider can renew, discontinue, or not take any action regarding the active orders for each patient. A new order will be required for any new medication prescribed or for any changes in the dosage or directions of an existing order. If no action is taken, a new order is not required.

If the user chooses to enter a start and stop date, only patients with active orders occurring between those dates will print (for the ward or wards chosen). The start and stop dates must be in the future (**NOW** is acceptable). Time is required only if the current date of **TODAY** or **T** is entered.

It is recommended that the action profiles be printed on two-part paper, if possible. Using two-part paper allows a copy to stay on the ward and the other copy to be sent to the pharmacy.

Note: This report uses a four-digit year format.

Example: Action Profile #1

```
Select Reports Menu Option: AP1  Action Profile #1

Select by WARD GROUP (G), WARD (W), or PATIENT (P): Patient

Select PATIENT: ABC,PATIENT         123-45-9111   08/18/20   1 EAST

Select another PATIENT: <Enter>
Enter medication type(s): 2,3,6// 1
...this may take a few minutes...(you should QUEUE this report)...
Select PRINT DEVICE: <Enter>  NT/Cache virtual TELNET terminal

Enter RETURN to continue or '^' to exit: <Enter>
```

----------*report follows*----------

Example: Action Profile #1 (continued)

```
                          UNIT DOSE ACTION PROFILE #1         09/11/2000  11:01
                           WHOEVER YOU WANT IT TO BE HEALTHCARE SYSTEMS
                       (Continuation of VA FORM 10-1158)                Page: 1
--------------------------------------------------------------------------------
   This form is to be used to REVIEW/RENEW/CANCEL existing active medication
 orders for inpatients.  Review the active orders listed and beside each order
 circle one of the following:
                              R - to RENEW the order
                              D - to DISCONTINUE the order
                              N - to take NO ACTION (the order will remain
                                  active until the stop date indicated)

   A new order must be written for any new medication or to make any changes
 in dosage or directions on an existing order.
--------------------------------------------------------------------------------
 ABC,PATIENT                          Ward: 1 EAST
    PID: 123-45-9111      Room-Bed: B-12             Ht(cm): ______ (________)
    DOB: 08/18/1920  (80)                            Wt(kg): ______ (________)
    Sex: MALE                                      Admitted: 05/03/2000
     Dx: TESTING
 Allergies:
       ADR:
--------------------------------------------------------------------------------
 No. Action     Drug                                ST Start Stop  Status/Info
 - - - - - - - - - - - - - - - - - A C T I V E - - - - - - - - - - - - - - - - - -
1  R D N AMPICILLIN 1 GM                          C  09/07 09/14 A
          in 0.9% NACL 100 ML QID
          Special Instructions: THIS IS AN INPATIENT IV EXAMPLE

  2  R D N AMPICILLIN CAP INJ                       C  09/07 09/21 A
          Give: 250MG PO QID

  3  R D N HYDROCORTISONE CREAM,TOP                 C  09/07 09/21 A
          Give: 1% TOP QD
  4  R D N MULTIVITAMINS 5 ML                       C  09/07 09/12 A
          in 0.9% NACL 1000 ML 20 ml/hr

  5  R D N PROPRANOLOL 10MG U/D                     C  09/07 09/21 A
          Give:  PO QD


               ___________________      ______________________________________
               Date AND Time            PHYSICIAN'S SIGNATURE


         MULTIDISCIPLINARY REVIEW
               (WHEN APPROPRIATE)       ______________________________________
                                        PHARMACIST'S SIGNATURE

                                        ______________________________________
                                        NURSE'S SIGNATURE


   ADDITIONAL MEDICATION ORDERS:

--------------------------------------------------------------------------------

--------------------------------------------------------------------------------

--------------------------------------------------------------------------------

--------------------------------------------------------------------------------

--------------------------------------------------------------------------------


               Date AND Time            PHYSICIAN'S SIGNATURE

  ABC,PATIENT                           123-45-9111                 08/18/1920
```

6.2.5. Action Profile #2
[PSJU AP-2]

The *Action Profile #2* option is similar to the *Action Profile #1* option (see previous report) with the added feature that the nurse can show only expiring orders, giving in effect, stop order notices (see *INpatient Stop Order Notices*).

The user can run the *Action Profile #2* option by ward group, ward, or by patient. If this option is run by patient, the opportunity to select as many patients as desired is given, but the user will not get a report if the patient has no active orders.

If the option for a ward or a ward group is chosen, a prompt to choose the ward or ward group for which the user wants to run the option is displayed. The user will be asked to sort (print) Action Profiles by team or treating provider. Start and stop dates will be prompted next. Only those patients with at least one active order that has a stop date between the dates chosen will print. If entered, the start and stop dates must be in the future (**NOW** is acceptable). Time is required only if the current date of **TODAY** or **T** is entered. A future date does not require time to be entered.

At the "Print (A)ll active orders, or (E)xpiring orders only? A//" prompt, the user can choose to print all active orders for the patient(s) selected, or print only orders that will expire within the date range selected for the patient(s) selected.

It is recommended that the action profiles be printed on two-part paper, if possible. Using two-part paper allows a copy to stay on the ward and the other copy to be sent to the pharmacy.

Note: This report uses a four-digit year format.

Example: Action Profile #2

```
Select Reports Menu Option: AP2  Action Profile #2

Select by WARD GROUP (G), WARD (W), or PATIENT (P): PATIENT

Select PATIENT: ABC,PATIENT         123-45-9111   08/18/20   1 EAST

Select another PATIENT: <Enter>
Enter START date/time: NOW// <Enter>  (SEP 11, 2000@11:02)
Enter STOP date/time: SEP 11,2000@11:02// T+7  (SEP 18, 2000)

Print (A)ll active orders, or (E)xpiring orders only? A// <Enter>  (ALL)


Enter medication type(s): 2,3,6// 1

Select PRINT DEVICE: <Enter>   NT/Cache virtual TELNET terminal

...this may take a few minutes...(you really should QUEUE this report)...
Enter RETURN to continue or '^' to exit: <Enter>
```

----------report follows----------

Example: Action Profile #2 (continued)

```
UNIT DOSE ACTION PROFILE #2         09/11/2000  11:03
                          WHOEVER YOU WANT IT TO BE HEALTHCARE SYSTEMS
                      (Continuation of VA FORM 10-1158)               Page: 1
-------------------------------------------------------------------------------
   A new order must be written for any new medication or to make any changes
 in dosage or directions on an existing order.
-------------------------------------------------------------------------------
                                Team: NOT FOUND
 ABC,PATIENT                    Ward: 1 EAST
    PID: 123-45-9111        Room-Bed: B-12          Ht(cm): ______ (________)
    DOB: 08/18/1920  (80)                           Wt(kg): ______ (________)
    Sex: MALE                                     Admitted: 05/03/2000
     Dx: TESTING
 Allergies:
       ADR:
-------------------------------------------------------------------------------
No. Action      Drug                          ST Start Stop  Status/Info
 - - - - - - - - - - - - - - - - - - A C T I V E - - - - - - - - - - - - - - - -
1  AMPICILLIN 1 GM                            C  09/07 09/14 A
     in 0.9% NACL 100 ML QID
     Special Instructions: THIS IS AN INPATIENT IV EXAMPLE

       TAKE NO ACTION       DISCONTINUE       RENEW   COST/DOSE: 1.32
  ---------------------------------------------------------------------------

2  AMPICILLIN CAP INJ                         C  09/07 09/21 A
     Give: 250MG PO QID

     __TAKE NO ACTION     __DISCONTINUE     __RENEW   COST/DOSE: 0.731
  ---------------------------------------------------------------------------

3  HYDROCORTISONE CREAM,TOP                   C  09/07 09/21 A
     Give: 1% TOP QD

     __TAKE NO ACTION     __DISCONTINUE     __RENEW   COST/DOSE: 0.86
  ---------------------------------------------------------------------------

4  MULTIVITAMINS 5 ML                         C  09/07 09/12 A
     in 0.9% NACL 1000 ML 20 ml/hr

       TAKE NO ACTION       DISCONTINUE       RENEW   COST/DOSE: 468.795
  ---------------------------------------------------------------------------


                _________________      ________________________________________
                Date AND Time          PHYSICIAN'S SIGNATURE


          MULTIDISCIPLINARY REVIEW
                (WHEN APPROPRIATE)
                                       PHARMACIST'S SIGNATURE

                                       ________________________________________
                                       NURSE'S SIGNATURE

   ADDITIONAL MEDICATION ORDERS:

-------------------------------------------------------------------------------

-------------------------------------------------------------------------------

-------------------------------------------------------------------------------

-------------------------------------------------------------------------------

-------------------------------------------------------------------------------


                _________________      ________________________________________
                Date AND Time          PHYSICIAN'S SIGNATURE

  ABC,PATIENT                          123-45-9111                 08/18/1920
```

