

# **Development of a Chemotherapy Ordering Management System**

**Department of Veterans Affairs (VA)  
Strategic Incubation Initiative**

## **Use Case for Nursing Documentation Module v.1.4**



**August 2012**

Prepared for

Department of Veterans Affairs

By

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## Revision History

Date	Version	Description	Author(s)
6/04/2012	1.0	Initial	Lou Ferrucci
6/14/2012	1.1	Functionality updates	Lou Ferrucci
7/06/2012	1.2	Scenario revisions	Lou Ferrucci
7/20/2012	1.3	Scenario revisions	Lou Ferrucci
8/3/2012	1.4	Scenario revisions	Lou Ferrucci

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## **1.0 Nursing Documentation**

### **1.1 Brief Description**

The primary module of the Chemotherapy Ordering Management System (COMS) application for oncology nurses is Nursing Documentation (ND). The ND module permits the oncology nurse to view relevant clinical data and document the provision of chemotherapy and nursing assessments of the patient since the previous administration and throughout the current treatment. These assessments may be entered into COMS – regardless of administration day or day of rest – for inclusion in the Flow Sheet (FS) and consideration for End of Treatment Summary (EoTS).

Following the Chemotherapy Template Order Source (CTOS) establishment of the regimen and Order Entry Management (OEM) customizing medications for each individual patient, the ND module facilitates the crucial role of documenting the administration of the regimen's prescribed medications. Pre-populated data from the OEM module serves as the foundation for recording medications administered with the attending nurse documenting doses administered, dates, start/stop times, patient and dose verification, symptom assessments, and infusion reactions.

The ND module supports the oncology nurse with six activity-specific panels to convey information previously obtained and to facilitate the documentation of new information relevant to the administration of prescribed medications.

- General Information – Provides laboratory results and historic vital signs; enables the nurse to document patient verification (from two sources) and consent, patient teaching, dual verification of medication dosing, and vital signs obtained that day.
- Assessment – Enables the nurse to document the Top 10 chemotherapy symptoms and clinical grading of those side effects plus any other symptom the patient has encountered since the previous administration.
- IV Site – Facilitates nurse documentation of the intravenous (IV) site access and appearance as well as verification of the patient's brisk blood return before, during, and after treatment.
- Treatment – Enables the nurse to annotate the administration of pre-therapy, therapy, and post-therapy medications. These medications are pre-populated from the OEM module once orders are cleared for preparation and medications are dispensed by the pharmacy. In support of clinical practices and guidelines, "positive action" by the nurse is required to properly document medication administration.
- Infusion Reactions – Facilitates nurse documentation of three common chemotherapy infusion reactions (Extravasation, Cytokine-Release Syndrome, and Hypersensitivity/Anaphylaxis) and any other reaction to the administration of medications on the treatment day.
- Discharge Instructions – Facilitates communication as a reminder for the patient on the next administration day and scheduled laboratory tests; enables the nurse to record patient education topics and teaching methodology.

