NHS
Kent and Medway
Cancer Collaborative

Aria User Guide

Pharmacists

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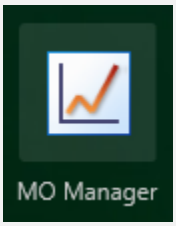
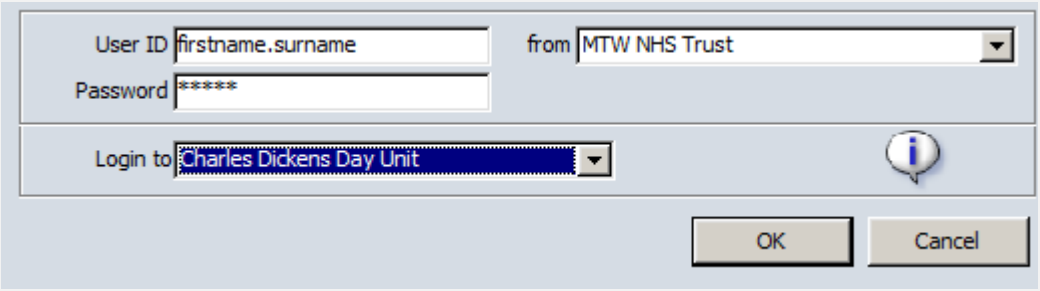
SECTION 1:
LOGGING IN TO MANAGER AND OPENING PATIENT RECORDS

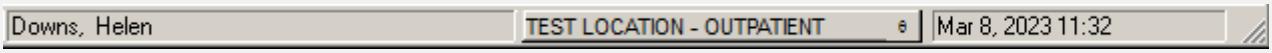
Enter your user name and password. These are usually, but not always, the same as your windows details.

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.

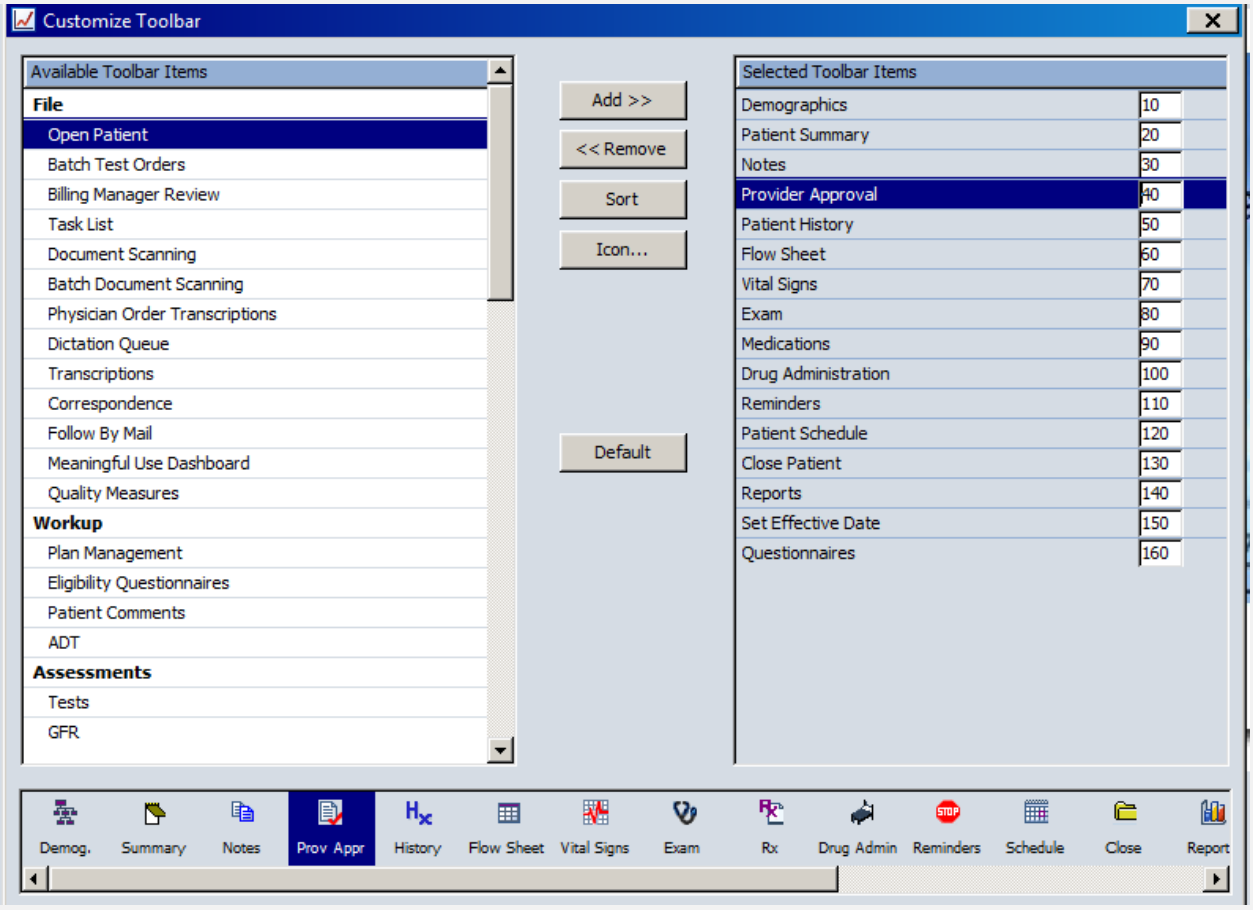
Ensure you are working in the correct area. This should show the department where the patient will be treated. Click on the location displayed to change.

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

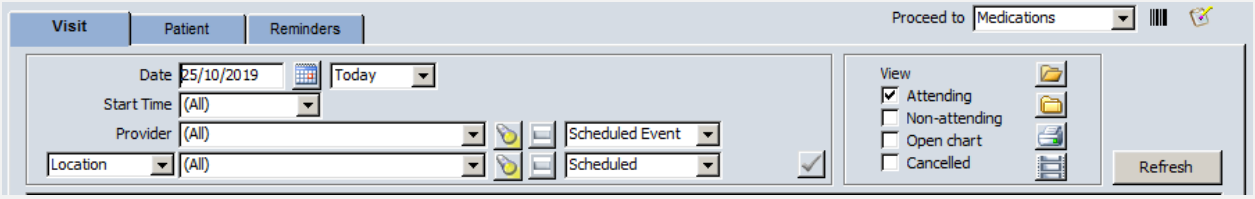
Select an item from the menu on the left by clicking on it once then select '**Add**' to add to your toolbar. Select an item on the right then select '**Remove**' to remove it from your toolbar. Click on an item on the right then select '**Icon**' to change the picture of that icon. Change the numbers 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.



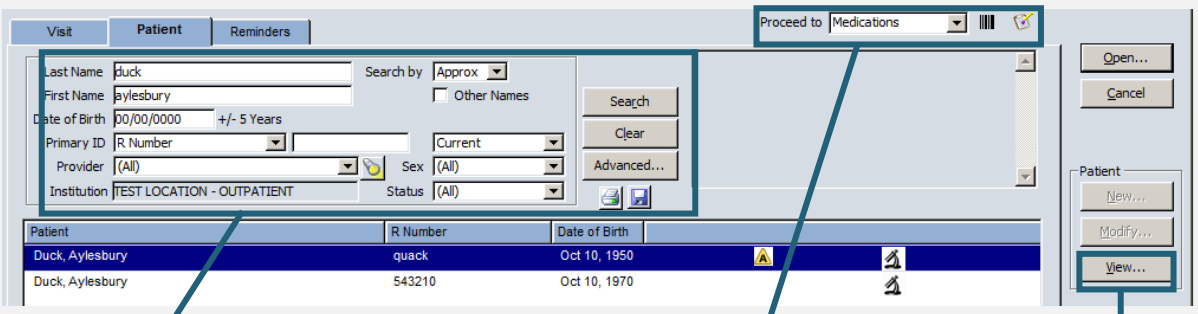
The items listed as 10 – 160 above, show from left to right in the order defined by their numbers

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.