6.2.6. AUthorized Absence/Discharge Summary [PSJU DS]

The *AUthorized Absence/Discharge Summary* option creates a report to allow the user to determine what action to take on a patient's Unit Dose orders if the patient is discharged from the hospital or will leave the hospital for a designated period of time (authorized absence). The form is printed so that the provider can place the active orders of a patient on hold, not take any action on the order or continue the order upon discharge or absence. If the provider wishes to continue the order upon discharge, then he or she can identify the number of refills, the quantity and the number of days for the order to remain active. If no action is taken on the order, it will expire or be discontinued.

The user can run the Authorized Absence Discharge Summary by ward group, ward, or by patient. If the user chooses to run this report by patient, the opportunity is given to select as many patients as desired, but only patients with active orders will print.

If the option by ward or ward groups is chosen, the user will be prompted for start and stop date. Entry of these dates is not required, but if a start and stop date is entered, a discharge summary will print only for those patients that have at least one order that will be active between those dates. If the user does not enter a start date, all patients with active orders will print (for the ward or ward group chosen). If a clinic visit has been scheduled, the date will print. If more than one has been scheduled, only the first one will print. It is recommended that this report be queued to print when user demand for the system is low.

For co-payment purposes, information related to the patient's service connection is shown on the first page of the form (for each patient). If the patient is a service-connected less than 50% veteran, the provider is given the opportunity to mark each non-supply item order as either SERVICE CONNECTED (SC) or NON-SERVICE CONNECTED (NSC).

Note: This report uses a four-digit year format.

Example: Authorized Absence/Discharge Summary

```
Select Reports Menu Option: AUthorized Absence/Discharge Summary

Print BLANK Authorized Absence/Discharge Summary forms? NO// <Enter>


Select by WARD GROUP (G), WARD (W), or PATIENT (P): Patient

Select PATIENT: XYZ,PATIENT         222-32-4321   02/22/42   1 West

Select another PATIENT: <Enter>
...this may take a few minutes...(you should QUEUE this report)...

Select PRINT DEVICE: <Enter>  TELNET
```

```
----------------------------------------report follows----------------------------------------
```

Example: Authorized Absence/Discharge Summary (continued)

```
                      AUTHORIZED ABSENCE/DISCHARGE ORDERS     09/19/2000  12:43
                              VAMC:  REGION 5 (660)
 VA FORM: 10-7978M
 Effective Date:                                                        Page: 1
================================================================================
Instructions to the physician:
    A. A prescription blank (VA FORM 10-2577F) must be used for:
         1. all class II narcotics
         2. any medications marked as 'nonrenewable'
         3. any new medications in addition to those entered on this form.
    B. If a medication is not to be continued, mark "TAKE NO ACTION".
    C. To continue a medication, you MUST:
         1. enter directions, quantity, and refills
         2. sign the order, enter your DEA number, and enter the date AND time.
================================================================================
 XYZ,PATIENT                          Ward: 1 West
    PID: 222-32-4321      Room-Bed: A-6              Ht(cm): 167.64 (04/21/1999)
    DOB: 02/22/1942  (58)     Team: * NF *           Wt(kg):  85.00 (04/21/1999)
    Sex: MALE                                      Admitted: 09/16/1999
     Dx: TEST PATIENT
 Allergies: CARAMEL, CN900, LOMEFLOXACIN, PENTAMIDINE, PENTAZOCINE, CHOCOLATE,
            NUTS, STRAWBERRIES, DUST
 NV Aller.: AMOXICILLIN, AMPICILLIN, TAPE, FISH, FLUPHENAZINE DECANOATE
       ADR:

================================================================================

                  *** THIS PATIENT HAS NON-VERIFIED ORDERS. ***

    ___ AUTHORIZED ABSENCE <96 HOURS    ___ AUTHORIZED ABSENCE >96 HOURS
        NUMBER OF DAYS:         (NO REFILLS allowed on AA/PASS meds)

        REGULAR DISCHARGE       OPT NSC       SC

       SC Percent: %
     Disabilities: NONE STATED

        Next scheduled clinic visit:
================================================================================
                                                     Schedule        Cost per
No.      Medication                                 Type            Dose
--------------------------------------------------------------------------------
  1 ACETAMINOPHEN 650 MG SUPP                         CONTINUOUS      0.088
    Inpt Dose: 650MG PO QD

    ___ TAKE NO ACTION (PATIENT WILL NOT RECEIVE MEDICATION)

    Outpatient Directions:

    ___SC  ___NSC   Qty: _____   Refills:  0  1  2  3  4  5  6  7  8  9  10  11

    ___________________________________ _____________ ___________________________
    Physician's Signature               DEA #         Date AND Time

Enter RETURN to continue or '^' to exit:
```

----------*report continues*----------

Example: Authorized Absence/Discharge Summary (continued)

```
                      AUTHORIZED ABSENCE/DISCHARGE ORDERS              Page: 2
                              VAMC:  REGION 5 (660)
 VA FORM: 10-7978M
 XYZ,PATIENT                           222-32-4321        02/22/1942
-------------------------------------------------------------------------------
                                                        Schedule        Cost per
 No.      Medication                                    Type            Dose
-------------------------------------------------------------------------------
  2 BENZOYL PEROXIDE 10% GEL (2OZ)                      CONTINUOUS      3.78
    Inpt Dose: APPLY SMALL ABOUNT TOP QD
    Special Instructions: TEST

    ___ TAKE NO ACTION (PATIENT WILL NOT RECEIVE MEDICATION)

    Outpatient Directions:

    ___SC  ___NSC   Qty: _____   Refills:  0  1  2  3  4  5  6  7  8  9  10  11

    ___________________________________ _____________ ________________________
    Physician's Signature               DEA #         Date AND Time
-------------------------------------------------------------------------------
  3 RANITIDINE 150MG                                    CONTINUOUS      0.5
    Inpt Dose: 150MG PO QID

    ___ TAKE NO ACTION (PATIENT WILL NOT RECEIVE MEDICATION)

    Outpatient Directions: ____________________________________________________

    ___SC  ___NSC   Qty: _____   Refills:  0  1  2  3  4  5  6  7  8  9  10  11

    Physician's Signature               DEA #         Date AND Time
-------------------------------------------------------------------------------
  4 THEO-24 200MG                                       CONTINUOUS      0.086
    Inpt Dose: 400MG PO QID
    Special Instructions: TESTING

    ___ TAKE NO ACTION (PATIENT WILL NOT RECEIVE MEDICATION)

    Outpatient Directions:

    ___SC  ___NSC   Qty: _____   Refills:  0  1  2  3  4  5  6  7  8  9  10  11

    ___________________________________ _____________ ________________________
    Physician's Signature               DEA #         Date AND Time
===============================================================================
    OTHER MEDICATIONS:

  5 Medication:

    Outpatient Directions: ____________________________________________________

    ___SC  ___NSC   Qty: _____   Refills:  0  1  2  3  4  5  6  7  8  9  10  11

    ___________________________________ _____________ ________________________
    Physician's Signature               DEA #         Date AND Time
-------------------------------------------------------------------------------

  6 Medication: ______________________________________________________________

    Outpatient Directions: ____________________________________________________

    ___SC  ___NSC   Qty: _____   Refills:  0  1  2  3  4  5  6  7  8  9  10  11

    Physician's Signature               DEA #         Date AND Time

Enter RETURN to continue or '^' to exit: <Enter>
```