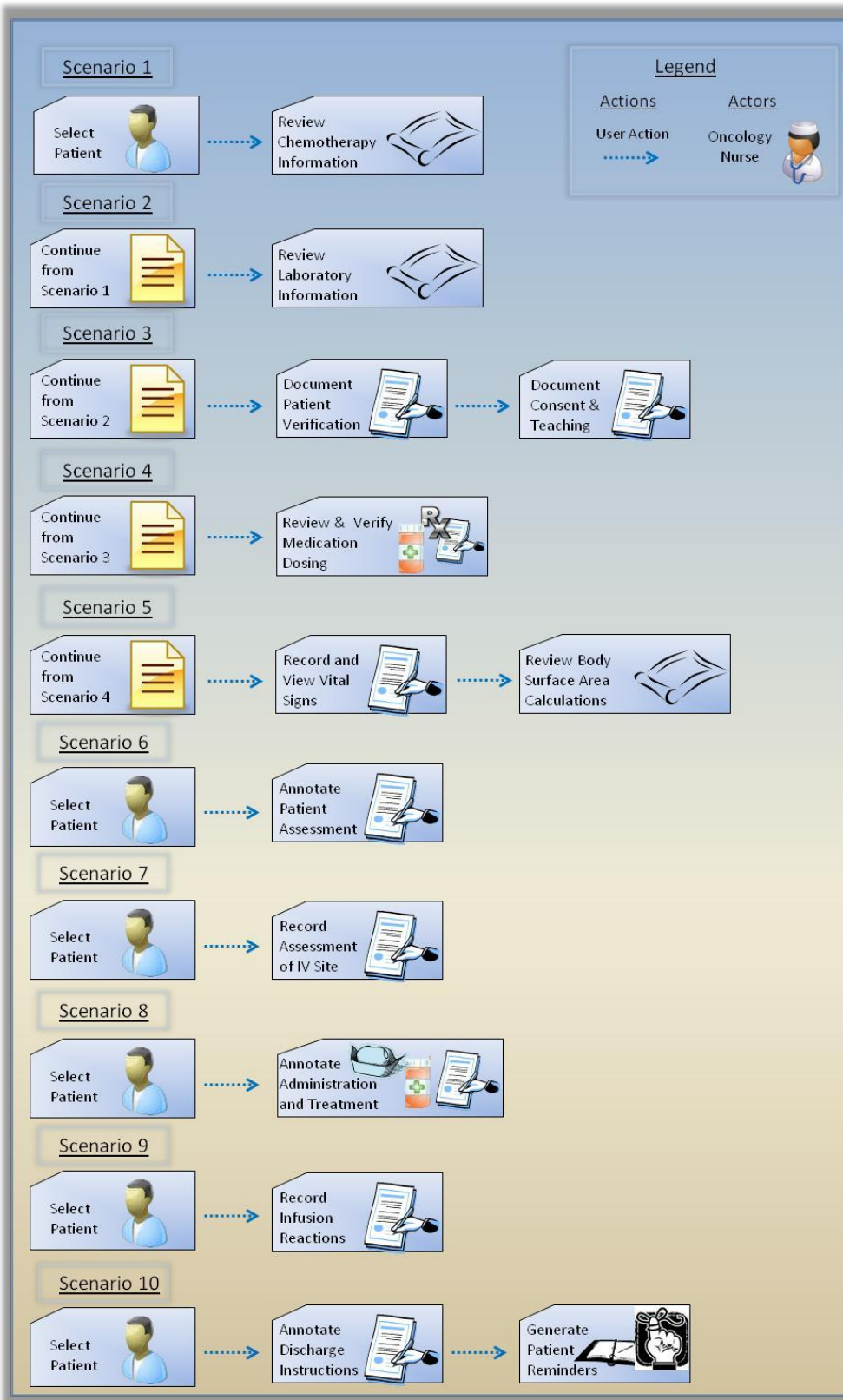
Altogether, the ND module enables oncology nurses to thoroughly document assessment, treatment, and instructions of individual patients. The 10 most common scenarios encountered within the ND module are the primary focus of this Nursing Documentation Use Case and are detailed in section 5.

## **1.2 Use Case Diagram**

Common ND module scenarios involving direct patient care activities of oncology nursing services within the individualized patient treatment plans are as follows:

- Scenario 1 – Review Chemotherapy/Biotherapy Information
- Scenario 2 – Review Laboratory Information
- Scenario 3 – Document Patient Verification and Pre-Treatment Consent and Teaching
- Scenario 4 – Verify Medication Dosing
- Scenario 5 – Record and View Vital Signs and Review Body Surface Area Calculations
- Scenario 6 – Annotate Assessment of Patient Symptoms Since Last Treatment
- Scenario 7 – Record Assessment of IV Site
- Scenario 8 – Annotate Medications Administered and Patient Treatment
- Scenario 9 – Record Infusion Reactions to Treatment
- Scenario 10 – Annotate Patient Discharge Instructions and Generate Patient Reminders

These scenarios are detailed in section 5 and depicted graphically in the Use Case diagram shown in **Figure 1** on the next page.



**Figure 1 – COMS Nursing Documentation Use Case Diagram**

### 1.3 Background

Within the COMS application, the ND module facilitates oncology nurse awareness of historic relevant clinical information and nurse documentation of medication administration actions with assessment of the patient's corresponding response. Central to the provision of oncology services, administration of prescribed regimen medications and its documentation in the ND module serves as the foundation for the Flow Sheet snapshot of care and the regimen's End of Treatment Summary. The ND module captures the specifics of the tangible provision of oncology services to provide detailed insight for members of the healthcare team and fulfills legal/professional requirements. Overall, this functionality fosters Joint Commission compliance and enhances patient safety with documentation ultimately stored in VA's electronic health record comprised of Veterans Health Information Systems and Technology Architecture (Vista) and Computerized Patient Record System (CPRS).