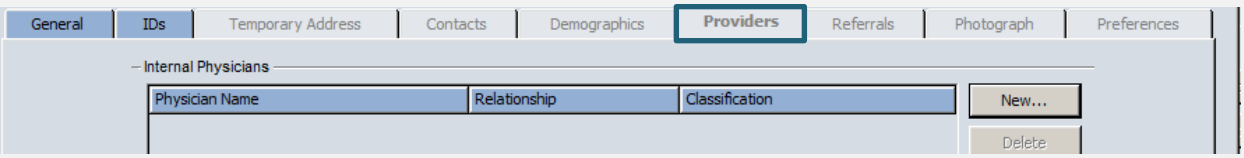
Selecting displays the last 20 patients you have viewed in the department selected

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

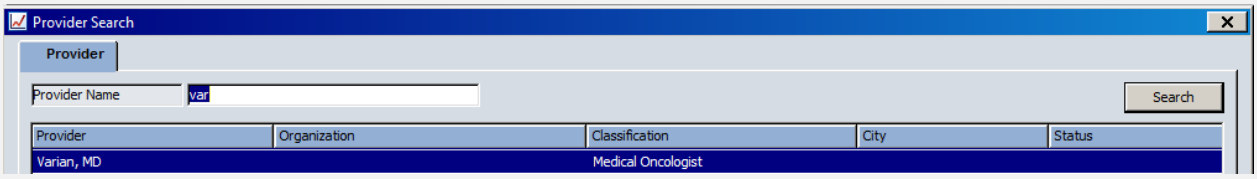
PATIENT DETAILS

Open Patient Window → View Patient

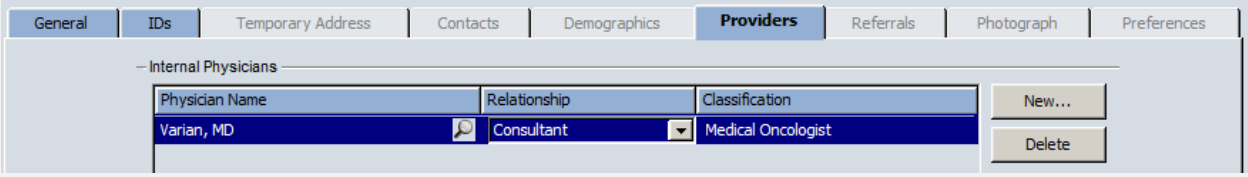
All information in the demographics tabs is imported from KOMS however the patient's Provider (Consultant) will need to be added manually. To add the Provider, select the **Providers** tab.



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



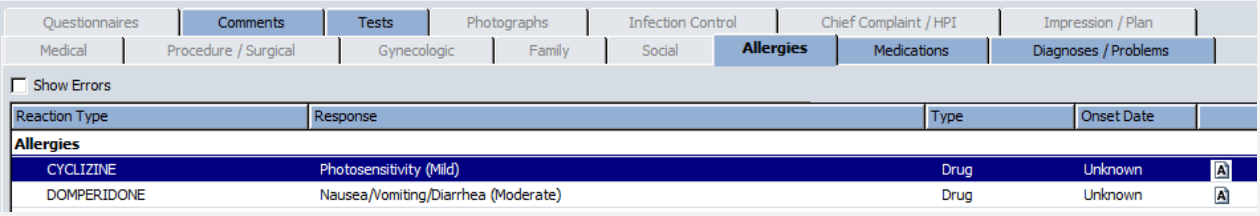
Once added, the nominated consultant will remain in the patient record

SECTION 2:
PATIENT HISTORY

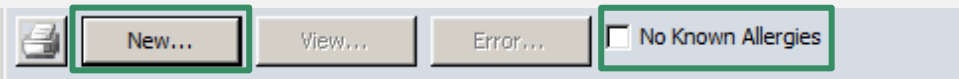
DRUG ALLERGIES
Patient History → Allergies Tab

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

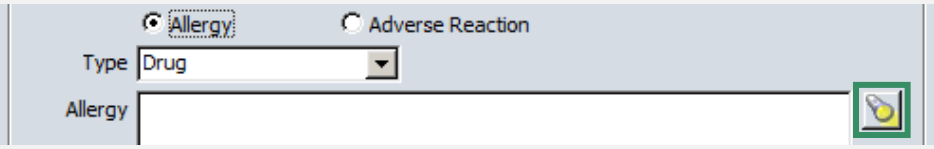
= Allergy status not completed = NKDA = Documented allergy



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



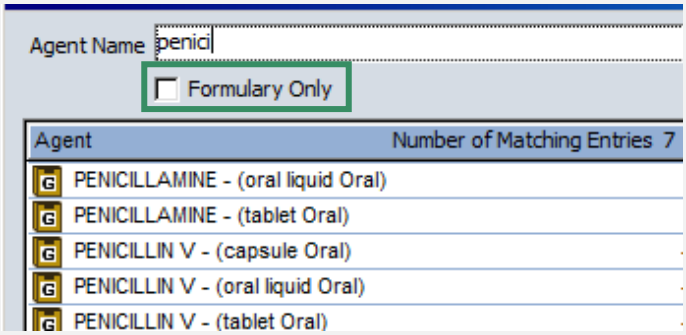
Always select **Drug** from **Type** drop down menu and not drug class. For drug allergies click to search



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

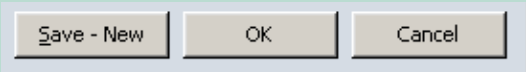
Ensure the **Formulary Only** box is unchecked then type the first few letters of the drug; this will then display a list of matching agents.

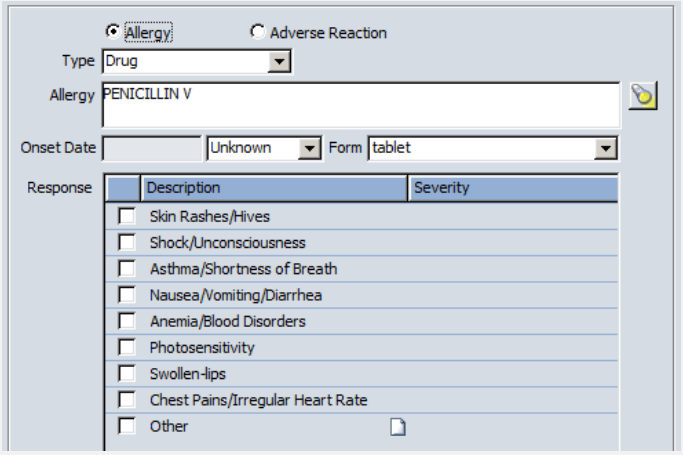
Highlight the drug you require from the list then select **OK** to add



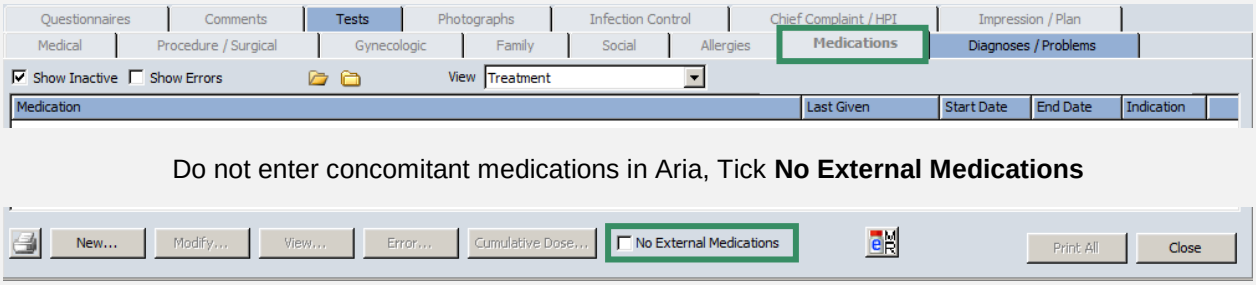
Tick the box(es) beside the correct reaction description then select the severity from the drop-down menu

