Each time this manual is updated, the Title Page lists the new revised date and this page describes the changes. If the Revised Pages column lists “All,” replace the existing manual with the reissued manual. If the Revised Pages column lists individual entries (e.g., 25, 32), either update the existing manual with the Change Pages Document or print the entire new manual.

<table>
<thead>
<tr>
<th>Date</th>
<th>Revised Pages</th>
<th>Patch Number</th>
<th>Description</th>
<th>(Author)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/2007</td>
<td>iv, 74a-74d</td>
<td>PSJ<em>5</em>175</td>
<td>Modified outpatient header text for display of duplicate orders. Added new functionality to Duplicate Drug and Duplicate Class definitions. Modifications for remote allergies, to ensure all allergies are included when doing order checks using VA Drug Class; Analgesic order checks match against specific class only; check for remote data interoperability performed when entering patient’s chart; and list of remote allergies added to Patient Information screen.</td>
<td>(R. Singer, PM; E. Phelps/C. Varney, Tech Writer)</td>
</tr>
<tr>
<td></td>
<td>5, 12, 16-17, 26, 34-38, 41-42, 72-73</td>
<td>PSJ<em>5</em>160</td>
<td></td>
<td></td>
</tr>
<tr>
<td>07/2007</td>
<td>79a-79b, 86a-86b, 92a-92b</td>
<td>PSJ<em>5</em>145</td>
<td>On 24-Hour, 7-Day, and 14-Day MAR Reports, added prompt to include Clinic Orders when printing by Ward or Ward Group. Also added prompt to include Ward Orders when printing by Clinic or Clinic Group.</td>
<td>(R. Singer, PM; E. Phelps, Tech. Writer)</td>
</tr>
<tr>
<td>12/2005</td>
<td>1, 73-74b</td>
<td>PSJ<em>5</em>146</td>
<td>Remote Data Interoperability (RDI) Project: Removed document revision dates in Section 1. Introduction. Updated Section 4.9. Order Checks, to include new functionality for remote order checking.</td>
<td>(E. Williamson, PM; M. Newman, Tech. Writer)</td>
</tr>
<tr>
<td>01/2005</td>
<td>All</td>
<td>PSJ<em>5</em>111</td>
<td>Reissued entire document to include updates for Inpatient Medications Orders for Outpatients and Non-Standard Schedules.</td>
<td>(S. Templeton, PM, R. Singer, PM, M. Newman, Tech. Writer)</td>
</tr>
</tbody>
</table>
# Table of Contents

1. **Introduction** ...............................................................................................................1

2. **Orientation** ..................................................................................................................3

3. **List Manager** ..............................................................................................................5
   3.1. Using List Manager ........................................................................................................7
   3.2. Hidden Actions ................................................................................................................7

4. **Order Options** .............................................................................................................11
   4.1. Order Entry ......................................................................................................................12
   4.2. Non-Verified/Pending Orders ........................................................................................13
   4.3. Inpatient Order Entry .....................................................................................................16
   4.4. Patient Actions ...............................................................................................................17
      4.4.1. Patient Record Update ..............................................................................................17
      4.4.2. New Order Entry .......................................................................................................18
      4.4.3. Detailed Allergy/ADR List .........................................................................................33
      4.4.4. Intervention Menu ....................................................................................................34
      4.4.5. View Profile ...............................................................................................................39
      4.4.6. Patient Information ...................................................................................................41
      4.4.7. Select Order ...............................................................................................................42
   4.5. Order Actions ...............................................................................................................44
      4.5.1. Discontinue ................................................................................................................45
      4.5.2. Edit ...........................................................................................................................47
      4.5.3. Verify ........................................................................................................................49
      4.5.4. Hold ..........................................................................................................................51
      4.5.5. Renew .........................................................................................................................53
      4.5.6. Activity Log ...............................................................................................................59
      4.5.7. Finish ........................................................................................................................60
      4.5.8. Flag ............................................................................................................................66
      4.5.9. Speed Actions ............................................................................................................67
   4.6. Discontinue All of a Patient’s Orders ............................................................................68
   4.7. Hold All of a Patient’s Orders ......................................................................................68
   4.8. Inpatient Profile .........................................................................................................70
4.9. Order Checks ................................................................................................................. 72
  4.9.1 Outpatient Duplicate Orders .................................................................................. 74b
  4.9.2 Inpatient Duplicate Orders ................................................................................... 74b
  4.9.3 Discontinuing Duplicate Inpatient Orders ............................................................. 74d

5. Maintenance Options ................................................................................................. 75
  5.1. Edit Inpatient User Parameters ............................................................................... 75
  5.2. Edit Patient’s Default Stop Date ............................................................................ 76