----------*report continues*----------

Example: Authorized Absence/Discharge Summary (continued)

```
                    AUTHORIZED ABSENCE/DISCHARGE INSTRUCTIONS  09/19/2000  12:43
                              VAMC:  REGION 5 (660)
 VA FORM: 10-7978M
 Effective Date:
================================================================================
 XYZ,PATIENT                          Ward: 1 West
    PID: 222-32-4321      Room-Bed: A-6              Ht(cm): 167.64 (04/21/1999)
    DOB: 02/22/1942  (58)     Team: * NF *           Wt(kg):  85.00 (04/21/1999)
    Sex: MALE                                      Admitted: 09/16/1999
     Dx: TEST PATIENT
 Allergies: CARAMEL, CN900, LOMEFLOXACIN, PENTAMIDINE, PENTAZOCINE, CHOCOLATE,
            NUTS, STRAWBERRIES, DUST
 NV Aller.: AMOXICILLIN, AMPICILLIN, TAPE, FISH, FLUPHENAZINE DECANOATE
       ADR:

================================================================================

        Next scheduled clinic visit:
================================================================================
 DIETARY INSTRUCTIONS: (Check One)
 __ NO RESTRICTIONS __ RESTRICTIONS (Specify) ___________________________________

 ________________________________________________________________________________



================================================================================
 PHYSICAL ACTIVITY LIMITATIONS: (Check One)
 __ NO RESTRICTIONS __ RESTRICTIONS (Specify) ___________________________________

 ________________________________________________________________________________



================================================================================
 SPECIAL INSTRUCTIONS: (list print information, handouts, or other
 instructions pertinent to patient's condition)__________________________________

 ________________________________________________________________________________



================================================================================
 DIAGNOSES: _____________________________________________________________________

 ________________________________________________________________________________

 ________________________________________________________________________________
Enter RETURN to continue or '^' to exit: <Enter>
```

----------*report continues*----------

Example: Authorized Absence/Discharge Summary (continued)

```
                    AUTHORIZED ABSENCE/DISCHARGE INSTRUCTIONS  09/19/2000  12:43
                              VAMC:  REGION 5 (660)
 VA FORM: 10-7978M
 Effective Date:
================================================================================
 XYZ,PATIENT                        Ward: 1 West
    PID: 222-32-4321      Room-Bed: A-6              Ht(cm): 167.64 (04/21/1999)
    DOB: 02/22/1942  (58)     Team: * NF *           Wt(kg):  85.00 (04/21/1999)
    Sex: MALE                                      Admitted: 09/16/1999
     Dx: TEST PATIENT
 Allergies: CARAMEL, CN900, LOMEFLOXACIN, PENTAMIDINE, PENTAZOCINE, CHOCOLATE,
            NUTS, STRAWBERRIES, DUST
 NV Aller.: AMOXICILLIN, AMPICILLIN, TAPE, FISH, FLUPHENAZINE DECANOATE
       ADR:


================================================================================

        Next scheduled clinic visit:


                    ___________________________________ ________________________
                    Nurse's Signature                   Date AND Time

                    ___________________________________ ________________________
                    Physician's Signature               Date AND Time


                    ==========================================
                    >>>>> I HAVE RECEIVED AND UNDERSTAND <<<<<
                    >>>>> MY DISCHARGE INSTRUCTIONS      <<<<<
                    ==========================================

                    ___________________________________ ________________________
                    Patient's Signature                 Date And Time


XYZ,PATIENT                          222-32-4321                02/22/1942
```

6.2.7. Extra Units Dispensed Report [PSJU EUDD]

The *Extra Units Dispensed Report* option allows the user to print a report showing the amounts, date dispensed, and the initials of the person who entered the dispensed drug. This can be printed by ward group, ward, or by patient. If the user chooses to select by ward, the administration teams may be specified. The default for the administration team is ALL and multiple administration teams may be entered. If selecting by ward or ward group, the profile may be sorted by patient name or room-bed.

Example: Extra Units Dispensed Report

```
Select Reports Menu Option: EXtra Units Dispensed Report


Enter Start Date and Time:  T@1000  (SEP 19, 2000@10:00)
Enter Ending Date and Time: T@2400  (SEP 19, 2000@24:00)


Select by WARD GROUP (G), WARD (W), or PATIENT (P): Patient

Select PATIENT:    XYZ,PATIENT      2-22-42    222324321     YES     ACTIVE DUTY


Select another PATIENT: <Enter>
Select output device: 0;80  TELNET

this may take a while...(you should QUEUE the Extra Units Dispensed report)
```

```
                            EXTRA UNITS DISPENSED REPORT          PAGE: 1
                 REPORT FROM: 09/19/00  10:00 TO: 09/19/00  24:00


XYZ,PATIENT                            Room Bed: A-6
222-32-4321                                Ward: 1 West


DRUG NAME                                       UNIT  DATE            DISP.
                                                      DISPENSED       BY

ACETAMINOPHEN 650 MG SUPP                          3  09/19/00  12:54 MV
                                                   5  09/19/00  12:54 MV
    ........................................       8

BENZOYL PEROXIDE 10% GEL (2OZ)                     2  09/19/00  12:58 PM
    ........................................       2

RANITIDINE 150MG                                   3  09/19/00  12:54 MV
                                                   3  09/19/00  12:58 PM

    ........................................       6

  TOTAL FOR XYZ,PATIENT......................     16


Press Return to continue...
```

6.2.8. Free Text Dosage Report [PSJU DOSAGE REPORT]

The *Free Text Dosage Report* option creates a report to track commonly ordered free text dosages over a date range. This report evaluates Unit Dose orders that were active during the specified dates against the DISPENSE DRUG file. If the applicable Possible Dosages or Local Possible Dosages do not match the Dosage Ordered, then this is considered a Free Text Dosage Entry and is contained in this report. This report includes the:

- Dispense Drug
- Free Text Dosage Entry
- Total number of occurrences of each Free Text Dosage Entry
- Number of occurrences by the Provider Name

Each entry in the Free Text Dosage Report consists of at least two lines of display. The first line shows the Dispense Drug name, followed by the drug internal entry number in parentheses. The first line continues with the Free Text Dosage Entry and the total number of occurrences of this entry. The second line shows the name of the Providers that used this Free Text Dosage Entry during the requested date range, and the number of times Providers used this free text dosage. Since all Providers are listed, multiple lines will be displayed.