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





OTHER MEDICATIONS
Patient History → Medications Tab

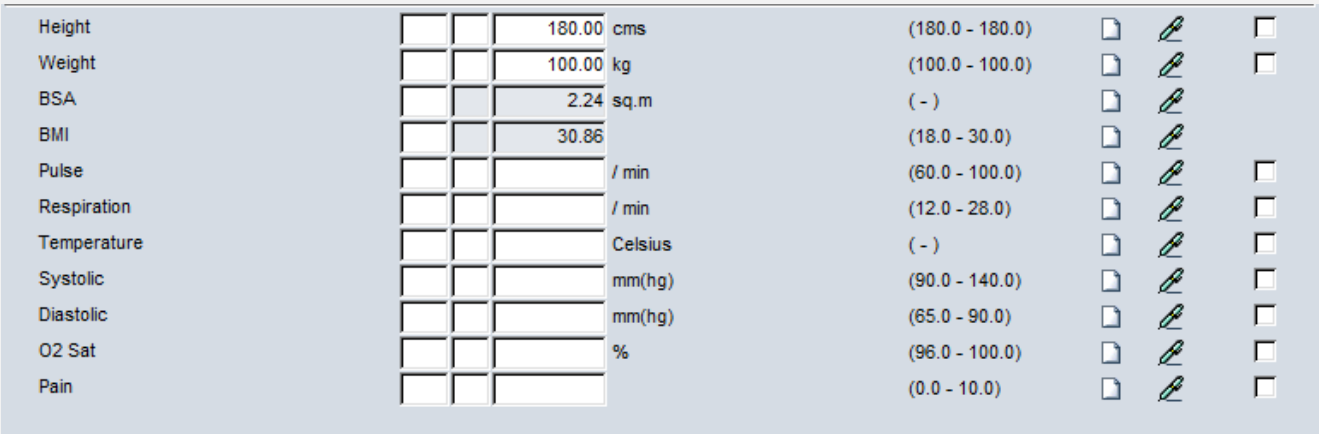


Do not enter concomitant medications in Aria, Tick **No External Medications**

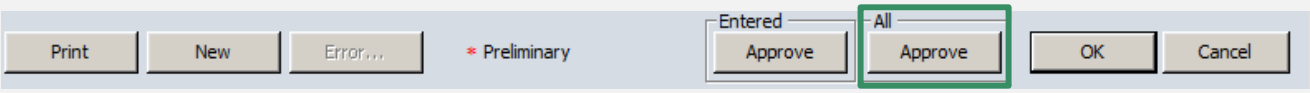
SECTION 3:
PATIENT VITAL SIGNS

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

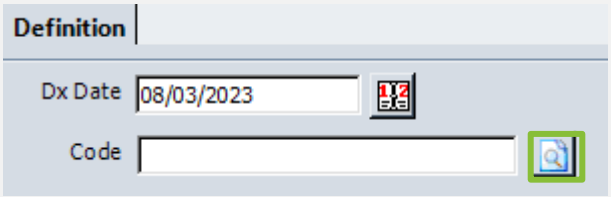


SECTION 4:
ENTER PATIENT DIAGNOSIS

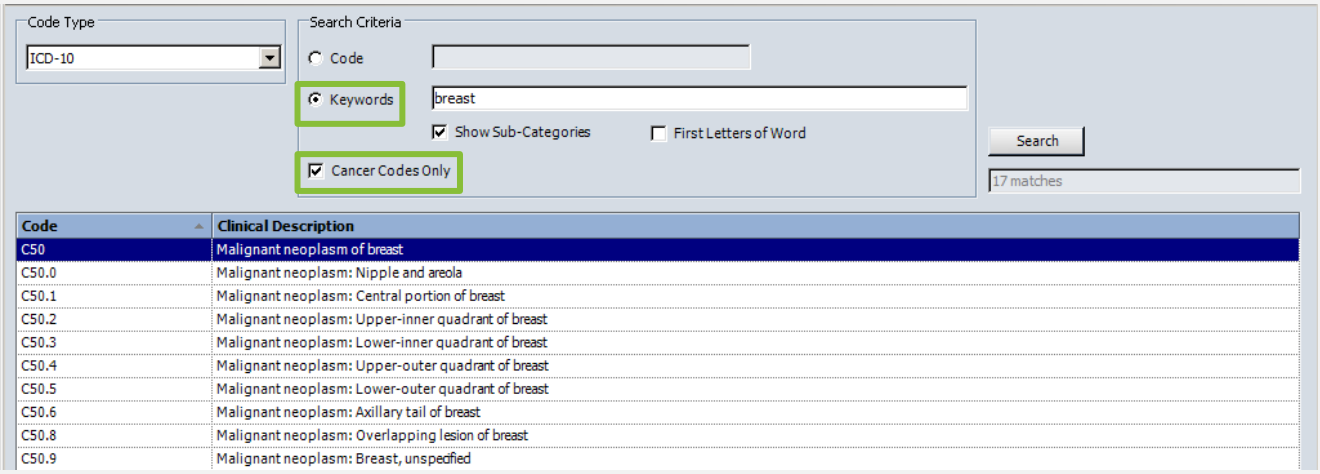
ENTER DIAGNOSIS
Exam ➔ Diagnosis / Problems Tab

Select **New** to enter a diagnosis

Click on the magnifying glass to enter diagnosis

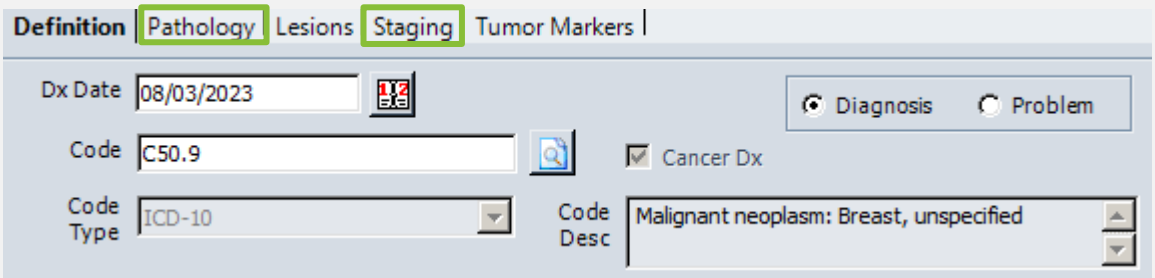


Check the **Keywords** and **Cancer Codes Only** boxes then enter the first few letters of the diagnosis. All matching codes will populate the list below.

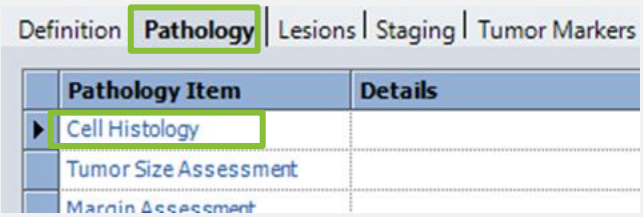


Select the appropriate clinical description from the list then **OK** to complete

Once a diagnosis has been selected, further tabs appear. **Pathology** and **Staging** must be completed.