6. Output Options ........................................................................................................... 77
  6.1. PAatient Profile (Unit Dose) .................................................................................... 77
  6.2. Reports Menu ........................................................................................................... 78
    6.2.1. 24 Hour MAR ....................................................................................................... 79
    6.2.2. 7 Day MAR .......................................................................................................... 86
    6.2.3. 14 Day MAR ......................................................................................................... 92
    6.2.4. Action Profile #1 .................................................................................................. 98
    6.2.5. AAuthorized Absence/Discharge Summary ....................................................... 103
    6.2.6. Extra Units Dispensed Report ............................................................................. 108
    6.2.7. Free Text Dosage Report ..................................................................................... 109
    6.2.8. INpatient Stop Order Notices ............................................................................. 110
    6.2.9. Medications Due Worksheet ................................................................................ 112
    6.2.10. Patient Profile (Extended) ................................................................................. 114
  6.3. Align Labels (Unit Dose) ........................................................................................ 116
  6.4. Label Print/Reprint .................................................................................................. 116

7. Inquiries Option ............................................................................................................ 117
  7.1. Dispense Drug Look-Up ......................................................................................... 117
  7.2. Standard Schedules ............................................................................................... 118

8. Glossary ...................................................................................................................... 119

9. Index ............................................................................................................................ 133
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

<table>
<thead>
<tr>
<th>Screen Title</th>
<th>CWAD* Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Information</td>
<td>Sep 15, 2000 11:32:08</td>
</tr>
<tr>
<td>PSJPATIENT2, TWO</td>
<td>Ward: 1 West</td>
</tr>
<tr>
<td>PID: 000-00-0002</td>
<td>Room-Bed: A-6</td>
</tr>
<tr>
<td>DOB: 02/22/42 (58)</td>
<td>Ht(cm): 167.64 (04/21/99)</td>
</tr>
<tr>
<td>Sex: MALE</td>
<td>Wt(kg): 85.00 (04/21/99)</td>
</tr>
<tr>
<td>Dx: TEST PATIENT</td>
<td>Admitted: 09/16/99</td>
</tr>
<tr>
<td>Allergies - Verified: CARAMEL, CN900, LOMEFLOXACIN, PENTAMIDINE, PENTAZOCINE, CHOCOLATE, NUTS, STRAWBERRIES, DUST</td>
<td></td>
</tr>
<tr>
<td>Non-Verified: AMOXICILLIN, AMPICILLIN, TAPE, FISH, FLUPHENAZINE DECANOATE</td>
<td></td>
</tr>
<tr>
<td>Remote:</td>
<td></td>
</tr>
<tr>
<td>Adverse Reactions:</td>
<td></td>
</tr>
<tr>
<td>Inpatient Narrative: Inpatient narrative for PSJPATIENT2</td>
<td></td>
</tr>
<tr>
<td>Outpatient Narrative: This patient doesn't like waiting at the pickup window. He gets very angry.</td>
<td></td>
</tr>
</tbody>
</table>

---------Enter ?? for more actions---------------------------------------

<table>
<thead>
<tr>
<th>Action Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>PU Patient Record Update</td>
</tr>
<tr>
<td>DA Detailed Allergy/ADR List</td>
</tr>
<tr>
<td>VP View Profile</td>
</tr>
<tr>
<td>Select Action: View Profile//</td>
</tr>
</tbody>
</table>

* Crises, Warnings, Allergies, and Directives (CWAD)
**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).

**CWAD Indicator:** This indicator will display when the crises, warnings, allergies, and directives information has been entered for the patient. (This information is entered via the Text Integration Utilities (TIU) package.) 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). Crises, warnings, and directives are displayed respectively, “<C>”, “<W>”, “<D>”. This data may be displayed using the CWAD hidden action. Any combination of the four indicators can display.

**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 is displayed as “Allergies/Reactions: No Allergy Assessment”. 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.
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
- Edit Inpatient User Parameters
- Edit Patient's Default Stop Date
- Hold All of a Patient's Orders
- Inpatient Order Entry
- 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.

Note: When the selected order type (non-verified or pending) does not exist (for that patient) 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 for that patient.

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 VistA 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 VistA packages.