Unit Dose orders that were active during the specified date range and have free text dosages are included in this report. The user is prompted to enter the "Beginning Date:" and an "Ending Date:" for the report to print. If no value is entered in either of the two prompts, the report will not print. The date range will be listed in the "Period:" section of the report header with the beginning date appearing as the first date and the ending date appearing as the second date.

It is strongly recommended that this report be queued to print at a later time.

Example: Free Text Dosage Report

```
Select Reports Menu Option: FREE Text Dosage Report

Beginning Date: T-100  (SEP 29, 2001)

Ending Date: T  (JAN 07, 2002)
DEVICE: HOME// 0;80  NT/Cache virtual TELNET terminal


Working - please wait.........................
```

----------report follows----------

Example: Free Text Dosage Report (continued)

```
                                                                        Page 1
               Inpatient Free Text Dosage Entry Report
                 Period: Sep 29, 2001 to Jan 07, 2002
Drug                                  Free Text Entry                  Count
    Provider:Count
-------------------------------------------------------------------------------

A-METHYL-PARA-TYROSINE CAPS,25 (5098)   100MG                             1
    INPATIENT-MEDS,PROVIDER:1

ACETAMINOPHEN 325MG C.T. (263)          1000MG                            1
    BOISE,WILLIAM:1
                                        100MG                             2
    JACKSON,ROBERT:1   MONTPELIER,MELINDA A.:1
                                        100mg                             1
    MONTPELIER,MELINDA A.:1
                                        300MG                             1
    BOISE,WILLIAM:1
                                        325MG                             7
    MONTPELIER,MELINDA A.:1   INPATIENT-MEDS,PROVIDER:4
    INPATIENT-MEDS,PHARMACIST:2

 Press Return to Continue or ^ to Exit:
```

6.2.9. INpatient Stop Order Notices [PSJ EXP]

The *INpatient Stop Order Notices* option produces a list of patients' medication orders that are about to expire. Action must be taken (using VA FORM 10-1158) if these medications are to be re-ordered. This option will list both Unit Dose orders and IV orders. The user may choose to print All, which is the default, or either the Unit Dose or IV orders.

Special Instructions for Unit Dose orders and Other Print Information for IV orders are listed on the report. IV orders are sorted by the Orderable Item of the first additive or solution in the order. The Orderable Item with each additive and solution is displayed along with the strength/volume specified. The schedule type for all IV orders is assumed to be continuous.

If the user chooses to print by ward, the selection to sort by administration teams is displayed. ALL teams, which is the default, multiple teams, or one administration team may be chosen.

Example: Inpatient Stop Order Notices

```
Select Reports Menu Option: INpatient Stop Order Notices

Select by WARD GROUP (G), WARD (W), or PATIENT (P): PATIENT

Select PATIENT:    XYZ,PATIENT       222-32-4321   02/22/42   1 West

Enter start date: T  (SEP 19, 2000)

Enter stop date: T+7  (SEP 26, 2000)

List IV orders, Unit Dose orders, or All orders: ALL// <Enter>

Select PRINT DEVICE: 0;80  TELNET

...this may take a few minutes...
                         ...you really should QUEUE this report, if possible...
Enter RETURN to continue or '^' to exit: <Enter>

----------------------------------------report follows----------------------------------------
```

Example: Inpatient Stop Order Notices (continued)

```
AS OF: 09/19/00  13:14                                          Page: 1


                   THE FOLLOWING MEDICATIONS WILL EXPIRE
                FROM 09/19/00  00:01 THROUGH 09/26/00  24:00
          TO CONTINUE MEDICATIONS, PLEASE REORDER ON VA FORM 10-1158.

 XYZ,PATIENT                        Ward: 1 West
    PID: 222-32-4321      Room-Bed: A-6             Ht(cm): 167.64 (04/21/99)
    DOB: 02/22/42  (58)                             Wt(kg):  85.00 (04/21/99)
    Sex: MALE                                     Admitted: 09/16/99
     Dx: TEST PATIENT
 Allergies: CARAMEL, CN900, LOMEFLOXACIN, PENTAMIDINE, PENTAZOCINE, CHOCOLATE,
            NUTS, STRAWBERRIES, DUST
 NV Aller.: AMOXICILLIN, AMPICILLIN, TAPE, FISH, FLUPHENAZINE DECANOATE
       ADR:


 Medication                                ST Start  Stop          Status/Info
   Dosage                                                          Provider
-------------------------------------------------------------------------------

 AMPICILLIN 100 GM                         C  09/19 09/22/00  18:00 A
   in 0.45% NACL 1000 ML 8MG/HR                          INPATIENT-MEDS,PROVIDER
 IV  8MG/HR@1

 PENTAMIDINE ISETHIONATE 1 MG              C  09/19 09/22/00  18:00 A
   in 0.45% NACL 1000 ML 8 MG/HR                         INPATIENT-MEDS,PROVIDER
 IV  8 MG/HR@1

 ACETAMINOPHEN 300/CODEINE 30 TAB          C  09/16 09/22/00  22:00 A
 Give: 650MG PO QD                                       INPATIENT-MEDS,PROVIDER

 BENZOYL PEROXIDE GEL,TOP                  C  09/19 09/22/00  22:00 A
 Give: APPLY SMALL ABOUNT TOP QD                         INPATIENT-MEDS,PROVIDER
     Special Instructions: TEST

 RANITIDINE TAB                            C  09/18 09/22/00  22:00 A
 Give: 150MG PO QID                                      INPATIENT-MEDS,PROVIDER

 THEOPHYLLINE CAP,SA                       C  09/18 09/22/00  22:00 A
 Give: 400MG PO QID                                      INPATIENT-MEDS,PROVIDER
     Special Instructions: TESTING


XYZ,PATIENT                     222-32-4321   1 West           A-6
```

6.2.10. Medications Due Worksheet [PSJ MDWS]

The *Medications Due Worksheet* option creates a report that lists active medications (Unit Dose and IV) that are due within a selected 24-hour period. The user will be able to select by ward group, ward, or individual patients. If the user chooses to select by ward, the administration teams may be specified. The default for the administration team is ALL and multiple administration teams may be entered. If selecting by ward or ward group, the Medications Due Worksheet may be sorted by administration time, patient name, or room-bed. However, if the user chooses to select by patient, multiple patients can be entered.

For IV orders that have no schedule, the projected administration times will be calculated based on the order's volume, flow rate, and start time. An asterisk (*****) will be printed for the administration times instead of the projected administration times.

If the MAR ORDER SELECTION DEFAULT prompt for the ward parameter is defined, the default will be displayed at the "Enter medication type(s):" prompt.

The default choice is 2 or Non-IV Medications only if:

1. The MAR ORDER SELECTION DEFAULT parameter was not defined.
2. Selection by Ward group.
3. Selected by patients and patients are from different wards.

The PRN medication orders will be printed if the user enters **YES** at the "Would you like to include PRN Medications (Y/N)? NO//" prompt. PRN orders will be listed after all continuous and one-time orders are printed.