Using drop-down menus with browse and search functionality, the oncology nurse may select and retrieve a patient's entire treatment regimen, administration requirements, and relevant clinical data. Along with Vista and CPRS, the oncology nurse may use the COMS ND module to gain a deep understanding of patient history, insight into the prescribed individualized treatment and goal, and ability to thoroughly record all relevant aspects of the administration of oncology medications and the patient's reaction/response to the treatment.

As the provision of oncology services proceeds through the point of administration, the ND module supports documentation for patient receipt of the regimen's medications and any immediate infusion reactions and adverse effect symptoms since the previous treatment. Through the ND module, COMS enhances and standardizes documentation for oncology nursing activities. It supports oncology services through a specialty-focused application and interoperability with VA legacy healthcare systems of Vista and CPRS. The ND module serves as the regulatory record for the administration of chemotherapy.

### 1.4 Stakeholders

COMS stakeholders include oncology patients, those involved with management of the contract, the clinical healthcare team, and the dbITpro development team. For the ND module, oncology nurses account for the most involved and concerned stakeholders, as shown in **Figure 2**.

Name	Role	Organization	Phone	Email
Janet Cogswell	Oncology Nurse	Veterans Affairs	973.676.1000 ext 1531	Janet.Cogswell@va.gov
Lori Hoffman-Hogg	Oncology Nurse	Veterans Affairs	518.626.6446	Lori.Hoffman-Hogg2@va.gov
Michele Johnson	Oncology Nurse	Veterans Affairs	432.926.1176 ext 2687	Michele.Johson2@va.gov

**Figure 2 – COMS Nursing Documentation Stakeholders**

## **1.5 Supporting Requirements**

As a uniquely high-risk and high-complexity domain of health care, oncology requires significant documentation of treatment. Effective and efficient documentation requires fully interfaced support of all participating healthcare applications. Notably, this includes VistA, CPRS, and COMS to create a clinical environment with standardized documentation of medication administration and the provision of oncology nursing services. This environment will capture automated annotations with discrete data points, promote VA-wide standardization of documentation, augment adverse event tracking/reporting, and fortify patient safety through enhanced efficiencies in the provision of oncology services. Accordingly, an interoperable environment among VistA, CPRS, and COMS is an essential supporting requirement for this Nursing Documentation Use Case.

## **2.0 Actors**

As the primary healthcare professionals interacting with patients in the administration of medications and providing hands-on treatment, oncology nurses fulfill the ND module central role. Within the ND module, the oncology nurse reviews existing patient documentation and orders; verifies patient identification and medication dosages; annotates assessments and treatments; and provides the majority of documentation for medication administration and overall provision of medical care. For each administration day and non-administration days where the patient presents for care, the ND module facilitates granular documentation of patient care and reaction to that treatment. COMS supports nursing requirements for thorough documentation of hands-on patient care.

The ND module facilitates and captures the documentation of nursing activities in support of the provision of oncology services. The oncology nurse is the critical human link to facilitate oncology services documentation of chemotherapy administration within VA's expansive healthcare enterprise. Oncology nurse actions within the ND module serve as the annotation capstone of the desired clinical environment within the construct of standardization and direct order entry of chemotherapy. The oncology nurse utilizes this standardized and interoperable environment between COMS and VistA/CPRS to facilitate appropriate documentation of healthcare within VA's electronic health record.

## **3.0 Supporting Use Case List**

The Chemotherapy Template Order Source (CTOS) module and Order Entry Management (OEM) module Use Cases both support this ND module Use Case. The actions described within the CTOS module Use Case scenarios provide the foundation for COMS functionality and support ordering. Subsequent actions within the OEM module Use Case scenarios support nursing activities described in this ND module Use Case.



## 4.0 Preconditions

The ND module requires several precursor actions and conditions within the CTOS module and OEM module. Accordingly, the Nursing Documentation Use Case scenarios build upon those expressed in the CTOS and OEM Use Case documents. In addition, the following are required to support the Nursing Documentation Use Case scenarios detailed in section 5:

- Availability of relevant patient information (e.g. laboratory results, future treatment dates) is essential to Review Laboratory Information and Generate Patient Reminder Information.
- A regimen order, by virtue of the applied template and order sheet, is required to Verify Medication Dosing, Annotate Medications Administered and Patient Treatment, and Annotate Patient Discharge Instructions, and Record Infusion Reactions to Treatment. A current regimen order is also required to View Chemotherapy/Biotherapy Information.
- In practice, a patient is required to obtain, and subsequently, Record and View Vital Signs. Further examination of the patient (or notional data) is required to Document Patient Verification and Pre-Treatment Consent and Teaching, Annotate Patient Assessment of Adverse Events Since Last Treatment, and Record Assessment of IV Site.