The three different paths for entering a new order or taking an action on an existing order are summarized in the following sections.
4.1. Order Entry

The Order Entry option allows the nurse to create, edit, renew, hold, and discontinue Unit Dose orders while remaining in the Unit Dose Medications 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., P0001). The Patient Information Screen is displayed:

Example: Patient Information Screen

<table>
<thead>
<tr>
<th>Patient Information</th>
<th>Sep 11, 2000 16:09:05</th>
<th>Page: 1 of 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSJPATIENT1,ONE</td>
<td>Ward: 1 EAST</td>
<td></td>
</tr>
<tr>
<td>PID: 000-00-0001</td>
<td>Room-Bed: B-12</td>
<td>Ht(cm): _____</td>
</tr>
<tr>
<td>DOB: 08/18/20 (80)</td>
<td>Wt(kg): _____</td>
<td></td>
</tr>
<tr>
<td>Sex: MALE</td>
<td>Admitted: 05/03/00</td>
<td></td>
</tr>
<tr>
<td>Dx: TESTING</td>
<td>Last transferred: *****</td>
<td></td>
</tr>
</tbody>
</table>

Allergies/Reactions: No Allergy Assessment
Remote:
Adverse 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.
Example: Short Profile

Non-Verified/Pending Orders Mar 24, 2002@21:02:14 Page: 1 of 1

PSJPATIENT1,ONE Ward: 1 EAST
PID: 000-00-0001 Room-Bed: B-12 Ht(cm): ______ (______)
DOB: 08/18/20 (81) Wt(kg): ______ (______)
Sex: MALE Admitted: 05/03/00
Dx: TESTING Last transferred: ********

- - - - - - - - - - - - - A C T I V E - - - - - - - - - - - - -
1  ->POTASSIUM CHLORIDE 40 MEQ C 03/22 03/29 A
   in DEXTROSE  5% 1000 ML 150 ml/hr
   - - - - - - - - - - - - - P E N D I N G - - - - - - - - - - - - -
2   PENICILLIN INJ ? ***** ***** P
   Give: 5000000UNT/1VIL IV Q8H

Enter ?? for more actions

PI Patient Information SO Select Order
PU Patient Record Update NO New Order Entry
Select Action: Quit//

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

When the nurse holds the PSJ RNURSE key, it will be possible to take any available actions on selected Unit Dose or IV orders and verify non-verified orders.

The following keys may be assigned if the user already holds the PSJ RNURSE key:

- PSJ RNFINISH key will allow the nurse to finish Unit Dose orders.
- PSJI RNFINISH key will allow the nurse to finish IV 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 Medications module.

When the user accesses the Inpatient Order Entry option from the Unit Dose Medications 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: PSJPATIENT1

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., P0001). The Patient Information Screen is displayed:

Example: Patient Information Screen

<table>
<thead>
<tr>
<th>Patient Information</th>
<th>Sep 12, 2000 10:36:38</th>
<th>Page: 1 of 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSJPATIENT1,ONE</td>
<td>Ward: 1 EAST</td>
<td></td>
</tr>
<tr>
<td>PID: 000-00-0001</td>
<td>Room-Bed: B-12</td>
<td></td>
</tr>
<tr>
<td>DOB: 08/18/20</td>
<td>Ht(cm):</td>
<td></td>
</tr>
<tr>
<td>Sex: MALE</td>
<td>Wt(kg):</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Admitted: 05/03/00</td>
<td></td>
</tr>
<tr>
<td>Dx: TESTING</td>
<td>Last transferred: *****</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergies/Reactions: No Allergy Assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remote:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adverse Reactions:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Narrative: INP NARR...</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Narrative:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Patient Information</th>
<th>Sep 12, 2000 14:39:07</th>
<th>Page: 1 of 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSJPATIENT1,ONE</td>
<td>Ward: 1 EAST</td>
<td></td>
</tr>
</tbody>
</table>
| PID: 000-00-0001    | Room-Bed: B-12         | Ht(cm): _____ (_____)
| DOB: 08/18/20 (60)  | Wt(kg): _____ (_____)
| Sex: MALE           | Admitted: 05/03/00      |
| Dx: TESTING         | Last transferred: ***** |

Allergies/Reactions: No Allergy Assessment
Remote:
Adverse 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 PSJPATIENT1
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.

Note: If the Unit Dose order, being finished by the nurse, is received from CPRS and has a duration assigned, the UD DEFAULT STOP DATE/TIME is displayed as the Calc Stop Date/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--the apostrophe following the number indicates minutes).
- **Time is REQUIRED in this response.**

4.4.2. **New Order Entry**

**Unit Dose**

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 VistA applications. This minimizes the chance of duplicate orders.

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 Checks for more information.)
• **“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.