Example: Medications Due Worksheet

```
Select Reports Menu Option: MEDications Due Worksheet

Would you like to include PRN Medications (Y/N)? NO// YES

Enter Start Date and Time:  T@1000  (SEP 19, 2000@10:00)

Enter Ending Date and Time: T@2400  (SEP 19, 2000@24:00)

Select by WARD GROUP (G), WARD (W), or PATIENT (P): Patient

Select PATIENT:    XYZ,PATIENT      2-22-42    222324321     YES     ACTIVE DUTY

Select another PATIENT: <Enter>

Enter medication type(s): 2// 1
Select output device: 0;80  TELNET
```

----------report follows----------

Example: Medications Due Worksheet (continued)

```
MEDICATIONS DUE WORKSHEET For: XYZ,PATIENT                        Page: 1
Report from: 09/19/00  10:00 to: 09/19/00  24:00           Report Date: 09/19/00
Continuous/One time Orders for: ALL MEDS

For date: 09/19/00

XYZ,PATIENT          A-6         12:00 09/18 | 09/18  12:00 | 09/22/00  22:00
222-32-4321                            RANITIDINE TAB
1 West                                 Give: 150MG PO QID
                                       RN/LPN Init: ________

                                       09/18 | 09/18  12:00 | 09/22/00  22:00
                                       THEOPHYLLINE CAP,SA
                                       Give: 400MG PO QID
                                       TESTING
                                       RN/LPN Init:

                                 *     09/19 | 09/19  12:00 | 09/22/00  18:00
                                       AMPICILLIN 100 GM
                                       in
                                       0.45% NACL 1000 ML 8MG/HR
                                       IV  8MG/HR@1
                                       RN/LPN Init:

                                 15:00 09/18 | 09/18  12:00 | 09/22/00  22:00
                                       RANITIDINE TAB
                                       Give: 150MG PO QID
                                       RN/LPN Init: ________

                                       09/18 | 09/18  12:00 | 09/22/00  22:00
                                       THEOPHYLLINE CAP,SA
                                       Give: 400MG PO QID
                                       TESTING
                                       RN/LPN Init: ________

                                 20:00 09/18 | 09/18  12:00 | 09/22/00  22:00
                                       RANITIDINE TAB
                                       Give: 150MG PO QID
                                       RN/LPN Init:

                                       09/18 | 09/18  12:00 | 09/22/00  22:00
                                       THEOPHYLLINE CAP,SA
                                       Give: 400MG PO QID
                                       TESTING
                                       RN/LPN Init: ________



* Projected admin. times based on order's volume, flow rate, and start time.

Enter RETURN to continue or '^' to exit:
```

6.2.11. Patient Profile (Extended) [PSJ EXTP]

The *Patient Profile (Extended)* option creates a report to allow the viewing of all the orders on file for a patient. The user can view all of the orders that have not been purged or enter a date to start searching from.

Example: Patient Profile (Extended)

```
Select Reports Menu Option: PATient Profile (Extended)

Select PATIENT:    XYZ,PATIENT       222-32-4321   02/22/42   1 West

Date to start searching from (optional):  083100

Select another PATIENT: <Enter>

Show PROFILE only, EXPANDED VIEWS only, or BOTH: PROFILE// BOTH

Show SHORT, LONG, or NO activity log?  NO// SHORT

Select PRINT DEVICE: <Enter>  TELNET
```

```
               I N P A T I E N T   M E D I C A T I O N S      09/20/00  09:42
                          VAMC:  REGION 5 (660)
 - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -
 XYZ,PATIENT                        Ward: 1 West
    PID: 222-32-4321      Room-Bed: A-6             Ht(cm): 167.64 (04/21/99)
    DOB: 02/22/42  (58)                             Wt(kg):  85.00 (04/21/99)
    Sex: MALE                                     Admitted: 09/16/99
     Dx: TEST PATIENT
 Allergies: CARAMEL, CN900, LOMEFLOXACIN, PENTAMIDINE, PENTAZOCINE, CHOCOLATE,
            NUTS, STRAWBERRIES, DUST
 NV Aller.: AMOXICILLIN, AMPICILLIN, TAPE, FISH, FLUPHENAZINE DECANOATE
       ADR:

 - - - - - - - - - - - - - - - - A C T I V E - - - - - - - - - - - - - - - - -
   1  -> AMPICILLIN INJ                        C  09/21/00  10/01/00  A
          Give: 2GM IM QD
 - - - - - - - - - - - - - - - N O N - A C T I V E - - - - - - - - - - - - - -
   2     AMPICILLIN INJ                        ?  ********  ********  P
          Give: 500MG IM QID
 - - - - - - - - - - - - - - N O N - A C T I V E - - - - - - - - - - - - - -
   3     AMPICILLIN 100 GM                     C  09/19/00  09/20/00  D
         in 0.45% NACL 1000 ML 8MG/HR
Enter RETURN to continue or '^' to exit:
```

----------*report continues*----------

Example: Patient Profile (Extended) (continued)

```
     ----------------------------------------------------------------------
Patient: XYZ,PATIENT                            Status: ACTIVE
Orderable Item: AMPICILLIN INJ
  Instructions: 2GM
Dosage Ordered: 2GM
                                                 Start: 09/21/00  01:00
     Med Route: INTRAMUSCULAR (IM)                Stop: 10/01/00  22:00
 Schedule Type: CONTINUOUS                   Self Med: NO
      Schedule: QD
   Admin Times: 0100
      Provider: INPATIENT-MEDS,PROVIDER
                                                 Units   Units   Inactive
 Dispense Drugs                             U/D  Disp'd  Ret'd   Date
-------------------------------------------------------------------------------
 AMPICILLIN INJ 2GM                         1    0       0

ORDER NOT VERIFIED
Entry By: INPATIENT-MEDS,PROVIDER                Entry Date: 09/20/00  08:35
Enter RETURN to continue or '^' to exit:

    Date: 09/20/00  08:47     User: INPATIENT-MEDS,PROVIDER
Activity: ORDER VERIFIED BY PHARMACIST
Enter RETURN to continue or '^' to exit:
     ----------------------------------------------------------------------
     Patient: XYZ,PATIENT                           Status: PENDING
Orderable Item: AMPICILLIN INJ
  Instructions: 500MG
Dosage Ordered: 500MG
                                                 Start: ********
     Med Route: INTRAMUSCULAR (IM)                Stop: ********
 Schedule Type: NOT FOUND                    Self Med: NO
      Schedule: QID
   (No Admin Times)
      Provider: INPATIENT-MEDS,PROVIDER
                                                 Units   Units   Inactive
 Dispense Drugs                             U/D  Disp'd  Ret'd   Date
-------------------------------------------------------------------------------
 AMPICILLIN INJ 500MG                       1    0       0

ORDER NOT VERIFIED
Entry By: INPATIENT-MEDS,PROVIDER                Entry Date: 09/20/00  08:35
Enter RETURN to continue or '^' to exit:
     ----------------------------------------------------------------------
     Patient: XYZ,PATIENT                             Status: DISCONTINUED

*(1) Additives:              Order number: 468          Type: ADMIXTURE
       AMPICILLIN 100 GM  *N/F*
*(2) Solutions:
       0.45% NACL 1000 ML
                                                    IV Room: HALL CLOSET
*(3)  Infusion Rate: 8MG/HR@1                 *(4)     Start: 09/19/00  12:00
*(5)      Med Route: IV                       *(6)      Stop: 09/20/00  08:34
*(7)       Schedule:                               Last Fill: ********
 (8)    Admin Times:                                Quantity: 0
*(9)       Provider: INPATIENT-MEDS,PROVIDER     Cum. Doses:
 (10)   Other Print:

 (11)  Remarks :
       Entry By: INPATIENT-MEDS,PROVIDER            Entry Date: 09/19/00  10:17
Enter RETURN to continue or '^' to exit:

ACTIVITY LOG:
#  DATE       TIME      REASON                    USER
===============================================================================
1  SEP 20,2000 08:34:29 DISCONTINUED         INPATIENT-MEDS,PHARMICIST
   Comment:

          Field: 'STOP DATE/TIME'
   Changed from: 'SEP 22,2000 18:00'
Enter RETURN to continue or '^' to exit:
             To: 'SEP 20,2000 08:34'
Enter RETURN to continue or '^' to exit:
```

6.3. Align Labels (Unit Dose)
[PSJU AL]

Align Labels (Unit Dose) option allows the user to align the label stock on a printer so that Unit Dose order information will print within the physical boundaries of the label.