## 5.0 Use Case Scenarios

The intent of the Use Case scenarios is to walk the user through common process flows associated with the ND module and the provision of oncology nursing services. Scenarios 1 – 5 are iterative, building upon each other for the extensive General Information panel. All scenarios require the selection of a specific patient. For Use Case scenario testing, patients will be assigned to each test team as follows:

Team	Use Case Patient	Patient Identifier
1	PATIENT FOURHUNDRED	F0400
2	PATIENT FOURHUNDREDFIFTEEN	F0415
3	PATIENT FOURHUNDREDTWENTYFIVE	F0425
4	PATIENT FOURHUNDREDFORTYFIVE	F0445
5	PATIENT FOURHUNDREDFIFTY	F0450
6	PATIENT FOURHUNDREDFIFTYTWO	F0452
7	PATIENT FOURHUNDREDFIFTYFIVE	F0455
8	PATIENT FOURHUNDREDSIXTY	F0460
9	PATIENT FIVEHUNDREDFIFTEEN	F0515
10	PATIENT FIVEHUNDREDFIFTY	F0550

Each scenario requires the selection of the test team's specific patient as follows:

Step	Action	COMS Reaction
1	From the Patient tab, enter the patient identifier for team's assigned patient in the Patient panel and click on the "Query CPRS for Patient" link	Displays "Please Click Here to Confirm This is the Patient You Want"
2	Select the link for team's assigned patient to confirm the	Presents patient information for

Step	Action	COMS Reaction
	patient	team's assigned patient
3	Select/Open/Expand the "Patient Information" panel	Expands "Patient Information" panel
4	View patient gender, age, and amputation(s); Body Surface Area (BSA) weight method, BSA method, and BSA calculations; template information; regimen status; type(s) of cancer; allergies; and clinical trial information	Permits viewing of information
5	Select/Open/Expand the "Patient History" panel	Expands "Patient History" panel
6	View vital signs historical information (date taken, temperature, pulse, blood pressure respirations, pain level, oxygen saturation, performance status, height, weight, and four columns for BSA information of weight formula, body weight, BSA method, and calculated BSA)	In reverse chronological order, displays information as obtained from VistA, COMS OEM module, and COMS ND module/ General Information panel
	ALTERNATE	ALTERNATE
1	From the Patient tab, enter the patient identification for team's assigned patient in the Patient panel and press enter	Displays "Select Patient from CPRS" pull-down menu
2	Select the team's assigned patient from the pull-down menu	Presents patient information for team's assigned patient
3	Select/Open/Expand the "Patient Information" panel	Expands "Patient Information" panel
4	View patient gender, age, and amputation(s); Body Surface Area (BSA) weight method, BSA method, and BSA calculations; template information; regimen status; type(s) of cancer; allergies; and clinical trial information	Permits viewing of information
5	Select/Open/Expand the "Patient History" panel	Expands "Patient History" panel
6	View vital signs historical information (date taken, temperature, pulse, blood pressure respirations, pain level, oxygen saturation, performance status, height, weight, and four columns for BSA information of weight formula, body weight, BSA method, and calculated BSA)	In reverse chronological order, displays information as obtained from VistA, COMS OEM module, and COMS ND module/ General Information panel
	ALTERNATE	ALTERNATE
1	From the Patient tab, using the Enter a Range of Administration Dates to Search functionality and the default of today's date for the "from" range, select a future date from the pop-up calendar "to" range, and click on the "Select Patient by Administration Date(s)" link	Displays "Select Patient from CPRS" pull-down menu
2	Select team's assigned patient from the pull-down menu	Presents patient information for team's assigned patient
3	Select/Open/Expand the "Patient Information" panel	Expands "Patient Information" panel
4	View patient gender, age, and amputation(s); Body Surface Area (BSA) weight method, BSA method, and BSA calculations; template information; regimen status; type(s) of cancer; allergies; and clinical trial information	Permits viewing of information
5	Select/Open/Expand the "Patient History" panel	Expands "Patient History" panel
6	View vital signs historical information (date taken,	In reverse chronological order,