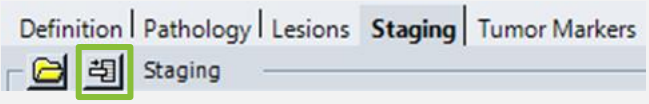


Select the **Pathology** tab then click on the words **Cell Histology**



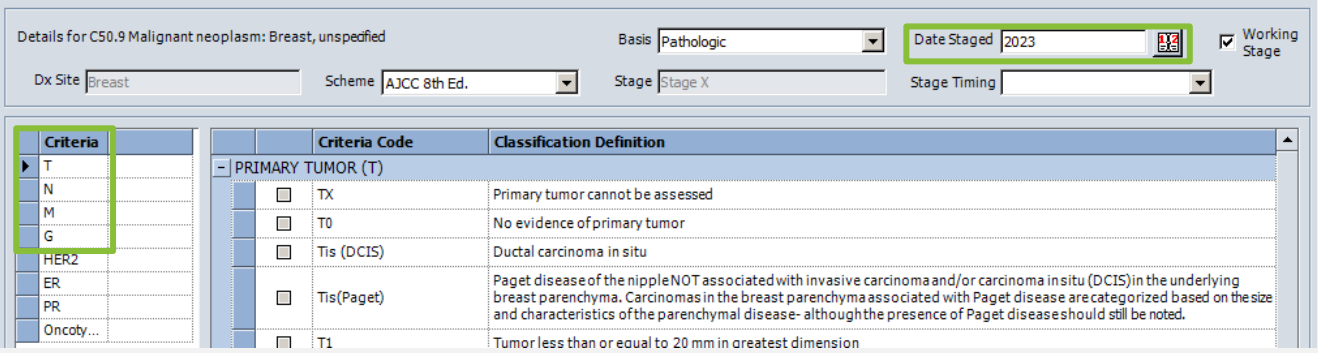
Complete the top three drop down menus then select **OK** to complete

Select the **Staging** tab then click on the white symbol to the left of the word Staging

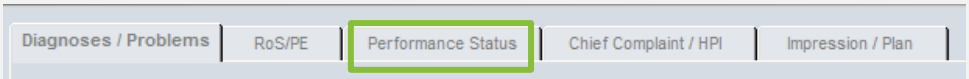


Click on the letter **T** to open up list of tumour classifications then check box for appropriate code. Follow this procedure for **N**, **M** and **G** classifications as appropriate. Other grading schemes are displayed as appropriate for the diagnosis but the process for adding the staging is the same. Add the date of the staging via the calendar.

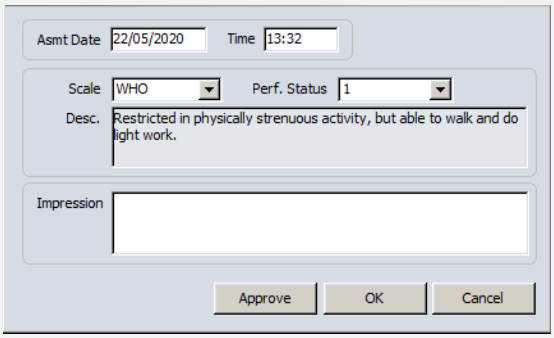
Select **Approve** to complete



Click on the **Performance Status** tab



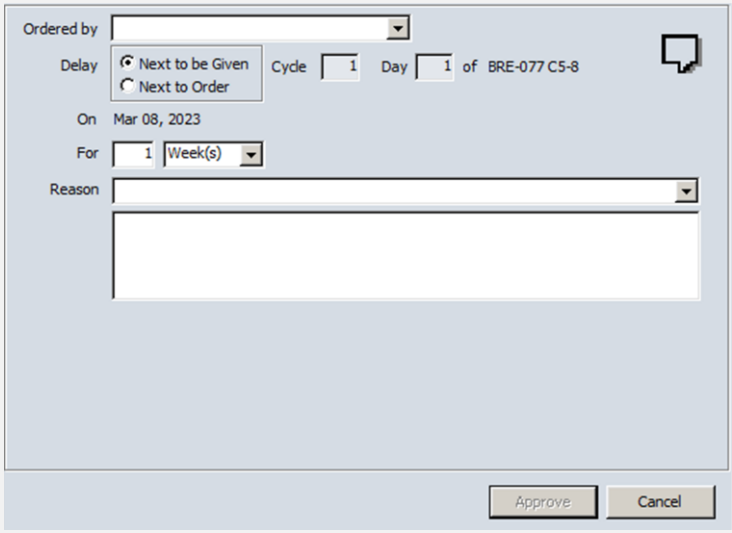
Select **Assess** then select the appropriate WHO performance status from the drop down menu. Select **Approve** to complete



SECTION 5:
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

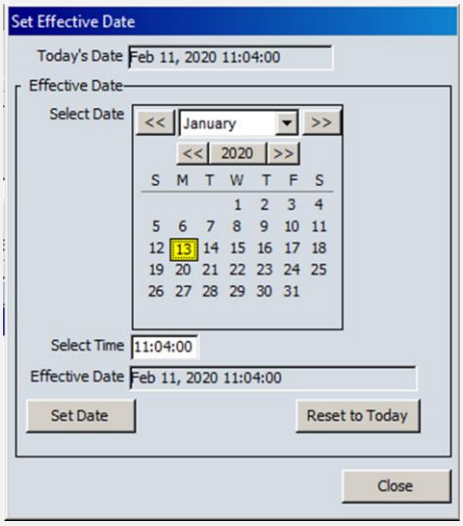
Enter duration of delay in number of days or weeks then select Approve to complete. To bring treatment forward, prefix number of days/weeks delay with a minus

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

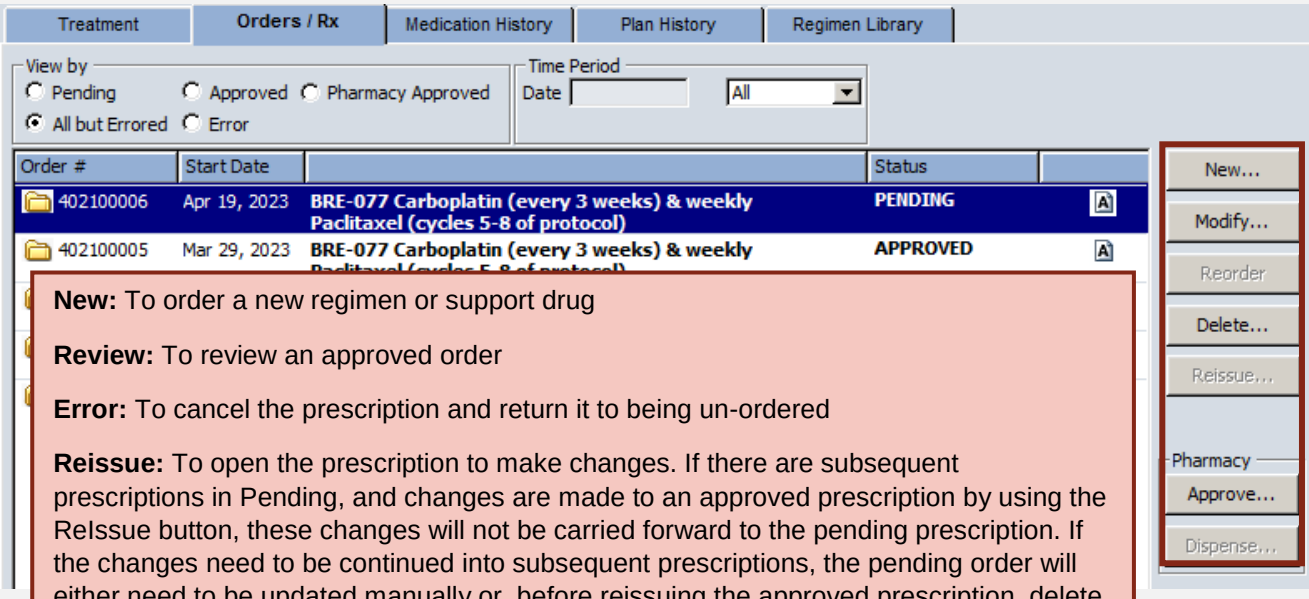
Jan 13, 2020 11:05 (past)