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

The Nature of Order abbreviation will display on the order next to the Provider’s Name. The abbreviations will be in lowercase and enclosed in brackets. Written will display as [w], telephoned as [p], verbal as [v], policy as [i], electronically entered as [e], and service correction as [s]. If the order is electronically signed through the CPRS package **AND** the CPRS patch OR*3*141 is installed on the user’s system, then [es] will appear next to the Provider’s Name instead of the Nature of Order abbreviation.
Example: New Order Entry

Patient Information           Feb 14, 2001 10:21:33          Page:    1 of    1
PSJPATIENT1,ONE                  Ward: 1 EAST
   PID: 000-00-0001          Room-Bed:             Ht(cm): ______ (________)
   DOB: 08/18/20 (80)                              Wt(kg): ______ (________)
   Sex: MALE                                     Admitted: 11/07/00
   Dx: TEST                             Last transferred: ********
Allergies/Reactions: No Allergy Assessment
Remote: Adverse Reactions:
Inpatient Narrative: Narrative for Patient PSJPATIENT1
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: PSJPROVIDER,ONE//  <Enter>

-----------------------------------------report continues--------------------------------
Example: New Order Entry (continued)

Example: New Order Entry (continued)

Orderable Item: MULTIVITAMINS INJ
Give: IV QID

754

[29]0001 3 EAST 02/28/02
PSJPATIENT1,ONE B-12

MULTIVITAMINS 2 ML
0.9% SODIUM CHLORIDE 100 ML
INFUSE OVER 125 MIN.
QID
09-13-17-21
Fld by:______Chkd by:______
1[1]

Start date: FEB 28,2002 13:56 Stop date: MAR 30,2002 24:00

Is this O.K.: YES//<Enter> YES
NATURE OF ORDER: WRITTEN//<Enter> W
...transcribing this non-verified order....

NON-VERIFIED IV Feb 28, 2002813:56:44 Page: 1 of 2
PSJPATIENT1,ONE Ward: 1 EAST
PID: 000-00-0001 Room-Bed: B-12 Ht(cm): ______ (______)
DOB: 08/18/20 (81) Wt(kg): ______ (______)
Sex: MALE Admitted: 05/03/00
Dx: TESTING

*(1) Additives: MULTIVITAMINS 2 ML
*(2) Solutions: 0.9% SODIUM CHLORIDE 100 ML
*(3) Infusion Rate: INFUSE OVER 125 MIN.
*(5) Med Route: IV
*(4) Start: 02/28/02 13:56
*(6) Stop: 03/30/02 24:00
*(7) Schedule: QID
*(8) Admin Times: 09-13-17-21 Quantity: 0
*(9) Provider: PSJPROVIDER,ONE [w]
*(10)Orderable Item: MULTIVITAMINS INJ

Instructions:

*(11) Other Print:

Select Item(s): Next Screen// VF Verify

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**

```plaintext
Patient Information          Sep 22, 2000 08:03:07          Page:    1 of    1
PSJPATIENT2, TWO            Ward: 1 West
  PID: 000-00-0002           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, CH900, LOMEFLOXACIN, PENTAMIDINE, PENTAZOCINE,
                         CHOCOLATE, NUTS, STRAWBERRIES, DUST
  Non-Verified: AMOXICILLIN, AMPICILLIN, TAPE, FISH,
                FLUPHENAZINE DECANOATE
Remote:
Adverse Reactions:
Inpatient Narrative: Inpatient narrative
Outpatient Narrative: This is the Outpatient Narrative. This patient doesn't like waiting at the pickup window. He gets very angry.
```

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
PT Print Pharmacy Intervention

Select Item(s): NE Enter Pharmacy Intervention
Select APSF INTERVENTION INTERVENTION DATE: T SEP 22, 2000
Are you adding 'SEP 22, 2000' as a new APSF INTERVENTION (the 155TH)? No// Y
(Yes)
APSP INTERVENTION PATIENT: PSJPATIENT2, TWO
APSP INTERVENTION PATIENT: 02-22-42 00000002  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: PSJPROVIDER, ONE
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

<table>
<thead>
<tr>
<th>PSJPATIENT2,TWO</th>
<th>Ward: 1 West</th>
<th>DOB: 02/22/42 (58)</th>
<th>Sex: MALE</th>
<th>Dx: TEST PATIENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>PID: 000-00-0002</td>
<td>Room-Bed: A-6</td>
<td>Ht(cm): 167.64 (04/21/99)</td>
<td>Wt(kg): 85.00 (04/21/99)</td>
<td>Admitted: 09/16/99</td>
</tr>
<tr>
<td>PSJPATIENT2,TWO</td>
<td>Room-Bed: A-6</td>
<td>Ht(cm): 167.64 (04/21/99)</td>
<td>Wt(kg): 85.00 (04/21/99)</td>
<td>Admitted: 09/16/99</td>
</tr>
</tbody>
</table>

Allergies - Verified: CARAMEL, CN900, LOMEFLOXACIN, PENTAMIDINE, PENTAZOCINE, CHOCOLATE, NUTS, STRAWBERRIES, DUST

Non-Verified: AMOXICILLIN, AMPICILLIN, TAPE, FISH, FLUPHENAZINE DECANOATE

Remote:
Adverse Reactions:

Inpatient Narrative: Inpatient narrative
Outpatient Narrative: This is the Outpatient Narrative. This patient doesn't like waiting at the pickup window. He gets very angry.