Step	Action	COMS Reaction
	temperature, pulse, blood pressure respirations, pain level, oxygen saturation, performance status, height, weight, and four columns for BSA information of weight formula, body weight, BSA method, and calculated BSA)	displays information as obtained from VistA, COMS OEM module, and COMS ND module/ General Information panel
Step	Action	
7*	Proceed to Step 7 for ND Module Use Case Scenario 1 and 6 – 10	

### 5.1 Scenario 1: Review Chemotherapy/Biotherapy Information

Step	Action	COMS Reaction
7*	Select/open the “Nursing Documentation” module tab	Expands ND module
8	View Chemotherapy/Biotherapy information	Permits viewing of information for Regimen, Cycle, Day, and Date immediately above the six ND module panels
9	Proceed to Scenario 2	N/A

### 5.2 Scenario 2: Review Laboratory Information

Step	Action	COMS Reaction
10	Select/Open/Expand the “Laboratory Information” panel	Expands “Laboratory Information” panel and presents relevant laboratory results for the patient
11	Proceed to Scenario 3	N/A
	ALTERNATE	ALTERNATE
10	Select/open the “Nursing Documentation” module tab (only required if not continued from previous scenario)	Expands ND module with six panels; defaults to the General Information panel display
11	Select/Open/Expand the “Laboratory Information” sub-panel	Expands “Laboratory Information” and presents relevant laboratory results for the patient
12	Proceed to Scenario 3	N/A

### 5.3 Scenario 3: Document Patient Verification and Pre-Treatment Consent and Teaching

Step	Action	COMS Reaction
13	Select/open the “Nursing Documentation” module tab (only required if not continued from previous scenario)	Expands ND module with six panels; defaults to the General Information panel display
14	From the General Information panel, select the “Yes” radio	Indicates “Yes” for selection

Step	Action	COMS Reaction
	button to indicate “Patient Identification Verified with 2 Information Sources?”	
15	Select “Yes” radio button to indicate “Consent Obtained?”	Indicates “Yes” for selection
16	Enter any relevant comments in the “Comments” field	Displays entered text
17	Select “Yes” radio button to indicate “Education Assessment Complete”	Indicates “Yes” for selection
18	Select “Yes” radio button to indicate “Pre-procedure plan reviewed with patient/significant other, questions answered?”	Indicates “Yes” for selection
19	Proceed to Scenario 4	N/A

#### 5.4 Scenario 4: Verify Medication Dosing

Step	Action	COMS Reaction
20	Select/open the “Nursing Documentation” module tab (only required if not continued from previous scenario)	Expands ND module with six panels; defaults to the General Information panel display
21	Within the General Information panel, scroll to the “Dual Verification of Dosing” section immediately above Vital Signs	Permits Scrolling
22	Select the “Sign to Verify” button	Opens window and displays medication/dosage ordered, finalized, and dispensed
23	Enter CPRS Access Code and Verify Code to provide verification of medication dosing	Displays user name for verification of dosing, today’s date, and time verified
24	If required by facility and enabled within the Admin tab, another healthcare professional may select the second “Sign to Verify” button	Opens window and displays medication/dosage ordered, finalized, and dispensed
25	Second healthcare professional enters CPRS Access Code and Verify Code to provide dual verification of medication dosing	Displays user name for second verification of dosing, today’s date, and time verified
26	Proceed to Scenario 5	N/A

#### 5.5 Scenario 5: Record and View Vital Signs and Review Body Surface Area Calculations

Step	Action	COMS Reaction
27	Select/open the “Nursing Documentation” module tab (only required if not continued from previous scenario)	Expands ND module with six panels; defaults to the General Information panel display
28	Within the General Information panel, scroll towards the bottom of the screen and enter Temperature value of “98.2”	Displays entered numeric value
29	Enter Height value of “70” inches	Displays entered numeric value
30	Enter Weight value of “176” pounds	Displays entered numeric value; calculates and displays BSA

