NHS
Kent and Medway
Cancer Collaborative

Aria User Guide

Nurses

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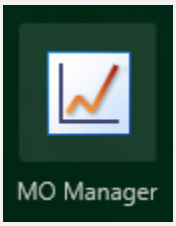
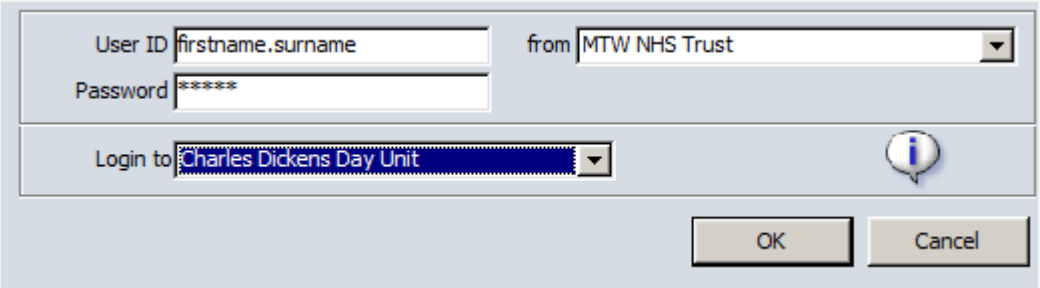
SECTION 1:
LOGGING IN TO MANAGER AND OPENING PATIENT RECORDS

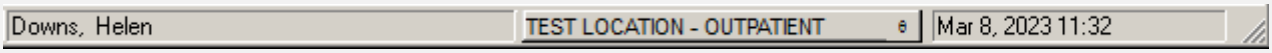
Enter your user name and password. These are usually, but not always, the same as your windows details.

Select MO Manager



Enter your username as **User ID**. This is usually **firstname.surname** format. **From** should <u>always</u> be MTW NHS Trust. **Log into** should be the area where the patient will be treated and should always be at ward/department level. Your password must be between 6 and 10 characters long, start with a capital letter and be mixed case. It should contain at least 2 numbers, no special characters and be unique from the previous 5 passwords.





Your name should be displayed. If it isn't click on the name displayed and select **Switch Users**. **<u>DO NOT USE</u>** Lock Application.

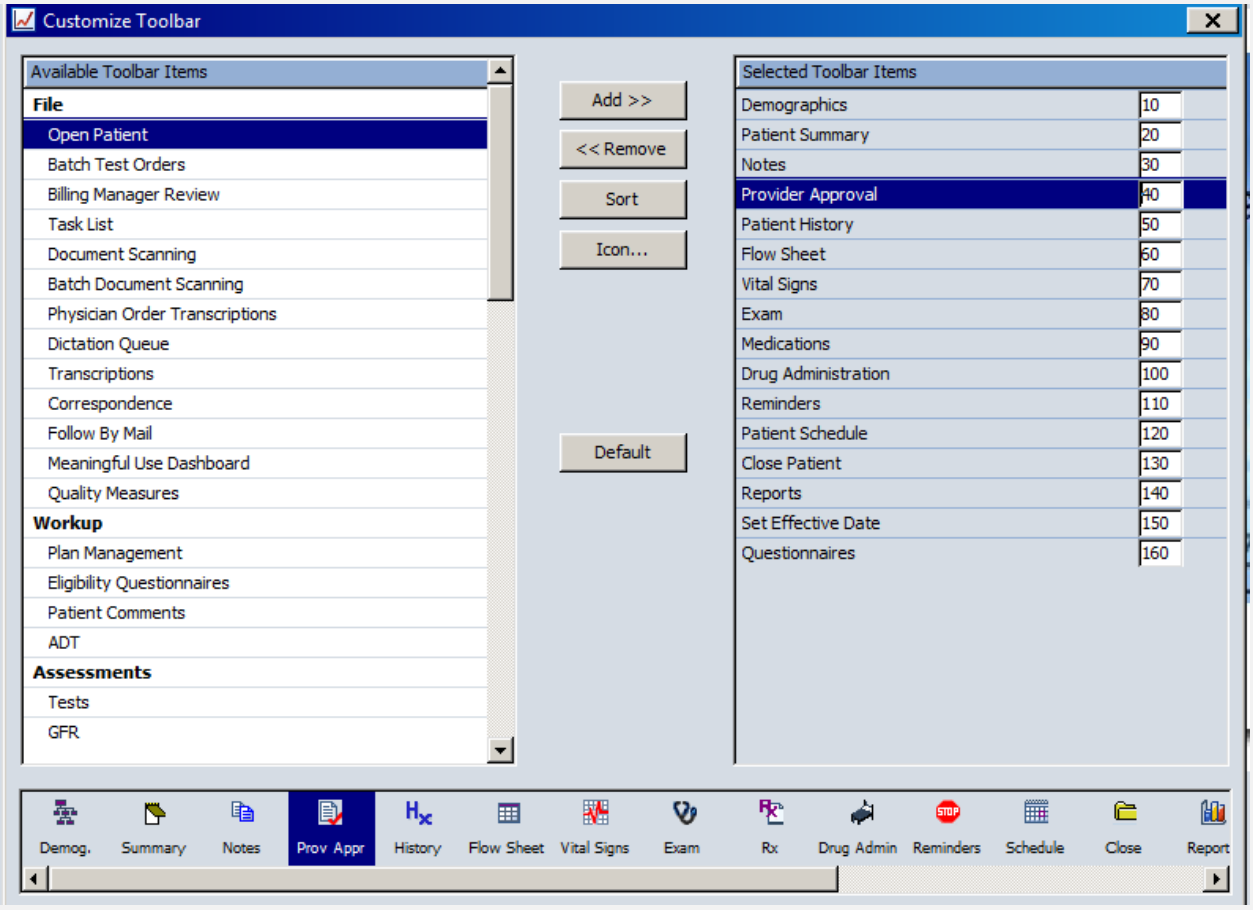
Ensure you are working in the correct area. This should show the department where the patient will be treated. Click on the location displayed to change.