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: SEP 22, 2000  PSJPATIENT2,TWO  WARFARIN 10MG
INTERVENTION DATE: SEP 22,2000// <Enter>
PATIENT: PSJPATIENT2,TWO// <Enter>
PROVIDER: PSJPROVIDER,ONE // <Enter>
PHARMACIST: PSJPHARMACIST,ONE // <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: <Enter>
REASON FOR INTERVENTION:
  1> ACTION TAKEN:
  1> CLINICAL IMPACT:
  1> FINANCIAL IMPACT:
- **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**

<table>
<thead>
<tr>
<th>Patient Information</th>
<th>Sep 22, 2000 08:03:07</th>
<th>Page: 1 of 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSJPATIENT2, TWO</td>
<td>Ward: 1 West</td>
<td></td>
</tr>
<tr>
<td>PID: 000-00-0002</td>
<td>Room-Bed: A-6</td>
<td>Ht(cm): 167.64 (04/21/99)</td>
</tr>
<tr>
<td>DOB: 02/22/42 (58)</td>
<td>Wt(kg): 85.00 (04/21/99)</td>
<td></td>
</tr>
<tr>
<td>Sex: MALE</td>
<td>Admitted: 09/16/99</td>
<td></td>
</tr>
<tr>
<td>Dx: TEST PATIENT</td>
<td>Last transferred: ********</td>
<td></td>
</tr>
</tbody>
</table>

- **Allergies - Verified**: Caramel, CN900, Lomefloxacin, Pentamidine, Pentazocine, Chocolate, Nuts, Strawberries, Dust
- **Non-Verified**: Amoxicillin, Ampicillin, Tape, Fish, Fluphenazine Decanoate

**Remote:**
- Adverse Reactions:
- Inpatient Narrative: Inpatient narrative
- Outpatient Narrative: This is the Outpatient Narrative. This patient doesn't like waiting at the pickup window. He gets very angry.

Enter ?? for more actions

<table>
<thead>
<tr>
<th>PU Patient Record Update</th>
<th>NO New Order Entry</th>
</tr>
</thead>
<tbody>
<tr>
<td>DA Detailed Allergy/ADR List</td>
<td>IN Intervention Menu</td>
</tr>
<tr>
<td>VP View Profile</td>
<td></td>
</tr>
</tbody>
</table>

**Select Action:** View Profile // **IN** Intervention Menu

--- Pharmacy Intervention Menu ---

<table>
<thead>
<tr>
<th>NE Enter Pharmacy Intervention</th>
<th>DEL Delete Pharmacy Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED Edit Pharmacy Intervention</td>
<td>VW View Pharmacy Intervention</td>
</tr>
<tr>
<td>PRT Print Pharmacy Intervention</td>
<td></td>
</tr>
</tbody>
</table>

**Select Item(s): DEL Delete Pharmacy Intervention**

You may only delete entries entered on the current day.

**Select APSP INTERVENTION INTERVENTION DATE:** T SEP 22, 2000 PSJPATIENT2, TWO

**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

<table>
<thead>
<tr>
<th>Patient Information</th>
<th>Sep 22, 2000 08:03:07</th>
<th>Page: 1 of 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSJPATIENT2,TWO</td>
<td>Ward: 1 West</td>
<td></td>
</tr>
<tr>
<td>PID: 000-00-0002</td>
<td>Room-Bed: A-6</td>
<td></td>
</tr>
<tr>
<td>DOB: 02/22/42 (58)</td>
<td>Ht(cm): 167.64 (04/21/99)</td>
<td></td>
</tr>
<tr>
<td>Sex: MALE</td>
<td>Wt(kg): 85.00 (04/21/99)</td>
<td></td>
</tr>
<tr>
<td>Dx: TEST PATIENT</td>
<td>Admitted: 09/16/99</td>
<td></td>
</tr>
<tr>
<td>Allergies - Verified: CARAMEL, CN900, LOMEFLOXACIN, PENTAMIDINE, PENTAZOCINE, CHOCOLATE, NUTS, STRAWBERRIES, DUST</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Verified: AMOXICILLIN, AMPICILLIN, TAPE, FISH, FLUPHENAZINE DECANOATE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remote:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adverse Reactions:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Narrative:</td>
<td>Inpatient narrative</td>
<td></td>
</tr>
<tr>
<td>Outpatient Narrative:</td>
<td>This is the Outpatient Narrative. This patient doesn't like waiting at the pickup window. He gets very angry.</td>
<td></td>
</tr>
</tbody>
</table>