Step	Action	COMS Reaction
31	Enter Pulse value of “74” for heart rate	Displays entered numeric value
32	Enter Respiration value of “19” for respirations	Displays entered numeric value
33	Select a Pain value of “3” from the 0-10 pull-down menu	Displays selected numeric value
34	Enter Systolic value of “118” and Diastolic value of “82” for blood pressure	Displays entered numeric value
35	Enter SPO2% value of “98” for peripheral oxygen saturation	Displays entered numeric value
36	Select “Save” to save entered vital signs information	Saves vital signs information and displays in the Vital Signs – Historical table
37	View entries in the Vital Signs – Historical table	Permits viewing and displays information saved in previous step
38	From the Vital Signs historical table, view the displayed Body Surface Area (BSA) and select “Show Calculation” link	Displays body weight selection and value, as well as, BSA formula name, formula, and calculated value

## 5.6 Scenario 6: Annotate Assessment of Patient Symptoms Since Last Treatment

Step	Action	COMS Reaction
7*	Select/open the “Nursing Documentation” module tab (only required if not continued from previous scenario)	Expands ND module with six panels; defaults to the General Information panel display
8	Select/open the “Assessment” panel	Opens and displays the Assessment panel
9a	Check box for “Fatigue”	Places check mark in box for Fatigue; Presents Level of Fatigue pull-down menu and Comments box
9b	Select Fatigue Level of “1” from pull-down menu	Displays selected fatigue level as “1. Fatigue relieved by rest”
9c	Enter comments to further qualify level of fatigue, as appropriate	Displays entered text
10a	Check box for “Nausea”	Places check mark in box for Nausea; Presents Level of Nausea pull-down menu and Comments box
10b	Select Nausea Level of “1” from pull-down menu	Displays selected fatigue level as “1. Loss of appetite without alteration in eating habits”
10c	Enter comments to further qualify level of nausea, as appropriate	Displays entered text
11	Repeat process for any other listed Top 10 symptom	Displays symptom information in similar manner

Step	Action	COMS Reaction
12	Check box for "Other"	Places check mark in box for Other; Presents Comments box for text entry
13	Select "Save" button to save entered assessment	Indicates assessment information was saved and continues panel display for remainder of the session

### 5.7 Scenario 7: Record Assessment of IV Site

Step	Action	COMS Reaction
7*	Select/open the "Nursing Documentation" module tab (only required if not continued from previous scenario)	Expands ND module with six panels; defaults to the General Information panel display
8	Select/open the "IV Site" panel	Opens and displays the IV Site panel
9a	To document IV Access, select today's date from the pop-up calendar for "Date Accessed"	Presents pop-up calendar and displays selected date
9b	Select "Peripheral IV" from Device pull-down menu	Displays "Peripheral IV" for Device
9c	Select "22g" from Gauge pull-down menu	Displays "22g" for Needle Gauge
9d	Select "Left Dorsal Proximal Forearm" from Location pull-down menu	Displays "Left Dorsal Proximal Forearm" for device Location
9e	Enter comments to further qualify IV Access, as appropriate	Displays entered text
10a	To document Site Appearance, check Site Appearance radio button(s) "Absence of Symptoms" or "Pain", "Swelling", "Erythema", or "Line Disconnected/Port De-accessed"	Displays check mark in corresponding boxes for selected site appearance descriptions
10b	Enter comments to further qualify Site Appearance, as appropriate	Displays entered text
11a	To verify Brisk Blood Return, check "Yes" or "No" radio buttons for each verification of brisk blood return (Pre-Treatment, During Treatment, and Post-Treatment)	Displays selected radio button for each response
11b	Enter comments to further qualify Brisk Blood Return Verified, as appropriate	Displays entered text
12	Select "Save" button to save entered IV Site assessment	Indicates IV Site assessment information was saved and continues panel display for remainder of the session

### 5.8 Scenario 8: Annotate Medications Administered and Patient Treatment

Step	Action	COMS Reaction
7*	Select/open the "Nursing Documentation" module tab (only	Expands ND module with six