Use **File** and **Exit** to close programme. **<u>DO NOT</u>** use **X** as this will close the window but will not log you off.

CUSTOMISE TOOLBAR

System Admin → Security → Customise Toolbar

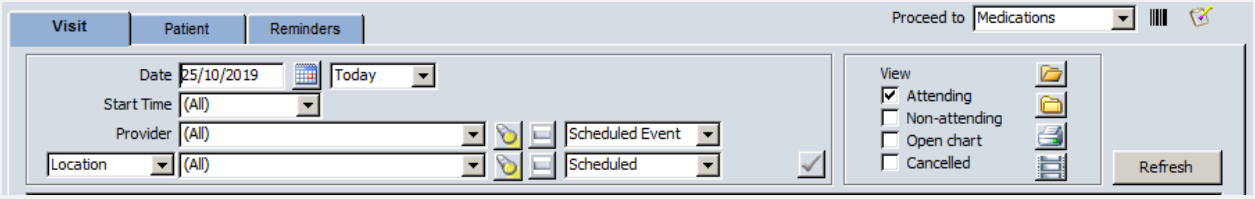
Select an item from the menu on the left by clicking on it once then select '**Add**' to add to your toolbar. Select an item on the right then select '**Remove**' to remove it from your toolbar. Click on an item on the right then select '**Icon**' to change the picture of that icon. Change the numbers to change the sequence in which the icons will appear on your toolbar, item 10 will be on the far left, item 20 second from left and so on. Select **Sort** to put in numerical order once re-numbered.



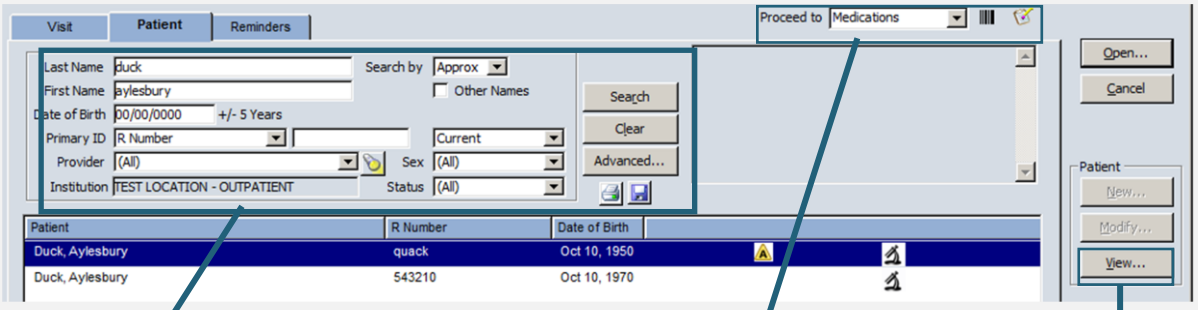
The items listed as 10 – 160 above, show from left to right in the order defined by their numbers

OPEN PATIENT – VISIT TAB

Ensure only the **Attending** box is ticked to view a list of patient appointments that match the selected criteria for the location currently logged into.



OPEN PATIENT – PATIENT TAB



To search for a patient enter at least the first 2 letters of their first and last names or select their primary ID type from the drop down list and enter in the box to the right then click **Search.** To select patient from list, highlight line by clicking once then select **Open** or double click on line.

Select an option from the **Proceed to** menu and whenever you open a patient record it will go directly to the area selected.

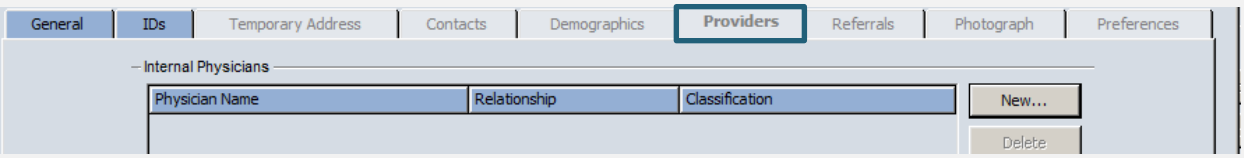
Selecting displays the last 20 patients you have viewed in the department selected

Select **View** to view patient demographics. This information is fed through from KOMS so if amendments are required they should be performed in KOMS which will then update the ARIA record too

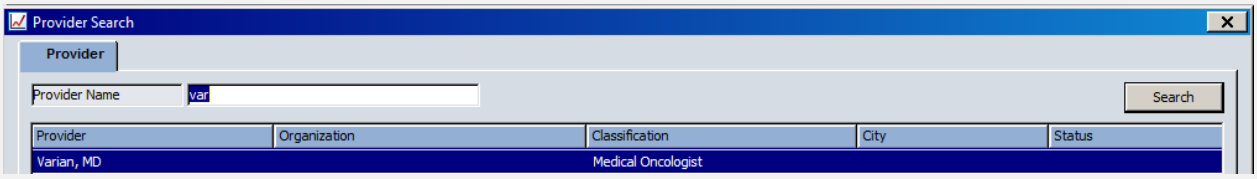
PATIENT DETAILS

Open Patient Window → View Patient

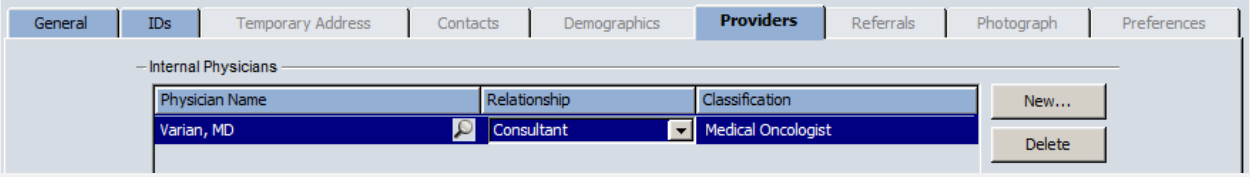
All information in the demographics tabs is imported from KOMS however the patient's Provider (Consultant) will need to be added manually. To add the Provider, select the **Providers** tab.