Enter ?? for more actions

Select Item(s): VW View Pharmacy Intervention

--- Pharmacy Intervention Menu ---

INTERVENTION DATE: SEP 22, 2000   PSJPATIENT2,TWO

PROVIDER: PSJPROVIDER,ONE       PHARMACIST: PSJPHARMACIST,ONE
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

--- Pharmacy Intervention Menu ---

NE Enter Pharmacy Intervention
ED Edit Pharmacy Intervention
VW View Pharmacy Intervention
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 ---

INTERVENTION: ALLERGY
INTERVENTION DATE: SEP 22, 2000 PATIENT: PSJPATIENT2,TWO
PROVIDER: PSJPROVIDER,ONE PHARMACIST: PSJPHARMACIST,ONE
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
4.4.6. Patient Information

The Patient Information screen is displayed for the selected patient. The header contains the patient’s demographic data, while the list area contains Allergy/Adverse Reaction data, including remote data and Pharmacy Narratives. If an outpatient is selected, all future appointments in clinics that allow Inpatient Medications orders will display in the list area, too.

Example: Patient Information

<table>
<thead>
<tr>
<th>Patient Information</th>
<th>Sep 13, 2000 15:04:31</th>
<th>Page: 1 of 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSJPATIENT1,ONE</td>
<td>Ward: 1 EAST</td>
<td></td>
</tr>
<tr>
<td>PID: 000-00-0001</td>
<td>Room-Bed: B-12</td>
<td></td>
</tr>
<tr>
<td>DOB: 08/18/20 (80)</td>
<td>Ht(cm): ______ (______)</td>
<td></td>
</tr>
<tr>
<td>Sex: MALE</td>
<td>Wt(kg): ______ (______)</td>
<td></td>
</tr>
<tr>
<td>Dx: TESTING</td>
<td>Admitted: 05/03/00</td>
<td></td>
</tr>
<tr>
<td>Last transferred:</td>
<td>************</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>CAPTOPRIL TAB</td>
<td>C 03/26  03/27 A</td>
</tr>
<tr>
<td>Give: 25MG PO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>CAPTOPRIL TAB</td>
<td>C 03/28  03/29 A</td>
</tr>
<tr>
<td>Give: 50MG PO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>CAPTOPRIL TAB</td>
<td>C 03/30  03/31 A</td>
</tr>
<tr>
<td>Give: 100MG PO</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Enter ?? for more actions

Select Action: View Profile

Allergies/Reactions: No Allergy Assessment
Remote:
Adverse Reactions:
Inpatient Narrative: Narrative for Patient PSJPATIENT1
Outpatient Narrative:

Enter ?? for more actions

Select Action: View Profile
Example: Patient Information Screen for Outpatient Receiving Inpatient Medications

Patient Information May 12, 2003 14:27:13 Page: 1 of 1
PSJPATIENT3,THREE Last Ward: 1 West
PID: 000-00-0003 Last Room-Bed: Ht(cm): ______ (________)
DOB: 02/01/55 (48) Wt(kg): ______ (________)
Sex: FEMALE Last Admitted: 01/13/98
Dx: TESTING Discharged: 01/13/98

Allergies/Reactions: No Allergy Assessment
Remote:
Adverse Reactions:
Inpatient Narrative:
Outpatient Narrative:

Clinic: Date/Time of Appointment:
Clinic A May 23, 2003/9:00 am
Flu Time Clinic June 6, 2003/10:00 am

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 (i.e., short or long).

Example: Selecting an Order

Inpatient Order Entry Mar 07, 2002@13:01:56 Page: 1 of 1
PSJPATIENT1,ONE Ward: 1 EAST
PID: 000-00-0001 Room-Bed: B-12 Ht(cm): ______ (________)
DOB: 08/18/20 (81) Wt(kg): ______ (________)
Sex: MALE Admitted: 05/03/00
Dx: TESTING Last transferred: ********

- - - - - - - - - - - - - - - - - A C T I V E - - - - - - - - - - - - - - - - -
1 in 0.9% SODIUM CHLORIDE 1000 ML 125 ml/hr C 03/07 03/07 E
2 in 5% DEXTROSE 50 ML 125 ml/hr C 03/06 03/06 E
3 CEPHAPRIN 1 GM C 03/04 03/09 A
in DEXTROSE 5% IN N. SALINE 100 ML QID
4 ASPIRIN CAP,ORAL O 03/07 03/07 E
Give: 650MG PO NOW
- - - - - - - - - - - - - - - - - P E N D I N G - - - - - - - - - - - - - - - - -
5 in DEXTROSE 10% 1000 ML 125 ml/hr ? ***** ***** P

Enter ?? for more actions
PI Patient Information SO Select Order
PU Patient Record Update NO New Order Entry
Select Action: Quit// 1

-----------------------------------------report continues--------------------------------
Example: Inpatient Profile