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 6:
PHARMACY APPROVE AND DISPENSE 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

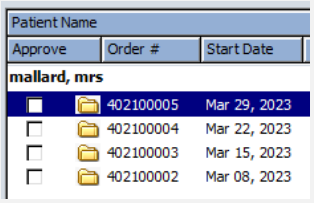
Review: To review an approved order

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



Click on the folder to expand it and view detail of prescription. When happy to proceed, check box by relevant date line and click **Checked Approve**

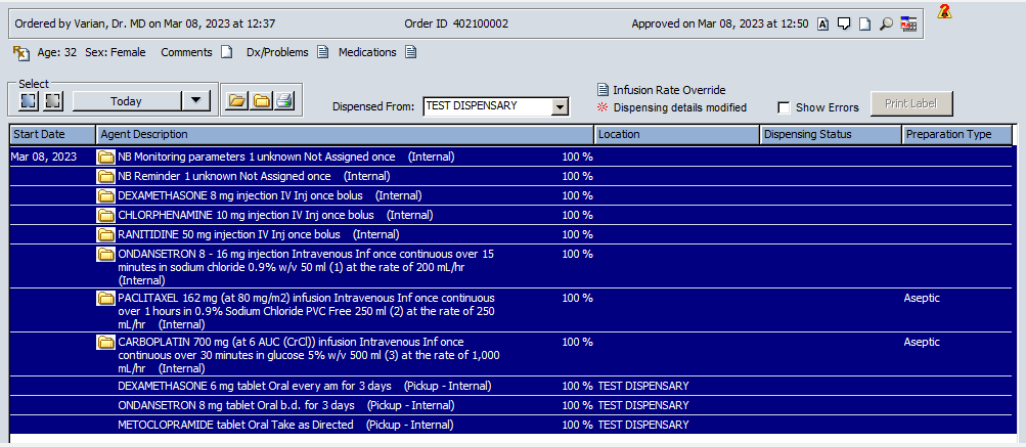
The prescription has been approved as indicated by

Select **Dispense** to proceed with releasing process. Dispense...

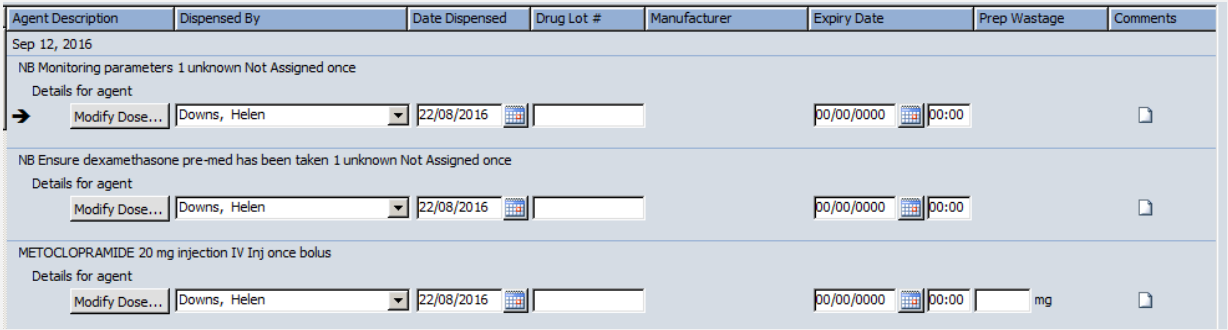
DISPENSE PRESCRIPTION

Medications → Orders/Rx tab → Dispense

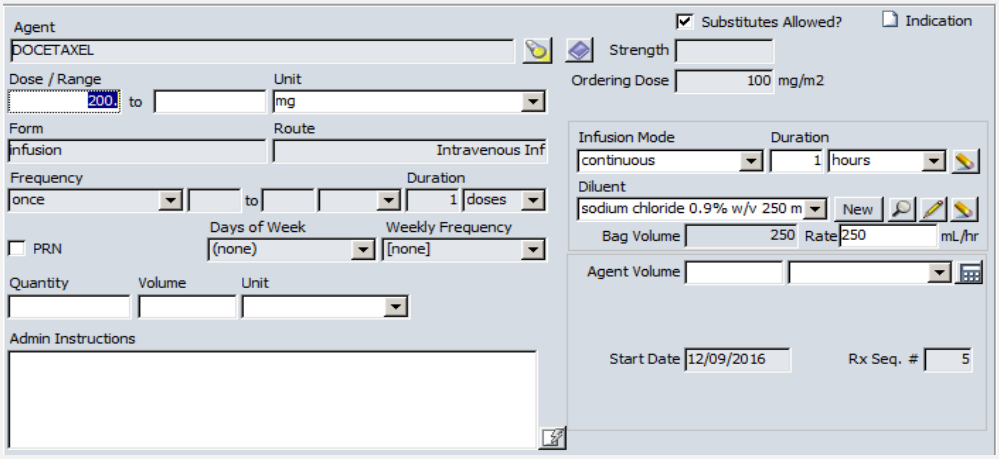
To dispense the order, click to select each item individually or use the blue and grey boxes to select or unselect all



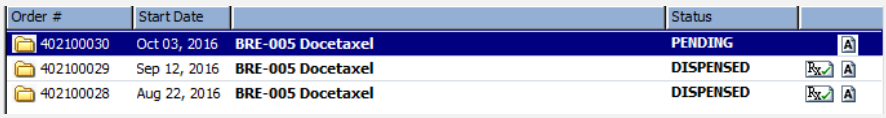
Select **Approve** to complete as prescribed or **Modify Dose** against the drug you wish to amend



Modify the drug as necessary.
Any changes made will not change the prescription or carry forward into subsequent cycles but will show as a change and will show on the drug admin windows, see main user guide for details.



The order now shows as **DISPENSED** by pharmacy



MEDICATION HISTORY
Medications → Medication History Tab

The medication history tab lists the medications prescribed and administered listed under **active chemotherapy** and **active non-chemotherapy** which will show drugs prescribed oin the current regimen. Inactive agents shows previously prescribed but now discontinued drugs

Medication	Last Given	Start Date	End Date	Indication
Active Chemotherapy Agents				
BORTEZOMIB (injection)		Dec 12, 2016		
Daratumumab (injection)		Apr 29, 2020		
DARATUMUMAB (infusion)		Apr 29, 2020		
Active Non-Chemotherapy Agents				
ACICLOVIR (tablet)		Jul 18, 2016		
ALLOPURINOL (tablet)		Jul 18, 2016		
CHLORPHENAMINE (injection)	Oct 02, 2019 14:00	Sep 14, 2016		
CO-TRIMOXAZOLE (trimethoprim and sulfamethoxazole) (tablet)		Jul 18, 2016		
DEXAMETHASONE (injection)		Apr 29, 2020		
DEXAMETHASONE (tablet)	Sep 14, 2016 09:00	Jan 12, 2016		