Select **Modify** then **New**. Type the surname of the required consultant then select **Search**. Highlight the relevant consultant then select **OK**



From the **Relationship** menu, always select **Consultant**. Select **OK** to complete



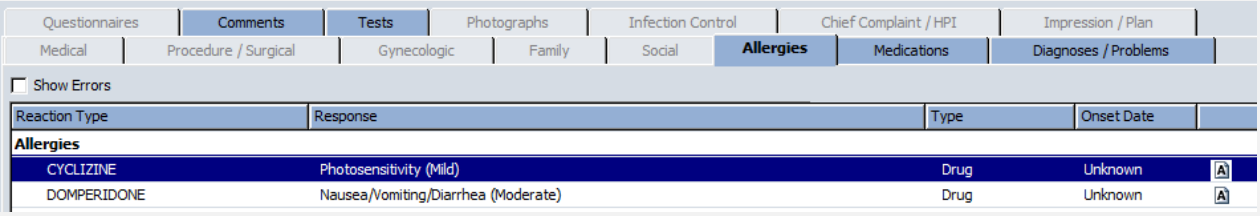
Once added, the nominated consultant will remain in the patient record

SECTION 2:
PATIENT HISTORY

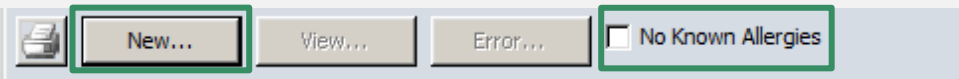
DRUG ALLERGIES
Patient History → Allergies Tab

Allergies already entered are displayed here. Highlight and click **View** to see details.
Icon is added to EMR for allergy information:

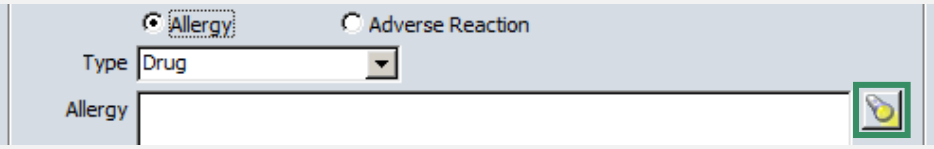
= Allergy status not completed = NKDA = Documented allergy



Check '**No Known Allergies**' if appropriate or select **New…** to add



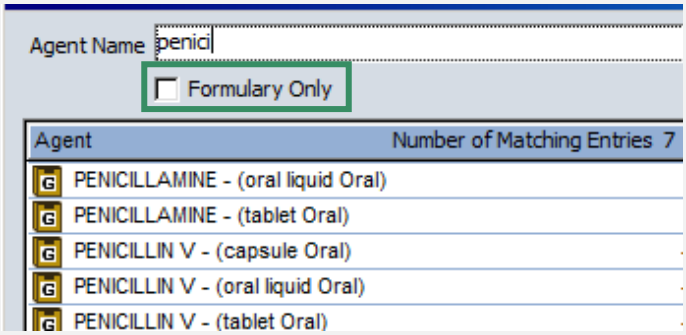
Always select **Drug** from **Type** drop down menu and not drug class. For drug allergies click to search



DO NOT FREE-TYPE DRUG NAMES as these won't then be linked to inputted information. Always select from list.

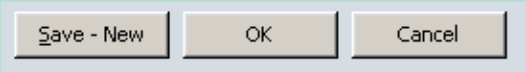
Ensure the **Formulary Only** box is unchecked then type the first few letters of the drug; this will then display a list of matching agents.

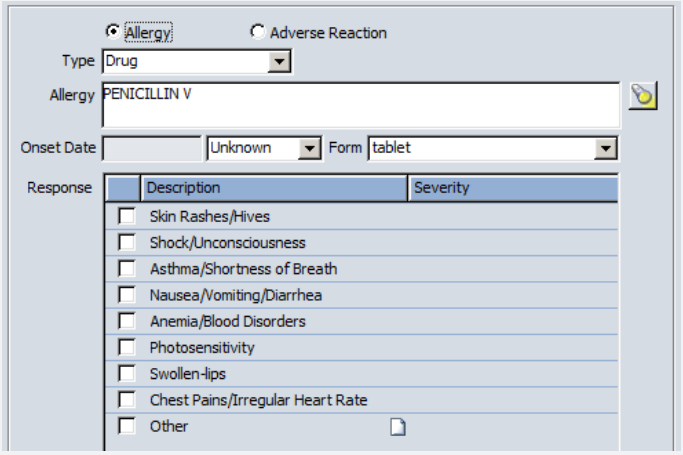
Highlight the drug you require from the list then select **OK** to add



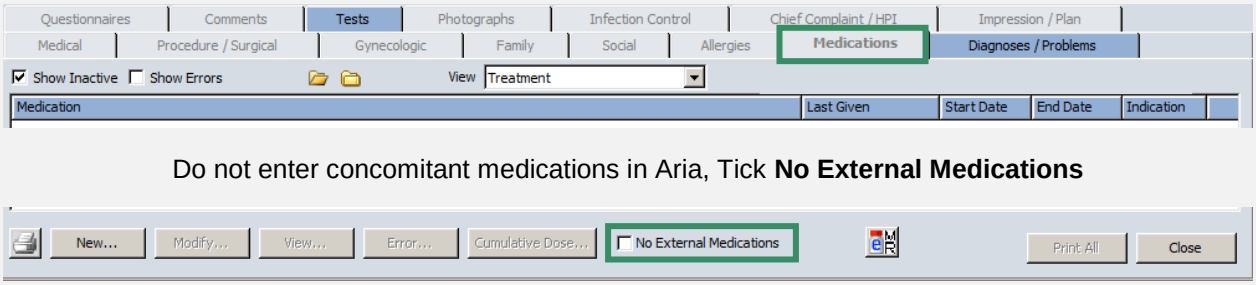
Tick the box(es) beside the correct reaction description then select the severity from the drop-down menu

Select **Save-New** to complete current entry then add another or select **OK** to complete task