Select Unit Dose Medications Option: IPF Inpatient Profile

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

Select PATIENT: PSJPATIENT1,ONE 000-00-0001 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
Example: Inpatient Profile (continued)

Patient: PSJPATIENT1,ONE                       Status: NON-VERIFIED
Orderable Item: DOXEPIN CAP, ORAL
Instructions:  
Dosage Ordered: 100MG
Duration:                  Start: 09/20/00  09:00
Med Route: ORAL (PO)            Stop: 10/04/00  24:00
Schedule Type: NOT FOUND
Schedule: Q24H
(No Admin Times)       Provider: PSJPROVIDER,ONE [es]
Special Instructions: special for DOXEPIN

<table>
<thead>
<tr>
<th>Dispense Drugs</th>
<th>Units</th>
<th>U/D</th>
<th>Disp'd</th>
<th>Ret'd</th>
<th>Inactive</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOXEPIN 100MG U/D</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DOXEPIN 25MG U/D</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ORDER NOT VERIFIED
Self Med: NO
Entry By: PSJPROVIDER,ONE              Entry Date: 09/19/00  09:55

4.9. Order Checks

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.

Note: The check for remote data availability is performed when entering a patient’s chart, rather than on each order.

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. Order checks for IV orders will use the Dispense Drugs linked to each additive/solution in the order. All pending, non-verified, active and renewed Inpatient orders, active Outpatient orders and active Non-Veterans Affairs (VA) Meds documented in CPRS will be included in the check. In addition, with the release of OR*3*238, order checks will be available using data from the Health Data Repository Historical (HDR-Hx) and the Health Data Repository Interim Messaging Solution (HDR-IMS). This will contain both Outpatient orders from other VAMCs as well as from Department of Defense (DoD) facilities, if available. Any remote Outpatient order that has been expired for 30 days or less will be included in the list of medications to be checked.
There is a slight difference in the display of local Outpatient orders compared with remote Outpatient orders. Below are examples of the two displays:

Example: Local Outpatient Order Display

The patient has the following Outpatient order(s):

```
----------------------------------------
Rx #: 40074 PHENYTOIN 100MG (Extended) CAP
Status: Active Issued: 07/11/05
SIG: TAKE ONE CAPSULE BY MOUTH TWICE A DAY
QTY: 60 # of refills: 11
Provider: PSOPROVIDER,ONE Refills remaining: 11
Last filled on: 07/11/05
Days Supply: 30
----------------------------------------
```

Example: Remote Outpatient Order Display

```
----------------------------------------
DAYTON Rx #: 2663878 WARFARIN NA 10MG TAB
Status: ACTIVE Issued: 07/11/05
SIG: TAKE ONE-HALF TABLET BY MOUTH BEFORE BREAKFAST --TO
     THIN BLOOD--
QTY: 4 Refills remaining: 0
Provider: PSOPROVIDER, TWO Last filled on: 07/11/05
Days Supply: 1
----------------------------------------
```

In the Remote Outpatient Order Display example above, notice the name of the remote location has been added. In addition, the number of refills is not available.
If the order is entered by the Orderable Item only, these checks will be performed at the time the Dispense Drug(s) is specified. The checks performed include:

- **Duplicate Drug** - If the patient is already receiving orders containing the Dispense Drug selected for the new order, these duplicate orders are displayed. Inpatient duplicate orders of this kind are displayed in a numbered list. The user is first asked whether or not to continue the current order. If the user selects to continue the order then the user is prompted with which, if any, numbered Inpatient duplicate orders to discontinue. The user may enter a range of numbers from the numbered list of duplicate orders or bypass the prompt by selecting <Enter> and continue with the order. Entry of duplicate drug orders will be allowed. Only Additives are included in the duplicate drug check for IV orders. The solutions are excluded from this check.

- **Duplicate Class** - If the patient is already receiving orders containing a Dispense Drug in the same class as one of the Dispense Drugs in the new order, the orders containing the drug in that class are displayed. Inpatient duplicate orders of this kind are displayed in a numbered list. The user is first asked whether or not to continue the current order. If the user selects to continue the order then the user is prompted with which, if any, numbered Inpatient duplicate orders to discontinue. The user may enter a range of numbers from the numbered list of duplicate orders or bypass the prompt by selecting <Enter> and continue with the order. Entry of orders with duplicate drugs of 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.
4.9.1. Outpatient Duplicate Orders

Outpatient duplicate order check results display together on the first screen before all other order check information. These results are displayed for informational purposes only. The header for Outpatient duplicate orders reads as follows:

The patient has the following Outpatient order(s):

4.9.2. Inpatient Duplicate Orders

Duplicate drug and duplicate drug class Inpatient orders display together in a numbered sequence. The user selects from the numbered sequence the order(s) to be discontinued, if any. The header for Inpatient duplicate orders reads as follows:

This patient is already receiving the following INPATIENT order(s) for the same drug or in the same drug class as WARFARIN SOD. 50MG COMB. PACK.:

After the user has discontinued an order, if any duplicate Inpatient orders remain, they are displayed again in a numbered list. The following header is displayed:

Now, this patient is already receiving the following INPATIENT order(s) for the same drug or in the same drug class as WARFARIN SOD. 50MG COMB. PACK.:

This cycle repeats until there are no more duplicate Inpatient orders or until the user indicates there are no more duplicate Inpatient orders they wish to discontinue.
Example: Duplicate Order Entry Screen

Unit Dose Order Entry       Jun 27, 2006@16:08:46       Page:   1 of   1
PSJPATIENT,ONE            Ward: 7B                        A
PID: 666-666-1234          Room-Bed:                     Ht(cm): ______ (_______)
DOB: --/--/70 (35)          Wt(kg): ______ (_______)
Sex: MALE                  Admitted: 03/08/06
Dx: SICK                   Last transferred: ********
-------------------------------------------------------------------------------

Select DRUG: warf
Lookup: DRUG GENERIC NAME
1   WARFARIN 2MG TABS           BL110
2   WARFARIN SOD. 50MG COMB.PACK.           BL110
3   WARFARIN SODIUM 5MG S.T.           BL110
CHOOSE 1-3: 2  WARFARIN SOD. 50MG COMB.PACK.         BL110

The patient has the following Outpatient order(s):
-------------------------------------------------------------------------------
Rx #: 300410         ASPIRIN BUFFERED 325MG TAB
Status: Active                          Issued: 06/08/06
SIG: TAKE TWO TABLETS BY BY MOUTH AFTER MEALS TAKE THESE
      AFTER YOU GET HOME
QTY: 100                       # of refills: 0
Provider: PSOPROVIDER,ONE    Refills remaining: 0
Last filled on: 06/08/06       Days Supply: 90
-------------------------------------------------------------------------------

This patient is receiving the following medication that has an interaction
with WARFARIN SOD. 50MG COMB.PACK.:

                        ASPIRIN TAB,EC                           C  06/19  07/03  A
                        Give: 324MG PO Q4H

This patient is already receiving the following INPATIENT order(s) for the same
drug or in the same drug class as WARFARIN SOD. 50MG COMB.PACK.:

1.      WARFARIN TAB                             C  06/27  07/03  A
        Give: 2MG PO Q6H                           PSJProvider, One

2.      WARFARIN TAB                             C  06/27  07/03  A
        Give: 2MG PO Q2H                           PSJProvider, Two

Do you wish to continue with the current order? YES// yes  YES
Do you wish to DISCONTINUE any of the listed orders? NO// Y
Choose for DISCONTINUE 1-2: 1

NATURE OF ORDER: (TBD)// <cr>
REQUESTING PROVIDER:  PSJProvider, One              P10

------------------screen continues on next page------------------
Now, this patient is already receiving the following INPATIENT order(s) for the same drug or drug class as WARFARIN SOD. 50MG COMB.PACK.:

1. WARFARIN TAB C 06/27 07/03 A
   Give: 2MG PO Q2H PSJProvider, Two

Do you wish to DISCONTINUE any of the listed orders? NO// <cr> NO

There is a CRITICAL interaction, you must enter an intervention log to continue
Do you wish to log an intervention? NO// yes YES

Now creating Pharmacy Intervention

PROVIDER: PSJPROVIDER,ONE BIRMINGHAM ALABAMA RR SYSTEMS ANALYST
RECOMMENDATION: no change

4.9.3. Discontinuing Duplicate Inpatient Orders

When duplicate Inpatient orders are found, the following prompt is presented after each display or redisplay of a numbered list:

Do you wish to DISCONTINUE any of the listed orders? NO//

Note: If the user selects the default of NO, the order process continues.

If the user enters YES to the DISCONTINUE prompt, the following prompt is presented to allow selecting orders:

Choose for DISCONTINUE 1-N:

Note: N represents the highest numbered duplicate order in the numbered list.

Exiting the Order Process

When duplicate Inpatient orders have been found, the following prompt is displayed after the first numbered list of duplicate Inpatient orders:

Do you wish to continue with the current order? YES//

Note: The wording of this existing prompt has been slightly modified. Also, the current default of NO has been changed to YES.

Each time a user chooses to discontinue an Inpatient duplicate order(s), a prompt is presented to enter a value for NATURE OF ORDER. This value applies to all of those orders just selected to be discontinued.

Also, each time a user chooses to discontinue an Inpatient duplicate order(s), a prompt is presented to enter a value for Requesting PROVIDER. This value applies to all of those orders just selected to be discontinued.