Example: Align Labels (Unit Dose)

```
Select Unit Dose Medications Option: ALIGn Labels (Unit Dose)

Select LABEL PRINTER: <Enter>  TELNET
\------------- FIRST LINE OF LABEL ------------/
<                                             >
<------------- LABEL BOUNDARIES --------------->
<                                             >
/--------------LAST LINE OF LABEL--------------\

 XX/XX | XX/XX | XX/XX/XX  XX:XX  (PXXXX)  | A T    PATIENT NAME
       ROOM-BED
 DRUG NAME                    SCHEDULE TYPE| D I    XXX-XX-XXXX       DOB (AGE)
           TEAM
 DOSAGE ORDERED   MED ROUTE   SCHEDULE     | M M    SEX          DIAGNOSIS
 SPECIAL INSTRUCTIONS                      | I E    ACTIVITY DATE/TIME  ACTIVITY
 WS HSM NF               RPH:_____ RN:_____| N S    WARD GROUP
           WARD



 Are the labels aligned correctly? Yes// Y  (Yes)
```

6.4. Label Print/Reprint
[PSJU LABEL]

Label Print/Reprint option allows the user to print new unprinted labels and/or reprint the latest label for any order containing a label record. When entering this option, the nurse will be informed if there are any unprinted new labels from auto-cancelled orders (i.e., due to ward or service transfers). The nurse will be shown a list of wards to choose from if these labels are to be printed at this time. The nurse can delete these auto-cancel labels; however, deletion will be for all of the labels.

Next, the nurse will be instructed if there are any unprinted new labels. The nurse can then decide whether to print them now or later.

The nurse can choose to print the labels for a ward group, ward, or for an individual patient. If ward group or ward is chosen, the label start date will be entered and the labels will print on the specified printer device. When the option to print by individual patient is chosen, an Inpatient Profile will be displayed and the nurse can then choose the labels from the displayed Unit Dose and IV orders to be printed on a specified printer.

7. Inquiries Option

All of the Inquiries Options are located under the *INQuiries Menu* option on the *Unit Dose Medications* menu.

INQuiries Menu
[PSJU INQMGR]

The *INQuiries Menu* option allows the user to view information concerning standard schedules and drugs. No information in this option can be edited, so there is no danger of disrupting the Unit Dose module's operation. The *INQuiries Menu* contains the following sub-options:

Example: Inquiries Menu

```
Select Unit Dose Medications Option: INQuiries Menu

Select INQuiries Menu Option: ?

          Dispense Drug Look-Up
          Standard Schedules
```

7.1. Dispense Drug Look-Up
[PSJU INQ DRUG]

The *Dispense Drug Look-Up* option allows the user to see what drugs are in the DRUG file and any Unit Dose information pertaining to them.

At the "Select DRUG:" prompt, the nurse can answer with drug number, quick code, or VA drug class code (for IV, solution print name, or additive print name). Information about the selected drug will be displayed.

Example: Dispense Drug Look-Up

```
Select Unit Dose Medications Option: INQuiries Menu

Select INQuiries Menu Option: DIspense Drug Look-Up

Select DRUG: ASP
     1   ASPIRIN 10 GRAIN SUPPOSITORIES           CN103       02-18-98     INPATIENT
     2   ASPIRIN 325MG           CN103     N/F       *90-DAY FILL*
     3   ASPIRIN 325MG E.C.           CN103         *90-DAY FILL*
     4   ASPIRIN 325MG E.C. U/D          CN103     N/F       TAB
     5   ASPIRIN 325MG U/D           CN103
Press <RETURN> to see more, '^' to exit this list, OR
CHOOSE 1-5: 5  ASPIRIN 325MG U/D         CN103

FORMULARY ITEM
 A UNIT DOSE DRUG

  DAY (nD) or DOSE (nL) LIMIT:
          UNIT DOSE MED ROUTE:
      UNIT DOSE SCHEDULE TYPE:
            UNIT DOSE SCHEDULE:
CORRESPONDING OUTPATIENT DRUG:
                 ATC MNEMONIC:
                 ATC CANISTER: WEST WING                12
                               SOUTH WING               12
                               JUNK ONE                 12
                               TESSS                    12
                               11;PS(57.5,              12
                               13;PS(57.5,              12
                               14;PS(57.5,              12
                               15;PS(57.5,              12
                               16;PS(57.5,              12
                               17;PS(57.5,              12
                               18;PS(57.5,              12
                               21;PS(57.5,              12
                               22;PS(57.5,              12

Select DRUG:
```

7.2. Standard Schedules
[PSJU INQ STD SCHD]

It is extremely important for all users to know the method of schedule input. When the user enters a standard schedule, the system will echo back the corresponding Administration times.

At the “Select STANDARD SCHEDULE:” prompt, enter an administration schedule abbreviation to view information pertaining to that schedule. An explanation of the selected schedule will be displayed. To view a list of the available administration schedule abbreviations, enter a question mark (**?**) at the prompt “Select STANDARD SCHEDULE:”.

Example: Standard Schedules

```
Select INQuiries Menu Option: STandard Schedules

Select STANDARD SCHEDULE: q4H      01-05-09-13-17-21

  Schedule: Q4H                                          Type: CONTINUOUS
  Standard Admin Times: 01-05-09-13-17-21

Select STANDARD SCHEDULE:
```

8. Glossary

Action Prompt

There are three types of "Action" prompts that occur during order entry. One type of requesting action on the order is the standard ListMan action prompt. The following actions are valid:

+	**Next Screen**
-	**Previous Screen**
UP	**Up a Line**
DN	**Down a Line**
>	**Shift View to Right**
<	**Shift View to Left**
FS	**First screen**
LS	**Last Screen**
GO	**Go to Page**
RD	**Re Display Screen**
PS	**Print Screen**
PT	**Print List**
SL	**Search List**
Q	**Quit**
ADPL	**Auto Display (on/off)**

The second type of "Action" prompts is the Inpatient Medications Patient/Order actions. These actions are:

PU	**Patient Record Updates**
DA	**Detailed Allergy/ADR List**
VP	**View Profile**
NO	**New Orders Entry**
IN	**Intervention Menu**
PI	**Patient Information**
SO	**Select Order**
DC	**Discontinue**
ED	**Edit**

VF	**Verify**
HD	**Hold**
RN	**Renew**
AL	**Activity Logs**
OC	**On Call**

The third type of "Action" prompts is the Hidden actions. These actions are:

LBL	**Label Patient/Report**
JP	**Jump to a Patient**
OTH	**Other Pharmacy Options**
MAR	**MAR Menu**
DC	**Speed Discontinue**
RN	**Speed Renew**
SF	**Speed Finish**
SV	**Speed Verify**
CO	**Copy**
N	**Mark Not to be Given**
I	**Mark Incomplete**
DIN	**Drug Restr/Guide**

Active Order

Any order which has not expired or been discontinued. Active orders also include any orders that are on hold or on call.

Activity Reason Log

The complete list of all activity related to a patient order. The log contains the action taken, the date of the action, and the user who took the action.