OTHER MEDICATIONS
Patient History → Medications Tab

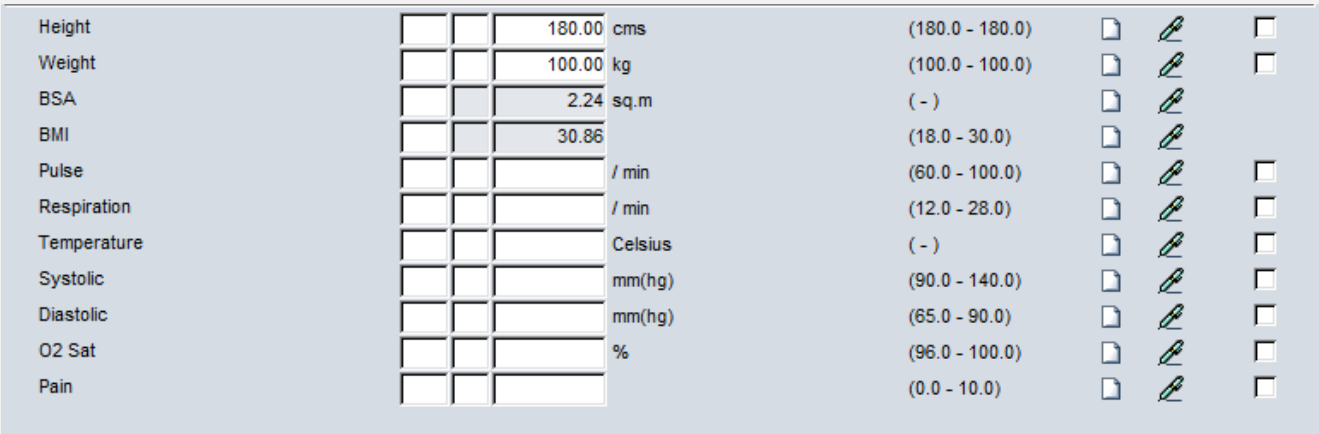


Do not enter concomitant medications in Aria, Tick **No External Medications**

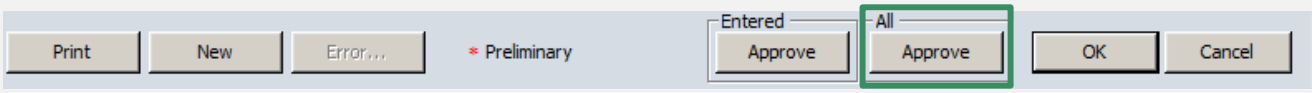
SECTION 3:
PATIENT VITAL SIGNS

ENTER VITAL SIGNS
Vital Signs → New

Enter Vital signs in the right hand box next to the unit of measure. Once height and weight are entered, the system will calculate BSA & BMI. Range parameters are provided for reference



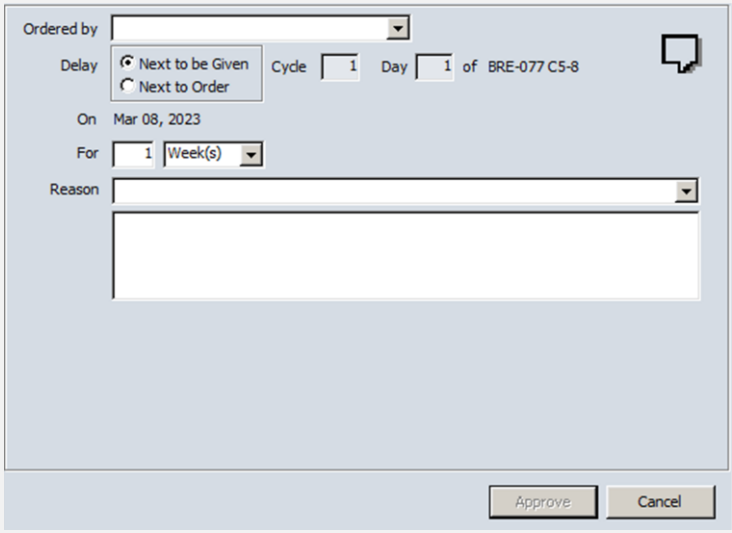
Select **All Approve** to complete



SECTION 4:
DELAY REGIMEN

DELAY REGIMEN

Medications → Treatment Tab → Green Pen → Delay



Treatment can be delayed from 2 points:

Next to be Given – Next ordered prescription that has not been administered

Next to Order – Next unordered prescription

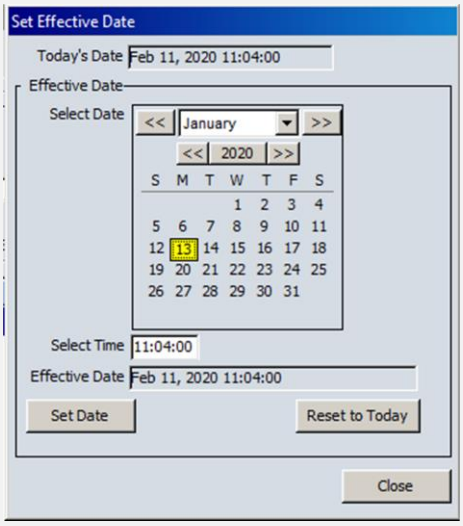
Enter duration of delay in number of days or weeks then select Approve to complete. To bring treatment forward, prefix number of days/weeks delay with a minus.

Pending orders cannot be delayed therefore Next to be Given and Next to Order may not be consecutive. To delay a pending order it should be approved first then delayed.