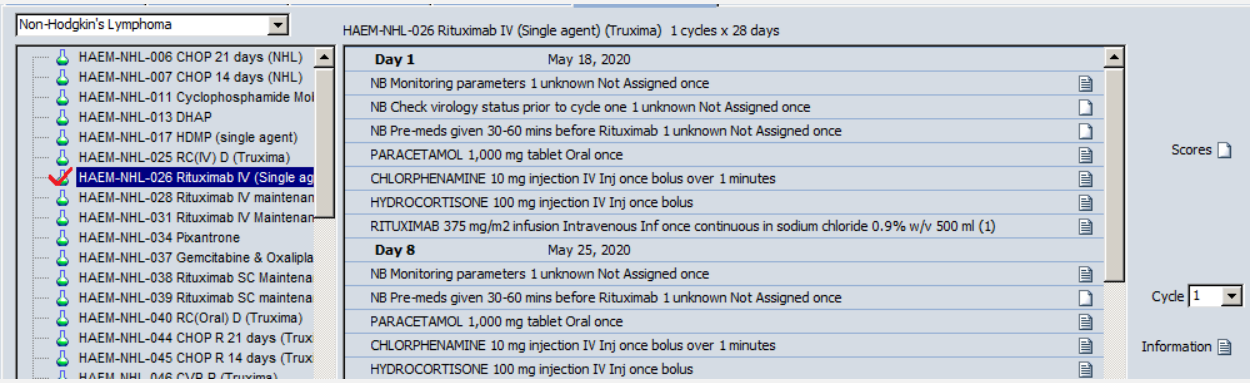
PLAN HISTORY
Medications → Plan History Tab

The **Plan History** tab lists current and previously prescribed regimens and shows their start date and end date (if appropriate). Click on the blue **Hx** symbol to view decision history e.g. reason for regimen discontinuation

Plan / Version	Start Date	End Date	Diagnosis
SUPP-008CV Daratumumab SC for substitution into M\	Apr 28, 2020	May 4, 2020	
Hx **Tx Intent:** 27646			
Tx Use: 27641			**Last Amendment Accepted:** v1.0
Line of Tx: 14			
HAEM-MYEL-037 Daratumumab, bortezomib (sc) & de:	Apr 28, 2020	May 4, 2020	Malignant neoplasm of ovary - C56
Hx **Tx Intent:** 27646			
Tx Use: 27641			
Line of Tx: 14			

REGIMEN LIBRARY
Medications → Regimen Library Tab

Prior to completing the first cycle of a regimen, the **Start Treatment** tab can be used to view available approved regimens, listed within their tumour site folders. Once a regimen cycle has been approved, the Start Treatment tab became the **Treatment** tab with details of the prescribed regimen only and the **Regimen Library** tab becomes available to view all regimens. Select the tumour site folder from the drop down menu then click once on the regimen to view. Regimen details appear in the middle window and the cycle can be changed using the drop down cycle menu.

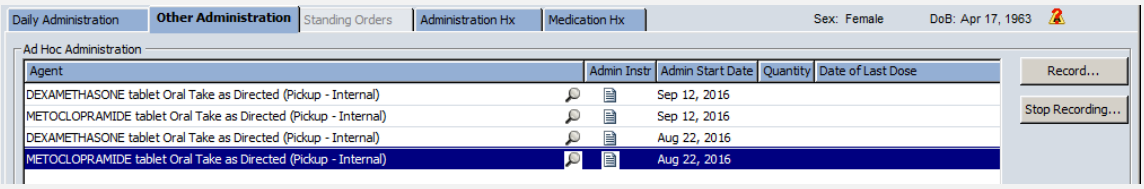


SECTION 7:
DRUG ADMINISTRATION

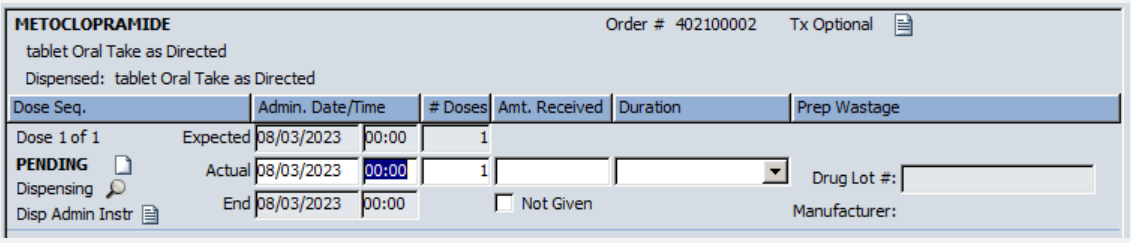
DRUG ADMINISTRATION – DRUGS MARKED PICK-UP INTERNAL
Drug Administration → Other Administration Tab

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

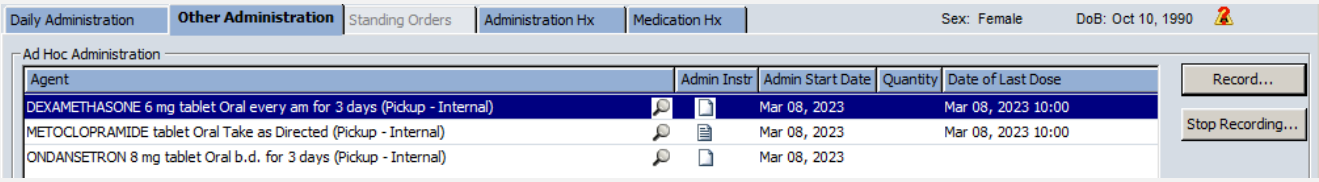
The **Other administration** tab shows all drugs to be given to the patient to take home. Should a subsequent day or cycle be ordered this will be listed at the top of the screen. Care should be taken to ensure the correct date is selected for each drug. To document issue of drug to the patient, highlight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

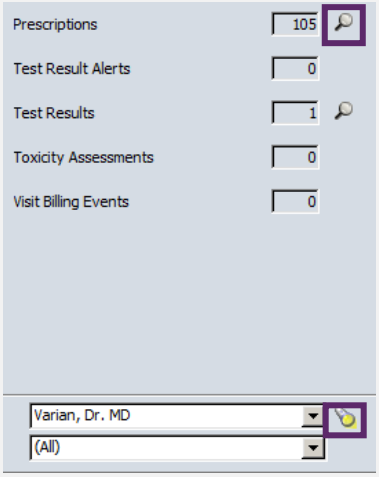


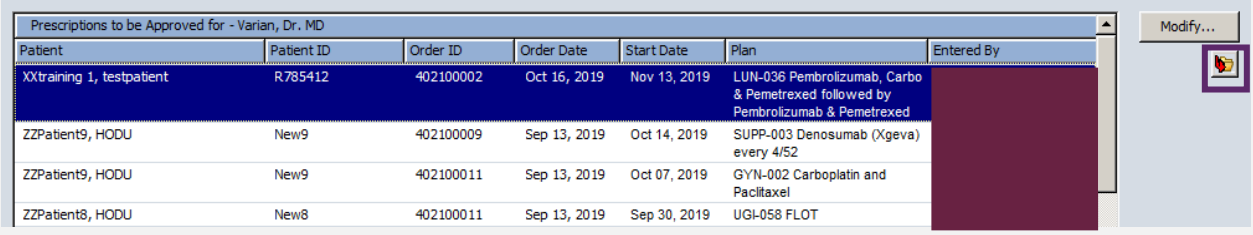
SECTION 8:
PRESCRIBER WORK-LIST

Provider Approval → Prescriptions

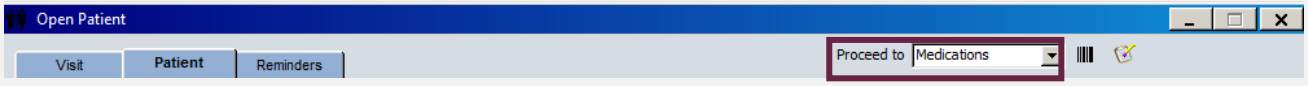
The **Provider Approval List** shows all prescriptions left Pending by prescriber. All prescribers can view and action any other prescriber's list. Registrars should leave prescriptions pending under the consultant name, not their own.

Select the name of the prescriber whose list you wish to view by clicking on the torch or by picking from the top drop-down menu then select (All) from the bottom drop-down menu. Once the list has refreshed with your selection, click on the magnifying glass next to the Prescriptions total to view the current list.