Step	Action	COMS Reaction
	required if not continued from previous scenario)	panels; defaults to the General Information panel display
8	Select/open the “Treatment” panel	Opens and displays the Treatment panel
9	For administration days, view pre-populated information for pre-therapy, therapy, and post-therapy medications	On administration days, pre-populates medications based on dispensed order; medication fields remain blank on non-administration days
10	Select entered value “Dose” for first pre-therapy medication and enter a numeric value for dosage administered (or accept defaulted value)	Displays entered “Dose” value to indicate administered dose
11	For the same medication, select the pull-down menu in “Start Time” column and select time value	Displays selected “Start Time” value to indicate medication administration start time
12	For the same medication, select the pull-down menu in “Stop Time” column and select time value	Displays selected “Stop Time” value to indicate medication administration end time
13	For the same medication, select “Comments” field and enter free text comment for administration of that specific medication	Displays entered text
14	Select “Verify to Sign” button for a pre-therapy, therapy, or post-therapy medication and enter CPRS Access Code and Verify Code (Note, this may take 12 seconds to process)	Displays user name for nurse certifying administration of the selected medication, today’s date, and time verified
15	Repeat steps 10 – 14 for each pre-therapy, therapy, and post-therapy medication listed on the Treatment panel	Responds in similar fashion for steps 10 - 14
16	After documenting medications administered for pre-therapy, therapy, and post-therapy, select “Treatment Complete” button	Asks user “Are you finished documenting administration of medications for this patient?” to proceed. (Note – positive action is required to record medication administration)
17	Select “Yes” to confirm your documentation is complete	Indicates Treatment panel information was saved and continues panel display for remainder of the session; Flow Sheet module is updated with details of medication administration

## 5.9 Scenario 9: Record Infusion Reactions to Treatment

Step	Action	COMS Reaction
7*	Select/open the “Nursing Documentation” module tab (only required if not continued from previous scenario)	Expands ND module with six panels; defaults to the General Information panel display
8	Select/open the “Infusion Reactions” panel	Opens and displays the Infusion Reactions panel
9a	For “Extravasation” infusion reaction, check box for “Topical Heating Applied”	Displays check mark in box for “Topical Heating Applied”; Presents “Frequency” text field
9b	Enter comments to qualify “Topical Heating Applied”, as appropriate	Displays entered text
10a	For “Cytokine-Release Syndrome” infusion reaction, check box for “Hypotension”	Places check mark in box for “Hypotension”; presents entry fields for systolic and diastolic blood pressure numeric values “(lowest value)”
10b	Enter Systolic value of “100” and Diastolic value of “68” for blood pressure	Displays entered values of “100/68” for blood pressure
11a	For “Cytokine-Release Syndrome” infusion reaction, check box for “Tachycardia”	Places check mark in box for “Tachycardia; presents entry field for numeric entry of heart rate “(highest value)”
11b	Enter value of “135” for tachycardia	Displays entered value of “135” for tachycardia heart rate
12	For “Hypersensitivity or Anaphylaxis” infusion reaction, check box for any listed symptom (Note: Hypotension fields present same functionality described in Steps 10a-10b above)	Displays check mark in box for selected “Hypersensitivity/ Anaphylaxis” infusion reaction
13	Check box for “Other” infusion reaction	Presents Comments box
14	Enter comments to qualify “Other” infusion reaction, as appropriate	Displays entered text
15	Select “Save” button to save entered Infusion Reactions documentation	Indicates Infusion Reactions documentation was saved and continues panel display for remainder of the session

## 5.10 Scenario 10: Annotate Patient Discharge Instructions and Generate Patient Reminders

Step	Action	COMS Reaction
7*	Select/open the “Nursing Documentation” module tab (only required if not continued from previous scenario)	Expands ND module with six panels; defaults to the General Information panel display
8	Select/open the “Discharge Instructions” panel	Opens and displays the Discharge Instructions panel



Step	Action	COMS Reaction
9a	Select "Yes" radio button to indicate Patient Education was provided	Indicates "Yes" for selection
9b	Enter desired comments in the "Comments" field	Displays entered text
10a	Select "Outpatient" radio button to indicate the next follow-up appointment is on an Outpatient basis	Indicates "Outpatient" for selection
10b	Select pop-up calendar for Next Chemotherapy Appointment and select future date	Displays selected date
11a	Select pop-up calendar for Next Clinic Appointment and select future date	Displays selected date
11b	Select pop-up calendar(s) for Laboratory Test(s) Scheduled and select future date(s)	Displays selected date(s)
12	Print Patient Education information	Prints patient reminder information for future appointments and scheduled laboratory tests
13a	Click box for "Patient was given Chemotherapy discharge instructions" to affirm instructions were provided	Displays check mark in box
13b	From "Select Instructions" pull-down menu, select the title for instructions provided to the patient. To indicate multiple instructions, depress the Control key while making selections	Displays title(s) for selected instructions
14	Enter comments to indicate "No instructions available at this time", if appropriate	Displays entered text
15	Save documentation of Discharge Instructions	Saves entries for Discharge Instructions panel and continues display for remainder of the session