If the date of treatment has elapsed then the delay will need to be performed by a user with access to set the effective date (see below)

DELAY A PRESCRIPTION FROM AN ELAPSED DATE

Open Patient Window → Security → Set Effective Date



Click on the prescription date from the calendar then select **Set Date** then **Close**. The date and time at the bottom of the window will now appear in red to indicate the date change to the system

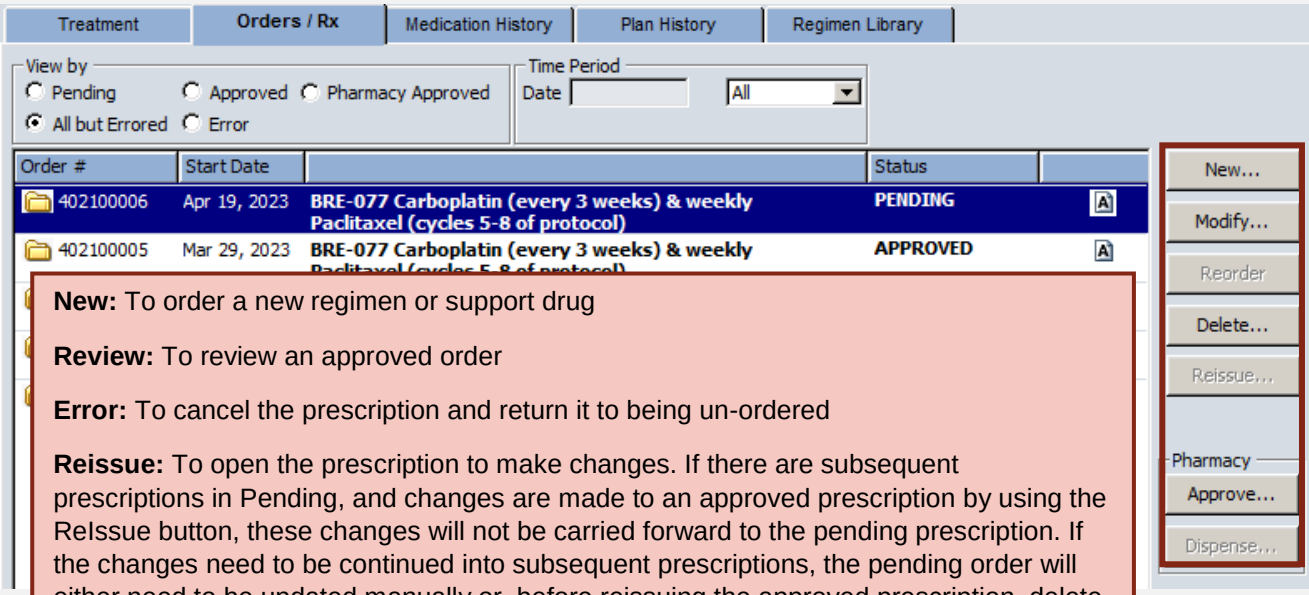
Jan 13, 2020 11:05 (past)

Perform the prescription delay as usual. When leaving the patient record, a pop-up will ask to reset effective date. Always select **Yes** to return the system to today's date.

SECTION 5:
REVIEW PRESCRIPTION

REVIEW PRESCRIPTION
Medications → Orders/Rx tab

Prescription statuses:
Approved: Approved by Doctor, **Pending**: Awaiting Doctor's approval,
Dispensed: Dispensed by pharmacy



New: To order a new regimen or support drug

Review: To review an approved order

Error: To cancel the prescription and return it to being un-ordered

Reissue: To open the prescription to make changes. If there are subsequent prescriptions in Pending, and changes are made to an approved prescription by using the ReIssue button, these changes will not be carried forward to the pending prescription. If the changes need to be continued into subsequent prescriptions, the pending order will either need to be updated manually or, before reissuing the approved prescription, delete the pending prescription then re-order once changes have been applied to the prescription being changed. If the button is greyed out and you would usually have access to this button, then pharmacy have locked the prescription as they have begun processing it. Contact pharmacy before proceeding

Approve: To pharmacy approve the order. Continued below

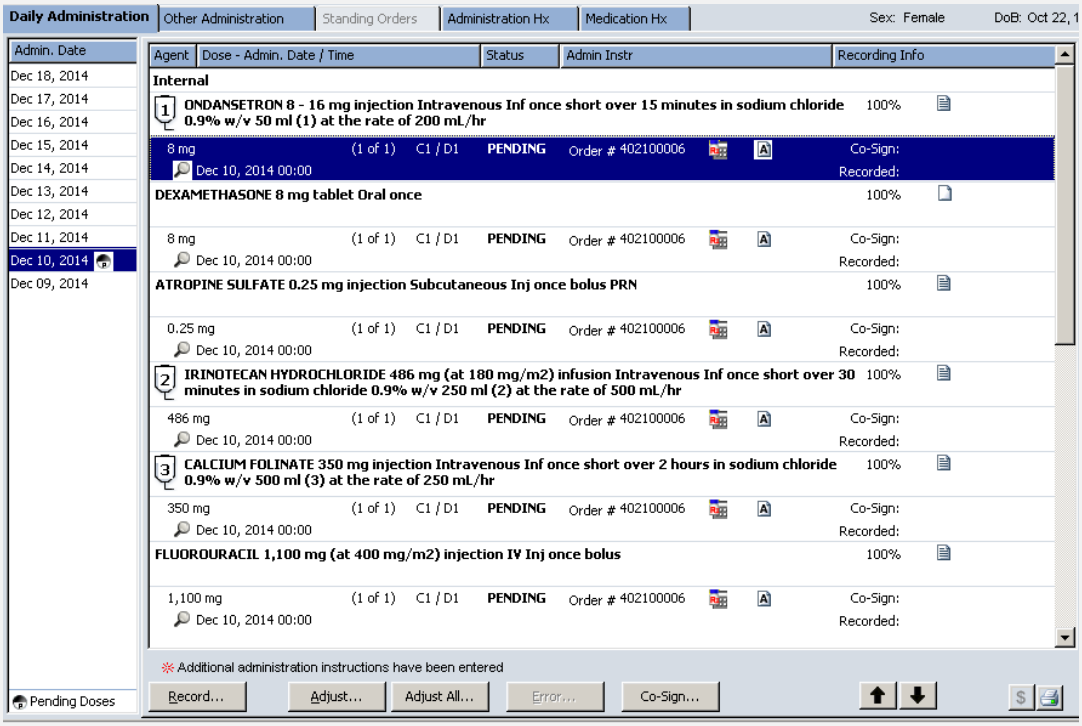
Dispense*:* Button only enabled if order is pharmacy approved

The prescription has been approved as indicated by
Select **Dispense** to proceed with releasing process. Dispense...