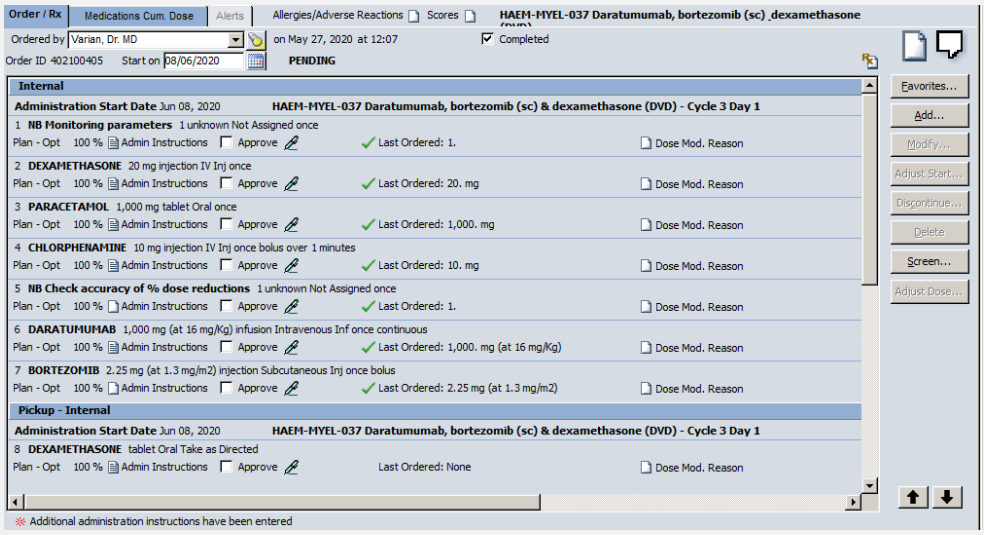




The list can be sorted by clicking on the column titles. This will sort them by Patient surname (A-Z or Z-A) or Start date (prescription start date). Select the prescription required by clicking once then select the folder icon to open the patient record. By selecting **Medications** in the **Proceed to** menu on the **Open Patient** window, whenever patient records are opened from the Provider Approval menu, it will open to the Medications window.



Selecting the Modify button will only open the Pending prescription rather than opening the full patient record so you won't be able to put the next cycle in Pending this way.

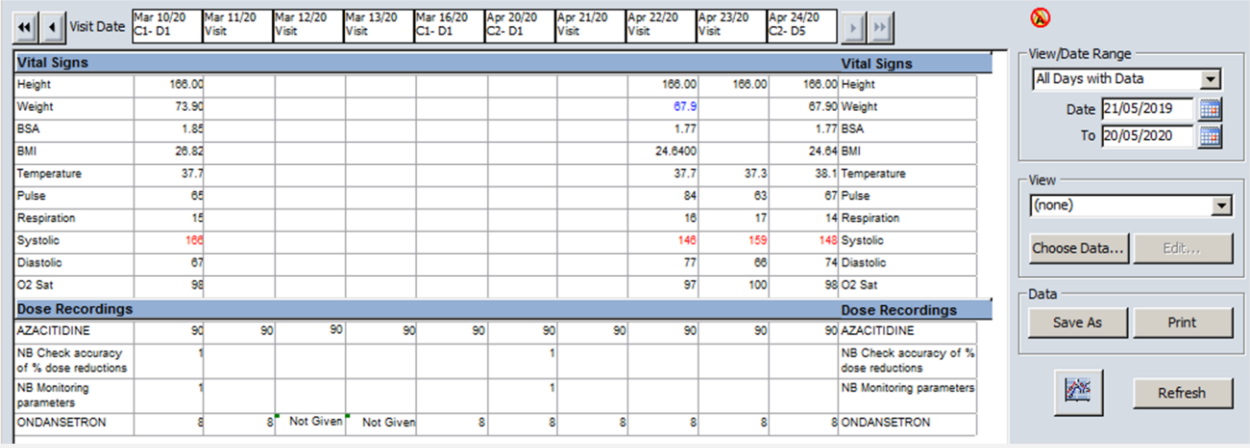


The prescription can then be reviewed and amended as required before approving. Once approved, remember to put the next cycle back into Pending under the consultant's name

SECTION 9:
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



Visit Date	Mar 10/20 C1- D1	Mar 11/20 Visit	Mar 12/20 Visit	Mar 13/20 Visit	Mar 16/20 C1- D1	Apr 20/20 C2- D1	Apr 21/20 Visit	Apr 22/20 Visit	Apr 23/20 Visit	Apr 24/20 C2- D5	
Vital Signs											**Vital Signs**
Height	166.00							166.00	166.00	166.00	Height
Weight	73.90							67.9		67.90	Weight
BSA	1.85							1.77		1.77	BSA
BMI	26.82							24.6400		24.64	BMI
Temperature	37.7							37.7	37.3	38.1	Temperature
Pulse	65							84	63	67	Pulse
Respiration	15							16	17	14	Respiration
Systolic	166							146	159	148	Systolic
Diastolic	67							77	66	74	Diastolic
O2 Sat	98							97	100	98	O2 Sat
Dose Recordings											**Dose Recordings**
AZACITIDINE	90	90	90	90	90	90	90	90	90	90	AZACITIDINE
NB Check accuracy of % dose reductions	1					1					NB Check accuracy of % dose reductions
NB Monitoring parameters	1					1					NB Monitoring parameters
ONDANSETRON	8	8	Not Given	Not Given	8	8	8	8	8	8	ONDANSETRON

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.

Neutrophils (Gran)				
Result	Unit		Date Collected	Normals
1.1	10^9/L	L	Jun 15 2015 09:30:55	(1.8/7.8)
1.5	10^9/L	L	Jun 15 2015 09:27:05	(1.8/7.8)
1.5	10^9/L	L	Jun 15 2015 09:25:29	(1.8/7.8)

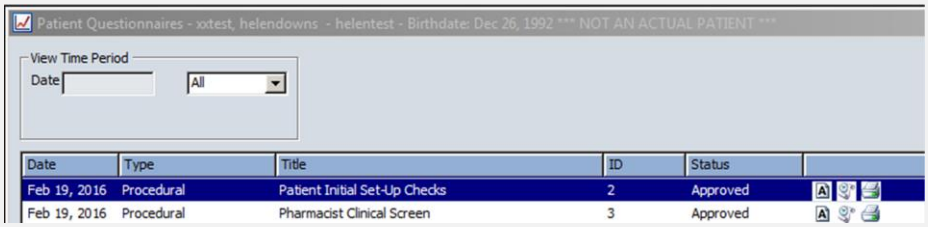
SECTION 8:
ARIA DOCUMENTATION

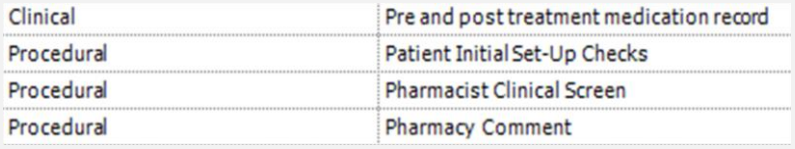
QUESTIONNAIRES
Assessments → Questionnaires

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

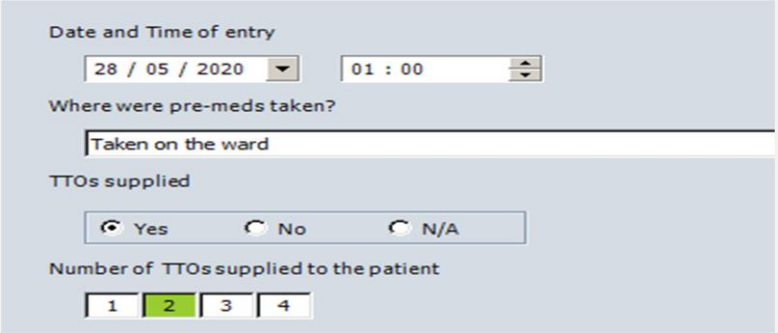
Highlight the required questionnaire then select **View** to open or **Error** to delete it. To start a new questionnaire, select **New**, select a questionnaire from the list then **OK** to open.