Activity Ruler

The activity ruler provides a visual representation of the relationship between manufacturing times, doses due, and order start times. The intent is to provide the on-the-floor user with a means of tracking activity in the IV room and determining when to call for doses before the normal delivery. The activity ruler can be enabled or disabled under the *SIte Parameters (IV)* option.

Additive	A drug that is added to an IV solution for the purpose of parenteral administration. An additive can be an electrolyte, a vitamin or other nutrient, or an antibiotic. Only an electrolyte or multivitamin type additives can be entered as IV fluid additives in CPRS.
ADMINISTRATION SCHEDULE File	File #51.1. This file contains administration schedule names and standard dosage administration times. The name is a common abbreviation for an administration schedule type (e.g., QID, Q4H, PRN). The administration time entered is in military time, with each time separated from the next by a dash, and times listed in ascending order.
Administering Teams	Nursing teams used in the administration of medication to the patients. There can be a number of teams assigned to take care of one ward, with specific rooms and beds assigned to each team.
Admixture	An admixture is a type of intravenously administered medication comprised of any number of additives (including zero) in one solution. It is given at a specified flow rate; when one bottle or bag is empty, another is hung.
APSP INTERVENTION File	File #9009032.4. This file is used to enter pharmacy interventions. Interventions in this file are records of occurrences where the pharmacist had to take some sort of action involving a particular prescription or order. A record would record the provider involved, why an intervention was necessary, what action was taken by the pharmacists, etc.
Average Unit Drug Cost	The total drug cost divided by the total number of units of measurement.
Chemotherapy	Chemotherapy is the treatment or prevention of cancer with chemical agents. The chemotherapy IV type administration can be a syringe, admixture, or a piggyback. Once the subtype (syringe, piggyback, etc.) is selected, the order entry follows the same procedure as the type that corresponds to the selected subtype (e.g., piggyback type of chemotherapy follows the same entry procedure as regular piggyback IV).

Chemotherapy "Admixture"

The Chemotherapy "Admixture" IV type follows the same order entry procedure as the regular admixture IV type. This type is in use when the level of toxicity of the chemotherapy drug is high and is to be administered continuously over an extended period of time (e.g., hours or days).

Chemotherapy "Piggyback"

The Chemotherapy "Piggyback" IV type follows the same order entry procedure as the regular piggyback IV type. This type of chemotherapy is in use when the chemotherapy drug does not have time constraints on how fast it must be infused into the patient. These types are normally administered over a 30 - 60 minute interval.

Chemotherapy "Syringe"

The Chemotherapy "Syringe" IV type follows the same order entry procedure as the regular syringe IV type. Its administration may be continuous or intermittent. The pharmacist selects this type when the level of toxicity of the chemotherapy drug is low and needs to be infused directly into the patient within a short time interval (usually 1-2 minutes).

Continuous Syringe

A syringe type of IV that is administered continuously to the patient, similar to a hyperal IV type. This type of syringe is commonly used on outpatients and administered automatically by an infusion pump.

Coverage Times

The start and end of coverage period designates administration times covered by a manufacturing run. There must be a coverage period for all IV types: admixtures and primaries, piggybacks, hyperals, syringes, and chemotherapy. For one type, admixtures for example, the user might define two coverage periods; one from 1200 to 0259 and another from 0300 to 1159 (this would mean that the user has two manufacturing times for admixtures).

CPRS

A **V***IST***A** computer software package called Computerized Patient Record Systems. CPRS is an application in **V***IST***A** that allows the user to enter all necessary orders for a patient in different packages from a single application. All pending orders that appear in the Unit Dose and IV modules are initially entered through the CPRS package.

Cumulative Doses	The number of IV doses actually administered, which equals the total number of bags dispensed less any recycled, destroyed, or canceled bags.
Default Answer	The most common answer, predefined by the system to save time and keystrokes for the user. The default answer appears before the two slash marks (//) and can be selected by the user by pressing <**Enter**>.
Dispense Drug	The Dispense Drug is pulled from DRUG file (#50) and usually has the strength attached to it (e.g., Acetaminophen 325 mg). Usually, the name alone without a strength attached is the Orderable Item name.
Delivery Times	The time(s) when IV orders are delivered to the wards.
Dosage Ordered	After the user has selected the drug during order entry, the dosage ordered prompt is displayed.
DRUG ELECTROLYTES File	File #50.4. This file contains the names of anions/cations, and their concentration units.
DRUG File	File #50. This file holds the information related to each drug that can be used to fill a prescription.
Electrolyte	An additive that disassociates into ions (charged particles) when placed in solution.
Entry By	The name of the user who entered the Unit Dose or IV order into the computer.
Hospital Supplied Self Med	Self medication, which is to be supplied by the Medical Center's pharmacy. Hospital supplied self med is only prompted for if the user answers Yes to the SELF MED: prompt during order entry.
Hyperalimentation (Hyperal)	Long term feeding of a protein-carbohydrate solution. Electrolytes, fats, trace elements, and vitamins can be added. Since this solution generally provides all necessary nutrients, it is commonly referred to as Total Parenteral Nutrition (TPN). A hyperal is composed of many additives in two or more solutions. When the labels print, they show the individual electrolytes in the hyperal order.

Infusion Rate	The designated rate of flow of IV fluids into the patient.
INPATIENT USER PARAMETERS File	File #53.45. This file is used to tailor various aspects of the Inpatient Medications package with regards to specific users. This file also contains fields that are used as temporary storage of data during order entry/edit.
INPATIENT WARD PARAMETERS File	File #59.6. This file is used to tailor various aspects of the Inpatient Medications package with regards to specific wards.
Intermittent Syringe	A syringe type of IV that is administered periodically to the patient according to an administration schedule.
Internal Order Number	The number on the top left corner of the label of an IV bag in brackets ([ ]). This number can be used to speed up the entry of returns and destroyed IV bags.
IV ADDITIVES File	File #52.6. This file contains drugs that are used as additives in the IV room. Data entered includes drug generic name, print name, drug information, synonym(s), dispensing units, cost per unit, days for IV order, usual IV schedule, administration times, electrolytes, and quick code information.
IV CATEGORY File	File #50.2. This file allows the user to create categories of drugs in order to run "tailor-made" IV cost reports for specific user-defined categories of drugs. The user can group drugs into categories.
IV Label Action	A prompt, requesting action on an IV label, in the form of "Action ( )", where the valid codes are shown in the parentheses. The following codes are valid: P – Print a specified number of labels now. B – Bypass any more actions. S – Suspend a specified number of labels for the IV room to print on demand.
IV Room Name	The name identifying an IV distribution area.

IV SOLUTIONS File	File #52.7. This file contains drugs that are used as primary solutions in the IV room. The solution must already exist in the DRUG file (#50) to be selected. Data in this file includes: drug generic name, print name, status, drug information, synonym(s), volume, and electrolytes.
Label Device	The device, identified by the user, on which computer-generated labels will be printed.
Local Possible Dosages	Free text dosages that are associated with drugs that do not meet all of the criteria for Possible Dosages.
LVP	Large Volume Parenteral — Admixture. A solution intended for continuous parenteral infusion, administered as a vehicle for additive(s) or for the pharmacological effect of the solution itself. It is comprised of any number of additives, including zero, in one solution.An LVP runs continuously, with another bag hung when one bottle or bag is empty.
Manufacturing Times	The time(s) that designate(s) the general time when the manufacturing list will be run and IV orders prepared. This field in the *SIte Parameters (IV)* option (IV ROOM file (#59.5)) is for documentation only and does not affect IV processing.
MEDICATION ADMINISTERING TEAM File	File #57.7. This file contains wards, the teams used in the administration of medication to that ward, and the rooms/beds assigned to that team.
MEDICATION INSTRUCTION File	File #51. This file is used by Unit Dose and Outpatient Pharmacy. It contains the medication instruction name, expansion, and intended use.
MEDICATION ROUTES File	File #51.2. This file contains medication route names. The user can enter an abbreviation for each route to be used at their site. The abbreviation will most likely be the Latin abbreviation for the term.