SECTION 6:
DRUG ADMINISTRATION

DRUG ADMINISTRATION – DRUGS MARKED INTERNAL
Drug Administration ➔ Daily Administration Tab

The **Daily Administration** tab shows all drugs that should be administered within the ward/department and are therefore defined as 'Internal'' on the prescription. They are listed in administration order. Ensure the correct administration date is selected from the left. All entries for the selected day should be completed, including NB notes, by either recording them as having been administered or by marking them as not given. This will result in an empty screen for the selected day.



Record: Click once on drug to highlight then click to record drug administration details

Adjust: Adjusts the administration date of the selected drug

Adjust All: Adjusts the administration date of all drugs due

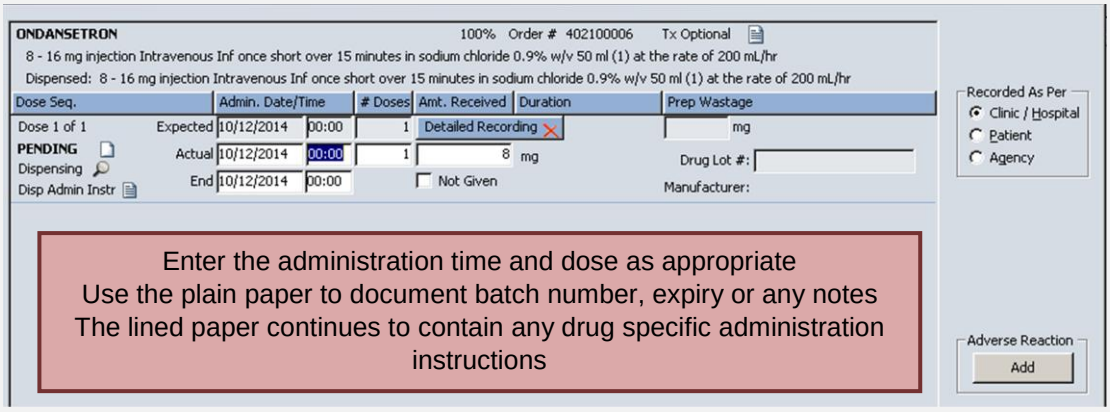
Co-Sign: Click to record co-sign of drug. Co-signee will then need to enter username and password. Hold shift and click on each drug to be co-signed to acknowledge co-sign for numerous drugs

Lined paper contains administration instructions, click to view

R in a yellow triangle indicates a previous reaction to the prescribed drug, Click to view

DOSE RECORDING
Drug Administration → Daily Administration Tab → Record

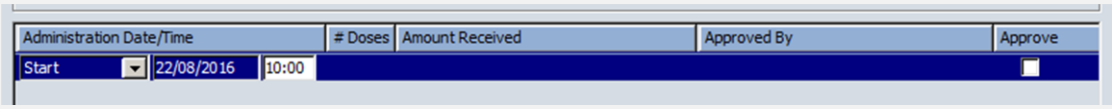
The top line displays what the prescriber ordered and the bottom line, what the pharmacy supplied. In most cases these will match but sometimes pharmacy may have made a change and they will differ e.g. change of diluent.



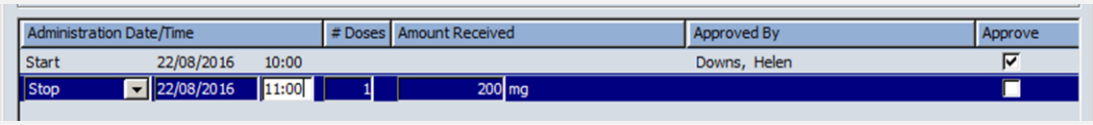
Detailed Recording

For infusions, select **Detailed Recording** to enable start and stop time details to be recorded

Enter a start time then select **Approve All** then **OK** to record but still leave item '**Active**' to allow a stop time to be entered



2nd nurse should follow the same process for entering a stop time then select **Approve All** then **Approve** at the admin screen to complete. This will then record at which stage each nurse was involved

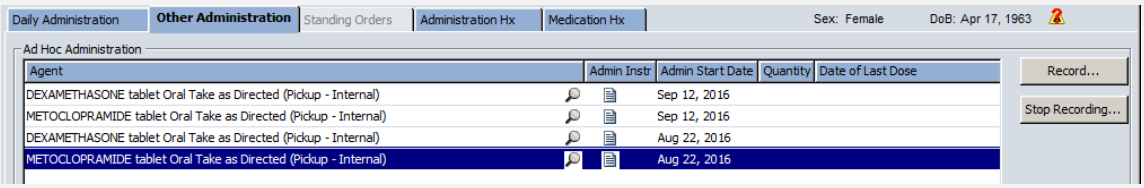


DRUG ADMINISTRATION – DRUGS MARKED PICK-UP INTERNAL

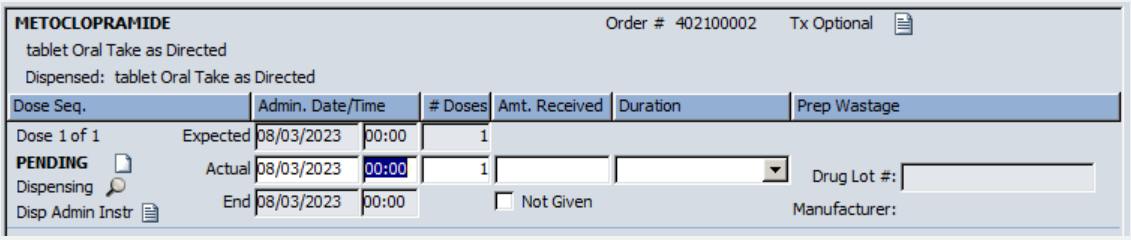
Drug Administration → Other Administration Tab

DO NOT COMPLETE OTHER ADMINISTRATION UNTIL COMPLETION OF DAILY ADMINISTRATION. Once recordings have been made against drugs on the 'Other administration' tab, the prescription cannot be amended e.g. to delay prescription following treatment failure or make dose adjustments