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



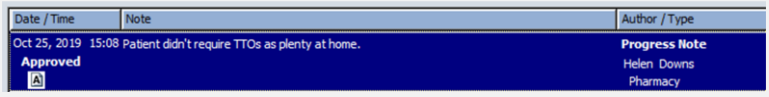


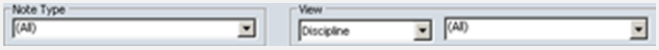
Complete the questionnaire as appropriate then select **Approve** to complete or **OK** to save part-completed details to return to later.



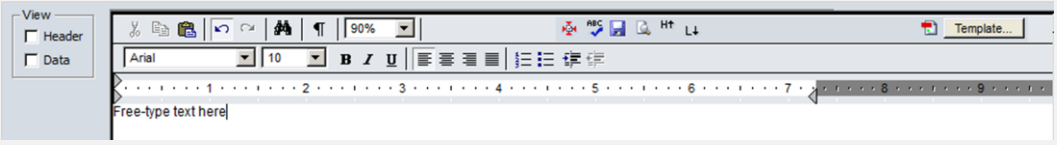
NOTES

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.





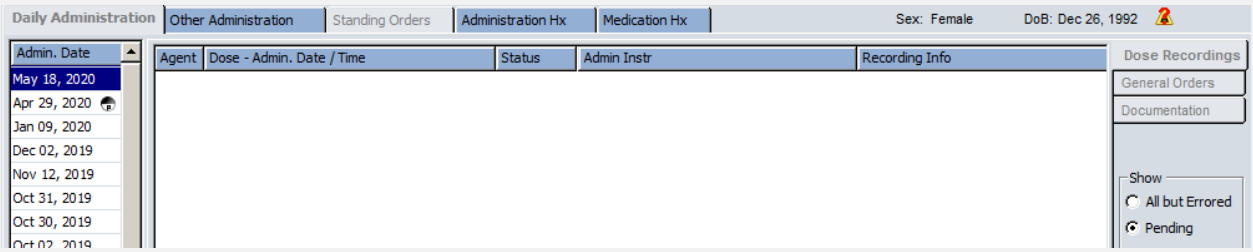
Use the filters at the bottom of the screen to show by note type and author type



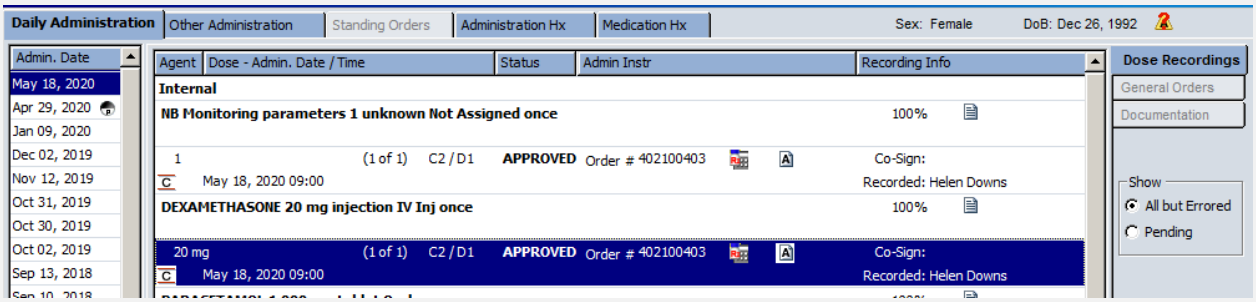
SECTION 9:
REVERSE FUNCTIONS

DRUG ADMINISTRATION – DOSE RECORDING – ERROR

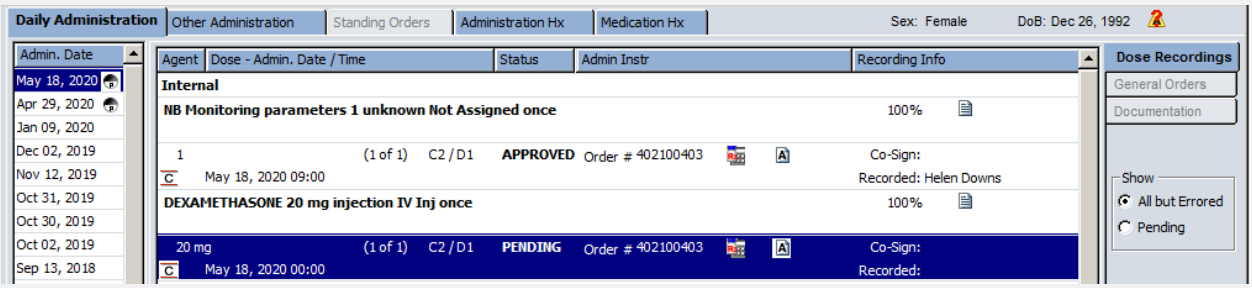
On the Daily administration tab, drugs whose dose recordings have been completed will not be listed and if all the internal drugs have been administered, the whole panel will be empty. To recall the drugs, check the '**All but errored'** radio button on the right.



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

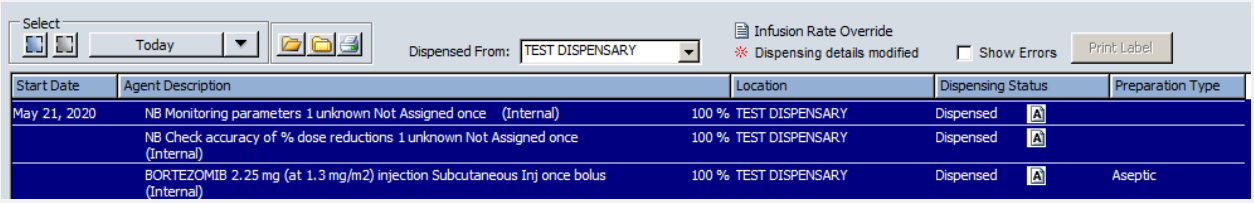


Enter a reason for erroring the dose recording when prompted and **OK** to complete. The dose recording entry will now return to a **Pending** state



ORDERS/RX - UNDISPENSE A PRESCRIPTION

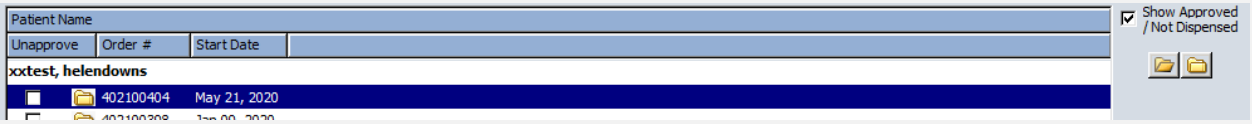
Highlight the order to be undispensed by clicking on it once then select '**Dispense'**. Select each drug individually or use the blue box to select all and the grey box to de-select all then select **Error**.



Select **OK** on the next screen then a reason into the pop-up box and **OK** to complete

ORDERS/RX – UNAPPROVE A PRESCRIPTION (PHARMACY)

Highlight the order to be unapproved by clicking on it once then select **Approve**. Select to '**Show Approved / Not dispensed'** in the top right of the window. Click on the folder symbol on the order to show further details if needed. Tick the box next to the order you wish to unapproved then select '**Unapprove'**



The status of the order will return to **APPROVED** by the precriber.