Medication Routes/ Abbreviations	Route by which medication is administered (e.g., oral). The MEDICATION ROUTES file (#51.2) contains the routes and abbreviations, which are selected by each VAMC. The abbreviation cannot be longer than five characters to fit on labels and the MAR. The user can add new routes and abbreviations as appropriate.
Non-Formulary Drugs	The medications that are defined as commercially available drug products not included in the VA National Formulary.
Non-Verified Orders	Any order that has been entered in the Unit Dose module that has not been verified (made active) by a nurse and/or pharmacist. Ward staff may not verify a non-verified order.
Orderable Item	An Orderable Item name has no strength attached to it (e.g., Acetaminophen). The name with a strength attached to it is the Dispense Drug name (e.g., Acetaminophen 325mg).
Order Sets	An Order Set is a set of N pre-written orders. (N indicates the number of orders in an Order Set is variable.) Order Sets are used to expedite order entry for drugs that are dispensed to all patients in certain medical practices and procedures.
Order View	Computer option that allows the user to view detailed information related to one specific order of a patient. The order view provides basic patient information and identification of the order variables.
Parenteral	Introduced by means other than by way of the digestive track.
Patient Profile	A listing of a patient's active and non-active Unit Dose and IV orders. The patient profile also includes basic patient information, including the patient's name, social security number, date of birth, diagnosis, ward location, date of admission, reactions, and any pertinent remarks.

Pending Order

A pending order is one that has been entered by a provider through CPRS without Pharmacy finishing the order. Once Pharmacy has finished (and verified for Unit Dose only) the order, it will become active.

Piggyback

Small volume parenteral solution for intermittent infusion. A piggyback is comprised of any number of additives, including zero, and one solution; the mixture is made in a small bag. The piggyback is given on a schedule (e.g., Q6H). Once the medication flows in, the piggyback is removed; another is not hung until the administration schedule calls for it.

Possible Dosages

Dosages that have a numeric dosage and numeric dispense units per dose appropriate for administration. For a drug to have possible dosages, it must be a single ingredient product that is matched to the VA PRODUCT file (#50.68). The VA PRODUCT file (#50.68) entry must have a numeric strength and the dosage form/unit combination must be such that a numeric strength combined with the unit can be an appropriate dosage selection.

Pre-Exchange Units

The number of actual units required for this order until the next cart exchange.

Primary Solution

A solution, usually an LVP, administered as a vehicle for additive(s) or for the pharmacological effect of the solution itself. Infusion is generally continuous. An LVP or piggyback has only one solution (primary solution). A hyperal can have one or more solutions.

Print Name

Drug generic name as it is to appear on pertinent IV output, such as labels and reports. Volume or Strength is not part of the print name.

Print Name{2}

Field used to record the additives contained in a commercially purchased premixed solution.

Profile

The patient profile shows a patient's orders. The Long profile includes all the patient's orders, sorted by status: active, non-verified, pending, and non-active. The Short profile will exclude the patient's discontinued and expired orders.

Prompt	A point at which the system questions the user and waits for a response.
Provider	Another term for the physician involved in the prescription of an IV or Unit Dose order for a patient.
PSJI MGR	The name of the *key* that allows access to the supervisor functions necessary to run the IV medications software. Usually given to the Inpatient package coordinator.
PSJI PURGE	The *key* that must be assigned to individuals allowed to purge expired IV orders. This person will most likely be the IV application coordinator.
PSJI USR1	The *primary menu option* that may be assigned to nurses.
PSJI USR2	The *primary menu option* that may be assigned to technicians.
PSJU MGR	The name of the *primary menu* and of the *key* that must be assigned to the pharmacy package coordinators and supervisors using the Unit Dose module.
PSJU PL	The name of the *key* that must be assigned to anyone using the Pick List options.
PSJ PHARM TECH	The name of the *key* that must be assigned to pharmacy technicians using the Unit Dose module.
PSJ RNFINISH	The name of the *key* that is given to a user to allow the finishing of a Unit Dose order. This user must also be a holder of the PSJ RNURSE key.
PSJ RNURSE	The name of the *key* that must be assigned to nurses using the Unit Dose module.
PSJ RPHARM	The name of the *key* that must be assigned to a pharmacist to use the Unit Dose module. If the package coordinator is also a pharmacist he/she must also be given this key.

Quick Code	An abbreviated form of the drug generic name (from one to ten characters) for IV orders. One of the three drug fields on which lookup is done to locate a drug. Print name and synonym are the other two. Use of quick codes will speed up order entry, etc.
Report Device	The device, identified by the user, on which computer-generated reports selected by the user will be printed.
Schedule	The frequency of administration of a medication (e.g., QID, QD, QAM, STAT, Q4H).
Schedule Type	Codes include: **O** - one time (i.e., STAT - only once), **P** - PRN (as needed; no set administration times). **C**-continuous (given continuously for the life of the order; usually with set administration times). **R** - fill on request (used for items that are not automatically put in the cart - but are filled on the nurse's request. These can be multidose items (e.g., eye wash, kept for use by one patient and is filled on request when the supply is exhausted)). And **OC** - on call (one time with no specific time to be given, i.e., 1/2 hour before surgery).
Self Med	Medication that is to be administered by the patient to himself.
Standard Schedule	Standard medication administration schedules stored in the ADMINISTRATION SCHEDULE file (#51.1).
Start Date/Time	The date and time an order is to begin.
Status	**A** - active, **E** - expired, **R** - renewed (or reinstated), **D** - discontinued, **H** - on hold, **I** - incomplete, or **N** - non-verified, **U** – unreleased, **P** – pending, **O** – on call, **DE** – discontinued edit, **RE** – reinstated, **DR** – discontinued renewal.
Stop Date/Time	The date and time an order is to expire.
Stop Order Notices	A list of patient medications that are about to expire and may require action.

Syringe	Type of IV that uses a syringe rather than a bottle or bag. The method of infusion for a syringe-type IV may be continuous or intermittent.
Syringe Size	The syringe size is the capacity or volume of a particular syringe. The size of a syringe is usually measured in number of cubic centimeters (ccs).
TPN	Total Parenteral Nutrition. The intravenous administration of the total nutrient requirements of the patient. The term TPN is also used to mean the solution compounded to provide those requirements.
Units per Dose	The number of Units (tablets, capsules, etc.) to be dispensed as a Dose for an order. Fractional numbers will be accepted.
VA Drug Class Code	A drug classification system used by VA that separates drugs into different categories based upon their characteristics. IV cost reports can be run for VA Drug Class Codes.
WARD GROUP File	File #57.5. This file contains the name of the ward group, and the wards included in that group. The grouping is necessary for the pick list to be run for specific carts and ward groups.
Ward Group Name	An arbitrarily chosen name used to group wards for the pick list and medication cart.
WARD LOCATION File	File #42. This file contains all of the facility ward locations and their related data, i.e., Operating beds, Bedsection, etc. The wards are created/edited using the *Ward Definition* option of the ADT module.

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