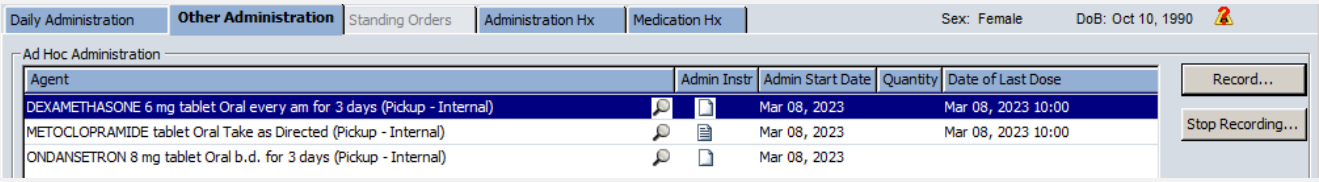
The **Other administration** tab shows all drugs to be given to the patient to take home. Should a subsequent day or cycle be ordered this will be listed at the top of the screen. Care should be taken to ensure the correct date is selected for each drug. To document issue of drug to the patient, highlight the line then select ***Record…***



Record in the same way as for items on the **Daily Administration** tab



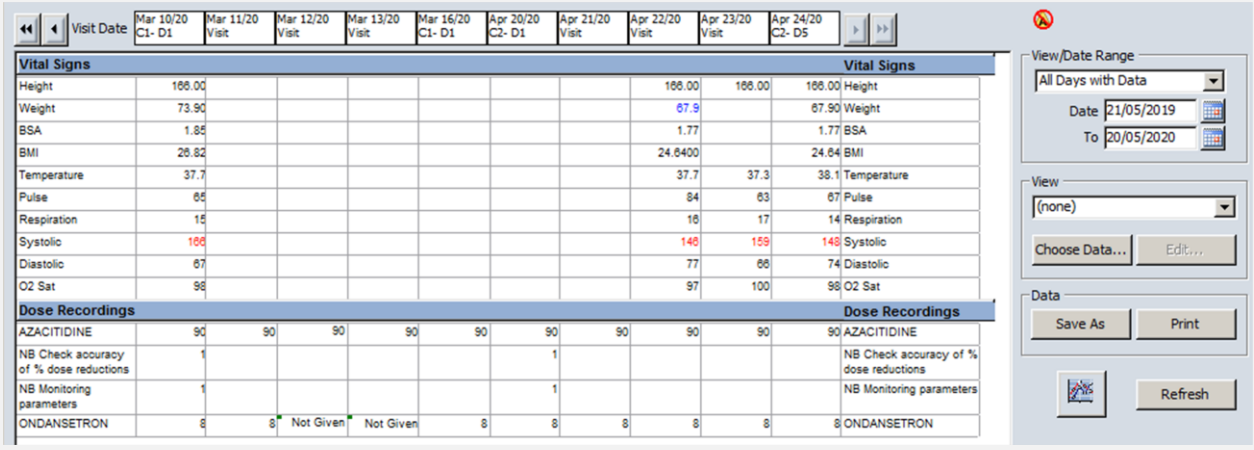
Once an item had been recorded, it must be removed from the screen to ensure no further dose recordings are made against it. Highlight the relevant item then select **Stop Recording**. On the following screen select **Yes**.



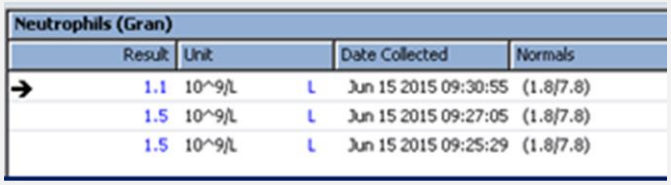
SECTION 7:
FLOW SHEET

Flow Sheet will display Vital Signs, Blood results (selected Trusts only) and Drug administrations, with the data dated at the top of the column with the cycle and day number if appropriate

When checking prescription doses, the flow sheet should be used to view values available at the time of prescribing



Select **Choose Data** to customize what is displayed on the flow sheet. Entries with multiple same day results will be indicated by the green square and the most recent entry of the day will appear on the main view of the flow sheet and on any graphs produced. Right click on the relevant result and select **View Details** to view all results for that entry for that day.



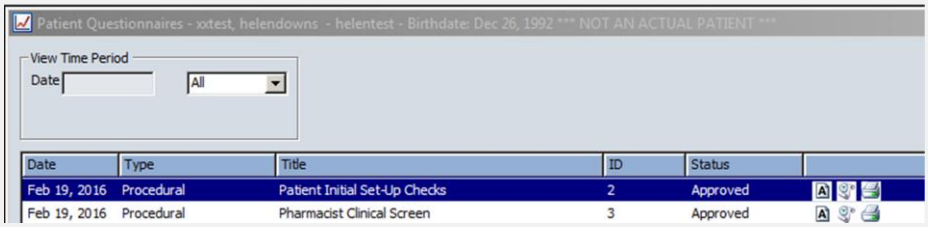
SECTION 8:
ARIA DOCUMENTATION

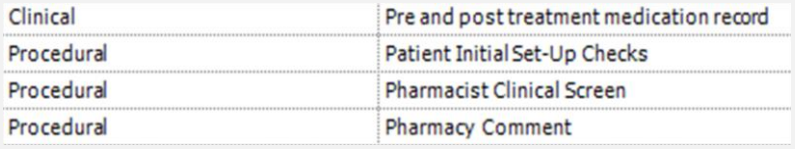
QUESTIONNAIRES
Assessments → Questionnaires

Questionnaires are patient specific so can only be opened from within the patient record. The window will open with '**Today**' selected in the drop down menu. Select '**All**' to view all questionnaires completed for the patient

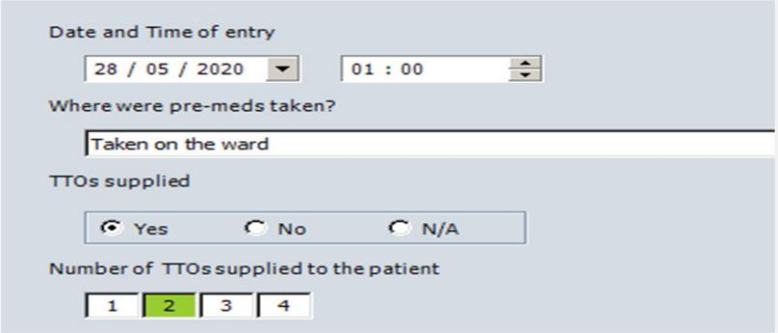
Highlight the required questionnaire then select **View** to open or **Error** to delete it. To start a new questionnaire, select **New**, select a questionnaire from the list then **OK** to open.

To view errored questionnaires, check the '**Show errors'** box



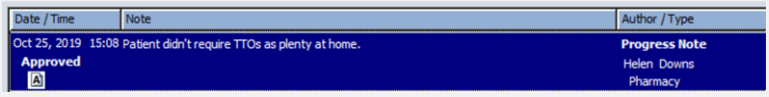


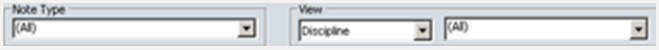
Complete the questionnaire as appropriate then select **Approve** to complete or **OK** to save part-completed details to return to later.



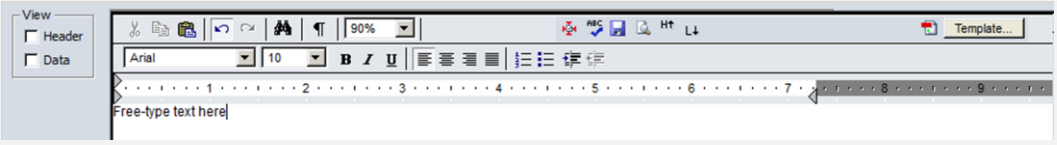
NOTES

Existing notes are listed in date order. Highlight note and select **View** to open. Select **Error** to delete. To view errored Notes, check the '**Show errors'** box.





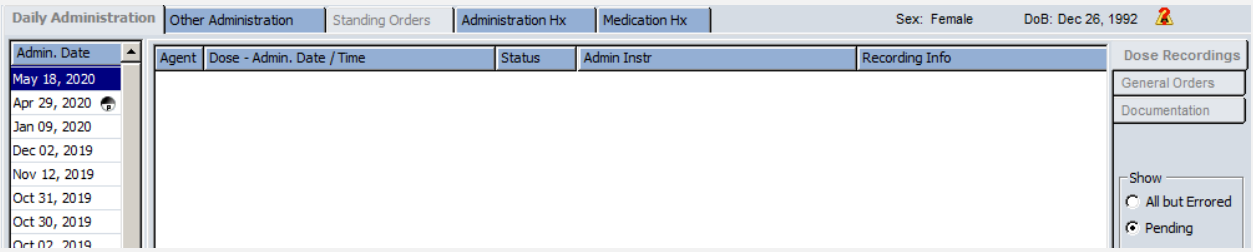
Use the filters at the bottom of the screen to show by note type and author type



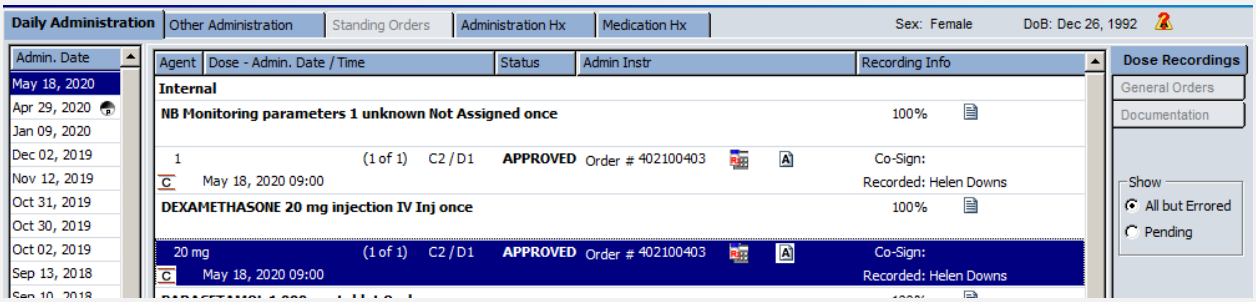
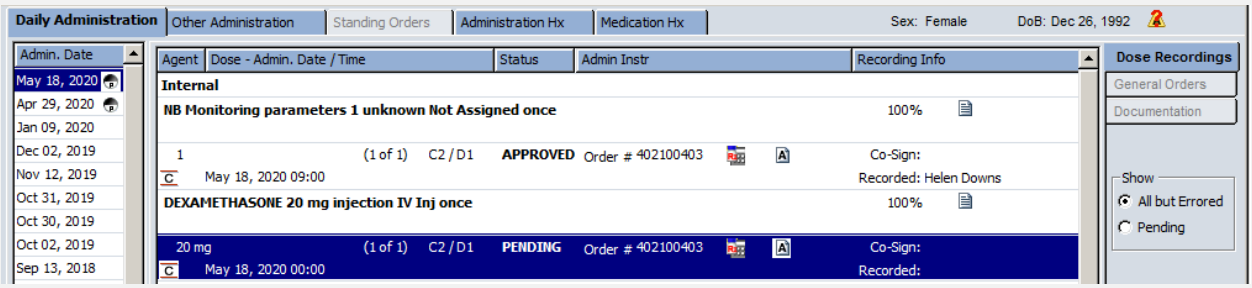
SECTION 9:
REVERSE FUNCTIONS

DRUG ADMINISTRATION – DOSE RECORDING – ERROR

On the Daily administration tab, drugs whose dose recordings have been completed will not be listed and if all the internal drugs have been administered, the whole panel will be empty. To recall the drugs, check the '**All but errored'** radio button on the right.



Click once on the bottom administration line of the drug you required, then select '**Error'** then '**Yes'** to the pop-up window.



Enter a reason for erroring the dose recording when prompted and **OK** to complete. The dose recording entry will now return to a **Pending** state